Zimbabwe
Country Operational Plan
(COP/ROP) 2018
Revised Strategic Direction Summary

Table of Contents

Acronym List

ACT	Accelerating Children's HIV/AIDS Treatment Initiative
AE	Adverse Event
AGYW	Adolescent Girls and Young Women
ANC	Antenatal Clinic
ART	Antiretroviral Treatment
ARVs	Antiretroviral
BMGF	Bill and Melinda Gates Foundation
CARGS	Community ART Refill Groups
CATS	Community Adolescent Treatment Support groups
CBO	Community Based Organization
CBS	Case-based Surveillance
CCM	Country Coordinating Mechanism
CCW	Community Case Workers
CDC	Centers for Disease Control and Prevention
CESHHAR	Centre for Sexual Health, HIV and AIDS research
CHW	Community Health Workers
CLHIV	Children Living with HIV
COP	Country Operational Plan
CrAg	Cryptococcal Antigen
CRFs	Client Referral Facilitators
CSE	Continuing Secondary Education
CSO	Civil Society Organizations
CTX	Cotrimoxazole
DBS	Dried Blood Spot
DfID	United Kingdom's Department for International Development
DHIS2	District Health Information System
DMPPT2	VMMC Decision Makers' Program Planning Toolkit
DoS	Department of State
DREAMS	Determined, Resilient, AIDS-free, Mentored, and Safe
DSD	Direct Service Delivery
ECD	Early Childhood Development
ECS	Early Childhood Stimulation
her	Electronic Health Records
EID	Early Infant Diagnosis
EIMC	Early Infant Male Circumcision
EMR	Electronic Medical Record System
eMTCT	Elimination of Mother to Child Transmission
FARG	Family ART Refill Group
FAST	Funding Allocation to Strategy Tool
FBO	Faith-Based Organization

FM	Families Matter
FP	Family Planning
FSW	Female Sex Workers
GALZ	Gay and Lesbian Association of Zimbabwe
GBV	Gender Based Violence
GEM	Girls Empowerment Clubs
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
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
ICF	Intensified Case Finding
INH	Isoniazid
IP	Implementing Partner
IPC	Inter-personal Communication
IPT	Isoniazid Preventive Therapy
KP	Key Population
LEEP	Loop Electrosurgical Excision Procedure
LGBTI	Lesbian, Gay, Bi-Sexual, Transgendered or Intersex
LMIS	Logistics Management and Information Systems
LOE	Level of Effort
LPV/r	Lopinavir/ritonavir
LTFU	Lost to Follow-Up
M&E	Monitoring and Evaluation
MC	Male Circumcision
MCH	Maternal and Child Health
MMD	Multi-Month Dispensing
MMS	Multi-Month Scripting
MOHCC	Ministry of Health and Child Care
MOLSW	Ministry of Labor and Social Welfare
MOPSE	Ministry of Primary and Secondary Education

MSF	Medecins Sans Frontiers
MSM	Men who have Sex with Men
NAC	National AIDS Council
NATF	National AIDS Trust Fund
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PITC	Provider-initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
POART	PEPFAR Oversight and Accountability Response
POC	Point of Care
PrEP	Pre-Exposure Prophylaxis
QA/QI	Quality Assurance/Quality Improvement
RDS	Respondent Driven Surveys
RTK	Rapid Test Kit
SCMS	Supply Chain Management System
SDS	Strategic Direction Summary
SI	Strategic Information
SID	Sustainability Index and Dashboard
SIMS	Site Improvement through Monitoring System
SNU	Sub National Unit
STI	Sexually Transmitted Infections
SW	Sex Workers
TA	Technical Assistance
TAG	Technical Advisory Committee
TAT	Turn Around Time
TB	Tuberculosis
TBD	To Be Determined
TBIC	Tuberculosis Infection Control
TLD	Tenofovir Lamivudine Dolutegravir
TLE	Tenofovir Lamivudine Efavirenz
TPT	TB Preventive Therapy
TTCV	Tetanus Toxoid Containing Vaccines
UE	Unit Expenditure
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USG	U.S. Government
VACS	Violence against Children Survey
VCT	Voluntary Counseling and Testing
VHWs	Village Healthcare Workers

VIAC	Visual Inspection with Acetic Acid and Cervicography
VL	Viral Load
VMMC	Voluntary Medical Male circumcision
WHO	World Health Organization
YAZ	Young Adult Survey of Zimbabwe
YWSS	Young Women Selling Sex
ZDHS	Zimbabwe Demographic and Health Survey
ZIMPHIA	Zimbabwe Population-Based HIV Impact Assessment

1.0 Goal Statement

The President's Emergency Plan for AIDS Relief (PEPFAR) interagency team worked collaboratively with key partners including the Government of Zimbabwe (GoZ), the Global Fund to Fight AIDS, Tuberculosis and Malaria (the "Global Fund"), civil society core advocacy members, and bilateral and multilateral health development partners to develop the Country Operational Plan for FY 19 (COP 18). It builds on an already successful program that has achieved 80% antiretroviral treatment (ART) coverage nationally at the end of 2017. The national ART program and other critical HIV programs in Zimbabwe are implemented under the leadership of the Ministry of Health and Child Care (MOHCC), the Ministry of Primary and Secondary Education (MOPSE), and the Ministry of Labor and Social Welfare (MOLSW), with human resources for health (HRH) and infrastructure primarily funded by the MOHCC. PEPFAR has successfully leveraged this capacity with key commodities, training, mentoring, some HRH for HIV testing and treatment, and other site-level support. COP 18 will build on this success and aim to support the country to achieve 90% ART coverage within all districts and across all age and sex bands by the end of FY 19.

The PEPFAR program will invest in the delivery of a comprehensive package of HIV care, treatment, and prevention activities within the 40 highest burden districts of Zimbabwe's 60 districts and will continue to provide support at all facilities with a focus on high volume sites to achieve greater overall results. Modeling resulting from the triangulation of the Zimbabwe Population-Based Health Impact Assessment (ZIMPHIA), Zimbabwe Demographic and Health Survey (ZDHS), and program data shows that the majority of those not yet on treatment are 25-49 year old men and women. Through an improved and integrated HIV testing model, the PEPFAR COP 18 strategy will enable the program to reach 90% ART coverage by identifying new HIV-positives through activities such as provider initiated testing and counseling (PITC), index testing in facilities and communities, and by using innovative interventions such as HIV self-testing in order to reach more men and women. In COP 18, district level testing strategies will be tailored based on district level gaps in order to reach each sub-population. In high gap districts the program will emphasize PITC accompanied by index testing to reach sexual partners outside of the clinic, and self-testing to a lesser degree. As the gap narrows within each district, the program will put more emphasis on targeted outreach and will also redirect direct service delivery (DSD) support (such as human resources) from the facility to the community. With well over 1 million Zimbabweans currently on ART, the PEPFAR program will continue to increase access to viral load (VL) monitoring, while strengthening and expanding efforts to improve retention and viral suppression, particularly among priority populations such as children, adolescents, and pregnant women.

In COP 18, PEPFAR will maintain its voluntary medical male circumcision (VMMC) target of 306,139, focusing its efforts on reaching young men between the ages 15 -29. The PEPFAR program will continue to support the Determined Resilient Empowered AIDS-Free Mentored and Safe (DREAMS) program through a package of services in six districts including Pre-Exposure Prophylaxis (PrEP) and complementary services supported within the orphans and vulnerable children (OVC) portfolio. Moreover, clinical services targeting female sex workers (FSW) and men who have sex with men (MSM) will be scaled up in COP 18.

PEPFAR Zimbabwe is committed to attaining the 95-95-95 goals outlined by UNAIDS and

continues to use monthly interagency partner meetings, quarterly PEPFAR Oversight and Accountability Response Team (POART) reviews and the Site Improvement through Monitoring System (SIMS) findings to assess performance and further sharpen strategies and approaches to most efficiently deliver expected results. Furthermore, PEPFAR works and will continue to work closely with the Global Fund's Country Coordinating Mechanism (CCM) to ensure alignment of programming during the Global Fund's next funding cycle (2018-2020). Strong health donor coordination, especially with the Global Fund and The Bill and Melinda Gates Foundation, ensures that all HIV investments are complementary and not duplicative.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Zimbabwe has a generalized epidemic with a projected 2017 population of 15 million based on the 2012 National Census. ZIMPHIA[1] showed that overall HIV prevalence for adults aged 15-49 was 14.0% in 2016, down from 18.1% in 2015 in the ZDHS[2]. Among persons aged 15 to 64 years, HIV prevalence varied geographically, higher in the provinces of Matabeleland North (19.5%), Bulawayo (17.9%), and Matabeleland South (21.7%) than in the other seven provinces, which were all below 15%. HIV prevalence varies by level of education, ranging from 7.2% in those with more than secondary education to 19.7% among persons with no formal education. The highest HIV prevalence estimated was nearly 30% for both males (28.1%) and females (29.6%), but occurred at a slightly older age (45-49 years) among males as compared to females (40-44 years). The disparity in HIV prevalence by sex was most pronounced among young persons: HIV prevalence was three times higher among females (8.1%) than males (2.7%) aged 20 to 24 years. For persons aged 10 to 49 years, point estimates of HIV prevalence were higher among females than their male counterparts. Among persons over the age of 50, point estimates of HIV prevalence were higher in males. HIV prevalence among children aged 0 to 14 was estimated to be 1.6%.

An estimated 1.4 million people were living with HIV in 2017, with 5.8% being children 0-14 years[3]. Among adults 15+ years living with HIV, 59% were females. HIV incidence for the same age group is currently at 0.48%, down from 1.06% in 2005. Annual AIDS related deaths have declined over the past decade with approximately 24,196 AIDS related deaths in 2017 compared to 120,674 in 2005. Total new HIV infections declined nationally from 75,305 in 2005 to 56,849 in 2017. Among adults 15+ years, new infections declined from 58,455 in 2005 to 50,934 in 2017. By 2017, ART coverage among all HIV positive adults was 80% and 84% among children compared to 65% and 70% among adults and children, respectively, in 2015. The Prevention of Mother-to-Child Transmission (PMTCT) coverage was 92% and has been maintained at above 90% over the last five years. In 2017, 301,366 men were medically circumcised, bringing the cumulative total to 1,144,061, representing an 83% coverage of the target population 15- 29 years[4]. Based upon a PEPFAR-funded study completed in 2017[6], there are an estimated 44,362 female sex workers (FSW) in Zimbabwe. The prevalence of HIV among FSW is 54%, with 69% of these women on ART and 85% virologically suppressed. It is estimated that 23.5% of men who have sex with men

[1] Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) 2016
[2] Zimbabwe Demographic and Health Survey 2015
[3] Zimbabwe 2017 HIV/AIDS Estimates (Spectrum/EPP model, February 2017)
[4] Zimbabwe HMIS

are living with HIV and 69% are on ART, with 85% virologically suppressed; an analogous size estimation protocol has recently obtained local clearance, and data collection is planned for 2018.

Standard Table 2.1.1

	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	15,032,280		3,053,304	20%	3,070,599	20%	1,471,651	10%	1,461,246	10%	3,133,403	21%	2,842,078	19%	2017 HIV Estimates
HIV Prevalence (%)		14.1% (15-64yrs)		1.50%		1.70%		5.90%		3%		16%(15+yrs)		12%(15+yrs)	Zimphia 2016
AIDS Deaths annually	24,196		1,507		1,558		1,198		1,001		8,947		9,984		2017HIV estimates
# PLHIV	1,397,217		40,405		41,017		101,616		52,358		673,576		488,245		2017HIV estimates
Incidence Rate (Yr)		0.47% (15-64yrs)						0.53%		0.14%		0.60%(15-64yrs)		0.33%(15-64yrs)	Zimphia 2016
New Infections (Yr)	56,849														2017 HIV Estimates
Annual births		34.2/1000 persons													2015 ZDHS
% of Pregnant Women at least one ANC visit		93.30%													2015 ZDHS
Pregnant women needing ARVs	66,261	91.41													2017 HIV Estimates
Orphans (maternal, paternal, double)	722,584														2017 HIV Estimates
Notified TB cases (Yr)	14,001		6% (all <15yrs)		6% (all <15yrs)						94%(all 15+ yrs)		94%(all 15+ yrs)		HMIS
% of TB cases that are HIV infected	14,001	63%													HMIS
% of Males Circumcised	1,144,061	14.1%(15-64yrs)			467798				477,225				199,038		Zimphia 2016
Estimated Population Size of FSW	30,026														
FSW HIV Prevalence	54%														
	*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.														

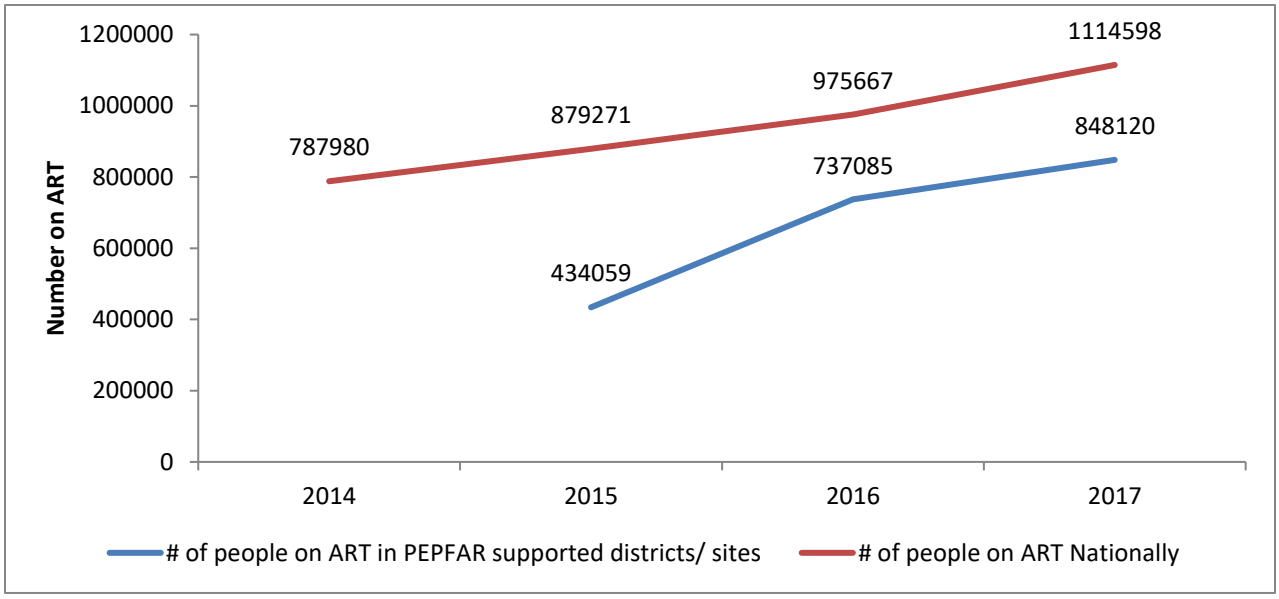
Standard Table 2.1.2

	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	15,032,280	14.1%(15-64yrs)	1,397,217		1,114,598	80%	86.50%	3,243,915	201,818	*158,695*
Population <15 years	6,123,903	1.60%	81,421		67,872	83%		376,051	10,864	*8,490*
Men 15-24 years	1,461,246	3%	52,358		39,871	76%	78.40%	313,347	13,629	*5,355*
Men 25+ years	2,842,078	12% (15-64yrs)	488,245		346,811	71%	84.4% (15-64yrs)	651,556	59,814	*53,838*
Women 15-24 years	1,471,651	4.40%	101,616		97,390	96%	89.00%	796,504	38,097	*22,373*
Women 25+ years	3,133,403	16% (15-64%)	673,576		562,654	84%	87.7% (15-64yrs)	1,122,611	78,670	*68,570*
MSM[5]										
FSW										
PWID										
Priority Pop										

**These data are taken from the 2016 Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA)
†These data are taken from the Ministry of Health and Child Care Program
~These data taken from 2017 Zimbabwe HIV Estimates

[5] National Size Estimations for SWs and MSM are still pending; Reliable National KP status is not recorded and over KP Status exists only at the Program level

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment[6]



Looking forward, the MOHCC aims to achieve the fast track 95-95-95 UNAIDS targets by 2020. As of December 2017, the average ART initiation was an estimated 13,224 persons per month up from 10,781 in 2016. Critical enablers to achieve the prevention and treatment targets included implementation of key policies: Test and Start (Treat All), PrEP, differentiated service delivery such as multi-month dispensing (MMD) and self-testing. Despite significant progress, serious challenges remain in achieving epidemic control across all five year age and sex bands. These challenges include: the risk of insufficient funding for ARVs and lab commodities, human resource shortages, crumbling infrastructure, continued economic instability, a deteriorating health system and heavy reliance on donor funding.

PEPFAR Zimbabwe is working in partnership with the Global Fund and the people of Zimbabwe, who contribute to the National AIDS Trust Fund ("AIDS Levy") through a 3% income tax. Nevertheless, combined funding from PEPFAR and the Global Fund measured per-person living with HIV is the lowest among the ten sub-Sahara African countries classified as low income by the World Bank. The per capita gross national income in Zimbabwe last measured in 2015 was $8.60.

PEPFAR Zimbabwe remains committed to attaining the fast track 95-95-95 goals and continues to support the MOHCC in fully implementing the national Treat All strategy in all 40 PEPFAR scale-up districts.

[6] PEPFAR ART Attribution definition changed between 2013 and 2014; the graphic shows the PEPFAR contribution based on the revised definitions as of 2014. PEPFAR historically has only counted the person years of ARVs for TX_Curr which was based on 160,000 patient years.

2.2 Investment Profile

Although Zimbabwe has witnessed a slight increase in national budget allocation to health in recent years from 6.5% in 2015 to the current 8.4%, it still falls far below the Abuja requirement of 15% and percentages actually disbursed fall far below the budgeted levels. Furthermore, the GoZ budget is mostly for salaries (70%) according to the 2017 Resource Mapping report. This leaves the bigger burden of health system functionality (e.g. commodity needs and distribution, laboratory sample transportation, and health facility operational costs, etc.) in the hands of external funding donors. Despite the support from Zimbabwe's health development partners, the consolidated total funding still falls short of projected requirements to fully implement the national health strategy, and user fees are often collected to provide basic requirements such as water and electricity in health facilities at all levels.

Specific analysis of HIV funding (Table 2.2.1) reveals that HIV funding makes up the largest share (43%) of health funding in the country, and HIV funding levels have remained consistent over the last three years. This is the disease component that is most reliant on external funders with around 80% of HIV funding provided by donors. PEPFAR and Global Fund together contribute 78% of the funding. While PEPFAR had a slight decrease from the 2017 funding level, the Global Fund experienced an increase as the new grant phase commenced. In 2017, the Global Fund funding was intended to maintain services during the costed extension year. Other funding partners, such as the Bill and Melinda Gates Foundation (VMMC) and the United Nations Population Fund (Key populations) have decreased their support in 2018. Contributors to the Health Development Fund (UK, Ireland, Sweden, and the EU) also decreased support, leading to gaps for HRH support as well as essential medicines procurement, especially medicines to treat sexually transmitted infections (STI). The Global Fund covered the HRH gap for late 2017; however, the country still needs to plan for a longer term staff retention mechanism as all programming support is hinged on the availability of skilled personnel in health facilities. The AIDS spending assessment report notes that the key contributors to domestic financing are the national AIDS levy, the government contribution, funding from the local authorities, the private sector, and household or out-of-pocket expenditure. Proportionally, private sector had the lowest contribution to HIV spending, reflecting a need for sustained workplace HIV programming.

Standard Table 2.2.1

Table 2.2.1 Annual Investment Profile by Program Area[7]					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	$168,641,753	26%	61%	13%	-
Community-based care, treatment, and support	$14,619,291	98%	2%	-	-
PMTCT	$2,665,131	12%	17%	34%	37%
HTS	$26,564,744	52%	31%	8%	9%
VMMC	$39,797,426	81%	-	2%	17%
Priority population prevention	$8,358,603	-	4%	14%	82%

[7] (National AIDS Spending Assessment, 2017 and Resource mapping report 2017), all amounts in USD

AGYW Prevention	$19,847,977	73%	12%	15%	-
Key population prevention	$6,355,485	58%	38%	2%	2%
OVC	$15,186,768	72%	-	26%	2%
Laboratory	$12,036,237	11%	48%	35%	6%
SI, Surveys and Surveillance	$7,022,911	31%	38%	27%	4%
HSS	$28,659,988	5%	30%	65%	-
Total	$349,756,314	39%	38%	17%	6%

Standard Table 2.2.2 shows the proportionate contributions across PEPFAR, Global Fund, domestic funding through the National AIDS Trust Levy.

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	$121,768,679	13.73%	58.53%	13.98%	
Rapid test kits	$2,507,936	6.05%	-	-	
Other drugs	$8,528,656	5.75%	51.27%	-	
Lab reagents	$1,655,481	54.36%	-	-	
Condoms	$1,303,364	100%		-	
Viral Load commodities	$2,444,640	3%	-	-	
VMMC kits	$17,292,864	0.08%	20.23%	-	
MAT	$22,178,594	13.53%	45.56%	-	4.43%
Other commodities	$1,461,147	100%	-	-	
Total	$440,658	100%	-	-	

*Other VMMC Commodities includes $940,935 for VMMC equipment (for reusable kit rollout) and other non-frequently used consumables for emergencies and infection control.
**Condoms only reflect those condoms distributed through the public sector.

Standard Table 2.2.3

Table 2.2.3 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	$4,200,000	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	$15,000,000	N/A	N/A	N/A	Reduce malaria-related mortality by 70%
USAID Family Planning	TBD	N/A	N/A	N/A	Increase access to modern family planning information and contraceptives to improve maternal and child health outcomes.
Total	**$22,200,000**	N/A	N/A	N/A	

*These estimated figures based on FY 18 Congressional Budget Request for FY 19 implementation.

Standard Table 2.2.4

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP		
Funding Source	**Total PEPFAR Non-COP Resources**	**Objectives**
Cervical Cancer Screening	$4,900,000	The group most at risk for aggressive cervical cancer, HIV-positive women, has been underserved by the "broad support" approach previously utilized by PEPFAR. Therefore, PEPFAR has developed an age-band appropriate, comprehensive strategy to reduce cervical cancer risk by 95% in HIV-positive women by every-other-year cervical cancer screening for HIV-positive women over age 30. PEPFAR plans to ensure all HIV-positive women over age 30 are being screened and treated for pre-invasive cervical lesions. To achieve this goal, a staged process will be used to increase the coverage of cervical cancer screening in PEPFAR-supported HIV treatment sites focusing on areas with high HIV-1 prevalence among women and high volume ART sites.
Total	**$4,900,000**	

2.3 National Sustainability Profile Update

To complete the Sustainability Index and Dashboard (SID) process, the PEPFAR Coordination Office met with UNAIDS, the Ministry of Health and Child Care (MOHCC) and National AIDS Council (NAC), the Clinton Health AIDS Initiative (CHAI), and the Centre for Sexual Health and HIV/AIDS Research Zimbabwe (CeSHHAR) in October and early November 2017. On November 9, UNAIDS and PEPFAR co-convened a stakeholder validation meeting with participants from the MOHCC, NAC, Global Fund CCM members, implementing partners, civil society, and other development partners. The participants broke into four domain subgroups to discuss and validate the SID questionnaire, with a facilitator from PEPFAR, UNAIDS, and/or CHAI to validate agreed upon scores, record data sources, and document points of clarification and context. The full group then reconvened to review the completed tool, discuss the findings and validate the conclusions.

Sustainability Strengths:

- **Planning and Coordination (10.00, dark green):** The MOHCC continues to effectively lead the coordination of the HIV response in Zimbabwe. A multi-year, costed national strategy exists, including specific activities and strategies to minimize the impact of HIV on vulnerable populations. The MOHCC also effectively leads the implementation of the National HIV Strategy. The MOHCC has made great effort to ensure the development of the national strategy is an inclusive process. This element saw an increased score from previous 2015 SID (9.33) to current 2017 SID (10.00).
- **Quality Management (8.67, dark green):** The MOHCC has institutionalized quality management systems and has demonstrated their emphasis on the application of quality

improvement methodologies to manage and provide HIV services. For example, peer-learning opportunities were developed and became available starting in 2016. Additionally, HIV program performance measurement data is used to identify areas of patient care and service that can be improved through national decision-making, policy, and priority setting. But specific areas of improvement remain. For example, the informal Community Health Worker (CHW), supported by various donors and partners, should be integrated into the MOHCC's formal Village Health Worker (VHW) cadre to ensure quality, harmonization, and sustainability. This element remained the same from previous 2015 SID to current 2017 SID (8.67).

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

Sustainability Vulnerabilities:

- No element received a score of red. Both Private Sector Engagement (2.71 to 6.19) and Domestic Resource Mobilization (3.06 to 4.58) increased from the previous SID.
- **Epidemiological and Health Data (4.51, yellow):** Zimbabwe continues to require additional capacity to lead and manage planning and implementation of epidemiological survey and surveillance activities. Additionally, key population epidemiological survey and behavioral surveillance activities are not funded or conducted by the MOHCC, but via external agencies, organization, and institutions. There is a lack of reporting for viral load data and viral load testing is not yet done routinely at clinics. However, the support for and engagement in the ZDHS and ZIMPHIA highlight GoZ's commitment to collect and utilize epidemiological and health data for strategic program planning.
- **Domestic Resource Mobilization (6.75, yellow):** The GoZ continues to remain highly dependent on outside donors to fund the national HIV response. Current resource mapping shows that around 20% of total funding is from the GoZ.
- **Laboratory (5.50, yellow):** Like many other components of service delivery, there are strategies in place, but not fully operationalized at all levels of the system. The entire network of laboratories and viral load testing to regulate and monitor quality is not covered. There continue to remain large gaps in capacity of laboratory workforce, viral load infrastructure, and domestic funds for laboratories as a whole.
- **Public Access to Information (5.00, yellow):** This element saw a decline in score from the previous SID (8.00). Much of the financial information shared by MOHCC is highly summarized when available to the public and therefore difficult to see the actual expenditure data. Additionally, HIV and AIDS program performance data is not often released to the public in a timely manner (e.g. same year). Lastly, regardless of outcomes in the tender

process, stakeholders requested feedback in order to foster capacity building and transparency.

- **Commodity Security and Supply Chain (6.14, yellow):** Beyond donor commitments, ARV funding remains uncertain one to three years into the future. The current Global Fund grant provides for ARVs at lower levels, but there remains a gap in funding if Zimbabwe aims for epidemic control by 2020. Supply chain systems are relatively strong, but still heavily reliant on support from outside donors.
- **Private Sector Engagement (5.92, yellow):** The private sector engagement still needs increased attention. For example, the private sector still does not actively engage with the MOHCC as part of the policy and budget decision for HIV and AIDS programs. Additionally, the legal framework and regulatory framework makes limited provisions for the needs of private businesses.

Sustainability priorities and proposed actions through 2020: Over the past several years, there has been significant progress in the expansion of ART initiation; however, major challenges to achieving high ART coverage and epidemic control continue to exist, including: potential for insufficient funding for ARVs and lab commodities, human resource shortages, continued economic instability, weakening infrastructure, a deteriorating health system, and heavy reliance on donor funding. As an example of donor funding reliance, the Global Fund and PEPFAR currently finance the purchase of test kits, condoms, a majority of laboratory services, and a significant portion of the efforts to strengthen the supply chain and logistics system.

In response, the PEPFAR team will continue to coordinate closely with the Global Fund, as well as other donors in the sector, such as Gates Foundation and CHAI, to ensure that investments are complimentary and PEPFAR contributions are maximized. At an operational level, the PEPFAR program will work closely with the MOHCC and other actors to ensure sufficient planning to mitigate potential shortages. This will be accomplished by ensuring accurate semi-annual quantifications, strengthening information sharing amongst relative stakeholders, targeted reinvestment of donor savings into commodities, and encouraging the GOZ to invest more in their HIV response. In the short term, PEPFAR and the Global Fund will continue to support both targeted human resources and strengthening of the overall health system. Additionally, PEPFAR is increasing efforts to implement new service delivery models for care and treatment, to improve facility and community linkages, and to strengthen efficiencies within existing programs working towards sustained epidemic control.

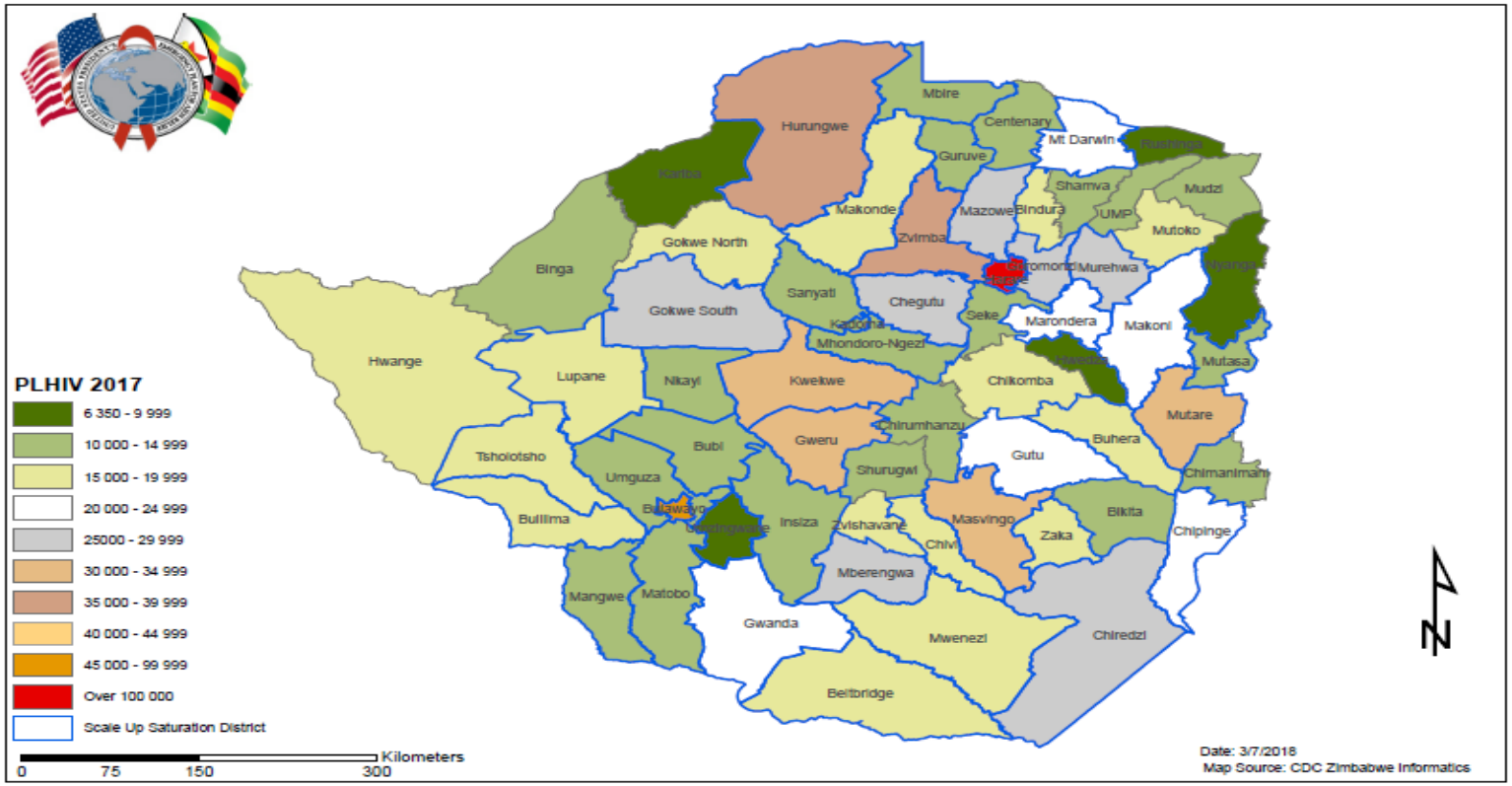
As epidemic control is achieved and evolves beyond 2020, PEPFAR support will need to change to respond to the new needs of managing HIV as a chronic condition. This will require policy changes as well as culture shifts within the HIV sector specifically, and the health system in general. The PEPFAR team will identify best practices emerging from "attained" districts, and attempt to quantify resource savings achieved by changing practices in order to build consensus and create momentum for change. These lessons will be scaled up as the epidemic comes under control.

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

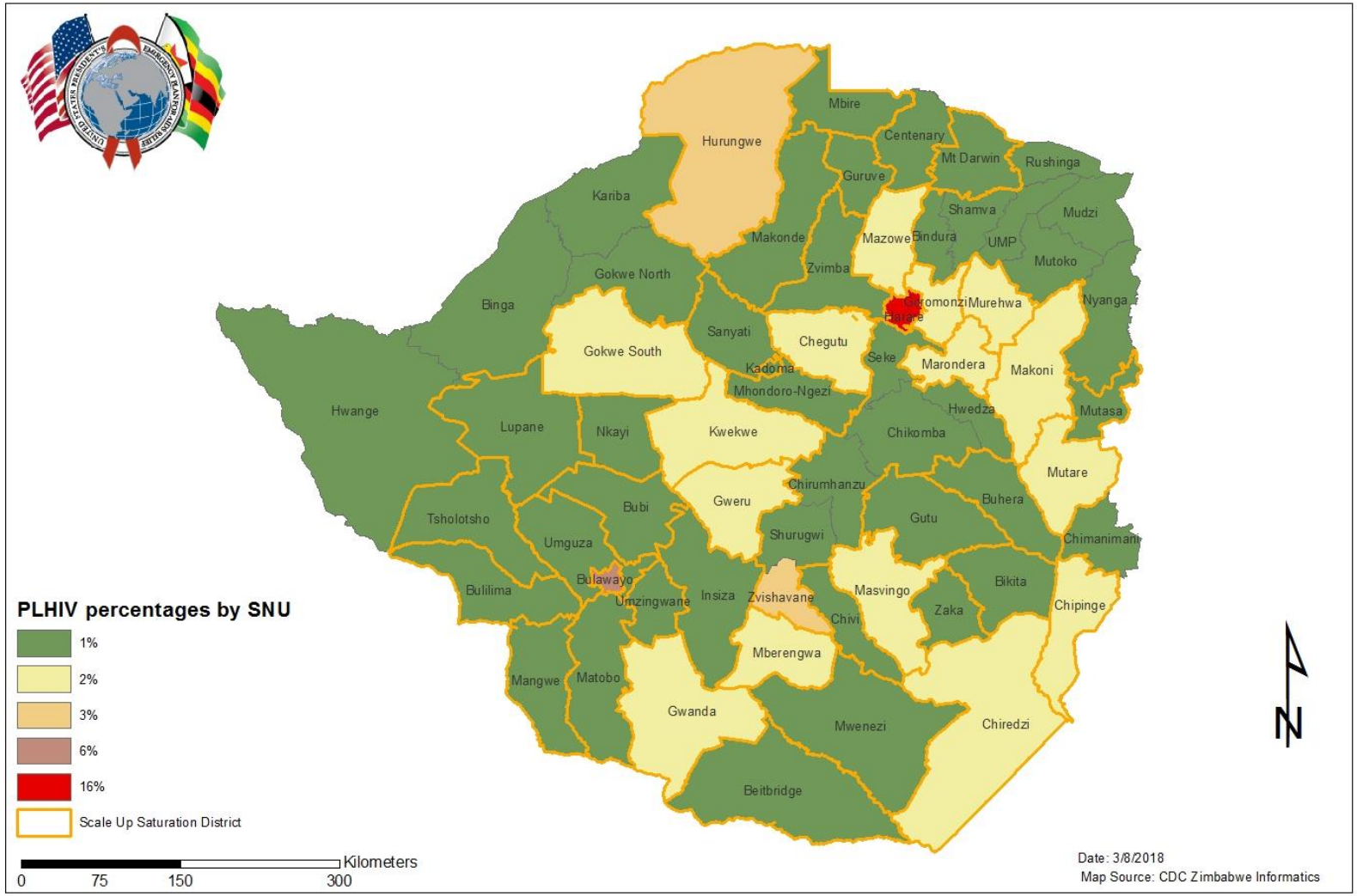
Since the geographic pivot to 36 districts (now 40) in COP 15, the Zimbabwe PEPFAR team has redirected expenditure towards scale-up districts. In FY 17, 90% of all district or site level expenditure was in the 40 scale-up districts. District expenditure was closely related to the number of PLHIV in each district with the six DREAMS districts being among the seven exceptions.

Figure 2.4.1 percent PLHIV by district, total PLHIV by district, coverage of total PLHIV with ART, and viral load coverage by district

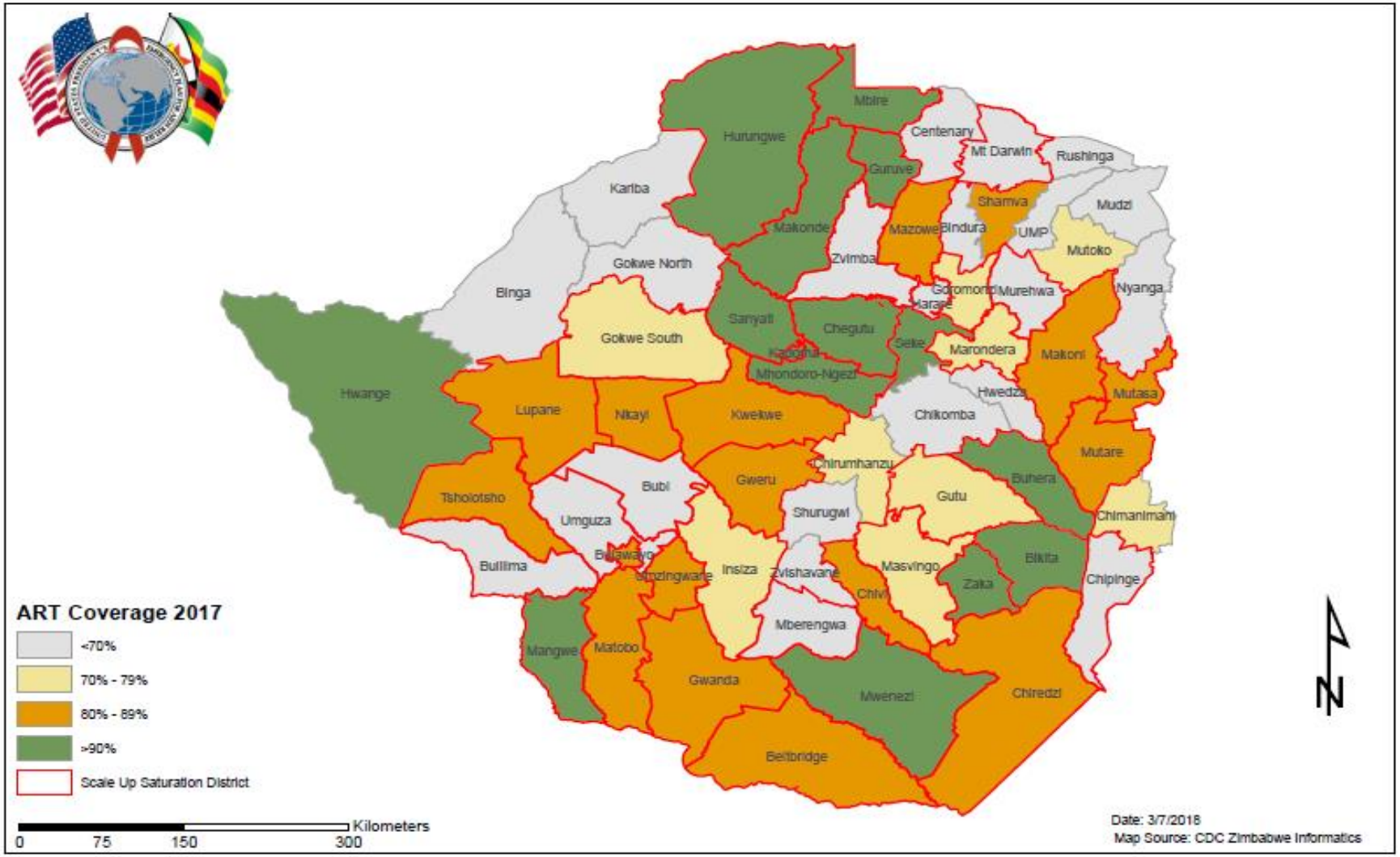
People Living with HIV/AIDS 2017



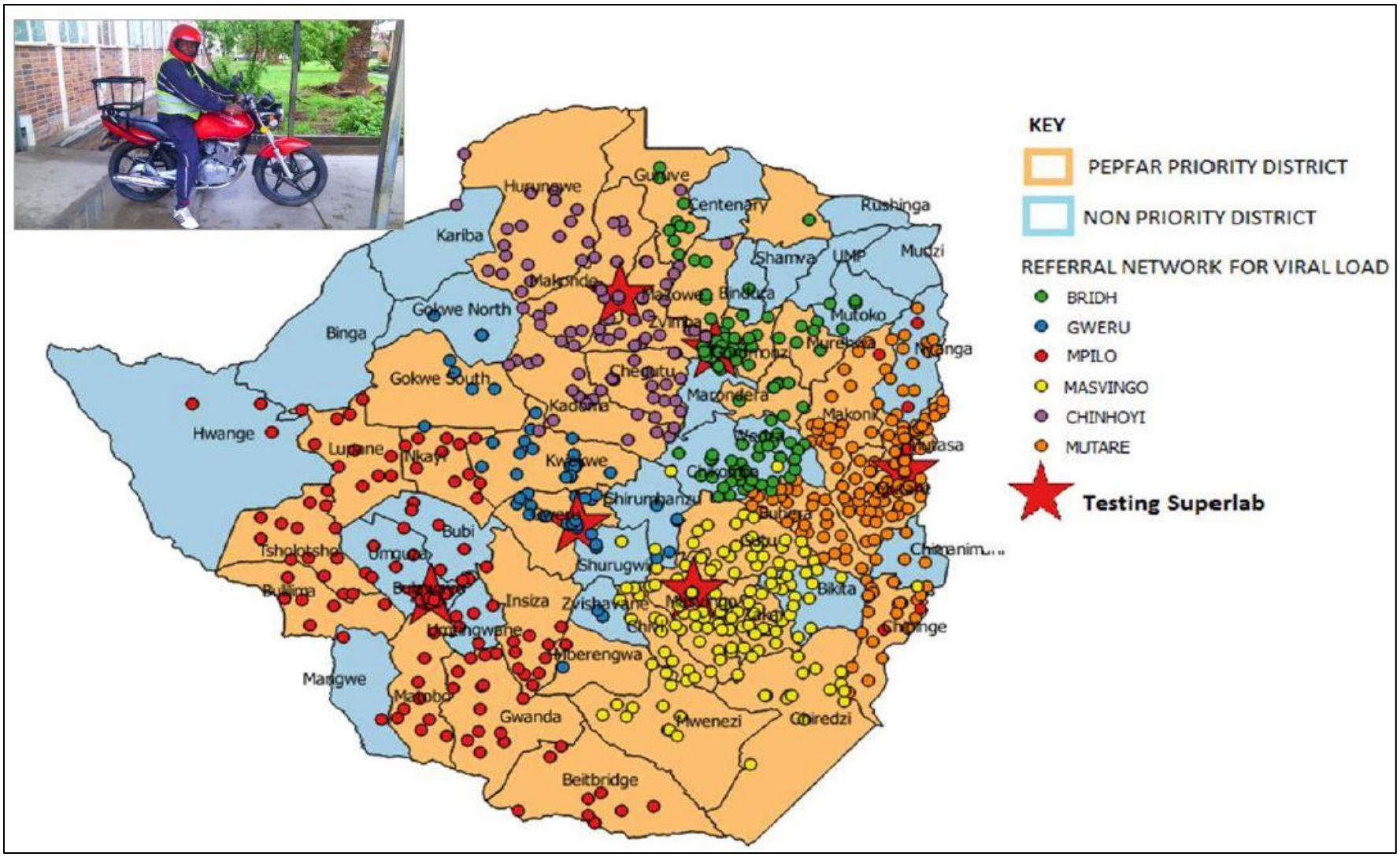
Zimbabwe % of PLHIV



Zimbabwe ART Coverage 2017



GIS Mapping and integrated specimen transport to reduce turnaround time



2.5 **Stakeholder Engagement**

1. **Host Country Government**
   Even before the COP 18 guidance was developed, the PEPFAR Zimbabwe team hosted the Deputy Principals and selected OGAC staff to examine the PEPFAR support to MOHCC national strategies in October 2017. This included a stakeholder workshop where all thematic areas were reviewed and the MOHCC presented annual achievements and key priorities. Ongoing interactions with a variety of Ministries in national technical working groups were supplemented with more structured dialogue and planning which occurred in quarterly reviews and the PEPFAR planning retreat. Ministry focal persons from the HIV prevention, PMTCT, Care and Treatment, KP/DREAMS and VMMC technical areas attended the retreat and contributed to thematic working groups throughout the retreat sessions. After consolidation of the strategic direction and specific priorities, PEPFAR convened a pre-Regional Planning Meeting session where the team's presentation was jointly reviewed. MOHCC had two representatives at this stakeholder consultative meeting.

2. **Global Fund And Other External Donors**
   COP 18 planning coincided with the launch of the Global Fund HIV and TB grant for the period 2018- 2020, and the PEPFAR team was able to take advantage of the Global Fund country team's presence in Zimbabwe during the launch activities in January 2018. Bilateral discussions covered PEPFAR and Global Fund target alignment, commodity and HRH needs, COP 18 planning, and TB laboratory issues. Previous issues regarding the PEPFAR and Global Fund target misalignment were due to the national program pursuing 90-90-90 targets and the PEPFAR team pursuing 95-95-95 targets. The success of the higher treatment targets resulted in national targets being greatly surpassed, contributing to shortages of RTKs and ARVs. However, additional orders were placed by the Global Fund using savings to avert gaps in FY 17 and FY 18. UNAIDS, the Bill and Melinda Gates Foundation, and WHO representatives participated in the retreat and the stakeholder meeting in an effort to align all HIV resources and prevent overlap or duplication. PEPFAR presented COP 18 intentions at the UN planning meeting attended by UNICEF, UNESCO, UNAIDS, UNDP, UN WOMEN, WHO, UNOD and the ILO, and the members present gave feedback on program gaps and areas for complimentary work.

3. **Civil Society/Community**
   Civil society organizations (CSOs), represented by the Core Advocacy Group, met at the beginning of November 2017 to map out their priorities in COP 18. The Core Group has representatives from youth, the LGBTI community, women, faith-based organizations (FBOs), people with disabilities, and covers constituencies in all regions. After additional consensus building and consolidation sessions were convened to review the COP 18 guidance, CSOs presented their priorities to the PEPFAR Coordination Office. Three CSO representatives attended the PEPFAR retreat, the pre Johannesburg stakeholder meeting, and the

Johannesburg Regional Planning Meeting to ensure that their priorities were reflected in the final product.

Moreover, excluding M&O, commodities and TBDs, PEPFAR Zimbabwe's COP 18 budget allocation to local prime partners is 48%. International Primes will continue to increase capacity building efforts to local organizations to enable indigenous partners to manage and compete for U.S. government funding. Small grants programs will also remain a key mechanism to increase the diversity and exposure of local partners to U.S. government funding.

4. **Private Sector**

Private sector coordination has faced challenges since mid-2017. A new board for the Zimbabwe Private Sector Wellness Program was commissioned in February 2018 with the National AIDS Council providing secretariat services. Discussions around COP18 priorities were conducted with the NAC noting congruence in the priority areas, particularly on testing and initiating men on treatment. Opportunities for further engagement exist in the Public Private Partnership Technical Working Group. However, an absence of standard monitoring tools for private sector health service providers was noted, creating the potential for national under-reporting of target achievement. Proposals were also made to introduce provider initiated VMMC in private surgeries.

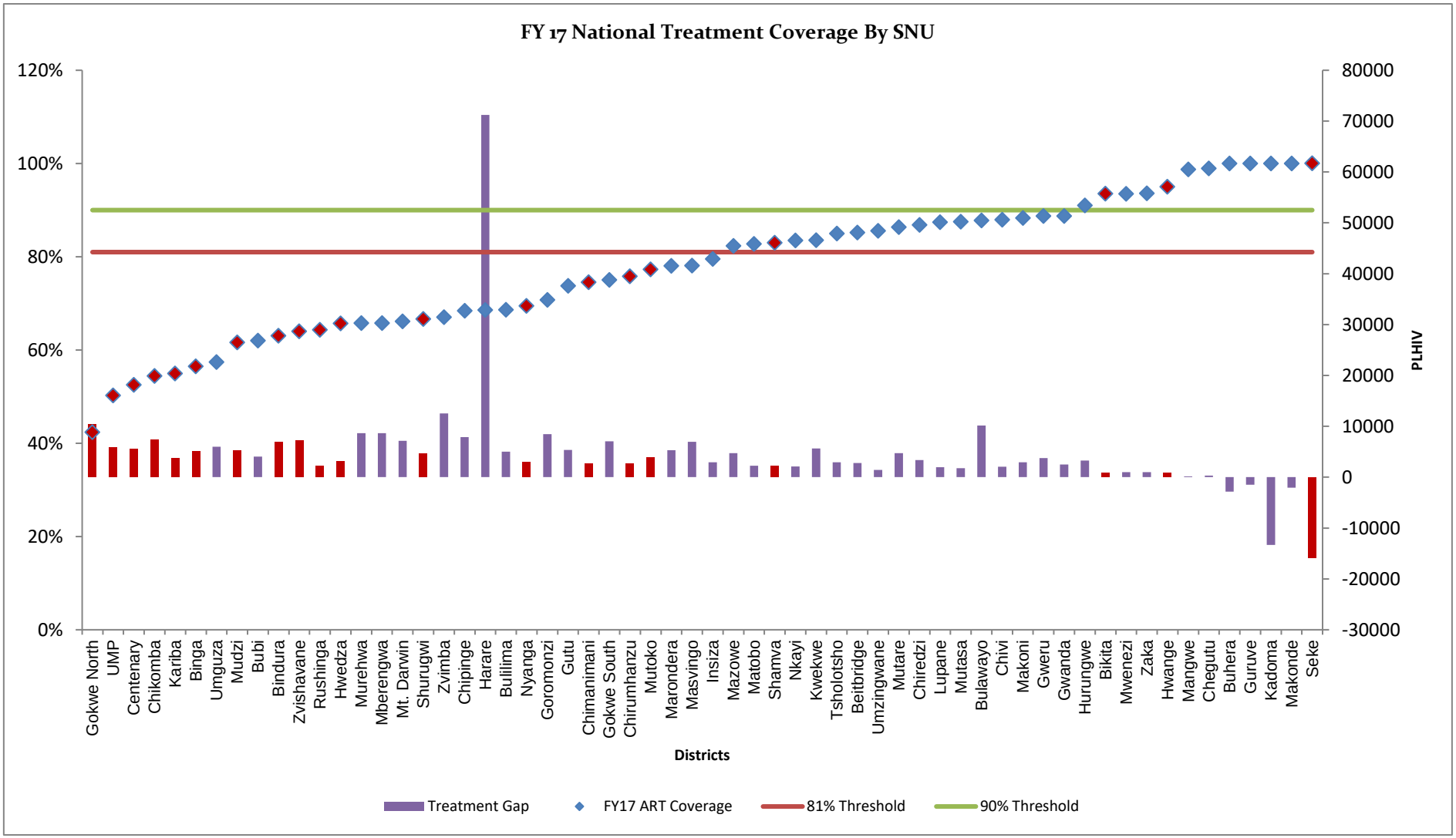
3.0 Geographic and Population Prioritization

The PEPFAR team used 2017 subnational HIV estimates from the UNAIDS HIVE model and the host country treatment uptake data to recalibrate the national HIV epidemic and measure progress towards UNAIDS fast track 95-95-95 epidemic control targets across all districts.

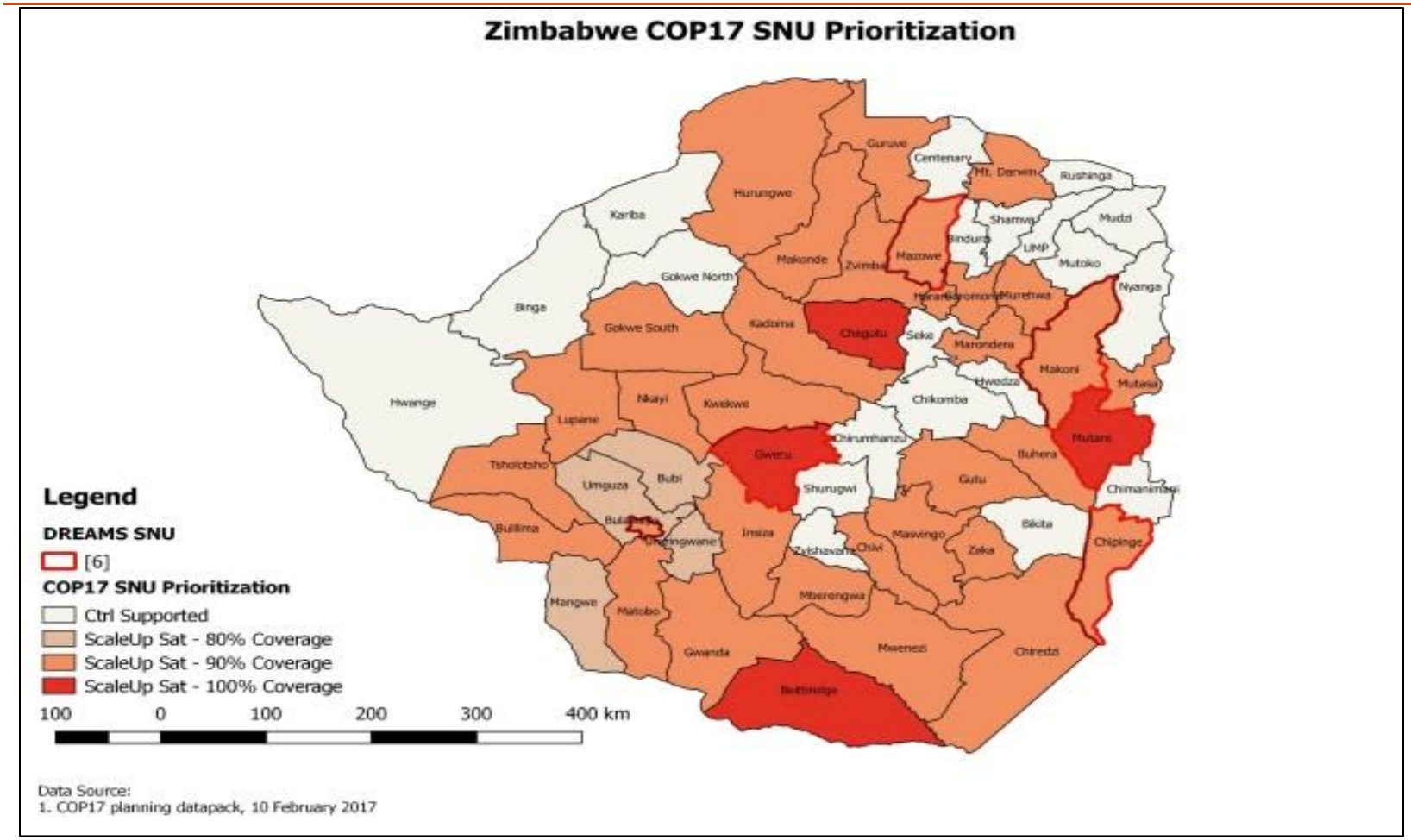
Table 3.1

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP 18**	**# Current on ART (FY 17)**	**# of districts COP 17 (FY 18)**	**# of districts COP 18 (FY 19)**
Attained	468,615/32.6%	345,106	0	6
Scale-up Saturation	697,532/48.5%	575,694	40	34
Scale-up Aggressive	0	0	0	0
Sustained	0	0	0	0
Central Support	271,482/18.9%	193,798	20	20

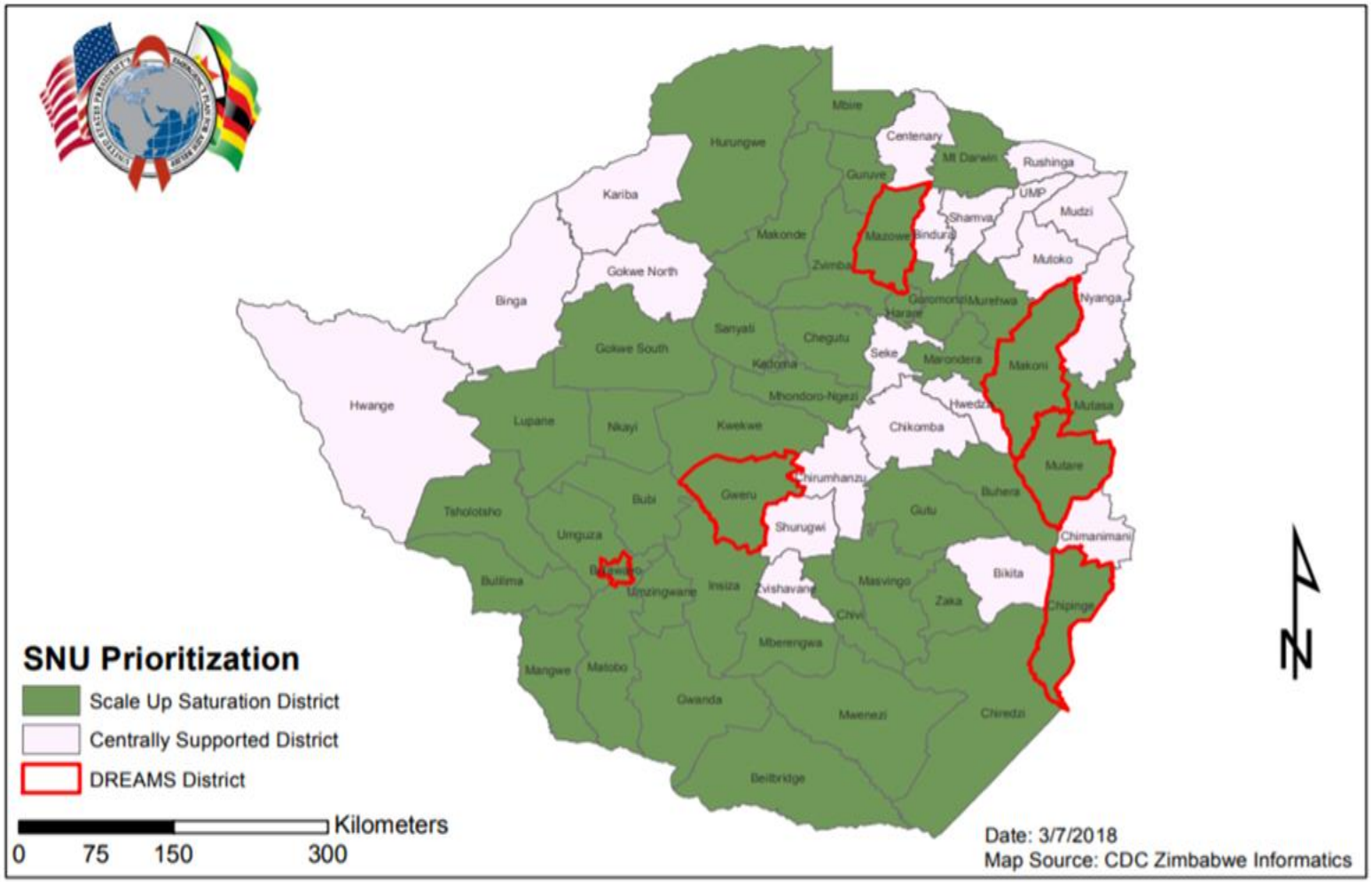
Based on the 2017 HIV model estimates, 29 districts have achieved the second 90 (81% of PLHIV on ART), of which, 25 are PEPFAR supported. None of the districts has achieved the second 90 across all age and sex disaggregation (see **Figure 4.1.1 ART Coverage Gap**). The ten lowest ART coverage districts range from 42% - 63%, with seven of these districts being centrally supported. District level ART coverage and treatment gap at the end of FY 17 are in the figure below.



The 40 districts identified in COP 17 that are highlighted in the map below continue to represent 80% of PLHIV and will continue to be prioritized in COP 18. Within these 40 districts, six are aiming to achieve 90% ART coverage across all age and sex groups by the end of FY 18, and the remaining 34 districts will scale-up to saturation (i.e. achieve 90% ART coverage) by the end of FY 19.


Zimbabwe COP17 SNU Prioritization
Legend
DREAMS SNU
[6]
COP17 SNU Prioritization
Ctrl Supported
ScaleUp Sat - 80% Coverage
ScaleUp Sat - 90% Coverage
ScaleUp Sat - 100% Coverage
100 0 100 200 300 400 km
Data Source:
1. COP17 planning datapack, 10 February 2017
Guruve
Centenary
Mt. Darwin
Rushinga
Hurungwe
Kariba
Shamva
Mudzi
Bindura
UMP
Makonde
Zvimba
Mazowe
Mutoko
Gokwe North
Nyanga
Binga
Harare
Goromonzi
Murehwa
Gokwe South
Kadoma
Chegutu
Seke
Marondera
Makoni
Hwedza
Mutasa
Hwange
Nkayi
Kwekwe
Chikomba
Lupane
Chirumhanzu
Mutare
Gweru
Buhera
Tsholotsho
Umguza
Bubi
Shurugwi
Gutu
Chimanimani
Bulilima
Insiza
Mwenezi
Zaka
Chipinge
Mangwe
Matobo
Mberengwa
Gwanda
Chiredzi
Beitbridge

Zimbabwe COP18 SNU Prioritization



Due to Zimbabwe's generalized epidemic, PEPFAR will target efforts to reach high-risk and vulnerable populations as follows:

- **DREAMS**: Adolescent girls and young women (AGYW) ages 15-24 and a sub-population of vulnerable girls ages 10-14 will receive a "layered package of services" including HIV and gender-based violence (GBV) prevention, HIV testing services (HTS), PrEP for young women over 18, access to family planning services, social protection, economic strengthening, parenting and other services to reduce HIV incidence. A Treat All Strategy will also be implemented in the six DREAMS districts to reach older men who are most likely the partners of the AGYW.
- **VMMC**: Direct service provision will be intensified in COP 18 towards a goal of 80% MC coverage in 78% of PEPFAR-supported districts by the end of the year. Currently, 11 districts (32%) are at greater than 60% coverage for MC. Scale-up in the DREAMS districts will be fast tracked to ensure that they are within reach of the target. Concurrently, PEPFAR will continue to participate in, and support, the MOHCC's collaboration with stakeholders to develop a more sustainable program, focusing on feasibility of interventions, baseline MC packages for saturating districts, and institutional (district and site level) capacity building.
- **Key Populations:** In COP 18, PEPFAR will continue the approach used in COP 17, which aimed at strengthening the clinical cascade for FSW (primary) and MSM (secondary) and reaching saturation in five urban locations with high numbers of FSWs: Harare, Bulawayo, Gweru, Mutare and Masvingo. In addition, services specific to key populations will be integrated into the public sector facilities in COP 18 in order to increase access in urban areas.

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

4.1 – 4.3 COP 18 Programmatic Priorities for Epidemic Control

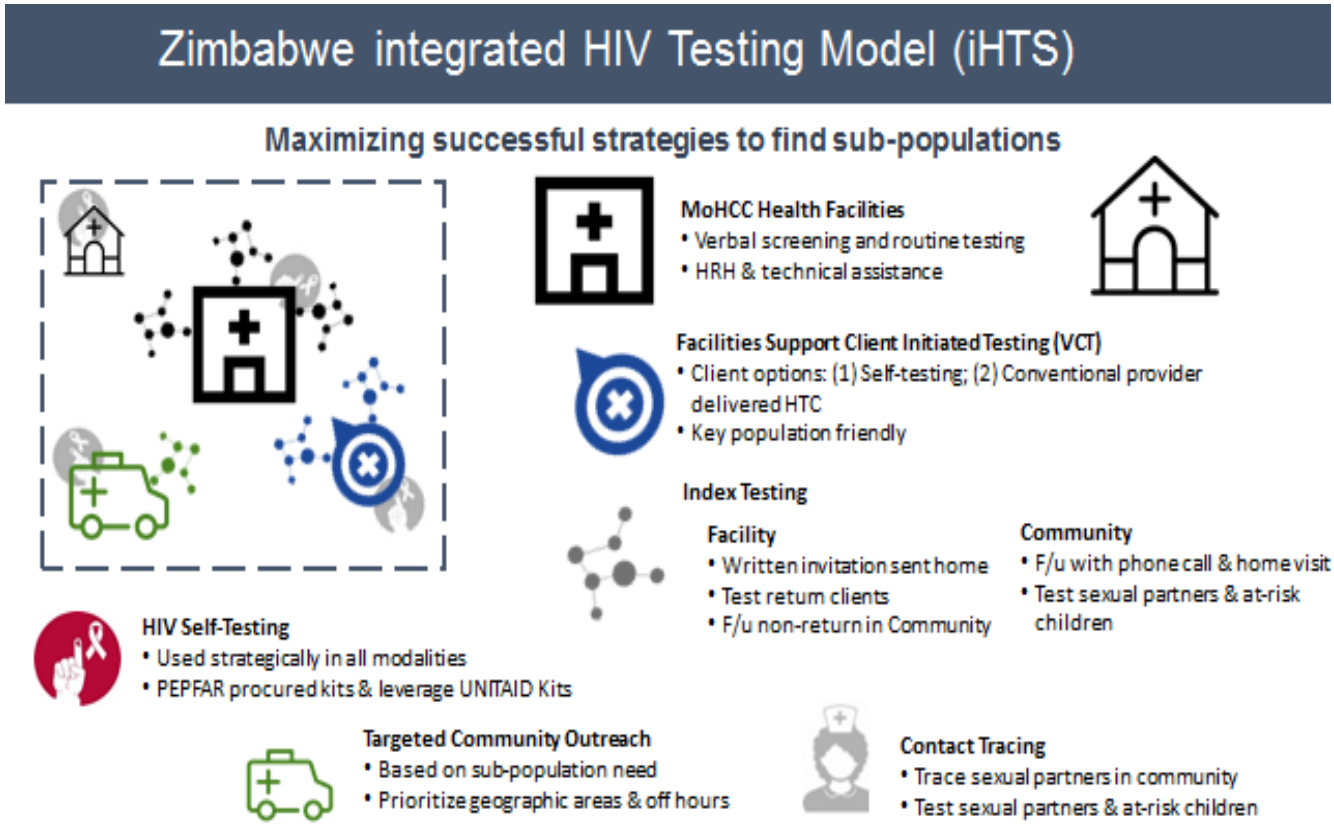
4.1 Finding the missing, getting them on treatment, and retaining them

COP 18 planning was informed by revised UNAIDS SPECTRUM estimates which indicate that by the end of FY 18, 29 of the 40 PEPFAR scale-up districts will reach overall saturation coverage, though gaps will remain in certain sub-populations. Accordingly, PEPFAR Zimbabwe will expand approaches that have proven effective, along with innovative strategies to reach the remaining sub-populations without known HIV status. As evidenced by ZIMPHIA results (74% achievement towards the 1st 90), the largest remaining barrier to achievement of epidemic control continues to be case finding, particularly among priority sub-populations.

The 40 PEPFAR scale-up districts have been categorized based upon their respective ART gaps in order to customize district-level HTS approaches. As such, there are 17 "High ART gap" districts (3,000-10,000) including Harare with an absolute gap of 46,224, eight "Medium ART gap" districts (1,500-3,000), seven "Low ART gap" districts (<1,500) and seven "No ART gap" districts. The "No ART gap" districts have estimates that suggest ART saturation has been achieved (though PLHIV will continue to be identified). Through facility-based testing (PITC, CITC), index testing (both facility and community), self-testing, and targeted mobile outreach testing, the PEPFAR Zimbabwe team has developed an integrated HTS model where the blend and relative emphasis upon each HTS modality will be tailored to the demographic makeup of the population to be found in each district (see Figure 4.1.1below). The emphasis, therefore, will be on intensifying efforts which have proven to be effective in reaching specific sub-populations, while also prioritizing cost efficiencies. For districts with larger ART gaps, facility-based PITC will be intensified through direct service delivery (DSD) implementation, as the volume of positives identified is highest and the cost of service delivery is lower through this entry stream. Among districts where the gap is smaller, facility-based investments will decrease, employing predominantly technical assistance (TA) rather than DSD; and more costly but more effective community efforts (index testing, self-testing, targeted mobile testing, and sexual network tracing) will be emphasized, as the populations of PLHIV remaining are harder to reach. As a rule, however, index testing for the sexual contacts and children of all known PLHIV will be intensified in all districts given the high positivity yield of this approach.

Figure 4.1.1 ART Coverage Gap

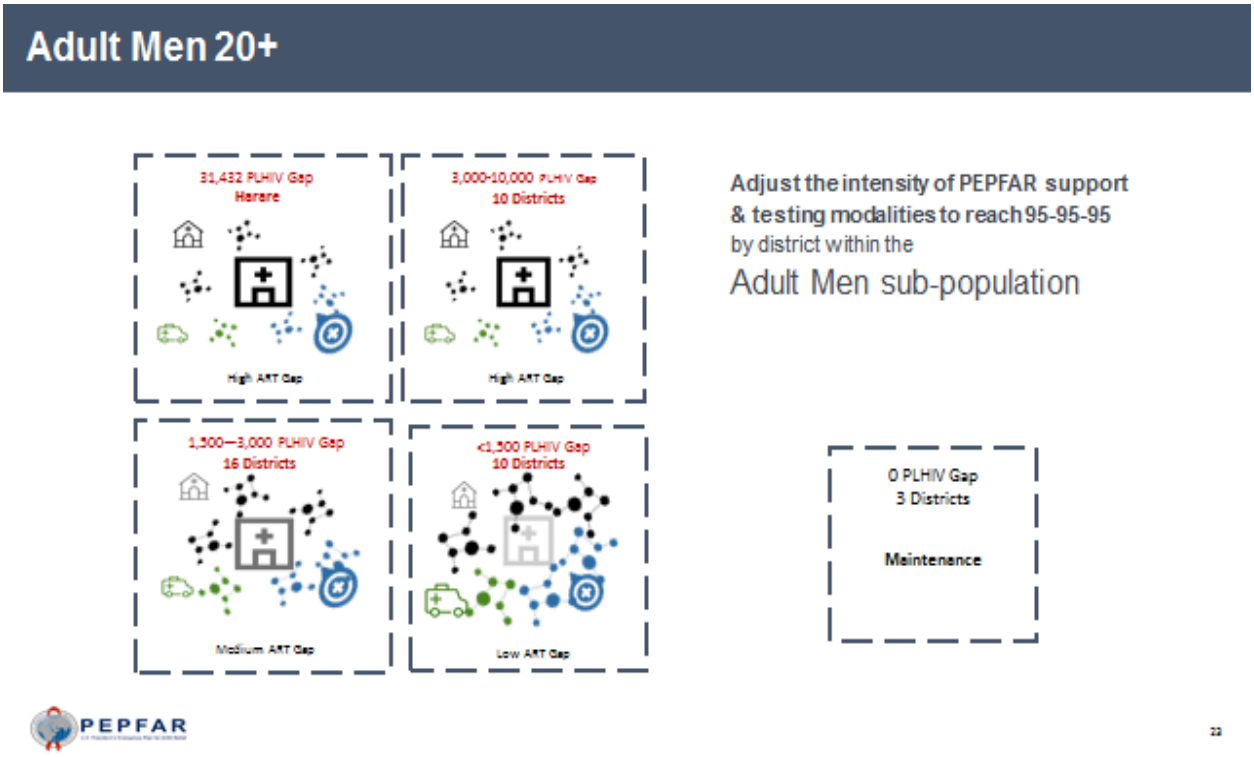
2017 ART Coverage & Absolute Treatment Number Gap													
District	PLHIV All Ages	F 15-19	M 15-19	F 20-24	M 20-24	F-25-29	M 25-29	F 30-49	M 30-49	F 50+	M 50+	Total (All Ages & Sexes)	Total Gap Abs Number (All Ages & Sexes)
01 National	1,315,900	92%	86%	98%	71%	89%	88%	84%	70%	75%	66%	85%	201,302
Harare	222,000	76%	98%	83%	66%	101%	98%	82%	66%	57%	50%	79%	46,224
Bulawayo	80,600	148%	112%	122%	94%	113%	103%	86%	74%	70%	67%	91%	7,412
Zvimba District	34,730	69%	48%	93%	48%	176%	252%	53%	52%	51%	42%	73%	9,299
Hurungwe District	34,300	97%	85%	133%	96%	115%	134%	87%	81%	75%	63%	96%	1,426
Mutare District	33,290	75%	69%	98%	76%	143%	128%	82%	72%	88%	71%	90%	3,437
Kwekwe District	32,610	84%	112%	125%	89%	77%	98%	81%	75%	85%	76%	88%	3,940
Gweru District	32,080	78%	80%	84%	61%	94%	99%	98%	77%	86%	75%	92%	2,454
Masvingo District	30,150	105%	87%	100%	71%	91%	92%	79%	61%	87%	70%	82%	5,353
Chegutu District	28,160	173%	123%	184%	88%	135%	145%	104%	88%	58%	51%	105%	-1,433
Goromonzi District	27,310	84%	57%	69%	36%	92%	51%	82%	68%	53%	65%	75%	6,861
Gokwe South District	26,100	95%	79%	107%	71%	76%	82%	79%	64%	71%	70%	81%	4,899
Mazowe District	25,390	68%	71%	74%	61%	142%	177%	78%	73%	65%	50%	87%	3,423
Murewa District	24,330	119%	86%	76%	43%	73%	61%	64%	55%	66%	61%	68%	7,715
Makoni District	23,130	91%	72%	118%	91%	223%	262%	67%	63%	86%	83%	95%	1,054
Mberengwa District	23,100	93%	70%	75%	52%	67%	61%	68%	49%	102%	77%	72%	6,437
Chipinge District	22,800	74%	52%	100%	86%	143%	150%	68%	49%	65%	47%	75%	5,736
Marondera District	22,640	174%	177%	117%	107%	98%	99%	81%	56%	60%	69%	83%	3,756
Chiredzi District	22,620	78%	71%	93%	105%	150%	145%	87%	81%	95%	72%	98%	441
Gwanda District	20,390	116%	99%	100%	97%	96%	141%	95%	69%	95%	83%	96%	744
Mount Darwin District	19,630	95%	77%	100%	78%	163%	165%	45%	38%	60%	43%	71%	5,682
Gutu District	18,980	81%	133%	83%	44%	87%	79%	75%	52%	97%	67%	79%	3,936
Tsholotsho District	18,330	118%	93%	78%	32%	170%	139%	68%	44%	131%	105%	91%	1,732
Buhera District	18,080	143%	164%	117%	124%	241%	241%	86%	79%	128%	146%	122%	-4,027
Makonde District	18,030	135%	112%	202%	186%	142%	154%	106%	94%	97%	79%	120%	-3,565
Beitbridge District	18,000	61%	63%	90%	60%	103%	85%	98%	70%	96%	63%	89%	1,931
Chivi District	16,150	97%	112%	160%	78%	193%	141%	68%	49%	90%	100%	93%	1,084
Bulilima District	14,850	86%	63%	96%	41%	108%	91%	65%	46%	77%	59%	74%	3,915
Zaka District	14,150	111%	121%	94%	45%	113%	101%	98%	65%	147%	95%	102%	-229
Mwenezi District	14,050	128%	113%	112%	71%	109%	108%	94%	71%	122%	84%	101%	-141
Lupane District	13,540	103%	111%	74%	46%	65%	63%	86%	94%	140%	139%	99%	108
Umguza District	13,380	51%	38%	53%	36%	60%	70%	50%	53%	87%	81%	60%	5,312
Insiza District	13,090	86%	62%	98%	56%	105%	86%	83%	71%	90%	66%	87%	1,696
Kadoma District	12,870	169%	124%	237%	185%	213%	235%	111%	105%	129%	73%	139%	-4,978
Mutasa District	12,540	110%	71%	129%	102%	196%	220%	78%	72%	93%	70%	99%	145
Nkayi District	12,490	94%	89%	92%	42%	115%	117%	65%	58%	109%	120%	86%	1,739
Matobo District	12,230	85%	81%	98%	38%	121%	85%	81%	57%	99%	82%	88%	1,525
Mangwe District	11,970	67%	97%	82%	45%	127%	133%	96%	87%	116%	122%	105%	-599
Umzingwane District	11,160	118%	73%	112%	43%	85%	53%	58%	55%	122%	72%	74%	2,871
Guruve District	10,830	77%	87%	109%	86%	90%	117%	85%	68%	64%	47%	86%	1,566
Bubi District	9,900	58%	40%	62%	21%	81%	74%	59%	54%	81%	78%	67%	3,277



SUB-POPULATION SPECIFIC HTS STRATEGIES

In addition to the magnitude of the ART gap, the demographic nature of this gap will guide the tailoring of district-level HTS approaches. As articulated below, different modalities will be emphasized based upon their effectiveness in reaching particular sub-populations.

A. Adult Men over 20 years old:



1. PITC: PITC will remain one of the key HTS strategies to identify men in the 10 high PLHIV gap districts and Harare, with 70% level of effort (LOE) dedicated to DSD. The proportion of DSD (human resources) support to facilities will reduce commensurate with a declining ART gap in districts. Community efforts will need to be intensified in order to find the remaining men. This is particularly important because program and survey data have indicated that men present to facilities considerably later than their female counterparts, and consequently have poorer health outcomes. Assessments will be conducted at high volume clinics to identify those with large testing gaps between eligible clients and number tested. Process mapping and HRH assessments will then be conducted to determine the need for additional testing points and HRH. The majority of facilities have only two to three testing points covering the antenatal and outpatient department (OPD) entry points; each manned by one to two nurses. To achieve 100% coverage of PITC in the facility, it is necessary to provide additional testing spaces and deploy additional nurses to conduct HIV screening and testing at all entry points. All clients visiting the facility will be screened and offered testing when found eligible. Additional staff will also be seconded to facilities to support linkage to ART and collection of weekly data. Expert clients will also be utilized to maximize linkage. The additional staff, utilization of expert patients, and expanded hours will all be used to render the facilities more accessible to men.

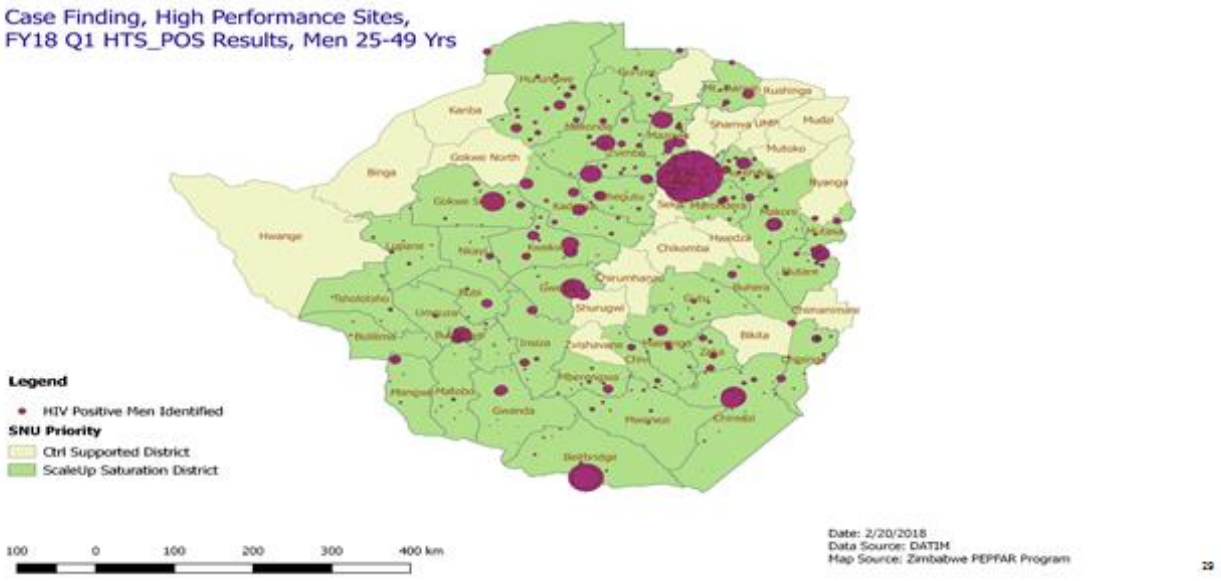
2. Index Testing (Facility and Community): In COP 18, PEPFAR Zimbabwe will quadruple its investment in index testing, much of which targets men. Male partners of female index cases and male partners of all females currently on ART will be actively offered index case testing and contact tracing. Females found positive in facilities will be provided with

written invitations for their male sexual contacts to return to the facility for testing. For those males who do not return to the facility for testing within a defined period, they will then be followed up through community index testing. As the PLHIV gap narrows, PEPFAR will correspondingly increase the intensity of the index case testing strategy.

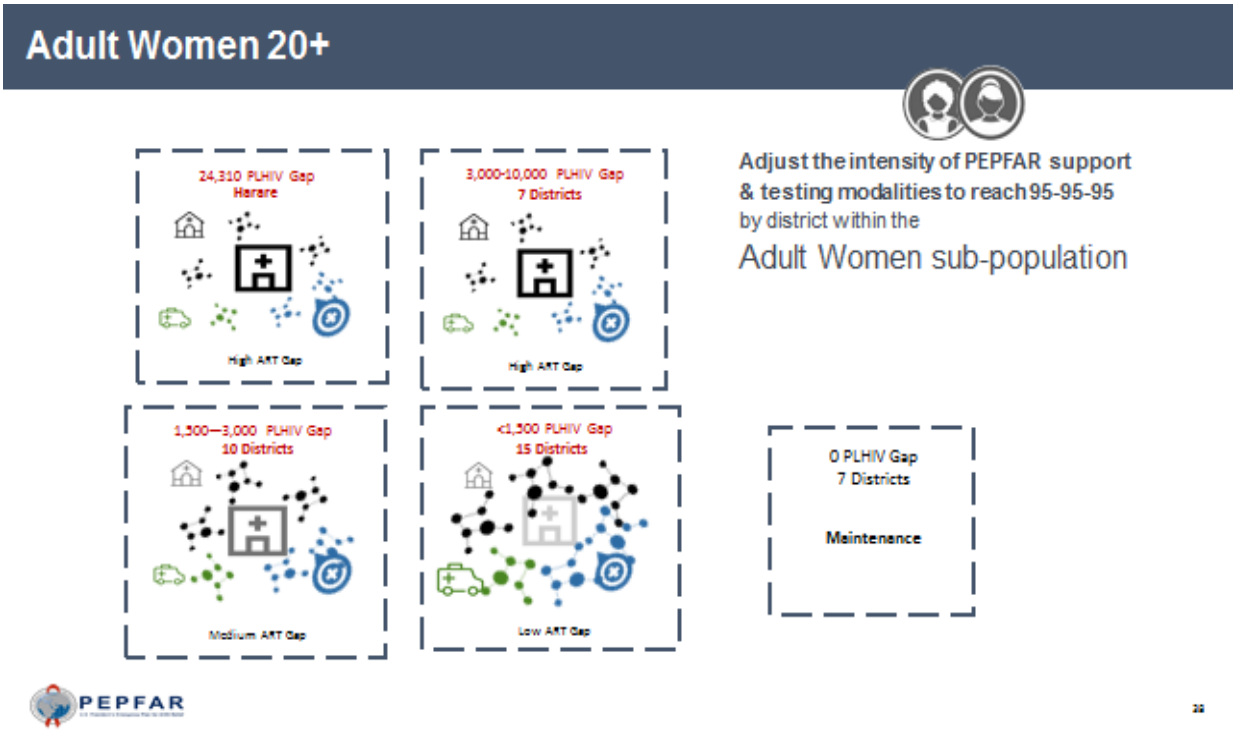
3. Targeted Mobile Outreach: This approach will be based on profiling of previously identified HIV positive females and use of Human Centered Design (HCD) to better understand characteristics of the targeted male population, and barriers to HIV testing. The program will intensify engagement of faith based leaders to broaden prospects of reaching more undiagnosed HIV positive men. Targeted mobile testing utilizing self-testing as a screening tool has been shown to be successful in improving yields and identifying hard to reach males such as farmers and artisanal miners. This strategy will be scaled-up as appropriate.

4. Self –Testing: Based on lessons learned in COP 17 and leveraging of both PEPFAR (300,000) and UNITAID (304,000) funded self-testing kits, self-testing will be intensified in all facilities currently identifying more than 800 PLHIV per annum. This is intended to make identification of HIV positive men more efficient whilst easing the HRH at either public health facilities or CITC (New Start Centres). Self-testing will also be used to increase efficiency of community-based HTS. To improve client choices and uptake among young men, service providers will offer options for clients to either be assisted by the providers to administer the self-test or self-administer the test at their own convenience. Community distribution of self-tests appropriately appeals to the youth, who for various reasons, are not currently accessing services at facilities. Social network messaging among adolescents/youth, especially using technology/social media; will be used to assist self-testing literacy and to improve linkage to care.

Where are men being diagnosed?



B. Adult Women over 20 years old: The program continues to reach more women through PITC (FY 18 Q1, 84% HIV positive women identified through PITC) than men due to better health seeking behavior than their male counterparts including through the PMTCT program:



1. PITC: As described above, PITC will be predominantly DSD-based in high-gap districts, and increasingly TA-based among districts with lower gaps. Adult women continue to represent the single largest group of undiagnosed PLHIV in Zimbabwe, and efforts to optimize PITC will include reaching women through the entry streams where they are found in large numbers (e.g. antenatal clinics, out-patient departments, and family and child health departments).

2. Index Testing (Facility & Community): In Q1 of COP 17, about 8% (1,689) of all HIV positive adult women (20 years old+) were identified through index case testing. Female partners of male index cases and female partners of all males currently on ART will be actively offered facility based index case testing through the invitation system. This has proven to be successful so it will be scaled up in all medium and high gap districts. Those who do not return for testing in the facility within a defined time or those who indicate that their partners will not present at health facilities for testing will then be reached through community index testing. As the PLHIV gap narrows, PEPFAR will correspondingly increase the intensity of the index case testing strategy.

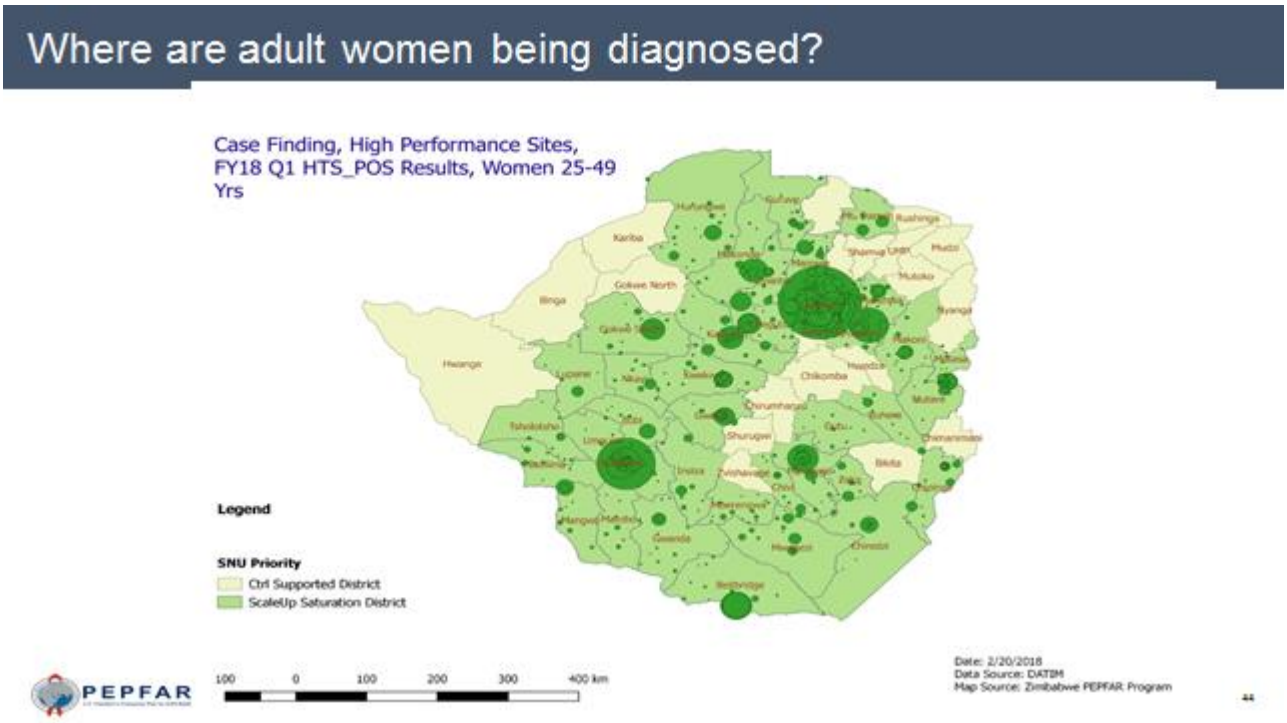
3. PMTCT: In COP 17, PEPFAR partners are focused on re-orienting staff on the re-testing strategy for HIV negative pregnant and post-natal women. Through on site mentorship, staff are being guided to ensure this is properly conducted, recorded, and reported correctly. The MOHCC has also requested support for a "DREAMS like" package of

services for HIV-negative pregnant women. Implementing partners (IPs) will be engaging the MOHCC on this request in FY 18 Q3, to include advice from PEPFAR DREAMS partners. Engagement of community level structures including CSOs is ongoing to promote early booking for antenatal and couples counselling and testing.

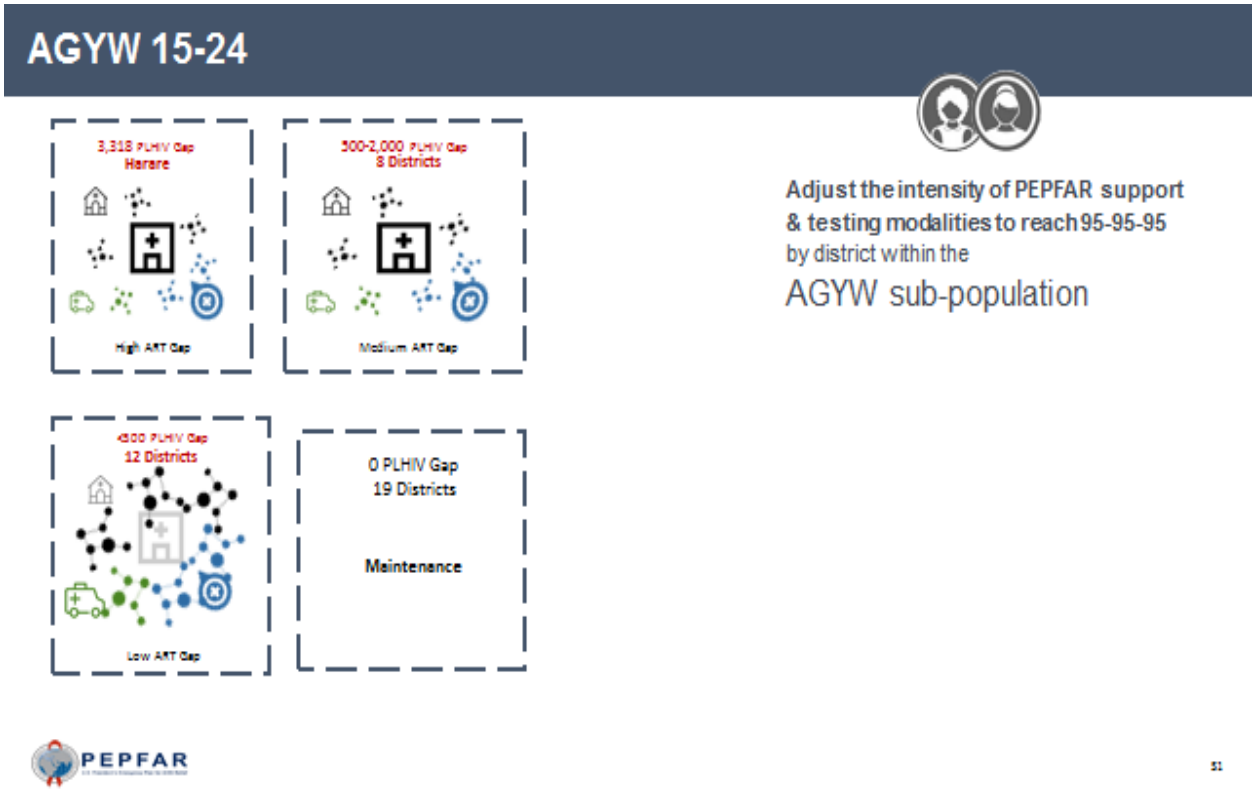
4. Targeted Mobile Outreach: This approach will be based on profiling of previously identified HIV positive females and use of Human Centered Design (HCD) to better understand targeted female population characteristics and barriers to their access to HIV testing. This strategy will be intensified to target females in sparsely populated rural districts (former commercial farming areas) where distances to facilities are a barrier. In addition, this strategy will also be utilized to reach female members of the apostolic faith who have traditionally shunned seeking care at any modern health care delivery system.

5. Self –Testing: Based on lessons learned in COP 17 and leveraging on both PEPFAR (300,000) and UNITAID (304,000) funded self-testing kits, self-testing will be scaled up in all facilities currently identifying more than 800 PLHIV per annum. This is intended to make identification of HIV-positive adult females more efficient whilst easing the HRH burden. Self-testing will also be used to increase the efficiency of community HTS when used as a screening tool.

In COP 18, the development of systems to enable recording and reporting on re-testing of HIV-negative women will be completed and expected to show re-testing cascades as well as report on indicators such as sero-conversion rates in selected high-volume sites. The treatment literacy package offered in the public sector will be reviewed to include a broad range of issues including services for HIV-negative pregnant women, the need for early booking as well as couples counselling, among others. These documents will be finalized and distributed to supported health facilities as well as with CSOs and networks of people living with HIV to educate their members. Support through the IP clinic referral facilitators (CRFs) and government village health workers (VHWs) will be provided to coordinate/facilitate these education sessions. These efforts will support earlier antenatal clinic booking and identification of mothers at high risk of MTCT.



C. Adolescent Girls and Young Women (15-24 year olds)



Current program data for Adolescent Girls and Young Women (AGYW) shows that ART gaps remain for AGYW in 28 of the 40 PEPFAR supported districts. Harare needs more intensified attention given the sheer number of AGYW remaining to be found. While 13% of HIV positive AGYW in FY 18 were identified through combined index case testing and targeted outreach, 85% were identified through PITC (DSD and TA).

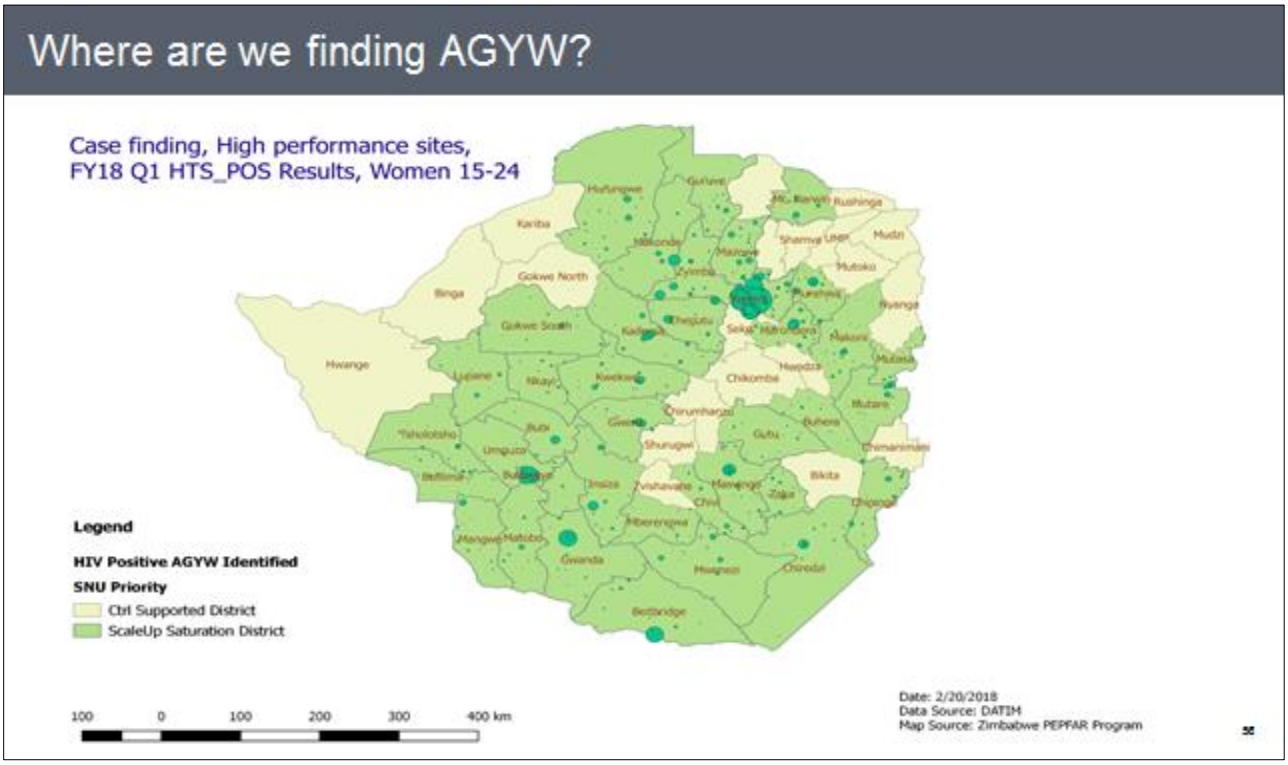
1. PITC: PEPFAR Zimbabwe will maximize coverage of adolescents presenting to health facilities at the following entry points: antenatal clinics, outpatient, inpatient, TB, malnutrition, STI, family planning, and adolescent-friendly spaces. DSD efforts will be expanded in Harare (where there is an ART gap of 3,318) and seven other districts with a "medium ART gap" of between 500 and 2,000 AGYW. Expansion of adolescent friendly services through Community Adolescent Treatment Supporters (CATS) groups and DREAMS programming will be used to improve uptake of HTS services. As described above, in "low ART gap" districts, TA will replace DSD interventions in facilities. Among other things, this TA will ensure that providers use standardized procedures to determine HTS eligibility; are aware of and compliant with national guidelines for consent (including Best Interest Determination); and track coverage of testing at each entry point on a regular basis (monthly or quarterly register reviews).

2. Index Testing (Facility & Community): In COP 18, PEPFAR Zimbabwe plans to expand index case testing embedded with self-testing to reach the remaining unidentified HIV positive AGYW. Index case testing will therefore be strategically targeted at female siblings and sexual partners of all those newly diagnosed, as well as those already on ART. The program will maximize coverage of HTS in adolescents through family index testing of infected adults, especially 10-14 year olds and work with partners to ensure the proper entering of finer age bands by modality.

3. Targeted Mobile Outreach: This approach will be based on profiling of previously identified HIV positive females and use of the Human Centered Design (HCD) and Early Intervention Program () demand creation/communication strategies and methods to better segment, characterize and target AGYW. This strategy will be intensified to target AGYW in sparsely populated rural districts (former commercial farming areas) where distances to facilities are a barrier. In addition, this strategy will be utilized to reach AGYW members of the apostolic faith who have traditionally shunned seeking care at any modern health care delivery system.

4. Self –Testing: Self-testing has been identified as a strategy to reach young people and as a demand creation strategy for prevention activities. However, there is limited program data regarding post-test linkage for adolescents and uptake among the younger age bands; COP 18 will therefore include evaluations of self-testing in adolescents and youth. This new testing method will be expanded to all 800+ high volume health facilities in COP 17 and intensified as the new norm in COP 18, leveraging on both PEPFAR (300,000) and UNITAID (304,000) funded self-testing kits. As highlighted elsewhere, self-testing is intended to make identification of HIV positive AGYW more efficient whilst easing the HRH burden. Community setting distribution of self-tests may be more appropriate for youth who are not currently accessing services at a facility while direct assisted models may be more appropriate for youth in facility settings. Social network messaging among

adolescents/youth, especially using technology/social media; will be used to assist self-testing literacy and to improve linkage to care.



D. Children (0-14 year olds)

Summary for Pediatrics	Treatment Gap	Number of Districts	Total Absolute Number
PLHIV Gap 500-1,300	High ART Gap	8	6,524
PLHIV Gap 200-500	Medium ART Gap	14	4,653
PLHIV Gap <200	Low ART Gap	9	483
PLHIV Gap 0	No ART Gap	9	

Current program data for children shows that an ART gap persists in the 31 of the 40 PEPFAR supported districts. Harare has by far the largest absolute gap of 6,524 children living with HIV to be identified and put on treatment. Whilst 15% of HIV positive children in FY 18 Q1 were identified through PITC, in FY 18 Q2 that number had increased dramatically to 50%. In terms of yield, community index case testing showed continued high yield of 14% in FY 18 Q1.

1. PITC: In COP 18, DSD efforts will be expanded in Harare (where there is a gap of 6,524 cases) and 7 other districts with a PLHIV gap of between 500-1,300 children living with HIV. Through both DSD and TA, the program will continue site supervision and clinical mentorship on early infant diagnosis - dried blood spot (EID-DBS) sample collection. EID-DBS sample collection is synchronized with the first immunization visit at six weeks. Results are expected after a minimum of four weeks and review dates are scheduled at the time of the next immunization visit at ten weeks.

2. Index Testing (Facility & Community): In COP 18, PEPFAR Zimbabwe plans to expand index case testing to reach the remaining unidentified HIV positive children. Index case testing will therefore be strategically targeted at all children of newly identified and HIV positive adults found in ANC, OPD, malnutrition, etc., in addition to, adults currently on ART with children of unknown status. Testing will be offered to children of adults via multiple entry points at facilities. Expanding index testing in PMTCT will be a key strategic entry point to identify HIV infected children and adolescents.

3. Targeted Mobile Outreach: This approach will be based on profiling of previously identified HIV positive females and their children and use of HCD and EIP demand creation/communication strategies and methods to better segment, characterize and target children. This strategy will be scaled up to target children in sparsely populated rural districts (former commercial farming areas) where distances to facilities are a barrier. In addition, this strategy will be utilized to reach children of members of the apostolic faith who have traditionally shunned seeking care at any modern health care delivery system.

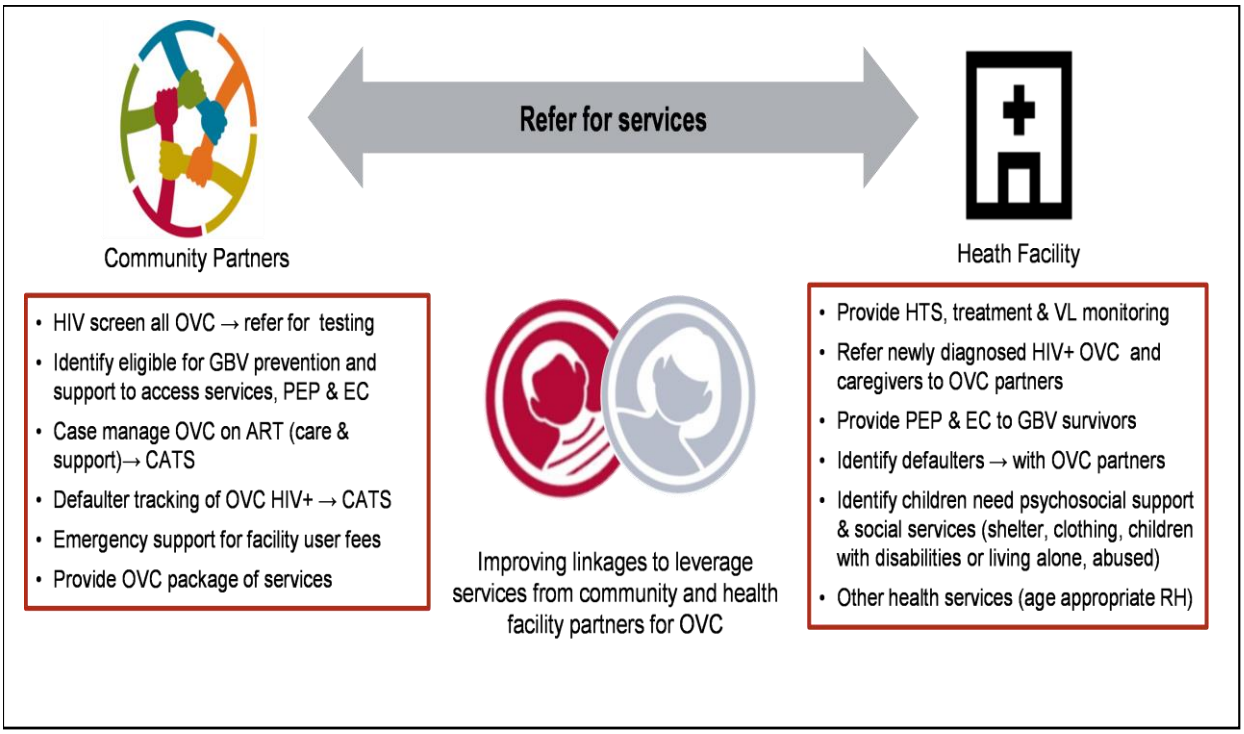
The PEPFAR program will continue to enhance linkages between OVC programs and health services through strengthened collaboration among health care workers and social workers who will be based at select health facilities. This will improve access to HIV services, particularly HIV testing for OVC. In turn, children identified at health facilities will also have improved access and linkages to social services upon discharge

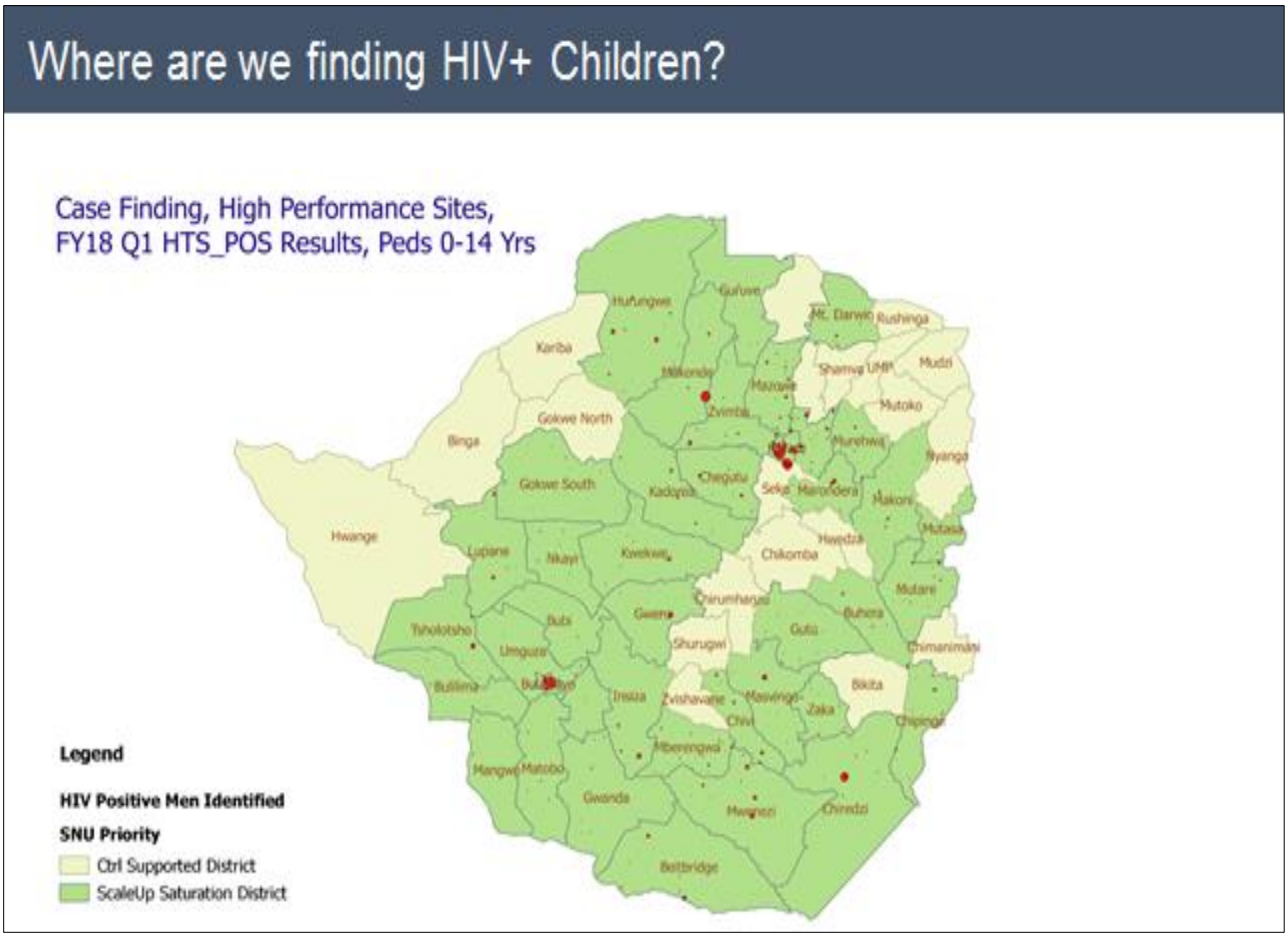
By the end of FY 17, 99% of enrolled OVC had been assessed with a reported HIVSTAT (the indicator for known HIV status) result, and 100% of HIV positive OVC were on ART. However, a significant proportion of those with unknown status, were reported as 'status known by caregiver but not disclosed to partner,' which indicates the need for strengthened counseling in order to ensure linkage to treatment services. A data quality assessment (DQA) of the HIVSTAT indicator was carried out in January 2018 which illuminated the need to improve both the data collection and management processes related to this indicator. In COP 18 PEPFAR will continue to prioritize HTS for OVC using an HIV sensitive screening tool. In addition, PEPFAR will support tool development and capacity building so that implementing partners are screening for HIV risk appropriately, monitoring change in HIV risk or change in HIV status, and documenting appropriate referrals.

The program will continue to coordinate with the MOHCC and MOLSW, to integrate HIV issues into the National Case Management System, thereby making it HIV sensitive. This helps ensure that all community case workers (CCWs) and other community-based para-professionals generate

demand for HIV services and offer adherence support to those on ART. In addition, an HIV-sensitive National Case Management system ensures that children/families are assessed for holistic health and social needs, linked to the appropriate services, and followed until case closure. In COP 18 PEPFAR will work with partners and MOLSW to develop case plan achievement/graduation benchmarks which will be applied consistently across the program.

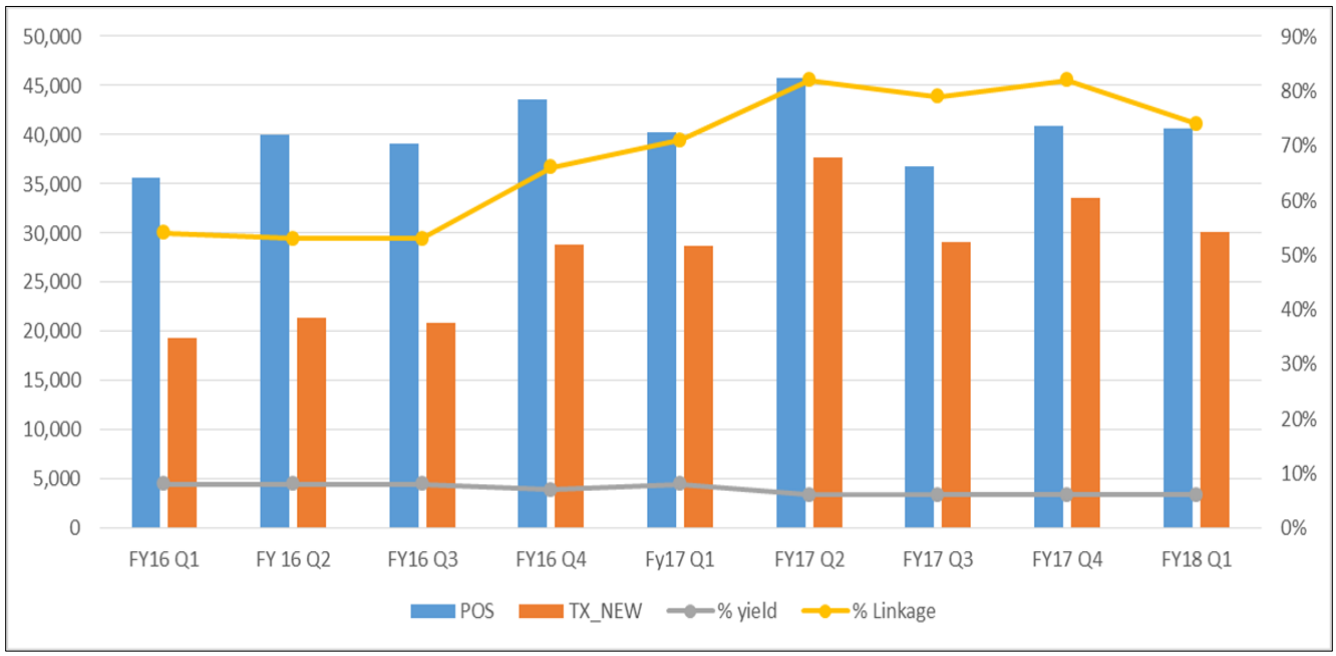
In COP 17, PEPFAR committed to strengthening the linkages between community-based OVC services and clinical services by placing para-professionals who would be responsible for referring at-risk children to community services. OVC partners ensure that health facilities are linked to a dedicated para-social worker from the current pool of CCWs with whom the health facility can liaise for follow-up and case management. To date significant progress has been made: 267 facilities (out of a target of 320 in FY 18) have been engaged, a linkage protocol was established, and MOUs between implementing partners and facilities have been drafted in 12 districts. The initiative will be further strengthened and expanded in COP 18.





Getting them on treatment

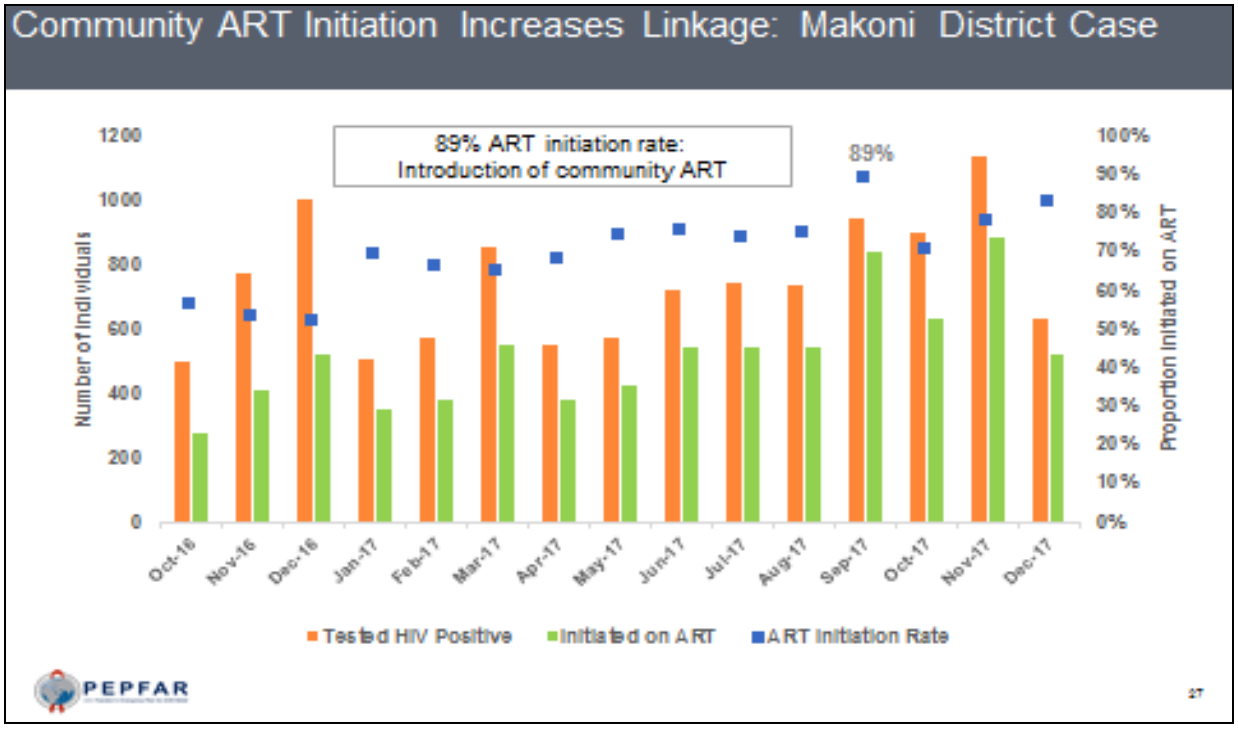
The introduction and scale-up of the Treat All guidelines has seen a lot more PLHIV being initiated on ART than would have been with the CD4/WHO staging eligibility criteria. In many facilities around the country, the monthly initiation rate increased initially with the introduction of Treat All but it has since regressed against the background of the country approaching epidemic control. As the Treat All approach was introduced and scaled up, the PEPFAR program emphasized 'same day initiation' (for clients who were ready to be initiated on treatment) and this, together with the introduction of DSD HRH in facilities, has seen the linkage rate (proportion of PLHIV testing positive initiated on ART) increase from an average of 56% in COP 2015 to 80% at the end of COP 2016 as illustrated in the figure below.



PEPFAR program linkage rates by quarter, FY 16 Q1 to FY 18 Q1.

New initiations in the PEPFAR program currently average 10,748 per month and this would be enough to meet the COP 18 target initiations of 104,945. However, the net new ART initiations nationwide are currently at approximately 9,253 per month because of the attrition due to deaths, loss-to-follow-up and transfers to non-PEPFAR districts, against a COP 17 net new target of 11,334 per month. This means that the PEPFAR program needs to further improve linkage rates to the desired ≥95%. As was the case with COP 2016 and COP 17, Zimbabwe's ongoing economic crisis contributes to significant human resource gaps which impact both PITC and ART initiation; PEPFAR partners will continue to provide DSD support for ART initiation at facilities experiencing significant gaps that impact service delivery; site-level linkage will be used as a metric to identify these facilities. This DSD support will include facility based and community based linkage facilitators and ART initiators.

Program data has shown that while intra-facility linkage rates are as high as 92%, the overall linkage rate is 74% because of poor community linkage rates. Linkage analysis of individual patients and cohorts will be significantly more reliable and useful with the roll-out of the Electronic Health Record (EHR). Nevertheless, the introduction of community ART initiation has been shown to significantly increase community linkages rates as illustrated in the figure below. Community ART initiation will therefore be scaled up to all geographic areas where community HIV testing services are provided, and as guided by national policy.



In COP 18, PEPFAR will support activities to improve treatment literacy among PLHIV to 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 early once diagnosed without waiting for one to be symptomatic, the importance of having all sexual partners on treatment or PrEP, the need for viral load monitoring and the meaning of viral load results. The PEPFAR program will also support the process of updating counseling guidelines to align with the current treatment guidelines and the shifts in the HIV program. 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 takes into account client feedback in order to promote client-centered care. PEPFAR support towards the national HIV Quality Improvement program takes the form of secondees who provide technical guidance, ensuring that this program is aligned with PEPFAR and UNAIDS strategy for achieving HIV epidemic control. Through this support in FY 17, the national Quality Improvement indicators were updated to reflect the revised treatment guidelines. At the site-level, systems-level interventions to improve monitoring of patient satisfaction, linkage rates, same day initiation and improved M&E for PEPFAR treatment indicators, will be streamlined into the site-level support provided by the clinical partners.

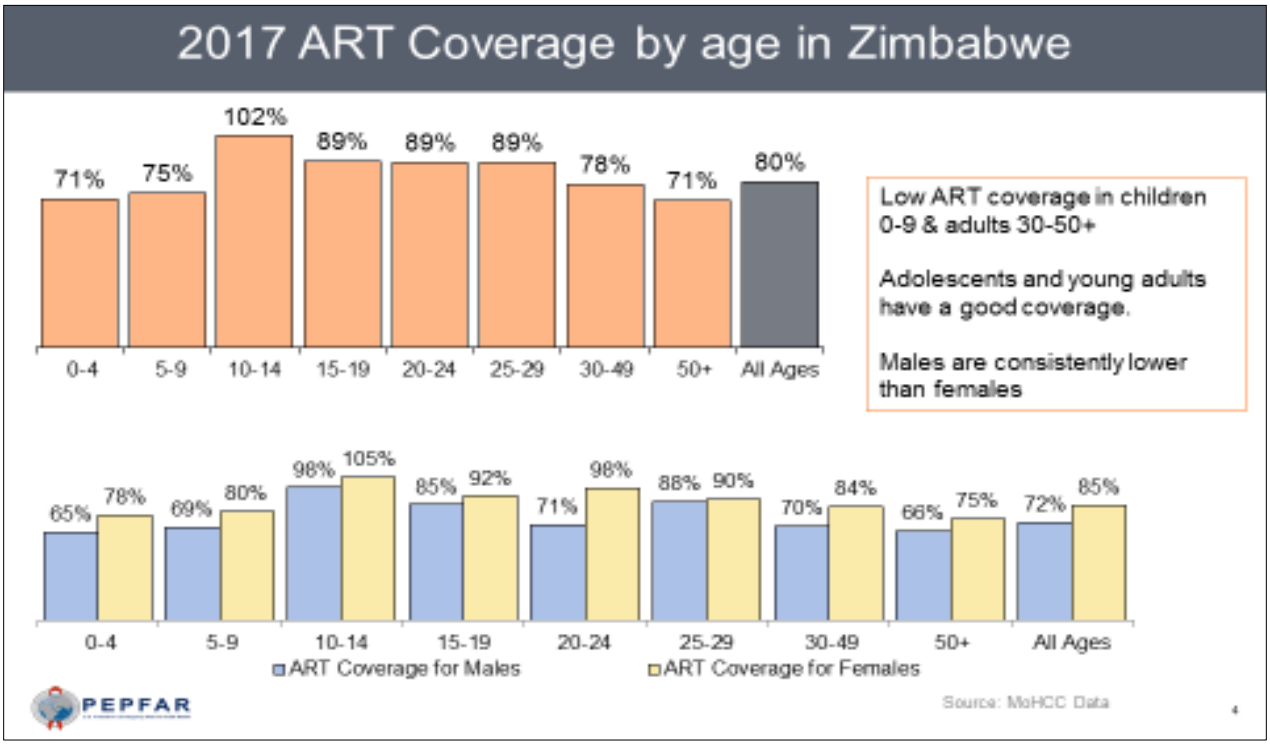
Adult Men:

ZIMPHIA and program data have revealed lower ART coverage rates among men compared to women, at 72% and 85% respectively at the end of 2017. This differential is consistent with lower success towards the 1st 90 among adult men 15 years and older (86% knowing their HIV status vs. 93% among adult women 15 years and older). As such, ART initiation strategies to reach this sub-population will be paired with PITC, index case testing and self-testing strategies to link them to treatment and to emphasize same-day ART initiation among those patients, both at the facility

and community levels. In high ART gap districts, the emphasis will be on facility-based DSD to improve linkage to ART; in lower-gap districts, efforts will be intensified to accelerate community ART initiation, and facility-based TA will focus on rendering facilities more "male friendly" through extended hours, sensitization of health care workers, and pairing ART initiation with community outreach activities.

Adolescent Girls and Young Women

Through the use of Community Adolescent Treatment Supporters (CATS) in the game changer Zvandiri model, PEPFAR has significantly improved ART coverage among adolescent girls and young women aged 15-25 years to 95% at the end of 2017 as illustrated in the figure below.

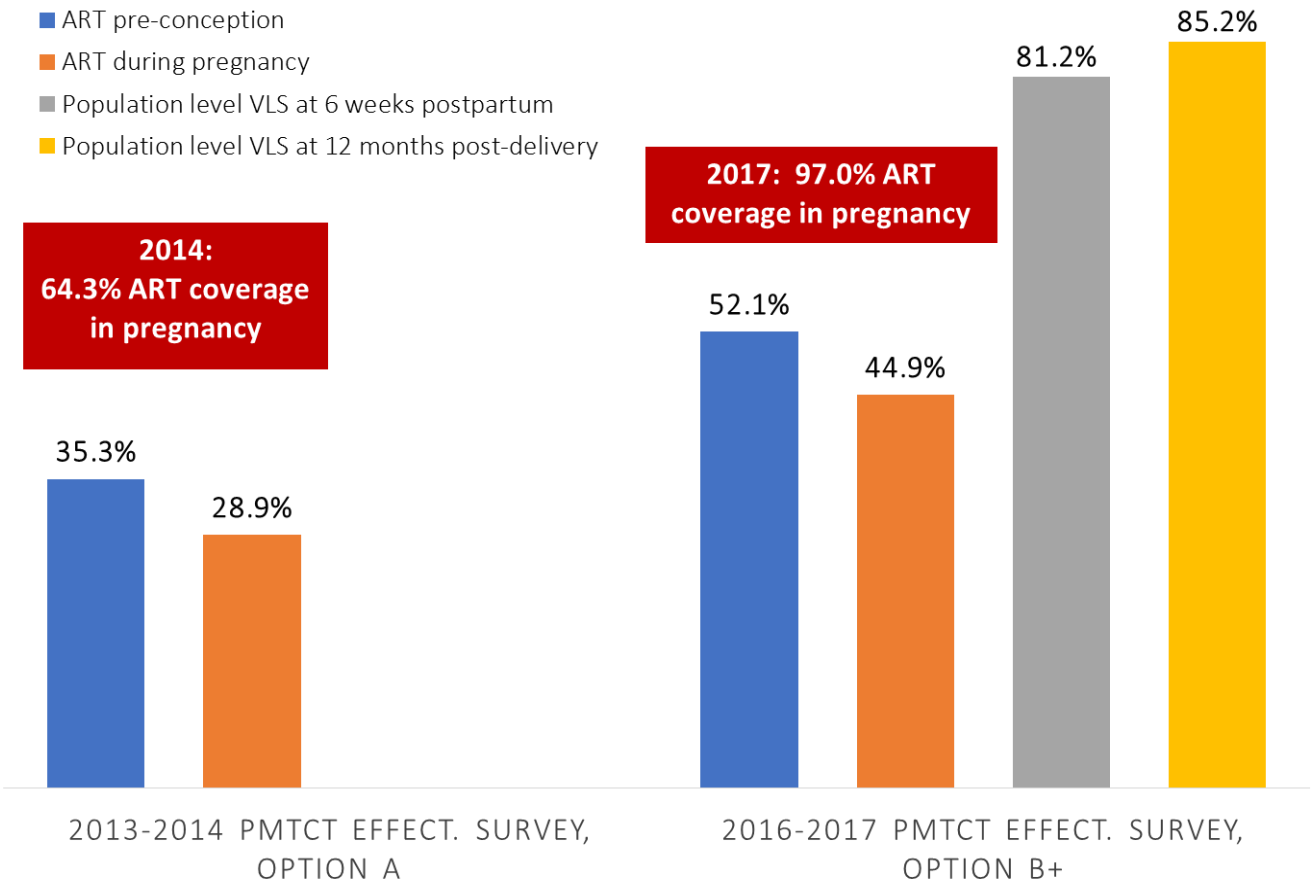


Nevertheless, program data suggest that proxy linkage among adolescents lags behind the general population. In order to improve linkage to ART in this population, PEPFAR partners will strengthen support groups and other peer-led strategies to encourage timely ART initiation. Clinical partners will also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

Adult women/PMTCT:

Data for HIV positive pregnant women from the national PMTCT Effectiveness Survey 2016-2017 has shown that over half (52%) are coming in with already known status and already on ART while 45% are initiated during pregnancy, giving an overall ART coverage in pregnancy of 97% (see Figure below). This trend is expected to continue in COP 18 where PEPFAR support will help to identify 15,002 new and 23,230 previously-diagnosed positives and approach 100% ART coverage in pregnancy. Programmatically, gaps include the fact that not all HIV positive pregnant women are getting initiated on ART and challenges identifying women who do not return for subsequent medication pick-up. In COP 17, IPs are conducting additional mentorship for both government and their own seconded staff on ART initiation to ensure trained ART initiators are available at each site offering PMTCT services. ART services should be routinely available within the antenatal clinics and the additional staff being mentored will be expected to provide roving coverage for unexpected absences such as sick leave. Site level analyses have not shown any major challenges with the supply of antiretroviral medicines but it has been difficult to keep track of whether or not women are coming back for refills due to lack of 2018 appointment diaries. The re-printing and distribution of new appointment diaries is on-going. In the meantime IPs are providing some diaries in selected high volume sites.

In COP 18, the PEPFAR program will continue to ensure all HIV positive pregnant women are linked to ART initiation, through both DSD and TA support based upon site-specific needs. Sites will be supported to conduct monthly linkage analyses to look at their performance and to identify and correct bottlenecks. Follow up systems to call back clients who miss appointments will be re-emphasized as the appointment diaries become more widely available. Finally, the roll-out of EHR in more districts during FY 19, will provide much needed data quality and efficiency in assessing linkage, as well as identifying defaulters.



ART coverage in pregnancy in Zimbabwe, PMTCT effectiveness survey, 2017-2017.

In COP 17, PEPFAR support expanded to all sites within the 40 scale-up districts (irrespective of patient volume). This will ensure increased coverage for ART initiation within PEPFAR supported districts and will also allow implementing partners to strengthen PMTCT support at increasingly peripheral sites in line with MOHCC's decentralization policy.

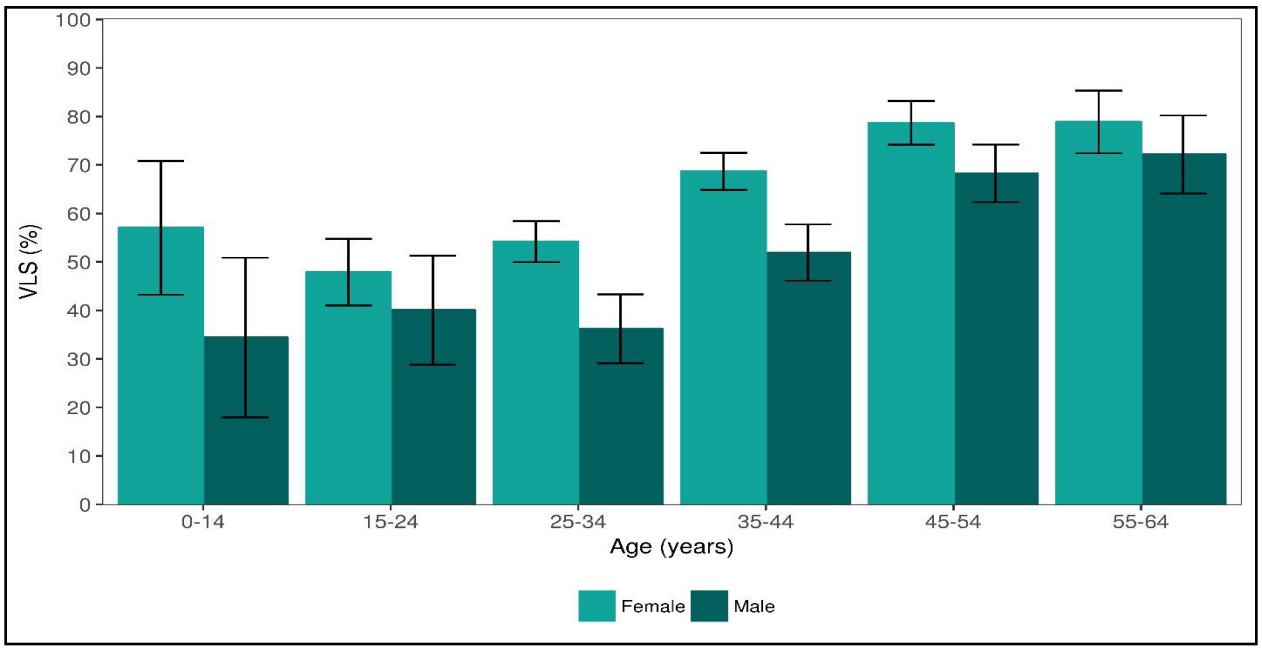
Children

The MOHCC's National Accelerated Action Plan for Pediatric and Adolescent ART in Zimbabwe – 2015-2018 has been merged with the Start Free, Stay Free, AIDS Free plan. Based on this and other bottle neck analyses, individual district implementation plans (DIPs) for pediatric and adolescent ART were developed. While these plans and targets therein will need to be revised based on the new survey data, they remain the overarching guidance for pediatric HIV service provision in the country. PEPFAR partners will work directly with district health teams to implement these plans in each supported district. Among other activities, partners will set weekly targets for HIV testing/treatment initiation by the different age bands (0-4, 5-9, 10-15), and conduct performance analyses. The PEPFAR program will continue to support nurse–led pediatric ART initiation through site-level DSD/TA and blended learning approaches, while strengthening integration of HIV within routine child care services. Administration of new pediatric formulations (e.g. LPV/r pellets) will be supported as the guidance from the MOHCC is released. PEPFAR partners will

support the decentralization of early infant diagnosis (EID) and the Integrated Specimen Transport system while strengthening the delivery of EID results to reduce the turn-around time. Positive EID results will be treated with urgency and the patients will be followed up and initiated on ART as soon as possible.

Retaining them

On World AIDS Day 2016, Zimbabwe officially released revised treatment guidelines in accordance with the 2015 WHO recommendations and these guidelines were accompanied by an updated Operations and Service Delivery (OSDM) manual which gives guidance on the "how to do it" with the aim of increasing retention at all steps of the cascade. PEPFAR Zimbabwe will continue to support the operationalization of this manual and specifically support the roll-out of differentiated service delivery models. PEPFAR Zimbabwe will specifically support expansion of Community ART Refill Groups (CARGs) to ~30% of interested clients over 15 years old on treatment in all PEPFAR supported districts with an emphasis on rural districts. CARGs will be tailor-made to address the needs of specific sub-populations e.g. adolescent men-only CARGs and cross-border CARGs to cater for ART patients working in South Africa and Botswana. Fast-track ART refills, multi-month scripting and dispensing (MMSD) DSD models will continue to be supported to ensure patients adhere to their treatment and are particularly important for men who have often cited work commitments as factors hindering adherence to appointments and/or drug pick-ups. PEPFAR Zimbabwe will support revitalization of widespread treatment literacy amongst ART patients. ZIMPHIA revealed viral suppression rates for children, adolescents and young people are much lower than adults (see Figure below). Males also have consistently lower viral suppression rates compared to their female counterparts.



ZIMPHIA Viral Suppression amongst PLHIV 0-64 years by age and sex

Expanding access to routine viral load monitoring improves treatment quality, contributes to adherence and subsequent retention in care. PEPFAR Zimbabwe will continue its support of Zimbabwe's national viral load scale-up plan (see sections 4.4 and 4.5 below) and will support prioritization of viral load access to children, adolescents, pregnant and lactating women.

Moreover, one of the national data gaps which has been noted with concern is the intersection of HIV with disability. At this point, it is not clear what percentage of PLHIV across the country struggle to access services or to remain adherent and virally suppressed as a function of physical and/or cognitive impairment. To this end, PEPFAR partners will begin generating some data from the patients served at the clinics they support; their goal will be to inform all stakeholders of the impact of disability upon HIV epidemic control, and specific interventions which may be useful to overcome these barriers. PEPFAR partners will also directly engage Disabled Peoples' Organizations with the aim of promoting HIV and AIDS responses that address needs and empowerment of persons with disabilities.

Adult Men:

Strategies to retain men will largely focus on expert client deployment, defaulter tracing, and the acceleration of differentiated service delivery in order to reduce clinic visit frequency for stable patients. In order to improve defaulter tracing, PEPFAR will increase support to improve documentation within facility registers through on-site mentorship as well as supporting the development of enhanced defaulter tracking tools for use in health facilities. The tools will be standardized for all the PEPFAR-supported districts and expanded to the national program. In turn, health facility workers, outreach workers, and VHWs' time will be better utilized to track "real" defaulters and return them back to care. Addressing defaulter tracing is even more critical as treatment initiation continues at a rapid pace and as CARGs are expanded. Enhanced adherence counseling sessions will be undertaken for defaulters and those with high a viral load to ensure they are retained on treatment and in care.

Programmatic data on defaulter tracking in FY 17 compared to FY 18 Q1 revealed that with better documentation, the rate of return to care significantly improves as the system is able to pick true defaulters. Systems-level interventions such as the EHR and the laboratory information management system (LIMS) will improve the identification and management of defaulters, as well as facilitating differentiated care based upon viral load results.

Adolescents and children:

Ongoing support to the CATS model specifically targets adherence and retention among HIV positive adolescents and children in the 40 PEPFAR supported districts. This model will be expanded to all high-volume facilities, and intensified in districts where the gap is highest for these groups, in order to reach a greater percentage of the population in need. Preliminary evaluations of the model have revealed that virologic failure is associated with poor treatment literacy and gender norms; as such, treatment literacy efforts will be intensified to ensure that adolescents and children living with HIV and their caregivers recognize the importance of ongoing ART adherence. The TA and DSD package of services to facilities will also include

sensitization on pediatric and adolescent retention strategies, as well as viral load prioritization.

Adult women/PMTCT:

In the PMTCT program, identified challenges include prioritization for viral load monitoring, coordination of facility and community services to support adherence and retention, and weaknesses in tracking referrals and defaulters. Currently there is a widespread re-orienting of antenatal clinic staff towards the provision of differentiated care/stratification depending on viral load results. Sites are being assisted to document action taken upon receipt of viral load results. The development of the community level package of services, and the mapping of potential partnerships among CSOs and PLHIV networks to support adherence/retention in care for women and children is an on-going process.

In COP 18, monthly support for site level data analyses will be maintained with selected sites identified to develop eMTCT specific, patient-level viral load cascades. Appointment diaries will also assist with tracking of missed appointments and will include due dates for viral load testing to make sure clients do not miss their tests. Engagement of CSOs will be formalized with specific deliverables laid out. The revised treatment literacy package will address issues of adherence and retention in care as well. IPs will ensure these issues are addressed in the CSO/PLHIV interactions with their constituencies. PEPFAR support for the convening of the national eMTCT partnership forum will continue and various MOHCC departments, including reproductive health, adolescent and sexual health, family planning departments, etc., will continue to participate. Formation of sub-groups to coordinate these activities will be encouraged.

The private sector continues to need support in order to provide services as prescribed in the national guidelines as well as report performance data to MOHCC. Most are confined to major urban centers where they provide services to a sizable portion of pregnant women. A mapping of private sector facilities in each district will be conducted in COP 18. Direct engagement of each provider will follow with assessments of their needs completed soon thereafter. Each provider will then be assisted to strengthen areas for improvement and enable reporting to the MOHCC in a sustainable way.

The program tracking and referral systems remain paper based and the eMTCT program is eagerly anticipating the rollout and scale-up of the EHR system, which will play a huge role in longitudinal tracking of clients (mother – baby pairs). At the health system level, retention in care for all sub-populations will also be supported through investments in Procurement and Supply Chain (including the transition to TLD) in order to ensure uninterrupted supply of ARVs (see section 4.4 below); the transition to TLD is also anticipated to improve retention as a function of its favorable side effect profile.

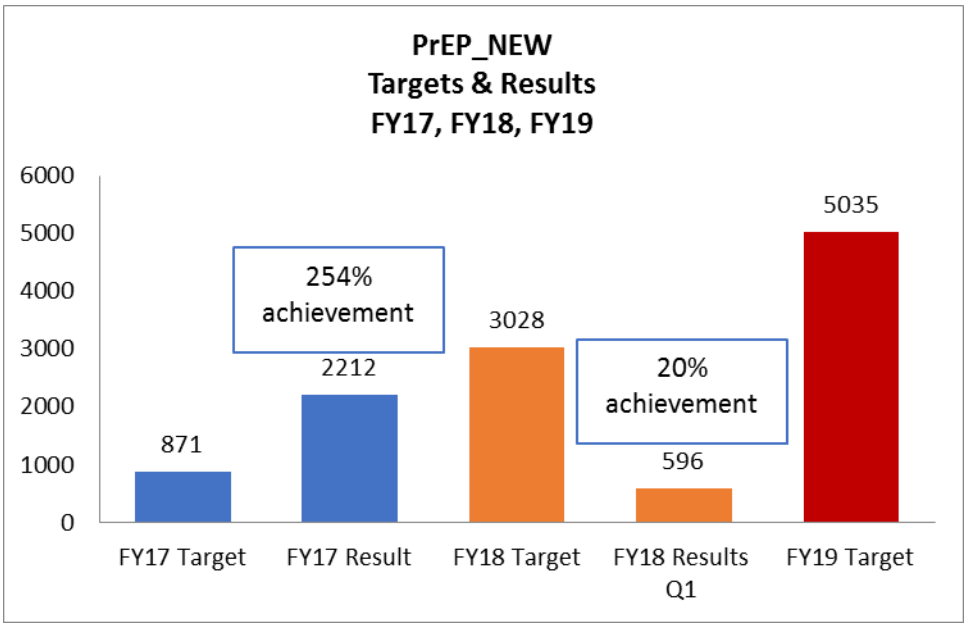
4.2 Prevention, specifically detailing programs for priority programming:

HIV prevention for priority populations is a key strategy in COP 18, with prevention activities tailored to specific populations being delivered through VMMC, HTS, PMTCT and ART services, as well as through the DREAMS and OVC platforms. Targeted priority populations include

AGYW between 15-24 years old, who are 3.6 times likely to be living with HIV than their male counterparts (9.8% as compared to 2.7%, according to the ZDHS, 2015), children (through prevention of vertical HIV transmission), MSM, FSWs, and men under the age of 30, with a focus of linking this group to HTS and VMMC. In addition, in COP 18 there will be an enhanced emphasis on HIV risk avoidance and sexual violence prevention for younger girls between 9-14 years old, as well as, for adolescent boys through the OVC program.

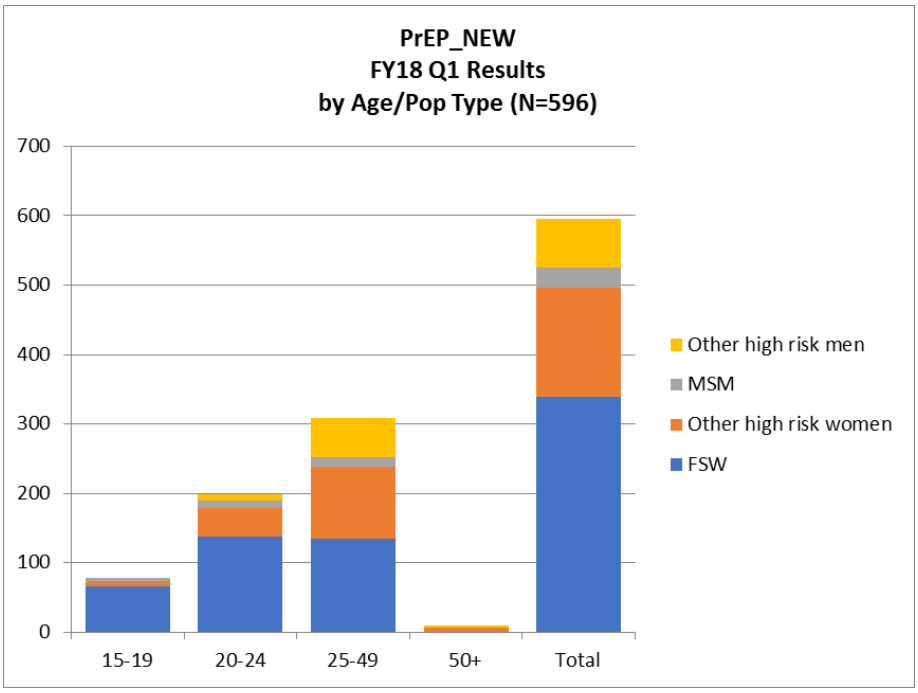
PrEP is a key prevention strategy for the AGYW who sell sex, FSW and MSM and is currently available in five New Start Centers, as well as through public sector sites in Mazowe and Makoni districts. A national TWG led by the MOHCC meets regularly to guide implementation and several PrEP readiness activities have been completed including a value chain situation analysis, oral PrEP roll out scenarios, costing and cost effectiveness analyses, and drafting of a national operational framework and implementation plan. In addition, a half day training module was developed for the HIV in-service training program for clinicians, as well as IEC materials and national site readiness tools. A knowledge, attitude, practice and behavior survey of health providers and a series of community engagement forums were held to garner input for PrEP roll out and communication. As part of DREAMS, an Empathy, Insight and Prototyping exercise was carried out to identify barriers and enablers to PrEP uptake among young women selling sex and young women transacting sex. Findings from this enquiry are being used to refine service delivery modalities and communication and support strategies in DREAMS.

The chart below summarizes PrEP_NEW targets and results from FY17 and FY18 Q1.

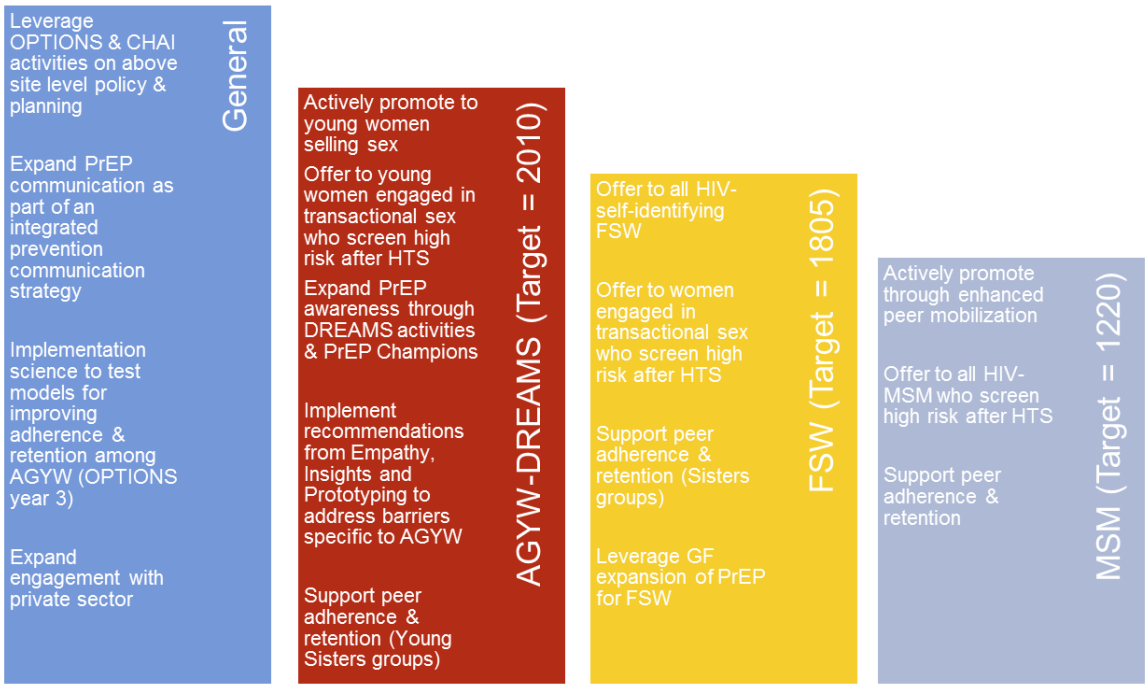


The total PrEP_New target in COP 18 is 5035 which accounts for AGYW in DREAMS, FSW and MSM. While PEPFAR is currently reaching mostly females a significant number of high risk men, including those in serodiscordant relationships or who screen high risk for other reasons (has multiple partners, low condom use, has a partner with unknown status, etc.) have taken up PrEP. In COP 18, should Gilead continue to provide PrEP drugs for AGYW in DREAMS, COP procured

drugs will be shifted to allow for PrEP provision to serodiscordant couples in existing sites where current investments for service delivery can be leveraged.



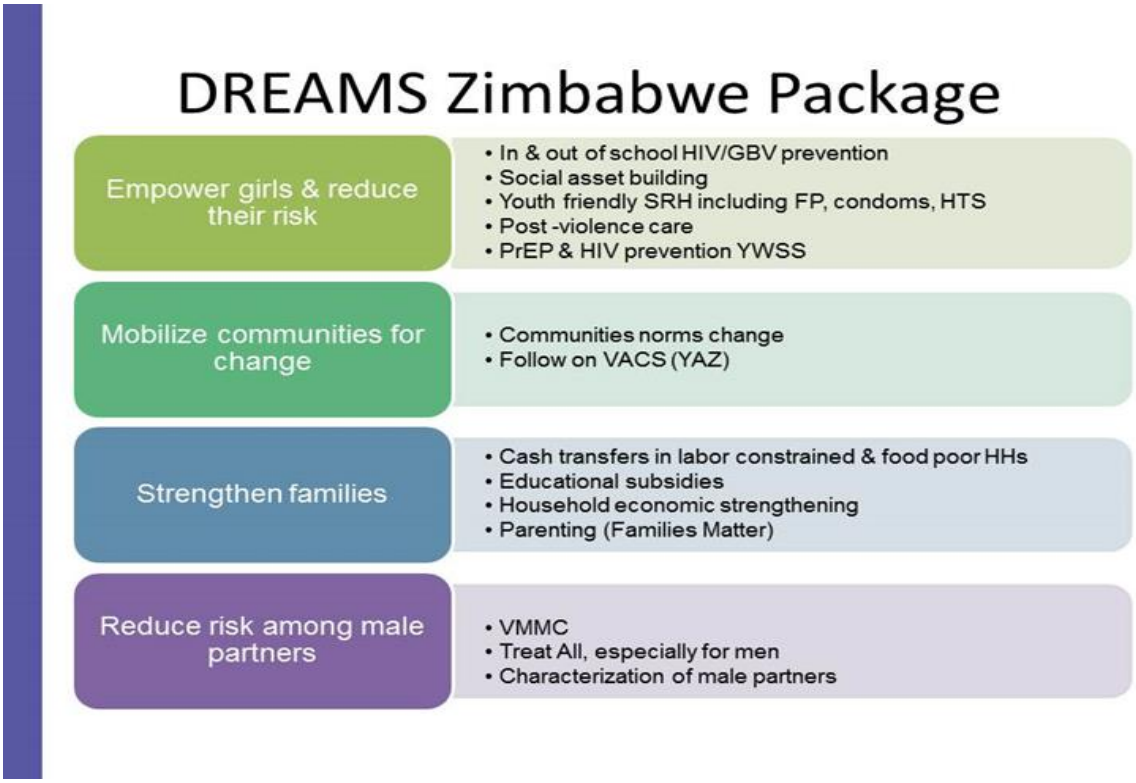
The COP 18 strategy for PrEP is summarized in the graphic below.



A gender analysis undertaken in COP 16 documented several issues that influence HIV prevention. These include low utilization of HIV services among men; high prevalence of GBV; numerous gender, cultural (and religious) practices and norms that fuel HIV transmission and/or treatment avoidance; and persistent stigma towards MSM and FSWs in the healthcare setting. Findings are being used to develop and/or improve male and adolescent friendly services; GBV screening, counselling and referrals in ART services; availability of male lay/peer cadres for counselling; psychosocial support for groups that have particular challenges with lifelong ART; and rights based training that promotes accepting and positive attitudes towards adolescents, MSM, and FSWs. Partners will work closely with traditional, community and religious leaders to promote positive gender norms and health seeking behaviors.

A. HIV prevention and risk avoidance for AGYW and OVC

Zimbabwe is currently implementing the full DREAMS package (shown in the figure below) in six districts: Bulawayo, Chipinge, Gweru, Makoni, Mazowe and Mutare.

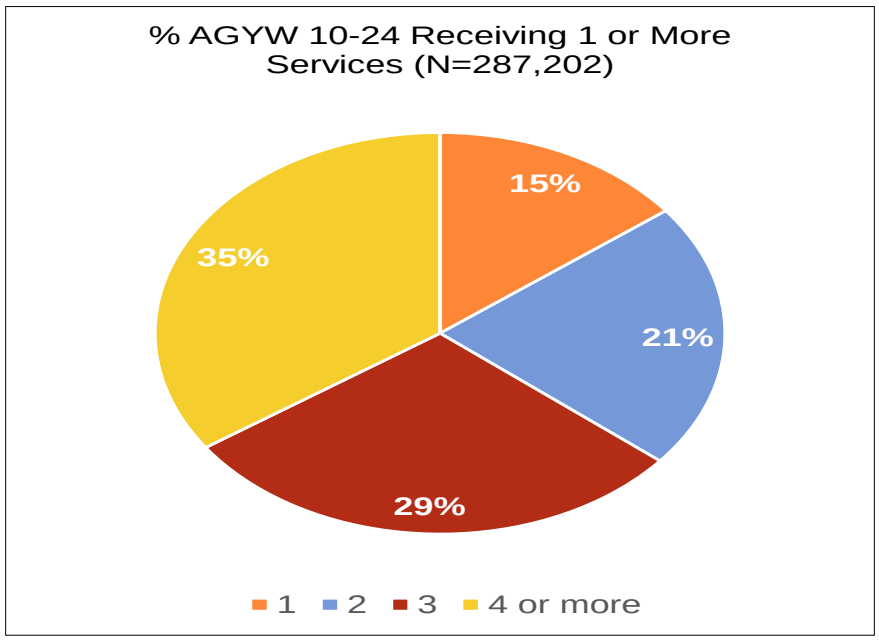


Vulnerable AGYW targeted through DREAMS include young women selling or trading sex (YWSS), out-of-school girls aged 15-24 years, OVC, GBV survivors, and economically disadvantaged AGYW and their caregivers. In addition, comprehensive sex education (CSE) programs reach both girls and boys in secondary schools. Regardless of the entry point, AGYW are assessed and referred for other DREAMS services according to minimum service packages defined by sub-population, using standard tools and referral procedures. The program employs a DHIS-2 (District Health Information System) database with unique identifier code to track

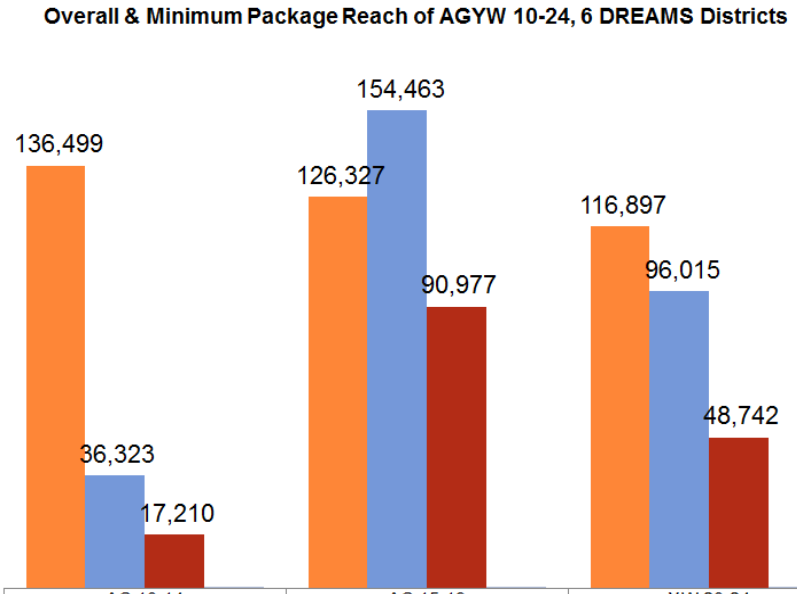
individuals, and layered services and referrals which provide visibility into strengths and weaknesses in the program. In COP 18, the DREAMS database will be further refined to better track referrals and to generate more granular data on specific sub-populations. Furthermore, PEPFAR will support NAC to adopt a simplified version of the database for use in the Global Fund districts.

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. In FY 18, NAC is expanding DREAMS to four additional districts with Global Fund assistance.

As of FY 18 Q1, 287,202 AGYW 10-24 years had been enrolled in DREAMS and 64% had received three or more services. DREAMS is on track to reach high levels of coverage among AGYW 15-24 years; as of FY 18 Q1 the majority in the 15-19 and 20-24 year age groups had received the minimum package (see figure below). This is likely an underestimate of the extent of layering since the DREAMS database is not yet able to capture individuals in households receiving cash transfers or services provided by partners outside of the DREAMS network including those in the public sector.



- Among AGYW 15-24 being reached, majority getting min package
- Robust systems in place to identify, screen & refer the most vulnerable
- Gaps remain among the AG 10-14



	AG 10-14	AG 15-19	YW 20-24
2015 Pop	136,499	126,327	116,897
Reached through 12/31/17	36,323	154,463	96,015
Reached with Min Pack	17,210	90,977	48,742
% Reached Min Pack	47%	59%	51%

A series of review meetings at district and national levels were carried out in late FY 17 to assess progress to date, troubleshoot challenges, and begin planning for the transition to a maintenance phase in districts reaching saturation in FY 18. This informed planning for COP 18 and guided the proposed directional shifts, as summarized in the figure below.

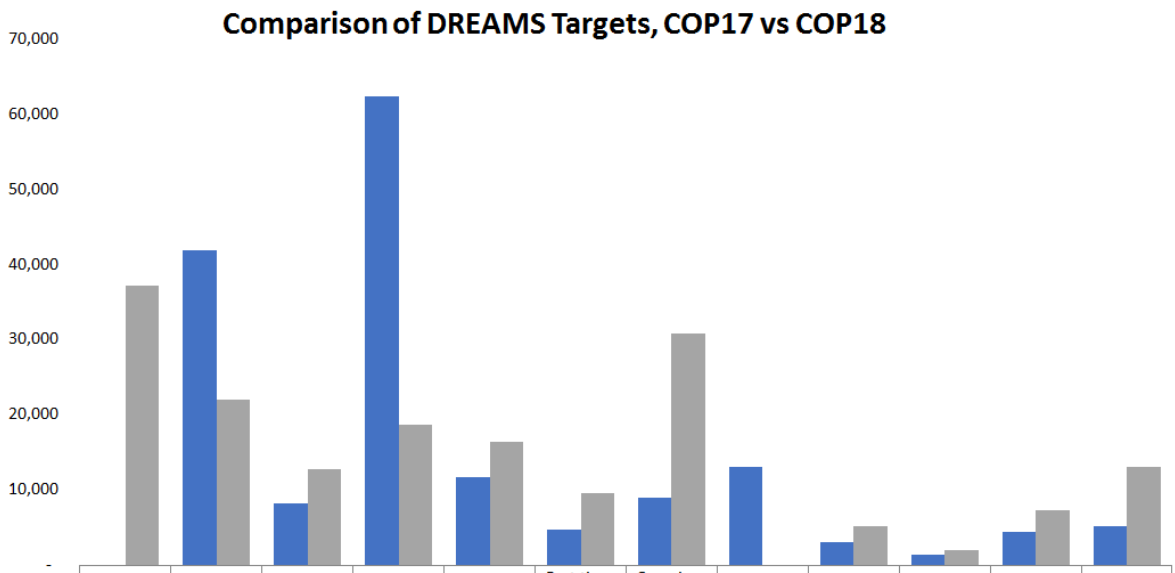
Scale up focus on AG 9-14	*Maintain services for the most vulnerable AGYW 15-24*	*Identify efficiencies & transition when appropriate*
☐ Develop age appropriate risk avoidance/violence prevention program for younger AG	☐ Implement a more holistic, but highly targeted approach for most vulnerable AGYW 15-24	☐ Institute maintenance package for secondary school CSE program
☐ Continue focus on this age group in secondary schools & expand to primary	☐ OVC, out of school girls, YWSS, teen/single mothers, economically vulnerable	☐ Transition out of cash transfers, but maintain educational subsidies & expand to 12-14s
☐ Leverage OVC program to expand depth & variety of services to AG 9-14	☐ Continue support for post violence care, PrEP, FP outreach, access to HTS and STI services using most appropriate modalities	☐ Streamline implementation arrangements to improve efficiencies, including targeting
☐ Continue community norms work but update focus on sexual violence prevention & risk avoidance for younger AG	☐ Continue active linkage of HIV+ AGYW to CATS	☐ Improve alignment with OVC program so all female OVC in DREAMS districts access the DREAMS package

A key shift in COP 18 is the increased focus on risk avoidance and violence prevention for girls 9-14 years. This will require adaptation of existing approaches in schools and the community norms programs, as well as expansion of DREAMS into primary schools. In COP 18, curriculum and materials will be reviewed to assess delivery and content to ensure sufficiently emphasis on knowledge and skills building for younger adolescents around sexual consent, healthy choices about sex, and prevention of sexual violence.

The other major shift in COP 18 is the move from a saturation approach for AGYW 15-24 years, to one that is more targeted. Once minimum package coverage levels are confirmed through the DREAMS database (by age group and district), districts will move into a maintenance phase targeting the most at risk AGYW such as OVC, out-of-school girls, GBV survivors, YWSS, and teen/single mothers with a comprehensive package of services. Access to condoms, post violence care and the provision of clinical services such as HTS, PrEP and family planning, will continue to be prioritized in COP 18 and delivered using the most effective modalities (e.g. Stop the Bus). PEPFAR will continue to draw on the Empathy, Insights, and Prototyping approach (adapted from Human-Centered Design) to increase PrEP and family planning service uptake among AGYW; COP 18 targets for both indicators were increased to reflect the upward trajectory already observed in FY 18 Q1. All HIV positive AGYW will continue to be actively linked to ART and to CATS for adherence and retention support.

As agreed in COP 17, DREAMS will no longer fund cash transfers in COP 18. Investments in educational subsidies, part-time continuing education, work readiness and caregiver interventions such as Families Matter and internal savings and loans groups will be increased to mitigate the loss of disposable income that may occur. Furthermore, in the second half of FY 18, PEPFAR will work closely with UNICEF, OVC partners, NAC, MOHCC and the MOLSW to carry out a transition plan for these households.

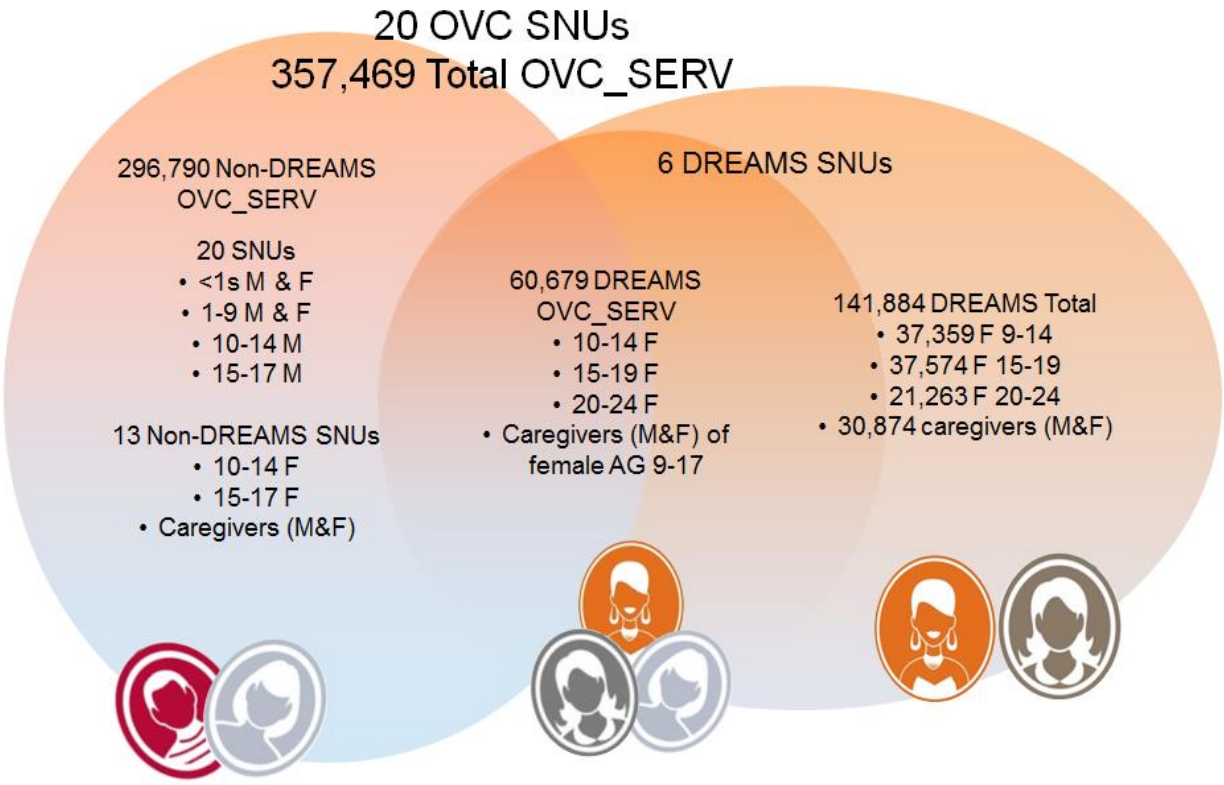
COP 18 DREAMS targets, reflecting the strategic shifts from COP 17 described above, are shown below:



	In-school HIV-GBV curriculum 9-14	In-school HIV-GBV curriculum 15-19	Out of School HIV-GBV curriculum 15-19	Out of School HIV-GBV curriculum 20-24	Ed subsidies 12-19	Part time cont'd education /work readiness 15-24	Caregiver interventions (Families Matter & ISALs)	Cash transfer (households)	KP_PREV 15-24	PrEP_NEW 15-24	GEN_GBV 9-24	Family Planning 15-24
COP17 (6 Districts)		42,103	8,331	62,590	11,749	4,815	9,017	13,151	3,094	1,458	4,450	5,251
COP18 (6 Districts)	37,359	22,119	12,786	18,724	16,540	9,677	30,873	-	5,209	2,010	7,346	13,163

Activities that reduce the risk of HIV acquisition among male sexual partners and onward transmission of HIV to adolescent girls and young women will continue to be fundamental in DREAMS districts. The DREAMS core package includes community norms change activities to increase understanding and engagement on sexuality, gender and masculinity, sexual and reproductive health, violence, and positive parenting among traditional and religious leaders. Male mobilizers coordinate Men's Wellness Days which include community dialogues, health information and delivery of HTS, VMMC and STI screening services (provided by the MOHCC and implementing partners). In addition, PEPFAR will continue to reach adolescent boys who participate, per MOPSE guidance, in the general assembly and teacher-led classroom comprehensive sex education sessions in DREAMS districts. DREAMS funded a follow on VAC survey, locally known as YAZ (Young Adult Survey of Zimbabwe), and preliminary findings are expected in the third quarter of FY 18. PEPFAR also supported a study to identify the sexual networks, partners, and behaviors of HIV positive AGYW. Further analysis of the ZIMPHIA and ZDHS will be undertaken to shed light on the demographic characteristics of male sexual partners, the type of partnerships/relationships, and venues where adolescent girls report meeting these males.

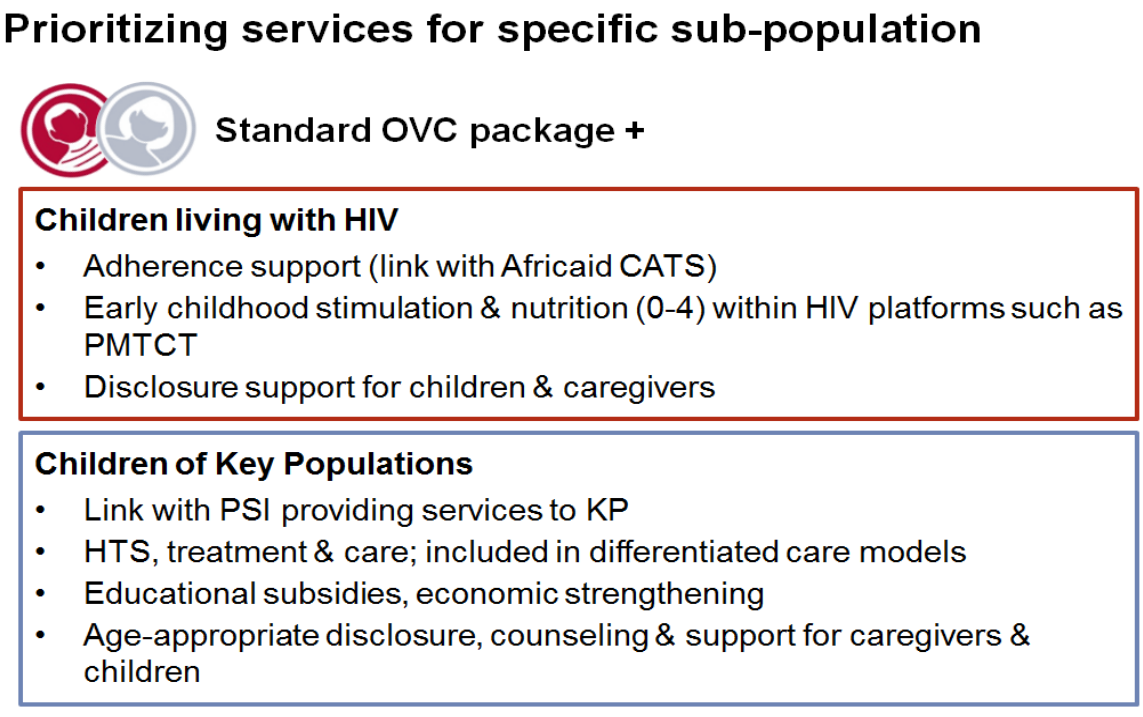
In COP 18 DREAMS will continue to leverage the OVC platform to ensure vulnerable female OVC access the full DREAMS package and AGYW (including their young children) identified through other DREAMS entry points access OVC services as required. The figure below illustrates the positioning of OVC services targets in the broader OVC program and DREAMS.



The PEPFAR OVC program demonstrated excellent performance in FY 17, reaching 118% (450,551) of the COP 2016 OVC services target of 381,733. In FY 18 the OVC program is implementing a number of program enhancements including an age pivot in order to shift focus to specific sub-populations (children less than 1 year, between 9-14 years old, AGYW); an improved monthly reporting structure; refining service packages to be responsive to specific sub-populations; and strengthening linkages between community and clinical services.

In COP 18 the OVC program will operate in 20 PEPFAR districts, targeting a total of 357,469 OVC and their caregivers, and will focus on contributing to epidemic control as well as ensuring children infected and affected by HIV access health, education, and socioeconomic support services according to their needs. As part of the planning for COP 18, PEPFAR reviewed progress and challenges in reaching priority sub-populations and available country and program data to inform size estimates and targeting strategies. Given the age pivot that is currently underway, and the need to ensure responsible transitioning of beneficiaries, it was decided to maintain COP 17 targets by age/sex group for COP 18, with the exception of DREAMS districts where an alignment process was undertaken. Service packages were then updated by sub-population as illustrated in the figure below.

In COP 18 services for specific sub-populations will be expanded as below.



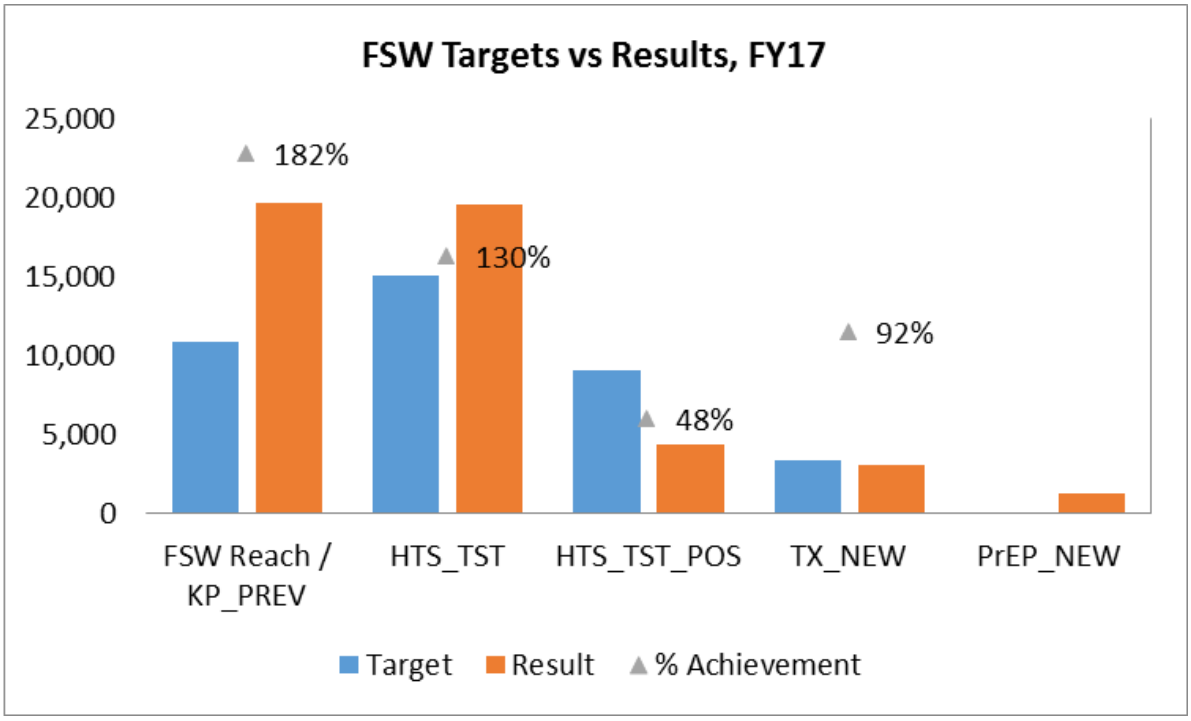
Moreover, in COP 18 PEPFAR will intensify HIV risk avoidance and sexual violence prevention activities using the OVC platform through the following activities:

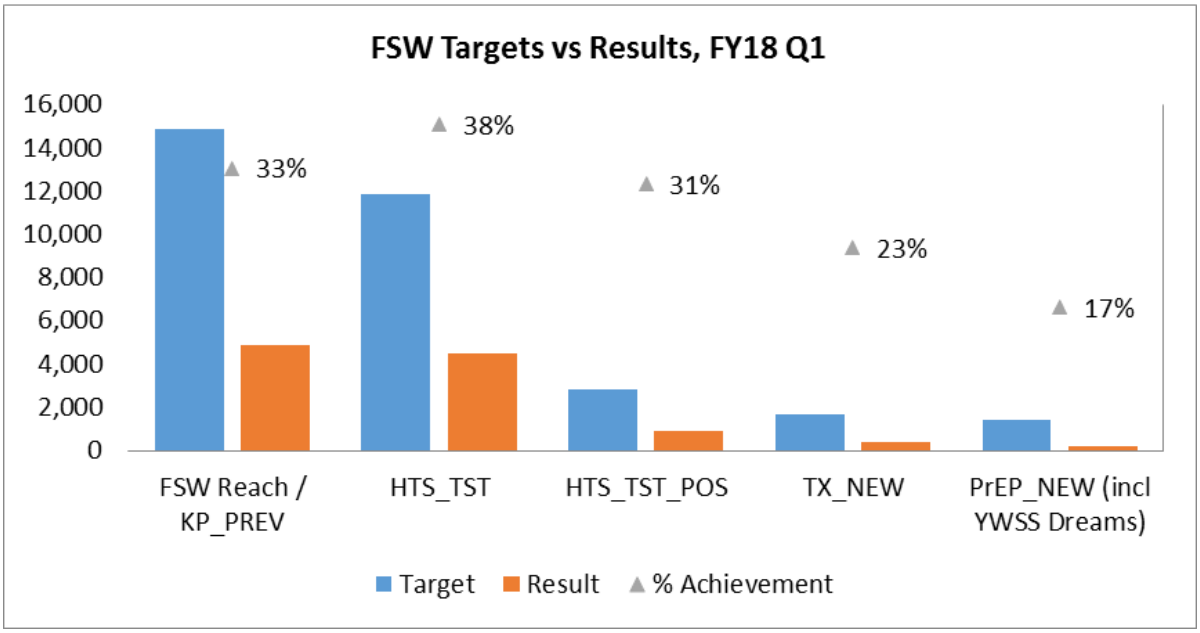
- **Keeping OVC in school:** Education for girls is associated with delayed marriage and child-bearing, better incomes, and greater decision making power within relationships. PEPFAR will continue to provide educational subsidies to OVC, prioritizing adolescent girls, in order to retain them in the protective school environment and ensure their progression in the school system. PEPFAR will support primary, secondary, part-time continuing education and vocational skills training through paying fees, stationery, uniforms and exam fees. PEPFAR will leverage MOPSE's non-formal education initiative that allows for re-integration of girls and young women who may have fallen out of the school system for whatever reason. The part-time continuing education approach also includes a strong social asset building component as a means of addressing self-esteem, confidence, and other psychosocial issues that may have contributed to school drop-out rates. All children in secondary school access the MOPSE comprehensive sex education program.
- **Enhancing parent/child communication:** PEPFAR will continue to utilize the Families Matter! Program which is a practical and evidence based parenting model aimed at improving caregiver–child relations and communications. Launched in FY 16 initially through DREAMS, the program has been well received by stakeholders and OVC caregivers as it addresses perceived gaps that have led to high HIV incidences among AGYW in the country**.**
- **School and club-based HIV & GBV prevention and social asset building:** OVC partners will continue to assist the MOPSE in administering the comprehensive sex education program in secondary schools and facilitate Girl Empowerment (GEM) and Boy Empowerment (BEM) clubs which offer more intensive sessions on reproductive health and life skills training, reaching adolescents with information and services that build self-esteem, confidence, and skills to delay sexual debut and prevent unplanned pregnancies and HIV. Menstrual hygiene features prominently in the GEM clubs as this is an issue that has been identified by girls as a driver in inequality, disempowerment, and dropout rates. All sessions are facilitated by trained facilitators using structured curriculum.
- In COP 18 curriculum and materials will be reviewed to assess delivery and content to ensure sufficient emphasis on healthy and unhealthy relationships, healthy choices about sex, prevention of sexual violence, and sexual consent, as well as skills-building components which are suitable for younger adolescents.

B. Key Populations

In COP 2016 a strategic decision was made to consolidate funding and make major shifts towards a more comprehensive and focused approach for key populations. Through expanded support of the national FSW program (Sisters with a Voice), and collaboration with community-based FSW networks, PEPFAR is identifying new targets and strengthening the clinical cascade among FSW in five urban locations with high numbers of FSWs: Harare, Bulawayo, Gweru, Mutare and Masvingo. This strategy is employing proven approaches for reaching, testing and immediately initiating ART for HIV positive FSWs, as evidenced by the strong performance in FY 17 and FY 18

Q1 (see figures below). This includes using a family-centered approach, and providing HIV services to the partners and children of FSWs.





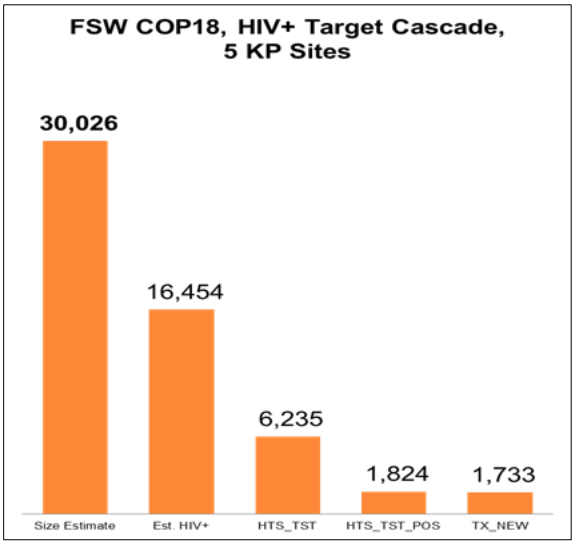
A variety of entry points are utilized in an effort to reach both self-identifying and 'hidden' FSWs who have had limited or no exposure to HIV services. In FY 17, 37% of women who reported transactional sex, but did not identify as a FSW, tested positive for HIV. Identification of these women, linkages between community and facility services, and follow up for FSWs has been challenging in the past, but is now being strengthened through the use of unique identifier codes (UIC) and screening tools. The development of microplanning tools is underway in the Sisters program, and definitions for 'contact' and 'reach' have been developed according to the intensity of interaction, follow up, and monitoring provided to different individuals.

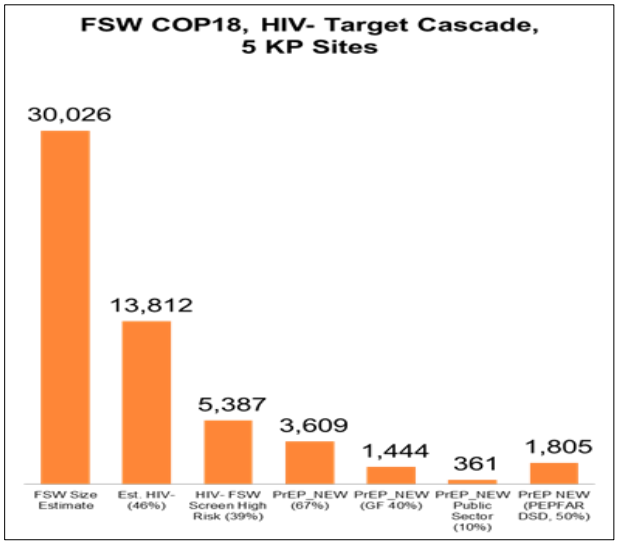
Distribution of self-testing kits through Sisters clinics has high acceptability, and the approach is being expanded in the community through the hair salon network. All HIV positive individuals are enrolled at public sector facilities or New Start Centers that offer a one-stop shop for health care (testing, sexually transmitted infection services, family planning, cervical cancer, post gender-based violence care, ART, TB, and laboratory services) and receive viral load monitoring at 6 and 12 months. Continuous adherence and retention support is offered through the Sisters peer adherence support groups, which integrate both PrEP and ART. ART review attendance is above 95%, and retention at 12 months is at 90%. HIV prevention (male/female condom and lubricant distribution, risk reduction counseling, and referral for HIV/STI/SRH clinical services), is delivered through a peer education (PE) approach. PrEP is currently offered to FSW at five locations through the New Start Center network.

While performance against specific indicators has been strong in the FSW program, linkages among those testing HIV positive to ART has been sub-optimal. There are several factors contributing to this including partners not using the same tracking tools (resulting in poor documentation), high mobility of FSW, use of false names and contact details in an effort to remain anonymous (resulting in a failure of the UIC system to match those who test in the community and initiate ART in the facility), cost of transportation, lack of sense of urgency and fear of being identified as HIV+ among peers. The program is currently conducting a linkage 'mop up' exercise, with initial results suggesting that 75% of those lost to follow up had actually enrolled in ART but weren't documented by the partner. All sub-partners are now using the same tracking template and detailed SOPs that clearly define linkages between partners, and between PEPFAR and public sector services, are under development. Going forward partners will conduct monthly reviews of referrals between partners and the public sector. In addition, as part of the KP friendly service initiative, KP members will be involved in facility management meetings to present client experiences and troubleshoot issues (such as stigma), and the most frequented public sector facilities will have peer navigation and support mechanisms in place. Values exploration and mentorship of health care workers is ongoing and is expected to reduce stigma and enable KP clients to disclose their true names and/or KP status.

Program and survey data suggest that 25-40% of FSW are less than 23 years old, with more than a quarter starting before age 20. Young FSWs report the highest numbers of unprotected sex acts with clients. They report more frequent HIV testing but they are the least likely to know they are HIV positive. HIV prevalence among young sex workers is approximately 30%, rising to nearly 80% among those over 40; prevalence rises with duration in sex work among young FSWs. Building on the work in DREAMS districts, efforts are underway to identify new and younger FSWs through an adaptation of the Sisters peer educator program specifically designed for this very hard to reach population. This effort will continue in COP18, with the Young Sisters program in the five sites that focus on key populations.

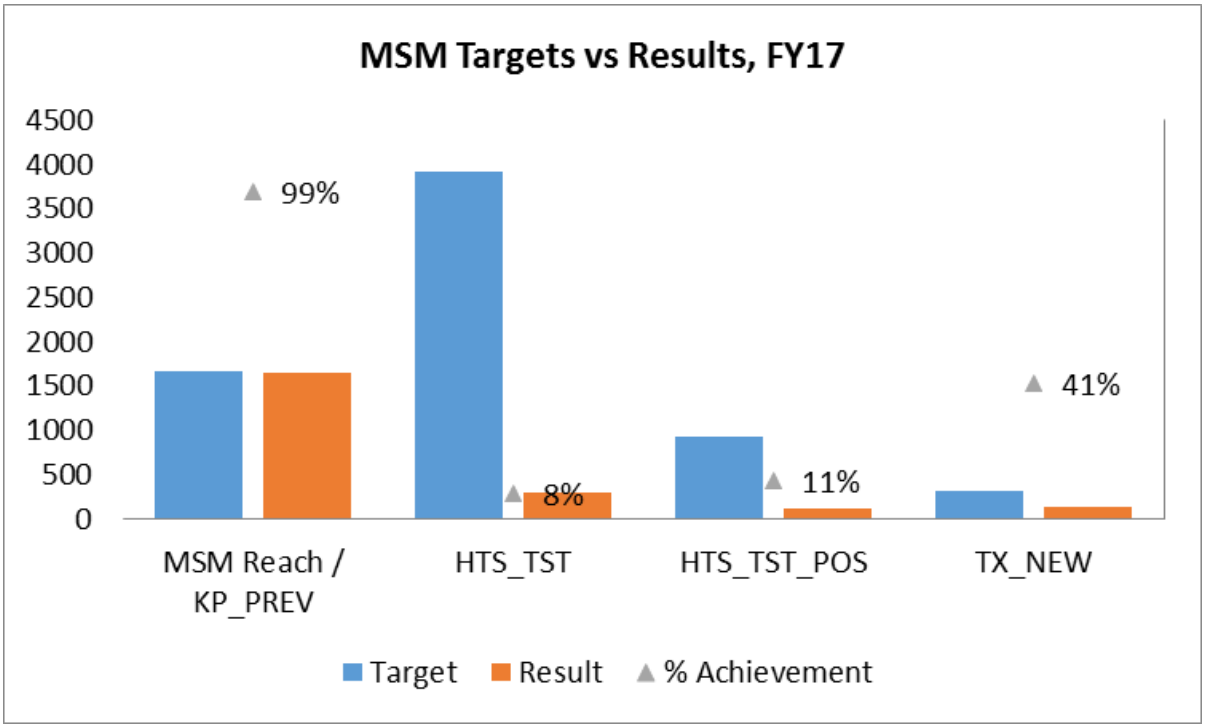
In FY 17 a FSW size estimate study was completed and the results were used as part of a consultative stakeholder process to generate urban and rural population estimates for all districts in Zimbabwe. This process yielded a 2019 national size estimate of approximately 46,000 FSW between 15-49 years. Common estimates (based on study results) applied across all districts estimate the number of FSWs living with HIV is 54%. Of those with HIV 78% know their status, of which 85% are on ART, and 85% of those on ART are virally suppressed. Program data was used to validate the number of FSW, ART coverage, and viral suppression rates in the five PEPFAR-supported locations that focus on key populations, which account for approximately 55% of the total number of FSW nationally. An additional 20% was added to the FSW size estimate to account for women engaging in transactional sex. COP 18 targets were set to reach at least 70% of FSWs and women engaging in transactional sex in the five locations with the goal of attaining 90% ART coverage of HIV positive FSWs. Importantly, COP 18 targets also assume full achievement of FY 18 targets, as well as substantial transitioning of stable FSWs on ART to the public sector (60% of those on ART through PEPFAR direct support at the end of FY 17). Targets for new recipients of PrEP through DSD were set based on program experience with screening, uptake, and retention among FSWs. PEPFAR targets for new recipients of PrEP were reduced to account for the approximately 50% of FSWs who will receive PrEP through Global Fund-supported or public sector sites.



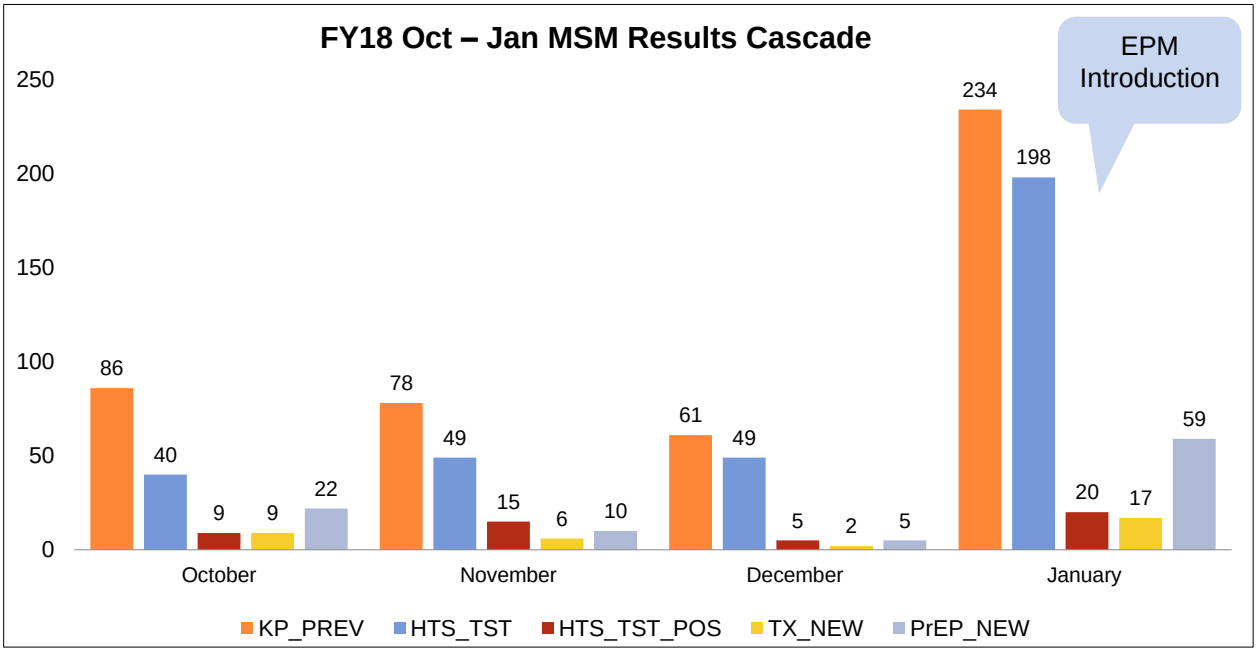


In the five locations that focus on key populations, the program is working with local MSM partners to identify and train peer educators to conduct inter-personal communication sessions on risk assessment and reduction, condom use, and referral into testing and other services. Condoms and water-based lubricant (procured through the Central Commodity Fund) are distributed. The use of social networking platforms, including WhatsApp and Facebook, are being explored to increase access to HIV information and services. The program is providing testing, PrEP, ART, STI management and viral load monitoring at 6 and 12 months for MSM at New Start Centers. Self-testing is offered via outreach at convenient locations/times through smaller MSM gatherings. MSM on ART are encouraged to disclose their status and have treatment buddies for adherence support. MSM groups are being supported to establish community adherence activities.

By the end of FY 17, PEPFAR had met 99% of its prevention target for MSM but the strong reach did not translate into uptake of clinical services, with low performance observed on testing, finding positives, and new treatment indicators.



In FY 18 Q1 the program introduced the Enhanced Peer Mobilization (EPM)model that strategically identifies peer educators from specific sexual networks, trains them, and incentivizes peer education and positive care seeking behavior (clinic visits, testing, ART, PrEP) among the recipients. PEPFAR has also identified new local partners which have helped to broaden and deepen reach in the MSM communities. Early results are promising and the Enhanced Peer Mobilization approach is being expanded to the two remaining locations that focus on key populations in FY 18 Q2. Ensuring all MSM testing HIV positive are initiated on ART is a priority and linkage strategies are being strengthened (see above description of linkages among FSW, which also apply to the MSM program).



A PEPFAR-funded MSM size estimation protocol has been cleared by the MOHCC and Medical Research Council of Zimbabwe, and is anticipated to begin data collection in FY 18. For the purposes of COP 18 planning, it was assumed that 1.5% of men in urban locations and 0.4% in rural locations are MSM. HIV prevalence among MSM is estimated at 23.5% based on 2013 unpublished research. COP18 targets were set assuming a reach of 30-40% of MSM in the five locations that focus on key populations, targeting 40% ART coverage among HIV positive MSM. Targets for new recipients of PrEP via DSD were set based on program experience with screening, uptake and retention among MSM and reduced to account for the approximately 10% of MSM who will receive PrEP through public sector sites.

In COP 17 PEPFAR began supporting key population friendly services in the public sector and in late FY 17 an assessment was carried out to guide that process. In the domains of drugs, commodities and space in particular, there is already substantial integration between the NGO and public sectors for service delivery to key populations. However, the situation is very different when comparing the FSW and MSM programs, with integration in the FSW program being much further along. Summary recommendations from the assessment follow.

	Sex Workers	MSM/TG
Strategic	• Strengthen national sex worker program, increase NAC/MOHCC ownership • Technical support (TSU)	• Priority is to gain trust of & access to communities • Strengthen networks linked to improved clinics (Wilkins, New Start, other sites)
Management	• Develop criteria to identify facilities • Need dedicated public sector staff with clear ToR, adequate capacity & support • Involve SWs in monitoring & QI	• Initially 'under the radar' with involvement of CBOs • Establish centers of excellence in existing New Start Centers • Involve MSM in monitoring & QI
Effectiveness	• Deepen integration of PrEP and ART provision at co-located Public/Sisters clinics • Strengthen STI services	• Expand and strengthen peer networks • Provide basic clinical package + STI/ART/PrEP at Wilkins, New Start, select new sites
Scale	• Phased, incremental focusing on areas of highest concentration of FSW • If resources allow, explore ~20 identified locations to extend coverage	• Prioritize Harare, Bulawayo, other urban areas
Intensity	• Extend micro-planning, achieve outreach and quarterly clinic targets	• Explore micro-planning, EPM, internet strategies, sex work interventions, etc

FY 18 Q1 updates on the status of integration of key population friendly services in the public sector include:

- DREAMS seconded positions at MOHCC and NAC were expanded to include key population facilitation/coordination.
- A technical working group was formed at the MOHCC.
- Preliminary public sector sites were identified.
- Harmonized site readiness tools and training materials are under development.
- A values exploration approach was tested.

In COP 18, PEPFAR will continue to support the roll out of key population friendly services into the public sector; however, expansion to additional sites is not planned until proof of concept is demonstrated. The following activities will be prioritized in COP 18:

- Build the capacity of health care workers in selected sites through clinical attachments, training in values exploration, gender sensitivity, and stigma reduction.
- Ensure appropriate models of peer support are in place in all targeted facilities such as patient navigators and peer educators.
- Develop patient transition plans and employ active follow up to ensure minimal loss of patients who are stable on ART and transitioning to public sector sites.
- Develop and test minimum service packages which are specific to type of key population.
- At each facility establish service monitoring and quality improvement committees which involve key populations themselves.
- Develop standardized training materials and M&E tools for use by all sites implementing key population friendly services. Of particular importance is the ability to track and confirm referrals between community and facility service providers.

It is important to note that the legal and social environment towards key populations, especially MSM, is not favorable and with elections in 2018 there are added risks that need to be carefully considered across the program. The current sites that focus on key populations will continue to be supported as long as there is a demonstrable need. Clients who are uncomfortable with the transition to public sector health services will not be forced, and care will be taken not to expose key populations to unnecessary risks to their health and security.

PEPFAR collaborates with UNDP, serving as a member of the Steering Committee guiding the Linking Policy to Programming (LPP) project. The LPP aims to improve sexual reproductive health outcomes for young key populations in Zimbabwe by addressing policy and legal barriers that limit their HIV and SRH-related rights. The Steering Committee is currently overseeing a second Legal Environment Assessment focusing specifically on young key populations (YWSS, young MSM, young people using drugs, young LGBTI, and young people in prisons). The report is expected in March 2018 will be used to generate recommendations and an implementation plan for addressing key structural barriers which impact the access of young members of key populations to services.

In COP 18 PEPFAR will continue to roll out differentiated models of care for key populations. Having different approaches is fundamental because meeting key populations where they are and with whom they trust is a cornerstone to engaging and keeping them in care. The types of services, frequency and location will also vary between FSW, MSM and LGBTI groups. In COP 18 the following enhancements and directional shifts will be made to the current key population program:

- Scale-up the Enhanced Peer Mobilization approach for greater reach into MSM and transgender communities.
- Continue to invest in and strengthen a broader base of local CBO/CSOs that work with key populations to expand networks, including unreached LGBTI populations, and support the identification and creation of safe spaces, particularly for MSM.
- Strengthen linkages between key population sites and the OVC platform to address the needs of children of key populations.
- Continue service delivery through New Start Centers and Sisters Clinics, but increase transition targets of stable FSWs on ART to the public sector.
- Ensure PEPFAR investments are complementary and not duplicative of Global Fund Support.
- Support the MOHCC and NAC to work collaboratively to develop and coordinate a single national key population plan that is inclusive of all donors.
- Building on the current DHIS-2 based UIC system used in the key population program, provide national-level technical assistance to MOHCC and NAC to develop data collection and reporting tools that will allow for referral tracking and more accurate reporting of results between PEPFAR and Global Fund.

C. Voluntary medical male circumcision (VMMC)

The Voluntary Medical Male Circumcision (VMMC) program in Zimbabwe has scaled up remarkably, with well-coordinated leadership from the MOHCC and PEPFAR's commitment to achieving efficiency and ensuring the quality of the program across all districts. PEPFAR's strategic approach to planning and weekly monitoring of partner implementation has markedly increased outputs across the target age bands (15 – 29 years) in all districts. Zimbabwe continues to be a high impact country for VMMC and prioritizing Zimbabwean males aged 15–29 will lead to the greatest reduction in HIV incidence in the short-term while inclusion of the 10-14 year age group will provide the greatest magnitude of impact after 15 years.

PEPFAR VMMC support started in 2009 and by December 2017, a cumulative total of 1,189,243 circumcisions had been carried out nationally. PEPFAR directly supported 227,299 male circumcisions in FY 17 (90% achievement towards the target of 252,847). A total of 46,222 circumcisions (15% of COP 17 target of 306,139) were conducted in FY 18 Q1. The national coverage by the end of FY 17 was 36.5% of 15-29 year olds. PEPFAR, the Bill and Melinda Gates Foundation, and the Global Fund are the key donors supporting the national VMMC program in Zimbabwe. PEPFAR support in previous years included VMMC commodities and supplies, demand creation (community mobilization and interpersonal communication), direct service delivery, mass media, technical assistance and information, education, and communication activities. In COP 18, PEPFAR will continue to support these services in the 35 scale-up districts and ramp up site level quality assurance and quality improvement activities for VMMC. The Bill and Melinda Gates Foundation currently supports 18 districts and this support ends in March 2019. Global Fund support to nine other districts (neither PEPFAR nor Bill and Melinda Gates Foundation supported) ceased in December 2017.

Key national policy shifts and considerations in FY 18 include the adoption of the dorsal slit (DS) method (in February 2018) as the standard method of circumcision for all age groups. Similarly, after the adoption of the WHO Technical Advisory Group (TAG) recommendations earlier in the year, the country adopted a fully surgical circumcision approach until Tetanus Toxoid Containing Vaccines (TTCV) was made available in the third quarter of FY 17. PEPFAR supported the rapid scale-up of surgical circumcision methods across all supported districts and sites, including supervised training of healthcare workers , introduction of reusable surgical kits, and increased availability of the disposable universal surgical kit (for both dorsal slit and forceps guided surgical procedures). Three national VMMC campaigns were also conducted and strategic assessments and meetings by PEPFAR partners in close collaboration with the MOHCC ensured that traditionally circumcising communities were engaged. These measures mitigated the impact of the cessation of PrePex on the program. Excess PrePex commodities procured by the Global Fund in FY 17 Q1 are now in use by the MOHCC which is piloting a phased and strategic approach to introduction of PrePex in a few districts in FY 18. However, anecdotal data suggests that uptake of the PrePex plus TTCV approach is slow and will take a while to reach any appreciable implementation scale.

In FY 18, a full application of the Decision-Makers' Program Planning Tool (DMPPT) was conducted and completed in Zimbabwe. The updated tool was used in the COP 18 planning process. The VMMC coverage outputs from the model were compared with the coverage levels from the ZimPHIA and harmonization of the DMPPT2 outputs with ZimPHIA provincial level

coverage is in process with completion expected before the end of the fiscal year. A policy brief will be shared with the MOHCC and other stakeholders before the end of FY 18. In the same year, the reusable kit pilot was concluded and the results contributed to the COP 18 planning process. Two national internal quality audits and an external quality assurance survey in 14 PEPFAR supported sites were conducted, with impressive results (96% score) on the quality of the VMMC program in Zimbabwe. These were implemented with quality management tools developed internally and externally by PEPFAR and the internally generated Health Network Quality Improvement System tool has been adopted by the MOHCC.

Direct service provision will be intensified in COP 18 towards a goal of 80% male circumcision coverage in 78% of PEPFAR-supported districts by the end of the year. Currently, 11 districts (32%) are at greater than 60% coverage for male circumcision. Scale-up in the DREAMS districts will be fast tracked to ensure that they are within reach of the target. Concurrently, PEPFAR will continue to participate in, and support, the MOHCC's collaboration with stakeholders to develop a more sustainable program, focusing on feasibility of interventions, baseline circumcision packages for saturating districts, and institutional (district and site level) capacity building.

While the Zimbabwe program has almost achieved a 50% pivot to 15 – 29 year olds, proportionately more male circumcisions are still being performed in the 10 – 14 year old age band. The national target age group is 10 – 29 year olds). Men aged 20 – 24 and 25 – 29have lower circumcision rates. Therefore, in COP 18, there will be continued focus on achieving the age pivot with renewed attention paid to the older age group through specifically designed demand creation activities. Based on a regional study including Zimbabwe, it has been shown that the quality of adolescent VMMC and HIV messaging is sub-standard. Similarly, many of the adverse events recorded were preventable infections, affecting mostly males in the younger age-group. Therefore, adolescent VMMC and HIV prevention messages, in addition to, improved infection control measures will be incorporated into the program.

Following the cessation of VMMC with PrePex, an upward trend in adoption of surgical VMMC has been observed and Zimbabwe achieved more annual cumulative male circumcisions than in previous years. Strategic and consolidated efforts to mitigate any disruptions to the VMMC program included appropriate messaging (on the benefits of the WHO guidance), opening up of new sites in high burden low coverage districts, increased capacity utilization and monitoring of new and existing sites, refreshers for service providers on surgical VMMC techniques, increasing 'boots' (Inter-personal Communication (IPC)and surgical teams) on the ground, and phased training of IPC agents in order to avoid disruption in service delivery. Innovative approaches included offering mobile services to settings in urban areas, community–organized soccer galas, promotions through social media, and use of mobile technology for geo-fencing (automatic service provider moderated promotional messages), information on demand platforms, and TTCV information/documentation.

In FY 17, a revamped demand creation strategy was developed, with a focus on strengthening interventions targeting the 15-29 year old age group. The findings from the IPSOS research funded by the Bill and Melinda Gates Foundation in 2015 informed implementation approaches in FY 18. Increased focus has now been placed on community mobilization strategies, IPC, and evidence generation at local and site levels. PEPFAR will continue to support capacity building to conduct national internal quality audits for sustainable quality assurance. There will be an increased focus on addressing issues around informed consent documentation, proper record keeping, adolescent

client counselling, and appropriate follow-up documentation. Both the internal quality audits and external quality assurance survey conducted in FY 18 informed these overarching recommendations as areas for improvement.

In COP 18, PEPFAR will define more efficient ways of implementation, in close collaboration with the MOHCC. To maintain COP 17 target levels in COP 18, the PEPFAR team has identified efficiencies in both service delivery and commodity costs. Cost savings will also be realized from adopting one standard surgical male circumcision method, maintaining the proportion of surgical circumcisions, introducing more reusable surgical kits, streamlining disposable surgical kits to universal and increasing the proportion of circumcisions performed at the lower levels of the health system. Additionally, three districts currently supported by USAID (Goromonzi, Marondera and Hurungwe will be supported by CDC in COP 18.

The PEPFAR team is in discussion with the MOHCC and other stakeholders to develop a more sustainable incentive system for VMMC, and discussions are ongoing to explore various models including the Results Based Financing for COP 18 implementation. PEPFAR will remain engaged in this conversation to ensure long-term sustainability of the VMMC program.

In COP18, a VMMC partner performance management plan will be developed and immediately implemented that has the long term goal of rapidly determining gaps in partner performance and implementation of remedial actions. Ultimately, if the remedial actions taken do not effect a change by the end FY18, review of the implementing partner and district issues will be carried out to determine if the partner should be changed, having considered any constraints beyond the partner's control. Key aspects that will be considered include ongoing (and documented) strategies to maintain quality by the in-country VMMC TWG, reports from TWG portfolio reviews and weekly check-in with implementing partners. Monthly and quarterly implementing partner achievements will be utilized, using weekly data from the MOHCC VMMC dashboards, DATIM and the national DHIS2. Quality of program implementation will be assessed through review of bi-annual national IQA reports, focusing on follow-up and adverse event management indicators, as agreed upon at the TWG and guided by the MER. Similarly, as we continue to discuss sustainability with the MOHCC, data harmonization between partner and MOHCC will be constantly assessed through DQA Comparisons of DATIM, DHIS2 and Partner database and source documents (CIF, Registers, Monthly return forms).

D. TB/HIV Collaborative Activities

A national TB prevalence survey conducted in 2015 showed that Zimbabwe has made great strides in TB prevention and control. There was improvement in the case detection rate from 42% in 2013 to 70% in 2015 and in the treatment success rate from 79% in 2013 to 81% in 2015. These achievements still fall short of the ideal 90% goal for both. There has been an overall decline in the total number of TB cases notified annually from more than 40,000 in 2010 to 26,524 cases in 2017. Despite the improvements in the national TB control program, Zimbabwe remains one of the eight countries in Africa that appear on all of the three World Health Organization (WHO) lists of the top 30 countries with a high burden of TB, TB-HIV co-infection and Multi-drug resistant TB (MDR-TB). The TB/HIV co-infection rates remain high at 65-70% and the multi drug resistant TB (MDR-TB) cases have been steadily increasing as the coverage for MDR-TB services has improved; from 29 MDR-TB cases diagnosed in 2010 to 222 in 2017.

According to both the HIV and TB Guidelines for Zimbabwe, all TB patients with unknown HIV status should be actively offered HIV testing while all known PLHIV should be screened for TB using verbal symptom screening tool on every scheduled visit. All HIV positive clients with presumptive TB should be tested for TB using GenXpert services where available, otherwise using smear microscopy. In COP 17, PEPFAR Zimbabwe performed extremely well against targets, achieving 194% for TB_STAT, 100% for TB_STAT_ POS and 150% for TB_ART.

In COP 18, the PEPFAR Zimbabwe program will continue to sensitize health care workers and DSD nurses on these provisions, as well as provide intensified supportive supervision and/or mentorship to ensure that: 1) all TB patients, including presumptive TB patients, from various entry streams (TB clinics, OPD, In-patient, FCH etc.) are tested for HIV and immediately prepared for/initiated on ART if positive and 2) HIV positive patients are screened for TB at every contact with health staff and all presumptive TB cases are offered diagnostic testing. This sensitization process will also focus on improving communication and coordination between TB and opportunistic infections (OI)/ART departments, to facilitate better monitoring and evaluation. DSD support for facility-based HTS activities will also continue to emphasize improved identification and linkage to ART of co-infected patients.

Childhood TB identification remains a priority for the TB program. While the TB/HIV screening tool has been implemented in some districts, COP 18 support will ensure scale up of the use of this tool to cover all supported districts and sites. Onsite orientation as well as mentorship will be provided to ensure the tool is implemented well and outcomes are well documented on the child health cards and patient files.

TB diagnosis in Zimbabwe is heavily dependent on efficient sample transportation because there are limited diagnostic centers. The PEPFAR program will support an integrated specimen transportation system to ensure that peripherals sites are closely linked with TB diagnosis centers and that results are rapidly relayed back to the facilities and to the patients. PEPFAR's DSD nurses will ensure that all presumptive TB cases have sputum samples collected and that these are transported for diagnosis and the results are delivered to the patient. They will work closely with linkage facilitators and community health workers to trace and track patients in the community for both TB testing (contacts) and treatment for those with positive results.

Although Zimbabwe adopted the treat all guidelines in December 2016, all PLHIV with TB in Zimbabwe have been eligible for ART irrespective of CD4 count. In COP 18, PEPFAR Zimbabwe will strengthen the linkage and ART initiation among TB patients infected with HIV through the use of linkage facilitators and ART initiators, with the aim of achieving a linkage (to ART initiation) of 100% among newly diagnosed co-infected patients in all facilities, with a 50% positivity rate among TB patients not already known to be co-infected with HIV.

In Zimbabwe, a policy for provision of TB Preventive Therapy (TPT) for PLHIV was adopted in 2013 and recommends use of isoniazid (INH) for six months for all PLHIV (including children 12 months and older, or less than 12 months with a known TB contact) in whom active TB has been excluded. To date, TPT uptake has been sub-optimal as reflected in SIMS visits and stakeholder consultation. INH is procured in Zimbabwe through support from the Global Fund. Barriers to scale up include supply chain disruption (stock outs of INH), and the negative media associated with reported cases of hepatotoxicity. Although the underlying cause of these cases was never

clearly determined, the suggestion that they may have been INH-related has increased provider and patient suspicion regarding the safety of TPT. In COP 18, PEPFAR will aim to strengthen TPT provision for PLHIV by supporting pharmacovigilance efforts to clearly document adverse events related to both HIV and TB regimens, and to allay public concerns where appropriate. PEPFAR's DSD and TA site support will assist HCWs with TPT as well as pharmacovigilance reporting.

E. Condom Programming for Priority Sub-Populations

Condoms are a crucial prevention intervention and Zimbabwe's condom program is recognized as one of the most successful globally. UNAIDS modeling estimates that between 2015 and 2030, 17 million HIV and STI infections will be averted as a result of condom use if targets are met. Condom use has increased steadily over time: condom use at last higher risk sex among men with a non-marital, non-cohabitating partner increased from 77.4 in 2010 to 85.4% in 2015; and among women from 57.6% to 66.7%. Men's use of condoms at last paid sexual intercourse rose from 88.3% in 2010 to 89.8% in 2015. These are among the highest condom use rates in the region. However, condom use with non-marital partners remains low for men and women, at 37.3% and 49.6% respectively (ZDHS, 2015).

Zimbabwe's total condoms need is about 218 million and based on 2016 data, distribution meets 54% of the need. Condom share is divided in Zimbabwe as 77% from the public sector, 22% social marketing and 0.02% commercial sector. The USG has a long history of investing in condom programming in Zimbabwe and USAID supplied 98% of the country's condoms in 2015.

Social marketing programs have been shown to contribute to substantial increase in condom demand and use among young people of both sexes. There is room to increase condom distribution to meet the overall need for condoms in Zimbabwe, and there are opportunities to increase the share of more sustainable approaches such as socially marketed and commercial sector condoms.

In COP 18, PEPFAR will continue to procure male and female condoms, as well as lubricants, through the Central Commodity Fund. Centrally procured condoms will be distributed to health facilities through the PEPFAR-supported national commodity distribution system, for free distribution at 1) health facilities, 2) for targeted distribution to key/priority populations, and 3) in hot spots and other community-based DREAMS activities supported by implementing partners. Condom promotion and distribution will continue to be integrated in testing, ART, PrEP, PMTCT and VMMC clinical services, through a wide array of distribution points linked to community activities targeting priority populations and through key population peer networks and key population-focused clinical services.

In COP 18 PEPFAR will apply a total market lens to inform the development of a sustainable Condom Strategy, reducing dependence of the condom market on donor funding and ensuring lasting impact of USG investments in Zimbabwe's condom program. Specifically, PEPFAR will design and implement evidence-based condom promotion activities focused on demand generation for the sustained use of condoms and addressing the condom use gap among youth and those engaging in higher risk sex such as key populations. Moreover, PEPFAR will facilitate

performance of the total condom market to improve market volumes, value, equity and sustainability through implementation of the following activities:

- Assign a market facilitator to work closely with MOHCC and support their capacity to use evidence and prioritize a Total Market Approach.
- Identify, understand and address market failures across the entire condom market.
- Support the MOHCC to engage the private sector to encourage an enabling environment and negotiate for space for all condoms.
- Leverage evidence to inform a revised Condom Strategy, including revised metrics, private sector involvement and an emphasis on addressing marketing failures and sustainability.
- Continue to increase revenues and reduce costs in the social marketing sector, thereby allowing a greater proportion of donor resources to be used towards demand creation.

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

Finding the missing, particularly men and young people have been described fully in 4.1.1. The Zimbabwe Integrated HIV Testing Strategy describes how the PEPFAR team will apply the right mix of modalities for specific sub-populations as described in section 4.1.1 above. Self-testing and index testing will be an integral part of the testing strategy. Index testing will be scaled up to contribute to 27% of the positives identified, which is an increase from 7% in COP 17.

In COP 18, PEPFAR Zimbabwe will support the MOHCC to roll out TLD transition throughout the country (see Section 4.4).

PEPFAR Zimbabwe will intensify implementing partner management through monthly partner meetings where data will be reviewed to assess are performance and apply lessons learned. Quarterly interagency partners meetings will also continue. Interagency technical working groups for the various technical areas will meet monthly to review progress towards targets as well as promoting cross-fertilization of technical approaches between agencies and their respective implementing partners.

Cervical Cancer Screening

Background

Cervical cancer, though easily prevented, is one of the leading causes of death among women. An estimated 2,270 new cases are diagnosed with 1,500 deaths from cervical cancer every year in Zimbabwe. In 2017, about 100,000 women were screened for cervical cancer with a treatment rate of 57% which is below the program target of 80 % treatment rate. The ZDHS 2015 reported overall 79% of women had heard of cervical cancer but only 13% ever had a cervical examination. The Cervical Cancer Prevention and Control Strategy (2016-20200) recommend screening using Visual Inspection with Acetic Acid and Cervicography (VIAC) for all sexually active women. In the past 7 years, 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.

Challenges

A five-year Cervical Cancer Prevention and Control Strategy was developed in 2016 and the following gaps have been identified:

a. See and treat approach not being fully implemented because of shortage of or non-functioning equipment, shortage and high staff turnover.
b. User fees; whereas screening is offered for free, some institutions are charging for treatment especially for LEEP. Histology for LEEP and punch biopsy specimens must be paid for.
c. Creation of demand for cervical cancer prevention strategies is inadequate
d. There are no systematic follow up mechanisms for clients who may need treatment or come for review after cryotherapy or LEEP.

Proposed PEPFAR Interventions

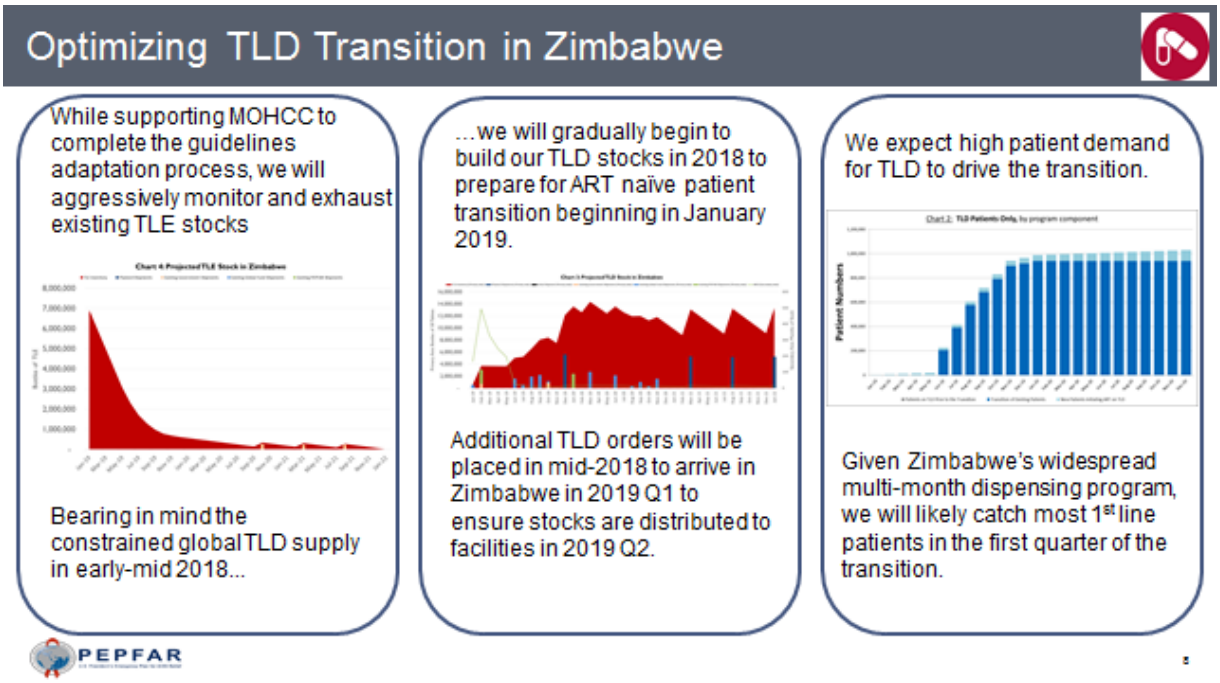
While discussions are on-going, it is envisioned that the PEPFAR support will be best placed to support the country to expand screening for pre-invasive lesions using the VIAC technique and allow early treatment using cryotherapy and LEEP for women who are HIV positive on treatment and above 30 years old.

4.4 Commodities

PEPFAR continues to provide critical support for commodities as well as direct service delivery and technical assistance to Zimbabwe's national supply chain management and distribution systems to ensure that these essential life-saving medicines and products are available in health facilities.

Zimbabwe has fully embraced the 95-95-95 targets for ART coverage with national targets for ARV coverage of 86% by the end of 2018, 88% by the end of 2019, and 90% by the end of 2020. Zimbabwe has also embraced the transition to TLD and will begin the transition with ART naïve patients beginning in January 2019. The current plan is to begin transitioning existing ART patients starting in August 2019. As such, the national semi-annual quantification reflected these assumptions and the supply plans have been developed accordingly.

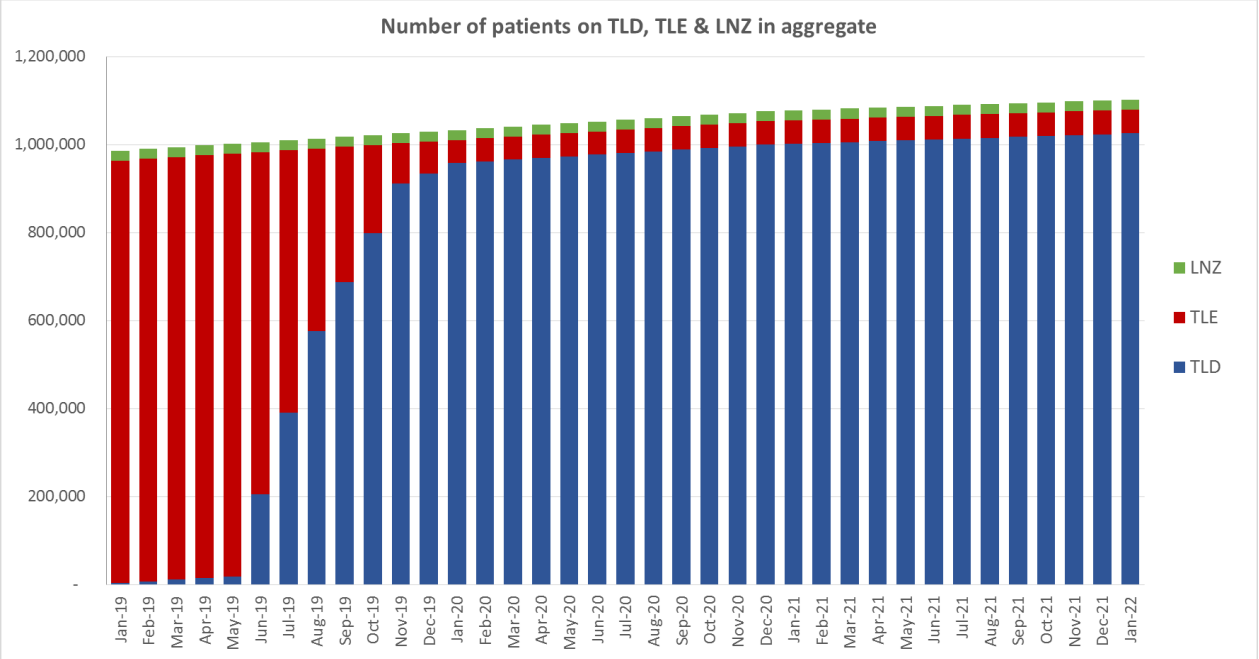
As of January 31, 2018 Zimbabwe has 11 months of TLE (400 and 600) [95.41% of patients], 12.4 months of LZN [1.95% of patients] and 13 months of TL+N [1.97% of patients]. TEE is not part of Zimbabwe's national guidelines. This means that the current stocks of adult first line medicines will not be sufficient to cover the national ART patient needs (existing and new ART patients initiated through December 2018) through July 2019. PEPFAR is working closely with the MOHCC Directorate of Pharmacy Services and the AIDS & TB Program as well as the Global Fund to manage additional 1st line ARV orders in 2018 to ensure adequate but not excessive stocks of these "legacy" ARVs are available to ensure existing patients have enough supplies until they are able to begin transitioning to TLD in August 2019. PEPFAR Zimbabwe's objective is to build up TLD stocks through late 2018 and early 2019 to facilitate Zimbabwe's two TLD transition phases in January and August 2019. This will involve ensuring the "legacy" ARV supplies are the minimum to ensure patients have what they need, avoiding unnecessary wastage.



The first TLD order, which is PEPFAR-funded, will be placed in March 2018 to ensure arrival in Zimbabwe with enough time to be distributed to health facilities in late 2018. In the meantime, PEPFAR will work closely with the MOHCC and UNDP/GF colleagues to initiate the process to update the UNDP/GF products list to include TLD, including assistance with any necessary supporting documentation.

ARV stock audits have been ongoing in Zimbabwe for the last nine years by the ARV consortium, which includes the Global Fund. This activity will continue and will be complemented by introduction, before the end of COP17, of the Procurement Planning and Monitoring Report – HIV (PPMR-HIV) tool to monitor central level stock levels of first line ARVs and RTKs. Data from the PPMR-HIV will be shared at a global level to aid in adjusting orders and deliveries as needed to maintain optimum stock levels in country.

In addition, pending further guidance from S/GAC and USAID/OHA on the referenced commodities DQA, the PEPFAR Zimbabwe team will continue to collaborate with S/GAC and USAID/OHA/SCH to implement a formal PEPFAR DQA over the next few quarters.



PEPFAR coordinates very closely with the Global Fund on HIV & AIDS-related commodity procurement both at the country level as well as with the Geneva country team to ensure our procurement and supply management resources are optimized to meet Zimbabwe's needs. Unfortunately, Zimbabwe's combined resources fall short of fully funding some critical commodity lines, including ARVs, conventional lab reagents, and viral load reagents and consumables, among others, as shown in the below Expected Commodity Gaps for the 2018 – 2020 Period table. According to the national semi-annual quantification exercise held from February 26th – March 2nd 2018 the following gaps are expected over the next three years by commodity line.

Expected Commodity Gaps for the 2018 – 2020 Period			
Commodity Category	**2018 Gap**	**2019 Gap**	**2020 Gap**
ARVs (Adult)	$18,527,286	$16,387,284	$54,543,317*
ARVs (Pediatric)	$5,801,812	$662,862	$432,909
PrEP	-	-	-
Conventional Rapid test kits	$117,568	$3,665,809	$4,965,153
HIV Self-Test kits	-	$755,481	$1,581,897
Lab reagents	$4,580,442	$16,225,136	$19,592,152
Condoms	-	-	-
Viral Load commodities	$5,790,661	$8,090,264	$9452,560
VMMC kits	-	-	-
VMMC medicines, supply items & tetanus	-	$76,677	$65,354
Total	$34,817,769	$45,863,513	$90,132,467

*The Adult ARV gap in 2020 is significantly larger due to two sizeable shipments in November and December 2020 to ensure the stocks are at the desired levels for the beginning of 2021.

The 2018 gaps take into consideration the PEPFAR COP 17 commodity commitments, which, for the most part have already been ordered with the majority already delivered. The 2019 gaps assume PEPFAR COP 18 proposed commodity commitments discussed at the Regional Planning Meeting, which are reflected in the FAST. The 2020 gaps assume level funding from COP18 for each commodity line.

4.5 Collaboration, Integration and Monitoring

The PEPFAR team continues to intensify collaboration with MOHCC, the Global Fund, representatives from civil society, and multilateral donors in order to maximize efficiencies in programming. Engagement and harmonization with the Global Fund remains crucial for commodity procurement including for VMMC devices, HIV rapid test kits, EID bundles, viral load reagents, and ARVs. PEPFAR technical teams continually engage with MOHCC to determine the optimal mix of strategies required to reach epidemic control in each supported district. The recently signed Global Fund award includes support for DREAMS-like activities in the non-PEPFAR supported districts. As the Global Fund begins their DREAMS-like support, the PEPFAR team is sharing its approaches and lessons learned with all stakeholders.

The PEPFAR monthly implementing partner meetings, augmented by exchange site visits provide opportunities for sharing best practices, on-the-job training, and cross fertilization of lessons learned within and across partners. These platforms also serve to facilitate coordination and collaboration in the implementation of strategies such as VMMC service delivery; integrated sample transport for laboratory specimens; HIV/TB prevention, diagnosis and treatment; and viral load scale-up.

PEPFAR Zimbabwe is strengthening partner management through reviewing position descriptions of key implementing partner staff to ensure critical program implementation, monitoring, and management functions are carried out. In addition, PEPFAR is reviewing program data at least monthly, to allow early identification of poor performance and timely implementation of corrective actions. The PEPFAR team will closely monitor and demonstrate the effectiveness of new COP 18 strategies for identifying positives, increasing ART linkage, increasing drug adherence, and reducing attrition rates. These activities will be conducted in partnership with civil society organizations that are monitoring performance and advocating for appropriate site level activities and interventions through a COP 17 grant. In addition, PEPFAR led SIMS visits followed by partner remediation action plans will be further strengthened in COP 18.

PEPFAR's COP 17 and COP 18 investments towards an integrated sample transport system and a LIMS will reduce turnaround time for diagnostic results. Optimizing the capacity of national viral load platforms to meet the need of ART patients will occur through the deployment of additional human resources to provincial PEPFAR-supported laboratories. Quality and reliability of results will be supported through strengthening of the external quality assessment schemes for major HIV related laboratory tests.

Health Information Systems support will focus on scale-up of the EHR and ongoing support for the DHIS2 system with which it is compatible. This support will improve the MOHCC and PEPFAR's ability to assess progress towards epidemic control. Case based surveillance of new HIV infections will incorporate bio-behavioral risk factors as well as bio-markers including rapid recency, viral load, and HIV drug resistance (HIVDR); in COP 18, case based surveillance will be implemented using both paper and electronic systems. Case based surveillance data will inform

the design and implementation of innovative and efficient differentiated models of care, and will be crucial to reach increasingly elusive populations.

4.6 Targets for scale-up locations and populations

The PEPFAR Zimbabwe team anticipates that approximately 47% of the testing will be among adult males with an overall yield rate of 5%, and 42% will be among adult women with an overall yield rate of 6% (note that children 0-14 have a yield of 3%). For those whose test positive we anticipate, 92% of adult men, 94% of women and 93% of children 0-14 to be linked to treatment. Strategies will vary for finding positive clients in districts with high, medium, and low ART coverage; but overall, 82% of HIV positive clients will be identified through PITC, facility/community index testing, mobile testing and VCT; 13% will be realized through antenatal clinics; 3% will be through TB patients screening; and 1% for both VMMC and EID. In COP 18 there are no clients in pre-ART awaiting treatment as the country has adopted a "treat all" policy.

Standard Table 4.6.1

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY 19) *HTS_TST***	**Newly Identified Positive (APR FY 19) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 19) *TX_NEW***
Total Men	976,407	50,191	46,311
Total Women	875,166	55,187	51,772
Total Children (<15)	235,351	7,566	7,032
Adults			
TB Patients	8,174	3,037	4,803
Pregnant Women	240,718	15,002	14,830
VMMC clients	306,153	1,222	1,100
Key populations			
Priority Populations			
Other Testing	1,403,067	86,767	78,090
Previously diagnosed and/or in care			
Pediatrics (<15)			
HIV Exposed Infants	34,409	1,349	1,282
Other pediatric testing	94,403	5,567	5,010
Previously diagnosed and/or in care	***N/A***	***N/A***	***N/A***

Standard Table 4.6.2

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts						
SNU	**Target Populations**	**Population Size Estimate (SNUs) +**	**Current Coverage (2017) ++**	***VMMC_CIRC* (in FY18)**	**Expected Coverage (2018)***	***VMMC_CIRC* (in FY19)**
National	15-29y*	**2,321,743**	**34%**	**354,426**	**45%**	
All PEPFAR	15-29y	**1,594,314**		**306,139**		**306,154**
Beitbridge	15-29y	**20,224**	**80%**	3,126	**98%**	**4,021**
Bulawayo	15-29y	**106,063**	**57%**	13,645	**63%**	**13,645**
Bulilima	15-29y	**14,618**	**51%**	3,055	**58%**	**3,055**
Chegutu	15-29y	**46,623**	**39%**	7,745	**56%**	**13,583**
Chipinge	15-29y	**52,338**	**28%**	13,736	**48%**	**9,635**
Chiredzi	15-29y	**51,487**	**31%**	4,869	**39%**	**7,839**
Chivi	15-29y	**26,531**	**32%**	3,470	**45%**	**3,901**
Gokwe South	15-29y	**53,895**	**31%**	12,136	**42%**	**9,408**
Goromonzi	15-29y	**48,257**	**16%**	4,362	**24%**	**3,895**
Guruve (Incl Mbire)	15-29y	**62,816**	**28%****	17,826	**56%****	**11,343**
Gutu	15-29y	**33,034**	**24%**	3,316	**38%**	**7,254**
Gwanda	15-29y	**22,848**	**48%**	4,293	**67%**	**6,583**
Gweru	15-29y	**41,518**	**75%**	12,433	**84%**	**11,323**
Harare (Urban)	15-29y	**358,593**	**22%**	65,724	**28%**	**32,094**
Harare (Chitungwiza)	15-29y	Not Available	Not Available	(included in Harare Urban)	Not Available	**12,232**
Hurungwe	15-29y	**62,202**	**22%**	7,164	**29%**	**6,564**
Insiza	15-29y	**17,251**	**33%**	1,738	**45%**	**2,172**
Kadoma (incl Mhondoro-Ngezi and Sanyati)	15-29y	**130,515**	**22%****	19,455	**37%****	**17,882**
Kwekwe	15-29y	**53,194**	**27%**	4,921	**34%**	**6,496**
Lupane	15-29y	**18,111**	**87%**	5,199	**133%**	**7,404**
Makonde	15-29y	**39,967**	**45%**	8,079	**52%**	**6,150**
Makoni	15-29y	**51,631**	**24%**	12,895	**40%**	**11,614**
Marondera	15-29y	**30,746**	**44%**	5,377	**53%**	**4,807**
Masvingo	15-29y	**48,813**	**35%**	6,712	**42%**	**6,586**
Matobo	15-29y	**15,705**	**100%**	7,666	**144%**	**10,194**
Mazowe	15-29y	**42,402**	**39%**	10,131	**53%**	**10,436**
Mberengwa	15-29y	**33,663**	**65%**	13,677	**95%**	**16,545**
Mt. Darwin	15-29y	**36,084**	**46%**	5,604	**61%**	**6,960**
Murehwa	15-29y	**32,961**	**31%**	1,523	**40%**	**5,149**
Mutare	15-29y	**74,992**	**22%**	9,524	**36%**	**11,227**
Mwenezi	15-29y	**27,053**	**35%**	3,210	**46%**	**4,507**

Nkayi	15-29y	**18,212**	**57%**	4,016	**75%**	**4,766**
Tsholotsho	15-29y	**18,507**	**47%**	3,917	**65%**	**5,217**
Zaka	15-29y	**33,977**	**42%**	5,595	**62%**	**11,666**

+ Population size estimates were derived from DMPPT2 Tool that pulled *data from the Spectrum estimates (specific sub pop) for use in* the datapack.

++ Coverage estimates from DMPPT2 Online, prior to completion of ongoing alignment process with ZimPHIA VMMC Coverage estimates (expected update before September 2018).

* National target Age group is 10 – 29y. This data is for 15 – 29y.

** Merged Districts: For all other districts, coverage is automatically calculated by the tool (numerator is achievement by end of target FY/ estimated male sub population, 15 – 29y). For these districts, coverage manually calculated from tool outputs, based on estimated population of men 15 – 29 years (denominator). Numerator is the sum of achievements from districts by end FY17 (actual) and end FY18 (actual result in tool plus FY18 target).

- Data for the expected coverage in FY 19 is not yet available.

Standard Table 4.6.3

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate**	**Coverage Goal (in FY18)**	**FY19 Target**
AGYW (10-24 yrs) Population Estimate 2019 ZimStat *in 6 DREAMS Districts*	407,339	325,872 (80% coverage)	89,970
Key Populations: FSW in 5 high volume districts	30,026	14,858	21,018 KP_PREV
Key Populations: MSM in 5 high volume districts	16,293	3,425	4,888 KP_PREV

Standard Table 4.6.4

Table 4.6.4 Targets for OVC and Linkages to HIV Services				
District	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC FY 19Target**	**FY 19 Target OVC_SERV <18**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY 19)**
		OVC_SERV	**OVC_SERV <18**	**OVC***
	2,460,700	**357,469**	**252,413**	**252,413**
Buhera	113,019	19,744	14,988	14,988
Bulawayo	225,651	27,732	13,133	13,133

Chegutu	80,364	13,998	10,626	10,626
Chipinge	146,076	25,275	17,825	17,825
Goromonzi	88,276	23,815	18,078	18,078
Guruve	51,169	6,326	4,802	4,802
Gutu	86,157	16,539	12,556	12,556
Gweru	79,839	12,446	6,925	6,925
Harare	741,208	58,150	44,183	44,183
Insiza	43,539	7,798	5,920	5,920
Kadoma	40,765	9,261	7,030	7,030
Lupane	46,764	7,798	5,920	5,920
Makonde	65,003	25,081	19,040	19,040
Makoni	114,626	22,392	16,304	16,304
Matobo	40,671	5,849	4,440	4,440
Mazowe	92,136	9,308	4,672	4,672
Mutare	181,412	32,315	22,169	22,169
Mutasa	69,452	13,405	10,175	10,175
Nkayi	51,479	5,849	4,440	4,440
Zvimba	103,094	14,388	9,187	9,187

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

5.1 COP 18 Programmatic Priorities

PEPFAR Zimbabwe will not support attained or sustained districts in COP 18. PEPFAR will provide above-site national level support for supply chain management and distribution, viral load scale-up, ART and testing literacy in centrally supported districts.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

The PEPFAR Zimbabwe team will invest in key above-site areas to ensure continued progress towards sustained epidemic control in Zimbabwe. These investments include support for TLD transition guidelines, supply chain improvements, commodity quantification, enhanced program coordination, expansion of key population clinical services, capacity strengthening for sustainability, and patient-centered focus to ensure retention in care and viral load suppression. In order to ensure that the over 1 million Zimbabweans on ART have access to viral load monitoring, PEPFAR will expand its above-site investments in the laboratory sector. Finally, investments in health information systems and case-based surveillance will be critical to improve data quality, facilitate appropriate differentiation of care, and to reach individuals and populations experiencing ongoing HIV acquisition/transmission. Many of these investments were identified or validated through the joint UNAIDS and PEPFAR SID 3.0 process which included MOHCC, NAC, bilateral and multilateral donors, CSOs, implementing partners, and other key stakeholders. These investments were also verified by the PEPFAR team during FY 17 Q4 and FY 18 Q1 SIMS visits. Finally, all investments were discussed and agreed to with the MOHCC and other stakeholders through multiple consultations.

Supply chain and commodities:
In COP 18 the PEPFAR team will continue its close coordination and support to MOHCC Directorate of Pharmacy Services to ensure the national quantification and supply planning exercise is conducted bi-annually. This exercise will inform the use of donor and GOZ resources for commodity procurement. This is particularly important as Zimbabwe plans to transition ARV from TLE600 and TLE400 to TLD in two phases, in January 2019 and August 2019. Securing additional commodities (e.g., test kits, condoms, VMMC kits) will also be critical to national HIV programming and epidemic control.

Laboratory Support:
Zimbabwe currently has adequate platform capacity to provide viral load monitoring access for all ART patients across the country; unfortunately, platforms and reagents will not make universal viral load monitoring a reality without significant investment into supporting systems. Nevertheless, viral load targets are as ambitious as possible, considering the existing budget and availability of commodities. With the TLD transition requiring more viral load testing for patient monitoring, and given the proposed national transition to TLD being in August 2019, we expect an increase in viral load targets in COP 2019 (beyond 90% coverage) with commensurate increases in the budget across all stakeholders. PEPFAR will work with the Global Fund to advocate for additional funding for VL reagents if savings from the current grant are identified. PEPFAR's above-site laboratory investments, therefore, will support integrated specimen transport, LIMS, and quality assurance 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. Finally, PEPFAR support for external quality assessment/ and quality management system activities will ensure that laboratory results are reliable and meet international standards.

Transition to TLD:
One of the barriers to the adoption of TLD is the lack of a comprehensive national implementation plan. MOHCC has indicated their willingness to swiftly move to TLD but are awaiting guidelines from WHO (o/a July 2018) before national adaptation process can begin. In anticipation of the soon-to-be adopted TLD transition, PEPFAR and other partners will support the revision and printing of the national ART guidelines and M&E tools to include TLD. Both OPHID and ITECH will jointly disseminate and train staff on the guidelines and tools at all PEPFAR supported sites. With Global Fund support, the MOHCC will ensure that all non-PEPFAR supported site staff receives the necessary training for national adoption of TLD as first-line ART.

Treatment literacy:
Feedback from MOHCC, stakeholders, CSOs, and patients has impressed upon the PEPFAR team that treatment literacy tools need updating to include aspects of self-testing, index testing, treat all, adherence, viral load, faith healing, and other important elements. In COP 18, PEPFAR clinical partners will support the MOHCC and NAC to review and revise existing materials, and plan any related roll-out and sensitization. This will include focus-group testing, development of a national communications strategy, and inclusion and sensitization of all stakeholders. During the Regional Planning Meeting, CSO and FBO stakeholders strongly encouraged peer-to-peer interaction to improve treatment literacy between expert clients and both newly-initiated clients and defaulter patients. Stakeholders also stressed the need to engage traditional leaders and the faith community to address harmful religious practices and "faith healing" that contribute to clients defaulting on ART. The PEPFAR team will work closely with these CSOs to explore successful models, and thereby strengthen peer-to-peer treatment literacy activities in COP 18.

Health Information Systems
Critical to PEPFAR goals of reaching epidemic control, MOHCC recognized three significant weaknesses in the ability to optimally support patients currently on treatment: 1) accuracy of longitudinal tracking of individual patients within a facility (2) accuracy in tracking patients across facilities and between service providers (referrals) and (3) defaulter tracking at the community level due to inaccurate registers. These areas for improvement were validated during multiple SIMS visits conducted by the PEPFAR team.

a. **Electronic Health Record and DHIS2**
   The current paper-based system of health service delivery leads to extraordinary inefficiency, challenges in data quality, and an inability to track individual patients and cohorts across facilities. Therefore, PEPFAR's above-site investments will continue to focus on the development and maintenance of health information systems; with special focus on a patient centric EHR that is integrated into DHIS2, for care, surveillance, monitoring and evaluation. The EHR will be a comprehensive patient record with historical information from the Enhanced Peer Mobilizers and encompassing laboratory data, pharmacy, human resource information and human resource training data.

   Continuing support for the EHR and maintenance of DHIS2 in public sector facilities in the two largest and heaviest-burden areas, Harare and Bulawayo and eventually at all high volume health facilities across Zimbabwe will aid in accuracy of data. Using a unique patient identifier and incorporation of a referral module within the EHR to allow for tracking patients between service providers will assist in de-duplication. Community

linkage referral slips will be returned to facilities for entry into the EHR to ensure that the loop is closed. To address the data challenges presented by proxy indicators, PEPFAR Zimbabwe will also work with partners to ensure that current cohort analysis to track retention and linkages are scaled to a representative sample size. Widespread EHR implementation will enable both PEPFAR and the National program to provide de-duplicated patient-level data. Through EHR, PLHIV who have previously tested positive within the system, or who are already on ART will no longer be erroneously counted within HTS_TST_Pos.

b. Defaulter tracking

In order to address the third weakness of inaccuracy of defaulter tracing in the community, PEPFAR support will improve documentation within facility through on-site mentorship as well as supporting the MOHCC in the development of enhanced defaulter tracking tools that feed into the EHR. The tools will be standardized for the national program. Ultimately, the mentorship and tools will help to improve the accuracy of defaulter lists generated from health facility-based registers. In turn, health facility workers, outreach workers, and village health workers' time will be better utilized to track "real" defaulters and return them to care. Addressing defaulter tracing is even more critical as treatment initiation continues at a rapid pace and as CARGs are expanded. Finally, enhanced adherence counselling sessions will be undertaken for defaulters and those with high viral load to ensure they are retained on treatment and in care. Getting defaulter patients back to care and virally suppressed will ensure progress towards epidemic control is not hampered.

Case Based Surveillance

As the nation approaches epidemic control, it becomes increasingly critical to identify geographic and demographic "pockets" of ongoing HIV transmission. Therefore, through both electronic and paper-based systems, PEPFAR will work with the MOHCC to support case-based surveillance to identify clients with new (or newly discovered) infections, combining sociodemographic data with biomarkers including viral load, recency testing, and HIVDR results. Priority populations including pregnant women, AGYW, and children will be specifically targeted for this activity.

DREAMS

Building on the success of the DREAMS initiative in six districts, the Global Fund plans to expand DREAMS-like interventions to four non-PEPFAR districts in Zimbabwe. As the Global Fund begins their DREAMS-like support, the PEPFAR team is sharing their approaches and lessons learned with the Global Fund. DREAMS activities are multi-sectoral and delivered by several different partners, which require careful routine planning, and coordination at national, provincial, and district levels. A key element of the coordination of DREAMS is to have DREAMS activities integrated into MOHCC and NAC semi-annual planning and quarterly partnership forums. This integration into the planning process and forum will ensure continued sharing of lessons learned and approaches, foster sustainability, and increase collective accountability and commitment at all levels within the MOHCC to reduce HIV infections among adolescent girls and young women.

A major success within PEPFAR's DREAMS programming is the ability to track and understand layering of DREAMS interventions by unique individual for each DREAMS participant. However, gaps still remain in understanding coverage of the minimum packages by sub-populations and a

system for completing referrals. In COP 2-18, the DREAMS database will be further developed to ensure coverage of minimum packages by sub-populations and ensure referrals are tracked. A simplified version of the DREAMS database will be adopted by the Global Fund and NAC as they start up their DREAMS-like activities in the four Global Fund-supported districts.

Key populations

In COP 18, PEPFAR will continue the approach initiated in COP 2016, which aimed to strengthen the clinical cascade for FSWs and MSM and will reach saturation in FY 18 in five urban locations with high numbers of FSWs: Harare, Bulawayo, Gweru, Mutare and Masvingo. In COP 18, PEPFAR support will continue the expansion of services to key populations in the PEPFAR-supported public sector sites. This expansion is supported by MOHCC and NAC's single country plan and with PEPFAR support, MOHCC and NAC will jointly facilitate quarterly national, provincial, and district stakeholder coordination planning meetings that are inclusive of key populations organizations to verify increased access of key populations to clinical services. The PEPFAR team will support MOHCC and NAC to develop a minimum package of services for key populations. These tools will serve as models to expand KP services into the public sector in PEPFAR supported KP locations, then taken to scale with leveraged resources. In addition, PEPFAR will provide TA to support a national database via the DHIS-2 platform for KP services that allows for referral and tracking and more accurate reporting of results between PEPFAR and Global Fund. The continued need to expand access of key populations to services was an area identified for improvement during the SID 3.0 stakeholder consultation. Further, to adequately monitor progress towards expansion of services to key populations, KP stakeholders will be consulted and feedback collected regarding their experience by sensitized individuals and organizations.

Surveys, Evaluations and Research

Evaluation Inventory

Project Title:	USG Agency:	Project Implementing Partner:	Is the Evaluation planned through COP or HOP?	Planned Budget of project :	What are the primary evaluation/study questions?	Current Stage of project (as of COP2018):	Target Population:	How does this project advance COP priorities and activities?
Violence Against Children (VACS-Young Adults Study)	HHS-CDC;	Elizabeth Glazier Paediatric Foundation	HOP	$0	Estimation of national prevalence of physical, emotional, and sexual violence amongst adolescents and young adults 2. Identification of potential risk factors of physical, emotional, and sexual violence amongst adolescents and young adults 3.Identification of possible health and social consequences associated with violence against adolescents and young adults 4.Estimation of the knowledge and utilization of medical, legal, and protective services available for adolescents and young adults who experience sexual, emotional, and physical violence.	Data collection: completed; Preliminary Data Available;	AGYW	The 2016 Young Adult Survey of Zimbabwe (YAZ) is a national survey aimed at collecting data on the health of the nation's youth as well as study the epidemiological patterns of risk factors for HIV and violence in Zimbabwe. The 2016 YAZ is incorporated in the DREAMS5 core package related to gender-based violence (GBV) prevention, as per PEPFAR's request and is a follow-up study to previous surveys on child health conducted in Zimbabwe such as the 2001-2002 young adult survey (YAS). Information gathered will measure progress to date as well as assist in developing more targeted and informed prevention programs and policy initiatives.
Optimizing Differentiated Service Delivery for Urban PLHIV in Zimbabwe	HHS-HRSA	ICAP & ZNNP+	HOP	$385,996	1) what are the demand-side facilitators and barriers to HIV service delivery in Harare 2) what are the reactions to a range of possible DSD models (including CARGs, facility-based clubs, community-based ART pickup, and others)	Ongoing	PLHIV	The use of differentiated service delivery models (DSDM) is critical towards addressing health system challenges and individual barriers to testing and linkage to treatment. The Community ART Refill Groups (CARGs) is a current model accepted by MOH. Although CARGs appear to be popular with PLHIV in rural areas, uptake in cities has been limited. This presents a significant challenge to scaling up DSD, as the majority of PLHIV live in urban areas.

Surveys and Surveillance Inventory

Project Title	USG Agency:	Technical Lead	Project Implementing Partner:	Is the Evaluation/Study planned through COP or HOP?	Planned Budget of project :	FY19 Funds Needed:	Outyear Costs:	What are the primary evaluation/study questions?	Current Stage of project (as of COP2018):	Project progress (as of COP 2018):	Target Population:	How does this project advance COP priorities and activities?
Implementing Case Based Surveillance in all subpopulations 1. ANC/PMTCT, Paeditric, Adult men and women, High Risk populations- AGYW,MSM,FSW	HHS-CDC;	Elizabeth Gonese	ICAP	COP;	$1,200,000	$1,200,000	$0	Identify and report real time new cases of HIV infection in order to identify risk and reduce spread and infection of HIV Routine tests- HIV Additional tests- Recency testing, viral load, HIVDR (Transmitted/Pretreatment)Demographic data- Risk data	Proposed in COP	Protocol/statement of work: under development;	Paeditric, PMTCT, Adult women &men, AGYW, MSM, FSW, other high risk adult populations	Conducting Case-based surveillance is critical to monitor Epidemic Control indicators, and the impact of the ART. CBS will allow real-time identification of new cases, contacts and ensuring that they are immedietaly put on treatment to reduce transmission. Utilise cellphones, tablets to capture individual level data at facility (CBS module in EHR) to transmit data to central Server.
HIV and STI Bio-Behavioral Survey and Qualitative Assessment among a selected male sub-population in Harare, Bulawayo, and Chinhoyi Zimbabwe	HHS-CDC;	Elizabeth Gonese	ICAP	COP;	$0	$0	$0	This project will provide the country with critical information for managing and tracking the HIV epidemic in high risk populations	Approved in COP (and reflected in Table 6)	Protocol/statement of work: in clearance; Activity approved in COP16, but due to political instability- protocol was not approved for implementation	MSM	This project will provide the country with critical information for managing and tracking the HIV epidemic in high risk populations

HIV drug resistance activities will be incorporated into the case base surveillance testing algorithm. PEPFAR will utilize the Rapid Asante for Recency testing.

7.0 Staffing Plan

For COP 18, the PEPFAR team took a critical look across the entire interagency team to ensure it consisted of staff with an adequate mix of technical, management, and administrative skills to support the Government of Zimbabwe's goal of epidemic control. Due to the protracted hiring freeze, CDC has merged two existing Public Health Specialist vacancies within the HIV Services Branch into one position. The TB/OI and Pediatrics positions will be merged into one Public Health Specialist position.

The current proposed staffing plan put forth in COP 18 equips all PEPFAR implementing 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.

[REDACTED]

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. PEPFAR already participates in an Embassy-wide Gender TWG and will utilize this platform to share best practices and lessons learnt. Additionally, PCO will utilize one of PEPFAR's quarterly stakeholder partner meetings to convene a GSD panel to discuss PEPFAR's strategy to reach sub-populations in need of ART including LGBTI individuals, adolescent girls and young women.

APPENDIX A -- PRIORITIZATION

District/SNU Prioritization

Table A.1

SNU	COP	SNU_Priority	Results Reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95:95:95 (90%) Overall Treatment Coverages at APR by Age and Sex																				Overall TX
				0-9		0-9		10-14		15-19		15-19		20-24		20-24		25-29		25-29		30-34		30-34		35-39		35-39		40-49		40-49		>=50		>=50		Cover
				F		M		F		M		F		M		F		M		F		M		F		M		F		M		F		M		
Beitbridge	COP 15	ScaleUp Sat	APR 16	88%		83%		96%		>100%		>100%		>100%		>100%		72%		64%		58%		47%		61%		44%		58%		34%		86%		55%		69%
	COP 16	ScaleUp Sat	APR 17	78%		74%		82%		68%		59%		64%		93%		59%		>100%		>100%		88%		77%		92%		71%		88%		55%		94%		61%		82%
	COP 17	ScaleUp Sat	APR 18	97%		96%		100%		85%		47%		43%		76%		26%		75%		68%		61%		50%		64%		46%		61%		35%		76%		49%		60%
	COP 18	ScaleUp Sat	APR 19	84%		83%		>100%		>100%		67%		67%		70%		53%		82%		83%		67%		61%		70%		56%		67%		43%		72%		54%		67%
Bubi	COP 15	Ctrl Supported	APR 16	56%		54%		82%		72%		60%		24%		62%		17%		58%		61%		47%		45%		52%		43%		47%		34%		63%		58%		50%
	COP 16	Ctrl Supported	APR 17	59%		58%		89%		89%		60%		39%		61%		18%		70%		76%		57%		55%		63%		54%		57%		43%		78%		76%		61%
	COP 17	ScaleUp Sat	APR 18	28%		28%		55%		32%		47%		41%		59%		62%		52%		44%		42%		32%		46%		31%		42%		24%		51%		50%		43%
	COP 18	ScaleUp Sat	APR 19	49%		48%		68%		66%		72%		72%		64%		50%		76%		75%		62%		54%		68%		53%		62%		42%		82%		72%		63%
Buhera	COP 15	ScaleUp Agg	APR 16	>100%		95%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		92%		99%		72%		59%		>100%		95%		>100%
	COP 16	ScaleUp Agg	APR 17	>100%		88%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		95%		81%		74%		49%		>100%		96%		>100%
	COP 17	ScaleUp Sat	APR 18	>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		100%		87%		78%		52%		>100%		>100%		>100%
	COP 18	ScaleUp Sat	APR 19	>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		79%		64%		>100%		95%		>100%
Bulawayo	COP 15	ScaleUp Sat	APR 16	>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		95%		89%		83%		70%		53%		37%		57%		43%		80%
	COP 16	ScaleUp Sat	APR 17	>100%		60%		>100%		>100%		>100%		>100%		>100%		94%		>100%		>100%		>100%		>100%		92%		79%		59%		42%		67%		54%		86%
	COP 17	ScaleUp Sat	APR 18	>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		92%		71%		80%		56%		51%		30%		62%		46%		77%
	COP 18	Attained	APR 19	>100%		>100%		>100%		>100%		>100%		>100%		>100%		88%		>100%		>100%		>100%		100%		89%		78%		57%		42%		61%		53%		84%
Bulilima	COP 15	ScaleUp Sat	APR 16	65%		52%		58%		71%		78%		47%		95%		60%		64%		73%		51%		53%		54%		53%		51%		38%		54%		39%		56%
	COP 16	ScaleUp Sat	APR 17	62%		62%		74%		81%		82%		60%		93%		41%		85%		71%		68%		52%		72%		52%		68%		37%		77%		56%		66%
	COP 17	ScaleUp Sat	APR 18	>100%		>100%		>100%		>100%		83%		71%		>100%		>100%		>100%		>100%		87%		90%		93%		90%		87%		64%		49%		39%		96%
	COP 18	ScaleUp Sat	APR 19	96%		95%		>100%		>100%		>100%		>100%		>100%		79%		>100%		>100%		98%		91%		>100%		91%		98%		65%		>100%		88%		98%
Chegutu	COP 15	ScaleUp Agg	APR 16	95%		85%		97%		95%		>100%		48%		>100%		61%		>100%		>100%		>100%		99%		93%		83%		69%		47%		49%		42%		87%
	COP 16	ScaleUp Agg	APR 17	90%		82%		>100%		100%		>100%		67%		>100%		87%		>100%		>100%		>100%		>100%		97%		98%		72%		55%		56%		48%		97%
	COP 17	ScaleUp Sat	APR 18	87%		86%		94%		99%		>100%		37%		>100%		67%		>100%		>100%		>100%		87%		87%		73%		65%		41%		44%		37%		81%
	COP 18	ScaleUp Sat	APR 19	89%		89%		>100%		>100%		85%		71%		>100%		76%		>100%		>100%		94%		94%		79%		79%		58%		44%		77%		63%		81%
Chipinge	COP 15	ScaleUp Sat	APR 16	49%		43%		57%		36%		54%		41%		>100%		45%		>100%		>100%		68%		58%		58%		44%		45%		27%		61%		48%		57%
	COP 16	ScaleUp Sat	APR 17	37%		36%		71%		61%		55%		42%		87%		82%		>100%		>100%		81%		71%		69%		53%		53%		33%		60%		43%		64%
	COP 17	ScaleUp Sat	APR 18	87%		86%		>100%		>100%		>100%		81%		>100%		58%		>100%		>100%		>100%		84%		100%		63%		77%		39%		>100%		87%		>100%
	COP 18	ScaleUp Sat	APR 19	87%		86%		>100%		>100%		>100%		96%		>100%		>100%		>100%		>100%		>100%		>100%		96%		94%		74%		58%		>100%		90%		>100%
Chiredzi	COP 15	ScaleUp Agg	APR 16	41%		38%		65%		51%		66%		66%		90%		>100%		>100%		>100%		78%		85%		75%		70%		63%		49%		78%		60%		75%
	COP 16	ScaleUp Agg	APR 17	48%		37%		61%		56%		68%		70%		99%		>100%		>100%		>100%		91%		100%		88%		82%		74%		58%		92%		71%		86%
	COP 17	ScaleUp Sat	APR 18	0%		0%		0%		0%		>100%		>100%		>100%		>100%		>100%		>100%		96%		98%		92%		81%		77%		57%		27%		21%		87%
	COP 18	ScaleUp Sat	APR 19	31%		31%		43%		42%		>100%		>100%		>100%		>100%		>100%		>100%		99%		>100%		95%		84%		79%		59%		>100%		94%		94%
Chivi	COP 15	ScaleUp Sat	APR 16	82%		82%		97%		>100%		78%		73%		>100%		69%		>100%		84%		76%		53%		72%		44%		62%		31%		73%		59%		70%
	COP 16	ScaleUp Sat	APR 17	86%		93%		>100%		>100%		98%		>100%		>100%		70%		>100%		>100%		83%		65%		78%		54%		68%		38%		91%		>100%		85%
	COP 17	ScaleUp Sat	APR 18	97%		97%		>100%		>100%		>100%		>100%		>100%		66%		>100%		90%		94%		57%		89%		47%		77%		33%		94%		66%		83%
	COP 18	ScaleUp Sat	APR 19	95%		94%		>100%		>100%		>100%		>100%		>100%		96%		>100%		>100%		83%		87%		79%		72%		68%		51%		91%		84%		87%
Gokwe South	COP 15	ScaleUp Agg	APR 16	56%		53%		72%		65%		65%		66%		84%		68%		76%		73%		57%		51%		59%		48%		48%		32%		58%		50%		57%
	COP 16	ScaleUp Agg	APR 17	65%		51%		77%		54%		72%		73%		>100%		65%		77%		79%		57%		55%		60%		52%		49%		34%		63%		59%		60%
	COP 17	ScaleUp Sat	APR 18	99%		98%		>100%		91%		>100%		>100%		>100%		>100%		>100%		>100%		96%		81%		100%		76%		82%		51%		>100%		81%		97%
	COP 18	ScaleUp Sat	APR 19	86%		85%		>100%		>100%		>100%		>100%		>100%		87%		>100%		>100%		97%		93%		>100%		88%		83%		59%		>100%		90%		97%
Goromonzi	COP 15	ScaleUp Agg	APR 16	33%		35%		45%		36%		46%		35%		76%		47%		66%		54%		47%		39%		49%		39%		35%		27%		20%		24%		41%
	COP 16	ScaleUp Agg	APR 17	56%		50%		57%		56%		>100%		>100%		64%		36%		>100%		90%		79%		65%		82%		65%		58%		44%		48%		61%		68%
	COP 17	ScaleUp Sat	APR 18	87%		87%		97%		80%		85%		61%		>100%		59%		>100%		>100%		91%		78%		94%		78%		67%		53%		36%		51%		80%
	COP 18	ScaleUp Sat	APR 19	80%		79%		>100%		>100%		>100%		>100%		>100%		76%		>100%		>100%		98%		83%		>100%		83%		72%		57%		86%		91%		92%
Guruve	COP 15	ScaleUp Agg	APR 16	90%		82%		79%		89%		88%		91%		>100%		65%		>100%		>100%		>100%		>100%		>100%		98%		92%		64%		80%		94%		>100%
	COP 16	ScaleUp Agg	APR 17	90%		82%		>100%		>100%		99%		>100%		>100%		97%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		78%		99%		78%		>100%
	COP 17	ScaleUp Sat	APR 18	>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		98%		>100%		>100%		>100%
	COP 18	ScaleUp Sat	APR 19	>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%
Gutu	COP 15	ScaleUp Agg	APR 16	75%		79%		98%		>100%		75%		82%		73%		40%		>100%		84%		67%		52%		64%		45%		54%		31%		92%		57%		65%
	COP 16	ScaleUp Agg	APR 17	79%		75%		>100%		>100%		82%		96%		81%		46%		>100%		94%		73%		59%		70%		50%		59%		35%		>100%		68%		72%
	COP 17	ScaleUp Sat	APR 18	>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		77%		98%		66%		83%		46%		>100%		95%		>100%
	COP 18	ScaleUp Sat	APR 19	>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		93%		87%		65%		>100%		>100%		>100%
Gwanda	COP 15	ScaleUp Sat	APR 16	75%		52%		89%		89%		58%		72%		86%		76%		85%		98%		66%		69%		73%		69%		66%		51%		82%		80%		73%
	COP 16	ScaleUp Sat	APR 17	78%		56%		95%		80%		75%		68%		96%		73%		95%		>100%		74%		77%		82%		77%		74%		57%		92%		82%		80%
	COP 17	ScaleUp Sat	APR 18	70%		70%		96%		98%		74%		84%		>100%		85%		91%		94%		71%		66%		78%		66%		71%		48%		>100%		95%		79%
	COP 18	ScaleUp Sat	APR 19	70%		70%		98%		95%		84%		86%		87%		68%		>100%		>100%		84%		77%		93%		77%		84%		57%		87%		75%		84%
Gweru	COP 15	ScaleUp Sat	APR 16	>100%		>100%		>100%		>100%		63%		67%		63%		44%		>100%		>100%		83%		77%		85%		71%		69%		49%		69%		57%		76%
	COP 16	ScaleUp Sat	APR 17	>100%		>100%		>100%		>100%		77%		82%		80%		60%		>100%		>100%		94%		90%		97%		82%		78%		57%		81%		71%		88%
	COP 17	ScaleUp Sat	APR 18	>100%		>100%		>100%		>100%		64%		65%		64%		44%		98%		88%		73%		62%		75%		57%		61%		39%		71%		58%		68%
	COP 18	Attained	APR 19	>100%		>100%		>100%		>100%		82%		85%		86%		66%		99%		99%		74%		70%		77%		64%		62%		44%		82%		66%		75%
Harare	COP 15	ScaleUp Agg	APR 16	60%		56%		69%		85%		90%		88%		74%		76%		88%		92%		67%		64%		60%		51%		37%		28%		44%		38%		55%
	COP 16	ScaleUp Agg	APR 17	68%		66%		82%		83%		57%		63%		67%		49%		>100%		>100%		77%		72%		69%		57%		43%		32%		40%		36%		58%
	COP 17	ScaleUp Sat	APR 18	79%		79%		89%		>100%		68%		>100%		>100%		93%		>100%		>100%		>100%		93%		95%		75%		59%		42%		65%		57%		81%
	COP 18	Attained	APR 19	76%		76%		>100%		>100%		>100%		>100%		>100%		87%		>100%		>100%		>100%		>100%		>100%		85%		65%		47%		85%		73%		91%
Hurungwe	COP 15	ScaleUp Agg	APR 16	>100%		>100%		>100%		>100%		66%		67%		>100%		83%		>100%		>100%		73%		>100%		59%		84%		43%		47%		60%		55%		72%
	COP 16	ScaleUp Agg	APR 17	>100%		>100%		>100%		>100%		91%		70%		>100%		80%		>100%		>100%		95%		>100%		78%		86%		57%		49%		66%		57%		84%
	COP 17	ScaleUp Sat	APR 18	>100%		>100%		>100%		>100%		87%		75%		>100%		88%		>100%		>100%		>100%		>100%		83%		99%		61%		56%		83%		73%		93%
	COP 18	Attained	APR 19	>100%		>100%		>100%		>100%		96%		81%		>100%		87%		>100%		>100%		>100%		>100%		90%		90%		66%		51%		88%		73%		94%
Insiza	COP 15	ScaleUp Sat	APR 16	39%		32%		39%		36%		80%		58%		>100%		46%		75%		79%		58%		56%		63%		55%		58%		43%		62%		70%		61%
	COP 16	ScaleUp Sat	APR 17	43%		37%		43%		44%		87%		58%		>100%		60%		94%		>100%		73%		76%		79%		74%		73%		57%		81%		62%		73%
	COP 17	ScaleUp Sat	APR 18	59%		59%		67%		68%		>100%		>100%		>100%		98%		>100%		>100%		>100%		94%		>100%		92%		>100%		71%		>100%		86%		>100%
	COP 18	ScaleUp Sat	APR 19	60%		60%		84%		81%		>100%		>100%		>100%		93%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		78%		>100%		98%		>100%
Kadoma	COP 15	ScaleUp Agg	APR 16	77%		60%		71%		67%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		89%		>100%		>100%		>100%
	COP 16	ScaleUp Agg	APR 17	75%		62%		97%		77%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%
	COP 17	ScaleUp Sat	APR 18	77%		77%		87%		83%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		90%		>100%		>100%		>100%
	COP 18	ScaleUp Sat	APR 19	96%		95%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		84%		>100%		>100%		>100%
Kwekwe	COP 15	ScaleUp Agg	APR 16	69%		57%		>100%		92%		80%		87%		>100%		>100%		78%		>100%		59%		71%		60%		68%		50%		47%		75%		63%		70%
	COP 16	ScaleUp Agg	APR 17	71%		55%		86%		83%		63%		97%		>100%		85%		77%		>100%		58%		75%		60%		72%		49%		50%		83%		78%		71%
	COP 17	ScaleUp Sat	APR 18	77%		76%		>100%		>100%		100%		83%		>100%		>100%		>100%		>100%		76%		72%		79%		69%		65%		48%		79%		58%		79%
	COP 18	Attained	APR 19	85%		85%		>100%		>100%		97%		100%		>100%		78%		>100%		>100%		87%		80%		89%		76%		74%		53%		95%		79%		86%
Lupane	COP 15	ScaleUp Sat	APR 16	87%		97%		99%		72%		90%		87%		94%		69%		91%		93%		77%		68%		82%		68%		77%		52%		>100%		>100%		82%
	COP 16	ScaleUp Sat	APR 17	82%		91%		>100%		90%		>100%		87%		87%		35%		89%		>100%		76%		82%		81%		81%		76%		62%		>100%		>100%		87%
	COP 17	ScaleUp Sat	APR 18	93%		92%		95%		74%		>100%		87%		>100%		76%		>100%		>100%		99%		90%		>100%		89%		99%		68%		>100%		>100%		>100%
	COP 18	ScaleUp Sat	APR 19	92%		91%		>100%		>100%		>100%		>100%		>100%		91%		>100%		>100%		>100%		>100%		>100%		99%		>100%		76%		>100%		>100%		>100%
Makonde	COP 15	ScaleUp Agg	APR 16	>100%		99%		>100%		>100%		>100%		88%		>100%		>100%		>100%		>100%		>100%		95%		98%		81%		76%		60%		45%		77%		66%		89%
	COP 16	ScaleUp Agg	APR 17	>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		95%		96%		70%		58%		93%		77%		>100%
	COP 17	ScaleUp Sat	APR 18	>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		94%		85%		73%		63%		44%		91%		81%		96%
	COP 18	ScaleUp Sat	APR 19	96%		95%		>100%		>100%		>100%		86%		>100%		93%		>100%		>100%		>100%		>100%		96%		93%		71%		56%		96%		78%		99%
Makoni	COP 15	ScaleUp Sat	APR 16	67%		52%		77%		67%		67%		73%		>100%		89%		>100%		>100%		78%		84%		67%		63%		54%		39%		68%		70%		73%
	COP 16	ScaleUp Sat	APR 17	70%		57%		92%		86%		87%		76%		>100%		90%		>100%		>100%		96%		>100%		83%		86%		66%		53%		88%		83%		90%
	COP 17	ScaleUp Sat	APR 18	95%		94%		>100%		>100%		83%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		>100%		96%		89%		77%		55%		96%		94%		>100%
	COP 18	ScaleUp Sat	APR 19	88%		88%		>100%		>100%		>100%		99%		>100%		>100%		>100%		>100%		>100%		>100%		95%		97%		76%		59%		>100%		88%		>100%

SNU	COP	SNU_Priority	Results Reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95:95:95 (90%) Overall																				Overall TX Coverag
				Treatment Coverages at APR by Age and Sex																				
				0-9 F	0-9 M	10-14 F	10-14 M	15-19 F	15-19 M	20-24 F	20-24 M	25-29 F	25-29 M	30-34 F	30-34 M	35-39 F	35-39 M	40-49 F	40-49 M	>=50 F	>=50 M	
Mangwe	COP 15	Ctrl Supported	APR 16	84%	63%	68%	77%	54%	38%	>100%	39%	>100%	>100%	81%	87%	88%	85%	81%	65%	71%	51%	80%
	COP 16	Ctrl Supported	APR 17	61%	58%	81%	72%	68%	57%	93%	41%	>100%	>100%	95%	82%	>100%	80%	95%	61%	>100%	82%	90%
	COP 17	ScaleUp Sat	APR 18	57%	56%	49%	48%	91%	57%	83%	64%	42%	41%	32%	30%	35%	29%	32%	22%	56%	30%	41%
	COP 18	ScaleUp Sat	APR 19	48%	47%	66%	64%	48%	49%	48%	38%	60%	59%	46%	42%	50%	41%	46%	32%	51%	40%	47%
Marondera	COP 15	ScaleUp Agg	APR 16	48%	33%	80%	73%	91%	62%	>100%	70%	89%	69%	67%	51%	70%	55%	50%	36%	43%	50%	60%
	COP 16	ScaleUp Agg	APR 17	51%	45%	>100%	95%	>100%	>100%	>100%	99%	>100%	91%	78%	67%	81%	71%	58%	46%	59%	67%	76%
	COP 17	ScaleUp Sat	APR 18	96%	95%	>100%	92%	>100%	89%	>100%	92%	93%	77%	70%	57%	73%	61%	52%	39%	53%	62%	69%
	COP 18	ScaleUp Sat	APR 19	86%	86%	>100%	>100%	>100%	96%	>100%	63%	>100%	92%	82%	68%	85%	72%	60%	47%	69%	76%	78%
Masvingo	COP 15	ScaleUp Agg	APR 16	71%	71%	93%	>100%	84%	70%	>100%	55%	>100%	>100%	72%	64%	70%	55%	59%	38%	75%	67%	71%
	COP 16	ScaleUp Agg	APR 17	79%	70%	100%	>100%	91%	81%	92%	66%	>100%	>100%	75%	69%	73%	59%	62%	41%	91%	71%	75%
	COP 17	ScaleUp Sat	APR 18	92%	91%	>100%	>100%	96%	69%	78%	63%	>100%	88%	66%	55%	64%	47%	54%	32%	69%	75%	66%
	COP 18	ScaleUp Sat	APR 19	91%	90%	>100%	>100%	91%	88%	>100%	83%	>100%	>100%	72%	74%	69%	64%	59%	44%	79%	71%	76%
Matobo	COP 15	ScaleUp Sat	APR 16	61%	64%	84%	80%	63%	53%	78%	30%	88%	73%	67%	52%	73%	51%	67%	40%	84%	66%	66%
	COP 16	ScaleUp Sat	APR 17	64%	59%	85%	80%	85%	77%	93%	38%	>100%	86%	81%	61%	88%	60%	81%	47%	97%	81%	78%
	COP 17	ScaleUp Sat	APR 18	75%	74%	>100%	97%	>100%	>100%	>100%	62%	>100%	>100%	>100%	88%	>100%	86%	>100%	68%	>100%	>100%	>100%
	COP 18	ScaleUp Sat	APR 19	74%	74%	>100%	>100%	>100%	>100%	>100%	94%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	82%	>100%	>100%	>100%
Mazowe	COP 15	ScaleUp Sat	APR 16	73%	69%	72%	82%	65%	54%	78%	52%	>100%	>100%	100%	87%	96%	76%	73%	48%	62%	61%	79%
	COP 16	ScaleUp Sat	APR 17	81%	68%	79%	>100%	75%	63%	76%	64%	>100%	>100%	>100%	>100%	>100%	>100%	79%	65%	73%	58%	91%
	COP 17	ScaleUp Sat	APR 18	78%	77%	73%	83%	78%	64%	84%	64%	>100%	>100%	>100%	>100%	>100%	96%	86%	60%	73%	73%	94%
	COP 18	ScaleUp Sat	APR 19	71%	70%	99%	96%	93%	94%	100%	77%	>100%	>100%	>100%	>100%	>100%	89%	79%	56%	96%	83%	94%
Mberengwa	COP 15	ScaleUp Sat	APR 16	42%	38%	72%	66%	68%	61%	73%	40%	94%	57%	68%	41%	71%	39%	58%	26%	88%	57%	60%
	COP 16	ScaleUp Sat	APR 17	47%	38%	54%	59%	69%	60%	66%	42%	80%	61%	58%	44%	60%	41%	50%	28%	89%	96%	59%
	COP 17	ScaleUp Sat	APR 18	64%	63%	>100%	98%	97%	87%	91%	49%	>100%	>100%	95%	75%	98%	70%	82%	47%	>100%	87%	89%
	COP 18	ScaleUp Sat	APR 19	84%	84%	>100%	>100%	>100%	>100%	>100%	87%	>100%	>100%	96%	93%	>100%	87%	83%	58%	>100%	87%	96%
Mt. Darwin	COP 15	ScaleUp Agg	APR 16	91%	81%	>100%	63%	80%	65%	91%	67%	78%	73%	59%	52%	59%	48%	43%	31%	60%	44%	58%
	COP 16	ScaleUp Agg	APR 17	72%	80%	>100%	>100%	93%	75%	96%	77%	93%	88%	71%	63%	71%	58%	52%	38%	59%	45%	66%
	COP 17	ScaleUp Sat	APR 18	79%	78%	98%	79%	>100%	88%	>100%	85%	90%	84%	69%	60%	69%	55%	50%	36%	73%	50%	68%
	COP 18	ScaleUp Sat	APR 19	73%	72%	>100%	98%	83%	84%	92%	69%	>100%	>100%	95%	87%	95%	80%	69%	52%	85%	73%	85%
Murewa	COP 15	ScaleUp Agg	APR 16	91%	81%	>100%	>100%	93%	67%	72%	82%	81%	59%	59%	44%	61%	44%	44%	30%	58%	53%	57%
	COP 16	ScaleUp Agg	APR 17	87%	79%	>100%	>100%	>100%	78%	69%	35%	90%	74%	66%	56%	68%	56%	50%	38%	62%	56%	63%
	COP 17	ScaleUp Sat	APR 18	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	91%	89%	68%	93%	68%	67%	46%	86%	>100%	98%
	COP 18	ScaleUp Sat	APR 19	>100%	>100%	>100%	>100%	>100%	>100%	>100%	79%	>100%	>100%	>100%	86%	>100%	86%	76%	58%	89%	91%	98%
Mutare	COP 15	ScaleUp Sat	APR 16	81%	81%	98%	91%	64%	67%	97%	64%	>100%	>100%	82%	82%	69%	61%	54%	37%	65%	59%	72%
	COP 16	ScaleUp Sat	APR 17	97%	95%	>100%	>100%	72%	78%	>100%	66%	>100%	>100%	95%	99%	81%	74%	63%	45%	84%	70%	85%
	COP 17	ScaleUp Sat	APR 18	99%	98%	95%	>100%	61%	66%	76%	32%	>100%	>100%	77%	68%	65%	50%	51%	30%	55%	52%	65%
	COP 18	ScaleUp Sat	APR 19	88%	88%	>100%	>100%	76%	61%	>100%	76%	>100%	>100%	70%	81%	60%	60%	47%	36%	63%	56%	68%
Mutasa	COP 15	ScaleUp Agg	APR 16	63%	49%	79%	60%	96%	55%	>100%	95%	>100%	>100%	88%	99%	76%	74%	60%	46%	81%	65%	80%
	COP 16	ScaleUp Agg	APR 17	62%	48%	87%	66%	>100%	63%	>100%	>100%	>100%	>100%	95%	>100%	83%	88%	65%	54%	82%	63%	88%
	COP 17	ScaleUp Sat	APR 18	88%	87%	>100%	>100%	>100%	91%	>100%	>100%	>100%	>100%	>100%	>100%	98%	91%	78%	56%	>100%	97%	>100%
	COP 18	ScaleUp Sat	APR 19	90%	90%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	82%	64%	>100%	94%	>100%
Mwenezi	COP 15	ScaleUp Agg	APR 16	64%	59%	>100%	72%	97%	74%	92%	84%	>100%	>100%	72%	64%	72%	58%	61%	38%	98%	69%	74%
	COP 16	ScaleUp Agg	APR 17	95%	78%	>100%	>100%	>100%	>100%	>100%	68%	>100%	>100%	89%	81%	89%	73%	75%	49%	>100%	81%	90%
	COP 17	ScaleUp Sat	APR 18	82%	82%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	89%	74%	89%	66%	75%	44%	>100%	>100%	95%
	COP 18	ScaleUp Sat	APR 19	92%	91%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	92%	94%	92%	85%	77%	57%	>100%	89%	97%
Nkayi	COP 15	ScaleUp Sat	APR 16	67%	65%	95%	82%	79%	71%	88%	31%	75%	82%	58%	59%	62%	57%	58%	45%	95%	>100%	68%
	COP 16	ScaleUp Sat	APR 17	81%	68%	>100%	>100%	94%	95%	94%	38%	92%	98%	71%	71%	77%	69%	71%	54%	>100%	>100%	81%
	COP 17	ScaleUp Sat	APR 18	>100%	>100%	>100%	>100%	>100%	>100%	>100%	81%	>100%	>100%	89%	91%	95%	88%	89%	69%	>100%	>100%	>100%
	COP 18	ScaleUp Sat	APR 19	>100%	>100%	>100%	>100%	>100%	>100%	>100%	79%	>100%	>100%	99%	88%	>100%	86%	99%	67%	>100%	>100%	>100%
Tsholotsho	COP 15	ScaleUp Sat	APR 16	77%	71%	86%	79%	91%	66%	80%	26%	98%	79%	76%	58%	84%	54%	76%	44%	98%	91%	75%
	COP 16	ScaleUp Sat	APR 17	72%	61%	76%	76%	>100%	91%	77%	25%	96%	74%	75%	55%	82%	51%	75%	42%	>100%	95%	75%
	COP 17	ScaleUp Sat	APR 18	71%	71%	99%	77%	>100%	83%	95%	31%	>100%	91%	87%	67%	96%	63%	87%	52%	>100%	>100%	87%
	COP 18	ScaleUp Sat	APR 19	76%	75%	>100%	>100%	>100%	>100%	94%	73%	>100%	>100%	88%	83%	98%	77%	88%	63%	>100%	>100%	93%
Umguza	COP 15	Ctrl Supported	APR 16	36%	39%	40%	42%	39%	24%	51%	27%	57%	61%	45%	44%	48%	43%	45%	33%	56%	57%	46%
	COP 16	Ctrl Supported	APR 17	36%	35%	45%	49%	48%	40%	51%	34%	68%	70%	53%	51%	57%	50%	53%	38%	78%	69%	55%
	COP 17	ScaleUp Sat	APR 18	39%	38%	45%	40%	55%	51%	50%	39%	46%	45%	36%	32%	39%	32%	36%	24%	54%	51%	40%
	COP 18	ScaleUp Sat	APR 19	64%	64%	90%	87%	59%	61%	52%	40%	63%	60%	49%	44%	53%	43%	49%	33%	66%	56%	53%
Jmzingwane	COP 15	Ctrl Supported	APR 16	52%	47%	64%	74%	>100%	66%	67%	78%	85%	87%	67%	62%	73%	61%	66%	46%	67%	62%	67%
	COP 16	Ctrl Supported	APR 17	40%	54%	62%	79%	95%	79%	>100%	50%	99%	95%	78%	68%	85%	67%	77%	51%	85%	77%	77%
	COP 17	ScaleUp Sat	APR 18	1%	1%	1%	0%	26%	21%	26%	22%	31%	29%	24%	20%	27%	20%	24%	15%	24%	17%	21%
	COP 18	ScaleUp Sat	APR 19	13%	13%	18%	17%	27%	27%	27%	21%	34%	34%	27%	24%	29%	24%	26%	18%	28%	22%	25%
Zaka	COP 15	ScaleUp Sat	APR 16	70%	71%	90%	93%	>100%	93%	80%	53%	>100%	>100%	88%	69%	88%	56%	74%	41%	>100%	81%	84%
	COP 16	ScaleUp Sat	APR 17	69%	70%	98%	100%	>100%	>100%	91%	43%	>100%	>100%	94%	77%	94%	63%	79%	46%	>100%	93%	92%
	COP 17	ScaleUp Sat	APR 18	92%	91%	>100%	>100%	>100%	>100%	94%	70%	>100%	>100%	>100%	84%	>100%	69%	90%	50%	>100%	>100%	>100%
	COP 18	ScaleUp Sat	APR 19	90%	89%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	>100%	88%	88%	65%	>100%	>100%	>100%
Zvimba	COP 15	ScaleUp Agg	APR 16	61%	57%	69%	63%	58%	48%	85%	49%	>100%	>100%	74%	77%	62%	60%	46%	35%	48%	49%	61%
	COP 16	ScaleUp Agg	APR 17	54%	45%	48%	51%	57%	42%	87%	45%	99%	>100%	67%	66%	57%	52%	41%	31%	39%	42%	55%
	COP 17	ScaleUp Sat	APR 18	>100%	>100%	99%	>100%	>100%	98%	>100%	64%	>100%	>100%	>100%	>100%	95%	88%	69%	52%	68%	47%	94%
	COP 18	Attained	APR 19	89%	89%	>100%	>100%	99%	84%	>100%	90%	>100%	>100%	>100%	>100%	93%	89%	68%	53%	91%	74%	95%

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY 18)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY 19) *TX_CURR***	**Newly initiated (APR FY 19) *TX_NEW***	**ART Coverage (APR 19)**
Attained	461,677	374,627	0	404,691	50,298	86%
Scale-Up Saturation	688,557	608,876	0	631,896	54,615	91%
Scale-Up Aggressive						
Sustained						
Central Support	266,761	222,678	0	626	31	0%
Total	1,416,995	1,206,181	0	1,037,213	104,945	

APPENDIX B – Budget Profile and Resource Projections

B1. COP 18 Planned Spending

Table B.1.1 COP18 Budget by Approach and Program Area

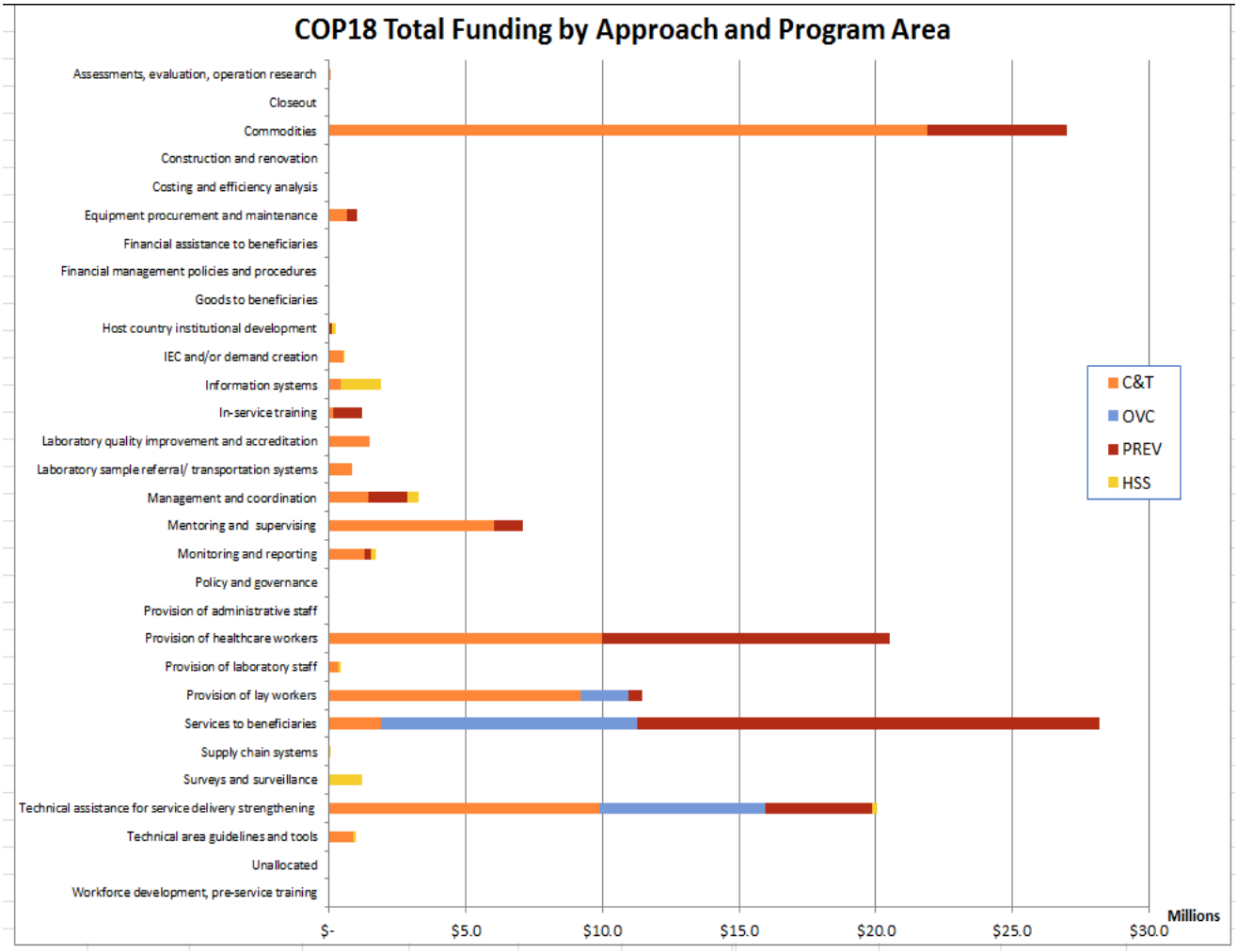
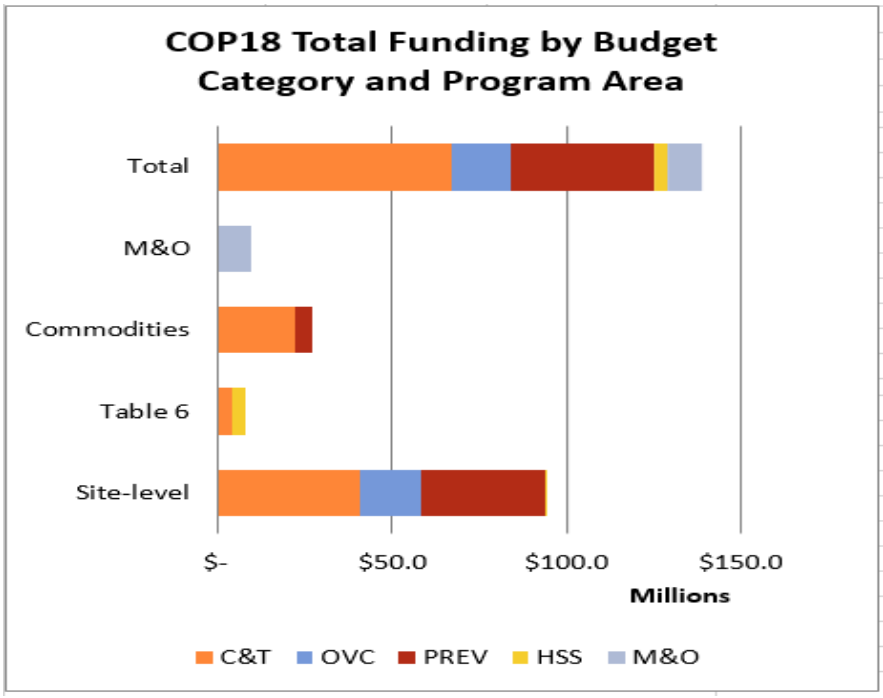


Table B.1.2 COP 18 Total Planning Level

Applied Pipeline	New Funding	Total Spend
$5,000	$$145,541,200	$$145,541,200


COP18 Total Funding by Budget Category and Program Area
Total
M&O
Commodities
Table 6
Site-level
$-
$50.0
$100.0
$150.0
Millions
C&T
OVC
PREV
HSS
M&O

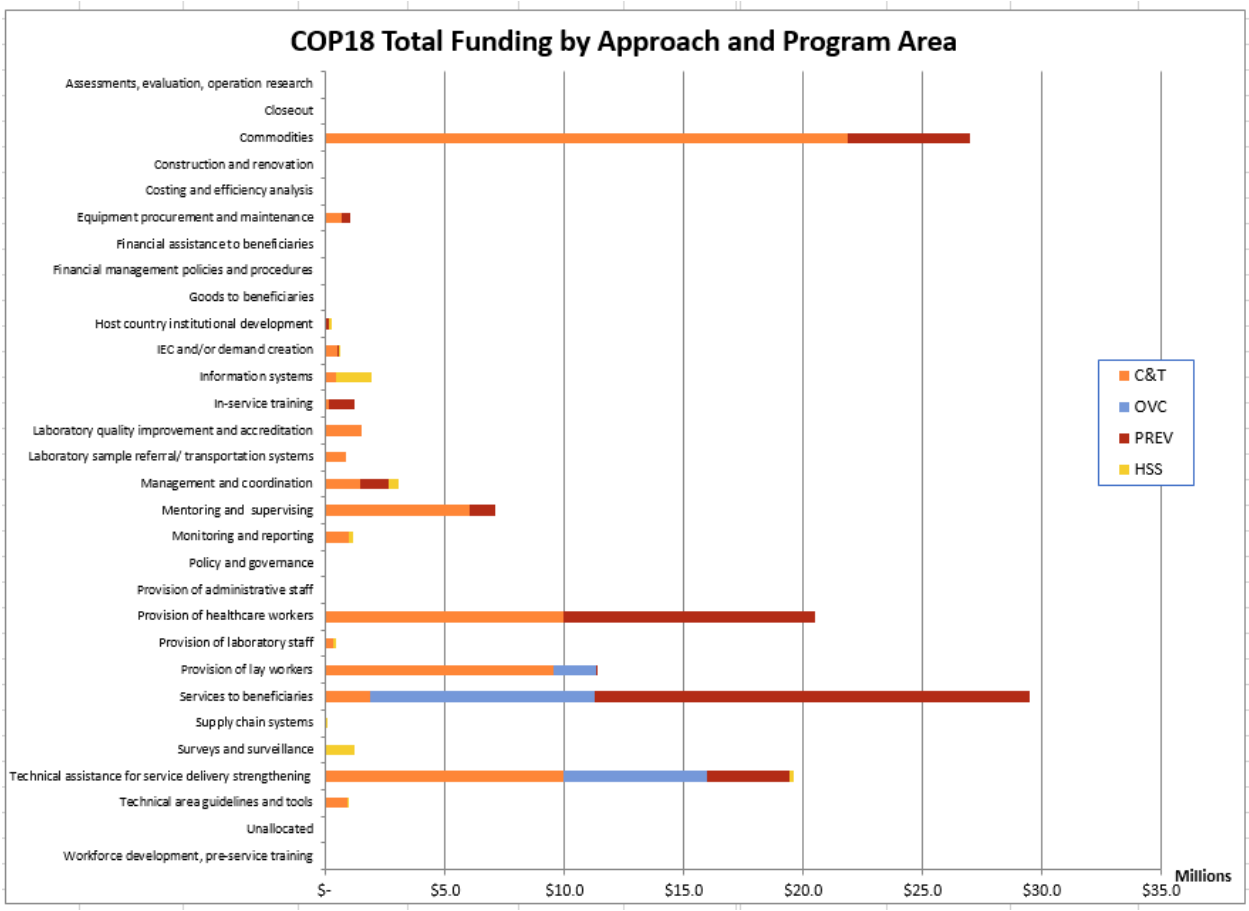

COP18 Total Funding by Approach and Program Area
Assessments, evaluation, operation research
Closeout
Commodities
Construction and renovation
Costing and efficiency analysis
Equipment procurement and maintenance
Financial assistance to beneficiaries
Financial management policies and procedures
Goods to beneficiaries
Host country institutional development
IEC and/or demand creation
Information systems
In-service training
Laboratory quality improvement and accreditation
Laboratory sample referral/ transportation systems
Management and coordination
Mentoring and supervising
Monitoring and reporting
Policy and governance
Provision of administrative staff
Provision of healthcare workers
Provision of laboratory staff
Provision of lay workers
Services to beneficiaries
Supply chain systems
Surveys and surveillance
Technical assistance for service delivery strengthening
Technical area guidelines and tools
Unallocated
Workforce development, pre-service training
$-
$5.0
$10.0
$15.0
$20.0
$25.0
$30.0
$35.0
Millions
C&T
OVC
PREV
HSS

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
Program Area	Budget code Description	TOTAL
Care and Treatment	Adult Care and Support	$11,759,809
	Adult Treatment	$16,093,872
	Pediatric Care and Support	$3,027,635
	Pediatric Treatment	$1,068,510
	ARV Drugs	$21,411,062
	TB/HIV Care	$4,000,381
	Counseling and Testing	$13,817,664
PREV	Mother to Child Transmission	$292,267
	Male Circumcision	$32,385,490
	Abstinence/Be Faithful Prevention/Youth	$2,453,912
	Other Sexual Prevention	$7,281,303
Orphans and Vulnerable Children	Orphans and Vulnerable Children	$17,490,718
Health Systems Strengthening	Lab	$1,253,108
	Strategic Information	$2,140,446
	Health Systems Strengthening	$1,315,302
M&O	Management and Operations	$9,749,721
	TOTAL	$145,541,200

B.2 Resource Projections

In COP 18, OGAC developed a Funding Allocation to Strategy Tool (FAST) as a replacement to the expenditure analysis driven process documented in the PEPFAR Budget Allocation Calculator. The FAST is a comprehensive planning and budgeting tool focused on short and long-term solutions and outcomes that will guide the financing and development of implementing partner work-plans in a deliberate effort to optimize PEPFAR investments. In order to populate the FAST, the PEPFAR Zimbabwe team considered the following sources of information to guide the apportionment of COP 18 resources:

- Incremental budget adjustments e.g. how much does a partner need to fund a specific activity such as CARGS;
- COP 17 strategic objectives and implementing partner work-plans;
- Regional and national costs associated with specific activities, e.g. self-testing and index testing;
- Review of recent program data including 2018 HIV Estimates (SPECTRUM); and
- Solution centered approaches to reach 95-95-95.

The development of a revised HIV testing strategy focused on sub-population gaps by age, sex and district was the primary change driver for COP 18 budgeting. By integrating self-testing strategies and shifting resources from direct service delivery within the public sector to the community through index testing and contact tracing additional resources needed to be added to partner budgets for the provision of healthcare workers, lay counselors, technical assistance for service

delivery improvement, mentoring and supervisory support. PEPAR also doubled funding for self-testing and plans to leverage commodities procured by UNITAID.

A secondary change driver was the targeted focus on linkage and retention rates, which have been ambitiously set to 95%, for newly enrolled on ART and retention after one year. Zimbabwe has surpassed the one million mark with the number of people on ART and incremental increases to partner budgets were deemed necessary to support treatment and testing literacy, differentiated models of care, guidelines adaptation and training for the roll-out of TLD. PEPFAR FY 17 results demonstrated the need to improve the rate at which the program links newly identified PLHIV to treatment and the rate at which new treatment enrollees are retained.

The PEPFAR team currently implements routine monitoring on a monthly basis to track partner performance and progress and will incorporate a review of expenditure analysis (EA) data from the start of FY 17 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

Please see separate Table 6 Excel workbook.

Table 6 Attachment

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element
1	USAID	Families and Communities for the Elimination of Pediatric HIV (FACE-Pediatric HIV)	C&T	Improve generation, dissemination and use of strategic information	Technical area guidelines and tools	TLD guidelines & tools developed and rolled out to facilities	A comprehensive national implementation plan for the adoption of TLD does not exist. MOHCC has indicated their willingness to move to TLD but are awaiting guidelines from WHO (o/a July 2018) before national adaptation process can begin.	2. Policies and Governance
2	USAID	HIV Community Care and Treatment	HSS	To increase the availability of quality comprehensive care and treatment services for HIV-positives at community level	Host country institutional development	Assist the DAC to coordinate DREAMS in 3 districts (drafting integrated workplans, facilitate referral meetings, monthly/quarterly progress monitoring meetings). Different partners are assigned as coordinating secretariats for DREAMS districts. FHI-360 is responsible for 3 of the 6 Districts	DREAMS activities are multisectoral, delivered by several different partners, which requires careful routine planning & coordination, and a well-functioning referral system, at district level.	1. Planning and Coordination
3	State/AF	Public Affairs Communications	PREV	To advance the PEPFAR 95-95-95 goals through the diseemination of HIV related messages through Public Affairs	IEC and/or demand creation	Public Affairs support for Demand Creation and HTS & TX Literacy	Adherrence and Retention remains a key barrier to achieving the third 90 due to literacy gaps	13. Epidemiological and Health Data
4	State/AF	Public Affairs Communications	HSS	To advance the PEPFAR 95-95-95 goals through the diseemination of HIV related messages through Public Affairs	IEC and/or demand creation	Public Affairs support to Journalists and PEPFAR print products in support of 95-95-95	Adherrence and Retention remains a key barrier to achieving the third 90 due to literacy gaps	2. Policies and Governance

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
1	7.11	Revised national ART guidelines and M&E tools that include TLD are finalized, printed and disseminated and that staff are trained on their implementation at all PEPFAR supported sites	1 year	Revised ART guidelines inclusive of TLD are in existence.	Zimbabwe is transitioning from TLE600 to TLE400 for all clients except pregnant women and TB patients.	Revised guidelines and M&E tools are finalized.
2	10	DREAMS districts have joint workplans, set benchmarks and track referral closure rates and carry out monthly stakeholder meetings.	1 year	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	1.) Referral protocol developed & used by 100% of partners; 2.) Districts have coordination/referral meetings at least monthly & provinicial meetings take place periodically	1.) Streamlined IP coordination responsibilities (FHI 360 will take on an additional district for total of 3) to capitalize on best practices & efficiencies; 2.) Targets for referral closure rates determined and closely monitored; 3.) MoPSE, MOHCC, MOLSW, NAC participate in DREAMS meetings.
3	4.51	Community dialouges with faith-based and traditional leaders to demystify myths and neggative messages preventing communities from accessing HIV treatment or remaining adeherrent to ART.	1 year	#of Community and Faith based dialogues	New Activity in COP18; ancedotal evidence provided by CSOs indicate that stable patients on ART default due to guidance from church and/or traditional leaders on being healed.	# of Community dialouges held with faith-based, traditional leaders and networks of PLWHIV to mitigate myths and negative messages preventing communities from accessing HIV treatment or remaining adeherrent to ART.
4	7.11	Development of communication strategy that addresses community norms	1 year	Development of communication strategy that addresses community norms	Lack of coordinated community strategy that reiterates benefits of ART and achiving viral suppression	Development of a communication strategy targeting communities with the goal of raising awarness on ART adherrance, viral suppression and differentiated care models.

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
1					
2					
3					
4					

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element
5	USAID	Global Health Supply Chain Program (GHSCP)	HSS	Improved strategic planning and implementation and strengthened enabling environment related to supply chain management and commodity security.	Supply chain systems	Supply Chain Management support for national quantification and supply planning	Lack of MOHCC funding for procurment and supply chain coordination and the bi-annual national quantification and supply planning exercise.	8. Commodity Security and Supply Chain
6	USAID	HIV Community Care and Treatment	HSS	To increase the availability of quality comprehensive care and treatment services for HIV-positives at community level	Technical area guidelines and tools	Standardized tools for defaulter tracking developed.	MOHCC capacity for retention and defaulter tracing is weak at community level. Tools to track and record defaulters are not standardized.	6. Service delivery
7	USAID	Families and Communities for the Elimination of Pediatric HIV (FACE-Pediatric HIV)	C&T	Strengthen clinical services for comprehensive HIV Care and Treatment	IEC and/or demand creation	Support maintained for 100% of clinical secondees at MOHCC AIDS and TB Program - for them to engage the MOHCC Communications department in creating the updated materials as well as updating their communication strategies as needed.	Treatment literacy tools need updating to include aspects of e.g. self-testing, index testing, treat all, adherence, viral load, faith healing etc.	2. Policies and Governance
8	USAID	<Placeholder - 70473 Zimbabwe USAID>	HSS	Strengthen HIV prevention, testing, treatment, and retention services for key populations	Management and coordination	KP National Coordination (secondee support, national KP operational plan, coordination meetings)	Coordination between MOHCC and NAC, and the rollout of different service delivery models and funding streams for KP needs strengthening to avoid fragmentation & duplication.	1. Planning and Coordination

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
5	6.84	Bi-annual national quantification and supply planning exercise conducted and informs use of donor and GOZ resources for commodity procurement.	1 year	1) Reports from semiannual quantification exercise 2) stockout rates of tracer medicines/products TLE & TLD <1%, LZN [peds]<1%, male condoms <5%, Determine RTK <5%, VMMC universal surgical disposable kit <5%	1) Semiannual quantification exercise conducted in February 2018. 2) stockout rates of tracer medicines/products at FY17Q4: TLE 0.82%, LZN [peds] 4.4%, male condoms 3.0%, Determine RTK 7.0%, VMMC FG surgical disposable kit 0.76%	1) Reports from semiannual quantification exercise 2) Maintain low stockout rates of tracer medicines/products within global industry standards. TLE &TLD<1%, LZN [peds]<1%, male condoms <5%, Determine RTK <5%, VMMC universal surgical disposable kit <5%
6	6.48	Standardized tools for defaulter tracking	1 year	Standardized defaulter tracking tool developed	Tools for defaulter tracking not standardized.	Standardized defaulter tracking tools developed and printed for community HIV service delivery.
7	7.11	Updated posters in all major languages of Zimbabwe are in existence at health facilities with smaller pamphlets available to issue to clients seeking services.	1 year	1) Number of facilities with updated information on treatment literacy; 2) Treatment literacy tools updated; 3) Communications strategies finalized	Facilities lack up to date information to share with clients seeking services.	Updated messages/communication strategies finalized and treatment literacy tools updated; All sites receive the revised documents; selected sites will be mentored on their implementation.
8	10	MOHCC and NAC work collaboratively to coordinate a single country plan and to facilitate quarterly national/provinicial/district stakeholder coordination planning meetings which are inclusive of KP organizations.	1 year	1.) Existence of ToRs for MOHCC KP TWG 2.) Existence of National KP Operational Plan	1.) KP Coordinators identified & in place at MOHCC and NAC; 2) MOHCC KP TWG formed; 3) Several National level stakeholder coordination meetings held already in FY18.	1.) Clear ToRs developed for MOHCC KP TWG and how it relates to other KP coordination forum; 2) A common, national operational plan inclusive of all donors, is developed and disseminated.

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
5					
6					
7				100% of PEPAR supported sites receive the revised documents and are mentored on their implementation.	
8					

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element
9	USAID	<Placeholder - 70473 Zimbabwe USAID>	HSS	Strengthen HIV prevention, testing, treatment, and retention services for key populations	Technical area guidelines and tools	KP Minimum Package Developed	Limited availability of Key Populations competent services in the public sector	2. Policies and Governance
10	USAID	<Placeholder - 70473 Zimbabwe USAID>	HSS	Strengthen HIV prevention, testing, treatment, and retention services for key populations	Information systems	DHIS2, referral protocol, KP M&E support	The public sector and CSO service providers lack a common system & capacity to accurately track referrals between them, and to monitor program performance across key HIV prevention and treatment indicators	13. Epidemiological and Health Data
11	USAID	<Placeholder - 70473 Zimbabwe USAID>	PREV	Support DREAMS service delivery and development of sustainable country capacity to manage DREAMS programming	Host country institutional development	Secondments for DREAMS coordination at national level	Limited Nat'l level coordination of DREAMS programming especially in light of GF expansion	1. Planning and Coordination
12	USAID	<Placeholder - 70473 Zimbabwe USAID>	PREV	Support DREAMS service delivery and development of sustainable country capacity to manage DREAMS programming	Information systems	Further refine DREAMS DHIS2 database and capacity to use it among DREAMS partners	While the ability to track and understand layering of DREAMS interventions by unique individual has dramatically imrpoved, gaps remain in understanding coverage of minimum packages by sub-populations and systems for closing referrals.	13. Epidemiological and Health Data

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
9	7.11	Tools and models to expand KP services into the public sector are developed and tested in PEPFAR supported KP locations.	2 years	1.) Number of task team meetings held; 2.) Number of sites trained; 3.) Number of sites offering at least minimum package for desginated KP groups	1) Public sector facilities in 5 existing KP locations identified; 2) Site readiness and training tools are in process of being harmonized/updated for use by all IPs; 3) Site plans for all sites will be developed by end FY18.	1.) Minimum service packages, based on specific KP group, are developed and tested. 2.) Service monitoring & quality improvement committees (which involve KPs themselves), are active in 100% of targeted sites.
10	4.51	A manageable, national database is instituted that allows for referral tracking and more accurate reporting of results between PEPFAR and GF.	2 years	1.) Number of IPs using database; 2.) Existence of KP Reporting SOP; 3.) Existence of KP referral protocol	New Activity in COP18	1.) A simple, common, DHIS2-based, UIC reporting system is developed and for use by PEPFAR and GF funded partners; 2.) SOP, that aligns indicators when possible, for reporting to NAC, MOHCC, PEPFAR, GF developed; 3.) KP referral protocol updated/expanded to include GF parters. and select public sector sites.
11	10	Strengthened national level coordination of DREAMS, with proven strategies being taken to scale with leveraged resources.	1 year	1.) at least 75% of monthly DREAMS partner meetings conducted; 2.) DREAMS Coordinators present updates at 100% of MOHCC quarterly meetings; 3) Forum for routine sharing & monitoring between PEPFAR and GF DREAMS partners is created.	1.) National coordination meetings take place monthly and are coordinated & hosted by the MOHCC; 2.) DREAMS activities are integrated into MOHCC semi-annual planning and quarterly partnership fora.	1.) National level DREAMS meetings are facilitated by MOHCC and NAC Coordinators (at least 75% of monthly meetings take place); 2.) DREAMS as a national program is incorporated in MOHCC quarterly prevention partnership meetings; 3.) MOHCC/NAC secondments act as PoCs for all PEPFAR learning visits.
12	4.51	The DREAMS Database is able to demonstrate coverage of minimum packages by sub-populations. A simple version is adopted by GF/NAC for comparability and is functionally linked to national DHIS-2 systems.	2 years	1.) % DREAMS beneficiaries receiving 1, 2, 3, 4+ services; 2) % DREAMS beneficiaries receiving minimum package by sub-population; 3) % referrals closed in the database.	1.) DREAMS database used by 100% of IPs; 2.) Database can report on number receiving 1, 2, 3+ services; 3.) Second generation of database can provide general information on % of DREAMS beneficiaries in different age groups receiving minimum package.	1.) DREAMS database is reconfigured for the third generation; 2.) DREAMS IP are using databased to track and close referrals; 3) Workshop with NAC and DREAMS partners held to develop DHIS2 fields.

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
9		1) Minimum service packages and tools used in 100% of GF supported sites. 2) Model of using service monitoring & quality improvement committees to support KP friendly services is extended to additional sites with leveraged resources.			
10		1) DHIS2-based reporting system is in use by 100% of PEPFAR and GF KP partners. 2) Dashboards and reporting templates developed for National level reporting. 3) Natinal coordination meetings include national KP data review as an agenda item to track progress across funding streams.			
11					
12		1) DHIS2-based reporting system is in use by 100% of PEPFAR and GF DREAMS partners. 2) Dashboards and reporting templates developed for National level reporting. 3) Natinal coordination meetings include national DREAMS data review as an agenda item to track progress across funding streams.			

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element
13	USAID	FACT Children Tariro	HSS	Support DREAMS service delivery and development of sustainable country capacity to manage DREAMS programming	Host country institutional development	Assist the DAC to coordinate DREAMS in 3 districts (drafting integrated workplans, facilitate referral meetings, monthly/quarterly progress monitoring meetings). Different partners are assigned as coordinating secretariats for DREAMS districts. FACT is responsible for 3 of the 6 Districts	Lack of routine planning & coordination, and a well-functioning referral system, with multiple implementers/stakeholders at district level.	1. Planning and Coordination
14	HHS/CDC	Lab Support	HSS	Monitoring and Evaluation system for ensuring accountability, transparency and reporting requirements to monitor epidemic control	Information systems	Supporting MOH Laboratory Services to roll out laboratory information management system (LIMS) at 4 centralized Viral Load testing laboratories	Lack of universally implemented Laboratory Information Management System (LIMS)	13. Epidemiological and Health Data
15	HHS/CDC	RTI Follow-on	HSS	Development, dissemination, and promotion of an HMIS evaluation framework to enhance HIV programming and support national epidemic control	Management and coordination	Provide strategic human resources (secondments) for development and support of DHIS2, EHR, and integration with EPMS, HRIS, LIMS -	Paper-based ART M&E tools and electronic systems using retrospective data entry are outdated; don't allow for maximum support to providers, are not integrated with other health services, and do not allow for monitoring retention over time	15.3 Comprehensiveness of service delivery data

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
13	10	DREAMS districts have joint workplans, set benchmarks and track referral closure rates and carry out monthly stakeholder meetings.	1 year	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	1.) Referral protocol developed & used by 100% of partners; 2.) Districts have coordination/referral meetings at least monthly & provinicial meetings take place periodically	1.) Streamlined IP coordination responsibilities (FHI 360 will take on an additional district for total of 3) to capitalize on best practices & efficiencies; 2.) Targets for referral closure rates determined and closely monitored; 3.) MoPSE, MOHCC, MOLSW, NAC participate in DREAMS meetings.
14	4.51	Data Management system installed and operationalized at 4 centralized VL testing laboratories.	2 years	# of PEPFAR supported laboratories with a functional laboratory information management system; sample processing efficiency will be measured through laboratory turn around time before and after LIMS implementation.	3 PEPFAR-supported VL labs have functional LIMS	All PEPFAR supported Viral Load laboratories will have a functional LIMS
15	1.22	Comprehensive DHIS2 data repository with EHR, EPMS,e-LMIS, LIMS,HRIS, TRAINSMART integrated and capacity to provide dashboards	3 years	Reports on HIV , TB and other health indicators provided by an Integrated DHIS2 system	DHIS 2 at all 62 district, 10 provincial and National level. Separate EHR, EPMS, LIMS ,TrainSmart systems	EPMS integrated into EHR and feeding data into DHIS 2. Comprehensive integrated and interoperable DHIS2 providing routine & custom reports

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
13					
14		Functional LIMS at all provincial labs enabling provincial, district, and site-level reports for priority populations (e.g. pregnant women and children), and profiling patient cohorts with virologic failure, as well as patient-level VL cascade data. While the system should be present and functioning in all labs by the end of year 1, customizing routine reports in accordance with PEPFAR and MoHCC/GF needs may take additional time to elicit and harmonize stakeholder input. Hence the 2-year timeframe.			
15		EHR, LIMS, HRIS,TRAINSMART fully integrated into DHIS2. Interoperability framework completed		DHIS2 Dashboards completed. ICT Policy completed	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element
16	HHS/CDC	RTI Follow-on	HSS	Development and support to Ministry of Health and Child Care (MOHCC) Health Management Information System (HMIS) services, RoadMap ,Framework to integrate electronic tools for program planning and evidence based clinical programming for HIV epidemic control	Information systems	1.Development of comprehensive electronic health record with functional HIV- HTS,ART-Retention, Laboratory , Pharmacy and Logistics modules . 2.Development of electronic systems that support patient level data availability at facility, across facilities and at national level enabling tracking of patients in the contiuum of care. 3.Establishmnent of a functional case based surveillance systems to enable tracking of the HIV epidemic	Paper-based ART M&E tools and electronic systems using retrospective data entry are outdated; don't allow for maximum support to providers, are not integrated with other health services, and do not allow for monitoring retention over time	15.4 Timeliness of service delivery data
17	HHS/CDC	4.51	C&T	Enhance the ability of national institutions to plan and coordinate SI activities and Strengthen systems to monitor and evaluate the coverage, quality, and effectiveness of the national HIV response	Surveys and surveillance	1. Implement cased based surveillance including Enhanced ANC/PMTCT surveillancewith - Recency Testing, VL, HIVDR (Transmitted and Acquired) all sub-populations(Paediatric, PMTCT, FSW,MSM, 2. Complete data analysis for YAZ (VACS study) and implement Data to Action activities 3. Implement a size estimates in MSM - collect risk data and use in program planning	Limited data on source and populations newly infected with HIV in PMTCT, MSM, Adult women and men, AGYW	13.5 Comprehensiveness of Prevalence and Incidence Data

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
16	1.33	1.Functional comprehensive EHR system at 100% of high-volume ART sites nationally 2. Integrated DHIS2 with EHR, E-LMIS, LIMS,HRIS, TRAINSMART systems that are interoperable 3.Dashboard reports and customised data outputs from the ICT systems	3 years	1. # Routine Program reports from EHR system and DHIS2 2. # Number of sites with E.H.R & Integrated DHIS2 system 3. Case based Surveillance reports	1.EHR implemented at all Harare facilities 2. Updated DHIS2 at district, provincial and national level	1. EHR implemented at all high-volume sites in Harare and Bulawayo 2. Comprehensive integrated and interoperable DHIS2
17	0.76	Reduced number of new HIV infection as a result of early identification and treatment of new HIV cases in all subpopulation- ANC/PMTCT, Paediatric, Adult men,women, AGYW	2 years	1. Relevant case reports on incident infections 2. Relevant reports on HIVDR in all sub-populations 3. Report on risk of HIV infection related to violence and policy/program recommendations YAZ report 4.Size estimates report on MSM	1. Case based surveillance protocol in development 2. YAZ data analysis in progress 3. MSM survey protocol approved	CBS implemented in 60 high volume sites Utilise cell-phones, tablets to capture individual level data at facility (CBS in module in EHR) transmitted to a Central Server

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
16		50% of all high volume sites have functional EHR 2. Comprehensive integrated and interoperable DHIS2		100 % all high volume facilities have EHR 2. Comprehensive integrated and interoperable DHIS2	
17		CBS implemented in 50 % high volume sites Utilise cell-phones, tablets to capture individual level data at facility (CBS in module in EHR) transmitted to a Central Server		CBS implemented in 100 % high volume sites Utilise cell-phones, tablets to capture individual level data at facility (CBS in module in EHR) transmitted to a Central Server	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element
18	HHS/CDC	SEAM Follow-On	HSS	Enhance the ability of national institutions to coordinate, monitor and evaluate strategic information systems; implement comprehensive, high quality surveys and surveillance to characterize the HIV epidemic; Conduct targeted surveys and surveillance systems and program evaluations that prioritize -Paeditric, PMTCT, AGYW,FSW, MSM and general population	Management and coordination	Secondee support to MOHCC to accelerate data integration and management at all levels	Lack of coordinated systems approach to M/E systems	15.5 Analysis of service delivery data
19	HHS/CDC	Lab Support	C&T	Operationalize National Viral Load Scale up plan to increase viral load monitoring from 5% to universal coverage for HIV patients, including quality management systems and data management ensuring accurate reliable results	Laboratory sample referral/ transportation systems	Integrated sample transport system for both VL and EID in all PEPFAR supported districts; National level support will be provided to MOHCC in the design/roll out of the National Integrated Sample Transport System in coordination with GF.	An inadequate laboratory specimen transport network	10. Laboratory
20	HHS/CDC	SEAM Follow-On	HSS	Enhance the ability of national institutions to coordinate, monitor and evaluate strategic information systems. Intensification and Implementation of high quality M/E for routine data collection	Management and coordination	Facility level data quality checks by PEPFAR staff	Discrepancy results between facility and data inputs in DATIM	15. Performance Data

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
18	0.67	Improved systems and availability of data to evaluate the coverage, quality, and effectiveness of the national HIV response	3 years	1. Case Based Surveillance Reports 2. Reports on indicators to measure progress towards reaching 95-95-95	1. YAZ survey data analysis in progress 2. MSM size estimates protocol inplace 3. CBS protocol in development	1. YAZ data uttilised for National Actional Plan 2. MSM size estimates report utilised in high risk program planning 3. CBS reports used in program plan
19	5.5	1077 Health Facilities will have access to VL testing services through a integrated PEPFAR supported sample transport that efficiently and effectively moves both VL and EID samples from all facilities to testing labs, and, VL results from laboratories to all facilities.	2 years	1,077 PEPFAR-supported health facilities have timely access to VL and EID testing at centralized laboratories, as measured by number of samples collected, proportion of samples tested, proportion of samples with results returned to the facilities, intra-lab and post lab turn around time (TAT), including time for results returned to facilities.	PEPFAR and leveraged USG funding (e.g. USAID TB Program) providing sample transport services in 55 health districts to ensure access to laboratory services, including EID and VL.	There exists an integrated sample transport system that measurably supports VL and EID sample transport from all 1,077 PEPFAR-supported facilities to the centralized laboratories, and, results returned on time to the health facilities for action by clinical service providers.
20	7.12	Records in DATIM match facility level data	1 year	0% of discrepancy of data between facility level and DATIM	Variance identified between Facility Data and DATIM	Data collection systems stregthened to reduce variance

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
18		1. YAZ results utilised in National Actional Plan 2. Size Estimates Results used in Programming 3. CBS at 50% of high volume sites		CBS implemented in 100 % high volume sites Utilise cell-phones, tablets to capture individual level data at facility (CBS in module in EHR) transmitted to a Central Server	
19		Results from the optimized GIS mapping exercise will be used to inform equipment placement to scale-up sample transport for all distrcits to acess Viral Load testing			
20					

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element
21	HHS/CDC	Lab Support	C&T	Operationalize National Viral Load Scale up plan to increase viral load monitoring from 5% to universal coverage for HIV patients, including quality management systems and data management ensuring accurate reliable results	Laboratory quality improvement and accreditation	Laboratories (42) will be mentored for implementing continuous quality improvement and producing quality results	An insufficient Quality Management System (QMS)for laboratory processes	10. Laboratory
22	HHS/CDC	<Placeholder - 70465 Zimbabwe HHS/CDC>	C&T	Improve district and facility performance for comprehensive treatment, care, and support of HIV/AIDS and HIV related conditions	IEC and/or demand creation	Produce and disseminate IEC materials(job aides, posters, fliers, pamphlets etc), sensitize health workers to give appropriate messaging on testing (index testing, self-testing, repeat testing), treatment literacy (same day initiation, VL monitoring and differentiated care services)	Inadeqaute resonse to invitations for index case testing and up to 10% repeat testing. Delays in both testing and ART initiation by well individuals. Poor understanding of a) the need for early ART initiation, b) the need for continued adherence and the meaning of viral load results, c) differentiated care models available	6.1 Responsiveness of facility-based services to demand for HIV services
23	HHS/CDC	<Placeholder - 70465 Zimbabwe HHS/CDC>	C&T	Improve district and facility performance for comprehensive treatment, care, and support of HIV/AIDS and HIV related conditions	Technical area guidelines and tools	Support the development, printing and dissemination of new/revised guidelines (self-testing, index testing,counselling, TLD transition etc), new/revised M&E tools and job aides, including health worker orientation on these.	MOHCC has inadeqaute capacity to rapidly revise/develop, print and disseminate guiidelines and M&E tools, and orient health workers nationally	6.1 Responsiveness of facility-based services to demand for HIV services

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
21	5.5	42 Laboratories implementing continuous quality improvement (CQI) and producing quality results, 4 of the 42 having ISO accreditation	2 years	# of PEPFAR-supported laboratories with ISO accreditation and implementing CQI	12 of the 42 PEPFAR supported laboratories have SLIPTA Audit scores in preparations for ISO accreditation	All 42 PEPFAR supported laboratories producing quality results and 4 Viral Load testing laboratories having ISO accrediatation
22	1.11	1. Increased Index Testing response rate from 60% to 75% among females and from 29% to 50% among men. 2. Same day initiation rates of over 80%. 3. VL suppression of at least 90%	1 year	1. Index testing response rate following invitation. 2. Proportion of same day initiation among new PLHIV identified 3. Proportion of PLHIV on ART virally suppressed	1. 60% among female adults and 29% among adult men 2. 70% same day initiation 3. 83% viral suppression among PLHIV on ART	1. 75% and 50% response rates for women and men respectively 2. 80% same day initiation among newly identified PLHIV 3. At least 90% of PLHIV on ART virally suppressed
23	1.11	Facilities have updated self-testing, index testing, counselling and TLD guidelines	1 year	Proportion of facility with updated guidelines (self-testing, counselling, TLD)	0% of facilities have updated guidelines (self-testing, counselling, TLD)	At least 80% of facilities will have updated guidelines (self-testing, counselling, TLD)

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
21		CQI needs to be ingrained - All 42 PEPFAR supported laboratories maintaining quality results and 4 Viral Load testing laboratories maintaining ISO accrediatation			
22					
23					

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element
24	HHS/CDC	<Placeholder - 70464 Zimbabwe HHS/CDC>	HSS	Development, dissemination, and promotion of an HMIS evaluation framework to enhance HIV programming and support national epidemic control	Information systems	Development and support to Ministry of Health and Child Care (MOHCC) Health Management Information System (HMIS) services, RoadMap ,Framework to integrate electronic tools for program planning and evidence based clinical programming for HIV epidemic control	Paper-based ART M&E tools and electronic systems using retrospective data entry are outdated; don't allow for maximum support to providers, are not integrated with other health services, and do not allow for monitoring retention over time	15. Performance Data

Row	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
24	7.12	1.Capacity building of a local partner to support implementation of a functional comprehensive EHR system at 100% of high-volume ART sites nationally 2. Integrated DHIS2 with EHR, E-LMIS, LIMS,HRIS, TRAINSMART systems that are interoperable 3.Dashboard reports and customised data outputs from the ICT systems	1 year	1. # Routine Program reports from EHR system and DHIS2 2. # Number of sites with E.H.R & Integrated DHIS2 system 3. Case based Surveillance reports	1.EHR implemented at all Harare facilities 2. Updated DHIS2 at district, provincial and national level	1. EHR implemented at all high-volume sites in Bulawayo 2. Comprehensive integrated DHIS2

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
24					