



Zimbabwe
Country Operational Plan
FY 2014

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 - Zimbabwe has one of the highest HIV prevalence in the world. The Zimbabwe Demographic Health Survey (DHS) 2010-2011 defined adult prevalence at 15%. Zimbabwe's population is 13 million (2012 National Census) with an estimated 1.3 million individuals living with HIV. An estimated 60,607 individuals were newly infected with HIV in 2013. HIV is the leading cause of death among adults and accounts for approximately 29,494 adult and 7,660 child deaths each year. HIV accounts for over 27% of all deaths among mothers and infants. The estimated number of orphans and vulnerable children (OVC) is 1.6 million. The 2010 DHS found that six in 10 children under age 18 were not living with both parents, and that 20% of children under age 18 were orphaned—one or both parents were dead.

The country continues to exhibit a generalized epidemic. The key social, cultural, and economic factors driving the epidemic in Zimbabwe are: 1) multiple concurrent partners; 2) transactional sex; 3) low levels of male circumcision (MC); 4) alcohol abuse; 5) low awareness of HIV infection status; 6) lack of ART use in undiagnosed individuals; and 7) poor treatment adherence. Populations of presumed highest risk include commercial sex workers (SW), military, and mobile populations including truck drivers, migrants, and displaced farm workers.

The majority (92%) of HIV transmission is through heterosexual contact, exacerbated by high-risk sexual practices (such as multiple concurrent partners). Among women age 15-49, the HIV prevalence rate is 18%, while among men aged 15-49 prevalence is 12%. Women become infected at younger ages than men. Prevalence for both women and men increases with age until it peaks at ages 30-39 for women (29%) and at age 45-49 for men (30%). The HIV epidemic is somewhat geographically diverse with provincial prevalence levels ranging from 13% to 21%. The Matabeleland South and Matabeleland North, which border South Africa and Botswana, have the highest prevalence levels at 21% and 19%. In contrast, Harare which is the most densely populated and a large urban area has a prevalence level of 13%.

There is no clear relationship between educational level and HIV prevalence among women; however, among men, HIV prevalence decreases as education increases. In general, HIV prevalence increases with number of lifetime sexual partners among both women and men. Almost half of women with 5-9 lifetime partners are HIV-positive. There is no clear relationship between wealth and HIV prevalence among women or men.

National Response - The Government of Zimbabwe (GoZ) continues to lead the national HIV/AIDS



response through the Ministry of Health and Child Care (MOHCC) and the National AIDS Council (NAC). The goals and objectives of the national response are outlined in Zimbabwe National Strategic Plan (ZNASPII) 2011-2015. There is a high level of institutional leadership within the MOHCC in terms of technical direction and policy setting; yet, the capacity for implementation continues to be limited. The MOHCC's low capacity is largely an outcome of limited national financial resources for programming, which affects its capacity to deploy and adequately train sufficient experienced health professionals, provide a high level of monitoring and supervision to ensure high quality service delivery, effectively forecast and plan for commodity procurements, and retain capable technical staff. As such, donor resources are essential to national prevention, care, treatment, and health systems strengthening (HSS) efforts. The majority of HIV/AIDS-related activities are donor funded. Zimbabwe is facing critical shortages of key inputs to achieve ambitious goals, particularly in the areas of treatment and prevention of mother-to-child transmission (PMTCT).

The MOHCC-led technical groups are the primary mechanisms through which donor investments are coordinated. MOHCC leadership of these groups is key to setting the pace of change and ongoing review of technical areas. MOHCC staff participate in these meetings as do USG, other donors, and implementing partners (IP).

USG within the National Response - Even prior to PEPFAR, the USG was considered a key partner in the response to the HIV epidemic in Zimbabwe. The evolution of PEPFAR support is a direct result of MOHCC's direction of their national program. PEPFAR's support has invested in the national efforts to scale-up HIV prevention, care, and treatment. PEPFAR has demonstrated a strong commitment to the GoZ's PMTCT priorities by taking a leading role to support the GoZ's PMTCT and Option B+ rollout. Under MOHCC's leadership, voluntary medical male circumcision (VMMC) has been scaled-up with a cumulative target of 1.2 million MCs by 2017. In FY13 the national treatment program reached universal high level of access (67% of adults) with PEPFAR playing a pivotal role. PEPFAR will support an increased focus on quality assurance (QA) within the treatment program. Additionally, the USG is building the capacity of GoZ through system strengthening in laboratories, informatics, and human resources for health (HRH).

USG Policy - There continue to be strained relations between the USG and GoZ. The USG has policy restrictions on direct support to the GoZ. [REDACTED]. Nevertheless, efforts will continue and the PEPFAR team is committed to ensuring coordination continues at all levels.

Other Donors - The USG is investing more than any other bilateral donor in the HIV/AIDS response. The Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria (GF) remains the largest source of support to the national response. In FY13, Zimbabwe was one of six countries to pioneer the New Funding Model (NFM) and was awarded a three-year \$311 million grant. Other key donors include the Health Transition Fund (a



multi-donor funding mechanism focused on maternal and child health (MCH), Bill and Melinda Gates Foundation (VMMC), the Children's Investment Fund Foundation (PMTCT) and the Integrated Support Program (a multi-donor funding mechanism including UK Department for International Development (DFID), Swedish International Development Cooperation Agency, and Irish Aid focused on integrated sexual reproductive health (SRH) program and HIV prevention). The USG shares PEPFAR and other health investments at a Health Development Partnership forum monthly meeting. Additionally, the USG is a voting member of the GF Country Coordinating Mechanism (CCM). The PEPFAR team meets monthly with UNDP, the Principle Recipient (PR) for the GF, to ensure coordination and information sharing.

PEPFAR FOCUS IN COP14

The COP14 priorities have not changed from COP13 and were reinforced in the COP14 funding level letter. Thus priorities remain: 1) PMTCT; 2) VMMC; 3) treatment; 4) support for OVC; 5) HSS, 6) QA; and 7) gender integration.

There is strong commitment to PMTCT at national level with the USG continuing to take a leadership role. GF, 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. The OVC program received additional central resources to increase integration of OVC and PMTCT services, referrals, prevention of gender-based violence (GBV), and adherence to pediatric ART.

An additional priority among PEPFAR programs is the synergies between behavioral and biomedical prevention interventions. VMMC continues to remain a focus with both the Gates Foundation and DFID adding resources to support the national VMMC program. The Gates Foundation is moving away from funding service delivery and focusing on national and provincial-level coordination and consumer research. VMMC scale-up will continue and service delivery expanded.

In spite of enormous challenges over the last several years, the MOHCC has developed a robust ARV treatment program since its inception in 2004. As of November 2013, an estimated 574,701 (based on May 2013 projection for the year) people were on treatment in Zimbabwe. The capacity of the national program, which is strongly supported by USG, the GF, and others, has been impressive with over 9,000 people initiated on ARVs monthly in FY13. In FY14, the MOHCC will continue to adopt the 2013 WHO guidelines and plan to expand treatment to a total of 1,207,127 individuals. Nevertheless funding limitations, accelerated adoption of WHO guidelines, commodity shortages, and program weaknesses threaten to slow progress. In order to minimize these shortages and program weaknesses, the USG is committed to supporting procurement and distribution of ARV commodities, improving quality of care activities, expansion of ART and MCH integration, and facilitating a strategic and realistic approach to adopting treatment guidelines. PEPFAR is the primary supporter of the MOHCC-led national HIV training and



mentoring programs. To help alleviate severe space constraints in ART clinics, PEPFAR is procuring over 100 prefabricated three-room clinics for distribution to MOHCC facilities nationwide. PEPFAR will continue to support for “super-laboratories,” each of which provides laboratory monitoring for ART patients in a network of surrounding clinics. In COP14, the PEPFAR team will better capture the full breadth of support to the national treatment program with the application of the new Monitoring, Evaluation, and Reporting (MER) framework.

In FY13, the National Baseline Survey on Life Experiences of Adolescents Report, 2011 (NBSLEA) was released by the GoZ. This report has renewed the focus to address the social protection needs and increasing the capacity of the Child Protection Committees (CPC) to respond to the welfare of OVCs. Under the OVC program, PEPFAR OVC interventions aim to have a measurable impact on the long-term welfare of Zimbabwe’s affected children by increasing the sustainability of OVC care and support services. This is in line with the GoZ priorities as articulated in the Second Phase of the National Action Plan for Orphans and other Vulnerable Children (NAP 2) and the NBSLEA Action Plan. PEPFAR will increase the focus of the OVC program on integration and coordination for increased impact, especially linking and integrating programs for children across the epidemic so that there are seamless, integrated services for children.

In-line with the Global Health Initiative (GHI) and PEPFAR Blueprint goals, COP14 activities will enhance efforts in HSS. Towards greater integration, key focus areas include greater emphasis within the PMTCT program to address weaknesses in family planning (FP) particularly in the postpartum period. Similarly through the network of New Life and New Start centers, strengthening of sexual and reproductive health services will occur with additional leveraged funding from DFID. To support all health programs, the MOHCC is devising an integrated system for supervision that, once completed, will be implemented using PEPFAR and other donor resources. The USG will build capacity of the GoZ through system strengthening in labs, informatics, and HRH. The USG will additionally build the capacity of the Department of Social Services (DSS) in the Ministry of Labour and Social Welfare (lead for children’s issues) by building the skills of DSS Officers to implement and monitor programs.

Quality assurance (QA) continues to be integrated into all aspects of the PEPFAR program. Under the leadership of the MOHCC QA Directorate, the USG team will continue to support quality of care improvement program in Zimbabwe. QA activities are already an integral part of the VMMC program. Supply Chain Management System (SCMS) and the University of Zimbabwe (UoZ), Department of Community Medicine (DCM) will continue to invest in human capacity to ensure the expansion of QA within the treatment program. Additionally, PEPFAR will be initiating a HIV Drug Resistance Early Warning Indicator Survey in COP14. To strengthen internal partner monitoring capacity, the USG SI team continues to conduct joint data quality assurance (DQA) site visits and uses the on-site data verification (OSDV) tools for all DQAs.



PEPFAR will increase our effort to take gender-specific vulnerabilities into consideration during program implementation in order to promote improved health outcomes for women and girls. Activities for COP14 include: directing 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, SRH, and HIV prevention. Additionally, an evaluation of the revised Families Matter! curriculum is planned for this year. The revised curriculum addresses sexual, emotional, and physical violence experienced by children. It further assists parents and care givers to recognize signs of violence and strengthen the referral network.

The interagency PEPFAR team evaluates the available resources and pipeline for each of its IP in a joint portfolio review (JPR). This review is also coupled with a performance review, assessing MOHCC's priorities, and content of the country COP funding level letter.

PROGRESS AND FUTURE

Country Strategy - The PEPFAR team planned a revised PEPFAR Five-Year Strategy but was instructed that the Sustainability Plan supersedes a Strategy. The PEPFAR team will submit a Sustainability Plan in FY14.

Country Ownership - Supporting the GHI principles of country ownership, activities remain focused on priorities set by the MOHCC for key HIV/AIDS programming and the DSS in Ministry of Labour and Social Services for OVC programming. The PEPFAR program supports MOHCC's leadership and national programs. All PEPFAR projects are guided by national policies, use national training curricula and guidelines, and rely on pools of national trainers rather than IP. The MOHCC-led technical groups are the primary mechanisms through which donor investments are coordinated. These groups have been instrumental to setting the pace of change and providing a platform for ongoing review of technical areas and implementation. Most PEPFAR programs are implemented in the public sector as MOHCC and DSS retains oversight of program activities.

The continued stabilization of the economy and to some degree the political situation in Zimbabwe has allowed for critical thinking of country ownership. During COP development, MOHCC was engaged in Technical Working Group (TWGs) forums, key leadership meetings, through key stakeholder meetings, and a special session for civil society organizations (CSO). The level of detail varied in each meeting to share budgets, key activities, targets, and to allow for dialogue and feedback.



Zimbabwe has contributed to gaps in the national HIV/AIDS response with resources from the National AIDS Trust Fund (NATF or AIDS Levy). Initiated in 1999, the AIDS levy, a 3% tax on income is raising increasing sums of money as the formal job sector expands. Projected FY13 income is \$35 million. The levy represents the expanding capacity of the GoZ to finance the national HIV/AIDS response and is managed by the NAC.

Trajectory of Future Activities

Global Fund (GF) – The GF is the largest donor to the national response. Zimbabwe was an early applicant for the NFM. In June 2013, the GoZ was awarded \$311 million of indicative funding for HIV/AIDS. UNDP remains the PR. UNAIDS attempted to document the process in a Case Study 2013: An AIDS Strategy Focused and Aligned with Our Vision and the United Nations Targets for 2015. The case study was rather misleading on the quality and scope of the gap analysis and country dialogue which informed the drafting of the concept note (CN). After the official signing of the award, Post has discovered that the CN did not prioritize key activities and commodities such as rapid test kits and ARVs. Remedial steps are being taken by the writing committee, acting on behalf to the CCM, to address the deficiencies by submitting an explanatory memo to explain changes in assumptions from the original CN submission.

Voluntary Medical Male Circumcision (VMMC) – PEPFAR continues to support the MOHCC's goal of 1.2 million MC by 2017. In January FY14, the MOHCC approved a policy shift to enable nurses to carry out MC procedures, both surgical and device. This development, with advocacy from the USG and IPs, is a huge success which should enable increased scale-up. The introduction of the PrePex device is expected to further speed up the scale-up. With PEPFAR support, the MOHCC has begun the active and passive surveillance phases for the PrePex device and wider use of the devices is expected to occur from August 2014. The Gates Foundation has moved away from funding MC service delivery and will focus on national and provincial-level coordination and consumer research. DFID will support delivery of an additional 70,000 MC in FY14 which will complement the PEPFAR investment.

Adoption of WHO Treatment Guidelines – Universal access is a goal in Zimbabwe reaching 67% adult coverage in FY13. In FY14, the MOHCC plans to aggressively adopt the WHO guidelines of initiating patients with a CD4<500 and adopting the single daily tablet of a combined three-drug formulation of tenofovir, lamivudine, and efavirenz (TLE). There are considerable cost implications. PEPFAR is working closely with MOHCC, GF, other donors, and UN agencies to guide thinking about a strategic plan to adopt the WHO guidelines.

Treatment as Prevention – The USG is convening stakeholders and conducting feasibility and needs assessment in COP14 of the demonstration project of treatment as prevention.



PMTCT Option B+ – In February 2013, the MOHCC called a national consultation to discuss the feasibility of Option B/B+. The consensus from this consultative process was to move ahead with option B+, a decision which has since been formally adopted. This new PMTCT regimen is due to be rolled out in FY14. PEPFAR will support the national rollout of Option B+ with a focus to ensure the availability of critical commodities, enhancing lab testing, and QA.

Human Resource Retention Scheme – Currently this is supported by the GF and the Health Transition Fund (HTF) donors. GFATM will fully cease providing resources for the retention scheme in FY15 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, although there is concern that with an overall shrinking budget this gap will not be filled.

PROGRAM OVERVIEW

Prevention

The PEPFAR prevention portfolio has several core interventions designed to achieve measurable results and produce significant impact. Key among these are: a comprehensive VMMC, PMTCT, HIV testing and counseling (HTC), and an extensive condom (sexual prevention) program. These efforts also include prevention services for most at risk populations and people 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 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. Assistance to expand the scale-up of VMMC services will include: the provision of necessary MC commodities; increase in the availability of the PrePex device; training of health providers including nurses in provision of surgical and device procedures; BCC to support VMMC acceptance; and 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 COP14 will help insure that comprehensive, high quality PMTCT services are provided uninterrupted at all MCH sites in all 62 districts of Zimbabwe. The



PMTCT program will support community initiatives designed to increase demand, uptake and retention of PMTCT and pediatric HIV care services, and support of the rollout of Option B+. 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 67,000.

HIV Testing and Counseling (HTC) – The USG's HTC program supports 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. PITC is offered in 92% of health facilities, but, other than for pregnant women, testing rates are not routinely monitored and are low. PEPFAR is supporting a pilot of efforts to increase opt-out testing rates at select facilities. Support for CITC services is channeled through centers (that include eight outreach teams) in the major urban areas 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 target high risk and vulnerable populations. HTC also is included in PEPFAR-supported PMTCT services. Funding to SCMS will help deliver HIV rapid test kits for use in both public facilities and NGO-managed sites.

Sexual Prevention – The USG's sexual prevention program comprises a comprehensive ABC program. Activities will include: risk reduction work; social marketing of male and female condoms; and support of male and female condom distribution through the public sector. Support will continue for the highly successful male and female condom program. FP services are also integrated within most sexual prevention activities. Currently activities for prevention with positives (PWP) includes positive prevention counseling, provision of information on positive living, ART, ART adherence counseling, outreach services to ART clinics, PMTCT, workplace services, FP and PWP, and PWP within HIV support groups. PWP services are integrated within the care and support setting with in the New Start and New Life networks. Additionally, there will be an increase of training of health care workers (HCW) to ensure quality of services for PWP.

Clinical Infection Control – The USG will continue strengthen the MOHCC's capacity for implementation of infection prevention and control (IPC) activities in health care facilities nation-wide. COP14 funds will contribute to reduction of nosocomial airborne infections and injection safety through a number of activities that include: dissemination of national IPC policy; establishing hospital IPC committees and policies; training of health workers; 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 to increase the number of facilities providing opportunistic infection (OI)/ART services. In COP14, PEPFAR will improve and expand the HIV/AIDS prevention and care capacity in health facilities in all eight provinces of the country.

PEPFAR will focus on supporting capacity building through training in management of OIs and HIV/AIDS. In FY13, a pool of mentors was established to provide site supervision to the participating facilities to improve the provision of OI/ART services that in turn yield sustainable high quality care outcomes. ITECH will strengthen distance e-learning for refresher training on HIV-related topics using tables distributed to HCW and a call-in support line for mentorship will be established to reduce time spent at workshops and out of the hospitals and clinics.

HIV Drug Resistance Monitoring – Support to national HIV drug resistance monitoring activities will continue. COP14 funds will enable the continuation of the early warning indicators survey and cross-sectional survey that will monitor drug resistance acquired during treatment at various time intervals.

Treatment as Prevention – COP12 funds supported the MOHCC to develop a policy framework and gain consensus for a model for implementation of the “treatment as prevention” strategy. In COP14, there will be a continuation of the demonstration project related to the feasibility and acceptability of treatment as prevention among key populations.

Health Quality Initiatives – Under the leadership of the MOHCC QA Directorate, the USG team will expand the HealthQual quality of care improvement program from 50 sites to 83 sites across Zimbabwe.

Support for Key Positions – SCMS will continue to second three medical officer positions to MOHCC AIDS & TB Program: the National ART Coordinator, Deputy National ART Coordinator for QA, and Assistant National ART Coordinator. Research Triangle International (RTI) will continue to support the Deputy Director for Health Information at the MOHCC. The UoZ/DCM will continue to support the M&E Coordinator, Data Management Officer, Surveillance Officer, and Masters of Public Health Officer for Health Information at the MOHCC. ITECH will support two Mater Training Officers, the Clinical Advisor for Training and Mentoring, and the TrainSmart Administrator positions in the MOHCC. ZACH will support the VMMC M&E Officer at the MOHCC.



Procurement of ARVs – The USG plans to maintain funding for first-line ARVs for 160,000 adult patients, assuming the cost for TLE is reduced. These will contribute to meeting the MOHCC goal to adopt the WHO treatment guidelines. If costs for TLE remain the same, additional resources will be required to procure TLE for all 160,000 patients. Internal PEPFAR team discussion re still on going on how best to sustain this commitment with a treatment TWG visit planned for July-August 2014. 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, GF, and DFID. SCMS will continue site readiness assessments and site supervision aimed at enhancing the MOHCC's ART scale-up activities, national quality of care initiative, and decentralization of ARV treatment.

Lab monitoring – PEPFAR will continue and expand support for provincial “super-laboratories” which will serve networks of OI clinic conducting regular laboratory monitoring for ART patients.

Care and Support

Leveraging – Non-PEPFAR funds will continue to augment some PEPFAR supported activities including 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 (nine 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 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 care and support services to over 110,000 new HIV-positive clients a year and ART adherence counseling to over 40,000 ART clients. All new HIV positive clients are provided with TB symptom screening. Clients are also provided with PSS and supportive counseling. The program trains more than 1,700 community-based PLWH support group leaders. All sites offer integrated FP services.

Orphans and Vulnerable Children (OVC) – The USG will continue to provide support to vulnerable children with a minimum of one core service, as outlined in the GoZ NAP 2. Areas of focus 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; focusing on the special needs of adolescent girls; and addressing NBSLEA Action Plan priorities. Additionally, in COP14 there will be a transition of awards to direct awards to three local organizations who are currently sub-partners of World Education International (WEI). This is in-line with greater country ownership and sustainability efforts by the USAID program.

Strategic Information

PEPFAR supports the provision of timely 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. The PEPFAR program plans in COP14-15 to conduct both a Demographic Health Survey (DHS) and AIDS Indicator Survey (AIS).

Health Management Information System (HMIS) – PEPFAR, in collaboration with the GF, will continue to provide extensive technical support to the national HMIS unit to strengthen the MOHCC's capacity to manage an integrated routine data collection system to provide timely information to guide policy formulation and programming. The USG also trained and provided on-going support and supervision for key personnel to strengthen routine monitoring. PEPFAR will continue to build the capacity of district and facility HCW in the use of data for decision making. In relation to this, PEPFAR will help MOHCC to strengthen production and timely dissemination of reports. With leveraged GF resources, PEPFAR will upgrade and build additional data sets into Demographic Health Information System (DHIS) 2, a more integrated system is being developed to include HIV, TB, Malaria, nutrition, laboratory and pharmacy, etc., to phase out vertical reporting systems.

Electronic Medical Records Systems (EMRS) – MOHCC has attempted to implement three EMRS in multiple facilities. Unfortunately this EMRS is not meeting the needs of the MOHCC. PEPFAR continues to provide technical support to develop and implement a viable EMRS for Zimbabwe. COP14 funds will be used to provide human and material resources for the pilot and roll-out of the selected EMRS.

Integrated Disease Surveillance and Response (IDSR) – The USG supported the strengthening of 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 with the goal to have this system fully integrated within the DHIS 2.

Surveys and Surveillance – PEPFAR continues to take the lead in supporting the MOHCC and NAC in



conducting surveys and in establishing and maintaining surveillance systems. 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 since 2006. Additionally, the second study within the Key Population Challenge Fund will be initiated. This study will estimate the size and characterization of SW populations and Men who have sex with Men (MSM), population sizes, characteristics including HIV prevalence, in three geographic settings.

Data Quality and Verification – To strengthen internal partner monitoring capacity, the USG SI team will continue to use the joint DQA and on-site data verification (OSDV) tools for use in country during joint DQAs and OSDVs visits. Over the past year, the USG conducted two project evaluations in line with the USAID Evaluation Policy. USAID will also continue with the regular environmental compliance visits, per USAID requirements.

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 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. Central funds focused on prevention of GBV are being implemented through RTI and WEI. RTI is piloting and evaluation the Family Matters! revised curriculum with the GBV modules added. WEI will be strengthening CPC to address the holistic needs of a child with emphases on prevention and referrals related to GBV. The NBSLEA is being used to better inform programmatic decision making. The PEPFAR team will continue to collaborate with UNICEF on a multi-country study related to violence against children.

The USG is supporting activities to address barriers to MCH services through focusing on providing minimum standards of care for MCH services, including 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 Life and New Start centers will continue with enhanced efforts to strengthen linkages to other GBV support services.

Government and Health Systems Strengthening

The MOHCC is the largest provider of diagnostic medical laboratory services. These laboratories operate as a network of 62 districts, 10 provincial, 5 central and 3 national reference laboratories. The USG is



providing laboratory services with External Quality Assurance (EQA). Currently 111 out of 186 public sector laboratories are participating in the EQA program. A new partner is reinvigorating the 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 COP14.

The USG will continue to support the national laboratory services to strengthen the lab monitoring and evaluation 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 FY12. There was an increase in number of sites reporting consistently and two outbreaks were detected through the laboratory based surveillance systems. In COP14, the USG will assist the MOHCC 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 provide technical assistance (TA) and support training to improve the accuracy of rapid HIV testing, which is especially important with the roll out of PMTCT Option B+.

The USG will support the development of an integrated approach to logistics within the MOHCC by working closely to build the capacity of both the MOHCC’s Directorate of Pharmacy Services (DPS) and the National Pharmaceutical Company, who together manage the procurement and distribution of the other drugs (including essential medicines which includes emergency medicines—adrenaline, oxytocin, insulin, antibiotics, pain relief medicines, etc.) and commodities (including gloves, needles, syringes, etc.) 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 COP14 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. Strengthening of the Masters in public health curriculum and training at the UoZ 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 Human Resource Information System (HRIS) for the MOHCC and the regulatory authorities will continue through a new mechanism. The goal of this follow-on project is to continue the development of 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. PEPFAR will support the DSS in the Ministry of Labor and Social Services to implement a comprehensive strategic plan for social services. USG funding will continue to upgrade the skills of District Social Services Officers, through the Diploma in Social Work Program, 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 National Association of Societies for the Care of the Handicapped and Disabled People's Organizations that work with children. This will ensure that they have access to critical services like education, health, and child protection.

GLOBAL HEALTH INITIATIVE, INTEGRATION, CENTRAL INITIATIVES

Global Health Initiative (GHI) - The Zimbabwe GHI strategy reflects two priority areas for GHI: 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 areas will reduce 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, COP14 activities will enhance efforts in HSS, see governance and system strengthening narrative. To ensure greater integration, key focus areas include emphasis within the PMTCT program to address weaknesses in FP particularly in the postpartum period. Similarly PEPFAR will continue to strengthen of FP services with additional leveraged funding from DFID. To support all health programs, the MOHCC is devising an integrated system for supervision and once completed, which will use PEPFAR and other donor resources for implementation. Supporting the GHI principles of country ownership, activities remain focused on priorities set by the MOHCC. Similarly all PEPFAR projects are guided by national policies, use national training curricula and guidelines, and rely on pools of national trainers rather than IPs.

Central Initiatives - The Zimbabwe PEPFAR team has embraced the opportunity to draw from central initiatives to bolster the PEPFAR program of support.

Together for Girls (TfG) will continue in COP14 to focus on prevention of GBV. TfG is being implemented through RTI and WEI. RTI is piloting and evaluation the Family Matters! revised curriculum with the GBV modules added. WEI will be strengthening CPC to address the holistic needs of a child with emphases on



prevention and referrals related to GBV.

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 includes: 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.

In COP14, the Local Capacity Initiative (LCI) will support local CSO to enhance country ownership and sustainability of the HIV/AIDS response. LCI will be building the capacity of the CSO to increase political leadership and stewardship, institutional and community ownership, and mutual accountability, including transparent financing.

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

The GF Collaboration Initiative is managed by UNICEF to support: capacity building 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 MOHCC joint bi-annual planning meetings; and improve consolidation of national health reports to inform decision making. This grant will come to an end in COP14.

The MEPI program will continue in COP14 with the Cerebrovascular Heart Failure, Rheumatic Heart Disease Intervention Strategy Committee implementing curricular in cardiovascular diseases to clinical courses and on the Med Medicine program. The MEPI program will deliver 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 with MEPI tutelage.