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Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18316	12033.08	U.S. Agency for International Development	Abt Associates	8048	6034.08	USAID/abt/AB/C SH	\$1,500,000
12033	12033.07	U.S. Agency for International Development	Abt Associates	6034	6034.07	USAID/abt/AB/C SH	\$913,250

Program Budget Code: 03 - HVOP Sexual Prevention: Other sexual prevention

**Total Planned Funding for Program Budget Code: \$1,147,871**

**Table 3.3.03: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 8176.09	<b>Mechanism:</b> USAID/PSP/ABT
<b>Prime Partner:</b> Abt Associates	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (USAID)	<b>Program Area:</b> Sexual Prevention: Other sexual prevention
<b>Budget Code:</b> HVOP	<b>Program Budget Code:</b> 03
<b>Activity ID:</b> 12034.28471.09	<b>Planned Funds:</b> \$550,000
<b>Activity System ID:</b> 28471	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 18317	

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18317	12034.08	U.S. Agency for International Development	Abt Associates	8049	6035.08	USAID/Abt/OP/CSH	\$550,000
12034	12034.07	U.S. Agency for International Development	Abt Associates	6035	6035.07	USAID/Abt/OP/CSH	\$553,559

**Table 3.3.03: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 5999.09	<b>Mechanism:</b> USAID/DELIVER II TO1/JSI
<b>Prime Partner:</b> John Snow, Inc.	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (USAID)	<b>Program Area:</b> Sexual Prevention: Other sexual prevention
<b>Budget Code:</b> HVOP	<b>Program Budget Code:</b> 03
<b>Activity ID:</b> 11890.28230.09	<b>Planned Funds:</b> \$500,000

**Activity System ID:** 28230

**Activity Narrative:** N/A

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 18383

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18383	11890.08	U.S. Agency for International Development	John Snow, Inc.	8073	5999.08	USAID/JSI/Deliver 2	\$500,000
11890	11890.07	U.S. Agency for International Development	John Snow, Inc.	5999	5999.07	USAID/JSI/Deliver 2	\$500,000

**Table 3.3.03: Activities by Funding Mechanism**

**Mechanism ID:** 4087.09

**Mechanism:** USAID - TA

**Prime Partner:** US Agency for International Development

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (USAID)

**Program Area:** Sexual Prevention: Other sexual prevention

**Budget Code:** HVOP

**Program Budget Code:** 03

**Activity ID:** 28396.09

**Planned Funds:** \$97,871

**Activity System ID:** 28396

**Activity Narrative:** N/A

**New/Continuing Activity:** New Activity

**Continuing Activity:**

Program Budget Code: 04 - HMBL Biomedical Prevention: Blood Safety

**Total Planned Funding for Program Budget Code:** \$0

## Program Area Narrative:

### Biomedical Prevention Strategic Context

During development of its 5 Year Strategy the USG team in Zimbabwe decided that it should focus resources on high priority areas, and that it did not have adequate financial or human resources to work in Blood Safety or Injection Safety. In May 2008, the team undertook a Joint Portfolio Review that included a validation of that 5 Year Strategy. The team found that in spite of the deterioration in the political and socioeconomic environment, to date Zimbabwe's blood supply remains safe. There is no indication that USG resources are needed for Blood Safety at this time.

Given the sharp decline in availability of clinical equipment and supplies, particularly in the public sector, the USG team discussed increasing concern about health providers' abilities to maintain universal precautions. The 2005-06 Zimbabwe Demographic Health Survey (ZDHS) found that 96% of recent medical injections among women and 89% among men were given with a syringe taken from a newly opened package. It is probable that these rates have decreased due to lack of syringe resupply at many sites, particularly at the clinic level. The team agreed that Injection Safety – with a broader focus on universal precautions -- could become an area of involvement for USG Zimbabwe should additional funding become available.

Given increased USG interest in injecting and non-injecting drug users (IDU/DU), the Zimbabwe team talked with partners about needs and determined that the country's IDU/DU population is still quite limited. Though data are scant, UNAIDS estimates that <1% of HIV transmission in Zimbabwe is IDU-related. Similarly, data on and experience with non-injecting drug users are scant. USG will address any IDU/DU needs as they arise through on-going HVOP outreach and counseling activities.

As part of the strategy revalidation, the USG team reaffirmed its strong commitment to HIV prevention in Zimbabwe. Given emerging international evidence on the benefits of male circumcision (MC) for prevention, and heightened interest in Zimbabwe (described below), the USG team decided to allocate modest PEPFAR funds to leverage pilot efforts in FY09. These are described below.

### Male Circumcision Program Context

Low male circumcision prevalence together with high level of concurrent sexual partnerships are important factors that seem to have contributed to the fast spread of HIV in Zimbabwe in the 1990s, reaching an adult (15–49 years) HIV prevalence peak in 1997 of 29.3 %. Despite the sharp decline in HIV prevalence that has been witnessed between 2001 and 2007, with a drop of approximately 1.8 percentage points/year, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence of 15.6%. 1.1 million adults and 133,000 children are currently living with HIV and AIDS in Zimbabwe. Average life expectancy has dropped in the past two decades by over 20 years to 37 years in men and 34 years in women, largely due to HIV and AIDS.

Except for minor ethnic groups like the Tonga, Chewa, Tshangan and small Moslem communities, traditional male circumcision is generally not practiced in Zimbabwe. The 2005-06 Zimbabwe Demographic and Health Survey (ZDHS) found a total of 10.5% of all men interviewed reporting that they had been circumcised, ranging from 5.3% in Mashonaland Central to 18.8% in Matabeleland North. Drawing from the ZDHS data, it is estimated that out of 2.5 million sexually active men above the age of 20 years, approximately 90%, or 2.25 Million are not circumcised.

In view of the heightened international interest in MC and unequivocal evidence for its protective effect on HIV transmission, the Zimbabwe National AIDS Council (NAC) and the Ministry of Health and Child Welfare (MOHCW) hosted a national MC consultative meeting in June 2007. The purpose of the meeting was to update stakeholders on recent evidence on male circumcision and HIV prevention, to obtain consensus on a national position regarding the integration of male circumcision into comprehensive HIV and AIDS programming within the Zimbabwean context and to initiate the development of a roadmap on MC and HIV prevention as guided by the national consensus. The meeting revealed a high level of interest and support by the MOHCW and NAC, UN agencies, NGOs and community groups for MC and resulted in development of a roadmap to rapidly scale up male circumcision.

Health services in Zimbabwe are provided through 5 central hospitals, ten provincial hospitals, 62 district and 88 mission hospitals as well as over thousand rural hospitals and health clinics. Until recently, all district hospitals and mission hospitals had functioning operating theatres and staffed with nurses and doctors. As the economic crisis has deepened an alarming number of health staff have left their posts, but it is believed that most hospitals still have operating capacity.

Although there has been significant out-migration of trained health personnel to the crisis, some level of health services at most health care facilities are still maintained. Currently male circumcisions are performed by Government Medical Officers at district and mission hospital level based on medical indications such as phimosis and paraphimosis in children and STIs including condylomata acuminata in adults. There are very few requests for MC for cultural and/or religious reasons performed at government hospitals. MC is routinely reported on the NHIMS as a minor surgical procedure. Generally, MC constitutes less than 5% of all minor surgical procedures done at district level. Currently only approximately 3–5 monthly procedures are performed in the private and public sector.

In 2005, an acceptability study of MC in Harare beer halls found that 14% of men reported being circumcised and 45% of the remainder was interested in becoming circumcised. (Halperin, McFarland, Woelk, 2005). A recent Tracking Results Continuously study conducted by Population Services International/Zimbabwe found acceptability levels among men of 62%.

The USG and UNFPA are currently supporting the Partnership Project to undertake a rapid assessment of the feasibility (service availability mapping) and acceptability of MC. With USG funding, a Partnership consultant team is also working on the development of the national MC policy. The information gathered through the different assessments is intended to guide future

## Zimbabwe MC program implementation.

### USG Male Circumcision Program and Prospects

USG's primary partner for its PEPFAR Sexual Prevention program is the Partnership Project, which seeks to reduce the rate of new HIV infections and the impact of HIV/AIDS on Zimbabweans. The Partnership Project undertakes comprehensive ABC prevention strategies as well as more focused AB work with youth, and risk reduction work with most at risk populations. Partnership is also a lead USG PEPFAR partner for HIV counseling and testing and PLHA care and support activities, and provides significant capacity building to local organizations. With other USG funds, Partnership is fostering family planning integration with Zimbabwe's national PMTCT program. The lead implementing agency for Partnership is Abt Associates, with Population Services International (PSI), Family Health International, and Banyan Global.

In FY2009, the Partnership Project will move into Biomedical Prevention as well, through a new Male Circumcision initiative. The initiative will initially be funded by \$1.3 million in PSI corporate funding and \$50,000 from UNFPA. Under the CIRC program budget code, the USG will provide \$100,000 through COP09 for a Program Coordinator. The Coordinator will play a lead role in championing scale up of MC with the MOHCW and other key stakeholders, and provide MC leadership on the PEPFAR Zimbabwe MC team. Under other program budget codes (HVAB, HVOP, HVCT, HBHC, OHSS) the USG will provide an additional approximately \$3.3 million to Partnership for its related prevention, care, treatment, and capacity building described elsewhere in this COP.

The new MC program will undertake the following in FY09:

#### (1) Integration of male circumcision services as part of a comprehensive HIV prevention intervention package:

In collaboration with the MOHCW, with PSI funding, the Partnership Project will test models to roll out comprehensive male circumcision services in Zimbabwe through the following steps: (a) Formation of a technical working group to develop national MC policies, standards, guidelines and roll out strategies to ensure the implementation of safe MC services. (b) Adaptation and development of standard guidelines for comprehensive MC services. (c) Selection of management information system (MIS) indicators and monitoring and evaluation (M&E) tools to measure performance and implementation of activities. (d) Development of information, education and communication messages and materials for MC clients. (e) Identification and upgrading of one MC training centre and three learning sites to offer safe MC services. (6) Training of MC trainers in comprehensive MC service delivery. The sites will be used to test the learning resource package and materials developed and to assess the feasibility of MC services implementation.

#### (2) Communication to generate demand for safe male circumcision services:

The Partnership Project will build on its existing capacity to develop and implement a communication strategy. The strategy will comprise messages and campaigns to create awareness about MC and its benefits and risks, including dispelling misconceptions and addressing fears. The aim of the strategy is to stimulate demand for male circumcision within defined frameworks of communication to address the primary and secondary target groups. Primary target groups consist of adolescent boys and young men aged 13– 29 years. The secondary target groups consist of parents of adolescent boys, health providers, female partners, community leaders as well as communities in general.

Formative research will be used to identify barriers to take up of MC services among the target group. These barriers will be addressed by pre-tested and evidence-based communication materials and messages disseminated through mass media as well as through interpersonal communication channels such as road shows, drama and peer education. The Partnership team will build upon existing innovative communications activities to achieve rapid awareness and increase demand for MC such as (a) a network of faith-based pastors to reach out to adolescent boys and their parents, (b) education-entertainment activities, such as theater and sports programs, in rural areas, (c) outreach teams conducting interpersonal communications (IPC) sessions in the workplace and in vocational training colleges, (d) a television and radio talk show with health experts to guide discussion and offer advice and (e) the large network of counselors in HIV testing sites who will counsel HIV negative male clients about MC.

#### (3) Service Delivery:

In FY09, with PSI corporate funding the project will establish the following MC service delivery sites and build capacity of health personnel in MC: (a) One MC training site will be established at central level to train MC trainers and program implementers. (b) Three MC learning sites will be established within existing health care facilities to offer safe MC services. (c) 26 health care workers (surgeons and nurses) will benefit from initial training in comprehensive MC service delivery. (d) 230 New Start counselors will benefit from training on MC counseling and MC referral. [New Start is the brand for the Partnership project-operated HIV testing and counseling (T&C) program in Zimbabwe. Partnership currently supports 20 New Start T&C centers and 21 outreach teams. In FY08 they tested over 200,000 individuals, and expect to reach or exceed that number in FY09.]

#### (4) Monitoring & Evaluation:

The Partnership team will monitor activities by tracking the number and type of providers trained, equipment and consumables used, number of clients seeking MC, number of testing and counseling clients referred for MC, number of clients receiving MC, number of follow up visits, number and nature of complications and side effects, number of quality assurance visits, number of people reached by communications and marketing materials/advertisements, and any other indicators being tracked through the national MIS systems. Demographic information on MC clients will be recorded including age, marital status, educational level, HIV testing history and outcome, medical history, and how the client heard about the MC provider.

Since male circumcision is a new prevention intervention in Zimbabwe, national MIS indicators for MC currently do not exist. The

MC program will support the integration of MC indicators in the current national MIS. Data collected during the pilot phase will be analyzed to inform the wider roll out of MC, which will follow the learning phase.

#### Expected Results

In FY09, through these sites and trained personnel, 2000 adolescent boys and men will be circumcised and will receive follow up services and intensive counseling on safer sexual behavior and 40 000 HIV negative adolescent boys and men 16 years and above will receive information and counseling on MC. In FY09, the project expects to reach 2,000,000 men aged 13 -29 years, as well as parents, community leaders, and health care workers, through mass media communications, and 5,000 young men in schools and church communities through interpersonal communication.

#### Wraparounds/Leveraging

As stated above, the USG investment of \$100,000 for an MC Coordinator (plus direct and indirect costs of the Partnership Project from other COP budget codes) will leverage \$1.3 million from PSI and \$50,000 from UNFPA. When the political and economic conditions in Zimbabwe improve, there is a good probability for significant funding from private foundations and other donor sources.

Program Budget Code: 05 - HMIN Biomedical Prevention: Injection Safety

**Total Planned Funding for Program Budget Code: \$0**

Program Budget Code: 06 - IDUP Biomedical Prevention: Injecting and non-Injecting Drug Use

**Total Planned Funding for Program Budget Code: \$0**

Program Budget Code: 07 - CIRC Biomedical Prevention: Male Circumcision

**Total Planned Funding for Program Budget Code: \$100,000**

#### Table 3.3.07: Activities by Funding Mechansim

**Mechanism ID:** 8176.09

**Mechanism:** USAID/PSP/ABT

**Prime Partner:** Abt Associates

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (USAID)

**Program Area:** Biomedical Prevention: Male Circumcision

**Budget Code:** CIRC

**Program Budget Code:** 07

**Activity ID:** 28881.09

**Planned Funds:** \$100,000

**Activity System ID:** 28881

**Activity Narrative:** N/A

**New/Continuing Activity:** New Activity

**Continuing Activity:**

Program Budget Code: 08 - HBHC Care: Adult Care and Support

**Total Planned Funding for Program Budget Code: \$750,727**

#### Program Area Narrative:

In spite of evidence of a sharp decline in HIV prevalence between 2001 and 2007, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence of 15.6%. About 1.1 million adults and 133,000 children are currently living with HIV and AIDS in Zimbabwe. Average life expectancy has dropped in the past two decades by over 20 years, to 37 years in men and 34 years in women, largely due to HIV and AIDS.

As part of the national response to this burden, Zimbabwe's National ART Program, started in 2004, is designed as a comprehensive care and treatment package of services that addresses medical, social, emotional, and economic needs of People Living with HIV/AIDS (PLHA), and is a complement to prevention interventions. Currently, 113 public health sites (primarily central, provincial, district and mission hospitals) offer ARV services. Out of an estimated 500,000 PLHA needing treatment, as of September 2008, approximately 152,000 adults and children were on ART, including an estimated 10,000 in the private sector and 6,000 NGO supported. As of September 2008, 11,020 children were receiving ART. Among children aged 0-14 years, there are an estimated 17,000 new infections annually and 12,000 AIDS-related deaths occurred in 2007. All branches of the military service have ART programs, including a model program in the Air Force, with access for all levels of personnel. The Government of Zimbabwe goal is to provide 230,000 PLHA with ART by the end of 2009 and 285,000 by the end of 2010.

Zimbabwe's palliative care package includes psychosocial support, nutritional counseling and support, positive prevention counseling, information on positive living, treatment for opportunistic infections (OI), Cotrimoxazole prophylaxis, bereavement counseling, spiritual counseling, succession planning, hospice care, and PLHA groups. Over the past several years, access to and quality of both non-clinical and clinical palliative care services have improved significantly. Non-clinical community-based care and support is provided through PLHA support groups, faith-based networks, NGOs, and numerous other organizations throughout the country, under the guidance of the National AIDS Council (NAC). The OI Clinic Model, developed by MOHCW with USG support, serves as the basis for comprehensive clinical HIV service delivery and transition to the ART program. Currently, 366 OI clinics at MOHCW and mission hospital sites are operational, vastly exceeding the national targets of 110 for 2008 and 140 for 2009. In FY08 these sites provided Cotrimoxazole for OI to 177,959 adults and 28,558 children. The Pfizer Diflucan donation program to Zimbabwe is now in its fifth year of operation, and between June 2007 and January 2008 provided 24,904 patients Diflucan at 125 OI sites.

Lack of financial resources, inadequate human resource capacity at all levels and inadequate laboratory services to support ART and pre-ART patient monitoring have been the main factors limiting Zimbabwe's PLHA care and treatment program expansion. Global Fund Round 1 (GF1) did not finance ARV drugs, and GF5 has encountered difficulties with disbursements. As described in the HTXD ARV Drugs narrative, over the FY07-08 period the USG and other donors began providing ARV drugs, and the situation for ARV drugs is relatively stable.

#### USG Program

USG's care and treatment program is of a scale appropriate to a mini-COP country and does not include widespread provision of USG-direct clinical care and treatment services. USG continues to provide technical assistance (TA), advocacy, and program support to the MOHCW and other partners to develop models and tools that can be replicated with non-USG leveraged funds to strengthen systems for care and treatment of PLHA. The USG also provides limited capacity building (primarily training and TA) so that systems can be sustained over time.

In FY08, USG funds for care and treatment supported the Supply Chain Management Systems (SCMS) mechanism to provide long-term TA to the national ART program. The USG also supported the MOHCW and the University of Zimbabwe's Clinical Epidemiological Resource and Training Center's HIV/AIDS Quality of Care Initiative (HAQOCI) to develop and provide pre- and in-service training in OI/ART; the bilateral Partnership Project for provision of non-clinical care and treatment of PLHA; the National AIDS Council (NAC) for training and supervision to support the roll-out of the national Community Home-Based Care (CHBC) program; and USG staffing and technical assistance. As described below, in FY08, these partners trained about 480 (direct) providers in PLHA care and treatment and reached 20,400 (direct) and an additional 20,000 (indirect) PLHA with palliative care services.

Also in FY08, USG provided final funding to a 2 year pilot project tracking mother-infant pairs who were cross-referred through an integrated PMTCT / Expanded Program of Immunization effort. The pilot achieved impressive results which will be fed into on-going PMTCT and follow-up care programs. Planned FY08 funding to new civil society organizations for care and treatment was not pursued, and funds were reprogrammed for training needs.

In FY09, the USG will continue support to SCMS, MOHCW, HAQOCI, Partnership, and NAC for Adult Care and Treatment, and will initiate some efforts with the MOHCW and HAQOCI in the Pediatric sphere as well (see separate Pediatric Care and Treatment program narrative).

#### FY08 Social, Economic, and Political Context

Implementation of the USG PEPFAR program in Zimbabwe during FY08 was subject to a number of severe stresses. From January to March, during the run-up to the March 29, 2008 general elections, the highly charged political atmosphere led to a number of disruptions and hampered implementation. The situation was even worse from April – June. Widespread Government sponsored violence effectively closed most rural areas in the country and many urban areas. Hundreds were killed and tens of thousands were displaced. A number of USG-supported community outreach activities were either suspended to protect staff and potential participants, or shifted to urban areas that required less travel and exposure. On June 4, the Government of Zimbabwe suspended most NGO activity for almost 3 months, until August 29, setting back many programs. Throughout the year the continuing collapse of the Zimbabwean economy and inflation that reached billions of percent put severe strains on programming and local partners. In general, the unprecedented hyperinflation and eventual collapse of Zimbabwean currency; lack of public utilities (water and electricity); widespread violence; and extreme political uncertainty created barriers to all programs.

#### USG Adult Care and Treatment Program and Prospects

At the national level, in FY08, SCMS seconded two medical officer positions to the MOHCW National AIDS and TB Program: the National ART Coordinator and the Assistant National ART Coordinator. SCMS also funded the training of 56 provincial ART team members in conducting ART site readiness assessments, assisted MOHCW in conducting 36 ART site readiness assessments, and funded 85 participants at HIV and AIDS provincial review workshops. In FY09, SCMS will continue similar support to the National Program leadership through the HTXS budget code; its assistance to the national logistics management system is discussed in HTXD.

To strengthen service delivery systems, the USG supports the MOHCW and HAQOCI for roll-out of the OI/ART clinical model. As part of this work, HAQOCI provides facilitative supervision to 4 large ART sites: Harare Central Hospital, Parirenyatwa Hospital, and Beatrice Road Hospital in Harare and Mpilo Hospital in Bulawayo. In FY08, HAQOCI provided coordination and implementation of national and regional OI/ART adult training workshops, and conducted training-of-trainers (ToT) on OI/ART management for 43 nurse tutors at the national level. In FY09, the partners plan to replicate the regional ToT workshops, reaching a planned 120 participants. Additionally, HAQOCI will continue its partnership with the Hospice Association of Zimbabwe (HOSPAZ) to train individuals to provide palliative care. In FY09, with USG funding HAQOCI plans to train 60 participants in two of Zimbabwe's 10 provinces in comprehensive care, including care for children and TB patients. The activity is part of a longer term program with HOSPAZ and NAC to improve home-based care (HBC).

With partial USG support, NAC is leading a multi-donor effort to improve the quality of Community HBC (CHBC) in Zimbabwe. The program started in October 2006, and to date has formed one national and 10 provincial CHBC Task Forces; started roll-out to the district level; and developed a national CHBC Strategy. As of September 2008, NAC supported 323 sites that provide HIV related palliative care throughout the country. In FY09, NAC plans to increase coverage to 350 sites, and to train 4,000 providers in HIV palliative care. USG will provide modest support to support NAC's cascade training to district CHBC Task Forces in all provinces. NAC projects in FY09, 130,000 PLHA will be provided with care and support services.

Through its funding to the Partnership Project, the USG also supports care of PLHA before HBC is needed, promoting positive living strategies through New Life counseling and support centers. From FY06-FY08 the USG supported expansion of the New Life network from 10 to 16 sites, reaching a cumulative total of 123,052 individuals with care and support according to national and international standards. The project also trained 500 individuals in HIV-related care and supportive counseling. (In general, the NAC-supported CHBC clients are more end-stage PLHA, whereas the Partnership clients are early-post-test and those receiving ART.)

New Life provides psychosocial, spiritual and preventive support to PLHA through post-test support centers that are staffed with professional and PLHA peer counselors. Palliative care services are provided at both the New Life centers and through an extensive outreach program whereby counselors provide palliative care services at public health care institutions in collaboration with public sector personnel (ART adherence counseling program, psychosocial support program for HIV+ pregnant women, mothers and their families enrolled in the national PMTCT program) as well as to employees at workplaces, to already existing PLHA support groups and to church members at churches that request support through the program. These services are also linked to PMTCT services to support outreach to PMTCT client partners and families. Currently 60-65% of New Life participants are female.

In FY09, the Partnership Project will: (1) Expand care and support services through an enhanced outreach program that is closely linked to the national PMTCT and CT programs. Among many other efforts, through linkages with the Partnership Project's New Start CT network and the International Organization for Migration, this work will include intensification of its outreach program to PLHA who are internally displaced persons and HIV-positive returned migrants, through two reception centers in Beitbridge and Plumtree. (2) Maintain high quality of care and support service delivery. With wraparound funding provided by the Dutch Government, during FY09 the project will provide intensive training in family planning (FP) to all counselors, with specific emphasis on dual protection. Through a grant to the Zimbabwe Nurses Association (ZINA) the project will strengthen pre-service training of nurse providers in the integration of FP and PMTCT. (3) Enhance referral and referral tracking system. The project will ensure that HIV+ clients seeking counseling and support at New Life centers will receive comprehensive information on HIV treatment, care and support services (including FP and PMTCT) and are appropriately referred for ongoing support. The project will increase the percentage of referrals tracked from the current 45% to 50% through intensified direct linkages to other post-test service providers. All identified TB suspects will be referred to TB diagnostic centers and referral tracking of TB referrals will be strengthened. (4) Improve knowledge and understanding of HIV treatment, care and support services. The project will launch generic communication campaigns through mass media and interpersonal communications to enhance understanding and to create demand for treatment, care and support services, including ART. The campaigns will also improve understanding of Positive Living and Positive Prevention.

FY09 funding is also allocated to the management firm Ernst and Young for select technical assistance and audit, and to USG agencies for technical expertise and staffing.

#### Wraparounds/Leveraging

USG support to Adult Care and Treatment leverages significant funding for all public sector ART, PMTCT, and HIV testing sites in the country. For ART commodities alone, as described in the ARV Drugs (HTXD) program area narrative, this donor support has a combined wraparound value of about \$25.3 million in FY2009. The value of Cotrimoxazole for OI purposes in FY09 is estimated at \$4.6 million, as compared to only \$560,000 in FY08. Cotrimoxazole donors include: ESP (\$1.91 million); UNICEF (\$0.96 million); CHAI (\$1.76 million). (Note: The US dollar values provided are estimates, based on actual shipments in 2008-2009, weighted by targets. Unit costs by patients should not be compared since arrays of commodities supplied by each donor are not comparable.)

USG is also leveraging DFID funds to complement palliative care efforts. Approximately \$450,000 will be allocated in FY09 to support program activities of the New Life post-test support services program, including staff salaries, training costs of counselors and other staff, M&E activities and furniture and equipment for the New Life centers. Several USG-supported partners will also

work in some of the 5 GF1 and 22 GF5 districts, although quantification of funds leveraged is not possible at this time.

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 9763.09 **Mechanism:** CDC/COAG/NAC  
**Prime Partner:** National AIDS Council, Zimbabwe **USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GAP **Program Area:** Care: Adult Care and Support  
**Budget Code:** HBHC **Program Budget Code:** 08  
**Activity ID:** 22693.27999.09 **Planned Funds:** \$50,000  
**Activity System ID:** 27999  
**Activity Narrative:** N/A  
**New/Continuing Activity:** Continuing Activity  
**Continuing Activity:** 22693

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
22693	22693.08	HHS/Centers for Disease Control & Prevention	National AIDS Council, Zimbabwe	9763	9763.08		\$50,000

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 11640.09 **Mechanism:** CDC/MGMT/EY  
**Prime Partner:** Ernst and Young **USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GAP **Program Area:** Care: Adult Care and Support  
**Budget Code:** HBHC **Program Budget Code:** 08  
**Activity ID:** 28448.09 **Planned Funds:** \$13,953  
**Activity System ID:** 28448  
**Activity Narrative:** N/A  
**New/Continuing Activity:** New Activity  
**Continuing Activity:**

**Table 3.3.08: Activities by Funding Mechanism**

**Mechanism ID:** 4087.09 **Mechanism:** USAID - TA  
**Prime Partner:** US Agency for International Development **USG Agency:** U.S. Agency for International Development  
**Funding Source:** GHCS (USAID) **Program Area:** Care: Adult Care and Support  
**Budget Code:** HBHC **Program Budget Code:** 08  
**Activity ID:** 28397.09 **Planned Funds:** \$58,889  
**Activity System ID:** 28397  
**Activity Narrative:** N/A





**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 6072.28342.09

**Planned Funds:** \$127,885

**Activity System ID:** 28342

**Activity Narrative:** N/A

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 18347

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18347	6072.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	8059	3933.08	CDC - Local	\$170,000
11664	6072.07	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	5840	3933.07		\$245,000
6072	6072.06	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	3933	3933.06	HHS/CDC Ops Base	\$577,500

**Table 3.3.09: Activities by Funding Mechansim**

**Mechanism ID:** 3874.09

**Mechanism:** CDC/COAG/MOHCW

**Prime Partner:** Ministry of Health and Child Welfare, Zimbabwe

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GAP

**Program Area:** Treatment: Adult Treatment

**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 6065.28337.09

**Planned Funds:** \$40,000

**Activity System ID:** 28337

**Activity Narrative:** N/A

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 18326

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18326	6065.08	HHS/Centers for Disease Control & Prevention	Ministry of Health and Child Welfare, Zimbabwe	8055	3874.08	CDC/CoAg/MO HCW	\$85,000
11619	6065.07	HHS/Centers for Disease Control & Prevention	Ministry of Health and Child Welfare, Zimbabwe	5829	3874.07	Co Ag MOHCW	\$100,000
6065	6065.06	HHS/Centers for Disease Control & Prevention	Ministry of Health and Child Welfare, Zimbabwe	3874	3874.06	Co Ag #CCU020903	\$100,000

**Table 3.3.09: Activities by Funding Mechansim**

**Mechanism ID:** 3906.09

**Mechanism:** CDC/COAG/HAQOCI

**Prime Partner:** University of Zimbabwe,  
HIV/AIDS Quality of Care  
Initiative

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Funding Source:** GAP

**Program Area:** Treatment: Adult Treatment

**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 6066.28233.09

**Planned Funds:** \$25,000

**Activity System ID:** 28233

**Activity Narrative:** N/A

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 18312

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18312	6066.08	HHS/Centers for Disease Control & Prevention	University of Zimbabwe, HIV/AIDS Quality of Care Initiative	8045	3906.08	CDC/CoAg/HAQ OCI	\$50,000
11638	6066.07	HHS/Centers for Disease Control & Prevention	To Be Determined	5835	3906.07	Co Ag TBA	
6066	6066.06	HHS/Centers for Disease Control & Prevention	University of Zimbabwe, Clinical Epidemiol	3906	3906.06	Co Ag #CCU020910	\$50,000

**Table 3.3.09: Activities by Funding Mechansim**

**Mechanism ID:** 4087.09

**Mechanism:** USAID - TA

**Prime Partner:** US Agency for International  
Development

**USG Agency:** U.S. Agency for International  
Development

**Funding Source:** GHCS (USAID)

**Program Area:** Treatment: Adult Treatment

**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 28398.09

**Planned Funds:** \$58,889

**Activity System ID:** 28398

**Activity Narrative:** N/A

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.09: Activities by Funding Mechansim**

**Mechanism ID:** 11640.09

**Mechanism:** CDC/MGMT/EY

**Prime Partner:** Ernst and Young

**USG Agency:** HHS/Centers for Disease  
Control & Prevention

**Funding Source:** GAP

**Program Area:** Treatment: Adult Treatment

**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 28455.09

**Planned Funds:** \$9,070

**Activity System ID:** 28455

**Activity Narrative:** N/A

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.09: Activities by Funding Mechanism**

**Mechanism ID:** 6003.09

**Mechanism:** USAID/ART  
Procurement/PFSCM

**Prime Partner:** Partnership for Supply Chain  
Management

**USG Agency:** U.S. Agency for International  
Development

**Funding Source:** GHCS (USAID)

**Program Area:** Treatment: Adult Treatment

**Budget Code:** HTXS

**Program Budget Code:** 09

**Activity ID:** 11691.28480.09

**Planned Funds:** \$500,000

**Activity System ID:** 28480

**Activity Narrative:** N/A

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 18652

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18652	11691.08	U.S. Agency for International Development	Partnership for Supply Chain Management	8188	6003.08	USAID/PFSCM/ARV Services (clinical services TA)	\$500,000
11691	11691.07	U.S. Agency for International Development	Partnership for Supply Chain Management	6003	6003.07	USAID/PFSCM S/ARV Services (clinical services TA)	\$2,061,000

**Program Budget Code:** 10 - PDCS Care: Pediatric Care and Support

**Total Planned Funding for Program Budget Code:** \$174,909

**Program Area Narrative:**

In spite of evidence of a sharp decline in HIV prevalence between 2001 and 2007, with a drop of approximately 1.8 percentage points/year, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence of 15.6%. About 1.1 million adults and 133,000 children are currently living with HIV and AIDS in Zimbabwe. Average life expectancy has dropped in the past two decades by over 20 years, to 37 years in men and 34 years in women, largely due to HIV and AIDS.

As part of the national response to this burden, Zimbabwe's National ART Program, started in 2004, is designed as a comprehensive care and treatment package of services that addresses medical, social, emotional, and economic needs of People Living with HIV/AIDS (PLHA), and is a complement to prevention interventions. In 2005, the Government of Zimbabwe made a deliberate effort to scale up pediatric HIV and AIDS care and treatment with the Clinton Foundation HIV/AIDS Initiative (CHAI) support of 1,000 pediatric formulation based treatments offered for 2006. A national task force, comprising of members from the Ministry of Health and Child Welfare (MOHCW), the PMTCT Partnership Forum, and the Pediatric Sub-Committee on HIV/AIDS Care, developed the initial plans and drafted training materials for pediatric care that were pre-tested at 11 learning sites designated to receive CHAI-purchased drugs. The MOHCW and the Pediatric Sub-Committee on Care, along with USG technical staff and partners EGPAF and the University of Zimbabwe's Clinical Epidemiological Resource and Training Center's HIV/AIDS Quality of Care Initiative (HAQOCI), collaboratively reviewed these training materials. USG technical assistance enabled the MOHCW to complete the layout, design, and full production of the materials. This national training in pediatric care has been

conducted since early 2007.

Currently, 113 public health sites (primarily central, provincial, district and mission hospitals) offer ARV initiation or follow up services, with 31 of them having specific OI/ART pediatric clinics. Out of an estimated 500,000 PLHA needing treatment, as of September 2008, approximately 152,000 adults and children were on ART, including an estimated 10,000 in the private sector and around 6,000 NGO supported. As of September 2008, 11,020 children were receiving ART. Among children aged 0-14 years, there are an estimated 17,000 new infections annually and 12,000 AIDS-related deaths occurred in 2007. The Government of Zimbabwe goal is to provide 230,000 PLHA with ART by the end of 2009 and 285,000 by the end of 2010, of which 70,000 will be children.

Zimbabwe's palliative care package includes psychosocial support, nutritional counseling and support, positive prevention counseling, information on positive living, treatment for opportunistic infections (OI), Cotrimoxazole prophylaxis, bereavement counseling, spiritual counseling, succession planning, hospice care, and PLHA groups. Over the past several years, access to and quality of both non-clinical and clinical palliative care services have improved significantly. Non-clinical community-based care and support is provided through PLHA support groups, faith-based networks, NGOs, and numerous other organizations throughout the country, under the guidance of the National AIDS Council (NAC).

The OI Clinic Model, developed by MOHCW with USG support, serves as the basis for comprehensive clinical HIV service delivery and transition to the ART program. Currently, 366 OI clinics at MOHCW and mission hospital sites are operational, vastly exceeding the national targets of 110 for 2008 and 140 for 2009. In FY08 these sites provided Cotrimoxazole for OI to 177,959 adults and 28,558 children. The Pfizer Diflucan donation program to Zimbabwe is now in its fifth year of operation, and between June 2007 and January 2008 provided 24,904 patients Diflucan at 125 OI sites.

Recently, the Pediatric Sub-Committee for Care has piloted early infant diagnosis in three central hospitals around the country, with CHAI support, and there are plans for roll out to other institutions for 2009.

Lack of financial resources, inadequate human resource capacity at all levels and inadequate laboratory services to support ART and pre-ART patient monitoring have been the main factors limiting Zimbabwe's PLHA care and treatment program expansion. Global Fund Round 1 (GF1) did not finance ARV drugs, and GF5 has encountered difficulties with disbursements. As described in the HTXD ARV Drugs narrative, over the FY07-08 period the USG and other donors began providing ARV drugs. CHAI is the main supplier for children's drugs, diagnostic tests, reagents for monitoring tests and therapeutic food for HIV positive malnourished children.

#### Summary USG Program

USG's care and treatment program is of a scale appropriate to a mini-COP country and does not include widespread provision of USG-direct clinical care and treatment services. USG continues to provide technical assistance (TA), advocacy, and program support to the MOHCW and other partners to develop models and tools that can be replicated with non-USG leveraged funds to strengthen systems for care and treatment of PLWHA. The USG also provides limited capacity building (primarily training and TA) so that systems can be sustained over time.

In FY08, USG funds supported the MOHCW and the University of Zimbabwe's Clinical Epidemiological Resource and Training Center's HIV/AIDS Quality of Care Initiative (HAQOCI) to provide pre- and in-service training in OI/ART pediatric management; the bilateral Partnership Project for provision of non-clinical care and treatment of PLHA; the National AIDS Council (NAC) for training and supervision to support the roll-out of the national Community Home-Based Care (CHBC) program; supporting the MOHCW development of guidelines for pediatric testing and counseling and USG staffing and technical assistance within the pediatric subcommittee for the new protocols on early infant diagnosis.

Also in FY08, USG provided final funding to a 2 year pilot project tracking mother-infant pairs who were cross-referred through an integrated PMTCT / Expanded Program of Immunization effort. The pilot achieved impressive results which will be fed into ongoing PMTCT and follow-up care programs. This is a key step to catch up earlier infected children into the pediatric care and support programs.

#### FY08 Social, Economic, and Political Context

Implementation of the USG PEPFAR program in Zimbabwe during FY08 was subject to a number of severe stresses. From January to March, during the run-up to the March 29, 2008 general elections, the highly charged political atmosphere led to a number of disruptions and hampered implementation. The situation was even worse from April – June. Widespread Government sponsored violence effectively closed most rural areas in the country and many urban areas. Hundreds were killed and tens of thousands were displaced. A number of USG-supported community outreach activities were either suspended to protect staff and potential participants, or shifted to urban areas that required less travel and exposure. On June 4, the Government of Zimbabwe suspended most NGO activity for almost 3 months, until August 29, setting back many programs. Throughout the year the continuing collapse of the Zimbabwean economy and inflation that reached billions of percent put severe strains on programming and local partners. In general, the unprecedented hyperinflation and eventual collapse of Zimbabwean currency; lack of public utilities (water and electricity); widespread violence; and extreme political uncertainty created barriers to all programs.

#### USG Pediatric Care and Treatment Program and Prospects

In FY09, the USG will continue to support the MOHCW within the pediatric sphere through the MOHCW-led roll-out of the new child counselling guidelines to the district level with the training of 150 health care workers. The USG will also support Training-of-Trainers for 30 participants on early infant diagnosis as a key step to expanding these services to additional pediatric OI/ART sites. USG will provide direct technical assistance (TA) to the MOHCW, including the Pediatric and Early Infant Diagnosis Subcommittees, and will also support the national public laboratory systems to develop its capacity to perform early infant diagnosis. All these activities are a contribution to Zimbabwe's national objective of providing support services to at least 80% of all children

under 15 years by the end of 2010, in the context of universal access, with the overall aim of improving child survival among HIV infected and affected children by at least 50%.

To strengthen service delivery systems, the USG supports the MOHCW and HAQOCI for roll-out of the OI/ART pediatric clinical model. As part of this work, HAQOCI is providing facilitative supervision to 4 large ART sites: Harare Central Hospital, Parirenyatwa Hospital, and Beatrice Road Hospital in Harare and Mpilo Hospital in Bulawayo. Renovations to the Beatrice Road Hospital for the pediatric clinic are ongoing and FY09 should see the initiation of child services in the renovated building. TB services provided in this hospital should facilitate comprehensive HIV/TB care for children in the same place. Additionally, as described under the Adult Care and Treatment program narrative, HAQOCI will continue its partnership with the Hospice Association of Zimbabwe (HOSPAZ) to train individuals to provide palliative care. HAQOCI will include pediatric care within their curriculum.

FY09 funding is also allocated to the management firm Ernst and Young for select technical assistance and audit, and to USG agencies for technical expertise and staffing.

#### Wraparounds/Leveraging

Through development of models and support to leadership, the USG support to Pediatric Care and Treatment leverages significant funding for all public sector ART, PMTCT, and HIV testing sites in the country. This includes commodities provided by CHAI (1,636 patients – \$4 million), Medecins Sans Frontieres and Swiss Foundation as well as private sector donations such as Pfizer and Axios/Abbott.

**Table 3.3.10: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 11640.09	<b>Mechanism:</b> CDC/MGMT/EY
<b>Prime Partner:</b> Ernst and Young	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GAP	<b>Program Area:</b> Care: Pediatric Care and Support
<b>Budget Code:</b> PDCS	<b>Program Budget Code:</b> 10
<b>Activity ID:</b> 28458.09	<b>Planned Funds:</b> \$6,628
<b>Activity System ID:</b> 28458	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> New Activity	
<b>Continuing Activity:</b>	

**Table 3.3.10: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 3933.09	<b>Mechanism:</b> CDC - TA
<b>Prime Partner:</b> US Centers for Disease Control and Prevention	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GAP	<b>Program Area:</b> Care: Pediatric Care and Support
<b>Budget Code:</b> PDCS	<b>Program Budget Code:</b> 10
<b>Activity ID:</b> 28349.09	<b>Planned Funds:</b> \$120,781
<b>Activity System ID:</b> 28349	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> New Activity	
<b>Continuing Activity:</b>	

**Table 3.3.10: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 3874.09	<b>Mechanism:</b> CDC/COAG/MOHCW
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**Prime Partner:** Ministry of Health and Child Welfare, Zimbabwe  
**Funding Source:** GAP  
**Budget Code:** PDCS  
**Activity ID:** 28347.09  
**Activity System ID:** 28347  
**Activity Narrative:** N/A  
**New/Continuing Activity:** New Activity  
**Continuing Activity:**

**USG Agency:** HHS/Centers for Disease Control & Prevention  
**Program Area:** Care: Pediatric Care and Support  
**Program Budget Code:** 10  
**Planned Funds:** \$47,500

Program Budget Code: 11 - PDTX Treatment: Pediatric Treatment

**Total Planned Funding for Program Budget Code: \$194,851**

**Table 3.3.11: Activities by Funding Mechansim**

**Mechanism ID:** 3874.09  
**Prime Partner:** Ministry of Health and Child Welfare, Zimbabwe  
**Funding Source:** GAP  
**Budget Code:** PDTX  
**Activity ID:** 28348.09  
**Activity System ID:** 28348  
**Activity Narrative:** N/A  
**New/Continuing Activity:** New Activity  
**Continuing Activity:**

**Mechanism:** CDC/COAG/MOHCW  
**USG Agency:** HHS/Centers for Disease Control & Prevention  
**Program Area:** Treatment: Pediatric Treatment  
**Program Budget Code:** 11  
**Planned Funds:** \$40,000

**Table 3.3.11: Activities by Funding Mechansim**

**Mechanism ID:** 3933.09  
**Prime Partner:** US Centers for Disease Control and Prevention  
**Funding Source:** GAP  
**Budget Code:** PDTX  
**Activity ID:** 28350.09  
**Activity System ID:** 28350  
**Activity Narrative:** N/A  
**New/Continuing Activity:** New Activity  
**Continuing Activity:**

**Mechanism:** CDC - TA  
**USG Agency:** HHS/Centers for Disease Control & Prevention  
**Program Area:** Treatment: Pediatric Treatment  
**Program Budget Code:** 11  
**Planned Funds:** \$120,781

**Table 3.3.11: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 11640.09	<b>Mechanism:</b> CDC/MGMT/EY
<b>Prime Partner:</b> Ernst and Young	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GAP	<b>Program Area:</b> Treatment: Pediatric Treatment
<b>Budget Code:</b> PDTX	<b>Program Budget Code:</b> 11
<b>Activity ID:</b> 28460.09	<b>Planned Funds:</b> \$9,070
<b>Activity System ID:</b> 28460	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> New Activity	
<b>Continuing Activity:</b>	

**Table 3.3.11: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 3906.09	<b>Mechanism:</b> CDC/COAG/HAQOCI
<b>Prime Partner:</b> University of Zimbabwe, HIV/AIDS Quality of Care Initiative	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GAP	<b>Program Area:</b> Treatment: Pediatric Treatment
<b>Budget Code:</b> PDTX	<b>Program Budget Code:</b> 11
<b>Activity ID:</b> 6049.28232.09	<b>Planned Funds:</b> \$25,000
<b>Activity System ID:</b> 28232	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> New Activity	
<b>Continuing Activity:</b>	

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18311	6049.08	HHS/Centers for Disease Control & Prevention	University of Zimbabwe, HIV/AIDS Quality of Care Initiative	8045	3906.08	CDC/CoAg/HAQ OCI	\$50,000
11637	6049.07	HHS/Centers for Disease Control & Prevention	To Be Determined	5835	3906.07	Co Ag TBA	
6049	6049.06	HHS/Centers for Disease Control & Prevention	University of Zimbabwe, Clinical Epidemiol	3906	3906.06	Co Ag #CCU020910	\$50,000

Program Budget Code: 12 - HVTB Care: TB/HIV

**Total Planned Funding for Program Budget Code: \$92,233**

**Program Area Narrative:**

Zimbabwe is ranked 20/22 among the high tuberculosis (TB) burden countries and a massive increase in the case load has been experienced since the 1990's. primarily due to the HIV epidemic. The reported incidence rates of all and sputum smear positive

TB cases were 557/100,000 population and 227/100,000 population in 2006, respectively. TB is the most common cause of death, particularly in age groups with high HIV prevalence (15-49 years).

In 2005, a total of 57,117 TB cases were notified, although the absolute number of cases registered annually is reported to be declining in recent years. This is thought to be due to operational rather than epidemiological reasons. Only approximately one-third of pulmonary TB cases are diagnosed on sputum smear microscopy. The proportion of unproven or clinically diagnosed TB cases is unacceptably high. An analysis of TB treatment outcomes of smear-positive cases registered between 1996 and 2001 showed that treatment success increased steadily from 62% in 1996 to 71% in 2001, while the proportion of treatment interruption decreased from 12% to 6% during the same period, with 10% to 12% of patients dying. More than 15% of registered patients were transferred out during the course of treatment and this is due to the fact that intra-district movement of TB patients while on treatment are recorded as transfers out and the 'real' outcomes are not elicited. This unhelpful practice increases the rate of unfavorable outcomes. It is unlikely that treatment outcomes have improved since 2001.

The last external program review was carried out by WHO in 2003, and rapid assessment with emphasis on laboratory services was done in 2005. Most of the recommendations made by these missions have not been implemented, and the findings are likely to be still largely valid.

The most recent drug resistance survey was performed in 1995, and showed less than 3% MDR-TB among new cases and less than 6% among retreatment patients. There is no systematic monitoring of drug resistance, nor is there available treatment. The National Tuberculosis Reference Laboratory (NTRL) in Bulawayo has suffered from frequent severe staffing shortages rendering it non-functional and unable to perform culture and DST. With USG and other donor support, NTRL services are being rebuilt and are increasingly more available, but sufficient reagent supplies still remain an obstacle. While the number of drug-resistant TB cases is unknown, multi-drug resistant (MDR)-TB is generally not thought to be a major problem in the country. However, in the past month two confirmed MDR patients were deported from Botswana, neither of which had access to adequate medication. USG in collaboration with other partners worked with the NTRL to fill this gap and make the required treatment and care accessible to these patients. If the quality of DOTS, access and adherence to treatment continue to degrade, while DR-TB remains unmonitored, the emergence of MDR-TB in this environment would be exceedingly difficult to address.

The NTRL continues to try to do culture and drug susceptibility testing (DST) for first line drugs, and in principle receives sputum from all re-treatment cases for this purpose. However, as of mid-2007 the NTRL had no reagents to carry out this testing. The number of drug-resistant TB cases is unknown though multi-drug resistant (MDR)-TB is not generally thought to be a major problem in the country.

It has been estimated that less than one-third of TB patients are presently tested for HIV even though various research findings indicate a substantial (approximately 80%) co-infection prevalence. In this context, TB patients experience a high mortality rate. This presents a considerable missed opportunity. Uptake of HIV testing is higher (up to 80%) in certain clinics in Harare and Bulawayo where Health Services Departments collaborate with The International Union Against Tuberculosis and Lung Disease (The Union) in operational research to strengthen joint TB/HIV services and ensure that co-infected TB patients and their household contacts, as appropriate, access HIV care.

There is no information on the proportion of PLHA who attend various OI/ART units and are screened for TB. TB symptoms screening is, however, done routinely at client-initiated HIV counseling and testing sites supported by the USG-supported Partnership Project, which has found that up to 14% of PLHA are found to be TB suspects. This is a second missed opportunity, and if attended to, could increase TB case detection and strengthen TB control efforts. Isoniazid preventive therapy (IPT) is presently recommended for under-five contacts of smear-positive TB patients. This practice is not implemented widely and opportunities to initiate the provision of IPT for PLHA warrant further attention.

The M&E system for TB/HIV needs to be revised for the data collected by NTP, because the current system collects data on HIV status only. TB/HIV data on the "three I's" (intensified TB case finding, isoniazid preventive therapy, and infection control for TB within HIV care services) is currently not being collected by the National AIDS Council.

A national level TB/HIV coordinating committee is in place and met in July 2008. Its meetings may be too infrequent (quarterly) and no minutes have been circulated up to date. There are no mechanisms for TB/HIV collaboration at the provincial or district level.

In the 1990's the Dutch government supported the NTP financially, and also seconded medical officers who worked both at the national and provincial levels. The Dutch also financed procurement of TB drugs and laboratory reagents. Presently, the NTP is supported by the Global Fund Rounds 1 and 5 (GF1, GF5) and the European Commission (EC) provides most TB drugs through its Vital Health Services Support Program. Recently, a grant application to the Global Drug Facility (GDF) has been made. In FY05-08, the USG has supported laboratory services and provided laboratory consumables and microscopes to support the National TB Program.

Implementation of the GF5 for TB (\$12 million) has been delayed for several years until recently when some activities have started. Phases 1 and 2 are to end in August 2009 and August 2010, respectively. The Principal Recipient is the Zimbabwe Association of Church-Related Hospitals (ZACH). The program is explicitly designed to focus on the same 22 districts covered by Zimbabwe's GF5 HIV/AIDS award, in order to strengthen TB/HIV linkages. In addition, the GF5 TB award is expected to: improve treatment outcomes by improving case management of TB patients; strengthen community TB directly observed therapy, short course (DOTS); support conduct of drug-resistance surveys; introduce fixed-dose combination therapy and train community DOTS workers in its use; and enable health facilities to offer all TB patients HIV testing and, for those who test positive, offer Cotrimoxazole prophylaxis and referral for consideration of ART. In addition, it will help to ensure that all HIV-infected individuals who present for HIV testing are offered TB screening as well. The TB and HIV/AIDS awards taken together are explicitly intended to improve significantly Zimbabwe's co-management of TB and HIV/AIDS at the national, provincial and district levels.

Zimbabwe's GF8 proposal for TB, for \$58.3 million, was recently approved by the technical review committee. Its priorities remain the same as those of GF5. Given problems in funds management found by a recent GF Inspector General audit in Zimbabwe, it is not clear when the funding will become available.

In summary, TB control in Zimbabwe has lost its former strength, and the country is challenged to respond to the increased case load driven by HIV infection. The global Stop TB targets of a case detection rate of 70% and a cure rate of 85% were not achieved by 2005, and their achievement in 2008 is highly unlikely. Without external support and a greatly strengthened robust national TB program, TB-related morbidity and mortality will continue unabated, and Zimbabwe's capacity to achieve the 2015 target of reducing prevalence of and deaths due to TB by 50% is at great risk.

#### USG Wraparound Program

In September 2008 the USG provided \$1.3 million in earmarked TB Initiative funding (non-GHCS) to the central TB Control Assistance Program (TB CAP) mechanism to support improved TB control in Zimbabwe. The International Union Against Tuberculosis and Lung Disease (The Union), which already had an in-country presence, is the coordinating partner. The goal of TB CAP support is to decrease TB-related morbidity and mortality through strengthening TB control activities in Zimbabwe, in line with the global Stop-TB Strategy and the Zimbabwe Health Sector Strategic Plan.

The long-term strategic approach of TB CAP in Zimbabwe is: (1) To provide technical and financial assistance to the NTP central unit to strengthen its leadership and management capacity in critical areas of TB control in the country; (2) To provide technical and financial assistance to the NTP provincial, city, district, and health facility level, ensuring re-establishment of standard basic DOTS program management through capacity building and assurance of essential inputs; with FY08 funds, in first quarter FY09 the project will start in one province and municipal health authority. Budget permitting based on lessons learned in the initial demonstration sites, the project will roll out programmatic and operational support to other provinces and cities in subsequent years. (3) To build NTP support on existing structures, teams and systems of the HIV/AIDS/STI/TB unit and MOHCW, and with other national and international partners to avoid duplication and overlap, and ensure efficient collaboration with all stakeholders. The Union is in the process of staffing up, and will develop project targets and indicators within the next few months.

#### USG PEPFAR Program and Prospects

In FY05-FY06 USG PEPFAR funds for TB/HIV contributed to development of two model programs at large urban clinics, (1) the Beatrice Road Hospital OI Clinic, which services 10,000 TB patients annually; and (2) the Bulawayo Municipal ARV program which receives priority referrals from TB clinics. By the end of FY07, both of these programs were providing clinical prophylaxis and/or treatment for TB for co-infected individuals on a high quality, routine basis.

In FY07-08, the USG-funded program lost focus, and HVTB funds were used primarily to support comprehensive OI/TB/ART training of health care providers. As part of the USG PEPFAR Zimbabwe team's Joint Portfolio Review in May 2008, the USG team concluded that although the USG has a strong comparative advantage in TB programs worldwide, its TB-HIV program in Zimbabwe is not achieving results.

Given the availability of significant new non-PEPFAR USG funds for TB and the involvement of The Union in their use, the USG PEPFAR Zimbabwe team decided to pursue development of a new strategic complementary TB-HIV program, in which TB CAP would provide TA and services at the national level and in 1-2 provinces, subject to availability of non-PEPFAR TB funds, and USG PEPFAR would focus on strengthening the national TB reference lab and TB surveillance with PEPFAR funds.

The FY09 COP follows that decision and will provide modest PEPFAR funding to the MOHCW, and direct USG technical support, to maintain the USG PEPFAR team's "place at the table" as the TB CAP and GF5 (and possibly GF8) programs move forward. With FY09 funding, in collaboration with TB CAP and other technical advisors, the MOHCW will be able to support the finalization of a five year TB strategic plan and the development of a standard TB/HIV course; introduce this new TB/HIV course through a national training-of-trainers (90 individuals trained); and support supervisory visits to each province three times a year.

With funding from other PEPFAR program areas, USG will also: build capacity for quality TB/HIV diagnostic services including culture for sputum-negative patients with the NTRL (HLAB funding); develop projections for TB/HIV diagnostic and treatment requirements (HLAB, HTXD funding); and support efavirenz-based ART nationally for co-infected patients during TB treatment (HTXD and HTXS funding). USG will also assist in the updating of the current laboratory standard operation procedures (HLAB funding).

As part of its general collaboration in National AIDS and TB Program implementation, the USG will also provide technical support in program design, planning, and evaluation to the MOHCW and ZACH on GF5 programs to scale up and improve integrated TB/HIV care delivery. On a policy level, USG will encourage the MOHCW, with GF5 and other donor funding, to establish separate, well-ventilated isolation wards for TB patients nationwide. Currently TB patients in district hospitals are housed in cubicles in the general wards.

In addition to funding for the MOHCW, FY09 funding is also provided for direct USG technical expertise and staffing, and to the management firm Ernst and Young for select technical assistance and audit requirements.

#### Wraparounds/Leveraging

Other USG TB funding of \$1.3 million in FY08 and \$1.5 million in FY09 provide an important wraparound to the modest PEPFAR funding. The combined USG PEPFAR and TB resources contribute to a larger effort including MOHCW, GF5, European Union (EU), and WHO. EU supports essential drug procurement for TB drugs. WHO has contributed to technical consultations and staffing for the National TB Program. GF5 monies of up to \$12 million over 3 years will provide a critical infusion of resources for human capacity development and the procurement of essential equipment and commodities.

**Table 3.3.12: Activities by Funding Mechanism**

**Mechanism ID:** 3933.09 **Mechanism:** CDC - TA  
**Prime Partner:** US Centers for Disease Control and Prevention **USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GAP **Program Area:** Care: TB/HIV  
**Budget Code:** HVTB **Program Budget Code:** 12  
**Activity ID:** 28351.09 **Planned Funds:** \$28,419  
**Activity System ID:** 28351  
**Activity Narrative:** N/A  
**New/Continuing Activity:** New Activity  
**Continuing Activity:**

**Table 3.3.12: Activities by Funding Mechansim**

**Mechanism ID:** 3874.09 **Mechanism:** CDC/COAG/MOHCW  
**Prime Partner:** Ministry of Health and Child Welfare, Zimbabwe **USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GAP **Program Area:** Care: TB/HIV  
**Budget Code:** HVTB **Program Budget Code:** 12  
**Activity ID:** 18471.28336.09 **Planned Funds:** \$56,000  
**Activity System ID:** 28336  
**Activity Narrative:** N/A  
**New/Continuing Activity:** Continuing Activity  
**Continuing Activity:** 18471

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18471	18471.08	HHS/Centers for Disease Control & Prevention	Ministry of Health and Child Welfare, Zimbabwe	8055	3874.08	CDC/CoAg/MO HCW	\$60,000

**Table 3.3.12: Activities by Funding Mechansim**

**Mechanism ID:** 11640.09 **Mechanism:** CDC/MGMT/EY  
**Prime Partner:** Ernst and Young **USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GAP **Program Area:** Care: TB/HIV  
**Budget Code:** HVTB **Program Budget Code:** 12  
**Activity ID:** 28463.09 **Planned Funds:** \$7,814  
**Activity System ID:** 28463  
**Activity Narrative:** N/A  
**New/Continuing Activity:** New Activity  
**Continuing Activity:**

**Total Planned Funding for Program Budget Code: \$2,372,800**

### Program Area Narrative:

In spite of evidence of a sharp decline in HIV prevalence between 2001 and 2007, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence of 15.6%. About 1.1 million adults and 133,000 children are currently living with HIV and AIDS in Zimbabwe. Average life expectancy has dropped in the past two decades by over 20 years, to 37 years in men and 34 years in women, largely due to HIV and AIDS.

Zimbabwe has one of the highest proportions of orphaned children in Africa. A recent UNICEF baseline survey indicated that up to 30% of all children are orphaned and 40% are vulnerable, the majority due to HIV and AIDS. This is corroborated by the Zimbabwe Demographic and Health Survey (ZDHS) 2005-06, which found that 24% of those under 18 were orphaned and 10% live in a household where an adult has been very sick or died in the last 12 months. These rates yield approximately 1.6 million orphans.

#### USG OVC Program Background

In FY01-FY07, USG funding for Orphans and Vulnerable Children (OVC) was primarily directed through the Support to Replicable, Innovative, Village/Community Level Efforts for OVC (STRIVE) Project that provided technical assistance (TA) and sub-grants to up to 16 local and international NGOs to work at the community level to provide education assistance and psychosocial support to OVC. STRIVE was the first major bilateral donor activity designed to address Zimbabwe's OVC crisis and reached 153,000 OVC with direct support and 164,000 OVC with indirect support between January 2002 and June 2007. In FY04-FY06 USG also provided modest funding to the International AIDS Alliance for grants to nascent NGOs, reaching an additional 30,000 OVC. In FY04-FY07, USG and partners were very involved in development of the National Action Plan for OVC (OVC NAP).

In FY06-FY07, the British Department for International Development (DFID) provided an initial impetus to bring donors together to develop a multi-donor Project of Support (POS) for OVC. The POS involves DFID, Swedish International Development Agency, Germany and New Zealand AID which have jointly committed over \$70 million to the UNICEF-managed pooled funding mechanism for the period 2006-2010.

In 2007 the POS issued a request for proposals and 23 NGOs were selected to receive grants. Each has several local partners. Implementation of activities is just beginning. The project is national in scope and includes activities that address all crucial core services for OVC. The POS reports that 165,396 OVC were reached under the POS in FY08.

In early FY07, USG undertook an assessment to document key changes in the OVC environment, identify lessons learned and provide recommendations to guide future USG OVC programs. Key observations and recommendations include: (1) The situation of children is worse today than in 2000, when USG became involved in OVC programming; (2) The new multi-donor POS, which is modeled after STRIVE, brings significant new resources to Zimbabwe for OVC programs and USG should complement this project; (3) The National Action Plan for OVC and National Secretariat within the Ministry of Public Service, Labor and Social Welfare (MOPSLSW) provide a framework and structure for working with OVC that should be supported.

#### USG OVC Current Program Summary

In response to recommendations of the STRIVE assessment and other consultation, the USG developed a new approach to OVC that builds on lessons learned, gaps in services, and USG comparative advantages. In conformance with the PEPFAR Zimbabwe Five Year Strategy, the POS is vastly exceeding USG's original "catalytic leveraging" scenario. Within this new environment, the USG is focusing on "filling the gaps," identifying new models, advocacy, and targeting highly vulnerable children such as those in child-headed households, abused children, and children outside of family care. This new approach is implemented through the Children First (CF) umbrella project under a four-year cooperative agreement awarded in the second quarter of FY08 with World Education, Inc. In addition to PEPFAR funding, the USG will provide wraparound USG Population funding to the project to facilitate provision of critical reproductive health information to adolescent girls and boys.

The CF project is an umbrella arrangement that provides non-governmental organizations (NGOs), community-based organizations (CBOs), faith based organizations (FBOs) and other community partners with technical support and funding to improve access to and the quality of OVC care and support services in targeted project areas. The project also provides increased advocacy for OVC social protection. World Education provides sub-partners with different types and levels of sub-agreements, including cash grants, in-kind grants, and purchase orders. With CF funding, the sub-partners provide increased access to a range of comprehensive OVC care services prioritized by the OVC NAP both directly and through referrals and linkages with other programs and service providers. World Education also provides targeted technical support to its sub-partners for quality improvement.

#### FY08 Social, Economic and Political Context

Implementation of the USG PEPFAR program in Zimbabwe during FY08 was subject to a number of severe stresses. From January to March, during the run-up to the March 29, 2008 general elections, the highly charged political atmosphere led to a number of disruptions and hampered implementation. The situation was even worse from April – June. Widespread Government

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sponsored violence effectively closed most rural areas in the country and many urban areas. Hundreds were killed and tens of thousands were displaced.

The Children First project team arrived in Zimbabwe in March 2008, one month before the general elections, when parliament was dissolved and public servants withdrawn from office to provide electoral process support. The ensuing inability of Children First to meet with government staff created delays with both official registration and the selection of project sites.

On June 4, the Government of Zimbabwe suspended most NGO activity for almost 3 months, until August 29, setting back many programs. During this period the CF office was forced to close temporarily, and the Ministry of Public Service and Social Welfare ordered a cease in pre-grant activities until the project registration process was completed. In spite of many difficulties CF finally accomplished this in August 2008 and was able to make the initial sub-awards. In consultation with the USG team, these initial awards are focused in Harare to limit travel expenses and exposure.

Throughout the year the continuing collapse of the Zimbabwean economy and inflation that reached billions of percent put severe strains on programming and local partners. In general, the unprecedented hyperinflation and eventual collapse of Zimbabwean currency, lack of public utilities (water and electricity), widespread violence, and extreme political uncertainty created barriers to all programs.

#### USG OVC Program and Prospects

Given the volatile operating environment, CF and its partners are targeting three groups of OVC in the Harare metropolitan area: children who are infected with HIV/AIDS, street children, and children who are victims of abuse. The project team made this selection based on a situation analysis that included a mapping exercise. The analysis also helped to identify the 12 NGO partners: Africaid, Childline, Christian Community Partnership Trust, Development Aid from People to People, Farm Orphan Support Trust, Hospice Association of Zimbabwe, Seke Rural Home Based Care, Child Protection Society, Mavambo Trust, New Dawn of Hope, Scripture Union, and Justice for Children Trust. The CF team selected the 12 NGOs – of which 3 are FBOs -- due to their strong community base and demonstrated capacity to reach vulnerable children in hard to reach under-served urban areas. They are currently reaching about 12,000 such children in selected areas of Harare.

Each of the 12 partners brings technical expertise in a particular domain. Five of the NGOs will in turn sub-grant to a total of 14 smaller CBOs/FBOs and strengthen the capacity of these community-based partners through the provision of technical assistance, exchange visits, shadowing and mentoring. Through funding and technical assistance to community initiatives, Children First will ensure that resources and technical support go directly to the frontline service providers who are best able to assist OVC.

The partner NGO/CBOs are providing distressed children with psychosocial support, violently displaced children with material assistance, children living with HIV/AIDS with clinical care and support; and street children with a range of critical OVC services.

In FY09 the CF project plans to expand project coverage to include more underserved urban and targeted rural areas, projecting to reach almost 12,900 primary direct OVC, and an estimated 25,700 supplemental direct OVC, for a total target of 38,600 children in FY09. The CF team will work closely with the USG Zimbabwe team to assess possibilities based on current political conditions, situational analyses, and selected targeted rural areas.

Key activities for COP09 include:

- (1) Undertaking a baseline survey to establish benchmarks for all project indicators.
- (2) Conducting frequent situational analyses and mapping surveys to understand more about under-served areas, the situation of children in targeted areas, organizations providing OVC services, gaps in services, community based trainers and collect more area specific baseline data.
- (3) Providing grants to local NGOs, CBOs and community groups in order to serve OVC.
- (4) Capacity building of local NGOs and community initiatives in management and M&E.
- (5) Providing trainings and follow-up to communities on scaling up quality and number of services provided.
- (6) Working with local communities to scale up advocacy on child protection.

During FY09, the CF project will continue to target children who have been displaced internally by politically motivated violence. The project will provide psychosocial support to children who were violently uprooted from their homes during the run-up to the second presidential elections in June. These children require reintegration into their communities. They also require material assistance as their belongings were destroyed during the political violence.

In FY09 the CF project will additionally provide training on conducting gender analysis in programming and gender-based violence to partner staff, community volunteers and members of community groups. The project will train relevant stakeholders in reducing violence and coercion against OVC and will carry out anti-gender violence advocacy as part of its advocacy strategy for OVCs. The project expects to work with advocacy and gender groups to scale up training on gender equity and establish networks of gender groups that would work to reduce violence and coercion of OVC.

Using USG Population wraparound funds, in FY09 CF staff will assist partners to implement interventions targeting reproductive health. This will be done through training, referrals to care and establishment of service networks. Experience has shown that girls with reproductive health knowledge are more likely to access health services and are less likely to engage in risky behavior. The CF project will facilitate training for programming on adolescent reproductive health issues. The project will work with stakeholders to ensure that adolescent OVC have access to reproductive health knowledge and services. The project also seeks to ensure that HIV positive adolescents specifically, are knowledgeable and able to access reproductive health information and services.

In addition to funding for Children First, FY09 funding is also provided for direct USG technical expertise and staffing.

**Leverage/Wraparounds**

USG is providing \$300,000 in FY09 Population funds and expects to provide similar levels in future years, subject to availability of such funds. USG's modest investment in STRIVE has leveraged the \$70 million POS, which is expected to reach 185,500 OVC in FY09 and a cumulative total of 350,000 – 400,000 over five years. Given continued USG investment in the National Secretariat and M&E for systems strengthening, and in development of models and tools for widespread replication, POS achievements are considered indirect PEPFAR targets.

**Table 3.3.13: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 8809.09	<b>Mechanism:</b> USAID/OVC/WEI
<b>Prime Partner:</b> World Education	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (USAID)	<b>Program Area:</b> Care: OVC
<b>Budget Code:</b> HKID	<b>Program Budget Code:</b> 13
<b>Activity ID:</b> 19807.28120.09	<b>Planned Funds:</b> \$2,300,000
<b>Activity System ID:</b> 28120	
<b>Activity Narrative:</b> n/a	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 19807	

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
19807	19807.08	U.S. Agency for International Development	World Education	8809	8809.08		\$2,190,000

**Table 3.3.13: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 4087.09	<b>Mechanism:</b> USAID - TA
<b>Prime Partner:</b> US Agency for International Development	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (USAID)	<b>Program Area:</b> Care: OVC
<b>Budget Code:</b> HKID	<b>Program Budget Code:</b> 13
<b>Activity ID:</b> 18642.28357.09	<b>Planned Funds:</b> \$72,800
<b>Activity System ID:</b> 28357	
<b>Activity Narrative:</b> n/a	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 18642	

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18642	18642.08	U.S. Agency for International Development	US Agency for International Development	8057	4087.08	USAID	\$0

**Total Planned Funding for Program Budget Code: \$2,377,871**

### Program Area Narrative:

In spite of evidence of a sharp decline in HIV prevalence between 2001 and 2007, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence of 15.6%. About 1.1 million adults and 133,000 children are currently living with HIV and AIDS in Zimbabwe. Average life expectancy has dropped in the past two decades by over 20 years, to 37 years in men and 34 years in women, largely due to HIV and AIDS.

With USG and other donor assistance, Zimbabwe is working toward a national goal of universal testing for HIV by 2010. The Zimbabwe Demographic and Health Survey (ZDHS) 2005-06 found that 21.7% of adult women and 16.4% of adult men had been tested and had received their results. In 2007, the USG-funded Partnership Project undertook a population-based survey and found that uptake had increased significantly, to 32% of adults. While impressive, these data indicate that the country has a long way to go before reaching its goal.

Counseling and testing (CT) services in Zimbabwe are offered through standalone voluntary counseling and testing sites, CT sites co-located within public health clinics and hospitals, and community-based outreach and mobile clinics. MOHCW also provides diagnostic testing at opportunistic infection clinics, PMTCT sites and other health facilities. Demand for CT services is high and growing as provider-initiated testing and counseling (PITC), launched in 2006, is rolled out.

Although the national program planned to shift from the current parallel rapid testing protocol to a serial testing protocol in mid-2008, this was not possible. The Laboratory Professionals Council is resisting the move to serial testing due to lack of human resources for necessary supervision. USG and its partners continue to pursue this issue with MOHCW and the Lab Council, and have offered technical support to public sector laboratories in terms of supervision and mentoring. At this time, the shift to serial testing is not projected to begin in 2010.

### Summary USG CT Program

USG's HIV CT program follows the PEPFAR Zimbabwe 5 Year Strategy to implement PITC while also maintaining a core set of VCT centers in urban areas, with increased mobile outreach to rural populations. The USG's lead implementing partners for Counseling and Testing are the Partnership Project, a bilateral contract, and the central Supply Chain Management Systems (SCMS) mechanism. In FY08, SCMS procured approximately 60% of Zimbabwe's HIV rapid test kits and provided technical assistance to maintain a less-than-5% stock out rate at CT sites around the country.

Over the period FY06-FY08 the Partnership Project counseled, tested, and provided results to 705,000 individuals through a total of 20 outlets that provide counseling and testing according to national and international standards. The Partnership Project is also the USG's lead implementing partner for sexual prevention and PLWH care and support activities - both of which have important linkages to CT - and provides significant capacity building to local organizations. With other USG funds, the Partnership Project is fostering family planning integration with Zimbabwe's national PMTCT program. The lead implementing agency for the Partnership Project is Abt Associates, with Population Services International (PSI), Family Health International, and Banyan Global.

By the end of FY08, a cumulative total of approximately 2,545,000 adults had been tested for HIV, with 1,231,184 (48 %) having accessed CT services through the USG-funded New Start network. A total of 254, 868 individuals were tested through New Start in FY08. This figure represents approximately 4% of the total Zimbabwean adult population].

### FY08 Social, Economic and Political Context

Implementation of the USG PEPFAR program in Zimbabwe during FY08 was subject to a number of severe stresses. From January to March, during the run-up to the March 29, 2008 general elections, the highly charged political atmosphere led to a number of disruptions and hampered implementation. The situation was even worse from April – June. Widespread Government sponsored violence effectively closed most rural areas in the country and many urban areas. Hundreds were killed and tens of thousands were displaced. A number of USG-supported community outreach activities – including those related to CT -- were either suspended to protect staff and potential participants, or shifted to urban areas that required less travel and exposure. On June 4, the Government of Zimbabwe suspended most NGO activity for almost 3 months, until August 29, setting back many programs. Neither SCMS nor the Partnership Project is an NGO, and both were able to continue providing vital HIV rapid test kits and New Start counseling and testing throughout the country. In June, however, during the final week of deliveries prior to the election, SCMS truck drivers were stopped on several occasions and ordered to unload everything to prove they were not distributing food aid. In each instance, the delivery vehicles were allowed to proceed with their delivery routes after the forced inspections.

Throughout the year the continuing collapse of the Zimbabwean economy and inflation that reached billions of percent put severe strains on programming and local partners. In general, the unprecedented hyperinflation and eventual collapse of Zimbabwean currency, lack of public utilities (water and electricity), widespread violence, and extreme political uncertainty created barriers to all programs.

## USG HVCT Program and Prospects

In FY08, SCMS procured approximately \$1 million worth of HIV rapid tests and assisted the MOHCW to quantify test kit requirements for future years. SCMS also assisted the MOHCW to implement a supply chain management system for rapid tests that will ensure their availability to the public. The USG-financed tests represented approximately 60% of Zimbabwe's national requirements.

Also in FY08, USG, MOHCW and SCMS agreed to add HIV rapid tests and PMTCT Nevirapine to the Zimbabwe National Family Planning Council's Delivery Team Topping Up (DTTU) system that achieved 95% coverage and reporting, with stock out rates below 10%. After a successful pilot phase, resulting in increased information essential for preventing stock-outs and expiries, SCMS facilitated roll-out of the system nationwide. By the May-June period the system achieved stock out rates of less than 5% or rapid test-kits and PMTCT Nevirapine.

In FY09, the SCMS project will again procure approximately \$1 million worth of HIV rapid tests (540,000 Determine rapid tests, 540,000 SD Bioline rapid tests, and 10,000 INSTI tie breaker rapid tests) and will assist the MOHCW in accurately quantifying HIV rapid test kit requirements. SCMS will continue to work with the MOHCW as it moves toward a serial HIV testing protocol. The project will also continue to assist the MOHCW in implementing a supply chain management system for rapid tests that will ensure their availability to the public. Based on the successful pilot and roll-out of integrating HIV rapid tests with the DTTU system during FY08, the system will continue throughout 2009. The performance indicator for the system will be less than 5% stock out of the two first-level HIV rapid tests at time of delivery by end 2009.

In FY09, the Partnership Project will continue its efforts to increase utilization of the USG/SCMS-procured test kits through CT outreach, counseling, testing and follow-up through the following activities:

(1) Further expansion of client initiated CT (CITC) services with focus on mobile outreach services to reach vulnerable population groups with CT services.

The Partnership Project will further expand its 20 New Start testing and counseling centers' (static sites) and its 21 mobile outreach teams' provision of CITC services using models to reach especially underserved vulnerable population groups in rural areas, at workplaces (through the workplace CT activity) and vulnerable, mobile populations in Zimbabwe. These efforts will include work with returned migrants in collaboration with the International Organisation of Migration. The partners will continue to provide CITC at two returned-migrant reception centers in Beitbridge and Plumtree established in FY08.

Each CT site and outreach team will continue to use geographic positioning systems (GPS) to map CT services coverage and identify coverage gaps to guide project implementation. Approximately 45%-50% of clients are expected to access CITC through mobile outreach services in peri-urban and rural areas.

(2) Maintain high quality of CITC service delivery.

The project will continue to implement mystery client surveys to assess service delivery standards and provide feedback for quality assurance and training. Project supervisors and site managers will undertake periodic assessments of counselors and sites using standardized supervisory tools. The project will conduct annual refresher courses of all counselors, receptionists, office assistants and drivers using practical exercises throughout the year. Training guidelines will be updated based on new developments in the HIV field. With funding from the Dutch Government in FY09, the project will provide intensive training in family planning to all counselors, with specific emphasis on the concept of dual protection.

(3) Enhance referral and referral tracking system.

Referral linkages strengthening will be the core of CT services. The project will ensure that all HIV positive clients are referred for post-test support services to access treatment, care and support. This will include referrals to New Life post-test support services (supported under the HBHC budget code) for ongoing psycho-social support and positive prevention counseling. The project will increase the percentage of referrals tracked from the current 45% to 50% through intensified direct linkages to post-test service providers. As described in the Biomedical Prevention program narrative, the project plans to integrate male circumcision (MC) into CT service provision and to establish a dual referral system to increase access to MC for HIV negative men (referral from CT services to MC sites) and vice versa.

(4) Support to the MOHCW in scaling up PITC.

Building on experience to date, the Partnership Project will continue to provide training and technical assistance to facilitate the scale up of PITC services to other health care facilities. As a member of the HIV testing and counseling and PMTCT partnership forum, the project will continue to share best practice to create an enabling environment for TC scale up.

(5) Increased demand creation for CT, including CITC for uniformed services.

The Partnership Project team will strengthen demand creation activities to focus on both CITC and PITC. PITC communications will improve understanding of the concept and inform individuals about the availability of PITC services at health care facilities. Specific tasks will include: (a) Developing and implementing new mass media campaigns to increase couple testing for HIV positive and discordant couples; (b) Developing and implementing new mass media campaigns to support targeted promotions for high risk groups such as couples and women; (c) Implementing IPC campaigns to increase couple client flow in rural areas; (d) Developing IEC materials (brochures, flipcharts) to promote knowledge of status.

Based on consultation with the USG country team in Zimbabwe, the Partnership project will further expand its workplace CT activity to include Zimbabwe's police and military personnel. Access to police and military camps has been limited because of concern about confidentiality. During FY06-08, the project reached prison officers and prisoners throughout the country, with high uptake of CT services. The project will continue to provide CT services to the prisons on a regular basis, where possible expanding in the number of prisons involved. The project will also expand CT activities to reach employees and their families in police and army camps wherever the political environment permits and will collaborate with the USG Defense Attache Office. The

project will continue CT activities at border posts, such as Beitbridge, Plumtree, Mutare, Nyamapanda and Chirundu, and will also target border officials, an important group at high risk of acquiring HIV infection.

(6) Increase Demand for other services beyond CT.

In FY09, the Partnership Project will finalize development of and implement communications to increase knowledge and use of ART literacy and care. The project will also continue to implement the mass media campaign to increase cross-referrals and uptake of PMTCT and family planning services, and to finalize the development of mass media and IPC campaigns to increase risk perception and knowledge of the link between TB and HIV.

The project has established a strong referral system for TB suspects, who are referred from the CT network to TB diagnostic centers for TB investigations and treatment. All HIV positive clients are screened for TB symptoms at the 20 project New Start centers. Currently 14% of all HIV positive CT clients are TB suspects. All TB suspects are referred to the diagnostic centers, of which 50% -60% report for further investigations and TB treatment. The project will further strengthen the TB screening and referral system and expand TB screening to all clients (both those testing HIV positive and HIV negative clients) tested at the New Start centers in FY09.

In addition to funding for SCMS and Partnership, FY09 funding is also provided for direct USG technical expertise and staffing.

#### Wraparounds/Leveraging

In FY09 USG will provide approximately \$1 million in test kits, the Clinton Foundation \$148,000 and UNFPA \$120,000. Anticipated funding from DFID is expected to increase the number of NGO CT partners and anticipated funding from Global Fund Round 5 would be available to cover additional test kits if needed. The Dutch Government will provide \$550,000 to permit family planning counseling of positive and discordant couples at New Start sites.

**Table 3.3.14: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 4087.09	<b>Mechanism:</b> USAID - TA
<b>Prime Partner:</b> US Agency for International Development	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (USAID)	<b>Program Area:</b> Prevention: Counseling and Testing
<b>Budget Code:</b> HVCT	<b>Program Budget Code:</b> 14
<b>Activity ID:</b> 18645.28358.09	<b>Planned Funds:</b> \$97,871
<b>Activity System ID:</b> 28358	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 18645	

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18645	18645.08	U.S. Agency for International Development	US Agency for International Development	8057	4087.08	USAID	\$300,000

**Table 3.3.14: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 8176.09	<b>Mechanism:</b> USAID/PSP/ABT
<b>Prime Partner:</b> Abt Associates	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (USAID)	<b>Program Area:</b> Prevention: Counseling and Testing
<b>Budget Code:</b> HVCT	<b>Program Budget Code:</b> 14
<b>Activity ID:</b> 12035.28474.09	<b>Planned Funds:</b> \$780,000
<b>Activity System ID:</b> 28474	

Activity Narrative: N/A

New/Continuing Activity: Continuing Activity

Continuing Activity: 18319

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18319	12035.08	U.S. Agency for International Development	Abt Associates	8051	6037.08	USAID/Abt/CT/C SH	\$880,000
12035	12035.07	U.S. Agency for International Development	Abt Associates	6037	6037.07	USAID/Abt/CT/C SH	\$881,555

**Table 3.3.14: Activities by Funding Mechanism**

**Mechanism ID:** 6003.09

**Mechanism:** USAID/ART Procurement/PFSCM

**Prime Partner:** Partnership for Supply Chain Management

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (USAID)

**Program Area:** Prevention: Counseling and Testing

**Budget Code:** HVCT

**Program Budget Code:** 14

**Activity ID:** 11691.28481.09

**Planned Funds:** \$1,500,000

**Activity System ID:** 28481

**Activity Narrative:** N/A

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 18652

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18652	11691.08	U.S. Agency for International Development	Partnership for Supply Chain Management	8188	6003.08	USAID/PFSCM/ ARV Services (clinical services TA)	\$500,000
11691	11691.07	U.S. Agency for International Development	Partnership for Supply Chain Management	6003	6003.07	USAID/PFSCM S/ARV Services (clinical services TA)	\$2,061,000

Program Budget Code: 15 - HTXD ARV Drugs

**Total Planned Funding for Program Budget Code: \$4,058,889**

**Program Area Narrative:**

In spite of evidence of a sharp decline in HIV prevalence between 2001 and 2007, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence of 15.6%. About 1.1 million adults and 133,000 children are currently living with HIV and AIDS in Zimbabwe. Average life expectancy has dropped in the past two decades by over 20 years,

to 37 years in men and 34 years in women, largely due to HIV and AIDS.

As part of the national response to this burden, Zimbabwe's National ART Program, started in 2004, is designed as a comprehensive care and treatment package of services that addresses medical, social, emotional, and economic needs of People Living with HIV/AIDS (PLHA), and is a complement to prevention interventions. Currently, 113 public health sites (primarily central, provincial, district and mission hospitals) offer ARV services. Out of an estimated 500,000 PLHA needing treatment, as of September 2008, approximately 152,000 adults and children were on ART, including an estimated 10,000 in the private sector and 6,000 NGO supported. As of September 2008, 11,020 children were receiving ART. Among children aged 0-14 years, there are an estimated 17,000 new infections annually and 12,000 AIDS-related deaths occurred in 2007. All branches of the military service have ART programs, including a model program in the Air Force, with access for all levels of personnel. The Government of Zimbabwe goal is to provide 230,000 PLHA with ART by the end of 2009 and 285,000 by the end of 2010.

Lack of financial resources, inadequate human resource capacity at all levels and inadequate laboratory services to support ART have been the main factors limiting ARV service expansion. Global Fund Round 1 (GF1) did not finance ARV drugs. The drugs were instead to be purchased by the GOZ, supplemented by ad hoc supplies from donors. By late 2006, because of the rapidly devaluing Zimbabwe dollar, the GOZ was having serious difficulties in purchasing ARV drugs to maintain patients who had been started on ART. There was an imminent danger that 40,000 patients who had started on ART would have to discontinue because of lack of drugs. USG collaborated closely with the GF CCM and OGAC and in mid-2007 received a commitment from OGAC to provide ARV drugs for 40,000 existing patients for a three-year period, through 2010. The 4,500 patients in the GF1 focus districts are among those covered. The first shipments arrived in early July 2007 and the 40,000 patients are assured of a continuous supply of life-saving medicines for the near-term.

Zimbabwe's GF Round 5 (GF5) foresees supporting 54,000 patients (2008) and 74,000 patients (2009) in 22 districts on ARVs and is regularly financing ARV drugs for those patients. However, GF5 disbursements have been slow due to problems with Zimbabwe's exchange rate mechanisms and other financial management factors. In October 2008, a GF Inspector General Audit was particularly damaging regarding GF procurement and accountability of ARVs. Zimbabwe's Expanded Support Program (SP) foresees supporting 48,000 patients (2008) and plans to continue supporting the same number of patients in 2009. The ESP is led by the British Department for International Development (DFID) and includes participation of Canadian, Swedish, and Irish aid agencies. Thanks to the support from the three main donors (USG, GF, ESP), MOHCW targets will probably be achieved in 2008. ESP and GF funding, however, is focused on specific districts, while USG is able to fill gaps nationally. Even with all these resources, an estimated 20,000 PLWA who need ART will not have access. The USG's support for ARV drugs in Zimbabwe is expected to remain essential to the national response through at least 2010.

#### USG Program Summary

The USG continues to undertake ARV procurement in order to "fill in the gaps" in the national ARV program. This approach is consonant with the PEPFAR Zimbabwe Five Year Strategy. In addition technical assistance (TA) and training provided through the Supply Chain Management Systems (SCMS) mechanism will significantly strengthen national ARV delivery systems and build Zimbabwean capacity to continue the program when PEPFAR funding ceases.

#### FY08 Social, Economic, and Political Context

Implementation of the USG PEPFAR program in Zimbabwe during FY08 was subject to a number of severe stresses. From January to March, during the run-up to the March 29, 2008 general elections, the highly charged political atmosphere led to a number of disruptions and hampered implementation. The situation was even worse from April – June. Widespread Government sponsored violence effectively closed most rural areas in the country and many urban areas. Hundreds were killed and tens of thousands were displaced. A number of USG-supported community outreach activities were either suspended to protect staff and potential participants, or shifted to urban areas that required less travel and exposure.

On June 4, the Government of Zimbabwe suspended most NGO activity for almost 3 months, until August 29, setting back many programs. SCMS is not an NGO, and was able to continue providing vital ARVs throughout the country. In order to limit risks of incidents around the run-off elections, however, SCMS completed HIV commodity deliveries prior to the last week of June and resumed normal activities on July 7. During the final week of deliveries prior to the election, SCMS truck drivers were stopped on several occasions and ordered to unload everything to prove they were not distributing food aid. In each instance, the delivery vehicles were allowed to proceed with their delivery routes after the forced inspections.

Throughout the year the continuing collapse of the Zimbabwean economy and inflation that reached billions of percent put severe strains on programming and local partners. In general, the unprecedented hyperinflation and eventual collapse of Zimbabwean currency, lack of public utilities (water and electricity), widespread violence, and extreme political uncertainty created barriers to all programs.

As of October 2008, hyperinflation and the coexistence of multiple exchange rates are increasingly complicating financial operations for SCMS and local suppliers (and other USG partners), resulting in a rapidly degrading supply of products and services. Unfavorable exchange rates have recently led to the postponement of key activities. For instance, the Logistic Support Unit's support and supervision visits to ARV treatment sites could not take place in October due to cash challenges, and the Harare city OI/ART training workshop had to be cancelled. In spite of these challenges, drugs are getting out and being accounted for, and SCMS and the USG team are committed to keep ARV drugs available to PLWH for as long as conditions permit.

#### USG ARV Drug Program and Prospects

The USG commitment for ARV drugs is to provide first-line ARVs to support 40,000 patients from July 2007 through June 2010. These patients are on the following regimens: (1) stavudine + lamivudine+ nevirapine; (2) stavudine + lamivudine + efavirenz; (3) zidovudine + lamivudine + nevirapine; and (4) zidovudine + lamivudine + efavirenz.

In FY08, SCMS procured and distributed the following medicines: Lamivudine/Stavudine/Nevirapine 150/30/200mg for 37,000 patients on the standard first line regimen and 3,000 Lamivudine/Stavudine 150/30mg and Efavirenz 600mg for first line patients with tuberculosis. SCMS also supplied an emergency shipment of 10,000 bottles of Zidovudine 300 mg, an alternative first line drug, to help MOHCW preventing stock-out due to delay with shipments from other donors. These drugs are all FDA-approved/tentatively-approved.

Project activities supported the MOHCW's national ART Programme, with a focus on scaling up ART, the national quality of care initiative, and decentralization of ARV treatment.

For FY09, to quantify the number of drugs needed to support these patients, the following regimen breakdowns were used: (1) stavudine + lamivudine+ nevirapine, 90.7% (2) stavudine + lamivudine + efavirenz, 3.7% (3) zidovudine + lamivudine + nevirapine, 4.8%; (4) zidovudine + lamivudine + efavirenz, 0.8%. This regimen breakdown is based on the September 2008 Logistic Management Information System (LMIS) reports.

In FY09, SCMS will procure the following medicines: Lamivudine/Stavudine/Nevirapine 150/30/200mg for 38,000 patients on the standard first line regimen and 2,000 Lamivudine/ Stavudine 150/30mg and Efavirenz 600mg for first line patients with tuberculosis. These drugs will be FDA-approved/tentatively-approved generics, whenever possible and logical, and will be procured at a cost of approximately \$4 million per year. Any FDA-approved/tentatively approved generics that are not registered in Zimbabwe can still be imported under a Section 75 waiver.

(Although the ARV logistic management and support is funded under the OHSS budget code, in accordance with COP Guidance it is described in detail herein below.)

To assure efficient procurement, storage, and distribution of these drugs, the USG will continue to fund SCMS to provide ongoing TA and resource support to the MOHCW AIDS & TB Logistics sub-unit, based at National Pharmaceutical Corporation (NatPharm) which is the national drug warehouse. The eight current staff positions of the Logistics sub-unit are funded through SCMS, as is the HIV/AIDS Logistics focal person based at the MOHCW Department of Pharmacy Services. The Logistics sub-unit manages the supply chain for the national MOHCW ART program, which includes products supplied by the GOZ, USG, Global Fund, the ESP, the Clinton HIV/AIDS Initiative (CHAI), European Union (EU) and other donors such as Direct Relief International (DRI). SCMS and MOHCW colleagues utilize tools such as Quantimed and PipeLine to assist in supply chain management. The AIDS & TB Logistics sub-unit, along with the Department of Pharmacy Services, chairs the Procurement and Logistics sub-committee of the ART Partners Forum, one focus of which is donor and partner collaboration and communication. The sub-unit has designed a new logistics system, which has been implemented since late 2007, through the development of standard operating procedures, site trainings, and ongoing distribution.

SCMS through its support to the Logistics sub-unit (LSU) of the MOHCW AIDS & TB program provides support to the steps in the procurement cycle as follows:

(1) Product Selection: The LSU provides review of national treatment guidelines, offers logistics considerations of choosing products, and works to minimize pack size proliferation

(2) Quantification (Forecasting and Supply Planning): The LSU leads and manages quarterly updates of quantifications for ARV drugs, HIV test kits, TB drugs, cotrimoxazole, and fluconazole. Adult ARV quantification is disaggregated per main donor group (MOHCW including USG/SCMS, EU and Medecins du Monde; GF and ESP) in order to highlight donor specific issues, such as under- and overstocking that were harder to identify in a national quantification and allow the LSU to discuss supply plan adjustments with each particular donor.

(3) Procurement: The LSU prepares procurement plans for all USG funded products; assists other donors in the development of their procurement plans; highlights any supply gaps and mobilizes resources to fill these gaps

(4) Warehousing: The LSU is based at NatPharm, where all MOHCW HIV & AIDS commodities are stored. In 2008, SCMS performed an assessment of the physical infrastructure of NatPharm Harare warehouse for managing the vastly increased quantities of HIV & AIDS commodities projected to transit through the warehouse in the next 3 years and managed to leverage DFID/ESP and European Community Humanitarian Office (ECHO) funds for the implementation of the recommendation. In 2009, SCMS will second a part-time project coordinator to NatPharm to assist with the purchase and installation of a full racking system and mounting of a radiation heat barrier to preserve the quality of ARV medicines stored at the warehouse.

(5) Distribution: The LSU is supporting NatPharm with the national bi-monthly distribution of ARV drugs and OI drugs by providing 3 delivery trucks, fuel and maintenance, drivers, and per diem.

(6) Logistics Management Information System: Information generated by the LMIS managed by the LSU (patient data, consumption, and stock on hand data) is used for informed decision-making. The LMIS was computerized at central level in 2008 and SCMS will continue to support operation and maintenance of the computerized LMIS in

(7) Capacity Building: The LSU has been trained in logistics, inventory management, and warehousing. In 2009, the LSU will conduct system-specific trainings on logistics for ART sites as necessitated by addition of new sites and personnel attrition

In addition to funding for SCMS, FY09 funding is also provided for direct USG technical expertise and staffing.

#### Wraparounds/Leveraging

SCMS provides technical assistance and support to the Logistics Sub-unit (LSU) that is responsible for managing the HIV/AIDS commodities supply chain that serves all public sector ART, PMTCT, and HIV testing sites in the country. The LSU also

coordinates (but does not procure) the various sources of donor support for commodities, with a combined wraparound value of about \$25.3 million in FY2009, as follows: Global Fund (74,000 patients supported by the end of 2009 – \$11 million); ESP (48,000 patients – \$10 million); the European Union (3,000 patients - \$300,000); CHAI (1,636 patients – \$4 million), Medecins Sans Frontieres and Medecins du Monde and private sector donations such as DRI, Pfizer and Axios/Abbott. (Note: The US dollar values provided are estimates, based on actual shipments in 2008-2009, weighted by targets. Unit costs by patients should not be compared since arrays of commodities supplied by each donor are not comparable.)

**Table 3.3.15: Activities by Funding Mechansim**

**Mechanism ID:** 6003.09 **Mechanism:** USAID/ART  
Procurement/PFSCM

**Prime Partner:** Partnership for Supply Chain Management **USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (USAID) **Program Area:** ARV Drugs

**Budget Code:** HTXD **Program Budget Code:** 15

**Activity ID:** 11691.28482.09 **Planned Funds:** \$4,000,000

**Activity System ID:** 28482

**Activity Narrative:** N/A

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 18652

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18652	11691.08	U.S. Agency for International Development	Partnership for Supply Chain Management	8188	6003.08	USAID/PFSCM/ARV Services (clinical services TA)	\$500,000
11691	11691.07	U.S. Agency for International Development	Partnership for Supply Chain Management	6003	6003.07	USAID/PFSCM S/ARV Services (clinical services TA)	\$2,061,000

**Table 3.3.15: Activities by Funding Mechansim**

**Mechanism ID:** 4087.09 **Mechanism:** USAID - TA

**Prime Partner:** US Agency for International Development **USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (USAID) **Program Area:** ARV Drugs

**Budget Code:** HTXD **Program Budget Code:** 15

**Activity ID:** 28399.09 **Planned Funds:** \$58,889

**Activity System ID:** 28399

**Activity Narrative:** N/A

**New/Continuing Activity:** New Activity

**Continuing Activity:**

Program Budget Code: 16 - HLAB Laboratory Infrastructure

**Total Planned Funding for Program Budget Code: \$1,686,414**

### **Program Area Narrative:**

In spite of evidence of a sharp decline in HIV prevalence between 2001 and 2007, with a drop of approximately 1.8 percentage points/year, Zimbabwe still ranks among the highest HIV burdened countries in the world, with an adult HIV prevalence of 15.6%. About 1.1 million adults and 133,000 children are currently living with HIV and AIDS in Zimbabwe. Average life expectancy has dropped in the past two decades by over 20 years, to 37 years in men and 34 years in women, largely due to HIV and AIDS.

Laboratory services are an essential part of the Zimbabwe healthcare delivery system and play a pivotal role in its HIV/AIDS healthcare plan to support prevention, care and treatment programs. The Ministry of Health and Child Welfare (MOHCW) is the largest provider of diagnostic medical laboratory services, from district to central levels of healthcare. These laboratories operate as a network of 61 district, 7 provincial, 5 central and 2 national reference laboratories, the National Microbiology Reference Laboratory (NMRL) and National Tuberculosis Reference Laboratory (NTBRL). There are also 1,200 health centers that provide primary health care services and very limited laboratory testing. The Zimbabwe Association of Church Hospitals, a faith-based organization (FBO), also provides lab services at the rural hospital level, of which 14 are recognized district hospitals.

Zimbabwe has achieved ongoing success in laboratory system support to the national HIV and AIDS response, as demonstrated by: the successful national roll-out of HIV counseling and testing services to 930 sites (600 public sector sites); revision of the standard HIV testing package; expansion of CD4 capacity, evaluation and adoption of more cost effective CD4 testing technologies; and international accreditation of the Zimbabwe National Quality Assurance Program (ZINQAP). Currently, 28 sites in the public health system and 10 in the private sector offer CD4 testing services and participation in an external proficiency testing (PT) program through ZINQAP.

There are still challenges. In general, laboratory infrastructure for diagnosis of different diseases is underdeveloped in Zimbabwe. Reference and public hospital laboratories have limited facilities to meet existing demands for diagnosis, monitoring and surveillance of HIV, TB, malaria and various opportunistic infections. Given the economic crisis, reagents and other critical supplies are often in short supply. Human resources are also lacking, with out-migration of qualified health workers due to the economic crisis. In FY08, vacancy rates were 49% for lab scientists, and this has adversely affected service delivery. In response to the human resource crisis, in 2007 the MOHCW introduced new cadres to the system and embarked on redefining core competencies and task shifting. With USG and other donor assistance, the MOHCW, has initiated training of Microscopists and State-Certified Medical Laboratory Technicians, and is providing a new course of specialized lab training for Bachelors of Science generalists. These efforts are expected to retain critical staff and reduce out-migration to neighboring countries. In addition, these efforts will enable the MOHCW to fill the gaps and produce a critical mass for supporting the services.

### **USG Summary Program**

Laboratory organizational and physical infrastructure, procurement systems, supply availability, equipment, and trained staff are fundamental elements of PEPFAR Zimbabwe's program implementation. USG's laboratory strengthening program conforms to the PEPFAR Zimbabwe Five Year Strategy and focuses on national laboratory system strengthening and capacity building so that the system can be sustained over time. The USG provides the national laboratory system with direct technical assistance, training, commodity procurement and logistics, and other support. The USG also provides funding to ZINQAP, the MOHCW, and lab technical training providers.

In FY08, USG support focused on: (1) Strengthening the national laboratory Directorate as a policy coordinator and planning body; (2) Development of NMRL and the NTBRL for national quality assurance; (3) Improvement of the national PT system and quality system through technical and financial support to ZINQAP; (4) Support to the national laboratory training schools; (5) Improvement of laboratory networking, referral linkages and national laboratory management capacity through training; (6) National roll-out of rapid HIV testing training; and (7) Improvement of clinical lab services through revision of the standard operating procedures (SOP) manuals and procurement of equipment and supplies.

Forty public hospital laboratories supported by USG have now the capacity for laboratory monitoring of ARV treatment, i.e., CD4/CD8, hematology and chemistry tests. In FY08, with USG support, more than 50,000 HIV disease monitoring tests were performed in those laboratories and a total of 22 laboratory professionals were trained in HIV disease monitoring.

### **FY08 Social, Economic and Political Context**

Implementation of the USG PEPFAR program in Zimbabwe during FY08 was subject to a number of severe stresses. From January to March, during the run-up to the March 29, 2008 general elections, the highly charged political atmosphere led to a number of disruptions and hampered implementation. The situation was even worse from April – June. Widespread Government sponsored violence effectively closed most rural areas in the country and many urban areas. Hundreds were killed and tens of thousands were displaced. A number of USG-supported technical assistance and training activities – including those related to laboratory strengthening -- were either suspended or delayed because of high attrition rates of trained laboratory staff, and very limited logistic and management support by the government. On June 4, the Government of Zimbabwe suspended most NGO activity for almost 3 months, until August 29, setting back many programs. Throughout the year the continuing collapse of the Zimbabwean economy and inflation that reached billions of percent put severe strains on programming and local partners. In general, the unprecedented hyperinflation and eventual collapse of Zimbabwean currency, lack of public utilities (water and electricity), widespread violence, and extreme political uncertainty created barriers to all programs.

## USG HLAB Program and Prospects

Given the fundamental role that laboratories play in the national response, in FY09, USG will triple its funding to Zimbabwe's laboratory system to 6% of the total. The additional funding will permit a greater USG focus and is expected to build capacity of the national lab system to respond to the expanding CT, PMTCT, and ART programs. In the HLAB budget code, USG will support the following:

### (1) Strengthening Quality Assurance Program.

USG will continue its support to improve the quality of lab services through strengthening and expanding the External Quality Assessment (EQA) schemes to major tests (HIV rapid test, CD4 testing, TB, hematology and chemistry tests, DNA- based early infant diagnosis). In partnership with ZINQAP, NMRL and NTBRL support will be focused in implementation of quality system essentials at major facility levels that support laboratory diagnostic and monitoring services.

### (2) Training.

USG will support in-service training in HIV diagnosis and disease monitoring (hematology, chemistry, CD4, HIV serology, early infant diagnosis, TB and malaria smear microscopy). USG technical advisors, in conjunction with ZINQAP and the African Institute of Biomedical Science and Technology (AIBST), will collaborate to develop and standardize lab training modules, training of trainees, and roll-out of trainings to health districts. More than 600 laboratory staff will be trained. USG and its collaborators will also conduct follow-up of training to assess the performance of trainees and improve the laboratory services rendered.

As part of the longer term strategy for human capacity development, USG will provide technical and financial support to the MOHCW in pre-service training for mid- and high-level laboratory science professionals. With FY08 USG support, the MOHCW in collaboration with the University of Zimbabwe has initiated a 6 month course for HIV/TB Microscopists; an 18 month course for State Certified Laboratory Technician; and a 2 year supplementary upgrading course to enable non-lab Bachelor's of Science graduates to become laboratory scientists.

### (3) Strengthening policy, leadership and management capacity.

USG will continue to support the Director of Laboratory Services, MOHCW, to play a leadership and coordination role in implementation of national policies and guidelines, and strategic plans. Support will also be provided to implement the "Maputo Declaration" for standardization of the national laboratory system. As part of local capacity development and sustainability, the USG PEPFAR team will closely work with the MOHCW, reference laboratories and local partners.

### (4) Procurement of laboratory supplies, equipment and maintenance services.

USG will continue support for the procurement of rapid HIV test kits and laboratory equipment (CD4, hematology, chemistry analyzers) for additional public sector ART sites to expand coverage. In addition, to fill identified gaps, USG will provide limited quantities of reagents and supplies including CD4, hematology and chemistry, reagents, and other essential supplies to support the ART program, surveillance, and TB diagnosis at national reference laboratories.

### (5) Strengthening Laboratory Information System (LIS).

In Zimbabwe, almost all laboratories use a manual information system, but the scale-up of ART and monitoring programs is forcing these laboratories to develop and implement a computer-based LIS to handle the ever-increasing volume of data that they receive and report. The nascent LIS will support workflow and information flow in all steps of the laboratory testing process, including patient registration, test ordering, sample collection, testing, and reporting. The LIS will enable laboratories to manage their data, to maintain quality, and to improve efficiency. In FY08, USG supported the procurement of LIS software and related IT equipment, need assessment and piloting at NMRL. In FY09, USG will continue supporting the implementation of the LIS at national reference laboratories, with expansion to central and provincial laboratories when appropriate. The support includes procurement of LIS software and computer accessories (barcode printers, barcode readers, and barcode printer paper), training for laboratory technicians and receptionists, networking, cabling and internet connection, and supportive supervision. Technical assistance will also be provided MOHCW to strengthen the laboratory monitoring and evaluation system in all laboratories. These include the standardization of lab forms, record/register books and reporting and supportive supervision.

### (6) Surveillance.

USG will continue its support to the NMRL for performance of national ANC based HIV surveillance sample analysis, including incidence testing. Technical support will also be provided to both national reference laboratories to establish HIV and TB drug resistance surveys.

### (7) Strengthening Early Infant Diagnosis (EID):

USG will support the NMRL to expand capacity for EID referral testing and will improve quality through participation in the EQA program. Technical assistance will also be provided in for validation and evaluation of critical new technologies for infant diagnostics and more cost effective CD4 testing technologies.

In FY09, with USG support, 600 public health facilities will have the capacity to perform HIV tests and more than 40 public hospitals will provide laboratory monitoring services (CD4/CD8, hematology and chemistry tests). This support will enable these labs to undertake 800,000 HIV tests, 400,000 TB diagnostic tests, and 360,000 HIV disease monitoring tests, reflecting indirect

targets to be reached with USG funding.

In addition to funding to partners, USG will retain \$750,000 in FY09 funds for direct procurement of items above. FY09 funding is also provided for direct USG technical expertise and staffing, and to the management firm Ernst and Young for select technical assistance and audit requirements.

#### Wraparounds/Leveraging

USG funding is strengthening the national laboratory system and filling gaps not covered by other donor funding. For labs, this includes: Global Fund for AIDS, Tuberculosis and Malaria (GF) Round 1 (GF1 – 12 districts), GF5 (22 districts, including the first 12), the British Department for International Development-led, multi-donor Expanded Support Program (ESP - 16 districts), World Bank (training schools), and European Union (training schools). As discussed elsewhere in this COP, USG funding covers service delivery (outreach, counseling, provision of tests) in several other program areas (MTCT, HVCT, HTXS, PDTX) and broad system strengthening (OHSS). Limited and site specific laboratory support also is provided by NGOs including Medecins Sans Frontieres and Italian Cooperation.

Given USG's close relationship with MOHCW and familiarity with the national laboratory systems, USG provides extensive technical support to MOHCW in planning and coordinating lab services and GFATM and other donors. These include planning for lab procurement and training and incorporation of laboratory planning into national roll-out strategies. USG personnel are active members of Zimbabwe GF's Country Coordinating Mechanism's technical writing teams. Total support to national laboratory services over the past three years is estimated at \$20 million of which GF contributed about 75%.

**Table 3.3.16: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 3874.09	<b>Mechanism:</b> CDC/COAG/MOHCW
<b>Prime Partner:</b> Ministry of Health and Child Welfare, Zimbabwe	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GAP	<b>Program Area:</b> Laboratory Infrastructure
<b>Budget Code:</b> HLAB	<b>Program Budget Code:</b> 16
<b>Activity ID:</b> 5964.28338.09	<b>Planned Funds:</b> \$100,000
<b>Activity System ID:</b> 28338	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 18327	

#### Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18327	5964.08	HHS/Centers for Disease Control & Prevention	Ministry of Health and Child Welfare, Zimbabwe	8055	3874.08	CDC/CoAg/MO HCW	\$105,000
11615	5964.07	HHS/Centers for Disease Control & Prevention	Ministry of Health and Child Welfare, Zimbabwe	5829	3874.07	Co Ag MOHCW	\$120,000
5964	5964.06	HHS/Centers for Disease Control & Prevention	Ministry of Health and Child Welfare, Zimbabwe	3874	3874.06	Co Ag #CCU020903	\$120,000

**Table 3.3.16: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 3933.09	<b>Mechanism:</b> CDC - TA
<b>Prime Partner:</b> US Centers for Disease Control and Prevention	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GAP	<b>Program Area:</b> Laboratory Infrastructure
<b>Budget Code:</b> HLAB	<b>Program Budget Code:</b> 16
<b>Activity ID:</b> 5974.28343.09	<b>Planned Funds:</b> \$1,162,228

**Activity System ID:** 28343

**Activity Narrative:** N/A

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 18348

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18348	5974.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	8059	3933.08	CDC - Local	\$160,000
11658	5974.07	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	5840	3933.07		\$260,648
5974	5974.06	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	3933	3933.06	HHS/CDC Ops Base	\$299,455

**Table 3.3.16: Activities by Funding Mechansim**

**Mechanism ID:** 9764.09  
**Prime Partner:** Zimbabwe National Quality Assurance Programme  
**Funding Source:** GAP  
**Budget Code:** HLAB  
**Activity ID:** 22694.28121.09  
**Activity System ID:** 28121  
**Activity Narrative:** N/A  
**New/Continuing Activity:** Continuing Activity  
**Continuing Activity:** 22694

**Mechanism:** CDC/HLAB/ZINQAP  
**USG Agency:** HHS/Centers for Disease Control & Prevention  
**Program Area:** Laboratory Infrastructure  
**Program Budget Code:** 16  
**Planned Funds:** \$210,000

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
22694	22694.08	HHS/Centers for Disease Control & Prevention	Zimbabwe National Quality Assurance Programme	9764	9764.08		\$210,000

**Table 3.3.16: Activities by Funding Mechansim**

**Mechanism ID:** 11640.09  
**Prime Partner:** Ernst and Young  
**Funding Source:** GAP  
**Budget Code:** HLAB  
**Activity ID:** 28466.09  
**Activity System ID:** 28466

**Mechanism:** CDC/MGMT/EY  
**USG Agency:** HHS/Centers for Disease Control & Prevention  
**Program Area:** Laboratory Infrastructure  
**Program Budget Code:** 16  
**Planned Funds:** \$64,186

**Activity Narrative:** N/A

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.16: Activities by Funding Mechanism**

**Mechanism ID:** 11550.09

**Mechanism:** CDC/HLAB/TBD AIBST

**Prime Partner:** To Be Determined

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GAP

**Program Area:** Laboratory Infrastructure

**Budget Code:** HLAB

**Program Budget Code:** 16

**Activity ID:** 28195.09

**Planned Funds:** [REDACTED]

**Activity System ID:** 28195

**Activity Narrative:** N/A

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Program Budget Code:** 17 - HVSI Strategic Information

**Total Planned Funding for Program Budget Code:** \$752,293

**Program Area Narrative:**

USG has a well-developed and ongoing strategic information program built upon a strong commitment to the “Three Ones” and to coordinating SI activities among all key stakeholders in Zimbabwe. USG works directly with the Ministry of Health and Child Welfare (MOHCW), Ministry of Public Service, Labor and Social Welfare (MPOSLSW) and national AIDS Council (NAC) and plays a leading role in providing technical assistance (TA) in the design and development of health management information systems, including those for monitoring, evaluation, and logistics. USG’s SI liaison, who represents USG in National M&E Advisory Group, oversees the monitoring and reporting of PEPFAR indicators and has harmonized the various databases used by USG agencies for PEPFAR planning and reporting. The challenge is to now effectively use this data for program improvement through regular program area working group meetings.

**Summary of USG Program**

USG’s Strategic Information program is built around the PEPFAR Zimbabwe 5 Year Strategy and maintains the strategy’s 3-pronged approach of: (1) systems strengthening; (2) development of tools and models for broad use; and (3) building the capacity of local organizations to implement successful systems. USG is involved in several major, ongoing strategic information initiatives. Since 2000, the USG has supported routine sentinel Antenatal Clinic (ANC) surveillance by providing extensive technical support, purchase of necessary commodities, logistics planning and data analysis. USG involvement in ANC surveys helps ensure that reliable trend data on HIV prevalence are available. The ANC survey scheduled for FY08 has been deferred. Participation in population-based surveys has seen the USG leading the effort to carry out an extended analysis of the Demographic and Health Survey (ZDHS) 2005-06, in collaboration with the MOHCW, UN agencies, DFID and NGOs. Analysis teams have been put together and USG has provided extensive TA in the development of the analysis plans and in FY09 will conduct a workshop to train team members in using statistical analysis software packages. Results of the extended analysis will serve as a framework for planning for a Young Adult Survey. USG also supports the Early Warning Indicators Drug Resistance Survey (EWI) in conjunction with MOHCW and WHO which will be completed in FY09 and the development of an OVC Quality Standards manual with the Ministry of Public Service, Labor and Social Welfare (MOPSLSW).

USG provides extensive TA directly to the M&E department at the National AIDS Council (NAC) for strengthening the National M&E System. In FY08, USG provided contract support and facilitated visits by M&E consultants through the Global Fund TA mechanism to assist NAC in developing a National M&E Plan (2009 – 2014) and a National M&E Action Plan (2009) for all HIV/AIDS programs. This TA will continue in FY09 and further TA will be requested through this mechanism to follow up on implementation of the M&E Action Plan. Support also continued for the rolling out of the Country Response Information System (CRIS) which National M&E System. An electronic medical health record project is also underway to support patient care and information-gathering at USG-supported ART clinics. Data collected by these systems allows USG partners to better manage their programs.

To fill critical gaps that have been left by the exodus of experienced and qualified professionals due to Zimbabwe's difficult social and economic situation, in FY09 USG will continue to provide expertise in M&E, surveillance and HMIS to MOHCW and MOPSLSW to support national SI capacity. The M&E position in the MOPSLSW National Secretariat for the National Action Plan for OVC analyses the national OVC data so that it can be used to better coordinate the national response to OVS and advocate for children. In addition, this position allows the Secretariat to lead development and dissemination of national standards of service, develop tools to assess a child's well-being, and identify and document best practices. The surveillance position in the MOHCW is responsible for coordinating all ANC surveys, National Estimates, DHS, DRTS and other routine M&E and surveillance activities in the MOHCW. The IT position provides the routine IT support needs of the MOHCW AIDS & TB Unit. A large computer training center at the University of Zimbabwe's Health Information Unit, which USG helped build and jointly maintains with other donors, will host the ZHDS analysis workshops as well as other M&E workshops and trainings.

#### FY08 Social, Economic and Political Context

Implementation of the USG PEPFAR program in Zimbabwe during FY08 was subject to a number of severe stresses. From January to March, during the run-up to the March 29, 2008 general elections, the highly charged political atmosphere led to a number of disruptions and hampered implementation. The situation was even worse from April – June. Widespread Government sponsored violence effectively closed most rural areas in the country and many urban areas. Hundreds were killed and tens of thousands were displaced. On June 4, the Government of Zimbabwe suspended most NGO activity for almost 3 months, until August 29, setting back many programs. Throughout the year, the continuing collapse of the Zimbabwean economy and inflation that reached billions of percent put severe strains on programming and local partners, including NAC and government community structures. In general, the unprecedented hyperinflation and eventual collapse of Zimbabwean currency, lack of public utilities (water and electricity), widespread violence, and extreme political uncertainty created barriers to all programs.

#### USG HVSI Program and Prospects

With FY09 funding, USG will maintain its assistance to NAC and other partners to strengthen the National M&E System. Focus areas for FY08 include: 1) training of 138 participants (85 DACs and 53 DAAOs) on M&E/CRIS as prescribed by the Zimbabwe National Strategic Plan; 2) improve the management and reporting of data through the National M&E System including the use of an electronic database; 3) develop a communication strategy surrounding the National M&E System; 4) strengthen the ability of NAC national staff to monitor and support provincial and district staff, as well as local partners and stakeholders; 5) data validation/verification of Program/ Project M&E data in light of the constraints in supervision in FY08.

Surveillance needs to be continued with expanded analysis to look at trend data from multiple sources over time and to ensure data use for program planning. Key activities in this area include: 1) providing adequate M&E tools; 2) storing and using data collected at facility level and upwards; 3) train HCW in use of M&E tools for data collection and on standardized patient and facility numbering system in 20 district hospitals and 20 other health care facilities; 4) supportive supervision of facilities for ART and TB sites in 40% of the districts (60% is covered by Global Fund and ESP) and 25% of comprehensive PMTCT sites; 5) pilot HIV/AIDS program indicators database; and 6) complete an evaluation of ART outcomes; 7) implement HIV and syphilis prevalence in ANC & HIV DR – TS to strengthen national surveillance and Information systems. The key result is an improvement in the reporting rates of all OI/ART sites by 20% since reporting rates have generally been very low in FY08.

#### Wraparounds/Leveraging

Global Fund Round 5 includes funding to establish Service Availability Mapping, computerize the paper-based ART M&E system in 22 districts, an annual revision of the M&E system, the development and implementation of operational research on key national priority issues and support for development and implementation of the national ARV drug resistance surveillance system in a sample of selected districts. Total budget is \$848,500, where the main budget line is the ARV drug resistance surveillance (\$696,400).

FY09 funding is also provided for direct USG technical expertise and staffing, and to the management firm Ernst and Young for select technical assistance and audit requirements.

**Table 3.3.17: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 9763.09	<b>Mechanism:</b> CDC/COAG/NAC
<b>Prime Partner:</b> National AIDS Council, Zimbabwe	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GAP	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17
<b>Activity ID:</b> 18661.28000.09	<b>Planned Funds:</b> \$50,000
<b>Activity System ID:</b> 28000	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 18661	

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18661	18661.08	HHS/Centers for Disease Control & Prevention	To Be Determined	8194	8194.08	CDC/SI/M&E NAC	

**Table 3.3.17: Activities by Funding Mechansim**

**Mechanism ID:** 3933.09 **Mechanism:** CDC - TA  
**Prime Partner:** US Centers for Disease Control and Prevention **USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GAP **Program Area:** Strategic Information  
**Budget Code:** HVSI **Program Budget Code:** 17  
**Activity ID:** 6082.28344.09 **Planned Funds:** \$461,913  
**Activity System ID:** 28344  
**Activity Narrative:** N/A  
**New/Continuing Activity:** Continuing Activity  
**Continuing Activity:** 18349

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18349	6082.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	8059	3933.08	CDC - Local	\$330,000
11665	6082.07	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	5840	3933.07		\$567,750
6082	6082.06	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	3933	3933.06	HHS/CDC Ops Base	\$296,000

**Table 3.3.17: Activities by Funding Mechansim**

**Mechanism ID:** 3874.09 **Mechanism:** CDC/COAG/MOHCW  
**Prime Partner:** Ministry of Health and Child Welfare, Zimbabwe **USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GAP **Program Area:** Strategic Information  
**Budget Code:** HVSI **Program Budget Code:** 17  
**Activity ID:** 6079.28339.09 **Planned Funds:** \$69,000  
**Activity System ID:** 28339  
**Activity Narrative:** N/A  
**New/Continuing Activity:** Continuing Activity  
**Continuing Activity:** 18328

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18328	6079.08	HHS/Centers for Disease Control & Prevention	Ministry of Health and Child Welfare, Zimbabwe	8055	3874.08	CDC/CoAg/MO HCW	\$75,000
11620	6079.07	HHS/Centers for Disease Control & Prevention	Ministry of Health and Child Welfare, Zimbabwe	5829	3874.07	Co Ag MOHCW	\$75,000
6079	6079.06	HHS/Centers for Disease Control & Prevention	Ministry of Health and Child Welfare, Zimbabwe	3874	3874.06	Co Ag #CCU020903	\$75,000

**Table 3.3.17: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 4087.09	<b>Mechanism:</b> USAID - TA
<b>Prime Partner:</b> US Agency for International Development	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (USAID)	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17
<b>Activity ID:</b> 6532.28359.09	<b>Planned Funds:</b> \$154,775
<b>Activity System ID:</b> 28359	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 18331	

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18331	6532.08	U.S. Agency for International Development	US Agency for International Development	8057	4087.08	USAID	\$41,000
11641	6532.07	U.S. Agency for International Development	US Agency for International Development	5838	4087.07		\$150,000
6532	6532.06	U.S. Agency for International Development	US Agency for International Development	3937	3937.06		\$300,000

**Table 3.3.17: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 11640.09	<b>Mechanism:</b> CDC/MGMT/EY
<b>Prime Partner:</b> Ernst and Young	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GAP	<b>Program Area:</b> Strategic Information
<b>Budget Code:</b> HVSI	<b>Program Budget Code:</b> 17
<b>Activity ID:</b> 28467.09	<b>Planned Funds:</b> \$16,605
<b>Activity System ID:</b> 28467	
<b>Activity Narrative:</b> N/A	

**New/Continuing Activity:** New Activity

**Continuing Activity:**

Program Budget Code: 18 - OHSS Health Systems Strengthening

**Total Planned Funding for Program Budget Code: \$5,799,252**

**Program Area Narrative:**

In the past decade, the health care workforce in Zimbabwe has been severely depleted and the hard and soft structures of the health care system have steadily deteriorated. The Ministry of Health and Child Welfare (MOHCW) has identified healthcare worker retention and training as the most critical and recurrent issues facing the sector right now. Similarly, commodity and supply distribution systems are failing because key inputs are no longer available (i.e. fuel, auto parts, refrigerated warehouses, internet connection, etc.). Systems for information collection, storage, management, and distribution have disintegrated because of the lack of critical inputs. Routine disease surveillance is omitted because recording registers have not been printed for several years. Program monitoring and supervision don't happen because fuel/vehicles are not adequately available and trained supervisors are no longer reporting to work. Evaluation is often dismissed because the country's dramatic economic decline and current challenges preclude any real progress or results.

As of December 2007, the MOHCW reported medical staff vacancies at 63% and those for nurses at 39%. Instructors and facilitators are even more absent: 85-90% of all laboratory instructor positions are empty. The national drug logistics support unit, critical to supply of ARV and OI drugs, test kits, etc., is dependent on USG-funded personnel to function. There is a critical need to develop appropriate salary, retention, supervision, and bonus strategies to keep current staff healthy and employed.

Stabilization of the healthcare workforce is a prerequisite to reestablishing a functioning health care system and to the scale up of all programs needed and proposed by MOHCW and its partners. This is a critical need in the public and private health service delivery sectors, but also increasingly important to small NGOs that supply critical outreach, advocacy, care and support services. In addition to working with the MOHCW, University of Zimbabwe, and other training institutions to strengthen and human resources for health services delivery, there is a need to support complementary capacity building for local NGOs, cultural organizations and journalists to improve utilization of those services among target populations.

**Summary of USG Program**

USG PEPFAR support for Health Systems Strengthening represents a wide range of activities targeting different needs in the public and private health system. In FY08, the collection of activities provided technical assistance (TA) to 53 local organizations with HIV-related policy development, up from 22 organizations in FY07. The USG also greatly expanded support for TA to local organizations for HIV-related institutional capacity building, from 56 in FY07 to 146 in FY08, with the number of individuals trained in that topic increasing from 274 to 1,113. Based on expanded participation of local partners, including cultural organizations and journalists, the number of individuals trained in HIV-related stigma and discrimination reduction increased from 20 to 144.

In FY09 USG will build on these efforts through a variety of mechanisms with different partners:

(1) Support to the University of Zimbabwe's (UZ) Department of Community Medicine to build core competencies in HIV and AIDS in its Master's of Public Health program; (2) Funding to the MOHCW and (3) UZ's Clinical Epidemiological Resource and Training Center's HIV/AIDS Quality of Care Initiative (HAQOCI) to develop and provide training and supervision to public sector providers; (4) Direct USG support for human capacity development, in collaboration with MOHCW; (5) Funding for journalist training, library/resource center training and equipping, and destigmatization activities through cultural programming; (6) Support to the Partnership Project for capacity building with local NGOs/FBOs; (7) Continued funding for the Supply Chain Management Systems (SCMS) central mechanism for TA and operations support of the national ARV and OI supply chain. This support is described in the ARV Drugs program narrative but funded under OHSS as instructed in the COP Guidance.

**FY08 Social, Economic and Political Context**

Implementation of the USG PEPFAR program in Zimbabwe during FY08 was subject to a number of severe stresses. From January to March, during the run-up to the March 29, 2008 general elections, the highly charged political atmosphere led to a number of disruptions and hampered implementation. The situation was even worse from April – June. Widespread Government sponsored violence effectively closed most rural areas in the country and many urban areas. Hundreds were killed and tens of thousands were displaced. On June 4, the Government of Zimbabwe suspended most NGO activity for almost 3 months, until August 29, setting back many programs. Throughout the year, the continuing collapse of the Zimbabwean economy and inflation that reached billions of percent put severe strains on programming and local partners, including NAC and government community structures. In general, the unprecedented hyperinflation and eventual collapse of Zimbabwean currency, lack of public utilities (water and electricity), widespread violence, and extreme political uncertainty created barriers to all programs.

**USG OHSS Program and Prospects**

(1) MPH Program. The MPH is a program within UZ's Department of Community Medicine. The program has produced 102 MPH graduates since its inception in 1995. The USG has supported building HIV and AIDS core competencies within the program since 2002. In FY08, 13 students graduated and 12 new students began full-time study. An additional 10 students began a new part-

time course of study. Atlanta-based USG staff mentor student practicum and projects. USG support will be continued in FY09.

(2) MOHCW Cooperative Agreement: The MOHCW cooperative agreement covers several program areas. FY09 activities in OHSS include: (a) Standardize and distribute basic documents describing of roles, rights, and responsibilities of healthcare workers with respect to HIV/AIDS in the workplace, including government policy for retaining infected staff. (b) Develop a health worker wellness program to increase access to diagnosis, care and treatment for those HIV infected. (c) Conduct supervisory visits to all public health institutions in provinces and districts to provide support, information, and resources to health care staff. (d) Host 5 workshops in the reduction of HIV stigma and discrimination among healthcare workers (150 individuals trained).

(3) HAQOCI Cooperative Agreement: USG has supported HAQOCI to develop and provide pre- and in-service training in numerous technical areas related to HIV/AIDS since 2002. HAQOCI's successes in development and then roll-out of the OI/ART clinic model are particularly impressive. With USG support, HAQOCI provides supportive supervision to several health facilities; undertakes ART site assessments; and provides TA to public institutions in institutional capacity building. In FY09, HAQOCI will finalize assessment tools for HIV quality of care improvement that should enhance such activities. In 2007 HAQOCI developed a pre-service integrated curriculum for HIV and AIDS in all health worker programs in Zimbabwe, which was rolled out in January 2008. In FY09, it expects to train a new group of 400 student nurses on OI/ART adult and pediatric management at 20 nursing schools nationwide. Since 2006, HAQOCI has provided mentoring and technical assistance to the Masters of Clinical Epidemiology program of the University of Zimbabwe. During FY08, the program had 13 first year students, 17 second year students, and 12 finalists. Due to relatively high drop-out rates due to the economic crisis, in FY08 USG began providing scholarships for 5 students in the program, and similar support will continue in FY09.

(4) USG Direct OHSS Assistance: USG provides TA, support, guidance, and scientific expertise to the MOHCW and other partners on a wide range of topics, including: new best practices in HIV care, support, and treatment whether for adults or children; assistance in sample analysis for national health surveys; curriculum/module development or review for new courses for the health care sector; advice in standardization of minimum course requirements for GOZ approval; coordination of implementers and donors in support of specific health sector areas; national staff retention schemes (first phase to start Jan 2009); HIV M&E integration with the health information system; policy support to the Global Fund Country Coordinating Mechanism; governance/management support to partners, especially on financial management; etc. USG also directly procures goods and services, including: supporting working groups in the development of training materials, policies, plans and guidelines printing and distributing; purchasing laboratory analysis equipment for national surveys; purchasing maintenance and repair contracts for MOHCW equipment; etc.

Selected outcomes of direct USG assistance in FY09 will be: (a) Completion and review of selected health sector policies (laboratory, TB, training, M&E, full health sector, human resources, HIV testing/counseling guidelines for children, etc.); (b) Printing and distribution of key policies (laboratory, training); (c) A register of trainings according to MOHCW standards throughout the country; (d) Comprehensive review of current MOHCW training materials, curriculums, and methodologies; (e) Printed health facilities activities registers (M&E, for example). (f) Plans for health training institution libraries to build their hard and soft resources.

#### (5) (a) Journalism and Librarian/Resource Centers Training

During FY08 21 journalists in Matabeleland and Midlands provinces received USG-supported training through a workshop conducted with the Matabeleland AIDS Council. The training focused on providing key information on the HIV/AIDS epidemic and introducing the journalists to key messages and actors to be covered. In FY09 USG will conduct similar workshops with journalists in other provinces, while following up with those already trained. Should the political situation result in freer media conditions, the PEPFAR team will work to increase coverage of USG programming and messages. The USG plans to evaluate its journalism training programs on an ongoing basis through regular communication with the participants and major media advocacy organizations in the country. Any changes to the repressive media environment, positive or negative, will be assessed in continuing or expanding training of journalists in HIV/AIDS issues.

In FY08 USG worked with 29 librarians or resource center managers to train them in developing HIV/AIDS information resource centers. The librarians come from urban public and/or university libraries. All participants were provided with a small amount of material with which to create an HIV/AIDS library at their institution. In FY09 USG will continue support to help these centers grow and develop, while trying to expand the initiative by identifying libraries or resource centers in more rural areas. The goal is to build a network of libraries throughout Zimbabwe where ordinary citizens can access information on HIV/AIDS with the assistance of trained professionals. Stemming from the first resource center training in September 2008, USG now has a regular e-mail list of key actors around the country who are providing input for future programming in this area. They have already recommended several ideas for future workshops and hope to access PEPFAR funds to develop a national framework for information resource centers on HIV/AIDS.

#### (5) (b) Cultural Programming on HIV/AIDS

The USG will also use cultural programming to advance the USG message on de-stigmatization and prevention. USG will use the funds to bring artists to Zimbabwe and/or support Zimbabwean artists creating work that de-stigmatizes positive individuals and/or promotes the messages of abstinence and being faithful. Examples of such programming include bringing a Zimbabwean playwright resident in the US to Zimbabwe to conduct a week of workshops with youth about a play she wrote on the HIV/AIDS epidemic in Zimbabwe, or working with HIV positive Zimbabwean artists to de-stigmatize positive individuals.

#### (6) Partnership Project

In FY09 the Partnership Project will provide capacity building TA to all New Life, New Start, and interpersonal communications (IPC) and other communications partners working in HVAB, HVOP, HVCT, and HBHC. The objective of the TA is to enhance the capability of partner organisations in order to improve their efficiency and effectiveness in the delivery of their respective programmatic areas in the fight against HIV and AIDS. 30 organizations have been provided with TA since the project began, and

278 individuals from these organizations have received HIV-related institutional capacity building.

In FY09, the project will continue to focus on critical areas of capacity building, including: financial management and administrative support; management and human resources systems strengthening and leadership development; organisational development; resource mobilisation and sustainability; information, education and communication strategies; monitoring and evaluation and knowledge management; compliance visits and on-site support to address identified weaknesses among partners. The activities will be achieved through in-house support by technical staff, peer mentoring, coaching, outsourcing of specialised services to local capacity building agencies, on-site systems strengthening, training workshops, access to short courses and compliance visits. The project will enhance collaboration and coordination with other capacity building partners in order to leverage resources, share costs and responsibilities and reduce duplication of efforts and maximise the utilisation of available resources. The project will continue to provide small and large grants to old and new NGO/FBO partners to enable them continue to offer counseling and testing, post-test support services and IPC outreach interventions to promote abstinence and being faithful, correct and consistent condom use, reduce high risk behaviors and foster behavior change.

(7) SCMS's work to strengthen ARV drug supply chain management is described in the HTXD ARV Drugs program narrative.

FY09 funding is also provided for direct USG technical expertise and staffing, and to the management firm Ernst and Young for select technical assistance and audit requirements.

**Table 3.3.18: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 8176.09	<b>Mechanism:</b> USAID/PSP/ABT
<b>Prime Partner:</b> Abt Associates	<b>USG Agency:</b> U.S. Agency for International Development
<b>Funding Source:</b> GHCS (USAID)	<b>Program Area:</b> Health Systems Strengthening
<b>Budget Code:</b> OHSS	<b>Program Budget Code:</b> 18
<b>Activity ID:</b> 12038.28475.09	<b>Planned Funds:</b> \$300,000
<b>Activity System ID:</b> 28475	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 18320	

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18320	12038.08	U.S. Agency for International Development	Abt Associates	8052	6039.08	USAID/Abt/Policy/CSH	\$450,000
12038	12038.07	U.S. Agency for International Development	Abt Associates	6039	6039.07	USAID/Abt/Policy/CSH	\$451,958

**Table 3.3.18: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 8172.09	<b>Mechanism:</b> STATE/OHSS/PAS
<b>Prime Partner:</b> US Department of State	<b>USG Agency:</b> Department of State / African Affairs
<b>Funding Source:</b> GHCS (State)	<b>Program Area:</b> Health Systems Strengthening
<b>Budget Code:</b> OHSS	<b>Program Budget Code:</b> 18
<b>Activity ID:</b> 18662.28119.09	<b>Planned Funds:</b> \$50,000
<b>Activity System ID:</b> 28119	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> Continuing Activity	

Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18662	18662.08	Department of State / African Affairs	US Department of State	8172	8172.08	PAS (Public Affairs Section)	\$50,000

Table 3.3.18: Activities by Funding Mechansim

**Mechanism ID:** 3906.09  
**Mechanism:** CDC/COAG/HAQOCI  
**Prime Partner:** University of Zimbabwe, HIV/AIDS Quality of Care Initiative  
**USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GAP  
**Program Area:** Health Systems Strengthening  
**Budget Code:** OHSS  
**Program Budget Code:** 18  
**Activity ID:** 6085.28234.09  
**Planned Funds:** \$250,000  
**Activity System ID:** 28234  
**Activity Narrative:** N/A  
**New/Continuing Activity:** Continuing Activity  
**Continuing Activity:** 18313

Continued Associated Activity Information

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18313	6085.08	HHS/Centers for Disease Control & Prevention	University of Zimbabwe, HIV/AIDS Quality of Care Initiative	8045	3906.08	CDC/CoAg/HAQ OCI	\$50,000
11639	6085.07	HHS/Centers for Disease Control & Prevention	To Be Determined	5835	3906.07	Co Ag TBA	████████
6085	6085.06	HHS/Centers for Disease Control & Prevention	University of Zimbabwe, Clinical Epidemiol	3906	3906.06	Co Ag #CCU020910	\$50,000

Table 3.3.18: Activities by Funding Mechansim

**Mechanism ID:** 11640.09  
**Mechanism:** CDC/MGMT/EY  
**Prime Partner:** Ernst and Young  
**USG Agency:** HHS/Centers for Disease Control & Prevention  
**Funding Source:** GAP  
**Program Area:** Health Systems Strengthening  
**Budget Code:** OHSS  
**Program Budget Code:** 18  
**Activity ID:** 28469.09  
**Planned Funds:** \$71,163  
**Activity System ID:** 28469  
**Activity Narrative:** N/A  
**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.18: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 3874.09	<b>Mechanism:</b> CDC/COAG/MOHCW
<b>Prime Partner:</b> Ministry of Health and Child Welfare, Zimbabwe	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GAP	<b>Program Area:</b> Health Systems Strengthening
<b>Budget Code:</b> OHSS	<b>Program Budget Code:</b> 18
<b>Activity ID:</b> 6084.28340.09	<b>Planned Funds:</b> \$65,000
<b>Activity System ID:</b> 28340	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 18329	

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18329	6084.08	HHS/Centers for Disease Control & Prevention	Ministry of Health and Child Welfare, Zimbabwe	8055	3874.08	CDC/CoAg/MO HCW	\$55,000
11621	6084.07	HHS/Centers for Disease Control & Prevention	Ministry of Health and Child Welfare, Zimbabwe	5829	3874.07	Co Ag MOHCW	\$55,000
6084	6084.06	HHS/Centers for Disease Control & Prevention	Ministry of Health and Child Welfare, Zimbabwe	3874	3874.06	Co Ag #CCU020903	\$55,000

**Table 3.3.18: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 3933.09	<b>Mechanism:</b> CDC - TA
<b>Prime Partner:</b> US Centers for Disease Control and Prevention	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GAP	<b>Program Area:</b> Health Systems Strengthening
<b>Budget Code:</b> OHSS	<b>Program Budget Code:</b> 18
<b>Activity ID:</b> 6095.28345.09	<b>Planned Funds:</b> \$1,638,089
<b>Activity System ID:</b> 28345	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 18350	

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18350	6095.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	8059	3933.08	CDC - Local	\$335,000
11666	6095.07	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	5840	3933.07		\$406,000
6095	6095.06	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	3933	3933.06	HHS/CDC Ops Base	\$860,937

**Emphasis Areas**

**Human Capacity Development**

Estimated amount of funding that is planned for Human Capacity Development      \$550,000

**Public Health Evaluation**

**Food and Nutrition: Policy, Tools, and Service Delivery**

**Food and Nutrition: Commodities**

**Economic Strengthening**

**Education**

**Water**

**Table 3.3.18: Activities by Funding Mechanism**

<b>Mechanism ID:</b> 3909.09	<b>Mechanism:</b> CDC/MPH/UZDCM
<b>Prime Partner:</b> University of Zimbabwe, Department of Community Medicine	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GAP	<b>Program Area:</b> Health Systems Strengthening
<b>Budget Code:</b> OHSS	<b>Program Budget Code:</b> 18
<b>Activity ID:</b> 6087.28228.09	<b>Planned Funds:</b> \$195,000
<b>Activity System ID:</b> 28228	
<b>Activity Narrative:</b> N/A	
<b>New/Continuing Activity:</b> Continuing Activity	
<b>Continuing Activity:</b> 18314	

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18314	6087.08	HHS/Centers for Disease Control & Prevention	To Be Determined	8046	3909.08	CDC/OHPS/MP H Training	■
11640	6087.07	HHS/Centers for Disease Control & Prevention	University of Zimbabwe, Department of Community Medicine	5836	3909.07	Co Ag # CCU024052 plus supp.	\$0
6087	6087.06	HHS/Centers for Disease Control & Prevention	University of Zimbabwe, Department of Community Medicine	3909	3909.06	Co Ag # CCU024052 plus supp.	\$195,000

**Table 3.3.18: Activities by Funding Mechanism**

**Mechanism ID:** 8143.09  
**Prime Partner:** Partnership for Supply Chain Management  
**Funding Source:** GHCS (State)  
**Budget Code:** OHSS  
**Activity ID:** 18648.28483.09  
**Activity System ID:** 28483  
**Activity Narrative:** N/A  
**New/Continuing Activity:** Continuing Activity  
**Continuing Activity:** 18648

**Mechanism:** USAID/ART Logistics/PFSCM  
**USG Agency:** U.S. Agency for International Development  
**Program Area:** Health Systems Strengthening  
**Program Budget Code:** 18  
**Planned Funds:** \$3,230,000

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18648	18648.08	U.S. Agency for International Development	Partnership for Supply Chain Management	8143	8143.08	USAID/PFSCM/ ARV Drugs/GHAI	\$3,230,000

Program Budget Code: 19 - HVMS Management and Staffing

**Total Planned Funding for Program Budget Code: \$2,347,652**

**Program Area Narrative:**

**USG PEPFAR Zimbabwe Team**

The USG team in Zimbabwe comprises: US Department of Health and Human Resources (HHS) Centers for Disease Control (CDC); US Agency for International Development (USAID); US Department of Defense – Defense Attaché Office (DAO); and US Department of State – Public Affairs Section (PAS). The HHS National Institutes of Health (NIH) have headquarters funding for Zimbabwe but do not participate actively in PEPFAR planning or management at post.

The USG PEPFAR team in Zimbabwe consists of a seasoned group of skilled professionals with numerous years of experience working in HIV/AIDS in the US, Zimbabwe, and other countries. The team is recognized by the broader HIV community in

Zimbabwe for its leadership and technical skills. As shown in the previous Program Area Context sections of this COP, for FY09 the team plans to again leverage funds exceeding a 1:1 ratio, thus fulfilling the “catalytic leveraging” scenario of the 5 Year Strategy.

CDC brings to the PEPFAR Zimbabwe team technical expertise in clinical care and treatment -- including PMTCT, TB/HIV, adult and pediatric care and treatment, and laboratory infrastructure – as well as strategic information, surveillance, policy, and human capacity development. CDC Zimbabwe has reduced total staff numbers in the last 12 months, from 38 to 24 positions, due primarily to greater use of ICASS administrative services. These 24 positions comprise 3 US Direct Hires (USDH) and 21 Locally Employed Staff (LES). Within the USDH, while the position of Country Director is filled, the positions of Deputy Director for Operations and Senior Public Health Advisor (Deputy for Science) are currently vacant but are expected to be filled in FY 09. Under LES, there are 13 technical staff in the following areas, two Public Health Specialists (PHS) in Care and Support/Treatment, one PHS in Laboratory Infrastructure Support, one in Laboratory IT, one PHS in Human Capacity Development (HCD), one Finance and Coordination Specialist, two PHS in Data and Surveillance, one Program Assistant, and four Administrative Assistants. There are also nine administrative staff who spend 100% time on support activities. Two staff members split their time between administrative and technical activities: the Director and the Administrative Specialist.

USAID brings to the PEPFAR Zimbabwe team technical expertise in PMTCT, sexual prevention, OVC, counseling and testing, ART drugs and logistics, strategic information, policy, and organizational capacity development. USAID's HIV/AIDS office has shifted in composition in the last 12 months. The current staffing pattern includes 1 USDH, 1 Cooperative Assistance Support Unit (CASU) Senior Technical Advisor, 2 LES medical doctors, 1 LES Strategic Information Officer, 1 Monitoring and Evaluation Officer, 1 OVC Specialist, and 2 administrative support staff. USAID GHCS funds also support 55% time of the Chief Accountant and 1 full-time driver.

Both DOD and PAS manage their HIV/AIDS activities through staff funded by their respective agencies, estimated at 10%-25% time. DOD in Zimbabwe did not request FY09 funding due to the Zimbabwe Defense Force's well-documented participation in committing gross human rights violations to influence the outcome of Presidential and Parliamentary elections in Zimbabwe. Despite this, the military will have access to the broad spectrum of USG supported public health programs outlined above, and DOD staff will continue to participate in USG PEPFAR team events.

PAS provides journalism training and other media outreach, and provides technical expertise in positioning for the overall USG PEPFAR program.

#### FY08 Social, Economic, and Political Context

Implementation of the USG PEPFAR program in Zimbabwe during FY08 was subject to a number of severe stresses. From January to March, during the run-up to the March 29, 2008 general elections, the highly charged political atmosphere led to a number of disruptions and hampered implementation. The situation was even worse from April – June. Widespread Government sponsored violence effectively closed most rural areas in the country and many urban areas. Hundreds were killed and tens of thousands were displaced. A number of USG-supported community outreach activities were either suspended to protect staff and potential participants, or shifted to urban areas that required less travel and exposure.

On June 4, the Government of Zimbabwe suspended most NGO activity for almost 3 months, until August 29, setting back many programs. Throughout the year the continuing collapse of the Zimbabwean economy and inflation that reached billions of percent put severe strains on programming and local partners. In general, the unprecedented hyperinflation and eventual collapse of Zimbabwean currency, lack of public utilities (water and electricity), widespread violence, and extreme political uncertainty created barriers to all programs.

The impact of these stressors on the PEPFAR Zimbabwe program is summarized briefly in each of the program area narratives earlier in this COP. The impact on human resources essential to management is severe: as of December 2007, the Ministry of Health and Child Welfare reported a 68% vacancy rate in senior management positions, a 63% vacancy rate for doctors, and a 39% vacancy rate for nurses. These rates have certainly increased since that time. PEPFAR partners and USG agencies are also struggling to recruit and retain staff. Given the deteriorating environment, however, the desire of Zimbabweans to seek greener pastures is difficult to deny.

#### Staffing For Results

As reported in COP08, the PEPFAR Zimbabwe team began initial steps in its staffing for results (SFR) implementation plan in fourth quarter FY07. In May 2008, the team built on these initial efforts and held its first Joint Portfolio Review (JPR) on May 20-21, 2008. The participants represented the four USG agencies implementing PEPFAR in Zimbabwe: DAO, PAS, CDC and USAID.

The first JPR served both as a learning experience as well as a team building, a time for the PEPFAR Zimbabwe technical personnel to come together and share experiences on how the various activities were performing mid-way through the year. The review used a portfolio review template derived from the OGAC template, as modified and informed by templates used in Nigeria, Malawi, and Botswana. During the course of the review, the team identified necessary modifications and improvements for the next JPR. All agreed it was a valuable experience that should be repeated no less than annually.

The team reviewed the status of on-going and new PEPFAR activities for the period October 1, 2007 – March 31, 2008. The team found that in spite of the increasingly difficult operating environment for most of the reporting period, in terms of meeting planned targets the Zimbabwe portfolio was solidly on track. The team shared a written report-out of the JPR, and discussed the experience with the Core Team in a conference call. There were no significant issues raised.

The JPR and subsequent all-partner meetings (a new initiative of the inter-agency team) have greatly enhanced the information

available for, and quality of, the COP09 planning process. All team members and partners completed activity planning templates, even though they are not required for a Mini-COP. Partners and USG staff have a much better understanding of PEPFAR objectives and operations. The PEPFAR Zimbabwe team hopes to continue to hold JPRs annually, in April, to maintain inter-agency collaboration.

Unfortunately, shortly after the FY08 JPR, 4 senior CDC staff departed post (an additional person had departed a month earlier), followed by the USAID LES medical doctor a month later. These departures, on top of a number of existing staff vacancies, left the USG PEPFAR Zimbabwe team with what can only be described as skeleton staff. CDC was left with one USDH (the Director) and two LES technical staff for its \$6 million program, and USAID has operated its \$20 million (including USAID Population and TB wraparounds) program with 2 technical staff – the USDH Health Officer and the SI Advisor. (The SI Advisor has announced that he will depart Zimbabwe in December 2008). CDC has recently hired 3 LES consultants to fill critical gaps, and is benefiting from short-term assistance from CDC Ethiopia. USAID expects to fill the OVC Specialist and one medical doctor position soon. Conditions in Zimbabwe continue to deteriorate, so that recruiting expatriates and/or retaining professional national staff are both time-consuming and often fruitless tasks. For the USG PEPFAR team and its implementing partners, recruitment has become a top priority that must be balanced with on-going program implementation issues.

The current team of six (6) active full-time technical professionals (1-PAS; 3-CDC; 2-USAID), with as-indicated participation of DOD, can thus be considered one Technical Working Group (TWG) for the purposes of SFR to implement the \$26.5 million (without wraparounds) country program. As and when new positions are filled, this team foresees forming and working through three TWGs: Prevention, Care & Treatment, and Cross-Cutting. Given recruitment problems and the accelerated pace of hyperinflation, infrastructure failure, and political uncertainties, the team is not able to predict when this functional structure will be launched.

**Coordinator**

Zimbabwe has not to date had a full-time Coordinator due to its low level of funding (total COP09 \$26.5 million, of which \$3.3 million is GHCS-State funding) and to the ease of communication among the agencies at post. Based on discussions with OGAC, however, this COP09 includes a funding allocation within the USAID budget, with GHCS-State funds, for a Coordinator position. Recruitment is expected to begin in 3rd or 4th quarter FY09 when funds become available.

**Table 3.3.19: Activities by Funding Mechansim**

<b>Mechanism ID:</b> 3954.09	<b>Mechanism:</b> CDC - CODB
<b>Prime Partner:</b> US Centers for Disease Control and Prevention	<b>USG Agency:</b> HHS/Centers for Disease Control & Prevention
<b>Funding Source:</b> GAP	<b>Program Area:</b> Management and Staffing
<b>Budget Code:</b> HVMS	<b>Program Budget Code:</b> 19
<b>Activity ID:</b> 28355.09	<b>Planned Funds:</b> \$713,986
<b>Activity System ID:</b> 28355	

**Activity Narrative:** CDC Zimbabwe Staff

The request funding covers salaries, travel, overhead and related costs for 7.2 full-time equivalent (FTE) positions in HVMS. Salaries and related costs for the other 16.8 FTE are allocated to the respective technical areas in which they work.

CDC Zimbabwe is primarily involved in supporting the Ministry of Health and Child Welfare (MOHCW) of Zimbabwe and local partners through direct TA and cooperative agreements. The provision of technical and financial support enables partners to implement HIV/AIDS prevention, care and treatment programs and develops local capacity as well. However, economic constraints and limitations (hyperinflation, rising real-value costs and plummeting purchasing power, fewer vendors, fewer qualified partners, etc.) have made it difficult for partners to operate in Zimbabwe. Additionally, political complexities have limited some of the partners with whom CDC has been able to work.

Building on the fact that CDC worldwide is known for its scientific and data-based technical expertise, CDC Zimbabwe will continue to scale up its support in these areas. In FY09 CDC will continue the technical support with more active and direct involvement with MOHCW through its program officers and lead experts in different programmatic areas. CDC will also use limited contracting mechanisms. In order to be cost effective, CDC Zimbabwe is shifting towards fully utilizing ICASS services from the US Embassy/Harare.

COP09 reflects a reduction in total staff numbers in the last twelve months. CDC Zimbabwe's total staff composition has declined from 38 to 24 persons. These 24 persons comprise 3 US Direct Hires (USDH) and 21 Locally Employed Staff (LES). Within the USDH, while the position of Country Director is filled, the positions of Deputy Director for Operations and Senior Public Health Advisor (Deputy for Science) are currently vacant but are expected to be filled in FY 09. Under LES, there are 13 technical staff in the following areas, two Public Health Specialists (PHS) in Care and Support/Treatment, one PHS in Laboratory Infrastructure Support, one in Laboratory IT, one PHS in Human Capacity Development (HCD), one Finance and Coordination Specialist, two PHS in Data and Surveillance, one Program Assistant, and four Administrative Assistants. There are also nine Administration staff who spend 100% time on support activities: the PHA/Deputy for Operations, the Executive Administrative Assistant, the Office Manager, the Budget Analyst, the Procurement Officer, the Travel Officer, one Grants Manager, and one IT Specialist. Two staff members split their time between administrative and technical activities: the Director and the Administrative Specialist.

As part of the process of Staffing for Results (SFR) and due to existing service provision through ICASS, a reduction in support staff has taken place in the area of drivers and custodians. With proper justification and increased use of ICASS services, further staff reductions could take place in the future. The result of more technical staff, as well as support staff who are directly assigned to program areas, and a shift of administrative and operations functions to the US Embassy yields a much lower Management and Staffing budget for CDC Zimbabwe for COP 09 and beyond.

One of the focus areas in FY 09 will be the identification and recruitment of qualified candidates for the positions of Deputy Director for Operations, Senior Public Health Advisor (Deputy for Science), and other technical positions. Due to the challenging local economic and political conditions, it has proved difficult to attract suitable permanent direct hire staff to the critical positions in the organization. To implement COP 09, CDC Zimbabwe will also need to fill in the following positions: one in PHS for Data/Surveillance, one in PHS for Laboratory Infrastructure, and one in PHS for Care & Support/Treatment. There will also be a new position of PHS for Human Capacity Development (HCD). The position of PHS HCD is a technical position designed to promote sustainable workforce capacity development to deliver HIV/AIDS prevention, care and treatment. Activities under HCD include but are not limited to coordination, technical support in planning and prioritization training needs, monitoring and evaluation of the both in-service, and pre-service trainings.

Since many of the activities are implemented through cooperative agreements, the involvement of technical staff with partners – from planning to implementation and evaluation – is very significant. CDC TA also helps the local partners develop their capacity over time. The reorganization and prioritization of the CDC work force to program areas and recruitment of additional key technical staff is therefore critical for the success of the program which is inline with SFR.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.19: Activities by Funding Mechanism**

**Mechanism ID:** 3954.09

**Mechanism:** CDC - CODB

**Prime Partner:** US Centers for Disease Control and Prevention

**USG Agency:** HHS/Centers for Disease Control & Prevention

**Funding Source:** GAP

**Program Area:** Management and Staffing

**Budget Code:** HVMS

**Program Budget Code:** 19

**Activity ID:** 6101.28346.09

**Planned Funds:** \$453,033

**Activity System ID:** 28346

**Activity Narrative:** CDC Zimbabwe Cost of Doing Business  
The CDC total cost of doing business related to HVMS staff costs includes:

(1) \$230,265 for ICASS services.

(2) \$178,500 for CSCS.

(3) \$44,268 for ITSO

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 18352

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18352	6101.08	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	8060	3954.08	CDC - CODB	\$481,566
11669	6101.07	HHS/Centers for Disease Control & Prevention	US Centers for Disease Control and Prevention	5842	3954.07	CDC/Head Tax	\$478,111
6101	6101.06	HHS/Centers for Disease Control & Prevention	US Department of State	3954	3954.06	HHS/CDC CSCS	\$631,156

**Table 3.3.19: Activities by Funding Mechansim**

**Mechanism ID:** 8180.09

**Mechanism:** USAID - CODB

**Prime Partner:** US Agency for International Development

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (USAID)

**Program Area:** Management and Staffing

**Budget Code:** HVMS

**Program Budget Code:** 19

**Activity ID:** 18665.28356.09

**Planned Funds:** \$65,000

**Activity System ID:** 28356

**Activity Narrative:** USAID Cost of Doing Business  
USAID ICASS costs associated with HVMS-funded staff is \$34,000 and the IRM tax is \$31,000.

**New/Continuing Activity:** Continuing Activity

**Continuing Activity:** 18665

**Continued Associated Activity Information**

Activity System ID	Activity ID	USG Agency	Prime Partner	Mechanism System ID	Mechanism ID	Mechanism	Planned Funds
18665	18665.08	U.S. Agency for International Development	US Agency for International Development	8180	8180.08	USAID - CODB	\$305,350

**Table 3.3.19: Activities by Funding Mechansim**

**Mechanism ID:** 11622.09

**Mechanism:** USAID/HVMS/COORD

**Prime Partner:** US Agency for International Development

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (State)

**Program Area:** Management and Staffing

**Budget Code:** HVMS

**Program Budget Code:** 19

**Activity ID:** 28401.09

**Planned Funds:** \$50,000

**Activity System ID:** 28401

**Activity Narrative:** PEPFAR Zimbabwe Coordinator

Based on consultation with OGAC, USG will recruit and hire a PEPFAR Coordinator in FY09. The position description will be based on the standard OGAC Coordinator position description. The Coordinator will sit at the Embassy and will report to the Deputy Chief of Mission. Additional GHCS-USAID funding is set aside in HVMS for this position.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 3.3.19: Activities by Funding Mechanism**

**Mechanism ID:** 8180.09

**Mechanism:** USAID - CODB

**Prime Partner:** US Agency for International Development

**USG Agency:** U.S. Agency for International Development

**Funding Source:** GHCS (USAID)

**Program Area:** Management and Staffing

**Budget Code:** HVMS

**Program Budget Code:** 19

**Activity ID:** 28400.09

**Planned Funds:** \$1,065,633

**Activity System ID:** 28400

**Activity Narrative:** USAID Zimbabwe Staffing

The request funding covers salaries, travel, overhead and related costs for 5.05 full time equivalent (FTE) positions under HVMS.

USAID staff positions for PEPFAR include expertise in PMTCT, sexual prevention, OVC, counseling and testing, ART drugs and logistics, strategic information, policy, and organizational capacity development. USAID's HIV/AIDS office has shifted in composition in the last 12 months. The current staffing pattern includes 1 USDH, 1 Cooperative Assistance Support Unit (CASU) Senior Technical Advisor, 2 LES medical doctors, 1 LES Strategic Information Officer, 1 Monitoring and Evaluation Officer, 1 OVC Specialist, and 2 administrative support staff. USAID GHCS funds also support 55% time of the Chief Accountant and 1 full-time driver.

HVMS funding covers 100% time of the USDH Health Officer, 2 support staff, and 1 Driver (4 FTE HVMS). The Chief Accountant works 55% of time on PEPFAR, with 55% of costs allocated to HVMS (0.55 FTE HVMS). The OVC Specialist devotes 100% time to OVC programs and is thus funded 100% under HKID. The CASU Advisor's funding is allocated according to his/her time allocation, anticipated as 25% HVOP, 25% HVCT, and 50% HVMS (0.5 FTE). Both medical doctor positions are split 50%-50%; one is allocated between HTXS and HTXD, and the other between MTCT and HVTB.

Funding in this category also covers the funding for consultancies to help fill gaps due to staff vacancies, and limited office equipment due for replacement.

**New/Continuing Activity:** New Activity

**Continuing Activity:**

**Table 5: Planned Data Collection**

<b>Is an AIDS indicator Survey(AIS) planned for fiscal year 2009?</b>	<b>Yes</b>	<b>X</b>	<b>No</b>
If yes, Will HIV testing be included?	Yes		No
When will preliminary data be available?			
<b>Is a Demographic and Health Survey(DHS) planned for fiscal year 2009?</b>	<b>Yes</b>	<b>X</b>	<b>No</b>
If yes, Will HIV testing be included?	Yes		No
When will preliminary data be available?			
<b>Is a Health Facility Survey planned for fiscal year 2009?</b>	<b>Yes</b>	<b>X</b>	<b>No</b>
When will preliminary data be available?			
<b>Is an Anc Surveillance Study planned for fiscal year 2009?</b>	<b>Yes</b>	<b>X</b>	<b>No</b>
If yes, approximately how many service delivery sites will it cover?	Yes		No
When will preliminary data be available?			
<b>Is an analysis or updating of information about the health care workforce or the workforce requirements corresponding to EP goals for your country planned for fiscal year 2009?</b>	<b>Yes</b>	<b>X</b>	<b>No</b>

## Supporting Documents

File Name	Content Type	Date Uploaded	Description	Supporting Doc. Type	Uploaded By
Human Resources for Health Program Narrative COP09.doc	application/msword	11/12/2008	Human Resources for Health Program Narrative	HRH Program Area Narrative*	DKunaka
Zimbabwe Executive Summary.doc	application/msword	11/12/2008	Executive Summary - Zimbabwe	Executive Summary	DKunaka
Budgetary Requirements Worksheet COP09.xls	application/vnd.ms-excel	11/12/2008	Budgetary Requirements Worksheet	Budgetary Requirements Worksheet*	DKunaka
EGPAF 8% Justification COP09.doc	application/msword	11/12/2008	Single Partner Funding Justification	Single Partner Funding	DKunaka
Care & Treatment 50% Justification COP09.doc	application/msword	11/12/2008	Care & Treatment 50% Budgetary Requirement Justification	Budgetary Requirement Justifications	DKunaka
Gender Program Narrative COP09.doc	application/msword	11/12/2008	Gender Program Narrative	Gender Program Area Narrative*	DKunaka
Global Fund Supporting Doc COP09.doc	application/msword	11/12/2008	Global Fund Supplemental	Global Fund Supplemental	DKunaka
USAID Zimbabwe HIV-AIDS Office Org Chart COP09.doc	application/msword	11/12/2008	USAID Zimbabwe Organizational Chart	Other	DKunaka
Zim Salary Support Table.xls	application/vnd.ms-excel	11/12/2008	HCW Salary Support Table	Health Care Worker Salary Report	DKunaka
Management and Staffing Budget Table Zimbabwe COP09.xls	application/vnd.ms-excel	11/12/2008	M&S Budget Table	Management and Staffing Budget Table	DKunaka
Zim_Ambassador_Letter_COP09.pdf	application/pdf	11/14/2008	Zimbabwe Ambassador's Letter	Ambassador Letter	DKunaka
Zim Mini-COP staffing spreadsheet COP09.xls	application/vnd.ms-spreadsheet	11/14/2008	Zimbabwe Staffing Spreadsheet	Staffing Analysis	DKunaka
CDC Zimbabwe Org Chart COP09.doc	application/msword	11/14/2008	CDC Zimbabwe Organizational Chart	Other	DKunaka
WEI 8% Justification COP09.doc	application/msword	11/14/2008	OVC Partner Funding Justification	Single Partner Funding	DKunaka
Zimbabwe_Summary Targets and Explanations Table COP09 FINAL.xls	application/vnd.ms-excel	11/20/2008	Target Explanation spreadsheet	Summary Targets and Explanation of Target Calculations	DKunaka