# ZIMBABWE
# Country Operational Plan
# COP 2020


PEPFAR

U.S. President's Emergency Plan for AIDS Relief

## Strategic Direction Summary
## March 2020

# Table of Contents

# Acronym List

| | |
|---|---|
| AE | Adverse Event |
| AGYW | Adolescent Girls and Young Women |
| ANC | Antenatal Clinic |
| ART | Antiretroviral Treatment |
| ARVs | Antiretroviral |
| BMGF | Bill and Melinda Gates Foundation |
| CARGS | Community ART Refill Groups |
| CATS | Community Adolescent Treatment Supporters |
| CBO | Community Based Organization |
| CBS | Case-based Surveillance |
| CCM | Country Coordinating Mechanism |
| CDC | Centers for Disease Control and Prevention |
| CHW | Community Health Workers |
| CLHIV | Children Living with HIV |
| COP | Country Operational Plan |
| CRFs | Client Referral Facilitators |
| CSO | Civil Society Organizations |
| CTX | Cotrimoxazole |
| DBS | Dried Blood Spot |
| DHIS2 | District Health Information System Version 2 |
| DoS | Department of State |
| DREAMS | Determined, Resilient, AIDS-free, Mentored and Safe |
| DSD | Direct Service Delivery or Differentiated Service Delivery |
| EHR | Electronic Health Records |
| EID | Early Infant Diagnosis |
| EMR | Electronic Medical Record System |
| eMTCT | Elimination of Mother to Child Transmission |
| ePMS | Electronic Patient Monitoring System |
| FARG | Family ART Refill Group |
| FAST | Funding Allocation to Strategy Tool |
| FBO | Faith-Based Organization |
| FSW | Female Sex Workers |
| GBV | Gender Based Violence |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GoZ | Government of Zimbabwe |
| HCD | Human Centered Design |
| HCW | Health Care Workers |
| HDP | Health Development Partners |
| HEI | HIV Exposed Infant |

| | |
|---|---|
| HIV | Human Immunodeficiency Virus |
| HIVST | HIV Self-Testing |
| HMIS | Health Management Information System |
| HR | Human Resources |
| HRH | Human Resources for Health |
| HRIS | Human Resource Information System |
| HSS | Health Systems Strengthening |
| HTS | HIV Testing Services |
| INH | Isoniazid (isonicotinylhydrazide drug) |
| IP | Implementing Partner |
| IPT | Isoniazid Preventive Therapy |
| KP | Key Population |
| KPIF | Key Populations Investment Fund |
| LMIS | Logistics Management and Information Systems |
| LPV/r | Lopinavir/ritonavir |
| LTFU | Lost to Follow-Up |
| M&E | Monitoring and Evaluation |
| MC | Male Circumcision |
| MCH | Maternal and Child Health |
| MMD | Multi-Month Dispensing |
| MMS | Multi-Month Scripting |
| MoHCC | Ministry of Health and Child Care |
| MSM | Men who have Sex with Men |
| NAC | National AIDS Council |
| NATF | National AIDS Trust Fund |
| OI | Opportunistic Infections |
| OVC | Orphans and Vulnerable Children |
| PEPFAR | The U.S. President's Emergency Plan for AIDS Relief |
| PITC | Provider-initiated Testing and Counseling |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother-to-Child Transmission |
| POART | PEPFAR Oversight and Accountability Response Team |
| POC | Point of Care |
| PrEP | Pre-Exposure Prophylaxis |
| QA/QI | Quality Assurance/Quality Improvement |
| RTK | Rapid Test Kit |
| SCMS | Supply Chain Management System |
| SDS | Strategic Direction Summary |
| SI | Strategic Information |
| SID | Sustainability Index and Dashboard |
| SIMS | Site Improvement through Monitoring System |

| | |
|---|---|
| SNU | Sub National Unit |
| STI | Sexually Transmitted Infections |
| SW | Sex Workers |
| TA | Technical Assistance |
| TAT | Turn Around Time |
| TB | Tuberculosis |
| TBD | To Be Determined |
| TLD | Tenofovir Lamivudine Dolutegravir |
| TLE | Tenofovir Lamivudine Efavirenz |
| TPT | TB Preventive Therapy |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| UNICEF | United Nations Children's Fund |
| USAID | U.S. Agency for International Development |
| USG | U.S. Government |
| VACS | Violence against Children Survey |
| VCT | Voluntary Counseling and Testing |
| VHWs | Village Healthcare Workers |
| VL | Viral Load |
| VMMC | Voluntary Medical Male Circumcision |
| WHO | World Health Organization |
| YAZ | Young Adult Survey of Zimbabwe |
| YWSS | Young Women Selling Sex |
| ZDHS | Zimbabwe Demographic and Health Survey |
| ZIMPHIA | Zimbabwe Population-Based HIV Impact Assessment |

# 1.0 Goal Statement

The President's Emergency Plan for AIDS Relief (PEPFAR) interagency team collaborated with key partners including the Government of Zimbabwe (GoZ), the Global Fund to Fight AIDS, Tuberculosis and Malaria (the "Global Fund"), civil society organizations (CSOs) and other bilateral and multilateral health development partners to develop the Country Operational Plan (COP) for FY 2021 (COP 2020). The national ART program and other critical HIV service delivery and prevention programs in Zimbabwe are implemented under the leadership of the Ministry of Health and Child Care (MoHCC), the Ministry of Primary and Secondary Education (MoPSE) and the Ministry of Labor and Social Welfare (MoLSW).

The COP 2020 plan aims to achieve and maintain 95 percent ART coverage within all districts and across all age and sex bands by the end of FY 2021. PEPFAR Zimbabwe will invest in the delivery of a comprehensive package of HIV treatment and prevention activities within 44 of Zimbabwe's 63 districts. In order to ensure equitable gains towards achieving sustainable epidemic control across Zimbabwe, the PEPFAR program will also provide above-site technical assistance to monitor the response in the remaining 19 centrally supported districts. The program will have a specific focus in COP 2020 on improving patient retention, patient viral load coverage, and patient viral load suppression. With 1.1 million Zimbabweans currently on ART, the PEPFAR program must increase access to viral load monitoring, while strengthening and expanding efforts to improve retention and viral suppression, particularly among priority populations such as children, adolescents, and pregnant women. Viral load monitoring and scale-up has been a substantial and persistent challenge. PEPFAR and Global Fund are working collaboratively to better increase and harmonize support for lab services.

New in COP 2020 will be a pivot away from the integrated HIV testing strategy, introduced in COP 2018, which categorized districts by high, medium, and low ART gap and then tailored a testing approach for each of these categorizations. Current epidemiologic data show that all districts are approaching a low ART gap classification (i.e., >81% ART coverage). However, specific sub-populations (i.e., children, men ages 25-34) lag in both case identification and ART coverage. Testing in COP 2020 will shift to a more targeted model to reach the remaining undiagnosed patients in these sub-populations.

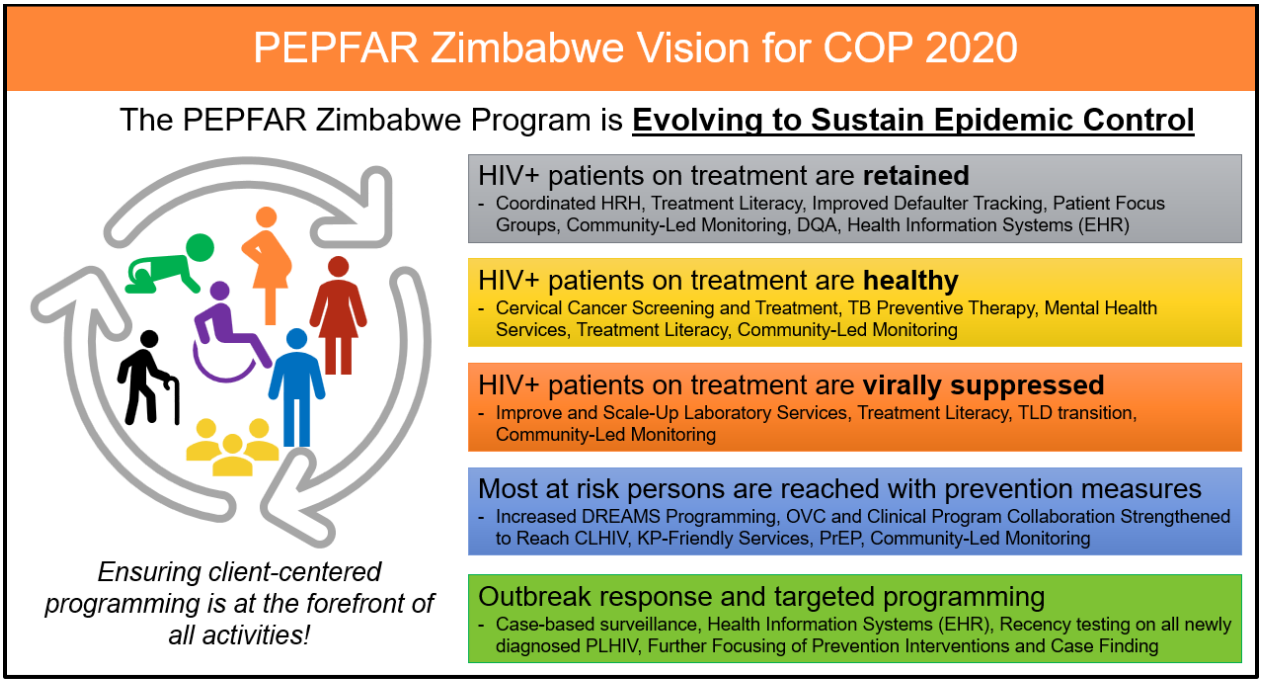
PEPFAR Zimbabwe will intensify prevention efforts to focus on reaching those populations most at risk for acquiring HIV with appropriate prevention measures. The voluntary medical male circumcision (VMMC) program will refocus efforts on reaching young men between the ages 15 - 29. For adolescent girls and young women (AGYW), the PEPFAR program will expand support for the Determined Resilient Empowered AIDS-Free Mentored and Safe (DREAMS) program into ten additional districts bringing the total number of districts supported to 16. These districts will receive a support package that includes Pre-Exposure Prophylaxis (PrEP) and complementary services supported within the orphans and vulnerable children (OVC) portfolio. Moreover, in COP 20 the PEPFAR Zimbabwe program will scale up clinical services targeting female sex workers (FSW), men who have sex with men (MSM), and introduce a focus on reaching transgender populations for the first time.

In COP 20, Zimbabwe will scale recency testing for all newly diagnosed adults and expand case-based surveillance to 100 percent coverage. This will allow the program to target the public health response and prevention interventions more strategically based on where clusters of new

infections are occurring. A focus on health information systems (EHR) will help build sustainability into the current programs. Zimbabwe's transition to TLD will be complete as COP 2019 draws to a close. The country will continue to move clients from three-month to six-month dispensing (MMD), where appropriate. Increasing MMD is also a strategy to keep HIV-infected clients healthy and away from crowded clinics during the impending COVID-19 pandemic.

Zimbabwe continues to be challenged with socio-economic issues, fuel shortages, load-shedding, health worker strikes and generally a fragile health care system. Investments in human resources for health (HRH) will ensure the presence of a more stable health care cadre in Zimbabwe. While HRH and health infrastructure are primarily funded by the MoHCC, PEPFAR has successfully leveraged and supplements this capacity with key commodities, site-level mentoring, and additional HRH support for HIV clinical services in retention. In COP 2020, PEPFAR will assess HRH support to ensure that additional clinical staff will be supported. In addition, PEPFAR will increase HRH for the CATS model and increase the number of viral load lab technicians from 1.5 to 2 per machine.

Finally, PEPFAR will continue to work closely with the Global Fund's Country Coordinating Mechanism (CCM) to ensure the alignment of programming as GF's current funding cycle (2018-2020) comes to close. PEPFAR has also been heavily engaged with Global Fund in planning a similar alignment for its next funding cycle (2021-2023).



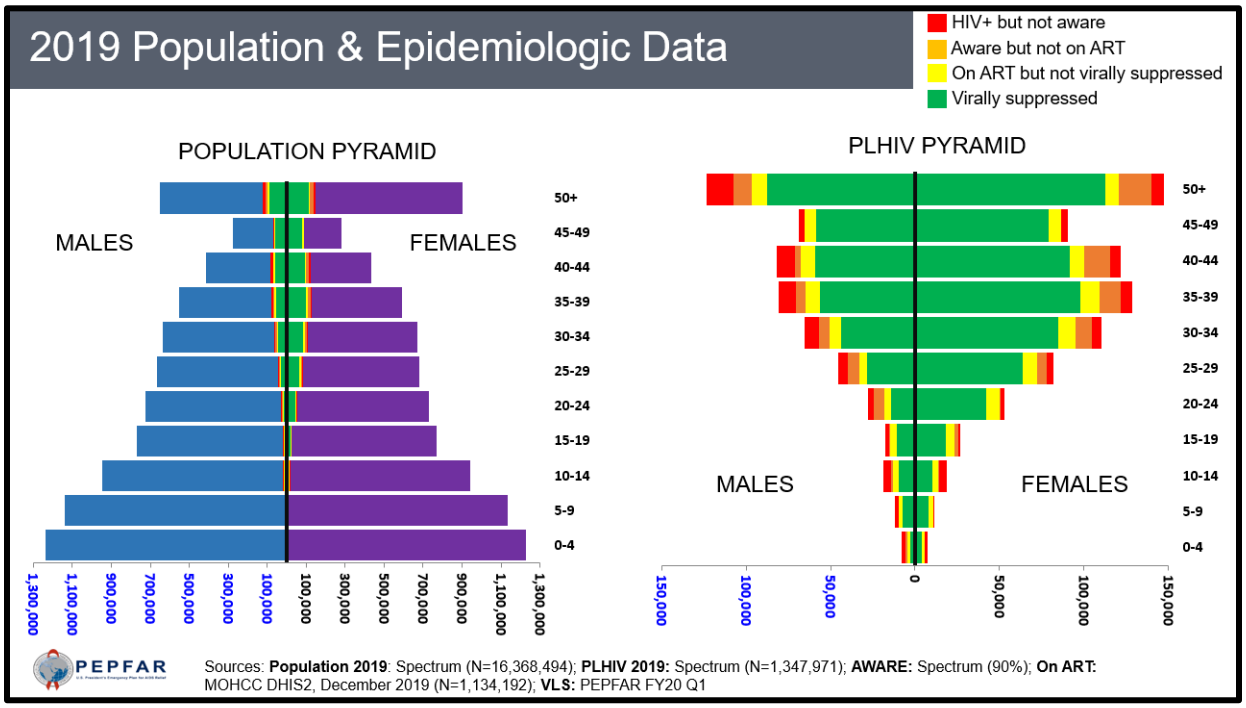

# 2.0 Epidemic, Response, and Program Context

### 2.1 Summary statistics, disease burden and country profile

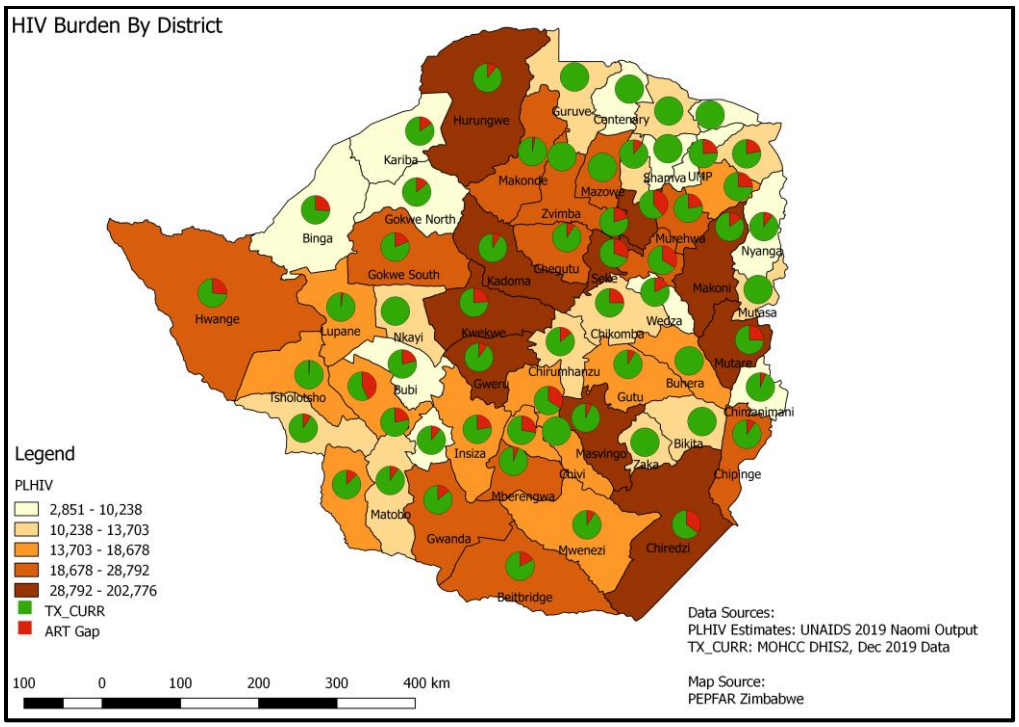
Zimbabwe has a generalized HIV epidemic and is home to 1.35 million people living with HIV (PLHIV), including 1.27 million adults and 76,300 children. An estimated 1.35 million people were

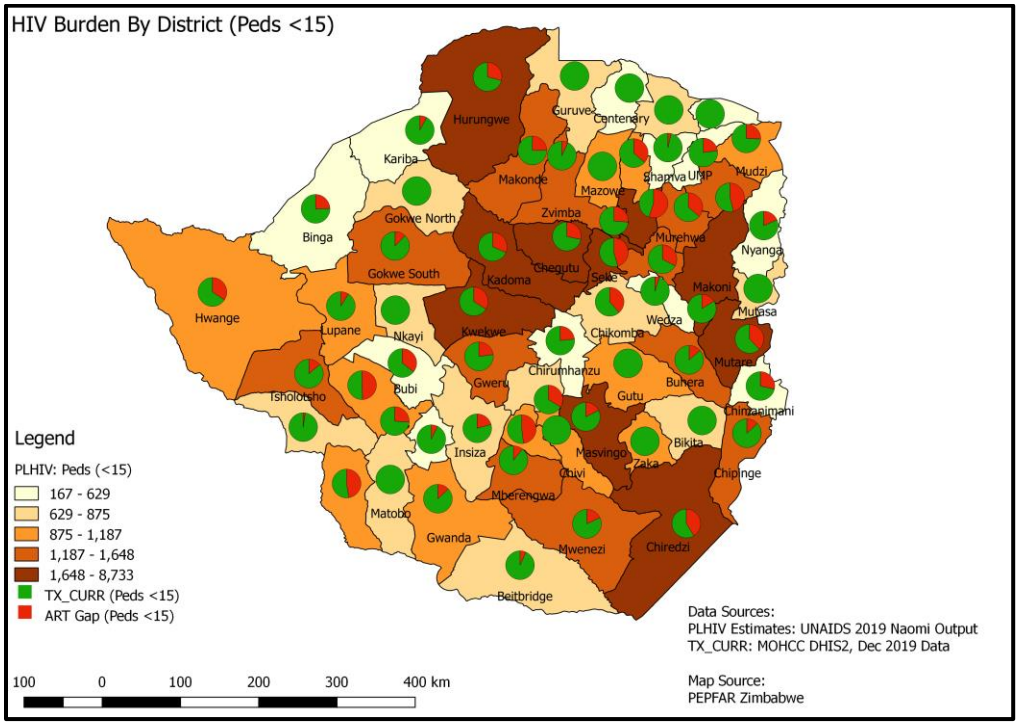
living with HIV in 2019, with 5.6% being children 0-14 years. Among adults 15+ years living with HIV, 60% were females. Annual all-cause deaths among PLHIV have declined over the past decade with approximately 30,003 all cause deaths among PLHIV in 2019 compared to 125,000 in the year 2003. Total new HIV infections declined nationally from 91,000 in 2003 to 35,000 in 2019.

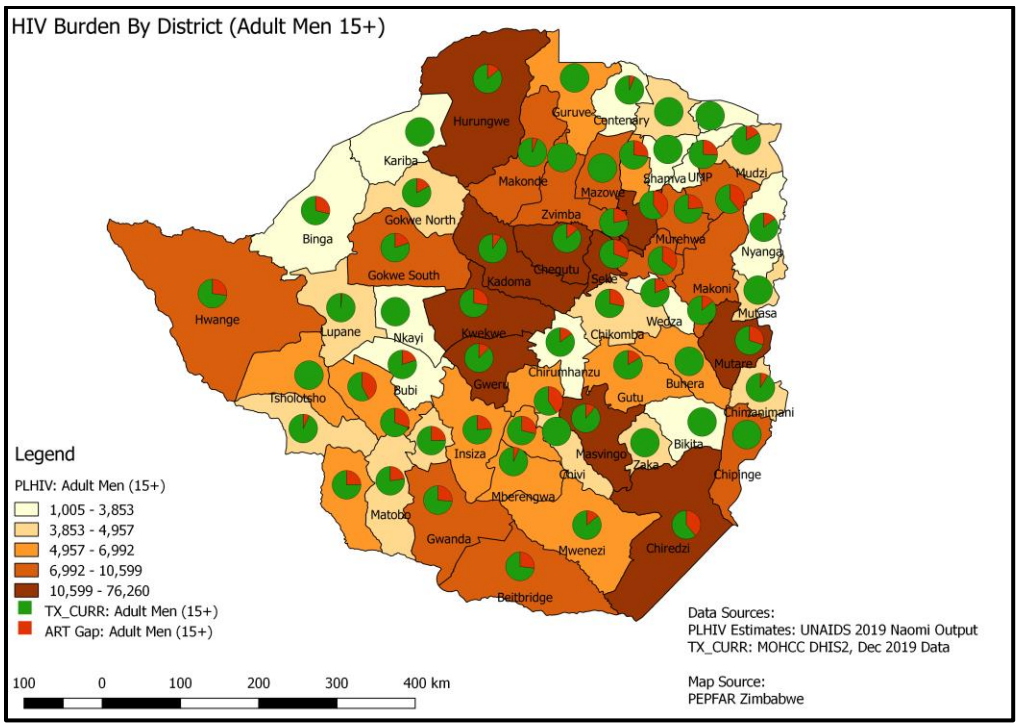
By the end of 2019, ART coverage among all HIV positive adults was 82% for adult men and 88% for adult women. Coverage for children was slightly lower at 78%.

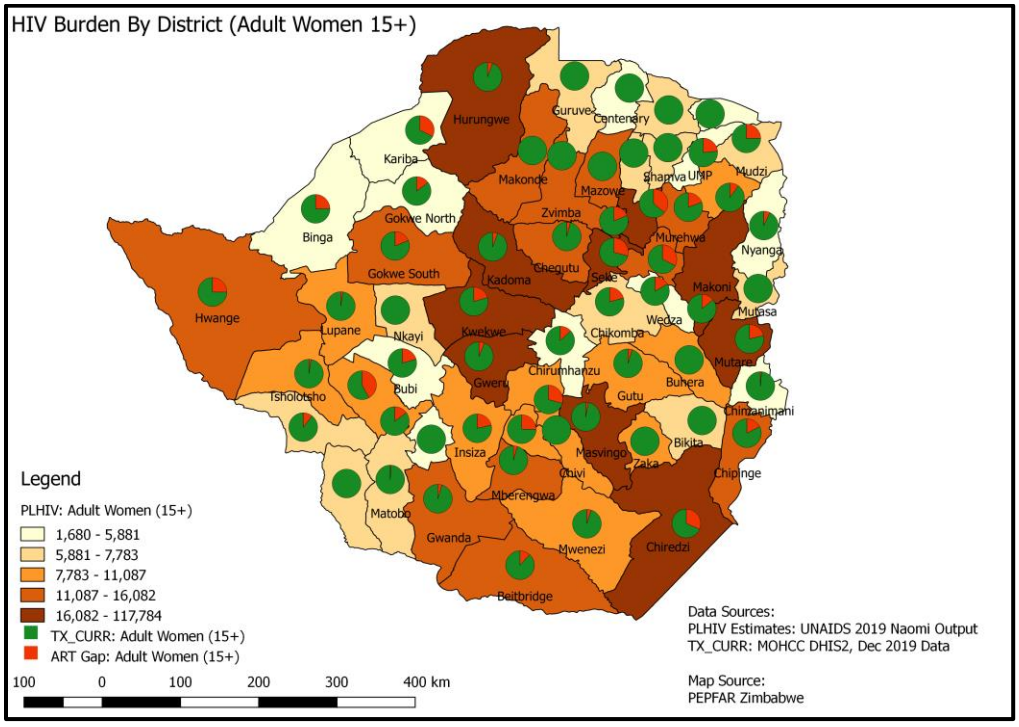



The 2016 ZIMPHIA showed that overall HIV prevalence for adults aged 15-49 was 14.0% in 2016, down from 18.1% in 2005 in the ZDHS. 2020 ZIMPHIA results are expected during FY 2020 implementation and the PEPFAR Zimbabwe program will use these results to reconfigure programming as needed to align with any updates in the HIV burden. Among persons aged 15 to 64 years, HIV prevalence in the previous ZIMPHIA varied geographically, with higher prevalence in the provinces of Matabeleland North (19.5%), Bulawayo (17.9%), and Matabeleland South (21.7%) than in the other seven provinces, which were all below 15%. HIV prevalence varied by level of education, ranging from 7.2% in those with more than secondary education to 19.7% among persons with no formal education. The highest HIV prevalence estimated was nearly 30% for both males (28.1%) and females (29.6%) but occurred at a slightly older age (45-49 years) among males as compared to females (40-44 years). The disparity in HIV prevalence by sex was most pronounced among young persons: HIV prevalence was three times higher among females (8.1%) than males (2.7%) aged 20 to 24 years. For persons aged 10 to 49 years, point estimates of HIV prevalence were higher among females than their male counterparts. Among persons over the age of 50, point estimates of HIV prevalence were higher in males. HIV prevalence among children aged 0 to 14 was estimated to be 1.6%.


HIV Burden By District
Hurungwe
Guruve
Centenary
Kariba
Makonde
Shamva
UMP
Mazowe
Zvimba
Gokwe North
Binga
Murehwa
Nyanga
Gokwe South
Chegutu
Seke
Kadoma
Makoni
Hwange
Mutasa
Lupane
Nkayi
Kwekwe
Wedza
Chikomba
Mutare
Chirumhanzu
Buhera
Gweru
Bubi
Tsholotsho
Gutu
Chimanimani
Insiza
Masvingo
Bikita
Zaka
Chipinge
Ntuivi
Mberengwa
Matobo
Gwanda
Mwenezi
Chiredzi
Beitbridge
Legend
PLHIV
2,851 - 10,238
10,238 - 13,703
13,703 - 18,678
18,678 - 28,792
28,792 - 202,776
TX_CURR
ART Gap
100 0 100 200 300 400 km
Data Sources:
PLHIV Estimates: UNAIDS 2019 Naomi Output
TX_CURR: MOHCC DHIS2, Dec 2019 Data
Map Source:
PEPFAR Zimbabwe


HIV Burden By District (Peds <15)
Hurungwe
Guruve
Centenary
Kariba
Makonde
Shamva
UMP
Mudzi
Mazowe
Zvimba
Gokwe North
Binga
Murehwa
Nyanga
Gokwe South
Chegutu
Seke
Kadoma
Makoni
Hwange
Mutasa
Lupane
Nkayi
Kwekwe
Wedza
Chikomba
Mutare
Chirumhanzu
Buhera
Gweru
Bubi
Tsholotsho
Gutu
Chimanimani
Insiza
Masvingo
Bikita
Zaka
Chipinge
Ntuivi
Mberengwa
Matobo
Gwanda
Mwenezi
Chiredzi
Beitbridge
Legend
PLHIV: Peds (<15)
167 - 629
629 - 875
875 - 1,187
1,187 - 1,648
1,648 - 8,733
TX_CURR (Peds <15)
ART Gap (Peds <15)
100 0 100 200 300 400 km
Data Sources:
PLHIV Estimates: UNAIDS 2019 Naomi Output
TX_CURR: MOHCC DHIS2, Dec 2019 Data
Map Source:
PEPFAR Zimbabwe


HIV Burden By District (Adult Men 15+)
Hurungwe
Guruve
Centenary
Kariba
Makonde
Shamva
Mudzi
Mazowe
Zvimba
Binga
Gokwe North
Murehwe
Nyanga
Gokwe South
Chegutu
Kadoma
Seke
Makoni
Hwange
Lupane
Nkayi
Kwekwe
Wedza
Chikomba
Mutasa
Mutare
Chirumhanzu
Buhera
Gweru
Bubi
Tsholotsho
Gutu
Chimanimani
Insiza
Masvingo
Bikita
Zaka
Chiredzi
Chipinge
Ntuivi
Mberengwa
Matobo
Gwanda
Mwenezi
Beitbridge
Legend
PLHIV: Adult Men (15+)
1,005 - 3,853
3,853 - 4,957
4,957 - 6,992
6,992 - 10,599
10,599 - 76,260
TX_CURR: Adult Men (15+)
ART Gap: Adult Men (15+)
100 0 100 200 300 400 km
Data Sources:
PLHIV Estimates: UNAIDS 2019 Naomi Output
TX_CURR: MOHCC DHIS2, Dec 2019 Data
Map Source:
PEPFAR Zimbabwe


HIV Burden By District (Adult Women 15+)
Hurungwe
Guruve
Centenary
Kariba
Makonde
Shamva
Mudzi
Mazowe
Zvimba
Binga
Gokwe North
Murehwe
Nyanga
Gokwe South
Chegutu
Kadoma
Seke
Makoni
Hwange
Lupane
Nkayi
Kwekwe
Wedza
Chikomba
Mutasa
Mutare
Chirumhanzu
Buhera
Gweru
Bubi
Tsholotsho
Gutu
Chimanimani
Insiza
Masvingo
Bikita
Zaka
Chiredzi
Chipinge
Ntuivi
Mberengwa
Matobo
Gwanda
Mwenezi
Beitbridge
Legend
PLHIV: Adult Women (15+)
1,680 - 5,881
5,881 - 7,783
7,783 - 11,087
11,087 - 16,082
16,082 - 117,784
TX_CURR: Adult Women (15+)
ART Gap: Adult Women (15+)
100 0 100 200 300 400 km
Data Sources:
PLHIV Estimates: UNAIDS 2019 Naomi Output
TX_CURR: MOHCC DHIS2, Dec 2019 Data
Map Source:
PEPFAR Zimbabwe

## Standard Table 2.1.1: Host Country Epidemiological Data Profile

| Table 2.1.1 Host Country Epidemiological Data Profile | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total | | <15 | | | | 15-24 | | | | 25+ | | | | *Source, Year* |
| | | | Female | | Male | | Female | | Male | | Female | | Male | | |
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | |
| Total Population | 16,368,494 | 100% | 3,303,600 | 20% | 3,321,579 | 20% | 1,497,006 | 9% | 1,491,274 | 9% | 3,558,213 | 22% | 3,196,822 | 20% | UNAIDS Spectrum, 2019 |
| HIV Prevalence (%) | | 11.3% | | 1% | | 1% | | 6% | | 3% | | 23% | | 18% | UNAIDS Spectrum, 2019 |
| AIDS Deaths (per year) | 20,118 | | 1,508 | | 1,538 | | 1,244 | | 1,069 | | 7,604 | | 7,155 | | UNAIDS Spectrum, 2019 |
| # PLHIV | 1,347,971 | | 37,975 | | 38,325 | | 79,694 | | 45,874 | | 680,498 | | 465,605 | | UNAIDS Spectrum, 2019 |
| Incidence Rate (Yr.) | | .3 | | | | | | .7 | | .3 | | .5 | | .4 | UNAIDS Spectrum, 2019 |
| New Infections (Yr.) | 30,785 | 100% | | | | | 8,161 | 27% | 3,784 | 12% | 9,383 | 30% | 9,456 | 31% | UNAIDS Spectrum, 2019 |
| Annual births | 520.762 | | | | | | | | | | | | | | UNAIDS Spectrum, 2019 |
| % of Pregnant Women with at least one ANC visit | | 93% | | | | | | | | | | | | | ZDHS, 2015 |
| Pregnant women needing ARVs | 63,511 | | | | | | | | | | | | | | UNAIDS Spectrum, 2019 |
| Orphans (maternal, paternal, double) | 149,405 | | | | | | | | | | | | | | UNAIDS Spectrum, 2019 |
| Notified TB cases (Yr.) | 26,401 | | 6% (all <15 years) | | | | 94% (all 15+ years) | | | | | | | | WHO, 2018 TB Profile |
| % of TB cases that are HIV infected | | 63% | | | | | | | | | | | | | WHO, 2018 TB Profile |
| % of Males Circumcised | | 14% | | | | | 14% (all ages 15-64) | | | | | | | | ZIMPHIA, 2016 |
| Estimated Population Size of MSM* | 20,000 | 100% | | | | | | | | | | | | | MSM IBBS, 2019 |
| MSM HIV Prevalence | | 31% | | | | | | | | | | | | | UNAIDS KP Atlas, 2016 |
| Estimated Population Size of FSW | 45,000 | 100% | | | | | | | | | | | | | UNAIDS KP Atlas, 2016 |
| FSW HIV Prevalence | | 54% | | | | | | | | | | | | | UNAIDS KP Atlas, 2016 |

## Standard Table 2.1.2: 95-95-95 cascade: HIV diagnosis, treatment and viral suppression

| 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 (PEPFAR FY19 MER Data) | | |
| | 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 | 16,368,494 | 8.2% | 1,347,971 | 1,222,652 | 1,146,026 | 85% | 73% | 2,371,838 | 118,119 | 104,251 |
| Population <15 years | 6,625,179 | 1.2% | 76,300 | 59,172 | 59,172 | 78% | 56% | 310,694 | 5,384 | 4,450 |
| Men 15-24 years | 1,491,274 | 3.1% | 45,874 | 39,910 | 34,041 | 74% | 75% | 274,350 | 4,380 | 3,495 |
| Men 25+ years | 3,196,822 | 14.6% | 465,605 | 405,706 | 384,997 | 83% | 89% | 435,284 | 38,978 | 35,545 |
| Women 15-24 years | 1,497,006 | 5.3% | 79,694 | 75,709 | 75,709 | 95% | 82% | 574,765 | 20,254 | 16,885 |
| Women 25+ years | 3,558,213 | 19.1% | 680,498 | 646,473 | 592,107 | 87% | 91% | 777,528 | 49,044 | 43,891 |
| | | | | | | | | | | |
| MSM | 23,326 (Harare + Bulawayo only) * | 17.1% Harare 23.3% Bulawayo * | 4,397 | 1,790 * | 1,667 | 91.7% Harare 94.7% Bulawayo * | 81.8% Harare 78.9% Bulawayo * | 2,836 | 397 | 483 |
| FSW | 45,000 # | 54% ^ | 24,300 ^ | 18,954 + | 16,281 + | 67% + | 73% + | 13,845 | 2,607 | 2,599 |

*From the MSM, IBBS (2019)
# UNAIDS KP atlas, Zimbabwe National Estimates (2016)
^FSW Size Estimates, multiple, compiled (2017)
+From Cowan et al, Strengthening the scale-up and uptake of effective interventions for sex workers for population impact in Zimbabwe (2017)

**Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment**

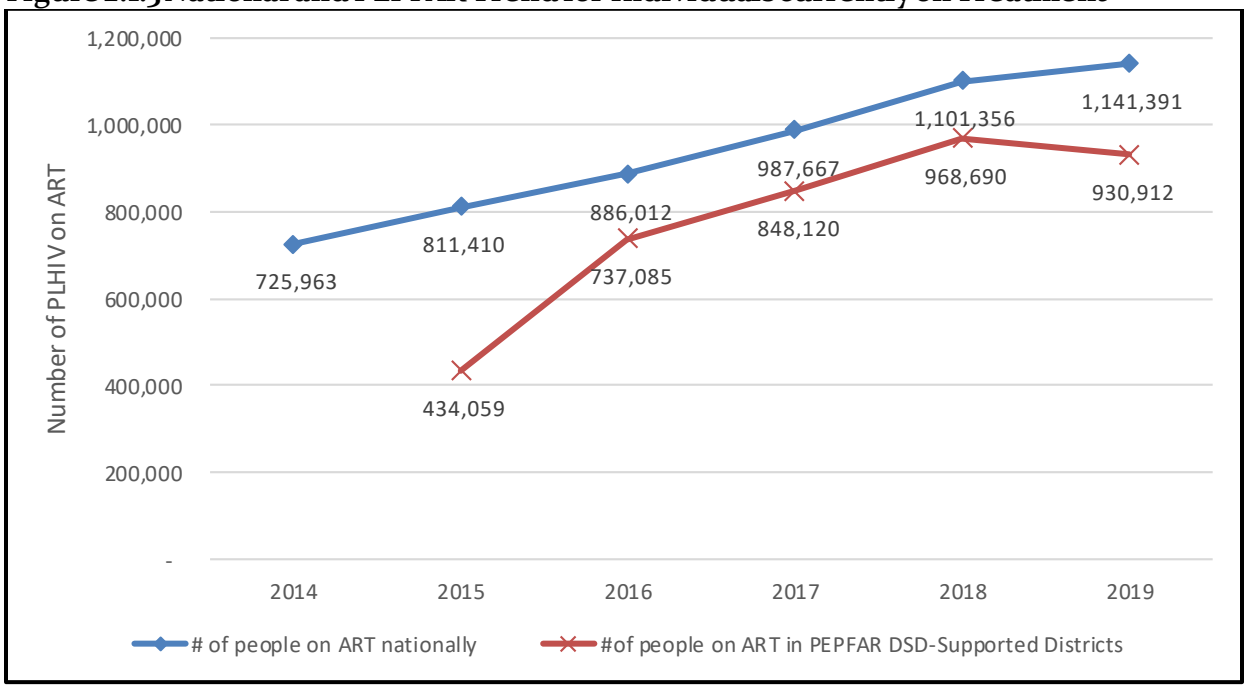



**Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV**

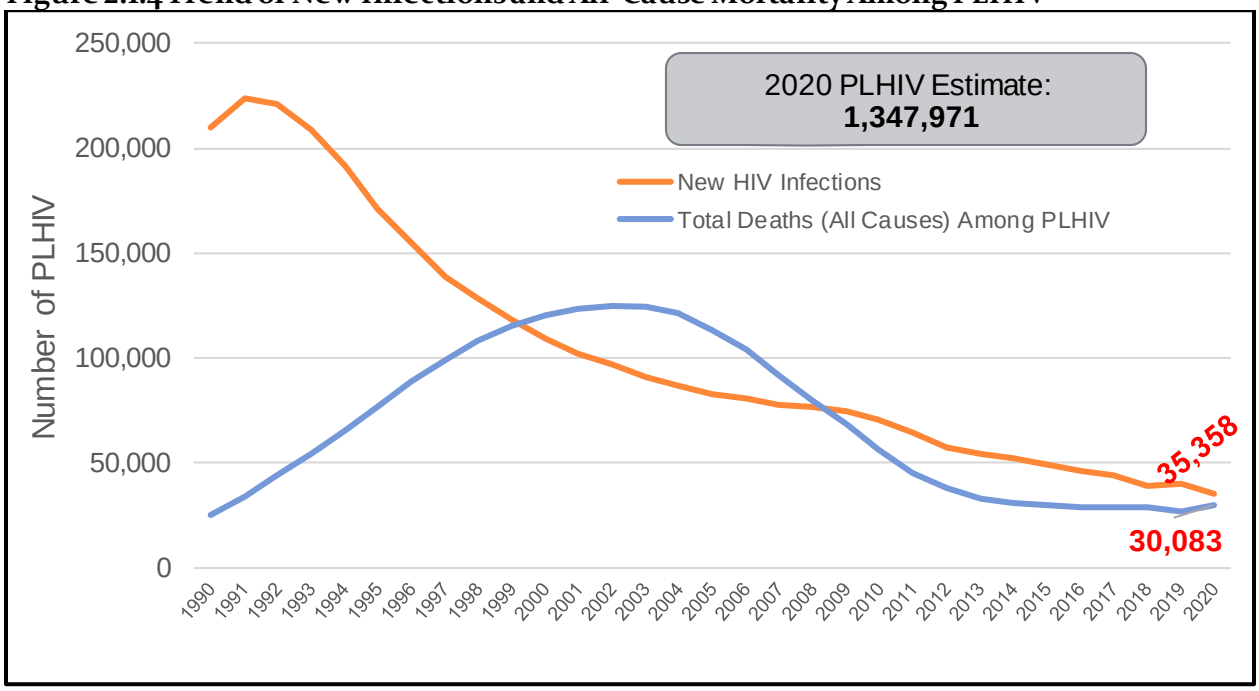


**Figure 2.1.5 Progress retaining individuals in lifelong ART in FY19**

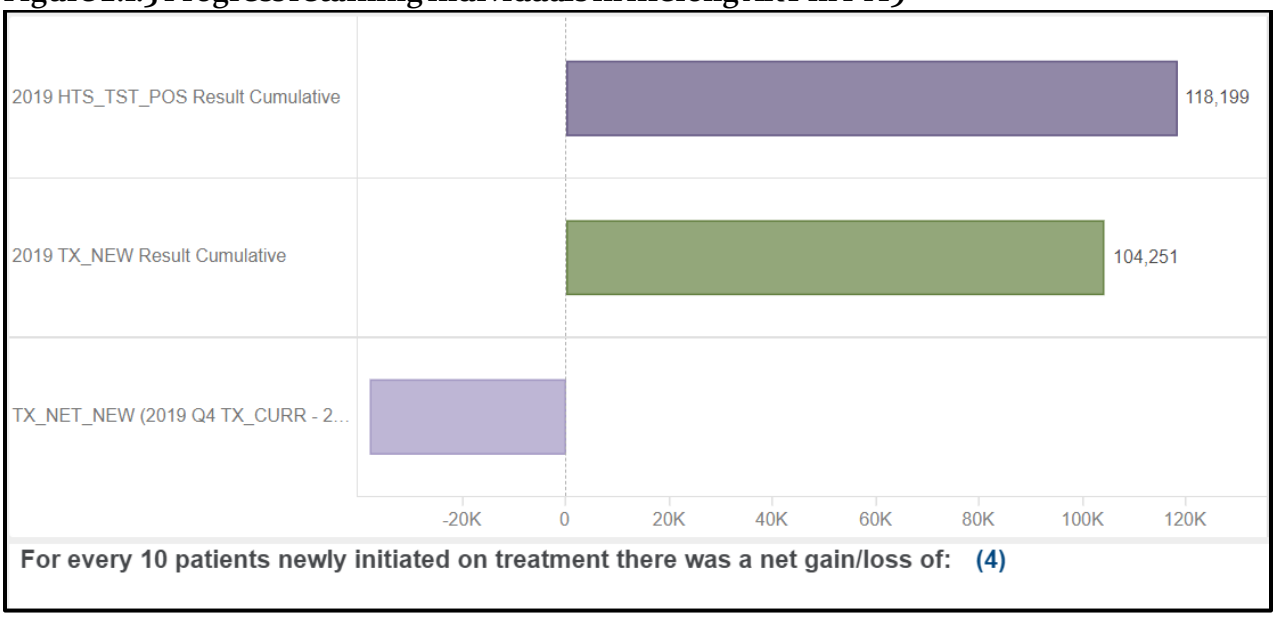



**Figure 2.1.6 Proportion of clients lost from ART 2018 Q4 to 2019 Q4**

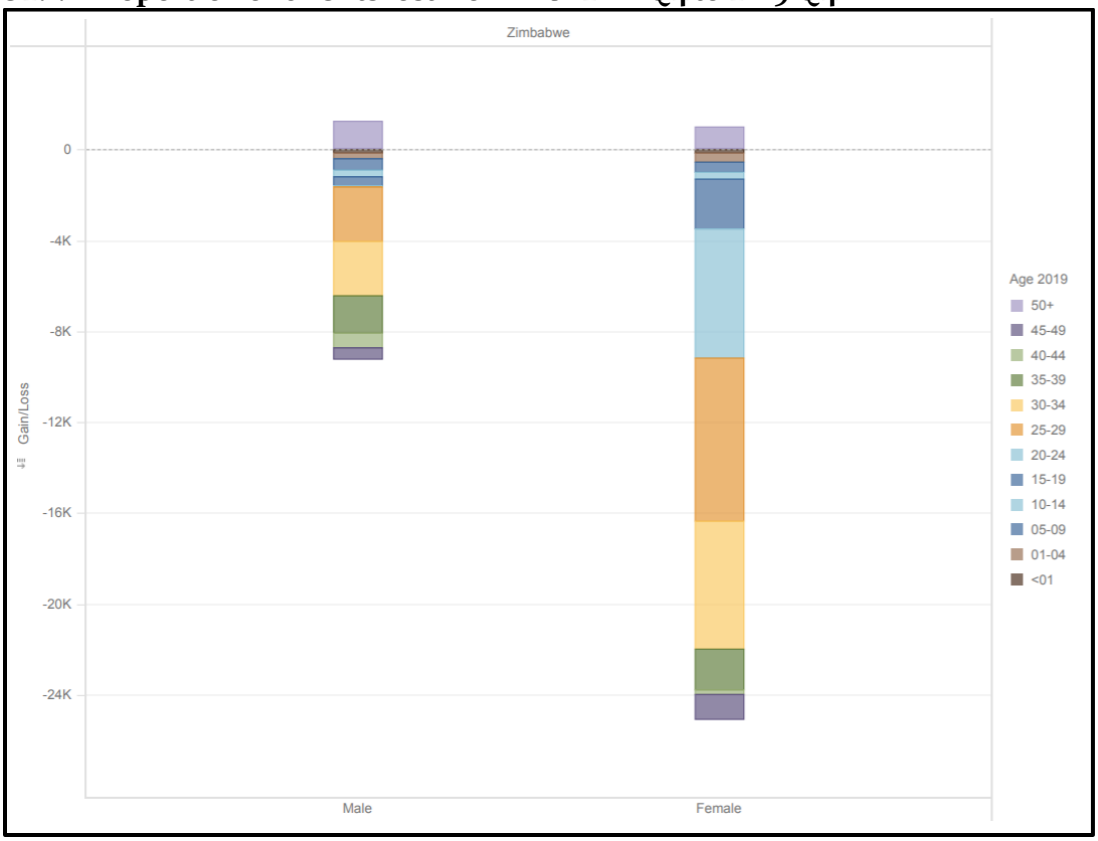
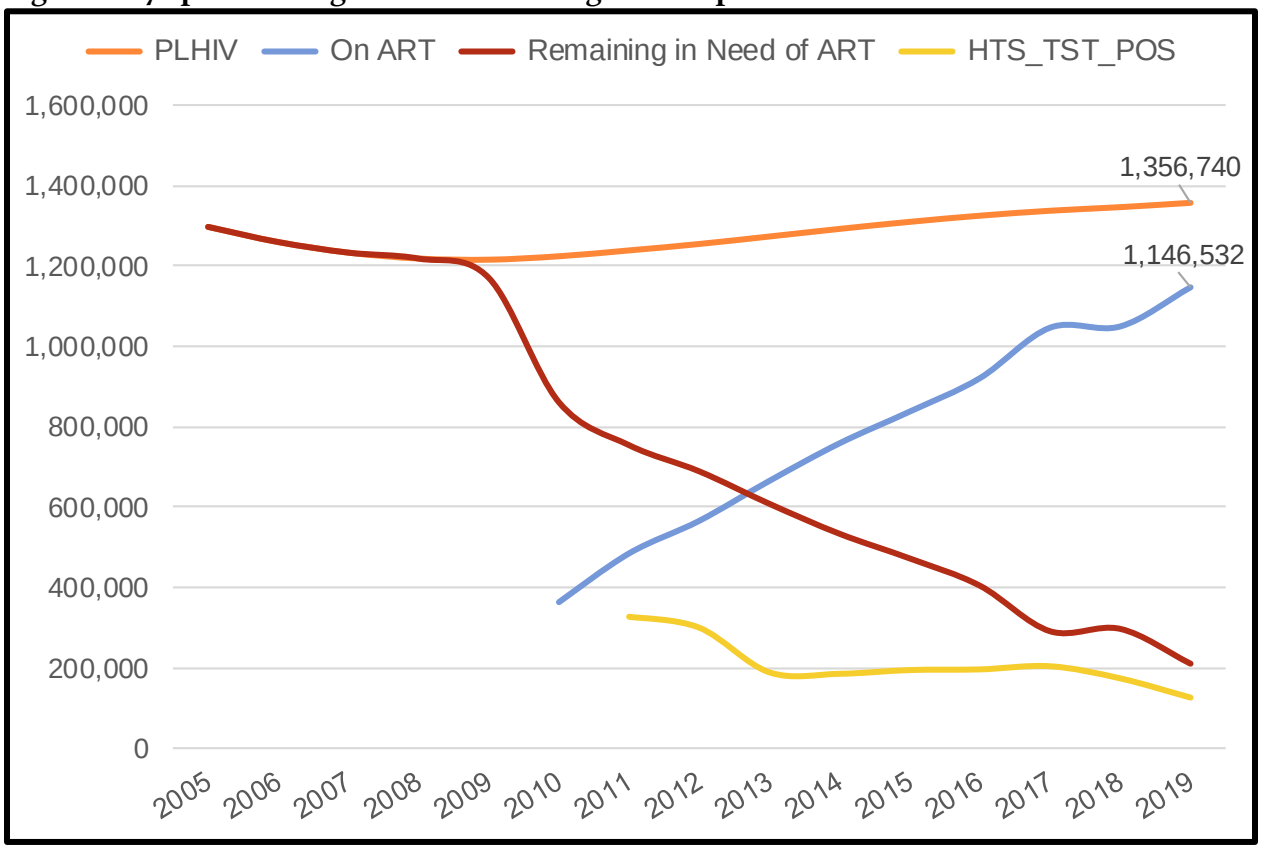


**Figure 2.1.7 Epidemiologic Trends and Program Response**



## 2.2 New Activities and Areas of Focus for COP20, Including Focus on Client Retention

### Core Retention Package: Interventions

Patient centered care; treatment literacy; CQI

**Prevent loss/drop out**

Transition eligible patients to TLD

**6 MMD to scale**

Mental health, cervical cancer, TPT

Individual-level interventions (e.g. early case management, SMS reminders, peer counseling)

Non-judgmental, friendly providers

Zvandiri model scale up of enhanced package

**Differentiated Service Delivery (DSD)**

**Improve tracking & documentation**

**Dedicated Retention facilitators (paid lay cadres)**

**EHR expansion**

Early missed appointments tracking within 24 hours

Intensive defaulter tracking with phone call, home visits using CHW

Systematic documentation of reasons for LTFU

**Interventions for special populations**

Men, children, Adolescents

Pregnant/Breastfeeding women

Key Populations

Unstable & advanced disease patients

People experiencing mental health or substance abuse issues

Mobile clients (Cross border DSD)

### Differentiated service delivery for retention

**Reduced clinic visits**

-6MMD

-CARGS

-Family refills

**Shorter clinic visit**

-Fast track refill

-Scheduled appointment times – reduce waiting time and congestion

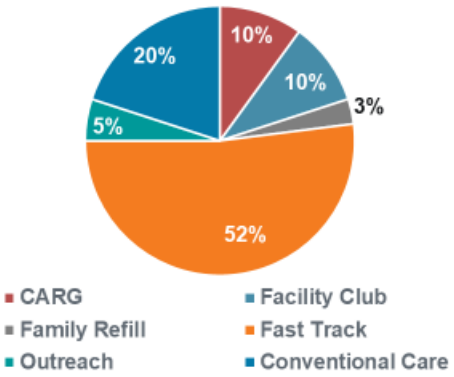
**Patient convenience**

-Family centered care, CARGs

-Convenient locations (community posts & private pharmacies)

-Explore roll-out and scale of OFCAD Model

2020 Targets: Increase the proportion of stable adolescent and adult clients in DSD models for ART to 80% of stable eligible clients by Dec 2020



## 2.3 Investment Profile

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

Zimbabwe also faces an economic downturn and rising inflation. The GoZ has established an AIDS levy that collects millions of dollars each year to procure ARVs and to support other activities. However, the value of these funds has declined as inflation has risen and it is unclear how much the levy is currently contributing to the response.

### Standard Table 2.3.1: Annual Investment Profile by Program Area

**Table 2.3.1 Annual Investment Profile by Program Area**

| Program Area | Total Budget (2020) | PEPFAR | | Global Fund | | Host Country | | Other | |
|---|---|---|---|---|---|---|---|---|---|
| | | Amount | % | Amount | % | Amount | % | Amount | % |
| Clinical care, treatment and support | $ 173,112,048 | $55,272,640 | 32 | $76,425,067 | 44 | $41,314,441 | 24 | $99,900 | 0 |
| Community-based care, treatment, and support | $333,938 | - | 0 | $146,738 | 44 | $187,200 | 56 | - | 0 |
| PMTCT | $1,541,535 | $734,753 | 48 | $351,257 | 23 | $455,525 | 30 | - | 0 |
| HTS | $10,392,980 | $9,186,684 | 88 | $725,157 | 7 | $481,139 | 5 | - | 0 |
| VMMC | $32,435,929 | $31,312,878 | 97 | $0 | 0 | $1,123,051 | 3 | - | 0 |
| Priority population prevention | $4,142,085 | - | 0% | $876,078 | 21 | - | 0 | $3,266,007 | 79 |
| AGYW Prevention | $20,795,339 | $15,310,785 | 74 | $5,137,554 | 25 | $347,000 | 2 | - | 0 |
| Key population prevention | $4,061,026 | $1,215,343 | 30 | $2,567,683 | 63 | $278,000 | 7 | - | 0 |
| OVC | $17,397,120 | $17,397,120 | 100 | - | 0 | - | 0 | - | 0 |
| Laboratory | $2,956,832 | $2,741,101 | 93 | - | 0 | $215,731 | 7 | - | 0 |
| SI, Surveys and Surveillance | $7,711,826 | $4,119,751 | 53 | $1,850,400 | 24 | $587,223 | 8 | $1,154,452 | 15 |
| HSS | $33,206,493 | $426,834 | 1 | $11,789,082 | 36 | $18,227,230 | 55 | $2,763,347 | 8 |
| **Total** | $308,087,151 | $137,717,889 | 45 | $99,869,016 | 32 | $63,216,540 | 21 | $7,283,706 | 2 |

### Standard Table 2.3.2: Annual Procurement Profile for Key Commodities

| Table 2.3.2 Annual Procurement Profile for Key Commodities | | | | | | |
|---|---|---|---|---|---|---|
| **Commodity Category** | **Total Expenditure** | **% PEPFAR** | **% GF** | **% GoZ/NAC** | **% Other** | **% Gap** |
| ARVs | $105,474,129 | 17% | 46% | 20% | 2% | 16% |
| ARVs for PrEP | $390,789 | 0% | 100% | 0% | 0% | 0% |
| Rapid test kits (conventional) | $5,421,370 | 6% | 38% | 0% | 0% | 56% |
| Rapid test kits (self-test kits) | $2,358,217 | 42% | 0% | 0% | 0% | 58% |
| Medicines for VMMC | $322,851 | 90% | 0% | 0% | 0% | 10% |
| Lab reagents for EID | $680,370 | 0% | 147% | 0% | 0% | 0% |
| Lab reagents for EID POC | $609,660 | 42% | 0% | 0% | 0% | 58% |
| Lab reagents (conventional) | $7,362,315, | 0% | 8% | 0% | 0% | 92% |
| Viral Load commodities | $20,528,372 | 24% | 48% | 1% | 0% | 27% |
| Condoms (male & female, and personal lubricant) | $5,777,735 | 74% | 0% | 0% | 0% | 26% |
| VMMC kits | $2,090,203 | 92% | 0% | 0% | 0% | 8% |
| Other commodities for VMMC | $617,232 | 100% | 0% | 0% | 0% | 0% |
| **Total** | $151,633,243 | - | - | - | - | - |

## Standard Table 2.3.3: Annual USG Non-PEPFAR Funded Investments and Integration

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

## 2.4 National Sustainability Profile Update

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

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

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

**Sustainability Analysis for Epidemic Control: Zimbabwe**

**Epidemic Type:** Generalized
**Income Level:** Lower middle income
**PEPFAR Categorization:** Long-term Strategy
**PEPFAR COP 19 Planning Level:** 162,947,750

| SUSTAINABILITY DOMAINS and ELEMENTS | 2015 (SID 2.0) | 2017 (SID 3.0) | 2019 | 2021 |
|---|---|---|---|---|
| **Governance, Leadership, and Accountability** | | | | |
| 1. Planning and Coordination | 9.33 | 10.00 | 8.57 | |
| 2. Policies and Governance | 7.16 | 7.11 | 5.82 | |
| 3. Civil Society Engagement | 6.17 | 6.46 | 3.00 | |
| 4. Private Sector Engagement | 2.71 | 5.92 | 5.92 | |
| 5. Public Access to Information | 8.00 | 5.00 | 5.67 | |
| **National Health System and Service Delivery** | | | | |
| 6. Service Delivery | 7.22 | 6.85 | 6.75 | |
| 7. Human Resources for Health | 8.42 | 8.40 | 7.76 | |
| 8. Commodity Security and Supply Chain | 6.14 | 6.14 | 4.81 | |
| 9. Quality Management | 8.67 | 8.67 | 9.33 | |
| 10. Laboratory | 4.72 | 5.50 | 6.89 | |
| **Strategic Financing and Market Openness** | | | | |
| 11. Domestic Resource Mobilization | 3.06 | 7.06 | 7.58 | |
| 12. Technical and Allocative Efficiencies | 6.70 | 8.56 | 8.56 | |
| 13. Market Openness | N/A | N/A | 6.88 | |
| **Strategic Information** | | | | |
| 14. Epidemiological and Health Data | 3.87 | 4.51 | 5.18 | |
| 15. Financial/Expenditure Data | 7.08 | 10.00 | 10.00 | |
| 16. Performance Data | 7.34 | 7.12 | 7.56 | |
| 17. Data for Decision-Making Ecosystem | N/A | N/A | 5.00 | |

**Sustainability Strengths:** Sustainability strengths identified as part of SID 2019 include the following:

- Planning and coordination (Element 1, Score 8.57): The MoHCC develops and implements a costed multiyear national strategy and serves as the convener of a coordinated HIV/AIDS response. Policies, guidelines and SOPs exist within the national response, but require greater oversight and stronger implementation.
- Quality management (Element 9, Score 9.33): Stakeholders consulted cited strong institutionalized quality management systems, plans, workforce capacities, and other key inputs to ensure that quality improvement methodologies are applied to managing and providing HIV/AIDS services. HIV program performance measurement data are systematically collected and analyzed to identify areas of patient care and services that can be continuously improved.
- Technical and allocative efficiencies (Element 12, Score 8.56): There is a demonstrated commitment among stakeholders to use relevant HIV/AIDS epidemiological, health, and economic data to inform HIV/AIDS investment decisions.
- Financial/expenditure data (Element 15, Score10.0): The government remains committed to collect, track, and analyze available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures.

**Sustainability Vulnerabilities:** Sustainability vulnerabilities identified as part of SID 2019 include the following:

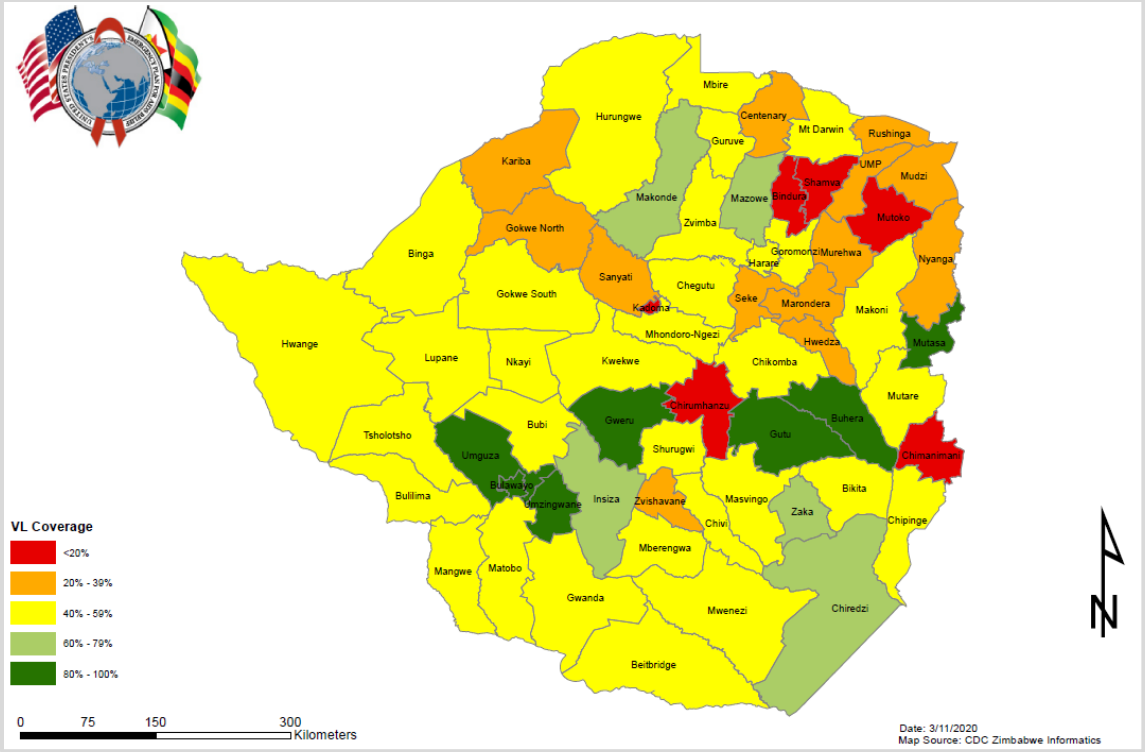
- Commodity Security and Supply Chain (Element 8, Score 4.81): The GoZ has established a successful AIDS levy to procure ARVs and support other program activities. However, the value of these funds has declined over the past two years as inflation has risen and the procurement of ARVs, HIV rapid test kits, and condoms is heavily dependent on donor funding. National contributions to supply chain financing are largely limited to health workforce and infrastructure. Multiple stakeholders and members from diverse CSOs expressed concern regarding a "weaknesses in the supply chain". This concern was not regarding a reliance or dependence on donors for commodity procurement. Stakeholders were concerned about NatPharm mismanagement and poor performance when it came to the delivery of commodities to facilities.

- Civil Society Engagement (Element 3, Score 3.00): Stakeholders consulted cited concerns regarding civil society engagement. Laws exist that indirectly restrict civil society from playing an oversight role in the HIV/AIDS response. There are opportunities for civil society groups to engage and provide feedback on HIV/AIDS policies and programs, however, this input is solicited in an ad hoc manner. Minimal funding (under 9%) for HIV/AIDS related civil society organizations comes from domestic sources and there are currently no laws and policies in place which provide for CSOs to receive funding from a government budget for HIV services through open competition.

**2.5 Alignment of PEPFAR investments geographically to disease burden**

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

**Figure 2.5.1**. 2019 Annual Viral load coverage by SNU




## 2.6 Stakeholder Engagement

1. **Host country government**
   The PEPFAR Coordination Office held bilateral meetings at MoHCC with both the Permanent Secretary of Health and the Director of the HIV/AIDS and TB unit to discuss the COP 2020 road map and the need for continued ministry leadership throughout the COP planning process. Subsequently, numerous MoHCC representatives attended the weeklong PEPFAR retreat in late January 2020. MoHCC counterparts deliberated on their specific program areas and contributed to synchronizing MoHCC priorities with PEPFAR's. At the conclusion of the retreat, MoHCC representatives expressed gratitude for the collaboration and informed the participants that MoHCC expected to fare very well in their progress towards 95-95-95 targets as PEPFAR had helped accelerate the achievement of these initiatives. Three MoHCC representatives, including the Permanent Secretary of Health, attended the Johannesburg Regional Meeting in February 2020.

2. **Global Fund and other external donors**
   The Global Fund Portfolio Manager and the local Principal Recipient, UNDP, attended the PEPFAR retreat and Johannesburg planning meetings. GF representatives reiterated the need to demonstrate results, especially with catalytic funding that the country secured through evidence of impact. The team shared concerns about lab support for viral load scale-up and potential ARV shortage in 2020 considering both GF and PEPFAR's flat lined budgets for the cost area. Possible funding flexibility to support emerging COP 20 program requirements would be achieved through reprogramming of savings. UNAIDS, WHO, and BMGF attended the retreat and the Johannesburg meeting.

3. **Civil Society/Community:**

Engagement with civil society around COP 2020 kicked off in December 2019 when the PEPFAR Team attended an Advocacy Core Team meeting to describe FY19 performance and COP20 strategic direction. In January, five representatives from community services organizations attended the PEPFAR retreat. The civil society organization (CSO) core group then convened three regional consultative meetings across the various geographical locations of the country to collect feedback from constituents receiving HIV prevention and treatment services in Zimbabwe. These consultations led to a streamlined list of community priorities that later culminated in a separate meeting with Ambassador Nichols and the PEPFAR Management Team to deliver the Zimbabwe People's COP outlining the following community priorities:

1. Fund the expansion of Viral Load Testing (VLT) from the current 44% to the 74% as per government set targets.
2. Fund and increase the numbers of human resources for health from 14,133 in COP19 to 20,000 health care workers including lab technicians, CATs, data clerks, community, peer and lay workers, nurses and pharmacists among others in PEPFAR priority districts.
3. PEPFAR should disburse funding contingent to the government of Zimbabwe adopting policies that support not inhibit HIV service scale up as per COP20 Guidance on Minimum Requirements.
4. Expand alternate models of care to increase retention of PLHIV on treatment.
5. Invest in strengthening the procurement and supply systems to prevent stockouts.
6. Fund a widespread expansion of treatment literacy and communication to increase linkage, adherence and retention rates.
7. Scale up access to 3HP for TB preventative therapy (TPT) and urine-LAM as a point of care diagnostic at health facilities.
8. Fund "Men and Boys Program" and wellness initiatives, rebrand condoms and strategically distribute them and expand PrEP scale up to all priority PEPFAR districts and populations.
9. Fund optimal pediatric formulations and increase pediatric ART coverage.
10. Fund US$2m to expand the existing community-led monitoring.
11. Invest in improving the data management platform and systems for accurate, reliable and timely data.

*Representatives from civil society organizations (CSOs) and community members who benefit from health services, discussed challenges they face when accessing antiretroviral therapy and other health services with U.S. Ambassador Brian A. Nichols at the Embassy in Harare on February 13*

4. **Private Sector**
   The structures for private sector engagement have not been functional given the poor economic and investment climate in Zimbabwe. Ultimately, there were no engagement meetings with the private sector during COP 2020 planning.

# 3.0 Geographic and Population Prioritization

PEPFAR used 2019 subnational HIV estimates from the UNAIDS NAOMI model and host country treatment program data to recalibrate the national HIV epidemic and measure progress toward the UNAIDS fast track 95-95-95 epidemic control targets across all districts. PEPFAR programming aims to have 100% of PLHIV in PEPFAR districts on ART at the end of FY20. PEPFAR anticipates some PLHIV residing outside of PEPFAR districts receive care within PEPFAR districts, particularly in urban centers. Together with the Government of Zimbabwe, >95% of PLHIV will be initiated on ART by the end of FY 21.

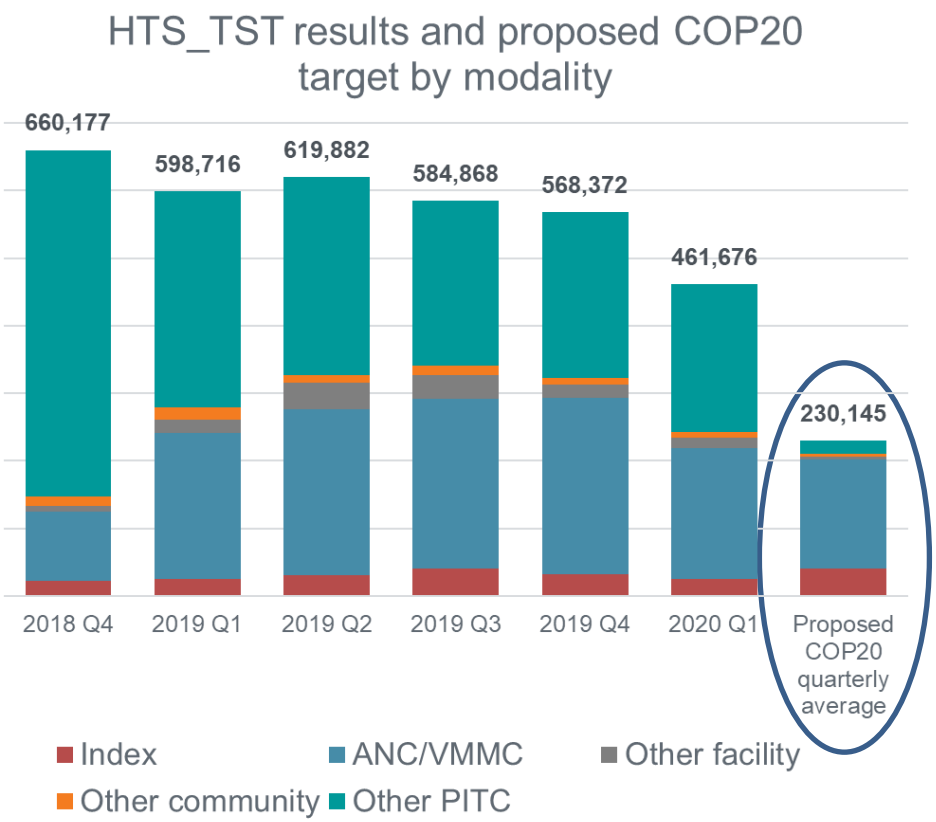
**Table 3.1: Current Status of ART saturation**

| Table 3.1 Current Status of ART saturation | | | | |
|---|---|---|---|---|
| **Prioritization Area** | **Total PLHIV/% of all PLHIV for COP20** | **# Current on ART (FY19)** | **# of SNU COP19 (FY20)** | **# of SNU COP20 (FY21)** |
| Attained | 1,139,928 | 930,885 | 44 | 44 |
| Scale-up Saturation | | | | |
| Scale-up Aggressive | | | | |
| Sustained | | | | |
| Central Support | 208,043 | 173,494 | 19 | 19 |
| TOTAL | 1,347,971 | 174 | 63 | 63 |

# 4.0Client Centered Program Activities for Epidemic Control

### 4.1 Finding the missing and getting them on treatment

As Zimbabwe reaches epidemic control, the COP 2020 strategy for case finding moves away from Zimbabwe's previously supported iHTS strategy towards an epidemic control HTS model that reduces testing volumes and eliminates unnecessary testing. The two-part strategy includes sustained, standard of care epidemic control testing services and targeted testing services for populations at continued high risk.



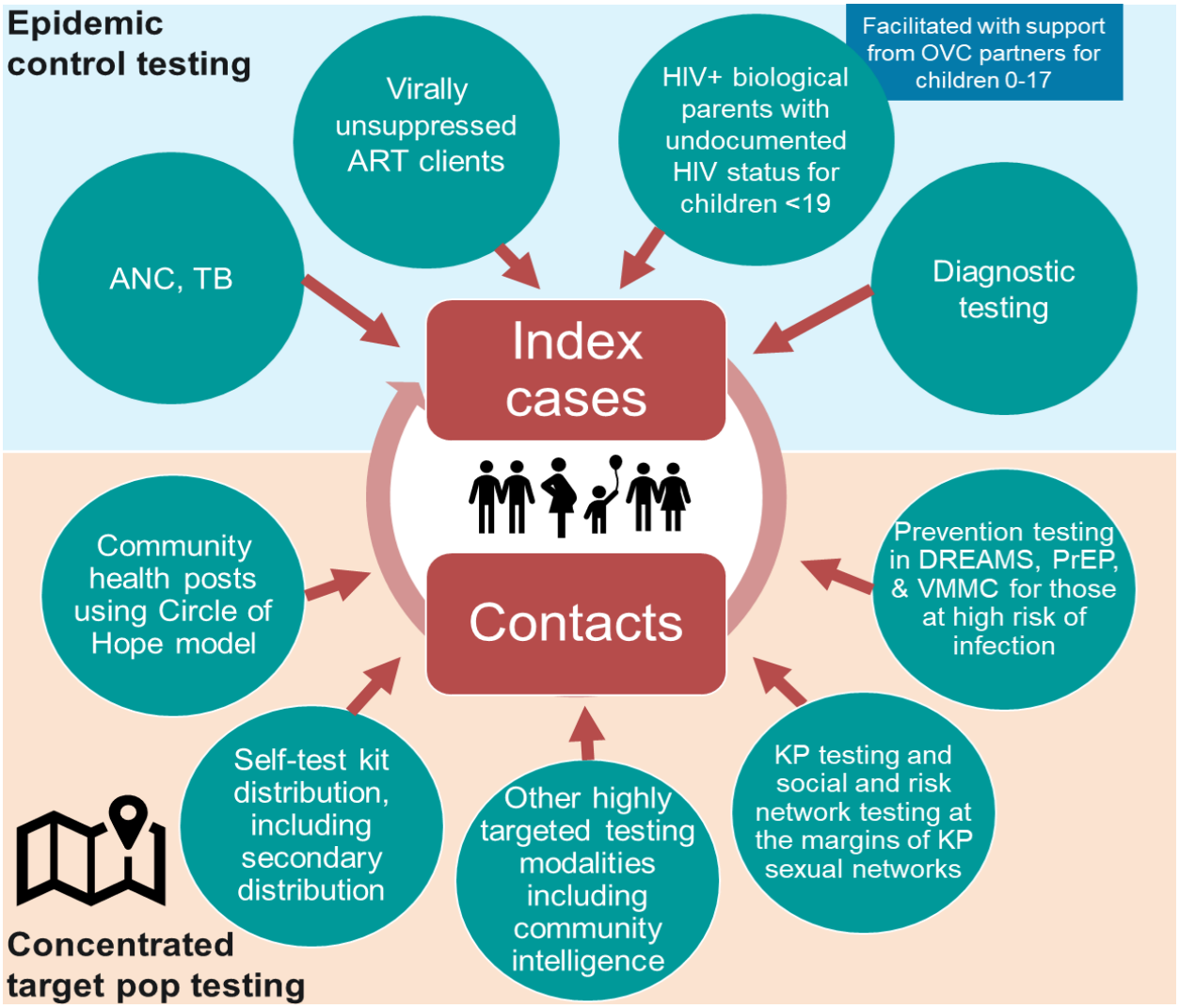

Facility initiated testing for epidemic control will focus on continued standard of care testing for ANC and TB programs, facility-based diagnostic testing, and index testing for sexual partners and biologic children of newly identified PLHIV and virally unsuppressed ART clients.

Additionally, targeted testing will focus on populations at highest risk. These include KP hotspots identified through mapping and urban and peri-urban hot spots with high ART gaps in men and/or youth. Targeted testing will also continue through targeted prevention programming, including DREAMS, OVC, and PrEP programs.

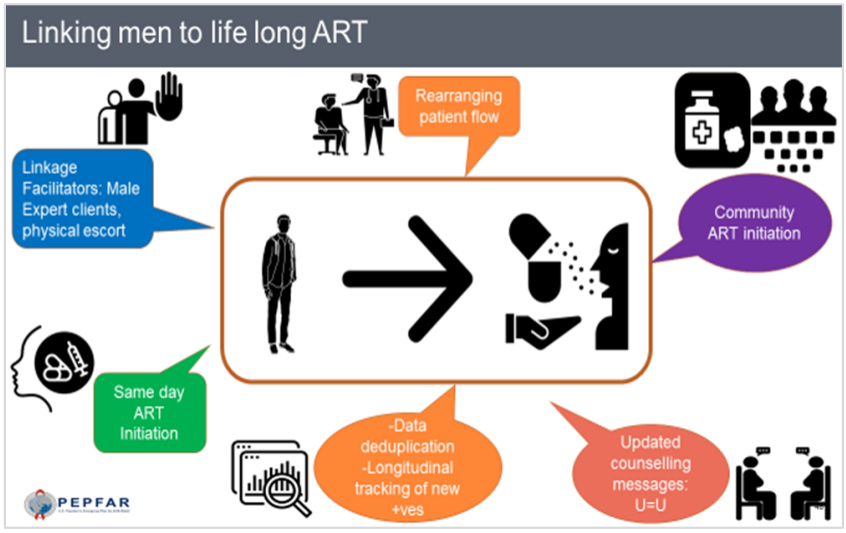
Finally, cased-based surveillance with recency will be used to identify clusters of recent infections and offer testing to targeted groups in those social and sexual networks. The client-centered testing and index testing approach will include screening for intimate partner violence before and after notification of partners and referral to appropriate HIV prevention and gender-based violence services. All PEPFAR funded sites offering index testing will be assessed to ensure that the quality of services provided respects the rights of patients.

A continuous monitoring plan in collaboration with MoHCC, CSOs and other stakeholders will be supported to ensure continuous quality services and sites will be expected to report on acceptance rates of index testing quarterly per the MER indicator, HTS_INDEX. In addition, an analysis will be conducted to look at the reduction in treatment retention among women alongside acceptance of index testing to ensure that retention of women is not affected by the index testing intervention. KP population programs will not provide index testing and the program will focus on other strategies such as social network strategies until each site is certified per the guidance from OGAC. PEPFAR will continue to reach out to communities of people living with HIV and

key population to improve methods of offering rights-based index testing. Lastly, HIV self-test kits will continue to be used as a screening tool targeting highest risk groups and for reaching contacts in index testing programs.



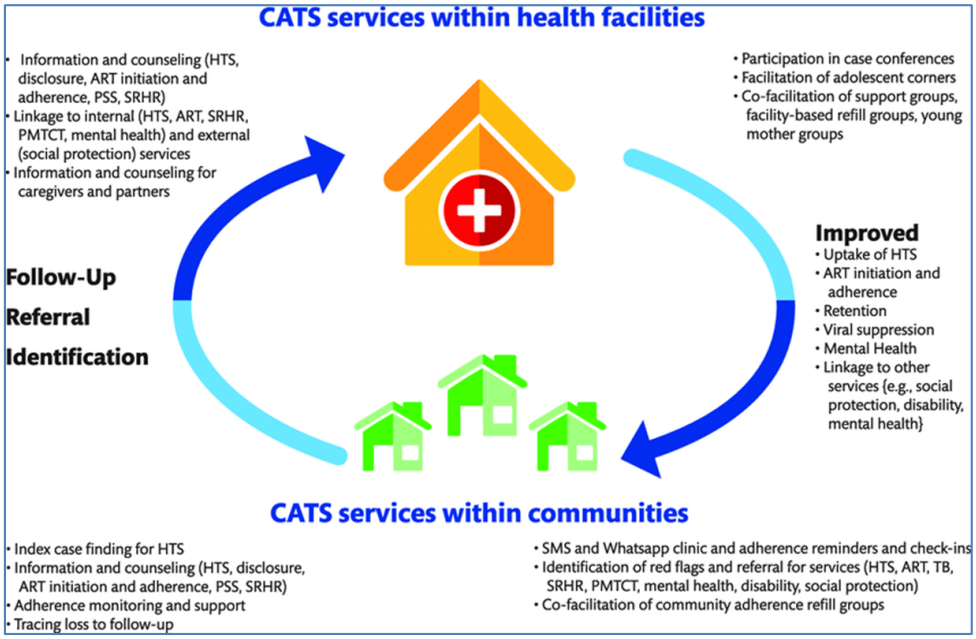

**Finding men:** Generally, men have lower ART coverage as compared to women. As the country reaches and maintains epidemic control, it must continue to close existing gaps in identifying men, linking them to treatment and ensure long-term viral suppression. Community posts (Circle of Hope, Zambia) have been identified as an effective modality to identify, link and retain high risk men. Through the Faith and Community Initiative, community posts are being launched in urban settings, including Harare and Mutare, during COP 19. These will be maintained as a case-finding strategy to test men and link them to care during COP20. Additionally, men will continue to be reached with index testing and through prevention modalities targeting men at high risk.




ART initiation strategies to reach men will be paired mainly with PITC, index case testing and self-testing strategies to link them to treatment and to emphasize same-day ART initiation. Facility-based support TA will continue to focus on rendering facilities more "male friendly" through extended hours, sensitization of health care workers, and pairing ART initiation with community testing activities. In high ART gap districts, the emphasis will be on facility based DSD to improve linkage to ART; while in low ART gap districts, efforts will be intensified to accelerate community ART initiation.

Since COP 2017, the PEPFAR program has strengthened strategies to link men to treatment, including the use of facility-based and community-based linkage facilitators which saw the linkage among men improving remarkably as shown in the figure below. The addition of community posts, which have shown strong linkage rates for males in Zambia, are expected to help link males to accessible, high quality HIV services closer to their home and work locations.

**Finding adolescents and young people:** According to ZIMPHIA and program data, adolescents and young people continue to perform poorly as compared to older people across the clinical cascade. However, using Community Adolescent Treatment Supporters (CATS) in the game changer Zvandiri model, PEPFAR has significantly improved case identification, linkage and eventually ART coverage among adolescents and young people, including using HIV self-testing. PEPFAR will be increasing support for this model to close the gap in case-finding and linkage to care for harder to reach adolescents and young people.




PEPFAR will be increasing support for the Zvandiri model in COP 2020 by rolling out additional CATS to close the gap in case-

finding and linkage to care for harder to reach adolescents and young people. During the regional meeting in Johannesburg, PEPFAR and CSOs discussed and PEPFAR has agreed to increase the number of CATS from 2 per district to 12-20 per district depending on the underlying population data and need of a given district.

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

**Finding children:** In COP20, index testing, which has become the main modality for finding children, will continue for biologic children of newly identified PLHIV and the virally unsuppressed clients currently on ART. In addition, diagnostic testing for sick children under five with full roll out of the pediatric screening tool within health facilities will be utilized to identify children.

PEPFAR will support EID POC commodities for mPIMA devices procured under the UNITAID pilot in Zimbabwe. Through the POCs, EID TAT including result transmission to caregiver was within 7 days in 92% of the cases and this facilitated the early initiation of life-saving ART in HIV Exposed Infants (HEI) found to be HIV positive. PEPFAR partners will support the decentralization of conventional EID platforms and the Integrated Specimen Transport system while strengthening the delivery of EID results to reduce the turn-around time.

Another important focus is to ensure the continued collaboration between the OVC and clinical partners to ensure cross-referrals and identification of HIV positive children within OVC programs.

Pediatric ART coverage in Zimbabwe is currently lower than that among adults, 56% versus 85%. Closing the treatment coverage gap is critical if the country is to achieve HIV epidemic control. HIV epidemic is not attained if certain populations are left behind. In COP20, PEPFAR will continue to support HIV pediatric and adolescent case finding, despite significant scale down in the adult population. Zimbabwe has one of the most efficient HIV case-finding strategy, with 51 children needing testing to identify one positive child. Such an achievement is due to the use of HIV screening tool for 5-19-year-old children implemented all entry points. During COP18, index HIV testing accounted for 18% of tests in children <15 yet accounted for 51% of all pediatric and adolescents testing HIV positive. In COP20 we will continue to strengthen index testing, through improved elicitation of contacts, as an efficient strategy for HIV case identification. Ensuring proper elicitation of children of newly diagnosed women, as well as newly diagnosed men where

the child's mother's status is unknown (mother deceased or away/unavailable for testing) will be prioritized.

Strategies to improve index testing for new and old parents in HIV care:

1. Regular chart review to identify children with unknown status.
2. Review messaging to improve elicitation of children <19 years.
3. Track coverage of testing among elicited children.
4. Facilities to identify reasons for children not being tested 5.Ensure elicitation among newly diagnosed women and men. where the child's mother's status is unknown.
5. Track testing coverage of elicited children.
6. Facilities to identify reasons for children not being tested.
7. Review and tracking of children of virally unsuppressed women.

Index case testing using CATS has shown significant promise (9% yield), and PEPFAR will improve recruitment of CATS to support case finding.

The PEPFAR program will support the procurement EID POC commodities, significantly reducing results turn-around time and enabling immediate linkage to patients will be followed up and initiated on ART as soon as possible. Efforts to improve and maintain high EID coverage (95% linkage to ART) include:

1. Support procurement of EID Point of care testing cartridges.
2. Decentralization of EID testing.
3. Integrated sample transportation and expedite electronic result transmission.
4. Expand use of EHR and diary system 5.Expedite result transmission through electronic means.
5. Continue HIV test and start.
6. Community ART initiation.
7. Cohort monitoring.
8. Use optimized regimens which are child friendly.

As guided by the MoHCC, PEPFAR will support rollout of optimized ART regimens. DTG will be rolled out for children with weight >20kgs. Nevirapine has been phased out as first line treatment, replaced by LPV/r granules procured with support from PEPFAR. Raltegravir granules for neonates diagnosed at birth rolled out in COP19 in a few sentinel health facilities. In COP20, PEPFAR will support the procurement and distribution of Raltegravir granules for sentinel sites.

**PMTCT:** Uptake of HIV testing during antenatal care has been consistently high, above 95%, across all PEPFAR supported districts. FY 19 Q4 program data indicate that 73.4% of HIV positive pregnant women were already receiving ART at time presenting for antenatal care (ANC).

Remaining gaps include:

- early diagnosis of pregnant women sero-converting after a HIV negative result at first
- reaching a small proportion of HIV positive pregnant women who are not initiating ART
- ensuring adherence across the whole continuum of PMTCT care

Currently, implementing partners are conducting additional mentorship for both government and their own staff on ART initiation to ensure trained ART initiators are available at each site offering PMTCT services. In COP20, the PEPFAR program will continue to link all HIV positive pregnant women to ART initiation, through both DSD and TA support based upon site-specific needs. The team will support sites to conduct monthly linkage analyses to look at their performance and address bottlenecks. Follow up systems to call back clients who miss appointments will be re-emphasized as the appointment diaries become more widely available.

Program data shows vertical 80% of vertical transmission is occurring in HIV exposed infants born to mothers who have not started ART, started ART late or stopped ART.

Zimbabwe is targeting achieving the bronze criteria for elimination of pediatric HIV and syphilis. To reduce vertical HIV transmission PEPFAR will implement the following strategies:

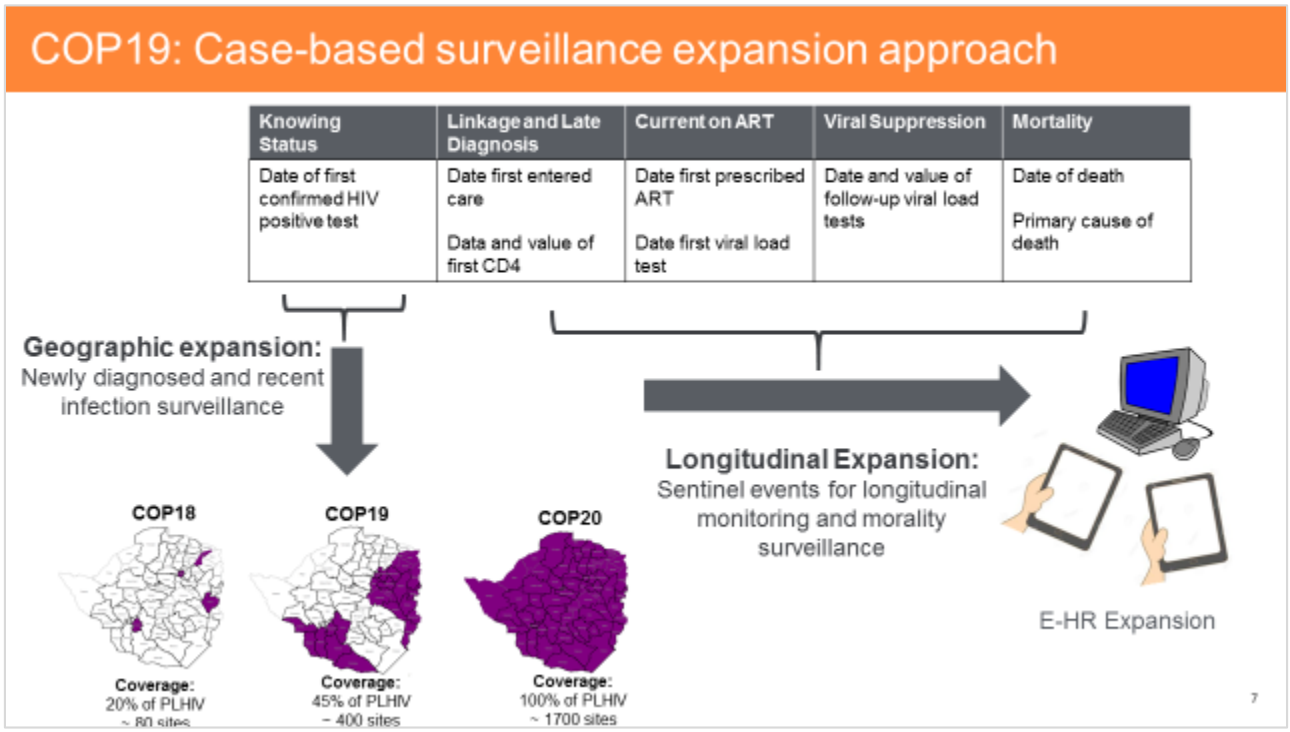
In order to enhance the early identification of pregnant and breastfeeding women seroconverting, PEPFAR will support HIV retesting through:

- development and dissemination of SOPs and job aides
- capacity building of health workers to conduct HIV testing
- procurement of HIV test kits
- procurement and distribution of HIV self-test kits
- integration of HIV retesting for women within immunization programs

In COP20, the PEPFAR program will continue to link all HIV positive pregnant women to ART initiation through DSD and TA support based upon site-specific needs. The team will support sites to conduct monthly linkage analyses to look at their performance and address bottlenecks. Follow up systems to call back clients/mother-baby pairs who miss appointments will be re-emphasized as the use of electronic systems appointment diaries become more widely available. Finally, the roll-out of electronic medical records such as the electronic health record (EHR) in four more districts during FY20, will provide much needed data quality and efficiency in assessing linkage, as well as identifying defaulters. The system will also enable efficient documentation and tracking of differentiated service delivery for pregnant and lactating women.

As part of the national PMTCT validation exercise, support will be extended to the private sector to ensure they adhere to national guidelines and report data to the MoHCC. Differentiated care models will be explored for pregnant and lactating women seeking services within the private sector as well, to ensure they are retained in care.

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



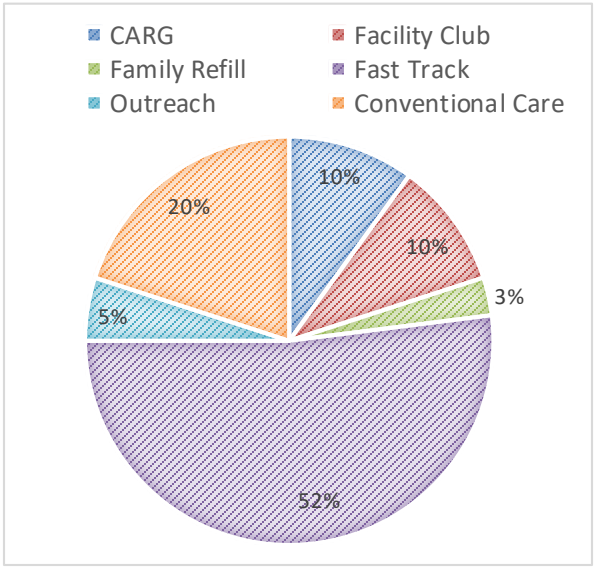

In COP 2019, Zimbabwe will geographically expand newly diagnosed and recent infection surveillance from four to 18 districts increasing coverage from about 80 to about 400 sites in line with the MoHCC's CBS roadmap. To rapidly target case finding efforts in areas of high HIV transmission, Zimbabwe will expedite implementation of recent infection surveillance. In COP19 all newly diagnosed persons over 15 years of age in the 40 PEPFAR districts will be offered recency testing which will be monitored at national level to inform geographical areas with high concentrations of new HIV infections.

Zimbabwe will continue to build and expand the electronic systems necessary to longitudinally monitor sentinel events along the continuum of care for all HIV-infected persons living in Zimbabwe. PEPFAR funds will be used to expand the MoHCC's Electronic Health Record (EHR) to ensure all CBS and sentinel events are captured. PEPFAR-support for EHR will focus on system development and adaptation to accommodate PEPFAR-related priorities including use of a unique patient identifier agreed on with communities of PLHIV to ensure human rights are upheld and incorporation of TB-and Cervical Cancer related modules. PEPFAR support will also fund a landscape analysis of ICT and transmission infrastructure to inform non-PEPFAR donors of system needs to expedite EHR expansion.

### 4.2 Retaining clients on treatment and ensuring viral suppression

The MoHCC's Operations and Service Delivery (OSDM) manual for HIV Care and Treatment in Zimbabwe gives guidance on increasing retention at all steps of the HIV clinical cascade. PEPFAR Zimbabwe will continue to support the operationalization of this manual and the roll-out of differentiated service delivery models. PEPFAR Zimbabwe will specifically support the expansion of DSD to increase the proportion of stable adolescent and adult clients in DSD models for ART to

80% among those eligible by December 2020. The pie chart details the proposed mix of DSD models.




DSD models will focus on the following key objectives:

- **DSD to reduce clinic visits:** multi-month dispensing, community ART refill groups (CARGSs, and family refills)
- **DSD to shorten clinic visit:** fast track refills, scheduled appointment times that reduce waiting time and congestion
- **DSD to improve patient convenience:** family centered care, convenient locations like community posts and private pharmacies

PEPFAR will explore implementation of the Out of Facility Community ART Distribution (OFCAD) model, developed by MSF, in COP 2020 as discussed with CSOs in Johannesburg at the Regional Planning Meeting. Implementation of this model will start at a small scale while the PEPFAR program works with partners and CSOs to understand the expenditure of this model. If found to be cost effective, the model will be discussed with the MoHCC so that it can be recognized as one of the of the standard differentiated service delivery models in the country.

CARGs will be tailor-made to address the needs of specific sub-populations (e.g., men-only or cross-border CARGs to cater for patients working in South Africa and Botswana). MoHCC currently considers multi-month scripting and dispensing as part of the minimum package with 3-month MMD being available at all health facilities. In COP20 we will prioritize 6-month MMD through supporting procurement of 90-tablet bottles and revision of treatment guidelines to include the strategy. To improve documentation, identification of defaulters, tracking and tracing we will expand use of the Electronic Health Record (EHR) to PEPFAR-supported health facilities. Repurposing of linkage facilitators to focus on retention activities will be done.

*Prevention of losses/dropouts:* Client level interventions will include early case management, formalized SMS reminders wherever available and access to peer counselling as needed. Through ongoing dialogue with the MoHCC, the PEPFAR program will support the orientation of facility staff on respectful management of clients including being friendly and non-judgmental. The implementation and scale up of 6 MMD and other differentiated services will be a priority. For adolescents the Zvandiri (CATS) model will be enhanced and adapted for scale up in districts with high HIV burden among this age group.

*Improved tracking and documentation:* The PEPFAR program will consider repurposing some of the existing lay cadres to become retention facilitators who will take on the role of intensive defaulter tracking that will begin within 24 hours of clients having missed appointments. These cadres will work with the clinicians to ensure follow up outcomes are documented in the client files. Support will be provided to clinicians to separate the files of client who have missed appointments from those who have defaulted and those who are lost to follow up.

*Special populations:* The PEPFAR program will engage the MoHCC to develop enhanced differentiated service delivery models tailored to suit each individual population group. Particular attention will be paid to clients who are unstable and/or have advanced disease. Additional emphasis will be on having mental health services/substance abuse screening introduced and scaled up. The feasibility of standardizing and formalizing the cross border DSD model will continue to be explored.

*Community Led Monitoring:* PEPFAR will support community led organizations to visit PEPFAR funded sites to evaluate the quality of services offered to communities including people living with HIV, young people, key populations. The organizations will be supported to visit sites across the country throughout the year and reports on quality of service will be shared to improve service delivery.

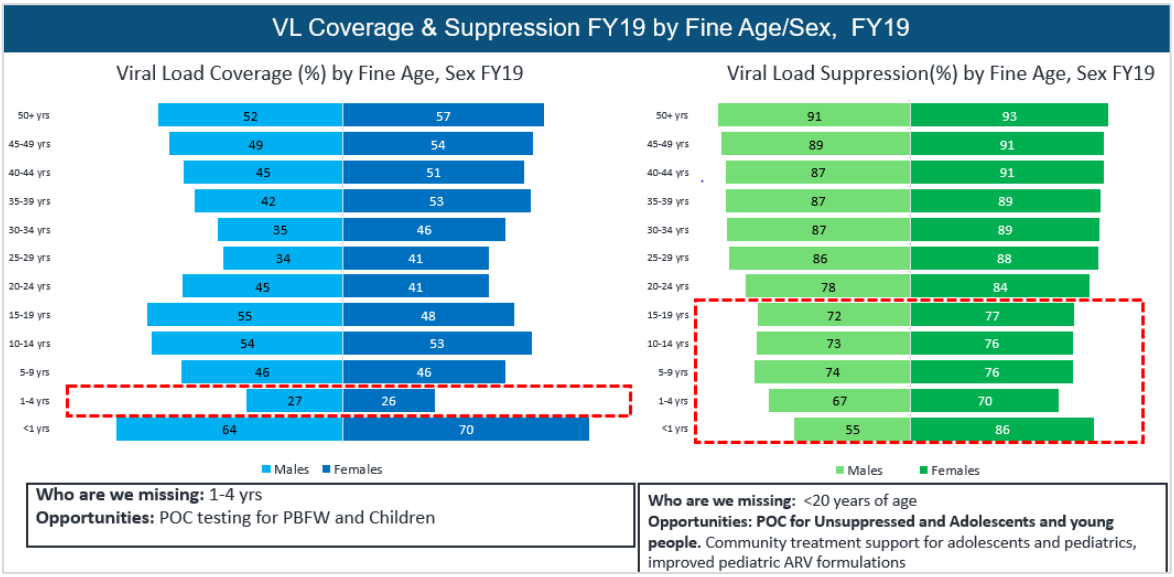
*Treatment Literacy:* In COP 2020, PEPFAR will ensure ongoing activities to improve treatment literacy among PLHIV and ensure that appropriate messages are delivered in appropriate ways to the various population subgroups. These messages will include the rationale for the Treat All approach, the benefits of testing and initiating ART prior to onset of symptoms, the superior efficacy and adverse event profile of dolutegravir (DTG)-based regimens, the importance of having all sexual partners on treatment or PrEP, the need for viral load monitoring and the meaning of viral load results, U=U (Undetectable = Untransmittable), and so on. The PEPFAR program will also continue to support the updating of counseling materials and guidelines to align with the current treatment recommendations and the shifts in the HIV program.

During COP 2019, PEPFAR Zimbabwe supported the development, printing and dissemination of a "Comprehensive National HIV Communications Strategy for Zimbabwe – 2019-2025". This document will be the basis for continued revitalization of widespread treatment literacy amongst ART patients. Working with civil society groups and their constituents, treatment literacy messages tailored to specific population groups in specific areas will be guided by the strategy. Given the inadequate knowledge on issues such as index testing, TLD transition, viral load etc., widespread dissemination of these messages will be a priority. These efforts will be continued in COP 2020.

*Quality Improvement:* The national HIV Quality Improvement strategy establishes indicators and guidelines for measuring the quality of service delivery and improving performance towards those indicators. Importantly, this strategy considers client feedback in order to promote client-centered care. PEPFAR support towards the national HIV Quality Improvement program takes the form of secondees who provide technical guidance, ensuring that this program is aligned with PEPFAR and UNAIDS strategy for achieving HIV epidemic control. Through this support since FY 18, facilities implemented QI initiatives resulting in improved patient care and this continued during COP20 to focus on improving VL and TPT uptake. At the site-level, systems-level interventions to improve monitoring of patient satisfaction, linkage rates, same day initiation and improved M&E for PEPFAR treatment indicators, will be streamlined into the site-level support provided by the clinical partners.

*Ensuring viral load suppression:* PEPFAR has identified viral load (VL) access and suppression as a critical area needing intervention in Zimbabwe as the country reaches epidemic control. Besides the obvious VL reagent gap, there are gaps in access, specimen transport and results utilization/

clinical status monitoring. This gap becomes more pronounced at the district-level and among specific sub-populations as shown in the figure below.




The program has also noted that the utilization of viral load results is sub-optimal pointing to the need to strengthen the clinic-laboratory interface (CLI). In COP20, PEPFAR will therefore continue to invest in scaling up CLI in at least 10 high VL gap districts, ensuring that the clinical partners, OVC/ community partners and the laboratory partner work harmoniously and measurably to increase access to VL services for all eligible PLHIV already on ART. The goal of the strategy is 85% coverage by the end of FY 20.

**Scaling up TPT:** Globally, TB continues to the leading infectious disease killer, yet it is a preventable and curable disease. The available prevention interventions, like TB preventive treatment (TPT), have not been taken to scale for various reasons. During COP18, 47,844 PLHIV were started TPT in 44 PEPFAR supported districts, and 39,521 (83%) completed TPT. In order to end TB by 2035 and achieve UN high level Mission on TB targets, the country must scale up TPT. However, several challenges need to be addressed if full TPT coverage is to be achieved.

The objective of the TPT program in Zimbabwe is to achieve full coverage among eligible PLHIV by the end of COP 20. The PEPFAR TPT target is 459,040. In COP 20, the PEPFAR program will support the procurement and distribution of TPT medicines and complement the Global Fund's support. Implementation of the shorter TPT regimens, 3HP (three months rifapentine and isoniazid) and 3HR (3 months isoniazid and rifampicin) commenced in COP19; these will be scaled up in COP20. The rollout of 3HP is expected to address some of the mistrust that health care workers had about 6H (six months of daily isoniazid) and increase treatment options available to patients. 3HP reduces high pill burden and improves adherence, as a once weekly regimen taken only for 3 months.

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

- PLHIV on DTG based ART regimens 6H plus Vitamin B6 (FDC - INH/CTX/Vitamin B6)

- PLHIV on EFV based ART regimens: 3HP
- HIV negative children and adolescents <15years TB contacts: 3HR

3HP and 3HR regimens are already part of national TPT guidance. In COP 2020 IPs will continue to support the MoHCC in training and mentoring of health care workers on implementation of 3HP and 3HR. Development of SOPs, job aides and patient communication material will address the existing communication gaps and create demand for TPT. Advocacy at policy level and site-level pharmacovigilance will be prioritized in order to change negative TPT perceptions amongst physicians, senior clinicians and nurses.

During COP 2020, among other strategies IPs will support the roll out of TPT differentiated service delivery to improve adherence and completion of TPT. Currently in COP19 there are studies being conducted on the feasibility and acceptability of TPT within CARGs. Such studies will then inform the design and implementation of differentiated TPT, with the expectation to improve uptake and adherence. There is evidence that TPT adherence and satisfaction can be improved with integration of TB and HIV services, and with co-formulation of INH with cotrimoxazole and vitamin B6. This fixed-dose combination pill has now received WHO pre-qualification and inclusion on the Essential Medicines List, and Zimbabwe has begun the registration in advance of procurement.

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

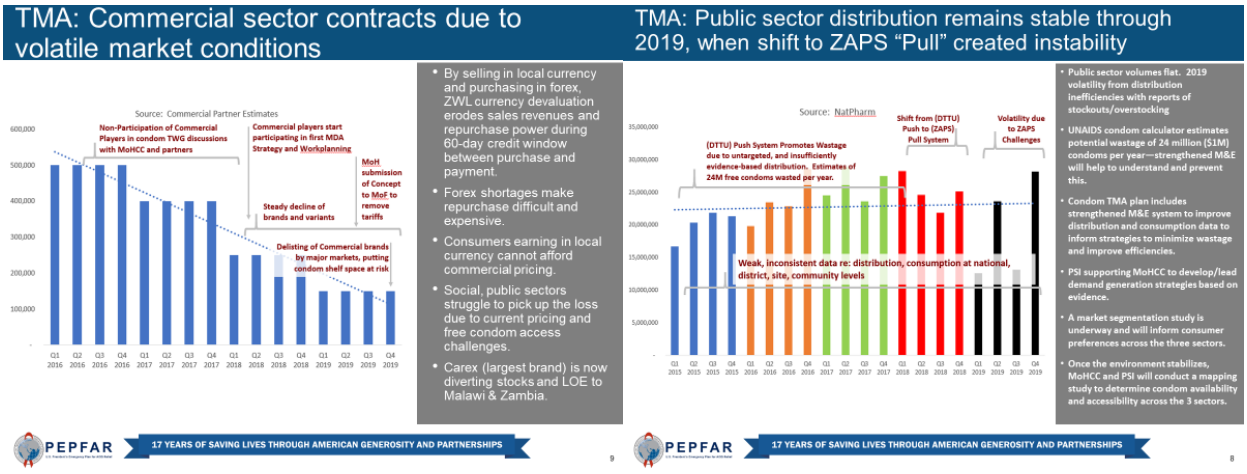
In 2014, a study conducted in Zimbabwe revealed that only half of patients received IPT due to inadequate advocacy, community sensitization, formally trained staff, education and communication materials, and IPT stocks. Planning for and addressing each of these components will be critical for successful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

**4.3 Prevention, specifically detailing programs for priority programming:**

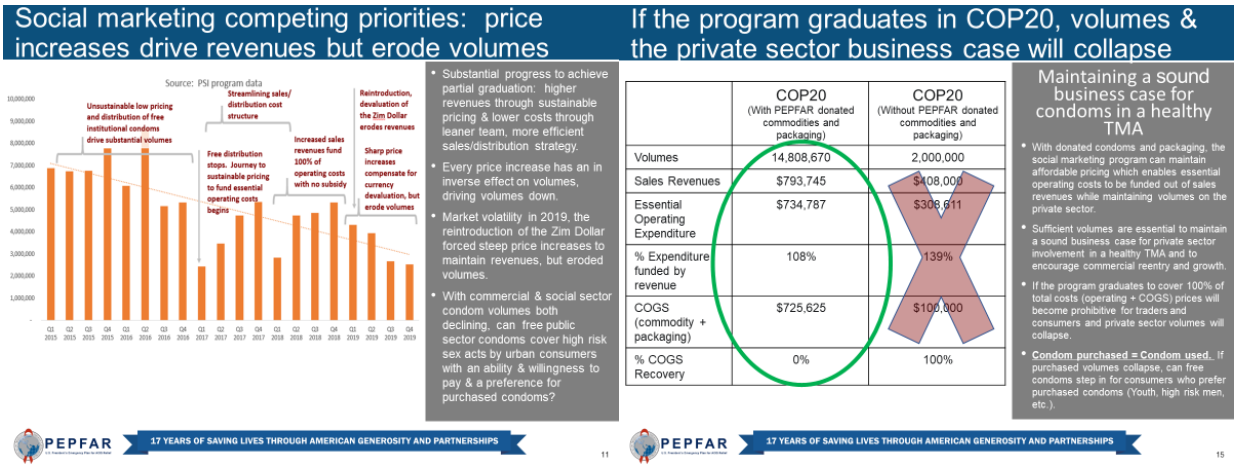
HIV prevention for priority populations is a key strategy in COP 20, with prevention activities tailored to specific populations being delivered through the VMMC, DREAMS, Key Populations (KP) and OVC platforms, as well as through HTS, PMTCT and ART services. Targeted priority populations include adolescent girls and young women (AGYW) between 15-24 years old, children (through prevention of vertical HIV transmission), sex workers, men who have sex with men, transgender women, and men under the age of 30, with a focus of linking this group to HTS and VMMC. In addition, in COP 20 there will be continued focus on primary prevention of sexual violence and HIV for adolescent boys and girls 9-14 years old through the OVC and DREAMS initiatives.

As part of the COP 20 development process, PEPFAR conducted a detailed, data-driven analysis of availability, access, and sources of funding for condoms to determine specific needs for commodities and to assess the feasibility of transitioning aspects of the condom program to

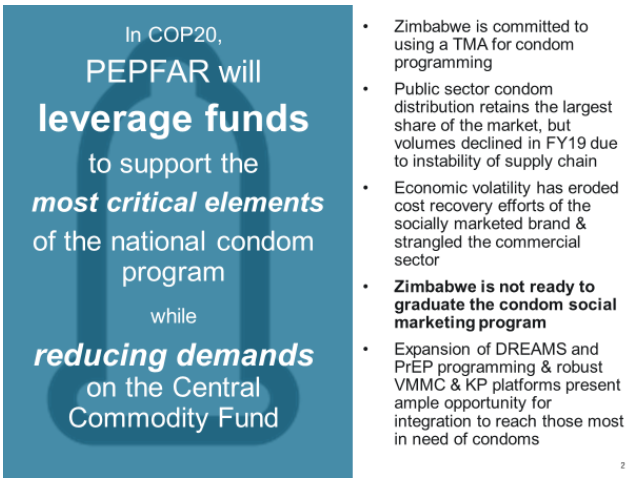
Government ownership. Zimbabwe has made significant strides in using a Total Market Approach for condom programming, with strong leadership by the MoHCC through high level advocacy efforts to improve market conditions for the commercial sector and advocacy to increase domestic financing for condoms. Despite those efforts, the share of commercial sector share to the condom market is shrinking (resulting from high inflation, reducing purchasing power of buyers) and there has been no commitment by Government to prioritize scare Forex to procure condoms going forward. Public sector condom distribution (currently funded 100% through PEPFAR) retains the largest share of the market, although volumes declined in FY19 due to temporary instability in the supply chain system.




While there has been substantial progress to achieve cost recovery of the Protector Plus Social Marketing program, with higher revenues and a more efficient sales/distribution strategy resulting in 100% of operating costs recovered by the end of 2018, Zimbabwe is not ready to graduate the social marketing program. The reintroduction of the "Zim Dollar" and high rates of inflation has made sustained cost recovery extremely difficult. If the program is forced to graduate in COP 20, prices will become prohibitive to consumers and volumes sold will collapse. With commercial and social sector condom volumes both declining, there is great over how urban consumers, with an ability, willingness and preference to pay, will access condoms to cover high risk sex acts.



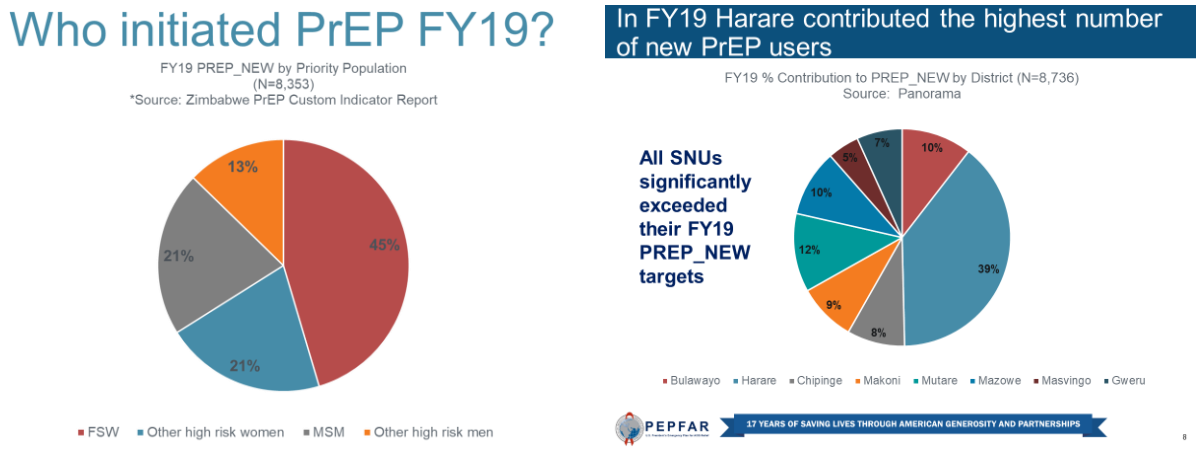
In COP 20 PEPFAR will leverage new Global Fund commitments, increase its COP contribution by 186% in order to decrease reliance on the Central Commodity Fund, while continuing to support the most critical elements of the national condom program. PEPFAR will continue to source male and female condoms and personal lubricants for distribution through public sector and program service delivery points, as well as for sale through the Protector Plus social marketing program (male condoms only). While PEPFAR will provide the commodities and packaging, the condom social marketing program will partially graduate, funding 100% of its operating costs through sales revenues, while maintaining affordable pricing to drive volumes, maintain shelf space and promote commercial sector re-entry. PEPFAR will continue to integrate condom education and distribution in and around all clinical touchpoints and strengthen targeted community-based distribution for high risk men, KP and AGYW. Finally, PEPFAR will continue to work closely with the MoHCC and the National Condom TWG to address regulatory impediments to market growth, ownership, stewardship and sustainability of the condom program, including domestic sources, beyond COP 20.



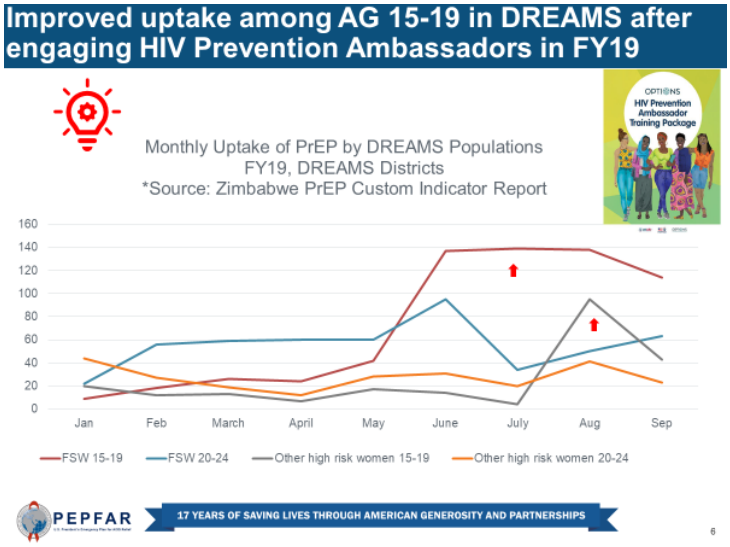

### a. Pre-exposure Prophylaxis (PrEP) for Priority Populations

The National PrEP Implementation Plan (2018-2020) identifies the following priority populations for PrEP: female sex workers (FSW), sero-discordant couples (SDC), men who have sex with men (MSM), AGYW 15-24 and pregnant and breastfeeding women. To date, PrEP has been delivered through New Starts Centers, Gender-Based Violence (GBV) clinics, public sector sites, Family Planning (FP) clinics and youth drop in centers. In 2019 the MoHCC scaled out PrEP training to public sectors sites in 31 priority districts.

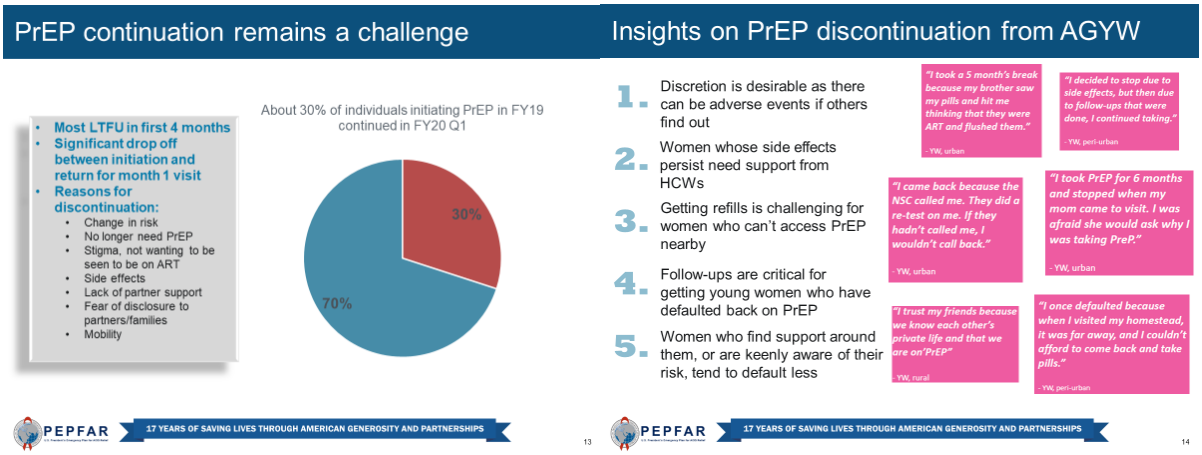
To date PEPFAR support for PrEP rollout has concentrated on AGYW (as part of DREAMS), FSW and MSM (as part of the KP program). The program initiated a total of 8,736 individuals on PrEP, reaching 265% of the FY 19 target. Uptake continued to be strong among MSM, FSW and other high-risk women, with Harare contributing the largest proportion of new on PrEP.




In the second half of FY 19 PEPFAR introduced the HIV Prevention Ambassador training package in DREAMS districts which contributed to increased uptake of PrEP among AG 15-19—a population that demonstrated lower demand in the past. This model will be expanded throughout DREAMS and to YW 20-24 in COP 20.




Despite improved uptake of PrEP among priority populations, continuation remains a challenge, with most discontinuation occurring in the first 4 months. The program routinely collects reasons for discontinuation for those individuals that can be traced, as depicted in the figure below, with AGYW facing unique challenges (insights from 'V' immersions). These findings point to the need for innovations and customized service delivery and retention approaches that meet the needs of different populations.



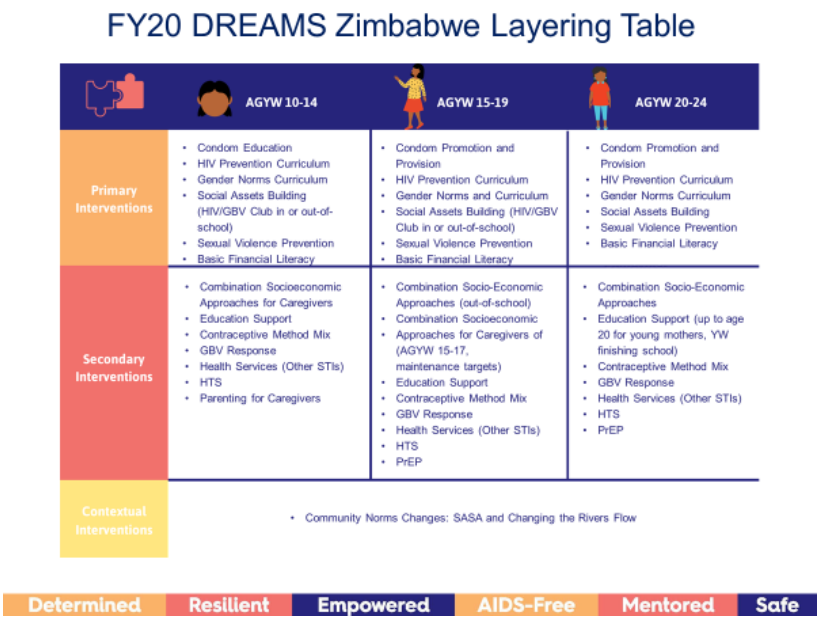

In COP 20 PEPFAR will expand PrEP for priority populations to 22 districts, delivering PrEP to 28,604 clients and increasing the number of new initiations by 177% increase from COP 19. PEPFAR will continue to expand coverage among KP and AGYW, capitalizing on the increased geographic footprint of DREAMS, and support service delivery for SDCs and pregnant and breastfeeding women. The COP 20 strategy for PrEP is summarized as follows:

- Strengthening PrEP integration across clinical entry points (ANC, OI/ART, STI and FP) and community platforms (DREAMS, KP). Ensure providers are trained in LIVES.
- Support public sector roll out of PrEP in high volume sites by reviewing patient flow and risk screening processes for different entry points; strengthening M&E tools, data capture, documentation; supporting clinical mentoring and patient navigation where needed.
- Communication efforts to increase demand and 'normalize' PrEP, as well as for PrEP literacy for PrEP users.
- Offer a mix of client-centered approaches to enable service delivery and improve continuation, including PrEP delivery through KP Drop-in Centers and mobile SW clinics, mobile PrEP refills integrated with community SRH, index testing, defaulter tracking, ART refills and VL sample collection.
- Utilize HCD approaches to better understand discontinuation especially among AGYW and KP; introduce PrEP readiness assessment tools; develop and implement SOP for more intensive, peer led support during first three months.

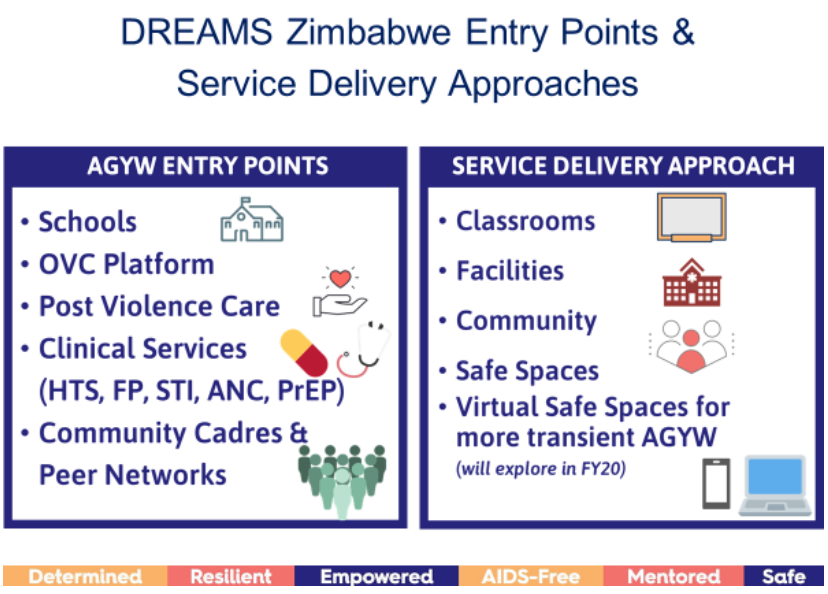
| COP 20 PrEP Targets by Population | COP 20 PrEP_NEW | COP 20 PrEP_CURR |
|---|---|---|
| AGYW 15-19 | 2,990 | 3,665 |
| AGYW 20-24 | 3,149 | 4,335 |
| Pregnant Women | 2,735 | 2,735 |
| Breast Feeding Women | 3,222 | 3,564 |
| FSWs | 5,770 | 7,593 |
| MSM | 2,913 | 4,694 |
| Transgender Women | 168 | 168 |
| Serodiscordant Couples | 1,850 | 1,850 |
| ***Total PrEP Targets*** | **22,797** | **28,604** |

**b. HIV Prevention and Risk Avoidance for AGYW and OVC**

In FY 20 PEPFAR updated its DREAMS Layering Table that documents the primary, secondary and contextual interventions currently provided through the program in the 6 current districts.




Vulnerable AGYW targeted through DREAMS include young women selling or trading sex (YWSS), out-of-school girls aged 15-24 years, GBV survivors, OVC and their caregivers. In addition, comprehensive sex education (CSE) programs reach both girls and boys in primary (begun in FY 19) and secondary schools (focus is on form 1 and 2). Regardless of the entry point, AGYW are assessed for risk and referred for other DREAMS services according to minimum service packages defined by sub-population, using standard tools and referral procedures. The program employs a DHIS-2 database with a unique identifier code (UIC) system to track individuals, layered services and referrals.

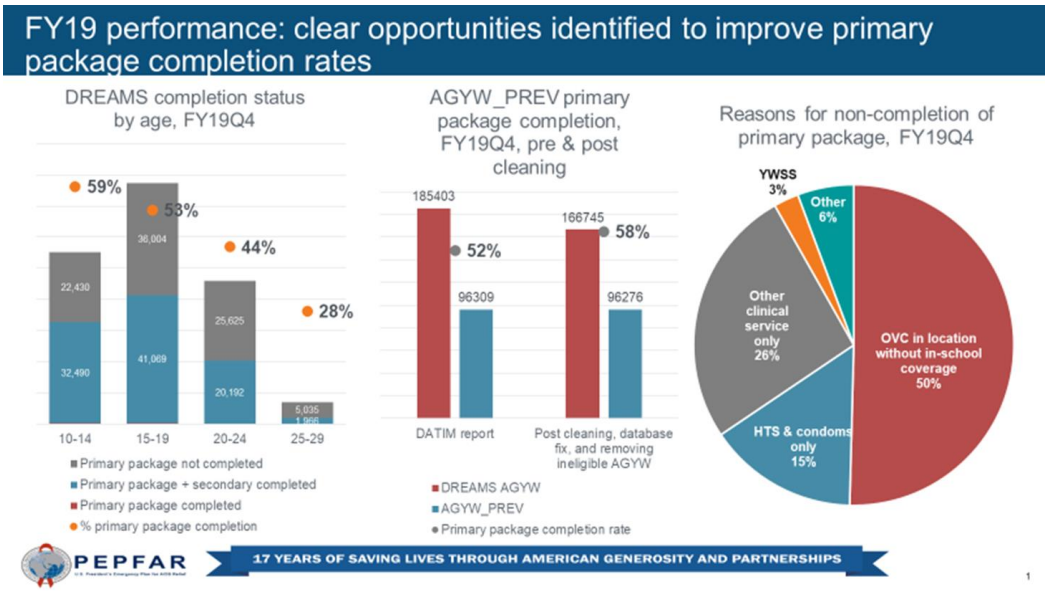



DREAMS is coordinated by the NAC structure at the national, provincial and district levels, to ensure broad participation by the different sectors, service providers and stakeholders. PEPFAR supports DREAMS Coordinators at the central levels of the MoHCC and NAC whose strong leadership has been essential for coordinating a complex, layered program, and advocating for the expansion of DREAMS activities. PEPFAR is supporting knowledge transfer through the sharing of systems, guidelines and tools to stakeholders and partners implementing "DREAMS-like" activities with Global Fund assistance. In COP 20 this collaboration will continue and deepen to include joint technical reviews and technical consultation, particularly in the areas of approaches to the prevention of sexual violence and HIV and M&E.

PEPFAR employs a standardized approach to partner management in DREAMS. PEPFAR reviews DREAMS performance data, against custom and MER indicators, on a monthly basis, and layering data quarterly. The MoHCC facilitates monthly DREAMS partner meetings at a national level to

review progress and address implementation challenges. At the district level, NAC coordinates quarterly review meetings and the PEPFAR Point of Contact (POC) partner bi-weekly referral meetings and monthly implementation meetings.

In FY 19, PEPFAR provided services to 157,623 AGYW 10-24 in six focus districts implementing DREAMS. In FY 19 completion of the primary package was highest among AG 10-14 as compared to other age groups but still sub-optimal. PEPFAR conducted a deep dive to understand factors contributing to non-completion. In addition to data quality issues, the reasons for non-completion of the primary package include incomplete geographic coverage of the in-school program targeting 10-14 (FY19 was the first year of implementation); inconsistent referrals from clinical service providers to primary package providers; and nuances in the primary package for young women selling sex (YWSS) which the DREAMS database is not yet able to capture in AGYW_PREV reporting.



In FY 20 Q1, PEPFAR carried out a saturation analysis in the current six districts. The process included generating different vulnerability estimates by age band and SNU, reviewing DREAMS cohort vulnerability data, determining estimates of the number of AGYW who have completed DREAMS as a program (using AGYW_PREV, triangulate with program data) and developing saturation scenarios based on these different criteria. According to this initial analysis, PEPFAR determined that saturation was achieved for AGYW 15-19 and 20-24 in all districts, but more time is needed to focus on AG 10-14. PEPFAR anticipates conducting saturation analysis on an annual basis and continuing to refine the process as the DREAMS database is strengthened to track more nuanced information on individual vulnerability, needs and completion of corresponding secondary services.

## Saturation achieved for 15-24s in all SNUs; more time needed to focus on 10-14s

Achieved saturation of AGYW 15-19 and 20-24 in all districts

Coverage among 10-14 is lower due to later emphasis (beginning in FY19) on this age group & incomplete geographic footprint

Using the highest estimate of vulnerability, we did not reach saturation among 10-14s in any district by end FY19

| District/ age band | Highest vulnerability estimate completion ITD | Second vulnerability estimate completion ITD | Third vulnerability estimate completion ITD | Fourth vulnerability estimate completion ITD |
|---|---|---|---|---|
| **Bulawayo** | | | | |
| 10-14 | 66% | 87% | 146% | 154% |
| 15-19 | 100% | 115% | 127% | 194% |
| 20-24 | 129% | 140% | 210% | |
| **Chipinge** | | | | |
| 10-14 | 34% | 39% | 67% | 74% |
| 15-19 | 113% | 122% | 172% | 174% |
| 20-24 | 164% | 179% | 181% | |
| **Gweru** | | | | |
| 10-14 | 41% | 50% | 68% | 71% |
| 15-19 | 119% | 134% | 177% | 196% |
| 20-24 | 139% | 152% | 165% | |
| **Makoni** | | | | |
| 10-14 | 42% | 46% | 57% | 97% |
| 15-19 | 112% | 118% | 163% | 167% |
| 20-24 | 146% | 159% | 166% | |
| **Mazowe** | | | | |
| 10-14 | 36% | 38% | 97% | 106% |
| 15-19 | 94% | 98% | 158% | 164% |
| 20-24 | 138% | 150% | 152% | |
| **Mutare** | | | | |
| 10-14 | 40% | 43% | 75% | 88% |
| 15-19 | 112% | 117% | 166% | 170% |
| 20-24 | 155% | 169% | 169% | |

PEPFAR 17 YEARS OF SAVING LIVES THROUGH AMERICAN GENEROSITY AND PARTNERSHIPS

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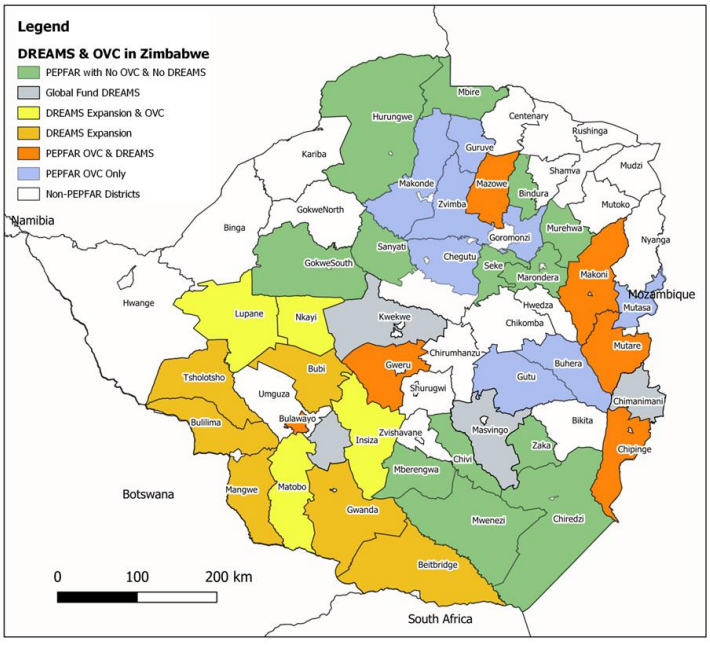
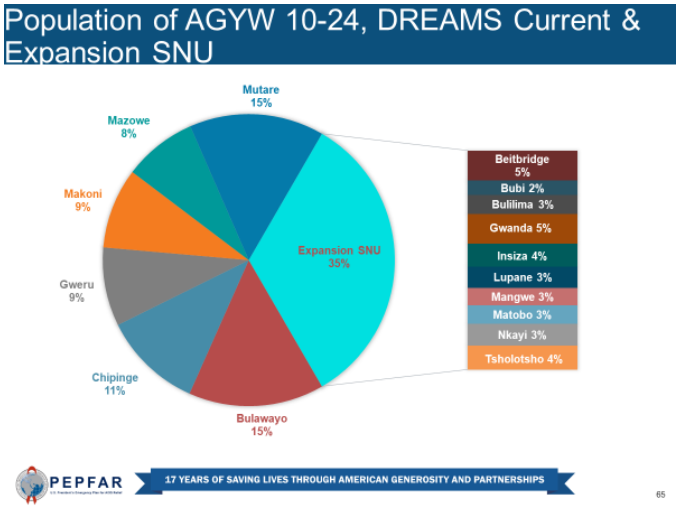
In COP 20 PEPFAR will expand AGYW prevention programming to 10 new districts in Matabeleland North and South provinces, bringing the successful DREAMS program to a total of 16 districts in Zimbabwe. The 10 new districts were ranked as very high according to the 2019 UNAIDS Incidence Classification for AGYW 15-24, and do not currently have DREAMS or Global Fund AGYW programs. In COP 20, PEPFAR will extend the full package of DREAMS services to these districts with the goal of reaching 40% of vulnerable AGYW with the primary package relevant for her age group.



In the current 6 districts, PEPFAR will implement a partial maintenance scenario, focusing on a smaller proportion of the most vulnerable AGYW in the 15-19 and 20-24 age groups, while extending geographic coverage of the primary package to reach a higher proportion of AG 10-14. The 10 new districts represent 35% of the total population of AGYW in the 16 DREAMS districts — an important point of reference when considering targets and resource allocations, even in a partial maintenance scenario. To support this ambitious expansion, PEPFAR will hire a USG DREAMS Coordinator, leverage and strengthen legacy coordination and M&E systems and, through DREAMS POC implementing partners, engage DREAMS Ambassadors to support coordination in each district.

COP 20 strategic priorities for DREAMS are summarized below:

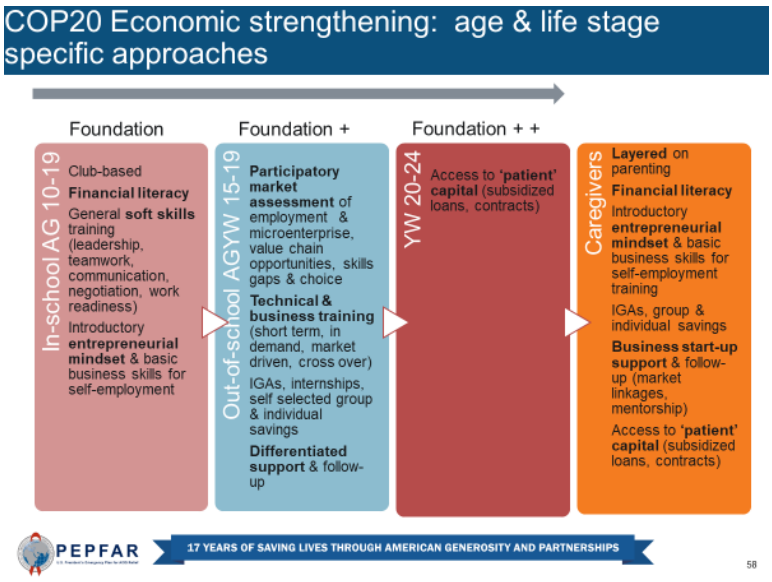



- Reframe DREAMS enrolment and monitoring pathways including alignment of HIV risk and vulnerability screening tools with COP 20 standard DREAMS eligibility criteria, strategically consolidating DREAMS enrolment function with selected IPs, strengthening SOP for identifying vulnerable AGYW through clinical entry points, updating DREAMS referral protocol, and assigning clear roles and responsibilities for IPs responsible for monitoring completion of the primary package and DREAMS as a program.

- Overhaul data entry, analysis and reporting workflows of the DREAMS DHIS2 database to enable capture of DREAMS eligibility and HIV risk and vulnerability factors, enhance individual level monitoring of completion of the primary package and completion of DREAMS as program, and to facilitate accountability of IPs.

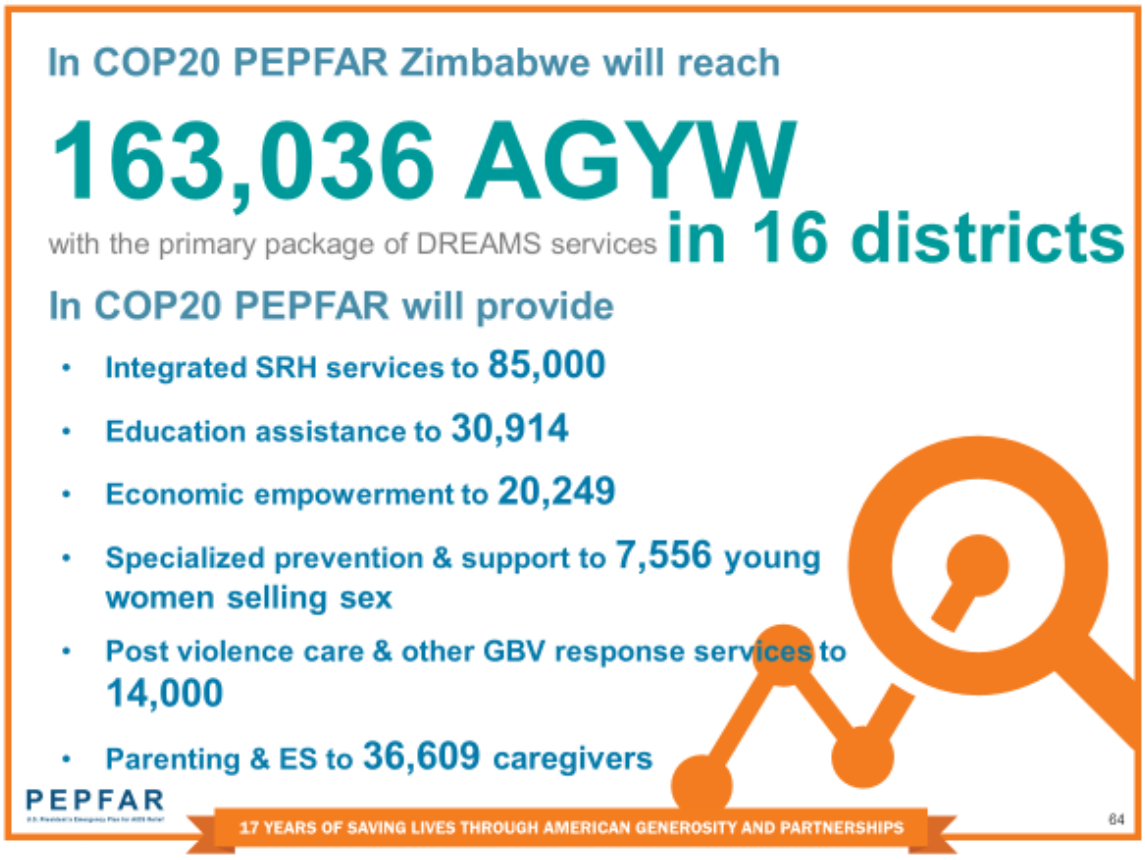
- Increase the depth and breadth of services for YWSS to improve retention in DREAMS over time, including scaling up a YWSS specific self-help approach; extending the Drop-In Center model to improve access to physical safe spaces; expanding microplanning as a tool for identifying different segments of YWSS, including non-self-identifying SW, and sustaining contact with them; continuing to offer differentiated service delivery approaches for STI, FP, HTS and PrEP services; exploring feasibility of an online virtual safe spaces model for mobile YW and YWSS.

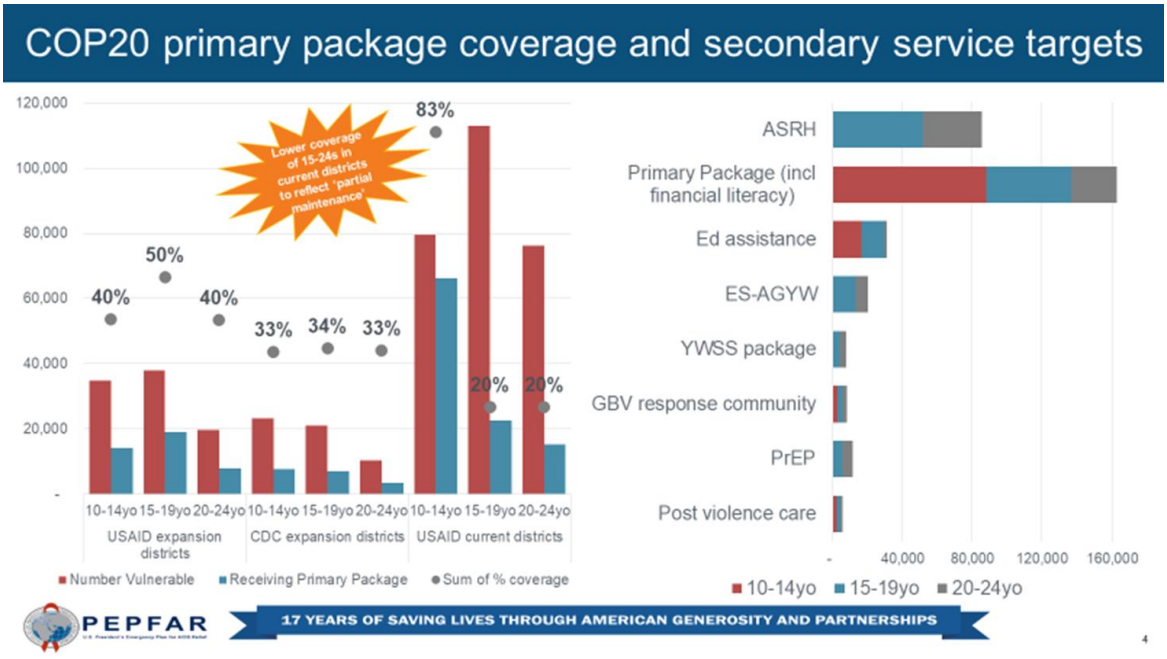
Revamp the economic strengthening approach: engage specialized technical assistance and build on the Zimbabwe Employment Market Opportunities Assessment and Siyakha pilot to review, update and standardize ES curricula; conduct market assessments; expand empowerment pathways; provide recoverable, in-kind starter packs where possible; offer differentiated support by age and life stage.




- Improve access to quality, integrated SRH: STI screening and treatment, contraceptive method mix, HTS, PrEP, condom promotion and distribution, menstrual health management) and post violence care services through community models and adolescent-friendly public sector options. Strengthen processes at clinical entry points to identify and refer eligible AGYW for DREAMS enrolment.
- Roll out training in LIVES for DREAMS facilitators and service providers.
- Ambitious scale up of PrEP, including provision of a robust PrEP support platform for AGYW in DREAMS districts.

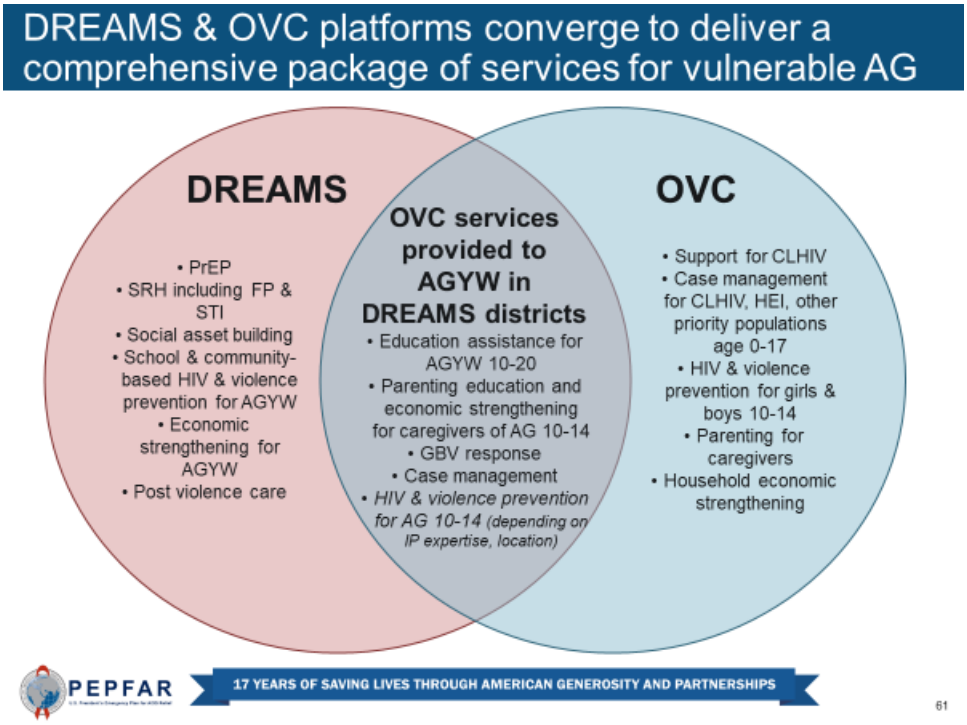
COP 20 DREAMS targets for the primary package and key secondary services are shown below.


In COP20 PEPFAR Zimbabwe will reach
163,036 AGYW
with the primary package of DREAMS services in 16 districts
In COP20 PEPFAR will provide
• Integrated SRH services to 85,000
• Education assistance to 30,914
• Economic empowerment to 20,249
• Specialized prevention & support to 7,556 young women selling sex
• Post violence care & other GBV response services to 14,000
• Parenting & ES to 36,609 caregivers
PEPFAR
17 YEARS OF SAVING LIVES THROUGH AMERICAN GENEROSITY AND PARTNERSHIPS
84


COP20 primary package coverage and secondary service targets
120,000
100,000
80,000
60,000
40,000
20,000
-
Lower coverage of 15-24s in current districts to reflect 'partial maintenance'
40%
50%
40%
33%
34%
33%
83%
20%
20%
10-14yo 15-19yo 20-24yo 10-14yo 15-19yo 20-24yo 10-14yo 15-19yo 20-24yo
USAID expansion districts
CDC expansion districts
USAID current districts
Number Vulnerable
Receiving Primary Package
Sum of % coverage
ASRH
Primary Package (incl financial literacy)
Ed assistance
ES-AGYW
YWSS package
GBV response community
PrEP
Post violence care
- 40,000 80,000 120,000 160,000
10-14yo
15-19yo
20-24yo
PEPFAR
17 YEARS OF SAVING LIVES THROUGH AMERICAN GENEROSITY AND PARTNERSHIPS
4

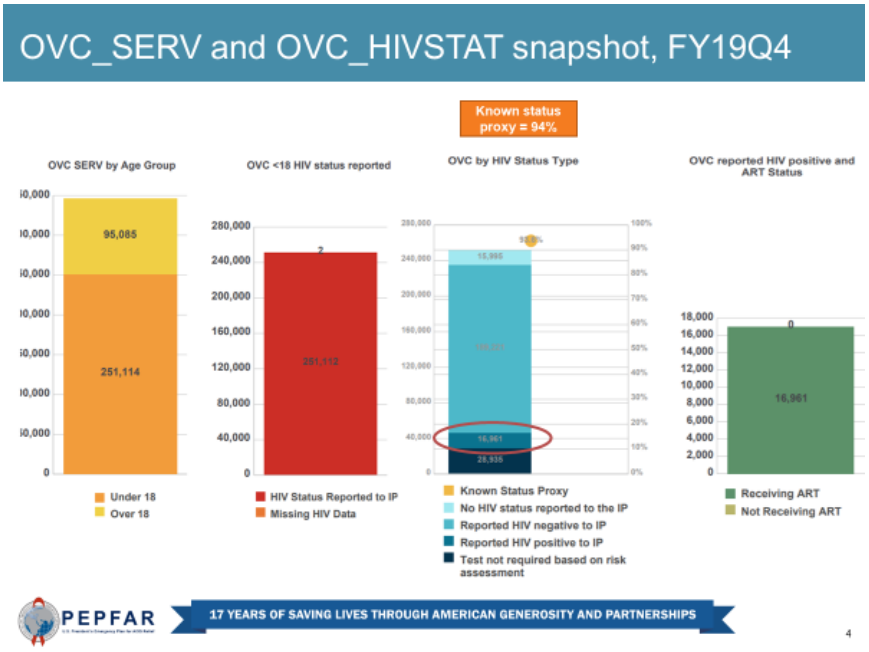
HIV prevention strategies for male partners of AGYW, including VMMC, targeted HTS and linkage to ART or PrEP and access to condoms, will continue to be fundamental in DREAMS districts. Additionally, the DREAMS core package includes community norms change activities (Changing the Rivers Flow, SASA) to increase understanding and engagement on sexuality, gender and masculinity, sexual and reproductive health and violence among traditional and religious leaders, as well as evidence-based parenting interventions (Families Matter Program, Sinovuyo) which also have strong sexual violence prevention components for caregivers of AG 10-14. PEPFAR will continue to use program data to understand the demographic characteristics of men who test HIV positive, as well as the type of partnerships/relationships they engage in, and venues where they can be reached with services.

PEPFAR will deliver HIV and sexual violence prevention education to adolescent boys and girls age 9-14, who participate in the CSE general assembly and teacher-led classroom sessions in schools supported through the DREAMS platform. The curriculum and companion materials were revised based on the PEPFAR curricula review process and now include the 3 PEPFAR Modules on Sexual Violence Prevention. Furthermore, leveraging COP 19 FCI investments, PEPFAR will continue to implement two additional evidence-based approaches: Coaching Boys to Men and IMPOWER for adolescent boys and girls age 9-14.

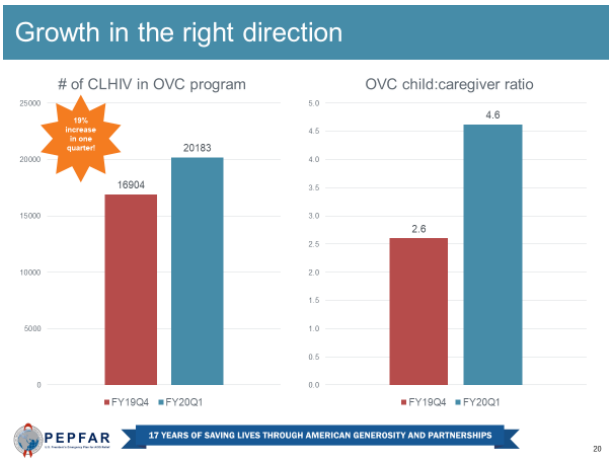


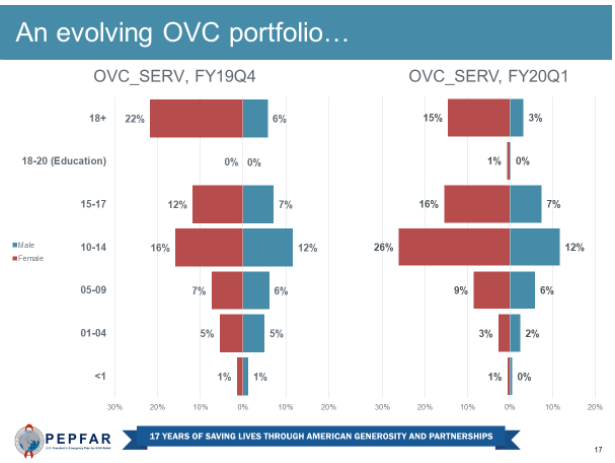

In COP 20 DREAMS will continue to leverage the OVC platform to ensure female OVC who meet the DREAMS eligibility criteria access the full DREAMS package and AGYW (including their young children) identified through other DREAMS entry points access OVC services as required. Key DREAMS-OVC collaborative activities in COP 20 include continued joint planning, implementation, and monitoring of DREAMS-OVC activities; aligning approaches for sexual violence and HIV prevention for adolescents and engagement with faith communities; and coordinating enhancements to the economic strengthening portfolio.

In FY 19 PEPFAR reached about 350,000 individuals in the OVC program, of which 250,000 were under the age of 18. Significant progress has been made in rolling out systematic HIV risk screening, ensuring children who need testing access it, documenting HIV status, reducing the proportion of children with unknown HIV status and linking HIV+ CLHIV to ART. By the end of FY 19 the known status proxy was 94% and of those self-reporting an HIV+ status, 100% were on ART.

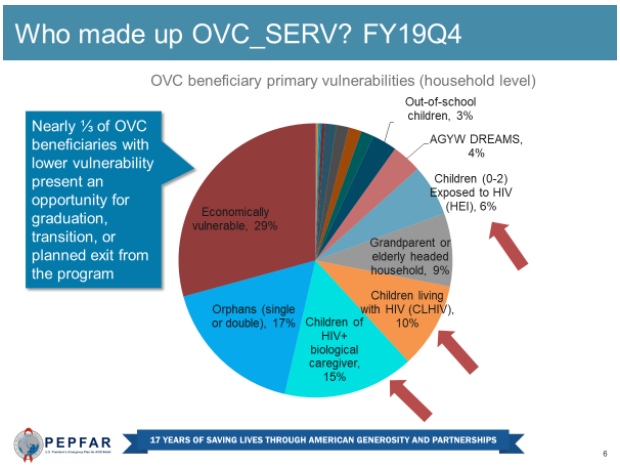


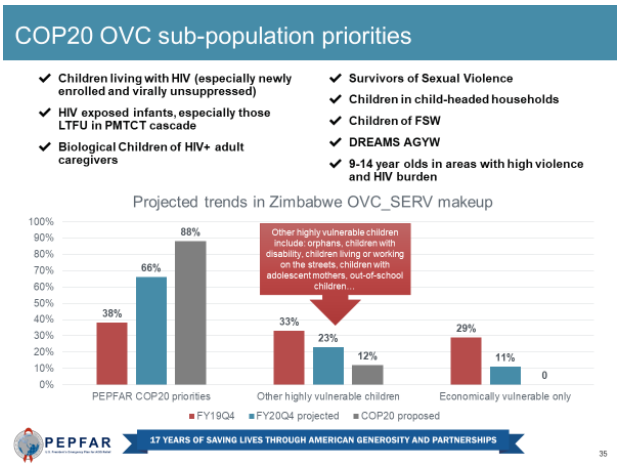

In late FY 19 and FY 20 Q1 PEPFAR carried out a caseload analysis to better understand vulnerability characteristics of the current OVC caseload, assess the current coverage of CLHIV in the OVC districts and monitor the status of planned age and sub-population pivots. The charts below demonstrate some progress in the number of CLHIV enrolled in the OVC program, which will continue to be a priority throughout FY 20. In addition, the analysis demonstrated an increasing OVC child to caregiver ratio and larger proportions of females in the 10-14 and 15-17 age groups making up the OVC caseload.



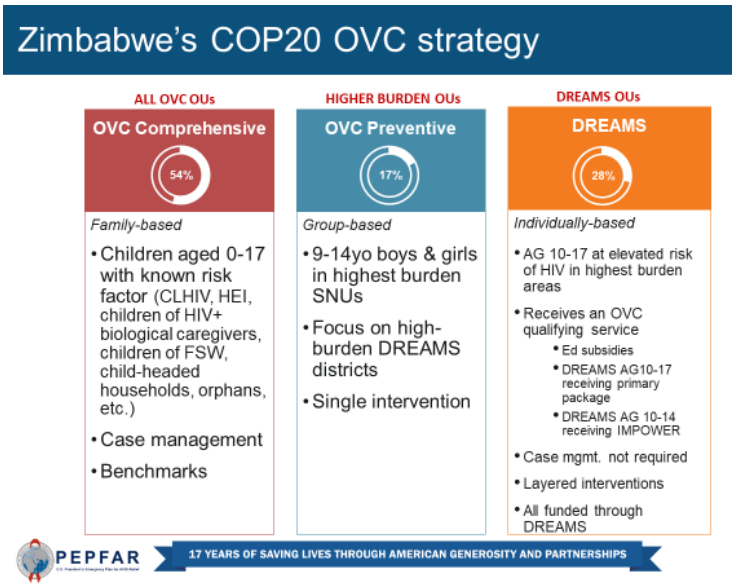
In FY 19 Q4, PEPFAR worked closely with OVC partners to redefine priority sub-populations based on risk of HIV acquisition and vulnerability to poor HIV outcomes. This process paved the way for alignment with the COP 20 guidance on OVC priority populations. The chart below shows the primary vulnerabilities of OVC enrolled in the program at the end of FY 19. When compared with the COP 20 guidance, it shows that nearly one third of beneficiaries (those who are primarily economically vulnerable) represent an opportunity for graduation, transition or planned exit from the program.




In COP 20 the OVC program will undergo a fundamental shift to respond to the changing epidemic in order to increase coverage of CLHIV and HIV exposed infants and channel scarce resources to other, specifically defined groups of highly vulnerable children and their caregivers.

The PEPFAR Zimbabwe OVC strategy will be delivered through three operational buckets (Comprehensive, Preventive and DREAMS) to reach at total of 451,010 children and caregivers in COP 20.




**OVC Comprehensive**

- 53,542 CLHIV and their caregivers
- 17,272 HIV-exposed infants and their caregivers
- 122,503 sexually or physically abused children, children of FSW, children in child-headed households, and children of HIV+ biological caregivers who are at risk of default + caregivers
- 51,939 other highly vulnerable children (orphans, children living with disability, out of school children, etc.) + caregivers

**OVC Preventive**

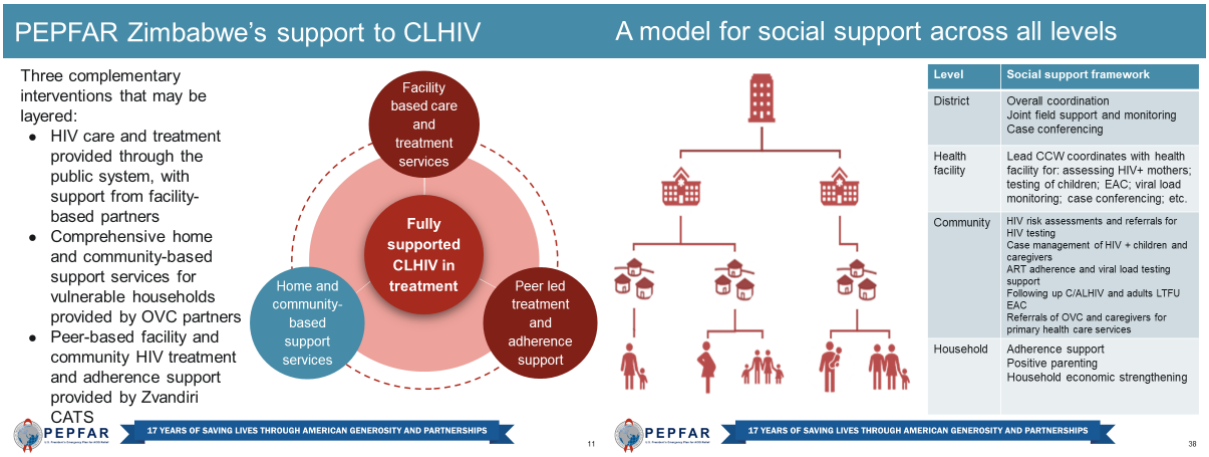
- 78,527 children 9-14 with evidence-based sexual violence prevention
- Plus, others in OVC comprehensive who will also receive this service

**DREAMS**

- 127,227 DREAMS AGYW
- Including 87,954 who will receive sexual violence prevention

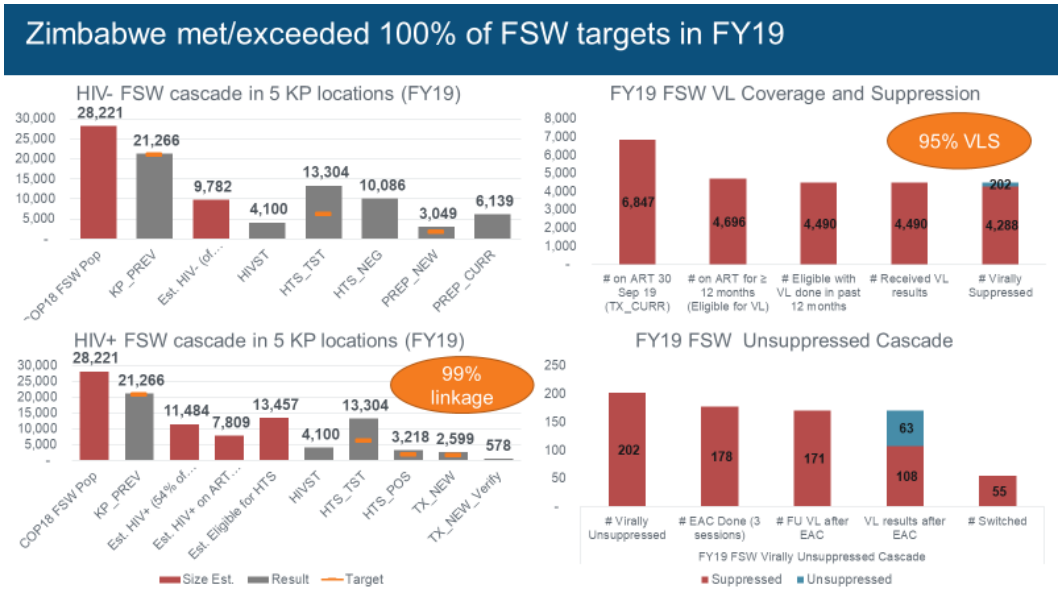
### c. Children / PMTCT

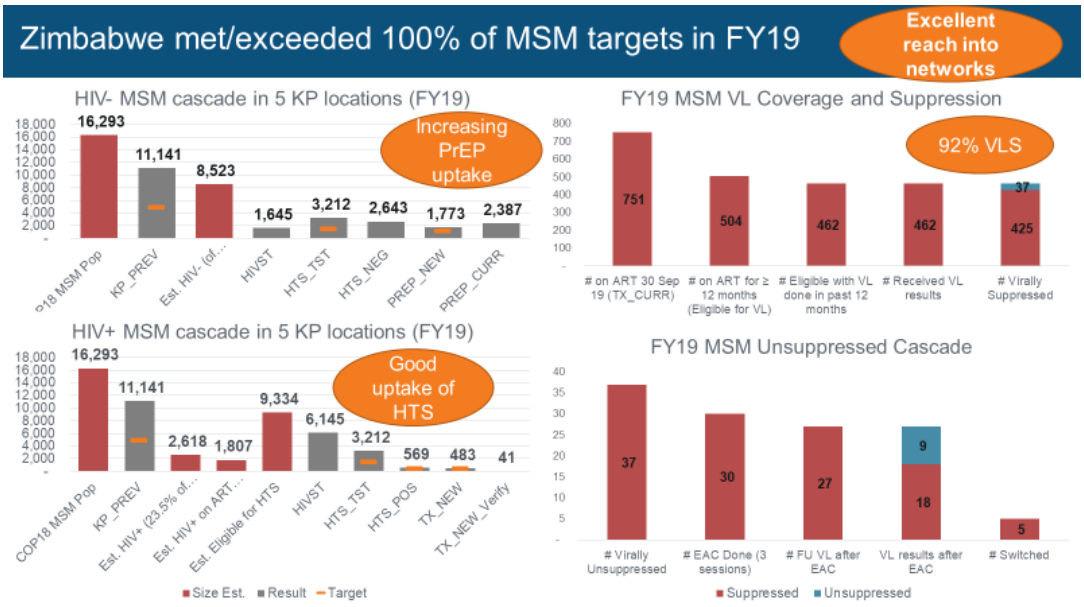
By the end of COP 20 PEPFAR will support 90% of CLHIV in the 21 OVC focus districts by ensuring at least 80% coverage of CLHIV in all health facilities within the OVC coverage areas. Currently, 100% of health facilities in OVC catchment areas are covered by MOUs granting the implementing partner permission to work within the facilities. The Draft Community-Clinic Linkage SOP will be finalized and utilized to refine these agreements and IPs will employ case managers at all high-volume clinics to ensure smooth coordination and referrals between health care workers and community case workers. In COP 20 PEPFAR will continue to assess HIV+ women in adult care who are pregnant and/or have children age 0-17 to determine if their families should be enrolled in the OVC program. PEPFAR will continue to conduct home visits to all enrolled OVC to encourage HIV testing (if indicated based on risk assessment), including for children lost to follow up in the PMTCT cascade.



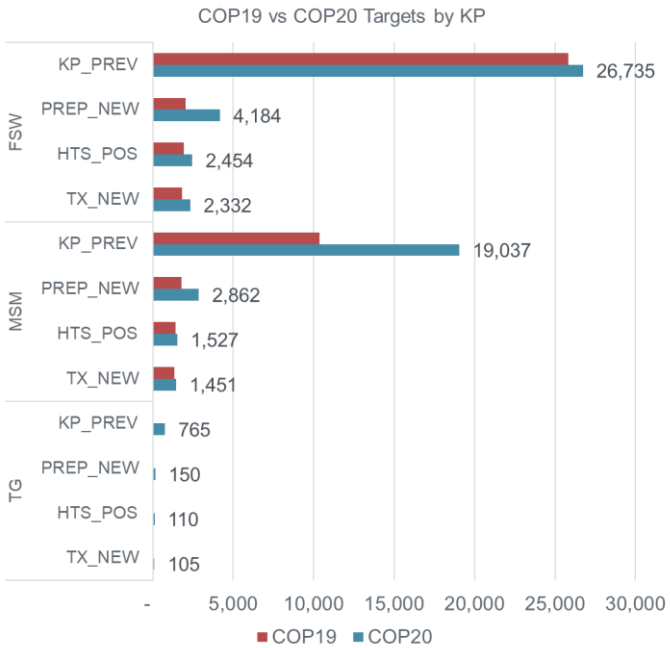

### d. Key Populations

PEPFAR continued to demonstrate strong performance in the Key Populations (KP) program in FY19, meeting or exceeding all targets for FSW and MSM in the 5 focus KP SNUs as demonstrated in the charts below.






In COP 2020, PEPFAR will expand quality, client-centered approaches for HIV prevention, treatment and retention for KPs, to reach 80% of FSW and 70% of MSM in the 6 largest urban districts in the country (Harare, Chitungwiza, Bulawayo, Gweru, Mutare, and Masvingo). Additionally, PEPFAR will initiate dedicated programming for transgender (TG) women. PEPFAR will work hand in hand with the KP community to address challenges to service uptake and retention and to meet KP where they are with services that meet their needs. A summary of the COP 20 targets in the six focus districts, and how they compare to COP 19 targets for the same locations, can be found in the chart below. Note targets for YWSS in non-KP focus districts are not captured below (refer to the DREAMS narrative above).



COP 20 strategic priorities for the KP program are summarized below:

- Scale up HIV prevention and risk reduction services through a) leveraging the expanding DREAMS footprint and microplanning to identify and engage FSW and non-self-identifying YWSS; b) expanding community mobilization and outreach to reach new networks of MSM and TG women; c) using HCD approaches to identify additional client centered models to support retention on PrEP; d) investing in demand creation for PrEP and PrEP literacy materials for different KP groups; e) distribution of male and female condoms and lubricants.

- Offer client-centered, DSD models meeting KP where they are with what they need: a) leverage GF DICs and DREAMS safe spaces, as well as mobile/moonlight services, New Start Centers, Sister's clinics, self-help groups and KP friendly public sector sites; b) offer starter-packs for SDART at non-treatment sites and ART & PrEP initiation and dispensation at DICs and other mobile sites; c) ensure six-monthly MMD; d) roll out VL DBS collection and integration at community points and KP DICs; e) scale up the KP DSD Assistant model and treatment literacy to support adherence, retention and defaulter tracking at community level; f) create linkages between Clinical centers offering HTS and KP serving/KP led organizations for continued support to improve retention.

- Offer a range of quality, safe HTS options including HIVST, provider delivered testing, social network testing for KP and their sexual partners. Re-orient HCWs in index testing procedures and principles of client choice and do no harm and ensure all HCWs are trained in LIVES. Educate HCWs on KP identity including needs of TG. Conduct a Joint review of existing SOPs for HTS and Linkage to include scripts/language and attention to the four partner notification modalities. Ensure all in the KP program complete the PEPFAR certification process for index testing.

- Scale up access to complementary services including community case management and microplanning for both prevention and treatment through KP Led and KP competent CBOs. Roll out clinical enquiry for GBV in KP clinical service delivery points and improve access to violence prevention and response services, including legal literacy & assistance for KP (linking to GF supported activities). Integrate feasible models for mental health/PSS, such as the Friendship Bench. Ensure children of KP are linked to OVC services and young women selling sex are linked to DREAMS where these platforms are geographically co-located with the KP program.

- Strengthen the quality of services at KP friendly public sector sites through a) supporting fully functioning health center management committees with KP representation; b) carrying out trust building activities between HCWs and KP communities; c) ensuring full time patient navigators at all targeted facilities; d) strengthening M&E across service delivery modalities, and using UICs and custom indicators to monitor KP programming.

- Implement KP community-led monitoring guided by a jointly developed SOP, with feedback loops at all relevant levels (service delivery points, KP Forum, TSC, PEPFAR CSO Core Group). Link internal KP program monitoring processes to the PEPFAR community

monitoring small grants program. Improve adverse events monitoring and communicate reporting process clearly through all touchpoints with KP communities and clients. Continue to support decentralization of KP forum to all KP focus districts.

- Leverage KPIF Year 2 investments for 1) cross-border sex worker services and Sisters Clinics and 2) support to the National Technical Support Committee (TSC) to strengthen quality, capacity and sustainability of the national KP program, including harmonization of investments and activities across funding partners. The TSC will coordinate and strengthen programming for all KP group. Learning from the cross-border sex worker and Sisters Clinics will be applied over time to expand activities to other KP groups such as MSM and TG.

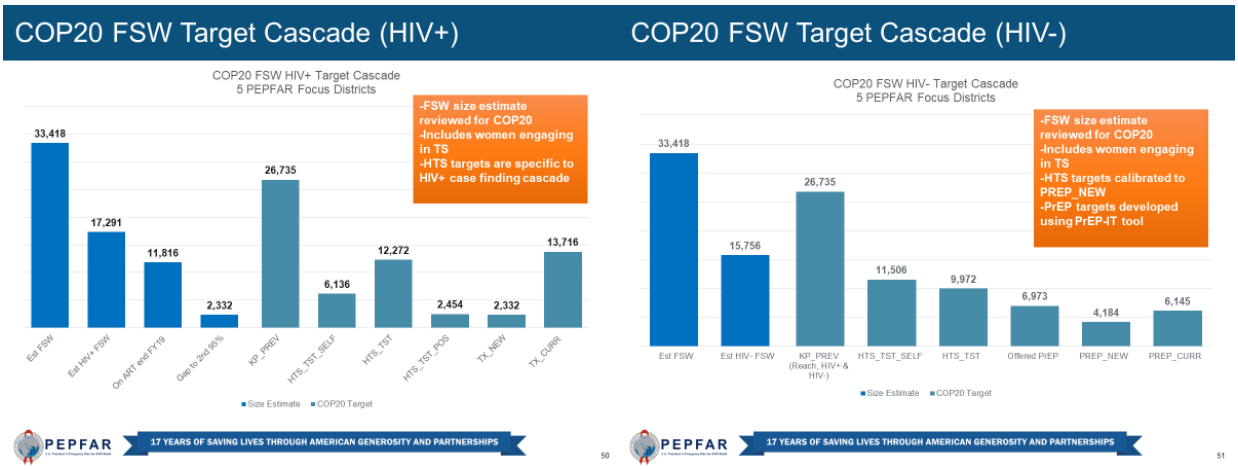
- As in past years, collaborate closely with the Global Fund to leverage investments for KP and ensure activities are complementary and not duplicative.

A variety of entry points including outreach, social networking, peer educators and mobilization to promote service uptake at KP friendly locations will continue to be utilized to reach both self-identifying and 'hidden' FSWs who have had limited or no exposure to HIV services. Program and survey data suggest that 25-40% of FSW are less than 23 years old, with more than a quarter starting before age 20. Young FSWs report the highest numbers of unprotected sex acts with clients. HIV prevalence among young sex workers is approximately 30%, rising to nearly 80% among those over 40; prevalence rises with duration in sex work among young FSWs. In COP 20 PEPFAR will continue to support the Young Sisters program, which is a peer-based approach designed specifically to reach younger FSW. PEPFAR will leverage the expanding DREAMS footprint to expand microplanning to engage both young women selling sex (YWSS) and non-self-identifying younger FSW.

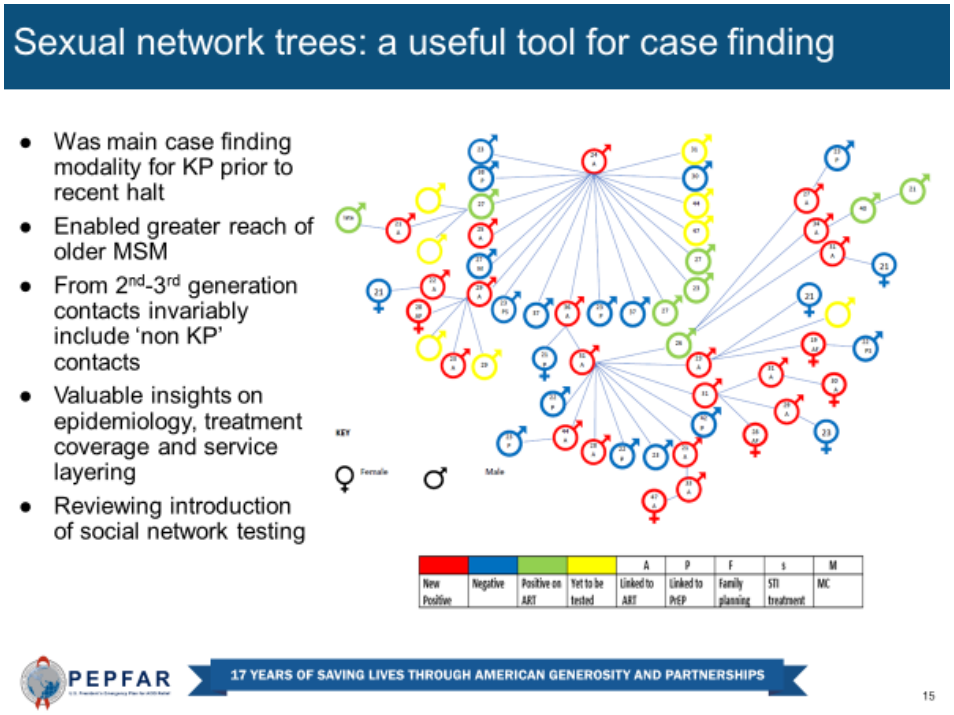
All HIV positive FSW will be enrolled on ART at public sector facilities, New Start Centers or Sisters Clinics (specialized SW clinics). Both New Start Centers and Sisters Clinics offer a one-stop shop for health care including HTS, STI services, FP and PrEP. New Start Centers also provide cervical cancer screening and LEEP, post violence care, ART, TB, and viral load monitoring. Continuous adherence and retention support are offered through the Sisters peer adherence support groups, which integrate both PrEP and ART. HIV prevention (male/female condom and lubricant distribution, risk reduction counseling, and referral for HIV/STI/SRH clinical services), is delivered through a peer education (PE) approach. Linkage between community and facility services, and follow up for FSWs, a challenge in the past, has improved with the roll out of unique identifier codes (UIC) and harmonized M&E tools. Detailed SOPs that define linkages between partners, and between PEPFAR and public sector services, have been developed.

Updated census and program data were used to recalibrate the FSW size estimates in the six PEPFAR-supported locations that focus on key populations, which account for approximately 55% of the total number of FSW nationally. On average 3% of females 15-49 were assumed to engage in SW and an additional 20% was added to account for women who do not self-identify or engage in transactional sex. ART coverage, PrEP uptake, and viral suppression rates were also considered when developing the target cascades. COP 20 targets were set to reach at least 80% in the six focus locations with the goal of attaining 95% ART coverage of HIV positive FSWs and at least 60% PrEP acceptance for the negatives. Importantly, COP 20 targets also assume full achievement of FY 20 targets, as well as continued transitioning of stable FSWs on ART to KP friendly public

sector sites. COP 20 targets for PrEP were set using the PrEP Implementer's Toolkit which considers national and program data on population estimates, risk, acceptance and continuation on PrEP, as well as scale up patterns, cost and capacity. In COP 20 PEPFAR will make a concerted effort with KP friendly public sector sites to strengthen their ability to report KP status for those KP receiving HIV clinical services.

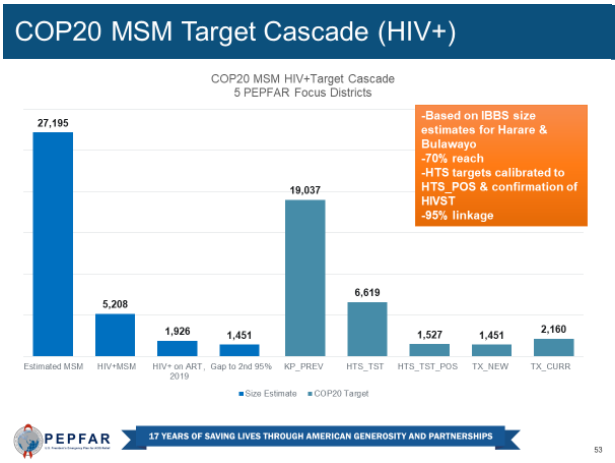


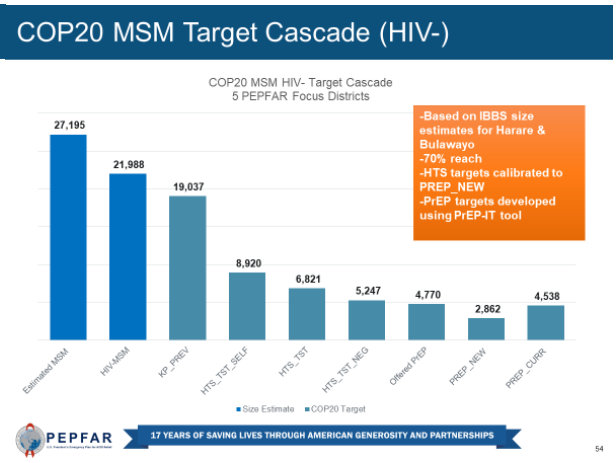

In COP 20 PEPFAR will continue to HTS, PrEP, ART, STI management and VL monitoring for MSM at New Start Centers and selected KP friendly public sector sites. PEPFAR will continue to work with local MSM partners to identify and train peer educators and Enhanced Peer Mobilizers (EPMs) to conduct inter-personal communication sessions on risk assessment and reduction, condom use, and referral and linkage to HTS, PrEP and ART as appropriate. Enhanced Peer Mobilizers will continue to work closely with HCWs to facilitate the mapping of sexual network trees, a tool that has provided valuable insights into identifying new networks of MSM and their sexual partners.



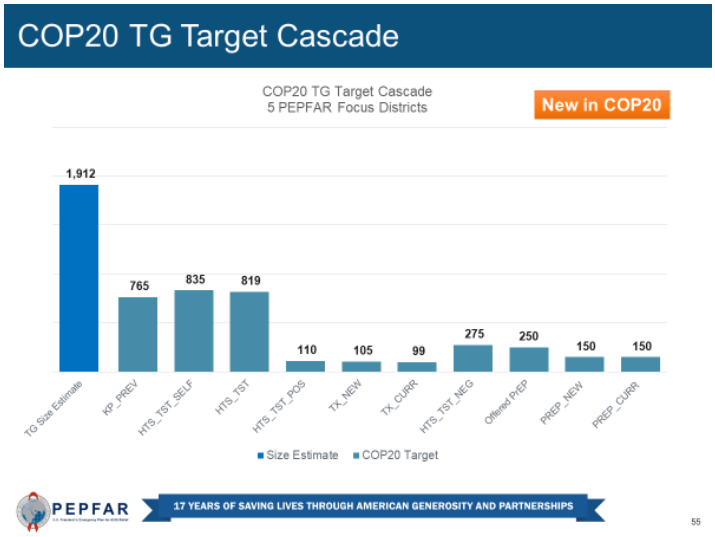

In COP19 PEPFAR introduced KP DSD Assistants, a higher-level peer cadre, who manages the microplanning/case management process which includes more intensive adherence support to higher risk KP, defaulter tracking, social/risk network mapping, and HIVST distribution and follow up. In COP 20 the KP DSD Assistant cadre will be scaled to support additional differentiated service delivery models for PrEP and ART and linkages to complementary services.

The PEPFAR-funded 2019 MSM Size Estimation for Harare and Bulawayo was used to generate the COP 20 MSM target cascades shown below. The population of MSM is estimated to be 2.1% of adult males in Harare and 3% of males in Bulawayo; and estimate of 1.5% was used for the other locations. HIV prevalence, knowledge of HIV status and coverage of ART among MSM in Harare and Bulawayo were also derived from the MSM Size Estimation study, with the other 4 sites using the same estimates according to location (i.e., Mutare and Chitungwiza estimates follow Harare; Gweru and Masvingo align with Bulawayo). COP 20 targets were set to reach at least 70% in the six focus locations with the goal of attaining 95% ART coverage of HIV positive MSM and at least 60% PrEP acceptance for the negatives. Importantly, COP 20 targets also assume full achievement of FY 20 targets, as well as continued tracking of MSM who choose to receive ART and PrEP at KP friendly public sector sites. The COP 20 PrEP target was set using the PrEP Implementer's Toolkit which considers national and program data on population estimates, risk, acceptance and continuation on PrEP, as well as scale up patterns, cost and capacity. In COP 20 PEPFAR will make a concerted effort with KP friendly public sector sites to strengthen their ability to report KP status for those KP receiving HIV clinical services.



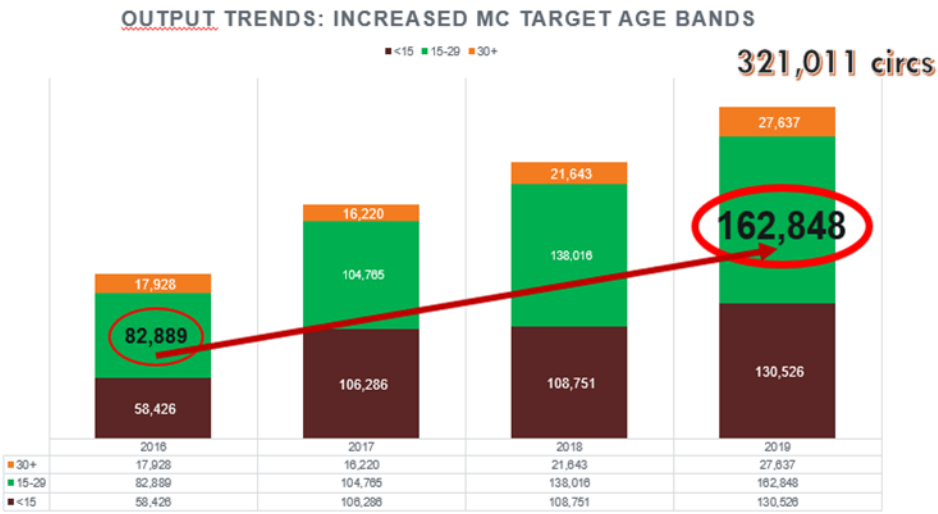

In COP 20 PEPFAR will engage CBOs to implement dedicated programming for TG women. The population of TG women is estimated to be 0.15% of adults born male. HIV prevalence, knowledge of HIV status and coverage of ART among TG women in Harare and Bulawayo were derived from the MSM Size Estimation study which also collected some data on TG. Estimates for the other 4 sites were generated according to location (i.e., Mutare and Chitungwiza estimates follow Harare; Gweru and Masvingo align with Bulawayo). Since this is a new population for PEPFAR, requiring new partnerships and approaches, COP 20 targets were based on reaching 40% of the TG population, with the goal of attaining 95% ART coverage of HIV positive TG and at least 60% PrEP acceptance for the negatives.




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

PEPFAR's strategic approach in COP 20 continues to support the implementation of the national VMMC Sustainability Transition Implementation Plan (STIP; 2019 – 2021). COP 20 Guidance specifically mandates circumcisions in males aged 15 and over, with minimal or no circumcisions (MCs) in males less than 15 years old. As a result, the VMMC targets and budget have reduced to ensure that the program focuses on providing quality, adverse-event-free MCs to the target age group. The VMMC program in Zimbabwe will also benefit from an additional 22,774 MCs as a

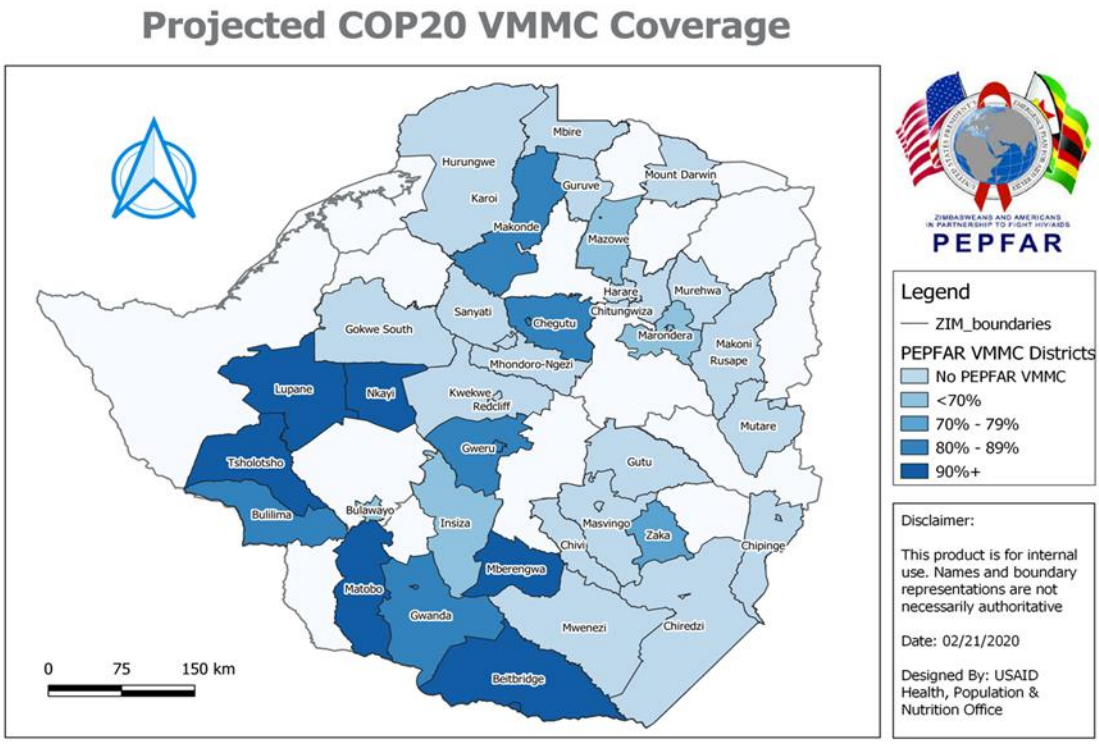
result of $2m of approved 'ambition funds.' PEPFAR collaborates with the World Health Organization (WHO), the Bill and Melinda Gates Foundation (BMGF) and the Clinton Health Access Initiative (CHAI), under the leadership and coordination of the Ministry of Health and Child Care (MoHCC), to build capacity for VMMC at the provincial and district levels. This approach for local capacity building will form the core of COP 20 implementation, as the focus shifts to sustainability, sustaining epidemic control, country ownership and assuring quality of service provision.




PEPFAR VMMC support started in 2009. From September 2016 to September 2019, Zimbabwe doubled the number of circumcisions in males aged 15 – 29 years.

In FY 19, PEPFAR directly supported 321,011 male circumcisions, a 107% achievement towards the target of 300,000 MCs and higher than the previous year achievement of 87%. This is a remarkable feat despite healthcare worker attrition and incessant strikes, political unrest and the volatile socio-economic environment. The COP 20 target is 185,168 MCs.

In FY 19, 59% of all MCs were done in males older than 15 years. National VMMC coverage in 15-29-year-old males is projected to be 58% at the beginning of COP 20 implementation, with significant district and 5-year age band variations. PEPFAR will accelerate towards 80% coverage in all 5-year age bands between 15-29 in the remaining 22 PEPFAR supported districts that are still in the scale up coverage phase.




To scale up VMMC coverage in these districts while aligning the VMMC program to the goal of sustaining epidemic control, districts have been classified into three categories based on the male HIV incidence in the 15+ age group, gap to ART coverage and unmet need for MCs. Implementation in these three districts will build on a common core package of surgical MCs, performance-based financing (PBF), quality assurance (QA) and continuous quality improvement (CQI) and adverse event monitoring (AEM).

| | Scale Up Districts | Sustainability Districts | Strategic Alignment Districts |
|---|---|---|---|
| **Number of Districts** | 22 | 4 | 10 |
| **VMMC Coverage** | Low (<60%) | High (>79%, low VMMC demand) | Medium to High (>60%, continued demand) |
| **VMMC Targets** | 133,551 MCs | 7,095 MCs | 44,522 MCs |
| **Core Package** | Surgical MCs (Dorsal Slit), all age bands | | |
| | Quality Management (routine DQAs, IQAs, annual EQA, cQI) | | |
| | Standardized, MoHCC led AEM and SAE dashboard | | |
| | PBF (PEPFAR structure, no pooling of funds, will be transitioned) | | |
| | Circumcisions in 15+, except for a few MCs in CDC districts where Shang Ring and Tanner Staging will be used in 13-14-year-old men that are eligible | | |
| **Strategy** | Maximize investments with a goal of 80% coverage while assuring quality of service provision<br>Maximum focus on 15+ | Maximize investments towards sustaining quality VMMC circumcisions in target age group, using local and existing institutions<br>Innovation | Align program towards sustaining HIV epidemic control, reducing HIV incidence in men 15+<br>Integrate service provision with other biomedical prevention, bi-directional referrals with treatment programs<br>Maximize coverage and demand using site cohorts**<br>Focus on sexually active and high-risk men (HRM) combined with innovation |
| **HRH and Service Approach** | Expanded MC Cadre footprint (Service provision)<br>Innovation- Shang Ring @ | Reduced MC Cadre Footprint and, in some cases, light touch TA (Technical Assistance) | Integrated HCP footprint (biomedical prevention and treatment) ++<br>Innovation: Shang Ring @ |
| **Demand Creation** | Active (Soccer Galas, IPC Agents, School campaigns, etc.) | Passive, Client led | Targeted, Service Delivery led (referrals, high risk, etc.) |
| **Linkage to other biomedical prevention methods** | High-risk men identified in VMMC referred for other biomedical interventions (PrEP, Condoms, STI, NCDs),<br>VMMC clinic acts as Biomedical Prevention Corner (provision of comprehensive HIV prevention education and psychosocial counselling) | Innovation example:<br>Linkage with vaccination campaigns (HPV for girls) and Mass drug administration campaigns for NTDs | Examples:<br>Health interventions that reach men:<br>Targeted outreach for sexual partners and referrals from DREAMS, KP and HRM, VCT, STI, PITC, PrEP, ANC, FP, ICT clinics<br>Referral coupons and Transport reimbursement to facilitate linkage |

*** Site cohorts- continue VMMC implementation and ensure bi-directional referrals at/ from high demand/ high saturation sites/ districts surrounded by low saturation districts*

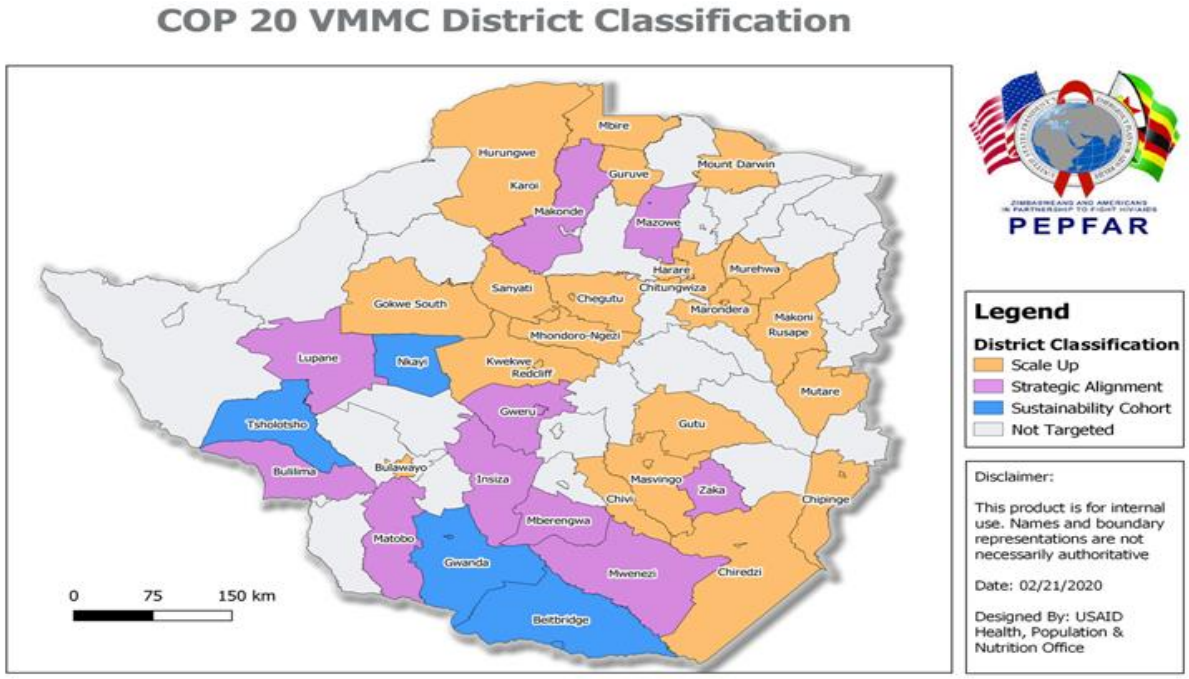
*++ Integrated HOP footprint- work with other programs to ensure that integrated services/ one stop shop approach to service provision e.g., PrEP, Condoms, STI screening and VMMC*

*@ while Shang Ring will be introduced for all ages (improve choice/ options), it will be minimally used in 13-14-year-old males in CDC districts only*

In FY 20, PEPFAR will collaborate with the MoHCC to initiate stakeholder meetings on the COP 20 strategy, transition to MCs in 15+, national AEM, the adoption of guidelines for the

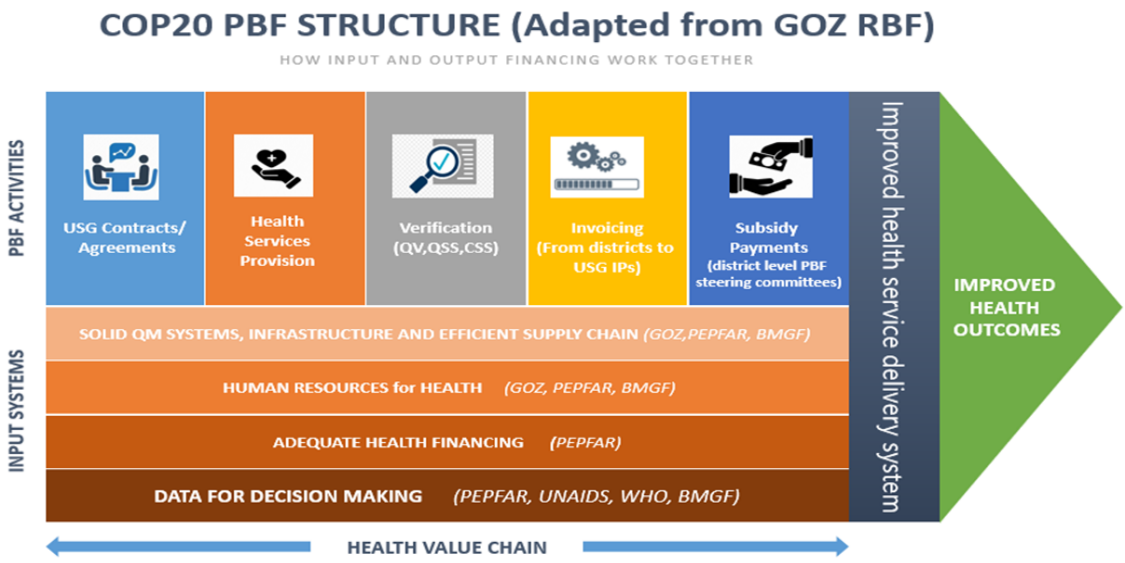
implementation of Tanner staging and the transition from cost reimbursement to PBF. An implementation strategy will be finalized, prior to the start of COP20 implementation.

PEPFAR will continue to address issues around infection control, informed consent documentation, adolescent client counselling, appropriate follow-up documentation, conduct intensive program monitoring and data reviews. This will inform tandem but structured site visits to the consistently underperforming sites to diagnose problems and institute corrective actions.




The dorsal slit (DS) surgical method will remain the standard method of circumcision for all age bands.

The key national policy shift and consideration in COP 20 is the adoption of a PEPFAR and BMGF supported PBF structure for the program, with a yet to be determined full transition to the country led Results Based Financing. In COP 20, the cost reimbursement structure will be completely replaced with the quality and system focused PBF, ending a decade long system that incentivized VMMC providers directly. PEPFAR will continue to support the national VMMC SID and the national STIP to ensure we remain on track to successful transition to sustainable and country-owned biomedical HIV prevention programs.


COP20 PBF STRUCTURE (Adapted from GOZ RBF)
HOW INPUT AND OUTPUT FINANCING WORK TOGETHER
PBF ACTIVITIES
USG Contracts/ Agreements
Health Services Provision
Verification (QV,QSS,CSS)
Invoicing (From districts to USG IPs)
Subsidy Payments (district level PBF steering committees)
Improved health service delivery system
IMPROVED HEALTH OUTCOMES
INPUT SYSTEMS
SOLID QM SYSTEMS, INFRASTRUCTURE AND EFFICIENT SUPPLY CHAIN (GOZ,PEPFAR, BMGF)
HUMAN RESOURCES for HEALTH (GOZ, PEPFAR, BMGF)
ADEQUATE HEALTH FINANCING (PEPFAR)
DATA FOR DECISION MAKING (PEPFAR, UNAIDS, WHO, BMGF)
HEALTH VALUE CHAIN

The table below shows the strategic shifts in COP 20:

| COP 19 Strategy | COP 20 Strategy |
|---|---|
| STIP era: focus on sustainable VMMC service provision with emphasis on evidence-based decision making, 80% coverage in all districts, efficiency in service provision and ensuring quality of services | **Focus: Shift to epidemic control alignment, with goal of coverage in unsaturated districts Additional: district classification to align with HIV epidemic control** |
| Routine, enhanced and intensive partner performance management and oversight (weekly, monthly, quarterly), with use of accessible data systems and tools aligned to MoHCC systems | **No Shift** |
| VMMC services will be further integrated with HTC services and partner specific strategies to ensure linkages with other prevention (DREAMS and PrEP) and HIV treatment (linkage to treatment for HIV+) programs | **Now clearly defined with implementation strategy for each district, based on classification and set targets** |
| Targeted and evidence based VMMC and HIV prevention messaging for male adolescents and young adults | **No shift** |
| Data driven and targeted demand creation at district level, to engineer access to older age group (20 – 29-year-old) and districts with low coverage in those age groups. | **No Shift** |
| PEPFAR will continue to work with MoHCC to implement the new cost reimbursement policy, with a view to eventually transitioning it into a locally driven PBF mechanism | **Year of transition to PBF, with a view to transitioning the incentive mechanism to the MoHCC within a stipulated timeframe.** |
| Ownership of the DMPPT2 Online will be transitioned to the MoHCC, and in-country stakeholders, with capacity for modelling built in-country as part of this process. | **Tool owned and utilized by MoHCC structures at national, provincial and district levels** |
| One System and Role Reversal: One AE management system will be developed for the MoHCC, with the support of both PEPFAR implementing partners (IPs) and CHAI. Responsibility for managing AEs will remain with IPs but under the stewardship of the MoHCC | **No shift** |
| Maintain Age pivot at 65% 15 – 29-year olds | **Age pivot at 100% 15 – 29-year-old males** |
| 2 central MoHCC led IQAs, several district level IQAs (mandatory for district management teams under the new Cost reimbursement scheme) and 1 USAID EQA planned, using the enhanced HNQIS tool | **Routine DQAs, IQAs, annual EQA, cQI (mandatory for PBF)) and 1 USAID EQA planned, using the enhanced HNQIS tool** |
| National roll out of the reusable kits to all districts, equipment and HR support for challenged sites | **Assessment of the use of the reusable kits and restructure program and SCM based on the results of the assessment; Establishment of autoclave super centers.** |

### 4.4 Commodities

Commodity procurement is essential for COP20 given the diminished capacity of the Government of Zimbabwe to provide funding for commodities. This year, planning has also been complicated by the simultaneous Global Fund grant writing process and COP development. It is still unknown the exact commodities that will be purchased by the Global Fund, and our commodity strategy considers that the new Global Fund grant may experience delays in getting commodities into Zimbabwe during COP20. Therefore, we have diversified our ARV portfolio to include pediatric and first line alternative ARVs for patients. The focus for ARV procurement will be on 90-tab bottles of TLD which will enable a smooth transition to multi-month dispensing of TLD. In COP20, PEPFAR Zimbabwe will begin procuring PrEP to scale up our PrEP program.

We anticipate that there may be a shortage of test kits within the country due to the decrease in test kits procured by the Global Fund and PEPFAR. Test kits will be prioritized for most at risk Zimbabweans and will be used judiciously through the new testing strategy implemented by the MoHCC and PEPFAR partners.

In order to support an increase in viral load testing, PEPFAR funds will be used to purchase Roche and Hologic viral load testing reagents. Careful coordination with the Global Fund and the MoHCC will be required to ensure that reagents are in stock for the various platforms used across the country.

Disposable and reusable VMMC kits will be purchased in COP20. Disposable kits are still needed due to the lack of electricity and water needed at sites for autoclaving reusable kits. Shang Ring kits will also be purchased for the first time in Zimbabwe.

In COP 2020, PEPFAR will ensure that PEPFAR-procured vehicles provide support for transportation of commodities to improve last mile delivery to service delivery points. PEPFAR will provide technical assistance for correct forecasting of quantities of commodities and creation of buffer stocks as well as the mapping allocation of commodities proportional to need. PEPFAR will continue to coordinate with the Global Fund for timely release of approved budget support for ART medicines and other commodities. PEPFAR will collaborate with Global Fund and NAC to support the establishment of a network that provides an interface between NatPharm and other health service providers (public health centers, local authority health facilities, and private health facilities including pharmacies).

PEPFAR and the Global Fund work together to mitigate the threats posed by the chronic shortages of ARV, reintroduction of user fees at facilities by supporting last mile delivery of commodities to the facilities, providing technical assistance to ensure correct forecasting of commodities as well as mapping allocation of commodities according to need. The Program will also work with MoHCC to use the EHR platforms for commodity monitoring.

### 4.5 Cervical Cancer

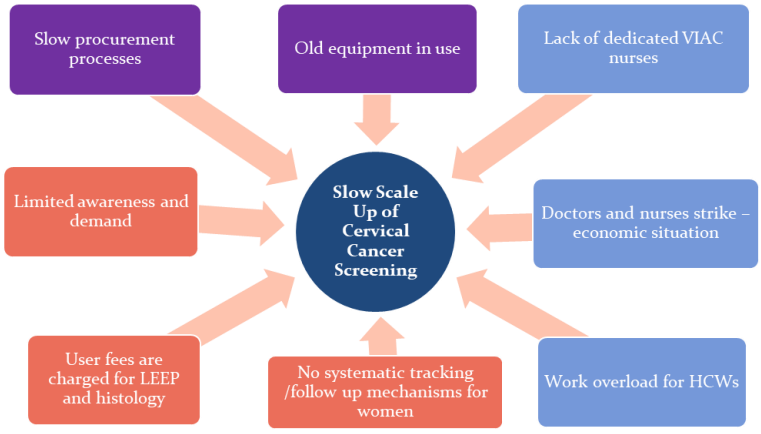
Countries with the highest HIV prevalence in women have the highest incidence of cervical cancer. Women with HIV are four to five times more likely to develop cervical cancer. Women are

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

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

An estimated 2,270 new cases are diagnosed with 1,500 deaths from cervical cancer every year in Zimbabwe. In 2017, about 100,000 women were screened for cervical cancer with a treatment rate of 57% which is below the program target of 80 % treatment rate. The ZDHS 2015 reported overall 79% of women had heard of cervical cancer but only 13% ever had a cervical examination. The Cervical Cancer Prevention and Control Strategy (2016-20200) recommend screening using Visual Inspection with Acetic Acid and Cervicography (VIAC) for all sexually active women. Since 2014, the MoHCC has been rapidly scaling up screening of cervical cancer using VIAC and over 100 VIAC sites have been set up at district, provincial and central levels countrywide. Women with lesions are treated with either cryotherapy or referred for Loop Electrosurgical Excision Procedure (LEEP) which is available at the provincial and central levels. The MoHCC adopted the "see and treat" approach for cervical cancer screening where secondary prevention is available within VIAC screening services. In this approach, the treatment for pre-invasive lesions is offered on the same day that the lesion is identified (e.g., with cryotherapy). For all women offered LEEP services a sample is taken to the laboratory for histology.

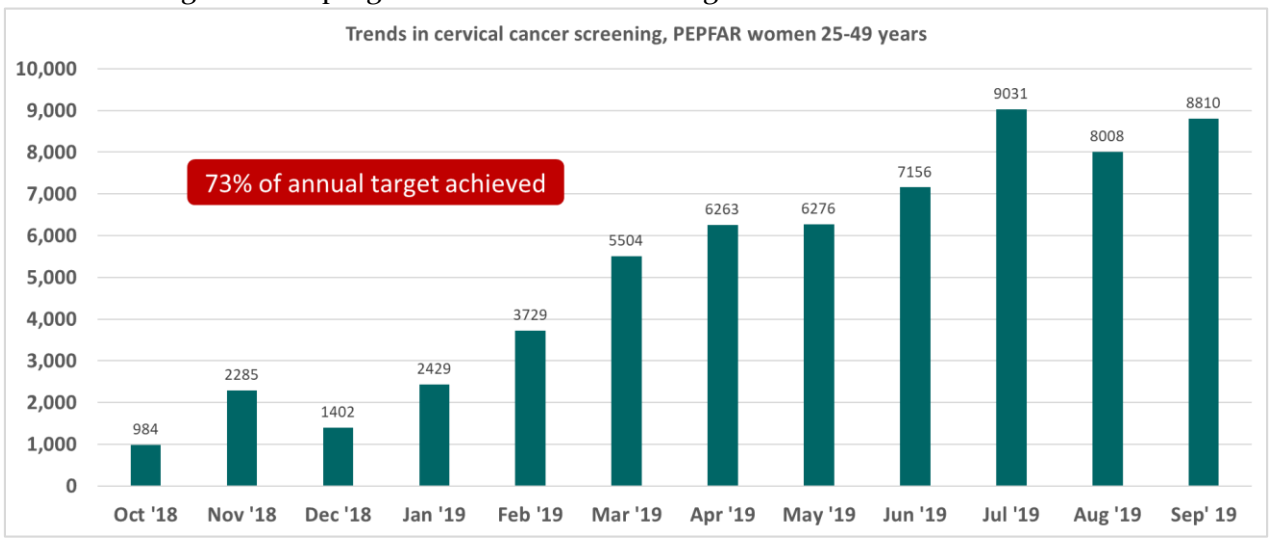
The current program is built on the established HIV care and treatment settings focusing on supporting VIAC sites and establishment of new screening and treatment sites.



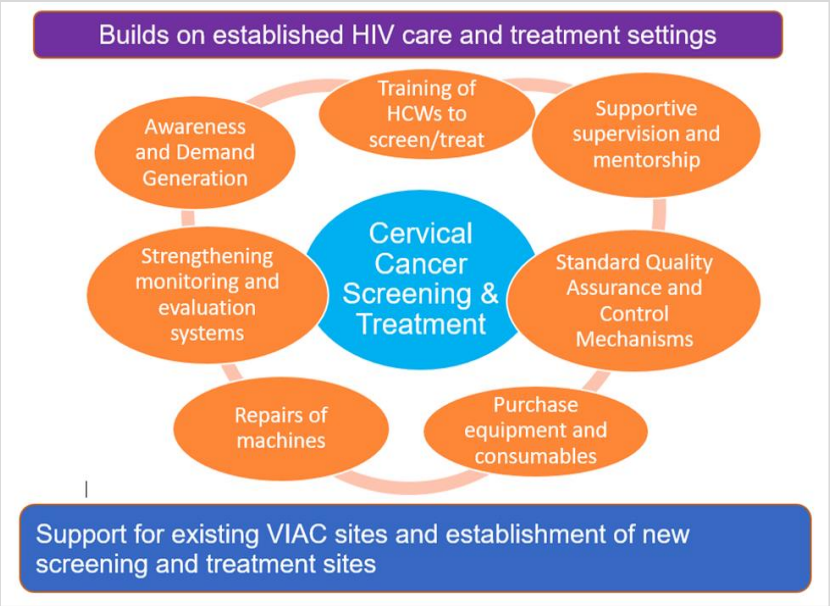

COP 18 activities included a s Stakeholder consultation meeting to explain the PEPFAR program have been held with and incorporate from the government and other partners. There was also engagement and sensitization of the provincial and district leadership of the supported districts. Procurement of equipment and commodities is ongoing. There has been also recruitment and training of VIAC nurses to work full time in the VIAC clinics. There have been challenges in HRH as most of the VIAC clinics do not have dedicated nurses and there is no prioritization of VIAC activities because of competing priorities in the health facilities. This activity also spearheaded the formation of a cervical cancer

monitoring and evaluation technical working group. The national VIAC register and the master MoHCC monthly return were revised to incorporate the PEPFAR VIAC indicators. Several challenges have been encountered in COP 18 and 19 remain an issue as shown below.

The graph below is showing the performance of the program **in COP18**. There has been an upward trend in the numbers of women being screened and treated. There is need to address the above challenges for the program to achieve the set targets.

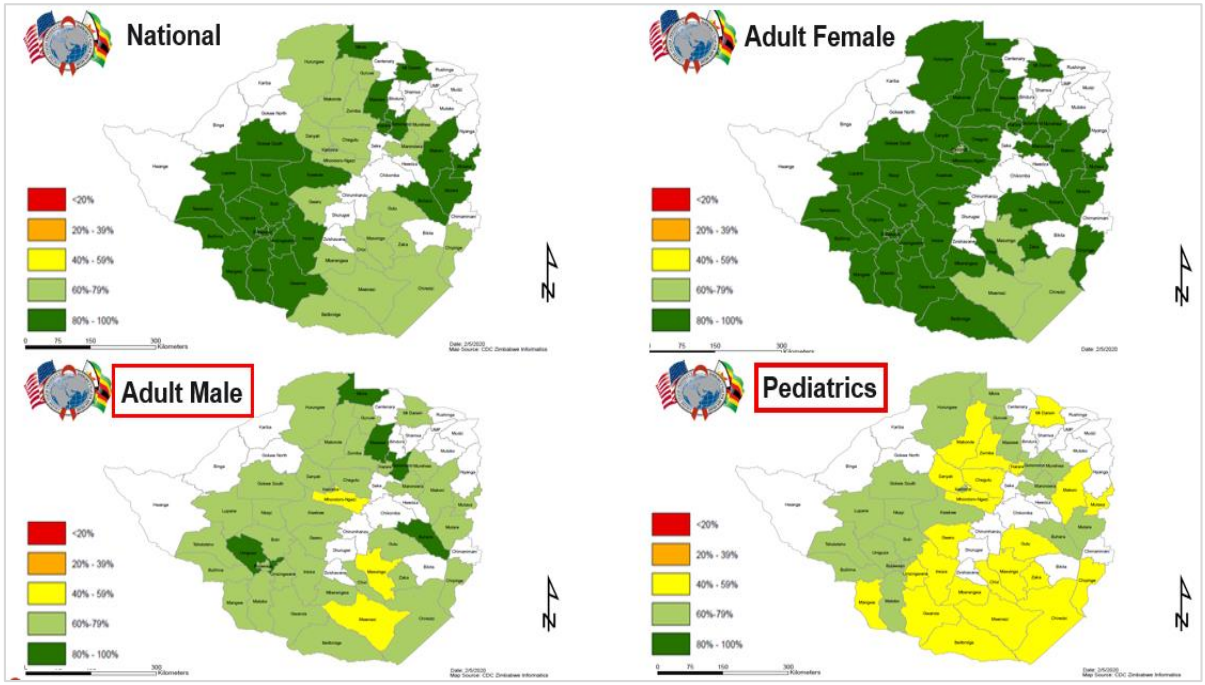



In COP 2020, the PEPFAR program will continue to support the secondary prevention of cervical cancer in women living with HIV. In COP 2020 the target is to screen 233,000 women living with HIV on ART aged 25-49 years every other year for pre-invasive lesions to allow early treatment. The figure below shows the PEPFAR Zimbabwe Cervical cancer program approaches.



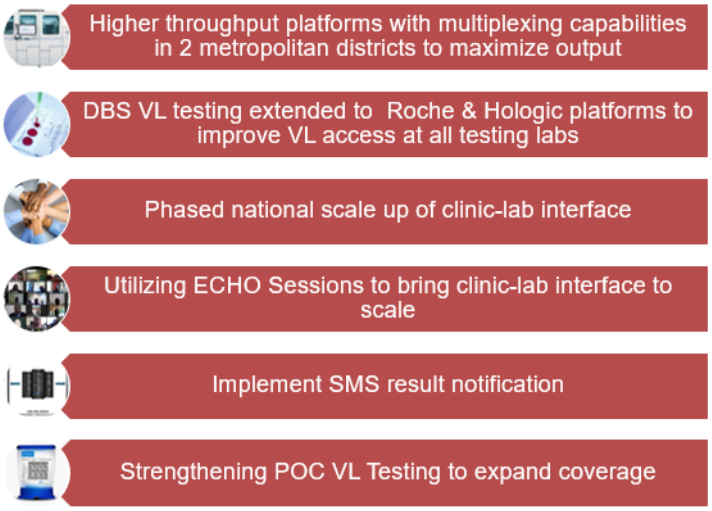

### 4.6 Viral Load and Early Infant Diagnosis Optimization

PEPFAR has identified viral load (VL) access and suppression as a critical area needing intervention in Zimbabwe as the country reaches epidemic control. Besides the VL reagent gap, there are gaps in access, specimen transport, HRH, and results utilization/ clinical status monitoring. SNU suppression data still shows suppression rates for all age, sex group as higher than 80% in most districts, while a further review of the data shows that men and children still have lower suppression rates than women.



In COP 2020, strong collaboration between GF and PEPFAR will accelerate VL coverage and access, through alignment of planning activities to reduce redundancies and improve efficiencies as well as ensuring national coordination. This collaborative approach between development partners will strengthen national laboratory systems and bring patient centered innovations.

The diagram below summarizes the PEPFAR Zimbabwe VL scale up acceleration strategies.




In COP 2020, PEPFAR will continue to invest in scaling up the Clinic – Laboratory Interface (CLI) approach in all supported districts, ensuring that the clinical partners, OVC/ community partners and the laboratory partner work collaboratively to increase access to VL services for all eligible PLHIV already on ART. The goal of the strategy is 95% coverage by the end of COP 20. Utilizing VL CQI coaches (facility and lab based) from the COP19 LARC cohort implemented in 10 low coverage, high testing gap districts and a USG interagency task team; there will be roll out of VL-CQI to other facilities and laboratories within all PEPFAR and GF supported districts. These continuous learning sessions will be replicated by district teams as the VL CQI becomes institutionalized. An HRH infusion will be strategically instituted to cover key gaps and areas of underperformance identified with the CLI cascade.

Increased access to ART and treatment monitoring for pregnant and breastfeeding women living with HIV is a priority to minimize the risk of vertical transmission of HIV to their infants. In COP20, the use of POC VL testing will be supported to ensure full utilization of the available platforms and quality assurance activities will be implemented to ensure uninterrupted service PEPFAR will leverage resources through GF and UNITAID to implement POC VL testing for unsuppressed patients and adolescents. POC-VL testing will be supported on the Cepheid GeneXpert and Abbott mPIMA platforms using a targeted, data driven approach considering the limited resources. There will be strong collaboration between development partners to strengthen TB/HIV laboratory integration and joint TB/HIV program planning to ensure efficient use of POC platforms in FY20. There will be further decentralization of conventional EID testing on the Roche platform from 3 laboratories to a further 4 labs, bringing the total labs to performing conventional laboratories EID testing to 7 in FY21. This will greatly enhance EID access and reduce turnaround times.

## 4.7 Targets by population

### Standard Table 4.7.1: Targets by Prioritization for Epidemic Control

| Table 4.7.1 ART Targets by Prioritization for Epidemic Control | | | | | | |
|---|---|---|---|---|---|---|
| Prioritization Area | Total PLHIV | Expected current on ART (APR FY20) | Additional patients required for 80% ART coverage | Target current on ART (APR FY21) *TX_CURR* | Newly initiated (APR FY21) *TX_NEW* | ART Coverage (APR 21) |
| Attained | 1,139,928 | 1,036,300 | - | 1,095,362 | 51,002 | 96% |
| Scale-Up Saturation | - | - | - | - | - | - |
| Scale-Up Aggressive | - | - | - | - | - | - |
| Sustained | - | - | - | - | - | - |
| Central Support | 208,043 | 184,783 | - | 184,783 | - | 88% |
| **Total** | 1,347,971 | 1,221,083 | - | 1,280,145 | 51,002 | 95% |

### Standard Table 4.7.2: VMMC Coverage and Targets by Age Bracket in Scale-up Districts

| Table 4.7.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts | | | | | |
|---|---|---|---|---|---|
| SNU | Target Populations | Population Size Estimate (SNUs) | Current Coverage (date) | *VMMC_CIRC* (in FY21) | Expected Coverage (in FY21) |
| Beitbridge | 15-29 | 19,967 | - | 891 | - |
| Bulawayo | 15-29 | 96,407 | - | 2,512 | - |
| Bulilima | 15-29 | 7,461 | - | 195 | - |
| Chegutu | 15-29 | 42,611 | - | 6,174 | - |
| Chipinge | 15-29 | 45,598 | - | 4,403 | - |
| Chiredzi | 15-29 | 57,699 | - | 1,475 | - |
| Chitungwiza | 15-29 | 56,651 | - | 6,303 | - |
| Chivi | 15-29 | 24,676 | - | 2,013 | - |
| Gokwe South | 15-29 | 53,775 | - | 7,007 | - |
| Goromonzi | 15-29 | 67,307 | - | 5,193 | - |
| Guruve | 15-29 | 16,481 | - | 4,439 | - |
| Gutu | 15-29 | 30,919 | - | 4,214 | - |
| Gwanda | 15-29 | 23,378 | - | 1,438 | - |
| Gweru | 15-29 | 49,592 | - | 6,528 | - |
| Harare | 15-29 | 252,395 | - | 30,000 | - |
| Hurungwe | 15-29 | 53,397 | - | 6,215 | - |
| Insiza | 15-29 | 19,372 | - | 1,029 | - |
| Kwekwe | 15-29 | 56,872 | - | 3,646 | - |
| Lupane | 15-29 | 13,518 | - | 5,403 | - |
| Makonde | 15-29 | 39,670 | - | 5,298 | - |
| Makoni | 15-29 | 53,864 | - | 6,470 | - |
| Marondera | 15-29 | 35,629 | - | 3,784 | - |
| Masvingo | 15-29 | 54,177 | - | 4,042 | - |
| Matobo | 15-29 | 13,740 | - | 4,947 | - |
| Mazowe | 15-29 | 38,636 | - | 8,946 | - |
| Mberengwa | 15-29 | 24,929 | - | 7,505 | - |
| Mbire | 15-29 | 11,584 | - | 4,188 | - |
| Mhondoro | 15-29 | 14,637 | - | 5,872 | - |
| Mt. Darwin | 15-29 | 28,094 | - | 4,931 | - |
| Murehwa | 15-29 | 35,477 | - | 2,957 | - |
| Mutare | 15-29 | 77,675 | - | 8,076 | - |
| Mwenezi | 15-29 | 27,332 | - | 1,947 | - |
| Nkayi | 15-29 | 14,311 | - | 1,138 | - |
| Sanyati | 15-29 | 40,984 | - | 6,360 | - |
| Tsholotsho | 15-29 | 15,256 | - | 852 | - |
| Zaka | 15-29 | 23,290 | - | 7,340 | - |
| Total/Average (Ages 15-29) | | 1,537,361 | - | 183,731 | - |

## Standard Table 4.7.3: Target Populations for Prevention Interventions to Facilitate Epidemic Control

| Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control | | | | |
|---|---|---|---|---|
| Target Populations | Population Size Estimate | Disease Burden | Coverage Goal (in FY21) | FY21 Target |
| MSM | 27,196 | 5,207 | 70% | 19,035 |
| FSW | 37,632 | 20,711 | 82% | 30,814 |
| TG | 1,913 | 517 | 40% | 764 |
| AGYW (15-24) | | | | 91,953 |

## Standard Table 4.7.4: Targets for OVC and Linkages to HIV Services

| Table 4.7.4 Targets for OVC and Linkages to HIV Services | | | | |
|---|---|---|---|---|
| SNU | Target # of Graduated OVC_SERV | Target # of Active OVC_SERV | Target # of Total OVC_SERV | Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (OVC_HIVSTAT) |
| Beitbridge | - | 7,586 | 7,586 | 7,586 |
| Bubi | - | 2,020 | 2,020 | 2,020 |
| Buhera | 962 | 18,285 | 19,248 | 14,309 |
| Bulawayo | 673 | 45,403 | 46,077 | 42,752 |
| Bulilima | - | 6,028 | 6,028 | 6,028 |
| Chegutu | 680 | 12,945 | 13,623 | 10,128 |
| Chipinge | 883 | 43,368 | 44,252 | 39,641 |
| Chitungwiza | 170 | 3,227 | 3,395 | 2,510 |
| Goromonzi | 574 | 10,875 | 11,450 | 8,459 |
| Guruve | 295 | 5,599 | 5,894 | 4,382 |
| Gutu | 616 | 11,754 | 12,371 | 9,197 |
| Gwanda | - | 9,049 | 9,049 | 9,049 |
| Gweru | 256 | 20,409 | 20,666 | 19,400 |
| Harare | 1,589 | 30,194 | 31,783 | 23,537 |
| Insiza | 361 | 13,662 | 14,021 | 12,256 |
| Lupane | 172 | 6,457 | 6,630 | 5,726 |
| Makonde | 1,190 | 22,619 | 23,810 | 17,701 |
| Makoni | 830 | 40,028 | 40,857 | 36,418 |
| Mangwe | - | 5,441 | 5,441 | 5,441 |
| Matobo | 148 | 8,341 | 8,489 | 7,832 |
| Mazowe | 154 | 23,710 | 23,863 | 22,729 |
| Mhondoro | 412 | 7,823 | 8,234 | 6,121 |
| Mutare | 572 | 45,206 | 45,779 | 42,638 |
| Mutasa | 724 | 13,773 | 14,498 | 10,778 |
| Nkayi | 182 | 6,789 | 6,972 | 6,019 |
| Tsholotsho | - | 3,461 | 3,461 | 3,461 |
| Zvimba | 775 | 14,739 | 15,514 | 11,533 |
| TOTAL | 12,218 | 438,793 | 451,010 | 387,652 |

# 5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Feedback from CSOs and patients has impressed upon the PEPFAR team that treatment literacy tools need updating to include aspects of self-testing, index testing, treat all, adherence, viral load, faith healing, and other important elements. In COP 2020, PEPFAR clinical partners will build on the partnerships with CSOs to scale up implementation of community-level treatment literacy to improve uptake of viral load, TLD transition, and TPT. COP 2020 will fund an aggressive expansion of treatment literacy across all PEPFAR supported districts run by, and for, communities living with HIV and key populations. This will include both a community lead component including: material development and dissemination to 100% of PEPFAR sites, training of trainers & subsequent trainings, social mobilization campaigns at community level, as well as a healthcare worker component ensuring that community and facility-based health workers understand HIV and TB fully to offer up to date prevention and treatment literacy information – and offer HIV and TB education in facilities, adherence clubs and beyond. PEPFAR will fund at least 10 community lead PLHIV and KP organizations to engage PLHIV including key populations (including MSM, sex workers, transgender people, and people who use drugs) to target those groups more specifically.

During FY 2019, PEPFAR Zimbabwe and UNAIDS jointly engaged a diverse group of stakeholders to complete the 2019 Sustainability Index (SID) with the aim of advancing a shared goal of sustainability. Stakeholders included MoHCC, NAC, MOF, CHAI, SAFAIDS, EGPAF, DFID, ZNNP+, and FBOs.

The PEPFAR Zimbabwe team will invest in above-site areas to address key vulnerabilities highlighted in the SID dashboard below and ensure continued progress towards sustained epidemic control.

| Zimbabwe Sustainability Index | 2015 (SID 2.0) | 2017 (SID 3.0) | 2019 |
|---|---|---|---|
| **Accountability** | | | |
| 1. Planning and Coordination | 9.33 | 10.00 | 8.57 |
| 2. Policies and Governance | 7.16 | 7.11 | 5.82 |
| 3. Civil Society Engagement | 6.17 | 6.46 | 3.00 |
| 4. Private Sector Engagement | 2.71 | 5.92 | 5.92 |
| 5. Public Access to Information | 8.00 | 5.00 | 5.67 |
| **Delivery** | | | |
| 6. Service Delivery | 7.22 | 6.85 | 6.75 |
| 7. Human Resources for Health | 8.42 | 8.40 | 7.76 |
| 8. Commodity Security and Supply Chain | 6.14 | 6.14 | 4.81 |
| 9. Quality Management | 8.67 | 8.67 | 9.33 |
| 10. Laboratory | 4.72 | 5.50 | 6.89 |
| **Openness** | | | |
| 11. Domestic Resource Mobilization | 3.06 | 7.06 | 7.58 |
| 12. Technical and Allocative Efficiencies | 6.70 | 8.56 | 8.56 |
| 13. Market Openness | N/A | N/A | 6.88 |
| **Strategic Information** | | | |
| 14. Epidemiological and Health Data | 3.87 | 4.51 | 5.18 |
| 15. Financial/Expenditure Data | 7.08 | 10.00 | 10.00 |
| 16. Performance Data | 7.34 | 7.12 | 7.56 |
| 17. Data for Decision-Making Ecosystem | N/A | N/A | 5.00 |

**Commodity Security and Supply Chain:** The GoZ has established a successful AIDS levy to procure ARVs and support other program activities. However, the value of these funds has declined over the past two years as inflation has risen and the procurement of ARVs, HIV rapid test kits, and condoms is heavily dependent on donor funding. In COP 20 PEPFAR will continue to provide support to Zimbabwe's national supply chain management and distribution systems to ensure that the national quantification and supply planning exercise is conducted bi-annually to inform the use of donor and GoZ resources for commodity procurement, and that life-saving

medicines and products are available in health facilities. The vehicle and distribution support have been particularly critical in the face a deteriorating economic situation, particularly the fuel crisis and the continued ARV transition from TLE to TLD. Securing additional commodities (i.e., HIVST kits, condoms, VMMC kits, TB, RTKs, Viral Load reagents) will also be critical to the national HIV programming and epidemic control.

**Civil Society Engagement:** Stakeholders consulted cited concerns regarding civil society engagement. Opportunities for civil society groups to engage and provide feedback on HIV/AIDS policies and programs, are affected by minimal domestic funding resources. In COP 20 PEPFAR will support CBOs to conduct community monitoring at 200 facilities in 40 PEPFAR supported districts. Each CBO will work in four districts monitoring at least 5 facilities targeting diverse communities including PLHIV, AGYW & ABYM, KP, adult men and women. Monitoring will be conducted through focus group discussion, observation, mystery clients, and key informant interviews. PEPFAR Zimbabwe will ensure close coordination among CBOs, MoHCC subnational levels, NAC, and PEPFAR Implementing Partners.

**Epidemiological, Health, and Performance Data:** PEPFAR's COP 20 support will expand the Electronic Health Record (EHR) and Case Based Surveillance with recency testing to 1125 PEPFAR supported facilities, 524 with a full EHR system and 601 facilities with a mobile EHR application. The full EHR system will produce 95% of site-level MER indicators with a less than 10% downtime across 90% of the 1125 facilities. The electronic systems will improve data quality and enable easy and accurate monitoring of 1) newly identified HIV-infected person and incident infections in defined geographic locations. 2) MER & MoHCC Monthly reports on all HIV/TB patients in all sub-populations, 3) Mortality surveillance among ART patients, and 4) Outbreak response and utilization of data to inform policy.

With COP 20 funding, PEPFAR Zimbabwe will ensure that: the DREAMS database is correctly used by all implementing partners; can report on vulnerability and risk factors of enrolled AGYW; the referral process is automated in database; and that the DREAMS M&E framework, SOPs, protocols, and layering table are updated.

In COP 20, PEPFAR Zimbabwe will finalize development of a standard OVC database that will be used by all partners to monitor caseloads and produce standard metrics across IPs allowing full utilization of program data for strategic decision-making.

**Planning, Coordination, Policies and Governance:** With COP 20 funding, PEPFAR Zimbabwe will continue to support secondments to the MoHCC AIDS and TB program and NAC that have helped to ensure high level planning and coordination of national programs and continued advocacy for technically sound national policy formulation and good governance. PEPFAR will also support secondments to identified critical and priority departments such as HMIS, SI, Labs, Quality Monitoring and Improvement, and DREAMS Coordination.

**Laboratory Support:** Zimbabwe currently has adequate platform capacity to provide VL monitoring access for all ART patients across the country. Unfortunately, platforms and reagents will not make universal VL monitoring a reality without significant investment into supporting systems. PEPFAR's above-site laboratory investments, therefore, will support integrated specimen transport, laboratory information management (LIMS), and quality assurance (EQA) activities. Specimen transport is a critical laboratory activity, where proper implementation reduces

turnaround time through transport efficiency, while also reducing the percentage of rejected samples. Implementing the LIMS system will accelerate transmission of results to clinicians, permitting differentiation of care and clinical decision-making. PEPFAR support for EQA/QMS activities will ensure that laboratory results are reliable and meet international standards. Finally, given the urgency of expanding VL coverage and results utilization, PEPFAR will provide central-level support to MoHCC's Directorate of Laboratory Services, to ensure that planning and implementation are focused upon the 95-95-95 targets.

**Transition to TLD:** As mentioned above, PEPFAR continues to provide technical assistance to Zimbabwe's national supply chain management and distribution systems to ensure that life-saving medicines and products are available in health facilities. Considering the current and deteriorating economic situation, particularly the fuel crisis, this vehicle and distribution support has been particularly critical. Zimbabwe is working to close the gaps across geographic and age/sex bands in order to achieve the 95-95-95 targets by the end of COP 20.

**Treatment literacy:** Feedback from MoHCC, stakeholders, CSOs, and patients has impressed upon the PEPFAR team that treatment literacy tools need updating to include aspects of self-testing, index testing, treat all, adherence, viral load, faith healing, and other important elements. In COP20, PEPFAR clinical partners will build on the partnerships with CSOs to scale up implementation of community-level treatment literacy to improve uptake of VL, TLD, and TPT. Lessons learned from the faith-based messaging in the Faith Communities Initiative (FCI) as well as from implementation of the circle of hope model will be evaluated for feasibility for adaptation and scale up. Investments in the FCI will continue to prioritize adherence, retention and stigma and intimate partner violence reduction at the community-level.

# 6.0 USG Operations and Staffing Plan to Achieve Stated Goals

For COP 20, the PEPFAR team took a critical look across the entire interagency team to ensure it consisted of staff with an adequate mix of technical, management, and administrative skills to support the Government of Zimbabwe's goal of epidemic control.

The current proposed staffing plan put forth by USAID, CDC and State equips the agencies to stay actively engaged in technical working groups and discussions, provide activity/project management oversight, conduct robust monitoring and analysis required to responsively adapt the program to ensure alignment with PEPFAR priorities, and conduct critical SIMS visits at the selected sites for the year.

USAID: As part of PEPFAR's local partner initiative, in COP 19 OGAC approved six additional FSN local positions that were funded centrally by USAID to support this key initiative. In COP20, those six positions are being absorbed into USAID's M&O budget. Those positions include:

- Strategic Information Advisor (currently under recruitment) - This position will strengthen data quality and promote learning from available project data, with an emphasis on HIV programs, leading to improved activity design and effectiveness and communicating program successes and challenges.

- Senior Clinical Specialist (under recruitment) - This position ensures that project implementation addresses program strategic goals and internationally recognized public health standards and best practices while maintaining constant and clear communication with implementing partners (including host government ministries, non-governmental and international organizations) for all issues related to the agency's HIV program activities. The incumbent provides expert technical support, advice and guidance to implementing partners for HIV services in alignment with PEPFAR priorities. He/she assures that projects are conducted in accordance with PEPFAR guidance and that United States Government (USG) funds are appropriately tracked and utilized.
- Supply Chain Advisor (under recruitment) - This position serves as the Activity Manager for the Global Health Supply Chain - Procurement and Supply Management program which provides approximately $40 million of commodities and technical assistance annually to strengthen the supply chain in Zimbabwe. The incumbent will liaise with the Ministry of Health and Child Care, NatPharm, donors and provide technical guidance to the interagency team on HIV related procurements.
- Supply Chain Assistant (under recruitment) - This position will support the Supply Chain Advisor to manage the $40 million supply chain portfolio in Zimbabwe, serving as the Alternate Activity Manager for the Global Health Supply Chain - Procurement and Supply Management program which procures all USG-funded commodities and technical assistance annually to strengthen the supply chain in Zimbabwe. The incumbent will liaise with the Ministry of Health and Child Care, NatPharm, donors and provide technical guidance to the interagency team on HIV-related procurements.
- DREAMS Specialist (will be out for recruitment in April) - This position provides leadership, technical guidance, oversight and coordination to USAID-funded DREAMS partners and to the interagency DREAMS program. S/he will ensure that DREAMS priorities and targets are met, and that funding is used in the most efficient and effective way as USAID scales up from 6 to 12 districts.
- Local Partnership Specialist (will be out for recruitment in April) - This position provides technical assistance, financial management guidance, and capacity building to local partners who are transitioning to managing USAID funding directly, and to international partners who would set up transition funding opportunities. S/he will also work to identify organizations that may be able to serve as prime partners and assist USAID in meeting the 70% local partner target.

CDC: The current proposed staffing plan includes the following new position requests:

2 LE Staff Positions

- One Laboratory Specialist: this position will strengthen the rapid scale up of Continual Quality Improvement (CQI) for the laboratory network to ensure quality laboratory services for the VL/EID (Early Infant Diagnosis) and TB services. In addition, additional human resource will facilitate the expansion of a comprehensive External Quality Assurance (EQA) program for HIV rapid Testing and Recency testing as part of the CBS program. One will support serology, point of care testing and sample referral systems of the program and the other will provide support in QMS, continuous Quality improvement and lab related-survey activities of the program to improve access to quality of care to the people of Zimbabwe.

- One Key and Vulnerable Populations Specialist: The Key and Vulnerable Population Specialist will be the technical expert on CDC-supported programs for DREAMS and key populations service delivery in the public sector, including PrEP, as well as programming for other vulnerable populations as needed. This position will support the growing CDC portfolio in DREAMS and KP activities.

2 Global Health Fellows requested

- HIV Services Monitoring and Evaluation Fellow: The HIV Services Monitoring and Evaluation Fellow will work on monitoring and evaluation activities supporting CDC clinical partners. The fellow will play a key role in DREAMS M&E activities, as well as CDC's tailored site monitoring and support program. The fellow will also support special analyses of EHR data, DREAMS, and other program data to support program monitoring and improvement.
- Lab Fellow: will support the expansion of the lab portfolio through implementation of LIMS, DR-Testing in the PEPFAR supported districts. The position will play a key role in developing data management tools that will strengthen the granular management of the laboratory program activities.

State Department (DOS): As part of PEPFAR's Community-led Monitoring Initiative, PEPFAR Zimbabwe agreed to put $909,261 in the DOS Ambassador Small Grants program. This is a giant leap from the historical $60,000 in grants that the program normally receives and therefore two new FSN positions are being requested to manage the grants. The DOS currently funds one position, the PEPFAR Communications Specialist, who is seconded to PAS. In COP20, DOS is proposing to maintain the Communications Specialist and add two new positions:

- Two Grants Specialists (to be recruited and hired in FY21) – These FSN9 positions will provide technical assistance, grant management guidance and build capacity in local grantees under the Community Monitoring grants. They will also work to identify organizations eligible to apply for these Small Grants, guide the grants committee in selecting grantees, monitor the grants and ensure PEPFAR is receiving in real-time the Community-Led Monitoring feedback to make course corrections to its programs.

Operational Updates:

Significant CODB changes in COP 19 included the move into the New Embassy Campus (NEC), which occurred in January 2019, with building contractual agreements closed out as of March 31, 2019. CDC no longer pays office rental or building maintenance contracts for upkeep. However, since moving into the New Embassy Compound, CDC and USAID incurs additional ICASS costs (i.e., Non-Residential Building Maintenance).

Overall M&O needs were reviewed during budgetary discussions. Technical and non-technical staff are conducting SIMS visits on a monthly basis. In alignment with COP guidance, the PEPFAR Coordination Office (PCO) will serve as the interagency point of contact for the oversight of the required Gender and Sexual Diversity Training (GSD) required for new staff within the first two months of arrival or hire at Post. PCO is also leading discussions with stakeholders on Index Testing requirements and certifications.

# APPENDIX A: SNU PRIORITIZATION AND CURRENT ART COVERAGE

| Province | District | <1 | | 01-04 | | 05-09 | | 10-14 | | 15-19 | | 20-24 | | 25-29 | | 30-34 | | 35-39 | | 40-44 | | 45-49 | | 50+ | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| Bulawayo | *Bulawayo* | 72% | 108% | 52% | 69% | 64% | 80% | 78% | 79% | 107% | 116% | 71% | 110% | 58% | 103% | 69% | 99% | 72% | 90% | 69% | 79% | 70% | 77% | 67% | 70% |
| Harare | *Harare* | 56% | 50% | 41% | 47% | 74% | 81% | 67% | 69% | 71% | 70% | 67% | 66% | 77% | 79% | 86% | 82% | 88% | 78% | 82% | 64% | 78% | 61% | 63% | 49% |
| | *Chitungwiza* | 138% | 131% | 78% | 70% | 42% | 41% | 28% | 30% | 32% | 49% | 26% | 109% | 36% | 142% | 68% | 157% | 62% | 136% | 53% | 110% | 58% | 104% | 45% | 92% |
| Manicaland | *Buhera* | 81% | 70% | 76% | 77% | 87% | 107% | 77% | 89% | 116% | 99% | 93% | 82% | 119% | 102% | 117% | 117% | 105% | 121% | 125% | 116% | 135% | 156% | 94% | 133% |
| | Chimanimani | 45% | 69% | 68% | 112% | 84% | 85% | 59% | 62% | 96% | 87% | 121% | 158% | 186% | 183% | 90% | 87% | 87% | 64% | 65% | 79% | 105% | 112% | 70% | 87% |
| | *Chipinge* | 125% | 117% | 95% | 121% | 101% | 118% | 67% | 66% | 73% | 108% | 93% | 99% | 127% | 95% | 132% | 93% | 124% | 84% | 118% | 69% | 112% | 94% | 69% | 62% |
| | *Makoni* | 47% | 88% | 69% | 92% | 88% | 107% | 76% | 80% | 81% | 94% | 55% | 88% | 86% | 95% | 90% | 81% | 91% | 83% | 89% | 69% | 94% | 93% | 82% | 92% |
| | *Mutare* | 31% | 46% | 53% | 66% | 67% | 80% | 53% | 62% | 78% | 87% | 60% | 74% | 75% | 82% | 68% | 74% | 66% | 70% | 66% | 70% | 75% | 88% | 73% | 91% |
| | *Mutasa* | 100% | 211% | 174% | 145% | 97% | 146% | 83% | 92% | 90% | 104% | 76% | 113% | 127% | 134% | 123% | 102% | 114% | 99% | 122% | 100% | 112% | 121% | 82% | 99% |
| | Nyanga | 51% | 52% | 86% | 73% | 102% | 103% | 75% | 69% | 114% | 164% | 98% | 95% | 84% | 75% | 76% | 66% | 67% | 69% | 85% | 118% | 79% | 108% | 98% | 99% |
| Mashonaland Central | Bindura | 113% | 161% | 84% | 94% | 79% | 97% | 43% | 45% | 52% | 68% | 52% | 102% | 46% | 106% | 66% | 126% | 74% | 126% | 86% | 107% | 109% | 129% | 67% | 88% |
| | Centenary | 210% | 181% | 106% | 111% | 162% | 177% | 97% | 83% | 73% | 86% | 53% | 86% | 48% | 95% | 96% | 146% | 105% | 122% | 117% | 122% | 118% | 116% | 92% | 81% |
| | *Guruve* | 0% | 42% | 111% | 130% | 110% | 126% | 78% | 77% | 92% | 102% | 92% | 135% | 115% | 174% | 118% | 136% | 103% | 125% | 113% | 124% | 147% | 127% | 71% | 71% |
| | *Mazowe* | 145% | 100% | 87% | 121% | 177% | 163% | 111% | 106% | 94% | 113% | 69% | 128% | 89% | 133% | 129% | 140% | 144% | 139% | 176% | 125% | 151% | 116% | 88% | 65% |
| | *Mbire* | 53% | 163% | 116% | 118% | 197% | 185% | 104% | 108% | 122% | 93% | 47% | 77% | 55% | 85% | 105% | 128% | 111% | 132% | 121% | 129% | 163% | 154% | 110% | 87% |
| | *Mt. Darwin* | 139% | 67% | 82% | 144% | 138% | 152% | 76% | 84% | 100% | 99% | 55% | 79% | 54% | 70% | 90% | 110% | 106% | 128% | 124% | 113% | 160% | 139% | 99% | 96% |
| | Rushinga | 206% | 35% | 83% | 76% | 223% | 274% | 180% | 161% | 170% | 163% | 70% | 97% | 56% | 103% | 81% | 133% | 127% | 141% | 151% | 185% | 206% | 191% | 146% | 139% |
| | Shamva | 93% | 170% | 106% | 121% | 115% | 109% | 88% | 75% | 96% | 109% | 75% | 82% | 64% | 78% | 92% | 102% | 101% | 102% | 115% | 172% | 134% | 97% | 100% | 74% |
| Mashonaland East | Chikomba | 23% | 31% | 32% | 68% | 54% | 64% | 77% | 62% | 63% | 65% | 50% | 67% | 61% | 92% | 59% | 63% | 71% | 88% | 78% | 91% | 107% | 99% | 71% | 70% |
| | *Goromonzi* | 69% | 54% | 29% | 27% | 51% | 39% | 50% | 54% | 56% | 63% | 54% | 64% | 40% | 60% | 54% | 68% | 74% | 72% | 64% | 62% | 67% | 65% | 58% | 56% |
| | Hwedza | 106% | 262% | 101% | 98% | 81% | 88% | 79% | 111% | 83% | 143% | 144% | 129% | 86% | 57% | 62% | 72% | 63% | 77% | 78% | 104% | 95% | 108% | 75% | 56% |
| | *Marondera* | 70% | 54% | 30% | 66% | 78% | 109% | 56% | 62% | 86% | 58% | 41% | 64% | 40% | 58% | 49% | 60% | 59% | 74% | 78% | 79% | 86% | 81% | 75% | 62% |
| | Mudzi | 124% | 84% | 70% | 102% | 75% | 82% | 59% | 70% | 75% | 86% | 69% | 60% | 91% | 66% | 106% | 75% | 89% | 80% | 85% | 75% | 84% | 109% | 67% | 66% |
| | *Murehwa* | 60% | 48% | 48% | 46% | 66% | 81% | 59% | 69% | 79% | 68% | 46% | 63% | 41% | 57% | 69% | 73% | 83% | 102% | 97% | 95% | 99% | 98% | 78% | 77% |
| | Mutoko | 26% | 37% | 53% | 52% | 56% | 67% | 50% | 51% | 59% | 59% | 35% | 65% | 32% | 62% | 39% | 76% | 61% | 98% | 73% | 105% | 91% | 144% | 74% | 94% |
| | *Seke* | 23% | 37% | 28% | 36% | 59% | 60% | 63% | 74% | 72% | 86% | 46% | 91% | 38% | 70% | 49% | 54% | 65% | 62% | 68% | 72% | 124% | 110% | 85% | 61% |
| | UMP | 41% | 21% | 47% | 111% | 81% | 97% | 72% | 69% | 87% | 88% | 44% | 82% | 65% | 83% | 88% | 73% | 85% | 80% | 75% | 78% | 79% | 100% | 68% | 57% |
| Mashonaland West | *Chegutu* | 56% | 76% | 68% | 100% | 93% | 83% | 56% | 63% | 71% | 91% | 70% | 127% | 85% | 128% | 123% | 116% | 113% | 96% | 85% | 84% | 91% | 89% | 63% | 74% |
| | *Hurungwe* | 68% | 108% | 79% | 86% | 80% | 104% | 53% | 59% | 89% | 107% | 79% | 111% | 107% | 129% | 107% | 107% | 101% | 91% | 89% | 81% | 95% | 83% | 60% | 82% |
| | Kariba | 64% | 163% | 77% | 96% | 98% | 139% | 79% | 76% | 103% | 81% | 61% | 42% | 82% | 48% | 95% | 71% | 142% | 86% | 113% | 65% | 202% | 80% | 102% | 58% |
| | *Makonde* | 8% | 29% | 85% | 134% | 79% | 111% | 57% | 59% | 86% | 100% | 72% | 108% | 85% | 111% | 100% | 115% | 118% | 112% | 105% | 91% | 102% | 101% | 76% | 84% |
| | *Mhondoro* | 70% | 163% | 59% | 102% | 90% | 121% | 61% | 79% | 113% | 128% | 88% | 129% | 74% | 102% | 103% | 107% | 92% | 90% | 80% | 79% | 93% | 97% | 64% | 87% |
| | *Sanyati* | 30% | 40% | 44% | 54% | 86% | 100% | 44% | 55% | 68% | 88% | 85% | 116% | 96% | 107% | 98% | 110% | 109% | 90% | 100% | 80% | 94% | 94% | 83% | 84% |
| | *Zvimba* | 55% | 101% | 52% | 77% | 135% | 155% | 65% | 82% | 106% | 110% | 144% | 363% | 394% | 124% | 142% | 129% | 107% | 103% | 89% | 84% | 93% | 95% | 64% | 100% |
| Masvingo | Bikita | 69% | 35% | 71% | 90% | 131% | 135% | 88% | 98% | 138% | 83% | 111% | 90% | 143% | 93% | 162% | 121% | 111% | 92% | 119% | 100% | 134% | 136% | 145% | 169% |
| | *Chiredzi* | 42% | 51% | 66% | 95% | 62% | 68% | 45% | 54% | 73% | 58% | 54% | 78% | 53% | 65% | 59% | 68% | 55% | 62% | 55% | 58% | 74% | 83% | 69% | 82% |
| | *Chivi* | 18% | 49% | 83% | 106% | 117% | 123% | 117% | 118% | 119% | 94% | 85% | 91% | 67% | 91% | 96% | 96% | 96% | 85% | 108% | 101% | 138% | 137% | 112% | 128% |
| | *Gutu* | 109% | 132% | 94% | 152% | 131% | 112% | 98% | 88% | 104% | 81% | 67% | 91% | 55% | 72% | 86% | 84% | 77% | 93% | 78% | 94% | 106% | 115% | 88% | 113% |
| | *Masvingo* | 58% | 99% | 61% | 74% | 92% | 84% | 91% | 77% | 103% | 111% | 92% | 126% | 74% | 95% | 82% | 83% | 73% | 80% | 90% | 87% | 88% | 114% | 113% | 123% |
| | *Mwenezi* | 78% | 58% | 89% | 137% | 68% | 116% | 74% | 66% | 97% | 72% | 76% | 89% | 85% | 87% | 87% | 64% | 68% | 81% | 79% | 92% | 116% | 137% | 89% | 135% |
| | *Zaka* | 14% | 48% | 88% | 103% | 134% | 149% | 116% | 99% | 146% | 97% | 100% | 97% | 111% | 102% | 120% | 103% | 115% | 102% | 124% | 117% | 168% | 175% | 136% | 141% |
| Matabeleland North | Binga | 18% | 54% | 30% | 42% | 106% | 96% | 65% | 95% | 75% | 83% | 33% | 67% | 42% | 57% | 46% | 62% | 55% | 71% | 86% | 76% | 107% | 98% | 110% | 101% |
| | *Bubi* | 10% | 10% | 51% | 40% | 77% | 85% | 59% | 71% | 57% | 78% | 27% | 93% | 57% | 81% | 73% | 66% | 78% | 74% | 86% | 70% | 96% | 91% | 115% | 97% |
| | Hwange | 25% | 30% | 27% | 30% | 92% | 72% | 72% | 88% | 98% | 91% | 46% | 75% | 40% | 56% | 44% | 58% | 58% | 64% | 69% | 74% | 109% | 99% | 143% | 119% |
| | *Lupane* | 56% | 34% | 70% | 58% | 118% | 108% | 99% | 81% | 91% | 86% | 51% | 98% | 56% | 79% | 63% | 98% | 93% | 96% | 107% | 102% | 131% | 100% | 149% | 111% |
| | *Nkayi* | 116% | 94% | 100% | 81% | 137% | 107% | 101% | 104% | 91% | 96% | 55% | 114% | 85% | 116% | 94% | 93% | 106% | 93% | 103% | 97% | 142% | 139% | 157% | 129% |
| | *Tsholotsho* | 97% | 85% | 40% | 73% | 87% | 98% | 92% | 93% | 89% | 94% | 51% | 83% | 56% | 87% | 84% | 99% | 105% | 99% | 116% | 97% | 126% | 111% | 154% | 106% |
| | *Umguza* | 28% | 23% | 41% | 44% | 59% | 64% | 46% | 50% | 39% | 48% | 38% | 59% | 39% | 47% | 42% | 48% | 53% | 50% | 67% | 58% | 83% | 73% | 86% | 88% |
| Matabeleland South | *Beitbridge* | 44% | 49% | 50% | 70% | 112% | 132% | 101% | 93% | 115% | 103% | 96% | 100% | 39% | 82% | 52% | 72% | 61% | 72% | 71% | 80% | 111% | 121% | 106% | 130% |
| | *Bulilima* | 36% | 66% | 80% | 115% | 126% | 131% | 89% | 80% | 78% | 86% | 69% | 74% | 105% | 89% | 104% | 91% | 101% | 98% | 95% | 87% | 107% | 103% | 81% | 89% |
| | *Gwanda* | 44% | 53% | 89% | 109% | 96% | 101% | 78% | 81% | 98% | 99% | 52% | 99% | 90% | 116% | 59% | 86% | 63% | 85% | 65% | 78% | 96% | 124% | 81% | 97% |
| | *Insiza* | 85% | 80% | 98% | 77% | 96% | 99% | 72% | 61% | 82% | 97% | 84% | 90% | 85% | 79% | 79% | 68% | 71% | 68% | 72% | 72% | 87% | 96% | 69% | 87% |
| | *Mangwe* | 36% | 49% | 53% | 69% | 62% | 59% | 45% | 49% | 57% | 55% | 42% | 69% | 47% | 85% | 66% | 104% | 77% | 118% | 91% | 121% | 116% | 141% | 84% | 114% |
| | *Matobo* | 17% | 78% | 106% | 64% | 132% | 119% | 97% | 100% | 131% | 110% | 44% | 84% | 50% | 85% | 77% | 109% | 83% | 104% | 79% | 98% | 92% | 114% | 80% | 95% |
| | *Umzingwane* | 12% | 23% | 56% | 48% | 137% | 111% | 93% | 95% | 141% | 108% | 62% | 100% | 55% | 94% | 70% | 99% | 75% | 99% | 74% | 93% | 88% | 115% | 78% | 108% |
| Midlands | Chirumhanzu | 46% | 38% | 51% | 41% | 91% | 87% | 83% | 81% | 112% | 93% | 85% | 83% | 58% | 72% | 63% | 76% | 73% | 77% | 81% | 85% | 129% | 111% | 89% | 99% |
| | Gokwe North | 64% | 102% | 92% | 114% | 124% | 164% | 107% | 106% | 98% | 104% | 52% | 99% | 55% | 58% | 90% | 91% | 74% | 75% | 87% | 73% | 123% | 102% | 75% | 102% |
| | *Gokwe South* | 67% | 57% | 70% | 96% | 96% | 119% | 81% | 79% | 85% | 111% | 83% | 103% | 104% | 108% | 88% | 70% | 65% | 69% | 81% | 72% | 83% | 85% | 76% | 79% |
| | *Gweru* | 37% | 44% | 47% | 59% | 70% | 86% | 93% | 91% | 125% | 128% | 82% | 114% | 99% | 104% | 70% | 74% | 72% | 86% | 87% | 91% | 100% | 104% | 96% | 99% |
| | *Kwekwe* | 81% | 69% | 56% | 62% | 80% | 77% | 58% | 62% | 85% | 82% | 71% | 91% | 60% | 73% | 68% | 74% | 65% | 67% | 68% | 73% | 104% | 99% | 72% | 93% |
| | *Mberengwa* | 50% | 56% | 70% | 112% | 121% | 103% | 75% | 81% | 83% | 95% | 66% | 102% | 83% | 99% | 93% | 92% | 84% | 85% | 98% | 79% | 123% | 113% | 94% | 107% |
| | Shurugwi | 47% | 54% | 56% | 66% | 80% | 73% | 63% | 63% | 76% | 73% | 47% | 70% | 36% | 58% | 49% | 57% | 56% | 70% | 64% | 71% | 78% | 79% | 66% | 90% |
| | Zvishavane | 26% | 54% | 35% | 51% | 52% | 59% | 55% | 54% | 75% | 83% | 75% | 71% | 38% | 64% | 45% | 63% | 57% | 59% | 68% | 76% | 115% | 119% | 91% | 80% |

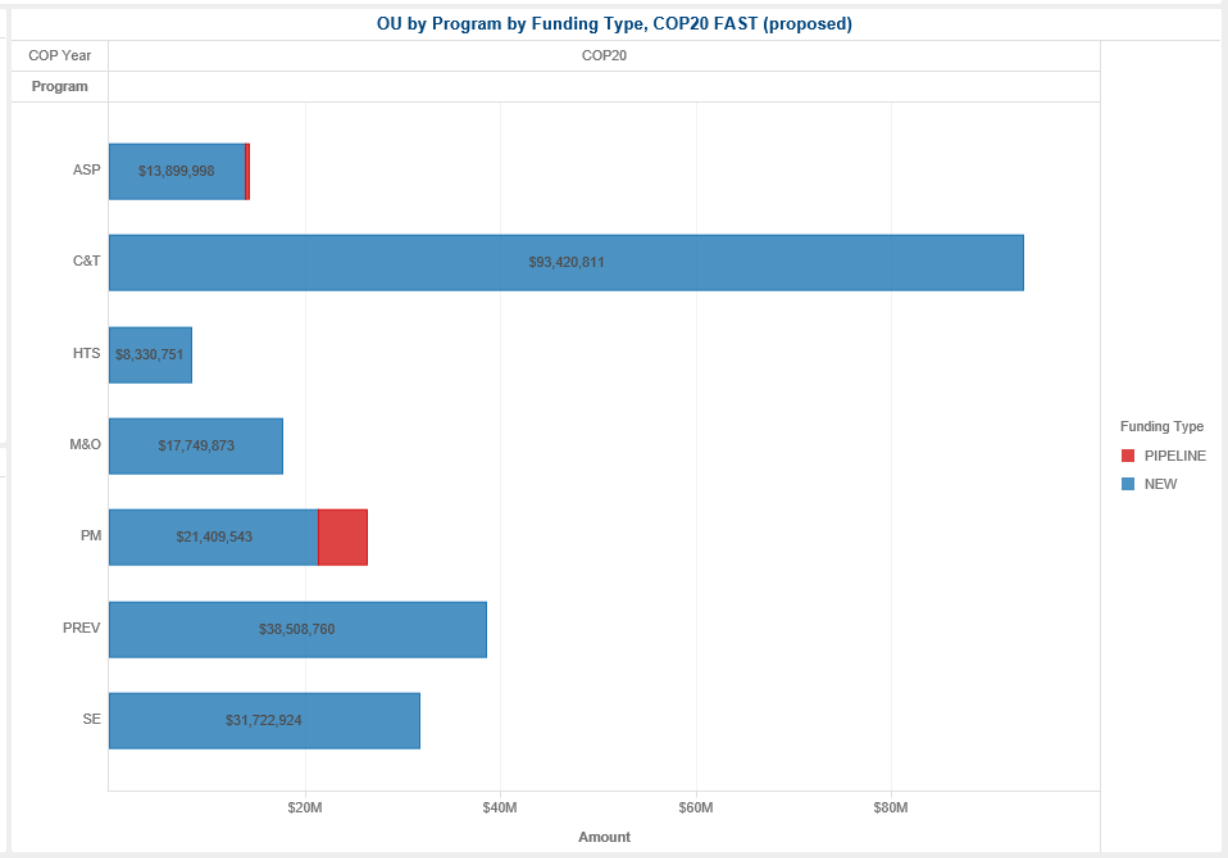
| Key |
|---|
| >95% |
| 90-95% |
| 80-89% |
| 70-79% |
| <70% |

| District Support |
|---|
| *CDC DSD Districts* |
| *USAID DSD Districts* |
| Above-Site TA Districts |

# 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** |
| **$5,330,861** | **$225,042,660** | **$230,373,521** |

*Data included in Table B.1.2 should match FACTS Info records and total applied pipeline amount required in PLL guidance.

| 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 | $ 1,556,694 |
| HVAB/Y | Abstinence/Be Faithful Prevention/Youth | $8,949,763 |
| HVOP | Other Sexual Prevention | $17,905,594 |
| IDUP | Injecting and Non-Injecting Drug Use | - |
| HMBL | Blood Safety | - |
| HMIN | Injection Safety | - |
| CIRC | Male Circumcision | $19,037,277 |
| HVCT | Counseling and Testing | $7,516,081 |
| HBHC | Adult Care and Support | $60,000 |
| PDCS | Pediatric Care and Support | $ 3,192,762 |
| HKID | Orphans and Vulnerable Children | $36,545,151 |
| HTXS | Adult Treatment | $81,320,193 |
| HTXD | ARV Drugs | $18,857,982 |
| PDTX | Pediatric Treatment | $ 1,286,075 |
| HVTB | TB/HIV Care | $7,889,593 |
| HLAB | Lab | $1,461,215 |
| HVSI | Strategic Information | $3,199,633 |
| OHSS | Health Systems Strengthening | $8,877,807 |
| HVMS | Management and Operations | $ 7,386,843 |
| **TOTAL** | | **$ 225,042,663** |

*Data included in Table B.2.2 should match FACTS Info records.

## B.2 Resource Projections

In COP 20, PEPFAR Zimbabwe used the Funding Allocation to Strategy Tool (FAST) to drive budget decisions and funding allocations across initiatives (HKID, VMMC, Cervical Cancer, DREAMS, etc.), beneficiaries and program areas. The FAST is a comprehensive planning and budgeting tool focused on short and long-term solutions and outcomes that will guide the financing and development of implementing partner work-plans in a deliberate effort to optimize PEPFAR investments. In order to populate the FAST, the PEPFAR Zimbabwe team considered the following sources of information to guide the apportionment of COP 18 resources: Incremental budget adjustments, pipeline and partner performance (e.g., how much does a partner need to fund a specific activity or package of services such as scaling up access to TPT); Review of COP19 work plans and budgets, with specific attention to program management costs; and solution centered approaches to reach 95-95-95. Further refinements and efficiencies made to the HIV testing strategy influenced budget decisions through the reduction of funding for PITC in all districts, increased focus on retention and scale-up of viral load. Zimbabwe will continue to scale up recency testing for all newly diagnosed adults and expand case-based surveillance to 100 percent coverage. For the first time in COP 20, PEPFAR has focused investments on health information systems (EHR) as part of its retention strategy and to build sustainability in current programs. The PEPFAR team currently implements routine monitoring on a monthly basis to

track partner performance and progress and will incorporate a review of expenditure analysis (EA) data quarterly to ensure partners are able to implement programs effectively and stay on track to achieve the targets with the budgets assigned to them.

# APPENDIX C: Tables and Systems Investments for Section 6.0

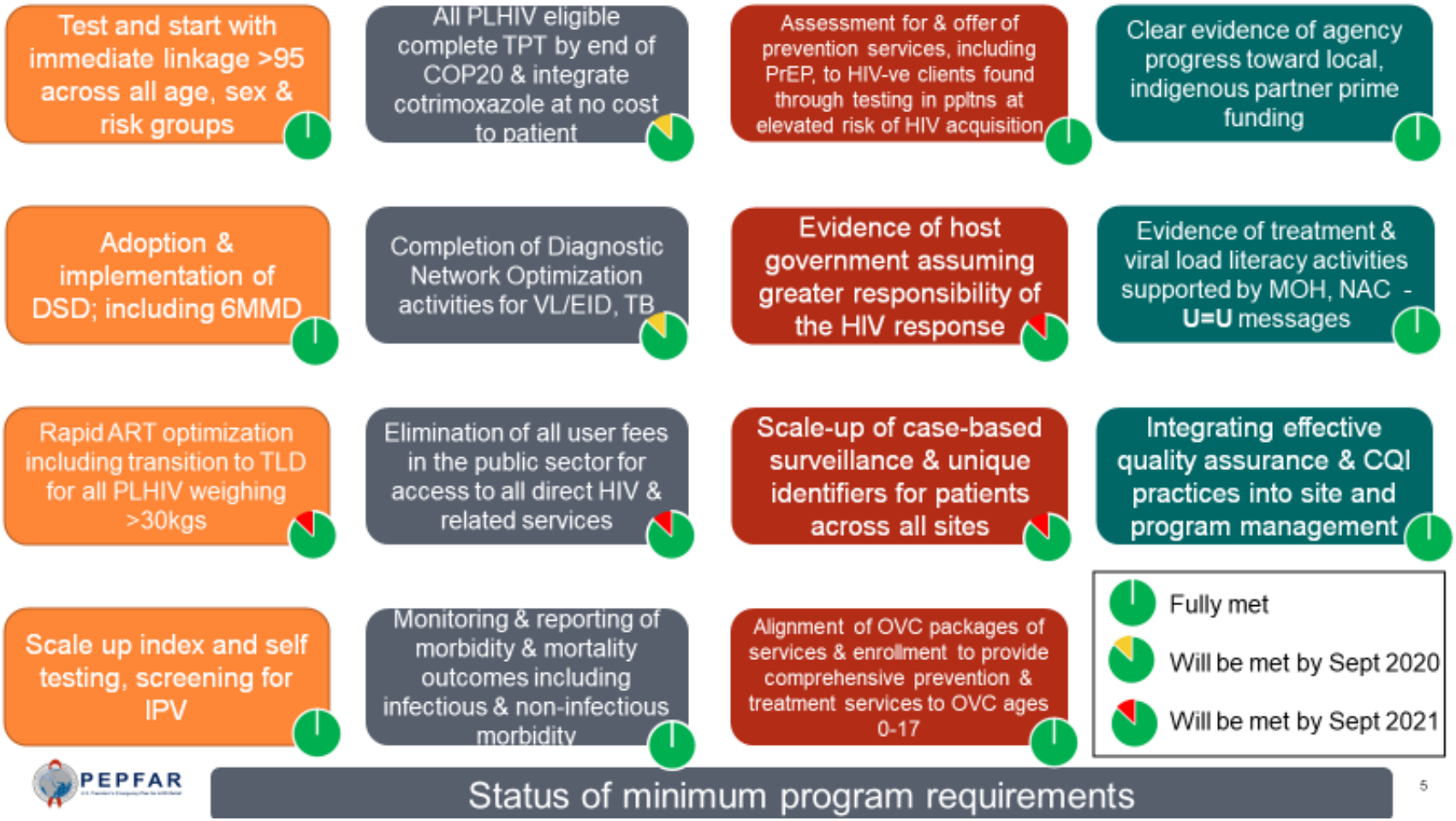
| Funding Agency | PrimePartner | COP20 Program Area | COP20 Beneficiary | COP20 Activity Category | Key Systems Barrier | Intervention Start | Intervention End | COP20 Benchmark |
|---|---|---|---|---|---|---|---|---|
| USAID | Family Health International | ASP: Policy, planning, coordination & management-NSD | Females: Young women & adolescent females | Oversight, technical assistance, and supervision to subnational levels | DREAMS activities are multisectoral, delivered by several different partners, which requires careful routine planning & coordination, and a well-functioning referral system, at district level. | COP18 | COP22 | 1) District referral directories updated at least annually; 2) Targets for referral closure rates set and closely monitored; 3) Layering and program completion data reviewed during stakeholder meetings to implementation adjustments; 4) DREAMS database and dashboards used in all district review meetings; 5) DREAMS Ambassador hired and on-boarded |
| USAID | FAMILY AIDS CARING TRUST | ASP: Policy, planning, coordination & management-NSD | Females: Young women & adolescent females | Oversight, technical assistance, and supervision to subnational levels | DREAMS activities are multisectoral, delivered by several different partners, which requires careful routine planning & coordination, and a well-functioning referral system, at district level. | COP17 | COP20 | 1) District referral directories updated at least annually; 2) Targets for referral closure rates set and closely monitored; 3) Layering and program completion data reviewed during stakeholder meetings to implementation adjustments; 4) DREAMS database and dashboards used in all district review meetings; 5) DREAMS Ambassador hired and on-boarded |
| USAID | Population Services International | ASP: Human resources for health-NSD | Females: Young women & adolescent females | Oversight, technical assistance, and supervision to subnational levels | Limited Nat'l level coordination of DREAMS programming especially in light of GF expansion | COP17 | COP22 | 1.) National level DREAMS meetings are facilitated by MOHCC Coordinator (at least 75% of bi-monthly meetings take place); 2.) PEPFAR supported DREAMS activities are incorporated in MOHCC quarterly prevention partnership meetings; 3.) MOHCC secondment acts as PoC for all PEPFAR learning visits |
| USAID | Population Services International | ASP: HMIS, surveillance, & research-NSD | Females: Young women & adolescent females | Program and data quality management | While the ability to track and understand layering of DREAMS interventions by unique individual has dramatically improved, gaps remain in understanding vulnerability and risk status of DREAMS AGYW and systems for ensuring referrals are completed. | COP17 | COP22 | 1) DREAMS database is used by 100% of IPs; 2) Database can report on vulnerability and risk factors of enrolled AGYW; 3) DREAMS referral process is automated in database; 4) DREAMS M&E framework, SOPs, protocols, and layering table are updated |
| USAID | Population Services International | ASP: Policy, planning, coordination & management-NSD | Non-Targeted Pop: Not disaggregated | Oversight, technical assistance, and supervision to subnational levels | Limited national coordination of biomedical prevention and other prevention activities. These activities are multisectoral and implemented by several stakeholders | COP16 | COP22 | 4 forums/ meetings; design of national prevention program; seamless multistakeholder coordination and transition to sustainable programming; implementation of national prevention programs sustains epidemic control; districts own integrated testing strategy |

| Funding Agency | PrimePartner | COP20 Program Area | COP20 Beneficiary | COP20 Activity Category | Key Systems Barrier | Intervention Start | Intervention End | COP20 Benchmark |
|---|---|---|---|---|---|---|---|---|
| USAID | Chemonics International, Inc. | ASP: Procurement & supply chain management-NSD | Non-Targeted Pop: Not disaggregated | Oversight, technical assistance, and supervision to subnational levels | Lack of MOHCC funding for procurment and supply chain coordination and the bi-annual national quantification and supply planning exercise. | COP16 | COP22 | 1) Reports from semiannual quantification exercise; 2) Maintain low stockout rates of tracer medicines/products within global industry standards: TLE &TLD<1%, LZN [peds]<1%,<br>male condoms <5%, Determine RTK <5%, VMMC universal surgical disposable kit <5% |
| USAID | Palladium International, LLC | ASP: HMIS, surveillance, & research-NSD | OVC: Not disaggregated | Program and data quality management | Harmonization of multiple case-load tracking systems is needed to support the Ministry in understanding the scope of services provided to OVCs. | COP19 | COP22 | 1) Exisiting OVC databases have been migrated into new database; 2) 100% of OVC partners are entering data in the new case management database; 3) Database can produce national level report on OVC_SERV across Ips |
| HHS/CDC | Trustees Of Columbia University In The City Of New York | ASP: Policy, planning, coordination & management-NSD | Non-Targeted Pop: Not disaggregated | Oversight, technical assistance, and supervision to subnational levels | No MOHCC suport for coordination and management | COP16 | COP22 | 1) CBS will be funcitoning at national level with recency testing at 1125 PEPFAR supported facilities.<br>2. A mobile E-HR application at 601 facilities<br>3. 524 facilities have full E-HR which includes 95% of site-level MER indicators with downtime <10% of the time across 90% of the facilities |
| HHS/CDC | UNIVERSITY OF WASHINGTON | ASP: HMIS, surveillance, & research-NSD | Non-Targeted Pop: Not disaggregated | HMIS systems | Enrolment and adherence to ART and TPT are a barrier to achieving epidemic control and PEPFAR/UNHLM targets on TB due to low demand, literacy gaps and misconceptions. | COP18 | COP22 | 1. All facilities with at least one completed QI project with results. 2. All facilities with ongoing QI initiatives |
| HHS/CDC | UNIVERSITY OF WASHINGTON | ASP: Policy, planning, coordination & management-NSD | Non-Targeted Pop: Not disaggregated | Oversight, technical assistance, and supervision to subnational levels | No MOHCC suport for coordination and management | COP18 | COP22 | 1. Ongoing review of HCW capacity development needs. 2. Ongoing revision of HCW capacity development curricula. 3. Availability of active PPPs. 4. Improved compliance of expenditure, liquidation and financial reporting. 5. SOPs for facility-community linkage initiatives |
| HHS/CDC | BIOMEDICAL RESEARCH & TRAINING INSTITUTE | ASP: HMIS, surveillance, & research-NSD | Non-Targeted Pop: Not disaggregated | HMIS systems | Lack of MOHCC funding for procurment and supply chain coordination and the bi-annual national quantification and supply planning exercise. | COP18 | COP22 | 1. 100% of PEPFAR supported sites have sample transportation in place<br>2. 60% of PEPFAR supported facilities implementing RTCQI<br>3. Facilities in 20 districts have an enhanced health systems and facility capaity including Intercadre functioning |

| Funding Agency | PrimePartner | COP20 Program Area | COP20 Beneficiary | COP20 Activity Category | Key Systems Barrier | Intervention Start | Intervention End | COP20 Benchmark |
|---|---|---|---|---|---|---|---|---|
| HHS/CDC | BIOMEDICAL RESEARCH & TRAINING INSTITUTE | ASP: Human resources for health-NSD | Non-Targeted Pop: Adults | HRH recruitment and retention | Limited implementation of the LIMS is a barrier to timely result transmission and reduced TAT | COP19 | COP22 | 15 VL labs with functional LIMS |
| HHS/CDC | BIOMEDICAL RESEARCH & TRAINING INSTITUTE | ASP: Laboratory systems strengthening-NSD | Non-Targeted Pop: Not disaggregated | Lab quality improvement and assurance | Slow and unstandardized rollout of DSD. Slow progress towards elimination of PMTCT | COP19 | COP22 | 100% of VL labs and 100% of facilities implementing CQI and EQA |
| HHS/CDC | BIOMEDICAL RESEARCH & TRAINING INSTITUTE | ASP: Policy, planning, coordination & management-NSD | Non-Targeted Pop: Not disaggregated | Oversight, technical assistance, and supervision to subnational levels | Lack of MOHCC funding for procurment and supply chain coordination and the bi-annual national quantification and supply planning exercise. | COP19 | COP22 | Improved coordination through TWG meetings, Quarterly site visits |
| HHS/CDC | UNIVERSITY OF WASHINGTON | ASP: Policy, planning, coordination & management of disease control programs-NSD | Females: Young women & adolescent females | Oversight, technical assistance, and supervision to subnational levels | While the ability to track and understand layering of DREAMS interventions by unique individual has dramatically improved, gaps remain in understanding vulnerability and risk status of DREAMS AGYW and systems for ensuring referrals are completed. | COP20 | COP22 | Four DREAMS district Ambassadors and coordination structure in place and active |
| HHS/CDC | Trustees Of Columbia University In The City Of New York | ASP: HMIS, surveillance, & research-NSD | Non-Targeted Pop: Not disaggregated | Surveillance | Limited data on source and populations newly infected with HIV in PMTCT, MSM, Adult women and men, AGYW | COP18 | COP21 | 1125 PEPFAR supported sites implementing HIV case surveillance with Recency Testing using Electronic Health Record and providing reports on 1) newly identified HIV-infected person and incident infections in defined geographic locations. 2) MER & MOHCC Monthly reports on all HIV/TB patients in all sub-populations, 3) Mortality surveillance among patients with EHR records. 4. Outbreak response and Policy utilization of data for epidemic control |

# APPENDIX D: Minimum Program Requirements

This should be addressed in narrative in the sections above however in this section succinctly note if the program is meeting or not meeting the minimum program requirement. The minimum requirements for continued PEPFAR support and the current status of these MPRs at the time of COP submission are included in the graphic below:



During FY 2020 (COP19 implementation), PEPFAR Zimbabwe expects to fully implement retention-related PEPFAR Minimum Program Requirements at every PEPFAR-supported site, as these have a known impact on continuity of ART. Site level implementation of the 4 elements listed in the table below will be routinely assessed via routine program data, SIMS, and community-led monitoring.

| **Site-Level Minimum Program Requirements** |
|---|
| Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. |
| 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. |
| Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services. |
| Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits. |