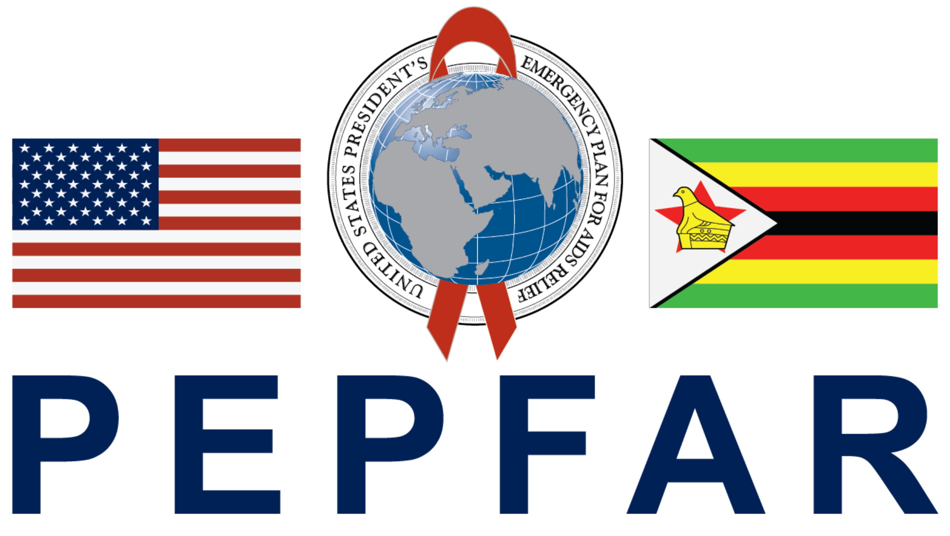
ZIMBABWE
Country Operational Plan
(COP) 2022



Strategic Direction Summary (SDS)

April 2022

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Acronym List

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

HDP	Health Development Partners
HEI	HIV Exposed Infant
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HMIS	Health Management Information System
HPV	Human Papillomavirus
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSS	Health Systems Strengthening
HTS	HIV Testing Services
INH	Isoniazid (isonicotinylhydrazide drug)
IP	Implementing Partner
IPV	Intimate Partner Violence
IPT	Isoniazid Preventive Therapy
KP	Key Population
KPIF	Key Populations Investment Fund
LMIS	Logistics Management and Information Systems
LPV/r	Lopinavir/ritonavir
LTFU	Lost to Follow-Up
M&E	Monitoring and Evaluation
M&O	Management and Operations
MC	Male Circumcision
MCH	Maternal and Child Health
MMD	Multi-Month Dispensing
MMS	Multi-Month Scripting
MoF	Ministry of Finance
MoHCC	Ministry of Health and Child Care
MSM	Men who have Sex with Men
MSP	Male Sexual Partners
NAC	National AIDS Council
NATF	National AIDS Trust Fund
NCD	Non-Communicable Disease
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PITC	Provider-initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
POART	PEPFAR Oversight and Accountability Response Team
POC	Point of Care
PrEP	Pre-Exposure Prophylaxis
PWD	People who use Drugs
QA/QI	Quality Assurance/Quality Improvement
RITA	Recent Infection Testing Algorithm
RM	Responsibility Matrix

RTK	Rapid Test Kit
RTRI	Rapid Test for Recent Infection
SCMS	Supply Chain Management System
SDS	Strategic Direction Summary
SI	Strategic Information
SID	Sustainability Index and Dashboard
SIMS	Site Improvement through Monitoring System
SMS	Short Message Service
SNU	Sub National Unit
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
SW	Sex Workers
TA	Technical Assistance
TAT	Technical Assistance for Treatment
TAT	Turn Around Time (Laboratory)
TB	Tuberculosis
TBD	To Be Determined
TG	Transgender
TLD	Tenofovir Lamivudine Dolutegravir
TLE	Tenofovir Lamivudine Efavirenz
TPT	TB Preventive Therapy
TSC	Technical Support Committee
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USG	U.S. Government
VACS	Violence Against Children Survey
VCT	Voluntary Counseling and Testing
VHWs	Village Healthcare Workers
VL	Viral Load
VLC	Viral Load Coverage
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
YAZ	Young Adult Survey of Zimbabwe
YWSS	Young Women Selling Sex
ZDHS	Zimbabwe Demographic and Health Survey
ZIMPHIA	Zimbabwe Population-Based HIV Impact Assessment

1.0 Vision and Goal Statement

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Zimbabwe interagency team collaborated with key partners including the Government of Zimbabwe (GoZ), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), civil society organizations (CSOs), and other bilateral and multilateral health development partners to develop the 2022 Country Operational Plan (COP 2022) for FY 2023. The national ART program and other critical HIV service delivery and prevention programs in Zimbabwe are implemented under the leadership of the Ministry of Health and Child Care (MoHCC), the National AIDS Council, the Ministry of Primary and Secondary Education (MoPSE) and the Ministry of Labor and Social Welfare (MoLSW).

COP 2022 aims to advance person-centered services and implement resilient programs designed to mitigate the impacts of COVID-19 and other external structural and economic factors on the PEPFAR program. Zimbabwe continues to be challenged with socio-economic issues, fuel shortages, load-shedding, health worker brain drain, and a fragile health care system. Further, national elections are expected in 2023 and these elections could further disrupt implementation of health programs.

ZIMPHIA 2020 found that 86.8 percent of adults living with HIV were aware of their status and of those aware of their status, 97.0 percent were on antiretroviral treatment. Among those on treatment, 90.3 percent achieved viral load suppression. These exciting results demonstrate that Zimbabwe has achieved the second and third 90s nationally. Subsequently, PEPFAR must continue to evolve to realign PEPFAR-supported resources with the current epidemic and overall country context. The graphic below outlines PEPFAR Zimbabwe's vision and strategic direction for COP 2022.

COP 2022 Vision and Strategic Direction

Advance person-centered services

Engage communities

Implement resilient adaptive approaches

Support capacity for sustainable epidemic control

Evolve to sustain epidemic control
Strengthening collaborations, sustainability roadmap, HRH

Sustain programmatic gains
High impact prevention, targeted testing, linkage for HIV+ and HIV-, VLS, retention

Integrate programming
Maximize entry points for treatment & prevention, GBV prevention & response, cervical cancer, DSD approaches

Treatment targets are set to achieve and maintain 95% ART coverage within all districts and across all age and sex bands by the end of FY 2023. PEPFAR Zimbabwe will invest in the delivery of a comprehensive package of HIV treatment and prevention activities within 44 of

Zimbabwe's 63 districts. To ensure equitable gains towards achieving sustainable epidemic control across Zimbabwe, the PEPFAR program will continue providing above-site technical assistance to monitor the HIV response in the remaining 19 centrally supported districts. With over 1.19 million Zimbabweans currently on ART, the PEPFAR program must increase access to viral load monitoring, while strengthening and expanding efforts to improve retention and viral suppression, particularly among key and priority populations. The infographic below outlines the full range of PEPFAR Zimbabwe's technical priorities for COP 2022.

COP 2022 Technical Priorities

Prevention Services

- VMMC 15+ years
- Increase provision of secondary services & measuring individual level completion
- Scale up PrEP
- Comprehensive KP services
- Strengthen OVC/Clinical services collaboration and alignment

Clinical Care

- Increase viral load coverage to 85%
- Pediatric case finding surge
- Treatment continuity services closer to communities, DSD
- Targeted case finding
- Complete TLD transition

Reduce Mortality

- TPT surge, scale up 3HP, 3HR
- Advanced HIV disease management, mental health management
- Catch up on cervical cancer screening services- LEEP camps
- Optimized TB screening using TUTT

Systems Strengthening

- Collaboration with GF
- Scale up EHR coverage
- Community led monitoring
- Strengthen supply chain management

PEPFAR investments in human resources for health (HRH) have been essential in securing a more stable health care cadre in Zimbabwe. While HRH and health infrastructure are primarily funded by the MoHCC, PEPFAR has successfully leveraged and supplements this capacity with key commodities, site-level mentoring, and additional HRH support for HIV clinical services. In 2021, PEPFAR Zimbabwe successfully completed the HRH inventory – a tracking tool to better understand PEPFAR's HRH investments at a granular level. As of September 30, 2021, PEPFAR Zimbabwe was supporting 19,202 healthcare workers including nurses, laboratory scientists, and community health workers with salaries, stipends, or other forms of non-monetary support (e.g., airtime, transport). Further, PEPFAR Zimbabwe supports secondments of senior-level technical experts to the MoHCC. These are Government of Zimbabwe employees within the MoHCC's AIDS and TB Program whose salaries are supported by PEPFAR implementing partners. HRH support totaled $58 million in FY 2021, 25% of that fiscal year's budget.

Why is PEPFAR-supported HRH so important?

- **Salary devaluation with rising costs** have made it difficult for HCWs to work
  - Rising prices and cost of living
- HCW unions continue negotiations and discussions with GoZ about salaries
- Threat of industrial action (HCW strike or "go-slow") is always looming
- Continuing **brain drain** as nurses and doctors leave for other countries
- **Irregular staffing patterns** among HCWs (not donor-supported) and clinic closures mean heavier burden on PEPFAR HRH
  - Led to increasing dependence on PEPFAR-supported HRH
  - COVID-19 lock-downs meant frequent facility closures
- **Irregular HIV services** (and documentation of services)
  - HTS availability
  - Flexible clinic hours (e.g., for adolescents and men)
  - Documentation issues in short-staffed clinics

Zimbabwe clinics struggle for nurses after exodus to the UK

Health clinics in Zimbabwe are facing a crisis as increasing numbers of nurses leave the country in search of better prospects, as the BBC's Shingai Nyoka writes.

Source: https://www.bbc.com/news/world-africa-60524576, March 9, 2022

Current National HRH Situation: High attrition of Clinical Staff Continues

Renewed exodus of healthcare workers hits Zimbabwe

Zimbabwe's brain drain in public health sector fueled by rising demand of health professionals in countries whose many medical workers succumbed to COVID-19

Jeffrey Moyo | 22.02.2022

Source: https://www.aa.com.tr/en/africa/renewed-exodus-of-healthcare-workers-hits-zimbabwe/2510150, February 22, 2022

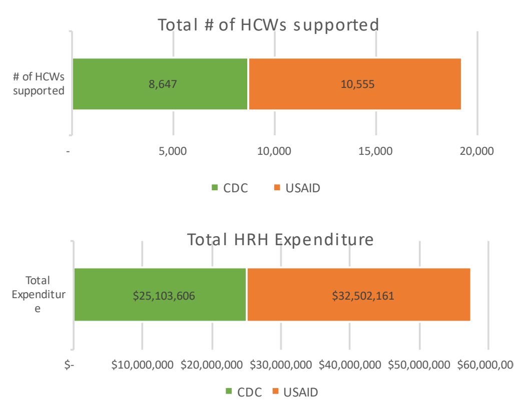
MOHCC HRH Taskforce Rapid Assessment:
Attrition among nurses and medical officers from the public health system over the last 3 years

	Nurses	Medical Officers
2019	385	55
2020	576	47
Jan – Jul 2021	1,176	57

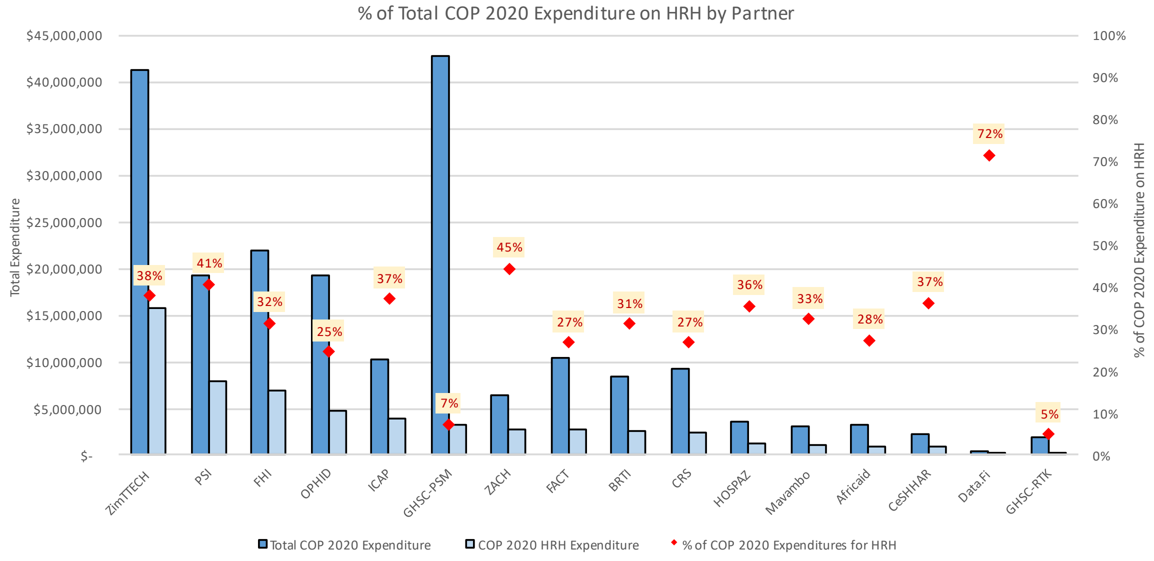
- Higher than ever staff attrition fueled by the rising demand for health professionals in other countries due to COVID-19
- PEPFAR-supported programs work with and through MOHCC structures
  - Therefore, extremely sensitive to changes in the MOHCC landscape
  - Increasing burden on PEPFAR-supported HRH
- HIV program has continued to grow – adding more complex and time-consuming interventions (e.g., index testing, VIAC) but there hasn't been a commensurate improvement in HRH capacity particularly with continuous brain drain.

Total FY21 HRH expenditures when partner program management and operations expenditures removed: $57.6 million

Primary Program Area	# of HCWs supported	% of Total HCWs supported	Total Expenditure	% of Total Expenditure
Site Level: Care and Treatment (C&T)	10,792	56.2%	$ 17,188,448	29.8%
Above Site: HMIS, surveillance, & research	224	1.2%	$ 6,245,075	10.8%
Above Site: Not Disaggregated	480	2.5%	$ 5,145,836	8.9%
Site Level: Socio economic (SE)	3,842	20.0%	$ 4,682,431	8.1%
Above Site: Procurement & supply chain management	129	0.7%	$ 4,090,765	7.1%
Above Site: Human resources for health	188	1.0%	$ 3,786,716	6.6%
Site Level: Prevention (PREV) Other	2,415	12.6%	$ 3,367,579	5.8%
Site Level: Prevention (PREV) VMMC	245	1.3%	$ 3,075,824	5.3%
Above Site: Policy, planning, coordination & management of disease control programs	41	0.2%	$ 2,933,342	5.1%
Above Site: Laboratory systems strengthening	170	0.9%	$ 2,300,535	4.0%
Site Level: Testing (HTS)	416	2.2%	$ 2,250,609	3.9%
Site Level: Prevention (PREV) PrEP	197	1.0%	$ 1,273,453	2.2%
Above Site: Public financial management strengthening	62	0.3%	$ 1,248,004	2.2%
Above Site: Laws, regulations & policy environment	1	0.0%	$ 17,149	0.0%
Grand Total	19,202	100.0%	$57,605,767	100.0%



Roughly 28% of COP 2020 (FY21) Partner Expenditures were for HRH

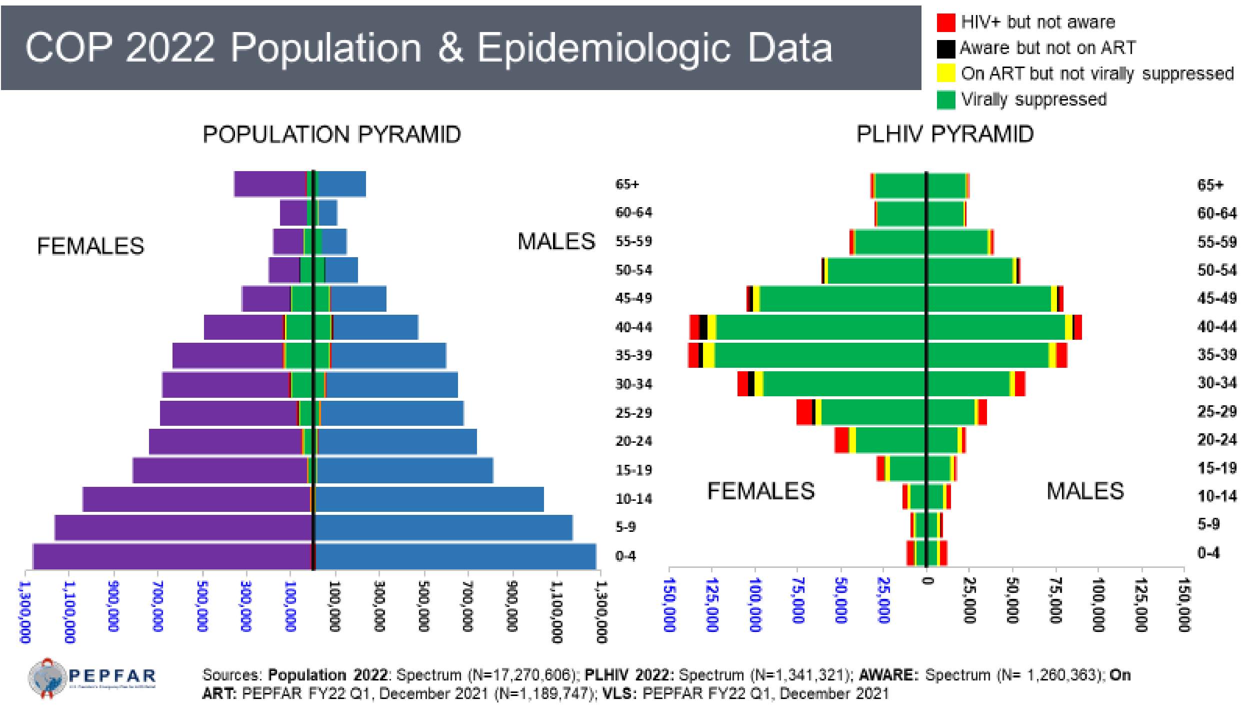


Lastly, PEPFAR Zimbabwe continues to work closely with the GFATM''s Country Coordinating Mechanism (CCM) to ensure the alignment of programming as GFATM's current funding cycle (2021-2023). PEPFAR, and the USG more broadly, continues to collaborate with the CCM to harmonize investments in COVID-19 mitigation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

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

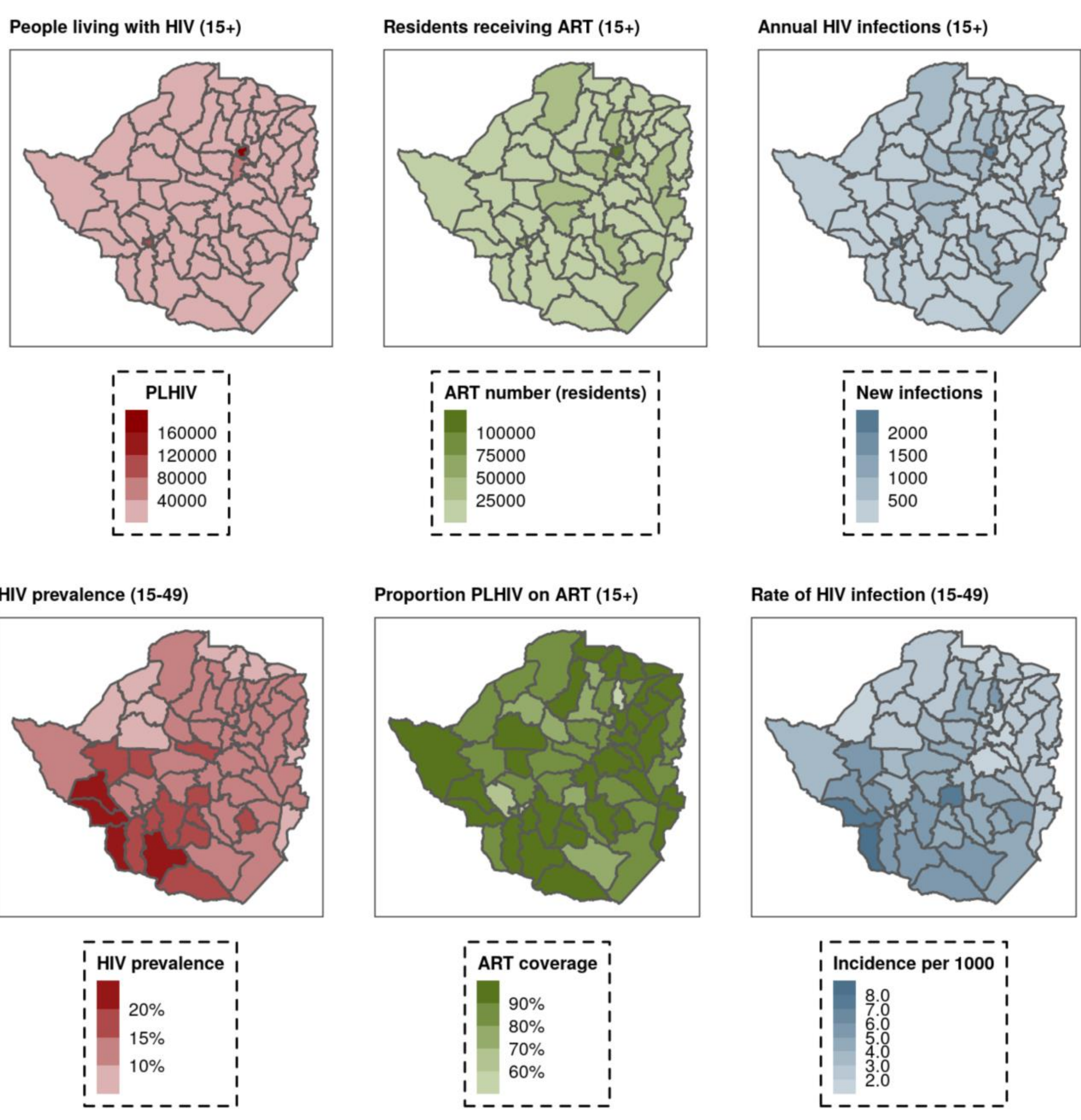
Zimbabwe has a generalized HIV epidemic and is home to 1.34 million people living with HIV (PLHIV), including 1.28 million adults and 65,694 (4.9%) children aged 0-14 years. Among adults 15+ years living with HIV, 61% were females. Annual all-cause deaths among PLHIV have declined over the past decade from 135,198 in 2003 to 26,305 in 2021. Total annual new HIV infections declined nationally from a high of 233,861 in 1991 to 22,822 in 2021.



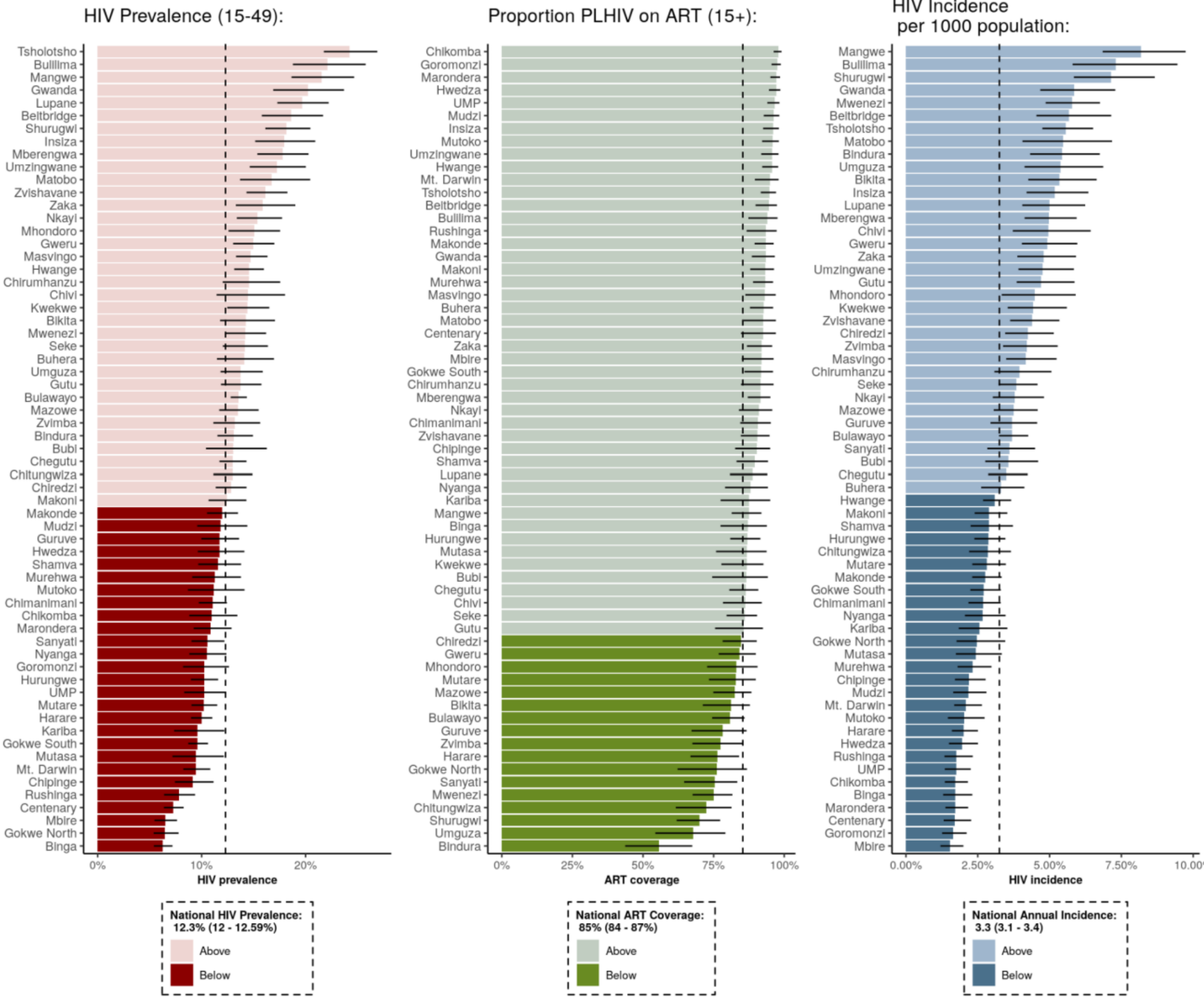
The 2020 ZIMPHIA showed that overall HIV prevalence for adults aged 15-49 was 11.8% in 2020, down from 18.1% in 2005 in the Zimbabwe Demographic and Health Survey (ZDHS). Among persons aged 15 to 64 years, HIV prevalence in the 2020 ZIMPHIA varied geographically, with higher prevalence in the provinces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

In terms of viral load suppression (VLS), the ZIMPHIA 2020 showed that among adults living with HIV (ages 15 years and older) in Zimbabwe, VLS ranged from 66.2% among women aged 15-24 years to 90.3% among women aged 45-54 years, and from 49.2% among men aged 15-24 years to 91.7% among men aged 65 years and older. VLS was higher among women than men at ages 25-34 years, with 70.7% of women and 52.4% of men achieving VLS. Among both sexes, there was a substantial increase in VLS among men and women aged 35-44 years

compared to those aged 15-24 years and aged 25-34 years. There was also a marked increase in VLS among women aged 45-54 years compared to women aged 35-44 years. Zimbabwe has now met the second and third 90-90-90 targets and has achieved the overall target for 2020 by exceeding 73% of VLS among all adults living with HIV. The graphics below from UNAIDS Spectrum 2021 show the geographic variability in adult PLHIV, HIV prevalence, PLHIV receiving ART, ART coverage, annual new HIV infections, and rate of new HIV infections. District-level trends in adult HIV prevalence, ART coverage, and HIV incidence are included on the subsequent page.



District-level HIV trends



Standard Table 2.1.1: Host Country Epidemiological Data Profile

Table 2.1.1 Host Country Epidemiological Data Profile															
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	16,959,211	100%	3,421,042	20%	3,439,784	20%	1,537,435	9%	1,532,223	9%	3,651,370	22%	3,377,357	20%	UNAIDS Spectrum, 2021
HIV Prevalence (%)		9%		1%		1%		5%		3%		19%		15%	UNAIDS Spectrum, 2021
AIDS Deaths (per year)	19,581		1,222		1,241		1,102		924		7,858		7,234		UNAIDS Spectrum, 2021
# PLHIV	1,341,321	100%	32,666	2.5%	33,028	2.5%	75,746	6%	37,644	3%	702,052	52%	460,185	34%	UNAIDS Spectrum, 2021
New Infections (Yr.)	23,908	100%	1,698	7%	1,730	7%	5,923	25%	1,775	7%	7,060	30%	5,722	24%	UNAIDS Spectrum, 2021
Annual births	537,283														UNAIDS Spectrum, 2021
% of Pregnant Women with at least one ANC visit		93%													ZDHS, 2015
Pregnant women needing ARVs	51,449														UNAIDS Spectrum, 2021
Orphans (maternal, paternal, double)	168,497														UNAIDS Spectrum, 2021
Notified TB cases (Yr.)	21,008		6% (all <15 years)				94% (all 15+ years)								WHO, 2018 TB Profile
% of TB cases that are HIV infected		60%													WHO, 2019 TB Profile
% of Males Circumcised		31%					14% (all ages 15-59)								ZIMPHIA, 2016
Estimated Population Size of MSM*	23,000	100%													UNAIDS KP, 2021
MSM HIV Prevalence		31%													UNAIDS KP Est, 2021
Estimated Population Size of FSW	45,000	100%													UNAIDS KP Est 2021
FSW HIV Prevalence		54%													UNAIDS KP Est, 2021

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

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression										
	Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year (PEPFAR FY21 MER Data)		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV Diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	16,959,211	9%	1,341,321	1,265d,659	1,197,261	89%	94%	1,251,181	71,973	68,078
Population <15 years	6,860,825	1%	65,794	54,320	52,085	74%	82%	75,038	2,448	2,547
Men 15-24 years	1,532,223	3%	37,644	34,878	32,256	84%	84%	123,091	2,291	2,069
Men 25+ years	3,377,357	14%	460,185	433,052	391,914	85%	95%	195,259	23,087	22,039
Women 15-24 years	1,537,435	5%	75,746	72,096	71,630	91%	89%	397,415	13,782	12,519
Women 25+ years	3,651,370	19%	702,052	673,311	635,250	91%	96%	460,280	30,360	28,900
MSM	23,326 (Harare + Bulawayo only) *	17.1% Harare 23.3% Bulawayo *	4,397	1,790 *	1,917	91.7% Harare 94.7% Bulawayo *	81.8% Harare 78.9% Bulawayo *	7,925	1,068	1,001
FSW	45,000 #	54% ^	24,300 ^	18,954 +	16,281 +	67% +	73% +	29,296	4,269	3,182

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

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment

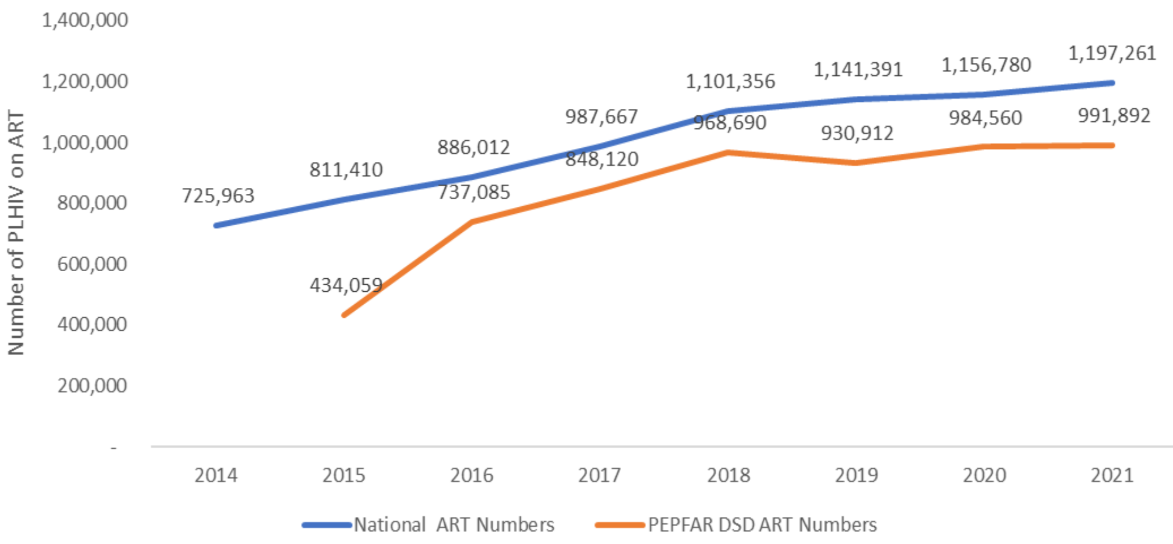


Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV

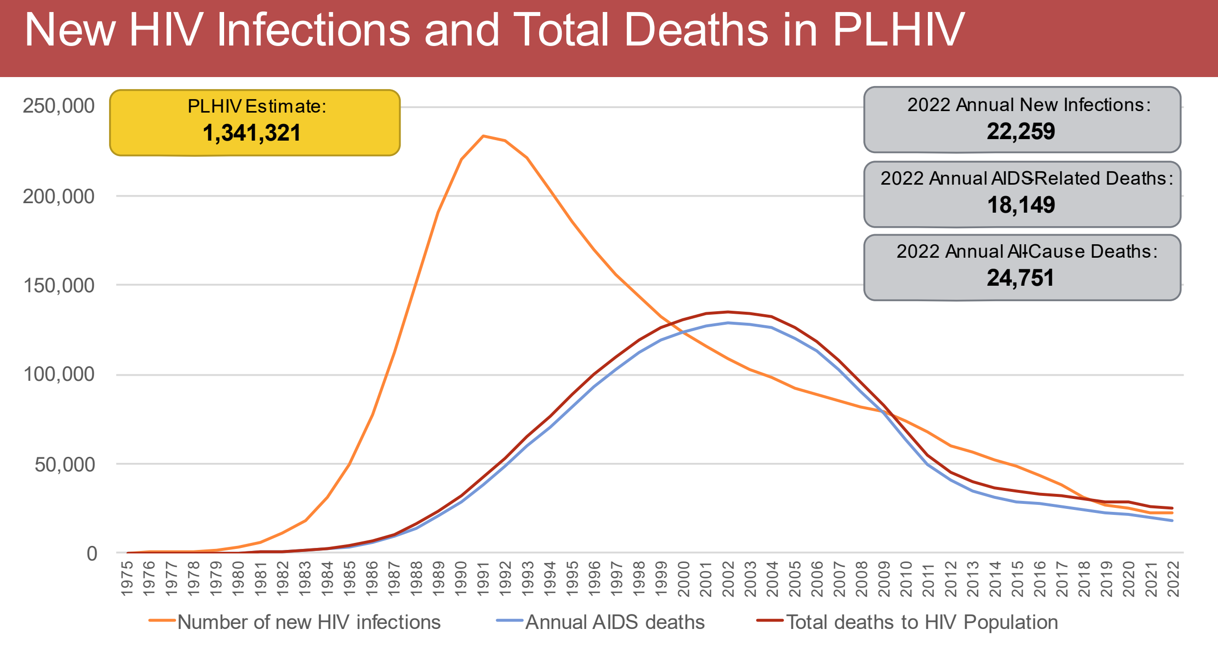


Figure 2.1.5 Assessment of ART program growth in FY21

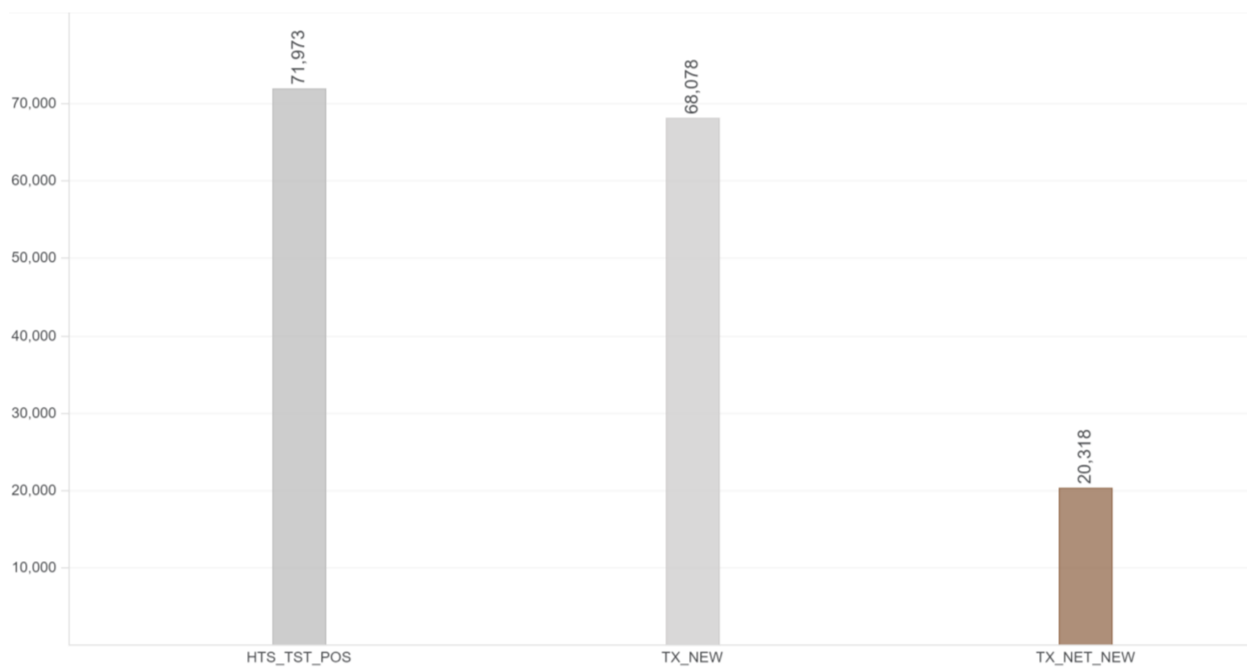


Figure 2.1.6 Clients Gained/Lost from ART by Age/Sex, FY21 Q4

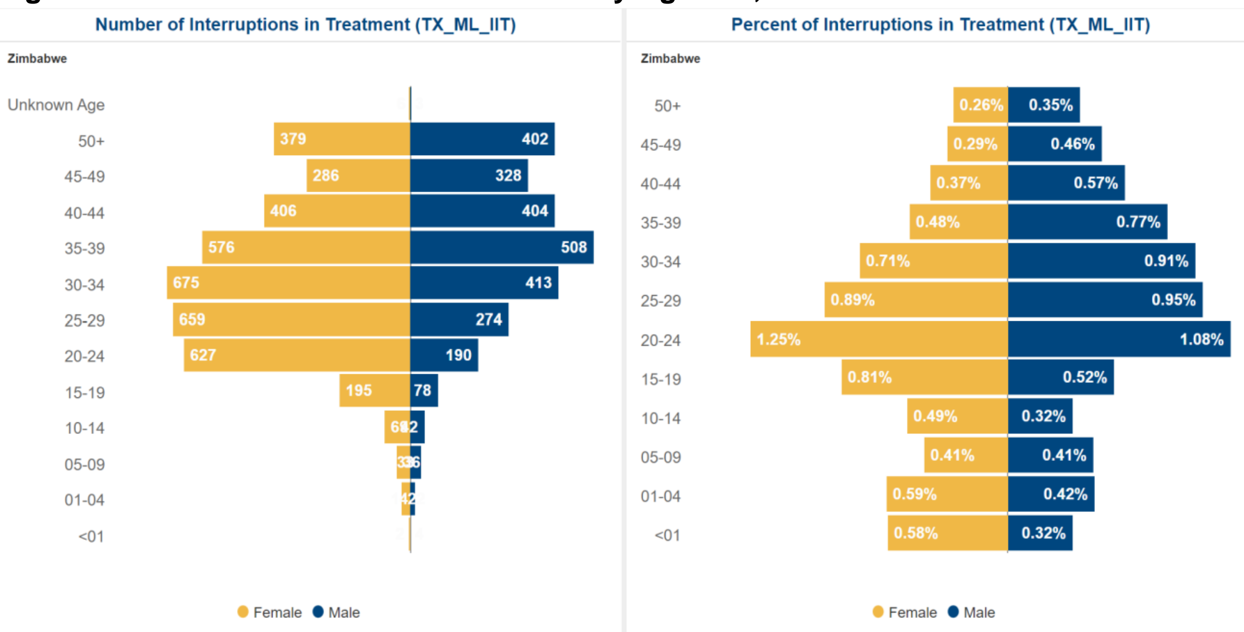


Figure 2.1.7 Epidemiologic Trends and Program Response for your Country (Figure 2.1.1.23 in COP 22 Guidance)

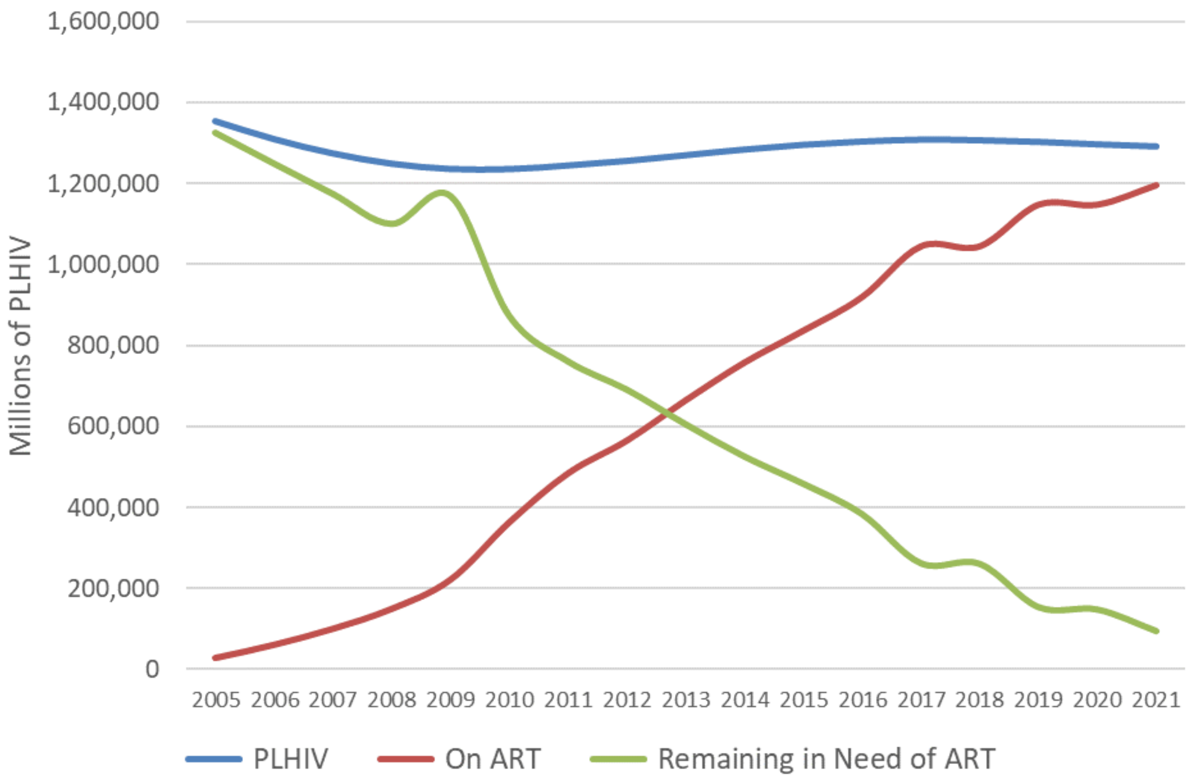
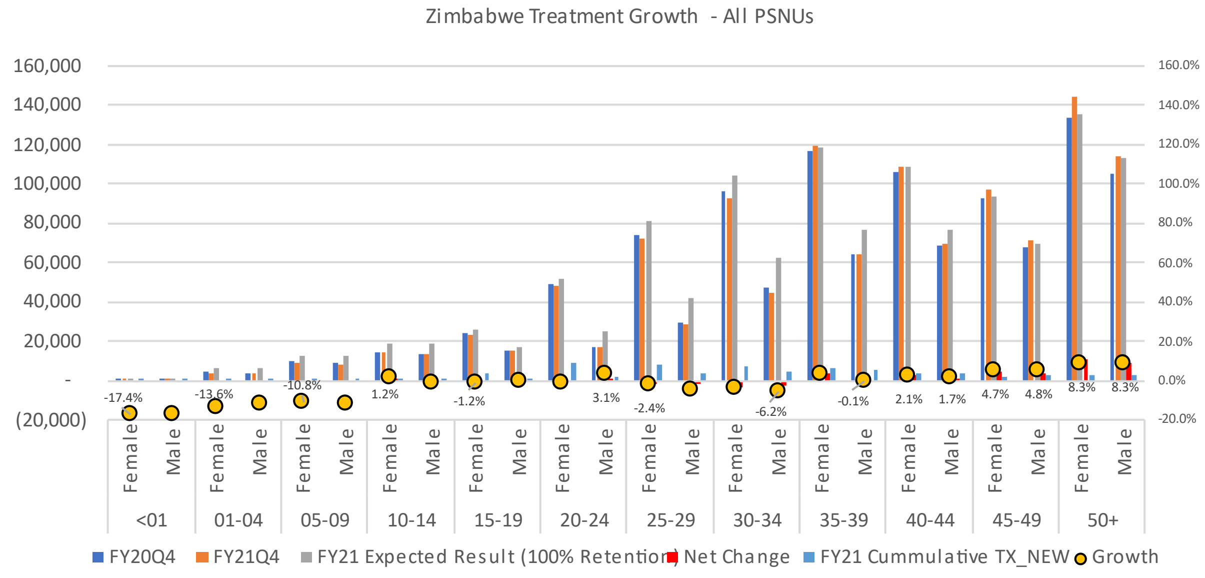


Figure 2.1.8 Net change in HIV treatment by sex and age bands 2020 Q4 to 2021 Q4



2.2 New Activities and Areas of Focus for COP 22, Including Client ART Continuity

New or modified activities and areas for focus are included throughout each section below. A few key and emerging areas of focus for COP 22 are summarized below:

Improving Viral Load Access and Coverage: In COP 22, the MoHCC and PEPFAR Zimbabwe agreed on a national viral load coverage (VLC) target of 85%. This decision was largely driven by continued gaps in funding and system optimization, which, while improving year over year, are not yet at a place to support higher levels of testing demand. These gaps within the national laboratory systems to support 100% VLC are compounded by perennial reagent stockouts, therefore multi-year testing targets for FY 2022 (80% VLC) and FY 2023 (85% VLC) were agreed on by stakeholders, with the goal of working towards 100% VLC in future years.

Pediatric ART surge: Zimbabwe has made significant progress towards the achievement of the 95-95-95 goals. However, the pediatric population significantly lags, when compared to adults. In COP 22, PEPFAR will support implementation of a 'pediatric surge' to accelerate progress towards closing the gap between adults and children. The focus of the surge will be on HIV case finding and linkage to ART for biological children of parents on ART. Guided by the available resources, the surge will be implemented in districts contributing 40% of the 1st and 2nd 95 gap. Surge strategies:

- Index testing for biological children of parents on treatment, to achieve 100% coverage
- Continuing use of HIV risk-based screening tool to reduce NNT
- Oral screening using HIVST kits (pending MOHCC approval) in cases where children can not immediately come to the health facility for testing
- Integration of pediatric HIV case finding, linkage and retention with EPI services, OVC services
- Monthly data collection and reporting
- Monthly interagency support, supervision, and meeting
- Collaboration with OVC

The pediatric surge will be implemented over and above the existing pediatric ART COP 22 core strategies across the cascade.

Further expansion of DSD models to improve ART continuity: PEPFAR will fully support the implementation of person-centered interventions including all the DSD models approved by the MoHCC as indicated in the MoHCC's Operations and Service Delivery (OSDM) Manual for HIV Care and Treatment with the aim of having at least 80% of eligible clients in a suitable DSD model of their choice by December 2023.

Inclusion of viral load to implement the complete recent infection testing algorithm (RITA): Zimbabwe will be pairing Rapid Test for Recency Infection (RTRI) and VL to implement the complete RITA in COP 2022. The implementation of RITA contributes to the program's precision public health approach.

Expansion of Community Led Monitoring (CLM) and greater inclusion of KP in CLM: In COP 22, we will strengthen the reach of CLM to key population communities by identifying eight additional KP-led/KP-serving organizations to support CLM implementation. These organizations are expected to cover at least 80% of the PEPFAR-supported facilities that are

actively programming and serving various key population groups. This expansion is also expected to increase the overall CLM program coverage from the current 22 districts to at least 30 districts. In COP 22, PEPFAR will continue working with the Key Populations Technical Support Committee (TSC) in strengthening the capacity of other non-KP CLM CBOs, thereby ensuring that all organizations involved in the CLM program are competent to work with and serve key populations.

Although the overall country allocation was flatlined in COP 22, we continue to recognize the priority of CLM. The CLM budget has been increased by $130,000 for a total investment of $1,189,262. We also commit to ensuring we identify equities in the budget allocations for the CLM coordination piece, as well as equities with respect to each CBO as informed by their respective program design and implementation contexts.

The HTS strategy is intentionally designed to work closely with the CLM teams to receive independent feedback on the quality of HTS delivered, how the HTS service providers can best package modalities to nimbly, appropriately, and proactively respond to the end-user inspired CLM feedback at scale.

Supporting integration of stigma and discrimination training and expanding community-centered KP programming: COP 22 priorities include supporting integration of stigma and discrimination training into preservice training for nurses, rolling out Gender and Sexuality Diversity (GSD) and LIVES (Listen, Inquire, Validate, Enhance safety, and Support) training for all KP and DREAMS IPs, supporting KP participation and leadership in health facility committees and other CLM efforts, expanding activities and targets for GBV response and prevention, expanding KP specific services linked to health outcomes (e.g., socioeconomic empowerment for Young Women Selling Sex (YWSS) in DREAMS, Gender Affirming Hormonal Therapy (GAHT) pilot), capacity strengthening of KP CSOs and expanding community-centered KP programming.

In COP 22 USAID will leverage the KP platform and explore the feasibility of a small pilot to integrate GAHT with non-PEPFAR funding.

PEPFAR will focus on rolling out an integrated One Stop Model for KP sexual minorities within existing One Stop Models.

OVC expansion and transition: The PEPFAR OVC program will expand into nine PEPFAR districts and transition out of five current districts in COP 22 for improved collaboration with the PEPFAR clinical program, thereby addressing gaps in treatment and care of children and adolescents living with HIV (C/ALHIV). In addition, the OVC caseload will be rationalized to enroll more C/ALHIV in the program. The OVC program will continue with intensified case management for priority OVC sub-populations, including C/ALHIV, strengthening the OVC clinical collaboration as well as linkages with other programs for improved outcomes for program enrollees. The program will continue to prioritize index testing for biological children of parents living with HIV as well as biological siblings of pediatric and adolescent index cases and link those who test HIV seropositive to treatment.

2.3 Investment Profile

According to the UNICEF 2021 Health Budget Brief, public health funding significantly increased and accounted for 13% of the 2021 national budget. This level of funding still falls below the

Abuja requirement of 15% and the actual amounts disbursed often fall below the budgeted levels. A further analysis of the funding allocations shows that recurrent costs account for 83% of the budget allocation while 17% will contribute to capital projects. This is in concordance with the 2020 Resource Mapping Report that shows that domestic funding is mostly channeled towards health systems strengthening while external funding is heavily skewed towards commodities and supply chain costs. Despite support from Zimbabwe's health development partners, the consolidated total funding still falls short of projected requirements to fully implement the National Health Strategy. A gap was noted in the 2020 Resource Mapping report where data from private sector, health insurance companies, households and mission facilities were not captured. This remains a huge potential area for domestic contribution to health expenditures.

Declining economic conditions and fiscal space have exacerbated the difficulties in mobilizing domestic resources for health, a plight that has been exaggerated further by the COVID-19 pandemic. The economic viability of enterprises and ventures declined due to lengthy shutdowns and other production factors. In proportional terms, the UNICEF Health Brief notes that as a share of total health sector funding, domestic resources accounted for 58% of health sector financing, up from 30% in 2020. The GoZ has an AIDS levy that collects millions of dollars each year to procure ARVs and to support other activities. However, the actual value of these funds has declined as inflation has risen, worsened by scarcity of foreign currency, and it is unclear how much the levy is currently contributing to the HIV/AIDS response.

Standard Table 2.3.1 Annual Investment Profile by Program Area

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Care and Treatment	$206,539,357	13%	42%	45%	0%	
HIV Care and Clinical Services	$155,575,484	0%	56%	44%	0%	
Laboratory Services incl. Treatment Monitoring	$10,901,949	0%	2%	98%	0%	
Care and Treatment (Not Disaggregated)	$40,061,924	66%	0%	34%	0%	
HIV Testing Services	$15,820,515	2%	43%	55%	0%	
Facility-Based Testing	$8,492,558	0%	72%	28%	0%	
Community-Based Testing	$623,764	0%	0%	100%	0%	
HIV Testing Services (Not Disaggregated)	$6,704,193	5%	11%	84%	0%	
Prevention	$48,792,537	16%	7%	77%	0%	
Community mobilization, behavior and norms change	$11,199,122	67%	10%	23%	0%	
Voluntary Medical Male Circumcision	$14,440,740	0%	1%	99%	0%	
Pre-Exposure Prophylaxis	$5,362,243	0%	0%	100%	0%	
Condom and Lubricant Programming	$4,183,085	2%	1%	98%	0%	
Opioid Substitution Therapy	$0					
Primary Prevention of HIV & Sexual Violence	$8,299,882	0%	4%	96%	0%	
Prevention (Not Disaggregated)	$5,307,464	3%	35%	62%	0%	
Socio-economic (incl. OVC)	$32,795,742	0%	10%	90%	0%	
Case Management	$5,059,678	0%	0%	100%	0%	
Economic Strengthening	$11,522,946	0%	0%	100%	0%	
Education Assistance	$8,017,889	0%	0%	100%	0%	
Psychosocial Support	$1,047,535	0%	0%	100%	0%	
Legal, Human Rights, and Protection	$1,533,489	0%	0%	100%	0%	
Socio-economic (Not Disaggregated)	$5,614,205	0%	59%	41%	0%	
Above Site Programs	$71,644,538	19%	63%	18%	0%	
HRH Systems	$34,236,158	0%	94%	6%	0%	
Institutional Prevention	$0					
Procurement and Supply Chain Management	$5,299,097	0%	57%	43%	0%	
Health Mgmt Info Systems, Surveillance, and Research	$12,434,904	9%	59%	32%	0%	
Laboratory Systems Strengthening	$2,528,330	0%	62%	38%	0%	
Public Financial Management Strengthening	$0					
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$4,292,672	0%	20%	80%	0%	
Laws, Regulations and Policy Environment	$0					
Above Site Programs (Not Disaggregated)	$12,853,377	98%	0%	2%	0%	
Program Management	$40,983,625	0%	40%	60%	0%	
Implementation Level	$40,983,625	0%	40%	60%	0%	
Total (incl. Commodities)	**$416,576,313**	**12%**	**39%**	**49%**	**0%**	
Commodities Only	**$140,135,915**	**17%**	**63%**	**20%**	**0%**	
% of Total Budget	*34%*					

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Standard Table 2.3.2 Annual Procurement Profile for Key Commodities

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Antiretroviral Drugs	$97,500,385	24%	62%	14%	0%	
Laboratory Supplies and Reagents	$16,420,114	0%	74%	26%	0%	
CD4	$0					
Viral Load	$3,776,729	0%	0%	100%	0%	
Other Laboratory Supplies and Reagents	$12,643,385	0%	97%	3%	0%	
Laboratory (Not Disaggregated)	$0					
Medicines	$2,706,822	0%	49%	51%	0%	
Essential Medicines	$1,291,110	0%	100%	0%	0%	
Tuberculosis Medicines	$711,595	0%	0%	100%	0%	
Other Medicines	$704,117	0%	6%	94%	0%	
Consumables	$5,498,307	6%	45%	49%	0%	
Condoms and Lubricants	$216,740	0%	100%	0%	0%	
Rapid Test Kits	$4,604,719	8%	49%	43%	0%	
VMMC Kits and Supplies	$676,848	0%	0%	100%	0%	
Other Consumables	$0					
Health Equipment	$674,232	0%	100%	0%	0%	
Health Equipment	$70,000	0%	100%	0%	0%	
Service and Maintenance	$604,232	0%	100%	0%	0%	
PSM Costs	$17,336,055	0%	64%	36%	0%	
Total Commodities Only	**$140,135,915**	**17%**	**63%**	**20%**	**0%**	

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

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

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	$3,000,000	N/A	N/A	N/A	• Increase utilization of quality family planning, maternal. neonatal, and child health services • Improve nutrition and water, sanitation, and hygiene practices. • Strengthen health system to enable sustainability
USAID TB	$6,000,000	N/A	N/A	N/A	• Prevent TB transmission and renew efforts to find the missing TB cases. • Strengthen the capacity of national TB programs. • Build country capacity to use existing resources and to turn evidence into policy. • Expand the development of new TB diagnostics, drugs, and vaccines
USAID Malaria	$14,000,000	N/A	N/A	N/A	• Reduce malaria-related mortality by 70%
USAID Family Planning	$2,000,000	N/A	N/A	N/A	• Increase access to modern family planning information and contraceptives to improve maternal and child health outcomes.
USAID COVID-19 American Rescue Plan Act (ARPA)	$4,000,000	• IM 85143 $1,350,000 • IM 70473 $2,150,000	2	$0	• Accelerate widespread and equitable access to and delivery of safe and effective COVID-19 vaccinations • Reduce morbidity and mortality from COVID-19, mitigate transmission, and strengthen health systems, including to prevent, detect, and respond to pandemic threats
USAID COVID-19 ARPA	$450,000	N/A	N/A	N/A	• Meeting urgent needs in support of public health interventions to manage COVID-19 and expanding access to diagnostics and therapeutics to detect, manage and treat COVID-19.
USAID COVID-19 ARPA	$2,000,000	• IM 18353 $2,000,000	1	N/A	• Rapid procurement of PPE for health workers, COVID-19 rapid test kits, and PCR reagents
USAID COVID-19 ARPA	$2,000,000	• IM 70473 $900,000 • IM 16082 $700,000	2	N/A	• To advance comprehensive country readiness to administer COVID-19 vaccines, including efforts to ensure uptake and access among all eligible populations, address vaccine hesitancy, and combat mis- and disinformation.
CDC COVID-19 ARPA	$912,276	• IM 82087 $286,200 • IM 70465 $626,076	2	$0	• Scale-up vaccination awareness • Community engagement and demand creation • Support for Human Resources for Health (HRH) for site and door-to-door vaccination
CDC COVID-19 ARPA	$54,000	N/A	N/A	N/A	• Improve adverse event following immunization (AEFI) surveillance
CDC COVID-19 Coronavirus Aid, Relief, and Economic Security (CARES) Act	$150,000	N/A	N/A	N/A	• Support the Zimbabwe Field Epidemiology Training Program (Zim-FETP) through continued support of field work, tuition, and training

2.4 National Sustainability Profile Update

Results from ZIMPHIA 2020 revealed Zimbabwe is on track to achieving 95-95-95 by 2030 and has made remarkable progress in the expansion of ART and viral suppression among people living with HIV. The study found that 86.8% of adults living with HIV were aware of their status and of those aware of their status, 97% were on antiretroviral treatment. Among those on treatment, 90.3% achieved viral load suppression.

Despite significant strides, the continuing COVID-19 pandemic has had a significant impact on HIV service delivery and on the supply of commodities. The Sustainability Index and Dashboard (SID) 2021 reflects many broad sustainability challenges which, in addition to the COVID-19 pandemic, include continued economic uncertainty and currency volatility, low national budget allocation to health, heavy reliance on donor funding, and significant human resource shortages that are impacting the health system.

Sustainability Analysis for Epidemic Control: Zimbabwe

Epidemic Type: Generalized
Income Level: Lower middle income
PEPFAR COP 19 Planning Level:

SUSTAINABILITY DOMAINS and ELEMENTS	2015 (SID 2.0)	2017 (SID 3.0)	2019 (SID 4.0)	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	9.33	10.00	8.57	10.00
2. Policies and Governance	7.16	7.11	5.82	6.52
3. Civil Society Engagement	6.17	6.46	3.00	6.75
4. Private Sector Engagement	2.71	5.92	5.92	6.72
5. Public Access to Information	8.00	5.00	5.67	7.00
National Health System and Service Delivery				
6. Service Delivery	7.22	6.85	6.75	5.79
7. Human Resources for Health	8.42	8.40	7.76	7.88
8. Commodity Security and Supply Chain	6.14	6.14	4.81	4.81
9. Quality Management	8.67	8.67	9.33	9.33
10. Laboratory	4.72	5.50	6.89	5.42
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	3.06	7.06	7.58	7.58
12. Technical and Allocative Efficiencies	6.70	8.56	8.56	9.00
13. Market Openness	N/A	N/A	6.88	9.38
Strategic Information				
14. Epidemiological and Health Data	3.87	4.51	5.18	6.64
15. Financial/Expenditure Data	7.08	10.00	10.00	7.50
16. Performance Data	7.34	7.12	7.56	8.00
17. Data for Decision-Making Ecosystem	N/A	N/A	5.00	6.33

Zimbabwe's 2021 Responsibility Matrix (RM) reflected continued and extensive donor funding reliance. PEPFAR and GFATM invest in significant components of the national response including financing the purchase of test kits, ARVs, and lab commodities, supporting the health workforce at both central and site levels, and contributing a significant portion of the efforts to strengthen laboratory services, supply chain, and logistics systems.

PEPFAR Zimbabwe and UNAIDS jointly engaged a diverse group of stakeholders and co-convened three days of virtual meetings to inform the SID 2021 with the aim of advancing our shared goal of sustainability. Participants engaged in completing the SID included members from MoHCC's Department of HIV/AIDS and TB, the National AIDS Council, the Ministry of Finance and Economic Development, UNDP (a PR for the GFATM), implementing partners, UN agencies, civil society, and representatives from the donor community.

Generally, Zimbabwe's SID scores improved between 2019 and 2021 in all domains except the National Health System and Service Delivery Domain where scores declined for two elements (Service Delivery and Laboratory). MoHCC representatives attributed improved scores across domains to increased political commitment from the GOZ despite diverse socio-economic and financial challenges. Others argued that score improvements had more to do with the way questions were interpreted, the weighting of scores, and focus on availability of programs rather than the more important aspects of adequacy, coverage, and quality.

COVID-19 Impact

Stakeholder discussions focused on the impact of COVID-19 on health programs, including its negative effects on the availability of human resources, service delivery and availability of services, client mobility, and supply chain disruptions. Thousands of health workers – including doctors and nurses – have contracted COVID-19 since the start of the pandemic and dozens have died, resulting in HRH challenges and temporary clinic closures.

Drug stockouts have also challenged Zimbabwe's HIV programs. The backlog of HIV viral load tests grew to more than 140,000 by June 2021 because supplies of needed testing reagents had run out and shipments did not arrive as expected. HIV services, including community

testing, voluntary medical male circumcision, laboratory services, and cervical cancer screening, slowed or halted during COVID-19 waves due to safety concerns, limited mobility of clients or commodity shortages. Most partners have successfully adapted programs and responded to various lockdown challenges with innovative outreach efforts and adoption of virtual modes of contact. However, the long-term impact of the pandemic on Zimbabwe's sustainability landscape has yet to be seen.

Sustainability Strengths

- Planning and coordination (Element 1, Score 10.00): The MoHCC has been proactive in updating policy documents and adopting new guidelines, but implementation fidelity needs improvement. The GOZ develops and implements a costed multiyear national strategy and serves as the convener of a coordinated HIV/AIDS response. Planning and coordination have significantly improved through GFATM/PEPFAR alignment, geographical streamlining of implementation areas and partner access to DHIS2 information systems.
- Quality management (Element 9, Score 9.33): This score remained constant from the 2019 SID due to evidence of MoHCC focus on quality management system. However, stakeholders pointed out that many questions in this domain focused more on availability of services rather than on service adequacy and quality data.
- Technical and allocative efficiencies (Element 12, Score 9.00): There is a demonstrated commitment among stakeholders to use relevant HIV/AIDS epidemiological, health, and economic data to inform HIV/AIDS investment decisions. MoHCC has adopted new guidance around COVID-19 in real time.
- Market Openness (Element 13, Score 9.38): Additional questions under this element improved assessment of market openness this year, but also made it difficult to compare scores with 2019. The score reflects a free and open market in Zimbabwe, however, stakeholders said there is much room for improvement in the current mix of public vs non-state actors in the HIV response.

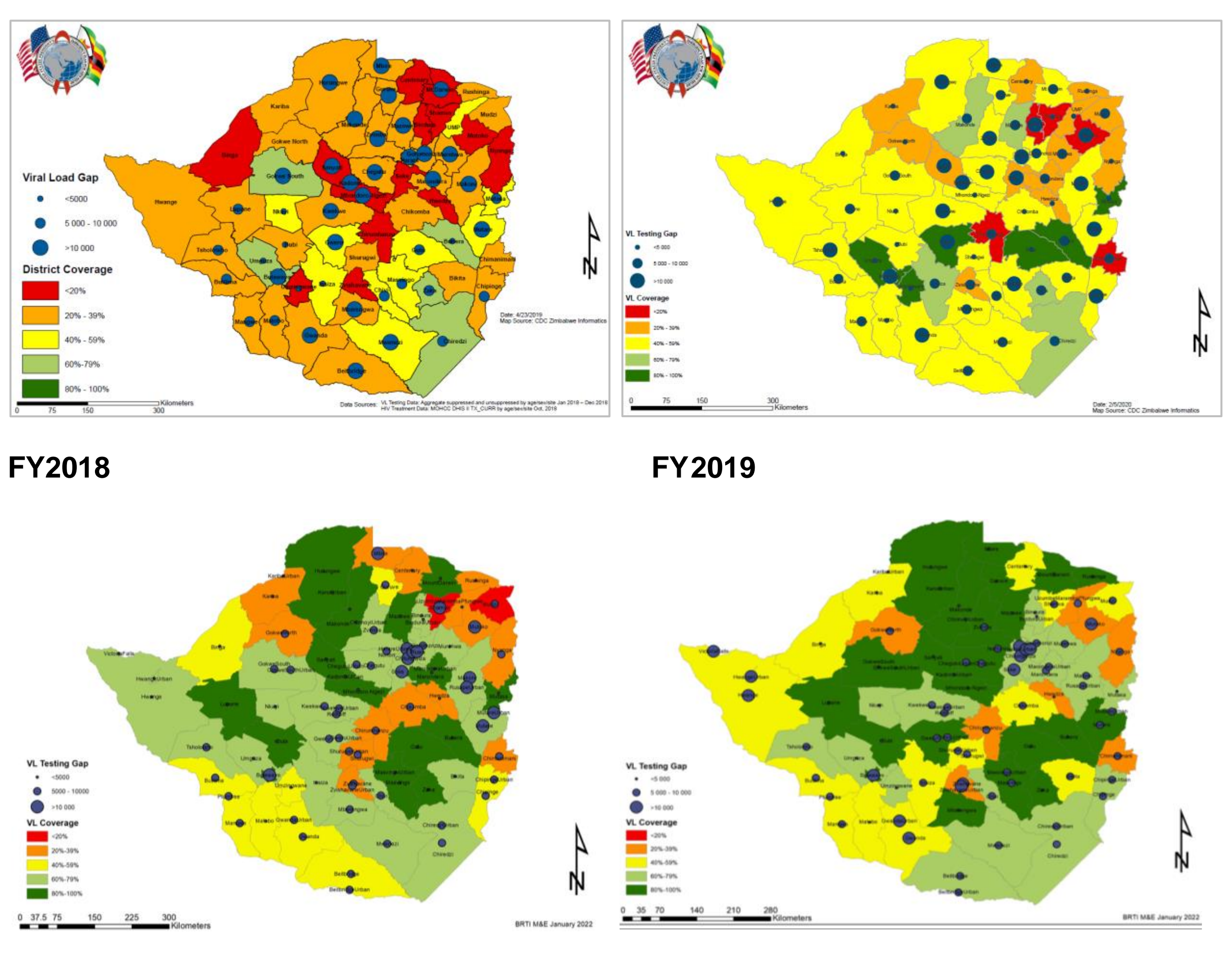
Sustainability Vulnerabilities

- Service Delivery (Element 6, Score 5.79): This element reflected a significant decline from 2019, mainly driven by the impact of COVID-19 on availability and quality of services. Increasing dependence on donor funding and technical assistance, inability to adapt to demand surges and centralized budgeting approaches have led to increased sustainability vulnerabilities. Meanwhile, partners have shown resilience in adapting programs during lockdowns and increasing community-based services options for clients.
- Commodity Security and Supply Chain (Element 8, Score 4.81): This element reflected the lowest SID score across all domains. The host government maintains an AIDS levy to procure ARVs and support program activities, however, the value of these funds is unpredictable due to inflation and decline in the purchasing power of the local currency. With minimal funding from domestic resources, Zimbabwe is heavily dependent on donor funding from PEPFAR and GFATM for supply chain and commodities. COVID-19 has played a role in delay of commodity deliveries from manufacturers, which ultimately resulted in stock outs of ARVs and viral load reagents at some facilities.
- Laboratory (Element 10, Score 5.42): Stakeholders cited the need for increased investment in laboratory support in coming years to sustain epidemic control. There is a costed national strategic plan being implemented by MoHCC and strong management and monitoring structures and systems in place. While capacity exists for viral load testing, the actual uptake of VL testing remains challenged by shortage of qualified lab personnel, dependence on donors and insufficient supply chain systems.

2.5 Alignment of PEPFAR investments geographically to disease burden

PEPFAR Zimbabwe continuously evaluates and redirects financial investments towards districts, communities, and sites with the greatest PLHIV burden and highest treatment gap (i.e., unmet need) for case-finding. Resources in high volume facilities are being prioritized for TPT scale-up, cervical cancer screening and treatment, viral load access and coverage, and treatment literacy to ensure that clients initiated on ART remain and adherent to treatment and are virally suppressed. Conversely, in districts with smaller ART gaps, testing and case-finding efforts will continue to be increasingly targeted, as resources shift towards adherence, retention, and long-term viral suppression. The figures below show how PEPFAR has worked with GOZ and GFATM to geographically focus resources in an effort to close the viral load testing gap and increase viral load coverage over time.

Figure 2.5.1 Improvements in Annual Viral Load Coverage and Testing Gap (2018-2021)



FY2018 **FY2019**

FY2020 **FY2021**

2.6 Stakeholder Engagement

Host country government

The PEPFAR Coordination Office held bilateral meetings with the MoHCC HIV/AIDS and TB unit to discuss the COP 2022 road map and the need for continued ministry leadership throughout the COP planning process. Both MoHCC and NAC representatives attended the PEPFAR Q4 POART call in December 2021. Additionally, many MoHCC representatives from the various technical units attended the weeklong PEPFAR retreat in early 2022 where the MoHCC and NAC led two key presentations including a dialogue on the GoZ's thoughts on the sustainability of health financing in the HIV response. MoHCC counterparts deliberated on their specific program areas and contributed to synchronizing MoHCC priorities with PEPFAR's throughout the COP process. Three MoHCC representatives and three NAC representatives, including the Director of the AIDS and TB Unit, participated in the virtual planning meeting from March 14-16, 2022.

Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)and other external donors

The GFATM Portfolio Manager and the local Principal Recipient, UNDP, attended the FY21 Q4 POART, the PEPFAR retreat, and the virtual planning meeting. PEPFAR continues to work closely with the GFATM's CCM to ensure the alignment of programming with GFATM's current funding cycle (2021-2023) and look forward to collaboration on the next grant cycle coinciding with COP 2023 planning. PEPFAR, and the USG more broadly, continues to collaborate with the CCM to harmonize investments in COVID-19 mitigation measures. The team has discussed the potential viral load reagent and other commodities shortages in FY 2023 considering both GFATM and PEPFAR's flat lined or reduced budgets. Funding flexibility to support emerging COP 22 program requirements could potentially be achieved through reprogramming of savings within the HIV grant. Several discussions were held on the harmonization of COVID-19 support funds between GFATM and the USG. Discussions continue at the time of the COP 22 submission during regular bi-weekly check-ins held between the GFATM, UNDP, and PEPFAR Zimbabwe. UNAIDS, WHO, UNICEF, and the Bill and Melinda Gates Foundation (BMGF) attended the retreat and the virtual planning meeting.

Civil Society/Community:

Engagement with civil society kicked off in December 2021 when PEPFAR invited Advocacy Core Team (ACT) leadership and other community representatives to the FY21 Q4 POART meeting. Ultimately, nine representatives were selected through various CSO advocacy forums to participate in COP 22 planning. The PEPFAR Coordination Office held an official kick-off meeting with CSO representatives on January 27th to review the guidance and details of the planning level letter and describe FY22 performance and COP 22 strategic direction. All representatives attended the planning retreat in early 2022 and shared their priorities and key findings from the CLM program. The CSO core group then convened regional consultative meetings across the various geographical locations of the country to collect feedback from constituents receiving HIV prevention and treatment services in Zimbabwe. These consultations led to a streamlined list of community priorities that later culminated in a separate meeting with U.S. Embassy Chargé Thomas Hastings and the PEPFAR team to deliver the 2022 Community COP outlining the key community priorities.

During COP 22 planning, PEPFAR Zimbabwe also engaged KP communities through the national KP TSC in a dialogue to share feedback on their experiences with service delivery and in a four-day target setting meeting to ensure that PEPFAR targets for KPs are set in agreements with the realities that KP communities are observing on the ground. Further, PEPFAR continues to engage CSOs and communities in dialogue on the structure and findings from the CLM program**.**

PEPFAR Zimbabwe with CSO and Community Representatives at the Community COP dialogue on March 10, 2022.

Private Sector Engagement:

The structures for private sector engagement have not been functional given the poor economic and investment climate in Zimbabwe. Ultimately, there were no specific engagement meetings with the private sector during COP 2022 planning.

2.7 Stigma and Discrimination

PEPFAR is committed to joining other institutions (multilateral, global, and local) to end stigma, discrimination, and violence and to foster an enabling environment that will increase access to, and uptake of, HIV prevention, treatment, and care services for all people living with and affected by HIV/AIDS, especially adolescents, young people, persons with disabilities, women, and key populations.

In COP 22 PEPFAR Zimbabwe is planning to implement and emphasize the following to address stigma and discrimination:

- PEPFAR will emphasize the importance of structural interventions in the KP program. Structural adjustment interventions are embedded throughout the KP program. USAID's estimated budget for structural interventions in COP22 is $1,936,259.
- COP 22 priorities include supporting integration of stigma and discrimination training into preservice training for nurses, rolling out GSD and LIVES training for all KP/DREAMS

IPs, supporting KP participation and leadership in health facility committees and other CLM efforts, expanding activities and targets for GBV response and prevention, expanding KP specific services linked to health outcomes (e.g., socio-economic empowerment for YWSS in DREAMS, GAHT pilot with non-PEPFAR funds), capacity strengthening of KP CSOs and expanding community-centered KP programming.

- PEPFAR will continue to work alongside and engage faith communities to address issues of discrimination. The Faith and Communities (FCI) Initiative was an initiative funded for COP19 and COP20 only. In COP 22 there are no funds towards this initiative. However, PEPFAR will continue to work engage and collaborate FCI stakeholders for interventions funded through COP funds; for example, working with faith communities in community posts and disseminating messages of hope and ensuring justice for children.

3.0 Geographic and Population Prioritization

PEPFAR used 2021 subnational HIV estimates from the UNAIDS NAOMI model and host country treatment program data to recalibrate the national HIV epidemic and measure progress toward the UNAIDS fast track 95-95-95 epidemic control targets across all districts. PEPFAR programming aims to have >95% of PLHIV on ART at the end of FY23. Together with the Government of Zimbabwe, >95% of PLHIV will be initiated on lifelong ART by the end of FY 22.

Table 3.1 Current Status of ART saturation

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP 22**	**# Current on ART (FY21)**	**# of SNU COP 21 (FY22)**	**# of SNU COP 22 (FY23)**
Attained	1,138,465 (85%)	994,037 (84%)	44	44
Scale-up Saturation	N/A	N/A	N/A	N/A
Scale-up Aggressive	N/A	N/A	N/A	N/A
Sustained	N/A	N/A	N/A	N/A
Central Support	202,856 (15%)	189,278 (16%)	19	19
TOTAL	1,341,321 (100%)	1,183,315 (100%)	63	63

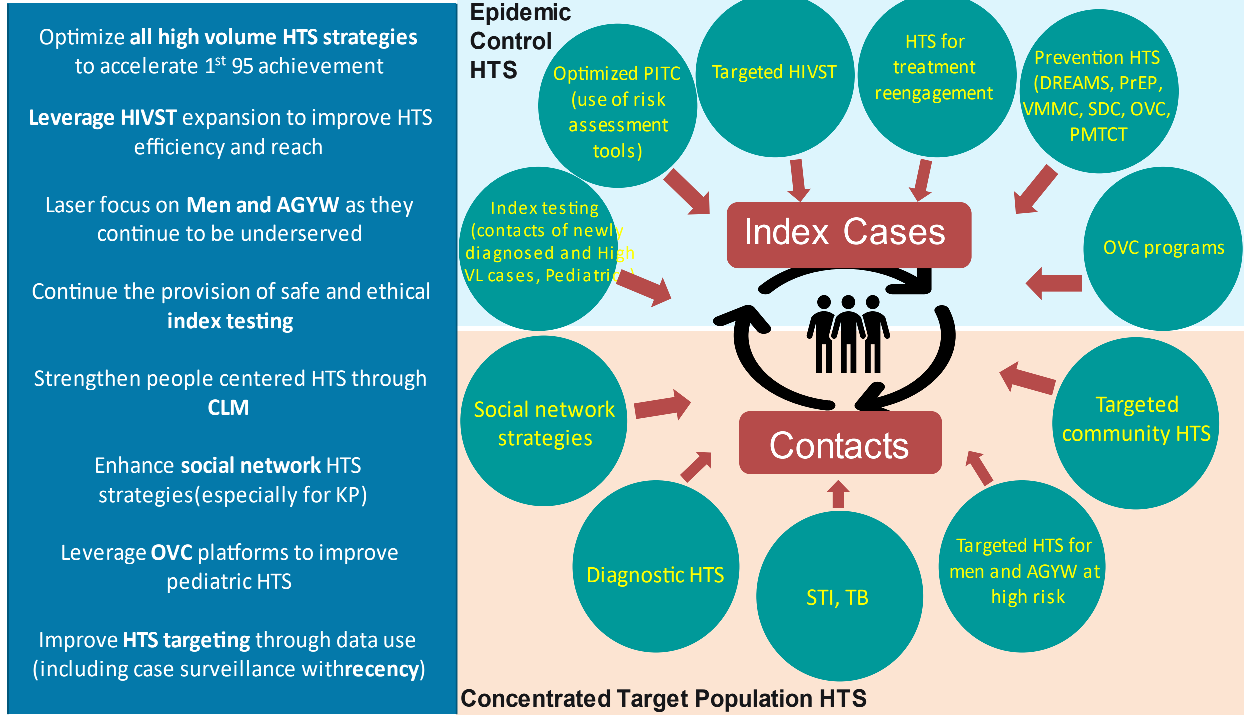
4.0 Person-Centered Program Activities for Epidemic Control

Figure 4.0.1 Overview of 95/95/95 Cascade, FY21

1st 95		2nd 95		3rd 95	
HTS_TST	1,219,557	HTS_TST_POS	70,675	TX_CURR	1,189,747
HTS_TST_POS	70,675	TX_NEW	67,275	TX_PVLS D	678,038
		TX_NET_NEW	33,344	TX_PVLS N	640,575

4.1 Finding people with undiagnosed HIV and getting them started on treatment

As Zimbabwe reaches epidemic control, the COP 2022 strategy for HIV case finding will continue to emphasize the need to employ HIV testing strategies that eliminate unnecessary testing using epidemic control and concentrated target population testing strategies.



While the PEPFAR Zimbabwe COP22 HTS strategy places emphasis on men and AGYW, other at-risk sub-populations will not be neglected. Adolescent boys will be reached specifically by targeted HTS in health facilities, OVC programs, VMMC, STI clinics, Community and SNS as shown in the diagram above.

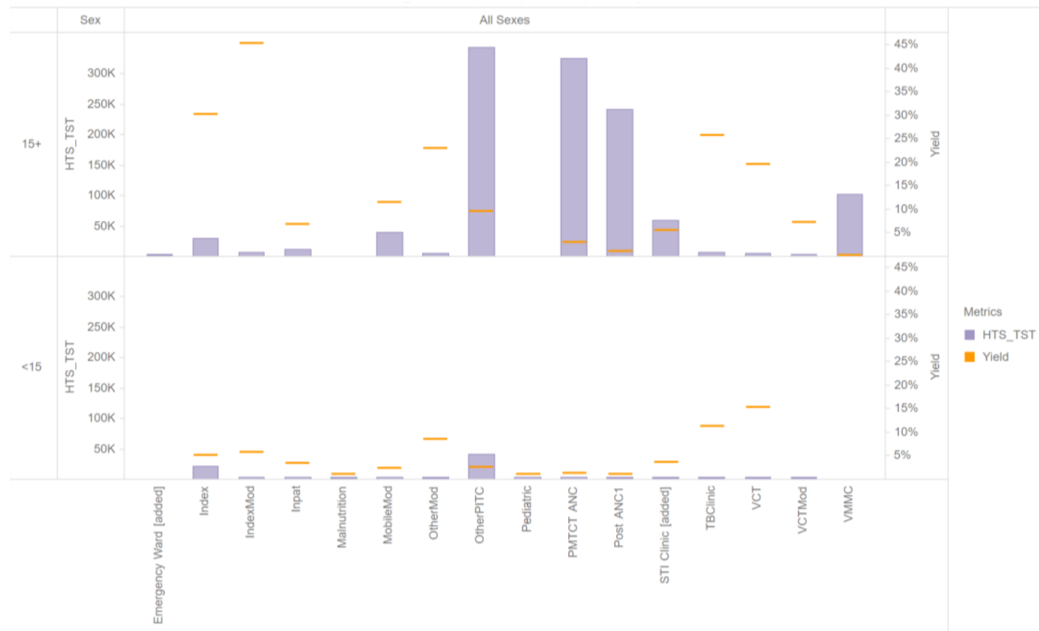
HIV testing for epidemic control will focus on person-centered, safe, and ethical index testing ensuring consent, confidentiality, providing counseling, correct results, and appropriate connection to follow on prevention and treatment services. Additionally, the program will continue to provide standard of care HIV testing at ANC, STI, and TB program entry points, while promoting the efficient use of HIV risk assessment tools as well as HIVST. PEPFAR will continue to closely support and monitor the quality of Index Case Testing (ICT) implementation to safeguard the clients' right to safety from any harm.

HIV testing services will be prioritized for targeted sub-populations which include men and adolescent girls and young women (AGYW) at community posts, whilst community intelligence-based models will continue to constitute a major part of the concentrated target population HIV testing strategy partnered with HIVST to make the testing even more efficient at identifying the sub-populations that remain underserved and are at highest risk. We will improve the KP program through mapping hotspots and scale up of differentiated HTS services in COP 22. Implementing partners will continue to provide targeted HIV testing through HIV prevention programming, including DREAMS, OVC, and PrEP programs.

PEPFAR will support a continuous monitoring plan in collaboration with MoHCC, CSOs, and other stakeholders to ensure quality HIV case finding services. Sites will monitor and report on acceptance rates of index testing as well as other parameters to assess service provision. The OVC program will continue to facilitate index testing for biological children and siblings of PLHIV on ART. KP programs will provide safe index testing as standard of care, coupled with other strategies such as social network HTS. HIV self-testing will continue to be used in conjunction with the various HTS models to improve testing efficiency while reaching the highest risk groups.

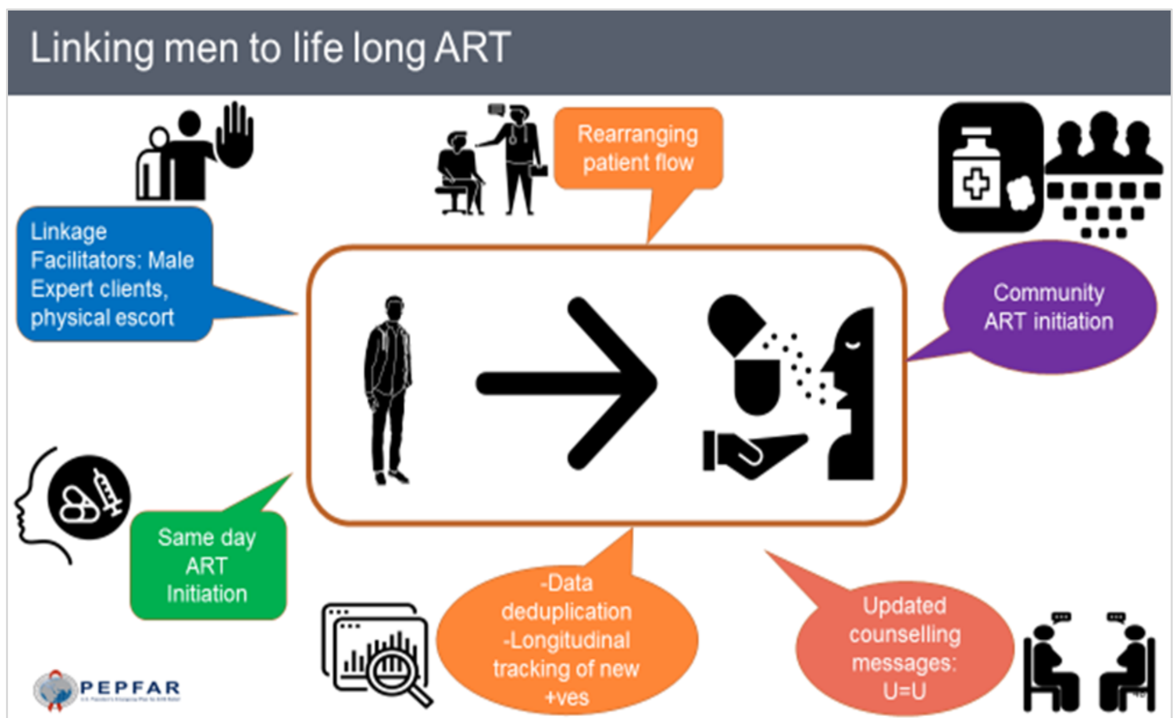
Finally, case-based surveillance with recency will be used to identify clusters of recent infections and offer HIV prevention and testing services to targeted groups in those social and sexual networks. Additionally, the program will make use of ZIMPHIA and other surveillance data to improve HTS targeting approaches to reach the sub-populations with the biggest case-finding gaps.

Figure 4.1.1 Testing Volume and Yield by Modality and Age, FY21



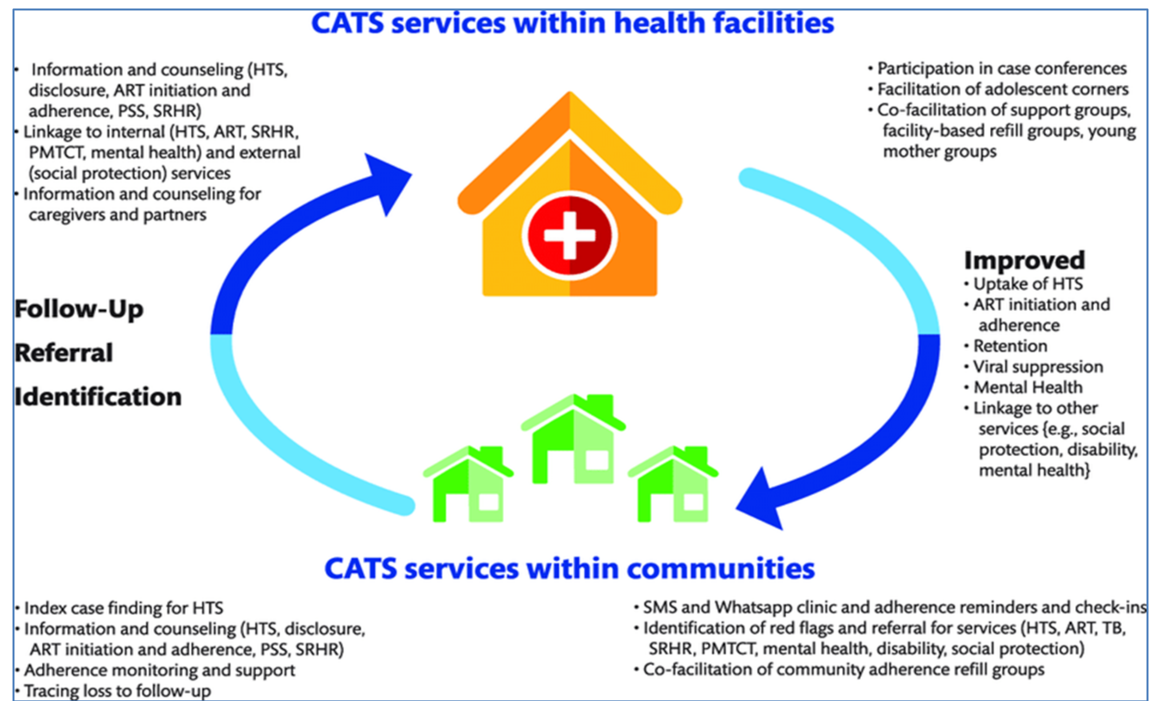
FINDING MEN: Our program data show that men have lower HTS and ART coverage as compared to women. As the country reaches and maintains epidemic control, it must continue to close existing gaps in identifying men, linking them to treatment and ensure long-term viral suppression. Community posts, which were successfully adapted from the Zambia Circle of Hope model, will be maintained as a HIV case-finding strategy for men and link them to care during COP 22. As the program expands the use of HIVST kits, it will also reach men through either their tested sexual partners or directly through targeted community level testing modalities. Furthermore, men will continue to be reached with index testing and through prevention modalities targeting men at high risk. The OVC program will be leveraged to reach men with demand creation for HTS, ART, VMMC and other HIV services, such as through father-child dialogues, which is an approach where children are encouraged to freely discuss HIV/AIDS, child protection, and child development topics with their father figures.

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



FINDING ADOLESCENTS AND YOUNG PEOPLE: Adolescents and young people continue to perform poorly compared to older people across the clinical cascade. However, using the Zvandiri model and leveraging the OVC program, PEPFAR has and will continue to significantly improve HIV case identification, linkage and eventually ART coverage among adolescents and young people. During COP 20 and COP 21, the PEPFAR program funded the Zvandiri model to achieve geographic saturation and impact. As a result, the gap between children and adults has been shrinking. In COP 22 the Zvandiri model will be funded to consolidate the gains realized in the last two years. PEPFAR will maintain support for this model and other person-centered adaptations to close the gap in case-finding and linkage to care for harder to reach adolescents and young people.

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



FINDING CHILDREN: Index testing continues to be the main modality for finding children and this will be supported by the program in COP 22. During COP 20, overall index testing contributed 55% of new HIV cases identified amongst children and adolescents <15 years of age despite accounting for 35% of the tests conducted. In COP 22 we intend to consolidate on these gains through building capacity of health workers to deliver safe index testing. File audits will be conducted to identify biological children of parents on ART who are eligible for testing, this is to achieve universal testing of children contacts. We have engaged the MOHCC ATP to add HIV self-testing kit as a tool for oral screening among children under or equal to two years of age as recommended by WHO and PEPFAR. Discussions are mainly centered on whether a guardian can administer the test versus having only health workers administer. Integration with the OVC program is further being pursued to achieve better targeting and coverage.

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

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

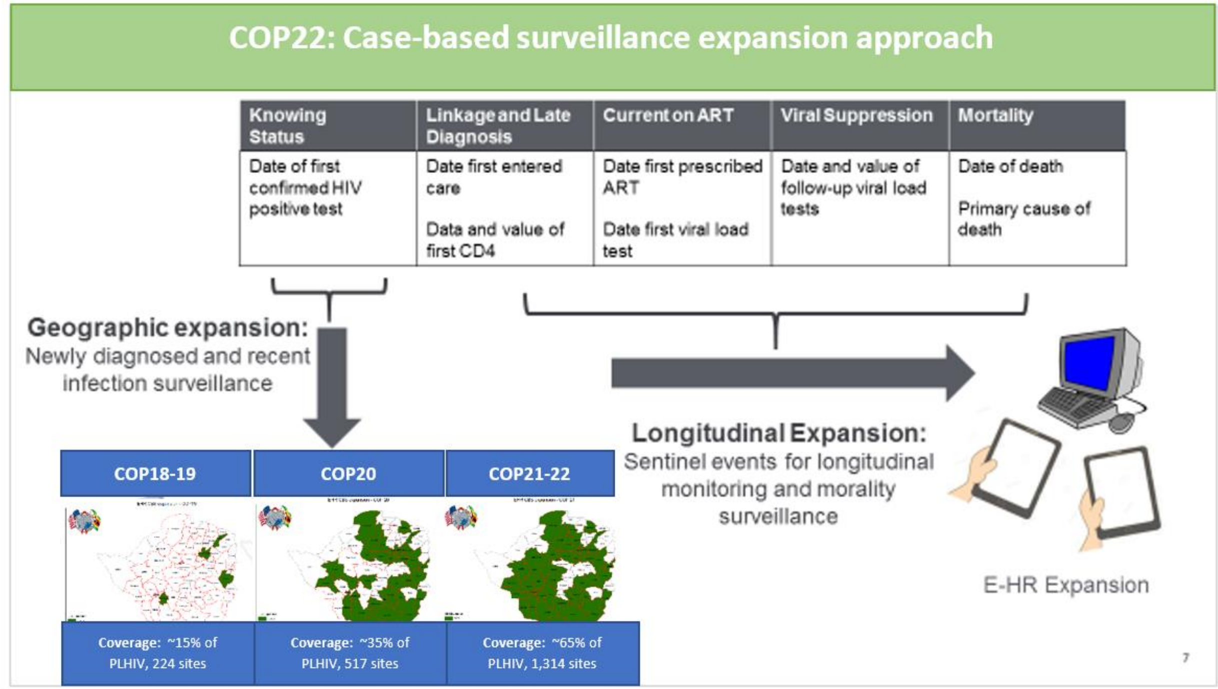
1. Support procurement of EID Point of care testing cartridges.

2. Decentralization of EID conventional testing.
3. Integrated sample transportation and expedite electronic result transmission.
4. Expand use of EHR and diary system.
5. Expedite result transmission through electronic means.
6. Continue HIV test and start.
7. Community ART initiation.
8. Cohort monitoring.
9. Use optimized regimens that are child-friendly.
10. Ensuring that all infants enrolled in the OVC Program access EID.

As guided by the MoHCC, PEPFAR will support rollout of differentiated HTS for pediatrics as well as optimized ART regimens. The country will complete the transition to pediatric DTG for children who weigh <20kgs. Nevirapine has been phased out as first line pediatric anchor ARV, and LPV/r is being phased out as pediatric DTG is being introduced and scaled. The program will also continue to support the procurement and distribution of raltegravir granules for sentinel sites.

CASE BASED SURVEILLANCE WITH RECENCY TESTING As a country nearing HIV epidemic control, Zimbabwe will focus on increasing efforts to establish case-based surveillance (CBS) and strengthen data use. Detecting recent HIV infections among all newly diagnosed individuals in near-real-time and establishing a surveillance system to longitudinally track HIV cases has been designated a high priority activity that will support the attainment and sustenance of HIV epidemic control. Linking this activity to case finding modalities will support targeted case finding efforts, and result in early detection of potential hot spots to inform subsequent mitigation efforts to reduce HIV incidence among populations. Zimbabwe will be pairing RTRI and VL to implement the complete RITA in COP 2022. The longitudinal patient monitoring aspects of CBS will be necessary to ensure high-quality HIV programming maximizes continuity of treatment and viral load suppression such that re-ignition of the epidemic does not occur.

Despite the COVID-19 induced delays, Zimbabwe expects to cover all 1,314 PEPFAR supported sites in COP 2022. To rapidly target case finding efforts in areas of high HIV transmission, Zimbabwe will expedite implementation of recent infection surveillance with VL testing for recent infections. As noted above, the country is currently not doing confirmation with VL testing. This position was arrived at following consultation with MoHCC in view of the low national viral load coverage. Going forward, with concurrence from the MoHCC, the program will add VL testing with recency. Upon analysis of the recency data that the program has, the program has targeted HIV testing outreach services to hotspots when selecting geographical areas with higher need. Additionally, the recency testing data are used in combination with other data (e.g., PHIAs, historic program performance, UNAIDS estimates, etc.). Outside HTS, the data have been used to advocate for scaling up interventions like community posts, outreach HIV services (especially for communities affected by access and movement restrictions). It is also important to point out that recency results are NOT shared with patients. Recency testing will be monitored at national level to inform geographical areas with high concentrations of new HIV infections.



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

4.2 Ensuring viral suppression and ART continuity

The MoHCC's Operations and Service Delivery (OSDM) Manual for HIV Care and Treatment in Zimbabwe gives guidance on increasing retention at all steps of the HIV clinical cascade. This document is currently being revised in line with the 2021 WHO guidelines for management of HIV. We anticipate that this revision process will be completed in COP 21 and will guide COP 22 implementation, particularly for differentiated ART delivery models, the viral load algorithm, advanced HIV disease management, mental health, and integration of HIV and NCDs. In COP 22, PEPFAR Zimbabwe will continue to support the operationalization of the updated OSDM manual and the rollout of enhanced differentiated service delivery models.

In COP 2022, PEPFAR will use the continuity of treatment framework below to guide support for various interventions that facilitate continuity of treatment and viral suppression for PLHIV.

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

COP22 Core continuity of treatment package: interventions

Prevent loss & drop out

Rapid COVID19 Adaptations

Advanced HIV disease support

Complete TLD transition

6 MMD scale up

DSD

Treatment literacy packages

Individual and Peer Support initiatives

Improve tracking and documentation

Dedicated retention facilitators

EHR functionality

Missed appointments tracked within 24hrs

Systematic documentation

Telephone/Physical tracking

Interventions for special populations

Men, children & adolescents

Key populations

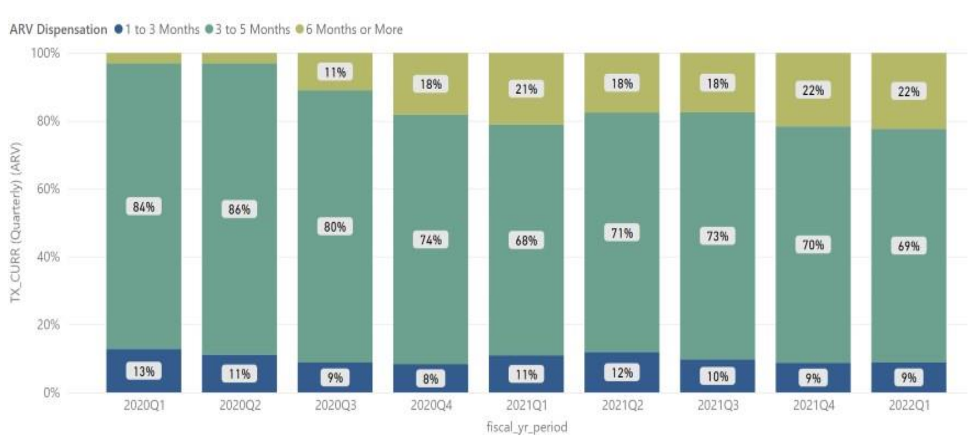
PLW

Unstable & advanced HIV

Mental health & substance abuse

PREVENTION OF LOSSES/DROPOUTS: Interventions will include completion of transition to TLD treatment for all eligible clients, early case management, formalized SMS reminders wherever available and access to individual and peer counseling as needed. Through ongoing dialogue with the MoHCC, the PEPFAR program will support the orientation of facility staff on respectful management of clients, including being friendly and non-judgmental. In COP 22 the PEPFAR program will continue to support various aspects of Advanced HIV Disease (AHD) management including adaptation of new WHO AHD guidelines and the AHD addendum to the Zimbabwe HIV guidelines, procurement of TB Urine-Lam and Serum CrAG test kits, and some medicines. The PEPFAR program will also support the adaptation of the latest WHO guidelines particularly regarding timing of ART initiation in patients with active TB disease to prevent loss through death. The implementation and scale up of six-multi-month dispensing (6MMD) and other differentiated services will continue to be a priority in COP 22. The graph below shows the Zimbabwe PEPFAR program progress towards 6MMD.

Progress towards 6MMD progress



For adolescents, the Zvandiri (CATS) model approach will continue and adapted for scale up in districts with high HIV burden among this age group.

Based on the experiences of the COVID-19 pandemic, we will continue support for rapid COVID-19 adaptations which will ensure that at any particular time, the program shifts resources to support needed adaptations that ensure that PLHIV continue their treatment uninterrupted and safely. An example of these adaptations would be setting up community ART pick up points when the usual ART sites have interrupted services due to COVID-19 and outreach ART refills to reduce clinic visits thereby reducing the risk of contracting COVID-19.

Figure 4.2.1 Number of Clients Receiving MMD by Age/Sex, FY21

Coarse Age <15
Sex: Female | Male
Result
24,000
20,000
16,000
12,000
8,000
4,000
Female (Zimbabwe): 6,342 / 13,687 / 2,050
Male (Zimbabwe): 6,041 / 12,295 / 1,822
MMD
Not on MMD
3 to 5 months MMD
6 or more months MMD

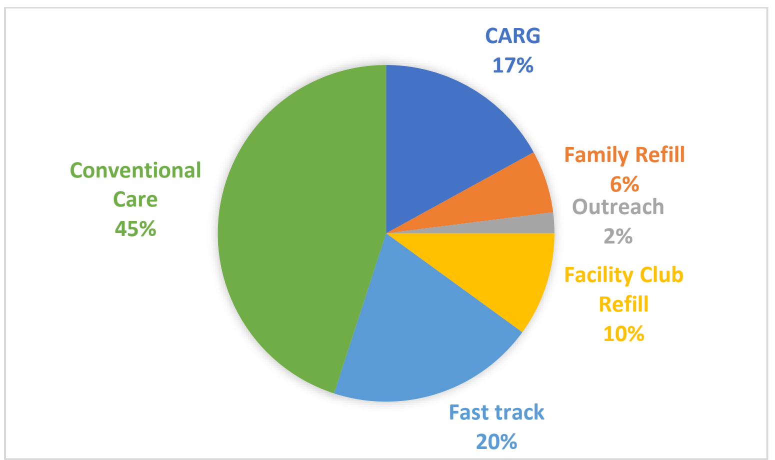
Coarse Age 15+
Sex: Female | Male
Result
600K
500K
400K
300K
200K
100K
Female (Zimbabwe): 45,433 / 417,755 / 131,017
Male (Zimbabwe): 28,262 / 242,499 / 77,980
MMD
Not on MMD
3 to 5 months MMD
6 or more months MMD

IMPROVED TRACKING AND DOCUMENTATION: By the end of COP 21, EHR is expected to have saturated PEPFAR DSD districts, and this is expected to be a game-changer with regards to client documentation. Use of EHR will facilitate systematic early missed appointment tracking, interruption in treatment, and gaps in services provided to an individual client, among other

functions. The PEPFAR program will engage some of the existing lay cadres to become retention facilitators who will take on the role of intensive defaulter-tracking that will begin within 24 hours of clients having missed appointments. These cadres will work with the clinicians to ensure clients return to care and follow up outcomes are documented appropriately in the client files. Support will be provided to clinicians to separate the files of clients who have missed appointments from those who have defaulted and those who are lost to follow up. In COP 22, efforts will be directed at further optimization of these PEPFAR DSD districts to ensure all sites maximally utilize the EHR for patient consultation and reporting.

SPECIAL POPULATIONS: The PEPFAR program is engaged in the ongoing MoHCC process to enhance differentiated service delivery (DSD) models tailored to suit each individual population group. Among other issues, the review process seeks to introduce additional differentiated care models such as the private pharmacy model, as well as inclusion of TB preventive therapy (TPT), family planning (FP) and non-communicable disease care in client schedules. Particular attention will be paid to clients who are unstable and/or have advanced disease. Added emphasis will be on having mental health services/substance abuse screening introduced and scaled up. The standardization and formalization of the cross-border DSD model is currently under consideration as part of the OSDM review. In COP 22, the PEPFAR program will support the implementation of this and other aspects of the updated OSDM.

PEPFAR will fully support the implementation of person-centered interventions, including all the DSD models approved by the MoHCC as indicated in the OSDM with the aim of having at least 80% of eligible clients in a suitable DSD model of their choice by December 2023. PEPFAR will also maintain flexibility to support new DSD models in consultation with all key stakeholders. The pie chart details the proposed mix of DSD models, which are in line with the MoHCC's targets.



DSD models will focus on the following key objectives:

- DSD to reduce clinic visits: multi-month dispensing, community ART refill groups (CARGSs, and family refills)
- DSD to shorten clinic visits: fast-track refills, scheduled appointment times that reduce waiting time and congestion.

- DSD to improve patient convenience: family-centered care, convenient locations like community posts, private pharmacies, and cross border models. Facilitating access to other chronic medications within the chosen DSD model - TPT, FP, NCDs etc.

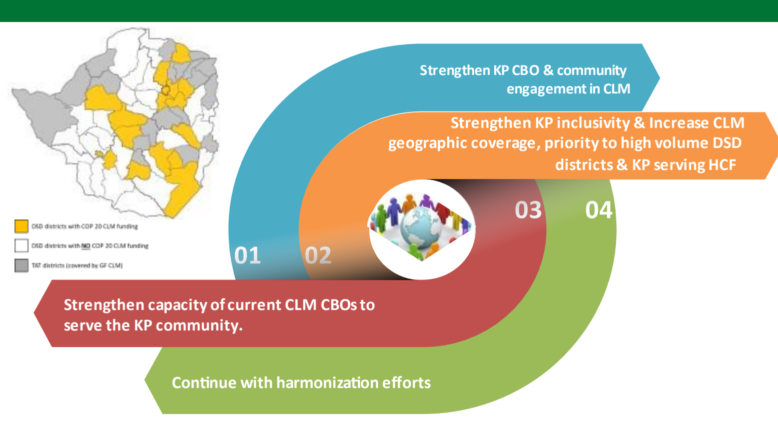
COMMUNITY LED MONITORING: PEPFAR will support community led organizations to visit PEPFAR funded sites to evaluate the quality of services offered to communities including people living with HIV, young people, key populations, people with disabilities, and people in confined settings like prisons. The community-based organizations will be supported to visit sites across the country throughout the year and report on quality of service to improve service delivery.

In COP 21, CLM will strengthen its reach to key population communities by identifying eight additional KP-led/KP-serving organizations to support in CLM implementation. These organizations are expected to cover at least 80% of the PEPFAR-supported facilities that are actively programming and serving various key population groups. This expansion is also expected to increase the overall CLM program coverage from the current 22 districts to at least 30 districts. In COP 22, PEPFAR will continue working with the KP TSC in strengthening the capacity of other non-KP CLM CBOs, thereby ensuring that all organizations involved in the CLM program are competent to work with and serve key populations.

PEPFAR continues to respond to CSO recommendations to prioritize the CLM program. So, while the overall country budget was flatlined in COP 22, the CLM budget has been increased by $130,000 for a total investment of $1,189,262. We also commit to ensuring we identify equities in the budget allocations for the CLM coordination piece, as well as equities with respect to each CBO as informed by their respective program design and implementation contexts.

CLM Priorities in COP22

- National Coverage of all 44 DSD Districts
- Aim to cover at least 80% of facilities targeting KPs.
- Decentralizing the NSC to Provincial level *(Accountability meetings)*
- Bring onboard about 8 additional KP CBOs as partners in CLM implementation
- TSC supporting the capacity strengthening of other non -KP CLM CBOs to be KP-receptive/sensitive, and be able to work with KPs in the areas they operate



Total Project Budget in COP 2022 = $1,189,262

In COP 22, CLM funding will transition to UNAIDS. We are working with UNAIDS to ensure that the transition does not have significant impacts on the overall CLM program design. UNAIDS has agreed to working with CLM CBOs required to cover the geographic areas and populations

prioritized under the CLM program. We are currently working with a template of 24 CBOs to be CLM grantees directly under UNAIDS though this is a moving target as informed by available funding. To support this, UNAIDS will erect a grants management unit within their institution. The grants management unit will be supported by the PEPFAR CLM Specialist and manned by one dedicated administrative assist, directly hired by UNAIDS to support grants management administrative work. CLM in COP 22 will continue to prioritize broader and meaningful CSO/CBO/community engagement at all levels of the program design.

TREATMENT LITERACY: In COP 22, PEPFAR will ensure ongoing activities to improve treatment literacy among PLHIV and ensure that appropriate messages are delivered in appropriate ways to the various population subgroups. These messages will include the rationale for the "Treat All" approach, the benefits of testing and initiating ART prior to onset of symptoms, the superior efficacy and adverse event profile of dolutegravir (DTG)-based regimens, the importance of having all sexual partners on treatment or PrEP, the need for viral load monitoring and the meaning of viral load results, such as U=U (Undetectable = Untransmittable). Once the VL literacy package "Flip the Script" is completed, the PEPFAR program will explore the use of this communication package to improve clients' understanding of treatment adherence and VL results interpretation. PEPFAR will continue to support the updating of counseling materials and guidelines to align with the current treatment recommendations and the shifts in the HIV program.

The "Comprehensive National HIV Communications Strategy for Zimbabwe – 2019-2025" remains the basis for continued revitalization of widespread treatment literacy amongst ART patients. The PEPFAR team will continue to work with civil society groups and their constituents to disseminate treatment literacy messages tailored to specific population groups in specific areas. Knowledge enhancement on issues such as index testing, ARV optimization, viral load, cervical cancer screening, targeted universal TB testing, AHD, etc., will remain a priority. These efforts will be continued for the remainder of COP 21 implementation and into COP 22.

QUALITY IMPROVEMENT: The national HIV Quality Improvement strategy establishes indicators and guidelines for measuring the quality-of-service delivery and improving performance towards those indicators. Importantly, this strategy considers client feedback to promote person-centered care. PEPFAR support towards the national HIV Quality Improvement program takes the form of secondees who provide technical guidance, ensuring that this program is aligned with PEPFAR and UNAIDS strategy for achieving HIV epidemic control. Through this support, facilities continue to implement QI initiatives resulting in improved patient care. This, as well as the focus on VL and TPT uptake will continue during COP 22. At the site level, systems-level interventions to improve monitoring of patient satisfaction, linkage rates, same day initiation and improved M&E for PEPFAR treatment indicators, will remain streamlined into the site-level support provided by the clinical partners.

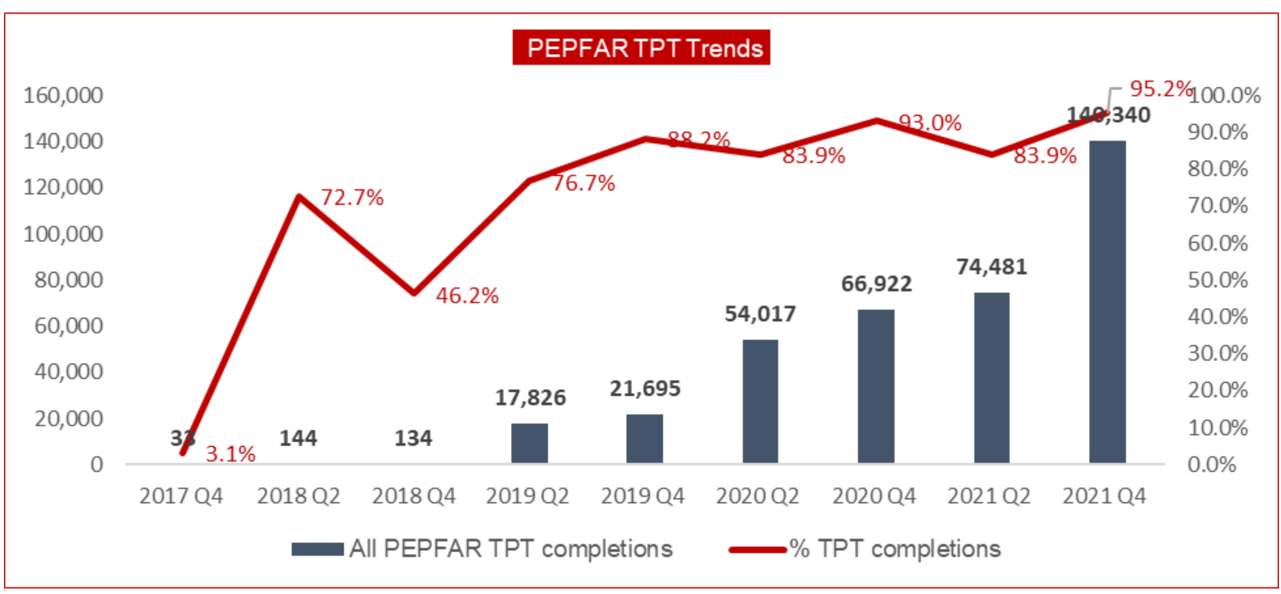
ENSURING VIRAL LOAD SUPPRESSION: PEPFAR has identified viral load access, coverage, and suppression as a critical area needing intervention in Zimbabwe as the country reaches epidemic control. Besides the obvious VL reagent gap, there are still gaps in access, specimen transport and results utilization/clinical status monitoring. PEPFAR will support capacity building of health workers and primary counselors who offer enhanced adherence counselling services to patients

with high viral loads to ensure that patients can re-suppress if ART adherence is the issue. Otherwise PEPFAR will support the transition of patients to second- or third-line ART, where indicated, and supported by MoHCC ART guidelines. PEPFAR will contribute to the procurement of ARVs in COP 22 in collaboration with the GFATM and MoHCC to ensure uninterrupted supply of ARVs to patients. As shown in the graph below, viral load suppression has steadily increased over time but still needs to be improved through some of the strategies mentioned above.

In COP 22, the MoHCC and PEPFAR Zimbabwe agreed on a national viral load coverage (VLC) target of 85%. This decision was largely driven by continued gaps in funding and system optimization, which while improving year over year, are not yet at a place to support higher levels of testing demand. These gaps within the national laboratory systems to support 100% VLC are compounded by perennial reagent stockouts, therefore multi-year testing targets for FY 2022 (80% VLC) and FY 2023 (85% VLC) were agreed on by stakeholders, with the goal of working towards 100% VLC in future years.

Figure 4.2.2 Viral Load Outcomes, FY21

Scaling Up TB Preventive Therapy: According to the 2021 Global TB report, 7.2 million people living with HIV completed TPT during 2018-2020; surpassing the 6 million UNHLM target 2 years ahead of time. This demonstrates momentum towards TPT universal coverage among eligible PLHIV. The PEPFAR program is successfully scaling up, with 214,821 clients completing TPT.



In COP 22, the PEPFAR program will support the procurement and distribution of TPT medicines and complement the GFATM's support. Implementation of the shorter TPT regimens, 3HP (three months rifapentine and isoniazid) and 3HR (3 months isoniazid and rifampicin) will be scaled up. Lessons learnt from the Clinton Health Access Initiative (CHAI) catalytic mechanism will be used to guide implementation nationally. Use of the shorter regimens is expected to improve uptake and completion of TPT.

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

- PLHIV on DTG based ART regimens: 6H plus Vitamin B6 (FDC - INH/CTX/Vitamin B6)
- PLHIV on EFV based ART regimens: 3HP
- HIV negative children and adolescents <15years TB contacts: 3HR

The high turnover of health workers is affecting implementation as trained and experienced nurses and doctors are leaving for greener pastures. In COP 22 capacity building for the existing health workers will be done through training and mentoring. Development, printing and distribution of SOPs, job aides and patient communication material will address the existing knowledge and communication gaps and create demand for TPT. Pharmacovigilance will continue to be prioritized to build trust in TPT regimens among beneficiaries, physicians, senior clinicians, and nurses.

During COP 22, among other strategies, IPs will support the roll out of TPT differentiated service delivery to improve adherence and completion of TPT. There is evidence that TPT adherence and satisfaction can be improved with integration of TB and HIV services.

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

Ambitious target towards universal TPT coverage amongst eligible

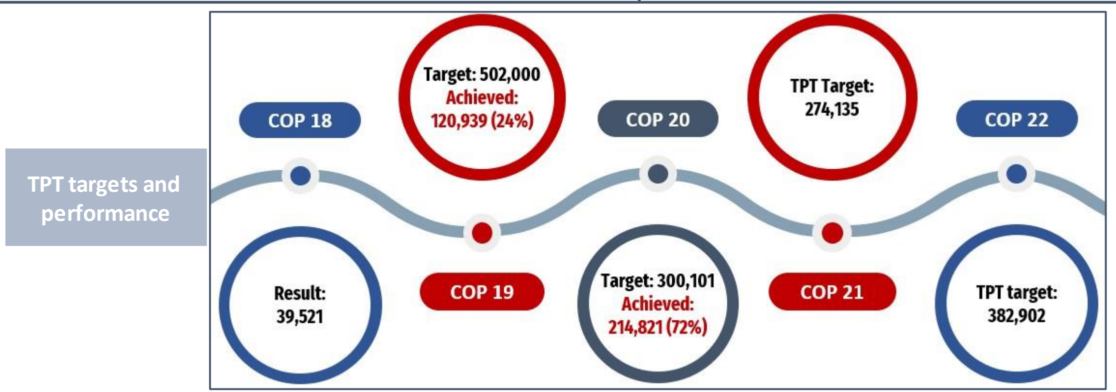
TPT regimen split

	6H	3HP
CY 2021	86%	14%
CY 2022	27%	73%
CY 2023	~~11%~~ 70%	~~89%~~ 30%

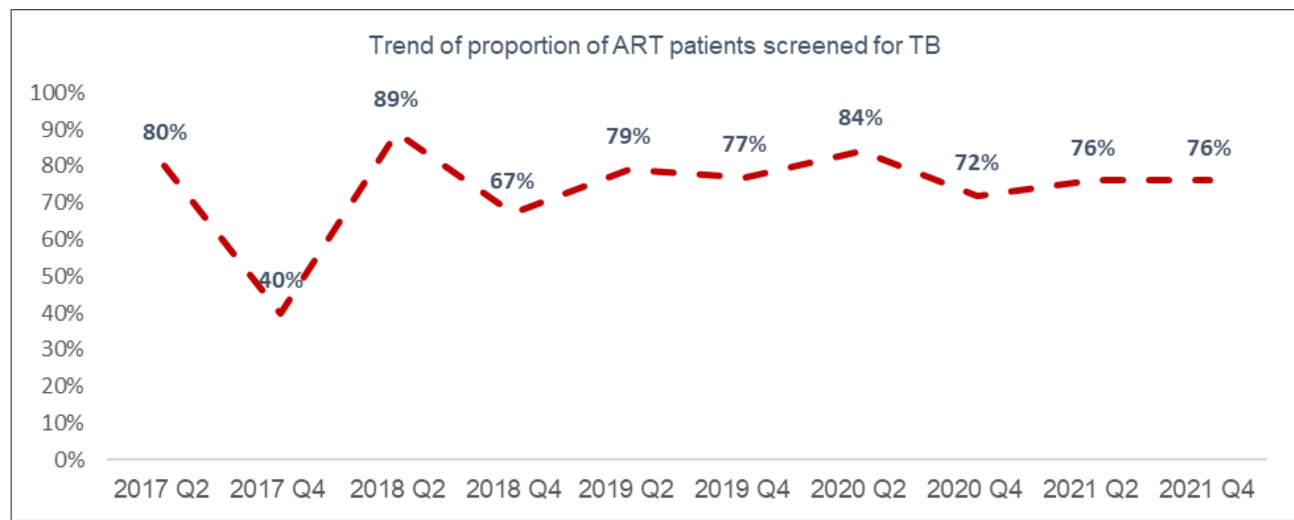
TPT funding analysis

Need	Global Fund	PEPFAR	Gap
$6,648,265	$2,304,465	$1,062,633	$3,280,967

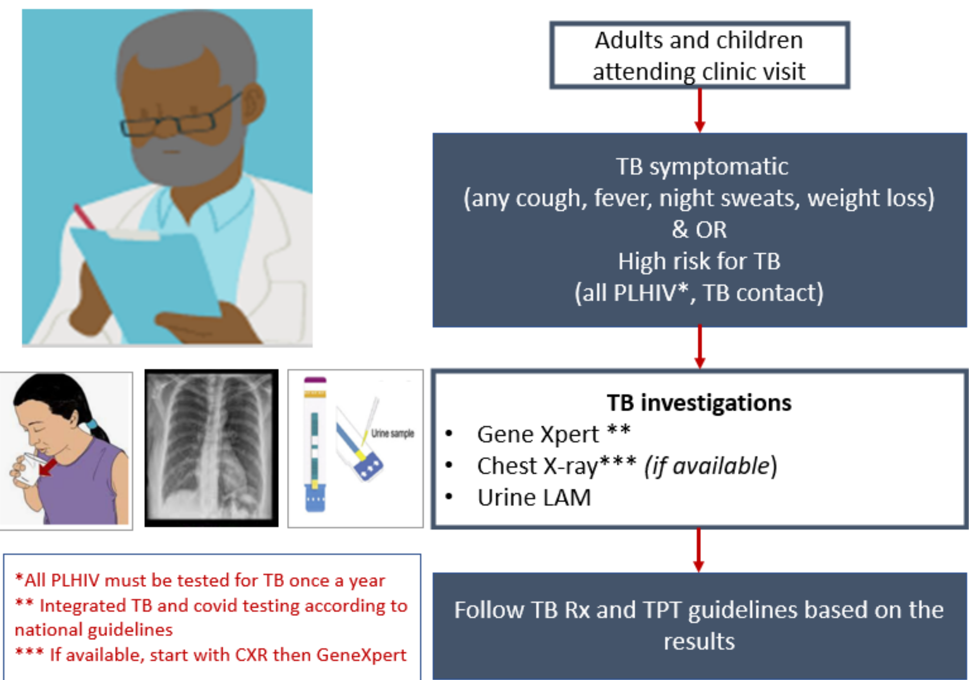
TPT targets and performance



TB SCREENING AND DIAGNOSIS: Since FY19 Q2 the proportion of clients screened for TB has plateaued below the target of 95%. Before this there was momentum towards target achievement, however COVID-19 has slowed the program.



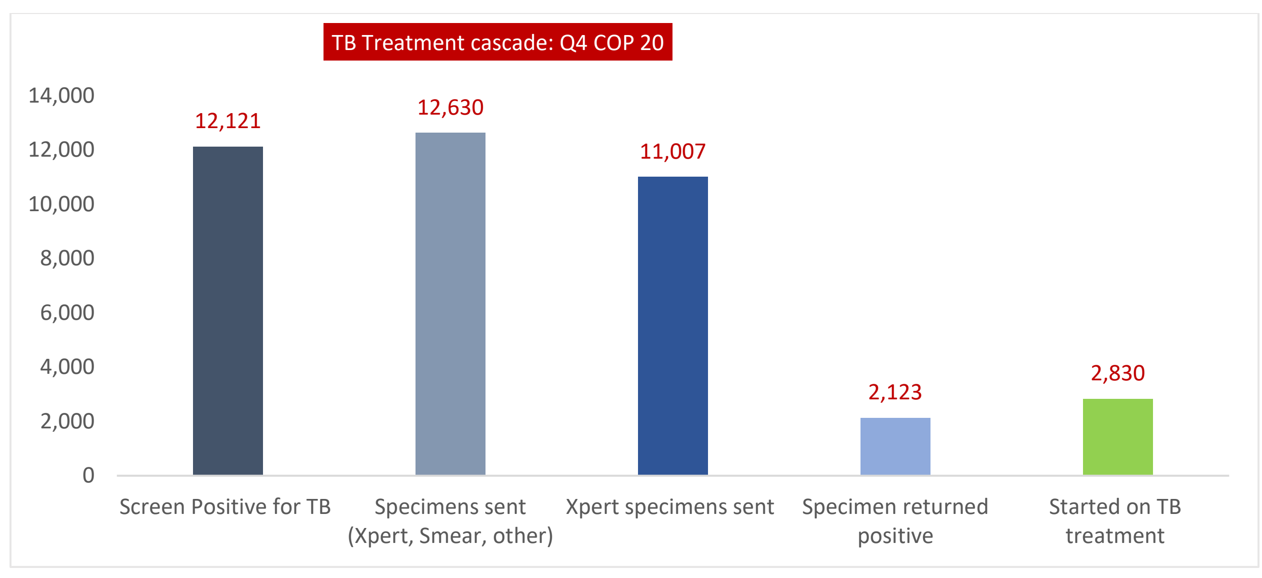
In COP 22 we intend to optimize TB screening through implementation of targeted universal TB testing (TUTT). PEPFAR will support guidelines revisions, revisions of SI tools to capture data on these tools, procurement of urine lateral flow lipoarabinomannan (LF-LAM) and health worker capacity building before implementation starts. The ministry supports the intervention, implementation has already started in some health facilities during COP 21.



Outside TUTT, scale of TB LF-LAM as a tool to improve screening and diagnosis is underway. Based on program data available, we have noted an increase in TB cases identified and linkage to appropriate treatment. Since LF-LAM is a point of care, health workers are realizing it is convenient for them and their clients. The following challenges have been noted and are being addressed:

- Reliance on CD4+ testing, which is not readily available
- Insecure pipeline, resulting in stock ruptures and short shelf life
- Overwhelmed nurses reluctant to task shifting
- Limited numbers of health workers trained
- Limited confidence and capacity of nurses to manage or offer advanced HIV disease packages
- High MOHCC HCW turnover of trained staff leading to missed opportunities
- No community level LF-LAM testing resulting in missed opportunities

In COP 20 there was optimal use of molecular WHO recommended rapid diagnostic tests (mWRD) i.e., with 91% of presumptive TB cases having GeneXpert testing done. Proxy linkage to TB treatment was >100% for all cases identified.



In COP 22 the program will consolidate the previous COPs performance through health worker capacity building, procurement of GeneXpert cartridges, supporting multiplexing platforms and improved supply chain.

4.3 Prevention, specifically detailing programs for priority programming:

HIV prevention for priority populations remains a key strategy in COP 22, with prevention activities tailored to specific populations being delivered through the VMMC, DREAMS, KP, and OVC platforms, as well as through HTS, PMTCT and ART services. Targeted priority populations include AGYW between 15-24 years old, children (through prevention of vertical HIV transmission), sex workers, men who have sex with men, PWUD, transgender women, and men under the age of 30, with a focus of linking this group to HTS and VMMC. PEPFAR will continue to focus on primary prevention of sexual violence and HIV for adolescent boys and girls 10-14 years old through the OVC and DREAMS initiatives.

a. HTS:

In line with the UNAIDS' call for "95% of people at risk of HIV infection to use appropriate, prioritized, person-centered and effective combination prevention options by 2025," the COP 22 Zimbabwe person-centered HIV Testing Services strategy aims to serve as a strategic entry point for access to prevention (including PrEP access and monitoring for persons with continued risk, VMMC for HIV negative young men, ongoing testing services for negative partners in discordant couples, OVC programs, DREAMS programs, ANC, and post-ANC services) and testing for re-engagement into treatment. Safe and ethical index case testing, which is a standard of care, will be used as a modality for tracing and breaking the cycle of transmission, thereby preventing further transmission in HIV-exposed infants and other biologically eligible children and sexual and needle sharing networks among the general, priority and KP communities. It should be noted that all IPs have trained and will continue to train and closely monitor ICT implementation to always ensure safe and ethical service delivery. PEPFAR will continue to support all testing modalities with a stronger emphasis towards deploying resources to community-based testing modalities where resources are most limited.

In COP 22 the country will continue to scale up targeted distribution of HIVST kits as a screening tool targeting partners of HIV positive pregnant and lactating mothers whose HIV status is unknown, KP clients (where client determines to be safe and feasible), adolescents, young and older men, and young women. HIVST kits will also be distributed through the Zvandiri model to reach sexual partners of young people living with HIV who hardly access health facilities. However, it is important to note that training of more cadres/health service providers on HIVST distribution modalities infused with IPV prevention can never be over emphasized due to the fluidity of HRH situation at health facilities. This training, which is conducted by MoHCC, is important to increase the quantum and quality of service providers skilled in HIVST distribution. Therefore, PEPFAR will work with MoHCC and the various KP in training appropriate cadres to scale this up.

In COP 22, the PEPFAR-supported CLM program will cover more SNUs. The HTS strategy is intentionally designed to work closely with the CLM teams to receive independent feedback on the quality of HTS delivered, how the HTS service providers can best package modalities to nimbly, appropriately, and proactively respond to the end-user inspired CLM feedback at scale.

b. DREAMS:

The COP 21 Layering Table that documents the primary, secondary, and contextual interventions currently provided through the program in the 16 DREAMS districts is below. In COP 21, the program will also begin to track, and report facilitated referrals to service providers outside the DREAMS partner network in the layering table.

Additional changes to the Layering Table are not anticipated in COP 22.

LAYERING TABLE: PRIMARY/ SECONDARY INTERVENTIONS (COP21 & COP22)

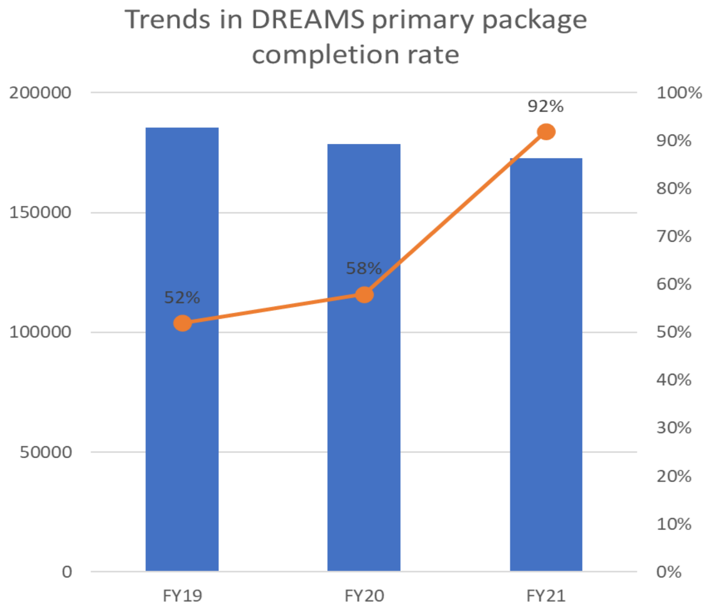
	AGYW 10-14	AGYW 15-19	AGYW 20-24
Primary Interventions	• Condom Education • HIV Prevention Curriculum • Gender Norms Curriculum • Social Assets Building (HIV/GBV Club in or out-of-school) • Sexual Violence Prevention • Financial Literacy	• Condom Promotion and Provision • Gender Norms and Curriculum • HIV Prevention Curriculum • Social Assets Building (HIV/GBV Club in or out-of-school) • Sexual Violence Prevention • Financial Literacy	• Condom Education • HIV Prevention Curriculum • Gender Norms Curriculum • Social Assets Building • Sexual Violence Prevention • Financial Literacy
Secondary Interventions	• Combination Socioeconomic Approaches for Caregivers • Education Support • Contraceptive Method Mix • GBV Response • Health Services (Other STIs) • HTS • Parenting for Caregivers • IMPOWER/IMSAFER	• Economic Strengthening • Combination Socioeconomic Approaches for Caregivers of AGYW 15-17 • Education Support • Contraceptive Method Mix • GBV Response • Health Services (Other STIs) • HTS • PrEP	• Economic Strengthening • Education Support (up to age 20 for young mothers, YW finishing school) • Contraceptive Method Mix • GBV Response • Health Services (Other STIs) • HTS • PrEP
Contextual Interventions	• Community Norms Changes: SASA and Changing the Rivers Flow • Coaching Boys into Men (leveraged with OVC program) • Male sex partners: male champions, information & linkages to HTS, VMM, ART, PrEP		

In COP 22 PEPFAR will continue to utilize the standard DREAMS eligibility criteria, which were contextualized for Zimbabwe, shown in the graphic below.

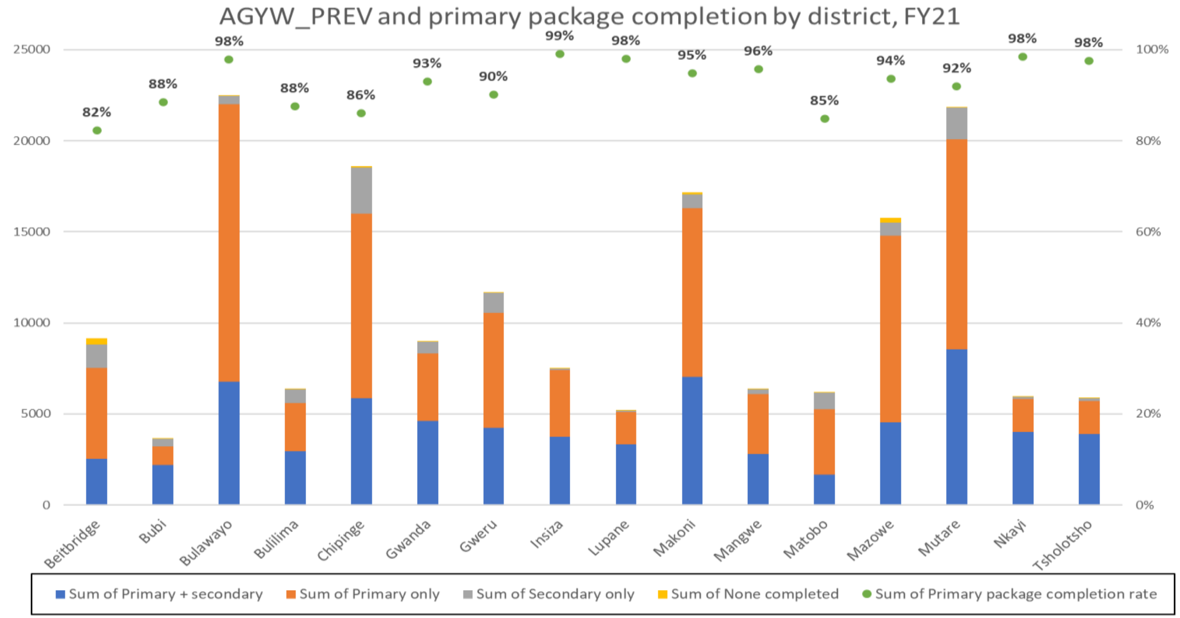
DREAMS Zimbabwe Eligibility Criteria YW 10-24

Determined | Resilient | Empowered | AIDS-Free | Mentored | Safe

In COP 22 PEPFAR will also continue to employ the Eligibility Screening Tool, which is used for screening AGYW against the standard eligibility criteria, and the Enrollment Tool which is a comprehensive needs assessment aimed at identifying specific needs for secondary services. In FY21 the program strategically consolidated the DREAMS enrolment function with selected IPs to facilitate the monitoring of AGYW while they are participating in DREAMS, completion of the primary package and completion of DREAMS as program. Consequently, completion of the primary package has increased from 52% in FY19 to 92% in FY21 as shown in the chart below.

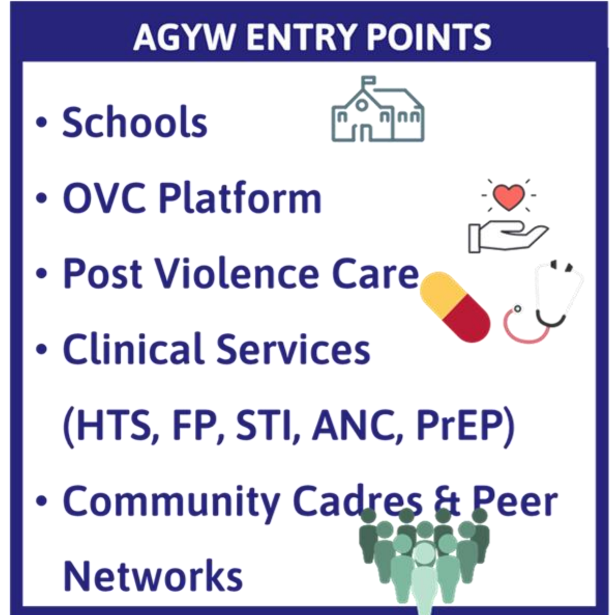


While there was some variation in primary package completion by SNU, completion of the primary package was above 80% across districts as shown in the chart below.



There is a significant improvement in primary package completion across districts as implementing partners were able to quickly offer the primary package once AGYW were enrolled.

In COP 22, the DREAMS program will continue to deliver services through a variety of approaches based on age, location, and subpopulation as depicted in the slide below.



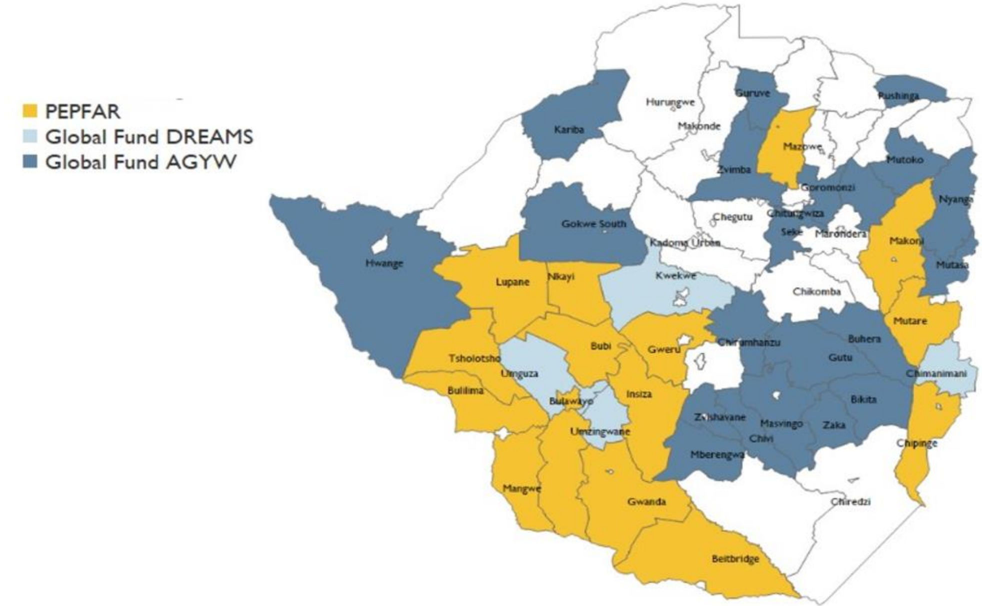
The DREAMS program draws on the strengths of multiple partners with different kinds of expertise and a well-developed coordination structure at the national and district levels. DREAMS is coordinated by the NAC structure at the national, provincial and district levels, to

ensure broad participation by the different sectors, service providers and stakeholders. PEPFAR supports DREAMS Coordinators at the central levels of the MoHCC and NAC whose strong leadership has been essential for coordinating a complex, layered program, and advocating for the expansion of DREAMS activities. PEPFAR is supporting knowledge transfer through the sharing of systems, guidelines and tools to stakeholders and partners implementing "DREAMS-like" activities with GFATM assistance. In COP 22 this collaboration will continue to include joint technical reviews and technical consultation, particularly in the areas of approaches to the prevention of sexual violence, PrEP demand creation, and M&E.

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

The program utilizes a DHIS2 database with a unique identifier code (UIC) system to track individuals, layered services, and referrals. In COP 20 PEPFAR overhauled the data entry, analysis, and reporting workflows of the DREAMS DHIS2 database to capture eligibility and HIV risk and vulnerability factors, better monitor AGYW's pathway through DREAMS as a program, and improve visibility into any weak links between services or referring partners.

In COP 20 PEPFAR expanded DREAMS to 10 new districts in Matabeleland North and South provinces, bringing the total to 16 districts in Zimbabwe. The 10 new districts were ranked as exceedingly high according to the 2019 UNAIDS Incidence Classification for AGYW 15-24 and did not have DREAMS or GFATM AGYW programs. Despite the challenges of COVID-19, implementation has progressed well in the new districts with all services fully operational.

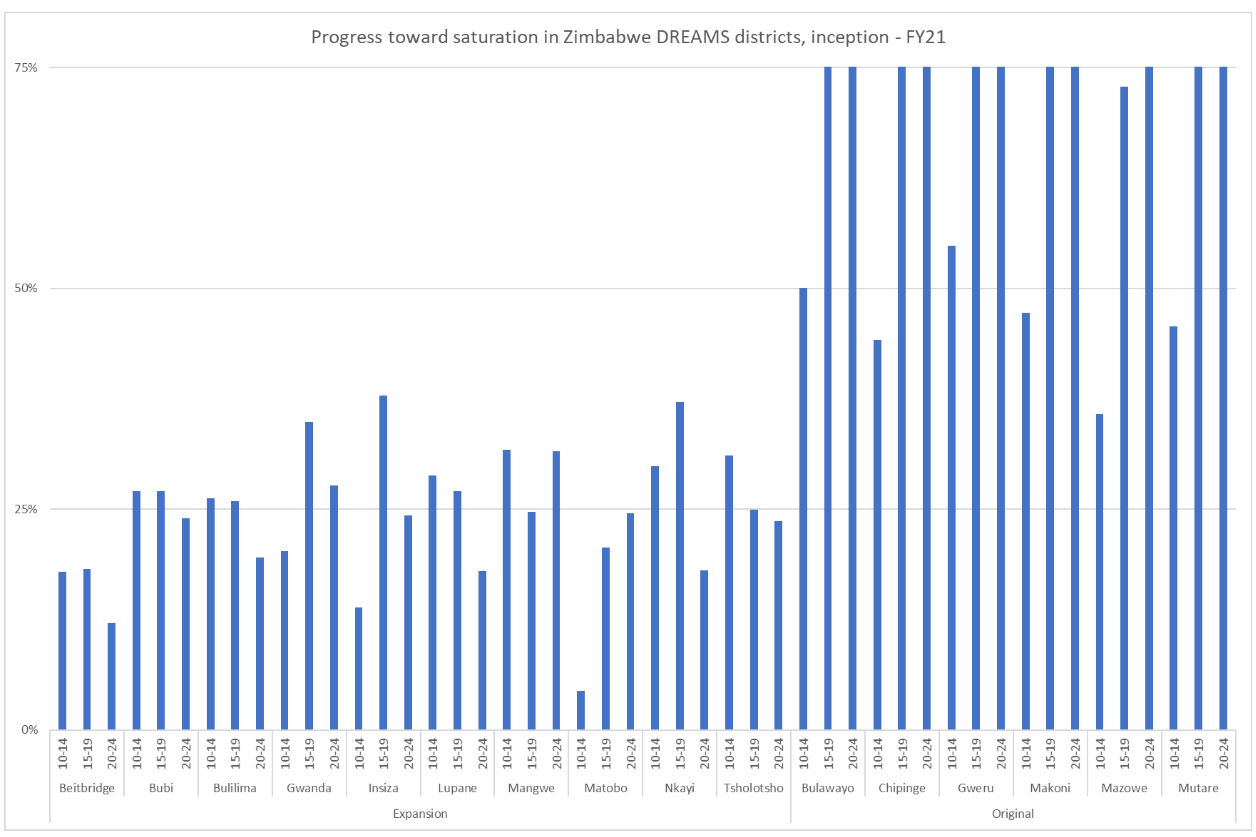


To support this ambitious expansion, PEPFAR hired a USG DREAMS Coordinator in COP 20 and is currently working on leveraging and strengthening legacy coordination and M&E systems

at the national level and through DREAMS POC implementing partners and DREAMS Ambassadors at the district level.

PEPFAR updated its saturation analysis for COP 22 with results shown below. As in previous years, a proxy for completion of DREAMS as a program (defined as completed the primary package plus one or more secondary services) was used to generate the saturation estimates. The saturation analysis indicated that DREAMS has reached at least 75% of AGYW 15-24 in the original six districts, while saturation has not been reached in the 10-14 age group. Accordingly, PEPFAR is implementing a partial maintenance scenario focusing on a smaller proportion of the most vulnerable AGYW in the 15-19 and 20-24 age groups, while extending geographic coverage of the primary package to reach a higher proportion of AG 10-14. PEPFAR is in the process of finalizing an SOP to guide implementation of DREAMS, specifically the process of tracking individual level completion in DREAMS, reassessing, and re-enrolling AGYW and considerations for programming in maintenance scenarios.

The chart below shows progress towards saturation in Zimbabwe. Saturation has been achieved amongst 15-19- and 20–24-year-olds in maintenance districts. However, 10–14-year-olds have not reached saturation levels owing to a cohort of adolescent girls aging into this age band. There is notable variation in saturation among the expansion districts since the program started in COP 21.



DREAMS activities were significantly impacted by COVID-19 and several national lockdowns that took place in 2021. The slide below summarizes the major impacts on the program as well as the many adaptations that were implemented to maintain services for AGYW and their

families and communities. Many of these adaptations will be carried forward to COP 22 and beyond the COVID-19 period.

COVID-19 Impact and Adaptations

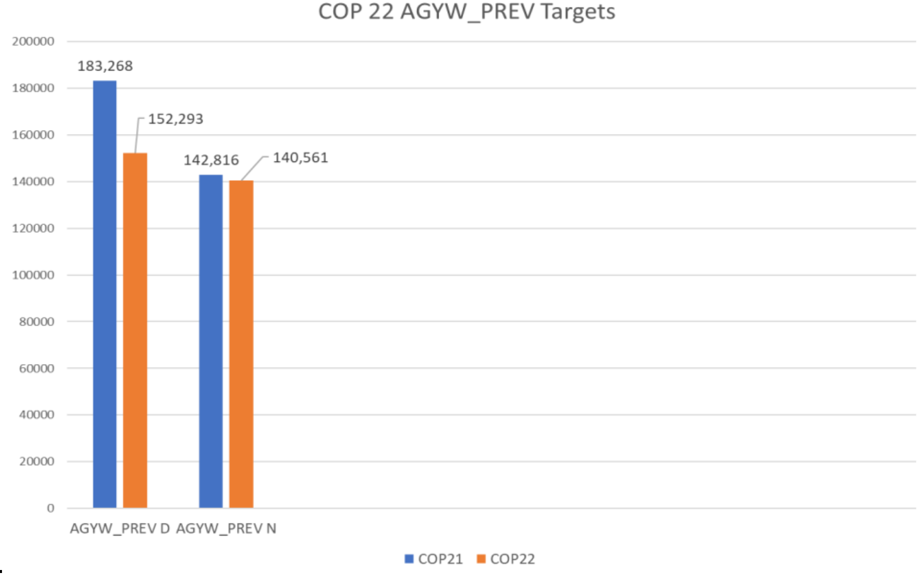
Impact on DREAMS program	Adaptations
Limited access to SRHR services due to restricted movement in communities.	Established MMD, PrEP home deliveries, offer transport to access services, strengthened outreach activities . Introduce the Services Referrals Network (SRN), Strengthened the use of virtual platforms and radio programs to keep girls engaged
Continued school closures affecting 10–14-year-old access to primary package services.	Introduced the Community Schools Program to keep the girls engaged in their communities
Prolonged time to complete sessions due to limited gathering of people in communities.	Conducted sessions in small groups for AGYW and Care givers. Introduced village-based approaches to reduce distances to access services
Increased GBV cases	Strengthen community sensitizations and use of various social media and other virtual platforms to encourage communities to report cases of GBV

COP 22 strategic priorities for DREAMS are summarized below:

- **Meaningful Engagement of AGYW-DREAMS Ambassadors** will continue to assist in coordinating DREAMS at the district level and participating in IPs' Project Advisory Committees. The mentoring TA currently underway will develop a handbook on visioning and career development.
- **Finding and Engaging the Most Vulnerable AGYW.** The program will continue to identify AGYW through multiple entry points including KP, OVC, and GBV platforms and clinical entry points. Screening and enrolment data will continue to be reviewed and used to inform programming.
- **SRHR- and Adolescent-Friendly Services.** SRHR will continue to be strengthened through community-based delivery and mentoring of HCWs at targeted public sector sites. HCD approaches will be used to further fine tune the approach. Targets for family planning will increase to meet the high demand for this service among AGYW in DREAMS districts. The program will explore the feasibility of integrating ASRH into the DDD activity with private pharmacies and continue to strengthen access to and quality of post violence care services.
- **STI Testing and Treatment.** STI screening and treatment is integrated in the community-based SRHR package.
- **Identifying New Solutions to Fill Programming Gaps.** The program will leverage MoHCC/NAC PLACE studies, and other COP funding streams, to carry out and assess a pilot targeting male sexual partners of YWSS in Bulawayo district. Pilot includes HIV testing and linkage to ART/PrEP/VMMC, condom promotion, and GBV prevention—targeted at hot spot locations and through microplanning.

- **Scale-Up Comprehensive Economic Strengthening.** Program will build on TA activity carried out in COP 20 to assess and adjust the proposed pathways for ES and use of standardized benchmarks to measure progress. Program will continue to engage the private sector for additional opportunities.
- **Enhance YWSS Services.** Based on lessons learned and internal program assessment, more DREAMS services for YWSS will be consolidated to a one-stop shop approach to limit the need for referrals. The program will assess how to make program offerings more relevant for YWSS: not beginning with group-based activities, more flexible and part-time training, simplifying screening and enrolment process, review roles and appropriateness of peers and mentors for YWSS.
- **Mentorship for AGYW.** Program will roll out an updated mentorship package based on COP 21 TA activities currently underway: updated/supplemental tools for mentor training and support, program management handbook, SOP for virtual mentoring.
- **PrEP scale-up will continue to be an important focus.** Demand creation initiatives will be scaled through integration across DREAMS services (e.g., PrEP parenting module). Lessons from the Dapivirine Ring pilot in COP 21 will be incorporated into the program. The program will leverage the centrally-funded MOSAIC award for continued TA to the MoHCC and introducing demand creation, literacy, and provider tools for the introduction of new PrEP products (the Ring, CAB-LA).
- **Mental Health.** The program will explore opportunities to integrate modules on self-care, wellness and resiliency skill building in group-based activities for AGYW. The scope will include district level mental health resources in DREAMS referral tools.

COP 22 AGYW_PREV targets are shown below. In COP 22 AGYW_PREV targets are slightly reduced to account for the program's completion and saturation scenarios. Moving forward, greater emphasis will be placed on individual level completion (AGYW receive the primary package plus all secondary services according to need), which will require a focus on secondary service layers.



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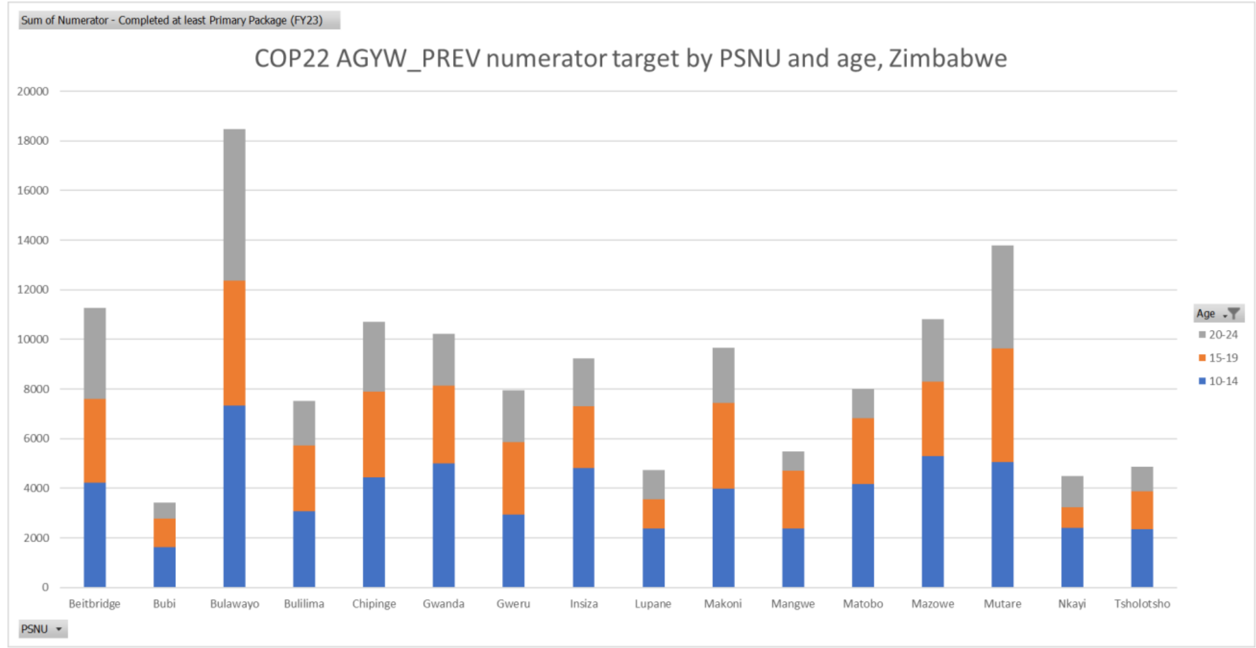
AGYW_PREV targets by age group and district for COP 22 are shown below.



HIV prevention strategies for male partners of AGYW, including VMMC, targeted HTS, linkage to ART or PrEP, and access to condoms, will continue to be fundamental in DREAMS districts. Additionally, the DREAMS core package includes community norms change activities (i.e., Changing the Rivers Flow, SASA) to increase understanding and engagement on sexuality, gender and masculinity, sexual and reproductive health, and violence among traditional and religious leaders, as well as evidence-based parenting interventions (i.e., Families Matter Program, Sinovuyo) which also have strong sexual violence prevention components for caregivers of adolescent girls ages 10-14. PEPFAR will continue to use program data to understand the demographic characteristics of men who test HIV positive, as well as the type of partnerships/relationships they engage in, and venues where they can be reached with services. In COP 22 the program will leverage an ongoing PLACE study to carry out and assess a pilot targeting Male Sexual Partners (MSP) of YWSS with the goal of identifying effective targeting strategies for MSP and increasing their uptake of HIV prevention and treatment services.

PEPFAR will deliver HIV and sexual violence prevention education to adolescent boys and girls aged 10-14, who participate in the Comprehensive Sexual Education (CSE) general assembly and teacher-led classroom sessions in schools supported through the DREAMS platform. CSE programs reach both girls and boys aged 10-14 years in primary and secondary schools (focus is on Form 1 and 2). The curriculum and companion materials were revised previously based on the PEPFAR curricula review process and now include the 3 PEPFAR Modules on Sexual Violence Prevention. Furthermore, leveraging FCI investments, PEPFAR will continue to implement two additional evidence-based approaches: Coaching Boys to Men and IMPower for adolescent boys and girls aged 10-14.

In COP 22 DREAMS will continue to leverage the OVC platform to ensure female OVC who meet the DREAMS eligibility criteria access the full DREAMS package and AGYW (including their young children) identified through other DREAMS entry points access OVC services as

required. Key DREAMS-OVC collaborative activities in COP 22 include continued joint planning, implementation, and monitoring of DREAMS-OVC activities; aligning approaches for sexual violence and HIV prevention for adolescents and engagement with faith communities; and coordinating enhancements to the economic strengthening portfolio.

c. OVC:

In COP 22, PEPFAR will continue prioritizing the following sub-populations for support through the OVC platform:

- Children and adolescents living with HIV (especially newly enrolled and virally unsuppressed)
- HIV exposed infants, especially those LTFU in the PMTCT cascade
- Biological children of adult caregivers who are living with HIV
- Survivors of sexual violence
- Children in child-headed households
- Children of KP
- DREAMS AGYW
- 10–14-year-olds in areas with high violence and HIV burden

In response to the evolving HIV epidemic, the need for operational efficiency and to increase coverage of C/ALHIV and HIV exposed infants, PEPFAR will undertake a geographic pivot of the OVC program in COP 22. Five districts will be transitioned from direct PEPFAR support, while nine districts will be added, to make a total of 25 operational districts. The caseload in the transitioned districts will be transferred to GoZ (Social Welfare), existing community systems or child-centered NGOs in those districts.

OVC geographical review: pivoting to reach more C/ALHIV

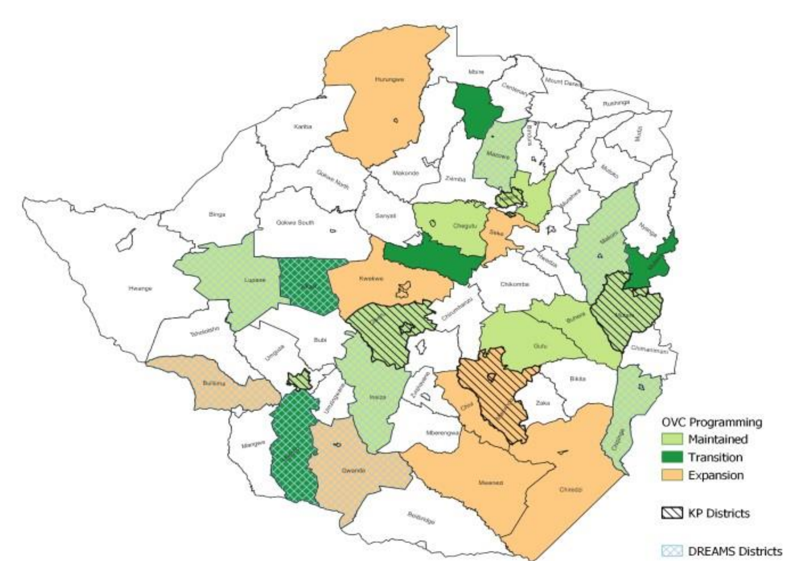
Factors considered

Epidemiological impact

- Children and adolescents living with HIV and their viral suppression status
- HIV exposed infants
- Collaboration with the clinical program to address gaps in C/ALHIV treatment and care

Operational efficiency

- Percent of identified populations served at high volume sites
- Complementarities with DREAMS and KPprogramming
- Feasibility of reaching C/ALHIV and families in communities in various districts (rural, large, access etc.)
- Resources needed for geographical expansion versus geographical shift



The process is gradual and is already in motion and the aim is to ensure that by September 2022, all enrolled children have been handed over to a functional system that will continue to

take care of their issues. There is an existing plan drawn jointly with GoZ and the affected communities and some of the activities already being implemented are:

i. Handing over children to the Ministry of Public Service Labour and Social Welfare's Department of Social Development's National Case Management System. It is important to note that the OVC Program has over the years been building the capacity of this system and is confident of the capacity and ability of this system.
ii. Engaging with the Basic Education Assistance Module (BEAM) to take up the payment of school fees component for the exiting cohort. Through advocacy from the OVC Program BEAM now has a comprehensive approach to educational assistance and now caters for uniforms and other school utilities.
iii. Strengthening Families: The OVC Program has over the years through the household economic strengthening program as well other family strengthening programs been preparing families to take over the care of their children once the program ended.
iv. Matobo and Nkayi are DREAMS districts, and the program is currently identifying and referring eligible girls to the DREAMS program.

In COP 21, PEPFAR worked with the MoHCC to establish a coordination forum comprised of OVC IPs and MoHCC PMTCT and pediatric program staff, which meets quarterly to discuss challenges and how the OVC program can further support EID, VL, and retention in care among infants and C/ALHIV. This forum will be carried on into COP 22.

The PEPFAR OVC strategy will continue to be delivered through three operational buckets: Comprehensive, Preventive, and DREAMS.

d. Primary Prevention of HIV and Sexual Violence among 9–14-year-olds:

PEPFAR will continue to prioritize primary prevention of HIV and sexual violence among children and adolescents aged 10-14 years which will be delivered through the OVC and DREAMS platforms. Interventions prioritized for COP 22 include IMPower/IMSafer, Families Matter, Sinovuyo, Coaching Boys into Men, SASA and the Health for Life materials used in the DREAMS program. In FY21, PEPFAR supported refresher training on Child Safeguarding for IPs working with children as well as LIVES training for first responders to GBV. In COP 22 PEPFAR will continue to work with government and civil society to strengthen local child welfare and protection capacity and to extend coverage for those at highest risk of violence. In addition, PEPFAR will prioritize digital safety with IPs and schools to address new and significant risks to children through the creation of new platforms that enable and facilitate bullying, hate speech, sexual abuse, exploitation, victimization, recruitment into trafficking, and radicalization to violence.

e. Children / PMTCT

Currently, 100% of health facilities in OVC catchment areas are covered by MOUs granting the implementing partner permission to work within the facilities. The Community-Clinic Linkage SOP will remain the guiding document utilized to refine these agreements. As feasible, the IPs will maintain support for case managers at high-volume clinics to ensure smooth coordination and referrals between health care workers and community case workers. In COP 22 PEPFAR will continue to assess HIV+ women in adult care who are pregnant and/or have children aged 0-19 to determine if their families should be enrolled in the OVC program. PEPFAR will continue

to conduct home visits to all enrolled OVC to encourage HIV testing (if indicated based on risk assessment), including for children lost to follow up in the PMTCT cascade.

PEPFAR is committed to scaling up evidence-based interventions that improve treatment outcomes for the pediatric population. Currently PEPFAR is funding the expansion of the home grown Zvandiri model to achieve saturation and make desired impact. In some districts, Operation Triple Zero (OTZ) is being rolled out. We remain committed to taking new interventions on board.

Zimbabwe has made significant progress towards the achievement of the 95-95-95 goals. However, the pediatric population significantly lags, when compared to adults. In COP 22, PEPFAR will support implementation of a ‘pediatric surge’ to accelerate progress towards closing the gap between adults and children. The focus of the surge will be on HIV case finding and linkage to ART for biological children of parents on ART. Guided by the available resources, the surge will be implemented in districts contributing 40% of the 1st and 2nd 95 gap. Surge strategies:

- Index testing for biological children of parents on treatment, to achieve 100% coverage
- Continue use of HIV risk-based screening tool to reduce NNT
- Oral screening using HIVST kits (pending MOHCC approval) in cases where children cannot immediately come to the health facility for testing
- Integration of pediatric HIV case finding, linkage and retention with EPI services, OVC services
- Monthly data collection and reporting
- Monthly interagency support, supervision, and meetings
- Collaboration with OVC

The pediatric surge will be implemented over and above the existing pediatric ART COP 22 core strategies across the cascade.

Figure 4.3.1 PMTCT Cascade, FY21

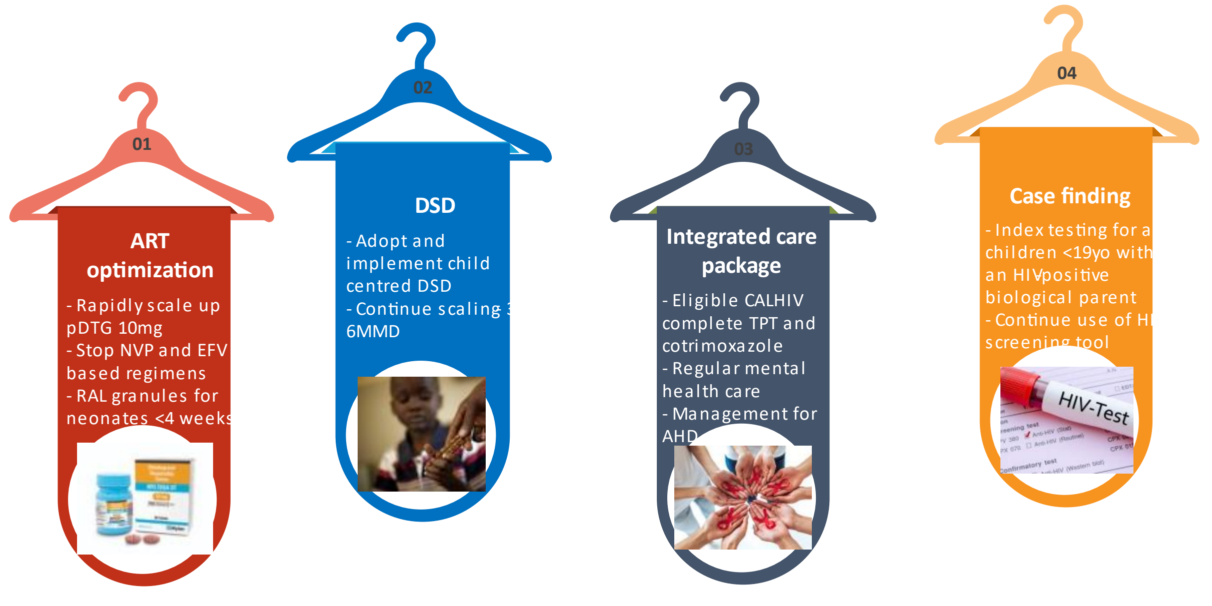
PMTCT_STAT D	PMTCT_STAT N
359,894	355,356

STAT_POS	PMTCT_ART	EID D	EID 2 Mo	EID 12 Mo
38,629	38,560	41,341	38,626	50,514

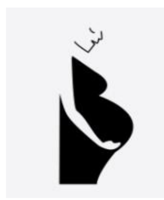
PMTCT_STAT Total Coverage
98.7%

% STAT Positive	PMTCT_ART Coverage	Proxy EID 2mo coverage	Proxy EID 12mo Coverage
10.87%	99.82%	93.43%	122.19%

Focus on achieving and consolidating pediatric minimum program requirements



COP22 strategies to address high vertical transmission



HIV infected women not on ART

- Treatment literacy for early ANC booking
- Elimination of ANC user fees
- Integrated ART in MCH, reduce missed opportunities

Incident infections

Continue to scale PrEP

Support disclosure among young mothers, those at risk for IPV

Maternal retesting for early identification

Reduce IIT & better Rx outcomes

- Tracking and tracing – audits, cohort monitoring, HER
- Peer support, YMM, DSD, 3-6MMD, OVC
- Optimized ART (TLD) plus VL monitoring
- Dual testing for HIV and syphilis

PW starting ART late >32wks

- Client literacy
- Community engagement and dialogues for pregnant & lactating women
- Male & female mobilisers

f. Key Populations

In COP 22, PEPFAR will continue to expand quality, person-centered approaches for HIV prevention, treatment, and retention for KP in the 6 largest urban districts in the country (Harare, Chitungwiza, Bulawayo, Gweru, Mutare, and Masvingo) in addition to the border districts for the FSW program (Beitbridge, Chriundu, Forbes, Plumtree, and Victoria Falls). PEPFAR will work hand in hand with the KP community and local CBOs to address obstacles to service uptake and retention and to meet KPs where they are with services that meet their needs. COP 22 strategic priorities for the KP program are summarized below:

- Build on what has worked well in service delivery: scale up PrEP, microplanning, further develop and strengthen KP DSD approaches and cross-border activities developed under KPIF.
- Continue to improve KP data quality and use; leverage ongoing studies to update FSW PSE, strengthen KP data in the EHR
- Coordinate with ongoing CLM initiatives to ensure greater engagement and leadership by KP.
- Fully implement the PEPFAR KP Program Standards.
- Promote enabling environments and address structural barriers that impede the scale-up of KP-led and KP-competent services.
- Promote funding, capacity building and other support to KP-led organizations.
- Strengthen the KP competency of HIV service providers.
- Coordinate strategically with relevant USG, GoZ, multilateral and other donor funding streams and institutions to mitigate harmful policy and social norms that fuel stigma, discrimination and violence faced by KP.
- Leverage continued support to the National TSC to strengthen quality, capacity, and sustainability of the national KP program, including harmonization of investments and activities across funding partners.

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

PEPFAR's strategy for prevention in the KP program is summarized below.

COP22 Strategy for Comprehensive & Integrated Services for KP: Prevention

NEW: integrated One Stop Model for KP sexual minorities within existing One Stop Models.

KP **integrated clinical services for prevention**, to include STI, FP, GBV.

Condom and lubricant promotion & distribution through peer cadres, community outlets, hotspots--safe spaces + increase number of service delivery points.

Differentiated HIV testing: community & facility HTS incl. DIC, moonlight, hotspot, index, HIVST, social network testing--increase safe space/community service delivery points PrEP demand creation, risk assessment.

PrEP clinical services: site level, community level building on COVID adaptations.

Community led PrEP services: PrEP demand creation, tracking, retention + **(NEW: community PrEP refills)** & adherence support through Champions, EMPs, microplanning, adherence groups.

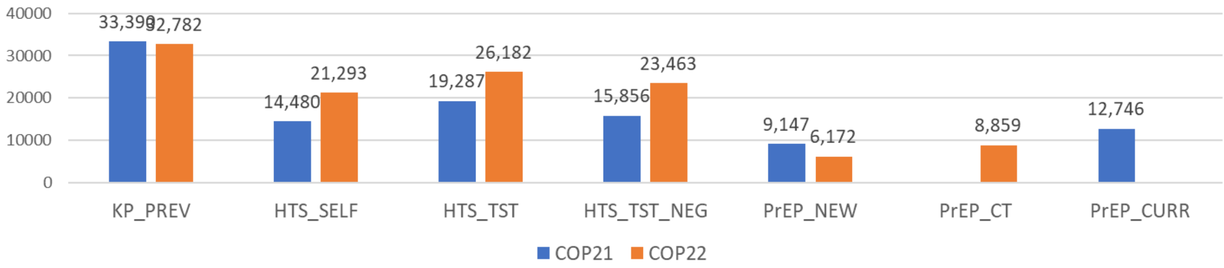
Increased service delivery at **safe spaces.**

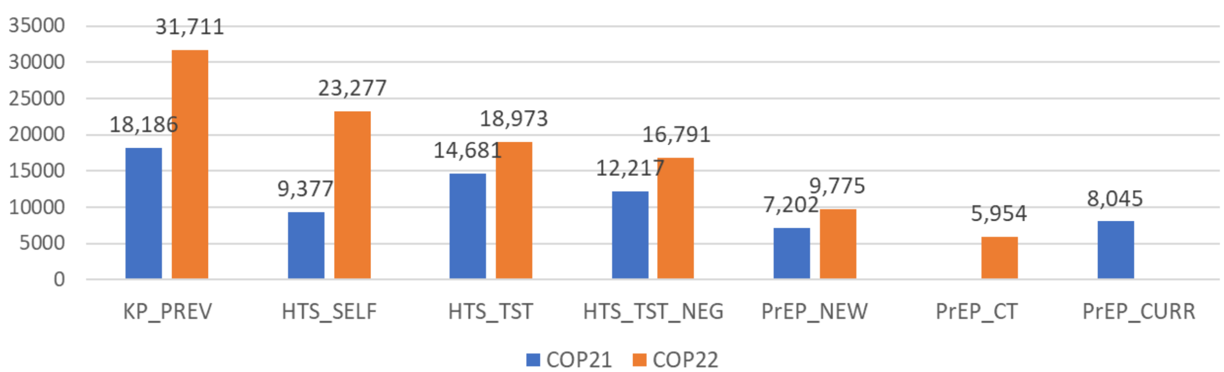
NEW: explore feasibility of a small pilot to integrate Gender Affirming Hormonal Therapy: to include leveraged funds & client cost share (leverage PEPFAR platform, no PEPFAR direct $).

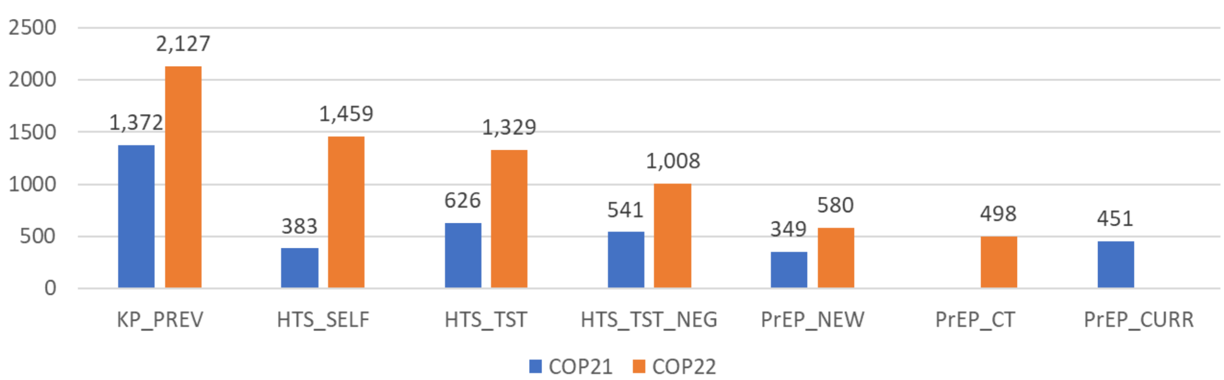
Dedicated **focus on capacity strengthening (institutional & for service delivery capacity) for young, diverse KP orgs.**

The COP 22 strategy will be underpinned with efforts to meet/sustain and monitor the 9 PEPFAR KP Program Requirements. See Appendix D for a detailed description of the status of these Program Requirements and plans for COP 22.

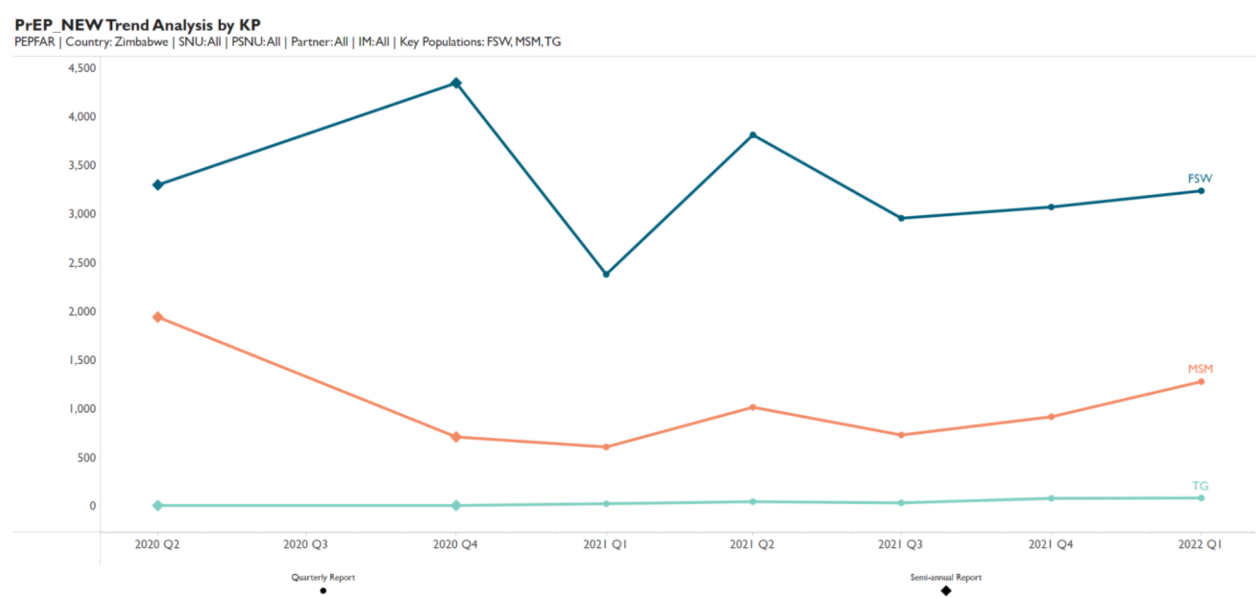
COP 22 targets for the prevention cascade in the six focus districts and border locations are below. Note targets for YWSS in non-KP focus districts are not captured below (refer to the DREAMS narrative above).







PEPFAR is on track to meet PrEP targets for KP in COP 21 and will continue ambitious PrEP scale-up in COP 22. FSW and MSM historically have been the highest PrEP users although COVID-19 disproportionately impacted MSM as this population was driven further underground during lockdowns. With the easing of COVID-19 restrictions, PrEP uptake by MSM and TG is beginning to recover as seen in the chart below.



In COP 22, PEPFAR PrEP_NEW targets for MSM and TG increased; for FSW they decreased because of fewer FSW who are PrEP-naïve. However, ambitious PREP_CT targets were set with the expectation to successfully re-engage FSW who had discontinued PrEP. PEPFAR will continue to support demand creation for PrEP and scale up successful models such as ColourZ for MSM. In COP 22 PEPFAR will leverage the KP platform and explore the feasibility of a small pilot to integrate GAHT. Given the long term financial and sustainability implications, the pilot will include client cost share and a cost recovery component. In addition, PEPFAR will strengthen education and counseling on drug interactions, including the safety of oral PrEP for TG women on GAHT.

PEPFAR's COP 22 strategy for care and treatment in the KP program is summarized below.

COP22 Strategy for Comprehensive & Integrated Services for KP: Care & Treatment

Expanding person-centered, differentiated models of care for PLHIV including:

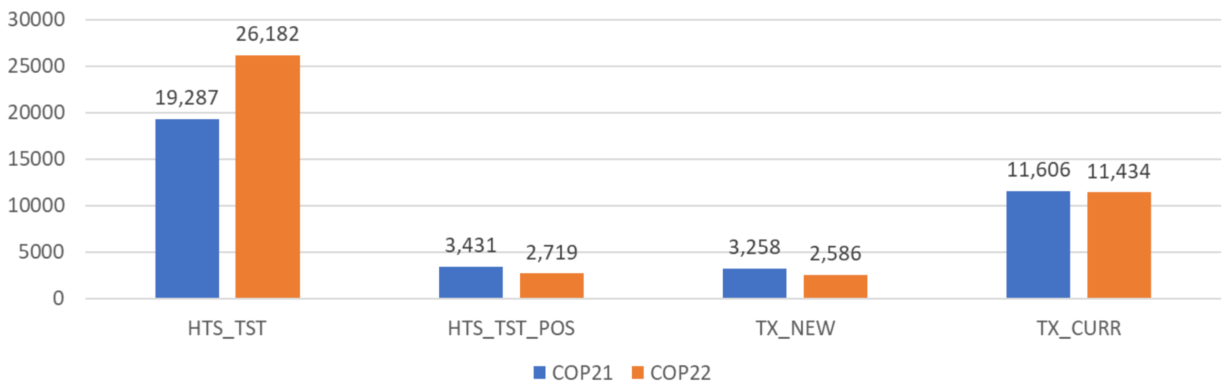
- **SDART initiation**, and subsequent **linkage and tracking** to public sector.
- **Expansion of community ART initiation and dispensation** including MMD, through DICs, community distribution, building on COVID adaptations.
- **Peer cadres** (PEs, EPM, microplanners) to support HTS, linkage, adherence support, tracking.
- Integrated, **one-stop shop model** for provision of services.
- Mobile and moonlight services.
- **VL services** including community collection, facilitated results return and enhanced adherence counseling.
- **Tracking of full cohort**, incl. those receiving TX in public sector through UIC + custom indicator reporting.

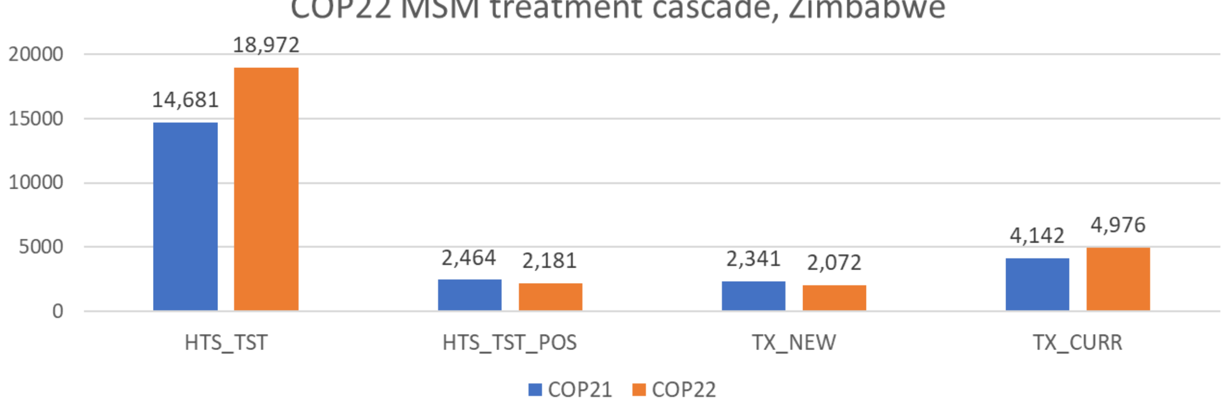
Greater focus on structural Interventions:

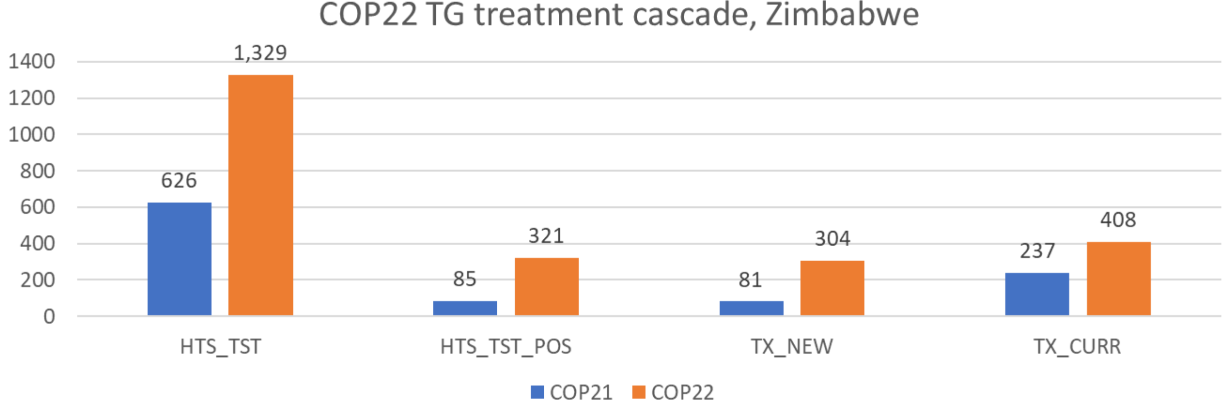
- Strengthen **integration of mental health** (friendship bench), **GBV prevention/response** tailored to specific KP groups
- Strengthen **capacity for KP services public sector**:
  - **Mentoring and attachment of health care workers** at its clinics especially in peripheral areas
  - **Site level training/ mentoring** to already identified KP friendly public sector sites in KP districts
  - **Capacitation of clinic committees** on KP friendly approaches for strengthened
  - Engage the KP TSC to **review effectiveness of strategies** being used to support the **public sector**

7

COP 22 care and treatment target cascades for the three priority KP groups (FSW, MSM, TG) are shown below.







PEPFAR will identify opportunities to strengthen case management of KP within the HIV program, such as a welcome-back package and increased access to mental health and psychosocial support (MHPSS). Currently IPs are making use of differentiated services (e.g., Friendship Bench, facility navigation and support, microplanning) to provide MHPSS as well as strengthen continuity in treatment for KP.

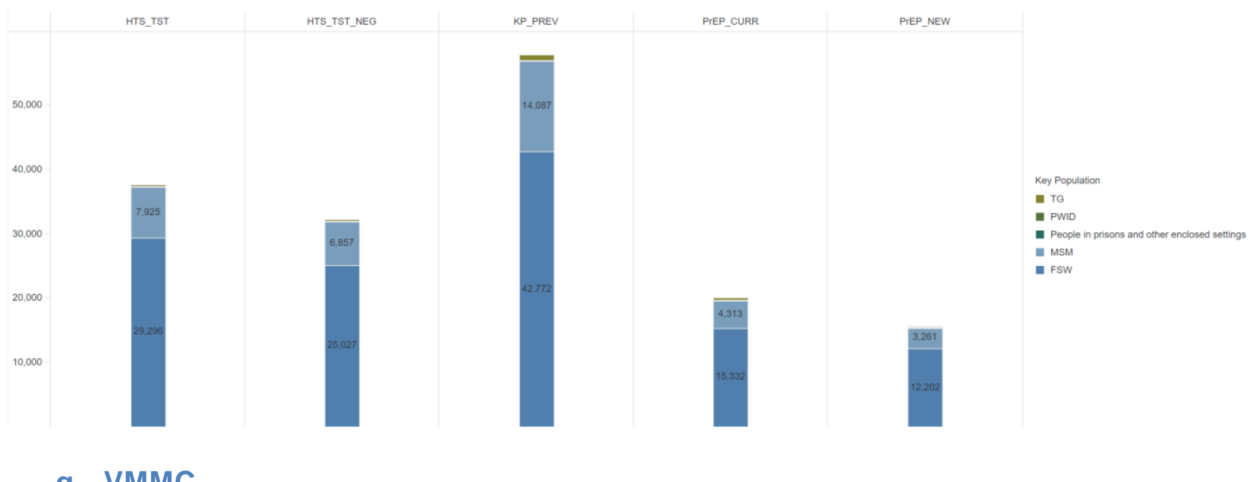
In COP 22 PEPFAR will emphasize the importance of structural interventions in the KP program. COP 22 priorities include supporting integration of stigma and discrimination training into preservice training for nurses, rolling out Gender and Sexuality Diversity and LIVES training for all KP and DREAMS IPs, supporting KP participation and leadership in health facility committees and other CLM efforts, expanding activities and targets for GBV response and prevention, expanding KP specific services linked to health outcomes (e.g., SE empowerment for YWSS in DREAMS, GAHT pilot with non-PEFPAR funds), capacity strengthening of KP CSOs and expanding community-centered KP programming.

PEPFAR commits to inclusive consultations with KP communities to expand DSD models, in context specific geographies and work with the TSC to review existing KP DSD models and support the process of adaptation, harmonization, and scaling as relevant. PEPFAR will also work with KP communities to expand safe spaces, especially for underserved KP groups such as the Transgender and Intersex communities, leveraging existing drop-in centers when possible. PEPFAR will continue to explore synergies and potential entry points to reaching

PWD. While activities aimed at preventing drug use have not been included in COP 22, PEPFAR is interested in exploring potential prevention activities as informed by the ongoing GFATM study. Young KP is an important constituency and PEPFAR will work with the TSC and IPs to ensure activities are more inclusive in COP 22.

PEPFAR has been investing in training of health care workers in KP-friendly services for several years. Unfortunately, the HCW crisis has eroded much of that investment as many trained nurses have left public service or the country. In COP 22 PEPFAR will continue with strategic and targeted training and mentoring of HCWs, remaining mindful of the ongoing exodus of nurses. In COP 22, PEPFAR will support the MoHCC to integrate KP-friendly service provision into nurses' pre-service curriculum as a more sustainable way to strengthen HCW capacity in this area.

Figure 4.3.2 Prevention Continuum by Key Population Group, FY21

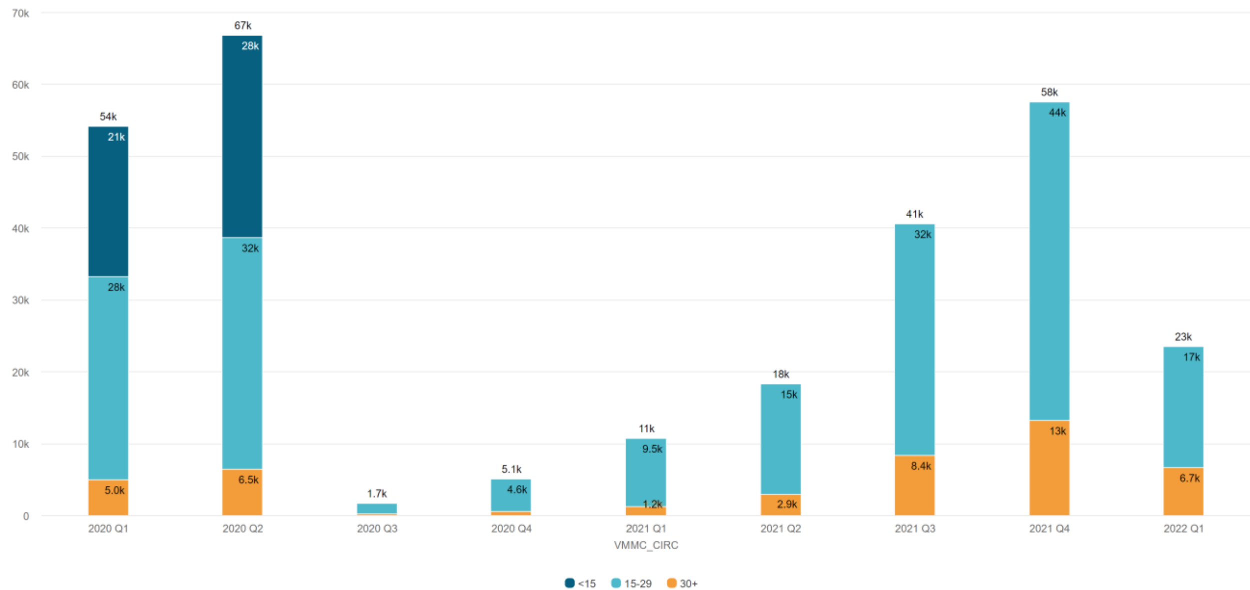


g. VMMC

PEPFAR's strategic approach in COP 22 continues to support the implementation of the National VMMC Sustainability Transition Implementation Plan (STIP; 2019 – 2021). COP 22 Guidance specifically limits voluntary medical male circumcisions to males aged 15 years and over, with no voluntary circumcisions in males less than 15 years old. In COP 22 VMMC targets and budget were reduced to ensure that the program focuses on providing quality, efficient and adverse-event-free MCs to the target age group. PEPFAR collaborates with the WHO, the BMGF and CHAI, under the leadership and coordination of the MoHCC, to build capacity for VMMC at the provincial, district and facility levels. This approach for local capacity building will form the core of COP 22 implementation, as the focus shifts to sustainability, sustaining epidemic control, country ownership and assuring quality of service provision.

PEPFAR VMMC support started in 2009. From September 2016 to September 2019, Zimbabwe doubled the number of circumcisions in males aged 15 – 29 years. The COP 22 target is 133,995 MCs.

Figure 4.3.3 VMMC Quarterly Trends by Age



Despite COVID-19 restrictions on full VMMC implementation, the number of MCs increased, which is attributed to adaptations and innovative measures by service providers.

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

	Scale Up Districts	Sustainability Districts	Strategic Alignment Districts
Number of Districts	22	4	10
VMMC Coverage	Low (<60%)	High (>79%, low VMMC demand)	Medium to High (>60%, continued demand)
VMMC Targets	133,551 MCs	7,095 MCs	44,522 MCs
Core Package	Surgical MCs (Dorsal Slit), all age bands		
	Quality Management (routine DQAs, IQAs, annual EQA, cQI)		
	Standardized, MoHCC led AEM and SAE dashboard		
	PBF (PEPFAR structure, no pooling of funds, will be transitioned)		
	Circumcisions in 15+, except for a few MCs in CDC districts where Shang Ring and Tanner Staging will be used in 13-14-year-old men that are eligible		
Strategy	Maximize investments with a goal of 80% coverage while assuring quality of service provision. Maximum focus on 15+	Maximize investments towards sustaining quality VMMC circumcisions in target age group, using local and existing institutions. Innovation	Align program towards sustaining HIV epidemic control, reducing HIV incidence in men 15+ Integrate service provision with other biomedical prevention, bi-directional referrals with treatment programs. Maximize coverage and demand using site cohorts** Focus on sexually active and high-risk men (HRM) combined with innovation

HRH and Service Approach	Expanded MC Cadre footprint (Service provision) Innovation- Shang Ring @	Reduced MC Cadre Footprint and, in some cases, light touch TA (Technical Assistance)	Integrated HCP footprint (biomedical prevention and treatment) ++ Innovation: Shang Ring @
Demand Creation	Active (Soccer Galas, IPC Agents, School campaigns, etc.)	Passive, Client led	Targeted, Service Delivery led (referrals, high risk, etc.)
Linkage to other biomedical prevention methods	High-risk men identified in VMMC referred for other biomedical interventions (PrEP, Condoms, STI, NCDs), VMMC clinic acts as Biomedical Prevention Corner (provision of comprehensive HIV prevention education and psychosocial counselling)	Innovation example: Linkage with vaccination campaigns (HPV for girls) and Mass drug administration campaigns for NTDs	Examples: Health interventions that reach men: Targeted outreach for sexual partners and referrals from DREAMS, KP and HRM, VCT, STI, PITC, PrEP, ANC, FP, ICT clinics Referral coupons and Transport reimbursement to facilitate linkage

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

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

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

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

In COP 22, PEPFAR will train clinicians for VMMC service delivery across all supported districts to achieve at least two certified clinicians per team. The dorsal slit surgical method will remain the standard method of circumcision for all age bands. PEPFAR is committed to rolling out the Shang Ring in COP 22 to 13- to 14-year-olds once the safety, cost effectiveness and market appeal of the product is demonstrated by the assessment.

PEPFAR is using reusable kits in almost half of the supported districts and expects to roll out to the remaining districts during the second half of FY22 and during COP 22.

PEPFAR will continue to reinforce COVID-19 prevention measures, general surgical infection control, informed consent documentation, adolescent client counseling, appropriate follow-up documentation, conduct intensive program monitoring and data reviews. This will inform tandem, but structured, site visits to underperforming sites to diagnose problems and institute corrective actions.

COP 22 will continue the adoption of a PEPFAR- and BMGF-supported performance-based financing structure for the program, with a yet-to-be-determined full transition to the country-led Results Based Financing. In COP 22, the cost reimbursement structure will be replaced with the quality and system focused PBF, ending a decade long system that incentivized VMMC providers directly. PEPFAR will continue to support the national VMMC SID and the national STIP to ensure the program remains on track to successful transition to sustainable and country-owned biomedical HIV prevention programs.

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

Improve Viral Load Coverage and Early Infant Diagnosis:

In COP 22, PEPFAR will implement a multi-year strategy and strong partnerships with GFATM, the GoZ, and others to mobilize and coordinate resources to address priority interventions. PEPFAR will:

- Continue to work closely with the GFATM to address commodity forecasting and funding needs while ensuring alignment on key priorities for viral load testing coverage and suppression.
- Standardize prioritization of VL samples for most at-risk clients including virally unsuppressed patients, pediatrics, and key populations.
- Continue to address laboratory system optimization and establish plan for VL equipment breakdowns, technology transitions for efficient resource use and time taken for repairs; including supporting VL specimen collection according to protocol balanced with commodities availability to process tests.

Optimize PEPFAR Programs to Achieve and Maintain Epidemic Control:

We will work with the MoHCC to implement TUTT. PEPFAR has committed to optimize TB screening and diagnosis using TUTT in all PEPFAR-supported health facilities.

Zimbabwe will continue to scale up targeted distribution of HIVST kits as a screening tool targeting partners of HIV positive pregnant and lactating mothers whose HIV status is unknown, KP clients (where client screening is determined to be safe and feasible), adolescents, young and older men, and young women. HIVST kits will also be distributed through the Zvandiri model to reach sexual partners of HIV positive young people who rarely access health facilities.

PEPFAR will fully support the implementation of person-centered interventions including all the DSD models approved by the MoHCC as indicated in the MoHCC's Operations and Service Delivery (OSDM) Manual for HIV Care and Treatment with the aim of having at least 80% of eligible clients in a suitable DSD model of their choice by December 2023.

Strengthen Prevention, Care, and Treatment, especially for Key Populations and Pediatrics:

PEPFAR will continue to improve reach and offer tailored, person-centered prevention, testing, care, and treatment interventions for MSM and TG populations in COP 22. Specifically, PEPFAR commits to inclusive consultations with KP communities to expand DSD models such as incorporating TG-specific space and activities into existing Drop-in Centers and piloting gender-affirming hormone therapy. Furthermore, in COP 22 the KP TSC will lead the review of existing KP DSD models and support the process of adaptation, harmonization and scaling as relevant**.** PEPFAR is closely following the people who use drugs (PWD) study proposal funded by the GFATM and will continue to explore synergies and potential entry points to reaching PWD**.** Young KP is an important constituency and PEPFAR will work with the TSC and IPs to ensure program activities are more inclusive in COP 22. PEPFAR has identified additional KP CBOs to lead CLM activities with the goal of covering 80% of facilities with KP programming with CLM in COP 22. The KP TSC will play a key role in coordinating KP-led CLM interventions

across funders and ensuring CLM findings inform strategies, remedy bottlenecks, and increase equitable access to services.

For DREAMS, in COP 22 PEPFAR will increase targets for comprehensive economic strengthening interventions for AGYW within the limitations of the COP 22 budget. In addition, PEPFAR will build on the technical assistance activity carried out in COP 20 to assess and adjust the proposed pathways for economic strengthening and use of standardized benchmarks. PEPFAR will deepen engagement with the private sector to expand opportunities for AGYW. Based on lessons learned and internal program review, PEPFAR will further consolidate services for YWSS to a one-stop shop approach to limit the need for referrals and potential for loss to follow up. PEPFAR will also assess how to make DREAMS program offerings more flexible such as conducting training part-time, simplifying the screening and enrolment process for YWSS and reviewing the roles and appropriateness of peers and mentors. Finally, PEPFAR will leverage MoHCC and NAC PLACE studies to carry out and assess a pilot targeting male sex partners of YWSS in Bulawayo district**.** The pilot will target hotspots and include HTS and linkage to ART, PrEP, VMMC, condom promotion, and GBV.

The PEPFAR OVC program will expand into 9 PEPFAR districts and transition out of 5 current districts in COP 22 for improved collaboration with the PEPFAR clinical program, thereby addressing gaps in C/ALHIV treatment and care. In addition, the OVC caseload will be rationalized to enroll more C/ALHIV in the program. The OVC program will continue with intensified case management for C/ALHIV and the other priority OVC sub-populations, strengthening the OVC clinical collaboration as well as linkages with other programs for improved clinical outcomes for C/ALHIV. The program will continue to prioritize index testing for biological children of HIV positive parents as well as siblings of C/ALHIV indexes and link those who test positive to treatment**.**

Strengthen Health Systems:

Local partner development and transition is an ongoing priority for PEPFAR. USAID will ensure its awards include capacity building of nascent/new CSO partners, support for mature CSOs to become direct recipients of USG funding, and ongoing capacity building to existing prime CSOs to ensure strong systems and good stewardship of investments.

PEPFAR will continue collaborative discussions on HRH including advancing discussions on harmonizing salary scales across partners by specific cadres. Further, PEPFAR will continue engagement with the Health Development Partners Group (HDPG) on the HRH crisis more broadly and completion of consolidated HDP HRH investments analysis. Next, PEPFAR will review and adjust secondments secondment with the MoHCC where necessary, to ensure alignment with PEPFAR goals and objectives. Lastly, PEPFAR will continue to seek opportunities to discuss greater diversification of country health financing for HRH from both public and private sectors (MoF and MoHCC engagement).

Build Lasting Collaborations:

As described in detail in Appendix E, PEPFAR will leverage UNICEF's strengths in convening GoZ and health stakeholders to develop a Draft Sustainability Roadmap in COP 22. This activity

will build on ongoing discussions with development partners, particularly in the HDPG, and GoZ on HRH and options for sustainable health financing. USAID is finalizing a Private Sector Engagement Strategy for the mission which identifies opportunities, challenges, and priorities for increasing private sector engagement in health programming in Zimbabwe. Short-term areas include:

- Identifying private sector engagement opportunities in supply chain management.
- Continuing to develop the concept for DDD systems and integrate other HIV and health commodities.
- Expanding socially marketed services beyond condoms to other health commodities and services to cater to market segments that can pay.
- Support the MoHCC to increase the number and functionality of Public Private Partnerships.
- Expanding options for HIV service delivery through targeted private providers for individuals who are willing and able to pay.
- Supporting efforts for data exchange between public and private service providers.

As stated above, expanding KP leadership and involvement in CLM is already underway in FY22 with new CLM grants being awarded to KP-led CSOs. In COP 22 PEPFAR will continue to support KP participation and leadership in health facility committees and other CLM efforts with the goal of covering 80% of facilities with KP programming. In addition, the KP TSC will play a key role in coordinating KP-led CLM interventions across funders and ensuring CLM findings inform strategies, remedy bottlenecks, and increase equitable access to services.

PEPFAR will continue to engage with GFATM directly and through UNDP, UNAIDS, WHO, and UNICEF in a joint strategy to work with the government on initial planning to set the stage for sustaining impact over time. Additionally, PEPFAR will continue dialogue with development partners, NAC and the MoF on sustainable health financing options. We will continue working in collaboration with MoHCC, and other development partners, to leverage the MoHCC Public Private Partnership framework to consider opportunities for private sector engagement in areas such as:

- Supply chain
- Distribution of drugs
- Service provision

PEPFAR will continue strengthening and expanding KP leadership and involvement in PEPFAR supported CLM; collaborate with the GFATM and other stakeholders to support the national CLM working group to integrate CLM outputs into continuous quality improvement efforts.

4.5 Additional Program Priorities

Monitoring Partner Performance: In COP 22, partner performance will be constantly improved across the various HIV cascades. Expenditures and results will be monitored monthly and quarterly. Implementing partner work plans will reflect the targets and quarterly funding linked to performance, reflect the changes in implementation strategies and funding dependent on meeting results and reflect outcomes expected (i.e., viral load coverage, EHR key performance

indicators). The PEPFAR SIMS assessments will be administered across all program areas and geographies. These assessments will also be combined with improvement plans for areas that would not be performing according to standard. We intend to involve our MoHCC counterparts in these assessments so that we jointly foster accountability and improvement in all supported sites. During these interactions, we also aim to transfer skills to MoHCC staff at HQ and provincial levels that can be used in PEPFAR technical assistance for treatment districts.

4.6 People-Centered Supply Chain Management

During COP 22, the country will strive to move more towards a people-centered supply chain to achieve HIV epidemic control and maximize product availability, quality, and affordability as well as convenience for the individual. To achieve a people-centered supply chain, PEPFAR will continue to support forecasting, quantification, supply chain planning, implementation, monitoring and strengthening of the national supply chain system. In addition, PEPFAR will continue to play the critical role of supply chain coordination.

The availability of HIV commodities is essential for the achievement of both PEPFAR and national HIV program objectives. In this vein, PEPFAR will continue to support both the procurement of HIV commodities and coordination with other funders such as the GFATM and the GoZ to ensure availability of all the necessary HIV commodities. It is important to note that there are funding gaps for commodities because of the limited PEPFAR budget and budget constraints from the GoZ and other donors. PEPFAR will continue to engage with the GFATM and the GoZ to identify any savings which can be used to cover the current commodity funding gaps. PEPFAR will also engage with GoZ and CSOs to advocate for increased GoZ funding towards HIV commodities. However, it is important to note that CY 2023 is an election year and coupled with the current economic situation, it might not be feasible for GoZ to increase funding.

The focus for PEPFAR will be continued support for scaling up multi-month dispensing of TLD and transition to pediatric DTG based regimens including other optimized regimens. The program will continue to support decentralized drug delivery models through private sector channels as part of differentiated service delivery options. This will ensure that stable patients can receive their medicines in a more convenient manner in the community. These models will help reduce patient travel times and waiting times while decongesting public facilities.

To support an increase in the viral load coverage to 85%, PEPFAR has increased funding in COP 22 to procure additional viral load reagents. PEPFAR will support key coordination activities to ensure availability of kits, and hence, reduced turnaround time and sample backlogs. The country program will ensure that USG and other donors procure viral load commodities at all-inclusive globally negotiated prices. PEPFAR will engage with the viral load and EID vendors to replace the older machines with new technologies and enforce the service level agreements (SLAs). This is expected to reduce the machine downtime and turnaround time. As part of the SLAs all vendors including POC vendors will be required to have machine connectivity for easy result transmission and monitoring of machine functionality.

The availability of EID commodities is critical for the success of the PMTCT program. There are funding gaps for both viral load and EID reagents; PEPFAR will engage with the GFATM, GOZ, and any other donors to close the funding gaps. Currently, there are no buffer stocks for both

viral load and EID reagents resulting in stochastic testing and long turnaround times. PEPFAR will support the gradual buildup of buffer stocks to shield the pipeline from global supply chain disruptions.

PEPFAR will continue supporting the procurement of VMMC kits and commodities to meet program targets. Shang Ring kits will continue to be purchased in COP 22. There is a need to advocate with the GoZ to avail additional resources to meet national targets.

Currently, commodity reporting and ordering is done manually at the facility once every quarter. Over the last 12 months there has been significant attrition of HCWs from Zimbabwe, which has resulted in a high number of vacancies at both central and facility level and further degradation of end-to-end visibility in the supply chain management system. During COP 22 PEPFAR will continue to support the scale up of the Electronic Logistics Management Information System (eLMIS) and related supply chain strengthening activities.

In COP 22, PEPFAR-procured vehicles will continue to assist the National Pharmaceutical Company (NatPharm) by providing support for transportation of commodities to improve last mile delivery to service delivery points. PEPFAR will collaborate with GFATM and GoZ to support the Zimbabwe Assisted Pull System (ZAPS) and other distribution systems, this will ensure that facilities are optimally stocked at all times. PEPFAR will strengthen NatPharm's capacity for third party contract management and explore the possibility of NatPharm outsourcing some of the services to the private sector. PEPFAR will increasingly engage with the private sector on solutions to modernize the supply chain. We will explore the use of vendor-managed inventory beyond viral load and EID commodities. PEPFAR will seek private sector players' insights on beneficiary preferences, and their expertise for getting products to people as quickly, efficiently, and accurately as possible. PEPFAR aims to have a supply chain which is reliable, flexible, responsive, efficient, effective, and sustainable in the long term. PEPFAR funds will be used to continue purchasing Roche, Hologic and Abbott viral load testing reagents, as well as mPIMA and GeneXpert point of care cartridges leveraging off USG global negotiated price schemes in COP 22/FY2023. Careful coordination with the GFATM and the MoHCC will be required to ensure that reagents are in stock for the various platforms used across the country.

4.7 Collaboration, Integration, and Monitoring

Collaboration, integration, and monitoring are key to the success of the PEPFAR platform. During COP 22, PEPFAR is prioritizing the following areas:

- PEPFAR will continue to engage in regular, bi-weekly meetings with the GFATM and UNDP to ensure that priority issues are addressed and responded to in real-time. In COP 22, continued collaboration between GFATM and PEPFAR will accelerate progress in key areas of focus for the national HIV program including VL coverage and access, through alignment of planning activities to reduce redundancies and improve efficiencies as well as ensuring national coordination. This collaborative approach between development partners will strengthen national laboratory systems.
- PEPFAR will continue to collaborate with GFATM and other funders in the harmonization of CLM. With guidance from MoHCC and NAC, the objective of the CLM harmonization process is to ensure that Zimbabwe has a unified CLM program where community

voices are coordinated, and advocacy is amplified and directed to the right decision makers. In COP 21, through facilitation by the CLM National Steering Committee, UNAIDS availed funding to support the harmonization of CLM data collection tools. amfAR also supported the development of the Zimbabwe CLM Dashboard, where CLM data is managed. In COP 22, PEPFAR will continue engaging and collaborating with various stakeholders to continuously strengthen implementation of CLM, as well as effective use of CLM findings.

- PEPFAR will continue supporting CLM of treatment services across PEPFAR DSD districts. CLM CBOs will be supported to conduct monthly feedback meeting with Health Center Committees and health facility leadership from the facilities they are monitoring. CLM CBOs will further be supported to participate in quarterly District AIDS coordination meetings, Provincial AIDS coordination meetings as well as other strategic platforms where CLM findings can be presented as feedback and advocacy.
- The PEPFAR Zimbabwe team, together with the implementing partners, will continue to support and be part of MoHCC efforts towards HIV program collaboration. We will be part of various technical working groups (TWGs) both at PEPFAR and MoHCC levels. This will ensure that we support the establishment and implementation of good technical priorities for our program. PEPFAR will continue to support secondment of highly experienced HRH to MoHCC HQ. This investment will ensure national coordination of our HIV programs across the clinical cascade.
- PEPFAR IPs implementing KP programs have been using a unique identifier system-- the same system, across IPs-- for several years, which has resulted in routine robust results cascades for the program. The KP UIC has been critical for ensuring gaps in the clinical cascade are identified quickly and addressed and has been instrumental in improving linkage rates and most recently, VLC. Because the UIC system is shared by partners, the process of de-duplication is also facilitated; this is particularly important as KP may receive services from more than one IP. The same UIC algorithm is used in the DREAMS database, which has been successful in tracking layering of services delivered by multiple IPs to individual AGYW.
- PEPFAR will continue collaborative discussions on HRH, including advancing discussions on harmonizing salary scales across partners by specific cadres. Further, PEPFAR will continue engagement with the HDPG on the HRH crisis more broadly and completion of consolidated HDPG HRH investments analysis. Next, PEPFAR will review and adjust secondments secondment with the MoHCC where necessary, to ensure alignment with PEPFAR goals and objectives. Lastly, PEPFAR will continue to seek opportunities to discuss greater diversification of country health financing for HRH from both public and private sectors (MoF and MoHCC engagement).

4.8 Targets by population

The targets for the following four tables should be generated using data from the COP 22 approval memos:

Standard Table 4.8.1 ART Targets by Prioritization for Epidemic Control

Table 4.8.1 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY22)	Additional patients required for 80% ART coverage	Target current on ART (APR FY23) *TX_CURR*	Newly initiated (APR FY23) *TX_NEW*	ART Coverage (APR 23)
Attained	**1,138,465**	**1,065,244**	**N/A**	**1,079,447**	**37,389**	**95%**
Scale-Up Saturation	N/A	N/A	N/A	N/A	N/A	N/A
Scale-Up Aggressive	N/A	N/A	N/A	N/A	N/A	N/A
Sustained	N/A	N/A	N/A	N/A	N/A	N/A
Central Support	**202,856**	**199,537**	**N/A**	**203,256**	**N/A**	**100%**
Total	**1,341,321**	**1,264,781**	**N/A**	**1,282,703**	**37,389**	**96%**

Standard Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage**	***VMMC_CIRC* (in FY23)**	**Expected Coverage (in FY23)**
Bulawayo	Male 15+	258,672	N/A	5,907	79%
Harare	Male 15+	966,911	N/A	27,122	81%
Manicaland	Male 15+	603,813	N/A	13,858	80%
Mashonaland Central	Male 15+	436,717	N/A	7,712	80%
Mashonaland East	Male 15+	535,322	N/A	11,148	79%
Mashonaland West	Male 15+	561,298	N/A	25,117	80%
Masvingo	Male 15+	519,222	N/A	15,876	77%
Matabeleland North	Male 15+	257,763	N/A	3,472	80%
Matabeleland South	Male 15+	246,640	N/A	5,473	79%
Midlands	Male 15+	619,927	N/A	18,280	80%
Total/Average	**Male 15+**	**5,006,285**	*	**133,965**	**80%**

Standard Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate (SNUs)**	**Disease Burden**	**FY23 Target**
TG in 6 KP target districts	4,288	28% of TG are estimated to be HIV positive	KP_PREV: 2,127
MSM in 6 KP target districts	54,219	19% of MSM are estimated to be HIV positive	KP_PREV: 31,382
FSW in 6 KP target districts and DREAMS districts	39,683	45% of FSW are estimated to be HIV positive	KP_PREV: 32,782
AGYW at risk of HIV acquisition in DREAMS districts	407,332		AGYW_PREV D: 152,293 AGYW_PREV N: 140,561PP_PREV: 83,421
HIV positive young men 18-24 and those at risk of HIV acquisition			PP_PREV: 3,458
TOTAL			AGYW_PREV D: 152,293 AGYW_PREV N: 140,561 KP_PREV: 66,291 PP_PREV: 86,879

Standard Table 4.8.4 Targets for OVC and Linkages to HIV Services

Table 4.8.4 Targets for OVC and Linkages to HIV Services					
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY23 Target) OVC_SERV Comprehensive**	**Target # of OVC (FY23 Target) OVC_SERV Preventative**	**Target # of active OVC (FY23 Target) OVC_SERV DREAMS**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC***
Bulawayo		10,819	8,173	10,482	7,600
Harare		28,608	1,394	0	20,016
Manicaland		46,136	15,698	20,409	30,123
Mashonaland Central		2,431	5,888	7,159	1,699
Mashonaland East		13,311	591	0	8,877
Mashonaland West		40,654	2,051	0	28,017
Masvingo		22,951	943	0	13,897
Matabeleland North		3,161	3,840	9,153	2,204
Matabeleland South		9,249	26,352	33,694	5,681
Midlands		9,826	3,444	4,860	6,112
TOTAL	**N/A**	187,146	68,374	85,757	124,226

4.9 Cervical Cancer

Cervical cancer, largely caused by human papillomavirus (HPV), is the most prevalent form of cancer among women in Zimbabwe, with an estimated 3,186 new cases and 2,151 deaths annually. About 35% of women in the general population are estimated to harbor cervical HPV infection at a given time, and 79.6% of invasive cervical cancers are attributed to HPV subtypes 16 and 18. The Zimbabwe HPV and Related Cancers Summary Report 2010 indicate that the prevalence of HPV in women with cervical cancer is 79.6%, which is higher than the global prevalence of (70.9%).

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

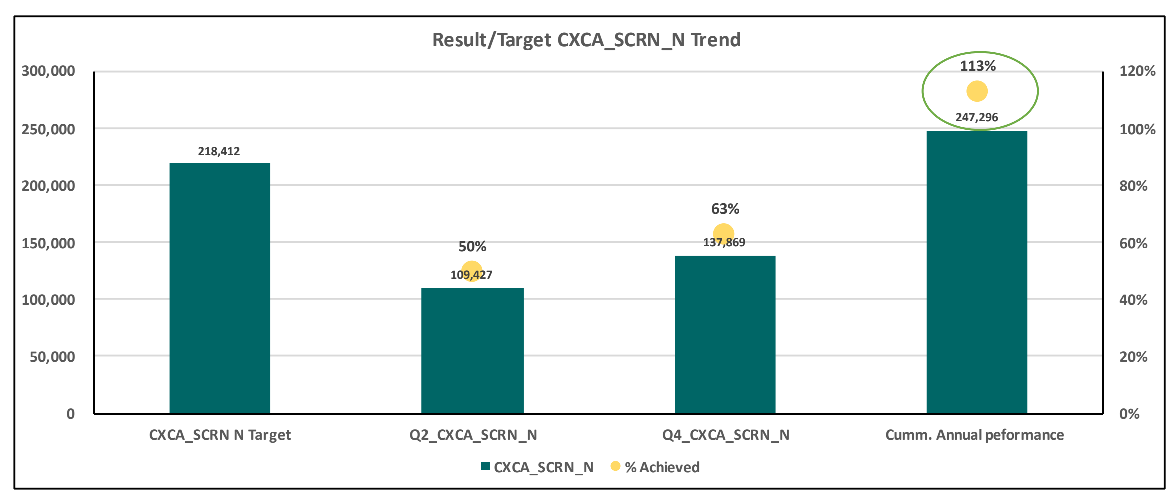
In 2017, about 100,000 women were screened for cervical cancer with a treatment rate of 57% which is below the program target of 80% treatment rate. The 2015 ZDHS reported overall 79% of women had heard of cervical cancer but only 13% ever had a cervical examination. The Cervical Cancer Prevention and Control Strategy (2016-2020) recommends screening using Visual Inspection with Acetic Acid and Cervicography (VIAC) for all sexually active women. Since 2014, the MoHCC has been rapidly scaling up screening of cervical cancer using VIAC and over 100 VIAC sites have been set up at district, provincial and central levels countrywide. Women with lesions are treated with either cryotherapy or referred for Loop Electrosurgical Excision Procedure (LEEP), which is available at the provincial and central levels. The MoHCC adopted the “see and treat” approach for cervical cancer screening where secondary prevention is available within VIAC screening services. In this approach, treatment for pre-invasive lesions is offered on the same day that the lesion is found (e.g., with cryotherapy). For all women offered LEEP services, a sample is taken to the laboratory for histology.

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

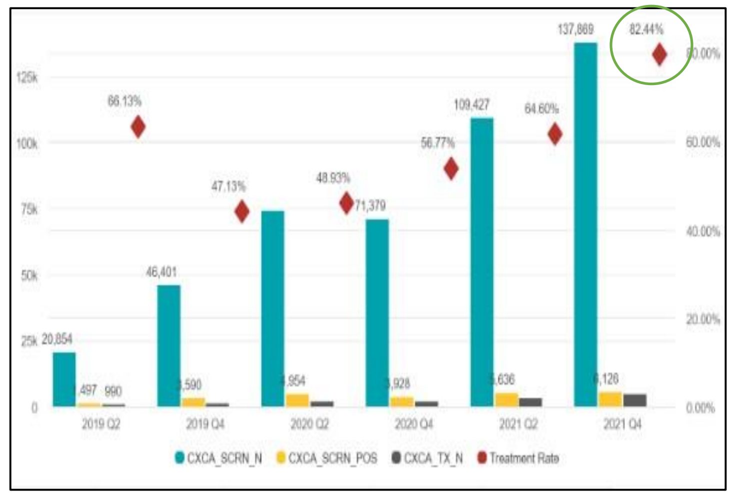
COP 19 (FY20) implementation of activities was affected by the lockdown restrictions due to the COVID-19 pandemic. Cervical cancer screening activities were de-prioritized by the MoHCC to protect clients and staff from COVID-19 infection. This was further affected by inadequate PPE, facility closures and the nationwide strike action that followed the lifting of the restrictions. While the strike has since been called off, human resource challenges continue to surface within the program. The implementing partners continue to recruit and train VIAC nurses to work full time in the VIAC clinics. In COP 21, the PEPFAR program will support the scaling up of outreach services for VIAC. Other support will be directed towards the decentralization of LEEP services. The program thus plans to obtain additional thermo-coagulators as well as LEEP machines. COP 22 will see the scale up HPV-DNA screening for women. The PEPFAR program has supported the MoHCC in development of guidelines and protocols as well as the implementation of this service. The program will also be supported to shift to the screen-triage-treat mode of operation. The PEPFAR program will continue to support the cervical cancer monitoring and evaluation technical working group. In addition, utilization of the national VIAC register and the master MoHCC monthly return forms will be monitored to ensure timely

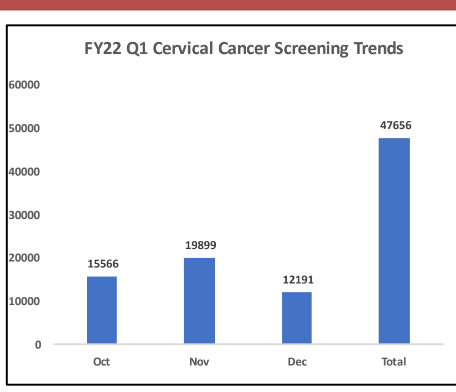
submission. The graphs below show the performance of the program in COP 20 (FY21). There has generally been an upward trend in the numbers of women being screened and treated but this was severely impacted by COVID-19. The program is, however, showing signs of recovery. The above challenges need to be addressed for the program to achieve the set targets.

Exceeded COP 20 screening targets



Scaling up cervical cancer screening, improving treatment rates





- 23% of annual target achieved
- 83% treatment rate
- Dip in numbers during festive season

In COP 22, the PEPFAR program will continue to support the secondary prevention of cervical cancer in women living with HIV. In COP 22, the target is to screen 233,000 women living with HIV on ART aged 25-49 years every other year for pre-invasive lesions to allow early treatment. The figure below shows the PEPFAR Zimbabwe cervical cancer program approaches.

Going forward.....COP21 and COP 22 catch up strategies

- Continue to scale up outreach service provision
  - Continue demand creation
  - Observance of COVID 19 prevention measures
  - LEEP camps

- Line-listing/call backs for women who are due for screening/treatment
- Scale up HPV DNA screening

- Continue to monitor for quality service provision
  - Staff mentoring/monitoring
  - Support for interpretation of images
  - Strengthen SAE reporting system

- Decentralize LEEP services
  - Additional LEEP machines
  - Capacity building/training of service providers

- Strengthen referral systems for women with invasive disease

4.10 Viral Load and Early Infant Diagnosis Optimization

PEPFAR has identified viral load access and suppression as a critical area needing intervention in Zimbabwe as the country reaches epidemic control. Besides the VL reagent gap, there are system gaps in VL access especially in the technical assistance for treatment (TAT) districts, specimen transport coverage, HRH supporting laboratory processes, and results utilization/clinical status monitoring. SNU suppression data still shows suppression rates for all age and sex groups as higher than 80% in most districts, while a further review of the data shows that children still have lower suppression rates than adult men and women. In COP 22, continued collaboration between GFATM and PEPFAR will accelerate VL coverage and access, through alignment of planning activities to reduce redundancies and improve efficiencies as well as ensuring national coordination. This collaborative approach between development partners will strengthen national laboratory systems and bring person-centered innovations.

In COP 22, PEPFAR will implement a multi-year strategy to address gaps in laboratory systems and VL/EID commodities towards HIV epidemic control through the following:

- Strengthening CQI at district level to ensure quality service delivery across all supported laboratories
- Sustaining the investments in the national integrated sample transport system to maintain a people-centered quality service delivery
- Supporting HRH capacity to support the HIV VL/EID testing network
- Strengthening integration efforts of electronic systems to LIMS
- Prioritizing POC VL for priority population groups
- Collaborating with other stakeholders to support strengthening of supply chain systems including closing the commodities gap
- Building a VL/EID commodities buffer to minimize unnecessary service interruptions

- Implement multiplexing on all platforms including expanding DBS to Hologic platforms and VL/EID/TB on POC
- Supporting accreditation at VL laboratories
- Strengthening LIMS implementation at supported labs including scaling electronic results delivery systems
- Phased CLI rollout to all districts
- Completing instrument transition to higher throughput platforms at VL testing laboratories
- Collaborating with GFATM to:
    - Fully establish national genomic sequencing to respond to future threats of public health concern (HIV DR testing included)
    - Support waste management through packaging and transportation as well as disposal
    - Supplement sustainable power solutions at the VL testing labs

Increased access to ART and treatment monitoring for pregnant and breastfeeding women living with HIV is a priority to minimize the risk of vertical transmission of HIV to their infants. In COP 22, the use of POC VL testing will be supported to ensure full utilization of the available platforms, and quality assurance activities will be implemented to ensure uninterrupted service. PEPFAR will leverage resources through GFATM and CHAI to implement POC VL testing for priority population groups such as unsuppressed patients, pregnant women, breastfeeding women, children, adolescents, and patients presenting with advanced disease. POC-VL testing will be supported on the Cepheid GeneXpert and Abbott mPIMA platforms using a targeted, data-driven approach considering the limited resources. There will be strong collaboration between development partners to strengthen TB/HIV laboratory integration and joint TB/HIV program planning to ensure efficient use of POC platforms. There will be further expansion of conventional EID testing from the Roche platform to other platforms such as Hologic. This will greatly enhance EID access and reduce turnaround times. Strengthening the district laboratories will be key in ensuring quality, people centered services for POC and sample referral activities.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

The PEPFAR Zimbabwe team will invest in above-site areas to address key vulnerabilities identified through the 2021 SID and ensure continued progress towards sustained epidemic control.

During FY 2021, PEPFAR Zimbabwe and UNAIDS jointly engaged a diverse group of stakeholders through virtual platforms to complete the 2021 SID with the aim of advancing a shared understanding and common goal of sustainability. Stakeholders included MoHCC, NAC, MoF, CHAI, SAFAIDS, EGPAF, DFID, ZNNP+, and FBOs.

Commodity Security and Supply Chain: Commodity security and supply chain remains the weakest system component with the lowest 2021 SID score of 4.81. The GoZ has established a successful AIDS levy to procure ARVs and support other program activities. However, the value of these funds has declined over the past several years as inflation has risen and the procurement of ARVs, HIV rapid test kits, and condoms is heavily dependent on donor funding. In COP 22 PEPFAR will continue to provide support to Zimbabwe's national supply chain management and distribution systems to ensure that the national quantification and supply planning exercise is conducted bi-annually to inform the use of donor and GoZ resources for commodity procurement, and that life-saving medicines and products are available in health facilities. The vehicle and distribution support have been particularly critical in the face of a deteriorating economic situation and rising global fuel prices. Securing additional commodities (i.e., HIVST kits, condoms, VMMC kits, TB, RTKs, viral load reagents) is paramount to achieving epidemic control.

Civil Society Engagement: The SID score for civil society engagement increases remarkably between 2019 and 2021. Stakeholders cited good CSO engagement in policy development and program design but weak involvement in program implementation. CSO appreciated increased access to funding through the PEPFAR CLM initiative and the development of social contracting guidelines. CLM is gaining traction and there is evidence of improved program quality through this initiative. In COP 22 PEPFAR will continue to support CBOs to conduct community-led monitoring across the 44 PEPFAR supported districts.

Epidemiological, Health, and Performance Data: Discussions with MoHCC and stakeholders helped identify key systems barriers impacting EHR and CBS with recency implementation. PEPFAR's COP 22 support will optimize the EHR and CBS with recency testing in the 1,314 PEPFAR supported facilities, 970 with a full EHR system and 344 facilities with a mobile EHR application. The full EHR system will produce 95% of site-level MER indicators with less than 10% downtime across 90% of the 1,314 facilities. The electronic systems will improve data quality and enable easy and accurate monitoring of 1) newly identified HIV-infected person and incident infections in defined geographic locations. 2) MER and MoHCC Monthly reports on all HIV/TB patients in all sub-populations, 3) Mortality surveillance among ART patients, and 4) Outbreak response and utilization of data to inform policy. PEPFAR will also address technical

and managerial capacity barriers within the MoHCC by providing support and capacity building for secondees to ensure CBS with recency is implemented and data used to inform programming at national and all sub-national levels. Our COP 22 support plan has accounted for investments by other stakeholders such as MoHCC/GoZ, BMGF, GFATM, UNDP, GAVI/UNICEF that have between them committed towards providing human resources, equipment, power back-up, internet connectivity, technical assistance, and capacity building.

Constantly evolving DREAMS guidance requires continuous system enhancements to ensure program data systems meet data quality standards. With COP 22 funding, PEPFAR Zimbabwe will upgrade DREAMS screening, enrollment, and layering database to account for changes to DREAMS programming. PEPFAR will promote data quality and data use through support for regular SI TWG meetings, TA for DREAMS reporting, and training and TA on DREAMS SI and database use to DREAMS partners. In addition, PEPFAR will promote system sustainability through support for updated program and SI documents (SOPs, protocols, guidance, layering tables, etc.) PEPFAR will support development of an app that tracks referrals across IPs.

With COP 2022 funding, PEPFAR will support full transitioning of the OVC MIS to a local partner, support SI TWG coordination platforms, TA for OVC reporting, and training and TA to OVC partners and sub-partners on OVC SI and MIS use. In addition, PEPFAR will support MIS enhancements requested by OVC IPs to improve case management and strengthen support to CLHIV, e.g., ARV regimen, MMD, and EID tracking.

Planning, Coordination, Policies and Governance: With COP 22 funding, PEPFAR Zimbabwe will continue to support secondments to the MoHCC AIDS and TB program and NAC that have helped to ensure high level planning and coordination of national programs and continued advocacy for technically sound national policy formulation and good governance. PEPFAR will also support secondments to identified critical and priority departments such as HMIS, SI, Labs, Quality Monitoring and Improvement, and DREAMS Coordination.

In FY 2021, PEPFAR Zimbabwe conducted its first HRH inventory exercise. The data has been shared with national stakeholders and PEPFAR TWGs have reviewed the data extensively and will use it to ensure continued alignment of investments with PEPFAR goals and objectives given the evolution of the HIV epidemic in Zimbabwe. In addition, PEPFAR will begin discussions on harmonizing salary scales across partners by specific cadres; continue engagement with the health development partners (HDP) on how to work collaboratively with the government to address the ongoing HRH crisis that in threatening to derail progress towards epidemic control.

In COP 22, PEPFAR will make above site investments geared towards development of a broad national HIV response sustainability plan through active stakeholder participation. The plan will chart a course that directs GoZ to assume greater responsibility for functional and financial aspects of the national HIV response. The plan will examine HRH investments, cadres, and levels of site support needed to sustain the HIV program, among other things, and include a transition plan with short-, medium-, and long-term goals for MoHCC.

COP 2022 above site investments will include national level support to improve the quality of public post violence care services in selected DREAMS districts. Supported activities will include stakeholder consultations to identify and prioritize critical gaps in the health sector response to post violence care for AGYW, implementing the GBV QA tool in selected sites to identify key gaps and challenges in service provision, and making plans to address skills gaps.

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

Treatment literacy: Continued feedback from MoHCC, stakeholders, CSOs, and patients has impressed upon the PEPFAR team that treatment literacy tools need updating to include aspects of self-testing, index testing, treat all, adherence, viral load, faith healing, and other important elements. In COP 21, PEPFAR clinical partners will build on the partnerships with CSOs to scale up implementation of community-level treatment literacy to improve uptake of VL, TLD, and TPT. In COP 22, PEPFAR will ensure ongoing activities to improve treatment literacy among PLHIV and ensure that appropriate messages are delivered in appropriate ways to the various population subgroups. These messages will include the rationale for the "Treat All" approach, the benefits of testing and initiating ART prior to onset of symptoms, the superior efficacy and adverse event profile of DTG-based regimens, the importance of having all sexual partners on treatment or PrEP, the need for viral load monitoring and the meaning of viral load results, U=U (Undetectable = Untransmittable), and so on. Once the VL literacy package "Flip the Script" is completed, the PEPFAR program will explore the use of this communication package to improve client's understanding of adhering to treatment and VL results interpretation. PEPFAR will continue to support the updating of counseling materials and guidelines to align with the current treatment recommendations and the shifts in the HIV program.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

For COP 22 the PEPFAR team took a critical look across the entire interagency team to ensure it consisted of staff with an adequate mix of technical, management, and administrative skills to support the GoZ's goal of epidemic control.

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

USAID: Since April 2021, USAID filled four vacancies: 1) Biomedical Prevention Specialist (local hire), 2) Project Management Specialist - DREAMS (local hire), 3) Project Management Specialist - OVC (local hire), and 4) Senior Supply Chain Advisor (TCN). As of April 2022, USAID Zimbabwe has one local hire position pending recruitment: Project Management Specialist - Data. This position has been vacant for less than 6 months and USAID anticipates filling it before the end of FY 2022.

USAID: In COP 22, USAID does not propose any new positions.

CDC: Since April 2021, CDC filled two vacancies (DREAMS Coordinator and Laboratory Specialist, both local hires). Both positions were filled before the start of FY 2022. As of April 2022, CDC Zimbabwe has two local hire positions and two US direct hire positions pending recruitment. These positions have been vacant for less than 6 months and CDC anticipates filling them before the end of FY 2022. The vacant positions are:

- Public Health Specialist, Surveillance (local hire)
- Communications Specialist (local hire)
- Strategic Information Branch Chief (US direct hire)
- HIV Services Branch Chief (US direct hire)

CDC: Proposed one new position, Associate Director of Programs (local hire). This non-supervisory leadership position reports directly to the Country Director and serves as a senior advisor. The position will be funded in COP 23. CDC has requested this new position in COP 22 to allow time for finalization of the position description, classification, and recruitment before the start of COP 23.

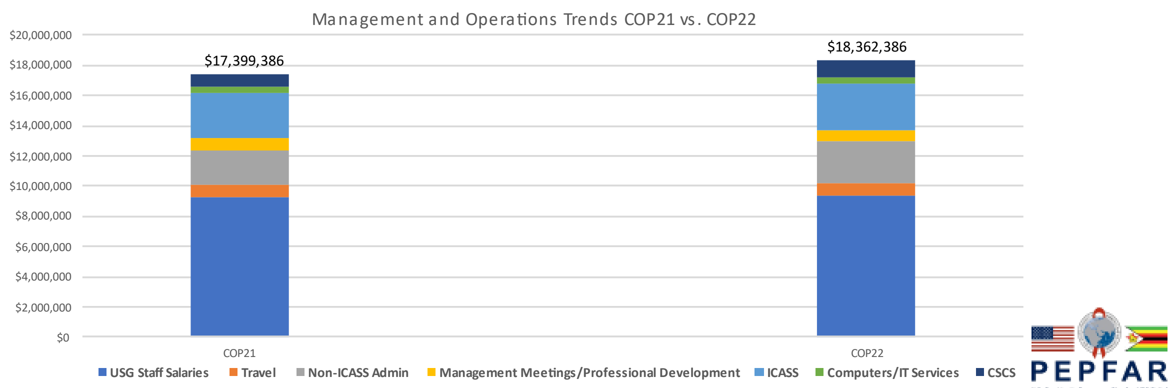
State Department (DOS): As part of PEPFAR's CLM Initiative, PEPFAR Zimbabwe agreed in COP 20 to fund a new local hire Grants Officer Representative position (informally known as the CLM Grants Specialist). While the funding mechanism for CLM grants is being shifted in COP 22 from PEPFAR Small Grants to UNAIDS, the CLM Grants Specialist will be retained under the Department of State. Therefore, in COP 22, DOS will continue to fund two positions: CLM Grants Coordinator and the PEPFAR Communications Specialist.

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

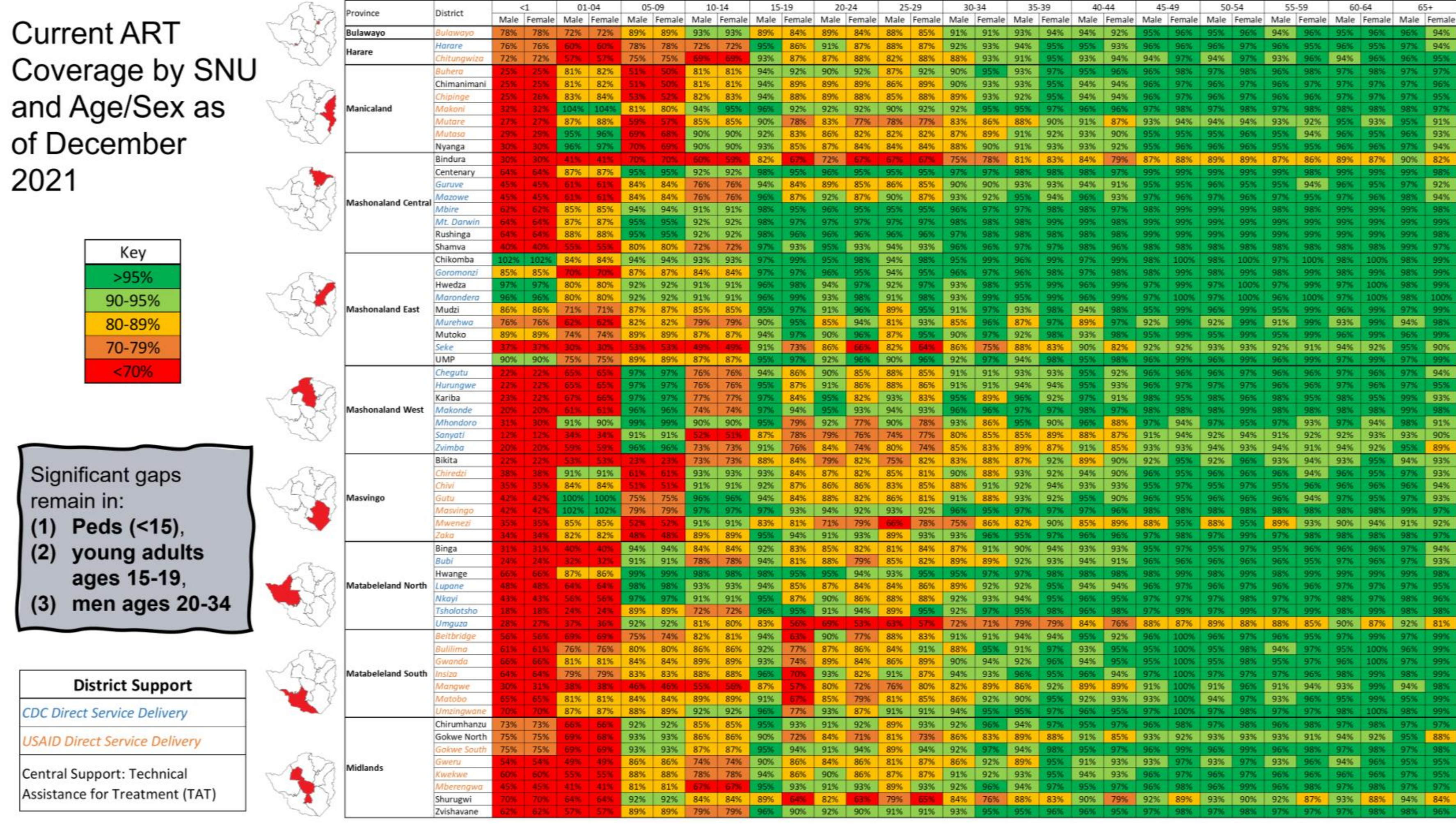
The total COP 22 CODB budget request ($18,362,386) is an increase of 5.5% above the COP 21 amount (See graphic below). The budget shift does not include an increased USG footprint in COP 22 but are due to 1) Increases in the general Costs of Doing Business, including ICASS and salary increases for local and US Direct Hire staff; 2) Increase in CDC's Capital Security Cost Sharing (HQ-imposed costs).

COP22 USG Management and Operations

Budget Category	COP21	Proposed COP22	Diff	Notes
Management and Operations (M&O)	**$17,399,386**	**$18,362,386**	**5.5%**	1) No increased USG footprint in COP22 2) Increases in M&O due to: • *Increase in the general Costs of Doing Business, including ICASS and salary increases for local and US Direct Hire staff.* • *Increase in Capital Security Cost Sharing (HQ imposed costs)*



APPENDIX A: SNU Prioritization and Current ART Coverage



Province	District	<1		01-04		05-09		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50-54		55-59		60-64		65+	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Bulawayo	Bulawayo	78%	78%	72%	72%	89%	89%	93%	93%	89%	84%	89%	84%	88%	85%	91%	91%	93%	94%	94%	92%	95%	96%	95%	96%	94%	96%	95%	96%	96%	94%
Harare	Harare	76%	76%	60%	60%	78%	78%	72%	72%	95%	86%	91%	87%	88%	87%	92%	93%	94%	95%	95%	93%	96%	96%	96%	97%	96%	95%	96%	95%	97%	94%
	Chitungwiza	72%	72%	57%	57%	75%	75%	69%	69%	93%	87%	87%	88%	82%	88%	88%	93%	91%	95%	93%	94%	94%	97%	94%	97%	93%	96%	94%	96%	96%	95%
Manicaland	Buhera	25%	25%	81%	82%	51%	50%	81%	81%	94%	92%	90%	92%	87%	92%	90%	95%	93%	97%	95%	96%	96%	98%	97%	98%	96%	98%	97%	98%	97%	97%
	Chimanimani	25%	25%	81%	82%	51%	50%	81%	81%	94%	89%	89%	89%	86%	89%	90%	93%	93%	95%	94%	94%	96%	97%	96%	97%	96%	97%	97%	97%	97%	96%
	Chipinge	25%	26%	83%	84%	53%	52%	82%	83%	94%	88%	89%	88%	85%	88%	89%	93%	92%	95%	94%	94%	96%	97%	96%	97%	96%	96%	97%	97%	97%	95%
	Makoni	32%	32%	104%	104%	81%	80%	94%	95%	96%	92%	92%	92%	90%	92%	92%	95%	95%	97%	96%	96%	97%	98%	97%	98%	97%	98%	98%	98%	98%	97%
	Mutare	27%	27%	87%	88%	59%	57%	85%	85%	90%	78%	83%	77%	78%	77%	83%	86%	88%	90%	91%	87%	93%	94%	94%	94%	93%	92%	95%	93%	95%	91%
	Mutasa	29%	29%	95%	96%	69%	68%	90%	90%	92%	83%	86%	82%	82%	82%	87%	89%	91%	92%	93%	90%	95%	95%	95%	96%	95%	94%	96%	95%	96%	93%
	Nyanga	30%	30%	96%	97%	70%	69%	90%	90%	93%	85%	87%	84%	84%	84%	88%	90%	91%	93%	93%	92%	95%	96%	96%	96%	95%	95%	96%	96%	97%	94%
Mashonaland Central	Bindura	30%	30%	41%	41%	70%	70%	60%	59%	82%	67%	72%	67%	67%	67%	75%	78%	81%	83%	84%	79%	87%	88%	89%	89%	87%	86%	89%	87%	90%	82%
	Centenary	64%	64%	87%	87%	95%	95%	92%	92%	98%	95%	96%	95%	95%	95%	97%	97%	98%	98%	98%	97%	99%	99%	99%	99%	99%	98%	99%	99%	99%	98%
	Guruve	45%	45%	61%	61%	84%	84%	76%	76%	94%	84%	89%	85%	86%	85%	90%	90%	93%	93%	94%	91%	95%	95%	96%	95%	95%	94%	96%	95%	97%	92%
	Mazowe	45%	45%	61%	61%	84%	84%	76%	76%	96%	87%	92%	87%	90%	87%	93%	92%	95%	94%	96%	93%	97%	96%	97%	96%	97%	95%	97%	96%	98%	94%
	Mbire	62%	62%	85%	85%	94%	94%	91%	91%	98%	95%	96%	95%	95%	95%	96%	97%	97%	98%	98%	97%	98%	99%	99%	99%	98%	98%	99%	99%	99%	98%
	Mt. Darwin	64%	64%	87%	87%	95%	95%	92%	92%	98%	97%	97%	97%	97%	97%	98%	98%	98%	99%	99%	98%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
	Rushinga	64%	64%	88%	88%	95%	95%	92%	92%	98%	96%	96%	96%	96%	96%	97%	98%	98%	98%	98%	98%	99%	99%	99%	99%	99%	99%	99%	99%	99%	98%
	Shamva	40%	40%	55%	55%	80%	80%	72%	72%	97%	93%	95%	93%	94%	93%	96%	96%	97%	97%	98%	96%	98%	98%	98%	98%	98%	98%	98%	98%	99%	97%
Mashonaland East	Chikomba	102%	102%	84%	84%	94%	94%	93%	93%	97%	99%	95%	98%	94%	98%	95%	99%	96%	99%	97%	99%	98%	100%	98%	100%	97%	100%	98%	100%	98%	99%
	Goromonzi	85%	85%	70%	70%	87%	87%	84%	84%	97%	97%	96%	95%	94%	95%	96%	97%	96%	98%	97%	98%	98%	99%	98%	99%	98%	99%	98%	99%	98%	99%
	Hwedza	97%	97%	80%	80%	92%	92%	91%	91%	96%	98%	94%	97%	92%	97%	93%	98%	95%	99%	96%	99%	97%	99%	97%	100%	97%	99%	97%	100%	98%	99%
	Marondera	96%	96%	80%	80%	92%	92%	91%	91%	96%	99%	93%	98%	91%	98%	93%	99%	95%	99%	96%	99%	97%	100%	97%	100%	96%	100%	97%	100%	98%	100%
	Mudzi	86%	86%	71%	71%	87%	87%	85%	85%	95%	97%	91%	96%	89%	95%	91%	97%	93%	98%	94%	98%	95%	99%	96%	99%	95%	99%	96%	99%	97%	99%
	Murehwa	76%	76%	62%	62%	82%	82%	79%	79%	90%	95%	85%	94%	81%	93%	85%	96%	87%	97%	89%	97%	92%	99%	92%	99%	91%	99%	93%	99%	94%	98%
	Mutoko	89%	89%	74%	74%	89%	89%	87%	87%	94%	97%	90%	96%	87%	95%	90%	97%	92%	98%	93%	98%	95%	99%	95%	99%	95%	99%	96%	99%	96%	99%
	Seke	37%	37%	30%	30%	53%	53%	49%	49%	91%	73%	86%	66%	82%	64%	86%	75%	88%	83%	90%	82%	92%	92%	93%	93%	92%	91%	94%	92%	95%	90%
	UMP	90%	90%	75%	75%	89%	89%	87%	87%	95%	97%	92%	96%	90%	96%	92%	97%	94%	98%	95%	98%	96%	99%	96%	99%	96%	99%	97%	99%	97%	99%
Mashonaland West	Chegutu	22%	22%	65%	65%	97%	97%	76%	76%	94%	86%	90%	85%	88%	85%	91%	91%	93%	93%	95%	92%	96%	96%	96%	97%	96%	96%	97%	96%	97%	94%
	Hurungwe	22%	22%	65%	65%	97%	97%	76%	76%	95%	87%	91%	86%	88%	86%	91%	91%	94%	94%	95%	93%	96%	97%	97%	97%	96%	96%	97%	96%	97%	95%
	Kariba	23%	22%	67%	66%	97%	97%	77%	77%	97%	84%	95%	82%	93%	83%	95%	89%	96%	92%	97%	91%	98%	95%	98%	96%	98%	95%	98%	95%	99%	93%
	Makonde	20%	20%	61%	61%	96%	96%	74%	74%	97%	94%	95%	93%	94%	93%	96%	96%	97%	97%	98%	97%	98%	98%	98%	99%	98%	98%	98%	98%	99%	98%
	Mhondoro	31%	30%	91%	90%	99%	99%	90%	90%	95%	79%	92%	77%	90%	78%	93%	86%	95%	90%	96%	88%	97%	94%	97%	95%	97%	93%	97%	94%	98%	91%
	Sanyati	12%	12%	34%	34%	91%	91%	52%	51%	87%	78%	79%	76%	74%	77%	80%	85%	85%	89%	88%	87%	91%	94%	92%	94%	91%	92%	92%	93%	93%	90%
	Zvimba	20%	20%	59%	59%	96%	96%	73%	73%	91%	76%	84%	74%	80%	74%	85%	83%	89%	87%	91%	85%	93%	93%	94%	93%	94%	91%	94%	92%	95%	89%
Masvingo	Bikita	22%	22%	53%	53%	23%	23%	73%	73%	88%	84%	79%	82%	75%	82%	83%	88%	87%	92%	89%	90%	92%	95%	92%	96%	93%	94%	93%	95%	94%	93%
	Chiredzi	38%	38%	91%	91%	61%	61%	93%	93%	93%	84%	87%	82%	85%	81%	90%	88%	93%	92%	94%	90%	96%	95%	96%	96%	96%	94%	96%	95%	97%	93%
	Chivi	35%	35%	84%	84%	51%	51%	91%	91%	92%	87%	86%	86%	83%	85%	88%	91%	92%	94%	93%	93%	95%	97%	95%	97%	95%	96%	96%	96%	96%	94%
	Gutu	42%	42%	100%	100%	75%	75%	96%	96%	94%	84%	88%	82%	86%	81%	91%	88%	93%	92%	95%	90%	96%	95%	96%	96%	96%	94%	97%	95%	97%	93%
	Masvingo	42%	42%	102%	102%	79%	79%	97%	97%	97%	93%	94%	92%	93%	92%	96%	95%	97%	97%	97%	96%	98%	98%	98%	98%	98%	98%	98%	98%	99%	97%
	Mwenezi	35%	35%	85%	85%	52%	52%	91%	91%	83%	81%	71%	79%	66%	78%	75%	86%	82%	90%	85%	89%	88%	95%	88%	95%	89%	93%	90%	94%	91%	92%
	Zaka	34%	34%	82%	82%	48%	48%	89%	89%	95%	94%	91%	93%	89%	93%	93%	96%	95%	97%	96%	96%	97%	98%	97%	99%	97%	98%	98%	98%	98%	97%
Matabeleland North	Binga	31%	31%	40%	40%	94%	94%	84%	84%	92%	83%	85%	82%	81%	84%	87%	91%	90%	94%	93%	93%	95%	97%	95%	97%	95%	96%	96%	96%	97%	94%
	Bubi	24%	24%	32%	32%	91%	91%	78%	78%	94%	81%	88%	79%	85%	82%	89%	89%	92%	93%	94%	91%	96%	96%	96%	96%	96%	95%	97%	96%	97%	93%
	Hwange	66%	66%	87%	86%	99%	99%	98%	98%	98%	95%	95%	94%	93%	95%	95%	97%	97%	98%	98%	98%	98%	99%	98%	99%	98%	99%	99%	99%	99%	98%
	Lupane	48%	48%	64%	64%	98%	98%	93%	93%	94%	85%	87%	84%	84%	86%	89%	92%	92%	95%	94%	94%	96%	97%	96%	97%	96%	96%	97%	97%	97%	95%
	Nkayi	43%	43%	56%	56%	97%	97%	91%	91%	95%	87%	90%	86%	88%	88%	92%	93%	94%	95%	96%	95%	97%	97%	97%	98%	97%	97%	98%	97%	98%	96%
	Tsholotsho	18%	18%	24%	24%	89%	89%	72%	72%	96%	95%	91%	94%	89%	95%	92%	97%	95%	98%	96%	98%	97%	99%	97%	99%	97%	99%	98%	99%	98%	98%
	Umguza	28%	27%	37%	36%	92%	92%	81%	80%	83%	56%	69%	53%	63%	57%	72%	71%	79%	79%	84%	76%	88%	87%	89%	88%	88%	85%	90%	87%	92%	81%
Matabeleland South	Beitbridge	56%	56%	69%	69%	75%	74%	82%	81%	94%	63%	90%	77%	88%	83%	91%	91%	94%	94%	95%	92%	96%	100%	96%	97%	96%	95%	97%	99%	97%	99%
	Bulilima	61%	61%	76%	76%	80%	80%	86%	86%	92%	77%	87%	86%	84%	91%	88%	95%	91%	97%	93%	95%	95%	100%	95%	98%	94%	97%	95%	100%	96%	99%
	Gwanda	66%	66%	81%	81%	84%	84%	89%	89%	93%	74%	89%	84%	86%	89%	90%	94%	92%	96%	94%	95%	95%	100%	95%	98%	95%	97%	96%	100%	97%	99%
	Insiza	64%	64%	79%	79%	83%	83%	88%	88%	96%	70%	93%	82%	91%	87%	94%	93%	96%	95%	96%	94%	97%	100%	97%	97%	97%	96%	98%	99%	98%	99%
	Mangwe	30%	31%	38%	38%	46%	46%	55%	56%	87%	57%	80%	72%	76%	80%	82%	89%	86%	92%	89%	89%	91%	100%	91%	96%	91%	94%	93%	99%	94%	98%
	Matobo	65%	65%	81%	81%	84%	84%	89%	89%	91%	67%	85%	79%	81%	85%	86%	92%	90%	95%	92%	93%	93%	100%	94%	97%	93%	96%	95%	99%	95%	99%
	Umzingwane	70%	70%	87%	87%	88%	89%	92%	92%	96%	77%	93%	87%	91%	91%	94%	95%	95%	97%	96%	95%	97%	100%	97%	98%	97%	97%	98%	100%	98%	99%
Midlands	Chirumhanzu	73%	73%	66%	66%	92%	92%	85%	85%	95%	93%	91%	92%	89%	93%	92%	96%	94%	97%	95%	97%	96%	98%	97%	98%	96%	98%	97%	98%	97%	97%
	Gokwe North	75%	75%	69%	68%	93%	93%	86%	86%	90%	72%	84%	71%	81%	73%	86%	83%	89%	88%	91%	85%	93%	92%	93%	93%	93%	91%	94%	92%	95%	88%
	Gokwe South	75%	75%	69%	69%	93%	93%	87%	87%	95%	94%	91%	94%	89%	94%	92%	97%	94%	98%	95%	97%	96%	99%	96%	99%	96%	98%	97%	98%	97%	98%
	Gweru	54%	54%	49%	49%	86%	86%	74%	74%	90%	86%	84%	86%	81%	87%	86%	92%	89%	95%	91%	93%	93%	97%	93%	97%	93%	96%	94%	96%	95%	95%
	Kwekwe	60%	60%	55%	55%	88%	88%	78%	78%	94%	86%	90%	86%	87%	87%	91%	92%	93%	95%	94%	93%	96%	97%	96%	97%	96%	96%	96%	96%	97%	95%
	Mberengwa	45%	45%	41%	41%	81%	81%	67%	67%	95%	93%	91%	93%	89%	93%	92%	96%	94%	97%	95%	97%	96%	98%	96%	99%	96%	98%	97%	98%	97%	97%
	Shurugwi	70%	70%	64%	64%	92%	92%	84%	84%	89%	64%	82%	63%	79%	65%	84%	76%	88%	83%	90%	79%	92%	89%	93%	90%	92%	87%	93%	88%	94%	84%
	Zvishavane	62%	62%	57%	57%	89%	89%	79%	79%	96%	90%	92%	90%	91%	91%	93%	95%	95%	96%	96%	95%	97%	98%	97%	98%	97%	97%	97%	98%	98%	96%

APPENDIX B – Budget Profile and Resource Projections

B1. COP 22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP 22 Budget by Program Area

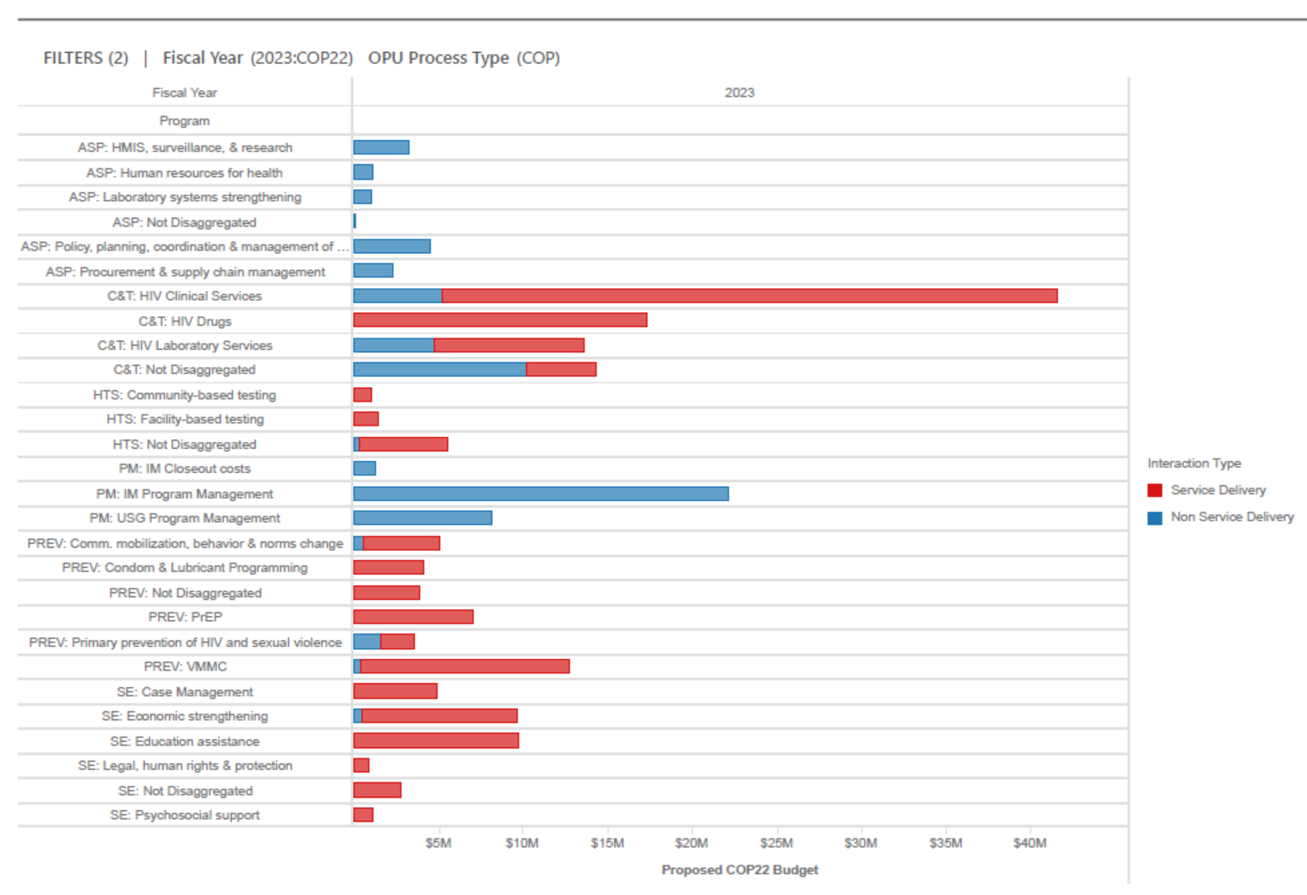


Table B.1.2 COP 22 Budget by Program Area

FILTERS (2) | Fiscal Year (2023:COP22) OPU Process Type (COP)

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		$67,584,374	$136,215,626	$203,800,000	33%	67%	100%
C&T	Total	$20,207,274	$66,482,069	$86,689,343	23%	77%	100%
	HIV Clinical Services	$5,238,175	$36,281,390	$41,519,565	13%	87%	100%
	HIV Drugs		$17,292,280	$17,292,280		100%	100%
	HIV Laboratory Services	$4,768,962	$8,792,764	$13,561,726	35%	65%	100%
	Not Disaggregated	$10,200,137	$4,115,635	$14,315,772	71%	29%	100%
HTS	Total	$329,750	$7,681,238	$8,010,988	4%	96%	100%
	Community-based testing		$1,014,507	$1,014,507		100%	100%
	Facility-based testing		$1,472,767	$1,472,767		100%	100%
	Not Disaggregated	$329,750	$5,193,964	$5,523,714	6%	94%	100%
PREV	Total	$2,669,952	$33,687,150	$36,357,102	7%	93%	100%
	Comm. mobilization, behavior & norms change	$578,043	$4,490,704	$5,068,747	11%	89%	100%
	Condom & Lubricant Programming		$4,114,690	$4,114,690		100%	100%
	Not Disaggregated		$3,834,684	$3,834,684		100%	100%
	PrEP		$7,058,625	$7,058,625		100%	100%
	Primary prevention of HIV and sexual violence	$1,620,229	$1,949,537	$3,569,766	45%	55%	100%
	VMMC	$471,680	$12,238,910	$12,710,590	4%	96%	100%
SE	Total	$483,600	$28,365,169	$28,848,769	2%	98%	100%
	Case Management		$4,852,067	$4,852,067		100%	100%
	Economic strengthening	$483,600	$9,108,015	$9,591,615	5%	95%	100%
	Education assistance		$9,707,053	$9,707,053		100%	100%
	Legal, human rights & protection		$879,300	$879,300		100%	100%
	Not Disaggregated		$2,759,733	$2,759,733		100%	100%
	Psychosocial support		$1,059,001	$1,059,001		100%	100%
ASP	Total	$12,405,555		$12,405,555	100%		100%
	HMIS, surveillance, & research	$3,316,479		$3,316,479	100%		100%
	Human resources for health	$1,128,962		$1,128,962	100%		100%
	Laboratory systems strengthening	$1,047,365		$1,047,365	100%		100%
	Not Disaggregated	$40,000		$40,000	100%		100%
	Policy, planning, coordination & management of disease control programs	$4,555,868		$4,555,868	100%		100%
	Procurement & supply chain management	$2,316,881		$2,316,881	100%		100%
PM	Total	$31,488,243		$31,488,243	100%		100%
	IM Closeout costs	$1,241,508		$1,241,508	100%		100%
	IM Program Management	$22,084,486		$22,084,486	100%		100%
	USG Program Management	$8,162,249		$8,162,249	100%		100%

Table B.1.3 COP 22 Total Planning Level

Metrics	Proposed COP22 Budget	Proposed COP22 Budget	Proposed COP22 Budget
Operating Unit	Applied Pipeline	New	Total
Total	$720,415	$203,079,585	$203,800,000
Zimbabwe	$720,415	$203,079,585	$203,800,000

Table B.1.4 COP 22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics	Proposed COP22 Budget							Percent to Total						
	Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total
Zimbabwe	**Total**	**$86,717,893**	**$8,010,988**	**$36,357,102**	**$28,848,769**	**$12,377,005**	**$31,488,243**	**$203,800,000**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
	Females	$7,177,318	$107,250	$11,920,996	$15,899,068	$1,515,750		**$36,620,382**	8%	1%	33%	55%	12%		**18%**
	Key Pops	$2,612,297	$42,206	$6,601,047	$437,500	$573,759		**$10,266,809**	3%	1%	18%	2%	5%		**5%**
	Males	$1,811,057	$455,650	$15,383,253				**$17,649,960**	2%	6%	42%				**9%**
	Non-Targeted Pop	$74,792,753	$7,405,882	$582,592	$60,000	$10,012,497	$31,488,243	**$124,341,967**	86%	92%	2%	0%	81%	100%	**61%**
	OVC			$483,600	$12,452,201	$274,999		**$13,210,800**			1%	43%	2%		**6%**
	Pregnant & Breastfeeding Women	$324,468		$359,994				**$684,462**	0%		1%				**0%**
	Priority Pops			$1,025,620				**$1,025,620**			3%				**1%**

B.2 Resource Projections

In COP 22, PEPFAR Zimbabwe used the Funding Allocation to Strategy Tool (FAST) to drive budget decisions and funding allocations across initiatives, beneficiaries, and program areas. The FAST is a comprehensive planning and budgeting tool focused on short and long-term solutions and outcomes that will guide the financing and development of implementing partner work-plans in a deliberate effort to optimize PEPFAR investments. To populate the FAST, the PEPFAR Zimbabwe team considered the following sources of information to guide the apportionment of COP 21 resources: Incremental budget adjustments and partner performance (e.g., how much does a partner need to fund a specific activity or package of services such as scaling up access to TPT); Review of COP 21 work plans and budgets, with specific attention to program management costs and human resources for health (HRH) investments. Further refinements and efficiencies were found by examining above-site investments in this flat budget year, which maintaining focus on laboratory systems strengthening and viral load. In COP 22, PEPFAR will maintain focused investments on CLM, while shifting the funding management under UNAIDS and away from PEPFAR Small Grants. The PEPFAR team currently implements routine monitoring monthly to track partner performance and progress and will incorporate a review of expenditure analysis (EA) data to ensure partners are able to implement programs effectively and stay on track to achieve the targets with the budgets assigned to them.

APPENDIX C – Tables and Systems Investments for Section 6.0

Key Systems Barriers-E

Key Systems Barriers-E (Entry of Objectives, Related SID Elements, Barriers to Local Responsibility)					Zimbabwe	
Step 1: Select SID element	SID score (a	Step 2 - What is the outc	Step 3: What are the barriers to lo	Step 4: Describe the barrier	Step 5: Timeline to Barrier Addres	Comments
1. Planning and Coordination	8	Improved coordination of	Lack of technical capacity	Insufficient MOHCC support for coo	1 year	Knowledge transfer and building technical capac
14. Epidemiological and Health I	6.2	Identification of newly inf	Lack of technical capacity	Inadequate knowledge on how to u	1 year	Knowledge transfer and building technical capac
17. Data for Decision-Making Ec	7.7	An electronic health recor	Physical infrastructure not complete	Poor network access and power ba	1 year	Includes optimisation of hardware setup and imp
11. Domestic Resource Mobiliza	5.2	GoZ assumes greater shar	Lack of Financial Resources	Against the background of a chaotic	4-5 years	
2. Policies and Governance	7.1	GoZ adopts policies and p	Legal, policy or regulatory constrain	The GoZ is missing opportunities for	4-5 years	
1. Planning and Coordination	8	Improved planning and co	Lack of USG-Government integratio	The GoZ does not have a concrete p	4-5 years	
6. Service Delivery	5.8	Improve quality and acces	Lack of technical capacity	Public facilities have several gaps in	2-3 years	
8. Commodity Security and Sup	6	Enhanced procurement ar	Lack of technical capacity	There is limited number of qualified	2-3 years	
8. Commodity Security and Sup	6	Increased availability of H	Lack of Financial Resources	Currently most HIV commodities a	6-9 years	
8. Commodity Security and Sup	6	Increased utilization of HI	Lack of sufficient HRH	Currently there are limited staff at	4-5 years	

Table 6-E

Activity Budg	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	SID component the activity is expected to impact	Expected Outcome	Primary Barrier to Local Responsibility this activity addresse	Barrier to Local Responsibility this activity addresses-2 (optional)	Barrier to Local Responsibility this activity addresses-3 (optional)
$1,155,500	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	5.18	6.64	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	1. CBS with recency testing implemented in all PEPFAR supported sites 2. Improved use of CBS with recency testing, sentinel events & EHR data	Lack of technical capacity	Lack of managerial capacity	
$710,950	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	5.18	6.64	14.9 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)?	1. Implement cased based surveillance including expansion of the newly identified and recent infection surveillance components of CBS using a patient-centric electronic system. 2. Ensure electronic health record is meeting CBS sentinel events and longitudinal monitoring including mortality surveillance requirements. 3. Update and optimise registers and reports to meet PEPFAR and MOH requirements. 4. Further enhance data visualisation, customization, and usage of EHR data at national, district, and facility levels.	Lack of technical capacity	Lack of managerial capacity	Physical infrastructure not complete/further investment needed by donors
$658,750	ASP: Policy, planning, coordination & management of disease control programs-NSD	Females: Young women & adolescent females	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	6.75	5.79	6.9 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?	Improved subnational coordination and implementation of the DREAMS program leading to reduced HIV incidence	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources
$191,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Females: Young women & adolescent females	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	6.75	5.79	6.9 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?	Improved subnational coordination and implementation of the DREAMS program leading to reduced HIV incidence	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources
$130,900	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	6. Service Delivery	6.75	5.79	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.)	National HIV and Cervical Cancer program implemented inline with latest PEPFAR and WHO guidelines	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources
$638,694	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	6.75	5.79	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV	Improved national technical leadership and coordination of the national HIV response leading to Epidemic Control	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources
$274,999	ASP: HMIS, surveillance, & research-NSD	OVC: Not disaggregated	Program and data quality management	16. Performance Data	7.56	8.00	16.5 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	Improved use of data to strengthen delivery of social protection services (safety, stability, health, schooling) to vulnerable children and households in PEPFAR priority districts.	Lack of technical capacity	Lack of managerial capacity	Lack of sufficient HRH
$318,000	ASP: HMIS, surveillance, & research-NSD	Females: Young women & adolescent females	Program and data quality management	16. Performance Data	7.56	8.00	16.5 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)?	Improved use of data to strengthen delivery of prevention services to vulnerable AGYW in DREAMS districts.	Lack of technical capacity	Lack of managerial capacity	Lack of sufficient HRH
$178,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Females: Young women & adolescent females	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	6.75	5.79	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV	Strengthened coordinatio of DREAMS as a national program within the MOHCC and NAC	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources
$528,759	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	6.75	5.79	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	Increase equity through improved technical leadership and coordination of the national KP program	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources
$145,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	6. Service Delivery	6.75	5.79	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	Reduced HIV incidence through improved technical leadership and coordination of the national HIV Prevention program	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources
$127,500	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization	11. Domestic Resource Mobilization	7.58	7.58	11.1 Long-term Financing Strategy for HIV/AIDS: Has the host country government developed a long-term financing strategy for HIV/AIDS?	GoZ assumes greater responsibility for functional and financial aspects of the national HIV response	Lack of Financial Resources	Legal, policy or regulatory constraint	Lack of USG-Government integration planning
$170,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Females: Young women & adolescent females	Clinical guidelines, policies for service delivery	6. Service Delivery	6.75	5.79	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.)	Improved quality of public post violence care services in selected DREAMS districts	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources
$2,316,881	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	4.81	4.81	8.8 Management and Monitoring of Supply Chain: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - supply chain activities including forecasting, stock monit	Maintain minimum stock levels of supported commodities within acceptable international standards and	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources

$45,000	ASP: HMIS, surveillance, & research-NSD	Key Pops: Sex workers	Evaluations	14. Epidemiological and Health Data	5.18	6.64	14.6 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? (Note: Full score possible without selecting all disaggregates.)	Reduce HIV incidence among young women who sale sex (YWSS) and increased identification of HIV infection and treatment of Male Sexual Partners of YWSS	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources
$693,800	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	5.18	6.64	14.9 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)?	1. Increased capacity for implementation of EHR, recency testing and case-based surveillance 2. Improved completeness and timeliness of EHR data in all PEPFAR supported sites 3. CBS with recency testing implemented in all PEPFAR	Lack of technical capacity	Lack of Financial Resources	
$536,365	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	7. Human Resources for Health	7.76	7.88	7.8 Management and Monitoring of Health Workforce Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for health workforce activities in HIV service delivery sites, including training, supervision, deployments, quality	1. Improved planning, coordination, monitoring and management of HIV service delivery	Lack of managerial capacity	Lack of managerial capacity	
$173,450	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	5.18	6.64	14.9 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	1. Increased capacity for implementation of EHR, recency testing and case-based surveillance 2. Improved completeness and timeliness of EHR data in all PEPFAR supported sites	Lack of technical capacity	Lack of Financial Resources	
$73,500	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Lab policy, budgets, and strategic plans	10. Laboratory	6.89	5.42	10.2 Management and Monitoring of Laboratory Services: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, purchase, and provide guidance - laboratory services at the regional and district level across all sectors? Select only ONE answer.	Strengthened national laboratory policy planning, programme coordination and management	Lack of managerial capacity	Lack of technical capacity	
$1,100,280	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	5.18	6.64	14.7 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? (if exact or approximate percentage known, please note in Comments column)	Functional LIMS at all PEPFAR supported sites with interoperability with other health information systems and optimized electronic results transittal.	Lack of technical capacity	Lack of Financial Resources	
$1,128,962	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	7. Human Resources for Health	7.76	7.88	7.1 Health workforce 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?	Adequate laboratory HRH supporting HIV/TB related service delivery	Lack of sufficient HRH	Lack of Financial Resources	
$1,047,365	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	6.89	5.42	10.2 Management and Monitoring of Laboratory Services: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, purchase, and provide guidance - laboratory services at the regional and district level across all sectors? Select only ONE answer.	Functional national Quality Assurance programme to ensure quality of testing services (Point of care and conventional). A strengthened national quality management systems throughout the diagnostic network and continous quaity improvement efforts for POC testing as well as clinical-community-laboratory interface.	Lack of technical capacity	Lack of Financial Resources	
$21,900	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	6.75	5.79	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	Improved national technical leadership and coordination of the national HIV response leading to Epidemic Control	Lack of technical capacity	Legal, policy or regulatory constraint	Lack of Financial Resources

COP22 Activity Description	Interventi on Start	Interventi on End	If ongoing from a previous year, please provide rationale for	Benchmark from COP21 (if activity existed in COP21)	Met benchmark past 2 years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activity be continued	Notes
1. CBS with recency testing will be implemented in all PEPFAR-supported sites (1,314 sites) 2. Full EHR at 970 high volume sites and mobile EHR application at 344 sites 3. National and subnational MOHCC and IP personnel using data to inform outbreak response activities & providing reports	COP18	COP22	COVID-19 impacted rate of trainings and roll out	1. Full EHR at 970 high volume facilities and mobile EHR application at 344 facilities	Partial	CBS with recency testing will be implemented in all PEPFAR-supported sites (1,314 sites)	1. CBS with recency testing will be implemented in all PEPFAR-supported sites (1,314 sites) 2. 4 quarterly outbreak response and data use reports for each of the 44 PEPFAR-supported districts	1. Number of sites implementing case surveillance with recency testing and tracking key sentinel events 2. Quarterly case surveillance and outbreak reports	Yes	
1,314 facilities (970 high volume sites on full EHR, 344 on mobile EHR) using EHR to track individual patients using a unique identifier and generating key PEPFAR, GF and MOHCC Reports using the system	COP18	COP22	COVID-19 impacted rate of trainings and roll out	1. Full EHR at 1,005 high volume facilities and mobile EHR application at 702 facilities	Partial	1,314 facilities (970 high volume sites on full EHR, 344 on mobile EHR) using EHR to track individual patients using a unique identifier and generating key PEPFAR, GF and MOHCC Reports using the system	1. 1,314 sites using EHR with zero hours downtime 2. Users and stakeholders obtaining relevant patient and program management lists and reports from EHR	1. Number of activated full and mobile EHR sites 2. Number of sites with zero hours downtime 3. MER indicators and MOHCC reports generated out of EHR	Yes	Original proposed roll-out plan shared in February 2020 included expansion into non-PEPFAR districts but due to COVID delays, expansion into non-PEPFAR districts was now planned after COP22
USAID RISE Activity assists the District AIDS Committee (DAC) to coordinate DREAMS activities (drafting integrated workplans, facilitate referral meetings, monthly/quarterly progress monitoring meetings). The RISE Activity is responsible for 9 of the 12 DREAMS districts.	Prior to COP 18	Post COP25	The activities are an important part of implementing DREAMS due to the multi-sectoral nature of the DREAMS program.	1.) District referral directories updated at least annually; 2.) Targets for referrals which cross partners are set and closely monitored; 3.) Layering and program completion data	Yes	1.) Joint acitivites were reduced during COVID; 2.) Coordination meetings were impacted by COVID but have become	1.) District referral directories updated at least annually; 2.) Targets for referrals which cross partners are set and closely monitored; 3.) Layering and program completion data reviewed during stakeholder	1.) # districts with joint annual workplans; 2.) Referral closure rates (by district, reviewed quarterly); 3.) # of districts that conducted at least 75% of monthly stakeholder meetings; 4.) # of joint implementation activities (high volume events)	Yes	
USAID SMART Girls Activity assists the District AIDS Committee (DAC) to coordinate DREAMS activities (drafting integrated workplans, facilitate referral meetings, monthly/quarterly progress monitoring meetings). The SMART Activity is responsible for 3 of the 12 DREAMS districts.	Prior to COP 18	Post COP25	This activitity ensures implementation of evidence-based programs through updates to national policy documents, operational service delivery manuals, M&E tools, etc., inline with WHO guidelines	1.) District referral directories updated at least annually; 2.) Targets for referrals which cross partners are set and closely monitored; 3.) Layering and program completion data reviewed during stakeholder meetings to inform implementation adjustments; 4.) DREAMS database and dashboards used in all district review meetings; 5.) DREAMS Ambassadors are playing active coordination	Yes	1.) Joint acitivites were reduced during COVID; 2.) Coordination meetings were impacted by COVID but have become more regular in FY22; 3.) Joint workplans were developed for all 3 districts for FY22; 4.) Form 1 and Form 2 tools were introduced in FY21 and are used by all	1.) District referral directories updated at least annually; 2.) Targets for referrals which cross partners are set and closely monitored; 3.) Layering and program completion data reviewed during stakeholder meetings to inform implementation adjustments; 4.) DREAMS database and dashboards used in all district review meetings; 5.) DREAMS Ambassadors are playing active coordination roles in all 3 districts.	1.) # districts with joint annual workplans; 2.) Referral closure rates (by district, reviewed quarterly); 3.) # of districts that conducted at least 75% of monthly stakeholder meetings; 4.) # of joint implementation activities (high volume events)	Yes	
Policy and Guidelines Development - the national ART guidelines and the Operational and Service Delivery Manual are being revised in COP 21. This funding will be used to support the revision of data collection tools which is expected to begin early in COP22. This funding will aslo go towards supporting the revision of cervical cancer SOPs to include "screen, triage and treat" and	COP22	COP23	This funding will be used to support the revision of data collection tools which is expected to begin early in COP22. This	The national ART guidelines and the Operational Service Delivery Manual revisions completed.	Yes	The national ART guidelines and the OSDM revisions would have been completed.	The data collection tools and SOPs are revised and disseminated to the facilities. Staff are oriented on the updated guidelines/OSDM and SOPs.	Updated ART gudelines available. Updated OSDM availabe. Updated SOPs available. Documents disseminated. Health care workers oriented.	No	
Secondments to support the MOHCC: National ART Coordinator/Deputy Director AIDS & TB Unit, Deputy National ART Coordinator, National ART Officer, Deputy National PMTCT Coordinator, Senior M&E Officer,	COP22	COP23	The national secondments are key to ensure implementation of	1) National policy documents, operational service delivery manuals, M&E tools, etc., updated	Yes	1) National policy documents, operational service delivery manuals,	1) National policy documents, operational service delivery manuals, M&E tools, etc., updated inline with WHO	1) Number of national policy documents, operational service delivery manuals, M&E tools, etc., updated inline with WHO guidelines	Yes	
HMIS: Upgrade OVC MIS to account for changes to OVC programming; provide training and TA on OVC SI and MIS use to OVC partners; conduct DQAs; TA for OVC reporting; and leading development of program and SI documents (SOPs, protocols, guidance, etc.)	COP19	Post COP25	The OVC MIS is a critical tool used by all OVC partners and PEPFAR to monitor and report OVC services and improve program quality. Ongoing	No benchmarks set in COP21.	Yes	1) Database tracks caregiver and OVC needs and service completion as well as household benchmarks 2) Database used by all partners for data	1) Database hosting, and administration fully transitioned to a local implementing partner; 2) Database enhancements to improve case management and strengthen support to CLHIV completed per OVC SI TWG priorities; 3) OVC MIS SOP	1) OVC MIS award to local IP established 2) Database enhancements to improve case management and strengthen support to CLHIV completed per OVC SI TWG priorities completed 3) OVC MIS SOP developed and disseminate	Yes	
HMIS: Upgrade DREAMS layering database to account for changes to DREAMS programming; provide training and TA on DREAMS SI and database use to DREAMS partners; conduct DQAs; TA for DREAMS reporting; and leading development of program and SI documents (SOPs, protocols, guidance, layering tables, etc.)	Prior to COP 18	Post COP25	The DREAMS layering database is a critical tool used by all DREAMS partners, PEPFAR, and the MOHCC to monitor and report DREAMS services and improve program quality. Ongoing investment is required to ensure it reflects PEPFAR guidance,	1) Rollout screening and enrolment modules 2) Institutionalize quarterly reviews of UIC compliance, district/partner coherence, quaterly enrolment progress reviews 3) Triangulation of DREAMS data with MER data for PrEP and GBV 4) Introduce service dashboards, trend analysis dashboard, referrals tracking dashboard, and AGYW_PREV dashboard	Yes	1) Database tracks individual level completion by end FY22. 2) Database used by all partners for data entry and analysis 3) PowerBI dashboards available for service delivery and layering	1) DREAMS to OVC MIS export process automated; 2) Partners are able to manage referrals in WorkForce App; 3) Layering analysis is automated; 4) Related SOPs developed and disseminated	1) DREAMS to OVC MIS export process automated; 2) Partners are able to manage referrals in WorkForce App; 3) Layering analysis is automated; 4) Related SOPs developed and disseminated	Yes	
Secondment of MOHCC and NAC DREAMS Coordinators. The two positions are responsible for leading internal/external DREAMS coordination meetings, quarterly progress monitoring and reporting, quarterly	Prior to COP 18	Post COP25	The secondments are critical to the management and ownership of	1.) National level DREAMS meetings are facilitated by MOHCC and NAC Coordinator (100% of	Yes	1.) National coordination meetings take place quarterly are co- led	1.) National level DREAMS meetings are facilitated by MOHCC and NAC Coordinator (100% of quarterly meetings	1.) 100% of monthly DREAMS partner meetings conducted; 2.) DREAMS Coordinators present updates at 100% of MOHCC quarterly meetings; 3.)	Yes	
Secondment of Key Populations Technical Steering Committee (TSC) to the MOHCC. TSC positions include: Clinical Officer, Communications Officer, and Monitoring and Evaluation Officer	COP19	Post COP25	National secondments are key in 1) Assisting the GoZ to harmonize investments behind	1) Key secondments in place and holding monthly and quarterly coordination meeting, 2) conducting regular supportive and supervision visits to districts,	Yes	1) Key secondments in place and holding monthly and quarterly coordination meeting, 2)	1) Key secondments in place and holding monthly and quarterly coordination meeting, 2) conducting regular supportive and supervision visits to districts, 3) submitting	1) Number of monthly and quarterly coordination meetings held; 2) Number of site visit conducted; 3) Number of policy advocacy initiatives acted upon; 4) Program guidelines updated/established	Yes	
Secondment of National HIV Prevention Coordinator and National Advocacy and Communications Manager to MOHCC	Prior to COP 18	Post COP25	The national secondments are key to ensure implementation of evidence-based programs through	1) Key secondments in place and holding monthly and quarterly coordination meeting, 2) conducting regular supportive and supervision visits to districts,		1) Key secondments in place and holding monthly and quarterly coordination meeting, 2)	1) Key secondments in place and holding monthly and quarterly coordination meeting, 2) conducting regular supportive and supervision visits to districts, 3) submitting	1) Number of monthly and quarterly coordination meetings held; 2) Number of site visit conducted; 3) Number of policy advocacy initiatives acted upon; 4) Program guidelines updated/established	Yes	
Support development of a national HIV Response Sustainability Roadmap	COP22	Post COP25		No benchmarks set in COP21.		The national HIV response is highly reliant on donor assistance. The GoZ does not have a concrete plan to	1.) Development partners sensitized on the PEPFAR Sustainability Roadmap through one-on-one or group meetings and consensus reached on a collaborative process to engage	1.) Coordination structure formed; 2.) Action plan for engagment developed; 3.) Draft Sustainability Roadmap developed.	Yes	

Provide technical assistance to the MOHCC to improve quality and accessibility of public, clinical post violence care services in selected DREAMS districts.	COP22	COP24		No benchmarks set in COP21.		Outside of facilities that have One Stop Centers, public facilities have several gaps in post violence care	1.) Stakeholder consultations are conducted to identify and prioritize critical gaps in the health sector response to post violence care for AGYW. 2.) Any gaps in key policy and	1.) MOHCC GBV register finalized, printed and distributed to sites in targeted DREAMS districts. 2.) Action plans developed with the MOHCC to address major quality and skills gaps. 3.) Key tools and SOPs are available at	No	
Procurement and Supply Chain Management staff secondments for national quantification, supply planning, incountry commodity logistics(23 staff seconded to the Directorates of Laboratory and Pharmacy Services - DPS & DLS) to support the planning, implementation and monitoring of the supply chain. The project is supporting the Logistics Unit which is a key unit in managing the coordination of supply chain actibities in the country. 36 transport staff support the	Prior to COP 18	COP23	The country still faces HRH and financial challenges and there is continued need for proper supply chain management in order to ensure proper management	1. Reports from semi-annual quantification 2. Maintain low stock out rates of tracer commodities within global industry standards TLD > 1% most used 1st line pediatric ARV > 1% male condoms >5% HIV First RTK > 5% VMMC universal surgical disposable	Partial	Two quantification reports TLD = 0.55% Most used 1st line pediatric ARV = 6.5% Male Condoms = 3.12% HIV First RTK = 7.4% VMMC Universal	1. Reports from semi-annual quantification 2. Maintain low stock out rates of tracer commodities within global industry standards TLD > 1% pDTG > 1% male condoms >5% HIV First RTK > 5% VMMC universal surgical disposable kit >5%	1. Approved quantification reports 2. Logistics Management Information System Reports	Yes	This activity is intended to ensure proper planning ,implementation and monitoring of the supply chain activities for the HIV/AIDS program. It aims to improve track and
Evaluating an intervention to reach male sexual partners of young women who sale sex (YWSS) with HIV services	COP22	COP22			Not applicable	Protocol finalized	Evalaution completed	Evalaution completed	No	See 3b. SRE Tool - Eval for more details on the evaluation
Provide support to the MOHCC in collaboration with ICAP and other partners for the expansion of Electronic Health Records (EHR) systems. •Training HCWs •TA support to monitor implementing Updating of databases; transition of EPMS to EHR Case-based Surveillance (CBS)/Recency: Collaborate with ICAP to support CBS/recency rollout •Training HCWs on recency •Identification and maintenance of CBS sentinel sites	COP18	COP22	Phased (multi-year) approach to strengthening investments in data systems. Covid-19 affected activity implementation and system resources	Training of HCWs on CBS, recency and EHR ongoing. Roll out of CBS and recency ongoing. Maintenance of CBS sentinel sites ongoing	Partial	Baseline data not available		1. Proportion of sites implementing recency testing routinely 2. Proportion of sites implementing CBS 3. Proportion of sites with functional EHR that are using it for reporting	Yes	
Secondments to the MOHCC to support policy, planning and coordination of TB/HIV programs. Specifcically, to strengthen private sector involvement in HIV and TB services provision through Public Private Partnerships (PPPs), harmonization of capacity building initiatives within AIDS and TB programmes, coordination of facility-community linkages initiatives and support finance, administration and logistics to ensure expenditure control and compliance. Secondees: 1. National Continuous Quality Improvement (CQI) Coordinator; 2. National Data Quality Officer, 3. National Public-Private Partnership(PPP) and HIV	Prior to COP 18	COP22	Phased (multi-year) approach to strengthening the ministry of health's capacity for policy, planning and coordination at national level. Capacity remains inadequate.	6 MoHCC secondees to be supported to strengthen policy, planning and coordination of the HIV program	Partial	6 MoHCC secondees supported	6 MoHCC secondees supported	Number of secondees supported and actively supporting the HIV program	Yes	
and other partners for the expansion of Electronic Health Records (EHR) systems. •Training HCWs •TA support to monitor implementing Updating of databases; transition of EPMS to EHR Case-based Surveillance (CBS)/Recency: Collaborate with ICAP to support CBS/recency rollout	COP18	COP22	Phased (multi-year) approach to strengthening investments in data systems. Covid-19 affected activity implementation and system resources	Training of HCWs on CBS, recency and EHR ongoing. Roll out of CBS and recency ongoing. Maintenance of CBS sentinel sites ongoing	Partial	Baseline data not available		1. Proportion of sites implementing recency testing routinely 2. Proportion of sites implementing CBS 3. Proportion of sites with functional EHR that are using it for reporting		
Maintain DLS secondments to strengthen policy planning, programme coordination and management	COP18	COP22	Phased (multi-year) approach to strengthening investments in laboratory systems. Covid-19 affected activity implementation and system resources	12 MoHCC secondees to be supported with level of effort fees to stregthen coordination structures with the laboratory directorate to ensure sustainability of PEPFAR investments	Partial	12 MoHCC secondees to be supported with level of effort fees	Continued support for 12 MoHCC secondees to be supported with level of effort fees	Number of MoHCC DLS seconments	Yes	
Phased approach to LIMS implementation at districts hubs in PEPFAR DSD districts, including supporting remote log-in, and strengthening results transmittal. Selected high volume sites to be supported to establish data disaster recovery and system fail oversights. Limited support for DHIS2, E-LIMS intergration work. Maintain ongoing LIMS development work i.e. module creation, dashboard development, and POC testing data intergration.	COP18	COP22	Phased (multi-year) approach to strengthening investments in laboratory systems. Covid-19 affected activity implementation and system resources	LIMS installed and functional at 68 labs in PEPFAR DSD districts. Scaling of electronic results transmittal including SMS, email	Partial	80% coverage of all labs in PEPFAR DSD districts with LIMS	100% coverage of all labs in PEPFAR DSD districts with LIMS	Number of sites with functional, optimized LIMS	Yes	
Phased approach to strengthening DSD HRH coverage in 68 labs in PEPFAR DSD districts. 25-40% of the scientist and DEC needs to be covered for the programme. Maintain a minimal staff retention and performance fee for MoHCC staff to prevent attrition. Includes cost of living adjustments.	COP18	COP22	Phased (multi-year) approach to strengthening investments in laboratory systems. Covid-19 affected activity implementation and system resources	Provide support for level of effort fees for MoHCC laboratory HRH supporting HIV/TB laboratory service delivery at 68 laboratories. 43 scientist and 29 data entry clerks to be supported (COP21 HRH support boosted by ARPA funding) to address HRH shortages and gaps	Partial	13 scientists and 14 DEC supported in 68 labs in PEPFAR DSD districts. ARPA funds discontinued in COP22 which supported additional HRH	Maintain 13 scientists and 14 DEC HRH support in 68 PEPFAR DSD labs. Numbers may be revised due to HRH gaps affecting the programme	Number of laboratory scientists and DEC supporting HIV VL/EID testing. Laboratory HRH staffing gap (%)	Yes	
Phased approach to strengthening national quality assurance programme. Selected high volume PEPFAR DSD hubs to be supported for CQI.PEPFAR funding to support smart start and CLI collaborative learning sessions in select districts and CLI committee meetings. Increased focus on activities to strengthen the clinic-community-laboratory interface.	COP18	COP22	Phased (multi-year) approach to strengthening investments in laboratory systems. Covid-19 affected activity implementation and system resources	Maintain accreditation for VL labs, Establish national certification program for district labds and implement RTCI for all POC testing including rapid testing and mPIMA and Gene Xpert testing	Partial	80% HIV EQA coverage for approximately 3,000 tester programme in 44 PEPFAR DSD districts. 100% of VL labs maintain Accreditation status, 30% of District labs implementing national CQI program	95% HIV EQA coverage for approximately 3,000 testers to support clinical staff in 44 PEPFAR DSD districts. 100% of VL labs maintain Accreditation status, 40% of District labs implementing national CQI program	1. Number of sites participating in HIV/TB related EQA . EQA Pass-rate (>90%). Number of failed sites supported for EQA corrective action. Number of accredited VL labs , number of district labs implementing CQI and facilities implementing RTCQI	Yes	
Support MOHCC in developing, updating, and printing of SIE tools to capture new interventions or new data requirements: e.g. TB-LAM, 3HP. Support adaptation and training on new WHO consolidated HIV care guidelines. Develop, print and distribute new SOPs, job aides and tools	COP18	COP22	Phased (multi-year) approach to strengthening the ministry of health's capacity for policy, planning and coordination at	No benchmarks set in COP21.	Partial	National ART guidelines are reviewed. The OSDM is reviewed. Annual program performance meetings are held.	WHO guidelines are adapted and adopted for use within the local context through revised SOPs. Donor collaboration/coordination meetings are held. Technical working group meetings to assess program performance are held.	Revised National ART guidelines and OSDM finalized. Document dissemination plans in place. National staff orientation plans developed.		

APPENDIX D – Minimum Program Requirements

Care and Treatment

Adaptation and implementation of HIV test and start across all age, sex and risk groups

Rapid optimization of ART offering TLD to PLHIV weighing > 20kgs, including adolescents and WCB potential

Adaptation and implementation of DSD for all PLHIV for PLHIV, incl. 6 MMD, decentralized ART

All eligible PLHIV, incl. children & adolescents, complete TPT and CTZ integrated in HIV care at no cost

Completion of diagnostic network optimization activities for EID, VL, TB & other co-infections

HIV Case Finding

Scale up of index testing and HIV self testing ensuring consent & confidentiality are protected & assess IPV. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.

Prevention and OVC

Direct & immediate assessment for & offer of prevention services, incl. PrEP, to HIV-ve clients at high risk of HIV acquisition (PBFW & AGYW, high-risk HIV-ve partners of index cases, KPs & adult men engaged in high-risk sex)

Alignment of OVC services, enrollment for comprehensive prevention & Rx services to OVC ages 0-17, focus on 1) active HIV testing for at risk children, 2) facilitate linkage to treatment, support & case management, 3) reduce sexual violence & HIV risk for AGYW and for 10-14yo girls & boys

The graphic above shows that most of the minimum program requirements under the care and treatment, HIV case finding, and prevention broad categories have been achieved. The HIV "test and start" approach has become standard practice throughout the supported health facilities, and of note contributed to high linkage rates that the program continues to report. The program has scaled up safe HIV Index testing and HIVST, we have found this strategy to be effective especially now when we have experienced challenges related to COVID-19. TPT universal coverage is in the process of being achieved with about 375,000 clients having completed TPT over the last 3 years. In COP 21 Q2 and Q3 PEPFAR will support the MOHCC to roll out a TPT surge targeting eligible patients already on ART. PrEP is being scaled up targeting those at risk. The initial focus was on KPs, but now we have started targeting PBFW, AGYW, and sero-discordant couples.

Policy and Public Health Systems Support

Demonstrate progress toward advancement of equity, reduction of stigma & discrimination, & promotion of human rights to improve HIV prevention & treatment outcomes for KPs, AGYW & other vulnerable groups.	Clear evidence of agency progress towards local, indigenous direct funding; incl. funding to KP-led & women-led orgs. Support community-, KP- & women-led responses.
Elimination of all formal & informal user fees in public sector	Evidence of GoZ assuming greater financial responsibility; evidence of year after year increased resources expended
Integrating effective quality assurance and CQI practices into site & program management	Monitoring and reporting of morbidity and mortality outcomes
Evidence of treatment and VL literacy activities supported by MOH, NAC U=U messaging	Scale up of case surveillance and unique identifier for patients across sites

Under policy and public health systems support, most MPRs have been achieved except the new ones that focus on equity, stigma reduction and promotion of human among those who are often left behind. PEPFAR commits to working with CSOs to ensure this MPR is achieved. CLM will ensure that we stay on the right path. Completion of diagnostic network optimization has been achieved, but this is a moving target given the technology keeps evolving, hence performance of this MPR will be monitored continually. EHR now generates a 36 digit Universally Unique ID Number that it assigns to everyone newly registered in the system. This unique number facilitates deduplication through an algorithm that considers certain variables from a patient; their name, DOB, gender, ID number, and any other program ID available (OI ART number).

APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

Background

While Zimbabwe has made commendable progress, the national HIV/AIDS program remains highly dependent on external resources for commodity procurement, many aspects of service delivery, including human resources, and technical assistance required for reaching and sustaining epidemic control. The COP 22 SDS highlights the most critical gaps in the program: adequate supplies of critical commodities, Viral Load Coverage (VLC), pediatric treatment and Viral Load Suppression (VLS), Tuberculosis (TB) screening and reporting, coverage of prevention services for priority populations, and a variety of contextual and structural barriers that impede equitable access to HIV services. Zimbabwe's heavy reliance on donor funding for the procurement, management, and distribution of health commodities is a severe risk to the stability of the entire health system.

The macroeconomic environment remains significantly challenged, with high inflation rates, currency erosion, and stagnant economic growth. The health system struggles with deteriorating infrastructure, shortages of drugs and commodities, and low morale among HCWs. Civil servants are frequently not paid, and when paid, it is in local currency, which at a USD equivalent does not allow for a living wage. To appease HCWs, the GoZ has used different strategies, including allowing health facilities and HCWs to reduce working hours. Still, several HCW industrial actions in recent years have led to facility closures and an absence of trained medical personnel to treat emergencies and health conditions that were deemed a lower priority.

COVID-19 exacerbated an already difficult situation. The number of nurses and doctors leaving the country continues to increase, and there is high attrition in the public sector. The impact on the public cannot be overstated. There is almost a complete lack of specialist services available for free or low cost in the public sector, patients are experiencing high ad hoc out of pocket costs, and the trust in the health system that was once affordable and high quality has eroded.

The GoZ has consistently led in the policy space, proactively adopting new public health approaches and technologies, such as the upcoming HIPAA policy. The commitment to financing the HIV response (and the health sector) remains unclear and is continually complicated by the ongoing currency erosion. However, recently, the GoZ committed $4.5M to support health informatics, which includes the EHR system. This allocation of funding is a huge step forward to sustaining a PEPFAR supported initiative, though whether it comes to fruition remains to be seen. In 2021, the GoZ increased the amount budgeted for health in the national budget to the 15% Abuja recommendation. Still, while the actual expenditure figure is not known, it is definitely not to that level.

As shown in figure 1, the GoZ has struggled to absorb programs and services previously funded by development partners, and they have not been able to fill shortfalls in commodities, including those critical to the HIV response: viral load commodities, ARVs, PrEP, condoms, STI drugs, contraceptives, etc. as shown in figures 2 and 3.

Figure 1 SID: Financing by Domestic Sources:

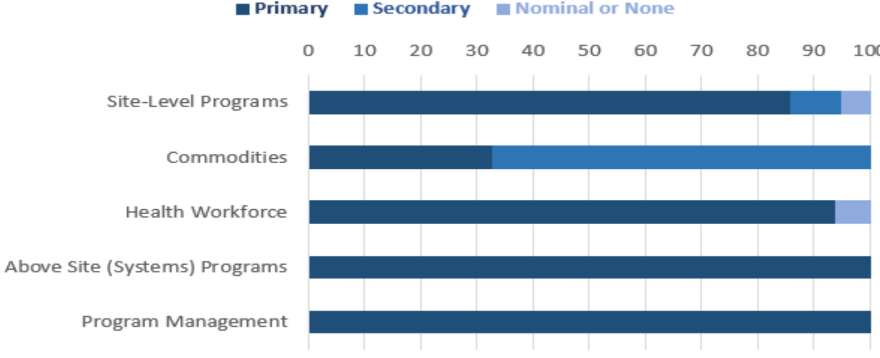
SID: Financing by Domestic Sources	2017 Response	2019 Response	2021 Response	Change Over Time
National HIV Response				
% financed with domestic public and private sector funding	Some (10-49%)	Some (10-49%)	Some (10-49%)	
Service Delivery				
% financing for service delivery from host country	Some (10-49%)	Some (10-49%)	Some (10-49%)	
% financing for service delivery to key populations from host country	Some (10-49%)	Some (10-49%)	Some (10-49%)	
Health Workforce				
% health worker salaries provided by host country institutions	All or almost all (90%+)	All or almost all (90%+)	or almost all (90%	
Commodities				
% financing for ARVs from host country	Minimal (1-9%)	Minimal (1-9%)	Minimal (1-9%)	
% financing for rapid test kits from host country	Minimal (1-9%)	Minimal (1-9%)	Minimal (1-9%)	
% financing for condoms from host country	None	None	None	
Supply Chain Plan				
% financing for supply chain plan from host country	Some (10-49%)	Some (10-49%)	Some (10-49%)	
Laboratories				
% financing for laboratories from domestic public or private sources	Some (10-49%)	Some (10-49%)	Some (10-49%)	
Surveys and Surveillance				
% financing for general population surveys and surveillance from host country	Minimal (1-9%)	Minimal (1-9%)	Some (10-49%)	
% financing for key population surveys and surveillance from host country	None	None	Some (10-49%)	
Service Delivery Data				
% financing for service delivery data collection from host country	Some (10-49%)	Some (10-49%)	Some (10-49%)	

Figure 2: Tabulation of Responsibility Matrix Responses

Tabulation of Responsibility Matrix Responses 2021

	Host Govt.			PEPFAR		
Functional Element	**Primary**	**Secondary**	**Nominal or None**	**Primary**	**Secondary**	**Nominal or None**
Total across elements	126	40	4	105	78	15
Above Site (Systems) Programs	52	0	0	35	15	2
Commodities	17	34	0	36	15	0
Health Workforce	17	0	1	5	13	6
Program Management	2	0	0	1	1	0
Site-Level Programs (excl. Commodities and Health Workforce)	38	6	3	28	34	7

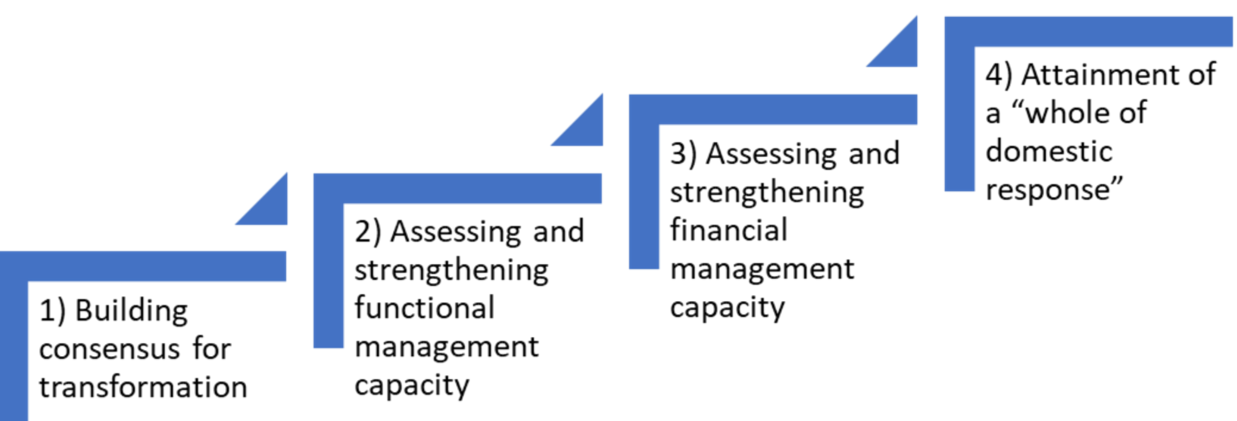
Figure 3: Government Level of Responsibility



Sustainability Planning in COP 22: Developing a Sustainability Roadmap

Against this backdrop, the PEPFAR team formed an internal Sustainability Taskforce composed of representatives from USAID, CDC, and PCO to review key sustainability questions related to helping the country progress towards sustainable control of the HIV/AIDS epidemic. Recognizing the USG's unique bilateral working relationship with the GoZ, the importance of having broad participation of development partners, civil society, and complete buy-in and leadership by the GoZ, PEPFAR allocated funding in COP 22 to UNICEF to support the development of a Sustainability Roadmap. For the process to gain traction, it is of utmost importance to allocate sufficient time for consultation and consensus-building. Equally important is identifying and leveraging related efforts within GoZ and among development partners that are underway or planned.

It is expected that developing a roadmap toward sustainability will require country programs to go through four stages that can span several years:



The COP 22 scope of work will entail the execution of activities under the first two stages. A snapshot of potential actions that PEPFAR Zimbabwe will undertake in COP 22 is shown below, with the main deliverable being a Draft Sustainability Roadmap.

Building consensus for transformation	• Using existing platforms (such as the HPDG, HDF), sensitize and engage development partners on the PEPFAR Sustainability Roadmap. Take stock of other ongoing/planned efforts related to sustainability of the health system, health financing, etc., and propose how such efforts may be linked for synergistic impact. • Review existing policies, strategies, guidance, and frameworks related to sustainability of the HIV response, the resiliency of the health system, and the country progress towards Universal Health Coverage more broadly. Identify critical opportunities and bottlenecks. • Build consensus among development partners on a collaborative process, with clearly defined objectives, for engaging the GoZ in Sustainability Planning. Support multi-stakeholder HIV-specific high-level dialogues. • Leverage partnerships, related efforts, and platforms, such as PHC costing and high-level child budgeting series to embed HIV and AIDS, including the Health Financing Symposium, to dialogue with the GoZ, at strategic levels to generate the political will necessary for Sustainability Planning.

	• Engage the MoHCC's Policy and Planning Unit and identify Champions within the MoHCC and other GoZ line ministries and some members of the HDPG to actively lead the Sustainability Planning process. • Facilitate the formation of a coordination structure for Sustainability Planning, inclusive of GoZ, donors, multilaterals, civil society, the private sector, and other relevant key actors and stakeholders in the health system. The coordination structure should lay out leadership, management, oversight, and communication functions. • Engage broadly but strategically with community groups on Sustainability Planning and ensure decision-makers amplify and hear community voices. • Convening relevant policy dialogues. • Disseminate updates, decisions, and policy/cultural changes with stakeholders. • Develop a structured engagement process to ensure GoZ planners and development partners understand Sustainability Planning for the HIV response and advocate for the inclusion of key activities in annual budgets, COPs, GFATM 2023 funding requests, etc.
Assessing and strengthening of functional management capacity	• Conduct an HIV-specific public expenditure review to deepen the analysis in the NASAs and produce an HIV budget brief to inform the consensus-building dialogues and inform advocacy. • Identify the system capacity, policy/legal, and financial needs required to realize the prioritized transition areas (e.g., domestic resource mobilization, service delivery). • Identify and support opportunities for regional engagement and learning from neighboring countries on Sustainability Planning through regular regional policy dialogue and documentation. • Support the Sustainability Coordination structure to prioritize short-, medium- and long-term areas for the transition of the HIV response informed by SID, RM, HRH data, LAST, health systems assessments, and other sustainability assessments. • Identify explicit capacity strengthening approaches, activities, and benchmarks required to achieve transition and secure endorsement of the plan by GoZ, multilaterals, donors, civil society, and private sector partners. • Organize south-to-south learning events.

Potential Areas for Early Transition

PEPFAR engaged GoZ in sustainability discussions during the development of COP 22. Zimbabwe National AIDS Strategic Plan (ZNASP) 2020-2025 has sustainability embedded into its mission: *To accelerate the scale-up of HIV programs and transition the HIV response into a sustainable phase through cost-efficient and effective strategies.* The ZNASP contains many priorities, which if implemented fully, would strengthen the health system and community functions and capacities that support sustained epidemic control. The following strategies were shared to sustainably close the funding gap for the HIV response:

- Strengthen public-private partnerships to increase domestic resources for HIV. This will involve cooperation with the private sector to increase private pharmacies' access to low-priced HIV drugs, which will reduce the cost for clients accessing ARVs in the private sector and utilization of Corporate Social Responsibility (CSR) to support HIV interventions.

- Implement social contracting whereby government resources fund entities that are not part of the government to provide health / HIV services.
- Establish or participate in regionally coordinated pooled procurement of ARVs and other commodities.
- Increase allocative, technical and implementation efficiencies through HIV integration, improve coordination to minimize duplication of efforts, strengthen accountability, and invest in community response.
- Stretch the dollar--buy local products and invest in HIV prevention programs like KP and AGYW.

The PEPFAR Sustainability Taskforce brainstormed a list of **potential** areas to support the transition of some PEPFAR funded activities. These areas were selected because they either scored well in the SID (figure 4), progress towards transition has already been made in some form, they emerged as recommendations from stakeholders during the COP 22 development process, and/or they leverage USG agency priorities and competencies.

Figure 4: Sustainability Index Dashboard Trends over Time

SID

Domain	SID Element (Sum of SIDweighted_answer)	FY2017	FY2019	FY2021	Score Over
Governance, Leadership & Accountability	1. Planning and Coordination Score:	10.00	8.57	10.00	
	2. Policies and Governance Score:	7.11	5.82	6.52	
	3. Civil Society Engagement Score:	6.46	3.00	6.75	
	4. Private Sector Engagement Score:	5.92	5.92	6.72	
	5. Public Access to Information Score:	5.00	5.67	7.00	
National Health System & Service Delivery	6. Service Delivery Score:	6.85	6.75	5.79	
	7. Health Workforce Score:	8.40	7.58	7.88	
	8. Commodity Security and Supply Chain Score:	6.14	4.81	4.81	
	9. Quality Management Score:	8.67	9.33	9.33	
	10. Laboratory Score:	5.50	6.89	5.42	
Strategic Financing & Market Openness	11. Domestic Resource Mobilization Score:	7.06	7.58	7.58	
	12. Technical and Allocative Efficiencies Score:	8.56	8.56	9.00	
	13. Market Openness Score:		6.88	9.38	
Strategic Information	14. Epidemiological and Health data Score:	4.51	5.18	6.64	
	15. Financial/Expenditure data Score:	10.00	10.00	7.50	
	16. Performance Data Score:	7.12	7.56	8.00	
	17. Data for Decision-Making Ecosystem Score:		5.00	6.33	

It is important to note that these areas are illustrative only. In consultation with all stakeholders, the draft Sustainability Roadmap will carefully assess these and other areas, to determine a realistic plan that includes the required functional and financial competence, necessary activities for transition, roles and responsibilities, and estimated timeframe.

- Through further analysis and work with the PEPFAR HRH Inventory, identify opportunities to harmonize and streamline community cadres and their support with GoZ and other development partners.
- Support catalytic policy development or updates for areas which the MoHCC can move forward independently.
- Strengthen private sector engagement for efficiencies and domestic resource mobilization:
- Specific support for CSOs to develop capacity as social enterprises and strengthening GoZ capacity for contract management including social contracting with CSOs for relevant services.
- Transition elements of PEPFAR site-level technical assistance (TA) to the district level and then national level.
- Fast track integration of key program and technical skills into pre-service curriculum for nurses and other HCWs to limit the need for repeated PEPFAR-funded training.

- Transition the ongoing establishment of new health posts and the activities undertaken within GoZ.
- Identify elements of PEPFAR support for strategic information at the national/district/site levels, which can be transitioned to GoZ.
- Identify options for PPEs to support ongoing digital transformation and connectivity.

Figure 5: Actual Annual Spend by Site Level, Program, and Sub-Program. Source: CHAMP, HRH Inventory

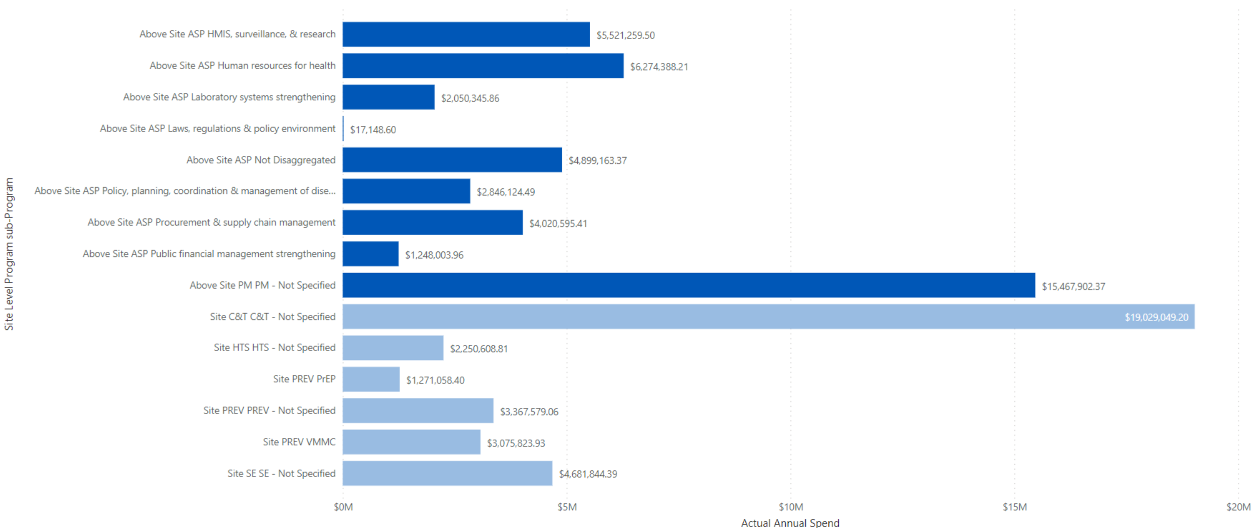


Figure 6: Actual Annual Spend by Site Level and Interaction Type. Source: CHAMP, HRH Inventory

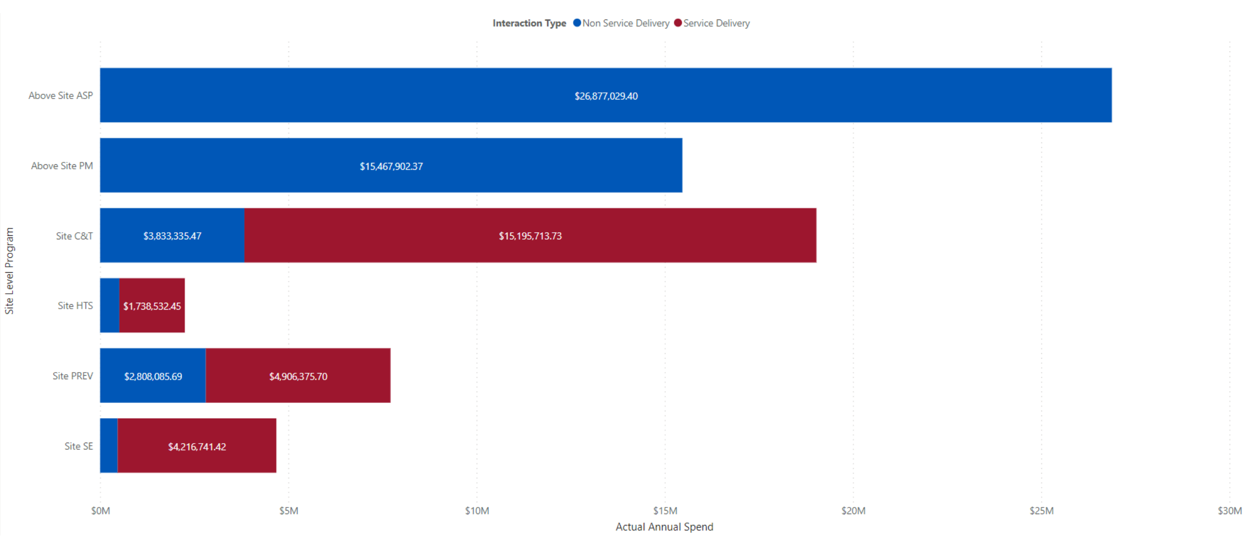


Figure 7: Actual Annual Spend, Service Delivery. Source: CHAMP, HRH Inventory

Site Level	Non Service Delivery	Service Delivery	Total
Above Site	**$42,344,931.77**		**$42,344,931.77**
ASP	**$26,877,029.40**		**$26,877,029.40**
HMIS, surveillance, & research	$5,521,259.50		**$5,521,259.50**
Human resources for health	$6,274,388.21		**$6,274,388.21**
Laboratory systems strengthening	$2,050,345.86		**$2,050,345.86**
Laws, regulations & policy	$17,148.60		**$17,148.60**
Not Disaggregated	$4,899,163.37		**$4,899,163.37**
Policy, planning, coordination & management of disease control programs	$2,846,124.49		**$2,846,124.49**
Procurement & supply chain management	$4,020,595.41		**$4,020,595.41**
Public financial management strengthening	$1,248,003.96		**$1,248,003.96**
PM	**$15,467,902.37**		**$15,467,902.37**
PM - Not Specified	$15,467,902.37		**$15,467,902.37**
Site	**$7,618,600.49**	**$26,057,363.30**	**$33,675,963.79**
C&T	**$3,833,335.47**	**$15,195,713.73**	**$19,029,049.20**
C&T - Not Specified	$3,833,335.47	$15,195,713.73	**$19,029,049.20**
HTS	**$512,076.36**	**$1,738,532.45**	**$2,250,608.81**
HTS - Not Specified	$512,076.36	$1,738,532.45	**$2,250,608.81**
PREV	**$2,808,085.69**	**$4,906,375.70**	**$7,714,461.39**
PrEP	$37,862.00	$1,233,196.40	**$1,271,058.40**
PREV - Not Specified	$1,534,976.61	$1,832,602.45	**$3,367,579.06**
VMMC	$1,235,247.08	$1,840,576.85	**$3,075,823.93**
SE	**$465,102.97**	**$4,216,741.42**	**$4,681,844.39**
SE - Not Specified	$465,102.97	$4,216,741.42	**$4,681,844.39**
Total	**$49,963,532.26**	**$26,057,363.30**	**$76,020,895.56**

APPENDIX F – Key Populations Program Requirements

Key Populations Program Requirement #1: Document the trajectory of KP budget and expenditures over the prior two COP cycles utilizing PEPFAR financial classification system.

KP Budget & Expenditure Trajectory

Concept "How has the KP beneficiary budget and expenditures shifted, both proportionally and in actual dollars, by program area and cost category for the past COP cycles for each OU?"

Deliverable Analyses

- Table 1: KP spending & budget, compared to national
  - Overall KP spending and budget
  - Show trends for last 3 fiscal years
  - KP as % of total OU spending and budget
  - Calculates KP and total (overall) budget execution
- Table 2: KP spending by Program Area
  - Itemizes KP spending by program area
  - Show trends for last 3 fiscal years
  - Highlights attainment for key MER indicators for last 3 fiscal years
  - Calculates percent change between fiscal years
- Table 3: KP spending by cost category
  - KP spending, by cost category and total
  - Show trends for last 3 fiscal years
  - Calculates % change in spending by cost category between fiscal years

Table 1: KP spending & budget, compared to national

KEY POPULATION EXPENDITURE AND BUDGET, ALL AGENCIES

OU: Zimbabwe

**KP budget and expenditures are based on those attributed to the Key Pop beneficiary*

	2019	2020	2021	2022
Expenditure	$152,967,248	$137,687,625	$204,602,654	
KP Spend	$4,908,176	$3,532,368	$8,190,501	
KP Spend % of Total	3.2%	2.6%	4.0%	0.0%
Total Planned Funding	$150,446,200	$162,947,748	$234,669,212	$213,229,251
KP Budget		$2,325,943	$7,586,386	$8,871,881
KP Budget % of Total	0.0%	1.4%	3.2%	4.2%

Notes:

- Budget & expenditures based on those attributed to KP beneficiary which includes core KP and DREAMS programming
- Dip in spending between in FY20 needs further interrogation: may be related to how KPIF expenditures were tracked at this time

Table 2: KP spending by Program Area

KEY POULATION PROGRAM AREA EXPENDITURES AND PERCENT CHANGE FORM PREVIOUS FISCAL YEAR, ALL AGENCIES
OU: Zimbabwe
**Based on expenditures attributed to the Key Pop beneficiary*

Program ..	2019	2020	2021
ASP	$261,884	$674,561 157.6%	$545,687 -19.1%
C&T	$1,740,414	$1,337,042 -23.2%	$3,422,143 155.9%
HTS			$149,643
PREV	$2,905,878	$1,520,765 -47.7%	$4,073,028 167.8%
Grand Total	$4,908,176	$3,532,368 -28.0%	$8,190,501 131.9%

KEY POULATION INDICATOR RESULTS AND PERCENT CHANGE FORM PREVIOUS FISCAL YEAR, ALL AGENCIES
OU: Zimbabwe
** Indicator results are based on the USAID KP-Focused and and Integrated (GP+KP) indicators and do not include any mechanisms from CDC or Other Agencies*

Program Area	Indicator	2019	2020	2021
C&T	TX_CURR	930,885	1,162,994 24.9%	1,183,594 1.8%
	TX_NEW	104,304	76,394 -26.8%	68,437 -10.4%
HTS	HTS_TST_NEG	2,254,530	1,358,602 -39.7%	1,179,689 -13.2%
	HTS_TST_POS	118,253	81,185 -31.3%	72,042 -11.3%
PREV	KP_PREV	33,599	37,271 10.9%	57,773 55.0%
	PrEP_CURR	8,363	19,183 129.4%	49,085 155.9%
	PrEP_NEW	8,736	13,971 59.9%	38,253 173.8%

Notes:
- Reported expenditures by program area in FY20 need further interrogation
- Reduction in TX_NEW results likely reflect the narrowing gap of undiagnosed HIV+ SWs
- Reduction in HTS results reflects increased use of HIVST and more targeted testing approaches
- Increase in prevention targets reflect increased focus on PrEP

Table 3- KP spending by cost category

KEY POPULATION COST CATEGORY EXPENDITURES ADN PERCENT CHANGE FROM PREVIOUS FISCAL YEAR, ALL AGENCIES
OU: Zimbabwe
**Based on expenditures attributed to the Key Pop beneficiary*

Cost Category	2019	2020	2021
Contractual	$618,554	$468,378 -24%	$695,439 48%
Equipment	$184,045	$445 -100%	$242,138 54,313%
Fringe Benefits	$576,955	$202,741 -65%	$731,348 261%
Other			$407,479
Personnel	$1,742,006	$803,436 -54%	$2,408,256 200%
Subrecipient	$1,268,050	$1,707,698 35%	$2,693,531 58%
Supplies	$228,188	$152,722 -33%	$554,879 263%
Training	$132,366	$85,841 -35%	$110,695 29%
Travel	$158,012	$111,107 -30%	$346,736 212%
Grand Total	$4,908,176	$3,532,368 -28%	$8,190,501 132%

Notes:
- Increase in equipment due to start up of costs of new CeSHHAR award & DREAMS expansion
- Increase in personnel due to scale up of DREAMS to new districts
- Increase in sub-recipients reflects new sub-awards to KP CSOs
- Decrease in travel in FY20 due to COVID

Key Populations Program Requirement #2: Greater commitment to regular and safe key populations size estimation exercises as part of PEPFAR's planning cycle in all countries with updates for new data and methods, where PSE are conducted separately from BBS, they should be conducted every 2-5 years. In intervening years, PSE and BBS data should be triangulated with program data. Mathematical and statistical models estimating population size should be updated as needed, as they are for generalized population estimates.

- When was the last time this OU/Region conducted a BBS and or a PSE?
    - FSW: 2017 with data collected in 2015, 2016 and 2017
    - TG: 2020
    - MSM: 2020
    - PWD: situational analysis and needs assessment for People Who Use and/or Inject Drugs in Zimbabwe commenced in January 2022, with final report expected by March 31, 2022
- Does the OU/Region plan to conduct a BBS or PSE during COP 22?
    - In COP 22 PEPFAR will support a **consultative process to update PSEs for sex workers**, using recent biological and behavioral survey data (CeSHHAR) and data from planned PLACE studies, which will be triangulated with program data and reviewed by key stakeholders and the KP community.
- What other strategic data is available?
    - Microplanning and other program data, PLACE studies (ongoing)
- In COP 22 PEPFAR will support a **consultative process to update PSEs for sex workers**, using recent biological and behavioral survey data (CeSHHAR) and data from planned PLACE studies, which will be triangulated with program data and reviewed by key stakeholders and the KP community

Key Populations Program Requirement #3: Establishment of an independent PEPFAR-funded KP community consortium where/if it does not already exist, in collaboration with diverse stakeholders; emphasis should be on avoiding the creation of duplicative or parallel systems, and on ensuring there is regular engagement with KP communities in the geographies where PEPFAR works and with the national program.

Zimbabwe KP Forum:

Vision: The Zimbabwe National Key Populations Forum is a platform where CSOs working with key populations can meet and converse as the community and specialists who collaborate and compliment effort to support development and implementation of the national response to key populations programming and meaningfully contribute to ending AIDS. At its inception in 2014 it was funded by UNFPA, with NAC and MoHCC as conveners of quarterly or extra ordinary Forum meetings and UNFPA, UNAIDS and/or ILO providing, as requested by the convener, administrative and secretariat services including meeting facilities, maintenance of records and distribution of documents.

At handover to NAC in 2015, the KPF was semi-autonomous attended by few CSOs including CeSHHAR, GALZ, SAfAIDS, Batanai HIV & AIDS Service Organisation (BHASO), Pow Wow and Sexual Rights Centre (SRC), now +/- 70 organizations attendance with the aim of achieving a more positive level of KP engagement with the MoHCC, NAC, UN agencies, PEPFAR and other donors

Mission: Through this platform, CSOs ensure that sound, shared and comprehensive programming will be offered to KPs based on National and WHO guidance and recommendations, donor policies and relevant global best practices

Elements of success in Zimbabwe:

- Effective KP program coordination through a strong membership of majority KP-led and focused organizations in Zimbabwe
- Strengthened engagement and cooperation between the MOHCC and NAC, TSC, PEPFAR, and GFATM mechanisms and KP CSOs
- Involvement in the creation of KP national HIV guidelines
- Recognition and inclusion of the Zimbabwe KP Forum in all key national KP-related interventions.
- Strengthened KP advocacy voice

Options to further support KP Forum:

- Currently KPF meetings are funded by PEPFAR (PSI) and UNFPA (through NAC), one each respectively for 2 consecutive quarterly meetings per quarter
- Partner with GFATM and other donors to diversity financing
- PEPFAR Small Grants Program
- Partner with CLM Implementing Partners
- Sponsorship from KP program IPs

Key Populations Program Requirement #4: PEPFAR remains committed to its affirming 'do no harm' principle that emphasizes voluntary, confidential, non-judgmental, non-coercive, and non-discriminatory services. Additionally, this includes a focus on all activities related to data collection, analysis and use of strategic information and data on key populations. All IPs will be required to implement ethical, non-discriminatory service provision for key populations in line with their approved work plan and the terms of their award.

COP 22 is an opportunity to amplify USG agencies' long-standing nondiscrimination requirements as reflected both in principles and policies that all beneficiaries should be able to participate in programs without discrimination, this includes expanding rights and opportunities for marginalized and vulnerable groups including lesbian, gay, bisexual, transgender, and intersex (LGBTI) individuals. This program requirement will be handled in IP work plans and language, per Agency policies and guidelines.

Key Populations Program Requirement #5: Community-led Monitoring activities must include provision for distinct participation and leadership of key populations.

Consider: Who is doing the monitoring?

- Through KP CBOs, the KP communities themselves are contracted as monitors in the implementation of CLM
- CLM resources are given to KP serving, KP led and KP sensitive organizations operating in localized communities, to serve within their community

Ensure KP leaders are part of CLM processes and design

- CLM incorporated the national KP Forum leadership (which is also the TSC leadership) into the CLM National Steering Committee to ensure that the KP community is represented at the highest level of CLM decision making and advocacy. The KP Forum leadership Co-chairs the CLM National Steering Committee, together with the NAC.

- In COP 22 there are plans to decentralize the CLM Steering Committee structure into provincial and district structures through the coordination of KP Officers under the KP TSC

Consider bringing KP-led CSOs on board as CLM partners

- CLM currently has 2 organizations that serve KPs (1 SW and 1 MSM, TG)
- In COP 21 and 22 PEPFAR will onboard about 8 additional KP CBOs as partners in CLM implementation
- With Support from the TSC, PEPFAR is strengthening the capacity of other non-KP CLM CBOs to be KP-receptive/sensitive and be able to work with KPs in the areas they operate

Consider: Are all facilities that serve KPs being monitored?

- CLM is currently being implemented in 5 of the 6 priority districts where active KP programing is being implemented (all except Chitungwiza)
- In COP 22 CLM aims to cover at least 80% of facilities targeting KPs (including the proposed expansion sites under the Public Sector expansion program spearheaded by the TSC). This CLM expansion plan will cover all health facility types including public sector, NGO-run facilities, KP-serving drop-in centers/One Stop Centers, and other private providers as relevant

Consider: Are specific KP indicators* being measured?

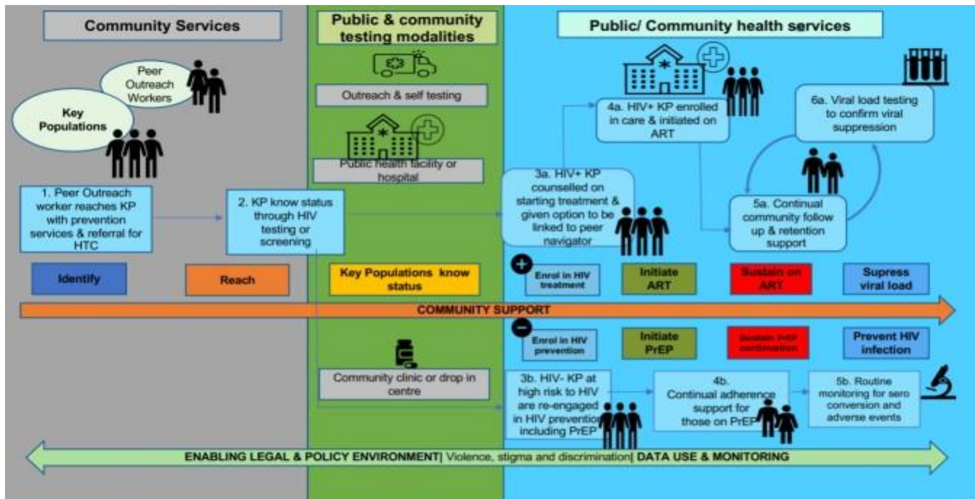
- ✓ KP competency of health services/health service providers
- ✓ Availability of KP-specific commodities
  - Condoms & lubricants
  - Gender affirming hormone treatment (GAHT)
  - Medicated assisted treatment (MAT) for PWID
- ✓ Availability of KP-competent comprehensive health services
  - STI prevention and treatment services
  - Mental health services/referral
  - Legal services/referral

All the indicators listed to the left are being monitored in the CLM program. There are various data collection tools being used to capture data including the following:

- Facility Manager Survey
- Service User Survey
- Transgender people survey
- Sex Worker Survey
- PWUD Survey
- MSM Survey
- Observation Survey
- Focus group questions
- Individual testimony

Key Populations Program Requirement #6: Provision of integrated KP-competent public and private service delivery that provides the opportunity for person-centered prevention, care, and treatment for the multitude of issues affecting key populations. Emphasis is placed on integrated services that facilitate access to and continuity of services.

Zimbabwe Visualization of KP Service Delivery Model



Strengths:

- High coverage of FSW
- Robust community footprint
- Increasing number of-KP led CBOs engaged

Challenges:

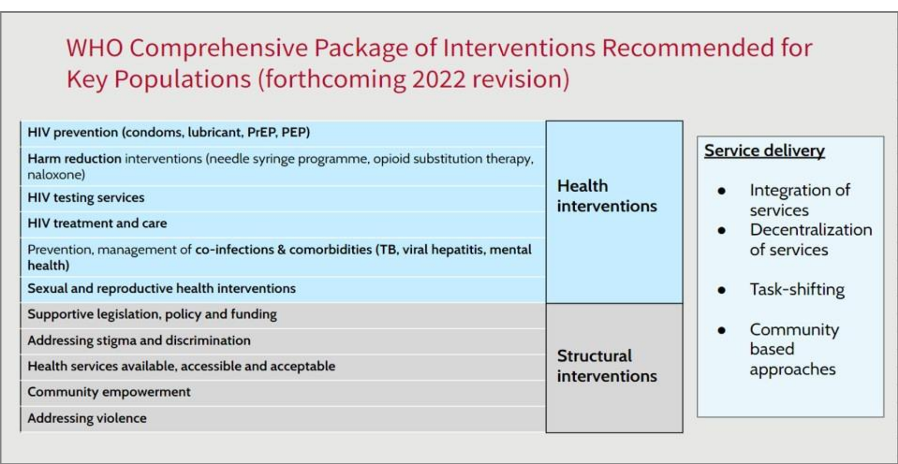
- HRH—attrition
- Reporting & tracking KP in the public sector for
- Lack of gender materials
- Lack of differentiated approaches for sexual/gender minorities

- COP22 strategy includes a variety of activities to buil on strengths and address challenges of the program's integrated service delivery model.

Key Populations Program Requirement #7: Each OU that serves key populations will submit, as part of its formal COP submission, a table or other visualization that details how the OU's key populations program will ensure a comprehensive, integrated service package, guided by WHO guidelines, for each key population group. The table will indicate:

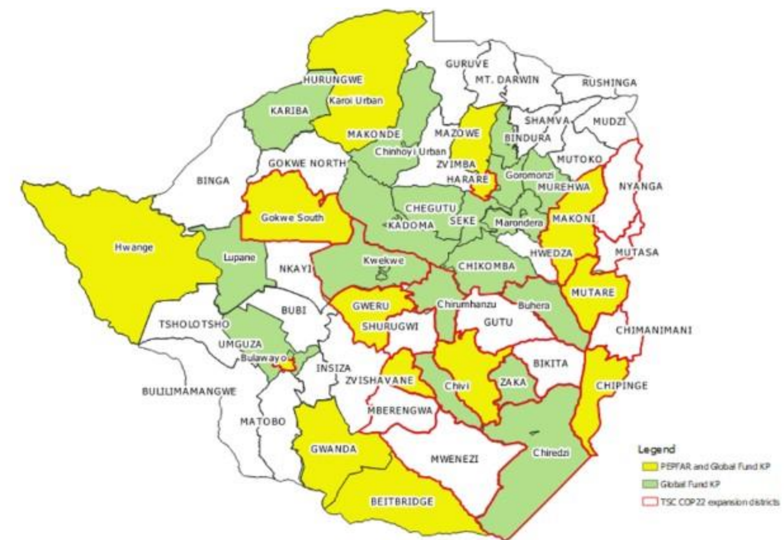
- **Specific key populations sub-groups served including geographic variations**
- **Specific prevention, testing, treatment, and structural interventions, by implementing partner, and where not financed by PEPFAR, the collaborating organizations**
- **Clear mapping of intervention, partner, geography and expected indicators to report**

Reference – WHO Comprehensive Package of Interventions



Zimbabwe KP Program Mapping

- COP 21 / COP 22 map to the right, including PEPFAR & GF supported areas
- Draft program tracking matrix developed



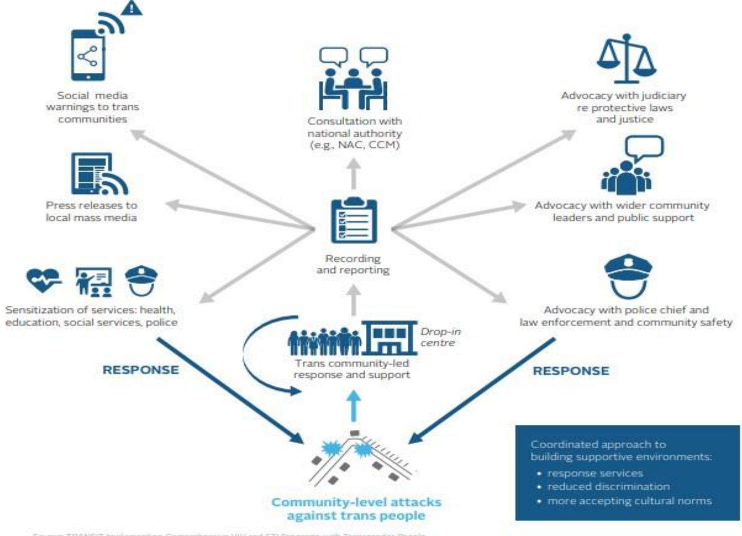
Key Populations Program Requirement #8: Development of risk mitigation and continuity plans to ensure the safety and security for KP clients and organizations and related data in the event of political upheaval and/or violence directed at key populations.

Risk Mitigation and Continuity Plans: COP 21 & COP 22

- Information dissemination on violence prevention to KPs and stakeholders
- Training to capacitate KPs in violence prevention, detection, and support – LIVES
- Integration of support to violence survivors and strengthen referral for violence survivors
- KP data confidentiality: co-create data security protocols and encrypted software for UIC
- Conduct safety and security audit (survey) to gauge violence prevention and response preparedness within the network for all consortium partners including with fully fledged, registered KP implementing partners and informal, unregistered networks where they exist. (Adopt checklist on safety and security within the implementation of HIV Programs for and with KPs for an organization, an individual or workplace)
    - Resource: https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-safety-security-toolkit.pdf
- Build knowledge among KP community members about their human/legal rights, violence, safety tips, and how to seek help, including digital tips for minimizing online involuntary self-exposure and risks
- Establish crisis response system for KP to have immediate access to support through partners already working with KPs
- Conduct security drills/ mock scenarios to test effectiveness of safety and security measures

Schematic for demonstrating comprehensive approach to violence prevention and mitigation for KP (proposed–for adaptation in COP22)

Adapted from : The Transgender Implementation Tool - Implementing comprehensive HIV and STI programs with Transgender people



Proposed strategies to prevent, mitigate and document safety challenges for KPs

Source: https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-safety-security-toolkit.pdf

TYPE 1: PREVENTION AND PLANNING Strategies to prevent or plan for safety and security challenges	TYPE 2: IMMEDIATE RESPONSE Strategies to mitigate or stop safety and security challenges that are actively occurring	TYPE 3: LONGER-TERM RESPONSE Strategies to document safety and security challenges and build an enabling and protective environment
KEY STRATEGIES: • **Prioritizing safety and security as an organization:** Prioritizing safety and security in all strategies and decisions, such as about where activities occur (e.g., location of drop-in centers), how services are delivered (e.g., outreach workers always in pairs), and how resources are allocated (e.g., contingency budget for crises). • **Developing safety and security plans:** Developing organizational plans/theories of change (supported by budgets) to prevent, mitigate, or respond to safety and security scenarios. • **Building security platforms/response teams:** Working with other stakeholders (e.g., CSOs, police, lawyers) to build platforms to prevent/urgently respond to safety and security challenges. This includes monitoring the media, coordinating a crisis response team, and creating a directory of organizations/resources that can be called upon when safety and security challenges occur. • **Developing safety and security protocols:** Developing organizational protocols and standard operating procedures to implement safety and security plans and platforms and include these in proposals. • **Developing emergency-readiness tools and building individuals' capacity to use them:** Preparing tools (e.g., phone trees, know-your-rights cards) to deploy during incidents and building beneficiaries' and implementers' understanding of their rights when issues occur. • **Conducting risk and security assessments:** Implementing risk/security assessments for activities, locations, and partners, and implementing preventative measures according to findings. • **Strengthening human resources policies:** Integrating safety, security, and well-being into organizational human resources policies (e.g., on health insurance), processes (e.g., for staff induction), and services (e.g., provision of trauma counseling). • **Training personnel:** Training staff, volunteers, and partners in knowledge and skills to prevent/respond to physical and virtual safety and security challenges (e.g., self-defense, first aid, and safe passwords). • **Taking preventative measures:** Taking practical, up-front measures to prevent or mitigate safety and security incidents (e.g., installing closed-circuit television, using encryption and other methods to secure communications and data, creating WhatsApp groups to immediately notify program staff and community members if a location or event is no longer safe). • **Developing consistent messages about the purpose of the project:** Developing and training peer educators and other workers to give consistent messaging about the purpose of their activities in case someone is stopped by the police or other authorities, having a designated spokesperson who can speak to the media if needed, and training all workers on how to reach the spokesperson. • **Setting up documentation systems:** Establishing systems (e.g., databases) to record safety and security incidents.	**KEY STRATEGIES:** • **Implementing emergency plans, teams, and tools:** Deploying prepared strategies (e.g., emergency response teams, phone trees) to respond to safety and security incidents and coordinate with other stakeholders. • **Providing practical emergency support:** Providing or facilitating emergency support (e.g., medical care, safe space, legal advice, counseling) to the people targeted. • **Providing emergency funds:** Providing or facilitating access to emergency funds to address safety and security incidents (e.g., to pay for medical costs or relocation). • **Making immediate changes to security measures:** Urgently modifying practical safety and security measures (e.g., hiring guards, changing locks, installing electric fencing). • **Making immediate changes to working practices:** Urgently modifying individual, organizational, or program practices (e.g., relocating offices, changing outreach sites). • **Documenting what happened:** Completing incident forms or databases to immediately capture the facts of safety and security incidents.	**KEY STRATEGIES:** • **Compiling evidence:** Systematically documenting safety and security incidents and using the data to inform advocacy and exchange experiences with other key population groups. • **Making strategic changes to how we work:** Using evidence and documenting cases to make longer-term, strategic changes, such as service delivery method, to respond to the safety and security context. • **Building coalitions:** Linking with other national/regional/global key population organizations and other sectors (e.g., human rights groups) to work collectively on safety and security issues. • **Advocating to decision makers:** Advocating to decision makers (e.g., government) on the impact of safety and security challenges and the changes needed (e.g., to laws). • **Sensitizing key stakeholders** (e.g., police, health workers, religious leaders, media) about safety and security challenges and their roles in responses. • **Taking legal action:** Conducting strategic litigation or campaigning for legal redress on safety and security (including engaging with Human Rights Commissions).

This resource will be used as a guide for IPs to develop their own specific plans–based on their specific roles, capacities and other factors

REAct// EpiC Violence Response Resources

- Response is first- assist client/activist in need
- Develop relationships with various service providers to assist client
- Use of encrypted data system (MARTUS)
- Develops record of abuse to use for advocacy efforts

REAct Use Guide – https://frontlineaids.org/resources/react-user-guide/

- Build Core Knowledge among Implementers & Key Population Communities
- Map the Prevalence of Violence and Stakeholders Working to Address It
- Create Networks to Ensure Key Populations' Access to Holistic Services
- Create Systems to Detect and Respond to Violence
- Promote Accountability to Prevent Violence
- Document and Monitor

EpiC/LINKAGES InfoGraphic - https://www.fhi360.org/sites/default/files/media/documents/infographic-hiv-gpv.PDF
EpiC Violence Response System Toolkits - https://www.fhi360.org/resource/linkages-violence-prevention-and-response-series

Key Populations Program Requirement #9: Articulation of a remuneration standard for peer outreach workers/navigators, to ensure decent work and fair pay is provided.

Checklist of Components to Work Towards

- ✓ Develop national (government) policy or guidance or other agreed to norms for KP peer remuneration
- ✓ Ensure PEPFAR KP peer renumeration aligns with national guidance
- ✓ Other issues to address:
    - ✓ Part time vs. full time
    - ✓ Peer vs. health worker

- ✓ Incentives vs. proper financial compensation

PEPFAR guidance for KP peer remuneration & working standards (hours and numbers of days of a week peers work; travel expectations and reimbursement policy) include:

- ✓ Peer ratio for outreach (in physical and online settings and for prevention as well as care with KP PLHIV);
- ✓ Weekly/monthly peer remuneration given to peer outreach workers in physical hotpots;
- ✓ Standards for incentives if provided. This includes social network testing, other online or more limited peer outreach;
- ✓ As relevant, description of different levels of peers or KP program staff within programs and their remuneration;
- ✓ Reference to relevant international guidelines including the WHO Key Populations consolidated guidelines;
- ✓ Annual geographic deduplication of peer lists.

Work in progress: Mapping PEPFAR Zimbabwe IPs Remuneration & Working Standards

Organization	Cadre	Monthly USD	Role/working arrangements brief
ZimPAAC	Community facilitator	104	Mobilize and navigates KP clients at the facility, Mapping hotspots, conduct treatment literacy sessions, Conduct basic mental health screening
	Zonal Facilitator	234	Supervise, promote and support CFs and PrEP Champions' navigation of clients while coordinating all zonal plans, hotspot mapping and identification
PSI	Enhanced Peer Mobilizer	242	Multi-disciplinary cluster team with a cluster team lead at a ratio of 1 team leader to 5/6 EPMs. Additional monthly allowances, training, travel, phone/data support; opportunities to advance from EPM to KP-DSDA and full-time positions including as KP Officers; ratio 1:50
	KP-SDA	14.50/worked day	Demand creation, peer navigation, differentiated service delivery and provision of support for retention in care (PrEP and treatment continuity).
CeSHHAR	Microplanners	50 additional 30 if PrEP champions	Provide risk differentiated support and condom distribution to KPs in their cohort in the community as they engage in sex work activities or at locations convenient for the KP; ratio is 1:50
	KP Friendship Bench Buddies	75	Offer Friendship Bench mental health support to KPs ; come to a facility once a week, micro-planners expected to come to a facility at least once a month for submission of data.
	DREAMS Ambassadors	300	KPs engaged on a full time basis for coordinating and implementing DREAMS activities at district level; support demand creation, program implementation and stakeholder interaction