ZIMBABWE Country Operational Plan
COP 2017

Strategic Direction Summary

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Acronym List

ACT	Accelerating Children's HIV/AIDS Treatment Initiative
AE	Adverse Event
AGYW	Adolescent Girls and Young Women
ANC	Antenatal Clinic
ART	Antiretroviral Treatment
ARVs	Antiretroviral
BMGF	Bill and Melinda Gates Foundation
CARGS	Community ART Refill Groups
CATS	Community Adolescent Treatment Support groups
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CCW	Community Case Workers
CDC	Centers for Disease Control and Prevention
CESHHAR	Centre for Sexual Health, HIV and AIDS research
CHW	Community Health Workers
CLHIV	Children Living with HIV
COP	Country Operational Plan
CrAg	Cryptococcal Antigen
CRFs	Client Referral Facilitators
CSE	Continuing Secondary Education
CSO	Civil Society Organizations
CTX	Cotrimoxazole
DBS	Dried Blood Spot
DfID	United Kingdom's Department for International Development
DHIS2	District Health Information System
DMPPT2	VMMC Decision Makers' Program Planning Toolkit
DoS	Department of State
DREAMS	Determined, Resilient, AIDS-free, Mentored, and Safe
DSD	Direct Service Delivery
EA	Expenditure Analysis
ECD	Early Childhood Development
ECS	Early Childhood Stimulation
EID	Early Infant Diagnosis
EIMC	Early Infant Male Circumcision
EMR	Electronic Medical Record System
eMTCT	Elimination of Mother to Child Transmission
FBO	Faith-Based Organization
FM	Families Matter
FP	Family Planning
FSW	Female Sex Workers

GALZ	Gay and Lesbian Association of Zimbabwe
GBV	Gender Based Violence
GEM	Girls Empowerment Clubs
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoZ	Government of Zimbabwe
HCW	Health Care Workers
HDP	Health Development Partners
HEI	HIV Exposed Infant
HIV	HIV Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HMIS	Health Management Information System
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
ICF	Intensified Case Finding
INH	Isoniazid
IP	Implementing Partner
IPC	Inter-personal Communication
IPT	Isoniazid Preventive Therapy
KP	Key Population
LCI	Local Capacity Initiative
LGBTI	Lesbian, Gay, Bi-Sexual, Transgendered or Intersex
LMIS	Logistics Management and Information Systems
LPV/r	Lopinavir/ritonavir
LTFU	Lost to Follow-Up
M&E	Monitoring and Evaluation
MC	Male Circumcision
MCH	Maternal and Child Health
MMS	Multi-Month Scripting
MOHCC	Ministry of Health and Child Care
MOLSW	Ministry of Labor and Social Welfare
MOPSE	Ministry of Primary and Secondary Education
MSF	Medecins Sans Frontiers
MSM	Men who have Sex with Men
NAC	National AIDS Council
NATF	National AIDS Trust Fund
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children

PBAC	PEPFAR Budget Allocation Calculator
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PITC	Provider-initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of mother-to-child Transmission
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal Care
POART	PEPFAR Oversight and Accountability Response
POC	Point of Care
PrEP	Pre-Exposure Prophylaxis
QA/QI	Quality Assurance/Quality Improvement
RDS	Respondent Driven Surveys
RTK	Rapid Test Kit
SCMS	Supply Chain Management System
SDS	Strategic Direction Summary
SI	Strategic Information
SID	Sustainability Index and Dashboard
SIMS	Site Improvement through Monitoring System
SNU	Sub National Unit
STI	Sexually Transmitted Infections
SW	Sex Workers
TA	Technical Assistance
TAG	Technical Advisory Committee
TAT	Turn Around Time
TB	Tuberculosis
TBBAT	Target Based Budgeting Allocation Tool
TBD	To Be Determined
TBIC	Tuberculosis Infection Control
TLE	Tenofovir Lamivudine Efavirenz
TPT	TB Preventive Therapy
TTCV	Tetanus Toxoid Containing Vaccines
UE	Unit Expenditure
UNAIDS	UNAIDS Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USG	U.S. Government
VACS	Violence against Children Survey
VCT	Voluntary Counseling and Testing
VHWs	Village Healthcare Workers
VL	Viral Load
VMMC	Voluntary Medical Male circumcision
WHO	World Health Organization
YAZ	Young Adult Survey of Zimbabwe

YWSS	Young Women Selling Sex
ZDHS	Zimbabwe Demographic Health Survey
ZIMPHIA	Zimbabwe Population-Based Health Impact Assessment

1.0 Goal Statement

The PEPFAR interagency team, working collaboratively with key partners including the Government of Zimbabwe (GoZ), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), civil society core advocacy members, bilateral and multilateral health development partners, have contributed to the development of the Country Operational Plan for FY 2018 (COP 2017). It builds on the current roll-out of Treat All (Test and Start) to rapidly increase national antiretroviral (ART) coverage and accelerate progress towards sustained epidemic control. The national ART program and other critical HIV programs in Zimbabwe are implemented under the leadership of the Ministry of Health and Child Care (MOHCC), the Ministry of Primary and Secondary Education (MOPSE), and the Ministry of Labor and Social Welfare (MOLSW), with human resources (HRH) and infrastructure primarily funded by the MOHCC. PEPFAR has successfully leveraged this capacity with key commodities, training, mentoring, some HRH for HIV testing and treatment, and other site-level support. This has resulted in the successful scale up to an estimated 76% national ART coverage by early 2016.

Building on the geographic prioritization developed in COP 2015, and further refined in COP 2016, the PEPFAR program will support the Ministry of Health and Child Care (MOHCC) to reach at least 90% treatment coverage in 36 districts, and 80% treatment coverage in four newly added PEPFAR districts by the end of FY 2018. The PEPFAR program will invest in the delivery of a comprehensive package of HIV care, treatment, and prevention activities within 40 of Zimbabwe's 60 districts and will transition away from a tiered site support approach which previously excluded PEPFAR support at clinics with fewer than 260 ART patients. This new approach will ensure that quality services are delivered at smaller, fast growing sites in a context of rapid decentralization. Utilizing new Joint United Nations Program on HIV/AIDS (UNAIDS) Spectrum estimates, which incorporate 2016 Zimbabwe Population-Based Health Impact Assessment (ZIMPHIA) and Zimbabwe Demographic Health Survey (ZDHS) population survey results, the PEPFAR program has developed district specific strategies targeting hard to reach priority populations to close the coverage gaps identified with the new data.

An improved PEPFAR-Zimbabwe HIV Testing and Counseling (HTC) strategy will enable the program to reach the first 90 by identifying new HIV-positives through activities such as index testing (contact tracing), and innovative interventions such as HIV self-testing, in order to better reach more men and young adults. In addition to targeted high-impact prevention activities, PEPFAR will increase its voluntary medical male circumcision (VMMC) target from 252,847 to 306,139, focusing its efforts on reaching young men ages 15-29, with the help of additional central funds provided this year. The second 90 will be achieved in 40 PEPFAR Saturation districts through Treat All (expected to reach full implementation by April 2017, which includes differentiated models of care such as mobile ART and same-day ART-initiation). PEPFAR will also increase its procurement of antiretroviral drugs (ARVs) from 192,989 to 215,000 patients, and support patient access to viral load testing which will reach 92% national coverage by December 2017 in order to measure progress towards the third 90. Support to Community Adolescent Treatment Support groups (CATS) and Community ART Refill Groups (CARGS) will also continue in COP 2017.

Through increased funding for COP 2017, the PEPFAR program will scale up the Determined Resilient Empowered AIDS-Free Mentored and Safe (DREAMS) program by increasing the package of services in six districts where DREAMS is already operating (including the expansion

of Pre-Exposure Prophylaxis (PrEP), and complementary activities supported within the orphans and vulnerable children (OVC) portfolio, by linking beneficiaries to HIV clinical services and concentrating on household economic strengthening. Moreover, clinical services targeting female sex workers (FSW) and men who have sex with men (MSM) will be scaled up significantly from the plan developed in COP 2016, and for the first time, will integrate key pops services into public health facilities.

In COP 2016, PEPFAR expanded and introduced a number of new direct-service delivery (DSD) differentiated models of care to increase access and quality of services received both at the facility and community level based on feedback from civil society organizations and the MOHCC. Total funding for DSD activities excluding (DREAMS, VMMC and OVC proprogramming) was $10,422,068. In COP 2017, over $20M has been programmed to expand existing DSD activities including HIV Self-Testing, human resources for health at public facilities for testing and antiretroviral (ART) initiation, PreP, CATS, CARGS and defaulter tracing. Moreover, PEPFAR Zimbabwe will also introduce new DSD activity focused an adolescent friendly mental health services through the pilot "Friendship Bench," to increase adherence, retention and address psychosocial challenges experienced by adolescents.

PEPFAR Zimbabwe is committed to attaining the 90-90-90 goals outlined by UNAIDS and continues to use quarterly PEPFAR Oversight and Accountability Response Team (POART) reviews and the Site Improvement through Monitoring System (SIMS) findings to assess performance and further sharpen strategies and approaches to most efficiently deliver expected results. Furthermore, PEPFAR is and will continue to work closely with the Global Fund's Country Coordinating Mechanism (CCM) to ensure alignment of programming during the Global Fund's next funding cycle (2018-2020).

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

According to the 2012 census, the projected 2015 population of Zimbabwe was 14.2 million. In 2016, Zimbabwe completed the Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA), a household-based national survey that measured the national HIV incidence, prevalence and viral load suppression. Similar to the Zimbabwe Demographic Health Survey (ZDHS), ZIMPHIA showed that overall HIV prevalence for adults aged 15-49 is 14.0% while incidence for the same age is now 0.48%[1], down from 2.63% in 2000. An estimated 1.3 million people were living with HIV in 2016. Annual AIDS related deaths have declined over the past decade with approximately 21,671[2] AIDS related deaths in 2016 compared to 134,247 in 2004. New HIV infections among all adults 15+ years declined nationally from 54,762 in 2014 to 35,650 in 2016. Among children, new infections declined from 35,893 in 2000 to 3,316 in 2016. By 2016, ART coverage among all HIV+ adults was 76% and 73% among children compared to 51% and 39% among adults and children, respectively, in 2014.

[1] Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) 2016
[2] Zimbabwe 2016 HIV/AIDS Estimates (Spectrum/EPP model, February 2017)

Looking forward, the MOHCC estimates 2017 HIV Prevalence at 14.16% among adults ages 15-49 and annual AIDS related deaths at 21,570. As of December 2016, average ART initiation is about 10,781 persons per month, however there remain some serious challenges to achieving high ART coverage and epidemic control, including: Potential insufficient funding for ARVs and lab commodities, human resource shortages, crumbling infrastructure, a deteriorating health system and heavy reliance on donor funding.

PEPFAR Zimbabwe is working in partnership with the Global Fund and the people of Zimbabwe, who contribute to the National AIDS Trust Fund ("AIDS Levy") through a 3% income tax, which totaled $34.2 million in 2013. Nevertheless, combined funding from PEPFAR and the Global Fund measured per-person living with HIV (PLHIV) is the lowest among the ten sub-Sahara African countries classified as low income by the World Bank. The GNI per capita in Zimbabwe last measured in 2015 was $8,604.

PEPFAR Zimbabwe remains committed to attaining the 90-90-90 goals outlined by UNAIDS, with continued effort to support the MOHCC in fully implementing the national Treat All strategy in all 40 priority districts.

[3] Total 2015 AIDS Levy revenue is unknown, however the proportion of NAC funds allocated to commodities is estimated at $16 million per year for both 2016 and 2017.

Table 2.1.1 Host Country Government Results

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	14,463,886	100	2,896,259	49.9	2,909,365	50.1	1,439,106	50.4	1,417,635	49.6	3,082,188	53.1	2,719,332	46.9	Spectrum, 2016
HIV Prevalence (%)		14.14		1.6		1.6		5.51		5.51		15.57 (15+)		11.65 (15+)	Total & 15-24 - Spectrum, 2016 <15 - ZIMPHIA
AIDS Deaths (per year)	21,671		1,870		1,840		995		1,039		9,011 (15+)		8,950 (15+)		Spectrum, 2016
# PLHIV	1,275,845		89,715		45,283		86,858		70,528		703,989 (15+)		482,141 (15+)		Spectrum, 2016
Incidence Rate (2016)		0.52		Data unavailable		Data unavailable		0.66		0.51		0.50 (15+)		0.39 (15+)	Spectrum, 2016
New Infections (2015/2016)	35,650														Spectrum 2016
Annual births	433,914	n/a													NAC Annual Report, 2016
% of Pregnant Women with at least one ANC visit	384,695	92	N/a	N/a			N/a	N/a			N/a	N/a			NAC Annual Report, 2016
Pregnant women needing ARVs	65,158	7%													Spectrum, 2016 (PMTCT coverage is 93% - gap is 7%)
Orphans (maternal, paternal, double)	21,218		10,528 (0-17 year olds)		10,689 (0-17 year olds)		N/a		N/a		N/a		N/a		ZDHS, 2015 (<18), n = survey sample
Notified TB cases (2016)	38,000														WHO Global Tuberculosis Report, 2016

% of TB cases that are HIV infected	26,000	68.4	2400	N/a	2,600	N/a				14,000 (15+)	N/a		19,000 (15+)	N/a	WHO Global Tuberculosis Report, 2016
% of Males Circumcised	1201 (surveyed men 15-54 years)	14.3			N/a				650 (surveyed men 15-24)	18.8			497 (surveyed men 25-54 years)	10.8	ZDHS 2015, Programmatic MOH VMMC program data 2009 –Sep 2014) Total – 364, 320 (all ages 15-24 - 143,812 25+ - 220,508
Estimated Population Size of MSM*	Data not available	Data not available													
MSM HIV Prevalence	Data not available	23.5% (Sexual Minorities and HIV in Zimbabwe Draft Report (2013 BRTI)													2013 research carried out by Biomedical Research Training Institute in collaboration with GALZ and NAC.
Estimated Population Size of FSW	~40,000-80,000 (Approximation)														RDS 2011-2013
FSW HIV Prevalence		57.5%													SAPPH-IRE Baseline, 2013
Estimated Population Size of PWID	Data not available	Data not available													
PWID HIV Prevalence	Data not available	Data not available													

Estimated Size of Priority Populations (specify)	Data not available														
Priority Populations HIV Prevalence (specify)	Data not available														
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*														

Standard Table 2.1.2

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*

	Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Est. Total PLHIV (#)**	**PLHIV diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	5,787,919	1.6 [1.2-2.0]	94,043	---	66,159†	6.8†	46.24	217,144	7,111	5,374
Population less than 15 years										
15-24 year olds	2,977,207	4.6 [4.0-5.2]	135,515	----	58,486	83.6	85.1	619,048	29,949	15,321
25+ year olds (0-80)	5,714,457	19.1 [18.3-19.9]	1,090,463	----	706,630	87.1	86.6	970,611	101,075	69,656
MSM[5]	---	---	---							
FSW	---	---	---							
PWID	---	---	---							
Priority Pop (specify)										

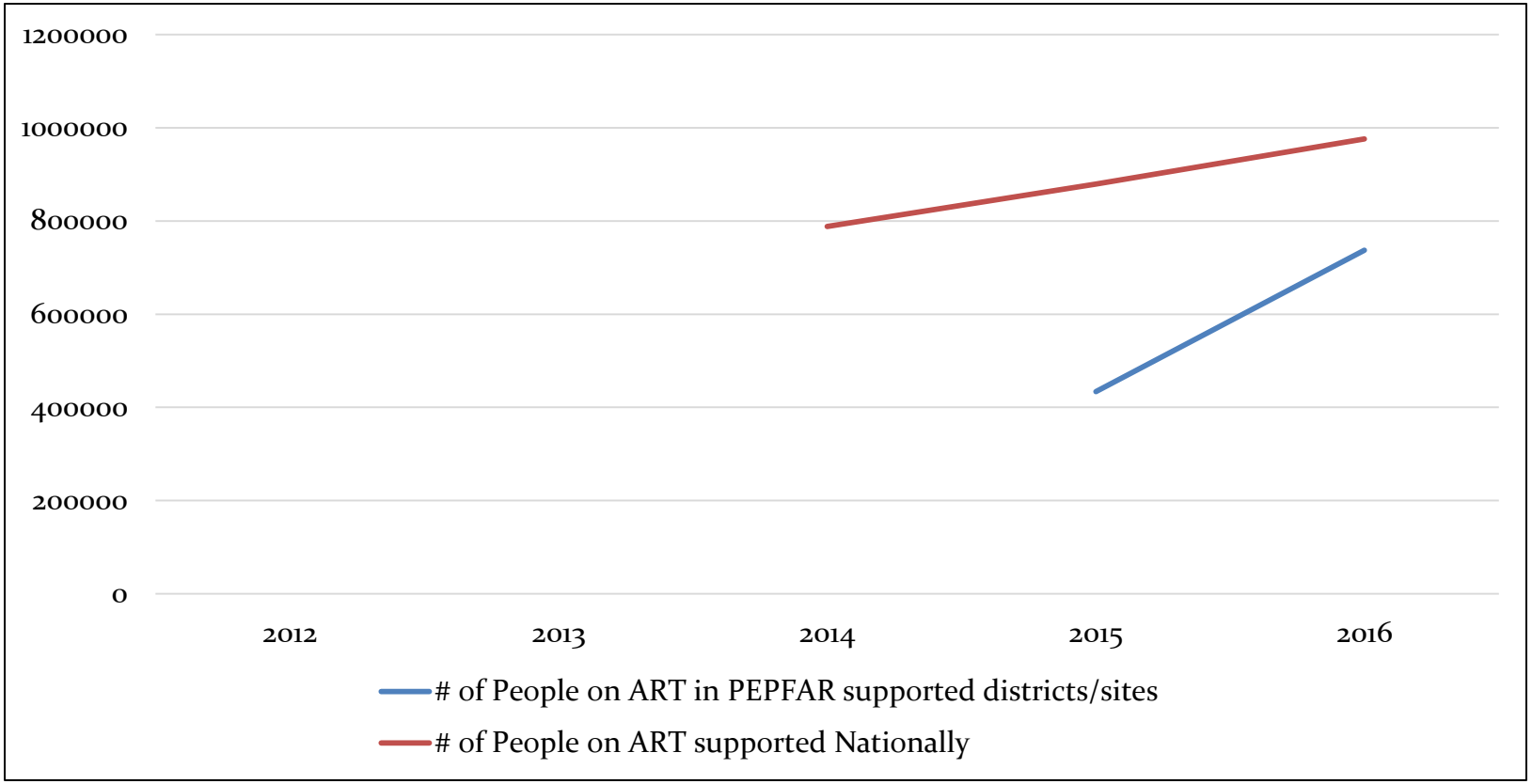
*These data are taken from the 2016 Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA)

†These data are taken from the Ministry of Health and Child Care Program or PEPFAR program data.

Estimates for testing, treatment, retention and suppression for key and priority population groups (below grey line) should only be included if reliable data exists.

[5] National Size Estimations for SWs and MSM are still pending; Reliable National KP status is not recorded and over KP Status exists only at the Program level.

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment[6]



[6] PEPFAR ART Attribution definition changed between 2013 and 2014; the graphic shows the PEPFAR contribution based on the revised definitions as of 2014. PEPFAR historically has only counted the person years of ARVs for TX_Curr which was based on 160,000 patient years.

2.2 Investment Profile

According to the Resource Mapping Round 2 report and the National AIDS Spending Assessment 2014-2015 Report, the major funders for HIV in Zimbabwe are the Global Fund and PEPFAR. ARV support has narrowed from a broader range of funders who have included Medicins Sans Frontiers (MSF) and the United Kingdom's Department for International Development (DfID) to the current three: the Global Fund, USG, and the government financed by the AIDS levy. Annual PEPFAR support has grown by approximately 29% between 2016 and 2017 reflecting the $98 million COP base funding and an additional $29 million in treatment performance, DREAMS and ACT funding. In addition, PEPFAR Zimbabwe will benefit from $22.5 million of central voluntary medical male circumcision (VMMC) funds to accelerate VMMC achievements in COP 2017.

Health commodities and equipment comprise up to 70% of the Global Fund grant and this poses a risk to long-term sustainability given the high dependence of the MOHCC on donor funding for not only commodity support but also more broadly throughout the health sector. Treatment requirements cannot be sustained by the host country government at the current capacity levels. The NATF is projected to total $37.3 million for 2017 and the levels of contribution to HIV prevention, treatment and care will, at best, remain flat-lined in 2017 and out years. NATF funding is dependent on the total number of formerly employed people in the country. Thus with the high unemployment levels prevalent in the country, the likelihood of increased funding for NATF is minimal without significant changes in the economic landscape. Health development partners' (HDP) (bilateral health donors) contributions to human resources for health are declining. This is primarily because the available funding under the new Health Development Fund is roughly 30% less than what was available under the previous fund (formerly known as the Health Transition Fund), due to budget cuts in the countries contributing to this pooled basket funding approach. In 2016 and 2017 the gap had to be offset with savings from the Global Fund grant. Private sector contributions are provided mainly from mining companies across the country who contribute to HIV prevention and treatment through privately-run clinics and some community outreach health services.

Direct support from MOHCC is in the form of infrastructure and basic staff salaries. Most health facility operational costs are borne by development partners. With MOHCC resource limitations, PEPFAR Zimbabwe has had to increase direct service delivery (DSD) support, in multiple staffing cadres such as primary counselors, roving initiation teams and laboratory scientists, for accelerated implementation. Continued support for seconded staff is also critical to retain institutional memory for program continuity. The country is currently implementing a one year costed extension of the Global Fund supported HIV grant that was supposed to end in December 2016. Zimbabwe has since been allocated $431 million for the period 2018 - 2020. The PEPFAR team has proactively identified areas for leveraging from the Global Fund and continues to work very closely with the Global Fund writing teams to ensure incorporation of the programming requirements to achieve fast track targets.

Table 2.2.1 Annual Investment Profile by Program Area

PROGRAM AREA	PEPFAR %	GLOBAL FUND %	HDP %	GOVERNMENT%	PRIVATE SECTOR%
Clinical care , treatment and support	28.50	49.40	10.44	10.22	1.44
Community based treatment and support	7.32	16.53	61.90	-	14.26
Prevention of mother-to-child Transmission	17.16	.61	62.55	19.67	-
HIV Testing and Counseling	39.67	17.25	23.08	12.10	7.91
Voluntary Medical Male Circumcision	36.34	11.45	41.14	11.06	-
Priority population prevention	3.01	7.18	80.48	6.71	2.62
Key population prevention	12	10	78	-	
Orphans and Vulnerable Children	46.88	-	53.12	-	
Laboratory	17.38	55.74	-	26.88	
Strategic Information, Survey & Surveillance	11.37	37.00	43.48	8.15	
Health Systems Strengthening	1.26	16.19	47.85	34.7	

Table 2.2.2 Annual Procurement Profile for Key Commodities[7]

Commodity Category	Total Expenditure	% PEPFAR	% Global Fund[8]	% GOZ/NAC	% Other	% Gap
ARVs[9]	$129,573,401	15	75	10	0	0
Rapid test kits[10]	$6,220,558	8	54	37	0	1
HIV self-test kits	$2,929,337	14	13	0	0	72
Other drugs[11]	$1,041,464	73	27	0	0	0
Lab reagents (EID)	$1,486,000	19	81	0	0	0
Lab reagents (POC)	$1,643,450	0	48	12	0	39
Lab reagents (conventional)	$9,709,333	0	50	7	0	43
Lab reagents (VL)	$15,289,128	7	63	1	0	29
Condoms [12](male & female)	$5,039,300	100	0	0	0	0
VMMC kits[13]	$5,702,055	54	20	0	0	26
Other commodities[14]	$535,398	91	9	0	0	0
Total	**$179,169,424**					

[7] All commodity groups are based on Calendar Year 2018 forecast and commitments from preliminary results presented after the March 2017 quantification exercise.
[8] For all commodity groups supported by the Global Fund, figures included are those in the new funding request (within allocation and above allocation)application, which is subject to TRP review and Global Fund approval.
[9] ARVs covers adult and pediatric
[10] Rapid Test kits do not include the tests required for syphilis
[11] Others drugs refer to drugs used in the VMMC program
[12] Male and female condoms are for the public sector program. Refer to PSI for social marketing.
[13] VMMC kits include requirements for surgical and PrePex methods.
[14] Other commodities refer to commodities and equipment used in the VMMC program other than the VMMC kits

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$3,000,000				To reduce MNCH morbidity and mortality and improve quality of care for MNCH services.
USAID TB	$6,000,000				To improve TB control through diagnostics, treatment, and infection control.
USAID Malaria	$15,000,000				To improve malaria control through case management, long-lasting insecticidal net distribution, and indoor residual spraying.
USAID Family Planning	$2,000,000	$2,000,000	1	$140,000	To increase access to and availability of FP services through a private franchise model.
National Institutes for Health	$4,060,633				In support of 2017 health related research grants
Peace Corps	$0				
DOD Ebola	$0				
MCC	$0				
Total	**$30,060,633**				

Table 1.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP (COP17 Funding Allocation unless otherwise noted)					
Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**Objectives**
DREAMS Innovation	$3,376,537			1	Prevention interventions for adolescent girls and young women (AGYW)
VMMC – Central Funds	$22,545,390			3	To scale-up VMMC in six DREAMS districts to reach saturation.
LCI (COP16)	$288,333			1	Health policy advocacy for KP health access and resource accountability
PEPFAR HOP - CDC Global TB Branch (COP16)	$375,000			2	Occupational health support. TB screening for health workers and infection prevention control
PEPFAR Drought Relief (COP16)	$4,000,000			4	To mitigate the impacts of the drought on HIV through nutrition support and WASH activities.
Community Adherence Treatment Supporters (CATS) Game Changer (COP16)	$2,468,999			2	To mitigate the impact of HIV through CATS to enhance testing, initiation, retention, and adherence in children and adolescents aged 15-24.
Total	**$33,054,259**				

2.3 National Sustainability Profile Update

SID Update: The sustainability profile in Zimbabwe remains largely the same as last year. Commodity security remains uncertain; however funding commitments from the Global Fund and PEPFAR indicate that necessary commodities are likely to be fully covered by external donors over the coming years.

The economic situation remains tenuous and could potentially impact the Government of Zimbabwe's ability to meet its obligations to health care workers who provide most of the HIV services throughout the country.

COP16 SID:

Sustainability Strengths:

- **Planning and Coordination (9.33, dark green):** The MOHCC effectively leads the coordination of the HIV response in Zimbabwe. A multi-year, costed national strategy exists, including specific activities and strategies to minimize the impact of HIV on vulnerable populations. The MOHCC also continues to effectively lead the implementation of the National HIV Implementation, and coordination with the National AIDC Control (NAC) program is strong. The MOHCC has made great effort to ensure the development of the national strategy is an inclusive process.

- **Quality Management (8.67, dark green):** The GoZ has institutionalized quality management systems and plans to ensure quality improvement methodologies are applied to managing and providing HIV/AIDS services. For example, peer-learning opportunities have been developed and were available as of the end of 2016. Additionally, HIV program performance measurement data are used to identify areas of patient care and service that can be improved through national decision-making, policy, and priority setting.

Sustainability Vulnerabilities:

- **Private Sector Engagement (2.71, red):** Private sector engagement needs increased attention. For example, the private sector does not actively engage with the GoZ as part of the policy and budget decision for HIV programs. Additionally, the government's policy legal and regulatory frameworks make limited provisions for the needs of private businesses.

- **Domestic Resource Mobilization (3.06, red):** The GoZ continues to remain highly dependent on outside donors to fund their national HIV response to the economic situation. Current resource mapping shows around 20% of total funding is from the

GoZ.

- **Epidemiological and Health Data (3.87, yellow):** Zimbabwe requires additional capacity to lead and manage planning and implementation of epidemiological survey and surveillance activities. Additionally, key population epidemiological and behavioral surveillance activities are not funded or conducted by the MOHCC, but by external agencies, organization, and institutions. Lastly, there is a lack of reporting for viral load data and viral load testing is not done routinely at clinics.

- **Laboratory (4.72, yellow):** Like many other components of service delivery, there are strategies in place, but not fully in operation at all levels of the system. There remain large gaps in capacity of laboratory workforce, and the viral load infrastructure, and a lack of domestic funds for laboratories as a whole.

- **Commodity Security and Supply Chain (6.14, yellow):** ARV funding for future years is uncertain given that planning for the Global Fund beyond 2016 is currently unknown. Furthermore, as ART coverage is expected to increase with the introduction of Treat All, ARV needs will increase while overall available domestic funding is expected to remain stable or decrease. Supply chain systems are relatively strong, but still heavily reliant on support from outside donors.

2.4 Alignment of PEPFAR investments geographically to disease burden

Since the pivot in COP 2014, the Zimbabwe PEPFAR team has redirected expenditure towards scale up SNUs. In FY 2016, 90% of all district or site level expenditure was in the 36 scale up SNUs. SNU expenditure was closely related to the number of PLHIV in each district with the six DREAMS districts being among the seven exceptions.

Figure 2.4 Zimbabwe People Living with HIV (PLHIV), Total PEPFAR Expenditure and Percent PLHIV by District

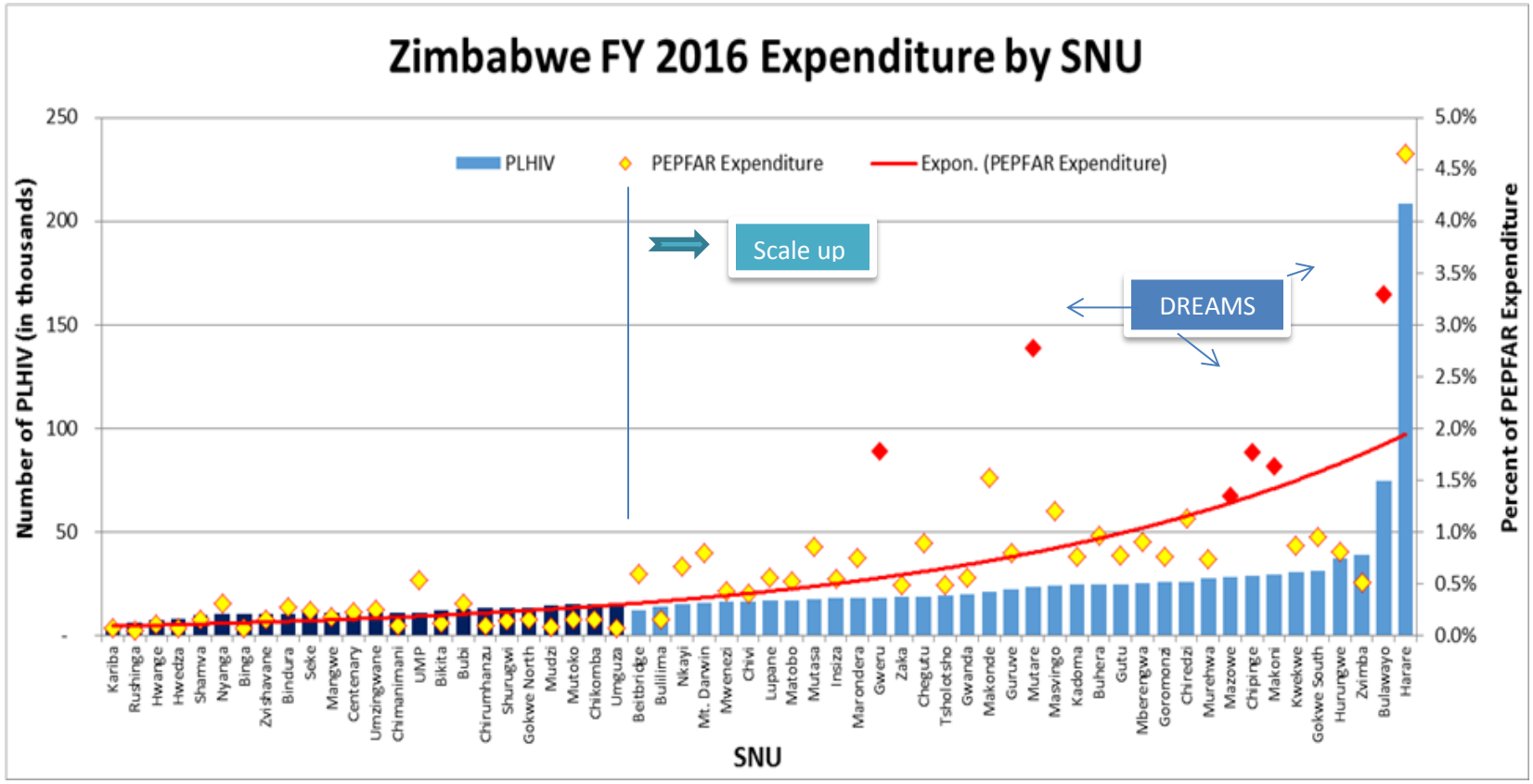
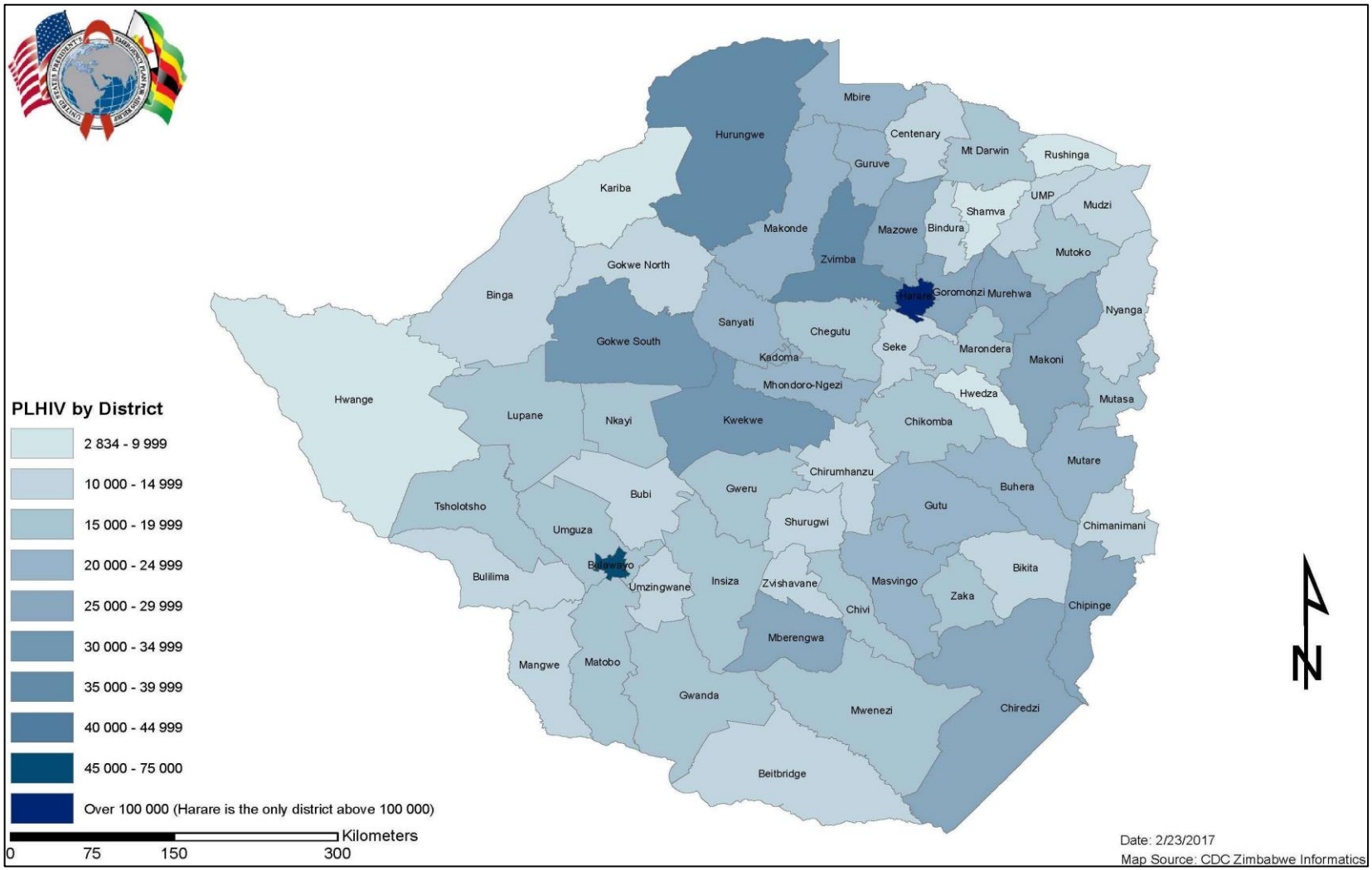
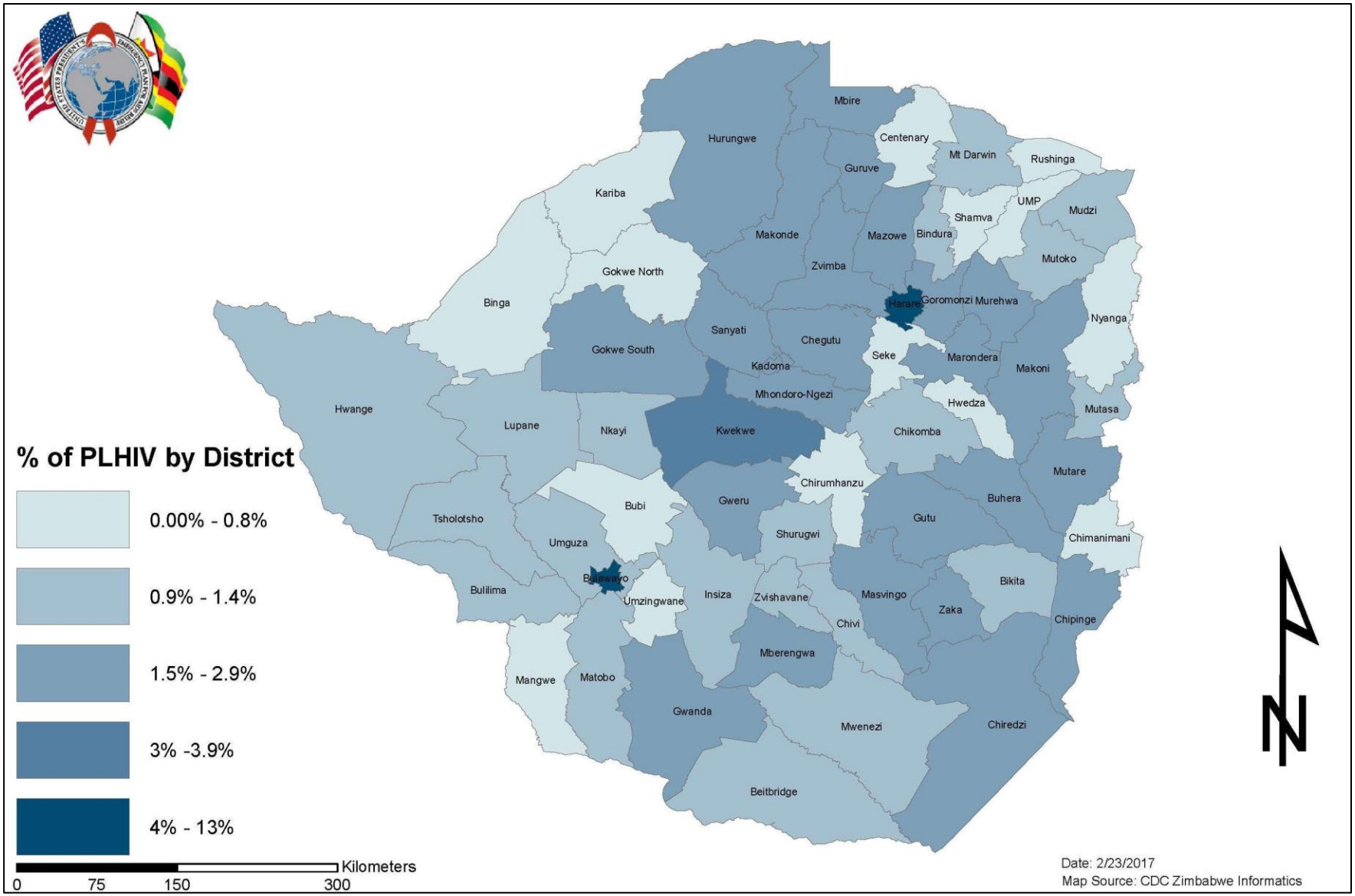
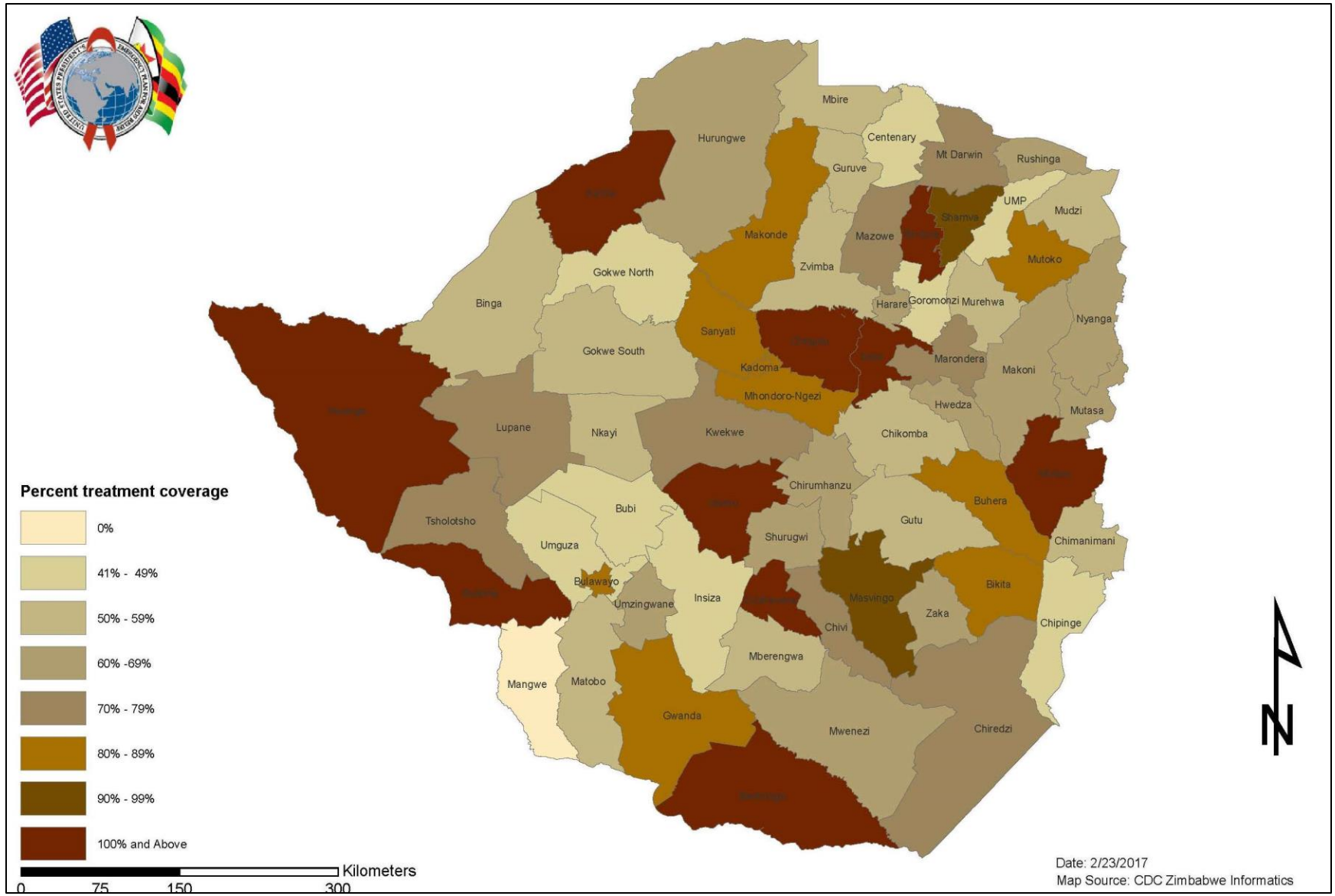
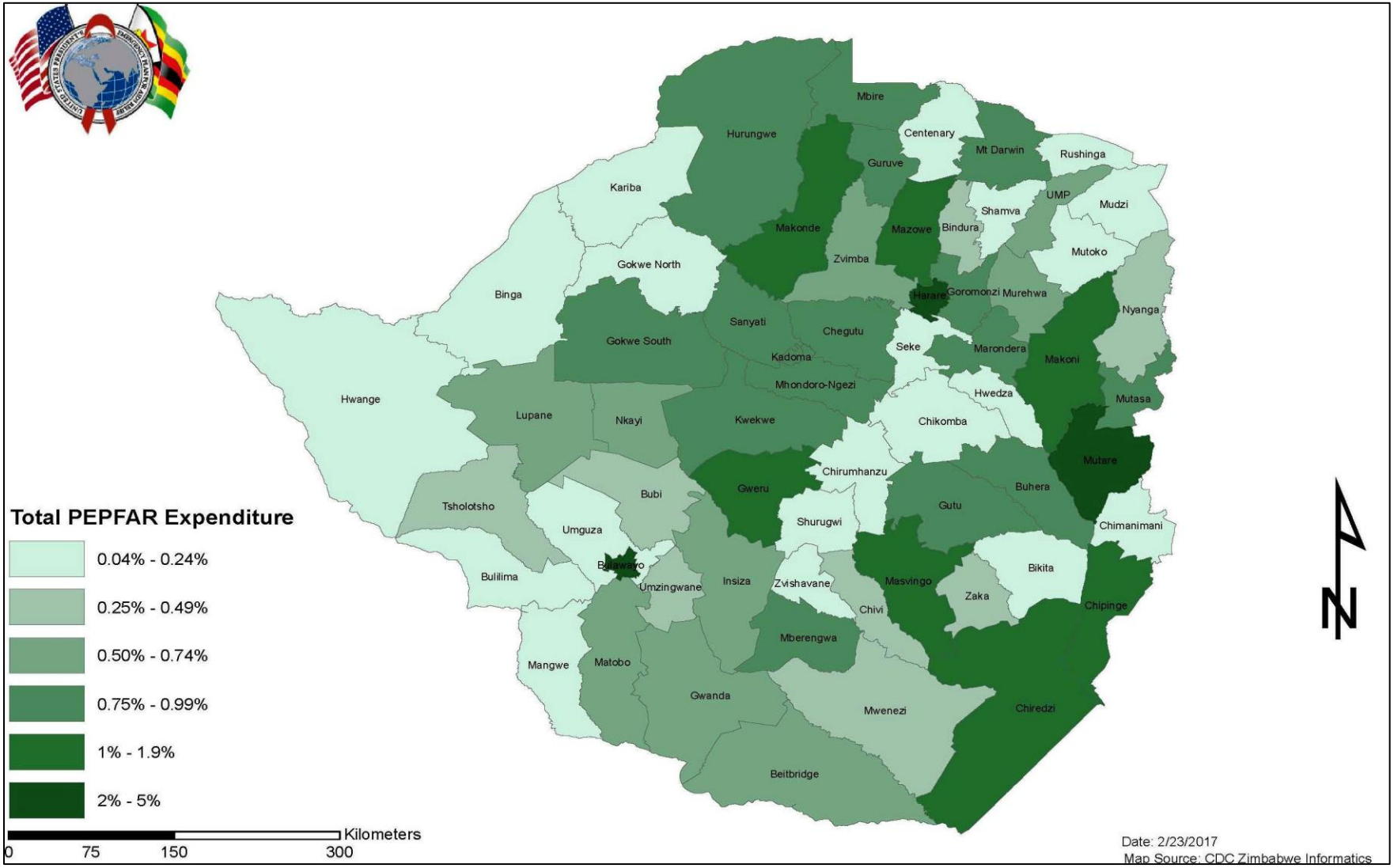


Figure 2.4.1 Zimbabwe People Living with HIV (PLHIV), Treatment Coverage, Total PEPFAR Expenditure and Percent PLHIV by District




% of PLHIV by District
0.00% - 0.8%
0.9% - 1.4%
1.5% - 2.9%
3% -3.9%
4% - 13%
Kilometers
0
75
150
300
Mbire
Hurungwe
Centenary
Mt Darwin
Rushinga
Guruve
Kariba
UMP
Shamva
Mudzi
Makonde
Mazowe
Bindura
Mutoko
Zvimba
Gokwe North
Binga
Harare
Goromonzi
Murehwa
Nyanga
Sanyati
Chegutu
Gokwe South
Seke
Marondera
Makoni
Kadoma
Mhondoro-Ngezi
Hwedza
Hwange
Lupane
Nkayi
Kwekwe
Chikomba
Mutasa
Mutare
Chirumhanzu
Buhera
Bubi
Gweru
Tsholotsho
Gutu
Shurugwi
Chimanimani
Umguza
Bulawayo
Bikita
Bulilima
Umzingwane
Insiza
Zvishavane
Masvingo
Zaka
Chivi
Chipinge
Mberengwa
Mangwe
Matobo
Gwanda
Mwenezi
Chiredzi
Beitbridge
N
Date: 2/23/2017
Map Source: CDC Zimbabwe Informatics


Mbire
Hurungwe
Centenary
Guruve
Mt Darwin
Rushinga
UMP
Mudzi
Shamva
Makonde
Mazowe
Mutoko
Zvimba
Gokwe North
Binga
Harare
Goromonzi
Murehwa
Nyanga
Sanyati
Gokwe South
Marondera
Makoni
Kadoma
Mhondoro-Ngezi
Hwedza
Mutasa
Lupane
Nkayi
Kwekwe
Chikomba
Chirumhanzu
Buhera
Bubi
Tsholotsho
Gutu
Shurugwi
Chimanimani
Umguza
Bulawayo
Bikita
Umzingwane
Insiza
Masvingo
Zaka
Chivi
Chipinge
Mberengwa
Mangwe
Matobo
Gwanda
Mwenezi
Chiredzi
Percent treatment coverage
0%
41% - 49%
50% - 59%
60% -69%
70% - 79%
80% - 89%
90% - 99%
100% and Above
Kilometers
0
75
150
300
N
Date: 2/23/2017
Map Source: CDC Zimbabwe Informatics


Total PEPFAR Expenditure
0.04% - 0.24%
0.25% - 0.49%
0.50% - 0.74%
0.75% - 0.99%
1% - 1.9%
2% - 5%
Kilometers
0
75
150
300
Mbire
Hurungwe
Centenary
Mt Darwin
Rushinga
Guruve
Kariba
UMP
Mudzi
Shamva
Makonde
Mazowe
Bindura
Mutoko
Zvimba
Gokwe North
Binga
Harare
Goromonzi
Murehwa
Nyanga
Sanyati
Chegutu
Gokwe South
Seke
Marondera
Makoni
Kadoma
Mhondoro-Ngezi
Hwedza
Hwange
Mutasa
Lupane
Nkayi
Kwekwe
Chikomba
Mutare
Chirumhanzu
Gweru
Buhera
Bubi
Tsholotsho
Gutu
Shurugwi
Chimanimani
Umguza
Bulawayo
Bikita
Bulilima
Insiza
Zvishavane
Masvingo
Umzingwane
Zaka
Chivi
Chipinge
Mberengwa
Mangwe
Matobo
Gwanda
Mwenezi
Chiredzi
Beitbridge
Date: 2/23/2017
Map Source: CDC Zimbabwe Informatics

2.5 Stakeholder Engagement

Host country government

In addition to regular meetings with senior leadership at the MOHCC, representatives from the Ministry attend each of the PEPFAR quarterly partner review meetings. This has allowed them to jointly monitor partner progress and achievements on a regular basis, as well as, inform staekohlders of strategic decisions such as increasing direct service delivery activities for HIV testing and/or recruiting back to care facilitators to minimize treatment cascade leakages. The FY 2016 Q4 report provided the launch pad for COP 2017 planning and was extensively deliberated with the Ministry. Bilateral meetings were held with the leadership of the AIDS and TB unit, as well, as with the thematic leads in the Ministry to deliberate on priority areas for PEPFAR support. The PEPFAR team also participated in the Ministry's semi-annual provincial planning meeting where progress updates and strategic intensions for COP 2017 were presented. The PEPFAR COP 2017 planning retreat ran in parallel to the MOHCC strategic planning and review meeting in Bulawayo where programmatic priorities were shared and exchanged. Two representatives from the MOHCC also attended the February 2017 PEPFAR Management Meeting in Washington, D.C.

Global Fund and other external donors

Members of the PEPFAR team are part of the country coordinating mechanism (CCM) Technical Committees which continually monitor the progress of the Global Fund's grants implementation. Quarterly bilateral meetings with the Global Fund's Principal Recipients are also held to explore synergies between the two programs. COP 2017 planning coincides with Zimbabwe's development of the Global Fund funding request 2018-2020. In support of the funding request development PEPFAR presented the strategic priorities for COP 2017 to the CCM writing team and has dedicated several team members to contribute full time to the planning process. Among the key inputs to Global Fund planning is the need to support community based organizations who contribute to the mobilization of people seeking services, treatment support to sites outside of PEPFAR scale up districts, support to condom programming, and additional investments to tuberculosis (TB) prevention. Other HDPs were also part of the writing team and welcomed PEPFAR's increased support to key populations.

Civil Society/Community

Civil Society Organization (CSO) representatives attended quarterly PEPFAR/CSO engagement meetings, as well as, PEPFAR partner quarterly progress review meetings. These CSO members contributed to strategies for scaling up work to reach testing, treatment and viral load monitoring targets. Feedback from CSOs on the FY2016 Q4 POART also provided significant insight on what PEPFAR should prioritize for COP 2017. Four CSO representatives attended the PEPFAR COP 2017 planning retreat and have provided continued input after further consultations with regional CSO groups. CSO representatives also convened their own consultative meetings on Global Fund and PEPFAR support priorities in three regions of the country and a synopsis of the key priorities was presented to PEPFAR. Suggestions from these meetings were adopted for discussion and inclusion in COP 2017.

Private Sector

There has not been any significant private sector engagement with the PEPFAR team and it was one of the recommendations made by the Global Fund writing team. They appealed to PEPFAR to also consider HIV and general health needs of the workforce and adjust programming to address workplace needs. However, it is important to note that in the current economic and political environment, an estimated 95% of adults are unemployed, and industry has come to a virtual halt.

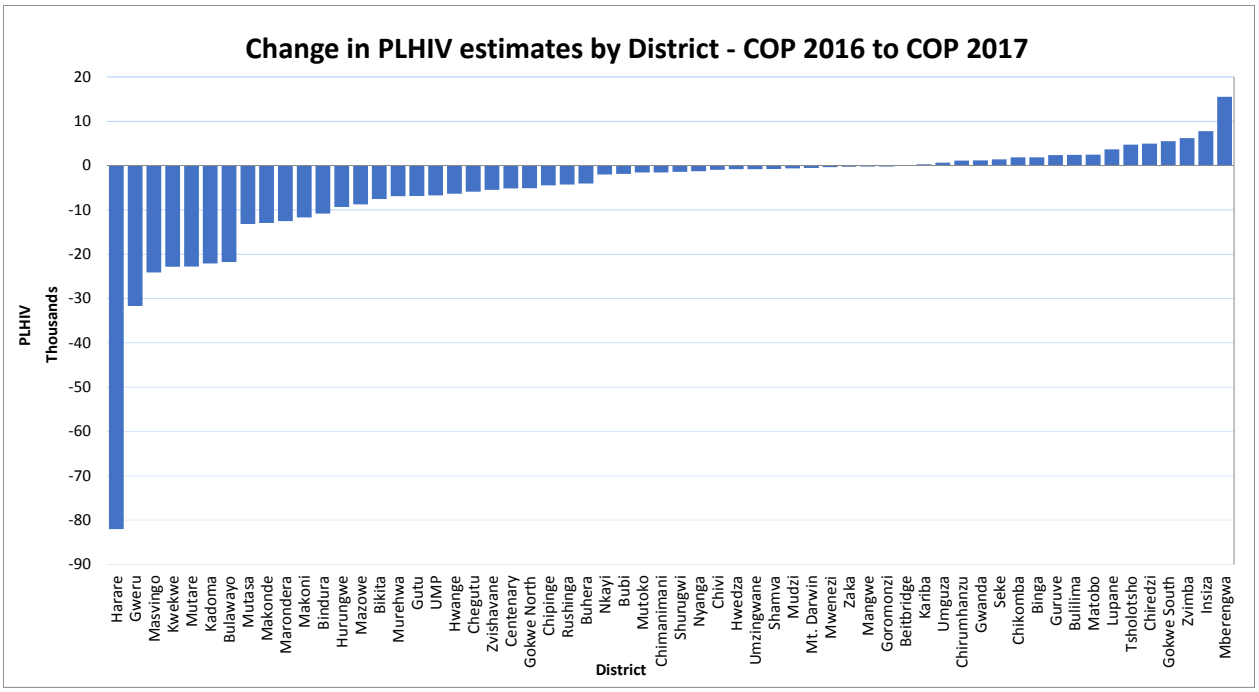
3.0 Geographic and Population Prioritization

The PEPFAR team has used data from the Zimbabwe Population-Based HIV Impact Assessment 2015-2016 (ZIMPHIA) and the Zimbabwe Demographic and Health Survey (ZDHS) to recalibrate the national HIV epidemic and measure progress towards UNAIDS 90-90-90 epidemic control targets.

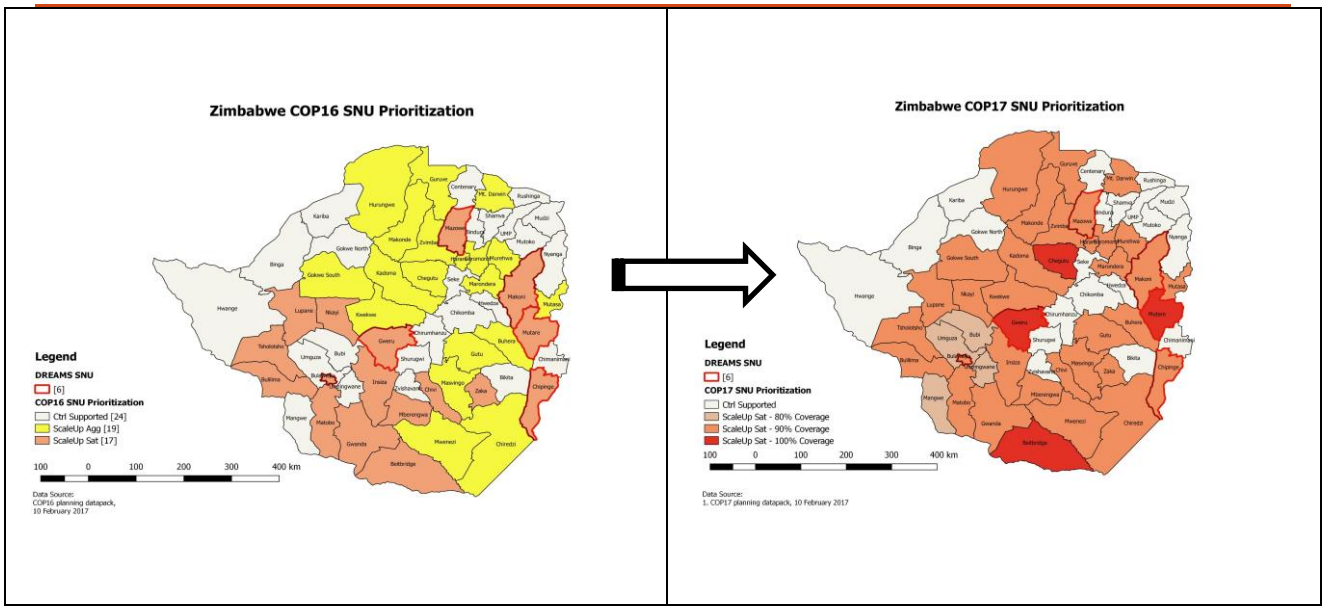
Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP17		# Current on ART (FY16)	# of SNU COP16 (FY17)	# of SNU COP17 (FY18)
Attained	0	0%	0	0	0
Scale-up Saturation	1,100,076	84%	779,903	17	40
Scale-up Aggressive	0	0%	0	19	0
Sustained	0	0%	0	0	0
Central Support	216,982	16%	169,215	24	20

A rerun of the UNAIDS HIV estimates models in January 2017 using recent ZIMPHIA and ZDHS data resulted in a 20% decline in the total number of PLHIV between COP 2016 and COP 2017, resulting in a new PLHIV total of 1,317,058. District level changes in PLHIV estimates are distributed in the figure below.



The 36 SNUs (see figure below) identified in COP 15 continue to represent 80% of PLHIV. Within these SNUs, PEPFAR will achieve 100% ART coverage in four and 90% ART coverage in 32 by the end of FY 2018. In COP 2017, PEPFAR will transition an additional four SNUs from "central support" to "scale up to saturation" bringing the total number of scale up SNUs to 40.



In COP 2017, PEPFAR will expand support to additional sites in the current 36 SNUs where

patient volumes have increased over the past year as government continues to decentralize ART clinics.

Due to Zimbabwe's generalized epidemic, PEPFAR will target efforts to reach high-risk and vulnerable populations as follows:

- **DREAMS**: Adolescent girls and young women (AGYW) ages 15-24 and a sub-population of vulnerable girls ages 10-14 will receive a "layered package of services" including HIV/GBV Prevention, HTS, Pre-exposure Prophylaxis (PrEP) for ages >18, access to family planning services, social protection, economic strengthening, parenting and other services to reduce HIV incidence. A Treat All Strategy will also be implemented in the six DREAMS districts to reach older men who are most likely the partners of the AGYW.
- **VMMC**: In COP 2017, PEPFAR will further improve on the age pivot, focusing demand creation and service provision on the 15-29 year age group. Seventy-three percent of COP17 VMMC targets are focused on the 15-29 year age group, an increase from 62% in COP16. Three SNUs will achieve 80% coverage of circumcised men among the 15-29 year age group, including one DREAMS SNU, by end of FY 2017. In COP 2017, seven additional SNUs, including three DREAMS SNUs: Gweru, Mazowe, and Chipinge will achieve 80% coverage.
- **Key Populations**: In COP 2017, PEPFAR will continue the approach used in COP 2016, which aimed at strengthening the clinical cascade for FSW (primary) and MSM (secondary) and reaching saturation in five urban locations with high numbers of FSWs: Harare, Bulawayo, Gweru, Mutare and Masvingo. In addition, key-pops-specific services will be integrated into the public sector facilities in COP 2017 in order to increase access in urban areas.

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for scale-up locations and populations

In contrast to the past two years, the COP 2017 process benefited from the input of population-based survey data which allowed the PEPFAR Zimbabwe team to recalibrate its progress towards epidemic control, and to refocus its efforts upon geographic and demographic sub-populations most in need of services. As stated above, ZIMPHIA and ZDHS results were incorporated into a re-run of the UNAIDS SPECTRUM model in January 2017. Results from this model (which provided revised district-level PLHIV estimates), together with MOHCC program data for ART coverage from September 2016, formed the basis for the COP 2017 the target setting process. ZIMPHIA, as described elsewhere, revealed significant progress towards the 90-90-90 goals overall, though certain sub-populations (e.g. AGYW and men <30) continue to experience significant gaps in HIV diagnosis and ART coverage. In response to these new data points, COP 2017 planning aims to achieve saturation coverage (or higher) among these sub-populations, going above and beyond saturation at the district level in PEPFAR priority SNUs.

All PEPFAR priority SNUs are anticipated to reach saturation coverage by the end of COP 2017. COP 2017 planning, therefore, only includes one SNU designation: Scale-Up to Saturation. In addition, four SNUs have been added to the original 36 designated in COP 2015 resulting in a total of 40 scale-up SNUs that will reach saturation coverage by the end of COP 2017. The additional four SNUs were selected based upon their peri-urban (neighboring the second-largest city, Bulawayo) location and highly mobile population; many of whom have been decentralized to treatment facilities outside of the city. Central support to the remaining 20 districts continues, in the form of commodity distribution and laboratory system support, but targets have not been set in these SNUs. Among the 40 scale-up districts, 29 will reach overall saturation (80%) coverage by the end of COP 2016. For these, a COP 2017 target of 90% ART coverage has been set among specific sub-populations in need (based upon ZIMPHIA data), namely men (overall) and women aged 15-24, and men and women 25 and older. In the remaining 11 districts, a COP 2017 target of 80% ART coverage has been set for these sub-populations.

In COP 2015 and 2016, within the scale-up SNUs, sites were prioritized for PEPFAR support based upon ART patient volume thresholds; the basis of this assumption was that larger-volume sites accounted for the vast majority of ART patients within these districts. In COP 2015, PEPFAR support was based on a site-volume threshold of >260 patients due to resource constraints. This ensured that PEPFAR support could still be provided to 94% of ART patients in the 36 scale-up SNUs. In COP 2016, with a threshold of >200 patients, 90% of ART patients could still be reached. However, as Zimbabwe's MOHCC continues its policy of decentralization of HIV services in order to improve access for remote and rural populations, the landscape has changed significantly. In many scale-up SNUs, PEPFAR support is only reaching 40-60% of patients, as ART and PMTCT patients are increasingly transferred from larger to smaller facilities closer to their residences. As a result of successful decentralization efforts, PEPFAR Zimbabwe will eliminate the site-prioritization criteria in COP 2017, and all public sector facilities within the 40 scale-up SNUs will receive technical assistance (TA) and/or direct-service delivery (DSD) support as per the specific site needs.

On World AIDS Day 2016, Zimbabwe officially released new treatment guidelines in accordance with the 2015 WHO recommendations, including the elimination of eligibility criteria for ART (Treat All), HIV re-testing prior to ART initiation, and routine viral load monitoring for all ART patients. The Treat All policy is now being rolled out nationwide, and will be in full implementation well before the onset of COP 2017; as such, COP 2017 planning contains no assumptions pertaining to a "pre-ART" population, and both adult and pediatric testing/treatment targets are based upon a projected linkage rate of 90%.

PEPFAR Zimbabwe anticipates that approximately 91.9% of new initiations will come from provider initiated facility and community-based testing (including index testing, HIV self-testing, and identification of HIV/TB patients), 5.4% from the PMTCT program, and 2.7 % from the pediatric population. This distribution reflects the increasing proportion of HIV-positive ANC clients who are already on ART, and increased ART coverage among children as demonstrated by ZIMPHIA. The expected positivity yield for pediatric testing (in outpatient/inpatient departments and expanded immunization settings) is projected at 3%, based upon the adoption of validated screening tools to identify the highest-risk children. Positivity yields for adults will vary depending upon the modality, and the overall testing strategy has been significantly modified in accordance with both survey and programmatic data on populations in particular need, e.g. AGYW and men <30 (see HTC section below). Progress towards the "third 90" will be supported

through facility- and community-based activities on adherence and retention. In addition, PEPFAR Zimbabwe will continue its support of Zimbabwe's national viral load scale-up plan (see sections 4.12 and 4.13 below).

As with COP 2016, facility- and community-testing and treatment targets were costed on a per person reached basis, based upon expenditure analysis (EA) data from COP 2015. Where such data were not yet available (as in new initiatives begun in COP 2016), unit expenditure (UE) assumptions from COP 2016 were maintained. For new activities proposed in COP 2017, estimates were generated from pilot demonstrations and stakeholder consultation.

Table 4.1.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY18) HTS TST	Newly Identified Positive (APR FY18) HTS TST POS	Newly initiated on ART (APR FY 18) *TX_NEW*
Adults			
TB Patients	47,983	**4,319**	**3,887**
Pregnant Women including EID	243,109	**15,402**	**15,250**
VMMC clients	265,056	**2561**	**2,304**
Other Testing Modalities (Incl. Key and Priority Pop)	2,093,244	**268,870**	**241,983**
Total Adults	2,649,392	291,152	263,424
Pediatrics (<15)			
HIV Exposed Infants	***37,324***	**850**	**808**
Other pediatric testing	261,775	**7,853**	**7,068**
Total Pediatrics	***299,099***	***8,703***	***7,876***

Table 4.1.2 VMMC

(1) SNU	FY16 Total	Projected Coverage by End FY16 in 15-29	Projected Coverage by End FY16 in 10-29	Projected FY17 Results (i.e. COP16 Targets)	Projected Coverage by End FY17 in 15-29	Projected Coverage by End FY17 in 10-29	Targets for COP17 by Age band				Total COP17 Target
							10-14 yrs	15-19 yrs	20-24 yrs	25-29 yrs	
National	206,526	31%	32%	310,561	42%	42%	88,103	100,134	78,232	101,486	367,954
PEPFAR Only							74,296	80,068	67,620	84,155	306,139
Beitbridge	4,017	70%	81%	4,152	96%	95%	950	669	789	718	3,126
Bulawayo	10,095	72%	72%	10,215	81%	77%	9,583	0	0	4,062	13,645
Bulilima	2,463	63%	76%	368	74%	79%	596	2,459	0	0	3,055
Chegutu	6,033	20%	26%	11,240	38%	43%	1,930	178	2,096	3,541	7,745
Chipinge	23,88	22%	22%	12,790	42%	40%	2,625	3,961	3,718	3,432	13,736
Chiredzi	5,661	30%	31%	5,040	38%	38%	893	1,104	1,520	1,352	4,869
Chivi	1,385	27%	30%	4,500	40%	42%	0	740	858	1,872	3,470
Gokwe South	4,978	19%	17%	9,445	31%	30%	488	3,811	3,540	4,297	12,136
Goromonzi	2,058	13%	15%	3,500	19%	20%	439	1,720	923	1,279	4,362
Guruve (Incl Mbire)	2,968	11%	13%	15,220	39%	44%	2,344	5,301	5,173	5,008	17,826
Gutu	3,146	21%	21%	6,500	35%	35%	420	648	1,242	1,007	3,316
Gwanda	6,098	33%	45%	5,780	55%	64%	0	3,175	52	1,066	4,293
Gweru	9,535	61%	62%	5,828	75%	72%	3,414	3,610	2,985	2,424	12,433
Harare	22,654	26%	24%	35,846	33%	30%	26,069	14,685	13,412	11,557	65,724
Hurungwe	4,687	16%	17%	5,600	23%	24%	1,242	2,295	1,942	1,685	7,164
Insiza	1,397	33%	40%	2,442	46%	50%	0	414	161	1,163	1,738

Kadoma (incl Mhondoro-Ngezi and Sanyati)	2,022	29%	29%	9,067	41%	39%	1,182	6,633	5,282	6,358	19,455
Kwekwe	2,402	26%	27%	4,688	33%	33%	617	1,582	1,076	1,646	4,921
Lupane	4,439	77%	78%	11,565	123%	122%	1,390	1,809	1,000	1,000	5,199
Makonde	4,776	37%	38%	4,108	47%	45%	541	2,468	2,919	2,151	8,079
Makoni	4,184	21%	25%	9,510	38%	39%	2,669	3,458	3,040	3,728	12,895
Marondera	4,302	35%	37%	3,920	47%	46%	2,154	817	828	1,578	5,377
Masvingo	3,398	37%	36%	5,250	46%	43%	0	2,745	1,410	2,557	6,712
Matobo	6,256	65%	90%	8,797	114%	131%	5,722	1,577	367	0	7,666
Mazowe	3,766	35%	35%	7,930	51%	49%	0	1,975	3,153	5,003	10,131
Mberengwa	9,922	34%	40%	13,930	65%	70%	6,085	5,698	1,215	679	13,677
Mt. Darwin	5,293	41%	36%	7,330	58%	51%	630	1,113	2,830	1,031	5,604
Murewa	2,671	22%	27%	3,920	33%	36%	0	221	218	1,084	1,523
Mutare	3,333	24%	25%	12,512	38%	37%	1,057	2,663	2,429	3,375	9,524
Mwenezi	2,061	31%	36%	3,920	44%	46%	360	404	623	1,823	3,210
Nkayi	5,384	47%	62%	3,920	71%	80%	479	1,000	263	2,274	4,016
Tsholotsho	2,529	42%	56%	3,920	63%	71%	415	107	730	2,665	3,917
Zaka	3,046	17%	18%	9,390	35%	37%	0	1,029	1,825	2,741	5,595

Table 4.1.3 Target Populations for non-ART HIV Prevention Interventions to Facilitate Epidemic Control**

	Population Size Estimate (scale-up SNUs)	Coverage goal (in FY17)	FY18 Target
AGYW 15-24 years (PP_PREV)	243,224	37%	113,024
Female Sex Workers (KP_PREV)	18,378	80%**	14,859
Males 15-29 undergoing VMMC (CIRC)	1,611,637	42%	306,140
MSM (KP_PREV)	3,876	49%	2,907

**Note: FY18 target for AGYW is PP_PREV in DREAMS districts and is an estimate derived from a subset of services most likely to represent unique individuals. FY17 coverage goal for FSW is 80% of 13,500, the size estimate used in COP16.Rough size estimate of MSM population in 5 focus location is 0.2%; protocol for size estimation study is under review. For VMMC, expected coverage for FY17 is adopted from the latest DMPPT2 estimates and may be adjusted following a full country application in COP17. However, it reflects a higher coverage than expected (31% in COP16 SDS).

Table 4.1.4 Targets for OVC and Linkages to HIV Services *(excluding DREAMS targets)*

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY18Target) OVC_SERV
Buhera	25,588	20,254
Bulawayo	65,334	16,000
Chegutu	28,184	14,360
Chipinge	32,413	23,176
Goromonzi	30,499	24,431
Guruve	20,642	6,489
Gutu	20,308	16,967
Gweru	24,967	9,000
Harare	217,981	59,489
Insiza	10,033	8,000
Kadoma	30,971	9,500
Lupane	12,400	8,000
Makonde	38,147	25,728
Makoni	30265.6	24,967
Matobo	9394	6,000
Mazowe	24399.9	5,160
Mutare	44974.5	32,926

Mutasa	16874.7	13,752
Nkayi	10913.5	6,000
Zvimba	26302	13,301
Total	720,591	343,500

Program Area Summaries 4.2-4.10

4.2 Priority Population Prevention

HIV prevention among adolescents and young adults under 30 is a priority in COP 2017. HIV prevention is an integral component of the PEPFAR Zimbabwe program and a comprehensive package of activities is integrated into VMMC, HTS, PMTCT and ART services. The prevention package includes targeted risk assessment and provision of risk reduction information, condom promotion and distribution, skills training, referral to or provision of HTS, and referral for PrEP for specific sub-populations. Targeted priority populations include AGYW 15-24, who are 3.6 times likely to be living with HIV than their male counterparts (9.8% as compared to 2.7%, ZDHS, 2015) men under the age of 30, with a focus of linking this group to HTS and VMMC (see respective SDS sections),), Key Populations (KP) and sero-discordant couples. Prevention activities include the continuation of DREAMS in six districts, male and female condom procurement, distribution and promotion, and comprehensive services for KPs in five urban locations. PEPFAR will expand PrEP services to the remaining two DREAMS districts, Mazowe and Makoni, using a public sector model utilizing such entry points as family planning and STI clinics.

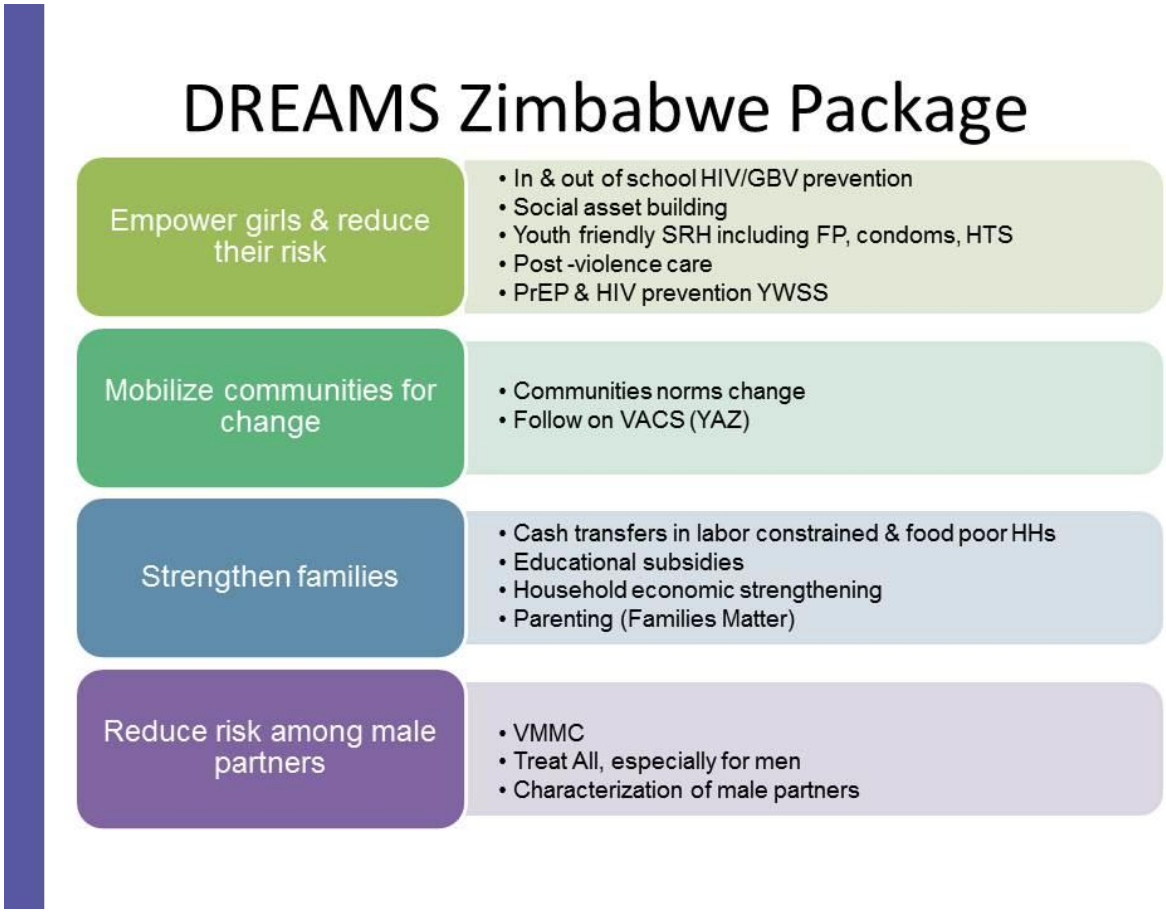
A gender analysis undertaken in COP 2016 documented several issues that influence HIV prevention. These include low utilization of HIV services among men, high prevalence of GBV, numerous gender, cultural (and religious) practices and norms that fuel HIV transmission and/or treatment avoidance, and persistent stigma towards KPs in the healthcare setting. Findings are being used to design new, as well as, to fine tune existing activities including male and adolescent friendly services; GBV screening, counselling and referrals in ART services; availability of male lay/peer cadres for counselling; psychosocial support for groups that have particular challenges with lifelong ART (children & adolescents, GBV survivors, individuals from conservative religious groups); and rights based training that promotes accepting and positive attitudes towards adolescents, SWs, and MSM. Partners will work closely with traditional, community and religious leaders who have significant influence in changing harmful gender and social norms and promoting positive health seeking behaviors.

In consultation with civil society organizations, PEPFAR will include people living with disabilities and HIV as a priority population. While formal size estimations are not yet available, a 2011 baseline report "Exploring Health Equity and Experiences of People with Disabilities in Regards to HIV and AIDS in Zimbabwe," highlights poor health seeking behaviors among people with disabilities due to accessibility challenges, stigma and discrimination, and confidentiality. PEPFAR will also follow-up with the MOHCC to understand policies and procedures and advocate for practices that create a friendlier environment for people living with HIV and disabilities. PEPFAR partners have previously assisted in identifying facilities in need of ramps for example for wheelchair access and will work with

communities through outreach to link people with disabilities to HIV services. As part of the DREAMS Innovation Challenge, a local organization (Nzeve) is providing HIV prevention services including referrals HTC, family planning and treatment at a local school for deaf girls. OVC partners collaborate with local NGOs with expertise on disability to actively identify disabled children and provide or link them to relevant services. PEPFAR will also explore opportunities to allocate resources through mechanisms such as the Self-Help grant program to reach individuals living with HIV and disabilities.

4.2.1 DREAMS

DREAMS will continue to be PEPFAR's core HIV prevention program in Zimbabwe, operating in six of the 36 PEPFAR scale up districts (Bulawayo, Chipinge, Gweru, Makoni, Mazowe and Mutare) with the goal of achieving saturation, or substantially increasing the coverage of high impact interventions.[15] Zimbabwe is implementing the full DREAMS package as described in the figure below.



[15] Note: The DREAMS budget in COP 2017 is between half of the original two year DREAMS budget/targets.

The main implementation challenge in the first year of DREAMS was the lengthy process of household targeting and verification for the cash transfer component. Since the parenting/caregiver, educational subsidies and combination socioeconomic approaches were layered onto these households, the late start of the cash transfers had a significant impact. Catch up strategies are currently underway including targeting wards with high volumes of cash transfer beneficiaries, developing weekly targets and plans by ward, increasing frequency of district coordination meetings to twice monthly, and training additional community facilitators.

There are assessment procedures at each DREAMS entry point that enable the identification of specific vulnerabilities and guide referrals to other service providers. The Young Sisters program is effectively identifying young women selling or trading sex and health/HIV/GBV services are offered through this entry point; they are then assessed and referred for other components of the DREAMS package. The most economically disadvantaged AGYW are identified and enrolled in DREAMS through the national cash transfer program, which conducts comprehensive poverty assessments in all district households prior to enrollment. OVC partners, who work closely with Department of Social Welfare, conduct secondary assessments and validation of the cash transfer households. The health service delivery entry points (HTS, family planning) do not currently have systems in place for offering socioeconomic assessment or needs identification outside of HIV/SRH, meaning the program may be missing AGYW who have other non-health risks and vulnerabilities. This is a gap that is being addressed in FY 2017 through the development of standardized criteria, SOPs and schematics for identification, assessment and channeling of AGYW into different DREAMS services. In addition, a DHIS-2 database that uses unique identifier codes to track individuals, layered services and referrals is being rolled out.

There were no major performance issues in DREAMS that would necessitate shifting approaches or partners. New community partners may be brought on to support specific interventions or expansion within the core districts. Based on site monitoring visits, all DREAMS services are in demand and proving valuable, a finding that is supported by target achievment. Directional shifts were made as a result of program performance and lessons learned during the first year of DREAMS. Key areas of emphasis and milestones are to:

- Continue/expand in-school HIV/GBV prevention and social asset building activities, adding additional schools to reach 85-100% coverage in all districts.
- Maintain interventions for out-of-school adolescent girls to provide for additional girls identified, and higher than anticipated school dropout rates.
- Triple investments in educational subsidies to cover 10% of 15-19 year olds (when comparing the current annual DREAMS budget to the COP 2017 funding allocation).
- Expand interventions to assist girls who have dropped out of school but are able to return, while scaling up mentoring for work readiness for those unable, doubling the annual targets in the first two years of DREAMS.
- Reach 65-77% coverage of young women age 20-24 with HIV/GBV prevention and social asset building activities.
- Double current annual PrEP targets for AGYW and expand PrEP provision to two additional districts by piloting a public sector model.
- Increase by four fold current annual prevention for KPs (KP_PREV) targets for interventions for young women selling sex.
- Adapt the program to place emphasis on teen pregnancy prevention. Annual family planning targets will increase by 25% through continued leveraging of the USAID family planning program.

- Reinstate COP funding for condom social marketing.
- Maintain households enrolled in the National Harmonized Social Cash Transfer program and develop transition strategy for COP 2018.
- Fill remaining gaps to achieve 85% coverage of economic strengthening and parenting education among cash transfer households.
- Ensure coverage of norms change, community mobilization and male engagement activities, in wards of existing districts not yet covered.

Activities that reduce the risk of HIV acquisition among male sexual partners and onward transmission of HIV to adolescent girls and young women will continue to be fundamental in DREAMS districts. The DREAMS core package includes community norms change activities targeting community leaders. . . Male mobilizers are used to engage and sensitize political, traditional and religious leaders in their communities on improved health seeking behavior and to form Men and Boys Clubs which discuss issues relating to sexuality, gender and masculinity, sexual and reproductive health, violence and positive parenting. Male mobilizers coordinate Men's Wellness Days which include community dialogues and mobilization, health information and delivery of HTS, VMMC and STI screening services (through the MOHCC and relevant implementing partner). In COP 2017 male mobilizers will be formally linked to Clinic Based Referral Facilitators as a strategy to increase uptake of HTS and strengthen linkages to treatment.

It is anticipated that one DREAMS district (Bulawayo) will reach 80% VMMC coverage among the 15-29 year group at the end of FY 2017, and an additional three (Gweru, Mazowe, Chipinge) by the end of FY 2018. In addition, PEPFAR will continue to reach young men in secondary schools who participate, per MOPSE guidance, in the general assembly and teacher-led classroom CSE sessions in DREAMS districts.

PEPFAR will use a number of data sources to refine and better target prevention and treatment services to male sexual partners. DREAMS funded a follow on VAC survey, locally known as YAZ (Young Adult Survey of Zimbabwe), and findings are expected in the fourth quarter of FY 2017. PEPFAR also supported a study to identify the sexual networks, sexual partners and behaviors of HIV positive adolescent girls and young women. Further analysis of the ZIMPHIA and ZDHS will be undertaken to shed light on the demographic characteristics of male sexual partners, the type of partnerships/relationships, and venues where adolescent girls report meeting these males.

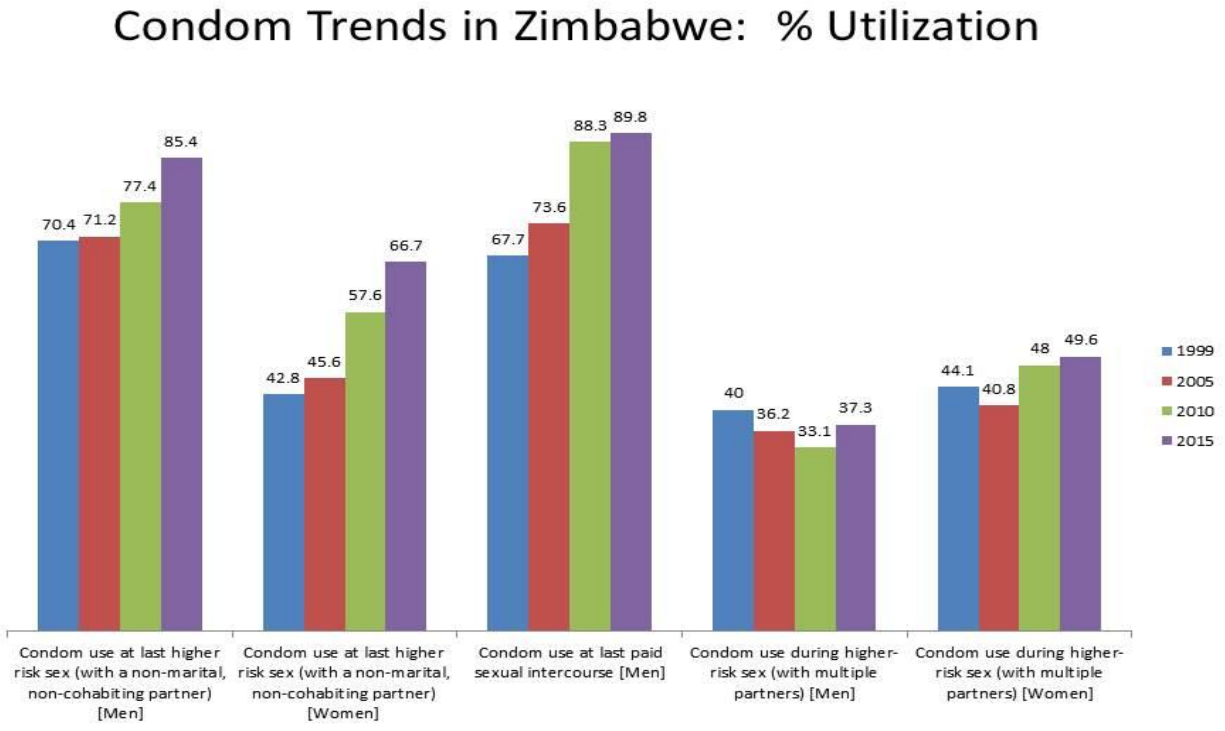
DREAMS approaches and activities will be integrated in the PEPFAR program at large in COP 2017. The evidence-based Families Matter parenting education model, and social asset building, will be staples of the OVC program in all districts. The OVC program will also extend ECD activities to the DREAMS districts to address the needs of teen moms in the program. PrEP, a model of HIV prevention targeting young women selling sex (YWSS), and HIVST were all new activities piloted under first years of DREAMS that will be scaled up in COP 2017. Male engagement is also a central theme of ongoing community dialogues led by NAC, and involving PEPFAR partners and CBOs/FBOs at the district and ward level.

DREAMS is coordinated by the NAC structure, including at the national, provincial and district levels, to ensure broad participation by the different sectors, service providers and stakeholders. PEPFAR supports DREAMS Coordinators at the central levels of the MOHCC and NAC who are responsible for day-to-day coordination of DREAMS. At the time of writing, an expansion of DREAMS to four additional districts (Chimanimani, Mguza, Kwekwe, Umzingwane) was approved by the CCM for

inclusion in the Global Fund concept note. These districts were selected based on a hotspot analysis and extensive consultation with stakeholders.

4.2.2 Condoms

Condoms are a crucial prevention intervention and Zimbabwe's condom program is recognized as one of the most successful globally. UNAIDS modeling estimates that 17 million HIV and STI infections will be averted between 2015-2030 as a result of condom use if targets are met. Condom use has increased steadily over time: condom use at last higher risk sex among men with a non-marital, non-cohabitating partner increased from 77.4% in 2010 to 85.4% in 2015; and among women from 57.6% to 66.7%. Men's use of condoms at last paid sexual intercourse rose from 88.3% in 2010 to 89.8% in 2015. These are among the highest condom use rates in the region; however condom use with non-marital partners remains low for men and women, at 37.3% and 49.6% respectively (ZDHS, 2015).



Condom share is divided in Zimbabwe as 77% from the public sector, 22% social marketing and 0.02% commercial sector. Social marketing programs have been shown to contribute to substantial increase in condom demand and use among young people of both sexes. The USG has a long history of investing in condom social marketing in Zimbabwe and USAID supplied 98% of the country's condoms in 2015.

In COP 2017, PEPFAR will continue to procure male and female condoms, as well as lubricants, through USAID's central commodity fund. Centrally procured condoms will be distributed to health facilities through the PEPFAR-supported national commodity distribution system, for free distribution at 1) health facilities, 2) for targeted distribution to key/priority populations, 3) in hot spots supported by implementing partners, and 4) through community-based DREAMS activities. Condom promotion and distribution will continue to be integrated in HTS, ART, PMTCT and VMMC clinical services, through a wide array of distribution points linked to community activities targeting priority populations, and through KP peer networks and KP-focused clinical services. Priority populations targeted with condom distribution include adolescents and youth under 25 years, men age 25-35 with multiple and younger partners, KPs and clients of SWs.

In COP 2016 the social marketing funding was eliminated from the country budget due to funding constraints. However, USAID secured funding from a centrally managed award to continue support for the male condom social marketing program in FY2017. This funding comes in the form of a study that seeks to understand the impact of social marketing on condom uptake, which will be important for securing funding going forward. The research is also supporting the program to move towards sustainability defined as reducing costs, by adjusting distribution and sales strategies, and increasing cost recovery (increasing price and reducing margins to traders) so that the program can meet its basic packaging, warehousing, distribution costs. Once the program's basic costs are sustainable, additional funding can be used for demand creation and marketing, which are important for attracting new users. Consumer willingness to pay surveys are used regularly to ensure the condom is priced affordably for the marget segment—high enough to promote cost recovery while being affordable, but not too low as to erode the brand. The study also includes activities to make the public sector condom more attractive to other segments of the population, serving as an alternative for previous Protector Plus users.

Recent UNAIDS modeling suggests a small, but growing gap in condom commodities, as well as a significant gap in the investment in condom social marketing. In COP 2017 PEPFAR will continue to supply male and female condoms and the amount can be increased to meet the projected gap. In addition PEPFAR will allocate $500,000 for condom social marketing with the aim of applying a total market lens to inform the development of a sustainable condom strategy, reducing dependence of the condom market on donor funding and ensuring lasting impact of USG investments in Zimbabwe's condom program. Specifically, PEPFAR will design and implement evidence-based condom promotion activities focused on demand generation for the sustained use of condoms and addressing the condom use gap among adolescents and young adults. COP 2017 funding will enable the distribution of 15 million condoms and provide space for the social marketing program to reinforce the work started in FY 2017, and a longer timeframe for the program to move towards cost recovery and sustainability.

4.2.3 Oral Pre-Exposure Prophylaxis (PrEP)

Oral anti-retroviral-based PrEP is now considered an important part of the prevention toolkit. The provision of PrEP for populations at substantial risk was included in the MOHCC updated National ART Guidelines. This policy change moves PrEP out of the pilot realm and into routine service delivery. With technical contributions from the headquarter operational plan (HOP)-funded OPTIONS program, a number readiness activities were completed in FY 2016, and several more are currently underway.

***Completed*:** A value chain situation analysis, formation of a National PrEP TWG with KP and CSO representation, development of Oral PrEP National Guidelines and a PrEP Fact Sheet for providers, gap analysis of providers, review and documentation of PrEP M&E indicators and frameworks.

Underway/Planned: Landscaping of oral PrEP trials and implementation projects, oral PrEP modeling, roll out and costing scenarios, development of provider training and supervision materials.

Under DREAMS, PrEP is being offered to young women age 18-24 selling or engaged in transactional sex in four sites in four DREAMS districts. With leveraged funding, PrEP is also being provided to women 25+ and MSM. Demand among the DREAMS cohort has been relatively low as compared to demand among women 25+, which speaks to the need for active demand creation targeting younger women. Between August 2016 and January 2017, 167 women age 18-24 started PrEP (against a two year DREAMS target of 1451), as compared to 434 other enrollees (women 25+ and MSM).

In COP 2017 the priority target populations for PrEP will be AGYW 16-24 at substantial risk, FSW, other females at substantial risk age 25+, sero-discordant couples and MSM. PrEP will be offered to HIV- FSW and MSM at New Start Centres (Harare, Bulawayo, Gweru, Masvingo, Mutare) as part of a comprehensive package of KP services. PrEP will continue to be offered to young women selling sex and other AGYW at substantial risk in the four current DREAMS sites (Bulawayo, Chipinge, Gweru, Mutare). In addition, PEPFAR will expand PrEP services to the remaining two DREAMS districts (Makoni and Mazowe) using a public sector model utilizing such entry points as family planning and STI clinics. Beyond increasing access by a wider segment of the population, introduction of PrEP in the public sector will counter the assumption that PrEP is only for FSWs. A half day curriculum is currently being added to the HIV In-Service Training manual for health workers and training and monitoring materials will be developed in the latter part of FY 2017. In COP 2017 PEPFAR will alsooffer PrEP to discordant couples and other females at substantial risk in sites where PrEP is available. A summary of PrEP targets in COP 2017 follows.

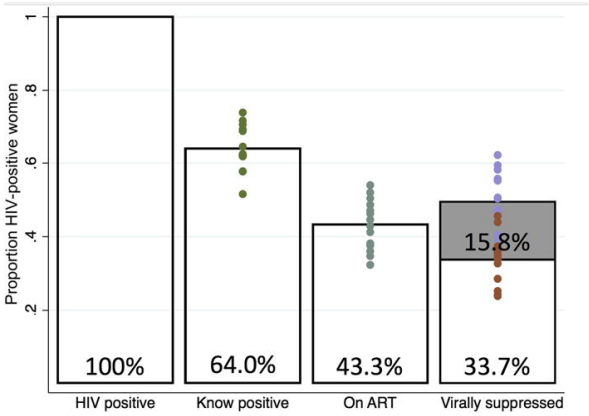
Population Type	Total
AGYW 16-24 years, including young women transacting sex	1,458
FSW	708
Other females at substantial risk 25+ years	250
Gen pop males (discordant couples)	145
MSM	467
Total	**3,029**

Given the high incidence rate among AGYW, a concerted effort will be made in COP 2017 to address demand, recruitment and retention for PrEP among AGYW. Two implementation science studies under the OPTIONS project are expected to help in this regard: "Retention Strategies for Recruiting AGYW" and "PrEP Delivery for AGYW." To date, demand creation has been mostly limited to FSWs and young women selling sex. Going forward, community-based demand creation through the broader DREAMS platform will be intensified. In COP 2017 linkages with private sector pharmacies, which are already distributing 12,000 emergency contraceptive packs per month, will be explored. A broader 'what is PrEP' communication strategy, including integration of PrEP demand creation into

existing community engagement platforms, will be implemented to increase awareness among the general public, as well as reduce stigma of the populations that will initially be targeted for PrEP.

4.2.4 Key Populations

Zimbabwe lacks reliable size estimates of FSW and MSM populations. A size estimation and retention/clinical cascade of care study is currently underway for FSWs with results expected in June 2017. The protocol for the MSM size estimation has been approved by the MOHCC and the Medical Research Council of Zimbabwe (MCRZ) and the research team is responding to comments. There is a strong desire on the part of the MOHCC and research team to complete the size estimation in 2017 prior to election activities in 2018.. According to estimates from previous respondent driven surveys the estimated number of FSWs nationally is between 40,000-80,000. The current estimate for HIV prevalence among FSWs is 57.5%, derived from a 2013 baseline survey of 2,722 FSWs in 14 sites participating in the SAPPH-IRe trial. The chart below shows HIV care cascade data from the same baseline. In FY 2016, HIV positivity among FSWs testing in the program was 20%, and 41-43% among non-self-identifying FSWs.



HIV prevalence among MSM is estimated at 23.5% based on 2013 unpublished research by Biomedical Research Training Institute in collaboration with GALZ and NAC.

In COP 2016 a strategic decision was made to consolidate funding and make major shifts towards a more comprehensive and focused approach for KP. Through expanded support of the national FSW program (Sisters with a Voice), and collaboration with community-based FSW networks, PEPFAR is identifying new targets and strengthening the clinical cascade among FSW in 5 urban locations with high numbers of FSWs: Harare, Bulawayo, Gweru, Mutare and Masvingo. This new strategy is employing proven approaches for reaching, testing and immediately initiating of ART for HIV+ FSWs. This includes using a family-centered approach, and providing HIV services to the children of FSWs. A variety of entry points (FSW networks and support groups, bars, beerhalls, hair salons) are utilized in an effort to reach both self-identifying and 'hidden' FSWs who have had no or limited exposure to HIV services. In FY 2016 over 40% of women who reported transactional sex, but did not identify as a FSW, tested positive for HIV. Identification, linkages between community and facility services, and follow up of FSWs has been challenging in the past, and is now being strengthened through the use of unique identifier codes and screening tools. The development of microplanning tools is underway in the Sisters program and definitions (to guide reporting) for 'contact' and 'reach' have been developed according to the intensity of interaction, follow up and monitoring provided to different individuals.

Distribution of HIVST kits through Sisters clinics has commenced with high acceptability, and the approach is being expanded in the community through the hair salon network. All HIV+ individuals are enrolled at public sector facilities or New Start KP treatment sites that offer a one-stop shop for health care (HTS, STI, FP, cervical cancer, post GBV care, ART, TB, and lab) and provided with viral load monitoring at 6 and 12 months. As of Q1 FY 2017, 550 new FSWs were initiated onto treatment (17% of the annual target). An additional 164 women engaging in transactional sex were also initiated on ART. Continuous adherence and retention support is offered through the Sisters peer adherence support groups, which integrate both PrEP and ART. ART Review attendance is above 95% and retention at 12 months is 90%. Delivered through a peer education (PE) approach, HIV prevention (male/female condom and lubricant distribution, risk reduction counseling and referral for HIV/STI/SRH clinical services), are core components of the strategy. PrEP is now offered at three of the five sites through DREAMS (women 18-24) and leveraged funding (women 25+ and MSM).

Program and survey data (Sisters with a Voice/ Centre for Sexual Health, HIV and AIDS research (CeSHHAR)) suggest that 25-40% of FSW are less than 23, with the median age of those starting sex work, and more than a quarter starting before, age 20. Young FSWs report the highest numbers of unprotected sex acts with clients. They report more frequent HIV testing but they are the least likely to know they are HIV+. HIV prevalence among young sex workers is approximately 30%, rising to nearly 80% among those over 40; prevalence rises with duration in sex work among young FSWs. Building on the work underway in DREAMS districts, efforts are now underway to identify new and younger FSWs through an adaptation of the Sisters peer educator program specifically designed for this very hard to reach population. This effort will continue in COP 2017, with the expansion of the Young Sisters program to all KP sites.

In COP 2016 PEPFAR formed partnerships with the organizations Gays and Lesbians of Zimbabwe (GALZ) and the Sexual Rights Center (SRC), with the aim of increasing their ownership and management of activities targeting their constituencies. SRC is currently receiving a sub-grant, whereas GALZ, due to the status of the organization's registration, is in a direct contracting arrangement for personnel and services with the prime (PSI). In the five KP locations, the program is identifying and training PEs to conduct interpersonal communication (IPC) sessions on risk assessment and reduction, condom use and referral into HTS and other high impact clinical services. Condoms and water-based lubricant (procured through central commodity fund) are distributed. The use of social networking platforms, including WhatsApp and Facebook, will be explored to increase access to HIV information and services. The program is providing HTS, ART, STI management and viral load monitoring at 6 and 12 months for MSM at New Start Centers. MSM are expressing high demand for PrEP and the program has begun to offer it with leveraged funds in three sites. HTS is also offered through outreach at GALZ and other convenient locations/times including evenings and through smaller MSM groups. MSM on ART are encouraged to disclose their status and have treatment buddies for adherence support. MSM groups are being supported to establish community adherence activities.

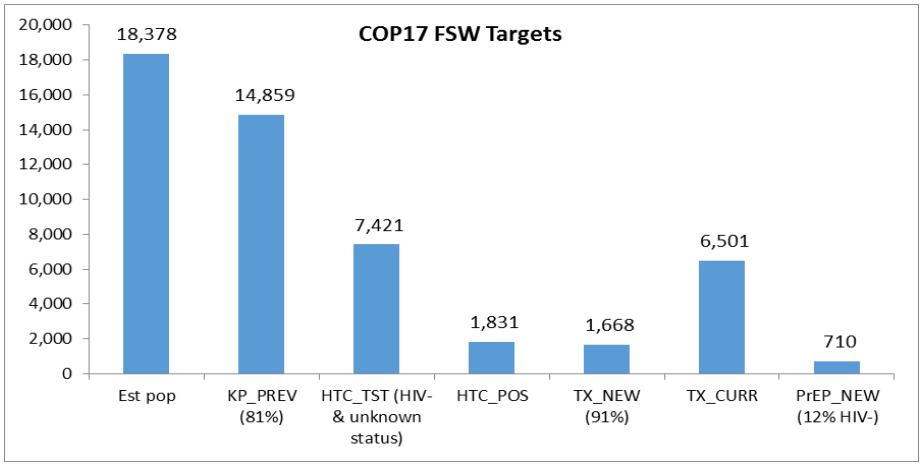
While enrollment has increased when compared to FY 2016, as of Q1 FY 2017 only 8% of the annual target for TX_NEW among MSM had been met. Acceleration strategies for achievement of the TX_NEW target for MSM already underway include identifying and working with smaller organizations and networks; creating safe spaces; bringing prevention and HTS services to where MSM congregate such as homes, night clubs, colleges (based on mapping); and strengthening the relationship between MSM PEs and New Start Centers so that prevention and treatment services are

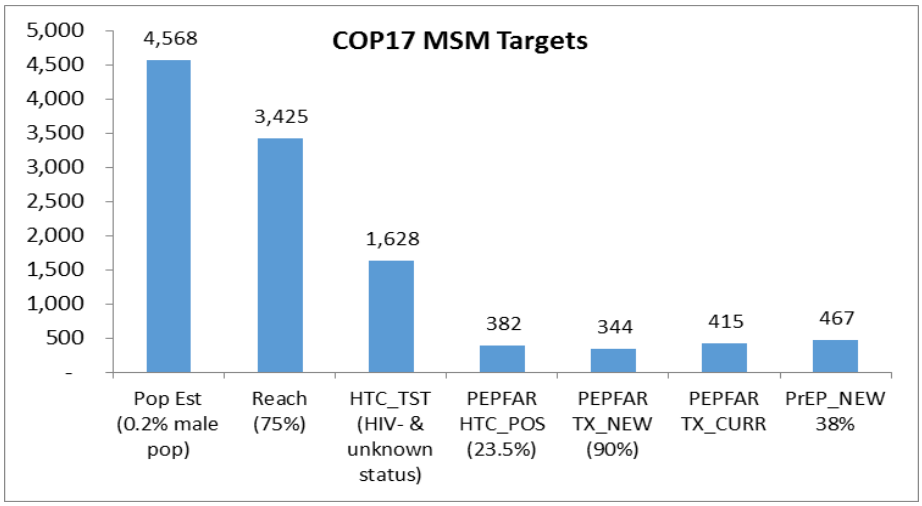
jointly planned and seamlessly linked with bi-directional referrals. Project management is now decentralized to the district level and involves KP groups, NAC and New Start Centre providers, with plans to engage City Health Councils.

An UIC system (using the same configuration as DREAMS) is being utilized in order to track individuals through the continuum of HIV prevention and treatment services. Use of a UIC is beneficial because the same individual can easily be tracked through different service entry points, allowing for a cohort analysis at the level of program monitoring. It allows for greater data security as personally identifiable information is not stored in the program database. Data is captured in real time in a DHIS-2 based platform which allows for weekly monitoring; on a monthly basis district level analytic reviews are carried out with all partners. While the system is showing promise there has been some reluctance on the part of KP to share certain personal information required to generate the UIC; in addition not all locations where KP are reached are conducive to using tablets or even paper data collection tools. As a result the UIC analysis of program data does not yet provide a full picture or the KP cohorts receiving services in the program and data cannot yet be aggregated to provide, for example, size estimates. The program will continue to refine the UIC system in order to facilitate monitoring and tracking of individuals through the continuum, while being sensitive to the concerns of KP around identification and confidentiality.

In COP 2017 the following enhancements and directional shifts will be made to the current KP program:

- Continue COP 2016 strategy of comprehensive KP programming in 5 existing urban locations to achieve 81% coverage of an estimated 18,378 FSW. In COP 2017 the FSW size estimate was revised upwards to factor in growth projections since the 2012 census. The prevalence of SW in Harare and Bulawayo is estimated at 2.5%, as compared to 2% in the three other sites. The reach target for MSM is 3,876, or 75% of the estimated number of MSM (based on .2% of adult male population).
- Invest in and strengthen a broader base of local KP CBO/CSOs to expand networks, including unreached LGBTI populations, and support the identification and creation of safe spaces, particularly for MSM.
- Expand the microplanning approach for delivering a prevention minimum package and to support adherence and retention for those on ART or PrEP.
- Continue the use of multiple approaches to HTS including at fixed sites (New Start Centers, Sisters clinics, public sector), moonlight testing at bars and shebeens where high risk groups congregate, and outreach to safe spaces to reach smaller, more hidden networks. In addition increase uptake of HTS through HIVST delivered via FSW and MSM peer networks.
- Offer PrEP for all HIV- KPs.
- Strengthen linkages between KP sites and the OVC platform to address the needs of children of KP, who are often marginalized and highly vulnerable.
- Integrate KP services into selected, safe public health facilities in the existing five locations, including the development of new tools to ensure confidentiality and minimize stigma, while ensuring services specific to KP can be monitored (i.e. Routine STI testing)





In COP 2017 PEPFAR will continue to roll out differentiated models of care for KPs. This includes continuing to offer the full gamut of prevention and treatment services through static and outreach DSD approaches, developing mechanisms of transitioning KPs into community care, and transitioning stable clients to 'KP competent' public sector facilities. Having different approaches is fundamental because meeting KP where they are and with whom they trust is a cornerstone to engaging and keeping them in care. The types of services, frequency and location will also vary between FSW, MSM and LGBTI groups.

Findings from the SAPPH-IRe trial suggest that it is feasible to achieve viral suppression among FSWs on ART in the public sector when coupled with provision of a standard FSW support package (i.e. Sisters), and that parallel ART outreach services outside the public sector may be unnecessary. In COP 2017 PEPFAR, in consultation with KP groups, will build on previous investments (e.g. Corridors of Hope) and existing infrastructure to design and implement a model to expand KP competent services in the public sector, while ensuring linked and complementary KP community support is available. Utilizing existing PEPFAR funded KP sites and Sisters clinics as centers of excellence, PEPFAR will support such approaches as as clinical attachments, training in values exploration, gender sensitivity and stigma reduction, placement of patient navigators, mentoring and quality improvement strategies that involve formal involvement of local KP groups. Public sector integration will take place in a phased approach beginning with one public facility in each of the current five KP locations, then

expanding to facilities in border areas and along key transportation corridors. PEPFAR will second a KP Coordinator to support the MOHCC to spearhead the 'KP competent facility' agenda (there is no MOHCC KP position at present). Standards for competency will be developed and facilities will be assessed with KP representatives so that targeted facilities are more likely to be promoted and utilized by KPs. PEPFAR has set an ambitious target of 30% of stable and virally suppressed KPs on ART at the current DSD KP sites totransition to KP competent public sector sites in COP 2017. Development of patient transition plans, peer navigation and active follow up—the approaches currently being used in a PEPFAR-supported community ART initiation program—will be employed to ensure minimal loss of those transitioning.

It is important to note that the legal and social environment towards KP, especially MSM, is not favorable and with elections in 2018 there are added risks that need to be carefully considered across the program. Districts and specific facilities where the integration will occur need to be assessed to ensure the environment is as conducive as possible. The current KP sites will continue to be supported as long as there is a demonstrable need. Clients who are uncomfortable with the transition to public sector health services will not be forced, and care will be taken not to expose KP to unnecessary risks to their health and security. Once findings from an ongoing Legal Envirnomental Analysis (funded through UNDP and conducted by the University of Zimbabwe) are finalized (expected late summer) the PEPFAR team will review the findings to determine what additional strategies need to be developed to reach Key Populations and ensure that MSM in particular are able to access HIV services. We recognize that the targets for KP_PREV among MSM, included in COP 2017, are insufficient due to limited resources. We will review this target during the Quarter 4 POART and consider revising it upwards based on performance and availability of any savings or pipeline that may accrue for 2017.

4.3 Voluntary medical male circumcision (VMMC)

VMMC is a highly impactful biomedical prevention method. Among the 15 VMMC priority countries, Zimbabwe has the potential to avert the highest proportion of new HIV infections with VMMC. Recent modeling suggests that as few as five circumcisions will avert one new HIV infection and circumcising 1.9 million Zimbabwean men aged 15–49 by 2017 will avert between 240,000-310,000 new infections by 2030 (30% of all new HIV infections). Between 2009 and 2015, estimated 4,000-8,000 HIV infections have been averted, which will prevent 75,000 new HIV infections by 2030 (10% of all new infections). Prioritizing Zimbabwean males aged 15–29 will lead to the greatest reduction in HIV incidence in the short-term and inclusion of the 10-14 year age group will provide the greatest magnitude of impact after 15 years.

PEPFAR VMMC support started in 2009 and scaled up in 2013, with additional central funding. As of December 2016, a total of 883,027 circumcisions have been conducted (national target of 1,300,000). The national estimated coverage by the end of FY2017 is 43% (15-29 year olds), an increase from 32% in 2016. PEPFAR, the Bill and Melinda Gates Foundation (BMGF) and the Global Fund are the key stakeholders supporting the national VMMC program in Zimbabwe. PEPFAR support includes VMMC commodities and supplies (through the PSM project), demand creation (community mobilization and interpersonal communication), mass media, technical assistance and communication (IEC) activities (such as IPSOS research). PEPFAR will continue to support services in 35 priority districts while BMGF supports 18 districts previously supported by PEPFAR. There are ongoing collaborative efforts with BMGF and other development partners to ensure that the full GoZ package is supported across all districts. For example, the Global Fund will continue to provide PrePex circumcision commodities for

the national VMMC program and also support service delivery in nine districts, some of which were previously PEPFAR-funded.

Key national policy shifts and considerations in COP 2017 include the adoption of the World Health Organization (WHO) Technical Advisory Group (TAG) recommendations (released in September 2016) on confirmation of protection against tetanus or adequate vaccination against tetanus in all males prior to the application of any VMMC device method where the foreskin is left in situ. Following guidance received from OGAC on November 30, PEPFAR supported MOHCC to adopt the WHO recommendations, ceasing all circumcisions with PrePex until the end of the transition period (to stock up on Tetanus Toxoid Containing Vaccines, TTCV) in March 2017. In addition to providing additional support for two tetanus (TTCV) doses for all males who choose PrePex over the surgical method, PEPFAR will provide support for rapid scale up of surgical circumcision methods across all supported districts and sites, including supervised training of healthcare workers (HCWs), introduction of reusable surgical kits and increased availability of the disposable universal surgical kit (for both dorsal slit and forceps guided surgical procedures). These commodities will be procured for PEPFAR supported districts through the PEPFAR funded PSM project. PrePex commodities procured by GF in FY17 Q1 are estimated to be in excess and will be used in COP17, where needed. There are ongoing discussions with the Global Fund on providing national support for waste management.

National costing assumptions for commodities now reflect the age pivot and decreased proportion of PrePex procedures among men age 15 and above. COP 2017 planning coincided with the national Global Fund Application process and two major tools were used for both processes - the VMMC Decision Makers' Program Planning Toolkit (DMPPT2) and the Site Capacity Utilization Assessment Tool. The Site Capacity Utilization Assessment was completed in December 2016 with PEPFAR national level technical support. The DMPPT2 was used to calculate district level VMMC coverage and estimate the number of circumcisions required to reach at least 80% coverage in males aged 15–29 (for PEPFAR) and 10–29 (national) in each district by 2020. Input into this tool was received from the MOHCC, stakeholders and all supported districts. Together, both tools were used to generate the optimal district capacity, to project the total number of annual circumcisions needed and to set targets for number of circumcisions for each district and priority age band. In COP 2017, a full application of the DMPPT2 will be conducted in Zimbabwe to improve the accuracy of coverage levels and estimates generated from the tool.

Moving towards more efficient ways of delivering VMMC services, in close collaboration with MOHCC and the implementing partners, the VMMC UE will reduce from $122.82 in COP 2016 to $113.25 in COP 2017. Cost savings will be realized from increasing the proportion of surgical circumcisions, introducing reusable surgical kits, streamlining disposable surgical kits to universal and increasing the proportion of circumcisions performed at the lower levels of the health system. This reduced cost has allowed PEPFAR to increase targets (53,293, a 21% increase from COP16) and allocate more resources to actual provision of services and demand creation, in order to improve the VMMC coverage nationally. In addition, the national VMMC program commodity list has been updated and revised with current pricing for kits and other consumables. Cost savings from more efficient commodity distribution systems have been identified. The PEPFAR team will closely monitor partner expenditure to ensure that the reduced UE does not impact the country's ability to reach targets.

The transition to more surgical (85%) than device-mediated (15%) circumcisions at all levels of healthcare will be phased in, starting in the third quarter of FY 2017. Despite a decreased demand for VMMC with PrePex (secondary to the adoption process of the WHO TTCV recommendations limiting

the use of the devices until appropriate structures and systems for effective vaccination with TTCV have been put in Q4 FY17), an upward trend in adoption of surgical VMMC has been observed. Strategic and consolidated efforts to mitigate any disruptions to the VMMC program in COP 2017 are being implemented through COP 2016. These include appropriate messaging (on the benefits of the WHO guidance), described in detail under the demand creation section below, opening up new sites in each district (in high burden low coverage districts with limited capacity currently), capacity utilization and monitoring for new and existing sites, refreshers for service providers on surgical VMMC techniques, increasing 'boots' (IPC and surgical teams) on the ground and phased training of IPC agents in order to avoid disruption in service delivery. Innovative approaches include offering mobile services to congregate settings in urban areas, promotions through social media, and use of mobile technology for geo-fencing (automatic service provider moderated promotional messages), information on demand platforms and TTCV information/ documentation.

There are ongoing discussions between PEPFAR, MOHCC (VMMC program and ZEPI) and other stakeholders (including BMGF and UNICEF) on how to procure, store, distribute and implement TTCV administration for male clients opting for PrePex. When a feasible and implementable national policy is put in place by the MOHCC, PEPFAR will provide some support for the cold chain (cooler boxes and some other ancillary equipment) in PEPFAR supported districts, ensuring that the cold chain is not affected and the potency of the vaccines are maintained. This support includes TTCV administration for device-related circumcisions at static sites and outreaches. Importantly, service delivery modalities may need to be adjusted to accommodate the complexity of implementing the new WHO guidance. The MOHCC is leading these discussions through its VMMC Steering Committee. Limited disruptions to the program from attrition due to TTCV administration for those opting for device-related circumcisions will be achieved through deployment of nurses (as vaccinators) as part of existing demand creation teams so that the vaccine can be administered at first contact, shortening the waiting time to circumcision. Appropriate TTCV messaging will also be in these frontline demand creation services. PrePex will still be used in outreach settings in COP 2017, specifically in those districts and areas where access to an autoclave in an accredited health facility is not possible. In addition, patients who opt for PrePex and provide valid documentation of TTCV vaccination, and/or agree to be vaccinated will be offered PrePex. In FY 2016 the training of new MC providers and re-training of current providers in the dorsal slit method was completed. Circumcisions in boys younger than 15 years will be carried out using the dorsal slit method. PEPFAR funding will not be used to circumcise clients younger than ten years or clients without documented evidence of adequate TTCV coverage.

In COP 2017, a revamped demand creation strategy is being developed and will focus on strengthening interventions targeting the 15-29 year age group. The findings from the IPSOS research funded by BMGF in 2015 will inform implementation approaches in COP 2017. Increased focus will be placed on community mobilization, IPC and evidence generation at local and site levels. In addition, new messages, channels and interventions for IPC will be developed such as conveying honest communication on pain, procedure and healing; converting past clients into champions; and targeting mass media campaigns to mitigate the impact of the tetanus guidelines on the program by promoting appropriate messaging on TTCV prior to VMMC.

Cost reimbursements for VMMC follow PEPFAR's Best Practice for VMMC Site Operations guidance; the reimbursement plan was revised in 2015 to account for type of procedure, location and service delivery approach—resulting in cost savings in COP 2016. In FY17 Q1 and Q2, USAID proactively engaged in discussions with one of our funding partners (a VMMC stakeholder in Zimbabwe) who will

cover the cost reimbursement in USAID districts in the last 2 quarters of FY17 (when DfID funding ceases) and FY18. This will allow PSI to continue services unhindered in all those districts, at the COP17 target levels. Suffice to say that broader national and stakeholder engagement and commitment is required if VMMC services are to be sustained at baseline levels in future, as we approach target coverage levels. An external quality assessment (EQA) in September 2016 shows the Zimbabwe VMMC program to be of high quality. Anecdotal data from SIMS assessments conducted in FY 2017 Q1 and Q2 showed improvements in scores on the Adverse Event and Prevention Management CEE; in particular those sites that scored red for having an incomplete crash cart in FY16 now score green, indicating that partners are making efforts to address observations raised by the assessors, having garnered better understanding of the importance of having a fully stocked crash cart.

In FY 2016, there were 159,127 circumcisions, 83% of the COP15 target (191,720). A total of 89,252 circumcisions (36% of COP16 target of 253,847) were recorded in Q2; most of these, were surgical with a significantly steep weekly increase in results from 338 at the start of Q2 (January) to 6957 at the end of of the quarter (March 31). PrePex circumcisions reduced to 24% in Q1, compared to 33% in FY 2016. Analyses of program data reveals that these reductions are due to the impact of the implementation of the WHO recommendations mandating documented evidence of adequate TTCV coverage prior to VMMC. Our implementing partners have been advised to aggressively expand quality surgical VMMC services in FY17, therefore, further reductions in device-mediated VMMCs expected in FY 2017 Q3 and Q4 will not adversely affect the program beyond what was recorded in Q1 and Q2.

In COP 2017, PEPFAR will further improve on the age pivot, focusing demand creation and service provision on the 15-29 year age group (VMMC priority age group). 53% of all circumcisions (in PEPFAR supported sites) in FY 2016 and FY 2017 were in the 15-29 year age group while 62% and 73% of all circumcisions are targeted for the same age group in COP 2016 and COP 2017 respectively. While emphasis will be on the priority age band, services will not be withheld from any medically eligible male. With COP base funds and additional central funding received in COP 2016, three districts will achieve 80% coverage among the 15-29 year age group, including one DREAMS district (Bulawayo District). In COP 2017, seven more districts (including three DREAMS districts: Gweru, Mazowe and Chipinge) will achieve 80% coverage. Emphasis will be placed on scaling up VMMC services in the remaining PEPFAR supported districts with a goal of achieving 80% coverage in 78% of all PEPFAR supported districts by FY 2019. To achieve this, a target of 306,139 has been set in COP 2017. Accelerating coverage towards saturation in DREAMS districts and achieving at least 75% of targets in the 15-29 year old age group have both been prioritized in the target setting process—an ambitious but feasible proposal, assuming the revamped demand creation strategy is successful.

4.4 Preventing mother-to-child transmission (PMTCT)

Following the roll out of Option B+ in 2014/2015, the national prevention of mother-to-child transmission of HIV (PMTCT) program has performed well. In 2016, the antenatal care (ANC) attendance was 93% (population data) with 98% of all clients receiving HIV testing and results (program data). The coverage of maternal ART seems to be lagging behind at 89% (program data) and 84% (population data). The PMTCT program is currently preparing for “pre-elimination” status, to recognize progress as well as remaining challenges in the elimination of mother to child transmission of HIV (eMTCT) and syphilis. In COP 2017, the PEPFAR program will provide support for the eMTCT agenda in the 40 scale-up SNUs.

First 90
The PEPFAR program will continue to support the national PMTCT program to provide HIV testing to all pregnant women attending ANC. This support will enable 97% of expected ANC clients to receive HIV testing and results. As HIV services are provided within ANC, an emphasis will be made on aspects of respectful maternity care. Additional support will be availed to implement MOHCC guidelines on re-testing within ANC and postnatal care (PNC)[16]. With the adoption of Treat All, PEPFAR partners will continue mentoring sites to make them more accessible and male friendly (e.g. extended opening hours, opening on weekends) to encourage men/couples testing. Moreover, PEPFAR partners will support MOHCC to expand index testing (in facilities and communities) and HIVST (see section 4.5) to improve testing coverage among male partners. PEPFAR will support community systems to find and refer into care women who do not attend ANC.

In COP 2017, PEPFAR will support early infant diagnosis (EID) for 17,500 newborns. While EID is generally available in all facilities, there is a worrying increase in sample rejections as well as delays in results transmission. The PEPFAR Zimbabwe team will support refresher courses and mentorship for sites with the highest sample rejection rates. As the viral load services scale up, EID-dried blood spot testing (DBS) platforms are also expected to decentralize to more laboratories. This will in-turn cut down some of the sample referral challenges as well as results transmission delays. Moreover, PEPFAR's laboratory support and clinical care/treatment partners are working together to prioritize HIV positive EID samples as "critical values," warranting immediate results communication to HCWs at the facility where the sample was drawn.

Second 90
PEPFAR partners will support site level, ANC-specific bottle neck analyses to identify the gaps in ART initiation as well as appropriate interventions. Data for HIV positive pregnant women from the national PMTCT program is showing that the majority are coming in with already known status and already on ART. This trend is expected to continue in COP 2017 where our support will help to identify 14,594 new and 17,907 previously-diagnosed positives. The plan is to initiate 15,250 on ART (i.e 656 more than will be identified)[17]. This number is expected to continue to decrease and in future, will more closely mirrior the number newly identified. All of these women will be supported to initiate and/or remain on ART.

Third 90
Pregnant women will be prioritized for viral load (VL), in line with national guidelines; PEPFAR's clinical partners will therefore ensure a VL is done upon registration for all known HIV positive

[16] The "number of pregnant women tested" refers to the actual number of women we hope to support to get tested not the number of tests. The number of tests to accommodate repeat testing in ANC is taken into account at national quantification time.

[17] Client mobility-though we will expand to cover all sites in a district, we will not be covering all districts. There are women who may seek ART services in a different district than where they were tested. Secondly, though Treat All is now policy, it is possible that some women would have been tested and initiated on ART previously but due to various factors (e.g. LTFU after breastfeeding) would not be on ART when they present with another pregnancy.

pregnant women on ART, and the laboratory partner will ensure that results transmission is prioritized for these samples (as mentioned above regarding EID). Newly diagnosed/initiated pregnant women will receive a viral load after three months of ART. Pregnant women with viremia will receive an intensified package of services including enhanced adherence support, more frequent visits, and repeat VL testing to ensure that they are switched to 2nd line ART in a timely manner should this be necessary. HIV-exposed infants of viremic mothers will be classified as high-risk, receiving an extended regimen of infant prophylaxis (12 weeks of AZT nevaripine (NV)P).

Through the Client Referral Facilitators (CRFs) that have been seconded to the health facilities, the PEPFAR program will strengthen facility-community and community-facility referrals and follow-up systems to ensure women remain in care, particularly after the postnatal period. The CRFs responsibilities include weekly review of appointment diaries/electronic appointment lists and initiate follow up for those who would not have attended. Decentralization and "silent transfers" are particularly salient with regards to PMTCT, as clients frequently deliver in larger facilities, then return to more peripheral sites to continue their HIV care; in this process, they are often "lost" or double-counted in paper registers. With PEPFAR support for electronic health information systems (see section 4.13), tracking of mother-baby dyads will be facilitated across departments within larger facilities, as well as among separate facilities in the case of transfers/decentralization.

4.5 HIV testing and counseling (HTS)

With MOHCC's launch of the revised National Consolidated ART guidelines on World AIDS Day 2016, Zimbabwe's adoption of the Treat All strategy has placed a demand on the PEPFAR team to adjust its HTS strategies to more efficiently and cost effectively identify PLHIV and prepare them for immediate ART initiation, treatment and adherence. As previously mentioned, the availability of revised SPECTRUM estimates incorporating recent population-survey data has provided robust data to inform the COP 2017 planning process. ZIMPHIA results show that among the 15-49 year old age band, HIV incidence is at 0.48%. The country is 16% shy of attaining the first 90 among 15-49 year olds, with 74% of PLHIV with known HIV status.

By the end of COP 2016, 29 of the 40 PEPFAR scale-up districts will reach overall saturation coverage, though gaps remain in certain sub-populations. Accordingly, PEPFAR must expand approaches that have proven effective, along with innovative strategies to reach the remaining individuals without known HIV status (newly infected, hard to reach, walking well, etc.). In addition, PEPFAR must be mindful of the current and expected future investments from all stakeholders, and the unique position of the program to provide direct service delivery and specific technical assistance for HTS. Based on this scenario, PEPFAR investments will:

- Optimize PITC through DSD support: The DSD strategy of adding staff in facilities with human resources shortages which started in COP 2016 will continue to be monitored closely in all scale up districts to increase efficiency in identifying HIV positives across all entry points at health facilities, to include piloting HIV Self Testing in outpatient departments and the use of screening tools to identify children at highest risk at both facility and community levels;
- Continue to support PITC through TA at all health facilities in the 40 priority SNUs, to eliminate "missed opportunities" and render facilities more accessible to partners through flexible hours and communications/demand creation strategies;

- Strengthen Index Case Finding/Partner Testing through DSD and TA, focusing mobile outreach to populations (males and females 15-24 years and males 25 years+, KP) who would otherwise not be reached by other testing modalities;
- Scale up HIVST to all priority SNUs based on results and lessons from the UNITAID STAR project: ideally this will be a cost-effective and attractive testing modality for previously hard-to-reach populations; HIVST will be introduced at selected health facilities, becoming a routine testing option alongside provider facilitated testing for clients presenting at outpatient departments and at standalone VCT sites and integrated into partner testing for existing and new HIV positive clients. HIVST will also be used as a targeted community based strategy for specific hard to reach populations such as Key Populations, young people and men;
- Support CATS to strengthen the identification of adolescents and young people through approaches such as snowballing, partner notification and other forms of index testing beginning with the young people living with HIV in their current cohort.
- Provide community HTS services through strategically located static sites targeting high yielding populations and locations, with an intensified focus on AGYW and their male sex partners, males aged 25+ as well as KPs; and
- Engage community structures in promoting positive health seeking behavior such as uptake of HTS, VMMC, PMTCT and adherence to ART and retention in care;
  Ensure that all HTS includes TB screening and active linkage to treatment for positives, and prevention services (e.g. VMMC, PrEP, etc.) for negatives. In addition, all newly diagnosed will be offered assistance to disclose to partners, and encouraged to facilitate index case testing for sexual partners and children either at facility or community level.

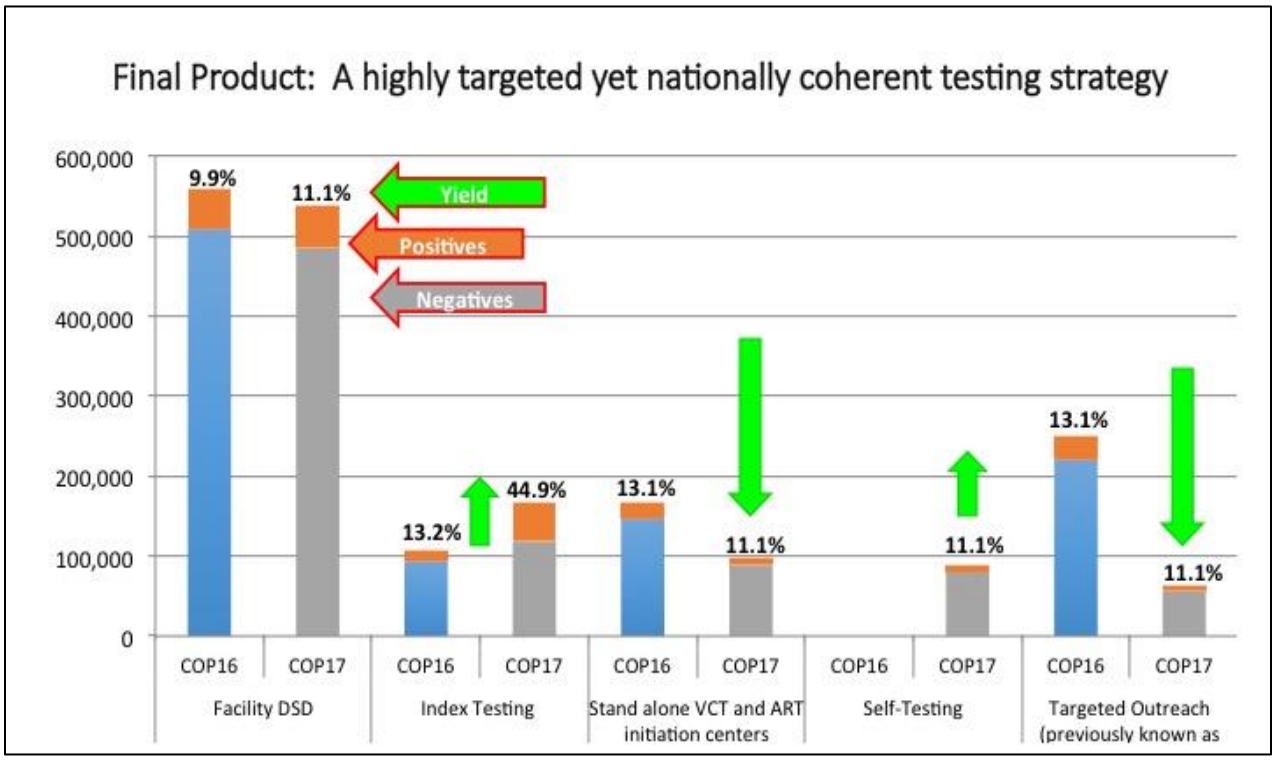
In COP 2017, facility based PITC (both TA and DSD) will continue to be the mainstay for identifying HIV positives across all PEPFAR SNUs. Based on analysis of the cost efficiency per modality as well as which modalities have proven to be most effective in different sub-populations in FY 2016 and FY 2017 Q1 (e.g. AGYW, men <30, etc.), the following modality proportions have been proposed to close the testing gap: PITC (TA, with 1% VMMC) - 51%, PITC (DSD) - 20%, Index Case Testing (both facility and community based) 19%, targeted mobile testing (outreach) - 2%,VCT standalone sites 3% and HIVST-4%. Throughout the remainder of FY 2017, the PEPFAR team will intensify real time data analysis at frequent intervals, to enable nimble course correction where indicated. Program data (including GIS technology) will be regularly analyzed and used to adjust testing modalities, maximize facility entry point testing efficiencies and better target high yielding geographic areas and populations

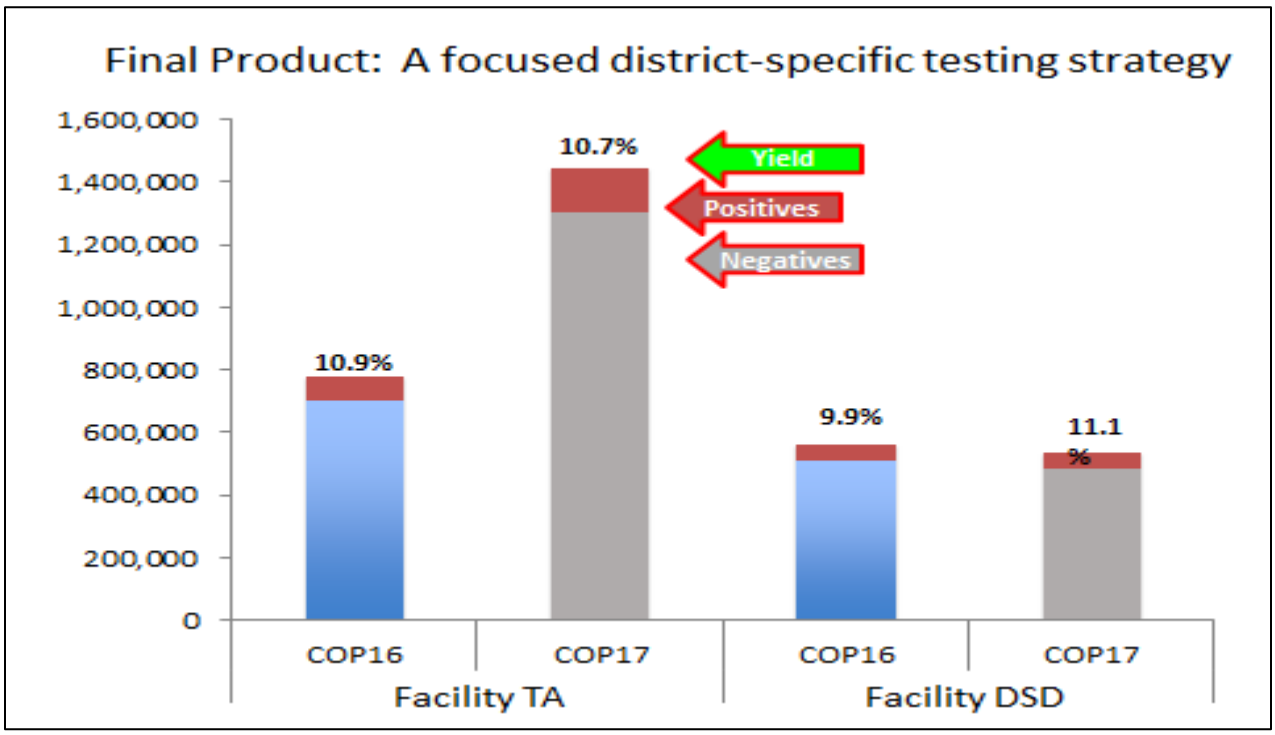
Common issues identified across facilities during SIMS include inconsistencies in rapid test kit (RTK) quality control, insufficient referral and tracking documentation and low linkage rates. All issues are being addressed through remedial action plans and review during repeat visits. PEPFAR's support of a national, standardized community-facility referral tool has helped to strengthen linkage between community and facility-based partners; increased coordination among clinical and OVC partners will also help to ensure that HTS referrals result in service delivery and documentation of outcomes.

In COP 2017 PEPFAR will continue implementation of the comprehensive strategy for KP that was developed in COP 2016. PEPFAR will emphasize the identification of new targets and strengthen the clinical cascade among Sex Workers (primary) and MSM (secondary) in five urban locations with high numbers of SWs. PEPFAR will continue to support the national FSW program, Sisters with a Voice, as well as broaden reach into new networks by expanding partnerships with smaller SW CBOs. MSM will be identified through partnerships with GALZ and the Sexual Rights Center, in addition to, new collaborations with smaller networks, including LGBTI groups, to expand services to these often

hidden populations. HTS will be provided through the Sisters with a Voice SW clinics, New Start Clinics, outreach testing and through peer distribution of HIVST kits. All newly diagnosed KPs will be initiated on ART immediately at New Start centers or the public sector health facilities that have had KP services integrated into their programs, or who have received 'KP friendly service' training as described elsewhere (section 4.8): Significant efforts to improve KP services within the public sector will feature in the COP 2017 strategy. PEPFAR will incorporate a new testing strategy in COP 17 to roll out a community census and multi-disease health fair testing effort, based on the SEARCH trial model, in 4 of the districts with the highest prevalence and lowest treatment coverage levels.

COP 2017 Testing Strategy





4.6 Facility and community-based care and support

Community-based care and support activities are crucial to ensuring adherence to therapy and retention within treatment programs. With Zimbabwe's case load of ART patients approaching 950,000 (program data, Sep. 2016), epidemic control will depend increasingly on ART retention and viral suppression, rather than initiation alone. In order to increase access to and retention in care, the MOHCC has incorporated the concept of differentiated service delivery packages within its Operational Service Delivery Manual (recently revised to reflect the new treatment guidelines). In COP 2017, PEPFAR Zimbabwe will continue to support DSD community-based adherence and retention models using lay cadres, expert patients, and leveraging the presence of existing community cadres such as village health workers (VHWs) and community case care workers (CCWs). Community ART refill groups (CARGs) are also growing in popularity among both patients and providers; as of January 2017, over 5,000 ART patients are participating in CARGS benefiting from this innovation across the country. In COP 2017, PEPFAR support for CARGs will continue to decongest public facilities through reduced appointment frequency for stable ART patients throughout the 40 scale-up SNUs; the aim is for approximately 30% of the ART population in the scale-up SNUs (represented by TX_CURR) to be transitioned to CARGs and/or other community activities interventions to support ART iniation, linkages and retention. New Start facilities will employ a Test, Start, Stabilize and Transfer model with an emphasis on finding and intiating HIV+men and transferring their care to the public sector.

Approximately 72,000 adolescents living with HIV will continue to benefit from the Community Adolescent Treatment Supporters (CATS) model, which employs adolescents with HIV to provide home-based support to their peers and care givers. CATS are assigned to facilities with the goal of one CAT per 80 young people living with HIV, and an even male to female ratio. CATS provide adherence counseling and disclosure support to children and young people living with HIV, and play an active role in defaulter tracing. The CATS program will continue to improve the "adolescent-friendliness" of clinical facilities, through provider sensitization on critical issues including age of consent and Best Interest Determination. Strong anecdotal evidence suggests that adherence and retention among adolescents is significantly undermined by caregiver discomfort with disclosure; the CATS program will therefore bolster caregiver support to improve adherence among ALHIV.

PEPFAR implementing partners carrying out community-based adherence support will also assist facilities with defaulter tracing, and improve the implementation and documentation of community-care referrals. At public facilities, PEPFAR's technical assistance package will continue to include clinical mentoring on provision of cotrimoxazole, STI screening, nutritional counseling, and infant feeding counseling. Mentoring support will include on site sensitization training to ensure equitable access to services for all clients, irrespective of sexual orientation.

The following new activities will be introduced in COP 2017:

- **Mental health support**: As illustrated by studies in the region, depression and anxiety play a significant role in contributing to treatment default, among both adults and adolescents; recent and ongoing studies in Zimbabwe have shown promising results for mental health interventions carried out by lay cadres. Therefore, PEPFAR Zimbabwe's clinical partners will support such low-cost interventions among facility-based lay cadres, targeting both adults and adolescents who may be suffering from undiagnosed and/or untreated mental illness.
- **Treatment literacy**: Patient education is an increasing challenge with recent changes to HIV management including Treat All and VL monitoring. As such, PEFPAR partners will support

patient education initiatives in collaboration with community- and faith-based organizations to combat HIV exclusivity, increase patient awareness, and enhance demand creation for both ART and VL.

4.7: Tuberculosis (TB)/HIV

In accordance with WHO 2013 guidelines, all PLHIV with TB in Zimbabwe have been eligible for ART irrespective of CD4 count. As part of PEPFAR Zimbabwe's core package of services (detailed in Appendix A), continuous sensitization around the guidelines will be provided at all scale-up sites to ensure: 1) all TB patients are tested for HIV and immediately prepared for/initiated on ART if positive and 2) HIV positive patients are screened for TB at every contact with health staff. This sensitization process will also focus on improving communication and coordination between TB and opportunistic infections (OI)/ART departments, to facilitate better monitoring and evaluation. In COP 2017, PEPFAR Zimbabwe is projecting a linkage (to ART initiation) of 100% among newly diagnosed co-infected patients at scale-up facilities, with a 50% positivity rate among TB patients not already known to be co-infected with HIV. DSD support for facility-based HTS activities will also continue to emphasize improved identification and linkage to ART of co-infected patients.

In Zimbabwe, a policy for provision of TB Preventive Therapy (TPT) for PLHIV was adopted in 2013 and recommends use of isoniazid (INH) for six months for all PLHIV (including children 12 months and older, or less than 12 months with a known TB contact) in whom active TB has been excluded. To date, TPT uptake has been sub-optimal as reflected in SIMS visits and stakeholder consultation. Currently, approximately 630 facilities (36 %) across the country are implementing TPT. INH is procured in Zimbabwe through support from the Global Fund. Barriers to scale up include supply chain disruption (stock outs of INH), and the negative media associated with a number of hepatotoxicity cases in 2015-2016; though the underlying cause of these cases was never clearly determined, the suggestion that they may have been INH-related has increased provider and patient suspicion regarding the safety of TPT. Efforts to address these barriers in FY 2017 include increased participation of the PEFPAR team in the funding request application development for the next Global Fund allocation period (2018-2020). Additionally, PEPFAR will take outcomes from the initial pilot in four districts to reach 90% of 22,597 patients with INH prophylaxis through site level support.

In COP 2017, PEPFAR will aim to strengthen TPT provision for PLHIV further by supporting pharmacovigilance efforts to clearly document adverse events related to both HIV and TB regimens, and to allay public concerns where appropriate. With COP 2017 funds, PEPFAR plans to support improved TB case finding through integrated specimen transport to include blood and sputum samples (see Lab section below), and targeted infrastructural support to increase the utilization of the nation's GenXpert equipment. Data for reporting on TB prevention will be collected from Ministry registers, which capture initiation and completion rate of TPT. PEPFAR's TA site support will assist HCWs with TPT as well as pharmacovigilance reporting.

Through the New Start network focusing on KPs in the 40 scale-up districts, TB screening will be undertaken for all newly identified HIV positive clients using a standardized checklist. HIV positive clients with presumptive TB will be tested for TB using smear microscopy and GenXpert services available through 4 of the 16 New Start sites. The other 12 New Start sites that do not have microscopy and GenXpert services will either refer to another New Start site or MOHCC facility that offers the services. Clients with diagnosed HIV/TB co-infection through the New Start network will be linked and tracked into treatment services.

TB infection control (TBIC) is recognized as an important systems-level activity to reduce nosocomial infections for PLHIV, and to reduce TB infection among health care workers. This reality was underlined in a recent South African study showing that 69% of XDR TB transmission was person-to-person, rather than the result of inadequate/incomplete treatment. In COP 2017, TBIC activities will focus on developing and implementing TB screening for health care workers in the scale-up SNUs. This activity will also be paired with HIV screening, given the HIV co-infection rate of 69% among TB patients in Zimbabwe. Ongoing site-level support will include improving ventilation, hygiene, isolation of suspected and confirmed cases, and decongestion to reduce TB transmission at health care facilities.

4.8 Adult treatment

With the introduction of the Treat All guidelines, many facilities and providers around the country anticipated an overwhelming surge of PLHIV seeking to initiate ART. Unfortunately, this has not been a consistent finding; while the monthly initiation rate increased initially in the Treat All pilot districts, within 4-5 months, the rate has shown a "regression to the mean." Net new ART initiations nationwide are currently at approximately 8,689/month, a relatively constant rate over the past year. ZIMPHIA revealed ART coverage rates of 87.8% and 81.5% among >30 and <30 year old adults who were aware of their status, respectively. This differential is consistent with lower success towards the 1st 90 among adults <30 as well (55.5% knowing their HIV status, vs 79.3% among adults >30). As such, ART initiation strategies to reach this sub-population will be paired with PITC, index and HIVST strategies to emphasize same-day ART initiation among those patients expressing readiness. As was the case with COP 2016, Zimbabwe's ongoing economic crisis contributes to significant human resources for health (HRH) gaps which impact both PITC and ART initiation; PEPFAR partners will continue to provide DSD support for ART initiation at facilities experiencing significant gaps that impact service delivery. The HIV Quality Improvement program will continue to receive PEPFAR support, at the national and facility level in line with the national QI framework; through this support in FY 2017, the national QI indicators are being updated to reflect the revised treatment guidelines. At the site-level, QI partners support systems-level interventions including the routine monitoring of patient satisfaction, and improved M&E for PEPFAR treatment indicators. The QI Collaborative model will continue to support clinical partners, focusing on accelerating the implementation of Treat All and the uptake of VL monitoring.

Mental health assessment and interventions (see section 4.6 above) will also be supported at the time of ART initiation for those patients in need. As described in section 4.1, PEPFAR support of all sites within the 40 scale-up SNUs (irrespective of patient volume) will also allow implementing partners to strengthen ART initiation at increasingly peripheral sites in line with MOHCC's decentralization policy. Given varying rates of discordance between MOHCC program data and ZIMPHIA (self-reported) findings regarding the number of ART patients by province, a PEPFAR Zimbabwe will support a data quality analysis; ongoing roll-out of a patient-level electronic health record (EHR) will also improve accuracy on ART coverage and linkage rates.

Through expanded support of the Sisters with a Voice program, PEPFAR will emphasize the identification of new targets and strengthen the clinical cascade among sex workers (primary) and MSM (secondary) in five urban locations with high numbers of SWs: Harare, Bulawayo, Gweru, Mutare and Masvingo. This new strategy will employ proven approaches for reaching, testing and

immediate initiation of ART for HIV positive SWs and MSM. All HIV positive will be enrolled at New Start KP treatment sites that offer a one-stop shop for health care (HTS, STI, FP, cervical cancer, post GBV care, ART, TB, and lab) and provided with viral load monitoring at 6 and 12 months. In COP 2017, PEPFAR will significantly increase its support to integrate KP-friendly and KP-competent services within public health facilities in urban areas (including Harare and Bulawayo). This will facilitate the transfer of more KPs to the public sector for ongoing ART, while also moving towards more long-term sustainability of the program. Given, however, the sensitivities involved with documentation of KP populations within the public sector, COP 2017 DATIM targets are not associated with this activity. To further support this transition, a KP-service coordinator will be seconded to the Ministry's AIDS and TB Unit.

Based upon current projections, an ARV funding gap is not expected for FY 2017; as described further in section 4.12, it is impossible to comment definitively upon the commodity status for FY 2018, given that Zimbabwe's current Global Fund HIV grant ends on December 31, 2017 and the funding request for the new allocation period (2018-2020) is currently being developed. Given the need for a harmonized approach to commodity forecasting and procurement among PEPFAR, the Global Fund and MOHCC, the PEPFAR team is providing significant technical input into the current funding application development.

COP 2016's Gender Analysis and the recent population-based surveys documented several factors that could impact ART enrollment, adherence and retention. These include lower utilization of HIV services among men, high prevalence of GBV, numerous cultural (and religious) practices and norms that can fuel HIV transmission and/or treatment avoidance, and persistent stigma towards KPs in the healthcare setting. Findings will be used to design new, as well as fine tune existing, program activities including male and adolescent friendly services including mobile/workplace/community ART; flexible clinic hours; GBV screening, counselling and referrals in ART services; availability of male lay/peer cadres for adherence counselling; psychosocial support for groups that may have particular challenges with lifelong ART (children & adolescents, GBV survivors, individuals from conservative religious groups); and rights based training that promotes accepting and positive attitudes towards adolescents, SWs, and MSM. Additionally, the use of male champions to raise awareness on negative gender norms, cultural and religious practices that affect health seeking behavior of men will be implemented.

4.9 Pediatric Treatment

The ZIMPHIA and ZDHS surveys completed in 2016 revealed that the country had fewer numbers of children (0-14 years) living with HIV (CLHIV) than previously expected. Consequently, the surveys suggest close to 80% of the CLHIV are on already on ART. However, the surveys also revealed poor retention in care as well as low viral load suppression in children. To help close these and other gaps in COP 2017, PEPFAR Zimbabwe will continue to support pediatric and adolescent HIV services in 40 of the 60 districts in the country.

First 90

In COP 2017, the PEPFAR program will support the MOHCC to initiate 7,876 children on ART (based on 90% linkage from diagnosis to treatment and overall prevalence of 3%). The PEPFAR program will support strengthening and standardization of HIV testing in pediatric outpatient settings using the four question screening tool; in addition, an emphasis will be placed on children in maternal child health settings whose HIV positive mothers may have been missed by the PMTCT program, or whose mothers' status is unknown. The program will enhance linkages between orphans and vulnerable

children (OVC) programs and health services through strengthened collaboration among health care workers and social workers who will be based at select health facilities. This will improve access to HIV services, particularly HIV testing for OVC. In-turn, children identified at health facilities will also have improved access and linkages to social services upon discharge. The program will continue on site supervision and mentorship of staff on early infant diagnosis - dried blood spot (EID-DBS) sample collection. EID-DBS sample collection is synchronized with the first immunization visit at six weeks. Results are expected after a minimum of four weeks and review dates are scheduled at the time of the next immunization visit at ten weeks. Zimbabwe has not yet implemented birth testing, for this reason, virtually no infants would have a DBS result documented before eight weeks (less than two months) of age.

Second 90
In 2015, the MOHCC developed the National Accelerated Action Plan for Pediatric and Adolescent ART in Zimbabwe – 2015-2018. Based on this and other bottle neck analyses, individual district implementation plans (DIPs) for pediatric and adolescent ART were developed. While these plans and targets therein will need to be revised based on the new survey data, they remain the overarching guidance for pediatric HIV service provision in the country. PEPFAR partners will work directly with district health teams to implement these plans in each supported district. Among other activities, partners will set weekly targets for HIV testing/treatment initiation by the different age bands (0-4, 5-9, 10-15). At the end of each week a performance analysis will be done to address any gaps. The PEPFAR program will continue to support nurse–led pediatric ART initiation through site-level TA and blended learning approaches, while strengthening integration of HIV within routine child care services. Administration of new pediatric formulations e.g. LPV/r pellets, will be supported as the guidance from the MOHCC is released. To address the issues of poor adherence and retention among adolescents, PEPFAR Zimbabwe will introduce mental health screening among adolescents during pre and post ART initiation counselling sessions. Some simple mental health tools e.g. Shona Symptom Questionnaire (SSQ) have been tested and found to be effective in this age group. The PEPFAR program will scale up the use of these tools in select health facilities in COP 2017.

Third 90
PEPFAR Zimbabwe will support the scale up of routine viral load monitoring for children on ART as well as support the use of differentiated models of care for children and adolescents who are stable on ART. Differentiated packages will include multi-month dispensing for children with stable weight, inclusion in family ART refill groups as well as links to the CATS program for adolescents, among others. Use of appointment systems will be standardized across sites. PEPFAR seconded health facility staff will review the appointment diaries/lists weekly to identify missed appointments and initiate tracking systems in the community accordingly. Community based PEPFAR partners will continue to strengthen these community systems to track, and document defaulters brought back to care.

4.10 Orphans and Vulnerable Children (OVC)

In COP 2017, the OVC program will make shifts based on the recommendations of the Zimbabwe PEPFAR OVC 2016 Portfolio Review. Those shifts include:

i. Incorporate strategies and tools to improve targeting and identification of the most at-risk households, including and especially households identified through facility-based HIV services (PMTCT, adult HIV care and treatment).

ii. Accelerate the adoption and utilization of evidence-informed interventions across the OVC portfolio, such as evidence-informed Early Childhood interventions and models such as the Special Initiative's Integrated ECD model (which is adapted from WHO/UNICEF's Care for Child Development).
iii. Creatively redeploy existing human resources to strengthen the presence of social workers in clinics– e.g. placing a managerial/supervisory cadre within clinics (e.g. case manager, case coordinator) to improve case coordination
iv. Target for certain high-risk segments or sub-populations like Adolescent and young parents as well as children in the earliest years (0 to 5).

The program will be operational in 19 out of 40 PEPFAR priority districts, completing the transition from non-priority districts started in COP 2015. The package of services will be the same in all the 19 districts, encompassing Education, Health, Social Protection and Child Protection domains. PEPFAR Zimbabwe will continue with the programmatic shifts, aligning itself with the UN's 90-90-90 goals to ensure all children have access to HIV testing services and HIV infected children are linked to care and treatment services. This will be achieved through increased collaboration with the Accelerating Children Treatment (ACT) Initiative. The program will utilize its strong community presence through the various structures like the child protection committees and community case care workers, to mobilize parents and caregivers for HIV services. It will facilitate access to testing services for those who need them.

Education: In line with the recommendations of the Zimbabwe PEPFAR OVC 2016 Portfolio Review, the program will shift towards ensuring that more OVC especially girls in the 14 to 18 age group remain in school through payment of school levies and fees. Whilst in schools, the OVC will also receive sexual and reproductive health education.

Social Protection: The program will work towards making the National Case management System the vehicle for the operationalization of the second 90. The program will strengthen its linkages with health facilities to ensure that children of parents on ART and children on ART are enrolled into the National Case management System where they would be monitored and also receive other wrap around services as necessary.

Child Protection: The program will adopt some of the DREAMS GBV prevention and response initiatives chief among them the Community Dialogues and the community safe houses.

PEPFAR Zimbabwe will also continue to provide a platform for DREAMS implementation and co-ordination with OVC implementing partners serving as District Secretarial partners in four of the six DREAMS districts. Furthermore, in COP 2017, there will be greater effort to increase enrollment in the under-5 (from below 2% in FY16 to 12% in FY 2018) and 15 to 17 (from 10% in FY 2016 to 22% in FY 2018) years age groups. For the under 5 year olds, the aim would be to reach out to HIV exposed children, whilst for the 15 to 17 the aim would be to reduce HIV incidence as it is very high. To assist with this, the follow-on OVC mechanism will adopt an age structure that has a substantial percentage of the above age groups from its inception.

In working with the children under-5, the program will adopt the Early Childhood Stimulation (ECS) model developed under the PEPFAR-funded Special Initiative. This model works with community-based structures to stimulate demand for pediatric HIV services; supports mothers/caregivers and HIV-exposed children 0–24 months in order to assure early HIV diagnosis, adherence, and retention

on treatment; and provides holistic parenting support to optimize HIV-exposed children's developmental outcomes.

In working with the 15-17 years age groups, the program will draw lessons from the DREAMS and centrally supported initiatives. Both initiatives seek to improve the delivery of a comprehensive service package that addresses the unique needs and risk factors of OVCs and their families to contribute to the achievement of 90-90-90 goals. Adoption of these girl- oriented models e.g. Girls Empowerment Clubs (GEM) will be sensitive to ensure that boys do not feel alienated from the program. The program will maintain a 60% female and 40% male ratio.

Three of the current OVC implementing mechanisms will continue into COP 2017 whilst the fourth will end December 2017. Plans for a follow-on mechanism are at an advanced stage. PEPFAR Zimbabwe will continue to work with key ministries responsible for the welfare of orphans and vulnerable children including the MOHCC, Ministry of Primary and Secondary Education, and the Ministry of Labor and Social Welfare.

In COP 2017, PEPFAR Zimbabwe will begin to collect data on the new MER Indicator (OVC_HIVSTAT). Implementing partners will continue to build relationships with OVC and their parents and caregivers to encourage them to know and share the HIV status of their children and support those with an unknown status to seek HIV testing services. To help in this process, the program will adopt an OVC HIV Screening Tool which is currently being developed and will be ready at the beginning of FY 2018.

The program will coordinate with the MOHCC and Ministry of Labor and Social Welfare (MoLSW), to continue the current efforts of infusing HIV/AIDS issues into the country-wide Government of Zimbabwe's National Case Management System, thereby making it HIV sensitive. Having an HIV Sensitive National Case Management system will ensure that all community case workers (CCWs) and other community-based para-professionals, not just those supported by PEPFAR, are trained in HIV issues with the aim of generating demand for HIV services as well as offering adherence support to those on ART.

A HIV-sensitive National Case Management System is one of the key vehicles in achieving the 90-90-90 goals. It will ensure that children/families are assessed for holistic health and social needs, linked to the appropriate services, and followed until case closure. This will be realized through development of case plans with concrete family goals, connecting families with appropriate services, and identifying critical actions to be taken by families to improve child wellbeing and protection, monitoring implementation of case plans, progress towards family goals, and closing cases once families have achieved a level of self-sufficiency and are ready to graduate from direct project support.

COP 2017 will focus on increased collaboration between the OVC and clinical partners through joint planning. The expected result is to have a dedicated OVC provider in supported health facilities refer children at risk of sub-optimal health outcomes to OVC partners where they can access a package of support services that includes adherence, education and psychosocial support, as well as economic strengthening. To facilitate this linkage, the OVC partners will ensure that health facilities have a dedicated para-social worker from the current pool of MoLSW Child Community Case Workers (CCWs) with whom the health facility can liaise with for the follow-up and case management of vulnerable children. The deployment of the para social workers will be in phases, beginning with

districts that would have been trained in HIV sensitive Case Management. The para social worker will have a screening tool that incorporates social protection issues, as well as, HIV and GBV issues.

4.11 Addressing COP17 Technical Considerations

As described above, care and support activities targeting the <30 year old population will include the CATS model to improve viral suppression among children and adolescents on ART up to age 24. The CATS program will also begin carrying out index testing (and, for those aged 16 and older, HIVST) for the family members of known beneficiaries. Moreover, index testing and HIVST will be implemented in various settings to improve case-finding among the male partners of PMTCT patients. As described in Section 4.5, the overall PEPFAR Zimbabwe testing strategy has been realigned in accordance with the findings from ZIMPHIA and ZDHS, as well as, the reported yields by modality from FY 2017 Q1 data. Increased targeting and risk-stratification will improve the yield of facility-based PITC among children. Testing modalities which have shown lower yields and higher costs (e.g. mobile VCT) are being phased-out in favor of higher yielding strategies. Implementing partners are also expected to find innovative solutions to contain the costs of various testing modalities; close collaboration with the MOHCC to expand HIVST, and to increase the capacity of lay cadres to carry out community testing will also help to contain costs and promote sustainability.

As described in Section 4.3, the aggressive targets for VMMC in the scale-up districts, and particularly the six DREAMS districts, reflects a clear prioritization of prevention activities among the existing and potential male partners of AGYW in these districts. The expansion of CARGs and other differentiated service models will promote enhanced retention and sustainability through convenience for patients and decreased strain upon the facility workforce. Expansion of VL testing, reporting, and interpretation, particularly among pregnant women and children/adolescents, will allow for better risk stratification and differentiation of care based upon patient needs. In this regard, support for HIVDR surveillance will be crucial, as the increasing access of VL monitoring will inevitably improve the case finding of patients potentially requiring alternate ARV regimens. Finally, the national HIVQI model is premised upon increasing the capacity of facility staff to learn and implement QI techniques with rapid "graduation" of these sites, obviating the need for ongoing external support.

4.12 Commodities

During FY 2016, Zimbabwe's national supply chain systems performed well overall, with the exception of the pediatric ARV tracer commodity, which had an average stock out rate over the year of 3.95% compared to the <1% target. All other tracer products had stock out rates well under the targets (<1% and <5%). COP 2017 PEPFAR funds will be used to provide ongoing support to Zimbabwe's national supply chain systems, including critical seconded staff at the MOHCC Directorate of Pharmacy Services Logistics Unit and distribution support.

In COP 2017, PEPFAR funds will be used to procure 215,000 person years of ARVs, in addition to, ARVs for PreP, VMMC surgical kits and related medicines and consumables for the PEPFAR COP 2017 surgical method target ,as well as, reagents for 65,250VL tests. As a result of stock outs experienced in FY 2016 due to Global Fund procurement delays and nearly 100% dependence on GF for certain HIV commodity categories (RTKs, PrePex devices, etc.), PEPFAR Zimbabwe has decided to make investments in critical commodity categories (EID reagents and RTKs) to ensure we have some means to mitigate potential stock outs in FY 2018. As such COP 2017 funding will also be used to procure

roughly one quarter of the annual EID bundle and reagent needs, HIVST kits and conventional HIV rapid test kits.

Zimbabwe's current Global Fund HIV grant ends on December 31, 2017 and the funding request for the new allocation period (2018-2020) was submitted on March 20, 2017. As such, no final decisions have been made in terms of future Global Fund commodity investments, although it is anticipated that commodities will be adequate assuming the funding request is fully funded. PEPFAR does acknowledge that with the focus on 95-95-95, there is a potential for a commodity gap of $11.8 million in 2018, should the PEPFAR COP16 and COP17 targets be met. The other anticipated commodity gaps in FY 2018 include RTKs: conventional ($647k) and HIVST ($2.1M), VMMC kits ($1.5M) and conventional laboratory reagents ($4.2M), in addition to, viral load reagents ($4.4M).

In COP 2017, Zimbabwe will continue to receive central funding to procure male and female condoms through the USAID central commodity fund. They will be distributed to health facilities where they will be provided free of charge to the public via the national (PEPFAR-supported) commodity distribution system that delivers other HIV related medicines and commodities. Implementing partners will also distribute condoms.

4.13 Collaboration, Integration and Monitoring

As mentioned throughout the aforementioned Program Area narratives, close collaboration with MOHCC, representatives from civil society, multilateral donors and the Global Fund is a consistent theme throughout PEPFAR Zimbabwe's strategy. Harmonization with the Global Fund continues to be crucial for commodity procurement including VMMC devices, HIV RTKs, EID bundles, VL reagents, and ARVs. Moreover, implementation of strategies such as VMMC service delivery; integrated sample transport for laboratory specimens; HIV/TB prevention, diagnosis and treatment; and cash transfers for the households of AGYW at risk are all contingent upon such collaboration. As such, PEPFAR Zimbabwe is directly participating in the funding request application development for the next Global Fund allocation period (2018-2020).

In order to strengthen implementing partner management and allow for data-driven course correction, PEPFAR Zimbabwe is reviewing weekly and bi-weekly data outputs for critical HTS strategies including index testing and DSD support for PITC; in addition, we are closely monitoring the roll-out of Treat All and patient/systems-level barriers to ART initiation. The Clinical Cascade TWG meets every 1-2 months, bringing together all involved implementing partners, and a myriad of stakeholders including MOHCC and civil society. In additional, PEPFAR will be supporting civil society through a partnership for performance accountability, to ensure appropriate activities and interventions are being implemented at the site level. Through rigorous data analysis and comparisons of partner performance, PEPFAR Zimbabwe will continue to adjust strategies on a quarterly basis in line with the POART framework. The COP 2016 shift to an increasingly DSD strategy has required very close collaboration with MOHCC to ensure that interventions lay the groundwork for sustainability, and that individual partner approaches are harmonized.

Expanding access to routine viral load monitoring improves treatment quality, contributes to prevention, and potentially reduces resource needs for second- and third-line ART; effective implementation of VL monitoring requires close collaboration between partners supporting laboratory services as well as clinical service delivery. As such, PEPFAR Zimbabwe's laboratory partner is working very closely with clinical support partners to sensitize facility staff, improve results transmission, while

our procurement and supply management partner is working to ensure availability of the necessary commodities/consumables. This collaboration will be also be strengthened through PEPFAR support for integrated sample transport for specimens including VL, EID, TB, etc. Furthermore, the expansion of innovative and differentiated models of care (e.g. HIVST, CARGs, MMS, KP-competent public sector services), and community-level adherence/retention support (e.g. through the CATS) are helping to improve efficiency, render HIV service delivery more patient-centered, and lay the groundwork for sustainability. In COP 2017, these innovations will be increasingly crucial as the "last mile" of epidemic control will necessitate reaching increasingly elusive populations.

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

Note: In COP 2017, commodity and supply chain support, along with national level laboratory system support will be provided to centrally supported districts. PEPFAR Zimbabwe does not have districts supported under the attained or sustained categories.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps and 6.2 Critical Systems Investments for Achieving Priority Policies

In line with COP 2017 guidance, the systems barriers and interventions described in Section 6 of the COP 2016 SDS have not been significantly altered; as a three-year (minimal) timeframe was originally envisioned for these investments. Nevertheless, updates are reflected in the associated tables, including new activities and those that have been completed. The overall COP 2017 framework reflects further refinement of COP 16 strategies, such as ensuring that testing and clinical services target hard-to-reach populations and those with increased HIV incidence (e.g. AGYW, men <30). As is shown in Table 6.1.1, supply chain issues are the only relevant above site investments, with the remainder of interventions and investments to ensure improved HTC alignment and yield occurring at the site and community levels. In addition, under section 6.2.1 (Test and Start), the outcomes and benchmarks regarding differentiated care have been updated to include pregnant women. An additional activity has been incorporated regarding data quality, in response to the variance seen in ART coverage between MOHCC program data in DHIS 2 and self-reports in recent population-based surveys.

The HRIS (Human Resources Information System) has been successfully decentralized to SNU levels; this activity is therefore complete. The remaining activity (reflected in Section 6.3 under HRH) is integration of this database into the DHIS2 system, along with the TRAINSmart database, such that facility-level HIV program outcomes (e.g. ART coverage, monthly testing performance, etc.) can be related to staffing and capacity building activities.

In Zimbabwe, KP health services have not historically been integrated into the public sector, nor have these services been coordinated within a national policy/strategy within the MOHCC's AIDS and TB unit. PEPFAR Zimbabwe will second a KP Coordinator to the MOHCC to spearhead the 'KP competent facility' agenda, filling a critical gap, as at present, there is no MOHCC KP position. S/he will strengthen the coordination between MOHCC and NAC, support the development of a National KP Strategy, champion creation and roll out of standards and tools and work with both KP groups and health facilities to implement KP institute services.
Additional information can be found in Section 4.2.4.

Finally, the Young Adults Survey (YAZ) and PMTCT Effectiveness surveys are ongoing surveillance activities with important implications for Zimbabwe's sub-populations of interest. Section 6.3 Strategic Information describes dissemination and integration of these study findings to ensure the appropriate programmatic shifts.

6.2 Proposed system investments outside of programmatic gaps and priority policies.

Other systems investments supported by PEPFAR Zimbabwe are reflected in Table 6.3 and reflect investments across the Governance, HRH Systems and Institutional Investments, Institutional and Organization Development, SI and DREAMS activity categories. Many of the activities are carried over from COP 2016 though a few are new.

As highlighted in multiple program area narratives above, Zimbabwe's current paper-based medical records and health registers limit health care workers' ability to deliver quality care to their patients. Such limitations also impede accurate assessment of critical areas such as linkage to treatment, retention in care, and viral suppression among specific cohorts. Consequently, in COP 2016, PEPFAR Zimbabwe supported the initial pilot of a real-time electronic health record which, to date, has shown promising results and gained ongoing support from the MOHCC. In COP 2017, PEPFAR will increase its support to accelerate electronic health records (HER) implementation nationally, while focusing first on all polyclinics in the urban capital of Harare. PEPFAR Zimbabwe has supported pre-treatment drug resistance and early warning indicator surveys in 2015 to improve prescribing practices and loss to follow up. Furthermore, COP 2017 SI activities include HIV drug resistance testing to better inform national ART programming and regimen decision-making as critical components to achieving viral suppression and retention (e.g. the 3rd 90).

Zimbabwe's pharmacovigilance (PV) system is weak with limited adverse event (AE) reporting. PEPFAR Zimbabwe will second a pharmacovigilance specialist to the Medicines Control Authority of Zimbabwe in an effort to strengthen the existing PV system, AE reporting and response. The goal is to strengthen AE reporting throughout the health system and to ensure that civil society organizations are also engaged and aware of the process in response to AE reporting. This above-site level investment will complement site-level support to improve adverse event reporting among clinical providers and patients.

In COP 2017, PEPFAR Zimbabwe will conduct a full country application of the DMPPT tool. This full country application will support a more comprehensive, holistic, evidence-based and transparent way of setting VMMC targets in Zimbabwe. A one-time investment, the tool will be developed and completely available for all VMMC stakeholders in Zimbabwe. Of note, the activity not only harmonizes the target setting process and assumptions, it will provide the PEPFAR program accurate

coverage levels (to monitor program performance at district levels) and accurate estimates of HIV infections averted across different years.

PEPFAR will continue to support DREAMS Coordinators at MOHCC and NAC (central level) who are responsible for day-to-day DREAMS coordination, including such activities as managing monthly partner meetings at the national level, conducting site visits and problem-solving, engaging DREAMS Ambassadors, and ensuring DREAMS is prominent in the routine MOHCC and NAC operations. At the district level DREAMS is coordinated by the District AIDS Coordinator (DAC) and assisted by a DREAMS Secretariat partner. PEPFAR will continue to fund modest budgetary support for Secretariat partners to facilitate monthly coordination meetings, joint planning and review events, and monitoring visits by the DAC and key stakeholders. COP 2017 will also include funding for a LAG Avidity study to identify populations with the highest incidence for priority HTS and prevention activities. Finally, PEPFAR will strengthen the DREAMS database functionality, as well as partners' abilities to report into it, in order to enable the tracking of service delivery, referrals, and extent of layering. The database uses a unique identifier code and is built on the DHIS-2 platform. Please see section 4.2.1 for additional details.

7.0 Staffing Plan

[REDACTED]

SIMS requirements and overall Management and Operations (M&O) needs were reviewed during budgetary discussions. Technical and non-technical staff is conducting SIMS visits on a monthly basis. PEPFAR staff will spend approximately 65 person-working-days in the field per quarter in COP 2017.

APPENDIX A. SNU Prioritization

SNU Prioritization

Table A.1SNU	COP15 Prioritization	APR16 Achievement	COP16 Prioritization	APR17 Expected Achievement	COP17 Prioritization	COP17 Target: (APR18)
Beitbridge	ScaleUp Agg	89%	ScaleUp Sat	104%	ScaleUp Sat	100%
Bulawayo	ScaleUp Agg	69%	ScaleUp Sat	88%	ScaleUp Sat	90%
Bulilima	ScaleUp Agg	>100%	ScaleUp Sat	65%	ScaleUp Sat	90%
Chipinge	ScaleUp Agg	47%	ScaleUp Sat	80%	ScaleUp Sat	90%
Chivi	ScaleUp Agg	67%	ScaleUp Sat	85%	ScaleUp Sat	90%
Gwanda	ScaleUp Agg	75%	ScaleUp Sat	89%	ScaleUp Sat	90%
Gweru	ScaleUp Agg	66%	ScaleUp Sat	130%	ScaleUp Sat	129%
Insiza	ScaleUp Agg	61%	ScaleUp Sat	80%	ScaleUp Sat	90%
Lupane	ScaleUp Agg	71%	ScaleUp Sat	80%	ScaleUp Sat	90%
Makoni	ScaleUp Agg	57%	ScaleUp Sat	80%	ScaleUp Sat	90%
Matobo	ScaleUp Agg	52%	ScaleUp Sat	80%	ScaleUp Sat	90%
Mazowe	ScaleUp Agg	78%	ScaleUp Sat	80%	ScaleUp Sat	90%
Mberengwa	ScaleUp Agg	69%	ScaleUp Sat	64%	ScaleUp Sat	90%
Mutare	ScaleUp Agg	67%	ScaleUp Sat	80%	ScaleUp Sat	100%
Nkayi	ScaleUp Agg	57%	ScaleUp Sat	67%	ScaleUp Sat	90%
Tsholotsho	ScaleUp Agg	75%	ScaleUp Sat	80%	ScaleUp Sat	90%

Zaka	ScaleUp Agg	58%	ScaleUp Sat	80%	ScaleUp Sat	90%
Buhera	ScaleUp Agg	87%	ScaleUp Agg	87%	ScaleUp Sat	90%
Chegutu	ScaleUp Agg	99%	ScaleUp Agg	115%	ScaleUp Sat	130%
Chiredzi	ScaleUp Agg	70%	ScaleUp Agg	80%	ScaleUp Sat	90%
Gokwe South	ScaleUp Agg	58%	ScaleUp Agg	64%	ScaleUp Sat	90%
Goromonzi	ScaleUp Agg	57%	ScaleUp Agg	65%	ScaleUp Sat	90%
Guruve	ScaleUp Agg	55%	ScaleUp Agg	68%	ScaleUp Sat	90%
Gutu	ScaleUp Agg	46%	ScaleUp Agg	86%	ScaleUp Sat	90%
Harare	ScaleUp Agg	78%	ScaleUp Agg	75%	ScaleUp Sat	90%
Hurungwe	ScaleUp Agg	78%	ScaleUp Agg	80%	ScaleUp Sat	90%
Kadoma	ScaleUp Agg	88%	ScaleUp Agg	68%	ScaleUp Sat	90%
Kwekwe	ScaleUp Agg	55%	ScaleUp Agg	80%	ScaleUp Sat	90%
Makonde	ScaleUp Agg	82%	ScaleUp Agg	80%	ScaleUp Sat	90%
Marondera	ScaleUp Agg	60%	ScaleUp Agg	81%	ScaleUp Sat	90%
Masvingo	ScaleUp Agg	64%	ScaleUp Agg	86%	ScaleUp Sat	90%
Mt. Darwin	ScaleUp Agg	71%	ScaleUp Agg	80%	ScaleUp Sat	90%
Murehwa	ScaleUp Agg	64%	ScaleUp Agg	65%	ScaleUp Sat	90%
Mutasa	ScaleUp Agg	60%	ScaleUp Agg	65%	ScaleUp Sat	90%
Mwenezi	ScaleUp Agg	74%	ScaleUp Agg	80%	ScaleUp Sat	90%
Zvimba	ScaleUp Agg	75%	ScaleUp Agg	68%	ScaleUp Sat	90%
Bubi	Ctrl Supported	53%	Ctrl Supported	no target	ScaleUp Sat	80%
Mangwe	Ctrl Supported	0%	Ctrl Supported	no target	ScaleUp Sat	80%
Umguza	Ctrl Supported	50%	Ctrl Supported	no target	ScaleUp Sat	80%
Umzingwane	Ctrl Supported	70%	Ctrl Supported	no target	ScaleUp Sat	80%
Bikita	Ctrl Supported	74%	Ctrl Supported	no target	Ctrl Supported	no target
Bindura	Ctrl Supported	87%	Ctrl Supported	no target	Ctrl Supported	no target
Binga	Ctrl Supported	65%	Ctrl Supported	no target	Ctrl Supported	no target
Centenary	Ctrl Supported		Ctrl Supported	no target	Ctrl Supported	no target
Chikomba	Ctrl Supported	55%	Ctrl Supported	no target	Ctrl Supported	no target
Chimanimani	Ctrl Supported	63%	Ctrl Supported	no target	Ctrl Supported	no target
Chirumhanzu	Ctrl Supported	82%	Ctrl Supported	no target	Ctrl Supported	no target
Gokwe North	Ctrl Supported	65%	Ctrl Supported	no target	Ctrl Supported	no target
Hwange	Ctrl Supported	88%	Ctrl Supported	no target	Ctrl Supported	no target
Hwedza	Ctrl Supported	62%	Ctrl Supported	no target	Ctrl Supported	no target
Kariba	Ctrl Supported	>100%	Ctrl Supported	no target	Ctrl Supported	no target
Mudzi	Ctrl Supported	53%	Ctrl Supported	no target	Ctrl Supported	no target
Mutoko	Ctrl Supported	98%	Ctrl Supported	no target	Ctrl Supported	no target
Nyanga	Ctrl Supported	63%	Ctrl Supported	no target	Ctrl Supported	no target
Rushinga	Ctrl Supported	61%	Ctrl Supported	no target	Ctrl Supported	no target
Seke	Ctrl Supported	>100%	Ctrl Supported	no target	Ctrl Supported	no target
Shamva	Ctrl Supported	>100%	Ctrl Supported	no target	Ctrl Supported	no target
Shurugwi	Ctrl Supported	65%	Ctrl Supported	no target	Ctrl Supported	no target
UMP	Ctrl Supported	50%	Ctrl Supported	no target	Ctrl Supported	no target
Zvishavane	Ctrl Supported	85%	Ctrl Supported	no target	Ctrl Supported	no target

Table A.2 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY 17)	Additional patients required for 80% ART coverage	Target current on ART (APR FY18) *TX_CURR*	Newly initiated (APR FY 18) *TX_NEW*	ART Coverage (APR 18)
Attained	0	0	0	0	0	
Scale-Up Sat – 80%	50,205	no target[18]	21,501	21,501	24,453	80%
Scale-Up Sat – 90%	977,145	755,395	117,759	879,646	230,026	90%
Scale-Up Sat – 100%	72,725	76,812		83,263	8,946	100%
Scale-Up Aggressive	0	0	0	0	0	0%
Central Support	216,982	no target	no target	no target	no target	no target
Total	**1,317,058**	**832,207**	**139,260**	**984,410**	**263,424**	

[18] PEPFAR is not currently supporting PLHIV on ART in the new districts proposed for COP 17

APPENDIX B

B.1.1 Total Funding Level		
Applied Pipeline	**New Funding**	**Total Spend**
$0US	**$126,973,404US**	**$126,973,404US**

Table B.1.2 Resource Allocation by PEPFAR Budget Code (new funds only)

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$426,588
HVAB	Abstinence/Be Faithful Prevention	$947,317
HVOP	Other Sexual Prevention	$5,502,975
IDUP	Injecting and Non-Injecting Drug Use	$0
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$13,088,607
HVCT	Counseling and Testing	$13,266,704
HBHC	Adult Care and Support	$9,800,367
PDCS	Pediatric Care and Support	$1,402,116
HKID	Orphans and Vulnerable Children	$18,678,395
HTXS	Adult Treatment	$27,271,361
HTXD	ARV Drugs	$20,029,673
PDTX	Pediatric Treatment	$2,650,041
HVTB	TB/HIV Care	$4,365,365
HLAB	Lab	$213,426
HVSI	Strategic Information	$2,034,837
OHSS	Health Systems Strengthening	$475,262
HVMS	Management and Operations	$6,820,373
TOTAL		**$126,973,404**

B.2 Resource Projections

In alignment with COP16 processes, PEPFAR Zimbabwe used EA data throughout the COP process to inform planning and budget setting. Various inputs and methods were used to calculate required resources for implementation of COP 2017 activities. Unit costs were estimated based on the analysis of FY2016 UEs and the required program inputs to sustain epidemic control according to PEPFAR prioritization categories. In COP 2017 PEPFAR will have four additional scale-up districts previously categorized as centrally supported. Since service delivery costs are unavailable for these additional SNUs, cost category adjustments were made based on need to support partners as they expand to additional facilities, with the assumption that most general service delivery costs will be aligned with

other scale-up SNUs. In an effort to maximize efficiency, given the rationalized landscape by partner and SNU and programmatic context, the PEPFAR team used the same adjusted applied national UEs for partners to budget in COP 2017 after reviewing data derived from the EA data navigation tool. Any adjustments necessary due to program context e.g., environmental, economical and/or political factors in the districts and wards where partners operate, was further applied where necessary in consultation with the EA Advisor.

All target driven activities used the adjusted applied UEs in the PBAC tool and in the development of partner budgets in the target based budget allocation tool (TBBAT). Budget code amounts were derived in PBAC after budgeting for targets by SNU and importing these targets into the TBBAT and subsequently the PBAC.

The PEPFAR team currently implements routine monitoring on a monthly basis to track partner performance and progress and will incorporate a review of EA data from the start of FY 2017 to ensure partners are able to implement programs effectively and stay on track to achieve the targets with the budgets assigned to them.

In the HTC example below, the PEPFAR team determined that a modality based budgeting approach was necessary to ensure that the revised testing strategy was sufficiently funded to reach priority populations based on SNU. In COP 2016 the HTC methodology applied a weighted average for direct-service delivery costs based on the contribution of each modality. In COP 2017, program management and strategic information costs (PM/SI) were excluded from target based UEs and targets were budget based on individual modality costs.

UE DSD PITC	UE DSD VCT	UE DSD CBCT	UE TA PITC
$ 5.70	$ 11.70	$ 9.73	$ 0.80
$ 5.70	$ 11.70	$ 9.73	$ 0.80
$ 5.70	$ 11.70	$ 9.73	$ 0.80
$ 5.70	$ 11.70	$ 9.73	$ 0.80
$ 5.70	$ 11.70	$ 9.73	$ 0.80

For OVC, the technical team, with EA Advisor support, reviewed the mechanism level UE cost category data and made adjustments for the package of services specific to each of the four mechanisms. An overall OVC UE was derived for higher level discussion, but for target-based budgeting, mechanism-specific unit budgets were applied based on these programmatic differences.

MechName	Description	DSD UB
Children Tariro	DREAMS: GBV Response	$267.38
TBD (WEI Follow-on)	DREAMS: GBV Response	$252.30
Children Tariro	DREAMS: HES	$33.19
TBD (WEI Follow-on)	DREAMS: HES	$31.32
Children Tariro	DREAMS: Work Rediness	$230.50
TBD (WEI Follow-on)	DREAMS: Work Rediness	$217.50
Children Tariro	DREAMS: parenting	$42.41
Social Protection Fund	DREAMS: cash transfers	$223.43
Children Tariro	DREAMS: educational subsidies	$165.96
TBD (WEI Follow-on)	DREAMS: educational subsidies	$156.60

APPENDIX C

Section 6.0 Tables: Program Support Necessary to Achieve Sustained Epidemic Control

Please see supplemental PDF Table 6 Attachment.

APPENDIX D

Zimbabwe Local and Civil Society Organizations Receiving PEPFAR Funding

COP 2016 Approved Funding Allocations		
Local Prime	**Local Sub-Partners**	
BRTI BioMedical Research & Training Institute	Regal Dzive Shiri	Tsungirirai Welfare Organisation
University of Zimbabwe	Rujeko Home-based Care	Pamuhacha HIV Prevention Project
FACT Family AIDS Care Trust, Mutare	St. Alberts Mission Hospital	AIDS Counselling Trust
SAfAIDS	Kapnek Trust	Zimbabwe AIDS Prevention Project
Zimbabwe Association of Church related Hospitals (ZACH)	Centre for Sexual Health and HIV AIDS Research Zimbabwe (CeSHHAR)	Colin Saunders - Triangle New Start Centre
HOSPAZ	Rainbow Alliance (GALZ)	FACT Chipinge New start Centre
Mavambo	Sexual Rights Center	Bekezela Home Based Care
Africaid	Securico	Diocese of Mutare Community Care Program
OPHID	Howard Hospital	Midlands AIDS Services Organisation
Population Services Zimbabwe	Chiedza Child Care Centre	Real Open Opportunities for Transformation Support
Total Allocation for CSO in 2016 $56,939,455 **Note**: *This includes the Self-Help & Public Affairs CSO Grant Programs*	Child Protection Society	Regional Psychosocial Support Initiative
	FACT Chiredzi	Disability, HIV and AIDS Trust
	Bekezela Home Based Care	Girls Legacy
	Unzingwane AIDS Network	Girls Legacy
	Insiza Godlwayo AIDS Council	Hope for a Child in Christ
	Nzeve Deaf Children Centre	Jointed Hands Welfare Organisation
	OASIS Zimbabwe	Life Empowerment Support Trust
	Excelsior Study Centre	Musasa Project
	Painted Dog Conservancy	Faith Ministries
	Youth Advocates Zimbabwe	Revelation Trust
	Zimbabwe Network for People Living with HIV (ZNNP+)	Hospaz
	Zimbabwe Women Lawyers Association	Mavambo
	Childline	Dot Youth
	Family Support Trust	Centre for Total Transformation
		Uzumba Orphan Care

COP 2017 Proposed Funding Allocations	
Local Prime	**Local Sub-Partners**
BRTI BioMedical Research & Training Institute	*Funding Allocation for Local Partners will be made available post COP approval.*
SAfAIDS	
FACT Family AIDS Care Trust, Mutare	
Zimbabwe Association of Church related Hospitals (ZACH)	**Tentative Allocation for Local Primes** (including Small Grant Programs) $31,336,365 **Note**: COP 2017 budget is expected to meet or exceed the 2016 allocations.
Population Services Zimbabwe	
HOSPAZ	
Mavambo	
Africaid	
OPHID	
Population Services Zimbabwe	

ZIMBABWE COP 2017 TABLE 6

Table 6.1.1 Key Programmatic Gap #1: Need for improved HTC alignment, yield and ongoing ART patient monitoring

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP16) Annual Benchmark	Year Two (COP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
Supply chain system challenges and funding gaps result in intermittent stock outs of testing commodities and lab reagents	Stockout rates for tracer RTK maintained at <5%	Stockout rates for tracer RTK maintained at <5%	Stockout rates for tracer RTK maintained at <5%	Stock out rate of tracer RTK (Determine)	Support to national pharmaceutical systems, including forecasting, quantification, supply planning and monitoring; and monitor performance of nascent integrated assisted pull system.	HTXS	$650,000	GHSC-PSM	8. Commodity Security and Supply Chain 6.14
	~~2. Selection of RTKs optimized to reduce or eliminate wastage~~ [this has been completed and will be implemented in CY2018]	~~Re-institute regular (bimonthly) bilateral PSM coordination meeting between USG/PEPFAR and UNDP/Global Fund.~~	N/A	N/A	~~Regular coordination with UNDP/Global Fund has occurred but needs to be more formalized and include escalating procurement delay issues to Geneva when necessary.~~	~~HTXS~~			
	>75% of tracer laboratory commodities delivered according to national supply plan.	>40% of tracer laboratory commodities delivered according to supply plan.	>60% of tracer laboratory commodities delivered according to supply plan.	Proportion of tracer laboratory commodities delivered according to supply plan and donor commitments	Continue support for Directorate of Laboratory Services (DLS) logistics unit seconded staff (3 positions) to ensure RTK procurement is optimized and implement activities from laboratory system roadmap from the joint national laboratory system assessment conducted in late 2016. Continue efforts to improve coordination of procurement and supply management activities with the Global Fund PR.	HLAB	$67,383	GHSC-PSM	8. Commodity Security and Supply Chain 6.14
Lack of capacity at the National Reference Laboratory (NMRL) to implement External Quality Assurance (EQA) for all HIV-related testing.	NMRL has EQA implemented at 100% of PEPFAR supported sites and 50% of all non-PEPFAR supported sites	NRML has EQA implemented at 100% of PEPFAR supported sites	NRML has EQA implemented at 100% of PEPFAR supported sites	LAB PT CQI	For HIVRDT-PT, all PEPFAR sites will be covered in COP16 and the program will progress from facility to tester based EQA. COP17 the program will be maintained and not expanded to all MOHCC facilities. All PEPFAR supported laboratories will participate in EQA for HIV monitoring tests and TB diagnostics through Gene Xperts POC	HTXS, PDTX	$759,289	APHL	10. Laboratory 4.72
Limited capacity for laboratory testing services for Viral Load/EID.	Eight centralized testing laboratories will have testing capacity for Viral load and EID testing services	Viral Load/EID testing capacity built at 6 centralized testing laboratories	Viral Load/EID testing capacity extended from 6 to 8 centralized testing laboratories	Number of laboratories with Viral load and EID testing capacity	All laboratories in the network will be supported for gap consumables, ancillary equipment maintenance and quality testing	HTXS, PDTX	$634,390	APHL	10. Laboratory 4.72
An insufficient Quality Management System for laboratory processes	8 superlabs will have implemented SLMTA based quality management system for laboratory processes	24 lab scientists receive training on quality management systems for reliable testing results in PEPFAR districts	12 laboratories have accreditation progress audits conducted	Number of laboratories with a SLIPTA audit	Strengthening laboratory operations towards quality to achieve accreditation recommendation and to support the national disease surveillance system	HTXS, PDTX	$750,000	APHL	10. Laboratory 4.72
An inadequate laboratory specimen transport network	100% of MOHCC facilities (PEPFAR and non-PEPFAR) have sample transportation in place	50% of PEPFAR supported sites have sample transportation in place	100% of PEPFAR supported sites have sample transportation in place	Number of facilities with access to Viral Load testing	Facilities will have an integrated sample transport to the testing labs for VL and EID. National level support will be provided to MOHCC in the design/roll out of the National Integrated Sample Transport System, in order to establish an efficient hub-and-spoke model	HTXS, PDTX	$820,000	APHL	10. Laboratory 4.72
Absence of a Laboratory Information Management System (LIMS)	LIMS is functional in all 8 superlabs	LIMS is functional in 4 (50%) of superlabs	LIMS is functional in all 8 superlabs	Turn around time of test results to the patients from the laboratory (LIMS)	Viral Load/EID LIMS modules will be supported for data management, laboratory testing efficiencies and result transmission to facilities	HTXS, PDTX	$308,712	APHL	10. Laboratory 4.72
TOTAL							$3,989,774		

Table 6.1.2 Key Programmatic Gap #2: Coordination of national Key Populations Strategy									
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**
Limited integration of Key Populations activities into public sector health services	MOHCC supports NAC to facilitate quarterly provincial/district stakeholder coordination and planning meetings which are inclusive of KP organizations. 100% of urban facilities have participated in orientation and/or training. 100% of urban facilities in priority districts are using revised M&E tools.	New activity for COP17	1) KP Coordinator recruited and in place; 2) National KP TWG established and chaired by MOHCC; 3) National KP Strategy finalized and launched; 4) Non-discriminatory MOHCC M&E tools developed for 'highest-risk' clients; 5.) KP competent services established in at least 8 public sector sites in 8 districts.	1.) Number of facilities having received KP competent training; 2.) Number of national stakeholder coordination meetings held; 3.) Number of KP TWG meetings held	Provide secondee support for MOHCC National KP Coordinator	HBHC, HTXS, HVOP, HVSI	$100,000	PSI	7. Human Resources for Health 8.42
Coverage of KPs with HIV services is hampered by insufficient involvement and capacity of smaller KP groups (e.g. LGBTI)	Structured participation in planning and monitoring service delivery of all 4 key KP groups (FSW, MSM, male SW, LGBTI) in 100% of locations where there are KP investments	New activity for COP17	1.) At least 2 new KP CSOs or networks are engaged as partners in each of the 5 KP focus areas; 2.) Monthly district level coordination meetings take place with KP representation in 100% of districts with KP investments.	1.) Number of new KP CSOs or networks engaged as partners on the KP program; 2.) Minutes from district planning/coordination meetings	Mapping of district level KP networks. Identification and onboarding of new networks as partners in the KP program. Training and capacity building of new networks.	HVOP	$50,000	PSI	7. Human Resources for Health 8.42
Provision of health services for KPs characterized by stigma and discrimination within the public sector	KP CSOs report 50% reduction in stigma and discrimination as reported on community score card at 100% of targeted health facilities	New activity for COP17	1.) KP CSO ongoing feedback mechanism established & taken up by 100% of targeted sites (as evidenced by meeting minutes, MOU or advisory committee TOR); 2.) At least 1 HCW completes attachment in 100% of targeted facilities; 3.) At least 8 puublic sector facilities in 8 districts complete values exploration training.	1.) Facility-level assessments for KP-competent services involving KP themselves; 2.) Number of HCWs completing attachments; 3.) Number of facilities having completed values exploration training	Mechanisms for ongoing KP CSO feedback established. Attach public sector HCWs to current KP service delivery sites for observation and practice. Values exploration exercises facilitated at all targeted facilities. Establish referral system with CSOs and private sector to ensure KP not comfortable accessing services in public sector can access them elsewhere.	HBHC, HTXS	$217,700	PSI	13. Epidemiological and Health Data 3.87
Limited availability of KP-competent services in the public sector	100% of urban health facilities provide KP-specific and KP-competent services	New activity for COP17	1.) KP package of services for integration into the public sector is defined/documented in a SOP; 2.) 100% of providers in at least 8 public sector facilities in 8 districts are oriented to the KP services	Number of public sector facilities providing KP competent services	Define package of KP services for public sector based on WHO guidelines. Train HCWs and orient service providers in targeted facilities. Establish KP community feedback process for ongoing monitoring.	HTXS	$1,000,000	PSI, ITECH	13. Epidemiological and Health Data 3.87
Lack of sustainability in condom program which threatens availability and uptake of condoms at the level required for epidemic control	Condom use with non-marital partners for men increases from 37% to 47% and for women, from 50% to 60%	New activity for COP17	100% of costs for basic packaging, warehousing and distribution are recovered, allowing all donor funding to be focused on demand creation and marketing to attract new users	1.) Number of new users willing to pay for social marketed condoms; 2.) Number of existing users retained; 3) DHS condom use data for 3 year outcome	Accelerate cost recovery measures. Increase demand creation and marketing for new users among priority populations; reposition public sector condom to cater for those who will fall out of Protector Plus market	HVOP	$500,000	PSI - SPSS	13. Epidemiological and Health Data 3.87
TOTAL							$1,867,700		

Table 6.1.3 Key Programmatic Gap #3: Suboptimal ART initiation and adherence								
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**
Inconsistent monitoring and reporting of ART side-effects, and insufficient data sharing with stakeholders, leads to community concerns about ARV safety and reduced adherence	**Quarterly AE reports shared with all stakeholders including CSOs, and AE analysis with CSO feedback shared at semi-annual MOHCC planning meetings**	**New activity in COP17**	**All quarterly reports on ART side effects shared with stakeholders quarterly**	**Number of facilities reporting side effects regularly** **Number of consolidated quarterly reports shared with community and other stakeholders**	**Central-level support to improve monitoring and reporting of ARV side effects, and routine analysis and utilization of data**	**HTXS**	**$40,000**	**ITECH**	**13. Epidemiological and Health Data 3.87**
Lack of consistency and coordination of HIV QI activities	Standardized QI process and methodology implemented in 100% of PEPFAR-supported sites	National QI M&E indicators are developed and aligned with updated treatment guidelines	60% of sites are implementing standardized services and QI processes	National QI framework and indicators utilized at all facilities implementing HIVQI projects	Expand the National QI framework and harmonization with goals for HIV epidemic control	HTXS, PDTX	$300,000	HealthQual	9. Quality Management 8.67
Facilities lack capacity and dedicated processes for HIV QI	100% of PEPFAR-supported facilities demonstrate: 1. Site specific systems analyses for selected challenges in service delivery, and 2. Documentation of interventions and their impact	10% of facilities have: 1) Developed capacity on HIV QI methodology 2) Dedicated personnel working on HIV QI projects	50% of PEPFAR-supported facilities demonstrate: 1. Site specific systems analyses for selected challenges in service delivery, and 2. Documentation of interventions and their impact	# of sites implementing systems-level QI interventions; % improvement in selected QI indicators post-intervention	Site specific systems analyses are conducted to understand challenges and gaps in HIV service delivery Mentorship TA to initiate projects and quarterly meetings for ongoing monitoring of progress Implementation of self-sufficient facility- level QI systems identify HIV service delivery challenges and gaps (e.g. Treat All uptake, VL uptake, EID performance) and implement strategies to address them	HTXS,HVTB, PDTX	$600,000	EGPAF, EQUIP	9. Quality Management 8.67
TOTAL							$940,000		

Table 6.1.4 Key Programmatic Gap #4: Insufficient national data for programmatic decision making								
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**
Limited availability and dissemination of national AGYW and youth data to address epidemiologic control	**AGYW-specific programs have documented responses to emerging data in their tailored interventions**	**New activity in COP17**	**Implementation of two data analysis/data to action workshops**	**Final dissemination report & workshop assessment report**	**Data Analysis Workshop and Data to Action Workshops to improve MOHCC, ZIMSTAT, SNU level staff capacity in data analysis and dissemination of YAZ/VACS, ZDHS and ZIMPHIA results**	**HVSI**	**$53,910**	**EGPAF**	**13. Epidemiological and Health Data 3.87**
Incomplete implementation of national HR Information System (HRIS) [formerly TrainSMART] and integration into nationwide DHIS-2	HRIS has been integrated into DHIS2	~~TrainSMART decentralization of HRIS to the district level~~ Completed	100% interoperability of HRIS with DHIS2	DHIS-2 integration of Trainsmart and HR information system into the national platform	1. Complete transition and interoperability of HR system to the MOHCC and Regulatory Authorities 2. Trained system administrators to maintain the system (7 from councils, 12 from MOHCC, 6 from central hospitals	HVSI	$300,000	ITECH	7.6 HR Data Collection and Use: 1.17
Limited knowledge of Drug Resistance prevalence in Zimbabwe	**National HIVDR system fully implemented** **Documented use of data to guide MOHCC decision-making**	**New activity in COP17**	**Drug resistance framework and strategy developed** **HIVDR protocol approved and implementation started**	**HIVDR annual report**	**Develop national drug resistance framework and strategy** **HIVDR protocol drafted, approved and implementation started**	**HVSI**	**$270,000**	**ICAP**	**13. Epidemiological and Health Data 3.87**
PMTCT knowledge gaps in results and outcomes to inform public health policy, guidelines and quality of care	**Documentation of 2+ programmatic changes based on outcome of study results**	**New activity in COP17**	**Documentation of 2+ programmatic changes based on outcome of study results**	**Data and results from completed PMTCT-E study**	**Provide TA to MOHCC for translating the PMTCT-Effectiveness study into programmatic shifts**	**HVSI**	**$53,000**	**ICAP**	**13. Epidemiological and Health Data 3.87**
National VMMC target-setting process is currently based on program data of varying quality and completeness, and subjectively estimated district level VMMC capacity	**PEPFAR-supported VMMC targets reflect most recent data and highest impact areas of Zimbabwe**	**New activity in COP17**	**Fully Operational Online DMPPT with accurate estimates accessible by PEPFAR and stakeholders**	**PEPFAR and national output and outcome level targets and assumptions are aligned with accurate estimates of national coverage levels**	**Rerun the DMPPT model for all districts (not just PEPFAR-supported districts), with wide stakeholder participation, and with most recent DHS and ZIMPHIA data, to ensure alignment of VMMC program with highest impact districts**	**CIRC**	**$150,000**	**Project SOAR**	**13. Epidemiological and Health Data 3.87**
TOTAL							$826,910		

Table 6.2.1: Test and START									
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**
Systems for retention and defaulter tracing are weak--both in facilities & communities	Health care workers in 100% of PEPFAR supported sites receive on site orientation on OSDM and provide differentiated care for clients Health care workers in 100% of PEPFAR-supported sites receive on site orientation on the referral tool.	Operational and service delivery manual (OSDM) updated and distributed to 100% of PEPFAR supported facilities. Health care workers in 30% of PEPFAR supported sites receive on site orientation on OSDM and provide differentiated care for clients National guidelines for linkages, retention and adherence are developed Standard referral tools are distributed to 100% of PEPFAR supported sites	Health care workers in 60% of PEPFAR supported sites receive on site orientation on OSDM and provide differentiated care for clients Health care workers in 60% of PEPFAR-supported sites receive on site orientation on the referral tool.	1a. Number (%) of sites with a copy of the OSDM. 1b Number (%) of health care workers oriented on the OSDM. 1c. Number (%) of clients receiving differentiated care. 2a. Number (%)of sites with the standard referral tool. 2b. Number (%) of health workers oriented on the referral tool. 2c. Number (%) of clients referred from facility to community using the referral tool.	Continued support for clinical secondees at MOHCC AIDS and TB Program [Update: Secondee program continuing in COP17. National guidelines have been revised as has the Operational Service Delivery Manual. Linkage and referral tool has been developed]	HBHC, PDTX, PDCS, HTXS	$400,000	OPHID	7. Human Resources for Health 8.42
Inadequate mental health services for diagnosis and treatment of common conditions that undermine adult and adolescent ART adherence	**80 high volume PEPFAR-supported sites offer mental health services**	**New activity in COP 17**	**1.) 2 facilities (high volume) per district staffed with trained lay cadres for mental health 2.) 80 high volume facilities are equipped with job aids/tools for screening and intervention on common mental health disorders**	**Number of facilities implementing lay cadre mental health intervention**	**1.) Training and deployment of 80 lay cadre staff using existing, locally validated mental health screening and intervention tools 2.) Printing and distribution of screening/intervention tools**	**HBHC, PDCS**	**$542,689**	**OPHID, ITECH**	**6. Service Delivery 7.22**
Lack of coordination among facilities and partners in Harare to accelerate Treat All and VL activities using QI methodology	100% of facilites in Harare/Chitungwiza are implementing QI	QI committees established in 100% of Harare/Chitungwiza facilites Quarterly collaborative meetings are documented	100% of facilites in Harare/Chitungwiza are implementing QI	1a. # of sites where Treat All systems analyses conducted whose recommendations have been implemented. 1b.% change in performance of Treat All between pre and post intervention. 2a. # of VL systems analyses conducted whose recommendations have been implemented. 2b. % change in VL uptake between pre and post intervention.	QI Collaborative for Harare/Chitungwiza established; Documentation and dissemination of pre- and post-intervention performance, and improvements/challenges in Treat All and VL uptake is implemented	HTXS	$225,000	HealthQual	9. Quality Management 8.67
TOTAL							$1,167,689		

Table 6.2.2: New and efficient service delivery models									
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**
Facility capacity (HRH, infrastructure, and record keeping) challenges to increased ART scale-up	All stable patients (approximately 30% of patients on ART) shifted to differentiated care models to decongest facilities, and intensified package of services for pregnant women at elevated risk of MTCT	Initial roll-out: 10% of ART patients receiving differentiated care.	50% of pregnant women monitored with VL: differentiation of care and extended HEI prophylaxis for those with viremia. 30% of adult ART patients transitioned to CARGs and/or other models of service delivery	Percentage of pregnant women receiving VL. Percentage of adult ART patients enrolled in CARGs	Secondee support to MOHCC to accelerate data integration and management. Intensification and targeting of Lab HRH/Systems support to prioritize pregnant women	HXTS, HVSI	$650,000	ICAP	13. Epidemiological and Health Data 3.87
Paper-based ART M&E tools and electronic systems using retrospective data entry are outdated; don't allow for maximum support to providers, are not integrated with other health services, and do not allow for monitoring retention over time	100% of high-volume ART sites nationally have EHR in place	EHR saturation completed in 1 district MOHCC joint development and endorsement of EHR Roadmap Development of additional E.H.R modules to accommodate HIV-related services including Lab, Pharmance, HTS	EHR implemented at all high-volume sites in Harare and Bulawayo	Number of sites with E.H.R.	1. National scale-up of EHR to provinces & districts beyond UMP with additional modules (HIV, LMIS, Pharmacy) included. 2. Continued support of the MOHCC's health information systems roadmap and framework to integrate, track, and manage electronic systems and case-based surveillance	HTXS, PDTX, HVSI	$1,768,289	RTI	13. Epidemiological and Health Data 3.87
As a high risk group, HCWs lack appropriate services to ensure screening, diagnosis and treatment of TB	TB infection control activities no longer need support from PEPFAR	1.) National HCW screening policy developed 2.) HCW screening/wellness programs established in pilot sites 3.) TBIC oversight by MOHCC provincial and district structures	1.) National HCW screening policy disseminated and shared regionally as best practice 2.) TB screening among HCW established at all district-level and high-volume facilities 3.) Semi-annual dissemination of TBIC implementation and performance data by MOHCC	1.) National policy on HCW screening 2.) # of facilities implementing HCW screening/wellness programs 3.) Quarterly data on TBIC indicators routinely reported	1) Development of national HCW TB screening policy with MOHCC, private sector, professional societies, and community stakeholders 2) Initiate HCW TB screening in pilot facilities through wellness programs 3) Incorporate TBIC implementation and M&E into routine provincial and district MOHCC processes	HVTB	$500,000	BRTI	6. Service Delivery 7.22
Facility systems for tracking pre- and post lab activities for viral load are weak, impeding differentiation of care for high risk and stable patients alike.	VL testing is available at 100% of ART facilities nationally	50% of PEPFAR sites receive standardized job aids disseminated to all PEPFAR supported sites. 50% of ART providers at PEPFAR supported sites receive onsite orientation to VL testing	100% of PEPFAR sites receive standardized job aids disseminated to all PEPFAR supported sites. 100% of ART providers at PEPFAR supported sites receive onsite orientation to VL testing	1a. # of health care workers oriented on the job aids. 1b. # of viral load samples collected per site. 1c. # of samples rejected by the lab from each site. 2a. # of health care workers oriented on the job aids. 2b. # of viral load results received and appropriately filed at each facility. 2c. # of clients notified of results and managed appropriately.	Clinical viral load scale-up support to approximately 900 sites in all districts through provider training, site preparation and patient flow review, and sample transportation systems review.	HTXS	$546,929	OPHID, FHI, ITECH, ZACH	13. Epidemiological and Health Data 3.87
TOTAL							$3,465,218		

Table 6.3 Other Proposed Systems Investments									
Activity	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)**	**Outcomes expected after 3 years of investment**	**Year One (COP16) Annual Benchmark**	**Year Two (COP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
HRH - Systems/Institutional Investments									
Supply Chain Management Institutional and Systems Support	1st/2nd/3rd 90s: 1) National support for quantification and supply planning 2) Secondees to Directorate of Pharmacy Services logistics unit 3) Support for pharmaceutical storage and distribution systems (contributes to benchmark item #2 along with secondees)	Maintain low stockout rates of tracer medicines/products within global industry standards. TLE <1%, LZN [peds]<1%, male condoms <5%, Determine RTK <5%, VMMC FG disposable kit <5%	1) Reports from semiannual quantification exercise 2) Maintain low stockout rates of tracer medicines/products within global industry standards. TLE <1%, LZN [peds]<1%, male condoms <5%, Determine RTK <5%, VMMC FG disposable kit <5%	1) Reports from semiannual quantification exercise 2) Maintain low stockout rates of tracer medicines/products within global industry standards. TLE <1%, LZN [peds]<1%, male condoms <5%, Determine RTK <5%, VMMC FG disposable kit <5%	Stockout rates of key tracer medicines or products at or below global industry standards.	OHSS, HTXS, CIRC, HBHC, PDTX, PTCS	$6,314,159	GHSC-PSM	7. Human Resources for Health 8.42 8. Commodity Security and Supply Chain 6.14
TOTAL							$6,314,159		

Inst & Org Development									
Communications and Public Affairs	1st/2nd/3rd 90: Support to communications activities	At least once-monthly references to PEPFAR-supported programs in print, online and social media	At least 3 positive references to PEPFAR and USG HIV support in print, online and social media	At least 6 positive references to PEPFAR and USG HIV support in print, online and social media	1) Public affairs will track positive media reports on PEPFAR. 2) Monthly newsletter will feature stories and updates about PEPFAR 3) Scheduled engagement meetings with action points and outcomes. A formal engagement plan with # of meetings will be agreed to with CSOs.	HBHC, HVOP, HVSI, OHSS	$50,000	TBD	3. Policies and Governance 7.16
Ambassador's Self-help program	1st/2nd/3rd 90: Support to small projects that touch on various aspects of the cascade with a focus on small organizations	6 small organizations capable of delivering HIV services at the community level	2 small organizations capable of delivering HIV services at the community level	4 small organizations capable of delivering HIV services at the community level	Reports from Self Help project evaluations (conducted at the end of year funding) show completion of projected activities and results	HBHC, HTXS, HVCT, HVOP, HVSI, PDCS	$80,000	TBD (Various)	6. Service Delivery 7.22
Improve Access to Quality HIV Services through monitoring the following at the site and community level: -Quality – Monitoring quality of services and improved access from a community lens, retention in care and linkages between community and health facilities. -Data Gaps & Management- Analysis of approaches to improve data management, this will entail the improving of a data bank in the form of documented case studies, most significant change stories, assessments, -Use – Packaging and utilizing the data and evidence based programming for District level advocacy thus using data to inform program performance, effectiveness, efficiencies and impact.	**1st/2nd/3rd 90: Support to local accountability and monitoring**	**Quarterly community-level feedback on the quality and availability of HIV services, supported by all funding sources.**	**New activity in COP17**	**Quarterly reports covering the following: • Quality • Data Gaps & Management • Data Use**	**Community Scorecards -on patient centric quality of care -adverse reactions -HCW and Partner attitudes -human rights approach -Drug stock outs -TAT**	**HTXS**	**$170,000**	**TBD**	**6. Service Delivery 7.22**
Enhance Local oversight and accountability through structured feedback to PEPFAR and other stakeholders	**1st/2nd/3rd 90: Support to local accountability and monitoring**	**Quarterly civil society meetings to consolidate and share feedback ahead of PEPFAR POART reviews.**	**New activity in COP17**	**• Quarterly CSO/PEPFAR meetings including SIMS results feedback meeting with CSOs • Quarterly Clinical Partners meeting attendance and share reviews and analysis of previous Quarters` results and CSO reflections in the presented results. • Identify implementation bottlenecks**	**# of meetings held #key deliverables**				
TOTAL							$300,000		

DREAMS									
DREAMS activities are not yet integrated into planning at national and district levels; integration of services and bi-directional referrals between facility and community needs strengthening	DREAMS activities are integrated into MOHCC semi-annual planning and quarterly partnership fora Database is routinely used by partners as DREAMS expands and is functionally linked to national DHIS-2	1.) National planning meetings take place monthly. 2.) Referral protocol developed and used by 100% of partners at district level.	1.) National meetings continue to take place monthly and are hosted/facilitated by MOHCC or NAC. 2.) At least 66% of DREAMS districts have coordination/referral meetings at least monthly.	1.) National meeting agendas or minutes. 2.) DREAMS District Secretariat Partner Agendas or minutes	DREAMS Coordinators seconded to MOHCC and NAC at National Level; modest coordination budgets for DREAMS District Secretariat partners	HVOP, OHSS	$292,906	PSI - SPSS, SafAIDS, TBD (WEI f/o), TBD (Africaid), FACT	1. Planning and Coordination 9.33
		DREAMS database developed and interoperable with DHIS2. 100% of DREAMS core partners reporting into DREAMS DHIS 2 database.	DREAMS beneficiaries receiving more than 1 service increases by 100%	DREAMS database: number individuals receiving 1, 2, 3+ services	Refinement of DREAMS database to track DREAMS beneficiaries including what services they've accessed and dropped referrals. Mentoring of partners through monthly DREAMS SI TWG meetings.	HVSI	$150,000	PSI - SPSS	13. Epidemiological and Health Data 3.87
TOTAL							$442,906		

*Reference Appendix C for a list of activity types that fit in each category.

Total: $19,314,356

$ 19,464,356.00

-150,000