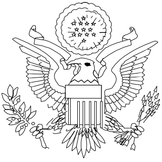

United States Department of State

Washington, D.C. 20520

UNCLASSIFIED

January 14, 2020

INFORMATION MEMO FOR AMBASSADOR NICHOLS, Zimbabwe

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

SUBJECT: FY 2020 PEPFAR Planned Country Allocation and Strategic Direction

Dear Ambassador Nichols:

First, I wanted to personally thank you and your Deputy Chief of Mission for your dedication to PEPFAR and working every day to achieve the most possible with the United States taxpayers' dollars. The ability to translate these resources into effective and impactful programming has and continues to be core to our collective progress. Your PEPFAR team in country is extraordinary and we are fortunate to witness their passion and compassion. We are very excited about your progress in:

- 95-95-95 HIV cascade. In spite of a very difficult economic and social situation, Zimbabwe has continued to ascend towards epidemic control. Post data quality assessment (DQA) activities, the program data demonstrates that 91% of estimated persons living with HIV (PLHIV) in Zimbabwe are diagnosed, 86% are receiving ART and 75% are virally suppressed. This is an impressive achievement and we look forward to seeing the results of the nationwide PHIA survey in hopes to validate those estimates.
- Index testing. Zimbabwe has seen improvements in testing efficiency and yield with the roll out of index testing; the proportion of clients identified through index testing (as compared to other testing modalities) has increased dramatically, reflecting an appropriate shift in strategy.
- Saving lives with prevention. In fiscal year 2019 Zimbabwe exceeded its PrEP targets by 265% among key populations and adolescent girls and young women.

Together with the People of Zimbabwe and civil society leadership we have made tremendous progress together. Zimbabwe should be proud of the progress made over the past 16 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

We did want to highlight both overarching issues we see across PEPFAR and a few specific to Zimbabwe. Full details will follow in a more comprehensive letter from your S/GAC Chair and PPM.

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Throughout the PEPFAR family of supported countries and communities, five gaps are shared across the globe holding us collectively back from achieving Sustainable Development Goal 3 related to controlling the HIV AIDS epidemic:

1. Continued new HIV infections in adolescents and young women
2. Supporting key populations with prevention and treatment services
3. Ensuring men are diagnosed and treated early (testing positive and new on treatment (linkage surrogate))
4. Ensuring 15-35-year-old asymptomatic clients are maintained on treatment and virally suppressed (net new on treatment and treatment current growth, (retention surrogate))
5. Ensuing all children are diagnosed and are on the best treatment regimens and virally suppressed

Moreover, we note that the PEPFAR Zimbabwe program faces the following challenges:

- Retaining patients. Retention continues to be a challenge with Zimbabwe. The country program ended COP19 with 37,805 fewer patients than the previous year, despite a high level of enrollment. While a proportion of this number is explained by poor data quality, the remainder makes clear a serious problem with retention that must be addressed.

- Data quality. The lack of clarity in the program data has been a persistent problem and has created much confusion about program progress and strategic planning.

- Viral load coverage. Only 44% of clients received a viral load test result, well below the targeted 74%. A lack of awareness of viral load results can be unmotivating, and a contributor to loss to follow-up.

- Impediments to optimal therapy and multi-month dispensing. Currently, clients on treatment require documentation of suppressed HIV viral load before they are allowed to switch to optimal therapy or receive 6 months of medication at a time. Because viral load testing is not widely available, many clients may not have access to these interventions, compromising their willingness to adhere and stay on treatment.

In a recent Office of Inspector General audit around PEPFAR coordination there were four draft preliminary recommendations based on their discussions with PEPFAR staff in the field from four countries; three of their recommendations are relevant to this Country Operational Plan planning cycle related to target setting, tool development, and timelines. Although we just received the draft report a few days ago we did not want to wait another COP cycle to make substantive changes related to the recommendations. The first was around targets and target-setting and the need for a clear and transparent understanding and dialogue in establishing targets. PEPFAR targets are not PEPFAR's but flow directly from the UNAIDS Fast Track Strategy of 2016. Since 2016, both the PEPFAR strategy and targets were directly derived from the global communities of UNAIDS, WHO, and specifically Heads of State in their commitment to SDG 3 and are aligned to support the country's specific ambition towards those goals.

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The global community in 2015 through their Heads of State committed to achieving SDG 3.3 by 2030 which for HIV is ending the HIV/AIDS epidemic as a public health threat. This was followed by a United Nations High Level Meeting on HIV/AIDS in June 2016, whereby these Heads of State committed to the 90/90/90 Fast Track Strategy. Essential to the strategy was 73% community viral load suppression (VLS) by 2020 and 86% community VLS by 2030 combined with increased prevention interventions and zero stigma and discrimination to ensure all ages, genders and risk groups have access to life saving prevention and treatment services. Also, in 2016, 22 PEPFAR-supported high HIV burden countries committed to the three Frees of "Start Free, Stay Free, AIDS Free" with 2020 targets of a decrease in new infections in children to 20,000, 85% of pregnant women on ART, AGYW new infections to < 100,000, 90% of children on ART and 25 million VMMCs. Since 2016, PEPFAR and the GF resources have been focused on achieving these global goals that have been translated to each country by UNAIDS and subsequently supported financially and technically by the PEPFAR family. Since 2016, PEPFAR has utilized these global commitment targets as PEPFAR targets with commensurately increased funding to countries in 2016, 2017, and 2018 to achieve the goals set out by the Heads of State. Many countries have made tremendous progress towards these targets and others need to accelerate. Zimbabwe is on track to achieve the 2020 and 2030 goals if specific programmatic gaps are addressed.

Over the past 4 years, PEPFAR resources were allocated based on need, performance, and specifically on the country's and communities' desire to achieve the SDG, Fast Track Strategy, and Three Free goals and country specific targets. Based on the OIG recommendation, S/GAC will take a different approach this year to target-setting. Our collective hope is that together we use this moment of reflection on progress and challenges along with the realization that the end of 2020 is only 11 months away to address these overarching challenges this year through COP 2019 implementation and use COP 2020 to maintain our progress, address any ongoing challenges and finally fund ambition for greater impact. Thus, S/GAC will not assign targets to countries but only provide notional budget levels. After the PEPFAR country team submits their targets the notional budget will then be adjusted to the presented level of ambition. Additional funding is available as ambition funding for treatment and VMMC.

The PEPFAR Country/Regional Operational Plan (COP/ROP 2020) notional budget is **$223,900,000** inclusive of all new funding accounts and applied pipeline and reflects the following:

1. Sustaining the gains in treatment services based on your projected COP 2019 treatment result (FY2020 treatment current funded in COP19) $131,000,000
    a. The care and treatment budget was determined by all of your FY18 C/T expenditure services and commodities (no RTK commodities), including all aspects of the health system inclusive of human resources, laboratory and systems, commodities (exclusive of RTKs), an upward adjustment from FY19 treatment current to the FY2020 treatment current fully burdened cost of treatment services and commodities, and 100% of partner program management costs and data needs

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   b. This Budget is broken down by
      i. Care and Treatment services including partner program management costs, FY2020 upward adjustment, EMR and data with surveillance, recency $85,000,000
      ii. ARV drugs and treatment commodities (everything except RTKs) $27,000,000
      iii. TB preventive treatment $6,000,000
      iv. Cervical cancer $4,500,000
      v. For earmark purposes 50% of M/O costs $8,500,000
      vi. Care and Treatment qualifies for ambition funds if addresses gap #3-5
2. Continued orphans and vulnerable children funding to include DREAMS vulnerable girls less than 20-year-old. $53,100,000
   a. HKID or $17,400,000 dollars for continued historical OVC services
   b. DREAMS funding of $40,000,000 of which 85% is for vulnerable girls under 20 $34,000,000
   c. 10% of M/O or $1,700,000
3. Continued VMMC funding based on your percent of VMMC in the appropriate age band of >15 years old
   a. Total VMMC $17,000,000
   b. VMMC qualifies for ambition requests
4. Dramatic expansion of DREAMS programming $40,000,00 as noted above
   a. $6,000,000 in addition to the $34,000,000 above for a total of $40,000,000 as noted above
5. Continued expansion of Key Populations prevention and expansion of PrEP depending on country submitted targets
   a. Key Population (non-treatment) $4,900,000
   b. PrEP total: $3,700,000 dollars
6. RTK and service support to ANC HIV testing $1,400,000
7. Remaining 40% M/O based on COP19 $6,800,000

Total COP2020 notional budget of **$223,900,000** is comprised of **$218,569,139** new and **$5,330,861** pipeline.

Overall, across the PEPFAR portfolio, we have dramatically increased DREAMS funding to prevent new infections in adolescent girls and young women. For the first time we find across all districts implementing DREAMS, declines in new diagnoses of HIV in young women. These funds should be used to expand to the highest burden districts not currently covered and saturated in urban areas.

Teams will develop their own targets across PEPFAR program areas described above, with the treatment current target no less than the result that was to be achieved in COP 2019. Testing support outside of ANC should be consistent with any targets above FY2020 treatment current and be submitted with any ambition funding. Targets should reflect continued and sustained OVC programming and KP programming. For DREAMS, PrEP, cervical cancer and TB Prevention, we expect increased targets consistent with the level of increased budgets.

Again, the team has received a notional budget as noted above and a final budget approval will be contingent on the team's desired targets. As always, funding is associated with a performance target that will be achieved with those resources. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Zimbabwe and civil society of Zimbabwe, believes is critical for the country's progress towards controlling the pandemic and maintaining epidemic control.

Additionally, country teams and agencies can independently request additive ambition funds in the OU FAST to be submitted, based on their stated increased ambition in Treatment and VMMC, with commensurate increased partner level targets. This funding is available to agency partners with the highest performance with evidence that they are addressing one of the critical gaps outlined above. Budget requests must be consistent with the cost of expanded targets and address one of the gaps in programming #3-5 above. These requests should be discussed with the S/GAC chair and PPM during the January strategy retreat and tentatively approved and be submitted with the DataPack and FAST tool. The final budget and associated country level targets will be discussed and approved during the Johannesburg meeting.

We are hoping this new approach to target-setting and budget will establish an open dialogue on target-setting and empower teams to work with all stakeholders to plan a strategic and impactful COP. The expectation is for country teams and agencies to propose to S/GAC the targets they believe are achievable and feasible and hold their partner's accountable to that achievement. In addition, this new approach to target-setting gives high performing partners and agencies with additional aspirations the opportunity to do more to achieve even greater impact with additional ambition resources.

In the next 48 hours, more detailed descriptions of OU's programmatic successes and challenges will be conveyed to your wider PEPFAR team by the S/GAC Chair and PPM in a phone call, after which the detailed planning level letter will be immediately released.

Again, thank you for your work and we are looking forward to working with you to achieve your Fast Track Strategy and ultimately the SDG 3 goal.

Together we can.

Deborah Birx

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United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 16, 2020

COP 2020 Planning Level Letter | PART 2

INFORMATION MEMO FOR AMBASSADOR NICHOLS, ZIMBABWE

SUBJECT: Fiscal Year (FY) 2020 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly POARTs and from Headquarters Country Accountability and Support Teams, we have thoroughly reviewed progress of the program in Zimbabwe over time and specifically the end of year results of the Country Operational Plan (COP) 2018 and current COP 2019 implementation as we plan for COP 2020. We have noted the following key successes and specific areas of concern:

The gains across the HIV cascade are impressive, and a testament to successful case-finding, linkage and patient adherence (as demonstrated by the 90% viral load suppression among those tested). The country has been using self-testing effectively and there are clear improvements in the quality and relative scale of index testing. These accomplishments are all the more notable against the backdrop of the current socioeconomic situation in Zimbabwe – which we recognize has made your work substantially more difficult and your accomplishments substantially more impressive. Despite these successes, the recent data quality assessment (DQA) demonstrates that there are considerable problems with retention and data quality, which undermine both program accomplishment and confidence in these data. The low viral load coverage is problematic, especially given the requirement for documentation of viral load suppression for transition to TLD and participation in differentiated service delivery – two critically important interventions to address retention. And we need to ensure that participants in DREAMS are completing and getting the full benefit of the program.

SECTION 1: COP/ROP 2020 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total COP/ROP 2020 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

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Table 1. COP 2020 Total Budget including Applied Pipeline

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
Total New Funding	$218,569,139	$ -	$ -			$218,569,139
GHP-State	$217,319,139	$ -	$ -			$217,319,139
GHP-USAID	$ -	$ -	$ -			$ -
GAP	$ 1,250,000	$ -	$ -			$ 1,250,000
Total Applied Pipeline				$ 4,330,861	$ 1,000,000	$ 5,330,861
DOD				$ -	$ -	$ -
HHS/CDC				$ 1,889,472	$ -	$ 1,889,472
HHS/HRSA				$ -	$ -	$ -
PC				$ -	$ -	$ -
State				$ -	$ -	$ -
USAID				$ 2,441,389	$ 1,000,000	$ 3,441,389
TOTAL FUNDING	$218,569,139	$ -	$ -	$ 4,330,861	$ 1,000,000	$223,900,000

***Based on agency reported available pipeline from EOFY 2019.*

SECTION 2: COP/ROP 2020 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

The expectation based on the notional budget provided in Part 1 of the PLL is that Zimbabwe should plan to program for the full Care and Treatment (C&T) level of $131,000,000 and the full Orphans and Vulnerable Children (OVC) level of $53,100,000 that are listed. These levels listed in Table 2 below are subsets of these total amounts, which must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

Table 2. COP 2020 Earmarks by Fiscal Year

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	$100,000,000	$ -	$ -	$100,000,000
OVC	$ 47,400,000	$ -	$ -	$ 47,400,000
GBV	$ 1,821,275	$ -	$ -	$ 1,821,275
Water	$ 125,000	$ -	$ -	$ 125,000

** Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. These earmark controls above represent the **minimum** amounts that must be programmed in the given appropriation year.*

SECTION 2: COP/ROP 2020 BUDGETARY REQUIREMENTS

Table 3. Total COP 2020 Initiative Controls

	COP 20 Total
Total Funding	$111,900,000
VMMC	$ 17,000,000
Cervical Cancer	$ 4,500,000
DREAMS	$ 40,000,000
HBCU Tx	$ -
COP 19 Performance	$ 33,000,000
HKID Requirement	$ 17,400,000

***See Appendix 1 for detailed budgetary requirements and other budgetary considerations.*

SECTION 3: PAST PERFORMANCE – COP/ROP 2018 Review

Table 4. COP/ROP OU Level FY19 Program Results (COP18) and FY20 Targets (COP19)

Indicator	FY19 result (COP18)	FY20 target (COP19)
TX Current Adults	883,625	1,144,153
TX Current Pediatrics	47,260	76,930
VMMC among males 15 years or older	190,485	193,681
DREAMS (AGYW completing at least the primary package)	96,309 (51.9% of total AGYW reached)	---
Cervical Cancer	67,670	244,620
TB Preventive Therapy	39,521	502,019
PrEP (NEW/CURR)	8,736/8,363	8,239/6,462

Table 5. COP/ROP 2018 | FY 2019 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP/ROP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays**
OU	$150,446,200	$142,709,581	$8,104,420
HHS/CDC*	$42,853,449	$42,469,944	$383,505
HHS/HRSA	N/A	$224,987	($224,987)
State	$92,000	$10,845	$81,155
State/AF	$130,000	$141,789	($11,789)
USAID*	$107,370,751	$95,650,974	$7,876,537

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Grand Total	$150,446,200	$142,709,581	$8,104,420

**Includes Central Funds*
*** All figures are sourced from the Zimbabwe EOFY Tool, however State and USAID obligations and outlays may have not yet been reconciled and the numbers in this table may change based on reconciliation.*
****Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

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Table 6. COP/ROP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget

Mech ID	Prime Partner	Funding Agency	COP/ROP18/FY 19 Budget (New funding + Pipeline + Central)	Actual FY19 Outlays ($)	Over/Under FY19 Outlays (Actual $ - Total COP/ROP18 Budget $)
16806	ZIMBABWE ASSOCIATION OF CHURCH RELATED HOSPITAL	HHS/CDC	$1,980,401	$2,375,341	$(394,940)
16515	ITECH	HHS/CDC	---	$2,888,105	($2,888,105)
18151	Elizabeth Glaser Pediatric AIDS Foundation	HHS/CDC	---	$307,242	($307,242)
17884	Regents of the University of California, San Francisco, The	HHS/HRSA	---	$224,987	($224,987)
18174	DEPARTMENT OF STATE	State/AF	$50,000	$61,789	($11,789)
18141	UNICEF	USAID	---	$91,079	---
17887	John Snow Inc (JSI)	USAID	---	$139,420	---
12933	Population Services International	USAID	$0	$144,132	---

13890	Organisation for Public Health Interventions and Development	USAID	$8,877,244	$9,821,130	$(943,886)

This table was based off the FY19 EOFY submissions. Agencies outlaid to the following Implementing Mechanisms 110% or more in excess of their COP18 approved planning level.
**Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

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Table 7. COP/ROP 2018 | FY 2019 Results & Expenditures

Agency	Indicator	FY19 Target	FY19 Result	% Achievement	Program Classification	FY19 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	1,059,720	1,192,865	112.6%	HTS Program Area	$5,984,415	57%
	HTS_TST_POS	58,604	55,196	94.2%			
	TX_NEW	59,041	50,313	85.2%	C&T Program Area	$9,890,057	18%
	TX_CURR	496,289	422,464	85.1%			
	TX_NET_NEW		(42,266)				
	VMMC_CIRC	125,709	129,118	102.7%	VMMC Subprogram of PREV	$11,921,624	90%
HHS/HRSA	TX_NEW	---	---	---	C&T Program Area	$134,431	---
	TX_CURR						
USAID	HTS_TST	984,784	1,181,000	119.9%	HTS Program Area	$5,422,170	86%
	HTS_TST_POS	52,026	63,058	121.2%			
	TX_NEW	47,065	53,991	114.7%	C&T Program Area	$45,901,462	80%
	TX_CURR	540,764	508,421	94.0%			
	TX_NET_NEW		4,461				
	VMMC_CIRC	180,434	191,968	106.4%	VMMC Subprogram of PREV	$17,515,382	100%
	OVC_SERV	357,471	346,199	96.8%	OVC Major Beneficiary	$10,794,209	81%
					Above Site Programs	$8,385,663	
					Program Management	$24,085,678	

Subject t

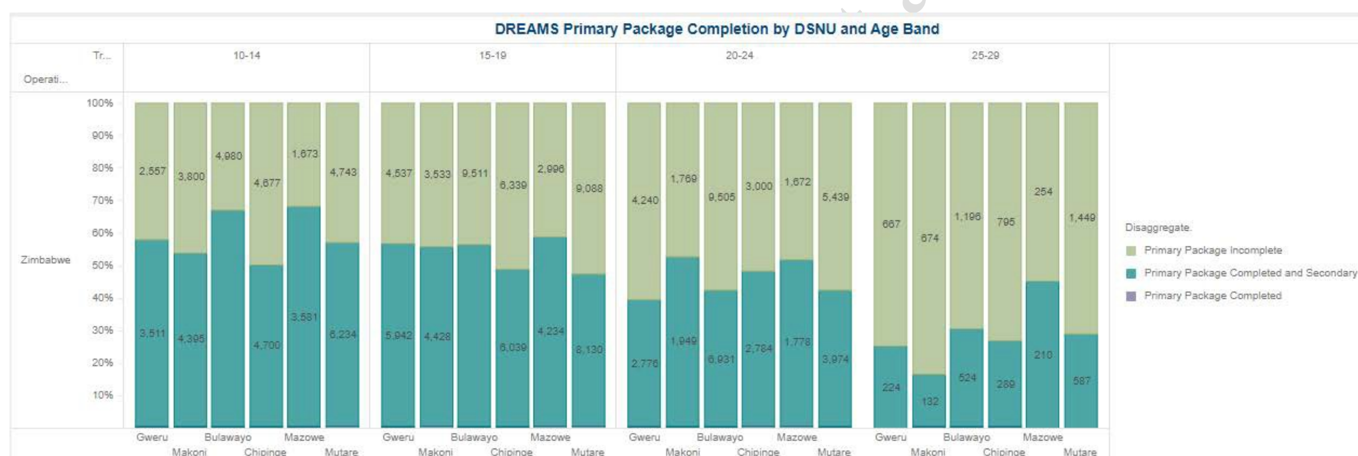
COP/ROP 2018 | FY 2019 Analysis of Performance

OU/PSNU Levels

- Historic case-finding efforts have been largely successful, and the program has begun the shift toward index testing, with steadily increasing yield and proportion of clients that are found through index testing (nearly 29% at Q4); however, delays in implementing the proposed targeted testing strategy (iHTS) and the full scale up of the index testing program has thwarted progress.
- The country has made notable progress toward epidemic control, and the post-DQA data (the most reliable data currently available) demonstrate that the country currently has 86%

of the estimated PLHIV in Zimbabwe on ART - this is a remarkable achievement. ART coverage is lower for men compared to women (82% vs 91%) and substantially lower for children under 15 years (64%).

- These program successes are undermined by retention issues. **Despite the addition of over 104,000 new clients, the program ended COP19 with 37,805 fewer documented clients on ART.** It is understood that a large proportion of those represent data errors from a paper- based system in a country with substantial internal migration; nonetheless, this strongly suggests a serious issue with continuation of care and retention.
- The viral load coverage is 44% (51% for USAID partners and 36% for CDC partners). This is a potential bottleneck, given policy requirements for documentation of suppressed viral load to transition to TLD and participate in differentiated service delivery (especially six month dispensing). Additionally, knowledge of viral load suppression can motivate adherence, which is part of the strategy to address retention difficulties.
- The DREAMS program has a relatively high proportion of women over 20 ears old and very high proportion of AGYW who did not complete the primary package; the program is currently not well-aligned with the UNAIDS high-incidence districts.



Partner Performance

- CDC partners achieved 94% of their HTS_POS target and 85% of TX_NEW; after the data reconciliation, CDC dropped the total number on treatment by 42,266, as compared to a gain in the number on treatment in COP17 of 84,817 (for a total net gain of 42,551 across the two years, despite adding 109,343 new patients)
  - iTECH achieved 94% and 86% of their HTS_POS and TX_NEW targets, respectively, but they only added a total of 31,434 to their number of patients in COP17 and COP18; in COP18, they overspent their Testing budget by approximately $750K and underspent their Treatment budget by over $3M
  - ZACH achieved 92% and 75%, of their HTS_POS and TX_NEW targets, respectively, but they only added a total of 11,117 to their total number of patients in COP17 and COP18; in COP18, they underspent their Testing budget by $435K and underspent their Treatment budget by $400K
- USAID partners achieved 121% of their HTS_POS target and 115% of TX_NEW target; they started data reconciliation in COP17, and only added 38,730 to the total number on

treatment over the past two years, despite adding 114,544 new patients

- FHI achieved 155% of their HTS_POS target and overspent their Testing budget by $425K
- OPHID achieved 135% of their HTS_POS target and 111% of TX_NEW, but they only added 36,636 to their total number of patients in COP17 and COP18; in COP18, they underspent their Testing budget by $3.3M and overspent their Treatment budget by $2.5M
- PSI achieved 68% of their HTS_POS targets and 128% of TX_NEW (from FHI case-finding), but they only added 2.094 to their total number of patients in COP17 and COP18; in COP18, they underspent their Testing budget by $220K and spent at level for Treatment

SECTION 4: COP/ROP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

Table 8. COP/ROP 2020 (FY 2021) Minimum Program Requirements

	Minimum Program Requirement	**Status**	**Outstanding Issues Hindering Implementation**
Care and Treatment	Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Attained	None at present
	Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing >20kg, and removal of all nevirapine-based regimens.[2]		Delays imposed by current stock of TLE400; requirement for documentation of VLS prior to switching may impose barrier when old patients start transitioning to TLD
	Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	DSD attained; 6MMD being scaled	Though not uniformly enforced, documentation of VLS is required for participation in DSD and MMD
	All eligible PLHIV, including children, should have been offered a course of TB preventive treatment (TPT) by end of COP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	Scale-up in progress	Supply and distribution of INH and pyridoxine are limiting scale-up
	Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and	Scale-up in progress	Funding limitations have prohibited optimization. Plans to address this with GF are in development

[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

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2 Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

3 Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

4 Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

	ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.		
Case Finding	Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	Largely attained, although index testing still requires further scale-up. The program is still documenting complete testing of all biologic children	Need improvements in index testing cascade to achieve targets.
Prevention and OVC	Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	Attained – program has achieved targets	Need to revisit targets to ensure all those at substantially elevated risk have access (including those who engage in transactional sex but don't identify and aren't identifiable as FSW)

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5 Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing- guidelines/en/

6 Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

	Alignment of OVC packages of services and enrollment to provide comprehensive prevention and Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	Attained	None at present
Policy & Public Health Systems Support	Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	In progress.	This is a re-emerging concern given socio- economic conditions and under-funding of public health infrastructure

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[7] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

	OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	Attained – active SIMS program with almost 400 initial assessments	Cost and difficulty of transportation is increasing dramatically, threatens CQi productivity
	Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Attained	Limited funding hinders further scale-up
	Clear evidence of agency progress toward local, indigenous partner prime funding.	In progress – major local partners for both agencies	Availability and capacity of local partners is limited
	Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	Not attained – MoH has defaulted on commitments and is unable to meet them	Current socio-economic conditions have stalled any discussion/planning
	Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	In progress – reporting in TX_ML is active and increasing; data need to be validated	Pending validation of data
	Scale-up of case-based surveillance and unique identifiers for patients across all sites.	In progress (but limited)	Funding limitations

8 Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

Subject to COP Development and Approval

In addition to meeting the minimum requirements outlined above, it is expected that Zimbabwe will meet the following directives:

Table 9. COP/ROP 2020 (FY 2021) Technical Directives

OU –Specific Directives
HIV Case-Finding and Treatment
1. Testing strategy will be informed by PHIA results, but the program should plan to consolidate and fully scale index testing (community and facility), target and reduce facility testing (to maintain yields >10%), and incorporate recency testing for all who newly test positive
2. The program needs a specific strategy and focus on identifying men living with HIV and bringing them into treatment. This strategy should include elements from both MenStar and the Faith and Community Initiative (FCI). The country should submit a proposal for additional funding ("ambition funding") to scale-up and expand FCI activities as they demonstrate success in bringing men and children into treatment (and success in supporting adherence).
3. Conduct full analysis of HRH investments to ensure maximum impact, given current socio-economic situation
4. Develop mid and long-term strategy for improving Procurement and Supply Management (PSM)
HIV Prevention
1. OVC and clinical implementing partners in Zimbabwe must work together to ensure that 90% or more of PEPFAR-supported children and adolescents on ART in OVC SNUs are offered the opportunity to enroll in the comprehensive OVC program
2. Ensure that DREAMS programming expands to include the high-risk districts, appropriately targets high-risk age groups and demonstrates improvement in completion rates (see below for more details). For program re-alignment, definitions of saturation and maintenance must be finalized.
3. Accelerate identification of high-risk individuals, such as those who engage in transactional sex but do not identify as sex-workers, and expand PrEP programming
Other Government Policy or Programming Changes Needed
1. Address policy barriers to TLD and multi-month dispensing. These are key strategies to improve retention (especially in areas with high migration) and need to be fully implemented by or during COP20

COP/ROP 2020 Technical Priorities

Client and Family Centered Treatment Services

COP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term,

Subject to COP Development and Approval

continuous ART for a population that is often young and asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services. Zimbabwe must ensure 100% "known HIV status" for biological children of TX_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

Community-led Monitoring
In COP 20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)
Groups to be prioritized for PrEP include those testing negative in index testing but remaining at increased risk of HIV acquisition by virtue of unprotected exposure to a PLHIV with unsuppressed viral load, key populations including sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls and young women (AGYW), including pregnant and breastfeeding women, AGYW in areas with high HIV incidence or with high risk partners or who engage in transactional sex (but do not identify as a sex-worker), and other identified serodiscordant couples.

TB Preventive Treatment (TPT)
TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP20; targets should be set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

DREAMS
DREAMS funding is allocated within your COP 2020 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 2020 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP20 DREAMS implementation include: systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition, improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR), and accelerating PrEP uptake for AGYW.

DREAMS is receiving an increase in new funding which should be used for the following:

- **Interagency** expansion into new districts: The following 10 districts should receive new

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DREAMS funds for COP20. These districts have a very high incidence (1.13-1.64%) and over 10,000 PLHIV, but have no DREAMS or Global Fund AGYW presence.

Country	DREAMS SNU	UNAIDS F15-24 Incidence	UNAIDS Incidence	Classification	PLHIV (COP19 DataPack)
Zimbabwe	Bubi	1.64 Very high			11,066
Zimbabwe	Tsholotsho		1.62	Very high	19,773
Zimbabwe	Bulilima	1.45 Very high			15,056
Zimbabwe	Lupane		1.38	Very high	14,489
Zimbabwe	Mangwe	1.27 Very high			11,906
Zimbabwe	Gwanda		1.22	Very high	21,360
Zimbabwe	Nkayi	1.18 Very high			13,794
Zimbabwe	Beitbridge		1.17	Very high	18,728
Zimbabwe	Insiza	1.15 Very high			14,198
Zimbabwe	Matobo		1.13	Very high	13,207

Note: The geographic expansion mentioned here is limited to NEW DREAMS funds.

Any expansion within the existing DREAMS envelope is subject to the criteria laid out in COP20 guidance (i.e., must have reached saturation, must have shown progress via WAD modeling data, or some other data).

- PrEP: Significantly scale-up PrEP for AGYW in all DREAMS districts.
- Minimum Requirements for new funds: To receive additional funds, Zimbabwe must present a strategy and a timeline at the COP meeting for the following:
  - Hire a dedicated DREAMS Coordinator (100% LOE)
  - Hire a DREAMS ambassador for each Division to support DREAMS coordination and oversight
  - Implement approved, evidence-based curricula in line with the current DREAMS Guidance
  - Ensure a fully operable layering database with unique IDs across IPs and SNUs
  - Ensure a full geographic footprint in all districts
  - Address challenges and ensure DREAMS implementation in all districts with fidelity

In addition, DREAMS Zimbabwe should focus on the following:

- Layering: The Zimbabwe team should focus on ensuring that each AGYW in DREAMS receives a layered package of services. Q4 AGYW_PREV data shows that 40-55% of AGYW in DREAMS have not completed the full primary package of services (variation by age band), though layering does increase over time for AGYW over 15.

OVC

To support the Minimum Program Requirement described above, in COP 20 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, case conferencing, shared confidentiality, and joint case identification. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their

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knowledge in areas such as adherence, retention, and disclosure.

VMMC
Funds have been provided to conduct VMMC for males 15 years or older. The team is reminded of the revised guidance which allows surgical VMMC under the age of 15 only by the dorsal slit method and only for those who have attained Tanner stage 3 or higher of development and are able to provide full informed consent for the procedure. While Shang ring may be considered for those below age 15 regardless of Tanner stage, the same informed consent issues apply. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

Cervical Cancer Screening and Treatment:
Funding for cervical cancer screening and treatment of pre-invasive lesions. The target for screening must be equal to half of the TX_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance. Basic treatment should be available for pre-cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results. In order to raise demand at existing sites, program should Incorporate perspectives of women living with HIV (WLHIV) into demand creation materials and Offer same day, fast-tracked services for WLHIV; Share additional information on outcomes of LEEP camp for possible PEPFAR solution document and lessons with other Go Further countries.
PLHIV Stigma Index 2.0
PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0 or complement Global Fund or other donors financing implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma and can inform future HIV program planning. If the revised Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 20, whether supported by PEPFAR or other resources.

COP/ROP 2020 Stakeholder Engagement (see section 2.5.3 of COP Guidance)
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/ROP 2020 remains a requirement for all PEPFAR programs, and as such the COP/ROP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP/ROP 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2020. It is critical that meaningful involvement of civil society and

Subject to COP Development and Approval

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. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, GA 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. Specific guidance for the 2020 meeting delegations have been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP/ROP 2020 development and finalization process. As in COP/ROP 2019, 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/ROP 2020 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Table 11. COP/ROP 2020 New Funding Detailed Controls by Initiative

<u>Care and Treatment</u>: If there is no adjustment to the COP/ROP 2020 new funding level due to an

	COP 2020 Planning Level			
	FY20			COP 20 Total
	GHP-State	GHP-USAID	GAP	
Total New Funding	**$217,319,139**	**$ -**	**$ 1,250,000**	**$218,569,139**
Core Program	$166,919,139	$ -	$ 1,250,000	**$168,169,139**
COP19 Performance	$ 33,000,000			**$ 33,000,000**
HKID Requirement ++	$ 17,400,000			**$ 17,400,000**

++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia

adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.

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Orphans and Vulnerable Children (OVC): Countries must program to the full OVC amount from Part 1 of the planning across all funding sources. Your OVC requirement is made up of the HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.

HKID Requirement: Zimbabwe's COP/ROP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your COP/ROP 2020 HKID requirement is derived based upon the approved COP/ROP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The COP/ROP 2020 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/ROP 2020 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2020** funding programmed to the GBV cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 GBV earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.*

*Water: Zimbabwe's COP/ROP 2020 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2020 funding** programmed to the water cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 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 OU 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/ROP 2019 submission.*

COP/ROP 2020 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)
All agencies in Zimbabwe should hold a 4 month pipeline at the end of COP/ROP 2020 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/ROP 2019 implementation

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(end of FY 2020) with a pipeline in excess of 4 months is required to apply this excessive pipeline to COP/ROP 2020, decreasing the new funding amount to stay within the planning level.

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