Zimbabwe

Operational Plan Report

FY 2013

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

Operating Unit Overview

OU Executive Summary

COUNTRY CONTEXT

Epidemiology - Tremendous progress has been made in Zimbabwe to reduce the HIV prevalence. UNAIDS highlighted the 50% decline in the number of adults (15-49 years old) acquiring HIV infection in Zimbabwe from 2001-2011. The latest estimates, based on the Zimbabwe Demographic Health Survey (DHS) 2010-2011, define adult prevalence at 15%, compared with 1997 rate of 25%. However, an estimated 58,472 individuals were newly infected with HIV in 2012. The estimated number of orphans and vulnerable children is 941,024.

The country continues to experience a generalized HIV epidemic with an estimated 1.2 million HIV-infected adults and children in 2011 and approximately 58,000 deaths each year. Social, cultural, and economic factors contributing to HIV transmission include transactional sex, multiple and concurrent partners, alcohol abuse, low awareness of HIV infection status, lack of ART use in undiagnosed individuals, poor treatment adherence, and low levels of male circumcision (MC). While prevalence among youth has dropped significantly, it is worth noting that prevalence among girls was twice that of boys of the same age. HIV is the leading cause of death among adults and accounts for over 27% of all deaths among mothers and infants. Maternal mortality rate nearly tripled between 1994 and 2010.

Zimbabwe‘s TB case rate (603 per 100,000) is one of the highest in the world. The TB epidemic in Zimbabwe is largely HIV driven with a very high TB/HIV co-infection rate (at 80%) with an increasing number of MDR and XDR cases. TB is the second leading cause of adult morbidity and mortality in Zimbabwe.

National Response - The National AIDS Council (NAC) and the Ministry of Health and Child Welfare (MOHCW) lead the national HIV/AIDS response and have outlined their goals in Zimbabwe National Strategic Plan (ZNASPII) 2011-2015. While the level of institutional leadership within the MOHCW is high in terms of technical direction and policy setting, the capacity for implementation continues to be limited. For the MOHCW low capacity is largely an outcome of limited national resources for programming, which affects its capacity to deploy and adequately train sufficient experienced health professionals, provide adequate commodities, and provide a high level of monitoring and supervision to ensure high quality service delivery. As such, donor resources have been essential to national prevention, care, treatment, and health systems strengthening (HSS) efforts. The majority of HIV/AIDS-related activities are donor funded. Nevertheless, Zimbabwe has not received the magnitude of donor funding that countries with similar HIV burden have been fortunate to access. Zimbabwe is facing potential critical shortages of key

inputs to achieve ambitious goals, particularly in the areas of treatment, prevention of mother-to-child transmission (PMTCT), and MC.

USG within the National Response - The USG responded to the national call to action through HIV programming prior to the advent of the PEPFAR program. PEPFAR's support has invested in the national efforts to scale-up HIV prevention, care, and treatment. Provider initiated testing and counseling (PITC) is now offered in 92% of health facilities. PEPFAR has demonstrated a strong commitment to the Government of Zimbabwe's (GoZ) PMTCT priorities by taking a leading role to support the GoZ's vertical transmission agenda. Under MOHCW's leadership, voluntary medical male circumcision (VMMC) will be scaled-up with a 2015 target of 1.2 million MCs. In 2012 the national treatment program reached universal access with PEPFAR playing a pivotal role. Additionally, the USG is CB the GoZ though system strengthening in labs, informatics, and human resources for health.

Other Donors - The USG is a key partner, investing more than other bilateral donors in the HIV/AIDS response. The Global Fund to Fight HIV/AIDS, TB, and Malaria (Global Fund), however, remains the largest source of support to the national response with a total investment through Round 8 of US$353,975,343 disbursed to date. Other key donors include the Heath Transition Fund (a multi-donor funding mechanism with a strong focus on maternal and child health), Bill and Melinda Gates Foundation (focus on VMMC), DFID (focus on integrated SRH program and broader MCH activities), and EU (focus on MCH).

PEPFAR FOCUS IN COP13

The COP13 priorities remain PMTCT, HIV testing and counseling (HTC), sexual prevention, VMMC, treatment, support for orphans and vulnerable children (OVC), HSS, and gender integration.

There is strong commitment to PMTCT at national level with the USG continuing to take a leadership role. Global Fund, Children's Investment Fund Foundation (CIFF), Clinton Health Access Initiative (CHAI), and UNICEF are other key stakeholders working to support the GoZ's vertical transmission elimination agenda. A priority among PEPFAR programs is the synergies between behavioral and biomedical prevention interventions. With scale-up and proposed Key Population Challenge Fund resources, the USG will continue to integrate and expand services and identify access and barriers to care and treatment for most at risk population (MARPs). VMMC continues to remain a focus with both the Gates Foundation and DFID adding resources to support the national VMMC program. However, a shortage and delay of planned PEPFAR funds and leveraged funds from the Global Fund will limit planned targets in COP13. In spite of enormous challenges over the last several years, the MOHCW has developed a robust ARV treatment program since its inception in 2004. As of November 2012, an estimated 524,412 people were on treatment in Zimbabwe with the country now at universal access. The capacity of the national program,

which is strongly supported by USG, the Global Fund, and others, has been impressive with over 9,069 people being initiated on ARVs monthly in 2012. Nevertheless commodity shortages as well as program weaknesses have threatened to slow progress. Additional challenges include procurement delays leading to ARV shortages by the Global Fund. In order to minimize these shortages and program weaknesses, the USG is committed to directing support towards treatment including additional resources for phasing in revised treatment guidelines, procurement and distribution of ARV commodities, improving quality of care activities, and expansion of ART and MCH integration.

The Zimbabwe PEPFAR Team is not a Partnership Framework Country; however a revised PEPFAR Five-Year Strategy was submitted with COP13. The revised PEPFAR Five-Year Strategy is in-line with and adopted targets of the ZNASPII. The Strategy is a roadmap for PEPFAR and GoZ in coordination of support, technical assistance (TA), policy reform, and service delivery.

PROGRESS AND FUTURE

Country Strategy - The PEPFAR Zimbabwe team submitted a draft PEPFAR Five-Year Strategy in the beginning of February 2013. Comments were received from OGAC at the end of February 2013. A revised PEPFAR Five-Year Strategy will be submitted April 2013.

Country Ownership - The PEPFAR program supports MOHCW's leadership and national programs rather than pilot programs benefiting a single district or province. The MOHCW–led technical groups are the primary mechanisms through which donor investments are coordinated. These groups have been in instrumental to setting the pace of change and providing a platform for ongoing review of technical areas and implementation.

The continued stabilization of the economy and to some degree the political situation in Zimbabwe has further allowed for critical thinking of country ownership. There is a potential risk that the current political stasis could unravel during the upcoming elections. Nevertheless the team remains committed to invest in strong collaborative relationships with MOHCW. During COP development, there was a process to engage the MOHCW in Technical Working Group (TWGs) forums, key MOHCW leadership meetings, and through key stakeholder meetings. The level of detail varied in each meeting to share budgets, key activities, and targets.

Trajectory of Future Activities

Global Fund – The Global Fund is the largest source of support to the national response with an annual investment through Round 8 of approximately US$80 million annually. The Round 8 grant covers HIV, TB, and malaria with UNDP as the Prime Recipient (PR). Round 8 Grant is set to expire June 2014.

Voluntary Medical Male Circumcision (VMMC) – PEPFAR will support the MOHCW's goal of 1.2 million MC by 2015. This is an extremely ambitious target that will require major policy shifts to enable nurses to carry out MC procedures. The introduction of the PrePex device is expected to speed up the scale-up although the MOHCW is still waiting for the device to receive WHO approval. The Gates Foundation, which has heavily invested in VMMC since its introduction, will be scaling down activities at the end of 2013 and this will leave a major funding gap.

Treatment Universal Access – Universal access is a reality in Zimbabwe with switching of patients on more toxic regimes expected to be completed by 2014. The next phase is to improve the quality of service provision in this area.

Treatment as Prevention – The USG is convening stakeholders and conducting feasibility and needs assessment in COP13 for a demonstration project of treatment as prevention.

PMTCT Option B or B+ – In February 2013, the MOHCW called a national consultation to discuss the feasibility of Option B/B+. USG supports and will follow national plans as they are finalized. However, it is important to note due to the challenges with commodities, lab testing, and quality assurance, Option B+ may be premature in Zimbabwe.

Human Resource Retention Scheme – currently this is supported by the Global Fund and the Health Transition Fund (HTF) donors. GFATM will fully cease providing resources for the retention scheme in 2014 and the HTF donors currently do not have plans to meet the shortfall in this area. The GoZ is therefore expected to cover these costs in the future with an estimated additional $20million per year.

PROGRAM OVERVIEW

Prevention

PEPFAR/Zimbabwe's prevention portfolio has several core interventions designed to achieve measurable results and produce significant impact. Key among these are: a comprehensive VMMC, PMTCT, HTC, and an extensive condom (sexual prevention) program. These efforts also include prevention services for MARPS and persons living with HIV/AIDS (PLWH), which are incorporated within the primary core interventions. Additionally, behavior change communication (BCC) efforts support all of the core interventions and focus activities to encourage behaviors that maximize popular uptake of all core interventions.

Voluntary Medical Male Circumcision (VMMC) – Under the national VMMC scale-up program, services are part of a comprehensive HIV prevention package along with provision of HTC, screening and treatment for STIs, promotion of safer sex (including counseling of men and their partners to prevent them

from developing a false sense of security), and provision of condoms (including instructions about correct use). Assistance to expand the scale-up of VMMC services will include the provision of necessary MC commodities, training of health providers, BCC to support VMMC acceptance and support of expansion of outreach services and mobile units. Efforts will also focus on integrating MC services for HIV prevention into routine clinical care provided by public health facilities.

Prevention of Mother-to-Child Transmission (PMTCT) – The USG is supporting Zimbabwe's PMTCT continuum of care for the elimination of new pediatric infections and a reduction in maternal mortality. A national vertical transmission elimination agenda within the national strategic plan provides the framework for USG investment in PMTCT services. Implementation under COP13 will help insure that comprehensive, high quality PMTCT services are provided uninterrupted at all MNCH sites in all 62 districts of Zimbabwe. Families and Communities for the Elimination of Pediatric HIV (FACE-Pediatric HIV) program will support community initiatives designed to increase demand, uptake and retention of PMTCT and pediatric HIV care services. The USG also will support selected OI/ART units at Mission hospitals to provide PMTCT services as part of the integrated package of HIV/AIDS continuum of care. The number of HIV-positive pregnant women who received ARVs to reduce risk of MTCT during pregnancy and delivery is expected to reach 60,410. FACE-Pediatric HIV partners will support the national PMTCT unit in assessing the feasibility of Option B/B+. A new activity will be a PMTCT costing study to provide information on per patient cost of providing PMTCT services at public health facilities.

HIV Testing and Counseling (HTC) – The USG's HTC program supports provider initiated testing and counseling (PITC) while also maintaining a core set of client initiated testing and counseling (CITC) centers in urban areas, with increased mobile outreach to rural and vulnerable populations. Support for CITC services is channeled through centers (that include 8 outreach teams) in the major urban areas of Harare, Chitungwiza, Bulawayo and Masvingo as well as 13 NGO-managed HCT sites together with outreach teams. Assistance is designed to increase the proportion of men and women accessing HTC as couples and to further increase couples HTC services at static sites in both urban and rural areas. Twenty-three mobile outreach teams will provide HTC services to all districts of the country.

Mobile outreach HTC services currently contribute 60% of the total number of monthly clients and about 20% of the mobile services are targeted at population groups in high risk areas such as workplaces, prisons, resettlement areas and to mobile, vulnerable population groups. HTC also is included with PEPFAR-supported PMTCT services. The total target for HTC will be 1,060,000 clients tested and counseled. Funding to SCMS will help procure HIV rapid test kits for use in both public facilities and NGO-managed sites to help prevent stock-outs of commodities.

Sexual Prevention – The USG's sexual prevention program comprises a comprehensive ABC program

that includes the provision of mass media and interpersonal communication (IPC) tools within the national program. Activities include: risk reduction work; social marketing of male and female condoms; and support of male and female condom distribution through the public sector. Support is also provided for national condom forecasting, condom logistics systems, and condom off-take reporting for both male and female condoms. Social marketing efforts will focus on condom distribution through targeted high risk areas and outlets, as well as increasing coverage of male and female condoms in hard to reach areas. About 28.6 million male condoms will be distributed through a direct distribution mechanism to 8,000 retail outlets and around 1.43 million female condoms through a network of 1,500 hair salons and barbers. Family planning (FP) services are also integrated within most sexual prevention activities.

Clinical Infection Control – The USG will continue to support the Zimbabwe Infection Prevention and Control Program (ZIPCOP) to strengthen the MOHCW's capacity for implementation of infection control and prevention activities in health care facilities nation-wide. COP13 funds will contribute to injection safety through a number of activities that include: training of health workers at all levels in injection safety; information, education and communication activities among health workers and clients; and, strengthening the provision of post-exposure prophylaxis (PEP) through improving monitoring and reporting of occupational injuries and strengthening the PEP drug supply chain.

Treatment

Working with Faith-based Organizations (FBOs) – PEPFAR supports the continuum of care through a partnership with the Zimbabwe Association of Church Hospitals (ZACH) to increase the number of facilities providing opportunistic infection (OI)/ART services. Currently 24 ZACH sites provide diagnosis and treatment of OIs , co-trimoxazole prophylaxis and ART to HIV positive patients. With the current program ending this year, USG through a follow-on mechanism that is TBD will continue to improve and expand the HIV/AIDS prevention and care capacity in health facilities in all 10 provinces of the country. A second TBD partner will focus on supporting capacity building (CB) through training and precepting in management of OIs and HIV/AIDS. A pool of mentors will be established who will provide site supervision to the participating facilities to improve the provision of OI/ART services that will in turn yield sustainable high quality care outcomes. To bridge the gap until this follow-on activity is established, USG has tasked ITECH to conduct a nationwide needs assessment for training and mentorship. The current HIV integrated curriculum will be reviewed and recommendations made to further improve the quality of the training for health care workers.

HIV Drug Resistance Monitoring – Support to national HIV drug resistance monitoring will continue. COP13 funds will enable the continuation of the monitoring for 12, 24 and 36 months at 3 sites.

Treatment as Prevention – COP12 funds will support the MOHCW to develop a policy framework and

gain consensus for a model for implementation of the “treatment as prevention” strategy. Assessing feasibility and acceptability of the concept among key populations and various stakeholders and advocacy groups will follow as a demonstration project in COP13.

Health Quality Initiatives – Under the leadership of the MOHCW Quality Assurance Directorate, the USG team will continue to support quality of care improvement program in 50 sites across Zimbabwe.

Support for Key Positions – SCMS will continue to second three medical officer positions to MOHCW AIDS & TB Program: the National ART Coordinator, Deputy National ART Coordinator for Quality Assurance, and Assistant National ART Coordinator. SCMS will continue to support the funding of site readiness assessments and site supervision aimed at enhancing the MOHCW's ART scale-up activities, national quality of care initiative, and decentralization of ARV treatment.

Procurement of ARVs – The USG through SCMS will provide first-line ARVs for 160,000 adult patients treated in public sector health facilities. These will contribute to meeting the MOHCW target (542,305 adult ART patients by the end of 2014). All the USG supported medicines will be Tenofovir or Zidovudine containing regimens in line with the MOHCW strategy to withdraw Stavudine and have all clients on newer safer regimens by the end of 2013. The USG will continue to support the national quantification and supply plan activities of the logistics unit to ensure stock availability/shortages are reported on a monthly basis and addressed through a coordinated partner response with ARVs supported by the GoZ through NAC, Global Fund, and DFID.

Care and Support
TB Control – A TB screening tool has been piloted in 56 municipal clinics in Harare and the focus of the national ART program is to scale up the proper use and reporting on this tool. This scale up began in COP12 and the focus in COP13 will be to continue this scale up to reach, initially, all the ART initiating sites (~300) in the country.

In addition, COP13 funds will be used to continue the scale-up of a TB/HIV integrated care model that was piloted in three clinics in Harare and Bulawayo. The integrated health care model will be scaled-up to an additional 20 sites to bring the total to 43. After an initial training period and re-organization of some clinic procedures, the integrated care activities are fully implemented by the existing health staff in the municipalities as part of their daily duties. This frees up much needed resources to take this model of care to additional facilities.

The USG will continue to support MOHCW efforts to set up MDR-TB surveillance in strategic sites to provide national coverage. Health personnel from the 65 district hospitals will participate in active

surveillance for MDR TB. The two reference laboratories (the National Microbiology Reference Laboratory in Harare and the TB Reference Laboratory in Bulawayo) will be strengthened to provide culture and sensitivity analysis for suspected MDR TB cases.

Leveraging – Non-PEPFAR funds will continue to augment some PEPFAR supported activities including Support for the national MDR-TB survey currently being undertaken by the National TB Control Program (NTP); facilitating the introduction of infection control interventions in approximately 265 TB clinics (municipal as well as government facilities) - increasing the geographic coverage of infection control interventions; and procuring additional Gene-Xpert machines as well as provide the TA to facilities to make them ready to access this technology.

Care and Support Activities for People Living with HIV/AIDS (PLWH) – USG assistance includes continuing funding for care and supports to PLWHs through the national "New Life" Program (13 sites nationwide). New Life enhances the continuum of care through focusing on psychosocial (PSS) support, nutritional counseling, ART adherence counseling, and tracked referrals and linkages to HIV care, treatment, and support for HIV positive clients. All New Life sites have an outreach team complemented by peer counselors who provide ART adherence counseling support to 101 public sector ART/OI clinics nationwide. The program provides ART adherence counseling to over 200,000 ART clients annually, including over 150,000 clients provided with PSS and supportive counseling. In addition, the outreach program provides TA and training to about 350 PLWH community and workplace-based support groups. The number of PLWH reached through these support groups is over 60,000 annually. All New Life sites offer integrated FP services.

Orphans and Vulnerable Children (OVC) – The USG will to provide at least 138,000 vulnerable children with a minimum of one core service through proven models, as outlined in the 2012 PEPFAR Guidance for OVC Programming as well as the GoZ National Action Plan for OVCs.

Areas of focus in COP13 include: reaching more out-of-school children with comprehensive services; scaling up early childhood interventions and models for reaching children with disabilities; expanding and enhancing economic strengthening interventions to reach more vulnerable families; combining caregiver support interventions with internal savings and lending groups; expanding geographic coverage to under-served rural communities; and focusing on the special needs of adolescent girls.

Strategic Information

PEPFAR supports the provision of timely and focused strategic information (SI) in order to inform policy, support evidence-based programming and ensure efficient resource utilization. PEPFAR technical officers have advanced the Zimbabwe national HIV SI capacity through TA and support of activities as outlined by

the Monitoring and Evaluation Plan for ZNASPII.

Health Management Information System (HMIS) – PEPFAR will continue to provide extensive technical support to the national HMIS unit to strengthen the MOHCW's capacity to manage an integrated routine data collection system to provide timely information to guide policy formulation and programming. In 2012 with USG support, updated Distract Health Information Systems (DHIS) software was introduced at eight provincial and sixty-two district offices. The USG also trained and provided on-going support and supervision for key personnel to strengthen routine monitoring. COP13 funds will be used to continue building the capacity of district and facility health care workers in the use of data for decision making. In relation to this, PEPFAR will help MOHCW to strengthen production and timely dissemination of reports. Through upgrading and building additional data sets into DHIS, a more integrated system will be developed to include HIV, TB, Malaria, nutrition, laboratory and pharmacy, etc., thus phasing out vertical reporting systems.

Electronic Medical Records Systems (EMRS) – MOHCW piloted three electronic medical records systems (EMRS). PEPFAR provided technical support for this phase. COP13 funds will be used to provide human and material resources for the roll-out of the selected EMRS.

Integrated Disease Surveillance and Response (IDSR) – The USG supported the strengthening of Integrated Disease Surveillance and Response (IDSR) through continual software upgrades, provision of internet access and assistance in outbreak investigation and control. Weekly diseases surveillance reporting timeliness and completeness improved from below 40% to over 80% in at least 1,200 health facilities. The USG will continue to support the strengthening of the system in FY 2013, with the goal to have this system fully integrated within the DHIS.

Surveys and Surveillance – PEPFAR continues to take the lead in supporting the MOHCW and NAC in conducting surveys and in establishing and maintaining surveillance systems. COP12 supported implementation of the 2012 ANC survey at 55 sentinel sites. An additional activity in this survey was the comparison of ANC survey derived estimates with national routine PMTCT data, with a goal to determine the efficacy of transitioning from the use of ANC surveys to routine PMTCT data in order to estimate the population prevalence of HIV. A follow up study is planned in COP13.

COP13 funding will also support a follow up study to determine HIV incidence using BED and avidity assays on ANC and ZDHS samples in collaboration with MOHCW, ZVITAMBO project and Manicaland HIV prevention project. The aim of the study is to provide more accurate estimate of HIV incidence in Zimbabwe. PEPFAR technical officers continue to participate in the updating of HIV estimates and the UNAIDS Global Health HIV and AIDS Report.

In response to new and emerging issues, the USG has provided technical leadership in protocol development and implementation of the HIV Drug Resistance Surveillance System (HIVDR) since 2006. To date, the team has conducted five rounds of Early Warning Indicators Surveys. The MOHCW plans to implement a requirement that all facilities offering ART services collect and report their EWI data sets to the national level.

Data Quality and Verification – To strengthen internal partner monitoring capacity, the USG SI team developed joint data quality assurance (DQA) and on-site data verification (OSDV) guidelines and tools for use in country during joint DQAs and OSDVs, which have proven to be a very successful platform for joint learning, accountability and collaboration. Over the past year, the USG conducted two project evaluations in line with the new USAID Evaluation Policy. The two end-of-project evaluations for the PMTCT and OVC projects will derive important lessons on the application of the USG GHI principles in project implementation to inform future project design.

Gender Integration

Greater effort is being given to take gender-specific vulnerabilities into consideration during program implementation in order to promote improved health outcomes for women and girls. The new OVC program has integrated gender throughout the project and will ensure interventions address gender imbalances, promote male involvement, reduce women's and children's vulnerability to sexual abuse, HIV infection, and exploitation, and take into account specific needs of girls and boys. Activities for COP13 include: directing gender-based violence (GBV) prevention messages to reach in and out-of-school children; initiating Family Support Groups that target men and women and address gender-related roles within the household; expanding school-based clubs that equip adolescent girls and boys with HIV prevention information and skills to prevent sexual abuse and exploitation; and enhancing life skills by integrating co-ed discussions on values, leadership, counseling, and communication, sexual reproductive health (SRH), and HIV prevention.

USG supported, Maternal and Child Health (MCH) activities also address barriers to maternal and child health services through focusing on providing minimum standards of care for MCH services, which include providing gender-sensitive training regarding health provider attitudes, knowledge and practices. This process helps to improve the quality of care, therefore providing greater reassurance to women and girls that they will receive the appropriate level of care that they seek. Some of the major efforts to address gender equity include an increased emphasis on integrating health services such as offering ART in MCH facilities and bringing services closer to women through outreach. Expanding the integration of STI, FP, HIV services at the New Start and New Life centers will continue with enhanced efforts to strengthen linkages to other GBV support services.

Government and Health Systems Strengthening

The MOHCW is the largest provider of diagnostic medical laboratory services. These laboratories operate as a network of 52 district, 8 provincial, 5 central and 3 national reference laboratories. The USG, through the Zimbabwe National Quality Assurance Program (ZINQAP), is providing laboratory services with External Quality Assurance (EQA) through Proficiency Testing (PT). Currently 104 out of 186 public sector laboratories are participating in the EQA program. Also, ZINQAP is establishing a laboratory mentorship program to improve laboratories towards accreditation. Zimbabwe is using the Strengthening Laboratory Management toward Accreditation (SLMTA) model to strengthen laboratory testing for improved service delivery and in preparation for accreditation. This program will continue to be supported as part of COP13.

The USG will continue to support the national laboratory services to strengthen the lab monitoring and evaluation (M&E) system, communicable disease surveillance, disease outbreak confirmation, and improve the availability of data for decision making. A reporting tool for disease surveillance was introduced in 2012. There was an increase in number of sites reporting consistently and two outbreaks were detected through the laboratory based surveillance systems. In COP13, the USG will assist the MOHCW with the establishment of a Laboratory Management Information System to effectively manage laboratory data. USG support will provide point of care (POC) diagnostics for CD4, early infant diagnosis (EID), and viral load; thus supporting the national “decentralization” of lab services to the district as the basic unit working to offer health services.

The USG will support the development of an integrated approach to logistics within the MOHCW by working closely to build the capacity of both the MOHCW’s Directorate of Pharmacy Services (DPS) and the National Pharmaceutical Company (NatPharm), who together manage the procurement and distribution of the other drugs and commodities for the national system. Strengthening efforts will build on successes achieved in logistics systems for FP and HIV/AIDS supplies. The assistance will help build a single, efficient and integrated health logistics management and information system, resulting in low stock-outs. In COP13 TA and resources will be provided for training and supervision, and forecasting of national procurement needs.

The USG will continue to support the GoZ to ensure a continuous supply of competent healthcare workers through both pre and in-service training. This training will support and strengthen the management, coordination, implementation, and monitoring of services, resulting in a stronger, more efficient, effective, and sustainable health care delivery system. Support will also be given to health professional associations, councils, and boards, all of whom are key actors in the training and development of health workers. USG will continue to support the training of public sector health managers

in leadership, management and governance issues through the Department of Community Medicine (DCM). Strengthening of the Masters in public health curriculum and training at the University of Zimbabwe's (UZ) DCM will continue. The program's activities have assisted to increase the capacity and skill set of public health practitioners in public health leadership, policy development and response to public health events.

The development of a robust Human Resource Information System (HRIS) for the MOHCW and the regulatory authorities will continue through the Informatics and Training Research Advancement Center (HITRAC); the Information, Communication, and Technology (ICT) wing of the DCM at the UZ School of Medicine. The goal of this project is to develop a robust, integrated and interoperable HRIS which routinely produces accurate, high quality health workforce surveillance data for effective decision making.

Additionally, the USG will continue to build and strengthen the capacity of the GoZ social service system to sustainably care for vulnerable children. Through the OVC mechanism, the Department of Social Services in the Ministry of Labor and Social Services will be supported in implementing a comprehensive strategic plan for social services. The skills of District Social Services Officers, through the Diploma in Social Work Program, will continue to be upgraded at the Women's University of Africa. The USG has signed the Convention on the Rights of Persons with Disabilities and the USG has developed a disability policy and directives related to disability. In fulfilling the policy, the OVC program will continue working with Disabled People's Organizations that work with children. This will ensure that they have access to critical services like education, health and child protection. Programs will work closely with the National Association of Societies for the Care of the Handicapped.

GLOBAL HEALTH INITIATIVE, INTEGRATION, CENTRAL INITIATIVES

Global Health Initiative (GHI) - The Zimbabwe GHI Strategy was approved in August 2012, after an inclusive process of consultation with partners, MOHCW, and USG agencies on priority areas and interventions for the GHI to address. The strategy reflects two key priority areas for GHI in Zimbabwe which are: the integrated delivery of health services with a particular emphasis on women and children; and building the capacity of health systems for sustainable programming. These focus areas are oriented towards reducing morbidity and mortality related to HIV, TB, malaria, reproductive health and maternal, newborn, and child health conditions. Progress towards this goal will involve increasing availability of and access to quality health services.

In support of GHI, COP13 activities will enhance efforts in HSS, as already outlined in the governance and system strengthening section. Towards greater integration, key focus areas include greater emphasis within the PMTCT program to address weaknesses in FP particularly in the postpartum period. Similarly through the network of New Life and New Start centers, strengthening of FP services will occur with

additional leveraged funding from DFID. To support all health programs, an integrated system for supervision is being devised by the MOHCW and once completed, will be implemented using PEPFAR and other donor resources. Supporting the GHI principles of country ownership, activities remain focused on priorities set by the MOHCW. Similarly all PEPFAR projects are guided by national policies, use national training curricula and guidelines, and rely on pools of national trainers rather than implementing partners.

Central Initiatives - The Zimbabwe PEPFAR team has embraced the opportunity to draw from central initiatives to bolster the PEPFAR program of support. These complementary activities include Gender Challenge Fund (GCF), the Global Fund Collaboration Initiative, and Medical Education Partnership Initiative (MEPI).

The GCF will continue to work with 10 local organizations to enhance local capacity to utilize and generate data to inform gender-related programming. A key component of the project is a grant-making mechanism to facilitate gender related operational research.

The Global Fund Collaboration Initiative is being managed by UNICEF with activities planned to support: CB of the CCM secretariat to support improved coordination; establishing a resource tracking process to annually update donor/GoZ support to the health sector; develop funding proposals; strengthen overall coordination through MOHCW joint bi-annual planning meetings; and improve consolidation of national health reports to inform decision making.

The MEPI program will continue in COP13 with the Cerebrovascular Heart Failure, Rheumatic Heart Disease Intervention Strategy (CHRIS) Committee implementing curricular in cardiovascular diseases to clinical courses and on the Med Medicine program. The University of Colorado School of Medicine (UCSOM) will continue as the primary partner and will deliver a series of 25 lectures on cardiovascular physiology to the second year medical students. CHRIS Scholars will be integrated as lecturers, delivering a total of at least five lectures under UCSOM tutelage. The intent is that by year five of the grant, CHRIS fellows will deliver the entire series of 25 lectures. The IMHERZ linked award will continue to develop expertise of faculty and postgraduate students through master classes, establish and conduct short courses in mental health research and improve a system of monitoring activities.

PEPFAR BLUEPRINT

PEPFAR and the National HIV continuum of response - The MOHCW continues its leadership to ensure that there is continuum of response by bringing together the representatives from GoZ, donors, UN agencies, civil society, and the private sector so that unique roles and areas of comparative advantage can collectively address a comprehensive HIV response. Collaboration happens through TWG and at

national review meetings, to inform the development of national annual work plans that incorporate the investments of multiple stakeholders.

The GoZ and all stakeholders work from the same guiding document, the Zimbabwe National AIDS Strategic Plan (2011-2015) which is in its second iteration and the National Health Strategy (2010-2013). Priority areas have been established that focus on high impact interventions. National benchmarks and ambitious targets are incorporated into the PEPFAR COP and Strategic plans and drive the process.

Road Map for Saving Lives - PEPFAR efforts are focused on taking evidence based interventions to scale as prioritized in the ZNASPII and PEPFAR Blueprint. Results for improving access to HTC are incorporated in the PEPFAR prevention activities. PITC is routinely offered in 92% of facilities offering ANC and delivery services, with continuing priority given to scaling-up EID. USG support will continue to procure 98% of the condoms distributed through both public and private sector outlets, complementing DFID investment, who procure all FP commodities. The USG programs will further complement activities funded by DFID and Sida, to strengthen the integration FP within an MNCH and OI/ART setting.

A major focus in COP13 is to scale-up a national VMMC program. While numbers of clients is increasing, challenges remain on overstretched HR and limited funding for demand creation. In COP13, the Gates Foundation will be withdrawing their substantial support with an exit from service delivery. PEPFAR alongside DFID will fill some of these gaps, but it is likely that shortfalls will remain for rapid expansion.

PEPFAR continues to play a critical role in helping GoZ maintain universal access to treatment. In COP13, PEPFAR will directly support ART for 160,000 Zimbabweans and the national supply chain and logistics which supports the treatment program in-country. In Zimbabwe, it is generally recognized that there are complex interrelationships amongst prevention interventions that make each core intervention important in helping each country progress toward achieving an AIDS-free generation. Zimbabwe's declining adult HIV incidence rate and high ART coverage indicates that the country is progressing toward achieving this. However, more work is needed to reach treatment saturation in order to expand ART to individuals below 500 cells/mm3 and expand treatment as prevention. It is anticipated that a policy shift—along with the continued scale-up of PMTCT, VMMC, and other prevention interventions—would avert a significant number of new infections.

Road Map for Smart Investment - Sex workers (SWs) in Zimbabwe are disproportionately affected by HIV and current estimates for HIV prevalence among SW range between 40-60 %. Data on the population size and HIV prevalence among MSM are limited or not available. Current rates of SW and MSM enrolment in HIV treatment and retention in care do not reflect their heightened levels of risk. Through existing program and with additional resources from the KPCF, PEPFAR plans to enhance health

services among SWs and their clients by providing an integrated package of SRH, HIV prevention and treatment for SWs, their families, and clients. The program has the following components: on-site provision of STI treatment; cervical cancer screening; SRH services including FP, as well as ART for eligible HIV positive SWs; peer adherence support; and, a repeat HTC program for women who test HIV negative or initially decline testing. Finally a greater understanding of the needs of SW and MSM will be solicited through an assessment.

Road Map for Shared Responsibility - PEPFAR plays an integral role in strengthening the ability of the GoZ, private sector, and civil society to design, manage, and monitor HIV programs at all levels. The USG is involved in strengthening the management and governance of the GoZ, civil society and NGOs through its financial support and participation in the Country Coordinating Mechanism (CCM), and MOHCW-led TWGs. PEPFAR representatives in the CCM assist with and facilitate greater government and civil society responsibility for decision making, resource allocation and prioritization, and management of conflicting interests within the MOHCW.

In order to acknowledge the role that PEPFAR plays in the overall national HIV response, the PEPFAR team has been particular about sharing achievements and work plans through a number of channels; including: monthly one-on-one meetings with the Permanent Secretary of MOHCW; ad-hoc USG organized stakeholder meetings; participation in the bi-annual MOHCW review and planning meetings; quarterly USG partner meetings; and information sharing at the donor coordination meetings. These provide an opportunity to clearly outline the role of the PEPFAR programs in working with the MOHCW to achieve an AIDS-free generation and increase complementarity of support and leverage resources, thus reducing duplicative efforts.

PEPFAR supports the strengthening of private sector health services to efficiently provide quality care to PLWH. The private sector continues to expand to workplace (i.e. commercial farms, mines, etc.) health programs through the provision of such support as direct PSS counseling and information on positive living to HIV positive employees. The teams will CB workplace peer educators to provide ongoing support, establish support groups for PLWH, and sensitize employers and employees on the importance of post-test support services for their HIV positive colleagues. The program will also include counseling on GBV.

Driving Results with Science - Recognizing the need for a country driven research agenda, the PEPFAR team participated in an NAC led initiative to finalize and launch the Zimbabwe HIV and AIDS Research Agenda. PEPFAR continues to support NAC to implement small grants for research by providing technical support for review of research proposals and the implementation of small studies.

MEPI will improve undergraduate, postgraduate, and faculty training in clinical management and research capacity. Partnerships with international universities will provide training to new health care workers and improve the capacity of health institutions to deliver care. The GCF focuses on enhancing local capacity to utilize and generate data to inform gender-related programming.

Other areas of research relevant to the PEPFAR program are the PMTCT impact evaluation which will follow a cohort of mother/baby pairs to establish transmission rates from mother to child at the intermittent points.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	100,000	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	15	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	200,000	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	58,000	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	60,000	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults and children	74,000	2011	AIDS Info, UNAIDS, 2013			
Estimated number of pregnant women in the last 12 months	374,000	2010	UNICEF State of the World's Children 2012. Used "Annual number of births as a proxy for number of pregnant women.			
Estimated number of pregnant women	66,000	2011	WHO			

living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS	1,200,000	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	1,000,000	2011	AIDS Info, UNAIDS, 2013			
The estimated number of adults and children with advanced HIV infection (in need of ART)	619,496	2011	WHO			
Women 15+ living with HIV	600,000	2011	AIDS Info, UNAIDS, 2013			

Partnership Framework (PF)/Strategy - Goals and Objectives

Number	Goal / Objective Description	Associated Indicator Numbers	Associated Indicator Labels
1	Zimbabwe is not a Partnership Framework Country. A revised Five-Year Strategy will be submitted April 2013. Goal 1: Support the MOHCW to reduce estimated annual number of new infections from 63,144 in 2009 to 44,287 by 2015.		
1.1	1. Increase the impact of behavior change communication interventions using evidence based strategies within the generalized population and among targeted higher risk populations	P5.1.D	P5.1.D Number of males circumcised as part of the minimum package of MC for HIV prevention services
		P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV)

			reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions
		P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required
		P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required
1.2	2. Increase availability and utilization of male and female condoms	P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions
1.3	3. Increase % of HIV-positive Zimbabweans who have been tested, received their results and know their HIV status	P11.1.D	P11.1.D Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results
1.4	4. Expand access to and acceptance of comprehensive voluntary medical male circumcision (VMMC) services	P5.1.D	P5.1.D Number of males circumcised as part of the minimum package of MC for HIV prevention services
1.5	5. Improve coverage, integration, and efficacy of PMTCT services in support of the national vertical elimination	P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to

	agenda		reduce risk of mother-to-child-transmission during pregnancy and delivery
		P1.2.N	P1.2.N Percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery

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

How is the USG providing support for Global Fund grant proposal development?

The Global Fund recently announced that Zimbabwe is one of the three early applicant countries for the New Funding model. The PEPFAR/Zimbabwe team played a critical role in advocating for this decision and will continue to be a critical partner to the development of the concept note that will be submitted by the CCM.

The Zimbabwe Global Fund CCM is currently developing a roadmap for the concept note development with PEFPAR support, using resources from the Country Collaboration Initiative (CCI). The roadmap will include a detailed budget for technical assistance and other administrative costs. Once finalized, it will be presented to the donor community to request their buy-in and to identify the activities donors are willing to support.

To date, preliminary discussions with other key stakeholders, specifically UN agencies, have been held and it was agreed that PEPFAR will channel its financial support for proposal development through the UN agencies. With PEPFAR funding and technical assistance, WHO is expected to conduct green light reviews for the three diseases gap analysis while UNAIDS will develop an HIV investment case. Additionally, PEPFAR, as a member of multiple MOHCW-led technical working groups, will provide technical assistance and critical information, data, and statistics as required for proposal development. The PEPFAR Coordinator and the SI team will provide key financial and program data to inform the gap analysis and projections as required by the proposal template. The Global Fund liaison will provide overall coordination between PEFPAR and the proposal development team and other Global Fund stakeholders. PEPFAR supported implementing partners will also provide technical support to the propose for example JSI/SCMS will provide technical insights in forecasting, quantification and development of a procurement and supply management plan for all pharmaceuticals, ZINQAP will also provide technical knowledge on laboratory needs and requirements.

Are any existing HIV grants approaching the end of their agreement (Phase 1, Phase 2, NSA, CoS, or RCC) in the coming 12 months?
Yes

If yes, please indicate which round and how this may impact USG programming. Please also describe any actions the USG, with country counterparts, is taking to inform renewal programming or to enable continuation of successful programming financed through this grant(s).
The HIV Round 8 Grant ends on 31 December 2014; however, due to critical shortages in ARV supplies created by the countries adoption of the new WHO treatment guidelines and rapid scale-up for universal treatment access, funding for ARVs will be depleted by 31 December 2013. The Global Fund, at the request of the CCM, moved money from the 2014 ARV budget line to cover gaps in 2012 and 2013. To close the gap created by moving money from 2014 to 2012 and 2013, the HIV concept note for the new funding model will prioritise ARVs as well as the development of an electronic patient tracking system for the ART program.

The CCM is exploring two other options: (1) use some of the cost savings within the Round 8 grant or (2) to access the Global Fund Continuity of Service (CoS) vehicle which will provide two years funding while the country secures new resources. If Zimbabwe is unable to secure resources for ARVs, PEPFAR activities will be detrimentally affected since all drugs in Zimbabwe are pooled together and drug stock outs will be experienced nationwide. The PEPFAR team in Zimbabwe has communicated with OGAC to explore accessing the Emergency Commodity Fund as a last resort if the two options explored by the CCM are not successful.

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To date, have you identified any areas of substantial duplication or disparity between PEPFAR and Global Fund financed programs? Have you been able to achieve other efficiencies by increasing coordination between stakeholders?
Yes

If yes, how have these areas been addressed? If not, what are the barriers that you face?
Redacted

Public-Private Partnership(s)

(No data provided.)

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
Surveillance	ANC Survey and Assessment of the Utility of PMTCT Data for Sentinel Surveillance, 2012	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Implementation	03/01/2014
Survey	ART Costing Study	Other	General Population	Implementation	09/01/2014
Survey	Behavioral Survey on current sexual reproductive health knowledge, attitudes, beliefs and practice among youth	Population-based Behavioral Surveys	Youth	Other	09/01/2014
Survey	Cost effectiveness of PMTCT strategies	Evaluation of ANC and PMTCT transition	Pregnant Women	Other	09/01/2014
Survey	Costs of comprehensive HIV treatment at out-patient clinics in Zimbabwe	Evaluation	General Population	Implementation	09/01/2013
Surveillance	Estimation of HIV Incidence in Zimbabwe	Recent HIV Infections	General Population	Implementation	09/01/2014
Surveillance	Estimation of HIV incidence in Zimbabwe using multiple methods	Recent HIV Infections	Other	Other	06/01/2013
Survey	Evaluation of the Male Circumcision Program	Evaluation	Other	Planning	09/01/2014
Survey	Evaluation of using POC CD4 machines on identification/treatment of	Evaluation	Pregnant Women	Other	03/01/2013

	HIV+ women				
Survey	Evaluation of Viral Load Trends in Zimbabwe	Evaluation	General Population	Implementation	09/01/2014
Survey	Factors associated with non-utilization of ANC services by unbooked women in Chitungwiza	Evaluation	Pregnant Women	Other	09/01/2012
Survey	Gender Challenge Studies	Other	General Population	Implementation	09/01/2013
Surveillance	HIV drug resistance early warning indicators monitoring	HIV Drug Resistance	General Population	Implementation	09/01/2014
Surveillance	HIV drug resistance prevention and associated factors in sentinel anti-retroviral treatment sites in Zimbabwe, 2010 - 2015	HIV Drug Resistance	General Population	Implementation	09/01/2015
Surveillance	HIV Drug Resistance Surveillance	HIV Drug Resistance	General Population	Other	09/01/2015
Surveillance	HIVDR Monitoring at 12 sentinel sites	HIV Drug Resistance	Other	Other	04/01/2013
Surveillance	HVDR Cross-Sectional Survey, 2014	HIV Drug Resistance	General Population	Implementation	09/01/2014
Survey	Key Population Size Estimates and Bio-Behavioral Surveys	Behavioral Surveillance among MARPS	Other	Planning	09/01/2015
Survey	MDR TB Survey	TB/HIV Co-Surveillance	General Population	Other	09/01/2015
Surveillance	Multi-drug Resistant TB Surveillance	Sentinel Surveillance (e.g. ANC Surveys)	General Population	Development	09/01/2015
Survey	PMTCT Costing Study	Other	Pregnant Women	Planning	09/01/2014

Survey	PMTCT Impact Evaluation	Evaluation of ANC and PMTCT transition	General Population	Other	12/01/2014
Survey	PMTCT Program evaluation	Evaluation	Pregnant Women	Other	09/01/2012
Survey	Population-based survey on concurrent sexual relationships	Population-based Behavioral Surveys	General Population	Other	09/01/2008
Survey	Qualitative study on perceptions and barriers to male circumcision	Qualitative Research	Mobile Populations, Youth	Other	03/01/2013
Survey	Qualitative study to improve communications on male circumcision	Qualitative Research	Youth	Other	03/01/2013
Survey	Reproductive health needs and behaviors of HIV + women on HART in Buhera	Evaluation	Pregnant Women	Other	09/01/2013
Survey	Sexually Transmitted Disease Surveillance	Population-based Behavioral Surveys	General Population	Implementation	09/01/2015
Survey	Survey of effectiveness of PMTCT Program	Evaluation	Other	Implementation	09/01/2014
Survey	Survey to profile status of OVC using the Child Status Index to measure access to services and assessing impact of interventions	Evaluation	Youth	Other	12/01/2012
Survey	TB Program evaluation in Matebeleland North	Evaluation	General Population	Planning	09/01/2014
Survey	Treatment as Prevention Evaluation Study	Evaluation	General Population	Planning	09/01/2014
Survey	User fees study	Evaluation	General	Development	09/01/2014

			Population		
Survey	Zimbabwe Demography and Health Survey	Population-based Behavioral Surveys	General Population	Data Review	09/01/2013

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source			Total
	GAP	GHP-State	GHP-USAID	
HHS/CDC	6,645,000	19,503,000		**26,148,000**
HHS/HRSA		250,000		**250,000**
State		57,000		**57,000**
State/AF		245,000		**245,000**
USAID		51,800,000	16,500,000	**68,300,000**
Total	**6,645,000**	**71,855,000**	**16,500,000**	**95,000,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency						Total
	State	HHS/CDC	HHS/HRSA	State/AF	USAID	AllOther	
CIRC		5,450,000			14,730,445		**20,180,445**
HBHC				19,000	425,939		**444,939**
HKID	10,344			61,000	7,483,580		**7,554,924**
HLAB		2,677,517			700,000		**3,377,517**
HMBL		500,000					**500,000**
HMIN		100,000					**100,000**
HTXD					19,689,348		**19,689,348**
HTXS		6,308,382	250,000		3,884,022		**10,442,404**
HVAB	20,056			90,000	250,500		**360,556**
HVCT		360,000			2,365,900		**2,725,900**
HVMS	11,400	3,335,799			1,984,659		**5,331,858**
HVOP	9,711	47,127		37,000	1,582,352		**1,676,190**
HVSI		2,826,281			489,039		**3,315,320**
HVTB		825,377			1,739,319		**2,564,696**
MTCT		1,754,000			5,172,298		**6,926,298**
OHSS	5,489	1,956,267		38,000	5,300,000		**7,299,756**

PDCS					601,732		**601,732**
PDTX		7,250			1,900,867		**1,908,117**
	57,000	**26,148,000**	**250,000**	**245,000**	**68,300,000**	**0**	**95,000,000**

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

Policy Area: Counseling and Testing						
Policy: TBD						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	TBD	TBD	TBD	TBD	TBD	TBD
Narrative						
Completion Date						
Narrative						

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	444,939	0
HKID	7,554,924	0
HVTB	2,564,696	0
PDCS	601,732	0
Total Technical Area Planned Funding:	**11,166,291**	**0**

Summary:
CARE Technical Area Narrative

Overall Programmatic Strategy:

The care technical area encompasses a wide spectrum of interventions targeting HIV infected and affected adults and children. These activities are supported both through public and private sectors, complementing the work of not only the Ministry of Health and Child Welfare (MOHCW) but also the National AIDS Council (NAC) and other government ministries. The PEPFAR Care portfolio addresses a number of key gaps in the national HIV/AIDS response through integrating with national plans as well as contributions by other donors. Priorities for FY12 include: continued support for a high-quality comprehensive package of care services for positive adults including a strong component of sexual prevention; introducing treatment as prevention; quality improvement programs to be integrated into many ART clinics to continually improve retention, adherence, and response to ART; expanding access to early infant diagnosis and entry into care for HIV-exposed infants; expanding integrated HIV/AIDS services in urban clinics; improving infection control and prevention activities; integrating TB screening with mobile HIV testing services; and building the capacity of social welfare systems to enhance OVC care and support.

PEPFAR-supported care activities realized significant accomplishments in FY 11. For example, the New Life NGO-operated network reached 151,906 new HIV positive clients with services. In addition, about 200,000 continuing HIV-positive individuals received care and support services through the same network. Nearly 46,000 new positive clients received ART adherence counseling and 106, 095 new positive clients received psycho-social support and nutrition services.

In the same realm, 258974 HIV-positive adults and children received a minimum of one clinical service in FY11. The major clinical services offered included Cotrimoxazole prophylaxis, TB screening within New Life and New Start Centers as well laboratory monitoring (CD4 testing).

Overall, about 567265 eligible adults and children were provided with a minimum of one care service in FY 11. With increased HIV counseling and testing services as well as the subsequent increase in the number of people on ART, the demand for HIV care services continue to increase in the country, coupled with an increase in the number posttest support centers and support groups. As highlighted above, this includes all HIV positive T&C and PTSS

clients who received TB screening and referral into care, HIV positive clients reached with care services (psycho-social counseling, ART adherence counseling, nutritional counseling, PMTCT counseling).It also includes OVC, HBC, clients receiving Cotrimoxazole prophylaxis as well as clients who received CD4 tests. The majority of the counted individuals are HIV positive clients, with the exception of the OVC clients. The USG program is supporting one OVC program which reached 126, 374 children with health, nutrition, education, protection and psychosocial support services.

PEPFAR-supported care interventions are designed to work within the framework of national strategies and plans and to expand access to services while strengthening the national capacity for program management and leadership. Through infection prevention and control activities, PEPFAR is supporting the development of national guidelines and training on infection control. Early infant diagnosis (EID) activities are supported as a key component of a national strategic plan to eliminate new pediatric infections and are coordinated through a national sub-committee to the PMTCT Partnership Forum. These activities are discussed in more detail in the PMTCT Acceleration Plan. TB/HIV collaborative activities are coordinated through the National TB Program (NTP), which generally convenes around the TB sub-committee to the CCM.

The country team has begun to look at laboratory sample transport and result notification as one area to develop more efficient approaches to health care service delivery. Access to essential diagnostic and monitoring laboratory services, particularly in the areas of EID and TB care, has been a critical challenge. Laboratory services in Zimbabwe are still quite weak in large part due to a severe shortage of laboratory scientists. As such, the national strategic approach has been to strengthen provincial laboratories and strengthen transport networks to strengthen linkages between provincial, district, and lower level facilities. In the past year the country team has been exploring mechanisms to link rural and district health facilities as well as urban satellite clinics to provincial or national laboratories. The PEPFAR team is now working to explore options for integrating sample transport systems for TB and early infant diagnosis to create more fluid and integrated laboratory referral systems.

Zimbabwe's National Anti-Retroviral Therapy (ART) Program was designed to provide comprehensive care and treatment services that address the medical, social and emotional needs of adults and children living with HIV/AIDS. Zimbabwe's palliative care package, as defined by MOHCW, includes psychosocial support, nutritional counseling and support, treatment for opportunistic infections (OI), co-trimoxazole prophylaxis, bereavement and spiritual counseling and hospice care. Over the past several years, access to and quality of both non-clinical and clinical palliative care services have improved. Non-clinical community-based care and support is provided through home based care, support groups, faith-based networks, NGOs, and numerous other organizations throughout the country, under the guidance of the National AIDS Council (NAC) and the Ministry of Labour and Social Services.

Throughout its care initiatives, PEPFAR/Zimbabwe seeks to maximize collaboration with other development partners. USG-funded New Life centers, providing care services to people living with HIV/AIDS, partner with MOHCW facilities in order to provide high-quality care services. USG also seeks to leverage funding from other donors. For instance, New Life receives additional support from the UK Department for International Development (DFID). USG is also partnered with the World Food Program to provide nutritional support to vulnerable children, particularly those on ART. PEPFAR support for HIV/TB activities is complementary to significant non-PEPFAR USG Child Health and Survival funding to the NTP, which has increased in FY12. PEPFAR/Zimbabwe has been successful in maximizing efficiencies throughout its care provision programs in other ways as well. The care program is part of the continuum of response, providing not only necessary services to people living with HIV/AIDS, but ensuring linkages to clinical services. Individuals enrolled in care should be monitored to the extent that they are prepared for PMTCT or ART initiation at the appropriate time, leading to a more efficient and timely transition to treatment. USG also supports a variety of integration programs (TB/HIV, PMTCT/MOH) which seek to more efficiently utilize existing space and human resources for complementary purposes. In the same way, PEPFAR supports VCT partnerships with institutions like the Gweru city council providing care in existing facilities. USG supports programs that harness existing human resources for health, such as for OVCs, improving the quality of care and maximizing service delivery.

Throughout its care services, PEPFAR/Zimbabwe is devoted to building the capacity of health workforce through the recruitment, training, mentoring, supervision, and retention of health care workers and social workers as well as the provision of basic care service projects, like HBC kits. In order to assure the sustainability of capacity-building efforts, USG assists partners in developing job aids, manuals, and strategies for care. Our care programs support training (including refresher courses) and on-site support supervision and mentoring for the following cadres OVC caregivers, HBC caregivers, PLWHA support group members, PMTCT Village Health Workers, counselors as well as peer educators.

PEPFAR/Zimbabwe maintains high-quality programs through a strong M&E component. All care programs have data collection and reporting systems in place and undergo data quality assessments and data verifications. Program data is used for targeting, resource allocation, program prioritization, and the integration of services. In addition, all training of health care workers, including community and social workers includes the improvement of documentation and reporting. The NAC also collects care-related information and uses it for national and international reporting and to improve programs. At the country-level, all institutions and organizations that provide care services report to NAC or through the national system on all care activities. The major M&E challenge is double counting due to service double dipping among clients.

USG TB CARE support has enabled M&E aspects of program management to be incorporated into the overall TB management training curriculum and some improvements in the quality of reported data have been seen. There has been a corresponding increase in facility level analysis and use of locally generated TB data. Data collection tools have been reviewed and updated and have been distributed to all facilities in the country. One TB M&E Medical Officer has been seconded to the NTP to strengthen the overall system for data management.

The existence of parallel HIV data collection systems (NAC and MOHCW) remains a challenge. The MOHCW hosts data from ART clinics and data from pharmacies. The two data sets do not always match within facilities. The USG team is strengthening the national health information to integrate all health information including HIV care data. The starting point has been the weekly notification system, which excludes HIV care data. The next stage will be the monthly notification system which includes HIV and TB data. Each program (e.g. TB, ART. Malaria) strives to collect their own information for programming purposes and this information does not always tally with the national HIS or with NAC data for the same district or province. The strengthening of the HIS as a source of accurate, timely information will result in all programs using the HIS as their trusted source of programming information.

Adult Care and Support

The National ART Program, currently implemented in 520 national, provincial, district, and rural health centers, provides a full clinical package including preventive care services such as co-trimoxazole prophylaxis to all HIV infected TB patients and all HIV positive patients with CD4 counts less than 350 or in disease stages 2-4. Public-sector facilities, traditionally, have not been strong in providing a comprehensive package of adherence counseling, prevention for HIV positive clients, or psychosocial support. The PEPFAR-supported network of New Life Centers has helped fill the gap, providing positive clients with care services at 14 locations throughout Zimbabwe. The New Life care package encompasses both support and prevention services. These New Life services to positives include counseling, communication materials and products related to positive-prevention and safer sexual practices. The package includes information designed to increase awareness of family planning, dual protection options, partner disclosure and coping mechanisms for couple discordance. To ensure continuum of care for HIV positive clients, PEPFAR supports the integration of additional laboratory services for TB screening (smear microscopy) and CD4 cell count point of care services at care and support facilities. These additional laboratory services enhance the entry into HIV related care for HIV positive clients. A strong referral and referral follow up system has been put in place to ensure that all HIV positive clients get immediate access to care, treatment and HIV prevention services. The high quality of services offered in these private-sector settings are also offered in public facilities (ART clinics) through partnerships between the New Life Centers and high volume MOHCW ART service delivery sites.

Persons counted as receiving HIV clinical care include: HIV positive testing and counseling and post test support service clients who received TB screening and referral into care, HIV positive clients reached with care services (psycho-social counseling, ART adherence counseling, nutritional counseling, PMTCT counseling), OVC and HBC clients receiving co-trimoxazole prophylaxis and clients who received CD4 tests. In order to ensure that pre-ART patients are retained in care services, the MOHCW is continuously increasing the number of people enrolled in ART prior to actual ART initiation. New Life center staff are specifically trained to care for and follow up pre-ART clients. As the majority of ART clients nationally are women, vital gender issues are being addressed: New Life training and support services, provided to any HIV positive individual, include screening and referral for gender-based violence, education on sexual risk reduction strategies and related gender issues, as well as counseling and the voluntary provision of family planning.

PEPFAR care programs specifically target sex workers, truckers, people living with disabilities, migrant and displaced populations, mining communities, uniformed forces, and individuals frequenting liquor outlets. Improved collaboration with sex worker groups and other organizations working at grass roots level largely contributed to increased reach.

Pediatric care

PEPFAR support to pediatric care is largely provided through the PMTCT program. The scale-up of pediatric care services has, to some degree, lagged behind the progress of the national ART program and the decentralization of pediatric care and treatment services has been limited. One significant challenge is a lack of confidence among trained health care workers to provide care services to young children. The national program has resolved that there is need for more intensive mentorship for health care workers in pediatric ART initiation and care services for children under five and particularly for those under two years of age. In 2012, the USG will continue to support the roll out of the MOHCW's mentorship program. To date the training modules have been developed, and with input from PEPFAR/Zimbabwe, modified to include more practical sessions, exposing the trainees to situations they are likely to encounter in the field. Support for these activities is envisioned to continue in FY12. The government is implementing the integration of FP/PMTCT into the broader MNCH program. For additional information on the PMTCT program, please see Zimbabwe's 2012 PMTCT Acceleration Plan.

PEPFAR/Zimbabwe also supports a cohort of 65,000 orphans and vulnerable children with a comprehensive continuum of three or more services including: social protection, health, education, psychosocial support and ad hoc emergency programs (e.g., the recent cholera or current typhoid outbreaks). The follow on OVC program will include a component on household economic strengthening as well as support to the Ministry of Labour and Social Services Department of Social Services (DSS) to provide guidance to OVC programs in the country.
As discussed in the PMTCT Acceleration Plan, access to early infant diagnosis EID has lagged behind access to other PMTCT continuum services. In 2008, with CHAI support, the Pediatric Sub-Committee for Care piloted EID in three central hospitals around the country. In FY09 USG funding supported the scale-up of EID. A total of 862 infants below 12 months tested as of June 2009 using Polymerase Chain Reaction (PCR) testing. With continued USG support, the EID program rapidly expanded and by the end of December 2009, about 60 sites were collecting dried blood spot (DBS) samples and close to 4500 samples had been processed by the National Microbiology Reference Laboratory (NMRL). By the end of December 2010, there were 360 sites collecting DBS and over 16,500 samples were processed by the NMRL. Between January and April 2011, a total of 11,682 samples have been processed in the NMRL with a positivity rate of about 10%. Though the number of samples being collected and tested has risen, only about one third of expected HIV exposed infants in the country are currently being tested. Currently, Zimbabwe's only laboratory capable of EID is in Harare. In FY12, PEPFAR will support the establishment of an additional laboratory in order to decentralize and increase access to testing. This year, the program will also seek to strengthen the PEPFAR funded sample transport and notification systems.

According to national guidelines, all HIV-exposed infants over the age of six weeks are prescribed co-trimoxazole. The number of infants receiving co-trimoxazole within the USG supported program is also steadily increasing.

During the 2009/2010 fiscal year, 11,369 infants were initiated on co-trimoxazole prophylaxis (47% of 24,176 who got ARVs for PMTCT prophylaxis). As of September2011, 23,138 infants were commenced on this prophylaxis. This represents 69% of all infants (24,065) that received ARV prophylaxis in the same period within the program. While improvements are being made, challenges still remain with infants lost to follow up. Strengthened linkages between the facilities and the communities are being developed which may help to reduce the loss to follow up rates (see below).

The adoption of the 2010 World Health Organization (WHO) PMTCT guidelines has necessitated greater emphasis on issues to do with infant nutrition. The Zimbabwe MOHCW has since adopted the guidelines, which advocate for the provision of ARV prophylaxis to the mother throughout the breastfeeding period. The USG has been one of the leading partners in capacitating health care workers to deal with this new guidance. Through the PMTCT program, the USG has facilitated training for 242 health care workers on counseling pregnant, postnatal and lactating women on infant and young child feeding. Training on this module will continue and will be delivered alongside the integrated PMTCT training course.

Through additional funding from the Children's Investment Fund Foundation, the national PMTCT/pediatric care program is expanding a USG-supported model of care that was previously only implemented in select districts. The additional funding has also enabled the employment of 30 district focal persons (DFPs) who have been deployed nation-wide. Among many other duties, the DFPs will provide direct ongoing technical assistance to all facilities. These DFPs will also be instrumental in strengthening the linkages between health facilities and their surrounding communities, ensuring, for instance, that mothers access necessary services. In addition, 108 community mobilizers and nurse aides as well as 91 community leaders have received PMTCT training and are expected to provide the crucial link between the facility and the community, educating and encouraging mothers (particularly those who are HIV positive) to return to facilities for further care. Through multiple facility-community linkages, the program expects to minimize loss to follow up among mothers and infants in need of services along the HIV continuum of care.

TB/HIV: Integration of care

Zimbabwe is one of the 22 tuberculosis (TB) high burden countries which account for 81% of all estimated cases worldwide (WHO, 2010). The TB caseload in Zimbabwe has increased drastically since the 1990's, primarily due to the HIV epidemic. Tuberculosis is the most common cause of death in Zimbabwe, particularly in age groups with high HIV prevalence (15-49 years). In 2009, there were an estimated 93,000 incident TB cases in Zimbabwe (equivalent to 742 cases per 100,000 people) (WHO, 2010). An estimated 80% of these TB cases are HIV co-infections. The last TB Drug Resistance Survey (DRS) which was conducted in 1994-1995 indicated a prevalence of < 3% and 9% of multi-drug resistant (MDR) mycobacterial strains among new and retreatment TB cases, respectively. In response to the dual epidemic of TB/HIV, the MOHCW promotes routine screening for TB among PLHIV. PEPFAR will continue to support the MOHCW to increase access to TB diagnostic and treatment services for PLHIV.

The National TB Control Program (NTP) is housed within the MOHCW AIDS &TB unit. The NTP plans and directs the general course of action for TB prevention and control in Zimbabwe and provides overall leadership and oversight of related activities. All relevant donors contribute to these overall plans. Consequently, all USG activities are implemented by and through the existing MOHCW infrastructure through existing staff and facilities. Individual donors are discouraged from setting up parallel service delivery systems. Donor coordination is thus a responsibility of the NTP, but is not well executed due to competing priorities within the program. Instead, collaboration issues are handled through the HIV/AIDS and TB Partnership Forum .

PEPFAR/Zimbabwe supported the development and dissemination of the National TB/HIV Guidelines and the training of health service providers in TB/HIV case management in 2011. PEPFAR team members also participate in the MOHCW's HIV and TB Partnership Forum. A recent national program evaluation found that joint TB/HIV

planning and service provision is occurring at facility level and that surveillance for HIV among TB patients is being routinely implemented. A recent assessment indicated that HIV treatment information in the TB patient registers are not complete, resulting in an underreporting of TB patients on ART. Thus, the true proportion of TB/HIV co-infected patients receiving co-trimoxazole prophylaxis and ART is not known. However, in the five provinces that are being supported by the USG, there are ongoing trainings, site support supervision, mentoring and data verifications as part of improving data quality.

In FY12, PEPFAR will continue to support the MOHCW in integrating TB/HIV activities and services. For example, PEPFAR funds will be used to continue FY11 activities to scale up a successful TB/HIV integration model that was piloted in Harare and Bulawayo (funded by the EU). According to the integration model, facility nurses are trained to offer the following package of services: counseling and testing for HIV, screening for TB, TB treatment initiation and follow up, ART initiation and follow up. The nurses are also trained on proper documentation and reporting of activities. This activity is expected to cover 10-15 facilities with FY11 funds and an additional 10-15 with FY 12 funds. These facilities will be predominantly in urban areas with high population densities and consequently high HIV/TB disease burdens. With the anticipated improvements in the ability of health care workers to diagnose TB, it is estimated that there will be between 50 and 60 such facilities nationwide at the end of 2012. The MOHCW is making efforts to integrate TB/HIV services including data collection processes. The MOHCW together with partners is in the process of developing a TB/HIV strategy including the monitoring and evaluation piece.

The MOH is deliberately prioritizing TB patients and pregnant women for ART initiation. In New Start centers, the PEPFAR supported program is offering TB screening services for all TB suspects. Once confirmed, via referral or on-site sputum testing, the TB patients receive CD4 count services and are referred to ART initiation sites (regardless of CD4 count).

The expected outcomes from the TB/HIV integration program include:

-Enhanced human resource capacity for TB/HIV care at primary health care level;
-A high degree of clinical suspicion of TB in all patients visiting health care centers, among clinic health workers;
-TB/HIV care decentralization to primary care clinics, including initiation of TB treatment and ART;
-Reduced barriers for HIV testing of TB suspects and reduced barriers for TB screening of HIV infected patients;
-Strengthening of directly observed TB treatment (DOT) at clinics;
-Improved rapport between TB/HIV patients and health workers;
-Facility level TB and HIV data analysis and use for planning.

TB/HIV: Laboratory support
PEPFAR supports the MOHCW diagnostic medical services laboratory network (52 district, 8 provincial, 5 central and 3 national reference laboratories including the National Microbiology Reference Laboratory (NMRL) and the National Tuberculosis Reference Laboratory (NTBRL)). The two national laboratories, the NTBRL (Southern region) and NMRL (Northern region) offer TB smear and culture, liquid culture using MGIT and drug sensitivity testing. TB microscopy is available in every MOHCW laboratory in the country and where health facilities do not have laboratories, there are TB microscopy centres (134 TB microscopy centres are functional and 11 nearly functional). Ordinary MOHCW public health labs offer baseline tests for HIV related infections including full blood count, liver function test, glucose and urea & electrolytes.

PEPFAR has assisted the NTBRL to achieve Bio-safety Level 3 capacity for TB diagnosis. In FY12, PEPFAR will continue to provide significant assistance to NTBRL and NMRL and the national laboratory system with the main objective of increasing access to TB diagnostic testing, including testing for drug-resistant TB.

In three cities (Harare, Bulawayo and Chitungwiza), courier systems have been set up by TB CARE in partnership with a locally based non-governmental organization to move sputum samples from all the municipal clinics collection points to the designated laboratories for processing and transporting the results from the laboratories back to the clinics. This has shortened the turnaround time between sample collection and receiving of results from 4 weeks or more to 5-7 days. Research is planned to determine whether or not the time savings has translated to earlier identification and initiation of TB treatment among clients. In FY12, TB CARE hopes to support the NTP with the purchase of one Expert MTB/RIF machine for operational assessment of new sputum microscopy and gene expert technology in diagnosis of pulmonary tuberculosis. This will primarily assess the feasibility of integrating this new technology with routine service provision.

TB/HIV Intensified Case Finding

With support from PEPFAR, more than 300,000 Zimbabweans each month continue to receive HIV tests in the MOHCW approved New Start testing and counseling centers. These tests are offered through a national network of 19 New Start static sites and 23 New Start outreach teams. The New Start centers already offer TB screening checklist to clients (particularly those who test HIV positive) and, in some facilities, sputum microscopy for TB suspects.

PEPFAR FY12 funds will continue to support the TB smear sputum microscopy laboratory facilities at five New Start testing and counseling 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 tuberculosis symptoms. All clients with productive cough, identified as TB suspects, will submit sputum for smear microscopy. All clients with Acid Fast Bacilli (AFB) positive sputum results will be referred for anti-TB treatment to be commenced immediately at TB treatment centers. All other 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. PEPFAR/Zimbabwe will also continue to support the development and implementation of multimedia communication campaigns to increase awareness of the availability of TB diagnostic services to those who test HIV+ at the New Start centers. The campaigns will utilize mass media (TV, radio, print) and community-based interpersonal communication activities to position New Start as the gateway to accessing care, support and treatment services, including TB diagnosis.

The USG has provided technical and financial support to the National Tuberculosis Control Program (NTP) for training and upgrading of health care workers' skills has been provided from the USG through TB CARE since early 2009. Geographical coverage has expanded from one province in 2009 to five additional provinces (in 2012. The Global Fund is the main supporter of training activities in the remaining three provinces. USG assistance has enabled the secondment of a national TB trainer (medical officer) to the NTP to assist with the roll out of training to all provinces in the country. Over 1200 health care workers benefited from the training in the last year in USG supported sites. In general, TB case management, data collection and program indicators are beginning to show improvements. In the Midlands province, for instance, there's been a marked increase in the number of TB suspects and subsequently the number of TB cases actually diagnosed.
TB/HIV: Infection control

PEPFAR/Zimbabwe aims to strengthen the MOHCW capacity for implementation of infection control and prevention activities in health care facilities nation-wide to reduce TB and HIV infection among health care workers and patients. Through the infection control program, the USG aims to develop the capacity of HCW at various

levels to deliver sustainable training and support for the infection control program of the ministry beyond the project period. Two national-level cadres will be trained in infection control in the first quarter of FY12. Renovations will be carried out to improve environmental conditions for infection control such as maximization of natural ventilation in patient waiting areas and consulting rooms. Collaboration with other partners implementing TB/HIV activities is a vital component of the project in order to prevent exposure among patients and staff to blood and airborne diseases. The USG will further promote infection control through the incorporation of injection safety activities and the provision of p ersonal Protective Equipment (PPE). Finally, PEPFAR/Zimbabwe will support the development of recording and reporting tools to capture infection control data from within the system.

Through its infection prevention and control program, PEPFAR Zimbabwe is also supporting the MOHCW in drafting a National Infection Prevention and Control Manual. The manual will be finalized by the end of the 2nd quarter of 2012. USG is also supporting the incorporation of infection control and prevention curricula in pre-service and in-service training. The curricula should be available in September, 2012, and by 2016, 600 health care workers will have received training. Finally, between 2012 and 2016, PEPFAR will support twenty district hospitals per year in developing and implementing facility infection prevention and control plans.

TB/HIV: Isoniazid preventive therapy

The MOHCW is adopting the recently revised WHO guidelines on intensified case finding for TB (ICF) and infection control for TB. However, because it is still challenging to diagnose TB in Zimbabwe, the ministry has been reluctant to rapidly scale-up the use of isoniazid preventive therapy (IPT) among the general population living with HIV. The MOHCW is proposing to expand the provision of INH to all HIV-positive individuals with latent TB infection, including those > 5 years of age, to prevent progression to active disease. PEPFAR Zimbabwe is providing support to the MOHCW to improve infection prevention and control practices in health care facilities nationwide in order to reduce the transmission of infectious diseases, including TB, among patients and staff.

The policy for IPT in HIV-positive children under five exists but so far has been poorly implemented. TB CARE has plans to support the development of job aids for pediatric TB as well as the reporting and recording tools for IPT in children in FY 12. They will also help the NTP to conduct the national training of trainers for pediatric TB.

TB/HIV: Directly observed treatment (DOT) implementation

With intensified site support and supervision, the NTP is successfully shifting its focus from family-based DOT supervision to facility-based supervision, particularly for people living in urban areas. The use of the TB screening tool is gaining momentum as well. Facility-level DOT is being encouraged for all clients with ready access to health facilities. Community health workers are being mobilized to assist with DOT for those unable to come to the clinics. Sputum collection is being done at the facilities in designated areas outside the main buildings. USG support will continue to support the NTP in getting DOT implemented as per WHO strategies.

TB/HIV: MDR – TB

There has been some improvement in the management of Multi-Drug Resistant TB (MDR-TB) cases. NTP staff has been trained in the programmatic management of MDR-TB and the MDR-TB program was formally established in December 2010. Capacity to do culture and drug susceptibility testing (DST) has steadily improved.

TB drugs are procured from the government's national warehouse, National Pharmaceuticals (NatPharm). Stock outs have been reduced since the introduction of the PEPFAR-supported Zimbabwe Informed Push (ZIP) distribution system which handles TB and malaria drugs and commodities.

Other donors: The EU has supported essential drug procurement for TB drugs as well as the development of successful integrated health care models for the NTP (one of which the USG will support for scale up). W.H.O. continues to provide technical consultations for the National TB Program. The Global Fund is the single largest

financial supporter of the NTP and is expected to continue to support human capacity development through training and procurement of essential equipment and commodities.

Food and Nutrition

Infant and young child feeding is an integral component of the PMTCT program supported by PEPFAR and in FY10, 220 health care workers were trained. Whilst there have been some gains in increases of exclusive breast feeding rates at six months from 22% in 2005/2006 to 32% in 2010/2011, there is still much to be done. Using complementary funding from USAID Feed the Future and MCH funds, a number of assessments are planned in 2012 to both understand the barriers and facilitators to optimize IYCF practices and to identify good practices being implemented within the national programs. Based on this evidence, in FY12 new community based IYCF training and materials will be developed for roll out in the national programs. A critical focus will be on engaging village health workers to promote better nutrition for both pregnant mothers and infants and young children. In FY12, using both PEPFAR and USAID MCH funds, revitalization of the village health worker program will be supported that will integrate nutrition efforts as part of a broader MNCH package of care.. Efforts are being made to strengthen the linkages between nutrition units and HIV care and treatment sites, acknowledging that approximately 60-70% of infants and children with malnutrition are infected with the virus.

Orphans and Vulnerable Children (OVCs)

In 2010, Zimbabwe attained some success in the area of support to orphans and vulnerable children (OVCs) through the national plan of action (NAP) for OVC, which was a significant milestone in mitigating the impact of AIDS. This national initiative was supported through a multi donor initiative and impacted 400,000 children (25% of the total 1.6 million OVCs in Zimbabwe). Among OVCs supported, up to 30% were provided with educational assistance and about 80% received nutritional support. USG support contributed to this national success through the distribution of textbooks and assisting with monitoring and evaluation.

In FY11, the USG supported OVC initiatives provided a comprehensive package of support to a cohort of children. While over 120,000 children received one service, the indicator selected by the PEPFAR team is the number of children receiving at least three services. In FY11 over 65,000 children were reached with a package of support including education, health, protection, economic strengthening, nutritional and psychosocial services.

During the next two years, PEPFAR OVC interventions aim to have a measurable impact on the long-term welfare of Zimbabwe's OVCs by increasing the sustainability of OVC care and support services. This is in line with the Government of Zimbabwe (GoZ) priorities as articulated in the Second Phase of the National Action Plan for Orphans and other Vulnerable Children (NAP 2). The goal of NAP 2 is to ensure that, by December 2015, most vulnerable children in Zimbabwe are able to secure their basic rights through the provision of quality social protection and child protection services. The PEPFAR/Zimbabwe program will continue to support a cohort of vulnerable children under a new follow-on TBD mechanism.

The USG will also assist the GoZ to develop a Comprehensive strategic plan for workforce strengthening within the Department of Social Services. Illustrative activities include:

-Assisting the Department of Social Services (DSS) to coordinate and implement a strategic plan for social service workforce strengthening, including the development and implementation of provincial-level HR capacity development plans;
-Advocating for reinstatement of Social Worker Assistant (SWA);
-Strengthening monitoring and evaluation programming for vulnerable children, including collecting critical NAP data and developing and implementing a casework management system, including casework tools, a casework database, and a mobile phone case monitoring;
-Building the capacity of the District and Sub-District level Child Protection Committees.

The project will also build economic sustainability at the family level for both caregivers and children. The following are some of the proposed activities;

-Assessing the economic capacity of target households;
-Facilitating the development of savings and lending groups;
-Identifying market opportunities;
-Facilitating basic financial education and business training opportunities;
-Supporting households in initiating individual or group income generating activities;
-Facilitating the creation of Social Protection Funds to enable savings and loan groups or cooperatives to address the emergency needs of members.

A focus of the OVC program will be integration and coordination for increased impact, especially linking and integrating programs for children across the epidemic (i.e. adolescent prevention, PMTCT, treatment and care) so that there are seamless, integrated services for children, as recommended by the recent Global PEPFAR OVC Evaluation. We will continue to build on opportunities to use the OVC program platform to reach young adolescents with evidence-based behavior change strategies for sexual risk reduction as well as to identify children in need of referral to clinical care and treatment services. The OVC program will also continue to provide a platform for training and outreach related to child protection with particular attention to gender-based violence. In FY 12, the program will continue to support GBV response services including post-exposure prophylaxis.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	3,377,517	0
HVSI	3,315,320	0
OHSS	7,299,756	0
Total Technical Area Planned Funding:	**13,992,593**	**0**

Summary:
Introduction

In 2008, at the height of the economic crisis in Zimbabwe, the public health system faced collapse. Dwindling Government of Zimbabwe (GoZ) investment in the health sector had led to substantial loss of personnel, neglected infrastructure, and a lack of basic commodities. As the economy stabilized after dollarization in 2009, a tentative recovery of the health system restored functionality of health service delivery. In 2012, most primary care nurse posts are filled and donor support is assisting the Ministry of Health and Child Welfare (MOHCW) to deliver basic and essential services at primary, district, provincial and national levels. While slowly increasing government wages and a donor funded retention scheme have helped retain health workers, concerns about the sustainability of the current pay rates point to the uncertainty of the continued revitalization of services. Patient user fees help facilities meet operating costs that are generally inadequately catered for through the 2012 budget, yet there are indications that the fees may deter users, including pregnant women, from seeking care.

Ongoing political uncertainty, limited economic growth, and a bloated civil service wage bill limit the capacity of the Zimbabwean government to adequately fund the health sector. While the national budget allocation for health increased from US $256 million in 2011 to US $345 million in 2012, this represents a decrease in the percentage of the total budget from 9.3 percent in 2011 to 8.6 percent in 2012. Advocacy efforts within the GoZ to increase health spending are nascent. Donor funding, including the Global Fund, USG, DFID, the EU, and others sustains critical

curative and preventative services including HIV-related interventions. The recent cancellation of Global Fund Round 11 has prompted increasing dialogue between donors, the GoZ, and other stakeholders about the need for the GoZ to increase investment in health, particularly for critical programs such as the national ART program.

Observers within and outside government are increasingly looking to the National AIDS Trust Fund (NATF) to fill gaps in the national HIV/AIDS response. Initiated in 1999, the levy, a 3% tax on income is raising increasing sums of money as the formal job sector expands. From $5.7 million collected in 2010 to $20.5 million collected in 2011, the levy trust fund represents the expanding capacity of the GoZ to finance the National HIV/AIDS response. Commitments have already been made for the National AIDS Council (NAC)- managed funds to support increased numbers of people on treatment from 2011 to 2015. In the past, NAC funds have also been used to support male circumcision commodities and laboratory equipment.

The MOHCW's capacity for program implementation is limited due to a shortage of resources; however, Zimbabwe health programs are generally well-coordinated and robustly led by the MOHCW from a technical and coordination perspective. Evidence-based decision making provides a solid foundation for MOHCW policy making and coordination of inputs. It is within this complex context of macroeconomic challenge that the USG is working to support an appropriate balance of service delivery and systems strengthening activities.

Global Health Initiative

The basic premise used in formulating the GHI strategy was to identify how to best reduce preventable deaths and lessen the burden of disease within Zimbabwe. Development of the strategy considered the major causes of death and approaches of assistance that could save the maximum number of lives. Additionally, the strategy was produced with the objective of including interventions that had the potential for greatest public health impact within the general population.

Under GHI, one of the ways the USG will improve health is by strengthening the integration of selected health services. USG efforts in these areas will complement the work of other development partners to improve the availability of and access to a comprehensive package of quality health care. With PEPFAR support, the integration of HIV/AIDS and TB services at the health facility level will be expanded and strengthened (through training, technical assistance and formative supervision) to better respond to the needs of patients who are both HIV-positive and have TB. In addition, PEPFAR is helping to scale-up the availability of more efficacious regimen (MER) of antiretroviral drugs for PMTCT across the country. Under GHI, PEPFAR is supporting the expansion of the number of sites that offer MER, integrating ART into PMTCT programs.

The strategy promotes the integration of PMTCT and MNCH services and builds on the work that the Zimbabwe ART and MCH Task Forces have begun. Using a variety of funding sources, the integration of family planning within HIV/AIDS services will also build on past work and, under the new strategy, will be strengthened and expanded. The USG will continue to work closely with NGOs, government technical counterparts, and other donors to ensure that synergies among programs are captured and resources optimized.
USG efforts in integration are designed to increase the availability of and access to comprehensive health services by creating opportunities for vertical health services to co-locate and integrate with related services and with longstanding USG-assisted efforts (such as PMTCT services) to better serve clients. The USG will also have new opportunities for shared investments in improving service-delivery and improving efficiencies that span across disease-specific activities.

Under GHI, one focus for systems strengthening is the optimal utilization of laboratory support in providing quality care and reliable diagnostic support for all disease areas. A major PEPFAR emphasis has been on laboratory strengthening because of the central role of the laboratory in supporting all HIV program activities. It is important to institute quality systems in the functioning of laboratories since diagnosis, initiation of treatment and proper management of people on antiretroviral therapy depends upon reliable laboratory results. The quality system refers to the organizational structure, procedures, processes and resources needed to implement quality across

other health areas. PEPFAR-funded efforts can also help to bring CD4 testing closer to women as part of ANC services.

The GHI strategy incorporates a more deliberate approach to integrated USG and host-country planning and measurement across PEPFAR, PMI and other USG health assistance areas in order to realize improved health outcomes for Zimbabweans. Drawing upon already existing health activities and programs being implemented by USG agencies, there is a group of health intervention platforms that are generating valuable lessons-learned that can inform future efforts to improve health care in Zimbabwe. Past experience will help evaluate the potential of new approaches to accelerate positive change in health service delivery.

In addition, the GHI strategy strives to strengthen district-level recording and reporting for HIV, and other health conditions and services provided. Improvements in the district level health information system can, in turn, strengthen the national health information system. PEPFAR funding is helping to provide training and technical support to make the information system more relevant and useful to health workers. USG and host-country monitoring and evaluation activities are designed to use common national health indicators that are part of the Zimbabwean health information systems. Data quality is a key element of health information support for service delivery and is one of the emphasis areas for monitoring efforts for improvements in integrated HIV/AIDS, malaria, MNCH, FP/RH and TB service-delivery.

Leadership and Governance and Capacity Building

PEPFAR/Zimbabwe plays an integral role in strengthening the ability of the government, private sector, and civil society to design, manage, and monitor HIV programs at the national, regional and local levels. In supporting the development of the National HIV and AIDS Strategic Plan (ZNASP II), PEPFAR/Zimbabwe assisted the GoZ in assuming greater responsibility for decision making and priority setting related to its HIV/AIDS response for 2011-2015.

Through its support of an infection control program, PEPFAR/Zimbabwe aims to strengthen the capacity of the MOHCW to implement infection control and prevention activities in health care facilities nationwide to reduce TB and HIV infection among health care workers and patients. The project aims to develop the capacity of healthcare workers at various levels to deliver sustainable training and support for the ministry's infection control program beyond the project period. A key component of the program is health worker training. The project will also collaborate with other partners implementing TB/HIV activities to prevent exposure to blood and airborne diseases for both patients and staff in health care facilities.

In another capacity building activity, the USG's support of health care worker training in OI/ART services is critical to improve Zimbabwe's ability to follow up patients on ART, reinforce the use of DOTS as a TB management strategy for co-infected patients, and ensure appropriate pharmacy management, basic lab services, recording and reporting of activities. To enhance and strengthen the basic training, USG has provided technical assistance and financial support to the national mentorship program as well as site supervision to underperforming and newly established OI/ART sites. USG supports a physician position at the ZACH secretariat to provide direct mentoring and leadership to institutions that lack resident doctors.

The USG, through support to the PMTCT program, will also continue to support the resuscitation of village/community health workers, strengthening the community aspects of health care. In keeping with MOHCW's commitment to improve the quality of life of mothers and infants infected and affected by HIV, PEPFAR/Zimbabwe will support a continuum of care that integrates HIV care and support into the overall health system. It is envisioned that community health workers will strengthen the follow up/referral systems for mother-baby pairs and their families and will help link them with psychosocial and other supportive services available within their communities. The USG will support efforts to develop training materials, tools and aids for community health workers to use in delivering PMTCT and Paediatric HIV services. Non-PEPFAR funds will also be used to develop a model(s) for community TB/HIV care. Various models will be piloted in 8 districts to determine feasibility and the potential for

scale-up.

The USG is also involved in strengthening the management and governance of the GoZ, civil society and NGOs through its financial support and participation in the Country Coordinating Mechanism (CCM). The CCM is a country-level partnership of stakeholders that is central to the Global Fund's commitment to local ownership and participatory decision making. Composed of representatives from both the public and private sectors, including government bodies, multilateral or bilateral agencies, nongovernmental organizations, academic institutions, the private sector and people living with HIV/AIDS, the CCM is responsible for developing and submitting grant proposals based on country needs, nominating the grantee or principal recipient(s), and providing oversight of grant implementation. PEPFAR representatives in the CCM assist with and facilitate greater government and civil society responsibility for decision making, resource allocation and prioritization and management of conflicting interests within the MOHCW.

Through the network of New Life Centers, PEPFAR/Zimbabwe supports the strengthening of private sector health services to efficiently provide quality care to HIV positive individuals. The centers will expand their reach, aiming to strengthen workplace (i.e. commercial farms, mines, etc) health programs through the provision of such support as direct psycho-social counseling and information on positive living to HIV positive employees. The teams will also build the capacity of workplace peer educators to provide ongoing support, establish support groups for PLHIV and sensitize employers and employees on the importance of post-test support services for their HIV positive colleagues. The program will also include counseling on gender-based violence. The USG plans to leverage funding from addition donors to maintain service delivery throughout the country.

The USG is supporting the University of Zimbabwe (UZ)/Department of Community Medicine (DCM) in re-establishing the national health leadership program that trains District Health Executives (DHEs) and Provincial Health Executives (PHEs) on human resources management, cost-effective use of resources, data analysis for decision making, basic epidemiology, and the coordination of civil society and NGO partners in HIV prevention, care and treatment. In 2011, PEPFAR/Zimbabwe supported the UZ/DCM in assessing management and leadership needs in Zimbabwe. The results indicated that the high attrition of experienced health personnel has led to a lack of knowledge, skills and experience among individuals occupying leadership positions and that the experienced staff who do remain in-country do not have the means to provide support, supervision, or mentorship to other staff. Overall, gaps in leadership have led to poor data and information systems to inform planning and monitoring of service delivery, poor human resources management and a lack of capacity to promote, coordinate and facilitate collaboration in public-private partnerships and community involvement in health service planning and delivery.

Strategic Information

PEPFAR/Zimbabwe supports the provision of timely and focused strategic information (SI) in order to inform policy, support evidence based programming and ensure efficient resource utilization. The country team has participated in program monitoring and evaluation (M&E), the Health Management Information Systems (HMIS), and national Surveillance and Surveys.

PEPFAR/Zimbabwe Technical Officers have advanced the Zimbabwe national HIV SI capacity through technical assistance in the development of two national strategic plans, the Zimbabwe National HIV and AIDS Strategic plan (ZINASP) and the Monitoring and Evaluation Plan for ZINASP. The PEPFAR SI team provided technical support to the National Monitoring and Evaluation Group (NMEAG) in drafting the Zimbabwe Universal Access Report which was presented at the UN High Level Meeting on AIDS in 2011. Last year, the SI team also provided technical support to the MOHCW AIDS and TB Unit to harmonize key PEPFAR indicators into the Essential Data Set Guide for AIDS programs in Zimbabwe. Further efforts are being made to introduce an electronic individual patient tracking system for the PMTCT, ART and TB programs. Recognizing the need for a country driven research agenda, the PEPFAR team participated in an NAC led initiative to finalize and launch the Zimbabwe HIV and AIDS Research agenda (2010-2011). In 2011, PEPFAR/Zimbabwe continued to support NAC in the implementation of small grants for research by providing technical support for review of research proposals and the implementation of

small studies.

PEPFAR/Zimbabwe also provides extensive support to the national HMIS to strengthen the MOHCW's capacity to provide an integrated routine data collection system to provide information and guide policy formulation and programming. During 2011, the USG supported the successful roll-out the DHIS software and updates to eight provincial and sixty-two district offices. The USG also provided capacity building activities including training and ongoing support and supervision for key personnel.

The PEPFAR team supports the strengthening of Integrated Disease Surveillance and Response (IDSR) through the facilitation of software development, loading of data collection forms and distribution of cell phones procured by GFTAM Round 8. Additionally, the USG supported the training of health personnel from 1200 facilities and provided internet connectivity for a weekly disease surveillance system. The PEPFAR team will continue to support the strengthening of the system in FY12, ensuring all districts are fully furnished with the software and able to report data. Challenges include low human resource capacity at the national level which has delayed implementation of collaborative activities in the Global Fund work plan. A long-term goal of the project is to ensure that interoperable systems are established and that parallel systems are integrated into one functional unit.

The USG provided technical and financial support to the Zimbabwe Demographic and Health Survey (ZDHS) 2010/2011. Additionally, PEPFAR/Zimbabwe provided support to the National Microbiology Reference Laboratory (NMRL) for HIV testing. Preliminary results from the DHS were released in June 2011 and data on HIV prevalence are expected in March 2012. An Extended data analysis is also planned for FY12.

PEPFAR/Zimbabwe continues to take the lead in supporting the MOHCW and National AIDS Council in conducting surveys and in establishing and maintaining surveillance systems. The USG has supported the main source of HIV prevalence data, the antenatal clinic survey (ANC), since 2000. The last survey was conducted in 2009 and a 2012 ANC survey is planned. The 2012 survey will increase the number of sentinel sites from the 19 included in past years to a total of 55. The 2012 survey will involve both ANC sentinel surveillance as well as the analysis of PMTCT based routine data. The goal is to determine the efficacy of transitioning from the use of ANC surveys to routine PMTCT data in order to estimate the population prevalence of HIV.

A follow up study to determine HIV incidence using BED and avidity assays on ANC and ZDHS samples is planned in collaboration with MOHCW, ZVITAMBO project and Manicaland HIV prevention project. The aim of the study is to provide a more accurate estimate of HIV incidence in Zimbabwe. PEPFAR technical officers also participated in the ANC/HIV Estimates technical working group that produced updated Zimbabwe national HIV Estimates (2011) for the Global Health HIV and AIDS Report.

In response to new and emerging issues, PEPFAR/Zimbabwe has provided technical leadership in protocol development and implementation of the HIV Drug Resistance Surveillance System (HIVDR) since 2006. To date, the team has conducted four rounds of Early Warning Indicators Surveys 2007, 2008, 2009 and 2010. The PEPFAR team collaborated with the MOHCW, WHO and other partners in onsite health worker training to collect and analyze an indicator data set from routine data collection tools. The MOHCW plans to implement a requirement that all facilities offering ART services collect and report their EWI data sets to the national level. Facility reports will enable managers to prioritize site level interventions that support good quality service delivery.

PEPFAR/Zimbabwe recently supported the Broadreach team to conduct an efficiency demonstration project for ART services delivery. The main finding was that due to bottlenecks at observation stations and pharmacies, 90 percent of patient time in facilities is time spent waiting for services. Major recommendations include reducing the number of visits to quarterly for stable patients and creating additional service delivery points within existing structures. Plans are also underway to support a 2012 assessment of the PMTCT program in public health facilities, focusing on survival rates of mothers and babies. Another study to evaluate access and acceptability of alternative male circumcision procedures is also planned (contingent on WHO approval of the Prepex device).

Service Delivery

PEPFAR investments are working to ensure availability and access to essential services in Zimbabwe. Two basic approaches are being taken to support service delivery: 1) investing in public sector programs and 2) where substantial gaps in implementation capacity exist, complimenting public sector offerings though the provision of high quality services through the private sector.

In an effort to support sustainable country owned programs, PEPFAR/Zimbabwe works closely with the MOHCW to support service delivery in the public sector. In alignment with the country's GHI strategy, USG program investments enhance the availability and quality of services through national level technical assistance as well as facility-based support.

Along the continuum of response, USG provides inputs to bolster the MOHCW public sector implementation of provider initiated treatment and counseling (PITC), PMTCT and ART/OI management. The strength of these national programs has largely eliminated the demand for complimentary private sector programs. In areas where public sector implementation capacity has been weak or where GoZ counterparts have encouraged complimentary service delivery, PEPFAR has provided support to promote the availability of high quality essential services through NGOs. The preferred mechanism has been to use awards that use an umbrella type structure to strengthen local capacity for service delivery.

The Strengthening Private Sector Health Care Services (SPSS) program supports behavior change communication for sexual prevention as well as demand based programming for counseling and testing, male circumcision, and TB screening. The national SPSS network offers voluntary counseling and testing (static and mobile services), TB screening, and broad post-test support services. The MOHCW considers the SPSS programs part of the national response and has encouraged the delivery of services through non-governmental entities. There is generally good collaboration between local facilities and SPSS NGO partners. Thus, counselors from the private sector provide regular post-test support services, generally a four session package for adherence counseling at MOHCW facilities. Similarly, district and provincial staff of the National AIDS Council (NAC) coordinate community-based behavior change efforts.

The PEPFAR program has taken a dual approach in order to balance system strengthening efforts while ensuring the availability of vital prevention and care services. In building local capacity, the program engages a prime partner that trains local organizations to provide service delivery. Through a franchise-based system the local organizations run and operate sites. Laboratory strengthening provides another example of our dual approach. USG invests significantly in supporting the national Laboratory Directorate in developing its capacity to provide HIV-related services throughout the country. Capacity building activities include support for laboratory quality assurance, equipment, maintenance, human resources, essential commodities, training and transport services. Due to weaknesses in the system and continuing challenges in ensuring the availability of CD4 testing, PEPFAR also supports targeted point of care testing with a focus on pregnant women to facilitate the timely initiation on ART.

Human Resources for Health

Human Resources for Health (HRH) continues to be a significant challenge in Zimbabwe due to financial obstacles within the MOHCW to recruit and retain skilled health workers including doctors, midwives and laboratory technicians. Primary Care Nurses (PCNs) currently make up the bulk of frontline providers in health facilities and the USG supports trainings that have been adapted to target these crucial health care workers. PEPFAR/Zimbabwe supported the development of the MOHCW Human Resources for Health policy and strategic plan through support of the review processes and document printing. The USG plans to further support the printing and dissemination of the Policy through the Leadership project.

In recognition of the need to have highly qualified and competent leaders to run national programs, the USG supports several key positions in the MOHCW AIDS and TB unit as well as the Directorate of Pharmacy Services

(DPS). Previous attempts to employ and retain such staff on government conditions of service have failed or attracted less qualified individuals. USG support has provided for the retention of qualified staff, bringing stability and ensuring continued expansion and strengthening of supported programs. The USG supports 10 positions within the AIDS and TB unit, including the national program coordinators (and their deputies) for ART and PMTCT programs. The USG also provides support for 14 individuals to run the National Logistics Unit which forecasts, quantifies, procures and distributes medicines and other medical commodities nationwide. Although the human resource support is envisioned to continue, the USG is cognizant of the need to eventually transition these positions to the GoZ. In this regard, all the supported positions in the ART and PMTCT programs are part of the established MOHCW organogram.

The PEPFAR/Zimbabwe program is also supporting the MOHCW in the development of a Human Resources Information System (HRIS). The project will establish connectivity, functional integration and interoperability of databases at the Nurses Council of Zimbabwe, the MOHCW and five professional bodies. The HRIS will improve the efficiency of the HRH data exchange, plan for interoperability with other health information systems, and link HRH data so that it is more readily usable for public health decision makers. USG support covers the design, development and testing of databases and provides training for health managers in data analysis, utilization and reporting.

PEPFAR, with the US National Institutes of Health, is partnered with UZ to improve undergraduate, postgraduate and faculty training in clinical management and research capacity. Partnerships with international universities will provide training to new health care workers and improve the capacity of health institutions to deliver care. Similarly, the USG supports a two-year, full time MPH training using the Field Epidemiology Training (FETP) model. The goal is to train highly competent multi-disciplinary public health professionals who will assume influential posts in the country's public health structures and thereby comprehensively address priority public health problems in Zimbabwe.

Laboratory Systems Strengthening

The Ministry of Health and Child Welfare (MOHCW) is the largest provider of diagnostic medical laboratory services. The network includes 52 district, 8 provincial, 5 central and 3 national reference laboratories: the National Microbiology Reference laboratory (NMRL), the National Tuberculosis Reference Laboratory (NTBRL) and a National Virology Reference Laboratory. There are also 1,200 health centers that provide primary health care services and limited laboratory testing. PEPFAR/Zimbabwe supports the Zimbabwe Association of Church Hospitals (ZACH), a faith-based organization (FBO) that provides lab services at rural hospitals,.

Zimbabwe has achieved ongoing success in providing laboratory system support to the national HIV and AIDS response. PEPFAR-supported accomplishments include 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 and evaluation; the adoption of more cost effective CD4 testing technologies; and international accreditation of the Zimbabwe National Quality Assurance Program (ZINQAP). Currently, PEPFAR supports 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.

Despite substantial progress, the laboratory systems in Zimbabwe continue to face many challenges including: a lack of human resources (40% of national capacity) due to low salaries, a lack of funding specifically for laboratories since laboratories are part of a facility and the absence of a laboratory logistics system for distribution of laboratory consumables. Other challenges include: shortages in supplies and subsequent interruptions in testing services due to financial and logistical difficulties, a lack of laboratory equipment standardization, especially in chemistry, and a decrease in funding partners to support laboratory services. Finally, Zimbabwe is in need of a functional laboratory M&E system for laboratory testing as well as commodity and reagent quantification and laboratory surveillance systems.

PEPFAR/Zimbabwe has supported a national laboratory systems strengthening effort to address major gaps in the quality of services rendered by the public health laboratories. Shortcomings identified include the absence of: a

national laboratory policy and strategic plan, national laboratory standards, a laboratory information management system, standardized laboratory monitoring and evaluation systems and an effective laboratory quality assurance program.

A comprehensive assessment of the laboratory services was conducted in 2009 to generate quantitative and qualitative data for developing a national laboratory strategic plan. The USG supported the MOHCW/Laboratory Directorate in the writing and dissemination of the National Laboratory Policy and National Laboratory Strategic Plan. Together the policy and strategic plan shape all laboratory assistance to Zimbabwe. In August 2010, the USG funded the launch, printing, and distribution of the Laboratory Policy and the Strategic Plan (more than 50 stakeholders attended the launch). PEPFAR/Zimbabwe and its partner ZINQAP, along with the Laboratory Council and the Laboratory Directorate developed, printed, and launched the Laboratory Standards in 2011. The team anticipates providing scientists with in-service training on the Laboratory Standards in 2012.

PEPFAR/Zimbabwe is providing laboratory services with External Quality Assurance (EQA) through Proficiency Testing (PT) to improve the quality of services. Currently, 157 laboratories and testing sites participate in the EQA program. PEPFAR/Zimbabwe is establishing a laboratory mentorship program to improve laboratories towards accreditation through the WHO Stepwise program and for South African National Accreditation System (SANAS). Zimbabwe is using the Strengthening Laboratory management Toward Accreditation (SLMTA) model to strengthen laboratory testing for improved service delivery and in preparation for accreditation. Eleven laboratories are currently piloting the SLMTA and the model will be rolled out to ten more sites in 2012. In the first quarter of FY12, in preparation for the roll-out, mentors were trained to assist sites through the SLMTA process. The target is to prepare a total of 30 sites for accreditation over the next few years. The USG is further working to build the capacity of the laboratory council to oversee quality laboratory services. The USG supports the strengthening of the lab directorate and NMRL/NTBRL to oversee the purchase of equipment, lab reagents, equipment contracts and trainings of scientists for the MOHCW reference laboratory services.

In order to improve the availability of data for evidence-based decision making and in strengthening the laboratory capacity for communicable disease surveillance and disease outbreak confirmation, PEPFAR/Zimbabwe also supports the national laboratory services in the development and implementation of a lab M&E system. Standardized M&E tools have been developed and were piloted in October 2010. In September 2011, the USG supported the nationwide launch of the M&E tools and trained laboratory scientists for implementation. A reporting tool for disease surveillance will also be introduced in 2012. PEPFAR/Zimbabwe is also working with Laboratory services in Zimbabwe to establish Laboratory Management Information Systems (LMIS) and has seconded an IT officer to the NMRL to handle all laboratory related IT issues.

Through its support of the National Micro-biology Reference Lab (NMRL), the USG assists Zimbabwe in completing samples testing, processing and dispatch for all provinces. The lab receives an estimated 120 samples a day for processing and a photocopy of the results are sent back to the facilities through courier (EMS or FedEx). Authorized users can access the web-based EID system from any location using the internet. However, results are currently printed and dispatched through a local courier. A lack of capacity and connectivity at sites impedes real time results dispatch. The lab is exploring expansion to include the results of viral load testing. The NTBRL has a similar LIMS in place for TB results. The system went live in January 2010 with Global Fund and USG support and is currently used internally. However, due to a lack of funding, the capability to dispatch results electronically has not been developed. Due to current financial challenges in the MOHCW, there are no plans in place to move the project forward.

In partnership with CHAI, the USG supported a pilot project for Sample Referral and Structured Transport to allow more patients access to care. The Mpilo laboratory in Bulawayo now has LIMS in place to dispatch results to its ten referral sites. The USG has also invested in an HIV/AIDS Patient Monitoring project through ZINQAP which will implement Labware at more laboratories to effectively manage laboratory data in early 2013.

PEPFAR/Zimbabwe has assisted the NTBRL in renovating its building to become a Bio-safety Level 3 facility for TB

diagnosis and has assisted the lab purchasing reagents and commodities to process TB samples. The goal is to generate clinically significant results to be used to initiate therapy. The planned MDR TB survey has been postponed and PEPFAR funding has been reprogrammed to strengthen MDR TB surveillance.

In 2012 PEPFAR/Zimbabwe plans to:

1) Support the MOHCW in decentralizing lab services with the district as the basic unit, working strengthen the referral network among laboratories of different levels for efficient use of resources and provision of care. The USG proposes using the Supra laboratory and structured referral and transport network with a new funding opportunity announcement: Improving Access to Laboratory Testing for HIV/AIDS Patient Monitoring in the Republic of Zimbabwe under the President's Emergency Plan for AIDS Relief (PEPFAR);
2) Strengthen and integrate the SCMS logistic unit(s) to cater for laboratory commodities and ensure support of comprehensive health care service delivery;
3) Support the establishment and maintenance of the Bio-medical Engineering Unit to service and maintain national laboratory equipment;
4) Promote the establishment of a Technical Advisory Board to support the laboratory directorate in decision making and strategic planning;
5) Advocate integrating the financial resources from vertical programs for laboratory tests to form a laboratory budget to address the challenges that laboratory services are facing;
6) Assist the MOHCW in the coordination of laboratory services among partners.

Health Efficiency and Financing

PEPFAR is supporting the MOHCW National ART Program to conduct a study to cost the national HIV and AIDS Treatment and Care Package. The MOHCW introduced the Opportunistic Infections and Antiretroviral Therapy (OI/ART) program in April 2004. As of December 2011, a total of 414,250 of the estimated 576,683 patients needing treatment were receiving HIV treatment (MOHCW, 2011). The broad objective of the PEPFAR-supported study is to assess the cost of providing a comprehensive HIV and AIDS Care and Treatment package for PLHIV in Zimbabwe. PEPFAR/Zimbabwe is also working with the new multi-donor Health Transition Fund to better coordinate donor investments and financing of health programs.

Supply Chain and Logistics

In support of Zimbabwe's national ARV treatment program, PEPFAR utilizes the Supply Chain Management Systems (SCMS) mechanism and the Partnership for Supply Chain management (PFSCM) as procurement agents for ARVs. PEPFAR/Zimbabwe investments in SCMS, along with the globally declining costs of ARVs, have resulted in considerable program cost savings. Operating globally, SCMS is able to pool procurements across countries and is better positioned to negotiate reduced prices for large orders from manufacturers. PEPFAR funds adult ARV supplies to Zimbabwe through an SCMS buffer stock in a Regional Distribution Center (RDC) in South Africa, further enabling cost efficiency. Historically, SCMS Zimbabwe shipped ARVs utilizing a costly air freight method that shipped orders directly from manufacturers in India. Now ARVs are transported by road from the RDC in South Africa at a significantly reduced cost. The cost savings achieved have enabled the PEPFAR team to support the increased costs of switching to Tenofovir-based treatments.

PEPFAR/Zimbabwe also supports system strengthening efforts at the national ART program. In 2006, the MOHCW, with the support of PEPFAR-funded SCMS, established the Logistics Sub Unit (LSU) to coordinate the procurement and distribution of HIV/AIDS commodities. The LSU is a unit of the MOHCW based at NATPHARM, the central medical store in Harare. Through SCMS, PEPFAR/Zimbabwe will continue to provide technical assistance and trainings to the LSU and funding for the 20 LSU staff positions as well as a Supply Chain Management Advisor based at the MOHCW DPS. The LSU plays an essential role in ensuring commodity security and the quality of national treatment programs through its technical oversight and efficient management of the national health commodity supply chain. The technical duties of the 20 LSU staff are to engage in product selection,

conduct forecasting and supply planning, coordinate donor procurements, expedite clearance of goods through customs, conduct physical inventories, facilitate sampling of medicines for quality assurance, distribute commodities, manage a central level computerized logistics management information system (LMIS), and supervise and train staff at ART facilities. SCMS continues to train LSU staff to promote a technically capable, sustainable and efficient LSU. In addition, the LSU, along with the DPS, chairs the Procurement and Logistics Sub-Committee of the ART Partners forum, which serves as a central body for donor and partner collaboration. In supporting the LSU, the PEPFAR works to promote country ownership and ensure commodity security and the quality of ART services.

In recognition of the LSU's achievements, in April 2010 the MOHCW recommended the LSU be moved from the MOHCW Aids and TB Unit to the MOHCWs DPS, in order to expand the role of the LSU beyond HIV/AIDS. In 2010, the LSU was formally integrated into the DPS, and renamed LSU-DPS, where it currently serves as the health commodity management unit for the MOHCW including Malaria, TB, and PMTCT related commodities. The LSU now manages all levels of the national country supply chain which is essential to ensure that patients receive a continuous supply of best value medicines. As a result of the leadership of the LSU the forecasting, quantification and supply planning for all health commodities is now harmonized at the national level and stock-outs have been reduced. Through the strategic efforts of LSU, PEPFAR/Zimbabwe has strengthened the capacity of the national supply chain to a level where stock-outs at central and facility levels rarely occur. Efforts to reduce stock outs include encouraging partners and other donors to import medicines that have been registered and pre-qualified by the Medicines Control Authority (MCAZ), reducing lead time to central warehouses and promoting the importation of quality medicines. In addition, the LSU has designed and implemented a training curriculum, enabling LSU staff to train over 296 ART facilities on ARV best management practices. Finally, the LSU has established an ARV ordering distribution system and standard operating procedures (i.e. for emergency orders when drug stock levels are below 3 months).

The LSU-DPS also holds quarterly presentations of quantification results. The presentations serve as a forum in which the donor community and the MOZ participate, enabling the LSU-DPS to concurrently highlight supply gaps and mobilize resources to fill gaps for all health commodities. PEPFAR/Zimbabwe funds will also continue to support the development of the LSU's Logistics Management Information System (LMIS), currently Zimbabwe Information System for HIVAIDS Commodities (ZISHAC). The LMIS will be used to capture data related to: ART patients and MC procedures; ARV, Fluconazole and MC commodity consumption; stock levels, losses and adjustments. Data will inform decision making on quantification, storage and distribution. SCMS will also continue supporting Top-up and Auto-DRV, the LMIS and data capturing tools used to operate the Delivery Team Top Up (DTTU) distribution system for HIV RTK, PMTCT, CD4 POC commodities and EID bundles.

The investment of PEPFAR/Zimbabwe in SCMS and the LSU has been remarkably strategic in that a small amount of funding works to ensure commodity security for the entire health supply chain. SCMS and the LSU work collaboratively to coordinate with other donors and leverage donor inputs to support the national supply chain. Under GHI, USG support is also working to leverage the resources and increase the reach of the multilateral Global Fund, the newly established multi-donor Health Transition Fund and the World Bank (WB)-administered Multi-Donor Trust Fund. The LSU plays an indispensable role in the national supply chain, and given the increasing number of patients and treatment sites, declining support from other international donors, and low national health budgets, the USG will continue to fund the LSU staff and LSU capacity building activities. With PEPFAR funds, the LSU will continue to ensure access to ART for over 469,927 HIV-positive patients in FY12.

Gender:

The MOHCW national strategic plan is heavily focused on equity with core priority areas addressing the needs of women and girls for health services (including and HIV). The USG team participates in policy development at the national level (such as for the revision of the national reproductive health policy) and helps to identify gaps in the current policy environment to respond to inequities in gender will be part of this process. In addition, Zimbabwe already has many laws in place to protect women including: Termination of Pregnancy Act; Marriage Act; Sexual

Offences Act 2003; Domestic Violence Act 2006; National Gender Policy; Policy on HIV testing; and Male Circumcision Policy. The USG team ensures implementing partners are aware of these policies and laws so that appropriate action can be taken if they are violated.

Nevertheless, pre-adolescent and adolescent girls face systematic disadvantages including in health, education, nutrition, labor force participation, and the burden of household tasks. Because of social isolation, deprivation, economic disadvantage, and discriminatory cultural norms, many girls are forced to marry at very young ages and are extraordinarily vulnerable to unintended pregnancy, HIV, sexual violence, and physical exploitation. Lacking a full range of opportunities and devalued because of gender bias, many girls are seen as unworthy of investment or protection by their families, communities and governments.

USG-supported programs address gender issues through such efforts as: the use of positive youth development through peer networks and mentorship programs in and out of schools; OVC activities for the most vulnerable out-of-school adolescent and pre-adolescents (especially married adolescent girls); the promotion of youth-friendly "safe spaces" for health information and service delivery activities; age-appropriate sexual and reproductive health and HIV/AIDS education and interventions; and, interventions to prevent and respond to sexual abuse of minors.

The PEPFAR/Zimbabwe program considers gender in the development of services communications and service delivery and most programs include a gender mainstreaming component. Given that most health care workers in Zimbabwe are women (ex: Primary Care Nurses and village health workers), PEPFAR programs support the retention and training of women.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	5,331,858	0
Total Technical Area Planned Funding:	**5,331,858**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	20,180,445	0
HMBL	500,000	0
HMIN	100,000	0
HVAB	360,556	0
HVCT	2,725,900	0
HVOP	1,676,190	0
MTCT	6,926,298	0
Total Technical Area Planned Funding:	**32,469,389**	**0**

Summary:
Zimbabwe Prevention TAN

Overview:

Zimbabwe continues to experience a generalized HIV epidemic, but in recent years has noted a significant decline in adult prevalence, from a peak of approximately 27.2% in the mid-1990s to an estimated 13.3% in 2011. HIV incidence has also fallen from an infection rate of 5.5% among 15-49 year olds to about 1%. The decline is been attributed both to mortality and to reductions in risky behaviors. Despite obvious gains, Zimbabwe remains one of the five highest HIV/AIDS burdened countries in the world. Women aged 15-49 continue to experience a disproportionate rate of infection (21.1%) compared with their male counterparts (14.5%) with the most notable differences among those aged 30 and under. The difference is likely attributable to patterns of transactional sex and intergenerational sex. PEPFAR/Zimbabwe supported the GoZ in completing a Demographic and Health Survey in 2011. HIV prevalence data are expected in March 2012. The preliminary report indicates that most Zimbabweans aged 15-49 have heard of HIV (98%) and that most women (77%) and men (79%) know that using condoms and having sex with only one uninfected partner limits the risk of contracting HIV (DHS, 2011). In FY12, the USG will support the next antenatal care (ANC) survey. Both the 2011 DHS and the 2012 ANC survey will provide more recent data to inform HIV prevalence estimates. In addition, data collection for the next population census is scheduled to begin in August 2012. The results will inform more accurate population-based HIV estimates, especially considering suspected population fluctuations following the political and economic unrest of 2008.

Among the general population, key risk factors for HIV include sex with multiple concurrent partners, which is, to some degree socially sanctioned through the common practice of polygamy and long-term extramarital relationships often called "small houses." Gender inequality is pervasive and is evident in social, political and economic spheres. A history of sexually transmitted infections (STIs) is also associated with an increased risk of HIV. There are few differences in HIV prevalence according to wealth or across geographic areas in Zimbabwe, including province or urban/rural residence . In the past, highly educated Zimbabweans were at increased risk of HIV infection, but in recent years the correlation between education and HIV is diminishing.

Population data and HIV prevalence estimates are scarce for most at risk populations (MARPs) in Zimbabwe. While prevention efforts target commercial sex workers, the size of the population, along with HIV prevalence, is unknown. The 2005-2006 DHS survey, however, found that the 4% of men who reported paying for sex had a 12.5% lower rate of HIV than those who reported never having paid for sex. The difference could be attributable to the rigorous efforts targeting the use of condoms for commercial sex. To date, there are no data on the population size or HIV rates among men who have sex with men (MSM) or among injecting drug users (IDU). However, the UNFPA is taking the lead to support surveys to learn more about these two groups. Since commercial sex work, homosexual acts, and injection drug use are illegal in Zimbabwe, data collection and programming are challenging.

Reported gender-based violence in Zimbabwe is high. Among currently married women, 28% reported experiencing physical violence from their husband and 18% experienced sexual violence. Currently married women who had experienced physical violence only or both physical and sexual violence were significantly more likely to be HIV positive than those who had not experienced any physical or sexual violence. After controlling for other factors, number of children ever born, polygamy, accepting attitudes to violence, and disclosure of HIV status were found to be strongly associated with spousal violence among HIV positive women. Because the study was based on cross-sectional data, it cannot draw conclusions on the causal relationship between violence against women and HIV transmission. A multi-agency team will conduct a PEPFAR/Zimbabwe prevention portfolio review in the third quarter of FY12. While a number of shifts have been made to the prevention portfolio since last year, the team will review current prevention investments in consideration of new sexual prevention guidance and the latest epidemiologic data and will identify opportunities to expand the impact of investments.

Recent successes in PEPFAR/Zimbabwe's prevention efforts include the significant coverage achieved in the

PMTCT program and the rapid scaling up of revised 2010 PMTCT Guidelines to enhance the efficacy of the program. Through integrating PMTCT and MCH, the national PMTCT program is working to increase the proportion of women receiving ART for their own health. In 2011, more than 700,000 people received counseling and testing in PMTCT, PITC, and VCT settings, including a significant number of couples. Other achievements include sustained behavior change interventions that are linked to key services including HCT and voluntary medical male circumcision (VMMC). The USG provides the majority of male and female condoms distributed in Zimbabwe through both the private and public sectors. Through its robust assistance in commodity and supply chain management, the program has been successful in maintaining consistent stock levels, with stock-out rates at less than 5% countrywide.

Trends in the PEPFAR/Zimbabwe prevention portfolio reflect programmatic changes to promote evidence-based priorities. For instance, the proportion of funding in AB activities has dropped dramatically, as the budget code allocations were shifted to mirror identified needs in PMTCT, sexual prevention, and VMMC. Other trends in the prevention portfolio budget include a slight increase for counseling and testing and for VMMC service delivery, but a small decrease in resources for MC commodities, and a decrease for blood safety as part of the planned program phase-out.

USG supported prevention interventions are well-aligned with national strategies, including the Zimbabwe National AIDS Strategic Plan II (2011-2015), the National Strategy to Eliminate Pediatric Infections and the Strategy for Safe Medical Male Circumcision Scale up to Support
Comprehensive HIV Prevention In Zimbabwe. PEPFAR activities are coordinated through MOHCW-led technical working groups (i.e. PMTCT Partnership Forum, Male Circumcision and others) as well as through the HIV sub-committee of the CCM to promote harmonization of related efforts and policy adherence while reducing duplication among partner efforts. These forums provide the primary mechanism for coordination with technical partners and donors. Overall health coordination among donors also takes place in the Health Development Partners group. In addition, USG staff members are playing a key role in a GOZ-led "HIV Prevention Think Tank" developing a comprehensive combination HIV prevention strategy.

The USG continues to provide robust support to the national HIV testing program. In the public sector, the Global Fund provides the bulk of HIV test kits and the USG provides gap-filling procurements. As in other technical areas, the Global Fund is the largest donor for HIV prevention, supporting PITC in the public sector through staff support, training, and test kits. DFID also provides important funding to the USG supported integration of PITC and national scale VCT services with family planning and TB screening services. In 2011, PEPFAR/Zimbabwe supported the MOHCW in authorizing primary counselors and, at the district level, microscopists to administer the HIV rapid test. To date, around 300 counselors have been trained. In expanding the cadres allowed to perform the rapid test, Zimbabwe made a major policy advance in expanding accessibility and coverage of PITC.

During FY12, PEPFAR/Zimbabwe will embark upon a number of efforts to strengthen the availability of strategic information to inform the prevention portfolio. In addition to the population-based DHS and ANC surveys, USG is funding a survey to measure health service utilization, sexual behavior, risk reduction behaviors, and exposure and response to communication interventions. The survey results will inform program targeting and design. Through the PMTCT Plan, a PMTCT program effectiveness survey is also in development. The survey will provide information on infant outcomes to inform program priorities.

Sexual prevention interventions remain an important component of the PEPFAR/Zimbabwe prevention portfolio. Among general population, efforts focus on reducing multiple and concurrent partnerships. In FY11, the program supported Zimbabwe's National Behavior Change Program in producing a mass media campaign that reached 262,521 individuals throughout Zimbabwe with messages on the risks of multiple and concurrent sexual relationships. In the upcoming year, phase two of the communications campaign will target young women ages 15-24 years and married men ages 25-39 years. The target groups were selected based on epidemiologic trends showing higher HIV prevalence among young women than men in the same age group, reflecting significant levels of age disparate sexual relationships. Among young women, messages will target those who engage in concurrent

partnerships for 'luxuries' (i.e., cell phones, cash, transportation).

Additional behavior change communication activities will include "edutainment" shows coupled with small group discussions. Standard discussion guides and flipcharts will guide the discussions at schools, colleges, marketplaces, beer halls, and community meetings. The program will focus on urban areas, growth points, farming areas (including resettlement and commercial farms), and other high risk areas like places near highways. The discussions will be complimented by lecture series at schools, colleges, and at community gatherings. The lectures will target young women, providing them with tips and stories from successful women in the community, aiming to demonstrate that success is a result of personal drive and effort. The program will reach approximately 100 schools.

USG funded sexual prevention activities also target MARPs such as commercial sex workers, truck drivers, migrants, and displaced farm workers, primarily through condom promotion and distribution activities. The USG provides the majority (99%) of all condoms supplied in Zimbabwe through both the public and private sectors. The USG complements its condom distribution efforts through its support of the social marketing of condoms. Overall, PEPFAR/Zimbabwe's prevention efforts largely focus on providing linkages to services, especially counseling and testing and condom promotion. Closely linking behavior change communications with services, the prime partner that delivers most behavior change interventions also provides HTC services allowing direct, often immediate, referral.

PEPFAR/Zimbabwe provides HCT services through a franchised network of New Start centers, including fifteen static sites. New Start also provides mobile services to underserved populations through approximately 20 outreach teams that. In order to address the issue of discordant HIV status among couples, representing 13.3 percent of couples in Zimbabwe, New Start centers encourage partner testing and counseling whenever possible. Discordant couples, among others, also benefit from the promotion of dual protection (HIV prevention and family planning), STI management, counseling on alcohol misuse, and counseling and referral for sexual abuse. Additional services offered at New Start centers counseling and referrals for family planning and sexual abuse.

Within the New Start network, the majority of sites are operated by one of approximately 20 NGOs that receive awards to provide testing or behavior change communications. The mechanism acts much as an umbrella award, providing substantial technical assistance to support local organizations in operating the centers. The organizations receive commodities, training and support for monitoring and evaluation. It is also important to note here that testing and counseling depends upon laboratory quality assurance. As discussed in Governance and Systems, laboratory support is essential to the basic capacity for the country to provide key services along the continuum of care, but the program has not yet attracted additional donors.

In a strong effort to ensure service delivery across the continuum of care, the New Start centers have a sister network of 14 New Life sites which provide post-test support services throughout Zimbabwe. The sites offer comprehensive counseling (psychosocial, adherence, nutritional, and family planning). The HCT network acts as a feeder for the post-test service sites. Some New Start testing centers now also offer point of care CD4 testing to strengthen the link between testing and entry into care. This has greatly supported the referral chain to ART since one of the key obstacles to entry in care has been some of the challenges of getting a CD4 count at public facilities. The post-test counseling network maintains client records and has established a very strong prevention with positives protocol, addressing transmission prevention with each client at each visit. Referrals are bi-directional between the local MOHCW treatment site and New Life Centers. To strengthen this linkage, New Life counselors provide similar services, particularly around adherence, on an outreach basis to MOHCW facilities. Unfortunately the linkage between New Start and New Life centers is limited in that the outcomes of HCT clients referred for care and treatment cannot be determined due to confidentiality protections at New Start.

PEPFAR/Zimbabwe's OVC prevention portfolio is mainly carried out within schools. The program covers 65,000 children through youth friendly corners and HIV/AIDS education including social protection, psychosocial support, and treatment (linking positive children with services).

Voluntary Medical Male Circumcision (VMMC)

Another key priority area in FY11 and FY12 is VMMC. Modeling exercises have demonstrated that enormous prevention benefits that could be realized in Zimbabwe through a concentrated scale-up of VMMC. The MOHCW has established ambitious targets in an effort to maximize the potential reduction in HIV incidence. Although the media in Zimbabwe has given a mixed reception to the VMMC scale-up plans, small population-based surveys demonstrate a high degree of acceptance. In FY11, the national program circumcised 30,608 boys and men. Although the 2011 reach was below target, the program is gaining momentum. In FY12, the program will expand from four to ten VCCM sites, one in each province. Sites include both public and private sites providing technical mentorship to both the MOHCW and small local partners tasked with operating a franchise. Ten mobile teams will reach the majority of the estimated 60,000 new clients projected to receive VCCM in FY12. In order to maximize the capacity to scale up VCCM in Zimbabwe, USG is encouraging the MOHCW to train primary care nurses to perform the procedure. PEPFAR/Zimbabwe will provide support to increase the safety of VCCM through trainings and standardized national training guidelines. The program had hoped to target much higher in FY12; however, resources from other donors remain uncommitted. In addition to the USG, The Bill and Melinda Gates Foundation is the second key supporter of VMMC, focusing on the uniformed services. Global Fund resources have been minimal and the failed Round 10 application and postponed Round 11 application have created significant uncertainty that the national MC program can achieve the five-year targets to achieve maximum impact.

Through a successful referral system between VMMC sites and testing and counseling centers, a 99.5 percent HIV testing rate has been achieved. All clients who are found to be HIV positive are provided with on-site counseling and receive referrals to care and treatment sites. M&E tools are already in place and performance indicators are nationally standardized. The performance of regular quality assurance as well as internal and external supervisory visits will ensure service quality.

The VMMC program will continue to focus primarily on 13-19 year old males, most of whom have not yet reached sexual debut, and 20-29 year old males, many of whom are sexually active. With leveraged funds, the program will continue to create communications materials to increase awareness through the mass media, providing accurate information about HIV prevention, the benefits of circumcision, women's involvement, and the need to continue preventive behaviors after the procedure. Through the use of school holiday campaigns, harnessing traditionally circumcising communities, and advocating with key women's, political, and religious groups, traditional leaders and the media, the program will maximize uptake of VMMC.

PMTCT:

The PEPFAR/Zimbabwe prevention portfolio for FY12 includes strong support for the PMTCT continuum of care. The elimination of new pediatric infections and reduction in maternal mortality through PMTCT is a key priority of the Zimbabwean national HIV/AIDS program (NAP) and is strongly supported by a number of donors including the USG. A national vertical transmission elimination agenda and national strategic plan provide the framework for USG investment in PMTCT services. A national PMTCT Partnership Forum, chaired by MOHCW, is the coordinating body for PMTCT activities. In addition to USG, key PMTCT donors include: The Global Fund, the Children's Investment Fund Foundation (CIFF), and the Canadian International Development Agency. Zimbabwe submitted a new FY12 PMTCT Acceleration Plan and looks forward to supporting MOHCW in accelerating expanded access to the continuum of PMTCT services. Please see the acceleration plan for further details on the status of the national PMTCT program and planned USG assistance.

The MOHCW continues to develop its human resources capacity to optimize its prevention activities. In order to expand HTC services, the Global Fund supports the training and deployment of primary counselors to public facilities. The USG compliments staffing efforts through limited HCT trainings and support for primary counselors at Mission Hospitals. Through the PMTCT program, USG is also supports the preparation of voluntary Village health Workers (VHWs) for prevention outreach through job aids such as bicycles.

Medical transmission:

Medical transmission has not been a significant challenge for Zimbabwe as there has long been 100 percent HIV screening for blood donations. However, an increasing maternal mortality rate has highlighted the need for increased availability of safe blood throughout the country. In FY10, PEPFAR/Zimbabwe launched a health systems strengthening effort to develop sustainability plans and expand the capacity of the National Blood Services of Zimbabwe (NBSZ) to collect and distribute blood throughout the country. The ongoing project is working to build country ownership of the NBSZ as it builds its capacity to manage a sustainable blood collection testing, and transfusion system. This program will phase out gradually over the next two years and will be sustained financially through such provisions as the use of fees for cost-recovery.

Injection safely activities have also been integrated into a larger PEPFAR/Zimbabwe project on infection control. The primary goals of the project are the prevention and control of Tuberculosis; however, the program also supports a nationally owned project to revise and develop national guidelines and practices on infection prevention and control. In order to offer a holistic package, injection safety messages were included in the service delivery package. The USG also provides support for post-exposure prophylaxis (PEP) in the case of accidental health care worker exposure.

Gender

Gender is a vital consideration in all USG funded prevention activities. PEPFAR/Zimbabwe supports a family-centered approach to HCT programming, encouraging partners to attend and providing counseling on gender issues such as family planning, the use of condoms, and sexual violence. A communication package has been developed to encourage the involvement of male partners. All program data is disaggregated analyzed by sex.

Strategic information

Challenges in strengthening strategic information to inform prevention programming include a lack of current population estimates. This year, however, Zimbabwe plans to conduct its ten-year census which will allow more accurate estimates of HIV prevalence and incidence. In order to maximize efficiencies and to provide a sustainable method of prevalence estimation, the 2012 ANC survey will include an analysis of routinely collected PMTCT data. The results of both datasets will be analyzed to determine whether or not PMTCT data could be used to make accurate population estimates. In place of ANC surveillance, the use of PMTCT data would allow for significant cost savings.
In general, the program has already established standard data collection tools for the monitoring and evaluation of its programs that are in line with both national guidelines and PEPFAR systems. Some programs have recently incorporated new registers, such as in the PMTCT adoption of the new WHO guidelines. In order to achieve optimal data quality, additional training, onsite support and supervision and mentoring are needed along with on-site data quality assessments.

Capacity Building

In order to ensure that prevention activities continue as the GoZ takes a greater role in managing its HIV response, PEPFAR-funded programs incorporate strong capacity building efforts. Throughout its programs, including HCT, male circumcision, and NBSZ strengthening, the USG provides for the sustainability of a high-quality health care workforce, supporting training and mentoring across cadres. In supporting the various NGOs that run the New Start centers, the program strengthens the capacity of multiple actors to provide prevention counseling, testing, and referrals alongside the MOHCW. The excellent referral system that has developed among the New Start and New Life centers, among others, will also remain a crucial element of the continuum of response in the long term.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	19,689,348	0
HTXS	10,442,404	0
PDTX	1,908,117	0
Total Technical Area Planned Funding:	**32,039,869**	**0**

Summary:

Adult Treatment Section

Adult Treatment Section: ART Program Context & Background

The Zimbabwe National Anti-Retroviral Therapy (ART) Program is housed within the Ministry of Health and Child Welfare's (MOHCW) AIDS and TB Unit. The program is led by a national coordinator who drives service provision in the public health sector. Over 85% of clients on antiretroviral therapy (ART) in the country access services from the public sector which includes both government and faith-based/mission health facilities. The private sector in Zimbabwe plays a smaller role and includes private health facilities (for profit and non-profit) as well as research centers. The Zimbabwe PEPFAR program currently supports the public sector. All PEPFAR supported activities are implemented entirely within existing government and mission infrastructures. From its inception in 2004, the Zimbabwe National ART program has coordinated and directed all efforts towards strengthening ART services within the existing health delivery system. The MOHCW, with support from donors and other non-state actors, has been in the forefront in developing policies, strategic plans and guidelines which shape and determine the overall direction of the program. All activities supported by various donors (internal /external) are expected to feed into and be in line with the priorities as determined by the national leadership. With the exception of a few research centers, the establishment of parallel service delivery points in the country has been discouraged.

Adult Treatment Section: Access and integration

A key priority for the MOHCW's AIDS and TB Unit is the scale-up of anti-retroviral therapy (ART). The MOHCW has prioritized expanding access to treatment for people living with HIV/AIDS and succeeded in initiating over 8,556 patients per month in 2011. As of December 2011, a total of 414,250 (393,872 patients on adult formulations and 20,378 patients on pediatric formulations) of the estimated 576,683 (480,231 adults and 96,452 children) patients needing treatment were receiving ART (based on logistics management information system data). Overall, 64% of all clients receiving ARVs in 2011 were female. Considering that more women than men are HIV positive and that women are more likely to seek health services than men, the PEPFAR/Zimbabwe program results demonstrate excellent gender equity.

The MOHCW has produced guidelines for ARV Therapy based on the WHO recommendation to switch all adult patients from Stavudine containing regimens to Tenofovir-based regimens as well as initiating ART at higher CD4 count of 350 or less for all HIV positive adults. The MOHCW initially planned to put all new patients on Tenofovir-containing regimens and switch 20% of existing patients from Stavudine to Tenofovir and/or Zidovudine regimens in 2011, 50% in 2012, and 100% by the end of 2013. However, resources to enable implementation of this transition plan were limited. The MOHCW with support from the donor group revised the transition plan. The new plan allowed for transition of 20% of existing clients, pregnant women, children and patients with severe side effects to new Tenofovir and Zidovudine-based regimens with continued use of Stavudine for all new adult patients. The MOHCW will continue to initiate new clients on Stavudine based regimens in 2012. Pregnant women, children and individuals with drug induced adverse events will continue to receive new regimens while an additional 50% of

existing clients will be switched to the new regimens. The MOHCW plans to continue the scale up of people on ART to reach 451,944 adults and 54,460 children by the end of 2012. The current delays in disbursements of funds from some donors notably the global fund, may however necessitate further revision to these scale up plans later in the year.The current estimate of the total number of patients in need of treatment is 611,264 i.e 518,810 adults and 92,454 children. The USG contribution of 80,000 person-years of ARVs is part of the ministry's overall targets for 2011-2013. The procurement plan for ART drugs feeds into the MOHCW's 3 year transition plans to the new regimens. For FY11-12 the USG contribution will include the new regimens (Tenofovir/Zidovudine) for 50% of the clients (40,000). In FY12-13, contributions all 80,000 clients (100%) will consist of the new regimens only.

The patient scale-up and regimen change comes at a cost, where the cost of Tenofovir-based regimens is more expensive than the cost of Stavudine-based regimens. The increase in costs has made it difficult for the MOHCW and the international donor community to fully support the national ARV treatment plan. Similarly, the lingering effects of the global financial crisis have hindered donors from increasing commitments to support ART. In particular, the reduced budget for Global Fund Round 8 and Zimbabwe's unsuccessful round 10 application have created a shortfall in funding for Adult ART. The National ART program has maintained the three year transition plan but has made changes in the groups targeted for switching to the new regimens in 2011. The original plans advocated for the provision of Tenofovir-based regimens to all new clients by January 2011. However, low funding levels have only allowed implementation among pregnant women and children aged 14 and under. All other clients continue to be initiated on the less expensive Stavudine-based regimens.

PEPFAR/Zimbabwe hopes to further mitigate challenges in the national scale-up plan through the Treatment Targeting Update and Treatment and Scale-Up Proposal, the program seeks to provide vital gap-filling ARVs along with capacity building activities such as training on the new national treatment guidelines and strengthening of ART program quality of care activities. The plan also provides for the improvement of forecasting and procurement of lab commodities, the creation of space at public health facilities, and planning for implementation of HIV treatment as prevention (Please see Zimbabwe's Treatment Targeting Update and Treatment and Scale-Up Proposal).

PEPFAR not only contributes ARVs directly to the national program through a pooled supply and distribution system, but also pledges to support the continuum of care through other support to the health system (testing and counseling, TB screening, CD4 counting as well as post-test support services). One way PEPFAR/Zimbabwe supports the continuum of care is through a partnership with the Zimbabwe Association of Church Hospitals (ZACH) to increase the number of facilities providing OI/ART services. The goal is that at the end of 2013, 24 additional ZACH sites will provide opportunistic infection diagnosis and treatment, co-trimoxazole prophylaxis and ART to HIV positive patients.

In addition to increasing the number of health institutions offering OI/ART services and in coordination with the MOHCW and the National AIDS Council (NAC), the USG will support in-service training for health care workers in the delivery of OI/ART services. For community care givers, trainings will focus on the provision of follow up to patients in the community. The program will also include the implementation of necessary minor infrastructural changes, including physical renovations where necessary, to improve the provision of services.

In FY12, PEPFAR funds will also be used to scale-up a successful TB/HIV integration model that was piloted in Harare and Bulawayo through EU funding. In this model, the nurses in a facility are trained to offer a package of services including counseling and testing for HIV, screening for TB, initiating TB treatment, initiating ART and recording/reporting services provided. The TB/HIV integration model will be rolled out initially to select high burden areas, particularly cities with high population densities.

The roll-out of IPT has been very slow due to challenges in diagnosing TB. A vital concern in the integration of TB/HIV services, the basic infrastructure for infection control is in place in all the institutions providing ART. However, OI/ART sites were historically designed with inadequate space. As a result, infection control practices have been compromised at most of OI/ART sites. Findings from the USG supported infection prevention and control (IPC) assessment, conducted at 33 sites in 2010, highlighted inadequacies in skilled health personnel,

administrative and environmental controls, personal protective equipment and laboratory support. Through a new cooperative agreement, PEPFAR/Zimbabwe will assist the MOHCW to address challenges in IPC through the development of a policy document, a pool of skilled IPC personnel, strengthening administrative and environmental controls, and procuring personal protective equipment within selected institutions.

In order to better serve ART clients, the PEPFAR/Zimbabwe team is also working with the MOHCW to strengthen its laboratory guidelines based on the WHO recommendations and the Global Fund Round 8 Phase 2 country implementation plan. According to the country implementation plan, the laboratory guidelines should incorporate CD4 testing at baseline and viral load testing for monitoring people on ART. The PEPFAR team is also strengthening Zimbabwe's laboratory capacity for microbiology, hematology and biochemistry monitoring for people in treatment.

Adult Treatment Section: Quality and oversight

In a bid to ensure the quality and oversight of HIV treatment programs, PEPFAR/Zimbabwe is implementing HEALTHQUAL, a public sector Quality Improvement (QI) program. Through HEALTHQUAL, the USG will train MOHCW technical staff and healthcare providers in facility QI, conducting an initial assessment of quality management programs at participating clinics to determine areas in need of improvement. Providers will receive training on collecting and using performance data to track the provision of the basic treatment and care package in order to improve HIV treatment and care. Throughout the program, PEPFAR will support ongoing QI coaching and mentoring at participating sites in order to transfer knowledge and skills to local technical advisors in the MOHCW. Finally, the program will promote consumer engagement in HIV care to increase patient participation, thereby fostering ownership, transparency and leadership in HIV/AIDS programs. Indicators of improved quality management will include the extent to which quality management activities have been incorporated at the facility and overall improvement of staff members' skills in QI.

In alignment with the ART program's strategy to scale-up the number of patients on ART and to bring ART services closer to the people, PEPFAR/Zimbabwe has supported the MOHCW in developing a site assessment and readiness tool to prepare new facilities to offer ART. Currently, just over 520 ART facilities in the country have benefitted from the tool and have been formally designated ART initiation or follow up sites. PEPFAR/Zimbabwe provides support to train and mentor staff members in HIV counseling and testing, case management, opportunistic infections management and ART drug management. Advanced plans are in place to recruit a national ART Program Quality Focal Person at the MOHCW.

PEPFAR supports the monitoring of HIV drug resistance and outcomes every two years though the MOHCW's early warning indicator surveys. The latest survey, conducted in 2010 at 44 sentinel sites, indicated about 15% of patients were lost to follow up at 12 months after initiation of ART (target <20%), 72% of those ever initiated on ART were still in care (target 80%) and 81% of those in care attended all clinic consultations on time (target >80%). The retention rate of those ever initiated on ART (72%) was affected by poor record keeping in most instances. Data collection and record keeping will be emphasized during subsequent PEPFAR supported trainings in attempt to mitigate the loss of information. In FY12, PEPFAR/Zimbabwe will continue to support site readiness assessments and trainings and will participate in the next early warning indicator survey in 2012.

In 2011, the USG also supported the MOHCW in analyzing data from a USG supported ART outcomes study which evaluated a cohort of patients who initiated treatment between 2007 and 2009. The results indicate good ART program performance similar to that of neighboring countries. As a result, the USG team will continue supporting the current treatment program.

Overall, key challenges in the monitoring and evaluation of the national ART program include poor record keeping at the facility-level due to high workloads, a lack of training and duplicative data collection tools. In addition, the MOHCW often lacks the human resources capacity to analyze data. There is need to integrate M&E within program implementation trainings and to streamline data collection and reporting to allow for analysis and use at all levels.

Adult Treatment Section: Sustainability and efficiency

Although the National AIDS Council (NAC) contributes to treatment through the national AIDS trust fund (AIDS levy), the ART program in Zimbabwe is currently donor-driven and most ARVs, including those purchased through USG, are provided to the MOHCW through one pool of commodities. If future national targets are achieved, the PEPFAR contribution will translate to 17% and 15% of the national ARV supplies in FY12 and FY13, respectively. There are no standalone PEPFAR sites, so the targets for PEPFAR/Zimbabwe reflect the current breakdown by sex of patients enrolled in the national program. Similarly, the PEPFAR/Zimbabwe annual treatment results reflect the national proportion of men and women on treatment. The target figures are for the ART medicines procured by the USG team. However, USG support to the national ART program reaches far beyond the figures for patients provided with direct ART. PEPFAR/Zimbabwe also supports the national ART program through the funding of key positions in the national ART program head office; the provision of leadership and management training to more than 60% of DHE teams managing the ART program; and support of 167 laboratories monitoring people on ART treatment.

Through Supply Chain Management Systems (SCMS), USG provides full support to the Logistics Sub Unit (LSU), through which all ARTs and many additional health commodities are procured for Zimbabwe. Through SCMS, the USG has led the way in streamlining the procurement of ARVs, reducing costs and shipment time and reducing national stock-out rates to less than 5%. Given its broad impact on ART and commodity provision in Zimbabwe, the actual number of patients the USG supports far exceeds the 80,000 for whom the program procures drugs. The USG also plays a substantive role in the care and support of all patients on ART. Additionally, the USG has supported monitoring and evaluation efforts by leveraging the Global Fund's initiative of setting up 12 HIV drug resistance sentinel monitoring sites.

The National Medicine and Therapeutics Policy Advisory Committee (NMTPAC) is responsible for the rational use of all medicines in the country including ARVs. This committee is fully functional and it liaises with other regulatory bodies such as the Medicines Control Authority of Zimbabwe (MCAZ). The committee is made up of members from different units of the ministry of health some of whom occupy USG supported positions, and ensures secure procurement of quality drugs and improve forecasting (in conjunction with the LSU).

In addition to the USG, numerous stakeholders contribute to the supply chain in Zimbabwe through the procurement of ARV drugs for ART and PMTCT, ready test kits, conventional CD4 machines and reagents, point of care (POC) CD4 machines and reagents, and chemistry and hematology machines and reagents. Contributing international donors include the USG, GFATM, UNDP, DFID, ESP, CHAI, UNITAID, EPAF, and CIFF. In addition to the USG's provision of technical assistance and personnel support to the MOHCW Directorate of Pharmacy Services and Logistics Unit, CHAI and UNITAID provide technical assistance to the MOHCW Lab Services and GFATM/UNDP provide technical service in supply chain management to NatPHARM.

Adult Treatment Section: Systems Strengthening

The Zimbabwe PEPFAR program supports the National ART program in a number of ways that have key outcomes for systems strengthening and service delivery. On-going support includes activities in three broad areas; strengthening technical/leadership capacity at the national level, institutional capacity building for quality service provision and strengthening of health systems.

In support of technical/leadership capacity strengthening at national level, the PEPFAR/Zimbabwe currently seconds three medical officers (the national ART coordinator and two assistants), two surveillance officers and one laboratory logistics officer to MOHCW AIDS & TB Unit. The USG has also seconded six laboratory scientists at the National Microbiological Reference laboratory (Including the Coordinator post). In the same vein, PEPFAR supports the site readiness assessments for decentralization of ART (initiation/follow up) and site supervision aimed at enhancing the MOHCW's ART scale-up activities. The USG also supports stock audits at national level,

monitoring of HIV drug resistance and outcomes, support for the national quality of care initiative, and MOHCW ART quality monitoring activities.

The USG also supports the training of District Health Executive (DHE) teams on leadership and management to strengthen program and public health interventions. As part of enhancing on the job capacity, the USG is also providing training and mentorship of health workers in HIV care and disease management, Opportunistic infections diagnosis and management, reporting and recording of patient data and pharmacy stock management.

The ART program relies heavily on laboratory services. As such, the USG is supporting in service training of laboratory scientists in M&E, disease surveillance and quality management systems, while also offering pre-service training of State Certified Medical Laboratory Technicians. The USG is also providing support to increase access to CD4 testing for HIV positive patients to support the roll out of the ART program according the new WHO guidelines and early identification of treatment failure as well as providing access to other laboratory tests that are essential to monitor the health of people living with HIV/AIDS and side effects of ART. Laboratory strengthening includes the provision of quality assurance to 167 laboratories providing follow up monitoring for people on ART (Stop gap procurement of laboratory consumables). Support also includes laboratory equipment purchase (with service contracts) for HIV testing and monitoring (CD4, Chemistry, hematology) for continued service delivery. PEPFAR/Zimbabwe is also supporting the laboratory directorate and partners in the development of a CD4 point of care machine procurement and distribution plan and ensuring the machines provide reliable service. The USG has supported a national tiered, quality-assured laboratory network, for the monitoring for ART patients, laboratory strengthening and procurement of laboratory consumables, monitoring of HIV drug resistance and outcomes Laboratory service - pilot program to improve access to CD4 testing,

Pediatric Section

As of December 2011, a total of 20,378 patients were on pediatric formulations of the estimated 96,452 pediatric patients needing treatment in Zimbabwe. The total number of people on treatment in the country at the end of 2011 was 414,250 and five percent of all persons on ART were children. Of Zimbabwe's approximately 500 ART follow up sites, approximately 200 offer pediatric ART services. Over the next two years, PEPFAR/Zimbabwe's key priorities will be to support the MOHCW in finalizing and implementing the PMTCT and pediatric HIV strategy. PEPFAR/Zimbabwe's strategy focuses on the elimination of vertical transmission of HIV, strengthening linkages to care, and providing follow up to mother-baby pairs.

While facing some challenges across the health sector in funding and human resources, the MOHCW maintains the capacity to implement pediatric HIV treatment. As pediatric ART services are expanded to additional sites, the USG will contribute to the training and mentorship of health care workers to enable them to provide various HIV services to children. The USG will place additional effort into advocating (with other donors) for task sharing policies to be officially accepted and adopted.

Integrating pediatric HIV treatment services into the broader MCH program is a critical issue for Zimbabwe in decentralizing services and improving child health outcomes. National efforts to integrate HIV treatment include training individual health care workers to provide multiple services such as: IMNCI, PMTCT, ANC, FP, and IYCF in the same physical location. The MOHCW is continuing to explore the potential for additional integration opportunities, such as the design of integration guidelines and protocols.

As part of efforts to improve health care worker capacity to provide quality pediatric treatment services, the USG is also working with MOHCW to introduce integrated training curricula into pre-service training and in-service training programs. The plan is to transition from the current predominantly in-service training to more of the pre-service training and short refresher in-service trainings thereafter. The USG is also strengthening laboratory services as part of the plans to expand the capacity to monitor HIV-infected children on treatment, and specifically to identify treatment failure and drug resistance.

To improve early treatment initiation in young infants, the USG will focus efforts on expanding coverage of more efficacious regimens (MER) according to revised 2010 guidelines. The program will increase access to ART for pregnant women eligible for life-long therapy and will support procurement and distribution of reagents to facilitate CD4 testing of HIV positive pregnant women for ART initiation. PEPFAR/Zimbabwe will also work to improve service delivery, providing site-level training, support supervision and mentoring as well as in-service and pre-service trainings on revised WHO guidelines. Community support will include the development of village health worker materials and trainings to expand mobilization efforts for PMTCT awareness and to increase uptake of counseling and testing, ARV prophylaxis, and follow up. In support of the implementation of the new national communications strategy, USG will support printing and dissemination of key IEC materials. Finally, PEPFAR/Zimbabwe will continue its support of the Pharmacy Directorate and NATPHARM for supply chain management and logistics for HIV commodities (PMTCT ARVs and POC reagents) as well as the procurement and distribution of EID commodities.

The USG is working with GOZ and relevant partners to develop a rational list of pediatric ARVs in order to simplify ARV drug forecasting, facilitate procurement, increase the use of FDCs, and minimize unnecessary and costly redundancies. The 6th edition of the "Essential Medicines List and Standard Treatment Guidelines for Zimbabwe" (which includes ARVs and other aspects of HIV care) was released by the NMTPAC just over a month ago. This is currently being distributed to all facilities and health care workers in the country. The USG contributed to the printing of this booklet.

As is the case with adult treatment, the USG provides support to the MOHCW PMTCT program and its sub-units, notably the LSU and Nat pharm (for quantification, forecasting, procurement and distribution of medicines and other commodities). Traditionally, the USG has not supported the purchase of pediatric ARVs, although a one-off gap filling purchase was made in 2010/2011 to support 22,000 children. Stock-out rates for pediatric formulations remained at less than 5% across health facilities in 2011. With funding for the PMTCT Acceleration Plan, the program plans to supply commodities for scale-up of integration of ART in MCH settings along with commodities and technology to increase coverage and effectiveness of early infant diagnosis (EID) services. Funding for the acceleration plan will also allow PEPFAR/Zimbabwe to evaluate the outcomes of the national PMTCT program.

The USG is supporting the government's pediatric HIV strategy and scale-up plan by assisting with forecasting, quantifications and procurement of commodities for the proposed scale-up plans and advising on the best possible approaches to make such plans succeed. Donors such as NAC/GOZ, Global Fund, DFID, ESP, CHAI, UNITAID, AXIOS, UNICEF, WHO and MSF also support the national pediatric agenda through contributions of ARVs to the national pool as well as capacity- building through training and mentorship programs.

Pediatric Treatment: Strategic Information

In Zimbabwe, the child health card is still standard in all health facilities and is issued to all mothers upon delivery of the baby. The card contains relevant HIV sections which when fully completed are able to facilitate the linkages to care at various stages of the infected child's life. The postnatal register is under development to help track exposed/infected infants from birth till 24 months of age. In addition, a child health master card in each facility documents similar information along with outcomes.

The capacity to collect, analyze and use pediatric HIV program data is available locally, though it needs strengthening in terms of human resources and the transition from paper-based to computerized systems. As part of building this capacity, the USG is providing supportive supervision teams to facilities as well as on the job training and mentorship in data collection, analysis and use of locally generated data and transmission to higher levels. Pediatric HIV data, particularly that which is centralized, is and will continue to be used for all planning (ARV purchases, decentralization, training, etc.) and advocacy (task sharing, access to HIV testing, etc.) purposes.

Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P1.1.D	P1.1.D Percent of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	n/a	Redacted
	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	470,000	
P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	95 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	60,116	
	Number of HIV-	63,280	

	positive pregnant women identified in the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)	13,921	
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	0	
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY)	44,195	
	Single-dose nevirapine (with or without tail)	2,000	
	Newly initiated on treatment during current pregnancy (subset of life-long ART)	0	
	Already on treatment at the beginning of the current pregnancy (subset of life-long ART)	0	
	Sum of regimen type disaggregates	60,116	
	Sum of New and	0	

	Current disaggregates		
P5.1.D	Number of males circumcised as part of the minimum package of MC for HIV prevention services per national standards and in accordance with the WHO/UNAIDS/Jhpiego Manual for Male Circumcision Under Local Anesthesia	136,800	Redacted
	By Age: <1	650	
	By Age: 1-9	1,300	
	By Age: 10-14	41,892	
	By Age: 15-19	48,051	
	By Age: 20-24	31,247	
	By Age: 25-49	45,581	
	By Age: 50+	2,279	
	Sum of age disaggregates	171,000	
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection through occupational and/or non-occupational exposure to HIV.	348	Redacted
	By Exposure Type: Occupational	0	
	By Exposure Type: Other	74	

	non-occupational		
	By Exposure Type: Rape/sexual assault victims	274	
P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions	n/a	Redacted
	Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People Living with HIV (PLHIV) interventions	90,000	
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are	803,500	

	based on evidence and/or meet the minimum standards required		
P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	6,300	
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive	n/a	Redacted

	interventions that are based on evidence and/or meet the minimum standards required		
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	78,000	
	By MARP Type: CSW	10,000	
	By MARP Type: IDU	0	
	By MARP Type: MSM	0	
	Other Vulnerable Populations	68,000	
	Sum of MARP types	78,000	
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	1,062,762	Redacted
	By Age/Sex: <15 Male	89,585	
	By Age/Sex: 15+ Male	621,001	
	By Age/Sex: <15 Female	89,531	
	By Age/Sex: 15+ Female	250,644	
	By Sex: Female	707,532	
	By Sex: Male	340,230	
	By Age: <15	179,196	

	By Age: 15+	868,646	
	By Test Result: Negative		
	By Test Result: Positive		
	Sum of age/sex disaggregates	1,050,761	
	Sum of sex disaggregates	1,047,762	
	Sum of age disaggregates	1,047,842	
	Sum of test result disaggregates		
C1.1.D	Number of adults and children provided with a minimum of one care service	414,977	Redacted
	By Age/Sex: <18 Male	81,501	
	By Age/Sex: 18+ Male	84,040	
	By Age/Sex: <18 Female	86,655	
	By Age/Sex: 18+ Female	162,781	
	By Sex: Female	249,436	
	By Sex: Male	165,541	
	By Age: <18	168,156	
	By Age: 18+	246,821	
	Sum of age/sex disaggregates	414,977	
	Sum of sex disaggregates	414,977	
	Sum of age disaggregates	414,977	
C2.1.D	Number of	264,227	Redacted

	HIV-positive individuals receiving a minimum of one clinical service		
	By Age/Sex: <15 Male	20,155	
	By Age/Sex: 15+ Male	75,915	
	By Age/Sex: <15 Female	20,501	
	By Age/Sex: 15+ Female	147,656	
	By Sex: Female	168,157	
	By Sex: Male	96,070	
	By Age: <15	40,656	
	By Age: 15+	223,571	
	Sum of age/sex disaggregates	264,227	
	Sum of sex disaggregates	264,227	
	Sum of age disaggregates	264,227	
C2.2.D	C2.2.D Percent of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	38 %	Redacted
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	101,340	
	Number of HIV-positive individuals receiving a minimum of one clinical service	264,227	

C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	92 %	Redacted
	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	243,290	
	Number of HIV-positive individuals receiving a minimum of one clinical service	264,227	
C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	1 %	Redacted
	Number of HIV-positive patients in HIV care who started TB treatment	3,952	
	Number of HIV-positive individuals receiving a minimum of one clinical service	264,227	
C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV	97 %	Redacted

	test within 12 months of birth		
	Number of infants who received an HIV test within 12 months of birth during the reporting period	61,381	
	Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positive at entry)	63,280	
	By timing and type of test: virological testing in the first 2 months	31,640	
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	29,741	
T1.1.D	Number of adults and children with advanced HIV infection newly enrolled on ART	20,071	Redacted
	By Age: <1	2,984	
	By Age/Sex: <15 Male	3,839	
	By Age/Sex: 15+ Male	4,400	
	By Age/Sex: <15 Female	1,868	
	By Age/Sex: 15+ Female	9,964	
	By: Pregnant Women	13,954	

	Sum of age/sex disaggregates	20,071	
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	140,000	Redacted
	By Age: <1	0	
	By Age/Sex: <15 Male	0	
	By Age/Sex: 15+ Male	50,260	
	By Age/Sex: <15 Female	0	
	By Age/Sex: 15+ Female	89,740	
	Sum of age/sex disaggregates	140,000	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	114	Redacted
H1.2.D	Number of testing facilities (laboratories) that are accredited according to national or international standards	6	Redacted
H2.1.D	Number of new health care workers who graduated from a pre-service training institution or program	327	Redacted
	By Cadre: Doctors	0	
	By Cadre: Midwives	0	

	By Cadre: Nurses	0	
H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program	3,180	Redacted
H2.3.D	The number of health care workers who successfully completed an in-service training program	5,638	Redacted
	By Type of Training: Male Circumcision	375	
	By Type of Training: Pediatric Treatment	195	

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7524	John Snow, Inc.	Private Contractor	U.S. Agency for International Development	GHP-State, GHP-USAID	420,000
7549	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHP-State, GHP-USAID	33,565,913
12290	Population Services International	NGO	U.S. Agency for International Development	GHP-State, GHP-USAID	18,066,513
12862	University of Zimbabwe	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHP-State	850,000
12893	Research Triangle International	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHP-State	2,154,000
13037	The International UNION against TB and Lung Disease (TB Care)	Implementing Agency	U.S. Agency for International Development	GHP-State	500,000
13063	National Blood Service	Host Country Government	U.S. Department of Health and	GAP, GHP-State	500,000

	Zimbabwe	Agency	Human Services/Centers for Disease Control and Prevention		
13152	University of Zimbabwe	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHP-State	2,150,000
13173	Biomedical Research and Training Institute	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHP-State	800,000
13293	University of Zimbabwe	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHP-State	600,000
13320	University of Washington	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State, GAP	300,000
13401	University of Zimbabwe	University	U.S. Department of Health and Human	GHP-State, GAP	425,000

			Services/Centers for Disease Control and Prevention		
13692	Organisation for Public Health Interventions and Development	Implementing Agency	U.S. Agency for International Development	GHP-State, GHP-USAID	5,800,000
13889	World Education 's Batwana Initiative	Implementing Agency	U.S. Agency for International Development	GHP-State, GHP-USAID	7,155,562
13911	New York AIDS Institute	Other USG Agency	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	250,000
16795	TBD	TBD	Redacted	Redacted	Redacted
16804	ITECH	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State, GAP	4,450,000
16805	TBD	TBD	Redacted	Redacted	Redacted
16806	TBD	TBD	Redacted	Redacted	Redacted
16813	TBD	TBD	Redacted	Redacted	Redacted
17013	Department of State/AF - Public Affairs Section	Other USG Agency	U.S. Department of State/Bureau of African Affairs	GHP-State	205,000
17015	State/AF Ambassador's PEPFAR Small	Implementing Agency	U.S. Department of State/Bureau of African Affairs	GHP-State	40,000

	Grants Program				

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 7524	**Mechanism Name: USAID | DELIVER PROJECT (TO4)**
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	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 420,000	
Funding Source	**Funding Amount**
GHP-State	20,000
GHP-USAID	400,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The DELIVER PROJECT designs, develops, strengthens 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. 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 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 USAID funded SCMS Project assistance this system also distributes HIV rapid tests, PMTCT more efficacious regimens (MER), POC CD4 reagents and consumables, and EID bundles. With Child

Survival funding DELIVER assisted the MOHCW to pilot test in one province a system in which TB drugs and Malaria ACTs and RDTs were managed on a DTTU type system called the Zimbabwe Informed Push (ZIP) system. The MOHCW is now using this system nationwide. VEHICLES: Purchased/leased under this mechanism from the start of the mechanism through COP FY2011= 16. New requests in COP FY 2012 = 0. Total planned/purchased/leased vehicles for the life of this mechanism = 16

Cross-Cutting Budget Attribution(s)

Human Resources for Health	82,000

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**7524**		
Mechanism Name:	**USAID | DELIVER PROJECT (TO4)**		
Prime Partner Name:	**John Snow, Inc.**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	120,000	0
Narrative:			

HVSI Strategic Information

In FY 2012, DELIVER will continue to implement the Top Up 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). 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 has upgraded the AutoDRV software.

DELIVER will also upgrade the Top Up software, which houses the data for all commodities currently carried by the DTTU. More recently the MOHCW and NatPharm are using the Top Up software to manage the data for the TB and Malaria commodities distributed on the ZIP system and the data for the Primary Health Care Packages (PHCP) which contain 38 essential primary health care medicines and medical supplies for health centers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	300,000	0

Narrative:

In FY 2012, 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 over 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%. For FY11 the stock out rate was below 2%.

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 USAID-funded 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 and 2010, with funding from the SCMS Project, PMTCT MER ARV drugs were added to the DTTU system. In FY 11 POC CD4 reagent cartridges and consumables and EID bundles were added to the DTTU distribution system.

The DTTU system will distribute approximately 60 million male condoms, 4 million female condoms, 8 million cycles of combined oral contraceptives, 4.5 million cycles of progestin only oral contraceptives, and 800,000 vials of injectable contraceptives to 1,500 health centers and hospitals and 300 community-based distributors in FY

2012. *In addition to its HIV-funded DTTU delivery activities, DELIVER is also assisting the MOHCW and NatPharm to operate the ZIP distribution system for TB drugs and malaria ACTs & RDTs with DELIVER's Child Survival and Malaria funding.*

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	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 33,565,913	
Funding Source	**Funding Amount**
GHP-State	25,965,913
GHP-USAID	7,600,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

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 80,000 adult patients, PMTCT ARV, HIV Rapid Test Kits, CD4 POC reagents and Male Circumcision kits and commodities. 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.
VEHICLES

a. Inventory (purchased/leased):

- Purchased/leased under this mechanism
from the start of the mechanism through COP FY2011 = 20
- New requests in COP FY 2012 = 0
- Total planned/purchased/leased vehicles for the life
of this mechanism = 20

Cross-Cutting Budget Attribution(s)

Human Resources for Health	2,433,922

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)
Child Survival Activities
TB
Family Planning

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**
Governance and Systems	HLAB	700,000	0
Narrative:			

Funds will support treatment scale-up

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	200,000	0

Narrative:

In FY 2012, SCMS will continue to support the maintenance and adjustment when necessary of the Logistics Management Information System (LMIS), ZISHAC (Zimbabwe Information System for HIVAIDS Commodities) used by the LSU to capture ART patient data and MC procedures and ARV, Fluconazole and Male Circumcision commodities consumption, stock on hand and losses and adjustment data, all used for informed quantification, storage and distribution decision-making.

The project will also continue to support the cell phones rolled out to the most remote ART sites to facilitate timely patient and logistics data transmission and, based on the successful outcomes of the pilot implemented during the previous year, SCMS will continue to support a ARV dispensing software at selected high volume sites.

SCMS will also continue supporting TopUp and AutoDRV, the LMIS and data capturing tools integrated in the NatPharm Navision Warehouse Management System and used to operate the Delivery Team Topping Up (DTTU) distribution system for HIV and Syphilis RTK, PMTCT, CD4 POC commodities and EID bundles.
In addition SCMS will continue to support monthly stock audits by an independent audit firm of USG and other donor funded ARVs that were initiated in 2009 to controls receipt, storage and distribution of ARVs by the Harare and Bulawayo warehouses to the treatment sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	5,000,000	0

Narrative:

In FY 2012, SCMS will provide ongoing technical assistance and resource support to the Logistics sub-unit (LSU) which is serving as the health commodities management unit for the whole MOHCW and operates from Harare and Bulawayo. The 15 current staff positions of the LSU are funded through SCMS, as is the SCM Advisor based at the MOHCW Directorate of Pharmacy Services.

The LSU manages the MOHCW supply chains for the national AIDS and TB Program (ART, VCT, PMTCT, OI and MC) as well as the supply chains for Essential Medicines, TB and Malaria commodities. The LSU 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 HIV/AIDS, TB and Malaria commodities and other Essential Medicines.

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 and support NatPharm to address any existing or potential storage challenges.

Distribution: support NatPharm with national bi-monthly distribution of ARV drugs and Male Circumcision Commodities providing 3 delivery trucks, fuel and maintenance, drivers, and per diem. SCMS will also continue to assist the MOHCW in implementing DTTU (Delivery Team Topping Up, an informed push distribution system for HIV diagnostics and PMTCT commodities.)

Capacity Building: provide technical and operational support to MOHCW and system-specific training on logistics for HIV/AIDS commodities SDPs as necessitated by addition of new sites and personnel attrition, as well as trainings to personnel in associated delivery systems like ZNFPC's DTTU. In addition, the project supports Supply Chain Management Pre-Service Training for Pharmacists, Pharmacy Technician and Nurses at local training institutes.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	4,735,000	0

Narrative:

SCMS will procure MC male circumcision kits and related commodities and equipment for approximately 61,000 procedures, based on a average commodities cost of $27.01 per procedure, including the Forceps Guided Disposable Kit at $15.50 based on a weighted average. This will support the MOHCW strategy for safe medical male circumcision scale up to promote comprehensive HIV prevention in Zimbabwe 2010-2015 aims at contributing to the reduction of HIV incidence by scaling up male circumcision (MC) to reach 80% of 15-29 year old HIV negative adolescents and men by 2015. MOHCW is planning to perform a total of 236,000 procedures in 2013 and has not identified other partners to support the procurement of MC commodities for the public civilian sector at the time of writing.

SCMS will continue to provide technical and operational support to assist the Ministry of Health & Child Welfare

to operate the ordering and distribution system for Male Circumcision (MC) kits and related commodities for the supply of static and outreach sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	200,000	0

Narrative:

SCMS will continue in FY 2012 to procure up to approximately $ 200,000 of HIV rapid tests to contribute to the achievement of the MOHCW targets (2,061,935 adults and children to be tested in CY 2013, including 1,581,935 person tested in public health facilities and 480,000 person tested in PSI supported New Start Centers) and will assist the MOHCW in accurately quantifying HIV rapid test kit requirements. Distribution for the rapid tests is part of SCMS's OHSS activities (see below).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,327,740	0

Narrative:

In FY 2012, approximately $540,000 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.

MOHCW will continue to implement the revised PMTCT strategy initiated in 2010 to progressively increase the proportion of pregnant women who received more efficacious regimens (MER) based on WHO recommended option A (Mothers on AZT from 14 weeks and breastfeeding infants on daily Nevirapine during breastfeeding period). It is expected that 43,909 pregnant mothers will need PMTCT during Sept 2012- Aug 2013; 29,858 (68%) will receive the AZT based PMTCT More Efficacious Regimen; 878 (2%) will receive single dose Nevirapine and 13,172 (30%) will be provided ART for their own health. About 5,708 (13%) of HIV exposed babies will take Nevirapine Solution for 18 months. SCMS will use approximately $220,000 from COP 12 to procure medicines for about 1,500 mother/ infants. Other potential donors include GF and GOZ/NAC and MOHCW will continue resource mobilization.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	19,684,038	0

Narrative:

In FY 2012, SCMS will provide first-line ARVs for 80,000 adult patients treated in public sector health facilities. SCMS-supplied ARVs will contribute to meeting the MOHCW target (496,197 adult ART patients by the end of 2013 according to the Zimbabwe National AIDS Strategic Plan 2011-2015) and which is also supported by the Government of Zimbabwe, Global Fund, the DFID-led Expanded Support Programme, UNITAID/CHAI, and other

donors such as Axios/Abbot.

To support these patients in accordance with the revised MOHCW Guidelines for ARV Therapy in Zimbabwe based on the WHO recommendation to switch patients away from Stavudine containing regimens, and based on the MOH strategy to put all new patients on Tenofovir-containing regimens and switch respectively 20%, 50% and 100% of the existing patients from Stavudine to Tenofovir containing regimens in 2011, 2012, and 2013, SCMS will procure the following medicines: Tenofovir/Lamivudine 300mg/300mg + Nevirapine 200mg for patients on the new standard first line regimen, Tenofovir/Lamivudine 300mg/300mg and Efavirenz 600mg for first line patients with tuberculosis; LamivudineZidovudine/Nevirapine 150/300/200mg and LamivudineZidovudine 150/300mg and Efavirenz 600mg as alternative first line patients with tuberculosis. These drugs will be FDA-approved/tentatively-approved generics, whenever possible and logical

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	740,000	0

Narrative:

In FY 2012, SCMS will continue to second two medical officer positions to MOHCW AIDS & TB Programme: the National ART Coordinator and one Assistant National ART Coordinator. SCMS will continue supporting the 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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	979,135	0

Narrative:

The USG team had proposed to expand support for treatment of an additional 45,000 adult and 25,000 pediatric patients through procurement of medicines, health worker training, quality of care investments, and strengthening laboratory supply chain management should additional resources be availed. SCMS will procure EID bundles, CD4 POC machine cartridges, and consumables.

Implementing Mechanism Details

Mechanism ID: 12290	**Mechanism Name: Strengthening Private Sector Services (SPSS)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 18,066,513	
Funding Source	**Funding Amount**
GHP-State	14,932,513
GHP-USAID	3,134,000

Sub Partner Name(s)

Batanai HIV and AIDS Support	Bulawayo City Health	FACT Chiredzi
FACT Mutare	Gweru City Health	Harare City Health
Hope Humana People to people	Matabeleland AIDS Council (MAC)	Ministry of Health and Child Welfare, Zimbabwe
Murambinda Mission Hospital	Mutare City Health	North Eastern Medical Centre

Overview Narrative

The goal of this program is to improve the health of the people of Zimbabwe through reduced HIV prevalence among young adults and reduced mortality and morbidity among PLHIV. The strategic objective is to increase the availability of social sector services and related products through the private sector. The program will aim to achieve the following objectives: (i) Expand and improve private sector based health services; (ii) Improve the availability and range of affordable health products or supplies (iii) Promote healthy behaviors. Implementation is at national scale with focus on areas of elevated HIV prevalence. Key target groups include women and men 15-29 years and most at risk populations. The project will maximize private sector contributions and rigorously monitor and contain costs. The program supports the national strategy and uses national indicators to measure performance. Linkages with both public and private sectors and activities complement national programs and strategies. Activities are conducted in close collaboration with MOHCW, NAC and ZNFPC, as well as numerous local and community based organizations. Monitoring and evaluation efforts continue to be strengthened and form the basis for the program's evidence based decision making process. VEHICLES purchased under this mechanism = 10. New requests in COP FY 2012 = 11. Total planned/purchased/leased vehicles for the life of this mechanism = 21. New request justification - COP FY 2012: 6 vehicles ($246,000) will be used for delivery of community outreach services for VCT and HIV prevention. 2 vehicles ($52,000) will be used for condom distribution and delivery of MARP prevention services. 3 vehicles ($75,000) will be used for monitoring and supervision of HIV prevention services.

Cross-Cutting Budget Attribution(s)

Gender: GBV	980,000
Human Resources for Health	3,010,000
Key Populations: FSW	150,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Mobile Population
TB
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**12290**		
Mechanism Name:	**Strengthening Private Sector Services (SPSS)**		
Prime Partner Name:	**Population Services International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	403,000	0
Narrative:			
With more people knowing their HIV status, the demand for post-test support services has increased significantly in			

recent years. PSI and local partners operate a franchise of 14 New Life post-test support centers and 14 outreach teams. A network of community-based counselors, peer counselors and support groups for PLHIV provide services directly in communities and to patients enrolled in the national PMTCT and ART programs. 138,094 PLHIV accessed care services delivered by New Life between Oct '10 and Aug '12 and 103 ART and OI clinics have been supported through the ART adherence counseling program. With FY12 funds, SPSS will continue to provide care services through New Life and will leverage funding from other donors to maintain service delivery throughout the country. New Life counselors and peer counselors will continue to provide psycho-social counseling and ART adherence counseling to patients and their families accessing public sector health care facilities. All centers will expand reach to workforces with provision of direct psycho-social counseling and information on positive living to HIV positive employees. These teams will also build the capacity of peer educators at workplaces to provide ongoing support, establish support groups for PLHIV and to sensitize employers and employees on the importance of post-test support services for their HIV positive colleagues. Quarterly supervisory visits to all sites are essential to assuring that quality of service is maintained. These visits are complemented by external mystery client surveys, refresher trainings for all providers and counselors and ongoing sharing of best practices. 24,000 HIV positive New Start clients received CD4 cell count through 4 centers and 4 outreach teams in FY2011, using point of care CD4 cell count laboratory services, funded by USG and 6 more devices were received recently. The additional laboratory services will ease the bottleneck in accessing antiretroviral therapy for people testing HIV positive at New Start CT facilities. Due to financial constraints the program had to postpone the expansion of the care services to include antiretroviral therapy and treatment of opportunistic infections to FY13.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	1,220,000	0

Narrative:

PSI, in collaboration with the MOHCW, integrated TB symptomatic screening for all HIV positive clients accessing CT services in 2005 and currently 14% of all HIV positive clients tested through New Start are TB suspects. Due to constraints in the health system, referred HIV+ TB suspects are often not able to access clinical diagnosis or services. SPSS has therefore integrated TB smear microscopy into two New Start sites to facilitate early diagnosis and treatment of HIV infected TB patients. The program has successfully leveraged funds through TBREACH and will expand smear microscopy services to two additional sites in Masvingo and Mutare. In addition the program will:

I. Intensify active TB case finding and HIV testing at the community level through mobile units in 4 urban and peri-urban areas.
II. Identify 20,000 TB suspects with chronic cough, detect 5,460 smear-negative and 1,200 smear positive TB cases among 4 urban and peri-urban communities.
iii. Introduce GenXpert technology at New Start centers in Bulawayo and Harare to improve active TB case finding

among HIV positive clients and detect an additional 300 HIV+ TB patients and refer these into TB care.
iv. Intensify the referral system between HTC and TB treatment centres, including referral tracing using SMS messaging and active referral tracking
PSI will monitor TB laboratory performance using internal and national external quality control mechanisms which are already in place. The program will use existing national M&E tools to report on implementation progress and participate in regular TB partnership meeting chaired by the MOHCW to exchange on progress and challenges in program implementation. The program will build on the work started so far by developing a multi - media communication campaign to increase awareness of the availability of TB diagnostic services to those who test HIV positive at the New Start centers. The campaign will seek to encourage sexually active people to know their status early at the New Start centers in order to receive early diagnosis of TB and receive appropriate medication if they are HIV positive.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	9,941,513	0

Narrative:

Over 40,000 males have been circumcised since May 2009 including 30.608 in FY11. Assuming leveraging of funds from other donors (Gates and DFID) the program expects to reach 100,000 males in FY12. Service delivery at four major urban sites will be maintained and expansion to six additional fixed sites will cover all provinces. The majority of clients will be reached via mobile services provided by10 teams. The program will increase the number of health care staff providing safe MC through additional training using standard national training guidelines. Performance will be monitored using the current M&E tools, which are part of the national HMIS and using national agreed performance indicators. Quality of service is measured through regular internal and external supervisory visits using standard monitoring tools and a quality assurance and monitoring system ensures safe medical services. 99.5% of clients are tested for HIV prior to the procedure. To ensure this high percentage is maintained, all MC sites will provide CT services and the existing referral systems between CT and MC programs will continue. Currently all HIV positive clients are referred into appropriate care and treatment and receive comprehensive counseling at the MC sites. Leveraged funds will also be used to produce communications materials to increase awareness of MC in the communities through both Mass Media and interpersonal communications and the program will continue to use national MMC campaigns during school holidays and with traditionally circumcising communities to increase demand for MMC. Communication and demand creation activities will primarily target adolescent males 13-19 years old, the majority of whom have not yet initiated sexual activity and young adult males 20-29 years, many of whom are sexually active. A multi media campaign will provide accurate knowledge about the HIV prevention benefits of MC, women's involvement and the need to maintain positive behaviors post procedure. PSI will work with community-based youth organisations and volunteers to IPC activities and advocate with key groups including the media, women's groups and political, religious and traditional leaders.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVAB	234,000	0

Narrative:

PSI supported Zimbabwe's National Behavior Change Program in implementing interpersonal and mass media communications to address concurrent sexual partnerships. Based on research which showed perceived costs and benefits as the key determinants of concurrency among sexually active adults, PSI developed and implemented a communications campaign in all provinces reaching 262,521 individuals in FY 2011.

FY12 funds will be used to implement the on-going Phase 2 communications campaign to reach young women ages 15-24 years who engage in concurrent sexual partnerships for 'luxuries' (cell phone, cash, transportation) and married men, 25 – 39 years. Target group selection was based on epidemiological trends showing higher HIV prevalence among females in the 15-24 age groups than men in the same age groups reflecting significant levels of age disparate sexual relationships among the younger women and older men.

Edutainment shows coupled with small group discussions using standard discussion guides and flipcharts will be implemented in schools, colleges, at market places, beer halls, and community meetings. Special focus areas will include urban areas, growth points, farming areas including resettlement and commercial farms, along the highway and other high risk areas in all districts. IPC sessions will be complimented by lecture series in schools, colleges and at community gatherings to target young women and present tips and stories from successful women in the community to demonstrate that success is a result of personal drive and effort. An estimated 100 schools in urban and rural areas will be reached. Based on recent media research by the Zimbabwe Advertising Research Foundation showing higher listenership and readership figures of radio over television, emphasis will be on radio and newspaper placements to maximize reach of the target audience.

PSI will continue to monitor IPC sessions using the current M&E tools, field visits and regular training workshops for implementing partners.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	2,130,000	0

Narrative:

59% of Zimbabweans have ever tested for HIV and 2.3 million have been tested through New Start since its inception in 1999 (an estimated 60% of the adult population in Zimbabwe). The program reaches equal proportions of men and women and 17% of all clients are couples. Mobile services ensure coverage of every district and provide services to the 60% of clients from rural areas. Currently 20% of 35,000 clients reached each month are from vulnerable population groups and populations at increased risk of HIV acquisition, such as migrant workers, displaced populations and sex workers and their clients. Over 95% of services are provided through a client initiated approach, but the program also supports the government in provider initiated CT at 4 sites located within public sector health care facilities. Client initiated services constitute an important approach to identify people living with HIV and represent an important HIV prevention intervention especially for discordant couples. PSI will

maintain its 4 directly managed sites including 8 outreach teams located in the major urban areas as well as 13 local partner managed sites and outreach teams. The program expects to provide C&T services for 370,000 adults >16 years and 2,000 children <16 years of age and will continue to monitor performance using the current M&E tools and PEPFAR indicators. Quality will be monitored by Mystery Client surveys and quarterly supervisory visits. A strong referral system has been established and all referred clients are actively followed up to ensure that they reach the service provider. The program uses the serial testing algorithm in line with national guidelines and will monitor lab performance using internal and national external quality control mechanisms. Communications will normalize the process of accessing testing as a couple. IPC using small group discussions will encourage couples to get tested together and advocacy will also be conducted with political and traditional leaders, the media and religions organizations. Print materials (leaflets and posters) will promote couple testing and PSI will support the MOHCW to conduct nationwide HTC campaigns during specific calendar events.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,538,000	0

Narrative:

Male and female condoms

29.2 million Protector Plus male condoms were distributed through SPSS in Zimbabwe in FY11 representing 35% of national distribution. High risk outlets, (liquor, tuck shops, pharmacies, service stations support groups and lodges) contributed 47% of total sales. 29,450,000 male condoms will be distributed in FY12 and direct distribution through 14 sales officers will continue to ensure availability in high risk areas including business centers, border towns, mining and farming encampments, and along the highway. Emphasis will be on stocking high risk outlets with late opening hours and catering to alcohol users. New emerging retail outlets will be identified to bridge the gap created by the virtual collapse of the wholesale channel. Small group discussions will aim to increase self efficacy to use condoms correctly; improve negotiation skill; normalize condom use and increase quality perceptions especially among couples in sero- discordant relationships, sex workers, migrant populations and alcohol users. PSI will integrate messages on knowledge of status, concurrency and MC and will support local implementing partners to provide behavior change communicaiotns using standard discussion guides. PSI will review the price, positioning and packaging to maintain positive value perceptions of the product. Radio, print and outdoor channels will be utilized to increase quality perceptions and acceptability of the product. According to ZNASP II, female condoms are an important prevention tool among high risk groups such as sex workers. PSI will continue to distribute care female condoms through a network of over 1,500 hair salons and will distribute 1,320,000 care condoms in FY12. To expand reach, new hair dressers and barbers will be identified and trained in high risk areas. PSI will work with local partners to reach young women in tertiary colleges and sex workers in high risk areas. Strong MIS systems will monitor route cycle compliance and coverage, access and product visibility will be measured to ensure targeting of high risk areas. PSI will continue to use existing monitoring tools to assess IPC implementing partners' performance and improved based on feedback.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	2,600,000	0
Narrative:			
Additional funding will support Treatment Scale-up. Please refer to scale-up proposal.			

Implementing Mechanism Details

Mechanism ID: 12862	**Mechanism Name: Development of Health Leadership Capacity and Support of Human Resources for Health Systems 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: University of Zimbabwe	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 850,000	
Funding Source	**Funding Amount**
GAP	200,000
GHP-State	650,000

Sub Partner Name(s)

MSH/Leadership Management & Sustainability (LMS)		

Overview Narrative

The overall goals of this project are: 1) Effective leadership in health planning, program implementation and patient care in the public sector in Zimbabwe.2) Implementation of the MOHCW national Human Resources for Health policy at all levels of the public sector delivery system. 3) Development and implementation of a national leadership training and mentorship program. This project will support the National HIV/AIDS Strategy and Plan

through improving the skills of health care managers for the efficient use of the available human, financial and material resources for improved quality of services to the population. The coverage of these activities will be national and targeting all health managers of Zimbabwe in the public sector. More emphasis will be given to the Districts with some support to Provincial and National Levels. The impact of this program is enhanced through the capacity building of the existing leaders within the public sector across all levels of care through training in leadership, management, and governance. T he above activities aim to increase the skills of managers and health leaders for better provision of health services in Zimbabwe. The cost-efficiency strategy of this cooperative agreement will be based on the use of experienced facilitators in these topics to have the greatest impact possible and through regular evaluation of the program to make adjustments as needed. Monitoring and evaluation of the activities is going to be done through training reports, site visit reports and evaluations from trainees of provincial and district health executives presented as quarterly progress reports. a. VEHICLES - Purchased under this mechanism from the start of the mechanism through COP FY2011 = 1 - New requests in COP FY 2012 = 0 – Total vehicles =1

Cross-Cutting Budget Attribution(s)

Human Resources for Health	850,000

TBD Details

(No data provided.)

Key Issues

Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	12862
Mechanism Name:	Development of Health Leadership Capacity and Support of Human Resources for Health Systems in Zimbabwe
Prime Partner Name:	University of Zimbabwe

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	850,000	0

Narrative:

COP 12 funding will ensure the continued development and support of effective leadership in health planning, program implementation and patient care in the public sector in Zimbabwe at provincial and district level through:

1) Provision of leadership and management training to the District Health Executive teams.
2) Provision of support to District supervision,support and mentorship.
3) Supporting Provincial and District strategic planning and review meetings.
4) Team - building activities in district groups.
5) Provision of support to printing and dessemination of the HRH policy document.
6) Provision of short courses such as summer and winter school

Implementing Mechanism Details

Mechanism ID: 12893	Mechanism Name: Building Health Data Dissemination and Information Use Systems
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Research Triangle International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,154,000	
Funding Source	**Funding Amount**
GAP	224,000
GHP-State	1,930,000

Sub Partner Name(s)

Biomedical Research and Training Institute	Health Information Systems Programme	

Overview Narrative

The Strategic Objective of the project is to strengthen public health resources to analyze health data for programmatic and policy development, and improvement and development of methods and systems for information dissemination. The project has national coverage and targets health personnel, including information officers, program managers, epidemiology officers, provincial and district health teams, and facility level managers. The project aims to achieve the following intermediate results that will lead to achievement of the strategic objective: 1: capacity of MOHCW to coordinate and conduct effective HIS strengthening activities increased. 2: Capacity of national, provincial, district, and clinic-level health care workers in the use of data for decision making increased. 3. DHIS strengthened to become the central repository and reference for routine health data
The project efforts will become more cost efficient over time as skills are transferred to MOHCW staff and they are able to carry out tasks with less project assistance. The end goal of the project is to transfer as much capacity as possible to the MOHCW and to local organizations that can assist MOHCW over the long term to strengthen its health information system. The project M&E plan is based on the results above and indicators will be finalized in coordination with the CDC, MOHCW and project partners. Indicators will include PEPFAR as well as custom indicators. Data is collected and reported regularly in Quarterly reports and analyzed by the project team and MOHCW. a. VEHICLES - Purchased under this mechanism from the start of the mechanism through COP FY2011 = 2 - New requests in COP FY 2012 = 0 – Total vehicles =2

Cross-Cutting Budget Attribution(s)

Human Resources for Health	400,000
Motor Vehicles: Purchased	50,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**12893**		
Mechanism Name:	**Building Health Data Dissemination and Information Use Systems**		
Prime Partner Name:	**Research Triangle International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	1,600,000	0

Narrative:

COP12 funds will be used to continue to strengthen the DHIS. The project will support HIS resources through renewal and strengthening of health information officer training through local universities/polytechnics. Furthermore the project will provide support to MOHCW to leverage Global Fund and other resources effectively. The project will strengthen the underlying HIS planning structures through technical assistance and provision of resource support for NHIS technical committee and working groups. In addition, the project team will assist MOHCW in the development and M&E of an HIS implementation plan that will enable MOHCW to better manage HIS strengthening activities and resources. Finally, the project will assist MOHCW to develop consensus on core/essential indicators that can be used to monitor the health system. Funds will also be used to build the capacity of national, provincial, district, and clinic-level health care workers in the use of data for decision making. This will be done through training and supportive supervision of PEDCOs, PHIOs/DHIOs and program managers in data presentation and analysis with a focus on the use of the DHIS. In relation to this we will help MOHCW to strengthen production & dissemination of reports. Finally, we will strengthen routine mechanisms for use and dissemination of health data, through support of provincial and district health team meetings. The third intermediate result is to strengthen the DHIS to become the central repository for routine health data. To do that we focus efforts on the following areas: building additional data sets into DHIS so that it can be relied on increasingly as a source of data by multiple programs (e.g. HIV/TB, nutrition, etc.) so that parallel vertical reporting systems can be phased out. In order to build DHIS as central repository for health information, we need to strengthen data quality. We will do this by providing resources, tools and training supervisors on data quality monitoring. We will work to ensure MOHCW has the capacity to monitor DHIS system performance & to provide effective user support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	554,000	0

Narrative:

RTI will support commodities commodities and technology to increase coverage and effectiveness of EID services and a program evaluation to assess outcomes of the national PMTCT program.

Implementing Mechanism Details

Mechanism ID: 13037	**Mechanism Name: The International Union against Tuberculosis and Lung Disease (THE UNION)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: The International UNION against TB and Lung Disease (TB Care)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHP-State	500,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

While improvements have occurred in TB control in selected areas, there are still many challenges in clinical TB and TB/HIV patient management, programmatic issues, and overall collaboration between the HIV and TB units in the MOHCW. Tuberculosis is the most common cause of death in Zimbabwe, particularly in age groups with high HIV prevalence (15-49 years). To reduce disease burden and mortality from TB/HIV, it is imperative to scale up TB/HIV care, as well as strengthen the overall health system that provides these and other health services. The objectives of this USG support are to: (1)scale up decentralization of TB diagnostic and treatment services to primary health care (PHC) clinics in urban areas through activities based on the STOP TB Strategy; (2) expand

integration of HIV diagnostic and care services, including antiretroviral treatment (ART), into management of TB suspects, patients and their family members in these settings; (3) expand integration of TB diagnostic and treatment services into management of persons living with HIV (PLHIV) and their family members in these settings; (4) strengthen TB infection control measures in health facilities in urban areas; and (5)strengthen recording and reporting of TB, TB/HIV and HIV care activities. These activities will be implemented by The Union and will essentially be a continuation of the scale up activities from COP 11. An additional 10 - 15 TB/HIV integrated care sites will be added to the 12 that would have been established in FY 12 with COP 11 funds.
VEHICLES: Inventory (purchased/leased) under this mechanism = 2; New requests in COP FY 2012 = 0; Total planned/purchased/leased vehicles for the life of this mechanism = 2

Cross-Cutting Budget Attribution(s)

Human Resources for Health	150,000
Renovation	200,000

TBD Details

(No data provided.)

Key Issues

TB

Budget Code Information

Mechanism ID:	**13037**
Mechanism Name:	**The International Union against Tuberculosis and Lung Disease (THE UNION)**
Prime Partner Name:	**The International UNION against TB and Lung Disease (TB Care)**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	500,000	0

Narrative:
In FY 12, PEPFAR funds will be used to continue FY 11 activities to scale up a successful TB/HIV integration model that was piloted in Harare and Bulawayo (funded by the EU). This model of TB / HIV integrated care was piloted in the cities of Harare and Bulawayo. In this model , the nurses in a facility are trained to offer a package of services including counseling and testing for HIV, screening for TB, initiating/following up TB treatment, initiating/following up ART and recording/reporting these activities. This model will be rolled out initially to select high burden areas particularly the cities with high population densities. The expected outcomes from this intervention will include: *• Enhanced human resource capacity for TB/HIV care at primary health care level;* *• High degree of clinical suspicion of TB in all patients visiting health care centers, among clinic health workers;* *• TB/HIV care decentralization to primary care clinics, including initiation of TB treatment and ART;* *• Reduced barriers for HIV testing of TB suspects; reduced barriers for TB screening of HIV infected patients;* *• Strengthening of directly observed TB treatment at clinics;* *• Improved rapport between TB/HIV patients and health workers* *• Facility level TB and HIV data analysis and use for planning.* *This activity is expected to cover 12 facilities with FY11 funds and an additional 8-10 with FY 12 funds. These facilities will be predominantly in urban areas with high population densities and consequently high disease burdens. With the anticipated improvements in the ability of health care workers to diagnose TB, it is estimated that there will be between 50 and 60 such facilities nationwide by end of 2012.*

Implementing Mechanism Details

Mechanism ID: 13063	**Mechanism Name: Strengthening Blood Safety in the Republic of Zimbabwe**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National Blood Service Zimbabwe	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

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

GAP	196,000
GHP-State	304,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The NBSZ aims to maintain 100% testing of all donated blood for HIV, Hepatitis B&C, and Syphilis, and also produce blood components. Two more distribution centers will be set up. Blood utilization information shall be available when the haemovigilance systems are set up through the CDC task order given to AABB. NBSZ's target is to reduce the HIV rate to 0.55% from 0.60% projected for FY12. NBSZ shall aim to attained blood collections of 6.5 per 1 000 population in 2012 through voluntary non remunerated blood donors. NBSZ will continue to educate donors on blood safety issues. A KAP study is planned for 2012 to inform NBSZ strategy. About 200 healthcare workers will be trained in 2012 in blood donor counseling, M&E, and blood utilization. NBSZ will increase donor retention from 36% to 40% in 2012 and repeat donors from 30% to 35%. New satellite Pledge 25 Club centers, tele-recruiting and sporting events shall aid donor retention. NBSZ shall finalize its M&E plan and identify and capacitate staff in M&E through appropriate training. M&E awareness training will be provided to counseling partners and hospitals. The use of M&E data in program planning will be strengthened through and integrated planning, M&E and strategic meetings. Products and services in the 2012 budget shall be procured consistent with the current Purchasing policy and CDC regulations. VEHICLES purchased under this mechanism from the start of the mechanism through COP FY2011 = 5 New requests in COP FY 2012 = 3 Total planned vehicles for the life of this mechanism = 8. New request justification - COP FY 2012: This is for one additional mobile blood collection team and for replacement for the existing 2 teams. The difference in cost price of double cabs relate to inflation.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	170,000
Motor Vehicles: Purchased	100,000

TBD Details

(No data provided.)

Key Issues

Safe Motherhood

Budget Code Information

Mechanism ID:	13063		
Mechanism Name:	Strengthening Blood Safety in the Republic of Zimbabwe		
Prime Partner Name:	National Blood Service Zimbabwe		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	500,000	0

Narrative:

A. Blood Safety and laboratory Activities

The NBSZ aims to maintain testing of all donated blood for HIV, Hepatitis B&C, and Syphilis, and also produce blood components. Data on demand versus supply shall be maintained. Efforts are underway to set up two more distribution centres (Chinhoyi and Mt Darwin) to promote customer access in the provinces. Blood utilisation information shall be available when the haemovigilance systems are set up. NBSZ's target is to reduce the HIV rate to 0.55%.

B. Donor Education Recruitment

NBSZ shall recruit voluntary non remunerated blood donors.NBSZ shall aim to attained blood collections of 6.5 per 1 000 population in 2012. NBSZ will continue to educate donors through Information Educational & Communication material, giving education talks. A knowledge, attitude and practices study is planned for 2012. The study will better inform NBSZ strategy by providing empirical evidence. Percentage of donors accessing their test results and counselling shall increase due to the blood donor counseling model that was implemented in 2010.

C. Training

About 200 healthcare workers are expected to be trained in 2012 in blood donor counselling and blood utilization.

D. Donor Retention

To enhance blood safety NBSZ wants to increase donor retention from 36% to 40% in 2012. New satellite Pledge 25 Club centres, tele-recruiting and recruiting donors at sporting events shall aid donor retention.

E. Monitoring and Evalaution - staff will be capacitated to do M&E activities. M&E plans, blood safety logic model shall be developed through workshops. M&E meetings will be held to review programme results.

F. Procurement Narrative

Products and services in the 2012 budget shall be procured consistent with the current Purchasing policy and CDC regulations. A cost benefit analysis on buying versus leasing shall be carried out for purchase of equipment with

high value.

Implementing Mechanism Details

Mechanism ID: 13152	**Mechanism Name: Surveys, Evaluation, Assessments, and Monitoring**
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	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,150,000	
Funding Source	**Funding Amount**
GAP	200,000
GHP-State	1,950,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of this partnership is to support MOHCW in the implementation of health related surveys, program evaluations, operations research, assessments and program specific monitoring that would contribute data to guide health related policy decisions for Zimbabwe. The activities will support the HIV/AIDS national strategy in the areas of survey design, data collection, data analysis and data dissemination. Activities include: the HIV prevalence survey among ANC attendees, national population surveys, National HIV Estimates, TB and HIV drug resistance prevalence, and data triangulation. The key contributions of these activities to HSS will be updated information for health related policy decisions and improved resource allocation. This project will require collaboration with National Institute of Health Research (NIHR), the University of Zimbabwe, ZIMSTAT, as well as, with UN agencies, bilateral, multilateral and local NGOs. The project will continue to support secondments of three key MOHCW positions in the AIDS and TB Program. Cost-efficiency strategies will be based on close coordination with the MOHCW so that most of the activities will be organized by existing MOHCW staff. External technical expertise will only be requested for targeted activities that require specialized technical assistance. M&E will involve regular

supervision of data collection, data quality assessments, input of partners on draft documents and final reports. VEHICLES a. Purchased from the start of the mechanism through COP FY2011 = 0 b. New requests in COP FY 2012 = 3 – Total vehicles =3 Justification: Basic program operations and transport of personnel for survey activities. One will be dedicated to MDR TB surveillance.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000
Key Populations: FSW	250,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

TB

End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**13152**		
Mechanism Name:	**Surveys, Evaluation, Assessments, and Monitoring**		
Prime Partner Name:	**University of Zimbabwe**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVTB	100,000	0
Narrative:			
This program will set up the National MDR TB surveillance System as a continuation of the MDR TB survey supported with FY10 funds. Health personnel from the 65 district hospitals will participate in active surveillance for MDR TB. The two reference laboratories (the National Microbiology Reference Laboratory in Harare and the			

TB Reference Laboratory in Bulawayo) will be strengthened to provide culture and sensitivity analysis for suspected MDR TB cases.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	800,000	0

Narrative:

This program will support the completion of the 2011 ANC survey as a priority. Funding will also support the HIV Estimates Process, data triangulation, program assessments,evaluations and provide start up funding for population based surveys as required by the MOHCW and partners.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	600,000	0

Narrative:

PMTCT Effectiveness study: These funds will be used to implement the final 8 months of the survey: including personnel costs, support and supervision costs and field work costs (air time, transport)

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	650,000	0

Narrative:

These funds will contribute to the continuation 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 Antiretroviral Therapy (ART).

3) Monitoring surveys - prospective cohort survey among patients initiating ART for the purpose of reducing or preventing HIV drug resistance while on treatment. Additionally this survey will monitor behavioral indicators among people on ART treatment (Prevention with Positives). Monitoring will be expanded to include women accessing PMTCT services and their babies.

Implementing Mechanism Details

Mechanism ID: 13173	**Mechanism Name: Strengthening Infection Control and Prevention in Health Care Facilities in Zimbabwe under the President's Emergency Plan for AIDS Relief (PEPFAR)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Biomedical Research and Training Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 800,000	
Funding Source	**Funding Amount**
GAP	200,000
GHP-State	600,000

Sub Partner Name(s)

Management Sciences for Health		

Overview Narrative

The project objectives are to: 1) Support the development of a National Strategic Plan and a monitoring and evaluation system for infection control. 2) Strengthen Infection control training at all levels. 3) Facilitate infrastructural renovations to improve infection control in health facilities. 4) Provide technical support to health care facilities in the development and implementation of infection control plans. 5) Procure, when needed, personal protective equipment for health care facilities. The activities of this project will support the HIV/AIDS national strategy and plan through strengthening infection control measures as a key TB/HIV collaborative activity at national level. This project will support directly or indirectly all health facilities in the country on infection control activities. The project will collaborate with other partners implementing TB/HIV activities to prevent exposure to blood and airborne diseases for both patients and staff in health care facilities. The strategy for cost-efficiency will be based on bulk procurement of materials. Activities will be implemented with existing Ministry of Health staff and resources that are already in place will be utilized as much as possible. Monitoring and evaluation of the program will be done through procurement records, follow up of renovation contracts, site visits reports, training reports and

other relevant documentation, all consolidated into quarterly progress reports. a. VEHICLES - Purchased/leased under this mechanism from the start of the mechanism through COP FY2011 = 2 - New requests in COP FY 2012 = 1 – Total vehicles for the life of this mechanism =3 b. New request justification - COP FY 2012: To support training and follow-up of supported sites at provincial and district level

Cross-Cutting Budget Attribution(s)

Human Resources for Health	295,000
Motor Vehicles: Purchased	50,000
Renovation	151,000

TBD Details

(No data provided.)

Key Issues

TB

Workplace Programs

Budget Code Information

Mechanism ID:	**13173**
Mechanism Name:	**Strengthening Infection Control and Prevention in Health Care Facilities in Zimbabwe under the President's Emergency Plan for AIDS Relief (PEPFAR)**
Prime Partner Name:	**Biomedical Research and Training Institute**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	700,000	0

Narrative:

The project aims to strengthen the MOHCW capacity for implementation of infection control and prevention

activities in health care facilities nation-wide. The overall goal is to reduce TB and HIV infection among health care workers and patients. COP12 funds will: • Support MOHCW in the elaboration and implementation of a national infection control strategic plan and monitoring and evaluation plan to guide and monitor the activities to be implemented in the coming 5 years. • Support the implementation of national training on infection control at in-service and pre-service level to strengthen the implementation of infection control activities at facility level. • Support renovations of selected provincial/district hospitals to ensure appropriate environmental conditions for optimum infection control. • Provide technical support to health care facilities in the development and implementation of infection control plans, including basic procurement of personal protective equipment. These activities are in line with the 'Three Is for HIV/TB. BRTI will coordinate the implementation of the project in close collaboration with the MOHCW to ensure effective complementarity with other related activities. The project aims to develop capacity of HCW at various levels to deliver sustainable training and support for the infection control program of the ministry beyond the project period. This includes the employment of an IPC focal person in the MOHCW and the training of trainers at provincial and district level. The development of a curriculum for IPC will ensure sustained pre and in-service training and quality thereof. An M&E system and tools will be developed to monitor process, outputs and outcome/impacts of the project. In addition, an M&E system for the MOHCW IPC program will also be developed. The cross-cutting programs of this project are: human resources for health and construction/renovation. Training of health workers is a key component of the program. Renovations will be carried out to improve environmental conditions for infection control such as maximization of natural ventilation in patient waiting areas and consulting rooms.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	100,000	0

Narrative:

The project aims to strengthen the Ministry of Health and child Welfare's (MOHCW) capcity for implementation of infection contrl and prevention activities in health care facilities nation-wide. One of the key objectives of the project is contribute to injection safety (needle stick inhjury, medical transmission of blood borne pathogens) through a number of activities that include: (1) Training of HCW at all levels in relevant areas of injection safety as applicable through infection control practice, (2) Cnduct intensive information, education and Communication (IEC) activities among HCW and patients, (2) strengthen provision of post exposure prophylaxis (PEP) through improving monitoring and reporting of occupational injuries and strengthening the PEP drug supply chain. Key issues are TB and Workplace program. The workplace programs will include : 1) Promoting HIV prevention among health care workers through injection safety, provision of PEP and promoting HIV testing and relocation of staff at high risk. 2) Regular TB screening of all health care workers.

Implementing Mechanism Details

Mechanism ID: 13293	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: University of Zimbabwe	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 600,000	
Funding Source	**Funding Amount**
GAP	150,000
GHP-State	450,000

Sub Partner Name(s)

IntraHealth International, Inc	JEMBI	

Overview Narrative

The main objective of the Health Informatics Training and Research Advancement Centre project is to strengthen the management of Human Resources for Health in Zimbabwe. This program provides information on the number of health care workers available at all health care levels by training skills, distribution and other variables. The project targets all health workforce of Zimbabwe in the public sector. The key contribution of this program is a fully functional database at all levels (National, Provincial and District level) that will enable policy makers to make strategic decisions related to Human Resources for Health. The impact of this project will be enhanced through collaboration with the Health Informatics Public Private Partnership (HI-PPP) which will provide additional technical support to the Zimbabwean Human Resource Information System (ZHRIS) programmers. In 2012, this project is focused on strengthening connectivity, training in both system usage and data driven decision support systems. The system will track of human resources of the health sector at all levels throughout the health system, from their licensure to their deployment and retirement outcomes. In year 2, the project will support processes that look at human resources for health demand and supply dynamics. Monitoring and evaluation of the project activities will be done through site visits, training reports, procurement records and other relevant tools that will allow tracking of the project and consolidation of the information into quarterly progress reports. VEHICLES a.

Purchased under this mechanism from the start of the mechanism through COP FY2011 = 0 b. New requests in COP FY 2012 = 1 – Total vehicles =1 Justification: basic program operations.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	555,000
Motor Vehicles: Purchased	45,000

TBD Details

(No data provided.)

Key Issues

End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**13293**		
Mechanism Name:	**Development and Strengthening of Human Resources for Health Activities in Zimbabwe**		
Prime Partner Name:	**University of Zimbabwe**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	600,000	0
Narrative:			
COP12 resources will allow: 1) expansion of the existing program to 3 additional provinces, 2) expansion of training of personnel in data capture and analysis, 3) maintenance of the existing networks, 4) inclusion of additional professional regulatory bodies in the system, and 5) training in data and information use. This new mechanism will continue to support development of the HRIS where the former partner left off.			

Implementing Mechanism Details

Mechanism ID: 13320	**Mechanism Name: Health Resources and Services Administration (HRSA) International AIDS Training and Education Center - (IATEC) cooperative agreement**
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 Washington	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 300,000	
Funding Source	**Funding Amount**
GAP	100,000
GHP-State	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The International Training and Education Center on HIV (I-TECH), founded in 2002, is a collaboration between the University of Washington (UW) and the University of California, San Francisco (UCSF). I-TECH's mission emphasizes working with local partners to develop skilled healthcare workers, strengthening national health systems, and ensuring sustainability by promoting local ownership. I-TECH's strengths lie in the areas of health system strengthening, health workforce development, operations research and evaluation, and prevention, care and treatment of infectious diseases. Since 2003, I-TECH has supported programs in Zimbabwe in care and treatment (HTXS), tuberculosis (TB/HIV), and laboratory infrastructure (LAB).

I-TECH's overall goal in Zimbabwe is to provide technical assistance to strengthen government health systems and to ensure that health care providers deliver high-quality care for HIV/AIDS patients, in a manner that promotes country ownership. I-TECH works in collaboration with the Centers for Disease Control and Prevention Global AIDS Program in Zimbabwe primarily in the area of human resources for health.

For COP 2012, I-TECH will continue focusing on supporting Zimbabwe through providing technical assistance in strengthening the laboratory health systems. I-TECH's support to laboratory infrastructure is in line with GHI core principles of building sustainability through health systems strengthening, and encouraging country ownership and investing in country-led plans. (No vehicle purchases)

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

TBD Details

(No data provided.)

Key Issues

TB

Budget Code Information

Mechanism ID: **Mechanism Name:** **Prime Partner Name:**	**13320** **Health Resources and Services Administration (HRSA) International AIDS Training and Education Center - (IATEC) cooperative agreement** **University of Washington**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	300,000	0
Narrative:			
Additional funds received for treatment scale-up.			

Implementing Mechanism Details

Mechanism ID: 13401	**Mechanism Name: Strengthening the Master's Level Public Health Training Program in the Republic of Zimbabwe under the President's Emergency Plan for AIDS Relief (PEPFAR)**
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	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 425,000	
Funding Source	**Funding Amount**
GAP	150,000
GHP-State	275,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The objectives of this project are: 1) To increase the number of health workers graduating from the Master of Public Health (MPH) program at the University of Zimbabwe. 2) To attract non-traditional Master's of Public Health (MPH) students (i.e., those without a degree in nursing or medicine). 3) To 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. The activities that are being implemented support the HIV/AIDS National Strategy and Plan through program evaluation at district and provincial level within the public sector to provide evidence for health related decision making. The students also engage in field projects which include HIV related subjects and evidence from these projects will help inform policy at local and national level. MPH students are recruited nationally, and for the fieldwork portion of the degree program they are deployed to all provinces where they engage in planning, implementation and evaluation of public health interventions. The key contribution of this program to HSS and HRH is the building of competencies and skills in the public health sector to improve health services provision. Cost-efficiency strategies include bulk production of training materials for the program. Monitoring and evaluation of our activities will be accomplished

through field supervision visits, monthly meeting feedback from the trainees, and documentation of student progress. This information will be presented in quarterly reports. a. VEHICLES - Purchased under this mechanism from the start of the mechanism through COP FY2011 = 1 - New requests in COP FY 2012 = 0 – Total vehicles =1

Cross-Cutting Budget Attribution(s)

Human Resources for Health	425,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13401**
Mechanism Name:	**Strengthening the Master's Level Public Health Training Program in the Republic of Zimbabwe under the President's Emergency Plan for AIDS Relief (PEPFAR)**
Prime Partner Name:	**University of Zimbabwe**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	HVSI	100,000	0

Systems			

Narrative:

The MPH Programme in consultation with the Ministry of Health and Child Welfare, CDC and other stakeholders conduct targeted evaluations on priority interventions in line with the objectives of PEPFAR. These evaluations will include local level projects which are mainly led by the student for purposes of learning and providing feasible recommendations at the sites they are attached to. in addition MPH trainees will participate in a national level targeted evaluation together with their field supervisors,CDC and faculty. It is envisaged that this evaluation will provide recommendations which will influence policy and public health practice in line with the golas of PEPFAR.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	325,000	0

Narrative:

The MPH Programme relies on field supervisors, mostly MoHCW technical officers at provincial and district levels, to supervise the field-based work of MPH students. Each supervisor is provided with a small allowance to compensate him/her for the contributions made to the students' activities. In addition, both supervisors and the provincial office are provided with mileage reimbursements, through the grant. The Field Coordinators provide the technical leadership for MPH training with support staff which includes a secretary, administrator and driver. Their salaries are paid this grant. Funds will be utilized to buy office equipment, supplies and consumables as well as printing of training materials. Students will be supported with small allowances to carry out projects at their field sites with logistical support of the Ministry of health and child welfare and other host institutions. Funds will also enable students to travel to the monthly MPH meeting. As part of learning and networking students will make presentations at national, regional and international scientific conferences. This travel will be suppported with funding from this grant

Implementing Mechanism Details

Mechanism ID: 13692	**Mechanism Name: PMTCT Acceleration Service Delivery in Zimbabwe**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Organisation for Public Health Interventions and Development	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 5,800,000	
Funding Source	**Funding Amount**
GHP-State	3,184,000
GHP-USAID	2,616,000

Sub Partner Name(s)

TBD		

Overview Narrative

This service provision mechanism will be focused on the direct implementation of activities in supported health facilities (in-service training, support and supervision etc) and is a follow-on to an expiring mechanism. The PMTCT program is a key component of Zimbabwe's HIV/AIDS prevention strategy. Zimbabwe's PMTCT program has made significant strides in increasing coverage and quality. The program recently adopted a pediatric HIV elimination agenda in which they aim to reduce HIV transmission to babies from the current estimated rate of 10 - 12% to less than 5% nationwide. The program is thus at a critical turning point in its commitment to rapid expansion toward full national coverage. It remains essential for the USG to continue to support PMTCT and for this support to be harmonized with MOHCW goals and priorities. The follow-on program will build on the strong links already established in order for the pediatric HIV elimination agenda to come to fruition. The overall activities and targets of these mechanisms have also been articulated in the FY 2012 PMTCT Acceleration Plan. Based on the current national PMTCT program status, four key areas of support have been proposed for the new five year cooperative agreement and for the USG 2012/2013 PMTCT funding cycle: Comprehensive PMTCT services, Pediatric support, care and treatment, Community support strengthening, Monitoring, evaluation and implementation research. VEHICLES - Planned vehicle purchases are unknown at this time.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	250,000
Human Resources for Health	2,200,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's legal rights and protection
Child Survival Activities
Safe Motherhood
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**13692**
Mechanism Name:	**PMTCT Acceleration Service Delivery in Zimbabwe**
Prime Partner Name:	**Organisation for Public Health Interventions and Development**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	580,000	0

Narrative:

In FY 12 the new mechanism will be expected to continue to support the early identification of HIV exposed and infected children and getting them into care.
Major activities will include

- *Strenghtening early diagnosis (through EID/PITC) and enrollment into care and treatment.*
- *Strengthen provision of prophylaxis/follow up.*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	3,799,000	0

Narrative:

In FY12 the USG, through the new mechanism, will continue to expand geographic coverage and to support the provision of quality comprehensive PMTCT services in the new sites. Please reference the FY2012 Zimbabwe PMTCT Acceleration Plan for more details.
Major areas of support will include:

- Support to the MOHCW for the implementation of the 2010 guidelines in all USG supported facilities
- Strengthen the integration of PMTCT with ART, MNCH, RH and other family health delivery systems
- Strengthen monitoring and evaluation/data quality assessments at site level
- PMTCT demand creation activities

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	521,000	0

Narrative:

The new mechanism will be expected to continue to prioritze the treatment of HIV positive pregnant women who require ARVs for their own health.
Major areas of support will include
- *Increasing availability of MCH/PMTCT/ART integrated sites*
- *Strengthening referrals between PMTCT/MCH and ART*
- *Increasing access to CD4 testing for HIV positive pregnant women*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	900,000	0

Narrative:

The new mechanism will continue to support and strenghten pediatric ART care and treatment.
Major area of support will include
- *Support for the implementation of the pediatric HIV/AIDS care and treatment strategy nationwide.*

Implementing Mechanism Details

Mechanism ID: 13889	**Mechanism Name: Vana Batwana Zimbabwe Orphans and Vulnerable Children Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Umbrella Agreement
Prime Partner Name: World Education 's Batwana Initiative	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 7,155,562	

Funding Source	Funding Amount
GHP-State	5,605,562
GHP-USAID	1,550,000

Sub Partner Name(s)

Bekezela	Chiedza Child Care	FACT Chiredzi
FACT Mutare	Hospaz	Howard
Mavambo	Oasis	TBD
Umzingwane Aids Network	Uzumba Orphan Care	

Overview Narrative

The combined effect of AIDS, poverty, drought, and the collapse of the social protection and education systems has placed a heavy burden on Zimbabwe's children and the families caring for those children.

An estimated 1.6 million children, including 1.0 million who have lost one or both parents, have been made vulnerable by the HIV and AIDS epidemic (Zimbabwe National HIV and AIDS Estimates, 2009). However, Zimbabwe's high HIV prevalence rate effectively means that all children in Zimbabwe have been affected by HIV and AIDS to some degree.

Zimbabwe's orphans are primarily cared for by their extended families, including grandparents, although many live in child-headed households. Many orphans live in extremely poor households and are unable to access basic services (education, health care) at the same rate as other children in their community. They are also more likely to suffer from psychological problems, engage in child labor, and be subjected to abuse, discrimination and social stigma. At the same time, although orphanhood contributes to vulnerability, it is not necessarily the only or most important factor in vulnerability. Other key factors include poverty; exposure to violence, abuse and exploitation; displacement; mobility; trafficking; discrimination due to disability, gender and other differences. The last Implementing Mechanism has been providing a comprehensive package of service including health, education and protection services to a cohort of 65,000 children and it is the intent of this new mechanism to continue working with this cohort. VEHICLES - Planned vehicle purchases are unknown at this time.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	350,000

Education	850,000
Human Resources for Health	90,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Family Planning

Budget Code Information

Mechanism ID:	**13889**
Mechanism Name:	**Vana Batwana Zimbabwe Orphans and Vulnerable Children Project**
Prime Partner Name:	**World Education 's Batwana Initiative**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	7,155,562	0

Narrative:

The new mechnism will focus on the following areas: Provide at least three services (education, health, psychosocial, protection, etc.) to a cohort of at least 65,000 orphans and other vulnerable children. Strengthen the capacity of the GOZ social services system to sustainably care for vulnerable children by providing assistance for social services workforce planning, training and development.
Enhance the capacity of communities and local service providers to sustainably care for children and vulnerable families by assisting schools, health centers, child protection committees, case management systems and other relevant groups to develop, implement and maintain sustainable mechanisms to support OVC.
Strengthen vulnerable households to sustainably provide better care for children through economic strengthening and educational activities.

Implementing Mechanism Details

Mechanism ID: 13911	**Mechanism Name: HIV Quality Improvement Project**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: New York AIDS Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 250,000	
Funding Source	**Funding Amount**
GHP-State	250,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This activity is to be conducted under the leadership of the MOHCW Quality Assurance Directorate in close collaboration with CDC Zimbabwe and the US-based HIVQUAL team for technical support. The program will be started in 15 districts of Zimbabwe and will target at least five health centers offering HIV care through the Integrated Management of Adolescent and Adult Illness (IMAI) strategy. Activities in COP12 will focus on program set up, policy development and quality program implementation in these sites. 1) Quality Improvement (QI) training. The USG-MOHCW HIVQUAL team will continue to build capacity for QI in public healthcare facilities and among MOHCW technical staff and healthcare providers. 2) Assessment of quality management programs at the participating clinics. An assessment tool to measure the capacity of the quality management program at each facility will be used to measure the growth of quality management activities as well as the quality of staff members' skills. 3) Performance measurement (at six-month intervals) on selected core indicators. 4) Ongoing QI coaching and mentoring at participating sites. The program will continue to invest in transferring knowledge and skills to local technical advisors in the MOHCW. The transfer of QI skills will be accomplished through coaching and mentoring for MOHCW staff and health care providers. 5) Promotion of consumer engagement in HIV care. HIVQUAL will provide technical assistance to the MOHCW on strategies to develop local, regional, and national

strategies and programs to increase consumer (patient) involvement in HIV/AIDS programs. Vehicle requirements unknown at this time.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	150,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	**13911**		
Mechanism Name:	**HIV Quality Improvement Project**		
Prime Partner Name:	**New York AIDS Institute**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	250,000	0

Narrative:

1) QI training. Advanced in-service trainings will be provided to staff who have received training in prior years. Basic training in QI will be provided to all relevant new staff. Specifically activities will include Training of Trainers workshops to promote decentralization of QI trainings throughout Zimbabwe, and to support the expanded national quality program. 2) Assessment of quality management programs. The findings from these assessments will guide coaching interventions. Aggregated facility-specific data will provide population-level performance data to indicate priorities for national quality improvement activities and campaigns. Similarly, local performance data will be used to identify facility-specific gaps in the delivery packages of care and then devise customized interventions to improve services at local facilities.3) Performance measurement on selected core indicators.

HIVQUAL will continue to develop providers' skills for collecting and using performance data within their own organizations to improve their HIV treatment and care. Indicators will track the provision of the basic treatment and care package. Selected national core indicators will monitor proportions of pediatric patients receiving HAART, ART adherence, Cotrimoxazole prophylaxis, pediatric nutrition, immunizations, growth monitoring and TB screening. Facility-level data derived from the national health information system will be used to improve quality. 4) QI Coaching and Mentoring at participating sites. These QI skills will include performance data interpretation skills, quality program planning and design of quality improvement projects and implementation through improvement project cycles. 5) Consumer engagement in HIV care. This activity, which was started in two sites in late 2009, will include working with the MOHCW to devise a written national plan for consumer involvement. The plan will outline structures to ensure active participation of people living with HIV/AIDS in the development and improvement of HIV/AIDS programs. This will also include a needs assessment to determine local, regional, and national priorities. Regional civil society groups will be engaged at local facility level to identify and solicit diverse community opinions.

Implementing Mechanism Details

Mechanism ID: 16795	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16804	**Mechanism Name: VMMC Scale up**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: ITECH	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 4,450,000	
Funding Source	**Funding Amount**
GAP	354,000
GHP-State	4,096,000

Sub Partner Name(s)

TBD		

Overview Narrative

The overarching goal of this program is to contribute towards a reduction in HIV incidence in Zimbabwe by scaling up voluntary medical male circumcision (VMMC). Intervention studies in multiple African countries have demonstrated that voluntary medical male circumcision can reduce a man's risk of acquiring HIV by 60%.Traditionally, Zimbabwe has not been a circumcising country, with only about 9% of the male population circumcised. Recent national data demonstrates an increase in HIV prevalence amongst adult males. The Zimbabwe Ministry of Health and Child Welfare estimates that achieving 80% VMMC coverage among all adult and new born males by 2015 could avert ~750,000 new infections by 2025. Currently, only about 91,000 VMMC have been conducted, and a mix of innovative approaches to rapidly increase demand and expand access to VMMC is needed to impact the epidemic.

The main objective of this program is to scale up VMMC services in selected provinces in Zimbabwe as part of a comprehensive HIV prevention package. The project will establish facility based VMMC sites in target provinces, train outreach teams to develop community-based campaigns to generate demand for VMMC and establish mobile or satellite VMMC sites. The target is to complete VMMC on 40,000 uncircumcised males aged 15-49 years in the 2013 financial year. Monitoring and Evaluation activities will be done through regular data collection and quality assessments and review of quaterly program reports. There will be dedicated staff to monitor and ensure quality service provision. Mid-term and end of program evaluations are planned

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,000,000
Motor Vehicles: Purchased	900,000
Renovation	100,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	**16804**		
Mechanism Name:	**VMMC Scale up**		
Prime Partner Name:	**ITECH**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	4,450,000	0

Narrative:

The purpose of this program is to scale up Voluntary Medical Male Circumcision as an evidence-based biomedical prevention intervention in Zimbabwe within the concept of “combination HIV prevention strategies”.

Zimbabwe has traditionally not been a circumcising country, with only about 9% of the male population circumcised. However, intervention studies done in recent years in multiple African countries have demonstrated that voluntary medical male circumcision (VMMC) can reduce a man’s risk of acquiring HIV by 60%. In addition, although overall HIV prevalence among 15-49 year old males in Zimbabwe is 15%, the most recent Demographic Health Survey (2010-11) demonstrates dramatic increases in HIV prevalence from 3.4% among males aged 15-19 years to 29.9% among males 45-49 years of age. The Ministry of Health and Child Welfare (MOHCW) estimates that achieving 80% VMMC coverage among all adult and new born males by 2015 could avert ~750,000 new infections by 2025. Currently, only about 91,000 VMMC have been conducted, and a mix of innovative approaches to rapidly increase demand and expand access to VMMC is needed to impact the epidemic.

The first year of the project will focus on adult male VMMC service delivery scale-up in selected districts as determined by the Zimbabwe Ministry Health. Sites may be expanded or reduced in later years of project award. The aim is to establish 10 facility based VMMC sites within three months of commencement of activities and further create 25 mobile or satellite VMMC sites in targeted districts within the first year of implementation. Other strategies will include the establishment of 15 outreach teams mandated to develop community based campaigns aimed at generating demand for VMMC in addition to performing VMMC procedures. Vehicles will be purchased as needed to facilitate outreach. By the end of the 2013 financial year, the target is to complete VMMCs on 40,000 uncircumcised males as part of a comprehensive HIV prevention package consisting of HIV prevention education, risk

reduction counselling, HIV testing and counselling, provision of condoms, prevention with positives, etc. Males identified as HIV infected will be counselled and referred for further treatment. Dedicated staff will be assigned to each implementing district to monitor service provision and ensure quality. Monitoring and Evaluation activities will be done through regular data collection and review of quarterly program reports. Rigorous data will be collected on occurrence of any adverse events. Mid-term and end of program evaluations will be incorporated in the work plan . The PrePex device was recently piloted in Zimbabwe and found to be safe for use in male circumcisions delivered by both physicians and nurses. It was also found to be highly acceptable as a circumcision method by participants in the study as well as their partners. Training on use of the device is anticipated to commence in the near future as part of the VMMC program, and once approval for PrePex use has been granted by the WHO, the country will be able to purchase devices using PEPFAR and other funding. This will be beneficial in further scaling up VMMC services as it will be possible to shift from a predominantly physician led to a nurse led program. With the necessary policy changes, the project will incorporate use of the PrePex device in both adults and adolescents.

Implementing Mechanism Details

Mechanism ID: 16805	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16806	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 16813	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 17013	**Mechanism Name: Department of State Public Affairs Section**
Funding Agency: U.S. Department of State/Bureau	Procurement Type: Grant

of African Affairs	
Prime Partner Name: Department of State/AF - Public Affairs Section	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 205,000	
Funding Source	**Funding Amount**
GHP-State	205,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The overarching goals of the Public Affairs Section (PAS) is to increase the Zimbabwean public's understanding and awareness of PEPFAR contributions, and to strengthen the health sector's communications abilities in the national – and global – response against HIV/AIDS in Zimbabwe. PAS works with groups not specifically targeted by other programs, including individuals, the media, student leaders and well-known artists and cultural figures, who spread the messages effectively to larger groups.

PAS will attempt to reach a wide geographic region, including less frequently visited regions of the country, and economically disadvantaged rural and high-density areas. For example, Mbare is arguably the most crowded area outside of the capital; its bustling trade markets and everyday business locations (bars, hair salons, etc.) are ripe but untapped information outlets. PAS will support information, communication and education (IEC) material distribution in locations frequented by at-risk populations, particularly traders of all ages and genders.

Target audiences include students, faculty and administrators in academia; the media; members of the public; religious and tribal leaders; and civil society organizations. We will also reach out through PAS' three American Corners in Manicaland, Midlands and Bulawayo Provinces.

PAS will also work with the Ministry of Health and Child Welfare to strengthen its media capacity. A monitoring, evaluation and reporting template will be developed in line with the State Department's Mission Activity Tracker and PEPFAR reporting mechanisms.

Cross-Cutting Budget Attribution(s)

Education	20,000
Gender: GBV	20,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Mobile Population
Workplace Programs
End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**17013**
Mechanism Name:	**Department of State Public Affairs Section**
Prime Partner Name:	**Department of State/AF - Public Affairs Section**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	40,000	0

Narrative:

PAS will work with campus groups, and will produce and distribute a musical DVD made by young people living with HIV in tandem with local personalities. A second outreach tool will incorporate new media technology in sharing stories about stigma, service provision, and prevention.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	OHSS	38,000	0

Systems			

Narrative:

PAS systems strengthening activities will focus on media training and development with the Ministry of Health and Child Welfare (MOHCW). PAS is supporting the construction of a public space at an adolescent resource center at an OI clinic to accommodate public lectures and presentations. PAS will also support the production of information, communication and education materials for distribution in densely populated areas such as Mbare's upcoming Disease Advisory Centre. The Center will be equipped with computers to aid access to HIV/AIDS related information by local communities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	90,000	0

Narrative:

PAS will work with out-of school boys and girls aged between 16-25. These will be linked with well established artists who will mentor the upcoming artists to produce positive HIV/AIDS messages that will be communicated through art, music, theatre and dance. PAS will support the production and distribution of a wide range of information, communication and education materials for distribution in trade markets, hair saloons and other national events such as the World AIDS Day Commemoration and International Candlelight Memorial, Commemoration of 365 Days of Gender activism as well as cultural/musical outreach programmes nationwide.

PAS will expand the sports for HIV/AIDS program successfully done with male soccer players and work with female soccer netball/soccer players. The idea is to enlighten women about HIV prevention and opportunities presented by knowing one's status and taking up readily available ARVs. Specific activities will include utilizing females who can promote themselves as ambassadors for HIV counseling and testing in their respective areas.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	37,000	0

Narrative:

PAS will replicate HIV/AIDS awareness raising projects amongst mobile populations such as drivers, conductors and touts in a variety of provinces. Specific activities include HIV prevention awareness raising; training of combi crews and workplace programers like peer educators. Mobile populations are considered high risk populations and key drivers for HIV infection.

Implementing Mechanism Details

Mechanism ID: 17015	**Mechanism Name: Department of state Ambassador"s Self-Help Fund**
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: Grant
Prime Partner Name: State/AF Ambassador's PEPFAR Small Grants Program	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 40,000	
Funding Source	**Funding Amount**
GHP-State	40,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Ambassador's PEPFAR Self-Helf Fund's objective is consistent with PEPFAR Country Operational Plan (COP) guidance for small grants and existing Ambassador's Special Self-Healp Program guidelines. The program expands teh Zimbabwe Mission's engagement of local partners through support and care activities, including orphans and vulnerable children. The goal of teh expanded program is to fund projects proposed by local communities seeking economic strengthening, nutritional support, education assistance, and access to water for persons affected and infected by HIV/AIDS. Our activities will benefit adults, children, and youth who are directly affected by HIV/AIDS.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	20,000
Education	10,000
Water	1,000

TBD Details

(No data provided.)

Key Issues

Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID:	**17015**
Mechanism Name:	**Department of state Ambassador"s Self-Help Fund**
Prime Partner Name:	**State/AF Ambassador's PEPFAR Small Grants Program**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	19,000	0

Narrative:

Ambassador Self-Helf Fund plans to award $20,000 to local communities in the area of Adult Care and Support (HBHC). Individual award will range from $5,000 to $15,000 and will be selected from submitted proposals. Examples of activities we expect to fund include income generating projects like peanut butter making mills, grinding mills, and brick molding. Access to clean water projects such as boreholes are among other types of project proposals that will be financed. Lastly, we expect to fund nutritional projets like market gardens and water irrigation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	21,000	0

Narrative:

Ambassador Self-Helf Fund plans to support children affecty by HIV/AIDS including support to orphanges and schools to provide essential care and support services to OVCs. Individual awards will range from $5,000 to $15,000 and will be selected from submitted proposals.

USG Management and Operations

Assessment of Current and Future Staffing.

Redacted

Interagency M&O Strategy Narrative.

Redacted

USG Office Space and Housing Renovation.

Redacted

Agency Information - Costs of Doing Business
U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services		15,000	3,000	18,000
ICASS		239,500	190,000	429,500
Institutional Contractors		111,700	48,300	160,000
Management Meetings/Professional Developement		35,000	20,000	55,000
Non-ICASS Administrative Costs		90,000	6,200	96,200
Staff Program Travel		40,000	25,000	65,000
USG Staff Salaries and Benefits		1,060,812	907,500	1,968,312
Total	**0**	**1,592,012**	**1,200,000**	**2,792,012**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		15,000
Computers/IT Services		GHP-USAID		3,000
ICASS		GHP-State	Embassy levy on new ICASS costs	239,500

			for USAID	
ICASS		GHP-USAID	Embassy levy on new ICASS costs for USAID	190,000
Management Meetings/Professional Developement		GHP-State		35,000
Management Meetings/Professional Developement		GHP-USAID		20,000
Non-ICASS Administrative Costs		GHP-State		90,000
Non-ICASS Administrative Costs		GHP-USAID		6,200

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

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Capital Security Cost Sharing	20,994			20,994
Computers/IT Services		204,000		204,000
ICASS	850,000			850,000
Institutional Contractors	257,871			257,871
Management Meetings/Professional Developement	148,274			148,274
Non-ICASS Administrative Costs	600,326			600,326
Non-ICASS Motor Vehicles	25,800			25,800
Staff Program Travel	126,520			126,520

USG Staff Salaries and Benefits	2,241,215	25,000		2,266,215
Total	**4,271,000**	**229,000**	**0**	**4,500,000**

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		20,994
Computers/IT Services		GHP-State		204,000
ICASS		GAP		850,000
Management Meetings/Professional Developement		GAP		148,274
Non-ICASS Administrative Costs		GAP		600,326
Non-ICASS Motor Vehicles		GAP		25,800

U.S. Department of State

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
USG Staff Salaries and Benefits		57,000		57,000
Total	**0**	**57,000**	**0**	**57,000**

U.S. Department of State Other Costs Details