ZIMBABWE

Country Operational Plan 2019

Strategic Direction Summary

April 5, 2019

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Acronym List

AE	Adverse Event
AGYW	Adolescent Girls and Young Women
ANC	Antenatal Clinic
ART	Antiretroviral Treatment
ARVs	Antiretroviral
BMGF	Bill and Melinda Gates Foundation
CARGS	Community ART Refill Groups
CATS	Community Adolescent Treatment Supporters
CBO	Community Based Organization
CBS	Case-based Surveillance
CCM	Country Coordinating Mechanism
CCW	Community Care (Case) Workers
CDC	Centers for Disease Control and Prevention
CESHHAR	Centre for Sexual Health, HIV and AIDS research
CHW	Community Health Workers
CLHIV	Children Living with HIV
COP	Country Operational Plan
CrAg	Cryptococcal Antigen
CRFs	Client Referral Facilitators
CSE	Continuing Secondary Education
CSO	Civil Society Organizations
CTX	Cotrimoxazole
DBS	Dried Blood Spot
DfID	United Kingdom's Department for International Development
DHIS2	District Health Information System Version 2
DMPPT2	VMMC Decision Makers' Program Planning Toolkit
DoS	Department of State
DREAMS	Determined, Resilient, AIDS-free, Mentored and Safe
DSD	Direct Service Delivery
ECD	Early Childhood Development
ECS	Early Childhood Stimulation
EHR	Electronic Health Records
EID	Early Infant Diagnosis
EIMC	Early Infant Male Circumcision
EMR	Electronic Medical Record System
eMTCT	Elimination of Mother to Child Transmission
ePMS	Electronic Patient Monitoring System
FARG	Family ART Refill Group
FAST	Funding Allocation to Strategy Tool

FBO	Faith-Based Organization
FMP	Families Matter Program
FP	Family Planning
FSW	Female Sex Workers
GALZ	Gays and Lesbians Association of Zimbabwe
GBV	Gender Based Violence
GEM	Girls Empowerment Clubs
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoZ	Government of Zimbabwe
HCD	Human Centered Design
HCW	Health Care Workers
HDP	Health Development Partners
HEI	HIV Exposed Infant
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HMIS	Health Management Information System
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
ICF	Intensified Case Finding
INH	Isoniazid (isonicotinylhydrazide drug)
IP	Implementing Partner
IPC	Inter-personal Communication
IPT	Isoniazid Preventive Therapy
KP	Key Population
LEEP	Loop Electrosurgical Excision Procedure
LGBTI	Lesbian, Gay, Bi-Sexual, Transgendered or Intersex
LMIS	Logistics Management and Information Systems
LOE	Level of Effort
LPV/r	Lopinavir/ritonavir
LTFU	Lost to Follow-Up
M&E	Monitoring and Evaluation
MC	Male Circumcision
MCH	Maternal and Child Health
MMD	Multi-Month Dispensing
MMS	Multi-Month Scripting
MoHCC	Ministry of Health and Child Care
MoLSW	Ministry of Labor and Social Welfare

MoPSE	Ministry of Primary and Secondary Education
MSF	Medecins Sans Frontiers
MSM	Men who have Sex with Men
NAC	National AIDS Council
NATF	National AIDS Trust Fund
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PITC	Provider-initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
POART	PEPFAR Oversight and Accountability Response Team
POC	Point of Care
PrEP	Pre-Exposure Prophylaxis
QA/QI	Quality Assurance/Quality Improvement
RDS	Respondent Driven Surveys
RTK	Rapid Test Kit
SCMS	Supply Chain Management System
SDS	Strategic Direction Summary
SI	Strategic Information
SID	Sustainability Index and Dashboard
SIMS	Site Improvement through Monitoring System
SNU	Sub National Unit
STI	Sexually Transmitted Infections
SW	Sex Workers
TA	Technical Assistance
TAG	Technical Advisory Group
TAT	Turn Around Time
TB	Tuberculosis
TBD	To Be Determined
TBIC	Tuberculosis Infection Control
TLD	Tenofovir Lamivudine Dolutegravir
TLE	Tenofovir Lamivudine Efavirenz
TPT	TB Preventive Therapy
TTCV	Tetanus Toxoid Containing Vaccines
UE	Unit Expenditure
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USG	U.S. Government
VACS	Violence against Children Survey
VCT	Voluntary Counseling and Testing

VHWs	Village Healthcare Workers
VIAC	Visual Inspection with Acetic Acid and Cervicography
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
YAZ	Young Adult Survey of Zimbabwe
YWSS	Young Women Selling Sex
ZDHS	Zimbabwe Demographic and Health Survey
ZIMPHIA	Zimbabwe Population-Based HIV Impact Assessment

1.0 Goal Statement

The President's Emergency Plan for AIDS Relief (PEPFAR) interagency team worked collaboratively with key partners including the Government of Zimbabwe (GoZ), the Global Fund to Fight AIDS, Tuberculosis and Malaria (the "Global Fund"), civil society core advocacy members, and bilateral and multilateral health development partners to develop the Country Operational Plan for FY 20 (COP 19). The national ART program and other critical HIV programs in Zimbabwe are implemented under the leadership of the Ministry of Health and Child Care (MoHCC), the Ministry of Primary and Secondary Education (MoPSE), and the Ministry of Labor and Social Welfare (MoLSW), with human resources for health (HRH) and infrastructure primarily funded by the MoHCC. PEPFAR has successfully leveraged this capacity with key commodities, site-level mentoring, some HRH for HIV testing and treatment, and other site-level support. COP 19 will support Zimbabwe to achieve 95 percent ART coverage within all districts and across all age and sex bands by the end of FY 20.

The PEPFAR program will invest in the delivery of a comprehensive package of HIV treatment and prevention activities within 40 of Zimbabwe's 60 districts and will continue to provide support at all facilities with a focus on high volume sites to achieve greater overall results. Current data shows that men between 20 and 35 make up the majority of those not yet on treatment. Through a targeted and integrated HIV testing model, the PEPFAR COP 19 strategy will enable the program to reach 95 percent ART coverage by identifying new HIV-positives through scaled up index testing in facilities and communities, and by using innovations such as HIV self-testing in order to reach more men and women. Initiated in COP 18, the PEPFAR program will continue to tailor testing strategies based on district level ART gaps in order to reach each sub-population. In high ART gap districts, the program will emphasize targeted provider-initiated testing and counseling (PITC) and index testing to reach sexual partners outside of the clinic, and self-testing. As the ART gap narrows within each district, the program will put more emphasis on index testing and diagnostic PITC only. With well over 1 million Zimbabweans currently on ART, the PEPFAR program will continue to increase access to viral load (VL) monitoring, while strengthening and expanding efforts to improve retention and viral suppression, particularly among priority populations such as children, adolescents, and pregnant women.

In COP 19, PEPFAR will maintain its voluntary medical male circumcision (VMMC) target of 300,000, focusing its efforts on reaching young men between the ages 15 -29. The PEPFAR program will continue to support the Determined Resilient Empowered AIDS-Free Mentored and Safe (DREAMS) program through a package of services in six districts including Pre-Exposure Prophylaxis (PrEP) and complementary services supported within the orphans and vulnerable children (OVC) portfolio. Moreover, in COP 19 the program will scale up clinical services targeting female sex workers (FSW) and men who have sex with men (MSM).

In COP 19 the program will introduce recency testing for all newly-diagnosed adults and expand case-based surveillance to 45 percent coverage in COP 19 and 100 percent coverage by COP 20. This will allow the program to target the public health response more strategically, and when the electronic health records system is rolled out nationally, this will include linkage, ART status, viral suppression and mortality data. Zimbabwe's transition to TLD will also be well underway as COP 19 implementation begins. Zimbabwe is a leader in multi-month dispensing (MMD), and will begin shifting patients from 3-month to 6-month dispensing where appropriate.

PEPFAR Zimbabwe is committed to attaining the 95-95-95 goals outlined by UNAIDS and continues to use weekly monitoring tools, monthly interagency partner meetings, quarterly PEPFAR Oversight and Accountability Response Team (POART) reviews and the Site Improvement through Monitoring System (SIMS) findings to assess performance and furt1her sharpen strategies and approaches to most efficiently deliver expected results. Furthermore, PEPFAR will continue to work closely with the Global Fund's Country Coordinating Mechanism (CCM) to ensure alignment of programming during the Global Fund's current funding cycle (2018-2020) as well as planning similar alignment and leveraging during the next funding cycle (2021-2023). Strong health donor coordination, especially with the Global Fund and The Bill and Melinda Gates Foundation, ensures that all HIV investments are complementary and not duplicative.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Zimbabwe has a generalized epidemic with a projected 2017 population of 15.3 million based on the 2012 National Census. ZIMPHIA[1] showed that overall HIV prevalence for adults aged 15-49 was 14.0% in 2016, down from 18.1% in 2005 in the ZDHS[2]. Among persons aged 15 to 64 years, HIV prevalence varied geographically, higher in the provinces of Matabeleland North (19.5%), Bulawayo (17.9%), and Matabeleland South (21.7%) than in the other seven provinces, which were all below 15%. HIV prevalence varies by level of education, ranging from 7.2% in those with more than secondary education to 19.7% among persons with no formal education. The highest HIV prevalence estimated was nearly 30% for both males (28.1%) and females (29.6%), but occurred at a slightly older age (45-49 years) among males as compared to females (40-44 years). The disparity in HIV prevalence by sex was most pronounced among young persons: HIV prevalence was three times higher among females (8.1%) than males (2.7%) aged 20 to 24 years. For persons aged 10 to 49 years, point estimates of HIV prevalence were higher among females than their male counterparts. Among persons over the age of 50, point estimates of HIV prevalence were higher in males. HIV prevalence among children aged 0 to 14 was estimated to be 1.6%.

[1] Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) 2016
[2] Zimbabwe Demographic and Health Survey 2015

An estimated 1.35 million people were living with HIV in 2018, with 7.2% being children 0-14 years[3]. Among adults 15+ years living with HIV, 59% were females. HIV incidence for the same age group is currently at 0.30%, down from 1.06% in 2005. Annual AIDS related deaths among adults have declined over the past decade with approximately 20,386[3] AIDS related deaths in 2018 compared to 101,902 in year 2000. Total new HIV infections declined nationally from 65,147 in 2010 to 37,403 in 2018. Among adults 15+ years, new infections declined from 92,346 in 2005 to 31,640 in 2018. By end of 2018, ART coverage among all HIV positive adults was 87% and 74% among children compared to 29% and 40% among adults and children, respectively, in 2010. The Prevention of Mother-to-Child Transmission (PMTCT) coverage was 93% and has been maintained at above 90% over the last ten years. In 2018, 301,366 men were medically circumcised, bringing the cumulative total to 1,144,061, representing an 83% coverage of the target population 15- 29 years[4]. Based upon a PEPFAR-funded study completed in 2017[6], there are an estimated 44,362 female sex workers (FSW) in Zimbabwe. The prevalence of HIV among FSW is 54%, with 69% of these women on ART and 85% virologically suppressed. It is estimated that 23.5% of men who have sex with men are living with HIV and 69% are on ART, with 85% virologically suppressed; an analogous size estimation protocol has recently obtained local clearance, and data collection is planned for 2018.

Standard Table 2.1.1

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	15,302,349	100 %	3,103,096	20 %	3,120,301	20 %	1,452,285	9%	1,443,419	9%	3,237,776	21%	2,945,475	19%	HIVestimates 2018
HIV Prevalence (%)		14.1 % (15-64yrs)		1.50%		1.70%		5.90%		3%		16%(15+yrs)		12%(15+yrs)	zimphia 2016
AIDS Deaths (per year)	24588		2081		2121		1342		1315		8861		8870		2018HIV estimates
# PLHIV	1,346,538		48239		48717		79027		52918		658064		459573		2018HIV estimates
Incidence Rate (Yr)		0.47 % (15-64yrs)						0.53%		0.14%		0.60%(15-64yrs)		0.33%(15-64yrs)	zimphia 2016

[3] Zimbabwe 2018 HIV/AIDS Estimates (Spectrum/EPP model, January 2019)
[4] Zimbabwe HMIS

New Infections (Yr)	37,403														2018HIV estimates
Annual births		34.2/1000 persons													
% of Pregnant Women with at least one ANC visit		93.30%													ZDHS 2015
Pregnant women needing ARVs	63,249														
Orphans (maternal, paternal, double)	184,757														
Notified TB cases (Yr)	26,401		6% (all <15yrs)		6% (all <15yrs)						94%(all 15+ yrs)		94%(all 15+ yrs)		2018 Tb profile, WHO report
% of TB cases that are HIV infected		63%													2018 Tb profile, WHO report
% of Males Circumcised		14.1%(15-64yrs)													zimphia 2016
Estimated Population Size of FSW	44586														
FSW HIV Prevalence	54%														

Standard Table 2.1.2

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	15,302,349	9%	1,346,538		1,101,356	82%		3,011,027	173,557	*126,768*
Population <15 years	6,223,397	2%	96956		71,889	74%		316,310	8,943	*5,957*
Men 15-24 years	1,443,419	4%	52,918		36,256	69%		279,261	9,646	*4,461*
Men 25+ years	2,945,475	16%	459,573		354,472	77%		585,820	57,562	*43,667*
Women 15-24 years	1,452,285	5%	79,027		57,541	73%		762,815	29,610	*19,677*
Women 25+ years	3,237,776	20%	658,064		581,197	88%		1,066,821	67,796	*53,006*
MSM	65,833	27%								
FSW	48,358	54%								

National Data*

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment

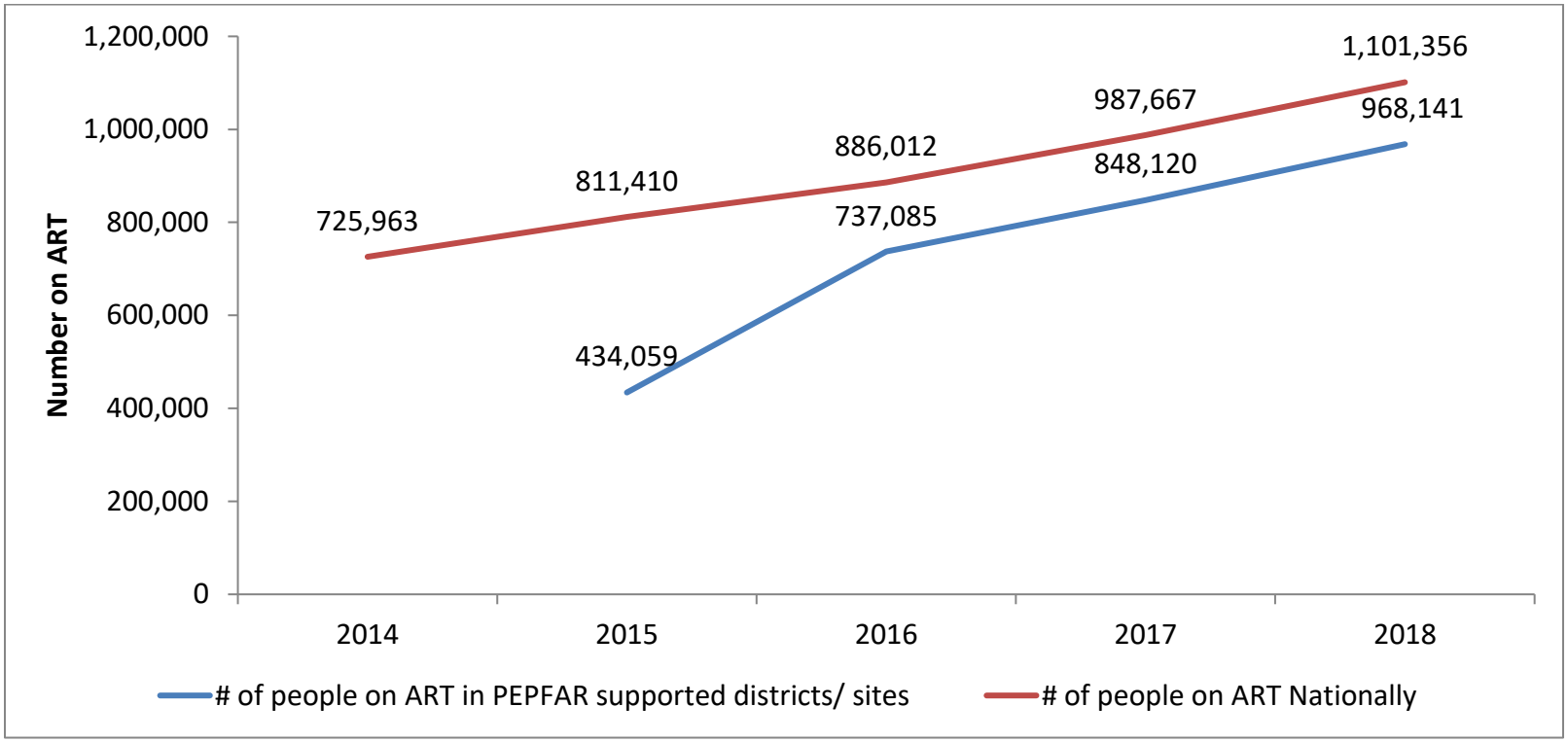
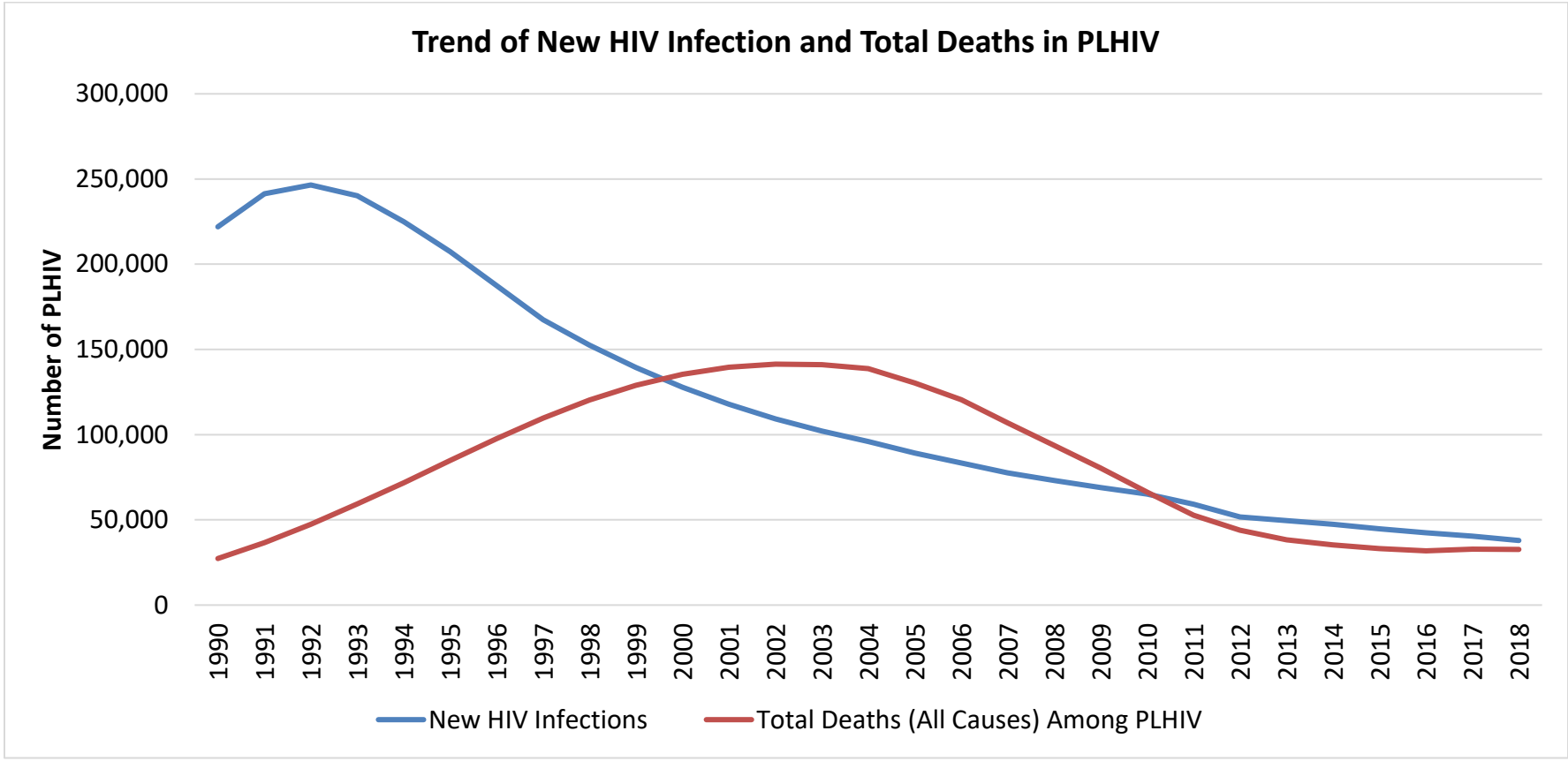


Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV



2.2 Investment Profile

Although Zimbabwe has witnessed a slight absolute increase in national budget allocation to health in recent years from 6.5% in 2015 to the current 8.6%, it still falls far below the Abuja requirement of 15% and the amount actually disbursed fall far below the budgeted levels. Furthermore, the GoZ budget is mostly for salaries (70%) according to the 2017 Resource Mapping report. This leaves the larger burden of health system functionality (e.g., commodity needs and distribution, laboratory sample transportation, and health facility operational costs, etc.) in the hands of external funding donors. Despite support from Zimbabwe's health development partners, the consolidated total funding still falls short of projected requirements to fully implement the national health strategy.

Zimbabwe also faces an economic downturn and rising inflation. The GoZ has established a very successful AIDS levy that collects millions of dollars each year to procure ARVs and to support other activities. However, the value of these funds has declined over the past two years as inflation has risen.

Standard Table 2.2.1

Investment Profile by Programme Area										
Programme Area	Total Budget (2019)		PEPFAR		Global Fund		GOZ		Other HDP	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Clinical care, tx and support	$203,449,742	100%	$64,378,101	32%	94,688,251.00	47%	$41,314,441	20%	$3,068,949	2%
Community Based Care and Treatment	$979,646	100%		0%		0%	$0.00	0%	$979,646	100%
PMTCT	$1,596,813	100%	$693,488	43%	447,800.00	28%	$455,525	29%		0%
HTS	$14,849,591	100%	$6,137,726	41%	8,141,530.00	55%	$481,139	3%	$89,196	1%
VMMC	$33,733,811	100%	$31,212,878	93%	-	0%	$1,123,051	3%	$1,397,882	4%
Priority popn prevention					256,050.00					

Prevention AGYW	$17,289,588	100%	$14,769,045	85%	2,520,543.00	15%		0%		0%
prevention MSM/FSW	$3,815,303	100%	$1,215,343	32%	2,599,960.00	68%		0%		0%
OVC	$17,397,120	100%	$17,397,120	100%		0%		0%		0%
Lab	$610,792	100%		0%		0%		0%	$610,792	100%
Surveillence	$4,281,190	100%	$4,281,190	100%		0%		0%		0%
HSS	$39,753,435	100%	$5,058,796	13%	14,819,502.00	37%	$18,227,230	46%	$1,647,907	4%
Total	$337,757,031	$1	$145,143,687	43%	$123,473,636	37%	$61,601,386	18%	$7,794,372	2%

Standard Table 2.2.2: Shows the proportionate contributions across PEPFAR, Global Fund, domestic funding through the National AIDS Trust Levy.

Table 2.2.2 Annual Procurement Profile for Key Commodities						
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% Global Fund**	**% GOZ/NAC**	**% Other**	**% Gap**
ARVs	$105,474,129	17%	46%	20%	2%	16%
ARVs for PrEP	$390,789	0%	100%	0%	0%	0%
Rapid test kits (conventional)	$5,421,370	6%	38%	0%	0%	56%
Rapid test kits (self-testing)	$2,358,217	42%	0%	0%	0%	58%
Medicines for VMMC	$322,851	90%	0%	0%	0%	10%
Lab reagents for EID	$680,370	0%	147%	0%	0%	0%
Lab reagents for EID POC	$609,660	42%	0%	0%	0%	58%
Lab reagents (conventional)	$7,362,315,	0%	8%	0%	0%	92%
Viral Load commodities	$20,528,372	24%	48%	1%	0%	27%
Condoms (male & female, and personal lubricant)	$5,777,735	74%	0%	0%	0%	26%
VMMC kits	$2,090,203	92%	0%	0%	0%	8%
Other commodities for VMMC	$617,232	100%	0%	0%	0%	0%

Total	$151,633,243					

Standard Table 2.2.3

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	$2,000,000	N/A	N/A	N/A	• Increase utilization of quality family planning, maternal. neonatal, and child health services • Improve nutrition and water, sanitation and hygiene practices • Strengthen health system to enable sustainability
USAID TB	$4,200,000	N/A	N/A	N/A	• Prevent TB transmission and renew efforts to find the missing TB cases • Strengthen the capacity of national TB programs • Build country capacity to use existing resources and to turn evidence into policy • Expand the development of new TB diagnostics, drugs and vaccines
USAID Malaria	$14,000,000	N/A	N/A	N/A	Reduce malaria-related mortality by 70%
Family Planning	TBD	N/A	N/A	N/A	Increase access to modern family planning information and contraceptives to improve maternal and child health outcomes.
Total	$20,200,000	N/A	N/A	N/A	

**Based on FY 19 Congressional Budget Request for FY 20 implementation*

Standard Table 2.2.4

Table 2.2.4 Annual PEPFAR Central Initiatives		
Funding Source	**Total PEPFAR Non-COP Resources**	**Objectives**
Faith-Based Initiative	$11,000,000	Through the centrally-funded Faith-based initiative, PEPFAR Zimbabwe will focus efforts on maximizing existing organizational infrastructure of faith-based health systems and within communities of faith to reach communities impacted by HIV, including children ages 9-14; orphans, vulnerable children, and their families; AGYW; men and boys; and other marginalized populations, with a strong focus within these networks on demand creation for optimized HIV testing, active consent-based and fully informed index testing, treatment, retention, and on prevention of sexual and gender-based violence.
Cervical Cancer Screening	$5,482,750	The group most at risk for aggressive cervical cancer, HIV-positive women, has been underserved by the "broad support" approach previously utilized by PEPFAR. Therefore, PEPFAR has developed an age-band appropriate, comprehensive strategy to reduce cervical cancer risk by 95% in HIV-positive women by every-other-year cervical cancer screening for HIV-positive women over age 30. PEPFAR plans to ensure all HIV-positive women over age 30 are being screened and treated for pre-invasive cervical lesions. To achieve this goal, a staged process will be used to increase the coverage of cervical cancer screening in PEPFAR-supported HIV treatment sites focusing on areas with high HIV-1 prevalence among women and high volume ART sites.
Total	**$16,482,750**	

2.3 National Sustainability Profile Update

Over the past several years, there has been significant progress in the expansion of ART initiation. However, major challenges to achieving high ART coverage and epidemic control continue to exist. These include insufficient funding for ARVs and lab commodities, human resource shortages, continued economic instability, weakening infrastructure, a deteriorating health system, and heavy reliance on donor funding. As an example of donor funding reliance, the Global Fund and PEPFAR currently finance the purchase of test kits, condoms, a majority of laboratory services, a majority of human resources at both central and site levels, and a significant portion of the efforts to strengthen the supply chain and logistics system.

In response, the PEPFAR team will continue to coordinate closely with the Global Fund, as well as other donors in the sector, such as the Bill and Melinda Gates Foundation (BMGF) and CHAI, to ensure that investments are complimentary and PEPFAR contributions are maximized. In the short to medium-term, PEPFAR and the Global Fund will continue to support both targeted human resources and strengthening of the overall health system. Over time, direct support for human resources will be drawn down strategically as the Ministry of Health's capacity as well as the overall economic situation improves.

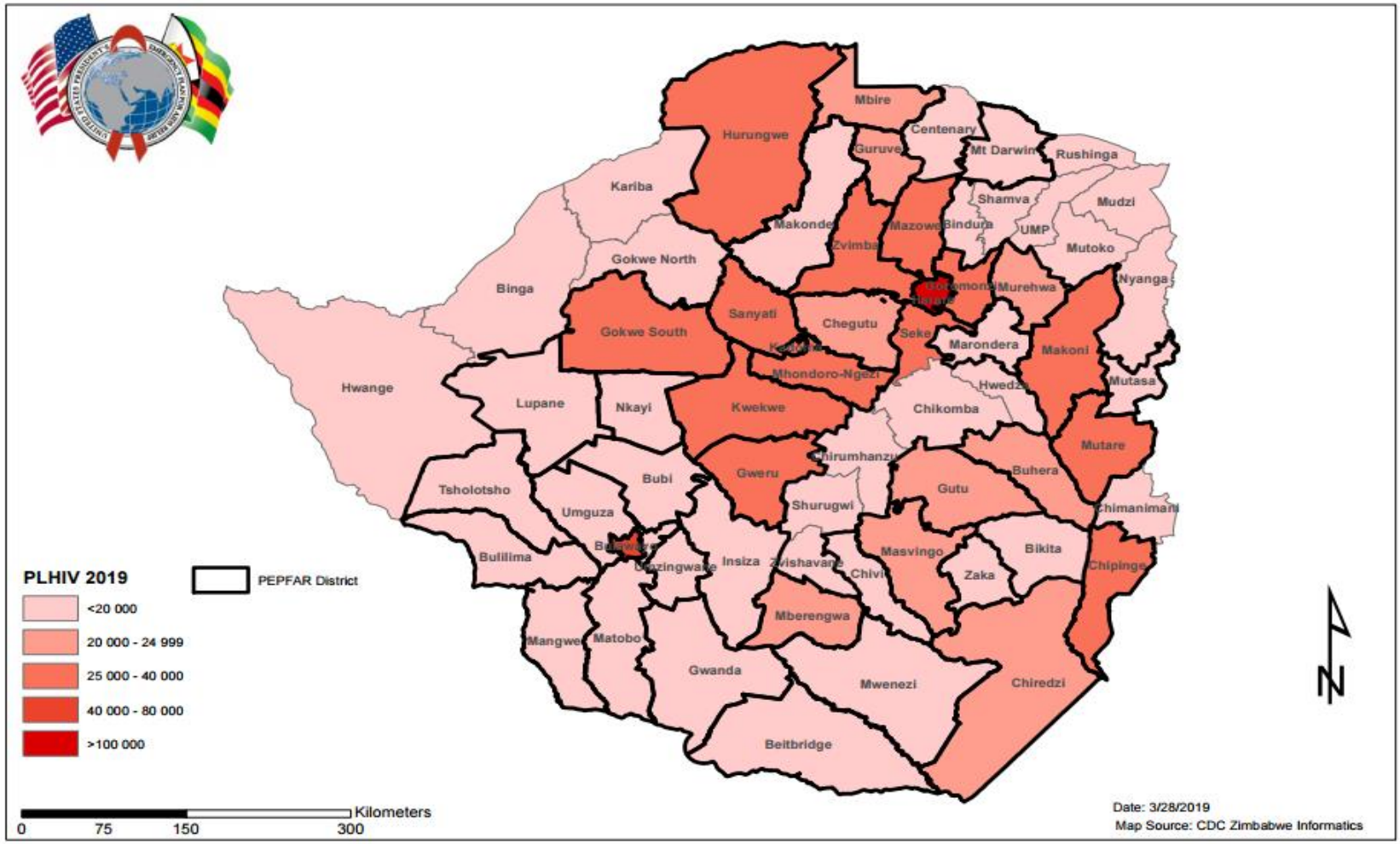
As epidemic control is achieved and evolves beyond 2020, PEPFAR support will evolve to respond to the new needs of managing HIV as a chronic condition. This will require policy changes as well as culture shifts within the HIV sector specifically, and the health system in general. To achieve this, PEPFAR will continue to support and strengthen the health information system that reflects a program at epidemic control. Support to indigenous partners will also continue to increase as PEPFAR shifts funding from international organizations to local community and faith-based organizations.

2.4 Alignment of PEPFAR investments geographically to disease burden

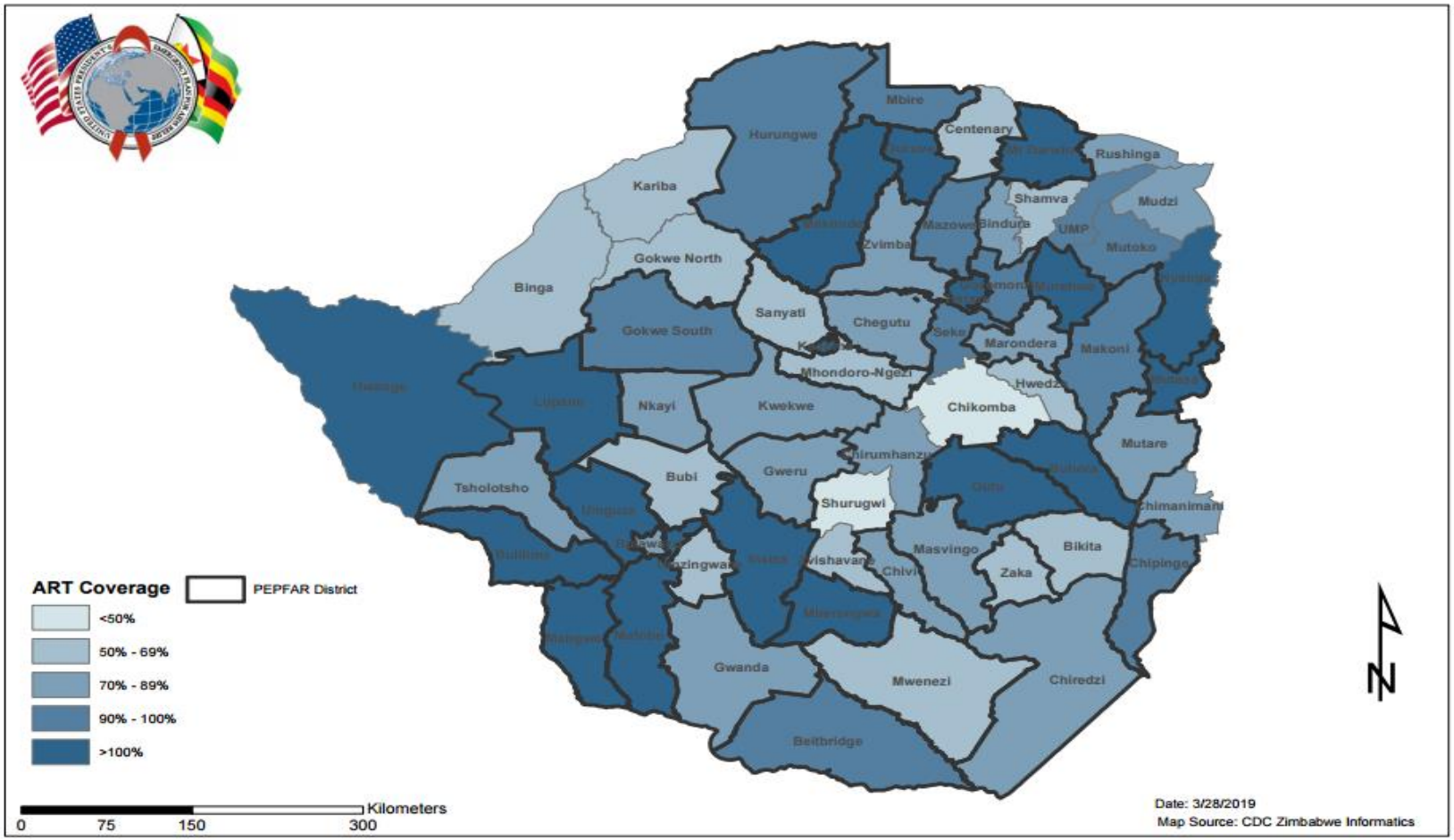
PEPFAR Zimbabwe continues to evaluate and redirect financial investments towards districts with high and medium ART gaps for case-finding while resources in high volume facilities are being prioritized for TPT scale-up, cervical cancer access, viral load access and treatment literacy to ensure that clients initiated on ART remain virally suppressed. Conversely, in districts with smaller ART gaps, testing and case-finding efforts will be increasingly targeted, as resources shift towards adherence, retention, and long-term viral suppression.

Figures 2.4.1

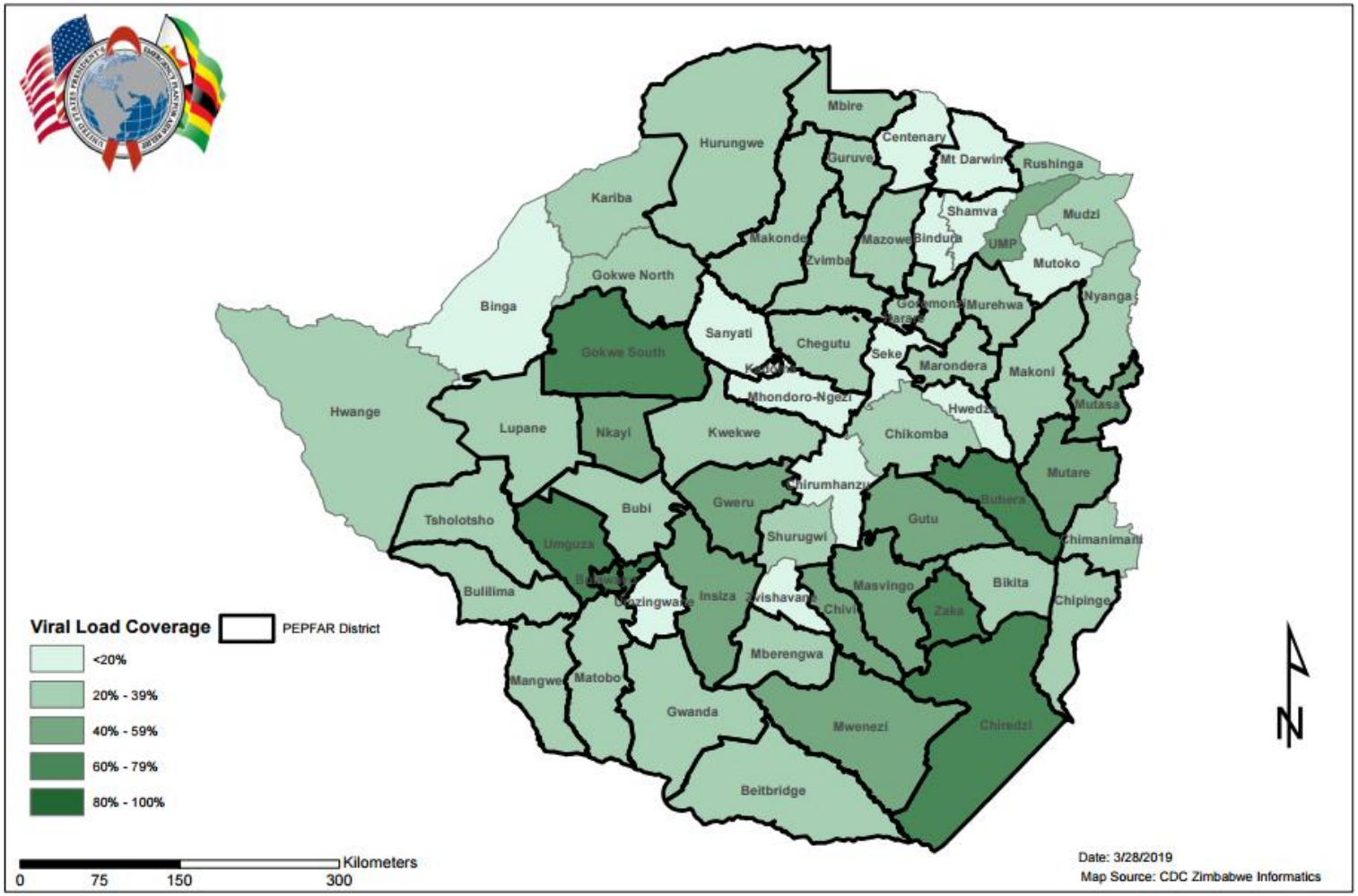
People Living with HIV/AIDS 2019



ART Coverage 2019



Viral Load Coverage 2019



2.5 Stakeholder Engagement

1. **Host country government**(s)
   The PEPFAR Coordinator had a bilateral meeting with the Director of the HIV/AIDS and TB unit to discuss the COP 19 road map and the need for continued MoHCC leadership throughout the planning process. Subsequently, two MoHCC representatives attended the week long PEPFAR Retreat in early February 2018. Program Managers for the Directorate of Laboratory Services, HIMS, PMTCT, Directorate and the Department of Pharmacy services alternated participation on days three and 4 according to relevance of sessions. MoHCC counterparts deliberated on their specific program areas and contributed to synchronizing MoHCC priorities and the outlined program quality requirements for COP 19. At the conclusion of the retreat the MoHCC representatives expressed gratitude for the collaboration and informed the participants that MoHCC expected to fare very well in their assessment for the Vision 2020 and 90-90-90 targets as PEPFAR had helped accelerate the achievement of these initiatives. They also acknowledged PEPFAR's support to facilitate NAC's work in dealing with traditionally taboo areas of key populations programming. Further bilateral discussions with respective units were held for target setting and budget estimation. In addition, two MoHCC representatives attended the Johannesburg Regional Meeting in March 2019.

2. **Global Fund and other external donors**
   PEPFAR retreat, as well as, the local Principal recipient, UNDP**.** Of note from the team was the highly commoditized nature of the GF grant, accounting for 68% of the funding envelope, and a further 9% in procurements under RSSH. GF representatives reiterated the need to demonstrate results, especially with catalytic funding that the country secured through evidence of impact. The team shared concern about the impending ARV shortage in 2020 considering both GF and PEPFAR's flat lined budgets for the cost area; they also recommended making a business case for financing the gap. The team observed grant risks in ePMS data and lab support for VL scale up. Possible funding flexibility to support emerging COP 19 program requirements would be achieved through reprogramming of savings. UNAIDS, WHO, and BMGF attended the retreat and the Johannesburg meeting. UNAIDS applauded the integrated testing (iHTS) model, which was showcased at the World AIDS Day 2018 event.

   UNAIDS also noted that recency testing and provision of PrEP were gaining prominence on the HIV agenda, and encouraged PEPFAR to optimize limited resources by working with existing partners to advance the FBO initiative. WHO expressed readiness to support the Electronic Health Record (EHR), particularly given the aforementioned risks and challenges with the ePMS system, and the need to build sustainability into current programs. BMGF pointed out the need to keep incidence in mind and applauded the Zimbabwe team's resilience in working with one- third per capita allocation compared with neighboring countries and still achieve so much impact. COP 19 strategic direction

was shared with the health development partners group, as well as in the joint Health Development Partners and GF CCM meetings.

3. **Civil Society/Community**

   Two representatives from AIDS Service Organizations and one from Faith Based Organizations attended the PEPFAR retreat. The representatives present noted that HIV/TB service users start and end in the community. Thus the continuum of care requires grassroots support for mobilization, adherence support and case identification. The support is needed to sustain structures, cadres and systems for generating evidence for advocacy. Continued capacity building was critical for sustainability. The civil society organization (CSO) core group convened three regional consultative meetings across the various geographical locations of the country and the PEPFAR team attended one of the consultative meetings. A comprehensive paper on CSO input has since been submitted to PEPFAR. The FBO representative highlighted their openness to dialogue with various population groups including key populations, and their ongoing role as a pillar of social support for the HIV infected and affected.

4. **Private Sector**

   The structures for private sector engagement have not been as functional given the poor economic and investment climate so there were no engagement meetings during COP 19 planning. Ongoing collaboration with the private sector has involved partners providing HIV services during wellness days in the workplace.

3.0 Geographic and Population Prioritization

PEPFAR used 2018 subnational HIV estimates from the UNAIDS HIVE model and host country treatment program data to recalibrate the national HIV epidemic and measure progress toward the UNAIDS fast track 95-95-95 epidemic control targets across all districts. PEPFAR programming aims to have 100% of PLHIV in PEPFAR districts on ART at the end of FY20. PEPFAR anticipates some PLHIV residing outside of PEPFAR districts to receive care within PEPFAR districts- particularly, particularly in urban centers which contributes to greater than 100% coverage in some PEPFAR districts. Together with the Government of Zimbabwe, all PLHIV will be initiated on ART by the end of FY 20.

Table 3.1

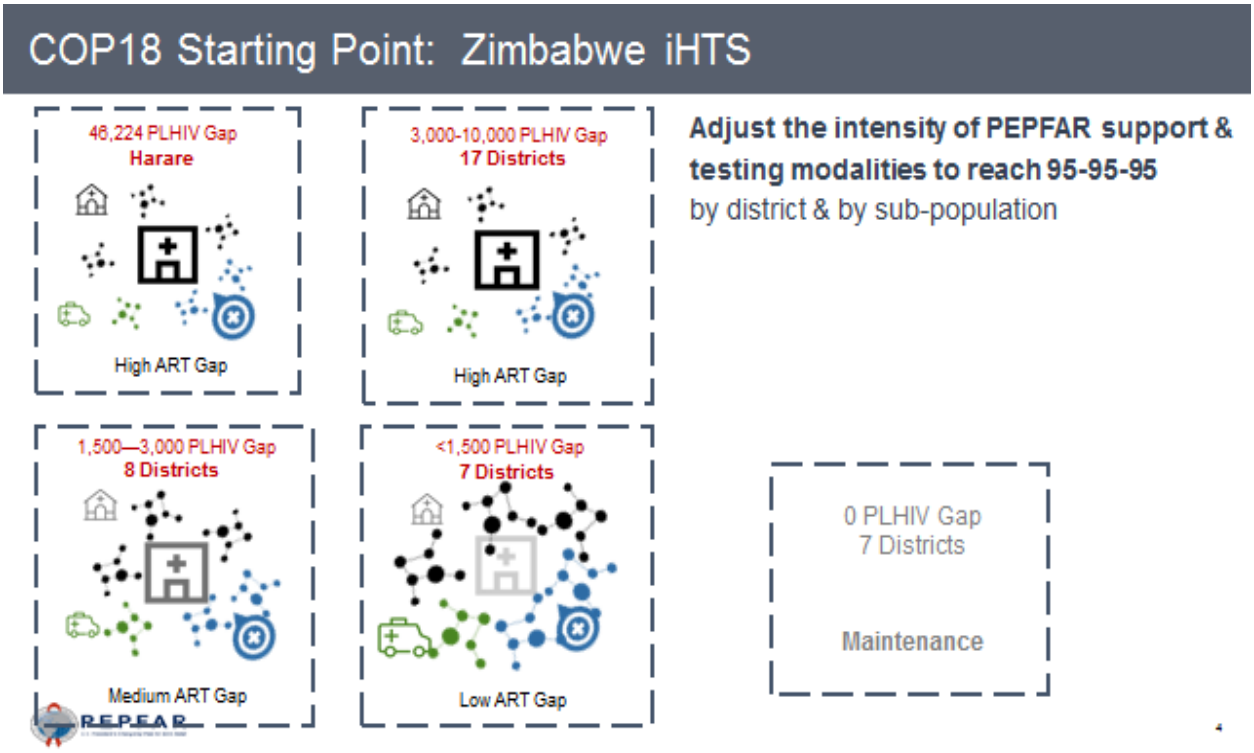
Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP 19**	**# Current on ART (FY 18FY 18)**	**# of SNU COP 18 (FY 19)**	**# of SNU COP 19 (FY20)**
Attained	1,221,083/90%	468,615	6	40
Scale-up Saturation		697,532	34	
Scale-up Aggressive				
Sustained				
Central Support	139,979/10%	139,979		20

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

4.1 – 4.3 COP 19 Programmatic Priorities for Epidemic Control

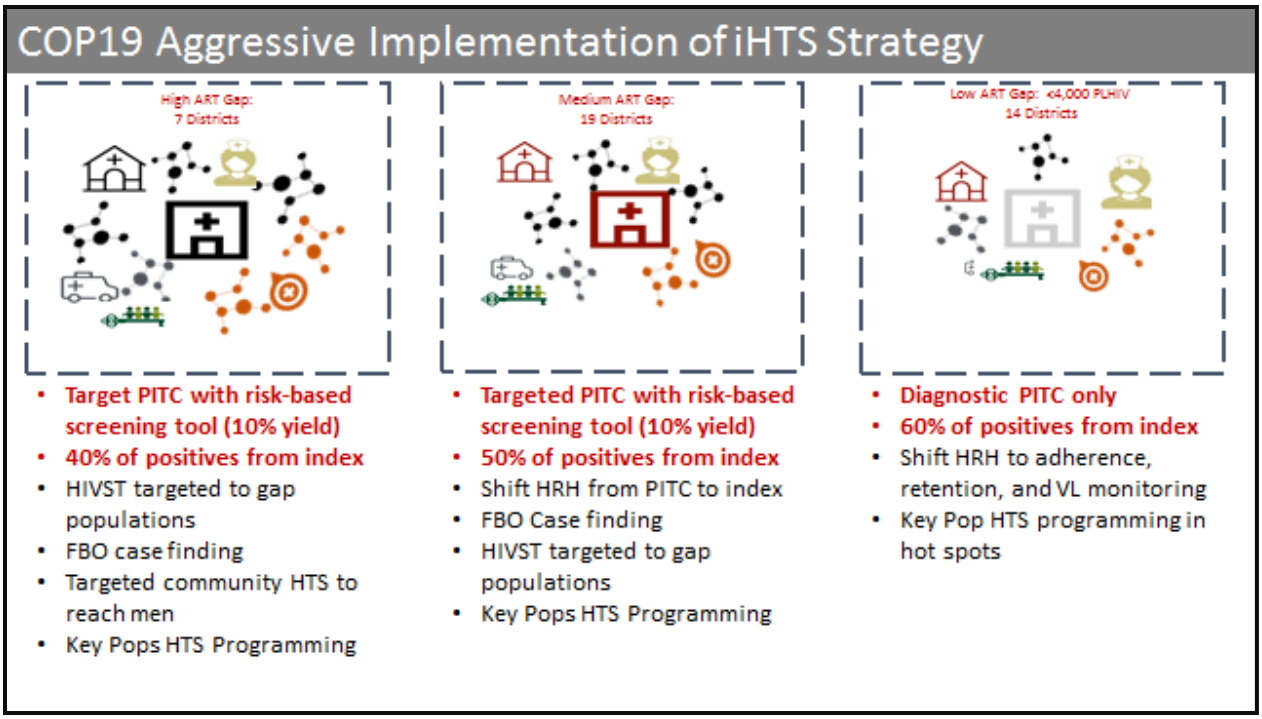
4.1 Finding the missing, getting them on treatment, and retaining them ensuring viral suppression

The COP 19 strategy for case finding builds upon the following COP 18 strategy, which emphasized the differentiation of HTS modality intensity and support based on the ART gap in the SNU. The following graphic shows the COP 18 Integrated Testing Strategy (iHTS) for PEPFAR Zimbabwe.



COP 19 planning drew upon the revised UNAIDS SPECTRUM estimates which indicate that by the end of FY 19, 100% of the 40 PEPFAR scale-up districts will reach overall saturation coverage, though gaps will remain in certain sub-populations. Accordingly, PEPFAR Zimbabwe will intensify implementation fidelity of the iHTS strategy including significantly expanding the index case testing modality in general and use of screening tools in PITC in order to increase the yield to 10% from the current average of ~5%. The MoHCC has recently developed a screening tool based upon HTS eligibility, and PEPFAR partners are supporting its roll-out. The tool however may need further refinement to make its screening questions more predictive of HIV infection during COP 19 implementation. In COP 19, HIV self-testing (HIVST) will be highly focused upon clients avoiding facility-based services: specifically, community-based index testing for AGYW and their partners; for index testing among male partners of ANC clients; for sex workers and their clients; and for KPs and their partners. The team will significantly curtail non-index community HTS, and will only support it as a high-yielding case finding strategy with specific sub-populations following both programmatic and recency data. Targeted mobile testing will contribute only 2.5% of newly identified HIV positives down from 5% in COP 18 strategy. Other innovative strategies to reach the remaining sub-populations will be scaled up accordingly and are further described in the sub-populations section.

In COP 19, the PEPFAR Zimbabwe program will refine, evolve and focus its iHTS) strategy to reach targeted sub-populations based upon district ART gap classification better. In COP 19, the program has reclassified districts based upon updated ART coverage, with more districts categorized as medium and low ART gapas the country heads towards epidemic control. The COP 19 reclassifications were made as follows depicted in the graphic below.



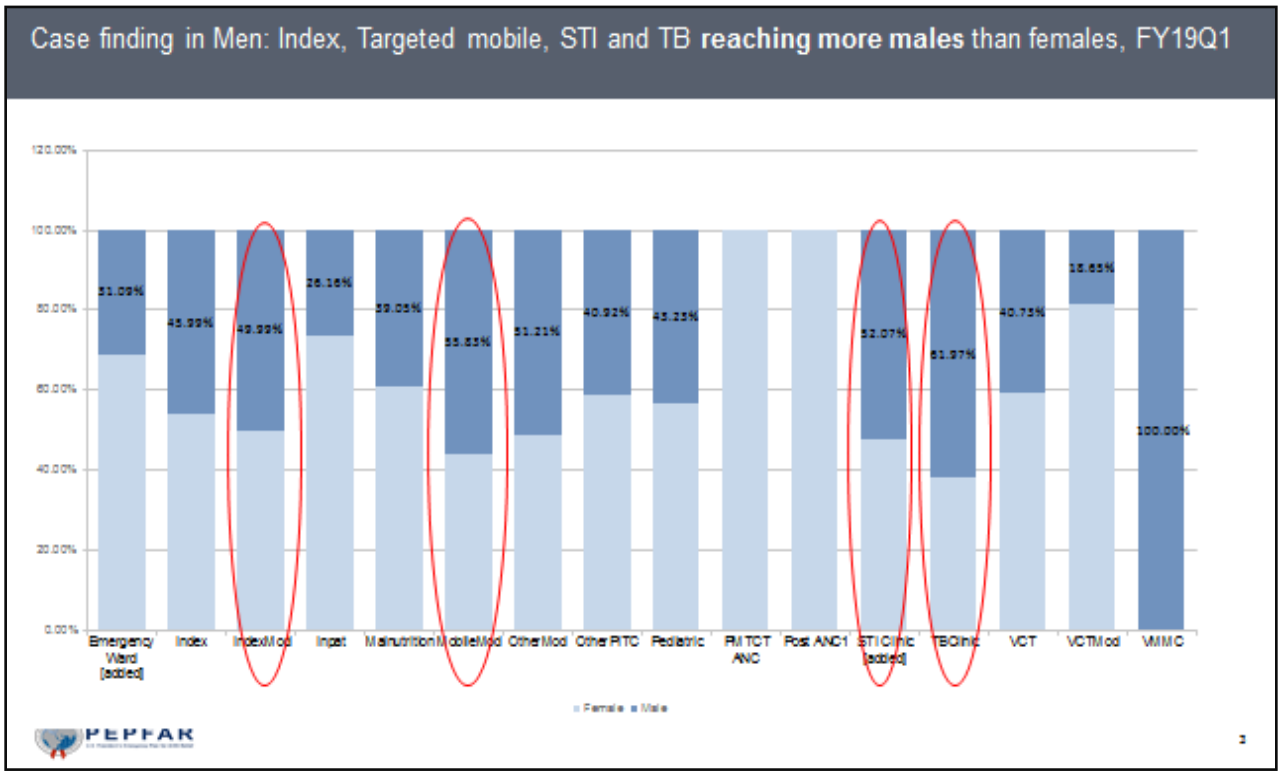
In districts with **High and Medium ART Gap** the PEPFAR Zimbabwe program will focus its testing strategies on optimizing PITC through screening for eligibility, risk stratification, and use of diagnostic testing. Index testing will continue to expand, targeting sexual contacts and exposed biological children of newly identified and viremic PLHIV. The PEPFAR program will support strategies to enhance the quality of counseling, which in turn will increase the acceptance of contact tracing/partner notification to at least 80%, while also increasing the number of sexual partners elicited from a single index case. Currently, PEPFAR implementing partners are sensitizing their teams on active screening and referral for intimate partner violence (IPV), andincorporating this into index testing implementation. In COP 19, among all newly identified PLHIV, at least 40% in high ART gap districts and 50% in medium ART gap districts are expected to come via index testing. The remaining proportion is expected to come from PITC and highly-targeted non-index testing in areas/groups where recent infections are identified. In high gap districts HRH will continue to be deployed to high volume facilities,, while in medium gap districts HRH will be redeployed to index testing modalities.

In **Low ART Gap** districts the focus will be on clinical diagnostic testing within PITC settings in order to increase the yield for these SNUs. Index testing (facility and community) will be emphasized as the most efficient case-finding modality. Key Population HTS programming in hot spots will also be supported in low ART gap districts, whilst HRH investments will be redeployed to activities that support adherence, retention and VL monitoring.

In COP 19, case finding strategies will be supported for sub-populations as follows:

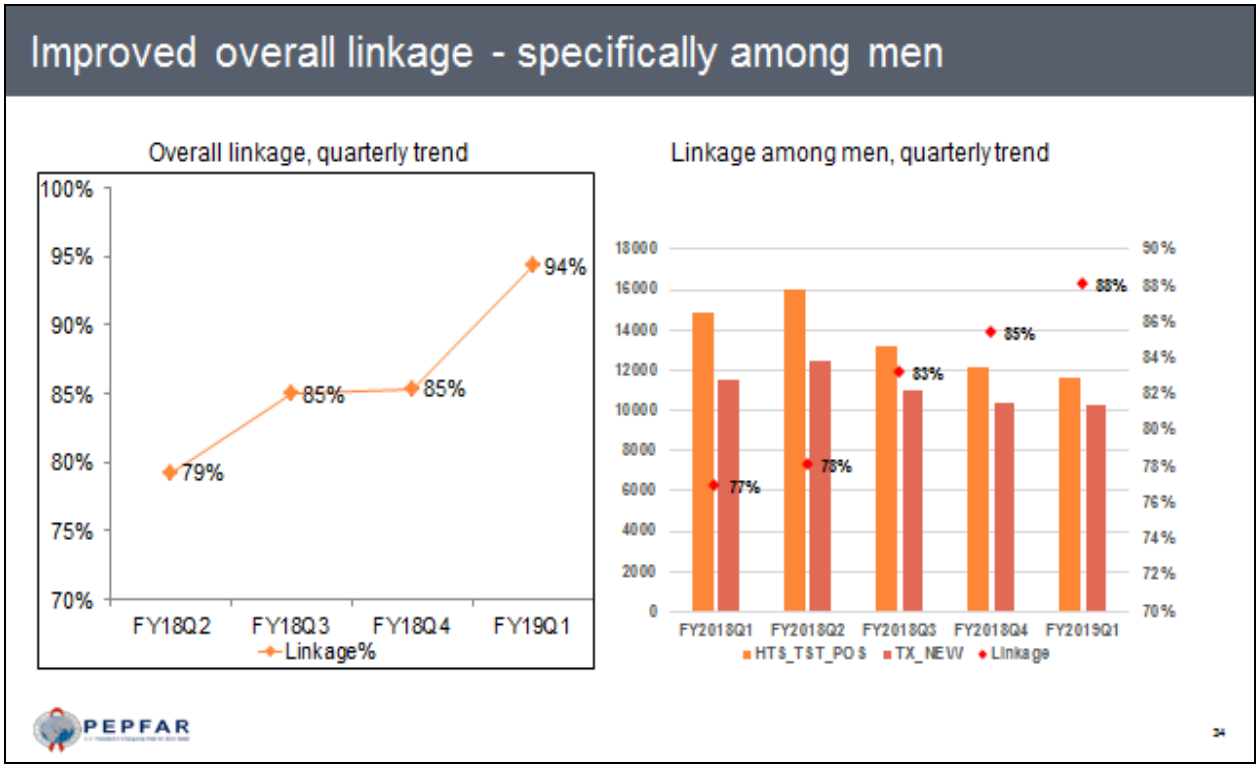
Finding Men

Generally, men have lower ART coverage as compared to women. As the country aims to reach epidemic control, it must intensify efforts to find men, link them to treatment and ensure long-term viral suppression. FY 19 Q1 data illustrates a higher percentage of male (vs. female) positives through index and targeted mobile testing, in addition to the STI and TB entry streams as shown below.



In COP 19 the following strategies to find men will be supported through the mainstream program as well as the FBO initiative:

1. Index case testing as a testing modality of choice for male partners of HIV positive women identified in health facilities including in the PMTCT program
2. Use of HIVST to encourage men to test privately (particularly with the FBO initiative)
3. Promoting positive messaging that encourages men to test e.g. U=U literacy



Finding children and adolescents

In COP 19, following strategies will be supported for case finding amongst children and adolescents:

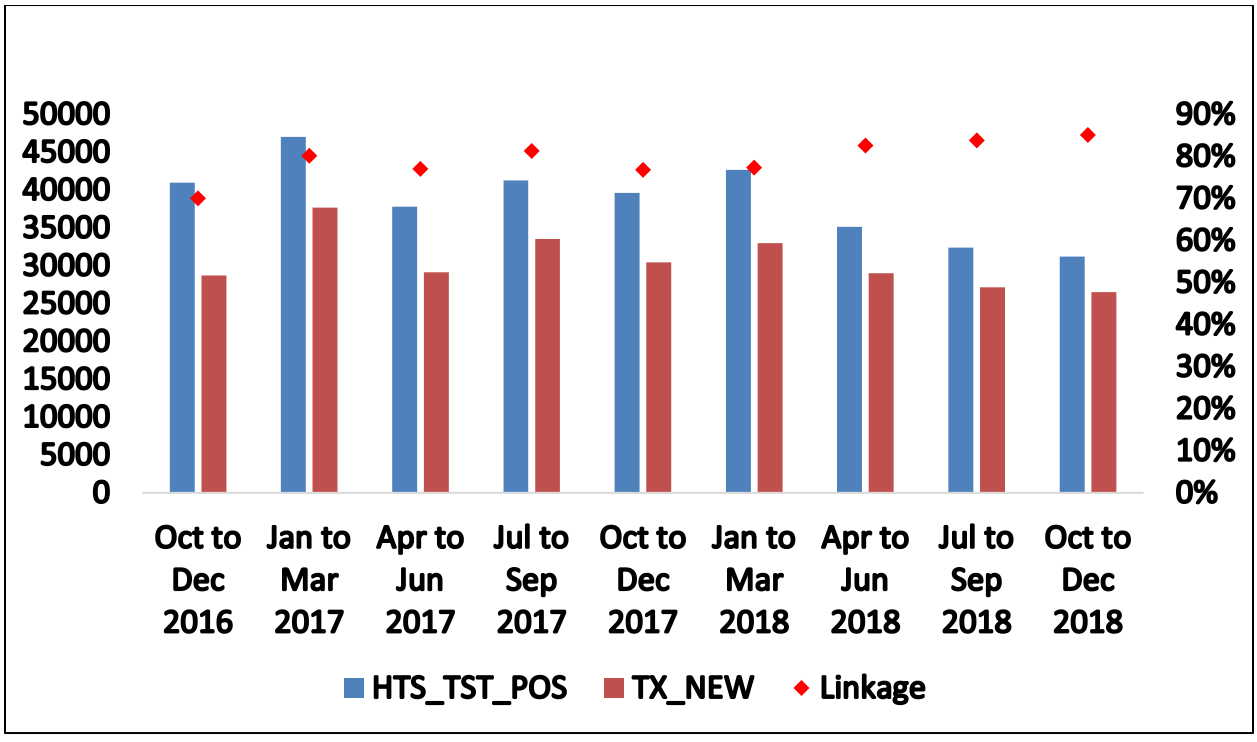
1. Index testing for biological children of all newly identified HIV+ clients.
2. Testing all sick children under five with full roll out of the pediatric screening tool within health facilities.
3. PEPFAR will support EID POC commodities for mPIMA devices procured under the UNITAID pilot in Zimbabwe. Through the POCs, EID TAT including result transmission to caregiver was within 7 days in 92% of the cases and this facilitated the early initiation of life-saving ART in HIV Exposed Infants (HEI) found to be HIV positive.
4. PEPFAR partners will support the decentralization of conventional EID platforms and the Integrated Specimen Transport system while strengthening the delivery of EID results to reduce the turn-around time.
5. Continued collaboration between the OVC and clinical partners to ensure cross-referrals and identification of HIV positive children within OVC programs.

Recency Testing

In COP 19, Zimbabwe becomes an Epidemic Control Team (ECT) 1 country and as such the program will shift to expand HIV surveillance including the use of HIV recency testing for all newly identified PLHIV. The Team will analyze recency data to determine the recency of the infection, map the profiles of the newly identified PLHIVs and develop subsequent strategies to test and treat within hotspots. Recency testing will also be tied to Cased Based Surveillance (CBS). See section 6 for more details on how CBS will be deployed.

4.1.2 Getting patients on treatment

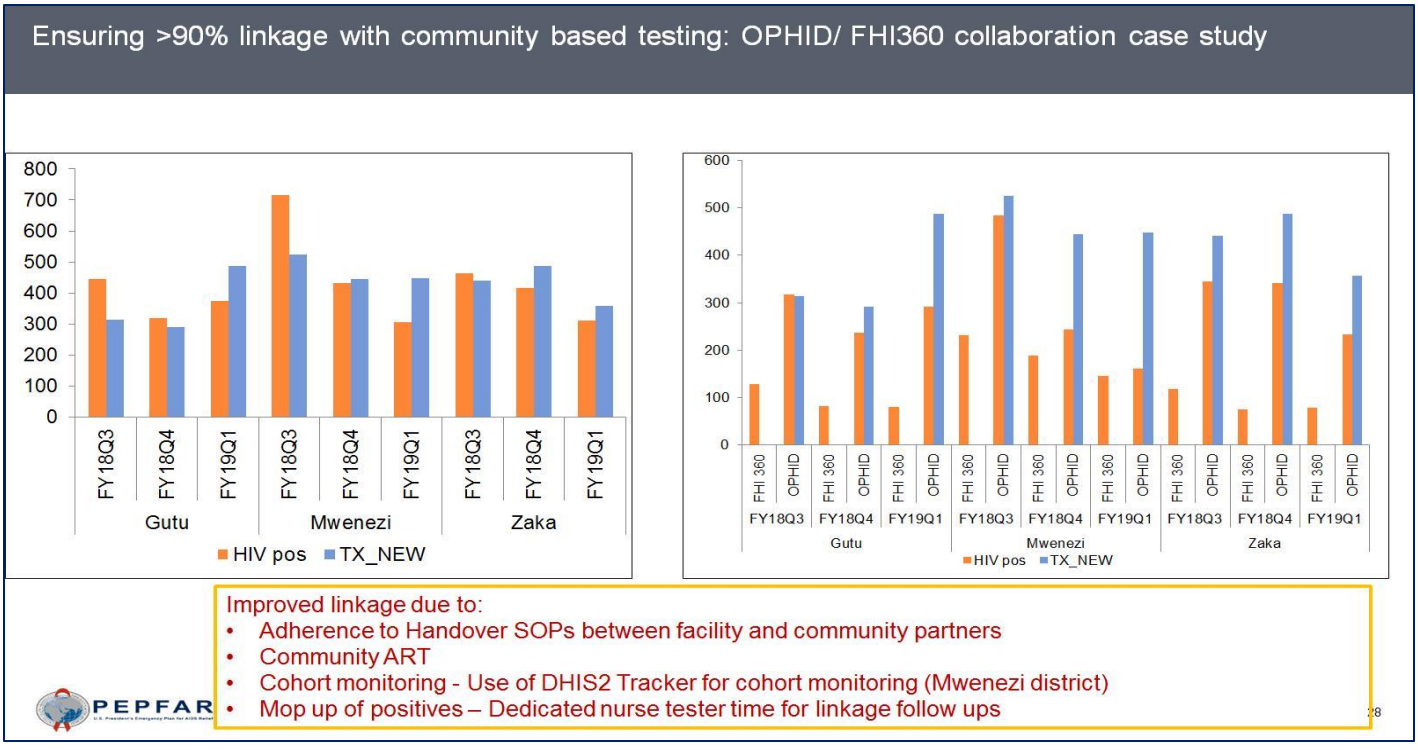
The continued scale-up of the Treat All guidelines with same day ART initiation and the introduction of community ART initiation have increased ART coverage and linkage rates across all sub-populations. In many facilities around the country, the monthly initiation rate increased initially with the introduction and scale up of Treat All but it has since regressed against the background of the country approaching epidemic control. As the Treat All approach was introduced and scaled up, the PEPFAR program emphasized 'same day initiation' (for clients who were ready to be initiated on treatment), and follow up of those not ready to initiate on the same day with additional counselling, including the use of facility-based and community-based linkage facilitators most of which are expert patients. This, together with the introduction of direct service delivery (DSD) HRH in facilities, has seen the linkage rate (proportion of PLHIV testing positive initiated on ART) increase from an average of 80% in COP 2016 to 85% at the end of COP 2017 and to 94% in Q1 of COP 2018 as illustrated in the figure below.



PEPFAR program linkage rates by quarter, FY 16 Q1 to FY 19 Q1.

PEPFAR supported districts currently average 8,815 new initiations per month and this would be sufficient to meet the COP 18 target initiations of 104,945. However, this will not be sufficient to meet the COP 19 target of 141,264. This means that the PEPFAR program needs to further improve linkage rates to the desired ≥95% while improving case finding across all sub-populations. Moreover, the net new ART initiations nationwide significantly went into the negative in FY 19 Q1 by 15,695 leading to a reduction in the number people currently on treatment. This was mainly due to corrections to the numbers of active ART patients at some sites following DQAs and data actualization exercises, but also because of the attrition due to deaths, loss-to-follow-up and transfers to non-PEPFAR districts. Zimbabwe's ongoing economic crisis contributes to significant human resource gaps which impact both PITC and ART initiation. PEPFAR partners will continue to provide DSD support for ART initiation at facilities experiencing significant gaps that impact service delivery and site-level linkage will be used as a metric to identify these facilities. This DSD support will include facility based and community based linkage facilitators and ART initiators.

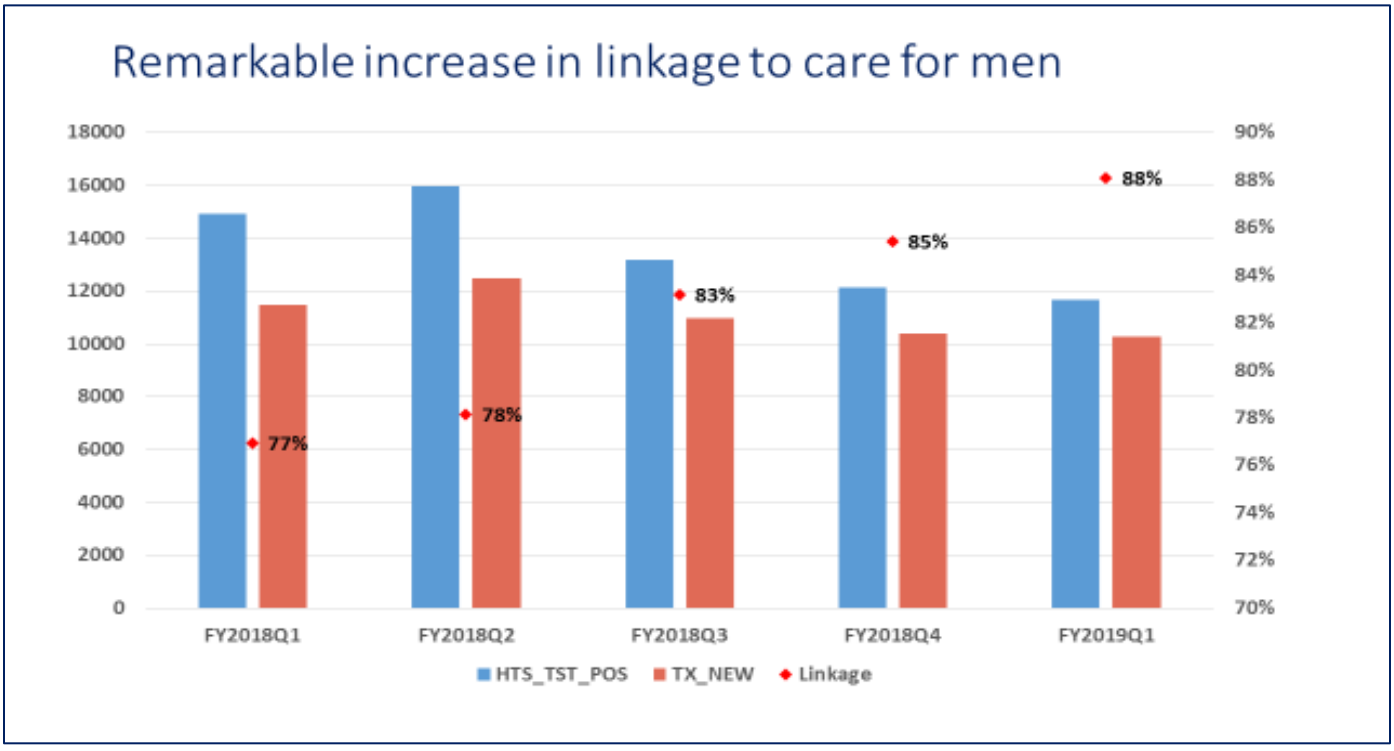
The introduction of community ART initiation has seen a marked improvement in ART linkage within community testing strategies. Community ART initiation will therefore be scaled up to all geographic areas where community HIV testing services are provided, and as guided by national policy.



In COP 19, PEPFAR will further scale up activities to improve treatment literacy among PLHIV to ensure that appropriate messages are delivered in appropriate ways to the various population subgroups. These messages will include the rationale for the Treat All approach, the benefits of testing and initiating ART prior to onset of symptoms, the superior efficacy and adverse event

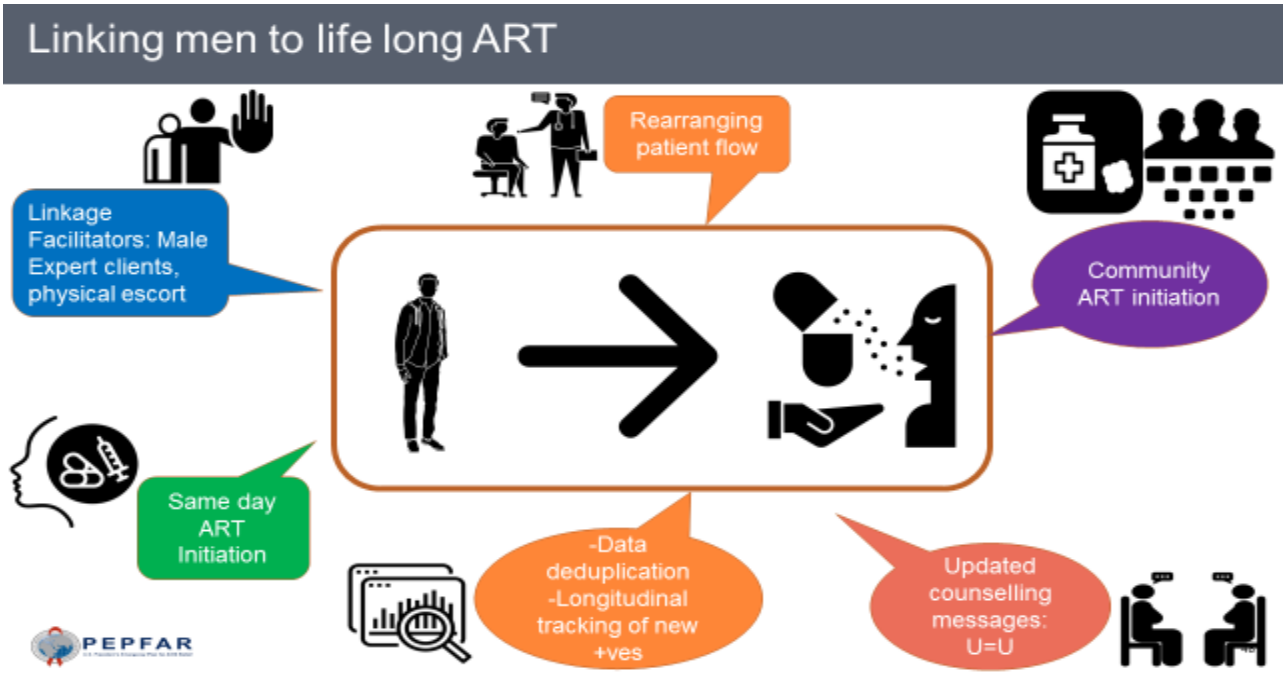
profile of dolutegravir (DTG)-based regimens, the importance of having all sexual partners on treatment or PrEP, the need for viral load monitoring and the meaning of viral load results, U=U (Undetectable = Untransmittable). The PEPFAR program will also support the updating of counseling materials to align with the current treatment guidelines and the shifts in the HIV program. The national HIV Quality Improvement strategy establishes indicators and guidelines for measuring the quality of service delivery, and improving performance towards those indicators. Importantly, this strategy takes into account client feedback in order to promote client-centered care. PEPFAR support towards the national HIV Quality Improvement program takes the form of secondees who provide technical guidance, ensuring that this program is aligned with PEPFAR and UNAIDS strategy for achieving HIV epidemic control. Through this support in FY 18, some facilities implemented QI initiatives resulting in improved patient care and this will be scaled up in COP 19 to focus on improving VL and TPT uptake. At the site-level, systems-level interventions to improve monitoring of patient satisfaction, linkage rates, same day initiation and improved M&E for PEPFAR treatment indicators, will be streamlined into the site-level support provided by the clinical partners.

Adult Men: Since COP 17, the PEPFAR program has continued to strengthen strategies to link men to treatment including the use of facility-based and community-based linkage facilitators which saw the linkage among men improving remarkably as shown in the figure below.



This achievement however, still falls short of a target minimum of 95% linkage rate. As such, ART initiation strategies to reach men will be paired with PITC, index case testing and self-testing

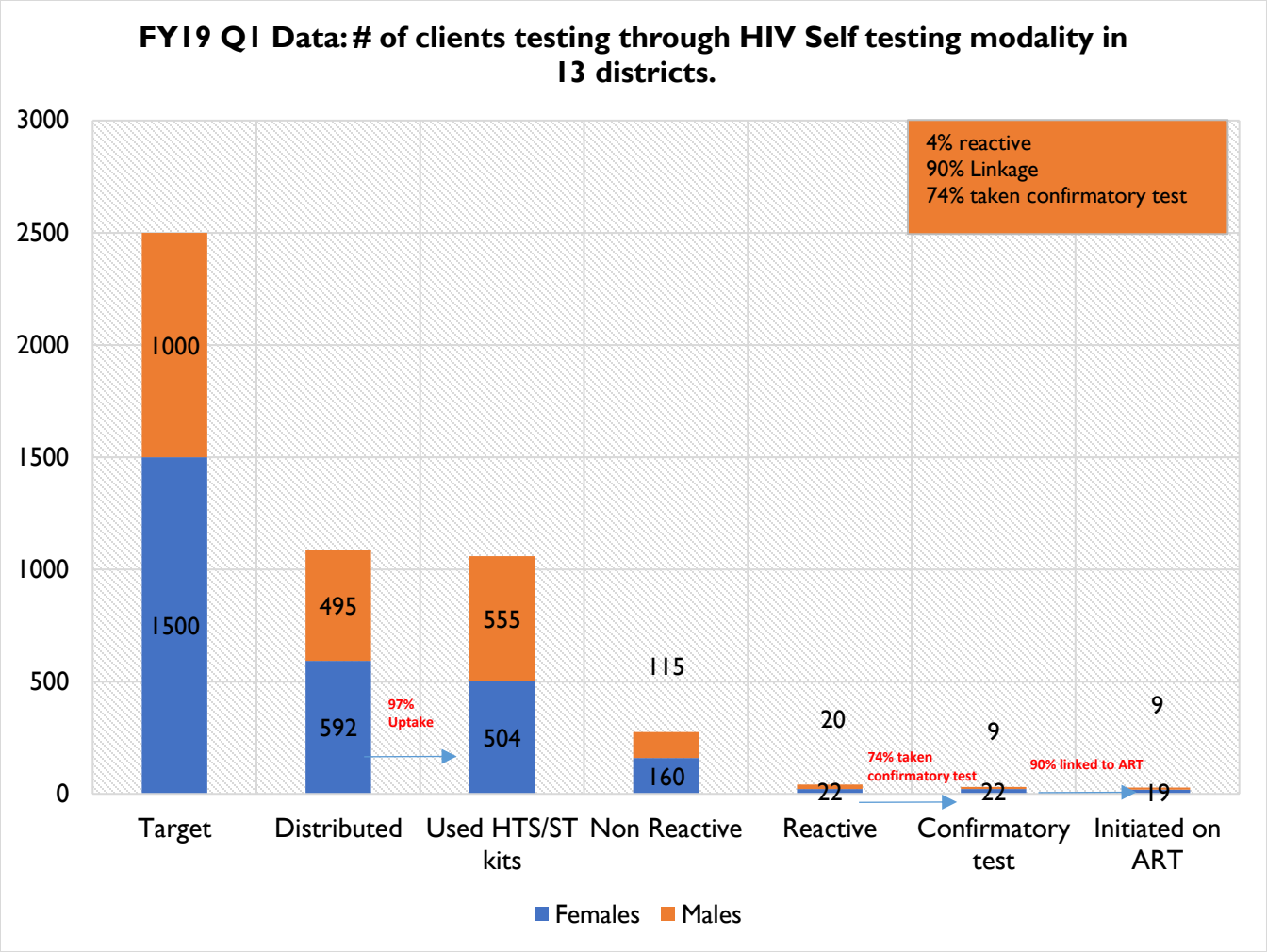
strategies to link them to treatment and to emphasize same-day ART initiation among those patients through updated and enhanced counselling messages (U=U), both at the facility and community levels as illustrated below.



In high ART gap districts, the emphasis will be on facility-based DSD to improve linkage to ART; while in low ART gap districts, efforts will be intensified to accelerate community ART initiation, and facility-based TA will focus on rendering facilities more "male friendly" through extended hours, sensitization of health care workers, and pairing ART initiation with community testing activities.

Adolescent Girls and Young Women

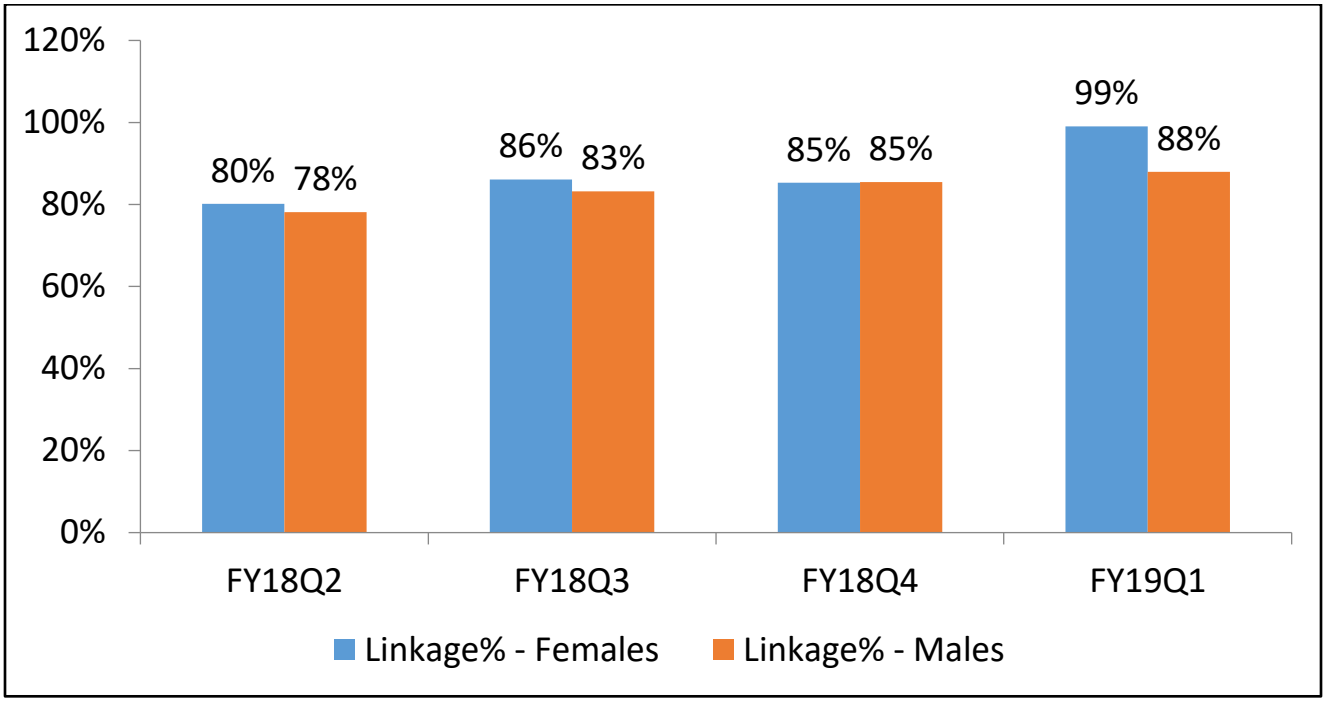
According to ZIMPHIA and program data, adolescents and young people continue to perform poorly as compared to older people across the clinical cascade. However, through the use of Community Adolescent Treatment Supporters (CATS) in the game changer Zvandiri model, PEPFAR has significantly improved case identification, linkage and eventually ART coverage among adolescent girls and young women, including through the use of HIV self-testing, as illustrated in the figures below.



Nevertheless, overall program data suggest that proxy linkage among adolescents lags behind the general population. In order to improve linkage to ART in this population, PEPFAR partners will strengthen support groups and other peer-led strategies to encourage timely ART initiation. Clinical partners will also strengthen communication and referral networks with community-based OVC partners to improve linkage among OVC beneficiaries. While the national MTCT rate has come down significantly, to approximately 6% by 18 months post-partum, program data suggests ongoing challenges with identification, ART initiation, and viral suppression among adolescent and young adult mothers. In order to address this population and their HIV exposed infants (HEIs), PEPFAR partners will strengthen young mothers' support groups (both ante- and post-natal), linkage to community-based services (e.g. OVC, DREAMS), and differentiated service delivery packages for their pre-natal care.

Adult women/PMTCT:

PEPFAR program data has revealed that women consistently link to treatment better than their male counterparts and in FY 18 Q1, their linkage exceeded the target of 95% as shown in the figure below.

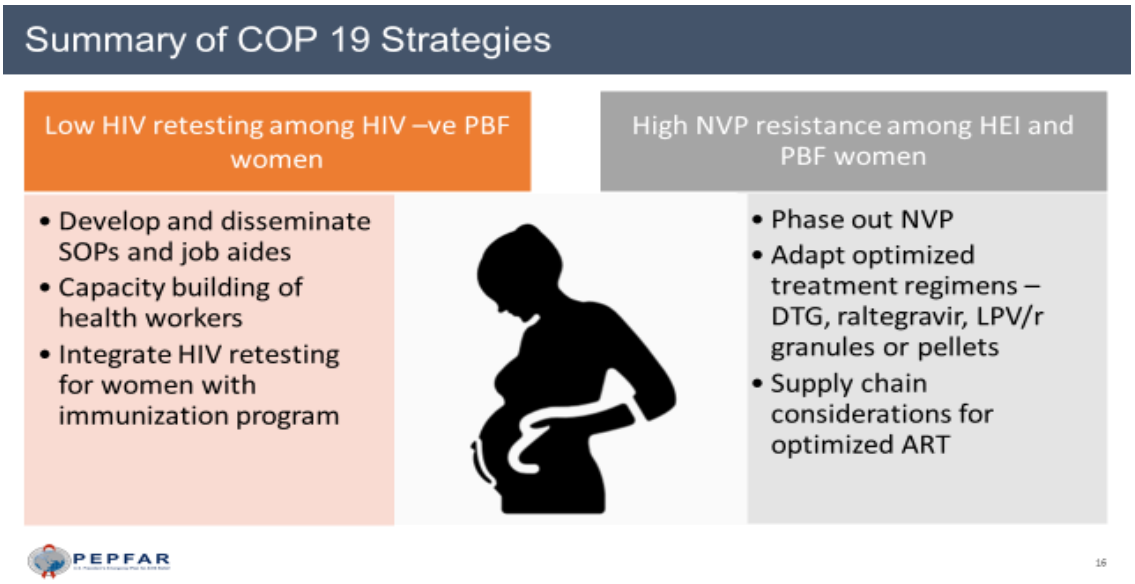


Trends in linkage by sex.

The national PMTCT Effectiveness Survey 2016-2017 has shown a very high ART coverage in pregnancy of 97% where over half (52%) are coming in already on ART while 45% are initiated during pregnancy. FY 18 Q4 program data indicate that 71% of HIV positive pregnant women were already receiving ART. Remaining gaps include reaching a small proportion of HIV positive pregnant women were not initiated on ART and identifying women who do not return for subsequent medication pick-up after same day ART initiation. Currently, implementing partners are conducting additional mentorship for both government and their own staff on ART initiation to ensure trained ART initiators are available at each site offering PMTCT services. ART services should be routinely available within the antenatal clinics and the additional staff being mentored will be expected to provide roving coverage for unexpected absences such as sick leave.

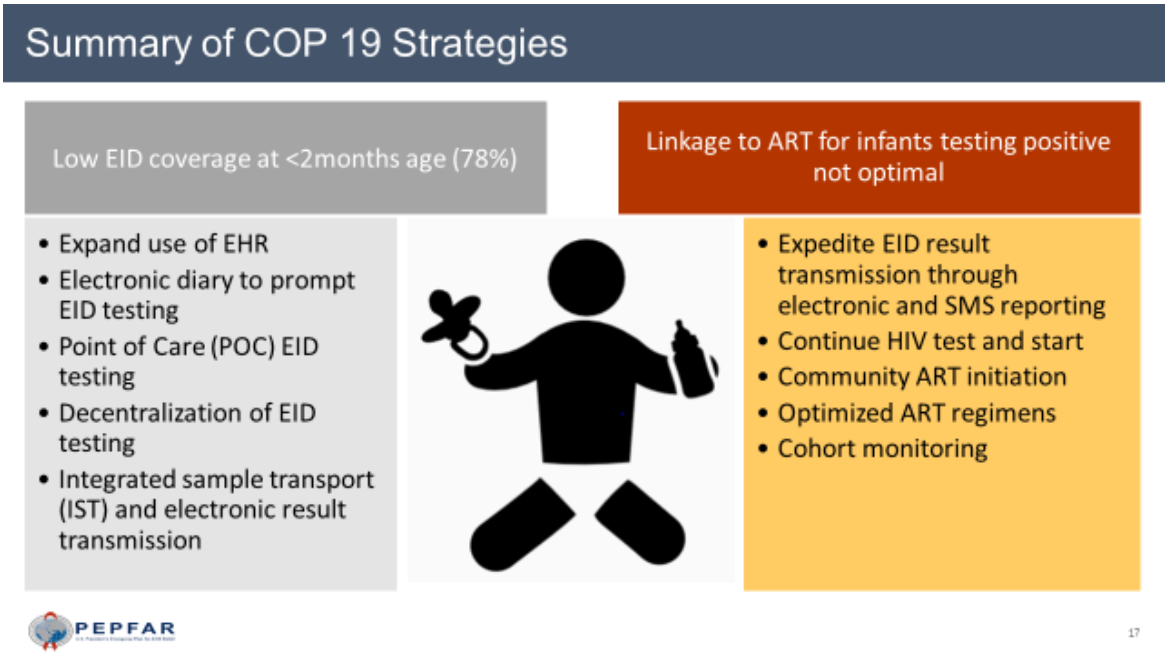
Site level analyses have not shown any major challenges with the supply of antiretroviral medicines. However, resistance to Nevirapine has been shown to be high and all Nevirapine based regimens are being phased out. In COP 19, the PEPFAR program will continue to link all HIV positive pregnant women to ART initiation, through both DSD and TA support based upon site-specific needs. The team will support sites to conduct monthly linkage analyses to look at their performance and address bottlenecks. Follow up systems to call back clients who miss

appointments will be re-emphasized as the appointment diaries become more widely available. Finally, the roll-out of EHR in four more districts during FY 20, will provide much needed data quality and efficiency in assessing linkage, as well as identifying defaulters.



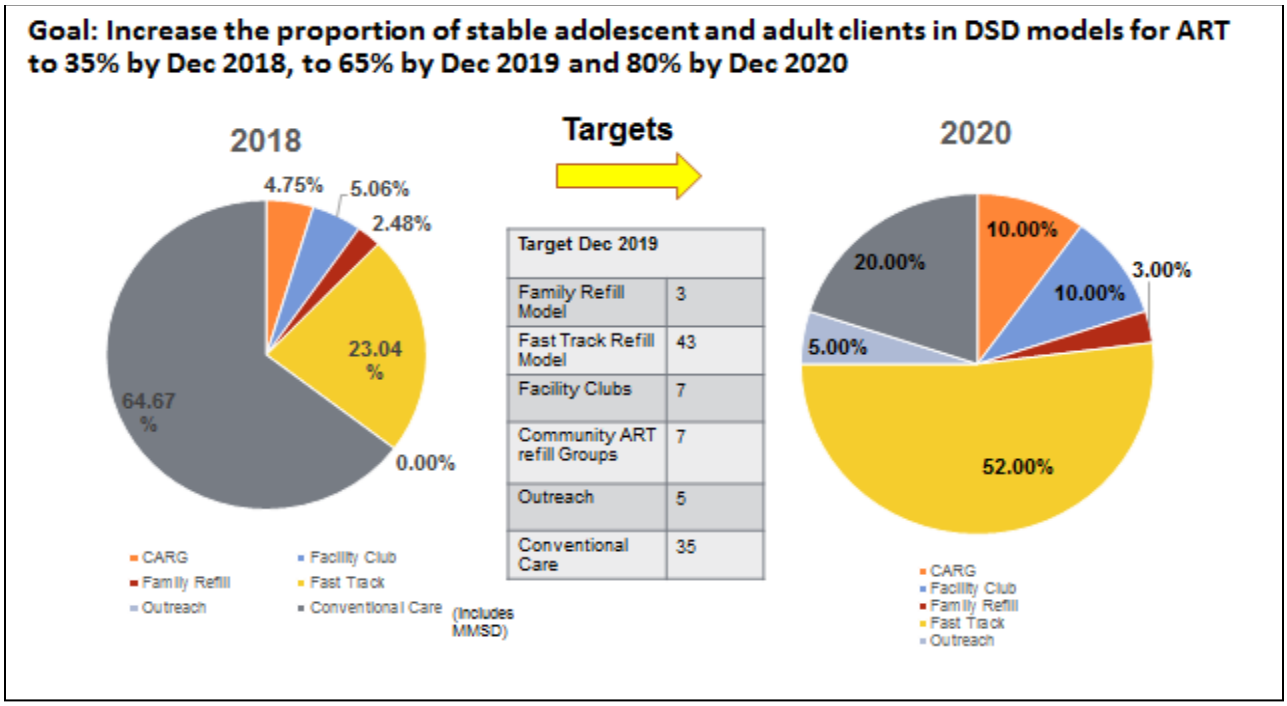
Children

In COP 19, the PEPFAR program will further support nurse–led pediatric ART initiation through site-level DSD/TA and blended learning approaches, while strengthening integration of HIV within routine child care services. Administration of new pediatric formulations (e.g. LPV/r pellets/granules) will be supported as the guidance from the MoHCC is released. The PEPFAR program will support the procurement EID POC commodities, significantly reducing results turn-around time and enabling immediate linkage to treatment. In areas without POC EID testing, positive results will be treated with urgency and the patients will be followed up and initiated on ART as soon as possible.



4.1.3 Retaining them

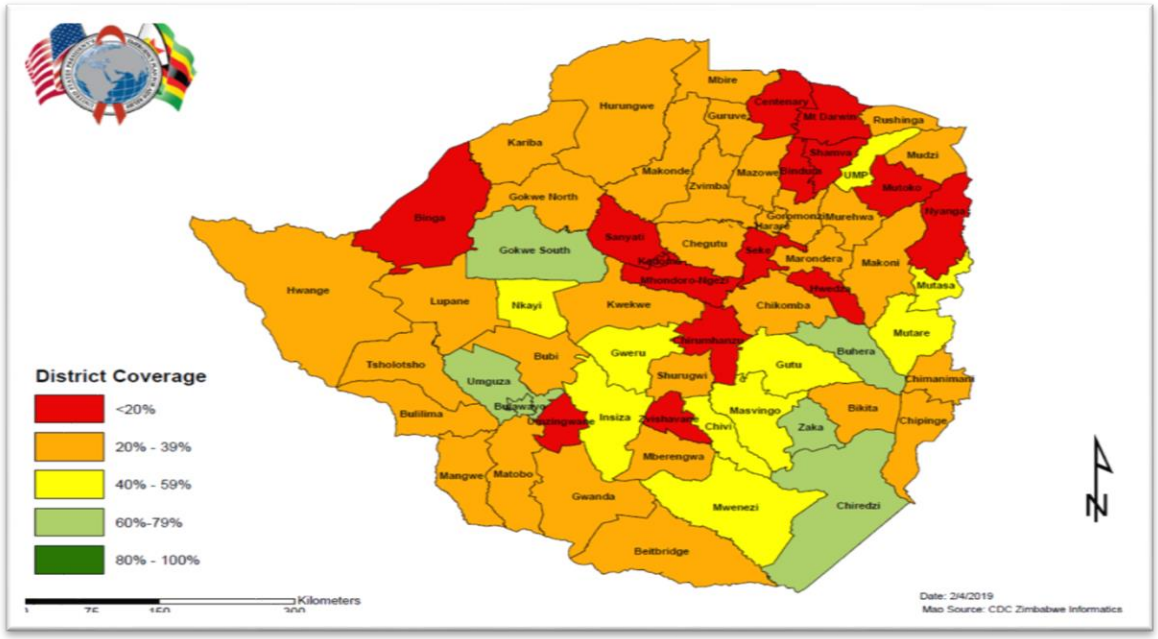
The MoHCC'S Operations and Service Delivery (OSDM) manual for HIV Care and Treatment in Zimbabwe gives guidance on the "how to do it" with the aim of increasing retention at all steps of the HIV clinical cascade. PEPFAR Zimbabwe will continue to support the operationalization of this manual and specifically continue to support the roll-out of differentiated service delivery models. PEPFAR Zimbabwe will specifically support expansion of Fast Track Refills to 43% of eligible interested clients both in urban and rural districts. PEPFAR will support the expansion of Community ART Refill Groups (CARGs) to interested clients over 15 years old in all PEPFAR supported districts, with an emphasis on rural districts. CARGs will be tailor-made to address the needs of specific sub-populations (e.g. men-only CARGs and cross-border CARGs to cater for patients working in South Africa and Botswana). MoHCC currently considers multi-month scripting and dispensing (MMSD) part of conventional care, as the country has managed to roll out 3-month MMSD to all health facilities. PEPFAR Zimbabwe will support the MoHCC to increase the threshold of MMSD from the current 3 months to 6 months where feasible. The chart below shows the differentiated care targets for COP 19 and ultimately the goal for 2020.



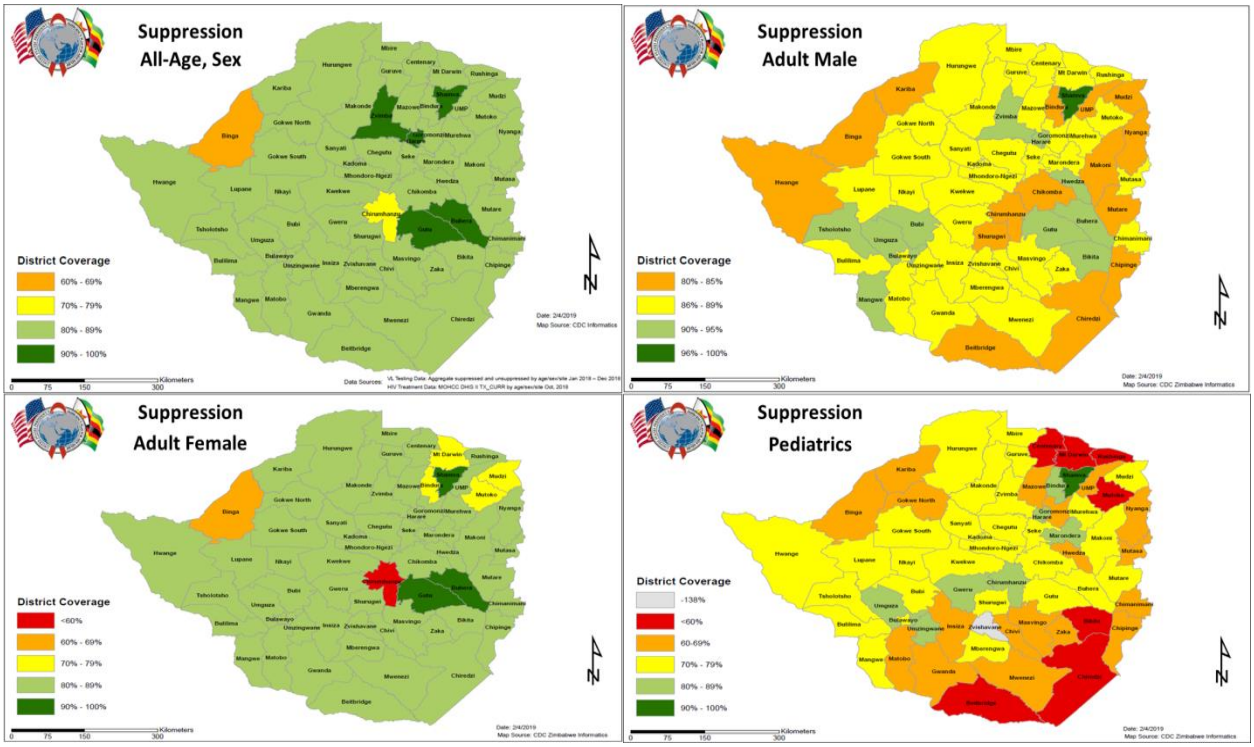
The documentation of differentiated care models has been noted as a gap within the current MoHCC M&E systems and service delivery practices. As such, PEPFAR Zimbabwe will support the following to improve this documentation:

- Identify sites not offering differentiated ART and develop **remediation plans** to address the documented challenges
- Identify models/areas requiring **program emphasis for expansion of differentiated care** to meet MoHCC/ PEPFAR targets
- **Support documentation systems** (improvised registers, printing/copies of CARG/Club Refill registers in OSDM)
- **Support filing systems** for pulling out and filling OI/ART books of clients in differentiated models and conventional care
- **Labelling OI/ART booklet** e.g. the use of the Sticker system
- **Ensure the EHR system** allows for tracking various models of differentiated care

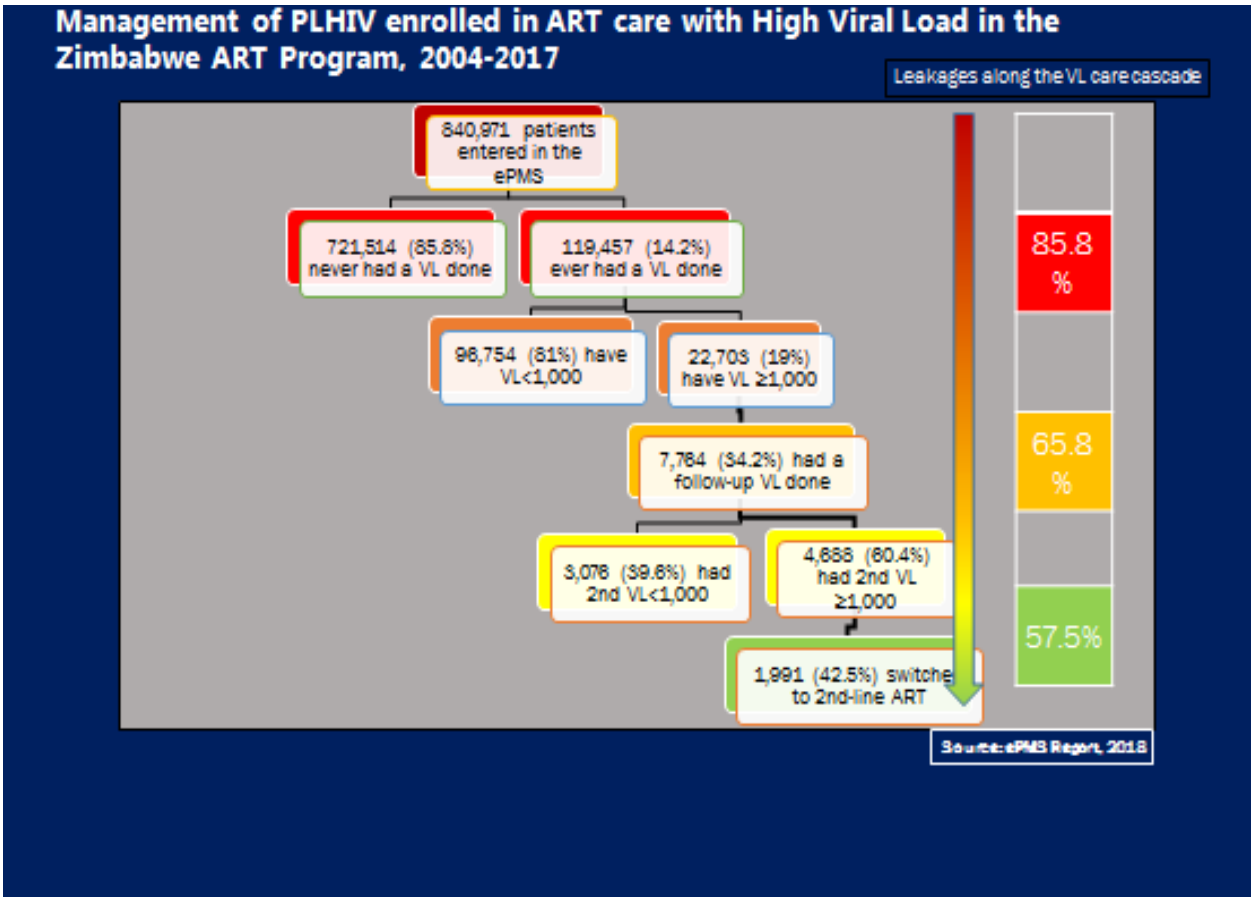
During COP 18, PEPFAR Zimbabwe supported the revitalization of widespread treatment literacy amongst ART patients. These efforts will be continued in COP 19. PEPFAR has identified viral load (VL) access and suppression as a critical area needing intervention in Zimbabwe as the country reaches epidemic control. Besides the obvious VL reagent gap, there are gaps in access, specimen transport and results utilization/ clinical status monitoring. This gap becomes more pronounced at the district-level and among specific sub-populations. The figure below shows that only 5 districts had VL coverage greater than 60% in FY 18.



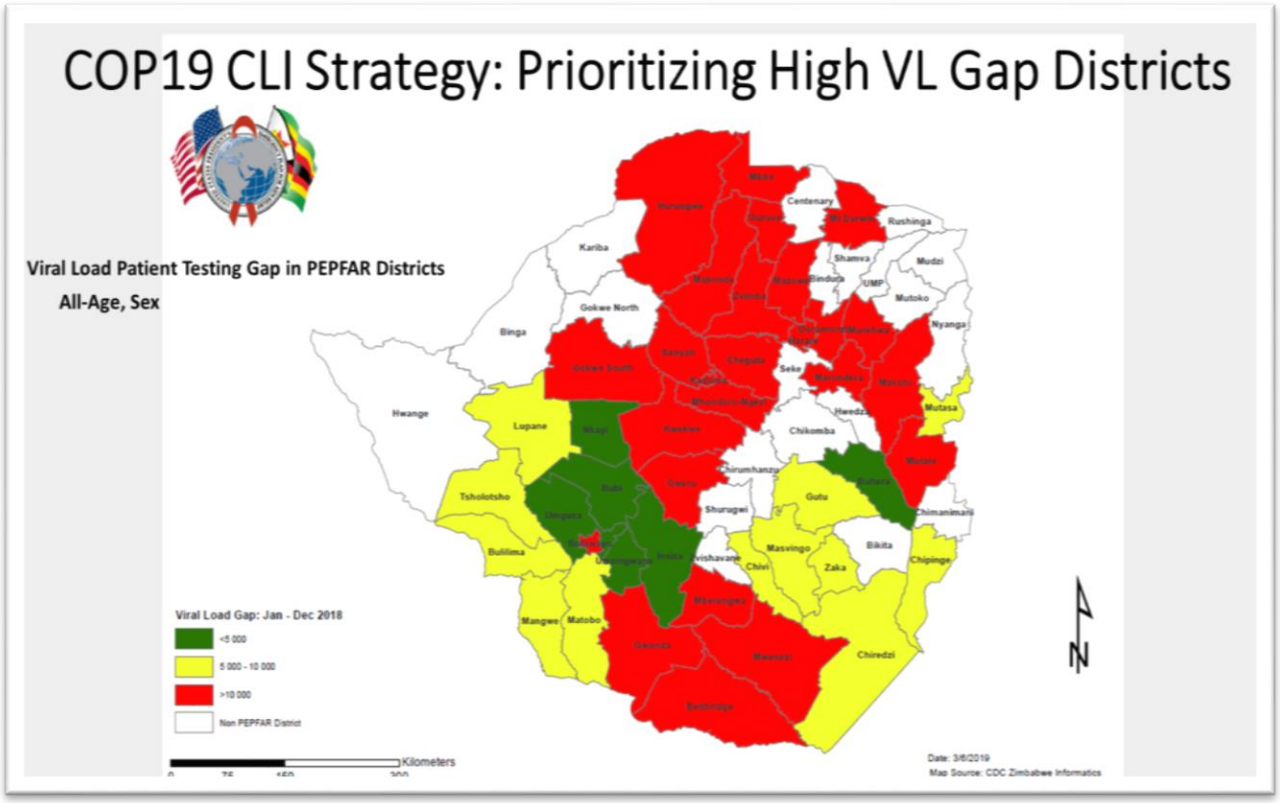
While suppression appears higher than 80% in most districts, further review of the data shows that men and children have lower suppression rates than women nationwide.



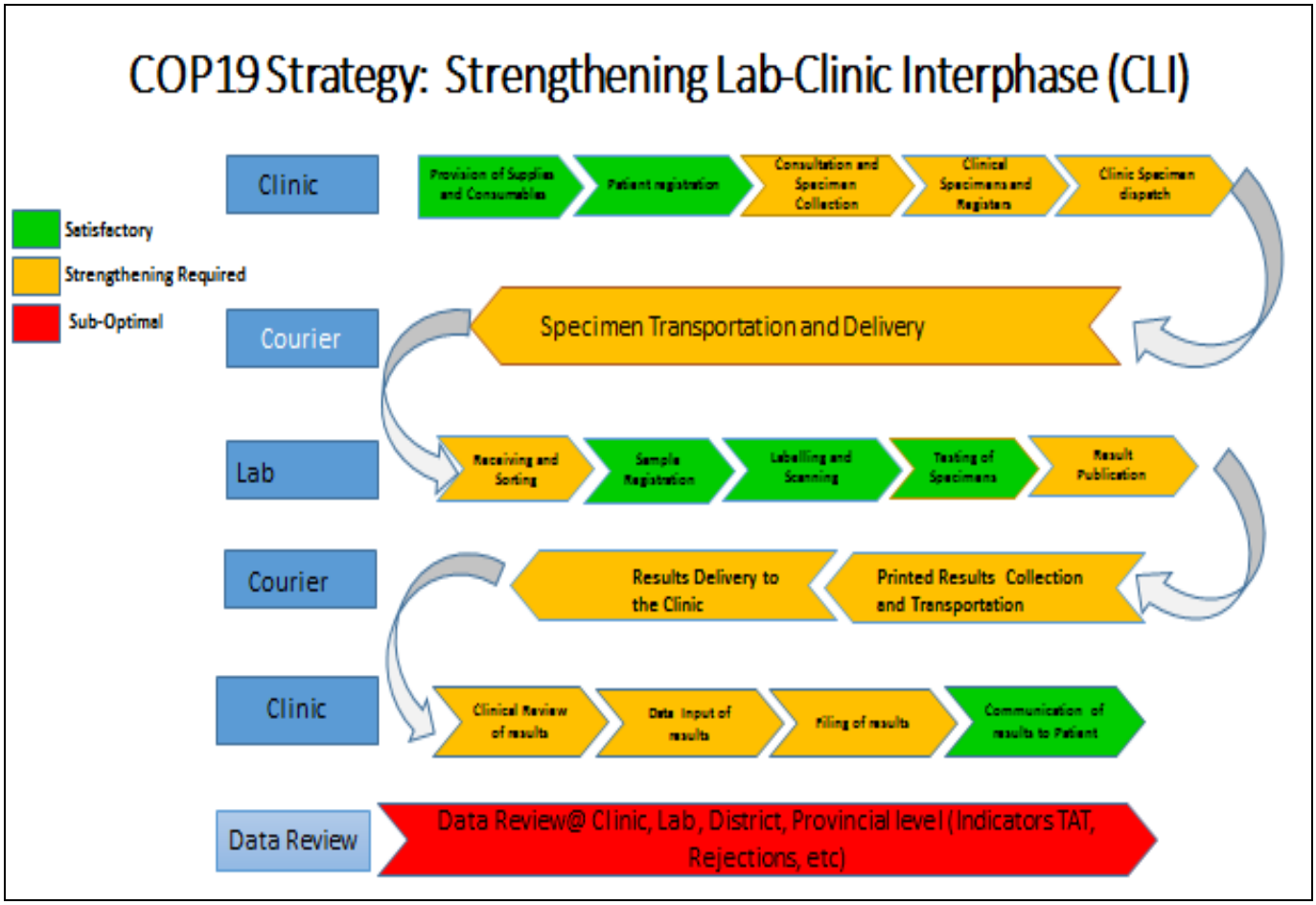
The program has also noted that the utilization of viral load results is sub-optimal pointing to the need to strengthen the clinic-laboratory interface (CLI) as shown in the chart below.



In COP 19, PEPFAR will therefore invest in scaling up the Clinic – Laboratory Interface (CLI) approach in at least 10 high VL gap districts, ensuring that the clinical partners, OVC/ community partners and the laboratory partner work harmoniously and measurably to increase access to VL services for all eligible PLHIV already on ART. The goal of the strategy is 70% coverage by the end of FY 20.



The plan will involve the selection of high gap districts, establishment of a USG task team, inter-agency adaptation of an existing VL process monitoring tool and recruitment of highly skilled and well positioned human resource cadres (HRH) at national and district levels by PEPFAR partners. The HRH infusion will be strategically instituted to cover key gaps and areas of underperformance identified with the CLI cascade.



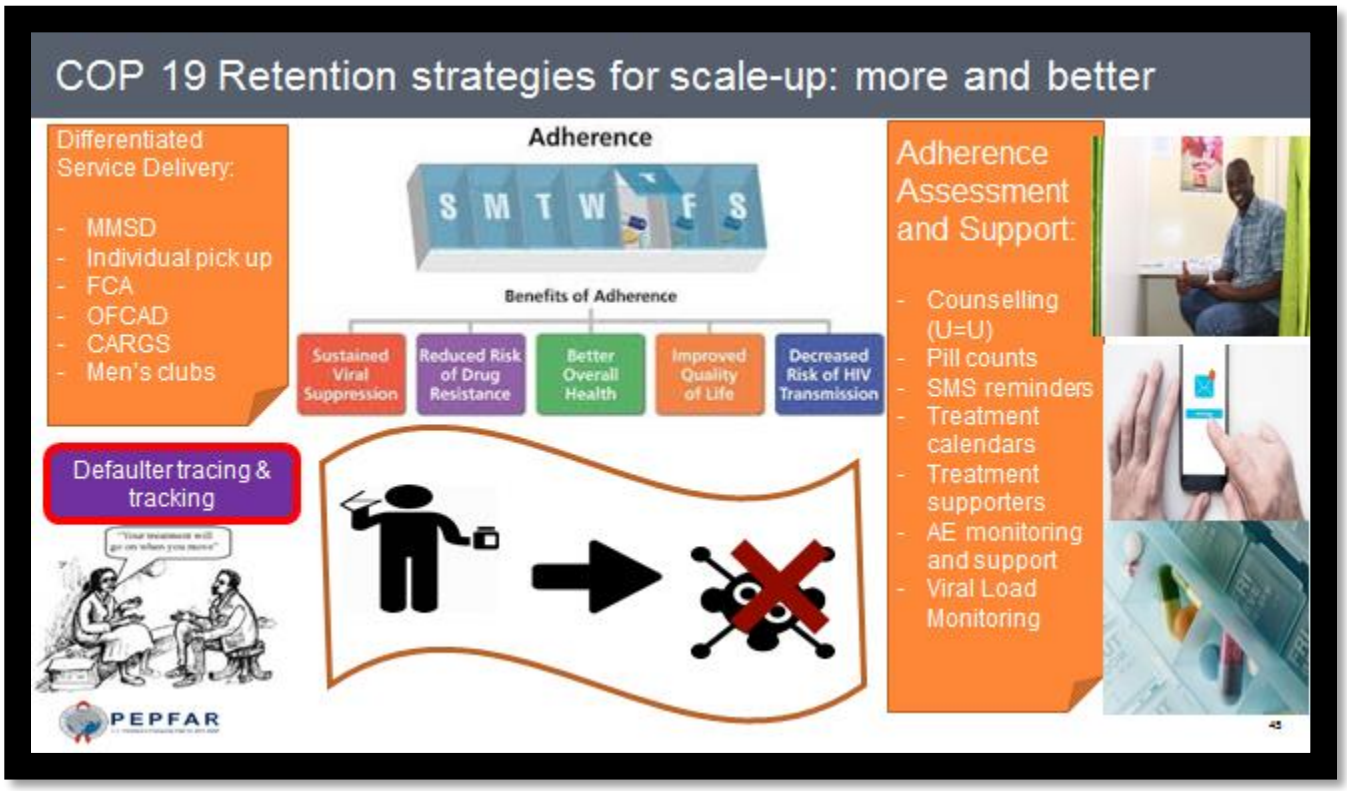
PEPFAR will also support targeted demand creation for VL among men and children and ensure results of VL tests are properly documented and acted upon, with close monitoring of the virally unsuppressed, provision of quality enhanced adherence counselling (EAC) sessions, regimen switch where necessary and index partner tracking.

Use of optimized regimens especially DTG will be supported in COP 19 in order to improve treatment tolerability and subsequently improve adherence and retention in care (See TLD transition and ARV optimization section). At the health system level, retention in care for all sub-populations will also be supported through procurement and supply chain investments (including the transition to TLD) in order to ensure uninterrupted supply of ARVs (see section 4.4 below).

In COP 18, PEPFAR Zimbabwe supported the development of standardized defaulter tracking tools for use in health facilities. In COP 19, the program will support the full roll out and use of these tools. Defaulter tracking efforts have shown that a significant proportion of defaulters are still in care either at that facility or another facility. In order to improve defaulter tracing, PEPFAR will increase support to improve documentation within facility registers and patient charts through on-site mentorship. This in turn will help health facility workers, outreach workers, and VHWs utilize their time efficiently to only to track "real" defaulters and return them back to care. Wider roll-out of EHR will obviously improve data quality and efficiency by immediately

distinguishing "real" defaulters from others. Enhanced adherence counseling sessions will be undertaken for defaulters and those with high a viral load to ensure they are retained on treatment and in care. The PEPFAR Zimbabwe team has begun dialogue with the MoHCC to change the definition of lost-to-follow-up (LTFU) from the current 90 days to 30 days, given the significant risks of developing viremia after only a short period of ART disruption.

The diagram below summarizes the PEPFAR Zimbabwe retention strategies.



The following sections will give further description of specific sub-population strategies for retention.

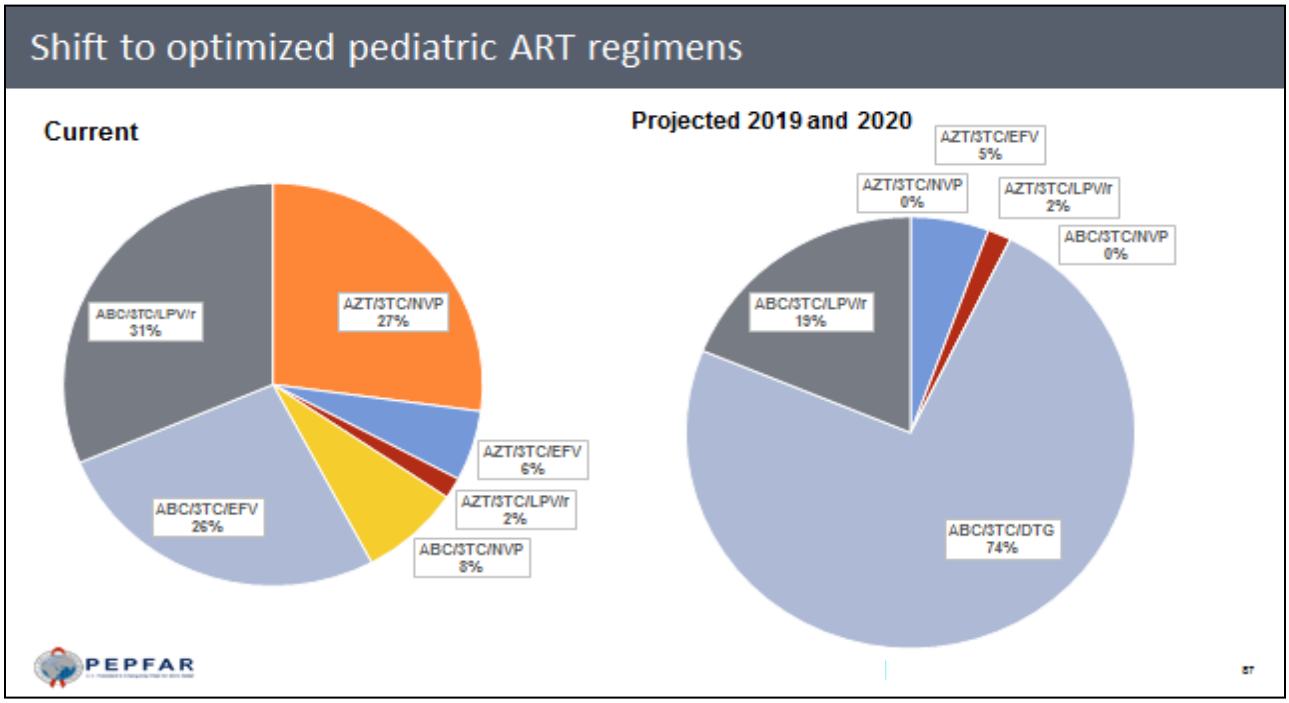
Adult Men: Strategies to retain men draw upon program assessments and data reviews regarding preferences for men. PEPFAR Zimbabwe will support the following specific strategies for retaining men:

1. Differentiated service delivery models including fast track refills, MMSD, family-ART refill groups (FARGs), and tailor-made CARGs (e.g. cross border CARGs) will be emphasized given work commitments as often-cited factors hindering retention.
2. Defaulter tracking
3. Treatment literacy particularly positive messaging e.g. U=U

Adolescents and children: Adolescents and children have lower retention and viral suppression rates in comparison to adults. In COP 19, the PEPFAR program will support the following

strategies specifically to increase retention and viral suppression amongst children and adolescents:

1. Expand the reach of the Zvandiri (CATS) model (including within the FBO initiative). CATS coverage of CAYLHIV was only ~ 52% in supported districts by FY19 Q1, due to resource constraints. In COP 19, the Team will expand and intensify the model in more districts where the gap is highest for these groups in order to reach a greater percentage of the population in need. Evidence has shown that adolescents enrolled in the Zvandiri program demonstrate higher retention and viral suppression over time.
2. Define minimum package of services for adolescents and use of a Quality Improvement (QI) approach to improve outcomes. PEPFAR Zimbabwe program will continue to support mentorship and supportive supervision specific to pediatrics adolescent HIV. The TA and DSD package of services to facilities will also include sensitization on pediatric and adolescent retention strategies, as well as viral load prioritization.
3. Continual review of age-disaggregated PEPFAR and national data (10-14, 15-19 +/- 20-24) to identify gaps and potential strategies through QI approaches.
4. Increase the proportion of HIV exposed infants and infected children and adolescents enrolled in OVC programs based on eligibility criteria, including socio-economic criteria.
5. Transition to optimal ART should include DTG for adolescents. Adolescent girls will be supported to have access to DTG-containing ART with informed choice and access to contraceptives. The following chart shows the targets for optimizing treatment regimens in children and adolescents;



Adult women/PMTCT:

Although retention and viral suppression among females generally exceeds results for males, efforts to sustain this trend will be maintained and scaled up especially for pregnant and lactating women. ART drop out during pregnancy and breastfeeding significantly increases risk for MTCT; therefore in COP 19, PEPFAR will continue to support the PMTCT program as follows:

1. Prioritization of viral load access and results utilization as previously described above. Currently there is widespread mentorship of antenatal clinic staff towards the provision of differentiated care/stratification depending on viral load results. Sites are being assisted to document action taken upon receipt of viral load results.
2. Continued support for appointment diaries to assist with tracking of missed appointments and will include due dates for viral load testing to make sure clients do not miss their tests.
3. Scale up of the young mentor mothers model to improve VL suppression amongst pregnant adolescents and young mothers.
4. PEPFAR support for the national eMTCT partnership forum will continue, and various MoHCC departments, including reproductive health, adolescent and sexual health, family planning departments, etc., will continue to participate. Formation of sub-groups to coordinate these activities will be encouraged.
5. The program tracking and referral systems remain paper based and the eMTCT program is eagerly anticipating the rollout and scale-up of the EHR system, which will play a huge role in longitudinal tracking of clients (mother – baby pairs).

4.1.3 Scaling up TPT

Globally, TB continues to the leading infectious disease killer, yet it is a preventable and curable disease. The available prevention interventions, like TB preventive treatment (TPT), have not been taken to scale for various reasons. According to MoHCC program data, since the inception of the TPT program in Zimbabwe, 359,560 PLHIV have received isoniazid preventive therapy. The WHO 2018 Global TB report indicates a TPT coverage of 11% among new HIV patients. In order to end TB by 2035 and achieve UN high level Mission on TB targets, the country must scale up TPT. However the following challenges need to be addressed if full TPT coverage is to be achieved.

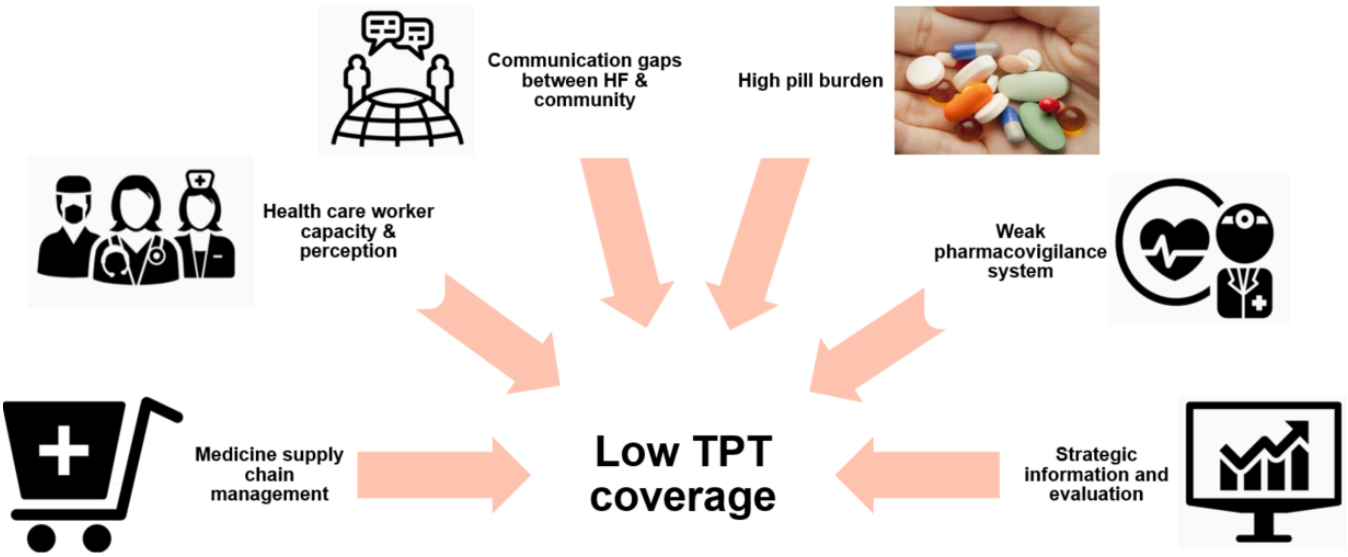


Figure 1: TPT Policy challenges

The objective of the TPT program in Zimbabwe is to achieve full coverage among eligible PLHIV by the end of COP 20. During COP 19, the TPT target will be 458,389. In COP 19, the PEPFAR program will support the procurement and distribution of TPT medicines. PEPFAR support will complement the already existing Global Fund support which was the major contributor in COP18. A roll out to the new shorter TPT regimens, specifically 3HP (three months of rifapentine and isoniazid) will be supported through procurement and distribution. The rollout of 3HP is expected to address some of the mistrust that health care workers had about 6H (six months of daily isoniazid) causing hepatotoxicity. 3HP will also address patients' high pill burden concern and improve adherence, as a once weekly regimen taken only for 3 months.

As guided by PEPFAR and MoHCC guidelines the following groups will be prioritized TPT scale up.

Target group	TPT regimen
PLHIV on DTG based ART regimens	6H plus Vit. B6 (FDC - INH/CTX/Vit. B6)
PLHIV on EFV based ART regimens	3HP
HIV negative children and adolescents <15years TB contacts	3HR

Implementing partners will support the MoHCC in revising and updating the TPT training guidelines to ensure include the new shorter regimens. Revision will also streamline the curriculum to be shorter and concise, so that it can be rapidly disseminated. Development of SOPs, job aides and patient communication material will address the existing communication

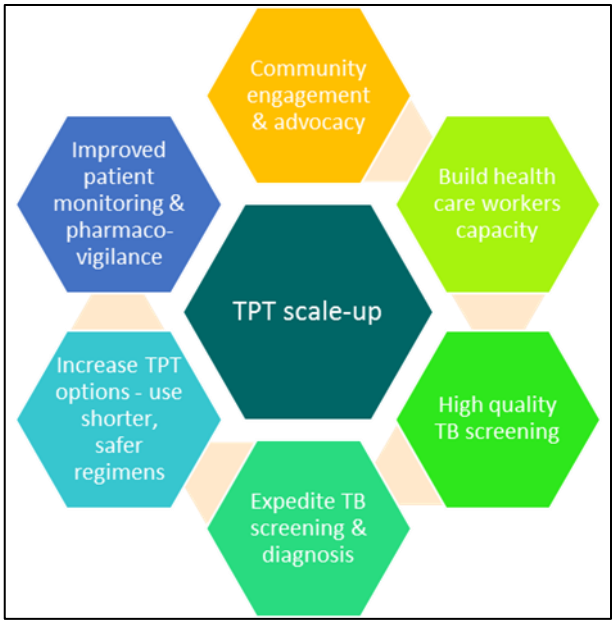


Figure 2: COP 19 strategies for TPT scale up

gaps and create demand for TPT. Advocacy at policy level and site-level pharmacovigilance will be prioritized in order to change negative TPT perceptions amongst physicians, senior clinicians and nurses.

During COP 19, among other strategies (fig.3) IPs will support the roll out of TPT differentiated service delivery to improve adherence and completion of TPT. Currently in COP18 there are studies being conducted on the feasibility and acceptability of TPT within CARGs. Such studies will then inform the design and implementation of differentiated TPT, with the expectation to improve uptake and adherence. There is evidence that TPT adherence and satisfaction can be improved with integration of TB and HIV services, and with co-formulation of INH with cotrimoxazole and vitamin B6. This fixed-dose combination pill has now received WHO pre-qualification and inclusion on the Essential Medicines List, and Zimbabwe has begun the registration in advance of procurement.

The Zimbabwe TPT program scale up will be adequately monitored and evaluated through adaption of the current data collection tools that capture TPT uptake, duration, completion, outcomes and adverse events. We will continue to strengthen TPT M&E by adding a TPT module in the Electronic Health Records (EHR) and develop an electronic reporting system. Currently IPs have been supporting the MoHCC to standardize the TPT data collection and reporting tools. Printing and distribution is also being supported.

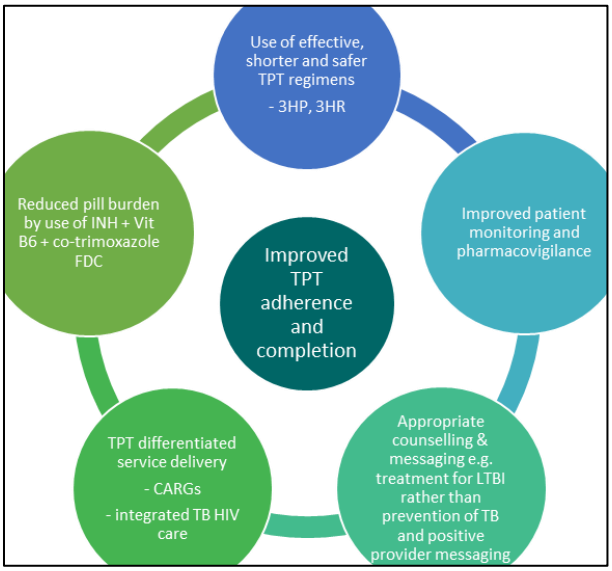


Figure 3: Strategies to improve TPT adherence and completion

In 2014, a study conducted in Zimbabwe revealed that only half of patients received IPT due to inadequate advocacy, community sensitization, formally trained staff, education and communication materials, and IPT stocks. Planning for and addressing each of these components will be critical for successful TPT scale up.

4.2 Prevention, specifically detailing programs for priority programming:

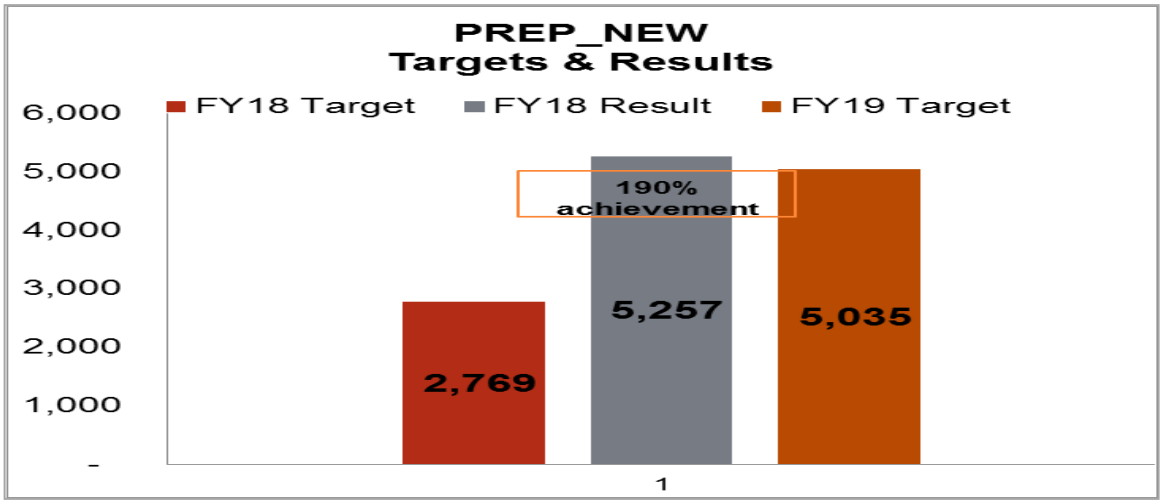
HIV prevention for priority populations is a key strategy in COP 19, with prevention activities tailored to specific populations being delivered through the VMMC, DREAMS and OVC platforms, as well as through HTS, PMTCT and ART services. Targeted priority populations include adolescent girls and young women (AGYW) between 15-24 years old, who are 3.6 times more likely to be living with HIV than their male counterparts (9.8% as compared to 2.7%, according to the ZDHS, 2015), children (through prevention of vertical HIV transmission), Key Populations (KP), and men under the age of 30, with a focus of linking this group to HTS and VMMC. In addition, in COP 19 there will be expanded focus on primary prevention of sexual violence and HIV for adolescent boys and girls 9-14 years old through the OVC, DREAMS and FBO initiatives.

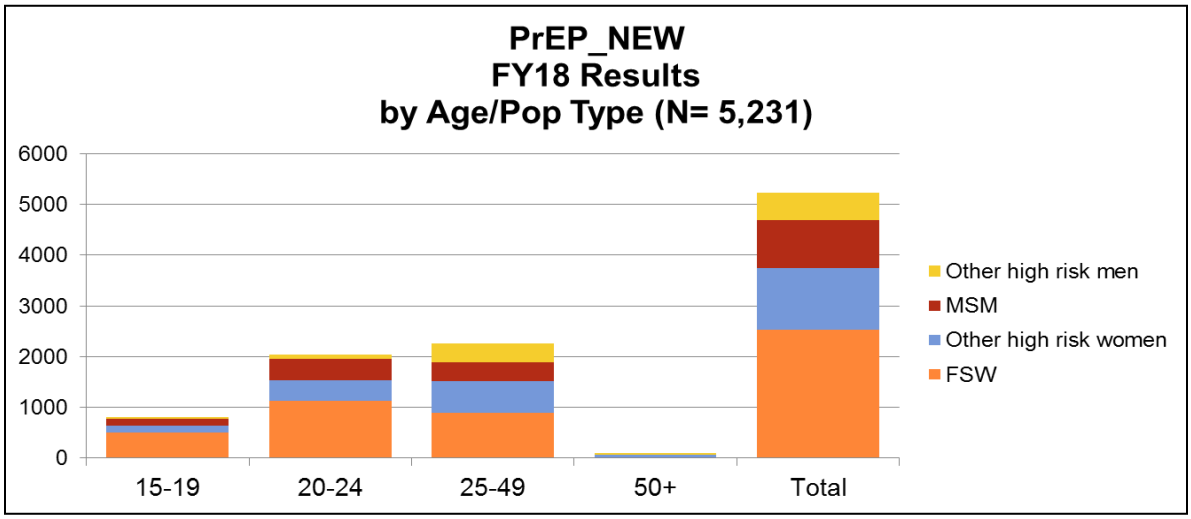
In COP 19 PEPFAR will continue to source male and female condoms and personal lubricants for distribution through public sector and program service delivery points, as well as for sale through the Protector Plus social marketing program. In addition to the $4.3 million provided through the Central Commodity Fund, more than $700,000 was made available for condom procurement and packaging through the COP 19 budget. Accumulated revenue from the Protector Plus program in FY 18 will be leveraged to fund shortfalls in basic operating costs for Protector Plus (due to projected significant decrease revenue as a result of RTGS devaluation), limited demand creation focusing on AGYW and their sexual partners, and to technical assistance to address regulatory impediments to market growth, ownership, stewardship and sustainability of Protector Plus. Finally PEPFAR will work closely with the MoHCC and the National Condom TWG to mobilize alternative funding for condoms, including domestic sources, beyond COP 19.

a. Pre-exposure Prophylaxis (PrEP) for Priority Populations

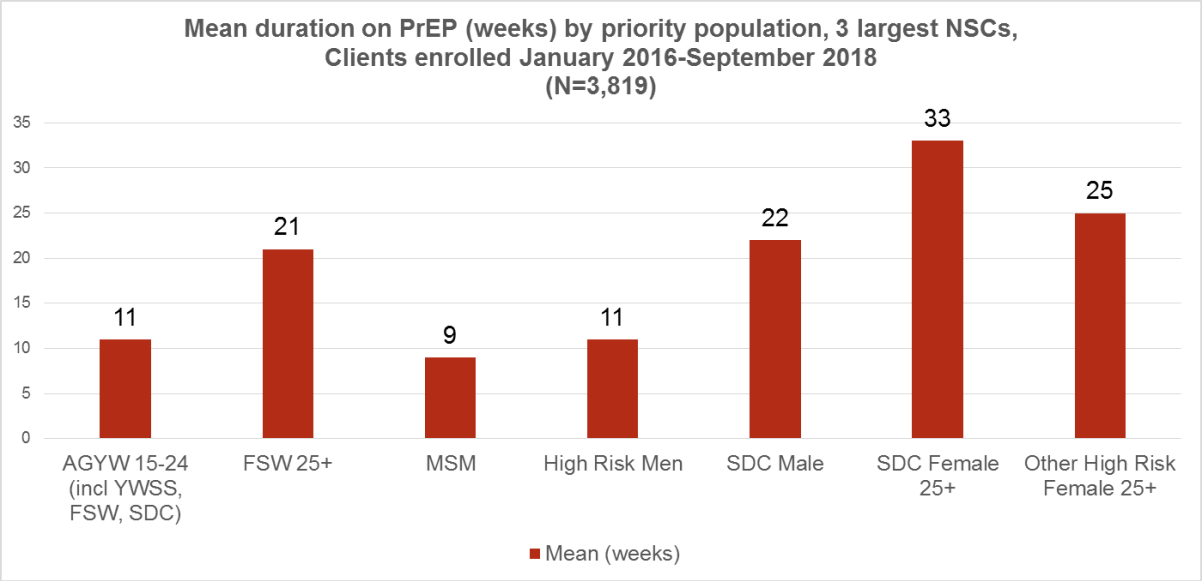
As of December 2018, approximately 7,000 individuals had enrolled in PrEP since the program was launched two years ago, with PEPFAR results contributing to more than 90% of all enrollments. Twenty eight sites were offering PrEP in 50% of provinces nationwide including New Starts Centers, Gender-Based Violence (GBV) clinics, public sector sites, Family Planning (FP) clinics and youth drop in centers. The National PrEP Implementation Plan (2018-2020) identifies the following priority populations for PrEP: female sex workers (FSW), sero-discordant couples (SDC), men who have sex with men (MSM), AGYW 15-24 and pregnant and breastfeeding women. Currently the total annual target is approximately 10,500 enrollments.

To date PEPFAR support for PrEP rollout has concentrated on AGYW (as part of DREAMS), FSW and MSM (as part of the KP program). The program reached 190% of its FY 18 target as a result of increased uptake among MSM, FSM and other high risk women in particular.





Despite improved uptake of PrEP among priority populations, continuation remains a challenge, with many (especially younger men and women), starting and discontinuing PrEP within the first 1-2 months. Duration on PrEP also varies by sub-population, with MSM staying on PrEP for less time, while SDCs and other high risk (non FSW) females 25+ stay on PrEP longer. These program findings point to the need for innovations and customized service delivery and retention approaches that meet the needs of different populations.

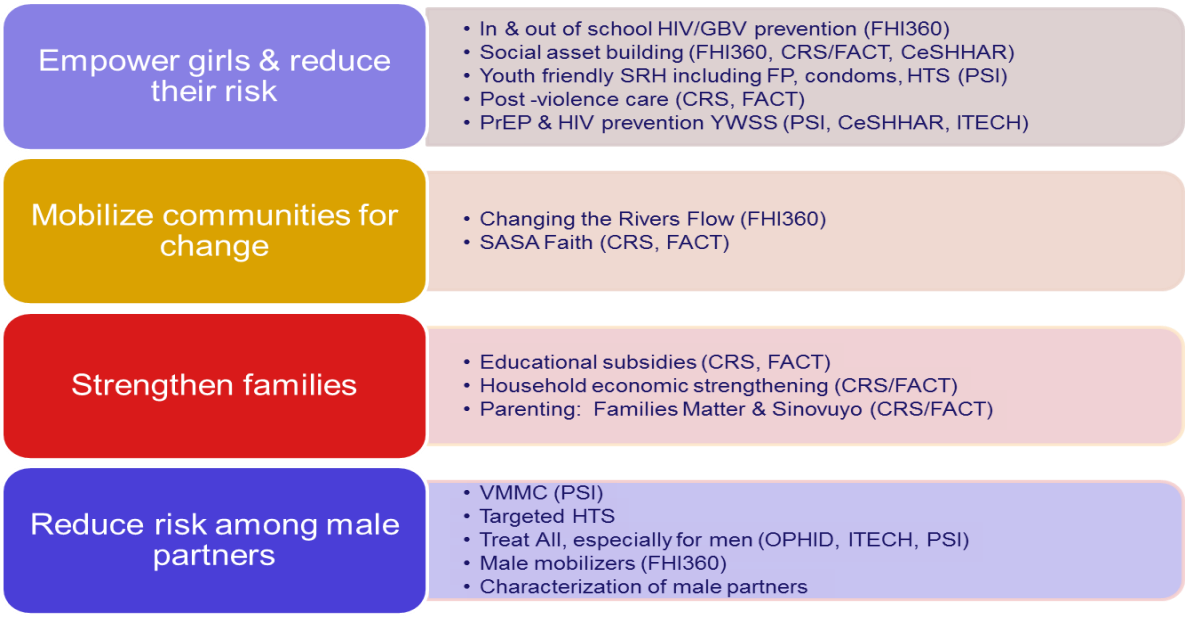


In COP 19 PEPFAR will expand PrEP for priority populations, increasing the overall PREP_NEW target to 8,239 (78% of the national target and a 64% increase from COP 18). PEPFAR will continue to expand coverage among KP and AGYW and support service delivery for SDCs, pregnant and breastfeeding women in eight focus districts. The COP 19 strategy for PrEP is summarized in the graphic below.

Continue what's working	• Mixed approaches to service delivery • PrEP champions • Integrated demand creation, service delivery & adherence
Expand services through public sector	• SDC, pregnant & breastfeeding women, high risk AGYW & older women in 8 districts
Targeted demand creation	• V for AGYW, support MOHCC HIV Communication Strategy for PrEP, expand networking approaches for AGYW
Explore DSD models for PrEP	• Community distribution *integrated with adherence* support using lay cadres or CBOs for groups less likely to access public sector - KP & AGYW
QI	• For services targeting adolescents and to understand factors contributing to PrEP discontinuation & risk
Leverage GF investments	• For commodities & FSW service delivery through SW clinics

b. **HIV Prevention for Adolescent Girls and Young Women (DREAMS)**

Zimbabwe is currently implementing the full DREAMS package (shown in the figure below) in six districts: Bulawayo, Chipinge, Gweru, Makoni, Mazowe and Mutare.



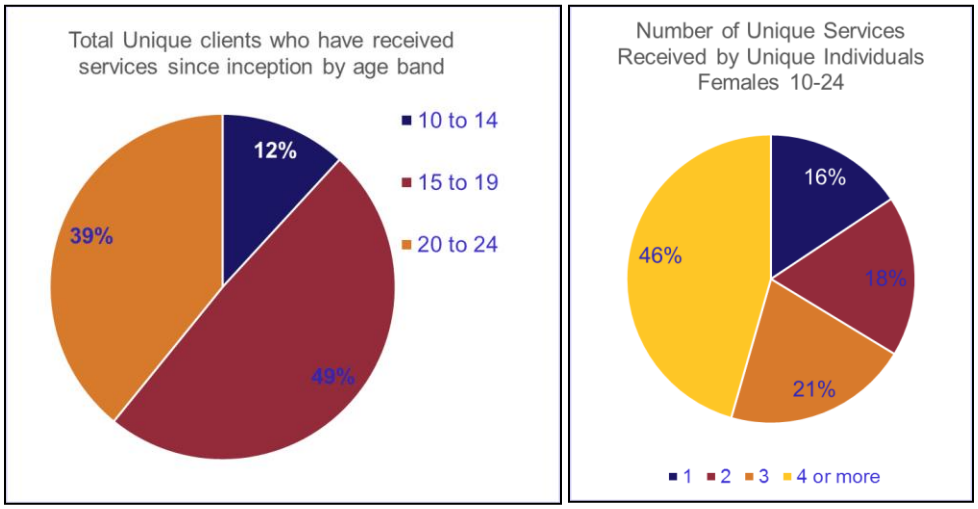
Vulnerable AGYW targeted through DREAMS include young women selling or trading sex (YWSS), out-of-school girls aged 15-24 years, GBV survivors, OVC and their caregivers. In addition, comprehensive sex education (CSE) programs reach both girls and boys in primary (begun in FY 19) and secondary schools. Regardless of the entry point, AGYW are assessed for risk and referred for other DREAMS services according to minimum service packages defined by sub-population, using standard tools and referral procedures. The program employs a DHIS-2 database with a unique identifier code (UIC) system to track individuals, and layered services and referrals which provide visibility into strengths and weaknesses in the program. In COP 19, the DREAMS database will be further refined to track completion of DREAMS by sub-population and improve active follow up of AGYW by introducing a new SMS functionality.

DREAMS is coordinated by the NAC structure at the national, provincial and district levels, to ensure broad participation by the different sectors, service providers and stakeholders. PEPFAR supports DREAMS Coordinators at the central levels of the MoHCC and NAC whose strong leadership has been essential for coordinating a complex, layered program, and advocating for the expansion of DREAMS activities. PEPFAR is supporting knowledge transfer through the sharing of systems, guidelines and tools to stakeholders and partners implementing "DREAMS-like" activities with Global Fund assistance. In COP 19 this collaboration will continue and deepen to include joint technical reviews and technical consultation, particularly in the areas of approaches to the prevention of sexual violence and HIV and M&E.

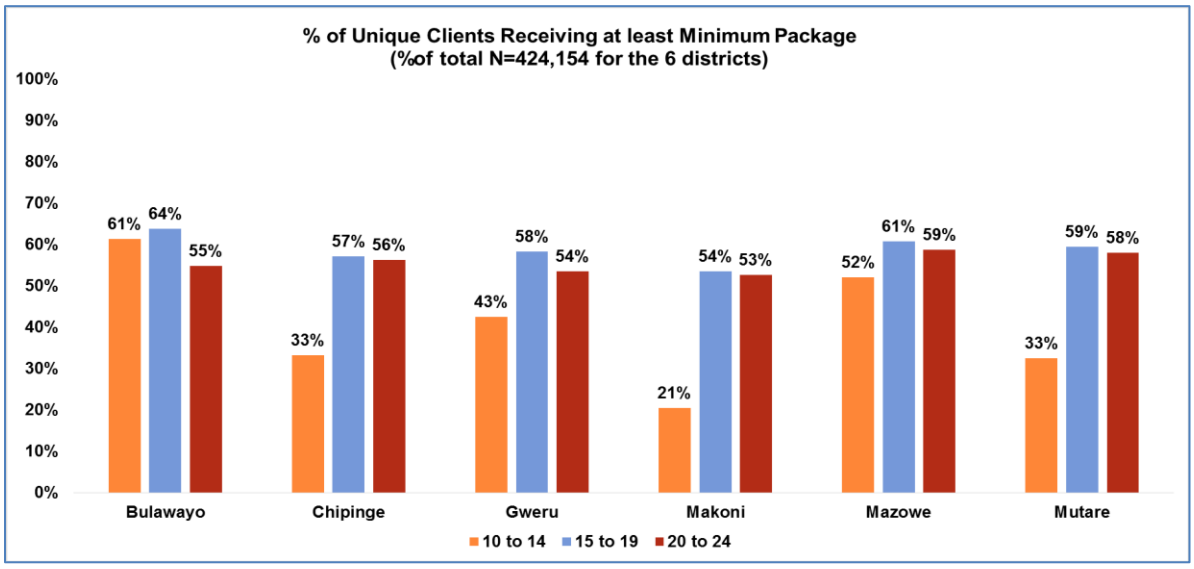
PEPFAR employs a standardized approach to partner management in DREAMS. PEPFAR reviews DREAMS performance data, against custom and MER indicators, on a monthly basis, and layering data quarterly. The MoHCC facilitates monthly DREAMS partner meetings at a national level to review progress and address implementation challenges. At the district level, NAC coordinates

quarterly review meetings and the PEPFAR Point of Contact (POC) partner (two IPs share POC responsibility for three districts, each) coordinates bi-weekly referral meetings and monthly implementation meetings.

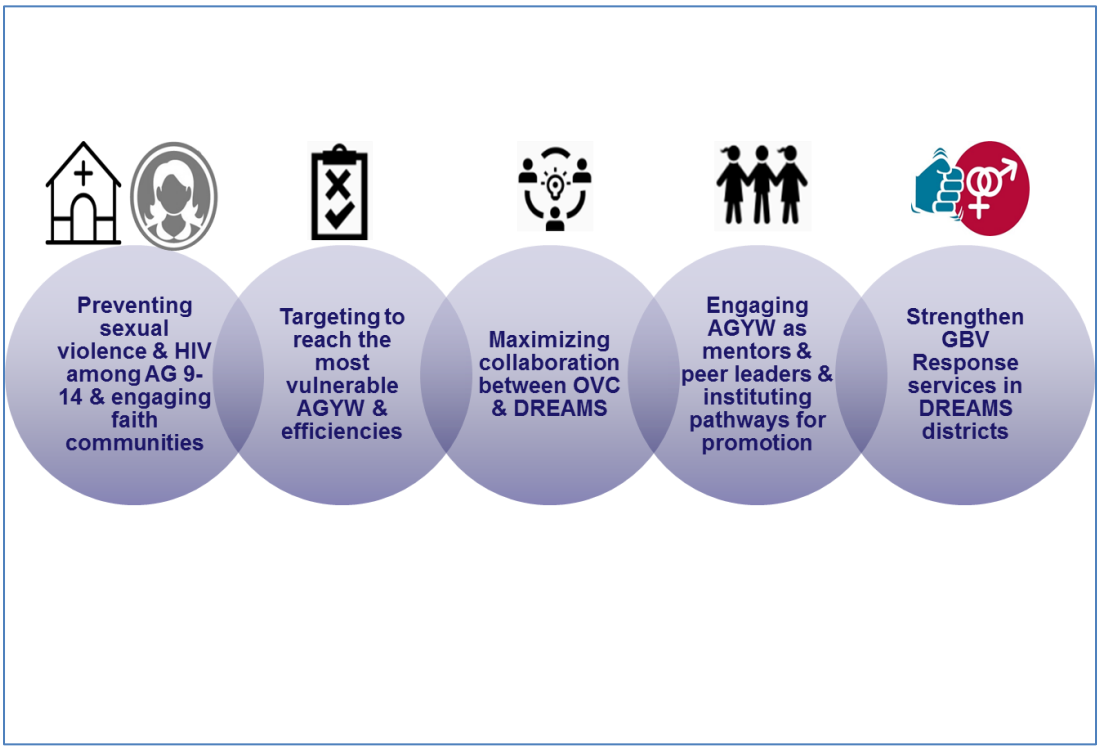
As of FY 19 Q1, more than 424,000 AGYW 10-24 years had been enrolled in DREAMS and 67% had received three or more services.



In COP 19 PEPFAR will monitor completion and saturation data and continue to refine targeting strategies to ensure the most vulnerable AGYW are identified and access critical prevention services. As of FY 19 Q1 the majority in the 15-19 and 20-24 year age groups had received the minimum package of DREAMS services as defined by broad age group (see figure below). The proportion of AG 10-14 completing at least the minimum package is comparatively low and is a reflection of the limited focus on this age group prior to COP 18. Coverage of the minimum package among AG 10-14 will increase in FY 19 following the enhanced emphasis on prevention of sexual violence and HIV for girls 9-14 years and the expansion of CSE into primary schools.



COP 19 priorities in DREAMS are summarized in the figure below.

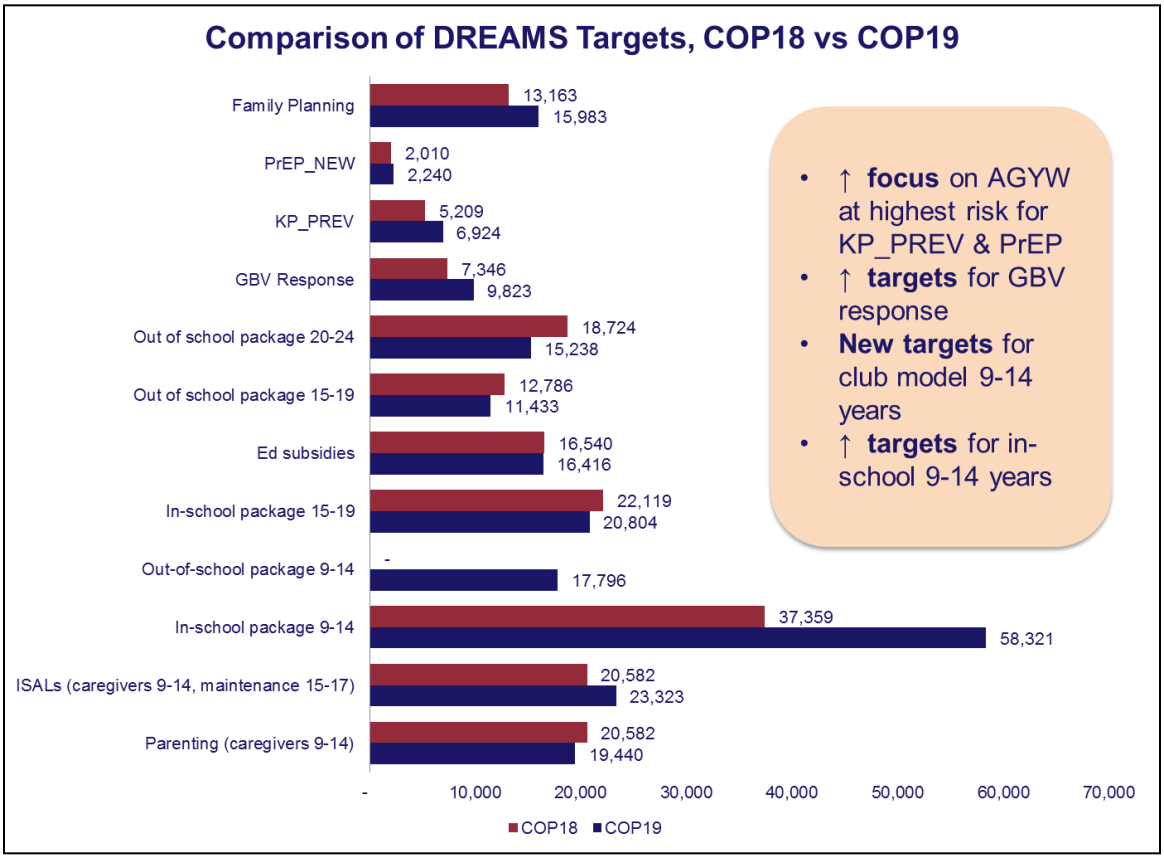


COP 19 priorities and key directional shifts for DREAMS include:

- Creating a learning platform and standardizing approaches for sexual violence prevention across OVC/DREAMS partners; aligning with the FBO initiative to strategically engage faith communities; scaling up SASA (meaning "Now!" in Kiswahili, an intervention to reduce GBV and HIV infection among women). Supporting curricula review, rolling out PEPAR modules, and updating SOPs and program documents as needed.
- Continuing expansion of DREAMS to primary schools, including the 72 Hour GBV Desk model, and expanding the out-of-school club model to AG 9-14 years.
- Revitalizing strategy of identifying out-of-school AG, using multiple approaches to address barriers, focusing on high risk and hard to reach areas and implement solutions with FBOs/communities of faith to return AG to school, including access to non-formal education.
- Downscaling targets for parenting (Families Matter Program, Sinovuyo) of AG 15-17, in favor of increasing scale among caregivers of AG 9-14.
- Developing a SOP that defines the role of peer leaders and promotion opportunities in DREAMS and implementing a leadership, network building and advocacy component for motivated DREAMS participants who reach completion but wish to continue to work on DREAMS issues in their communities.

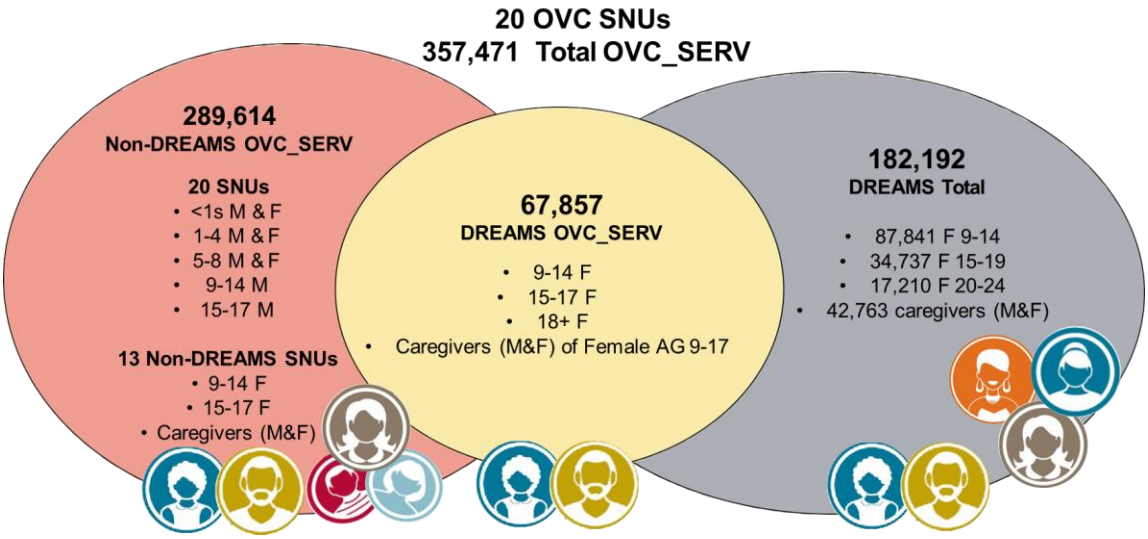
- Strategically aligning violence prevention and response activities, targeting hot spots and leveraging the FBO initiative to engage faith communities and traditional courts. Training service providers (clinical and community) in clinical and routine enquiry, expanding the One-Stop Center model for post violence care to Mutare district, supporting the use and roll out of the GBV Quality Assurance Tool.
- Expanding use of social networking approaches to identify high risk AGYW and utilizing DREAMS Ambassadors to risk assess and manage referrals to other DREAMS services. Targeting AGYW who demonstrate care seeking barriers with outreach services for SRH, PrEP, HTS, while expanding KP friendly services and PrEP into the public sector for sustainability. Strengthening PrEP demand creation targeting AGYW and use of PrEP Champions, microplanning and other strategies to support retention. Actively linking all HIV positive AGYW will continue to be actively linked to ART and to CATS for adherence and retention support.
- Encouraging the full range of Embassy partners to consider employing DREAMS AGYM in USG supported programs to provide additional income generation opportunities for DREAMS AGYM, as well as a positive example that will encourage participation of younger AGYM.

COP 19 DREAMS targets, reflecting the strategic shifts from COP 18 described above, are shown below:



Activities that reduce the risk of HIV acquisition among male sexual partners and onward transmission of HIV to adolescent girls and young women will continue to be fundamental in DREAMS districts. The DREAMS core package includes community norms change activities to increase understanding and engagement on sexuality, gender and masculinity, sexual and reproductive health, violence, and positive parenting among traditional and religious leaders. PEPFAR will continue to engage adolescent boys, who participate, per MoPSE guidance, in the general assembly and teacher-led classroom CSE sessions in schools, through school and community-based VMMC mobilization platforms, and through the OVC program. In COP 19, leveraging on the FBO initiative in selected districts, PEPFAR will introduce Coaching Boys to Men. Male mobilizers coordinate Men's Wellness Days which include community dialogues, health information and delivery of HTS, VMMC and STI screening services (provided by the MoHCC and implementing partners). PEPFAR will continue to use program data to understand the demographic characteristics of men who test HIV positive, as well as the type of partnerships/relationships they engage in, and venues where they can be reached with services.

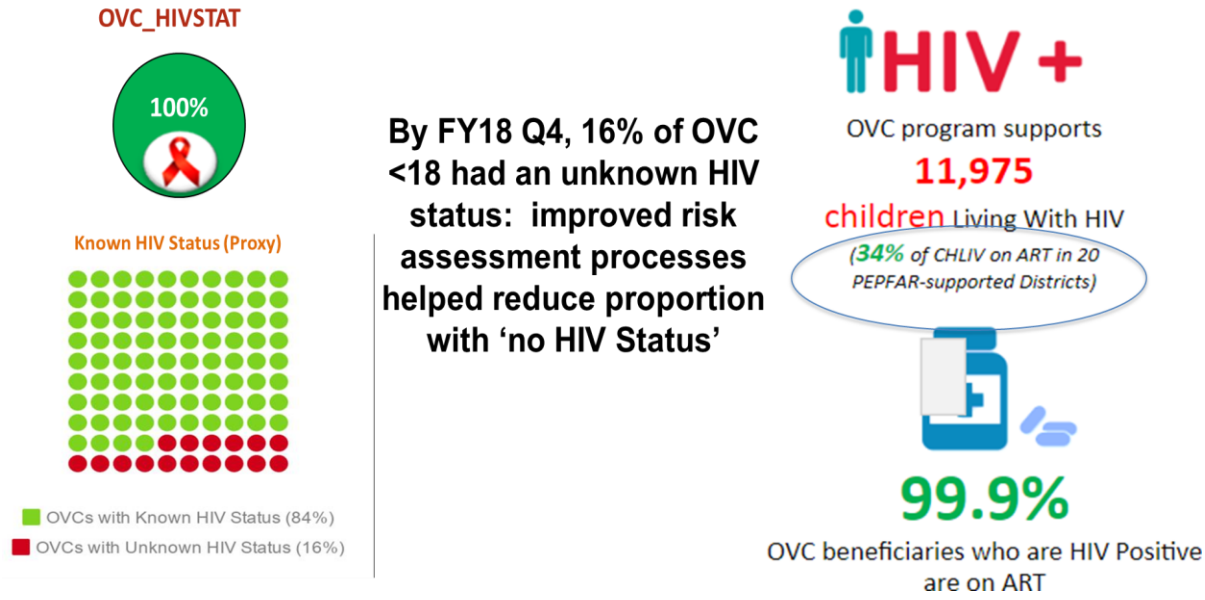
In COP 19 DREAMS will continue to leverage the OVC platform to ensure vulnerable female OVC access the full DREAMS package and AGYW (including their young children) identified through other DREAMS entry points access OVC services as required. Key collaborative activities in COP 19 include continued joint planning, implementation, and monitoring of DREAMS-OVC activities; aligning approaches for sexual violence and HIV prevention for adolescents and engagement with faith communities; and improving the analysis of female sub-populations enrolled in the OVC portfolio, their needs and risks, and tracking of referrals between OVC and DREAMS services. The figure below illustrates the positioning of OVC and DREAMS targets and services in COP 19.



c. **Orphans and Vulnerable Children**

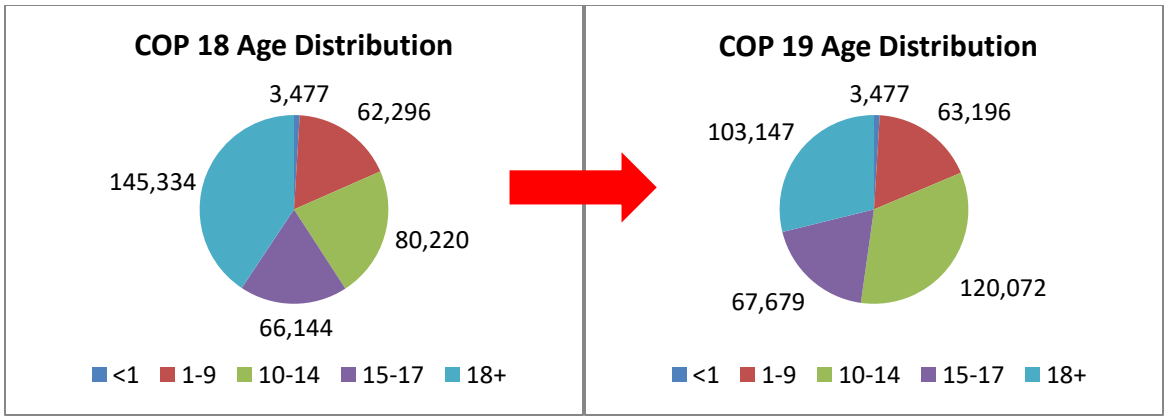
The PEPFAR OVC program demonstrated adequate performance in FY18, reaching 87% of the annual OVC_SERV target. In 2018 all partners conducted case load audits to ensure inclusion of prioritized sub-populations and fully pivot to family-centered vulnerability assessment, enrolment and case management. By FY 19 Q1, PEPFAR had reached 78% of the OVC_SERV target for the year. The COP 18 strategy includes an age pivot, shifting targets into the 10-17 year age bands away from the 5-9 year age group—a process that is still underway.

Significant progress has been made in rolling out systematic HIV risk screening, ensuring children who need testing access it, documenting HIV status, reducing the proportion of children with unknown HIV status and linking HIV+ CLHIV to ART. As of January 2019, PEPFAR had enrolled 37% of CLHIV registered in health facilities in the 20 OVC districts into the OVC program.



In COP 19 the OVC program will continue to operate in 20 of the 40 PEPFAR districts through four prime implementing partners (three local, three FBO) targeting a total of 357,471 OVC and their caregivers. PEPFAR will continue to collaborate with the Ministry of Labor and Social Welfare, MoHCC and Ministry of Primary and Secondary Education to contribute to epidemic control and ensure children infected and affected by HIV access health, education and socioeconomic support services according to their needs.

In an effort to strengthen the prevention of sexual violence and HIV for 9-14 year adolescents, the program will increase the proportion of younger adolescents enrolled in the program (while reducing the number of caregivers).



In COP 19 PEPFAR will focus on the four key strategies highlighted in the figure below:

Implementing partners will continue to use, and scale, evidence-based approaches including Families Matter, Better Parenting Plus/Sinovuyo, SASA Faith and Stepping Stones for violence prevention targeting parents and communities. A Families Matter Master Trainers program was implemented in FY 19 which resulted in five Master Trainers who will be available in-country to train new facilitators. PEPFAR will also strengthen systematic referral procedures to link adolescent boys and girls to other prevention services such as VMMC and PrEP.

Through the FBO initiative, PEPFAR will collaborate with FBOs as implementation platforms to deliver these evidenced based models, while supporting their capacity to cascade the interventions in their congregations. PEPFAR will introduce Coaching Boys to Men to expand access to sexual reproductive health information and norms change for positive masculinity, targeting boys in particular, through church youth groups. The FBO initiative will create linkages and strengthen capacity for GBV response services including systems for reporting abuse within faith communities; this will be especially critical as reporting of cases is expected to increase as a result of increased community mobilization and dialogue. Finally, at national level, PEPFAR will support the roll out of messages (drawing on Every Hour Matters) for timely reporting of sexual

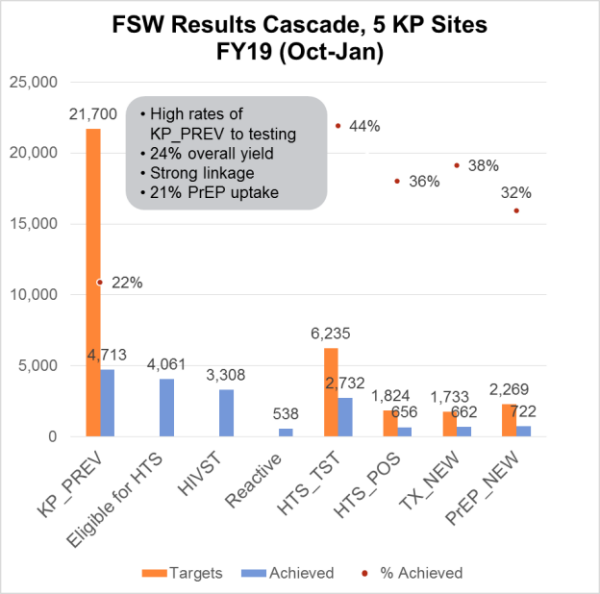
violence and provide technical assistance in Child Safeguarding policy development to FBO umbrella bodies.

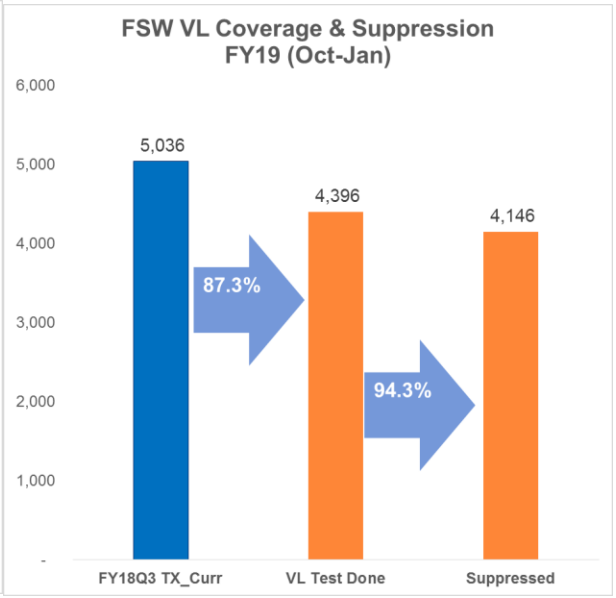
In COP 19 PEPFAR will enhance community-facility linkages for case finding, ART initiation, adherence and retention for CLHIV and increase the number of children on ART enrolled and case managed in the program. Key activities include development of an SOP to standardize service packages, roles and responsibilities of cadres, referrals and case conferencing, and data review at site, district and program level; standardizing monitoring materials and case management tools (e.g. for defaulter tracking, viral load monitoring); developing a screening tool to identify pregnant mothers and children at high risk of lost to follow up; and updating clinical messages and educational themes for OVC cadres to use with families and communities. Para social workers will continue to be supported at high volume sites to facilitate referrals, case conferencing, and coordination with other service providers at site and community level.

PEPFAR will continue to emphasize close collaboration between OVC and DREAMS programming in COP 19. OVC are a key sub-population targeted in DREAMS. Evidence-based models implemented in DREAMS (Families Matter, SASA) are being adopted and scaled throughout the OVC program and this will continue in COP 19. OVC partners who are also DREAMS partners are adopting the layering and coordination approaches in other OVC districts. Additional key activities include: joint planning, implementation and monitoring; adopting a common DHIS2 based database for all OVC partners; employing DREAMS M&E good practices for tracking referrals and layering; standardizing models for sexual violence prevention (including roll out of the PEPFAR Sexual Violence Prevalence Modules); and expanding opportunities for joint capacity building and learning.

d. **Key Populations**

PEPFAR investments to reach, test, treat and retain FSW in HIV and SRH services are yielding strong results and the program is on track to meet COP 18 targets as demonstrated in the charts below.



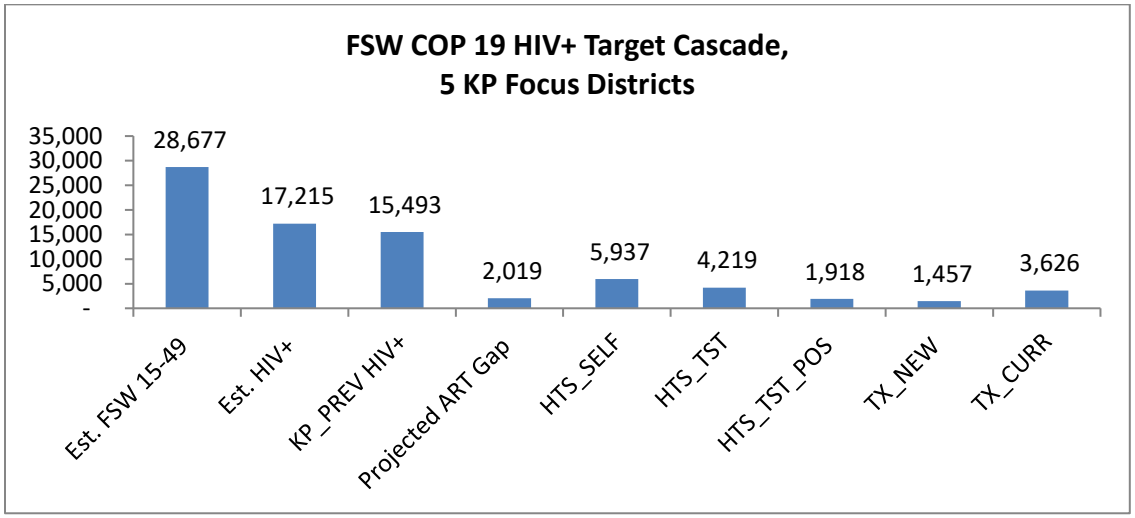


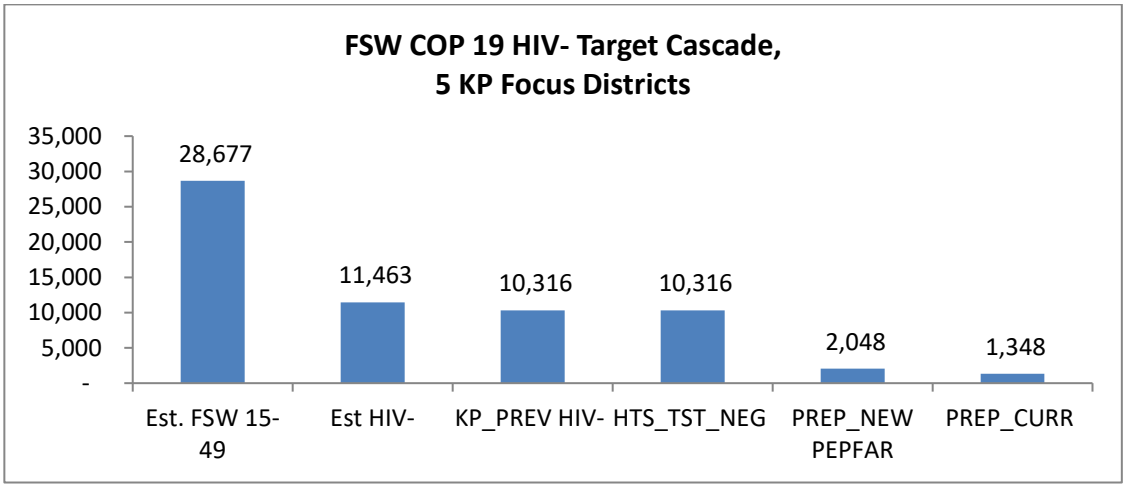
A variety of entry points including outreach, social networking, peer educators and mobilization to promote service uptake at KP friendly locations are utilized in an effort to reach both self-identifying and 'hidden' FSWs who have had limited or no exposure to HIV services. All HIV positive individuals are enrolled at public sector facilities or New Start Centers that offer a one-stop shop for health care (testing, sexually transmitted infection services, family planning, cervical cancer, post gender-based violence care, ART, TB, and laboratory services) and receive viral load monitoring at 6 and 12 months. Continuous adherence and retention support is offered through the Sisters peer adherence support groups, which integrate both PrEP and ART. ART review attendance is above 95%, and retention at 12 months is at 90%. HIV prevention (male/female condom and lubricant distribution, risk reduction counseling, and referral for HIV/STI/SRH clinical services), is delivered through a peer education (PE) approach. PrEP is currently offered to FSW through the New Start Center network, specific public sector sites and beginning in FY 19 Sisters clinics. Linkage between community and facility services, and follow up for FSWs, a challenge in the past, has improved with the roll out of unique identifier codes (UIC) and harmonized M&E tools. Detailed SOPs that define linkages between partners, and between PEPFAR and public sector services, are under development.

Program and survey data suggest that 25-40% of FSW are less than 23 years old, with more than a quarter starting before age 20. Young FSWs report the highest numbers of unprotected sex acts with clients. HIV prevalence among young sex workers is approximately 30%, rising to nearly 80% among those over 40; prevalence rises with duration in sex work among young FSWs. Building on the work in DREAMS districts, efforts are underway to identify new and younger FSWs through an adaptation of the Sisters peer educator program specifically designed for this very hard to reach population. This effort will continue in COP 19, with the Young Sisters program in the five sites that focus on key populations.

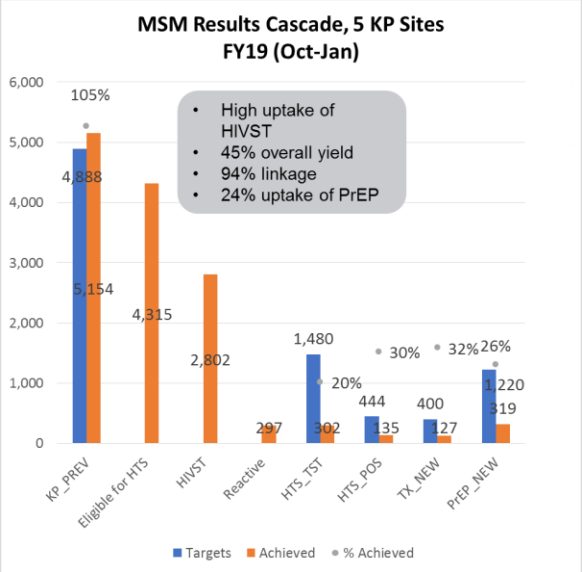
In FY 17 a FSW size estimate study was completed and the results were used as part of a consultative stakeholder process to generate urban and rural population estimates for all districts

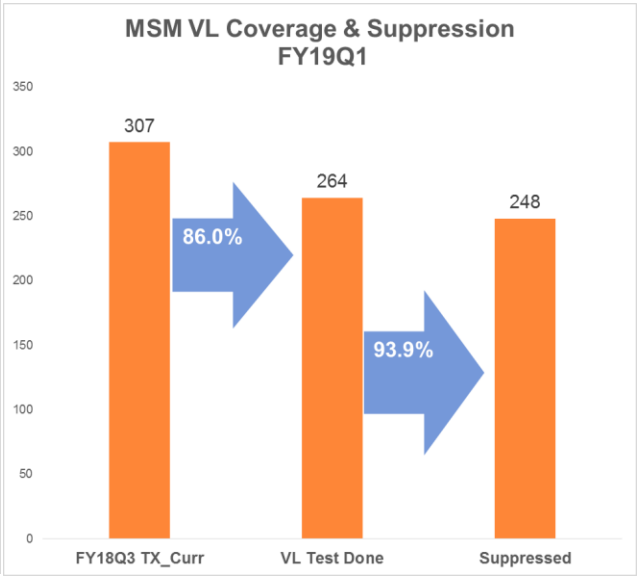
in Zimbabwe. This process yielded a 2019 national size estimate of approximately 46,000 FSW between 15-49 years. The estimated proportion of FSWs living with HIV is 54% based on the FSW size estimate study, related studies and the country validation process. Updated census and program data was used to recalibrate the number of FSW for 2020, ART coverage, and viral suppression rates in the five PEPFAR-supported locations that focus on key populations, which account for approximately 55% of the total number of FSW nationally. An additional 20% was added to the FSW size estimate to account for women who do not identify as a FSW or engage in transactional sex. COP 19 targets were set to reach at least 90% of FSWs and women engaging in transactional sex in the five locations with the goal of attaining 95% ART coverage of HIV positive FSWs and 50% PrEP acceptance for the negatives (through GF, PEPFAR or public sector). Importantly, COP 19 targets also assume full achievement of FY 19 targets, as well as substantial transitioning of stable FSWs on ART to the public sector in COP 19 (60% of TX_CURR cohort). COP 19 targets for PrEP were set using the PrEP Implementer's Toolkit which takes into account national and program data on population estimates, risk, acceptance and continuation on PrEP, as well as scale up patterns, cost and capacity.





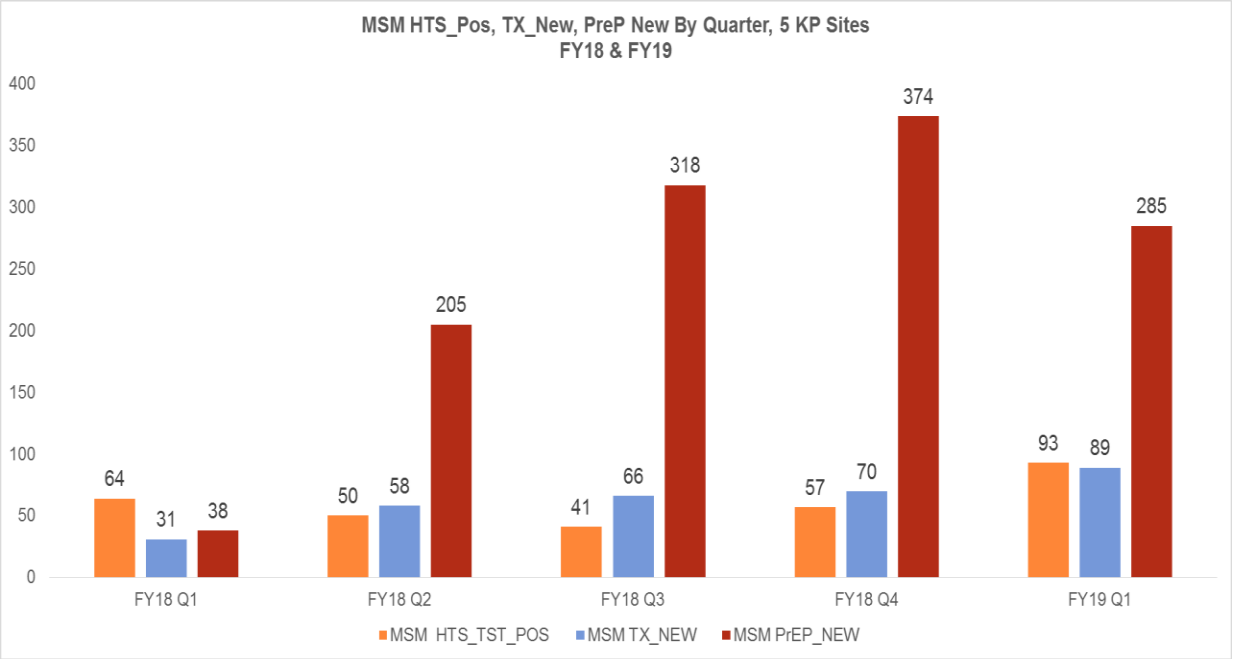
The MSM program has made great strides and is on track to meet the COP 18 targets as demonstrated in the charts below.





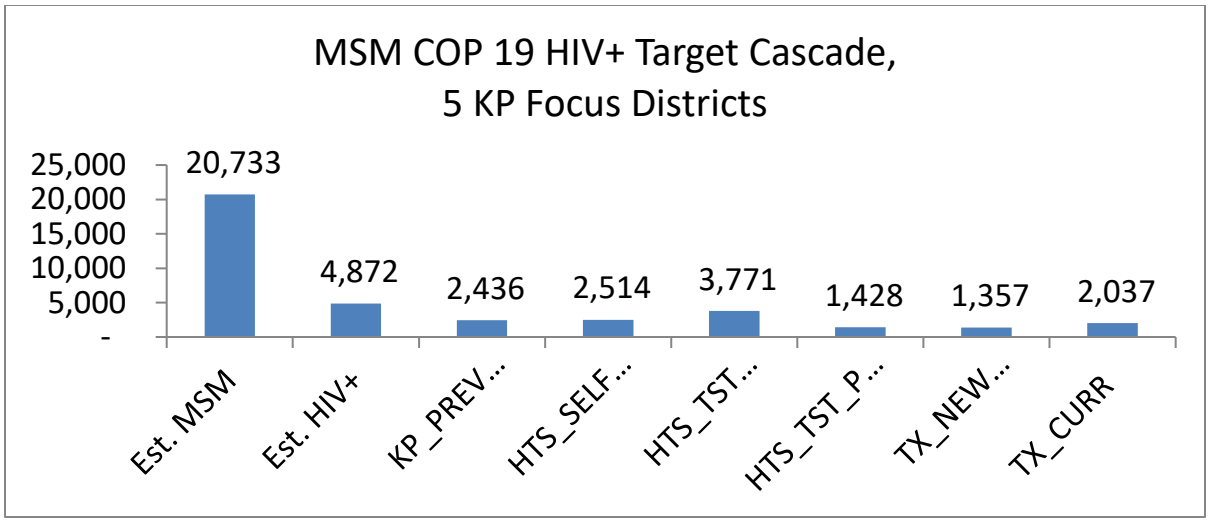
In the five locations that focus on key populations, the program is also working with local MSM partners to identify and train peer educators to conduct inter-personal communication sessions on risk assessment and reduction, condom use, and referral into HTS and other services. Condoms and water-based lubricant (procured through the Central Commodity Fund) are distributed. The use of social networking platforms, including WhatsApp and Facebook, are being explored to increase access to HIV information and services. The program is providing testing, PrEP, ART, STI management and viral load monitoring at 6 and 12 months for MSM at New Start Centers and select public sector sites. Self-testing is offered via outreach at convenient locations/times through smaller MSM gatherings. MSM on ART are encouraged to disclose their status and have treatment buddies for adherence support. MSM groups are being supported to establish community adherence activities.

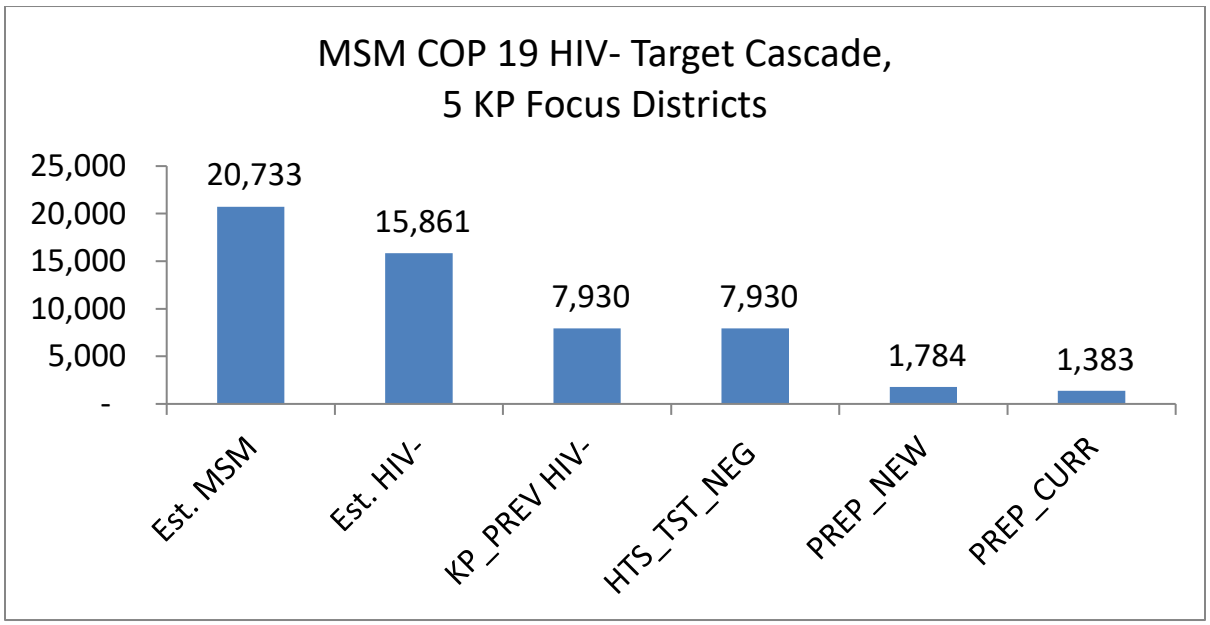
In FY 18 the program introduced the Enhanced Peer Mobilization (EPM) model that strategically identifies peer educators from specific sexual networks, provides training, and incentivizes peer education and positive care seeking behavior (clinic visits, testing, ART, PrEP) among the recipients. PEPFAR has also identified new local partners which have helped to broaden and deepen reach in the MSM communities. The EPM approach has led to an improvement in uptake of clinical services as shown in the chart below.



While PrEP uptake has improved dramatically, the average time on PrEP is lowest among MSM. This suggests either intermittent risk, low risk perception, challenges accessing PrEP or other barriers that warrant further interrogation. PEPFAR is currently rolling out microplanning to the MSM program, and adherence and retention support for ART and PrEP is a key component of the approach. Younger MSM form the majority of PrEP users which points to the ongoing challenge of low program reach among older MSM. PEPFAR is currently intensifying efforts to recruit new and older MSMs and to support partners to strengthen age-specific, targeted programming.

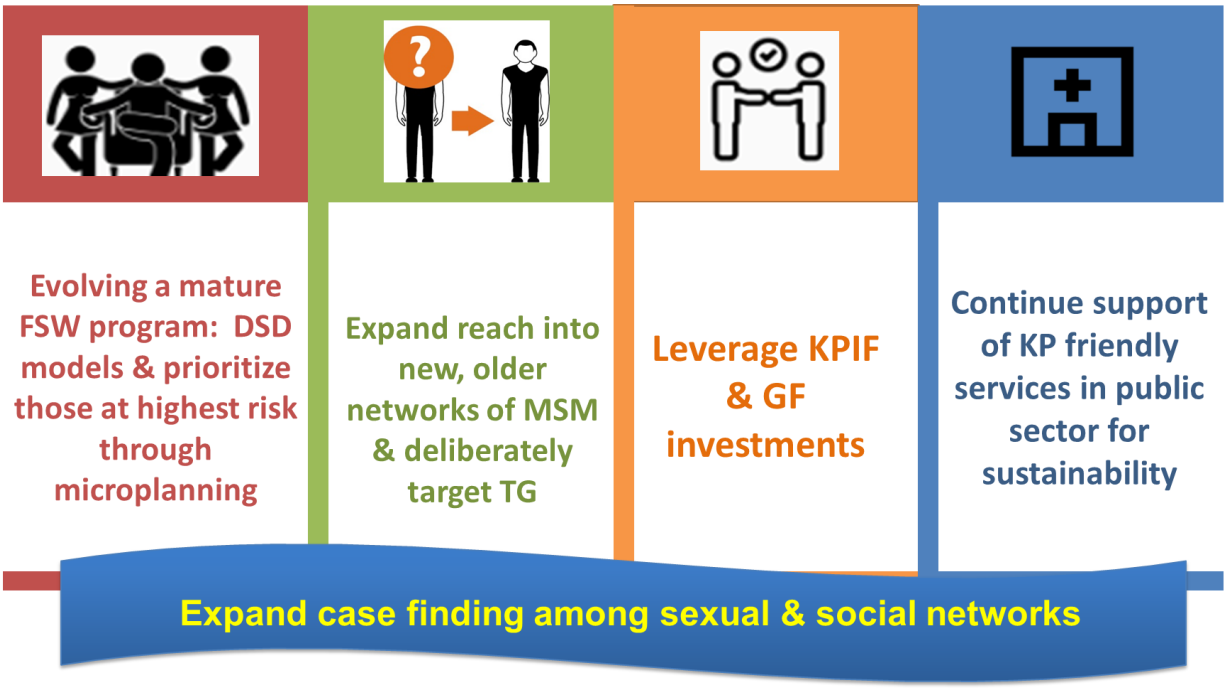
A PEPFAR-funded MSM size estimation is currently underway with results expected by September 2019. For the purposes of COP 19 planning, it was assumed that 1.5% of males 15+ are MSM. HIV prevalence among MSM is estimated at 23.5% based on 2013 unpublished research. An estimate of the ART gap among MSM in five sites was generated assuming the FY 19 TX_CURR target will be met. The COP 19 target for TX_NEW assumes identification of 75% of HIV positive MSM (within the 50% reached by the program), 95% linkage, all ART initiation at PEPFAR supported sites, and transition of 20% of the current TX_CURR cohort to KP friendly public sector sites in COP 19. The COP 19 PrEP target was set using the PrEP Implementer's Toolkit which takes into account national and program data on population estimates, risk, acceptance and continuation on PrEP, as well as scale up patterns, cost and capacity.





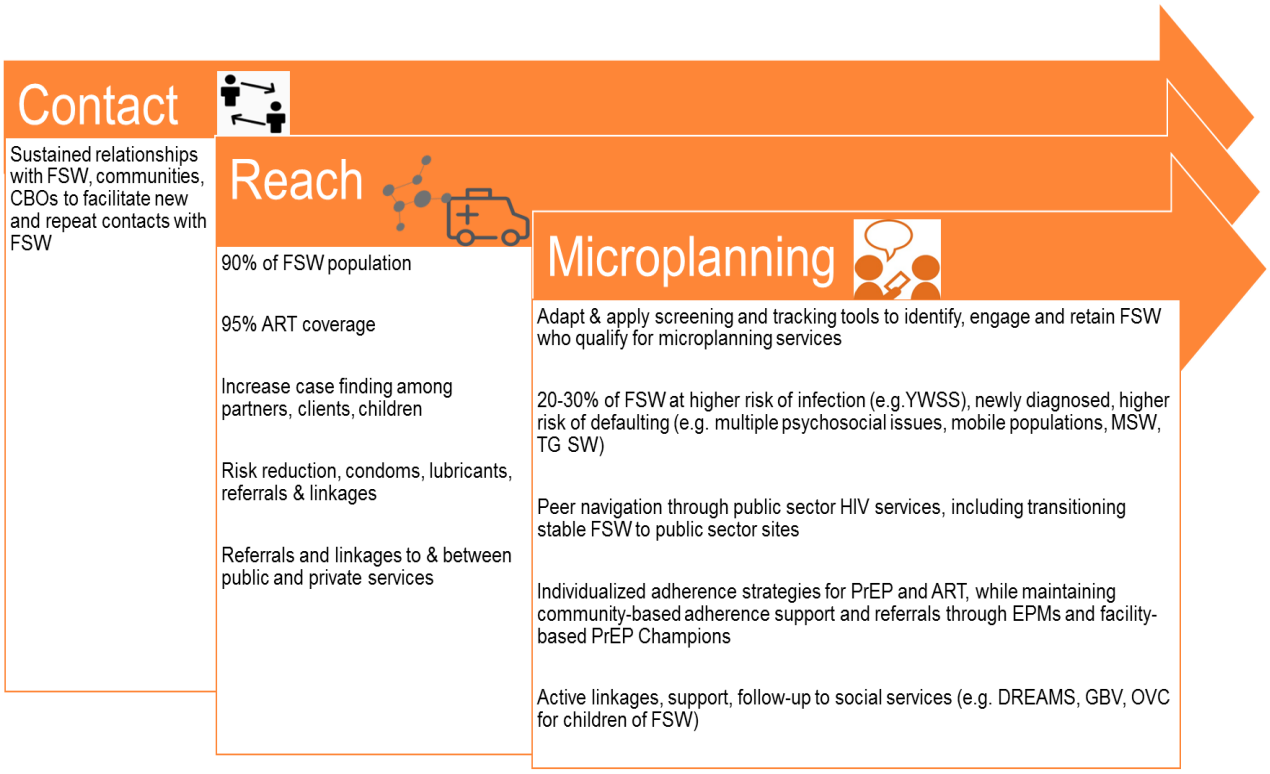
PEPFAR will begin reporting on the disaggregates for male sex worker (MSW) and transgender (TG) in COP 18 as the program is beginning to reach these populations. In COP 19 PEPFAR will engage stakeholders to use available information to estimate the size of the transgender (TG) population, at which time program targets and tailored interventions will be developed.

In COP 19 PEPFAR will continue to pursue a saturation approach to reach, test, treat and retain key populations in the five largest urban cities of Harare, Bulawayo, Gweru, Mutare and Masvingo, focusing on the four key strategies highlighted in the figure below.



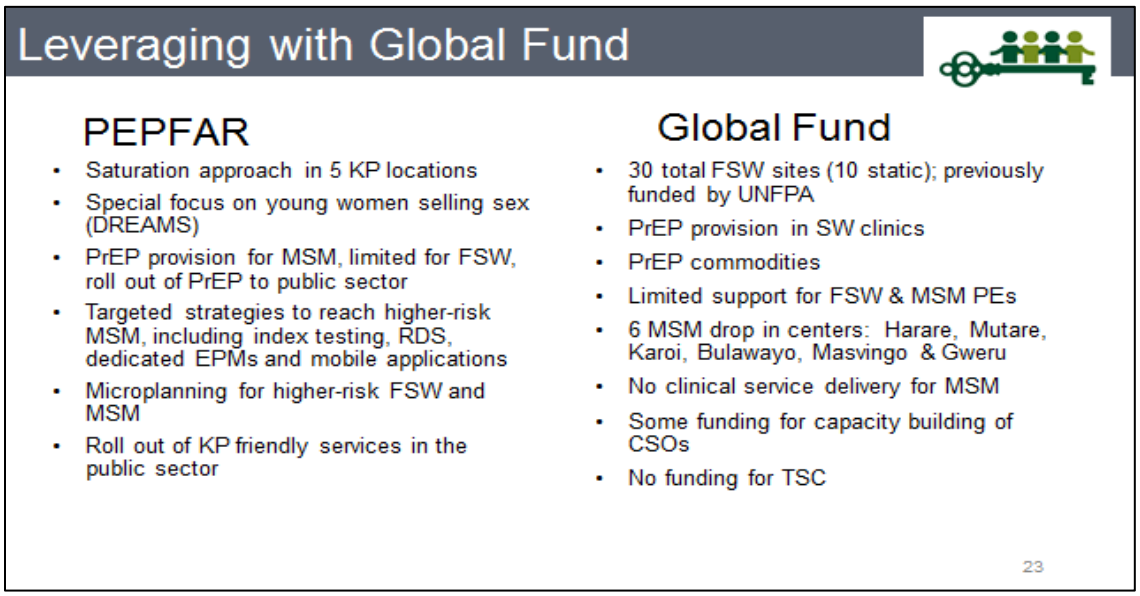
PEPFAR will continue to roll out differentiated models of care for key populations. Having different approaches is fundamental because meeting key populations where they are and with whom they trust is a cornerstone to engaging and keeping them in care. The types of services, frequency and location will also vary between FSW, MSM and LGBTI groups.

Key highlights of the COP 19 strategy for FSW include:



Key highlights of the COP 19 strategy for MSM are shown in the figure below:

As in past years, in COP 19 PEPFAR will continue to work closely with the Global Fund to leverage investments for key populations and ensure activities are complementary and not duplicative.



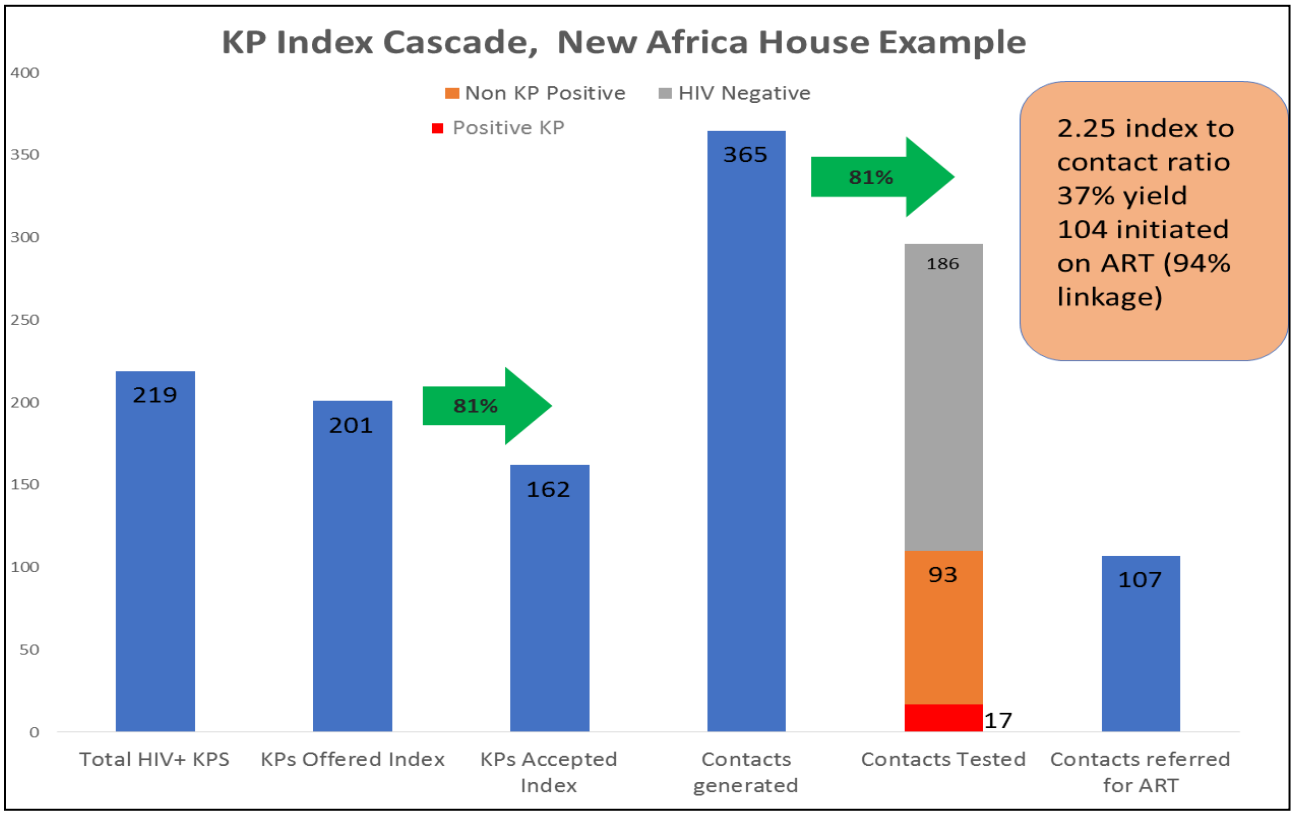
With a view towards sustainability, PEPFAR is currently supporting 30 public sector facilities in the five focus sites to offer KP friendly services. In FY 18, under the leadership of the MoHCC and national TWGs, PEPFAR supported the development of training materials and job aids—based on WHO guidelines and using a consultative process that included extensive input from KP networks. Additionally a site selection tool was developed and KP led/friendly organizations played a key role in defining criteria and identifying sites. In FY 19 Q1 provider trainings were conducted, led by MoHCC, PEPFAR IPs and KP led/dedicated CBOs. Stable FSW will begin to be transitioned to public sector facilities in June 2019 following development and implementation of a certification process for targeted facilities. Clients who are uncomfortable with the transition to public sector health services will not be forced, and care will be taken not to expose key populations to unnecessary risks to their health and security. Going forward partners will conduct monthly reviews of referrals between partners and the public sector. Efforts are currently underway to develop data collection and reporting tools, building on the existing UIC system used in the DREAMS and KP programs, that will allow for referral tracking between partners and sites, as well as more accurate reporting of results between PEPFAR and Global Fund.

In COP 19 PEPFAR will continue to support KP friendly services in the initial 30 public sector sites; expansion to additional sites is not planned until proof of concept is demonstrated. The following activities will be continued in COP 19:

- Build the capacity of health care workers in selected sites through clinical attachments, training in values exploration, gender sensitivity, and stigma reduction.
- Ensure appropriate models of peer support are in place in all targeted facilities such as patient navigators and peer educators.

- Develop patient transition plans and employ active follow up to ensure minimal loss of patients who are stable on ART and transitioning to public sector sites.
- Use the developed national minimum service packages which are specific to type of key population.
- At each facility establish service monitoring and quality improvement committees which involve key populations themselves.
- Use standardized training materials and M&E tools for use by all sites implementing key population friendly services. Of particular importance is the ability to track and confirm referrals between community and facility service providers.

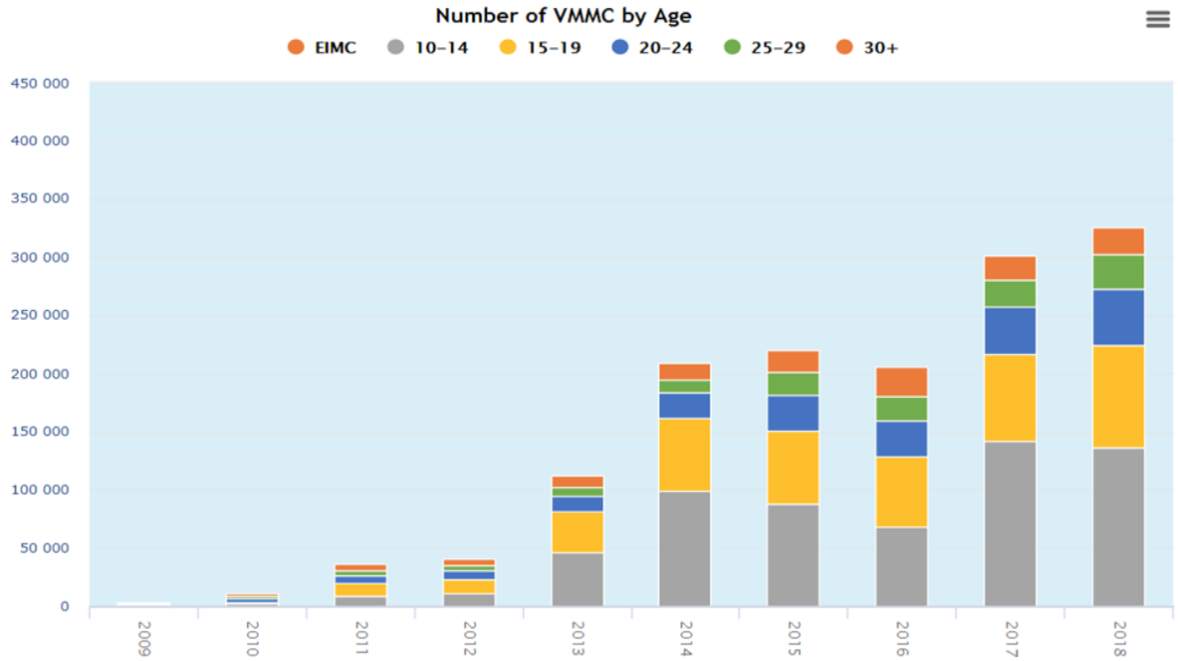
Index testing within (or originating from) key populations represents a challenge because indices often resist sharing details of sexual and biological contacts. Names and contact information of sexual partners may be incomplete or false and the contacts are often more mobile than the general population (e.g., clients of FSW). In FY 19 PEPFAR piloted a structured, social network approach to KP index testing that employed incentives for indices to 'bring a buddy' for HTS, follow up by peer supporters and community index testing for those who did not present at the facility. Initial results (shown below for one site) show promise and suggest that acceptability improves when peers participate. The Team will maximize this approach using microplanning and taken to scale in COP 19.



e. **Voluntary medical male circumcision (VMMC)**

Zimbabwe is a high impact country for VMMC and prioritizing Zimbabwean males aged 15–29. PEPFAR's strategic approach in COP 19, in support of the new national VMMC Sustainability Transition Implementation Plan (STIP; 2019 – 2021), will effectively utilize routine data at site, district and provincial levels for weekly performance monitoring of partner implementation and efficiency-focused VMMC program shifts. In COP 19, PEPFAR will collaborate with Clinton Health Access Initiative (CHAI), World Health Organization (WHO) and the Bill and Melinda Gates Foundation (BMGF) to build the capacity of the national, provincial and district level VMMC programs for decision making, evidence informed programming and strategic information.

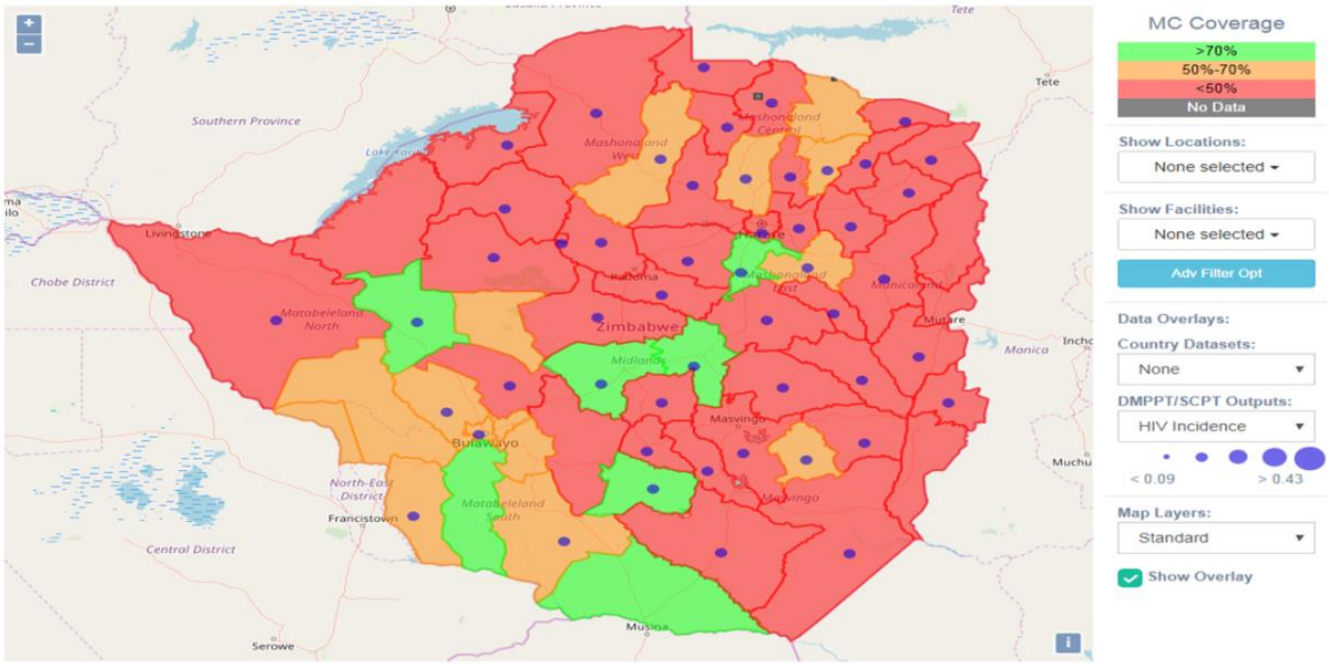
PEPFAR VMMC support started in 2009 and by December 2018, Zimbabwe had circumcised a cumulative total of 1.4 million men.



In FY 18, PEPFAR directly supported 268,495 male circumcisions in FY 18 (87% achievement towards the target of 306,144, previous year achievement was 90% of a target of 252,847). Major partner transitions/ disruptions, political unrest and the volatile socio-economic environment were responsible for the lower level of achievement in FY 18. A total of 59,652 circumcisions (19% of COP 18 target of 306,143) were conducted in FY 19 Q1, an increase from 15% in the same quarter in FY 18. PEPFAR, BMGF, and the Global Fund are the key donors supporting the national VMMC program in Zimbabwe. The BMGF continues its support for 18 more districts until the end of 2019.

In FY 18 51% of all MCs were done in the 15-29 year age group, an improvement from FY 17. PEPFAR will accelerate towards 80% coverage in all 5 year age bands (between 15-29) in the remaining PEPFAR supported districts that are either in the catch-up or scale up phase (n=13 and 19 respectively). National VMMC coverage in 15-29 year olds is estimated at 42% by the end of FY 18 (increased from 36.5% in FY 17), with significant district and 5 year age band variations. 14% of PEPFAR supported districts (n=5) are estimated to be at >80% coverage, but only 3 districts (Beitbridge, Gweru and Lupane), including one DREAMS district (Gweru), have attained this coverage in all 15-29 year olds and 5 year age bands.

These three districts will now transition to circumcising males in the 10 – 14 year age band, providing a package of services that are focused on sustaining coverage at that level, including surgical circumcisions (Dorsal Slit method) with reusable kits, locally driven and evidence informed target setting, efficient and targeted demand creation, locally driven adverse event (AE) management, provision of targeted adolescent HIV prevention messaging and transitioning of incentives from the parallel quality-based cost reimbursement approach to the national performance- based financing (PBF).



In COP 19, PEPFAR will maintain the target of 65% of all MCs done in 15-29 years old, and continue the strategic approaches to implementation that have already yielded results with the older age group (20-29 year olds) in the first half of FY 19.

In FY 18, Zimbabwe adopted the dorsal slit (DS) surgical method as the standard method of circumcision for all age groups. PEPFAR also supported the VMMC programs to collaborate with both traditional circumcisers in traditionally circumcising districts like Mberengwa and Chiredzi and FBO-led programs in select districts like Gweru and Mutare. The latter approach resulted in Mutare and Manicaland Province exceeding their targets in the same year. The strictly controlled and monitored implementation of the Harare remediation strategy also resulted in an upsurge in the proportion of MCs performed in Harare in FY 18.

Key national policy shifts and considerations in FY 20 include the transition to more sustainable and efficient VMMC programs at district and site levels with intense community, FBO, and Ministry of Education and School Health program participation. The flagship sustainability strategy of the MoHCC has been launched and is now being rolled out across all districts. PEPFAR will support the national VMMC SID, provincial, district and site level baseline assessments for sustainable VMMC service provision in FY 19 to ensure successful implementation of the strategy. This process involves site readiness assessments for provision of sustainable services, (considering the different strategic pillars) and the iterative development of district level work plans to ensure that the contextualized interventions at each district are implemented with fidelity. A repeat

exercise at the national level will be supported in COP 19 in order to measure the progress to sustainability.

The table below shows the strategic shifts in COP 19:

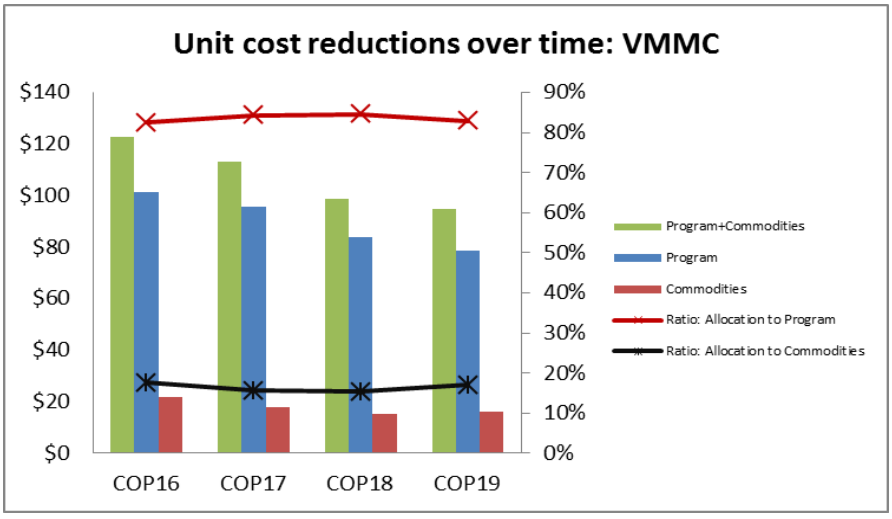
COP 18 Strategy	COP 19 Strategy
ASCOP era: focus on quantity and service provision across all districts	STIP era: focus on sustainable VMMC service provision with emphasis on evidence based decision making, 80% coverage in all districts, efficiency in service provision and ensuring quality of services
Partner performance Management was at its rudimentary stage of development, with emphasis on quarterly and annual reviews	Routine, enhanced and intensive partner performance management and oversight (weekly, monthly, quarterly), with use of accessible data systems and tools aligned to MoHCC systems
VMMC services were stand-alone, with little integration with other services and programs	VMMC services will be further integrated with HTC services and partner specific strategies to ensure linkages with other prevention (DREAMS and PrEP) and HIV treatment (linkage to treatment for HIV+) programs
Generalist HIV prevention messages provided to all males accessing VMMC services	Targeted and evidence-based VMMC and HIV prevention messaging for male adolescents and young adults
Demand creation now implemented and contextualized for district level	Data driven and targeted demand creation at district level, to engineer access to older age group (20 – 29 year olds) and districts with low coverage in those age groups.
Cost Reimbursement reduced and National Policy on Cost Reimbursement reviewed to focus on quality	PEPFAR will continue to work with MoHCC to implement the new cost reimbursement policy, with a view to eventually transitioning it into a locally driven PBF mechanism
The use of the DMPPT2 Online by the MOHCC and all stakeholders was further enhanced and utilized by the in-country team for strategic planning and COP	Ownership of the DMPPT2 Online will be transitioned to the MoHCC, and in-country stakeholders, with capacity for modelling built in-country as part of this process.
Adverse Event management was a PEPFAR implementing partner responsibility, with databases and systems for reporting managed by each individual partner and little MoHCC ownership or visibility	One System and Role Reversal: One AE management system will be developed for the MoHCC, with the support of both PEPFAR implementing partners (IPs) and CHAI. Responsibility for managing AEs will remain

	with IPs but under the stewardship of the MoHCC
Age Pivot to reach 65% for 15 – 29 year olds	Maintain Age pivot at 65% 15 – 29 year olds
2 central MoHCC led Internal Quality audits (IQAs) using the enhanced HNQIS tool	2 central MoHCC led IQAs, several district level IQAs (mandatory for district management teams under the new Cost reimbursement scheme) and 1 USAID EQA planned, using the enhanced HNQIS tool
Phased introduction of the reusable kit to 20 high volume VMMC sites in 12 districts	National roll out of the reusable kits to all districts, equipment and HR support for challenged sites

PEPFAR will continue to support capacity building to conduct national internal quality audits for sustainable quality assurance. There will be continued focus on addressing issues around infection control, informed consent documentation, adolescent client counselling, and appropriate follow-up documentation.

In COP 19, PEPFAR will maintain a target of 300,000 MCs and will leverage on the national roll-out of reusable kits, the adoption of one standard surgical male circumcision method (Dorsal slit), maintaining the proportion of surgical circumcisions, streamlining the use of disposable surgical kits to outreaches in hard to reach areas, targeted demand creation efforts.

A trend graph of unit cost reductions over a 4 year period.



In COP 19, VMMC partner performance management plans will now reflect more intensive monitoring by the USG team, as part of SIMS, continuous data reviews and quality (weekly, monthly and quarterly), performance remediation (as needed, based on bi-weekly and monthly data reviews and adverse event reporting patterns), and routine site visits to the consistently

underperforming sites to diagnose problems and institute corrective actions. Other aspects started in COP 18, including reports from TWG portfolio reviews and weekly check-in with implementing partners, utilization of weekly data from the MoHCC VMMC dashboards, DATIM and the national DHIS2, review of bi-annual national IQA reports focusing on follow-up and adverse event management indicators, will continue.

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

Program direction decisions for COP 19 based upon COP 17/18 performance:

COP 17 and COP 18 Q1 performance both indicate insufficient implementation of the iHTS model; specifically, implementing partners have been slow to aggressively scale-up facility and community-based index testing nationwide. To rectify this situation during Q3/Q4 of COP 18, the PEPFAR team worked closely with MoHCC and implementing partners on an iHTS "surge" strategy to ensure implementation fidelity. For COP 19, the PEPFAR team is committing to increasing percentages of all positives identified to come from index testing, based upon the categorization of districts as "high," "medium," or "low" ART gap. To effect this change, implementing partners will be shifting human and financial resources away from routine testing and towards index testing in lower ART gap districts.

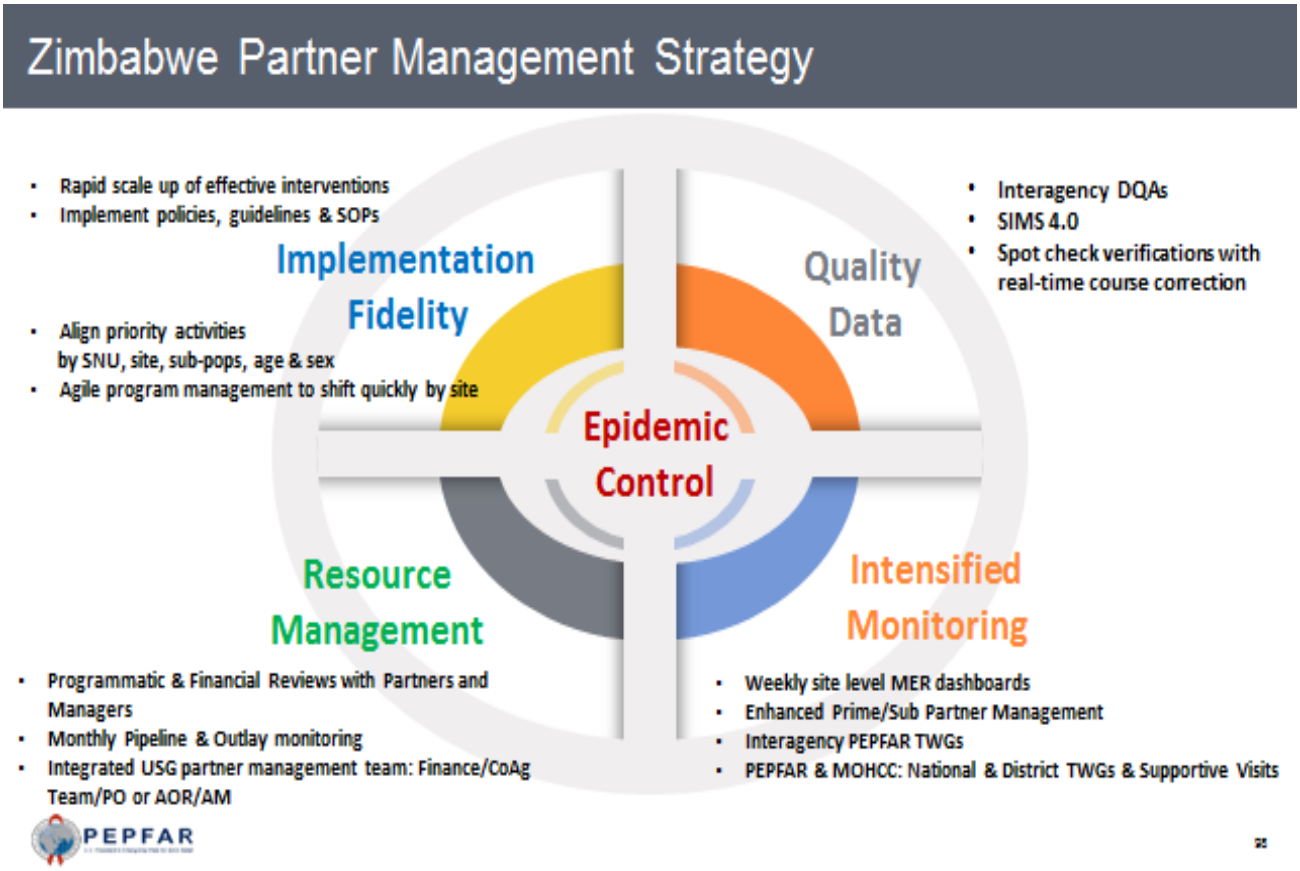
The PEPFAR team will continue to work closely with implementing partners to ensure rapid scale up of index testing with fidelity. This includes ensuring that staff in all levels of the health system understand who is prioritized for index testing and the ways a contact can be linked to the index case to be eligible for index testing. Currently, everyone newly and recently identified as positive as well as clients who do not have suppressed viral load are prioritized for index testing services. The PEFPAR team is also working with the MoHCC and implementing partners to clarify who is included under index testing, including the sexual partners of the index case and the biologic children of HIV positive mothers, as well as the biologic children of HIV positive fathers when the mother is deceased. When the index case is a child, biologic siblings and parents are targeted. The PEPFAR team is currently working with IPs to manage and supervise HRH to ensure better time management and prioritization around index testing at site and community levels. PEPFAR is also working with IPs to understand the processes and labor involved in tracing clients from sites into the community. Enhanced monitoring of the index testing cascade is also being implemented for intensified monitoring and program improvement.

Zimbabwe's national viral load coverage target for calendar year 2018 was 60% of all ART patients, but the performance was only approximately 40%. Reasons for this shortfall include inadequate reagent procurement, inefficiencies in sample collection and processing at the clinical facility-level, inadequate demand creation, and lack of coordination in sample transportation from facilities to laboratories. In COP 19, PEPFAR Zimbabwe has increased its commitment to VL reagents by more than 60%, and the team is also working closely with the Global Fund to ensure that their reagent commitments also increase in accordance with the gap. PEPFAR is also

coordinating specimen transport support closely with the MoHCC and Global Fund, such that funding streams and implementation are geographically complementary and similarly costed to maximize efficiency. The PEPFAR team will implement demand creation efforts in concert with local civil society organizations in order to maximize impact and reach among the community, and facility-based partners will provide TA to clinical providers to increase efficiency and effectiveness in VL specimen collection.

TB Preventive Therapy (TPT) has been a part of MoHCC's national HIV guidelines for several years, but implementation has lagged behind for various reasons. COP 17 performance was no exception. Some providers doubt the efficacy of TPT and weaknesses in the diagnostic cascade result in provider concerns about unwittingly prescribing TPT in the case of undiagnosed active disease. Patients have concerns about side effects,issues related to stigma, and often do not appreciate the importance of TPT when they are otherwise asymptomatic. Finally, national procurement of TPT stocks has not kept pace with a significant acceleration in TPT coverage. In COP 19, PEPFAR Zimbabwe is making an unprecedented commitment to TPT scale-up, with over $3m allocated for commodity procurement aligned to a target of nearly 400,000 eligible PLHIV being treated with either INH/pyridoxine or 3-HP. Furthermore, PEPFAR partners will contribute site-level support to increase familiarity and confidence among providers, and above-site support to disseminate guidelines, sensitize communities, and improve adverse event reporting (pharmacovigilance).

To address and monitor partner performance, the PEPFAR Zimbabwe team has instituted an intensive Partner Management Strategy as indicated in the below figure to monitor performance on a weekly basis in collaboration with the MoHCC to ensure implementation fidelity. The PEPFAR solutions platform will also be utilized as a resource to scale promising interventions.

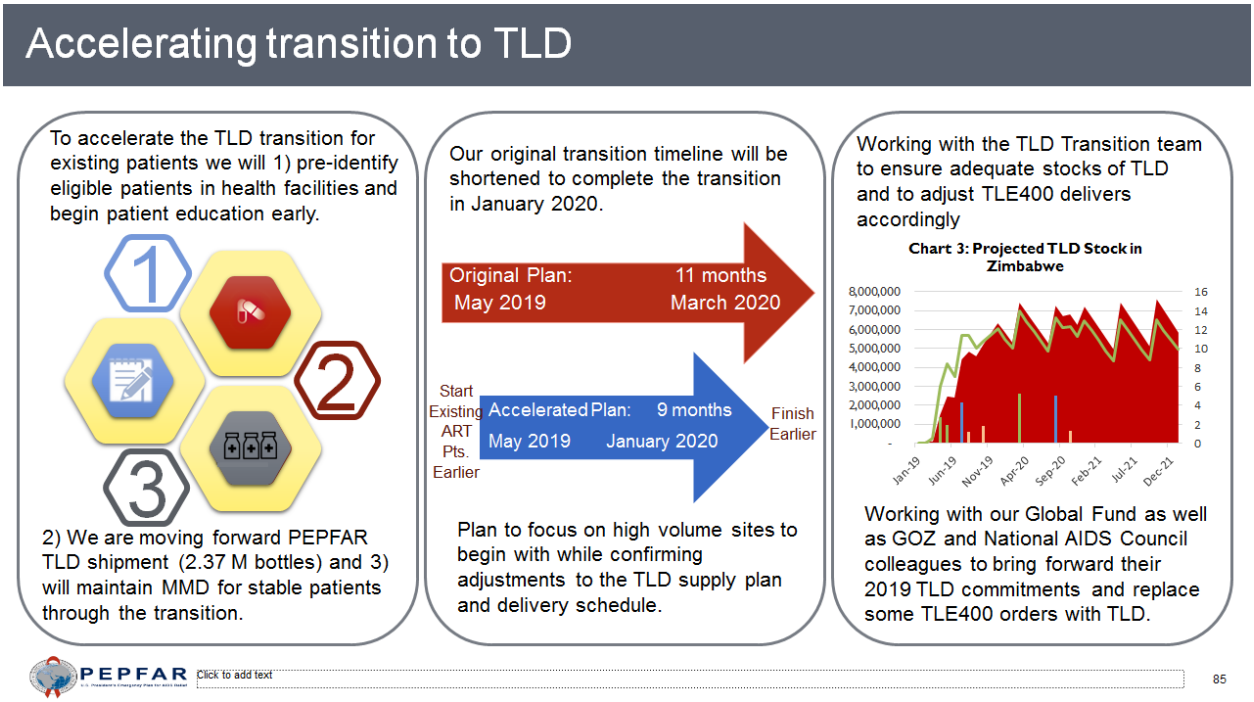


4.4 Commodities

PEPFAR continues to provide critical support for commodities as well as direct service delivery and technical assistance to Zimbabwe's national supply chain management and distribution systems to ensure that these essential life-saving medicines and products are available in health facilities. In light of the current and deteriorating economic situation, particularly the fuel crisis, this vehicle and distribution support has been particularly critical.

Zimbabwe is working to close the gaps across geographic and age/sex bands in order to achieve the 95-95-95 targets by the end of COP 19. Adequate stocks of ARVs, RTKs, VL reagents, and other critical commodities is an essential component to being able to achieve this goal. In addition, Zimbabwe is embarking on the TLD transition in the next few months. ART naïve patients will begin to transition in May 2019 and, to accelerate the transition overall, existing ART patients will begin to transition in June 2019. The goal is to complete this transition by the end of January 2020. In order to achieve this accelerated transition the team has moved up the second PEPFAR TLD order to arrive in April 2019 instead of late May 2019. We are also coordinating closely with the Global Fund to move forward their TLD shipments to ensure adequate stocks in country to support the accelerated transition. The U.S. Ambassador to Zimbabwe has also engaged with the Ministry of Finance and Reserve Bank of Zimbabwe around the availability of foreign currency for

the GoZ TLD contributions, which also need to be moved up and will be extremely important to ensure sufficient TLD stocks through the transition.



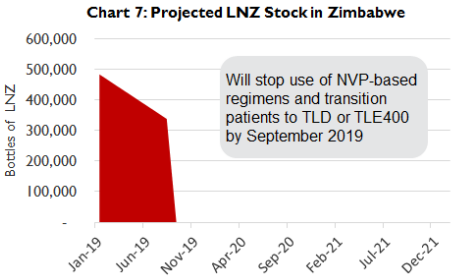
Zimbabwe has been at the forefront of implementing multi-month dispensing (MMD) widely. Data show that more than 80 percent of patients on ART are receiving a three or more month supply. PEPFAR Zimbabwe's COP 19 ARV order will be for 90 day bottles to facilitate ongoing MMD efforts.

Zimbabwe has removed nevirapine-based regimens from the ART guidelines and will be transitioning patients on NVP-based regimens to TLD as soon as possible. The remaining stocks of LZN and NVP 200mg were procured under the Global Fund and NAC. During the Johannesburg meeting Global Fund representatives confirmed that wastage of this legacy, and non-optimal medicines should not be a barrier to getting patients on the most efficacious ART regimen. The value of the remaining stocks is $958,455.

Optimized adult ARV regimens and phasing out NVP

ARV Regimen	Number of Patients on Regimen	% of Patients on ART	Comments
First Line			
AZT-based regimens	21,164	2.12%	AZT/3TC/NVP being phased out
TDF-based regimens	926,247	92.65%	TDF/3TC/NVP being phased out
ABC-based regimens	5,911	0.60%	ABC/3TC/NVP being phased out
TDF/3TC/DTG	-	0.00%	Pending transition
Second Line			
TDF-based regimens	14,097	1.41%	
AZT-based regimens	14,078	1.41%	
ABC-based regimens	18,013	1.80%	
Third Line			
DTG/DRV/RTV	231	0.02%	
Total		**100%**	

PEPFAR procures 1st line, GF procures 1st, 2nd, and 3rd line and GOZ/NAC procures 1st, 2nd, and 3rd line



Expected loss due to NVP phase out:
LZN 300/150/200mg: $467,026
NVP 200mg: $491,429
Total: $958,455
GF has confirmed this should not be a barrier to switching these patients to an optimized regimen.

PEPFAR

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ARV stock audits have been ongoing in Zimbabwe for the last nine years and have been complemented by the PPMR-HIV tool, which monitors central level stock levels of first line ARVs and RTKs. Data from the PPMR-HIV is shared at a global level to aid in adjusting orders and deliveries as needed to maintain optimum stock levels in country.

PEPFAR continues to coordinate very closely with the Global Fund on HIV & AIDS-related commodity procurement both at the country level as well as with the Geneva country team to ensure PEPFAR's procurement and supply management resources are optimized to meet Zimbabwe's needs. Unfortunately, Zimbabwe's combined resources fall short of fully funding some critical commodity lines, including ARVs, conventional lab reagents, and viral load reagents and consumables, among others, as shown in Table 2.2.2. The 2019 ARV Gap (in early COP 19) is expected to be filled using savings from pharmaceutical procurement under the Global Fund grant. The projected ARV gap for 2020 will be in the beginning of COP 21 so we will continue to monitor the gap and work with Global Fund colleagues to ring-fence grant savings to cover the gap. We are hopeful that the global viral load and EID RFP will bring down the unit price across most, if not all, VL/EID platforms that will help us to fill the anticipated VL reagent gap. PEPFAR will continue to advocate with the Global Fund to prioritize any additional grant savings to fill any remaining VL gap after the RFP process is completed.

4.5 Collaboration, Integration and Monitoring

The PEPFAR team continues to intensify collaboration with MoHCC, the Global Fund, representatives from civil society, and multilateral donors in order to maximize efficiencies in programming. Engagement and harmonization with the Global Fund remains crucial for commodity procurement including for VMMC devices, HIV rapid test kits, EID bundles, viral load

reagents, and ARVs. PEPFAR teams continually offer technical assistance and engage MoHCC to determine the optimal mix of strategies required to reach epidemic control in Zimbabwe. PEPFAR continues to leverage on some of the Global Fund resources and planning together has minimized duplication of activities. Best practices from PEPFAR are being adopted and rolled out within Global Fund and vice versa.

The PEPFAR implementing partner and technical working group meetings, augmented by exchange site visits provide opportunities for sharing best practices, on-the-job training, and cross-fertilization of lessons learned within and across partners. These platforms also serve to facilitate coordination and collaboration in the implementation of strategies such as VMMC service delivery; integrated sample transport for laboratory specimens; HIV/TB prevention, diagnosis and treatment; DREAMS and OVC; key pops programming and viral load scale-up.

PEPFAR Zimbabwe is strengthening partner management through reviewing position descriptions of key implementing partner staff to ensure critical program implementation, monitoring, and management functions are carried out. In addition, in COP 18 PEPFAR was reviewing program data at least monthly, to allow early identification of poor performance and timely implementation of corrective actions. Going forward in COP 19, PEPFAR technical teams will work with implementing partners to set up weekly reporting of selected indicators in order to closely monitor and demonstrate the effectiveness of new COP 19 strategies for identifying positives, increasing ART linkage, increasing drug adherence, and reducing attrition rates.

PEPFAR Zimbabwe will continue to working in close in partnership with civil society organizations to ensure that there is meaningful involvement of target populations in developing interventions that are feasible, acceptable and easily taken to scale. In addition, PEPFAR led SIMS visits followed by partner remediation action plans will be strengthened in COP 19. Elective SIMS modules which are data driven will allow health facility tailored interventions.

PEPFAR's COP 18 and COP 19 investments towards an integrated sample transport (IST) system and a LIMS will reduce turnaround time for diagnostic results. The ministry is currently developing a comprehensive IST with support from Global Fund and other stakeholders; hence, this is an opportunity to leverage on other resources. Optimizing the capacity of national viral load platforms to meet the need of ART patients will occur through procurement of VL point of care (POC) resources and the deployment of additional human resources to provincial PEPFAR-supported laboratories. VL quality control and assurance will be supported through strengthening of the external quality assessment schemes for major HIV related laboratory tests.

Health Information Systems support will focus on scale-up of the EHR and ongoing support for the DHIS2 system with which it is compatible. This support will improve the MoHCC and PEPFAR's ability to assess progress towards epidemic control. Case based surveillance of new HIV infections will incorporate bio-behavioral risk factors as well as bio-markers including rapid recency, viral load, and HIV drug resistance (HIVDR); in COP 19, case based surveillance will be

implemented using both paper and electronic systems. Case based surveillance data will inform the design and implementation of innovative and efficient differentiated models of care, and will be crucial to reach increasingly elusive populations. PEPFAR will continue to engage and support the MoHCC in the development of unique identifiers for all PLHIV.

4.6 Targets for scale-up locations and populations

Standard Table 4.6.1

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 FY20) *HTS_TST***	**Newly Identified Positive (APR FY20) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 20) *TX_NEW***
Total Men	**907,830**	**81,755**	**77,862**
Total Women	**453,581**	**50,929**	**48,424**
Total Children (<15)	**304,103**	**15,677**	**14,780**
Total from Index Testing	**333,582**	**67,300**	**63,935**
Adults			
TB Patients	***13,437***	**1,512**	**1,614**
Pregnant Women	***153,222***	**2,269**	**2,173**
VMMC clients	***300,000***	**0**	**0**
Key populations	***24,410***	**4,007**	**3,674**
Priority Populations	-	-	-
Other Testing	-	-	-
Previously diagnosed and/or in care	-	-	-
Pediatrics (<15)			
HIV Exposed Infants	***124,948***	**895**	**1082**
Other pediatric testing	***179,155***	**14,782**	**13,930**
Previously diagnosed and/or in care	-	-	-

Standard Table 4.6.2

SNU	Target Populations	Population Size Estimate (SNUs)	Current Coverage (date)	VMMC_CIRC (in FY20)	Expected Coverage (in FY20)
Beitbridge	10-14	8,097	183%	3,102	80%
	15-19	7,647	67%	-	80%
	20-24	7,464	46%	-	80%
	25-29	6,847	48%	-	80%
Bulawayo	10-14	27,946	171%	8,313	80%
	15-19	29,056	91%	6,879	80%
	20-24	31,239	55%	2,823	80%
	25-29	30,681	36%	1,541	80%
Bulilima	10-14	5,597	232%	1,124	80%
	15-19	5,285	73%	1,089	80%
	20-24	5,159	27%	798	80%
	25-29	4,733	20%	316	80%
Chegutu	10-14	17,280	95%	5,848	80%
	15-19	14,980	58%	4,836	80%
	20-24	14,299	35%	2,510	80%
	25-29	14,302	25%	562	80%
Chipinge	10-14	21,852	59%	2,178	80%
	15-19	19,292	41%	1,350	80%
	20-24	17,020	12%	1,712	80%
	25-29	15,020	6%	1,754	80%
Chiredzi	10-14	24,847	50%	1,894	80%
	15-19	18,563	37%	2,293	80%
	20-24	14,551	20%	2,167	80%
	25-29	14,424	13%	2,602	80%
Chivi	10-14	13,405	64%	1,507	80%
	15-19	10,014	56%	531	80%
	20-24	7,850	15%	1,085	80%
	25-29	7,782	5%	1,077	80%
Gokwe South	10-14	22,529	31%	4,569	80%
	15-19	19,891	42%	3,771	80%
	20-24	18,795	18%	3,533	80%
	25-29	18,971	8%	263	80%
Goromonzi	10-14	15,220	57%	3,115	80%
	15-19	14,095	29%	2,384	80%
	20-24	13,920	10%	1,379	80%
	25-29	13,071	7%	860	80%

SNU	Target Populations	Population Size Estimate (SNUs)	Current Coverage (date)	VMMC_CIRC (in FY20)	Expected Coverage (in FY20)
Guruve	10-14	9,332	103%	4,778	80%
	15-19	8,404	100%	3,786	80%
	20-24	7,429	64%	2,573	80%
	25-29	6,357	42%	717	80%
Gutu	10-14	17,001	36%	1,450	80%
	15-19	12,701	54%	1,611	80%
	20-24	9,956	21%	1,241	80%
	25-29	9,869	7%	1,542	80%
Gwanda	10-14	8,931	157%	1,313	80%
	15-19	8,434	57%	946	80%
	20-24	8,232	32%	946	80%
	25-29	7,552	20%	946	80%
Gweru	10-14	20,652	68%	2,057	80%
	15-19	18,234	91%	1,883	80%
	20-24	17,229	88%	1,076	80%
	25-29	17,390	53%	1,076	80%
Harare	10-14	107,906	42%	16,149	80%
	15-19	104,786	27%	15,144	80%
	20-24	99,351	29%	12,635	80%
	25-29	93,478	28%	7,438	80%
Hurungwe	10-14	27,155	32%	3,585	80%
	15-19	23,540	40%	3,302	80%
	20-24	22,469	11%	1,846	80%
	25-29	22,475	6%	489	80%
Insiza	10-14	6,311	150%	343	80%
	15-19	5,960	63%	343	80%
	20-24	5,817	15%	343	80%
	25-29	5,337	9%	1,454	80%
Kadoma	10-14	8,393	233%	6,950	80%
	15-19	7,276	181%	6,072	80%
	20-24	6,945	136%	3,379	80%
	25-29	6,947	97%	2,481	80%
Kwekwe	10-14	20,965	70%	1,881	80%
	15-19	18,510	43%	1,749	80%
	20-24	17,490	22%	1,617	80%
	25-29	17,654	13%	1,640	80%
Lupane	10-14	6,861	188%	5,599	80%

SNU	Target Populations	Population Size Estimate (SNUs)	Current Coverage (date)	VMMC_CIRC (in FY20)	Expected Coverage (in FY20)
	15-19	5,633	221%	2,147	80%
	20-24	5,426	59%	1,515	80%
	25-29	5,670	23%	88	80%
Makonde	10-14	12,096	70%	1,307	80%
	15-19	10,486	104%	1,887	80%
	20-24	10,009	48%	1,024	80%
	25-29	10,011	27%	2,482	80%
Makoni	10-14	19,535	86%	1,109	80%
	15-19	17,246	47%	1,003	80%
	20-24	15,215	15%	1,043	80%
	25-29	13,427	8%	924	80%
Marondera	10-14	12,267	71%	2,265	80%
	15-19	11,360	57%	1,594	80%
	20-24	11,219	31%	1,246	80%
	25-29	10,535	21%	227	80%
Masvingo	10-14	26,155	46%	1,839	80%
	15-19	19,539	54%	2,113	80%
	20-24	15,317	27%	2,501	80%
	25-29	15,184	15%	1,762	80%
Matobo	10-14	5,954	248%	2,382	80%
	15-19	5,623	131%	2,920	80%
	20-24	5,488	77%	1,729	80%
	25-29	5,035	60%	802	80%
Mazowe	10-14	18,229	68%	618	80%
	15-19	16,417	68%	1,667	80%
	20-24	14,513	38%	2,280	80%
	25-29	12,419	25%	1,884	80%
Mberengwa	10-14	12,829	131%	4,498	80%
	15-19	11,327	106%	3,164	80%
	20-24	10,703	66%	2,593	80%
	25-29	10,803	33%	2,512	80%
Mt. Darwin	10-14	15,842	43%	2,606	80%
	15-19	14,267	80%	1,029	80%
	20-24	12,613	39%	1,022	80%
	25-29	10,792	24%	528	80%
Murehwa	10-14	12,949	59%	2,023	80%
	15-19	11,991	42%	1,432	80%

SNU	Target Populations	Population Size Estimate (SNUs)	Current Coverage (date)	VMMC_CIRC (in FY20)	Expected Coverage (in FY20)
	20-24	11,842	19%	963	80%
	25-29	11,120	15%	1,065	80%
Mutare	10-14	33,110	56%	1,975	80%
	15-19	29,230	35%	1,536	80%
	20-24	25,788	19%	1,757	80%
	25-29	22,758	13%	2,944	80%
Mwenezi	10-14	12,424	80%	1,407	80%
	15-19	9,281	58%	836	80%
	20-24	7,275	23%	831	80%
	25-29	7,212	14%	890	80%
Nkayi	10-14	7,433	178%	2,945	80%
	15-19	6,102	114%	699	80%
	20-24	5,879	26%	295	80%
	25-29	6,142	13%	740	80%
Tsholotsho	10-14	8,004	167%	2,523	80%
	15-19	6,572	62%	926	80%
	20-24	6,331	10%	908	80%
	25-29	6,615	5%	908	80%
Zaka	10-14	14,385	61%	3,062	80%
	15-19	10,747	85%	3,139	80%
	20-24	8,424	60%	2,214	80%
	25-29	8,351	26%	1,530	80%
	Total/Average	**2,094,202**	**59%**	**300,000**	**80%**

Standard Table 4.6.3 Target Population for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal(in FY19)	FY20 Target
AGYW (10-24 yrs) Population Estimate 2020 ZimStat *in 6 DREAMS Districts*	413,163	89,970	100,935 PP_PREV
Key Populations: FSW in 5 high volume districts	28,677	21,018	28,626 KP_PREV
Key Populations: MSM in 5 high volume districts	20,733	4,888	10,366 KP_PREV
TOTAL	**462,573**	**115,876**	**139,927**

Standard Table 4.6.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC 9fy20 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target) OVC*
Buhera	113,019	19,744	16,200
Bulawayo	225,651	27,732	17,097
Chegutu	80,364	13,998	13,038
Chipinge	146,076	25,275	13,276
Goromonzi	88,276	23,816	18,961
Guruve	51,169	6,326	4,918
Gutu	86,157	16,539	11,694
Gweru	79,839	12,445	4,942
Harare	741,208	58,150	48,411
Insiza	43,539	7,798	7,324
Kadoma	40,765	9,261	7,319
Lupane	46,764	7,798	5,441
Makonde	65,003	25,081	17,731
Makoni	114,626	22,393	13,153
Matobo	40,671	5,849	4,147
Mazowe	92,136	9,308	2,942
Mutare	181,412	32,315	15,992
Mutasa	69,452	13,406	10,497
Nkayi	51,479	5,849	4,867
Zvimba	103,094	14,388	13,111

TOTAL	**2,460,700**	**357,471**	**251,061**

4.7 Cervical Cancer Program Plans

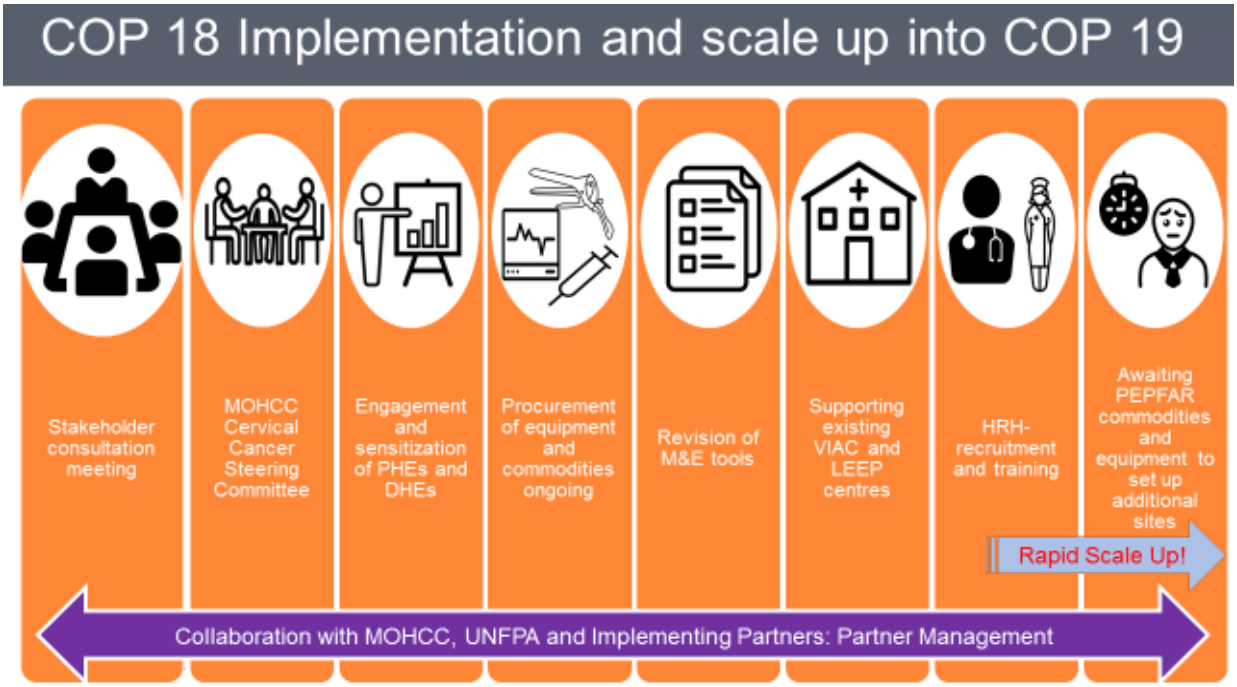
Countries with the highest HIV prevalence in women have the highest incidence of cervical cancer. Women with HIV are four to five times more likely to develop cervical cancer. Women are now surviving a diagnosis of HIV because of antiretroviral therapy (ART), but dying of a preventable disease – cervical cancer. Cervical cancer, though easily prevented, is one of the leading causes of death among women. Cervical cancer, largely caused by human papillomavirus (HPV), is the most prevalent form of cancer among women in Zimbabwe, with an estimated 2,270 new cases reported and about 1,500 deaths every year. The Zimbabwe HPV and Related Cancers Summary Report 2010 indicate that the prevalence of HPV in women with cervical cancer is 79.6 percent, which is higher than the global prevalence of (70.9 percent).

Cervical cancer is an AIDS-defining condition, and Zimbabwe has one of the highest HIV prevalence rates in the world, with 14.1 percent of the population aged 15-64 years living with HIV (16 percent prevalence in women vs. 14 percent prevalence in men). HIV remains an important risk factor for cervical cancer.

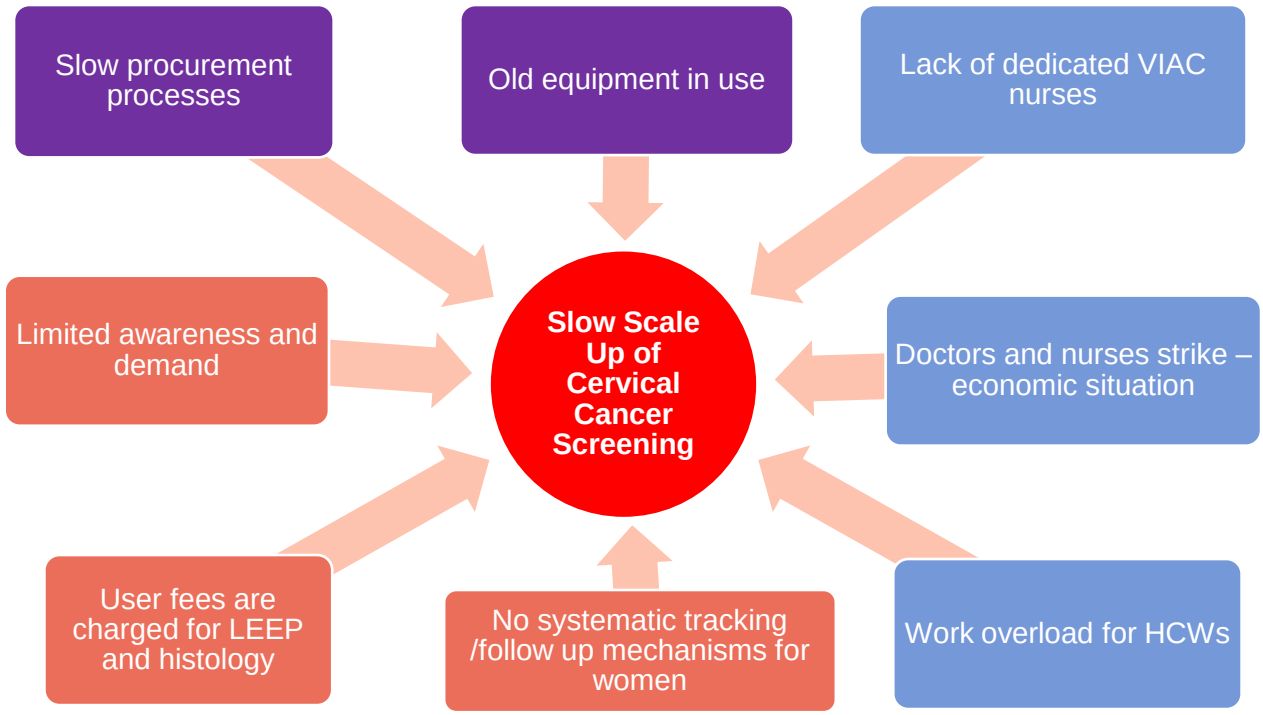
An estimated 2,270 new cases are diagnosed with 1,500 deaths from cervical cancer every year in Zimbabwe. In 2017, about 100,000 women were screened for cervical cancer with a treatment rate of 57% which is below the program target of 80 % treatment rate. The ZDHS 2015 reported overall 79% of women had heard of cervical cancer but only 13% ever had a cervical examination. The Cervical Cancer Prevention and Control Strategy (2016-20200) recommend screening using Visual Inspection with Acetic Acid and Cervicography (VIAC) for all sexually active women. Since 2014, the MoHCC has been rapidly scaling up screening of cervical cancer using VIAC and over 100 VIAC sites have been set up at district, provincial and central levels countrywide. Women with lesions are treated with either cryotherapy or referred for Loop Electrosurgical Excision Procedure (LEEP) which is available at the provincial and central levels.

The MoHCC adopted the “see and treat” approach for cervical cancer screening where secondary prevention is available within VIAC screening services. In this approach, the treatment for pre-invasive lesions is offered on the same day that the lesion is identified (e.g. with cryotherapy). For all women offered LEEP services a sample is taken to the laboratory for histology.

The current program is built on the established HIV care and treatment settings focusing on supporting VIAC sites and establishment of new screening and treatment sites.

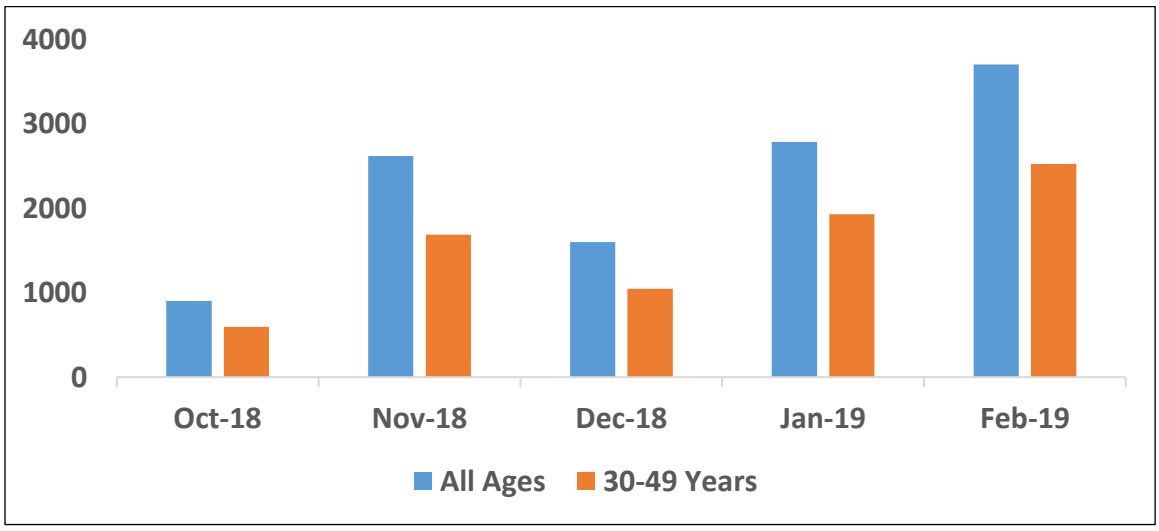


COP 18 activities included a stakeholder consultation meeting to explain the PEPFAR program and incorporate from the government and other partners. There was also engagement and sensitization of the provincial and district leadership of the supported districts. Procurement of equipment and commodities is ongoing. There has been also recruitment and training of VIAC nurses to work full time in the VIAC clinics. There have been challenges in HRH as most of the VIAC clinics do not have dedicated nurses and there is no prioritization of VIAC activities because of competing priorities in the health facilities. This activity also spearheaded the formation of a cervical cancer monitoring and evaluation technical working group. The national VIAC register and the master MoHCC monthly return were revised to incorporate the PEPFAR VIAC indicators. Several challenges have been encountered in COP 18 as shown below.



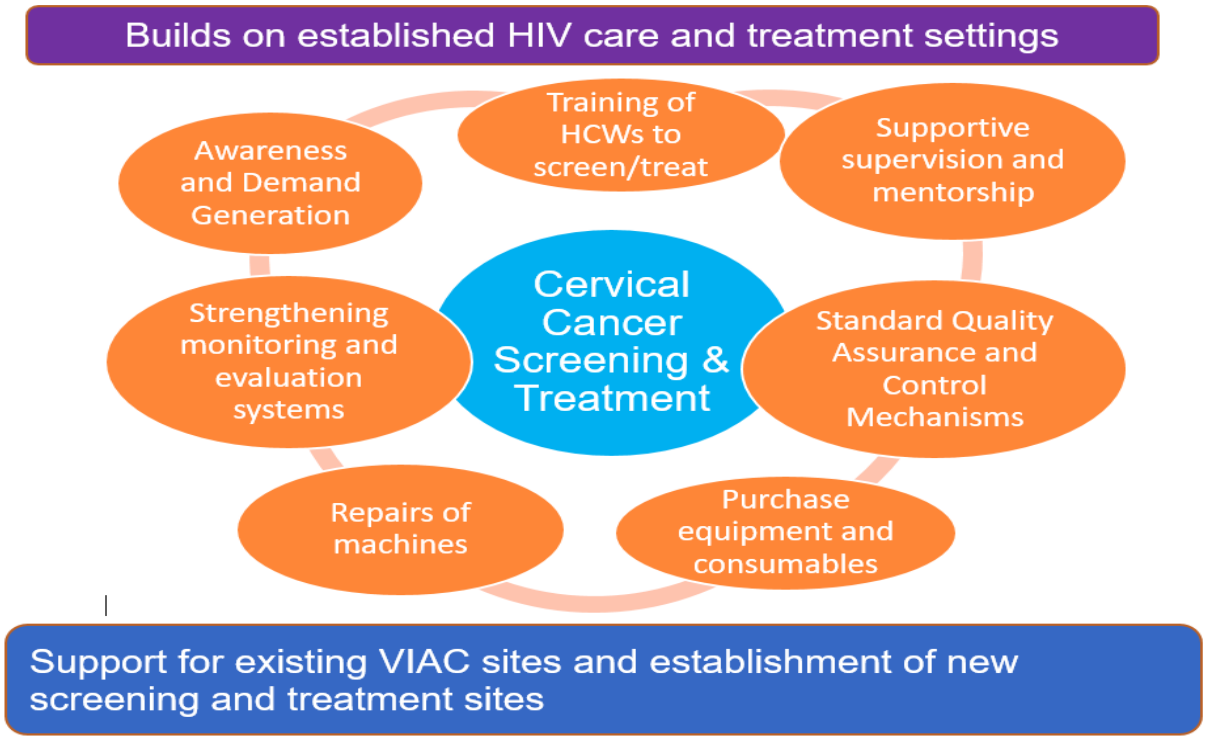
The graph below is showing the performance of the program since October 2018 to date. There has been an upward trend in the numbers of women being screened and treated. There is need to address the above challenges for the program to achieve the set targets.

An Upward Trend in Cervical Cancer Screening



In COP 19, the PEPFAR program will support the secondary prevention of cervical cancer in women living with HIV. In COP 19 the target is to screen 205,433 women living with HIV on ART aged 25-49 years every other year for pre-invasive lesions to allow early treatment. The PEPFAR support will build on established HIV care and treatment settings to leverage resources and provide one stop care for women. This allows screening and treatment in a single visit, improving

compliance and reducing costs. It is expected that 145 new sites will be established by end of COP 19. The figure below shows the PEPFAR Zimbabwe Cervical cancer program approaches.



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

5.1 COP 19 Programmatic Priorities

All PEPFAR supported districts (40) are expected to achieve attainment by the end of COP 19. Zimbabwe will not support sustained districts in COP 19; however, PEPFAR will provide above-site national level support for supply chain management and distribution, national level support for sample transport and treatment literacy in centrally supported districts.

5.2 Targets for attained and sustained locations and populations

Standard Table 5.2.1:

Table 5.2.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts*			
Attained Support Volume by Group		**Expected result APR 19**	**Expected result APR 20**
HIV testing (all populations)	*HTS_TST*	1,369,491	1,368,253
HIV positives (all populations)	*HTS_TST_POS*	143,637	147,494

Table 5.2.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts*			
Attained Support Volume by Group		**Expected result APR 19**	**Expected result APR 20**
Treatment new	*TX_NEW*	106,106	141,264
Current on ART	*TX_CURR*	1,151,503	1,221,083
OVC	*OVC_SERV*	357,471	357,471
Key populations	*KP_PREV*	26,588	38,991

*Calculations for targets for clinical services are based on maintaining 80% ART coverage levels in the Attained districts. [Current Retention + (Passive HTC_POS * Linkage)]/PLHIV = 80% ART Coverage

Standard Table 5.2.2

Table 5.2.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group		**Expected result APR 19**	**Expected result APR 20**
HIV testing in PMTCT sites	*PMTCT_STAT*	0	0
HTS (only sustained ART sites in FY18)	*HTS_TST/HTS_TST_POS*	0	0
Current on ART	*TX_CURR*	0	0
OVC	*OVC_SERV*	0	0

*PEPFAR does not have sustained districts

5.3 Establishing service packages to meet targets in attained districts

By definition, all 40 PEPFAR supported districts in Zimbabwe are designated attained status; that is they have achieved ≥90% treatment coverage in both males and females within the following age bands: <1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, and 50+. Hence, the COP 19 strategies will focus on national case-finding surveillance systems, public health response approaches, and quality assurance at the site and above site. In COP18, none of the districts had reached the attained status.

Prioritized activities for Attained SNUs include:

Surveillance, program monitoring, and laboratory systems: During COP 19, the country will implement the following:

- HIV recency testing in order to monitor evolution of the epidemic and inform programming. HIV recency testing identifies recent HIV infections, from which geographic areas they are coming from and the frequency/prevalence. When we identify the geographic areas and populations, appropriate prevention programs will be scale up depending on the population dynamics;
- Monitoring ARV drug resistance and clinical services to break onward transmission;

- Strengthen the clinic and laboratory interface to improve viral load result turnaround time, cohort monitoring, result utilization and patient management. The goal is to achieve PEPFAR 95-95-95 goal;
- Continuous quality assurance and improvement for selected indicators and program activities;
- Clinical mentoring to sustain treatment coverage above 90% and ensure quality treatment services
- Support client-based ART retention services based on specific age, sex, and HIV risk factors. This includes expansion of differentiated ART to reach the PEPFAR targets of DSD coverage. Currently supply chain management has been a bottleneck to 6months multi-month dispensing, this being addressed in COP18 going forward;
- Support to the MoHCC to expand electronic health records for better data quality collection and reporting;
- Weekly electronic reporting of selected indicators to improve programming;
- Monitoring implementing partners' performance through SIMS, financial, and activity report reviews and monthly performance reviews of MER indicators.

Clinical Services and retention:

- Clinical services will focus on sustaining the gains made but also move towards epidemic control. The country will continue to implement HIV test and start in order to reduce treatment opportunities and allow early treatment. In order to improve the quality of care offered to clients, viral load scale up and result utilization for patient management are key.
- To address linkage to care and treatment services, the following will be done:
- Support the use of expert patients or peer navigators to physically escort newly diagnosed PLHIV to treatment rooms;
- SMS reminders and physical tracking of newly diagnosed PLHIV to remind them to enroll in care;
- Extended weekend and evening hours; and
- Expansion of the Zvandiri model for adolescents.
- To address loss to follow up the following will be implemented:
- Use of the new loss follow up definition which is more sensitive allowing early tracking and tracing of patients. We will engage the MoHCC to adopt this new definition;
- Cohort monitoring of patients to determine outcomes
- Continued roll out of differentiated service delivery for ART

Limited demand creation and HIV-negative prevention:

- Generalized and aggressive demand creation is not going to be supported; instead, it will be for targeted populations. Hot spot mapping using latest program data will be done.
- PEPFAR will support HIV prevention through PMTCT, VMMC, condom programming, and DREAMS, this mirrors the interventions described above.

Continue outreach, prevention, testing, and clinical services for key populations:

- HIV case identification will mirror the integrated HTS model, describe above. Generalized testing campaigns is not going to be supported; instead, focused testing strategies; intensified PITC focusing on in-patient wards, STI, TB and presumptive TB clients; family testing in HIV clinics, ANC, and pediatrics; as well as family members of index clients.
- HIV prevention, testing and treatment activities for key populations (MSM, sex workers, and transgender) will continue to be implemented across the country. Currently these services are offered through direct service delivery at designated clinics and outreach points. However, in COP 19 integration of these services into public health facilities is planned. Building capacity of health workers in public facilities will be key if this is to succeed.

Prioritized activities for Centrally Supported SNUs include:

- All health care facilities will conduct passive HIV testing and counseling where the tests will be provided on request or as indicated by clinical symptomatology or identified risk behaviors
- Case based surveillance with recency testing will be maintained at all health facilities.
- Essential laboratory services for PLHIV will be maintained.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

The PEPFAR Zimbabwe team will invest in key above-site areas to ensure continued progress towards sustained epidemic control in Zimbabwe. These investments include TLD transition guidelines, supply chain improvements, quantification support, enhanced program coordination, expansion of key population clinical services, capacity strengthening for sustainability, and patient-centered focus to ensure retention in care and VL suppression. In order to ensure that the over 1 million Zimbabweans on ART have access to viral load monitoring, PEPFAR will expand its investments in VL reagents. Finally, investments in health information systems and case-based surveillance will be critical to improve data quality, facilitate appropriate differentiation of care, and to reach individuals and populations experiencing ongoing HIV acquisition/transmission. Many of these investments were identified or validated through the joint UNAIDS and PEPFAR SID 3.0 process which included MoHCC, NAC, donors, CSOs, implementing partners, and other key stakeholders. These investments were also verified by the PEPFAR team during FY 18 Q4 and FY 19 Q1 SIMS visits. Finally, all investments were discussed and agreed to with the MoHCC and other stakeholders through multiple consultations.

Supply chain and commodities:

In COP 19 PEPFAR will continue its close coordination and support to MoHCC Directorate of Pharmacy Services (DPS) to ensure the national quantification and supply planning exercise is conducted bi-annually. This exercise will inform the use of donor and GoZ resources for commodity procurement. This is particularly important as Zimbabwe plans to transition ARV from TLE600 and TLE400 to TLD beginning June 2019. Securing additional commodities (e.g., HIVST kits, condoms, VMMC kits) will also be critical to the national HIV programming and epidemic control.

Laboratory Support:

Zimbabwe currently has adequate platform capacity to provide VL monitoring access for all ART patients across the country. Unfortunately, platforms and reagents will not make universal VL monitoring a reality without significant investment into supporting systems. PEPFAR's above-site laboratory investments, therefore, will support integrated specimen transport, laboratory information management (LIMS), and quality assurance (EQA) activities. Specimen transport is a critical laboratory activity, where proper implementation reduces turnaround time through transport efficiency, while also reducing the percentage of rejected samples. Implementing the LIMS system will accelerate transmission of results to clinicians, permitting differentiation of care and clinical decision-making. PEPFAR support for EQA/QMS activities will ensure that laboratory results are reliable and meet international standards. Finally, given the urgency of expanding VL coverage and results utilization, PEPFAR will provide central-level support to MoHCC's Directorate of Laboratory Services, to ensure that planning and implementation are focused upon the 95-95-95 targets.

Transition to TLD:

As mentioned above, PEPFAR continues to provide technical assistance to Zimbabwe's national supply chain management and distribution systems to ensure that life-saving medicines and products are available in health facilities. In light of the current and deteriorating economic situation, particularly the fuel crisis, this vehicle and distribution support has been particularly critical.

Zimbabwe is working to close the gaps across geographic and age/sex bands in order to achieve the 95-95-95 targets by the end of COP 19, and is embarking on the TLD transition in the next few months. ART naïve patients will begin to transition in May 2019 and, to accelerate the transition overall, existing ART patients will begin to transition in June 2019. The goal is to complete this transition by the end of January 2020.

Treatment literacy:

Feedback from MoHCC, stakeholders, CSOs, and patients has impressed upon the PEPFAR team that treatment literacy tools need updating to include aspects of self-testing, index testing, treat

all, adherence, viral load, faith healing, and other important elements. In COP 19, PEPFAR clinical partners will partner with CSOs to implement community-level treatment literacy to improve uptake of VL, TLD, and TPT. Moreover, investments in FBOs will prioritize communication to improve adherence and retention and reduce stigmatization and IPV at the community-level.

Health Information Systems:

Critical to PEPFAR goals of reaching epidemic control, MoHCC recognized three significant weaknesses in the ability to optimally support patients currently on treatment: 1) accuracy of longitudinal tracking of individual patients within a facility (2) accuracy in tracking patients across facilities and between service providers (referrals) (3) defaulter tracking at the community level due to inaccurate registers. These weaknesses are evident in ongoing efforts to improve data quality in TX_CURR and retention reporting.

Assessment of People Living with Disabilities:

As part of Epidemic Control goals, PEPFAR will invest in a disabilities assessment in COP 19 to determine the size and need of people living with HIV and disabilities as PEPFAR Zimbabwe nears the last mile.

Electronic Health Record and DHIS2:

PEPFAR's ongoing above-site investments will continue in expanding the Electronic Health Record (EHR) that is integrated into DHIS2, for care, surveillance, monitoring and evaluation. The EHR will be particularly critical in the roll-out of CBS (see below), given that geographic and demographic mapping of recent infections will never be adequate via paper-based reporting systems. Using a unique patient identifier and incorporation of a referral module within the EHR to allow for tracking patients between service providers will assist in de-duplication. Community-based data collection for recency testing will then be incorporated into the EHR for centralized data analysis. The DREAMS program will also continue updating a DHIS 2 based system to track layering of services to ensure beneficiaries are receiving appropriate services based on risk.

Defaulter tracking:

In order to address the third weakness of inaccuracy in community-level defaulter tracing, PEPFAR will increase support to improve documentation within facilities through on-site mentorship as well as supporting the development of enhanced defaulter tracking tools that feed into the EHR. The tools will be standardized for all the PEPFAR-supported districts and expanded to the national program. Ultimately, the mentorship and tools will help to improve the accuracy of defaulter lists generated from health facility-based registers. In turn, health facility workers, outreach workers, and village health workers' time will be better utilized to track "real" defaulters and return them back to care. Addressing defaulter tracing is even more critical as treatment initiation continues at a rapid pace and as CARGs are expanded. Finally, enhanced adherence counselling sessions will be undertaken for defaulters and those with high VL to ensure they are

retained on treatment and in care. Getting defaulter patients back to care and virally suppressed will ensure progress towards epidemic control is not hampered.

Key Populations:

In COP 18, PEPFAR will continue the approach initiated in COP 16, which aimed to strengthen the clinical cascade for FSWs and MSM and will reach saturation in FY 18 in five urban locations with high numbers of FSWs: Harare, Bulawayo, Gweru, Mutare and Masvingo. In COP 18, PEPFAR will continue to support the expansion of KP services in the PEPFAR-supported public sector sites. This expansion is supported by MoHCC and NAC's single country plan and with PEPFAR support, MoHCC and NAC will jointly facilitate quarterly national, provincial, and district stakeholder coordination planning meetings that are inclusive of KP organizations to verify KP's increased access to clinical services. The continued need to expand KP access to services was an area identified for improvement during the SID 3.0 stakeholder consultation. Further, to adequately monitor progress towards expansion of KP services, KP stakeholders will be consulted and feedback collected regarding their experience by sensitized individuals and organizations.

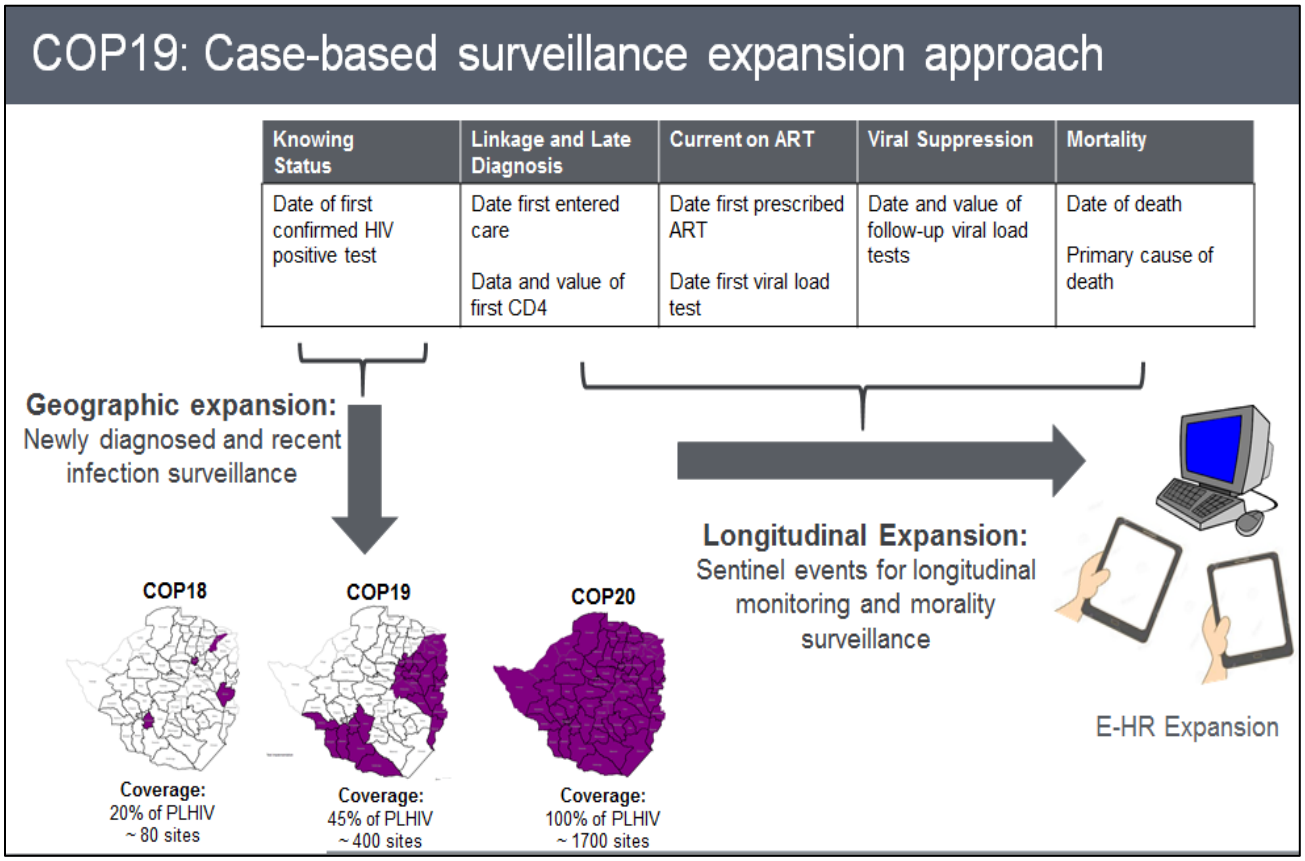
Case Based Surveillance with Recency Testing:

As an EVOLVE country, Zimbabwe will focus on increasing efforts to establish case-based surveillance. Detecting recent HIV infections among all newly diagnosed individuals in real-time and establishing a surveillance system to longitudinally track HIV cases has been designated a high priority activity that will support the attainment and sustenance of HIV Epidemic control. Linking this activity to case finding modalities will help increase HIV-positive yield, early detection of potential hot spots and subsequent mitigation to reduce HIV incidence among populations. The longitudinal patient monitoring aspects of CBS will be necessary to ensure high-quality HIV programming is retaining people in care and keeping them virally suppressed such that re-ignition of the epidemic does not occur.

In COP 19, Zimbabwe will geographically expand newly diagnosed and recent infection surveillance through expansion from 4 to 18 districts increasing coverage from about 80 to about 400 sites in line with the MoHCC's CBS roadmap. By COP 20, all PEPFAR supported districts will be covered. In an effort to rapidly target case finding efforts in areas of high HIV transmission, Zimbabwe will expedite implementation of recent infection surveillance. In COP 19 all newly diagnosed persons over 15 years of age in the 40 PEPFAR districts will be offered recency testing which will be monitored at national level to inform geographical areas with high concentrations of new HIV infections.

Zimbabwe will continue to build and expand the electronic systems necessary to longitudinally

monitor sentinel events along the continuum of care for all HIV-infected persons living in Zimbabwe. In COP 19, PEPFAR funds will be used to expand EHR to ensure all CBS and sentinel events are captured. PEPFAR-support for E-HR will focus on system development and adaptation to accommodate PEPFAR-related priories including use of a unique patient identifier and incorporation of TB-and Cervical Cancer related modules. PEPFAR support will also fund a landscape analysis of ICT and transmission infrastructure to inform non-PEPFAR donors of system needs to expedite EHR expansion.



7.0 Staffing Plan

For COP 19, the PEPFAR team took a critical look across the entire interagency team to ensure it consisted of staff with an adequate mix of technical, management, and administrative skills to support the Government of Zimbabwe's goal of epidemic control. Due to the protracted hiring freeze, CDC has merged two existing Public Health Specialist vacancies within the HIV Services Branch into one position. The TB/OI and Pediatrics positions will be merged into one Public Health Specialist position. The current proposed staffing plan put forth in COP 19 equips all PEPFAR implementing agencies to stay actively engaged in technical working groups and discussions, provide activity/project management oversight, conduct robust monitoring and analysis required to responsively adapt the program to ensure alignment with PEPFAR priorities, and conduct critical SIMS visits at the selected sites for the year.

New proposed positions:

As part of PEPFAR's local partner initiative, OGAC approved six additional FSN local positions for USAID to support this key initiative. These positions are below:

- Capacity Building Specialist (1 FSN position)
- Contracting Specialist (2 FSN positions)
- Technical Care & Treatment Specialist (1 FSN position)
- Strategic Information Specialist (1 FSN position)
- Procurement & Supply Chain Specialist (1 FSN position)

Funding for these six additional positions will be from central funds in COP 19 and it is anticipated that USAID will absorb these costs in subsequent years. In terms of space, four of these positions will be based at the Embassy and the two remaining positions will be housed at USAID partner offices.

Current vacancies:

As of April 5, 2019 PEPFAR Zimbabwe has a total of five vacant positions. USAID has one vacancy currently in the solicitation phase and CDC has three local hire positions pending recruitment. Since March 2018, CDC has filled seven vacancies, three of which were USDH positions. CDC continues to work closely with State Human Resources department on finalization of position classifications and recruitment for outstanding vacancies. After careful consideration of program needs and resources, CDC altered its staffing footprint by reducing one vacant position. The CDC Epidemiologist (Biostatistician) position was removed.

The five positions include:

- PCO: Strategic Information Liaison
- CDC: M&E Specialist
- CDC: Epidemiologist/Health Systems Strengthening
- CDC: Communications and Strategic Planning
- USAID: Strategic Information Advisor (recruitment underway; anticipate hiring by May/June 2019)

Operational Updates:

Significant CODB changes in COP 19 for CDC mainly include the move into the New Embassy Campus (NEC), which occurred in January 2019, with building contractual agreements closed out as of March 31, 2019. CDC will no longer pay office rental or building maintenance contracts for upkeep. However, since moving into the New Embassy Compound, CDC incurs additional ICASS Cost Centers (i.e., Non-Residential Building Maintenance) for which at the time of COP 19 submission, costs are not known. In addition, CDC anticipates having a full staffing complement with increased benefit costs for USDH (e.g., increased COLA, additional R&R). Budget reductions have been made due to the decreased number of SIMS visits. M&O costs have increased slightly for USAID as a result of increased benefits for USDHs and onboarding of new staff.

SIMS, DQAs requirements and overall M&O needs were reviewed during budgetary discussions. Technical and non-technical staff are conducting SIMS and DQA visits on a monthly basis. PEPFAR staff will spend approximately 65 person-working-days in the field per quarter in COP 19. In alignment with COP guidance, the PEPFAR Coordination Office (PCO) will serve as the interagency point of contact for the oversight of the required Gender and Sexual Diversity Training (GSD) required for new staff within the first two months of arrival or hire at Post. PEPFAR already participates in an Embassy-wide Gender TWG and will utilize this platform to share best practices and lessons learnt. Additionally, PCO will utilize one of PEPFAR's quarterly stakeholder partner meetings to convene a GSD panel to discuss PEPFAR's strategy to reach sub-populations in need of ART including LGBTI individuals, adolescent girls and young women.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

SNU	COP	SNU_Priority	Results Reported	Attained 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90$) Overall																										Overall TX Coverage
				<1	<1	1-4	1-4	5-9	5-9	10-14	10-14	15-19	15-19	20-24	20-24	25-29	25-29	30-34	30-34	35-39	35-39	40-44	40-44	45-49	45-49	>=50	>=50	
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Beitbridge	COP 15	ScaleUp Sat	APR 16	88%	83%	88%	83%	88%	83%	96%	>100%	>100%	>100%	>100%	>100%	72%	64%	58%	47%	61%	44%	58%	34%	58%	34%	86%	55%	69%
	COP 16	ScaleUp Sat	APR 17	78%	74%	78%	74%	78%	74%	82%	68%	59%	64%	93%	59%	>100%	>100%	88%	77%	92%	71%	88%	55%	88%	55%	94%	61%	82%
	COP 17	ScaleUp Sat	APR 18	97%	96%	97%	96%	97%	96%	100%	85%	47%	43%	76%	26%	75%	68%	61%	50%	64%	46%	61%	35%	61%	35%	76%	49%	60%
	COP 18	ScaleUp Sat	APR 19	84%	83%	84%	83%	84%	83%	>100%	>100%	67%	67%	70%	53%	82%	83%	67%	61%	70%	56%	67%	43%	67%	43%	72%	54%	67%
	COP 19	Attained	APR 20	>100%	>100%	>100%	>100%	63%	62%	86%	83%	87%	94%	>100%	94%	>100%	>100%	>100%	96%	83%	95%	>100%	98%	>100%	96%	99%	93%	>100%
Bubi	COP 15	Ctrl Supported	APR 16	56%	54%	56%	54%	56%	54%	82%	72%	60%	24%	62%	17%	58%	61%	47%	45%	52%	43%	47%	34%	47%	34%	63%	58%	50%
	COP 16	Ctrl Supported	APR 17	59%	58%	59%	58%	59%	58%	89%	89%	60%	39%	61%	18%	70%	76%	57%	55%	63%	54%	57%	43%	57%	43%	78%	76%	61%
	COP 17	ScaleUp Sat	APR 18	28%	28%	28%	28%	28%	28%	55%	32%	47%	41%	59%	62%	52%	44%	42%	32%	46%	31%	42%	24%	42%	24%	51%	50%	43%
	COP 18	ScaleUp Sat	APR 19	49%	48%	49%	48%	49%	48%	68%	66%	72%	72%	64%	50%	76%	75%	62%	54%	68%	53%	62%	42%	62%	42%	82%	72%	63%
	COP 19	Attained	APR 20	33%	37%	90%	90%	58%	57%	62%	74%	80%	95%	82%	94%	87%	96%	86%	94%	80%	>100%	80%	90%	80%	90%	80%	90%	87%
Buhera	COP 15	ScaleUp Agg	APR 16	>100%	95%	>100%	95%	>100%	95%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	92%	99%	72%	59%	72%	59%	>100%	95%	>100%
	COP 16	ScaleUp Agg	APR 17	>100%	88%	>100%	88%	>100%	88%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	95%	81%	74%	49%	74%	49%	>100%	96%	>100%
	COP 17	ScaleUp Sat	APR 18	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	100%	87%	78%	52%	78%	52%	>100%	>100%	>100%
	COP 18	ScaleUp Sat	APR 19	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%
	COP 19	Attained	APR 20	90%	89%	>100%	>100%	62%	53%	70%	73%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	96%	83%	>100%	>100%	>100%	>100%	>100%
Bulawayo	COP 15	ScaleUp Sat	APR 16	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	95%	89%	83%	70%	53%	37%	53%	37%	57%	43%	80%
	COP 16	ScaleUp Sat	APR 17	>100%	60%	>100%	60%	>100%	60%	>100%	>100%	>100%	>100%	>100%	94%	>100%	>100%	>100%	>100%	92%	79%	59%	42%	59%	42%	67%	54%	86%
	COP 17	ScaleUp Sat	APR 18	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	92%	71%	80%	56%	51%	30%	51%	30%	62%	46%	77%
	COP 18	Attained	APR 19	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	88%	>100%	>100%	>100%	100%	89%	78%	57%	42%	57%	42%	61%	53%	84%
	COP 19	Attained	APR 20	>100%	>100%	70%	79%	75%	64%	77%	92%	>100%	>100%	>100%	99%	>100%	>100%	>100%	>100%	100%	91%	90%	97%	>100%	91%	76%	91%	>100%
Bulilima	COP 15	ScaleUp Sat	APR 16	65%	52%	65%	52%	65%	52%	58%	71%	78%	47%	95%	60%	64%	73%	51%	53%	54%	53%	51%	38%	51%	38%	54%	39%	56%
	COP 16	ScaleUp Sat	APR 17	62%	62%	62%	62%	62%	62%	74%	81%	82%	60%	93%	41%	85%	71%	68%	52%	72%	52%	68%	37%	68%	37%	77%	56%	66%
	COP 17	ScaleUp Sat	APR 18	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	83%	71%	>100%	>100%	>100%	>100%	87%	90%	93%	90%	87%	64%	87%	64%	49%	39%	96%
	COP 18	ScaleUp Sat	APR 19	96%	95%	96%	95%	96%	95%	>100%	>100%	>100%	>100%	>100%	79%	>100%	>100%	98%	91%	>100%	91%	98%	65%	98%	65%	>100%	88%	98%
	COP 19	Attained	APR 20	>100%	>100%	>100%	>100%	90%	91%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	92%	72%	90%	>100%	90%	96%	90%	>100%
Chegutu	COP 15	ScaleUp Agg	APR 16	95%	85%	95%	85%	95%	85%	97%	95%	>100%	48%	>100%	61%	>100%	>100%	>100%	99%	93%	83%	69%	47%	69%	47%	49%	42%	87%
	COP 16	ScaleUp Agg	APR 17	90%	82%	90%	82%	90%	82%	>100%	100%	>100%	67%	>100%	87%	>100%	>100%	>100%	>100%	97%	98%	72%	55%	72%	55%	56%	48%	97%
	COP 17	ScaleUp Sat	APR 18	87%	86%	87%	86%	87%	86%	94%	99%	>100%	37%	>100%	67%	>100%	>100%	>100%	87%	87%	73%	65%	41%	65%	41%	44%	37%	81%
	COP 18	ScaleUp Sat	APR 19	89%	89%	89%	89%	89%	89%	>100%	>100%	85%	71%	>100%	76%	>100%	>100%	94%	94%	79%	79%	58%	44%	58%	44%	77%	63%	81%
	COP 19	Attained	APR 20	>100%	80%	>100%	>100%	59%	64%	63%	61%	>100%	92%	>100%	92%	>100%	>100%	>100%	>100%	94%	>100%	47%	94%	66%	92%	67%	93%	>100%
Chipinge	COP 15	ScaleUp Sat	APR 16	49%	43%	49%	43%	49%	43%	57%	36%	54%	41%	>100%	45%	>100%	>100%	68%	58%	58%	44%	45%	27%	45%	27%	61%	48%	57%
	COP 16	ScaleUp Sat	APR 17	37%	36%	37%	36%	37%	36%	71%	61%	55%	42%	87%	82%	>100%	>100%	81%	71%	69%	53%	53%	33%	53%	33%	60%	43%	64%
	COP 17	ScaleUp Sat	APR 18	87%	86%	87%	86%	87%	86%	>100%	>100%	>100%	>100%	>100%	58%	>100%	>100%	>100%	>100%	>100%	84%	100%	63%	77%	39%	>100%	87%	>100%
	COP 18	ScaleUp Sat	APR 19	87%	86%	87%	86%	87%	86%	>100%	>100%	>100%	96%	>100%	>100%	>100%	>100%	>100%	>100%	96%	94%	74%	58%	74%	58%	>100%	90%	>100%
	COP 19	Attained	APR 20	91%	90%	>100%	>100%	46%	57%	76%	74%	>100%	90%	>100%	99%	>100%	>100%	>100%	>100%	>100%	91%	71%	95%	87%	95%	79%	93%	>100%
Chiredzi	COP 15	ScaleUp Agg	APR 16	41%	38%	41%	38%	41%	38%	65%	51%	66%	66%	90%	>100%	>100%	>100%	78%	85%	75%	70%	63%	49%	63%	49%	78%	60%	75%
	COP 16	ScaleUp Agg	APR 17	48%	37%	48%	37%	48%	37%	61%	56%	68%	70%	99%	>100%	>100%	>100%	91%	100%	88%	82%	74%	58%	74%	58%	92%	71%	86%
	COP 17	ScaleUp Sat	APR 18	0%	0%	0%	0%	0%	0%	0%	0%	>100%	>100%	>100%	>100%	>100%	>100%	96%	98%	92%	81%	77%	57%	77%	57%	27%	21%	87%
	COP 18	ScaleUp Sat	APR 19	31%	31%	31%	31%	31%	31%	43%	42%	>100%	>100%	>100%	>100%	>100%	>100%	99%	>100%	95%	84%	79%	59%	79%	59%	>100%	94%	94%
	COP 19	Attained	APR 20	58%	57%	89%	90%	50%	49%	55%	50%	>100%	90%	>100%	96%	>100%	>100%	>100%	97%	91%	93%	80%	92%	>100%	>100%	82%	>100%	>100%
Chivi	COP 15	ScaleUp Sat	APR 16	82%	82%	82%	82%	82%	82%	97%	>100%	78%	73%	>100%	69%	>100%	84%	76%	53%	72%	44%	62%	31%	62%	31%	73%	59%	70%
	COP 16	ScaleUp Sat	APR 17	86%	93%	86%	93%	86%	93%	>100%	>100%	98%	>100%	>100%	70%	>100%	>100%	83%	65%	78%	54%	68%	38%	68%	38%	91%	>100%	85%
	COP 17	ScaleUp Sat	APR 18	97%	97%	97%	97%	97%	97%	>100%	>100%	>100%	>100%	>100%	66%	>100%	90%	94%	57%	89%	47%	77%	33%	77%	33%	94%	66%	83%
	COP 18	ScaleUp Sat	APR 19	95%	94%	95%	94%	95%	94%	>100%	>100%	>100%	>100%	>100%	96%	>100%	>100%	83%	87%	79%	72%	68%	51%	68%	51%	91%	84%	87%
	COP 19	Attained	APR 20	>100%	>100%	>100%	>100%	72%	69%	89%	85%	>100%	93%	>100%	97%	>100%	>100%	>100%	93%	87%	92%	86%	>100%	>100%	>100%	>100%	>100%	>100%
Gokwe South	COP 15	ScaleUp Agg	APR 16	56%	53%	56%	53%	56%	53%	72%	65%	65%	66%	84%	68%	76%	73%	57%	51%	59%	48%	48%	32%	48%	32%	58%	50%	57%
	COP 16	ScaleUp Agg	APR 17	65%	51%	65%	51%	65%	51%	77%	54%	72%	73%	>100%	65%	77%	79%	57%	55%	60%	52%	49%	34%	49%	34%	63%	59%	60%
	COP 17	ScaleUp Sat	APR 18	99%	98%	99%	98%	99%	98%	>100%	91%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	96%	81%	100%	76%	82%	51%	82%	>100%	81%	97%
	COP 18	ScaleUp Sat	APR 19	86%	85%	86%	85%	86%	85%	>100%	>100%	>100%	>100%	>100%	87%	>100%	>100%	97%	93%	>100%	88%	83%	59%	83%	59%	>100%	90%	97%
	COP 19	Attained	APR 20	>100%	>100%	>100%	>100%	90%	77%	90%	90%	88%	90%	>100%	93%	>100%	>100%	>100%	>100%	96%	93%	93%	68%	90%	97%	94%	92%	91%	>100%
Goromonzi	COP 15	ScaleUp Agg	APR 16	33%	35%	33%	35%	33%	35%	45%	36%	46%	35%	76%	47%	66%	54%	47%	39%	49%	39%	35%	27%	35%	27%	20%	24%	41%
	COP 16	ScaleUp Agg	APR 17	56%	50%	56%	50%	56%	50%	57%	56%	>100%	>100%	64%	36%	>100%	90%	79%	65%	82%	65%	58%	44%	58%	44%	48%	61%	68%
	COP 17	ScaleUp Sat	APR 18	87%	87%	87%	87%	87%	87%	97%	80%	85%	61%	>100%	59%	>100%	>100%	91%	78%	94%	78%	67%	53%	67%	53%	36%	51%	80%
	COP 18	ScaleUp Sat	APR 19	80%	79%	80%	79%	80%	79%	>100%	>100%	>100%	>100%	>100%	76%	>100%	>100%	98%	83%	>100%	83%	72%	57%	72%	57%	86%	91%	92%
	COP 19	Attained	APR 20	>100%	99%	>100%	>100%	69%	68%	89%	90%	>100%	>100%	>100%	94%	>100%	>100%	>100%	>100%	>100%	94%	61%	90%	82%	93%	79%	91%	>100%
Guruve	COP 15	ScaleUp Agg	APR 16	90%	82%	90%	82%	90%	82%	79%	89%	88%	91%	>100%	65%	>100%	>100%	>100%	>100%	>100%	98%	92%	64%	92%	64%	80%	94%	>100%
	COP 16	ScaleUp Agg	APR 17	90%	82%	90%	82%	90%	82%	>100%	>100%	99%	>100%	>100%	97%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	78%	>100%	78%	99%	78%	>100%
	COP 17	ScaleUp Sat	APR 18	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%
	COP 18	ScaleUp Sat	APR 19	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%
	COP 19	Attained	APR 20	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%
Gutu	COP 15	ScaleUp Agg	APR 16	75%	79%	75%	79%	75%	79%	98%	>100%	75%	82%	73%	40%	>100%	84%	67%	52%	64%	45%	54%	31%	54%	31%	92%	57%	65%
	COP 16	ScaleUp Agg	APR 17	79%	75%	79%	75%	79%	75%	>100%	>100%	82%	96%	81%	46%	>100%	94%	73%	59%	70%	50%	59%	35%	59%	35%	>100%	68%	72%
	COP 17	ScaleUp Sat	APR 18	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	77%	98%	66%	83%	46%	83%	46%	>100%	95%	>100%
	COP 18	ScaleUp Sat	APR 19	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	93%	87%	65%	87%	65%	>100%	>100%	>100%
	COP 19	Attained	APR 20	>100%	>100%	>100%	>100%	83%	82%	90%	90%	>100%	94%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	89%	67%	90%	99%	90%	>100%	>100%	>100%
Gwanda	COP 15	ScaleUp Sat	APR 16	75%	52%	75%	52%	75%	52%	89%	89%	58%	72%	86%	76%	85%	98%	66%	69%	73%	69%	66%	51%	66%	51%	82%	80%	73%
	COP 16	ScaleUp Sat	APR 17	78%	56%	78%	56%	78%	56%	95%	80%	75%	68%	96%	73%	95%	>100%	74%	77%	82%	77%	74%	57%	74%	57%	92%	82%	80%
	COP 17	ScaleUp Sat	APR 18	70%	70%	70%	70%	70%	70%	96%	98%	74%	84%	>100%	85%	91%	94%	71%	66%	78%	66%	71%	48%	71%	48%	>100%	95%	79%
	COP 18	ScaleUp Sat	APR 19	70%	70%	70%	70%	70%	70%	98%	95%	84%	86%	87%	68%	>100%	>100%	84%	77%	93%	77%	84%	57%	84%	57%	87%	75%	84%
	COP 19	Attained	APR 20	>100%	>100%	>100%	>100%	62%	63%	70%	76%	>100%	90%	>100%	90%	>100%	>100%	92%	92%	88%	90%	73%	90%	>100%	90%	>100%	91%	97%
Gweru	COP 15	ScaleUp Sat	APR 16	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	63%	67%	63%	44%	>100%	>100%	83%	77%	85%	71%	69%	49%	69%	57%	76%
	COP 16	ScaleUp Sat	APR 17	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	77%	82%	80%	60%	>100%	>100%	94%	90%	97%	82%	78%	57%	78%	57%	81%	71%	88%
	COP 17	ScaleUp Sat	APR 18	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	64%	65%	64%	44%	98%	88%	73%	62%	75%	57%	61%	39%	61%	39%	71%	58%	68%
	COP 18	Attained	APR 19	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	82%	85%	86%	66%	99%	99%	74%	70%	77%	64%	62%	44%	62%	44%	82%	66%	75%
	COP 19	Attained	APR 20	60%	59%	79%	78%	51%	43%	58%	55%	77%	92%	>100%	91%	>100%	>100%	90%	93%	80%	94%	81%	93%	>100%	93%	97%	94%	92%
Harare	COP 15	ScaleUp Agg	APR 16	60%	56%	60%	56%	60%	56%	69%	85%	90%	88%	74%	76%	88%	92%	67%	64%	60%	51%	37%	28%	37%	28%	44%	38%	55%
	COP 16	ScaleUp Agg	APR 17	68%	66%	68%	66%	68%	66%	82%	83%	57%	63%	67%	49%	>100%	>100%	77%	72%	69%	57%	43%	32%	43%	32%	40%	36%	58%
	COP 17	ScaleUp Sat	APR 18	79%	79%	79%	79%	79%	79%	89%	>100%	68%	>100%	>100%	93%	>100%	>100%	>100%	93%	95%	75%	59%	42%	59%	42%	65%	57%	81%
	COP 18	Attained	APR 19	76%	76%	76%	76%	76%	76%	>100%	>100%	>100%	>100%	>100%	87%	>100%	>100%	>100%	>100%	>100%	85%	65%	47%	65%	47%	85%	73%	91%
	COP 19	Attained	APR 20	70%	69%	89%	88%	65%	86%	82%	90%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	59%	97%	67%	97%	67%	92%	>100%
Hurungwe	COP 15	ScaleUp Agg	APR 16	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	66%	67%	>100%	83%	>100%	>100%	73%	>100%	59%	84%	43%	47%	43%	47%	60%	55%	72%
	COP 16	ScaleUp Agg	APR 17	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	91%	70%	>100%	80%	>100%	>100%	95%	>100%	78%	86%	57%	49%	57%	49%	66%	57%	84%
	COP 17	ScaleUp Sat	APR 18	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	87%	75%	>100%	88%	>100%	>100%	>100%	>100%	83%	99%	61%	56%	61%	56%	83%	73%	93%
	COP 18	Attained	APR 19	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	96%	81%	>100%	87%	>100%	>100%	>100%	90%	90%	66%	51%	66%	51%	88%	73%	94%
	COP 19	Attained	APR 20	>100%	>100%	>100%	>100%	82%	63%	85%	72%	>100%	90%	>100%	91%	>100%	>100%	>100%	>100%	>100%	>100%	62%	90%	70%	90%	72%	90%	>100%
Insiza	COP 15	ScaleUp Sat	APR 16	39%	32%	39%	32%	39%	32%	39%	36%	80%	58%	>100%	46%	75%	79%	58%	56%	63%	55%	58%	43%	58%	43%	62%	70%	61%
	COP 16	ScaleUp Sat	APR 17	43%	37%	43%	37%	43%	37%	43%	44%	87%	58%	>100%	60%	94%	>100%	73%	76%	79%	74%	73%	57%	73%	57%	81%	62%	73%
	COP 17	ScaleUp Sat	APR 18	59%	59%	59%	59%	59%	59%	67%	68%	>100%	>100%	>100%	98%	>100%	>100%	>100%	94%	>100%	92%	>100%	71%	>100%	71%	>100%	86%	>100%
	COP 18	ScaleUp Sat	APR 19	60%	60%	60%	60%	60%	60%	84%	81%	>100%	>100%	>100%	93%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	78%	>100%	78%	>100%	98%	>100%
	COP 19	Attained	APR 20	>100%	>100%	>100%	>100%	75%	75%	89%	>100%	97%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	84%	>100%	>100%	>100%	>100%	90%	>100%
Kadoma	COP 15	ScaleUp Agg	APR 16	77%	60%	77%	60%	77%	60%	71%	67%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	89%	>100%	89%	>100%	>100%
	COP 16	ScaleUp Agg	APR 17	75%	62%	75%	62%	75%	62%	97%	77%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%
	COP 17	ScaleUp Sat	APR 18	77%	77%	77%	77%	77%	77%	87%	83%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	90%	>100%	90%	>100%	>100%	>100%
	COP 18	ScaleUp Sat	APR 19	96%	95%	96%	95%	96%	95%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	84%	>100%	84%	>100%	>100%	>100%
	COP 19	Attained	APR 20	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	827%	901%	>100%	>100%	>100%	>100%	75%	>100%	>100%	>100%	>100%	>100%	>100%
Kwekwe	COP 15	ScaleUp Agg	APR 16	69%	57%	69%	57%	69%	57%	>100%	92%	80%	87%	>100%	>100%	78%	>100%	59%	71%	60%	68%	50%	47%	50%	47%	75%	63%	70%
	COP 16	ScaleUp Agg	APR 17	71%	55%	71%	55%	71%	55%	86%	83%	63%	97%	>100%	85%	77%	>100%	58%	75%	60%	72%	49%	50%	49%	50%	83%	78%	71%
	COP 17	ScaleUp Sat	APR 18	77%	76%	77%	76%	77%	76%	>100%	>100%	>100%	83%	>100%	>100%	>100%	>100%	76%	72%	79%	69%	65%	48%	65%	48%	79%	58%	79%
	COP 18	Attained	APR 19	85%	85%	85%	85%	85%	85%	>100%	>100%	>100%	97%	100%	>100%	78%	>100%	>100%	87%	80%	89%	76%	74%	53%	74%	53%	95%	79%	86%
	COP 19	Attained	APR 20	72%	71%	>100%	>100%	71%	71%	90%	89%	80%	92%	>100%	92%	>100%	>100%	>100%	>100%	88%	92%	71%	92%	94%	92%	89%	91%	99%
Lupane	COP 15	ScaleUp Agg	APR 16	87%	97%	87%	97%	87%	97%	99%	72%	90%	87%	94%	69%	91%	93%	77%	68%	82%	68%	77%	52%	77%	52%	>100%	>100%	82%
	COP 16	ScaleUp Agg	APR 17	82%	91%	82%	91%	82%	91%	>100%	90%	>100%	87%	87%	35%	89%	>100%	76%	82%	81%	81%	76%	62%	76%	62%	>100%	>100%	87%
	COP 17	ScaleUp Sat	APR 18	93%	92%	93%	92%	93%	92%	95%	74%	>100%	87%	>100%	76%	>100%	>100%	99%	90%	>100%	89%	99%	68%	99%	68%	>100%	>100%	>100%
	COP 18	ScaleUp Sat	APR 19	92%	91%	92%	91%	92%	91%	>100%	>100%	>100%	>100%	>100%	91%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%
	COP 19	Attained	APR 20	>100%	>100%	>100%	>100%	96%	89%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	78%	90%	>100%	>100%	>100%	>100%	>100%
Makonde	COP 15	ScaleUp Agg	APR 16	>100%	99%	>100%	99%	>100%	99%	>100%	>100%	>100%	88%	>100%	>100%	>100%	>100%	95%	98%	81%	76%	60%	45%	60%	45%	77%	66%	89%
	COP 16	ScaleUp Agg	APR 17	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	96%	70%	58%	70%	58%	70%	93%	77%	>100%
	COP 17	ScaleUp Sat	APR 18	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	94%	85%	73%	63%	44%	63%	44%	91%	81%	96%
	COP 18	ScaleUp Sat	APR 19	96%	95%	96%	95%	96%	95%	>100%	>100%	>100%	86%	>100%	93%	>100%	>100%	>100%	>100%	>100%	>100%	96%	93%	71%	56%	71%	56%	96%	78%	99%
	COP 19	Attained	APR 20	>100%	>100%	>100%	>100%	78%	73%	62%	73%	>100%	90%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	55%	90%	74%	97%	88%	94%	>100%
Makoni	COP 15	ScaleUp Sat	APR 16	67%	52%	67%	52%	67%	52%	77%	67%	67%	73%	>100%	89%	>100%	>100%	78%	84%	67%	63%	54%	39%	54%	39%	68%	70%	73%
	COP 16	ScaleUp Sat	APR 17	70%	57%	70%	57%	70%	57%	92%	86%	87%	76%	>100%	90%	>100%	>100%	96%	>100%	83%	86%	66%	53%	66%	53%	88%	83%	90%
	COP 17	ScaleUp Sat	APR 18	95%	94%	95%	94%	95%	94%	>100%	>100%	83%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	96%	89%	77%	55%	77%	55%	96%	94%	>100%
	COP 18	ScaleUp Sat	APR 19	88%	88%	88%	88%	88%	88%	>100%	>100%	>100%	99%	>100%	>100%	>100%	>100%	>100%	>100%	95%	97%	76%	59%	76%	59%	>100%	88%	>100%
	COP 19	Attained	APR 20	>100%	>100%	>100%	>100%	51%	54%	72%	76%	>100%	92%	>100%	97%	>100%	>100%	>100%	>100%	99%	91%	72%	92%	99%	92%	94%	>100%	>100%

SNU	COP	SNU_Priority	Results Reported	Attained 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90$) Overall																										Overall TX Coverage
				<1		<1		1-4		1-4		5-9		5-9	10-14	10-14	15-19	15-19	20-24	20-24	25-29	25-29	30-34	30-34	35-39	35-39	40-44	40-44	45-49	45-49	>=50	>=50	
				F		M		F		M		F		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Mangwe	COP 15	Ctrl Supported	APR 16	84%		63%		84%		63%		84%		63%	68%	77%	54%	38%	>100%	39%	>100%	>100%	81%	87%	88%	85%	81%	65%	81%	65%	71%	51%	80%
	COP 16	Ctrl Supported	APR 17	61%		58%		61%		58%		61%		58%	81%	72%	68%	57%	93%	41%	>100%	>100%	95%	82%	>100%	80%	95%	61%	95%	61%	>100%	82%	90%
	COP 17	ScaleUp Sat	APR 18	57%		56%		57%		56%		57%		56%	49%	48%	91%	57%	83%	64%	42%	41%	32%	30%	35%	29%	32%	22%	32%	22%	56%	30%	41%
	COP 18	ScaleUp Sat	APR 19	48%		47%		48%		47%		48%		47%	66%	64%	48%	49%	48%	38%	60%	59%	46%	42%	50%	41%	46%	32%	46%	32%	51%	40%	47%
	COP 19	Attained	APR 20	84%		82%		70%		90%		68%		55%	79%	66%	89%	>100%	>100%	92%	>100%	91%	97%	94%	>100%	97%	>100%	>100%	>100%	>100%	>100%	>100%	>100%
Marondera	COP 15	ScaleUp Agg	APR 16	48%		33%		48%		33%		48%		33%	80%	73%	91%	62%	>100%	70%	89%	69%	67%	51%	70%	55%	50%	36%	50%	36%	43%	50%	60%
	COP 16	ScaleUp Agg	APR 17	51%		45%		51%		45%		51%		45%	>100%	95%	>100%	>100%	>100%	99%	>100%	91%	78%	67%	81%	71%	58%	46%	58%	46%	59%	67%	76%
	COP 17	ScaleUp Sat	APR 18	96%		95%		96%		95%		96%		95%	>100%	92%	>100%	89%	>100%	92%	93%	77%	70%	57%	73%	61%	52%	39%	52%	39%	53%	62%	69%
	COP 18	ScaleUp Sat	APR 19	86%		86%		86%		86%		86%		86%	>100%	>100%	>100%	96%	>100%	63%	>100%	92%	82%	68%	85%	72%	60%	47%	60%	47%	69%	76%	78%
	COP 19	Attained	APR 20	90%		89%		>100%		>100%		73%		56%	80%	74%	>100%	93%	>100%	91%	>100%	>100%	>100%	97%	93%	94%	78%	91%	83%	93%	78%	91%	>100%
Masvingo	COP 15	ScaleUp Agg	APR 16	71%		71%		71%		71%		71%		71%	93%	>100%	84%	70%	>100%	55%	>100%	>100%	72%	64%	70%	55%	59%	38%	59%	38%	75%	67%	71%
	COP 16	ScaleUp Agg	APR 17	79%		70%		79%		70%		79%		70%	100%	>100%	91%	81%	92%	66%	>100%	>100%	75%	69%	73%	59%	62%	41%	62%	41%	91%	71%	75%
	COP 17	ScaleUp Sat	APR 18	92%		91%		92%		91%		92%		91%	>100%	>100%	96%	69%	78%	63%	>100%	88%	66%	55%	64%	47%	54%	32%	54%	32%	69%	75%	66%
	COP 18	ScaleUp Sat	APR 19	91%		90%		91%		90%		91%		90%	>100%	>100%	91%	88%	>100%	83%	>100%	>100%	72%	74%	69%	64%	59%	44%	59%	44%	79%	71%	76%
	COP 19	Attained	APR 20	82%		81%		>100%		>100%		53%		52%	67%	64%	>100%	93%	>100%	93%	>100%	>100%	87%	93%	78%	93%	77%	93%	>100%	94%	94%	>100%	94%
Matobo	COP 15	ScaleUp Agg	APR 16	61%		64%		61%		64%		61%		64%	84%	80%	63%	53%	78%	30%	88%	73%	67%	52%	73%	51%	67%	40%	67%	40%	84%	66%	66%
	COP 16	ScaleUp Sat	APR 17	64%		59%		64%		59%		64%		59%	85%	80%	85%	77%	93%	38%	>100%	86%	81%	61%	88%	60%	81%	47%	81%	47%	97%	81%	78%
	COP 17	ScaleUp Sat	APR 18	75%		74%		75%		74%		75%		74%	>100%	97%	>100%	>100%	>100%	62%	>100%	>100%	>100%	88%	>100%	86%	>100%	68%	>100%	68%	>100%	>100%	>100%
	COP 18	ScaleUp Sat	APR 19	74%		74%		74%		74%		74%		74%	>100%	>100%	>100%	>100%	>100%	94%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	82%	>100%	82%	>100%	>100%	>100%
	COP 19	Attained	APR 20	>100%		>100%		>100%		>100%		69%		77%	96%	91%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	82%	90%	>100%	98%	>100%	99%	>100%
Mazowe	COP 15	ScaleUp Sat	APR 16	73%		69%		73%		69%		73%		69%	72%	82%	65%	54%	78%	52%	>100%	>100%	100%	87%	96%	76%	73%	48%	73%	48%	62%	61%	79%
	COP 16	ScaleUp Sat	APR 17	81%		68%		81%		68%		81%		68%	79%	>100%	75%	63%	76%	64%	>100%	>100%	>100%	>100%	>100%	>100%	79%	65%	79%	65%	73%	58%	91%
	COP 17	ScaleUp Sat	APR 18	78%		77%		78%		77%		78%		77%	73%	83%	78%	64%	84%	64%	>100%	>100%	>100%	>100%	>100%	>100%	96%	86%	60%	86%	60%	73%	73%	94%
	COP 18	ScaleUp Sat	APR 19	71%		70%		71%		70%		71%		70%	99%	96%	93%	94%	100%	77%	>100%	>100%	>100%	>100%	>100%	89%	79%	56%	79%	56%	96%	83%	94%
	COP 19	Attained	APR 20	>100%		>100%		>100%		>100%		68%		67%	81%	77%	96%	91%	>100%	92%	>100%	>100%	>100%	>100%	>100%	>100%	65%	92%	91%	91%	74%	91%	>100%
Mberengwa	COP 15	ScaleUp Sat	APR 16	42%		38%		42%		38%		42%		38%	72%	66%	68%	61%	73%	40%	94%	57%	68%	41%	71%	39%	58%	26%	58%	26%	88%	57%	60%
	COP 16	ScaleUp Sat	APR 17	47%		38%		47%		38%		47%		38%	54%	59%	69%	60%	66%	42%	80%	61%	58%	44%	60%	41%	50%	28%	50%	28%	89%	96%	59%
	COP 17	ScaleUp Sat	APR 18	64%		63%		64%		63%		64%		63%	>100%	98%	97%	87%	91%	49%	>100%	>100%	95%	75%	98%	70%	82%	47%	82%	47%	>100%	87%	89%
	COP 18	ScaleUp Sat	APR 19	84%		84%		84%		84%		84%		84%	>100%	>100%	>100%	>100%	>100%	87%	>100%	>100%	96%	93%	>100%	87%	83%	58%	83%	58%	>100%	87%	96%
	COP 19	Attained	APR 20	>100%		>100%		>100%		>100%		90%		90%	>100%	>100%	96%	90%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	95%	70%	90%	>100%	90%	>100%	>100%	>100%
Mt. Darwin	COP 15	ScaleUp Agg	APR 16	91%		81%		91%		81%		91%		81%	>100%	63%	80%	65%	91%	67%	78%	73%	59%	52%	59%	48%	43%	31%	43%	31%	60%	44%	58%
	COP 16	ScaleUp Agg	APR 17	72%		80%		72%		80%		72%		80%	>100%	>100%	93%	75%	96%	77%	93%	88%	71%	63%	71%	58%	52%	38%	52%	38%	59%	45%	66%
	COP 17	ScaleUp Sat	APR 18	79%		78%		79%		78%		79%		78%	98%	79%	>100%	88%	>100%	85%	90%	84%	69%	60%	69%	55%	50%	36%	50%	36%	73%	50%	68%
	COP 18	ScaleUp Sat	APR 19	73%		72%		73%		72%		73%		72%	>100%	98%	83%	84%	92%	69%	>100%	>100%	95%	87%	95%	80%	69%	52%	69%	52%	85%	73%	85%
	COP 19	Attained	APR 20	82%		81%		99%		97%		56%		71%	88%	66%	>100%	90%	>100%	>100%	>100%	>100%	>100%	>100%	100%	90%	63%	90%	80%	90%	79%	90%	>100%
Murewa	COP 15	ScaleUp Agg	APR 16	91%		81%		91%		81%		91%		81%	>100%	>100%	93%	67%	72%	82%	81%	59%	59%	44%	61%	44%	44%	30%	44%	30%	58%	53%	57%
	COP 16	ScaleUp Agg	APR 17	87%		79%		87%		79%		87%		79%	>100%	>100%	>100%	78%	69%	35%	90%	74%	66%	56%	68%	56%	50%	38%	50%	38%	62%	56%	63%
	COP 17	ScaleUp Sat	APR 18	>100%		>100%		>100%		>100%		>100%		>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	91%	89%	68%	93%	68%	67%	46%	67%	86%	>100%	98%
	COP 18	ScaleUp Sat	APR 19	>100%		>100%		>100%		>100%		>100%		>100%	>100%	>100%	>100%	>100%	>100%	79%	>100%	>100%	>100%	86%	>100%	86%	76%	58%	76%	58%	89%	91%	98%
	COP 19	Attained	APR 20	>100%		>100%		>100%		>100%		82%		81%	93%	90%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	97%	63%	90%	85%	90%	77%	>100%	>100%
Mutare	COP 15	ScaleUp Sat	APR 16	81%		81%		81%		81%		81%		81%	98%	91%	64%	67%	97%	64%	>100%	>100%	82%	82%	69%	61%	54%	37%	54%	37%	65%	59%	72%
	COP 16	ScaleUp Sat	APR 17	97%		95%		97%		95%		97%		95%	>100%	>100%	72%	78%	>100%	66%	>100%	>100%	95%	99%	81%	74%	63%	45%	63%	45%	84%	70%	85%
	COP 17	ScaleUp Sat	APR 18	99%		98%		99%		98%		99%		98%	95%	>100%	61%	66%	76%	32%	>100%	>100%	77%	68%	65%	50%	51%	30%	51%	30%	55%	52%	65%
	COP 18	ScaleUp Sat	APR 19	88%		88%		88%		88%		88%		88%	>100%	>100%	76%	61%	>100%	76%	>100%	>100%	70%	81%	60%	60%	47%	36%	47%	36%	63%	56%	68%
	COP 19	ScaleUp Sat	APR 20	49%		48%		90%		90%		36%		35%	42%	41%	80%	92%	>100%	92%	>100%	>100%	92%	93%	77%	92%	77%	93%	>100%	93%	77%	93%	88%
Mutasa	COP 15	ScaleUp Agg	APR 16	63%		49%		63%		49%		63%		49%	79%	60%	96%	55%	>100%	95%	>100%	>100%	88%	99%	76%	74%	60%	46%	60%	46%	81%	65%	80%
	COP 16	ScaleUp Agg	APR 17	62%		48%		62%		48%		62%		48%	87%	66%	>100%	63%	>100%	>100%	>100%	>100%	95%	>100%	83%	88%	65%	54%	65%	54%	82%	63%	88%
	COP 17	ScaleUp Sat	APR 18	88%		87%		88%		87%		88%		87%	>100%	>100%	>100%	91%	>100%	>100%	>100%	>100%	>100%	>100%	98%	91%	78%	56%	78%	56%	>100%	97%	>100%
	COP 18	ScaleUp Sat	APR 19	90%		90%		90%		90%		90%		90%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	82%	64%	82%	64%	>100%	94%	>100%
	COP 19	Attained	APR 20	>100%		>100%		93%		92%		45%		40%	68%	76%	>100%	90%	>100%	99%	>100%	>100%	>100%	>100%	>100%	96%	59%	90%	85%	90%	81%	>100%	>100%
Mwenezi	COP 15	ScaleUp Agg	APR 16	64%		59%		64%		59%		64%		59%	>100%	72%	97%	74%	92%	84%	>100%	>100%	72%	64%	72%	58%	61%	38%	61%	38%	98%	69%	74%
	COP 16	ScaleUp Agg	APR 17	95%		78%		95%		78%		95%		78%	>100%	>100%	>100%	>100%	>100%	68%	>100%	>100%	89%	81%	89%	73%	75%	49%	75%	49%	>100%	81%	90%
	COP 17	ScaleUp Sat	APR 18	82%		82%		82%		82%		82%		82%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	89%	74%	89%	66%	75%	44%	75%	44%	>100%	>100%	95%
	COP 18	ScaleUp Sat	APR 19	92%		91%		92%		91%		92%		91%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	92%	94%	92%	85%	77%	57%	77%	57%	>100%	89%	97%
	COP 19	Attained	APR 20	>100%		>100%		>100%		>100%		>100%		>100%	96%	90%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	96%	90%	95%	90%	>100%	98%	>100%	>100%	>100%
Nkayi	COP 15	ScaleUp Sat	APR 16	67%		65%		67%		65%		67%		65%	95%	82%	79%	71%	88%	31%	75%	82%	58%	59%	62%	57%	58%	45%	58%	45%	95%	>100%	68%
	COP 16	ScaleUp Sat	APR 17	81%		68%		81%		68%		81%		68%	>100%	>100%	94%	95%	94%	38%	92%	98%	71%	71%	77%	69%	71%	54%	71%	54%	>100%	>100%	81%
	COP 17	ScaleUp Sat	APR 18	>100%		>100%		>100%		>100%		>100%		>100%	>100%	>100%	>100%	>100%	>100%	81%	>100%	>100%	89%	91%	95%	88%	89%	69%	89%	69%	>100%	>100%	>100%
	COP 18	ScaleUp Sat	APR 19	>100%		>100%		>100%		>100%		>100%		>100%	>100%	>100%	>100%	>100%	>100%	79%	>100%	>100%	99%	88%	>100%	86%	99%	67%	99%	67%	>100%	>100%	>100%
	COP 19	Attained	APR 20	84%		82%		>100%		>100%		84%		89%	96%	91%	>100%	>100%	>100%	97%	>100%	>100%	>100%	>100%	>100%	90%	66%	90%	>100%	90%	>100%	>100%	>100%
Tsholotsho	COP 15	ScaleUp Sat	APR 16	77%		71%		77%		71%		77%		71%	86%	79%	91%	66%	80%	26%	98%	79%	76%	58%	84%	54%	76%	44%	76%	44%	98%	91%	75%
	COP 16	ScaleUp Sat	APR 17	72%		61%		72%		61%		72%		61%	76%	76%	>100%	91%	77%	25%	96%	74%	75%	55%	82%	51%	75%	42%	75%	42%	>100%	95%	75%
	COP 17	ScaleUp Sat	APR 18	71%		71%		71%		71%		71%		71%	99%	77%	>100%	83%	95%	31%	>100%	91%	87%	67%	96%	63%	87%	52%	87%	52%	>100%	>100%	87%
	COP 18	ScaleUp Sat	APR 19	76%		75%		76%		75%		76%		75%	>100%	>100%	>100%	>100%	>100%	94%	73%	>100%	>100%	88%	98%	77%	88%	63%	88%	63%	>100%	>100%	93%
	COP 19	Attained	APR 20	91%		89%		>100%		100%		76%		77%	89%	90%	>100%	99%	>100%	94%	>100%	>100%	>100%	93%	94%	94%	62%	96%	>100%	92%	>100%	>100%	>100%
Umguza	COP 15	Ctrl Supported	APR 16	36%		39%		36%		39%		36%		39%	40%	42%	39%	24%	51%	27%	57%	61%	45%	44%	48%	43%	45%	33%	45%	33%	56%	57%	46%
	COP 16	Ctrl Supported	APR 17	36%		35%		36%		35%		36%		35%	45%	49%	48%	40%	51%	34%	68%	70%	53%	51%	57%	50%	53%	38%	53%	38%	78%	69%	55%
	COP 17	ScaleUp Sat	APR 18	39%		38%		39%		38%		39%		38%	45%	40%	55%	51%	50%	39%	46%	45%	36%	32%	39%	32%	36%	24%	36%	24%	54%	51%	40%
	COP 18	ScaleUp Sat	APR 19	64%		64%		64%		64%		64%		64%	90%	87%	59%	61%	52%	40%	63%	60%	49%	44%	53%	43%	49%	33%	49%	33%	66%	56%	53%
	COP 19	Attained	APR 20	47%		46%		90%		90%		60%		58%	84%	81%	80%	94%	80%	91%	80%	96%	80%	95%	80%	90%	66%	90%	80%	90%	80%	91%	83%
Umzingwane	COP 15	Ctrl Supported	APR 16	52%		47%		52%		47%		52%		47%	64%	74%	>100%	66%	67%	78%	85%	87%	67%	62%	73%	61%	66%	46%	66%	46%	67%	62%	67%
	COP 16	Ctrl Supported	APR 17	40%		54%		40%		54%		40%		54%	62%	79%	95%	79%	>100%	50%	99%	95%	78%	68%	85%	67%	77%	51%	77%	51%	85%	77%	77%
	COP 17	ScaleUp Sat	APR 18	1%		1%		1%		1%		1%		1%	1%	0%	26%	21%	26%	22%	31%	29%	24%	20%	27%	20%	24%	15%	24%	15%	24%	17%	21%
	COP 18	ScaleUp Sat	APR 19	13%		13%		13%		13%		13%		13%	18%	17%	27%	27%	27%	21%	34%	34%	27%	24%	29%	24%	26%	18%	26%	18%	28%	22%	25%
	COP 19	Attained	APR 20	16%		31%		75%		80%		60%		79%	58%	71%	82%	>100%	80%	95%	80%	92%	80%	95%	80%	93%	92%	96%	98%	95%	89%	94%	87%
Zaka	COP 15	ScaleUp Sat	APR 16	70%		71%		70%		71%		70%		71%	90%	93%	>100%	93%	80%	53%	>100%	>100%	88%	69%	88%	56%	74%	41%	74%	41%	>100%	81%	84%
	COP 16	ScaleUp Sat	APR 17	69%		70%		69%		70%		69%		70%	98%	100%	>100%	>100%	>100%	91%	43%	>100%	>100%	94%	77%	94%	63%	79%	46%	79%	46%	>100%	93%	92%
	COP 17	ScaleUp Sat	APR 18	92%		91%		92%		91%		92%		91%	>100%	>100%	>100%	>100%	>100%	94%	70%	>100%	>100%	>100%	>100%	>100%	>100%	84%	>100%	69%	90%	50%	90%	50%	>100%	>100%	>100%
	COP 18	ScaleUp Sat	APR 19	90%		89%		90%		89%		90%		89%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	88%	88%	65%	88%	65%	>100%	>100%	>100%
	COP 19	Attained	APR 20	>100%		>100%		>100%		>100%		73%		76%	88%	83%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	90%	88%	90%	>100%	>100%	>100%	>100%	>100%
Zvimba	COP 15	ScaleUp Agg	APR 16	61%		57%		61%		57%		61%		57%	69%	63%	58%	48%	85%	49%	>100%	>100%	74%	77%	62%	60%	46%	35%	46%	35%	48%	49%	61%
	COP 16	ScaleUp Agg	APR 17	54%		45%		54%		45%		54%		45%	48%	51%	57%	42%	87%	45%	99%	>100%	67%	66%	57%	52%	41%	31%	41%	31%	39%	42%	55%
	COP 17	ScaleUp Sat	APR 18	>100%		>100%		>100%		>100%		>100%		>100%	99%	>100%	>100%	98%	>100%	64%	>100%	>100%	>100%	>100%	>100%	95%	88%	69%	52%	69%	52%	68%	47%	94%
	COP 18	Attained	APR 19	89%		89%		89%		89%		89%		89%	>100%	>100%	99%	84%	>100%	90%	>100%	>100%	>100%	>100%	>100%	89%	68%	53%	68%	53%	91%	74%	95%
	COP 19	Attained	APR 20	>100%		>100%		>100%		>100%		62%		62%	78%	74%	>100%	90%	>100%	94%	>100%	>100%	>100%	>100%	>100%	>100%	64%	90%	75%	90%	76%	90%	>100%

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Attained	**1,109,156**	**1,151,503**	**0**	**1,221,083**	**141,298**	**100%**
Scale-Up Saturation	-	-	-	-	-	-
Scale-Up Aggressive	-	-	-	-	-	-
Sustained	-	-	-	-	-	-
Central Support	**251,906**	-	-	-	-	-
Commodities	-	-	-	-	-	-
Total	**1,361,062**	**1,151,503**	**0**	**1,221,083**	**141,298**	**100%**

APPENDIX B – Budget Profile and Resource Projections

B1. COP 19 Planned Spending

Table B.1.1 COP 19 Budget by Program Area

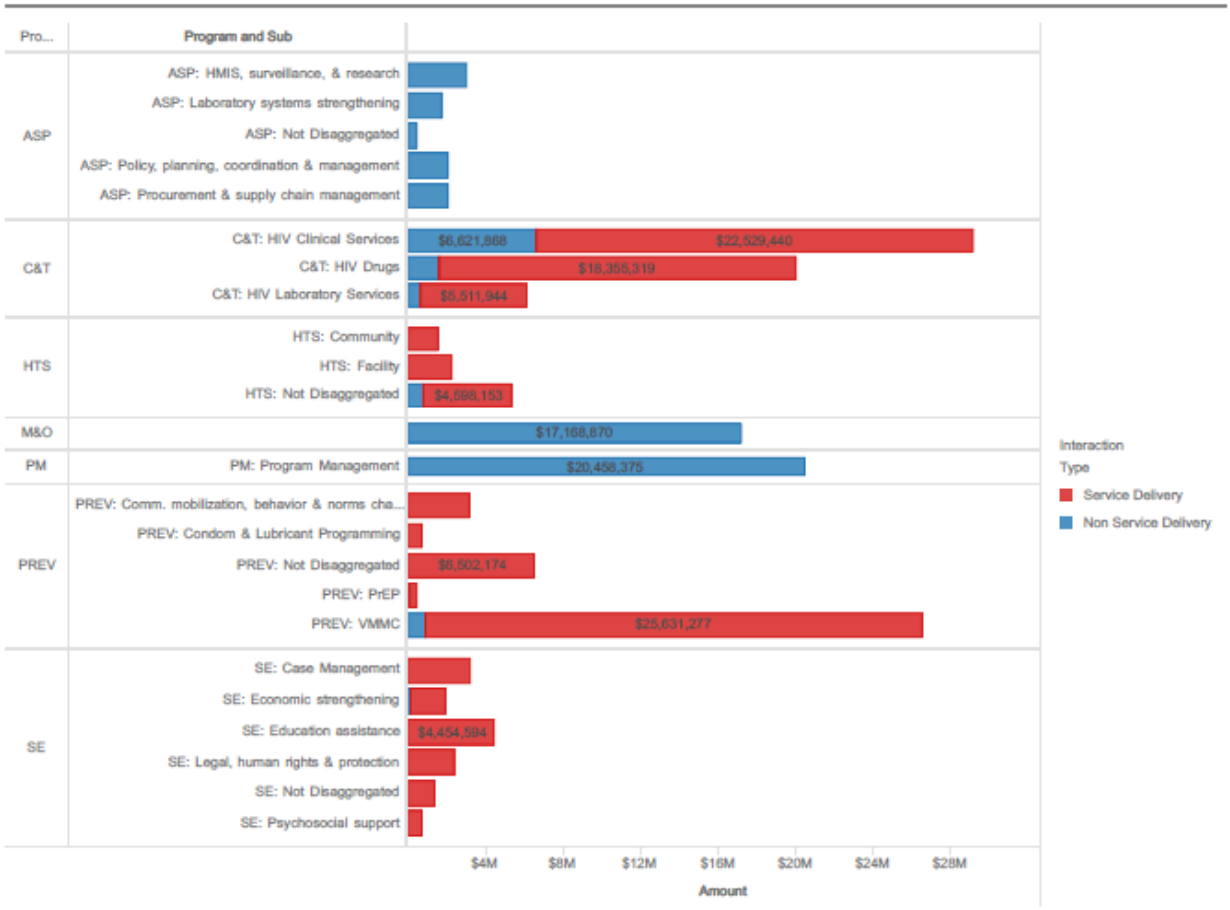


Table B.1.2 COP 19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$ 19,603,554	**143,344,196**	**$ 162,947,750**

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)	
PEPFAR Budget Code	**Amount Allocated**
CIRC	$31,444,867
HBHC	$15,826,990
HKID	$17,431,583
HLAB	$2,741,100
HTXS	$19,439,004

HVAB	$4,609,385
HVCT	$12,167,150
HVMS	$9,741,559
HVOP	$12,368,075
HVSI	$4,360,174
HVTB	$6,064,272
MTCT	$734,751
OHSS	$475,081
PDCS	$3,890,476
PDTX	$2,049,726

B.2 Resource Projections

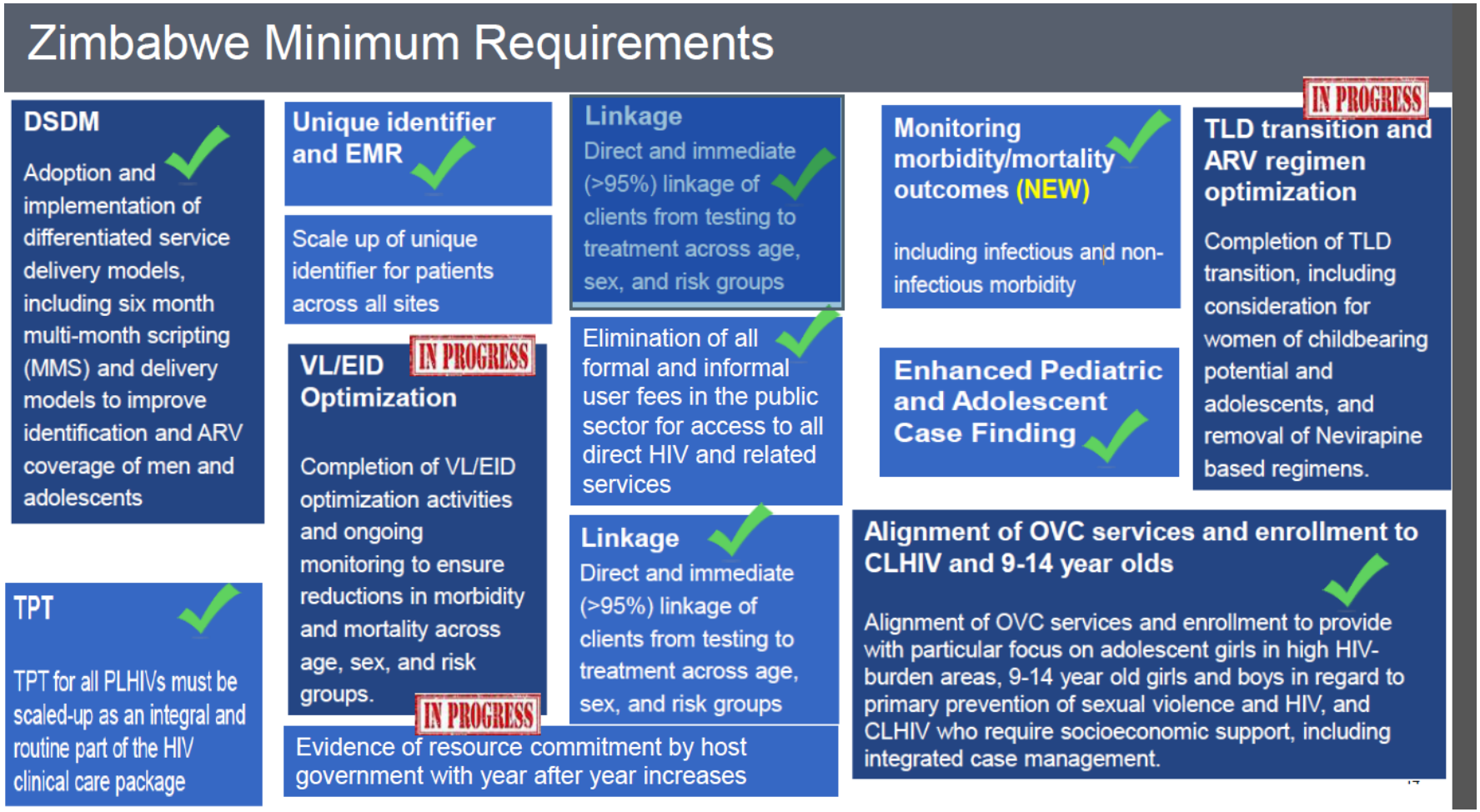
In COP 19, PEPFAR Zimbabwe used the Funding Allocation to Strategy Tool (FAST) to drive budget decisions and funding allocations across initiatives (bilateral, VMMC, Cervical Cancer), beneficiaries (OVC, adult men, girls, etc.)and program areas e.g. Care and Treatment, Above-Site, etc.) process documented in the PEPFAR Budget Allocation Calculator. The FAST is a comprehensive planning and budgeting tool focused on short and long-term solutions and outcomes that will guide the financing and development of implementing partner work-plans in a deliberate effort to optimize PEPFAR investments. In order to populate the FAST, the PEPFAR Zimbabwe team considered the following sources of information to guide the apportionment of COP 18 resources:

- Incremental budget adjustments, pipeline and partner performance (e.g. how much does a partner need to fund a specific activity or package of services such as scaling up access to TPT);
- Regional and national costs associated with specific activities, e.g. self-testing and index testing;
- Review of recent program data including 2019 HIV Estimates (SPECTRUM); and
- Solution centered approaches to reach 95-95-95.

Further refinements and efficiencies made to the integrated HIV testing strategy influenced budget decisions through the reduction of funding for non-index community testing modalities, increased focus on case-finding and reduction of PITC in low gap districts. PEPAR will be procuring TPT commodities for the first time in COP 19, in addition to, commodities for recency testing.

The PEPFAR team currently implements routine monitoring on a monthly basis to track partner performance and progress and will incorporate a review of expenditure analysis (EA) data from

the start of FY 17 to ensure partners are able to implement programs effectively and stay on track to achieve the targets with the budgets assigned to them.


Zimbabwe Minimum Requirements
DSDM
Adoption and implementation of differentiated service delivery models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents
Unique identifier and EMR
Scale up of unique identifier for patients across all sites
Linkage
Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups
Monitoring morbidity/mortality outcomes (NEW)
including infectious and non-infectious morbidity
IN PROGRESS
TLD transition and ARV regimen optimization
Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine based regimens.
VL/EID Optimization
IN PROGRESS
Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.
Elimination of all formal and informal user fees in the public sector for access to all direct HIV and related services
Enhanced Pediatric and Adolescent Case Finding
TPT
TPT for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package
Linkage
Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups
Alignment of OVC services and enrollment to CLHIV and 9-14 year olds
Alignment of OVC services and enrollment to provide with particular focus on adolescent girls in high HIV-burden areas, 9-14 year old girls and boys in regard to primary prevention of sexual violence and HIV, and CLHIV who require socioeconomic support, including integrated case management.
IN PROGRESS
Evidence of resource commitment by host government with year after year increases

APPENDIX E – Addressing Gaps to Epidemic Control including through Communities of Faith

The September 2018 FBO TDY and a consultative process held with CSOs in Zimbabwe recommended the following:

FBO TDY

- Engaging 'Heads of Church Denominations' (HOCD, over EFZ, ZCC, ZCCB, and UNACIZA) at national level, to work within their structures to raise awareness about the new positive epidemic control messages.
- Raising awareness and empowering key Faith Alliance and traditional leaders, Sunday School teachers, parents, youth, and children, about need for violence prevention policies
- Prevention training: for select evidence-based violence and HIV prevention interventions for 9-14s
- Sexuality & violence prevention education through children's programming for 9-14s
- Implementing child protection policies, training faith leaders to access legal, health, protection services referrals for those in need
- Demand creation for reaching men & children – Train HOCD leaders in demand creation, including index, family, risk-based, and in new messaging (Test & Start, Men as Protectors (U=U) and VMMC.

CSO

- IEC and promotional events to address misinformation and lack of understanding on health matters among the Apostolic groups, particularly the ultra-conservative
- Dialogue and engagement with ultra-conservative Apostolic leadership and influential figures

In response, USAID and CDC will undertake a 3-pronged approach at both national and district level.

1. **National level engagements targeting FBO leadership and umbrella bodies (HOCD, ZCC, EFZ, UDACIZA) will focus on:**
    - Developing positive updated messaging and materials on the epidemic (U=U, Test and Start) including timely reporting on sexual violence drawing on Every Hour Matters material

- Conducting training of trainers sessions for national and provincial coordinating bodies with the expected outcome of clear roll out plans
- Engaging TA to support the national coordinating bodies in developing faith community specific child safeguarding policies with clear implementation strategies.

2. **District level engagement for the prevention of sexual violence and HIV risk among adolescents (9-14 year olds) will:**
    - Target religious and traditional leaders with the positive updated messaging on the epidemic and prevention of sexual violence and HIV risk among adolescents including identifying and training champions from the group.
    - Work with and build capacity of FBOs/communities of faith to deliver Families Matter, Communities Matter, SASA Faith!, Keeping Children Safe leveraging DREAMS and OVC platforms
    - Expanding SRHR/norms change education for church youth groups on positive masculinity "Coaching Boys to Men"
    - Creating linkages and strengthening capacity for response to violence, including systems for reporting abuse and justice for children.

3. **District level engagement to increase uptake of HIV testing services among target populations will prioritize districts based on ART gap for men, adolescents and children to:**
    - Secure buy-in from faith leaders, congregants and FBOs in current case finding approaches
    - Coordinate HTS activities within selected congregations, focusing on case finding, children, adolescents and men
    - Targeted distribution of HIV self-test kits, with effective monitoring and linkage strategies
    - Leverage DREAMS DHIS2 database to monitor FBO initiative

FBO TDY and CSO recommendations

Engage 'Heads of Church Denominations' at national level, to work within their structures to raise awareness about new positive epidemic control messages

Raise awareness & empower key Faith Alliance and traditional leaders, Sunday School teachers, parents, youth, & children, about need for violence prevention policies

Prevention training for select evidence-based violence & HIV prevention interventions for 9-14s

Sexuality & violence prevention education through children's programming for 9-14s

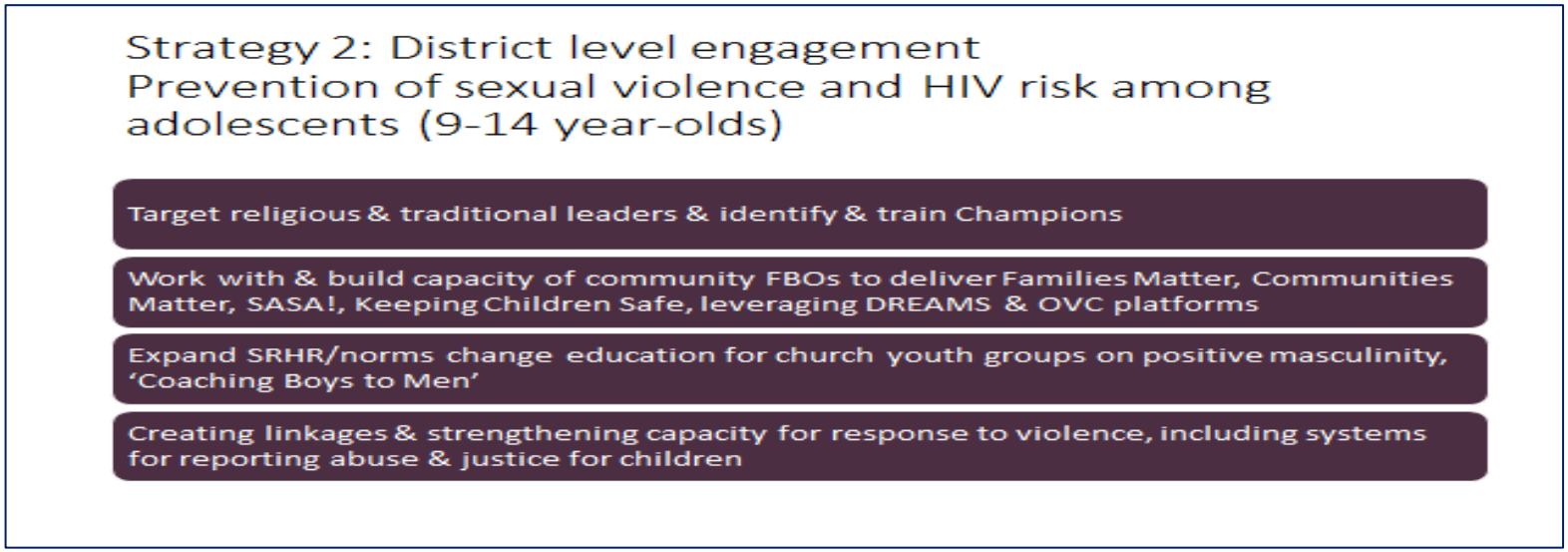
Support child protection policies, training faith leaders to access legal, health, protection services referrals for those in need

Demand creation for reaching men & children: train HOCD leaders in demand creation, including index, family, risk-based, and in new messaging (Test & Start, Men as Protectors (U=U))

Specifically engage Apostolic ultra conservative leaders

Strategy 1: Focused, national level engagement

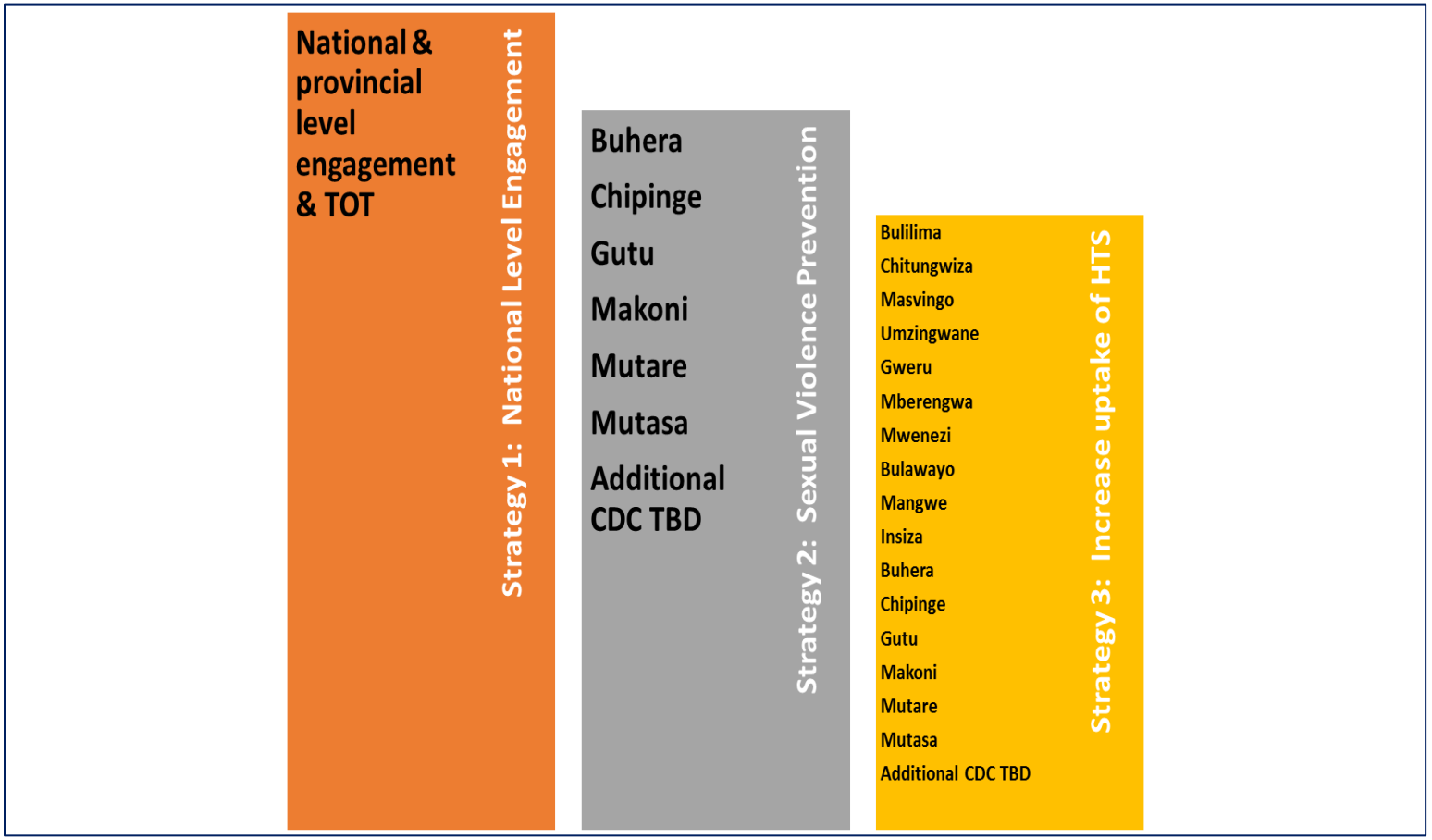
- Target FBO leadership & umbrella bodies (HOCD, ZCC, EFZ, UDACIZA)
- Develop positive, updated messaging & materials on the epidemic (U=U, Test and Start), including timely reporting of sexual violence drawing on Every Hour Matters materials
- Conduct training of trainers sessions (national, provincial coordinating bodies) & develop clear roll out plans
- TA to develop Child Safeguarding policies


Strategy 2: District level engagement
Prevention of sexual violence and HIV risk among adolescents (9-14 year-olds)
Target religious & traditional leaders & identify & train Champions
Work with & build capacity of community FBOs to deliver Families Matter, Communities Matter, SASA!, Keeping Children Safe, leveraging DREAMS & OVC platforms
Expand SRHR/norms change education for church youth groups on positive masculinity, 'Coaching Boys to Men'
Creating linkages & strengthening capacity for response to violence, including systems for reporting abuse & justice for children

Strategy 3: District level engagement to increase uptake of HIV testing services among targeted populations

- Secure buy in from faith leaders, congregations & FBOs in current case finding approaches
- Coordinate HTS activities within selected congregations, focusing on case-finding for children, adolescents & men
- Targeted distribution of HIV self test kits, with effective monitoring & linkage strategies
- Leverage DREAMS DHIS2 database to monitor FBO initiative

FBO Intervention Districts



APPENDIX C – Tables and Systems Investments for Section 6.0

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 1,974,679	Surveillance	Limited data on source and populations newly infected with HIV in PMTCT, MSM, Adult women and men, AGYW	COP18	COP21	1) New diagnosis and recent infection surveillance will be functioning in 400 facilities in Harare, Manicaland, Mash East and Mat South with recency test reporting at patient-level CBS areas. 2) EHR system will have all data elements for longitudinal monitoring of patient sentinel events for CBS 3) TB and cervical cancer modules will be functioning and integrated into version 1.3 addressing all PEPFAR requirements 4) Demonstration of data from YAZ used for policy/program planning. 5) Completed and cleared MSM size estimate report and demonstrated use for policy/program planning.
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 525,161	Oversight, technical assistance, and supervision to subnational levels	Lack of coordinated systems approach to M/E systems	COP16	COP21	1) New diagnosis and recent infection surveillance will be functioning in 400 facilities in Harare, Manicaland, Mash East and Mat South with recency test reporting at patient-level CBS areas. 2) EHR system will have all data elements for longitudinal monitoring of patient sentinel events for CBS 3) TB and cervical cancer modules will be functioning and integrated into version 1.3 addressing all PEPFAR requirements 4) Demonstration of data from YAZ used for policy/program planning. 5) Completed and cleared MSM size estimate report and demonstrated use for policy/program planning.
HHS/CDC	Research Triangle Institute	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 38,800.00	HMIS systems	Lack of coordinated systems approach to M/E systems	COP16	COP21	Costed report outlining the ICT infrastructure needs for facility implementation of E-HR and needs for data transmission to central level for case-based surveillance and longitudinal monitoring of HIV patients.
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 40,000.00	Research	Clinical guidelines and policy for service delivery	COP19	COP19	1.Completed assessmnet tool to be implemented by clinical parnters. 2. Completed data anlysis with report developed for dissemination of findings.
USAID	Family Health International	ASP: Policy, planning, coordination & management	Females: Young women & adolescent females	$ 36,246.00	Service organization and management systems	DREAMS activities are multisectoral, delivered by several different partners, which requires careful routine planning & coordination, and a well-functioning referral system, at district level.	COP17	COP21	1.) District referral directories updated at least annually; 2) Targets for referral closure rates set and closely monitored; 3.) Layering and program completion data reviewed during stakeholder meetings to implementation adjustments; 4) Referral meeting SOP developed; 5) DREAMS database and dashboards used in all district review meetings; 6) at least 2 district exchange visits/meetings are conducted to share best practices in layering & monitoring completion
USAID	FAMILY AIDS CARING TRUST	ASP: Policy, planning, coordination & management	Females: Young women & adolescent females	$ 75,000.00	Service organization and management systems	DREAMS activities are multisectoral, delivered by several different partners, which requires careful routine planning & coordination, and a well-functioning referral system, at district level.	COP17	COP21	1.) District referral directories updated at least annually; 2) Targets for referral closure rates set and closely monitored; 3.) Layering and program completion data reviewed during stakeholder meetings to implementation adjustments; 4) Referral meeting SOP developed; 5) DREAMS database and dashboards used in all district review meetings; 6) at least 2 district exchange visits/meetings are conducted to share best practices in layering & monitoring completion

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	Population Services International	ASP: Policy, planning, coordination & management	Females: Young women & adolescent females	$ 98,832.00	Oversight, technical assistance, and supervision to subnational levels	Limited Nat'l level coordination of DREAMS programming especially in light of GF expansion	COP16	COP21	1.) National level DREAMS meetings are facilitated by MOHCC Coordinator (at least 75% of bi-monthly meetings take place); 2.) PEPFAR supported DREAMS activities are incorporated in MOHCC quarterly prevention partnership meetings; 3.) MOHCC secondment acts as PoC for all PEPFAR learning visits
USAID	Population Services International	ASP: HMIS, surveillance, & research	Females: Young women & adolescent females	$ 150,000.00	HMIS systems	While the ability to track and understand layering of DREAMS interventions by unique individual has dramatically imrpoved, gaps remain in understanding coverage of minimum packages by sub-populations and systems for closing referrals.	COP16	COP21	1.) Referral tracker rolled out & used by all DREAMS IPs; 2.) Interoperability plan developed to link DREAMS database to other relevant national data management systems; 3.) Reporting framework developed for national level DREAMS results incorporating PEPFAR & GF inputs; 4.) Database reconfigured to produce completion data; 5.) National & district level dashboards and SOPs for data review are developed
USAID	Population Services International	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 84,000.00	Oversight, technical assistance, and supervision to subnational levels	Limited national coordination of biomedical prevention and other prevention activities. These activities are multisectoral and implemented by several stakeholders	COP16	COP21	4 forums/ meetings; design of national prevention program; seamless multistakeholder coordination and transition to sustainable programming; implementation of national prevention programs sustains epidemic control; districts own integrated testing strategy
HHS/CDC	UNIVERSITY OF WASHINGTON	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 106,247.00	HMIS systems	Limited MOHCC capacity to meet the M&E demands of an evolving and dynamic program while meeting strict reporting deadlines, with high qaulity data	COP16	COP21	1. All facilities reporting using updated tools (to include FBO initiative and any new reporting requirements), and in a timely manner. 2. Quarterly DQAs conducted. 3. Under 10% data variance
HHS/CDC	UNIVERSITY OF WASHINGTON	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 136,316.28	Oversight, technical assistance, and supervision to subnational levels	Limited MOHCC capacity to coordinate and supervise Continuous Quality Improvement initiatives	COP16	COP21	1. All facilities with at least one completed QI project with results. 2. All facilities with ongoing QI initiatives
HHS/CDC	UNIVERSITY OF WASHINGTON	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 515,551.00	Oversight, technical assistance, and supervision to subnational levels	Inadequate MOHCC capacity to initiate, coordinate and manage HCW capacity building programs and curricula, disseminate trainings as well as to design and implement PPPs. Limited MOHCC capacity to support and strengthen facility-community linkages. Limited MOHCC capacity monitor expenditures, compliance with budgets and timely liquidation of expenditures	COP16	COP21	1. Ongoing review of HCW capacity development needs. 2. Ongoing revision of HCW capacity development curricula. 3. Availability of active PPPs. 4. Improved compliance of expenditure, liquidation and financial rporting. 5. SOPs for facility-community linkage initiatives
HHS/CDC	BIOMEDICAL RESEARCH & TRAINING INSTITUTE	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 1,761,175	Lab quality improvement and assurance	An inadequate laboratory specimen transport network	COP19	COP21	1. 50% of PEPFAR supported sites have an optimized sample transportation in place 2. 30% of PEPFAR supported facilities implementing RTCQI program. 10 non PEPFAR districts to implement tester based HIVRDT-PT 3. Facilities in 8 districts have an enhanced health systems and facility capaity including Intercadre functioning

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	BIOMEDICAL RESEARCH & TRAINING INSTITUTE	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 400,000.00	HMIS systems	Poor functionality of the Laboratory Information Management System (LIMS)	COP18	COP21	11VL labs with functional LIMS
HHS/CDC	BIOMEDICAL RESEARCH & TRAINING INSTITUTE	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 70,000.00	Service organization and management systems	Poor coordination of Laboratory Services, Viral Load Scale Up and multiple stakeholders by the MOHCC	COP19	COP21	Improved coordination through TWG meetings, Quarterly site visits
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 2,056,575.00	Forecasting, supply chain plan, budget, and implementation	Lack of MOHCC funding for procurment and supply chain coordination and the bi-annual national quantification and supply planning exercise.	COP16	COP21	1) Reports from semiannual quantification exercise 2) Maintain low stockout rates of tracer medicines/products within global industry standards. TLE &TLD<1%, LZN [peds]<1%, male condoms <5%, Determine RTK <5%, VMMC universal surgical disposable kit <5%
USAID	TBD	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 400,000.00	Oversight, technical assistance, and supervision to subnational levels	No MOHCC suport for coordination and management	COP16	COP21	Addendum fully implemented at all PEPFAR supported sites. Seconded staff maintained.
USAID	TBD	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ 300,000.00	FBO engagement to reach epidemic control	Lack of treatment literacy packages specifically targeting FBOs	COP19	COP21	Treatment literacy materials disseminated. Trainings done
HHS/CDC	TBD	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 105,181.00	HMIS systems	Limited MOHCC capacity to meet the M&E demands of an evolving and dynamic program while meeting strict reporting deadlines, with high qaulity data	COP16	COP21	1. All facilities reporting using updated tools (to include FBO initiative and any new reporting requirements), and in a timely manner. 2. Quarterly DQAs conducted. 3. Under 10% data variance