ZIMBABWE
Country Operational Plan
COP 2021

PEPFAR

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

Strategic Direction Summary
May 2021

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Acronym List

AE	Adverse Event
AGYW	Adolescent Girls and Young Women
ANC	Antenatal Clinic
ARPA	American Rescue Plan Act
ART	Antiretroviral Treatment
ARVs	Antiretroviral
BMGF	Bill & 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
PEP	Post-Exposure Prophylaxis
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	Technical Assistance for Treatment
TAT	Turn Around Time (Laboratory)
TB	Tuberculosis
TBD	To Be Determined
TG	Transgender
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

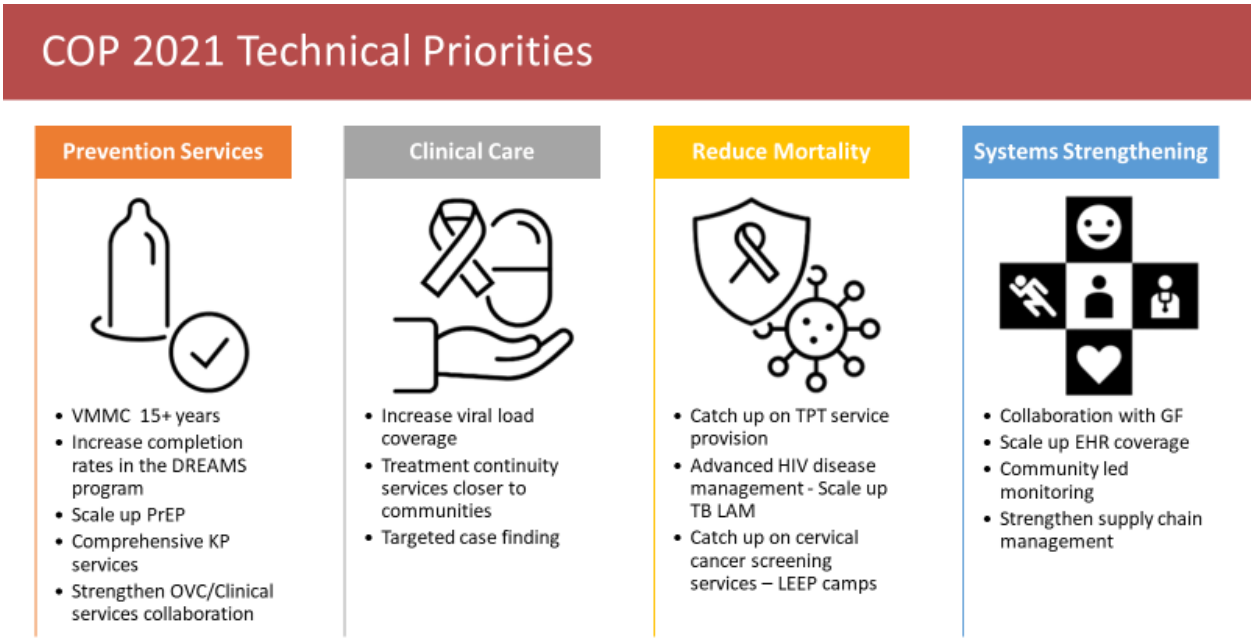
The President's Emergency Plan for AIDS Relief (PEPFAR) interagency team collaborated with key partners including the Government of Zimbabwe (GoZ), the Global Fund to Fight AIDS, Tuberculosis and Malaria (the "Global Fund"), civil society organizations (CSOs), and other bilateral and multilateral health development partners to develop the 2021 Country Operational Plan (COP) for FY 2022. 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).

COP 2021 aims to advance client centered services and implement resilient programs designed to mitigate the impacts of COVID-19 on the PEPFAR program. ZIMPHIA 2020 found that 86.8 percent of adults living with HIV were aware of their status and of those aware of their status, 97.0 percent were on antiretroviral treatment. Among those on treatment, 90.3 percent achieved viral load suppression. These exciting results demonstrate that Zimbabwe has achieved the second and third 90s nationally. Consequently, PEPFAR must evolve to realign PEPFAR-supported resources with the current epidemic context (and in the context of COVID-19).

Treatment targets are set to achieve and maintain 100 percent ART coverage within all districts and across all age and sex bands by the end of FY 2022. PEPFAR Zimbabwe will invest in the delivery of a comprehensive package of HIV treatment and prevention activities within 44 of Zimbabwe's 63 districts. To ensure equitable gains towards achieving sustainable epidemic control across Zimbabwe, the PEPFAR program will also provide above-site technical assistance to monitor the HIV response in the remaining 19 centrally supported districts. With over 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 populations lagging in these areas such as children, young women, young men, and pregnant women.

Zimbabwe continues to be challenged with socio-economic issues, fuel shortages, load-shedding, health worker strikes, and a fragile health care system. Investments in human resources for health (HRH) have been essential in securing 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.

Lastly, PEPFAR continues to work closely with the Global Fund's Country Coordinating Mechanism (CCM) to ensure the alignment of programming as GF's current funding cycle (2021-2023). PEPFAR, and the USG more broadly, continues to collaborate with the CCM to harmonize investments in COVID-19 mitigation measures.

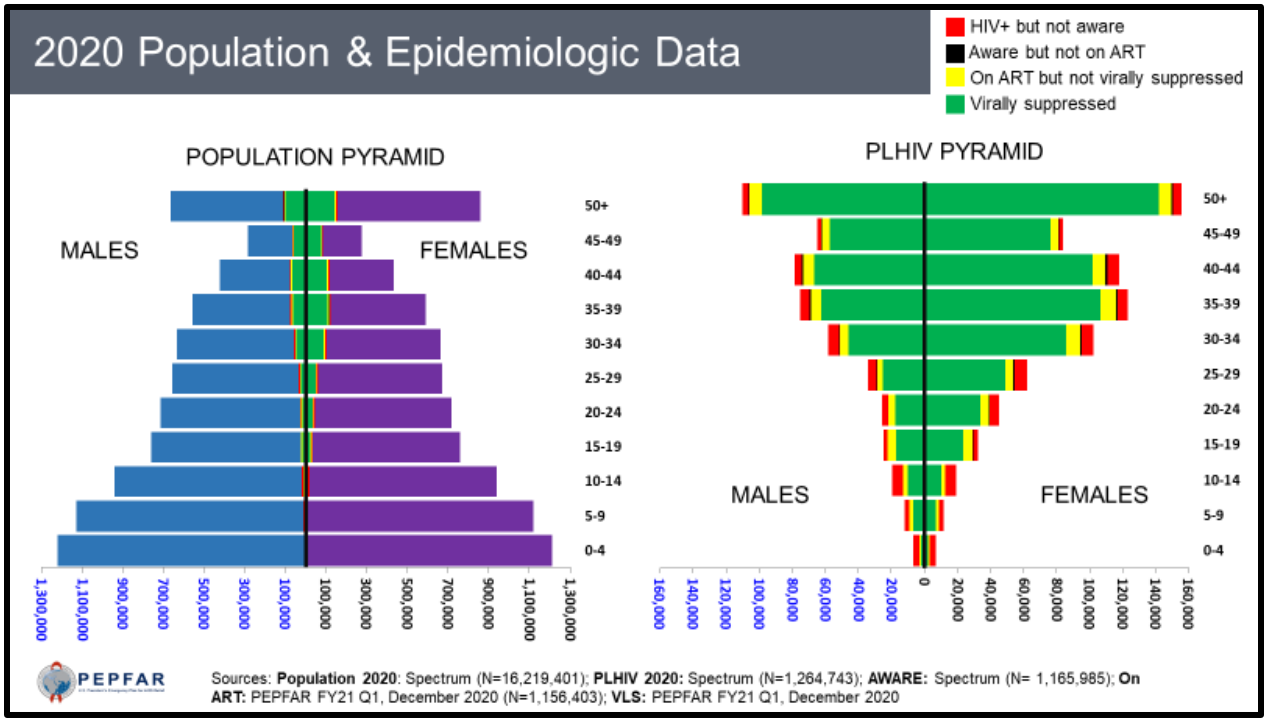


2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Zimbabwe has a generalized HIV epidemic and is home to 1.27 million people living with HIV (PLHIV), including 1.19 million adults and 69,972 children. An estimated 1.27 million people were living with HIV in 2020, with 5.53 being children 0-14 years. Among adults 15+ years living with HIV, 60.6% were females. Annual all-cause deaths among PLHIV have declined over the past decade with approximately 28,201 all cause deaths among PLHIV in 2020 compared to 127,871 in the year 2003. Total new HIV infections declined nationally from 98,668 in 2003 to 24,524 in 2020.

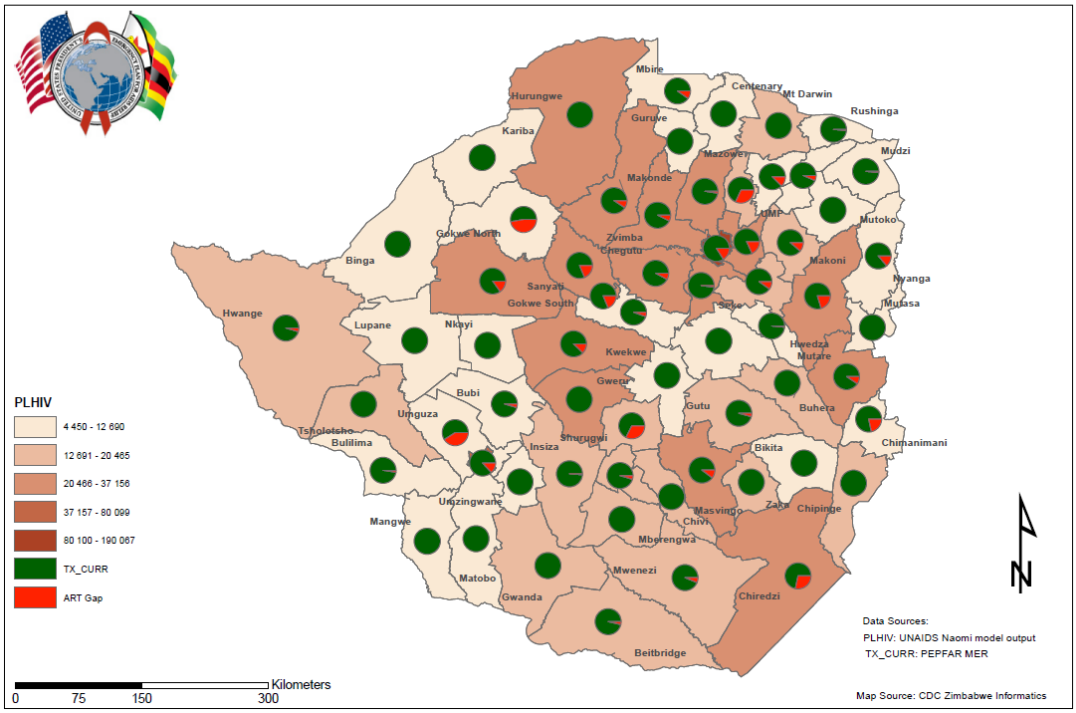
By the end of 2020, ART coverage among all HIV positive adults was 92% for adult men and 93% for adult women. Coverage for children was slightly lower at 66%.



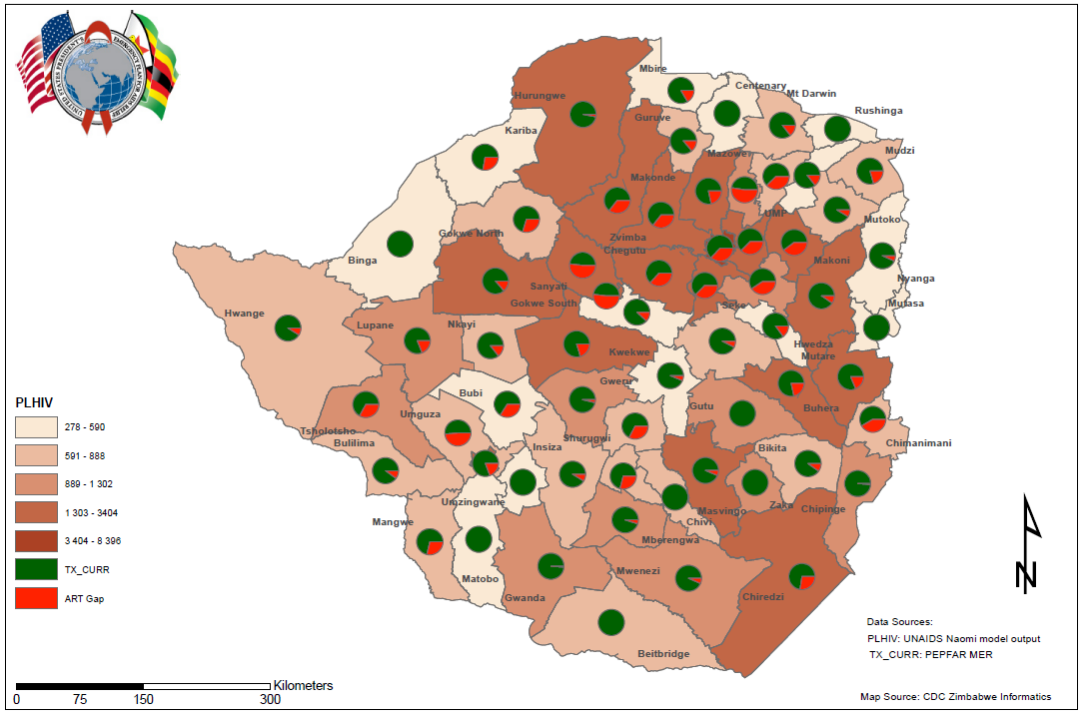
The 2020 ZIMPHIA showed that overall HIV prevalence for adults aged 15-49 was 11.8% in 2020, down from 18.1% in 2005 in the ZDHS. Among persons aged 15 to 64 years, HIV prevalence in the 2020 ZIMPHIA varied geographically, with higher prevalence in the provinces of Matabeleland North (14.9%), Bulawayo (14.0%), and Matabeleland South (17.6%) than in the other seven provinces, which were all below 14%. The highest HIV prevalence estimated was nearly 30% for both males (30.9%) and females (33.3%) but occurred at a slightly older age (50-54 years) among males as compared to females (45-49 years). The disparity in HIV prevalence by sex was most pronounced among young persons: HIV prevalence was three times higher among females (6.4%) than males (2.8%) aged 20 to 24 years.

In terms of viral load suppression (VLS), the ZIMPHIA 2020 showed that among adults living with HIV (ages 15 years and older) in Zimbabwe, VLS ranged from 66.2% among women aged 15-24 years to 90.3% among women aged 45-54 years, and from 49.2% among men aged 15-24 years to 91.7% among men aged 65 years and older. VLS was higher among women than men at ages 25-34 years, with 70.7% of women and 52.4% of men achieving VLS. Among both sexes, there was a substantial increase in VLS among men and women aged 35-44 years compared to those aged 15-24 years and aged 25-34 years. There was also a marked increase in VLS among women aged 45-54 years compared to women aged 35-44 years. Zimbabwe has now met the second and third 90-90-90 targets and has achieved the overall target for 2020 by exceeding 73% of VLS among all adults living with HIV.

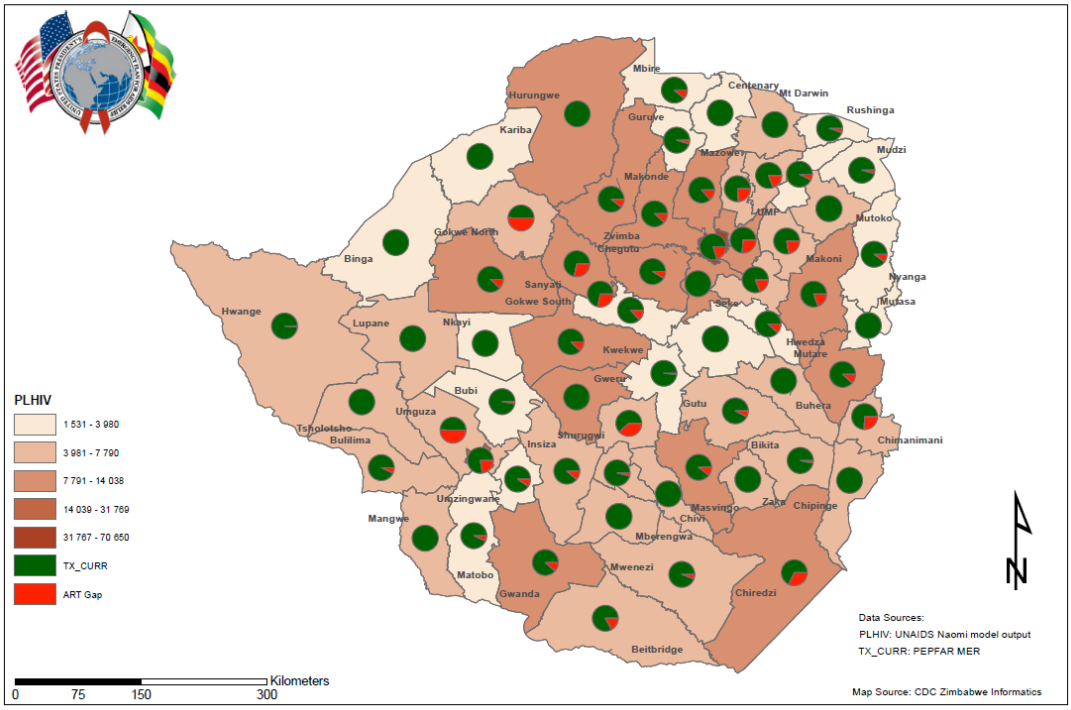
HIV Burden by District



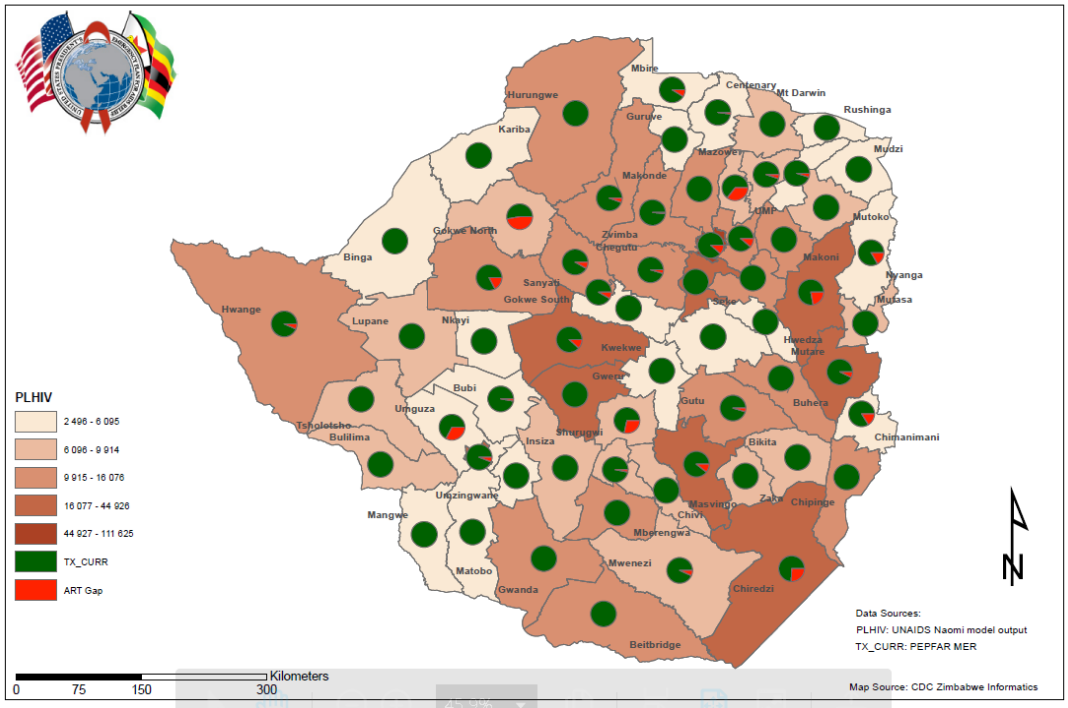
HIV Burden by District (Peds)



HIV Burden by District (Adult Men 15+)



HIV Burden by District (Adult Women 15+)



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	16,219,401	100%	3,272,011	20%	3,289,815	20%	1,477,082	9%	1,471,405	9%	3,494,383	22%	3,214,702	20%	UNAIDS Spectrum, 2020
HIV Prevalence (%)		7.8%		1.1%		1%		5.2%		3.3		18%		13%	UNAIDS Spectrum, 2020
AIDS Deaths (per year)	21,909		1,629		1,654		1,272		1,091		8,143		8,120		UNAIDS Spectrum, 2020
# PLHIV	1,264,743		34,805		35,167		72,861		45,790		651,819		424,301		UNAIDS Spectrum, 2020
Incidence Rate (Yr.)		.002						.004		.001		.006		.005	UNAIDS Spectrum, 2020
New Infections (Yr.)	22,470	100%					5,300	27%	1627	12%	6264	30%	5143	31%	UNAIDS Spectrum, 2020
Annual births	519,859														UNAIDS Spectrum, 2020
% of Pregnant Women with at least one ANC visit		93%													ZDHS, 2015
Pregnant women needing ARVs	51,655														UNAIDS Spectrum, 2019
Orphans (maternal, paternal, double)	162,368														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	16,219,401	7.8%	1,270,056	1,165,985	1,156,780	91%	89%	1,439,295	81,147	76,371
Population <15 years	6,561827	1.16%	75,796	50,105	49,863	66%	72%	149,198	2,881	2,752
Men 15-24 years	1,471,406	3.3%	48,947	43,117	42,786	87%	88	131,954	2,761	2,437
Men 25+ years	3,214,703	13.8%	422,555	393,772	391,064	92%	88%	245,664	26,945	25,602
Women 15-24 years	1,477,083	5.2%	77,342	68,526	67,999	88%	90%	400,810	14,277	13,003
Women 25+ years	3,494,383	18.5%	645415	610,465	605,068	94%	90%	511,669	34,283	32,577
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 *	4,933	1,225	1,241
FSW	45,000 #	54% ^	24,300 ^	18,954 +	16,281 +	67% +	73% +	13,510	2,615	2,242

*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

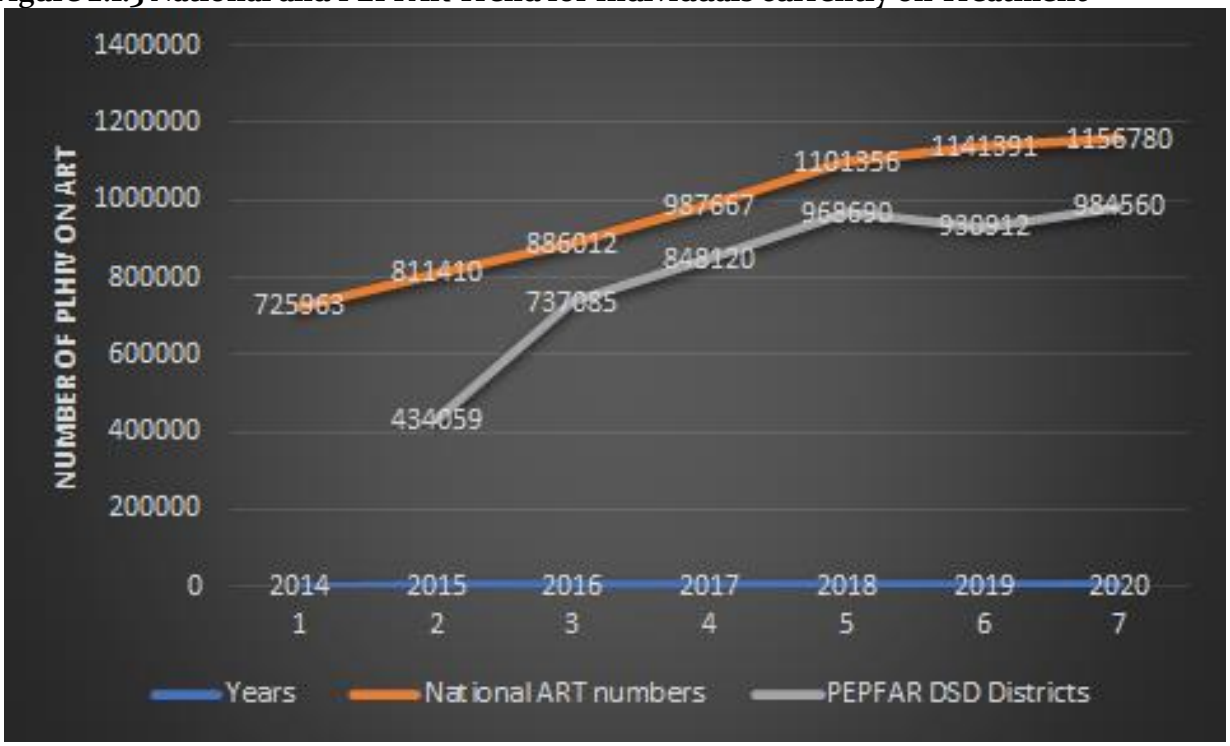


Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV

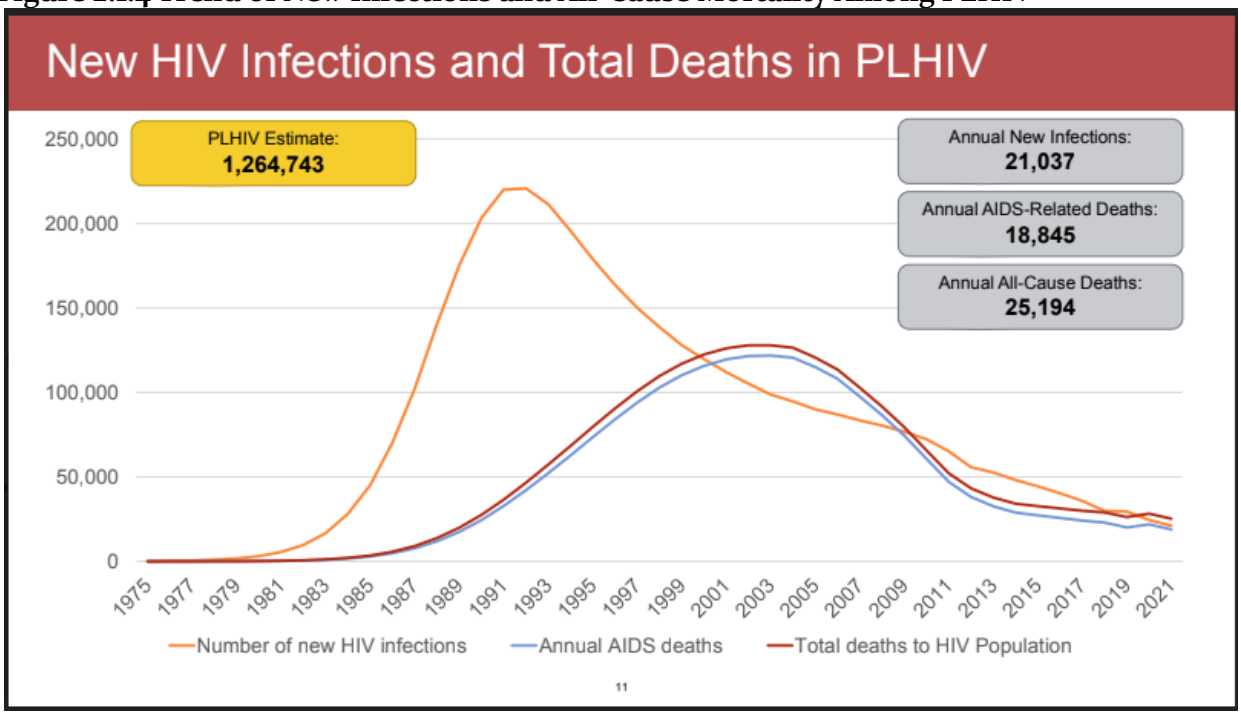


Figure 2.1.5 Progress retaining individuals in lifelong ART in FY20.

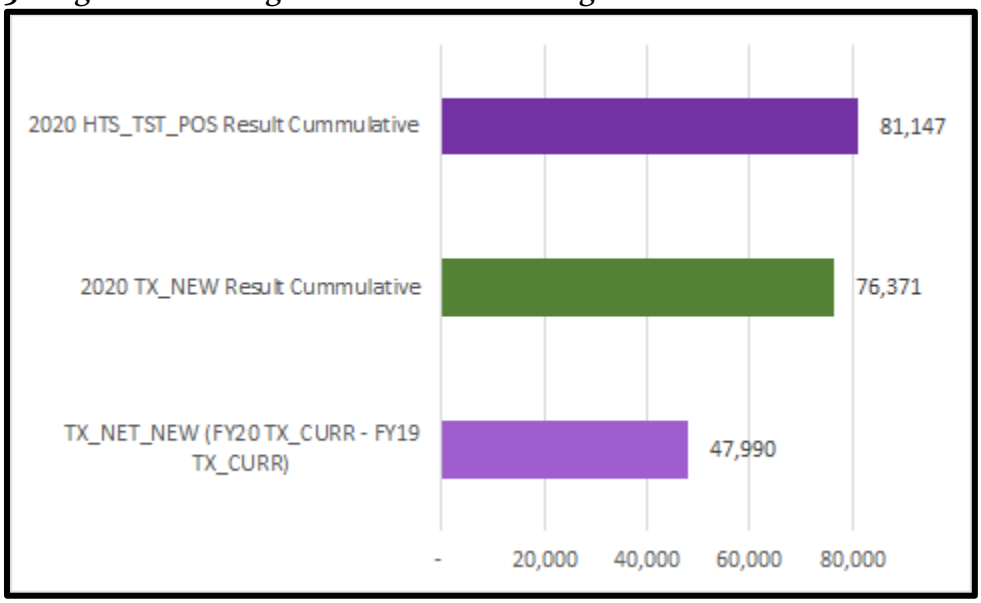


Figure 2.1.6 Number of clients lost from ART 2019 Q4 to 2020 Q4

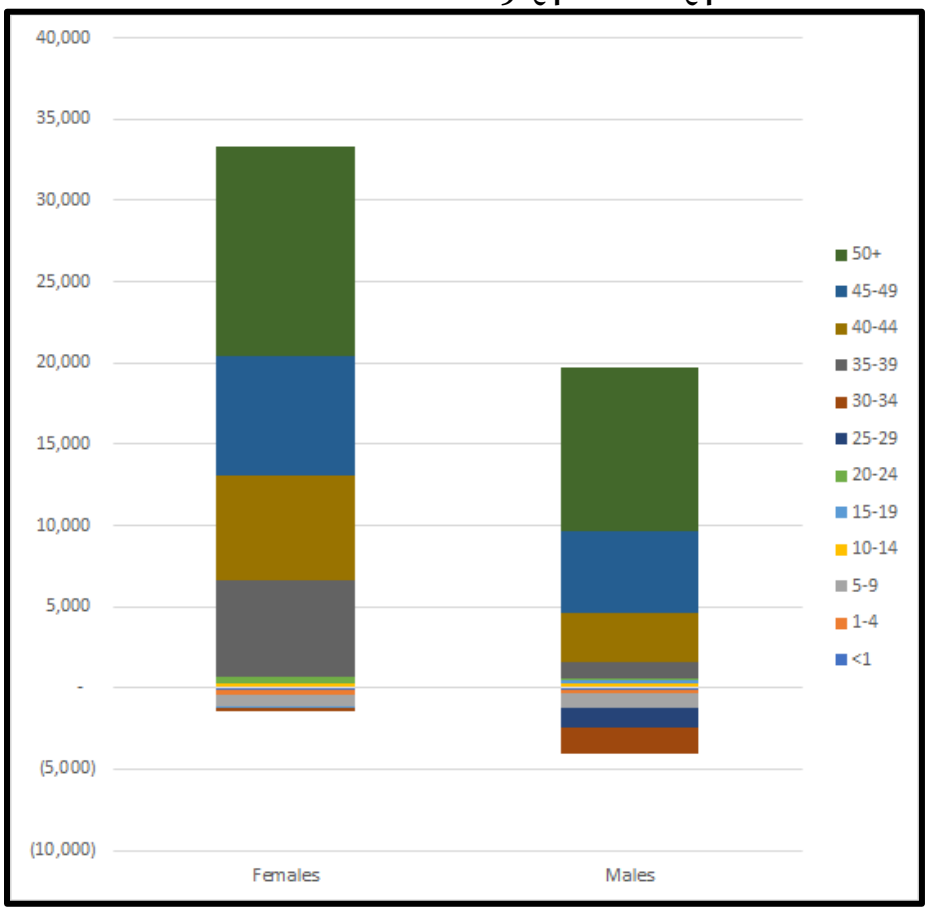
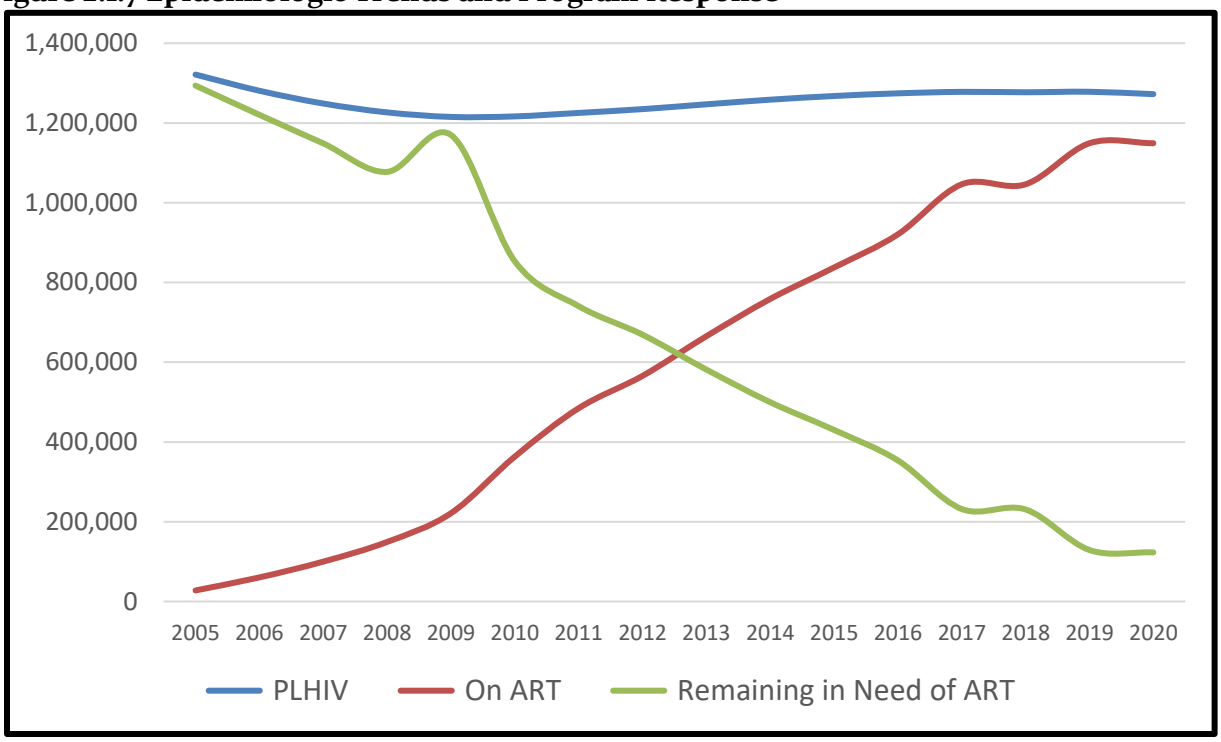
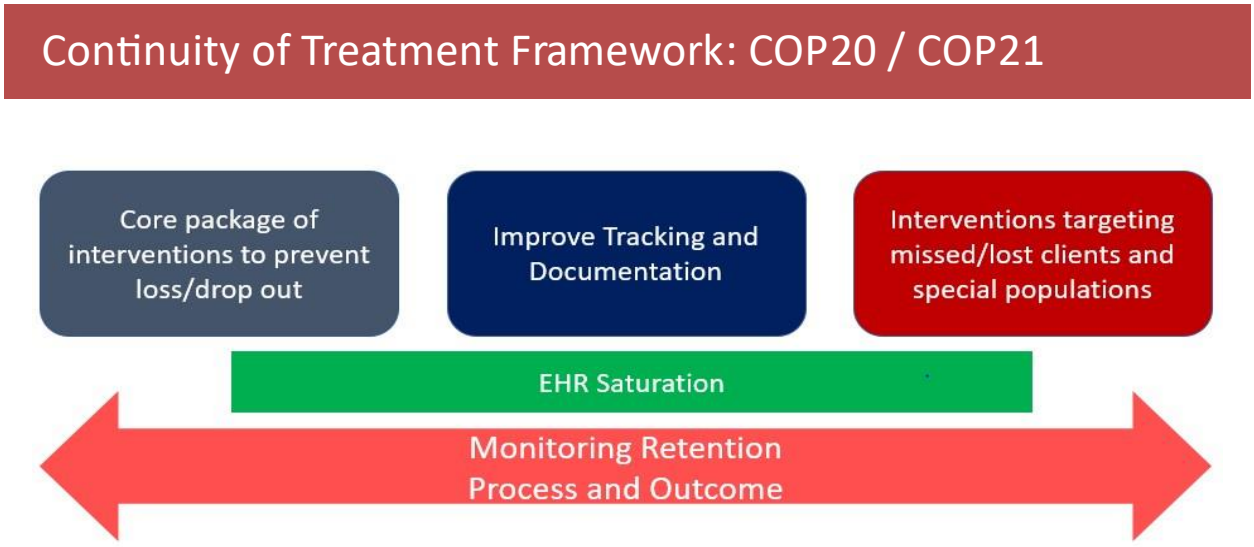


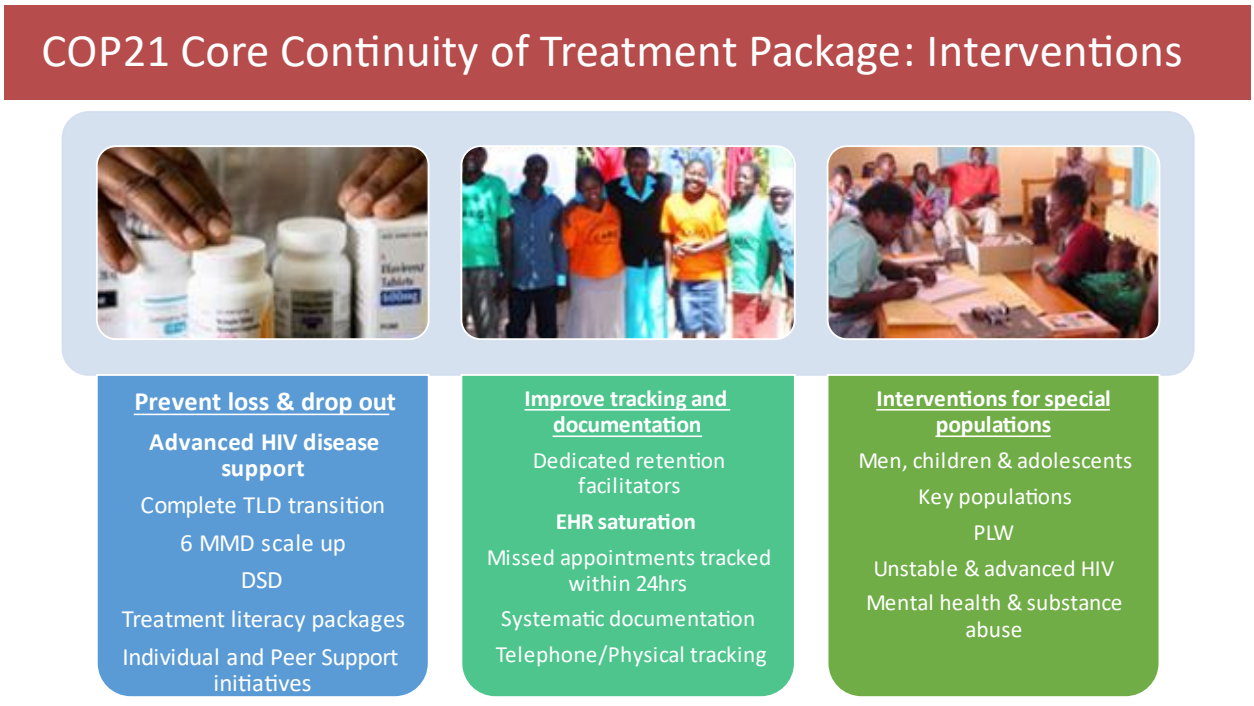
Figure 2.1.7 Epidemiologic Trends and Program Response



2.2 Activities and Areas of Focus for COP 21, Including Focus on Treatment Continuity

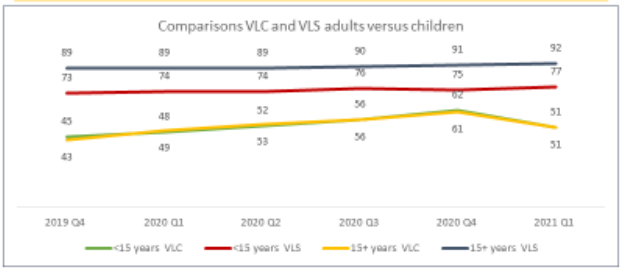
As the country achieves epidemic control, the program will focus on ensuring continuity of care and treatment and keeping clients on treatment healthy using the interventions and activities illustrated in the figures below.

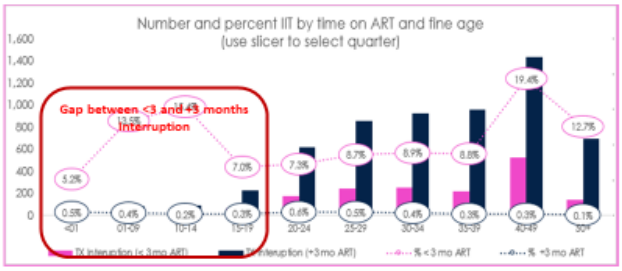




Pediatric HIV Treatment Services

Current Program Synopsis





What's New (or Continuing) for COP 2021?

Roll out HIV oral screening

Universal testing coverage for child contacts

Continue risk screening for efficiency

POC EID testing

Treatment optimization

pDTG, LPV/r granules, stop NVP

Scale VL testing

DSD, outreach, regular audits, CLI

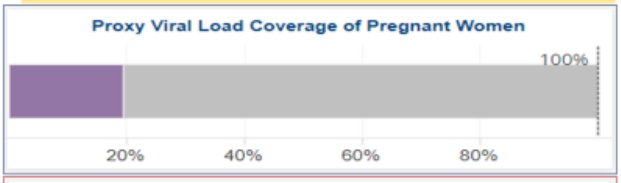
Evidence based interventions

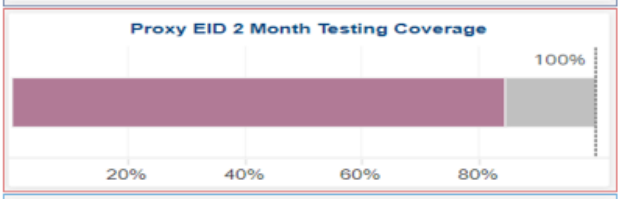
CATS, OTZ, peer support, OVC integration

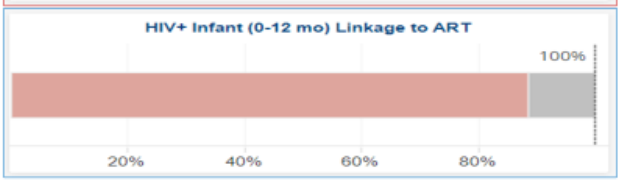
PEPFAR

Antenatal Services & PMTCT

Current Program Synopsis







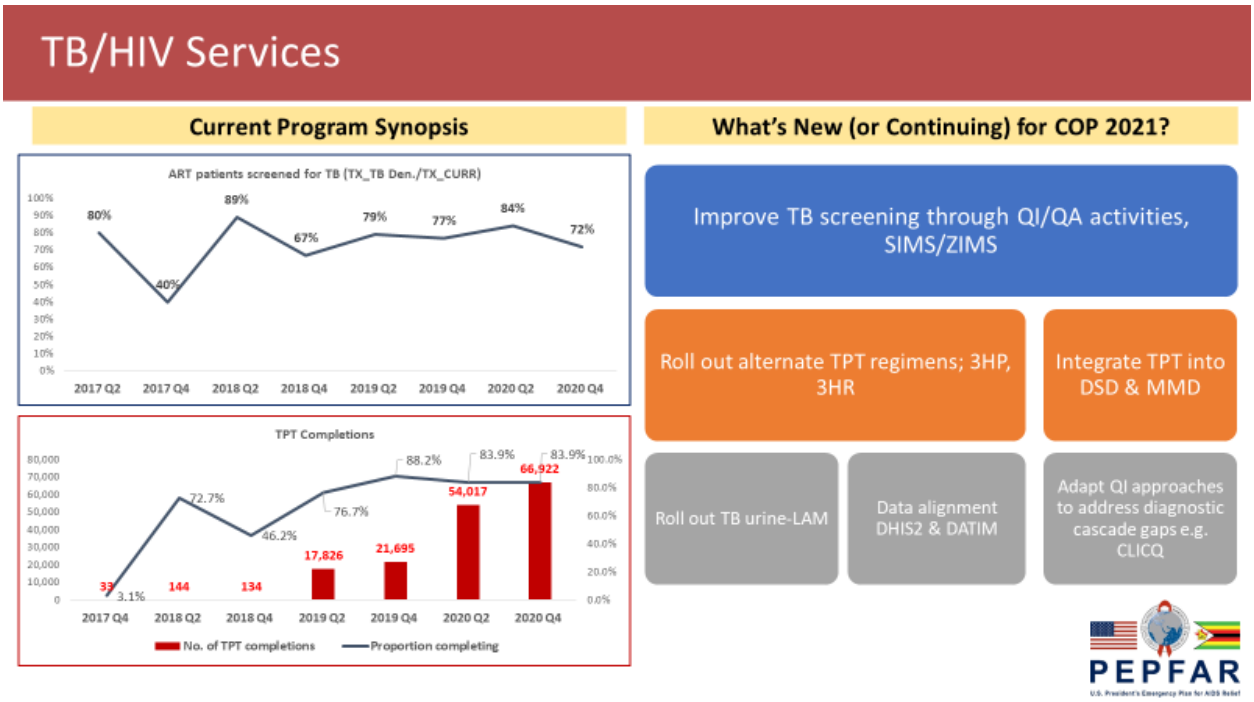
What's New (or Continuing) for COP 2021?

Rollout POC VL testing, action prioritization of PLW and peds for VL testing

Birth testing, scale up POC EID, expand cohort monitoring

Test and start, neonate Raltegravir, pDTG

PEPFAR



2.3 Investment Profile

Although Zimbabwe's national budget allocation to health has modestly increased in recent years from 6.5% in 2015 to the current 7.6%, it still falls far below the Abuja requirement of 15% and the actual amounts disbursed often fall 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 continues to face an economic downturn and high inflation, a plight which has been exacerbated even further by the COVID-19 epidemic. The GoZ has established an AIDS levy that collects millions of dollars each year to procure ARVs and to support other activities. However, the real value of these funds has declined as the exchange rate has fallen 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 S1. Investment Profile (Budget Allocation) for HIV Programs, 2021

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2021
Care and Treatment	$163,713,829	1%	36%	62%	0%	
HIV Care and Clinical Services	$140,748,453	0%	41%	59%	0%	
Laboratory Services incl. Treatment Monitoring	$9,906,345	0%	4%	95%	1%	
Care and Treatment (Not Disaggregated)	$13,059,031	18%	5%	74%	3%	
HIV Testing Services	$14,938,578	0%	46%	53%	0%	
Facility-Based Testing	$9,666,003	0%	64%	36%	0%	
Community-Based Testing	$1,026,545	0%	0%	100%	0%	
HIV Testing Services (Not Disaggregated)	$4,246,030	1%	17%	81%	1%	
Prevention	$51,894,158	2%	10%	82%	6%	
Community mobilization, behavior and norms change	$8,755,363	12%	17%	43%	28%	
Voluntary Medical Male Circumcision	$17,982,507	0%	1%	95%	4%	
Pre-Exposure Prophylaxis	$2,873,429	0%	2%	98%	0%	
Condom and Lubricant Programming	$2,255,003	0%	0%	100%	0%	
Opioid Substitution Therapy	$0					
Primary Prevention of HIV & Sexual Violence	$7,961,201	0%	3%	97%	0%	
Prevention (Not Disaggregated)	$12,066,656	1%	25%	74%	0%	
Socio-economic (incl. OVC)	$33,475,538	0%	10%	90%	0%	
Case Management	$5,499,323	0%	0%	100%	0%	
Economic Strengthening	$11,280,318	0%	0%	100%	0%	
Education Assistance	$8,334,522	0%	0%	100%	0%	
Psychosocial Support	$1,115,881	0%	0%	100%	0%	
Legal, Human Rights, and Protection	$3,446,300	0%	0%	100%	0%	
OVC (Not Disaggregated)	$3,799,194	0%	87%	13%	0%	
Above Site Programs	$31,164,356	1%	53%	46%	0%	
Human Resources for Health	$2,671,511	1%	54%	45%	1%	
Institutional Prevention	$0					
Procurement and Supply Chain Management	$5,825,653	0%	60%	39%	0%	
Health Mgmt Info Systems, Surveillance, and Research	$9,737,027	0%	54%	46%	0%	
Laboratory Systems Strengthening	$2,619,248	0%	55%	45%	1%	
Public Financial Management Strengthening	$0					
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$5,636,598	4%	20%	76%	1%	
Laws, Regulations and Policy Environment	$0					
Above Site Programs (Not Disaggregated)	$4,674,319	0%	82%	17%	0%	
Program Management	$40,135,898	0%	34%	66%	0%	
Implementation Level	$40,135,898	0%	34%	66%	0%	
Total (incl. Commodities)	**$336,297,687**	**1%**	**31%**	**66%**	**1%**	
Commodities Only	**$101,089,863**	**2%**	**57%**	**40%**	**0%**	
% of Total Budget	*30%*					

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available.

Standard Table 2.3.2: Annual Procurement Profile for Key Commodities

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2021 Budget						
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2021
Antiretroviral Drugs	$53,562,004	4%	65%	30%	0%	
Laboratory Supplies and Reagents	$17,408,807	0%	69%	31%	0%	
CD4	$1,586	0%	0%	0%	100%	
Viral Load	$4,229,401	0%	0%	100%	0%	
Other Laboratory Supplies and Reagents	$13,177,821	0%	91%	9%	0%	
Laboratory (Not Disaggregated)	$0					
Medicines	$5,106,524	1%	7%	91%	1%	
Essential Medicines	$311,357	15%	71%	0%	14%	
Tuberculosis Medicines	$4,680,473	0%	0%	100%	0%	
Other Medicines	$114,694	0%	100%	0%	0%	
Consumables	$7,739,061	0%	33%	67%	0%	
Condoms and Lubricants	$1,728,382	0%	12%	88%	0%	
Rapid Test Kits	$4,207,820	0%	55%	45%	0%	
VMMC Kits and Supplies	$1,802,859	0%	0%	100%	0%	
Other Consumables	$0					
Health Equipment	$914,819	0%	66%	0%	34%	
Health Equipment	$325,259	0%	52%	0%	48%	
Service and Maintenance	$589,559	0%	73%	0%	27%	
PSM Costs	$16,358,649	0%	44%	56%	0%	
Total Commodities Only	**$101,089,863**	**2%**	**57%**	**40%**	**0%**	

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available.

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	$3,000,000	N/A	N/A	N/A	• Increase utilization of quality family planning, maternal. neonatal, and child health services • Improve nutrition and water, sanitation, and hygiene practices. • Strengthen health system to enable sustainability
USAID TB	$6,000,000	N/A	N/A	N/A	• Prevent TB transmission and renew efforts to find the missing TB cases. • Strengthen the capacity of national TB programs. • Build country capacity to use existing resources and to turn evidence into policy. • Expand the development of new TB diagnostics, drugs, and vaccines
USAID Malaria	$14,000,000	N/A	N/A	N/A	• Reduce malaria-related mortality by 70%
Family Planning	$2,000,000	N/A	N/A	N/A	• Increase access to modern family planning information and contraceptives to improve maternal and child health outcomes.
Total	$25,000,000				

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 & 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. During COP 2021, PEPFAR implementing partners will complete the PEPFAR HRH inventory so that PEPFAR and the GOZ can document more granular details on PEPFAR's HRH support. Further, PEPFAR will intensify discussions with the MoHCC and GF to discuss HIV HRH investments, cadres, and levels of site support needed to sustain the HIV program to help inform the development of a potential transition plan. PEPFAR will also continue engagement with the national health development partners working group on the national HRH crisis.

As sustainable 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: The 2021 SID will be completed in late 2021. The sustainability profile included here is from SID 2019. 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, Score 10.0): 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.

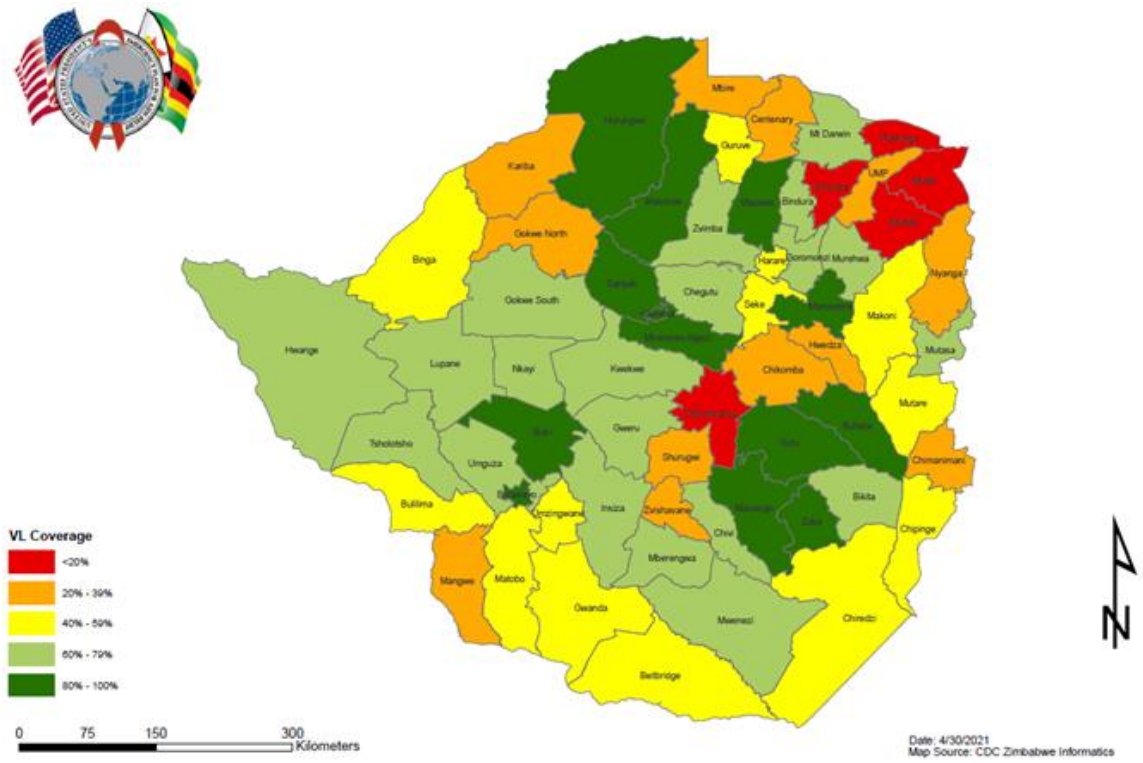
Sustainability Vulnerabilities: Sustainability vulnerabilities identified as part of SID 2019 include the following:

- 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, communities, and sites with the greatest PLHIV burden and highest treatment gap (i.e., unmet need) for case-finding. Resources in high volume facilities are being prioritized for TPT scale-up, cervical cancer screening and treatment, viral load access and coverage, 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. 2020 Annual Viral load coverage by SNU



2.6 Stakeholder Engagement

1. **Host country government**
   The PEPFAR Coordination Office held bilateral meetings with the MoHCC HIV/AIDS and TB unit to discuss the COP 2021 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 2021. MoHCC counterparts deliberated on their specific program areas and contributed to synchronizing MoHCC priorities with PEPFAR's. Three MoHCC representatives, including the Director of the AIDS and TB unit participated in the virtual planning meeting on April 26 and 27, 2021.

2. **Global Fund and other external donors**
   The Global Fund Portfolio Manager and the local Principal Recipient, UNDP, attended the PEPFAR retreat and the virtual planning meeting. PEPFAR continues to work closely with the Global Fund's Country Coordinating Mechanism (CCM) to ensure the alignment of programming as GF's current funding cycle (2021-2023). PEPFAR, and the USG more broadly, continues to collaborate with the CCM to harmonize investments in COVID-19 mitigation measures. The team has discussed the potential ARV shortage in 2021 considering both GF and PEPFAR's flat lined or reduced budgets for the cost area. Possible funding flexibility to support emerging COP21 program requirements would be achieved through reprogramming of savings within the HIV grant. Several discussions were held on the harmonization of COVID-19 support funds between GF and PEPFAR.

Discussions continue at the time of the COP submission. UNAIDS, WHO, and BMGF attended the retreat and the virtual planning meeting.

3. Civil Society/Community:

Engagement with civil society around COP 2021 kicked off in December 2020 when the PEPFAR Team attended an Advocacy Core Team meeting to describe FY20 performance and COP21 strategic direction. In January, several representatives from community services organizations attended the PEPFAR retreat. The civil society organization (CSO) core group then convened 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 Team to deliver the 2021 Community COP outlining the following community priorities:

1. Prevention

1.1	Expand PrEP Program Rollout
1.2	Expand VMMC Uptake
1.3	Roll out Microbicides for AGYW – Dapivirine Ring (DVR)
1.4	Invest in Social Behavior Change Communication (SBCC)
1.5	Fund and expand "Men and Boys Program" and wellness initiatives, rebrand condoms and strategically distribute them

2. Treatment

2.1	Improve Pediatric HIV Management and provide optimal Pediatric ART
2.2	Invest in Treatment Literacy: Women, Girls, Men and Boys
2.3	Expand viral load to 85% of all eligible people
2.4	Improve Sample Transportation

3. Consolidate and strengthen the existing Community-Led Monitoring (CLM)

4. Expand Investment in Key Population Programs (Leave No one Behind)

4.1	Invest in KP Specific DSD Models
4.2	Strengthen ICT Design Structure
4.3	People and Young Men Using Drugs
4.4	SGBV and Psycho-social Support for KPs.

5. Fund and increase the numbers of Human Resources for healthcare workers including lab technicians, CATs, data clerks, counsellors, nurses, and pharmacists among others in PEPFAR priority districts. Fund a joint Human Resources for Health inventory and situation and gap analysis of all frontline health care workers in the country funded by PEPFAR, Global Fund, Government of Zimbabwe, and other private and bilateral donors in Zimbabwe.
6. TB/HIV/COVID-19
7. Mental Health
8. Advanced HIV Disease
9. Older Adults Living with HIV and Aging with HIV
10. Integration of COVID-19, SRHR, HIV AIDS in PEPFAR Programs for AGYW living with Disability.

4. **Private Sector**
   The poor economic and investment climate has made engagement with the private sector challenging in Zimbabwe. While there were no engagement meetings with the private sector during COP 2021 planning, PEPFAR will explore opportunities in the coming year for possible inclusion in COP 2022.

3.0 Geographic and Population Prioritization

PEPFAR used 2020 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 on ART at the end of FY22. Together with the Government of Zimbabwe, >95% of PLHIV will be initiated on ART by the end of FY 22.

Table 3.1: Current Status of ART saturation

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP 21**	**# Current on ART (FY20)**	**# of SNU COP20 (FY21)**	**# of SNU COP21 (FY22)**
Attained	1,067,394	986,982	44	44
Scale-up Saturation				
Scale-up Aggressive				
Sustained				
Central Support	197,349	176,012	19	19
TOTAL	1,264,743	1,162,994	63	63

4.0 Client Centered Program Activities for Epidemic Control

4.1 Finding the missing and getting them on treatment.

As Zimbabwe reaches epidemic control, the COP 2021 strategy for case finding will continue to emphasize the need to employ HIV testing strategies that reduce testing volumes and eliminate unnecessary testing using the epidemic control and concentrated target population testing strategies that were developed in COP20.

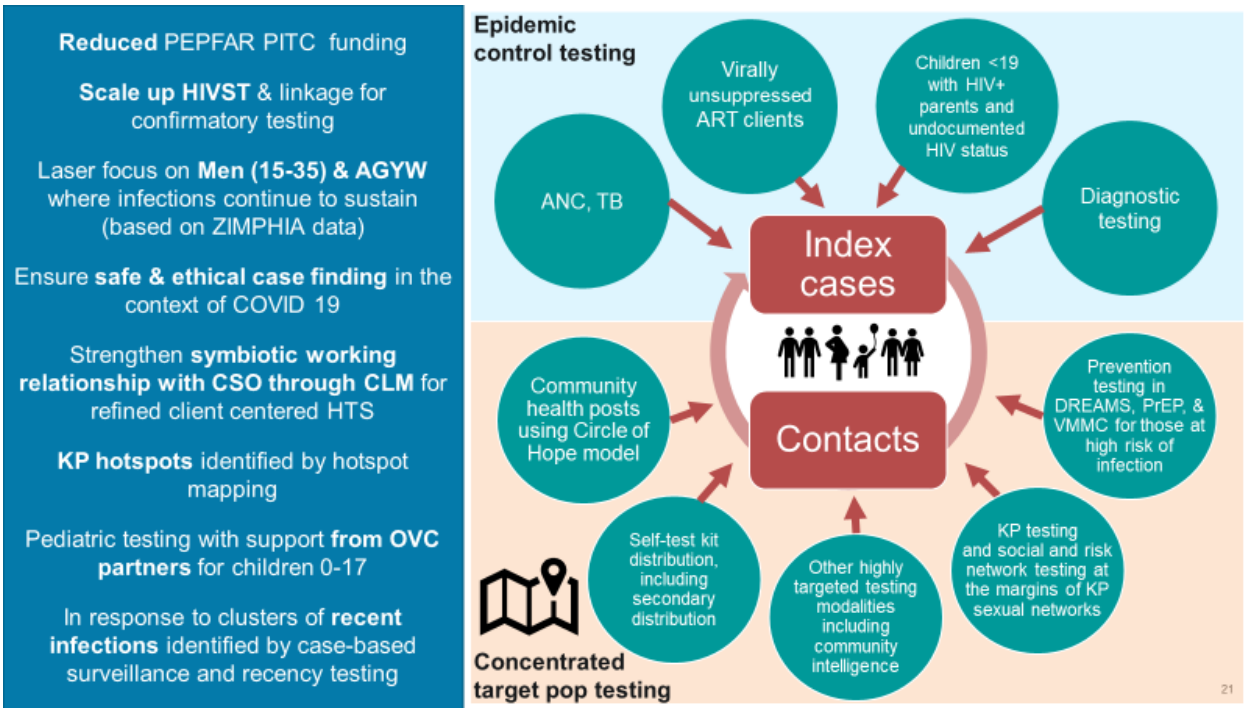
HIV testing for epidemic control will focus on client centered, safe and ethical index testing which complies with the WHO HTS principles (5Cs) of ensuring consent, confidentiality, providing counseling, correct results, and appropriate connection to follow on services. Additionally, the program will continue to provide standard of care testing for 100% testing coverage at ANC, STI and TB programs and diagnostic HIV testing under the epidemic control testing model. Safe and ethical index testing will be supported by implementing recommendations following Redcap assessment. Regular review of index testing performance will

be done to ensure that the program closes the loop on all listed contacts in a safe and ethical manner.

HIV testing at community posts, and community intelligence-based models will continue to constitute a major part of the concentrated target population HIV testing strategy partnered with HIVST to make the testing even more efficient at identifying the sub-populations that remain underserved and are at highest risk. Improvements to the KP program through mapping hotspots and scale up of differentiated HTS services will be done in COP 21. Targeted HIV testing will also continue to be provided through HIV prevention programming, including DREAMS, OVC, and PrEP programs.

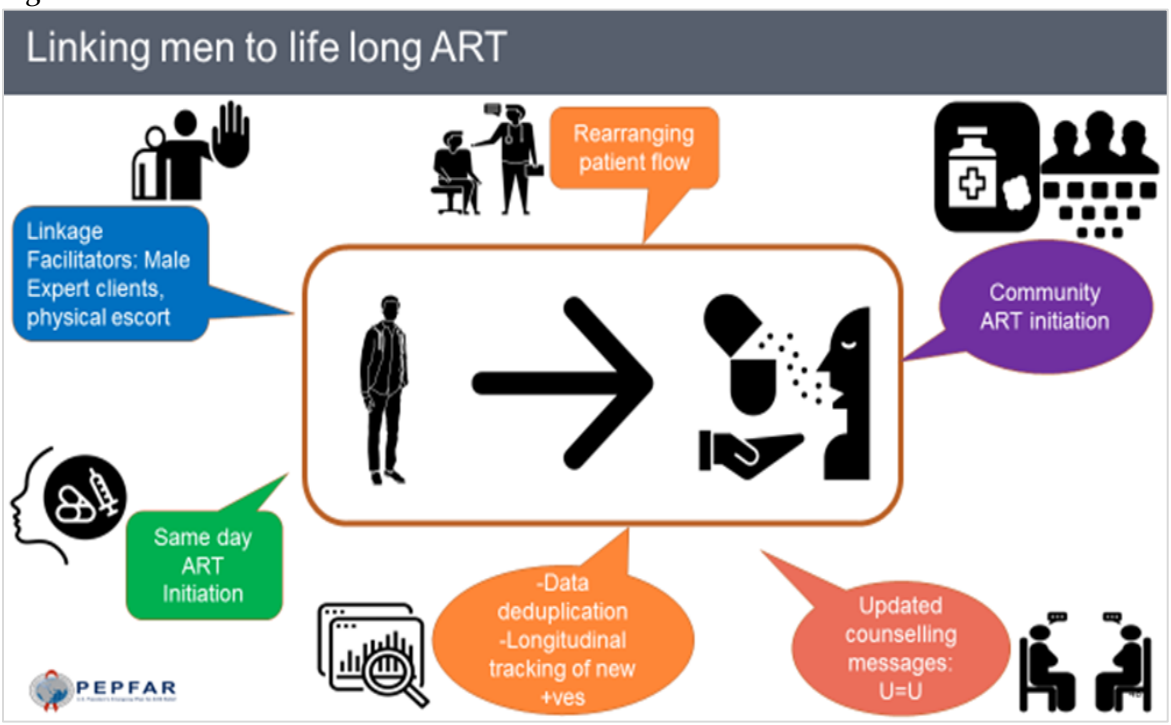
A continuous monitoring plan in collaboration with MoHCC, CSOs and other stakeholders will be supported to ensure continuous quality HIV case finding services. Sites will be expected to monitor and report on acceptance rates of index testing quarterly. KP population programs will provide index testing coupled with other strategies such as social network HTS. HIV self-testing will continue to be used in conjunction with the various HTS models to improve testing efficiency while reaching highest risk groups.

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. Additionally, the program will also make use of the latest ZIMPHIA data to fine tune HTS targeting approaches to reach the sub-populations with the biggest case finding gaps.

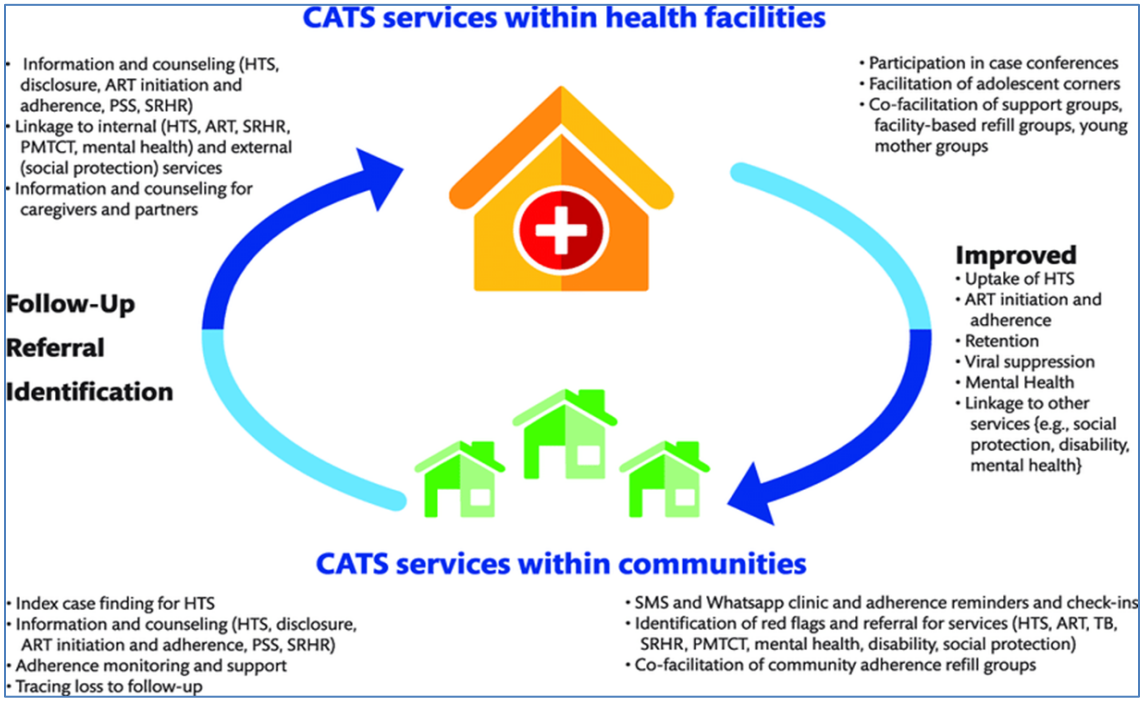


Finding men: Generally, men have lower HTS, and ART coverage as compared to women. As the country reaches and maintains epidemic control, it must continue to close existing gaps in identifying men, linking them to treatment and ensure long-term viral suppression. Community posts, which were successfully adapted from the Zambia Circle of Hope model, will be maintained as a case-finding strategy to test men, and link them to care during COP 21. Additionally, men will

continue to be reached with index testing and through prevention modalities targeting men at high risk.



To improve the quality of HIV case finding services for men, the program will continue to support health facilities to ensure that they are "male friendly" through extended or flexible service hours, sensitization of health care workers, and other client-centered innovations.



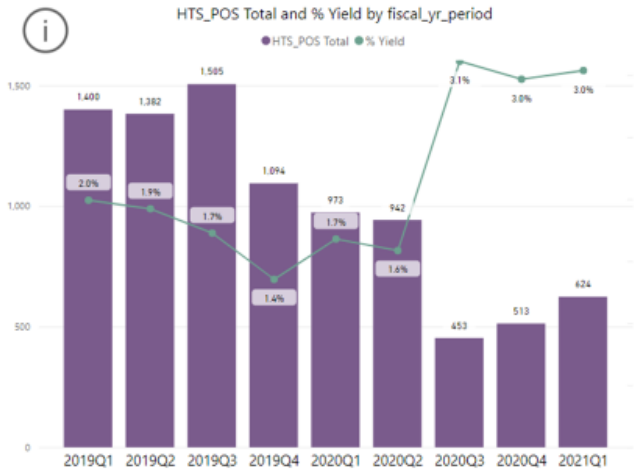
Finding adolescents and young people: Adolescents and young people continue to perform poorly compared to older people across the clinical cascade. However, using the Zvandiri model, PEPFAR has significantly improved case identification, linkage and eventually ART coverage among adolescents and young people. PEPFAR will maintain support for this model and other client centered adaptations to close the gap in case-finding and linkage to care for harder to reach adolescents and young people.

Faced with reduced funding for COP 21, the program has found it difficult to sustain the Zvandiri model budget at COP20 levels although the utility of this model for case finding among children, adolescents and young people and their subsequent linkage to treatment, care and support is well-known. Therefore, sustaining epidemic control among the said sub-population will need continued prioritization, monitoring and focus going forward.

PEPFAR will continue to support and strengthen support groups and other peer-led strategies to encourage timely ART initiation and retention in care for adolescents and young people. Clinical partners will continue to strengthen communication and bi-directional referral networks with community based OVC partners to improve linkage among OVC to critical programs. PEPFAR will also continue to prioritize case finding and linkage to care among young mothers through strengthening young mother support groups and linkage to community-based services (e.g., OVC, DREAMS).

Finding children: Index testing continues to be the main modality for finding children and this will be supported by the program in COP 21. HIV case finding among children will be strengthened in COP21 through the epidemic control and concentrated target population model that incorporates diagnostic testing, as well as collaboration with the OVC program for more targeted pediatric case finding. Our current aim in COP20 is to achieve full testing coverage for all biological children of adults in care. Our IPs will intensify index testing among children so that the case finding recovers to pre-COVID-19 levels.

Pediatric case finding has started to recover but not yet at pre-COVID level



PowerBI Dashboard

PEPFAR will continue to support EID POC commodities for mPIMA devices, initially 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.

The PEPFAR program will support the procurement of 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 conventional testing, including piloting of community-based DBS for children who haven't been brought to the facility.
3. Integrated sample transportation and expedite electronic result transmission.
4. Expand use of EHR and diary system.
5. Expedite result transmission through electronic means.
6. Continue HIV test and start.
7. Community ART initiation.
8. Cohort monitoring.
9. Use optimized regimens which are child friendly.
10. Ensuring that all infants enrolled in the OVC Program access EID.

As guided by the MoHCC, PEPFAR will support rollout of differentiated HTS for pediatrics as well as 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. PEPFAR is coordinating with CHAI to introduce DTG 5mg. Most children will be gradually transitioned onto DTG as it becomes available. The program will also continue to support the procurement and distribution of Raltegravir granules for sentinel sites.

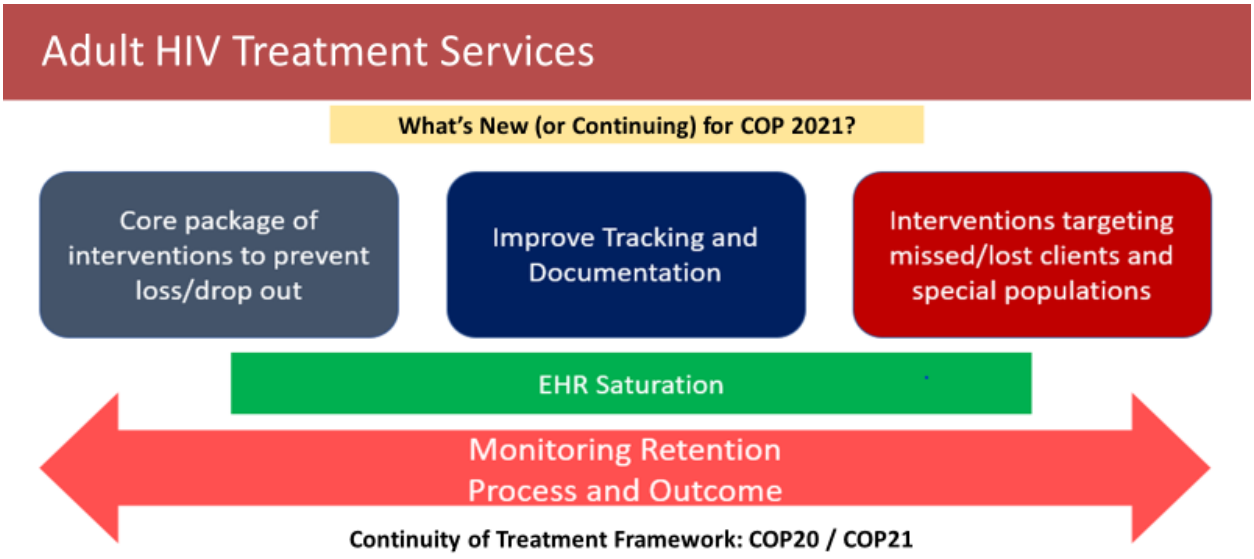
Case Based Surveillance with Recency Testing
Zimbabwe will focus on increasing efforts to establish case-based surveillance and strengthen data use. Detecting recent HIV infections among all newly diagnosed individuals in real-time and establishing a surveillance system to longitudinally track HIV cases 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, which is integrated into the EHR, 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.

Despite the COVID-19 induced delays, in COP 2021, Zimbabwe will continue rapid geographical expansion of newly diagnosed and recent infection surveillance from 800 sites (expected to have been covered by end of COP 20) to full national coverage of 1725 by end of COP 21. To rapidly target case finding efforts in areas of high HIV transmission, Zimbabwe will expedite implementation of recent infection surveillance. In COP21 all newly diagnosed persons over 15 years of age in the 44 PEPFAR districts and remaining 19 districts supported by Ministry of Health and Child Care, will be offered recency testing which will be monitored at national level to inform geographical areas with high concentrations of new HIV infections.

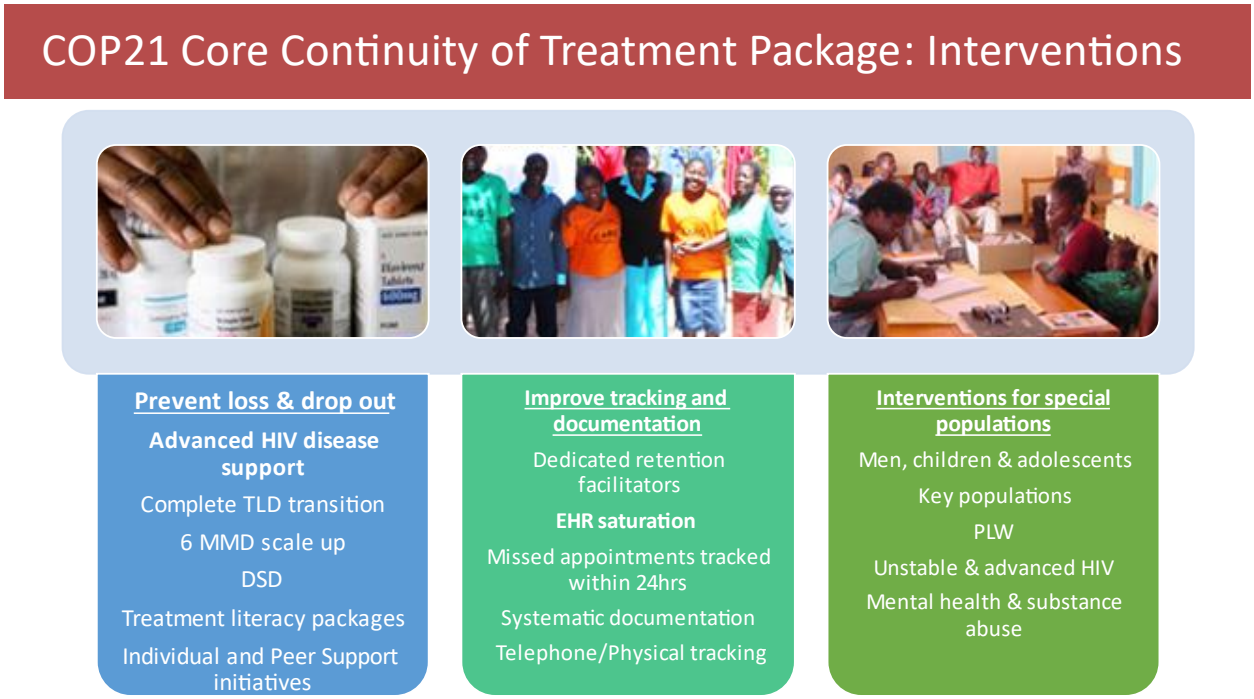
Zimbabwe will continue to build and expand the electronic systems necessary to longitudinally monitor sentinel events along the continuum of care for all HIV-infected persons living in Zimbabwe. PEPFAR funds will be used to expand the MoHCC's Electronic Health Record (EHR) to ensure all CBS and sentinel 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 Continuity of Treatment and Ensuring Viral Suppression

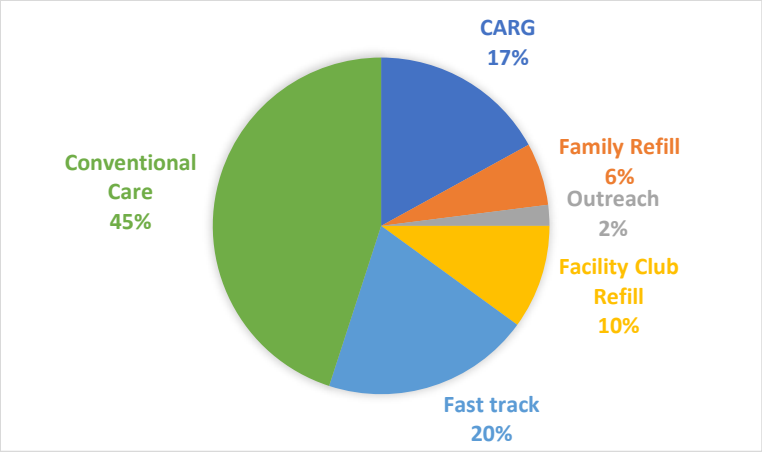
The MoHCC's Operations and Service Delivery (OSDM) manual for HIV Care and Treatment in Zimbabwe gives guidance on increasing retention at all steps of the HIV clinical cascade. PEPFAR Zimbabwe will continue to support the operationalization of this manual and the roll-out of differentiated service delivery models. In COP 21, PEPFAR will use the continuity of treatment framework below to guide support for various interventions that facilitate continuity of treatment and viral suppression for PLHIV.



PEPFAR Zimbabwe will support interventions that prevent loss or interruption in treatment, activities that improve tracking and documentation and lastly interventions targeting missed/ lost clients and special populations as outlined in the figure below.



PEPFAR Zimbabwe also will continue to 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 2021. The pie chart details the proposed mix of DSD models which are in line with the MoHCC's targets.



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 fund and expand differentiated service delivery for ART refills that are convenient and confidential (e.g., private drug pick-up and refill points). Implementation of differentiated service delivery for HIV treatment will be scaled to reach at least 60% of all PLHIV and ensure a minimum 25% are accessing treatment from a community model and at least 20% from a group model.

Prevention of treatment interruption: Interventions will include completion of transition to TLD treatment for all eligible clients, early case management, formalized SMS reminders wherever available and access to individual and 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. In COP21 the PEPFAR program will support various aspects of Advanced HIV Disease (AHD) management including adaptation of new WHO AHD guidelines, TB Urine-Lam, and Serum CrAG. PEPFAR will leverage medicines for opportunistic infections which will be procured under the GF. The PEPFAR program will also support the adaptation of the latest WHO guidelines particularly regarding timing of ART in patients with active TB disease to prevent loss through death. The implementation and scale up of 6 MMD and other differentiated services will continue to be a priority. For adolescents, the Zvandiri (CATS) model approach will continue with a focus those with the highest HIV burden among this age group.

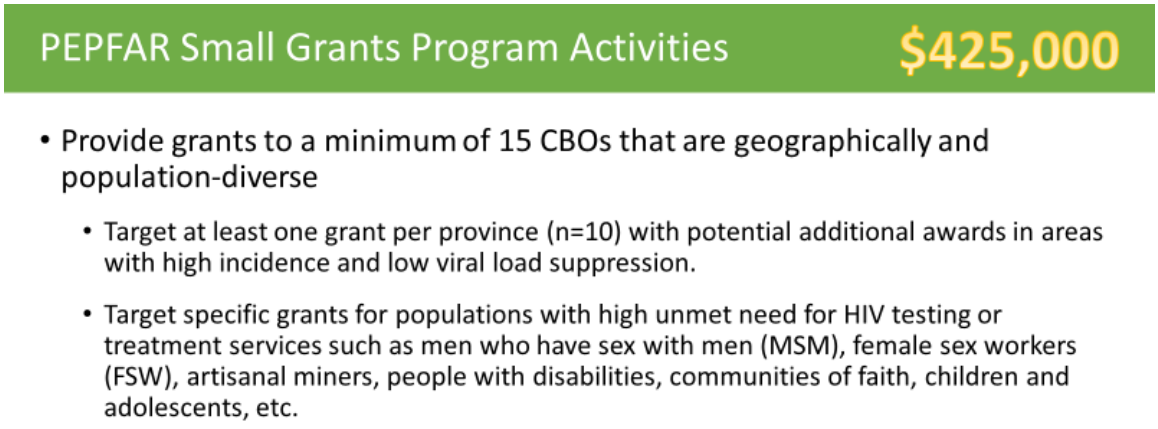
The OVC Program currently is case managing about 67% of C/ALHIV in 21 Districts and through various activities, will continue to ensure that they are retained in care as well as monitoring and ensuring that they are virally suppressed.

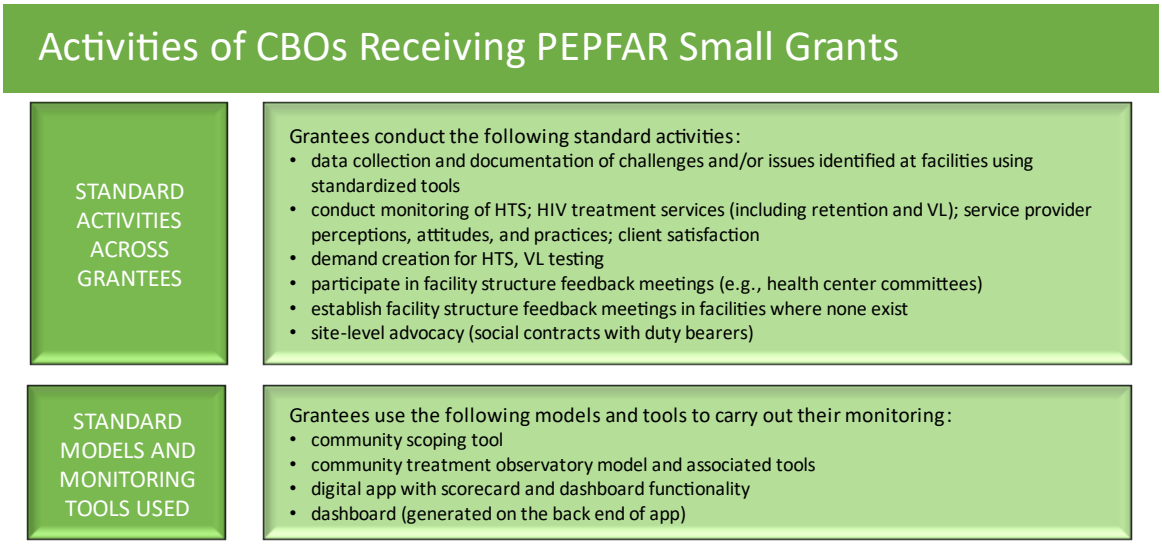
Improved tracking and documentation: In COP 21, EHR is expected to have saturated PEPFAR DSD districts, and this is expected to be a game-changer with regards to client documentation. Use of EHR will facilitate systematic early missed appointment tracking, interruption in treatment, gaps

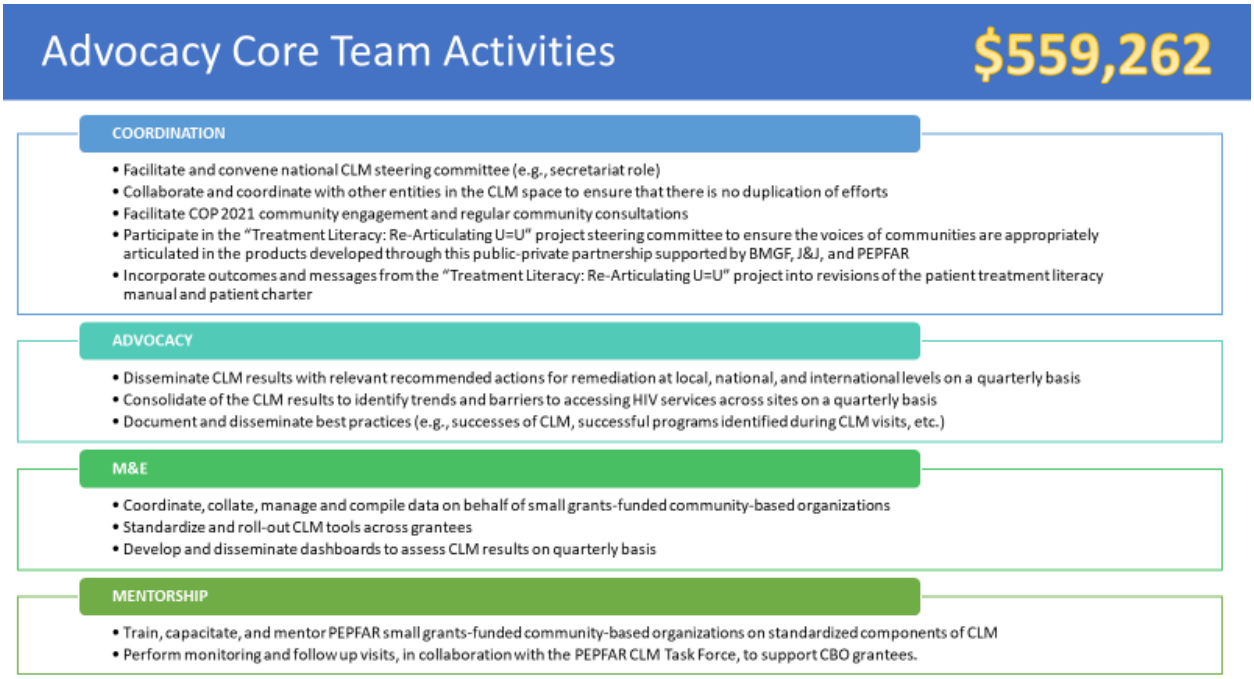
in services provided to an individual client among other functions. The PEPFAR program will engage some of the existing lay cadres to become retention facilitators who will take on the role of intensive defaulter tracking that will begin within 24 hours of clients having missed appointments. These cadres will work with the clinicians to ensure clients return to care and follow up outcomes are documented appropriately in the client files. Cadres conducting support will be provided to clinicians to separate the files of clients who have missed appointments from those who have defaulted and those who are lost to follow up.

Special populations: The PEPFAR program will continue to 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.





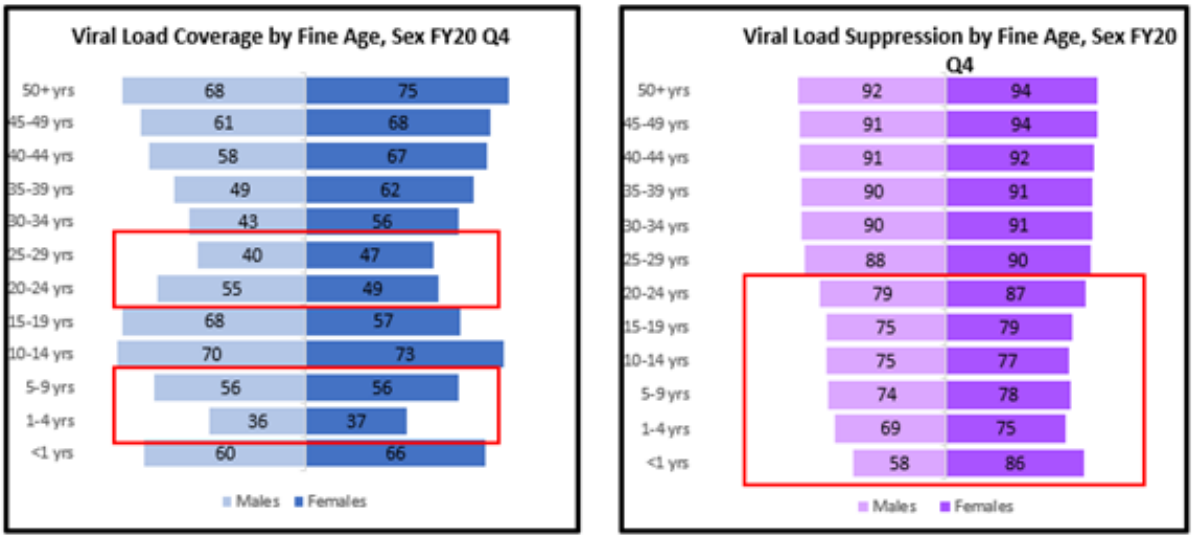


Treatment Literacy: In COP 2021, PEPFAR will ensure ongoing activities to improve treatment literacy among PLHIV and ensure that appropriate messages are delivered in appropriate ways to the various population subgroups. These messages will include the rationale for the Treat All approach, the benefits 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. Once the VL literacy package "Flip the Script" is completed, the PEPFAR program will explore the use of this communication package to improve clients' understanding of adhering to treatment and VL results interpretation. PEPFAR will 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 for the remainder of COP 2020 implementation and into COP 2021.

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 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, facilities implemented QI initiatives resulting in improved patient care and this will continue during COP21 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 still gaps in access, specimen transport and results utilization/ clinical status monitoring. FY20 Q4 PEPFAR data from the indicates an observed lower VLC in young adults and children below 14 years as shown in the figure below.

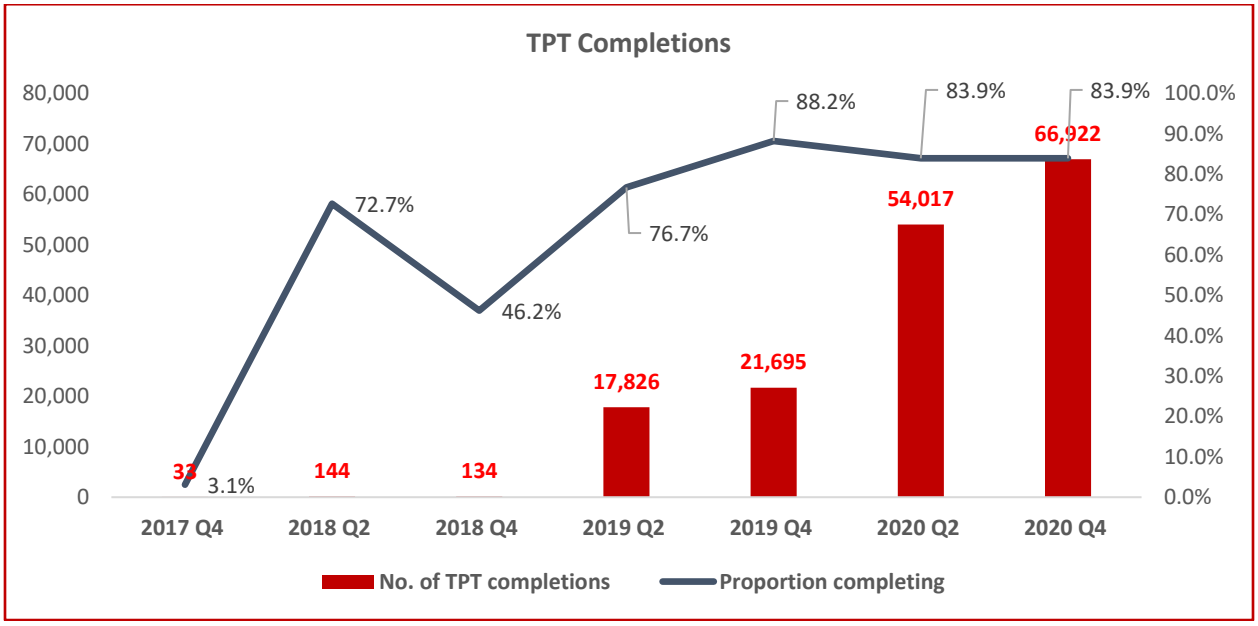


The program has also noted that the utilization of viral load results is sub-optimal pointing to the need to strengthen the capacity of clinicians. In COP 21, PEPFAR will therefore continue to invest in scaling up CLI in all supported districts, ensuring that the clinical partners, OVC/ community partners, 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 90% coverage by the end of FY 21, which exceeds the Community COP request for 85% coverage.

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 COP19 (FY20) implementation, 120,939 PLHIV completed TPT in PEPFAR supported districts, with completion rate of 83.9%. This is a significant increase from 39,541 that completed TPT in COP18 (FY19). In COP21 we will continue to scale up TPT to achieve universal coverage over the next two financial years. However, there are challenges that our program is committed to overcome to achieve universal TPT coverage. 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. These challenges are still present today and planning for and addressing each of these components will be critical for successful TPT scale up.

In consultation with the MoHCC, and in line with the existing capacity within the health care system, TPT targets were agreed as 275,842 for COP 21.



In COP 21, the PEPFAR program will continue to 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) will be fully brought to scale in COP21 such that an estimated 69% of patients will be on 3HP. The rollout of 3HP started in COP20 in 18 health facilities through a Clinton Health Access Initiative (CHAI) catalytic mechanism. The first delivery of 3HP fixed dose combination (FDC) tablets was received and distributed during COP20 Q2. 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

In COP21 IPs will continue to support the MoHCC in training and mentoring of health care workers on implementation of 3HP and 3HR. Development, printing and distribution of SOPs, job aides and patient communication material will address the existing knowledge and communication gaps and create demand for TPT. Advocacy and communication meetings will be held with beneficiaries to drive uptake of TPT. The communications and advocacy departments (or relevant focal person) within the IPs will be responsible for implementing and organizing the proposed meetings. Pharmacovigilance will continue to be prioritized to build trust in TPT regimens among beneficiaries, physicians, senior clinicians, and nurses.

During COP 21, among other strategies, IPs will support the roll out of TPT differentiated service delivery to improve adherence and completion of TPT. There is evidence that TPT adherence and satisfaction can be improved with integration of TB and HIV services. During COP19 and COP20 other IPs have successfully increased uptake of TPT during outreach; the same strategy will be scaled up in COP 21.

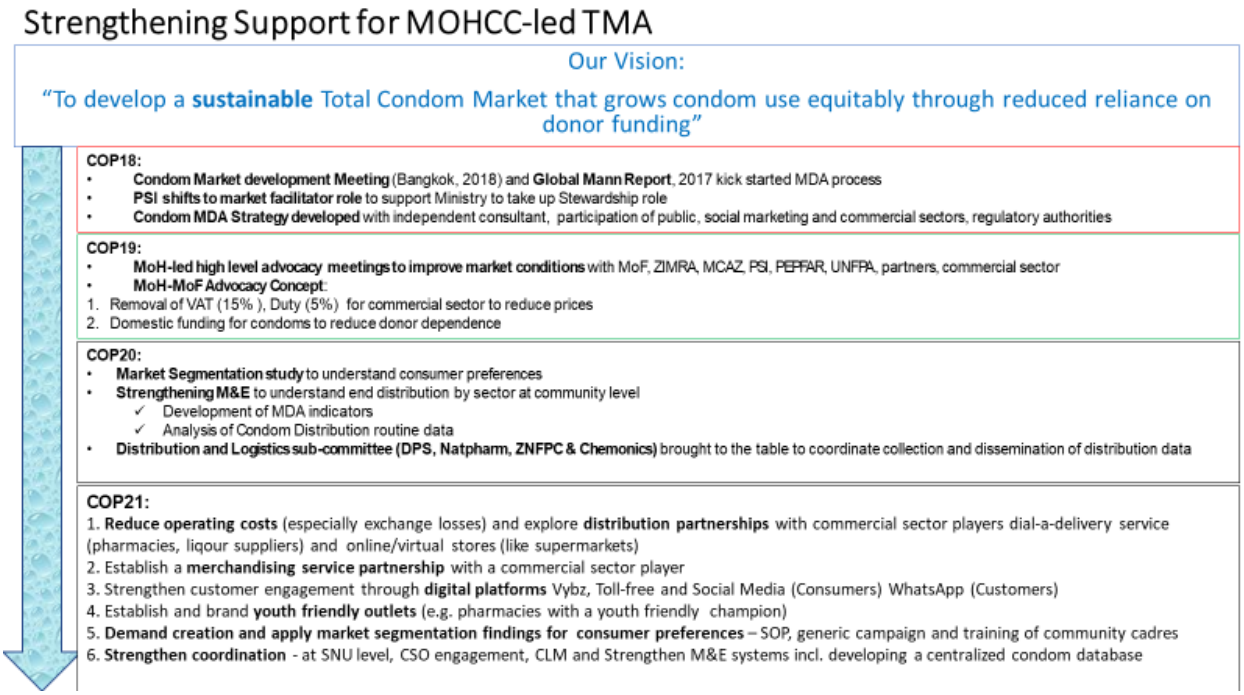
TPT scale up will be adequately monitored and evaluated through adaption of the current data collection tools that capture TPT uptake, duration, completion, outcomes, and adverse events. We will continue to strengthen TPT M&E by adding a TPT module in the Electronic Health Records (EHR) and develop an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

TB screening and diagnosis: During COP19 (FY20), 72% of PLHIV on ART were screened for TB; significantly below the >95% screening target. Presumptive TB rate among new and existing patients on ART was 4.8% and 0.9% respectively. During COP20 and continuing in COP21 the program is systematically working to increase screening coverage and quality. Health facilities with support from PEPFAR IPs are rolling out quality improvement and assurance projects to improve screening. Sensitization and mentoring on TB screening has been scaled up. TB screening with urine lipoarabinomannan (urine-LAM) was introduced to complement the existing strategies. In COP21 urine-LAM will be introduced in all PEPFAR supported districts to improve TB screening and diagnosis. PEPFAR funds will be used to procure urine-LAM kits, develop appropriate SOPs and job aides, and support training and mentoring of health workers.

4.3 Prevention, specifically detailing programs for priority programming:

HIV prevention for priority populations remains a key strategy in COP 21, 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. PEPFAR will continue to 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 COP20 development process, on which COP21 will build, 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.

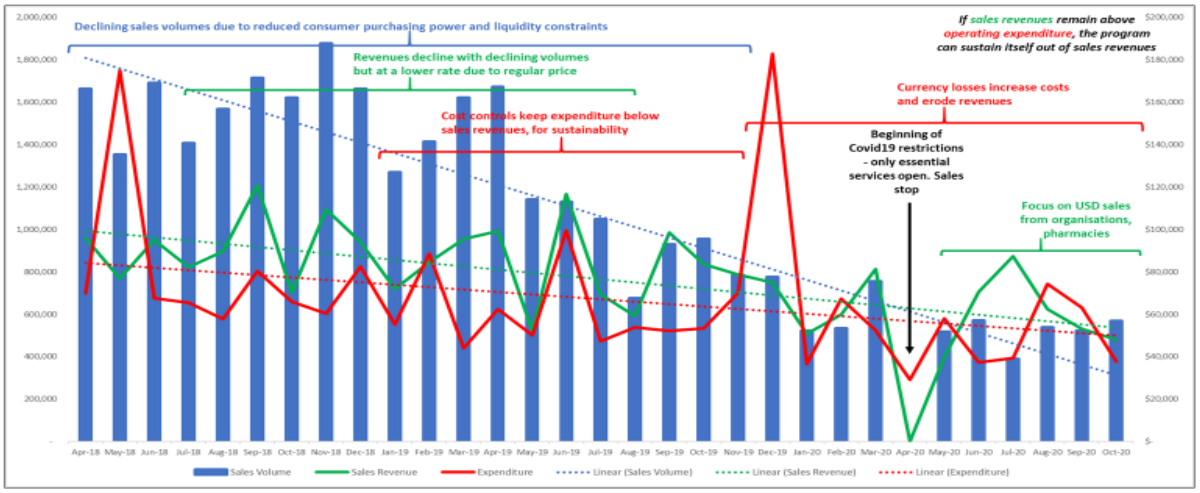


Despite those efforts, the share of commercial sector share to the condom market is shrunk (resulting from high inflation, reducing purchasing power of buyers) and there has been no commitment by Government to prioritize scare Forex to procure condoms going forward. Public sector condom distribution (currently funded 100% through PEPFAR) retains the largest share of the market, although volumes declined from FY19 to FY20 due to temporary instability in the supply chain system (e.g., delivery of condoms to service points, closed outlets) because of COVID-19.

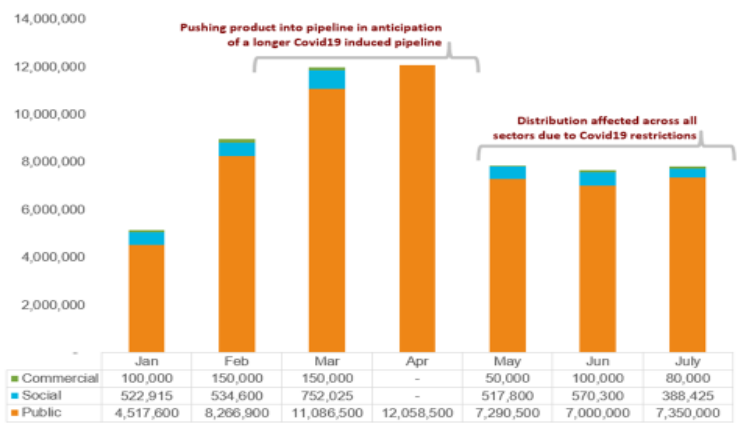
While there has been substantial progress to achieve cost recovery of the Protector Plus Social Marketing program, with higher revenues and a more efficient sales/distribution strategy resulting in 100% of operating costs recovered by the end of 2018, Zimbabwe is still not ready to graduate the social marketing program. PEPFAR still needs to donate commodities and packaging.

Initially, the collapse of the "Zim Dollar" and high rates of inflation made sustained cost recovery extremely difficult. Recently, the impact of COVID-19 and high cost of living within the harsh economic environment has led to low sales even in the dollarized economy.

Driving CSM Sustainability in a Harsh Economic, Covid19 Environment



Impact of Covid19 on Condom distribution across sectors



	Jan	Feb	Mar	Apr	May	Jun	July
Commercial	100,000	150,000	150,000	-	50,000	100,000	80,000
Social	522,915	534,600	752,025	-	517,800	570,300	388,425
Public	4,517,600	8,266,900	11,086,500	12,058,500	7,290,500	7,000,000	7,350,000

Condom Market Development Work

- **Market Analytics** – M&E team analyzing public sector sample data to respond to MDA indicators agreed with MOH.
- **Support to Commercial sector** – Scheduled a meeting with Elecare and TM PnP to speak with one voice as a category and advocate for favorable terms for category
- **Condoms Accessibility during Covid19** - Conducted a mini survey to assess public sector condoms accessibility during C19:
  - Condom uptake has dropped significantly from most facilities
  - Most facilities allow access to condoms via entrance gates, windows, waiting areas, reception and toilets
  - Working with ZNFPC to replicate ways of increasing access identified at some facilities

In COP 21, PEPFAR will leverage innovations to sustain CSM through reducing operating costs, exploring distribution partnerships with commercial sector players, establishing a merchandising service partnership with a commercial sector player, strengthening customer engagement through digital platforms, and establishing and branding youth friendly outlets.

Program to Recover Operating Costs from Sales Revenues Assuming PEPFAR Donates Commodities and Packaging

	COP21*
Volumes	13,000,000
Sales Revenues	$910,000
Essential Operating Expenditure	$890,596*
% Operating Recovery	107%

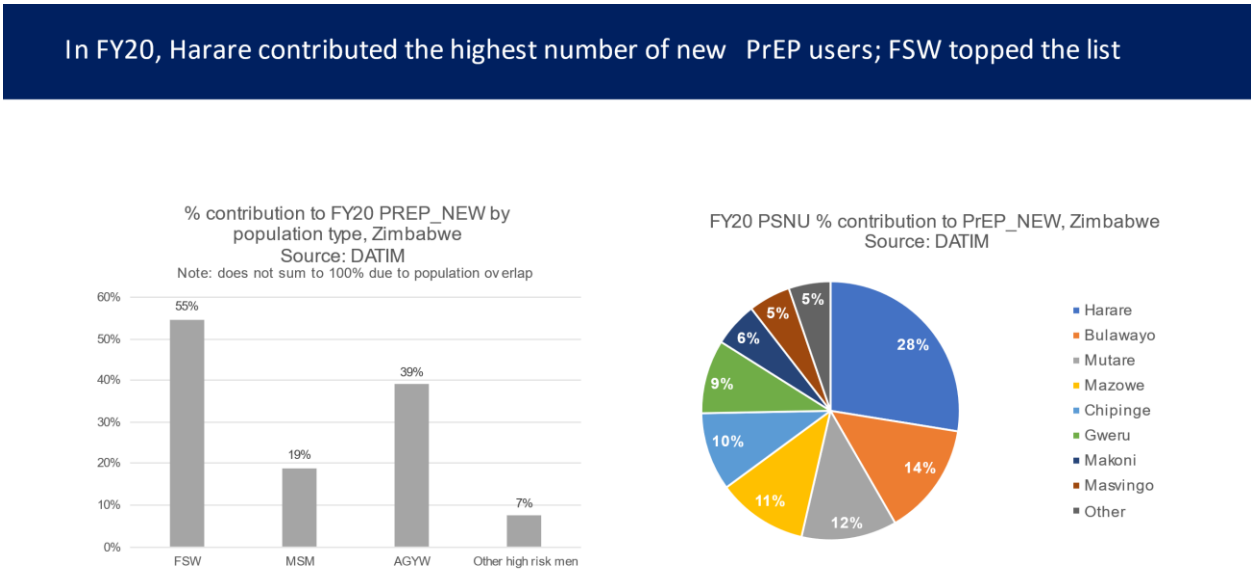
**With PEPFAR donated commodities and packaging*

- Program to sell 13 million pieces (and distribute 1.3 million for free through the KP program)
- $910,000 revenues to be generated to cover estimated essential operating expenditure of $763,920
- The program will recover 119% operating costs assuming a stable economic environment and PEPFAR donated commodities and packaging
- 7% positive operating recovery margin buffers against external shocks and currency devaluation. Can fund market development requests by MoHCC

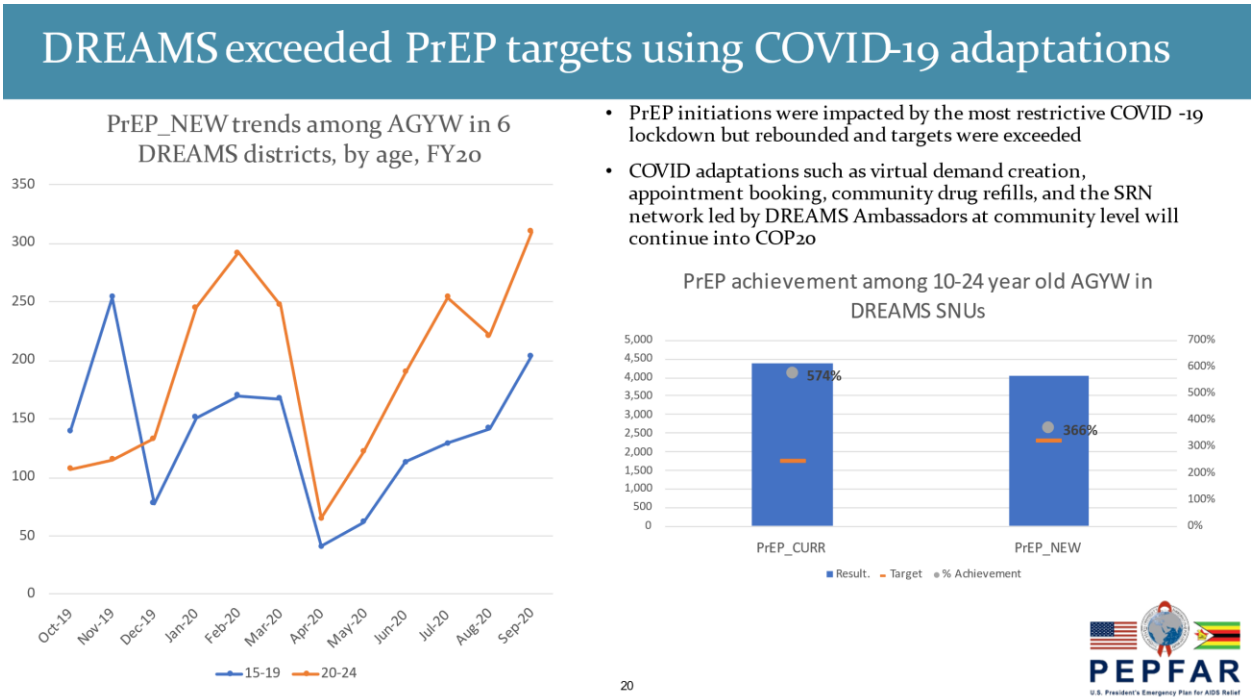
In COP21 PEPFAR will contribute $3,800,000 to condom programming and continue to coordinate with the Global Fund on their new commitments, increase its COP contribution by 186% to decrease reliance on the Central Commodity Fund, while continuing to support the most critical elements of the national condom 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

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 13,004 individuals on PrEP, reaching 158% of the FY 20 target despite the COVID-19 lockdown restrictions. Uptake continued to be strong among MSM, FSW, AGYW and other high-risk women, with Harare contributing the largest proportion of new on PrEP.



The strong performance is attributed to COVID-19 adaptations such as virtual demand creation and appointment bookings, community refills, the DREAMS Sexual Referral Network (SRN) model and the models that were in place prior to COVID-19: ColourZ for MSM, scale up of differentiated PrEP delivery using drop-in centers managed by GALZ, SRC and HoH, visiting homes of sex worker queens to initiate and re-supply PrEP and the use of DREAMS Ambassadors that were leveraged to increase access to PrEP services for other high risk women. The scale up and expansion of the DREAMS Ambassador model to YW 20-24 in COP20 also contributed to increased uptake among AGYW 15-24.



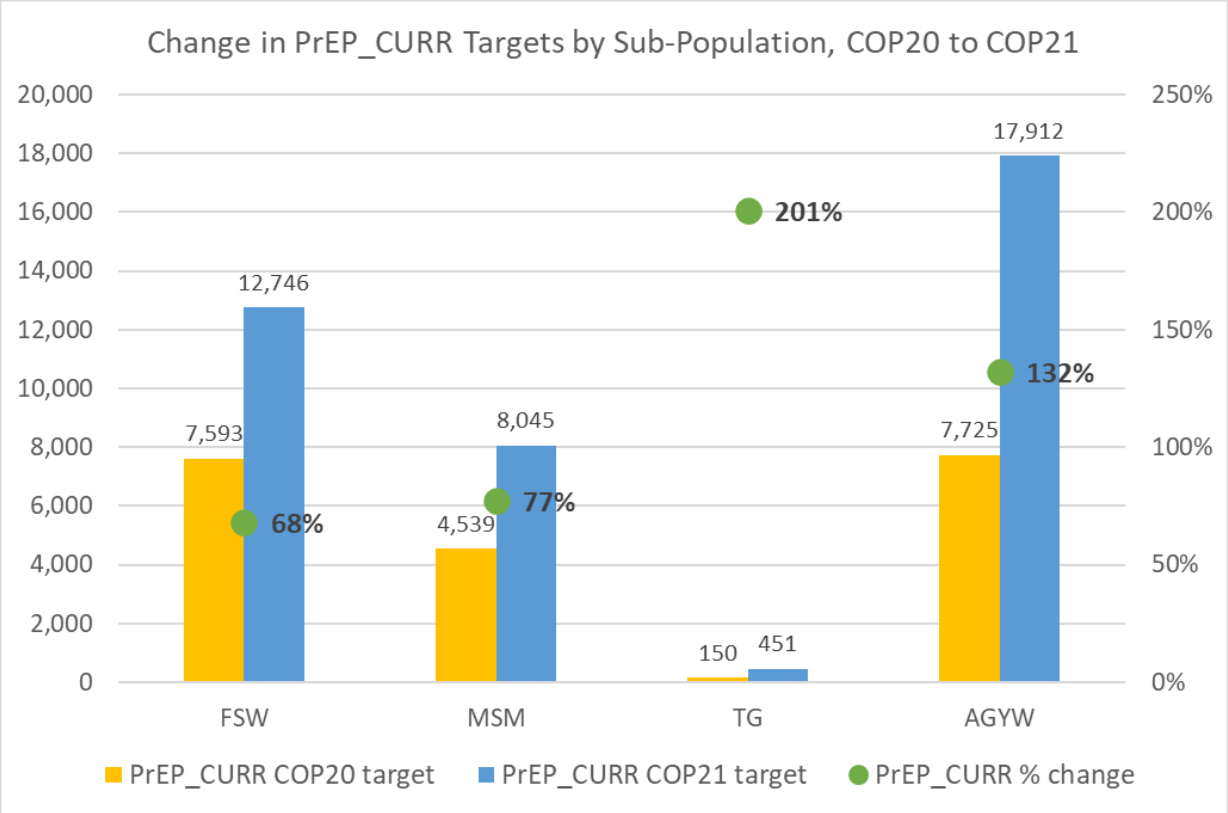
Despite improved uptake of PrEP among priority populations, continuation remains a challenge, with most discontinuation occurring in the first 4 months. Commonly cited reasons for PrEP

discontinuation were self-reported change in risk level, poor tolerance of side effects, and COVID-19 induced relocation to areas where PrEP is unavailable.

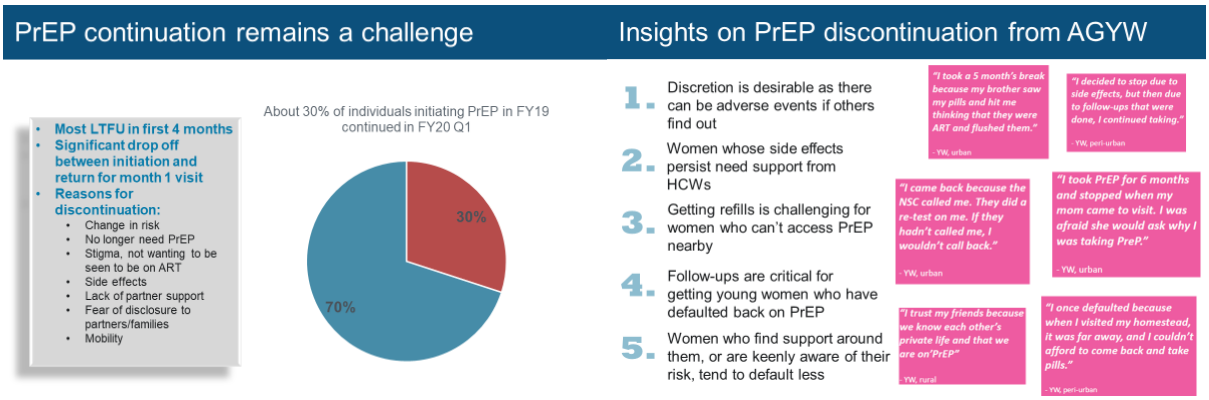
In COP21 PEPFAR will expand PrEP for priority populations delivering PrEP to 50,117 clients and increasing the number of new initiations by 70% in COP 21. PEPFAR will continue to expand coverage among KP and AGYW, capitalizing on the increased geographic footprint of DREAMS, and support service delivery for SDCs, TG, and pregnant and breastfeeding women.

The COP 2021 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 to prevent and provide comprehensive and timely response to any cases of violence.
- Support public sector roll out of PrEP in selected health facilities by reviewing patient flow and risk screening processes for different entry points;
- Strengthening M&E of the PrEP program, data capture and use, documentation, and program improvement
- Supporting clinical mentoring and patient navigation where needed.
- Communication efforts to increase demand and 'normalize' PrEP.
- Improve 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.
- All newly diagnosed HIV infected PrEP clients (especially KPs, AGYW and PBFW) will be screened for gender-based violence at ART initiation and supported.
- The program will continue to offer PEP to all those with a recent exposure with potential for HIV transmission, with those completing PEP and testing negative linked to PrEP and relevant prevention intervention e.g., DREAMS for AGYW, OVC sexual violence prevention interventions for 9–14-year-old boys and girls, KP programming for KPs etc.
- Leverage centrally funded microbicide technical assistance through centrally funded USAID microbicide program and support a demonstration project of the Dapivirine Ring. Please note that the details of this demonstration project are still under consideration at the time of the SDS submission. Discussions will be held with civil society as the project unfolds.



PEPFAR PrEP programming will continue to strengthen collaboration with the GF in COP 21. The COP21 targets are based on the national PrEP targets and gaps taking GF commodity contributions and geographic coverage into consideration.

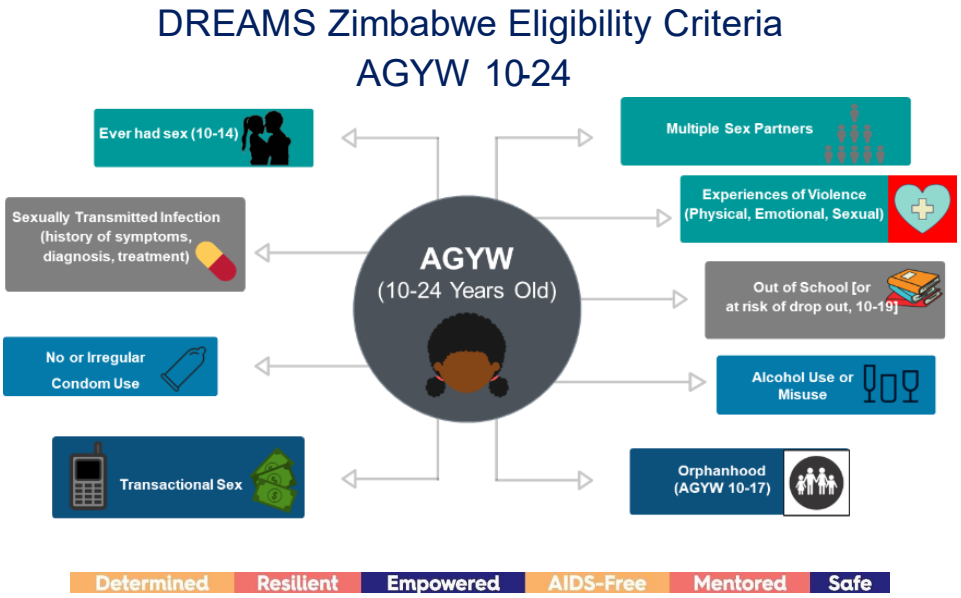


b. HIV Prevention and Risk Avoidance for AGYW and OVC

The COP20 Layering Table that documents the primary, secondary, and contextual interventions currently provided through the program in the 16 DREAMS districts is below. Changes to the Layering Table are not anticipated in COP 21.

	AGYW 10-14	AGYW 15-19	AGYW 20-24
Primary Interventions	• Condom Education • HIV Prevention Curriculum • Gender Norms Curriculum • Social Assets Building (HIV/GBV Club in or out-of-school) • Sexual Violence Prevention • Financial Literacy	• Condom Promotion and Provision • Gender Norms Curriculum • HIV Prevention Curriculum • Social Assets Building (HIV/GBV Club in or out-of-school) • Sexual Violence Prevention • Financial Literacy	• Condom Education • HIV Prevention Curriculum • Gender Norms Curriculum • Social Assets Building • Sexual Violence Prevention • Financial Literacy
Secondary Interventions	• Combination Socioeconomic Approaches for Caregivers • Education Support • Contraceptive Method Mix • GBV Response • Health Services (Other STIs) • HTS • Parenting for Caregivers	• Economic Strengthening (out-of-school) • Education Support • Contraceptive Method Mix • GBV Response • Health Services (Other STIs) • HTS • PrEP	• Economic Strengthening • Education Support (up to age 20 for young mothers, YW finishing school) • Contraceptive Method Mix • GBV Response • Health Services (Other STIs) • HTS • PrEP
Contextual Interventions	• Changing the Rivers Flow • SASA (leveraged with OVC program in selected SNU) • Faith Matters, Coaching Boys into Men (leveraged with FCI & OVC program in selected SNU) • Reducing risk of sex partners: HIVST distribution; information & linkages to HTS, VMMC, ART		

During COP 20, PEPFAR operationalized the COP20 standard DREAMS eligibility criteria, which were contextualized for Zimbabwe, shown in the graphic below.



PEPFAR developed two new standardized tools: the Eligibility Screening Tool, which is used for screening AGYW against the standard eligibility criteria, and the Enrollment Tool which is a comprehensive needs assessment aimed at identifying specific needs for secondary services. The program also strategically consolidated the DREAMS enrolment function with selected IPs to facilitate the monitoring of AGYW while they are participating in DREAMS, completion of the primary package and completion of DREAMS as program.

Vulnerable AGYW are identified by offering Eligibility Screening at strategic entry points including clinical service points, schools, OVC and community platforms, GBV response services and through social networking approaches. The DREAMS program delivers services through a variety of approaches based on age, location, type of sub population as depicted in the slide below. Comprehensive sex education (CSE) programs reach both girls and boys aged 10-14 years in primary and secondary schools (focus is on form 1 and 2). The DREAMS program draws on the strengths of multiple partners with different kinds of expertise and a well-developed coordination structure at the national and district levels.

DREAMS Zimbabwe service delivery approach

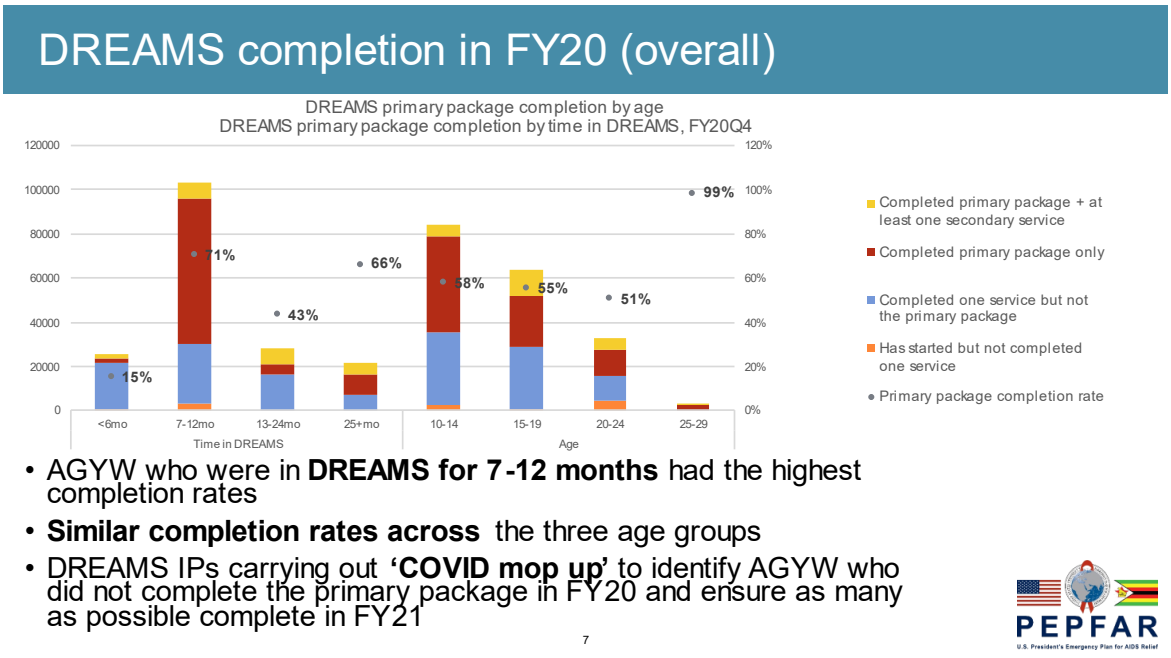
DREAMS is coordinated by the NAC structure at the national, provincial and district levels, to ensure broad participation by the different sectors, service providers and stakeholders. PEPFAR supports DREAMS Coordinators at the central levels of the MoHCC and NAC whose strong leadership has been essential 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 COP21 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, monthly, 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.

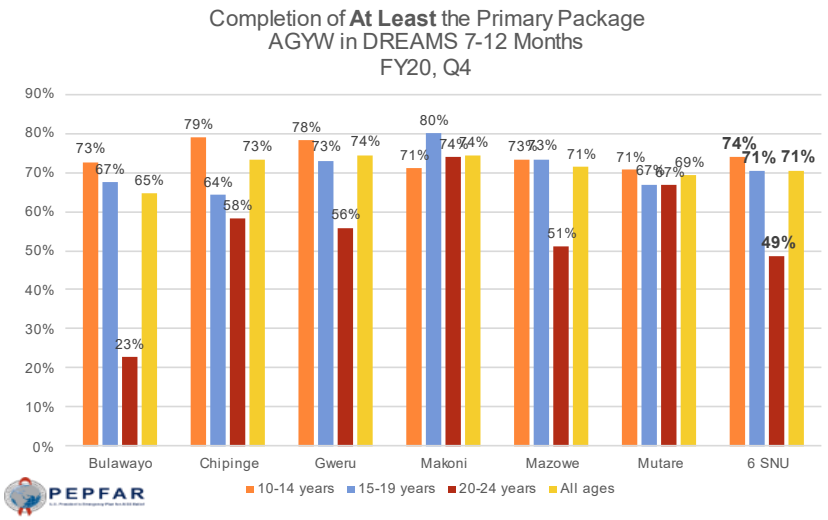
The program utilizes a DHIS-2 database with a unique identifier code (UIC) system to track individuals, layered services, and referrals. In COP20 PEPFAR overhauled the data entry, analysis, and reporting workflows of the DREAMS DHIS2 database to capture eligibility and HIV risk and vulnerability factors, better monitor AGYW's pathway through DREAMS as a program, and improve visibility into any weak links between services or referring partners.

In FY 20, completion of the primary package was similar across the three age groups, with AGYW in DREAMS between 7-12 months having the highest. In FY 21 Q1 the program made a concerted effort to identify and re-engage any AGYW who started the primary package in FY 20 but did not complete.



This chart below shows primary package completion rate by age and SNU. Primary package completion rates among AGYW 10-14 and 15-19 who were active in FY 20 were high compared to YW 20-24, with similar trends across SNUs.

DREAMS completion in FY20 (by age, SNU, 712 months)

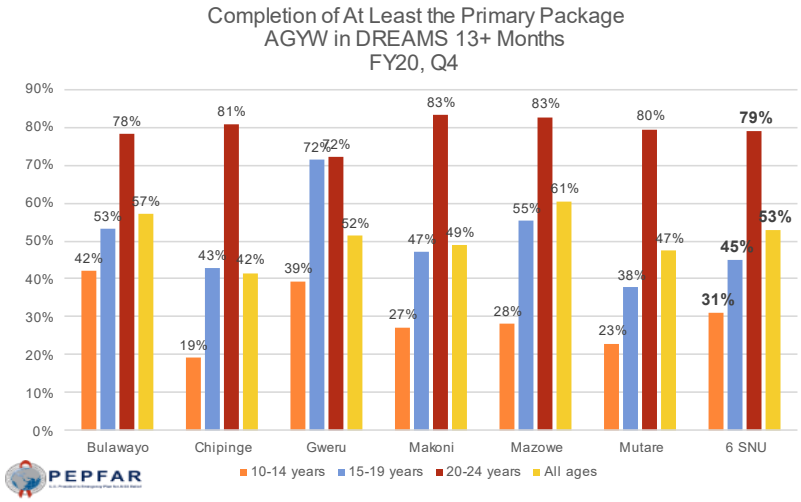


- Relatively high completion rates among AGYW 10 - 14 and 15 -19 years who began DREAMS in FY20
- Lower completion rates among YW 20-24
- Similar trends across SNU

8

It is important to consider completion of the primary package among AGYW who have been in DREAMS longer than 13 months (refer to the chart below). One would expect that AGYW in DREAMS for a longer period would be more likely to finish the primary package and this is true for YW 20-24. Of concern, however, is AG 10-14: only 31% of AG 10-14 who were in DREAMS 13+ months completed the primary package. 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 was not yet able to capture in AGYW_PREV reporting.

DREAMS completion in FY20 (by age, SNU, 13+ months)

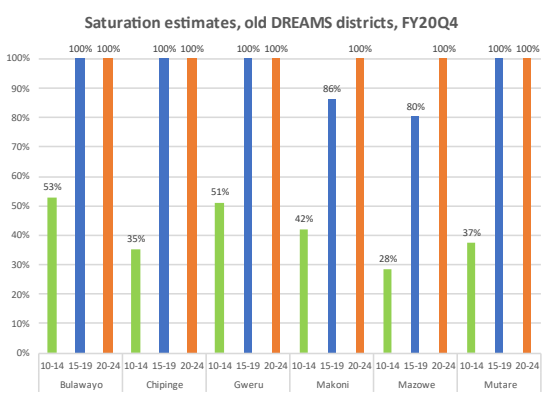


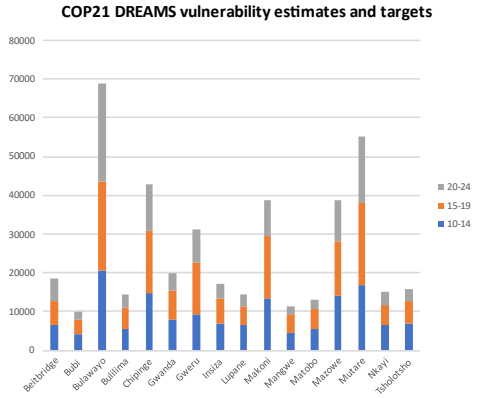
- Only 31% of AG 10 - 14 who were in DREAMS 13+ months completed the primary package
- YW 20-24 in DREAMS longer than 1 year had higher primary package completion rates
- Similar trends across SNUs, with some exceptions

9

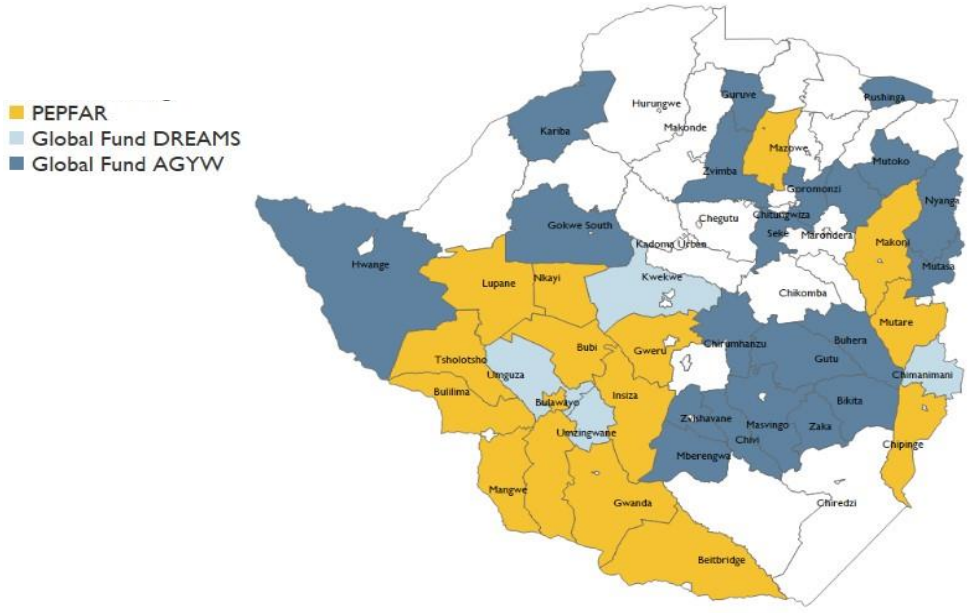
In FY 21 Q2, PEPFAR refined the DREAMS district vulnerability estimates based on additional analysis of the VACS, 2017. The saturation analysis for the original six districts was also updated as shown below. As in COP 20, a proxy for *completion of DREAMS as a program* (defined as completed the primary package plus one or more secondary services) was used to generate the saturation estimates.

COP20 DREAMS saturation estimates and COP21 vulnerability targets and estimates





In COP20 PEPFAR expanded DREAMS to 10 new districts in Matabeleland North and South provinces, bringing the total to 16 districts in Zimbabwe. The 10 new districts were ranked as exceedingly high according to the 2019 UNAIDS Incidence Classification for AGYW 15-24 and did not have DREAMS or Global Fund AGYW programs. The first two quarters of FY 21 focused on variety of startup activities, training and beneficiary identification and enrolment. Despite the challenges of COVID-19, implementation was well underway by FY 21 Q2, with all services expected to be fully operational in the new districts by June 2021.



In the original 6 districts, PEPFAR is implementing 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.

To support this ambitious expansion, PEPFAR is hiring a USG DREAMS Coordinator (expected to start in FY 21 Q3), leveraging and strengthening legacy coordination and M&E systems and, through DREAMS POC implementing partners, engaging DREAMS Ambassadors to support coordination in each district.

DREAMS activities were significantly impacted by COVID-19 and the national lockdowns that took place in March-May 2020 and again in January-February 2021. The slides below summarize the major impacts on the program as well as the many adaptations that were implemented to maintain services for AGYW and their families and communities. Many of these adaptions will be carried forward to COP21 and beyond the COVID-19 period.

	Impact	Adaptations
Movement Restrictions	• Livelihood shocks for AGYW & caregivers • AGYW recruitment participation in DREAMS activities • Comp ES for AGYW impacted	• Online safe spaces • Virtual approaches, many examples • **Social network approaches for identifying YWSS in new districts**
School closure	• Delivery of primary package for 10-14s • Extent of education assistance, particularly in new districts	• **Community School Programs approach** • Moved primary package model to community • Supported MoPSE's community school program through radio, homework clubs, radio lessons, provision of materials & smart phones, airtime • Consolidating waiting lists of beneficiaries eligible for school support
Limitations on group gatherings	• Smaller numbers reached • Caregiver interventions paused or slow to start • Inability to launch IMPOWER • Comp ES for AGYW impacted • Community norms change activities paused	• Primary package: delivered in smaller groups, outdoors with full use of COVID safety measures • Sinovuyo: training in new districts will follow PEPFAR COVID-19 guidance; virtual reinforcement of sessions • Families Matter: reinforced sessions previously delivered using phone, whatsapp; virtual enrolment of caregivers to be on standby • Caregiver ES: virtual support & follow up

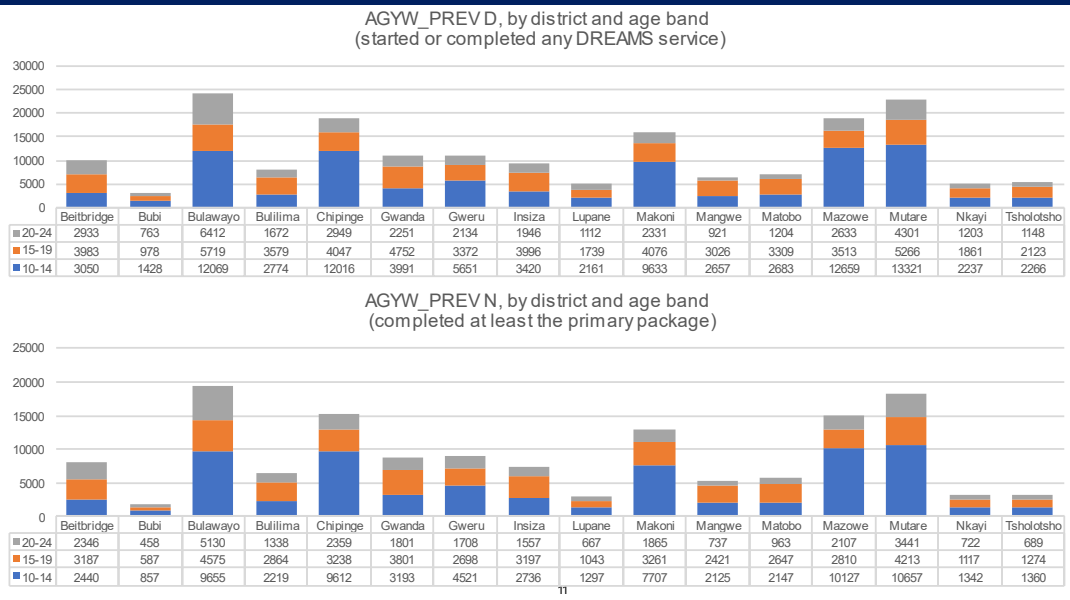
	Impact	Adaptations
GBV	• Increased reports of GBV • Survivors experience difficulties accessing services due to restrictions on movement; shelters unable to admit; some health facilities reduced operations	• Increased communication on **where/how to access help, hot lines through GBV mobile awareness campaigns (radio, mobile trucks, public address systems, expanded tool free lines operated by organizations)** • Active support & referrals by community cadres • SRN model • **Mobile & virtual counseling sessions, including pre-trial counseling & trauma counseling** • Survivors prioritized for home visits in coordination with DSW • COVID testing before admission to shelters
Interruptions in clinical service delivery	• Some health facilities reduced operations • Health facility closures due to COVID in the workplace, HCWs infected or in quarantine • Low stocks of PrEP, other commodities	• Increased community outreach & service delivery for distribution of condoms, PrEP, HIVST, MHM materials • **SRN model, network approach led by DREAMS Ambassadors focused on identifying AGYW in need of a clinical ASRH service & organizing services to be brought to community, focusing on those areas with highest vulnerability** • Increased **virtual follow up** by community cadres/outreach workers • Implementing strict health screening measures, appointment booking to decongest sites • Generally, we have good results for FP and PrEP as a result of COVID adapatations
Mgmt & coordination	• Limited office presence • Reduced capacity for field trips & monitoring visits • Data collection & entry slow down	• Separating work teams • **Virtual district coordination meetings** • **Virtual monitoring** • **Using whatsapp to track referrals** • Focus on developing/updating SOPs

COP21 strategic priorities for DREAMS are summarized below:

1. Demonstrate progress towards saturation in the 10 expansion districts (new in COP20).
2. Implement/test maintenance strategy in 6 original districts, using program data to develop an aging-in program for 10-year-olds, targeting strategies for continued identification of the most vulnerable AGYW, including AGYW who are newly vulnerable.
3. Continue to mitigate the impacts of COVID-19 through innovation and adaptation.
4. Continue to refine eligibility and enrolment processes and database to strengthen referrals, completion of the primary package and the full DREAMS Continuum.
5. Strengthen and standardize the Mentorship Strategy.
6. Fully roll out the updated comprehensive, evidence-based economic strengthening interventions for AGYW, based on PEPFAR Guidance and findings from program review (begun in COP 20).
7. Continue to scale up PrEP for AGYW, addressing critical gaps in commodities and scaling up client centered, differentiated approaches to support AGYW to stay on PrEP.
8. Leverage centrally funded Microbicide technical assistance through USAID and support a demonstration project of the Dapivirine Ring.
9. Continue to strengthen clinical post violence care and other GBV response services, growing the number of sites offering the minimum package and strengthening linkages to community services.

COP21 AGYW_PREV targets are shown below.

DREAMS: COP21 AGYW_PREV Targets



	Beitbridge	Bubi	Bulawayo	Bulilima	Chipinge	Gwanda	Gweru	Insiza	Lupane	Makoni	Mangwe	Matobo	Mazowe	Mutare	Nkayi	Tsholotsho
20-24	2933	763	6412	1672	2949	2251	2134	1946	1112	2331	921	1204	2633	4301	1203	1148
15-19	3983	978	5719	3579	4047	4752	3372	3996	1739	4076	3026	3309	3513	5266	1861	2123
10-14	3050	1428	12069	2774	12016	3991	5651	3420	2161	9633	2657	2683	12659	13321	2237	2266

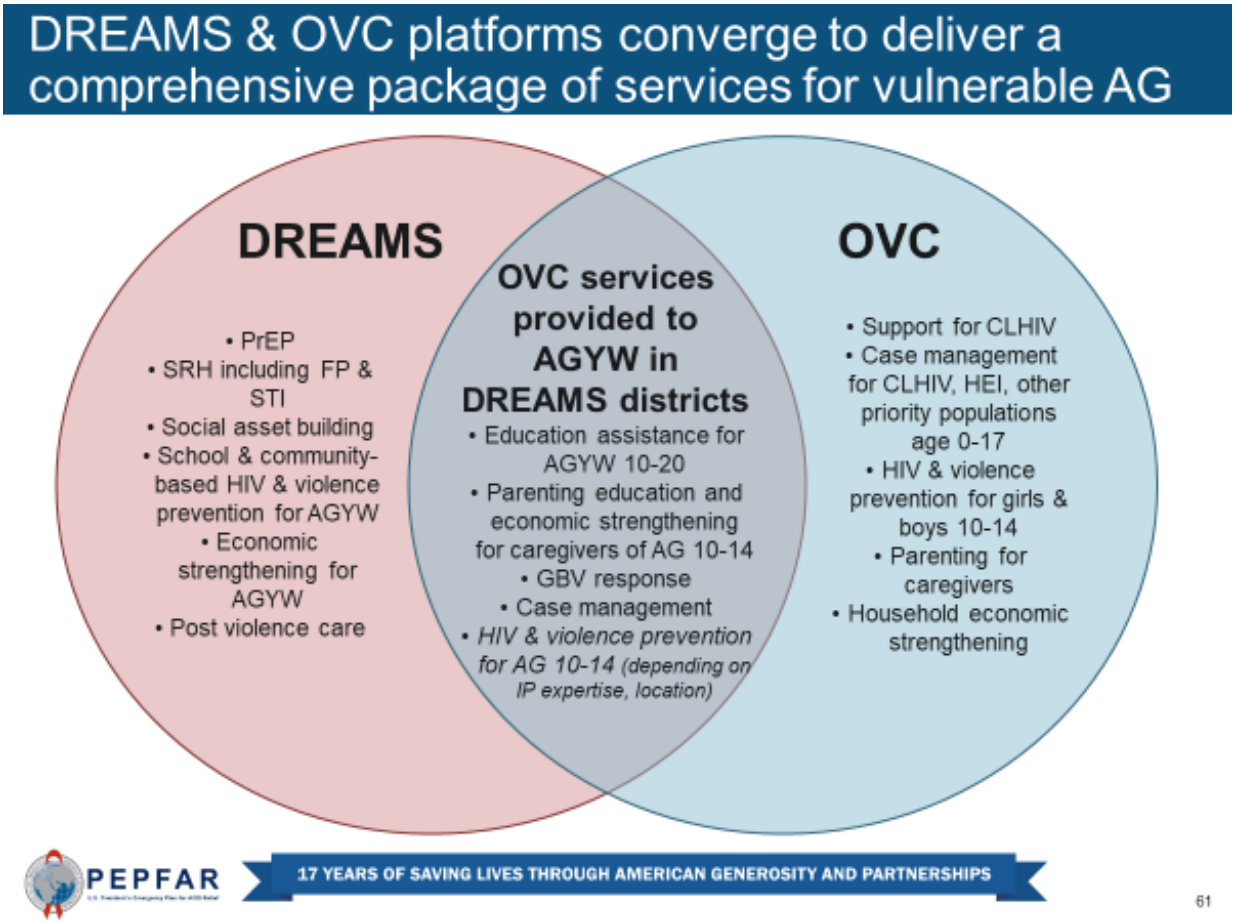
	Beitbridge	Bubi	Bulawayo	Bulilima	Chipinge	Gwanda	Gweru	Insiza	Lupane	Makoni	Mangwe	Matobo	Mazowe	Mutare	Nkayi	Tsholotsho
20-24	2346	458	5130	1338	2359	1801	1708	1557	667	1865	737	963	2107	3441	722	689
15-19	3187	587	4575	2864	3238	3801	2698	3197	1043	3261	2421	2647	2810	4213	1117	1274
10-14	2440	857	9655	2219	9612	3193	4521	2736	1297	7707	2125	2147	10127	10657	1342	1360

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 aged 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 FCI investments, PEPFAR will continue to implement two additional evidence-based approaches: Coaching Boys to Men and IMPower for adolescent boys and girls aged 9-14.

In COP21 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 COP21 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.

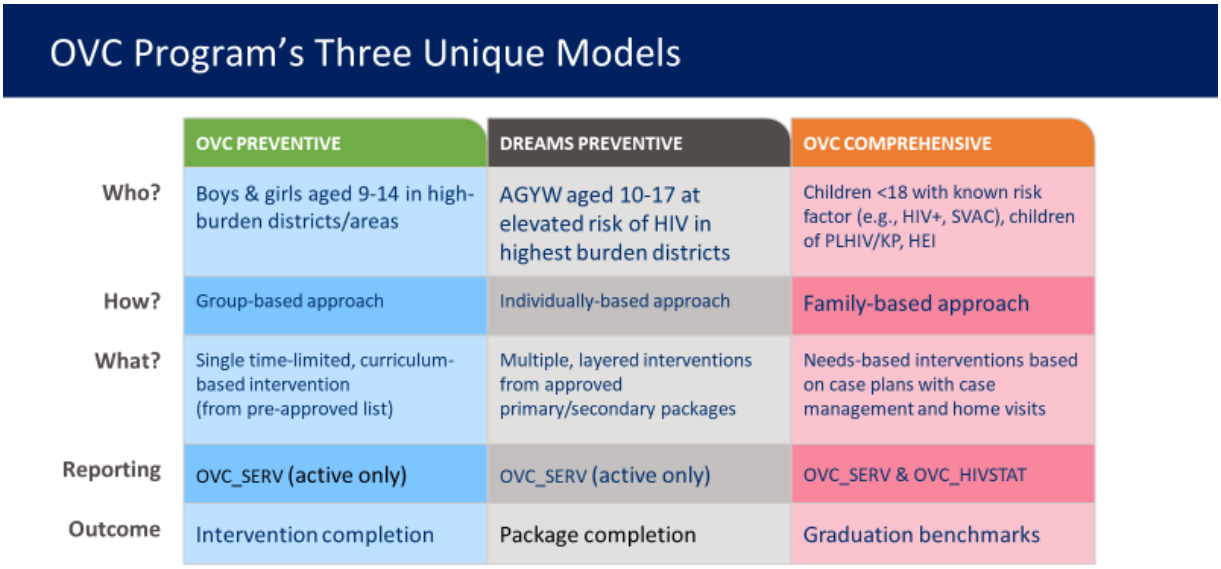


In FY 22, the program will continue prioritizing the following sub- populations:

- ✔ Children living with HIV (especially newly enrolled and virally unsuppressed)
- ✔ HIV exposed infants, especially those LTFU in PMTCT cascade
- ✔ Biological Children of HIV+ adult caregivers
- ✔ Survivors of Sexual Violence
- ✔ Children in child-headed households
- ✔ Children of FSW
- ✔ DREAMS AGYW
- ✔ 9–14-year-olds in areas with high violence and HIV burden

In COP21 the OVC program will undergo a fundamental shift to respond to the changing epidemic 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):



OVC COP 21 Targets

OVC Comprehensive

- 39,351 CALHIV and their caregivers
- 25,618 HIV-exposed infants and their caregivers
- 32,954 sexually or physically abused children,
- children of FSW 13,506
- children in child-headed households,11,041
- children of HIV+ biological caregivers who are at risk of default + caregivers 21,563.
- 36,169 other highly vulnerable children (orphans, children living with disability, out of school children, etc.) + caregivers.

OVC Preventive

- 97,172 (all from DREAMS Program) children 9-14 with evidence-based sexual violence prevention
- Plus, others in OVC comprehensive who will also receive this service.

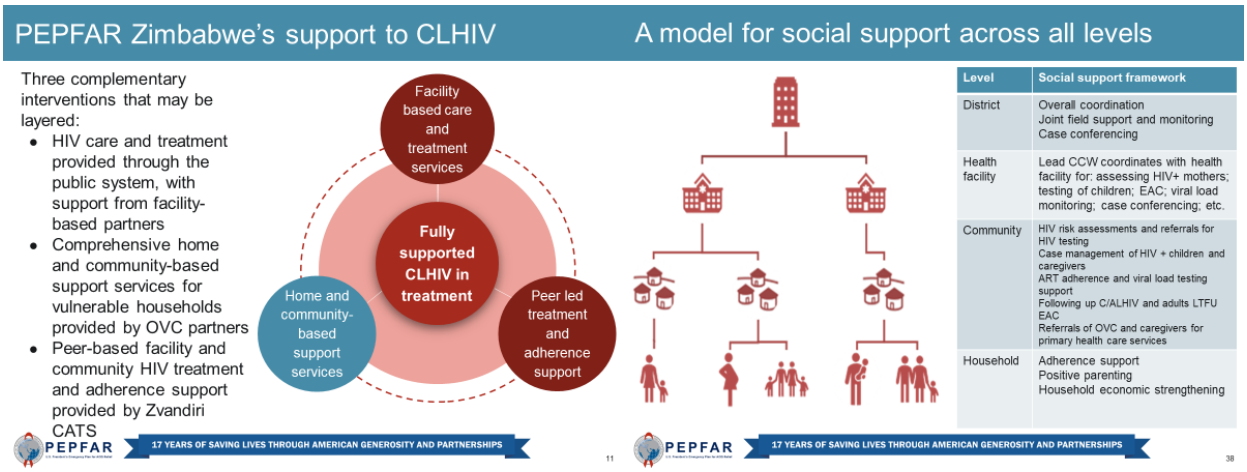
DREAMS

- 113,105 DREAMS AGYW

In COP 21, the program will continue to offer comprehensive case management services to OVC ensuring linkage to relevant Health, Safety, Education and Economic Strengthening services for OVC and their caregivers. Sexual violence prevention interventions for 9-14 years old boys and girls as well as response to GBV, including referral for other prevention and response services will also remain priorities.

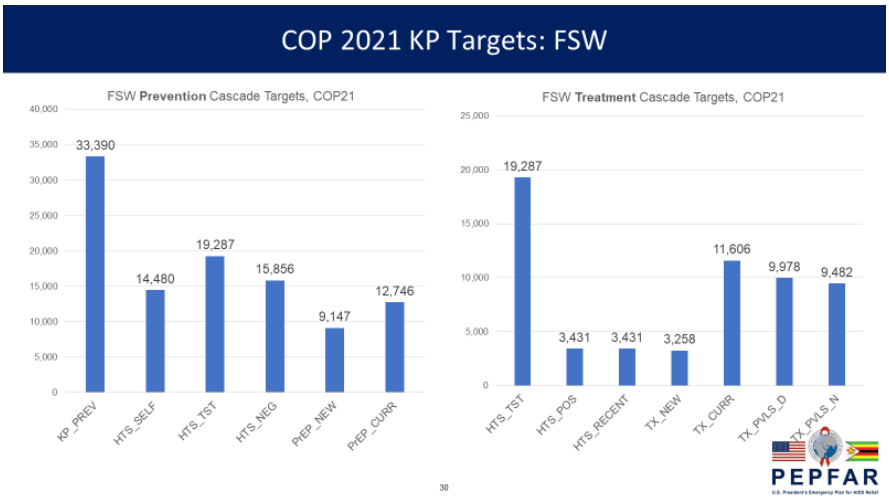
c. Children/PMTCT

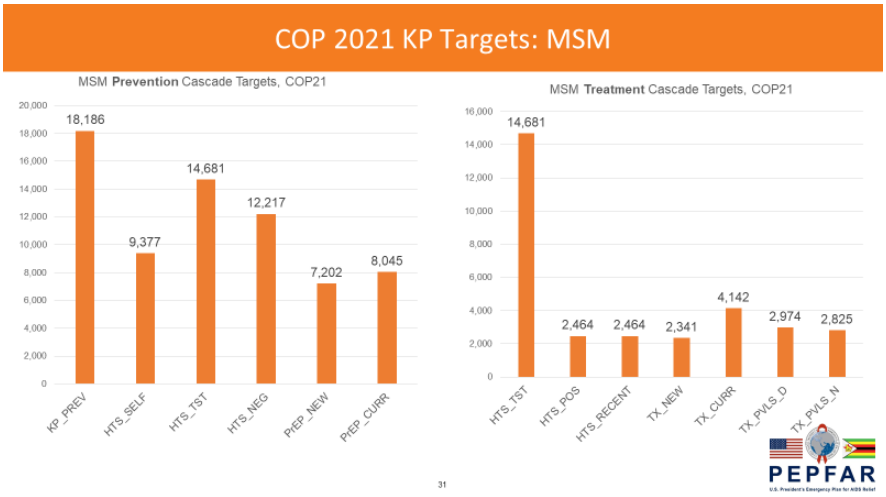
By the end of COP 21, the PEPFAR OVC Program will increase support of CLHIV in the 21 OVC focus districts from the current rate of 60% to 73% within the OVC coverage areas. In addition, we will ensure that 90% of CLHIV receiving clinical care in these areas will be offered enrollment into the OVC Comprehensive Program. Currently, 100% of health facilities in OVC catchment areas are covered by MOUs granting the implementing partner permission to work within the facilities. The Community-Clinic Linkage SOP will remain the guiding document utilized to refine these agreements. As feasible, the IPs will maintain support for case managers at high-volume clinics to ensure smooth coordination and referrals between health care workers and community case workers. In COP21 PEPFAR will continue to assess HIV+ women in adult care who are pregnant and/or have children aged 0-19 to determine if their families should be enrolled in the OVC program and referred for index testing. 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. OVC IPs will collaborate with clinical IPs to pilot community EID for children who have not been brought to the facility for testing.

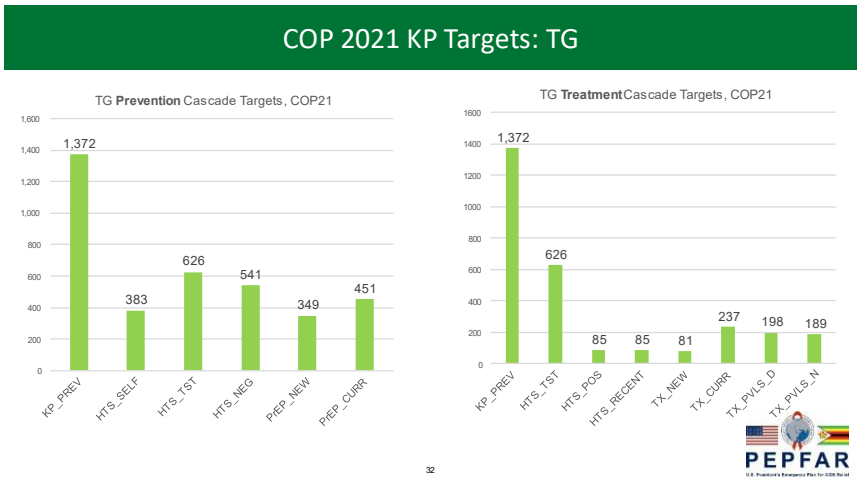


d. Key Populations

PEPFAR is on track to meet PrEP targets for Key Populations (KP) in COP20 and will continue ambitious KP PrEP scale-up in COP 21. Event Driven PrEP (ED-PrEP) will remain a focus and a Dapivirine demonstration project will be undertaken (under DREAMS) in COP21 with possible scaling up in COP22.

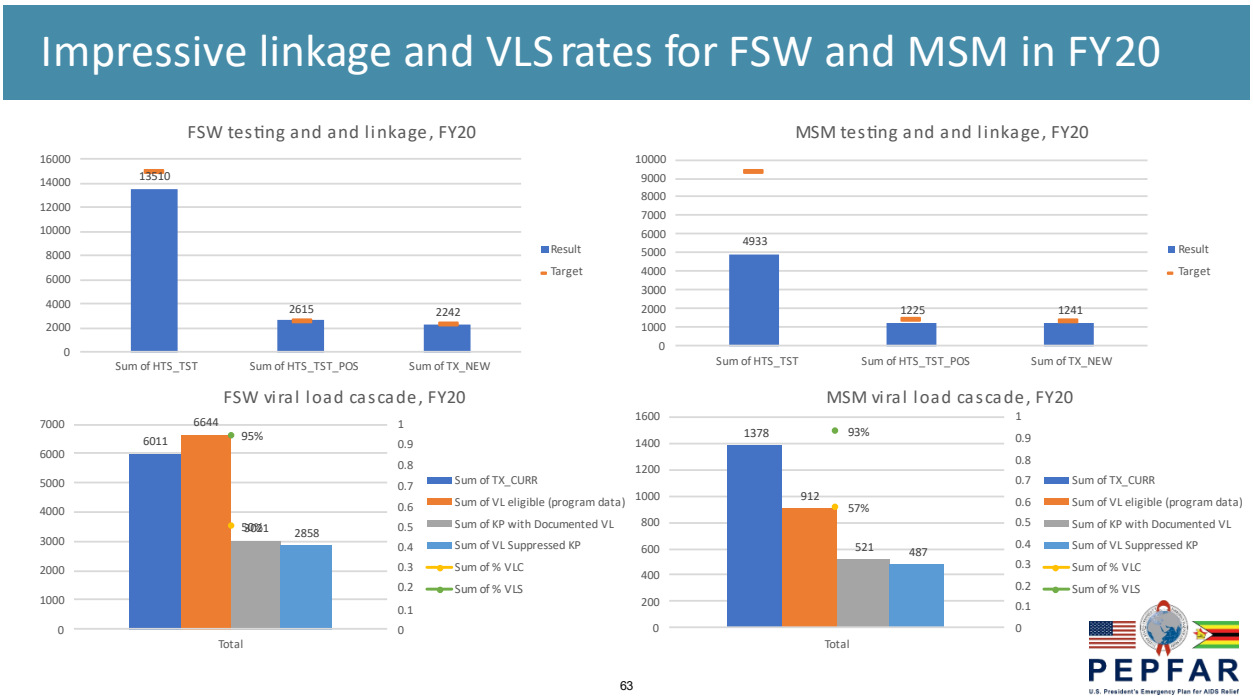


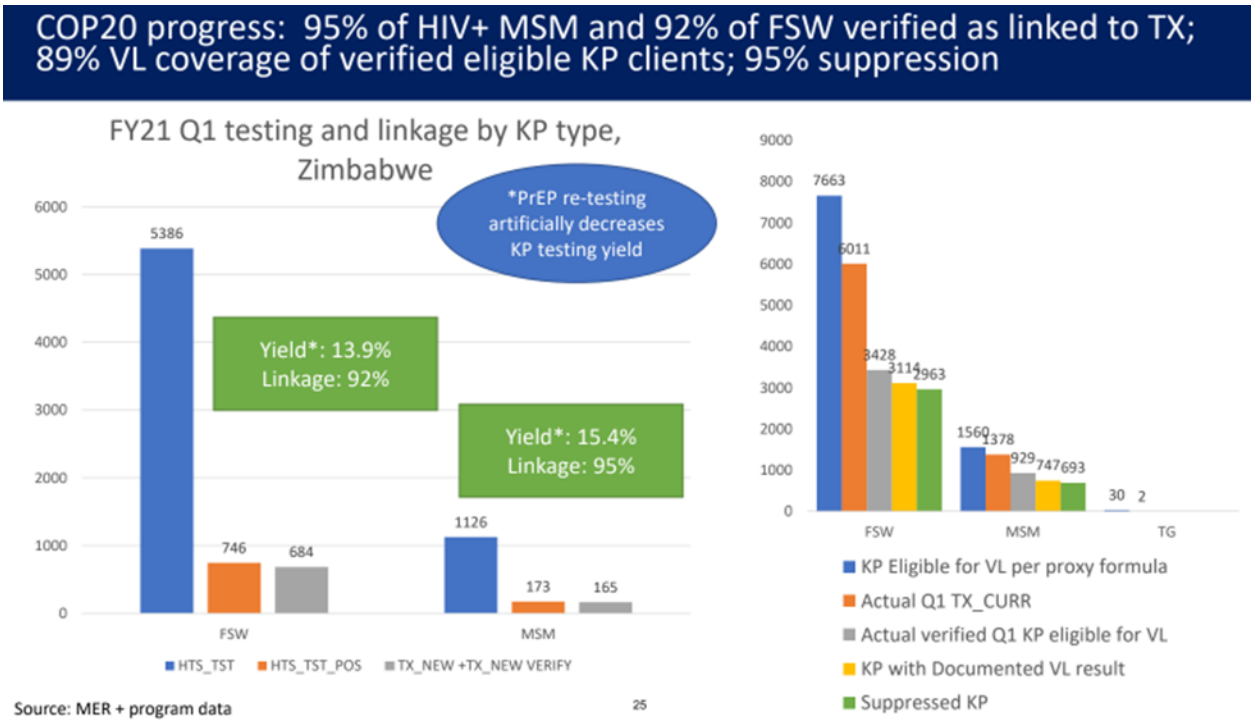




PEPFAR also demonstrated high linkage and viral suppression rates among FWS and MSM in FY20. COVID-19 related restrictions impacted programming including viral load coverage during COP20 implementation, but Q1 data show continued strong linkage to treatment and 89% VL coverage for those KPs that were eligible in FY21 Q1. In COP 21, the program will focus on improving adherence, retention and VLS for KP through differentiated service delivery models such as scaling up community level refills, MMD, community VL sample collection, continued use

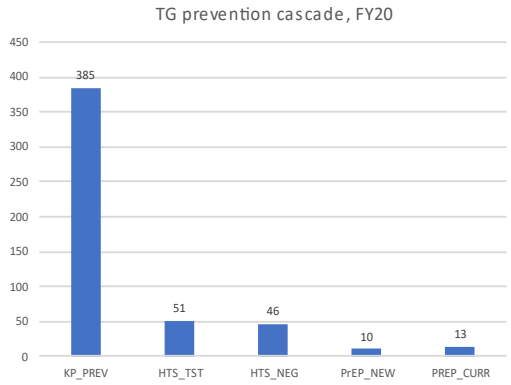
of DSD Assistants and peer cadres for intensified case management and strengthening of the public sector sites.

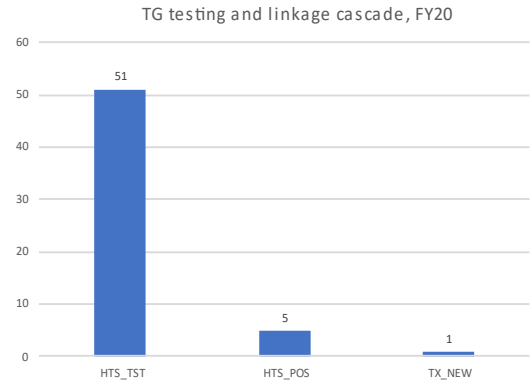




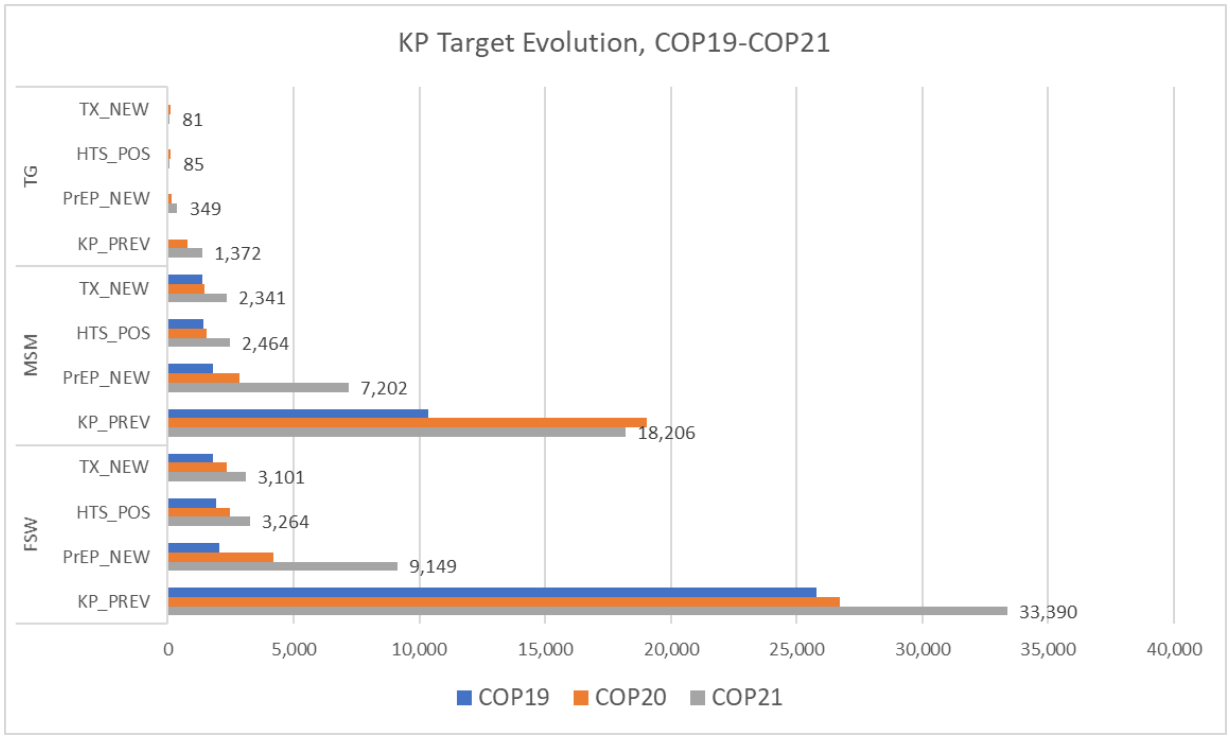
While there were no TG targets for FY20, PEPFAR reached out to this group with prevention, treatment, and linkage support as shown below. PEPFAR has TG targets in COP20 and will continue with dedicated TG targets in COP 21.

PEPFAR reached out to TG in FY20 despite not having TG targets





In FY21, PEPFAR will continue to expand quality, client-centered approaches for HIV prevention, treatment, and retention for KPs, to reach 82% of FSW, 66% of MSM and 70% of TG in the 6 largest urban districts in the country (Harare, Chitungwiza, Bulawayo, Gweru, Mutare, and Masvingo) in addition to the border districts for the FSW program (Beitbridge, Chriundu, Forbes, Plumtree, and Victoria Falls). PEPFAR will work hand in hand with the KP community and local CBOs to address challenges to service uptake and retention and to meet KPs where they are with services that meet their needs. A summary of the COP21 targets in the six focus districts and border locations, and how they compare to COP20 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).



COP21 strategic priorities for the KP program are summarized below:

- Continue scaling up of 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 (specialized SW 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 testing providers 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.

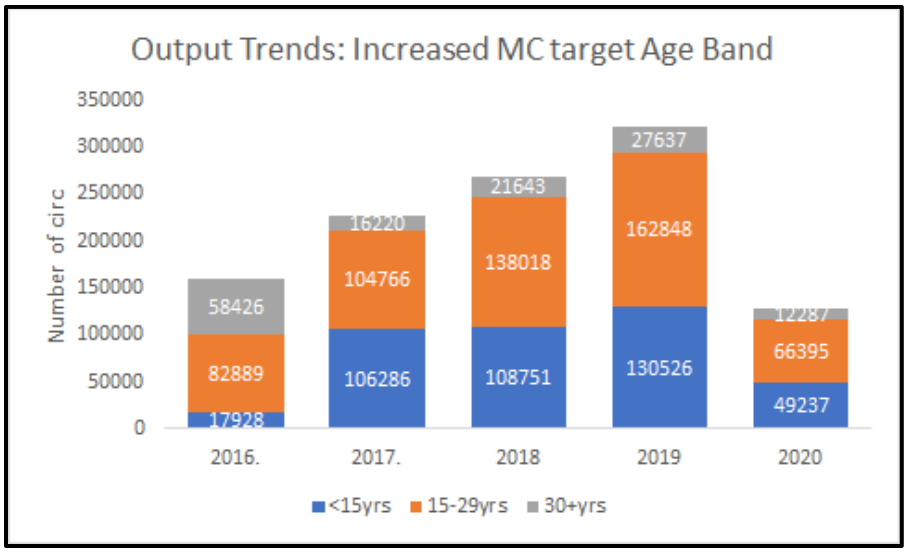
- Leverage continued support to the National Technical Support Committee (TSC) to strengthen quality, capacity, and sustainability of the national KP program, including harmonization of investments and activities across funding partners. The TSC will coordinate and strengthen programming for all KP group. 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.

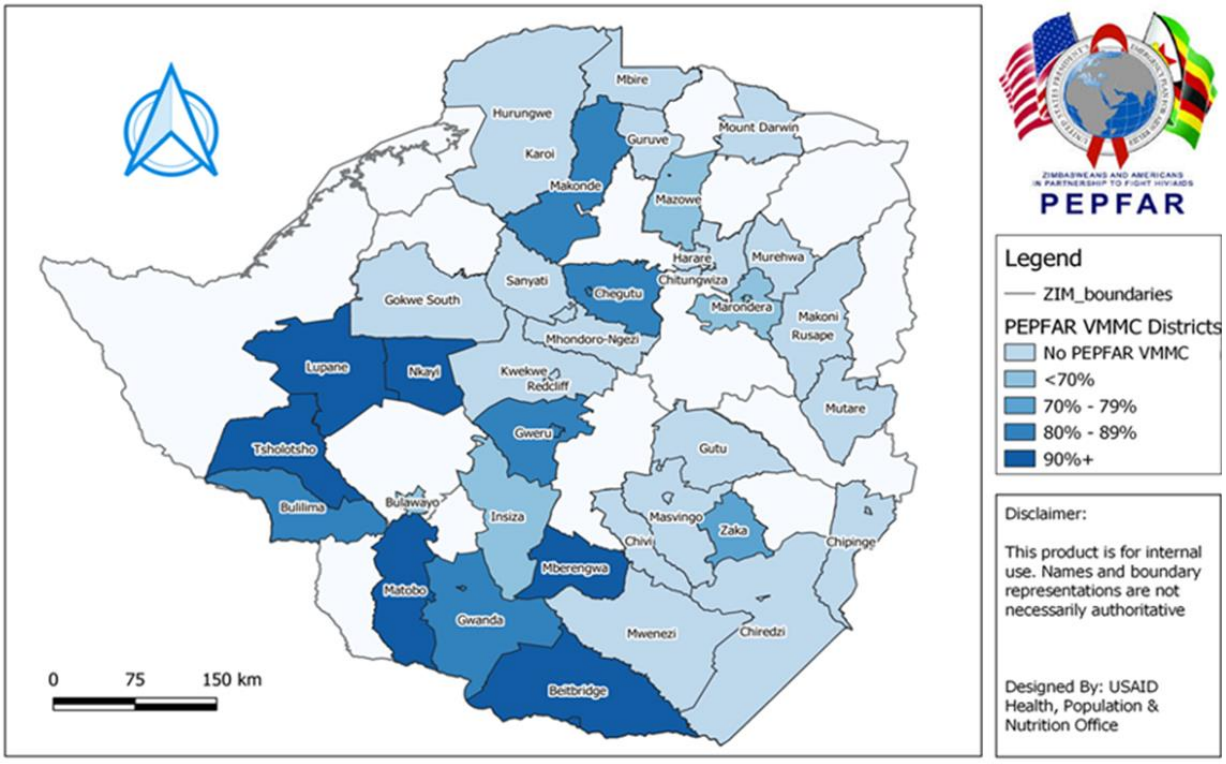
e. **Voluntary medical male circumcision (VMMC)**

PEPFAR's strategic approach in COP21 continues to support the implementation of the national VMMC Sustainability Transition Implementation Plan (STIP; 2019 – 2021). COP21 Guidance specifically mandates circumcisions in males aged 15 and over, with 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 in a context of ongoing COVID-19. PEPFAR collaborates with the World Health Organization (WHO), the Bill & 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 COP21 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. The COP21 target is 133,955 MCs. The target for COP21 is a reduction from the COP20 target of 249,026. The target reduction is a result of rising programming costs and a higher unit expenditure as the program pivots to reach men ages, 15-29.



Projected COP21 VMMC coverage

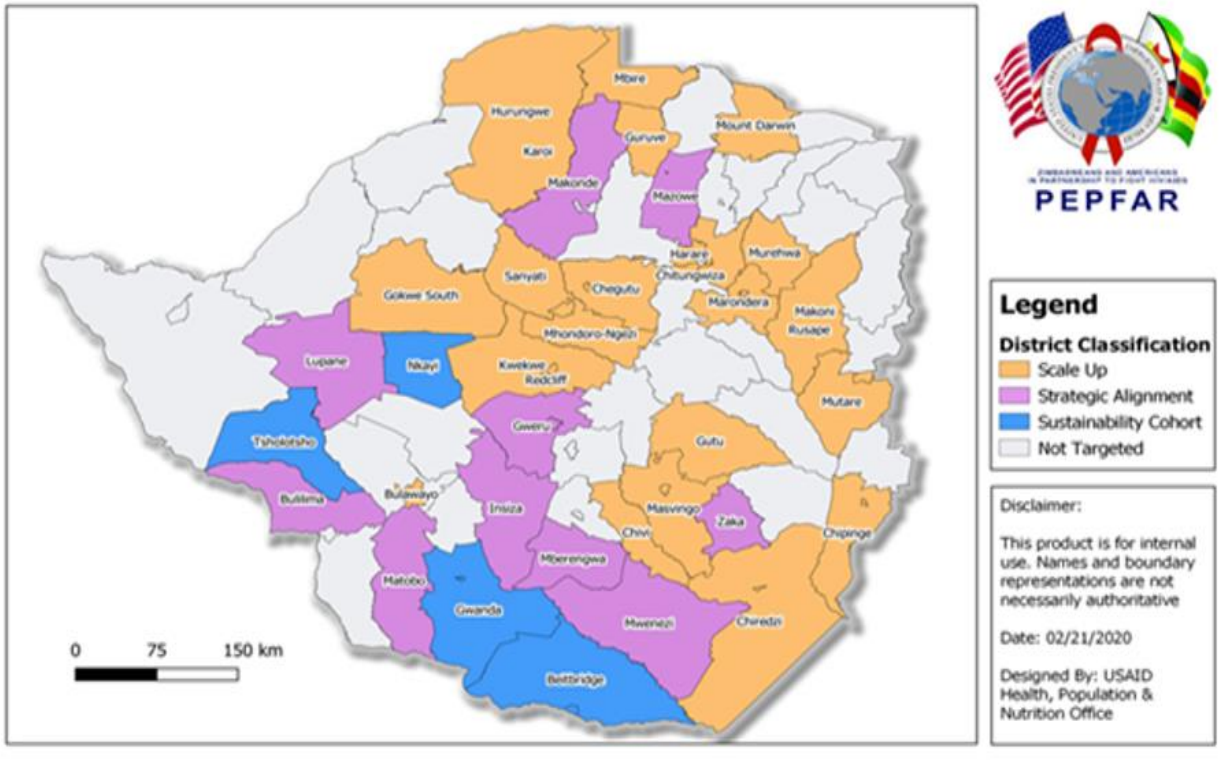


To continue saturation of VMMC coverage in these districts while aligning the VMMC program to the goal of sustaining epidemic control, districts have been classified into three categories based on the male HIV incidence in the 15+ age group, gap to ART coverage and unmet need for MCs. Implementation 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).

In FY 22, PEPFAR will collaborate with the MoHCC to initiate stakeholder meetings on the COP21 strategy, continue transition to MCs in 15+, national AEM, and the transition from cost reimbursement to PBF. An implementation strategy will be finalized, prior to the start of COP21 implementation.

PEPFAR will continue to address issues around COVID-19 prevention measures, general surgical 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.

COP21 District Classification

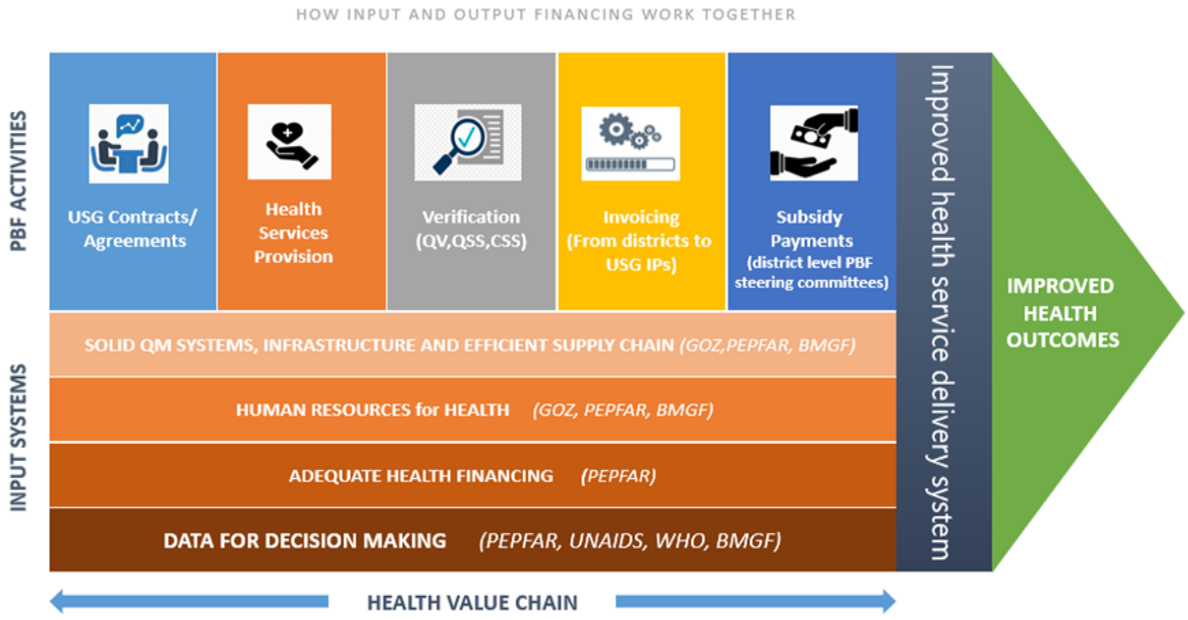


The dorsal slit (DS) surgical method will remain the standard method of circumcision for all age bands.

COP21 will continue the adoption of a PEPFAR and BMGF supported PBF structure for the program, with further exploration of transition to the country led Results Based Financing. In COP 21, the cost reimbursement structure will be 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 the program remains on track to successful transition to sustainable and country-owned biomedical HIV prevention programs. The program continues to use community-based mobilisers either as directly employed by the program or on incentive basis depending on numbers mobilized.

The PEPFAR program has reservations around adoption of the full RBF approach to finance VMMC services in Zimbabwe given the uncertainty of the funding landscape in the country. However, the program has agreed to pilot an RBF–like approach in 3 of the 14 districts supported by CDC and 5 of the 22 districts supported by USAID. These RBF-like pilots will mirror RBF systems and structures whilst maintaining PEPFAR funding stewardship within PEPFAR implementing partners. Lessons from these districts will inform whether to fully transition to RBF or not for the PEPFAR VMMC program.

COP 2020 and 2021 PBF Structure (Adapted from GOZ RPF)



The table below shows the strategic shifts in COP 21:

COP20 Strategy	COP21 Strategy
Focus on epidemic control alignment	**No Shift**
Enhanced partner performance management and oversight	**No Shift**
VMMC services 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	**No Shift**
Targeted and evidence based VMMC and HIV prevention messaging for male adolescents and young adults, ages 15-29	**No shift**
Data driven and targeted demand creation at district level, to engineer access to older age group (20-29-years-old) and districts with low coverage in those age groups.	**No Shift**
Year of transition to PBF, with a view to transitioning the incentive mechanism to the MoHCC within a stipulated timeframe	**No Shift**
Ownership of the DMPPT2 Online transitioned to the MoHCC, and in-country stakeholders, with capacity for modelling built in-country as part of this process.	**No Shift**
One System and Role Reversal: One AE management system will be developed for the MoHCC with PEPFAR support	**No shift**
Maintain Age pivot at 100% 15 – 29-year-olds	**No Shift**
Routine DQAs, IQAs, annual EQA, cQI (mandatory for PBF)) using the enhanced HNQIS tool	**No Shift**
National roll out of the reusable kits to all districts, equipment, and HR support for challenged sites	**No Shift**

4.4 Commodities

Commodity procurement is essential for COP21 given the diminished capacity of the Government of Zimbabwe to provide funding for commodities due to economic decline and competing priorities for the GOZ. The COVID-19 pandemic has made quantification and forecasting more complicated for COP21 due to slow-down in some program areas and the uncertainty of manufacturing ability, timeliness and increase in freight times and costs. The Global Fund also began a new grant cycle this year, and it is unclear if there will be cost savings from this year that can be used to cover gaps for the COP21 period.

The focus for ARV procurement will be on 90-tab bottles of TLD which will continue to support multi-month dispensing of TLD. In COP 21, PEPFAR Zimbabwe will continue to procure Emtricitabine/Tenofovir 200/300mg to scale up our PrEP program.

To support an increase in viral load testing, PEPFAR funds will be used to purchase Roche and Hologic viral load testing reagents, as well as mPIMA and GeneXpert point of care cartridges. 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. PEPFAR will also collaborate with CHAI/UNITAID in the implementation of the 16 module Gene Xpert pilot prioritizing high volume- hard to reach facilities.

Disposable and reusable VMMC kits and commodities needed to compliment the reusable kits in country will be purchased in COP 21. Disposable kits are still needed due to the lack of electricity and water needed at sites for autoclaving reusable kits. Shang Ring kits will continue to be purchased in Zimbabwe.

In COP 21, PEPFAR-procured vehicles will continue to assist the National Pharmacy by providing 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 maintaining 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.

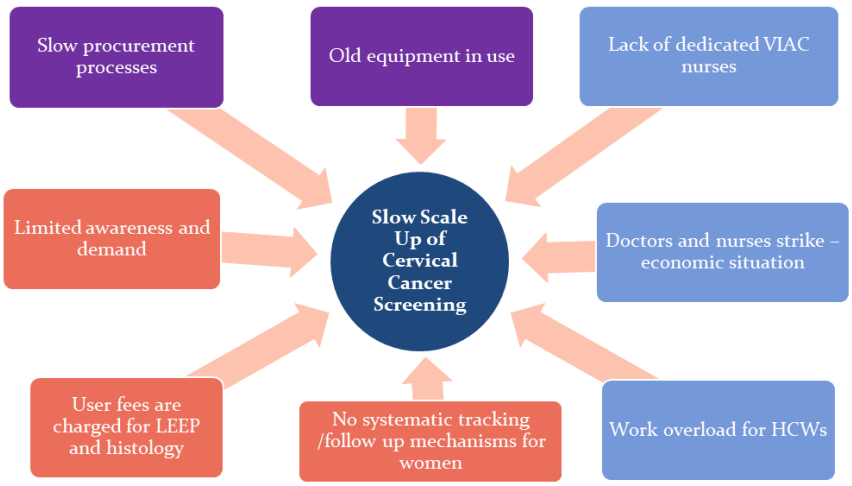
4.5 Cervical Cancer

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, largely caused by human papillomavirus

(HPV), is the most prevalent form of cancer among women in Zimbabwe, with an estimated 3,186 new cases and 2,151 deaths annually. About 35% of women in the general population are estimated to harbor cervical HPV infection at a given time, and 79.6% of invasive cervical cancers are attributed to HPV subtypes 16 and 18. 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).

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%. 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 (2016-2020) recommends 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.

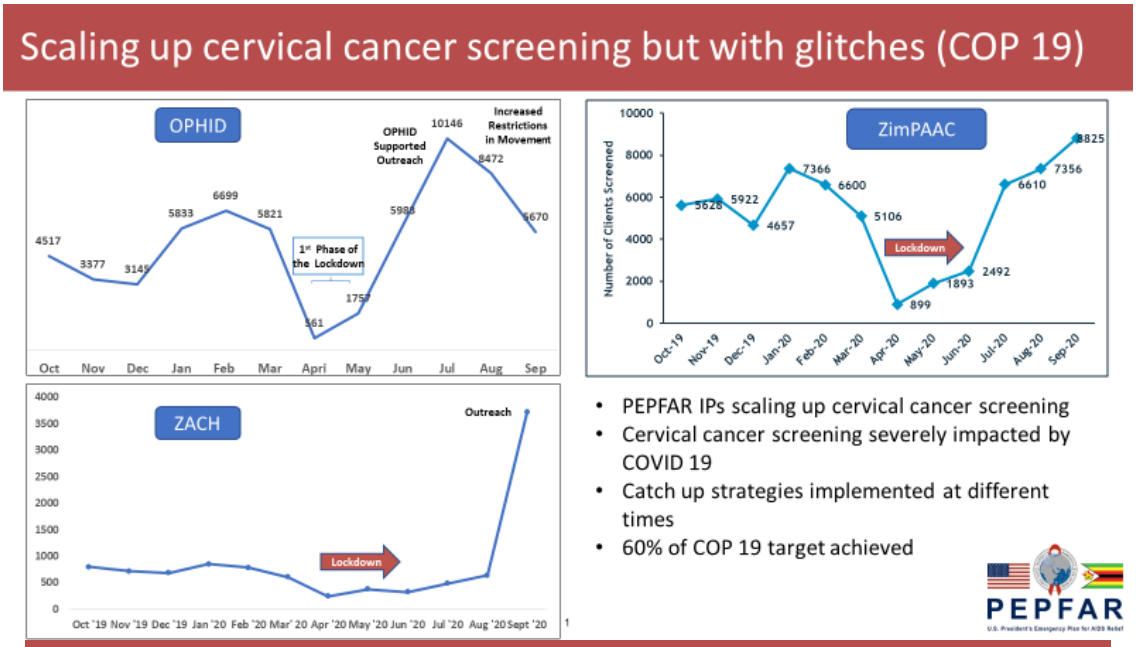
The current program is built on the established HIV care and treatment settings focusing on supporting VIAC sites and establishment of new screening and treatment sites.

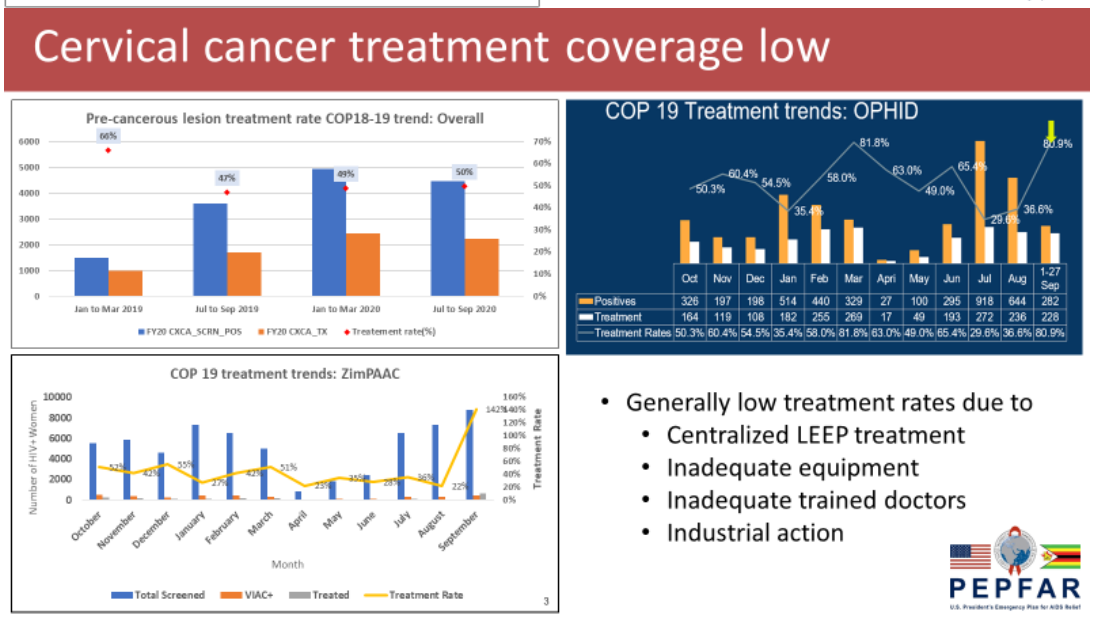


COP 19 (FY20) implementation of activities was affected by the lockdown restrictions due to the COVID-19 pandemic. Cervical cancer screening activities were de-prioritized by the MoHCC to protect clients and staff from COVID-19 infection. This was further affected by inadequate PPE, facility closures and the nationwide strike action that followed the lifting of the restrictions. While the strike has since been called off, human resource challenges continue to surface within the program. The implementing partners continue to recruit and train VIAC nurses to work full time in the VIAC clinics. In COP 21, the PEPFAR program will support scaling up outreach services for VIAC. Other support will be directed towards the decentralization of LEEP services. The program thus plans to procure additional thermo-coagulators as well as LEEP machines. COP21 will also see the adoption and scale up HPV-DNA screening for women. The PEPFAR program will support the MoHCC in development of guidelines and protocols, as well as the implementation of this service. The program will continue to support the cervical cancer monitoring and evaluation technical working group as

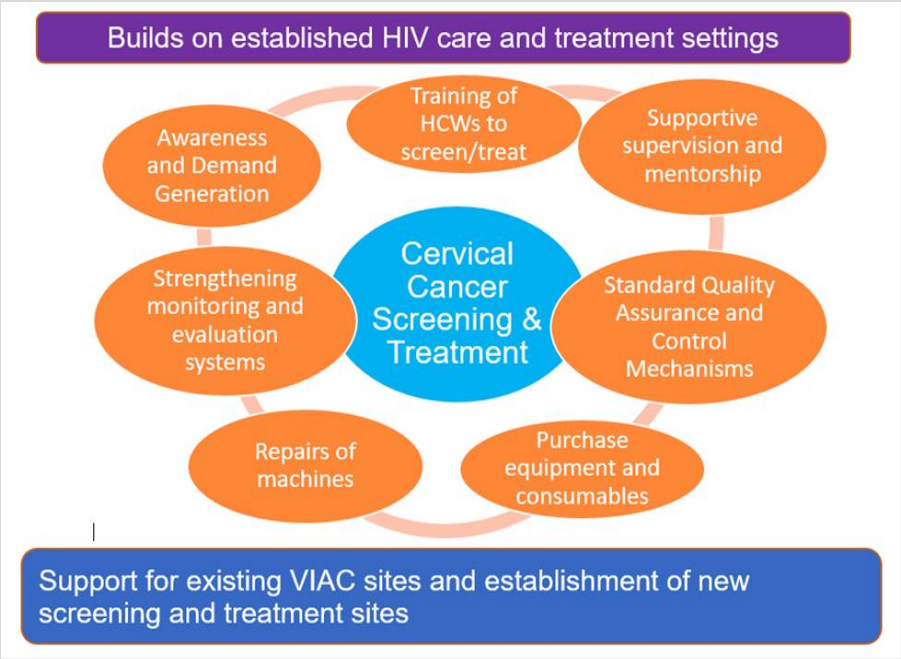
well as the national VIAC register and the master MoHCC monthly return forms which were revised to incorporate the PEPFAR VIAC indicators.

The graphs below show the performance of the program **in COP19 (FY20)**. There has generally been an upward trend in the numbers of women being screened and treated but this was severely impacted by COVID-19. The program is however showing signs of recovery. There is need to address the above challenges for the program to achieve targets.



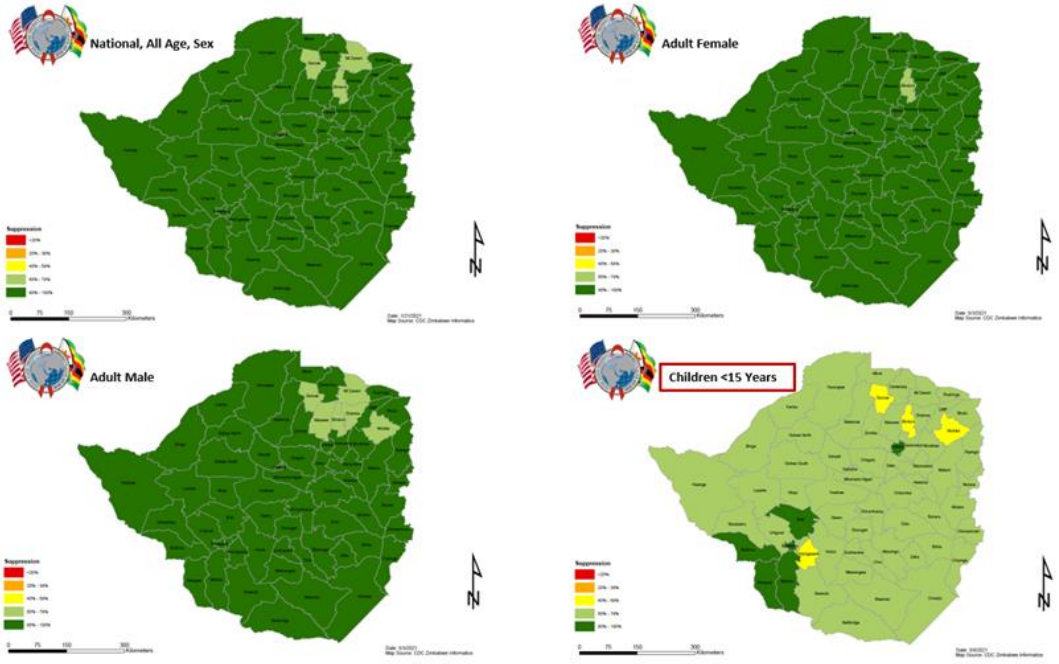


In COP 21, the PEPFAR program will continue to support the secondary prevention of cervical cancer in women living with HIV. In COP 21, the target is to screen 207,974 women living with HIV on ART aged 25-49 years every other year for pre-invasive lesions to allow early treatment. The figure below shows the PEPFAR Zimbabwe Cervical cancer program approaches.



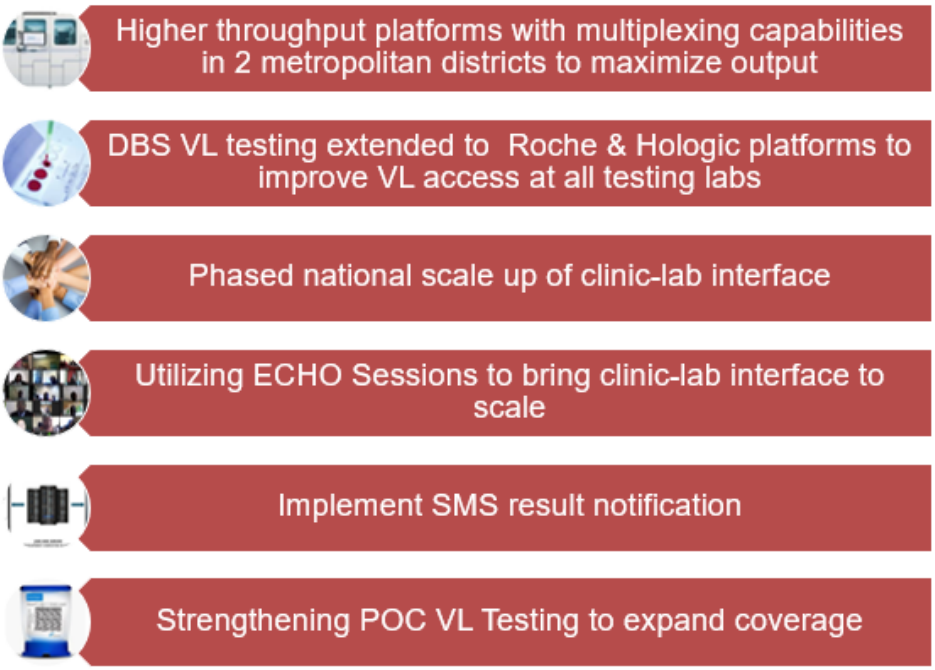
4.6 Viral Load and Early Infant Diagnosis Optimization

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. Children continue to have lower suppression rates than adult men and women.



In COP 2021, continued 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 funds available through the American Rescue Plan Act (see Appendix D for further details) and the Global Fund COVID-19 Response mechanism have further enhanced laboratory collaboration between PEPFAR and the GF. PEPFAR has been in continuous dialogue with the GF, UNDP, and the Country Coordinating Mechanism (CCM).

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



In COP 21, 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 90% coverage by the end of COP 21. Utilizing VL CQI coaches (facility and lab based) from the COP19/20 LARC cohort initially 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 COP 21, 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 CHAI to implement POC VL testing for priority population groups such as unsuppressed patients, pregnant women, breast feeding women, children,

adolescents, and patients presenting with advanced disease. POC-VL testing will be supported on the Cepheid GeneXpert and Abbott mPIMA platforms using a targeted, data driven approach considering the limited resources. PEPFAR will continue to prioritize POC for EID due to the urgency in diagnosing an HIV exposed child. 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 FY21. There will be further decentralization of conventional EID testing on the Roche platform from 6 laboratories to a further 2 labs, bringing the total labs to performing conventional laboratories EID testing to 8 in FY22. 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 FY21)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY22) *TX_CURR***	**Newly initiated (APR FY22) *TX_NEW***	**ART Coverage (APR 22)**
Attained	**1,067,394**	**1,036,300**	-	**1,067,394**	**64,667**	**100%**
Scale-Up Saturation	-	-	-	-	-	-
Scale-Up Aggressive	-	-	-	-	-	-
Sustained	-	-	-	-	-	-
Central Support	**197,349**	**189,455**	-	**197,349**	-	**100%**
Total	**1,264,743**	**1,214,153**	-	**1,264,743**	**64,667**	**100%**

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 FY22**	**Expected Coverage (in FY22)**
Beitbridge	15-29	**26,203**	-	**568**	-
Bulawayo	15-29	**94,252**	-	**1,772**	-
Bulilima	15-29	**13,011**	-	**125**	-
Chegutu	15-29	**42,656**	-	**4,634**	-
Chipinge	15-29	**45,970**	-	**2,806**	-
Chiredzi	15-29	**59,024**	-	**1,274**	-
Chitungwiza	15-29	**58,141**	-	**5,280**	-
Chivi	15-29	**24,986**	-	**1,529**	-
Gokwe South	15-29	**52,960**	-	**6,186**	-
Goromonzi	15-29	**57,796**	-	**4,200**	-
Guruve	15-29	**20,036**	-	**3,854**	-
Gutu	15-29	**31,188**	-	**2,686**	-
Gwanda	15-29	**22,859**	-	**1,355**	-
Gweru	15-29	**48,437**	-	**4,161**	-
Harare	15-29	**258,149**	-	**19,123**	-
Hurungwe	15-29	**53,313**	-	**6,186**	-
Insiza	15-29	**19,108**	-	**1,742**	-
Kwekwe	15-29	**55,601**	-	**6,026**	-
Lupane	15-29	**13,204**	-	**2,651**	-
Makonde	15-29	**40,102**	-	**3,372**	-
Makoni	15-29	**54,394**	-	**4,124**	-
Marondera	15-29	**29,903**	-	**3,535**	-
Masvingo	15-29	**54,806**	-	**2,577**	-
Matobo	15-29	**13,255**	-	**2,244**	-
Mazowe	15-29	**47,610**	-	**5,703**	-
Mberengwa	15-29	**24,322**	-	**4,420**	-
Mbire	15-29	**14,206**	-	**2,357**	-
Mhondoro	15-29	**14,154**	-	**4,774**	-
Mt. Darwin	15-29	**34,114**	-	**3,143**	-
Murehwa	15-29	**29,939**	-	**2,238**	-
Mutare	15-29	**78,224**	-	**5,148**	-
Mwenezi	15-29	**28,119**	-	**1,503**	-
Nkayi	15-29	**13,913**	-	**1,265**	-
Sanyati	15-29	**41,920**	-	**4,509**	-
Tsholotsho	15-29	**14,828**	-	**2,760**	-
Zaka	15-29	**23,310**	-	**4,125**	-
Total/Average (Ages 15-29)		**1,554,013**	-	**133,955**	-

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	-		**8,638**	
Bubi	-		**2,300**	
Buhera	**931**	**14,588**	**15,519**	**12,400**
Bulawayo	**1,294**	**20,299**	**29,449**	**15,999**
Bulilima	-		**21,747**	
Chegutu	**741**	**11,605**	**12,346**	**9,449**
Chipinge	**645**	**10,108**	**38,220**	**8,388**
Chitungwiza	**387**	**6,057**	**6,444**	**4,755**
Goromonzi	**592**	**9,265**	**9,857**	**7,682**
Guruve	**320**	**5,041**	**5,361**	**4,132**
Gutu	**587**	**9,217**	**9,804**	**7,762**
Gwanda	-		**6,683**	
Gweru	**441**	**6,923**	**14,493**	**5,514**
Harare	**2,148**	**33,640**	**35,788**	**27,326**
Insiza	**442**	**6,889**	**14,170**	**5,577**
Lupane	**285**	**4,483**	**8,404**	**3,634**
Makonde	**702**	**10,977**	**11,679**	**9,026**
Makoni	**584**	**9,128**	**36,465**	**7,551**
Mangwe	-		**27,915**	
Matobo	**198**	**3,124**	**33,261**	**2,527**
Mazowe	**379**	**5,972**	**16,464**	**4,633**
Mhondoro	**460**	**7,200**	**7,660**	**5,938**
Mutare	**604**	**9,446**	**23,161**	**7,763**
Mutasa	**492**	**7,695**	**8,187**	**6,434**
Nkayi	**368**	**5,781**	**9,850**	**4,721**
Tsholotsho	-		**3,993**	
Zvimba	**705**	**11,012**	**11,717**	**8,940**
TOTAL	**13,305**	**208,450**	**429,575**	**170,151**

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 2021, 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.

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. The 2021 SID will be completed in late 2021. The sustainability profile included here is from SID 2019.

During FY 2021, PEPFAR Zimbabwe and UNAIDS jointly engaged a diverse group of stakeholders to complete the 2021 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.

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 several years as inflation has risen and the procurement of ARVs, HIV rapid test kits, and condoms is heavily dependent on donor funding. In COP21 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 COP21 PEPFAR

will support CBOs to conduct community-led monitoring across the 44 PEPFAR supported districts.

Epidemiological, Health, and Performance Data: PEPFAR's COP21 support will expand the Electronic Health Record (EHR) and Case Based Surveillance with recency testing to 1,125 PEPFAR supported facilities, 730 with a full EHR system and 395 facilities with a mobile EHR application. The full EHR system will produce 95% of site-level MER indicators (where "produce" can be defined as report creation and its operation from within the EHR system) with a less than 10% downtime across 90% of the 1125 facilities (where "downtime" can be considered as time where the system is in some way inoperable by a site's worth of users while there is not concurrent power outages). 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 COP21 funding, PEPFAR Zimbabwe will continue to ensure that the DREAMS layering 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.

Planning, Coordination, Policies and Governance: With COP21 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. During COP 21, PEPFAR Zimbabwe has committed to reviewing the above-site secondments to ensure continued alignment with PEPFAR goals and objectives given the evolution of the HIV epidemic in Zimbabwe.

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. In COP21 PEPFAR will introduce Key Performance Indicators (KPI) as a basis for monitoring continuous improvement in specimen transport. Examples of KPIs include % of missed visits, % on-time specimen delivery, specimen delivery rate, results delivery rate, % of specimens lost/damaged in transit, specimen turnaround time. 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. Despite the current context of COVID-19, Zimbabwe is working to close the gaps across geographic and age/sex bands to achieve the 95-95-95 targets by the end of COP 21.

Treatment literacy: Feedback from MoHCC, stakeholders, CSOs, and patients has impressed upon the PEPFAR team that treatment literacy tools need updating to include aspects of self-testing, index testing, treat all, adherence, viral load, faith healing, and other important elements. In COP 21, 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.

In conformity with the MoHCC's integrated communication strategy, PEPFAR IPs will be supporting the development and dissemination of health information and education (HIE) materials with specific focus on treatment and viral load literacy. The type and mode of dissemination will be tailor made to the target audience, particularly children and adolescents and their caregivers, men, young adults, and KPs. Where necessary and appropriate, given the COVID 19 situation, IPs will work with CSOs to conduct targeted community treatment literacy campaigns.

For the newly diagnosed, those at higher risk of defaulting and those with unsuppressed viral load, enhanced adherence counselling using updated messages of hope such as U=U will be used coupled with the use of treatment supporters mostly in the form of expert clients to ensure adherence and continuity of treatment.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

For COP21 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: USAID currently has two PEPFAR funded positions in recruitment:

- DREAMS Specialist (in recruitment) - 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 continues to work in 12 DREAMS districts in COP 21. This position is planned for recruitment in COP20 but may overlap into COP21 due to delays related to COVID-19.
- Local Partnership Specialist (in recruitment) - 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. S/he will also support the start-up and management of new local partners as awards are made. This position is planned for recruitment in COP20 but may overlap into COP21 due to delays related to COVID-19.

CDC: As of April 28, 2021 CDC Zimbabwe has two local hire positions pending recruitment. Since March 2020, CDC has filled ten vacancies, two of which were USDH positions and three Fellows. CDC continues to work closely with State Human Resources department on finalization of recruitment for outstanding vacancies.

The two positions are:

- CDC: DREAMS Coordinator (PCO)- candidate selected 04/2021; start date pending security background check.
- CDC: Laboratory Specialist- recruitment underway, anticipate filling by end of FY.

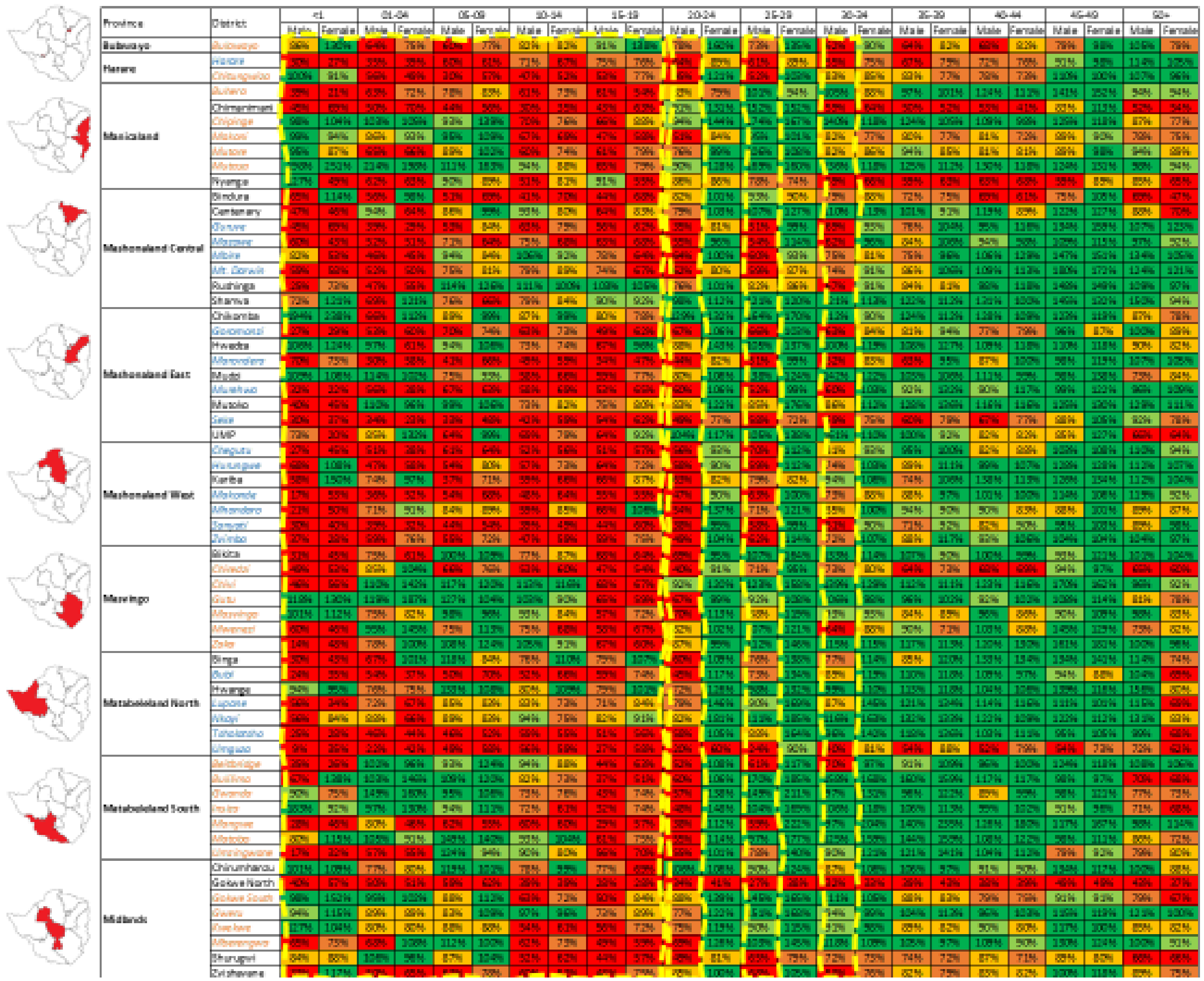
State Department (DOS): As part of PEPFAR's Community-led Monitoring Initiative, PEPFAR Zimbabwe agreed in COP21 to maintain $425,000 in the DOS Ambassador's Small Grants program. This is a giant leap from the historical $60,000 in grants that the program normally receives, and therefore a new FSN position is currently being filled in COP20 to help manage the grants. The DOS currently funds two positions, the PEPFAR Communications Specialist and a CLM grants specialist.

Operational Updates: Overall M&O needs were reviewed during budgetary discussions. Technical and non-technical staff are planning to conduct SIMS visits monthly in COP 2021. However, current SIMS implementation has been restricted due to the COVID-19 pandemic and associated restrictions on movement in the country. 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.

APPENDIX A: SNU Prioritization & Current ART Coverage

Current ART Coverage by SNU and Age/Sex as of December 2020

Significant gaps remain in: (1) **peds**, (2) **young adults ages 15-19**, and (3) **men ages 20-34**



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

District Support
CDC Direct Service Delivery
USAID Direct Service Delivery
Central Support: Technical Assistance for Treatment (TAT)

APPENDIX B: Budget Profile and Resource Projections

B1. COP21 Planned Spending in alignment with planning level letter guidance.

Table B.1.1 COP21 Budget by Program Area

Table B.1.2 COP21 Budget by Program Area

COP21 FAST Dossier — SDS Appendix B - Table B.1.3 COP 21 Budget by... - Table B.1.2 COP21 Budget by Pro...

Program	Fiscal Year	2022					
	Metrics	Proposed COP21 Budget			Percent of COP 21 Proposed Budget		
	Subprogram	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
	Psychosocial support		$1,047,535	**$1,047,535**		100.00%	**100.00%**
ASP	**Total**	**$12,820,555**		**$12,820,555**	**100.00%**		**100.00%**
	HMIS, surveillance, & research	$3,992,370		**$3,992,370**	100.00%		**100.00%**
	Human resources for health	$4,221,293		**$4,221,293**	100.00%		**100.00%**
	Laboratory systems strengthening	$969,510		**$969,510**	100.00%		**100.00%**
	Not Disaggregated	$209,300		**$209,300**	100.00%		**100.00%**
	Policy, planning, coordination & management of disease control programs	$3,428,082		**$3,428,082**	100.00%		**100.00%**
PM	**Total**	**$31,797,208**		**$31,797,208**	**100.00%**		**100.00%**
	IM Closeout costs	$1,666,912		**$1,666,912**	100.00%		**100.00%**
	IM Program Management	$22,799,356		**$22,799,356**	100.00%		**100.00%**
	USG Program Management	$7,330,940		**$7,330,940**	100.00%		**100.00%**

Program	Fiscal Year	2022					
	Metrics	Proposed COP21 Budget			Percent of COP 21 Proposed Budget		
	Subprogram	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$71,715,106**	**$132,084,894**	**$203,800,000**	**35.19%**	**64.81%**	**100.00%**
C&T	**Total**	**$20,831,452**	**$64,521,698**	**$85,353,150**	**24.41%**	**75.59%**	**100.00%**
	HIV Clinical Services	$7,162,308	$38,219,134	**$45,381,442**	15.78%	84.22%	**100.00%**
	HIV Drugs		$17,087,451	**$17,087,451**		100.00%	**100.00%**
	HIV Laboratory Services	$3,600,698	$5,604,800	**$9,205,498**	39.11%	60.89%	**100.00%**
	Not Disaggregated	$10,068,446	$3,610,313	**$13,678,759**	73.61%	26.39%	**100.00%**
HTS	**Total**		**$7,983,813**	**$7,983,813**		**100.00%**	**100.00%**
	Community-based testing		$623,764	**$623,764**		100.00%	**100.00%**
	Facility-based testing		$2,381,106	**$2,381,106**		100.00%	**100.00%**
	Not Disaggregated		$4,978,943	**$4,978,943**		100.00%	**100.00%**
PREV	**Total**	**$5,960,396**	**$31,783,132**	**$37,743,528**	**15.79%**	**84.21%**	**100.00%**
	Comm. mobilization, behavior & norms change	$1,182,000	$1,357,118	**$2,539,118**	46.55%	53.45%	**100.00%**
	Condom & Lubricant Programming		$4,087,000	**$4,087,000**		100.00%	**100.00%**
	Not Disaggregated		$3,272,596	**$3,272,596**		100.00%	**100.00%**
	PrEP		$5,362,243	**$5,362,243**		100.00%	**100.00%**
	Primary prevention of HIV and sexual violence	$4,304,076	$3,219,295	**$7,523,371**	57.21%	42.79%	**100.00%**
	VMMC	$474,320	$14,484,880	**$14,959,200**	3.17%	96.83%	**100.00%**
SE	**Total**	**$305,495**	**$27,796,251**	**$28,101,746**	**1.09%**	**98.91%**	**100.00%**
	Case Management		$5,059,678	**$5,059,678**		100.00%	**100.00%**
	Economic strengthening	$305,495	$10,636,251	**$10,941,746**	2.79%	97.21%	**100.00%**
	Education assistance		$7,224,689	**$7,224,689**		100.00%	**100.00%**
	Legal, human rights & protection		$1,533,489	**$1,533,489**		100.00%	**100.00%**
	Not Disaggregated		$2,294,609	**$2,294,609**		100.00%	**100.00%**

Table B.1.3 COP21 Total Planning Level

Fiscal Year	2022	2022
Metrics	Proposed COP21 Budget	
Operating Unit	New	Total
Total	**$203,800,000**	**$203,800,000**
Zimbabwe	$203,800,000	**$203,800,000**

Table B.1.4 COP21 Resource Allocation by Program and Beneficiary

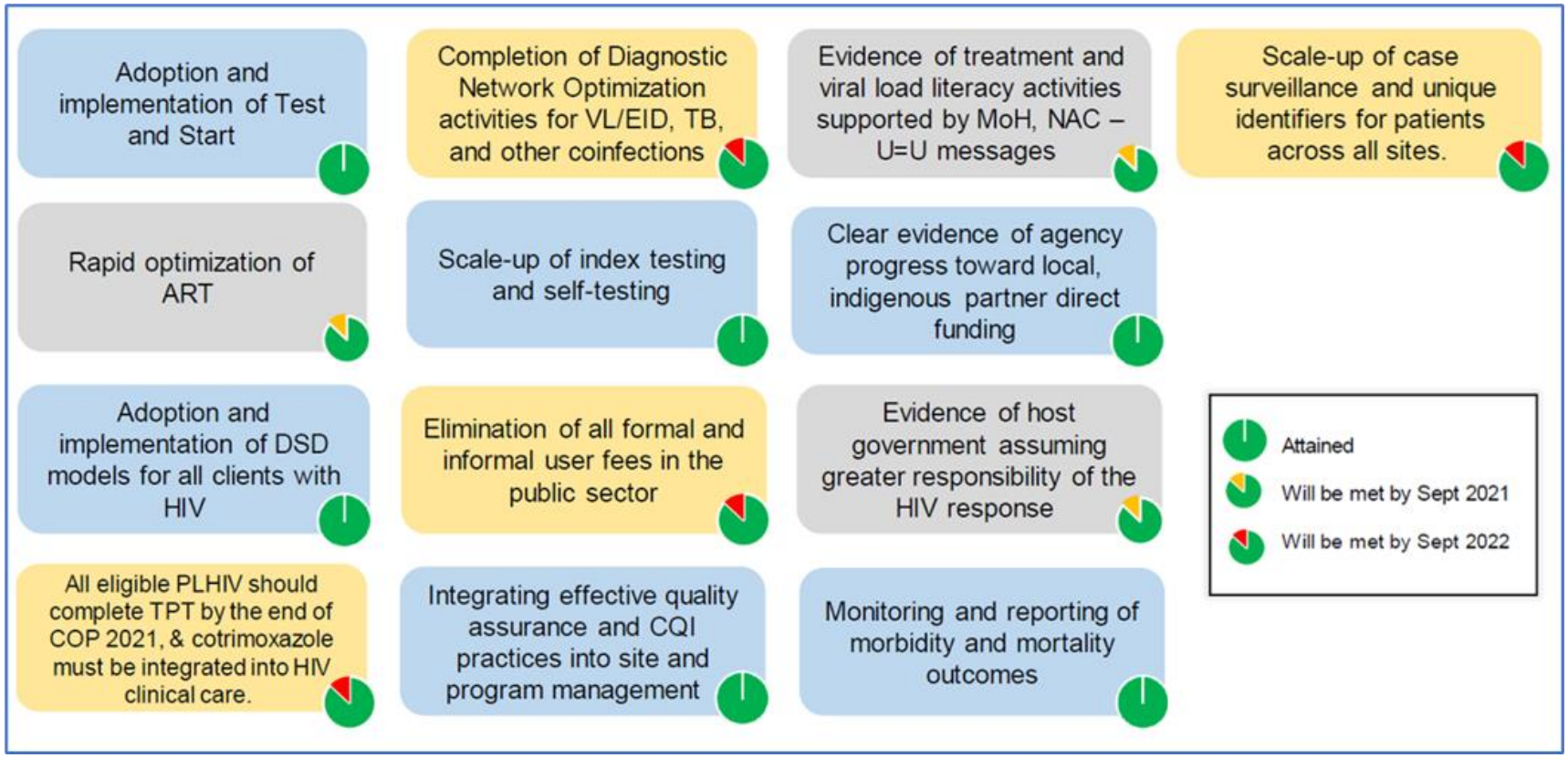
Fiscal Year	2022													
Program	C&T		HTS		PREV		SE		ASP		PM		Total	
Beneficiary	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total
Total	**$85,353,150**	**100%**	**$7,983,813**	**100%**	**$37,743,528**	**100%**	**$28,101,746**	**100%**	**$12,820,555**	**100%**	**$31,797,208**	**100%**	**$203,800,000**	**100%**
Females	$6,198,796	7%	$255,000	3%	$10,732,407	28%	$15,188,698	54%	$1,502,325	12%			**$33,877,226**	**17%**
Key Pops	$2,812,285	3%			$4,620,099	12%	$826,438	3%	$613,059	5%			**$8,871,881**	**4%**
Males	$1,598,684	2%			$14,959,200	40%							**$16,557,884**	**8%**
Non-Targeted Pop	$74,411,013	87%	$7,162,591	90%	$4,996,428	13%	$60,000	0%	$10,521,071	82%	$31,797,208	100%	**$128,948,311**	**63%**
OVC					$617,248	2%	$12,026,610	43%	$184,100	1%			**$12,827,958**	**6%**
Pregnant & Breastfeeding Women	$332,372	0%	$566,222	7%	$303,868	1%							**$1,202,462**	**1%**
Priority Pops					$1,514,278	4%							**$1,514,278**	**1%**

B.2 Resource Projections

In COP 21, PEPFAR Zimbabwe used the Funding Allocation to Strategy Tool (FAST) to drive budget decisions and funding allocations across initiatives (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. To populate the FAST, the PEPFAR Zimbabwe team considered the following sources of information to guide the apportionment of COP21 resources: Incremental budget adjustments 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 COP20 work plans and budgets, with specific attention to program management costs; and solution centered approaches to reach 95-95-95. Further refinements and efficiencies were found by examining above-site investments in this downward budget year, which maintained while maintaining focus on continuity of care and scale-up of viral load. Zimbabwe will continue to scale recency testing for all newly diagnosed adults and expand case-based surveillance to 100 percent coverage. In COP 21, PEPFAR will maintain 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 monthly to track partner performance and progress and will incorporate a review of expenditure analysis (EA) data 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: 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 status of these MPRs at the time of COP submission are included in the graphic below:



The graphic above shows that most of the minimum program requirements, have been achieved. The program is expected to achieve the other four by the end of COP20 implementation. Progress has been made in the development and use of unique identifier for patients across all health facilities. In each health facility, EHR generates a 36-digit unique ID for each new patient. When online - deduplication & merging happens instantly (also using variables e.g., name, DOB, sex, other program IDs); when offline- the

deduplication is delayed but will happen when data is synchronized. MoHCC will have stakeholder engagement to discuss use of biometrics or a unique ID for all health events.

Completion of diagnostic network optimization activities for viral load/EID, TB and other coinfections is ongoing we expect it to be completed by the end of COP20. Treatment and viral load literacy are being scaled up. Implementing partners are working with the MoHCC, NAC, CSOs and other patient advocacy groups to develop messages on U=U.

Despite advocacy and lobbying being done by the Front and PEPFAR offices, there is little movement by the government towards assuming greater responsibility to fund the HIV response. The worsening socio-economic environment and COVID-19 pandemic has exacerbated the situation. As a result, there has been an increase in reports of clients being asked to pay informal user fees. Whenever these are reported our program is immediately engaging the MoHCC to ensure clients continue to receive appropriate care.

APPENDIX D: American Rescue Plan Act COVID-19 Activities & Budget

Zimbabwe has been especially hard-hit by clinic closures and reduced health facility operations during the last year due to COVID-19 infections and death among health workers. The health sector had already suffered from years of neglect and health worker strikes leading up to the pandemic, but the coronavirus has worsened the situation with limited COVID-19 testing, limited access to protective equipment and reduced access to HIV services.

PEPFAR Zimbabwe was approved to receive $10,190,000 in ARPA funds to conduct outreach and improve access to HIV services and treatment in communities outside of high-volume clinics. This will mitigate the impact of COVID-19 on some of the most vulnerable populations, including orphans, adolescent girls, and young women. Zimbabwe will also conduct a viral load surge campaign to find clients who missed appointments during the last year due to lockdowns or other COVID-related reasons. Routine viral load tests improve treatment quality and individual health outcomes for people living with HIV and contribute to prevention.

PEPFAR Zimbabwe will support optimized HIV screening for infants, TB screening for adults, and will procure HIV commodities to sufficiently cover short-term gaps and support the viral load surge activities. Finally, Zimbabwe's ARPA funding will help PEPFAR-supported staff quickly and affordably access COVID-19 testing, which will reduce the number of days lost from program implementation due to long waiting and quarantine periods.

Category	How support will be used	Proposed agency	Proposed IM	Requested budget	Brief description of gap or need	How activity supports and complements national COVID-19 plans
Mitigation and Repair: Laboratory	Purchase VL and EID cartridges. This will fill 100% of the gap in these commodities while continuing to advocate for GF to fill national commodity gaps in TLD, DTG for children and VL reagents through HIV grant savings. Gap in VL reagents needed to support the surge will be procured through COP21 funds.	USAID	#18353	$760,749	Commodities will ensure VL surge is able to begin at the start of COP21 while awaiting delivery of routine VL commodities through GF.	POC activity is being closely coordinated with CHAI and leverages their contributions to this effort. The USG has been in dialogue with the GF directly and through the PEPFAR-GF Liaison. The PEPFAR team works closely with the CCM and the national COVID response
Prevention: Testing	COVID-19 symptom screening, nasal swabs collection, sample transportation, Testing, reporting	USAID	#70473	$100,000	Category I activity will equip partners to implement activities	The USG has been in dialogue with the GF directly and through the PEPFAR-GF Liaison. The

	of results (national and PEPFAR), Conduct tracing. These activities exclude the care process.				described in Category II in a safe manner.	PEPFAR team works closely with the national COVID response mechanisms.
Prevention: Clinical Management	Outreach support for ART refill, viral load monitoring, TPT, HIV testing, EID, prophylaxis for HEIs, ART initiation, PrEP, enhanced adherence counselling (EAC), condom distribution and VIAC screening and treatment.	CDC	#70465 #82087	$2,148,298	Category I activities will equip partners to implement activities described in Category II in a safe manner, while enhancing the awareness and safety of beneficiaries in PEPFAR programs.	The USG has been in dialogue with the GF directly and through the PEPFAR-GF Liaison. The PEPFAR team works closely with the national COVID response mechanisms.
Mitigation and Repair: Laboratory	Viral load surge campaign to find and collect VL samples from most clients without a current VL. Expanded POC optimization for EID and VL. Communicating with Global Fund to coordinate.	CDC	#17885	$1,345,429	Category I activities will equip partners to implement activities described in Category II in a safe manner, while enhancing the awareness and safety of beneficiaries in PEPFAR programs.	The USG has been in dialogue with the GF directly and through the PEPFAR-GF Liaison. The PEPFAR team works closely with the national COVID response mechanisms.
Mitigation and Repair: Repair of Program Injury	Priority 1: Increased access to ART refills Priority 2: Catch up education for AGYW/OVC. Priority 3: Decentralized drug distribution to expand options for ART pick up. Priority 4: Provide site level support to increase use of point of care devices for EID and Viral load testing for children and pregnant/breast feeding women.	USAID	#85143 #160827 #18555 #17546 #17541 #160826 #18551 #17534 #85145	$4,708,918		The USG has been in dialogue with the GF directly and through the PEPFAR-GF Liaison. The PEPFAR team works closely with the national COVID response mechanisms.
Mitigation and Repair: Repair of Program Injury	Viral load surge campaign to find and collect VL samples from most clients without a current VL. Expanded POC optimization for EID and VL. Communicating with	CDC	#82087 #70465	$1,126,606	Category I activities will equip partners to implement activities described in Category II in a safe manner, while enhancing the awareness and safety of	The USG has been in dialogue with the GF directly and through the PEPFAR-GF Liaison. The PEPFAR team works closely with

	Global Fund to coordinate as PEPFAR supports training, quality control and implementation/use at sites of POC machines for rapid results turnaround for lab programming also supported by Global Fund. Rapid implementation of TB using the Targeted Universal TB testing strategy (LAM, GeneXpert, Chest X-ray)				beneficiaries in PEPFAR programs.	the national COVID response mechanisms.