# 2017 Sustainability Index and Dashboard Summary: Zimbabwe

**The HIV/AIDS Sustainability Index and Dashboard (SID)** is a tool completed every two years by PEPFAR teams and partner stakeholders to sharpen the understanding of each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to 89 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with other contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

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| **Dark Green Score (8.50-10 points)**<br>**(sustainable and requires no additional investment at this time)** |
| **Light Green Score (7.00-8.49 points)**<br>**(approaching sustainability and requires little or no investment)** |
| **Yellow Score (3.50-6.99 points)**<br>**(emerging sustainability and needs some investment)** |
| **Red Score (<3.50 points)**<br>**(unsustainable and requires significant investment)** |

**Zimbabwe Overview:** In 2016, Zimbabwe completed the Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA), a household-based national survey that measured the national HIV incidence, prevalence and viral load suppression levels. Similar to the Zimbabwe Demographic Health Survey (ZDHS), ZIMPHIA showed that overall HIV prevalence for adults aged 15-49 is 14.0% while incidence for the same age is now 0.48%[1], down from 2.63% in 2000. An estimated 1.4 million people were living with HIV in 2016. The significant HIV prevalence, combined with a worsening economic environment, an uncertain political setting, and inadequate human resources have created difficult circumstances for our efforts to address the HIV epidemic. Even with such challenging circumstances, Zimbabwe is nearing epidemic control. The Government Zimbabwe (GOZ) has demonstrated leadership in crafting a national HIV/AIDS strategy and coordinating the response. An additional note of success is the National AIDS Trust Fund ("AIDS Levy") that has mobilized domestic resources to address the HIV epidemic and funded purchase of ARVs, community-based HIV prevention programming, and monitoring and evaluation.

Over the past several years, there has been significant progress in the expansion of ART initiation; however, major challenges to achieving high ART coverage and epidemic control continue to exist, including: potential for insufficient funding for ARVs and lab commodities, human resource shortages, weakening infrastructure, a deteriorating health system, and heavy reliance on donor funding. As an

[1] Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) 2016

example of donor funding reliance, the Global Fund and PEPFAR fund test kits, condoms, the majority of laboratory services, and a significant portion of the efforts to strengthen the supply chain and logistics.

In response, the PEPFAR program will work closely with the Ministry of Health and Child Care and other donors to ensure that sufficient planning is done to mitigate potential shortages by reinvesting savings into commodities, keeping donors up to date on commodity needs and encouraging the Government of Zimbabwe to invest more towards the HIV response. In the short term, PEPFAR and the Global Fund will continue to support human resources and strengthening of the overall health system. Additionally, PEPFAR is increasing efforts to implement new service delivery models for care and treatment, increase efforts to link facilities and communities, and strengthening efficiencies within existing programming working towards sustained epidemic control.

**SID Process:** To complete the SID, the PEPFAR Coordination Office met with UNAIDS (Girmay Haile, UNAIDS Country Director and designated point of contact Jane Kalweo, UNAIDS Global Outreach Advisor), the Ministry of Health and Child Care (MOHCC) and National AIDS Council (NAC), the Clinton Health AIDS Initiative (CHAI), and the Centre for Sexual Health and HIV/AIDS Research Zimbabwe (CeSHHAR) in October and early November. On November 9 UNAIDS and PEPFAR co-convened a stakeholder validation meeting with participants from the MOHCC, NAC, Global Fund Country Coordinating Mechanism (CCM) members, implementing partners, civil society, and other development partners. The participants broke into four domain subgroups to discuss and validate the SID questionnaire, with a facilitator from PEPFAR, UNAIDS, and/or CHAI to validate agreed upon scores, record data sources, and document points of clarification and context. The full group then reconvened to review the completed tool, discuss the findings and validate the conclusions.

**Sustainability Strengths:**

- **Planning and Coordination (10.00, dark green):** The MOHCC continues to effectively lead the coordination of the HIV response in Zimbabwe. A multi-year, costed national strategy exists, including specific activities and strategies to minimize the impact of HIV on vulnerable populations. The MOHCC also effectively leads the implementation of the National HIV Strategy. The MOHCC has made great effort to ensure the development of the national strategy is an inclusive process. This element saw an increased score from previous 2015 SID (9.33) to current 2017 SID (10.00).
- **Quality Management (8.67, dark green):** The MOHCC has institutionalized quality management systems and has demonstrated their emphasis on the application of quality improvement methodologies to manage and provide HIV/AIDS services. For example, peer-learning opportunities were developed and became available starting in 2016. Additionally, HIV program performance measurement data is used to identify areas of patient care and service that can be improved through national decision-making, policy, and priority setting. But there still are areas of improvement. For example, the informal Community Health Worker (CHW), supported by various donors and partners, should be integrated into the MOHCC's formal Village Health Worker (VHW) cadre to ensure quality, harmonization, and sustainability. This element remained the same from previous 2015 SID to current 2017 SID (8.67).

- **Technical and Allocative Efficiencies (8.56, dark green):** This area saw significant improvement from two years ago, mainly due to investments and improvement in data management and data utilization. These improvements saw greater use of data for costing and resource management. With PEPFAR's geographic prioritization, we also see an overall shift to focusing resources based more on need than in the past.
- **Financial Expenditure Data (10.00, dark green):** Stark improvements in the collection and reporting of expenditure data by the MOHCC was observed since the previous SID two years ago.

**Sustainability Vulnerabilities:**

- No element received a score of red. Both Private Sector Engagement (2.71 to 6.19) and Domestic Resource Mobilization (3.06 to 4.58) increased from the previous SID.
- **Epidemiological and Health Data (4.51, yellow):** Zimbabwe continues to require additional capacity to lead and manage planning and implementation of epidemiological survey and surveillance activities. Additionally, key population epidemiological survey and behavioral surveillance activities are not funded or conducted by the MOHCC, but via external agencies, organization, and institutions. There is a lack of reporting for viral load data and viral load testing is not yet done routinely at clinics. However, the support for and engagement in the Zimbabwe Demographic Health Survey (DHS) and the Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) highlight GOZ's commitment to collect and utilize epidemiological and health data for strategic program planning.
- **Domestic Resource Mobilization (6.75, yellow):** The GOZ continues to remain highly dependent on outside donors to fund their national HIV response. Current resource mapping shows around 20% of total funding is from the government of Zimbabwe.
- **Laboratory (5.50, yellow):** Like many other components of service delivery, there are strategies in place, but not fully operationalized at all levels of the system. The entire network of laboratories and viral load testing to regulate and monitor quality is not covered. There continue to remain large gaps in capacity of laboratory workforce, viral load infrastructure, and domestic funds for laboratories as a whole.
- **Public Access to Information (5.00, yellow):** This element saw a decline in score from the previous SID (8.00). Much of the financial information shared by MOHCC is highly summarized when available to the public and therefore difficult to see the actual expenditure data. Additionally, HIV/AIDS program performance data is not often released to the public in a timely manner (e.g. same year) . Lastly, regardless of outcomes in the tender process, stakeholders requested feedback in order to foster capacity building and transparency.
- **Commodity Security and Supply Chain (6.14, yellow):** Beyond donor commitments, ARV funding remains uncertain one to three years into the future. The current Global Fund grant provides for ARVs at lower levels, but there remains a gap in funding if Zimbabwe aims for epidemic control by 2020. Supply chain systems are relatively strong, but still heavily reliant on support from outside donors.

- **Private Sector Engagement (5.92, yellow):** The private sector engagement still needs increased attention. For example, the private sector still does not actively engage with the MOHCC as part of the policy and budget decision for HIV/AIDS programs. Additionally, the legal framework and regulatory framework makes limited provisions for the needs of private businesses.

**Additional Observations:** Commodity shortages, especially for ARVs and viral load instruments and reagent continue to remain an area of concern that requires continuous monitoring, attention, and advocacy.

**Contact:** For questions or further information about PEPFAR's efforts to support sustainability of the HIV response in Zimbabwe, please contact Mark Troger at trogerm@state.gov.

# Sustainability Analysis for Epidemic Control: Zimbabwe

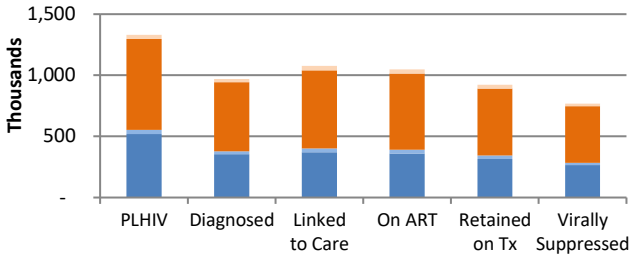
**Epidemic Type:** Generalized
**Income Level:** Low income
**PEPFAR Categorization:** Long-term Strategy
**PEPFAR COP 17 Planning Level:** $126,973,404

## SUSTAINABILITY DOMAINS and ELEMENTS

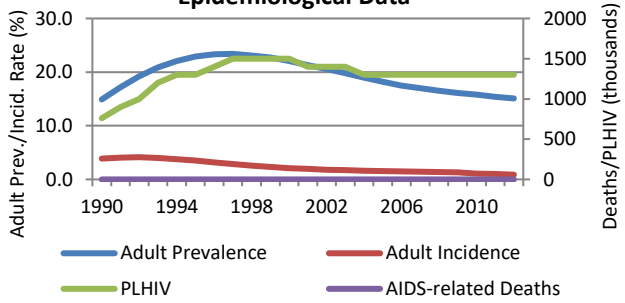
| | 2015 (SID 2.0) | 2017 (SID 3.0) | 2019 | 2021 |
|---|---|---|---|---|
| **Governance, Leadership, and Accountability** | | | | |
| 1. Planning and Coordination | 9.33 | 10.00 | | |
| 2. Policies and Governance | 7.16 | 7.11 | | |
| 3. Civil Society Engagement | 6.17 | 6.46 | | |
| 4. Private Sector Engagement | 2.71 | 5.92 | | |
| 5. Public Access to Information | 8.00 | 5.00 | | |
| **National Health System and Service Delivery** | | | | |
| 6. Service Delivery | 7.22 | 6.85 | | |
| 7. Human Resources for Health | 8.42 | 8.40 | | |
| 8. Commodity Security and Supply Chain | 6.14 | 6.14 | | |
| 9. Quality Management | 8.67 | 8.67 | | |
| 10. Laboratory | 4.72 | 5.50 | | |
| **Strategic Investments, Efficiency, and Sustainable Financing** | | | | |
| 11. Domestic Resource Mobilization | 3.06 | 7.06 | | |
| 12. Technical and Allocative Efficiencies | 6.70 | 8.56 | | |
| **Strategic Information** | | | | |
| 13. Epidemiological and Health Data | 3.87 | 4.51 | | |
| 14. Financial/Expenditure Data | 7.08 | 10.00 | | |
| 15. Performance Data | 7.34 | 7.12 | | |

## CONTEXTUAL DATA

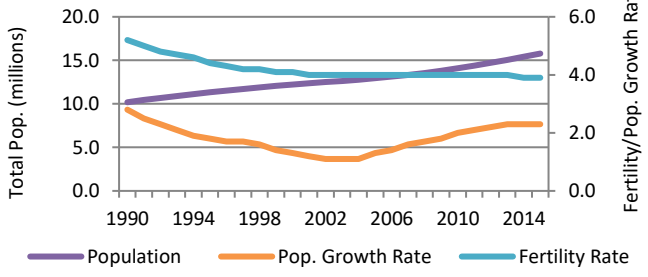
### National Clinical Cascade




### Epidemiological Data

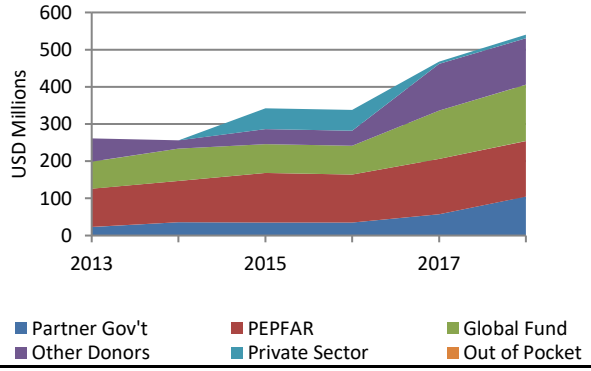



### Population and Fertility

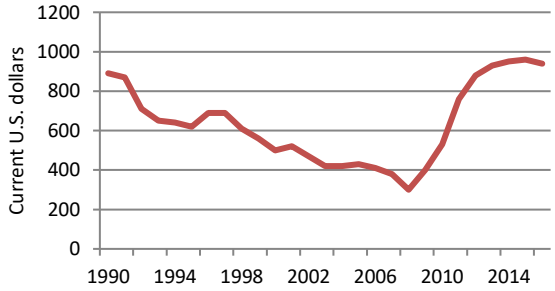



## CONTEXTUAL DATA

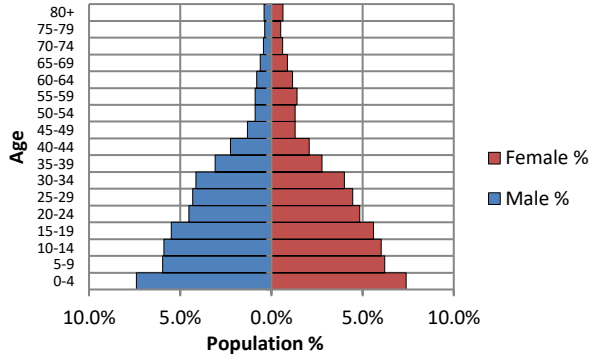
### Financing the HIV Response




### GNI Per Capita (Atlas Method)




### Population Pyramid (2017)



# Domain A. Governance, Leadership, and Accountability

**What Success Looks Like:** Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, provides accurate information and education on HIV/AIDS, and supports mechanisms for eliciting feedback. Relevant government entities take actions to create an enabling policy and legal environment, ensure good stewardship of HIV/AIDS resources, create space for and promote participation of the private sector, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

| **1. Planning and Coordination:** Host country develops, implements, and oversees a costed multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. | | | **Data Source** | **Notes/Comments** |
|---|---|---|---|---|
| **1.1 Content of National Strategy:** Does the country have a multi-year, costed national strategy to respond to HIV? | ○ A. There is no national strategy for HIV/AIDS<br>◉ B. There is a multiyear national strategy. Check all that apply:<br>☑ It is costed<br>☑ It has measurable targets.<br>☑ It is updated at least every five years<br>☑ Strategy includes all crucial response components for prevention and treatment (HIV testing, treatment and care [including children and adolescents], PMTCT, transition from 'catchup' to sustainable VMMC if country performs VMMCs, scale-up of viral load, EID, and other key metrics)<br>☑ Strategy includes explicit plans and activities to address the needs of key populations.<br>☑ Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children<br>☑ Strategy (or separate document) includes considerations and activities related to sustainability | 1.1 Score: 2.50 | Zimbabwe National HIV/AIDS Straetgic Plan (ZNASP), 2015-2018<br>Costed National Health Strategy 2016 - 2020, Other costed HIV sub-strategies also exist: HIV Testing Strategy 2017-2020, EMTCT Strategy 2017-2021, Consultation with CHAI | Yes, it was costed. In order to submit a concept note to the GF, a costed National Strategy was required. A gap analysis for 2016 and 2017 was also developed for the strategy and for HIV specific funding (The strategy document has been shared however stakeholders have not seen a costed ZNASP)<br><br>ZNASP remains in draft form. It has not yet been disseminated. |
| **1.2 Participation in National Strategy Development:** Who actively participates in development of the country's national HIV/AIDS strategy? | ○ A. There is no national strategy for HIV/AIDS<br>◉ B. The national strategy is developed with participation from the following stakeholders (check all that apply):<br>☑ Its development was led by the host country government<br>☑ Civil society actively participated in the development of the strategy<br>☑ Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy<br>☑ Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR)<br>☑ External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy | 1.2 Score: 2.50 | Zimbabwe National HIV/AIDS Straetgic Plan (ZNASP), 2015-2018<br>Costed National Health Strategy 2016 - 2020, Other costed HIV sub-strategies also exist: HIV Testing Strategy 2017-2020, EMTCT Strategy 2017-2021, Consultation with CHAI | Development of Strategies led by MOHCC through multi-stakeholder Technical Working Groups (TWGs) |

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| **1.3 Coordination of National HIV Implementation:** To what extent does the host country government coordinate all HIV/AIDS activities implemented in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners? | Check all that apply:<br>☑ There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc.<br>☑ The host country government routinely tracks and maps HIV/AIDS activities of:<br>☑ civil society organizations<br>☑ private sector (including health care providers and/or other private sector partners)<br>☑ donors<br>☑ The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes.<br>☑ Joint operational plans are developed that include key activities of implementing organizations.<br>☑ Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed. | 1.3 Score: 2.50 | Ministry of Health and Child Care (MOHCC) Technical Working Group (TWG) minutes; CMM minutes; MOHCC annual planning and review minutes, National AIDS Council (NAC) reports; Terms of Reference for Partnership Forum | MOHCC, through CHAI, is conducting donor mapping of HIV services that are funded by multiple donors (60-70% completed) and will assist in efforts of coordination, de-duplication, and identifying gaps. There is a strategy for engage private sector for implementation and M&E reporting. That engagement is not yet operationalized the M&E system. TWG and partnership forum are the convening for other donors. Private sector is not as engaged to the extend of the public sector (general there is need for practitioners, private clinics, and providers). Private sector not reporting directly to MOHCC and the National M and E System. EMCOZ, ZNCC and CZI to be present at meetings and give employer perspective on HIV Programming. There is not a full or comprehensive information to the MOHCC. MOHCC is able to gather and collect some information through health insurance. Though if private practitioners do not accept medical aide cards, if people are not accessing services through medical insurance, or if patients are paying with cash, the health insurance do not collect information, and it isn't passed to MOHCC. For example, about 8,000-10,000 patients accessing ARVs through private sector and MOHCC is unable to accurately track those patients. MOHCC is better able to track CSO (through NAC and GF) as they are sub-recipients of GF.<br>NAC`s Coordination of CSOs needs improvement<br>Key private sector representatives in strategy development and CCM processes are from the Zimbabwe Bussiness council on wellness and ZCTU. |
| **1.4 Sub-national Unit Accountability:** Is there a mechanism by which sub-national units are accountable to national HIV/AIDS goals or targets? (note: equal points for either checkbox under option B) | ○ A. There is no formal link between the national plan and sub-national service delivery.<br>◉ B. There is a formal link between the national plan and sub-national service delivery. (Check the ONE that applies.)<br>☑ Sub-national units have performance targets that contribute to aggregate national goals or targets.<br>☐ The central government is responsible for service delivery at the sub-national level. | 1.4 Score: 2.50 | Annual District Integrated Plans; Annual NAC Reports | An Example of MOHCC target setting and division to SNU: ART, VMMC, HTS - divide targets by the SNU, population, burden. SNUs report monthly or every three months—depending on program area—through DHIS2. Proposed targets are at SNU level are tracked and followed-up at national and SNU-level.<br><br>PAAC & DAAC Meeting Minutes and PHT |
| | | **Planning and Coordination Score:** 10.00 | | |

| **2. Policies and Governance:** Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response. | | | **Data Source** | **Notes/Comments** |
|---|---|---|---|---|
| **2.1 WHO Guidelines for ART Initiation:** Does current national HIV/AIDS technical practice follow current WHO guidelines for initiation of ART, i.e. Test and START for all populations? | For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines for each of the following:<br><br>A. Adults (>19 years)<br>☑ Yes<br>☐ No<br><br>B. Pregnant and Breastfeeding Mothers<br>☑ Yes<br>☐ No<br><br>C. Adolescents (10-19 years)<br>☑ Yes<br>☐ No<br><br>D. Children (<10 years)<br>☑ Yes<br>☐ No | 2.1 Score: 1.11 | National Operational Plan<br>Adapted WHO guidelines and Service Delivery Manual | Test and start is already rolled out for pregnant women, discordant couples, TB co-infected patients, and children under 5 years of age. The country has started the ART guidelines 2015 adaptation process. |

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| **2.2 Enabling Policies and Legislation:** Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery?<br><br>Note: If one of the listed policies differentiates policy for specific groups, please note in the Notes/Comments column. | Check all that apply:<br>☑ A national public health services act that includes the control of HIV<br>☑ A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART<br>☑ A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits<br>☑ Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months)<br>☑ Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months)<br>☑ Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready<br>☑ Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS<br>☑ Policies that permit HIV self-testing<br>☑ Policies that permit pre-exposure prophylaxis (PrEP)<br>☑ Policies that permit post-exposure prophylaxis (PEP)<br>☑ Policies that allow HIV testing without parental consent for adolescents, starting at age 15<br>☑ Policies that allow HIV-infected adolescents, starting at age 15, to seek HIV treatment without parental consent | 2.2 Score: 1.11 | National AIDS Council Act of 1998, Satutory instrument 202 (workplace policy), Children's Act (get the details). Letter written by PS outlining task-shifting (specific to VMMC). Document (scaling up/decentralization of HIV services - nurses to initiate) for decentralization of ART services (Tx can be provided by nurses--check with Dr. Apollo). (Consitution of Zimbabwe section 76 - right to health, ZNASP 3, units in government ministries and departments)<br>Consultations with MOHCC<br>Amended Public Health Act | HIV/AIDS Policies exist, but harmonization remains a gap. Specifically, a task shifting policy exist in the form of written guidance (VMMC) and document for scaling up/decentralizing HIV services and ART initiation to allow nurses to initiate, HTS taskshifted to lay providers. [Check with Dr. Apollo for specific form of documentation]. Medical and Dental Practitioners Act and Organization of District Health Services (early 1980s) state that facilities are run under the direction of the DMO and DMO has authority to delegate duties to specific cadres. As for CHW to disperse ARVs, the preference at this point is for a member of an adherence clubs (one patient from adherence clubs) to collect the ARVs every 6 months for distribution to other club members. Delayed introduction of the public health bill in parliament)<br><br>The "mature adolescent" policy allows health care providers to decide whether to test and treat without parental concent. PHact should include prisoners. |

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| **2.3 Data Protection:** Does the country have policies in place that support the collection and appropriate use of patient-level data for health, including HIV/AIDS? | The country has policies in place that (check all that apply):<br>☑ Govern the collection of patient-level data for public health purposes, including surveillance<br>☑ Govern the collection and use of unique identifiers such as national ID for health records<br>☑ Govern the privacy and confidentiality of health outcomes matched with personally identifiable information<br>☑ Govern the use of patient-level data, including protection against its use in crimincal cases | 2.3 Score: 1.11 | Confirmation from MOHCC. National constitution, Medical practitioners Act, Patient charter | |
| **2.4 Legal Protections for Key Populations:** Does the country have laws or policies that specify protections (not specific to HIV) for specific populations? | Check all that apply:<br>Transgender people (TG):<br>☐ Constitutional prohibition of discrimination based on gender diversity<br>☐ Prohibitions of discrimination in employment based on gender diversity<br>☐ A third gender is legally recognized<br>☐ Other non-discrimination provisions specifying gender diversity (note in comments)<br>Men who have sex with men (MSM):<br>☐ Constitutional prohibition of discrimination based on sexual orientation<br>☐ Hate crimes based on sexual orientation are considered an aggravating circumstance<br>☐ Incitement to hatred based on sexual orientation prohibited<br>☐ Prohibition of discrimiation in employment based on sexual orientation<br>☐ Other non-discrimination provisions specifying sexual orientation<br>Female sex workers (FSW):<br>☐ Constitutional prohibition of discrimination based on occupation<br>☐ Sex work is recognized as work<br>☐ Other non-discrimination protections specifying sex work (note in comments) | 2.4 Score: 0.00 | UNAIDS NCPI 2016 | Where laws and policies are available they may not be fully implemented e.g. Consitution of Zimbabwe section 76 - limits the right of health to availability of resources. Prisoners have policy that allows access to treatment however this is not comprehensive because other preventive strategies are not available. but there are questions if the policy is actually implementation. CSW, no policy exists and there was a recent court ruling that CSW should not be targeted for loitering without clear evidence. CSW continue to be persecuted.<br><br>Constitution and law on "Loitering for the purposes of Prostitution". |

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| | People who inject drugs (PWID):<br>☐ Specific antidiscrimination laws or other provisions for people who use drugs (specify in comments)<br>☐ Explicit supportive reference to harm reduction in national policies<br>☐ Policies that address the specific needs of women who inject drugs | | | |
| **2.5 Legal Protections for Victims of Violence:** Does the country have protections in place for victims of violence? | The country has the following to protect key populations and people living with HIV (PLHIV) from violence:<br>☑ General criminal laws prohibiting violence<br>☑ Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population<br>☑ Programs to address intimate partner violence<br>☑ Programs to address workplace violence<br>☑ Interventions to address police abuse<br>☑ Interventions to address torture and ill treatment in prisons<br>☑ A national plan or strategy to address gender-based violence and violence against women that includes HIV<br>☑ Legislation on domestic violence<br>☑ Criminal penalties for domestic violence<br>☑ Criminal penalties for violence against children | 2.5 Score: 1.11 | UNAIDS NCPI (2016)<br><br>National Gender Strategy , Constitution, Domestic Violence ACT | This guideline should enable rating based on the national definition of key populations and separate questions for KP and PLHIV. |

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| **2.6 Structural Obstacles:** Does the country have laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services? | **For each question, select the most appropriate option:**<br>Are transgender people criminalized and/or prosecuted in the country?<br>☑ Both criminalized and prosecuted<br>☐ Criminalized<br>☐ Prosecuted<br>☐ Neither criminalized nor prosecuted<br><br>Is cross-dressing criminalized in the country?<br>☑ Yes<br>☐ Yes, only in parts of the country<br>☐ Yes, only under certain circumstances<br>☐ No<br><br>Is sex work criminalized in your country?<br>☑ Selling and buying sexual services is criminalized<br>☐ Selling sexual services is criminalized<br>☐ Buying sexual services is criminalized<br>☐ Partial criminalization of sex work<br>☐ Other punitive regulation of sex work<br>☐ Sex work is not subject to punitive regulations or is not criminalized.<br>☐ Issue is determined/differs at subnational level | 2.6 Score: 0.44 | UNAIDS NCPI (2016) | | |

Does the country have laws criminalizing same-sex sexual acts?

- [ ] Yes, death penalty
- [ ] Yes, imprisonment (14 years - life)
- [x] Yes, imprisonment (up to 14 years)
- [ ] No penalty specified
- [ ] No specific legislation
- [ ] Laws penalizing same-sex sexual acts have been decriminalized or never existed

Does the country maintain the death penalty in law for people convicted of drug-related offenses?

- [ ] Yes, with high application (sentencing of people convicted of drug offenses to death and/or carrying out executions are a routine and mainstreamed part of the criminal justice system)
- [ ] Yes, with low application (executions for drug offenses may have been carried out in recent years, but in practice such penalties are relatively rare)
- [ ] Yes, with symbolic application (the death penalty for drug offenses is included in legislation, but executions are not carried out)
- [x] No

Does the country have laws criminalizing the transmission of, non-disclosure of, or exposure to HIV transmission?

- [x] Yes
- [ ] No, but prosecutions exist based on general criminal laws
- [ ] No

Does the country have policies restricting the entry, stay, and residence of people living with HIV (PLHIV)?

- [ ] Yes
- [x] No

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| | Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people?<br>☐ Yes, promotion ("propaganda") laws<br>☑ Yes, morality laws or religious norms that limit LGBTI freedom of expression and association<br>☐ No | | | |
| **2.7 Rights to Access Services:** Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights? | There are host country government efforts in place as follows (check all that apply):<br>☑ To educate PLHIV about their legal rights in terms of access to HIV services<br>☐ To educate key populations about their legal rights in terms of access to HIV services<br>☑ National law exists regarding health care privacy and confidentiality protections<br>☐ Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found | 2.7 Score: 0.56 | Constitution of Zimbabwe; Health Care Act 2013; Public Health Act 2013 | The key populations have varied reach and policies available - PWD have non-discriminatory laws, however prisoners, SWs and MSM remain with discriminatory laws and policies. The education is tokenistic.<br>Young people - abiguity and non alignment of laws e.g. age of marraige is 18 however age of sexual consent is 16, youths do not have access to comprehensive SRH services - policies were avaiable are not fully implemented |
| **2.8 Audit:** Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)? | ○ A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry.<br>◉ B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more.<br>○ C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less. | 2.8 Score: 0.56 | Annual NAC report<br>MOHCC | Audit occurs and is available on NAC website, through other types of media, and a printed report is disseminated. The last that was publicly shared was in 2011 , so CSOs are not sure whether audits happen especially to NAC. |
| **2.9 Audit Action:** To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS? | ○ A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted.<br>○ B. The host country government does respond to audit findings by implementing changes as a result of the audit.<br>◉ C. The host country government does respond to audit findings by implementing changes which can be tracked by legislature or other bodies that hold government accountable. | 2.9 Score: 1.11 | MOHCC | The biggest challenges of the audit finding implementation is the legal framework which does not change as required. |
| | **Policies and Governance Score:** | **7.11** | | |

| **3. Civil Society Engagement:** Local civil society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions. | | | **Data Source** | **Notes/Comments** |
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| **3.1 Civil Society and Accountability for HIV/AIDS:** Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response? | ○ A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response.<br>○ B. There are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it does not happen.<br>◉ C. There are no laws or policies that prevent civil society from providing an oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight. | 3.1 Score: 1.67 | Zimbabwe National HIV/AIDS Straetgic Plan (ZNASP), 2015-2018 | CSO are active members of CCM |
| **3.2 Government Channels and Opportunities for Civil Society Engagement:** Does host country government have formal channels or opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services (not including Global Fund CCM civil society engagement requirements)? | Check A, B, or C; if C checked, select appropriate disaggregates:<br>○ A. There are no formal channels or opportunities.<br>○ B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback.<br>◉ C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply:<br>☑ During strategic and annual planning<br>☑ In joint annual program reviews<br>☑ For policy development<br>☑ As members of technical working groups<br>☑ Involvement on government HIV/AIDS program evaluation teams<br>☑ Involvement in surveys/studies<br>☑ Collecting and reporting on client feedback<br>☐ Service delivery | 3.2 Score: 1.46 | MOHCC TWG meetings/minutes, CCM meetings/minutes, MOHCC strategy reports give a participants list. Board member of Zimbabwe AIDS Network (ZAN). | "functional" - regular basis, organized, own groups, and has organizaed coordination forum. |

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| **3.3 Impact of Civil Society Engagement:** Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS? | ○ A. Civil society does not actively engage, or civil society engagement does not impact policy, programming, and budget decisions related to HIV/AIDS.<br>◉ B. Civil society's engagement impacts HIV/AIDS policy, programming, and budget decisions (check all that apply):<br>☑ In policy design<br>☑ In programmatic decision making<br>☑ In technical decision making<br>☑ In service delivery<br>☑ In HIV/AIDS basket or national health financing decisions | 3.3 Score: 1.67 | CCM minutes, Annual NAC reports, MOHCC TWG minutes | Some of it is tokenistic, especially participation in implementation of grants. Local NGOs are left out and as aforementioned NAC competes in implementation. Technical decision making is limited to certain discussions and for some it is not a privilege. |
| **3.4 Domestic Funding of Civil Society:** To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)?<br><br>(if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column) | ○ A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources.<br>◉ B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).<br>○ C. Some funding (approx. 10-49%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).<br>○ D. Most funding (approx. 50-89%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).<br>○ E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). | 3.4 Score: 0.83 | CSO Consultation | Majority of resources for CSOs are not domestic funding, but outside donors. AIDS Levy provides a small portion to CSO. |

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| **3.5 Civil Society Enabling Environment:** Are there laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition (from any Ministry or Department, at any level - national, regional, or local)?<br><br>Note: This sometimes referred to as "social contracting" or "social procurement." | ○ A. There is no law, policy, ore rgulation which permits CSOs to be funded from a government budget for HIV Services through open competition (not to include Global Fund or other donor funding to government that goes to CSOs).<br><br>◉ B. There is a law, policy or regulation which permits CSOs to be funded from a government budget for HIV services. Check all that apply:<br><br>☐ Competition is open and transparent (notices of opportunities are made public)<br><br>☐ Opportunities for CSO funding are made on an annual basis<br><br>☐ Awards are made in a timely manner (within 6-12 months of announcements)<br><br>☐ Payments are made to CSOs on time for provision of services | 3.5 Score: | 0.83 | CSO Consultation, Aids Act, PVO Act | In some countries NACs and Government support CSOs through grants but in Zimbabwe NAC implements on the ground using DACs and taking officers from organisations to implement. |
| | | **Civil Society Engagement Score:** | **6.46** | | |

| **4. Private Sector Engagement:** Global as well as local private sector (both private health care providers and private business) is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, innovation, and as a key stakeholder to inform the national HIV/AIDS response. There are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs, services and fiscal management of the national HIV/AIDS response. The public uses the private sector for HIV service delivery at a similar level as other health care needs. | | | **Data Source** | **Notes/Comments** |
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| **4.1 Government Channels and Opportunities for Private Sector Engagement:** Does the host country government have formal channels and opportunities for diverse private sector entities (including service delivery, corporations, and private training institutions) to engage and provide feedback on its HIV/AIDS policies, programs, and services?<br><br>(If option B is true, check all subsequent boxes that apply.) | ○ A. There are no formal channels or opportunities for private sector engagement.<br><br>◉ B. There are formal channels or opportunities for private sector engagement.<br><br>i. The following private sector stakeholders formally contribute input into national or sub-national processes for HIV/AIDS planning and strategic development (check all that apply):<br><br>☑ Corporations<br><br>☑ Employers<br><br>☑ Private training institutions<br><br>☑ Private health service delivery providers<br><br>ii. Stakeholders contribute in the following ways (check all that apply):<br><br>☑ The private sector contributes technical expertise into HIV program planning<br><br>☑ Data and strategic input into supply chain management for HIV commodities<br><br>☑ Service delivery and/or client satisfaction data from private service delivery providers is included in health sector and HIV program planning<br><br>☑ Data on staffing in private health service delivery providers<br><br>☑ Data on private training institution's human resources for health (HRH) graduates and placements are included in health sector and HIV program planning<br><br>☑ For technical advisory on best practices and delivery solutions | 4.1 Score: 2.22 | Private Sector Board Terms of Reference. Business coailtion and private practictioners isn't as formalized and ad hoc.<br>MOHCC consultations confirm mechanisms in place for contributions by the private sector. Private Sector response to HIV/AIDS, TB and Wellness; National Strategic Plan 2014-2018 I would suggest the data sources be NAC, ZBCW, MoHCC, NSSA and ZIPSHAW. You may also consider other partners such asZCTU, EMCOZ, SHWAP, ZAPSO, SafAIDS, ZFTU, CZI. | Private Sector Board and Zimbabwe Business (College of Primary Care Physician) are channels for private sector engagement and coordination. There is a public-private partnership policy for structured engagement with the private sector health delivery systems. MOHCC agrees that engagement could and should be enhanced. The establishment of ZIPSHAW is the first step towards private sector coordination of the HIV response. At present it is at its infancy and lacks the resources for meaningful coordination. ZBCW acts more as a source for private sector information but with no ligitmate authority to coordinate. Information on the private sector is ad-hoc glimpsed from service providers and government records. There is currently no formal coordination structure.<br><br>Government consultants with the private sector on various issues. However representation tends to be at individual entity level rather than a common position as the cooredianting structure is weak. Labour through the ZCTU is more coordinated. The employers' side is poorly coordinated. In planning the voice of the private sector tends to be through partners, such as the ILO. This tends to give more a social than a private sector perspective. |

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| | iii. The national HIV/AIDS strategic plan explicitly addresses private sector's role in the HIV/AIDS response (check all that apply):<br><br>☑ The national HIV/AIDS strategic plan has a specific section that specifies the private sector's role in the HIV/AIDS response.<br><br>☑ A recent (within past 4 years) market analysis informs the private sector strategy that is included in the HIV/AIDS strategic plan<br><br>☐ The government and private sector effectively coordinates and executes a total market approach for HIV service delivery, which accounts for whether people are able and/or willing to pay for HIV services. | | | |
| **4.2 Enabling Environment for Private Corporate Contributions to HIV/AIDS Programming:** Does the host country government have systems and policies in place that allow for private corporate contributions to HIV/AIDS programming? | Check all that apply:<br><br>☐ Tax policies and incentives are designed to encourage corporate social responsibility efforts from companies who are contributing financial commitments and/or non-financial resources (including, but not limited to, product donations, expertise, and employee staff time).<br><br>☐ The host country government has in-house expertise in contracting services to private sector corporations when appropriate and necessary (e.g., transportation and waste management).<br><br>☐ The host country government has standards for reporting and sharing data across public and private sectors.<br><br>☑ Regulations help ensure that workplace programs align with the national HIV/AIDS program (e.g., medical leave policies, on-site testing, on-site prevention and education, anti-discrimination policies).<br><br>☐ There are strong linkage and referral networks between on-site workplace programs and public health care facilities. | 4.2 Score: 0.50 | Tax contribution from mobile networks and tobacco contribution towards the Health Fund. Domestic financing strategy; World Bank. Private Sector National Strategic Framework 2014-2018 | There is a staturtory instrument to guide HIV program implementation. Its scope needs to be amended to cover a broader specturm of implementation phases. The reporting system is through relevant government departments such as diffirent ministries and NSSA. The private sector monitoring, evaluation and reporting system was developed but never fully implemented. This weakens the reporting on private sector initiatives. There is need to strengthen ZIPSHAW capacities to carry out this responsibility. |

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| **4.3 Enabling Environment for Private Health Service Delivery:** Does the host country government have systems and policies in place that allow for private health service delivery?<br><br>Note: Full score possible without checking all boxes. | ○ A. Private health service delivery providers are not legally allowed to deliver HIV/AIDS services.<br><br>○ B. The host country government plans to allow private health service delivery providers to provide HIV/AIDS services in the next two years.<br><br>◉ C. Private health service delivery providers are legally allowed to deliver HIV/AIDS services. In addition (check all that apply):<br><br>☐ Policies are in place to ensure that private providers receive, understand, and adhere to national guidelines/protocols for ART, and appropriate quality standards and certifications.<br><br>☑ Systems are in place for service provision and/or research reporting by private facilities to the government, including guidelines for data reporting.<br><br>☐ Joint (i.e., public-private) supervision and quality oversight of private facilities.<br><br>☐ The government offers tax deductions for private facilities delivering HIV/AIDS services.<br><br>☐ The government offers tax deductions for private training institutions.<br><br>☑ The private sector is eligible to procure HIV/AIDS and/or ART commodities via public sector procurement channels and/or national medical stores<br><br>☐ The host country government has formal contracting or service-level agreement procedures to compensate private facilities for HIV/AIDS services.<br><br>☑ HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes<br><br>☑ There are open competitions for private health care providers to compete for government service contracts<br><br>☑ There is a systematic and timely process for private company registration and/or testing of new health products (e.g., drugs, diagnostic kits, medical devices, etc.) that support HIV/AIDS programming<br><br>☐ The government effectively regulates the flow of subsidized commodities into the private sector. | 4.3 Score: 1.94 | PPP strategy<br>MOHCC Consultations | Private Sector reports to both MOHCC and NAC, though MOHCC stated that it depends on which private facility. For example, Mission Hospitals are private not for profit but in terms of service delivery, they are part of public sector. Mission Hospital (but not all private health sector) do not adhere to the entirety of the legislative and regulatory framework. Private sector service providers provide services in the individual private capacities and not as coordinated private sector contribution. The policies and guidelines are available but basically to meet the regulatory requirements of relevant government departments. Larger corporates especially international companies also contribute as part of the CSR. The coordination systems are weak and not directly relating to a coordinated private sector contribution. The response to private sector support is slow, caught up in bureaucratic inefficiencies resulting in the private sector pursuing individual interests. |

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| **4.4 Private Sector Capability and Interest:** Does the private sector possess the capability to support HIV/AIDS services, and do private sector stakeholders demonstrate interest in supporting the national HIV/AIDS response? | ○ A. The host country government does not leverage the skill sets of the private sector for the national HIV/AIDS response.<br>○ B. The private sector does not express interest in or actively seek out opportunities to support the national HIV/AIDS response.<br>◉ C. The private sector has expertise and has expressed interest in or actively seeks out (check all that apply):<br>☐ Market opportunities that align with and support the national HIV/AIDS response<br>☑ Opportunities to contribute financial and/or non-financial resources to the national response (including business skills, market research, logistics, communication, research and development, product design, brand awareness, and innovation) | 4.4 Score: 1.25 | MOHCC consultations<br>International partners such as Global Fund, ILO, PEPFAR and some NGOs have made efforts to strengthen capacities and interest in the national response. | The private sector, especially large corporates, have the capacity and have demonstrated willingness to support national response. Whilst some actors have supported but government bureacracy and at time political interest has made the private sector shan some initiatives. The current economic meltdown has also limited the extent to which the private sector can contribute. The informalization of the economy has marginalized private sector potential and limited its capacity and interest. More effort is required to coordinate this sector if the full potential is to be realized. |
| | | **Private Sector Engagement Score:** 5.92 | | |

| **5. Public Access to Information:** Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards , etc.) related to HIV/AIDS. Program and audit reports are published publically. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information. | | | **Source of Data** | **Notes/Comments** |
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| **5.1 Surveillance and Survey Transparency:** Does the host country government ensure that HIV/AIDS surveillance and survey data and analyses are made available to stakeholders and general public in a timely and useful way? | ○ A. The host country government does not make HIV/AIDS surveillance and survey data available to stakeholders and the general public, or they are made available more than one year after the date of collection.<br>◉ B. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within 6-12 months.<br>○ C. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within six months. | 5.1 Score: 1.00 | ZDHS (Every five years), Annual HIV/AIDS Estimates, ANC/PMTCT survey (Every 2 years), HIVDR Survey (Pretreatment and Acquired) EWI (annual) | ZDHS information is released. National HIV/AIDS Estimates are released quickly per the MOHCC. HIVDR Survey (Pretreatment and Acquired) on annual rotational basis. Early Warning Indicators Survey retrospective yearly |
| **5.2 Expenditure Transparency:** Does the host country government make annual HIV/AIDS expenditure data available to stakeholders and the public in a timely and useful way? | ○ A. The host country government does not track HIV/AIDS expenditures.<br>○ B. The host country government does not make HIV/AIDS expenditure data available to stakeholders and the general public, or they are made available more than one year after the date of expenditures.<br>◉ C. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within 6-12 months after date of expenditures.<br>○ D. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within six months after expenditures. | 5.2 Score: 1.00 | National AIDS Spending Assement (NASA) every two years, National Health Accounts (2010, 2015) Resource Mapping Report (annually since 2015) | Data is highly summarised for the public - it is therefore difficult for the public to see actual expenditure. Resource mapping and NHA are very detailed and provide data on actual spending as well as budgeted spending (resource mapping) |
| **5.3 Performance and Service Delivery Transparency:** Does the host country government make annual HIV/AIDS program performance and service delivery data available to stakeholders and the public in a timely and useful way? | ○ A. The host country government does not make HIV/AIDS program performance and service delivery data available to stakeholders and the general public or they are made available more than one year after the date of programming.<br>◉ B. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within 6-12 months after date of programming.<br>○ C. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within six months after date of programming . | 5.3 Score: 1.00 | NAC website; NAC 2016 report; MOHCC website not kept up to date, but regular publications go out to all health facilities through Health Matters Magazine. MOHCC consultations | Yes, the host country government makes available but likely not same year |

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| **5.4 Procurement Transparency:** Does the host country government make government HIV/AIDS procurements public in a timely way? | ○ A. The host country government does not make any HIV/AIDS procurements.<br>○ B. The host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available.<br>◉ C. The host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available.<br>○ D. The host country government makes HIV/AIDS procurements, and both tender and award details available. | 5.4 Score: 1.00 | Public Tenders (aderts in paper) | |
| **5.5 Institutionalized Education System:** Is there a government agency that is explicitly responsible for providing scientifically accurate education to the public about HIV/AIDS? | ○ A. There is no government institution that is responsible for this function and no other groups provide education.<br>◉ B. There is no government institution that is responsible for this function but at least one of the following provides education:<br>☑ Civil society<br>☑ Media<br>☑ Private sector<br>○ C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS. | 5.5 Score: 1.00 | MOHCC consultations | NAC is responsible for coordination of all partners and some of the partners educate the public. MOHCC said that NAC previously did provide education, but they were told they were treading into implementation. MOHCC has recommended that it could be explored to pull that responsibility back to the MOHCC/NAC to be the conduit for public information. |
| | | **Public Access to Information Score: 5.00** | | |

**THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A**

# Domain B. National Health System and Service Delivery

**What Success Looks Like:** Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving prevention, treatment, and care services and interventions. There is a high demand for HIV/AIDS services, which are accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and/or are affected by the HIV/AIDS epidemic.

| **6. Service Delivery:** The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services. | | | **Data Source** | **Notes/Comments** |
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| **6.1 Responsiveness of facility-based services to demand for HIV services:** Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.) | ☑ Public facilities are able to tailor services to accommodate demand (e.g., modify or add hours/days of operations; add/second additional staff during periods of high patient influx; customize scope of HIV services offered; adapt organization/model of service deliver to patient flow)<br>☑ Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics)<br>☑ There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services | 6.1 Score: 1.11 | MOHCC Consultations | Public facilities are not able to increase staff as hiring for additional workers has been frozen by the government. Demand generation is typically coordinated by facilities and partners. |
| **6.2 Responsiveness of community-based HIV/AIDS services:** Has the host country standardized the design and implementation of community-based HIV services? (Check all that apply.) | The host country has standardized the following design and implementation components of community-based HIV/AIDS services through (check all that apply):<br>☑ Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services<br>☑ National guidelines detailing how to operationalize HIV/AIDS services in communities<br>☑ Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities<br>☑ Providing financial support for community-based services<br>☑ Providing supply chain support for community-based services<br>☐ Supporting linkages between facility- and community-based services through formalized bidirectional referral services (e.g., use of national reporting systems to refer and monitor referrals for completeness) | 6.2 Score: 0.93 | MOHCC Consultations | The government does not have nationalized guidelines around structuring engagement within communities (e.g Community-based organizations), but has however incorporated recommendations into different guidelines and SOPs, including the HTS, and the operational and service delivery manual. Insufficient Village Health Workers (VHW) and supplement with partner Community Health Workers (CHW) needs to standardize/harmonize. VHW, CHW, and other community cadres to allign roles and responsabilities, pay, duties, reporting, acountability, management, etc. Even if it is standardized on paper, there is a gap in the communiy (especially peri-urban) for service delivery and supplies. Linkages from community to facilities are poor and need to be strengthened by community-based organizations and community cadres. Bi-directional referral system guidelines are under development. |

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| **6.3 Domestic Financing of Service Delivery:** To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services (i.e. excluding any external financial assistance from donors)?<br><br>(if exact or approximate percentage known, please note in Comments column) | ○ A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services<br>○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services<br>◉ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services<br>○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services<br>○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services | 6.3 Score: 0.83 | National Health Funding Reports, NHA 2015, Resource mapping report 2015, 2016 | Significant domestic resources are contributed to HR, infrastructure, and running cost. NAC earmarks 50% of total budget for procurement of HIV drugs and commodities.The AIDS trust fund contributes almost 15% of HIV/AIDS budget. (Domestic funding earmarked for HIV through GoZ budget and NAC, systems funding through salaries, infrastructure, etc. from MOHCC budget) Total domestic contribution as per RM 2016 report is 18% of total AIDS spending. |
| **6.4 Domestic Provision of Service Delivery:** To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services without external technical assistance from donors? | ○ A. HIV/AIDS services are primarily delivered by external agencies, organizations, or institutions.<br>○ B. Host country institutions deliver HIV/AIDS services but with substantial external technical assistance.<br>◉ C. Host country institutions deliver HIV/AIDS services with some external technical assistance.<br>○ D. Host country institutions deliver HIV/AIDS services with minimal or no external technical assistance. | 6.4 Score: 0.74 | Annual Report | MOHCC Primarily responsible for delivery of services. Local and International NGOs assist MOHCC through signed MoUs. |
| **6.5 Domestic Financing of Service Delivery for Key Populations:** To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services to key populations (i.e. without external financial assistance from donors)?<br><br>(if exact or approximate percentage known, please note in Comments column) | ○ A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations.<br>○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations.<br>◉ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations.<br>○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations.<br>○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations. | 6.5 Score: 0.83 | National Health Funding Reports; Zimbabwe GFATM 2018 - 2020 approved grant | There is more detailed information on FSW (est. population size, where they access services, est. HIV prevalence and incidence, etc.) compared to MSM and transgender populations. Plans are in progress for MoHCC to officially launch a program focused on friendly and adequate service provision to key populations through public health faciltiies with support from various funding, technical, and implementation partners. |
| **6.6 Domestic Provision of Service Delivery for Key Populations:** To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services to key populations without external technical assistance from donors? | ○ A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions.<br>○ B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance.<br>◉ C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance.<br>○ D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance. | 6.6 Score: 0.74 | National Health Funding Reports | There is a partial data for FSW but no clarity on denominator on this population or other key populations. Population size estimates for FSW in the final stages; population size estimates for MSM postponed until after national elections. Challenges remain in identifying key populations. Services to key populations may largely be provided though general services and not necessarily as targeted services for key populations with the exception of SW through the national SW program. But exact figures are unknown. |

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| **6.7 National Service Delivery Capacity:** Do national health authorities have the capacity to effectively plan and manage HIV services? | National health authorities (check all that apply):<br>☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities.<br>☑ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations.<br>☐ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations.<br>☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations.<br>☑ Effectively engage with civil society in program planning and evaluation of services.<br>☑ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship. | 6.7 Score: 0.93 | Partner Consultations, MOHCC Annual Planning Meetings, MOHCC MIPA and DIPA set program and provincial perfomance targets for implementation that are monitored bi-annually and reported on - tracking and reporting is based on the National Health startegy (NHS) and Program Based Budget (PBB). HIV/AIDS department also sets targets and tracks these with provinces through annual planning meetings | MOHCC does factor staffing in the planning and management, but told there are constraints around hiring new positions at all levels and planning is not specific to HIV needs. Community health center committees and district committees are run by community/CSO. Limited resources prevent planning and management capabilities. Though larger CSO are enaged effectively, greater enagement for KP should be increased. |
| **6.8 Sub-national Service Delivery Capacity:** Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control? | Sub-national health authorities (check all that apply):<br>☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities.<br>☐ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations.<br>☐ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations.<br>☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations.<br>☑ Effectively engage with civil society in program planning and evaluation of services.<br>☑ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship. | 6.8 Score: 0.74 | Partner Consultations | Same constraints exist at sub-national level as at the national level. Epi data is limited to deliver services to especialy vulnerable groups and to measure effectiveness. It is acknowledged that there is greater KP enagagement at the district level as compared to national level. Staff performance management seems to be donor driven but seen as a MOHCC priority. |
| | | **Service Delivery Score** | **6.85** | |

| **7. Human Resources for Health:** HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors. | | | **Data Source** | **Notes/Comments** |
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| **7.1 HRH Supply:** To what extent is the clinical health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or community site level? | Check all that apply:<br>☑ The country's pre-service education institutions are producing an adequate supply and skills mix of clinical health care providers<br>☐ The country's clinical health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden<br>☑ The country has developed retention schemes that address clinical health worker vacancy or attrition in high HIV burden areas<br>☑ The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children | 7.1 Score: 0.83 | MOHCC | The MOHCC has undertaken a study to review the current staff establishment (SARA). A Workload Indicator of Staffing Needs study is currently under way. The current HRIS data does not allow analysis of adequate staff because it is based on an establishment that has not been reviewed since 1981 and disease burden and population size have both increased since then.<br><br>The country has a freeze on hiring which results in clinicians and social workers are being trained but not employed despite vacancies. In addition, anecdotal evidence indicates inadequate staffing at health facility level.<br><br>MOHCC:<br>Bullet 1 – There is an adequate mix, but there is room for improvement. Nurses and doctor curriculum and the amount of time provided for lectures around HIV/AIDS and STIs versus and amount of time in other health related components, there are additional opportunities to increase HIV/AIDS information to increase workers capability. Post-graduate training is still required to increase their skills (i.e. initiate children on ARV) due to changing policies and some lack of specific HIV training during graduate studies.<br>Bullet 2 – Staff are distributed, but a challenge is that high burden district may not have adequate staff.<br>Bullet 4 - institution capacity exist, but financial capacity is limited. |
| **7.2 Role of Community-based Health Workers (CHWs):** To what extent are community-based health workers' roles and responsibilities specified for HIV/AIDS service delivery? | Check all that apply:<br>☑ There is a national community-based health worker (CHW) cadre that has a defined role in HIV/AIDS service delivery (e.g., through a national strategy or task-sharing framework/guidelines).<br>☑ Data are made available on the staffing and deployment of CHWs, including non-formalized CHWs supported by donors.<br>☑ The host country government officially recognizes non-formalized CHWs delivering HIV/AIDS services. | 7.2 Score: 1.11 | MOHCC Consultation. Work plans | |

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| **7.3 HRH transition:** What is the status of transitioning PEPFAR and/or other donor supported HIV/AIDS health worker salaries to local financing/compensation?<br><br>Note in comments column which donors have transition plans in place. | ○ A. There is no inventory or plan for transition of donor-supported health workers<br>◉ B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support<br>○ C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented<br>○ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan<br>○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated | 7.3 Score: 0.28 | HDF and Global Fund | A plan and inventory has been developed and agreed, but exact timing of the transition is still unknown due to funding constraints. |
| **7.4 Domestic funding for HRH:** What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)?<br><br>(if exact or approximate percentage known, please note in Comments column) | ○ A. Host country institutions provide no (0%) health worker salaries<br>○ B. Host country institutions provide minimal (approx. 1-9%) health worker salaries<br>○ C. Host country institutions provide some (approx. 10-49%) health worker salaries<br>○ D. Host country institutions provide most (approx. 50-89%) health worker salaries<br>◉ E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries | 7.4 Score: 3.33 | Government budget and accounts, Resource Mapping Report 2015, 16, NHA 2015 | Health Worker retention plan for GF Dec 2014 gives an overview of expenditures on HR. Other reference includes the national budget document released Dec 2014. Note that GOZ expenditure on wages was approximately $176 million (90%) in 2014 and donor contribution an additional 10%.<br><br>More retention funding coming from HDF than GF. |
| **7.5 Pre-service:** Do current pre-service education curricula for any health workers providing HIV/AIDS services include HIV content that has been updated in last three years?<br><br>Note: List applicable cadres in the comments column. | ○ A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years)<br>◉ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):<br>☑ Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services<br>☑ Institutions maintain process for continuously updating content, including HIV/AIDS content<br>☐ Updated curricula contain training related to stigma & discrimination of PLHIV<br>☐ Institutions track student employment after graduation to inform planning | 7.5 Score: 0.83 | Q4 Score:<br>2.2 RN Curriculum Review Workshop 2013; Updated Guidelines Training for RN Tutors 2014 | When new guidance emerge (WHO or other bodies), MOHCC shares with institutions to incorporate.<br><br>HIV content is basic, and the majority of capacity builing is provided as part of in-service training. |

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| **7.6 In-service Training:** To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control?<br><br>(if exact or approximate percentage known, please note in Comments column) | Check all that apply among A, B, C, D:<br><br>☑ A. The host country government provides the following support for in-service training in the country (check ONE):<br>☐ Host country government implements no (0%) HIV/AIDS related in-service training<br>☐ Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training<br>☐ Host country government implements some (approx. 10-49%) HIV/AIDS in-service training<br>☑ Host country government implements most (approx. 50-89%) HIV/AIDS in-service training<br>☐ Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training<br><br>☑ B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS<br><br>☑ C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians<br><br>☑ D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden areas) | 7.6 Score: 1.04 | MOHCC Training plans. Trainsmart database. | All PEPFAR training is guided by the MOHCC training plans that are decentralized to Provincial and District levels. There is no system in place for separate PEPFAR trainings to be planned or implemented. |
| **7.7 HR Data Collection and Use:** Does the country systematically collect and use health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management? | ○ A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management<br><br>○ B. There is no HRIS in country, but some data is collected for planning and management<br>☐ Registration and re-licensure data for key professionals is collected and used for planning and management<br>☐ MOH health worker employee data (number, cadre, and location of employment) is collected and used<br>☐ Routine assessments are conducted regarding health worker staffing at health facility and/or community sites<br><br>◉ C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country:<br>☐ The HRIS is primarily financed and managed by host country institutions<br>☑ There is a national strategy or approach to interoperability for HRIS<br>☑ The government produces HR data from the system at least annually<br>☑ Host country institutions use HR data from the system for planning and management (e.g. health worker deployment) | 7.7 Score: 0.97 | National HRIS SOP and framework | Significat donor support. PEPFAR. |
| | **Human Resources for Health Score** | **8.40** | | |

| **8. Commodity Security and Supply Chain:** The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, diagnosis and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality. | | | **Data Source** | **Notes/Comments** |
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| **8.1 ARV Domestic Financing:** What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds)<br><br>(if exact or approximate percentage known, please note in Comments column) | ○A. This information is not known.<br>○B. No (0%) funding from domestic sources<br>◉C. Minimal (approx. 1-9%) funding from domestic sources<br>○D. Some (approx. 10-49%) funded from domestic sources<br>○E. Most (approx. 50 – 89%) funded from domestic sources<br>○F. All or almost all (approx. 90%+) funded from domestic sources | 8.1 Score: 0.21 | GOZ contribution was 10% in 2013 and 12% in 2014. From LSU procurement and forecasting reports. Last available report August 2014. GF NFM gap analysis 2013. Health budget statement Dec 2014. (Only NAC has budgets for commodity procurement, in 2017, $18million ( 11%) out of total $156million for HIV commodities was from domestic (Resource Mapping Report) resources | Last year response: GOZ contribution is coming from NAC through the AIDS Levy. The DPS Logistics Unit reports stock status of ARV, RTK and condoms on a bimonthly basis at the PSM meetings.<br>In 2015 domestic funding for ARVs was about $10m (total $160m)<br>Pediatrics has 0% coming from domestic financing and the majority of adult ARVs are funded externally. |
| **8.2 Test Kit Domestic Financing:** What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds)<br><br>(if exact or approximate percentage known, please note in Comments column) | ○A. This information is not known<br>○B. No (0%) funding from domestic sources<br>◉C. Minimal (approx. 1-9%) funding from domestic sources<br>○D. Some (approx. 10-49%) funded from domestic sources<br>○E. Most (approx. 50-89%) funded from domestic sources<br>○F. All or almost all (approx. 90%+) funded from domestic sources | 8.2 Score: 0.21 | Same as above. GOZ contribution 30% in 2013 and 15% in 2014. | RTK are funded by the GF. Some test kits procured by USAID and HDF. |
| **8.3 Condom Domestic Financing:** What is the estimated percentage of condom procurement funded by domestic (not donor) sources? *Note:* The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs.<br><br>(if exact or approximate percentage known, please note in Comments column) | ○A. This information is not known<br>◉B. No (0%) funding from domestic sources<br>○C. Minimal (approx. 1-9%) funding from domestic sources<br>○D. Some (approx. 10-49%) funded from domestic sources<br>○E. Most (approx. 50-89%) funded from domestic sources<br>○F. All or almost all (approx. 90%+) funded from domestic sources | 8.3 Score: 0.00 | N/A | USG provides majority of condoms in public health domain.<br><br>Global Fund and UNFPA procures for key populations. |

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| **8.4 Supply Chain Plan:** Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain? | ○A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP).<br>◉B. There is a plan/SOP that includes the following components (check all that apply):<br>☑Human resources<br>☑Training<br>☑Warehousing<br>☑Distribution<br>☑Reverse Logistics<br>☑Waste management<br>☑Information system<br>☑Procurement<br>☑Forecasting<br>☑Supply planning and supervision<br>☑Site supervision | 8.4 Score: 2.22 | MOHCC procurement plan and other SOPs (quantification, stock management, etc). | |
| **8.5 Supply Chain Plan Financing:** What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)?<br><br>(if exact or approximate percentage known, please note in Comments column) | ○A. This information is not available.<br>○B. No (0%) funding from domestic sources.<br>○C. Minimal (approx. 1-9%) funding from domestic sources.<br>◉D. Some (approx. 10-49%) funding from domestic sources.<br>○E. Most (approx. 50-89%) funding from domestic sources.<br>○F. All or almost all (approx. 90%+) funding from domestic sources. | 8.5 Score: 0.42 | Limited domestic funding for commodities and supply chain. NATPHARM allocation for salaries and administration are GoZs main contribution to SCM and NAC allocates 50% of total budgets for commodities inluding proucurement | Per MOHCC: Lower side of 10-49%. Resource Mapping Report 2016 |

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| **8.6 Stock:** Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system? | Check all that apply:<br>☑ The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities<br>☑ Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time<br>☑ MOH or other host government personnel make re-supply decisions with minimal external assistance:<br>☐ Decision makers are not seconded or implementing partner staff<br>☑ Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects<br>☑ Team that conducts analysis of facility data is at least 50% host government | 8.6 Score: 1.98 | MOHCC procurement plan and staffing data. | The new pull system still needs to be strenthened and health workers/pharmacist need to be continue to receive capacity and evaluate work load. |
| **8.7 Assessment:** Was an overall score of above 80% achieved on the National Supply Chain Assessment or top quartile for an equivalent assessment conducted within the last three years?<br><br>(if exact or approximate percentage known, please note in Comments column) | ○ A. A comprehensive assessment has not been done within the last three years.<br>◉ B. A comprehensive assessment has been done within the last three years but the score was lower than 80% (for NSCA) or in the bottom three quartiles for the global average of other equivalent assessments<br>○ C. A comprehensive assessment has been done within the last three years and the score was higher than 80% (for NSCA) or in the top quartile for the assessment | 8.7 Score: 1.11 | COMPREHENSIVE ASSESSMENT OF THE SUPPLY CHAIN FOR HEALTH COMMODITIES IN THE PUBLIC SECTOR IN ZIMBABWE - March 2014 - Euro Health Group | |
| | **Commodity Security and Supply Chain Score:** | **6.14** | | |

| **9. Quality Management:** Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services | | | **Data Source** | **Notes/Comments** |
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| **9.1 Existence of a Quality Management (QM) System:** Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels? | ○ A. The host country government does not have structures or resources to support site-level continuous quality improvement<br>◉ B. The host country government:<br>☑ Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement<br>☑ Has a budget line item for the QM program<br>☐ Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions | 9.1 Score: 1.33 | MOHCC 2016 National plan for Quality Improvement. (QI/QM) | Peer learning opportunities are being developed and will be available by the end of 2016 |
| **9.2 Quality Management/Quality Improvement (QM/QI) Plan:** Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.) | ○ A. There is no HIV/AIDS-related QM/QI strategy<br>○ B. There is a QM/QI strategy that includes HIV/AIDS, but it is not utilized<br>◉ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements, and it is partially utilized.<br>○ D. There is a current HIV/AIDS program specific QM/QI strategy, and it is fully utilized. | 9.2 Score: 1.33 | 2016 National Plan for QI/QM. National Quality Improvement Strategy 2015-2018. | |
| **9.3 Performance Data Collection and Use for Improvement:** Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting? | ○ A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting.<br>◉ B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply):<br>☑ The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement<br>☑ There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities<br>☑ There is documentation of results of QI activities and demonstration of national HIV program improvement through sharing and implementation of best practices across HIV/AIDS sites at all levels | 9.3 Score: 2.00 | DHIS and National HIV/TB Annual Reports | There is concern that reporting and QI done by CHWs outside of formal MOHCC structures, is not be capturing and of quality.<br><br>Concern at all levels for the ability/quality to report by finer disag (age/sex).<br><br>Limited information on KP denominators. |

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| **9.4 Health worker capacity for QM/QI:** Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services? | ○ A. There is no training or recognition offered to build health workforce competency in QI.<br>◉ B. There is health workforce competency-building in QI, including:<br>☑ Pre-service institutions incorporate modern quality improvement methods in curricula<br>☑ National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services | 9.4 Score: 2.00 | Training plan and HIV/TB Annual Reports | But the informal CHW (outside of MOHCC) to be included in the formal MOHCC training to ensure they receive QI training. |
| **9.5 Existence of QI Implementation:** Does the host country government QM system use proven systematic approaches for QI? | The national-level QM structure:<br>☑ Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services<br>☑ Regularly convenes meetings that include health services consumers<br>☑ Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement<br>Sub-national QM structures:<br>☑ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services<br>☑ Regularly convene meetings that includes health services consumers<br>☑ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement<br>Site-level QM structures:<br>☑ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement | 9.5 Score: 2.00 | National QI Guide | The informal CHW do not fall within the formal MOHCC strucutre and are represented in the meetings and improvement efforts. |
| | **Quality Management Score:** | **8.67** | | |

| **10. Laboratory:** The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV. | | | **Data Source** | **Notes/Comments** |
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| **10.1 Strategic Plan:** Does the host country have a national laboratory strategic plan? | ○A. There is no national laboratory strategic plan<br>○B. National laboratory strategic plan is under development<br>○C. National laboratory strategic plan has been developed, but not approved<br>○D. National laboratory strategic plan has been developed and approved<br>◉E. National laboratory plan has been developed, approved, and costed<br>○F. National laboratory strategic plan has been developed, approved, costed, and implemented | 10.1 Score: 1.33 | Lab Strategy | Elements of the plan that were costed are being implemented, but not everything was costed. |
| **10.2 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites:** To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites?<br><br>(if exact or approximate percentage known, please note in Comments column) | ○A. Regulations do not exist to monitor minimum quality of laboratories in the country.<br>○B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated).<br>○C. Regulations exist, but are minimally implemented (approx.. 1-9% of laboratories and POCT sites regulated).<br>○D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated).<br>◉E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated).<br>○F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated). | 10.2 Score: 1.25 | Lab system reporting system shows implementation at>50%. | Slow scale-up of POC and deployment plan is on-going. Zimbabwe National Quality Assurance Program is the parastatal in country tasked with monitoring quality in the laboratories with Medical Laboratory Scientists Council of Zimbabwe which administers licenses. |
| **10.3 Capacity of Laboratory Workforce:** Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression? | ◉A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control<br>○B. There are adequate qualified laboratory personnel to perform the following key functions:<br>☐ HIV diagnosis by rapid testing and point-of-care testing<br>☐ Routine laboratory testing, including chemistry, hematology, microbiology, serology, blood banking, and malaria<br>☐ Complex laboratory testing, including HIV viral load, CD4 testing, and molecular assays<br>☐ TB diagnosis | 10.3 Score: 0.00 | According to HSB there is a 44% vacancy rate for Laboratory and pharmacy combined. The national system is failing to retain highly trained laboratory scientists.<br>NAC | Concern regarding infrastructure.<br><br>Other cadres such as microscopists, primary care counselors, and nurses are carrying out testing in light of inadequate laboratory staffing. Significant number of laboratory staff are donor supported (esp. EID and Viral Load). Human Resources for the laboratories is a challenge; freezing of posts does not allow recruitment of new scientists needed to meet current testing. |

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| **10.4 Viral Load Infrastructure:** Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control? | ○A. There is not sufficient infrastructure to test for viral load.<br>◉B. There is sufficient infrastructure to test for viral load, including:<br>☑ Sufficient HIV viral load instruments<br>☑ All HIV viral load laboratories have an instrument maintenance program<br>☑ Sufficient supply chain system is in place to prevent stock outs<br>☐ Adequate specimen transport system and timely return of results | 10.4 Score: 1.25 | MOHCC viral load coverage reports | Current VL coverage is 35%. A VL scale-up plan exists and capacity exists to expand.<br><br>Viral Load infrastructures are being established:<br>Equipment- 6 platforms available<br>Reagents - 4 platforms partially covered through GF to meet National program targets; gap of ~10 million exists<br>Sample Transport- these needs strengthening through integration and coordination. Partners and GF have funding to support an integrated sample transport.<br>Laboratory Information System- this is currently being rolled out for testing efficiency at the laboratories, to be followed by results transmission to clinics.<br>Human Resources- this is a severe challenge to meeting Viral Load testing targets and maintaining regular laboratory testing. |
| **10.5 Domestic Funds for Laboratories:** To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)?<br><br>(if exact or approximate percentage known, please note in Comments column) | ○A. No (0%) laboratory services are financed by domestic resources.<br>○B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources.<br>◉C. Some (approx. 10-49%) laboratory services are financed by domestic resources.<br>○D. Most (approx. 50-89%) laboratory services are financed by domestic resources.<br>○E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources. | 10.5 Score: 1.67 | Donor and Government funding mapping. | Anticipate the lower end of the range of the contributions. There is no Government budget for laboratory services. National AIDS Council provides ad hoc support. Curative Service through hospital management provides some support on a case by case issue. Primary funding partner is Global Fund, followed by PEPFAR and CHAI. |
| | | **Laboratory Score:** **5.50** | | |

**THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B**

# Domain C. Strategic Investments, Efficiency, and Sustainable Financing

**What Success Looks Like:** Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

| **Fiscal Context for Health and HIV/AIDS**<br>This section will not be assigned a score, but will provide additional contextual information to complement the questions in Domain C. | | | **Data Source** | **Notes/Comments** |
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| 1. What percentage of general government expenditures goes to health? | 8% | | Resource Mapping Report 2016, NHA report | |
| 2. What is the per capita health expenditure all sources? | $103.83 | | NHA 2015 | |
| 3. What is the total health care expenditure all sources as a percent of GDP? | 10.34% | | NHA 2015 | |
| 4. What percent of total health expenditures is financed by external resources? | 24.92% | | NHA 2015 | Only includes general health expenditures, does not include disease specific funding. |
| 5. What percent of total health expenditures is financed by out of pocket spending net of household contributions to medical schemes/pre-payment schemes? | 23.74% | | NHA 2015 | |

| **11. Domestic Resource Mobilization:** The partner country budgets for its HIV/AIDS response and makes adequate resource commitments and expenditures to achieve national HIV/AIDS goals for epidemic control in line with its financial ability. | | | **Data Source** | **Notes/Comments** |
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| **11.1 Long-term Financing Strategy for HIV/AIDS:** Has the host country government developed a long-term financing strategy for HIV/AIDS? | Check all that apply:<br>☑ A. Yes, there is a universal, comprehensive financing scheme that integrates social health insurance, public subsidies, and national budget provisions for public health aspects (e.g., disease surveillance). It includes the following (check all that apply):<br>☑ ARVs are covered<br>☑ Non-ARV care and treatment is covered<br>☑ Prevention services are covered<br>☐ B. Yes, there is an affordable health insurance scheme available (check one of the following).<br>☐ It covers 25% or less of the population.<br>☐ It covers 26 to 50% of the population.<br>☐ It covers 51 to 75% of the population.<br>☐ It covers more than 75% of the population.<br>☐ C. The affordable health insurance scheme in (B.) includes the following (check all that apply):<br>☐ ARVs are covered.<br>☐ Non-ARV care and treatment services are covered.<br>☐ Prevention services are covered.<br>☐ It includes public subsidies for the affordability of care. | 11.1 Score: 0.32 | MOHCC Consultations.<br>NATF, NHA 2015, Resource Mapping Report 2016 | Public sector provides HIV services for free through limited domestic funding and mainly rely on donor funding. Social Health Inusrance only cover 8.04% of total population mostly the upper quintile. Medical cover do not include HIV care and treatment<br><br>The affordable health insurance scheme is currently under development, but coverage is not available yet. Confirmed the insurance scheme is still in its formative stages. A feasibility study to inform design has commenced. |

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| **11.2 Domestic Budget:** To what extent does the national budget explicitly account for the national HIV/AIDS response? | ○ A. There is no explicit funding for HIV/AIDS in the national budget.<br>◉ B. There is explicit HIV/AIDS funding within the national budget.<br>☑ The HIV/AIDS budget is program-based across ministries<br>☑ The budget includes or references indicators of progress toward national HIV/AIDS strategy goals<br>☑ The budget includes specific HIV/AIDS service delivery targets<br>☑ National budget reflects all sources of funding for HIV, including from external donors | 11.2 Score: 0.95 | 2016, 2017 National Budget | 2016 was the first year for program based budgeting which aligns the budgeting to programs. Domestic sources of funding are from the National Budget and from NAC. Domestic budgets still in PBB. Specific allocations under Communicable Diseases for HIV/AIDS |
| **11.3 Annual Goals/Targets:** To what extent does the national budget contain HIV/AIDS goals/targets? | ○ A. There are no HIV/AIDS goals/targets articulated in the national budget<br>◉ B. There are HIV/AIDS goals/targets articulated in the national budget.<br>☑ The goals/targets are measurable.<br>☑ Budget items/programs are linked to goals/targets.<br>☑ The goals/targets are routinely monitored during budget execution.<br>☑ The goals/targets are routinely monitored during the development of the budget. | 11.3 Score: 0.95 | 2016, 2017 National Budget | PBB reflects targets for each program and specific HIV targets are included under the communicable diseases program. All resource mobilisation efforts by the MOHCC including requesting funding from MOF in the National budget are derived from the NHS which has used the Project Based Budgeting system which specifies targets and KPI under the communicable diseases programme area. |
| **11.4 HIV/AIDS Budget Execution:** For the previous three years, what was the average execution rate for budgeted domestic HIV/AIDS resources (i.e. excluding any donor funds) at both the national and subnational level?<br><br>(If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column) | ○ A. There is no HIV/AIDS budget, or information is not available.<br>○ B. 0-49% of budget executed<br>○ C. 50-69% of budget executed<br>○ D. 70-89% of budget executed<br>◉ E. 90% or greater of budget executed | 11.4 Score: 0.95 | NAC Annual Reports, MOHCC MODO Finance Director' Reports | Budget execution is high in 2016 and 2017. Due to limited funding, all disbursed funds are used up. |

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| **11.5 Donor Spending:** Does the Ministry of Health or Ministry of Finance routinely, and at least on an annual basis, collect all donor spending in the health sector or for HIV/AIDS-specific services? | ○ A. Neither the Ministry of Health nor the Ministry of Finance routinely collects all donor spending in the health sector or for HIV/AIDS-specific services.<br>○ B. The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services.<br>◉ C. The Ministry of Health or Ministry of Finance routinely collects all donor spending all the entire health sector, including HIV/AIDS-specific services. | 11.5 Score: 0.95 | Annual ministry funding reports<br>Resource Mapping Report (annual) NHA report 2010, 2015, NASA (every two years) | Resource tracking being institutionalised through annual Resource Mapping exercises, NHA and NASA |
| **11.6 Domestic Spending:** What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding? (Domestic funding excludes out-of-pocket, Global Fund grants, and other donor resources)?<br><br>(if exact or approximate percentage known, please note in Comments column) | ○ A. None (0%) is financed with domestic funding.<br>○ B. Very liitle (approx. 1-9%) is financed with domestic funding.<br>◉ C. Some (approx. 10-49%) is financed with domestic funding.<br>○ D. Most (approx. 50-89%) is financed with domestic funding.<br>○ E. All or almost all (approx. 90%+) is financed with domestic funding. | 11.6 Score: 1.67 | NASA Survey 2016<br>2015 National health accounts(WHO) and the NAC/UNAIDS NASA 2016 | Resource Mapping shows around 20% of total funding is from government. However, more information and verification is needed from NAC and UNAIDS on the private sector component. Based on NASA 2012 domestic resources were 29% - 11% Aids levy, 5% from for profit and NGOs, 13% OOP and Private Insurance. The NASA 2014-2015 draft report indicates a slight increase in Private sector spending on HIV from $5,627,254 in 2014 to $9,626,561 in 2015. household OOP expenditure was 9.3% amounting to $37,060,557. |
| **11.7 Health Budget Execution:** What was the country's execution rate of its budget for health in the most recent year's budget? | ○ A. There is no budget for health or no money was allocated.<br>○ B. 0-49% of budget executed.<br>○ C. 50-69% of budget executed.<br>○ D. 70-89% of budget executed.<br>◉ E. 90% or greater of budget executed. | 11.7 Score: 0.95 | Resource Mapping Report 2015 , MOHCC MoDO Finance Directors Report | All disbursed resources used up. |
| **11.8 Data-Driven Reprogramming:** Do host country government policies/systems allow for reprograming domestic investments based on new or updated program data during the government funding cycle? | ○ A. There is no system for funding cycle reprogramming.<br>◉ B. There is a policy/system that allows for funding cycle reprogramming, but is seldom used.<br>○ C. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, but not based on data.<br>○ D. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, and is based on data. | 11.8 Score: 0.32 | MOHCC consultations and annual budget. | MOHCC has overal authority over budgets, especially under PBB, where program directors have responsibility of their overall budget and what to spend on. |
| | **Domestic Resource Mobilization Score:** | **7.06** | | |

| **12. Technical and Allocative Efficiencies:** The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time). Unit costs are tracked and steps are taken to improve HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). | | | **Data Source** | **Notes/Comments** |
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| **12.1 Resource Allocation Process:** Does the partner country government utilize a recognized data-driven model to inform the allocation of domestic (i.e. non-donor) public HIV resources?<br><br>If yes, please note in the comments section when the model was last used and for what purpose (e.g., for Global Fund concept note development)<br><br>(note: full score achieved by selecting one checkbox) | ○ A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources.<br><br>◉ B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply):<br><br>☐ Optima<br><br>☑ Spectrum (including EPP and Goals)<br><br>☐ AIDS Epidemic Model (AEM)<br><br>☐ Modes of Transmission (MOT) Model<br><br>☑ Other recognized process or model (specify in notes column) | 12.1 Score: 2.00 | MOHCC Consultations/MODO, NHS Costing Report (Used OneHealth tool) | There is no direct link between data driven models and resource allocation, however at programming level there is a conscious reallocation of resources based on the spectrum model and hot spot mapping for HIV. |

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| **12.2 Geographic Allocation:** Of central government HIV-specific resources (excluding any donor funds) allocated to geographic subunits in the most recent year available, what percentage is being allocated in the highest burden geographic areas (i.e. districts that cumulatively account for 80% of PLHIV)?<br><br>(if exact or approximate percentage known, please note in Comments column) | ○ A. Information not available.<br><br>○ B. No resources (0%) are targeting the highest burden geographic areas.<br><br>○ C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas.<br><br>◉ D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas.<br><br>○ E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas.<br><br>○ F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas. | 12.2 Score: 1.00 | HMIS reports; Quarterly reports from DHIS 2 NASA 2016 shows HIV expenditure per province | NAC allocates funding based on thematic areas as follows (2012): 55% treatment, care and support, 11% prevention, 4% enabling environment, 5% M&E, Prog coordination and management, 25% program and logistics. When allocating to provinces, allocations are based on results from hot spot mapping. The 2014 and 2015 provincial level spending on HIV and AIDS. Manicaland, Mashonaland East, Matabeleland South and Harare realized increased HIV and AIDS expenditure compared to other provinces. Manicaland province had the highest spending at US$12.2 million up from US$6.3 million in 2014. Mashonaland East province's total spending more than trebled from US$1.5 million in 2014 to 6.3 million in 2015 while that of Matabeleland South increased from US$4.5 million in 2014 to US$7.4 million in 2015. Harare province spending increased from US$3.7 million in 2014 to US$6 million in 2015. Masvingo had the second largest spending in 2015 with US$10.2 million up from US$8.9 million in 2014. Other provinces such as Midlands, Bulawayo and Mashonaland Central recorded reduced HIV and AIDS spending from 2014 to 2015. The least spending was recorded by Bulawayo province. |
| **12.3 Unit Costs:** Does the host country government use recent expenditure data or cost analysis (i.e. data from within the last three years) to estimate unit costs of HIV/AIDS services for budgeting or planning purposes?<br><br>(note: full score can be achieved without checking all disaggregate boxes). | ○ A. The host country government does not have/use recent expenditure data or cost analysis to estimate unit costs<br><br>◉ B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply):<br><br>☑ HIV Testing<br>☑ Laboratory services<br>☑ ART<br>☑ PMTCT<br>☑ VMMC<br>☐ OVC Service Package<br>☑ Key population Interventions | 12.3 Score: 2.00 | Unit cost analysis report - UNAIDS<br>Global Fund funding request<br>Investment case report | Unit costs are not used in allocation of resources from the national budget but are used for applying for donor funds. Unit cost analyses also used in resource mobilization activities for HIV and other health services. |

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| **12.4 Improving Efficiency:** Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years? | Check all that apply:<br>☑ Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies<br>☑ Reduced overhead costs by streamlining management<br>☑ Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc.<br>☐ Improved procurement competition<br>☐ Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years)<br>☑ Integrated HIV into primary care services with linkages to specialist care (need not be within last three years)<br>☑ Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years)<br>☑ Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years)<br>☑ Developed and implemented other new and more efficient models of HIV service delivery (specify in comments) | 12.4 Score: 1.56 | PMTCT cost effectiveness study was used to plan for PMTCT strategy; VMMC modelling study; Hot spot analysis for geographic targeting is in process. MOHCC consultations, Costed and Prioritised NHS 2016-2020, Costed HTS 2016-2021, Costed EMTCT Strategy 2017-2021 | Various HIV and national health strategies are costed and prioritised with high impact low cost interventions prioritised eg, NHS costed 3 scenario including optimal, prioritised and baseline with prioritised scenario adopted.<br><br>UNDP has managed to lower the unit costs for ARVs through their LTA (long-term agreements).<br><br>New and more efficient models: CARGS and CATS, self-testing, door-to-door model, VMMC, same-day initiation, PrEP. |
| **12.5 ARV Benchmark prices**: How do the costs of ARVs (most common first line regimen) purchased in the previous year by the partner government using domestic resources compare to international benchmark prices for that year?<br><br>(Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.) | ○ A. Partner government did not pay for any ARVs using domestic resources in the previous year.<br>○ B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen.<br>○ C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen.<br>○ D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen.<br>◉ E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen. | 12.5 Score: 2.00 | http://apps.who.int/hiv/amds/price/hdd/Default.aspx | |
| **Technical and Allocative Efficiencies Score:** | | **8.56** | | |

**THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN C**

## Domain D: Strategic Information

**What Success Looks Like:** Using local and national systems, the host country government collects, analyzes and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

| **13.Epidemiological and Health data:** Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV, HIV incidence, HIV prevalence, viral load and AIDS-related mortality rates. | | | **Data Source** | **Notes/Comments** |
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| **13.1 Who Leads General Population Surveys & Surveillance:** To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)? | ○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years<br>○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions<br>◉ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies<br>○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies<br>○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies | 13.1 Score: 0.48 | ZDHS, ZIMPHIA, and YAZ | ZDHS conducted with substantial TA from MACRO, ZIMPHIA with substantial TA from ICAP. YAZ in prepatory phase with TA from EGPAF and UNICEF.<br>- Substantial financial support from external partners.<br>-The surveys are include in the M&E framework developed by government.<br>- The government provides coordination and monitoring the implementation of the surveys. |
| **13.2 Who Leads Key Population Surveys & Surveillance:** To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)? | ○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years<br>◉ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions<br>○ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies<br>○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies<br>○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies | 13.2 Score: 0.24 | Size estimates for FSW undertaken and report disseminated | LGBTI, IDU, MSM/WSW - not included in targeted surveys and surveillance.<br><br>FSW estimates done with substantial TA from CESHHAR, a local nongovernmental institution |
| **13.3 Who Finances General Population Surveys & Surveillance:** To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)?<br><br>(if exact or approximate percentage known, please note in Comments column) | ○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years<br>○ B. No financing (0%) is provided by the host country government<br>◉ C. Minimal financing (approx. 1-9%) is provided by the host country government<br>○ D. Some financing (approx. 10-49%) is provided by the host country government<br>○ E. Most financing (approx. 50-89%) is provided by the host country government<br>○ F. All or almost all financing (90% +) is provided by the host country government | 13.3 Score: 0.42 | National AIDS Trust Fund | |

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| **13.4 Who Finances Key Populations Surveys & Surveillance:** To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)?<br><br>(if exact or approximate percentage known, please note in Comments column) | ○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years<br>◉ B. No financing (0%) is provided by the host country government<br>○ C. Minimal financing (approx. 1-9%) is provided by the host country government<br>○ D. Some financing (approx. 10-49%) is provided by the host country government<br>○ E. Most financing (approx. 50-89%) is provided by the host country government<br>○ F. All or almost all financing (approx. 90% +) is provided by the host country government | 13.4 Score: 0.00 | FSW Size Estimates Report | The FSW size estimation study was funded by PEPFAR |
| **13.5 Comprehensiveness of Prevalence and Incidence Data:** To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregations, populations and geographic units?<br><br>(Note: Full score possible without selecting all disaggregates.) | Check ALL boxes that apply below. (A.) refers to prevalence data. (B.) refers to incidence data:<br>☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by:<br>☑ Age (at coarse disaggregates)<br>☑ Age (at fine disaggregates)<br>☑ Sex<br>☐ Key populations (FSW, PWID, MSM, TG, prisoners)<br>☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)<br>☑ Sub-national units<br>☑ B. The host country government collects at least every 5 years HIV incidence disaggregated by:<br>☑ Age (at coarse disaggregates)<br>☑ Age (at fine disaggregates)<br>☑ Sex<br>☐ Key populations (FSW, PWID, MSM, TG, prisoners)<br>☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)<br>☑ Sub-national units | 13.5 Score: 0.76 | HIV Estimates | Incidence is generated by ZIMPHIA at national level and HIV estimates by sex and age. There is no incidence data for KPs. Data avilable for some PP like AGYW.<br>Sub-national unit disaggreagates started in 2015. |

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| **13.6 Comprehensiveness of Viral Load Data:** To what extent does the host country government collect/report viral load data according to relevant disaggregations and across all PLHIV?<br><br>(if exact or approximate percentage known, please note in Comments column) | ○ A. The host country government does not collect/report viral load data or does not conduct viral load monitoring<br><br>◉ B. The host country government collects/reports viral load data (answer both subsections below):<br><br>According to the following disaggregates (check ALL that apply):<br>☑ Age<br>☑ Sex<br>☐ Key populations (FSW, PWID, MSM, TG, prisoners)<br>☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)<br><br>For what proportion of PLHIV (select ONE of the following):<br>☑ Less than 25%<br>☐ 25-50%<br>☐ 50-75%<br>☐ More than 75% | 13.6 Score: 0.36 | HMIS or LMIS ( Laboratory Information Management System) | Lab capacities limitations. Majority of facilities are feeding VL samples to the provincial level labs and must report results back to lower level facilities.<br><br>Progess update report for 2017 (Jan to June) shows 17 % of PLHIV in care had VL test. |
| **13.7 Comprehensiveness of Key and Priority Populations Data:** To what extent does the host country government conduct IBBS and/or size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.)<br><br>Please note most recent survey dates in comments section. | ○ A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM, TG, prisoners) or priority populations (Military, etc.).<br><br>◉ B. The host country government conducts (answer both subsections below):<br><br>IBBS for (check ALL that apply):<br>☐ Female sex workers (FSW)<br>☐ Men who have sex with men (MSM)<br>☐ Transgender (TG)<br>☐ People who inject drugs (PWID)<br>☑ Prisoners<br>☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)<br><br>Size estimation studies for (check ALL that apply):<br>☑ Female sex workers (FSW)<br>☐ Men who have sex with men (MSM)<br>☐ Transgender (TG)<br>☐ People who inject drugs (PWID)<br>☑ Prisoners<br>☐ Priority populations (AGYW, clients of sex workers, miliitary, mobile populations, non-injecting drug users) | 13.7 Score: 0.36 | 2016 Prisons Surveillance report by UNOD includes IBBS<br><br>2017 SW size estimate report by CESHA. | |

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| **13.8 Timeliness of Epi and Surveillance Data:** To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)? | ○ A. There is no national HIV surveillance and surveys strategy, or a national surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys<br>○ B. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), but the strategy does not outline a timeline for data collection for all relevant population groups<br>◉ C. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), and outlines a timeline for data collection for all relevant population groups | 13.8 Score: 0.95 | ZNASP outlines entire list and timeline | |
| **13.9 Quality of Surveillance and Survey Data:** To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data? | ○ A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented.<br>◉ B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply):<br>☑ A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data<br>☑ A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance<br>☑ Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection<br>☑ An in-country internal review board (IRB) exists and reviews all protocols. | 13.9 Score: 0.95 | Medical Research Council of Zimbabwe (MRCZ) , Research Council of Zimbabwe and ZimStat | |
| | | **Epidemiological and Health Data Score:** | **4.51** | |

| **14. Financial/Expenditure data:** Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness. | | | **Data Source** | **Notes/Comments** |
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| **14.1 Who Leads Collection of Expenditure Data:** To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data? | ○ A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years<br>○ B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions<br>○ C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with substantial external technical assistance<br>○ D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with some external technical assistance<br>◉ E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance | 14.1 Score: 3.33 | NASA and NHS undertaken annually by MOHCC and NAC | NAC leads NASA tracking, MOHCC leads Resource Mapping and NHA tracking |
| **14.2 Comprehensiveness of Expenditure Data:** To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area? | ○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years<br>◉ B. HIV/AIDS expenditure data are collected (check all that apply):<br>☑ By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others<br>☑ By expenditures per program area, such as prevention, care, treatment, health systems strengthening<br>☑ By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel<br>☑ Sub-nationally | 14.2 Score: 3.33 | NASA, Resource Mapping Report and NHA<br>NASA and NHS undertaken annually by MOHCC and NAC | Yes it is by SNU (province and district level). Better utilization of the data would be beneficial to the national program.<br>Resource mapping very detailed by various sub categories such as funding source, geography, etc |
| **14.3 Timeliness of Expenditure Data:** To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions? | ○ A. No HIV/AIDS expenditure data are collected<br>○ B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago<br>○ C. HIV/AIDS expenditure data were collected at least once in the past 3 years<br>○ D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures<br>◉ E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures | 14.3 Score: 3.33 | Resource Mapping Report<br>NASA and NHS undertaken annually by MOHCC and NAC | Collected annually to inform future budgeting cycles and gap analysis of costed plans |
| | | **Financial/Expenditure Data Score: 10.00** | | |

| **15. Performance data:** Government routinely collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention. | | | **Data Source** | **Notes/Comments** |
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| **15.1 Who Leads Collection of Service Delivery Data:** To what extent is the routine collection of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government? | ○A. No system exists for routine collection of HIV/AIDS service delivery data<br>○B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions<br>○C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution<br>◉D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution<br>○E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government | 15.1 Score: 1.00 | National AIDS Reporting Form (every implementor fills and submits monthly and compiled quarterly by NAC), DHIS for MOHCC | DHIS for MOHCC with TA from PEPFAR through RTI |
| **15.2 Who Finances Collection of Service Delivery Data:** To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)?<br><br>(if exact or approximate percentage known, please note in Comments column) | ○A. No routine collection of HIV/AIDS service delivery data exists<br>○B. No financing (0%) is provided by the host country government<br>○C. Minimal financing (approx. 1-9%) is provided by the host country government<br>◉D. Some financing (approx. 10-49%) is provided by the host country government<br>○E. Most financing (approx. 50-89%) is provided by the host country government<br>○F. All or almost all financing (90% +) is provided by the host country government | 15.2 Score: 1.67 | NASA | MOHCC provides salaries for health workers who do primary data collection and reporting at service delivery points.<br><br>GF provides significant resources.<br><br>DHIS2 TA is provided by PEPFAR |

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| **15.3 Comprehensiveness of Service Delivery Data:** To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.) | Check ALL boxes that apply below:<br>☑ A. The host country government routinely collects & reports service delivery data for:<br>☑ HIV Testing<br>☑ PMTCT<br>☑ Adult Care and Support<br>☑ Adult Treatment<br>☑ Pediatric Care and Support<br>☑ Orphans and Vulnerable Children<br>☑ Voluntary Medical Male Circumcision<br>☑ HIV Prevention<br>☐ AIDS-related mortality<br>☑ B. Service delivery data are being collected:<br>☐ By key population (FSW, PWID, MSM, TG, prisoners)<br>☐ By priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users)<br>☑ By age & sex<br>☑ From all facility sites (public, private, faith-based, etc.)<br>☑ From all community sites (public, private, faith-based, etc.) | 15.3 Score: 1.22 | National AIDS Reporting Form (every implementor fills and submits monthly and compiled quarterly by NAC), DHIS for MOHCC | For some of KP (CSW), some data is being collected. |

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| **15.4 Timeliness of Service Delivery Data:** To what extent are HIV/AIDS service delivery data collected in a timely way to inform analysis of program performance? | ○ A. The host country government does not routinely collect/report HIV/AIDS service delivery data<br>○ B. The host country government collects & reports service delivery data annually<br>○ C. The host country government collects & reports service delivery data semi-annually<br>◉ D. The host country government collects & reports service delivery data at least quarterly | 15.4 Score: 1.33 | National AIDS Reporting Form (every implementor fills and submits monthly and compiled quarterly by NAC), DHIS for MOHCC | Monthly reporting |
| **15.5 Analysis of Service Delivery Data:** To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)? | ○ A. The host country government does not routinely analyze service delivery data to measure program performance<br>◉ B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply):<br>☐ Continuum of care cascade for each identified priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users), including HIV testing, linkage to care, treatment, adherence and retention<br>☐ Continuum of care cascade for each relevant key population (FSW, PWID, MSM, TG, prisoners), including HIV testing, linkage to care, treatment, adherence and retention<br>☑ Results against targets<br>☑ Coverage of key treatment & prevention services (ART, PMTCT, VMMC, etc.)<br>☑ Site-specific yield for HIV testing (HTC and PMTCT)<br>☐ AIDS-related mortality rates<br>☑ Variations in performance by sub-national unit<br>☑ Creation of maps to facilitate geographic analysis | 15.5 Score: 0.83 | National AIDS Reporting Form (every implementor fills and submits monthly and compiled quarterly by NAC), DHIS for MOHCC | The key word within the question is routinely. AIDS-related mortality rates are not collected and analyzed routinely. |
| **15.6 Quality of Service Delivery Data:** To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data? | ○ A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented.<br>◉ B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply):<br>☑ A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance<br>☑ A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of key HIV program indicators, which are led and implemented by the host country government<br>☑ Standard national procedures & protocols exist for routine data quality checks at the point of data entry<br>☐ Data quality reports are published and shared with relevant ministries/government entities & partner organizations<br>☑ The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans | 15.6 Score: 1.07 | National QA/QI Strategy | |
| | | **Performance Data Score: 7.12** | | |

**THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D**