PEPFAR Zambia

Country Operational Plan (COP) 2018

Strategic Direction Summary

March 15, 2018

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1.0 Goal Statement

In close partnership with the Government of the Republic of Zambia (GRZ), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program in Zambia has made tremendous progress towards reaching HIV epidemic control targets (≥90% treatment coverage among people living with HIV). Since the 2015 Country Operational Plan (COP) pivot, the program has continued to focus its resources where the burden is greatest. The 2016 Zambia Population Based HIV Impact Assessment (ZAMPHIA) along with UNAIDS HIVe-Map Geospatial model helped PEPFAR Zambia better understand Zambia's epidemic by district, age and sex in order to better target our resources required to reach HIV epidemic control targets through the implementation of COP 2018.

COP18 builds on Zambia's progress towards epidemic control, with a focus on finding the undiagnosed positives, putting them immediately on treatment, and keeping them on treatment in order to achieve viral suppression. Key highlights of COP18 include optimizing testing modalities (such as index testing), improving linkage and retention rates by scaling-up community-based interventions, drastically scaling-up viral load (VL) testing and monitoring, ensuring quality services across the continuum of care for key populations, ensuring universal HIV testing among all persons with TB (or presumptive TB) and immediate treatment for those found co-infected with HIV, and continuing to address the needs of adolescent girls and young women (AGYW).

PEPFAR Zambia acknowledges that reaching HIV epidemic control by 2020 will be challenging, and will require regular site and partner-level management that is informed through (at minimum) monthly data analysis. PEPFAR Zambia also recognizes that success depends on immediate implementation of approaches that are working, and not waiting until COP18 to bring successful approaches to scale. Success will also require close collaboration with the GRZ, Global Fund, and other donors to make sure that the coordination of resources is optimized. Finally, success will require close coordination with civil society in order to make sure that all who are able to contribute are effectively incorporated into Zambia's national HIV response.

Although there are challenges, GRZ recognizes that this is an exciting and significant moment in the country's national HIV response. Zambia has the opportunity to reach epidemic control by 2020, a goal that has been fully endorsed by President Lungu and its implementation is being managed and coordinated by the Ministry of Health (MOH). PEPFAR Zambia is a key stakeholder to GRZ and is committed to ensuring that the $385 million programmed in COP18 results in the achievement of this common goal.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Zambia is a lower, middle-income country (GNI: 3,690 per capita, PPP adjusted[1]) with an estimated population of 17,381,168 in 2019 (population demographics: 49% male, 51% female; 58% rural, 42% urban). According to the 2016 ZAMPHIA released on December 1st, 2016, 12.3% of persons aged 15 – 59 years are infected with HIV (9.5% among adult males, 14.9% among adult females).[2] HIV prevalence among children under 15 years is estimated to be 1.3%. Detailed demographic and epidemiological data is presented in Table 2.1.1.

The HIV epidemic in Zambia is generalized, with heterosexual sex as the primary mode of transmission.[3] Spectrum 2018 data for morbidity and mortality approximates the total number of deaths attributed to AIDS as 15,962 (52.6% male and 79.7% adult). Adult women are disproportionally affected by HIV compared to adult men (8.6% among adult males, 14.5% among adult females). Among persons aged 15-59 years, Lusaka province has the highest prevalence (16.1%), followed by Western (16.0%), Copperbelt (14.2%) and Central provinces (13.4%). Muchinga and North Western provinces have the lowest prevalence, estimated at 5.9% and 6.9% respectively. ZAMPHIA indicates that most HIV positive individuals live in high population density areas. Disease burden is highest in densely-populated Lusaka, Copperbelt, and Southern provinces with populations of PLHIV of 283,831, 235,380, and 164,390 respectively.

To reach epidemic control, and in alignment with Sustainable Development Goal (SDG) number three, to ensure health and well-being for all, including a bold commitment to end the epidemics of AIDS, tuberculosis, malaria, and other communicable diseases by 2030, PEPFAR Zambia will focus on clinical treatment and core combination prevention interventions—specifically those reaching priority locations with elevated HIV burden, treatment gaps, and populations with the greatest unmet need. The PEPFAR ART program will increase the number of patients enrolled in ART from 964,141 (FY 2018 target) to 1,135,316 in 2019.

According to ZAMPHIA, 66% of PLHIV ages 15 - 59 in Zambia reported knowing their status; 85.4% of PLHIV who reported knowledge of sero-status, reported current use of ART and 89.2% of them were virally supressed. The national program retained 86% of those on treatment for at least 12 months during the last fiscal year (FY).The program has demonstrated great success in getting HIV positive pregnant women into treatment; among women ages 15-49 who delivered in the 12 months preceding ZAMPHIA, 93.1% knew their HIV status; while 98.9% of HIV-positive women who gave birth in the 12 months preceding ZAMPHIA received ARVs. Getting HIV positive children less than 15 years of age to get tested for HIV and into treatment has been more challenging. According to ZAMPHIA, 51% of PLHIV < 15 of age are known positives and the overall treatment coverage among paediatrics is 47%.

TB continues to be the leading cause of death among PLHIV; MOH program data indicate 58% TB/HIV co-infection rate in 2017. Great strides are being made to ensure that all TB patients are

[1] World Bank 2014 data.

[2] This estimation is derived from EIA testing; field-based rapid testing preliminarily reported in August 2014 yielded a national HIV prevalence rate of 10.3%.

[3] UNAIDS data estimated 90% of adult infections are attributable to heterosexual transmission.

tested for HIV; in FY 17 over 90% of TB patients knew their HIV status and over 83% of TB/HIV co-infected patients were initiated on ART.

There is limited data on size estimates for MSM and FSWs. Limited program data indicate size estimates of 18,521 and 43,740 for MSM and FSW, respectively. These are probably under estimations of these populations. A protocol, just approved, should begin a robust system of surveillance resulting in better population sizes that can be used for program planning in coming years.

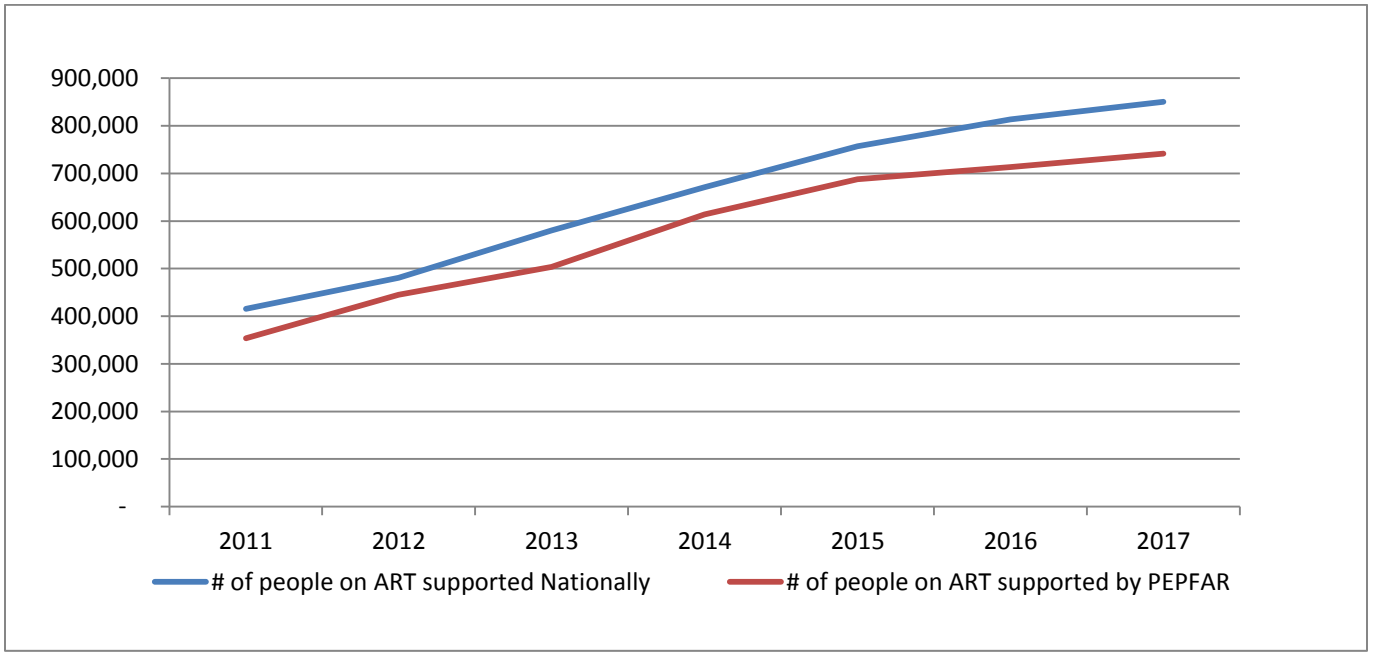
Building on the GRZ's support for the World Health Organization (WHO) 2014 guidelines of treatment for all (Test and Start) and differentiated service delivery models, PEPFAR Zambia will support implementation of a quality, cost-efficient package of integrated HIV care and treatment services consistent with national policies and PEPFAR guidance; with the goal of expanding ART access in prioritized populations and geographic locations; and reducing morbidity and mortality amongst PLHIV.

PEPFAR Zambia acknowledges that a great deal of work is still required to achieve epidemic control and there is a need for more empirical evidence to better define the epidemic in Zambia. Our understanding has drastically improved with the release of ZAMPHIA results, however, we need more detailed statistics on prevalence data from other data sources (e.g., electronic health records (EHR), District Health Information System (DHIS), TB Survey) and have only limited data on key populations (e.g., female sex workers (FSW) and men who have sex with men (MSM)).

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	17,381,168		3,949,804		3,993,734		1,767,512		1,747,959		3,061,740		2,860,419		Central Statistical Office Projections, 2017
HIV Prevalence (%)		12.30%		1.187		1.41		5.72		1.88		21.24		15.04	Zambia Population Based HIV Impact Assessment (ZAMPHIA), 2017
AIDS Deaths (per year)	18,777		21,117		2,167		1,074		691		6,390		6,338		Spectrum Estimates, 2017
# PLHIV	1,261,320						101,555		42,510		568,509		412,615		Spectrum Estimates, 2017
Incidence Rate (Yr)		0.54		N/A		N/A		1.00		0.33					Spectrum Estimates, 2017
New Infections (Yr)	58,900														Spectrum Estimates, 2017
Annual births	834,296	4.80%													Ministry of Health estimates
% of Pregnant Women with at least one ANC visit	825,953	99%	N/A	N/A			N/A	N/A			N/A	N/A			Zamphia 2016
Pregnant women needing ARVs	100,116	12%													Zamphia 2016
Orphans (maternal, paternal, double)	1,328,000		N/A		N/A		N/A		N/A		N/A		N/A		NACMIS, 2010
Notified TB cases (Yr)	40,153		1,012		1,281						13,518		24,342		Ministry of Health National TB program NTP report. Data is only by <15 and 15+
% of TB cases that are HIV infected	23,289	58%													Ministry of Health National TB program NTP report, 2017
% of Males Circumcised	2,000,000	23%			800,000	40%			1,080,000.00	54%			120,000	6%	Ministry of Health, HMIS, 2017

Figure 2.1.3 National ad PEPFAR Trend for Individuals currently on Treatment



2.2 Investment Profile

The U.S. Government through PEPFAR continues to fund the majority of Zambia's HIV response. However, the GRZ budget allocation for procurement of ARVs is increasing with $35M allocated for purchasing ARVs in 2018 compared with $23M in 2017. This trend is expected to continue as GRZ implements the recently finalized Health Care Financing Strategy.

In December 2017, the MOH presented the National Health Insurance (NHI) bill to Parliament. The NHI would, for the first time in Zambia's history, provide a single designated funding pool for health revenues including HIV/AIDS. It is a welcome development in light of the fact that PEPFAR support has decreased by 7% ($26M) from COP17 to COP18. The U.S. government will continue its support towards the NHI, as failure to implement will weaken GRZ's resource mobilization efforts, which will impact gains made towards achieving HIV epidemic control. Other factors that could impact the government's sustainability efforts are the application of the debt management policy and the contraction of the public wage bill with a target of 45% of domestic revenues by 2020.

The private sector has shifted its funding portfolio from largely supporting OVC, HIV prevention and program management to HIV treatment and prevention.

WHO estimates that between 20%–40% of all resources spent on health are wasted through leakages, inefficient combinations of interventions, and sub-optimal use of medicines and human resources. Improving efficiency is about preventing more new infections and saving more lives by doing the right things for the right populations, as well as delivering quality services at the lowest cost. In COP18, PEPFAR will work with GRZ and other donors such as Global Fund to ensure that efficiencies are maximized.

Table 2.2.1 Annual Investment Profile by Program Area[4]

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	$265,681,326	75%	11%	14%	0%
Community-based care, treatment, and support	$35,302,198	93%	7%	0%	0%
PMTCT	$20,286,696	71.0%	10%	19%	0%
HTS	$21,209,846	95%	5%	0%	0%
VMMC	$19,830,360	93%	7%	0%	0%
Priority population prevention	$7,594,038	78%	22%	0%	0%
AGYW Prevention	$14,969,567	88%	7%	0%	5%
OVC	$24,861,322	96%	4%	0%	0%
Laboratory	$10,335,194	82%	15%	3%	0%
SI, Surveys and Surveillance	$19,237,974	91%	9%	0%	0%
HSS	$28,178,610	35%	26%	32%	7%
Total	$467,469,131	78%	11%	10%	1%

Table 2.2.2 Annual Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRZ	% Other
ARVs	$107,210,071	69.53%	24.31%	6.16%	0.00%
Rapid test kits	$8,852,313	51.00%	49.00%	0.00%	0.00%
Other drugs	$492,793	0.00%	0.00%	100.00%	0.00%
Lab reagents	$25,863,550	73.71%	13.14%	13.15%	0.00%
Condoms	$4,010,311	26.00%	0.00%	4.00%	70.00%
VL commodities	$9,995,350	71%	29%	0.00%	0.00%
VMMC kits	$0.00%	$0.00%	$0.00%	$0.00%	$0.00%
MAT	$0.00%	$0.00%	$0.00%	$0.00%	$0.00%
Other commodities	$0.00%	$0.00%	$0.00%	$0.00%	$0.00%
Total	$156,424,388	68.09%	22.45%	7.65%	1.81%

[4] (2017-2018 Yellow Book, 2017 Funding Landscape, National AIDS Spending Assessment 2012)

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	$13,300,000	$4,880,000	6	$0	Maternal, newborn, and child health (MNCH) activities target pre-service training in Emergency Obstetric and Neonatal Care (EmONC) targeting nurse clinical instructors in the midwifery schools and advocating for the integration of EmONC into the midwifery curriculum. Complement PEPFAR and FP activities, particularly through close provincial and district level collaboration. Saving Mothers, Giving Life (SMGL), in particular represents a nexus of activities (PEPFAR and MNCH/FP) to reduce maternal and newborn deaths in targeted districts.
USAID TB	$3,500,000	$2,500,000	1	$2,352,000	TB activities strengthen high-quality DOTS expansion and enhancement, address TB-HIV, MDR-TB and the needs of poor and vulnerable populations in six high burden target provinces, engage all categories of care providers, and enable and promote operational research.
USAID Malaria	$30,000,000	$8,717,330	2	$0	Malaria activities designed to reduce malaria mortality by two-thirds, malaria incidence by three-fourths, and malaria parasitemia in children under age five by one-half in four targeted provinces through Insecticide-treated bed nets (ITN) distribution, case management, delivery of intermittent preventive treatment to pregnant women, behavioral change interventions, development of policies and guidelines, and strengthening management capacity at a provincial and district level.
Family Planning	$13,000,000	$8,850,000	9	$5,750,000	Reproductive health (RH)/FP activities will increase modern contraceptive prevalence

					rates in all women of reproductive age by 2% annually from the second year as compared to the baseline through increased access to and improved quality of family planning services in targeted sites via a strengthened, community-based family planning service delivery system.
Nutrition	$2,375,000	$500,000	4	$1,850,000	Nutrition resources target integrated management of childhood illness, expanding immunization, Vitamin A supplementation, and de-worming activities. Training of health workers and community volunteers in child health and nutrition helps reduce under-five morbidity and mortality. Activities strengthen infant and young child feeding and are integrated with other Feed the Future activities that help vulnerable households improve food security through strengthened economic resilience and improved nutrition status. Nutrition activities are also designed in collaboration with other donors as part of the global Scaling up Nutrition Initiative. (USAID is part of the Cooperating Partner Nutrition Group (co-convened by DFID and UNICEF) that coordinates assistance for Zambia's work to address malnutrition. The group has helped develop a multi-stakeholder platform and a civil society umbrella group to address under nutrition).
NIH	$0	$0	0	$0	No direct funding to CDC Country office.
CDC (Global Health Security)	$0	$0	0	$0	No direct funding to CDC Country office.
Peace Corps	$152,754	$0	0	$0	Peace receives Health funds from USAID through an Inter-Agency Agreement. This is a Cross Cutting Health Systems Strengthening fund focused on Maternal & Child Health, and Malaria.
DOD Ebola	$0	$0	0	$0	No direct funding to DOD Country office.
MCC (FY2018)	$141,368,413	$0	0	$0	The $355 million Zambia Compact aims to expand and improve the reliability of water supply, sanitation and drainage services in

					select urban and peri-urban areas of Lusaka with the objective of decreasing the incidence of water-related diseases and flood losses incurred by businesses and residences, therefore generating significant time savings. The Infrastructure Activity supports improvements and expansion of infrastructure managed by the Lusaka Water and Sewerage Company (LWSC), the utility primarily responsible for managing the city's water and sanitation infrastructure, as well as the Lusaka City Council (LCC), the local government entity responsible for managing Lusaka's drainage infrastructure. The Institutional Strengthening Activity supports sector and institutional strengthening for LWSC and LCC with a focus on sustainability. The MCC Zambia Compact is expected to benefit 1.2 million people in the city of Lusaka.
MCC (CDC)	$100,000		0	$0	Strengthen capacity to collect surveillance data for opportunistic infection, primarily diarrhea, at health facilities by enhancing trained human resource in surveillance, laboratory capacity, and outbreak response in the Zambia. Water and Sanitation (Diarrhea Sentinel Surveillance) Surveillance Human Resource Enhancement. By the end of the first report period at least 1 quality assurance training in microbiology will be held with 30 Ministry of Health staff involved in diarrhea surveillance to promote quality in laboratory testing of diarrhea and reporting of surveillance data By the end of the first reporting period procure select laboratory equipment, media and reagents, and other laboratory consumables to enhance laboratory confirmation of pathogens causing diarrhea in patients presenting to select health facilities. Laboratory Sentinel Surveillance Enhancement.

					By the end of the first report period test at least 1,500 stool samples for patients (both under five and over years of age) presenting to health facilities with diarrhea By the end of the first report period document all cases meeting the case definition of diarrhea and forward these to the next level of the diarrhea surveillance system.
Total	**$203,796,167**	**$25,447,330**	**22**	**$9,952,000**	

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
DREAMS Innovation	$0	$0	$0	0	$0	n/a
VMMC – Central Funds	$0	$0	$0	0	$0	n/a
Other PEPFAR Central Initiatives	$0	$0	$0	0	$0	n/a
Other Public Private Partnerships:						
PRRR	$0	$850,000	$300,000	5	$4,400,000	Scaling up of Cervical Cancer testing; Support for tissue pathology preparation; HR; Capacity building, equipment & consumables; SMS
Total Market Approach to Health	$0	$4,800	$0	0	$0	Extend partnership to more private sector employers to increase reach. Support advocacy for health insurance companies to cover VMMC in their package of services.

Eradicate TB	$0	TBA	$0	0	$0	i) Engage mobile provider for TB initiative to support improved communication and systems strengthening, in addition to offering effective TB information. Such as patient reminders for treatment adherence, toll free health professional and community TB information line ii) Capacity building of community care givers.
Partnership for Support of OVC & Youth	$0	$21,000	$0	0	$0	Life skills training for Young Women and Barclays Bank Ready to Work program for youths
Total	**$0**	**$875,800**	**$300,000**	**5**	**$4,400,000**	

2.3 National Sustainability Profile Update

The PEPFAR Zambia team used a transparent and participatory process to complete the Sustainability Index and Dashboard (SID). PEPFAR and UNAIDS co-convened a multi-stakeholder SID consultation workshop on November 7, 2017. This meeting was attended by representatives from several host government ministries and departments, multilateral organizations, local non-governmental organizations, and civil society organizations[5].

An analysis of SID findings identified strengths in some sustainability elements that may facilitate the attainment of epidemic control (Table 2.3.1). The analysis also revealed weaknesses in some priority elements, ranked on the basis of element score and criticality to sustained epidemic control (Table 2.3.2).

Section 4.5.5 outlines how the SID informed the development of COP18, specifically activities within Table 6.

[5] A total of 41 people attended the meeting with representation from:
Government of Zambia (MOH,MNDP, MOD); Multilateral organizations (UNAIDS, UNDP, WHO, UNFPA):
Local and international NGOs and Civil Society (NZP+, ZNARVS, THPAZ, Bwafano, ABWENZI, TALC, ZNADWO, ZATULET, SWAAZ, CITAM+); USG.

Table 2.3.1 Sustainability Strengths	
Element/Score Description	Notes on Sustainability
Planning and Coordination (Score 9.29/10)	
This element score has increased from 7.73 in SID 2.0. Zambia has a costed, multi-year national strategy, which is updated at least every five years (with key stakeholders) and includes critical components of prevention and treatment. The GRZ leads the development/revision of the National AIDS Strategic Framework (NASF) with active participation from civil society, businesses and corporate sector, and external agencies. Additionally, the GRZ routinely tracks HIV/AIDS activities of CSOs and donors, leads the process that convenes stakeholders, and develops joint operational plans with implementing organizations.	Effective planning and coordination are critical to the implementation and scale up of treatment and prevention programs and the achievement of 90-90-90 goals. The importance of the role of the MOH and the National AIDS Council (NAC) in this regard cannot be overemphasized. Host country leadership in planning and coordination promotes country ownership and sustainability of the national response. PEPFAR Zambia will continue to provide technical and financial support to the GRZ, as required, to further strengthen planning and coordination capacity.
Private Sector Engagement (Score 8.39/10)	
This element score has increased from 6.11 in SID 2.0.The host country government has formal channels and opportunities for diverse private sector entities to engage and provide feedback on its HIV/AIDS policies, programs, and services. Systems and policies that allow for private corporate contributions and health service delivery exist.	PEPFAR will strengthen private sector capacity in HIV service provision to facilitate implementation of test and start and routine VL testing, which contribute to reduced congestion and better quality of service in public health facilities. PEPFAR will continue to support social marketing (SM) of condoms as a key strategy for implementing a total market approach; SM condoms are distributed at over 500 sales points across Zambia. Additionally, PEPFAR will engage the private sector to support training of community health workers to improve access to HIV services in high burden areas.
Commodity Security and Supply Chain (Score 7.22/10)	
This element score has increased from 5.69 in SID 2.0. Domestic resources fund 10-49% of ARV, rapid test kit and condom procurements. The country has a national supply chain plan that guides investments and the host government manages processes and systems that ensure appropriate ARV stock at all levels. However, the country faces challenges with storage space, and this is likely to be exacerbated by scale up of prevention, care and treatment services. PEPFAR continues to support expansion of storage space in COP 17.	Stakeholders that contribute towards commodity security and supply chain include GRZ, PEPFAR, Global Fund, World Bank, DFID, SIDA and EU. The availability of life-saving antiretroviral (ARV) medications and other HIV commodities is essential for the achievement of sustained epidemic control. As such, PEPFAR will continue to prioritize investment in this element in COP 18. This will include assuring the availability of stocks at facility level by: strengthening forecasting and qualification capacity; supporting commodity procurement, distribution and tracking at the point of service; and supporting electronic logistics management information systems.

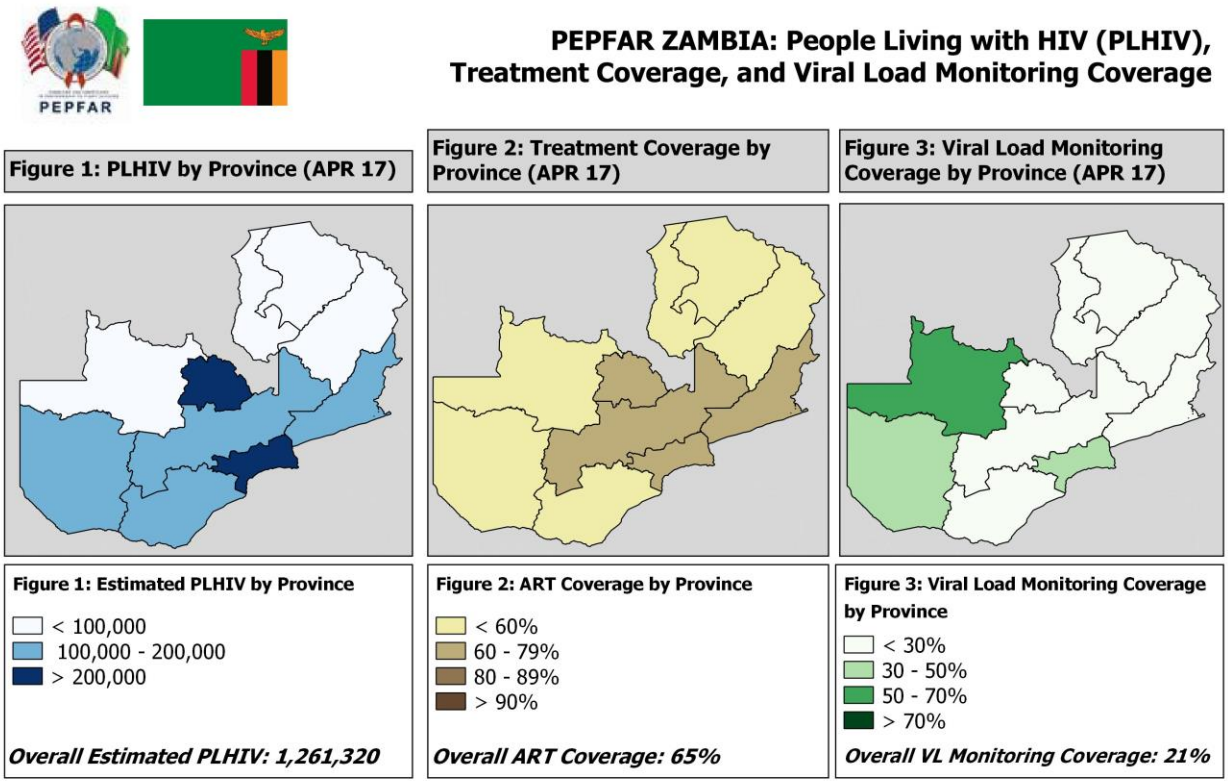
Table 2.3.2 Sustainability Vulnerabilities	
Element/Score Description	Notes on Sustainability
Laboratory (Score 2.33/10)	
This element score has decreased from 4.86 in SID 2.0. The availability of high quality laboratory services is critical to scale up HIV services, including implementation of test and start and achievement of the third 90. The SID found that Zambia does not have adequate qualified laboratory personnel to achieve sustained epidemic control. Current infrastructure is not sufficient to test for VL to reach sustained epidemic control. Although regulations to monitor quality of laboratory and POC testing sites exist, they are partially implemented, and the national laboratory strategic plan has not been approved. Domestic resources fund only 1-9% of laboratory services.	Main stakeholders that have invested in HIV lab services include the GRZ, PEPFAR, Global Fund, World Bank, and other bilateral cooperation initiatives. PEPFAR will continue to support activities to increase laboratory capacity, including addressing the staffing gap, procurement of equipment/reagents, targeted infrastructure improvement and provision of backup power solutions for labs in high HIV burden areas. Sample transportation and result return systems will also be strengthened.
Epidemic and Health Data (Score 4.37/10)	
This element score has decreased from 4.62 in SID 2.0. The timely availability of accurate and reliable data is critical to plan and implement a successful national HIV response. The SID found that key population surveys and surveillance are primarily planned, financed and implemented by external agencies, organizations or institutions. The host government does not conduct IBBS or size estimation studies for key populations	Main stakeholders that have invested in Epidemic and Health Data include the GRZ, PEPFAR, EU, DFID, WHO, Global Fund, World Bank, and other bilateral cooperation initiatives. In FY 2019 PEPFAR will: support scaling up of case-based surveillance systems; conduct key population estimates and integrated bio-behavioral survey; provide tools and TA to improve program data quality and support HIV-related surveillance; build HMIS management capacity by utilizing an MOH standardized approach and support tools; and develop a national action plan to strengthen capacity development within Zambian research institutions.
Service Delivery (Score 5.32/10)	
This element score has increased from 4.72 in SID 2.0. Facility – community linkages are critical for HIV prevention, care and treatment scale up, including implementation of differentiated service delivery models and test and start. Although the country has standardized the design and implementation of community-based HIV services, not all representative service providers are included. It is unclear whether 10% of District Health Office budgets actually go towards implementation of community activities. Further, inadequate facility infrastructure has impeded effective facility linkage to community. Host country institutions deliver HIV services with substantial external technical assistance and provide minimal (1-9%) financing for delivery of HIV services to key populations. National and sub-national health authorities do not develop sub-national budgets that allocate resources to high HIV burden service delivery locations. Resources are allocated based on catchment population.	Stakeholders that have invested in HIV service delivery include the GRZ, PEPFAR, Global Fund, World Bank, and local non-governmental organizations such as Churches Health Association of Zambia (CHAZ). PEPFAR will strengthen facility-community linkages to facilitate the implementation of differentiated models of care and decongest health facilities. PEPFAR will also support delivery of HIV services to key populations.
Human Resources for Health (Score 6.27/10)	
This element score has increased from 6.17 in SID 2.0. An adequate number of trained and motivated health workers, with the appropriate skills mix, deployed to areas of greatest need (at facility and community level) is critical to implementation of Test and Start and differentiated service delivery models. Zambia is facing a critical shortage of health workers with approximately 60% of	Several key stakeholders have invested in HRH, including the GRZ, World Bank, DFID, EU, and Clinton Health Access Initiative (CHAI). Given the importance of this element to achieving sustainability of the national response, continued investment is warranted despite the relatively high sustainability score. PEPFAR will continue to support PSE to increase the number of new health workers. This will include the training of community health assistants to

positions in the health sector establishment remaining vacant (MOH Establishment Analysis, January 2018). The SID found that Zambia has an inadequate supply of health workers to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or community site level. Pre-service training institutions are not producing an adequate supply and skills mix of health care providers and the country's health workers are not adequately deployed to facilities and communities with high HIV burden. Although an inventory of donor-supported health workers exists, there is no official plan to transition these staff to local support.	facilitate the implementation of community ART programs. PEPFAR will recruit and deploy community based workers to high HIV burden areas in order to improve linkage to and retention in treatment. Despite the fact that GRZ grants treasury authority for net recruitment of health workers on an annual basis, there is inadequate fiscal space to absorb all health workers on the market. Salary support for a limited period of time will be required to address this challenge.

2.4 Alignment of PEPFAR investments geographically to disease burden

An essential component of the annual COP design process is the refinement of the geographic alignment of PEPFAR investments to disease burden. In COP 18 PEPFAR Zambia utilized UNAIDS HIVe-Map Geospatail model PLHIV estimations that disaggregate HIV burden by district, age and sex. PEPFAR Zambia then organized districts by burden from greatest to least and selected the 73 of 107 districts that constitute a full 80% of overall HIV burden for Zambia. These districts were prioritized to achieve 95% ART coverage at the end of COP18 and were classified as either attained or scale up to saturation based on the feasibility of reaching epidemic control across all age and sex bands within the COP18 implementation period. Two districts (Kazungula and Masaiti) previously classified as central support were promoted to the scale up to saturation category as a result of this analysis; the HIVe estimations showed greater PLHIV burdens in these districts than previously estimated. This district selection process ensured that no high burden districts were left behind and that COP18 targets were concentrated in districts with the greatest unmet need for ART and greatest preponderance of new infections.

Of the remaining 34 districts, 17 scale up aggressive and sustained districts constitute 6% of the PLHIV burden in Zambia. These districts received aggressive targets that were calculated based upon a 50 percentage point increase to the ART coverage rate from baseline at APR 2017. COP18 maintains the final 17 districts as central support due to low relative PLHIV burden.



Province	Estimated Number of PLHIV	Percent PLHIV by Province	Estimated Current on ART, end of FY17	ART Coverage
Central Province	140,485	11%	106,783	76%
Copperbelt Province	241,371	19%	174,404	72%
Eastern Province	105,787	8%	76,304	72%
Luapula Province	74,214	6%	37,340	50%
Lusaka Province	285,632	23%	208,593	73%
Muchinga Province	29,669	2%	15,037	51%
Northern Province	58,748	5%	30,708	52%
North western Province	41,563	3%	21,120	51%
Southern Province	175,365	14%	95,647	55%
Western Province	108,486	9%	58,807	54%
Grand Total	**1,261,320**		**824,743**	65%

VL Suppression Data

Province	Indicator	TX_PVLS			TX_RET		
	Numerator/ Denominator	FY17 Cumulative Results	FY17 Target	FY17 %	FY17 Cumulative Results	FY17 Target	FY17 %
_Military Zambia	N	4,809	10,488	46%	424	3,499	12%
	D	6,943	10,488	66%	438	3,499	13%
Central Province	N	7,263	19,856	37%	9,699	10,432	93%
	D	13,923	76,823	18%	10,782	11,641	93%
Copperbelt Province	N	22,328	56,039	40%	17,874	25,303	71%
	D	25,316	217,567	12%	19,898	28,093	71%
Eastern Province	N	8,874	25,152	35%	7,217	14,399	50%
	D	10,611	25,152	42%	9,287	14,399	64%
Luapula Province	N	1,943	6,010	32%	3,986	4,304	93%
	D	3,643	22,839	16%	4,786	5,085	94%
Lusaka Province	N	66,109	55,880	118%	21,066	31,083	68%
	D	71,441	59,860	119%	28,721	33,238	86%
Muchinga Province	N	1,880	4,487	42%	1,815	2,343	77%
	D	2,348	17,060	14%	2,234	2,624	85%
Northern Province	N	3,363	6,655	51%	4,091	5,622	73%
	D	4,575	26,620	17%	4,777	6,227	77%
North Western Province	N	5,577	4,455	125%	1,961	3,588	55%
	D	11,844	17,818	66%	2,475	4,158	60%
Southern Province	N	11,370	29,669	38%	9,209	19,610	47%
	D	13,699	29,398	47%	11,341	19,650	58%
Western Province	N	11,340	11,823	96%	4,654	6,293	74%
	D	17,468	11,823	148%	5,749	6,293	91%

2.5 Stakeholder Engagement

PEPFAR Zambia engages with MOH on an ongoing basis. This includes policy and guideline development, technical-level oversight through national-level working groups, performance management (national, provincial, district and site-levels), supply chain management, development of national strategies and annual program/budget planning. MOH participated in all COP18 stakeholder meetings, including the Regional Planning Meeting (RPM). In addition, PEPFAR Zambia met regularly with the Minister of Health and other senior leadership to ensure joint priority setting in COP18. This included discussions around the TLD transition, rapidly scaling-up effective testing modalities, and HRH.

PEPFAR Zambia continues to engage with the Ministry of Finance (MOF). It is anticipated that the PEPFAR-funded Treasury Advisor will begin work in July 2018, providing additional support around sustainable HIV financing. MOF participated in all COP18 stakeholder meetings.

PEPFAR Zambia works closely with the National AIDS Council (NAC) and UNAIDS. In COP18, both NAC and UNAIDs provided extensive support in convening all stakeholders in Zambia's HIV response. UNAIDS served as a co-facilitator during the COP18 strategic retreat. NAC convened weekly COP update meetings with the RPM delegation (GRZ, WHO, Global Fund, UNAIDS and civil society). NAC and UNAIDS participated in all COP18 stakeholder meetings.

PEPFAR Zambia works closely with civil society (PLHIV, women, youth, people with disabilities, FBOs, LNGOs and TB constituencies) through COP development and implementation. This includes working with civil society through the CCM and CCM committees. In COP18, PEPFAR Zambia will continue to support meetings in collaboration with the CCM that bring together over 300 civil society members from across the country representing 10 different constituencies. In COP18 PEPFAR Zambia will also work with UNAIDS and NAC to support civil society engagement, coordination and capacity building—this will be designed in consultation with civil society in FY18. Civil society participated in all COP18 stakeholder meetings, will continue to be part of the quarterly POART process. Finally, in COP18, the PEPFAR Small Grant program will make adjustments based on recommendations from civil society to allow both small and medium-sized groups to access PEPFAR resources through the Small Grant portfolio.

Finally, private sector engagement has been ongoing as PEPFAR Zambia aims to broaden the private sector's support of Zambia's national HIV response. PEPFAR Zambia is collaborating with banks, hotels, mobile telephone companies, retail conglomerates and private health service providers and manufacturers, to support of vulnerable populations comprising orphans and vulnerable children, youth and young women. These include but are not limited to skills training and in-kind contribution to support economic resilience start up initiatives and support toward shelters for survivors of gender based violence.

3.0 Geographic and Population Prioritization

In COP18 PEPFAR Zambia is concentrating programmatic focus on populations with high unmet ART need, low VL suppression, and high incidence to ensure that PEPFAR resources are programmed for the greatest reduction of new infections. Specifically, PEPFAR Zambia will work to disrupt the transmission cycle between older men (who have an overall VL suppression rate of 55%) and young women (who have an incidence rate of 1.06). Given that PHIA data show an unmet ART need among pediatrics of 50% and that adult women constitute more than 50% of individuals on treatment supported by PEPFAR, PEPFAR Zambia will also continue to improve identification, linkage, and retention for these populations as well in COP18 (see section 4).

As demonstrated in the maps above, programmatic focus will continue to align with geographic burden, and the provinces of Lusaka and Copperbelt will continue to be focal provinces for PEPFAR support given that a full 40% of unmet need for ART are in these provinces.
As of FY18Q1 PEPFAR Zambia had saturated 2 districts (Solwezi and Mambwe) with ART coverage rates above 90%. Some 16 districts currently show ART coverage over 90% across multiple age/sex bands. By the end of FY18 PEPFAR Zambia expects to achieve 90% ART coverage in an additional 39 districts. COP18 targets build off of this expected achievement to reach 95% ART coverage in 73 high burden districts and an overall national ART coverage rate of 90%.
With regard to VMMC, as of FY18 only Northwestern province has achieved saturation (VMMC coverage of ≥80% among 15 – 29 year old males). Remaining provinces will move aggressively toward VMMC saturation in FY19 however none are expected to reach the 80% saturation threshold during the COP18 implementation year.

Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP18	# Current on ART (FY17)	# of SNU COP17 (FY18)	# of SNU COP18 (FY19)
Attained	448,182 (36%)	306,937	22	12
Scale-up Saturation	665,728(53%)	459,269	16	61
Scale-up Aggressive	36,822 (3%)	15,036	33	7
Sustained	34,833 (3%)	10,965	15	10
Central Support	75,755 (6%)	32,536	19	17

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

4.1 Finding the missing, getting them on treatment, and retaining them

4.1.1 HIV Testing Services (HTS)

The PEPFAR Zambia COP 18 HTS activities and targets are in line to support GRZ's efforts to reach the 95-95-95 goals. The total HTC target is 2,932,491 with an HTS_Pos target of 203,028. These targets are based on the aggressive treatment targets set by age and sex, including a treatment linkage rate of 90% from the current rate of 67%. The PEPFAR Zambia team has made strides in improving linkage from HTC to treatment and care services. Improving linkage and monitoring patient level linkages will continue to be expanded for all PEPFAR partners in COP18. All implementing partners will be mandated to aim for >90% linkage rates to ensure that linkages from HTS to treatment are 90% and above.

It is anticipated that the majority of the HTS targets will be reached through continued scale-up of high quality index testing and optimization of provider-initiated testing and counseling (PITC). PITC will cover out-patient departments, TB corners, STI clinics, MCH, and ANC clinics. Additionally, a screening tool will be employed to more accurately identify high-risk clients and avoid duplicative or over-testing of lower risk clients.

Best practice index testing models in Zambia have produced yields of up to 46%. COP 18 will mark a significant scale up of index testing which is expected to identify 49,974 new cases. In order to implement index testing with high quality, ensuring confidentiality and client safety, all partners will continue providing specific initial and refresher training and on-site mentoring on index testing and partner notification. Index testing and partner notification is voluntary and trained counselors will work with clients to identify optimal ways for sexual partners and HIV-exposed children to be tested. To date, PEPFAR partners have not reported any cases of GBV as a result of index testing. PEPFAR Zambia will closely monitor index testing practices through routine site visits and reviews of index testing data. All PEPFAR partners will ensure continuous availability and use of resources for the optimal implementation of all index testing-related activities. This includes the adequate space and number trained health workers (testers, clinicians, counselors, supplies officers etc.), strong linkage between facility and community-based partners. All the PEPFAR partners will ensure that they have tools to track all new HIV positive persons and confirm that they are enrolled in HIV treatment. The use of linkage registers and use of smartcare will be priority in ensuring optimal linkage to services for all the positives identified. Active follow up of those who test positive but are not started on treatment will be enforced by all PEPFAR partners.

Several strategies will be employed for clients 25 years and below. For children under 15, the main case finding strategies will be PMTCT_EID, index testing targeting children of PLHIV, PITC ensuring all eligible children interacting with the health services are provided with HTS services, "Know Your Child's Status campaigns", DREAMS Centers, integration of HTS promotion within school health programs, and optimizing HTS services with the OVC platform.

PEPFAR Zambia will also continue to advocate for policy level changes to support reducing age of consent to at least 12 years. For 15 to 24 year olds, utilization of social networks and peer models for young KPs will also be a priority. KPs will be reached through mobile testing, with a focus on retesting of negatives as well as linkage to treatment for those who test positive. The highest treatment gap of PLHIV in the PEPFAR Zambia program is among adult men age 40 to 49 and above 50. To reach these men, index testing will be scaled up as well as HTS workplace programs for men in the formal and informal sector will be conducted. PEPFAR Zambia will also scale up testing services in men's social groups. Other strategies to reach men include using male champions to reach fellow males, using the ANC platform where pregnant women will be encouraged to come with their partners to test for HIV and also through working with traditional and civic leaders to drive HIV testing efforts among men in their constituencies.

The community platform will play an important role in increasing uptake and sustainability of HIV services. The OVC program provides the largest community network for PEPFAR Zambia, with over 10,000 community volunteers, 90 local organizations, and strong ties with the faith community. The platform will contribute to the 95-95-95 goals through HIV case finding, HIV status disclosure, linkage to treatment, PrEP, adherence support, and VL literacy. Index tracing is used to support testing of sexual partners of index clients, and biological children of index clients. Targeted community testing will be augmented by self-testing (the operational guidelines for self-testing are currently being developed by the Ministry of Health). The Zambian PEPFAR program will improve case management for young PLHIV and their families to increase adherence to HIV treatment and assure a seamless transition into adult care. Key sub-populations will be targeted to find the missing among teen moms and their children, school dropouts, child-headed households, and household members who experienced violence. The OVC partners will increase engagement with prevention and treatment partners to provide expertise on community entry points relevant to children and their families, such as schools, market places, and the faith community.

When fully scaled-up, self-testing, used for HIV screening, will greatly contribute to reaching first-time testers, people with undiagnosed HIV and those at ongoing risk who are in need of frequent retesting. . The program will target men who have sex with men and female sex workers to provide HVST in their networks in selected sites. Targeted community outreach testing using HVST as a screening test will be employed to increase efficiencies. Within the OVC program, HVST will support finding the missing among adolescents who are averse to engaging with health facilities. OVC partners will then be able to link them to HIV treatment and provide on-going support that reinforces adherence and viral suppression.

PEPFAR Zambia will continue to place great emphasis on targeted testing, including community partnerships and mobilization for multi-disease community health campaign (CHC) for different age groups, children, adolescents and young adults. These campaigns will include mobilizing the community for HTS and linkage to care and treatment. In COP 18 PEPFAR partners will strengthen these targeted community multi-disease health campaigns to include both the out of school and in school, as well as university/college students who are at risk of infection.

PEPFAR Zambia will continue support for quality-assured HIV testing through provider training, targeted technical support and supervision, and proficiency testing. In centrally support sites, PEPFAR Zambia will provide periodic targeted quality improvement and quality assurance technical assistance at provincial and district levels.

PEPFAR Zambia has allocated sufficient funding in COP 18 to support the procurement of HIV test kits nationwide. PEPFAR Zambia will work with partners to ensure that test kits are readily available in both communities and facilities to meet the COP 18 targets. An anticipated challenge is that of lay counsellor attrition rates, which can be overcome by engaging GRZ in discussions on the need for policy guidance on working with community volunteers. Volunteers within the OVC platform have already been trained in the spectrum of HIV services and will receive additional capacity building to help address HRH gaps.

4.1.2 Adult Care and Support

In Cop 18, PEPFAR Zambia will accelerate performance to achieve epidemic control by 2020. To achieve this aggressive goal, linkage to treatment among identified positives and retention on ART will be key focus areas. Priorities COP 18 will be improved linkage to HIV treatment from 67% at APR 17 to 90% in FY 2019 through: same day ART initiation, better patient preparation for HIV treatment, and assisted referrals for treatment, aiming to link all HIV-infected patients to HIV treatment and within fourteen days of being diagnosed with HIV. PEPFAR Zambia will increase access to HIV treatment services by upgrading PMTCT only sites and mobile ART sites to full static ART sites, training more ART providers, and deploying linkage coordinators who are mandated to ensure all identified positives are initiated. Linkage coordinators will also be mandated to actively track identified positives who are not linked to treatment.

In FY 17, PEPFAR Zambia recorded an overall 12-month retention on ART of 82%. However, males age 20-24 only had a retention rate of 73%. In FY 19 (COP 18), PEPFAR Zambia will support activities to improve 12-month retention to 90%. To achieve this goal, proven interventions that have demonstrated strong retention will be brought to full scale including: differentiated service delivery models (e.g. community based ART), multi-month scripting for stable patients, community adherence groups (CAGs) and youth clubs/friendly services. These approaches have demonstrated 12-month retention rates of up to 95% and will be brought to scale in FY 2019.

Recognizing the role of strong data management in mitigating loss to follow-up, PEPFAR Zambia will increase the coverage of electronic records, monthly registers of clients suspected to have been lost to follow-up and tracking registers documenting the outcomes of the tracking activities. In addition, PEPFAR Zambia will support MOH's policy shift to provide services in the evening and weekends to address common barriers (e.g. school, work, etc.) to accessing HIV services. Treatment literacy will also be expanded to build understanding and demand around viral load suppression, which will further strengthen DSD components such as multi-month scripting. Scaling-up youth friendly services will also be prioritized in COP18, building on lessons learned through DREAMS.

PEPFAR Zambia will support a wide range of quality improvement and quality assurance activities to strengthen adherence. This includes streamlining processes to ensure a 14 day VL and EID results turnaround time, and working to address issues that negatively impact the client experience (e.g. health provider attitude, long wait times, congestion, etc.).

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4.1.3 Pediatric Care and Support

In COP 18, the pediatric care and support program will provide comprehensive pediatric HIV care services in priority geographic locations.

The focus for PEPFAR Zambia Pediatric HIV services will include:

- High yield Case finding of HIV infected children through the EID and index case tracing;
- At least 95% linkage to treatment;
- At least 95% retention and
- At least 95% VL Suppression.

The core package of services includes but is not limited to:

- Ensure at least 100% EID testing of all eligible HEIs at all-time points including demand creation among clients and providers and capacity building;
- Activities to reduce the EID TAT (results return to caregiver) to 14 days including support for Courier systems and accurate data capture and reporting systems;
- Activities to ensure at least 95% linkage to treatment for all HIV infected children including provision of HR and capacity building of HR; Infrastructure improvements and commodity security. This is in an effort to increase access and improve Pediatric ART coverage;
- Activities to support the promotion a comprehensive package of pediatric HIV care and treatment, including prevention and treatment of Opportunistic Infections, TB/HIV services including screening and IPT provision, Non communicable diseases and pain and symptom using a family-centered approach;
- Activities to optimize retention on treatment of children and adolescents on treatment including Positive Health, Dignity and Prevention activities, provision of patient centered DSD models provided at scale, psychosocial support for caregivers and adolescents, rational appointment and tracking systems and robust data management systems;
- Activities to optimize VL coverage for all children and adolescents on treatment including activities to enhance VL suppression; and
- Implementing of consolidated pediatric treatment guidelines and recommendations as well as alignment with the OVC Minimum Standards, National Plan of Action for Children, and forthcoming GRZ standards for vulnerable children.

4.1.4 TB/HIV co-infection

At 58 percent, Zambia has a one of the highest TB/HIV co-infection rates in the world. Zambia must therefore continue to strengthen the management of the TB and HIV co-morbidity. The TB

program made tremendous progress in testing TB patients for HIV (93 percent) and initiating 83 percent of Zambians with TB and HIV co-infection on life-long HIV treatment (WHO, 2016). The HIV program has however not done as well with screening all HIV-infected patients for TB and in turn initiating clients without active Isoniazid preventive therapy (IPT) to prevent reactivation of latent TB. Zambia was only able to initiate 7,758 HIV-infected clients on IPT from an estimated 250,000 individuals in need of the service (National TB Control Program, 2016). With COP 2018 funding, Zambia will strengthen TB and HIV integrative work by expanding IPT, intensified TB case finding, and infection control activities.

PEPFAR Zambia will support the following TB and HIV integrative activities with COP 18 funding:

- Joint planning for TB and HIV services/activities at provincial and district levels;
- Joint implementation of activities;
- Quarterly TB/HIV meetings; and
- Joint quarterly district and provincial supportive supervision and mentorship.

PEPFAR Zambia will support the Ministry of Health to scale-up IPT services, beginning with support for incorporating new World Health Organization guidance on IPT (including alternative regimens) in the national guidelines. Other IPT activities will include the following:

- Printing of IPT recording and reporting tools;
- Orientation of facility and district TB staff in IPT recording and reporting tools;
- Conducting mentorship in IPT targeting high volume sites in project provinces;
- Working closely with HIV partners to ensure that IPT is provided to all eligible patients in the ART facilities;
- Procuring Isoniazid; and
- Establishing a case ssurveillance system for individuals on IPT to document outcomes of interest such as course completion rates, adverse events, and active TB outcomes.

PEPFAR Zambia will support the following TB infection prevention activities:

- Training in TB biosafety;
- Support for personal protective equipment;
- Minor renovations;
- Increased supervision; and
- Instituting infection control plans based on the universal concept of hierarchy of controls.

PEPFAR Zambia will support the following case finding activities:

- Expand coverage of "new" diagnostic equipment: universal coverage with florescent microscopy, expanding the use of Xpert MTB/RIF testing, and introducing the LAM test;
- Develop childhood TB job aids and monitoring tools ;
- Roll out of childhood TB trainings;
- Screen prisoners for TB and HIV on entry into prison; annually; and exit from prison; and
- HIV testing among all persons with TB disease and persons with presumptive TB.

PEPFAR Zambia will implement TB and HIV collaborative activities through the following entities:

- Directly funding the GRZ through Government-to-Government grants;

- Contracts and cooperative agreements with international nongovernmental organizations (NGOs);
- Subcontracts with Zambian NGOs;
- Through partnerships with the private sector; and
- Civil society organizations (CSO), current and former TB patients; and community volunteers and leaders.

4.2 Prevention, specifically detailing programs for priority programming:

4.2.1 HIV prevention and risk avoidance for AGYW and OVC

Targeted prevention activities for adolescents will continue to include community mobilization for clinical services, social norms change, HTS, and condom promotion/distribution. Evidence-based prevention interventions will be anchored by peer outreach and layered service delivery (i.e. DREAMS) and will address risk reduction among adolescents and their sexual networks. In order to find the undiagnosed adolescents, partners will focus on the scale-up of quality index-testing and targeted PITC. Linkages will be enhanced through the use of escorted referrals, adolescent-friendly hours/spaces, and increased site-level collaboration among implementing partners.

In COP 2017, PEPFAR Zambia used program and ZAMPHIA data to determine geographic expansion of DREAMS from three to eight districts. Current operational districts include Lusaka, Ndola, Chingola, Kitwe, Kapiri Mposhi, Kabwe, Livingstone, and Chipata. Within these districts, the number of DREAMS zones increased from 21 to 40. In COP 2018, DREAMS will not expand geographically, but will focus on programmatic saturation of current zones. All zones will offer a comprehensive package of layered services, targeted at AGYW ages 10-24. Core activities include Safe Spaces, HTS, Family Planning, GBV awareness and response, school-based prevention, and programming for families of AGYW (e.g, Families Matter!). Scale-up of PreP will continue and DREAMS Center staff will work closely with clinical partners to support adherence. Ongoing emphasis will be placed on testing uptake among DREAMS enrollees, with special efforts to engage and test 20-24 year old AGYW- historically the most difficult to reach with DREAMS programming. DREAMS Center-based male partner testing will continue as well as index testing for AGYW who test HIV positive. In addition, HIV incidence surveillance system using the HIV rapid-recency assay to identify people newly infected with HIV is currently being rolled out at DREAMS sites and this effort will be continued through COP18.

The DREAMS DHIS2-based M&E database will be used to track and measure layering of interventions for individual beneficiaries. It will also record risk factors, program uptake and completion, and open and closed referrals. The DREAMS USG team will continue to analyze key facility-level indicators (family planning, PMTCT, HTS, and treatment) to measure trends in service update and yield. It is also expected that the Implementation Science study, which is looking at program fidelity, effectiveness, and cost will generate results that can be used to inform programming.

Within the OVC portfolio, implementing partners will prioritize teen moms, adolescent girls who have dropped out of school, child-headed households, young PLHIV, children of sex workers, and children/adolescents living in a household with at least one HIV positive adult. OVC partners will use district-level secondary data on school dropouts, teen pregnancy, child-headed households, children living with an HIV positive adult, young PLHIV, and sex-worker size estimation combined with fertility rates for program planning. In 2018, each OVC partner is conducting an analysis of their current beneficiaries per sub-population category to inform coverage gaps. Evidence-based interventions (e.g., Mothers-to-Mothers, Positive Connections, AIM) will be incorporated into existing OVC programming to address specific needs of key sub-populations. Messaging will be age-sensitive to address sexual risk avoidance and reduction. Messaging around delayed sexual debut will be delivered through youth clubs and increased engagement with the faith community.

AGYW and their partners will be targeted with interventions that increase condom use and HTS uptake, particularly among those who are at highest risk. Interventions may include social network approaches, parenting mentorship approaches, and community dialogue. Partners will strengthen linkages between communities and health facilities using provider behavior change, social accountability mechanisms, and increasing demand of quality services by patients.

Gender-based violence (GBV) interventions will be prioritized in areas with high HIV burden, with a focus on DREAMS districts and zones. Special attention will be paid to programming that prevents sexual violence among AGYW, ages 9-14. Community level activities will include increased awareness and prevention of GBV, demand creation for GBV services, and engagement of traditional and other community leadership in advancing GBV prevention and response. GBV response service availability will be expanded in the community and scaled-up across health facilities. GBV survivor support services will continue to include counseling, medical services and examinations, HTS, post exposure prophylaxis (PEP), and legal support. The Every-hour Matters campaign will expand to improve timely PEP access.

The COP 18 Core HIV prevention package for AGYW and OVC will include:

- Targeting of AGYW and their male partners with prevention and treatment services in the highest burden districts
- Targeting of AGYW with layered service packages to reduce HIV risk
- Prioritization of enrollment of most-at-risk sub-populations into OVC programming
- Expansion of sub-population specific interventions proven to be effective
- Improvement of targeted testing through optimization of PITC and index testing
- Promotion and provision of PrEP for the highest risk AGYW
- Initiation on treatment (90% linkage) and improved retention for all adolescents and young adults identified as HIV positive
- Demand creation for HIV prevention, condoms, HTS, clinical services
- Expanding and strengthening key GBV response services and community mobilization activities
- Continued programmatic saturation of current DREAMS zones, with special focus on delaying sexual debut and preventing sexual violence among AGYW, ages 9-14

4.2.2 Key Populations

The FY 19 target for Key Populations (KPs) is 48,153, and comprises of 23,815 female sex workers (FSW) and 9,397 men who have sex with men (MSM), 350 transgender (TG) and 14,591 prisoners. Targets were based on 2017 USG size estimates for MSM and FSW for priority districts. Size estimates were calculated utilizing Central Statistical Office (CSO) district data that include rural and urban distributions of populations. Prevalence was estimated of FSW and MSM in rural and urban areas given literature from the region. In districts with USG KP estimations done by implementing partners on the ground, an average of the estimate generated by the national-level tool with those estimations done on the ground, allowing for the specific characteristics of districts to be taken into consideration in the estimations. These are probably under estimations of these populations. PEPFAR Zambia is the process of updating its protocol in FY18 to allow for better population size estimates to inform COP18 implementation. PEPFAR Zambia will work through NAC in its existing coordination role to facilitate stakeholder engagement and validation in the protocol update process.

In COP18 PEPFAR Zambia will continue to provide and scale up KP package which includes condom and lubricant promotion and distribution, HIV testing and counselling, peer outreach STI screening and treatment, provision of (PrEP), strengthening linkages from communities to facilities, reduction of stigma and discrimination, gender-based and intimate partner violence screening and support, and alcohol and mental health harm reduction. All KPs will be tracked across the continuum of care to ensure that those who test positive are put on treatment, and are virally suppressed.

Ensuring that all KPs are tested for HIV is an essential component of the KP prevention strategy. In addition, enhanced peer outreach approach will focus on KPs that are not found at traditional hotspots, and will complement peer outreach by engaging new KP networks that are hard to reach and have never tested. This approach will improve HIV case finding and extend program coverage into subpopulations of KP such as older KPs that continue to be a challenge to reach.

Stigma and discrimination continues to be a barrier faced by KPs when accessing health care services. Health care worker training will focus on addressing and reducing stigma and discrimination directed at KPs. A stigma monitoring tool kit will be operationalized to guide stigma reduction efforts at the facility level and help assess outcomes overtime. KP sensitivity training will provide HCWs with information about KPs and create self-awareness about their own biases toward KPs that may prevent them from offering quality, KP-friendly services. HCWs will be trained on how to provide the recommended package of services in a non-judgmental, supportive, responsive, and respectful manner.

In COP 18 implementing partners will engage police officers in support of a safe and enabling environment for KPs. Activities will include advocacy with top-ranking officials and continued engagement with the police victim support unit (VSU) and local implementing partners; training for low-ranking officers on the connection between HIV and violence, stigma and discrimination against KPs, services needed by victims of violence and where to refer victims to meet their needs.

PEPFAR Zambia will participate in joint planning and implementation of activities including quarterly data quality assessments, SIMS and site visits to ensure that KP implementing partners are providing a comprehensive and standardized package of services to KPs and strengthen linkages between the community and facilities. PEPFAR Zambia will continue to work with the

GRZ, donors and civil society organizations to plan and coordinate KP activities through NAC to reduce duplication and improve efficiencies. KP representatives and beneficiaries will continue to serve in advisory roles including program design and implementation. Zambian KP organizations will continue to receive PEPFAR funding to provide direct service delivery. PrEP implementation is coordinated through a national task force that is led by NAC and includes GRZ officials, implementing partners, USG, WHO, UNAIDS, and civil society.

4.2.3 Voluntary Medical Male Circumcision (VMMC)

In COP 18, the PEPFAR VMMC program will continue to prioritize high HIV burden provinces, focusing on regions with high unmet VMMC need as highlighted in ZAMPHIA and targeting males 15-29 years of age for maximum impact. WHO defines a series of three evaluation activities that a country must undertake prior to scaling up device use in that population, a pilot, active adverse events (AE) surveillance, and passive AE surveillance. Zambia completed a pilot phase in 2014 and is now on the second phase, active AE surveillance for both Prepex and Shang Ring devices. Implementation of active AE surveillance of Prepex began in COP 17, however, the issuance of new guidance for Prepex and administration of tetanus-toxoid-containing vaccines (TTCV) (which required procurement and setting up of systems to incorporate vaccines in the program) has been challenging as there is a time period between administration of the two vaccinations and the procedure. However, active surveillance for Prepex devices will be completed by the end of COP 17 while Shang Ring active AE surveillance which has been delayed, will be finalized in COP 18.

The core VMMC program strategies for COP 18 include:

- Targeted demand creation, including engaging community health workers to support community mobilization and sensitization;
- Training, mentorship and supportive supervision of health workers in the provision of age appropriate VMMC services to the adolescent, young males and older males;
- Provision of age-appropriate WHO recommended VMMC package;
- Service delivery through the use of static and mobile models with extended hours;
- Linkages to care and treatment for HIV infected clients;
- Strengthening quality assurance and response to adverse events;
- Institutionalizing M&E;
- Implementation of WHO pre-qualified male circumcision devices; and
- Private sector engagement efforts in prioritized geographic areas with the highest disease burden.

Strategies to address gaps/challenges include:

- Reaching 15-29 year olds and encouraging utilization of services among late adopter: targeted Adolescent/young adult male tailored communication and demand generation activities during sports events, juvenile correctional facilities, universities and colleges,

bars, sports clubs, and faith based gatherings; scaling up adolescent and young adult peer champions; workplace policies; and after hours/ weekend operations.
- Addressing seasonality of demand and sustaining demand throughout the year: Routinization of services; periodic intensified service delivery during mini-campaigns and extended campaigns.
- Infrastructure: Use of tents, mobile surgical units
- Human Resources for Health: Addressing the gap by hiring of full time providers/mobilizers; Operations after normal shift work/ afterhours/weekends

As part of the transition and country ownership plan for sustainability, in COP 18 PEPFAR Zambia will continue to provide technical support to early infant male circumcision (EIMC) for selected medical personnel and quarterly technical assistance to Ministry of Health sites implementing EIMC. The Department of Defense (DOD) program will continue to increase access of VMMC services among the military countrywide and will look at opportunities to reach more men such as offering services to new recruits including use of VMMC devices as an alternative. Areas with lower HIV prevalence will receive national-level PEPFAR technical assistance for quality assurance activities, promulgation of policy, and training of trainers.

Results from SIMS have been used to identify programmatic gaps and provide solutions. Adverse events prevention and management due to most mobile/outreach sites lacking the pediatric component for emergency resuscitation is being addressed.

4.2.4 Pre-exposure Prophylaxis (PrEP)

In FY 19, the PrEP target is 8,668 (54% FSW; 12% MSM; 20% AGYW and 14% sero-discordant couples) and will focus on reaching HIV negative individuals at high risk of contracting HIV infection. These include MSM, female sex workers, discordant couples (including pregnant and breastfeeding women) and AGYW. PEPFAR supports WHO guidelines on the use of PrEP as part of a package of comprehensive prevention services. PreP will be implemented in the contexts combination prevention primarily in high burden districts of Lusaka, Ndola, Kitwe, and Livingstone. PrEP services will continue to be provided as a part of comprehensive HIV prevention services that include HIV testing, sexual risk reduction education and counselling, condom distribution, contraceptives, post-exposure prophylaxis and medical male circumcision. PrEP will be provided as a key layer in existing Key Populations and DREAMS programs to support adherence and reinforce other prevention messages. PEPFAR will support Zambia's scale up of PrEP services at facility that provide ART services in order to leverage on the availability of ART-trained health workers, and laboratory and pharmaceutical services for clients.
Key package of services for PrEP will include the following:

- Health worker training
- HIV testing
- Sexual risk education and counselling
- STI screening and treatment
- Condom promotion
- Adherence support

4.2.4 Prevention of Mother-to-Child Transmission (PMTCT)

The introduction of Option B+ in 2013 resulted in implementation of test and start for HIV infected pregnant and breast feeding women (PBFW) within MCH. The current ART coverage above 90% demonstrates the progress made since 2013 when option B+ was initiated with sustained universal PMTCT service utilization and coverage. In FY 19, PEPFAR Zambia will continue to support activities aimed at elimination of mother to child transmission of HIV by scaling up HCT, lifelong ART and VL monitoring within MCH. As the roadmap to virtual elimination of MTCT is rolled out, there is need for more accurate determination of MTCT rates if the less than five percent earmark within the supported geographical locations is to be realistic. To achieve this, PEPFAR Zambia will support the MOH to scale up cohort monitoring and cohort reporting for maternal and infant pairs to ensure more reliable final outcomes. In addition, cohort monitoring will help improve Early Infant Diagnosis (EID) coverage at 0-2 months which has generally been low at about 50%.

The PMTCT programming will strengthen community engagement and sensitization to improve uptake of PMTCT services, male involvement, and early antenatal booking and facility deliveries. EID will be supported through purchase of back up supplies, fast tracking of results to improve turn-around time for results and facilitating sample/result transport courier system. Need based recruitment and capacity building of HCWs and CHWs and exchange visits for learning best practices to enhance HIV testing and treatment services in MCH will be done. Using the maternal and child care service platform, support will also be provided for Family Planning/HIV integration with key priorities such as expanding contraceptive options mix for women of reproductive age (including adolescents), ensuring access, and health systems strengthening.
Current PMTCT program challenges include: limited health care worker capacity; prolonged turnaround times for early infant diagnosis and results return; poor 24-month retention associated with MTCT in the breastfeeding period; weak cohort monitoring systems for tracking mother-baby pairs along the PMTCT cascade; and limited community support systems.
The following strategies will be employed to ensure attainment of virtual eMTCT of HIV: a) maximizing early and accurate maternal and infant HIV case identification, b) Scaling up cohort monitoring for HEI and maternal cohorts, c) optimizing VL monitoring and viral suppression of PBFW, d) strengthening community-based peer support groups as a platform for enhancing adherence and retention in care, e) service integration (such as ART/antenatal, expanded program for immunization/ early infant diagnosis, family planning/HIV service integration) and f) improving monitoring and evaluation systems. Furthermore, the PMTCT program will collaborate with the OVC program to provide support for HIV infected pregnant and breast feeding adolescents and young women.

Key activities will include:

- Recruitment, Training and Mentorship of health care workers and community health workers to ensure improvement in HIV testing and treatment services along the MCH platform; coupled with support for facility exchange visits for learning best practices as part of capacity building.
- Quality HIV case identification among PBFW and HEIs; including re-testing of HIV negative PBFW
- Increasing initial attendance rates and repeat antenatal care visits through community outreach programs, and coordinating with community-based reproductive health workers
- Scaling up of VL monitoring for all HIV positive PBFW
- Providing and increasing adherence to treatment for HIV positive PBFW

- Strengthening mother-baby follow up at community platforms to ensure adherence to ART and enhancement of retention in care and adherence of mother-baby pairs
- Improving the uptake of EID and linkage to treatment for infected infants
- Strengthening the EID system (supplies, specimen transportation, improve turnaround time for results)
- Adopting a holistic approach for PMTCT within the context of a safe and healthy pregnancy, delivery and postpartum care, including family planning and partner testing.
- Implementation of differentiated care models focused on families with a goal to improve retention.
- Promoting an enabling environment for increased male involvement through PITC for expectant couples attending ante-natal services to improve disclosure among couples
- Supporting enhanced program monitoring and evaluation (including real time monitoring) that includes cohort monitoring, retention on ART and documentation of infant outcomes up to final outcomes post-exposure.

4.2.5 Military Populations

Targeted prevention activities for active duty military will continue to include community mobilization for clinical services, social norms change, HTS, and condom promotion/distribution. Evidence-based prevention interventions will address risky sexual behaviors due to issues of mobility and long absences from home. In order to find the undiagnosed military and their partners, the program will focus on the scale-up of quality index-testing and targeted PITC. Linkages will be enhanced through the use of escorted referrals, strengthened partner notification and access to services whilst in the operation areas and increased site-level collaboration among implementing partners.

1.1 Additional country-specific priorities listed in the planning level letter

4.3.1 Policy/Guideline Changes

Issue	Action	Responsible	Status
Introduction of TLD as the first line regimen for HIV treatment.	Development and dissemination of guidelines	MOH/Other stakeholders	-Guidelines have been developed -Dissemination is on-going -Implementation will start in June
Operationalizing self-testing.	Development of clinical protocols/framework to operationalize self-testing	MOH/Other stakeholders	Awaiting finalization by end of March, 2018
Operationalizing PrEP.	Development of clinical protocols/framework to operationalize self-testing	MOH/Other stakeholders	Awaiting finalization by end of March, 2018
Revision of the 2014 IPT guidelines	MOH/Other stakeholders	Revision work has started in 2018.	Work will finish by March, 2018.

4.3.2 Performance Review for COP18 Direction-setting

During the COP18 target setting process, USAID reviewed both FY17 and Q1FY18 results compared to targets. For both new and existing partners, results have shown an upwards trajectory and improved performance over time. USAID is undergoing a phased transition between treatment partners to minimize disruptions and service. The transition began on October 1, 2017 and will be fully completed by April 1, 2018. After the transition is complete, USAID will remain with three treatment partners covering geographically district areas and targeting high-burden hot spots. COP18 targets were assigned to partners based on this results analysis and transition, ensuring that the correct partners received appropriate targets based on unmet need within geographic regions and ability to achieve targets.

Based on partners' performance in FY17 and Q1FY18, CDC adjusted placement of its main treatment partners to ensure continued scale up of treatment and to consolidate the gains that were made in COP17. These changes are intended to continue the improved performance through greater retention, adherence, and VL suppression especially among youth and men. In COP18, two of the highest performing treatment partners will focus on scaling up treatment in Lusaka, Southern and Western Provinces where there are still significant treatment gaps. The other two partners, which have good models for retention and VL testing, will focus on scaling up differentiated models of care in some districts in Lusaka and Eastern provinces..

DOD has strategically placed its partners to address the issue of linkages to ensure all patients identified are enrolled on treatment. Areas of operation are military health facilities which are spread throughout the country located in almost all the high burden areas. Additional criteria used to determine USG support taking into consideration is volumes of patients on treatment seen at the military run facilities. These facilities run under the Zambia Defense Force serve active duty military, their families and dependents as well as civilians from the surrounding communities.

4.3.3 Implementing Partners Management

PEPFAR Zambia recognizes the critical importance of site-level partner management. Throughout the implementation of COP17, PEPFAR Zambia will be conducting monthly (minimum) analysis of partner performance to identify changes needed in FY18 implementation to ensure a successful COP18. This includes close monitoring of established milestones of the "sister surges" in Lusaka and Copperbelt. In FY18, PEPFAR Zambia will prioritize comprehensive rapid assessments of sites with >1,000 clients to ensure 90% linkage and an absolute 90% of all cases with VLS is achieved in COP18. Site improvement plans will continue to be utilized in partner management in COP18, and will include sites with linkage rates under 90%. Quarterly partner reviews (through POART) will include the review of quarterly expenditures—with the understanding that it is unacceptable for partners to spend COP funding without achieving proportional results.

USAID has implemented multiple management approaches to improve partner performance. These approaches have been phased in over time, and their results can be seen in the doubling of the number of new HIV treatment initiates each quarter between Q1 FY17 and Q4 FY17. These approaches include the use of performance based contracts which tie contractor fee payments to the achievement of results, regional data review meetings in coordination with the MOH, site level remediation plans for all sites, the collection of daily, site level data from high impact sites, the establishment of regional situation rooms to review data in real-time, and increased site visits with improved tools that focus on identifying performance gaps and fixing them. Through this combined approach, USAID is identifying issues far more rapidly than in the past, and working with partners to fix issues in real time as they are identified.

CDC is focusing on performance improvement at the site level. This entails breaking down the overall targets into monthly and weekly targets. Partners are reporting weekly to CDC on key indicators and CDC staff are conducting visits to sites that are underperforming and working with partners on remediation plans. On a bi-weekly (for larger partners) or monthly basis, CDC technical and business staff are meeting with implementing partners and reviewing progress towards targets and outlays. These meetings result in decisions on actions that need to be taken by partners to improve performance and ensure that outlays are matching performance.

DOD will ensure enhanced partner management to monitor implementation in the field and provide technical assistance to facility staff. Monthly meetings with partners instituted to provide a platform of engagement to review results and identify operational bottlenecks and ensure effective sharing of information among all partners operating at facilities. Joint site visits and enhanced SIMS to include DQA and SQA. Monitoring monthly achievements vs spend are done through the monthly meetings.

4.3.4 Innovation and Evidence-based Solutions

PEPFAR Zambia has identified high impact interventions that are immediately being brought to scale that will ensure the achievement of COP18 results—all pilots with effective results will be taken to scale. These high impact interventions serve to improve HIV testing yield, linkages to treatment, and retention in care. The interventions are: Index testing, optimized PITC, multi-month scripting, scheduled appointments, and the use of community ART groups. Both index testing and optimized PITC will improve yield and linkages to treatment, and allow PEPFAR to target specific populations by utilizing different index patients and ensuring that PITC testing locations are appropriately staffed to identify patients of specific target age and sex groups. Multi-month scripting, scheduled appointments and community ART programs all serve to provide ARVs to patients at times and locations that are more convenient to them. This will not only improve adherence, but will also decongest facilities and improve services provided to new ART initiates. PEPFAR Zambia will also improve case identification at health facilities through the use of self-testing that will allow better targeting of testing and more efficiently use the time HIV testing counsellors. Additionally, to address retention, PEPFAR Zambia is scaling up Community Adherence and Urban adherence groups and expect that the levels of retention shown in this differentiated service delivery model will improve quality of care to the Zambian population.

4.4 Commodities

Stakeholder coordination around commodities in Zambia continues to be strong. The current HIV commodity gap, as of March 2018, is largely due to the fact that other donors and the GRZ have yet to officially indicate their contributions for the upcoming year. VL/EID and the HIV tests Kits are the commodity categories with the largest gaps ($7.6 million and $3.2 million) respectively. However, PEPFAR is working closely with the Global Fund to close commodity gap. It is anticipated GF savings from the FY 17 and FY 18 will be reprogrammed and applied to close the VL/EID and HIV tests commodity gap. The condoms line items includes increase of 500,000 units of lubricants as agreed during the Regional Planning Meeting.

4.4.1 Funding Gap

Commodity Category	Fiscal Year 18 Funding Need	Fiscal Year 18 Funding Commitment	FY 19 GAP
Rapid test kits	$8,900,749	$5,674,167	$3,226,582
VL/EID	$26,814,804	$19,126,829	$$7,687,975
Condoms	$6,961,637	$4,295,508	$2,666,129
Cotrimoxazole	$2,528,925	$2,528,925	0
ARVs	$114,057,612	$114,057,612	0
Other HIV Lab Commodities	$19,436,745	$19,436,745	0

4.5 Collaboration, Integration and Monitoring

4.5.1 Strengthening Cross Technical Collaboration and Implementation

PEPFAR Zambia is committed to continued collaboration with GF and MOH on all technical aspects of program implementation through external stakeholder engagement. These engagements have engendered broad participation including representation from several host government ministries and departments, multilateral organizations, local and international non-governmental organizations, and civil society organizations. Close collaboration and engagement with the GRZ through Ministry of Defense is obtained through joint planning, site visits and agreement in areas of support and implementation. There is a common understanding on USG support to ensure sustainability and continuity of core activities.

USAID and CDC are collaborating with regional MOH offices to convene regular site level data reviews, and conduct site visits to identify performance weaknesses and develop remediation plans. Once a site has been assessed and a remediation plan developed, progress towards site level targets is reviewed during regular meetings. Additional follow-up to improve site level performance is then provided by a USAID or CDC implementing partner in collaboration with the MOH. In addition, PEPFAR Zambia technical staff will continue to participate in the monthly Lusaka and Copperbelt surge review meetings; and meet routinely within the national TWG structure to address policy barriers, respond to technical issues at the site-level and share best practices. DOD through Ministry of Defense have put in place a forum for the ZDF to meet and interact with senior command to review poorly performing sites.

In COP18, PEPFAR Zambia will continue as a voting member of the CCM, will have a seat on the CCM Oversight Committee, will continue its leadership roles within the Health and HIV Cooperating Partners, and will place a technical advisor within the Ministry of Finance (MOF) through Treasury's Office of Technical Assistance (OTA). PEPFAR Zambia will continue to work closely with UNAIDS in the areas of SI (e.g. Zambia's Integrated Health Situation Room), advocacy and civil society capacity building and coordination.

4.5.2 Strengthening IP Management and Monitoring

USAID has implemented multiple management approaches to improve partner performance. These approaches have been phased in over time, and their results can be seen in the doubling of the number of new HIV treatment initiates each quarter between Q1 FY17 and Q4 FY17. These approaches include the use of performance based contracts which tie contractor fee payments to the achievement of results, regional data review meetings in coordination with the MOH, site level remediation plans for all sites, the collection of daily, site level data from high impact sites, the establishment of regional situation rooms to review data in real-time, and increased site visits with improved tools that focus on identifying performance gaps and fixing them. Through this combined approach, USAID is identifying issues far more rapidly than in the past, and working with partners to fix issues in real time as they are identified.

CDC will strengthen partner management further by focusing on performance improvement at the site level Overall targets will be broken down into monthly and weekly targets with heightened monitoring of progress weekly. CDC will review weekly reports in collaboration with the district and provincial health offices and increase site visits focusing on those that are underperforming to more closely work with partners and sites to quickly fix performance gaps as they are identified. CDC technical and business staff will continue to meet on a monthly basis

with implementing partners to review progress towards targets and outlays and will focus these meetings to make decisions on immediate actions that need to be taken by partners to improve performance and match to outlays. Other USG agencies will be invited to some monthly meetings for experience and best practice sharing.

DOD will focus on partner performance and ensure they have a clear understanding of technical guidance on program implementation and PEPFAR requirements. Regular review of the program results and monitoring of implementation in the field and provide technical assistance to partner staff.

4.5.3 Improving Integration of Key Health System Interventions

In COP18, PEPFAR Zambia priorities have directed the implementation of key health system interventions including Human Resources for Health (HRH) and VL activities. In order to achieve the programmatic priorities outlined in sections 4.1 and 4.2, PEPFAR Zambia recognizes that a robust community health work-force is essential, as is the need to optimize existing HRH. PEPFAR Zambia HRH strategy in COP18 aims to further reduce the gap of community based workers by providing salary support to the existing 495 Community Health Assistants which are not on the government pay role as well as providing salary support and incentives for an additional 2,000 community based workers including lay counselors, community Liaison officers, treatment/adherence support workers, peer educators/mentors and para-social workers. The deployment of the staff will be based on treatment current (TX_CURR) target, with more community workers deployed to the highest burden provinces. PEPFAR Zambia will routinely incorporate HRH reviews (including site and individual performance reviews) into monthly site and partner-level management. This will allow PEPFAR to identify sites where increased HRH support or optimized HRH is necessary, recognizing that optimization of existing HRH may be the most time and cost-effective. Routine HRH analyses will be coordinated with the GRZ and Global Fund, to make sure that resources towards this critical intervention are coordinated for maximum impact. Results from routine HRH reviews will be incorporated into the POART Process. PEPFAR Zambia is the process of finalizing its draft HRH strategy, and is currently working to complete a comprehensive HRH inventory in PEPFAR-supported sites. This includes reviewing estimated costs and the roles and responsibilities of the different cadres. Stakeholder validation will be an important step in the finalization of PEPFAR's HRH strategy and will include GRZ, cooperating partners and civil society.

PEPFAR Zambia's COP18 lab interventions are focused on collaborating with the Ministry of Health (MOH) to leverage PEPFAR, Global Fund and MOH resources to achieve the aggressive goal of reaching 90% VL coverage, a critical step towards reaching 95% VL suppression for all PLHIV on ART. This includes addressing all age bands with a VL suppression under 50% by age, gender and geography. According to ZAMPHIA, the overall VL suppression is lower in the pediatric age groups but this is primarily because of low ART coverage. Solutions to address this in COP18 includes improving case finding especially through index testing and improving ART coverage in this age group by increasing access to ART through the conversion of all PMTCT only sites to ART sites, and converting mobile to static ART sites. To manage pediatrics who are initiating or are already on ART, PEPFAR Zambia will support the rollout of a decision support tool for clinicians in pediatric ART. The tool will allow nurses and clinical officer to use simple algorithm to provide the appropriate dosing for their pediatric patients. Additionally, PEPFAR Zambia will support the introduction of effective regiments such as DTG for eligible populations, the use of LPV/r pellets for children under 3 years old and the utilization of caregiver support

groups to improve adherence. Additional solutions to meet this goal include the acquisition of additional VL platforms by reagent rental, the increase in samples submitted at site level by systematic identification of each TX_CURR by facility and tracing of all patients due for VL as well as management and monitoring of unsuppressed VL at site level.

PEPFAR Zambia will support interventions to increase the timely availability high quality data and promote its use to enhance program performance and achieve better health outcomes. This will include: nation-wide scale up of case-based surveillance system; provision of tools and technical assistance to improve program data quality and support HIV-related surveillance; building HMIS management capacity by utilizing an MOH standardized approach and support tools; and conducting rapid qualitative assessments of selected research institutions on the real and perceived gaps in research capacity. Resources will be used to improve patient management and tracking by supporting roll out of the electronic health records system, including increasing the number of facilities using the E-First system. PEPFAR will also support roll out of the human resource information system and laboratory information system. In addition to procuring life-saving medications and commodities, PEPFAR will invest in the electronic logistic management information system (e-LMIS) to assure adequate stocks at facility level. In accordance with the national e-strategy, PEPFAR will promote linkage and interoperability among information systems.

In COP18 PEPFAR Zambia will promote participation and coordination of stakeholders in the national response in order to accelerate progress towards sustained epidemic control. PEPRFAR will strengthen the National AIDS Council's capacity to coordinate the national response and improve civil society engagement; build the capacity of community structures and CBOs to implement community level HIV activities to improve facility-community linkages and linkages to treatment; and build capacity of Community Welfare Assistance Committees (CWACS) to enhance community level OVC case management.

4.5.4 Improving Quality and Efficiencies of Service Delivery

The Zambia Consolidated Guidelines for Prevention and Treatment of HIV Infection that were updated and released in December 2017 outline Zambia's strategic approach for implementing differentiated service delivery models (DSD) that focuses on patient centeredness and health system efficiency. The four primary approaches include: 1) Patients receive their ART refills in a group and either a professional or a lay health care worker manages this group; 2) Clients receive their ART refills in a group but this group is managed and run by clients themselves (e.g. Community Adherence Groups (CAGs); 3) ART refills are provided to individuals outside of health care facilities (e.g., of health post dispensation, home delivery and community based drug pick-ups); and 4) ART refill visits are separated from clinical consultations and patients can proceed directly to receive their medication so as to reduce their waiting time at facilities. Currently and in COP 18, PEPFAR partners will work with health facility staff to continue scaling up these approaches in order to improve retention in care and reduce congestion at health facilities. Priority focus of DSD models target adolescents and men, who have had lower linkage and retention rates.

PEPFAR's largest OVC programs are concentrated in Southern, Lusaka, Central and Copperbelt provinces where the HIV burden is highest. OVC programs support: standardized referral forms, improved parenting skills, specialized support to transition from child into adult care, increased engagement of the faith community, and quality of life services focused on building personal and

economic resilience. The OVC program service package and target populations has been described in section 4.1.

Additional Community Health Workers will be trained and given a stipend to support both the CAGs and support groups. Standardized MoH training of community volunteers will be rolled out to support the expanded community program. PEPFAR Zambia will continue placement of full-time para-professionals in health facilities to facilitate and manage linkages between community and facility service providers.

Significant effort has been made to increase access to ART in health posts as well as non-traditional sites (e.g. on church grounds, community sites, etc.). For example, working closely with the MOH, DISCOVER-Health and other PEPFAR partners have established over 100 of these sites that are linked to parent health facilities. As a result, patients have reduced waiting times and are able to access ART care in underserved communities with high HIV burden. In order to achieve the COP 18 targets, these facilities will play a critical role in case identification, linkage and retention.

Finally, in COP 18, PEPFAR will invest additional resources to increase the number of PEPFAR-supported facilities using the national electronic health record system (SmartCare) at all points of service within each facility. This will build on the efforts in COP17 to roll out this resource to all PEPFAR-supported high volume facilities. Having SmartCare at each point of care within facilities provides health workers with real-time individual patient-level information for clinical decision-making at facility-level and reporting from facility to district to province and to the national level. At facilities where SmartCare is being used in this way, it provides complete tracking for individual patients from HIV testing, through treatment to VL monitoring to access the effectiveness of treatment and to manage patients through the full clinical cascade, allowing for better tracking of patient services and reducing loss to follow up. PEPFAR Zambia will also focus on scaling up the use of the SmartCare community module, referred to as "SmartCare Lite", which allows PEPFAR community partners to track clients and their contacts, have access to real-time patient information while providing HIV testing and ART services in communities. SmartCare Lite allows facilities working closely with their community partners to track index testing and differentiated models of care in use within their catchment areas. By scaling up the use of SmartCare and SmartCare Lite within PEPFAR supported facilities and communities in Zambia, health workers will be better equipped with the appropriate information to support improvements in linkage and retention of HIV positive people, as we strive towards HIV epidemic control.

4.5.5 Ensuring Above Site Activities are Related to Reaching Epidemic Control

PEPFAR Zambia conducted analysis of the SID 3.0 findings, along with MER results and SIMS visit reports, and identified key barriers gaps to achieving epidemic control by 2020. These barriers include: Insufficient practice of HIV prevention behaviors; Low testing yield; Low linkage rates Inadequate retention rate to sustain epidemic control; Low VL capacity; Weak sample transport system; Insufficient PSCM System; Inadequate HRH; Inadequate domestic financing to sustain HIV epidemic control; Limited EMR for patient tracking; and Inadequate use of Epidemic and Health Data.

The table below (Table 4.5.1) illustrates how PEPFAR Zambia has mapped above-service delivery activities to key barriers and measurable outcomes related to reaching epidemic control. Please refer to Table 6 (APPENDIX C) for more details.

Table 4.5.1 Mapping Above-Service Delivery Activities to Key Barriers				
COP18 Activity	Key Barriers	Expected Outcome	Relevant Indicator or Measurement Tool	Year One (COP18) Annual Benchmark
Provide socially marketed condoms to increase access and condom use as well as increase demand for condom use	Insufficient practice of HIV prevention behaviors	Increased availability and distribution of socially marketed condoms to target populations and increased overall condom uptake across sectors (public and private)	# Socially marketed condoms sold; free condoms distributed	100% increase in socially marketed condoms sold to target populations; and at least 15% increase in free condoms distributed by MSL
TA –E-first implementation and maintenance to 380 additional sites	Limited EMR for patient tracking	Timely and accurate turnaround of data reporting at site level	EMR at site	E-first implementation in 380 sites
Support two VL laboratories in Kabwe and Kitwe to increase VL capacity	Low VL capacity	Patients on treatment receive timely VL tests	# VL tests processed; VL turnaround times	All eligible clients in project-supported ART sites have a documented VL
Build the capacity of community structures and CBOs to implement community level HIV activities to improve facility-community linkages and linkages to treatment	Low linkage rates	Strengthened linkages between communities and facilities to increase access to and utilization of HIV services.	Number of CBOs receiving TA	20 CBOs receive TA
EPHO will coordinate the laboratory sample/referral system	Weak sample transport systems	Coordinated functional sample referral system	VL coverage	Laboratory sample referral systems developed to increase VL coverage to 80%.

4.6 Targets for scale-up locations and populations

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY19) *HTS_TST***	**Newly Identified Positive (APR FY19) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 19) *TX_NEW***
Total Men	1,047,780	98,236	88,412
Total Women	1,343,550	93,494	84,145
Total Children (<15)	518,484	12,262	11,036
Adults			
TB Patients	*19,354*	6,322	5,690
Pregnant Women	*404,861*	21,929	19,736
VMMC clients	*330,297*	3,094	2,785
Key populations	*34,891*	5,606	5,045
Priority Populations	*NA*	*NA*	*NA*
Other Testing	*NA*	*NA*	*NA*
Previously diagnosed and/or in care	*NA*	*NA*	*NA*
Pediatrics (<15)			
HIV Exposed Infants	*51,877*		
Other pediatric testing	*190,611*		
Previously diagnosed and/or in care	*NA*	*NA*	*NA*

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY17 end, %)**	***VMMC_CIRC* (in FY18)**	**Expected Coverage (in FY19)**
	[Specify age bands for focus]				
Scale-up	Males, 15-29	1,637,621	20.7	138,256	35.9%
Scale-up	Total males	4,998,324	7.5	102,932	14.0%
All SNUs	Males, 15-29	2,747,408	18.7	198,913	35.5%
All SNUs	Total males	8,720,090	6.6	266,510	13.4%
	Total/Average				

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate** (scale-up **SNUs**)	**Coverage Goal (in FY18)**	**FY19 Target**
[Specify target populations for focus, e.g. AGYW] *Indicator Codes include PP_PREV and KP_PREV*			
FSW (KP_PREV)	14,074	86%	7,406
MSM (KP_PREV)	5,423	26%	2,690
Prison Populations	21,000	97%	6,899
TOTAL	**40,397**		16,995

Table 4.6.4 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY19Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY19 Target) OVC***
[Specify SNUs for focus]			
Ndola District	91,037	37,111	1,113
Chipata District	45,015	3,970	0
Kabwe District	25,242	30,708	21,803
Mazabuka District	43,273	25,061	22,054
Chibombo District	26,001	11,435	9,948
Monze District	27,714	7,120	5,696
Kapiri Mposhi District	29,558	24,156	15,460
Luanshya District	27,124	4,728	0
Mongu District	28,034	777	0
Chongwe District	20,595	6,791	0
Kalomo District	32,316	410	0
Mumbwa District	16,852	11,865	10,204
Kalulushi District	14,183	1,500	1,500
Kafue District	21,387	6,184	0
Chilanga District	--	3,653	0
Chililabombwe District	15,540	3,262	2,838

Katete District	17,963	700	0
Sinazongwe District	7,303	5,592	5,033
Mpongwe District	9,380	3,800	0
Nyimba District	4,950	578	0
Nakonde District	11,028	780	0
Shibuyunji District	--	1,300	1,300
Chirundu District	--	3,350	2,647
Rufunsa District	--	1,500	1,500
Luangwa District	3,800	1,500	1,500
TOTAL	**518,295**	**197,831**	**102,595**

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

5.1 COP18 Programmatic Priorities

Based on the COP18 definition of 'attained' (achieving >90% coverage by all finer age disaggs), there are currently no attained districts**;** by the end of COP18, PEPFAR Zambia aims to have 12 attained districts. In order to achieve COP18 targets, PEPFAR Zambia aims to employ targeted approaches for HIV case finding, linkage and retention across all PEPFAR-supported districts that have been described in section 4.

5.2 Targets for attained and sustained locations and populations

Table 5.2.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts*			
Attained Support Volume by Group		**Expected result APR 18**	**Expected result APR 19**
HIV testing (all populations)	*HTS_TST*	2,188,867	911,944
HIV positives (all populations)	*HTS_TST_POS*	219,995	61,148
Treatment new	*TX_NEW*	195,379	73,533
Current on ART	*TX_CURR*	663,203	708,133
OVC	*OVC_SERV*	371,939	300,280
Key populations	*KP_PREV*	15,106	41,293

Table 5.2.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group		**Expected result APR 18**	**Expected result APR 19**
HIV testing in PMTCT sites	*PMTCT_STAT*	102,225	72,909
HTS (only sustained ART sites in FY 17)	*HTS_TST/HTS_TST_POS*	9,187	6,206
Current on ART	*TX_CURR*	8,236	5,781
OVC	*OVC_SERV*	1,777	

5.3 Establishing service packages to meet targets in attained and sustained districts

Copy of SERVICE PACKAGES BY CATEG

5.3.1 Prioritized Activities for Attained SNUs Include:

- Surveillance, program monitoring, and laboratory systems
- Clinical Services and retention
- Limited demand creation and HIV-negative prevention
- Index case testing and Partner Notification services
- Optimizing PITC in the IPD, STI clinics, TB Clinic
- Know Your Child's HIV Status campaign
- Integrating HTS with school health programs
- Linking with OVC platform to optimize linkages to treatment and care
- Leveraging of social networks
- Peer models for young KPs
- Workplace programs for reaching men
- HIV testing for GBV survivors
- HTS for all VMMC clients
- Hotspot Testing for KPs
- PITC testing especially to increase HIV testing for men
- 90% linkage to care across all age and gender bands
- Mobile HTS services for adolescents
- HTS in PMTCT for all pregnant and breastfeeding women
- Integration of HTS with Well Child clinics
- Increased male targeted CBTS
- Care services for PLHIV
- Treatment services including routine clinic visits, ARVs, and care package
- Essential laboratory services for PLHIV

5.3.2 Prioritized Activities for Sustained SNUs Include:

- Surveillance, program monitoring, and laboratory systems
- Clinical Services and retention
- Limited demand creation and HIV-negative prevention
- Index case testing and Partner Notification services
- Optimizing PITC in the IPD, STI clinics, TB Clinic
- Know Your Child's HIV Status campaign
- Integrating HTS with school health programs
- Linking with OVC platform to optimize linkages to treatment and care
- Leveraging of social networks
- Peer models for young KPs
- Workplace programs for reaching men
- HIV testing for GBV survivors
- HTS for all VMMC clients
- Hotspot Testing for KPs
- PITC testing especially to increase HIV testing for men
- 90% linkage to care across all age and gender bands
- Mobile HTS services for adolescents
- HTS in PMTCT for all pregnant and breastfeeding women
- Integration of HTS with Well Child clinics
- Increased male targeted CBTS
- Care services for PLHIV
- Treatment services including routine clinic visits, ARVs, and care package
- Essential laboratory services for PLHIV

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Analyses conducted by the PEPFAR Zambia team revealed a number of sustainability vulnerabilities and programmatic gaps that must be addressed for the country achieve sustained epidemic control. The Sustainability Index and Dashboard (SID), which was completed through a participatory process with key stakeholders, revealed vulnerabilities in four sustainability elements: Laboratory; Service Delivery; Commodity Security and Supply Chain; and Human Resources for Health. Analysis of the SID 3.0 findings, along with MER results and SIMS visit reports, identified three critical programmatic gaps that must be addressed in order to achieve epidemic control by 2020. These programmatic gaps are: 1) inadequate community systems to improve linkage and retention; 2) inadequate supply chain capacity and infrastructure; and 3) limited VL capacity and infrastructure.

PEPFAR Zambia has included in the COP 2018 budget activities to address threats to achieving 95-95-95 goals and sustained epidemic control. These resources will be used to fund activities that will complement other systems investments. Specifically, they will be used to support the

continued implementation of the Test and Start and alternative service delivery models including Community Based ART models. These funds will be applied to high burden geographic areas and/or populations (including key populations) for epidemic control. Resources will be used to expand VL activities including increasing the number and capacity of VL platforms, installation of power back up solutions, and laboratory information systems. The funds will also be used to improve the supply chain to improve facility level stock availability by strengthening commodity forecasting and quantification capacity and electronic logistic management information systems. Additional resources will be used to build the capacity of community-based organizations and structures to deliver HIV services and strengthen community-facility linkages.

PEPFAR will continue to work closely with and leverage resources of key stakeholders, including the Global Fund (GF) and GRZ. PEPFAR has set annual benchmarks for each above-site activity that will be used to monitor implementation and ensure achievement of results.

Analyses conducted by the PEPFAR Zambia team identified a number of gaps in the treatment and prevention cascade that threaten the implementation of Test and Start and new service delivery models. These include:

- Inadequate human and infrastructure capacity to commence and retain patients on treatment, resulting in sub-optimal quality of care and congestion of health facilities. In particular, inadequate community based workers to achieve optimal linkage and retention.
- Routine VL testing is constrained by limited capacity. In addition, while tests are being performed, only half end up in patient files.
- Inadequate commodity assurance along the continuum of care. HTC, EID and VMMC commodities are particularly vulnerable.
- Limited EMR for patient tracking.
- Lack of adequate laboratory quality standards.
- Weak linkages between community services and facilities with no clear coordination systems. There is no centralized data system and limited use of modern technology such as electronic health mobile devices, mobile phones, to manage coordination.

In order to address these barriers, PEPFAR Zambia has included specific activities listed in Table 6. These include, technical assistance for implementation of electronic health records at high volume sites, salary support for community based workers, activities targeted at improvement of on-time delivery of supplies at all facilities, support for laboratory quality management systems, and effective courier systems and electronic results transmission to ensure timely return of VL results in patient files for effective patient management.

7.0Staffing Plan

7.1 Staffing Analysis

7.1.1 USAID
USAID is not requesting any new positions in COP18, rather the Agency conducted a thorough review of existing positions and proposed the re-purposing of several vacant positions to address emerging needs. Over the past year USAID's offices in Copperbelt and Central have improved both coordination with provincial governments and oversight of implementing partners. Given this success and the increased need to provide site level oversight of implementing partner activities, USAID is re-purposing three previously Lusaka-based approved positions and re-purposing them to be stationed in Northern, Luapula and Central Provinces. These re-purposed regional positions will not only facilitate SIMS visits, but will also provide on-going, day-to-day monitoring of implementing partner activities.

7.1.2 CDC
CDC is not requesting any new positions in COP18 but has reviewed current positions to better align staffing with key programmatic shifts to better focus on helping each province and district achieve HIV treatment coverage of 90%, CDC is strengthening support to regional and district health offices by directly placing a program and a management staff in each of the four provinces supported by CDC.

Currently, SIMS visits are scheduled early in the year and the schedule is shared with all staff. While most visits are done by technical staff, business staff are expected to participate in a few visits a year. The placement of CDC staff in each of the four the provinces, will allow for a separate provincial SIMS schedule managed by the provincial team with support from CDC staff in Lusaka.

A few of CDC vacancies are currently with the Regional Classifiers. CDC anticipates filling these positions as soon as they are classified and will continue to invest in training, based on identified needs during performance evaluations. CDC's alignment was approved in COP17 and no further alignment is planned in COP18.

7.1.3 DOD
Staff complement remains the same; reorganization and repurposing of positions made to address the gaps required to meet the latest needs and technical requirements of the program being finance, clinical, monitoring and evaluation aspects. These changes will go towards strengthening partner supervision and monitoring especially at site level. An additional change is to have an American Direct Hire to manage the program on behalf the Defense Attaché.

7.1.4 Peace Corps
Peace Corps Zambia has 22 PSC positions of which 19 are filled and 3 vacant. The 3 vacant positions were previously approved positions which are in the process of recruitment. Peace Corps Zambia staffing remains unchanged and is not requesting additional staff.

7.1.5 State/PEPFAR Coordination Office

The PEPFAR Coordination Office (PCO) has been restructured over the last 18 months to better reflect the priorities of the PEPFAR program and the needs of the interagency team. Instead of increasing positions, PCO focused on streamlining responsibilities and repurposing some positions in order to increase the efficiency and impact of each position. For example, the PEPFAR Small Grants position has been expanded to include broader civil society engagement.

7.2 Long-term Vacant Positions

USAID currently has 9 open vacancies that are being carried into COP18. Two of these positions are awaiting security clearances, while four have been cleared for advertisement and will be filled before October 2018. The remaining three vacancies are referenced above, and are being re-purposed to cover regional functions for improved implementing partner oversight.

CDC's vacant positions are mainly due to the State Department-required reclassification process.

DOD's previously approved could not be filled due to space in the embassy and this has been resolved and guarantees hiring

Peace Corps currently has 3 open vacancies. Interviews have been conducted all of them. It is anticipated that they will all be filled before the end of FY18.

State currently has 3 open vacancies. An offer has been extended for one of the positions and it is anticipated that the person will start in May 2018. A second position has just been reclassified and is currently in recruitment. The third position being reclassified and the reclassification for the position should be completed in the next few months (started in April 2017), and will then move immediately into recruitment. All positions will be filled before the end of FY18.

7.3 Justification for Proposed New Positions

There are no new positions in COP18, only repurposing of previously approved/unfilled positions.

7.4 Justification for Major Changes to CODB

For USAID, the major line item changes in the COP18 CODB reflect an increase in the amount requested for locally employed staff. This is the result of over 10 long standing vacancies being filled during the past year and the need to fully fund each of these positions for the entire 12 months of COP18.

ICASS costs contributed to a slight increase in CODB for CDC.

For DOD, the major increase in the CODB is due to the repurposing of an EFM position to an American Direct Hire to manage the program on behalf the Defense Attaché. This has also contributed to an increase in the ICASS costs.

APPENDIX A -- PRIORITIZATION

SNU Prioritization

Table A.1

Appendix A SDS .xlsx

Table A.2 ART Targets by Prioritization for Epidemic Control					
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY 18)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY19) *TX_CURR***	**Newly initiated (APR FY 19) *TX_NEW***
Attained	**754,885**	**698,485**		**721,199**	**59,910**
Scale-Up Saturation	**359,025**	**258,064**	**75,124**	**344,398**	**110,572**
Scale-Up Aggressive	**36,822**	**14,489**	**14,969**	**28,983**	**16,668**
Sustained	**34,833**	**3,138**	**24,728**	**8,251**	**5,781**
Central Support	**75,755**	**32,536**	**28,068**	**32,536**	**1,627**
Commodities (if not included in previous categories)					
Total	**1,261,320**	**1,006,712**	**142,889**	**1,135,367**	**194,558**

APPENDIX B – Budget Profile and Resource Projections

B1. COP 18 Planned Spending

Table B.1.1 COP18 Budget by Approach and Program Area

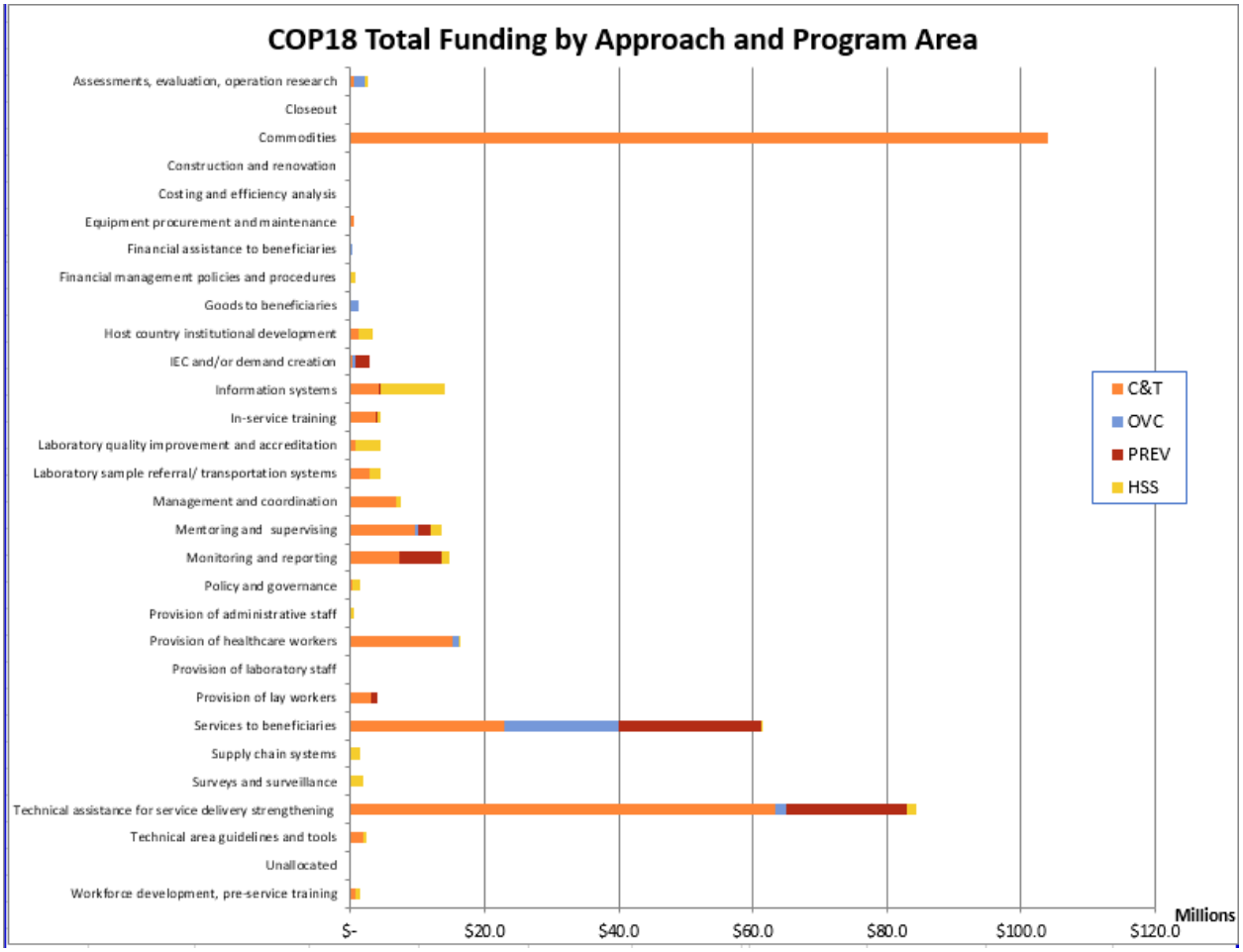

Table B.1.2 COP 18 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US 10,886,742	**$US 374,113,258**	**$US 385,000,000**

*Data included in Table B.1.2 should match FACTS Info records, and can be double-checked by running the "Summary of Planned Funding by Agency" report.

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$13,933,621
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$5,260,185
HVOP	Other Sexual Prevention	$13,491,170
IDUP	Injecting and Non-Injecting Drug Use	
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	$18,003,045
HVCT	Counseling and Testing	$19,323,691
HBHC	Adult Care and Support	$21,873,711
PDCS	Pediatric Care and Support	$9,852,955
HKID	Orphans and Vulnerable Children	$23,408,094
HTXS	Adult Treatment	$109,253,403
HTXD	ARV Drugs	$58,623,796
PDTX	Pediatric Treatment	$17,977,800
HVTB	TB/HIV Care	$9,203,599
HLAB	Lab	$7,644,377
HVSI	Strategic Information	$17,288,346
OHSS	Health Systems Strengthening	$8,819,624
HVMS	Management and Operations	$20,155,301
TOTAL		**$374,113,258**

*Data included in Table B.2.2 should match FACTS Info records, and can be double-checked by running the "Summary of Planned Funding by Budget Code" report

B.2 Resource Projections

Resource projections were based on an incrementally adjusted methodology consistent with OGAC guidance and the FAST process. There was also a review of literature on unit costs to inform decision making. As Zambia received a 7% ($26M) decrease in the program's overall budget, strategic cuts across all program areas were necessary. PEPFAR Zambia engaged in thoughtful and deliberate discussions to determine the most efficient and effective use of the COP18 budget. Following a technical priority-setting process which involved getting stakeholder feedback, TWGs (prevention, community services, clinical services, health systems strengthening, and strategic information) worked together during the targeting and budgeting processes to ensure strong coordination between program areas and partners.

Based on priorities and proposed activities, the TWGs together came up with budgets for each implementing mechanism and identified program area budgets based on targets and expected contributions towards achieving 95/95/95 by September 30, 2019.

Commodity purchases by PEPFAR under COP 18 are stable compared to COP17, despite an increase in the number of people on treatment and a three-fold increase in the number of VL tests being purchased. This was accomplished through reducing ARV purchases under COP18 and utilizing existing stock on-hand in country, eliminating all commodity purchases not directly related to HIV, and reducing the number of HIV test kits purchased in alignment PEPFAR's objective of more efficient, higher yield HIV testing. At the time of writing, a gap of approximately $7.5 million in commitment versus needed amounts for VL tests exists, however ongoing discussions between the GF and MOH are expected to identify resources in order to close the gap before COP18 implementation begins.

APPENDIX C – Tables and Systems Investments for Section 6.0

Table 6 Attachment

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective
1	USAID	USAID/District Coverage of Health Services (DISCOVER-H)	John Snow Inc (JSI)	17399	HSS	0	Increase VL capacity and improve VL turnaround times
2	USAID	USAID/District Coverage of Health Services (DISCOVER-H)	John Snow Inc (JSI)	17399	PREV	0	Condom Social Marketing Provided to Targeted Populations
3	State/AF	National AIDS Council Joint Financing Arrangement	National HIV/AIDS/STI/TB Council - Zambia	11027	HSS	National AIDS Council Joint Financing Arrangement	Capacity Building for National HIV Response
4	HHS/CDC	BroadReach	Broadreach	18323	C&T	HIS development, deployment, training and maintenance	HIS development, deployment, training and maintenance
5	HHS/CDC	BroadReach	Broadreach	18323	HSS		HIV strategic information systems strengthening
6	HHS/CDC	CLSI	Clinical and Laboratory Standards Institute	17478	HSS	Strengthening laboratory quality management	Strengthening laboratory quality management
7	HHS/CDC	CRS (FBO Follow-on 2)	Catholic Relief Services	18327	C&T	0	Scale up interventions targeting men
8	HHS/CDC	EPHO Follow On	Eastern Province Health Office	10225	C&T	Courier and electronic health record implementation	Courier and electronic health record implementation
9	HHS/CDC	EPHO Follow On	Eastern Province Health Office	10225	HSS	0	HIV strategic information systems strengthening

#	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool
1	Laboratory sample referral/ transportation systems	Support two VL laboratories in Kabwe and Kitwe to increase VL capacity	Low VL capacity	Laboratory	2.33	Patients on treatment receive timely VL tests	3 years	VL tests processed; VL turn around times
2	IEC and/or demand creation	Provide socially marketed condoms to increase access and condom use as well as increase demand for condom use	Insufficient practice of HIV prevention behaviors	Service Delivery	5.32	Increased availability and distribution of socially marketed condoms to target populations and increased overall condom uptake across sectors (public and private)	1 year	Socially marketed condoms sold; free condoms distributed
3	Host country institutional development	Support to build NACs capacity to coordinate effective participation processes for the national HIV/AIDS response	Engagement of civil society in PEPFAR program planning	Civil Society Engagement	5.79	Effective mechanisms to exchange information between NAC and CSOs	2 years	Appropriate mix of mode of engagement and type of CSO
4	Information systems	TA -Efirst implementation and maintenance to 380 additional sites	Limited EMR for patient tracking	Service Delivery	5.32	timely and accurate turn around of data reporting at site level	3 years	EMR at site
5	Surveys and surveillance	Case-based surveillance system scale-up nationwide and Surveillance of facility-based and community deaths	Limited EMR for patient tracking	Service Delivery	5.32	Examine the progress toward epidemic control in the general population and where are the gaps (geographic and demographic) in the clinical cascade and Provide estimates of community-level HIV-associated mortality and describe populations and causes that contribute to the highest burden	3 years	surveillance reports
6	Laboratory quality improvement and accreditation	Laboratory quality improvement and accreditation	lack of quality standards and accreditation in central labs	Laboratory	2.33	QMS implementation in Laboratories, ISO Accreditation	3 years	Laboratory Accreditation Certificate
7	IEC and/or demand creation	Conduct Quarterly sensitization and advocacy meeting targeting Men	lack of trained/sensitizatio n of staff	Human Resources for Health	6.27	Staff sensitized in advocacy for men	2 years	Number of district hospitals receiving this training
8	Laboratory sample referral/ transportation systems	*[REDACTED]* will coordinate the laboratory sample/referral system	Weak sample transport systems	Laboratory	2.33	Coordinated functional sample referral system	2 years	viral load coverage
9	Information systems	Increase the number of facilities using the E-First system in the province and strengthen Smart care system in facilities without power.	Limited EMR for patient tracking	Service Delivery	5.32	Coordinated and functional electronic medical record system	2 years	% facilities with EMR

#	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
1	As of APR, 25% of all patients supported by PEPFAR had a documented VL test nationally	All eligible clients in project-supported ART sites have a documented VL	All eligible clients in project-supported ART sites have a documented VL		All eligible clients in project-supported ART sites have a documented VL	
2	As of APR 14.2 Million socially marketed condoms sold; and number of free condoms distributed by Medical Stores Limited	100% increase in socially marketed condoms sold to target populations; and at least 15% increase in free condoms distributed by MSL				
3	N/A	Documentation of identification of appropriate form of CSO engagement for NAC activities as part of planning events and meetings	Civil Society Engagement as a sustainability strength			
4	226 efirst sites	E-first implementation in 380 sites	e-first implementation in additional 400 sites		completed E-first implementation in all PEPFAR supported sites	
5	N/A	scale up case-based surveillance to 3 additional Provinces and conduct survey of HIV-associated mortality	scale up case-based surveillance to 3 additional Provinces		scale up case-based surveillance to 2 additional Provinces	
6	3 labs with accreditation	Total of 7 central labs with accreditation	11 labs accredited		15 (all) VL labs accredited	
7	<50% district hospitals trained in advocacy for men	90% district hospitals in supported province receiving this training	100% district hospitals in supported province receiving this training			
8	50% VL coverage at Provincial level	Laboratory sample referral systems developed to increase VL coverage to 80%	Laboratory sample referral systems developed to increase VL coverage to 80%			
9	<25%	increase by 25% # sites with Electronic medical record system	increase by 50% # sites with Electronic medical record system			

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective
10	HHS/CDC	EPHO Follow On	Eastern Province Health Office	10225	HSS	0	Implementation of guidelines and tools
11	HHS/CDC	ICAP (Population Council)	Columbia University Mailman School of Public Health	18332	HSS	0	National level surveillance support
12	HHS/CDC	LPHO Follow On	Lusaka Provincial Health Office	14420	C&T	Courier and electronic health record implementation	Courier and electronic health record implementation
13	HHS/CDC	LPHO Follow On	Lusaka Provincial Health Office	14420	HSS	0	HIV strategic information systems strengthening
14	HHS/CDC	LPHO Follow On	Lusaka Provincial Health Office	14420	HSS	0	Implementation of guidelines and tools
15	HHS/CDC	Ministry of Health	Ministry of Health, Zambia	17513	C&T	Policy guidance, oversight, coordination and supervision	Policy guidance, oversight, coordination and supervision
16	HHS/CDC	Ministry of Health	Ministry of Health, Zambia	17513	HSS	Policy guidance, oversight, coordination and supervision	Policy guidance, oversight, coordination and supervision
17	HHS/CDC	Ministry of Health	Ministry of Health, Zambia	17513	HSS	Policy guidance, oversight, coordination and supervision	Policy guidance, oversight, coordination and supervision
18	HHS/CDC	Ministry of Health	Ministry of Health, Zambia	17513	C&T	0	National health system improvement and pre-service training
19	HHS/CDC	SPMO Follow On	Southern Provincial Health Office	14421	C&T	Courier and electronic health record implementation	Courier and electronic health record implementation
20	HHS/CDC	SPMO Follow On	Southern Provincial Health Office	14421	HSS	0	HIV strategic information systems strengthening
21	HHS/CDC	SPMO Follow On	Southern Provincial Health Office	14421	HSS	0	Implementation of guidelines and tools

#	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool
10	Host country institutional development	Provide and disseminate the guideline to the district staff in the nine districts.	lack of staff trained in HIV guidelines	Human Resources for Health	6.27	Availability of required guidelines and tools for service delivery	2 years	Number of sites with guidelines
11	Surveys and surveillance	Key pops size estimates and integrated bio-behavioral survey	lack of data for programming	Epidemic and Health Data	4.37	Provide estimates of key populations and HIV prevalence and identify the behaviors that put them at higher risk using integrated bio-behavioral surveys (IBBS)	3 years	KP_PREV
12	Laboratory sample referral/ transportation systems	*[REDACTED]* will coordinate the laboratory sample/referral system	Weak sample transport systems	Laboratory	2.33	Coordinated functional sample referral system	2 years	viral load coverage
13	Information systems	*[REDACTED]* will provide coordinate and manage the information systems in the province	Limited EMR for patient tracking	Service Delivery	5.32	Coordinated and functional electronic medical record system	2 years	% facilities with EMR
14	Host country institutional development	[*REDACTED]* will provide update guidelines to all health institutions in the province	lack of staff trained in HIV guidelines	Human Resources for Health	6.27	Availability of required guidelines and tools for service delivery	2 years	Number of sites with guidelines
15	Policy and governance	Provide oversight and coordination of clinical training and mentorship programs driven across the country AND QI	lack of staff trained in HIV guidelines	Human Resources for Health	6.27	Improved service quality in all facilities providing ART services	2 years	policy enactments
16	Management and coordination	deployment of national E.H.R, HRIS, logistics and LAB information systems oversight and coordination	Limited EMR for patient tracking	Service Delivery	5.32	increased integration and interoperability of various health sector information systems	2 years	National Health information systems rollout countrywide (E.H.R, HRIS, DHIS2)
17	Policy and governance	deployment of national E.H.R, HRIS, logistics and LAB information systems oversight and coordination	Limited EMR for patient tracking	Service Delivery	5.32	increased integration and interoperability of various health sector information systems	2 years	National Health information systems rollout countrywide (E.H.R, HRIS, DHIS2)
18	Workforce development, pre-service training	Provide TA and other support for data analyses to run at optimal capacity	Clinicians lacking capacity in data use	Human Resources for Health	6.27	Improve ability of MOH clinicians to better analyze data at district, provincial, and national level	3 years	Number of districts meeting recommended benchmark (1 trained epidemiologist per 100,000 population)
19	Laboratory sample referral/ transportation systems	*[REDACTED]* will coordinate the laboratory sample/referral system to 16 sites	Weak sample transport systems	Laboratory	2.33	Coordinated functional sample referral system in all the sites	2 years	TAT
20	Information systems	*[REDACTED]* will coordinate and manage the information systems in the province	Limited EMR for patient tracking	Service Delivery	5.32	Coordinated and functional electronic medical record system	2 years	% of health facilities with functional electronic medical record system
21	Host country institutional development	Provide updated guidelines to all health institutions in the province for improved health service delivery	lack of staff trained in HIV guidelines	Human Resources for Health	6.27	Availability of required guidelines and tools for service delivery	2 years	% of health facilities with updated guidelines and tools at all levels of service delivery point.

#	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
10	<25%	90% sites with updated guidelines and tools available at required levels of service delivery	90% sites with updated guidelines and tools available at required levels of service delivery			
11	~17,000 HIV-invested KPs	Estimate the number of KP members in Zambia and the HIV prevalence	Understand treatment and risk behaviors among identified KPs		Surveillance report	
12	0.5	Laboratory sample referral systems developed to increase VL coverage to 80%	Laboratory sample referral systems developed to increase VL coverage to 80%			
13	<25%	increase by 50% # sites with Electronic medical record system	increase by 50% # sites with Electronic medical record system			
14	<25%	90% sites with updated guidelines and tools available at required levels of service delivery	90% sites with updated guidelines and tools available at required levels of service delivery			
15	no policy for "lowering age of consent", "school testing policy", "retesting for verification", "ART nurse prescriber policy"	Policy "retesting for verification", "ART nurse prescriber policy"	Policy for "lowering age of consent", "school testing policy",			
16	90% HRIS completed, no integration of the 3 systems	100% HRIS completed and being used for decision making; integration of DHIS2 and EHRintegration	100% HRIS completed and being used for decision making; integration of HRIS, DHIS2 and EHRintegration			
17	90% HRIS completed, no integration of the 3 systems	100% HRIS completed and being used for decision making; integration of DHIS2 and EHRintegration	100% HRIS completed and being used for decision making; integration of HRIS, DHIS2 and EHRintegration			
18	N/A	15 districts with trained clinicians/ 3 HIV surveillance proposals	15 additional districts with trained clinicians/3 HIV analysis reports		15 additional districts with trained clinicians / 3 HIV surveillance proposals	
19	1week-4months	TAT 1-2weeks	TAT 1-2weeks			
20	<25%	increase by 50% # sites with Electronic medical record system	increase by 50% # sites with Electronic medical record system			
21	<25%	90% sites with updated guidelines and tools available at required levels of service delivery	90% sites with updated guidelines and tools available at required levels of service delivery			

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective
22	HHS/CDC	TBD (In Country Lab partner)	TBD	18532	C&T	Develop laboratory capacity for diagnostics and monitoring treatment	Develop laboratory capacity for diagnostics and monitoring treatment
23	HHS/CDC	TBD (In Country Lab partner)	TBD	18532	HSS	Develop laboratory capacity for diagnostics and monitoring treatment	Develop laboratory capacity for diagnostics and monitoring treatment
24	HHS/CDC	TBD (IntraHealth)	TBD	18528	C&T	0	Strengthening EHR use in community testing
25	HHS/CDC	TBD (M&E)	TBD	18527	HSS	0	HIV strategic information systems strengthening
26	HHS/CDC	TDRC	Tropical Diseases Research Centre	17499	HSS	Strengthen reference laboratories and public health surveillance	Provision of administrative staff
27	HHS/CDC	TDRC	Tropical Diseases Research Centre	17499	C&T	Strengthen reference laboratories and public health surveillance	Evaluation of TB preventive therapy
28	HHS/HRSA	Twinning Centre	American International Health Alliance Twinning Center	10207	HSS	0	Improving Laboratory Quality and Leadership
29	HHS/HRSA	Twinning Centre	American International Health Alliance Twinning Center	10207	HSS	Provision of HIV training and mentorship to clinicians	Provision of HIV training and mentorship to clinicians
30	HHS/CDC	UNAIDS	World Health Organization	18297	HSS	0	HIV strategic information systems strengthening
31	HHS/CDC	University Teaching Hospital (Combined HAP & LAB)	University Teaching Hospital	10236	PREV	0	Improve site level data management systems for KP and PP Programs
32	HHS/CDC	University Teaching Hospital (Combined HAP & LAB)	University Teaching Hospital	10236	HSS	0	Support to the optimization of HIV testing and Viral Load monitoring in supported districts

#	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool
22	Laboratory sample referral/ transportation systems	provide hardware, training and logistic support in clinics and laboratories for VL and EID testing	inadequate trained technologists and capacity	Laboratory	2.33	Laboratory system with the capacity to test 90% of PLHIV for VL and EID	3 years	Number of patients with VL result on file
23	Laboratory quality improvement and accreditation	Provide TA and other support for labs to run a optimal capacity	inadequate trained technologists and capacity	Laboratory	2.33	Laboratories with VL/EID throughput that reach 80% of capacity	3 years	number of tests performed (by test counter) relative to manufacturer capacity
24	Information systems	*[REDACTED]* will manage the use of EHR for community testing	Limited EMR for patient tracking	Service Delivery	5.32	Utilization of electronic health record system for community testing.	3 years	% of community sites with functional electronic medical record system
25	Technical area guidelines and tools	provide tools and TA to improve program data quality and support HIV-related surveillance	inadequate data for planning	Epidemic and Health Data	4.37	Improved accuracy and completeness of data for HIV surveillance and program monitoring and evaluation	3 years	alignment of HMIS and DATIM
26	Provision of administrative staff	Maintain information network relevant to public health and laboratory science	limited information systems	Laboratory	2.33	Functional information system for all staff at the reference laboratories	3 years	% of operation of the network
27	Assessments, evaluation, operation research	Conduct a formal evaluation of TPT Including assessment	inadequate data for planning	Epidemic and Health Data	2.33	effectiveness of TPT intensified program in PLHIV and children	1 year	TPT initiation
28	Laboratory quality improvement and accreditation	Provide logistics and technical support that is essential to maintain laboratory accreditation.	sub-optimal standard of laboratories	Laboratory	2.33	National Calibration Centers for laboratory equipment	3 years	number of functional calibration centers providing services
29	Workforce development, pre-service training	Clinical practice transformation to develop clinician skills aimed at better HIV outcomes (linkage and retention) through HBCU	Inadequate skills of staff to provide quality HIV services	Human Resources for Health	6.27	Improved HIV linkage and retention outcomes	1 year	Linkage and Retention
30	Surveys and surveillance	Case-based surveillance, strategic information capacity building (estimates)	inadequate data for planning	Epidemic and Health Data	4.37	Increased quality of national and sub-national HIV estimates and ability to use them to focus sub-national HIV efforts. Increased implementation of data systems with the ability to link data and use it for program planning.	3 years	Number of 90:90:90 cases tracked and number of facilities participating in case-based surveillance. Number of provinces with working Situation Rooms.
31	Information systems	Development unique IDs, of SOPs and capacity building including HW KP sensitization	Health Information System has no way of uniquely identifying KPs/PPs resulting in duplication	Service Delivery	5.32	HIS with improved data management and reporting for KPs and PPs	3 years	Data collection and reporting tools developed
32	Laboratory quality improvement and accreditation	EQA for HTS and VL	Not all sites enrolled in EQA for HTS/VL	Laboratory	2.33	Improved quality of HTS and VL in PEPFAR supported sites	2 years	Lab_PT

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22	Tx_PVLS_180000	Tx_PVLS_750000	Tx_PVLS_1000000		Tx_PVLS_1150000	
23	50%	80%	80%		80%	
24	Not known	Purchasing and deployment of Electronic medical record system at community level	Support functioning of the community electronic medical system		Electronic medical record system (Smartcare lite) scaled to all community testing sites	
25	Difference of 109,178 PLHIV on treatment reported by MOH vs. PEPFAR	Reduce difference in ART coverage reported by MOH vs. PEPFAR by 20%	Reduce difference in ART coverage reported by MOH vs. PEPFAR by 20%		Reduce difference in ART coverage reported by MOH vs. PEPFAR by 20%	
26	85%	95%	100%		100%	
27	TB_PREV 11%	Evaluation report and dissemination				
28	none	3 functional calibration centers	6 functional calibration centers		9 functional calibration centers	
29	70% linkage	90% Linkage; 90% Retention	N/A			
30	N/A	Implement a system for case-based surveillance that will give HIV cascade data fully functional in 1 Districts. 2 provinces with functional Situation Rooms.	Implement a system for case-based surveillance in 2 Districts. 4 provinces with functional Situation Rooms.		Implement a system for case-based surveillance in 3 Districts. 6 provinces using the Situation Rooms for policy and planning.	
31	USG KP estimates and ZAMPHIA	At least 50% of KPs/PPs reached have a Unique ID	At least 70% of KPs/PPs reached have a Unique ID		At least 80% of KPs/PPs reached have a Unique ID	
32	16 VL labs enrolled in PT	20 labs enrolled in EQA/PT program	All 23 labs enrolled in EQA/PT program			

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective
33	HHS/CDC	WPHO Follow on	Western Province Health Office	10227	C&T	Courier and electronic health record implementation	Courier and electronic health record implementation
34	HHS/CDC	WPHO Follow on	Western Province Health Office	10227	HSS	0	HIV strategic information systems strengthening
35	HHS/CDC	WPHO Follow on	Western Province Health Office	10227	HSS	0	Implementation of guidelines and tools
36	HHS/HRSA	JHPIEGO (HRH)	Johns Hopkins University Bloomberg School of Public Health	18530	C&T	Build & strengthen a Health Workforce to sustain HIV epidemic control	Build & strengthen a Health Workforce to sustain HIV epidemic control
37	HHS/HRSA	JHPIEGO (HRH)	Johns Hopkins University Bloomberg School of Public Health	18530	C&T	Build & strengthen a Health Workforce to sustain HIV epidemic control	Build & strengthen a Health Workforce to sustain HIV epidemic control
38	HHS/HRSA	JHPIEGO (HRH)	Johns Hopkins University Bloomberg School of Public Health	18530	HSS	Build & strengthen a Health Workforce to sustain HIV epidemic control	Build & strengthen a Health Workforce to sustain HIV epidemic control

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33	Laboratory sample referral/ transportation systems	*[REDACTED]* will coordinate the laboratory sample/referral system	Weak sample transport systems	Laboratory	2.33	Coordinated functional sample referral system	2 years	TAT
34	Information systems	*[REDACTED]* will provide coordinate and manage the information systems in the province	Limited EMR for patient tracking	Service Delivery	5.32	Coordinated and functional electronic medical record system	2 years	% of health facilities with functional electronic medical record system
35	Host country institutional development	*[REDACTED*] will provide update guidelines to all health institutions in the province	lack of staff trained in HIV guidelines	Human Resources for Health	6.27	Availability of required guidelines and tools for service delivery	2 years	% of health facilities with updated guidelines and tools at all levels of service delivery point.
36	Workforce development, pre-service training	*[REDACTED]* will provide Technical Assistance in workforce development optimization	sub-optimal HCW retention	Human Resource for Health	6.27	Adequate supply, quality and retention of HRH to provide HIV services	1 year	HCW retention
37	Workforce development, pre-service training	*[REDACTED]* will support HIV Nurse Prescribers program cont.NEPI	Inadequate supply of skilled health care workers	Human Resource for Health	6.27	Adequate supply, quality and retention of HRH to provide HIV services	1 year	HRH-PRE
38	Information systems	*[REDACTED]* will support the development of rHRIS and interoperability into MOH HRIS system	inadequate HRH data use for planning	Human Resource for Health	6.27	Coordinated, integrated and functional Human Resource Information System	1 year	rHRIS

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33	1week-4months	TAT 1-2weeks	TAT 1-2weeks			
34	<25%	increase by 50% # sites with Electronic medical record system	increase by 50% # sites with Electronic medical record system			
35	<25%	90% sites with updated guidelines and tools available at required levels of service delivery	90% sites with updated guidelines and tools available at required levels of service delivery			
36	Not known	Development of workforce optimization tools and management of Health workforce	retention improved by 25% above baseline			
37	HRH-PRE_100	HRH-PRE_100	N/A			
38	incomplete automation of rHRIS	operationalization of rHRIS	integrated rHRIS and MOH HRIS			

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective
39	DOD	<Placeholder - 70432 Zambia DOD>	<Placeholder - 70432 Zambia DOD>	70432	C&T	Strengthened capacity of the ZDF to increase access to care and support services across the continuum of care	Strengthen access to care and support services across the continuum of care and maximize these platforms to strengthen linkages
40	DOD	<Placeholder - 70432 Zambia DOD>	<Placeholder - 70432 Zambia DOD>	70432	HSS	Strengthened health commodity supply chain system and processes in ZDF health Facilities.	Strengthened capacity of the ZDF to implement behavioral interventions with linkages to biomedical interventions among military personnel, their families and surrounding communities
41	DOD	Society for Family Health	Population Services International	14452	C&T	Improve the military, their families, and the surrounding communities' knowledge, attitudes, and behaviors related to VMMC as a key intervention for HIV prevention;	Implementing Quality Management and Standards

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39	Laboratory quality improvement and accreditation	Strengthen referral linkages for viral load testing between 20 Zambia Defence Force (ZDF) ART sites and 10 public provincial viral load labs in Central, Copperbelt, Lusaka and Southern Provinces and two military central laboratories and address all gaps across the viral load testing cascade Support 6 ZDF clinical laboratories to receive intensive support for Quality Management Systems (QMS) in medical laboratory to bring them up to the level of accreditation standards using the Stepwise Laboratory Improvement Process towards Accreditation in the Africa Region (SLIPTA) and serve as learning centers for other ZDF HIV laboratories	Weak infrastructure including weak transport network to support the rapid transportation of VL samples from testing facilities to central labs, inadequate number of VL testing equipment to support ZDF VL testing facilities, weak cold chain system to support transportation of samples at required temperature; weak laboratory information systems to support rapid transmission of VL test results from central labs to testing facilities to inform patient management; high ART staff turn-over and inadequate knowledge and skills on the importance of VL testing, ordering for VL	Laboratory	2.33	Existence of a functional and efficient referral system for viral load testing between 20 ZDF ART facilities and 10 public viral load labs and 2 military central labs Labs near ready for accreditation or labs that achieve 5 stars as per SLIPTA audit guidelines supported to enroll in an established ISO 15189 accreditation scheme	3 years	95% of HIV patients on ART have at least one viral load test result per year 6 Labs near ready for accreditation enroll in an established ISO 15189 accreditation scheme
40	Supply chain systems	Transition 32 ZDF sites from a paper-based ARV, HIV test kits, and laboratory commodities logistics management system to the electronic Logistics Management Information System (eLMIS) to enable efficient management of HIV related logistics	Inadequate infrastructure and poor internet connectivity in remote sites to support rapid and effective eLMIS roll out	National Health System: Commodity security and supply chain	7.22	eLMIS is rolled out to 32 ZDF ART sites and there is efficient management of HIV related logistics	2 years	eLMIS rolled out in 32 ZDF ART sites 88% (46/52) of facilities reporting no stock out of ARVs, HIV test kits and HIV related lab tests reagents
41	IEC and/or demand creation	Quality improvement through training counselors and Health promoters, implement a mentorship program for MC providers, carry out data quality audits, support supervisory activities, Peer Education that will target military recruits and Demand creation by introducing the Human Centered Design.	Restricted entry in military facilities. Data on military personal is not available/accessible.	Service Delivery	5.32	Reduced incidences of HIV among the military personnel, their families and surrounding communities	1 year	Number people circumcised

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39	47% of HIV patients on ART have at least one viral load test result per year 6 labs enrolled in the AFRO SLIPTA accreditation program; 36 laboratory personnel trained in the first of the three series of SLMTA trainings; and baseline and post training audits conducted by external SLIPTA assessors	70% of HIV patients on ART have at least one viral load test result per year 36 laboratory personnel trained in the second and third series of the SMTA training; Conduct post-training laboratory audits in 6 SLMTA sites using the SLIPTA checklist and the 6 Laboratories audited against laboratory standards outlined in the SLIPTA checklist and recognized for each level of performance they attain by a star rating	20 ZDF ART sites show a minimum of one annual viral load test done for 80% of their ART clients and have their test results 24 quarterly post- SLMTA training laboratory audits conducted Laboratory technicians and technologists in 14 ZDF sites supported to conduct 4 bi-annual (2 in year 3 and 2 in year 4) learning visits to 6 learning centers		20 ZDF ART sites show a minimum of one annual viral load test done for 90% of their ART clients and have their test results 24 quarterly post- SLMTA training laboratory audits conducted - 6 learning centers and sites are supported to gain ISO 15189 accreditation status	
40	eLMIS rolled out in 14 ZDF ART sites	eLMIS rolled out in 25 ZDF ART sites 75% (39/52) of facilities reporting no stock out of ARVs, HIV test kits and HIV related lab tests reagents	Transition 32 ZDF sites from a paper-based ARV, HIV test kits, and laboratory commodities logistics management system to the electronic Logistics Management Information System (eLMIS) to enable efficient management of HIV related logistics			
41	29,246	24,900				

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective
42	DOD	DAO Lusaka	U.S. Department of Defense (Defense)	11627	HSS		To conduct a Surveillance and Behavioral Epidemiology Risk Survey (SABERS), a military specific study to understand the HIV prevalence and networks in the Zambia Defense Force; To improve data management use and enhance program quality.
43	USAID	Sexual and Reproductive Health for All Initiative (SARAI)	Society for Family Health	17396	OVC	OVCs empowered with knowledge on nutrition, HIV/SRH and life skills	Training of OVC service providers on HIV prevention and life skills
44	USAID	Sexual and Reproductive Health for All Initiative (SARAI)	Society for Family Health	17396	OVC	OVCs empowered with knowledge on nutrition, HIV/SRH and life skills	Training of OVC service providers on HIV prevention and life skills
45	USAID	Sexual and Reproductive Health for All Initiative (SARAI)	Society for Family Health	17396	OVC	OVCs empowered with knowledge on nutrition, HIV/SRH and life skills	Training of OVC service providers on HIV prevention and life skills
46	USAID	Eradicate TB	Program for Appropriate Technology in Health	17400	C&T	Intensified Research and Innovation	Conduct operations research in newer drugs, new diagnostics and TB preventive the
47	USAID	SAFE	John Snow Inc (JSI)	17413	HSS	Strengthen the health system to support the objectives of 95/95/95	Strengthen the health system to support the objectives of 95/95/95
48	USAID	SAFE	John Snow Inc (JSI)	17413	HSS	Strengthen M&E capacity at the facility, district and provincial levels for improved program management	Strengthen M&E capacity at the facility, district and provincial levels for improved program management

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42	Surveys and surveillance	The goal of SABERS is to describe the prevalence of HIV and other sexually transmitted infections (possibly syphilis, Chlamydia, and gonorrhea) and to examine associated risk behaviors among the Zambian military members. The study consists of two parts: a sero-prevalence component that tests for HIV and perhaps other sexually transmitted infections and a tablet-based survey about sexual risk behaviors. This will help to inform HIV and AIDS programs currently being conducted in the military and also generate data to strengthen programs. This SABERS study can serve as a timely follow on to the previous sero-prevalence studies conducted in the ZDF.	Data collection challenges and delayed approvals from the respective military structures	Epidemiology and health data	4.37	Data to support informed implementation with evidence supporting data and interventions	2 years	Nil
43	IEC and/or demand creation	Trainings for LARCs, HTC and YFHS for DHO and Providers	Lack of trained providers data base	Service Delivery	5.32	Improved capacity of DHO staff and health providers to provide essential OVC services	2 years	Number of DHO and health care providers trained
44	IEC and/or demand creation	District GLOW/ELITE youth Camps	Insufficient practice of HIV prevention behaviors	Service Delivery	5.32	Improved SRH knowledge for youth	2 years	Number of OVC served
45	IEC and/or demand creation	OVC Coordination meetings	Low linkage rates	Service Delivery	5.32	Heightened partner awareness of necessary OVC services	2 years	Number of OVC served
46	Assessments, evaluation, operation research	Design and implementation of locally relevant operational research for prevention, detection and treatment of TB	Inadequate use of epidemic and health data	Epidemiological and Health Data	4.37	Improved capacity to use locally generated evidence to inform strategic programming	3 years	Number of targeted research activities conducted
47	Laboratory sample referral/ transportation systems	Establish improved VL sample delivery systems for SAFE supported districts and provinces	Low VL capacity	Laboratory	2.33	Improved VL sample transport systems	2 years	Number of VL tests completed
48	Information systems	Build HMIS management capacity by utilizing an MOH standardized approach and support tools, through the sustained mentorship of facility, district and provincial staff.	Inadequate use of Program Health Data for planning and evidence based decision making	Performance Data	6.4	Strengthened capacity of health sector staff at the provincial, district, and facility levels to meet the HMIS data collection, analysis, and use standards established by the MOH.	2 years	Number health care providers trained and mentored in data collection, analysis, and use

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42	2005-6 & 2011-12 prevalence study	Continuation of study from COP17 - drafting of protocols	data analysis completion of SABERS and report writing			
43	796 DHO, peer educators and Teachers have been trained	350 DHO and other service providers will be trained	50 DHO and other service providers will be trained. Project will be winding up			
44	16,803 OVCs have been reached with SRH & HIV messages and services	40 (20 girls and 20 boys) per camp will be invited to attend GLOW/ELITE Camps in 2 regions.	20 girls and 20 boys will be invited to attend GLOW/ELITE Camps in 1 region			
45	144 OVC SRH meetings-DAPP and OVC partnership meetings with ZAMFAM and DAPP	72 OVC SRH meetings-DAPP and OVC partnership meetings with ZAMFAM and DAPP	20 OVC SRH meetings-DAPP and OVC partnership meetings with ZAMFAM and DAPP			
46	Not known	1 Research activity conducted	1 research activity conducted		1 research activity conducted	
47	No routine VL transport systems operating	Routine VL transport systems operational for 75% of samples	Routine VL transport systems operational for 100% of samples			
48	0 (zero) districts are eFirst compliance	Quarterly reports submission	6 (six) districts are eFirst compliant			

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective
49	USAID	SAFE	John Snow Inc (JSI)	17413	HSS	Strengthen the public financial management systems of the Ministry of Health and Ministry of Finance to enable the efficient use of direct G2G funds from USAID	Strengthen the public financial management systems of the Ministry of Health and Ministry of Finance to enable the efficient use of direct G2G funds from USAID
50	USAID	USAID Systems for Better Health	Abt Associates	17425	C&T	Support the government and community-based organizations to increase the quality, availability, and use of health services	Improve the quality, availability and use of facility and community level HIV services by addressing current gaps
51	USAID	USAID Systems for Better Health	Abt Associates	17425	C&T	Support the government and community-based organizations to increase the quality, availability, and use of health services	Improve the quality, availability and use of facility and community level HIV services by addressing current gaps
52	USAID	USAID Systems for Better Health	Abt Associates	17425	HSS	Design, implement and monitor national level interventions to strengthen health stewardship by the Ministry of Health	Implement HRH interventions to support Test and Treat and Differentiated Service Delivery
53	USAID	USAID Systems for Better Health	Abt Associates	17425	HSS	Design, implement and monitor national level interventions to strengthen health stewardship by the Ministry of Health	Implement HRH interventions to support Test and Treat and Differentiated Service Delivery

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49	Financial management policies and procedures	Strengthening of provincial public financial management systems in USAID G2G provinces to improve financial management planning and execution for both USAID G2G activities and GRZ HIV activities.	Poor HIV budget execution	Technical and Allocative Efficiencies	7.33	Improved budget execution for HIV activities	2 years	HIV/AIDS Budget Execution
50	Technical area guidelines and tools	Build the capacity of community structures and CBOs to implement community level HIV activities to improve facility-community linkages and linkages to treatment	Low linkage rates	Service Delivery	5.32	Strengthened linkages between communities and facilities to increase access to and utilization of HIV services.	2 years	Number of CBOs receiving TA
51	Technical area guidelines and tools	Technical assistance to the MOH to develop, update and disseminate policies, technical guidelines and job aids. Technical assistance to MOH at central and provincial levels to implement QA/QI programs	Low testing yield/ Inadequate retention rate to sustain epidemic control/Low linkage rates	Service Delivery/Quality Management	5.32/7.10	Improved quality of services at facility and community level	2 years	National and Provincial QI Committee meeting minutes
52	Workforce development, pre-service training	Support pre-service training of Community Health Assistants and nurse/midwives. (Continued from COP 17).	Inadequate HRH	Human Resources for Health	6.27	Decreased work load and increased quality of service provided by HCWs in high burden sites in Copperbelt and Central Provinces.	2 years	HRH_PRE, HRH_STAFF
53	Workforce development, pre-service training	Support MOH to undertake workforce optimization studies to improve utilization of HR planning, management and decision making in high burden districts	Inadequate HRH	Human Resources for Health	6.27	Strengthened use of data for HR decision making at the central and subnational level leading to increased efficiency in the utilization of available human resources	1 year	Study/Assessment Report

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49	70-89% of HIV budget executed	80-95% of HIV budget executed	95% of HIV budget executed			
50	More that 800 neighborhood health committee members trained in community action planning, implementation and monitoring in FY 2017	20 CBOs receive TA	Additional 20 CBOs receive TA			
51	National QI Guidelines exist and have been updated. National and provincial QI committees are in place.	National and Provincial QI committees holding regular (at least quarterly) meetings and documentation of active monitoring of QA/QI activities. Documented evidence of implementation and use new/updated technical guidelines.	National and Provincial QI committees holding regular (at least quarterly) meetings and documentation of active monitoring of QA/QI activities. Documented evidence of implementation and use new/updated technical guidelines.			
52	625 graduates (421 nurse/midwives, 204 CHA)	600 (400 CHA and 200 nurse midwives) graduate with PEPFAR support.	600 (400 CHA and 200 nurse midwives) graduate with PEPFAR support.			
53	No baseline information	Study/Assessment Completed.				

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective
54	USAID	USAID Systems for Better Health	Abt Associates	17425	HSS	Design, implement and monitor national level interventions to strengthen health stewardship by the Ministry of Health	Implement HRH interventions to support Test and Treat and Differentiated Service Delivery
55	USAID	USAID Systems for Better Health	Abt Associates	17425	HSS	Design, implement, and monitor interventions to strengthen program management capabilities of provincial and district teams	Implement interventions in support of Sustainable HIV Financing
56	USAID	USAID Systems for Better Health	Abt Associates	17425	HSS	Design, implement, and monitor interventions to strengthen program management capabilities of provincial and district teams	Implement interventions in support of Sustainable HIV Financing
57	USAID	USAID Systems for Better Health	Abt Associates	17425	HSS	Design, implement, and monitor interventions to strengthen program management capabilities of provincial and district teams	Implement interventions in support of Sustainable HIV Financing
58	USAID	USAID/South-Central Zambia Family Activity	Development Aid from People to People Humana Zambia	17788	OVC	Shared learning and evidence base to improve programming and inform policy and program investment strengthened.	Shared learning and evidence base to improve programming and inform policy and program investment strengthened.
59	USAID	<Placeholder - 70455 Zambia USAID>	<Placeholder>	70455	HSS	Strengthened logistics information systems to avail critical data for informed supply chain decision- making	Management Information Systems technical assistance

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54	Workforce development, pre-service training	Support roll out of HRIS to high burden districts in Copperbelt and Central Provinces to improve HR planning, management and decision-making. (Continued from COP 17)	Inadequate HRH	Human Resources for Health	6.27	Strengthened use of data for HR decision making at the central and subnational level leading to increased efficiency in the utilization of available human resources	2 years	Quarterly HRIS reports
55	Financial management policies and procedures	Health financing assessments (e.g. NHA, Expenditure Analysis and Business/Investment Cases)	Inadequate domestic financing to sustain HIV epidemic control	Domestic Resource Mobilization/Technical and Allocative Efficiencies	5.44/7.33	Availability and use of data for HCF decision making and policy formulation leading to increased efficiency in the use of resources for the national HIV response	2 years	NHA, Analysis Reports
56	Financial management policies and procedures	Support the implementation of the Social Health Insurance Scheme per the national road map	Inadequate domestic financing to sustain HIV epidemic control	Domestic Resource Mobilization/Technical and Allocative Efficiencies	5.44/7.33	More Zambians have access to health and HIV services without catastrophic financial risk thus facilitating sustained epidemic control	2 years	Minutes of National HCF TWG meetings. Actuarial study reports
57	Financial management policies and procedures	Build capacity in public financial management among accounting and non accounting staff in Copperbelt and Central Province Districts. Support roll out of NAV accounting system to Copperbelt and Central Provinces.	Inadequate domestic financing to sustain HIV epidemic control	Domestic Resource Mobilization/Technical and Allocative Efficiencies	5.44/7.33	Increased accountability in the use of public resources.	2 years	Quarterly District and Provincial Financial Reports. Annual Audit Reports
58	Assessments, evaluation, operation research	Building capacity of Community Welfare assistance committees (CWACS)	Strengthening of community level structures for OVC case management.	Performance Data	6.4	Improved community level OVC case management.	2 years	quarterly report.
59	Information systems	Provide technical support and supervision for central and facility level electronic logistics information system (eLMIS), training MOH staff at central, provincial, and district	Insufficient PSCM System	Commodity Security and Supply Chain	7.22	Increased use of eLMIS tools and other non-electronic logistics information systems for decision making	2 years	eLMIS reporting, ordering, and data accuracy

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54	With USG support, MOH cleaned on the master facility list that was developed for the system and has developed an instructional guide for the new integrated HRIS (iHRIS). 59 District and Provincial Human Resource Officers have been trained in iHRIS.	HRIS rolled out to ten districts	HIRS rolled out to additional ten districts			
55	Data has been collected for NHA 2013-16	NHA 2017 completed	NHA 2018 completed			
56	MOH and Ministry of Justice have reviewed stakeholders' comments on SHI Bill and it is ready for presentation to Parliament	Benefit package that includes HIV services completed	TBA- Pending consultation with stakeholders.			
57	USG provided technical assistance to MOH to revise resource allocation formula for districts. This will be used as a reference guide for allocating resources to districts by Ministry of Finance.	Budget execution increased to at least 75% in five districts. NAV rollout to Copperbelt and Central Provinces complete.	Budget execution increased to at least 75% in ten districts			
58	No baseline	200 CWAC members trained	200 CWAC members trained.	TBA- Pending consultation with stakeholders.		
59	Poor accuracy of LMIS data e.g. stock accuracy, consumption data, losses and adjustments leading to incorrect orders- across both manual and electronic LMIS systems	Selection, ordering, and reporting are informed by LMIS activities at 85% of facilities.	Selection, ordering, and reporting are informed by LMIS activities at 95% of facilities.			

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective
60	USAID	<Placeholder - 70455 Zambia USAID>	<Placeholder>	70455	HSS	Increased ownership by the Zambian government to lead quantification and procurement planning processes	Forecasting and supply planning technical assistance
61	USAID	<Placeholder - 70455 Zambia USAID>	<Placeholder>	70455	HSS	Improved effectiveness and efficiency in warehousing and distribution	Warehousing, inventory management, transportation, storage, and distribution
62	USAID	<Placeholder - 70455 Zambia USAID>	<Placeholder>	70455	HSS	Increased innovation for strategic management and planning for improved commodity security	Supply Chain human resource capacity development
63	USAID	AIDS Free ZAMBIA	John Snow Inc (JSI)	18160	C&T	An integrated data repository that will provide a data entry module for logistics reports and other routine logistics data	An integrated data repository that will provide a data entry module for logistics reports and other routine logistics data
64	USAID	AIDS Free ZAMBIA	John Snow Inc (JSI)	18160	C&T	Increase use of logistics data for decision making	Increase use of eLMIS logistics data for decision making, including capacity building and generating evidence of effectiveness for policy makers.

#	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool
60	Host country institutional development	Complete annual forecasts and quarterly supply plans for HIV, malaria, FP, and maternal and child health (MCH) program commodities.	Insufficient PSCM System	Commodity Security and Supply Chain	7.22	MOH led forecast and supply plan workshops resulting in plans developed, tracked and monitored- these include gap analyses for procurement and budget that are updated and shared with IPs and donors	2 years	Pipeline
61	Supply chain systems	Strengthen MSL governance and leadership to enable agile management and responsiveness to organizational needs.	Insufficient PSCM System	Commodity Security and Supply Chain	7.22	Improve MSL capacity in warehouse operations to increase on-time in-full deliveries to facilities.	2 years	eLMIS reports
62	Host country institutional development	Data and best practices globally reviewed to develop interventions for consideration and adaptation in the Zambia context.	Insufficient PSCM System	Commodity Security and Supply Chain	7.22	Technology and innovation leveraged to improve commodity availability in Zambia.	1 year	Supply Chain Assessment, eLMIS reports showing improved performance
63	Information systems	Enhance facility and central editions to ensure future rollout success, develop additional modules and integrate with other health information systems	Insufficient PSCM System	Commodity Security and Supply Chain	7.22	eLMIS capable of integration with in-country systems like SmartCare and other e-solutions for health	1 year	eLMIS development tracker
64	Host country institutional development	Improve quality of data captured in the eLMIS system and generate evidence on the effectiveness of eLMIS for policy makers in Zambia and in the region	Insufficient PSCM System	Commodity Security and Supply Chain	7.22	Increased use of logistics data for key decision-making and continuous improvement of supply chain performance to meet patient demand at health facilities nationwide	1 year	eLMIS reports

#	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
60	HIV, malaria, FP, and maternal and child health (MCH) program Forecast and Supply Plans (FASPs)	FASPs completed and shared with MOH, IPs, donors and other stakeholders for HIV, malaria, FP, and maternal and child health (MCH) program commodities. Pipeline updated with forecasted procurements	Forecast and Supply Plans (FASPs) completed and shared with MOH, IPs, donors and other stakeholders for HIV, malaria, FP, and maternal and child health (MCH) program commodities. Pipeline updated with forecasted procurements			
61	On time delivery at the government hospitals LVL 1, 2 &3 and CHAZ hospitals level 2&3 were around 50% for percentage of commodities delivered on or before promised delivery date and below this performance at the lower levels facilities.	Increase on time delivery at all facilities to 75%	Increase on time delivery at all facilities to 90%			
62	No baseline	Research on state of the art concepts in supply chain resulting in concept papers and pilots implemented in-country. As an example, Zambia is a focus for potential unmanned aerial vehicle (UAV) as a possible transport solution for hard to reach health centers				
63	Integration with SmartCare tested in 3 facilities and discussions with electronic Zambia Inventory Control System (eZICS) team	eLMIS and SmartCare roll-out coordinated to leverage resources and avoid duplication at e-First sites				
64	Across both manual and electronic LMIS systems, there are challenges with accuracy of information and challenges keeping LMIS systems up to date, especially in rural areas	Assessment of data quality shows improvements in accuracy and impact on uses for decision makers				

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective
65	USAID	AIDS Free ZAMBIA	John Snow Inc (JSI)	18160	C&T	Deploy eLMIS for improved logistics data management at facility, district, and provincial level	Deploy eLMIS for improved logistics data management at facility, district, and provincial level
66	USAID	AIDS Free ZAMBIA	John Snow Inc (JSI)	18160	C&T	Develop a plan for sustained use of eLMIS as a national commodity management system in Zambia	Develop a plan for sustained use of eLMIS as a national commodity management system in Zambia
67	USAID	AIDS Free ZAMBIA	John Snow Inc (JSI)	18160	HSS	Easy-to-use interfaces for operations and support personnel	Easy-to-use interfaces for operations and support personnel for key decision making and improvement of commodities security.
68	USAID	Cash Plus Care	UNICEF	18263	OVC	Evidence generation around i) alignment of USAID-supported programming under GRZ structures, and ii) optimal service delivery scenarios for vulnerable children and adolescents	Evidence generation around i) alignment of USAID-supported programming under GRZ structures, and ii) optimal service delivery scenarios for vulnerable children and adolescents
69	USAID	Surveillance and Data Use Support to the National Health Information System	TBD	18278	HSS	Strengthen the usability, accessibility and interoperability of HMIS data and its systems	Strengthen HMIS policies, systems, and governance for improved data quality and data use

#	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool
65	Information systems	Provide technical support to users and assist with data quality while strengthening helpdesk support centers at all levels of the system	Insufficient PSCM System	Commodity Security and Supply Chain	7.22	eLMIS used by facilities at all levels to place orders, report stock on hand, and generate reports which inform supply chain decisions	1 year	Site list with eLMIS
66	Host country institutional development	Implement eLMIS sustainability strategy and continue with the transition of key eLMIS activities to GRZ	Insufficient PSCM System	Commodity Security and Supply Chain	7.22	At project close (April 2019), GRZ can manage key eLMIS activities	1 year	Sustainability Strategy
67	Management and coordination	At a national level, provide technical and operational support for all activities while liaising with other partners and donors for a coordinated response	Insufficient PSCM System	Commodity Security and Supply Chain	7.22	Partners and donors can access eLMIS data and reports easily to inform decisions for commodity availability	1 year	eLMIS reports
68	Assessments, evaluation, operation research	Support MCDSS to obtain evidence on provision of cash and social services to households in high HIV disease burden areas	Inadequate evidence on improved wellbeing of children and adolescents living in households participating in GRZ social protection programs	Service Delivery	5.32	Outcomes are increased coverage of government social cash transfers combined with care that is linked to improved wellbeing of OVC in high HIV burden areas	3 years	MER 1.5 indicators, case files with Child Status Index, qualitative interviews, viral suppression results as relevant
69	Information systems	Support the MOH in adopting recommendations from an HMIS assessment then facilitating the development of a Ministry-wide HMIS Strategy.	Inadequate use of Program Health Data for planning and evidence based decision making	Performance Data	6.4	High quality, timely, and accessible HMIS data at the national, provincial, district, and facility levels.	1 year	Proportion of sites submitting HMIS reports on time

#	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
65	200 new sites expected by end FY18	Helpdesk fully operational on 3 cellular carriers and roll-out to 250 new sites complete				
66	No Baseline Data	Sustainability Strategy finalized and adopted by MOH and ICT				
67	eLMIS accounts set up for stakeholders that want to access eLMIS	All stakeholders can access eLMIS and receive technical support through helplines or supervision as needed.				
68	No baseline	protocol approved, sample selected, baseline data collection completed	Tracking of case files with Child Status Index measures and clinical documentation of ART compliance as relevant. expenditure data. increased # of households participating in GRZ social protection programs		Second round of MER 1.5 indicators, case file reviews, qualitative interviews, viral suppression result as relevant	
69	79.6	Rapid Assessment Report, HMIS Strategic Plan				

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective
70	USAID	TBD-GBV Follow on	TBD	18487	PREV	To prevent GBV and increase support for gender equality among women, men, children and members of key and priority populations	To prevent GBV and Increase support for gender equality among women, men, children and members of key and priority populations
71	USAID	TBD - Improving Prevention and Adherence to Care and Treatment (IMPACT)	TBD	18652	PREV	Reduced barriers to adoption of priority social and individual behaviors	Reduce barriers to the adoption of key HIV prevention and testing behaviors among priority populations
72	USAID	TBD - Improving Prevention and Adherence to Care and Treatment (IMPACT)	TBD	18652	PREV	Strengthened functional linkages between health facilities and communities	Strengthen functional linkages between communities and health facilities to increase HIV testing and improve ARV adherence
73	USAID	EQUIP	Right To Care, South Africa	18304	HSS	0	Strengthen the health system to support the objectives of 95/95/95
74	USAID	EQUIP	Right To Care, South Africa	18304	HSS	0	Strengthen M&E capacity at the facility, district and provincial levels for improved program management
75	USAID	Surveillance and Data Use Support to the National Health Information System	TBD	18278	HSS	0	Strengthen HMIS policies, systems, and governance for improved data quality and data use

#	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool
70	IEC and/or demand creation	Support Mohr for continued post GBV services (psychosocial counseling, Medical care including HIV Counselling & Testing and legal advice). In addition, intensify prevention of GBV and Child Marriage through community evidence based approach and traditional leaders engagement.	Inadequate GBV performance systems under the Mohr. Weak referral networks for GBV survivor services & case management. Strong negative traditional social norms that perpetuate gender inequalities.	Service Delivery	5.32	Increased access and uptake of post GBV care services among survivors including key populations. Decreased societal acceptance of GBV as a norm. Reduced perpetrations and enhanced protective factors that would create enabling environment for GBV response. Increased number of Chiefs denouncing GBV and Child Marriages in their chiefdoms	2 years	Number of Health Facilities providing quality post GBV care/services. Number of Survivors accessing quality post GBV services including counselling and testing. Number of men, women, girls & Boys and key populations reached through HIV/GBV prevention package. Number of Children prevented from going into early marriage and supported through counselling & economic opportunities including education
71	IEC and/or demand creation	Scale up proven behavior change interventions	Insufficient practice of HIV prevention behaviors; low testing yield; inadequate retention rates	Service Delivery	5.32	Improved practice of HIV prevention, testing, and treatment behaviors, particularly among priority populations	2 years	Number of people reached through HIV-related messaging and programming
72	IEC and/or demand creation	Scale up proven interventions to strengthen HIV service delivery activities	Low testing yield; inadequate retention rates; inadequate use of epidemic and health data	Service Delivery	5.32	Increased HTS yield, linkage rates, and retention rates	2 years	Number of health facilities applying evidence-based SBC to improve HTS yield, linkage rates, or retention rates
73	Laboratory sample referral/ transportation systems	Establish improved VL sample delivery systems for EQUIP supported districts and provinces, and VL information systems	Low VL capacity	Laboratory	2.33	Improved VL sample transport systems	2 years	Number of VL tests completed
74	Information systems	Build capacity, through sustained mentorship of facility, district and provincial staff in HMIS management, including data collection, analysis, utilizing an MOH-standardized approach and support tools.	Inadequate use of Program Health Data for planning and evidence based decision making	Performance Data	6.4	Strengthened capacity of health sector staff at the provincial, district, and facility levels to meet the HMIS data collection, analysis, and use standards established by the MOH.	2 years	Number health care providers trained and mentored in data collection, analysis, and use
75	Policy and governance	Support the MOH in adopting recommendations from an HMIS assessment then facilitating the development of a Ministry-wide HMIS Strategy.	Inadequate use of Program Health Data for planning and evidence based decision making	Performance Data	6.4	High quality, timely, and accessible HMIS data at the national, provincial, district, and facility levels.	1 year	Proportion of sites submitting HMIS reports on time

#	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
70	Continued TA to 24 GBV OSC already established under the USAID/DFID funded STOP GBV Program. 10 functional Anti GBV secretariat. GBVIMS developed	Comprehensive Annual work Plan produced with information on comprehensive survivor services data and prevention targets reached. Functional GBVIMS in all existing GBV OSC.	Five new D2G GBV OSC established within health facilities. 10 more Anti-GBV secretariats established with written down by-laws. GRZ coordination and GBV referral mechanism established.			
71	0	Four evidence-based innovative behavior change interventions implemented at scale; new interventions are designed and iteratively tested	seven evidence-based innovative behavior change interventions implemented at scale			
72	0	Health facilities roll out evidence-based SBC interventions; monitoring data is collected	two evidence-based supply side behavioral interventions are implemented at scale			
73	No routine VL transport systems operating	Routine VL transport systems operational for 75% of samples	Routine VL transport systems operational for 100% of samples			
74	0 (zero) districts are eFirst compliance	Quarterly reports submission	6 (six) districts are eFirst compliant			
75	79.6	Rapid Assessment Report, HMIS Strategic Plan				

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective
76	USAID	Surveillance and Data Use Support to the National Health Information System	TBD	18278	HSS	0	Build capacity for the collection, analysis, and dissemination of HIV/AIDS behavioral and biological surveillance information
77	HHS/CDC	UNZA ZEPACT+ Follow On	University of Zambia	18325	C&T	0	Support of advanced treatment centers (ATC)

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76	Assessments, evaluation, operation research	Conduct rapid qualitative assessments of selected research institutions on the real and perceived gaps in research capacity. Upon findings, develop a national action plan to strengthen capacity development within Zambian research institutions.	Key population surveys and surveillance are primarily planned, financed and implemented by external agencies, organizations or institutions without MOH leadership.	Epidemiological and Health Data	4.37	Improved monitoring, evaluation, and research (MER) capacities within government partners and key non-governmental research institutions to support accountability and management for results in the health sector.	1 year	Number of institutions provided with capacity to conduct health research
77	Laboratory sample referral/ transportation systems	Support to ATC for transportation of Sample to central labs and support for genotyping and resistance testing	Viral load suppressio	Service Delivery	5.32	Prevalence of HIV drug resistanc	2 years	Number of samples tested for HI

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76	None	Report on the Rapid Assessment of the Gaps in Research Capacity, Report on creation of capacity development plans	Report on the Rapid Assessment of the Gaps in Research Capacity, and MOH Research Capacity Building Action Plan			
77	0	Laboratory sample referral systems developed. Collection of samples from at least 3	Laboratory sample referral systems functional. Expansion of specimen collection to 10			