Zimbabwe

Operational Plan Report

FY 2010

Operating Unit Overview

OU Executive Summary

Overview
The PEPFAR program is a key element in the evolving USG "humanitarian-plus" program in Zimbabwe, and fully supports Zimbabwe's own National AIDS Strategic Plan (ZNASP). Zimbabwe's Ministry of Health and Child Welfare (MOHCW) provides overall country leadership for the national HIV and AIDS response within the framework of the ZNASP. As a consequence of President Obama's pledge of additional support to Zimbabwe, increased PEPFAR funding is being programmed in close collaboration with MOHCW and other Zimbabwean governmental and non-governmental partners. The working assumption is that given the massive deterioration in public health systems in Zimbabwe, USG assistance must focus on immediate and short-term "gap filling" within a longer term systems strengthening approach that fosters Zimbabwean leadership and ownership and avoids creation of parallel donor-dependant systems.

Zimbabwe FY2009 Operational Context
Major political and economic developments continued to affect the PEPFAR program during FY 2009. From November to February, most public health facilities and schools – with the exception of some clinics providing care and treatment for People Living with AIDS (PLHA) - were closed due to lack of funds to pay staff. Inflation was estimated into the trillions of percent. Public utilities operated sporadically in major urban areas. The deterioration of services led to a widespread cholera epidemic affecting 100,000 and killing 4,200. At the peak of the crisis in January-February 2009 the international community was feeding almost 7 million individuals, or more than half of the estimated resident population. The USG and its PEPFAR partners continued to work as conditions permitted. In January, Zimbabwe adopted use of multiple foreign currencies (primarily the U.S. dollar, South African Rand and Botswana pula). Official "dollarization" saw an influx of foreign currency and the gradual stabilization of prices. In February, the three opposing political parties finally created an inclusive government which re-opened most health care facilities and schools. While the economy has begun to stabilize, basic infrastructure has so deteriorated that health services have not returned to even acceptable levels. More broadly, human rights and the rule of law are still not respected which is preventing full donor reengagement and private investment necessary for true recovery.

HIV Statistics
In spite of continuing decline in HIV prevalence, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence estimated at 13.7% as of 2009 (Zimbabwe National AIDS Estimates 2009). This rate is less than half of Zimbabwe's HIV prevalence peak in 1997 of 29.3%. The MOHCW believes that the epidemic in Zimbabwe is declining as a result of combined effects of behavior change in the population, prevention and treatment programs, and mortality. As of 2009, about 997,000 adults and 106,000 children are living with HIV and AIDS in Zimbabwe.

The Zimbabwe Demographic and Health Survey (ZDHS) 2005-2006 recorded that HIV prevalence is higher among women (21%) than men (15%), and prevalence among 15-19 year olds is twice as high among females (6.2%) than males (3.1%). HIV prevalence increases with age for both sexes, with rates being highest for females aged 15-30 years while for males it is highest from 35-44 years of age. Heterosexual contact remains the primary means of transmission for the epidemic.

As part of the national response to this burden, Zimbabwe's National Antiretroviral Therapy (ART) Program, started in 2004, provides comprehensive care and treatment services that address medical,

social, emotional, and economic needs of PLHA, and is a complement to prevention interventions. Currently, 134 public health sites (primarily central, provincial, district and mission hospitals) offer ART services. Out of an estimated 343,500 adults and 35,000 children needing treatment, as of September 2009, approximately 178,000 adults and children were on ART, including an estimated 10,000 in the private sector and over 7,800 supported by non-governmental organizations (NGO). Among children aged 0-14 years, there are an estimated 15,000 new infections annually and 9,400 AIDS-related deaths (Zimbabwe National AIDS Estimates 2009). All branches of the military service have ART programs, including a model program in the Air Force, with access for all levels of personnel. The Government of Zimbabwe goal is to provide 285,000 PLHA with ART by the end of 2010 and 340,000 by the end of 2011.

USG PEPFAR Team in Zimbabwe

The USG team in Zimbabwe comprises: the Executive Office, the US Department of Health and Human Services (HHS) Centers for Disease Control and Prevention (CDC); US Agency for International Development (USAID); US Department of Defense – Defense Attaché Office (DAO); and US Department of State – Public Affairs Section (PAS). DOD in Zimbabwe did not request PEPFAR funding in FY 2009 or FY 2010 due to the Zimbabwe Defense Force's well-documented participation in committing gross human rights violations to influence the outcome of Presidential and Parliamentary elections in Zimbabwe. The HHS National Institutes of Health (NIH) have headquarters funding for Zimbabwe but do not participate actively in PEPFAR planning or management at post. A new USG PEPFAR Coordinator will assume responsibilities in the first quarter of FY 2010.

USG Program Accomplishments to Date

Over the first five years of PEPFAR the USG has been a key partner in Zimbabwe's national HIV and AIDS response. Program results are particularly impressive considering the massive political, social, and economic changes underway in Zimbabwe during the same timeframe, and the reality of a PEPFAR "small country" budget of under $27 million/year from 2004-2008.

In the Prevention of Mother-to-Child Transmission (PMTCT) technical area, over the past five years the USG has provided leadership in development and roll-out of protocols that increase protection up to 70% for infants born to HIV+ mothers. The USG works through an international NGO that supports delivery of PMTCT services by three Zimbabwean NGOs at MOHCW clinics in over half of Zimbabwe's districts. In FY 2008 and FY 2009 this partnership reached over 15,000 HIV+ pregnant women with PMTCT services annually, representing about 30% of the total HIV+ pregnant women in Zimbabwe each year.

In response to the wealth of international data demonstrating the positive impact of male circumcision (MC) on HIV transmission, in FY 2009 a modest USG investment leveraged private funds to undertake advocacy, protocol development, and pilot efforts for MC in Zimbabwe. In FY 2010, USG PEPFAR funding will be used to scale up services at MOHCW and religious mission hospitals and NGO clinics to reach an estimated 25,000 men, up from about 700 in FY 2009.

In Sexual Prevention, USG and other prevention campaigns are credited as one of the factors contributing to the decrease in national prevalence between 2005 and 200. The USG works to decrease sexual transmission with an extensive network of Zimbabwean NGOs, faith-based organizations (FBOs), high schools and colleges, professional associations, and community-based groups. USG partners have undertaken ground-breaking research to identify multiple and concurrent partnerships as the lead driver of HIV transmission in Zimbabwe, and are undertaking carefully developed and targeted mass media and interpersonal communications campaigns to reach the most vulnerable populations. These campaigns now routinely reference PMTCT and client-initiated HIV and TB counseling and testing. Among many other achievements, USG partners' creative promotion of the "Care" female condom through beauty salons and barbershops has made Zimbabwe the highest consumer of female condoms in the world.

HIV Testing & Counseling is both a "gateway" to prevention – enabling people to know their HIV status

and act responsibly -- as well as a primary means of identifying candidates for HIV care and treatment. USG partners provide about 55% of all testing in Zimbabwe through an extensive NGO client-initiated testing and counseling (CITC) system involving static sites and outreach teams, and in FY 2009 reached about 5% of the resident adult population. In CY 2008, the USG provided significant support for training and roll-out of MOHCW provider-initiated counseling and testing (PITC) at public sector facilities. Because approximately 14% of candidates presenting for HIV testing are found to have TB, in FY 2010 the USG will launch provision of TB screening at CITC centers and intensify assistance for TB-HIV cross-referrals within PITC at national and provincial hospitals.

Key to the functioning of any health system, particularly ART programs, is the ability to ensure the smooth and safe flow of commodities in a timely manner. The impact of donor programs is fruitless unless PLHA clients are able to routinely access their ARV and opportunistic infection drugs when they need them. In Care and Treatment, the USG provides key staff for the MOHCW AIDS & TB Program and is the leader in strengthening MOHCW's supply chain management systems and commodity information systems for HIV/AIDS commodities. The commodities handled include: ARV drugs, PMTCT commodities, HIV rapid test kits, public sector family planning/reproductive health commodities, and related supplies. In FY 2009, the USG's $4 million investment in supply chain management systems leveraged and provided internal distribution for an additional $30 million in other donor commodities. USG non-PEPFAR funding is strengthening Zimbabwe's TB program at national and provincial levels, serving as an important wraparound to USG PEPFAR assistance in strengthening Zimbabwe's TB laboratory system.

Zimbabwe has an estimated 1 million - 1.3 million Orphans and Vulnerable Children (OVC). USG OVC programming under PEPFAR-1 served as the model for the $80 million multi-donor Program of Support, which reached 277,000 children in CY 2007-2008. Current USG OVC activities are assisting about 55,000 OVC, and developing national models for improving OVC access to education and health services and care of HIV+ OVCs.

Laboratories which can provide international standard analysis and quality services are the backbone of any health system. The USG is an important donor improving Zimbabwe's deteriorated Laboratory Infrastructure, providing significant systems strengthening at national and provincial levels through close collaboration with the MOHCW, the National Medical and Laboratory Council, and two strong Zimbabwean non-profit laboratory organizations. In FY 2010 USG partners will roll-out use of a new testing protocol to improve Zimbabwe's Blood Safety and launch NGO-operated mobile laboratories to shore up the weakened public sector lab system so essential to other prevention, care, and treatment activities.

Sound and reliable information is essential for planning and targeting responses. USG assistance is critical for Zimbabwe's Strategic Information systems. The USG was the lead donor and TA provider for the 2005-2006 ZDHS and will serve that same role in 2010-2011. The USG has historically been the lead TA provider for all Antenatal Care Surveys, including the 2009 survey.

The desperate state of the health system in Zimbabwe is well documented. Central to the decline is the lack of staff and the hiatus in training to maintain staff skills. USG support for Human Resources for Health supported in-service training of over 7,000 Zimbabwean's in FY 2009 in clinical and community-based prevention, care and treatment. The USG additionally supports two masters-level programs that graduated 15 students in FY 2009.

New Program Directions FY 2010 and Beyond

As stated above, the USG PEPFAR program in Zimbabwe contributes directly to Zimbabwe's own National AIDS Strategic Plan. Individual elements of the USG PEPFAR program are implemented in conjunction with and are monitored by national technical working groups convened by the AIDS and TB Unit of the MOHCW. The specific needs addressed by the USG program have been, and will continue to

be, identified in consultation with senior officials of the MOHCW and the National AIDS Council (NAC).

The USG PEPFAR Program works to build the capacity of Zimbabweans to lead initiatives to address HIV. Previous assistance helped to develop Zimbabwean capacity to assume ownership of both measures to better understand the epidemic and to drive mitigation responses. USG efforts have strategically supported pilot projects identified by the MOHCW as opportunities to improve the domestic response to HIV/AIDS. In response to requests by the MOHCW, the FY 2010 program includes several new initiatives that build upon USG-supported pilot efforts. These include scale-up of combined short-course therapy for pregnant HIV+ women and complementary early infant diagnosis and prophylaxis; scale up of male circumcision for males over 15 years of age; significant technical, training, and commodity assistance to rebuild the national laboratory systems; and human resources for health strengthening.

Under the new PEPFAR vision, the USG Zimbabwe team will continue to support MOHCW leadership in HIV/AIDS and health care provision and will focus on strengthening linkages among health systems components. As stated above, the working assumption is that given the massive deterioration in public health systems in Zimbabwe, USG assistance must focus on immediate and short-term “gap filling” within a longer term systems strengthening approach that fosters Zimbabwean leadership and ownership and avoids creation of parallel donor-dependant systems. In FY 2010-2011, the USG is supporting a new Demographic and Health Survey, followed by a full health Service Provision Assessment, to establish new baselines for the health status of the population, and the physical and human resource status of the health infrastructure that is to care for them. These two surveys will provide essential data to inform future collaborative decision-making on key areas of focus.

In the near term, the USG is placing particular attention on two key systemic linkages: commodity supply and logistics systems, and laboratory systems. For the first, the USG vision is to help the MOHCW expand the staffing and mandate of the small USG-supported Logistics Support Unit and have it report to the MOHCW Directorate of Pharmacy Services, thereby becoming the overall body for coordinating medicines and medical supply management in the public sector. There are currently several parallel supply systems for different commodities (HIV/AIDS, family planning, malaria, TB, etc.). The USG is working with the MOHCW, several parastatal organizations, and the donor community to harmonize these systems. The USG hopes that within five years the MOHCW will be leading and coordinating harmonized systems for greater efficiencies overall.

Similarly, Zimbabwe’s national laboratory system has been decimated by a decade of neglect, yet remains critical to work in prevention (PMTCT, blood safety, HIV testing and counseling); care (client hematological and other monitoring for opportunistic infections, including TB), and treatment (viral load monitoring). The USG is the primary donor on a 2009 National Laboratory Assessment to guide the MOHCW, various professional associations and boards, and the donor community in a coordinated effort to strengthen the national laboratory system and bring it in line with the 2008 Maputo Declaration on Strengthening Laboratory Systems. The USG will also continue to provide short-term support for necessary equipment and supplies as the system is rebuilt.

In addition to these “horizontal” linkages so critical to all other programs, the USG will continue its focus on selected key “vertical” systems that provide short-term results in prevention, care and treatment while developing longer-term skills and capacity to sustain such results over time. A key example is the USG support to PMTCT, which is covering about 36% of all health facilities in Zimbabwe and reaching over 30% of HIV+ pregnant women annually. USG support is provided through an international NGO that seconds personnel to the National PMTCT Unit in the MOHCW, and also delivers services in the field through three well-established Zimbabwean NGOs. This partnership has expanded services beyond prevention to include development and scale-up of new models of care and treatment for mother-infant pairs. The program relies heavily on the USG-supported commodity supply and logistics and laboratory

strengthening systems, creating synergies that yield efficiencies and effectiveness in service delivery.

The USG is working on other key linkages, including real-time information access (electronic, telephonic connectivity), supportive staff supervision and mentoring, data dissemination upward and downward, TB and HIV care referral mechanisms, training critical cadres to provide client-oriented care, and strategic leadership capabilities. USG programs and targeted technical assistance in FY 2010 and beyond will focus on solidifying national foundational MOHCW documents that all partners refer to – policies, strategic plans, monitoring and evaluation plans, training curricula, etc. The USG will build MOHCW systems to ensure accurate and timely data for decision-making, whether in human resources for health, laboratories, periodic surveillance, or other venues.

The FY 2010 proposed activities reflect regular and substantive consultation with the MOHCW, other donors, and a range of implementing partners. In 2010 the USG interagency team will develop a new five year Strategic Plan in close consultation with the MOHCW. The new Strategic Plan will use the foundation of many of the FY 2010 activities described below to continue to promote MOHCW sustainability as the public health leader in Zimbabwe.

FY 2010 Prevention Program

The USG prevention program is a well-balanced mix of evidence-based clinical and non-clinical strategies to reduce HIV transmission among vulnerable populations. The primary clinical approach is PMTCT, where the USG provides key personnel to the national directorate and significant technical assistance (TA) and training for roll-out of new regimens. In FY 2010, the USG will provide TA, training, and commodity support to 680 MOHCW PMTCT sites, achieving over 41% coverage of Zimbabwe's health facilities in 31 of its 60 districts, and reaching at least 25,000 women with different regimens. The USG will procure point of care rapid CD4 testing machines and related products and will facilitate delivery of drugs to support PMTCT nationwide using stocks provided by UNITAID (the UN sustainable drug financing facility), USG, and the Global Fund.

In close collaboration with the MOHCW, the USG will provide TA, training, kits, and required supplies to support roll-out of Zimbabwe's new male circumcision program in 4 sites in Harare, Mutare, Bulawayo, and Masvingo, the largest cities. The USG program expects to support the circumcision of 25,000 men in 2010. The USG is leveraging funds from the United Kingdom's Department for International Development (DFID) and the Global Fund to complement clinical aspects of the program with a mass media activity to increase awareness on the benefits of male circumcision as an HIV prevention intervention.

In 2010 the USG will enter a new arena of biomedical prevention, blood safety. The National Blood Service Zimbabwe (NBSZ) has a long history and has maintained a safe blood supply from the beginning of the HIV and AIDS pandemic. In 2007 the Service attained international standards certification for its head office in Harare and its Bulawayo Branch. Due to a combination of socio-economic crises, disappearance of the Zimbabwe dollar, excessive transport and material costs, and widespread school closings in 2008-2009, blood donations and overall blood supply decreased to dangerous levels and safe blood became too expensive for most Zimbabweans who needed it. In FY 2010 the USG will provide TA, training, and new laboratory technologies to institute new procedures to bring down costs and make blood affordable again to the majority of patients.

A primary "gateway" to HIV prevention is HIV testing and counseling, and in FY2010 the USG will support testing of 7% - 9% of Zimbabwe's estimated resident adult population. To attain this coverage, the USG will expand provision of client-initiated testing and counseling services to reach 280,000 adults >16 years and 2,000 children <16 years of age, and will support testing through antenatal care sites of 180,000 pregnant women, 10,000 of their partners, and 9,000 newborn infants. The USG is also providing HIV rapid test kits for approximately 60% of Zimbabwe's needs, and TA and logistics support for 100% of all test kits used nationwide.

To complement clinical approaches to prevention, the USG is supporting a comprehensive Sexual Prevention program that combines use of mass media and interpersonal communications approaches for behavior change with promotion of male and female condoms nationwide. This well-integrated program addresses Abstinence-Being faithful-Correct and consistent condom use (ABC) targeted at vulnerable population segments identified through prior year research. In FY 2010 the USG will continue to collaborate closely with MOHCW leadership in behavior change, and will increasingly target specific vulnerable population segments, especially mobile and vulnerable populations, university students, adherents to faiths that discourage open discussion of sexuality and/or promote unsafe practices such as girl-pledging and early marriages, and polygyny.

Through non-PEPFAR headquarters mechanisms, the USG contributes 100% of Zimbabwe's male and female condom supply needs. The USG supports distribution of male and female condoms through the public and private sectors. Of all male condoms distributed in FY 2009, 68% were through social marketing outlets and the remainder through public and commercial sector venues. Of all female condoms distributed in FY 2009, 60% were through social marketing outlets and the remainder through public sector venues.

FY 2010 Care & Treatment Program

The USG will provide ARV drugs for 59,000 adults in Zimbabwe, accounting for almost 23% of MOHCW's goal for adults on treatment in 2010 (59,000/260,000 adults), as well as complementary training and supportive supervision in adult and pediatric care and support.

The USG will continue to provide key staff for the MOHCW AIDS & TB Program and its supply chain management systems and commodity information systems for HIV/AIDS commodities. In FY 2010, this will include USG and other donor commodities valued at over $30 million, including ARV drugs, PMTCT commodities, HIV rapid test kits, public sector family planning/reproductive health commodities, and related supplies.

In FY 2010 USG partners will provide TA and training for scale-up of early infant diagnosis, pediatric ART; point of care CD4 testing for women in a PMTCT setting; and HIV testing of 9,000 newborns. Other USG funding will continue to strengthen Zimbabwe's TB program at national and provincial levels, serving as an important wraparound to USG PEPFAR assistance in strengthening Zimbabwe's TB laboratory system and TB and HIV testing, referrals and treatment at NGO and religious mission health networks. USG will also refurbish MOHCW clinics that treat opportunistic infections and TB to improve environmental infection control measures to decrease TB transmission among patients attending the clinics.

The USG will continue important care and support programs for almost 550,000 PLHA through several established NGO and faith-based organization networks and well as the MOHCW. In FY 2010, the USG will initiate support for new care initiatives with a religious mission health network and a university clinic.

In FY 2010 USG OVC activities will support improved quality of care for approximately 55,000 OVC in Harare and Matabeleland South province. The USG will continue to support development of national models for improving OVC access to education and health services, and care of HIV+ OVCs.

FY 2010 Cross-Cutting Systems Strengthening Programs

The USG's new vision for PEPFAR Zimbabwe is predicated upon filling short-term gaps within a longer term systems strengthening approach. In collaboration with the MOHCW, the USG has identified four priority systems for joint focus. These are the commodity supply and logistics systems summarized above; national laboratory infrastructure; strategic information and knowledge management; and human resources for health. The USG will continue to work with the MOHCW, the NAC, and university and Zimbabwean NGO parts to provide guidance and influence policy in these critical areas.

The USG will expand its support to Zimbabwe's national laboratory system, and will initiate the refurbishment of some district laboratories based on a USG-sponsored National Laboratory Assessment in October/November 2009. Procurement will include essential commodities, consumables and post-exposure prophylaxis materials to provide general lab services at district level. To complement the weak national system, the USG will set up two mobile laboratory units to reach out to HIV patients in remote areas where laboratories do not have the capacity to provide adequate diagnostic and monitoring services. The maximum capacity of each mobile laboratory unit is anticipated to be 10, 000 patients per year.

The USG will continue to assist MOHCW efforts in strategic information and knowledge management. With PEPFAR and other USG wraparound funds, the USG will be the lead donor for the Zimbabwe Demographic and Health Survey 2010-2011, an ART outcomes evaluation, an HIV drug resistance survey, and several other surveys that will inform Zimbabwe's national program. The USG will also continue to provide TA and training for operation of several information systems critical to the national commodity supply and logistics systems.

In FY 2010, the USG will initiate human resources for health (HRH) activities to develop a personnel database for a new human resources information system (HRIS) for the MOHCW. The USG will continue to support master's level training, with 14 graduates expected, and in-service training for over 7,000 clinical and community health care workers. The USG will additionally re-start a management training program for MOHCW provincial and district level staff. The area of HRH and associated health care financing are top priorities for the MOHCW. Accordingly, the USG team is developing new proposed activities in these areas that, should resources become available, would enormously support program sustainability in Zimbabwe.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV						
Adults 15-49 HIV Prevalence Rate						
Children 0-14 living with HIV						
Deaths due to HIV/AIDS						
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						

Estimated number of pregnant women in the last 12 months						
Estimated number of pregnant women living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS						
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with advanced HIV infection (in need of ART)						
Women 15+ living with HIV						

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

Redacted

Public-Private Partnership(s)

Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned	Private-Sector USD Planned	PPP Description

			Funds	Funds	
Coca Cola			0	100,000	Since 2001, PSI has been working with Coca-Cola to distribute condoms throughout Zimbabwe's rural areas. Coca-Cola's distribution system in Zimbabwe accesses a vast commercial network of outlets. Coca-Cola also contributed to PSI's safe water activities during the protracted cholera epidemic. While the partnership has suffered under Zimbabwe's current economic environment, both organizations are committed to reviving distribution activities in the near future.
Farm Community Trust of Zimbabwe			20,000	0	PSI maintains a partnership with Farming Community Trust of Zimbabwe to promote male and female condoms in resettlement areas.

Hair Salon Network			35,000	0	Hair Salon Network: PSI's network of over 1,500 hair salons provides a platform for hairdressers to educate potential consumers on correct use of female condoms as well as general discussions on risk perception and other HIV & AIDS messages.
Procter and Gamble			0	100,000	PSI worked with Procter & Gamble during the cholera epidemic to distribute PUR household water treatment product to thousands of households in Zimbabwe.

Surveillance and Survey Activities

Name	Type of Activity	Target Population	Stage
ANC Survey 2011	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Planning
ART Outcomes Evaluation	Evaluation	General Population, Men who have Sex with Men	Implementation
Baseline survey to establish current	Other	General Population	Data Review

knowledge of children's rights issues, especially those concerning OVC, by communities and children			
Behavioral Survey on current sexual reproductive health knowledge, attitudes, beliefs and practice among youth	Population-based Behavioral Surveys	Youth	Data Review
Cost effectiveness of PMTCT strategies	Evaluation of ANC and PMTCT transition	Pregnant Women	Data Review
Enumeration of children living and working on the streets	Population size estimates	Street Youth	Publishing
Evaluation of Home based Care in Harare	Evaluation	General Population	Data Review
Evaluation of PMTCT program focusing on infant feeding counseling	Evaluation	Pregnant Women	Implementation
Evaluation of using POC CD4 machines on identification/treatment of HIV+ women	Evaluation	Pregnant Women	Planning
Factors associated with non-utilization of ANC services by unbooked women in Chitungwiza	Evaluation	Pregnant Women	Development
HIV + women aware of HIV status prior to pregnancy	Evaluation	Pregnant Women	Data Review
HIV Drug Resistance Surveillance	HIV Drug Resistance	General Population	Implementation
MDR TB Survey	TB/HIV Co-Surveillance	General Population	Development
PMTCT Program evaluation	Evaluation	Pregnant Women	Data Review
Population-based survey on concurrent sexual relationships	Population-based Behavioral Surveys	General Population	Data Review
Qualitative study on perceptions and barriers to male circumcision	Qualitative Research	Mobile Populations, Youth	Planning
Qualitative study to improve communications on male circumcision	Qualitative Research	Youth	Planning
Reproductive health needs and behaviors	Evaluation	Pregnant Women	Implementation

of HIV + women on HART in Buhera			
Survey to profile status of OVC using the Child Status Index to measure access to services and assessing impact of interventions	Evaluation	Youth	Data Review
TB Program evaluation in Matebeleland North	Evaluation	General Population	Implementation
User fees study	Evaluation	General Population	Development
Violence against Children	Population-based Behavioral Surveys	Youth	Data Review

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHCS (State)	GAP	GHCS (State)	GHCS (USAID)	
HHS/CDC		6,670,000	6,255,000		**12,925,000**
HHS/HRSA			200,000		**200,000**
State/AF			200,000		**200,000**
USAID			17,675,000	16,500,000	**34,175,000**
Total	**0**	**6,670,000**	**24,330,000**	**16,500,000**	**47,500,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency					Total
	HHS/CDC	HHS/HRSA	State/AF	USAID	AllOther	
CIRC				2,883,000		**2,883,000**
HBHC	850,400	100,000		405,000		**1,355,400**
HKID				3,350,000		**3,350,000**
HLAB	1,330,000					**1,330,000**
HMBL	1,490,000					**1,490,000**
HTXD				5,625,000		**5,625,000**
HTXS	730,000			1,040,000		**1,770,000**
HVAB	397,500		70,000	1,134,000		**1,601,500**
HVCT				1,980,000		**1,980,000**
HVMS	4,310,000			2,204,000		**6,514,000**
HVOP	100,000		70,000	1,386,000		**1,556,000**
HVSI	1,125,000			1,490,000		**2,615,000**
HVTB	750,000			1,320,000		**2,070,000**
MTCT	100,000			4,419,000		**4,519,000**
OHSS	1,204,600		60,000	5,350,000		**6,614,600**
PDCS	200,000	100,000		669,000		**969,000**

PDTX	337,500			920,000		**1,257,500**
	12,925,000	**200,000**	**200,000**	**34,175,000**	**0**	**47,500,000**

Budgetary Requirements Worksheet

(No data provided.)

National Level Indicators

National Level Indicators and Targets

REDACTED

Policy Tracking Table

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Adult Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	1,355,400	
HTXS	1,770,000	
Total Technical Area Planned Funding:	**3,125,400**	**0**

Summary:
Zimbabwe FY2009 Operational Context Major political and economic developments continued to affect the PEPFAR program during FY 2009. From November to February, most public health facilities and schools – with the exception of some OI and ART clinics - were closed due to lack of funds to pay staff. Inflation was estimated into the trillions of percent. Public utilities operated sporadically in major urban areas. The deterioration of services led to a widespread cholera epidemic affecting 100,000 and killing 4,200. At the peak of the crisis in January-February 2009 the international community was feeding almost 7 million individuals, or more than half of the estimated resident population. USG and its PEPFAR partners continued to work as conditions permitted. In January, Zimbabwe adopted use of multiple foreign currencies (primarily the U.S. dollar, South African Rand and Botswana pula). Official “dollarization” saw an influx of foreign currency and the gradual stabilization of prices. In February, the three opposing political parties finally created an inclusive government which re-opened most health care facilities and schools. While the economy has begun to stabilize, basic infrastructure has so deteriorated that health services have not returned to even acceptable levels. More broadly, human rights and the rule of law are still not respected which is preventing full donor reengagement and private investment necessary for true recovery.Adult Care and Treatment Program Context & BackgroundIn spite of a decline in HIV prevalence between 2001 and 2009, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence estimated at 13.7% (Zimbabwe National HIV/AIDS Estimates 2009). About 1.1 million adults and children are currently living with HIV and AIDS in Zimbabwe. Heterosexual contact remains the primary means of transmission for the epidemic. As part of the national response to this burden, Zimbabwe’s National ART Program, started in 2004, provides comprehensive care and treatment services that address medical, social, emotional, and economic needs of People Living with HIV/AIDS (PLHA), and is a complement to prevention interventions. Currently, 134 public health sites (primarily central, provincial, district and mission hospitals) offer ARV services. Out of an estimated 343,500 PLHA needing treatment, as of September 2009, approximately 178,000 adults and children were on ART, including an estimated 10,000 in the private sector and 7,800 NGO supported. As of September 2009, 11,020 children were receiving ART. Among children aged 0-14 years, there are an estimated 15,000 new infections annually and 9,400 AIDS-related deaths (Zimbabwe National HIV/AIDS Estimates 2009). All branches of the military service have ART programs, including a model program in the Air Force, with access for all levels of personnel. The Government of Zimbabwe goal is to provide 285,000 PLHA with ART by the end of 2010 and 340,000 by the end of 2011. Zimbabwe’s palliative care package includes psychosocial support, nutritional counseling and support, positive prevention counseling, information on positive living, treatment for opportunistic infections (OI), Cotrimoxazole prophylaxis, bereavement counseling, spiritual counseling, succession planning, hospice care, and PLHA groups. Over the past several years, access to and quality of both non-clinical and clinical palliative care services have

improved significantly. Non-clinical community-based care and support is provided through PLHA support groups, faith-based networks, NGOs, and numerous other organizations throughout the country, under the guidance of the National AIDS Council (NAC). Recently, in the 2009 ANC Survey report, the MOHCW highlighted Prevention with Positives (PwP), including increasing advocacy and treatment literacy campaigns, as a key strategy in the national response against HIV and AIDS. The OI Clinic Model, developed by MOHCW with U SG support, serves as the basis for comprehensive clinical HIV service delivery and transition to the ART program. Currently, 536 OI clinics at MOHCW and mission hospital sites are operational, vastly exceeding earlier national targets (140 for 2009). In FY09 these sites provided Cotrimoxazole for OI to 342,599 adults and 45,692 children, up significantly from FY08. The Pfizer Diflucan donation program to Zimbabwe is now in its sixth year of operation, and as of July 2009, had provided 26,978 patients Diflucan at 134 OI sites. Lack of financial resources, inadequate human resource capacity at all levels and inadequate laboratory services to support ART and pre-ART patient counseling and monitoring have been the main factors limiting Zimbabwe's PLHA care and treatment program expansion. USG ProgramUSG's care and treatment program is of a scale appropriate to a PEPFAR small country program and does not include widespread provision of USG-direct clinical care and treatment services. USG continues to provide technical assistance (TA), seconded staff, advocacy, and program support to the MOHCW and other partners to strengthen systems for care and treatment of PLHA, including PwP. The USG also provides capacity building (primarily training and TA) so that systems can be sustained over time. Achievements since last COPIn FY09, USG funds for Adult Care & Treatment were provided to: the Supply Chain Management Systems (SCMS) mechanism to support staff and provide long-term TA to the national ART program; the University of Zimbabwe's Clinical Epidemiological Resource and Training Center's HIV/AIDS Quality of Care Initiative (HAQOCI) to develop and provide pre- and in-service training in OI/ART for clinical staff; the bilateral Partnership Project and two NGOs, Africare and The Center, for provision of non-clinical care, support, and treatment of PLHA. Planned funding to the NAC to support the roll-out of the national community home-based care program, and to MOHCW for in-service training and supervision, was frozen until the GOZ meets established political conditions for resumption of bilateral aid.At the national level, in FY09, SCMS seconded two medical officer positions to the MOHCW Naitonal AIDS and TB Unit: the National ART Coordinator and the Assistant National ART Coordinator. SCMS also collaborated with its main MOHCW counterparts and USG's lead PMTCT partner, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), to train logistics system team leaders from three provinces to incorporate requirements of the new PMTCT short-course combined therapy into logistics systems operations in Zimbabwe. To strengthen service delivery systems, the USG supported HAQOCI for coordination and implementation of national and regional OI/ART adult training workshops, and training-of-trainers on OI/ART management, covering an estimated 1,000 professionals during FY09.The USG Partnership Project supports an NGO New Life network throughout the country that provides psychosocial, spiritual and preventive support and PwP services to PLHA through post-test support centers that are staffed with professional and PLHA peer counselors. Services are provided at both the New Life centers and through an extensive outreach program whereby counselors provide palliative care services at public health care institutions in collaboration with public sector personnel. From FY06-FY10, the USG supported expansion of the New Life network from 10 to 16 sites, reaching a cumulative total of approximately 236,000 individuals with care and support according to national and international standards. The project also trained about 650 individuals in HIV-related care and supportive counseling. Two NGOs, Africare and The Centre, began adult care programs with PEPFAR in FY09. Africare works with the Evangelical Fellowship of Zimbabwe (EFZ) and Methodist Development and Relief Agency in three provinces -- Manicaland, Harare and Bulawayo. As of June 2009, Africare and its FBO part ners had reached 4,000 PLHA with palliative, PwP, and psychosocial support. The Centre undertakes capacity building for AIDS service organizations and PLHA support groups. In 2009 it initiated partnerships with local NGOs – primarily women's groups -- in Mashonaland East, Midlands, Matebeleland North, and Masvingo. Goals and strategies for the coming yearIn FY10, at the national level, SCMS will continue to second two medical officer positions to MOHCW AIDS & TB Program: the National ART Coordinator and the Assistant National ART Coordinator. The project's support will include funding of site readiness assessments and site supervision aimed at enhancing the

MOHCW's ART scale-up activities, the national quality of care initiative, and decentralization of ARV treatment. If USG policy permits direct disbursements to the GOZ, the MOHCW will revise the existing site assessment tool (in consultation with SCMS and other key partners) for the provision of OI/ART services to ensure its comprehensiveness. Funds permitting, the MOHCW also plans to carry out an assessment of the implementation of OI/ART activities within the private sector to have a better picture of its contribution to the national program. USG will support an ART Clinical Outcomes survey examining clinical records from public and private providers to better understand how patients fare over time and to inform MOHCW policy and clinic management measures might be instituted to improve outcomes.EGPAF will support the introduction of point of care CD4 testing in PMTCT sites (machines to be procured by Clinton HIV/AIDS Initiative, or CHAI, and UNICEF) at medium/low volume PMTCT sites and ART initiation for eligible pregnant women at an initial 25 PMTCT sites. In addition, the program will strengthen linkages between high volume PMTCT sites and ART clinics using application of standardized referral forms to improve access to CD4 and ART. EGPAF will provide TA and support to the MOHCW national program for, inter alia, development of national protocols and tools including revision of national ART registers; updating national ARV guidelines; finalization of referral forms and national scale up of these to strengthen linkages between PMTCT, laboratory and OI/ART clinics; training of mother-child health staff on adult OI/ART management and on-the-job training of CD4; and scale up of the national mentorship pilot to improve ART delivery. Similarly, with FY10 funds, at the national level, a new mechanism will initiate the scaling up of OI/ART services in Zimbabwe's extensive church related hospitals/clinic network to sites with no existing OI/ART programWith FY09 Supplemental funds, HAQOCI will conduct site supervisory visits and clinical mentorship to 9 sites offering adult and pediatric services. With FY10 funds HAQOCI will conduct trainings for health care workers and in adult management of OI/ART and conduct site supervisory visits and clinical mentorship to 9 sites offering adult and pediatric services. The team will be able to work within the national mentorship plan to train mentors in the provincial sites who will in turn train mentors at the district and rural level to ensure that protocols and guidelines are understood and implemented as expected at site level. HAQOCI will also procure an additional 18,000 Home Based Care kits for national distribution by NAC to enhance the safe provision of home based care throughout the country. HAQOCI will also collaborate with NAC and other partners to conduct trainings of community volunteers in home base care. The African Institute of Biomedical Science and Technology (AiBST) will continue the training of private health professionals on OI/ART care and monitoring in the 10 provinces of Zimbabwe with a special focus on strengthening the confidence of health care workers in the clinical and laboratory monitoring to identify at early stage patients failing the first line regimen. AiBST will establish and operate mobile laboratory services covering the 10 province s of Zimbabwe that will provide Rapid HIV testing, CD4, Viral loads, HIV DR tests, chemistry and hematological tests, for monitoring of patients on ART. The mobile lab will provide additional diagnostics services including TB and malaria, and will ship samples for HIV/TB drug resistance testing to AiBST laboratories in Harare where Real Time - PCR and direct sequencing will be used to genotype for known drug resistance mutations. In FY10 in total, AiBST expects to serve 17,000 patients through the mobile labs. USG's new laboratory quality assurance partner will undertake procurement of CD4, biochemistry and hematology reagents for HIV monitoring of patients on ART to ensure equitable, uninterrupted provision of laboratory services in support of the National ART program.FY10 is the last year of the 5 year Partnership Project. The project will continue to support the New Life site-based and outreach work and, as described in the HVTB narrative, expand services to include TB screening to all clients accessing New Life services to PLHA who have not been previously tested. In anticipation of the end of the Partnership Project, in early FY10 USG is undertaking a solicitation for a follow-on Strengthening Private Sector Services for Health (SPSS) Project. SPSS is expected to begin in mid-2010, thus providing some overlap to assure continuity of key services when Partnership ends on September 30, 2010. SPSS will build on the successes of Partnership and continue to provide care and support to about 140,000 new clients and 270,000 continuing clients. The new project will expand community outreach services for PLHAs and add home-based care support services to community-based operations supported by the NGO New Life network. If USG policy permits direct disbursements to the GOZ in FY10, NAC will provide training to HBC task forces in all provinces, conduct supervisory visits to provinces and districts and disseminate at the same time the new HBC policy,

strategy and standards developed in FY09. REDACTED. Wraparounds/LeveragingUSG support to Adult Care and Treatment leverages significant funding for all public sector ART, PMTCT, and HIV testing sites in the country. For ART commodities alone, as described in the ARV Drugs (HTXD) program area narrative, this donor support has a combined wraparound value of about $30 million in FY09. USG is also leveraging DFID funds to complement palliative care efforts. Approximately $1,450,000 was allocated in FY09 to support program activities of the New Life post-test support services program, including staff salaries, training costs of counselors and other staff, M&E activities and furniture and equipment for the New Life centers, and similar funds are expected in FY10

Technical Area: ARV Drugs

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	5,625,000	
Total Technical Area Planned Funding:	**5,625,000**	**0**

Summary:
Zimbabwe FY2009 Operational Context Major political and economic developments continued to affect the PEPFAR program during FY 2009. From November to February, most public health facilities and schools – with the exception of some OI and ART clinics - were closed due to lack of funds to pay staff. Inflation was estimated into the trillions of percent. Public utilities operated sporadically in major urban areas. The deterioration of services led to a widespread cholera epidemic affecting 100,000 and killing 4,200. At the peak of the crisis in January-February 2009 the international community was feeding almost 7 million individuals, or more than half of the estimated resident population. USG and its PEPFAR partners continued to work as conditions permitted. In January, Zimbabwe adopted use of multiple foreign currencies (primarily the U.S. dollar, South African Rand and Botswana pula). Official “dollarization” saw an influx of foreign currency and the gradual stabilization of prices. In February, the three opposing political parties finally created an inclusive government which re-opened most health care facilities and schools. While the economy has begun to stabilize, basic infrastructure has so deteriorated that health services have not returned to even acceptable levels. More broadly, human rights and the rule of law are still not respected which is preventing full donor reengagement and private investment necessary for true recovery.ARV Drugs Program Context & BackgroundIn spite of a decline in HIV prevalence between 2001 and 2009, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence estimated at 13.7% (Zimbabwe National HIV/AIDS Estimates 2009). About 1.1 million adults and children are currently living with HIV and AIDS in Zimbabwe. Heterosexual contact remains the primary means of transmission for the epidemic. As part of the national response to this burden, Zimbabwe’s National ART Program, started in 2004, provides comprehensive care and treatment services that address medical, social, emotional, and economic needs of People Living with HIV/AIDS (PLHA), and is a complement to prevention interventions. Currently, 134 public health sites (primarily central, provincial, district and mission hospitals) offer ARV services. Out of an estimated 343,500 adults and about 35,000 children needing treatment, in 2009, approximately 178,000 adults and children were on ART, including an estimated 10,000 in the private sector and over 7,800 NGO supported. As of September 2009, 11,020 children were receiving ART. Among children aged 0-14 years, there are an estimated 15,000 new infections annually and 9,400 AIDS-related deaths (Zimbabwe National HIV/AIDS Estimates 2009). All branches of the military service have ART programs, including a model program in the Air Force, with access for all levels of personnel. The Government of Zimbabwe goal is to provide 285,000 PLHA with ART by the end of 2010 and 340,000 by the end of 2011. Lack of financial resources, inadequate human resource capacity at all levels and inadequate laboratory services to support ART have been the main factors limiting ARV service expansion. Global Fund Round 1 (GF1) did not finance ARV drugs. The drugs were instead to be purchased by the GOZ, supplemented by ad hoc supplies from

donors. By late 2006, because of the rapidly devaluing Zimbabwe dollar, the GOZ was having serious difficulties in purchasing ARV drugs to maintain patients who had been started on ART. There was an imminent danger that 40,000 patients who had started on ART would have to discontinue because of lack of drugs. USG collaborated closely with the GF Country Coordinating Mechanism (CCM) and OGAC and in mid-2007 received a commitment from OGAC to provide ARV drugs for 40,000 existing patients. The 4,500 patients in the GF1 focus districts are among those covered. The first shipments arrived in early July 2007 and the 40,000 patients were assured of a continuous supply of life-saving medicines. Zimbabwe's GF Round 5 (GF5) foresees supporting 54,000 patients (2008) and 74,000 patients (2009) in 22 districts on ARVs and is regularly financing ARV drugs for those patients. However, in 2008 GF5 disbursements were slow due to problems with Zimbabwe's exchange rate mechanisms and other financial management factors. In October 2008, a GF Inspector General Audit was particularly damaging regarding GF procurement and accountability of ARVs, and the Principal Recipient responsibility was subsequently shifted to the UNDP. Zimbabwe's Expanded Support Program (ESP) supported about 48,000 patients in 2009 and plans to continue supporting the same number of patients in 2010. The ESP is led by the British Department for International Development (DFID) and includes participation of Canadian, Swedish, and Irish aid agencies. Thanks to the support from the three main donors (USG, GF, ESP), the Ministry of Health and Child Welfare (MOHCW) targets were achieved in 2008. ESP and GF funding, however, is focused on specific districts, while USG is able to fill gaps nationally. USG Program SummaryThe USG continues to undertake ARV procurement in order to "fill in the gaps" in the national ARV program. This approach is consonant with the PEPFAR Zimbabwe 5 Year Strategy. In addition technical assistance (TA) and training provided through the Supply Chain Management Systems (SCMS) mechanism will significantly strengthen national ARV delivery systems and build Zimbabwean capacity to continue the program when PEPFAR funding ceases. Accomplishments since last COPIn FY09 SCMS was able to continue more-or-less regular resupply of ART sites in spite of the severe operating environment. The highlight of the year came in the third quarter, when SCMS was able to resume overland (as opposed to air) shipments of ARVs. In May, a truck carrying nine tons of first line ARVs, representing two months of treatment for 40,000 patients, left SCMS Johannesburg Regional Distribution Center (RDC) and arrived 2 days later in Harare without incident. MOHCW and NatPharm, the parastatal storage agent for all MOHCW HIV & AIDS commodities, received the freight the following morning. Encouraged by the relative stabilization in Zimbabwe, SCMS opted to switch from air to road shipment, which represents a cost savings of 63% -- or $130,000 per year – on transportation costs between the RDC and NatPharm's central warehouse. In FY09, SCMS supported MOHCW to set up the Procurement and Logistics Sub-Committee (PLS) to present the most recent quantification updates and to coordinate procurement of all HIV-related medicines and rapid test kits among partner agencies. MOHCW has now fully assumed the leadership of this mechanism and is the driving force behind the main, monthly coordination meeting attended by all MOHCW units, NatPharm and partner agencies. The PLS oversaw updating of USG-donated ARV drugs and HIV rapid test kit supply plans were updated. Another highlight of FY09 was a request from a non-USG client in Zimbabwe to procure drugs. During the third quarter, WHO Zimbabwe placed a $130,000 emergency order of Zidovudine and Lamivudine/Zidovudine with the lead partner for SCMS, the US-based Partnership for Supply Chain Management (PfSCM). This is the first request to PfSCM from a non-USG client in Zimbabwe and will widen the perception among partners in country about the procurement options available to donor agencies locally. This will, more importantly, enable MOHCW and its partners, including the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), WHO and the Canadian International Development Agency (CIDA), to speed up the roll-out of the new PMTCT short-course combined therapy throughout the country.Goals and strategies for the coming yearWith FY09 supplemental funds, SCMS will purchase an additional $1,080,000 worth of ARVs to support treatment of an additional 19,000 adults (Stavudine) on standard first line regimens on a te mporary basis, to fill gaps caused by delays in GF funding and procurement. This will augment the USG base supply for 40,000 adults and result in USG providing for almost 23% of MOHCW's goal for adults on treatment in 2010 (59,000/260,000 adults).With FY2010 funds, SCMS will continue the provision of first-line ARVs (Stavudine) worth $4,000,000 for 40,000 adult patients treated in public sector health facilities. An additional $1,645,000 will be used to help MOHCW address temporary gaps in first line ARV funding

and avoid stock outs that could lead to treatment disruption. SCMS-supplied ARVs will provide 19% of ARVs toward the MOHCW's goal of 310,000 adults on treatment in 2011 (59,000/310,000). Achievement of these targets is also supported by the Government of Zimbabwe, Global Fund, ESP, the Clinton HIV/AIDS Initiative (CHAI), European Union (EU), UNITAID and other donors such as Direct Relief International and Axios/Abbot. To support these patients and in accordance with the MOHCW Guidelines for ARV Therapy in Zimbabwe, SCMS will procure the following medicines: Lamivudine/Stavudine/Nevirapine 150/30/200mg for patients on the standard first line regimen, Lamivudine/Stavudine 150/30mg and Efavirenz 600mg for first line patients with tuberculosis and Lamivudine-Zidovudine 150+300mg plus Nevirapine 200mg for pregnant women. All ARV procured by SCMS Zimbabwe are FDA tentatively approved generic products: d4t/3tc/nvp and d4t/3tc: Cipla and efv: Aurobindo.(Although the ARV logistic management and support is funded under the OHSS budget code, following COP Guidance it is described in detail herein below.)In FY 2010, SCMS will provide ongoing technical assistance and resource support to the MOHCW/AIDS & TB Logistics sub-unit (LSU). REDACTED. The LSU manages the supply chain for the national MOHCW ART program. The LSU, along with the Directorate of Pharmacy Services (DPS), chairs the Procurement and Logistics Sub-committee of the ART Partners Forum, a central body for donor and partner collaboration and communication. SCMS, through the LSU, will continue to provide the following:Product Selection: review national treatment guidelines, offer logistics considerations of choosing products, and work to minimize pack size proliferationQuantification/Forecasting /Supply Planning: lead and manage quarterly updates of quantifications for Adult and Pediatrics ARV drugs fro treatment and PMTCT, HIV test kits, TB drugs, Cotrimoxazole, and Fluconazole. Procurement: prepare procurement plans for all USG funded products; assist other partners in the development of procurement plans; highlight supply gaps and mobilize resources to fill these gapsWarehousing: work with NatPharm to address any existing or potential storage challenges. In 2009, SCMS seconded a part-time project coordinator to NatPharm to assist with the ESP-funded purchase and installation of a racking system, a radiation heat barrier to preserve MOHCW ARVs, and a new roof. SCMS plans to provide the same level of support to Phase II of the refurbishment in FY2010.Distribution: support NatPharm with national bi-monthly distribution of ARV drugs and OI drugs, providing 3 delivery trucks, fuel and maintenance, drivers, and per diem. SCMS will also continue to assist the MOHCW in implementing an ordering and distribution system for rapid tests to ensure their availability to the public for roughly $500,000 per year, with an additional $500,000 in supplemental funding for PMTCT MER roll-out on the same system. As described in the PMTCT narrative, HIV rapid tests and PMTCT Nevirapine, followed by a pilot of the PMTCT MER, were added to the national "Delivery Team Topping Up" distribution system that serves mother-child health sites in 2009.Logistics Management Information System: continue to support operation and maintenance of the L ogistics Management Information System (LMIS), Zimbabwe Information System for HIVAIDS Commodities (ZISHAC), managed by the MOHCW/AIDS & TB's Logistics Sub-Unit. The system captures patient data, consumption, stock on hand and losses and adjustment data, all used for informed quantification, storage and distribution decision-making. In addition to ZISHAC, SCMS plans to support an expanded version of the ARV stock audit of USG-funded ARVs, completed at the central level in FY09. The expanded audit will include ARVs funded by all donors and managed by the MOHCW system and cover central level and ART site level on a sample basis.Capacity Building: provide system-specific training on logistics for ART sites as necessitated by addition of new sites and personnel attrition, as well as trainings to personnel in associated delivery systems like the DTTU. SCMS will also work with EGPAF to transition from Nevirapine to MER for PMTCT. With UNITAID providing funding for MER drug procurement, SCMS will assist the MOHCW and Zimbabwe National Family Planning Council to fully roll out MER distribution on the DTTU. REDACTED. Wraparounds/LeveragingSCMS provides technical assistance and support to the LSU that is responsible for managing the HIV/AIDS commodities supply chain that serves all public sector ART, PMTCT, and HIV testing sites in the country. The LSU also coordinates (but does not procure) the various sources of donor support for commodities. The LSU manages drugs and commodities from CHAI, Global Fund, EU, UNICEF, UNITAID, UNFPA, other donors. In FY09, the value of commodities managed by LSU was $30,619,770 (ARVs: $ 24,632,550; OI Drugs: $4,860,314) HIV Rapid Test Kits: $1,126,906). (Note: The US dollar values provided are estimates, based on actual shipments in 2008-2009, weighted

by targets. Unit costs by patients should not be compared since arrays of commodities supplied by each donor are not comparable.)

Technical Area: Biomedical Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	2,883,000	
HMBL	1,490,000	
Total Technical Area Planned Funding:	**4,373,000**	**0**

Summary:
Zimbabwe FY2009 Operational ContextMajor political and economic developments continued to affect the PEPFAR program during FY 2009. From November to February, most public health facilities and schools – with the exception of some OI and ART clinics - were closed due to lack of funds to pay staff. Inflation was estimated into the trillions of percent. Public utilities operated sporadically in major urban areas. The deterioration of services led to a widespread cholera epidemic affecting 100,000 and killing 4,200. At the peak of the crisis in January-February 2009 the international community was feeding almost 7 million individuals, or more than half of the estimated resident population. USG and its PEPFAR partners continued to work as conditions permitted. In January, Zimbabwe adopted use of multiple foreign currencies (primarily the U.S. dollar, South African Rand and Botswana pula). Official “dollarization” saw an influx of foreign currency and the gradual stabilization of prices. In February, the three opposing political parties finally created an inclusive government which re-opened most health care facilities and schools. While the economy has begun to stabilize, basic infrastructure has so deteriorated that health services have not returned to even acceptable levels. More broadly, human rights and the rule of law are still not respected which is preventing full donor reengagement and private investment necessary for true recovery.Biomedical Prevention Program Context & BackgroundIn spite of a decline in HIV prevalence between 2001 and 2009, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence estimated at 13.7% (Zimbabwe National HIV/AIDS Estimates 2009). About 1.1 million adults and children are currently living with HIV and AIDS in Zimbabwe. Heterosexual contact remains the primary means of transmission for the epidemic. Given the characteristics of Zimbabwe’s epidemic, USG PEPFAR Zimbabwe’s original 5 Year Strategy did not include a focus on Biomedical Prevention. Based on more recent international research, USG dialogue, and increased Ministry of Health and Child Welfare (MOHCW) interest in the benefits of Male Circumcision (MC) for HIV prevention, in FY09 USG provided a modest US$100,000 in PEPFAR funds to leverage private grant funding for an MC pilot in Zimbabwe. As described below, this small investment helped nurture the roll out of an MC pilot program, with national scale up starting in FY10. MC is likely to be key area of investment for PEPFAR Zimbabwe for several years to come. Given Zimbabwe’s economic and social crisis in the past year, and the availability of increased PEPFAR funding, in mid-2009 USG Zimbabwe re-evaluated needs and opportunities for activities in other areas of Biomedical Prevention. Though data are scant, UNAIDS estimates that <1% of HIV transmission in Zimbabwe is related to injecting drug users (IDU), and data on and experience with non-injecting drug users are minimal. The team thus decided to continue to address IDU and non-IDU through its Sexual Prevention programming. In terms of Injection Safety, data available to the team suggest that use and waste management of disposable sharps remains within acceptable ranges, and that USG and other donor programs are addressing supply within sub-sector programs. The team found, however, that although Zimbabwe’s blood supply remains safe, patient access to safe blood has deteriorated badly during the crisis. Following consultations with the Ministry of Health and Child Welfare (MOHCW), the team decided to invest some of the new resources into improving access to Safe Blood. Blood Safety Program Context & BackgroundThe National Blood Service Zimbabwe (NBSZ) has a

long history and has maintained a safe blood supply since the beginning of the HIV and AIDS pandemic. In 2007 the Service attained ISO9001-2000 certification for its head office in Harare and its Bulawa yo Branch. There are three other branches in Mutare, Gweru and Masvingo. The service relies on donated blood, with approximately 72% coming from secondary and tertiary schools from youth aged 16-20. Due to educational closings and increased costs of transport, maintenance, and supplies, donations have been cut almost in half in the past decade, from a high of almost 90,000 units in 1998 to 48,916 units in 2008. Overall blood supply decreased from 8.3/1000 in the 1990s to 4.2/1000 in 2005 and 1/1000 in 2008. The estimated window period risk in 2008 for HIV was 11 units per 100,000 donations, up from 7 units per 100,000 in 2007. The NBSZ obtains most of its income through the sales of donated blood, of which more than 70% goes to public hospitals based on pre-determined rates, and 30% is sold to the private sector. Prior to the crisis, the MOHCW provided a monthly grant to the Service to partially offset the costs of blood collection and testing. These monthly grants subsidized the cost of the blood to patients at public sector hospitals. Due to the hyperinflation of 2008-09, the value of the subsidy decreased to virtually zero and blood became expensive to all. In an effort to increase its sustainability, NBSZ established the National Blood Service Trust in 2007 to raise funds to serve as a safety net in times of need. During 2008-2009 the Trust's assets were rendered valueless because of the devaluation of the Zimbabwe dollar. In spite of both the loss of the Trust and the MOHCW grants due to hyperinflation, the NBSZ was able to maintain some level of services throughout the crisis. The Expanded Support Program (ESP), funded by Irish Aid, the Canadian International Development Agency, and the European Union, provided test kits and blood bags, and Zimbabwe's private sector continued to donate blood donor awards and support (soft drinks, biscuits) through most of the crisis. During the worst months of the crisis when the NBSZ could not afford to pay its staff, the Swiss Red Cross, a long-standing NBSZ partner, sent food baskets in from South Africa to enable NBSZ staff and their families to survive. The ESP is providing the NBSZ with new vehicles in 2009 and will continue to provide modest funding for consumables, while the Zimbabwean private sector is maintaining the commitment to provide blood donor support. Schools have reopened and it is likely that the Service will find an increase in willing blood donors in the last half of 2009. However, the cost of blood to patients has yet to find equilibrium in the "dollarized" environment, and access remains beyond the reach of many who need it. In an effort to cut costs, patients are increasingly requesting that doctors take blood from relatives who may or may not be good matches and have healthy blood. The USG has agreed to work with the NBSZ, MOHCW, and an NGO laboratory partner to institute new procedures to bring down costs and make blood safe and affordable again to the majority of patients. Blood Safety Accomplishments since last COP (no prior year program)Blood Safety Goals & Strategies for the Coming YearIn FY10, USG will collaborate with its existing laboratory and clinical training partner, the African Institute of Biomedical Science and Technology (AiBST) to provide technical and commodity assistance and quality assurance for the new PEPFAR blood safety program. AiBST is a non-profit pan-African biomedical initiative that aims to promote the sciences and technologies of drug discovery and development on the continent. AiBST will work closely with the NBSZ, MOHCW, and USG to define a mutually agreed workplan for the new blood safety program. The basic objective of the program is to introduce use of Nucleic Amplification Testing (NAT) for routine blood donation testing in Zimbabwe. The introduction of NAT testing on routine blood donation is expected to improve the effectiveness and efficiency of ZBSZ laboratory services by decreasing the processing time from 5 hours to 1.5 hours and doubling the number of samples from 40 to 80 per 96 microtiter or well plate (a flat plate with multiple depressions, or wells, that are used as small test tubes). Use of NAT will also reduce the cost of doing the tests, which will both reduce the cost to patients and make the NBSZ more efficient and sustainable.With FY09 Supplemental funds, AiBST will assist NBSZ to acquire NAT testing technology through the procurement of one real time polymerase chain reaction (RT-PCR) machine that will double the number of units screened at the main branch in Harare. Use of NAT and the RT-PCT machine will reduce the window period for detecting HIV from 22 to 11 days, detection of Hepatitis C Virus (HCV) from 82 to 23 days and detection of Hepatitis B Virus (HBV) from 59 to 34 days. AiBST will also assist NBSZ in procurement of accessory equipment to implement the new technology; training of laboratory scientists on management of the new equipment; revision of Standard Operating Procedures (SOP) for the new testing technology; and will provide external quality assurance. In FY10, AiBST will continue to provide

operational support services to the NBSZ as it scales up the screening of blood. The majority of the resources will be used to bring down the cost of blood to the final users through major support for procurement of test kits and implementation of other activities to contribute to this goal. Technical Blood Safety Priorities to be Addressed The Zimbabwe Blood Safety program addresses two PEPFAR key technical priorities: laboratory processes – through introduction of NAT and related quality assurance measures -- and sustainability, through improving NBSZ's efficiency. Male Circumcision Program Context & BackgroundExcept for minor ethnic groups like the Tonga, Chewa, Tshangan and small Moslem communities, traditional male circumcision is generally not practiced in Zimbabwe. The 2005-06 Zimbabwe Demographic and Health Survey (ZDHS) found a total of 10.5% of all men interviewed reporting that they had been circumcised, ranging from 5.3% in Mashonaland Central to 18.8% in Matabeleland North. Drawing from the ZDHS data, it is estimated that out of 2.5 million sexually active men above the age of 20 years, approximately 90%, or 2.25 Million are not circumcised.In 2007, in response to the wealth of international data demonstrating the efficacy of MC in HIV prevention, the Zimbabwe National AIDS Council (NAC) and the MOHCW hosted a national MC consultative meeting to obtain consensus on a national position regarding the integration of male circumcision into comprehensive HIV and AIDS programming within the Zimbabwean context and to initiate the development of a roadmap on MC and HIV prevention as guided by the national consensus. The meeting revealed a high level of interest and support by the MOHCW and NAC, UN agencies, NGOs and community groups for MC and resulted in development of a roadmap to rapidly scale up male circumcision. In 2008, the USG and UNFPA supported the Partnership Project – the USG's lead Prevention partner in Zimbabwe -- to undertake a rapid assessment of the feasibility (service availability mapping) and acceptability of MC. With USG funding, a Partnership consultant team also provided technical assistance on the development of the national MC policy. The information gathered through the different assessments was used to guide future Zimbabwe MC program implementation. Male Circumcision Accomplishments since last COPIn FY09 USG provided $100,000 in PEPFAR funding for Male Circumcision through the Partnership Project for an MC Coordinator (plus direct and indirect costs of the Partnership Project from other COP budget codes). This modest investment leveraged US$1.3 million from Population Services International (PSI) and $50,000 from UNFPA. The combined funding has resulted in successful advocacy, development of a national MC policy and protocols, establishment of a national training program and provision of training, development of MC operating guidelines and a procurement and supplies system for MC commodities, and launch of Zimbabwe's MC program in third quarter FY09. The program is now underway at 4 pilot sites and 1 national training center, in Harare, Mutare, Bulawayo, and Masvingo. The USG provides assistance to 4 of the 5 sites in the public and private sector: a mission hospital, a provincial hospital, the central hospital, and an NGO-operated facility. As of mid-September 2009, the new program had circumcised about 700 adult males,Male Circumcision Goals & Strategies for the Coming YearBuilding on the successful PSI/UNFPA/USG pilot, USG is allocating FY09 Supplemental funds to the final year of the Partnership Project to enable it to help scale up MC services in support of Zimbabwe's national MC strategy. Partnership will further increase the number of health care staff trained to provide safe MC services and the number of male clients benefitting from the intervention. The project is continuing to leverage the private funding from PSI and is receiving an additional $120,000 from DFID for scaling up MC services, and US$1 million from GF Round 8 (when approved) for mass media communication activities to increase awareness on the benefits of MC as HIV prevention intervention. The Partnership MC program will provide all necessary commodities, including disposable, cheap male circumcision kits, and will equip the MC sites with the necessary material and infrastructure to provide safe MC services. The main emphasis will be on integrating male circumcision services for HIV prevention into routine clinical care provided by public health facilities. Training and capacity building of health care staff in MC service delivery will also contribute to further strengthen the current health system. In anticipation of the end of the Partnership Project, in early FY10 USG is undertaking a solicitation for a follow-on Strengthening Private Sector Services for Health (SPSS) Project. SPSS is expected to begin in mid-2010, thus providing some overlap to assure continuity of key services when Partnership ends on September 30, 2010. SPSS will build on the successes of Partnership and will help Zimbabwe scale-up MC service delivery from pilot areas to the broader service delivery network,

integrating MC services within facilities that provide routine clinical care. The project also will build the capacity of health care providers to offer safe MC service delivery, expand the availability of MC services, and stimulate demand for MC through outreach efforts and health communications. In total, the USG-supported MC program expects to reach 25,000 males aged 15 and above with MC in FY10 and 70,000 in FY11.

Technical Area: Counseling and Testing

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	1,980,000	
Total Technical Area Planned Funding:	**1,980,000**	**0**

Summary:
Zimbabwe FY2009 Operational Context Major political and economic developments continued to affect the PEPFAR program during FY 2009. From November to February, most public health facilities and schools – with the exception of some OI and ART clinics - were closed due to lack of funds to pay staff. Inflation was estimated into the trillions of percent. Public utilities operated sporadically in major urban areas. The deterioration of services led to a widespread cholera epidemic affecting 100,000 and killing 4,200. At the peak of the crisis in January-February 2009 the international community was feeding almost 7 million individuals, or more than half of the estimated resident population. USG and its PEPFAR partners continued to work as conditions permitted. In January, Zimbabwe adopted use of multiple foreign currencies (primarily the U.S. dollar, South African Rand and Botswana pula). Official “dollarization” saw an influx of foreign currency and the gradual stabilization of prices. In February, the three opposing political parties finally created an inclusive government which re-opened most health care facilities and schools. While the economy has begun to stabilize, basic infrastructure has so deteriorated that health services have not returned to even acceptable levels. More broadly, human rights and the rule of law are still not respected which is preventing full donor reengagement and private investment necessary for true recovery.HVCT Program Context & BackgroundIn spite of a decline in HIV prevalence between 2001 and 2009, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence estimated at 13.7% (Zimbabwe National HIV/AIDS Estimates 2009). About 1.1 million adults and children are currently living with HIV and AIDS in Zimbabwe. Heterosexual contact remains the primary means of transmission for the epidemic. With USG and other donor assistance, Zimbabwe is working toward a national goal of universal testing for HIV by 2010. [The Ministry of Health and Child Welfare (MOHCW) acknowledges they will probably not reach this goal, and plans to re-evaluate and change the percentage and/or date during FY10.] The Zimbabwe Demographic and Health Survey (ZDHS) 2005-06 found that 21.7% of adult women and 16.4% of adult men had been tested and had received their results. In 2007, the USG-funded Partnership Project undertook a nationally representative population-based survey and found that uptake had increased significantly, to 32% of adults. While impressive, these data indicate that the country has a long way to go before reaching its goal. Counseling and testing (C&T) services in Zimbabwe are offered through standalone voluntary counseling and testing sites, C&T sites co-located within public health clinics and hospitals, and community-based outreach and mobile clinics. MOHCW also provides diagnostic testing at opportunistic infection clinics, PMTCT sites and other health facilities. Demand for C&T services is high and growing as provider-initiated testing and counseling (PITC), launched in 2006, is rolled out. As of September 2009, 1025 sites (980 public sector sites, 45 private sector sites) offer HIV counseling and testing in Zimbabwe. The MOHCW and the national Medical and Laboratory Council, with USG technical assistance and support, moved forward in FY09 toward shifting the national program from the current parallel rapid testing protocol to a serial testing protocol. The USG is funding a study to assess the best algorithm to be used for serial testing using pilot sites, three of the pilot sites being USG-supported New Start centers. The study started in June 2009 and

is likely to be finalized by September 2009.It is expected that policy guidance to introduce serial testing will be available by September or October 2009 with roll-out to start in CY2010.Summary USG C&T ProgramUSG's HIV C&T program follows the PEPFAR Zimbabwe 5 Year Strategy to implement PITC while also maintaining a core set of CITC centers in urban areas, with increased mobile outreach to rural and vulnerable populations. The USG's lead implementing partners for Counseling and Testing are the Partnership Project, a bilateral contract, and the central Supply Chain Management Systems (SCMS) mechanism. More modest testing is carried out within USG supported PMTCT, OVC, and Adult and Pediatric Care and Treatment programs.Over the period FY06-FY09, with USG and other donor funding, the Partnership Project counseled, tested, and provided results to almost 1 million individuals through 20 New Start C&T outlets (down to 19 in FY09) that provide counseling and testing according to national and international standards. When coupled with the half-million persons tested by pre-PEPFAR USG programs, this constituted about 55% of the total number of Zimbabweans tested for HIV in Zimbabwe. The Partnership Project is also the USG's lead implementing partner for sexual prevention and PLHA care and support activities - both of which have important linkages to C&T - and provides significant capacity building to local organizations. With other USG funds, Partnership is fostering family planning integration with C&T sites, post-test centers, and the national PMTCT program. The Partnership Project ends in fourth quarter FY10. USG plans to undertake a solicitation for a new mechanism that will cover, inter alia, a wide range of sexual prevention activities that will start in third quarter FY10, thus providing a smooth transition for key activities that merit continuation. Accomplishments since Last COPIn FY2008, SCMS procured approximately 60% of Zimbabwe's HIV rapid test kits for use in both public facilities and NGO-managed "stand-alone" sites. In FY09, other donors – notably the Global Fund -- have been able to fund the kit procurement, so SCMS shifted its support to procuring additional chase buffer. Health facility staff in Zimbabwe use more than one bottle of chase buffer to perform 100 HIV tests since, on average, one bottle serves only 35 tests and additional chase buffer bottles are needed to prevent stock outs. Chase buffer stock outs reached 9.8% in second quarter FY09, which is unusual as other test components were well under 5%. By the end of the year, with new stocks from SCMS, chase buffer levels were again below 5%. In FY09 SCMS worked with the MOHCW to set up a Procurement and Logistics sub-Committee (PLS) to present the most recent quantification updates and to coordinate procurement of all HIV-related medicines and rapid test kits among partner agencies. MOHCW has now fully assumed the leadership of this mechanism and is the driving force behind the monthly coordination meetings attended by all MOHCW units, NatPharm, and partner agencies. Despite the current challenging context and weakening in local communication systems, data generated by the SCMS-developed ZISHAC (Zimbabwe Information System for HIV/AIDS Commodities) is showing encouraging results and is supporting the work of the PLS. In third quarter FY09, monthly reporting rates varied between 73% and 93%, which provides good service statistics and logistics data for quantification and distribution purposes. Due to the serious communication challenges in Zimbabwe, on-time (less than 5 days after the end of the reporting period) reporting rates are lower; the MOHCW will keep monitoring this indicator and propose supportive measures that will allow treatment sites to expedite submission of orders and, possibly, review the reordering interval.In FY09, the Partnership Project-managed New Start HIV centers tested 250,510 adults (46.9% male, 53.1% female) between October 2008 and the end of June 2009. This figure represents approximately 4% of the total Zimbabwean adult population.Partnership carries out the C&T program through 19 static New Start centers and 23 outreach teams. (Down from 20 centers in FY2008 due to planned in tegration of two centers in Harare to increase program efficiencies.) As of the fourth quarter FY09, an average of 30,000 people was accessing C&T services through New Start, and demand for the C&T services was on the increase. Given this demand, in late FY09 Partnership's directly managed C&T sites in major urban areas expanded their opening schedule to include Sundays. In the third quarter of FY09, 59% of clients accessed services through mobile teams and16% of clients accessed the services as couples. The project achieved quarter-on-quarter increases during the year due to extensive expansion of outreach activities in new areas, especially the expansion of outreach C&T services to workplaces and vulnerable mobile population groups.During the third quarter FY09 South Africa lifted its visa requirements for Zimbabwean nationals, so the number of returned migrants passing the Beitbridge border decreased significantly. The project had planned to establish a satellite New Start

C&T site at the border post, but decided to put the plan on hold. Instead, the Bulawayo New Start C&T outreach team continues to provide C&T services on outreach basis to the International Organization for Migration (IOM) reception centre at the Beitbridge border. During FY09 the project continued to provide C&T services at workplaces in 44 (out of 60) districts. During the third quarter FY09, New Start outreach teams covered 168 workplaces (commercial farms, mines, prisons, businesses, including the transport sector) reaching 6,197 workers. All New Start sites intensified C&T outreach services to prisons and to border town officials. Partnership also explored the possibility of providing C&T services to Zimbabwe's uniformed services. Key personnel held meetings with the central office of the Zimbabwe Armed Forces, who showed interest in the services, but the project determined that the political environment is still not conducive to allow the outreach C&T teams to provide services at police and army camps. Between April and June 2009, the New Start program had referred 27,785 clients for post-test support services at Partnership "New Life" centers and health facilities, of which 12,467 (45%) could be tracked for having accessed the services. The program is working with partner facilities to improve its tracking abilities.With funds leveraged from Global Fund Round 5, Partnership pursued vigorous mass media campaigns for PITC as well as Treatment Literacy and TB/HIV co-infection. The project placed more focus on radio broadcasting than television in line with results from the Zimbabwe Advertising and Media Research Survey (ZAMPS) which showed high listenership figures compared to television viewership. Partnership identified local drama groups in designated Global Fund Round 5 districts and trained 195 drama group members (99 males and 96 females) to conduct drama and small group discussion on PITC. Food distribution points and community gatherings at schools, hospitals were the entry points for the IPC activities.Using wraparound USG Population funding and other donor support, the Partnership Project significantly increased the integration of family planning (FP) with HIV prevention during FY09. It developed training guidelines and presentations on FP/HIV with specific emphasis on dual protection, and trained counselors in both New Start and New Life (post-test) networks. The project also trained FP service providers. Additionally, Partnership trained all Bulawayo and Harare New Start C&T counselors in male circumcision counseling and referral. As a result HIV negative men at the New Start centers in Harare and Bulawayo are being referred for male circumcision at pilot sites.Goals and Strategies for the Coming YearWith FY09 supplemental funds, Partnership Project will maintain 4 directly managed C&T centers including eight outreach teams located in the major urban areas of Harare, Chitungwiza, Bulawayo and Masvingo as wel l as 15 local partner managed C&T sites. The four centers, two of which are serving as centers of excellence, along with their outreach services, are contributing to approximately 60% of clients tested for HIV through the program. The program has also been successful in increasing the proportion of men and women accessing C&T as a couple. The additional funds will be used to further increase couples C&T services at static sites in urban areas as well as in rural areas. Mobile outreach C&T services currently contribute 55% of the total number of monthly C&T clients and about 10% of the mobile C&T services are targeted at population groups in high risk areas such as workplaces, prisons, resettlement areas and to mobile, vulnerable population groups (MVP). Additional funds will be used to further expand mobile outreach services in order to reach these vulnerable and hard to reach population groups.The program expects to provide C&T services for a total of 489,500 adults >16 years and 10,000 children <16 years of age through CITC and PMTCT. Partnership will continue to monitor C&T performance using the current M&E tools. Quality of services will be monitored by Mystery Client surveys and quarterly supervisory visits of all C&T centers. In anticipation of the end of the Partnership Project, in early FY10 USG is undertaking a solicitation for a follow-on Strengthening Private Sector Services for Health (SPSS) Project. SPSS is expected to begin in mid-2010, thus providing some overlap to assure continuity of key services when Partnership ends on September 30, 2010. SPSS will build on the successes of Partnership and will increase both the number of VCT centers managed directly (under the New Start network), as well as those supported by other NGO organizations. Since community-outreach efforts now provide a larger portion of the total numbers accepting VCT, the project will expand community outreach activities and along with provider-initiated counseling and testing. In FY 2010, SCMS will continue to procure up to approximately $200,000 of HIV rapid tests (Determine, SD Bioline, and the INsti tie breaker rapid tests under the current parallel testing algorithm) to contribute to the achievement of the MOHCW targets (1,200,000 adults and children to be tested in CY2011) and will assist the

MOHCW in accurately quantifying HIV rapid test kit requirements. REDACTED. Wraparounds/Leveraging In FY10 USG will provide approximately $200,000 in test kits to complement other donor financing estimated at about $1 million. This will be complemented by provision of an estimated $6.6 Million from the United Kingdom Department for International Development for nationwide HIV testing and counseling services and TB screening of C&T clients, nationwide male and female condom distribution, and Behavior Change Communications.

Technical Area: Health Systems Strengthening

Budget Code	Budget Code Planned Amount	On Hold Amount
OHSS	6,614,600	
Total Technical Area Planned Funding:	**6,614,600**	**0**

Summary:
Zimbabwe FY2009 Operational Context Major political and economic developments continued to affect the PEPFAR program during FY 2009. From November to February, most public health facilities and schools – with the exception of some OI and ART clinics - were closed due to lack of funds to pay staff. Inflation was estimated into the trillions of percent. Public utilities operated sporadically in major urban areas. The deterioration of services led to a widespread cholera epidemic affecting 100,000 and killing 4,200. At the peak of the crisis in January-February 2009 the international community was feeding almost 7 million individuals, or more than half of the estimated resident population. USG and its PEPFAR partners continued to work as conditions permitted. In January, Zimbabwe adopted use of multiple foreign currencies (primarily the U.S. dollar, South African Rand and Botswana pula). Official “dollarization” saw an influx of foreign currency and the gradual stabilization of prices. In February, the three opposing political parties finally created an inclusive government which re-opened most health care facilities and schools. While the economy has begun to stabilize, basic infrastructure has so deteriorated that health services have not returned to even acceptable levels. More broadly, human rights and the rule of law are still not respected which is preventing full donor reengagement and private investment necessary for true recovery.OHSS Program ContextIn the past decade, the health care workforce in Zimbabwe has been severely depleted and the hard and soft structures of the health care system have steadily deteriorated. The Ministry of Health and Child Welfare (MOHCW) has identified healthcare worker retention and training as the most critical and recurrent issues facing the sector right now. Similarly, commodity and supply distribution systems are weak because key inputs are often not available (i.e. electricity, water, refrigerated warehouses, internet connection, etc.). Systems for information collection, storage, management, and dissemination have disintegrated because of the lack of critical inputs. Routine disease surveillance is omitted due to low reporting rates caused by lack of reliable communication (telephone land lines and cellular and internet services remain very poor). Program monitoring, supervision, and evaluation don’t happen because fuel/vehicles are not adequately available and trained supervisors are no longer reporting to work. As of December 2007, the MOHCW Human Resources for Health (HRH) Situational Analysis reported medical staff vacancies at 63% and those for nurses at 39%. Instructors and facilitators are even more absent: 85-90% of all laboratory instructor positions are empty. The national drug logistics support unit, critical to supply of ARV and OI drugs, test kits, etc., is dependent on USG-funded personnel to function. There is a critical need to develop appropriate salary, retention, supervision, and bonus strategies to keep current staff healthy and employed. Stabilization of the healthcare workforce is a prerequisite to reestablishing a functioning health care system and to the scale up of all programs needed and proposed by MOHCW and its partners. This is a critical need in the public and private health service delivery sectors, but also increasingly important to small NGOs that supply critical outreach, advocacy, care and support services. The USG works with the MOHCW, University of Zimbabwe, and other training institutions to strengthen and human resources for health services delivery. There is

additional need to support complementary capacity building for local NGOs, faith-based networks, community-based organizations, PLHA associations, etc. to improve utilization of those services among target populations. USG Program under first 5 years of PEPFARUSG PEPFAR support for Health Systems Strengthening (HSS) represents a wide range of activities targeting different needs in the public and private health system. In terms of OHSS indicators reported from FY07 to FY09: an average of 50 local organizations per year were provided TA for policy and capacity building; about 450 individuals were trained in health and HIV/AIDS policy; around 2,600 individuals were trained in various aspects of capacity building; about 965 individuals were trained in stigma reduction – and several million were reached through media and journalism programs in OHSS and other budget codes; about 1,000 individuals were trained in community mobilization reported under OHSS. Beyond reporting on the specific OHSS indicators, USG HSS program has traditionally focused on 5 main areas: 1) support to a Masters of Public Health (MPH) and Masters of Science (MSc) in Clinical Epidemiology program at the University of Zimbabwe (UZ) ; 2) in-service training and supportive supervision to public and private (commercial, NGO/FBO) sector care and treatment providers; 3) direct capacity development support at national and sub-national levels; 4) care and treatment supply chain TA and operations support; and 5) programming on de-stigmatization, through a media and cultural affairs program by the Department of State's Harare Public Affairs Section (PAS). In FY2010 USG will move the PAS work to Sexual Prevention, but otherwise will continue these areas of emphasis, and add two more, 5) Leadership Development, and 6) Human Resource Information System (HRIS). These FY2010 focused interventions for systems strengthening are summarized following required discussion of HSS areas not covered by other technical area narratives.Development, Testing and Scale-Up of Medical Products and TechnologiesAs described in several other technical area narratives, over the first 5 years of PEPFAR USG has been a leader in the HSS priority area of development, testing, and scale-up of medical products and technologies. In PMTCT, over 5 years of PEPFAR USG provided leadership in roll-out of single dose Nevirapine at time of diagnosis regimen; piloting and roll-out of short-course combined ARV therapy; integration of PMTCT commodities with Delivery Team Topping Up (DTTU) system; and integration of PMTCT services with Expanded Program of Immunization (EPI) services. In FY2010 USG PMTCT partners will lead scale-up of early infant diagnosis and pediatric ART, and point of care CD4 testing in a PMTCT setting. In Biomedical Prevention, USG leveraged private funds to pilot male circumcision in Zimbabwe, and will scale up to reach an estimated 25,000 men in FY2010 and 75,000 in FY2011. In Sexual Prevention, among many other achievements USG partners' promotion of the "Care" female condom has made Zimbabwe the highest consumer of female condoms in the world. In Counseling & Testing, USG partners provide about 55% of all client-initiated HIV testing (CITC) in Zimbabwe through an NGO network, and provided significant support for training and roll-out of provider-initiated (PITC) in CY2008. In FY2010 USG will launch provision of TB screening at CITC centers and intensify assistance for cross-referrals within PITC at national and provincial hospitals. In Care and Treatment, USG provides key staff for the MOHCW AIDS & TB Program and is the leader in supply chain management systems and commodity information systems (hardware and software) for HIV/AIDS commodities, including ARV drugs, PMTCT commodities, HIV rapid test kits, public sector family planning/reproductive health commodities, and related supplies. USG orphans and vulnerable children (OVC) programming under PEPFAR-I served as the model for the $80 million multi-donor Program of Support, which reached 277,000 children in CY2007-2008 and is becoming a model for care of HIV+ OVCs. USG is an important donor supporting Laboratory Strengthening: in FY2010 USG partners will roll-out use of Nucleic Amplification Testing (NAT) to improve Zimbabwe's blood safety and launch NGO-operated mobile laboratories to shore up the weakened public sector lab system. USG assista nce is critical for Zimbabwe's strategic information systems. USG was lead donor and TA provider for the 2005-2006 Zimbabwe Demographic and Health Survey (ZDHS) and will service that same role in 2010-2011, and USG has historically been the lead TA provider for periodic Antenatal Care Surveys.Health FinanceThe USG Zimbabwe team participates in the Multi-Donor Trust Fund (MDTF) effort to regularize the public sector budget in the post-"dollarization" era, and is an active member of the Global Fund (GF) Country Coordinating Mechanism (CCM). Within these (and other) fora, USG and other stakeholders are working with the MOHCW and Ministry of Finance to plan with a 'retention scheme' under which donors

would help to pay health workers a living wage. Several donors – excluding the USG -- put significant funds towards this scheme at its launch in January 2009. Their commitments, however, were tied to GF5 and GF8 funds continuing payments at some later date. The GF Geneva Secretariat has agreed to this approach, but proposed a near doubling of salaries to health care workers. Therefore, some GF5 Phase 2 funds will be used for salaries for the final four months of CY2009 and Round 8 grants were re-written and budgeted to pay for health worker salaries in CY2010. The high cost of the retention scheme means some program activities were cut, however, much of the scheme was paid for out of savings in per-unit costs for training, etc. The challenge for the CCM, Global Fund, and donors now is to figure out where the second year of the retention scheme funding will come from as it has not yet been identified. For USG Zimbabwe's 6 focused interventions in HSS, in summary, in FY2010: 1) HRH: Masters Programs: USG will continue to support the MPH program at UZ, which is expected to graduate 10 students in FY2010. USG will also continue modest support for 4 students in the MSc Clinical Epidemiology program. In FY2010 PAS will also provide one Fulbright Scholarship for an advanced degree in an HIV/AIDS-related field who is expected to graduate in FY11. 2) HRH: In-Service Training: As described in technical narratives and summarized in the HRH narrative, virtually all USG PEPFAR partners provide some level of in-service training to clinical, community, and management staff. The percentage of FY2010 budget attributable to HRH is 12.8%. An estimated 7,390 individuals will receive USG-funded in-service training in FY2010. 3) HRH: Capacity Development: As described in the technical narratives, USG is continuing to build the capacity of numerous local organizations through "cascade" funding, TA, and training in prevention, care, OVC, and treatment programs. With prior year OHSS funding, the Partnership Project will continue to build capacity of 30 local organizations engaged in HIV/AIDS programming through its end in September 2010. USG will undertake a new focus in FY2010 on capacity building of PLHA organizations to broaden member services, and to form a National Committee, which is a prerequisite for representation on the CCM and access future GF funding. 4) Care and Treatment Supply Chain TA and Operations Support is funded under OHSS but described in the ARV Drugs (HXTD) technical narrative. Of significance are the substantial targeted leveraging and "spill-over" effects of the ARV system: in FY09 the USG-supported MOHCW Logistics Supply Unit coordinated (but did not procure) drugs and commodities from Clinton HIV/AIDS Initiative, Global Fund, European Union, UNICEF, UNITAID, UNFPA, and other donors valued at $30,619,770 (ARVs $24,632,550; OI Drugs $4,860,314; HIV Rapid Test Kits $1,126,906); In FY09 the USG partner, Partnership for Supply Chain Management (PfSCM),received its first order from a non-USG partner (WHO) to procure drugs. In FY2010 USG and the key partners will increase efforts at harmonization of USG-operated systems with others in Zimbabwe, with a medium-term objective of merging all systems into one owned and operated by the MOHCW. 5) HRH: Leadership Training: FY09 Supplemental funding will be provided to UZ/Department of Community Medicine to re-establish the national leadership program that trains District Health Executives and Provincial Health Executives on human resources management, cost-effective use of resources, data analysis for decision making and basic epidemiology among others. The mechanism ends in FY2010, so USG will establish a new mechanism to continue and expand this critical work. 7) HRH: HRIS: With FY09 Supplemental and FY2010 new funding USG is collaborating with Emory University's School of Public Health, the Nurses Council of Zimbabwe, and the MOHCW to develop an HRIS that maintains real time information on the number of health care workers available at all health care levels by training skills, distribution and other variables. FY2010 work will focus on procuring and installing hardware and software in Harare and 3 other provinces.

Technical Area: Laboratory Infrastructure

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	1,330,000	
Total Technical Area Planned Funding:	**1,330,000**	**0**

Summary:
Zimbabwe FY2009 Operational Context Major political and economic developments continued to affect the PEPFAR program during FY 2009. From November to February, most public health facilities and schools – with the exception of some OI and ART clinics - were closed due to lack of funds to pay staff. Inflation was estimated into the trillions of percent. Public utilities operated sporadically in major urban areas. The deterioration of services led to a widespread cholera epidemic affecting 100,000 and killing 4,200. At the peak of the crisis in January-February 2009 the international community was feeding almost 7 million individuals, or more than half of the estimated resident population. USG and its PEPFAR partners continued to work as conditions permitted. In January, Zimbabwe adopted use of multiple foreign currencies (primarily the U.S. dollar, South African Rand and Botswana pula). Official “dollarization” saw an influx of foreign currency and the gradual stabilization of prices. In February, the three opposing political parties finally created an inclusive government which re-opened most health care facilities and schools. While the economy has begun to stabilize, basic infrastructure has so deteriorated that health services have not returned to even acceptable levels. More broadly, human rights and the rule of law are still not respected which is preventing full donor reengagement and private investment necessary for true recovery.Laboratory Strengthening Program Context & BackgroundIn spite of a decline in HIV prevalence between 2001 and 2009, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence estimated at 13.7% (Zimbabwe National HIV/AIDS Estimates 2009). About 1.1 million adults and children are currently living with HIV and AIDS in Zimbabwe. Heterosexual contact remains the primary means of transmission for the epidemic. Laboratory services are an essential part of the Zimbabwe healthcare delivery system and play a pivotal role in its HIV/AIDS healthcare plan to support prevention, care and treatment programs. The Ministry of Health and Child Welfare (MOHCW) is the largest provider of diagnostic medical laboratory services, from district to central levels of healthcare. These laboratories operate as a network of 52 district, 8 provincial, 5 central and 3 national reference laboratories, the National Microbiology Reference laboratory (NMRL), National Tuberculosis Reference Laboratory (NTBRL) and a National Virology Reference Laboratory. There are also 1,200 health centers that provide primary heath care services and very limited laboratory testing. The Zimbabwe Association of Church Hospitals, a faith-based organization (FBO), also provides lab services at the rural hospital level, of which 14 are recognized district hospitals.Zimbabwe has achieved ongoing success in laboratory system support to the national HIV and AIDS response, as demonstrated by: the successful national roll-out of HIV counseling and testing services to 1025 sites (980 public sector sites, 45 private sector sites); revision of the standard HIV testing package; expansion of CD4 capacity, evaluation and adoption of more cost effective CD4 testing technologies; and international accreditation of the Zimbabwe National Quality Assurance Program (ZINQAP). Currently, 28 sites in the public health system and 10 in the private sector offer CD4 testing services and participate in an external proficiency testing (PT) program through ZINQAP.There are still challenges. Reference and public hospital laboratories have limited capacity for diagnosis, monitoring and surveillance of HIV, TB, malaria and various opportunistic infections due to lack of financial and human resources for lab diagnostics. Given the economic crisis, reagents and other critical supplies are often in short supply. Human resources are also lacking, with out-migration of qualified health workers. In FY08, vacancy rates were 49% for lab scientists, and this has adversely affected service delivery. In response to the human resource crisis, in 2007 the MOHCW introduced new cadres to the system and embarked on redefining core competencies and task shifting. USG Summary Program Laboratory organizational and physical infrastructure, procurement systems, supply availability, equipment, and trained staff are fundamental elements of PEPFAR Zimbabwe’s program implementation. USG’s laboratory strengthening program conforms to the PEPFAR Zimbabwe 5 Year Strategy and focuses on national laboratory system strengthening and capacity building so that the system can be sustained over time. The USG provides the national laboratory system with direct technical assistance, training and provides funding to ZINQAP, the MOHCW, and other lab technical training providers. Achievements since last COPIn FY09, USG continued to improve the quality of lab services through strengthening and expansion of the external quality assurance/proficiency testing (EQA/PT) schemes to major tests (HIV rapid test, CD4 testing, TB, hematology and chemistry tests, DNA-based

early infant diagnosis). As part of its health systems strengthening approach, USG collaborated with the MOHCW to undertake a Situation Analysis of the current laboratory system and held workshops to develop a new Laboratory Policy and Strategic Plan. USG supported salaries of four key positions at NMRL to keep laboratory functions operational. Although the operating environment and closure of many facilities made progress difficult, ZINQAP was able to maintain its EQA/PT operation in order to maintain high quality testing throughout the country, and started to roll out the use of dried tube specimens (DTS) to strengthen the EQA process. With USG funding, ZINQAP had planned to help strengthen Zimbabwe's national Laboratory Information System (LIS) in 2009. However, work on the LIS was put on hold due to very bad network issues and lack of communication between the tiered system and the lack of referrals occurring in the laboratory system. Base on the USG-funded Situation Analysis, stakeholders agreed that a solid paper base system was what was needed prior to the introduction of LIS. USG thus assisted in standardization of laboratory forms to assist the central level to receive reliable information and support decision making and policy and also quantification of reagents. USG provided direct TA to NTBRL for setting up of EQA for TB smears; and supported NMRL for training in CD4 EQA as well as the roll-out of a Serial Testing Evaluation in collaboration with colleagues from the USG counseling & testing mechanism, the Partnership Project. Additionally, USG provided equipment and other technical support for training of 60 microscopists to reinforce existing staff capacity and mitigate staff shortages in the country, and provided for training for 4 GF-supported lab scientists for TB culture at the Biomedical Research and Training Institution. Due to the "freezing" of direct disbursements under the MOHWC Cooperative Agreement due to political considerations, USG undertook a significant level of direct stop-gap, emergency procurement of laboratory supplies, equipment and maintenance services. As described in the HVSI narrative, USG also provided laboratory and other TA to the 2009 HIV antenatal care (ANC) survey including incidence testing of drug resistance. In spite of difficult conditions, a new USG lab partner, the African Institute of Biomedical Science and Technology (AiBST), was able to undertake modest training of private practitioners in Manicaland, Midlands, Matabeleland North and South, and Mashonaland East. The general course content covered clinical management, treatment guidelines, pharmacogenetics, drugs resistance and other HIV/AIDS management issues. Goals and strategies for the coming yearWith FY09 Supplemental Funds, ZINQAP will initiate the refurbishment of some district laboratories based on the results of the Na tional Laboratory Assessment being led by USG in October/November 2009. Procurement will include essential commodities, consumables and PEP materials to provide general lab services at district level. These funds will additionally provide the necessary equipment and reagents to initiate HIV Drug Resistance Testing at the NMRL for the annual threshold survey. Additionally ZINQAP will fund staff and consultant salaries and support costs to implement these activities. The ZINQAP mechanism ends at the end of FY2010, so USG is planning for a follow-on EQA mechanism. With FY2010 funding, this new mechanism will: 1) Continue the process of refurbishment of district laboratories initiated with PEPFAR resources in FY09; 2) Consolidate the quality assurance program at national level in the testing areas of Hematology (CD4 count), clinical chemistry, microbiology and serology; 3) Conduct training of laboratory personnel in quality systems and lab techniques; 4) Conduct on-site assessments of selected sites to assess the implementation of laboratory quality systems on the ground; 5) Roll out the standardized HIV rapid testing log book to improve the quality of the data currently collected. 6) Provide technical support to provincial and districts laboratories in the country for the accreditation process with WHO Afro.With FY09 Supplemental Funds, AiBST will set up two mobile laboratory units which will be equipped with a flow cytometer, a centrifuge, a microscope, chemistry and hematology automatic analyzers and a PCR machine each. The mobile laboratory units will be equipped with Laboratory Information Management Systems (LIMS) for patient data management and to facilitate the consolidation of results for reporting. The mobile laboratory concept will enable AiBST to reach out HIV patients in remote areas where laboratories do not have the capacity to provide adequate diagnostic and monitoring services enabling clinicians at district and rural levels to provide the best care to their patients. The maximum capacity of each mobile laboratory unit is around 10, 000 patients per year based on the fact that each of them will be operating 2 weeks per month in the field while the other 2 weeks they will be at the base for maintenance and re-stock. This schedule will be reassessed after an initial period of operations of 6 months.In FY2010, AiBST will continue and increase the coverage of the mobile

laboratory services through higher procurement of reagents. A major addition to the AiBST laboratory will be a DNA Sequencer which will enable AiBST to detect a broader range of drug resistance mutations associated with first line and second line therapy failure. At the same time, the project will support on-site training of laboratory technologists at provincial and district level so that they can optimally utilize the equipment which is being installed at their laboratories by various funding agents.AiBST will additionally continue the short course training for lab scientists on molecular techniques at the AiBST laboratory minimum 3 times per year. If USG policies permit direct disbursements to the GOZ, with FY10 resources MOHCW hopes to support staff at the National Microbiology Reference Lab and undertake basic procurement of consumables/reagents for the NMRL and National Tuberculosis Reference Lab as needed. FY2010 resources will also support 3.40 FTE locally engaged staff for TA and program oversight.Wraparounds/LeveragingUSG funding is strengthening the national laboratory system and filling gaps not covered by other donor funding. For labs, this includes: GF5 (22 districts, including the first 12), the British Department for International Development-led, multi-donor Expanded Support Program (ESP - 16 districts), and European Union (training schools). As discussed elsewhere in this COP, USG funding covers service delivery (outreach, counseling, provision of tests) in several other program areas (MTCT, HVCT, HTXS, PDTX) and broad system strengthening (OHSS). Limite d and site specific laboratory support also is provided by NGOs including Medecins Sans Frontieres and Italian Cooperation. Given USG's close relationship with MOHCW and familiarity with the national laboratory systems, USG provides extensive technical support to MOHCW in planning and coordinating lab services, to GFATM and other donors. These include planning for lab procurement and training and incorporation of laboratory planning into national roll-out strategies. USG personnel are active members of Zimbabwe GF's Country Coordinating Mechanism's technical writing teams. Total support to national laboratory services over the past three years is estimated at $20 million of which GF contributed about 75%.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	6,513,985	
Total Technical Area Planned Funding:	**6,513,985**	**0**

Summary:
(No data provided.)

Technical Area: OVC

Budget Code	Budget Code Planned Amount	On Hold Amount
HKID	3,350,000	
Total Technical Area Planned Funding:	**3,350,000**	**0**

Summary:
Zimbabwe FY2009 Operational Context Major political and economic developments continued to affect the PEPFAR program during FY 2009. From November to February, most public health facilities and schools – with the exception of some OI and ART clinics - were closed due to lack of funds to pay staff. Inflation was estimated into the trillions of percent. Public utilities operated sporadically in major urban areas. The deterioration of services led to a widespread cholera epidemic affecting 100,000 and killing

4,200. At the peak of the crisis in January-February 2009 the international community was feeding almost 7 million individuals, or more than half of the estimated resident population. USG and its PEPFAR partners continued to work as conditions permitted. In January, Zimbabwe adopted use of multiple foreign currencies. Official “dollarization” saw an influx of foreign currency and the gradual stabilization of prices. In February, the three opposing political parties finally created an inclusive government which re-opened most health care facilities and schools. While the economy has begun to stabilize, basic infrastructure has so deteriorated that health services have not returned to even acceptable levels. More broadly, human rights and the rule of law are still not respected which is preventing full donor reengagement and private investment necessary for true recovery.Zimbabwe’s humanitarian crisis of 2008-2009 made the situation of orphans and vulnerable children even more precarious. During first quarter FY09, USG partners collaborated closely with the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), WPF, and UNICEF to target emergency feeding and health services to an increasing proportion of the population, many of them children. At the height of the crisis in February 2009, USG had provided 65,500 MT of emergency food assistance; by the end of September 2009 this figure was over 170,000 MT. Additionally, through the Office of Foreign Disaster Assistance (OFDA), as of February 2009 USG also provided US$12.8 million of other emergency assistance for vulnerable families, including those that were affected by HIV/AIDS. As of September 2009 OFDA had provided $31 million. USG and other OVC partners necessarily diverted from planned activities to link closely with OCHA, WFP, and OFDA to assure that their target OVC populations were benefitting from these important emergency programs. Partners also needed to ramp up psychosocial counseling to foster OVC resilience and reduce OVC vulnerability in the face of a deteriorating socioeconomic and political environment.HKID Program Context & BackgroundIn spite of a decline in HIV prevalence between 2001 and 2009, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence estimated at 13.7% (Zimbabwe National HIV/AIDS Estimates 2009). About 1.1 million adults and children are currently living with HIV and AIDS in Zimbabwe. Heterosexual contact remains the primary means of transmission for the epidemic. Zimbabwe has one of the highest proportions of orphaned children in Africa. A 2004-2005 UNICEF survey indicated that up to 30% of all children are orphaned and 40% are vulnerable, the majority due to HIV and AIDS. Nearly 50,000 households are headed by a child under 18. The Zimbabwe Demographic and Health Survey (ZDHS) 2005-06 found that 24% of those under 18 were orphaned and 10% lived in a household where an adult has been very sick or died in the last 12 months. These rates yield approximately 1.3 million orphans. More recent Zimbabwe National HIV/AIDS Estimates (2009) indicate that 989,000 children in Zimbabwe are orphans as a result of HIV/AIDS. From FY01-FY07, USG funding for OVC was directed through the Support to Replicable, Innovative, Village/Community Level Efforts for OVC (STRIVE) Project that provided technical assistance (TA) and sub-grants to up to 16 local and international NGOs to work at the community level to provide education assistance and psychosocial support to OVC. Between 2002 and 2007, STRIVE reached 153,000 OVC with direct support and 164,000 OVC with indirect support. During the same time, USG was very involved in the development of the National Action Plan for OVC (NAP-OVC). In FY06-FY07, the (then) Ministry of Public Service, Labor and Social Welfare (MOPSLSW) collaborated with a group of donors to develop a multi-donor Program of Support (POS) for OVC modeled to a large extent on STRIVE. The POS involves the United Kingdom Department for International Development (DFID), Swedish International Development Agency, the German Development Bank (KfW), the European Community, Australian Aid and New Zealand Aid. These donors have jointly committed over US$80 million to the UNICEF-managed pooled funding mechanism for the period 2006-2010. The program is national in scope and in CY2008 worked through 31 NGO partners with 143 sub-recipients.As of June 2009, POS reported a combined achievement of 277,000 children reached for Years 1 and 2 (CYs 2007 and 2008), of which 93,025 were new in CY2008. Services include: school-related assistance; medical support including support to children on ART, food/nutritional assistance, and psychosocial support. Discussions are underway as to the scope and level of a POS program extension and/or follow-on.Given the initiation of POS, in 2007 the USG undertook an assessment to guide future USG OVC programs. Based on the assessment, the USG decided to focus its new OVC strategy on “filling the gaps,” identifying new models, advocacy, and targeting highly vulnerable children such as those in child-headed households, abused children, and

children outside of family care. This new strategy is implemented through the Children First (CF) umbrella project led by World Education, Inc. In addition to PEPFAR funding, the USG provides wraparound Population funding to the project to facilitate provision of critical reproductive health information to adolescent girls and boys. Accomplishments Since Last COP In FY09, the USG and CF project continued to collaborate closely with the POS and the NAP-OVC through the National Secretariat to assure USG interventions were complementary to and not duplicative of the POS program. USG and CF also continued to undertake OVC advocacy activities to reinforce POS work. CF works primarily through direct grants to local non-governmental organizations (NGO), community-based organizations (CBO), and faith-based organizations (FBO) that work with OVC. The project provides referrals and linkages with other programs and service providers. As of August 2009, CF was working with 16 partners in Harare and greater Harare and 3 partners in Umzingwane district of Matebeleland south. These 19 NGO partners were in turn supporting 43 CBOs (of which 24 are FBOs) to reach a total of 57,922 highly vulnerable children (53% female, 47% male) with comprehensive care and support services, as follows: 19,487 children received educational assistance, of which 14,489 were reached through an innovative “block grant” program described below; 25,389 children received medical assistance, of which 24,758 had primary health assessment, 678 treatment and care, and 8,061 reproductive health counselling; 8,809 children received psychosocial support;1,843 children received food and nutritional supplementation; 1,832 children received shelter and material assistance; 3,883 children received protection. CF also provides significant capacity building technical assistance TA) and training to the partner NGOs and CBOs in financial management, monitoring and evaluation, and other key areas of need. CF works closely with District AIDS Committees in Harare and Umzingwane to improve their ability to monitor and respond to the needs of OVC in their communities, thus improving linkages between communities and the district and national AIDS response.CF’s “block grant” program with schools is proving particularly successf ul and served as a point of entry to USG participation in the new donor/GOZ Education Forum. As mentioned above, after the extreme crisis of November–January, by March 2009 many of the schools had re-opened and the situation had stabilized. After “dollarization,” however, payment of school fees was beyond the reach of most OVC households. Additionally, implementing CBO partners reported that payment of individual school fees unfairly “spotlighted” scholarship OVC and created stigma. CF initiated a program of school block grants to ensure access to and retention of OVC in schools. Access to education is a critical value for CF, not only because of the benefits provided by education but also because the school environment provides a distribution point for OVC services and a safe haven for OVC. Under the block grant program, schools submit requirements for basic educational materials such as chalk, exercise books, rulers, and text books to CF, which agrees to provide the materials in exchange for attendance of a given number of OVC for two terms. To date, CF has provided block grants to 34 schools, with 14,489 OVC reached.CF has found increasing success with its medical services, and is in discussion with the Clinton HIV/AIDS Initiative (CHAI) to launch a parallel block grant program for health clinics. The program hopes to assure access by decreasing clinic fees from around US$20 to US$3-$5.To complement this program CF has identified a pediatrician who is donating time to treat HIV+ OVC, and hopes to identify others in the coming year.CF is increasing linkages with international NGOs that have school feeding programs. During the crisis, provision of food also removed immense pressure on child-headed households and poverty-stricken OVC guardians. In FY09 CF entered into a strategic partnership with Catholic Relief Services, which included CF beneficiaries in its feeding programs. CF also hopes to engage Christian Care in a similar partnership in the future. Half of CF’s NGO partners offer significant reproductive health (RH) services under their grants. With USG Population wraparound funding CF provided TA to the CF NGO partners to develop an agreed set of performance standards for future RH work. These include, inter alia development of IEC material in relevant languages; development and delivery of Youth Friendly Services, in partnership with service delivery facilities; training personnel to assist pregnant youth and establishing effective referral systems for children with sexual protection needs; working with GOZ personnel to improve access to and affordability of services; engaging CBO leaders to raise awareness on child sexual protection; and advocating for a child sexual harassment free environment at home, schools, clinics, etc. CF also worked with partners to integrate child sexual protection into their programs and activities including protecting the girl child from coercion and gender

based violence done through community advocacy against child sexual abuse and life skills training of OVC. In FY09, CF initiated a community based response program by establishing drop in centers in the communities where children and community members can report child abuse through a network of volunteers. In addition, for children who are suspected to have fallen victim to child sexual abuse, CF facilitates transportation for children to access services for antiretroviral post exposure prophylaxis and follow up support from volunteers in the communities. During FY09, CF collaborated with another PEPFAR partner, Population Services International, to develop a child rights awareness radio program and sponsored articles written by children in national newspapers to commemorate the 'Day of the African Child. Through a separate grant to UNICEF, USG supported a senior M&E Officer in the M&E Unit for the POS. All POS partners, as well as other NGOs dealing with children, submit monthly reports on their activities. The M&E Officer processed all these d ata and produced reports which were widely shared with POS stakeholders. Goals and Strategies for the Coming YearIn FY2010, CF will focus on improving quality of care for about 55,000 children as opposed to increasing the number of children or expanding the current geographic area. In the Harare and Umzingwane areas, CF will: 1) Select the strongest and most cost-effective of the current NGO grantees to provide the basic package of services to ensure that each CF-supported child has access to at least 3 services. 2) Develop and refine a standard comprehensive package of services that will deliver at least 3 services. Each partner NGO will provide a minimum 3 services, and by creating standards of care developed by CF and its partners, quality assurance will be achieved. 3) Continue to support NGOs with interventions which serve the specific needs of highly vulnerable children, with an eye to achieving cost effectiveness to ensure USAID resources are used more efficiently. 4) Increase efficiency, achieve cost effectiveness and streamline operations by implementing the following: a) NGO grants will be awarded for a longer duration (2-3 years) to reduce staff attrition and to promote long-term planning; b) School block grants will be locked in for additional school terms to increase efficiency and cost effectiveness; c) CF and NGOs will refine and scale up the recently introduced school-based Primary Health Care package so that OVC will have access to screening, school-based care, and referral for more complicated cases; d) CF will integrate reproductive health and livelihood programs for youth; and e) School-based psychosocial support programs will be tested and implemented in CF-supported schools As part of its sustainability strategy, CF will initiate economic strengthening programs focused on nutritional support and Village Savings and Loans. CF will also increase its CBO support by issuing "challenge grants" ranging from $1,000-$10,000 to community groups to accomplish narrowly-defined, small-scale activities that improve existing community responses to OVC. These community groups include Parent-Teacher Associations, mothers' groups and self-formed PLWHA support groups. By supporting CBOs directly, CF will ensure quality improvement and facilitate access to resources by CBOs to enable them to carry out services that reach OVC directly. REDACTED. Wraparounds/LeveragingIn FY09, CF received $580,320 and in FY2010 is expected to receive an additional $42,000 in wraparound USG Population funds. CF leveraged an additional $116,000 in FY09 from UNICEF, CHAI, OSISA, and partner organizations. In FY2010, leveraged funds are expected to increase to $757,000, from OSISA, UNICEF, CHAI, and partners' cost share.

Technical Area: Pediatric Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
PDCS	969,000	
PDTX	1,257,500	
Total Technical Area Planned Funding:	**2,226,500**	**0**

Summary:

Zimbabwe FY2009 Operational Context Major political and economic developments continued to affect the PEPFAR program during FY 2009. From November to February, most public health facilities and schools – with the exception of some OI and ART clinics - were closed due to lack of funds to pay staff. Inflation was estimated into the trillions of percent. Public utilities operated sporadically in major urban areas. The deterioration of services led to a widespread cholera epidemic affecting 100,000 and killing 4,200. At the peak of the crisis in January-February 2009 the international community was feeding almost 7 million individuals, or more than half of the estimated resident population. USG and its PEPFAR partners continued to work as conditions permitted. In January, Zimbabwe adopted use of multiple foreign currencies (primarily the U.S. dollar, South African Rand and Botswana pula). Official “dollarization” saw an influx of foreign currency and the gradual stabilization of prices. In February, the three opposing political parties finally created an inclusive government which re-opened most health care facilities and schools. While the economy has begun to stabilize, basic infrastructure has so deteriorated that health services have not returned to even acceptable levels. More broadly, human rights and the rule of law are still not respected which is preventing full donor reengagement and private investment necessary for true recovery.Pediatric Care and Treatment Program Context & BackgroundIn spite of a decline in HIV prevalence between 2001 and 2009, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence estimated at 13.7% (Zimbabwe National HIV/AIDS Estimates 2009). About 1.1 million adults and children are currently living with HIV and AIDS in Zimbabwe. Heterosexual contact remains the primary means of transmission for the epidemic. As part of the national response to this burden, Zimbabwe’s National ART Program, started in 2004, is designed as a comprehensive care and treatment package of services that addresses medical, social, emotional, and economic needs of People Living with HIV/AIDS (PLHA), and is a complement to prevention interventions. In 2005, the Government of Zimbabwe (GOZ) made a deliberate effort to scale up pediatric HIV and AIDS care and treatment with the Clinton Foundation HIV/AIDS Initiative (CHAI) support of 1,000 pediatric formulation based treatments offered for 2006. A national task force, comprising of members from the Ministry of Health and Child Welfare (MOHCW), the PMTCT Partnership Forum, and the Pediatric Sub-Committee on HIV/AIDS Care, developed the initial plans and drafted training materials for pediatric care that were pre-tested at 11 learning sites designated to receive CHAI-purchased drugs. The MOHCW and the Pediatric Sub-Committee on Care, along with USG technical staff and partners EGPAF and the University of Zimbabwe’s Clinical Epidemiological Resource and Training Center’s HIV/AIDS Quality of Care Initiative (HAQOCI), collaboratively reviewed these training materials. USG technical assistance enabled the MOHCW to complete the layout, design, and full production of the materials. This national training in pediatric care has been conducted since early 2007.Currently, 134 public health sites (primarily central, provincial, district and mission hospitals) offer ARV initiation or follow up services, with 127 of them having specific OI/ART pediatric clinics (97 of which do ART initiation of children, and 30 do follow-up). Out of an estimated 343,460 adult PLHA and 35,189 children PLHA needing treatment, as of September 2009, approximately 178,000 adults and children were on ART, including an estimated 10,000 in the private sector and over 7,800 NGO supported. As of September 2009, 11,020 children were receiving ART. Among children aged 0-14 years, there are an estimated 15,000 new infections annually and 9,400 AIDS-related deaths (Zimbabw e National HIV/AIDS Estimates 2009). The GOZ goal is to provide 260,000 adults and 25,000 children ART by the end of 2010 and 310,000 adults and 30,000 children (340,000 total) by the end of 2011. Zimbabwe’s palliative care package includes psychosocial support, nutritional counseling and support, positive prevention counseling, information on positive living, treatment for opportunistic infections (OI), Cotrimoxazole prophylaxis, bereavement counseling, spiritual counseling, succession planning, hospice care, and PLHA groups. Over the past several years, access to and quality of both non-clinical and clinical palliative care services have improved significantly. Non-clinical community-based care and support is provided through PLHA support groups, faith-based networks, NGOs, and numerous other organizations throughout the country, under the guidance of the National AIDS Council (NAC). Recently, in the 2009 ANC Survey report, the MOHCW highlighted Prevention with Positives (PwP), including increasing advocacy and treatment literacy campaigns, as a key strategy in the national response against HIV and AIDS. The OI Clinic Model, developed by MOHCW with USG support, serves as the basis for comprehensive clinical HIV service delivery and transition to

the ART program. Currently, 536 OI clinics at MOHCW and mission hospital sites are operational, vastly exceeding earlier national targets (140 for 2009). In FY09 these sites provided Cotrimoxazole for OI to 342,599 adults and 45,692 children, up significantly from FY08. The Pfizer Diflucan donation program to Zimbabwe is now in its sixth year of operation, and as of July 2009, had provided 26,978 patients Diflucan at 134 OI sites. In 2008, with CHAI support, the Pediatric Sub-Committee for Care piloted early infant diagnosis (EID) in three central hospitals around the country. As described in the PMTCT narrative, in FY09 USG partners supported planning for scale up of EID with a total of 862 infants below 12 months tested as of June 2009 using Polymerase Chain Reaction (PCR) testing. In the past, CHAI was the main supplier for children's drugs, diagnostic tests, and reagents for monitoring tests and therapeutic food for HIV+ malnourished children. These commodities will be provided by the Global Fund beginning in 2011.USG ProgramUSG's pediatric care and treatment program is of a scale appropriate to a PEPFAR small country program and does not include widespread provision of USG-direct clinical care and treatment services. USG continues to provide technical assistance (TA), seconded staff, advocacy, and program support to the MOHCW and other partners to strengthen systems for care and treatment of PLHA, including infants and children. The USG also provides capacity building (primarily training and TA) so that systems can be sustained over time. Achievements since last COPIn FY09 the lead USG PMTCT partner, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) piloted short-course combination ARV prophylaxis (called "most efficacious regimen" or MER) at 76 sites in 5 districts. EGPAF is providing ongoing technical support to the national PMTCT unit for the roll out. In addition to provision of AZT to mothers beginning at 28 weeks, MER also provides ART to newborn infants for the first week of life. As of June 2009, the uptake of infant prophylaxis was 66% and of all infants who received prophylaxis, 28% received combination therapy. As stated above, in FY09 USG partners supported scale-up of EID with a total of 862 infants below 12 months tested as of June 2009 using PCR testing. This is equivalent to about 6% of the estimated number of HIV+ infants born in 2009.In FY09, USG funds supported the University of Zimbabwe's Clinical Epidemiological Resource and Training Center's HIV/AIDS Quality of Care Initiative (HAQOCI) to provide in-service training in OI/ART pediatric management and facilitative supervision at 4 centralized hospitals in Harare (subject to facility closures). Planned assist ance to the MOHCW for roll-out of the new child counselling guidelines to the district level was frozen until the GOZ meets established political conditions for resumption of bilateral aid.In FY09, the USG lead mechanism for orphans and vulnerable children (OVC), Children First, supported 314 HIV+ OVC on ART. As described in the OVC narrative, CF has found increasing success with its medical services, and is in discussion with CHAI to launch a grant program for health clinics. The program hopes to assure access for HIV+ children by decreasing clinic fees from around US$20 to US$3-$5.To complement this program CF has identified a pediatrician who is donating time to treat HIV+ OVC, and hopes to identify others in the coming year.Goals and strategies for the coming yearEGPAF will support the expansion of the national pilot effort on EID linked to initiation of pediatric ART that is using leveraged funding from Canada (CIDA), CHAI and the Global Fund. The roll-out of EID from the 4 Harare hospitals to more rural areas is underway but slow. EID training is integrated with MER although EGPAF and MOHCW will encourage stand alone trainings on EID in 2011. The program will target testing of 4,000 infants at less than two months of age with an additional 5,000 HIV-exposed infants tested at 18 months. EGPAF has mobilized resources through Global Fund to support training on pediatric OI/ART managementUsing PEPFAR funding, EGPAF will continue to strengthen the national ART unit through provision of direct technical support. In addition, the EGPAF will: 1) Support the decentralization of pediatric services in Harare and Chitungwiza through supervision, review meetings and development of decentralization standard operating procedure manuals. 2) Integrate EID training within existing PMTCT modules. 3) Provide training in EID and pediatric ART management. 4) Scale up the national mentorship pilot to 2 additional provinces, linked with ART initiation in MCH. EGPAF has utilized PEPFAR funding since 2004 to improve follow up of HIV-exposed infants by integrating postnatal activities within the expanded program of immunization (EPI) as well as developing a national follow-up register. With FY09 Supplemental and FY10 new funding, EGPAF will improve prescribing of Cotrimoxazole prophylaxis at 6 weeks to HIV-exposed infants from 9,000 to 14,000 infants. With USG, DIFID and UNICEF funds, in FY10 EGPAF will: 1) Finalize and print a national implementation guide and job aides to improve follow up services and integrate application within existing

training courses. 2) Distribute the national follow up register and include training on this into existing courses. 3) Support psychosocial support groups for children and carry out exchange visits (UNICEF). 4) Evaluate the child health card and provide on-the-job training to ensure cards are appropriately filled in to identify HIV-exposed infants (DFID). 5) Carry out community mobilization activities to raise awareness on infant feeding issues and care for children living with HIV (UNICEF). 6) Develop a community based follow up register (IUNICEF). 7) Support and train community cadres on psychosocial support (UNICEF and Global Fund). 8) Supplement national stocks of Cotrimoxazole using private funding. 9) Develop materials to support caregivers awareness of pediatric issues (UNICEF)With FY09 Supplemental funds, HAQOCI will conduct site supervisory visits and clinical mentorship to 9 sites offering adult and pediatric services. With FY10 funds HAQOCI will conduct trainings for health care workers and in pediatric management of OI/ART and conduct site supervisory visits and clinical mentorship to 9 sites offering adult and pediatric services. The team will be able to work within the national mentorship plan to train mentors in the provincial sites who will in turn train mentors at the district and rural level to ensure that protocols and guidelines are understood and implemented as expected at site level. With FY09 Supplemental Funds, The African Institute of Biomedical Science and Technology (AiBST) will contribute to the national roll-out of EID through establishing an additional testing site, including procurement of the needed equipment, renovating the lab to meet the required standards, training of the staff in the operation of the equipment and providing a retention package for the staff at the selected lab. This second site for referral of samples is expected to reduce the workload at the National Microbiology Reference Laboratory (NMRL) and decrease turnaround time for results. AiBST will also provide TA and training to strengthening the lab referral network, based on an assessment of sites where EID has been rolled out. AiBST will conduct CD4 counts, viral loads, HIV DR tests, and chemistry and hematological tests, for monitoring of pediatric patients on ART through a mobile laboratory that will serve the 10 provinces of Zimbabwe. Additional diagnostics services will cover TB and malaria. AiBST expects to screen at least 1,000 children countrywide with the mobile labs in FY10, and an additional 2,400 children in FY11. In addition AiBST will continue the training of private sector health professionals on updated ART guidelines and OI/ART pediatric care and monitoring in the 10 provinces of Zimbabwe. In FY10, a new mechanism will initiate the scaling up of pediatric care and support services in Zimbabwe's extensive church related hospitals/clinic network. The mechanism will target OI/ART clinics within the church related hospitals network that are not yet providing OI/ART services for children, using a family approach and comprehensive provision of services that will include psychological, social, spiritual, nutritional and preventive services. These activities will target HIV exposed and HIV+ children. EID will be a key intervention in this program. Wraparounds/LeveragingThrough development of models and support to leadership, the USG support to Pediatric Care and Treatment leverages significant funding for all public sector ART, PMTCT, and HIV testing sites in the country. In the past CHAI has provided all pediatric OI/ART drugs; this will be picked up by the Global Fund in 2011. Other donor resources that complement USG resources for PMTCT and Pediatric Care & Treatment are approximately $2.4 - $2.7 million in FY09-2010, from DFID ($1 million), UNFPA ($250,000), the Gates Foundation ($220,000), UNICEF ($850,000 and possibly an additional $300,000), and Johnson & Johnson Foundation ($150,000).

Technical Area: PMTCT

Budget Code	Budget Code Planned Amount	On Hold Amount
MTCT	4,519,000	
Total Technical Area Planned Funding:	**4,519,000**	**0**

Summary:
Zimbabwe FY2009 Operational ContextMajor political and economic developments continued to affect the PEPFAR program during FY 2009. From November to February, most public health facilities and schools

– with the exception of some OI and ART clinics - were closed due to lack of funds to pay staff. Inflation was estimated into the trillions of percent. Public utilities operated sporadically in major urban areas. The deterioration of services led to a widespread cholera epidemic affecting 100,000 and killing 4,200. At the peak of the crisis in January-February 2009 the international community was feeding almost 7 million individuals, or more than half of the estimated resident population. USG and its PEPFAR partners continued to work as conditions permitted. In January, Zimbabwe adopted use of multiple foreign currencies (primarily the U.S. dollar, South African Rand and Botswana pula). Official “dollarization” saw an influx of foreign currency and the gradual stabilization of prices. In February, the three opposing political parties finally created an inclusive government which re-opened most health care facilities and schools. While the economy has begun to stabilize, basic infrastructure has so deteriorated that health services have not returned to even acceptable levels. More broadly, human rights and the rule of law are still not respected which is preventing full donor reengagement and private investment necessary for true recovery.PMTCT Program Context & BackgroundIn spite of a decline in HIV prevalence between 2001 and 2009, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence estimated at 13.7% (Zimbabwe National AIDS Estimates 2009). About 1.1 million adults and children are currently living with HIV and AIDS in Zimbabwe. Heterosexual contact remains the primary means of transmission for the epidemic. As part of the national response to this burden, Zimbabwe’s National ART Program, started in 2004, provides comprehensive care and treatment services that address medical, social, emotional, and economic needs of People Living with HIV/AIDS (PLHA), and is a complement to prevention interventions. Currently, 134 public health sites (primarily central, provincial, district and mission hospitals) offer ARV services. Out of an estimated 343,500 adults and 35,000 children needing treatment, as of September 2009, approximately 178,000 adults and children were on ART, including an estimated 10,000 in the private sector and over 7,800 NGO supported. As of September 2009, 11,020 children were receiving ART. Among children aged 0-14 years, there are an estimated 15,000 new infections annually and 9,400 AIDS-related deaths (Zimbabwe National AIDS Estimates 2009). All branches of the military service have ART programs, including a model program in the Air Force, with access for all levels of personnel. The Government of Zimbabwe goal is to provide 285,000 PLHA with ART by the end of 2010 and 340,000 by the end of 2011. A primary source of ART candidates is the national PMTCT program. Zimbabwe’s Ministry of Health and Child Welfare (MOHCW) estimates that out of 300,000 pregnant women delivering each year, in 2009, 48,279 were HIV+ (Zimbabwe National HIV/AIDS Estimates 2009). Of the HIV-exposed infants to whom they give birth, an estimated 30% become HIV+, with almost 15,000 new pediatric HIV infections expected in 2009. Zimbabwe’s PMTCT program, with continuing USG and other donor support, is implementing the National 2006-10 PMTCT Strategy to prevent these infections. As of June 2009, the MOHCW reported that 95% of all health facilities (1560 out of 1643) provided some form of PMTCT services, with 920 sites providing comprehensive services (onsite testing and ARV prophylaxis). 200 comprehensive sites also provide ART for mothers, up from 82 in September 2008. Program uptake improved dramatically from 2004 to 2008, with the percentage of HIV+ pregnant women receiving single dose Nevir apine (sdNVP) prophylaxis increasing from 40% in CY2005 to 91% in CY2008. Also, the percentage of infants receiving NVP increased to 66% in CY2008. Numerous challenges to increasing uptake remain. The Zimbabwe Demographic & Health Survey (ZDHS) 2005-06 showed that use of antenatal care (ANC) by pregnant women was high at 94%. Data in a recently released MOHCW Maternal and Perinatal Mortality Study (2007) show that use of ANC decreased in CY2006 to only 91%, with only 34% tested during pregnancy. The study also found that 25.5% of maternal deaths were caused by AIDS defining conditions. MOHCW and USG partner statistics found decreases in ANC attendance in CY2008 and early CY2009 likely due to Zimbabwe’s crisis, although attendance improved to near pre-crisis levels in April-June. The MOHCW launched provider initiated testing and counseling (PITC) in 2005 and roll-out is progressing well, but about 41% of PMTCT sites (basic sites) do not have the capacity to test due to human resource constraints and lack of training on HIV rapid testing. Only the 134 public health sites that offer ART currently provide CD4 counts for HIV+ pregnant women; there is no specific policy to provide CD4 testing for pregnant women. The overall economic crisis and consequent out-migration of skilled personnel – particularly registered nurses and medical officers - will continue to hamper progress. PMTCT National

Scale UpUSG has supported PMTCT scale up since 2004, providing funding and technical assistance (TA) to the MOHCW through the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). Additional modest USG funding supports training by the MOHCW, should USG policy on direct funding so permit. The USG provides wraparound Population funding to other partners to support family planning (FP) at USG PMTCT sites. With PEPFAR funding to the DELIVER and SCMS mechanisms, USG provides logistics support to assure that FP commodities, test kits, and key PMTCT commodities are available. In past years, USG and EGPAF have collaborated with the MOHCW and other partners to achieve important policy reforms to facilitate national scale up, including: (1) Roll-out of single dose Nevirapine (sdNVP) at time of diagnosis regimen in January 2008, with a subsequent increase in the numbers of HIV+ pregnant women receiving ARV prophylaxis (sdNVP, with and without AZT) from 73% to 91% in CY2008. (2) Piloting and roll-out of MER, in which women start AZT at 28 weeks followed by both AZT and 3TC (Combivir) and sdNVP at start of labor, and then Combivir only until one week after delivery, and newborns receive ART for its first week of life. MER protects up to 70% of babies, whereas sdNVP protects 25-42% (with exclusive breast feeding).(3) Integration of PMTCT commodities with Delivery Team Topping Up (DTTU) system.In FY2008 USG partners in the Supply Chain Management Systems (SCMS) and DELIVER mechanisms undertook a successful pilot effort to improve delivery of essential PMTCT commodities which was expanded in FY09 with good results.(4) Integration of PMTCT services with Expanded Program of Immunization (EPI) Services. In August 2008, EGPAF completed a USG-funded pilot project assessing delivery of PMTCT post natal services at EPI entry points which had positive outcomes. Follow-on work with infant care in FY09 is described in the Pediatric Care & Treatment narrative.Accomplishments Since Last COPAs of September 2009, the USG PMTCT program operated in over half of Zimbabwe's districts (31 out of 60), covering about 36% of all MOHCW facilities (595 out of 1643) and providing over 30% of Zimbabwean pregnant HIV+ women with ARV prophylaxis that provides up to 70% protection for their newborn babies. Between January 2004 and June 2009, USG through EGPAF reached over 582,075 pregnant women attending ANC. Of these women, 409,774 were tested for HIV and 384,187 received their results. Approximately 72,325 HIV+ women were identified within the program a nd of these 55,387 women and 36,489 infants received ARV prophylaxis. Based on national HIV estimates, approximately 48,300 HIV+ pregnant women were in need of PMTCT in FY09. In FY2008, the program managed to reach 15,691 HIV+ pregnant women with ARV prophylaxis, contributing to approximately 31% of the national coverage (against a 2008 base of 50,700 HIV+ pregnant women). As of June 2009, the program had already reached almost 26% of national coverage, reaching 12,323 pregnant HIV+ women with prophylaxis against a base of 48,300. Increased attendance in third and fourth quarter FY09 suggest that PMTCT uptake will increase and exceed 2008 coverage significantly.As of June 30, 2009, 107,145 pregnant women booked for ANC at the 595 EGPAF-supported comprehensive service outlets, of which 88,787 (82.8%) women received HIV counseling and testing and were issued with results. Within the same period, 12,323 women received sdNVP therapy in the ANC setting; 1,289 received sdNVP + AZT in the ANC setting; and 775 received Combivir (AZT/3TC) at EGPAF sites. The major new strategy in FY09 was the pilot of the "MER" combination ARV prophylaxis at 76 sites in 5 districts. EGPAF is providing ongoing technical support to the national PMTCT unit for the roll out. The new MOHCW policy expects 15,000 mothers/infants to receive MER in 2010 and 25,000 in 2011. In addition to provision of AZT to mothers beginning at 28 weeks, MER also provides ART to newborn infants for the first week of life. As of June 2009, the uptake of infant prophylaxis was 66% and of all infants who received prophylaxis, 28% received combination therapy. USG partners have also supported planning for scale up of early infant diagnosis (EID) with a total of 862 infants below 12 months tested as of June 2009 using Polymerase Chain Reaction (PCR) testing. As described in more detail in the Pediatric Care & Treatment technical narrative, USG will support EGPAF in expansion of the EID program in FY10. Part of the USG program strategy is to increase male involvement in PMTCT. In FY09 EGPAF found some successes recruiting "father mentors" to give testimony to other men. During FY09 EGPAF also collaborated with the USG Partnership Project to develop and deliver a PMTCT mass media campaign, reaching an estimated average of 2,699,330 people. The campaign is increasing male involvement and family support for couples who access PMTCT services, and use of condoms and other family planning methods for HIV+ couples to prevent unintended pregnancies. Partnership also undertook

an exclusive breast feeding campaign that included significant male listenership (40%) to mobilize male support for this feeding method.In FY09, the MOHCW and SCMS updated the Quantimed database used for the forecasting of ARVs for the ART program and added ARVs for PMTCT. The new database will be used during quarterly quantification updates and will allow the MOHCW to rationally coordinate procurement of PMTCT commodities received from a growing number of partners. With USG wraparound Population funding, as of June 2009 the Partnership Project supported 104,000 FP/reproductive health counseling visits at 122 PMTCT sites, and collaborated closely with EGPAF and the MOHCW on strengthening integration of FP and PMTCT. Goals and Strategies for Coming YearIn FY10, USG will support EGPAF to expand the quality of the PMTCT program with a focus on ensuring that existing sites can deliver MER and ART to eligible pregnant women. The program will maintain coverage in the existing 31 districts and cities, and may expand into 3 new districts using funding from UNICEF. USG will provide direct support to 680 PMTCT sites, with 215 of these being upgraded to provide MER. In addition, 25 learning sites will be equipped to initiate ART in a MCH setting. The program intends to continue to provide: sdNVP to 11,000 identified women; MER to 10,000 pregnant women and ART to 4,000 eligible women in FY10. SCMS will procure point of care rapid CD4 testing machine s and related products and will facilitate delivery of drugs to support PMTCT (EGPAF and other sites) using stocks provided by UNITAID, USG/SCMS (4,200 in 2010), and the Global Fund. In FY10 EGPAF will continue to provide technical support to MOHCW to strengthen coordination and management at national and district level and will provide training and refresher courses for both national/provincial trainers as well as site level healthcare workers in PMTCT, OI/ART management, HIV rapid testing, infant feeding counseling, psychosocial support, and integrated FP. EGPAF and collaborating MOHCW personnel will undertake intensive on-site facilitative supervision and mentorship at all levels, and continue community mobilization and awareness activities including distribution of IEC materials and support to PMTCT psychosocial groups. The program will continue to focus on strengthening male support and involvement and will continue strong collaboration with partners that provide FP wraparound services.In FY10 USG will carry out an evaluation of both the national PMTCT program and a mid-program evaluation of the FAI program that are expected to inform future year programs. REDACTED.. Funding IssuesSome observers credited the decrease in ANC attendance in early FY09 to increased user fees with “dollarization.” In a 2009 UNICEF survey of 1065 health facilities in Zimbabwe that offer ANC services, 49% reported they levied no charge for ANC care, 35% said they charged less than $5 and another 14% of the facilities charged between $5 and $20. Less than 3% of the facilities reported charging clients more than $20 for ANC services. These new data suggest that the practice of charging user fees for ANC services may not be as widespread a practice as might have been originally assumed. The USG will continue to monitor use and address real barriers as they emerge. Harvard University and one of EGPAF’s sub-partners, OPHID, are undertaking research to evaluate the cost effectiveness of different PMTCT interventions. The group is developing a model and collecting both Zimbabwe-specific and other published data to feed into the model. The research is expected to produce a useful tool to evaluate different approaches in Zimbabwe’s national program. Wraparounds/Leveraging In FY06-09, USG incorporated family planning counseling and services into PMTCT programming via a wraparound of $700,000 of non-PEPFAR USG Population funding; similar levels are expected in FY10. Other donor resources that complement USG resources for PMTCT are $2.4 - $2.7 million in FY09-2010, from DFID ($1 million), UNFPA ($250,000), the Gates Foundation ($220,000), UNICEF ($850,000 and possibly an additional $300,000), and Johnson & Johnson Foundation ($150,000).

Technical Area: Sexual Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVAB	1,601,500	
HVOP	1,556,000	

Total Technical Area Planned Funding:	**3,157,500**	**0**

Summary:
Zimbabwe FY2009 Operational Context Major political and economic developments continued to affect the PEPFAR program during FY 2009. From November to February, most public health facilities and schools – with the exception of some OI and ART clinics - were closed due to lack of funds to pay staff. Inflation was estimated into the trillions of percent. Public utilities operated sporadically in major urban areas. The deterioration of services led to a widespread cholera epidemic affecting 100,000 and killing 4,200. At the peak of the crisis in January-February 2009 the international community was feeding almost 7 million individuals, or more than half of the estimated resident population. USG and its PEPFAR partners continued to work as conditions permitted. In January, Zimbabwe adopted use of multiple foreign currencies (primarily the U.S. dollar, South African Rand and Botswana pula). Official “dollarization” saw an influx of foreign currency and the gradual stabilization of prices. In February, the three opposing political parties finally created an inclusive government which re-opened most health care facilities and schools. While the economy has begun to stabilize, basic infrastructure has so deteriorated that health services have not returned to even acceptable levels. More broadly, human rights and the rule of law are still not respected which is preventing full donor reengagement and private investment necessary for true recovery.Sexual Prevention Program Context & BackgroundIn spite of a decline in HIV prevalence between 2001 and 2009, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence estimated at 13.7% (Zimbabwe National HIV/AIDS Estimates 2009). About 1.1 million adults and children are currently living with HIV and AIDS in Zimbabwe. Heterosexual contact remains the primary means of transmission for the epidemic. The Zimbabwe Demographic and Health Survey (ZDHS) 2005-06 recorded that HIV prevalence is higher among women (21%) than men (14%), and prevalence among 15-19 year olds is twice as high among females (6.2%) than males (3.1%). HIV prevalence increases with age for both sexes, with rates being highest for females aged 15-30 years while for males it is highest among 35-44 year olds. The ZDHS and other recent surveys identify a number of factors that contribute to these high rates of HIV infection in Zimbabwe. For example, the reported number of multiple sexual partners remains high with 22% of men and women in the 15-49 age groups reporting more than one sexual partner in the past 12 months. This practice is higher among males (31%) than females (14%). In 2008, a study undertaken by the USG-supported Partnership Project found that among sexually active Zimbabwean adults ages 15–49 years, 11% (males: 15%, females: 6%) reported practicing multiple and concurrent partnerships (MCP) in the past month. Practice of MCP is higher among married/cohabiting males, 21% compared to married/cohabiting females, 5%. Among sexually active and never married females, 15% report practice of MCP in the past month compared to 10.3% never married sexually active men. Cross-generational sex remains high with 15% of all young women age 15-24 years reporting cross-generational relationships which translates to 35% of those who are sexually active and, reported condom use is high in Zimbabwe, however, consistent condom use remains low, particularly in regular relationships. Zimbabwe’s Ministry of Health and Child Welfare (MOHCW) provides overall national leadership for sexual prevention within the framework of the Zimbabwe National AIDS Strategic Plan (ZNASP). The ZNASP includes sexual prevention as one of four main approaches to reduce HIV transmission. Most recently, in the 2009 ANC Survey report, the MOHCW highlighted the following priorities: Prevention with Positives (PwP), including increasing advocacy and treatment literacy campaigns; scaling up of comprehensive ABC prevention p rograms targeting youth 15-19 and 20-24; and scaling up PMTCT as well as HIV testing within the PMTCT and other program settings. USG Sexual Prevention ProgramThe USG sexual prevention program follows the ZNASP and comprises a well-developed comprehensive ABC program that includes provision of mass media and interpersonal communication (IPC) tools within the national HIV/AIDS program. USG programs are undertaken in close collaboration with MOHCW, the National AIDS Council (NAC), UNFPA, and the Zimbabwe National Family Planning Council (ZNFPC). Activities are implemented under the applicable national strategies (such as Zimbabwe’s National Behavior Change Strategy and the National Condom

Strategy) and in conjunction with relevant MOHCW Technical Working Groups.The USG's lead implementing partner for Sexual Prevention has been the Partnership Project, which undertakes comprehensive ABC prevention strategies and risk reduction work, including social marketing of male and female condoms. With USG Population funds, Partnership has fostered family planning integration with Zimbabwe's national PMTCT program. Partnership ends in fourth quarter FY10. USG plans to undertake a new solicitation for a mechanism that will cover, inter alia, a wide range of sexual prevention activities that will start in third quarter FY10, thus providing a smooth transition for key activities that merit continuation. Through non-PEPFAR headquarters mechanisms, the USG contributed 100% of Zimbabwe's male and female condom supply needs for FY09, valued at $5.2 million. The USG is committed to continuing condom supply for the foreseeable future. The USG provides annual funding to the central DELIVER mechanism which provides condom forecasting, logistics, distribution and reporting for public sector male and female condoms. With co-funding from DFID through Crown Agents, DELIVER ensures the availability of male and female condoms to consumers who use public sector health facilities by assisting the ZNFPC to implement the Delivery Team Topping Up (DTTU) distribution system. This system has achieved nearly 95% coverage of public sector health facilities and stock out rates below 5% for male condoms since 2004. In early FY09 USG began support to a new PEPFAR/Zimbabwe partner, Africare, to work on sexual prevention with faith-based networks in several provinces. Africare uses the evidence-based "Mopani Junction" BCC toolkit developed by USG during PEPFAR-I and has accomplished significant coverage in its first year of operation.Accomplishments Since Last COP Based on the 2008 research findings, during FY09 USG focused on MCP as a key driver of HIV/AIDS in Zimbabwe. Partnership worked on IPC campaigns with several local partners to facilitate small group discussions on reducing MCP, reaching over 100,000 individuals in 9 provinces. Partnership also facilitated small group discussions on increasing knowledge levels and risk perception of MCP at sites managed by the International Organization for Migration (IOM), targeting mobile and vulnerable populations (MVP), workplace, farming and mining settlements, tertiary colleges and vocational training centers for the disabled. The project also expanded the 'Love of your life' IPC program to reach high risk groups (MVPs, former commercial farm workers, people with disabilities) in six provinces, reaching MVPs in IOM and peri-urban sites (40%), mining communities (5%), organizations (1%), growth points and rural business centers (34%), people living with disabilities (3%) and farming areas (17%). In collaboration with the Elizabeth Glaser Pediatric AIDS Foundation, Partnership resumed a PMTCT mass media campaign on radio and TV reaching an estimated average of 2.7 million people in the 3rd quarter alone. The campaign seeks to increase male involvement and family support for couples who access PMTCT services, and use of condoms and other family planning methods for HIV+ couples to prevent unintended pregnancies. Partnership make s Protector Plus male condoms available through a nationwide system that had 12,250 outlets in FY09, about 20% below FY2008 levels, with high outlet mortality due to out-migration and the economic crisis. Liquor related outlets continue to drive the male condoms sales at 43%, up significantly from 25% in FY2008. Overall, high risk outlets (CSWs, support groups, hotels, liquor outlets, service stations, and snack shops) contributed 53% of the total condom sales. The Partnership network sold over 53.8 million male condoms in FY09, about 20% fewer than in FY2008. Of all male condoms distributed in FY09, 68% were through social marketing outlets and the remainder through public and commercial sector venues. Distribution of "Care" female condoms is carefully targeted, especially in rural areas, peri-urban areas, and growth points. The female condoms are made available through a network of IPC agents in over 2,000 highly focused outlets–notably hair salons--in high risk areas. Almost 2.5 million female condoms were sold in FY09, down about 13% from FY2008 levels. Of all female condoms distributed in FY09, 60% were through social marketing outlets and the remainder through public sector venues. In FY09, the DELIVER-assisted DTTU system assured that approximately 30 million male and approximately 2.3 million female condoms were distributed through 1,200 health facilities and 400 community-based distributors nationwide. These numbers show increases of 12% and 21% respectively, suggesting that some users may have shifted from the socially marketed Protector Plus and Care to the free public sector supplies. Using DFID funds, DELIVER also assists the DTTU system to distribute oral and injectable contraceptives to FP, counseling and testing, antenatal and PMTCT clinics, and out-patient sites. This coverage assures that condoms are available for discordant couples and PLHA

identified through PITC and/or otherwise accessing services.Africare works with the Evangelical Fellowship of Zimbabwe (EFZ) and Methodist Development and Relief Agency. The project targets beneficiaries from three provinces: Manicaland, Harare and Bulawayo. As of June 2009, Africare and its FBO partners had completed participatory assessments; partner strategies and work plans; trained 500 leaders; and provided BCC materials for outreach. Following Africare's training and provision of radios and Mopani Junction radio cassettes, the EFZ peer educator groups are now meaningfully involved in BCC activities. Overall, the two FBO networks have established 50 peer educator clubs and reached 50,000 individuals with AB messages. Goals and Strategies for the Coming YearIn FY10 the USG will continue its strong Sexual Prevention program, focusing on mass media and IPC for comprehensive ABC approaches, including social marketing of male and female condoms. The USG will continue to collaborate closely with MOHCW leadership in BCC, and will increasingly target specific vulnerable population segments, especially MVP; university students; and adherents to faiths that discourage open discussion of sexuality and/or promote unsafe practices such as girl-pledging, early marriages; and polygyny.FY10 is the last year of the 5 year Partnership Project. The project will continue its robust mass media and IPC campaigns in all areas and will continue social marketing of Protector Plus and "Care" condoms. Of note, in FY10, Partnership will launch a new MCP campaign which will first explain the concept of MCP and associated risks and subsequently address key behavioral determinants of threat susceptibility for young women and perceived costs for men. In anticipation of the end of the Partnership Project, in early FY10 USG is undertaking a solicitation for a follow-on Strengthening Private Sector Services for Health (SPSS) Project. SPSS is expected to begin in mid-2010, thus providing some overlap to assure continuity of key services when Partnership ends on September 30, 2010. SPSS will build on the successes of Par tnership and promote a comprehensive ABC strategy utilizing IPC, mass media, and complementary male and female condom social marketing.In FY10, the DTTU system will distribute approximately 27 million male condoms, 2.5 million female condoms, 10 million cycles of combined oral contraceptives, 4.5 million cycles of progestin only oral contraceptives, and 1,000,000 vials of injectable contraceptives to 1,200 health facilities and 400 community based distributors. Africare will expand its two partners' activities and initiate assistance to a third FBO network partner, the Union of Development of the Apostolic Church in Zimbabwe (UDACIZA). This is a network of African–Zionist churches, most of whose affiliates discourage the use of both traditional and western medicine by their followers. Girl-child pledging and early marriages are regarded as normal. Polygamy, a proxy to MCP, is common. The AB program will continue to work through youth clubs in all three networks, and will include gender equity as a key discussion topic. Particular emphasis will be placed on addressing male norms and behaviors through discussions with male youth about polygyny, MCP, and other traditional practices that may expose them to HIV/AIDS. In FY10, the HIV/AIDS Quality of Care Initiative (HAQOCI) will expand its on-campus activities at the University of Zimbabwe (UZ) with the HIV and AIDS Prevention and Support (HAPS) center for faculty, the Student Health Services Center and the staff clinic. The addition of new staff to HAQOCI's technical team will enable it to provide HIV/AIDS awareness information to students/staff and other members of the University community. HAQOCI offers services at the HAPS center in collaboration with the USG Partnership Project, which provides counseling to the students and staff at the clinic. The HAPS center staff also conducts outreach activities which include HIV awareness on the campus. In FY10, HAQOCI will additionally provide screening for sexually transmitted infections, condom promotion, counseling and provision of family planning methods among other services at the Student Health Services Centre at UZ.The PAS will expand prior year programs such as librarian resource center training, World AIDS Day activities and prevention messaging with the media, and also leverage PAS' programming expertise and contacts in the arts, cultural and education fields to promote prevention in innovative new ways. REDACTED

Technical Area: Strategic Information

Budget Code	Budget Code Planned Amount	On Hold Amount
HVSI	2,615,000	

Total Technical Area Planned Funding:	**2,615,000**	**0**

Summary:
Zimbabwe FY2009 Operational Context Major political and economic developments continued to affect the PEPFAR program during FY 2009. From November to February, most public health facilities and schools – with the exception of some OI and ART clinics - were closed due to lack of funds to pay staff. Inflation was estimated into the trillions of percent. Public utilities operated sporadically in major urban areas. The deterioration of services led to a widespread cholera epidemic affecting 100,000 and killing 4,200. At the peak of the crisis in January-February 2009 the international community was feeding almost 7 million individuals, or more than half of the estimated resident population. USG and its PEPFAR partners continued to work as conditions permitted. In January, Zimbabwe adopted use of multiple foreign currencies (primarily the U.S. dollar, South African Rand and Botswana pula). Official “dollarization” saw an influx of foreign currency and the gradual stabilization of prices. In February, the three opposing political parties finally created an inclusive government which re-opened most health care facilities and schools. While the economy has begun to stabilize, basic infrastructure has so deteriorated that health services have not returned to even acceptable levels. More broadly, human rights and the rule of law are still not respected which is preventing full donor reengagement and private investment necessary for true recovery.HVSI Program Context & Background In spite of a decline in HIV prevalence between 2001 and 2009, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence estimated at 13.7% (Zimbabwe National HIV/AIDS Estimates 2009). About 1.1 million adults and children are currently living with HIV and AIDS in Zimbabwe. Heterosexual contact remains the primary means of transmission for the epidemic. According to the Ministry of Health (2009), the epidemic in Zimbabwe is believed to be declining as a result of combined effects of behavior change in the population, prevention and treatment programs as well as the impact of mortality. The ANC 2009 survey showed a decline in prevalence in the young women 15-24 years which suggests a reduction in incidence.The drive towards evidence-based programming implies a greater need for up to date information in-country. The dearth of the national health systems has resulted in a paucity of data for decision making. To date the major source of information has been the Zimbabwe Demographic Health Survey conducted in 2005/06, while national population statistics remain unavailable. Nonetheless, concerted efforts continue to be made by the various state and non-state actors working within the health field to make sure that sufficient data is generated for decision making. National AIDS Council (NAC) as part of the “three ones” coordinates HIV and AIDS data collection from across the major response actors within the health realm, with strong collation units occurring at the district level. The Country Response Information System -- CRIS -- is implemented by NAC and was heavily promoted by USGThe National Monitoring and Evaluation Advisory Group (NMEAG) has also continuously played a pivotal role in ensuring that issues of data quality are given priority including the improvement of reporting rates from all health institutions across the country.There have also been deliberate efforts to harmonize data collection and reporting systems by the health sector actors in country, and this has been made possible by the strong coordination efforts, spearheaded mainly by the technical working groups and this is now reflected in the new National Health Information System Strategic Plan.Within the PEPFAR program, joint program reviews conducted annually help partners share information, including challenges during program implementation.Accomplishments since Last COP With prior-year USG fund ing, Macro International, together with local analysis experts, did an extended analysis of the 2005/06 Zimbabwe Demographic Health Survey (ZDHS) data set. The extended analysis focused on the following: the association between violence against women and HIV; comparison of HIV prevalence estimates from 2006 antenatal clinic surveillance and the 2005/06 demographic and health survey; trends in the burden of orphans and vulnerable children in Zimbabwe; trends in unmet need and demand for family planning in Zimbabwe; an evaluation of 2005/06 Zimbabwe Demographic Health Survey HIV prevalence estimates for potential bias due to non-response and exclusion of non-household populations; risk-taking behaviors of HIV-positive adults in Zimbabwe; and biological, social and environmental determinants of low birth weight and

stunting among infants and young children in Zimbabwe. The results were presented to the larger health community in Zimbabwe in September 2009 and have informed USG planning for COP10.With USG funding and technical assistance (TA), the Ministry of Health and Child Welfare (MOHCW) conducted an Antenatal Clinic Surveillance this year. Results of the HIV Antenatal Clinic Survey show that HIV prevalence among pregnant women in Zimbabwe declined from 17.7% in 2008 to 16.1% in 2009. Some of the data from the same survey were also used to compute HIV estimates for the country. The latest statistics show that HIV prevalence has declined to 13.7% in 2009, down from 14.1% in 2008.The USG provides continued technical assistance (TA) to the National AIDS Council's (NAC) monitoring and evaluation needs through participation in the National Monitoring and Evaluation Advisory Group (NMEAG) whose focus this year was the improvement of the national HIV M&E plan produced by a hired consultancy group. Through technical assistance offered by the USG, a final draft of the M&E plan was produced in February 2009 and the different sections were assigned to different sub-groups of the NMEAG for review in line with the UNAIDS' 12 components of an M&E system. In the same vein, the CRIS is being implemented at NAC through technical assistance rendered by the USG. The back up is via a routine paper based system.The USG has also supported surveillance of HIV Drug Resistance through USG supported staff at the MOHCW who provide leadership in all activities related to the implementation of the National HIV Drug Resistance Strategy. Support in this area included training and supervisory visits to implementing sites. Progress in this area will be publicized in the 2008 HIV DR report. Meanwhile, an ART outcomes study is in the pipeline and the protocol is in the review process. The USG is providing TA and other essential resources for the successful implementation of the study. The protocols have been approved by the Internal Review Board (IRB) in Atlanta and are awaiting approval by the Medical Research Council of Zimbabwe.Goals and Strategies for the Coming YearWith FY09 Supplemental funding, in FY 2010, USG will support the MEASURE Phase III Demographic and Health Survey (DHS) mechanism to initiate Zimbabwe's ZDHS 2010-2011, which will include collection of biological samples. The ZDHS+ will increase understanding of a wide range of health issues in Zimbabwe by improving the quality and availability of data on health status and services and enhancing the ability of local organizations to collect, analyze and disseminate such information. The new ZDHS+ data will provide more current information on fertility levels; sexual activity; awareness and use of family planning methods; breastfeeding practices; nutritional status of mothers and young children; early childhood mortality and maternal mortality; maternal and child health; awareness and prevalence regarding HIV/AIDS and other sexually transmitted illnesses. The new ZDHS+ will again include the gender-based violence module which is expected to enhance USG and other stakeholders' knowledge and programming in this area. I t will also include HIV anonymous testing.In FY 2010, the USG will also support the ART Outcomes Evaluation, whose major objective is to inform the national ART program about the current retention rates as well as highlighting the quality of the data being collected for the program. The protocol for this is in the final stages of approval.With FY 2009 supplemental funds and FY2010 funding, the USG will continue to support the HIV DRUG resistance activities being implemented in country. The national HIV drug resistance strategy takes a three-pronged approach: 1) The HIV threshold survey will assess the spread of the HIV drug resistant mutants in newly infected individuals. 2) The Early Warning Indicators survey will provide information for strengthening and instituting corrective measures at sites offering HAART. 3) The monitoring surveys (a cohort study among patients initiating HAART) will provide information used for reducing or preventing HIVDR while on treatment. USG will also provide TA and general support for the multi-drug resistant TB survey that is being prepared to update the country's information on drug resistance to anti-TB drugs and inform the development of a programmatic approach to MDR.With FY09 Supplemental funds, the USG will support a data validation exercise to be conducted by HAQOCI together with the MOHCW in a sample of facilities providing OI/ART care in Zimbabwe to assess the quality of the data currently being collected and reported within the program.In addition, through USG assistance, HAQOCI will be supporting priority activities contemplated in the national Health Information System strategic plan and facilitate the dissemination of updated guidelines through printing and distribution of these ones including the upcoming national TB/HIV guidelines.With FY2010 funding, the USG through MACRO International will support the implementation of Service Provision Assessment in the country. This will provide information about the quality of HIV/AIDS service

provision within the country's health sector. USG will additionally support the country undertake the bi-annual ANC sentinel surveillance which forms the basis for HIV estimates.In FY 2010, SCMS will continue to support operation and maintenance of the Logistics Management Information System (LMIS), Zimbabwe Information System for HIVAIDS Commodities (ZISHAC), managed by the MOHCW/AIDS & TB's Logistics Sub-Unit. The system captures patient data, consumption, stock on hand and losses and adjustment data, all used for informed quantification, storage and distribution decision-making.In addition to ZISHAC, SCMS plans to support an expanded version of the ARV stock audit of USG-funded ARVs, completed at the central level in FY09. The expanded audit will include ARVs funded by all donors and managed by the MOHCW system and cover central level and ART site level on a sample basis.FY2010 resources will also support 5.25 FTE locally engaged staff for TA and program oversight.Leverage/Wraparounds With USG wraparound Population and Child Survival funding, the new DHS will also provide critical information on maternal and child health, including malaria. The DHS should provide up-dated information on the numbers of orphans and vulnerable children in Zimbabwe, by age, gender and by province. USG will provide an estimated $1.5 million in FY2010 Child Survival funds and $200,000 in Population funds for the DHS. It is expected that DFID, UNFPA and other agencies will provide the balance of $200,000 to $300,000 needed, as well as other technical support for the DHS.

Technical Area: TB/HIV

Budget Code	Budget Code Planned Amount	On Hold Amount
HVTB	2,070,000	
Total Technical Area Planned Funding:	**2,070,000**	**0**

Summary:
Zimbabwe FY09 Operational Context Major political and economic developments continued to affect the PEPFAR program during FY 2009. From November to February, most public health facilities and schools – with the exception of some OI and ART clinics - were closed due to lack of funds to pay staff. Inflation was estimated into the trillions of percent. Public utilities operated sporadically in major urban areas. The deterioration of services led to a widespread cholera epidemic affecting 100,000 and killing 4,200. At the peak of the crisis in January-February 2009 the international community was feeding almost 7 million individuals, or more than half of the estimated resident population. USG and its PEPFAR partners continued to work as conditions permitted. In January, Zimbabwe adopted use of multiple foreign currencies (primarily the U.S. dollar, South African Rand and Botswana pula). Official "dollarization" saw an influx of foreign currency and the gradual stabilization of prices. In February, the three opposing political parties finally created an inclusive government which re-opened most health care facilities and schools. While the economy has begun to stabilize, basic infrastructure has so deteriorated that health services have not returned to even acceptable levels. More broadly, human rights and the rule of law are still not respected which is preventing full donor reengagement and private investment necessary for true recovery.HVTB Program ContextZimbabwe is ranked 17/22 among the tuberculosis (TB) high burden countries (WHO 09) and a massive increase in the case load has been experienced since the 1990's, primarily due to the HIV epidemic. According to WHO estimates incidence rates of all TB cases, and of sputum smear positive cases were 782/100,000 population and 298/100,000 population respectively in 2007, representing an increase over 2006. The case detection rate (sputum positive cases) has declined from 42% in 2002 to 27% in 2007. Tuberculosis is the most common cause of death, particularly in age groups with high HIV prevalence (15-49 years). The absolute number of TB cases registered annually has declined in recent years. This is due to operational rather than epidemiological reasons. Only approximately one-third of pulmonary TB cases are diagnosed on sputum smear microscopy. The proportion of unproven or clinically diagnosed TB cases is unacceptably high.There are very few Multi-Drug Resistant TB (MDR-TB) cases diagnosed in the country because culture and drug susceptibility

testing (DST) is done on a very limited scale and only in the private sector. A few Zimbabweans have been deported from Botswana and South Africa with confirmed MDR, and the International Organization for Migration (IOM) is supporting some of them with second line drugs. Although GF R8 includes funding for second line drugs for 200 patients, the current state of the National TB Program (NTP) is such that disbursement approval is in doubt. Directly-Observed Therapy (DOT) is practically non-existent, quality assurance of smear microscopy is virtually non-existent, ensuring drug supply without stock-outs is still a major problem and ensuring sufficient quality of the recording and reporting system to identify MDR suspects (failures of Category 2 and Category 1 treatment) is still a major challenge. The TB/HIV co-infection prevalence among persons with TB disease is estimated by clinical researchers in Zimbabwe to be 80%. There is no information on the proportion of PLHA who attend various OI/ART units and are screened for TB. Previously, TB symptoms screening, done routinely at client-initiated HIV testing and counseling and (CITC) supported by the USG Partnership Project, found that up to 14% of PLHA are found to be TB suspects. Whenever TB screening is not co-located with HIV testing, there is a missed opportunity that could increase TB case detection and strengthen TB control efforts. Isoniazid preventive therapy (IPT) is presently recommended for under-five contacts of smear-positive TB patients. This practice is not implemented widely and opportunities to initiate the provision of IPT for PLHA warrant further attention. The M&E system for TB/HIV needs to be revised as the current system collects data on HIV status only. TB/HIV data on the “three I’s” (intensified TB case finding, isoniazid preventive therapy, and infection control for TB within HIV care services) is currently not being collected by the National AIDS Council. A national level TB/HIV coordinating committee is finally in place and meets quarterly. There are no mechanisms for TB/HIV collaboration at the provincial or district level. The NTP is supported by the Global Fund Rounds 1 and 5 (GF1, GF5) and the European Commission (EC) provides most TB drugs through its Vital Health Services Support Program. Recently, a grant application to the Global Drug Facility has been made. In FY05-09, USG PEPFAR supported laboratory services and provided laboratory consumables and microscopes to support the National TB Program. Implementation of the GF5 for TB ($12 million) has been delayed for several years. The program is explicitly designed to integrate with GF5/AIDS award to improve Zimbabwe’s co-management of TB and HIV/AIDS at the national, provincial and district levels. Zimbabwe’s GF8 proposal for TB, for $58.3 million, was recently approved by the technical review committee. Its priorities remain the same as those of GF5. It is not clear when disbursement of GF8/TB will begin. In summary, TB control in Zimbabwe has lost its former strength, and the country is challenged to respond to the increased case load driven by HIV infection. The global StopTB targets of a case detection rate of 70% and a cure rate of 85% were not achieved by 2005, and their achievement in 2010 is highly unlikely. Without external support and a greatly strengthened robust national TB program, TB-related morbidity and mortality will continue unabated, and Zimbabwe’s capacity to achieve the 2015 target of reducing prevalence of and deaths due to TB by 50% is at great risk. USG Wraparound ProgramIn September 2008 the USG provided $1.3 million in earmarked TB Initiative funding (non-GHCS) to the central TB Control Assistance Program (TB CAP) mechanism to support improved TB control in Zimbabwe. The International Union Against Tuberculosis and Lung Disease (The Union) is the coordinating partner. The goal of TB CAP support is to decrease TB-related morbidity and mortality through strengthening TB control activities in Zimbabwe, in line with the global Stop-TB Strategy and the Zimbabwe Health Sector Strategic Plan. During FY09, TB-CAP collaborated with the NTP and other stakeholders, including USG TA, to: develop a 5 year national TB strategic plan and revise the M&E system and recording and reporting tools; develop clinical TB and TB/HIV training materials establish a demonstration province (Midlands) for TB management, including collaboration with the PEPFAR Supply Chain Management Systems (SCMS) mechanism on a pilot to ensure that supply of TB laboratory consumables and TB drugs is addressed; develop TB/HIV guidelines, led by USG direct TA in partnership with the University of Washington International Training and Education Center for HIV/AIDS (I-TECH); and facilitate coordination mechanisms for TB/HIV collaboration. In FY10, TB-CAP will continue to collaborate with the MOHCW, USG and other partners to strengthen national level systems, strengthen leadership and management capacity for TB control at national, provincial, and city level; strengthen human resource capacity at service delivery levels; and strengthened capacity for TB/HIV scale-up. USG mechanism funding ceilings have created some doubt as to the continuation of TB-CAP beyond FY10,

although the USG team is advocating for extension through 2011.USG PEPFAR Program Evolution and Achievements since last COPIn FY05-FY06 USG PEPFAR funds for TB/HIV contributed to development of two model pr ograms at large urban clinics in Harare and Bulawayo. By the end of FY07, both of these programs were providing clinical prophylaxis and/or treatment for TB for co-infected individuals on a high quality, routine basis. In FY07-08, the USG-funded program lost focus, and modest HVTB funds were used to support OI/TB/ART training of health care providers. With the launch of TB-CAP in FY09, the USG team decided that a logical strategy would be for TB CAP to provide TA and services at the national level and in 1-2 provinces, subject to availability of non-PEPFAR TB funds, and USG PEPFAR to focus on strengthening the national TB reference lab and TB surveillance with PEPFAR funds. In FY09, USG PEPFAR provided significant support to NTRL for reagents throughout the year; helped establish external quality assurance (EQA) for TB sputum smears, and provided for training for 4 lab scientists for TB culture at the Biomedical Research and Training Institution. USG also provides routine TA to the NTP in program design, planning and evaluation. Within the crisis operating environment, USG collaborated with IOM to design and pilot-test a rapid TB assessment tool for use during IOM staff “fit for travel” review of returnees, which is used in one IOM reception center. Goals and strategies for the coming yearGiven the availability of PEPFAR FY09 Supplemental and increased levels of FY10 PEPFAR funds for Zimbabwe, USG decided to re-invigorate its TB-HIV program by providing increased funding for TA, training, and facilitative supervision for public sector service providers. In parallel, based on the high rate of co-infected patients presenting at the NGO-managed CITC centers under the Partnership Project, USG will support initiation of TB testing in the Partnership New Start and New Life network as well. This re-invigorated PEPFAR TB-HIV program is designed to complement the more systemic work being undertaken by TB-CAP and the GF, with greater results overall. In FY10 USG will continue to provide significant assistance to NTRL and the national lab system. A new mechanism for laboratory EQA will support the procurement of reagents and consumables for TB microscopy, culture and DST for the national TB program. REDACTED. Additionally, the new mobile laboratory units initiated by the African Institute of Biomedical Science and Technology (AiBST) will provide direct sputum microscopy and PCR testing for TB diagnosis among HIV+ patients. Services will be provided to the 10 provinces of Zimbabwe. With FY09 Supplemental funds, the University of Zimbabwe’s Clinical Epidemiological Resource and Training Center’s HIV/AIDS Quality of Care Initiative (HAQOCI) will carry out an assessment of the infection control program implemented at 5 central hospitals and 7 provincial hospitals in Zimbabwe. REDACTED. REDACTED. HAQOCI will additionally work closely with the MOHCW to implement health worker training on the new TB/HIV guidelines for co-infected patients. In addition HAQOCI will continue incorporating TB management in the OI/ART standard training for health care workers. If USG policy permits direct disbursements to the GOZ in FY10, the MOHCW will renovate 2-3 health institutions for the provision of MDR TB care services as most of these patients are TB/HIV co-infected patients. Between 20,000 and 30,000 Zimbabweans receive HIV tests in the USG Partnership Project’s 19 New Start st atic sites and 23 New Start outreach teams on a monthly basis. With FY09 supplemental funds, Partnership will upgrade laboratory facilities and integrate TB smear sputum microscopy laboratory facilities at 5 New Start C&T centers in Harare, Bulawayo, Masvingo, Gweru and Mutare. All clients accessing services at these New Start sites will undergo clinical symptom screening using a brief questionnaire on TB symptoms. All clients with productive cough, identified as TB suspects, will collect sputum on 3 consecutive days for smear microscopy. All clients with Acid Fast Bacilli (AFB) positive sputum results will be referred for anti-TB treatment to be started immediately at TB treatment centers. TB suspects with negative smear results will be referred for further TB investigations requiring Chest X-Ray and clinical examination at public sector health care facilities. It is expected that a total of 350–400 TB suspects will benefit from the additional laboratory services, the intensified referral system and the improved access to immediate TB treatment offered at the five CT sites every month. Partnership will also develop and carry out a multimedia communication campaign to increase awareness of the availability of TB diagnostic services to those who test HIV+ at the New Start centers. In FY10, USG hopes to leverage additional IOM resources to re-test (and if necessary revise) the “fit for travel” TB screening tool and introduce the tool to other reception centers and perhaps other sites where rapid TB assessment could be useful.FY10 is the last year of the 5 year Partnership Project. In early FY10 USG is undertaking a solicitation for a follow-on

Strengthening Private Sector Services for Health (SPSS) Project. SPSS is expected to begin in mid-10, thus providing some overlap to assure continuity of key services when Partnership ends. SPSS will build on the successes of Partnership and continue to support the integration of TB testing services within the New Start network. REDACTED. Wraparounds/Leveraging Other USG TB funding of $1.587 million was provided to TB-CAP in FY09, with FY10 funding in doubt due to worldwide funding ceilings. EU supports essential drug procurement for TB drugs. WHO provides TA and staffing for the National TB Program, and $12 million of GF5 funds will support human capacity development and procurement of commodities.

Technical Area Summary Indicators and Targets
REDACTED

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
5453	I-TECH, University of Washington	Implementing Agency	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHCS (State)	200,000
7524	John Snow, Inc.	Private Contractor	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	500,000
7549	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	12,285,000
9990	Elizabeth Glaser Pediatric AIDS Foundation	NGO	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	5,788,000
10530	National AIDS Council-Mozambique	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP	100,000
10549	World Education	NGO	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	3,350,000
10570	African Institute of Biomedical Science and Technology	Implementing Agency	U.S. Department of Health and Human Services/Centers	GAP, GHCS (State)	1,950,000

			for Disease Control and Prevention		
10579	University of Zimbabwe	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHCS (State)	1,762,500
10609	Ministry of Health and Child Welfare, Zimbabwe	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP	500,000
11754	State/AF	Implementing Agency	U.S. Department of State/Bureau of African Affairs	GHCS (State)	200,000
12287	Africare	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHCS (State)	307,500
12288	Emory University	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	300,000
12289	Macro International	Private Contractor	U.S. Agency for International	GHCS (State)	1,140,000

			Development		
12290	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12291	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12292	The Centre for Counselling, Nutrition & Health Care, (COUNSENUTH)	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP	100,000
12293	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12294	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12295	TBD	TBD	U.S. Department of Health and Human Services/Centers	Redacted	Redacted

			for Disease Control and Prevention		
12296	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12297	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 5453	**Mechanism Name: International Training and Education Center on HIV (I-TECH)**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: I-TECH, University of Washington	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 200,000	
Funding Source	**Funding Amount**
GHCS (State)	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The International Training and Education Center on HIV (I-TECH) was founded in 2002 by the Health Resources and Services Administration (HRSA) in collaboration with the Centers for Disease Control and Prevention to share lessons learned from the U.S. domestic AIDS Education and Training Centers. I-TECH works primarily on activities that contribute to the achievement of PEPFAR. Working at the invitation of ministries of health and the United States Government, I-TECH supports the development of comprehensive training systems for health care workers in regions hardest hit by the AIDS epidemic. Ongoing mentoring activities, pre-services education, infusion of multimedia into training, and distance learning are high priority teaching methodologies for I-TECH. Through its primary home at the University of Washington in Seattle, and with support from its main partner at the University of California, San Francisco, I-TECH provides its network access to rich clinical and technical expertise.

The overall goal of our program is to develop skilled health care work force and strong health care delivery systems in Zimbabwe and across its wide network in the sub-Saharan region.

The objectives of our program are: 1) Production/Update of standardized training materials for use at

national level to improve the quality of care provided to HIV/AIDS patients in Zimbabwe 2) Contribute to the elaboration of technical guidelines that will support the roll out of health care initiatives country wide 3) Support mentorship activities that increase the quality of care provided at site level.

Our activities will be supporting the National HIV/AIDS Strategy and Plan through contributions in the development and update of guidelines and training materials for the provision of care to HIV infected adults and children at national level.

The implementation of our program will be done through consultancy visits to Zimbabwe where field visits to different provinces and districts in the country may be part of the gathering of the required information. Materials are developed together with in-country experts and target different health care cadres involved in the provision of health services.

I-TECH's main contribution to health systems strengthening is done through the support to in-country experts in the development of national guidelines and training materials for in-service training of health care workers with the final objective of improving the quality of care provided to HIV/AIDS patients in Zimbabwe.

The main Cross-cutting program involved is Human Resources for Health as the guidelines and materials produced will be used in the in-service training of health care workers. A Key PEPFAR issue addressed by our program is TB as guidelines and materials produced would include issues of clinical management of TB as the main Opportunistic infection among HIV patients.

Our cost-efficiency strategy is based on the use of existing resources (local or international) for the revision or production of new materials adapted to the country context.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	50,000

Key Issues

TB

Budget Code Information

Mechanism ID:	**5453**
Mechanism Name:	**International Training and Education Center on HIV (I-TECH)**
Prime Partner Name:	**I-TECH, University of Washington**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	100,000	

Narrative:

In FY10 we plan to support the revision of the existing opportunistic infections (OI) and ART training materials developed in 2004 which need to be updated based on the review that the national OI/ART guidelines are currently undergoing. Additionally we would be responding to requests from in–country technical teams for external support in mentorship initiatives, training of trainers and other technical related activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	100,000	

Narrative:

In FY10 we plan to support the elaboration/revision of pediatric guidelines and/or training materials for management of HIV/AIDS and/or other opportunistic infections based on updated guidelines produced internationally or in-country to respond to the new challenges and evidence based recommendations in the management of pediatric patients. Additionally we would be responding to requests from in–country technical teams for external support in mentorship initiatives, training of trainers and other technical related activities.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7524	**Mechanism Name: USAID/DELIVER II TO1/JSI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: John Snow, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHCS (State)	100,000
GHCS (USAID)	400,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The USAID | DELIVER PROJECT (USAID Contract #GPO-I-00-06-00007-00) has been awarded to John Snow, Inc. (JSI) to design, develop, strengthen and, upon request, operate safe, reliable, and sustainable supply systems that provide a range of affordable, quality essential health commodities including drugs, diagnostics and supplies to clients in country programs. USG field missions indicate a strong desire for technical support that strengthens all aspects of in-country supply chains, including forecasting, procurement, distribution, management information systems, quality assurance, storage and infrastructure, and medical waste disposal. While family planning and reproductive health remain a priority in the field and for this contract, there will be other priorities. Field missions are seeking supply chain systems that are designed to handle a range of health products, including contraceptives and condoms, essential drugs, and select commodities for HIV/AIDS, malaria, maternal and child health, and infectious diseases. This contract seeks to strengthen supply systems for all essential health commodities and create environments that are conducive to their sustainability.

In Zimbabwe, the USAID | DELIVER PROJECT (DELIVER) supports the Zimbabwe National Family Planning Council (ZNFPC) in preparing forecasts and supply plans for male and female condoms for HIV prevention and for contraceptives. DELIVER designed and, in partnership with a United Kingdom Department of International Development (DFID)-funded Crown Agents activity, assists the ZNFPC to implement the highly successful delivery team topping up (DTTU) distribution system (less than 5% stock out rates for condoms). With assistance from the PEPFAR funded Supply Chain Management Systems (SCMS) Project this system also distributes HIV rapid tests and PMTCT Nevirapine (NVP) nationwide, and has begun a pilot test of adding PMTCT ARV short-course therapy (called more efficacious regimens, or "MER") to the system. With wraparound USG Child Survival funding DELIVER is assisting the Ministry of Health and Child Welfare (MOHCW) to pilot test in one province a system in which TB drugs for continuation sites and Malaria artemisinin combination therapy (ACT) and rapid diagnostic tests (RDT) for all sites are being managed on a DTTU type system called the Zimbabwe Informed Push (ZIP) system.

DELIVER is improving Zimbabwe's Human Resources for Health by conducting trainings as needed to

ensure that team leaders are fully competent in critical software systems such as AutoDRV.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	50,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7524**
Mechanism Name:	**USAID/DELIVER II TO1/JSI**
Prime Partner Name:	**John Snow, Inc.**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	150,000	

Narrative:

In FY 2010, DELIVER will continue to implement the TOP-UP logistics management information system (LMIS) and the AutoDRV, its new automated data capture system, which combines the use of rugged laptops during deliveries with a software version of the DTTU paper Delivery Requisition Vouchers (DRVs). Under the manual system, the DTTU Delivery Team Leaders had to make seven calculations by hand for each commodity – 77 in total at sites receiving both the reproductive health and HIV testing/PMTCT lines of commodities – before completing one site delivery. AutoDRV automates the calculations needed to determine the correct quantity of each health commodity to be delivered, reducing both time spent on site and calculation errors. After each delivery run, the data is imported directly into the DTTU's main LMIS for review and reporting, shortening data-entry time from three weeks per province to two days. The project plans to purchase additional rugged laptops and to upgrade the AutoDRV software.

DELIVER also plans to upgrade the TOP-UP software, which houses the data for all commodities currently carried by the DTTU.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Other	OHSS	350,000	

Narrative:

In FY 2010, DELIVER, with co-funding from DFID through Crown Agents, will ensure the availability of male and female condoms and oral and injectable contraceptives to public sector consumers by assisting the Zimbabwe National Family Planning Council (ZNFPC) in implementing the Delivery Team Topping Up (DTTU) distribution system. Since its inception in 2004, this system routinely achieves nearly 95% coverage of public sector outlets and maintains stock out rates below 5% for male condoms. The performance indicator for this activity is to keep stock out rates for male condoms below 5%.

Because of the continuing success of the DTTU distribution system in the very difficult Zimbabwe operating environment, the national AIDS program and ZNFPC, assisted by the PEPFAR SCMS Project and DELIVER, linked HIV rapid test and PMTCT NVP distribution and reporting to this system in 2008 and have achieved the same high levels of site coverage and low stock out rates for HIV rapid tests and NVP. During 2009, with funding from the SCMS Project, PMTCT MER ARV drugs are being added to the DTTU system on a pilot basis, and if successful this will be rolled out nationwide in FY2010.

The DTTU system will distribute approximately 30 million male condoms, 2.3 million female condoms, 10 million cycles of combined oral contraceptives, 4 million cycles of progestin only oral contraceptives, and 1,000,000 vials of injectable contraceptives to 1,430 health centers and hospitals and 300 community-based distributors in FY 2010.

DELIVER will also be sponsoring a system-wide costing exercise for the DTTU, which will measure the total cost of running the system, taking into account all of the inputs and supporting partners, and compare this to the cost of running the traditional drug ordering system.

In addition to its HIV-funded DTTU delivery activities, DELIVER is also currently running a pilot for TB drugs, TB lab commodities and malaria ACTs & RDTs with DELIVER's wraparound Child Survival funding. If successful, additional DELIVER funding under Child Survival will be used to partially roll out the system.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7549	**Mechanism Name: Supply Chain Management System (SCMS)**

Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Partnership for Supply Chain Management	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 12,285,000	
Funding Source	**Funding Amount**
GHCS (State)	4,685,000
GHCS (USAID)	7,600,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Supply Chain Management Systems (SCMS) Project (USAID Contract #GPO-I-00-05-00032-00) brings together a partnership of 16 private sector, nongovernmental and faith-based organizations that are among the most trusted names in supply chain management and international public health and development. With offices in 17 countries and 350 dedicated staff members around the world, SCMS is helping to improve the lives of people living with HIV/AIDS in some of the countries most severely impacted by the pandemic. SCMS procures essential medicines and supplies at affordable prices; helps strengthen and build reliable, secure and sustainable supply chains systems; and fosters coordination of key stakeholders.

In Zimbabwe, the SCMS Project is implemented by JSI Research & Training Institute Inc, one of the 16 project partners. SCMS procures first line ARV drugs for approximately 59,000 adult patients. SCMS strengthens MOHCW, NatPharm and ZNFPC capacity in supply chain management through technical assistance and operations support which includes the design and implementation of distribution and LMIS systems; provision of staff to the MOHCW; provision of delivery and monitoring vehicles, fuel and maintenance; training in forecasting and quantification; an ARV stock audit system; support for warehousing improvements, and support for donor coordination. Additionally, the project strengthens MOHCW technical ART capacity by providing two key staff to the national ART program.

The program will strengthen Zimbabwe's human resources for health in FY10 by conducting a full, in-depth course in Supply Chain Logistics, training on PipeLine Software, and updated trainings on the ARV Pull System. Additionally, the project will support decentralization training by the AIDS & TB Program for

HIV care providers.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	350,000

Key Issues

Child Survival Activities

Safe Motherhood

TB

Budget Code Information

Mechanism ID:	**7549**
Mechanism Name:	**Supply Chain Management System (SCMS)**
Prime Partner Name:	**Partnership for Supply Chain Management**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	740,000	

Narrative:

In FY 2010, SCMS will continue to second two medical officer positions to MOHCW AIDS & TB Programme: the National ART Coordinator and the Assistant National ART Coordinator. The project's support will include funding of site readiness assessments and site supervision aimed at enhancing the MOHCW's ART scale-up activities, the national quality of care initiative, and decentralization of ARV treatment. SCMS will continue to support supply chain systems which ensure that the ART treatment sites have an adequate supply of ARV drugs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	200,000	

Narrative:

In FY 2009 and 2010, SCMS will continue to procure up to approximately $200,000 of HIV rapid tests (Determine, SD Bioline, and the INsti tie breaker rapid tests under the current parallel testing algorithm)

to contribute to the achievement of the MOHCW targets,(1,200,000 adults and children to be tested in CY 2011) and will assist the MOHCW in accurately quantifying HIV rapid test kit requirements. The national program's stated intention to move to a serial HIV testing protocol, originally targeted for June 2008, is not projected to begin until 2010.

Distribution for the rapid tests is part of SCMS's OHSS activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	200,000	

Narrative:

In FY 2010, SCMS will continue to support operation and maintenance of the Logistics Management Information System (LMIS), Zimbabwe Information System for HIVAIDS Commodities (ZISHAC), managed by the MOHCW/AIDS & TB's Logistics Sub-Unit. The system captures patient data, consumption, stock on hand and losses and adjustment data, all used for informed quantification, storage and distribution decision-making.

In addition to ZISHAC, SCMS plans to support an expanded version of the ARV stock audit of USG-funded ARVs, completed at the central level in FY2009. The expanded audit will include ARVs funded by all donors and managed by the MOHCW system and cover central level and ART site level on a sample basis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	5,000,000	

Narrative:

With FY2009 Supplemental funding and In FY 2010, SCMS will provide ongoing technical assistance and resource support to the MOHCW/AIDS & TB Logistics sub-unit (LSU). The fourteen current staff positions of the LSU are funded through SCMS, as is the SCM Coordinator based at the MOHCW/AIDS & TB Unit.

The LSU manages the supply chain for the national MOHCW ART program. The LSU, along with the Directorate of Pharmacy Services (DPS), chairs the Procurement and Logistics Sub-committee of the ART Partners Forum, a central body for donor and partner collaboration and communication. SCMS, through the LSU, will continue to provide the following:

Product Selection: review national treatment guidelines, offer logistics considerations of choosing products, and work to minimize pack size proliferation.

Quantification/Forecasting /Supply Planning: lead and manage quarterly updates of quantifications for Adult and Paediatrics ARV drugs fro treatment and PMTCT, HIV test kits, TB drugs, cotrimoxazole, and fluconazole.

Procurement: prepare procurement plans for all USG funded products; assist other partners in the development of procurement plans; highlight supply gaps and mobilize resources to fill these gaps.

Warehousing: work with NatPharm (parastatal storage agent for all MOHCW HIV & AIDS commodities) to address any existing or potential storage challenges. In 2009, SCMS seconded a part-time project coordinator to NatPharm to assist with the ESP-funded purchase and installation of a racking system, a radiation heat barrier to preserve MOHCW ARVs and a new roof. SCMS plans to provide the same level of support to Phase II of the refurbishment in FY10.

Distribution: support NatPharm with national bi-monthly distribution of ARV drugs and OI drugs, providing 3 delivery trucks, fuel and maintenance, drivers, and per diem.SCMS will also continue to assist the MOHCW in implementing an ordering and distribution system for rapid tests to ensure their availability to the public for roughly $500,000 per year, with an additional $500,000 in supplemental funding for PMTCT MER roll-out on the same system. HIV rapid tests and PMTCT NVP, followed by a pilot of the PMTCT MER, were added to the ZNFPC DTTU system in 2009.

Capacity Building: provide system-specific training on logistics for ART sites as necessitated by addition of new sites and personnel attrition, as well as trainings to personnel in associated delivery systems like ZNFPC's DTTU.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	520,000	

Narrative:

In FY 2010, up to $300,000 will be used for the procurement of point of care (POC) rapid CD4 testing machines and reagents or other products as necessary to increase the numbers of pregnant women initiated to ART.

During 2009, MOHCW revised the PMTCT strategy to progressively increase the proportion of pregnant women who received more efficacious regimens (MER). It is expected 15,000 mother/infants receive PMTCT MER in 2010 and 25,000 mother/infants in 2011. Part of the ARVs needed will be supplied by UNITAID; the balance being supplied by SCMS that will provide MER ARVs for 4,200 (2010) and 4,500

(2011) mother/infants.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	5,625,000	

Narrative:

With FY 2009 supplemental funds, SCMS will purchase an additional $1,880,000 worth of ARVs to support treatment of an additional 19,000 adult on standard 1st line regimen on a temporary basis, to fill gap caused by delays in GF funding and procurement.

In FY 2010, SCMS will provide first-line ARVs to continue the provision of ARVs worth $4,000,000 initiated in 2007 for 40,000 adult patients treated in public sector health facilities . An additional $1,625,000 will be used to help MOHCW address temporary gaps in 1st line ARV funding and avoid stock outs that could lead to treatment disruption. SCMS supplied ARVs will contribute to meeting the MOHCW target (310,000 adult ART patients by the end of 2011) which is also supported by the Government of Zimbabwe, Global Fund, the DFID-led Expanded Support Programme, the Clinton Foundation, EU, UNITAID and other donors such as Direct Relief International and Axios/Abbot.

To support these patients and in accordance with the MOHCW Guidelines for ARV Therapy in Zimbabwe, SCMS will procure the following medicines: Lamivudine/Stavudine/Nevirapine 150/30/200mg for patients on the standard first line regimen, Lamivudine/Stavudine 150/30mg and Efavirenz 600mg for first line patients with tuberculosis and Lamivudine-Zidovudine 150+300mg plus Nevirapine 200mg for pregnant women. These drugs will be FDA-approved/tentatively-approved generics, whenever possible and logical.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9990	**Mechanism Name: USAID/PMTCT/EGPAF**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Elizabeth Glaser Pediatric AIDS Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 5,788,000	
Funding Source	**Funding Amount**
GHCS (State)	3,172,000
GHCS (USAID)	2,616,000

Sub Partner Name(s)

J.F. Kapnek Trust	Organisation for Public Health Interventions and Development	Zimbabwe AIDS Prevention Project

Overview Narrative

Elizabeth Glaser Pediatric AIDS Foundation's (EGPAF) Family AIDS Initiatives (FAI) Program works to support the Ministry of Health and Child Welfare (MOHCW) to increase access to comprehensive, high quality PMTCT services linked to treatment, care and support of families, including children living with HIV and AIDS. This is achieved through direct support to the national AIDS&TB Unit to implement the national PMTCT program, guided by the national PMTCT and Pediatric Care and Treatment Strategic plan 2006-2010. Since 2001, EGPAF has seconded staff to the National AIDS&TB Unit to ensure overall technical leadership, coordination and development of the national PMTCT program. The FAI program also provides support at district and health facility levels through three partner organizations – the JF Kapnek Charitable Trust, the Zimbabwe AIDS Prevention Project, and the Organisation of Public Health Interventions and Development -- guided by the Foundation's country team.

The program's strategic objectives are: 1) to advance research that increases access to and uptake of high quality integrated services of prevention, care and treatment for HIV/AIDS in Zimbabwe; 2) to support the expansion and provision of quality PMTCT and care and treatment services for children and their families affected by HIV/AIDS; 3) to advance the Family AIDS Initiative consortium's leadership role in influencing public health policy and serve as a national advocate to seek the eradication of pediatric HIV/AIDS; 4) to enhance the Family AIDS Initiative partnership's capacity to operate in an effective, efficient, accountable and responsive manner.

The FAI program has been supported by USG since 2004. Between January 2004 and June 2009, the program reached over 582,075 pregnant women attending antenatal (ANC) clinics at a total of 595 USG supported PMTCT sites. Of these women, 409,774 were tested for HIV and 384,187 received their results. Through June 2009, the program identified approximately 72,325 women living with HIV and of these 55,387 women and 36,489 infants received ARV prophylaxis. As the program has matured, EGPAF has collaborated with the MOHCW and other partners to pilot a number of enhanced PMTCT

interventions including short-course combined ARV "more efficacious regimens" (MER) and early infant diagnosis (EID).

EGPAF is improving Zimbabwe's Human Resources for Health through training national, provincial and district trainers who have cascaded training to healthcare workers at a site level in a number of modules including PMTCT, MER, EID, infant feeding counselling, OI/ART, psychosocial support and HIV rapid testing. The FAI partners provide both direct technical support to these trainings and mentoring to national trainers. EGPAF has ensured that family planning (FP), and maternal and child health issues are integrated within the trainings and site support visits, with growing attention to FP and emergency obstetric care. EGPAF has worked with MOHCW to continually update the national training materials and job aides to support these activities. Gender issues, including increasing gender equity in HIV/AIDS activities and addressing male norms are included via EGPAF and partner family centered approach to encourage access to program services. In particular the benefit of male participation is highlighted during community mobilization activities and initiatives such as sending out of letters to invite men to accompany their partners to routine maternal and child health services. This has led to increasing numbers of male partners being tested for HIV in an ANC setting.

EGPAF's core activities funded under PEPFAR are complemented with additional resources from DFID, Gates Foundation, Johnson and Johnson, and UNFPA, particularly for operational research. In addition, EGPAF is expecting to receive funds under Global Fund Round 5 and UNICEF to support activities for children living with HIV.

The program relies on already existing national structures and works closely with provincial and district nursing officers through peer support and mentorship. In addition, EGPAF continues to build the capacity of the national PMTCT unit to coordinate and lead the overall process according to national strategic plans. Over time, these cadres become more proficient to undertake the responsibility to manage and monitor the program, enabling partners to support poorer performing districts and sites. Efficiency of the program is maintained by working at national, provincial, district and site level ensuring that national standards are applied and coordination efforts are not duplicated.

The FAI partners monitor the program according to national indicators and using national reporting formats. As new interventions have been scaled up e.g. MER, EGPAF has worked closely with MOHCW to revise existing registers and monitoring tools. Training on their use is then integrated into the training courses. Data from sites is collected by the sites and implementing partners on a quarterly basis using monthly reporting formats. These are then consolidated by EGPAF in quarterly reports submitted to both PEPFAR and the national PMTCT unit. Data validation assessments are an integral part of the program. Site support visits are undertaken by EGPAF and the partners to ensure that data is analyzed and utilized

for decision making and improvement in the quality of the program.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,410,000

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	**9990**		
Mechanism Name:	**USAID/PMTCT/EGPAF**		
Prime Partner Name:	**Elizabeth Glaser Pediatric AIDS Foundation**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HTXS	300,000	

Narrative:

Most adult treatment activities will be undertaken with FY09 supplementary funding. Specifically FAI will support the introduction of point of care CD4 testing in PMTCT sites (machines to be procured by CHAI and UNICEF) at medium/low volume sites and ART initiation for eligible pregnant women at an initial 25 sites. In addition, the program will strengthen linkages between high volume PMTCT sites and ART clinics using application of standardized referral forms to improve access to CD4 and ART. Specific activities include: 1) Organizing an exchange visit for senior policy makers to review successful roll out of ART initiation in MCH in the region (leveraged funding from DFID). 2) Development of national protocols and tools including revision of national ART registers. 3) Updating national ARV guidelines; 4) Finalization of referral forms and national scale up of these to strengthen linkages between PMTCT, laboratory and OI/ART clinics – training to be integrated. 5) Training of MCH staff on adult OI/ART management and on-the-job training of CD4. 6) Support to scale up of the national mentorship pilot to

improve ART delivery. 7) Support to MOHCW to mobilize resources to procure BD stabilizing tubes and introduce these at additional sites. 8) Intensive on-site supervision at the learning sites; 9) Strengthening coordination at national level. 10) Detailed documentation and review to inform policy changes and advocacy.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	669,000	

Narrative:

EGPAF has been working to improve follow up of HIV-exposed infants by integrating postnatal activities within the expanded program of immunization (EPI_ as well as developing a national follow-up register. The program intends to improve prescribing of Cotrimoxazole prophylaxis at 6 weeks to HIV-exposed infants from 9,000 to 14,000 infants using PEPFAR funding. Using FY09 Supplemental funds along with leveraged funding from DFID and UNICEF with the following to be undertaken:

1) Finalize and print a national implementation guide and job aides to improve follow up services and integrate application within existing training courses. 2) Distribute the national follow up register and include training on this into existing courses. 3) Support PSS groups for children and carry out exchange visits (leveraged funding from UNICEF). 4) Evaluate the child health card and provide on-the-job training to ensure cards are appropriately filled in to identify HIV-exposed infants (leveraged funding from DFID). 5) Carry out community mobilization activities to raise awareness on infant feeding issues and care for children living with HIV (leveraged funding from UNICEF). 6) Develop a community based follow up register (leveraged funding from UNICEF). 7) Support and train community cadres on PSS (leveraged funding from UNICEF and Global funds). 8) Supplement national stocks of Cotrimoxazole using private funding. 9) Develop materials to support caregivers awareness of pediatric issues (leveraged funding from UNICEF).

FY10 funds will be used to maintain and scale up the activities mentioned above.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	920,000	

Narrative:

Using FY09 Supplemental funding, EGPAF will support the expansion of the national pilot on early infant diagnosis linked to initiation of pediatric ART that is using leveraged funding from CIDA, CHAI and global funds. Expansion from 4 centralized hospitals to more rural areas is underway but slow. EID training is integrated with MER although stand alone trainings on EID will be encouraged with the new FY10 funds . The program will target testing of 4,000 infants at less than two months of age with an additional 5,000

HIV-exposed infants tested at 18 months. EGPAF has mobilized resources through Global Fund to support training on pediatric OI/ART management.

Using PEPFAR funding, EGPAF will continue to strengthen the national ART unit through provision of direct technical support. In addition, the FAI program will:

1) Support the decentralization of pediatric services in Harare and Chitungwiza through supervision, review meetings and development of decentralization standard operating procedure manuals.
2) Integrate EID training within existing PMTCT modules.
3) Provide training in EID and pediatric ART management.
4) Scale up the national mentorship pilot to 2 additional provinces, linked with ART initiation in MCH.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	3,899,000	

Narrative:

With FY 2009 supplemental and new FY2010 funding, EGPAF will expand the quality of the PMTCT program with a focus to ensure that existing sites can deliver MER and ART to eligible pregnant women. The program will maintain coverage in the existing 31 districts and cities and will expand into 3 new districts with complementary UNICEF funds. EGPAF will provide direct support to 680 PMTCT sites with 215 of these being upgraded to provide MER. In addition, 25 learning sites will be identified to initiate ART in a MCH setting. The program intends to continue to provide: sdNVP to 11,000 identified women; MER to 10,000 pregnant women and ART to 4,000 eligible women. Drugs to support PMTCT will be provided using national stocks (through UNITAID, PEPFAR and Global Funds).

Core activities will include: 1) Provision of technical support to MOHCW to strengthen coordination and management at national and district level including: secondment of existing and additional staff to the national PMTCT unit; hiring of additional EGPAF and partner technical staff; participation in technical working groups; and support to the PMTCT and ART partnership forums. 2) Training and refresher courses for both national/provincial trainers as well as site level healthcare workers in: PMTCT, OI/ART management, HIV rapid testing, Infant feeding counseling, psychosocial support, and integrated FP. 3) Intensive on-site supervision and mentorship at all levels. 4) Exchange visits between poorly and better performing districts. 5) Facilitation of national and district review meetings. 6) Community mobilization and awareness activities including distribution of IEC materials and support to PMTCT psychosocial groups. 7) Provision of essential commodities (using leveraged funding from J&J, DFID, UNFPA). 8) Regular monitoring and evaluation including; training in revised M&E tools, improved documentation and analysis; carry out an evaluation of both the national PMTCT program and a mid-program evaluation of

the FAI program. 9) Development and printing of program documents, abstracts and lessons learnt as an advocacy tool to raise the visibility of the PMTCT program. 10) Technical exchange visits within the region and attendance at technical conferences. 11) FAI planning and coordination meetings including performance monitoring meetings

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10530	**Mechanism Name: CDC/COAG/NAC**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National AIDS Council-Mozambique	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 100,000	
Funding Source	**Funding Amount**
GAP	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

NOTE: Since 2005, the USG has maintained bilateral Cooperative Agreements that provided direct USG disbursements to the Ministry of Health and Child Welfare (MOHCW) and the National AIDS Council (NAC) under the PEPFAR program. (These funds were part of the Department of Health and Human Services appropriation and were not subject to the Brooke-Alexander Amendment of the Foreign Assistance Act.).

In 2008, the USG froze disbursements to the MOHCW and NAC until the GOZ meets established conditions for resumption of bilateral aid. The conditions relate to: full and equal access to humanitarian assistance; restoration of the rule of law; a commitment to the democratic process and respect for applicable international human rights obligations; a commitment to macroeconomic stabilization in

accordance with guidance from relevant international agencies; and timely elections held in accordance with international obligations, and in the presence of international election observers.

The formation of the inclusive government in February 2009 and solid macroeconomic management since then are some positive signs. USG is thus including "placeholders" for the MOHCW and NAC mechanisms for FY2010 so that funds can flow quickly once conditions are met. If this does not occur by May 2010, USG will reprogram the funds to other mechanisms. END NOTE

The National AIDS Council (NAC) is an organization enacted through an Act of the Zimbabwean Parliament in 1999 to coordinate and facilitate the national multi-sectoral response to HIV and AIDS.

The Overall goals of NAC program under PEPFAR are: 1) To improve the quality of Home Based Care (HBC) in Zimbabwe through the leadership and coordination of standards, guidelines and training targeted to the enhancement of the standards of HBC. 2) To strengthen the capacity of the Zimbabwe National AIDS Council M&E Department to effectively monitor and evaluate the implementation of the National HIV and AIDS strategic framework including actual roll out of National M&E System.

Specific objectives of this program under its HBC component are: 1) To ensure effective coordination of stakeholders in home based care and review priorities for standardization of HBC activities. 2) To collaborate with relevant implementers and technical organizations towards updating the national guidelines and development of standard training for HBC. 3) To develop a strategy for disseminating information in local languages about HBC standardizations to implementing organizations and users of HBC. 4) To improve access to HBC services by caregivers and HBC clients.

Specific objectives under the M&E component are: 1) To improve the management and reporting of data through the National M&E System including the use of an electronic database. 2) To coordinate the implementation of training of trainers for improving the capacity of local organizations and DACs (District AIDS Coordinators) to effectively participate in the National M&E System. 3) To develop a communication strategy surrounding the National M&E System. 4) To strengthen the ability of NAC national staff to monitor and support provincial and district staff, as well as local partners and stakeholders

This program supports the HIV/AIDS National Strategy and Plan through increased capacity of NAC to coordinate HBC and M&E components of the National response to the HIV/AIDS epidemic.

The coverage of our activities is national and targets all institutions involved in the response to HIV/AIDS issues in Zimbabwe.

The key contributions of our program to health systems strengthening are an updated database at all levels (National, Provincial and District level) that can inform policy makers about strategic decisions related to the HIV/AIDS program and an unify training curriculum and standards for the provision of HBC.

The core of our activities is in the cross-cutting program of Human Resources for Health through training of M&E officers and standardization of training materials for HBC.

Our strategy for cost-efficiency is based on regional trainings equidistant to participants to reduce transport costs. The printing of materials in bulk and procurement of targeted equipment.

Monitoring and Evaluation of our activities will be done through quarterly progress reports based on site visits, training reports and delivery notes.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	70,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10530**		
Mechanism Name:	**CDC/COAG/NAC**		
Prime Partner Name:	**National AIDS Council-Mozambique**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	50,000	
Narrative:			
With FY10 funds NAC will provide training to HBC task forces in all provinces, conduct supervisory visits to provinces and districts and disseminate at the same time the new HBC policy, strategy and standards developed in FY09.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Other	HVSI	50,000	
Narrative:			
With FY10 funds NAC will do procurement of IT equipment to strengthen the M&E capacity of NAC and provinces; Do training of M&E officers on the new version of CRIS and conduct supervisory visits and quarterly data verification visits to sites by DACs.			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10549	**Mechanism Name: USAID/OVC/WEI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: World Education	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 3,350,000	
Funding Source	**Funding Amount**
GHCS (State)	1,800,000
GHCS (USAID)	1,550,000

Sub Partner Name(s)

John Snow, Inc.		

Overview Narrative

Children First (CF) is USG Zimbabwe's lead mechanism to improve the lives of orphans and vulnerable children (OVC) affected by and infected with HIV and AIDS by increasing OVC access to a range of comprehensive care services and the capacity of communities to provide these services. In addition to PEPFAR funding, USG provides annual wraparound Population funding for training, referrals to care and establishment of service networks for OVC reproductive health.

The goal of the CF project is to mitigate the impact of HIV/AIDS on children in Zimbabwe by improving

OVC access to quality care and support services. There are 3 objectives: 1) increased access to and quality of OVC services through community initiatives; 2)strengthened human capacity and performance of local communities to meet needs of OVC; 3) improved community and national-level advocacy for the social protection of OVC. The CF project was specifically designed to support Zimbabwe's National Action Plan for OVC (NAP-OVC) and to complement and fill gaps not addressed by the multi-donor $70 million Program of Support (POS) for OVC. CF is identifying new models, undertaking advocacy, and targeting highly vulnerable children such as those in child-headed households, abused children, disabled children, and children outside of family care. CF works closely with public and private sector providers to promote networking and complementarity of services to assure that OVC services are as cost-efficient as possible.

Given high levels of need and difficult security conditions in the country during much of 2008, CF initially focused on such children in underserved areas of Harare City. In early 2009 CF undertook a baseline and launched operations in Matebeleland South (Umzingwane district) province, an underserved province recommended by the OVC secretariat. As of June 2009, CF partners were providing a minimum of one care service to 57,922 (47 % male, % 53 female) OVC in all areas.

CF works primarily through direct grants to local NGOs, CBOs, and FBOs that work with OVC, and also provides referrals and linkages with other programs and service providers. As of June 2009, CF had given out grants to 19 NGO partners who sub-granted to 43 CBOs (24 FBOs). CF also works with District AIDS Committees in Harare and Umzingwane to improve their ability to monitor and respond to the needs of OVC in their communities, thus improving linkages between communities and the district and national AIDS response.

In terms of Human Resources for Health, during the first three quarters of FY 2009, CF trained 1,329 community-based providers/caregivers from 6 partner organizations. CF has initiated a system of placements with NGO/CBO partners for day to day mentoring. In 2009, CF conducted training of trainers in human rights and child protection for community-based volunteers working in 14 partner organizations.

In terms of Child Survival activities, CF is collaborating with Clinton HIV/AIDS Initiative to increase access to pediatric ART through a home based care program, and with city council clinics to provide primary health care assessments. For Advocacy and Child Protection, CF has a joint initiative with PEPFAR partner Population Services International (PSI) to develop and produce a national radio drama on child rights issues, and is working on modules on child legislation and children's rights.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	30,000
Education	350,000
Food and Nutrition: Commodities	30,000
Gender: Reducing Violence and Coercion	70,000
Human Resources for Health	50,000

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Child Survival Activities

Family Planning

Budget Code Information

Mechanism ID:	**10549**
Mechanism Name:	**USAID/OVC/WEI**
Prime Partner Name:	**World Education**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	3,350,000	

Narrative:

With supplemental FY2009 funding CF will focus on improving quality as opposed to increasing the number of children or expanding the current geographic area. In FY 2010, the CF project plans to: 1) Select the strongest and most cost-effective of the current NGO grantees to provide the basic package of services. NGOs partners will be selected that provide the greatest beneficiary coverage, and have the organizational capacity to ensure that each CF-supported child has access to at least 3 services. 2) Develop and refine a standard comprehensive package of services that will deliver at least 3 services. Each partner NGO will provide a minimum 3 services, and by creating standards of care developed by CF and its partners, quality assurance will be achieved. 3) Continue to support NGOs with interventions which serve the specific needs of highly vulnerable children. 4) Increase efficiency, achieve cost effectiveness and streamline operations by:

a) Awarding NGO grants for a longer duration (2-3 years instead of 1) to reduce staff attrition and to promote long-term planning;

b) Extending school block grants for additional school terms to increase efficiency and cost effectiveness; c) Refining and scaling up the recently-introduced school-based Primary Health Care (PHC) package so that OVC will have access to PHC screening, school-based care, and referral for more complicated cases; d) Integrating reproductive health and livelihood programs for youth; e) Launching school-based psychosocial support programs in CF- supported schools to standardize psychosocial support. f) Initiating economic strengthening programs focused on nutritional support and Village Savings and Loans. In FY2010, CF will administer direct CBO "challenge grants" ranging from $1,000 - $10,000 to enable community groups to accomplish narrowly-defined, small-scale activities.These community groups include Parent-Teacher Associations, mothers' groups and self-formed PLHA support groups. By supporting CBOs directly, CF will ensure quality improvement and facilitate access to resources by CBOs to enable them to carry out services that reach OVC directly.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10570	**Mechanism Name: AIBST: Capacity Building Project for Training Private Healthcare Professionals in Zimbabwe**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: African Institute of Biomedical Science and Technology	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,950,000	
Funding Source	**Funding Amount**
GAP	150,000
GHCS (State)	1,800,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The African Institute of Biomedical Science and Technology (AiBST) is a non for profit organization dedicated to biomedical research and development in HIV, TB and Malaria. Its core business also includes capacity building for laboratories with cutting edge biomedical technologies and the training of healthcare professionals.

The objectives of the project are: 1) To train private sector health care professionals (medical doctors, nurses, pharmacists and laboratory technologist) on the effective management of HIV, TB and sexually transmitted infections (STIs). 2) To establish a network of private sector health institutions for effective monitoring and evaluation of HIV&AIDS management.

For FY10 expansion of these objectives include: 1) To take diagnostics to the people in the diagnosis, treatment and monitoring of HIV/AIDS, tuberculosis and malaria. 2) To strengthen the Blood Transfusion Services of Zimbabwe (NBSZ) with laboratory capacity to screen for HIV, HCV, and HBV using nucleic acid tests (NAT). 3) To support the roll out of Early Infant diagnosis throughout the country.

The activities that AiBST implements support the HIV/AIDS National Strategy and Plan through: 1) Ensuring that more HIV positive people get access to laboratory diagnostic and monitoring services. 2) Training of health care professionals, especially from the private sector, in updated ART guidelines for adults and pediatrics. 3) Training of laboratory technologist on Molecular Diagnostic methods. 4) Supporting the National Blood Service Zimbabwe in setting up NAT tests for screening blood and training of its technical staff in running such tests and ensuring that the screening services meets international quality assurance.

Our activities will have a nationwide coverage and target mainly rural populations and Health Care Workers that do not have access to continuous training.

The key contributions of the program to health systems strengthening is in the area of labs where AIBST will be increasing access to lab services to the general population, especially to those in rural areas. Capacity building will be achieved through the training of lab personnel on molecular techniques which is helpful in early infant diagnosis and in the screening of blood.transfusions. Other health care cadres will also be trained on diagnosis, treatment and monitoring of HIV/AIDS in Zimbabwe.

Our activities contribute to the cross-cutting areas of Human Resources for Health as we provide training

to private medical personnel, doctors, pharmacists, nurses and laboratory technologists. This is a critical area in Zimbabwe for the provision of HIV/AIDS services as any expansion of activities need sufficient and skilled human resources in place. Among this group, laboratory technologists are a key cadre mainly in the area of Molecular diagnostics as the University of Zimbabwe does not have the equipment or expert tutors to train their students in this area.

REDACTED.

Other activities covered under the program include TB and Malaria as we will be providing microscopic and molecular diagnosis for these two diseases within the mobile services.

Our strategy for cost-efficiency is based on an integrated approach to training, biomedical research and provision of healthcare services within the execution of our project. Our team of experts at the mobile laboratories will also provide training to local clinical and laboratory staff on latest ART and diagnostics guidelines and technologies. The combined trip and use of the same team to achieve two key objectives will translate into significant savings. Simultaneous availability of a wide range of diagnostics and monitoring tests for HIV/AIDS, TB and Malaria cost-free for the patient will be highly cost-effective for our beneficiaries and for the health care delivery system. For the diagnostic services, the project has identified equipment which is relatively affordable and sourced for reagents that are also cost effective. This will go a long way in providing the service to more patients within the given budget. Procurement of reagents and consumables in bulk will be an additional strategy of cost-efficiency.

Monitoring and Evaluation of our activities is going to be done through quarterly progress reports based on a detailed implementation plan that outlines clear deliverables. The mobile laboratory services will be captured through a lab information system: InfCare, that will allow us detailed information on the services provided and characteristics of the patients served. This information will also be shared with the Ministry of Health and Child Welfare. Training of healthcare professionals will be captured through training reports. For laboratory technologists, indicators of the success will be the number of new diagnostic methods set up at the National Microbiology Reference lab, National Blood Service Zimbabwe and other beneficiary labs.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED
Human Resources for Health	450,000

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Malaria (PMI)
TB

Budget Code Information

Mechanism ID:	**10570**
Mechanism Name:	**AIBST: Capacity Building Project for Training Private Healthcare Professionals in Zimbabwe**
Prime Partner Name:	**African Institute of Biomedical Science and Technology**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	280,000	

Narrative:

With FY09 Supplemental Funds, AIBST will provide Rapid HIV testing, CD4, Viral loads, HIV DR tests, chemistry and hematological tests, for monitoring of patients on ART through a mobile laboratory that will serve the 10 provinces of Zimbabwe. Additional diagnostics services will cover TB and Malaria. This will be made possible through the procurement of a flow cytometer for CD4 and CD4% testing; a PCR machine for viral load determinations and drug resistance testing; a microscope for TB and Malaria diagnosis; chemistry and hematology automatic analyzers for glucose, creatinine, ALT, AST and FBC among others. Samples for HIV/TB drug resistance testing will be shipped to AiBST Laboratories in Harare where Real Time - PCR and direct sequencing will be used to genotype for known drug resistance mutations. We expect to be able to offer these services to at least 5,000 patients countrywide in the first year after commissioning of the mobile labs.

In FY2010 we will continue and increase the coverage of the mobile lab activities started with the supplemental funds of FY09 and target to reach at least 12,000 patients with these activities.

In addition AIBST will continue the training of health professionals on OI/ART care and monitoring in the 10 provinces of Zimbabwe as previously done with special focus on strengthening the confidence of health care workers in the clinical and laboratory monitoring to identify at early stage patients failing the first line regimen. A series of updated lectures on current and future trends in diagnosis, treatment and

monitoring in HIV/AIDS will be given to key medical associations like the Zimbabwe Medical Association (ZIMA), Pharmacist Association of Zimbabwe, Nurses Association, and the Zimbabwean Institute of Medical Laboratory Sciences (ZIMLS).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	150,000	

Narrative:

With FY09 Supplemental Funds, AIBST will provide CD4%, Viral loads, HIV DR tests, chemistry and hematological tests, for monitoring of pediatric patients on ART through a mobile laboratory that will serve the 10 provinces of Zimbabwe. Additional diagnostics services will cover TB and Malaria. This will be made possible through the procurement of a flow cytometer for CD4 and CD4% testing; a PCR machine for viral load determinations and drug resistance testing; a microscope for TB and Malaria diagnosis; chemistry and hematology automatic analyzers for glucose, creatinine, ALT, AST and FBC among others. Samples for HIV/TB drug resistance testing will be shipped to AiBST Laboratories in Harare where Real Time - PCR and direct sequencing will be used to genotype for known drug resistance mutations. We expect to be able to offer these services to at least 1,000 children countrywide In the first year after commissioning of the mobile lab units.

In addition we will do special workshops for health care practitioners in updated ART guidelines for pediatrics strengthening the confidence of clinicians in the initiation of pediatric patients and switch to second line.

In FY2010 we will continue and increase the coverage of the mobile lab activities started with the supplemental funds of FY09 and target to reach at least 2,400 children with these activities.

In addition AIBST will continue the training of health professionals, mainly from the private sector, on OI/ART pediatric care and monitoring in the 10 provinces of Zimbabwe as previously done.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	800,000	

Narrative:

With FY09 Supplemental Funds, AIBST will assist NBSZ to acquire NAT testing technology through the procurement of one RT-PCR machine that will increase the number of units screened from 40 to 80 and reduce the window period for detecting HIV from 22 to 11 days, detection of Hepatitis C Virus (HCV) from 82 to 23 days and detection of Hepatitis B Virus (HBV) from 59 to 34 days; procurement of accessory equipment to implement the new technology; training of laboratory scientists on the new

management of the new equipment; revising Standard Operating Procedures (SOP) according to the new testing technology and provision of External Quality Assurance. This activity will be implemented with the goal of getting safer blood at lower prices for the final user.

In FY2010, AIBST will provide operational support services to the National Blood Service Zimbabwe as they scale up the screening of blood and most of the resources will be used in bringing down the cost of blood to the final users through major support in the procurement of test kits and the implementation of other activities that could contribute to this goal.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	620,000	

Narrative:

With FY09 Supplemental Funds, AIBST will set up two mobile laboratory units which will be equipped with a flow cytometer, a centrifuge, a microscope, a chemistry and haematology automatic analyzers and a PCR machine each. The mobile laboratory units will be equipped with Laboratory Information Management Systems (LIMS) for patient data management and to facilitate the consolidation of results for reporting. The mobile laboratory concept will enable AiBST to reach out HIV patients in remote areas where laboratories do not have the capacity to provide adequate diagnostic and monitoring services enabling clinicians at district and rural levels to provide the best care to their patients. The maximum capacity of each mobile laboratory unit is around 10, 000 patients per year based on the fact that each of them will be operating 2 weeks per month in the field while the other 2 weeks they will be at the base for maintenance and re-stock. This schedule will be reassessed after an initial 6 month period of operations.

In FY2010, AIBST will continue and increase the coverage of the mobile laboratory services through higher procurement of reagents. A major addition to the AiBST laboratory will be a DNA Sequencer which will enable AiBST to detect a broader range of drug resistance mutations associated with first line and second line therapy failure. At the same time, the project will support on-site training of laboratory technologists at provincial and district level so that they can optimally utilize the equipment which is being installed at their laboratories by various funding agents.

AIBST will additionally continue the short course training for lab scientists on molecular techniques at the AiBST laboratory minimum 3 times per year. .

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	100,000	

Narrative:

With FY09 Supplemental Funds, AIBST will provide direct sputum microscopy and PCR testing for Tuberculosis diagnosis among HIV positive patients through the mobile laboratory units already mentioned. Services will be provided to the 10 provinces of Zimbabwe. In FY2010, AIBST will continue and expand the activities initiated with FY09 supplemental funding.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10579	**Mechanism Name: CDC/COAG/HAQOCI**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Zimbabwe	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,762,500	
Funding Source	**Funding Amount**
GAP	350,000
GHCS (State)	1,412,500

Sub Partner Name(s)

(No data provided.)

Overview Narrative

HAQOCI is a project within the Clinical Epidemiology Resource and Training Centre (CERTC) at the University of Zimbabwe College of Health Sciences. HAQOCI started in 2001 and is now completing the third year of the second cycle of 5 year funding with USG.

The Objectives of the program are: 1) Continue to develop a robust initiative to improve the Quality of HIV/AIDS prevention, care and treatment in Zimbabwe. 2) Strengthen training in Clinical Epidemiology in the region. 3) Pilot or set up demonstration projects in improved HIV/AIDS care. 4) Support training in improved HIV/AIDS care

HAQOCI's activities support the HIV/AIDS National Strategy and Plan through training of human resources for implementation of HIV/AIDS activities. These trainings include basic introduction to the management of opportunistic infections as well as delivery of ART using a public health sector approach. The technical team will continue to support Ministry of Health and Child Welfare (MOHCW) through conducting OI/ART site assessments which will be expanded to enable HAQOCI to take part in the clinical mentorship program as envisaged by MOHCW. Through these activities, HAQOCI will also be able to monitor and strengthen the clinical skills of the health care workers in the provision of care, encourage implementation of TB/HIV collaborative activities and look into issues of rational use of medicines such as monitoring ARV stock outs and availability of cotrimoxazole. Supervisory visits together with the MOHCW will ensure that protocols and guidelines are understood and implemented as expected at site level. Also, they give the opportunity to trouble-shoot based on the realities on the ground after a site has started the provision of OI/ART.

The coverage of our activities is national and target different cadres in the public sector including pre-service medical students and nurses as well as in-service staff such as doctors, nurses and pharmacists.

The key contributions of HAQOCI's activities to health systems strengthening are improvement of the quality of care and treatment provided to OI/ART clients in the clinics all over the country through site assessments, supervisory visits and clinical mentorship. Rational use of medicines is a major concern in low resources settings and is always assessed during the visits. HAQOCI is at the same time the main provider of technical assistance to the MOHCW in the production and revision of national HIV/AIDS related training materials.

A key cross-cutting area of our program is Human Resources for Health through the in - service training of doctors, nurses and home based care givers; pre-service training of primary care counselors and post-graduate training in Clinical Epidemiology. This is a critical area in Zimbabwe for the provision of HIV/AIDS services and any expansion of activities will need to ensure that clinicians possess the right skills to provide the needed services including being able to apply evidence based clinical care as well as being able to critically appraise research findings.

REDACTED

Key issues addressed in our activities include: 1) Family planning through counseling and provision of methods at the Students Health Services Center. 2) REDACTED 3) Workplace programs: Clinical staff supported by HAQOCI will provide services to the University of Zimbabwe staff through the Staff Clinic and the HIV and AIDS Prevention and Support (HAPS) center where faculty members and their relatives

will have the opportunity to receive post-test counseling, including psychosocial and nutritional counseling, participation in support groups, clinical care, provision of cotri-moxazole for HIV positives and TB screening.

Our strategy for cost-efficiency includes delivering Training of Trainers workshops to enable us to increase the number of available facilitators for our training programs so that we can reach more health care workers. Cost-efficiency will also be achieved based on bulk procurement of Home based care kits for national distribution through existing mechanisms. Integrated site visits will cover quality issues of pediatric care, adult care, proper data collection and rational use of medicines. REDACTED. Resources that are already in place will also be utilized.

Monitoring and Evaluation of our activities is going to be done through quarterly progress reports based on a detailed implementation plan, training reports, receipts of procurement, site visit reports, etc.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED
Human Resources for Health	586,000

Key Issues

TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**10579**
Mechanism Name:	**CDC/COAG/HAQOCI**
Prime Partner Name:	**University of Zimbabwe**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	500,000	

Narrative:

With FY2009 Supplemental funds, HAQOCI will procure around 9,000 Home Base Care kits for national distribution to enhance the safe provision of Home based care by care givers.

With FY2010 funds, HAQOCI will procure an additional 9,000 Home Based Care kits for national distribution to enhance the safe provision of Home based care country wide and conduct trainings of community volunteers in home base care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	250,000	

Narrative:

With FY2009 Supplemental funds, HAQOCI will conduct site supervisory visits and clinical mentorship to 9 sites offering adult and pediatric services. The team will be able to work within the national mentorship plan to train mentors in the provincial sites who will in turn train mentors at the district and rural level to ensure that protocols and guidelines are understood and implemented as expected at site level.

With FY2010 HAQOCI will conduct trainings for health care workers and in adult management of OI/ART; Conduct site supervisory visits and clinical mentorship to 9 sites offering adult and pediatric services. The team will be able to work within the national mentorship plan to train mentors in the provincial sites who will in turn train mentors at the district and rural level to ensure that protocols and guidelines are understood and implemented as expected at site level.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	187,500	

Narrative:

With FY2009 Supplemental funds, HAQOCI will conduct site supervisory visits together with the MOHCW and clinical mentorship to 9 sites offering adult and pediatric services. The team will be able to work within the national mentorship plan to train mentors in the provincial sites who will in turn train mentors at the district and rural level to ensure that protocols and guidelines are understood and implemented as expected at site level.

With FY2010 funds, HAQOCI will be able to continue training on Pediatric OI/ART management and conducting site supervisory visits. The Mentorship program will cascade to the district and rural levels to ensure that protocols and guidelines are understood and implemented as expected at site level and to increase the confidence of clinicians in the practical management of pediatric patients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Other	OHSS	200,000	

Narrative:

With FY2009 Supplemental funds, HAQOCI will support the revision of the draft National Human Resources for Health policy and move it through the process of development, approval, printing, dissemination and the training of management staff for its implementation.

In FY2010, HAQOCI will strengthen its workforce by increasing its technical team for clinical services that will free up time from other existing technical team to concentrate on the new activities taken up within our program like supervisory visits, clinical mentorship and additional training activities. A training coordinator will be hired to ensure the smooth running of the training program and coordinate with partners like the Ministry of Health and Child Welfare and other partners. He/she will additionally take on activities for resources mobilization and leveraging with other partners.

HAQOCI will also continue providing technical assistance to the Ministry of Health and Child Welfare, National AIDS Council and Hospice Association of Zimbabwe (HOSPAZ) and supporting the Clinical Epidemiology masters program at the University of Zimbabwe.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	150,000	

Narrative:

In FY2010, HAQOCI will expand its University of Zimbabwe Education and HIV/AIDS (UZEHA) Center Project which coordinates the activities of the HAPS center, Students Health Services Center and the staff clinic, through the expansion of its technical team (1 doctor and 2 nurse counselors). This will enable the UZEHA to provide HIV/AIDS awareness information to students/staff and other members of the University community through group education as well as individual counseling and access to the virtual module on life skills.

These services will be promoted also among other tertiary education institutions to increase HIV awareness among higher and tertiary education students as well as promoting the setting up of similar initiatives at other higher and tertiary institutions.

Services at the HAPS project are done in collaboration with PSI who provides counseling to the students and staff at the clinic. The HAPS center staff also conducts outreach activities which include HIV awareness on the campus.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVOP	100,000	
Narrative:			
None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HVTB	375,000	
Narrative:			
With FY2009 Supplemental funds, HAQOCI will do an assessment of the infection control program implemented at 5 central hospitals and 7 provincial hospitals in Zimbabwe. REDACTED HAQOCI will implement the training on the new TB/HIV guidelines to strengthen the provision of care to co-infected patients. In addition HAQOCI will continue incorporating TB management in the OI/ART standard training for health care workers. REDACTED. HAQOCI will continue scaling up the TB/HIV training for health care workers and incorporating TB management in the OI/ART trainings for health care workers.			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10609	**Mechanism Name: CDC/COAG/MOHCW**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health and Child Welfare, Zimbabwe	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 500,000	
Funding Source	**Funding Amount**
GAP	500,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

NOTE: Since 2005, the USG has maintained bilateral Cooperative Agreements that provided direct USG disbursements to the Ministry of Health and Child Welfare (MOHCW) and the National AIDS Council (NAC) under the PEPFAR program. (These funds were part of the Department of Health and Human Services appropriation and were not subject to the Brooke-Alexander Amendment of the Foreign Assistance Act.).

In 2008, the USG froze disbursements to the MOHCW and NAC until the GOZ meets established conditions for resumption of bilateral aid. The conditions relate to: full and equal access to humanitarian assistance; restoration of the rule of law; a commitment to the democratic process and respect for applicable international human rights obligations; a commitment to macroeconomic stabilization in accordance with guidance from relevant international agencies; and timely elections held in accordance with international obligations, and in the presence of international election observers.

The formation of the inclusive government in February 2009 and solid macroeconomic management since then are some positive signs. USG is thus including "placeholders" for the MOHCW and NAC mechanisms for FY2010 so that funds can flow quickly once conditions are met. If this does not occur by May 2010, USG will reprogram the funds to other mechanisms. END NOTE

The Ministry of Health and Child Welfare (MOHCW) is the only agency in Zimbabwe, public or private, that has responsibility for core functions of public health and coordinated and efficient response to HIV/AIDS in the health sector. These responsibilities includes: 1) Set of policy for provision of care to the population of Zimbabwe. 2) Direct provision of care to the overwhelming majority of the population, especially on maternal and child health. 3) Surveillance of HIV/AIDS issues in Zimbabwe.

The key Objectives of our program are: 1) To strengthen surveillance and monitoring of the epidemic, including the capacity of the MOHCW to manage information for HIV/AIDS prevention, and to make disseminate decisions and policy in a timely manner. 2) To strengthen the public health laboratory system. 3) To strengthen prevention, care and treatment for HIV/AIDS, particularly in PMTCT and through improved delivery of higher quality health care for HIV/AIDS.

This program supports the HIV/AIDS National Strategy and Plan through the implementation of activities in key areas of the HIV/AIDS national program like expansion of PMTCT services in clinics with no HIV testing, improvement in data management along all its different steps: collection, transmission, analysis and dissemination for better decision making within the HIV program and improvement of TB /HIV

services for co-infected patients.

The coverage of our activities is national and target all health care workers and populations served in the public sector in Zimbabwe.

Our program strengthens the National Health System through the targeted allocation of resources in the most needed technical and geographic areas for support. This includes components at National, Provincial and District level.

MOHCW activities cross-cut in the program areas of Human Resources for Health and REDACTED through training in key technical areas and implementation of basic renovations at facility level to improve the provision of TB/HIV services.

A Key PEPFAR issue addressed in our program is TB as renovations in key health institutions will target to provide adequate facilities for the treatment of MDR TB whose affected patients are usually co-infected with HIV.

Our strategy for cost-efficiency is based on integrated site visits and training covering several program components at the same time like: PMTCT, OI/ART care, M&E supervision, etc. Maximum use of resources already in place and implementation of key activities that address bottlenecks in the provision of care at national level.

Monitoring and Evaluation of our activities will be done through quarterly progress reports based on a detailed implementation plan.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED
Human Resources for Health	250,000

Key Issues

TB

Budget Code Information

Mechanism ID:	**10609**
Mechanism Name:	**CDC/COAG/MOHCW**
Prime Partner Name:	**Ministry of Health and Child Welfare, Zimbabwe**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	100,000	

Narrative:

With FY10 resources we will do a revision of the existing site assessment tool for the provision of OI/ART services to ensure its comprehensiveness and do dissemination of the updated version to partners and candidate sites to create awareness on the minimum requirements for approval. Additionally we plan to carry out an assessment of the implementation of OI/ART activities within the private sector to have a better picture of their contribution to the National program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	100,000	

Narrative:

With FY10 resources we plan to support the roll out of our electronic indicators database to improve reporting rates to the Ministry of Health and Child Welfare of HIV/AIDS and related activities as well as on-site training of staff on quality data collection, reporting and analysis. Part of these resources will be allocated to the procurement of packing materials and distribution of the PMTCT/HIV/TB/ M&E tools that have been printed by other partners to ensure adequate stocks of M&E tools at site level.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	100,000	

Narrative:

With FY10 resources we plan to increase access to PMTCT by women attending ANC services in those clinics where HIV testing is not yet available or where no other partners are supporting these services as yet. Activities will cover national training of health staff in HIV testing and integrated short course ART (called Most Efficacious Regimen, or MER), dried blood spot infant HIV testing, infant feeding and monitoring & evaluation training at district level for 6 districts.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	100,000	

Narrative:
With FY10 resources we plan to support staff at the National Microbiology Reference lab and do basic procurement of consumables/reagents for the National Microbiology Reference lab and National Tuberculosis Reference lab in response to identified gaps.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	100,000	

Narrative:
With FY10 resources we plan to renovate 2-3 health institutions for the provision of MDR TB care services as most are TB/HIV co-infected patients. This activity is in response to the need to ensure appropriate care to those individuals now being identified through the capacity building of culture and drug sensitivity testing at the National Tuberculosis Reference lab.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11754	Mechanism Name: STATE/OHSS/PAS
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: USG Core
Prime Partner Name: State/AF	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 200,000	
Funding Source	**Funding Amount**
GHCS (State)	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Public Affairs Section (PAS) program for PEPFAR FY09 supplemental and FY2010 funding fall under the areas of sexual prevention and health systems strengthening. The overarching goals of PAS

programs are to save lives, improve lives, increase the Zimbabwean publics understanding and awareness of PEPFAR contributions and generally strengthen the health sector in Zimbabwe in the fight against HIV/AIDS.

Depending on the arrival of funding support to PAS, we plan to conduct a balanced number of activities throughout the year, reaching a wide geographic region, including less frequently visited regions of the country, and rural and high-density areas that are economically disadvantaged. Our plan is to implement programs in all six geopolitical areas of the country and to partner with Zimbabwean organizations in communities outside Harare to build capacity and to strengthen local healthcare capacity. Target audiences include students, faculty and administrators in academia; key figures in arts, culture and music to reach other artists and to convey messages to the general public; health care practitioners to train and educate program partners and audience members attending events; religious and tribal leaders, and NGOs and civil society organizations.

PAS programs will expand pre-existing PEPFAR programs such as librarian resource center training, World AIDS Day activities and prevention messaging with the media, but also leverage PAS' programming expertise and contacts in the arts, cultural and education fields to promote prevention and health strengthening activities in innovate new ways.

Each PAS program will have an evaluation component. These will include specific measures linked to the project indicators, and may include questionnaires, surveys, questionnaires, testimonials, and tracking of media placements. These results will be reported through the Departments Mission Activity Tracker and through PEPFAR reporting mechanisms. Video and photographs of programs will be placed on Embassy website and social media outlets such as Facebook and Twitter when appropriate.

The quality of reporting around HIV/AIDS issues in Zimbabwe is extremely low, often little more than a blend of government pronouncement, NGO self-aggrandizement, rumor, fiction, misstatement, and offensive language. The situation has been made worse because of a high percentage of the country's experienced journalists leaving the country or the journalism field for high-paying jobs in NGOs. There is limited investigative reporting on HIV/AIDS. Most coverage has focused on treatment, where meaningful engagement by government has been witnessed. With 100,000 of the 600,000 reported persons living with HIV/AIDS receiving drugs, media attention has focused on the limited funding availed to treatment. Articles in both government-controlled and private media have focused on the management of HIV/AIDS funds collected internally as well as those sourced from donors, including PEPFAR. This has also included increased attention on Global Fund grants, particularly when NGOs could not access funds for programs as a result of diversion of the funds by the central bank.

Because of the media challenges facing PEPFAR Zimbabwe, PAS programs will include as much media cross-over as possible. Where possible, we will include a media component to promote events, donor recipients and beneficiaries. PAS will invite media to report on events and use PEPFAR resource staff to inform journalists about HIV/AIDS. Press releases and USG official statements will complement all PAS programs. PAS staff will also track media placement and report to PEPFAR.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	60,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**11754**
Mechanism Name:	**STATE/OHSS/PAS**
Prime Partner Name:	**State/AF**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	60,000	

Narrative:

For FY2010 funds, PAS proposes the following activity: PEPFAR Fulbright Scholarship: a fully-funded scholarship for one pre-service Zimbabwean health profession to study in the United States for a Master's or PhD in fields such as public health, counseling or epidemiology.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	70,000	

Narrative:

1) Week-long training programs for Zimbabwean librarians and resource center coordinators in the rural areas of Beitbridge & Plumtree on HIV/AIDS information dissemination. 2) Media reporting tours to HIV/AIDS partner sites on a monthly basis to highlight PEPFAR projects. 3) Support U.S. artists to amplify prevention and treatment themes at the Harare International Festival of the Arts (HIFA) and

perform at local high schools. 4) HIV/AIDS training workshop for Parliamentary Constituency Information Centers to teach information dissemination skills and increase officer's knowledge of HIV/AIDS information. 5) Support Zimbabwe Aids Network and PAS national speaking tour on youth advocacy for HIV/AIDS, and how to utilize IT in community-based HIV/AIDS work. 6) Support to the Zimbabwe Arts Trust for a music and performing arts group to travel throughout all six regions of the country with HIV/AIDS messages of prevention and behavioral modification. 7) Engage female youth through the Zimbabwean National Association of School Heads (NASH) and Grass Roots Soccer, to learn about HIV through sport. 8) PEPFAR Fulbright – to offer a Zimbabwean a fellowship to study for a two-year master's degree in the U.S. in the field of public health, counseling, management, or epidemiology. 9) Work with Community Radio Harare to train 20 radio producers in how to research and produce higher quality HIV/AIDS stories to raise awareness of HIV prevention among the general public. 10) High School Debate on HIV/AIDS and Youth. HIV/AIDS speaker teaches high school students about HIV/AIDS during two week intensive education program. 11) The University HIV/AIDS Peer Educators Partnership Project will work with peer educators groups at four universities to increase HIV/AIDS awareness and promote positive behavior on university campuses

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	70,000	

Narrative:

1) Week-long training programs for Zimbabwean librarians and resource center coordinators in the rural areas of Beitbridge & Plumtree on HIV/AIDS information dissemination. 2) Media reporting tours to HIV/AIDS partner sites on a monthly basis to highlight PEPFAR projects. 3) Support U.S. artists to amplify prevention and treatment themes at the Harare International Festival of the Arts (HIFA) and perform at local high schools. 4) HIV/AIDS training workshop for Parliamentary Constituency Information Centers to teach information dissemination skills and increase officer's knowledge of HIV/AIDS information.
Support Zimbabwe Aids Network and PAS national speaking tour on youth advocacy for HIV/AIDS, and how to utilize IT in community-based HIV/AIDS work. 5) Support to the Zimbabwe Arts Trust for a music and performing arts group to travel throughout all six regions of the country with HIV/AIDS messages of prevention and behavioral modification. 6) Engage female youth through the Zimbabwean National Association of School Heads (NASH) and Grass Roots Soccer, to learn about HIV through sport. 7) PEPFAR Fulbright – to offer a Zimbabwean a fellowship to study for a two-year master's degree in the U.S. in the field of public health, counseling, management, or epidemiology. 8) Work with Community Radio Harare to train 20 radio producers in how to research and produce higher quality HIV/AIDS stories to raise awareness of HIV prevention among the general public. 9) High School Debate on HIV/AIDS and Youth. HIV/AIDS speaker teaches high school students about HIV/AIDS during two week intensive

education program. 10) The University HIV/AIDS Peer Educators Partnership Project will work with peer educators groups at four universities to increase HIV/AIDS awareness and promote positive behavior on university campuses.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12287	**Mechanism Name: Africare: Supporting Civic Society Organizations (Faith Based Networks) Response to HIV and AIDS Policies in Zimbabwe**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Africare	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 307,500	
Funding Source	**Funding Amount**
GAP	180,000
GHCS (State)	127,500

Sub Partner Name(s)

Evangelical Fellowship of Zimbabwe (EFZ)	Methodist Development and Relief Agency (MeDRA)	

Overview Narrative

Africare is an international NGO which was formed in 1970 with the mandate to improve the quality of life for people in Africa in the major areas of Health and HIV/AIDS, Sustainable Livelihoods and Emergency Humanitarian Assistance.

The organization is supporting two faith –based networks in the implementation of National HIV and AIDS Policies: the Evangelical Fellowship of Zimbabwe (EFZ) and Methodist Development and Relief Agency

(MeDRA), providing them with technical expertise to strengthen their HIV and AIDS interventions.

The goal of Africare's PEPFAR program is to enhance the capacity of two faith based networks and their members, in the response to HIV and AIDS through the implementation of activities drawn from the existing national HIV and AIDS Policies. The program objectives are: 1) To support two local faith –based networks with local language technical assistance for strategic dissemination activities. 2) To facilitate two networks' development of HIV related policies congruent to the existing national policies for them to respond more effectively to the needs of their constituencies. 3) To provide HIV related institutional capacity building to the two participating networks to enable them to respond more effectively to the needs of their network members.

Africare was availed supplementary funding for FY09 and FY10 to expand the 2 partners' activities and also take on board a third FBO network partner called the Union of Development of the Apostolic Church Sect in Zimbabwe (UDACIZA). This is a network of African/Ethiopian –Zionist churches most of whose affiliates discourage the use of both traditional and western/modern medicine by their followers. Girl child pledging and early marriages, especially among girls, are regarded as normal. Polygamy, a proxy to Multiple Concurrent Partnerships (MCPs) is common and such practices are common drivers in the spread of HIV and AIDS.

Africare supports the HIV/AIDS national strategy and plan through the provision of HIV information/ education to pastors and other key focal persons who in turn cascade the crucial information to fellow parishioners at grassroots' level. The faith –based networks have also been assisted to establish peer educators clubs, support groups and to provide psychosocial support to people living with the HIV/AIDS, their immediate families and friends.

Our activities cover 3 provinces: Bulawayo, Harare and Manicaland. In the first year the project reached out to 50,000 individuals with preventive information, 4,000 people living with HIV with palliative and psychosocial support and 3,000 Orphans and other Vulnerable Children (OVC) with life skills and psychosocial support. With the provision of this supplementary grant our 3 partners will now be tasked to reach out to 128,000 individuals with prevention information, 7,500 people living with HIV and 6,250 Orphans and other Vulnerable Children.

The key contributions of our program to health systems strengthening are through sub-grants provided to faith based networks supported in the development of policies and strategies to address HIV issues within their organizations and training of trainers (TOT) workshops for pastors and key focal persons in the areas of Peer Education, Community and Home Based Care (CHBC), Psychosocial support (PSS), Counseling and Gender. Africare has also built the capacity of faith based network members in the areas

of project implementation, report writing, monitoring and evaluation.

Our main cross cutting programs are Human Resources for Health as we do training of new volunteer caregivers who are responsible for providing palliative and psychosocial support to clients in the Community and Home Based Care (CHBC) intervention. The other cross cutting program is Gender: Reducing Violence and Coercion as we are training our partners in HIV and AIDS and Gender Based Violence (GBV) and general gender issues.

The program addresses a number of key PEPFAR issues like: Increasing gender equity in HIV/AIDS activities by putting special attention on training of men as volunteer caregivers. Male norms and behaviors are addressed through discussions with male youths about polygamy, multiple and concurrent relationships and other traditional practices that may expose them to acquiring HIV/AIDS. During discussions with the groups, the issue of male circumcision will feature prominently. This practice is already popular among the apostolic sects. What training will achieve is emphasizing male circumcision's importance in prevention of transmission.

Our strategy for cost-efficiency is based on sourcing for and distributing resources that have already been developed like the Mopani Junction materials and Talk Time Guides which were developed by CDC. This material now forms the cornerstone of the prevention activities by the youth. Africare has also interacted and received materials on HIV and AIDS Policies and Community and Home Based Care from the National AIDS Council (NAC). The organization has also received support from Ministry of Health and Child Welfare (MoHCW), Zimbabwe AIDS Network (ZAN) and the Hospice Association of Zimbabwe (HOSPAZ). Additionally, we try to use the available technical expertise around for our trainings and source HBC kits from other donors

Monitoring and Evaluation of our activities is going to be done through the elaboration of internal monthly reports, submission of quarterly progress reports and annual reports based on a detailed implementation plan, visit reports and success stories documenting how individuals, groups or communities have benefited from the interventions.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	4,000
Human Resources for Health	76,000

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**12287**
Mechanism Name:	**Africare: Supporting Civic Society Organizations (Faith Based Networks) Response to HIV and AIDS Policies in Zimbabwe**
Prime Partner Name:	**Africare**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	60,000	

Narrative:

FY09

With FY09 funds Africare will: 1) strengthen community and home-based care responses by capacitating all the three partners in identifying and training a minimum of 200 new volunteer caregivers (at least 50 with UDACIZA) . Emphasis will be placed on training men as caregivers as this will lessen the burden of care on women and girls. The target is that of all those trained as caregivers, 50% should be men. Training of care givers on providing palliative care for children living with HIV and AIDS will be a critical component during training so that vulnerable children's needs will be more effectively addressed. Strategic partners, namely Island Hospice, the Hospice Association of Zimbabwe, the National AIDS Council, will participate in the roll-out of the trainings. 2) Assist UDACIZA to set up 5 support groups for PLWHA. 3) Assist 20 out of the current 40 support groups to set up nutrition gardens to help them to improve their nutrition status and as a means of building their group cohesion. They will receive additional training in small business management, stigma and discrimination and psychosocial support. 4) Africare will produce Information, Education and Communication (IEC) materials for the 1,200 volunteer care givers. The materials will be in the form of t-shirts and hats to help in the smooth dissemination of information.

FY10

With FY10 funds Africare will devote more time building UDACIZA's Community and Home Based Care interventions particularly in the following areas: 1) Training of additional 50 volunteer caregivers; 2) Establishment of 5 additional support groups; 3) Assistance to 5 support groups in the setting up of

nutrition gardens. 4) Train members of the support groups in leadership, group dynamics and income generation. 5) Exchange visit for volunteer caregivers.

Traditionally, the apostolic faith churches have shunned seeking medical attention from formal health facilities and the major thrust of the project would be to build the capacity of the Community Home Based Care (CHBC) which is easily accessible for the groups that have traditionally shunned hospitals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	247,500	

Narrative:

FY09
With the supplementary funds we will expand our activities in prevention based on the current high acceptance of youth groups and the thrust will be on expanding peer educator clubs to promote behavior change (BC) among youth, the group most at risk of contracting HIV and AIDS. Evangelical Fellowship of Zimbabwe and Methodist Development and Relief Agency established 40 peer educator clubs at the inception of the project. The new partner UDACIZA will be supported in establishing an additional 10 groups to bring the total to 50.

In the first year the groups were converging once a week to listen to the Mopani Junction Radio Serial Drama, however Africare will seek to improve on the quality of peer education activities by establishing 9 youth friendly corners (3 of these with UDACIZA) and each of the partners will receive audio-visual equipment in the form of television sets, radios and HIV and AIDS educational videos to improve the quality of their discussions.

The 3 faith based networks' peer educators will be supported in holding a total of 6 therapeutic sports galas (2 for UDACIZA, 2 for EFZ and 2 for MeDRA) Therapeutic sport galas will provide a platform for the youths to interact and exchange information on HIV and AIDS.

15 peer educators' clubs (5 from UDACIZA, 5 from MeDRA and 5 from EFZ) will be assisted in setting up nutrition gardens as a means of improving their life skills and group cohesion.

Africare will also hold a 2-day workshop to assist UDACIZA on National Strategies and Policies on HIV and AIDS for church leaders and other key focal persons from this network. In addition UDACIZA will also participate in the Capacity Building Workshop that will be held for all the 3 network members to build their capacity in project planning, implementation, report writing, monitoring and evaluation.

+C20 With FY10 funds we will be ensuring continuation of the FY09 activities; increase the number of peer educators clubs supported with nutrition gardens from 15 to 30 (10 from UDACIZA, 10 from MeDRA and 10 from EFZ) as a mean of improving their life skills and group cohesion. Initiate Life Skills trainings as an integral component of the children's after church program where they will be exposed to guided discussions on how to stay negative, positive living, gender dynamics, managing adolescence, dating, career guidance, leadership, decision making and communication skills. Child camps for children will be initiated whereby young people from different locations will share experiences. An annual interdenominational conference will be held to raise awareness about the importance of integrating HIV issues into the church's core messages and activities. A form of outreach will be an interdenominational HIV/AIDS newsletter to disseminate information and also encourage buy in not only by the leadership but also the members of the FBO network. Program activities will also address stigma & discrimination with the goal of having more people disclosing their status and finding support within their churches. The church must be able to respond to the diverse needs of their HIV positive members.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12288	**Mechanism Name: Development and Strengthening of Human Resources for Health Activities in Zimbabwe**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Emory University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 300,000	
Funding Source	**Funding Amount**
GHCS (State)	300,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Emory University is a private research University based in Atlanta – Georgia. In addition to its three undergraduate divisions, Emory has nine graduate and professionals schools including business, law, medicine, theology, nursing and public health.

This project will be carried out with the Public Health School of the Emory University and its objectives are to strengthen the management of Human Resources in Zimbabwe.

Emory's program will support the HIV/AIDS National Strategy and Plan through providing information on the number of health care workers available at all health care levels by training skills, distribution and other variables.

The coverage of Emory's activities will be national and targeting all health workforce of Zimbabwe in the public sector.

The key contributions of our program to health systems strengthening will be an updated database at all levels (National, Provincial and District level) that will inform policy makers about strategic decisions related to Human Resources for Health.

The core of our activities is in the cross-cutting program of Human Resources for Health. This is a critical area in Zimbabwe for the provision of HIV/AIDS services and any expansion of activities need to account for this key resource.

Our strategy for cost-efficiency is based on mass procurement of IT equipment and communication means for the setting up of a Human Resource Information System. Resources that are already in place will be utilized as much as possible or maintained if needed. Resources will be procured in a way that we will have national coverage with the lowest expenditure as possible.

Monitoring and Evaluation of our activities is going to be done through quarterly progress reports based on a detailed implementation plan that includes a description of the main activities, targets, indicators and timeframes.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	300,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12288**
Mechanism Name:	**Development and Strengthening of Human Resources for Health Activities in Zimbabwe**
Prime Partner Name:	**Emory University**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	300,000	

Narrative:

With FY09 Supplemental Funds, Emory will ensure Zimbabwe's regulatory nursing body, Nursing Council of Zimbabwe (NCA) has accurate, up-to-date data on accredited nurses that have been nationally licensed. This will involve migrating current data maintained by the Council to a software program that is compatible with Zimbabwe's MOHCW database system. The project will also provide IT connectivity between the NCZ database system and the MOHWCW Chief Nursing Office. Formation of requisite Steering Committee, process for ensuring MOHCW and stakeholder buy-in will also take place.

With FY2010 funding, Emory will consolidate the information gathered in the first year and do national, provincial and district trainings of IT officers in the use of the database plus expansion of the program to 3 more provinces. Sensitizations will be done with other Councils for expansion of the project to other health professions.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12289	**Mechanism Name: MEASURE Phase III Demographic and Health Surveys**

Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Macro International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,140,000	
Funding Source	**Funding Amount**
GHCS (State)	1,140,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

With FY2009 Supplemental funding, USG will support the MEASURE Phase III Demographic and Health Survey (DHS) mechanism to initiate Zimbabwe's DHS-2010/11. The purpose of MEASURE Phase III DHS is to improve the collection, analysis and presentation of data and promote better use in planning, policymaking, managing, monitoring and evaluating population, health and nutrition programs. The project seeks to increase understanding of a wide range of health issues by improving the quality and availability of data on health status and services and enhancing the ability of local organizations to collect, analyze and disseminate such information. Primarily, the DHS project seeks to provide up to date information on fertility levels; sexual activity; awareness and use of family planning methods; breastfeeding practices; nutritional status of mothers and young children; early childhood mortality and maternal mortality ; maternal and child health; awareness and prevalence regarding HIV/AIDS and other sexually transmitted illnesses.

Zimbabwe has conducted four DHS projects to date – 1988, 1994, 1999 and the 2005/06. The DHS project is highly valued by the GOZ and its major stakeholders within the health sector and has been widely used for decision making in-country on HIV/AIDS and maternal and child health. The DHS 2005/06 also included a gender-based violence module which has proven useful in HIV prevention, OVC, and other health and human rights programming.To date the country has been relying on the 2005/06 DHS information hence the need to conduct another DHS in 2010/11 which will provide updated information. The probability of an election in the coming years further adds the impetus for an urgent DHS to avert a possible information gap.

One of the key elements of the national HIV/AIDS strategy is the need for one agreed country level

monitoring (and evaluation) system to which the DHS conforms to. In other words, DHS, as part of the national monitoring and evaluation system, provides a comprehensive tracking system to collect , analyze and sharing information on HIV and AIDS that enhances decision making at all levels in the implementation of interventions under the multi-sectoral response to HIV and AIDS in Zimbabwe. With USG wraparound Population and Child Survival funding, the new DHS will also provide critical information on maternal and child health, including malaria. The DHS should provide up-dated information on the numbers of orphans and vulnerable children in Zimbabwe, by age, gender and by province. The new DHS will again include the gender-based violence module which is expected to enhance USG and other stakeholders knowledge and programming in this area.

The DHS is designed to provide population and health indicator estimates at national and provincial levels. In other words, the survey covers the whole country and the sampling targets all population groups – men, women, children among other population sub-groups.

The USG SI team will collaborate closely with and monitor the MEASURE DHS team and its partners in Zimbabwe to assure efficiency and quality of the work for the period of the exercise.

Locally Macro International will be working with the Central Statistical Office, a government institution mandated with data collection, collation, analysis and report writing.

With FY2010 funds, Macro International will also be offering implementation technical assistance for the Service Provision Assessment (SPA). SPA is a nationally representative survey of services and the quality of care provided through HIV service delivery sites. It is meant to provide a comprehensive body of information on the performance of the full range of public and private health care facilities that offer HIV/AIDS services and serve as a baseline and allow comparison of services across provinces and facility-type (i.e. governmental, non-governmental). While recent efforts, notably the Atlas Project, have been undertaken to determine what health services are being provided through various health facilities, there is little information regarding the quality of various HIV-related services that are being offered. Given the recent "collapse" in the health sector, continued depletion of health care workers, and changes in health financing, the current state of health care provision and therefore the most pressing areas for improvement are largely unknown.

Thus Macro International will help conduct this assessment across the country and help update decision and policy makers on the status of the services being offered within the HIV/AIDS realm.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Malaria (PMI)

Child Survival Activities

Safe Motherhood

Family Planning

Budget Code Information

Mechanism ID:	**12289**
Mechanism Name:	**MEASURE Phase III Demographic and Health Surveys**
Prime Partner Name:	**Macro International**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	1,140,000	

Narrative:

With FY 2009 Supplemental funding, Macro will offer technical assistance for the overall implementation of the DHS+ activities including the overall questionnaire structure (design), training of trainers and coordinators, training of enumerators, data analysis and report writing. The DHS will commence in CY2010, in line with the health information needs of the country. The major areas (modules) to be covered will include the following fertility levels; sexual activity; awareness and use of family planning methods; breastfeeding practices; nutritional status of mothers and young children; early childhood mortality and maternal mortality ; maternal and child health; awareness and prevalence regarding HIV/AIDS and other sexually transmitted illnesses. Also to be included will be a gender-based violence module.

With FY 2010 COP funding, Macro will also offer overall technical assistance for the implementation of Service Provision Assessment in the country. This will provide information about the quality of HIV/AIDS service provision within the country's health sector.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12290	Mechanism Name: Strengthening Private Sector Services (SPSS)
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Strengthening Private Sector Services for Health (SPSS) Project is a new mechanism that is scheduled to begin in mid FY 10. The SPSS Project is designed to replace the he Partnership Project which ends on September 30, 2010. Consequently, the SPSS Project is expected to build upon implementation successes in the Partnership Project while continuing to strengthen private sector services for HIV prevention and palliative care for PLWHA.

The SPSS Project will be a multi-pronged initiative aimed at: reducing the rate of HIV infection in Zimbabwe through increasing the public's knowledge of HIV risks and alternatives; promoting sound behaviour change; reducing stigma towards those infected; enhancing access to HIV-related products and services, including testing and counselling and male circumcision; and, building the capacity of local policy makers and research and service providers to address the epidemic.

Although focusing on implementation within the private sector, the SPSS Project will support and strengthen the overall national response to HIV/AIDS. Implementation will be rooted in and based upon national policy, strategic, programmatic and research identified priorities. These include: improving the breadth and depth of Zimbabweans' knowledge about HIV/AIDS and promoting behaviours that prevent its spread and mitigate its impact, and significantly scaling-up HIV testing and counselling in order to

increase the number of Zimbabweans who know their HIV status and are thus able to take appropriate actions such as personal risk reduction, Prevention of Mother to Child Transmission (PMTCT) and Antiretroviral Therapy (ART).

Activity areas include support for both prevention and palliative care and will expand the NGO-operated New Start and New Life networks that currently provide services to substantial numbers of Zimbabweans.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED
Economic Strengthening	REDACTED
Gender: Reducing Violence and Coercion	REDACTED
Human Resources for Health	REDACTED
Water	REDACTED

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Mobile Population
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**12290**		
Mechanism Name:	**Strengthening Private Sector Services (SPSS)**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted
Narrative:			
The existing New Life network provides care and support to about 200,000 continuing PLWHAs. This			

network offers both facility-based and outreach services. The project will provide the resources needed to expand community outreach services for PLWHAs and add home-based care support services to community-based operations supported by the NGO New Life network in a few pilot areas. In the pilot expansion areas, funds will support: the expansion of the NGO community outreach work force; service provider training; the production and distribution of communication materials for palliative care and home-based care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

The project will expand VCT services through the NGO-operated New Start network. Client-initiated counseling and testing, through both community outreach and static sites, has been growing. The project new activity will build upon this success and will increase both the number of VCT centers managed directly (under the New Start network), as well as those supported by other NGO organizations. Since community-outreach efforts now provide a larger portion of the total numbers accepting VCT, the project will expand community outreach activities and along with provider-initiated counseling and testing.

Expansion of VCT services is also planned among for mobile and vulnerable populations within which non-government outreach may increase the number of persons knowing their HIV status. A particular emphasis of the new activity will be to ensure that VCT is offered in firms or organizations with larger workforces and as part of a broader package of health services offered to employees. This expansion of VCT services is designed to contribute to the national goal of 80 percent of Zimbabweans knowing their HIV status.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	Redacted	Redacted

Narrative:

Endorsed by the WHO and UNAIDS, male circumcision (MC) is now viewed by the Ministry of Health and Child Welfare (MOHCW) in Zimbabwe as an important new intervention to prevent against the heterosexual acquisition of HIV in men. In 2009, the MOHCW endorsed the launch of a pilot program to initiate male circumcision services in Zimbabwe with some technical assistance funded by PEPFAR and funding from an international NGO. Thus far, approximately 90 clinical care providers have been trained in MC procedures and more than 700 MC procedures have been conducted in four pilot sites. The project will help Zimbabwe scale-up MC service delivery from pilot areas to the broader service-delivery network, integrating MC services within facilities that provide routine clinical care. The project also will build the capacity of health care providers to offer safe MC service delivery, expand the availability of MC

services and stimulate demand for MC through outreach efforts and health communications.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

Sexual prevention in AB within the national mitigation program in Zimbabwe has begun to focus on the problem of concurrent sexual partnerships. In 2008, a study was commissioned to examine the prevalence and factors affecting concurrent sexual partnerships (CSP). The research found that, among sexually active Zimbabwean adults ages 15–49 years, 11% (males: 15%, females: 6%) reported practicing MCP in the past month. Practice of MCP is higher among married/cohabiting males, 21% compared to married/cohabiting females, 5%. Among sexually active and never married females, 15% report practice of MCP in the past month compared to 10.3% never married sexually active men.

The findings from this research will be used to guide the design and implementation of a multimedia communications campaign and community outreach activities in an effort to reduce the prevalence of CSPs and promote being-faithful behaviors. A range of interpersonal communication (IPC) work aids will be developed, including highly illustrated flipcharts and drama themes to: guide the implementation of small group discussions in communities; enhance the quality of each IPC contact; and, reinforce key messages promoting reduction of CSPs. Multiple IPC channels (such as small group discussion, one on one discussions, street theatre and music) will be used to help define concurrent sexual partnerships and to explain why overlapping sexual partnerships increase the risk of HIV transmission in an interactive and participatory manner.

It is expected that this AB prevention will working in collaboration with the International Organization of Migration (IOM) to reach at risk populations which include former commercial farm workers and other mobile and vulnerable populations. IPC are also planned for rural growth points, farming and mining settlements, workplace, tertiary colleges and other areas with significant populations of older males and young females. Bearing in mind Zimbabwe's generalized HIV epidemic, the plan is to utilize mass media (using radio spots, television, posters, press and outdoor advertisements) to increase awareness and individual risk perception of CSPs and to complement IPC messages at community level.

In abstinence, the project will continue to train religious leaders to promote messages and enhance adolescent skills to delay sexual debut. The geographic focus of these efforts will be the rural areas of Masvingo and Midlands provinces. The project will also adapt current delayed sexual debut materials to reach adolescents ages 12-19 years and youth 20 - 24 years with a comprehensive interpersonal communication program to increase knowledge of reproductive health, sexual risks of cross generational

sex, sexual violence and gender roles and adoption of relevant risk reduction strategies. This program will be implemented among disadvantaged populations such as displaced and disabled populations and former commercial farm workers' families.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

To increase individuals' opportunity to use condoms, the project will work to continue to ensure that male condoms are widely available throughout the nation. This effort utilizes social marketing principles and will build upon the current direct distribution system and an indirect distribution network of wholesalers and stockists. It is expected that about 35% of the outlets will be alcohol distributors which will allow integration of condom availability with planned communication efforts that discuss the linkages of alcohol use with high-risk sex. In FY 09, social marketing resulted in over 63 million male condoms sold across the country. Of all male condoms distributed in FY09, 66% were social marketing and the remainder was public and commercial sector condoms.

The project will also support distribution of "Care" female condoms through carefully targeted outlets, especially in rural areas, peri-urban areas and growth points. It is anticipated that the project will continue to make female condoms available through a network of IPC agents and focused outlets in high risk areas targeting women in regular relationships, commercial sex workers (CSWs), PLHAs and discordant couples, young females in tertiary colleges, pregnant women and women in PMTCT programs. This type of focused marketing resulted in almost 2.5 million female condoms sold in FY09.

The overall strategy for the product delivery component will be to increase overall accessibility and availability of male and female condoms, with a special focus on high risk groups in Zimbabwe. The project will further efforts made to improve efficiency of the of the product delivery systems for male and female condoms and special focus will be on high risk outlets, that is, liquor outlets , tuck shops, hotels, brothels, guest houses/lodges, CSWs , Support Groups, and high risk priority areas, that is commercial farming areas, resettlement areas, growth points, border areas, mining areas, high density areas, rural areas and encampments.

Given the collapse of the commercial sector systems, the project will focus on strengthening direct distribution mechanisms, for maintaining high volume sales and overall product accessibility, until such a time that viable private sector alternative for product distribution re-emerge within formal commercial systems in Zimbabwe. However exploration of indirect product distribution through the private sector networks remains important as this could expand market coverage and reduce distribution costs if typical

commercial options return to the marketplace. Thus the project will continue monitoring the economic environment for such positive developments. In the meantime the project will explore possibilities of establishing CBD channels as part of market approach to fill in the gaps being created by the collapse in the commercial sector channels. In addition the project will implement the public sector free condom distribution to fill any potential gaps in access to condoms within the total market.

The project will also develop a two pronged pricing strategy for local and foreign currency in light of the authorization to peg prices in foreign currency given by the central bank to selected retail and wholesale outlets. The female condom product area will continue focusing on scaling up the past years' geographic expansion of the care female condom initiative. Additionally, the project will continue strengthening existing distribution channels for the care female condoms, primarily the interpersonal communication channels, (hair salons, CSW groups, PLA groups and care and support organizations.

In sum, the project will build on the successes of previous social marketing efforts for male and female condoms to increase the availability and use of condoms in sexual prevention of HIV. New social marketing initiatives may include the introduction of different condom brands to better market to diverse segments of the Zimbabwean consumer population.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

In Zimbabwe, about 80 percent of TB patients are also HIV positive; however, TB case detection rates are very low. In 2005, NGOs, in collaboration with the MOHCW, began integrating TB symptom screening for all HIV positive clients accessing counseling and testing services in private facilities. More than 300,000 Zimbabweans monthly receive HIV tests in 19 New Start static sites and through 23 New Start outreach teams. The project will support the integration of TB testing services within the VCT activities undertaken through the New Start network. Support will expand TB diagnostic services in both New Start and New Life centers (which provide post-test services for HIV-positive individuals) through refresher trainings in TB case finding, as well as trainings in sputum smear microscopy for existing and new laboratory staff. Clients receiving TB symptom screening and laboratory services in private facilities will be referred to TB treatment and care at public health facilities offering such services.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12291	Mechanism Name: TBD-Surveys
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The overall goal of this partnership will be to support the Ministry of Health and Child Welfare in the implementation of health related surveys that would provide data to guide health related policy decisions for Zimbabwe.

This program will support the HIV/AIDS national strategy and plan in the survey design, data collection, data analysis and data dissemination of key activities like the HIV prevalence survey among ANC attendees, National HIV estimates, TB and HIV drug resistance prevalence, among others.

The coverage of the strategic information activities to be implemented by this TBD will be national and targeting those site/patients selected as part of the studies samples.

The key contributions of these activities to health systems strengthening will be updated information for health related policy decisions in the area of HIV/AIDS and related diseases like Tuberculosis.

The activities to implement will involve cross-cutting programs like Human Resources for Health as training is a key activity in the implementation of any survey to ensure the quality of the data being collected. A PEPFAR key issue addressed by these activities is Tuberculosis through the implementation of the multi-drug resistant (MDR) TB survey that will provide the country with prevalence data about the level of resistance to anti-TB drugs whose last survey was in 1994.

Cost-efficiency strategies will be based on bulk procurement of reagents for sample testing as required by the ANC survey, MDR TB survey and other surveys according to the protocol. Resources that are already in place and have been procured in previous years for these surveys will be utilized as much as possible or maintained if needed. Involvement of local staff will be done as much as possible and external technical expertise will only be requested for targeted and relevant areas where there is not much experience in country.

Monitoring and Evaluation of the activities will be done through regular supervision of data collection, involvement of partners to provide feedback to draft documents and production of final reports after each strategic information activity developed.

The objective of the second portion of this TBD are 1) To ensure overall IT security including identifying important vulnerabilities, and putting in place and maintaining appropriate defensive and responsive mechanisms. This includes firewalls, antivirus systems and maintaining up to date patches on all systems. 2) To ensure day to day operation of email system and Internet connectivity at the MOHCW. 3) To upgrade all MS windows and rolling out new hardware and software. 4) To ensure hardware is protected by the procurement of UPS machines.

This project will support the HIV/AIDS National Strategy and Plan through the strengthening of the IT network and system which facilitates the efficient monitoring and evaluation of programs and real time communication between the national, provincial and district structures.

The coverage of these activities will be national and targeting main public health sector institutions.

The key contributions of this program to health systems strengthening will be an improvement in data transmission, networking and connectivity within the health sector.

The strategy for cost-efficiency of this TBD will be on bulk procurement of IT equipment and contracts for the long term provision of services. Resources that are already in place will be utilized as much as possible or maintained if needed.

Monitoring and Evaluation of our activities is going to be done through quarterly progress reports based on a detailed implementation plan, field site visit reports and minutes of local level meetings with IT staff in the provinces and districts.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	REDACTED

Key Issues

TB

Budget Code Information

Mechanism ID:	**12291**
Mechanism Name:	**TBD-Surveys**
Prime Partner Name:	**TBD**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	Redacted	Redacted

Narrative:

FY2009 Supplemental funds will be utilized in the implementation of the Zimbabwe ART Outcomes evaluation protocol. This protocol has already been approved by the IRB in Atlanta and is waiting final approval by the Medical Research Council of Zimbabwe. The implementation of this protocol will involve recruitment and training of at least 3 data collection teams that will visit 40 OI/ART sites in the country and review records for 4000 patients that have been on Anti-retroviral therapy for a minimum of 6 months to evaluate the proportion of patients still on treatment, lost to follow up, dead or switched to second line. This survey will inform the national program about current retention rates and highlight the quality of the routine data being collected in the program, among other key outcomes.

These funds will additionally contribute to the follow up of HIV Drug Resistance activities being implemented in the country as part of the National HIV Drug resistance strategy that includes three key components: 1) HIV Threshold survey - assessing the spread of HIV drug resistant mutants in newly infected individuals; 2) Early warning indicators survey- Collection of a set of indicators that are meant to provide information for action in strengthening and instituting corrective measures at individual sites offering HAART; 3) Monitoring surveys - Prospective cohort survey among patients initiating HAART for the purpose of reducing or preventing HIVDR while on treatment.

Finally part of these funds will be utilized in the preparatory activities of the Multi drug resistance TB survey that the country will implement in 2010.

FY2010 funds will contribute mainly to the implementation of the Multi drug resistance TB survey which includes training, procurement of reagents for testing, transport of samples from selected sites to the National TB reference lab, confirmatory testing by a supranational reference lab, among other activities.

HIV Drug Resistance activities will continue to be supported in 2010 covering the three key components of the National HIV DR Strategy: 1) HIV Threshold survey - assessing the spread of HIV drug resistant mutants in newly infected individuals; 2) Early warning indicators survey - Collection of a set of indicators that are meant to provide information for action in strengthening and instituting corrective measures at individual sites offering HAART; 3) Monitoring surveys - Prospective cohort survey among patients initiating HAART for the purpose of reducing or preventing HIVDR while on treatment.

A prospective cholera/HIV study is being prepared to determine the risk factors of contracting cholera among HIV positive patients to be implemented in the next cholera season.

A portion of funds will be allocated to the preparatory activities of the next ANC survey in 2011.

Additionally FY10 will support an IT Software Upgrade through the procurement of the following items: 1) Windows 2008 and Licenses (Quantity – 2000), 2) Anti virus program (Quantity – 200) 3) Server configuration and 4) Procurement of 1.5KVA UPS. (Quantity – 10)

This activity will minimize disruptions to the system and reduce downtime due to technical challenges. It will also equip the Ministry's personnel with the necessary tools to perform their duties and responsibilities which ultimately provide donors with informed program decision making.

In addition, this TBD will concentrate on provision of wireless connectivity through the procurement of the required hardware and software at national, provincial and district levels. This activity will improve reporting, monitoring and evaluation and the flow of data between the various ministry's structures and assist all stakeholders in making informed programming and operational decisions.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12292	**Mechanism Name: Capacity Building for Community AIDS Service Organizations and**

	PLWH Support Groups
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: The Centre for Counselling, Nutrition & Health Care, (COUNSENUTH)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 100,000	
Funding Source	**Funding Amount**
GAP	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Centre is an HIV Service organization (HSO) founded in 1994 whose vision is "to facilitate a healthy people in a world without AIDS".

The overall objective of the Centre's program is to strengthen the capacity of Provincial Implementing Partners (PIPs) to enhance the health and resilience of populations made vulnerable by HIV (PLHIV).

The main objectives of the Centre's program are: 1) To build the capacity of PIPs who are themselves Community AIDS Service Organizations (CASOs) and (PLHIV) support groups in the delivery of HIV-related services and initiatives, to strengthen appropriate coping mechanisms among vulnerable groups. 2) To assist PIPs to develop a cadre of multi-skilled district and ward level trainers. 3) To build the capacity of PIPs in project planning, management, monitoring and evaluation. 4) To provide technical assistance to PIPs in the development of HIV-related policies, advocacy and lobbying, decision making and gender mainstreaming for (PLHIV).

The Centre's activities support the HIV/AIDS National Strategy and Plan through the strengthening of support groups of PLHA providing survival skills information at three levels: Level 1- General issues related to HIV; Level 2 - Issues of psychosocial support, palliative care, and food and nutrition security; and Level 3 - issues of behavior change and HIV treatment. This information is disseminated through training-of-trainers (TOTs) at national, provincial and district level and involvement of key stakeholders.

The coverage of our activities is national and target mainly PLHIV and organizations working with PLHIV.

The key contributions of our program to health systems strengthening are promotion of the care and support to PLHIV through capacity building of support groups on issues of prevention, adherence to treatment, reduction of stigma and discrimination of people living positively and mainstreaming of gender into all programs.

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The Centre's program cover activities in the cross-cutting area of Human Resources for Health with training being provided through 20 TOTs to representatives of partner organizations in the 10 provinces of the country and 7 Outreach Officers based at provinces and working with partner organizations for the strengthening of support groups

Another cross-cutting program will be Water through the drilling of 20 boreholes to be placed in strategic / common areas where support groups exist to increase access to clean and safe water for HIV infected and affected; to improve hygienic conditions for carers of PLHIV and increase the productivity of nutrition and herbal gardens.

A key PEPFAR issue addressed by the Centre's program is: Increasing gender equity in HIV/AIDS activities and services through the inclusion of a module on gender issues in our TOTs. In addition, we ensure that more than 50% of the TOTs selected to cascade the training are women and the organizations' recruitment policy is deliberately designed to ensure that more than 50% of its employees are women.

Our strategy for cost-efficiency is based on working with decentralized district and provincial level structures that makes dissemination of information easier and targeted to our beneficiaries at low cost.

Monitoring and Evaluation of our activities is done through quarterly progress reports based on a detailed implementation plan, reports of visits to field sites, minutes of local level meetings with program staff of PIPs and progress reports from the PIPs

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**12292**
Mechanism Name:	**Capacity Building for Community AIDS Service Organizations and PLWH Support Groups**
Prime Partner Name:	**The Centre for Counselling, Nutrition & Health Care, (COUNSENUTH)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	40,400	

Narrative:

With FY09 Supplemental Funds, The Centre will increase access to clean and safe water for HIV infected and affected through the drilling of 20 boreholes to be placed in strategic / common areas where support groups exist. This activity will additionally support PLHIV to improve hygiene and the productivity of nutrition and herbal gardens.

In FY2010, The Centre will continue the strengthening of support groups providing nutrition counseling and psychosocial support to positive people. Outreach Workers will link up PLHIV to other centers for support and receive referrals from New Start Centers and clinics for ongoing supportive counseling and refer back to clinics those that need to be initiated on ART. The Outreach Workers will provide adherence counseling and follow up on defaulters.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	59,600	

Narrative:

With FY09 Supplemental Funds, the Centre will strengthen the network of people living with HIV/AIDS through the translation into vernacular languages i.e. Shona and Ndebele and rolling out of tool kits for support groups' capacity building in the 10 provinces and 62 districts of the country. The Centre will facilitate the setting up of district and provincial committees of People Living with HIV (PLHIV) and holding of the national Annual General Meeting (AGM) which will lead to the formation of the National Committee. The setting up of the national committee is a pre-requisite to accessing Global Fund resources for meaningful involvement of PLHIV. The Centre will strengthen support groups and its networking activities to leverage Global Fund resources.

In FY2010, The Centre will continue to strengthen the networking of positive persons and cascade the survival skills information through 20 Training of Trainers. These training will cascade from provincial to district level through the network structures, leveraging these activities with Global Fund resources. The Centre will consolidate the herbal gardens and document the case studies and successful models for replication and information sharing to other support groups. The Outreach Officers will continue the outreach program with Provincial Implementing Partners (PIPs), building their capacity to take on these activities in the future

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12293	**Mechanism Name: Quality Assurance of HIV/AIDS Related Testing and Strengthening of Laboratory Services in Zimbabwe**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goals of this TBD's PEPFAR program will be: 1) To improve patient care through improved and reliable HIV and HIV-related testing. 2) To increase awareness of Quality Systems among laboratory professionals. 3) To show the importance of good quality laboratory testing and introduce methods of measuring the quality of laboratory testing.

The program objectives will be: 1) Maintain quality assurance services in order to monitor, improve and maintain high quality testing in support of HIV prevention, surveillance, care and treatment programs. 2) Maintain accreditation of Proficiency Testing (PT) schemes that are already accredited. 3) Prepare laboratories in Zimbabwe for WHO accreditation. 4) Provide emergency equipment & reagents to avoid stock gaps in HIV & HIV related testing in Zimbabwe. 6) Strengthen the biomedical service centre set up with PEPFAR support in FY09 for the cost effective service and repair of medical laboratory equipment in Zimbabwe. 7) Strengthen the public health laboratory network in Zimbabwe. 8) Evaluate the impact of implementing quality assurance in laboratories and testing sites performing HIV and related testing. 9) Collaborate with the Health Professions Authority in order to strengthen its position as the regulatory body for laboratories and implement the Zimbabwe Medical Laboratory Standards/Guidelines. 10) Offer a comprehensive External Quality Assurance program in order to monitor, improve and maintain high HIV/AIDS related testing in support of HIV prevention, surveillance, care and treatment programs. 11) Continue to provide an internationally accredited Proficiency Testing program in HIV and related confidentiality testing. 12) Coordinate the routine review, printing & distribution of laboratory standard operating procedures. 13) Train laboratory personnel in laboratory techniques and quality systems.

The activities of this TBD should support the HIV/AIDS National Strategy and Plan through monitoring the quality of testing provided by laboratory and testing sites. Training laboratory personnel in quality systems of key tests such as CD4/CD8 testing, monitoring of liver function tests and others. Supporting provision of reagents and laboratory consumables in cases of stock-outs to allow uninterrupted provision of laboratory services. Providing technical support to provincial and district laboratories in the development and implementation of quality systems in preparation for WHO accreditation.

The coverage of the activities of this TBD should be national with particular focus in supporting development and quality systems at the National Microbiology Reference Lab and the National Tuberculosis Reference Lab.

Key contributions of this TBD's program to health systems strengthening will be accreditation of Zimbabwean laboratories in quality systems and thus providing confidence in the quality of results produced. Ability to sustain and expand the biomedical service center set up in FY09 through PEPFAR support for the maintenance and repairs of equipment required for testing throughout the country. This service center minimizes equipment down-time and ensures continuous provision of laboratory services in Zimbabwe.

Cross-cutting funding of this program will be in Human Resources for Health for significant in-service-training of laboratory personnel, performance assessment/ quality improvement, management and

leadership development, and retention of key staff at the National Microbiology Reference Laboratory (NMRL). REDACTED

A number of Key PEPFAR issues that this program will address include Malaria, for proficiency testing to be carried out together with the HIV proficiency testing, and, TB to account for commodity procurement and training at the National TB reference lab.

Cost-efficiency strategies of this TBD will be based on bulk procurement of reagents and consumables for TB and HIV-related monitoring tests. Application of good inventory management practices like first-in-first-out (FIFO) to avoid expiration of reagents. Continuation of lab refurbishments based on the National Lab assessment by USG in 2009 to procure only the necessary items for service provision. Resources that are already in place should be utilized as much as possible. The biomedical service center set up in FY09 with PEPFAR resources should allow this TBD to support the MOHCW in its regular maintenance and/or repair of laboratory equipment at the national level more cost-effectively than outsourcing the services from private companies. Cost savings should be done by conducting integrated site visits (covering quality assurance issues on HIV, TB and Malaria within the same visit) to sites within close vicinity to minimize traveling costs and time.

Monitoring and evaluation of activities should be done through quarterly progress reports based on a detailed implementation plan that includes targets and indicators. Site visit reports, Proficiency Testing shipment reports and training reports.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED
Human Resources for Health	REDACTED

Key Issues

TB

Budget Code Information

Mechanism ID:	**12293**

Mechanism Name:	Quality Assurance of HIV/AIDS Related Testing and Strengthening of Laboratory Services in Zimbabwe
Prime Partner Name:	TBD

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted

Narrative:

In FY2010, this TBD will support emergency procurement of CD4, Biochemistry and Hematology reagents for HIV monitoring of patients on ART within the National OI/ART program. This is to ensure equitable, uninterrupted provision of laboratory services in support of the National ART program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	Redacted	Redacted

Narrative:

In FY2010, this TBD will strengthen the national biomedical service center initiated with FEPFAR funding in FY09, which is designed to provide maintenance and repair of lab equipment in public laboratories. This unit consists of two equipment engineers provided with the necessary equipment and transport means to manage and repair standardized chemistry, hematology and CD4 analyzers in Zimbabwe. They attend to requests done through the National lab logistician and after consolidation of this small team the center should grow up to 8 engineers to be able to cover all provinces of the country.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	Redacted	Redacted

Narrative:

In FY2010, this TBD will: 1) Continue the process of refurbishment of district laboratories initiated with PEPFAR resources in FY09 ; 2) Consolidate the quality assurance program at national level in the testing areas of Hematology (CD4 count), clinical chemistry, microbiology and serology; 3) Conduct training of laboratory personnel in quality systems and lab techniques; 4) Conduct on-site assessments of selected sites to assess the implementation of laboratory quality systems on the ground; 5) Roll out the standardized HIV rapid testing log book to improve the quality of the data currently collected. 6) Provide technical support to provincial and districts laboratories in the country for the accreditation process with WHO Afro.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:
In FY2010, this TBD will support the procurement of reagents and consumables for TB microscopy, culture and Drug Sensitivity Testing for the national TB program. REDACTED

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12294	Mechanism Name: TBD-Leadership
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The project objective is to equip provincial and district health executives with good leadership and management skills so that they will be able to provide direction to partners and staff in facilitating change and achieving better health services management through efficient, creative and responsible allocation and accountability of resources.

The project will support the National HIV/AIDS Strategy and Plan by improving the skills of health care managers in the efficient use of available human, financial and material resources for improved quality of services.

The coverage of these activities will be national and targeting all public sector health managers of Zimbabwe.

The key contributions of this program to health systems strengthening will be improved leadership and management of HIV/AIDS related activities and resources to scale up and attain the Millennium Development Goals and other health related targets through efficient district health management.

The main cross-cutting program of this project is Human Resources for Health

The cost-efficiency strategy of this TBD will be based on the use of experienced facilitators in these topics to have the greatest impact possible and through the regular evaluation of the program to do the needed changes along the way of the implementation of the activities.

Monitoring and Evaluation of our activities is going to be done through quarterly progress reports, training reports, site visit reports and evaluations from trainees provincial and district health executives.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	REDACTED

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12294**
Mechanism Name:	**TBD-Leadership**
Prime Partner Name:	**TBD**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	Redacted	Redacted

Narrative:

With FY10 funds this mechanism should ensure the continued development and support of effective leadership in district health management teams through: 1) Attending instructional sessions in management modules. 2) Provision of skills for diagnosing and managing district health management problems. 3) Team - building activities through team exercises in district groups 4) Peer review sessions

between district health executives and higher education Masters students in the health field.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12295	**Mechanism Name: TBD-Network of Church-Related Hospitals**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The overall goal of the activities of this Church Network mechanism is to expand prevention, care and treatment on HIV & AIDS services among church related health institutions.

The objectives of the program are:
1) Strengthen and expand the provision of HIV and AIDS prevention, care and treatment programs including home based care within the church related hospitals not yet offering OI/ART services. 2) Increase the skills of the human resources in church related hospitals in the management of HIV & AIDS and Opportunistic infections.

This project will support the HIV/AIDS national strategy and plan through an increase in the network of hospitals providing OI/ART services in Zimbabwe.

The coverage of activities for this program will be national and targeting those church related institutions who are not yet offering OI/ART services for adults and/or children.

The key contributions of this program to health systems strengthening will be an increase in the network of health institutions offering OI/ART services for adults and children.

REDACTED. To become an OI/ART site, staff will need training and mentorship to acquire the confidence in the management of patients and some changes in the physical infrastructure will need to be done to ensure adequate conditions for the provision of services.

PEPFAR key issues addressed within this program will include child survival activities through the integration of routine immunization, growth monitoring, feeding counseling and treatment of life-threatening childhood illness within the services provided to HIV exposed and HIV positive children in the target health institutions. TB issues are going to be addressed among the care offered to all HIV positive patients as TB is the main Opportunistic infection in PLHIV. Workplace issues will be addressed in the target institutions to ensure that health care workers will have access to preventive measures and post-exposure prophylaxis if needed. Post-exposure prophylaxis will be offered to rape/sexual assault survivors too.

REDACTED. Supervisory/mentorship visits to sites close by in the same trip to cut on travel expenses.

Monitoring and Evaluation of the activities will be done through quarterly progress reports based on a detailed implementation plan and supervisory visits reports.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	REDACTED
Human Resources for Health	REDACTED

Key Issues

Child Survival Activities
TB
Workplace Programs

Budget Code Information

Mechanism ID:	**12295**
Mechanism Name:	**TBD-Network of Church-Related Hospitals**
Prime Partner Name:	**TBD**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	Redacted	Redacted

Narrative:

FY10 funds will be used in the scaling up of OI/ART services in church related hospitals/clinics with no OI/ART programs. This is in order to increase access to Opportunistic infections diagnosis and treatment, provision of Cotrimoxazole prophylaxis and ART to HIV positive patients. This will include strengthening institutional capacity to diagnose, treat and manage opportunistic infections, training of health care workers in the initiation and follow up of patients on ART, reinforce the use of DOTS as a TB management strategy for co-infected patients and strengthening laboratory and pharmacy management, mainly related to stock management and recording and reporting activities. Besides these activities, we will ensure that a PEP program is in place for the staff and survivors of rape/sexual assault and that community involvement is done to improve the follow up of patients under care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	Redacted	Redacted

Narrative:

FY10 funds will be used to support those OI/ART clinics within the church related hospitals network that are not yet providing OI/ART services for children. This service will be set up with a family approach and comprehensive provision of services that would include psychological, social, spiritual, nutritional and preventive services. These activities would target HIV exposed and HIV infected children to improve the quality of care and follow up being done at institutional level and community level through the involvement of community health workers. Early infant diagnosis will be a key intervention to incorporate in this program.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12296	Mechanism Name: Strengthening the Master's Level Public Health Training Program
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Objectives of this TBD will be: 1) To Strengthen the Master's-level public health training program; including attracting non-traditional Master's of Public Health (MPH) students. 2) Increase the applicability of the master's level public health training to HIV/AIDS, through integration of HIV/AIDS material and practicum options including projects of national and local importance on HIV/AIDS. 3) Sustain the cadre of public-health professionals who are working in Zimbabwe and expand the type of people available to work in public health. 4) Strengthen the Health Information Management System of Zimbabwe through support in the implementation of targeted activities of the National HIMS Strategic plan.

The activities to be implemented through this TBD should support the HIV/AIDS National Strategy and Plan in the area of operational research at district and provincial level within the public health sector to provide evidence for health related decision making.

The coverage should be national through the deployment of students to all provinces to support public health activities and target to support the Provincial Health Executives in planning, implementation and evaluation of public health interventions.

The key contributions of this program to health systems strengthening would be training and building of competencies and skills in public health practitioners to improve the provision of health services to the

general population.

Activities will have their base in the cross-cutting program of Human Resources for Health through development of management and leadership qualities in Zimbabwean health professionals.

Cost-efficiency strategies should include bulk production of training materials for the program. Maximum utilization of resources that are already in place providing maintenance when needed. Procurement of adequate technology that will increase the communication between trainees and field supervisors reducing costs in traveling. Field supervision in adjacent areas to decrease traveling costs.

Monitoring and Evaluation of its activities should be done through quarterly progress reports based on a detailed implementation plan, field supervision reports, monthly meeting feedback from the trainees, among others.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	REDACTED

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12296**
Mechanism Name:	**Strengthening the Master's Level Public Health Training Program**
Prime Partner Name:	**TBD**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	Redacted	Redacted

Narrative:

In FY 10 this TBD should support the implementation of the National Health Information System strategic plan that looks at channeling all health information in Zimbabwe through a single mechanism and capacity building of the human resources needs in the Health Information System. Its activities should focus on the building of data analysis skills among the relevant cadres involved in the collection,

transmission and use of the data. Some resources should be allocated to support the MPH students in program evaluation at the districts and provinces where they are deployed. Based on available resources some of the recommended actions should be supported at district and provincial level

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	Redacted	Redacted

Narrative:

In FY 10 this TBD should continue the strengthening of the full time MPH program and increase the number of field coordinators to support trainees in their field attachments, increase the number of students recruited per year, subsidize some of components of the part time program, acquire equipment to improve communication between trainees, field supervisors and field coordinators.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12297	Mechanism Name: Strengthening Blood Safety in Zimbabwe
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted

Funding Source	Funding Amount
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The purpose of this project is to improve the safety of the blood bank system in Zimbabwe through strengthening the National Blood Services of Zimbabwe and Ministry of Health and Child Welfare Blood Department laboratories. The expected outcome of this assistance is to prevent the deterioration of blood safety standards in the country and to improve access to safe blood in Zimbabwe through increasing the quantity of blood collected and the cost of blood. The initial phase of the project shall include identification of current needs and gaps of the national blood safety program and development of a work plan designed to address the key issues identified. Activities under this project may include any of the following: 1) Infrastructure: Provision of standard blood collection, laboratory and other equipment and reagents to five NBSZ blood collection facilities to: a) Improve blood collection and testing for transfusion transmitted infections; b) Perform blood grouping and cross matching; and c) Ensure a cold chain to enable mobile collection efforts to access a wider area, while preserving the integrity of the blood units collected. 2)Blood Collection: Development of site specific protocols and strengthening procedures for obtaining, handling, processing, storing, transporting, and distributing blood collected through a) Recruitment and retention of a network of blood donor recruiters and blood donor counselors; b) Development of a system to identify low-risk and repeat blood donors using BCC principles and approaches for promotion of voluntary, non-remunerated regular blood donation; c)Improvement of capacity of facilities to obtain, process and store blood safely with appropriate record keeping; and d) Maintain National quality assurance standards in collection, testing, and storage of blood. 3)Blood testing and utilization: Develop generic national and site-specific protocols based on accepted international standards for a)Testing blood for ABO, HIV, HBsAG, HCV, VDRL, and HTLV 1-2; b) Managing blood processing facilities, including procurement of supplies and reagents; c) Implementing effective quality assurance procedures for testing blood, including appropriate segregation and final disposal of medical waste; d) External quality assurance; e) Record-keeping; f) Blood utilization review to assure optimal and rational blood usage. 4) Training and education: Ensure that training and continuing education programs are provided to appropriate health care professionals throughout Zimbabwe who are involved with blood transfusion services, including physicians, nurses, physicians assistants, community health aides, counselors, phlebotomists and laboratory technicians on: a) Appropriate blood donor recruitment and blood collection; b) Basic principles in the practice of blood banking and transfusion medicine, including the rational utilization of blood products; c) Safe transfusion practices, including reducing the demand for unnecessary transfusions and recognizing community norms in practices regarding blood transfusions. 5) Monitoring and Evaluation: Development and implemenation of appropriate information and monitoring systems to a) Track donated units of blood; b) Allow for review and adjustment of program activities; c) Measure clinical outcomes to assess the impact of the program. 6) Equipment maintenance: Establish and maintain a complete inventory of equipment and a central maintenance contract to ensure routine maintenance and calibration of equipment in accordance with manufactuerers' specification. 7) Cost of blood: Reduce cost of blood to patients according to identified need-based criteria to increase access to safe blood especially in remote locations, such as at mission hospitals.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12297**		
Mechanism Name:	**Strengthening Blood Safety in Zimbabwe**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	Redacted	Redacted

Narrative:

The purpose of this project is to improve the safety of the blood bank system in Zimbabwe through strengthening the National Blood Services of Zimbabwe and Ministry of Health and Child Welfare Blood Department laboratories. The expected outcome of this assistance is to prevent the deterioration of blood safety standards in the country and to improve access to safe blood in Zimbabwe through increasing the quantity of blood collected and the cost of blood. The initial phase of the project shall include identification of current needs and gaps of the national blood safety program and development of a work plan designed to address the key issues identified. Activities under this project may include any of the following: 1) Infrastructure: Provision of standard blood collection, laboratory and other equipment and reagents to five NBSZ blood collection facilities to: a) Improve blood collection and testing for transfusion transmitted infections; b) Perform blood grouping and cross matching; and c) Ensure a cold chain to enable mobile collection efforts to access a wider area, while preserving the integrity of the blood units collected. 2)Blood Collection: Development of site specific protocols and strengthening procedures for obtaining, handling, processing, storing, transporting, and distributing blood collected through a) Recruitment and retention of a network of blood donor recruiters and blood donor counselors; b) Development of a system to identify low-risk and repeat blood donors using BCC principles and approaches for promotion of voluntary, non-remunerated regular blood donation; c)Improvement of capacity of facilities to obtain, process and store blood safely with appropriate record keeping; and d)

Maintain National quality assurance standards in collection, testing, and storage of blood. 3)Blood testing and utilization: Develop generic national and site-specific protocols based on accepted international standards for a)Testing blood for ABO, HIV, HBsAG, HCV, VDRL, and HTLV 1-2; b) Managing blood processing facilities, including procurement of supplies and reagents; c) Implementing effective quality assurance procedures for testing blood, including appropriate segregation and final disposal of medical waste; d) External quality assurance; e) Record-keeping; f) Blood utilization review to assure optimal and rational blood usage. 4) Training and education: Ensure that training and continuing education programs are provided to appropriate health care professionals throughout Zimbabwe who are involved with blood transfusion services, including physicians, nurses, physicians assistants, community health aides, counselors, phlebotomists and laboratory technicians on: a) Appropriate blood donor recruitment and blood collection; b) Basic principles in the practice of blood banking and transfusion medicine, including the rational utilization of blood products; c) Safe transfusion practices, including reducing the demand for unnecessary transfusions and recognizing community norms in practices regarding blood transfusions. 5) Monitoring and Evaluation: Development and implemenation of appropriate information and monitoring systems to a) Track donated units of blood; b) Allow for review and adjustment of program activities; c) Measure clinical outcomes to assess the impact of the program. 6) Equipment maintenance: Establish and maintain a complete inventory of equipment and a central maintenance contract to ensure routine maintenance and calibration of equipment in accordance with manufactuerers' specification. 7) Cost of blood: Reduce cost of blood to patients according to identified need-based criteria to increase access to safe blood especially in remote locations, such as at mission hospitals.

Implementing Mechanism Indicator Information

(No data provided.)

USG Management and Operations

1.

Redacted

2.

Redacted

3.

Redacted

4.

Redacted

5.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services				15,000	20,000	35,000
ICASS				20,000	20,000	40,000
Institutional Contractors				210,000	250,000	460,000
Management Meetings/Professional Developement				9,000	25,000	34,000
Non-ICASS Administrative Costs				70,000	215,000	285,000
Staff Program Travel				20,000	20,000	40,000
USG Staff Salaries and Benefits				660,000	650,000	1,310,000

Total	**0**	**0**	**0**	**1,004,000**	**1,200,000**	**2,204,000**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHCS (State)		15,000
Computers/IT Services		GHCS (USAID)		20,000
ICASS		GHCS (State)		20,000
ICASS		GHCS (USAID)		20,000
Management Meetings/Professional Developement		GHCS (State)		9,000
Management Meetings/Professional Developement		GHCS (USAID)		25,000
Non-ICASS Administrative Costs		GHCS (State)		70,000
Non-ICASS Administrative Costs		GHCS (USAID)		215,000

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Capital Security Cost Sharing			712,364			712,364
Computers/IT Services			204,000			204,000
ICASS			825,666			825,666
Management			208,543			208,543

Meetings/Professional Developement						
Non-ICASS Administrative Costs			319,527			319,527
Staff Program Travel			178,260			178,260
USG Staff Salaries and Benefits			1,861,640			1,861,640
Total	**0**	**0**	**4,310,000**	**0**	**0**	**4,310,000**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GAP		712,364
Computers/IT Services		GAP		204,000
ICASS		GAP		825,666
Management Meetings/Professional Developement		GAP		208,543
Non-ICASS Administrative Costs		GAP		319,527