



PEPFAR Zambia

Country Operational Plan (COP) 2020

Strategic Direction Summary

March 16, 2020

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1.0 Goal Statement

The US President's Emergency Plan for AIDS Relief (PEPFAR) Zambia's program is poised to achieve 90-90-90 targets for HIV epidemic control in COP19. In COP20, the focus will shift to retaining those people living with HIV (PLHIV) on treatment with client centered approaches and preventing new HIV infections through evidence-based prevention programs. The Government of the Republic of Zambia (GRZ) is committed to ending HIV by 2030 and is using the 90/90/90 Fast Track Strategy to measure epidemic control. PEPFAR and GRZ, through close collaboration, continue to achieve the needed milestones to reach the epidemic control targets and continually dialogue over resource allocation to ensure financially sustainable programs are developed.

According to the GRZ antiretroviral treatment (ART) data, Zambia has approximately 85% of PLHIV on ART (surpassing the 90/90/90 target). However, HIV models suggest that the number of new HIV infections still exceeds the number of AIDS related deaths and they have not declined to the levels that epidemic control should illustrate. Recognizing this, PEPFAR Zambia is focusing retaining PLHIV on treatment and on interrupting the HIV transmission cycle by finding and retaining men (20-34) and adolescent girls and young women (AGYW) (15-24) in geographic areas with the largest treatment gaps.

The key focus of COP20 is on retaining those in care. Two of the key strategies are transitioning 80% of adults on ART to the more efficacious and safer dolutegravir-based (TLD) by the end of 2021 and providing 6-month multi-month dispensation (MMD) of antiretroviral drugs (ARVs) to all eligible clients. Through improved adherence and retention, PEPFAR Zambia will aim to achieve 95% viral load (VL) suppression. Additionally, GRZ provincial health workers and civil society organizations (CSOs) are being trained to spread key messaging on HIV treatment literacy including promulgating the VL messaging of undetectable equals untransmittable (U=U) to encourage PLHIV to stay on HIV treatment.

Key COP20 strategies will include scale up of the community post model, which has demonstrated results especially in finding and retaining men, and an increase of differentiated models of care for AGYW such as support groups, adolescent clinics, etc. to all high-volume facilities. PEPFAR Zambia will also implement a Pediatric Surge, finding HIV-exposed infants and ensuring greater than 80% early infant diagnosis (EID) coverage starting at 6-8 weeks of life through cessation of breastfeeding. The Pediatric Surge will package innovative practices currently deployed in COP19, including offering family-centered services to treat and provide support services to the entire family. PEPFAR Zambia will continue to invest in and expand evidence-based prevention interventions such as Voluntary Medical Male Circumcision (VMMC), DREAMS, and pre-exposure prophylaxis (PrEP). Key populations (KPs) programming will be expanded while ensuring that in targeted areas, at least 95% of KPs living with HIV are linked to treatment and all those who test negative are offered PrEP.

PEPFAR Zambia will work with GRZ to assure enough funds to maintain and sustain epidemic control through advocating for GRZ to increase domestic resources for HIV response. A key aspect of sustaining the gains made requires a responsible transition of the PEPFAR supported staff paid through international NGOs to local NGOs and the GRZ. This will be supported with PEPFAR financing through government to government (G2G) agreements in 8 provinces supported by technical assistance by USG to train health workers and to build capacity in key service delivery areas. The PEPFAR interagency team continually monitors all investments to ensure the resources are where the burden is the greatest. The specificity in data required by PEPFAR Zambian implementing partners (IPs) not only gives performance data, but continually improves strategic data allowing for adjustments, if needed.

PEPFAR Zambia recognizes the integral role all external stakeholders have played and will continue to play in sustaining epidemic control. Collaboration with key stakeholders at all levels throughout the year allows for issues to be addressed quickly helping further the goal of an AIDS free Zambia.

2.0 Epidemic, Response, and Program Context

2.1 Summary Statistics, Disease Burden and Country profile

Zambia is a lower, middle-income country (GNI:4,100 per capita, PPP, World Bank 2018 data) with an estimated population of 17,381,168 in 2019 (population demographics: 49.5% male, 50.5% female; 56.9% rural, 43.1% urban). According to the 2018 Zambia Demographic Health Survey (ZDHS) Final Report, 11.1% of persons aged 15-49 are living with HIV (14.2% of adult women, 7.5% of adult men). HIV prevalence among children under 15 years is estimated to be 0.7% (Spectrum 2019).

In 2020, 1,240,262 Zambians are estimated to be living with HIV, with women disproportionately affected (60%). Adolescent girls and young women (AGYW) ages 15-24 have an incidence rate of 0.7% compared to 0.3% of men ages 15-24 and new infections among young women are more than double those among young men. Of the estimated PLHIV in Zambia, 95% are estimated to know their HIV status, 85% are on ART, and 77% are estimated to be virally suppressed. The ART coverage for adult males above the age of 25 is 79% compared to ART coverage of 89% among adult women above the age of 25 (DHS, 2018). ART coverage among children living with HIV (CLHIV) less than 15 years of age is 81%. Adolescent boys and young men (ABYM) (15-24) have the lowest coverage of any of these age/sex groups at 68%.

For key populations, robust data on population size and HIV impact remains a challenge. PEPFAR Zambia undertook a size estimate exercise in 2019 which estimated the population of men who have sex with men (MSM) to be 68,044 with a prevalence rate of 17.7% and the population of female sex workers (FSW) to be 133,566 with an HIV prevalence of 41.6%. PEPFAR Zambia is planning to implement an integrated biological and behavioral surveillance (IBBS) for FSW, MSM, and people who inject drugs (PWID) in COP19 and COP20 to better understand the HIV epidemic among these populations and develop better size estimates.

Geographically, the 2018 ZDHS shows that Copperbelt and Lusaka Provinces have the highest HIV prevalence (15.4 and 15.1%) and absolute HIV burden (250,329 and 353,808 respectively), accounting for 49% of Zambia's total PLHIV. Prevalence is greater than 10% in Central (12.4%) Western (10.6%), and Southern (12.4%), and below 10% in Luapula (7.9%), Eastern (7.4%), and Northern (5.6%), North-Western (6.1%), and Muchinga (5.4%). Spectrum data for morbidity and mortality approximates the total number of deaths attributed to AIDS in 2019 as 16,226 (a reduction of ~30% since 2010) with TB continuing to be the leading cause of death among PLHIV.

Table 2.1.1 Host Country Government Results

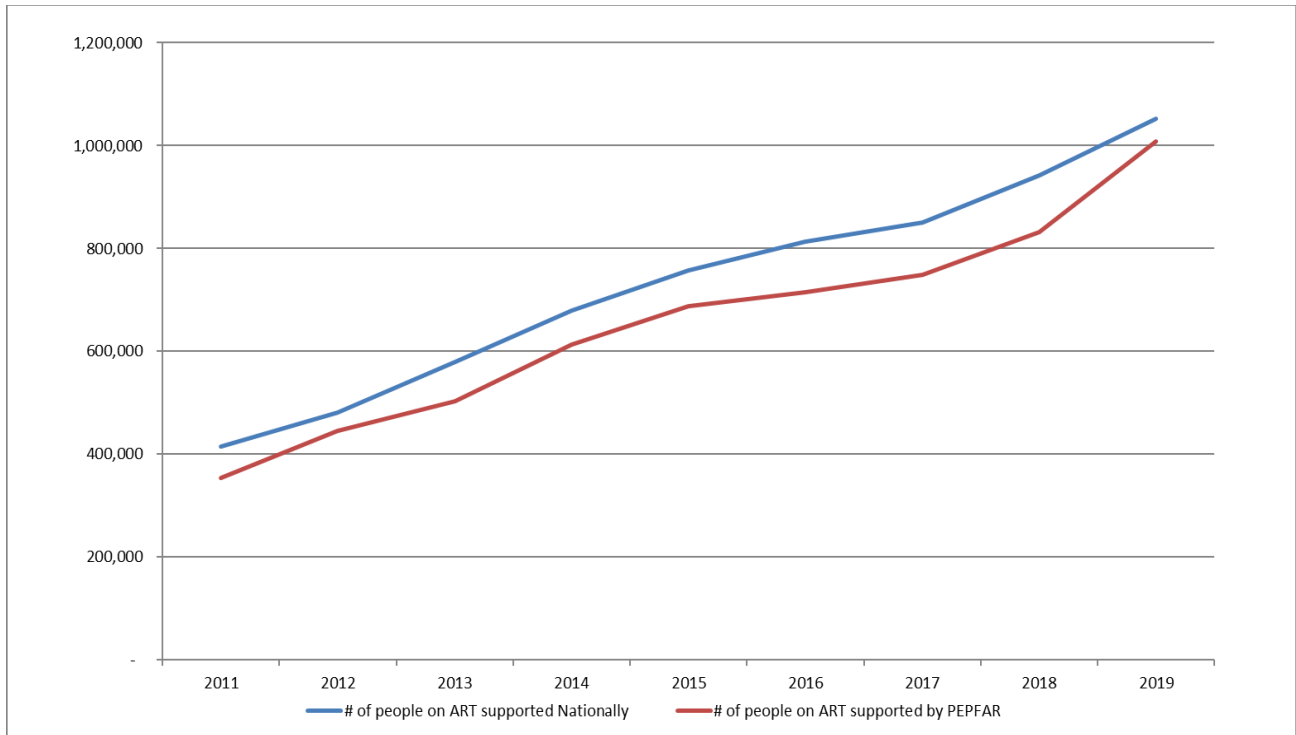
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	17922120		4,038,933	23%	3,990,050	22%	1,790,327	10%	1,725,557	10%	3,316,017	19%	3,061,238	17%	Spectrum, 2019
HIV Prevalence (%)		6.9%		0.7%		0.7%		4.7%		2.3%		18.8%		14.1%	Spectrum, 2019
AIDS Deaths (per year)	16038		1,371		1,389		1,318		806		5,968		5,186		Spectrum, 2019
# PLHIV	1240262		29,381		29,247		84,959		39,407		624,811		432,456		Naomi, 2019
Incidence Rate (Yr)		0.26%		NA		NA		0.7%		0.3%		0.4%		0.4%	Spectrum, 2019
New Infections (Yr)	44230														Spectrum, 2019
Annual births	740594	4.1%													Spectrum, 2019
% of Pregnant Women with at least one ANC visit	718376	97%	NA	NA			NA	NA			NA	NA			ZDHS, 2018
Pregnant women needing ARVs	52994														Spectrum, 2019
Orphans (maternal, paternal, double)	1073600														Spectrum, 2019
Notified TB cases (Yr)	37203														WHO, 2017
% of TB cases that are HIV infected	20362	58.9%													WHO Global report, 2018 *with known HIV status
% of Males Circumcised	1853436														HMIS
Estimated Population Size of MSM*	68044	1.4%													JHU, 2020
MSM HIV Prevalence	12044	17.7%													UCSF, 2018
Estimated Population Size of FSW	133566	2.6%													JHU, 2020
FSW HIV Prevalence	55563	41.6%					NA	NA			NA	NA			UCSF, 2018
Estimated Population Size of PWID	NA														
PWID HIV Prevalence	NA														

Table 2.1.2 95-95-95 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	18,066,765	7%	1,240,247	5,527,598	1,098,309	89%	90%	5,527,598	289,973	236,207
Population <15 years	8,087,486	1%	58,615	861,050	49,392	84%	75%	861,050	14,007	11,322
Men 15-24 years	1,739,918	2%	39,409	687,116	24,240	62%	77%	687,116	12,179	8,293
Men 25+ years	3,088,252	14%	432,448	1,156,524	371,284	86%	91%	1,156,524	99,420	80,567
Women 15-24 years	1,804,698	5%	84,970	1,212,886	61,124	72%	85%	1,212,886	43,842	33,108
Women 25+ years	3,346,411	19%	624,805	1,610,022	592,269	95%	92%	1,610,022	120,525	102,917
MSM	68,044	17.7%								
FSW	133,566	41.6%								
PWID	26,840	16.6%								
Priority Pop (AGYW)	1,804,698	5%								

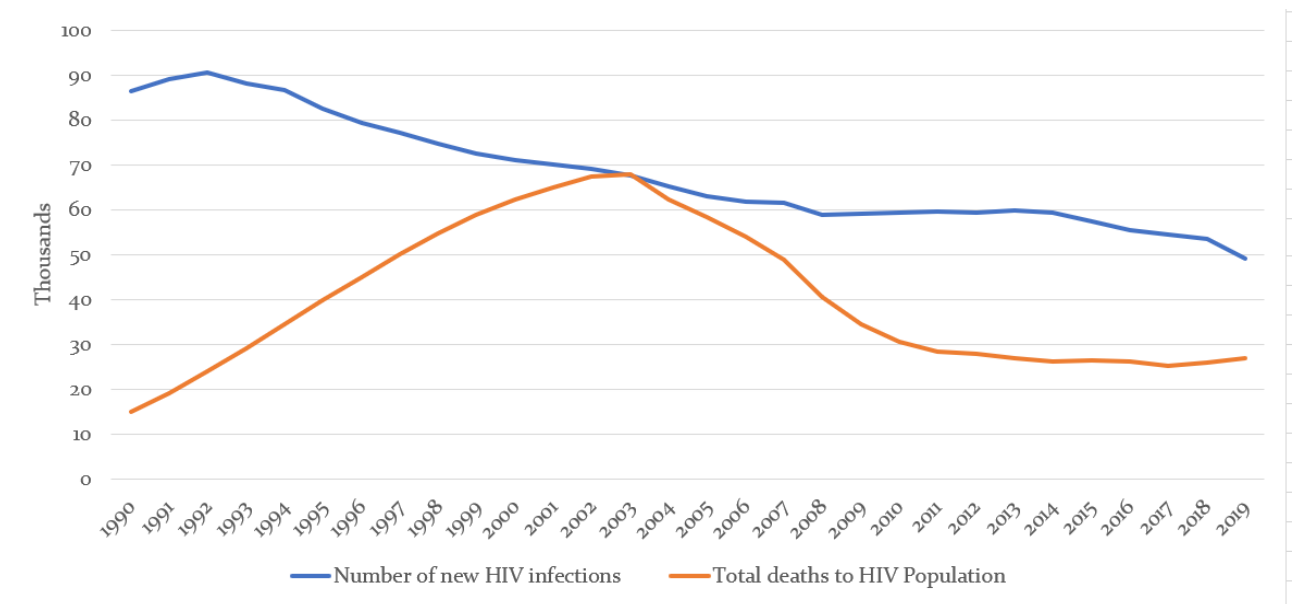
Source: COP20 Datapack & DATIM

Figure 2.1.3 Updated National and PEPFAR trend for Individuals Currently on Treatment



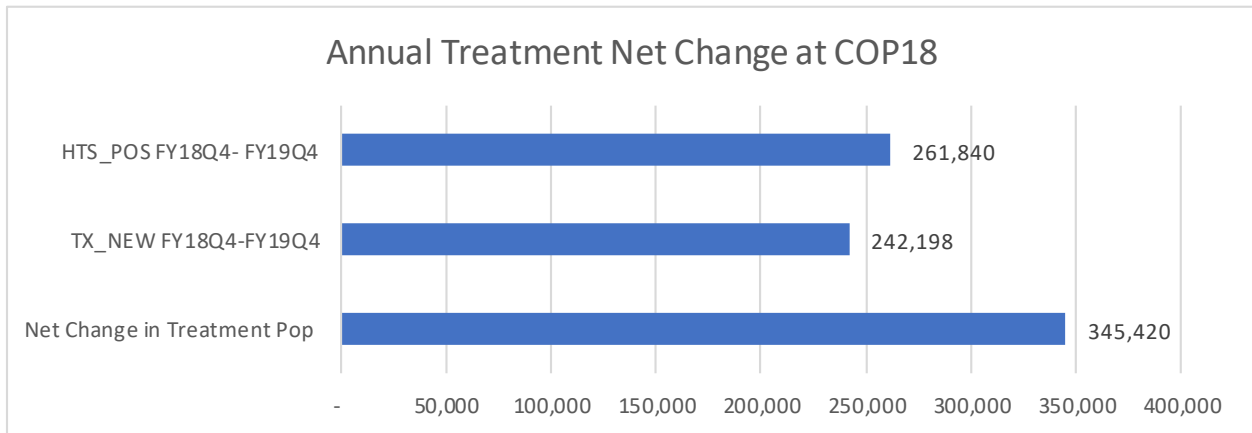
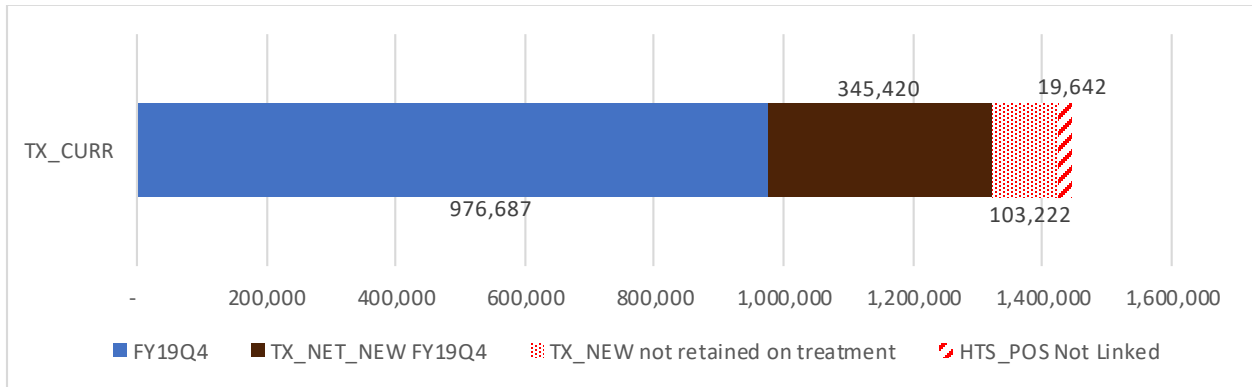
Source: HMIS & DATIM Program Reports

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



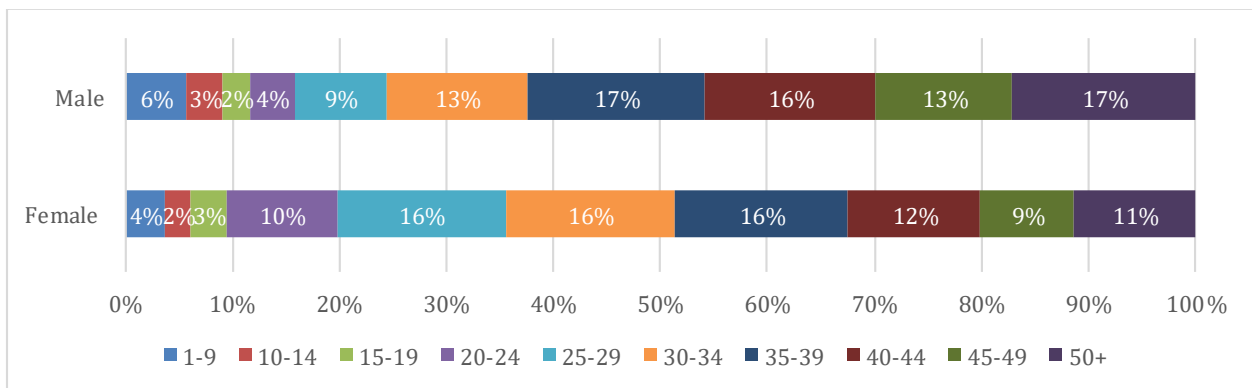
Source: HMIS & DATIM Program Reports

Figure 2.1.5 Progress Retaining Individuals in Life long ART in COP18 (FY19)



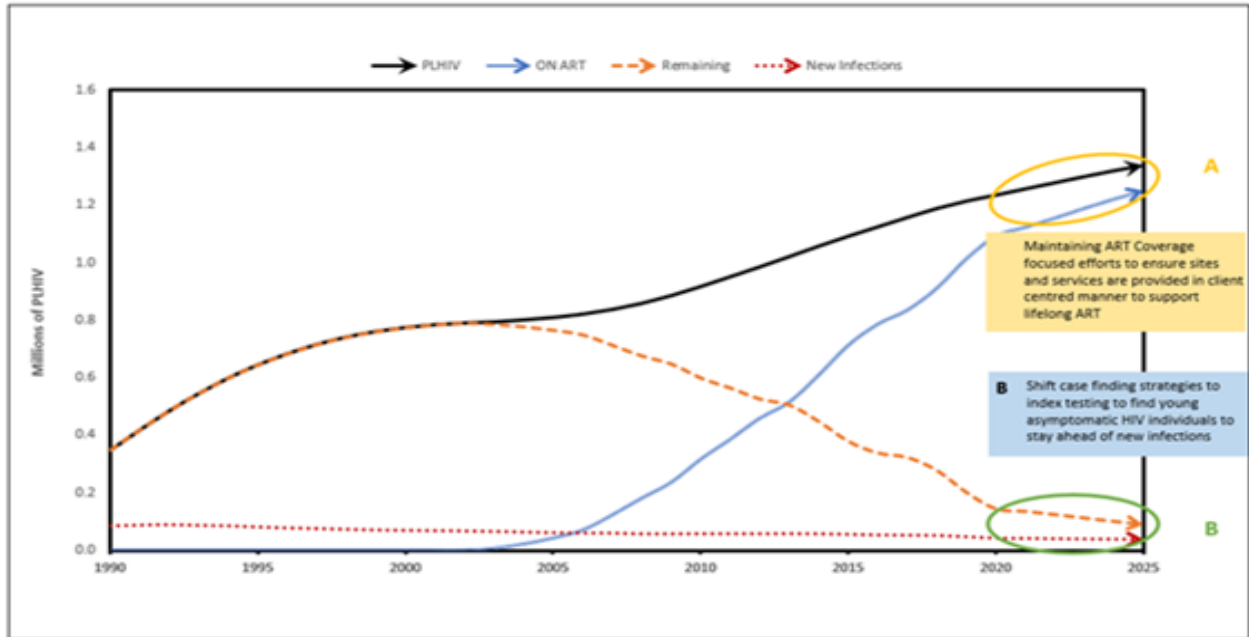
Source: DATIM

Figure 2.1.6 Proportion of Clients Lost from ART 2018 Q4 to 2019 Q4



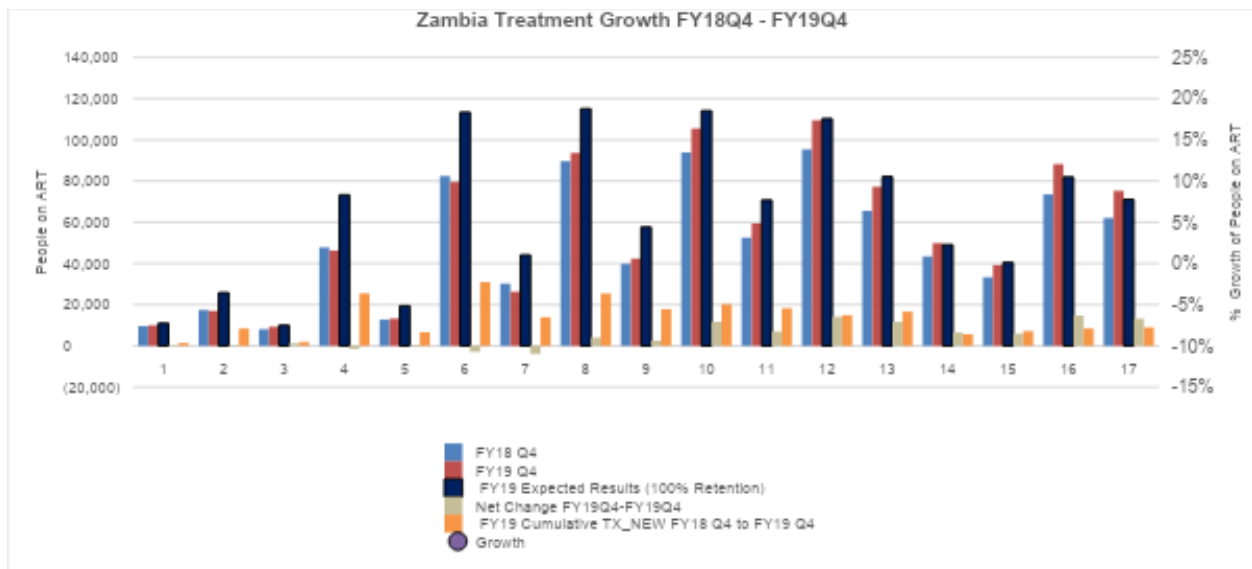
Source: Palantir

Figure 2.1.7 Epidemiologic Trends and Program Response for Zambia



Source: Spectrum estimates

Figure 2.1.8 Net Change in HIV Treatment by Sex and Age Bands 2018 Q4 to 2019 Q4



Source: DATIM

2.2 New Activities and Areas of Focus for COP20

In COP20 the focus will be on implementing highly targeted HIV testing to find the men and AGYW who do not know their status. This will primarily include index testing of sexual partners (and children of PLHIV), social networking testing for KPs, and use of HIV screening tool in high yield areas within facilities. Retaining clients in care will be the primary focus of COP 20 by scaling up community post model, differentiated service delivery for adolescents, 6-month MMD and increasing the proportion of adults on TLD to 80%. PrEP will be significantly scaled up from approximately 25,000 currently on PrEP to 110,000. DREAMS will be scaled up from 8 to 14 districts.

2.2.1. DREAMS Saturation and Expansion

To reduce HIV incidence among AGYW, PEPFAR Zambia will ensure saturation of the 8 existing DREAMS districts (Lusaka, Livingstone, Chipata, Chingola, Kabwe, Kapiri Mposhi, Ndola and Kitwe). To saturate the existing DREAMS districts, PEPFAR Zambia will enhance the economic strengthening layer, recruit the most at risk AGYW using OGAC criteria, employ DREAMS mentors and Ambassadors and strengthen the collaboration with the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) and the Ministry of Health (MOH). PEPFAR Zambia will also, expand DREAMS to six additional districts namely Monze, Mazabuka, Mongu, Kasama, Luanshya and Mufulira.

2.2.2 Key Population Program

To enhance HIV prevention and treatment among KPs the PEPFAR Zambia KP program will expand to one additional district i.e. Nakonde district, enhance the KP safety and security policies and provide increased access to PrEP for KPs ensuring all who test negative are offered PrEP.

2.2.3. Pre-exposure Prophylaxis

Based on the successful COP18 PrEP achievement, PEPFAR Zambia will expand PrEP services ensuring that all vulnerable and high-risk populations are reached, targeting to reach 110,000 clients with PrEP compared to an achievement of 24,397 at the end of COP18. The populations being offered PrEP have also been expanded to eligible pregnant and breastfeeding women (PBFW), AGYW in DREAMS and non-DREAMS districts KPs.

2.2.4 Case Finding and Linkage

In COP20, the main case finding modality will be index testing and social network testing with the aim of finding the majority of positives using this modality. PEPFAR Zambia will use provider-initiated testing and counseling (PITC) only in limited settings (ANC, TB and STI clinics, inpatient wards and among VMMC clients). In geographic areas where there are still treatment gaps, PEPFAR Zambia will leverage the COP20 ambition funds for Circle of Hope and DISCOVER Health to identify priority populations such as men 20-34 and AGYW 15-24 using the modalities

mentioned above. PEPFAR Zambia will also ensure index testing of all biological children (up to age 19) of PLHIV through the Pediatric Surge.

Furthermore, PEPFAR Zambia will expand HIV recency testing to all 10 provinces in Zambia compared to four provinces in COP19. Recency results will be used to identify demographic and geographic patterns of new HIV infections for appropriate public health response.

2.2.5. Orphans and Vulnerable Children

In COP20 PEPFAR Zambia will expand the OVC program to three additional districts (Mongu, Chipata and Petauke) and ensure closer alignment of the OVC and DREAMS programs in DREAMS districts. All CLHIV in OVC districts will be offered OVC services in COP20. The OVC program will support the Pediatric Surge and institute standardized formal agreements/standard operating procedures (SOPs) between OVC IPs and facilities. The OVC program will provide government to government funding for the Ministry of Community Development and Social Services and related technical assistance to build GRZ capacity to assume an increased role in service delivery of OVC programs.

2.2.6. Voluntary Medical Male Circumcision

In COP20, PEPFAR Zambia aims to saturate VMMC among the 15-29-year olds using base and ambition funds. At present, the current saturation rate among 15-29-year olds is approximately 66%. By the end of COP20, this age group will reach 80% saturation with VMMC. PEPFAR Zambia will not provide VMMC services to males <15.

2.2.7. Cervical Cancer

In COP20, PEPFAR Zambia will ensure district wide coverage of cervical cancer (CxCa) screening services in all 104 PEPFAR support districts. To improve treatment rates, PEPFAR Zambia will provide transport and assisted referrals for loop electrosurgical excision procedure (LEEP) services for clients coming from facilities without theatre services. Additionally, UNITAID/CHAI will support the MOH with handheld thermal ablation and LEEP devices for use in select CxCa screening clinics across the country.

2.2.8. Treatment

Having reached the second 90 target with an overall ART coverage of 85% at the end of COP19 Q1, PEPFAR Zambia will invest in retaining the existing cohort. These will include interventions such as 6-month MMD for eligible clients and transitioning 80% of adults to TLD by the end of 2021. In COP20, PEPFAR Zambia will also close the remaining gap at APR 20 using the community post model with focus on Lusaka, Copperbelt and Southern Provinces where the largest coverage gaps remain. Further, PEPFAR Zambia will follow up on all clients with missed appointments and bring them back in to care. Additionally, PEPFAR Zambia will provide baseline VL for all newly identified HIV infected clients to better track treatment outcomes. Finally, PEPFAR Zambia will build on the gains made in the COP 19 TB preventative therapy (TPT) Surge (being implemented with effect

from February 2020 and aiming to initiate at least 700,000 recipients of care (RoC) on TPT within COP19) to ensure all eligible RoC receive and complete TPT.

2.2.9. Viral Load Coverage

PEPFAR Zambia more than doubled VL coverage from about 32% at the beginning of COP18 to 74% at the end of COP18. To further optimize VL testing in COP20, PEPFAR Zambia will support both MOH and Ministry of Defense (MOD) to roll out the use of dried blood spot test (DBS) for VL testing beginning with sites/districts with VL coverage <50% at COP18. This is especially critical for improving coverage among children, whose access to VL testing may be limited by lack of phlebotomy skills among healthcare workers to successfully obtain blood through venipuncture.

Furthermore, PEPFAR Zambia will expand point of care services for viral and EID on the GeneXpert platform from 18 districts in COP19, to an additional 18 districts in COP20. Finally, in sites still using conventional PCR testing for VL and EID, PEPFAR Zambia will institute an on-call sample transfer system. The on-call sample transfer system will improve access to VL testing (and other support labs) for smaller sites which may have inadequate courier coverage. This system, in addition to the DBS and use of GeneXpert will facilitate at least 95% VL coverage for PEPFAR Zambia.

2.3 Investment Profile

The GRZ continues to demonstrate high commitment to the HIV response. The GRZ provides the majority of infrastructure and human resources, the backbone of the response. In its HIV response, GRZ is supported by key partners notably the U.S. government through PEPFAR as the major funder followed by the GFATM.

At the macro-economic level, GRZ's external debt as of December 2019 was \$11.2 billion compared to \$10.05 billion as of December 2018 (Ministerial Statement on the State of the Economy, February 2020). The value of the Zambia kwacha has been dropping. In November 2019, it hit the ZMW14: \$1 mark and has persisted at that level or below. The annual rate of inflation jumped to 13.9% in February 2020, the highest on record since October 2016 (Zambia Statistics Agency). For much of 2019, Zambia was plagued by electricity outages and load-shedding coupled by severe drought. These factors had a significant impact on service delivery and the economy in general. The high debt repayments, the depreciation of the kwacha, inflation, drought and other economic challenges pose a threat to the country's financial stability and could impede its ability to support the goals of maintaining epidemic control.

GRZ has taken some measures to address these challenges some of which include adopting output-based budgeting to improve on budgetary management and implementing the National Health Insurance scheme to increase domestic resource mobilization. One of the goals of the National Health Insurance scheme is to improve and harness private sector participation in the provision of health care services. (www.nhima.co.zm) It is a commendable goal as the private sector

contribution to the HIV response in Zambia is at less than 1.0%. (National AIDS Spending Assessment, 2019)

Success in maintaining epidemic control in COP20 hinges on the strong partnership between GRZ and other funders and stakeholders. PEPFAR Zambia is working closely with GRZ, GFATM and other funders to strengthen GRZ's efforts to increase efficiencies in health expenditures and working jointly with GFATM to effectively plan for sustainable high impact interventions that can lead to GRZ taking a greater share of the financial responsibility for the HIV response.

Table 2.3.1 Annual Investment Profile by Program Area					
Program Area	Total Expenditure	PEPFAR	GFATM	GRZ	Other
Care and Treatment	\$248,549,781	77%	21%	2%	0%
HIV Testing Services	\$35,782,421	97%	3%	0%	0%
Community mobilization, behavior and norms change	\$11,623,484	89%	11%	0%	0%
VMMC	\$12,087,710	95%	5%	0%	0%
Prevention incl. PrEP, Condom & Lubricant, Primary Prevention of HIV & Sexual Violence and Priority, AGYW and KP prevention	\$14,725,117	48%	45%	7%	0%
OVC	\$18,407,979	97%	3%	0%	0%
HMIS, Surveillance and Research	\$9,563,706	78%	21%	0%	0%
Lab Systems Strengthening	\$8,194,800	99%	1%	0%	0%
HRH, PSM Management; PFM Strengthening; Other above site/HSS programs	\$65,580,504	29%	7%	61%	3%
Total	\$424,515,502	72%	17%	11%	1%

Source: PEPFAR- COP17 Expenditure Reporting, GF Geneva submissions, GRZ – 2018 IFMIS, GIZ multisectoral budget. Amounts in USD. Exclude Program Management. Reporting available expenditures i.e. for COP17(FY18) and CY18.

Table 2.3.2 Annual Procurement Profile for Key Commodities 2019					
Commodity Category	Total Expenditure	PEPFAR	GFATM	GRZ	Other
ARVs	\$102,261,763	55%	27%	18%	0%
Rapid test kits	\$7,748,366	73%	10%	16%	3%
Other drugs	\$7,169,765	93%	0%	7%	0%
Lab reagents	\$15,983,580	71%	0%	29%	0%
Condoms*	\$2,115,219	0%	0%	0%	0%
Viral Load commodities	\$19,030,113	100%	0%	0%	0%
MAT	\$0	0%	0%	0%	0%
Other commodities	\$36,635,693	0%	0%	100%	0%
Total	\$190,944,498	52%	15%	32%	3%

Source: Source 2019 National Lab Commodities Forecasting and Quantification Report and the 2019 National ARV Forecasting and Quantification Report, COP20 proposed funding, and proposed GFATM concept note with GRZ/MOH

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	#Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	\$13,300,000	\$2,825,000	5	\$13,975,192	Maternal, newborn and child health (MNCH) activities support health systems strengthening and community engagement around high-impact interventions to save lives. These efforts address the leading causes of MNC death, and advance Zambia toward better health services and universal health care for all. Complement PEPFAR and FP activities, particularly through close provincial and district level collaboration. to reduce maternal and newborn deaths in targeted districts.
USAID TB	\$4,500,000	\$4,500,000	5	\$5,766,667	TB activities strengthen high-quality DOTS expansion and enhancement, address TB-HIV, Multidrug Resistant -TB and the needs of poor and vulnerable populations in six high burden target provinces, engage all categories of care providers, and enable and promote operational research.
USAID Malaria	\$30,000,000	\$12,970,000	3	\$82,608,114	Malaria activities scale up proven prevention and treatment interventions to reduce malaria illness and death and support the GRZ's malaria elimination goals primarily in five provinces. Interventions include distribution of insecticide-treated nets, indoor residual spraying, malaria case management, intermittent preventive treatment to pregnant women, behavior change interventions, policies and guidelines and strengthening management capacity at a provincial and district levels.
USAID Family Planning	\$10,000,000	\$4,782,137	6	\$43,428,772	Reproductive health/FP activities will increase modern contraceptive prevalence rates in women of reproductive age through increased access to and improved quality of family planning services in targeted sites via a strengthened, community-based FP service delivery system.
CDC (Global Health Security)	\$450,000	\$0	0	\$0	To strengthen disease surveillance, outbreak response and laboratory systems that help detect, prevent and control diseases
Total	\$58,250,000	\$25,077,137	19	\$145,778,745	

Source: CDC HQ supported Cooperative agreements; USAID's approved FY19 Operational Plan; COP19.

2.4 National Sustainability Profile Update

PEPFAR Zambia used a transparent and participatory process to complete the Sustainability Index and Dashboard (SID) 2019. PEPFAR and UNAIDS co-convened a multi-stakeholder SID consultative workshop in September 2019 attended by representatives from several host government ministries and departments, multilateral organizations, local NGOs and CSOs. This workshop was held over two days: the first day focused on completing the Responsibility Matrix while the second day was used to complete the SID 2019 tool.

2.4.1 Progress Addressing Sustainability Strengths

The SID 2019 process identified four sustainability strengths:

Performance Data (9.50): This element score has increased from 6.40 in SID 3.0. The country has a harmonized set of complementary information systems, managed and operated by the host country government with technical assistance from external agencies/institutions. The host country government finances more than 90% of routine collection of HIV service delivery data. These data are collected by population, program and geographic area in a timely manner (quarterly). GRZ routinely analyzes service delivery data to measure program performance, and structures, procedures and policies exist to assure data quality.

Availability of high-quality performance data is critical to effective program monitoring and management. Given the high element score, PEPFAR Zambia expects that no further external support will be required by the end of COP20.

Planning and Coordination (9.00): This element score has decreased slightly from 9.29 in SID 3.0. It was considered a strength in the previous SID. Zambia has a costed, multi-year national strategy, which is updated at least every five years (with key stakeholders) and includes critical components of prevention and treatment. GRZ leads the development/revision of the National AIDS Strategic Framework (NASF) with active participation from CSOs, businesses and corporate sector and external agencies. Additionally, GRZ routinely tracks HIV activities of CSOs and donors, leads the process that convenes stakeholders and develops joint operational plans with implementing organizations

Effective planning and coordination are critical to the implementation of treatment and prevention programs at scale and the achievement of 95-95-95 targets and sustained epidemic control. GRZ leadership in planning and coordination promotes country ownership and sustainability of the national response. Considering the high element score, PEPFAR Zambia expects that no further external support will be required by the end of COP20.

Quality Management (8.76): This element score has increased from 7.10 in SID 3.0. It supports quality management structures at national, sub-national and site level. The country has a current quality management/quality improvement (QM/QI) strategy that includes HIV program specific elements, and it is partially utilized. HIV program performance measurement data are used to identify areas of patient care and services that can be improved, and Zambia supports health workforce competency in QI.

Effective quality management improves case identification, retention and patient outcomes (VL suppression). In COP19, PEPFAR continues to support site level continuous QI interventions. PEPFAR expects that most of these activities will be transitioned to local entities (primarily GRZ) by the end of COP20.

Policies and Governance (8.62): This element score has increased from 5.31 in SID 3.0. The national HIV/AIDS technical practice follows current WHO guidelines for initiation of ART, and the country has policies and legislation on health care that are inclusive of HIV service delivery. HIV infected persons are not likely to be asked to pay fees for any HIV services in the public sector, although they are asked to pay for specialized non-HIV services, such as CT scan. The country has protections in place for victims of violence. However, the country does not have laws or policies that specify protections for specific populations. Morality and religious norms limit freedom of expression and association of lesbian, gay, bisexual, transgender and/or intersex individuals.

The MOH has demonstrated strong leadership and partnership in the national HIV response. The GRZ has developed and implemented policies around test and start, differentiated service delivery, index testing, TLD transaction, TB preventive therapy, user fees and VL management. All of these have facilitated progress towards 95/95/95 targets and epidemic control. In COP19 and COP20, PEPFAR will provide technical support to update and disseminate national policies, as needed. External support will likely be required to ensure that key populations have unhindered access to health and HIV services

2.4.2 Progress Addressing Sustainability Weaknesses

The SID analysis revealed weaknesses in six sustainability elements, which have been prioritized in COP20. Four of these (Laboratory, Epidemic and Health Data, Service Delivery and Human Resources for Health) were prioritized in COP19. Two additional elements have been prioritized in COP20 (Commodity Security and Supply Chain and Domestic Resource Mobilization).

Commodity Security and Supply Chain (4.79): This element score has decreased from 7.22 in SID 3.0. The country has a national supply chain plan that guides investments, but domestic resources fund less than 10% of its implementation. Domestic resources fund 10-49% of ARV procurements, while rapid test kit and condom procurements are almost entirely procured with external resources. The host country government manages processes and systems to ensure ARV stock in all levels of the system, but inadequate number of delivery vehicles has hindered last mile distribution. A national supply chain assessment has been done within the last three years, but the score was lower than 80%.

The availability of lifesaving ARVs and other HIV commodities is essential for the achievement of sustained epidemic control. As such, PEPFAR Zambia continues to prioritize investment in this element by assuring the availability of stocks at facility level through the following actions: supporting commodity procurement, storage, distribution and tracking at the point of service; and supporting the electronic logistics management information systems (eLMIS). As of COP19 Q1, facility edition of eLMIS has been deployed to 664 high volume facilities that account for 80% of the consumption of health commodities. Stock availability at sites with eLMIS has improved by 26% for ARVs and 45% for lab products.

In COP19 PEPFAR Zambia, in collaboration with GFATM, is supporting the conversion of regional hubs from cross-docking to stockholding facilities, thus bringing commodities closer to the service

delivery points. PEPFAR Zambia is also supporting the distribution of commodities via third party logistics (3PL) providers managed by GHSC-PSM.

In COP20 PEPFAR Zambia intends to award a contract directly to a local private sector 3PL provider, to roll out eLMIS to an additional 600 facilities, and begin to transition more than 100 MSL staff supported through GHSC-PSM to the newly established Zambia Medicines and Medical Supplies Agency (ZAMMSA), through a G2G agreement. Additionally, PEPFAR will spend \$108.5 million on procurement of commodities, while GF and GRZ will expend \$69.9 million and \$29.5 million, respectively. This represents a significant increase in the amount expected to be spent GFATM in COP19 (\$43.8 million). PEPFAR expects that continued external support will be required for procurement of commodities going forwards.

Laboratory (5.41): This element score has increased from 2.33 in SID 3.0. The country has adequate qualified laboratory staff and there is sufficient capacity to test for VL. A national laboratory strategic plan has been developed and approved, and an administrative entity does exist to manage laboratory services at regional and district level (although it has limited authority, insufficient staff and budget). GRZ has regulations in place that monitor the quality of its laboratories and POCT sites and they are implemented in 50 to 89% of sites. However, less than 10% of HIV laboratory services are funded by domestic resources.

In COP19, PEPFAR Zambia is focusing on the provision of point of care VL and EID for pregnant/breastfeeding women and infants in remote areas (using mostly existing GeneXpert machines) and all sample referral systems and routine diagnostics will be fully integrated under the direction of provincial and district health offices of the MOH. Zambia is on a trajectory to provide VL tests to all patients on ART by 2020. As of COP20 Q1 VL coverage and suppression stood at 74% and 91%, respectively.

In COP20 PEPFAR Zambia will support national laboratory optimization, national coordination of laboratory information systems, QA, recency testing and drug resistance testing. PEPFAR Zambia and the GFATM are major funders of laboratory commodities for the national response. PEPFAR Zambia and GFATM have committed \$36.4 million and \$14.5 million, respectively, for the procurement of lab commodities in COP20. Other stakeholders that have invested in HIV laboratory services include the GRZ (\$10.8 million in COP20), World Bank and other bilateral cooperation initiatives.

Service Delivery (5.44): This element score has increased from 5.32 in SID 3.0. Public health facilities respond to and generate demand for HIV services to meet local needs and the country has standardized the design and implementation of community-based HIV services. The country has a community health strategy (awaiting final approval by MOH) and it is GRZ policy that 10% of district health budgets are expended at community level. Host country institutions finance 10 to 49% HIV service delivery, which is done with some external technical assistance. However, HIV services to KPs are primarily delivered by external agencies, and even though an administrative office with specific authority to manage HIV service delivery activities exists, it does not have a

sufficient budget. Additionally, health authorities do not assess current and future staffing needs based on HIV program goals and budget realities for high burden locations.

Facility and community linkages are critical for effective implementation of HIV prevention, care and treatment interventions, including differentiated service delivery (DSD) models and test and start. PEPFAR Zambia will continue to strengthen community-facility linkages and support provision HIV services for key populations. The 2018 Zambia Consolidated Guidelines for Treatment and Prevention of HIV Infection outline Zambia's strategic approach for implementing DSD that focuses on client centeredness and health system efficiency. In COP19, PEPFAR Zambia's implementing partners are working with health facility and community-based health workers to continue scaling up DSD approaches, including multi-month scripting and dispensing (6-month MMD), in order to improve retention in care and reduce congestion at health facilities. Priority focus of DSD models target adolescents and men, who have had lower linkage and retention rates.

Stakeholders that have invested in HIV service delivery include the GFATM, World Bank and local non-governmental organizations such as Churches Health Association of Zambia, Bwafwano Integrated Services Organization and Centre for Infections Disease Research in Zambia. PEPFAR Zambia is transitioning service delivery to local entities and it is expected that the level of direct support to international NGOs will significantly reduce by the end of COP20.

Human Resources for Health (7.30): This element score has increased from 6.27 in SID 3.0. Despite this relatively high score, human resources for health (HRH) is a vulnerability. The county faces a shortage of health workers with 52% of positions on its 126,000 strong establishment remaining vacant. Zambia has a clinical health worker to population ratio of 12 per 10,000 – far short of 23 per 10,000 recommended by WHO. pre-service education institutions are producing an adequate supply and skills mix of clinical health care providers, but the current economic situation and reduced fiscal space constrains the GRZ's ability to hire and deploy new staff. Most HIV in-service training is supported by external sources and, which does not maintain a comprehensive inventory of donor-supported HIV/AIDS workers nor is there a written plan for transition of these workers. Even though an administrative office with specific authority to manage health workforce activities exists, it does not have a sufficient budget. Also, the current inventory does not include HIV/AIDS workers at MOD health facilities scattered across the country. Plans are under way to ensure MOD HIV/AIDS health care workers are included in MOH's inventory. This will enable improved staffing at the MOD facilities where 80% of the clientele are civilians.

An adequate number of trained and motivated health workers, with the appropriate skills mix, deployed to areas of greatest need (at facility and community level) is critical to implement an effective national HIV response and to achieve sustainable epidemic control. Under the current National Health Strategic Plan (2017-21), the MOH aims to recruit 30,000 new health workers, and 21,000 had been recruited by January 2020. Additionally, PEPFAR and GFATM support 24,849 and 3,114 health workers, respectively. An analysis done by Palantir revealed that increasing the number of ART health workers in facilities with retention challenges increased TX_CURR by 30% and reduced lost to follow up (LTFU) by 30%.

In COP19 PEPFAR is revising and updating its HRH Inventory and developing a database to track investments; supporting MOH to roll out an integrated human resource information system (HRIS); and supporting pre-service training of community health assistants (CHA) and HIV nurse prescribers (HNP). In COP20 PEPFAR will continue to support preservice training (240 CHA and 140 HNP); use G2G agreements with provincial health offices and ZAMMSA to fill staffing gaps (with the view to transition staff to GRZ payroll); continue to support HRIS; and scale up mentorship and ECHO to improve clinical skills and quality of service. PEPFAR also intends to repurpose some lay health workers to support retention. Direct support for HRH is being transitioned to local entities and the level of support is expected to significantly reduce by the end of COP20.

Domestic Resource Mobilization (5.56): This element score has increased from 5.44 in SID 3.0. Zambia has a long-term financing strategy for the health sector (Health Financing Strategy (2017-2017)) and the national budget includes HIV funding to health and other line ministries. However, budget execution is a challenge in the current economic situation. Release of funds from the Ministry of Finance (MOF) has not been regular for the past 12 months. In July 2019, the MOH reported a budget performance for 24% for the period January 1, 2019 to June 30, 2019. During this period provincial and district health offices received only one monthly operational grant from the MOF. Additionally, less than 50% of the annual national HIV resource is financed with domestic public and private sector funding.

The military SID found that partner ministries not fully aware of HIV program cost and activities as most are donor driven, using international implementing partners. There is a need to share data on PEPFAR Zambia costs and activities so that Zambia ministries move along with PEPFAR Zambia and develop a sense of ownership for all activities. Zambian government must be at the center of the HIV programing and should take a proactive stance on resource mobilization. Donor support and involvement should be considered supplementary and diminishing with time.

In COP20, PEPFAR Zambia plans to expand G2G assistance to provincial health offices. This assistance will be used to improve public financial management (PFM) and health information systems, as well as to strengthen PFM to improve efficiency, transparency and accountability. Additionally, resources will be used to support implementation of the national health insurance scheme to ensure that the most vulnerable have access to HIV services. Technical assistance will be provided to the Health Finance Unit at the MOH to support innovative approaches for sustainable HIV financing.

Epidemic and Health Data (5.18.): This element score has increased from 4.37 in SID 3.0. The SID found that key population surveys and surveillance are primarily planned, financed and implemented by external agencies, organizations or institutions. Zambia does not conduct IBBS or size estimation studies for KPs.

PEPFAR Zambia continues to support interventions to increase the timely availability of high-quality data and promote its use to enhance program performance and achieve better health

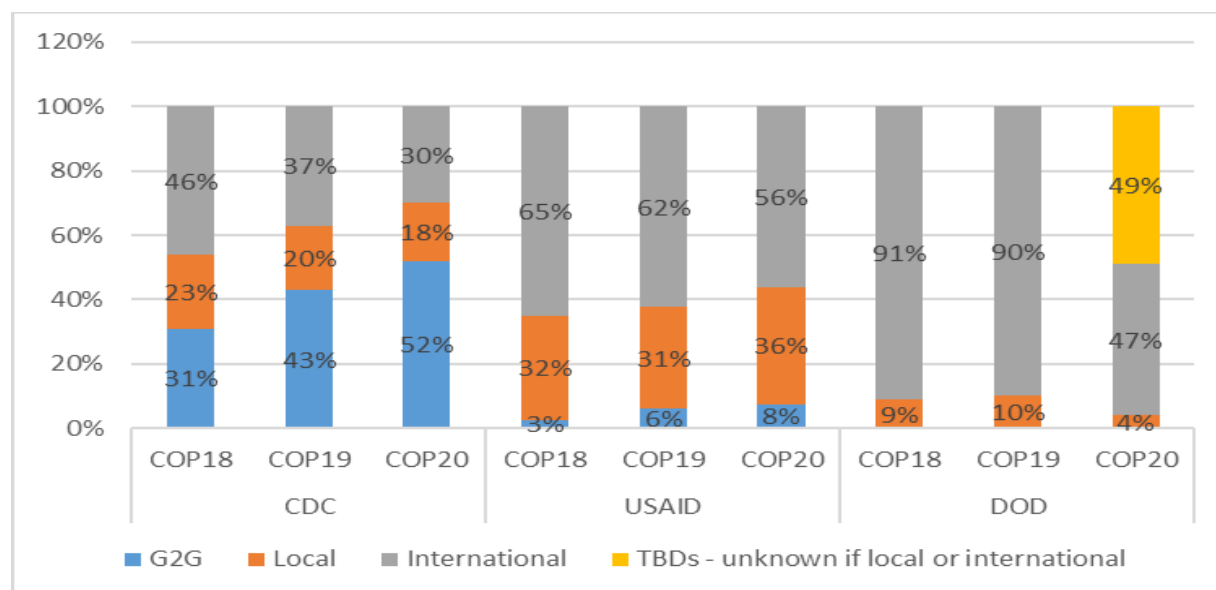
outcomes. This includes mortuary-based mortality surveillance; KP IBBS; nation-wide scale up of case-based surveillance system; building HMIS management capacity by utilizing an MOH standardized approach and support tools; and working with UNAIDS to provide quality PLHIV estimates to GRZ. Main stakeholders that have invested in epidemic and health data include the GRZ, PEPFAR, UNAIDS, EU, DFID, WHO, GFATM, World Bank and other bilateral cooperation initiatives.

In COP19 PEPFAR has been meeting with other stakeholders (MOH, Johns Hopkins University (JHU) and CSOs) to discuss KP data. JHU has used available data to extrapolate KP sizes. Protocol approval for mortality surveillance and KP IBSS will be obtained and implementation will commence. PEPFAR has budgeted \$1.2 million, \$909,000 and \$1.3 million, respectively for implementation of case surveillance, mortality surveillance and KP IBBS in COP20. Given the legislative environment, it is likely the external resources will be required for the collection, analysis and dissemination of key population data in COP20 and beyond.

2.4.3 Transition to Local/Indigenous Partners

As illustrated in Figure 2.1, CDC, DOD and USAID have increased the proportion of funds going to local organizations since COP18. In COP19, CDC and USAID awarded 63% and 37% of their funding to local partners (including G2G agreements), while DOD, which is constrained by restrictions on military to military funding, awarded 10%. As an agency, CDC is on track to achieve the target of allocating 70% of programmatic funding to local partners by the end of COP20. CDC will accomplish this through the phased transfer of direct service delivery to the provincial health offices with a focus on sustainability, increased capacity and improved local financial management and oversight. USAID expects to increase allocation to local partners to 44% through a combination of efforts including significantly increasing funding through G2G agreements with provincial health offices and other government entities and transitioning a number of HIV care and treatment, prevention and health systems strengthening activities to local partners. The funding allocation breakdown for DOD in COP20 is to be determined.

Figure 2.4.1 Transition to Local/Indigenous Partners by Agency



Source: Budgets from FACTS INFO

2.5 Alignment of PEPFAR Investments Geographically to Disease Burden

An essential component of the annual COP design process is the refinement of the geographic alignment of PEPFAR investments to disease burden. In the development of COP20, PEPFAR Zambia updated National Spectrum models by working closely with the Zambian National Spectrum team, which includes UNAIDS, the MOH, Zambia Statistics Agency (formerly the Central Statistical Office) and National HIV/AIDS/STI/TB Council (NAC). The draft national PHLIV estimates were then run through geospatial HIV modeling to generate estimations at the district level for both sexes and five-year age bands.

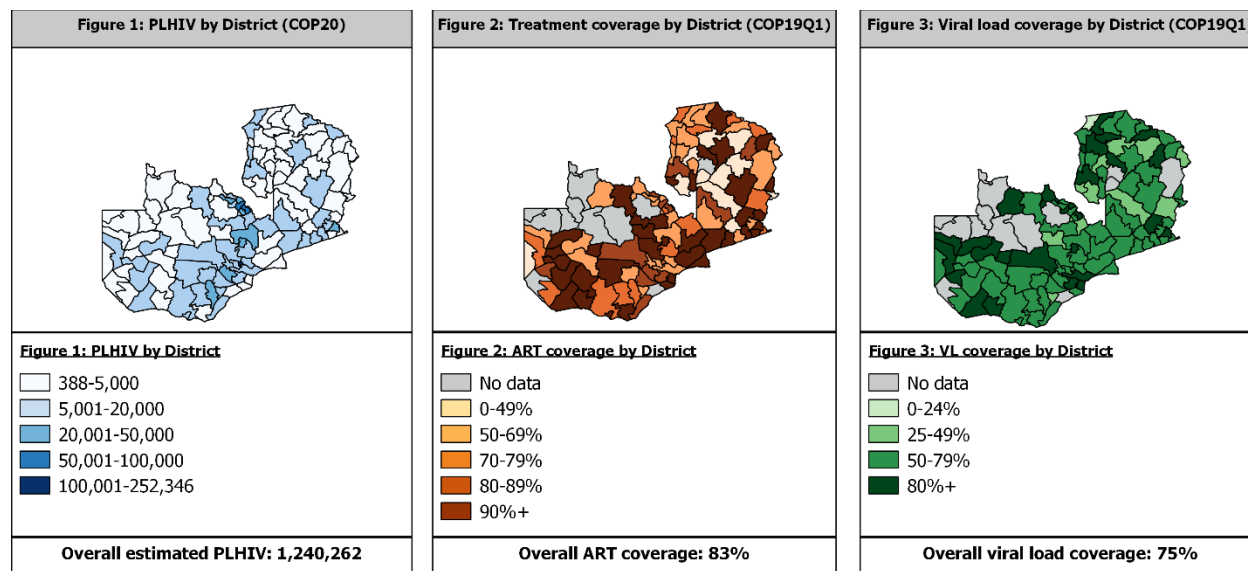
The National Spectrum team then examined (ART) coverage for sex and age band across Zambia’s 116 districts and set targets for COP20 that reached the following ART coverage rates:

- 88% ART coverage or higher in all age/sex bands for the 32 attained districts that constitute 66% of all PLHIV
- 89% ART coverage or higher in all age/sex bands for the 53 scale up to saturation districts that constitute 28% of all PLHIV
- 85% ART coverage or higher in all age/sex bands for the 8 aggressive scale up districts that constitute 2% of all PLHIV

The 10 sustained districts and 13 central support districts each constitute 2% (making up a total of 4%) of the PLHIV burden for Zambia. Sustained districts and 13 of 17 centrally supported districts maintained their prioritizations from COP19 given the lower burden of PLHIV relative to the attained and scale up districts. The National Spectrum team continues to refine national and

provincial PLHIV estimates and there may be a need to revisit the above estimates if the final estimates are significantly different from the estimates used to develop targets for COP20.

Figure 2.5.1 PLHIV, Treatment Coverage, and Viral Load Coverage by District



Source: COP20 PLHIV estimates, MER TX_CURR, TX_PVLS denominator

2.6 Stakeholder Engagement

PEPFAR Zambia has made noticeable strides in improving and strengthening their relationships with all external stakeholders. This was evident when close to 300 stakeholders attended the COP20 Development and Planning Meeting in January 2020.

PEPFAR Zambia and MOH have collaborated continuously throughout the development and planning of COP20. PEPFAR Zambia and MOH engagement extends beyond just COP20 development, MOH has been an integral partner throughout 2019 in implementing COP18 and COP19 top priorities. The collaboration between MOH and PEPFAR Zambia happens across technical fields and geographically all over Zambia. MOH participated in all COP20 stakeholder including the COP20 In-Person Planning Meetings and throughout implementation MOH attends POART meetings and national TWG meetings.

In COP20 planning, NAC was a vital contributor and key participant in the development of COP20. NAC chaired and hosted the weekly COP20 update meetings with the COP20 IPM delegation and other important stakeholders. The weekly update meetings, introduced in COP18 development, has proven to be a highly effective way for PEPFAR Zambia to engage with stakeholders throughout the COP development process. The meetings focus on key priorities presented by PEPFAR Zambia technical experts and allowed for invaluable feedback and questions on these priorities. The open dialogue and sometimes spirited debate that happens in these weekly meetings has helped PEPFAR Zambia structure its COP20 strategy in an inclusive way.

The strengthened partnership between PEPFAR Zambia and the MOF has continued in COP20 as a result of the PEPFAR-funded US Treasury Advisor engagement at MOF. The advisor supports PEPFAR Zambia's goal of promoting sustainable HIV financing from domestic sources. Additionally, the engagement of the US Treasury Advisor has provided PEPFAR Zambia and the greater embassy community with valuable insight on Zambia's budget allocation and funding releases for health. MOF also participated in COP20 stakeholder meetings.

The PEPFAR Zambia and UNAIDS relationship continued through the COP20 development process. Outside of the COP20 planning cycle, PEPFAR Zambia and UNAIDS share leadership of the HIV cooperating partners group, which aligning HIV programming and relationships in Zambia.

A key priority goal in both COP18 and COP19 was to increase CSOs' participation in the development and implementation of COP19. To achieve this goal, PEPFAR Zambia worked closely with CSOs self-selected representatives from a wide range of constituencies including: PLHIV, women, youth, people with disabilities, faith-based organizations (FBOs), KPs, local NGOs and TB. Working with these representatives, PEPFAR Zambia was able to capitalize on their insights and suggestions to increase the participation of CSOs. These suggestions resulted in PEPFAR Zambia funding capacity building training for civil societies, financing Country Coordinating Mechanism meetings and supporting VL literacy training. PEPFAR Zambia continues to operate a Small Grants portfolio to allow CSOs the opportunity to apply for PEPFAR resources to use their communities.

CSOs took on a larger role in the COP20 planning process with conceptualizing how the new PEPFAR community led monitoring initiative (CLM) would be implemented in Zambia. Collaborating with the CSAG, PEPFAR Zambia facilitated an extended working session for the civil societies directly after the COP20 Development and Planning Meeting. At the start of this session, PEPFAR Zambia presented the parameters of the CLM initiative and then CSOs were afforded the remaining time to work together on the CLM initiative. The CSOs delegation to the IPM presented the Zambian CLM plan.

PEPFAR Zambia continued engagement with the private sector has resulted in ART, VMMC and cervical cancer services being offered at private health clinics. DREAMS has leveraged Public Private Partnerships (PPP) to offer economic strengthening opportunities or support for AGYW allowing PEPFAR resources to stretch further.

Finally, PEPFAR Zambia also worked closely with UNAIDS, GFATM and other external donors in developing COP20. PEPFAR Zambia team also conducted consultative meetings with GFATM principal recipients to avoid duplication of efforts and leverage resources during COP20 implementation. PEPFAR Zambia team will continue in-country dialogues with Country Coordinating Mechanism (CCM), principal recipients and Geneva-based colleagues as part of the on-going Funding Request writing process to ensure that there is coordination in proposed resources to address unmet gaps and to coordinate jointly with GRZ to reach the goals laid out in national planning documents.

3.0 Geographic and Population Prioritization

In order to sustain the gains and meet the ambitious target of 95% of PLHIV on ART by the end of COP20, PEPFAR Zambia is prioritizing several focal areas. These include targeted prevention, scaling up index testing, initiating a broad-based Pediatrics Surge, optimizing HIV testing, improving ART linkage rates for priority populations (children, AGYW, men and KP). Additionally, PEPFAR Zambia will increase PrEP uptake to over 110,000 individuals with a special focus on AGYW, FSW, MSM and PFBW. Zambia will also provide 69 million condoms, focusing on the highest risk populations.

ZAMPHIA (2016) data reveals that AGYW, ages 15-24, have an incidence rate of 1.07% compared to 0.08% of men of the same age band. According to FY20 Q1 national level data, adult men, aged 20-34, have an ART coverage of 77% compared to 84% among women. ART coverage among CLHIV, less than 15 years, of age is 94% and overall population%. VL coverage and suppression have increased to 74% and 91% respectively.

For KP, PEPFAR Zambia undertook a size estimate exercise which estimated the population of MSM to be 68,044 with a HIV prevalence rate of 17.7% and FSW to be 133,566 with a prevalence of 41.6%. Geographically, Copperbelt province has the highest prevalence (15.4%), followed by Lusaka (15.1%), Southern (12.4%) and Central (12.4%) Provinces. Muchinga and North-Western Provinces have the lowest prevalence, estimated at 5.4% and 6.1% respectively.

In COP20, PEPFAR Zambia will initiate over 98,121 clients on treatment - with over 62,000 from the attained districts and 33,000 from scale-up districts. This will bring the total number of PLHIV on treatment to over 1,163,000. In total, 767,000 of PLHIV on treatment will be from attained districts and 328,000 from scale up districts. As illustrated in Figure 2.5.1 above, PEPFAR will continue to align resources and activities with the high HIV burden geographic areas with focus on the scale-up districts that contribute about 30% of unmet need for ART.

Men aged 20-34, AGYW aged 15-24 and children under 15 are specifically targeted and will achieve ART coverage of 90%, 89% and 91%, respectively by the end of COP20. COP20 also outlines plans to find and retain men and AGYW through expanding high-impact initiatives such as the community post model, increased male friendly services, case management, targeted HIV literacy and formation of adolescent support groups for AGYW. For pediatrics, COP20 outlines plans to improve and retain pediatric clients. A Pediatric Surge will provide pediatric-focused mentorship at all facilities to ensure basic level of comfort with initiating children on ART and enabling family centered care to improve retention.

Additional efforts will focus on improving HIV case finding among KPs, linking 95% of those who test HIV-positive to treatment and offering PrEP to all who test HIV negative. Specific details on case identification and linkage to treatment for all priority and key populations are detailed in section 4.

As of COP19 Q1, PEPFAR Zambia had 38 districts with ART coverage rates above 90% (two districts had VMMC coverage rates of over 90% for ages 15-29) and will have an additional 22 by the end of FY21 bringing the total to 60 districts with >90% ART coverage. Building off this achievement, COP20 targets will result in reaching 95% ART coverage by age and sex in high burden districts and an overall national ART coverage rate of 95%. For this to happen, COP20 will focus on retaining the individuals who are on treatment by ensuring that they are getting quality HIV services and are virally suppressed.

Table 3.1 Current Status of ART saturation				
Prioritization Area	Total PLHIV/% of all PLHIV for COP20	# Current on ART (COP18)	# of SNU COP19	# of SNU COP20
Attained	814,497/66%	638,855	30	32
Scale-up Saturation	342,705/28%	264,884	46	53
Scale-up Aggressive	28,987/2%	19,027	7	8
Sustained	24,335/2%	16,530	10	10
Central Support	29,723/2%	494	17	13

Source: COP20 Data pack & DATIM

4.0 Client Centered Program Activities for Epidemic Control

4.1 Finding the Missing and Getting Them on Treatment

Zambia's national treatment program continues to benefit from strong leadership at the national level, through President Edgar Lungu and the MOH, creating a policy-friendly environment that seeks to improve access to HIV testing services for the most at-risk populations while ensuring that those that are found positive are linked to and retained on treatment.

MOH, with support from PEPFAR Zambia, has moved away from universal testing and adopted a strategy to improve testing efficiencies. In COP18, MOH finalized an HIV screening tool through the national ART TWG. IPs continue to provide technical assistance and mentorship to supported sites to ensure that necessary testing reducing significantly and more efficient testing methods, such as index testing and social network testing, are brought to scale.

According to 2018 Zambia Demographic Health Survey (ZDHS), Lusaka and Copperbelt Provinces have the highest prevalence, 15.1% and 15.4% respectively. In COP20, PEPFAR Zambia will focus its

case finding efforts to bridge the treatment gap in these two provinces through high-impact interventions using the community post model.

In COP18, testing efficiencies resulted in the identification of 33,000 men and more than 14,000 CLHIV as HIV-positive and initiated them on life-saving treatment. Of those identified, 49% of CLHIV and 34% of men were reached through index testing. PEPFAR Zambia will continue to utilize targeted testing approaches to find newly identified positives and those that are diagnosed but not linked to treatment.

In COP20, PEPFAR Zambia will also focus on improving case identification of HIV-positive AGYW. HIV prevalence among 20- to 24-year-olds is three times higher among females (9%) than males (3%). (2018 ZDHS) To increase access to HIV testing and treatment services among this hard-to-reach population, PEPFAR Zambia will scale-up peer-driven models in facility settings and address structural barriers and health system issues through community-based interventions, like DREAMS.

In COP19, significant investments were made in building the capacity of lay counselors who conduct partner notification services (PNS), leading to an improvement in elicitation skills of this cadre. However, with the scale up of index testing, PEPFAR Zambia recognizes the importance of ensuring that clients, as well as lay counselors who provide PNS, are safe and secure and that measures are taken to ensure that clients are not put at-risk of any intimate partner violence (IPV). In COP20, PEPFAR Zambia will work closely with the MOH and CSOs to provide stringent oversight of implementing partners to ensure that supported sites are adhering to PEPFAR guidelines and policies on index testing.

4.1.1 Finding Men

In COP20, PEPFAR Zambia will use lessons learnt from the Men's Star Coalition to target the unreached males by providing positive, empowering messages and bringing services closer to where they are found, such as in community post model. The insights from Zambia's Male Characterization study, which show that services should be tailored to meet men's specific needs, will also continue to inform the men's program.

PEPFAR will continue to build on the progress made in COP19 to implement high-impact interventions to identify, reach and retain men, aged 25–39 years, in care and treatment. IPs will provide intensive mentorship to improve provider elicitation skills to increase case finding through contact elicitation of female index clients. PEPFAR will continue working with CSOs and IPs to improve monitoring of IPV in the index testing program. PEPFAR Zambia will continue to guide IPs to provide appropriate training and mentorship, covering IPV screening and actions to be taken to ensure safety of the client (adherence to WHO 5Cs).

Targeted communications through the Zambia Ending AIDS campaign will encourage more men to seek HIV prevention services and expand implementation of male-friendly services (e.g. use of male providers, differentiated HTS where men are found, weekend/after-hours services). PEPFAR

Zambia will also continue to scale up the implementation of the community post model in marketplaces/bus stations and faith communities in high burden districts in Zambia. In addition, IPs will provide training and equip male peers as service delivery uptake champions. Client centered interventions to improve men's facility experience will address stigma, trust, confidentiality, privacy and positive attitudes towards men.

HIV self-testing (HIVST) will be offered in informal and formal workplaces such as markets, bus stations and construction sites. Unassisted targeted testing has been shown to be the best way to reach at-risk persons in the community, and this will be expanded in COP20.

Another key strategy to find men includes expanding and strengthening partnerships with the private sector, such as in the mining communities on the Copperbelt Province, to increase access to HTS and linkage to treatment. IPs will also focus on conducting targeted outreach services to truckers and other mobile populations, such as fishing and timbering communities.

4.1.2 HTS Strategy for Children Living with HIV

Case identification of CLHIV in health facilities will be prioritized in COP20. IPs will ensure follow-up of these children's mothers and fathers through index testing. In the pediatric program, index testing has demonstrated high positivity yields. In COP18 Q1, index testing contributed about 27% of positives identified in the pediatric program, and in Q1 of COP19, this contribution had risen to around 46%. Building on these proven successes, in COP20, index testing will continue to be provided to all biological children (up to age 19) of PLHIV. In addition, IPs will test all HIV-exposed infants (HEI) for infection, per national guidelines, until cessation of breastfeeding. PEPFAR Zambia will also utilize the 'Mentor Mothers' model to ensure EID testing coverage. The case finding for pediatrics will also leverage the OVC platform to provide targeted risk-based testing and diagnostic testing e.g. poor growth/nutrition, known or suspected TB or other illnesses deemed concerning for HIV. All identified CLHIV will immediately be linked to treatment and care and provided focused mentorship and support.

4.1.3 HTS Strategy for adolescents living with HIV

Improving case finding efforts to reach adolescents living with HIV (ALHIV) will be a critical focus for PEPFAR Zambia in COP20. Zambia will build on the innovations that have demonstrated effective case finding of ALHIV. To reach ALHIV, PEPFAR Zambia will support partners to establish high-quality, facility-based, adolescent friendly spaces where comprehensive HIV services are provided. Providers will also be training in effective provision of adolescent friendly services in high-volume sites. Other strategies will include identifying referral and entry points to target the most vulnerable AGYW (schools, clinical partners, faith communities and government social welfare institutions) and scaling up peer-driven models. IPs will also provide packages of comprehensive HIV prevention services, that include HTS, and will address structural barriers and health system issues through community-based interventions. In addition, IPs scale up strategies like school-based mobilization through safe spaces and peer-led education activities. PEPFAR will

also enhance social network mapping in places where adolescents meet to socialize, such as markets, churches and other religious groupings.

Addressing healthcare provider attitudes (especially towards sexually active young people) will also be key in getting adolescents to seek HTS in facilities. PEPFAR Zambia will work closely with the MOH adolescent unit to improve providers' service delivery skills through joint site visits to health facilities for supportive supervision of providers serving adolescents. IPs will also ensure that the parents of adolescents are engaged and consent to testing their children. Index client testing will be the main testing strategy for adolescents, although other modalities such as mobile testing may be used in hotspots. All those testing HIV positive will immediately be linked to ART, whether identified at the health facility or in the community. Community IPs will continue supporting the newly initiated adolescents through adolescent support groups to ensure that they understand the need for adherence to ART and stay on treatment.

4.1.4 HTS Strategies

In COP20, PEPFAR Zambia has set targets to test 1,242,765 and aims to identify 103,125 positives, of whom 98,121 will be linked to treatment. The overall expected yield is 8% with a linkage of 95%. In scale-up districts, the target is to test 468,726 individuals, out of which 34,452 will be identified positive and 32,801 will be linked to treatment and care services.

PEPFAR partners have significantly increased yield and reduced unnecessary testing by working closely with MOH to formalize and roll out an HIV testing screening tool, with the goal of optimizing PITC. From COP18 to Q1 of COP19, Zambia has seen a drastic reduction in testing volumes. The PITC and VCT modalities have seen reductions in numbers, while the yields from these modalities have been going up. The VCT modality yield increased from 5% in Q1 of COP18 to 7% in Q1 of COP19. The PITC modality yield increased from 4% in COP18 Q1 to 5% in Q1 of COP19. Average yield from index testing increased from 16% in Q1 of COP18 to 24% at the same time period in COP19. In COP20, PEPFAR Zambia will no longer support broad case finding, but will prioritize index testing and restrict facility testing to high yield diagnostic testing (e.g. TB, malnutrition and STI clinics and individuals with signs or symptoms of HIV).

Routine, PITC that is low yield will no longer be supported in COP20. It is essential that testing protocols follow WHO guidance to ensure consent, confidentiality, adequate counseling, correct results (minimizing false negatives and false positives) and connection to treatment. For the HIV self-testing modality, IPs will use differentiated strategies, including providing referral cards, outreach follow up and phone calls/text messages to remind all those who test HIV positive to get confirmatory tests and link to treatment. PEPFAR Zambia will also strengthen collaboration between the OVC and DREAMS programs to ensure OVC and AGYW, who might not otherwise seek HIV testing at health facilities, have increased access to HIVST. In addition, DREAMS and OVC IPs will educate those who test HIV positive to go for confirmatory testing and immediately start treatment.

PEPFAR Zambia will continue to scale up recency testing in COP20 to characterize incidence, identify demographic and geographic outbreaks and target index testing in order to more effectively break the cycle of transmission. In Q1 of COP19, recency testing implementation started in Lusaka and Copperbelt Provinces, which account for more than 46% of all HIV positive results. A total of 41 recent infections, out of the 305 tested demonstrate recent infections (13.4%), 78% female and 22% male. Of the females, 72% are between 15-34 years of age and 100% are males between 20-34 years of age. Every recent infection triggers a public health action through Field Epidemiology Residents who are tracking in the communities. Implementation of recency testing will expand to Central and Southern Provinces in COP19, and to the rest of the country in COP20. To enhance the pace of implementation, PEPFAR Zambia is reducing barriers to participation by moving to verbal consent, integrating the new baseline VL policy and funding a recent infection implementation IPs in COP20.

Zambia will continue to leverage the network of faith-based organizations (FBOs), faith leaders and faith communities to create demand for the uptake of HIV services, especially encouraging the testing of men, children and adolescents. Special focus will be on bolstering case-finding and linkage to treatment, especially among men. PEPFAR Zambia will also work with FBOs to leverage their access to people with disabilities and facilitate their easier access to services.

PEPFAR Zambia will mandate all IPs to reach a linkage rate of 95% and above. In COP20, PEPFAR Zambia will continue the use of linkage registers and SmartCare to ensure that all those identified as HIV positive are linked to treatment. In addition, PEPFAR Zambia will continue working with IPs to ensure that all HIV positive clients from the community are correctly documented at the facility level to avoid double counting of positives.

In COP20, PEPFAR Zambia will continue to support quality HIV testing through provider training, targeted technical support and supervision and proficiency testing. All sites providing HIV testing will undergo site certification and certification of testers as required by the MOH policy.

4.1.5 Index Testing

PEPFAR Zambia has made significant progress in promoting index testing as demonstrated in COP19 Q1 results, which showed that 100% of newly identified positives (58,550) were offered index testing, 93% of whom accepted. Of those who accepted, 83% of their contacts elicited were tested, leading to the identification of 17,766 new positives, a positivity yield of 24%, up from 16% in COP18 Q1. Of the 17,766 positives identified, 43% were adult women and 37% were adult men; AGYW and ABYM accounted for 11% and 3% of the positives respectively, while 6% were children less than 10 years. In COP20, PEPFAR Zambia's primary case finding approach will remain as index testing, with the aim of ensuring that at least 75% of positives are being identified using this modality. Index testing will be offered to all recently diagnosed PLHIV as well as those with unsuppressed VL. Screening for IPV risk is a standard operation procedure for index testing services. The primary goal of IPV risk assessment is to ensure no harm comes to the index client as a result of index testing services. PEPFAR IPs will undergo certification to verify compliance with WHO guidelines. For

other priority populations, PEPFAR Zambia staff will continue to focus on expanding index testing by continuously building the capacity of implementing partners through refresher training and mentorship visits to ensure that both facility and community health workers are implementing quality index testing. PEPFAR Zambia will strengthen the collaboration between health facilities and community health workers (CHWs) to ensure all individuals newly diagnosed with HIV are assigned to a CHW for follow-up of their sexual partners and biological children. PEPFAR will, however, ensure that index testing remains voluntary, and that no client is forced to take up the service. PEPFAR Zambia will prioritize index testing of pediatrics, adolescents and young people, men aged 20-39, women aged 15-29, mobile populations, the military, clients of sex workers and discordant couples. In the meantime, index testing in key populations has been halted until further notice.

PEPFAR Zambia, GRZ and CSOs will work together to guarantee the safety and security of the clients. While currently there are no reports of IPV related to index testing, the Zambian PEPFAR team realizes that this could be a result of poor reporting, due to lack of knowledge on how or who to report to in their communities. In COP20, PEPFAR Zambia will be proactive and will work with CSOs, IPs and the government to dig deeper and determine if any abuses have taken place. CSOs will drive the process of getting feedback from the community, and the results of these exercises will inform the certification process and future monitoring for IPV. Additionally, the USG agencies will provide enhanced oversight during site visits and SIMS exercises to ensure that IPs are adhering to the guidelines for index testing. Monitoring IPV is key to ensuring a successful index testing program and is key in counselor training. In COP20, capacity building, monitoring and routine feedback with CHWs will be key to ensuring they have the skill set necessary to elicit information on IPV, provide counseling and any support the clients may need. Results of adverse event tracking will be monitored regularly alongside GRZ and CSOs, to ensure any reports of IPV are immediately addressed.

HIV index testing activities in hotspots will be guided by recency testing data from prioritized populations. In health facilities, index testing will target all newly diagnosed HIV positive clients, high VL patients and patients on treatment, but who have incomplete index testing, to link them to CHWs for follow up of their sexual partners and biological children. In addition, PEPFAR Zambia will continue to expand the use of registers for patients with unsuppressed VL in order to prioritize their sexual partners for index testing. With these strategies, PEPFAR Zambia expects that index testing will contribute to 75% of all positives identified.

4.1.6 HIVST Strategy

HIVST will continue to be implemented in COP20, targeting hard to find and underserved populations such as KPs, AGYW and at-risk men. PEPFAR will continue to optimize HIVST to reach first time testers and ensure that there is tracking of the HIV positives for further testing and initiation of the confirmed HIV positives. PEPFAR Zambia will scale up HIVST to all attained and sustained districts, incorporating both assisted and unassisted models. IPs will conduct education and sensitization activities, including social media, to increase the acceptability and demand for

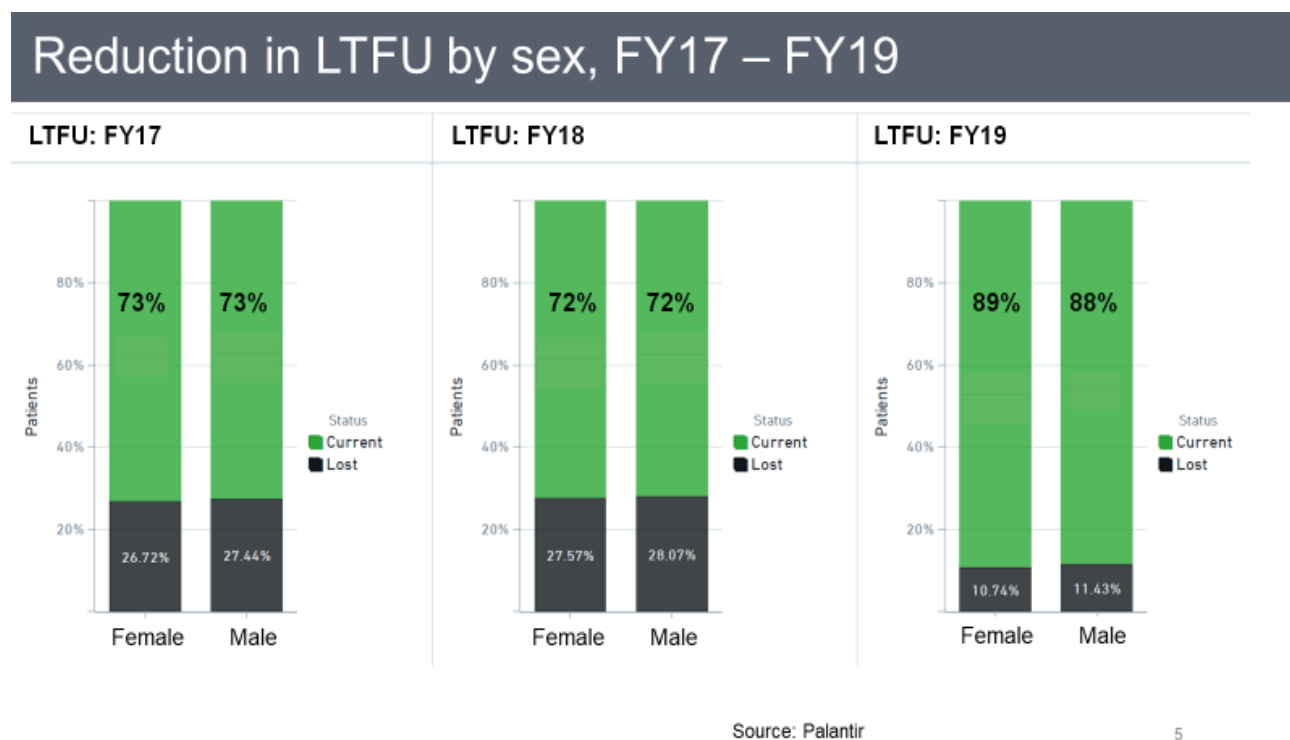
HIVST, especially among men, AGYW and their sexual partners and KPs. Additionally, HIVST kits will be distributed to the health facilities in high burden areas with low ART coverage, targeted workplaces, institutions working with people with disabilities, institutions of higher learning and communities. IPs will be directed to immediately report any instances of adverse events associated with HIVST, e.g. self-harm as a result of a reactive HIV test. PEPFAR Zambia will continue working closely with NAC and CSOs to help increase awareness of the availability of HIVST.

4.2 Retaining Clients on Treatment and Ensuring Viral Suppression

PEPFAR Zambia has made significant progress towards achieving the UNAIDS 90-90-90 targets with national treatment coverage of 85% in Q1 of COP19. Treatment retention has also improved from 73% in COP16 to 89% in COP18 (Palantir analysis, 2020). Despite this improvement, retention rates remain below the target of 95% which is required to sustain HIV epidemic control. In COP20, PEPFAR Zambia will work towards a treatment retention of at least 96%. To achieve this benchmark, PEPFAR Zambia will focus on improving both program and data quality.

To address data quality, PEPFAR Zambia will introduce and roll-out a national web-based facility level SmartCare Plus (SmartCare+) to track patients on HIV treatment and facilitate real-time deduplication of patient level information with COP20 funding. This will result in the ability for PEPFAR Zambia to report patient level retention, rather than proxy retention. Proxy retention measure may overestimate attrition as evidenced by the triangulation of program data and patient level. Palantir based analysis which indicated that approximately 6% of client records are duplicates. The duplicates/overestimates might, in part, be due to silently transferred patients being treated as new patients at sites receiving them and patients who have absconded from HIV treatment returning as new on HIV treatment (a study in Lusaka showed that 40% of clients who had presented for care as new on HIV treatment were actually virally suppressed). To address the issue of treatment for experienced patients appearing as new, PEPFAR Zambia will introduce a basal VL assay for all newly identified positives at the point of diagnosis. Subject to availability of resources, PEPFAR Zambia might explore using TLD urine metabolites for screening of all newly identified positives at the point of diagnosis.

Figure 4.2.1 Reduction in Loss to Follow Up by sex, COP16-COP18 (FY17-FY19)



Poor program quality and access barriers such as i) inadequate/sub-optimal counseling, ii) use of less tolerable regimens, iii) congestion at health facilities, iv) long distances and v) seasonal challenges contribute to poor retention of patients in HIV treatment. To address the geographic barriers, PEPFAR Zambia will continue to decentralize ART service provision through opening of more community post models in locations where people live or work. The community post model has demonstrated better retention compared to standard of care in most facility-based ART sites. Psychosocial barriers will be addressed with an enhanced treatment literacy strategy, driven by site-level data on gaps in linkage and retention. Working closely with the MOH, this strategy be scaled up to all PEPFAR supported sites. To address the service quality barriers at health facility level, IPs will implement rational appointment systems, with day and time blocks specifically for ART services, and continuous quality improvement (CQI) approaches for clients who miss appointments. These approaches, when implemented with fidelity, have demonstrated good retention at high volume sites in Lusaka and Copperbelt Provinces. In COP20, these will be scaled up to all sites. Palantir analyses show improved individual level retention outcomes among individuals who get 6-month MMD during clinical visits. Individuals on TLD were also demonstrated to have not only better VL suppression at 96% but also higher retention rates of 95%. As such, the PEPFAR Zambia treatment program will continue to scale up 6-month MMD to reach at least 80% of all eligible clients by the end of COP19. TLD transition, which will reach 70% of current on treatment by December 2020, will reach at least 80% of Tx_CURR by the end of COP20.

To prevent deaths among the treatment cohort, PEPFAR Zambia will focus on ensuring that both communicable and non-communicable diseases (NCDs) are prevented and managed. TB among RoC will be prevented by implementing the last phase (phase 3) of the ‘TPT Surge’ in COP20 with the aim of reaching at least 700,000 RoC with shorter TPT regimens, including 3HP. Presumptive TB clients will be screened with GeneXpert and managed according to the results. RoC with a CD4 <200 cells/μL will be screened for cryptococcal disease using CrAg. CrAg-positive patients with or without meningitis will be treated for cryptococcal infection. Cervical cancer disproportionately affects women living with HIV (WLHIV). In COP20, PEPFAR Zambia with support from UNITAID/CHAI and other stakeholders, will continue to provide CaCx screening (Visual Inspection of the cervix with Acetic Acid (VIA) and Human Papillomavirus (HPV)) and treatment services for eligible women RoCs aiming to provide treatment to at least 80% of those who screen positive.

In COP20, PEPFAR Zambia will support the integration of management of major NCDs into ART services through the procurement of sphygmomanometers for blood pressure measurement, along with glucometers and strips for blood sugar measurement.

To address retention challenges among adolescents on treatment, PEPFAR Zambia will adopt a client centered design to provide services that meet their needs, scale up adolescent friendly spaces both community and facility based and implement with fidelity adolescent led peer support groups.

Retention in care among pediatrics is lower than among adults, with similar challenges related to geographic access, psychosocial support and service quality. For children, this is made worse by provider discomfort in managing pediatric ART cases which results in the referral of children from lower level health facilities to higher level health facilities that are further away and costlier to access. A Pediatrics Surge focused on improving pediatric HIV case management through structured mentorship program will be implemented in COP20 to build the capacity of all frontline health care providers in pediatric ART. Furthermore, the use of an electronic pediatric decision support tool integrated into SmartCare+ will provide real-time support to providers for pediatric ART management. Additionally, PEPFAR Zambia will support the expansion of family centered DSD models that offer full coverage allowing mothers and their children to be seen at the same clinic, same day and time. VL monitoring is important for monitoring treatment efficacy. VL coverage has improved from 32% in Q1 of COP18 to 74% at the end of Q4 in COP19. However, in order to achieve full coverage for all districts and populations, PEPFAR Zambia will introduce and/or scale-up new initiatives such DBS for VLs in COP20, targeting children (because health care providers often experience challenges with phlebotomy in this population) and RoC in hard to reach populations in rural and remote health facilities (such as those cut off by seasonal flooding). In the 2020 Zambia Consolidated Guidelines, MOH has enhanced VL monitoring for PBFW from six monthly based testing to every three months. This more aggressive approach is intended to facilitate early identification of any treatment failure among PBFW RoCs and more timely remedial action to reduce mother-to-child transmission (MTCT).

To improve VL suppression among children < 15 years old, PEPFAR Zambia will continue phasing out of Non-Nucleoside Reverse Transcriptase Inhibitors based regimens and replace them with more efficacious DTG) and Protease Inhibitor based regimens.

To enhance responsiveness to the needs of ROCs, PEPFAR Zambia will support community led monitoring through civil society. CSOs will collect information of individual service users' experiences with ART services. This in turn will be used to improve quality of services and ensure client centered services are provided.

4.3 Prevention

4.3.1 HIV Prevention and Risk Avoidance for AGYW and Children

In COP20, PEPFAR Zambia will expand the DREAMS program to six more districts, which will bring the total of DREAMS districts in Zambia to 14. Selection of the new districts was based on an analysis of the sub-national level disease burden and AGYW incidence in each district. The districts without a current DREAMS presence were ranked from highest disease burden to the lowest, and the first six districts were then picked. Based on this analysis, the districts selected were Mongu, Monze, Mazabuka, Kasama, Luanshya and Mufulira.

One of the mandates from OGAC for COP20 was for OUs to conduct a saturation analysis in the current districts, to ensure that 75% of AGYW across all age groups in a district have been reached with DREAMS services. To do this analysis, Zambia used Central Statistical Office data and Pact program data to estimate the % of vulnerable AGYW by age band, per district. Saturation progress was then estimated using DREAMS results to date and expected results at the end of COP19. None of the current zones showed saturation across all the age bands, therefore Zambia will continue providing DREAMS services across all current districts.

PEPFAR Zambia will continue to provide the core DREAMS package in the current districts of Lusaka, Kabwe, Kapiri Mposhi, Ndola, Kitwe, Chingola, Livingstone and Chipata, and will expand to the new districts of Luanshya, Mufulira, Kasama, Mongu, Monze and Mazabuka. Comprehensive Sexuality Education and prevention of sexual violence will continue to be supported in select schools across DREAMS districts. PEPFAR Zambia will continue to support a package of services that includes gender base violence (GBV) one stop services in DREAMS districts, community-based gender norms change and GBV prevention programming, PrEP and other clinical services.

In order to identify AGYW most vulnerable to HIV, DREAMS IPs will leverage different entry points. Working with the clinical partners, DREAMS will recruit AGYW from the antenatal clinics (ANC), family planning (FP) and STI platforms in health facilities. Working with community IPs, leaders and stakeholders, DREAMS will also identify and recruit AGYW from community hotspots and other programs. In COP20, DREAMS Zambia will determine beneficiaries' eligibility for DREAMS using the following risk and vulnerability factors: multiple sexual partners, STI), no or inconsistent condom use, transactional sex, experience of violence, out-of-school/never schooled status, alcohol/drug use and orphanhood. Zambia will continue to use screening questions that are

designed to build rapport between a mentor and an AGYW, and to identify other risk and vulnerability factors to help with programming. That said, an AGYW will have to present with one or more of the above risks and vulnerability factors for them to be enrolled in DREAMS.

Working with the clinical partners, DREAMS Zambia will, in COP20, expand coverage of PrEP services for AGYW in DREAMS Centers and beyond. PrEP will be provided as part of a comprehensive prevention package for the 15 to 24-year-old AGYW. PEPFAR Zambia will also support the training of other clinical partners in AGYW PrEP service delivery. Trained female providers will deliver PrEP in DREAMS Centers and in facilities located in DREAMS districts. Additional psychosocial support will also be provided to AGYW on PrEP to support adherence.

In COP20, DREAMS Zambia will expand economic strengthening opportunities for all age bands, especially the 20 to 24-year-old group. DREAMS will leverage the economic strengthening platform to increase completion of the primary package for the 20 to 24-year-old age group. The economic strengthening package will focus on entrepreneurship, workforce development, employment among community partners, financial literacy/savings and linkages to the formal banking system. PEPFAR Zambia will provide differentiated packages by age band (i.e. basic financial literacy for 9-14-year-old AGYW, training on marketable skills for 15 to 19-year-old AGYW, and workforce development, employment, skills and entrepreneurship for the 20 to 24-year-old age group). DREAMS Zambia will also leverage existing public private partnerships for additional opportunities (including IT, construction, mining companies, trade/vocational schools and the formal tailoring and design industry). As part of empowering AGYW with financial independence, DREAMS Zambia will expand leadership roles for DREAMS AGYW Ambassadors at different levels of the OU. IPs will continue to provide opportunities for DREAMS graduates to work as mentors, peer educators, connectors, PrEP support staff and GBV survivor advocates.

Zambia will also strengthen integration and complementary service delivery between the DREAMS and OVC platforms. Bi-directional referrals with OVC partners will be essential to ensuring that the most vulnerable AGYW benefit from comprehensive programming through both programs.

Other DREAMS focus areas in COP20 will include ensuring that GBV prevention and crisis response are core components of Safe Spaces and expanding provision of mental health support services to all current DREAMS Centers.

In order to capture AGYW risk factors, service uptake and program impact, the DREAMS database will be expanded to all new partners to ensure that intervention layers across PEPFAR Zambia are captured and data is used to inform programming. This includes weekly analysis of site-level data to assess performance and implement course correction as needed. Inter-site and inter-district exchange visits will also be undertaken to address gaps and share lessons of successful models.

General targeted HIV prevention and risk avoidance/reduction for AGYW, aged 10 to 24, will continue to include community mobilization for HTS (including FP and PrEP), linkage to care, recency testing for HIV positive AGYW, GBV prevention and response and condom promotion/distribution. Hotspot mapping will continue to be used as a tool to ensure the most at-

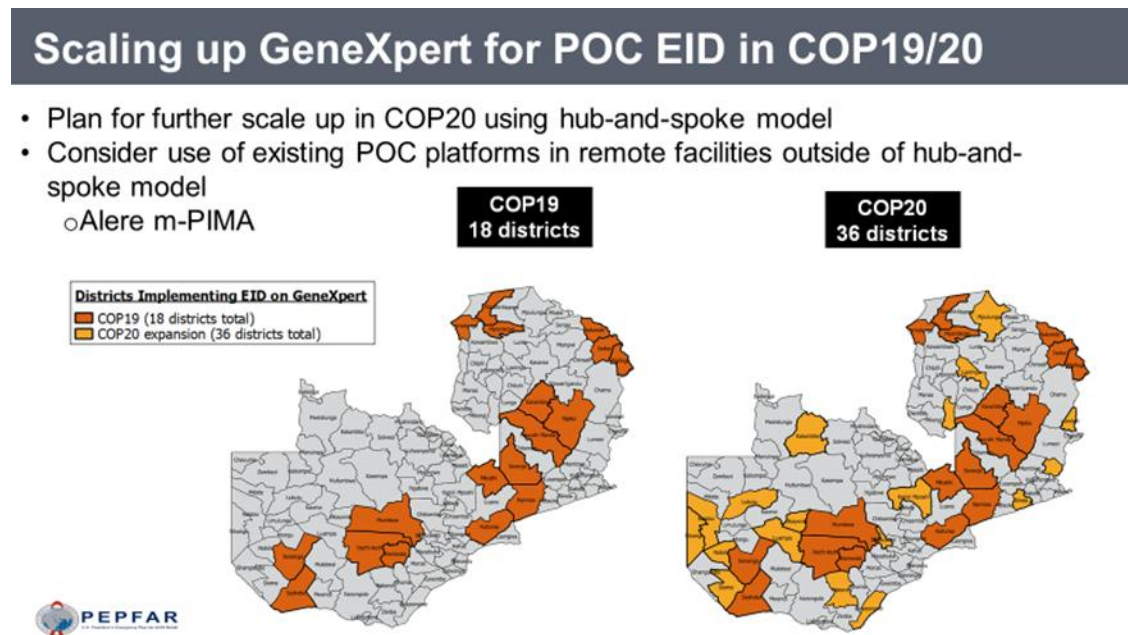
risk populations are found to provide them with high-impact prevention interventions. Special focus will be placed on identifying and referring those at highest risk for PrEP. Evidence-based interventions will continue to be led by peer outreach. Linkage to care will continue through the use of escorted referrals, adolescent friendly hours/spaces and increased site-level collaboration among IPs. IPs serving KPs will be supported to reach and refer AGYW KPs to clinical services and DREAMS programming.

In order to ensure that as many AGYW as possible are reached with prevention services, PEPFAR Zambia will continue to collaborate with the GFATM, MOH and other stakeholders to develop a unified strategy for AGYW across PEPFAR Zambia.

4.3.2 Children/PMTCT

Zambia has a mature PMTCT program with high ANC attendance rates, testing rates and linkage to ART among HIV positive PBFW. In COP18, ANC testing coverage was 96% and same day ART initiation was 95%. PEPFAR Zambia has been successful in reducing mother to child transmission with positivity yield at 2 months reducing from 2.2% in COP 17 to 0.8% in Q1 COP20. The HEI positivity at 12 months has also reduced from 3.0% to 1.2% over the same period. To simplify the PMTCT program among frontline health care providers, the national guidelines have been updated to provide 12 weeks of prophylaxis for all HEI regardless of risky category. To address suboptimal EID testing coverages in rural and remote districts, PEPFAR Zambia will continue to scale up point of care EID testing on the GeneXpert platform from 18 districts in COP19 to 36 in COP20 as shown in the figure below.

Figure 4.3.2.1 Scaling up GeneXpert for POC EID in COP19/COP20



Source: CHAI and National Tuberculosis Program

To improve retention of mother infant pairs (MIPs) until the outcome is determined, PEPFAR Zambia will support mentor mothers to facilitate tracking of MIPs who miss appointments and/or are LTFU. PEPFAR Zambia will continue to optimize utilization within MNCH care of the same appointments and tracking systems used in the main ART clinic. In COP20, PEPFAR Zambia will scale up positive infant audits in order to identify missed opportunities in the PMTCT cascade and be able to close those gaps. PEPFAR Zambia is also introducing a new PMTCT ART form that will be used for clinical follow up of PBFW. This electronic health record form will have a field for collecting data elements for the HEI which will be useful in linking MIPs, improve documentation for outcome and ease analysis of PMTCT outcomes as Zambia aims to attain the WHO goal of elimination of mother-to-child transmission.

4.3.3 Scaling up PrEP

Although Zambia has achieved the 90-90-90 target at the general population level, HIV incidence continues to be significant among some population groups and regions. According to ZAMPHIA, HIV incidence is 13 times higher among AGYW compared to their male age counterparts. Similar trends have also been demonstrated among PBFW and KP using regional data where local data is unavailable. In COP18, significant efforts were made to close this gap as 24,397 new clients were initiated on PrEP at the end of the fiscal year. PrEP services were provided as a part of comprehensive HIV prevention services that include HIV testing, sexual risk reduction education and counselling, condom distribution, contraceptives, post-exposure prophylaxis and VMMC. During the same period, PrEP was scaled up from 32 sites to over 600 sites nationwide. This achievement notwithstanding, national coverage is still below 70% of districts.

In COP20, PEPFAR Zambia will improve on the gains from the previous years of implementation. PrEP will continue to be provided as part of a package of comprehensive HIV prevention services, targeting AGYW, key populations such as MSM and FSWs and PBFW. PrEP clients will also be routinely screened for other STIs.

In COP20, PEPFAR Zambia will scale up the provision of PrEP through community and facility-based approaches to reach targeted population groups. Community based approaches will include differentiated service delivery models for key populations and AGYW through the DREAMS program. Health Facility based approaches will target sero-discordant couples (SDC) and PBFW. PrEP will continue to be provided to DREAMS girls in 14 DREAMS districts as an additional option and as part of an integrated HIV prevention service that also includes HTS, FP and condom provision. This differentiated service delivery for AGYW ensures that PrEP is provided in an environment that is safe and convenient for at-risk AGYW. IPs will recruit and place DREAMS 'graduates' to provide adherence support and conduct follow-ups.

Differentiated PrEP delivery to key populations will target community spaces where KPs feel safe as a critical approach to increasing uptake among these vulnerable groups. PEPFAR Zambia will work closely with gatekeepers, who will be equipped with the necessary skills to provide key messaging on PrEP and conduct follow-ups to improve adherence.

To improve uptake of PrEP among SDC and PBFW, PEPFAR Zambia will train maternal, newborn and child health (MNCH) nurses and FP providers to ensure that PrEP is also integrated into non-ART service provision throughout supported health facilities. This approach will reduce the workload of already overstretched ART providers and mitigate stigma and discrimination known to limit PrEP uptake in ART settings.

To mitigate the growing levels of incident infection among PBFW, PEPFAR Zambia will work closely with the national PrEP TWG to review best practices from the region and tailor implementation of PrEP for PBFW to the Zambian context. Although screening of potential IPV is routine in PrEP service provision, additional efforts will be required to ensure that PBFW initiated on PrEP are not placed at risk for IPV. To achieve this, PEPFAR Zambia will collaborate with the MOH to support community sensitization on the role of PrEP in averting new HIV infections in PBFW. This will also help to dispel myths and misconceptions that are barriers to uptake among eligible population groups.

PEPFAR investments will also be used to support the Zambia Ending AIDS (ZEA) campaign and the national social behavior change campaign on PrEP, which is anchored under ZEA. ZEA utilizes new and innovative ways to reach young people with key messaging on the various prevention products and services that can avert new HIV infections. The campaign consists of branded communication products on PrEP on different media outlets including public and private media. The products include billboards, newspaper advertisements, television and radio public service announcements and social media engagement primarily targeting AGYW and males 20 to 40 years old in order to increase PrEP uptake in these two groups that are so critical to HIV epidemic control efforts in Zambia.

In COP20, PEPFAR investments will also continue to focus on building capacity of healthcare workers to increase proficiency in PrEP service delivery. PEPFAR will also expand existing systems to include reminders for PrEP visits and closer monitoring of clients.

4.3.4 Gender Based Violence Prevention and Response

Although there is a dearth of local data on GBV in Zambia, evidence from the Zambia Violence Against Children survey, suggests that 27% of girls who had their first sex before the age of 18 years reported their experience to be forced, coerced and non-consensual. Among victims of sexual violence who are aged 18 to 24 years, only 19.8% of females and 24.6% of males knew where to seek help from. Female and male victims constituted only 1.4% and 7.2% respectively of those who sought help.

In part, these gaps are attributable to weak GBV program coordination systems at national and subnational levels. PEPFAR Zambia has continued to fill these gaps by collaborating with implementing partners and the MOH to prevent and respond to GBV. In COP18, 10,305 survivors received post GBV services of which 4,664 were victims of sexual violence.

In COP20, PEPFAR Zambia ensure that programs are routinely screening for IPV in the context of PrEP, index testing and care and treatment services. Through the use of standard screening tools, potential victims of IPV or survivors will be identified and linked or provided with the appropriate response services. For this reason, PEPFAR Zambia will strengthen and continue to support the provision of post-violence clinical care services at health facilities and existing One Stop GBV centres. Services offered will include psychosocial counseling, screening for sexual violence, victim support services through the Zambia Police Service, HIV testing services and referrals for ART. PEPFAR will strengthen the quality of such services by ensuring that the minimum standard of care for sexual GBV is maintained at all GBV service delivery points.

To improve the quality of GBV services, PEPFAR will build/strengthen the capacity of health workers and other key stakeholders to provide GBV services. For the same reason, it will support the training of police officers, NGO staff, medical professionals and other social services staff in GBV awareness, prevention and care. It is expected that service providers will provide improved post-GBV services for 10,464 survivors of physical or emotional violence, including prevention of IPV and post rape care to 3,481 survivors of sexual violence.

In COP20, PEPFAR Zambia will support community-based GBV prevention strategies to address the social/cultural norms and myths and misconceptions that catalyze GBV. This will include the implementation of evidence-based interventions such as “SASA” and “Families Matters”. The “Stepping Stones” program will target 9,009 AGYW in DREAMS zones to reduce sexual violence, delay sexual debut, maintain healthy sexual relationships and prevent HIV. “Coaching Boys into Men” programming will target 21,018 boys, aged 9 to 14 years focusing on building healthy nonviolent relationship skills.

PEPFAR Zambia will also strengthen the linkage between community-based GBV prevention interventions, including GBV chieftom secretariats, facility-based post-GBV care, GBV One Stop Centers and DREAMS Centers. With more health facilities providing higher quality GBV services, linkage will improve the chances of survivors receiving timely HIV prevention and other reproductive health services including emergency contraception.

At national level, PEPFAR Zambia will work with the Ministries of Gender, Justice, National Guidance and Religious Affairs and Chiefs and Traditional Affairs to improve the legal and policy environment on GBV prevention and response. A media strategy will be developed to communicate positive gender practices through radio, TV and social media and dispel myths and misconceptions.

In COP20, PEPFAR Zambia will also strengthen support for the monitoring GBV case identification, prevention and response activities. This includes strengthening the existing government GBV Information Management System to improve tracking GBV cases at national and subnational levels.

4.3.5 Key Populations

Although local data from bio-behavioral surveys confirm high levels of risky behavior among KPs and their sexual partners, the Zambia KP program has been challenged by high levels of sociopolitical resistance, violence, stigma and discrimination, and limited capacity of health workers to respond to the health care needs of KPs. These challenges create barriers to KPs accessing prevention and treatment services at facility and community levels, with consequences for HIV prevalence and incidence. In 2016, the IBBS estimated HIV prevalence among FSWs to be 56.4%.

PEPFAR Zambia recognizes that ensuring KPs access to and increased use of comprehensive HIV services is essential to achieving epidemic control. In CoP 18, PEPFAR Zambia reached 7,3621 KPs), with prevention messages. Among the KPs reached, 43% were FSWs, 39% prisoners and 15% MSM. Of the total KPs reached with prevention a package of interventions, 63% were tested for HIV. The highest positivity yield was among FSWs (35%), transgender (28%) and MSM (23%). A total of 4119 KPs were initiated on PrEP during the reporting period.

In COP20, PEPFAR Zambia will build on the achievements of the past years to strengthen access to HIV prevention, care and treatment services for KPs, and plans to reach 75,708 KPs with a package of prevention messages. Of this group, 31,447 will be offered HIV testing and 50% of all negative KPs recommended to have PrEP.

Differentiated service delivery models will be strengthened to improve access for KPs to prevention, care and treatment services. These includes condom and lubricant promotion and distribution, HIV testing and counselling, peer outreach, STI screening and treatment, provision of PrEP, strengthening community-facility linkages, preventing GBV and alcohol abuse, mental health screening and harm reduction, antiretroviral treatment and VL monitoring. Prevention efforts will include testing children of KPs, enhanced use of social media to access hard to reach KPs, cervical cancer screening for FSWs and distribution of lubricants and condoms.

To increase case finding among KPs, PEPFAR Zambia will intensify approaches such as the social network strategy, enhanced peer outreach models, the use of peer navigation approaches and HIV self-testing models. PEPFAR Zambia will strengthen the quality of HIV testing services by ensuring that testing strategies are in line with the WHO standards of the five “Cs” with increased monitoring of testing, provision of pre and post-test counselling services and engagement of client driven models of care. Testing services will also strengthen screening for intimate partner violence and ensure the safety and security of KPs.

Differentiated service delivery models will also be implemented to improve retention on PrEP and ART. This will involve community based follow up to further strengthen community initiation and refill, including the provision of event driven PrEP. PEPFAR will also continue to scale up treatment literacy messaging through workshops, including the development of information and educational materials for dissemination among target groups.

Differentiated services will be used to expand ART access in community-based settings. Efforts will focus on approaches wherein facility and KP outreach providers work together and develop an integrated KP case management strategy. To improve linkage and retention comprehensive community case management teams will be established to ensure that KP are supported along the continuum of care. PEPFAR Zambia will increase the use of KP organizations to plan, implement, monitor and assure quality of interventions at community level.

In COP20, PEPFAR will focus on addressing the safety and security challenges that impede KPs access to HIV services. Implementing partners will form KP protection networks, provide KPs with legal training to enhance safety and security, integrate human rights in KP sensitivity trainings for health care providers and expand sexual diversity training to key stakeholders. In addition, a stigma index will be conducted in COP20 involving key stakeholders to evaluate the impact of HIV interventions on stigma and discrimination among PLHIV.

4.3.6 Voluntary Medical Male Circumcision

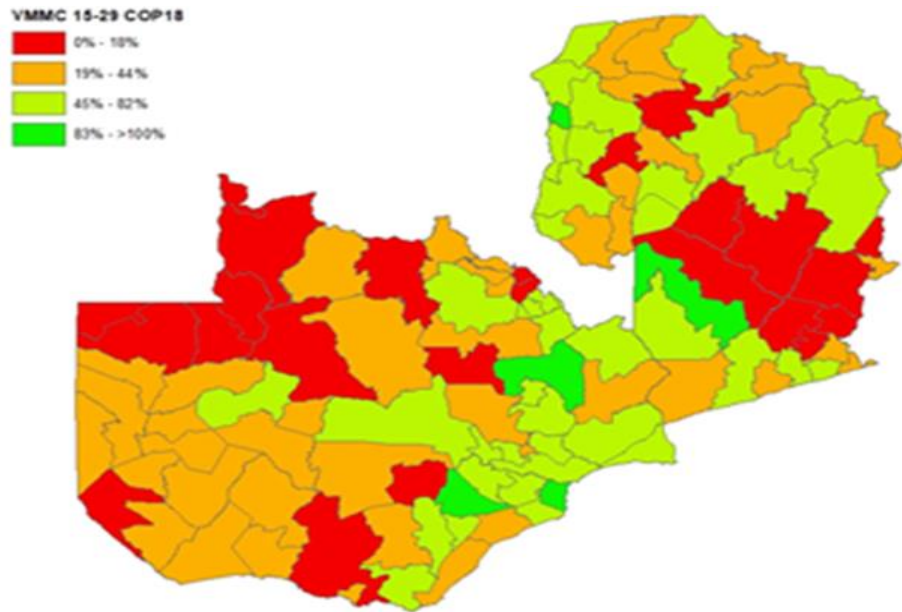
The VMMC program has made strides in reaching males with the comprehensive package of HIV prevention services. Nationally, from 2016 to December 2019, 1,874,244 males have been reached with VMMC services. PEPFAR Zambia has contributed to reaching 80% (1,499,395) of the national figures. Among those reached, males aged 15-29 years old who contribute significantly towards reduction of HIV prevalence, constituted 929,625 (62%) of those reached. In COP18, the screening tool for HIV testing services was introduced. Males were screened and only tested if eligible or deemed to be at high risk of HIV infection. The numbers tested reduced from 98% in Q1 of COP18 to 59% in Q4. In COP19, Q1, 43,366 (44%) males were tested out of the 107,976 circumcised with a positivity yield of 0.03%. This indicates that PEPFAR Zambia is reaching the relevant eligible males who HIV negative and would benefit most from this intervention. The adverse event (AE) rate remains at less than 2% with the majority of serious AEs presenting postoperatively with infection or bleeding. These cases were attended to at facilities by staff with favorable outcomes. In addition, a number of policy documents were launched by the MOH. These included the Guidelines on Quality Improvement for Voluntary Medical Male Circumcision Service Delivery in Zambia, a Training Guide for Early Male Circumcision under Anesthesia and the National Social Behavior Change Communication Strategy for Voluntary Medical Male Circumcision 2019-2022.

In COP20, using base and ambition funds, PEPFAR Zambia will reach an additional 400,000 males with VMMC services. Regions to be prioritized are those with high HIV prevalence and high VMMC unmet need, defined as VMMC coverage less than 80%. The majority of targets (80%) are assigned to regions with less than 50% VMMC saturation, while 8% of the target was allocated to military facilities. PEPFAR Zambia will prioritize attainment of 80% saturation for males aged 15 to 29 years old. Although most of the VMMCs are conducted during periodic campaigns in April, August and December, PEPFAR Zambia will shift reliance on campaigns to routine provision of the services year round.

PEPFAR Zambia will support direct service delivery by supplementing the government's efforts in human resources for health by hiring professional and lay health workers. Enhanced on-site mentorship, supervision and monitoring at site level to maximize the use and time of providers, enforce compliance with medical ethics and human rights principles (informed consent, confidentiality, absence of coercion) and delivery of quality MCs in sanitary conditions to promote client safety will be implemented. Support will also be provided to procurement of VMMC commodities, supplies and logistics tools will be used to mitigate program disruption due to stock outs. Assurance of data quality and utilization of programmatic data on an ongoing basis, and iteratively review of quality and program performance through service quality assurance and continuous quality improvement, will be implemented. In COP19 there will be passive surveillance of the Shang Ring device which will be completed by COP20. To expand the choice of method and increase the appeal of VMMC services, PEPFAR Zambia will support use of VMMC devices. In addition, there will be continued use of the 'Hub and Spoke' model to improve access for clients in hard to reach areas. The national program will be supported in coordinating stakeholders, providing oversight and technical assistance to regional programs in quality assurance, CQI, promulgation of policy and training of trainers.

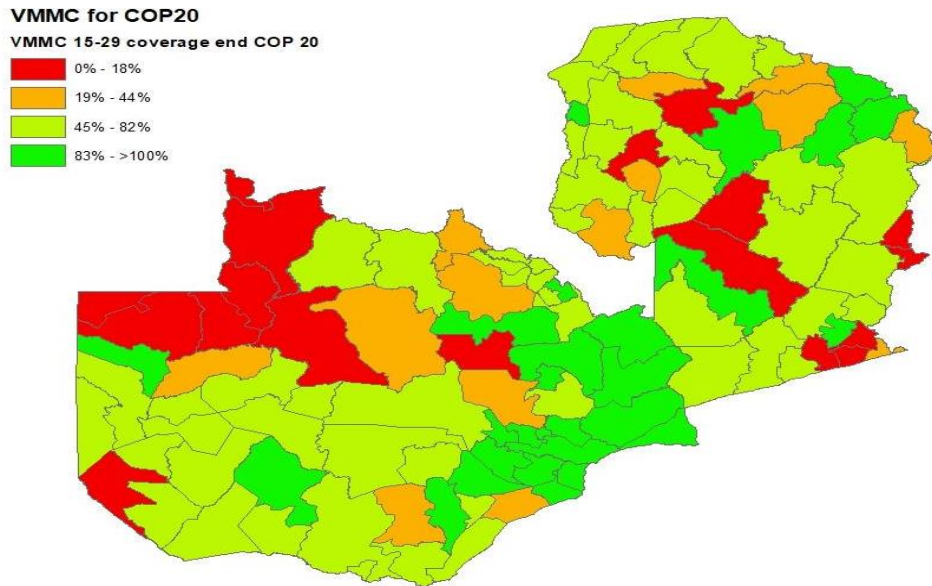
In COP20, demand generation approaches will prioritize bringing to scale evidence-based interventions that reach males aged 15-29 years for immediate impact on the HIV epidemic. This will include the client centered design approach of demand generation, sport-based approaches, such as soccer galas and community mobilization and activities using community mobilizers and peers to provide interpersonal communication messages and link targeted clients to VMMC and other relevant HIV services. The use of VMMC as an entry point to other health services presents an important opportunity for engaging adolescents and young men in health services, and holds great potential for HIV prevention, treatment and care, an opportunity which is often missed. Fostering partnerships with traditional and community leaders to generate demand and promote program ownership will also be implemented.

Figure 4.3.6.1 COP18 VMMC Coverage of Males 15-29 years old



Source: Spectrum estimates, HMIS & Program Reports

Figure 4.3.6.2 COP20 VMMC Coverage of Males 15-29 years old



Source: Spectrum estimates, HMIS & Program Reports

4.4. Zambia Specific Priorities

4.4.1 Recent Policy Changes

The major policy change for clinical services is the 2020 update of the HIV treatment guidelines. The main changes in guidelines are the introduction and/or expansion of use of more efficacious HIV treatment for both adults and children, diagnosis and management of severe HIV disease (including TB and cryptococcal disease) and resistance testing for first line HIV drugs.

4.4.2 Program Direction Based on Program Performance

There are many interventions across the treatment cascade that have been described in the previous section will be scaled up because of demonstrated ability to achieve results. For example, the community post model has been successful at reaching men, adolescents and providing DSD for PrEP. In regard to PrEP, because of Zambia's strong performance reported in COP18, Zambia will aim to increase targets from approximately 25,000 to 110,000 in COP20. Finally, Zambia received an additional \$12 million in VMMC funding because of demonstrated ability to achieve targets, which will enable Zambia to reach 80% coverage in 15-29 year old men.

4.4.3 Implementing Partner Management

PEPFAR Zambia will continue to implement an enhanced partner management system to ensure financial and performance accountability necessary to achieve and sustain HIV epidemic control. This includes regular and structured monitoring of performance on a weekly, monthly and quarterly basis as well as targeted site visits.

Each activity manager reviews outlays on a monthly basis to monitor spending is aligned with the COP approved budget.

4.4.4 New Innovative, Evidence-based Solutions for COP20

Clinical Services: Although the Zambian HIV treatment has done well, more work needs to be done to achieve and sustain the numeric goals of HIV epidemic control of 95-95-95. The HIV treatment program will implement evidence-based solutions with COP20 funding to bridge outstanding gaps such as “treatment experienced” presenting as new on HIV treatment at different treatment sites, relatively high unmet need for children on HIV treatment, low VL coverage for clients in hard-to-reach geographic areas and morbidity and mortality among people in HIV care. For “treatment experienced” patients who present as new on HIV treatment, PEPFAR Zambia will support the MOH to introduce a basal VL assay for all newly identified PLHIV at the point of HIV diagnosis to ascertain VL suppression status (if the client is virally suppressed, s/he is likely to be a “treatment experienced” rather than a “treatment naïve” patient. In rare circumstance, such a patient could also be an elite controller). In addition to the intervention mentioned above, and subject to availability of resources, PEPFAR Zambia might also support the use of urine TLD metabolites to

identify “treatment experienced” clients entering the health system as new on HIV treatment. With COP20 funding, PEPFAR Zambia will introduce a nationwide web based SmartCare+ system with inherent capability to track clients on HIV treatment in real time and avoid client duplication. In addition to the above intervention and subject to an enabling policy and legal framework, PEPFAR Zambia might support the introduction and scale-up of a nation-wide biometric system for client identification. To address the low treatment coverage among children under the age of 15, PEPFAR Zambia will implement a Pediatric Surge which, among other innovations, will utilize multiple platforms to provide pediatric HIV services, including OVC, schools and child-friendly spaces, train health care workers in pediatric HIV care and optimize the use of more tolerable pediatric HIV treatment regimes. PEPFAR Zambia will introduce and scale-up the use of DBS for VL testing, especially for children and adults in hard-to-reach areas on GeneXpert platforms to increase VL coverage. To counter background mortality and AIDS-related mortality among clients in HIV care, PEPFAR Zambia will invest in the management of communicable and noncommunicable co-morbidities among clients in HIV care. For communicable diseases, PEPFAR Zambia will invest in TPT, intensified TB case finding using GeneXpert and lipoarabinomannan and in TB infection control. For noncommunicable diseases, the focus will be on diabetes mellitus, renal disease and cardio-vascular diseases. PEPFAR Zambia will support the training, development of job aids and procurement of reagents needed for managing these co-morbidities. For renal disease particularly, PEPFAR Zambia will leverage other funders’ effort to provide renal sparing regimens.

OVC: The OVC program remains a critical component of PEPFAR Zambia’s strategy to maintain gains made in achieving epidemic control. In COP20, PEPFAR Zambia will align the OVC portfolio to the changing epidemic by providing structured, evidence-based interventions to targeted subpopulations and by formalizing relationships with health facilities and PEPFAR care and treatment partners to improve case finding, adherence, retention, VL coverage and VL suppression in pediatric clients through a family centered approach.

In COP20, PEPFAR Zambia will merge its pediatric ambitions with its OVC platform. In COP18, PEPFAR Zambia identified effective interventions to improve case finding of CLHIV and ensure that they remained in care to increase their likelihood to be virally suppressed. These innovative practices, which are currently being employed in COP19, will form a package of high impact interventions that will be implemented as part of PEPFAR Zambia’s Pediatric Surge in COP20. The Pediatric Surge will focus on sites accounting for 65% of CLHIV on ART, consisting of 215 health facilities in 75 districts. Beyond the package of targeted interventions implemented in these 215 facilities, PEPFAR Zambia will also ensure that mentorship is provided to all ART facilities to increase provider confidence in initiating children on treatment.

The OVC platform will provide additional support to the Pediatric Surge in 13 districts in 25 OVC focal sites, accounting for 40% of children and adolescents accessing treatment in the Pediatric Surge sites. PEPFAR Zambia will improve the health and well-being of children and families by mitigating the impact of HIV and increasing children’s resilience and reducing their risk to the disease.

Support to the Pediatric Surge will be two-fold: at the facility and in the community. At the facility, multidisciplinary teams consisting of clinicians, OVC case managers and CHWs will provide case conferencing and client centered service for improved adherence and retention for C/ALHIV. All WLHIV and their children will be assessed for enrollment in the OVC program and provided with supportive referrals for psychosocial support, socioeconomic interventions and parenting programs. Lastly, all C/ALHIV will be assessed to determine eligibility for enrollment into the OVC program.

In the community, multidisciplinary teams will provide bi-directional referrals to ensure pediatric recipients of care are comprehensively supported to assure retention in care while maintaining viral suppression. OVC case managers will provide strengthened caregiver treatment literacy and psychosocial support during OVC home visits. The OVC program will also leverage the power of the CHWs to identify children of WLHIV clients and facilitate access to conduct index testing of any children with an unknown HIV status.

The use of a multidisciplinary team is a key component of OVC comprehensive approach. This approach will be used to target highly vulnerable children and adolescents, including survivors of sexual violence, children of PLHIV, caregivers and siblings of C/ALHIV. Priority will also be given to children with low viral suppression, children of FSWs, teenage mothers and children with disabilities.

COP20 implementation will leverage COP19 implementation of Faith and Community Initiative. Under this initiative, Zambia Police's National Victim Support Unit was trained to advocate for timely, efficient processing of the cases of sexual violence against children. Over 120 traditional leaders were trained to assist children and adolescents who have survived sexual violence navigate the formal court system. Consultative meetings and dialogues were conducted to discuss prevention of GBV and align statutory and customary by-laws for child protection.

4.5 Commodities

Ensuring that HIV commodities are in full supply and accessible to all patients is a priority and critical to achieving the 95-95-95 goals and sustaining epidemic control in Zambia. PEPFAR Zambia and the GRZ are committed to client centered HIV treatment services. All PLHIV, will be offered TLD as the preferred first line regimen for HIV treatment.

By the end of 2020, PEPFAR Zambia aims to reach 70% of adults on TLD and by the end of 2021, Zambia aims to achieve 80%. All individuals on TLD will be provided with MMD. The transition to TLD 90 count bottles began in December 2019. PEPFAR Zambia orders of TLD in COP20 are 90 and 180 count bottles. This switch will further decrease the burden on limited storage space and will improve retention. Adult ARVs are funded by PEPFAR, GFATM and GRZ there is no gap projected for COP20.

Zambia has phased-out NVP-based regimens and has started transitioning pediatric patients to optimized regimens such as DTG, raltegravir granules and LPV/r granules. In COP20, orders of Lopinavir/Ritonavir are planned as 120 count bottles, or 120 count sachets. All pediatric ARVs are fully funded by PEPFAR with no gap projected.

For effective supply chain management for VL commodities, the COP20 goal is to provide VL testing to over 50% at baseline and to 100% of TX_CURR. PEPFAR Zambia continues to provide technical assistance to the ZAMMSA (formerly Medical Stores Limited) and MOH to manage and maintain cold chain systems that ensure full stock availability of all reagents, consumables and calibrators needed to conduct VL tests. There is no funding gap projected for HIV lab commodities which are currently purchased through reagent rental agreements with Hologic and Roche. Laboratory commodities are funded by PEPFAR, GFATM and GRZ with no gap projected.

In COP20, USAID plans to establish a new G2G agreement with ZAMMSA to strengthen its ability for commodity procurement and supply chain management. In addition, USAID plans to support a new local private sector entity responsibility for 3PLs to deliver drugs to service delivery points.

Table 4.5.1 Funding Gap					
Commodity Category	COP20 Funding Need	COP20 Funding Commitment	GFATM	GRZ	COP20 Funding Gap
ARVs	\$128,680,868	\$62,836,468	\$48,690,386	\$17,154,014	\$0
OIs (Prev. & Tx)	\$2,224,495	\$2,224,495	\$0	\$0	\$0
VL/EID	\$23,916,391	\$18,344,582	\$5,571,809	\$0	\$0
CrAg	\$100,000	\$100,000	\$0	\$0	\$0
GeneXpert Cartridges (VL)	\$7,450,126	\$1,743,764	\$5,706,362	\$0	\$0
GeneXpert Cartridges (TB)	\$1,853,418	\$1,853,418	\$0	\$0	\$0
Lipo-Arabinomannan (LAM) Strips	\$300,000	\$300,000	\$0	\$0	\$0
Other HIV lab Commodities	\$28,160,968	\$14,092,077	\$3,188,077	\$10,880,814	\$0
Rapid test kits	\$10,737,623	\$4,007,132	\$5,266,350	\$1,464,141	\$0
INH	\$1,926,455	\$1,091,891	\$834,564	\$0	\$0
Rifapentene	\$1,690,696	\$1,070,749	\$619,947	\$0	\$0
Vit B6	\$668,840	\$668,840	\$0	\$0	\$0

Source 2019 National Lab Commodities Forecasting and Quantification Report and the 2019 National ARV Forecasting and Quantification Report, COP20 proposed funding and proposed GFATM concept note with GRZ/MOH

4.6 Collaboration, Integration and Monitoring

4.6.1 Strengthening Cross Technical Collaboration and Implementation

PEPFAR Zambia has continued to collaborate with GFATM and MOH on all technical aspects of program implementation including through external stakeholder engagement. These engagements have stimulated broad participation including representation from several host government ministries and departments, multilateral organizations, local and international non-governmental organizations and CSOs. Close collaboration and engagement with the GRZ through the MOD were obtained through joint planning, site visits and formalized agreements specifying support and implementation. There is a common understanding on USG support to ensure sustainability and continuity of programs and activities.

USAID and CDC are collaborating with Provincial and District MOH offices to convene regular joint site level data reviews, conduct site visits to identify performance weaknesses and develop remediation plans. Once a site has been assessed and a remediation plan developed, progress towards site level targets is reviewed during regular meetings. Additional follow-up through technical supportive supervision to improve site level performance is then provided by a USAID or CDC implementing partner in collaboration with the MOH. PEPFAR Zambia technical staff participate in the monthly provincial surge review meetings and meet routinely within the national TWG structure to escalate and address policy barriers, respond to technical issues at the site-level and share best practices. PEPFAR Zambia supports Extension of Community Health Outcomes (ECHO) sessions every Monday afternoons to enhance the technical skills of the providers. The ECHO sessions are envisaged to be rolled out to all the provinces of Zambia. DOD through the MOD have put in place a forum for the Zambian Defence Force (ZDF) to meet and interact with senior command to review program gaps and poorly performing sites. In addition, enhanced joint facility assessments comprised of ZDF, IPs and DOD staff have been instituted to facilitate on the spot program correction. The enhanced site assessments have had the additional benefits of increasing the collaboration of all stakeholders, better problem solving and improved client service.

In COP20, PEPFAR Zambia will continue as a voting member of the CCM, will have a seat on the CCM Oversight Committee and will continue its leadership roles on both the Health (USAID and CDC) and HIV (PCO) Cooperating Partners Groups. PEPFAR Zambia has placed a technical advisor within the MOF through US Treasury's Office of Technical Assistance to strengthen Zambia's efforts to implement and manage a sustainable national response to HIV. The technical advisor provides assistance to strengthen technical capacity of the Oversight Working Group on Sustainable Financing; establish systems and processes to accurately track HIV resources and expenditures on country-wide basis; and develop sustainable funding options and efficient resource management systems. PEPFAR Zambia will continue to work closely with UNAIDS in the areas of SI, advocacy and CSO capacity building and coordination.

4.6.2 Strengthening IP Management and Monitoring

All USG agencies have prioritized partner management for achieving results. All partners report data on key 95-95-95 indicators on a monthly basis and these are jointly reviewed by PEPFAR Zambia to identify gaps and areas where course correction is needed.

In collaboration with the GRZ, CDC conducts granular site management as a strategy for partner management by focusing on performance improvement at the site level. Annual targets will be broken down into weekly targets which CDC will review in collaboration with the GRZ district and provincial health offices. Focused site visits to underperforming sites by the site management team comprising of MOH and CDC staff will take place to quickly fix performance gaps as they are identified. The monitoring of site performance through GSM has changed from a monthly basis to weekly situation rooms with facilities through the zoom platform. Surge meetings are held on a weekly basis for districts to learn from each other. CDC will continue to hold oversight and accountability meetings with IPs where issues at the above site and/or policy level can be resolved by the provincial leadership in consultation with CDC leadership and the IP leadership. PEPFAR Zambia will continue and expand its practice of utilizing evidence-based best practices by requesting the interagency team to implement evidence-based practices where feasible and applicable.

USAID has employed multiple management approaches to improve partner performance which has resulted in significant improvements across the treatment cascade. USAID will continue to use performance based contracts which tie contractor fee payments to the achievement of results, hold monthly regional data review meetings in coordination with the MOH, conduct regular joint site visits and develop site level remediation plans for all poorly performing sites. Regional situation rooms are used to review data in real time. USAID will also continue to meet IPs at least on a monthly basis to review activity performance and expenditure data. Through these enhanced partner performance methods, USAID is identifying issues far more rapidly than in the past and working with partners to fix issues in real time as they are identified.

DOD uses a client centered approach to monitoring and evaluation. This approach focuses on IPs having a clear understanding of the technical guidance on program implementation and PEPFAR requirements to ensure the client needs are met. Partner performance is assessed by joint collaboration meetings, regular review of PEPFAR Zambia results, enhanced monitoring of program implementation in the field and DOD provided technical assistance to partner staff.

4.6.3 Improving Integration of Key Health System Interventions

PEPFAR Zambia priorities have directed the implementation of key health system interventions including supplementing the GRZ's HRH efforts and electronic health record management. In order to achieve PEPFAR Zambia programmatic priorities, including case finding, linkage, retention on ART and VL, PEPFAR Zambia recognizes that a robust clinical and community health workforce is essential. Currently, the MOH employs more than 60,000 staff, including 35,000 clinical staff and 1,377 community health assistants. This staffing complement consists nearly 48% of the

establishment. To further supplement the HRH, PEPFAR Zambia in COP20 aims to maintain salary support for 2,949 clinical staff and 17,900 CHWs. These supplemental support staff will be deployed based on the geographical distribution of TX_CURR gap, with more community workers deployed to the highest burden provinces. Community cadres will be responsible for scaling up key case-finding strategies such as index testing, ensuring all clients found positive are properly counseled so they start on ARVs, tracing all defaulters and making sure clients who are eligible for VL testing get tested. Additionally, these CHWs will be the cornerstone for implementation of the community post model and other forms of community based DSD models. The deployment of PEPFAR Zambia will routinely incorporate HRH reviews (including site and individual performance reviews) into site and partner-level management to allow PEPFAR Zambia to identify sites where increased HRH support or optimized HRH is necessary.

In anticipation of reaching epidemic control targets by 2020, PEPFAR Zambia is conducting modeling and analysis of workforce requirements for the maintenance of HIV services. The results of this exercise are the foundation in the planning of HRH support and dialogue with the host country government towards greater shared responsibility of HRH requirements and as part of domestic resource mobilization efforts for HIV. PEPFAR Zambia is continuing to dialogue with MOH Community Health Unit regarding constant refinement of the standards for community health workers within the framework of the national HIV response as current standards are for the general population. Concurrently, PEPFAR Zambia is jointly investing in the revision and roll-out of standardized incentives, training packages and guidelines for non-community health assistance CHWs as well as harmonization of data collection tools for CHWs. PEPFAR Zambia is working to revamp the role of Neighborhood Health Committees, community-based support groups formed under the guidance of health personnel, to manage the performance of CHWs to maximize their performance and contribution to advancing the goal towards HIV epidemic control.

As PEPFAR Zambia transitions the sole management of the national HIV program to the GRZ, PEPFAR Zambia is investing in the MOH National HIV Clinical Mentoring program and the ECHO program. The Zambia ECHO program is a weekly virtual learning network where cases from facilities (spokes) are discussed by the network led by a hub of experts at the University Teaching Hospital. The cases are submitted based on a range of topics including TLD transition, TPT, pediatric HIV clinical management and management of treatment failure. This program will help make sure that frontline workers receive mentorship on key clinical issues on a regular basis and will ultimately improve quality clinical care at health facilities.

Additionally, PEPFAR Zambia will support interventions to increase the timely availability of high-quality data and promote its use to enhance program performance to achieve better health outcomes. This will include the nation-wide scale up of case-based surveillance system; provision of tools and technical assistance to improve program data quality and support HIV-related surveillance; building HMIS management capacity by utilizing an MOH standardized approach and support tools; conducting rapid qualitative assessments of selected research institutions on the real and perceived gaps in research capacity; and building the capacity of CSOs to utilize data.

In accordance with the Zambia National eHealth Strategy to improve data management, patient management and patient tracking, PEPFAR Zambia will continue to roll out an upgraded version of SmartCare+ to all provinces so that 95% of ART patients have their patient information in the system. Key features of this upgrade will include client centered enhancements such as patient satisfaction surveys by SMS that trace back to the specific provider, automated return and notification of lab results and improved patient identification incorporating lessons learned from the current implementation of fingerprint biometrics technology for unique patient identification to improve patient tracking, linkage and retention.

As a priority, PEPFAR Zambia will continue to support interoperability among information systems to improve retention and close monitoring of VL suppression. In this regard, PEPFAR Zambia will support the roll out of an integrated system that links the laboratory information system and the eLMIS to the EHR, in all facilities where these systems are being used. This system linkage will ensure efficient tracking of the 95-95-95 cascade and the availability of adequate stocks medications and commodities at facility level. PEPFAR Zambia supported the development of the National Data Warehouse, which is able to pull data from disparate systems (EHR, LIS, eLMIS and HRIS) and create visualizations which provide a broader view of the state of the epidemic, at national and sub-national levels. PEPFAR Zambia will continue to support the enhancement of the NDW functionality and visualization through the use of Palantir technologies to improve data utilization for program management, at all levels. PEPFAR will also support sub-national level roll out of the human resource information system to support HRH deployment.

4.6.4 Improving Quality and Efficiencies of Service Delivery

The Zambia Consolidated Guidelines for Treatment and Prevention of HIV Infection outlines Zambia's strategic approach for implementing DSD that focuses on client centeredness and health system efficiency. The four primary approaches are: 1) Patients receive their ARV refills in a group and either a professional or a lay health care worker manages this group; 2) Clients receive their ART refills in a group but this group is managed and run by clients themselves, e.g. Community Adherence Groups; 3) ART refills are provided to individuals outside of health care facilities (e.g., of health post dispensation, home delivery and community based drug pick-ups); and 4) ARV refill visits are separated from clinical consultations and patients can proceed directly to receive their medication so as to reduce their waiting time at facilities. In January 2019, the MOH issued a memorandum with guidance on the MMD of ARVs and directed that all stable clients be offered 6-month prescriptions. In COP20, IPs will work with health facility staff to continue scaling up these DSD approaches, including MMD, in order to improve retention in care and reduce congestion at health facilities. PEPFAR has targeted to transition 80% of patients to TLD by the end of 2021, all of whom will be on MMD. Priority focus of DSD models target adolescents and men, who have had lower linkage and retention rates.

4.6.5 Supporting Community-Led Monitoring

In COP20, PEPFAR Zambia will collaborate with Zambian based CSOs to conduct community-led monitoring (CLM) to help discover any persistent barriers or challenges clients are experiencing in Zambia revolving around HIV services. To accomplish this PEPFAR Zambia plans to award 10 grants to Zambian based CSOs, one per province. PEPFAR Zambia will also fund NAC to develop in partnership with all stakeholders a national survey that guides these CLM grantees on what issues to query about with tailored questions specific to all the different demographics. In conjunction with the national survey, NAC will likewise design a reporting mechanism to record survey results, observations and recommendations collected by the CLM grantees. NAC will also convene quarterly meetings with GRZ, PEPFAR, IPs and CSOs to review the findings from not just the CLM reporting mechanism but other stakeholders' monitoring tools allowing all stakeholders to see possible problems from every angle. Follow up on prior actionable issues will be also be reported at these meetings.

4.6.6 Ensuring Above Service Delivery Activities are Related to Reaching Epidemic Control

PEPFAR Zambia reviewed MER indicator results, as well as Sustainability Index and Dashboard (SID 2019) and SIMS/enhanced site visit findings, to determine above service delivery investments to achieve epidemic control by 2020. While notable progress was made overall, the analysis revealed the following gaps/barriers:

- Lack of policies that enable adolescent HIV testing from under the age of 15 years old
- CSOs funding for HIV programming is low
- Private sector engagement is weak
- No domestic financing and specific service provision or surveillance for key populations
- No definitive health workforce transition inventory/plan
- Interruptions in stock supply
- Low HIV, health domestic funding and budget execution

In COP20, PEPFAR Zambia will spend \$28,391,632 on above service delivery interventions to address the identified barriers.

4.6.7 Use of Unique Identifiers Across Sites and Programs in Clinical Settings

The challenge of unique identification has been identified within and across sites through such ways as silent transfers where clients move from one site to another without identifying at the destination site that they are already on treatment at the origin site there by leading them to be registered in PEPFAR Zambia a second time. This also occurs within site where a client is initiated on ART in one clinical area and when referred to the ART clinic for lifelong treatment, this client is registered a second time and provided with a different identifier from the one they initiated with.

In sites that are utilizing the SmartCare national electronic health record system, there are a number of solutions that are under implementation to better assure unique identification. These strategies include use of smart cards, fingerprint biometrics and web based SmartCare. The

SmartCare system provides for a client to be issued with a Smart card which is a portable electronic record that the patient carries from site to site in order that they are not only identified at every site they visit but also to allow for the next provider to be able to review their entire patient record and better plan for service provision. Because the card has a unique number assigned electronically, each patient can be identified as such as long as the they carry this card every time, they seek services. The use of fingerprint biometrics is being integrated into SmartCare to provide an additional biomarker in order to improve the system’s ability to uniquely identify clients as they receive services in facilities. This also helps with reconciling fragmented client records in the current set up where SmartCare is a standalone distributed system. In addition, deduplication of clients at higher than facility level especially for reporting is better aided with the addition of the fingerprint biometric. This is currently deployed in 10 sites and will be scaled up to an additional 100 by September 30th, 2020. SmartCare is being migrated to a web-based platform. This means that there will be one centralized system. The benefit for unique identification is that the web-based platform means that every client has one record that is shared for use across sites that they visit there by assuring that there is no duplication of records across sites. This will be implemented in 25 sites by September 30th, 2020.

It is important to note that there is no single identifier that assures uniqueness, however the combination of the solutions identified will improve confidence of uniqueness of client identification for both patient care and reporting.

4.7 Targets by Population

Table 4.7.1 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART (COP19)	Additional patients required for 95% ART coverage	Target current on ART (COP20) TX_CURR	Newly initiated (COP20) TX_NEW	ART Coverage (COP20)
Attained	814,497	739,521	34,251	804,444	62,658	99%
Scale-Up Saturation	342,705	293,822	31,748	315,835	30,405	92%
Scale-Up Aggressive	28,987	26,207	1,331	23,479	3,011	81%
Sustained	24,335	9,259	13,859	18,976	2,037	78%
Central Support	29,723	NA	N	513	10	2%
Commodities (if not included in previous categories)		NA	NA	NA	NA	NA
Total	1,240,247	1,114,777	63,458	1,163,247	98,121	94%

Source: COP20 Datapack and DATIM

Table 4.7.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts				
Target Age Group	Population Size Estimate (SNU's)	Current Coverage (COP19 Q1)	VMMC_CIRC (in COP20)	Expected Coverage (in COP20)
15-29	898,109	43%	615,737	69%

Source: COP20 Datapack and DATIM

Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	Population Size Estimate and disease burden (HIV prevalence)	Coverage Goal (in COP20)	COP20 Target
AGYW (PP_PREV)	1,804,698 (5% HIV prevalence)	11%	200,756
FSW (KP_PREV)	133,566 (41.6% HIV prevalence)	22%	29,584
MSM (KP_PREV)	68,044 (17.7% HIV prevalence)	22%	14,746
PWID (KP_PREV)	26,840 (16.6% HIV prevalence)	0.2%	57
Prison population	--	--	29,876
TG (KP_PREV)	6,426 (HIV prevalence unavailable)	22%	1,445
TOTAL	2,015,574	14%	276,464

Source: COP20 Datapack

Table 4.7.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of OVC who will be active in FY21 OVC_SERV <18	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC*
Military	--	12,714	12,714
Chadiza*	4,571	138	138
Chembe*	1894	22	22
Chibombo	17,801	6,558	6,558
Chikankata	9732	4,760	4,760
Chilanga	24,543	5,383	5,383
Chingola	34,685	24,184	24,184
Chinsali*	6,657	110	110
Chipata	29,987	19,971	19,971
Chipili*	9,457	132	132
Chisamba	7,345	4,655	4,655
Chitambo*	2,285	132	132
Choma	17,285	8,354	8,354
Chongwe	16,748	6,177	6,177
Ikelenge*	2477	22	22
Kabwe	21,965	29,777	29,777
Kafue	16,667	5,734	5,734
Kalabo*	9,898	50	50
Kalomo	29,544	5,738	5,738
Kanchibiya*	5780	66	66
Kapiri-Mposhi	26,887	26,913	26,913
Kasama	20,076	9,220	9,220
Kasempa*	3,388	253	253
Kawambwa*	9,918	110	110
Kazungula*	10,889	66	66
Kitwe	70,442	38,656	38,656
Livingstone	14,778	18,763	18,763
Luanshya	23,874	16,098	16,098
Lundazi*	21,654	372	372
Lusaka	104,623	74,885	74,885
Luwingu*	4,498	330	330
Mansa*	24,339	196	196
Mazabuka	25,980	15,278	15,278

Mbala*	14,987	317	317
Mkushi	14,272	5,926	5,926
Mongu	23,990	19,468	19,468
Monze	27,714	15,740	15,740
Mpika*	10,453	110	110
Mufulira	25,769	15,132	15,132
Mufumbwe*	2,372	165	165
Mumbwa	13,876	6,763	6,763
Mungwi*	7,654	88	88
Mwansabombwe*	3769	22	22
Mwense*	12,707	77	77
Mwinilunga*	8,333	440	440
Namwala	6,283	5,775	5,775
Nchelenge*	12,876	33	33
Ndola	77,765	38,796	38,796
Pemba*	1789	55	55
Petauke	14,776	4,529	4,529
Samfya*	10,112	66	66
Serenje*	13,889	330	330
Shiwang'andu*	3387	154	154
Sinazongwe	5,067	4,186	4,186
Sinda*	2041	110	110
Solwezi	17,867	6,848	6,848
Zimba*	3577	154	154
TOTAL	965,992	461,101	461,101

*Peace Corps/PEPFAR Small Grants Program District

Source: Estimates from 2018 National HIV/AIDS/STI/TB Council Management Information Systems, targets from COP20 Datapack

4.8 Cervical Cancer Program Plans

The highest cause of all cancer deaths in Zambia is cervical cancer. Most women with cervical cancer are also living with HIV. Since 2006, PEPFAR Zambia has collaborated with the MOH and other donors to implement cervical cancer screening services countrywide using VIA. Currently, the main approach being utilized for screening is the same day “screen and treat” VIA with 5% acetic acid approach and treatment with mostly cryotherapy for eligible precancerous lesions. Cold coagulation is being conducted on a smaller scale due to challenges in the availability of nitrous oxide. Women with ineligible lesions are referred for LEEP or punch biopsy. In COP19, approximately 76% of districts (ranging from 50%-100% of districts in a province with at least one VIA site) in Zambia offer ‘screen & treat’ services and approximately 49% of districts with 1 LEEP site (ranges from 33%-100%). Invasive cervical carcinoma cases are referred for further

management at provincial hospitals or the Cancer Diseases Hospital in Lusaka. In COP18, a total of 98 PEPFAR Zambia supported static sites were offering cervical cancer services with additional screening conducted through mobile outreach services. It is envisioned that the sites will increase to 128 in COP19. Further, in COP20 Zambia is embarking on making HPV DNA testing the gold standard for cervical cancer screening. With support from PEPFAR, Zambia started the scale up of HPV DNA testing in 6 selected sites in Lusaka. A total of 3925 HPV self-testing samples were collected, 45% of these tested positive and were referred for VIA screening and treatment according to the HPV DNA screening algorithm. In COP18, PEPFAR Zambia screened a total of 109,722 out of a total target of 130,000 set out for the year constituting an 84% achievement. Of those screened, 7,311 tested VIA positive, constituting 7% of the total women screened and 4,357 (60%) WLHIV were referred for LEEP services. In COP20 PEPFAR Zambia targets screening 258,343 WLHIV on ART.

In COP20, PEPFAR Zambia will continue to strengthen screening services country wide. PEPFAR Zambia will focus on approaches that target the screening of WLHIV women in the ART clinics and utilization of lay/adherence counsellors in the communities. Referral systems and linkage services will continue to be strengthened through improved health literacy of health care providers and community health workers to ensure consistent cervical cancer screening of WLHIV. PEPFAR Zambia's implementing partners will work with sites to create an enabling environment that will effectively target WLHIV with screening services. In addition, the development of the relevant guidelines, SOPs, job aids and training materials will continue to be prioritized.

In COP20, PEPFAR Zambia will focus on implementing the best practices building on the success achieved in previous years in the scale up of activities. Scale up 'screen & treat' using VIA and treatment with cryotherapy or thermoablation in all sites along with strengthening LEEP referral services will improve treatment rates of identified large precancerous lesions. HPV DNA self-testing, currently only offered in Lusaka, will be expanded to Central and Copperbelt Provinces and will be scaled up in COP20 to sites where VIA is not available. PEPFAR Zambia will also create demand through routine health literacy of staff and clients and sensitization/engagement of HIV advocacy groups such as Network of Zambian People Living with HIV/AIDS. Biopsy referral systems will be strengthened through expansion of histopathology services and specimen evaluation including telepathology to improve results return of specimens. Technical support supervision and mentorship will ensure VIA and LEEP quality assurance and participation in TWG and other relevant meetings will assistance in stakeholder and telemedicine coordination.

4.9 Viral Load and Early Infant Diagnosis Optimization

VL scale up was completed by the end of COP18 and in early COP19 PEPFAR Zambia moved into the optimization phase. PEPFAR will continue to optimize the high throughput and conventional VL system throughout COP20 and beyond. There are 21 facilities performing high throughput VL and/or EID currently comprising a total of 24 laboratories. The University Teaching Hospital in Lusaka has 3 separate centers that have their own high throughput VL and/or EID testing capacity. This number will decrease over time as the Cobas AmpliPrep/Cobas TaqMan HIV-1 (CAP/CTM) system is phased out and as selected testing moves to point of care. In COP20 and beyond, all

routine (follow-up and baseline) VL testing, including VL during breastfeeding, will be performed on conventional platforms. In accordance with the COP19 SDS, 18 districts with poor coverage for EID and/or VL for PBFW are being capacitated for point of care (POC) testing, specifically on the GeneXpert platform. An additional district was added by MOH direction, and in COP20, at least 20 more districts will be served by point of care testing for EID and VL during pregnancy. A slight change from the COP19 SDS has been necessitated by a change in Zambia Consolidated Guidelines that requires testing every 3 months during pregnancy and breastfeeding for WLHIV. The POC testing capacity could be overwhelmed by performing all tests during both pregnancy and breastfeeding on POC instruments. As a result, PEPFAR Zambia consensus is to conduct VL during pregnancy on POC, whereas during breastfeeding, VL tests will be referred to one of the 24 central VL/EID high throughput labs.

Point of care testing provides same day results whereas testing at a centralized facility requires sample referral and, in some cases, hard copy results return, in total requiring a minimum of 3 days. Logistics challenges in many settings have extended this turnaround time (TAT) substantially. The national minimum standard is for VL TAT to be less than 14 days. This is already achieved in COP19 for most facilities. Minimizing TAT will be a major focus of lab optimization efforts throughout the remainder of COP19, through COP20 and beyond. Minimizing TAT increases demand, which increases coverage and suppression rates, and thereby reduces transmission. The decentralized VL/EID testing system has proven successful in Zambia and will be maintained, while some individual facilities will cease to be counted among “high throughput” labs as the CAP/CTM 48 platform is obsoleted, possibly prior to the end of COP20. Currently, there are 11 CAP/CTM 48 platforms, and 3 of the 24 VL labs have only the CAP/CTM 48. As a result, when this system is obsoleted, these facilities will transition to a combination of referral and the use of GeneXpert to serve both VL and EID needs. The CAP/CTM 48 system contributes approximately 220,000 tests of the total capacity, but the system is now comparatively so inefficient as to become more problematic to maintain than beneficial. Removing the system from the lab network will leave Zambia with capacity for 1.5 million conventional system tests even in a normal work-year. This will allow most platforms to attain the recommended 50-80% utilization range which is a target of COP20 diagnostic network optimization. The remaining systems would be comprised of 10 CAP/CTM 96, 9 COBAS 4800, 7 Hologic Panthers and 2 COBAS 6800s, distributed among all 10 provinces in alignment with local testing demand.

The approximate total maximum volume of tests to be performed on conventional instruments is the Tx_CURR of approximately 1,000,000, plus retesting of unsuppressed (approximately 100,000), baseline VL (also approximately 100,000) and VL during breastfeeding (approximately 360,000 in addition to those that would count toward routine VL). Thus, the total conventional VL demand will be approximately 1.56 million in COP20. Currently, the high throughput testing system capacity is approximately 1.72 million and, as noted, with removal of the CAP/CTM system, capacity even within a normal work year, would still be approximately 1.5 million tests.

Approximately 270,000 EID tests and 180,000 VL tests will be required during pregnancy in COP20. All of these can be accommodated on POC systems. The current array of GeneXperts already in place in Zambia can perform far in excess of 1,000,000 tests in a normal work-year.

In order to meet the COP20 guidance to provide 100% access to VL, Zambia will substantially improve the sample referral system and introduce targeted use of DBS for VL. Optimization of the sample referral system will be harmonized by virtue of being coordinated by a single implementing partner in support of MOH.

In COP20, PEPFAR Zambia will support a major upgrade and harmonization of the lab information and digital results return systems. The COP19 commitment for access to digital results return for all sites is on track for achievement, however, 4 separate systems are used. In COP20 PEPFAR Zambia will get on a path to fully harmonizing the systems to arrive at one lab information system and one digital result return system. As such, TAT for VL will be less than 14 days and TAT for EID will be less than 5 days by the end of COP20. PEPFAR Zambia will minimize fuel, HR and reagents costs through a lab optimization process based on formal establishment of the lab network, the minimum standards of facilities at all levels and guided by computer modeling.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Analyses of the SID 2019 findings, along with MER results, SIMS visit reports and other sources, identified key systems barriers and sustainability vulnerabilities that must be addressed in order to achieve and maintain epidemic control. The systems barriers include inadequate data for planning; inadequate supply chain (specifically commodity distribution); inadequate financial management procedures/domestic resource mobilization (DRM); inadequate HR; and inadequate civil society engagement. Other key barriers relate to limitations in patient tracking using EMR, especially in the context of silent transfers, and the fact that subsystems are not sufficiently integrated leading to suboptimal use of information. The SID process identified six sustainability vulnerabilities that have been prioritized in COP20: commodity security and supply chain; epidemic and health data; laboratory; service delivery; DRM; and HRH.

Inadequate human and infrastructure capacity to commence and retain patients on treatment results in sub-optimal quality of care and congestion of health facilities. With a clinical health worker to population ratio of 12 per 10,000 and 52% of positions on the MOH establishment remaining vacant, there are inadequate numbers of health workers achieve optimal linkage and retention. Table 6 activities to resolve this gap include preservice training, recruitment and deployment of community health assistants and HIV nurse prescribers and the use of G2G agreements with provincial health offices and other entities to fill staffing gaps (with the view of transitioning them to the GRZ payroll. PEPFAR will support the continued roll out of an HRIS to

improve HR management, as well as support the operationalization of the national community health strategy that harmonizes the training and job descriptions of community-based workers.

To improve service delivery and retention PEPFAR will continued implementation of the Test and Start and differentiated service delivery models including community-based ART models, TLD transition and MMD PEPFAR will improve patient tracking by supporting the upgrade and maintenance of SmartCare, as well as integration with other systems to optimize use of information. Additionally, PEPFAR will support laboratory optimization, integration of laboratory information systems and lab quality assurance to improve VL capacity and suppression. These activities will focus on high burden geographic areas and/or populations, including KPs for epidemic control.

Inadequate commodity security is due to break down in planning and distribution along the continuum of care. HTS, EID and VMMC commodities are particularly vulnerable. PEPFAR will improve stock availability at facility level by engaging a local private sector 3PL provider to distribute commodities, rolling out eLMIS to all facilities in priority districts and strengthening commodity forecasting and quantification capacity.

During COP20 implementation, PEPFAR Zambia will also conduct Surveillance, Research, and Evaluations (SRE) including:

- CADRE: Conduct lab based acquired drug resistance surveillance
- Case-based surveillance
- Mortuary based mortality surveillance
- HIV Recency and Response
- Key populations IBBS
- Seroprevalence and Behavioral Epidemiology Risk Survey (SABERS)

Together, the above activities will not only help the PEPFAR Zambia team better understand the dynamics of the HIV population but will significantly improve the precision by which PEPFAR Zambia adjusts PEPFAR Zambia to accelerate towards the goal of HIV epidemic control.

PEPFAR Zambia will continue to work closely with and leverage resources of key stakeholders, including the GFATM, GRZ and civil society. PEPFAR Zambia has set measurable annual benchmarks and outcomes for each Table 6 investment that will be used to monitor implementation and ensure achievement of results. The goal of the PEPFAR Zambia systems investments is to address systems barriers to the timely identification, initiation and retention of clients on ART and to provide quality care to people living with HIV. PEPFAR Zambia will have reached its goal when the rate of new infections and mortality due to HIV significantly decreases from year to year.

APPENDIX A – PRIORIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

SNU	COP	Prioritization	Results Reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																											
				Treatment Coverage at APR by Age and Sex																											
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		Overall TX Coverage			
F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M						
Chadiza District	COP 15	ScaleUp Sat	APR 16	14%	14%	93%	52%	198%	138%	139%	139%	225%	77%	93%	83%	93%	90%	93%	71%	93%	89%	93%	71%	93%	72%	93%	72%	99%			
	COP 16	Sustained	APR 17	14%	14%	59%	59%	59%	59%	112%	88%	34%	141%	31%	182%	37%	144%	34%	126%	46%	116%	41%	106%	47%	92%	64%	90%	71%			
	COP 17	Sustained	APR 18	0%	0%	48%	48%	47%	47%	88%	82%	26%	110%	39%	166%	39%	162%	41%	160%	57%	176%	63%	153%	72%	133%	101%	140%	93%			
	COP 18	ScaleUp Sat	APR 19	107%	107%	52%	52%	38%	44%	327%	285%	80%	136%	36%	137%	54%	159%	26%	103%	73%	100%	51%	83%	59%	73%	80%	84%	77%			
Chama District	COP 18	ScaleUp Sat	APR 20	90%	90%	90%	90%	90%	90%	90%	90%	84%	100%	84%	93%	84%	100%	84%	80%	84%	100%	84%	80%	84%	80%	84%	80%	85%			
	COP 20	ScaleUp Sat	APR 21	50%	150%	257%	257%	170%	140%	200%	200%	128%	189%	140%	87%	142%	110%	156%	132%	195%	178%	193%	210%	231%	205%	177%	180%				
	COP 15	Central Support	APR 16	0%	50%	19%	29%					16%	89%															0%			
	COP 16	Central Support	APR 17	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
Chasefu District	COP 17	Central Support	APR 18	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
	COP 18	Central Support	APR 19	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
	COP 19	Central Support	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
	COP 20	ScaleUp Sat	APR 21	0%	0%	31%	75%	28%	42%	67%	50%	50%	39%	37%	15%	54%	48%	73%	74%	60%	63%	77%	84%	77%	83%	58%	83%	64%			
Chawuma District	COP 20	ScaleUp Sat	APR 20	0%	0%	45%	55%	39%	53%	36%	38%	57%	41%	41%	26%	39%	42%	52%	42%	54%	42%	56%	51%	53%	55%	50%	47%	49%			
	COP 16	Central Support	APR 17	33%	33%	50%	50%					60%	9%															3%			
	COP 17	Central Support	APR 18	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
	COP 18	Central Support	APR 19	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
Chembe District	COP 19	Central Support	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
	COP 20	Central Support	APR 21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
	COP 15	ScaleUp Sat	APR 16	33%	33%	18%	36%	27%	27%	25%	25%	48%	0%	31%	23%	31%	24%	31%	24%	41%	31%	42%	32%	42%	32%	41%	32%	33%			
	COP 16	ScaleUp Agg	APR 17	0%	0%	27%	27%	27%	27%	6%	31%	0%	27%	6%	74%	18%	65%	19%	61%	28%	75%	28%	73%	31%	68%	26%	44%	38%			
Chibombo District	COP 17	ScaleUp Agg	APR 18	33%	33%	27%	27%	33%	33%	31%	38%	15%	105%	22%	130%	28%	86%	37%	102%	38%	90%	43%	92%	45%	86%	25%	43%	54%			
	COP 18	ScaleUp Agg	APR 19	150%	150%	91%	91%	73%	67%	181%	144%	42%	86%	53%	128%	55%	133%	26%	130%	75%	152%	132%	177%	140%	166%	91%	135%	105%			
	COP 19	ScaleUp Agg	APR 20	90%	90%	90%	90%	90%	90%	90%	90%	90%	77%	75%	74%	75%	76%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	89%			
	COP 20	ScaleUp Agg	APR 21	0%	100%	83%	150%	82%	36%	75%	42%	171%	133%	226%	100%	225%	164%	185%	149%	158%	157%	111%	124%	100%	91%	64%	41%	123%			
Chiengi District	COP 15	ScaleUp Sat	APR 16	47%	31%	31%	15%	17%	17%	17%	17%	53%	15%	18%	12%	18%	15%	18%	15%	18%	15%	18%	15%	15%	15%	15%	17%				
	COP 16	ScaleUp Sat	APR 17	8%	8%	36%	35%	36%	36%	43%	30%	17%	51%	21%	113%	25%	27%	70%	29%	65%	32%	61%	34%	56%	22%	33%	41%				
	COP 17	ScaleUp Sat	APR 18	19%	19%	62%	60%	62%	61%	52%	44%	26%	132%	32%	211%	47%	162%	38%	105%	43%	97%	44%	73%	48%	67%	34%	48%	63%			
	COP 18	ScaleUp Sat	APR 19	347%	347%	91%	90%	65%	64%	19%	40%	89%	309%	49%	316%	95%	176%	89%	202%	86%	155%	21%	186%	131%	171%	98%	87%	128%			
Chifumabuli District	COP 19	ScaleUp Sat	APR 20	90%	90%	90%	90%	90%	90%	90%	90%	100%	100%	100%	89%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	84%	100%	97%			
	COP 20	ScaleUp Sat	APR 21	36%	47%	139%	159%	127%	114%	146%	141%	108%	99%	134%	82%	157%	121%	148%	131%	137%	143%	119%	143%	109%	119%	92%	79%	120%			
	COP 15	Central Support	APR 16	0%	23%	62%	49%					11%	14%															4%			
	COP 16	Central Support	APR 17	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
Chikankata District	COP 17	Central Support	APR 18	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
	COP 18	Central Support	APR 19	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
	COP 19	Central Support	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			
	COP 20	ScaleUp Sat	APR 21	13%	0%	89%	56%	61%	92%	91%	218%	207%	124%	159%	123%	128%	100%	101%	116%	87%	113%	78%	116%	67%	49%	29%	9%				
Chilanga District	COP 15	ScaleUp Sat	APR 17	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	2%													0%			
	COP 16	ScaleUp Sat	APR 18	0%	0%	0%	0%	0%	0%	0%	0%	3%	2%	8%	5%	8%	1%	4%	1%	6%	1%	6%					2%	1%	2%		
	COP 17	ScaleUp Sat	APR 19	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	1%	0%	1%	0%	1%	0%	0%	0%	0%	1%	0%			
	COP 18	ScaleUp Sat	APR 20	91%	91%	91%	91%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%		
Chitungo District	COP 15	ScaleUp Sat	APR 16	0%	0%	36%	164%	14%	77%	83%	52%	110%	50%	103%	62%	110%	75%	101%	85%	76%	75%	65%	70%	71%	45%	40%	39%	68%			
	COP 16	Central Support	APR 17	10%	30%	25%	28%	20%	20%	21%	21%	77%	120%	39%	69%	38%	60%	39%	56%	39%	60%	33%	69%	50%	60%	33%	48%	46%			
	COP 17	ScaleUp Sat	APR 18	10%	10%	23%	23%	23%	23%	243%	227%	175%	488%	182%	693%	34%	136%	37%	117%	45%	105%	50%	80%	56%	85%	22%	26%	95%			
	COP 18	ScaleUp Sat	APR 19	20%	20%	80%	80%	79%	79%	124%	114%	35%	116%	22%	141%	26%	134%	40%	143%	58%	145%	98%	159%	110%	170%	140%	173%	102%			
Chitungo District	COP 19	ScaleUp Sat	APR 20	25%	25%	93%	93%	49%	49%	250%	251%	154%	194%	71%	333%	79%	178%	61%	331%	87%	151%	102%	116%	114%	124%	34%	64%	119%			
	COP 20	ScaleUp Sat	APR 21	78%	78%	88%	109%	83%	102%	96%	119%	53%	63%	50%	42%	74%	41%	79%	64%	103%	82%	112%	99%	108%	97%	101%	108%	87%			
	COP 15	ScaleUp Sat	APR 16	56%	32%	66%	57%	85%	88%	91%	96%	171%	251%	52%	55%	74%	69%	55%	62%	53%	60%	47%	45%	52%	49%	46%	43%	58%			
	COP 16	ScaleUp Sat	APR 17	50%	47%	32%	26%	29%	32%	51%	85%	85%	243%	68%	403%	33%	148%	29%	104%	27%	102%	26%	62%	36%	51%	16%	21%	54%			
Chitungo District	COP 17	ScaleUp Agg	APR 18	28%	26%	74%	68%	71%	74%	57%	54%	16%	119%	19%	256%	44%	251%	40%	172%	42%	135%	35%	65%	46%	54%	32%	36%	63%			
	COP 18	ScaleUp Sat	APR 19	23%	19%	13%	13%	9%	8%	136%	176%	60%	417%	58%	215%	104%	285%	68%	193%	48%	166%	74%	132%	100%	129%	70%	64%	101%			
	COP 19	ScaleUp Sat	APR 20	107%	102%	115%	105%	110%	115%	123%	128%	124%	108%	113%	127%	160%	152%	119%	139%	115%	131%	102%	103%	113%	111%	100%	100%	116%			
	COP 20	ScaleUp Sat	APR 21	22%	47%	214%	154%	94%	70%	112%	83%	140%	89%	198%	107%	237%	205%	162%	152%	120%	135%	76%	103%	57%	78%	44%	43%	102%			

Table with columns for District, COP type, Status, Date, and 50 percentage values. Rows are grouped by district: Chilibombwe, Chlubi, Chingola, Chinsali, Chipangali, Chipata, Chipili, Chirundu, Chiaamba, Chitambo, Choma, Kalulushi, Kalumbila, Kanchibiya, Kaoma, Kapiri Mposhi, Kaputa, Kasama, Kasempa, and Katele.

	COP 15	Sustained	APR 16	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	1%	0%	1%	0%	0%	1%	0%	1%	0%	0%			
	COP 16	Sustained	APR 17	25%	25%	0%	0%	5%	5%	19%	24%	3%	16%	22%	107%	4%	21%	4%	16%	4%	14%	4%	6%	5%	7%	10%		
Vubwi District	COP 17	Sustained	APR 18	0%	0%	17%	14%	14%	48%	0%	13%	36%	19%	63%	16%	61%	21%	59%	20%	62%	12%	47%	16%	40%	21%	27%		
	COP 18	Sustained	APR 19	0%	0%	0%	0%	0%	0%	0%	69%	400%	36%	93%	27%	56%	24%	43%	22%	37%	24%	0%	33%	0%	41%	22%	32%	
	COP 19	Sustained	APR 20	90%	90%	90%	90%	90%	90%	90%	164%	168%	36%	93%	27%	56%	24%	43%	22%	37%	10%	36%	10%	43%	20%	44%	39%	
	COP 20	Sustained	APR 21	0%	0%	125%	100%	38%	54%	54%	92%	78%	145%	83%	92%	98%	51%	75%	90%	65%	95%	56%	81%	88%	59%	78%	50%	73%
	COP 15	Central Support	APR 16	14%	14%	33%	29%							45%	44%											2%		
Zambezi District	COP 16	Central Support	APR 17							0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
	COP 17	Central Support	APR 18							0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
	COP 18	Central Support	APR 19	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
	COP 19	Central Support	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
	COP 20	Central Support	APR 21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Zimba District	COP 15	Sustained	APR 16	57%	14%	11%	17%	74%	74%	75%	73%	180%	238%	62%	58%	65%	55%	65%	58%	65%	58%	55%	53%	65%	58%	55%	65%	
	COP 16	Sustained	APR 17	14%	14%	25%	24%	25%	24%	133%	85%	47%	97%	48%	273%	27%	105%	34%	88%	38%	79%	38%	60%	47%	64%	27%	47%	57%
	COP 17	Sustained	APR 18	29%	29%	50%	48%	51%	48%	107%	87%	17%	59%	11%	86%	41%	162%	44%	191%	58%	89%	48%	70%	59%	75%	65%	67%	71%
	COP 18	ScaleUp Sat	APR 19	0%	0%	296%	286%	153%	154%	165%	369%	0%	221%	51%	212%	52%	205%	82%	188%	78%	150%	84%	124%	103%	132%	92%	74%	112%
	COP 19	ScaleUp Sat	APR 20	90%	90%	90%	90%	90%	90%	90%	90%	100%	203%	96%	100%	100%	94%	100%	100%	100%	100%	84%	91%	100%	100%	84%	97%	97%
	COP 20	ScaleUp Sat	APR 21	50%	25%	150%	114%	97%	75%	95%	95%	78%	67%	55%	37%	72%	38%	100%	75%	115%	98%	121%	134%	102%	112%	103%	109%	95%

APPENDIX B – Budget Profile and Resource Projections

B1. COP20 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP20 Budget by Program Area

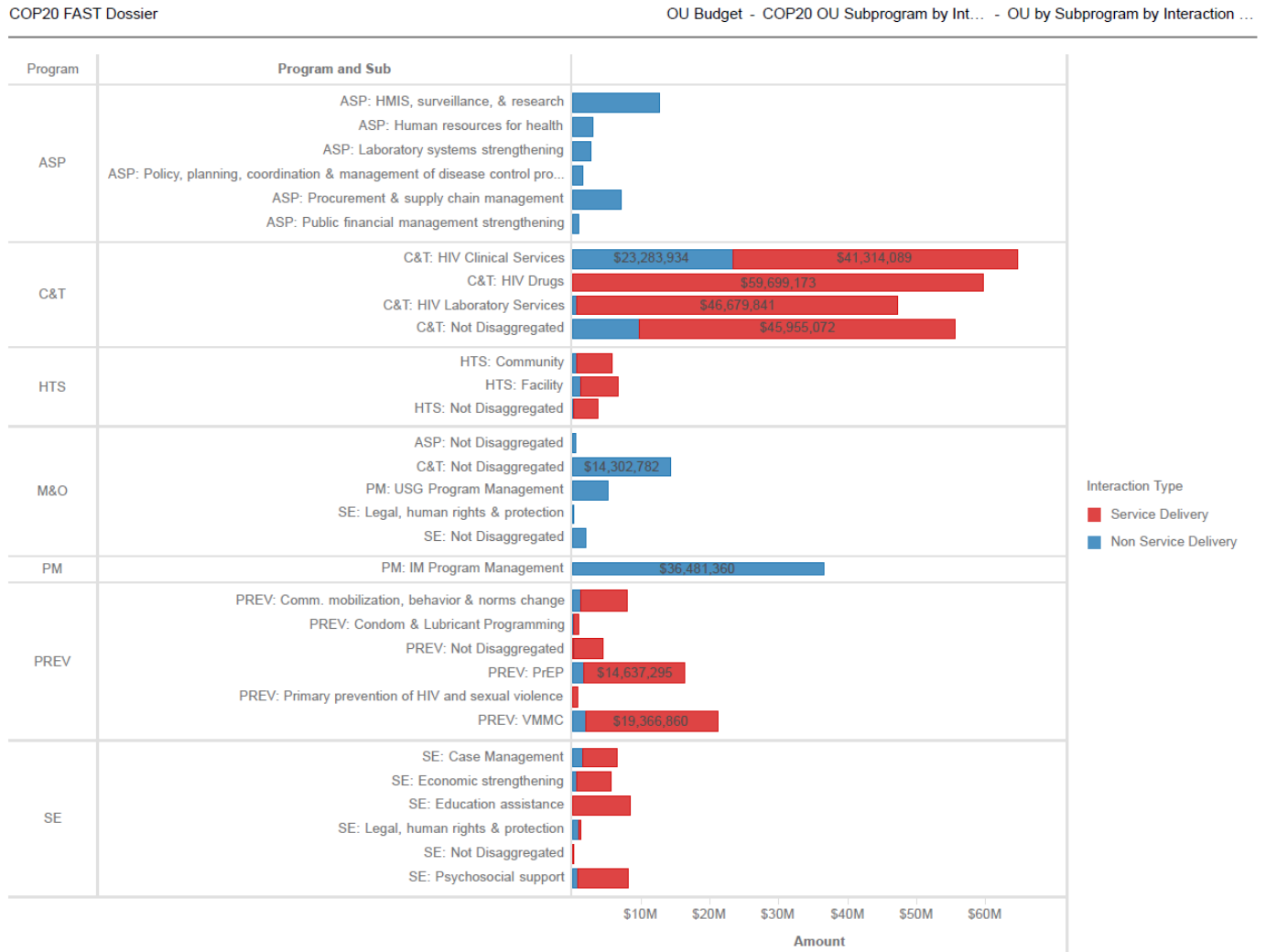


Table B.1.2 COP20 Total Planning Level		
Applied Pipeline	New Funding	Total Spend
\$23,803,868	\$414,855,015	\$438,658,883

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$6,563,946
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	\$1,235,675
HVOP	Other Sexual Prevention	\$33,993,795
IDUP	Injecting and Non-Injecting Drug Use	\$0
HMBL	Blood Safety	\$0
HMIN	Injection Safety	\$0
CIRC	Male Circumcision	\$23,530,440
HVCT	Counseling and Testing	\$12,460,052
HBHC	Adult Care and Support	\$8,316,809
PDCS	Pediatric Care and Support	\$6,239,009
HKID	Orphans and Vulnerable Children	\$33,413,415
HTXS	Adult Treatment	\$154,678,520
HTXD	ARV Drugs	\$55,771,120
PDTX	Pediatric Treatment	\$8,191,742
HVTB	TB/HIV Care	\$15,519,589
HLAB	Lab	\$2,052,998
HVSI	Strategic Information	\$13,254,153
OHSS	Health Systems Strengthening	\$10,726,388
HVMS	Management and Operations	\$10,888,303
TOTAL		\$396,835,954

B.2 Resource Projections

Resource projections were based on an incremental budgeting methodology consistent with S/GAC guidance and the FAST process. The base for budgeting was the COP19 budget as shown in the FAST tool. Incremental budget adjustments reflected in the COP20 budget were made at the IM level based on past performance against targets and outlays; COP18 results; projected targets and outlays for COP20; and accounting for intervention and programmatic shifts that may have occurred from the previous year's budget. Innovation was promoted through the budgeting process by undertaking a complete assessment of funding requirements for new IMs (formerly TBDs) prior to budget setting and for continuing IMs - changing the implementation strategy where warranted.

Throughout the resource allocation process, PEPFAR Zambia engaged in thoughtful and deliberate discussions to determine the most efficient and effective use of the COP20 budget to ensure that it was leading towards epidemic control and retention. Following a technical priority-setting process which involved getting stakeholder feedback, TWGs (prevention, community services, clinical

services, health systems strengthening and strategic information) worked together to set targets in a coordinated and multidisciplinary fashion ensuring that there was strong coordination between program areas. The TWGs triangulated program performance data and fiscal performance data from prior APRs' and COP19 Q1. The TWGs also conducted a review of literature on unit costs to inform decision making. Other sources of data to inform the resource projections, were gap analyses conducted in close collaboration with the GRZ through national TWGs as well as through working closely with CSOs.

APPENDIX C – Tables and Systems Investments for Section

5.0

Table 6-E

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
USAID	John Snow, Incorporated	ASP: HMIS, surveillance, & research NSD	Non-Targeted Pop: Young people & adolescents	Surveillance	Inadequate data for planning	COP19	COP21	1000
USAID	John Snow, Incorporated	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Domestic Resource Mobilization	Management Policy and Procedures	COP17	COP21	100%
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Training in supply chain systems	Client-centered supply chain	COP16	COP22	50
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Client-centered supply chain	COP16	COP22	1. GRZ manages and coordinates 95% of all national forecasting and quantification meetings for commodity security; 2. 95 % of facilities reporting no stock outs of ARVs, CTX, EID, viral load and CD4 reagents
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Product selection, registration, and quality monitoring	Client-centered supply chain	COP16	COP22	40 site visits conducted
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Client-centered supply chain	COP16	COP22	5 members of staff seconded to manage region hubs; 5 regional hubs fully operational as stocking holding facilities
USAID	MINISTRY OF HEALTH	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate HR	COP17	COP22	10
USAID	MINISTRY OF HEALTH	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Domestic Resource Mobilization	management policy and procedures	COP17	COP22	25
USAID	MINISTRY OF HEALTH	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate HR	COP17	COP17	10
USAID	MINISTRY OF HEALTH	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Domestic Resource Mobilization	management policy and procedures	COP17	COP22	25
USAID	MINISTRY OF HEALTH	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate HR	COP20	COP22	6

USAID	MINISTRY OF HEALTH	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate HR	COP20	COP22	6
USAID	MINISTRY OF HEALTH	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Domestic Resource Mobilization	management policy and procedures	COP20	COP22	15
USAID	MINISTRY OF HEALTH	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate HR	COP20	COP22	6
USAID	MINISTRY OF HEALTH	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Domestic Resource Mobilization	management policy and procedures	COP20	COP22	15
USAID	CLINTON HEALTH ACCESS INITIATIVE, INC.	ASP: Human resources for health-NSD	Non-Targeted Pop: Adults	Pre-service training	Inadequate HR	COP19	COP20	N/A
State/AF	National HIV/AIDS Council	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Civil society engagement	Inadequate Civil Society engagement	COP16	COP22	15 Documented CSO/stakeholder engagement and production of strategic and policy documents
HHS/CDC	Eastern Provincial Health Office	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	subsystems resulting in sub-optimal use of information	COP20	COP21	71 SmartCare sites for maintenance
HHS/CDC	Eastern Provincial Health Office	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Inadequate data for planning	COP20	COP20	N/A
HHS/CDC	Eastern Provincial Health Office	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate HR	COP18	COP21	100% HRIS completed and data utilized for programming
HHS/CDC	Western Provincial Health Office	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	subsystems resulting in sub-optimal use of information	COP20	COP21	104 maintenance
HHS/CDC	Western Provincial Health Office	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Inadequate data for planning	COP20	COP20	N/A
HHS/CDC	Western Provincial Health Office	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate HRH and CBWs data for decision making	COP18	COP21	100% HRIS completed and data utilized for programming
HHS/CDC	CENTRE FOR INFECTIOUS DISEASE RESEARCH IN ZAMBIA LIMITED	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Inadequate data for planning	COP18	COP20	To roll out into 30 Districts
HHS/CDC	CENTRE FOR INFECTIOUS DISEASE RESEARCH IN ZAMBIA LIMITED	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Inadequate data for planning	COP19	COP21	HTS_RECENT continued to be reported in all PEPFAR-supported districts in all 10 provinces.
HHS/CDC	Lusaka Provincial Health Office	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Non-uniform integration of subsystems resulting in sub-optimal use of information	COP20	COP21	72 Smartcare sites for maintenance
HHS/CDC	Lusaka Provincial Health Office	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate HRH and CBWs data for decision making	COP18	COP21	100% HRIS completed and data utilized for programming
HHS/CDC	Provincial Health Office Sp	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Non-uniform integration of subsystems resulting in sub-optimal use of information	COP20	COP21	123 maintenance
HHS/CDC	Provincial Health Office Sp	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate HRH and CBWs data for decision making	COP18	COP21	100% HRIS completed and data utilized for programming
HHS/CDC	NATIONAL SCHOOL OF PUBLIC HEALTH, GOVERNMENT OF REPUBLIC OF ANGOLA	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Lack of quality standards and accreditation in central labs	COP 19	COP21	74 hub labs passing EQA and PT
HHS/CDC	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	HMIS systems	Inadequate data for planning	COP18	COP21	1. 10 provinces with functional Situation Rooms. 2. 4 provinces with fully functional case based surveillance system
HHS/CDC	Broadreach Healthcare, LLC	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Non-uniform integration of subsystems resulting in sub-optimal use of information	COP20	COP21	1,031 E.H.R. upgraded

HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Surveillance	Inadequate data for planning	COP18	COP21	Surveillance report and data availability to inform program planning and understanding of the epidemic.
HHS/HRSA	JHPIEGO CORPORATION	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate HR	COP 17	COP20	MOH HRIS integrated and fully functional
HHS/HRSA	JHPIEGO CORPORATION	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate HR	COP 19	COP 20	33% (N:USG:24,000/D:Total: 72,000)
HHS/HRSA	JHPIEGO CORPORATION	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate HR	COP19	COP21	Integration of CBWs HRIS with MOH HRIS
HHS/HRSA	JHPIEGO CORPORATION	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate HR	COP18	COP21	HRH_PRE 140
DOD	U.S. Department of Defense	ASP: Policy, planning, coordination & management of disease control programs-NSD	Priority Pops: Military & other uniformed services	National strategic plans, operational plans and budgets	Inadequate financial management policy and procedures	COP20	COP21	Plans on leadership, sustainability & resource mobilization in place
DOD	JHPIEGO CORPORATION	ASP: HMIS, surveillance, & research-NSD	Priority Pops: Military & other uniformed services	Program and data quality management	EMR for patient tracking	COP20	COP21	200 CLWs oriented in the use of electronic devices. 3. 200 tablets & phones distributed to CLW
DOD	JHPIEGO CORPORATION	ASP: Human resources for health-NSD	Priority Pops: Military & other uniformed services	HRH recruitment and retention	Inadequate HR	COP20	COP21	implement and report in line with national Guideline
DOD	Family Health International	ASP: Laboratory systems strengthening-NSD	Priority Pops: Military & other uniformed services	Lab quality improvement and assurance	Maintain quality standards and accreditation in central labs	COP18	COP20	N/A
DOD	Population Services International	ASP: HMIS, surveillance, & research-NSD	Priority Pops: Military & other uniformed services	HMIS systems	Inadequate data for planning	COP19	COP21	Data reporting using Smartcare 20. 41 Facilities with effective SMARTCARE & VMCC being captured
DOD	Family Health International	ASP: HMIS, surveillance, & research-NSD	Priority Pops: Military & other uniformed services	HMIS systems	Inadequate data for planning	COP19	COP21	Data reporting using Smartcare 20. 1) 41 Facility staff with trained data entry clerks and SMARTCARE running effectively
DOD	Family Health International	ASP: Policy, planning, coordination & management of disease control programs-NSD	Priority Pops: Military & other uniformed services	National strategic plans, operational plans and budgets	HIV prevention, care and treatment policies, strategies and guidelines	COP19	COP21	Planning meeting with ZDF Senior Staff. Commanders Workshop, training on Leadership, Sustainability and Resource Mobilisation
HHS/CDC	CENTRE FOR INFECTIOUS DISEASE RESEARCH IN ZAMBIA LIMITED	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	VL for all PLHIV on ART	COP19	COP21	21;24;45; accredited high throughput VL/EID labs; high throughput VL/EID labs passing EQA; hub labs doing EID and VL on GeneXpert passing EQA respectively
DOD	U.S. Department of Defense	ASP: HMIS, surveillance, & research-NSD	Priority Pops: Military & other uniformed services	Surveillance	Inadequate data for planning	COP18	COP20	Final report and Dissemination

APPENDIX D – Minimum Program Requirements

Care and Treatment	<p>1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.¹</p> <p style="color: red;">Met</p>
	<p>2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥ 30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥ 20kg, and removal of all nevirapine-based regimens.²</p> <p style="color: red;">Met</p>
	<p>3. Adoption and implementation of differentiated service delivery models, including six-month MMD and delivery models to improve identification and ARV coverage of men and adolescents.³</p> <p style="color: red;">Met</p>
	<p>4. All eligible PLHIV, including children, should complete TPT by end of COP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.⁴</p> <p style="color: red;">In Progress</p>
	<p>5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.</p> <p style="color: red;">Met</p>
Case Finding	<p>1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment IPV is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.⁵</p> <p style="color: red;">In Progress</p>

¹ Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

² Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

³ Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

⁴ Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

⁵ Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 <https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/>

Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including PrEP, to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, KP and adult men engaged in high-risk sex practices) ⁶
	Met
Prevention and OVC	2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.
	Met
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention. ⁷
	Not Applicable
	2. OUs assure program and site standards are met by integrating effective quality assurance and CQI practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy. ⁸
	Met
	3. Evidence of treatment and VL literacy activities supported by MOH, NAC and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.
	Met
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.
Met	
Policy & Public Health Systems Support	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.
	Met
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.
Met	
Policy & Public Health Systems Support	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.
	In Progress

⁶ Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (<http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en>).

⁷ The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

⁸ Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019