United States Department of State

Washington, D.C. 20520

FY 2015 Zambia Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Zambia.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

3) *Sustainability Index and Dashboard*

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

U.S. President's Emergency Plan for AIDS Relief
Fiscal Year 2015 Country Operational Plan
Strategic Direction Summary
Zambia

September 3, 2015

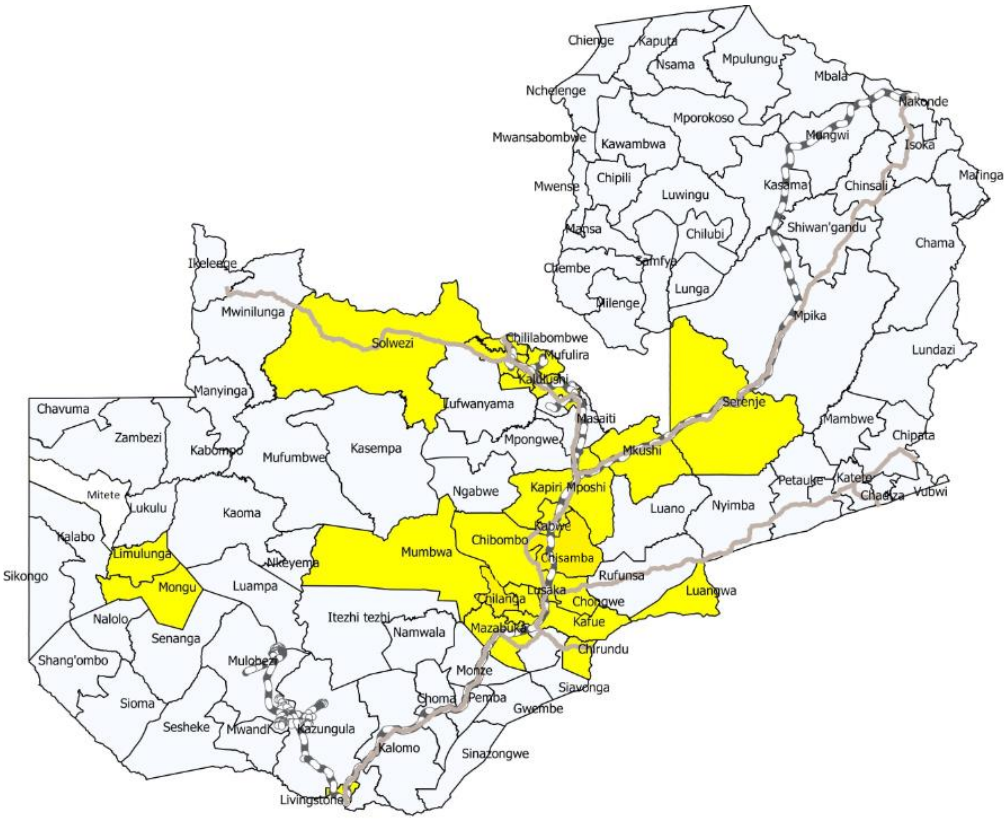


Table of Contents

Goal Statement

Over the last 11 years, the President's Emergency Plan for AIDS Relief (PEPFAR) program in Zambia has demonstrated that strategic allocation of resources aligned with the Zambian Government's National Health Strategic Plan and National AIDS Strategic Framework, paired with a USG team can accomplish great feats in addressing the vast challenges of HIV/AIDS. When PEPFAR Zambia first launched in 2004, only 3,500 Zambians were receiving life-saving anti-retroviral therapy. Today, more than 600,000 HIV-infected Zambians are alive as a result of HIV treatment. Over two million Zambians every year are counseled and tested for HIV. Over 700,000 orphans receive support and thousands of babies are born free from HIV every year because their mothers access prevention of mother to child transmission services. Programs focused on eliminating malaria, reducing maternal and newborn mortality in the hardest hit districts, and reducing deaths due to cervical cancer have benefitted from the sizeable PEPFAR investment in Zambia, which has proven to be a strong platform for other health and economic sector gains. PEPFAR has not only made its mark and brought hope to countless Zambians, but it has also cultivated hope for the future.

The Zambian government's leadership of the national HIV/AIDS response, financial support from cooperating and multilateral partners, and an open dialogue with civil society and beneficiaries form the foundation of a functional and effective partnership that can be leveraged for sustainability. Between 2001 and 2011, the rate of new HIV infections in Zambia dropped by 58 percent. The task at hand is clear: use program, financial, and epidemiological data to build on these successes and achieve sustained epidemic control so that Zambia can be one of the first countries with a generalized epidemic to achieve an AIDS-free generation.

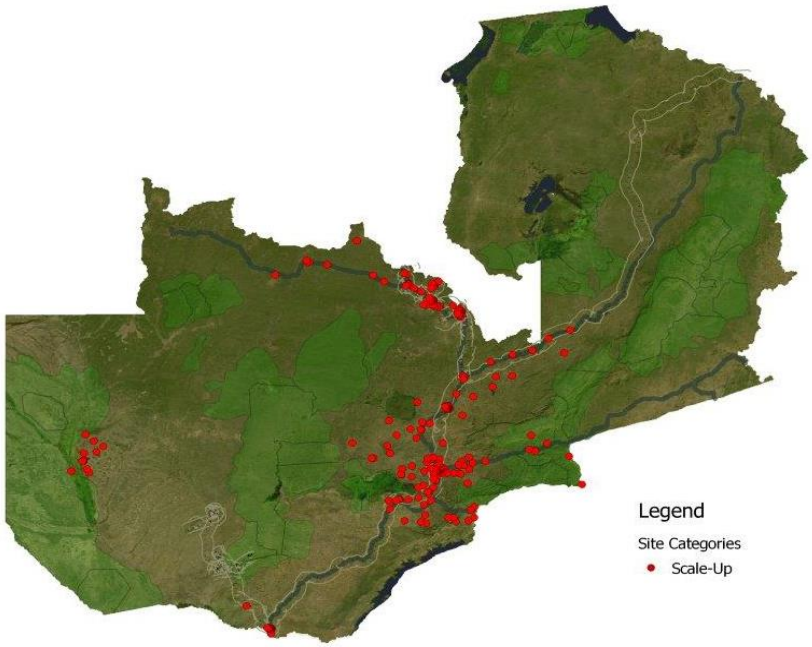
To achieve this goal, PEPFAR Zambia thoroughly analyzed a dozen data sources and proposes several programmatic pivots in the FY 2015 Country Operational Plan (COP). The USG team examined provincial and district level HIV prevalence, burden, unmet need, and Annual Progress Report (APR) 2014 site-level performance and unit expenditure data to determine geographic locations that would be prioritized for scale up, those that would receive sustained support, and those in which PEPFAR would provide central support. Based on site-level analysis across 1,594 sites; PEPFAR Zambia proposes to scale-up HIV prevention and treatment services in 258 sites (*Figure 1 and 2 below*), sustain services in 488 sites, and centrally support 624 sites. The patient volume (*i.e. HIV infected persons current on ART-based on 2014 APR*) represented in this site categorization is 315,176 for scale up sites, 203,540 in sustained high, 29,976 in sustained-low and 17,052 within the central-support sites. This approach is intended to reach 80% of Zambians in need of critical HIV/AIDS services within the priority locations and is aligned to the UNAIDS 90-90-90 global targets for arresting the AIDS epidemic by 2020.

Achieving sustainable epidemic control will require new and creative ways of working with implementing partners and the Zambian government to manage transitions and make budgetary and programmatic shifts that harmonize coverage. The Sustainability Index and Dashboard has

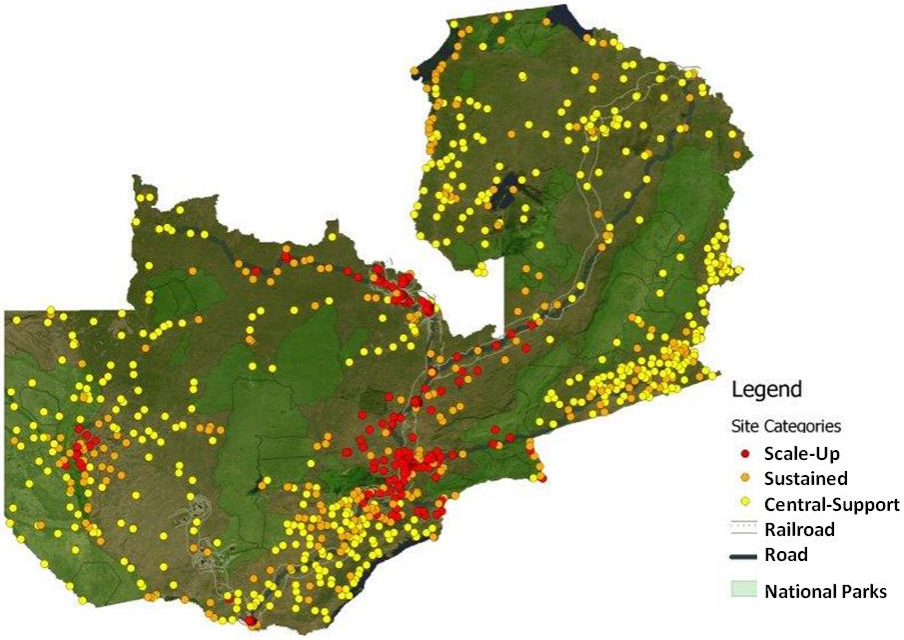
created a solid framework for engaging the Zambian government and partners on tangible aspects of sustainability.

Figure 1: Maps showing Scale-Up Site Distribution (a) and Distribution of All Sites (b)

(a)

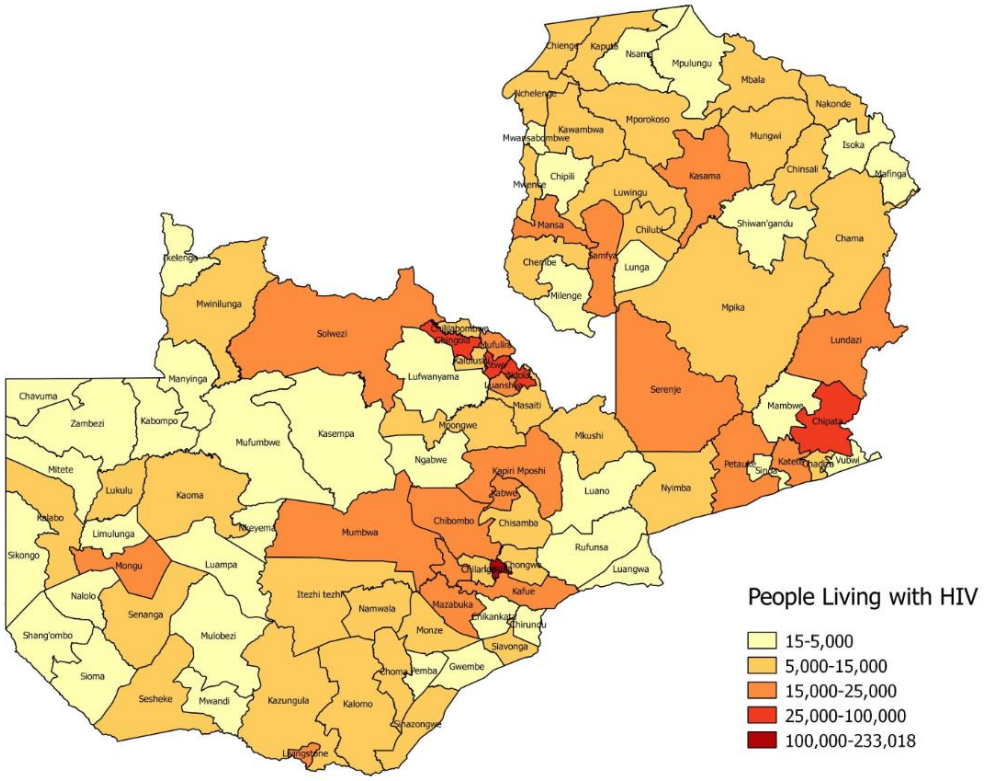


(b)

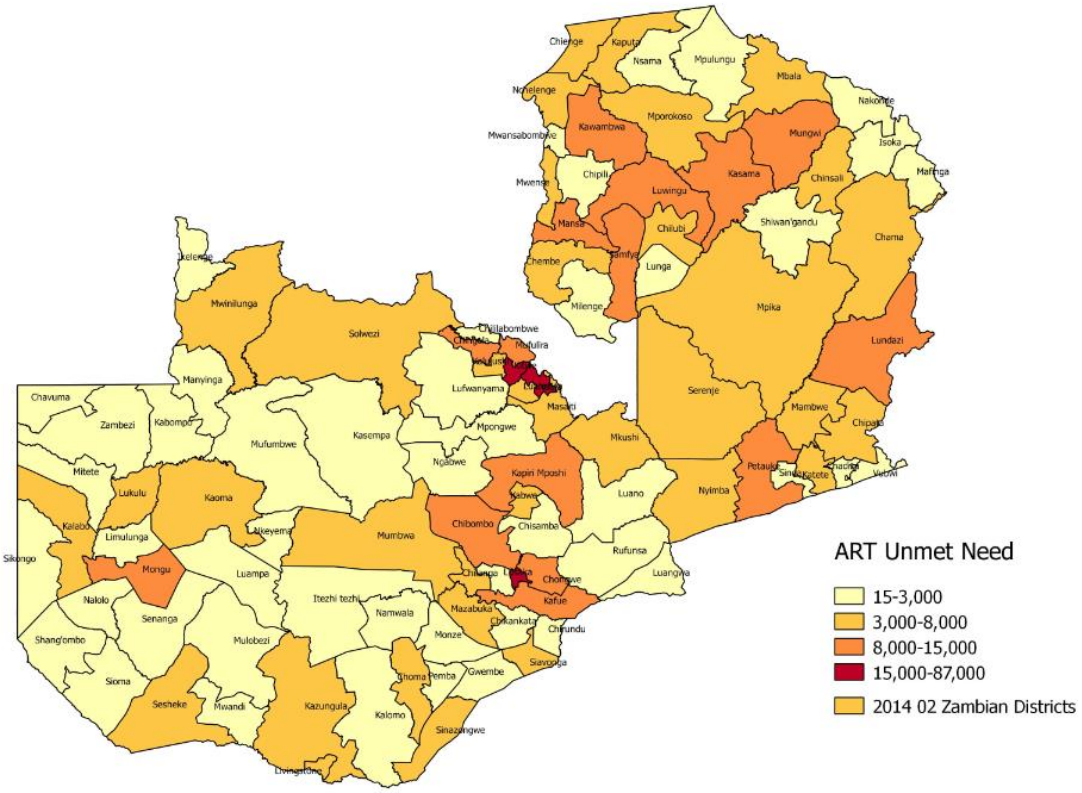


*District boundaries have recently been moved; as a result site positions might differ slightly from what is shown.

(a)


People Living with HIV
15-5,000
5,000-15,000
15,000-25,000
25,000-100,000
100,000-233,018

(b)


ART Unmet Need
15-3,000
3,000-8,000
8,000-15,000
15,000-87,000
2014 02 Zambian Districts

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Zambia is a lower, middle-income country (GNI: 3,810 per capita, PPP adjusted[1]) with an estimated current population of15,003,936[2] (population demographics: 49% male, 51% female; 58% rural, 42% urban).According to the 2013 Demographic and Health Survey (DHS) released on March 30, 2015, 13.3% of persons aged 15 – 49 years are infected with HIV (11.3% among adult males, 15.1% among adult females; 9.1% rural adults, 18.2% urban adults).[3]Detailed demographic and epidemiological data is presented in **Table 1.1.1** and prevalence data is displayed graphically in **Figure 1.1.1**.

In order to reach epidemic control, PEPFAR Zambia will focus clinical treatment and core combination prevention interventions in priority locations with a high burden of HIV and unmet need for HIV prevention and treatment services. Accordingly, the PEPFAR ART program will enrol 154, 647[4] (includes 29,052[5] children) HIV infected persons on ART and overall have a total of 748,225[6] on ART; this represents 60% coverage by the end of FY 2016. Working towards the UNAIDS 90-90-90 goal, PEPFAR Zambia targets to have 946,472[7]HIV infected persons on treatment by end of FY 2017; this represents approximately 80% coverage.

PEPFAR Zambia acknowledges, however, that a great deal of work is required to achieve epidemic control. PEPFAR Zambia encountered the following data challenges in trying to better define the epidemic in Zambia: 1) lack of data on viral suppression as this is not routinely collected; 2) lack of pediatric HIV prevalence data; 3) delay in availability of incidence data from the 2013 national level estimates of HIV/AIDS;[8] 4) variations in data from multiple data sources (e.g. PEPFAR and DHIS); and 5) limited data on key populations (KPs).[9]These gaps in data quality and availability create challenges in identifying specific scale up districts and priority populations to reach epidemic control.

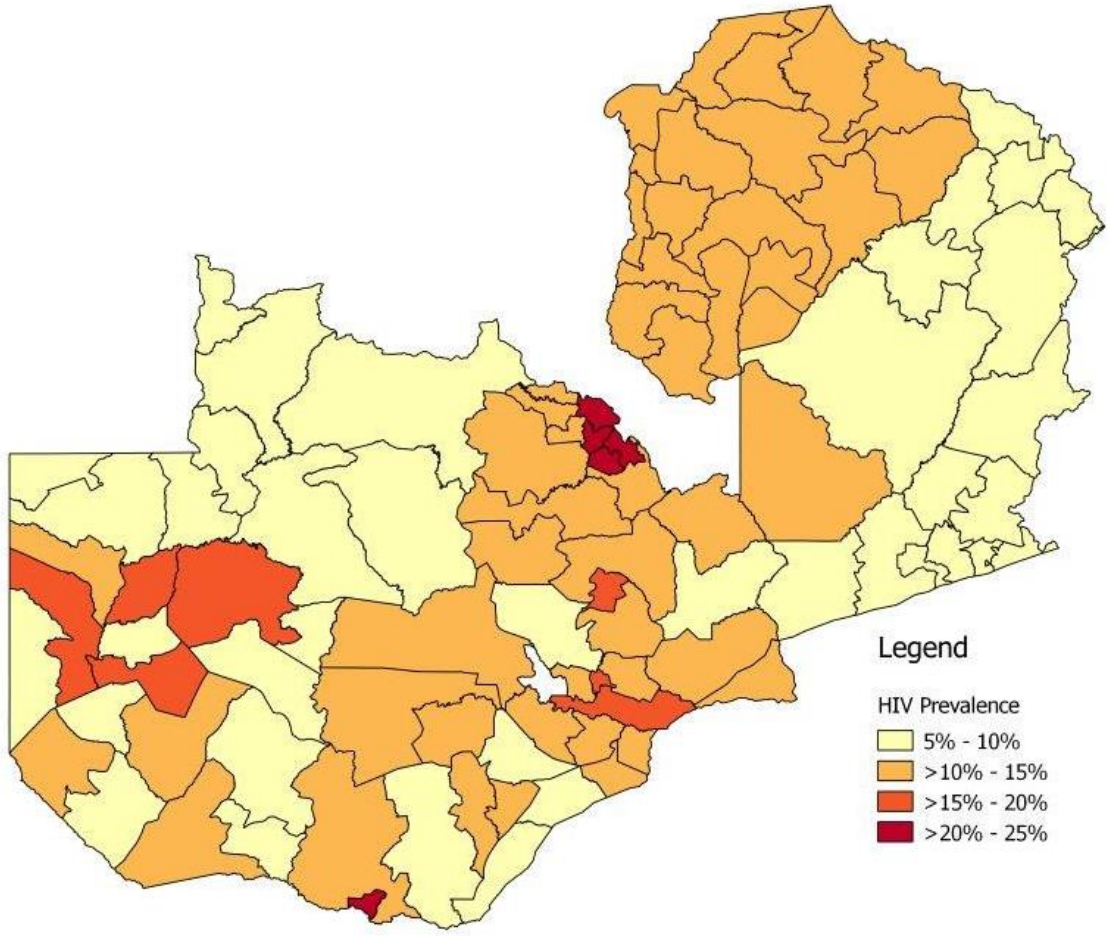
[1] World Bank, 2013.
[2] PEPFAR Zambia Data-pack
[3] This estimation is derived from EIA testing; field-based rapid testing preliminarily reported in August 2014 yielded a national HIV prevalence rate of 10.3%.
[4] PEPFAR Zambia Data-pack, excluding central support sites.
[5] Accelerating Children's Treatment Strategy and Implementation Plan.
[6] PEPFAR Zambia Data-pack, excluding central support sites.
[7] PEPFAR Zambia Data-pack.
[8] National level estimates of HIV/AIDS will be available *after* the Health Impact Assessment (HIA).
[9]While some targeted mapping and size estimations can tentatively guide PEPFAR Zambia in the size and location of high-risk populations, accurate HIV prevalence estimates among KPs will not be available until 2016 at the earliest. KP surveys incorporating biological specimen testing are currently under review by ethics committees.

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	15,003,936		3,453,164	23.0	3,484,984	23.2	4,138,028	27.5	3,947,139	26.3	Population and Demographic Projections 2013 (2014 estimates)
Prevalence (%)		13.3		1.96		1.98		15.1		11.3	DHS, 2013 [15-49], Total and 15+ HIV prevalence based on 2013 DHS EIA results. Under 15 based on Spectrum Projections point estimate 2014
AIDS Deaths (per year)	21,276		2,805		2,724		4,569		11,178		Spectrum,2015
PLHIV	1,244,493		101,356		103,105		543,933		496,100		Data pack, Spectrum 2015
Incidence Rate (Yr.)		0.34		0.13		0.14		0.5		0.53	Spectrum,2015
New Infections (Yr.)	50,809										Spectrum,2015, 2014 estimate
Annual births	743,654	4.95									Calculation based on 4.95% of the total population (as advised by MOH)
% >= 1 ANC visit	778,808	96	NA	NA			NA	NA			Calculation based on 96% of all expected pregnancies (as advised by MOH), DHS 2013
Pregnant women needing ARVs	97,351	12									Calculation based on 12% of all expected pregnancies. Based on ANC Positivity (APR 2014)
Orphans (maternal, paternal, double)	1,328,000		N/A		N/A		N/A		N/A		NACMIS, 2010
TB cases (Yr.)	45,793		1,623		1,726		16,678		25,766		MoH, 2013
TB/HIV Co-infection	25,676	63	NA	NA	NA	NA	NA	NA	NA	NA	MoH, 2013 [89% of all TB

											patients were tested and 63% were co-infected]
Males Circumcised	856,032	46			359,534	42			496,499	58	MoH 2014, 2007-2014. 2007-2011 (all ages); 2012-2014 (15-49)
Key Populations	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Total Adolescent girls and young women 15 – 19 yrs 20 – 24 yrs	745,025 612,600	4.8 11.2									Prevalence based on DHS 2013 and population based on Census 2010
Total MSM*	10,452	NA									Size estimate in six towns (Population Council 2014) No survey with biomarkers has been done
Total FSW	24,807	NA									Size estimate in six towns (Population Council 2014)
Total PWID	3,435	NA									
Military[10]	-	-	-	-	-	-	-	-	-	-	-

[10] Due to confidentiality requirements, the Zambian military is unable to provide specific epidemiology data; however, the military is considered a priority population.

Figure 1.1.1 HIV Prevalence by District



The HIV epidemic in Zambia is generalized with heterosexual sex as the primary mode of transmission.[11] Through Spectrum modelling data, HIV prevalence among children under 15 years is estimated to be 1.97%[12]. Spectrum data for morbidity and mortality also approximate the total number of deaths attributed to AIDS is 21,276; with 65% of AIDS deaths being male and 72% are adults. In Zambia, HIV disproportionately affects those living in urban areas and women. While only 42% of the population lives in urban areas, urban residents have an HIV prevalence of 18.2%, compared to 9.1% prevalence in rural areas. Equally, adult women have increased prevalence when compared to adult men in both urban (21% vs. 15%) and rural (9.9% vs. 8.1%) areas. The Copperbelt province has the highest prevalence (18.2%), followed by Lusaka (16.3%), Western (15.4%) and Southern provinces (12.8%). Muchinga and North Western provinces have the lowest prevalence, estimated at 6.4% and 7.2% respectively. Data support most of the HIV positive individuals are residing in high-density areas (refer to map in **Figure 2**). Because Lusaka, Copperbelt and Southern provinces have dense population centres, disease burden is highest in

[11] UNAIDS data estimated 90% of adult infections are attributable to heterosexual transmission.
[12] Approximately 45% of individuals living with HIV are 15+ females while adult males account for approximately 42%.

these provinces (435,088, 419,556 and 230,384 respectively). Detailed data regarding the cascade of HIV diagnosis, care and treatment is presented in **Table 1.1.2**.

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (Oct. 1, 2013 – Sept. 31, 2014)

				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	15,003,936	13.3*	1,244,493	679,404**[13]	679,404**	74,394	NA	2,009,754**	237,169	91,212
Population less than 15 years	6,938,148	1.97	204,461	42,000**	42,000**	N/A	NA	172,963**	NA	6,111
Pregnant Women	811,259	12	97,351	NA[14]	NA	NA	NA	Target is 95% but PEPFAR is estimated to contribute 80% to national targets	NA	Target is 95% but PEPFAR is estimated to contribute 80% to national targets
MSM**	10,452	NA	NA	NA	NA	NA	NA	NA	NA	NA
FSW**	24,807	NA	NA	NA	NA	NA	NA	NA	NA	NA
PWID**	3,435	NA	NA	NA	NA	NA	NA	NA	NA	NA
Military[15]	-	-	-	-	-	-	-	-	-	-

[13]There is no data from GRZ (national figures) for number 'In Care'. PEPFAR Zambia used number 'On ART' as a proxy.
[14] Detailed national level results regarding pregnant women are not available (affecting 'In Care', 'On ART', 'Retained on ART 12 Months', 'Viral Suppression 12 Months' figures).
[15] Due to confidentiality, the Zambian military is unable to provide specific epidemiology data; however, the military is considered a priority population.
*EIA based prevalence.
**Data not available.

1.2 Investment Profile

Through PEPFAR, the USG continues to be the largest contributor to Zambia's HIV response totaling approximately 60% of funding in 2014 with additional contributions from the Global Fund (27%)[16] and GRZ (10%) (See **Table 1.2.1**).[17] As in many countries, Zambia has seen a decline in overall donor activity in recent years, requiring the GRZ to take on additional fiscal responsibility. The GRZ increased budget allocations for key sustaining commodities (such as ARVs) from $6M in 2010 to $59.6M in 2014 (see **Table 1.2.2**). Quantifying GRZ funding for infrastructure, salaries, and other overhead costs remains a challenge; if these were to be quantified GRZ contribution would be greater than 10%.

Table 1.2.1 Investment Profile by Program Area[18]

Program Area	Total Expenditure	% PEPFAR	% GF	% GRZ	% Other
Clinical care, treatment and support	$243,204,795	56%	27%	17%	0%
Community-based care	$31,967,732	97%	3%	0%	0%
PMTCT	$22,175,230	89%	10%	0%	1%
HTC	$17,242,498	70%	21%	1%	9%
VMMC	$20,421,299	87%	10%	0%	3%
Priority population prevention	$272,517	0%	100%	0%	0%
Key population prevention	$12,155,210	96%	4%	0%	0%
OVC	$34,676,494	63%	35%	0%	2%
Laboratory	$11,956,095	68%	21%	8%	3%
SI, Surveys and Surveillance	$25,506,559	53%	32%	0%	15%
HSS	$62,588,597	32%	52%	8%	9%
Total	$482,167,026	60%	27%	10%	3%

Table 1.2.2 Procurement Profile for Key Sustaining Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRP	% Other
ARVs	$166,382,795	27%	37%	36%	0%
Rapid test kits	$5,248,800	52%	48%	0%	0%
Other drugs	$3,810,674	56%	0%	44%	0%
Lab reagents	$39,891,222	63%	30%	7%	0%
Condoms	$4,888,693	31%	0%	23%	47%
VMMC kits	$1,925,000	100%	0%	0%	0%
Other sustaining commodities	$19,366,590	31%	0%	47%	22%
Total	$241,513,774	35%	31%	31%	3%

The Revised National AIDS Strategic Framework (R-NASF) (2014-2016) estimates the overall funding gap for 2014-2016 at $263,845,320 (see **Table 1.2.i**).

[16]Contributions from the Global Fund are anticipated to decline in 2016 and 2017, since the majority of the New Funding Model resources will be spent in the first two years.
[17]Other contributors include the Department for International Development of the United Kingdom (DFID), World Bank, Sweden, the European Union, and Irish Aid – all contributing less than 1% each to the response.
[18]Revised National AIDS Strategic Framework (R-NASF) 2014-2016 - Counterpart summaries.

Table 1.2.i R-NASF Funding Projections: Macro Costing of the R NASF

	2014	2015	2016	Total
Total Resource Needs	499,145,748	588,040,877	563,739,863	1,650,926,488
Total Funding Available	482,167,026	467,371,155	437,542,987	1,387,081,168
Annual Gap/Surplus	**-16,978,722**	**-120,669,722**	**-126,196,876**	**-263,845,320**

To reduce the aforementioned funding gap, PEPFAR Zambia plans to: a) increase dialogue with GRZ on viable, sustainable health financing mechanisms; b) identify local funding opportunities from the private sector through public/private partnerships (PPP) and within communities; c) mainstream HIV within other key social and development sectors (e.g., health, social protection, education, infrastructure, and transport);[19] d) continue to analyze the funding gap within specific line items in order to make sure that limited resources are directed towards the activities with the highest impact (see **Tables 1.2.1** and **1.2.2**); and e) continue to coordinate with other USG-funded health programs (see **Table 1.2.3**).

Complementary non-PEPFAR funded programs must also be leveraged for epidemic control. In high-burden areas, USAID-supported TB, family planning, maternal and child health, and nutrition programs complement health systems and improve quality of services rendered by health care providers supporting a continuum of care from the community to the facility. Integrated programs, and even complementary activities, will enhance the quality of life of patients and improve the clinical capacity of health care providers, ultimately improving multiple health outcomes.

Zambia submitted a concept note under the Global Fund's New Funding Model (NFM) in June 2014. New resources under the NFM will be combined with existing resources currently programmed through UNDP. New resources are programmed through MOH and Churches Health Association of Zambia (CHAZ). New grants with MOH and CHAZ were signed in January 2015 and implementation has started. The PR transition from UNDP to MOH is on track, e.g. UNDP TB grant in May 2015.

Zambia Global Fund Grant Summary

Principal Recipient	Disease Area	Amount	Duration
UNDP	HIV	$87,048,402	Ends July 31, 2016
MOH	HIV-TB NFM	$100,702,951	Jan 2015-Dec 2017
CHAZ	HIV-TB NFM	$57,588,242	Jan 2015-Dec 2017

[19] The GRZ has demonstrated commitment to reducing the incidence of HIV through sustained resource allocation for ARVs, OI drugs and HIV diagnostic commodities.

UNDP Summary Budget

Service Delivery Area	2015	2016	Total
PMTCT	$163,419	$0	$163,419
VMMC	$9,099	$0	$9,099
Testing and Counseling	$2,237,345	$0	$2,237,345
Blood safety and universal precaution	$0	$0	$0
STI diagnosis and treatment	$0	$0	$0
ART	$56,143,378	$0	$56,143,378
M&E - Information Systems and Operational research	$1,579,749	$589,954	$2,169,703
Procurement & Supply Management (PSM) Strengthening	$24,608	$10,081	$34,689
Public Financial Management (PFM)	$42,170	$37,729	$79,899
Institutional Capacity Development	$708,217	$531,163	$1,239,380
Procurement Supply Management	$9,950,822	$369,522	$10,320,344
Institutional Capacity Development	$5,033	$0	$5,033
Program Management and Administration	$2,380,157	$1,755,113	$4,135,270
Program Management and Administration	$8,050,660	$2,460,180	$10,510,840
			$0
Total	**$81,294,658**	**$5,753,744**	$87,048,402

MOH Summary Budget

Service Delivery Area	2015	2016	2017	Total
Prevention programs for general population	$3,693,642	$2,453,331	$2,401,701	$8,548,673
PMTCT	$1,161,948	$1,301,103	$886,005	$3,349,056
Treatment, care and support	$13,894,926	$43,910,492	$860,737	$58,666,156
TB care and prevention	$1,950,128	$4,338,421	$667,825	$6,956,374
TB/HIV	$717,056	$3,016,352	$3,504,271	$7,237,679
MDR-TB	$53,627	$7,074	$8,478	$69,180
HSS - Procurement supply chain management (PSCM)	$3,251,280	$0	$0	$3,251,280
HSS - Health information systems and M&E	$2,710,144	$2,652,946	$1,000,000	$6,363,090
Removing legal barriers to access	$152,500	$100,000	$100,000	$352,500
Program management	$774,798	$1,818,727	$3,315,437	$5,908,962
Total	**$28,360,048**	**$59,598,447**	**$12,744,455**	**$100,702,951**

CHAZ Summary Budget

Service Deliver Area	2015	2016	2017	Total
Prevention programs for general population	$651,687	$1,127,668	$1,251,811	**$3,031,166**
Prevention programs for adolescents and youth, in and out of school	$2,109,413	$1,960,643	$1,027,836	**$5,097,892**
PMTCT	$575,597	$475,986	$351,140	**$1,402,723**
Treatment, care and support	$6,014,064	$9,043,312	$8,320,412	**$23,377,788**
TB care and prevention	$263,137	$60,158	$55,380	**$378,675**
TB/HIV	$61,372	$61,372	$61,372	**$184,116**
HSS - Procurement supply chain management (PSCM)	$3,241,920	$2,630,419	$797,960	**$6,670,299**
HSS - Health information systems and M&E	$763,534	$208,067	$177,385	**$1,148,986**
Community systems strengthening	$1,239,037	$1,200,957	$1,162,876	**$3,602,870**
Program management	$4,764,355	$4,041,625	$3,887,742	**$12,693,722**
Total	**$19,684,116**	**$20,810,207**	**$17,093,914**	**$57,588,237**

NFM Incentive Funding

Service Delivery Area	Intervention	MOH	CHAZ	Total
TB/HIV	Gene Xperts	$1,812,062	$0	**$1,812,062**
Prevention-gen pop	VMMC	$3,302,616	$1,415,407	**$4,718,024**
HMIS & M&E	ARV Resistance monitoring	$2,000,000	$0	**$2,000,000**
Treatment care & support		$181,660	$0	**$181,660**
Deficit on upper ceiling		$424,218	$181,807	**$606,025**
Savings included in grant budget		$6,872,120	$1,233,599	**$8,105,720**

Budget Summary for ARV Procurement	
2015	**2016**
$58,000,000	$41,000,000

*Consumption in 2016 and 2017 respectively

Global Fund investments contribute to national targets; as a result, grant targets are the national targets (from approved disease strategies), they are not grant specific, i.e. achieving the target is not only dependent on grant monies. Budgeting for the two new HIV-TB grants was based on the HIV-TB Zambia Concept Note. The UNDP grant supports part of the package of care for persons on ART; therefore, they cannot be counted as unique individuals being supported. Global Fund resources can be realigned (through grant reprogramming) with priorities agreed among country stakeholders in Zambia—Including the PRs, CCM, and key partners. Efficiencies found within the

grants during implementation can also be allocated to agreed priorities. Beyond the NFM, future allocations of Global Fund resources in Zambia will depend on a successful replenishment cycle and subsequent country allocation, the donor profile in country and the continued commitment of GRZ to support treatment within the national HIV response.

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives[20]					
Funding Source	**Total** / Non-COP Resources	**Non-COP Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution[21]**	**Objectives**
USAID MCH	13,300,000	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	○ MNCH activities target MDGs four and five; strengthening clinical capacity of provincial, district, and facility managers with mentorship and supportive supervision. ○ Pre-service training in EmONC targeting nurse clinical instructors in the midwifery schools and advocating for the integration of EmONC into the midwifery curriculum. ○ Complements PEPFAR and FP activities, particularly through close provincial and district level collaboration. ○ Saving Mothers Giving Life, in particular represents a nexus of activities (PEPFAR and MNCH/FP) to reduce maternal and newborn deaths in targeted districts.
USAID TB	4,500,000	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	○ TB activities strengthen high-quality DOTS expansion and enhancement, address TB-HIV, MDR-TB and the needs of poor and vulnerable populations in six high burden target provinces, engage all categories of care providers, and enable and promote operational research.

[20] Explanation of funds utilizes definitions provided in the SDS Guidance.

[21] Single year funding used for both COP and Non COP amounts. Per guidance, it was necessary to use investment and expenditure data from the most recent period available (FY14). In the case of our programming in Zambia, the PEPFAR funding will dictate where targeted districts will be saturated with support for not only HIV/AIDS, but other health accounts. In carrying out PEPFAR 3.0, we will not only be able to arrest the HIV/AIDS epidemic, but also ensure that patients have access to a continuum of care from the community to the facility, as well as other health services. Since USAID also receives funding for maternal and child health, family planning, nutrition, and TB, we considered how we could leverage those other accounts to further PEPFAR goals. Given that these awards are soon to be released, these geographic shifts and re-direction can easily be incorporated into new awards, and other health resources will complement PEPFAR goals.

USAID Malaria	24,000,000	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	○ Malaria activities designed to reduce malaria mortality by two-thirds, malaria incidence by three-fourths, and malaria parasitemia in children under age five by one-half in four targeted provinces through ITN distribution, case management, delivery of intermittent preventive treatment to pregnant women, behavioral change interventions, development of policies and guidelines, and strengthening management capacity at a provincial and district level.
Family Planning	13,000,000	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	○ FP/RH activities increase Modern Contraceptive Prevalence Rates in all women of reproductive age by 2% annually from the second year as compared to the baseline through increased access to and improved quality of family planning services in targeted sites via a strengthened, community-based family planning service delivery system.
USAID Nutrition	4,000,000	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	○ Nutrition resources target Integrated Management of Childhood Illness, expanding immunization, Vitamin A supplementation, and de-worming activities. ○ Training of health workers and community volunteers in child health and nutrition helps reduce under-five morbidity and mortality. ○ Activities strengthen infant and young child feeding and are integrated with other Feed the Future activities that help vulnerable households improve food security through strengthened economic resilience and improved nutrition status in Eastern Province (one of the high burden targeted provinces for HIV prevention, care, and treatment activities). ○ Nutrition activities are also designed in collaboration with other donors as part of the global Scaling up Nutrition Initiative. (USAID is part of the Cooperating Partner Nutrition Group (co-convened by DFID and UNICEF) that coordinates assistance for Zambia's work to address malnutrition. The group has helped develop a multi-stakeholder platform and a civil society umbrella group to address under nutrition).

1.3 National Sustainability Profile

PEPFAR Zambia completed the Sustainability Index and Dashboard (SID) in collaboration with key GRZ representatives, multilateral and bilateral donors, international non-governmental organizations, and local civil society organizations. The analysis revealed weaknesses in some priority elements, ranked on the basis of element score and criticality to sustained epidemic control (**Table 1.3.1**).

Table 1.3.1 Sustainability Index and Dashboard Results

Element/Score	Description	Notes on Sustainability
DRM: Resource Commitment (Score 7/20)		
	Financial commitment is a critical component of country ownership and essential for sustainability of the national response. The SID indicates that domestic HIV expenditures finance 10 to 24 % of the national response. Additionally, there is paucity of information on the proportion of key population-specific interventions financed by domestic resources. Data used to determine proportions contributed by the GRZ were derived from the National AIDS Spending Assessment (NASA) of 2012 and the Revised National AIDS Strategic Framework (R-NASF) 2014-2016. In responding to this question in the SID, it was not possible to quantify other contributions made by the GRZ towards the response, including human resources, infrastructure, equipment and utilities. There are, however, clear indications that the GRZ's spending on the HIV response has increased significantly in recent years, including the almost ten-fold increase in the GRZ's budget for ARVs between 2010 and 2014.	A number of key stakeholders have invested in activities aimed at promoting sustainable health financing. These include the GRZ, World Bank, DFID, Japanese International Cooperation Agency (JICA), Swedish International Development Agency (SIDA), Irish Aid, EU, and USG/PEPFAR. Multilateral and bilateral donors have advocated for increased domestic resources through diplomatic channels and other forums such as the Health Sector Cooperating Partners' Group (CPG). PEPFAR is cognizant of the fact that GRZ has a limited resource envelope with other competing priorities, and that increasing the sustainability score for this element may not be possible in the near term.
Access and Demand (Score 7.8/20)		
	This element combines key components of the national response, including access to ART, access to PMTCT Option B+ services, services to KPs, and the right to access services/nondiscrimination. The SID indicates that less than 20% of healthcare facilities provide ART services and fewer than 40% provide PMTCT care in high-prevalence areas. Additionally, there is no information available about services accessed by KPs. Facilities with traditional laboratory infrastructure are too few in number for the population size and it is estimated that only 25% of health facilities offer laboratory services (Source: 2012 MOH List of Health facilities in Zambia).	Key stakeholders who have invested in activities to increase access to and demand for HIV prevention, care and treatment services include GRZ, PEPFAR, Global Fund, United Nations Development Program (UNDP), UNAIDS and UNICEF. Given the current level of investment in service delivery by key stakeholders, it is possible to improve the sustainability score of this element in the next two to three years.
Epidemiological and Health Data (Score 9.8/20)		
	The timely availability of accurate and reliable data to inform policy, financing and programming decisions is essential for achieving epidemic control. The SID indicates that the GRZ contributed less than 20% towards financing of the latest HIV epidemiological data survey. GRZ does not routinely engage stakeholders in data analysis in a timely fashion and does not systematically collect viral load data. Size estimate studies of KPs are limited.	Key stakeholders that have invested in activities to ensure the availability of high quality data include GRZ, PEPFAR, Global Fund, and European Union (EU). The EU has invested in strengthening the national Health Management Information System. Considering the level of investment in this element by key stakeholders, it is possible to increase the sustainability score in the next two to three years.
Human Resources for Health (Score 14.8/20)		
	An adequate number of motivated health workers, with the appropriate skills mix, is critical to achieving epidemic control and a sustainable national HIV response.	Several key stakeholders have invested in HRH, including the GRZ, World Bank, DFID, EU, and Clinton Health Access Initiative (CHAI).

	Zambia is facing a critical shortage of health workers with approximately 40% of positions in the health sector establishment remaining vacant. Laboratory staffing is compromised by deficiencies in pre-service training, which has limited practicum. When laboratory students are deployed for internship they are sometimes inappropriately assigned to perform routine testing to compensate for chronic shortage of assigned personnel and heavy workload. The SID demonstrates that there are insufficient numbers of health workers trained in HIV to meet the service delivery needs. Given the importance of this element to achieving sustainability of the national response, continued investment is warranted despite the relatively high sustainability score of 14.8.	DFID supported the training, deployment and salaries of the initial cohort of 300 community health assistants, while CHAI provides technical support to the Ministry of Health and has conducted a number HRH studies and assessments.
Commodity Security and Supply Chain (Score 15)		
	The availability of life-saving antiretroviral medications and other HIV sustaining commodities is essential for epidemic control and a sustainable national response. While the GRZ's expenditure on ARVs has steadily increased over the past four years, the host government's contribution towards the procurement of rapid test kits is less than 30%. The country also faces challenges with storage space, and this is likely to be exacerbated by scale up of prevention, care and treatment services. GRZ provides less than 10% of the cost of lab sustaining commodities. PEPFAR supports the procurement of HIV-related sustaining commodities, but there is still a persistent $10M shortfall in the overall estimated commodity costs for laboratory services. PEPFAR/Zambia feels that the importance to this element to achieving sustainability warrants continued investment despite the relatively high sustainability score.	Stakeholders that contribute towards commodity security and supply chain include GRZ, PEPFAR, Global Fund, World Bank, DFIID, SIDA and EU. The Global fund procures 31% of key sustaining commodities for the national response (Table.1.2.2). PEPFAR and the World Bank are collaborating as they pilot a logistics management information system and an electronic inventory control system. SIDA provides technical assistance to Medical Stores Limited and provided funds to roll out the initial two regional commodity hubs. With the significant investments that have been made in this area, it is likely that the sustainability score will increase in the medium- to long- term.

Domestic Resource Mobilization

The Government of the Republic of Zambia through the national health strategic plan (2011-2015) identified the creation of HIV/AIDS fund, development of new health related taxes, establishing of the social health insurance scheme and participation of the private sector as some of the sustainable means of raising domestic resources for HIV/AIDS. PEPFAR will assist the Government of the Republic of Zambia to operationalize these by: a) provision of support to finalize and implement the national Health Financing strategy, b) provision of technical and financial support towards the establishment of HIV/AIDS fund and social health insurance scheme and for institutionalization of the National Health Accounts, d) supporting cost, efficiency and cost-effectiveness studies of HIV/AIDS interventions to promote evidence in decision making, e) promotion of Public-Private Partnerships in health, f) strengthening public financial management, g)supporting champions to advocate for increased domestic resources, h) working with other cooperating partners and using diplomatic channels to advocate for increased domestic resources and government commitments and i) collaborating with the World Bank to undertake results based financing initiatives that improve HIV/AIDS/Health outcomes.

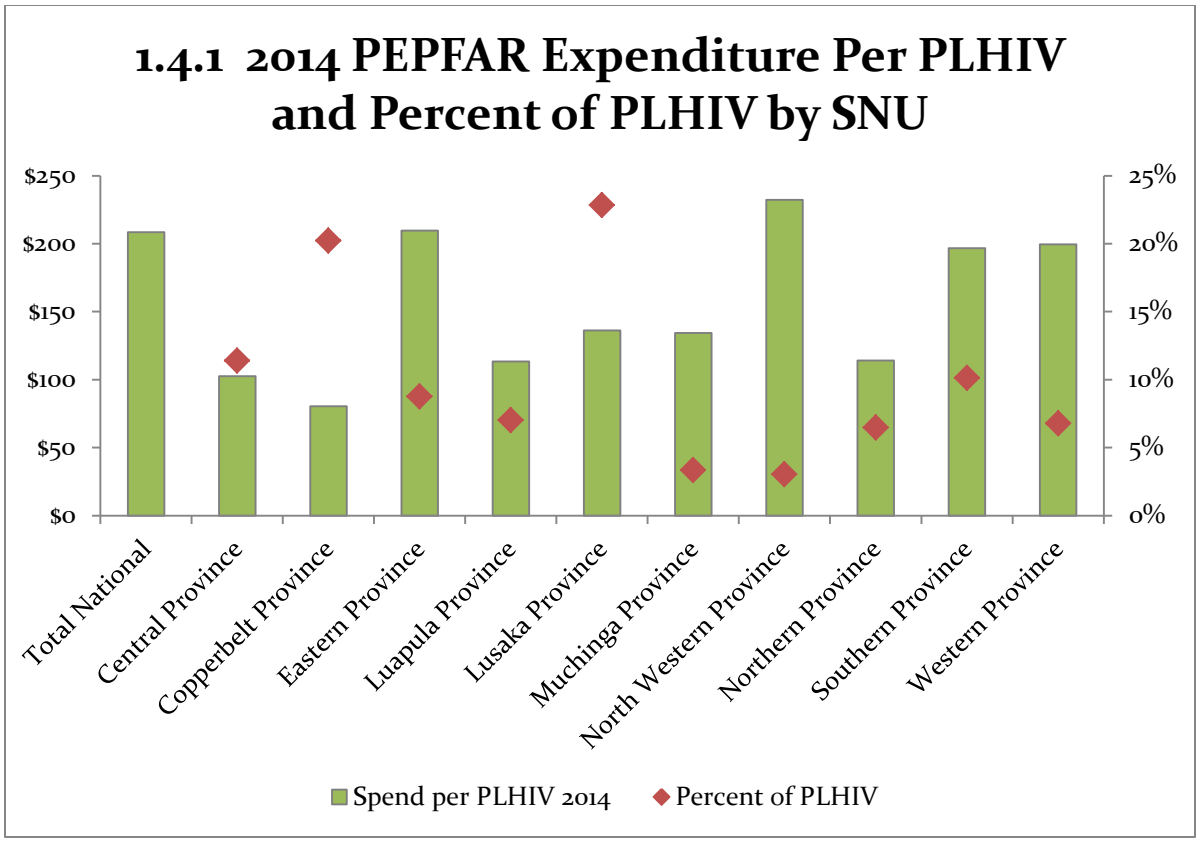


Figure 1.4.1 illustrates PEPFAR expenditure in FY2014 per person living with HIV/AIDS (PLHIV). Using 2014 EA data, the figure indicates that expenditure per PLHIV varied from $232.29 in Northwestern Province to $102.48 and $80.37 in Central and Copperbelt Provinces respectively.

This variability in cost across the country is influenced by many factors including program setting (rural, urban, peri-urban), sector (public, private, non-governmental), facility type (health center, district hospital, outreach facility), staffing patterns (physician, medical officer, nurse, lay provider), treatment protocols (time spent with patients, drugs and tests used) and the number of patients treated in a given unit of time (Rosen et al. 2008).

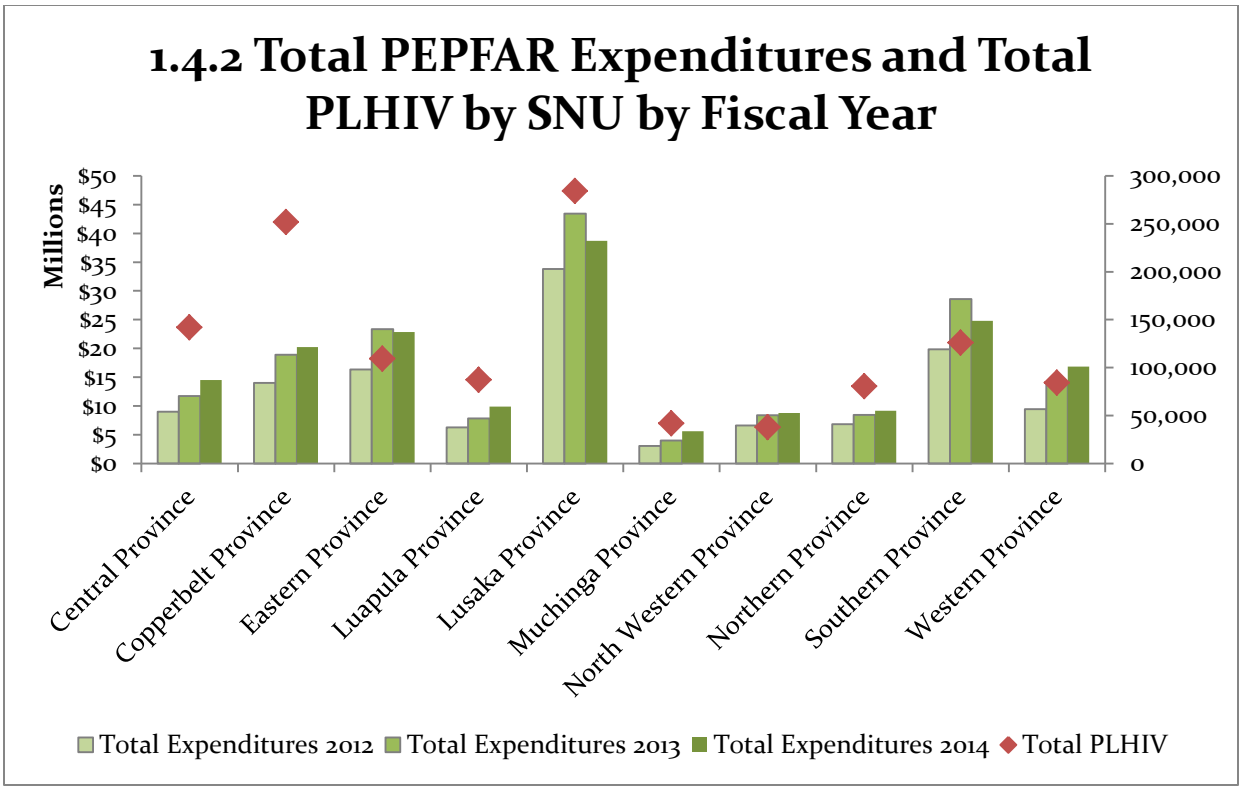
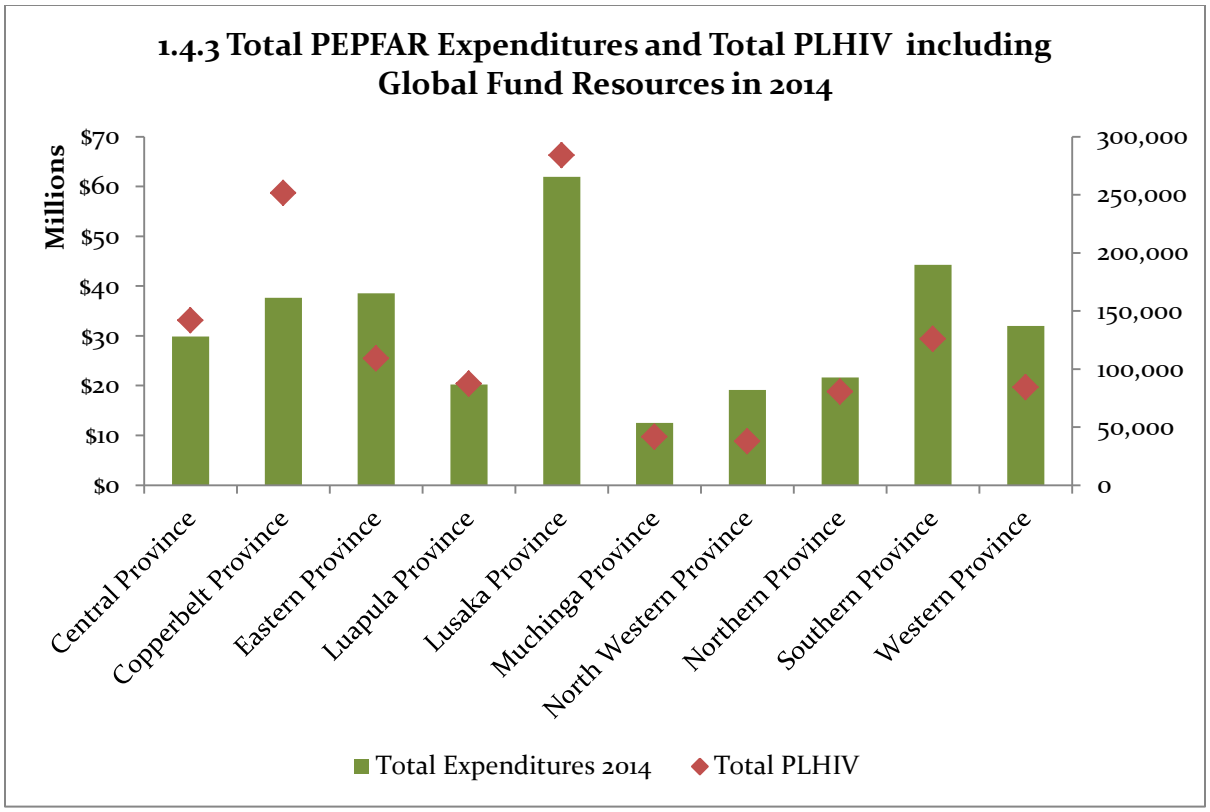


Figure 1.4.2 shows that in recent years, PEPFAR resources have generally been spent in Lusaka, Copperbelt, Southern and Eastern provinces. The graph also suggests that additional resources should have been spent for the Copperbelt and Central provinces in order to achieve closer alignment. The Global fund helped in closing this gap in 2014 as depicted in figure 1.4.3 below.



Using 2014 EA and the Revised National AIDS Strategic Framework (R-NASF) costing data, **Figure 1.4.3** Indicates that in 2014 PEPFAR and Global Fund expenditures considered together generally align with disease burden, except for Copperbelt province.

Figure 1.4.4Total PEPFAR expenditures and expenditure per PLHIV by province.

Figure 1.4.4i: Total PEPFAR 2014 Expenditures by Province

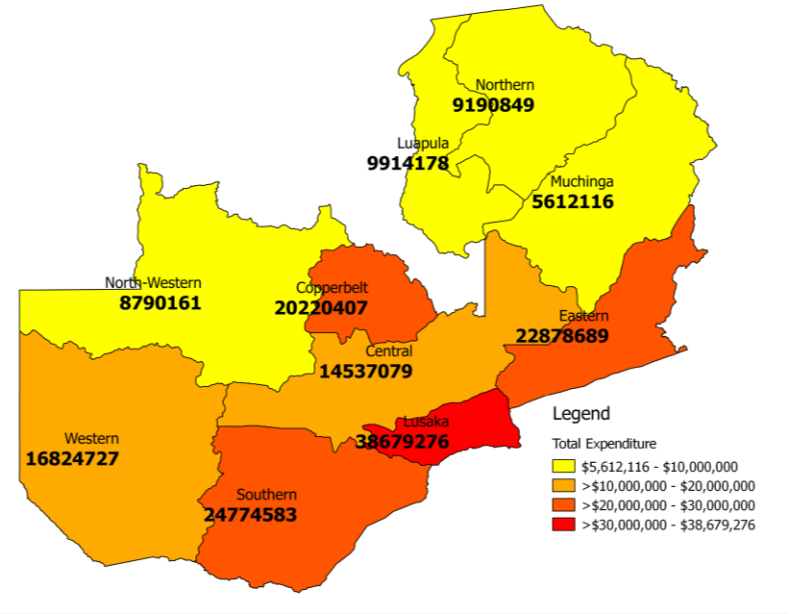
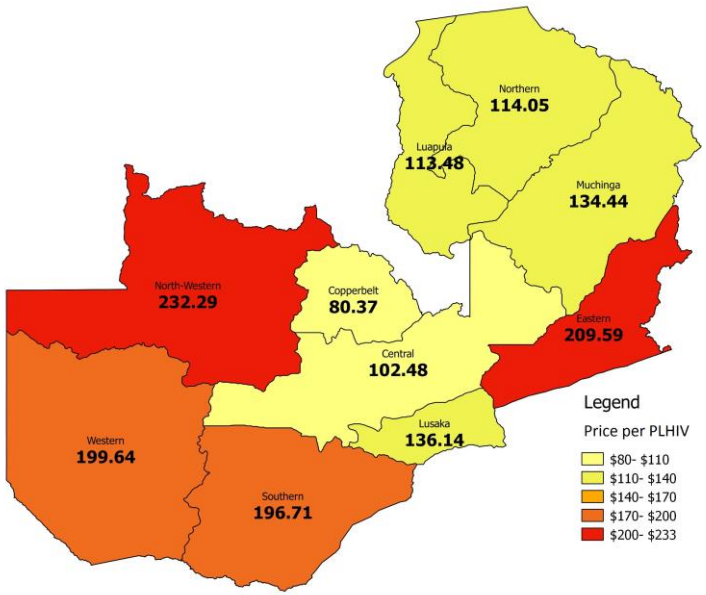


Figure 1.4.4ii: Unit Expenditure by Province



1.5 Stakeholder Engagement

After returning from an August 2014 PEPFAR meeting in Washington, PEPFAR Zambia met with the Ministry of Health (MOH), Ministry of Community Development Mother and Child Health (MCDMCH), and the National AIDS Council (NAC) to discuss the geographic priorities and core, near-core, and non-core activities. This created the foundation for continued dialogue throughout COP 2015 planning and development among all stakeholders. PEPFAR engaged with senior-level GRZ officials and GRZ technical experts to discuss funding, targets and priorities within their respective areas and worked with GRZ to develop and validate the SID. Finally, PEPFAR interagency leadership initiated discussions with the Ministry of Finance (MOF) focused on sustainable health financing. Dialogue with GRZ will continue throughout the implementation of COP 2015.

PEPFAR Zambia was actively engaged in the development of Zambia's New Funding Model application to the Global Fund—establishing a foundation for continued discussion through the COP development process. Team members participated in planning meetings and referenced the concept note as part of the overall review of Zambia's HIV funding landscape. Discussions with multilateral and bilateral donors were conducted through Zambia's HIV and Health Cooperating Partners' (HCPs) platforms. Engagement with the Global Fund will continue through the Country Coordinating Mechanism (the USG through the PEPFAR Country Coordinator is a voting member), meetings with the Fund Portfolio Manager and through the position of the PEPFAR Global Fund Liaison. Discussions with HCPs will continue through regular cooperating partner meetings and one-on-one meetings as needed.

PEPFAR Zambia conducted ten separate civil society consultations (including activists and advocates), having unique discussions with PLHIV, youth, local organizations, faith based organizations, and KPs that included a safe space meeting. Discussions with civil society focused on critical shifts under PEPFAR 3.0 —specifically geographic prioritization and classification of activities under core, near core and non-core. Civil society provided feedback on these shifts, and advised PEPFAR on how to further strengthen meaningful engagement with civil society. Key feedback through the consultations are documented and supported through meeting minutes and participant sign-in sheets. PEPFAR worked with the CCM constituencies to facilitate participation by out of town members. Civil society was also included in the development of Zambia's SID. Further details on continued engagement are outlined in PEPFAR Zambia's Civil Society Engagement Strategy (attached with this submission).

In 2014, PEPFAR Zambia introduced the prospect of developing a Country Health Partnership to the GRZ to continue to strengthen joint-decision-making through every COP development cycle. This included increasing the frequency of meetings with senior-level GRZ officials, strengthening the relationship with the MOF and increasing engagement with NAC. Dialogue within all of these levels includes discussions on program results and financial data, including joint review of data used during the August 2014 meeting and the development of Zambia's SID. Zambia will

develop a new National AIDS Strategic Framework in CY 2016, which will provide a vehicle for promoting mutually accountable measures of progress through clear indicators and benchmarks.

2.0 Core, Near-core and Non-Core Activities

PEPFAR Zambia considered the activities required to achieve sustained epidemic control, the current country investment portfolio, and the bottlenecks preventing program scale-up (as illustrated by the SID and SIMS data) in defining core, near-core, and non-core activities for program implementation in 2016.The following activities are considered core: a) prevention activities (e.g., scale-up of PMTCT Option B+, community linkages, integrated behavior change communication); b) implementation of intensified TB case finding among PLHIV; c) counseling and testing (e.g., quality targeted and timely HIV testing and counseling services); d) care and support (e.g., TB/HIV integration, family planning/HIV integration); e) treatment (e.g., early antiretroviral treatment initiation and retention); f) laboratory capacity (e.g. quality systems, viral load scale-up); g) OVC; and h) prevention with priority populations (e.g. lubricant procurement and promotion, and interventions addressing stigma and discrimination). Some of the near-core activities include MOH policy support, retention of health care workers in scale up districts, and ICT support. PMTCT Option A, water and sanitation, HTC for generalized populations, and palliative and end of life care have been categorized as non-core activities.

See Appendix A for full list of core, near-core, and non-core activities and transition plans.

3.0 Geographic and Population Prioritization

Epidemiologic and service provision data indicate that a substantial number of PLHIV are in *all* provinces and *all* districts in Zambia.

While nearly half of Zambia's estimated 1,244,493 PLHIV reside in two provinces (Lusaka and Copperbelt), over 40% of the total PLHIV reside in four of the remaining eight provinces. Provinces with high population density, including Lusaka and Copperbelt, comprise the majority of PLHIV since the majority of HIV-positive individuals on ART and/or in care live in urban centers. However, prevalence rates vary considerably within provinces and hotspots exist throughout the country, even in areas of lower population density. For this reason, rather than utilizing only provincial data, PEPFAR Zambia prioritized COP2015 programming based on district- and provincial-level epidemiologic, program, performance, and financial/expenditure data. We also took into account geography, aiming to cluster support and resources in areas with the greatest need.

Overview of decisions:
PEPFAR will realize substantial prevention and treatment gains by reallocating resources to facilitate scale-up of HIV treatment and prevention services to 258 sites (representing 315,176patients on ART) with the greatest need in 25 scale up districts. Scale up activities will include: active case finding, enhancing electronic and community linkages, extending clinic hours, demand generation, extending mobile ART provision, and establishing community-based ART service provision. PEPFAR/Zambia has identified 234sites outside scale up districts with highest need of HIV treatment and prevention services as well. These sites will be further categorized as "high" sustained (70 sites servicing 188,705 patients on ART) and 164 "low" sustained sites (29,976 patients on ART) and will receive a tiered package of HIV services to maintain currently PEPFAR-supported clients on HIV services (Section 5.0).

PEPFAR/Zambia has identified 624 sites for central support, the majority of which are outside of scale up districts. 75 central support sites service 17,052 patients on ART; 712 central support sites provided no ART services in FY2014. PEPFAR will no longer support HIV treatment and prevention services in these sites (commodities will be sustained) relying instead on existing GRZ structures to continue supporting them. In central-support sites with activities transitioned to the Government of the Republic of Zambia, PEPFAR/Zambia site-level support will end between September 2015 and March 2016.

Methods
PEPFAR Zambia utilized the EIA results from the DHS 2013 to select priority provinces based on prevalence and unmet need. We realize it includes false-positive results. However, while waiting for confirmatory tests, in consultation with OGAC, we used EIA DHS results to guide our COP. Participants in the ZDHS 2013 were given the opportunity to refuse participation at multiple points during survey conduct in this order: when answering survey questions, when providing

drops of blood for DBS paper (EIA), when taking rapid HIV tests (and receiving counseling and results), and when, if positive on rapid tests, being offered a blood draw for CD_4 testing and laboratory-based incidence estimation. For the record, there were differing opinions about the appropriateness of this complex consent algorithm.

We decided to use EIA results because we were concerned that PLHIV who knew their status may have been more likely to refuse rapid tests than others thus biasing results differentially by province. Although EIA false positives may be subject to differential errors by co-infection status, we felt this would not affect results by province as much as the refusal bias referred to above. Additionally, GRZ considers EIA to be the official prevalence rates, making using them preferable in Zambia.

Establishing district level estimates

PEPFAR Zambia estimated district prevalence using DHS-based provincial prevalence results, the ratio of urban to rural national DHS-based prevalence, 2010 Census and 2014 Census projections, and proportion of each district population designated urban were taken into account.

Then, to determine PLHIV, the >15 population per district was multiplied by the district prevalence. To determine current treatment coverage we used 2014 APR and DHIS data, specifically PEPFAR current on ART per district and national total on treatment per district. Finally, to determine unmet need, the total on treatment in that district (DHIS) was subtracted by the PLHIV for treatment.

Determining priority geographic areas

Districts in the four provinces with the most PLHIV (Copperbelt, Lusaka, Southern and Central) were considered first, then districts outside of these provinces with high burden were considered. Districts were categorized as priority and non-priority using unmet treatment need alongside prevalence, geography, and existing knowledge of both gaps/quality issues in DHIS data and special circumstances in specific areas (e.g., borders, key populations, and travel into population centers for better treatment).

Volume consideration for site categorization

First we ascertained whether all sites (regardless of prioritization) met minimum volume criteria, and then whether they had high- or low-volume of treatment and PMTCT.

According to APR 2014 data, sites met a minimum volume threshold: HCT ≥4 positives or PMTCT ≥4 positive pregnant women, or any patient on ART, they were considered to have met minimum volume criteria. Sites were then classified as low- or high-volume based on their contribution to total volume of ART or PMTCT services. Sites serving >1000 patients were considered high-volume and sites serving fewer patients were considered low-volume. Sites serving >25 HIV positive pregnant women were considered high-volume, and sites serving fewer patients were designated low-volume.

Site categorization (see Figure 3.1):

In scale up districts:
Sites in scale up districts were categorized as centrally-supported, high sustained or scale-up as follows:

Centrally-supported: sites that do not meet minimum volume criteria (<5 for HTC and/or <5 PMTCT and/or zero on ART) are considered low-volume. There are 14 sites.

High sustained: sites that meet the minimum volume threshold for ART (>1,000 clients), PMTCT (>25 clients), or HCT (>4 HIV positives). There are 254 sites.

Scale-up: sites are above the minimum volume threshold and are located in scale-up districts. There are 258 sites.

In non-scale up districts:
Sites in non-scale up districts were categorized as centrally-supported, high sustained or low sustained as follows:

Centrally-supported: sites that do not meet minimum volume criteria. There are 610 sites.

Low sustained: sites that meet the minimum volume threshold for ART, PMTCT, or HCT, but have client volumes of less than 25 for PMTCT and 1,000 for ART. These sites will be visited at least once a year. There are 164 sites.

High sustained: sites that have high-volume for ART (>1,000 clients) and will receive quarterly visits. There are 70 sites.

In total, PEPFAR Zambia selected 624 of sites across the country for central support, 164 for low sustained, 324 for high sustained and 258 for scale-up (table 3.1).

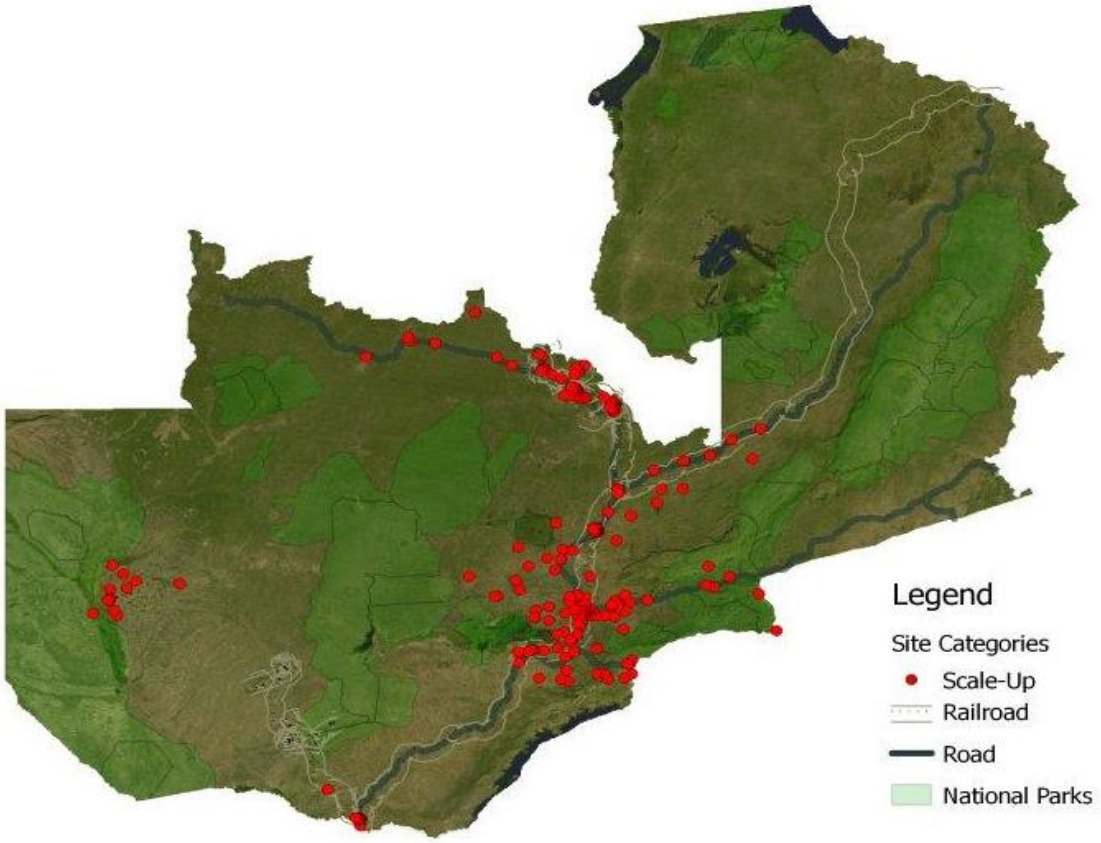
Table 3.1: Zambia Site Yield Analysis Summary for Current on ART

PRIORITY	# of sites	Achieved APR 2014	FY15 Target (current)	Target new for 2016	Net New after LTFU 2016	FY16 Target (current)	Target New for 2017	Net New after LTFU 2017	FY17 Target (current)
Scale-Up	258	315,176	389,588	82,485	65,988	455,576	100,000	80,000	535,576
Sustained High	254	14,835	19,486	41,218	32,974	52,460	51,522	41,218	93,678
Sustained Low									
Central Support	14								
Scale-Up									
Sustained High									
Sustained Low									
Central Support									
NON PRIORITY	**# of sites**		**FY15 Targets (Current)**						
Scale-Up									
Sustained High	70	188705	215,434	30,944	24,755	240,189	58,964	47,171	287,360
Sustained Low	164	29976	32,436						
Central Support	610	17052							
Scale-Up									
Sustained High									
Sustained Low									
Central Support									
Scale + Maint High	**582**	**518,716**	***656,944***	**154,647**	**123,717**	***748,225***	**210,486**	**168,389**	***916,614***

Notes:

- In line with guidance, no targets set in sustained low and central support sites.
- 123,717 new from scale up districts (scale-up and sustained high) while 47,171 new are from non-scale up districts.
- The total new on treatment of 154,647 is gross new before loss to follow-up. The subtraction of LTFU leaves current on therapy at the saturation target of 80%.

Figure 3.1 Geographic Focusing of Sites: Scale-up



4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

Given the geographic and population prioritizations made for COP 15, PEPFAR Zambia derived targets for all indicators by reviewing trend data, APR results, treatment cascade expectations, and site yield data analysis. Additionally, targeting requirements for the ACT Initiative and DREAMS Partnership were incorporated. Cost information from the PBAC and EA tool was used to guide the resource allocation to support these targets, while also adjusting for program efficiencies gained over several years of program implementation.

Targets for current on ART and ART enrollment (*newly initiated*) were determined based on the coverage required to attain 80% saturation for both the adult and pediatric populations living with HIV/AIDS in scale up districts within the next two fiscal years— as well as review of possible entry streams for ART from the pre-ART population, persons infected with TB, HIV infected pregnant women, and other priority and KPs. PEPFAR Zambia utilized the UNAIDS 90-90-90 framework in conjunction with epidemiologic data at the district level to set targets. Accordingly, the PEPFAR ART program will enrol 154,647[22](includes 29,052[23] children) HIV infected persons on ART and overall have a total of 748,225[24] on ART; this represents 60% coverage by the end of FY 2016. Working towards the UNAIDS 90-90-90 goal, PEPFAR Zambia targets to have 916,472[25] HIV infected persons on treatment by end of FY 2017; this represents 76% coverage with an additional 4% covered by Government of the Republic of Zambia resources.Treatment plus-up funding ($19M) is expected to support the country's attainment of the ambitious treatment targets.

Target setting, as shown in Table 4.1.2, is based upon assumptions included in the PEPFAR Zambia data-pack for the Prevention, Care and Treatment cascade.

To reach epidemic control, Zambia will focus on core combination prevention in scale up districts with greatest treatment gaps and populations with the greatest need (i.e. pregnant women, youth, AYWGs, persons with TB/HIV co-infection, and KPs). HTC targets represent a goal to reach saturation by covering 80% of the population in PEPFAR scale up districts. Provider-initiated testing and counseling (PITC) for all patients in TB, STI, and ANC clinics, outreach mobile, community mobilization and promotion of HTC will scale up HTC in scale up districts. In all settings, strengthening linkages to treatment, care and support, and quality assurance for HIV testing will improve the HTC package. Overall targets for PMTCT are set with the assumption that universal HIV testing coverage and service utilization that have been the trend over the last 3 years will be sustained.

[22] PEPFAR Zambia Data-pack, excluding central support sites.
[23] Accelerating Children's Treatment Strategy and Implementation Plan.
[24] PEPFAR Zambia Data-pack, excluding central support sites.
[25] PEPFAR Zambia Data-pack.

There are several challenges that must be overcome in order to meet these impressive targets.HTC and treatment targets rely on commodity assurance, adequate facilities, and the presence of a skilled, stable workforce. To reduce facility congestion, implementing partners will provide new static and mobile treatment sites in scale up districts with high unmet need and engage in strategic use of facilities by transitioning stable patients to community sites for ongoing care so that health facilities are available for initiating and stabilizing new patients. Attrition or instability among health care workers may affect service delivery, thus these targets assume that national capacity will be built and maintained at levels that will result in program implementation that is both sound and of high quality.

Other major challenges relate to the gathering and usage of data. Incidence and epidemiological data at the district, or ward level do not currently exist resulting in estimations being made at the national level.

To address some of the data challenges, PEPFAR Zambia is doing the following: 1) working with implementing mechanisms to collect epidemiological data at a more granular level; 2) training health workers on data verification (e.g., monitoring and evaluation, data analysis, and data use); 3) working with NAC to get KP data released to inform health programming; 4) funding a special evaluation of combination prevention involving bio-behavioral, service utilization, and post-service scale-up assessments; and 5) conducting an HIV impact assessment.[26]

[26] This assessment is tentatively proposed for late 2015 and will include children. As a result of this survey, PEPFAR Zambia is hoping to provide the first HIV prevalence estimates for pediatrics.

Table 4.1.1 ART Targets for Scale-up Sites in Scale up districts for Epidemic Control

SNU 2	Total PLHIV	Expected Current on ART	Net New Needed for Saturation	Target Current on ART (APR 2016)	Newly Initiated in FY16
Chibombo	20,000	6,715	10,910	12,112	5,695
Chilanga	8,455	5,069	3,386		3,419
Chililabombwe	7,221	3,583	437	3,720	228
Chingola	26,168	15,595	4,895	17,714	2,555
Chirundu	3,053	1,219	-	1,190	-
Chisamba	5,629		-		-
Chongwe	13,292	5,776	5,503	8,441	2,873
Kabwe	24,927	16,125	-	15,737	-
Kafue	23,626	9,595	7,336	13,101	3,829
Kalulushi	12,745	5,988	3,471	7,612	1,812
Kapiri-Mposhi	24,198	12,527	6,448	15,511	3,366
Kitwe	70,070	30,998	18,751	39,806	9,788
Limulunga	2,497		61		-
Livingstone	19,110	21,304	947	21,274	494
Luangwa	2,103	615	629	920	328
Lusaka	233,019	139,695	40,532	156,986	21,158
Mazabuka	18,060	15,727	3,380	17,071	1,764
Mkushi	14,831	7,638	3,292	9,131	1,718
Mongu	22,055	14,828	7,082	18,079	3,697
Mufulira	21,179	9,947	4,165	11,830	2,174
Mumbwa	21,679	343	3,123	1,926	1,630
Ndola	79,969	43,324	21,661	53,318	11,307
Serenje	15,278	7,339	1,544	7,949	806
Shibuyunji	7,075		3,559		1,858
Solwezi	16,454	20,707	3,805	22,148	1,986
Total	**712,692**	**389,588**	**151,532**	**455,576**	**82,485**

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Scale up and Sustained Sites

ART Entry Points in Scale Up Sites:

	Tested for HIV	Identified Positive	Enrolled on ART
*Routine counseling and testing	220,472	29,764	23,811
TB-HIV Patients not on ART	23,611	14,204	14,204
HIV-positive Pregnant Women	278,014	25,346	24,079
Other priority and key populations	16,826	3,381	3,414
Pediatrics	565,900	16,977	16,977
Total	**1,104,823**	**89,672**	**82,485**

ART Entry Points in Sustained Sites:

	Tested for HIV	Identified Positive	Enrolled on ART
*Routine counseling and testing	251,444	33,945	27,156
TB-HIV Patients not on ART	38,221	24,079	24,079
HIV-positive Pregnant Women	241,621	22,028	20,927
Other priority and key populations	0	0	0
Pediatrics	0	0	0
Total	**531,286**	**80,052**	**72,162**

*Some of the counseling and testing will be provided through other partners including the Zambian government and Global Fund.

Table 4.1.3 VMMC Coverage and Targets by Age Bracket

	Population Size Estimate (scale up districts)*	Current Coverage	APR 16 Target VMMC_CIRC	Expected Coverage APR 16
Males 15-29	963,817	31.6%	205,288	68.1%
Total	**963,817**		**205,288**	

*Population size is estimated number of uncircumcised males 15-29 in 25scale up districts from data-pack; total number in Zambia is 1,399,425

Table 4.1.4 Target Populations for Prevention Interventions for Epidemic Control

	Population Size Estimate (priority SNUs)	Coverage goal	APR 16 Target
Priority Population (All age groups)	1,375,000	80%	1,100,000
Total	**1,375,000**	**80%**	**1,100,000**

Table 4.1.5 Targets for OVC and Linkage to HIV Testing, Care and Treatment

District	Estimated # of Children PLHIV (<15)	Target # of active OVC (FY16 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target) OVC_ACC	Target # of children tested (FY16 Target)	Target # of children on ART (FY17)
Chibombo	4,920	6,629	1,525		2,163
Chilanga[27]	500	-	2		-
Chililabombwe	1,455	3,057	703		618
Chingola	3,099	8,645	1,988		1,675
Chirundu	250	119	27		114
Chisamba	350	-	-		-
Chongwe	3,140	10,107	2,325		1,329
Kabwe	2,625	24,105	5,544		1,621
Kafue	3,603	7,125	1,639		1,303
Kalulushi	1,609	614	141		790
Kapiri-Mposhi	4,070	11,488	2,642		1,792
Kitwe	8,112	33,537	7,714		4,144
Limulunga[28]					
Livingstone	1,803	8,148	1,874		1,552
Luangwa	396	7,699	1,771		117
Lusaka	26,292	27,488	6,320		11,398
Mazabuka	3,329	15,461	3,556		1,696
Mkushi	2,635	7,361	1,693		1,087
Mongu	2,620	691	159		1,717
Mufulira	2,341	7,132	1,640		1,070
Mumbwa	3,847	8,751	2,013		1,090
Ndola	6,772	30,096	6,922		3,915
Serenje	2,741	1,161	267		953
Shibuyunji	TBD	27	6		-
Solwezi	4,054	174	40		1,895
Non-scale up districts, High sustained sites	115,395	261,175	60,070	0	54,563
Total	**204,462**	**480,790[29]**	**110,581**	**967,424**	**96,602**

[27] New district with information-based on 'parent district' data estimates; data to be determined with program implementation.
[28] One priority district, Limulunga, is not included as the OVC program will not be implementing services in this district in Western Province.
[29] This table data represent the actual targets by district and does not match the same table in the PEPFAR Zambia Data-pack due to a limitation in the formula. The formula in the Data Pack uses total orphan population to project targets. Data on total vulnerable children due to HIV/AIDS is not available.

Program Area Summaries 4.2-4.10

4.2 Priority Population Prevention

In FY 2016, the program will focus on reaching targeted groups in priority geographic locations based on high HTC yield areas and the need for increased HTC uptake in scale up districts. Specific focus will be on high HIV prevalent groups including adolescent girls and young women (AGYW), female sex workers (FSW), MSM, and other priority populations—namely transient populations, clients of sex workers, prisoners, military, and other uniformed service people.

Through its implementing partners, PEPFAR Zambia will support scale up of comprehensive prevention packages improving care referrals and linkages to services;[30] that includes targeted interventions reaching high-risk populations in scale up districts and scale up sites. Across PEPFAR priority areas, the USG will target AGYW (beyond what is proposed for DREAMS) to reduce their risk of HIV and ensure they receive HTC, combination prevention activities, and linkages to family planning and GBV services, as needed. Sites within the non-scale up districts will not include a sustained package given the need to focus demand generation activities on the scale up sites in the scale up districts. Central support sites will no longer receive support at site level; PEPFAR Zambia will provide periodic targeted technical assistance to the provincial and district levels and sustain support including overarching QA/QI and sustained commodities at the national level.

The core prevention package includes:

- Quality VMMC services targeting ages 15-29 through static and mobile sites;
- Scale up PMTCT Option B+ with emphasis on retention of mother-baby pairs "along the continuum of care" and establishment of M&E systems;
- Condom promotion and distribution;
- Targeted HIV prevention interventions reaching high risk populations;
- Support community linkages/systems to timely access services in: ARV treatment and adherence, care & support, VMMC and PMTCT;
- Integrated Social Behavior Change Communication in PMTCT, HTC, VMMC, stigma/discrimination reduction, and other programs; including girls empowerment;
- Lubricant procurement and distribution for key populations; and
- Activities that decrease stigma and discrimination.

Communities will be involved through community mobilization, and community lay workers will conduct outreach to the priority and key populations. Hard to reach high-risk populations will be reached through mobile service provision and services in scale up districts.

[30] World Health Organization, 2014. In order to be classified as "comprehensive," service packages should include condom/lubricant provision, VMMC, HTC, access to ART, PMTCT, management of co-morbidities, provision of sexual reproductive health, STI screening and treatment and family planning to both priority populations and members of KPs (e.g., MSM and FSW).

Gender

The gender and gender-based violence (GBV) program will strategically target locations and populations with highest disease burden within scale up districts[31]. The gender activities are in line with PEPFAR's 2013 Gender strategy, which encourages integration of gender issues and equality throughout the continuum of prevention, care, treatment and support.

Services provided under the GBV program have been classified as core and will be implemented in one stop centers (OSCs). Services provided include counseling, medical services and examinations, the provision of HTC and post exposure prophylaxis (PEP), legal services, strengthening GBV coordination efforts in the community, strengthening the capacity of service providers to better manage GBV cases, engaging boys and young men, and increasing community awareness of GBV. All OSCs will be transitioned to the government to ensure sustainability.

4.3 Voluntary Medical Male Circumcision (VMMC)

The VMMC program has experienced recent policy and funding challenges affecting Zambia's circumcision targets. WHO released two information notes in 2014, advising programs not to circumcise young adolescents less than 14 years old using the forceps-guided method and to intensify education and monitoring of tetanus. Major circumcision partners also closed due to funding reductions *[REDACTED]*, adversely affecting service delivery. FY 14 central supplemental funds were allocated to Zambia to bridge subsequent gaps and to reach 56,801 additional men; most of these funds have been utilized.

The VMMC program will prioritize its efforts within high HIV prevalent areas in scale up districts reaching uncircumcised men in the target age group (15-29 years), to allow for maximum and immediacy of impact on the HIV epidemic. The core VMMC package will consist of a) demand creation; b)training, mentorship and supportive supervision; c)service delivery through the use of static and mobile models with extended hours; d)linkages to care and treatment for HIV infected clients; e) strengthening quality assurance; f) institutionalizing M&E; and g) engaging community health workers to support community mobilization and sensitization. Early infant male circumcision has been deemed non-core and will not be funded during this fiscal year; PEPFAR will restrict its support to national level quality assurance activities, promulgation of policy, and training of trainers (there will be no service delivery support). Within non-scale up districts, technical assistance will be provided periodically at regional level, during GRZ-sponsored campaigns, and occasionally at site level (less than twice a year) to allow for transition of VMMC services to GRZ by September 2016. VMMC investments are consistent with the core framework and have been found efficacious for epidemiologic control.

[31] Because of the correlation between HIV and GBV, the GBV program will focus on those geographic areas with the highest disease burden.

PEPFAR will strengthen the supply of VMMC sustaining commodities to assure achievement of the target; this will be addressed by strengthening HIV rapid HIV test kit logistics management at all levels in priority areas.

4.4 Preventing Mother-to-Child Transmission (PMTCT)

In 2013, Zambia adopted WHO Option B+ for PMTCT. In FY 2014, additional central funds were received tosupport enhanced program M&E systems and strengthen supply chain systems. Zambia will also receive Accelerating Children's Treatment Initiative (ACT) funds that will support increased pediatric HIV case finding and enrollment on treatment, which will result in increased EID of HIV exposed infants (HEIs) and enable the reporting of final outcomes.

The PMTCT program will tailor its response to targeting priority geographic locations with a goal of attaining 90% ART coverage among identified HIV positive pregnant women. The program will increase efforts in priority locations and maintain quality standards in sustained sites. The core package of services will include support for: a) training for healthcare workers; b) HIV case finding among pregnant and breastfeeding women and HIV exposed infants; c) institutionalization of M&E systems for cohort monitoring; d) incorporation of quality assurance systems for HIV rapid testing; e) laboratory clinical monitoring; f) scale-up of Option B+; and g) support for adherence and retention of mother-baby pairs in Option B+ and through community lay workers. The sustained package will include periodic technical assistance for purposes of quality assurance; for central support areas, transition to GRZ for central support sites will be completed by September 2016. Family planning/HIV integration is considered near-core. Option A is considered non-core and will not be funded in FY 2016. Reliable supply of EID testing commodities is of concern for program activities and targets although PEPFAR Zambia plans to support EID test procurement for adequate service delivery.

4.5 HIV Testing and Counseling (HTC)

The MoH 2014 HTC National Implementation Plan has a goal of 50% coverage by 2015 among Zambians age 15-49 that received an HIV test in the last 12 months and know their results. This is in line with the PEPFAR COP 15 plan to saturate the priority and key populations within scale up districts with 80% HTC by strategically targeting geographic locations with the highest burden of HIV to achieve the greatest impact. PEPFAR guidelines and the UNAIDS Gap Report emphasize the importance of location and population, focusing on populations that are underserved and at higher risk of HIV. Based on these guidelines, Zambia has an HTC target of 1,148,362 for COP 15.[32] Zambia plans to leverage relationships with GRZ, bilateral partners, and central funding initiatives (ACT, DREAMS, and SMGL) to test an additional one million Zambians to reach targets in COP 15.[33] The USG will encourage implementing partners to utilize innovative ways of scaling up testing in high yield settings.

[32] Historically, the Zambian HTC achievements have been increasing by an average of five percent per year. This target is much higher than previous years because of the increased treatment target and may, therefore, be challenging to reach.
[33] Through the ACT Initiative, Zambia aims to test 1,300,000 million children aged 0 to 19 years.

The HTC core service delivery package for will be comprised of: a) quality HIV testing and counseling services (including PITC) to individuals, couples and families, and to key and other priority populations in identified scale up districts, b) support community linkages/systems to timely access services in HTC (and early diagnosis), and c) demand generation activities to increase update of services.

Partners in low yield sites in non-scale up districts will transition HTC activities to GRZ. Commodities procured with PEPFAR funds for the GRZ pooled national level supply chain will be distributed through the regular supply chain system, though no additional investment or support will be made by the USG in non-scale up districts to distribute them.

With the expected increase in numbers of people accessing HTC services, potential challenges may occur such as commodity stock outs at the facility level, logistical challenges, and delay in the movement of commodities from the district (where they are delivered) to facility level. The community will play an important role in increasing uptake and sustainability of services in scale up districts; PEPFAR Zambia will support implementation of activities for community within priority locations around scale up sites. Hard to reach populations will be serviced by mobile HTC services.

4.6 Care and Support

For the 748,225[34] PLHIV (FY16 current on treatment) to be reached activities will focus on developing and implementing a quality, cost-efficient package of integrated HIV care and support services consistent with PEPFAR guidance, GRZ national guidelines, and standards of care. This package underscores the importance of implementing care and support activities that have an impact on reducing morbidity and mortality amongst PLHIV. In alignment with the 90-90-90 strategy, the adult care and support program will ensure ART acceptability and adherence for PLHIV through adoption of a patient and family-centered approach at both facility and community sites in addition to retaining PLHIV in care.[35]

The adult care and support program will support multi-directional referral linkages, including linkages across different types of HIV/AIDS services and between facility-based and community-level services; that promote retention in care and adherence to ART. One of the key activities to be implemented under COP 15 is the development and maintenance of functioning linkages and referral systems between caregivers at the community level as a means to guarantee quality care and ensure a continuum of care. Integration of HIV care and support services with other (non-HIV) health services at the community level will also improve efficiencies and access to services

[34] Since the GRZ does not have data for care and support, current on treatment is used as a proxy.
[35]These persons will receive a standard package of care that includes regular monitoring for HIV progression, condom provision and non-clinical services.

for PLHIV who may not seek out dedicated HIV services.

The core activities that will be implemented in COP 15 include:

- Prevent and manage opportunistic infections;
- Integrate TB/HIV services;
- Support nutrition assessment, counseling and support (NACS) services
- Support linkage, engagement and retention of patients in care and strengthening referral mechanisms and other systems of linking clinical and social services;
- Regular clinical and laboratory monitoring including CD4 and viral load testing
- Support case management of children and adolescents made vulnerable to or by HIV and AIDS;
- Support community level child protection/GBV prevention and response activities and referrals to other services;
- Facilitate group-based Household Economic Strengthening (HES) activities and access to social protection efforts using ACT Initiative funding

This core package of services will support PEPFAR priority geographic locations. Sites within the non-scale up districts will be tiered into high and low sustained categories to allow for a more gradual transition of support services and will receive tailored prevention packages. Central-support sites will no longer receive support at site level; PEPFAR Zambia will provide periodic technical assistance to the provincial and district levels but maintain support for sustaining commodities at national level.

Pediatric Care & Support:

In COP 15, the pediatric care and support program will provide comprehensive pediatric HIV care services targeted at priority geographic locations to a reduced number of children due to funding reductions from COP14 level. Resources from the Accelerating Children's HIV/AIDS Treatment (ACT) Initiative will be additive to the level funding for pediatric care and support. Most ACT funding is focused on treatment services versus care services. PEPFAR Zambia HIV services will include ensuring early identification of HIV infected children and enrolment into care and treatment. The core package of services will rely mostly upon ACT initiative funding to include:

a. Scaling up EID and linkage to appropriate care and treatment.
b. Appropriate clinical staging and laboratory monitoring to guide pediatric care and treatment.
c. Promoting a comprehensive package of pediatric HIV care and treatment, including antiretroviral treatment, treatment of malnutrition and life-threatening infections, and pain and symptom management, all within a family-centered context
d. Developing and implementing strategies to decrease loss to follow-up through health

facility- and community-based retention strategies.[36]

e. Implementing of consolidated pediatric treatment guidelines and recommendations as well as alignment with the OVC Minimum Standards, National Plan of Action for Children, and forthcoming GRZ standards for vulnerable children.
f. Training, mentoring, and supervision of health care workers to provide high quality pediatric care and treatment services.[37]
g. Providing psychosocial support for children and their families, including the promotion of adherence and timely disclosure. School-based psychosocial support will include teacher support for children.
h. Providing targeted prevention efforts and age-appropriate psychosocial support for HIV-infected adolescents, including vocational training, intensive adherence support, and coping with stressors.
i. Strengthening of GRZ monitoring and evaluation systems, including data collection for central reporting and data feedback for site level quality improvement
j. Strengthening of systems to link CBOs with government health services for under-five, child and adolescent health programs, including ART and PMTCT services. Programs will emphasize the needs of children living with HIV by helping families and communities identify children and adolescents living with HIV and ensuring immediate access to ART for those under 15 years.
k. Training, mentoring and support of CBOs to improve technical capacity in HIV prevention, care and support to scale-up evidence-based activities, including prevention with positives counseling by community caregivers, stigma education, alcohol education, Safe From Harm and other proven interventions.

4.7 TB/HIV

In line with the STOP TB Strategy and the recommendations of the 2010 Review of the TB Program, the TB/HIV program activities will include: 1) improving diagnosis of TB/HIV through the timely and effective use of new diagnostic tools, 2) reducing TB/HIV related morbidity and mortality through improved case management, 3) increasing access to high quality TB/HIV treatment and care to enhance the programmatic management of drug resistant TB, 4) strengthening the capacity of the health system to deliver quality TB/HIV care; and 5) enhancing community awareness and involvement in TB, TB/HIV and drug resistant TB management.

PEPFAR has provided support to the National TB/HIV program to provide HTC to TB patients. The TB patients tested and counseled for HIV increased from 86% in 2011 to 90% in 2013. The TB/HIV co-infected patients started on Cotrimoxazole prophylaxis increased from 87% in 2011 to 93% in 2013 and those initiated on ART increased from 53% in 2011 to 67% in 2013. Screening of

[36]Bi-directional referral networks between the community and facility will also be strengthened for pediatric ART. Programs will leverage the ability of CBOs to follow up with PLHIV at the household level, promoting retention in care.
[37]CBOs will improve quality delivery of HIV prevention information, such as implementing multi-dose, integrated prevention interventions and expanding HTC opportunities for families through strengthened referrals to HTC services.

HIV positive patients for TB has been implemented in the HIV program. Support has also been given to hire health care providers to complement government staff shortages, procurement of new diagnostics and other equipment and transport. Due to inadequate infrastructure to accommodate TB/HIV programs, minor renovations were done on selected facilities in order to improve on case identification, adherence and case holding, linkages and referral systems were strengthened between TB and HIV programs.

To address the many challenges in the TB and TB/HIV program, the National TB Program has the following objectives:

1. Increase case notification rate of all forms of tuberculosis from 321/100,000 in 2012 to 338/100,000 and screen all of previously treated TB cases (TB relapse and treatment failure) for MDR by 2016;
2. Increase treatment success of drug susceptible TB from 88% in 2012 to 90% by 2016;
3. Provide testing and counseling for HIV for 100% patients with presumptive TB and TB disease;
4. Successfully treat at least 70% of all MDR-TB patients initiated on treatment by 2016;
5. Reduce TB related morbidity and mortality among people living with HIV through the scale up of TB/HIV activities in at least 80% of TB and HIV sites by 2016;
6. Ensure that 100% of TB patients co-infected with HIV are initiated on ART by 2016;
7. Initiate 60% HIV + individuals with no signs of TB disease on Isoniazid Preventive therapy (IPT) by 2016;
8. Scale up TB prevention, diagnosis and care services for vulnerable and high risk populations by 2016;
9. Enhance TB surveillance and M&E; and
10. Strengthen the health system to deliver TB/HIV services through a primary health care approach at community level and the development of synergies.

PEPFAR is supporting the scale up of the 3Is project of Intensified TB case finding, TB infection control in HIV settings and Isoniazid Preventive Therapy among HIV positive individuals with no active TB disease in four provinces (Lusaka, Copperbelt, Central, and Southern) with a high burden of TB/HIV from 2012 to 2015. The objectives of this project are to:

- Increase TB case detection through development of national guidelines, screening of inmates from prisons and prison staff and community screening, strengthen existing laboratory networks and introducing new diagnostics like the Genexpert
- Improve treatment success rate among TB patients diagnosed in HIV settings through supporting and strengthening DOTS, strengthen linkages and referral systems between TB and HIV and strengthen the monitoring and evaluation systems
- Implementation of Isoniazid Preventive Therapy among HIV positive individuals with no signs of active TB disease
- Improve TB infection control measures in HIV and prison settings at facility and prison levels

- Improve linkages for ART provision for TB patients diagnosed in HIV settings

The project is implemented by the Ministry of Health and PEPFAR partners, but support will end in September 2015. PEPFAR partners, the Global Fund and GRZ will then scale up the 3Is initiative to selected districts and health facilities with high HIV yields in 2015 and 2016. In COP 15, PEPFAR will support the following priorities identified as core or near-core activities in the scale-up sites:

1. Ensure that 100% of patients with presumptive TB or TB disease receive HIV testing and counseling and initiate 100% of those that are co-infected on ART.
2. Support integration of TB/HIV care and treatment to ensure linkages and retention
3. Ensure that HIV positive patients are screened for TB and refer those identified for TB diagnosis and treatment
4. Ensure to initiate 60% of HIV positive individuals who do not have TB disease on Isoniazid Preventive therapy
5. Expand interventions, including Xpert MTB/RIF assay to improve early diagnosis and treatment of TB among PLHIV. Support to laboratory networks, courier systems and quality control will be provided.
6. Support TB infection control measures to prevent transmission of TB in healthcare and community settings
7. Strengthen TB/HIV program monitoring and evaluation.
8. Ensure that children, pregnant women, prisoners, miners and other vulnerable groups are included in the TB/HIV programs.

PEPFAR will further support revisions of national guidelines, TB/HIV data review meetings, TB/HIV coordinating body meetings, technical support through training and mentoring of health care providers in sustained sites.

4.8 Adult Treatment

FY 2015 represented the first year of a stepped-up level of implementation for the PEPFAR Zambia treatment program. The stepped up activity resulted in a highly ambitious target of increasing the number of PLHIV on HIV treatment from the FY14 result of 518, 716 to 656.944[38]. PEPFAR Zambia continues to support the national treatment program in order to reduce morbidity and mortality amongst PLHIV through increased and expanded ART access based on a thorough epidemiological analysis of the HIV epidemic in Zambia and the development of core and near-core packages. In COP 15, the program will continue to a) consolidate a number of key strategies such as early ART initiation in all individuals with HIV with CD4 count of less than or equal to 500 cells/mm; b) continue ART initiation of HIV infected pregnant and breastfeeding women; and c) maintain viral load monitoring activities that were initiated in FY15 in order to sustain and further accelerate the uptake of new patients onto ART while driving increased quality and efficiency within the program for improved overall program outcomes toward attainment of an

[38] PEPFAR Zambia data-pack.

AIDS Free Generation. In COP 15, the treatment budget earmark of 55%, the additive resources based on a one-time plus-up funding of $19m for HIV treatment, and the second year funding for the ACT initiative will be used for implementing the treatment program. In FY16 program targets are expected to increase the number of PLHIV on ART to 748,225, with 154,647 being new patients.

Based on the analysis of epidemiological data, the PEPFAR Zambia treatment program notes that the geographically prioritized locations represent areas with the highest HIV prevalence and greatest treatment gaps and represent 80% of the national PLHIV burden. In this regard, PEPFAR Zambia identified 25 scale-up districts with sites for scale up of HIV treatment services. PEPFAR Zambia has aligned its targets towards attaining the UNAIDS 90-90-90 goal; the treatment program plans to scale-up ART service delivery by introducing new strategies and innovations targeting the identification of new ART clients, early ART initiation of newly identified clients, improved adherence and retention, towards the goal of attaining viral load suppression of over 90% of PLHIV enrolled in treatment. Other strategies to be implemented will include: a) strategic static and mobile treatment sites that will be supported to operationalize in areas with high unmet need; b) limited/basic infrastructure improvements to support increased patient up-take; c) roll-out of more community HIV care and treatment model sites (including community linkages/systems to access HTC, ARV treatment and adherence, care and support, VMMC and PMTCT) as a means of decongesting the facilities that will primarily be maintained as treatment initiation and stabilization facilities for new patients; and d) transitioning stable patients on treatment to community units for on-going care. These activities are expected to improve accountability of each patient initiated on treatment, improve retention in care and provide better support for adherence.

Within PEPFAR priority areas, PEPFAR Zambia will support provision of a core package of services at site-level within scale up districts. Sustained sites will be tiered into high and low sustained categories to allow for a more gradual transition of support services and will receive tailored treatment prevention packages. Central-support sites will no longer receive support at site level; PEPFAR Zambia will provide periodic technical assistance to the provincial and district levels and maintain support for sustaining commodities at national level.

The core package of treatment support will include a) procurement of equipment and supplies for the existing large volume sites and new sites and mobile units to be established based on the epidemiology of disease, b) support for clinical and laboratory monitoring (CD_4 for staging only), c) training of health workers, d) support for adherence and retention systems, e) continuous quality improvement activities, and f) accreditation in scale-up sites.

Considering that all ANC sites should be full-fledged option B+ sites in COP16, integration and decentralization of PMTCT and ART services will continue with a focus on quality assurance and consolidation of weaker, previously PMTCT-only sites. Similarly, provision of ART in TB treatment settings will be supported by developing ART capacity in each TB treatment site.

To drive increased up-take of ART patients, the PEPFAR Zambia team will implement integrated HTC and ART continuum of care service models to increase early case findings enhanced adherence/retention strategies, and strengthening linkage between HTC to care & treatment. This will mean existing implementing partners (IP) programs that previously only implemented one service component of the cascade will now also implement other services in the sites in which they operate to make linkages better coordinated. This strategy will also reduce overlap of IPs and improve efficiency.

The PEPFAR country team plans to continue increasing access to ART by members of KPs by further expanding ART delivery to PEPFAR and other partner program platforms that have been reaching KPs with only "other prevention" interventions in prior years. In COP 15 programs will aim to reach commercial sex workers (CSW) and men who have sex with men (MSM).

4.9 Pediatric Treatment

Specific to pediatric HIV, the PEPFAR Zambia treatment program will emphasize implementation of activities by all implementing partners to enhance early identification of HIV infected children through index adult patient linked family testing, routine implementation of PITC in all service points where children are accessed (scale up districts), and quality improvement of EID services. An additional focus area in COP 15 will be the implementation of adolescent specific HIV services that will involve training of health care providers based on best practice models that have been implemented in Zambia in limited settings during prior years.

In order to optimize patient monitoring and support strengthened adherence and retention interventions, roll-out of improved Information Communications technologies (ICTs) will be supported by the treatment program. This will include use of a single patient level electronic health record system (EHR) across the continuum of care and integration of Short Messaging System (SMS) technologies with the EHR for purposes of patient tracking and retention interventions as well as real-time process monitoring of service delivery sites.

Quality of care standards will continue to be based on current national guidelines and will be integrated with the Site Improvement Monitoring System (SIMS) as a tool for tracking service quality and informing improvements.

In view of the many lessons that are still being learned on how to effectively delivery services using highly decentralized service models, the PEPFAR Zambia treatment team has prioritized the inclusion of targeted program evaluations (Community ART and HIV Test and Treat evaluations) to inform service delivery improvements during FY16.

Over and above the core strategic direction described above that is targeted at the scale-up sites from which the PEPFAR program will draw 80% of its target results, the program will support the following: technical assistance to supply chain systems at site level to assure commodity availability, procurement of HIV sustaining commodities including ARVs, EID, HIV test kits, viral

load reagents, quality assurance/quality improvement (QA/QI) processes, and in-service trainings both to scale-up sites and sustained sites. Site level in-service training and technical assistance (TA) and mentorship activities in sustained sites will be necessitated by quality monitoring indicators. Supporting QA/QI for sustained sites primarily through MOH provincial/district level TA will therefore form the foundation of PEPFAR support to sustained sites. To strengthen adherence, PEPFAR/Zambia plans to support training for community based support groups including safe mother action groups (SMAGs), traditional birth attendants (TBAs), Adherence Supporters and Youth Peer Educators.

As near-core activities, the PEPFAR Zambia program plans to support nutritional assessment counseling and support, ART monitoring and evaluation, AIDS Indicator Survey implementation, pre-service training, and HIV drug resistance monitoring.

4.10 Orphans and Vulnerable Children

The OVC portfolio underwent major changes in FY14 and FY15. Per the geographic prioritization, the flagship OVC program (STEPS OVC) transitioned all program activities away from non-priority provinces. Activities are only in priority provinces. Programs providing education and nutritional support remain active outside of the priority provinces. All stand-alone education services will end in FY16; however, nutritional support focused on young PLHIV and referrals to other HIV services within Eastern Province high sustained sites will continue until September 2017[39].

There will be sustained and scale-up sites for the OVC portfolio. GRZ data were used to determine districts with at least 20,000 orphans and treatment data were used to determine sites with highest volume (over 5,000 ART patients) as a first step to determine sites for OVC scale up. Catchment areas or constituency boundaries for the highest volume sites will be used to further geographically define scale-up OVC sites. In FY16, the new OVC flagship program, Zambia Family, will link with high volume ART facilities to assess the needs of families living with HIV to determine eligibility for enrolling in the program. A clinical-care partner will pilot the placement of a para-professional case worker to provide evidence on the value of such staff in facilitating clinical and community care linkages. As with STEPS OVC, the Child Status Index will be used to assess the children from families identified within the health facility.[40]

Services in the scale-up and sustained sites will include the Zambian core and near-core activities for OVC programs while all non-core activities will end in FY15. The primary difference between scale-up and sustained sites will be the number of children served. As children move away or graduate from the program in sustained sites, no new children will be added.[41]

[39] Per S/GAC guidance, OVC activities in non-scale-up districts must complete full transition by end of FY17.
[40]The Index will be modified to better accommodate assessing the community care needs of children and adolescents living with HIV.
[41] Most sustained sites are serving children that have been transitioned from the STEPS OVC program to the Zambia Family program.

As sustained sites scale-down, more children will be added to the OVC Zambia Family program from scale-up sites which will allow for increased support to achieve saturation and the goal of enrolling 80% of eligible children in the OVC program. The pivot within the provision of services and support to OVC and their families will be the emphasis on epidemic control in scale-up sites.[42]

PEPFAR Zambia will contribute to DREAMS through a focus on girls' ages 10 to 14 to ensure they stay in school and successfully transition into adolescence. For the ACT initiative, Zambia Family will have a lead role in case finding (up to 30,000 new cases over two years), ART adherence and care retention. Nutritional support will include growth monitoring of young children under five that will be conducted at both facility and community level through USAID/Thrive and USAID/MAWA projects respectively. Following nutritional assessment the malnourished children will be referred for rehabilitation and the household taking care of the OVC will be linked to livelihood activities within their communities. In addition to the above, DOD activities will provide technical support to the Ministry of Defense to strengthen their capacity to manage and coordinate OVC activities. OVC services in the military setting reach children in and around the base through community schools established there.

USAID Zambia will seek expertise in programming for vulnerable adolescents, ages 10 to 19 to fill gaps in capacity and services across the care, prevention, and treatment partners to address the needs of youth in adversity. An existing youth mechanism will provide a platform for scaling up DREAMS and ACT in sites where these initiatives are not based and provide targeted support to vulnerable adolescents who are at risk of HIV or living with HIV often having limited or no access to services (this includes adolescents outside of family care and in exploitive work situations along with MSM).[43]

Technical support will be provided to the GRZ social protection program[44] to increase their capacity to manage and coordinate activities for OVC and private sector resource leveraging will be increased to facilitate graduation from PEPFAR support. Capacity building support will be provided to existing government structures at the community, district and provincial levels to improve their ability to identify, refer and provide case management to OVC. Social service workforce development will remain a priority investment for the next three years and will address the need for government social protection structures to include paraprofessionals as well as adding case managers to health facilities who are trained in social service provision to bridge with community care and provide a well-functioning continuum of care. Workforce development

[42]Key interventions will include improved capacity of parents or guardians to mentor, protect and monitor their children; stronger referral systems to HIV and family planning services; elimination of GBV, and household economic strengthening.
[43] The intentions are to intervene early enough to prevent the on-set of risky behaviors or support alternatives for adolescents already engaging in risky behaviors in addition to providing support to help young PLHIV survive and thrive.
[44] The GRZ social protection program includes a household dependency burden with an emphasis on caring for orphans.

supports sustainability of PEPFAR investments and will involve resource leveraging with other donors and linkage with the GRZ social protection program.[45]

SIMS visits to date have found several areas for improvement. First, SIMS visits found there are gaps in meeting the needs of adolescents with HIV in part due to limitations of case management which is handled 100% by volunteers. Second, support for girls to successfully transition to and complete secondary school was not being covered by STEPS OVC. Lastly, timeliness of post-rape care was identified as an additional issue needing focused improvement. With the new OVC program, these issues will be discussed with the aim to resolve. The GBV program receiving HKID funds will continue to address the timeliness issue along with a new program focused on behavior-change communications.

[45]Programs providing technical support to GRZ are Zambia Rising and Community Rising.

5.0 Program Activities to Sustain Support for Other Locations and Populations

5.1 Sustained package of services in other locations and populations

The expected volume of patients needing the minimum package of services in these areas has been calculated by district and overall (Table 5.1.1).

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Non-scale up districts

	Expected Result APR15	Expected Result APR16	Percent increase (or decrease)
HIV testing in PMTCT sites	271,378	306,399	13%
HTC (only sustained ART sites in FY 16)	585,665[46]	585,665	0%
Care New (not yet initiated on ART)	27,440	27,440	0%
Current on ART	281,428	240,189	0%
OVC	326,468	261,175	(20%)

In addition to Table 5.1.1, the following tables describe the core package of services provided in the scale up districts, and the tiered sustained packages of services provided to sites outside of priority areas in the following tables (5.1.2 through 5.1.9) by program area.

[46] Number from site yield analysis, allocation from FY16 targets for sustained sites.

Table 5.1.2 PMTCT Package of Services

	SCALE UP	SUSTAINED (High)	SUSTAINED (Low)	CENTRAL SUPPORT
1	Procurement of critical sustaining commodities and drugs	Procurement of critical sustaining commodities and drugs	Procurement of critical sustaining commodities and drugs	Procurement of critical sustaining commodities and drugs
2	Human Resource: Salary support to fill HR gaps; Training, mentorship and supportive supervision	Training, mentorship and quarterly supportive supervision (includes training and mentorship in logistics management and QA/QI)	Technical Assistance to PMO/ DMO including targeted clinical mentorship and training updates	
3	Active case finding among pregnant and BF women, their sexual partners and their children	Active case finding among pregnant and BF women and their sexual partners and their children	Passive case finding among pregnant, BF women, and their sexual partners.	
4	Support EID (DBS sustaining commodities, sample transportation & results return)	Support EID (DBS sustaining commodities, sample transportation & results return)		
5	Support laboratory clinical monitoring including purchase of equipment and reagents	Support laboratory clinical monitoring (includes equipment *maintainance or replacement* and reagent purchase)		
6	Support adherence, retention and follow-up of MBPs using institutionalized M&E systems for cohort monitoring, community health workers (and using innovative technologies e.g. SMS reminders	Support adherence, retention and follow-up of MBPs for cohort monitoring		
7	Incorporation of QA systems for HIV RT – includes training, support for both routine IQA and EQA, development, updating and printing of tools			
8	Support sustaining commodities logistics management –training, mentoring, expansion of eLMIS to all PMTCT sites			
9	Support operations of mobile ART services –including transport/fuel, HR			
10	Support routine site level service and data QA/QI			
11	Targeted infrastructural renovations to improve clinic flow, reduce congestion and for infection prevention			

Table 5.1.3 Care and Support Package of Services

	SCALE-UP	SUSTAINED High	SUSTAINED Low
1	Support to regular clinical and laboratory monitoring to enable procurement of equipment and orientation on guidelines for HCWs	Provide technical assistance to DMO/ PMO	Provide technical assistance to DMO/ PMO
2	Support to training of health workers through clinical mentorship and monitoring	Targeted site level technical assistance to health care workers.	
3	Support for adherence systems such as counseling services, linkages with community structures that promote retention.	Support for enrolling PLHIV to community structures (HBC, support groups, posttest clubs) and support referral for adherence counseling	
4	Support Nutritional assessments, counseling and support through: o Procurement of job aids, BMI charts, counseling charts, counseling materials o Coordination with government to develop NACS	In the sustained sites NACS activities are almost established and with activities integrated into the health care system. Sites will still require regular follow up and support and these activities:	

	packages of services provided at both facility and community level o Training and mentorship of clinical and community health workers o Procurement of nutrition supplements o Provision of supplementary /therapeutic food for eligible clients o Integration with existing nutrition programs o Capacity building for data capturing and reporting systems o Training in quality improvement and quality assurance	o Continue with nutrition counseling and support o Specified training for health care providers o Procurement of Supplementary and therapeutic feeding o Continued engagement/ adherence /retention for clients o Scaling up HEPS commercialization with targeted free HEPS distribution o Provide support for community based NACS o Training facility teams in data capturing and reporting systems o Training sites in quality improvement and quality assurance o Implementation of graduation strategy for both facility and community NACS activities o Integration with existing nutrition programs	

Table 5.1.4 Orphans and Vulnerable Children Package of Services

	SCALE-UP *Same as sustained plus the following:*	**SUSTAINED** **High**	**SUSTAINED** **Low**
1	Increase linkages with high volume facilities in order to reach children and adolescents living with HIV or at risk of HIV as well as families living with HIV.	The majority of services to OVC occur in five provinces for PEPFAR Zambia. Sustained activities for these sites will include the OVC core and near-core activities for PEPFAR Zambia, with non-core activities phased out in FY15.	Provide technical assistance to DMO/ PMO twice a year
2	Activities in the core and near-core categories for OVC will be undertaken with a primary focus on sub-populations noted above.	Assessment of children using criteria based on PEPFAR 3.0 priorities, meaning that not every child will be transitioned into the new program. As children move away or graduate from the program, no new children will be added in the sustained sites.	
3	Support of DREAMS will be an additional consideration for designating scale-up sites for the OVC program.	Technical support will be provided to GRZ to increase their capacity to manage and coordinate activities for OVC and private sector resource leveraging will be increased in the sustained sites to facilitate graduation from PEPFAR support.	
4	Actions in support of ACT will occur in scale-up and sustained sites.	The education scholarship program (Time to Learn) has sites in all provinces which will be maintained until December 2016 when the last of the supported students will graduate from secondary school. No new students have been or will be added in FY 15.	
5		The DOD program reaches OVC located in and around the military base. Selection of sites is based on the scale-up, sustained and central support criteria; the community implementing partner will follow the scale and central-support sites selected to implement OVC programs as these will be the densely populated high prevalent areas.	

*ART and PMTCT scale up sites within 4 priority provinces will be scale-up sites for the OVC program.

Table 5.1.5 TB/HIV Package of Services

	SCALE-UP	SUSTAINED High	SUSTAINED Low
1	Support PITC for TB Presumptive and TB patients for HIV	Support technical assistance to PMO/ DMO/ Facility staff on HIV management and documentation.	Support technical assistance to PMO/ DMO/ twice a year
2	Screening PLHIV, prisoners, miners, children and Pregnant women for TB	Support integration of TB/HIV services where applicable	
3	Capacity building for TB diagnostic facilities	Capacity building for TB and HIV diagnostic facilities	
4	Strengthened referral systems that include volunteer participation and two-way referral forms	Strengthened referral systems that include volunteer participation and two-way referral forms	
5	Support Integration of TB/HIV services that include ART initiation for the TB/HIV co-infected individuals	Support provision of IEC materials to promote TB infection control measures	
6	Support TB infection control measures: minor renovations, procurement of Personal Protective equipment, patient flows systems, IEC materials	Support to M & E: update the data collecting and reporting tools, MER system and program review meetings	
7	Support to M & E: update the data collecting and reporting tools, MER system, SmartCare utilization and program review meetings	Support to specimen courier system from treatment to diagnostic facilities, from diagnostic facilities to culture laboratories	
8	Laboratory support: Procure new diagnostics-Genexpert/cartilages, increasing TB/HIV diagnostic centers, Support to specimen courier system and Support the scale up of new diagnostics-Genexpert technology	Support to quality control	
9	IPT for PLHIV: Support to Orientation on data collecting and reporting tools facility IPT data review meetings and community structures that facilitate IPT uptake	Orient of health care providers on the tools and support program review meetings	

Table 5.1.6 VMMC Package of Services [47]

	SCALE-UP	SUSTAINED High	SUSTAINED Low	CENTRALLY-SUPPORTED
1	Provision of technical assistance to the VMMC program at all levels of government i.e. National and subnational	Provision of technical assistance to the VMMC program at all levels of government i.e. National and subnational	Targeted above site level support to the GRZ, and limited (less than twice yearly) TA at the site level to sustained sites and those providing EIMC	Provision of technical assistance to the VMMC program at National level
2	Support the development, implementation and coordination of strategies to link the highest at risk sub-populations of the VMMC eligible population (e.g. males in sero-discordant relationships, males attending STI clinics, military population) to VMMC services	Support provision of the WHO prescribed minimum package of VMMC services at static and mobile service delivery points during quarterly nationally organized campaigns		Technical assistance visits to EIMC sites twice a year*
3	Support demand creation activities using a combination of communication approaches			
4	Support provision of the WHO prescribed minimum package of VMMC services at static and mobile service delivery points.			
5	Strengthen linkages to care and treatment by providing counseling and referral of identified HIV-infected VMMC clients.			
6	Support the community and facility staff in the provision of VMMC services offered in extended clinic hours.			
7	Provide Technical Assistance to health workers in commodity management particularly Rapid Test Kit LMS at VMMC sites			
8	Support continuous quality improvement (CQI) activities for both VMMC static and mobile sites, with emphasis on quality indicators			
9	Support institutionalization of VMMC M&E systems, both electronic and paper based.			
10	Training, mentorship and supportive supervision of health workers in all aspects of VMMC service delivery including provision of HTC and emergency management of VMMC Adverse events.			

[47] The VMMC program will operate in all scale-up districts, particularly in high population sites.

*Technical Assistance to EIMC sites will consist of twice yearly site clinical mentoring and supportive supervision of HCW at EIMC sites, EQA/ CQI activities at National level and point of service, commodities consumption forecasting and supply chain management support and Training of EIMC Trainers.

Table 5.1.7 HTC Package of Services

	SCALE-UP	SUSTAINED High	SUSTAINED Low	CENTRAL-SUPPORT
1	HTC training for HCWs & lay counselors in alignment with international standards	Targeted Technical Assistance to PMO/DMO	Targeted Technical Assistance to PMO/DMO twice per year	N/A
2	Provide HIV testing and counseling services to individuals, couples and families and to key and other priority populations	Support incorporation of quality assurance systems for HIV rapid testing	RTK's from GRZ pooled procurement *(not including additional support to distribute in non-scale up districts)*	
3	Strengthen linkages from HTC to treatment, care & support services (including linkages to VMMC).	Support the use of electronic and paper based systems to monitor linkages from HTC to care and treatment.		
4	Support site level service and data quality improvement/assurance activities	RTK's from GRZ pooled procurement (not including additional support to distribute in non-scale up districts)		
5	Support incorporation of quality assurance systems for HIV rapid testing			
6	Support the use of electronic and paper based systems to monitor linkages from HTC to care and treatment.			
7	PITC for all patients in TB, STI and ANC clinics and improving linkages for HIV infected persons to enroll in care and treatment at ART sites			
8	Support community mobilization for uptake of biomedical services.			
9	Support operations of mobile HTC services			

Table 5.1.8 Priority Prevention Package of Services

	SCALE UP	SUSTAINED High	SUSTAINED Low	CENTRAL-SUPPORT
1	Condom promotion and distribution, including; condom skills training, negotiation skills, and facilitate condom access (direct provision, linkages to social marketing outlets, and referrals)	N/A	N/A	N/A
2	Community and district level demand creation activities to increase awareness, uptake, and acceptability of relevant clinical services (VMMC, PMTCT, TB, ARV treatment, and RH)			
3	Improved community linkages to facilities to increase access to HTC testing, VMMC, PMTCT, FP/HIV and treatment services, including; information sessions and active referrals			
4	Community-level activities that promote gender equity, address sex/gender norms that contribute to the spread of HIV, reduce HIV stigma and discrimination, and prevent GBV			

** No activities in non-scale up districts

Table 5.1.9 Key Populations Package of Services

	SCALE-UP	SUSTAINED High	SUSTAINED Low	CENTRAL-SUPPORT
1	Condom promotion and distribution, including; condom skills training, negotiation skills, and facilitate condom access (direct provision, linkages to social marketing outlets, and referrals)	N/A	N/A	N/A
2	Behavior change activities incorporating; targeted risk assessment and the provision of risk reduction information, education and/or counseling to correctly identify HIV prevention methods, reject transmission misconceptions, and accurately assess personal risk			
3	Prevention, testing, treatment and care of other infections (STIs, TB and Hepatitis)			
4	Improved community linkages to facilities to increase access to HTC testing, ART, VMMC, PMTCT, FP/HIV and treatment services, including; information sessions and active referrals			
5	Reproductive health services including family planning and PMTCT			
6	Lubricant promotion and distribution for MSM			

** No activities in non-scale up districts.

Table 5.1.10 HIV Treatment Package of Services

	SCALE UP	SUSTAINED High	SUSTAINED Low	CENTRAL-SUPPORT
1	Procurement of critical sustaining commodities and drugs	Procurement of critical sustaining commodities and drugs	Procurement of critical sustaining commodities and drugs	Procurement of critical sustaining commodities and drugs
2	Human Resource: Salary support to fill HR gaps; Training, mentorship and supportive supervision (including logistics management, QA/QI)	Training, mentorship and supportive supervision (including logistics management, QA/QI & training updates)	Technical Assistance to PMO/ DMO twice a year	
3	Support routine site level service and data QA/QI	Support targeted site level service and data QA/QI		
4	Active case finding (PITC, HIV Index Case Tracing, CBTC) > emphasis on Paeds & adolescents	Active case finding (PITC in high yield settings – TB, ART, Medical wards, Nutrition clinics etc., HIV Index Case Tracing, targeted CBTC)		
5	Support lab. & clinical monitoring: purchase and maintenance of equipment, reagents (CD_4, VL, Chemistries etc.) , sample transportation and results return	Support lab.& clinical monitoring: equipment *maintenance or replacement*, reagents (CD_4, VL) and results return		
6	MER: Support for EHR roll out for optimized patient monitoring, review/updating of reporting tools for optimized monitoring	MER: Support for EHR roll out for optimized patient monitoring and tracking systems		
7	Strengthen linkages and support for active patient adherence, tracking and retention systems: includes training, mentoring and salary support for community health workers AND logistic requirement for follow-up (e.g. transport/phone/SMS or other technology)			
8	Support provision of ART to stable clients using community ART services (includes training, mentoring and salary support for community health workers)			
9	Support operations of mobile ART, extended clinic hours & other innovative strategies to reach underserved and key populations			
10	Targeted infrastructural renovations to improve clinic flow, reduce congestion and for infection prevention			

5.2 Central support plans for redirecting PEPFAR support to priority locations and populations

Prevention programs will transition sustained areas to the GRZ over the period of one year and will move to areas of high yield by September 2016. Increased engagement of the GRZ in site supervision and M&E will provide sustainability of activities. The HTC program will be driven by the need to identify HIV infected persons in the communities and will move from areas of low positivity; thus, the HTC program will transition all low yield sites to the Provincial Health Offices within one year by September 2016. Anticipated challenges include the ability of GRZ to provide the same standard of services which USG was providing, the supply of HIV rapid test kits, the attrition of lay counselors, the standard of HIV prevention services that GRZ will be able to deliver, and the sustainability of community programs due to low levels of dedicated community staff and incentives.

The PMTCT and EIMC implementing partners will provide above site technical assistance in sustained areas for purposes of quality assurance and provide periodic targeted site level technical assistance; transition to GRZ will occur by September 2016. Implementing partners in non-scale up districts will provide periodic targeted regional and site level technical assistance and will be transitioned to the government by September 2016.

For care and support, implementing partners providing palliative care have been advised to break out the components of their package of services; non-core components will not be supported by the end of FY15 and partners are to follow PEPFAR geographic refocusing in their implementation. Regarding cervical cancer, PEPFAR support will cease at the end of Sept 2015 for implementing partners using Pap smear and they will be advised to screen using VIA or refer to other partners that can support Pap smear.[48]Clients requiring treatment will be referred to specialist treatment facilities. Additionally, on-going support will be limited to activities for quality assurance; no DSD support will be provided to central-support or sustained sites; TA will be reduced to leave only targeted TA support; no equipment procurement in these sites; and no renovations will be made in care and support sites.

All OVC sites receiving HKID funding under the Time to Learn education program of USAID are central-support sites. As of FY15 no beneficiaries have been added and support to current beneficiaries will phase out through the end of the program in 2016. These beneficiaries receive support to complete secondary education. Non-core activities for OVC programming will cease in 2015, with the exception of a few remaining scholarship recipients who graduate at the end of 2016. All other OVC activities will occur in priority areas and two districts in Eastern Province as scale-up or sustained sites. As children graduate or move away from program sites that are sustained, additional children will not be added which will allow for more resource allocation in

[48] PEPFAR does not fund cytologic screening such as pap smears or any prevention HPV vaccines but does support visual inspection with acetic acid or LEEP.

scale up sites. DOD will centrally support 14 sites mostly located in the low prevalent areas in Luapula, Mansa, Northern and Northwestern.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

Based on the results of the SID analysis and sustainability index, PEPFAR Zambia has examined those activities that must be included in laboratory strengthening to address access & demand, human resources for health, quality management, and commodity security and supply chain. In order to strengthen the laboratory infrastructure for improved access, quality, and coverage of HIV related diagnostic testing, PEPFAR Zambia will focus its core activities on:

a. Provision of sustained laboratory commodities
b. Quality assurance programs for diagnosis of HIV, TB, other comorbidities, and opportunistic infections.
c. Support for the enhancement of laboratory infrastructure
d. Support for national equipment maintenance program
e. Training and capacity building of staff
f. Referral process improvement for laboratory specimens

Table 6.1 provides a brief description of activities to achieve sustained epidemic control through laboratory strengthening.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Work with stakeholders to identify laboratory gaps and address needs.	Develop implementation plan to address 2 major gaps (need for increased capacity for EID and viral load)	Develop implementation plan to address 2 additional gaps (expand VL testing and EID)	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Access and demand. 7.8	X	X	X		X
Expand enrollment and number of analysts currently evaluated in Proficiency Test (PT) programs	Expand to include hematology and chemistry analytics	Achieve 90% of analytics coverage in targeted facilities in scale up districts	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Performance data. 17.0	X	X			X
Establish capacity for evaluating new diagnostics	Evaluation of 1 new diagnostic	Evaluation of 1 new diagnostic	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Quality management. 14.0	X	X			X
Continue and extend SLMTA training programs laboratories toward accreditation scale up districts and targeted facilities	Achieve at least 1 star increase in 5 laboratory sites	Achieve international accreditation for one national laboratory	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Quality management. 14.0	X	X			X
Continue and expand EQA activities in high impact provinces and targeted sites for laboratory diagnosis of HIV, TB and other comorbidities and opportunistic infections.	Extend EQA activities to additional facilities in scale up districts	Extend EQA activities to additional facilities in scale up districts	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Quality management. 14.0	X	X			X
Address national deficiencies in biosafety training for laboratory staff and implementation of	Present biosafety workshop training in all scale up districts	Establish refresher training as required for lab accreditation for all scale up districts	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Quality management. 14.0	X	X			

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
biosafety procedures in clinical laboratories											
Address national deficiencies in procurement and distribution of laboratory supplies	Develop a plan of improvement together with GRZ stakeholders	Begin implementation of stakeholder plan	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Commodity Security and Supply Chain. 15.0	X	X			X
Enhance QA/QI procedures for HIV RT in Zambia	Train QA/QI trainers for all scale up districts	Develop sustainability in QA/QA services/activities in all scale up districts	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Quality management. 14.0	X	X			X
Improve and re-establish diagnostic microbiology services toward control of opportunistic infections and comorbidities in PLHIV in scale up districts	Extend bacteriology services to 4 level 1 clinic laboratories in Lusaka Province. Continue TA for strengthening services in 3 other scale up districts	Extend bacteriology services to 2 laboratories in Copperbelt Province. Continue TA for strengthening services in 3 other scale up districts	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Access and demand. 7.8		X			X
Support CDC HQ initiatives for broad health infrastructure improvements in Zambia	Established NPHI Expanded QA training for HIV RT	Establish NPHL	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data. 10.6	X	X			
Build laboratory equipment maintenance capacity in Zambia	Develop plan to train biomedical scientists in basic equipment maintenance in Zambia	Train 10 biomedical scientists in equipment maintenance for high scale up districts	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Access and demand. 7.8	X	X			X
Expand availability of Laboratory Information and Data Management Systems in high impact Provinces and at targeted sites	Extend LIS to 1 additional level 3 facility	Extend LIS to 1 additional level 3 facility	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data. 10.6	X	X			X

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Work to improve and enhance curriculum development, pre-service training and staff retention for laboratory staff	Develop curriculum development plan for pre-service training with GRZ stakeholders	Begin implementation of revised curriculum in Lusaka Province	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Human Resources for Health. 14.8	X	X			X
Work with MOH to improve laboratory specimen referral systems in Zambia	Improvement in reliability specimen courier service	50% increase in timely processing of referred specimens	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Access and demand. 7.8	X	X			X
Continue to improve laboratory infrastructure to accommodate appropriate lab equipment.	Improvement in laboratory service delivery and increased number of clients in 50 labs	Improvement in laboratory service delivery and increased number of clients in 50 labs	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Access and demand. 7.8	X	X			X
Provision of appropriate laboratory equipment	Efficiency in Laboratory service delivery	Improved efficiency	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Access and demand. 7.8	X	X			X

*Upon review it is confirmed that this is the amount for VL commodities alone. The GRZ has begun but not finalized guidelines for transition from CD4 count to VL as the primary tool for monitoring ARVs. PEPFAR Zambia is working closely with GRZ to make sure that VL replaces as appropriate CD4 count, rather than simply adding an additional test. We anticipate finalized guidelines by October 2015.

Table 6.2 Description of strategies used to achieve sustained epidemic control through SI activities

In FY2016, Strategic Information (SI) will be a critical component that will support PEPFAR Zambia's efforts in collection, analysis and use of information to make decisions on geographical prioritization and in assessing the outputs, outcomes and impacts of program interventions. In this FY, SI activities will focus on:

a. Strengthening M&E systems and improving data quality to inform data-use in HIV program decision making including analysis and reporting;
b. Improving HIV data quality and use by developing interfaces and outputs that directly use national data from HMIS, SmartCare and vital registration to direct program activities;
c. Preparing for and conducting population-based surveys that will produce HIV epidemiologic data; and
d. Providing technical assistance to build capacity of government staff to use existing data systems including SmartCare.

The Table 6.2, below, shows the specific mechanisms and areas for SI implementation, expenditure and impact.

	1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. COP15	5. COP16			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Health Communications Collaboration (HC3)	Baseline, midline, and endline impact evaluation of USAID community & behavioral activities for HIV prevention	• Evaluation plan developed • Baseline survey plan developed • Quarterly monitoring of site level data collection, and analysis	• Quarterly monitoring of site level data collection, and analysis	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	
Improving Prevention and Adherence to Care and Treatment (IMPACT)	Support SI activities in 14 districts in Lusaka, Central, Copperbelt, Southern and Luapula provinces.	Routine reporting requirements: 1. SAPR 2. APR Annual data quality assessments	Routine reporting requirements: 1. SAPR 2. APR Annual data quality assessments	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	
Zambia Community HIV Prevention Project (Z-CHPP)	Support SI activities in 20 districts in Lusaka, Central and Southern provinces.	Routine reporting requirements: 1. SAPR 2. APR Annual data quality assessments	Routine reporting requirements: 1. SAPR 2. APR Annual data quality assessments	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	
ZPCT II follow on (D-SERVE)	Support SI activities in 200 public health facilities in 27 districts in Central, Copperbelt, Northern, Muchinga and Northwestern provinces.	Routine reporting requirements: 1. SAPR 2. APR • Annual data quality assessments conducted • HMIS/SmartCare support	• HMIS/SmartCare support for a health information system providing monitoring data and reports to guide planning and program implementation • Annual data quality assessments. • Routine reporting: 1. Quarterly 2. SAPR	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	

	1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. COP15	5. COP16			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
			3. APR									
TB Care follow-on (TB/HIV mechanism)	• Secondary data analysis of TB prevalence survey data • SI support for X-pert technology implementation	• Recommendations for TB/HIV programming outlined • Strategy for implementing recommendations developed	• Analysis plan developed for TB prevalence • X-pert monitoring strategy and plan developed • Analysis of TB prevalence data • Recommendations for TB/HIV programming outlined • Strategy for implementing recommendations developed	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	
ZISSP follow-on (SHOTS)	Strengthen data collection, use and reporting systems in support of HIV program management at facility, district and provincial level in Central, Copperbelt, Lusaka and Southern provinces	• Improved data collection, use and reporting in targeted districts.	• Improved data collection, use and reporting in targeted districts • Support to national health HR database	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data score 10.6	X	X	X	X	
MEASURE Evaluation Phase IV –	Strengthen M&E systems and improve data quality to inform data use to inform program decision-making. This activity trains GRZ staff in data use	• People trained in data use • Support for Sample Vital Registration with Verbal Autopsy (SAVVY)	• Develop training modules through University of Zambia • People trained in data use • Support for Sample Vital Registration with Verbal Autopsy	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epi and Health Data score 10.6	X	X	X	X	

	1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. COP15	5. COP16			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
			(SAVVY)									
Better Health Services Delivery Through Community Based Monitoring in Zambia	Baseline and impact evaluation of USAID governance and health service utilization and uptake enhancement activity	• Evaluation plan design • Baseline design	• Baseline evaluation conducted and report produced	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data score 10.6	X	X	X	X	
Government to Government Health Improvement Project with GRZ	Strengthen monitoring and reporting systems of interventions implemented under the G2G mechanism		• Monitoring plan design • Monitoring tools developed • HMIS support • Monitoring system operational • Site monitoring • routine reporting requirements • data quality assessment	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	
Integrated Family Planning and Reproductive Health Project	Routine monitoring and strengthening M&E systems for FP/HIV integration including for HIV testing, and other combination prevention	Routine reporting requirements: 1. APR 2. Other reporting requirements Data quality assessment conducted	Routine reporting requirements: 3. SAPR 4. APR 5. Other reporting requirements Data quality assessment conducted	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	
DOD/PCI	Strengthen the ZDF Health Information Management System, analyze and disseminate	Functioning HMIS system generating M&E reports to guide planning and program implementation	Functioning HMIS system generating M&E reports to guide planning and program implementation	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and health data 10.6	X	X	X	X	

	1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. COP15	5. COP16			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
	information from program data.	OneZDF HMIS system functional and generates M&E and data for decision making reports 120 DQA visits conducted Finalize Sexual network study SIMS support Annual DQAs	OneZDF HMIS system functional and generates M&E and data for decision making reports 120 DQA visits conducted Finalize Sexual network study SIMS support Annual DQAs									
DOD/Jhpiego	Support of MoD/ ZDF to strengthen M&E, including data management, analysis and reporting through a centralized database.	Improved M&E systems in place Functioning data base in place M&E training to ZDF staff SIMS visits conducted Annual DQAs done End of project Evaluation APR, SAPR and SA reporting	Improved M&E systems in place Functioning data base in place M&E training to ZDF staff SIMS visits conducted Annual DQAs done End of project Evaluation APR, SAPR and SA reporting	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and health data 10.6	X	X	X	X	
DOD/FHI	Strengthen QA/QI aspects of supported service areas in all facilities in the 4 priority provinces, with oversight in the other 3 provinces.	Solid QA/QI teams in place Implementation QA/QA plans Capacity building on emerging M&E issues 100% SIMS visits conducted Annual DQA APR, SAPR and SA reporting	Solid QA/QI teams in place Implementation QA/QA plans Capacity building on emerging M&E issues 100% SIMS visits conducted Annual DQA APR, SAPR and SA reporting	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and health data 10.6	X	X	X	X	X

	1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. COP15	5. COP16			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
CIDRZ (HiLo)	Strengthen and streamline the monitoring and reporting system to improve program efficiencies,	80% of supported sites within saturation provinces submit timely reports Ensure quarterly DQA	80% of supported sites within saturation provinces submit timely reports Ensure quarterly DQA	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	X
DAPP	HCWs will be trained to use SmartCare and to store data and link clients to mobile ART, perform community based SmartCare enrollment pilot	Train all field officers in new areas on Smart Care and community based enrollment. Share electronic files with all health facilities in catchment areas.	New Mechanism	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	X
EGPAF	Support development, implementation and management of the national EHR system SmartCare	Model site implementation extended to an additional 250 site with primary role of providing facilitation for on the job training of trainers	New Mechanism	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	X
EPHO	Strengthen the PHO, DHOs and health care providers' capacity in collection, analysis and utilization of data for decision making and service delivery improvement.	Support and maintenance of SmartCare sites in the province, scale up to 20 if possible. Strengthen accurate and timely data collection and reporting systems Improved M&E systems in place Ensure quarterly DQA	Support and maintenance of SmartCare sites in the province, scale up to 20 if possible. Strengthen accurate and timely data collection and reporting systems Improved M&E systems in place Ensure quarterly DQA	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6		X	X		X

	1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. COP15	5. COP16			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Sinazongwe	Household survey and facility surveys to ascertain behavior and use of HIV PCT services and if combination prevention can reduce HIV incidence.	Final report from baseline surveys to inform combination prevention scale up.	Funding needed again for follow-up survey in FY17 (prep) and FY18 (survey)*		*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	X
LPHO	Strengthen PMO, DMOs capacity in collection, analysis and utilization of health data for program improvement and monitoring program	Support and maintenance of SmartCare sites in the province Strengthen accurate and timely data collection and reporting systems Improved M&E systems in place Ensure quarterly DQA	Support and maintenance of SmartCare sites in the province Strengthen accurate and timely data collection and reporting systems	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X		X
NAC	Provincial training and continuous data quality assessments and provincial data review meetings	Increased use of quality data in supporting the coordination of the HIV/AIDS response and monitoring of the status of the HIV/AIDS epidemic in Zambia	Takes over Pop Council key pops activities	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	X
Population Council	Surveillance of key populations in Zambia for mapping and population size estimation, behavioral and biological surveillance	Report of HIV prevalence, risk factors, care/ prevention behavior among MSM, DU and CSW in 4 high cities with highest number of key pops	Mechanism Ends	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	X

	1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. COP15	5. COP16			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
DNRPC	Collect and report national vital registration data document changes in HIV-related and other deaths in the context of art programs, also SAVVY	Report outlining national and age-, sex-, provincially-disaggregated mortality fraction and cause of death across Zambia. NEED to input sustainable deliverables (SK)	Report outlining national and age-, sex-, provincially-disaggregated mortality fraction and cause of death across Zambia. NEED to input sustainable deliverables (SK)	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6		X	X		X
SPHO	Strengthen the SPMO, CDMOs and health care providers in collection, analysis and utilization of health data, SmartCare, HMIS-DHIS	Support and maintenance of SmartCare sites in the province Strengthen accurate and timely data collection and reporting systems Improved M&E systems in place Ensure quarterly DQA	Support and maintenance of SmartCare sites in the province Strengthen accurate and timely data collection and reporting systems Improved M&E systems in place Ensure quarterly DQA	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X		x
Jhpiego	Strengthen the human resource capacity to use the SmartCare system	Creation of OJT materials, trainers, eLearning tools and distance learning materials. Develop a learner evaluation mechanism	Creation of OJT materials, trainers, eLearning tools and distance learning materials. Develop a learner evaluation mechanism	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X		X
MCDMCH	Support startup of SI systems to support PMTCT, TB/HIV, HTC and VMMC under the new ministry	An additional 24 Model sites established in high priority regions	An additional 24 Model sites established in high priority regions	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	X

	1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. COP15	5. COP16			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
MOH	Continue to expand, support and provide leadership in various routine and adhoc surveillance and survey activities particularly relating to the National EHR effort	Model site implementation extended to 10 other hospitals and additional 150 clinical personnel trained in the operation of a model site environment	Model site implementation extended to 10 other hospitals and additional 150 clinical personnel trained in the operation of a model site environment	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X	X	X
TDRC	Strengthen the ability to respond to HIV/AIDS related challenges, TDRC will continue sustaining ongoing HIV surveillance and initiating new ones	Preliminary or Completed HIA and ANCSS data analyzed to inform COP 16 programming	Preliminary or Completed HIA and ANCSS data analyzed to inform COP 17 programming	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data. 10.6	X		X		
UTH - HAP	Improve data quality and data use. Data review meetings to consolidate and review performance data. Quarterly data quality audits	Strengthen M& E capacity for reporting	Preliminary or Completed ANCSS data analyzed to inform COP 17 programming	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X		X		X
UNZA M&E Dept of Population Studies	Conduct a population-based HIA to obtain estimates of the prevalence and distribution of HIV and syphilis	Develop and execute, with TDRC and UTH a HIA protocol and survey instruments Assist with an endline, Maternal Mortality census.	Not funded under HVSI	*[REDACTED]*		*[REDACTED]*	Epidemiological and Health Data. 10.6		X	X		X

	1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
		2. 2015	3. 2016	4. COP15	5. COP16			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
WPHO	Strengthen the PHO, DHOs and health care provider's capacity in collection, analysis and utilization of data for decision making and service delivery improvement. Strengthen health care provider's capacity to utilize SmartCare application for improved patient management	Number of facilities with trained health care providers using data for decision making and service delivery improvement increase from 60% to 80% Number of facilities with functional SmartCare application increase from 50% to 80% Strengthen accurate and timely data collection and reporting systems Improved M&E systems in place Ensure quarterly DQA	Number of facilities with trained health care providers using data for decision making and service delivery improvement increase from 60% to 80% Number of facilities with functional SmartCare	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Epidemiological and Health Data 10.6	X	X	X		x

*In 2010 an evaluation to determine the effectiveness in reducing HIV incidence of community based prevention was started in a rural community of ~110,000 in a very underserved region within the Southern Province. Base line household survey found an HIV infection rate of 8.1% (sample of 9,300 persons tested). Approximately $5 million has been expended to bring ART services to the community and ~$1.5 million was spent on the baseline survey. Subsequently, the intervention model has been expanded to include community ARV adherence support. The remaining funding is required for the end line survey in 2016-17. Lessons learned will be used to implement community supported ARV delivery and adherence for the 25 scale up districts as saturation is achieved.

6.3 Health System Strengthening (HSS)

Based on the results of the SID, PEPFAR Zambia has examined those activities that must be included in health system strengthening to address access, demand, human resources for health, quality management, commodity security, and supply chain. HSS activities[49] will include a sustainability strategy to ensure that investments are managed appropriately to help reach epidemic control by providing focused support in the following areas:

a. Development of comprehensive electronic Human Resource Information System
b. Strengthening HR management to improve recruitment, deployment and retention of staff in high yield/volume sites[50];
c. Implementation of quality management/improvement (QM/QI) methodologies;
d. Strengthening national supply chain by improving commodity management systems;[51]
e. Supporting integrated procurement of commodities; improving distribution; and expanding storage capacity;
f. Training and capacity building of staff;[52] and
g. Continuing to build on sustainable financing strengths[53] and relationships with civil society and GRZ[54].

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[49]These activities will be implemented at national and sub-national levels. PEPFAR plans to expend substantially more resources supporting scale up HIV prevention, care and treatment services in high prevalence/disease burden locations compared to areas where sustained packages of care will be provided. Notably, however, activities implemented in priority areas are likely to have positive spill over effects in non-focus geographic areas. Additionally, PEPFAR will coordinate with and leverage resources of key stakeholders investing in health systems strengthening to promote efficiency and increase the impact of interventions.

[50] Recently, GRZ has made efforts to increase the health workforce by providing treasury authority for net recruitment of health professionals. Despite these efforts, the vacancy rate for clinical health worker positions is approximately 40 percent. Furthermore, pre-service training institutions have limited production capacity. PEPFAR will support pre-service training institutions to increase the production of new health workers by strengthening management capacity of schools, faculty development, procurement of teaching aids and training materials, and curriculum development and review. PEPFAR will work with GRZ to ensure that newly graduated health workers are recruited and preferentially deployed to high volume/yield sites in high prevalence geographic areas. This will include improvements to human resources through the development and roll out of an electronic human resource information system, training and orientations of HR staff, and implementation of task-sharing strategies. Additionally, PEPFAR will support needs-based in-service training, mentorship and supportive supervision of health providers and community health workers/volunteers.

[51]Technical area sustainability analyses identified stock-out of HIV commodities as a threat to achieving sustainable epidemic control, particularly for HTC, EID and VMMC activities that receive relatively low contribution from GRZ towards their procurement. PEPFAR will continue advocacy to GRZ to increase domestic financing on HIV commodities and support GRZ in conducting a national supply chain assessment to inform the National Supply Chain Strategy and Implementation Plan. USG will continue to support capacity building in commodity quantification and forecasting, warehousing, distribution, and expansion of storage space at sub-national level.

[52]One challenge faced by the PEPFAR team in formulating interventions to address the critical shortage of staff is the paucity of information on the staffing situation in high yield/volume sites. To address this, PEPFAR will use an existing mechanism (Emory University) to conduct an HRH assessment using FY 2014 funds. The assessment is expected to be completed before the end of FY15 so that the findings can inform investment decisions for COP 2016.

[53]Despite recent increases in GRZ spending on HIV, domestic resources finance only 10 percent of the national response. Increased domestic resource mobilization and expenditure is required in order to assure sustainable results as the country progresses towards epidemic control. PEPFAR will support accelerating progress towards sustainable financing of the HIV response. Zambia is a Phase 2 country under USAID's Bold Vision Initiative. In FY16, PEPFAR will provide technical and financial support to conduct National Health Accounts and other health financing surveys that will be used to advocate for increased domestic resource commitment towards health and the HIV response. Additionally, PEPFAR will focus on increasing efficiency and promoting innovative financing methods that leverage private sector resources.

[54]The SID analysis revealed that formal channels for civil society participation have weakened significantly over the years. PEPFAR will focus on improving strategic capabilities of targeted local civil society organizations to enhance delivery, oversight and ownership of HIV service delivery, particularly in high prevalence/disease burden locations. Activities will focus on improving the ability of citizens

Based on the results of the SID and technical area bottleneck/gap analyses, PEPFAR Zambia has identified priority health systems strengthening (HSS) activities that must be implemented to address weaknesses in domestic resource mobilization, access to and demand for HIV services, human resources for health, commodity security and supply chain, and stewardship and ownership. In addressing these, PEPFAR will coordinate with and leverage resources of key stakeholders to promote efficiency and increase the impact of interventions.

The SID indicates that less than 40% of health facilities in high-prevalence areas provide ART and PMTCT services. Existing high volume/yield facilities have insufficient space to provide services and only 25% of health facilities in Zambia have appropriate laboratory infrastructure to support service delivery. In FY16, PEPFAR will support targeted infrastructure improvements to increase access to services in these facilities. Furthermore, the SID and technical area analyses suggest that key populations may not be freely accessing HIV services. In response, PEPFAR will strengthen the capacity of civil society organizations to advocate for non-discriminatory rights for all persons to access HIV services.

to demand, and GRZ to deliver HIV services in a transparent, accountable manner through improvements to the HIV/AIDS policy and legal environment.

Table 6.3 Description of activities to achieve sustained epidemic control through HSS

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. COP 2015	3. COP 2016	4. COP 2015	5. COP 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Human Resources for Health											
Support Development of comprehensive electronic Human Resource Information System (eHRIS) to improve HR management in scale-up districts.	Expansion of the Human resource information system to link to existing systems in the health care worker regulatory boards Available electronic access of all registered HCWs	Expansion of the Human resource information system to link to existing systems in the health care worker regulatory boards Available electronic access of all registered HCWs	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	HRH Element score 14.8	X	X	X	X	
Support pre-service training to increase the number and improve quality of HRH in scale-up districts.	Number of graduates from PEPFAR supported pre-service training institutions increased by 5% Proportion of new graduates registered and licensed increased by 10% At least 50% of PEPFAR supported graduates recruited and deployed to high volume/yield sites and high prevalence geographic areas.	Number of graduates from PEPFAR supported pre-service training institutions increased by 10% Proportion of new graduates registered and licensed increased by 15% At least 60% of PEPFAR supported graduates recruited and deployed to high volume/yield sites and high prevalence geographic areas.	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	HRH Element score 14.8					

Support "blended learning" approach to in- service training that encompasses e-learning formats, mentorship/supervision and performance assessment to improve HRH performance and of quality HIV services in scale-up districts.	Establish 10 clinical care committees in high prevalence districts 25% increase in the number of high yield/volume sites that receive TSS from DMOs	Establish additional 10 clinical care committees in high prevalence districts Additional 30% increase in the number of high yield/volume sites that receive TSS from DMOs	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	HRH Element score 14.8 Access and Demand score 7.8	X	X	X	X	X
Support training and supervision of community health workers/volunteers to increase linkages between facilities and communities in scale-up districts.	Establish and equip Safe Motherhood Action Groups in six districts At least 50% of community volunteers in high prevalence geographic areas receive supportive supervision during the reporting period.	Establish and equip Safe Motherhood Action Groups in 10 districts At least 60% of community volunteers in high prevalence geographic areas receive supportive supervision during the reporting period.	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	HRH Element score 14.8 Access and Demand score 7.8	X	X		X	
Strengthen HR management to improve recruitment, deployment and retention of staff in scale-up districts.	Trained HCWs retained in high yield volume sites increased by 20%	Trained HCWs retained in high yield volume sites increased by 15%	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Access and Demand score 7.8 HRH Element score 14.8	X	X	X	X	X
Quality Management/Improvement											
Support for implementation of the quality management/improvement (QM/QI) methodologies in priority provinces and districts	Establish 10 QI committees in high volume/yield sites. Increased number of facilities developing and implementing QI	Establish 20 QI committees in high volume/yield sites. Increased number of facilities developing and	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Quality Management score of 14.0	X	X	X	X	X

	action plans/projects.	implementing QI action plans/projects.									
Infrastructure											
Targeted health infrastructure improvement and/or provision of equipment to increase access to quality HIV services in scale-up districts.	Improve health facility infrastructure in 50 sites Facility deliveries increased by 10% Furniture, Medical and Lab Equipment provided to 10 heath facilities		*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Access and Demand score 7.8	X	X	X	X	X
Health Care Financing											
Support efforts to accelerate progress towards sustainable financing of the national HIV/AIDS response.	Milestones TBD once national HCF strategy is complete. Resources mobilized locally increased by 5%.	Milestones TBD once national HCF strategy is complete. Resources mobilized locally increased by 10%.	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	DRM: Resource Generation score of 9.0 DRM: Resource Commitments score of 5.0	X	X	X	X	X
Support NAC to provide leadership for coordinated national HIV response through a joint financing agreement	Develop and implement Strategic Plan and Annual Work Plans; Improve coordination of all HIV and AIDS activities at National, Provincial and District levels, and in the Public and Private Sectors and Civil Society; Resources from various Co-operating Partners	Improve coordination of all HIV and AIDS activities at National, Provincial and District levels, and in the Public and Private Sectors and Civil Society; Resources from various Co-operating Partners locally and internationally mobilized; Local responses to HIV planned,	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	DRM: Resource Generation score of 9.0 DRM: Resource Commitments score of 5.0	X	X	X	X	X

	locally and internationally mobilized; Local responses to HIV planned, tracked, monitored, and capacity built. Operations of all Theme Groups (technical working groups) facilitated. Annual work plan and budget for the year drawn from the NAC Strategic Plan submitted.	tracked, monitored, and capacity built. Operations of all Theme Groups (technical working groups) facilitated. Annual work plan and budget for the year drawn from the NAC Strategic Plan submitted.									
Local Institutional Capacity Building											
Build national capacity for epidemic control through support for the National Public Health Institute	Establish a national and regional institution to strengthen public health.	Continued support for national and regional institution to strengthen public health.	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Policies, Laws, and Regulations score of 10.0		X			
Strengthen oversight and management capacity of the GRZ and local organizations to improve service delivery, transparency, accountability and efficiencies in the national HIV/AIDS response.	Increased local leadership of HIV programs in high prevalence/disease burden areas	Increased local leadership of HIV programs in high prevalence/disease burden areas	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Public Access to Information score 11.0 Oversight and Stewardship score 12.0 Planning and Coordination score of 17.0	X	X	X	X	

Supply Chain Management											
Pre-service training of MOH/MCDMCH/MSL staff in National Health Commodity Management Systems to ensure HIV services at PEPFAR-supported sites.	570 GRZ Staff trained in commodity logistics systems and eLMIS to ensure commodity security.	570 GRZ Staff trained in commodity logistics systems and eLMIS to ensure commodity security[55].	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Commodity Security & Supply Chain Score 4	X	X	X	X	
TA to GRZ to strengthen SCM.	Forecasting and quantification for ARVs, HIV, essential medicines, VMMC and lab commodities conducted	Forecasting and quantification for ARVs, HIV, essential medicines, VMMC and lab commodities conducted	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Commodity Security & Supply Chain Score 4	X	X	X	X	
Roll out of Logistics Management Information System/electronic inventory system in collaboration with World Bank. Procure IT equipment for implementation of the electronic Logistics Management Information System(eLMIS)	eLMIS rolled 108 districts. eLMIS equipment procured and installed.	Provide ongoing maintenance support to districts. Central Medical Store IT eLMIS updated	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Commodity Security & Supply Chain Score 4	X	X	X	X	
Support Medical Stores Limited (MSL) by expanding storage space and access to commodities by increased infrastructure in support of HUB model	3 Warehouse in the box (WIB) storage facilities procured and installed	5 Warehouse in the box (WIB) storage facilities procured and installed	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	Commodity Security & Supply Chain Score 4	X	X	X	X	

*Trainings include 65 EMLIP rollout, 18 OJT trips, 2 Labs rollout, 15 ARV rollout, 8 HIV rollout and 12 pre-service training trainings. Note: Number of trains reduced by 50% from 60 in current year to 30 in 2016.
**The same amount has been allocated for both years as the activities are ongoing and recurrent i.e. annual and semi-annual forecasting and quantification exercises.

[55] This includes expenses related to Essential Medicines Logistics Improvement (EMLIP) roll out training, lab logistics training, and pre-service training. The amount also covers travel expenses for on-the-job-training sessions.

7.0 Staffing Plan

Given the greater emphasis on data, evidence, monitoring, and coordination, PEPFAR Zambia repurposed existing positions and added additional technical staff to support care, treatment, strategic information, and provincial office coordination. The additional human resources will strengthen data analysis and interpretation, foster quality assurance checks, and promote coordination of activities from a provincial to a district level with the GRZ, civil society, donors, and other key stakeholders. Presence at the decentralized level would allow for direct technical assistance and transition support between USG PEPFAR and the provincial and district government partners, donors, and USG-funded projects for implementation, through a whole-of-government approach to staffing. Moreover, placement of staff at the provincial level will help ensure that PEPFAR funds are used efficiently and harmonized with GRZ and other donor activities to foster a greater continuum of care from the community to the facility and back, and strengthen country ownership of local programs by strengthening planning, budgeting, and sustainability. To support a growing team and increased monitoring visits, administrative staff will provide the necessary logistics for successful implementation. Across all agencies, we estimate a 10% increase in the overall cost of doing business for additional team members.

Proposed staff and current vacancies are listed in **Table 7.1**.

Table 7.1: Proposed New Staff *(Note: Justifications for vacant positions and positions proposed to be re-purposed are included in the staffing database)*			
Proposed New Staff			
Role	**Technical Area**	**Agency**	**Impact to CODB**
[REDACTED]	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*
[REDACTED]	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*
[REDACTED]	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*
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[REDACTED]	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*
[REDACTED]	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*
[REDACTED]	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*
[REDACTED]	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*
[REDACTED]	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*
[REDACTED]	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*
[REDACTED]	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*
[REDACTED]	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15			
Level of Implementation	**Core Activities**	**Near-core Activities**	**Non-core Activities**
Site level	X	X	
Sub-national level	X	X	
National level	X	X	X
	Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15		
Priority Population Prevention	a. Quality VMMC services targeting ages 15-29 through static and mobile sites; b. Scale up PMTCT Option B+ with emphasis on retention of mother-baby pairs "along the continuum of care" and establishment of M&E systems; c. Condom promotion and distribution; d. Targeted HIV prevention interventions reaching high risk populations; e. Support community linkages/systems to timely access services in: ARV treatment and adherence, care & support, VMMC and PMTCT; Integrated Social Behavior Change Communication in PMTCT, HTC, VMMC, stigma/discrimination reduction, and other programs; including girls empowerment	a. Family Planning/ HIV integration	a. Blood safety; b. PMTCT Option A
Key Populations	a. Lubricant promotion and distribution for key populations; b. Interventions addressing stigma , discrimination, and community empowerment		
Counseling and Testing	a. Quality HIV testing and counseling services (including PITC) to individuals, couples and families, and to key and other priority populations in high prevalence areas and HIV hot spots; b. Support community linkages/systems to timely access services in HTC (and early diagnosis).	Targeted PITC in sustained sites in non-scale up districts	a. HTC for generalized population in sustained sites
Care and Support	a. Strengthen FP/HIV integration for PLHIV on care; b. Continue providing support to GBV survivors; c. Improving patient record management; d. Early identification of HIV-infected persons, and improve linkage, adherence and retention in care using: e. Community support groups, care givers and volunteers f. Commodities which increase uptake of care- CTX; g. CD_4/VL testing, case management, IEC/BCC, care groups, patient tracking system(SMS)Clinical assessment and staging, measurement of CD_4 count, and Dx and RX of OI; h. HIV testing of Children for early Identification; i. CTX prophylaxis and basic health interventions for HIV-exposed and –infected children;	a. OI Prevention and Treatment; b. Cervical Cancer Screening; c. Strengthen community /facility referral system on nutrition; d. Training, capacity building, and institutional support activities to integrate nutrition in health facilities; e. Incorporate pre-service training on the integration of NACS into HIV and TB care into medical and nursing education partnership initiatives;	a. STI drugs used for broader populations (e.g. KPs seen in a general STI clinic) (HVOP) b. Services provided more broadly to key populations of unknown or negative serostatus (HVOP) c. With regard to cervical cancer, PEPFAR does not provide funding for primary prevention (HPV vaccine), cytologic

	j. Reduction in new HIV infections among Children and keeping their mothers alive by improve the postnatal continuum of PMTCT care for HIV-infected mothers and their infants; k. Strengthen the facility and community linkage and retention in life-long care and treatment; l. Strengthen EID including funding for DBS commodities; m. Improve infant feeding focusing on high impact interventions in the first 1000 days for pregnant mother and children; n. Improve basic child health interventions for HIV-exposed, -infected, and -affected children: PMTCT/Pediatric HIV/MNCH Integration; o. Provider Initiated Testing and Counseling to all patients with presumptive TB or TB disease for HIV; p. Providing Cotrimoxazole preventive therapy for HIV positive TB patients; q. Scaling up ART for PLHIV with TB: (Integration of TB and HIV services, strengthen linkages and referral systems between the two programs and training of staff); r. Providing TB infection control measures in HIV program areas: (Provide minor renovations to accommodate TB/HIV services, develop, print and distribute IEC materials, education of patients, procurement of Personal Protective equipment, Triaging of patients; s. Screening PLHIV for TB and other special populations: (Pregnant women, pediatrics, prisoners at entry and exit, miners and provide clinical care, strengthen linkages and referral systems between the two programs; t. Laboratory investments for TB/HIV (Increase TB/HIV diagnostic centers, provide diagnostics-genexpert, biosafety cabinets, AFB smear and culture; u. Provide Isoniazid Preventive Therapy to PLHIV with no signs of active TB: INH availability, orientation on data collecting and reporting tools, training of health care providers.	f. Strengthen the harmonization of the NACS approach and Integrated Management of Malnutrition (IMAM) services; g. Therapeutic /Supplementary feeding support for clinically wasted patients; h. Support to National, Provincial, district and facility TB/HIV coordinating bodies; i. Updating TB/HIV monitoring and evaluation tools (recording and reporting tools including electronic tools: presumptive TB and diagnostic/Treatment registers, treatment/identity cards and quarterly report forms); j. Evaluation of the updated recording and reporting tools; k. Conducting quarterly TB/HIV data review meetings; l. Providing technical support through Site Improvement Monitoring System; Semiannual and annual progress reports.	screening (Pap smears), or treatment for invasive cervical cancer d. Palliative & end of life care e. Water & Sanitation f. Develop national guidelines, training and reference materials, and job aids for the implementation of NACS. g. Costs associated with HIV testing among TB patients (HVCT) h. Support the documentation of nutrition categorization and results in medical records; Develop national guidelines, training and reference materials, and job aids for the implementation of NACS
Treatment	a. Clinical staging/CD_4 measurement/Viral load b. Early identification of children for HIV treatment – including EID c. Focus on pediatric and adolescent ART initiation and retention d. Support community linkages/systems to access HTC, ARV treatment and adherence, care & support, VMMC and PMTCT services e. Implementation of integrated HTC & ART continuum of care service models to increase early case finding, adherence/retention, and strengthening linkage between HTC to care & treatment f. Electronic Health Record roll-out for optimized patient monitoring and supporting strengthened adherence & retention interventions	a. Nutritional Assessment counseling and support b. Management of opportunistic infections c. Training for community based support groups including SMAGs, TBAs, HBC, Adherence Supporters and Youth Peer Educators d. Support ART transition monitoring and evaluation e. Pre-service training f. HIV Drug resistance monitoring	

	g. PHDP (positive health, dignity and prevention) programs for PLHIV within treatment services h. Support ART service delivery targeting Key populations i. Scale-up ART service delivery via static, mobile and community care & treatment models, including targeted infrastructure improvement and equipment procurement j. Integration and decentralization of PMTCT and ART services k. Targeted program evaluations to inform service delivery improvements l. Provision of ART in TB treatment settings (TB/HIV collaborative activities) and ANC settings (B+) m. Support laboratory capacity, quality and accreditation n. Supply Chain TA to assure commodity availability at site level o. Procurement of HIV commodities: ARVs, EID, HIV test kits, viral load) p. Quality assurance/quality improvement - cross cutting across program areas q. In-service trainings		
Lab	a. Work with stakeholders to identify laboratory gaps and address needs. b. Expand enrollment and number of analysts currently evaluated in Proficiency Test (PT) programs c. Continue and extend SLMTA training programs laboratories toward accreditation in high impact provinces and targeted facilities. d. Continue and expand EQA activities in high impact provinces and targeted sites for laboratory diagnosis of HIV, TB and other comorbidities and opportunistic infections. e. Address national deficiencies in biosafety training for laboratory staff and implementation of biosafety procedures in clinical laboratories f. Address national deficiencies in procurement and distribution of laboratory supplies g. Enhance QA/QI procedures for HIV RT in Zambia h. Build laboratory equipment maintenance capacity in Zambia i. Work with MOH to improve laboratory specimen referral systems in Zambia j. Provision of appropriate laboratory equipment	a. Establish capacity for evaluating new diagnostics b. Improve and re-establish diagnostic bacteriology services toward control of opportunistic infections and comorbidities in PLHIV in high impact Provinces and targeted sites c. Support CDC HQ initiatives for broad health infrastructure improvements in Zambia d. Expand availability of Laboratory Information and Data Management Systems in high impact Provinces and at targeted sites. e. Work to improve and enhance curriculum development, pre-service training and staff retention for laboratory staff f. Continue to improve laboratory infrastructure to accommodate appropriate lab equipment.	
HSS	a. Support in- service training, mentorship/supervision and performance assessment to improve HRH performance and of quality HIV services in high volume/yield sites and high burden geographic areas. b. Strengthen national supply chain by improving national commodity management systems; supporting integrated procurement of HIV commodities; improving distribution; and	a. Support Development of comprehensive electronic Human Resource Information System (eHRIS) to improve HR management in high volume/yield sites and high burden geographic areas.	

	expanding storage capacity	b. Support pre-service training to increase the number and improve quality of HRH in high volume/yield sites and high burden geographic areas. c. Strengthen HR management to improve recruitment, deployment & retention of staff in high yield/volume sites. d. Support training and supervision of community health workers/volunteers to increase linkages between facilities and communities in high burden geographic areas. e. Support for implementation of the quality management/improvement (QM/QI) methodologies in high volume/yield sites and high burden geographic areas f. Targeted health infrastructure improvement and/or provision of equipment to increase access to quality HIV services in high volume/yield sites and high burden geographic areas. g. Strengthen oversight and management capacity of GRZ and local organizations to improve service delivery, transparency, accountability and efficiencies in the national HIV/AIDS response. h. Support efforts to accelerate progress towards sustainable financing of the national HIV/AIDS response. i. Build national capacity for epidemic control through support for the National Public Health Institute	
OVC	a. Identify children and adolescents made vulnerable to or by HIV and AIDS b. Assessing child & family socio-economic status (across all areas: healthy, safe, stable, schooled) c. Developing care/ case management plans for children and families with monitoring of referral completion and	a. Training in case management for CHV and voluntary children's officers (including tracing of children LTFU) within PEPFAR catchment areas. b. Workforce development in social	a. Supporting the development of national MIS b. Mapping services within targeted communities and developing service

	coordination with other community service providers (e.g., MOU agreements) d. Stated case closure goals e. Implement special studies to build the evidence base for social services in HIV control and to identify gaps in programming f. Promotion of EID and confirmatory HIV testing (E.g. within early childhood development (ECD) programs, etc.) g. Coordination with commodity and counseling providers to ensure HIV prevention and family planning options are available to adolescent OVC. h. Integrating adherence assessment, counseling and support into routine household support i. Coordination with NACS (E.g., referral of suspected malnutrition, education) j. HIV case finding k. Facilitating uptake of and monitoring completion of <u>referrals for</u>: l. Nutrition and food security programs m. TB/HIV testing, treatment and care services for children and caregivers n. Child survival services o. Sexual and reproductive and family health services and support p. Growth monitoring and Promotion (GMP) q. Supporting community level child protection/ GBV prevention and response activities and referrals to other services. r. Positive Parenting & discipline (see "stable" below) s. Supporting clinic-based child abuse and GBV response services (including emergency medical services/PRC), post-trauma care t. Succession planning u. Child safeguarding support v. Linkage with victim support units w. Support to adolescent girls at high risk for HIV infection. x. Support special needs of child-headed households y. Facilitating group-based Household Economic Strengthening (HES) activities, such as savings groups z. Supporting access to social protection efforts (such as social grants, cash transfer programs, bursaries, etc) aa. Positive Parenting skills building (including topics on adolescent risk, HIV disclosure, child health & development knowledge & transitioning stages) bb. Addressing psychosocial health among children and their caregivers through individual, group-based and relationship based activities cc. Succession planning dd. Family preservation ee. Supporting vocational training linked to market potential ff. Supporting access to GRZ social protection program	service provision, including social workers and para-professionals c. Strengthening referral mechanisms and other systems for linking clinical and social services (cross-referrals) d. Facilitating birth registration e. Strengthening structures for community-based mediation of child abuse cases, and safe spaces programming f. National level child protection policy and government capcity to implement g. Supporting advocacy and policy efforts to improve safety of children from h. Carrying out market assessments for Income generating Activities (IGAs) i. Linking businesses/agricultural projects to markets/value chain development j. Savings and Internal Lending Communities (SILC)violence. k. Providing long-term or open-ended school block grants l. Improving education quality, especially making classroom environments gender and HIV sensitive m. Supporting community mobilization for education n. Supporting education quality, especially making classroom environments gender and HIV sensitive.	directories c. Providing HH supplies such as blankets and mattresses d. Carrying out home visits solely for the purpose of clinical linkages e. Providing food packages/ support f. Strengthening birth registration systems g. Supporting law enforcement and prosecution of child abuse and GBV cases and providing other legal aid h. Supporting placements in long-term residential care facilities i. Carrying out large-scale child rights awareness campaigns j. Strengthening government-managed and case management systems to prevent and respond to child abuse and support family placement and permanency for children k. Dissemination of child protection laws l. M&E systems for National child protection/ social welfare efforts m. Directly supporting IGAs with funds and other inputs n. Establishing or supporting business cooperatives o. Providing Housing p. Targeted food security initiatives q. Covering vocational training and IGAs without established market potential r. Providing support for tertiary education. s. Scholarships to individuals

	gg. Facilitating access to primary and secondary education through temporary and targeted support for: hh. -Uniforms, school fees, exam fees, adult mentors) ii. Providing temporary school block grants to promote enrollment and progression. jj. Based on analysis of gender disparities in completion rates (primary and secondary levels) kk. identify key at risk groups for education support ll. School-based psychosocial support, (including Teacher psychosocial support for children) mm. Supporting early childhood development (ECD) – (in coordination with PMTCT & Pediatric HIV) nn. integrating ECD into HIV care & treatment for children under five		
Strategic Information	a. Surveys and Surveillance	a. Promote data use for decision making b. Data quality assessments and site monitoring c. Program evaluations d. On-going implementing partner M&E support e. SI training/ capacity building	f. ICT Infrastructure (computers, servers, internet time for GRZ)

APPENDIX B

B.1 Planned Spending in 2016 by PEPFAR Budget Code

Budget Code	Budget Code Description	Amount (USD)
MTCT	Mother to Child Transmission	21,683,851
HVAB	Abstinence/Be Faithful Prevention	2,530,680
HVOP	Other Sexual Prevention	7,222,780
IDUP	Injecting and Non-Injecting Drug Use	-
HMBL	Blood Safety	800,505
HMIN	Injection Safety	-
CIRC	Male Circumcision	12,494,146
HVCT	Counseling and Testing	19,246,858
HBHC	Adult Care and Support	16,557,140
PDCS	Pediatric Care and Support	6,284,037
HKID	Orphans and Vulnerable Children	22,078,396
HTXS	Adult Treatment	70,744,572
HTXD	ARV Drugs	52,332,684
PDTX	Pediatric Treatment	12,925,079
HVTB	TB/HIV Care	15,854,530
HLAB	Lab	10,828,583
HVSI	Strategic Information	10,648,241
OHSS	Health Systems Strengthening	14,150,028
HVMS	Management and Operations	16,915,247
TOTAL		**313,297,357**

TableB.2.1 Adjustments to Unit Expenditures for Resources Projections

Indicator	UE 2014	Adjustment for geographic and site focus	Adjustment for outlier remediation	Adjustment for program/model pivots	Expected UE 2016
HTC - Above National	19.61	-7.75			11.86
HTC - National	19.61	-7.75			11.86
HTC - Central Province	19.61	-10.99			8.62
HTC - Copperbelt Province	19.61	-10.80			8.81
HTC - Eastern Province	19.61	-9.94			9.67
HTC - Luapula Province	19.61	-10.88			8.73
HTC - Lusaka Province	19.61	-3.67			15.94
HTC - Muchinga Province	19.61	-11.79			7.82
HTC - North Western Province	19.61	-0.88			18.73
HTC - Northern Province	19.61	-11.67			7.94
HTC - Southern Province	19.61	-6.68			12.93
HTC - Western Province	19.61	-2.35			17.26
FBCTS - Above National - TX_ CURR	147.60	-11.38			136.22
FBCTS - National - TX_ CURR	147.60	-11.38			136.22
FBCTS - Central Province - TX_ CURR	147.60	-11.39			136.22
FBCTS - Copperbelt Province - TX_ CURR	147.60	33.40			181.00
FBCTS - Eastern Province - TX_ CURR	147.60	-51.38			96.23
FBCTS - Luapula Province - TX_ CURR	147.60	100.54			248.14
FBCTS - Lusaka Province - TX_ CURR	147.60	-27.16			120.44
FBCTS - Muchinga Province - TX_ CURR	147.60	140.51			288.12
FBCTS - North Western Province - TX_ CURR	147.60	-11.39			136.22
FBCTS - Northern Province - TX_ CURR	147.60	46.48			194.08
FBCTS - Southern Province - TX_ CURR	147.60	-83.96			63.64
FBCTS - Western Province - TX_ CURR	147.60	8.13			155.73
CBCTS	178.92			-154.92	24.00
PMTCT_EID	39.44			23.56	63.00
INF_CARE	974.86			-243.27	731.59
VMMC	58.87			0.00	58.87
PP PREV	11.08			-0.21	10.87
KP - FSW	99.89			0.00	99.89
KP- MSMTG	2477.93			0.00	2477.93
OVC	19.30			19.70	39.00
PMTCT_CARE	114.07			0.00	114.07

Summary of Cost-Savings from Central-Support Sites

SEAT results below.

- HTC = $27,666,626
- ART = $936,951
- PMTCT = $4,113,465

APPENDIX C

Based on the results of the Sustainability Index and Dashboard (SID) and technical area bottleneck/gap analyses, PEPFAR Zambia has identified priority health systems strengthening (HSS) activities that must be implemented to address weaknesses in domestic resource mobilization, access to and demand for HIV services, human resources for health, commodity security and supply chain, and stewardship and ownership. These activities will be implemented at national level and in priority provinces and districts. PEPFAR plans to expend substantially more resources supporting scale up HIV prevention, care and treatment services in high prevalence/disease burden locations compared to areas where sustained packages of care will be provided. It should, however, be noted that activities implemented at national and/or provincial level are likely to have positive spillover effects into non-priority geographic areas and populations. In addressing the identified weaknesses in the national response, PEPFAR will coordinate with and leverage resources of key stakeholders investing in HSS to promote efficiency and increase the impact of interventions.

The SID analysis identified weaknesses in the domestic resource mobilization. Despite recent increases in the Zambian government's spending on HIV, domestic resources finance only 10 percent of the national response. Increased domestic resource mobilization and expenditure is required in order to assure sustainability of results as the country progresses towards epidemic control. In order to address this issue, PEPFAR Zambia will support efforts to accelerate progress towards sustainable financing of the HIV response. The United States will continue to use diplomatic channels to advocate for increased domestic resource mobilization and expenditure. Zambia is a Phase 2 country under USAID's *Bold Vision Initiative: Achieving Sustainable Domestic Financing for HIV and AIDS*. USAID Zambia will coordinate the activities of the Bold Vision Initiative in Zambia and the bilateral mechanism activities to ensure that there is no duplication of work. To assure coordination with other key stakeholders implementing health care financing activities, both central and bilateral mechanisms will work closely with the Ministry of Health's Finance and Economics Technical Working Group. In FY 2016, PEPFAR/Zambia will use government to government assistance to institutionalize National Health Accounts and provide will technical assistance to conduct other health financing surveys that will be used as advocacy tools for increased domestic resource commitment towards health and the HIV response. PEPFAR will focus on increasing efficiency and promoting the use of innovative financing methods that leverage private sector resources. Additionally, USG resources will be used to strengthen public financial management and build the capacity of district health management teams to mobilize local resources.

The SID indicates that ART and PMTCT services are provided by less than 40 percent of health facilities in high-prevalence areas. Existing high volume/yield facilities have insufficient space to provide HIV services and only 25 percent of health facilities in Zambia have appropriate laboratory infrastructure to support service delivery. Furthermore, the SID and technical area analyses suggest that key populations may not be freely accessing HIV prevention, care and treatment services. In FY 2016, PEPFAR will support targeted infrastructure improvements to increase access to services in high volume/yield facilities in scale up districts. PEPFAR will also procure equipment required to improve the quality of services provided by these facilities. To increase access to services by key populations (KPSs), PEPFAR will strengthen the capacity of civil society organizations to advocate for non-discriminatory rights for all persons to access HIV services. USG will also work with the Zambian government (GRZ) and civil society to promote formulation and implementation of policies that facilitate equitable access to services.

The SID indicates that Zambia has an insufficient number of trained health workers to provide needed HIV services. The GRZ has in the past few years made efforts to increase the health workforce by providing treasury authority for net recruitment of health professionals. In March 2015, the Ministry of Health (MOH) announced that $7 million had been released by the Ministry of Finance to recruit 2,500 health workers, most of who will be deployed to rural areas, where the human resource shortage is most severe. Despite these efforts, the vacancy rate for clinical health worker positions stands at approximately 40 percent. The situation is further compounded by limited production capacity of pre-service training institutions: less than seventy medical doctors graduate from the University of Zambia annually while no students have yet graduated from three other medical schools that were recently opened. PEPFAR will use an existing mechanism to conduct an HRH assessment using FY 2014 funds. It is expected that the assessment will be completed before the end of FY 2015 and that the findings will be used to inform investment decisions for FY 2016. PEPFAR will support pre-service training institutions in order to increase the production of new health workers. This will include strengthening management capacity of schools, faculty development, procurement of teaching aids and training materials, and curriculum development and review. PEPFAR will work with GRZ to ensure that new health workers that graduate from supported schools are recruited and preferentially deployed to scale up districts. PEPFAR will support activities to strengthen human resource management at national level and in priority provinces and districts to improve the recruitment, deployment and retention of health workers. This will include the development and roll out of an electronic human resource information system, training and orientations of HR staff, and implementation of task-sharing strategies. Additionally, PEPFAR will support needs-based in-service training, mentorship and supportive supervision of health providers and community health workers/volunteers. This coupled with other quality management activities will result in sustained improvement of HIV prevention, care and treatment services.

The technical area sustainability analyses identified stock-out of HIV commodities as a threat to achieving sustainable epidemic control. Achievement of prevention, care and treatment targets relies heavily on commodity assurance along the continuum of care. Analyses revealed that HTC, EID and VMMC commodities are particularly vulnerable due to the relatively low contribution by the GRZ towards their procurement (see Table 1.2.2). To address this weakness, PEPFAR will continue to advocate to GRZ to increase domestic financing of HIV sustaining commodities. In addition to this, PEPFAR will support the GRZ to conduct a national supply chain assessment that will be used to inform the review of the National Supply Chain Strategy and Implementation Plan. USG will continue to support capacity building in commodity quantification and forecasting, warehousing and distribution, as well as expansion of storage space in scale up districts and provinces.

The SID analysis revealed that formal channels for civil society participation have become significantly weaker over the years. PEPFAR will focus on improving the strategic capabilities of targeted local civil society organizations to enhance delivery, oversight and ownership of HIV services, particularly in priority provinces and districts. Activities will focus on improving the ability of government to deliver, and for citizens to demand, HIV services in a transparent and accountable manner. USG will continue to focus on improving the HIV/AIDS policy and legal environment.

APPENDIX C

Sustainability Analysis for Epidemic Control: ZAMBIA

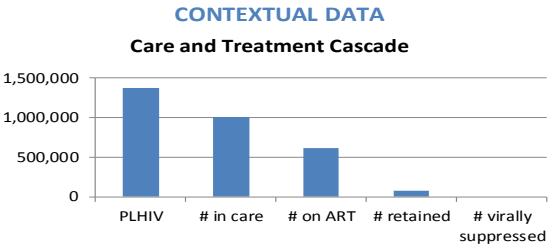
Epidemic Type:	Generalized
Income Level:	Lower Middle Income
PEPFAR Categorization:	Long Term Strategy
COP 15 Planning Level:	$325.7m

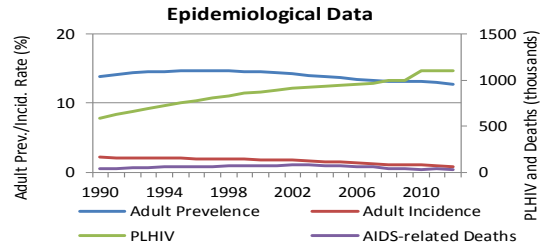
UNSUSTAINED → SUSTAINED

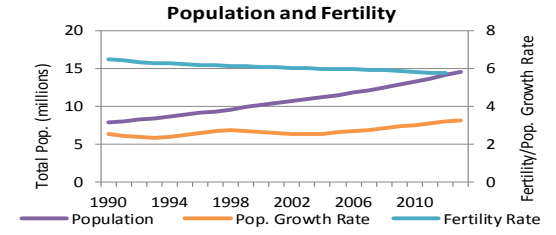
SUSTAINABILITY DOMAINS and ELEMENTS

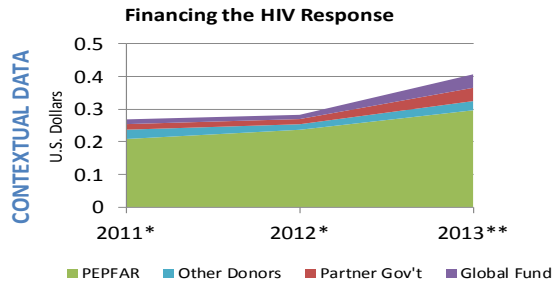
	Score
Institutionalized Data Availability	
1. Epidemiological and Health Data	10.6
2. Financial/Expenditure Data	17.0
3. Performance Data	16.0
Domestic Program and Service Delivery	
4. Access and Demand	7.8
5. Human Resources for Health	14.8
6. Commodity Security and Supply Chain	15.0
7. Quality Management	14.0
Health Financing and Strategic Investments	
8. DRM: Resource Generation	9.0
9. DRM: Resource Commitments	7.0
10. Allocative Efficiency	16.0
11. Technical Efficiency	17.3
Accountability and Transparency	
12. Public Access to Information	11.0
13. Oversight and Stewardship	12.0
Enabling Environment	
14. Policies, Laws, and Regulations	10.0
15. Planning and Coordination	15.0

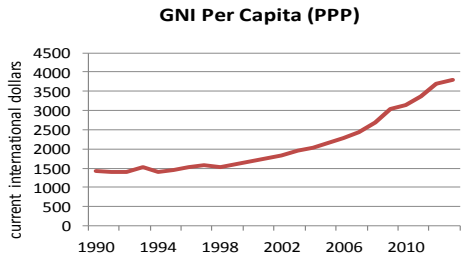
CONTEXTUAL DATA

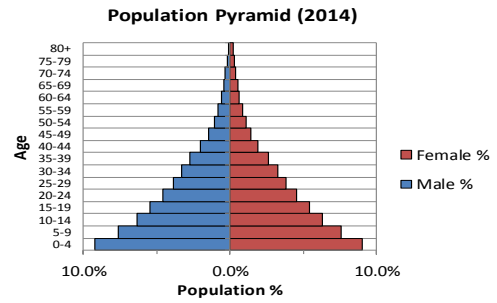












Zambia COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Chadiza District	2,948	662	3,236	639	2,728
Chama District	-	-	-	155	1,000
Chavuma District	-	334	1,000	-	593
Chibombo District	24,026	2,016	3,566	1,275	7,029
Chiengi District	5,962	727	1,220	-	1,865
Chikankata District	244	4	5	3	4
Chilanga District	-	-	-	-	-
Chililabombwe District	1,959	776	6,000	953	4,135
Chilubi District	694	730	911	-	1,029
Chingola District	9,777	3,388	22,200	3,063	16,836
Chinsali District	5,602	694	1,796	266	2,055
Chipata District	79,499	6,536	75,970	5,902	25,282
Chirundu District	-	-	-	-	-
Choma District	40,669	4,639	22,522	3,945	16,579
Chongwe District	28,660	5,996	12,270	4,967	26,406
Gwembe District	3,504	38	-	29	32
Ikeleng'i District	-	72	510	-	327
Isoka District	5,299	295	739	272	1,822
Itezhi-tezhi District	-	-	-	-	-
Itezhi-tezhi District	2,141	1,248	5,715	889	5,249
Kabompo District	640	878	2,100	105	1,118
Kabwe District	64,391	6,237	24,336	5,090	24,202
Kafue District	28,953	8,337	18,055	6,434	32,289
Kalabo District	1,727	172	849	2,008	9,743
Kalomo District	19,633	1,895	9,148	1,359	5,973
Kalulushi District	4,561	1,576	10,213	1,352	6,719
Kaoma District	300	-	-	-	-
Kapiri Mposhi District	10,456	1,565	12,707	1,617	9,924
Kaputa District	2,575	477	864	477	1,500
Kasama District	36,765	2,998	8,061	3,249	10,470
Kasempa District	2,470	377	2,817	454	1,789
Katete District	10,811	1,765	8,706	1,294	6,173
Kawambwa District	8,524	1,063	2,543	684	2,171
Kazungula District	5,814	292	367	294	398
Kitwe District	77,748	9,853	66,140	7,220	39,006
Livingstone District	68,637	6,778	39,857	5,247	22,399
Luangwa District	12,343	2,099	5,611	1,741	8,187
Luanshya District	6,984	1,587	15,000	2,117	8,820
Lufwanyama District	762	267	218	-	1,109
Lukulu District	617	125	661	51	248
Lundazi District	5,463	172	1,574	160	1,033
Lusaka Urban District	160,611	42,318	236,566	34,589	164,100
Luwingu District	2,724	302	2,000	490	1,500
Mafinga District	359	138	173	-	-

Zambia COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Mambwe District	1,763	833	4,713	691	3,249
Mansa District	11,629	2,386	4,966	2,091	6,759
Masaiti District	529	14	131	-	535
Mazabuka District	73,170	8,077	24,371	5,758	26,942
Mbala District	10,778	737	3,583	664	3,846
Milenge District	1,006	74	322	-	229
Mkushi District	11,101	4,906	26,774	1,509	7,169
Mongu District	80,088	11,422	34,743	8,137	37,672
Monze District	26,213	4,307	9,984	3,134	14,151
Mpika District	11,211	1,193	5,603	1,026	10,530
Mpongwe District	2,005	374	2,279	418	1,460
Mporokoso District	3,188	1,869	123	537	1,155
Mpulungu District	635	1,011	1,835	816	2,500
Mufulira District	37,322	3,236	18,098	2,216	10,913
Mufumbwe District	987	1,026	2,000	285	764
Mumbwa District	4,978	-	-	-	-
Mungwi District	-	401	506	-	1,383
Mwense District	6,233	673	1,713	329	3,071
Mwinilunga District	350	1,417	2,792	387	1,555
Nakonde District	3,697	571	1,641	613	3,768
Namwala District	13,797	491	2,260	407	1,917
Nchelenge District	13,456	2,137	5,143	1,160	6,995
Ndola District	66,115	8,249	54,255	8,780	48,941
Nyimba District	6,476	1,034	3,986	556	3,531
Pemba District	168	19	-	9	9
Petauke District	23,893	3,861	13,663	3,096	16,339
Rufunsa District	396	-	-	-	-
Samfya District	6,344	1,353	3,034	836	4,637
Senanga District	1,539	189	1,049	209	996
Serenje District	6,655	810	4,448	739	3,556
Sesheke District	7,112	772	3,947	542	2,815
Shangombo District	-	-	-	-	-
Shibuyunji District	528	1,377	3	1,140	5,372
Siavonga District	7,766	2,171	6,650	3,151	15,406
Sinazongwe District	2,787	331	3,391	611	2,875
Solwezi District	27,988	2,624	11,523	2,962	11,027
Zambezi District	655	608	1,973	-	1,504
Zimba District	-	-	-	-	-
Other_ Zambia	8,324	4,157	18,200	3,728	41,952
Total	**1,225,734**	**194,136**	**905,928**	**154,927**	**777,365**

Zambia COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Chadiza District	214	-	61
Chama District	-	-	44
Chavuma District	-	-	176
Chibombo District	625	-	6,638
Chiengi District	-	-	111
Chikankata District	11,845	-	3,102
Chilanga District	-	-	-
Chililabombwe District	14,806	-	3,000
Chilubi District	-	-	-
Chingola District	23,395	721	6,685
Chinsali District	1,533	-	78
Chipata District	6,928	721	75,991
Chirundu District	-	-	7,143
Choma District	41,340	13	7,327
Chongwe District	15,990	603	18,716
Gwembe District	-	-	4,263
Ikeleng'i District	196	-	117
Isoka District	613	-	37
Itezhi-tezhi District	-	-	-
Itezhi-tezhi District	-	-	10,038
Kabompo District	-	-	93
Kabwe District	48,342	18	14,636
Kafue District	37,473	215	11,763
Kalabo District	339	-	27
Kalomo District	68,927	13	19,669
Kalulushi District	23,690	-	2,000
Kaoma District	2,000	-	26
Kapiri Mposhi District	15,596	734	5,749
Kaputa District	-	-	20
Kasama District	16,089	-	51
Kasempa District	13	-	57
Katete District	648	-	804
Kawambwa District	316	-	70
Kazungula District	13,700	-	9,533
Kitwe District	47,772	13	20,573
Livingstone District	138,605	744	13,762
Luangwa District	11,513	-	7,143
Luanshya District	35,066	13	4,342
Lufwanyama District	-	-	4,000
Lukulu District	478	-	41
Lundazi District	2,808	-	82,221
Lusaka Urban District	249,666	2,350	55,955
Luwingu District	336	-	39

Zambia COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Mafinga District	-	-	16
Mambwe District	-	-	48
Mansa District	30,053	13	76
Masaiti District	-	-	10,000
Mazabuka District	103,899	21	8,585
Mbala District	387	-	20
Milenge District	-	-	29
Mkushi District	14,413	13	11,258
Mongu District	43,379	10	611
Monze District	68,873	-	9,651
Mpika District	471	-	412
Mpongwe District	14,830	-	949
Mporokoso District	2,344	-	13
Mpulungu District	-	-	27
Mufulira District	36,390	-	4,000
Mufumbwe District	347	-	120
Mumbwa District	8,884	-	6,597
Mungwi District	214	-	38
Mwense District	347	-	106
Mwinilunga District	349	-	186
Nakonde District	-	-	663
Namwala District	10,364	5	3,103
Nchelenge District	315	-	99
Ndola District	69,797	400	18,859
Nyimba District	-	-	239
Pemba District	323	-	2,603
Petauke District	351	-	116
Rufunsa District	-	-	7,143
Samfya District	28,301	13	70
Senanga District	228	-	100
Serenje District	15,540	-	5,643
Sesheke District	1,409	-	120
Shangombo District	-	-	42
Shibuyunji District	60	153	7,143
Siavonga District	32,932	906	1,977
Sinazongwe District	14,806	-	3,995
Solwezi District	37,081	1,041	423
Zambezi District	-	-	45
Zimba District	-	-	-
Other_ Zambia	16,500	-	10,000
Total	**1,384,049**	**8,733**	**511,226**

Zambia COP15 Targets by District: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Chadiza District	-	-
Chama District	-	-
Chavuma District	-	-
Chibombo District	11,531	520
Chiengi District	9,131	48
Chikankata District	58	3
Chilanga District	-	-
Chililabombwe District	4,094	783
Chilubi District	1,677	142
Chingola District	12,450	634
Chinsali District	6,050	30
Chipata District	46,972	3,138
Chirundu District	-	-
Choma District	16,445	871
Chongwe District	15,816	613
Gwembe District	420	24
Ikeleng'i District	-	-
Isoka District	4,797	137
Itezhi-tezhi District	-	-
Itezhi-tezhi District	1,450	64
Kabompo District	929	6
Kabwe District	12,436	1,559
Kafue District	14,466	542
Kalabo District	3,687	305
Kalomo District	15,456	534
Kalulushi District	7,752	403
Kaoma District	-	-
Kapiri Mposhi District	10,548	647
Kaputa District	4,469	51
Kasama District	7,799	107
Kasempa District	4,320	55
Katete District	1,802	93
Kawambwa District	4,219	33
Kazungula District	5,157	262
Kitwe District	21,053	2,370
Livingstone District	27,104	1,224
Luangwa District	7,608	492
Luanshya District	7,144	214
Lufwanyama District	1,435	37
Lukulu District	214	8
Lundazi District	-	-

Zambia COP15 Targets by District: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Lusaka Urban District	125,867	7,074
Luwingu District	2,126	93
Mafinga District	-	-
Mambwe District	2,888	-
Mansa District	13,027	445
Masaiti District	1,165	35
Mazabuka District	28,844	1,410
Mbala District	7,578	154
Milenge District	1,948	49
Mkushi District	6,860	139
Mongu District	27,210	1,440
Monze District	7,828	549
Mpika District	7,870	511
Mpongwe District	2,174	145
Mporokoso District	4,850	42
Mpulungu District	3,898	8
Mufulira District	6,513	359
Mufumbwe District	2,176	4
Mumbwa District	4,455	160
Mungwi District	-	-
Mwense District	11,015	563
Mwinilunga District	-	16
Nakonde District	4,771	90
Namwala District	9,928	305
Nchelenge District	11,118	546
Ndola District	25,750	2,080
Nyimba District	-	-
Pemba District	117	8
Petauke District	6,461	697
Rufunsa District	63	9
Samfya District	7,155	103
Senanga District	-	-
Serenje District	6,676	572
Sesheke District	1,123	51
Shangombo District	-	-
Shibuyunji District	59	1
Siavonga District	2,401	126
Sinazongwe District	1,867	176
Solwezi District	16,725	664
Zambezi District	1,234	-
Zimba District	-	-
Other_ Zambia	2,310	239
Total	**654,539**	**34,812**

Zambia COP15 Targets by District: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Chadiza District	302	190
Chama District	-	-
Chavuma District	-	-
Chibombo District	435	249
Chiengi District	176	112
Chikankata District	-	-
Chilanga District	-	-
Chililabombwe District	365	187
Chilubi District	24	15
Chingola District	365	307
Chinsali District	532	239
Chipata District	3,216	2,060
Chirundu District	-	-
Choma District	918	578
Chongwe District	147	94
Gwembe District	-	-
Ikeleng'i District	-	-
Isoka District	157	78
Itezhi-tezhi District	-	-
Itezhi-tezhi District	66	42
Kabompo District	23	14
Kabwe District	2,863	1,293
Kafue District	274	332
Kalabo District	235	148
Kalomo District	425	265
Kalulushi District	1	69
Kaoma District	-	-
Kapiri Mposhi District	1,779	780
Kaputa District	115	72
Kasama District	1,094	521
Kasempa District	112	75
Katete District	121	92
Kawambwa District	255	162
Kazungula District	-	-
Kitwe District	1,325	1,001
Livingstone District	411	353
Luangwa District	73	63
Luanshya District	-	129
Lufwanyama District	-	17
Lukulu District	197	124
Lundazi District	231	146
Lusaka Urban District	8,433	5,158
Luwingu District	105	46

Zambia COP15 Targets by District: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Mafinga District	13	8
Mambwe District	53	34
Mansa District	671	341
Masaiti District	-	13
Mazabuka District	391	235
Mbala District	330	181
Milenge District	36	23
Mkushi District	339	174
Mongu District	932	583
Monze District	424	266
Mpika District	377	220
Mpongwe District	51	51
Mporokoso District	98	62
Mpulungu District	20	12
Mufulira District	1,159	627
Mufumbwe District	36	22
Mumbwa District	166	82
Mungwi District	-	-
Mwense District	210	132
Mwinilunga District	13	8
Nakonde District	124	78
Namwala District	293	192
Nchelenge District	400	202
Ndola District	1,071	740
Nyimba District	234	147
Pemba District	-	-
Petauke District	900	533
Rufunsa District	-	-
Samfya District	197	124
Senanga District	794	500
Serenje District	226	124
Sesheke District	323	194
Shangombo District	-	-
Shibuyunji District	-	-
Siavonga District	163	102
Sinazongwe District	15	22
Solwezi District	812	427
Zambezi District	18	11
Zimba District	-	-
Other_ Zambia	500	450
Total	**36,164**	**21,931**

Zambia COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Chadiza District	666
Chama District	-
Chavuma District	-
Chibombo District	1,095
Chiengi District	538
Chikankata District	-
Chilanga District	-
Chililabombwe District	1,062
Chilubi District	-
Chingola District	1,731
Chinsali District	234
Chipata District	6,642
Chirundu District	-
Choma District	2,543
Chongwe District	3,708
Gwembe District	-
Ikeleng'i District	-
Isoka District	74
Itezhi-tezhi District	-
Itezhi-tezhi District	-
Kabompo District	260
Kabwe District	13,636
Kafue District	3,624
Kalabo District	2,191
Kalomo District	2,835
Kalulushi District	681
Kaoma District	-
Kapiri Mposhi District	94
Kaputa District	354
Kasama District	12,111
Kasempa District	-
Katete District	1,439
Kawambwa District	846
Kazungula District	-
Kitwe District	15,242
Livingstone District	18,613
Luangwa District	821
Luanshya District	323
Lufwanyama District	324
Lukulu District	802
Lundazi District	2,197
Lusaka Urban District	20,489
Luwingu District	70

Zambia COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Mafinga District	-
Mambwe District	-
Mansa District	7,272
Masaiti District	213
Mazabuka District	5,511
Mbala District	283
Milenge District	492
Mkushi District	1,748
Mongu District	17,753
Monze District	3,353
Mpika District	744
Mpongwe District	654
Mporokoso District	-
Mpulungu District	288
Mufulira District	8,589
Mufumbwe District	458
Mumbwa District	214
Mungwi District	-
Mwense District	-
Mwinilunga District	-
Nakonde District	362
Namwala District	457
Nchelenge District	591
Ndola District	15,992
Nyimba District	1,000
Pemba District	-
Petauke District	2,717
Rufunsa District	-
Samfya District	485
Senanga District	2,082
Serenje District	896
Sesheke District	1,960
Shangombo District	-
Shibuyunji District	1,927
Siavonga District	2,441
Sinazongwe District	666
Solwezi District	13,454
Zambezi District	-
Zimba District	-
Other_ Zambia	7,500
Total	**215,347**

HIV/AIDS Sustainability Index and Dashboard

To assist PEPFAR and government partners in better understanding each country's sustainability landscape and making informed investment decisions, PEPFAR teams and stakeholders completed the inaugural **Sustainability Index and Dashboard (SID)** during COP 2015. This new tool assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements, scores for which are displayed on a color-coded dashboard. As the SID is completed over time, it will allow stakeholders to track progress across these components of sustainability. On the pages that follow, you will find the 2015 country dashboard as well as the questionnaire responses that determined the scores. The legend for the colors depicted on the dashboard is below.

Dark Green Score (17-20 pts) **(sustainable and requires no additional investment at this time)**
Light Green Score (13-16.9 pts) **(approaching sustainability and requires little or no investment)**
Yellow Score (7-12.9 pts) **(emerging sustainability and needs some investment)**
Red Score (0-6.9 pts) **(unsustainable and requires significant investment)**

Sustainability Analysis for Epidemic Control: ZAMBIA

Epidemic Type: Generalized
Income Level: Lower Middle Income
PEPFAR Categorization: Long Term Strategy
COP 15 Planning Level: $325,694,631

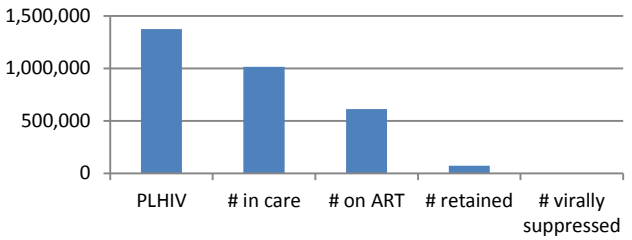
UNSUSTAINED → SUSTAINED

SUSTAINABILITY DOMAINS and ELEMENTS

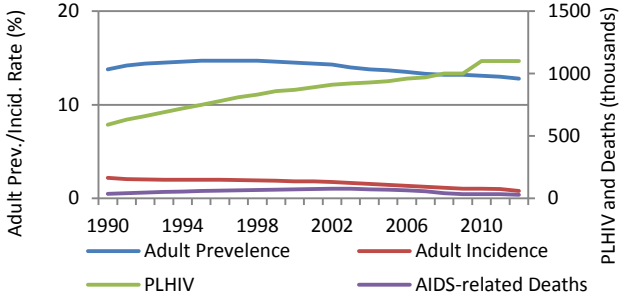
	Score
Institutionalized Data Availability	
1. Epidemiological and Health Data	9.8
2. Financial/Expenditure Data	17.0
3. Performance Data	16.0
Domestic Program and Service Delivery	
4. Access and Demand	7.8
5. Human Resources for Health	14.8
6. Commodity Security and Supply Chain	15.0
7. Quality Management	14.0
Health Financing and Strategic Investments	
8. DRM: Resource Generation	9.0
9. DRM: Resource Commitments	7.0
10. Allocative Efficiency	16.0
11. Technical Efficiency	17.3
Accountability and Transparency	
12. Public Access to Information	7.0
13. Oversight and Stewardship	12.0
Enabling Environment	
14. Policies, Laws, and Regulations	10.0
15. Planning and Coordination	15.0

CONTEXTUAL DATA

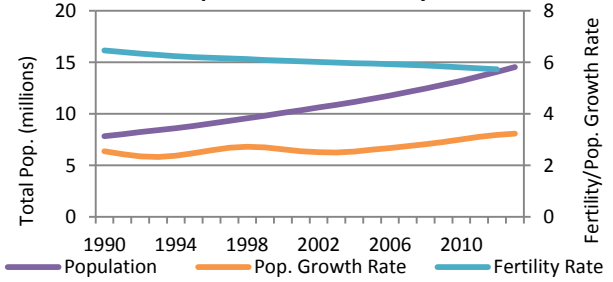
Care and Treatment Cascade



Epidemiological Data

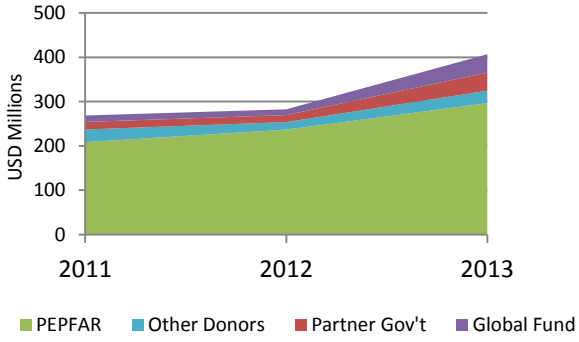


Population and Fertility

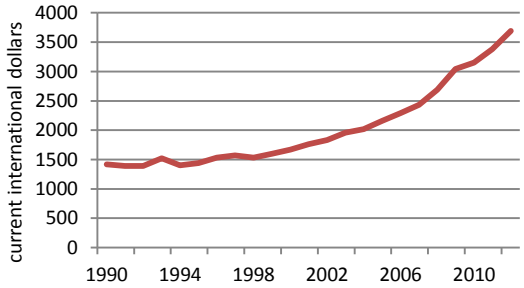


CONTEXTUAL DATA

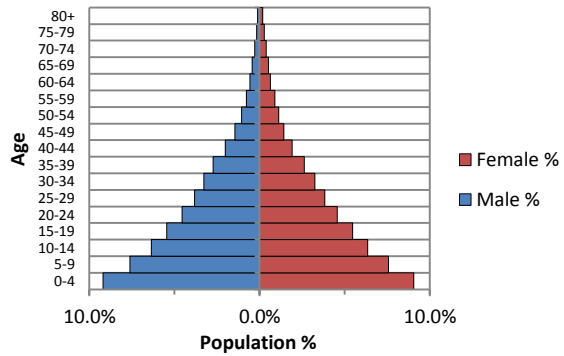
Financing the HIV Response



GNI Per Capita (PPP)



Population Pyramid (2014)



Domain A: Institutionalized Data Availability

What Success Looks Like: Using local and national systems, the Host Country Government collects and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

1.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV and OVC, HIV incidence, HIV prevalence, viral load, AIDS-related mortality rates, and co-infection rates.			**Source of data**	**Notes/Comments**
Q1. **Who leads**: Who leads/manages the planning and implementation of HIV/AIDS epidemiological surveys and/ or surveillance (convenes all parties and makes key decisions)?	◉ A. Host Country Government/other domestic institution ○ B. External agency with host country government ○ C. External agency, organization or institution ○ D. Not conducted	4.5	Ministry of Health, Minutes of the M&E Subcommittee Meeting Held on Wednesday 26th March 2014 in the Minsitry of Health Training Room from 09:48 to 10:58.	A technical working group consisting of UNZA, MOH, NAC, CSO meets quarterly or as per raising need. Last TWG meeting was on 03.26.14. Minutes attached.
Q2. **Who finances**: Within the last three years, what proportion of the latest HIV/AIDS epidemiological data survey did the host country government fund?	○ A. 80-100% of the total cost of latest survey was financed by Host Country Government ○ B. 60-79% of the total cost of latest survey financed by Host Country Government ○ C. 40-59% of the total cost of latest survey financed by Host Country Government ○ D. 20-39% of the total cost of latest survey financed by Host Country Government ◉ E. 10-19% of the total cost of latest survey financed by Host Country Government ○ F. 0-9% of the total cost of latest survey financed by Host Country Government	1	In country budget with sources of funding from most recent DHS HIV/AIDS Section, AIS, key population surveys, or other population-based survey; National HIV/AIDS spending Assessment 2012; 2013 Zambia Demographic and Health Survey Budget, 17/01/2013 (attached).	The Ministry of Health's M&E Sub-committee was the main forum used by stakeholders to discuss the DHS. Minutes of some of the meetings are attached.
Q3. **Comprehensiveness of Prevalence and Incidence Data**: Does Host Country Government collect HIV prevalence and or incidence data?	○ No, the government does not collect HIV prevalence or incidence data ◉ Yes, the government collects (check all that apply): ☑ A. HIV prevalence ☑ Collected by age ☐ Collected for children ☑ Collected by sex ☐ Collected by key population ☑ Sub-national data ☐ Collected every 3 years ☑ Data analyzed for trends ☑ Data made publicly available ☑ B. HIV incidence ☑ Collected by age ☐ Collected for children ☑ Collected by sex ☐ Collected by key population ☑ Sub-national data ☐ Collected every 3 years ☐ Data analyzed for trends	4.3	Most recent country prevelance and incidence reports (provide citation): DHS, 2013 [15-49], Total and 15+ HIV prevalence based on 2013 DHS home based testing results. Under 15 based on Spectrum Projections point estimate 2013.	Incidence data has been collected in the 2013 DHS but the report is not yet ready

	☑ Data made publicly available			
Q4. **Comprehensiveness of Viral Load Data**: Does Host Country Government collect viral load data?	◉ No, the government does not collect viral load data ○ Yes, the government collects viral load data (check all that apply): ☐ Collected by age ☐ Collected for children ☐ Collected by sex ☐ Collected by key population ☐ Sub-national data ☐ Collected every 3 years ☐ Data analyzed to understand trends	0	In country source such as government report: No Consolidated report available	Data available at selected Facilities
Q5. **Key Populations**: Does the Host Country Government conduct size estimation studies for key populations?	◉ No, the host country government does not conduct size estimation studies for key populations ○ Yes, the government conducts key population size estimates (check all that apply): ☐ Men who have sex with men (MSM) ☐ Female sex workers ☐ Transgender ☐ People who inject drugs (PWID) ☐ Government finances at least 50% of the size estimation studies ☐ Government leads and manages the size estimation studies	0	In country source such as government report: Copperbelt University/Tropical Disease Research Centre - A Survey of HIV-Related Risk Behaviours and HHIV Sero Prevalence in Zambian Prisons (1998); Oscar O. Simooya et al, Aggressive Awareness Campaigns May Not be Enough for HIV Prevention in Prisons – Studies in Zambia Suggest Time for Evidence Based Interventions, The Open Infectious Diseases Journal, 2014, 8, 1-7	The government has not done national MSM or PWD size estimation. What has been done is site specific size estimation such as the prisons sero-prevalence study.
	Epidemiological and Health Data Score:	9.8	Oscar	

2. Financial/Expenditure data: Government collects, tracks and analyzes financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS from all financing sources, costing, and economic evaluation for cost-effectiveness.			**Source of data**	**Notes/Comments**
Q1. **Expenditure Tracking**: Does the host country government have a nationally agreed upon expenditure tracking system to collect HIV/AIDS expenditure data?	○ No, it does not have a national HIV/AIDS expenditure tracking system ◉ Yes, the government has a system to collect HIV/AIDS expenditure data (check all that applies): ☑ A. Collected by source of financing, i.e. domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ B. Collected by expenditures per program area, such as prevention, care, treatment, and health systems strengthening ☑ C. Collected sub-nationally ☐ D. Collected annually ☑ E. Data is made publicly available	4	In country source, such as government HIV/AIDS expenditure tracking policy, strategy or SOP: National AIDS Spending Assessment 2012; National Health Accounts 2010; Zambia - Publci Expenditure Tracking Survey in Health 2007 http://catalog.ihsn.org/index.php/catalog/1049	

Q2. **Quality of Expenditure Tracking**: Is the Host Country Government tracking expenditures based on international standards? What type of expenditure data are available in the country, i.e. NHA, NASA, others: _____	○ No, they are not using any international standards for tracking expenditures ◉ Yes, the national government is using international standards such as WHO National Health Accounts (NHA), National AIDS Spending Assessment (NASA), and/or methodology comparable to PEPFAR Expenditure Analysis or the Global Fund new funding tracking model.	5	in country citations for latest NHA, NASA, government expenditure tracking report, global fund new funding model for country: National AIDS Spending Assessment 2012; National Health Accounts 2010.	
Q3. **Transparency of Expenditure Data:** Does the host country government make HIV/AIDS expenditure data (or at a minimum a summary of the data) available to the public?	○ No, they do not make expenditure data available to the public Yes, check the one that applies: ○ A. Annually ◉ B. Bi-annually ○ C. Every three or more years	3	In country source of latest expenditure data made available to the public: National AIDS Spending Assessment 2012; National Health Accounts 2010.	
Q4. **Economic Studies:** Does the Host Country Government conduct special health economic studies or analyses for HIV/AIDS, i.e. costing, cost-effectiveness, efficiency?	○ No, they are not conducting special health economic studies for HIV/AIDS ◉ Yes, check all that apply: ☑ A. Costing studies or analyses ☑ B. Cost-effectiveness studies or analyses ☑ C. Efficiency studies or analyses ☑ D. Cost-benefit studies or analyses	5	Institute for Health Metrics and Evaluation (IHME). Health Service Provision in Zambia: Assessing Facility Capacity, Costs of Care, and Patient Perspectives. Seattle, WA: IHME, 2014. Institute for Health Metrics and Evaluation (IHME)/University of Zambia. Understanding the costs of and constraints to health service delivery in Zambia Ministry of Health/CHAI National Facility Based Antiretroviral Treatment Costing Study in Zambia 2012	
	Financial/Expenditure Data Score:	**17**		

3. Performance data: Government collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data is analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including adherence and retention.			**Source of data**	**Notes/Comments**
Q1. Collection of service delivery data: Does the host country government have a system to routinely collect/report HIV/AIDS service delivery data?	○ No, the government does not have an HIV/AIDS service delivery data collection system ◉ Yes, service delivery data are collected/reported for (check all that apply): ☑ A. For HIV Testing ☐ B. For PMTCT ☑ C. For Adult Care and Support ☑ D. For Adult Treatment ☑ E. For Pediatric Care and Support ☑ F. For Pediatric Treatment ☑ G. For AIDS-related mortality	6	HIV/AIDS service delivery HMIS policy/SOP and latest report citation: Ministry of Health, Annual Health Statistical Bulletin, 2013.	
Q2. Analysis of service delivery data: Does	○ No, the government does not routinely analyze service delivery data to measure performance ◉ Yes, service delivery data are being analyzed to measure (check all that apply):	3	For each check, in-country source of latest data: PEPFAR 2014 APR data; National AIDS Strategic Framework	

the Host Country Government routinely analyze service delivery data to measure Program performance? i.e. continuum of care cascade, coverage, retention, AIDS-related mortality rates?	☑ A. Continuum of care cascade, including testing, care, treatment, retention and adherence ☑ B. Results against targets ☑ C. Coverage ☐ D. Site specific yield for HIV testing (HTC and or PMTCT) ☐ E. AIDS-related death rates		(2011 -2015) Joint Mid-term Review Report; Annual Health Statistical Bullentin 2013.	
Q3. Comprehensiveness of service delivery data: Does the host country government collect HIV/AIDS service delivery data in a manner that is timely, accurate and comprehensive?	○ No ◉ Yes, service delivery data are being: (check all that apply): ☑ A. Collected at least quarterly ☑ B. Collected by age ☑ C. Collected by sex ☑ D. Collected from all clinical sites ☐ E. Collected from all community sites ☑ F. Data quality checks are conducted at least once a year	5	In country source, such as the latest HMIS report or presentation on HIV/AIDS services; Ministry of Health, Annual Health Statistical Bulletin, 2013.	The host government conudcts routine Performance Assessment and Technical Support Supervision, data quality audits/assessments, and mentorship. Reports related to these activities are additional sources of data.
Q4. Transparency of service delivery data: Does the host country government make HIV/AIDS program performance and service delivery data (or at a minimum a summary of the results) available to the public routinely?	○ No, they do not make program performance data available to the public Yes, check the one that applies: ◉ A. At least annually ○ B. Bi-annually ○ C. Every three or more years	2	In country source of where HIV/AIDS service delivery data are available to public, such as a website: Annual Health Statistical Bulletin 2013;	Annual Statistical Bullentins are published on the Zambian Ministry of Health's webite. The lastest bullentin on the website is dated 2012. A hard copy of the 2013 was diseminated to stakeholders at the Health Sector Advisory Group meeting in March 2014.
	Performance Data Score:	**16**		

THIS CONCLUDES THE SET OF QUESTIONS ON THE INSTITUTIONALIZING DATA AVAILABILITY DOMAIN

Domain B. Domestic Program and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving HIVAIDS prevention, care and treatment services and interventions. There is a high demand for HIV/AIDS services, which accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and or are affected by the HIV/AIDS epidemic.

4. Access and Demand: There is a high uptake of HIV/AIDS prevention, care and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS, especially among those in the lowest socio-economic quintiles.			**Source of data**	**Notes/Comments**
Q1. Access to ART: What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?	○ This information is not available Check the one answer that best describes the current situation: ○ A. More than 80% of facilities in high prevalence/burden locations are providing ART. ○ B. 50-79% of facilities in high prevalence/burden locations are providing ART. ○ C. 21-49% of facilities in high prevalence/burden locations are providing ART. ◉ D. 20% or less of facilities in high prevalence/burden locations are providing ART.	Q1 Score: 0	In country source, i.e., SIMS, readiness assessments: Ministry of Community Development, Mother and Child Health (MCDMCH) service delivery reports/HMIS (up to Dec 31, 2014); Supply Chain Manager (LMIS) software; Ministry of Health (MOH) 2012 List of Health Facicities in Zambia - Preliminary Report (April 2013); Health Professions Council of Zambia (HPCZ) list of ART Accredited Sites (2014); Ministry of Health, Annual Health Statistical Bulletin, 2013.	Supply Chain Manager is a central warehouse Logistics Mnagement Infoormation System (LMIS) software deisinged to capture logistics data for decision making at central level. This includes data on stock on hand, average monthly consumption and loss/adjustments in stock levels. Furthermore it increases central level visibility of happenings at service delivery points. In responding to this question the group considered the total number of health facilities in four high prevalence provinces (and not only those designated to provide ART)
Q2. Access to PMTCT: What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?	○ This information is not available Check the one answer that best describes the current situation: ○ A. More than 80% of facilities in high prevalence/burden locations are providing Option B+. ○ B. 50-79% of facilities in high prevalence/burden locations are providing Option B+. ◉ C. 21-49% of facilities in high prevalence/burden locations are providing Option B+. ○ D. 20% or less of facilities in high prevalence/burden locations are providing Option B+.	Q2 Score: 1	In country source, i.e., readiness assessments: Ministry of Community Development, Mother and Child Health (MCDMCH) service delivery reports/HMIS (up to Dec 31, 2014); Supply Chain Manager (LMIS) software; Ministry of Health (MOH) 2012 List of Health Facicities in Zambia - Preliminary Report (April 2013); Ministry of Health, Annual Health Statistical Bulletin, 2013.	In responding to this question the group considered the total number of health facilities in four high prevalence provinces (and not only those providng antenatal care and delivery services).
Q3. Who is delivering HIV/AIDS services: What percent of Care and Treatment clients are treated at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).	○ This information is not available Check the one answer that best describes the current situation: ◉ A. 80% or more of HIV/AIDS care and treatment clients are treated at public service delivery sites ○ B. 50-79% of HIV/AIDS care and treatment clients are treated at public service delivery sites ○ C. 20-49% of HIV/AIDS care and treatment clients are treated at public service delivery sites ○ D. Less than 20% of HIV/AIDS care and treatment clients are treated at public service delivery sites	Q3 Score: 3	In country source, i.e. MOH report: Ministry of Health (MOH) 2012 List of Health Facicities in Zambia - Preliminary Report (April 2013); Supply Chain Manager (LMIS) software.	
Q4. Services to key populations: What percent of key population HIV/AIDS prevention program clients receive services at public service delivery sites? These can include	◉ This information is not available Check the one answer that best describes the current situation: ○ A. 80% or more of key population HIV/AIDS prevention program clients receive services at public service delivery sites	Q4 Score: 0	In country source, i.e., report on Key Populations.	PEPFAR and GRZ have different definitions of Key Populations.

service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).	○ B. 50-79% of key population HIV/AIDS prevention program clients receive services at public service delivery sites ○ C. 20-49% of key population HIV/AIDS prevention program clients receive services at public service delivery sites ○ D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites			
Q5. Uptake of services: What percent of PLHIV are currently receiving ART? _____%	○ This information is not available Check the one answer that best describes the current situation: ○ A. 80% or more of PLHIV are currently receiving ART ○ B. 50-79% of PLHIV are currently receiving ART ◉ C. 20-49% of PLHIV are currently receiving ART ○ D. Less than 20% of PLHIV are currently receiving ART	Q5 Score 2	In country source, i.e. government annual HIV/AIDS report: Zambia Demographic and Health Survey (DHS) 2013 (preliminary results, final report not yet released); Central Statistical Office,Zambia 2010 Census of Population and Housing - Population Summary Report (June 2012) http://www.zamstats.gov.zm/report/Census/2010/National/2010%20Census%20of%20Population%20National%20Analytical%20Report.pdf; PEPFAR APR 2014; Ministry of Community Development, Mother and Child Health (MCDMCH) service delivery reports/HMIS (up to Dec 31, 2014); Revised National HIV/AIDS Strategic Framework 2014 -2016; Ministry of Health, Annual Health Statistical Bulletin, 2013.	
Q6. Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?	Check the one answer that best describes the current situation: ○ No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations. ◉ Yes, there are efforts by the government (check all that apply): ☑ educates PLHIV about their legal rights in terms of access to HIV services ☐ educates key populations about their legal rights in terms of access to ☑ National policy exists for de-stigmatization in the context of HIV/AIDS ☑ national law exists regarding health care privacy and confidentiality protections ☐ government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	Q6 Score 1.8	Ministry of Health, National Health Policy (June 2013); Medical and Allied Professionals Act, Cap 297; Health Professions Act No. 24 of 2009; Nurse and Midwives Act No. 31 of 1997; Legal, Policy, and Socio-Cultural Barriers to HIV-Related Prevention, Treatment, Care, and Support for Key Populations in Zambia. Human Rights and the Law, UNAIDS 2014 Guidance note (2014) http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_humanrightsandthelaw_en.pdf; Constitution of Zambia, Chapter 1, Part IX, 112(a)(d); Revised National AIDS Strategic Framework, 2014-2016, p.60	GRZ does not provide fianacial support to individuals, but legal aid is available. Legislation exists to assure professional conduct of health professions. One of the guiding principles of the Nationa Health Policy is " Equity of Access: To ensure equitable access to health care for all the people of Zambia regardless of their geographic location, gender, age, race, social, economic, cultural or political status". Many health facilites display patient charters.
		Access and Demand Score	**7.8**	

5. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.			**Source of data**	**Notes/Comments**
	Check the one answer that best describes the current situation: ○ This information is not available	Q1 Score: 0	In country HRH assessments; HRIS data; in country training assessments; SIMS Above site SF tool "HRH Staffing CEE: " The Implications of Treatment Scale-Up Strategies on National Health Systems in Zambia, Clinton Health Access Initiative, October 2014; World	

Q1. **HRH Sufficiency**: Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?	◉ A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand ○ B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply) ☐ HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand ☐ HIV community-based service sites have adequate numbers of staff to meet the HIV patient demand, and CHWs have appropriate linkages to high HIV burden/ volume community and facility sites		Clinton Health Access Initiative, October 2014; World Bank Working Paper # 214 - The Human Resources for Health Crisis in Zambia; Ferrinho et al. Human Resources for Health 2011, http://www.human-resources-health.com/content/9/1/30; Human Resources for Health Strategic Plan 2011-15; Data from WHO Africa Health Workforce Observatory http://www.hrh-observatory.afro.who.int/en/country-monitoring/92-zambia.html	
Q2. **HRH Transition**: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?	Check the one answer that best describes the current situation: ○ A. There is no inventory or plan for transition of donor-supported health workers ○ B. There is an inventory and plan for transition of donor-supported workers but it has not been implemented to date ○ C. There is an inventory and plan for transition of donor-supported workers, but it has been only partially implemented to date. ◉ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	Q2 Score: 3	In country PEPFAR HRH transition plan and documentation: CDC-MOH Cooperative Agreements; PEPFAR Country Operational Plan; Implementing Mechnism SOWs and PDs.	The vast majority of HIV/AIDS health worker salaries are locally financied. PEPFAR seconds and pays salaries for a relatively small number of HCWs and there are plans to transition these staff. These plans are contained in implementing mechanisms' statements of work and program descriptions, as well as the Country Operational Plan and CDC Cooperative Agreements with Provincial Medical Offices.
Q3. **HRH Financial reform:** Has financial reform been undertaken in the last 5 years to address government financing of health workers?	Check the one answer that best describes the current situation: ○ A. No financial reform has been undertaken in the last 5 years to address government financing of health workers ◉ B. Financial reforms have been undertaken in the last 5 years to address government financing of health workers (check all that apply): ☑ Wage reform to increase salaries and or benefits of health workers ☑ Increase in budget allocation for salaries for health workers	Q3 Score: 2	In country source, i.e. report on HRH reform or civil service reform: 2015 GRZ Activity Based Budget (Yellow Book); Human Resources for Health Strategic Plan 2011 – 2015 http://www.moh.gov.zm/docs/hrsp.pdf; National Community Health Worker Strategy, August 2010 http://zschs.weebly.com/uploads/2/0/2/8/20289395/nchw_strategy-august-_2010_final.pdf	
Q4. **Pre-Service**: Does current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?	Check the one answer that best describes the current situation: ○ A. HIV/AIDS content used by pre-service institutions is out of date (has not been updated within the last 3 years) - For example, an average national score of RED in SIMS AS-SF "Pre-Service Education" CEE ◉ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☐ content updated for all HIV/AIDS services ☑ updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☐ updated curriculum is problem based/competency based	Q4 Score: 1.8	SIMS Above Site-SF Tool, "Pre-Service Education" CEE or if other country team knowledge: Pre-service training curricula; Project Reports e.g. MEPI and NEPI; National Training Operational Plan 2013 to 2016 http://www.moh.gov.zm/?wpdmact=process&did=Ni5ob3RsaW5r	Registrar of the General Nursing Council affirms that the nursing curriculum has been updated to include HIV/AIDS competency.

	☑ updated curriculum includes practicums at high volume clinical/ social services sites ☐ institutions that track students after graduation			
Q5. **In-Service**: To what extent is the country institutionalizing PEPFAR/other donor supported HIV/AIDS in-service training (IST) into local training systems?	Check the one answer that best describes the current situation: ◉ A. National IST curricula institutionalizes PEPFAR/other donor-supported HIV/AIDS training. ○ B. There is a strategy for institutionalizing PEPFAR/other donor-supported IST training and it is being implemented. ○ C. There is a strategy in place for institutionalizing PEPFAR supported IST training but it is not being fully implemented to date. ○ D. There is not a strategy in place for institutionalizing PEPFAR/other donor supported IST training.	Q5 Score: 3	Country Team Knowledge; SIMS Inservice Training CEE: Evolution of Pre Service Supply Chain Training in Zambia - USAID/DELIVER PROJECT; Zambia Management and Leadership Academy (ZMLA) training curriculum; Pharmacy and Laboritarian training curricula.	Management and leadership training curriculum that was developed and implemented with USG support has been institutionalized by the National Institute of Public Aministration (NIPA), which offers a higher diploma in management. Logistics management has been incorporated in Pharmacy and Laboratorian pre-service training curriculum. The M&E Short Course that was supported by USG is now offered by University of Zambia. Additionally, PEPFAR and other donors have trained trainers who are able to provide training to HCWs in all program areas i.e. ART, HTC, PMTCT, VMMC.
Q6. **HRIS**: Does the government have a functional Human Resource Information System (HRIS) for the health sector?	Check the one answer that best describes the current situation: ○ A. No, there is no HRIS ◉ B. Yes, the government does have a HRIS (check all that apply) ☐ The HRIS is primarily funded by host country institutions ☐ There is a national interoperability strategy for the HRIS ☑ The government produces HR data from the HRIS at least annually ☑ The government uses data from the HRIS for HR planning and management	Q6 Score: 1	national HRIS document or other country team knowledge: Ministry of Health's Human Resource Database; HRIS - Expanding on the existing Human Capital Management and Payroll Management and Establishment Control systems, MOH March 2011.	USG is providing support to GRZ to establish a comprehensive health sector HRIS.
Q7. **Domestic funding for HRH**: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are funded with domestic resources?	Check the one answer that best describes the current situation: ○ This information is not known ○ A. Less than 20% ○ B. 20-49% ○ C. 50-79% ◉ D. 80% or more	Q7 Score: 4	In country source, i.e. HRH report, HRIS data: 2015 GRZ Activity Based Budget (Yellow Book); Ministry of Health's Human Resource Database	
	Human Resources for Health Score	**14.8**		

6. **Commodity Security and Supply Chain:** The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.			**Source of data**	**Notes/Comments**
Q1. **ARV domestic financing**: What is the estimated obligated funding for ARV	Check the one answer that best describes the current situation: ○ This information is not known ○ A. 0-9% obligated from domestic public sources	Q1 Score: 2	2015 GRZ Activity Based Budget (Yellow Book).	

procurement from domestic public revenue (not donor) sources?	○ B. 10-29% obligated from domestic public sources ◉ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources			
Q2. **Test Kit domestic financing:** What is the estimated obligated funding for Rapid Test Kits from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: ○ This information is not known ○ A. 0-9% obligated from domestic public sources ◉ B. 10-29% obligated from domestic public sources ○ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources	Q2 Score: 1	Same as above	
Q3. **Condom domestic financing**: What is the estimated obligated funding for condoms from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: ○ This information is not known ○ A. 0-9% obligated from domestic public sources ○ B. 10-29% obligated from domestic public sources ◉ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources	Q3 Score: 2	In country source, i.e., NHA, MOH, Condom assessment report: Zambia Contraceptive Commodity Forecasting and Quantification report (2015 - 2016).	
Q4. **Supply Chain Plan:** Does the country have an agreed-upon national supply chain plan with an implementation plan or a thorough annually-reviewed supply chain SOP?	○ A. No, there is no plan or thoroughly annually reviewed supply chain SOP ◉ B. Yes, there is a Plan/SOP. It includes these components: (check all that apply) ☑ Human resources ☑ Training ☑ Warehousing ☑ Distribution ☑ Reverse Logistics ☑ Waste management ☑ Information system ☑ Procurement ☑ Forecasting ☑ Supply planning and supervision	Q4 Score: 4	National supply chain plan/SOP: National Supply Chain Strategic Plan. 2014 -2016	
Q5. **Stock:** Do Public and Private Sector Storage facilities (Central and intermediate level) report having HIV and AIDS commodities stocked according to plan (above the minimum and below the maximum stock level) 90% of the time?	○ A. No, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) less than 90% of the time ◉ B. Yes, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) 90% or more of the time ☑ Both public and (if they exist in the country) private storage facilities at central level ☑ Both public and (if they exist in the country) private storage facilities at intermediate level	Q5 Score: 3	In country source, i.e., supply chain assessment report, LMIS data: USAID, Supply & Logistics Internal Control Evaluation (SLICE) - Zambia Coutry Assessment Report, June 15, 2012.	
	○ A. No assessment has been conducted nor do they have a system to oversee the supply chain	Q6 Score: 3	In country Assessment Report: National Supply Chain Strategic Plan 2014 -2016.	

Q6. **Assessment**: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment? (If a different credible assessment of the national supply chain has been conducted, you may use this as the basis for response. Note the details and date of the assessment in the "source of data" column.)	○ B. Yes, an assessment was conducted but they received below 80% ◉ C. No assessment was conducted, but they have a system to oversee the supply chain that reviews: ☑ Commodity requirements ☑ Commodity consumption ☑ Coordinates procurements ☑ Delivery schedules ○ D. Yes, an assessment was conducted and they received a score that was 80% or higher			
	Commodity Security and Supply Chain Score	**15**		

7. **Quality Management:** Host country ensures that HIV/AIDS services are managed and provided in accordance with established national/global standards and are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence). Host country has institutionalized quality management approaches in its HIV/AIDS Program that ensure continued quality during and following donor to government transitions.			**Source of data**	**Notes/Comments**
Q1. **Existence of System**: Does the government have a functional Quality Management/Quality Improvement (QM/QI) infrastructure?	○ A. No, there is no QM/QI infrastructure within national HIV/AIDS program or MOH ◉ Yes, there is a QM/QI infrastructure within national HIV/AIDS program or MOH. The infrastructure (check all that apply): ☐ Routinely reviews national HIV/AIDS performance and clinical outcome data ☐ Routinely reviews district/regional HIV/AIDS performance and clinical outcome data ☐ Prioritizes areas for improvement	Q1 Score: 1	In country sources, i.e., QM/QI strategic plan/SOP, QM/QI Assessment Report: Guidelines on Quality Improvement for Health Care Workers in Zambia, First Edition 2012.	
Q2. **Strategy:** Is there a current (updated within the last 2 years) national QM/QI strategy that is either HIV/AIDS program-specific or includes HIV/AIDS program-specific elements?	○ No, there is no HIV/AIDS-related QM/Q strategy ◉ B. Yes, there is a QM/QI strategy that includes HIV/AIDS but it is not current (updated within the last 2 years) ○ C. Yes, there is a current QM/QI strategy that includes HIV/AIDS program specific elements ○ D. Yes, there is a current HIV/AIDS program specific QM/QI strategy	Q2 Score: 2	QM/QI Strategy document: Guidelines on Quality Improvement for Health Care Workers in Zambia, First Edition 2012.	
Q3. **Guidelines:** Does national HIV/AIDS technical practice follow current WHO guidelines for PMTCT and ART?	○ A. No, the national practice does not follow current WHO guidelines for PMTCT or ART ◉ B. Yes, the national practice does follow current WHO guidelines for: ☑ PMTCT (option B+) ☑ Adult ART ☑ Pediatric ART ☑ Adolescent ART	Q3 Score: 4	Current government SOP/technical guidelines for PMTCT and ART: Zambia Consolidated Guidelines for Treatment and Prevention of HIV Infection, February 2014; WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection - Recommendations for a Public Health Approach, June 2013.	Test and treat is for all positives in discordant relationships, HIV positive partners of pregnant women, Hepatitis B co-infected patients with active infection, CD4 <500/ml; TB coinfected clients.

	☑ Test and treat for specific populations			
Q4. **QI Data use**: Does the host country government monitor and use data for HIV/AIDS quality improvement?	○ A. No, there is no monitoring for HIV/AIDS quality improvement ◉ B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes: ☐ All sites ☑ Use of data to determine quality of program or services ☑ Making recommendations and action plan for mid-course corrections	Q4 Score: 4	In country sources, i.e., report, presentation, or annual plan indicating use of data for quality improvement: Spectrum 2013; National forecast and quantification review of HIV test kits 2014; National Laboratory commodities forecast and quantification review 2014; Zambia ARVs forecasting and quantification 2014; Ministry of Health technical support supervision reports 2014.	
Q5. **Post-transition:** Does the host country government monitor whether the quality of HIV/AIDS service outcome is maintained at sites where PEPFAR/other donors have transitioned from a direct implementation role?	○ A. No, there is no quality monitoring at sites post-transition ◉ B. Yes, there is quality monitoring at transition sites. Monitoring includes: ☐ All transition sites ☑ Review of service outcomes ☐ Client feedback on changes in quality ☑ Quality improvement action plan ○ C. PEPFAR/other donors have never supported direct service delivery in the country	Q5 Score: 3	In country sources, i.e., post-transition report or documentation: MOH/MCDMCH 2014 Performance Assessment and Technical Support Supervision reports.	Implementing Partners have transition tracking tools. The Zambian government continues to monitor transitioned sites through routine Performance Assessment and Technical Support Supervision.
	Quality Management Score	**14**		

THIS CONCLUDES THE SET OF QUESTIONS ON THE DOMESTIC PROGRAM AND SERVICE DELIVERY DOMAIN

Domain C. Health Financing and Strategic Investment

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

8. Domestic Resource Mobilization: Resource Generation: The host-country government costs its national HIV/AIDS response, solicits and generates revenue (including but not limited to tax revenues, public sector user fees, insurance, loans, private sector and other strategic partnerships, and/or other innovative sources of financing) and allocates resources to meet the national budget for HIV/AIDS.			**Source of data**	**Notes/Comments**
Q1. Domestic budget: Is there a budget line item for HIV/AIDS in the national budget?	○ A. No, there is no budget line item for HIV/AIDS in the national budget ○ B. Yes, there is an HIV/AIDS budget line item under the Health budget ◉ C. Yes, there is an HIV/AIDS program-based budget across ministries ○ D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators	Q1 Score: 4	In country source, i.e. national budget, budget summary or report for 2014: 2015 GRZ Activity Based Budget(Yellow Book).	Line ministries have HIV/AIDS budget lines in the Yellow Book.
Q2. Budgetary Framework: Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?	○ A. No ◉ B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program ○ C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program	Q2 Score: 3	In country source, i.e. national budget, budget summary or report for 2014: 2014 -2016 Medium Term Expenditure Framework and the 2014 Budget, Minstry of Finance (August 2013); The Proposed 2015 -2017 Medium Term Expenditure Framework and Policies for the 2015 Budget, Ministry of Finance (August 2014).	Yellow Book and MTEF downloaded from:http://zambiamf.africadata.org/en/ResourceCenter
Q3. Fiscal Policy: Does the country pass the MCC scorecard indicator for fiscal policy? (Countries without an MCC scorecard: Is general government net lending/borrowing as a percent of GDP averaged across 2011-2013 greater than (i.e. more positive than) -3.1 percent?)	○ Yes ◉ No	Q3 Score: 0	OGAC-provided data sheet (follows tab E) derived from: http://www.mcc.gov/pages/selection/scorecards	The country scored 35% for 2015
Q4. Domestic public revenue: What was annual domestic government revenue as a percent of GDP in the most recent year available? (domestic	Check the appropriate box for your country's income category: FOR LOW INCOME ○ A. More than 16.4% (i.e. surpasses category mean) ○ B. 14.8%-16.4%, (i.e. 90-100% of category mean) ○ C. Less than 14.8%, (less than 90% of category mean) FOR LOW MIDDLE INCOME ○ D. More than 22.3% (i.e. surpasses category mean)	Q4 Score: 2	OGAC-provided data sheet (follows tab E) Original Source: IMF Government Finance Statistics: http://zambiamf.africadata.org/en/ResourceCenter	2013 Economic report indicates domestic resources as percentage of GDP to be 20.3%

revenue excludes external grants)	◉ E. 20.1-22.3% (i.e. 90-100% of category mean) ◯ F. Less than 20.1% (less than 90% of category mean) FOR UPPER MIDDLE INCOME ◯ G. More than 27.8% (i.e. surpasses category mean) ◯ H. 25.0%-27.8% (i.e. 90-100% of category mean) ◯ I. Less than 25.0% (less than 90% of category mean)			
Score for Domestic Resource Mobilization: Resource Generation:		**9**		

9. **Domestic Resource Mobilization: Resource Commitments:** Host country government makes adequate multiyear resource commitments to achieve national HIV/AIDS goals for epidemic control and in line with the available fiscal space. These commitments for the national HIV/AIDS program ensure a well-trained and appropriately deployed workforce, functioning health systems, sufficient commodities and drugs, and local institutions at all levels able to perform activities and carry out responsibilities.			**Source of data**	**Notes/Comments**
Q1. Benchmarks for health spending: **African countries:** Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)? **Non-African countries:** Is government health expenditure at least 3 percent of GDP?	◉ A. Yes ◯ B. No	Q1 Score: 5	OGAC-provided data sheet (follows tab E) Original sources: WHO and World Bank http://apps.who.int/nha/database/Country_Profile/Index/en	Spending on health as a percentage of General Government Expenditure was above 15% between 2010 and 2014
Q2. Domestic spending: What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)? _____%	◯ A. Less than 10% ◉ B. 10-24% ◯ C. 25-49% ◯ D. 50-74% ◯ E. 75% or Greater	Q2 Score: 2	NASA or NHA data: NASA 2012, Revised National AIDS Strategic Framework (R-NASF) 2014 -2016, NAC (launched March 2015).	2012 National AIDS Spending Assessment shows 6 % of the national HIV response is financned by domestic resources. R-NASF shows 10% of the national HIV response is financed by domestic revenues
Q3. Key population spending: What percent of key population-specific interventions are financed with domestic public and domestic private sector funding (excluding out of pocket expenditure)?	◉ A. None or information is not available ◯ B. 1-9% ◯ 10-24% ◯ 25-49%	Q3 Score: 0	In country source, i.e., NASA data, national expenditure analysis report:	Government of the Republic of Zambia has different definition of key population. Even with what GRZ reports as key population, it was difficult to disagregate data.

expenditure)?	◯ 50-74% ◯ 75% or Greater			
Score for Domestic Resource Mobilization: Resource Commitments:	**7**			

10. **Allocative Efficiency:** The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time).			**Source of data**	**Notes/Comments**
Q1. Data-driven allocation: Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?	◯ A. No, data are not used annually ◉ B. Yes, data are used annually. Check all that apply: ☑ Epidemiological data are used ☑ Health/service delivery data are used ☑ Financial data are used ☑ There is integrated analysis across data streams ☑ Multiple data streams are used to model scenarios	Q1 Score: 10	In country documentation of strategic plan or annual planning: Revised National AIDS Strategic Framework (R-NASF) 2014 -2016, NAC (launched March 2015).	This is done with the help of partners
Q2. Geographic allocation: Does the host country government use data to determine the appropriate number and location of HIV/AIDS service sites (proportional to yield or burden data)?	◯ A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites ◯ B. Less than 20% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ◉ C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ◯ D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ◯ E. 80% or more of HIV/AIDS service delivery sites yield 80% or more of new positive HIV test results or ART clients	Q2 Score: 3	In country government source, i.e., presentation, GIS data, planning document: SMART CARE; Ministry of Health, Annual Health Statistical Bulletin, 2013.	SMART CARE is an electronic healhth record system that may be used to generate reports on the number of persons accessing HIV services and where.
	◯ A. No, there is no system for funding cycle reprogramming	Q3 Score: 3	In country source: policy/SOP: Fianace Act of 2004.	This is done through the Finance Act of 2004 and

Q3.Data driven reprogramming: Do host country government policies/systems allow for reprograming investments based on new or updated program data during the government funding cycle?	○ B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used ○ C. Yes, there is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data ◉ D. Yes, there is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data			existing data (Epidemiological, healh service delivery, financial)
		Allocative Efficiency Score:	**16**	

11. **Technical Efficiency:** Through enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, the host country is able to achieve improved HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). Thus, maximizing investments to attain epidemic control.			**Source of data**	**Notes/Comments**
Q1. Unit costs: Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services? (note: full score of five points can be achieved without checking all disaggregate boxes).	○ A. No ◉ B. Yes (check all that apply): ☑ Annually ☑ For HIV Testing ☐ For Care and Support ☑ For ART ☑ For PMTCT ☑ For VMMC ☐ For OVC Service Package ☐ For Key population Interventions	Q1 Score: 4.25	In country source, i.e., government document, report or presentation: The Implications of Treatment Scale-up Strategies on National Health Systems in Zambia, Clinton Health Access Initiative/UKAID (October 2014); Costs of HIV/AIDS outpatient services delivered through Zambian public health facilities(FHI/ZPCTII 2011); Zambia Contraceptive Commodity Forecasting and Quantification report (2015 - 2016); Spectrum 2013; National forecast and quantification review of HIV test kits 2014; National Laboratory commodities forecast and quantification review 2014; Zambia ARVs forecasting and quantification 2014;	Analysis is not done every year for VMMC.
	Check all that apply: ☑ Using findings from cost-effectiveness or efficiency studies to modify operations or interventions ☑ Streamlining management to reduce overhead costs	Q2 Score: 4	In country sources for each checked: National Health Strategic Plan 2011 -2015; Revised National AIDS Strategic Framework 2014 - 2017; Ministry of Health - National Health Policy (June 2013); Ministry of Health - Minutes of the April	

Q2. Improving efficiency: Which of the following actions is the Host Country Government taking to improve technical efficiencies?	☑ Reducing fragmentation to lower unit costs, i.e. pooled procurement, resource pooling ☑ Improving procurement competition ☑ Integration of HIV/AIDS into national or subnational insurance schemes (private or public) ☑ Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact ☑ Geographic targeting in high burden/high yield sites to increase impact ☑ Analysis of expenditure data to establish appropriate range of unit costs		of Health- Minutes of the April 2012 Sector Advisory Group Meeting; Ministry of Health- Minutes of the October 2012 Sector Advisory Group Meeting; National Health Accounts 2012; National AIDS Spending Assessment 2012: Update on the Social Health Insurance Scheme (Presentation to MOH Policy Meeting, September 2012)	
Q3. Loss ratio: Does host country government have a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery (not administrative/overhead costs)?	○ A. No ◉ B. Yes	Q3 Score: 3	In country source, i.e., national HIV/AIDS expenditure report:	This is done through Expenditure Tracking Sytem. Report 2007 is available
Q4. Benchmark prices: Are prices paid by the government for first-line ARVs and Test Kits within 5% variance of international benchmark prices (UNAIDS Investment Case)?	Check boxes that apply: ☐ They are not paying for any ARVs ☐ They are not paying for any test kits ☑ They are paying no more than 5% above the international benchmark price for first line ARVs ☐ They are paying no more than 5% above the international benchmark price for test kits	Q4 Score: 2	http://apps.who.int/hiv/amds/price/hdd/Default.aspx	
Q5. ART unit costs: Have average unit costs for providing ART in the country reduced within the last two years? Unit cost 2 years ago: $ _____ Current unit cost: $ _____	○ A. No ◉ B. Yes	4	WHO, Global Price Reporting Mechanism - http://apps.who.int/hiv/amds/price/hdd/	Clinton Health Initiative costing study (2012) found $ 278 as the total cost of providing ART in the country. CHAI conducted another study in 2014 but the results are not available. These studies were conducted on behalf of the GRZ. With the declining ARV costs and assuming other cost drivers for providng ART do not increase, then the unit cost for providing ART decreased over the past two years
		Technical Efficiency Score:	**17.25**	

THIS CONCLUDES THE SET OF QUESTIONS ON THE HEALTH FINANCING AND STRATEGIC INVESTMENT DOMAIN

Domain D. Accountability and Transparency

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders (donors) for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, and provides mechanisms for eliciting feedback.

12. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically.			**Source of data**	**Notes/Comments**
Q1. OBI: What is the country's "Open Budget Index" score? (Alternative for countries lacking an OBI score: What was the country's score on the most recent Public Expenditure and Financial Accountability Assessment (PEFA) for PI-10: "Public Access to Fiscal Information"?)	○ A. Extensive Information (OBI Score 81-100; or PEFA score of A- or better on element PI-10) ○ B. Significant Information (OBI Scores 61-80; or PEFA score of B or B+ on element PI-10) ○ C. Some Information (OBI Score 41-60; or PEFA score of B-, C or C+ on element PI-10) ○ D. Minimal Information (OBI Score 21-40; or PEFA score of C- or D+ on element PI-10) ◉ E. Scant or No Information (OBI Score 0-20; or PEFA score of D or below on element PI-10) ○ F. There is neither Open Budget Index score nor a PEFA assessment to assess the transparency of government budget	Q1 Score: 1.0	OBI score http://internationalbudget.org/wp-content/uploads/OBI2012-ZambiaCS-English.pdf PEFA score http://www.mofnp.gov.zm/index.php/pfm/viewdownload/22-pfmr/116-zambia-2012-pefa-final	The OBI score is based on the 2012 assessment. Since 2013 Zambia has produced a citizens budget which could affect the OBI score and the yellow book is publically available. The group also reviewed the PEFA score (2012). Under this assessment Zambia in 2012 scored B. A decision was made to use the OBI score given that its listed first in this template.
Q2. National program report transparency: Does the host country government make an annual national HIV/AIDS program progress report and or results publically available?	○ A. No, the national HIV/AIDS program progress report or presentation of results is not made public ◉ B. Yes, the national HIV/AIDS program progress report and/or results are made publically available (Check all that apply): ☑ On Website ☑ Through any type of media ☑ Disseminate print report or presentation of results	Q2 Score: 6.0	In country source, i.e., last annual national HIV/AIDS progress report or presentation: Zambia Country Report- Monitoring the Declaration of Commitment on HIV and AIDS and the Universal Access, NAC (March 2014) http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/ZMB_narrative_report_2014.pdf Ministry of Finance, Mid-term Eexpenditure Framework Progree Report (2011 -2013).	Aside from the UNGASS report and the annaul Ministry of Finance mid-term expenditure framework reports, the National Aids Council (NAC) media network also releases information prior to dissemination of the UNGASS report

Q3. Audit transparency: Does the host country government make an annual national HIV/AIDS program audit report publically available?	◉ A. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically ○ B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply: ☐ On website ☐ Through any type of media ☐ Disseminate print report	Q3 Score: 0.0	In country source, i.e., last HIV/AIDS audit report:	Zambian Office of the Auditor General Report (annually); however, some partner funds which are significant are not typically audited through the host government system. Information may not be available to the host country. This report is not a specific audit of the HIV/AIDS program but covers all government spending agencies.
		Public Access to Information Score: 7		

13. **Oversight and Stewardship**: Government institutions are held accountable for the use of HIV/AIDS funds and for the results of their actions by the electorate and by the legislature and judiciary. Public employees are required to account for administrative decisions, use of resources, and results obtained. There is timely and accurate accounting and fiscal reporting, including timely audit of public accounts and effective arrangements for follow-up. There are mechanisms for citizens and key stakeholders to review and provide feedback regarding public programs, services and fiscal management.			**Source of data**	**Notes/Comments**
Q1. Availability of Information on Resources Received by Service Delivery Units. PEFA score on PI-23 was C or higher in most recent assessment.	○ A. PEFA assessment never conducted, or data unavailable ○ B. PEFA was conducted and score was below C ○ C. PEFA was conducted and score was C ◉ D. PEFA was conducted and score was B ○ E. PEFA was conducted and score was A	Q1 Score: 3.0	OGAC-provided data sheet (follows tab E) Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)	PEFA report is from 2012 which is outdated; general public may not have access to information. Government entites and other stakeholders have access to information, however, the general public may not have easy access to this information.
Q2. Quality and timeliness of annual financial statements. PEFA score for element PI-25 was C or higher in most recent assessment. Actual scores are ____	Check A or B; if B checked, select appropriate disaggregates: ○ A. PEFA assessment never conducted, or data unavailable ◉ B. PEFA was conducted and score was C or higher for: ☑ (i) Completeness of the financial statements ☑ (ii) Timeliness of submission of the financial statements ☑ (iii) Accounting standards used	Q2 Score: 5.0	OGAC-provided data sheet (follows tab E) Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)	

Q3. Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels and opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services?	Check A, B, or C; if C checked, select appropriate disaggregates: ○ A. No, there are no formal channels or opportunities ◉ B. No, there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and feedback ○ C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☐ During strategic and annual planning ☐ In joint annual program reviews ☐ For policy development ☐ As members of technical working groups ☐ Involvement on evaluation teams ☐ Giving feedback through social media ☐ Involvement in surveys/studies ☐ Collecting and reporting on client feedback	Q3 Score: 1.0	In country source, i.e., reports indicating CSO engagement, policies or SOPs:	Formal channels for civil society participation have become significantly weak over the years. Key structures that enabled efficient and diverse civil society participation are no longer fully functional e.g. HIV Sector Advisory Group. The NGO Act is currently under review due to challenges noted by civil society. An effective and inclusive NGO Act would provide opportunities for stronger engagement between government and civil society organizations in the HIV sector.
Q4. Civil society Enabling Environment: What score did your country receive on the 2013 Civicus Enabling Environment Index (EEI), which measure the socio-cultural, socio-economic and governance environments for civil society? If your country is not included in the EEI, are there any laws or policies that prevent a full range of civil society organizations from providing oversight into the government's HIV/AIDS response?	○ A. EEI score of 0-0.38; or if no EEI score, there are laws or polices that restrict civil society playing an oversight role ◉ B. EEI score of 0.39-0.50; or there are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it is not accepted by government ○ C. EEI score of 0.51 - 0.76; or there are no laws or policies that prevent civil society from playing a role in providing oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight	Q4 Score: 3.0	OGAC-provided data sheet (follows tab E) Data derived from Civicus Enabling Environment Index (civicus.org/eei/)	Zambia scored 0.45 in the 2013 CIVICUS index. However, CIVICUS Report for 2013 notes Zambia among countries that have seen a shrinking space for civil society organizations. This is largely related to the operationalization of the NGO Act. This legal document is now under review by government and civil society organizations
		Oversight and Stewardship Score:	**12**	

THIS CONCLUDES THE SET OF QUESTIONS ON THE ACCOUNTABILITY AND TRANSPARENCY DOMAIN

Domain E. Enabling Environment

What Success Looks Like: Relevant government entities demonstrate transparent resolve and take actions to create an enabling policy and legal environment, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

14. **Policies, Laws, and Regulations:** Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.			**Source of data**	**Notes/Comments**
Q1. Structural obstacles: Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support?	○ A. No, there are no such laws or policies ◉ B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score): ☐ Criminalization of HIV transmission ☑ HIV testing disclosure policies or age requirements ☐ Non-disclosure of HIV status laws ☑ Anti-homosexuality laws ☑ Anti-prostitution legislation ☑ Laws that criminalize drug use, methadone use or needle exchange	Q1 Score: 2.0	In country source, i.e., name of law or policy: Anti sodomy and anti prostitution are obstacles, laws that criminalise drug use. DATA source here is the penal code, the narcotic and drug acts and the prisons act. Also HIV testing policy. ZARAN review of HIV laws (Sharon to share)	But disclosure and age should not have been put together. The requirement is that below a certain age children need parental guidance to be tested which prevents sexually active adolescents. RECOMENDATIONS: There is need to invest in changing the age policy to age 10/11 yrs and generally around ensuring adolescents disclose their statuses. We also need safe spaces for kids as these are few. Criminalization of young people who have (defilement) is a missed opportunity as this should be an opportunity to inform the young people. Sensitizing communities and also the VSU
Q2. Access protection: Is there a National HIV/AIDS Policy or set of policies and laws that creates a legal and policy environment that ensures non-discriminatory and safe access to HIV/AIDS services, providing social and legal protection where those rights are violated? (note: full score of six points possible without checking all boxes)	○ A. No, there are no such policies or laws ◉ B. Yes, there are such policies and laws. Check all that apply: ☑ For people living with HIV ☐ For men who have sex with men ☐ For transgendered persons ☐ For sex workers ☐ For people who inject drugs ☑ For children orphaned or affected by HIV/AIDS	Q2 Score: 4.0	In country source, i.e., the name of laws and policies: On strategic information PANOS has a study (formative assessment of women who have sex with women). SI, population council study (MSM, SW, IDUs). GBV ACT but it has a lot of gaps	Roadmap developed by MOH on the occurrence of sex in prisons.

	☑ For young girls and women vulnerable to HIV ☑ For survivors of gender-based violence			
Q3. Civil society sustainability: Does the legislative and regulatory framework make special provisions for the needs of Civil Society Organizations (CSOs) or give not-for-profit organizations special advantages?	○ A. No, there are no special provisions or advantages for CSOs ◉ B. Yes, there are special provisions and advantages for CSOs. Check all that apply: ☐ Significant tax deductions for business or individual contributions to not-for-profit CSOs ☐ Significant tax exemptions for not-for-profit CSOs ☐ Open competition among CSOs to provide government-funded services ☑ Freedom for CSOs to advocate for policy, legal and programmatic change	Q3 Score: 1.0	In country source, name of legislation: Tax law/code	Critical NGOs e.g ZNAN ZRAN closed which has proved detrimental to NGO engagement.
Q4. Enabling legislation: Are there policies or legislation that govern HIV/AIDS service delivery?	○ A. No ◉ B. Yes, there are. Check all below that are included: ☑ A national public health services act that includes the control of HIV ☐ A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services	Q4 Score: 3.0	In country source, name of legislation or policy: Ministry of Health, National Health Policy (June 2013); Revised National AIDS Strategic Framework, 2014-2016; Human Resources for Health Strategic Plan 2011-15; National Community Health Worker Strategy, August 2010.	Zambia does not have a comprehensive HIV/AIDS legislation. Control of HIV is provided for under: 1) Public Health Act CAP 295 Laws of Zambia (includes control of all infectious diseases); 2) National Health Policy of 2012 outlines broad strategies of HIV control; 3) National HIV/AIDS Policy of 2005 (Note: This policy expired in 2010 and has not yet been revised).
		Policies, Laws, and Regulations Score: **10**		

15. **Planning and Coordination:** Senior policy makers prioritize health and the HIV/AIDS response. Host country develops, implements, and oversees a multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated.			**Source of data**	**Notes/Comments**
	○ A. No, there is no national strategy for HIV/AIDS ◉ B. Yes, there is a national strategy. Check all that apply:	Q1 Score: 4.0	In country source, name of current strategy: Revised National AIDS	

Q1. National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	☑ It is multiyear ☑ It is costed ☑ Its development was led by the host country government ☑ Civil society actively participated in the development of the strategy		National AIDS Strategic Framework, 2014-2016.	
Q2. Data driven prioritization: Did the host country government develop the strategy using a data-driven prioritization approach, which coordinates the investment of multiple sources of funding, i.e. Investment Case?	○ A. No data-driven prioritization approach was used ◉ B. Yes, a data-driven prioritization approach was used but it did not coordinate the investment of multiple funding sources ○ C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources	Q2 Score: 2	National Health Strategic Plan (2011 – 2016); National AIDS Strategic Framework Mid Term Review 2013-2014; National AIDS Spending Assessment 2012.	NASF revision based on investment case. Global fund proposal based on national funding forecasts
Q3. CCM criteria: Has the country met the minimum criteria that all CCMs must meet in order to be eligible for funding by the Global Fund?	○ A. No or there is no CCM ○ B. Yes, with conditions ◉ C. Yes	Q3 Score: 2	Global Fund Eligibility List 2014: EPA	
Q4. Coordination of national response: Does the host country government coordinate (track and map) all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, to avoid duplication and gaps?	○ A. No, it does not track or map all HIV/AIDS activities ◉ B. the host country government coordinates all HIV/AIDS activities. Check all that apply: ☑ Of Civil Society Organizations ☑ Of private sector ☑ Of donor implementing partners ☐ Activities are tracked or mapped ☐ Duplications and gaps are addressed ☐ Joint operational plans are developed that include key activities of all implementing agencies	Q4 Score: 3.0	In country source, i.e., Coordination data or reports: YES, but there are gaps. Resource mapping tool under NAC: organizations are required to report this kind of information but few, if any, do. MOH is developing a tool to establish who is doing what, where...	The District and Provincial AIDS Taskforce are responsible for coordinating the district and provincial responses, including mapping/or identifying who is providing what services. In addition, NAC developed an online reporting portol (NACMIS) through which partners are able to report on their activites, and state what areas they are operating in. At a recent HIV Cooperating Partners' meeting, at which the preliminary findings of the SID were presented, the Director General of the National AIDS Council expressed surprise at the high score for Planning and Coordination. He did not, however, eloborate why he felt the score was too high.
	○ A. No	Q5 Score: 4.0	NATIONAL HIV/AIDS/STI/TB COUNCIL - MINUTES OF THE NATIONAL	Technical working groups exist under the National AIDS

Q5. Civil society engagement: Is there active engagement of diverse non-governmental organizations in HIV/AIDS advocacy, decision-making and service delivery in the national HIV/AIDS response?	◉ B. Yes, civil society (such as community-based organizations, non-governmental organizations and faith-based organizations, local leaders, and/or networks representing affected populations) are actively engaged. Check all that apply: ☑ In advocacy ☑ In programmatic decision-making ☑ In technical decision-making ☑ In service delivery		DIALOGUE FOR CIVIL SOCIETY PLANNING MEETING HELD ON 27TH JANUARY 2015 IN THE NAC BOARDROMM; NATIONAL HIV/AIDS/STI/TB COUNCIL- MINUTES OF THE MEETING TO PLAN FOR THE $2M RING FENCE BY THE GLOBAL FUND HELD ON 18TH MARCH 2015 IN THE NAC BOARD ROOM	Council that include civil society in advocacy, programmatic and technical decision making and service delivery. Guildelines for service delivery e.g Home based Care are developed with civil society participation.
		Planning and Coordination Score:	**15**	

THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN