United States Department of State

Washington, D.C. 20520

January 16, 2019

INFORMATION MEMO FOR AMBASSADOR NICHOLS, Zimbabwe

FROM: S/GAC – Ambassador Deborah L. Birx, MD

SUBJECT: FY 2019 PEPFAR Planned Allocation and Strategic Direction

We are grateful to you, Ambassador Nichols, and your Deputy Chief of Mission, for your engagement in planning, review and implementation, and with the community and Government to enhance PEPFAR program impact. We are appreciative for your attention to core policy adoption and holding partners to account and performance for improved outcomes and greater impact. Finally we are grateful to your incredible PEPFAR staff in country, working together across agencies to ensure the most effective and efficient use of taxpayer dollars. We recognize the very difficult economic and social situation in Zimbabwe, and deeply appreciate how well the team has continued to perform, despite these daunting circumstances. It is both instructional and inspirational.

As Zimbabwe approaches epidemic control, the country team is struggling to find the remaining undiagnosed persons living with HIV (PLHIV) and bring them into treatment, as demonstrated by achieving 102% of the testing targets, but only 51% of the target for HTS_TST_POS. Young men living with HIV, particularly, have been difficult to find and bring into treatment. During FY 2019, we expect that Zimbabwe will achieve epidemic control in the majority of age groups and geographic areas, and will lay the groundwork for key interventions to maintain control in those populations in COP19. We look forward to seeing the results from the integrated HIV Testing Services (iHTS) model, which should accelerate progress by employing testing strategies and resources that are appropriate for the local context.

As the program continues to focus on case-finding for the remainder of COP18, the number of positives left to be identified will decrease, making efforts incrementally more challenging, especially with facility-based testing. Increasingly, case-finding will require specific investigations; for COP18, we anticipate continued and improved success with index testing and targeted self-testing as those interventions are scaled, and will be following the pace of scale-up closely. We also expect that the new targeting strategy for provider initiated testing and counseling (PITC) will help lower the volume of testing and improve the yield. For COP19, once epidemic control has been achieved, the program should pivot from indiscriminate case-finding to a greater focus on sexual network tracing (index testing) and even more highly targeted facility testing for specific populations by modality, with a reliance on a solid surveillance system and use of recency testing to identify transmission hotspots. As such, it will be important to ensure that the surveillance system is well-established and rising to national scale by COP19.

Given the difficulties finding the remaining PLHIV, the team must ensure that all those who test positive are linked to treatment. The improvements in linkage that were demonstrated over the

past year must continue. In order to maximize the impact of the program and reduce transmission, it is critically important to ensure that all patients have access to viral load (VL) testing, and that at least 95% of those who are tested have a suppressed VL. This will require dedication of sufficient resources to allow for scale-up in VL testing and additional efforts to expand the successful models of differentiated service delivery.

An important shortcoming that must be addressed in COP19 is the currently stalled TB Prevention Treatment (TPT). It is expected that by the end of COP20, all PLHIV will have completed a course a TPT, and the team should plan accordingly in COP19 to ensure that Zimbabwe is on track to meet that expectation.

We recognize the strong collaborative relationship with the Ministry of Health and Child Care, and request continued advocacy on the full transition to dolutegravir-based antiretroviral therapy. This regimen is integral to an improvement in patient care and should be rolled out in full during FY19. In addition, we request additional advocacy to get the Ministry of Health to implement the policy on TB Preventive Treatment for PLHIV. We continue to appreciate all of the hard work done with your Front Office and all of the agencies in Zimbabwe to ensure that the national government policy align with the significant evidence base, to provide all Zimbabweans living with HIV with the lifesaving treatment they need.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) total planning level for Zimbabwe for the 2019 Country Operational Plan (COP 2019) is **$145,000,000**, inclusive of all new funding accounts and applied pipeline.

If you have questions about the priorities and guidance laid out in this letter, please contact your Chair and Program Manager. My office is continually grateful for your team's work on the PEPFAR program, helping us to move towards an AIDS-free generation by supporting the HIV response in Zimbabwe.

APPENDICES:

1. **COP 2019 PLANNING LEVEL**
2. **COP 2019 BUDGETARY REQUIREMENTS & GUIDANCE**
3. **PAST PERFORMANCE**
4. **COP 2019 DIRECTIVES**

APPENDIX 1: COP 2019 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the FY 2018 Q4 POART and performance information, the total COP 2019 planning level is estimated to be comprised as follows:

Table 1. COP 2019 Budget

Zimbabwe TOTAL COP 2019 PLANNING LEVEL: $145,000,000			
Total Base Budget for COP 2019 Implementation			**$ 145,000,000**
Total COP 19 New Funding	$	110,000,000	
of which, VMMC	*$*	*31,212,878*	
of which, DREAMS	*$*	*15,310,785*	
Total Applied Pipeline	$	35,000,000	
Total Faith Based Organization (FBO) Initiative Funding (FY 18 Funds)			**$ 11,000,000**

**Funding for the VMMC program must be at least the amount noted here; however, this total can come from both new and pipeline funds.*

Table 2. Applied Pipeline

ZIMBABWE	
COP 2019 APPLIED PIPELINE	
Total Applied Pipeline	$35,000,000

All planning levels are subject to further adjustment, **based upon appropriations**, further analysis determining the availability of excessive pipeline, and other developments during the course of COP 2018 implementation and the COP 2019 review process. The total spend in the implementation of COP 2019 (FY 2020) may not exceed the total COP 2019 planning level of $145,000,000.

Central Funding

Zimbabwe is also receiving $11,000,000 in Central Funds as a part of the FBO Initiative, of which USAID will receive $5,210,700, and CDC will receive $5,789,300. These FY 2018 funds are being notified to you via this letter; however, note that these funds are being released immediately, ahead of the release of the bilateral COP 2019 funds. Central Funds for the FBO Initiative should be used as soon as possible after receipt, during the current implementation cycle of COP 2018/FY 2019. Each country team should specify the purpose and use of these funds (based the data and analysis from the recent FBO TDYs) as part of the SDS.

APPENDIX 2: COP 2019 BUDGETARY REQUIREMENTS

Table 3. COP 2019 Earmarks

Zimbabwe COP 2019 EARMARK REQUIREMENTS	
Care and Treatment (C&T)	$ 71,038,239
% of base funds allocated to C&T	*65%*
HKID	$ 17,397,120
Gender Based Violence (GBV)	$ 1,821,275
Water	$ 125,000

Care and Treatment: If there is no adjustment to the COP 2019 new funding level due to an adjustment in applied pipeline, Zimbabwe's minimum requirement for the care and treatment earmark is reflected in the chart above. Your care and treatment requirement is calculated as the sum of total new FY 2019 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS budget codes, 30% of the total funding programmed to the MTCT budget code, 80% of the total funding programmed to the HLAB budget code, and 30% of the total funding programmed to the HVCT budget code. This minimum care and treatment earmark has been derived based upon a requirement that your country programs a minimum of 65% of all **new FY 2019 Base Funds** to care and treatment of people living with HIV.

HKID Requirement: Zimbabwe's COP 2019 minimum requirement for the HKID budget code is reflected in the chart above. The COP 2019 HKID requirement is derived based upon the approved COP 2018 HKID level. The COP 2019 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): Zimbabwe's COP 2019 minimum requirement for the GBV earmark is reflected in the chart above. The GBV earmark requirement is calculated as the total **new FY 2019** funding programmed to the GBV cross-cutting code. The COP 2019 earmark is derived by using the final COP 2018 GBV earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Zimbabwe's COP 2019 minimum requirement for the water earmark is reflected in the chart above. The water earmark requirement is calculated as the total **new FY 2019 funding** programmed to the water cross-cutting code. The COP 2019 earmark is derived by using the final COP 2018 water earmark allocation as a baseline. The COP 2019 planned level of new FY 2019 funds for water can be above this amount; however, it cannot fall below it.

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of

these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal **by agency** by the end of FY20, and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each Zimbabwe agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP 2019 submission.

COP 2019 Applied Pipeline

All agencies in Zimbabwe should hold a 4 month pipeline at the end of COP 2019 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP 2018 implementation (end of FY 2019) with a pipeline in excess of 4 months is required to apply this excessive pipeline to COP 2019, decreasing the new funding amount to stay within the planning level.

The Applied Pipeline amount of $35,000,000 given by S/GAC as a part of the COP 2019 planning level has been calculated to reflect the projected excessive pipeline as of the beginning of the COP 2019 implementation cycle (FY 2020), and is the minimum amount that Zimbabwe must apply as pipeline in the COP 2019 submission. As a special notification country, Zimbabwe was previously required to maintain a buffer of 9 months allowable pipeline. With the reduction of the buffer to 4 months of allowable pipeline, we estimate that PEPFAR Zimbabwe should have at least $35,000,000 in excessive pipeline.

Expired funds, funds on expired mechanisms and projected FY 2019 outlays as submitted in the EOFY report were all taken into consideration to inform the projected excessive pipeline and the required COP 2019 applied pipeline amount.

Unliquidated obligations on closed mechanisms identified in the FY 2018 EOFY report should be de-obligated in a timely manner. This will continue to be monitored throughout FY 2019 (COP 2018 implementation) and into COP 2019.

APPENDIX 3: PAST PERFORMANCE TRENDS

Table 4. COP 2017/ FY 2018 Outlays versus Approved Budget

Row Labels	Sum of Approved COP 2017 Planning Level	Sum of Total FY 2018 Outlays	Sum of Over/Under Outlays
Zimbabwe	**$ 127,095,077**	**$ 116,612,749**	**$ (10,482,328)**
HHS/CDC	$ 34,675,678	$ 33,828,525	$ (847,153)
State	$ 382,000	$ (209,559)	$ (672,559)
USAID	$ 92,037,399	$ 82,922,558	$ (9,114,841)
DOD	$ -	$ 152,225	$ 152,225
Grand Total	**$ 127,095,077**	**$ 116,612,749**	**$ (10,482,328)**

** State obligations and outlays have not yet been reconciled and the numbers in this table may change based on reconciliation.*

Zimbabwe's total FY 2018 outlay level of $116,612,749 is under your approved spend level of $127,095,077 (COP 2017 budget). Within this total, DOD agencies spent above its approved FY 2018 budgets and HHS, State, and USAID spent below their approved level. Agencies outlaid to the following Implementing Mechanisms 125% or more in excess of their COP2017 approved planning level.

Table 5. IP FY18 Outlays

***** *This table was based off the FY18 EOFY submissions, but edited to reflect OPU's as of January 15th, 2019. Agencies outlaid to the following Implementing Mechanisms 125% or more in excess of their COP17 approved planning level*

Mech ID	Prime Partner	Funding Agency	COP17/FY18 Budget (New funding + Pipeline + Central)	Actual FY18 Outlays ($)	Over/Under FY18 Outlays (Actual $ - Total COP17 Budget $)
12893	Building Health Data Dissemination and Information Use Systems	HHS/CDC	$ -	$ 5,798	$ 5,798
13152	Surveys, Evaluation, Assessments, and Monitoring	HHS/CDC	$ -	$ 87,919	$ 87,919
13173	Strengthening Infection Control and Prevention in Health Care Facilities in Zimbabwe under the President's Emergency Plan for AIDS Relief (PEPFAR)	HHS/CDC	$ -	$ 39,778	$ 39,778
17885	BRTI Follow-on	HHS/CDC	$ 500,000	$ 695,276	$ 195,276
70474	Rapid Test Kit (GHSC-RTK) Procurement	USAID	$ -	$ 71,466	$ 71,466

Table 6. COP 2017/ FY 2018 Results versus Targets*

** Financial and target performance data not a one-to-one match as program classification expenditures encompass more than those towards indicator/target presented.*

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Agency	Indicator	FY18 Target	FY18 Result	% Achievement	Program Classification	FY18 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	1,418,358	1,310,505	92%	HTS	$ 2,381,492	80%
	HTS_TST_POS	148,486	66,751	45%			
	TX_NEW	147,525	59,030	40%	C&T	$ 10,280,078	20%
	TX_CURR	451,539	464,730	103%			
	VMMC_CIRC	105,630	70,494	67%	PREV: CIRC	$ 8,558,213	90%
HHS/HRSA	OVC_SERV	N/A	N/A	N/A	SE for OVC	$ 0	0%
					Above Site Programs	$ 4,370,388	
					Program Management	$ 6,529,554	
	HTS_TST	N/A	N/A	N/A	HTS	$ 0	0%
	HTS_TST_POS	N/A	N/A	N/A			
	TX_NEW	N/A	N/A	N/A	C&T	$ 872,094	0%
	TX_CURR	N/A	N/A	N/A			
	VMMC_CIRC	N/A	N/A	N/A	PREV: CIRC	$ 0	0%
	OVC_SERV	N/A	N/A	N/A	SE for OVC	$ 0	0%
					Above Site Programs	$ 0	
					Program Management	$ 237,682	
State/AF	HTS_TST	N/A	N/A	N/A	HTS	$ 0	0%
	HTS_TST_POS	N/A	N/A	N/A			
	TX_NEW	N/A	N/A	N/A	C&T	$ 103,300	0%
	TX_CURR	N/A	N/A	N/A			
	VMMC_CIRC	N/A	N/A	N/A	PREV: CIRC	$ 0	0%
	OVC_SERV	N/A	N/A	N/A	SE for OVC	$ 101,421	100%
USAID					Above Site Programs	$ 73,007	
					Program Management	$ 0	
	HTS_TST	1,285,497	1,442,436	112%	HTS	$ 6,765,213	80%
	HTS_TST_POS	146,583	79,786	54%			
	TX_NEW	130,188	60,553	47%	C&T	$ 35,402,569	70%
	TX_CURR	532,963	503,960	95%			
	VMMC_CIRC	200,514	198,001	99%	PREV: CIRC	$ 18,457,401	99%
	OVC_SERV	354,704	307,429	87%	SE for OVC	$ 12,189,353	97%
					Above Site Programs	$ 2,719,244	
					Program Management	$ 18,085,401	

COP 2017/ FY 2018 Performance

Overall in FY 2018, PEPFAR/Zimbabwe achieved 98% of the TX _CURR target for FY 2018, with 968,690 PLHIV on ART, but did not reach the TX_NEW target (44.4% achievement). Zimbabwe also significantly over-tested this FY, by testing 11% more people than in FY 2017, and finding 10% fewer positives and only achieving 50.7% of the HTS_TST_POS target. The VMMC_CIRC (87.7% achievement) and OVC_SERV (86.7% achievement) also under-performed in FY 2018.

- **OPHID**, funded by USAID, with $1.8 million for testing, found 56,446 PLHIV and achieved 48.9% of the HTS_TST_POS target and achieved 44% of the TX_NEW target. OPHID spent 98% of the total approved budget.
- **ITECH**, funded by CDC with $2.1 million for testing, found 61,619 PLHIV and achieved 44.4% of the HTS_TST_POS target and achieved 44.4% of the TX_NEW target. ITECH spent 98% of the total approved budget.
- **PSI**, funded by USAID with $3.1 million testing, found 15,356 PLHIV and achieved 70% of the HTS_TST_POS target. PSI spent 100% of the total approved budget.
- The testing volume of provider initiated counseling and testing (PITC) increased from 2017 to 2018, but the HIV positive yield decreased, dropping to 4.5%.
- The scale of index testing is increasing appropriately, both in the facility and in the community, but yields fell to 30% overall; **ITECH** reported yields of 21% in the facility and 10% in the community, **FHI 360** reported yields of 42% in the community, and **PSI** reported yields of 47% in the facility and 43% in the community.
- Linkage has improved considerably, rising to 86% for both females and males by the end of FY 18; overall, **OPHID**, **ITECH** and **ZACH** demonstrated successful linkage (generally above 85%, except in men younger under 24 years, where linkage rates were just below 80%), linkage rates for **PSI** were below 40% in almost all age/sex groups, calling into question how the program is ensuring that those identified by PSI are linked to facilities for treatment.
- There are persistent problems in reaching men with HIV: the ART coverage rates among men in age groups between 20 and 35 are generally well-below 70%, especially for men aged 20-24.
- VL testing coverage was 40%, lower than the targeted 60%, and primarily the result of insufficient resources for reagents; among those tested, VL suppression was 86% - with a trend of superior VL suppression in older age groups.
- VMMC dramatically increased over FY 18, with **PSI** reaching almost 99% of their target and **ITECH** reaching only 67%; almost 60% were in males above 15 years of age.

APPENDIX 4: COP 2019 DIRECTIVES

Table 7. COP 2019 (FY 2020) Targets

Based on current progress towards epidemic control and funding level, the following FY 2020 treatment targets are recommended for Zimbabwe:

	Pediatric (<15) Treatment Target	Adult Men (15+) Treatment Target	Adult Women (15+) Treatment Target	Treatment Target Total[a]
COP 18 (FY 19 Targets)				
TX_NEW (New on Treatment)	6,304	45,144	54,657	106,105
TX_CURR (Current on Treatment)	62,267	367,424	607,362	1,037,053
TB_PREV				41,769
VMMC_CIRC		306,144		306,144
COP 19 (FY 20 Targets)				
TX_NEW (New on Treatment)	19,566	169,516	160,700	349,782
TX_CURR (Current on Treatment)	78,720	518,568	737,694	1,334,982
TB_PREV				585,411
VMMC_CIRC		300,000		300,000
National Treatment Coverage				
Treatment Coverage	90%	90%	90%	90%

[a]Targets should be further allocated by age and sex based on disaggregated PLHIV estimates and unmet need for ART.

These targets were developed based on the following assumptions:

- TX_NEW: Targets for TX_NEW assume that 95% of TX_CURR patients are retained from year to year, and that 90% of the TX_NEW target will be retained and thus contribute to the required TX_NET_NEW to achieve the TX_CURR target. Zimbabwe should consider has they move to Epidemic Control how they can exceed these minimum requirements.
- TX_CURR: TX_CURR targets were generated to move Zimbabwe to 95-95-95 at the country-level based on preliminary UNAIDS 2018 PLHIV and ART coverage estimates. In order to achieve this target, the team needs accurate reporting and minimization of loss and mortality.
- For Zimbabwe this means not only reaching 95-95-95 with service delivery at the sites with site level PEPFAR support, but working to assure that 95-95-95 is achieved at a national level.
- TB_PREV: Targets for TB_PREV were calculated using an Excel-based tool that utilized (among other considerations) estimated number of patients expected to be on ART at the start of COP 2019 who would screen negative for TB symptoms, the

proportion likely to be ineligible for clinical reasons, the estimated number who would have already received TPT by the start of COP 2019 and projected enrollment and completion rates.

- VMMC_CIRC: Targets for VMMC were developed based on current coverage, past performance, and available funding for prevention activities.

If COP 2018 targets and activities, including full execution of the iHTS model, are implemented with fidelity, the number of people living with HIV/AIDS that are undiagnosed at the start of COP 2019 should be minimal. In COP 2019, the iHTS model should be revised and highly targeted to identify the number of undiagnosed PLHIV in each district by age/sex, and strategies to link and retain everyone on ART should be firmly in place. Prevention programs should continue to focus on the specific groups for maximum impact, and above site programs should be aligned and expanded to ensure there is a clear path to sustainability as Zimbabwe achieves epidemic control; most importantly, a reliable surveillance system should be established, with plans for case-based surveillance and use of unique IDs, and capacity for dependable commodity procurement should be built.

COP 2019 Minimum Requirements

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements no later than the beginning of COP19 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs. Failure to meet any of these requirements by FY 2020 will result in reductions to the Zimbabwe budget.

Table 8. Minimum Requirements

Minimum Requirement	Zimbabwe Specific Guidance (if applicable in COP18 or COP19)
1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups.	Zimbabwe has adopted Test and Start and same-day ART is fully available to all age, sex and risk groups.
2. Adoption and implementation of differentiated service delivery models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents.	Zimbabwe has 5 adult models for DSD and a highly effective treatment support DSD model for adolescents; the program goal is to get at least 80% of patients enrolled into one form of DSD by December 2020.
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of nevirapine-based regimens.	The MOHCC has adopted a transition policy, to be implemented by May 2019. TA should be provided to support the MOHCC in expanding TLD policy.
4. Scale up of Index testing and self-testing, and enhanced pediatric and adolescent case	Zimbabwe has been implementing both index and self-testing since COP17; both are being

finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established.	scaled through COP18. IPV is not routinely monitored at present, but plans are in place to formalize IPV screening in all IP SOPs.
5. TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package.	Though there is an existing national policy, advocacy and TA are needed to support implementation and expansion.
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Linkage rates have improved; however, Q4 data found low linkage rates among adolescents, especially adolescent men. COP19 planning should ensure IP focus to increase treatment coverage.
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC and TB services, affecting access to HIV testing and treatment and prevention.	There are generally no user fees in Zimbabwe; however, as a result of the recent economic situation, some facilities are charging user fees to maintain procurement. PEPFAR is monitoring and intervening where possible.
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.	Given the existing limited VL resources and low VL coverage, PEPFAR/Zimbabwe should work with stakeholders on re-allocation of resources to expand coverage.
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	The Zimbabwe PEFPAR team does not routinely report morbidity and mortality, but has plans to develop this capacity in COP18 and COP19
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management.	SDS should include details on how OVC program is used to enhance pediatric and adolescent retention.
11. Evidence of resource commitments by host governments with year after year increases.	Discussions with the MoH on sustainability and transfer of expense to GoZ have begun, but given the current economic situation, resource commitments from GoZ are limited. GoZ does commit towards HIV commodities, spending over 30 million USD in 2018, and there are plans to earmark funds from the national health levy towards HER implementation in at least two districts.
12. Clear evidence of agency progress toward local, indigenous partner prime funding.	Discussion are underway and evidence will be evinced and provided in the SDS.

13. Scale up of unique identifier for patients across all sites.	Implementation is underway and plan to scale will be clarified in strategic planning in February and will be indicated in SDS.

In addition to meeting the minimum requirements outlined above, it is expected that Zimbabwe will ensure appropriate progress towards viral load management and improved use of efficient testing strategies.

Table 9. Other Requirements

Requirement	OU Specific Guidance (if applicable in COP18 or COP19)
1. Viral load management: Country policy updated.	Zimbabwe has capacity to test all PLHIV, and maintains a diversified platform. Challenges remain with adequate resources for reagents; will prioritize in COP19
2. Screen better and test smarter: Stop over-testing.	Zimbabwe has debuted a nuanced testing strategy for COP18 that uses epidemiologic and program data to determine priority of testing strategies; as the program attains epidemic control, the majority of testing will be through index testing and the strategic use of self-testing to reach marginalized populations, supported with highly targeted (primarily diagnostic) facility testing.

COP 2019 Technical Priorities

<u>Tuberculosis</u>

PEPFAR OUs are expected to offer Tuberculosis Preventive Treatment (TPT) as a routine part of HIV care, which means that all care and treatment partners are expected to offer TPT and report on it. Programs are expected to fully scale TPT over the next two years, such that all PLHIV who are on treatment and are eligible for TPT have received a course by the end of COP 2020. Therefore, the TB_PREV targets included in this letter were set as described above under the target table. For COP 2019, the number of patients that are expected to complete a course of TPT in OU is 585,411, approximately half the total number of eligible PLHIV, per the mandate from S/GAC to fully scale TPT over the next two years. COP 2020 TB_PREV targets will cover the remaining 50% of the eligible PLHIV on ART, adjusted upward for those that will be newly enrolled in ART during the COP 2019 implementation period. In order to ensure successful programming, it is expected that, at a minimum, $3,278,301 will be budgeted for TPT commodities.

DREAMS

Zimbabwe is allocated $15,310,785 funding for DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) programming in COP 2019, of which $2,453,912 of your COP 19 HVAB budget code needs to be part of your DREAMS programming. This funding is allocated within your COP 2019 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2019 Guidance. All new funding allocated to AGYW prevention programming, including DREAMS, must be allocated to the AGYW Prevention cross-cutting budget code.

Zimbabwe needs to strengthen HIV and violence prevention programming for 9-14 year old girls through strong collaboration and planning across OVC and DREAMS. The team must ensure that all curricula reaching DREAMS beneficiaries aligns to curriculum fidelity and complies with DREAMS and COP 2019 guidance, regardless if implemented by a DREAMS or OVC partner. In addition, the team should institute the use of mentors and peer leaders within the DREAMS program to help recruit and retain AGYW. Attention should be given to pathways for promotion from a DREAMS beneficiary to mentor and DREAMS Ambassador or peer leader.

VMMC

Zimbabwe is allocated $31,212,878 funding for VMMC. As with COP 2018, your total COP 2019 allocation to the CIRC budget code is included in your COP funding determined in this letter. VMMC funding must be used exclusively to support the implementation of VMMC programs in males 10 years and older as pursuant with the CIRC budget code guidance, including the minimum package of clinical and prevention services which must be included at every VMMC delivery point, circumcisions supplies and commodities, communication and demand creation, training, and case finding and linkages for high-risk men.

Zimbabwe's total VMMC target for COP 2019 is 300,000 and a minimum of 192,000 circumcisions should be done in men over age 14.

	COP19					
	target	**Total $**	**VMMC coverage 15-24**	**VMMC coverage 15-49**	Minimum % 15+	Minimum VMMC in 15+
Zimbabwe	300,000	31,212,878.25	19.00	14.00	64.00	192,000.00

Cervical Cancer Screening and Treatment:

Alongside COP 2018, Zimbabwe was allocated a total of $4,900,000 in two-year Central Funds for Cervical Cancer Screening and Treatment programming. These Central Funds were provided in order to reduce morbidity and mortality of women on ART in Zimbabwe by increasing the screening of HIV positive women for cervical cancer and the treatment for pre-invasive cervical lesions. The COP 2019 target for screening HIV positive women for cervical cancer is 205,433, calculated as 50% of women 25-49 on treatment per the number of women on ART for the 25-49

year old age band in Zimbabwe at the end of COP 2017 / FY 2018 implementation period. A detailed description of implementation status and scale-up plans is requested within the Strategic Direction Summary for COP 2019.

Addressing Gaps in Epidemic Control, including by Enhancing Engagement with Faith Communities

Zimbabwe has been selected as one of the countries to receive Central support through the FBO and Community Initiative in the amount of $11,000,000, *in order to accomplish these priority activities, as identified per the FBO TDY visits*.

Of this total, USAID will receive $5,210,700, and CDC will receive $5,789,300. These funds are to be used to engage those who work in high burden areas (including informal settlements) with faith communities, such as local faith-based and traditional networks, local faith-based and traditional organizations, as well faith and traditional leaders. Of this total, 50% should be invested in case-finding for young adult men, adolescents, and children living with HIV; and 50% should be invested in the primary prevention of sexual violence and HIV among children ages 9-14 year olds.

The case-finding investments should include the development and/or adaptation and dissemination of new messaging about HIV testing, linkage, and retention (e.g., Test & Start, U=U); building capacity among local faith leaders and faith organizations to create demand for and use of HIV self-tests, along with targeted distribution of HIV self-tests, engaging champions in faith communities to strengthen linkage and adherence support; and programming on basic HIV education and stigma reduction; ; and convening key stakeholders to facilitate sharing solutions.

The investments in primary prevention of sexual violence and HIV should include raising awareness among faith and traditional leadership about sexual violence and HIV risk faced by 9-14 year olds; using national-to-local infrastructures to train faith leaders in targeted implementation of evidence-based approaches within faith community infrastructures, including youth, parenting, and men's religious programing, with a focus on community mobilization, changing norms and parenting/caregiver programs (these programs include *Families Matter*, *Parenting for Lifelong Health, Real Fathers, Coaching Boys Into Men, and SASA! Faith)*; and engaging in child safeguarding policy development and implementation through faith and traditional community structures, assuring inclusion of the contextualized process for accessing health, legal, and social protection referrals.

Some Faith and Community partners support both HIV case-finding/linkage/retention and prevention of sexual violence and HIV risk among ages 9-14 years; in these cases, it may be possible to engage in comprehensive prevention and care by supporting both key FBO priorities.

Any further instructions or questions can be addressed by Chair and PPM.

Technical and programmatic priorities for Zimbabwe

- Continued full implementation of the iHTS model, to ensure that all remaining undiagnosed PLHIV are identified and linked to ART. This should be done by age/sex and by district.
    - More focus is needed for males 20-24 years, and males and females older than 30 years.
    - Need to ensure that testing does not include already known positives; the high testing yields and low linkage for PSI suggest some inaccuracies here.
- Efforts should continue to improve linkages for all age/sex groups. The targeted linkage rate from COP 2018 of 95% should be continued in COP 2019.
- Testing of FSWs remains robust, especially in Harare, with HIV-positive yields well over 20%. While just under 500 MSM were tested by PSI, the overall yield was over 40%, suggesting that wider testing should be performed in this group.
- PrEP increased over the year, and the team achieved almost double their target. Efforts should continue for further expansion of PrEP, as aligned with the prevention program.
- TPT has stalled due to a lack of political will and concern about INH toxicity; <1% of PLHIV who screened negative were started on TPT. Additional efforts are needed to ensure TPT is further scaled at a national level.
- OVC program should continue implementation, per the COP 2019 guidance, and additional efforts should be adapted and revised to ensure achievement of targets.
- VMMC scale up should continue in the highest burdened districts, with a focus on achieving saturation among men 15-29 years old. Program implementation should be adjusted to ensure older men are being targeted with demand creation activities.
- Budget for total commodities should consider full scale-up of TLD, comprehensive review of required stock, and an anticipated reduction in test kits in COP 2019.
- As Zimbabwe moves closer to epidemic control, efforts begun in COP 2018 to further align all above site activities should continue, to focus on building and maintaining a sustainable program.

COP 2019 Stakeholder Engagement

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP 2019 remains a requirement for all PEPFAR programs, and as such the COP 2019 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2018 Q4 and FY 2018 APR results and analyses and the convening of an in-country planning retreat with local stakeholders no later than the week of January 28, 2019 in order to introduce and discuss all COP 2019 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2019. In February, initial COP tools will be submitted to S/GAC for review and feedback. S/GAC will provide feedback prior to the in-person meetings in March and April, and teams should reflect the feedback with their revised submissions. It is critical that meaningful involvement of civil

society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team.

In March and April 2019, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Washington, DC where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Engagement with all stakeholders is required beyond the meetings and throughout the COP 2019 development and finalization process. As in COP 2018, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP 2019 Guidance for a full list of requirements and engagement timelines (Section 2.5.3).