



FY 2015 Zimbabwe Country Operational Plan (COP)

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Zimbabwe.

- 1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.

- 2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the “FY 2015 Country Operational Plan Budget and Target Report.”

PEPFAR Zimbabwe

Country Operational Plan (COP) 2015

Strategic Direction Summary

Table of Contents

Goal Statement

1.0 Epidemic, Response, and Program Context

- 1.1 Summary statistics, disease burden and epidemic profile
- 1.2 Investment profile
- 1.3 Sustainability Profile
- 1.4 Alignment of PEPFAR investments geographically to burden of disease
- 1.5 Stakeholder engagement

2.0 Core, near-core and non-core activities for operating cycle

3.0 Geographic and population prioritization

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

- 4.1 Targets for scale-up locations and populations
- 4.2 Priority population prevention
- 4.3 Voluntary medical male circumcision (VMMC)
- 4.4 Preventing mother-to-child transmission (PMTCT)
- 4.5 HIV testing and counseling (HTC)
- 4.6 Facility and community-based care and support
- 4.7 TB/HIV
- 4.8 Adult treatment
- 4.9 Pediatric Treatment
- 4.10 OVC

5.0 Program Activities to Maintain Support in Other Locations and Populations

- 5.1 Package of services for sustained sites and expected volume in other locations and populations
- 5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

- 6.1 Laboratory strengthening
- 6.2 Strategic information (SI)
- 6.3 Health system strengthening (HSS) – clear linkages to program

7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals

Appendix A- Core, Near-core, Non-core Matrix

Appendix B- Budget Profile and Resource Projections

Goal Statement

Through the delivery of a comprehensive package of HIV care, treatment, and prevention activities to 80% of the estimated number of people living with HIV (PLHIV) within 36 of 60 districts, the PEPFAR program in Zimbabwe aims to achieve epidemic control within those targeted areas over the next two years. In addition to providing antiretroviral drugs (ARVs) for 128,000 patients through the national supply chain system, the program will provide antiretroviral treatment (ART) through routine site-level technical assistance (TA) mentoring and support, HIV testing and counseling (HTC) services, voluntary medical male circumcision (VMMC), orphan and vulnerable children (OVC) support, and targeted high-impact prevention activities. By the end of FY 2017, the program should achieve 80% coverage within the 36 scale-up districts. As a result of these successful acceleration efforts, the major limiting factor to achieving 80% by the end of FY 2017 will be ARV and rapid test kits (RTK) commodity gaps.

The USG team has actively collaborated with key partners including the Government of Zimbabwe (GoZ), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), bilateral and multilateral health development partners, and civil society to ensure program changes align with national objectives. The national ART program and other critical HIV programs in Zimbabwe are implemented with the leadership and largely with the manpower and infrastructure of the Ministry of Health and Child Care (MOHCC). PEPFAR has successfully leveraged this capacity with key commodities, training, mentoring, and site support TA to scale up national coverage with current initiation of more than 12,000 ART patients per month. Based on the estimated number of PLHIV in each district, the 36 scale-up districts with the greatest number of PLHIV were chosen in order to reach 80% of the population in need of services. In order to focus further within those districts, the program will concentrate on higher-volume sites and will only deliver services at sites with over 200 ART patients. The program will coordinate with GoZ to ensure that sites in other districts and in smaller sites (<200 ART patients) within scale-up districts will continue to receive delivery of ARV and other key commodities and will continue to have ART and other services provided by the government with other donor support as needed. The PEPFAR program will also continue to support 53 high-volume sites (with >680 ART patients) in other sustained districts by providing a package of services for patients enrolled at these sustained sites. Focusing on the largest sites in a selected number of scale-up districts represents a major pivot with efforts geographically focused for impact. Moreover, COP 2015 reflects a substantial de-duplication of site-level support by PEPFAR partners, which provided an estimated savings of \$3.3 million to be re-allocated to sites in scale-up districts.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

According to the 2012 census, the total population of Zimbabwe was 13.1 million. The estimated HIV prevalence in 2015 is 14.7% among those between 15-49 years. The HIV annual incidence estimate in that age group for 2015 is 0.88%, down from 5.92% in 1994. Of the total estimated ART program need of 1,152,077 persons in 2014, treatment coverage in 2014 was at 65%. At present, ART initiation continues at 12,300 persons per month, however, the major gap in achieving high ART

coverage and epidemic control is insufficient funding for ARVs. Combined funding from PEPFAR and the Global Fund per PLHIV is lowest for Zimbabwe among ten sub-Saharan African countries classified as low income by the World Bank. The GNI per capita (2013) was US\$860. Zimbabweans contribute to the National AIDS Trust Fund (“AIDS Levy”) through a 3% income tax, which totaled \$34.2 million in 2013.

Table 1.1.1 Key National Demographic and Epidemiological Data

Note: Unless otherwise noted, 2014 National HIV and AIDS data estimates are not disaggregated by sex

	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Pop	13,061 239		2,691,143	50.10%	2,681,128	49.90%	4,089,557	53.20%	3,599,411	46.80%	Zim 2012.
Prevalence (%)		15% (15-49 yrs.) (DHS 2010/2011)		2.37% (for yr. 2015)		2.37% (for yr. 2015)		18% (DHS 2010/2011)		12% (DHS 2010/2011)	DHS 2010/2011. National HIV and AIDS estimates 2013.
AIDS Deaths per year	42,534		6,176		6,176		36,358		36,358		National HIV and AIDS estimates 2013.
PLHIV	1,420,604		156,718		156,718		748,451		515,436		National HIV and AIDS estimates 2013.
Incidence Rate (Yr.)		0.92		0.92		0.92		0.92		0.92	National HIV and AIDS estimates 2013.
New Infections (Yr.)	62,926										National HIV and AIDS estimates 2013)
Annual births	416,988	12.75%									Population census 2012; (416988/3 271 393 (number of child bearing age women)
% >= 1 ANC visit		87.40%	Data not available	Data not available			Data not available	not available			DHS 2010/2011
Pregnant women needing ARVs	70,280	100%									National HIV and AIDS estimates 2013; (mothers needing PMTCT 31 Dec)

Orphans (maternal, paternal, double)	889,339		889,339 aged 0-14 yrs.		889,339 aged 0-14 yrs.		Data not available		Data not available		National HIV and AIDS estimates 2013
TB cases (Yr.)	35,566 (total case notification)		1,300		1,370		14,251		18,645		NTP Data for 2013 WHO Global TB report
TB/HIV Co-infection	22,442	69%	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Global TB report 2014, WHO
Males Circumcised[1]	364,320 (all ages)				143,812				220,508		MOH VMMC program data 2009 -Sep 2014)
Key Populations											
Total MSM*	143,248 MOT estimates 2009). QI	Data not available									MOT 2009 estimates report. QI
MSM HIV Prevalence		16.8% Mot estimates 2009) QI									MOT 2009 estimates report. QI
Total FSW	85,949 MOT estimates 2009) QI										MOT 2009 estimates report. QI
FSW HIV Prevalence		28.7% (Mot estimates 2009) QI									MOT 2009 estimates report. QI
Total PWID	Data not available	Data not available									
PWID HIV Prevalence	Data not available	Data not available									

Priority Populations Men 15-29	1,776,239	13.6% (of total population)							1,776,239	Data not available	
Priority Populations Women 15-24	1,371,430	10.5% (of total population)							1,371,430		
Priority Populations Women 24-29	613,878	4.7% (of total population)							613,878		
Priority Populations Men 30-49	1,240,817	9.5% (of total population)									
Priority Populations Men 30-49	1,306,124	10% (of total population)									
Priority Populations	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	See HIV prevalence table below

¹ MC coverage for 15-29 year olds is 185,337 of total population of 15-29 year olds 1,286,918 – 14%.

HIV prevalence by priority populations: (1) age group aggregates are slightly different from table 1.1.1 – source (ZDHS) (2) Prevalence for each age group is represented as a proportion of total number of men or women in all age groups)

Age	Women (%)	Men (%)
15-19	4.2	3.4
20-24	10.6	3.8
25-29	20.1	10.3
30-34	29	17.3
35-39	29.1	25.2
40-44	25.7	26.2
45-49	22.5	29.9

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)

				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	13,061,239 (Zimbabwe Population census 2012)	15% (15-49 yrs.) (DHS 2010/2011)	1,352,667 (For Yr. 2013) National HIV and AIDS estimates 2013	Data not available	748,882 (by September 2014 – ART Program data)	85%. (HIV drug resistance EWI report 2013)	89.6% (HIV drug resistance monitoring survey report 2009-2011)	1,664,176 Year 2014 – HTC Program data) Among PLHIV age 15-49 years, 63.7% had ever been tested for HIV (ZDHS 2010-11)	175,568 Year 2014 – HTC Program data)	Data not available

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)

				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Population less than 15 years	5,372,281 (Zimbabwe Population census 2012)	2.99% National HIV and AIDS estimates 2013	170,717 (For Yr. 2013) National HIV and AIDS estimates 2013	Data not available	54,006 (by September 2014 – ART Program data)	Data not available	Data not available	200,352 Year 2014 – HTC Program data	11,603 Year 2014 – HTC Program data	Data not available
Pregnant Women	412,120 (For Yr. 2013) National HIV and AIDS estimates 2013	15.9% (15-49 years) ANC 2013 report	Data not available	Data not available	Data not available	Data not available	Data not available	173,916 (tested first time – January to September 2014) – PMTCT program data	13,624 January to September 2014 – PMTCT Program data	24,573 (January to September 2014) – Number of women initiated on ART in PMTCT
MSM	143,248 MOT estimates 2009)	16.8% MOT estimates 2009)	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	
FSW	85,949 MOT estimates 2009	28.7% MOT estimates 2009)	24,667 (MOT estimate 2009)	~30% Cowan F PLoS ONE 2013	~30% Cowan F PLoS ONE 2013	Data not available	Data not available	Data not available	Data not available (~50%, Cowan F PLoS ONE 2013)	~30% Cowan F PLoS ONE 2013
PWID	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	
Priority Pop (specify)	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	

1.2 Investment Profile

The HIV response in Zimbabwe is funded primarily from five sources (2013 data) – PEPFAR, the Global Fund, other bilateral donors (DFID, EU, Switzerland and Sweden), private sector and the national government (GOZ/NAC, National AIDS Spending Assessment 2012). PEPFAR support grew by approximately 74% between 2011 and 2012 and is now maintaining at a similar funding level (\$95 million COP support; \$7-15 million additional through central initiative funds).

Zimbabwe was one of three countries chosen to participate in the GF New Funding Model (NFM) pilot. Currently, the GF is providing \$145 million per year (\$437 million grant). The current grant started in January 2014 and will end in December 2016. PEPFAR is represented in the country coordinating mechanism (CCM). Zimbabwe is applying for HIV incentive funds to help mitigate their pediatric ARV gap, but has been informed that funding is limited.

The Government health spending has been slowly declining in recent years. Currently, it is 7.6% of the total GOZ budget. Funding for MOHCC continues at \$330 million per year in the 2014 and 2015 budget. These funds are primarily allocated for MOHCC personnel costs, a critical component of the national HIV response. However, the actual funding disbursement to other MOHCC budget lines is only approximately 10%. On a positive note, the Minister of Finance announced at the end of November 2014 that the AIDS Levy would be extended to the mining sector in 2015. This is expected to add approximately \$13 million to the \$39 million annual revenue of the Fund, a portion (35%) of which is expended on ARV procurement.

Table 1.2.1 Investment Profile by Program Area^{1 2}

Program Area	Total Expenditure	% PEPFAR	% GF	% GOZ/NAC	% Pvt sector	
					% HDPG	
Clinical care, treatment and support	152,565,455	32.54	24.95	15.64	25.84	1.03
Community-based care	524,316	-	50.16	-	-	49.84
PMTCT	6,094,830	64.50	6.97	-	-	28.53
HTC	7,283,825	42.83	47.29	-	-	9.87
VMMC	34, 514,361	54.41	3.42	-	-	42.17
Priority population prevention*	29,260,392	6.75	7.66	4.35	25.18	56.06
Key population prevention*	1,416,490	-	29.37	60.72	9.92	-
OVC*	14,676,306	49.34	-	0.84	27.26	22.56
Laboratory	504,000	100.00	-	-	-	-
SI, Surveys and Surveillance	7,726,594	19.93	74.29	0.13	-	5.65
HSS	42,767,954	4.90	60.58	19.75	11.43	3.34
Total	262,820,162	29.88%	26.13%	11.63%	18.77%	13.60%

¹ GRP, National AIDS Spending Assessment, 2012, all amounts in 2012 USD

² Note that Priority Population Prevention, Key Pop and OVC are not individual lines in the NASA

Table 1.2.2 Procurement Profile for Key Commodities³

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GOZ/NAC	% Other	% Gap
ARVs	\$171,422,991.12	12.82	45.06	7.86	0	34.26
Rapid test kits	\$4,915,277.66	0	30.30	0	0	69.70
Other drugs	\$1,029,880.55	3.20	0	0	0	96.80
Lab reagents (EID)	\$1,762,509.41	100	0	0	0	0
Lab reagents (POC)	\$3,413,932.70	1.25	0	0	0	98.75
Lab reagents (conventional)	\$8,858,509.00	0	26.78	0	0	73.22
Condoms (male & female)*	\$5,157,881.00	100	0	0	0	0
VMMC kits	\$5,965,842.55	65.12	0	0	0	34.88
Other commodities	\$287,796.65	100	0	0	0	0
Total	\$202,814,620.64					

³ **Note:** All commodity groups are based on the CY 2016 forecast and commitments from preliminary results presented after the February 2015 quantification exercise.

*Male and female condoms are for the public sector program. Refer to PSI for social marketing

- 1) Rapid test kits do not include the tests required for syphilis.
- 2) Other drugs refers to drugs used in the VMMC program.
- 3) VMMC kits include requirements for surgical and prepex methods. This may change if the circumcision methods change.
- 4) Other commodities refers to commodities and equipment used in the VMMC program other than the VMMC kits.

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources⁴	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	\$3,000,000				Reduce MNCH morbidity and mortality and improve quality of care for MNCH services.
USAID TB	\$6,000,000		1	\$200,000	Improve TB control through diagnostics, treatment, and infection control.
USAID Malaria	\$15,000,000				Improve malaria control through case management, long-lasting insecticidal net distribution, and indoor residual spraying.
Family Planning	\$2,000,000				Increase access to and availability of FP services through private franchise model.
NIH	\$57,728,637				Multiple grants to conduct HIV and TB related research
CDC NCD	N/A				
Peace Corps	N/A				
DOD Ebola	N/A				
MCC	N/A				
Private Sector	N/A				
PEPFAR Central Initiatives (CIs)	\$15,000,000	\$15,000,000	0		Medical Education (MEPI)
(Multiple FYs 2012-2014)	\$4,000,000	\$4,000,000	1	\$8,594,513	VMMC
	\$2,000,000	\$2,000,000	1	\$2,499,570	Pediatric technical assistance
	\$5,000,000	\$5,000,000	4	\$15,758,000	PMTCT/ART integration
	\$4,350,000	\$4,350,000	4	\$7,155,560	OVC
	\$1,400,000	\$1,400,000	2	\$3,800,000	Together for Girls
	\$1,900,000	\$1,900,000	0		Local Capacity Initiative
Total	\$117,378,637	\$33,650,000		\$38,007,643	

1.3 National Sustainability Profile

Results from the Sustainability Index demonstrate two broad areas of lower sustainability for the national HIV response: a) domestic HIV budget support; and b) oversight and stewardship. Other weak areas include insufficient staffing levels to support the HIV response, a reliance on donor support for logistics and distribution systems and weak monitoring of HIV interventions targeting key populations, specifically commercial sex workers (CSWs), men who have sex with men (MSM) and people who inject drugs (PWID).

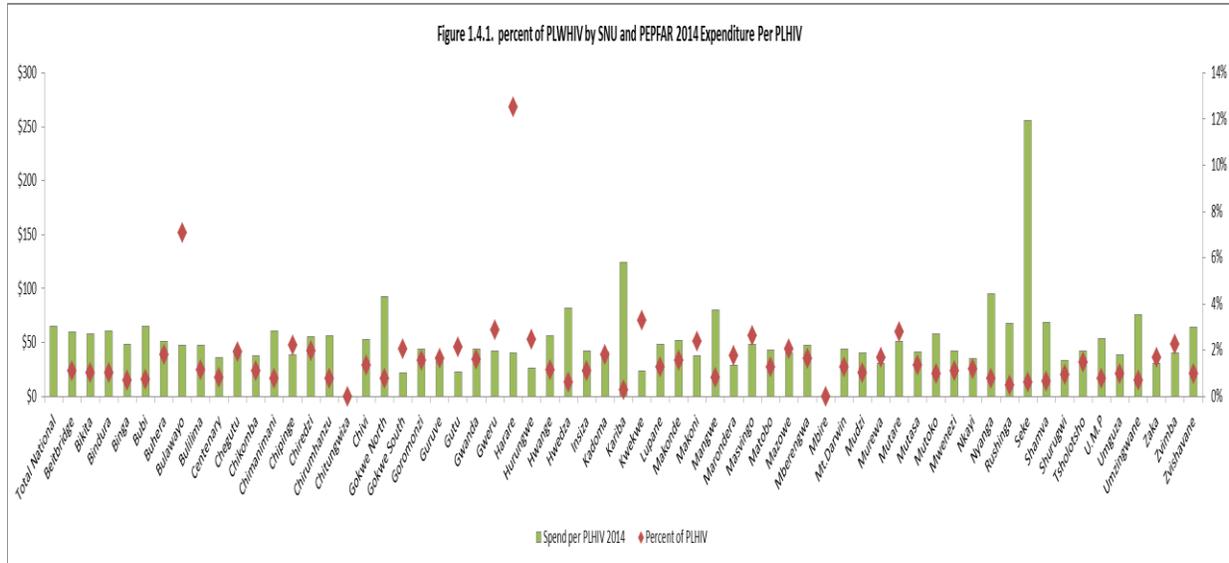
Government expenditures for health fall significantly below the Abuja target of 15% and the recent government allocation for health dropped from 8.2% in 2014 to 7.6% in 2015. Additional measures such as establishing more public-private partnerships, working with the medical insurance companies to cover some of the ARV costs, and continued advocacy with the Ministry of Finance are underway. PEPFAR will participate in a MOHCC-led sustainability technical working group (TWG) being established in 2015.

The second area where Zimbabwe scored poorly was on oversight and stewardship. Scores were based on outdated data coming from the 2012 PEFA and Civicus reports, which covered a period of instability in Zimbabwe following the general elections in 2008. Stakeholders agreed that, while the legal and policy frameworks are in place to allow civil society to participate in the HIV response, increased efforts are required to address access to HIV services particularly for marginalized key population communities. The recommendation to PEPFAR is to continue support for the national HIV size estimation study which will help characterize key populations such as MSM.

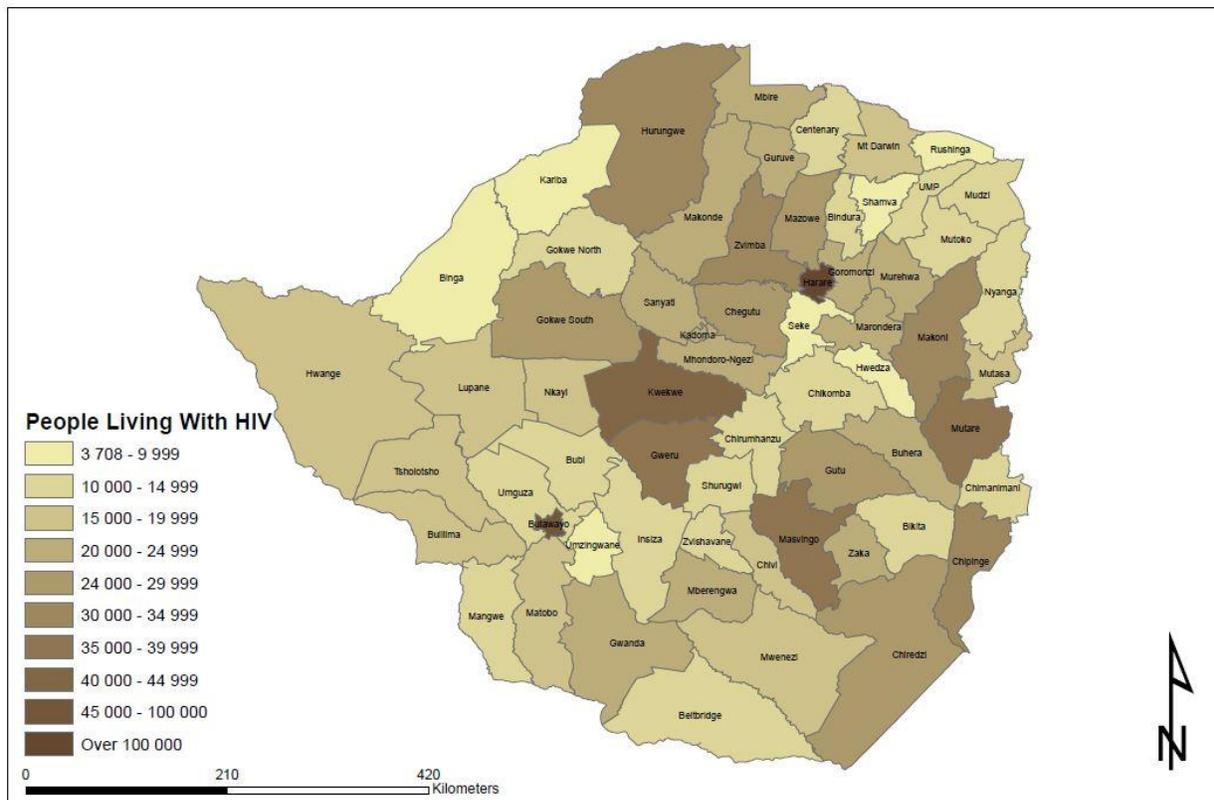
1.4 Alignment of PEPFAR investments geographically to disease burden

Figures 1.4.1 and 1.4.2 compare PEPFAR expenditures for HIV prevention, care, and treatment in 2014 to HIV burden by district. As Figure 1.4.1 illustrates, PEPFAR spent on average \$69.12 per PLHIV in Zimbabwe in 2014. Spend per PLHIV across districts varied from \$21.43 in Gokwe South to \$255.44 in Seke. Some of this variation can be explained by different service delivery models, such as outreach activities that operate out of a central district (such as Bulawayo and Harare), a mixture of both direct service delivery and TA, as well as activities co-funded to varying extents by other donors (such as DfID's support for VMMC in sites supported by USAID). Other aberrations in this graphic are due to the fact that some districts that have recently been combined or separated are represented differently across data sets. For example, Chitungizwa's spending (\$1,062,310) is not represented in Figure 4.1.1 since PLHIV from this district are represented under Harare. Similarly, results for Mbire and Guruve are combined under Guruve. Mobility and ARV availability in provincial capitals and select districts further skews the district level HIV burden data. There are only a few outliers (7% prevalence in Gokwe North and 27% in Bubi) due to Zimbabwe's fairly homogenous prevalence. The biggest expenditure differences are related to costs in reaching the facilities due to distance from the capital centers and remoteness/inaccessibility.

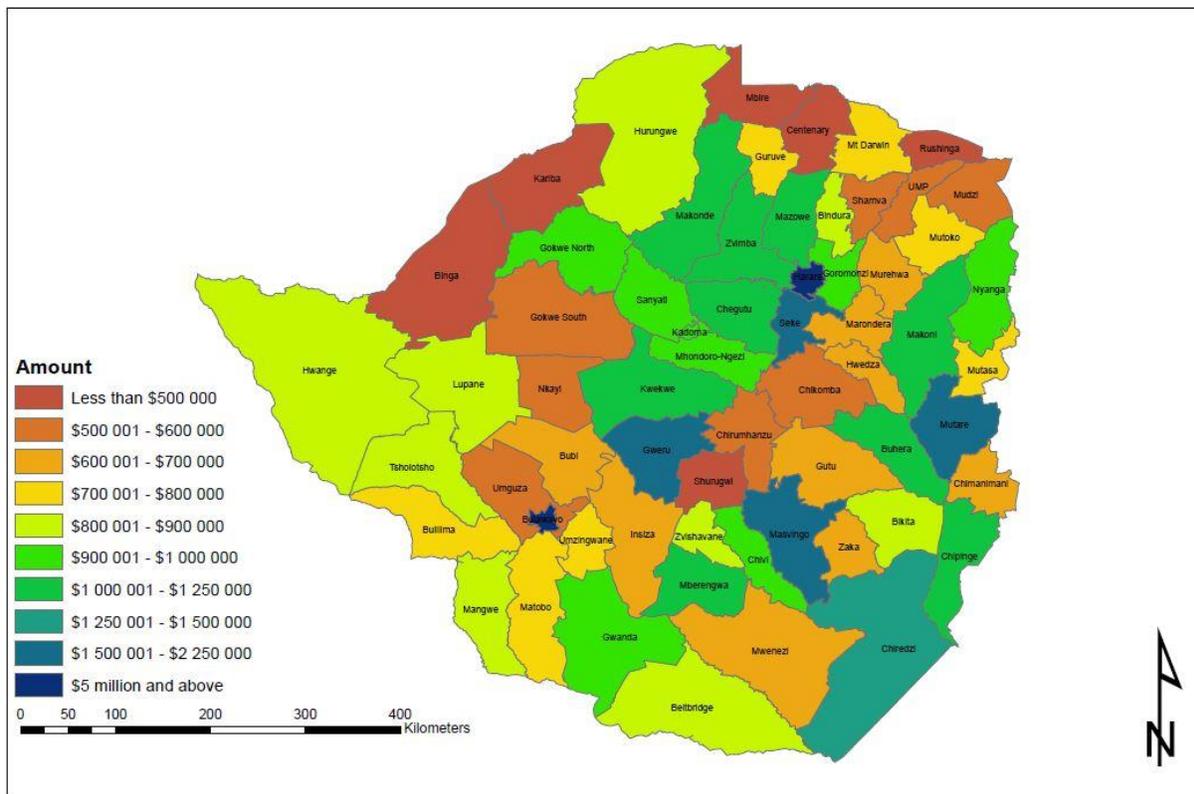
Figure 1.4.2 Total expenditure, PLHIV, and Expenditure per PLHIV by District



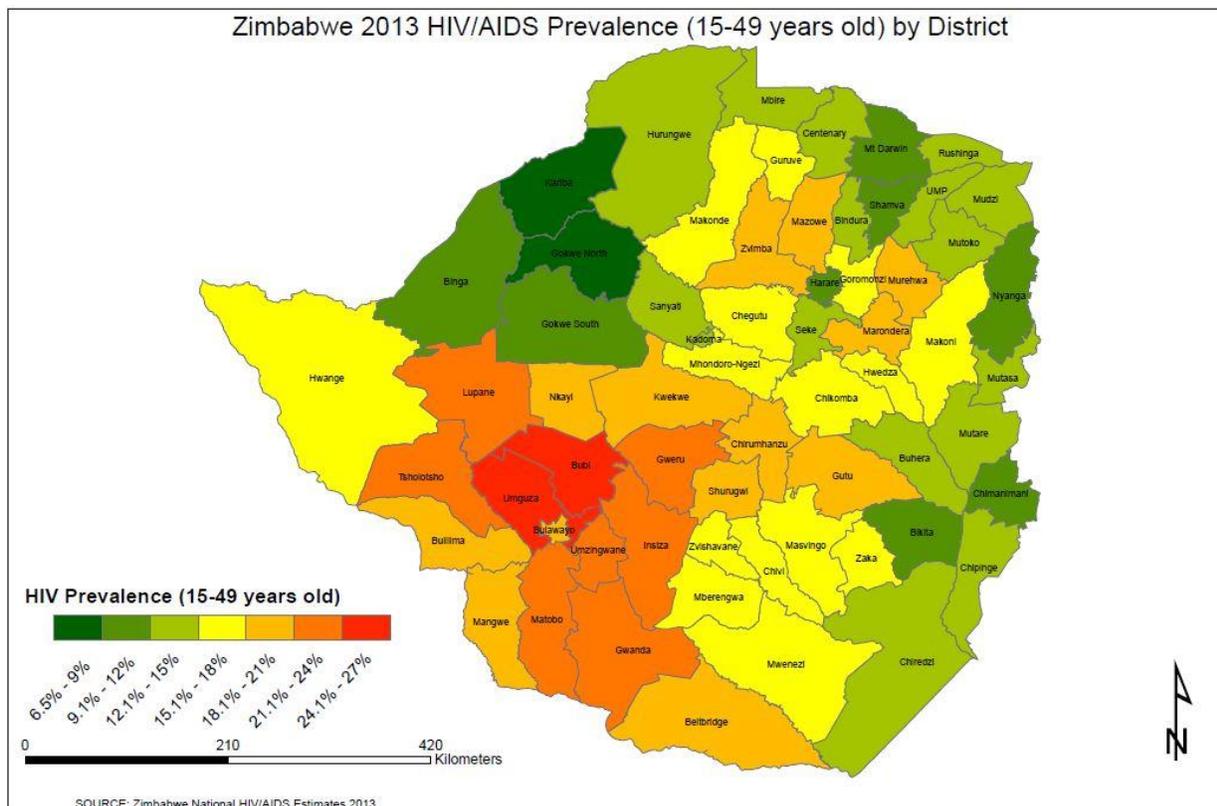
People Living with HIV/AIDS



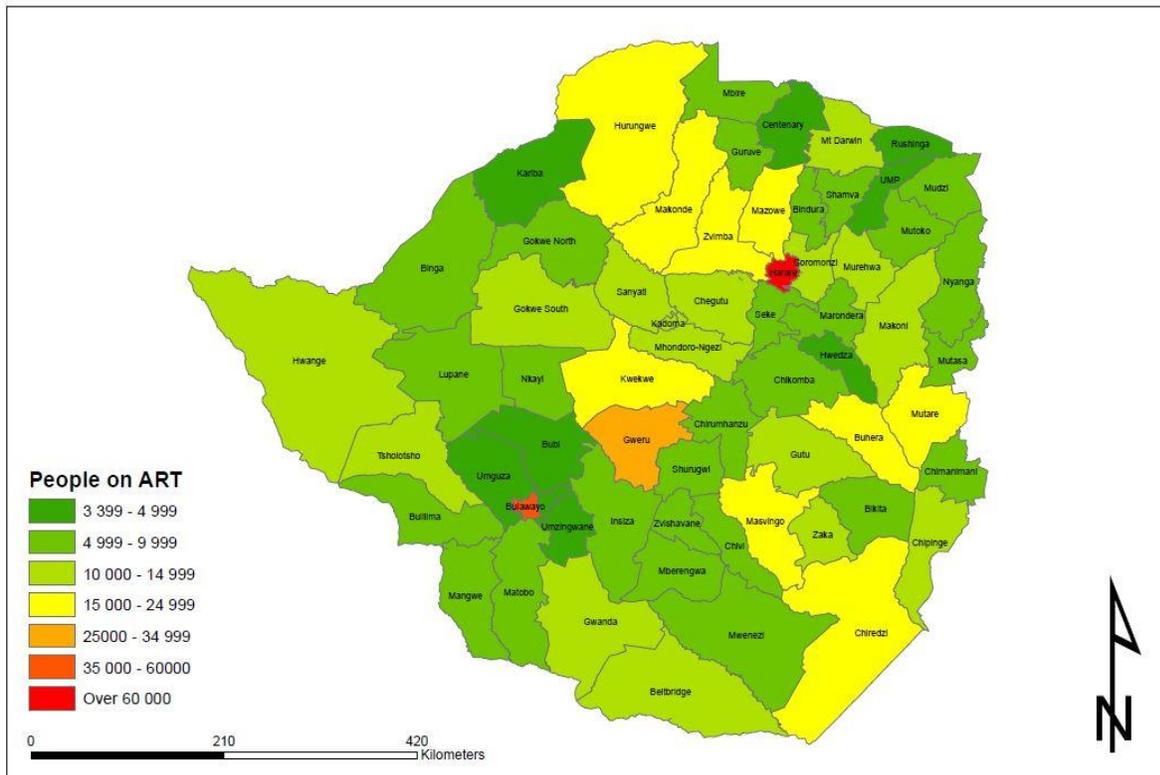
PEPFAR EXPENDITURE BY DISTRICT



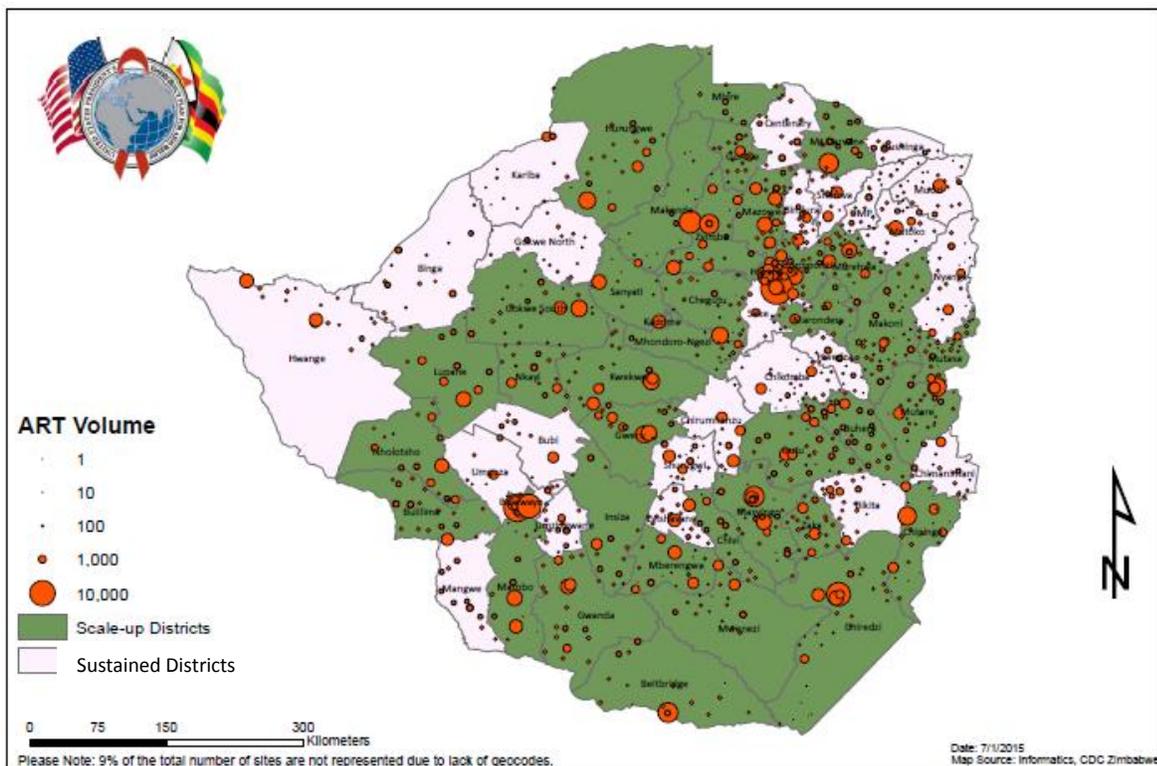
Zimbabwe 2013 HIV/AIDS Prevalence (15-49 years old) by District



Number of People on ART



Zimbabwe 2014 Site-Level ART Client Volume



1.5 Stakeholder Engagement

The PEPFAR team provides updates to constituents at various fora throughout the year which include: monthly health development partners meeting (donor and UN agencies); national bi-annual planning and review meetings, the last of which was in December 2014 (MOHCC from all levels, civil society, NAC and private sector); CCM meetings (multi-sectoral); and MOHCC-led TWG and partnership fora. During COP 15 development, the PEPFAR team met with the MOHCC and NAC leadership to discuss changes in the PEPFAR strategy and seek guidance on how to prioritize PEPFAR program support in line with the new PEPFAR vision. Follow up meetings with these TWGs helped to frame the prioritization process and guide de-duplication efforts.

Zimbabwe did not develop a Partnership Framework and may not develop a formal Country Health Partnership. Nevertheless, the PEPFAR team engages regularly with the MOHCC to provide information on PEPFAR-supported activities and results, budgets and expenditures. All PEPFAR activities align with national priorities as outlined in national strategic plans.

Global Fund and other external donors

The PEPFAR team engages regularly with the Global Fund, including regular meetings with the United Nations Development Programme (UNDP) as the Principal Recipient and with the Fund Portfolio Manager on country visits and by phone between visits. COP preparation coincided with a week-long, high-level delegation visit by DfID, GF, GAVI and EU; several bilateral and multilateral meetings took place during the visit. Of particular concern was the ARV gap for 2015 and 2016. Health development partners agreed to have a common message to the government on the risks of continuing to scale up treatment without a sustainability plan.

Civil Society and Private Sector

Engagement with civil society kicked off with a COP development meeting in March 2015 attended by 71 representatives from diverse organizations including CSOs, NAC, other bilateral and multilateral health development partners, implementing partners, the University of Zimbabwe, and the private sector. A 1½ hour question and answer session was conducted with responses provided by the PEPFAR team. Participants were encouraged to provide further input by email and they received copies of the presentation. Additional engagement is outlined in the civil society engagement plan which continues to be developed with input from PEPFAR. Agreement has been made to conduct quarterly meetings with civil society and to communicate more regularly on the progress of PEPFAR programs.

Human Rights and Partner Activities

As part of the Local Capacity Initiative, CDC has been working with the Zimbabwe Lawyers for Human Rights (ZLHR) to undertake a law and policy review and analysis of health laws, regulations and policies that pose a barrier to health access. Specifically, prioritized policies for reform include the Public Health Act, Criminal Law and Codification Act. In addition, CDC has also requested a core group of civil society organizations to engage in the selection of policies that need review or advocacy and reform.

Through USAID's democracy, rights and governance program, USAID/Zimbabwe has supported local human rights organizations, including ZLHR, which provides response mechanisms that foster a more secure environment for citizens to engage freely in political processes and attempts to hold those responsible for the abuse to account. With USAID assistance, ZLHR provides emergency and follow-on legal support services to human rights defenders; offers strategic impact litigation for human rights defenders and citizens to defend their rights and fundamental freedoms; monitor and document human rights violations; train human rights defenders to be able to effectively defend their democratic space and free political expression; and build human rights capacity and training in rural and other marginalized populations.

2.0 Core, Near-Core and Non-Core Activities

In determining core, near-core, and non-core activities for COP 2015, the PEPFAR team considered the activities necessary to achieve epidemic control, the current and expected future investments from all stakeholders, and the unique position of PEPFAR to provide direct service delivery and TA. PEPFAR will continue to fund key program areas in the national HIV response, including treatment, care and support, HIV prevention, HTC, OVC, lab strengthening, strategic information, procurement of commodities and health systems strengthening. All core or near-core activities in each of the technical areas will be either maintained or scaled up with a focus in the scale-up districts unless there is a sound justification for continuing them in sustained districts (see each technical narrative). Activities described as non-core are a mixture of activities either covered by another donor or activities that do not directly support epidemic control. Non-core activities in certain technical areas, e.g. health systems strengthening, blood and injection safety, management and leadership trainings, etc. will not be funded in COP 2015. For technical areas such as OVC, there will be a more gradual transition to hand over activities over a two-year period to relevant line ministries or other donors. For a complete list of core, near-core, and non-core activities and transition plans, refer to Appendix A.

3.0 Geographic and Population Prioritization

Based on epidemiological data, 36 districts represent 80% of the PLHIV; PEPFAR is currently operational in all 60 districts and both urban city centers. In order to reach 80% ART coverage nationally, an additional 333,177 patients will need to be initiated on ART, and will require continued work in HTC, PMTCT, community outreach through priority and key population interventions, and investments in HSS. Based on enrollment trends, national targets, expenditure analysis (EA), and program data, Zimbabwe would need to increase expenditures significantly on ARV commodity procurement to meet treatment needs in 2016. Given population distribution and budget constraints, PEPFAR Zimbabwe is focusing scale up activities in a subset of sites within the 36 districts mentioned above, and will establish a package of services for sustained sites within those districts and on a sub-set of high-volume sites outside those districts. The scale-up districts also account for 80% of the ART coverage gap. These districts include the major urban cities (Harare, Bulawayo, Chitungwiza and Mutare) in Zimbabwe. Fifty-three high-volume sites (with over 680 patients on ART) outside the scale-up districts will receive a package of services for sustained sites.

While Zimbabwe has a generalized epidemic, targeted high-risk and vulnerable populations include adolescent boys and young men 15-29 with a focus of linking this group to VMMC, HTC, and care and treatment services, adolescent girls and young women (AGYW) 15-24, who have a 1.5 times higher HIV prevalence than their male counterparts, and thirdly, men and women aged 15-49 years in “hot spots” that include mining areas, migrant workers and growth points where populations have limited access to all services.

Based on EA and national program data, reaching the 80% target for VMMC by 2016 would require \$120 million and 800,000 procedures. In COP 2015, PEPFAR funding for VMMC in Zimbabwe will not be sufficient to fill the total unmet need for effective saturation.

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

Summary Table -- Scale-up vs Sustained							
District Type	# of Districts	Estimated # PLHIV	# enrolled on ART as of Sept 14	Gap to 80%	Estimated HIV+ pregnant women 2014	# Pregnant Women receiving ARVs in FY14	Gap to 90%
Scale-up	36	1,089,939	599,911	272,040	57,025	44,910	6,413
Sustained	24	262,728	148,971	61,211	13,109	13,674	(1,876)
Total	60	1,352,667	748,882	333,251	70,134	58,584	4,537

The PEPFAR team developed targets for ART coverage using MOHCC data for district-level prevalence (from National AIDS Estimates 2013) and demographic health information system (DHIS) data on site-level ART coverage. The epidemiological data revealed that 80% of PLHIV in Zimbabwe reside in 36 (of the 60) districts, where 94% of ART patients are served at 59% of the facilities (see ART volume analysis). Within these 36 districts, targets for ART initiation have been set based upon the district-level gap to 80% coverage. Based on this, the COP 2015 national target for ART initiation is 153,030. This approach to target setting is significantly different from previous years in that it is based upon the geographic and site-level prioritization model, targeting the districts in the country representing the majority (80%) of PLHIV, and sites with the highest patient volume. As such, the denominator for target coverage is the PLHIV in these districts, rather than the national figure. However, these targets are contingent upon the availability of ARVs; current estimates project gaps of approximately \$15 million and \$58 million for 2015 and 2016, respectively, though further analysis is ongoing together with MOHCC, Global Fund and UNAIDS.

To identify and initiate PLHIV on ART, PEPFAR has developed an intensified package of services to scale up in selected areas. The mentoring package of TA support will emphasize increased HIV testing and ART initiation in TB clinics, facility-based outreach to improve adherence and retention, increased provider initiated testing and counseling (PITC) in health facilities (currently approximately 10% coverage), tracking systems to increase follow-up of mother-baby dyads in PMTCT settings, and targeted prevention interventions such as treatment for prevention (TaSP). Pediatric initiation will also be strengthened through increased testing within inpatient and outpatient pediatric departments, nutrition centers, and improved EID results transmission. HTC

activities will be refocused to increase the positivity yield by emphasizing areas with higher disease burden and at-risk populations. Additionally, pre-ART care services through the New Life network will increase efforts to transition pre-ART clients to treatment through strengthened referral systems to reduce loss to treatment and increase retention. Through the provision of clinical mentoring, supportive supervision, and above-site and community-based TA, the PEPFAR Zimbabwe team is anticipating approximately 45% of new ART initiations to come through intensified PITC activities, including improved linkages with the TB program. Twelve percent are anticipated to originate from the PMTCT program, with the remainder coming from other testing activities.

Based upon EA and program data from 2014, PEPFAR agencies determined an estimated per site cost for a core service package of TA to be delivered to the scale up sites on a quarterly basis. Sustained sites will receive a slightly reduced package of services, excluding community outreach and testing activities. Per site costs for centrally supported sites were based on a minimum service package and less than quarterly visits. EA data was also used to determine the above-site and national-level costs for activities such as curriculum and guideline development and coordination support to the MOHCC.

Because the PEPFAR Zimbabwe package of treatment services is largely TA (rather than DSD), meeting the above-mentioned targets will require that adequate human resources for health (HRH) and commodity resources are available. Testing, ART initiation and retention performance will be largely dependent upon the performance of MOHCC facility-based and community-based staff. The overall success of care and support services will also be dependent upon the performance of local non-government organizations (NGOs) that implement care and support services for HIV clients at facilities and in communities.

Targeting for key populations (KPs) is a challenge since data is largely unavailable due to political sensitivities in the country. Some size estimates are available for CSWs, but only in specific areas and are not amenable to extrapolation at the national level. Size estimations for other KP such as MSM are unavailable at this time. Nevertheless, both community and facility based TA will include efforts to reach the MSM population through sensitivity training and collaboration with community partners. PEPFAR will be working to carry out KP size estimation studies to address this gap in collaboration with the GF. Site-level data for ART coverage (vis-a-vis PLHIV in the respective catchment areas) is currently unavailable; PEPFAR will be working to improve data reporting and consolidation through its TA support for the electronic patient monitoring system, (ePMS) and the HIV Impact Assessment Study (HIA).

Table 4.1.1 ART Targets in 36 Scale-up Sub National Units for Epidemic Control

District	PLWHIV	Current on ART	Target New Initiations
Gweru	38,655	33,791	3,373
Chiredzi	26,660	21,081	2,107
Mount Darwin	16,956	13,263	1,420
Makonde	20,953	15,277	2,299
Masvingo	35,452	24,833	2,710
Beitbridge	14,916	10,611	1,045
Mazowe	27,659	18,720	1,676
Buhera	24,181	16,168	1,573
Tsholotsho	19,873	12,302	1,831
Gwanda	21,276	12,732	2,200
Mwenezi	15,095	8,310	1,955
Lupane	17,233	9,667	2,134
Matobo	16,949	9,334	2,194
Murewa	22,703	12,213	3,097
Goromonzi	21,316	11,059	3,131
Kadoma	25,246	13,705	3,376
Insiza	14,788	6,482	2,821
Chegutu	26,092	14,223	3,457
Chivi	17,990	8,491	3,101
Nkayi	15,902	6,999	3,018
Zvimba	30,373	16,270	4,180
Bulilima	15,088	5,780	3,334
Zaka	22,382	10,538	3,873
Mutasa	18,426	7,727	3,706
Guruve	22,226	9,645	4,293
Mberengwa	21,923	8,910	4,564
Mutare	37,604	18,455	6,097
Hurungwe	33,217	15,120	6,031
Gokwe South	27,600	10,887	5,926
Bulawayo	95,676	57,404	9,810
Chipinge	30,093	12,274	6,241
Gutu	28,639	11,073	6,271
Makoni	31,965	12,541	6,901
Marondera	23,840	5,582	7,205
Kwekwe	44,156	19,091	8,567
Harare	166,836	99,353	17,514
Total	1,089,939	599,911	153,031

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Scale-up Sub-national Units

Entry stream in Scale-up SNU*	Tested for HIV	Identified Positive	Enrolled on ART
Currently in care		105,866	37,047
ANC	238,961	18,639	17,707
TB/HIV	28,861	20,203	16,162
Peds	315,197	18,912	15,319
Community sites and outreach (DSD)	379,590	44,100	30,870
PITC (non-ANC)	498,960	49,904	35,925
Totals	1,461,569	257,624	153,030

*Note: In addition, a further 111,763 tests would be carried out both at facility and community level in the sustained districts. Of these 100,328 would through PITC channels at the 53 high-volume sites and 11,435 would be in the 4 sustained districts through outreach modalities.

Table 4.1.3 VMMC Coverage and Targets by Age Brackets

	Population Size Estimate (scale-up SNUs)	Current Coverage	APR 16 Target VMMC_CIRC	Expected Coverage APR 16
Males 15-29	792,114	15%	72,306	29%
Males 10-14	380,375	26%	52,607	47%
Total	1,172,489	18%	124,913*	35%

*Note: An additional 6,607 males older than 30 years will be circumcised to bring the total VMMC target for COP 2015 to 131,521. No boys younger than 10 years will be circumcised.

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

	Population Size Estimate (scale-up SNUs)	Coverage goal	APR 16 Target
AGYW 15-24 years	1,067,754	20%	211,205
Women 25-49	1,497,527	8%	116,937
Boys and young men 15-25 years	970,889	82%	795,582
Men 25-49	1,425,399	5%	64,249
Sex Workers*	51,306	46%	23,735
Total	5,012,875		1,211,708**

*Note: Sex Workers are a sub-set of the women categories and so have not been included in the totals. Also note that MSM are included as sub-categories within the boys and men categories although it is difficult to currently estimate the exact numbers.

**Note: The total HIV prevention number is for the 36 scale-up districts only. An additional 16,355 men and women including sex workers will be targeted in an additional four sustained districts where there are hotspots. The total target for HIV prevention would be 1,204,329 for COP 2015.

Table 4.1.5 Targets for OVC and Linkage to HIV Testing, Care and Treatment

SNU 2	Estimated number of PLHIV under 15	Estimated number of OVC	Number of OVC served	FY15 Target # of OVC served OVC_SERV	FY15 Target for OVC_ACC	FY16 Target # of OVC served OVC_SERV	FY16 Target for OVC_ACC
Bubi	1,422	6,188	7,653	10,425	2,971	10,325	5,163
Buhera	3,276	24,588	6,022	15,800	4,503	15,982	7,991
Centenary/Muzarabani	1,437	12,279	-	9,080	2,588	8,626	4,313
Chegutu	3,317	27,184	4,155	15,692	4,472	17,669	8,835
Chipinge	4,083	32,413	5,058	18,100	5,159	21,069	10,535
Chiredzi	3,960	30,621	5,876	9,100	2,594	9,100	4,550
Goromonzi	3,279	22,499	3,770	20,016	5,705	21,194	10,597
Gutu	3,314	20,308	-	15,800	4,503	16,200	8,100
Gweru	3,991	24,967	4,394	7,000	1,995	7,000	3,500
Harare	15,772	217,981	33,561	72,343	20,618	70,554	35,277
Insiza	1,944	10,033	7,679	10,325	2,943	9,809	4,905
Kadoma/Sanyati/Mhondoro	3,449	30,971	-	5,247	1,495	10,150	5,075
Makonde/Chinhoyi	2,996	23,147	-	28,500	8,123	29,070	14,535
Makoni	3,879	30,266	8,575	23,300	6,641	23,213	11,607
Mazowe	3,459	24,400	3,506	12,300	3,506	12,478	6,239
Mutare	4,606	44,975	5,378	26870	7523	29,233	14,617
Mutasa	2,037	16,875	5,850	14,800	4,218	13,500	6,750
Nyanga	1,217	12,660	5,365	5,000	1,425	2,477	1,239
Seke	2,851	10,076	17,070	10,561	3,010	5,000	2,500
UMP	1,297	11,261	4,317	4,101	1,169	3,896	1,948
Umzingwane	1,079	6,299	7,764	9,000	2,565	8,550	4,275
Zvimba	3,729	26,302	-	15,670	4,466	15,848	7,924
Zvishavane	1,537	11,774	1,325	3,050	869	2,550	1,275
Total	77,931	678,067	137,318	362,080	103,061	363,493	181,750

Program Area Summaries 4.2-4.10

4.2 Priority Population Prevention including Key Populations

As part of COP 2015, decisions were taken to prioritize HIV prevention activities to the 36 care and treatment scale-up districts, and within these, improve strategies for better targeting of highly vulnerable groups. In addition, hotspots in 4 sustained districts will be geographically targeted, where there are high numbers of sex workers (SW) and other at risk populations. In total, a target of 1,204,329 people will be reached with an HIV prevention intervention that fulfills the PEPFAR guidance. Of these, 1,187,974 will be reached in scale-up districts and 16,355 in sustained hotspot areas. High risk and vulnerable populations to be targeted will include AGYW 15-24, who have a 1.5 times higher HIV prevalence than the male counterparts and adolescent boys and young men 15-29 with a focus of linking this group to VMMC, HTC, and care/treatment services. Other emphasis for HIV prevention activities will be to strengthen the targeting of couples based on the evidence that 47% of couples with one partner infected with HIV are sero-discordant. Other priority populations include both men and women aged 15-49 years in hotspots such as mining areas, migrant workers, trucking routes and highways and growth points where populations have limited access to HIV services. According to the UNAIDS hotspot analysis, HIV prevalence in migrant agricultural workers, mining areas, and growth points were all above 24%.

Estimating the size of *key populations* in Zimbabwe has been challenging particularly for sub-populations including sex workers (SW), men having sex with men (MSM), transgender persons (TG) and people who inject drugs (PWID). A size estimation and retention/clinical cascade of care study are underway for SWs and the protocol for MSM is still under discussion with the MOHCC. Under the current USG policy environment, PEPFAR is unable to support any activities in prisons (these activities are funded by DFID, GF and NAC). Based on the modes of transmission study in 2009, there are an estimated 85,949 SWs in Zimbabwe and HIV prevalence among SWs from program and research data range from 28%-70%. More recent estimates based on local research suggest that the estimated number of SWs in the 36 scale-up districts is 51,306. In 2011, a mapping of hotspots of SWs was undertaken and as a result, the national SW program, commonly known as the 'Sisters' program, was scaled up to include 6 static sites and 36 outreach points services in 30 districts, four of which lie outside the 36 scale-up districts and include Bindura, Kariba, Hwange and Zvishavane. The national SW program has been designed to improve access to HIV prevention, care and treatment services acknowledging that SWs are a highly-stigmatized group who are reluctant to seek services through public health facilities.

Currently, the sex worker program reaches approximately 24,000 SWs. The age of SWs ranges between 18-49 years. Services are provided at both unique static sites staffed by trained health workers who are sensitive to the needs of SWs and through community-based outreach using peer educators. PEPFAR will support HIV prevention activities such as community based outreach, condom distribution, HIV testing and ART through the New Start network that includes outreach activities and will reach 23,759 CSWs in scale-up districts and 485 in sustained districts. An additional three thousand eligible SWs will receive ART through community-based outreach ART services. Identification and follow up of SWs has been a weak component of the CSW program and additional resources are being sought as part of the DREAMS proposal to

strengthen follow-up of 18-24 year old girls either involved with sex work or involved with transactional sexual activities. All commodities for the SW program are provided through NatPharm and supported by multiple donors including DfID, GF, NAC and USAID (condoms).

Following discussions with civil society, PEPFAR will also strengthen linkages with local civil society partners involved with providing HIV prevention, care and support services to the MSM community. PEPFAR will work closely with the Gay and Lesbians Association of Zimbabwe (GALZ) in 5 scale-up districts (Harare, Bulawayo, Gweru, Masvingo, Mutare) and 1 sustained district (Hwange/Victoria Falls) to provide outreach HIV prevention and ART services to members of GALZ. PEPFAR will provide 600 MSM with ART services through the New Start outreach model.

Prevention activities funded under COP 2014 in sustained districts will be scaled down and/or transitioned except for those targeting highly vulnerable groups such as SWs, MSMs and hot spots as described above.

Work in communities to address socio-cultural norms that drive the HIV epidemic will continue in scale-up districts. Within districts, mapping of high risk and vulnerable groups through TRAC surveys and an UN hotspot analysis will support plans on where to plan outreach activities. Community mobilization will be linked with provision of HTC, VMMC, OVC and care and treatment services. The 'Together for Girls' Initiative has been supporting HIV prevention activities under the OVC portfolio specifically on addressing gender norms and GBV.

HIV prevention activities are an integral component of other technical areas e.g. PMTCT, facility based HTC, VMMC, ART and a comprehensive package of activities include: targeted risk assessment and provision of risk reduction information; condom promotion, condom skills training and distribution; HTC with active referrals; demand creation to increase awareness, uptake and acceptability of clinical services and activities which address harmful norms, reduce stigma and discrimination and prevent gender-based violence.

The GoZ has highlighted that it will not have sufficient resources to pay for male and female condoms that the USG procures, creating concerns about the sustainability achievements. Pulling out support for the condom program would impact the consistently high condom use which according to the DHS has found condom use by men at last sex with a non-marital, non-cohabitating partner to be 70.2%, 70.9%, and 77.3% in 1999, 2005, and 2011 respectively. This is one of the highest condom use rates found within the region and is believed to be a contributing factor in the decline in HIV prevalence reported in Zimbabwe. Condom demonstrations and promotion activities will continue through an established network of hair salons and bars that are located in mainly urban and peri-urban areas. All male (approximately 75 million) and female (5 million) condoms will be procured through the USAID central condom procurement mechanism and are not included in COP 2015. PEPFAR will continue to support national condom distribution.

The MOHCC, MOLSW and the Ministry of Education have minimal funding to support significant coverage of HIV prevention activities. The NAC does support some HIV prevention activities through the AIDS Levy and GF but also has limited coverage. PEPFAR will however continue to work closely with the Ministries and NAC to ascertain gaps in the HIV prevention

portfolio, provide TA, and coordinate HIV prevention activities to reduce redundancies and promote complementarity.

Based on SIMS visits, the weakest component of current HIV prevention activities remains the linkages to HTC, VMMC, Care and Treatment service delivery. Innovations recently introduced have been a referral slip system that is being piloted through the hair salon network which is trying to link clients to other HIV prevention and treatment services. Other modalities to track clients such as SMS follow ups are also being scaled up.

An important component of the HIV prevention portfolio is addressing harmful social norms and partners will work closely with traditional and religious leaders who have significant influence in changing these. Community leaders are also critical in promoting positive health seeking behavior such as uptake of HTC, VMMC, PMTCT and adherence to ART and retention in care. Involvement of the community leaders in outreach activities will be critical for success. USG partners will work closely to engage these community gatekeepers e.g. there are plans to use chiefs in the promotion of VMMC uptake.

4.3 Voluntary medical male circumcision (VMMC)

Among the 14 VMMC priority countries, Zimbabwe has the potential to avert the highest proportion of new HIV infections with VMMC. Evidence suggests that for every four male clients circumcised, one HIV incident case is averted⁵; circumcising 1.9 million Zimbabwean men aged 15–49 by 2015 could avert 42% (600,000) of new HIV infections by 2025. This model suggests that prioritizing Zimbabwean males aged 15–29 will lead to the greatest reduction in HIV incidence in the short-term and inclusion of the 10-14 year age group provides the greatest magnitude of impact after 15 years⁶. In 2009, the MOHCC launched their flagship VMMC program targeting 13-29 year olds. Through September 2014, there have been 364,320 circumcisions towards a national target of 1,300,000. PEPFAR VMMC support started in 2009, but has scaled up since 2013 upon receiving additional central funding.

PEPFAR Zimbabwe made difficult tradeoffs due to the new COP 15 guidance. VMMC services are being provided in all the 60 districts in COP 14. Given the COP 15 guidance and recommendations during the review, the Zimbabwe PEPFAR team has reduced the number of VMMC districts to 26 which are all aligned with Care and Treatment scale-up districts, and the highest burden of HIV disease. The VMMC TWG has also proposed the following changes to the budget and targets to increase coverage for COP 15. The team shifted \$3,198,344 from the original CIRC commodity budget and \$732,097 from the M&O budget to cover SIMS visits to service delivery to allow for more circumcisions. In summary, the total MC budget for COP 15 (including central funds for VMMC kits) is \$21,048,920.

⁵ <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001132>

⁶ <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001132>

The total is calculated as follows:

Original CIRC Budget (less M&O)	15,467,723
ADD - Savings on USAID SIMS	632,097
ADD - Savings on CDC SIMS	100,000
ADD - Shift from SCMS Pipeline C&T budget	331,766
ADD - Additional Central Funding for commodities	4,217,334
ADD - Additional Central Funding for Reusable project	300,000
Total Budget	21,048,920

This will allow for a new target of 131,521 MCs at a cost of \$158/MC, which includes 15% buffer stocks and mass media costs. The increase in funding provides a 25% increase from the initial COP 2015 target which was set. The MC unit cost was re-examined by the team and a service delivery cost excluding commodities and mass media was \$115 which is higher than the EA data from the previous year as the EA data does not take into consideration leveraged resources received from DFID. The program continues to expect higher training costs to convert providers to dorsal slit and continue PrePex training, as well as additional costs to increase demand creation efforts to increase uptake of VMMC services among the 15-29 year olds.

There will still be an overall reduction in the number of districts offering VMMC services; and thus, Zimbabwe's capacity to achieve national targets in the short-term in districts not supported by PEPFAR will not likely be possible as the MOHCC has no additional resources to apply to the VMMC program. The GF is unlikely to absorb additional activities and DfID is slated to stop funding VMMC activities in January 2016. The program remains in a "catch-up" or accelerated phase and has reduced funding to meet this mandate. According to the national accelerated strategic and operational plan (2014-2018), Zimbabwe requires \$106.7 million over the next three years to reach 80% coverage of MCs for the greatest impact.

A number of scenarios were developed during the COP planning process to balance geographic targeting and performance:

- Aligning VMMC districts to the 36 scale-up districts to reach 80% coverage of 15-29 year old males.
- Seven smaller districts would reach 80% coverage. It is worth noting that even a 10% increase in community level MC coverage is associated with a 15% reduction in HIV incidence among men⁷.
- PEPFAR Zimbabwe examined high and low volume districts in terms of MCs performed and mapped these against scale-up and sustained districts. High volume at the district level was

⁷ <http://www.croiconference.org/sessions/impact-male-circumcision-scale-community-level-hiv-incidence-rakai-uganda>

defined as achieving more than 1,000 MCs among 15-29 year olds in the past year or having MC coverage among 15-29 year olds above 7%⁸.

	Low volume <1000	High Volume >1000	Grand Total		Low coverage <7.3%	High Coverage >7.5%	Grand Total
Sustained	13	11	24	Sustained	12	12	24
Scale-up	10	26	36	Scale-up	13	23	36
Grand Total	23	37	60	Grand Total	25	35	60

In consultation with the MOHCC and implementing partners, 26 districts under the care and treatment scale-up districts were chosen based on capacity to efficiently deliver at the lowest cost and potential to scale up services to reach highest coverage. The 26 VMMC districts now also completely align with the DREAMS proposal. The 34 districts not included above will become centrally supported sites which will transition to the MOHCC; it is assumed that VMMC services will not be maintained. The PEPFAR Zimbabwe team did consider a maintenance package in these districts; however, based on the EA data, the cost per procedure of the maintenance package was only slightly less (\$94 versus \$117 per procedure - excluding commodities), with a significant cost driver being the assurance of high quality and safety of services. The minimum support that PEPFAR will cover to non-prioritized districts will be delivery of VMMC commodities to avoid a parallel system for delivery of commodities.

The MOHCC launched a new accelerated VMMC plan (2014-2018), where the MOHCC has reduced the target age groups to now include 10-12 year olds. Of note, since the national guidance prior to December 2014 was to focus MC programming on males aged 13-29 years old, over 90% of MCs reported in the 10-14 year old are actually 13-14 year olds (many of whom now contribute to MC coverage rates in the 15-29 year old group). The MOHCC has developed new guidance based on the WHO cautionary note about tetanus. Primary coverage of tetanus toxoid has been historically high in Zimbabwe and no cases of tetanus have been reported in the last three years. All circumcisions in boys younger than 15 years are carried out using the dorsal slit method. MOHCC is now training all new MC providers and re-training all current providers on the dorsal slit surgical method. Prior to this decision, Zimbabwe had been using the forceps guided method for all age groups⁹. This shift requires additional training costs, particularly for nurses¹⁰. The use of the PrePex device in 15-29 year olds continues under a passive surveillance approach based on current WHO guidance.

Strong quality assurance and improvement systems are in place at all PEPFAR-supported VMMC sites, which are strengthening referral systems such as instant messaging (SMS) technology and

⁸ The national average coverage of 15-29yrs is 10.7%. Only 8 districts have coverage above 20%.

⁹ The decision to completely transition to only one surgical method was based on acknowledgement that one type of surgical method is: easier for providers to manage and providers are more likely to become proficient quicker when using only two methods rather than three e.g. forceps guided, dorsal slit and PrePex; simplifies procurement and distribution of commodities; and easier to monitor quality issues and adverse events.

¹⁰ Doctors are trained in dorsal slit as part of their pre-service medical training.

basic emergency management that are also planned for COP 2015. Emergency equipment and supplies will be procured using PEPFAR resources as required. No PEPFAR funding is being used to circumcise clients younger than 10 years. PEPFAR is providing TA only to develop a national VMMC sustainability plan that includes consideration of early infant male circumcision (EIMC). Research on the feasibility of introducing EIMC is being funded by other partners. The revised VMMC client's death or occurrence of notifiable adverse events forms have been adopted and implementation of this system has started. All cost reimbursements for VMMC follow PEPFAR's Best Practice for VMMC Site Operations guidance and services are based on the Models for Optimizing the Volume and Efficiency (MOVE) of MC services. Dorsal slit commodities and equipment will be procured and delivered by PEPFAR. An external quality assessment (EQA) was carried out in September 2014 which showed the Zimbabwe program to be of high quality. The next EQA is planned for late 2016.

When looking back, a number of initiatives were used to support rapid scale-up and national implementation such as device-based circumcisions, disposable kits, task-shifting to nurses, and the introduction of community mobilisers. With ambitious targets aimed to reach 80% male circumcision coverage, and reduced and reprioritized donor funding, the MOHCC is starting to focus on building the national infrastructure to maintain the program. Additionally, the MOHCC and providers have noted recurrent challenges with disposable kits including the large amount of waste produced and the poor quality of some components. By comparison, reusable kits are less expensive and better quality than disposable kits and will cut down on recurrent costs of distribution and waste management.

To support a transition to more sustainable systems for VMMC, PEPFAR is proposing to assess the requirements to transition from disposable kits to reusable kits in static and outreach settings. In COP 15, through a CDC-supported partner, PEPFAR proposes to pilot the transition from disposable kits to reusable kits in two VMMC districts. These two districts have a total of six static sites, two of which are major hospitals.

In order to do this, the following considerations and recommendations are proposed for commodities:

- Based on recent program data, 90% of procedures are surgical and 10% are device-based (PrePex).
- The two selected districts are projected to circumcise a total of 7,453 males in COP15.
- In Kenya where reusable kits are widely used, the determination of the number of reusable kits per site is based on number of teams and their efficiency. PEPFAR is proposing to start with a ratio of 35% disposable kits and 65% reusable kits.
- It is then anticipated that 90% of clients (n=6,708) will be surgically circumcised and of these 65% (n=4,360) will be circumcised using reusable kits.
- Based on past performance, an optimistic weekly per-site average number of surgical VMMCs performed is 100. Providing a week's supply of reusable kits for each site will therefore require 600 kits, with an additional 100 as buffer. The program plans to purchase double this number, for a total of 1400 reusable kits, in order to facilitate rapid scale-up to other sites as soon as sufficient experience develops in the pilot sites. As re-sterilization becomes routine, sites should require less than a one-week supply of reusable kits in order to maintain services, and additional kits can be redistributed.

- The implementing partner will work with facility personnel designated to sterilize other facility equipment to also sterilize VMMC instruments. Additional personnel will not be hired. Infection prevention and control measures will be enforced in line with other sterilization activities.
- In addition to the costs of procuring reusable kits (which are less expensive than a one-time use disposable kit), onetime costs for the procurement of generators and autoclave machines have been accounted for. These will be erected at the six sites. This is because other reusable-kit-based programs have faced difficulties with consistent access to autoclaves when depending on the preexisting autoclaves obtained for general use by the facility. The autoclaves will be subjected to quality control tests and will be periodically serviced/ maintained to ensure all the parts are functioning as required.
- PEPFAR/Zimbabwe is proposing that an additional \$161,000 is approved from the central commodity fund for VMMC to cover the additional costs for generators and re-useable kits for this pilot in addition to the already revised VMMC COP15 budget.

4.4 Preventing mother-to-child transmission (PMTCT)

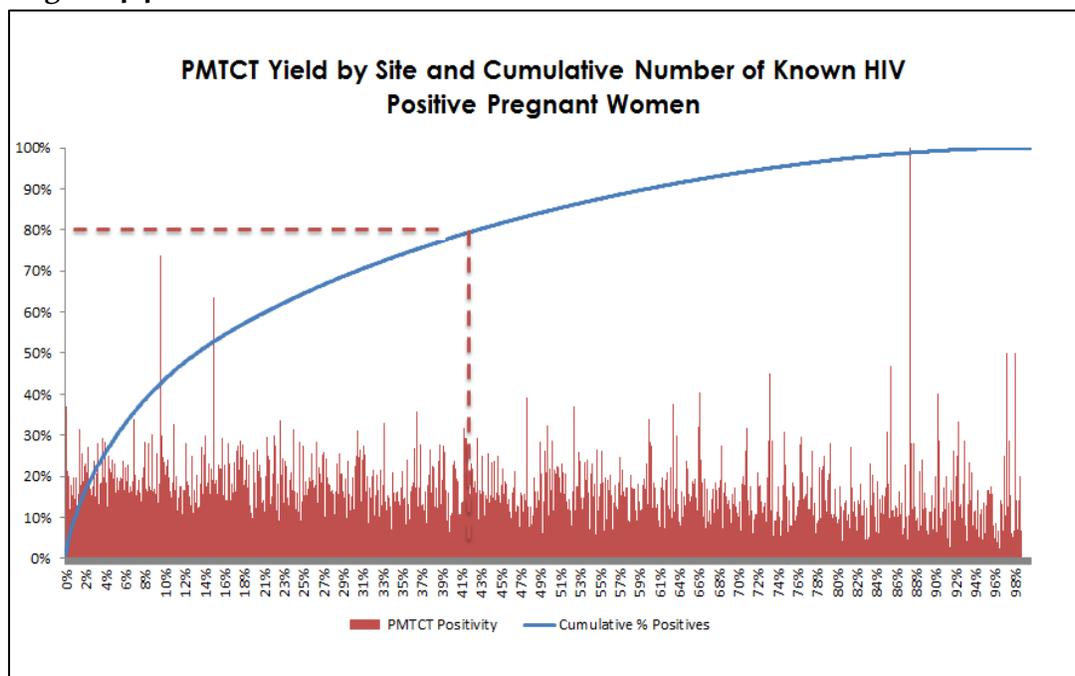
One of the most significant changes in the Care and Treatment program (for both children and adults, including pregnant women) has been the enthusiastic embrace of the move to Option B+ and the resulting, extremely rapid, roll-out nationally. Option B+ is now available in virtually every facility providing antenatal care (ANC), in essence making all of these facilities ART centers. The family-centered approach that Zimbabwe has taken to implementing B+ means that all facilities have been trained to not only initiate pregnant women, but also their adult partners and their children. To achieve epidemic control, PMTCT program targets were set to reach 95% of pregnant women with HTC and initiate 95% of those tested on ART in the 36 scale-up districts. The WHO 2013 ART guidelines were launched in December 2013, with phased implementation beginning in January 2014 and have included changes such as:

- The use of a single-tablet efavirenz-based regimen for first line therapy (TLE replacing TLN)
- Initiation of ART for all HIV positive under-fives (up from “all under two years”) regardless of clinical/immunological status
- The change in ART eligibility from CD4<350 to CD4<500
- Initiation of ART irrespective of CD4 count in individuals with HIV/TB co-infection and severe chronic liver disease

Efficiency Analysis

PEPFAR provided above-site and site level TA for PMTCT in 1,514 sites in FY 2014. As shown below in Figure 4.4.1, 41% of sites (620) identified 80% of HIV-positive individuals (49,790%) with 15 sites finding 0 positives and 93 sites identifying <4 positives. Eighty percent of individuals identified as positives were tested in sites within the 36 scale-up districts.

Figure 4.4.1



4.5 HIV Testing and Counseling (HTC)

Previously, PEPFAR’s HTC efforts were oriented to support the national strategy to achieve universal uptake of HTC services and maximize public access to testing. In COP 2015, PEPFAR support for HTC will be refined to focus on maximizing the number of HIV-positives identified for initiation into the cascade of treatment, care and support.

Data analyses were conducted to identify where testing should be focused to better identify PLHIV. In 2014, the national average positivity rate through testing in all ages was 11 percent, with men above 15 years at 13 percent and women at 10 percent. Within the ANC setting, positivity rates were on average 7.8% and within a pediatric setting, yields of approximately 6% were documented.

In addition to facility-based testing, the national program relies on outreach voluntary, counseling and testing. The table below shows positivity rates for a sample of VCT and community outreach modalities in 2014. For the general population, the highest average yield was at PSI’s New Start fixed sites which provided VCT in 15 scale-up districts and one sustained district. Among community outreach sites, door-to-door, places with high numbers of KPs, and growth points yielded the highest positivity rates. The low positivity rates at schools reflect in part VMMC outreach campaigns that support the identification of HIV-negative adolescent boys and young men to be referred for VMMC services. Under the national VMMC scale-up program, HTC services are part of a comprehensive HIV prevention package.

HTC Service Modality	Number of persons tested and counseled	Number of Positives	Positivity Rate
Growth Point	1,524	125	8.20%
MARPS	4,545	410	9.02%
Rural Business Centre	69,709	2,708	3.88%
School	41,434	1,002	2.42%
Urban Business Centre	109,266	7,714	7.06%
Workplace	30,322	2,088	6.89%
Door-to-Door	1,059	108	10.20%
Healthcare Facility	4,698	320	6.81%
Church/FBO	4,509	196	4.35%
VMMC	9,214	369	4.00%
New Start Fixed Site	157,801	21,611	13.70%
Total	434,081	36,651	8.44%

(Source: PSI APR and program data, FY2014)

Based on the analyses, in COP 2015, both facility-based and community HTC activities will be focused within the 36 scale-up districts. In scale-up districts, 1,461,569 people will be tested through multiple entry points (see Table 4.1.2) resulting in 153,030 newly identified HIV-positives clients. PEPFAR will also support PITC at high volume sustained sites in 24 sustained districts and expects to support through technical assistance an additional 100,328 tests. Community outreach HTC activities will also be carried out in four additional hotspot areas in sustained districts reaching 11,435 high risk populations including sex workers.

As well as a more rigorous geographic focus, HTC strategies will focus on better targeting of vulnerable groups and key populations where higher positive yields (above 9 percent) are expected with stronger linkages of clients to care and treatment services. PITC in ANC is already well established with 97 percent uptake. However, HIV testing on in-patient wards, nutrition rehabilitation units and during general outpatient visits remains weak and TA will focus on strengthening testing in these areas.

For VCT activities and community based testing, PEPFAR will support direct service delivery for testing at fixed New Start sites in the scale-up districts and community outreach testing services to at-risk and vulnerable populations¹¹. The targeted groups will include SWs, MSMs and both men and women, aged 15-49 years, in “hotspots” such as mining areas, migrant worker communities, growth points, and communities along the major transportation corridors¹². Other

¹¹ HTC will be offered as part of an integrated combination HIV prevention package and clients seeking HTC services will also be screened for TB, and receive family planning counseling and services as required (using leveraged resources from Dfid)

¹² According to the UNAIDS “hotspot” analysis, HIV prevalence in migrant agricultural workers, mining areas, and growth points were all above 24 percent.

priority groups for HTC include AGYW ages 15-24, who have a 1.5 times higher HIV prevalence than their male counterparts. Within districts, mapping of high risk and vulnerable groups through TRAC surveys, and analysis of a UN “hotspot” analysis will support plans on where to conduct HTC outreach activities. Different modalities such as index tracing will also be scaled up, linked to the community care and support outreach activities where higher yields are also expected. HTC services will be provided during VMMC campaigns targeted at 15-29 year old adolescents and through VMMC outreach. Analyses for all testing service modalities and for PITC sites will be refined on an on-going basis to better focus testing activities toward locations and modalities that produce the highest yield of HIV positives.

Outside the care and treatment scale-up districts and at sustained sites, TA support to strengthen PITC in sustained districts will be transitioned. For community sites, locations identifying less than 4 positives (such as churches and rural business centers) will not be funded in COP 2015. PEPFAR will continue to distribute HIV test kits to all facilities using DfID leveraged funds. Community leaders, other community members, and families are critical in promoting positive health seeking behavior such as uptake of HTC, VMMC, PMTCT and adherence to ART and retention in care. USG partners will work closely to engage these community gatekeepers for increased uptake in HTC services. Other efforts through strengthening the Social Welfare case management systems for children described under the OVC section will also be applied to support greater access to HTC services and linkages into care.

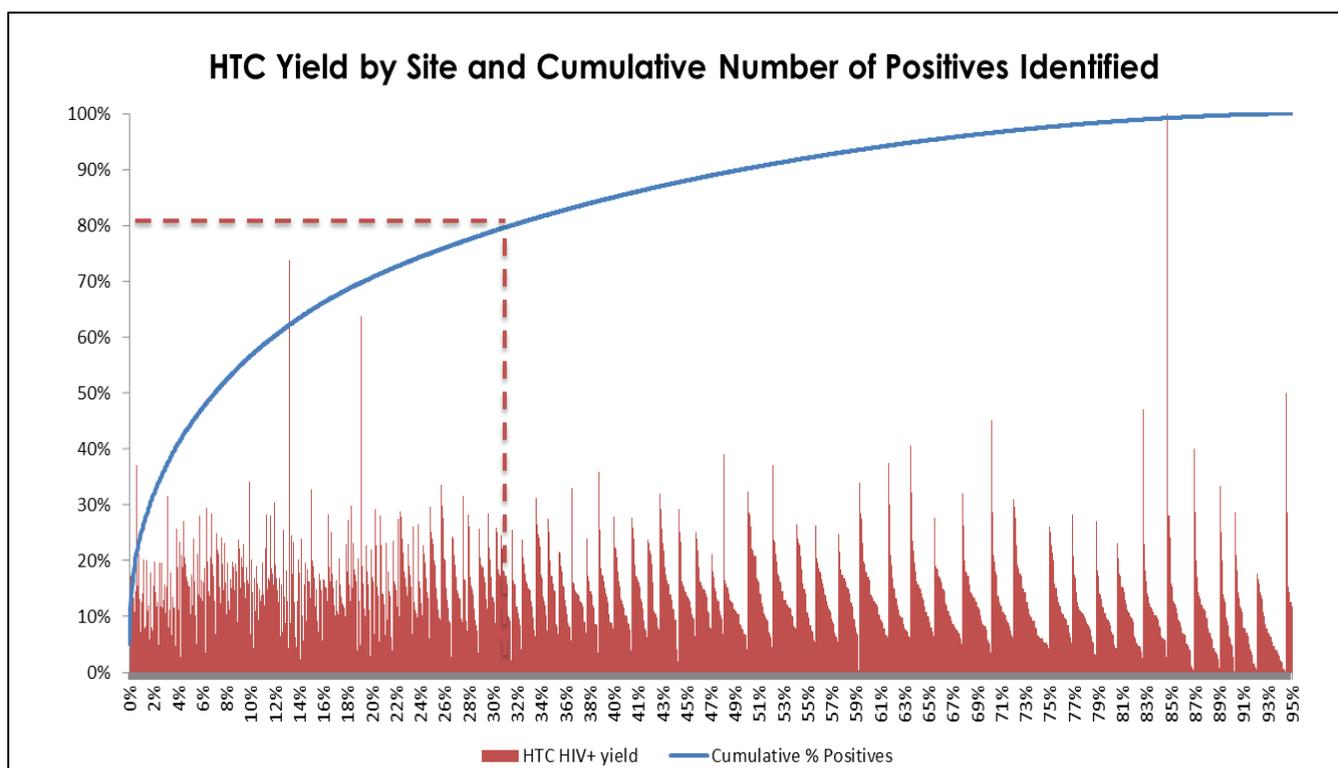
The MOHCC allocates minimal funding to support HIV prevention activities, including HTC services. The primary funders for rapid test kits have typically been PEPFAR (emergency gaps), GF, NAC, and occasionally UNFPA and AXIOS. PEPFAR will continue to work closely with the MOHCC to determine gaps in HTC, provide TA to support national resource mobilization efforts from all funding sources, and harmonize HTC activities at national, facility and community levels to increase efficiencies and coordination. Test kits will not be procured using COP 2015 funding except to cover emergency gaps. The GF, NAC and other donors will continue to fund RTKs and identify ways to mobilize resources for an estimated \$3.43 million gap for 2016. PEPFAR intends to procure 300,000 RTKs under the DREAMS initiative if approved.

Zimbabwe is one of 10 countries selected for the DREAMS initiative. Upon approval of Zimbabwe’s proposal, DREAMS will support the expansion of HIV prevention activities, including HTC services, targeted at AGYW ages 15-24 and pregnant women aged 15-24 in six districts and three cities. Through DREAMS, an additional 235,000 AGYW will be tested.

Efficiency Analysis

During the site level APR reporting, community HTC was reported under the facility indicator and could not be adjusted in time in the system. Figure 4.5.1 represents all HTC regardless of testing modality (1,724 sites and community intervention points). In FY2014, 103,434 HIV-positives were cumulatively identified, 49 sites identified zero positives, and 123 sites identified <4 HIV positive individuals.

Figure 4.5.1¹³



4.6 Facility and Community Based Care and Support

Community-based care and support activities are crucial to ensuring adherence to therapy and retention within treatment programs. In COP 2015, these activities will include support for the implementation/use of the MOHCC appointment diaries and tracking registers (training of facility and community health care providers to allocate appointment dates, to send reminders to clients as dates approach and to follow up those who miss their appointments). These activities will be focused in the 36 scale-up districts with some community based follow up activities occurring linked to the sustained sites in sustained districts.

Resources will be allocated to train peer educators and community health care workers to organize and lead support group meetings (peer to peer, provide psychosocial support, early child stimulation, and to deal with disclosure, stigma, adherence issues etc.) increase demand for HIV services and facilitate referrals to care and treatment, hygiene and nutritional support. Community cadres in scale-up districts will also employ index HTC strategies to identify members of households HIV status. At the facility, PEPFAR will provide TA in clinical mentoring, provision of cotrimoxazole, STI screening, nutritional counseling, and infant feeding counseling. Mentoring TA

¹³ **Note:** Community and Clinical HTC could not be disaggregated.

HTC_TST facility indicator includes service delivery points; ANC, L&D, <5 Clinic, MCH, TB, STI, Outpatient, Inpatient, CTC, VMMC, VCT co-located & standalone, Mobile, HBC

will include sensitization training to ensure equitable access to services for all clients, irrespective of sexual orientation.

National tracking systems will be developed and supported to enable facility and community health workers to track patients in care and reduce loss to follow-up (LTFU). National guidelines to support community care and support practices will also be developed.

4.7 TB/HIV

The WHO 2013 guidelines recommend the initiation of ART in all patients with active tuberculosis infection regardless of CD4 cell count. Zimbabwe has adopted this recommendation and the National Tuberculosis Program has revised its tools. As part of the core package of services (detailed in Appendix A), TA will be provided at all “scale-up” sites to ensure: 1) all TB patients are tested for HIV and immediately prepared for/initiated on ART if positive and 2) HIV positive patients are screened for TB at every contact with health staff. TA will also focus on improving communication and coordination between TB and OI/ART departments, to facilitate better monitoring and evaluation. Program data currently suggests an approximately 70% rate of linkage into care for TB patients found to be co-infected with HIV. For COP 2015, PEPFAR Zimbabwe aims to increase this linkage rate to 80% among newly diagnosed co-infected patients at scale-up facilities.

Through the New Start network in the 36 scale-up districts and 4 ‘hot spot’ districts, TB screening will be undertaken of all newly identified HIV positive clients using a standardized checklist. HIV positive clients with presumptive TB will be tested for TB using smear microscopy and GeneXpert services available through 4 of the 16 New Start sites. The other 12 new start sites that do not have microscopy and GeneXpert services will either refer to another new start site of MOHCC facility that offers the services. Clients with diagnosed HIV/TB co-infection through the New Start network will be linked and tracked into treatment services.

TB infection control (TBIC) is recognized as an important systems-level activity to reduce nosocomial infections for PLHIV, and to reduce TB infection among health care workers. To this end, PEPFAR Zimbabwe will continue to provide MOHCC with TA at the national, sub-national (SNU) and site level to implement an infection, prevention and control (IPC) policy, guidelines and M&E tools. Site-level interventions for TBIC will focus on improved ventilation, hygiene, isolation of suspected and confirmed cases, and decongestion to reduce TB transmission at health care facilities.

4.8 Adult Treatment

As previously mentioned, the PEPFAR team will prioritize scale-up activities in 36 districts, where sites with at least 200 ART patients will receive a comprehensive package of TA services with at least quarterly visits. Smaller sites (<200 ART patients) in the scale-up districts will be designated as centrally supported sites; PEPFAR will access these sites by extension, through its support of the national commodity forecasting and distribution program. TA visits to these sites will be as needed/requested by the MOHCC to address specific concerns and visits will be less than quarterly. Within the sustained districts, 53 sites have been identified as high-volume (>680 ART patients each). These sites also tend to be referral centers for complicated patients; managing this combination of high volume and high complexity contributes significantly to epidemic control. In

order to maintain the quality of services at these sites, they will be designated as sustained sites and thus receive package of services for sustained sites, as outlined on page 41. A complete description of this approach, as well as the related packages can be found in Section 5. It should be noted, however, that there are no truly “low prevalence” sites in the country, given that even “lower burden” areas have prevalence at or above 6%.

Current MOHCC data suggests a loss-to-follow-up (LTFU) rate of approximately 15% for individuals in their first year of ART, and an approximately 10% annual LTFU for subsequent years on therapy. Based upon current initiation rates, this suggests an overall LTFU rate of 10.9% for the roughly 748,000 patients on ART across the country. Through improved patient tracking systems, facility-based outreach and follow-up, appointment diaries and improved medical records systems in OI/ART and PMTCT departments, PEPFAR Zimbabwe aims to reduce the LTFU rate to 7.5% in FY 2016, and to 5% in FY 2017. This improvement in ART retention is targeted for scale-up facilities within the prioritized districts.

PEPFAR Zimbabwe’s Care and Treatment program also includes a small number of direct service delivery sites (11 sites in scale-up and 3 sustained districts) which serve primarily SWs and other hard-to-reach communities with facility and community-based services including OI screening and STI management, ART initiation, TB screening and case finding, adherence counseling, and gender-based violence (GBV) prevention counseling. These efforts will also include outreach to MSM communities.

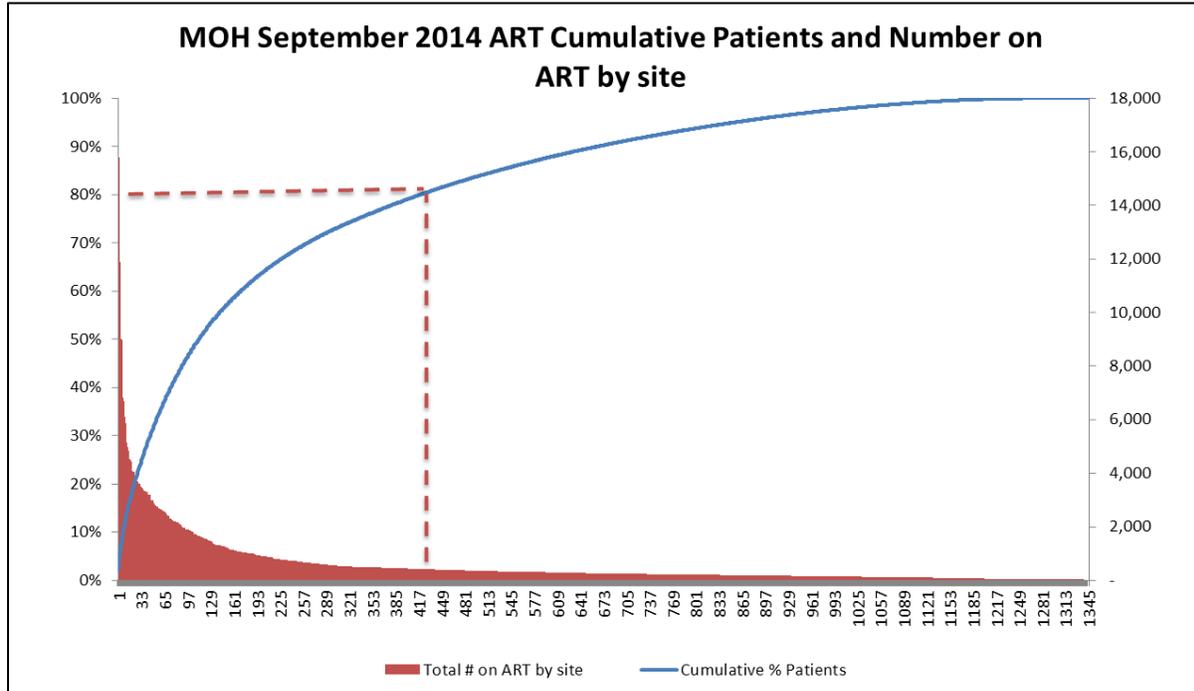
The Sustainability Index and Dashboard exercise revealed several areas of concern with regards to sustainability including the gap for ARVs and other HIV commodities, the need for an HRH transition scheme, and the lack of data on KPs. PEPFAR will play an active role in the health financing TWG and in carrying out size estimation studies to try define these gaps and ways to address them. There is a potential small ARV gap for calendar year 2015 and a real gap for 2016, and the gap for rapid test kits is expected to be approximately \$3.43 million for 2016. While there is no gap for EID commodities in 2016, there is a significant gap for CD4 reagents at \$3.37 million for 2016. These gaps are not related to weaknesses in the supply chain, but rather due to insufficient resources to support the scale-up needed to reach 90-90-90 targets. Action needs to be taken fairly urgently to either dramatically curtail enrollment or to identify resources to place orders to avert stock outs and treatment interruptions in 2016.

Based on the SIMS visits conducted to date, there were no sites that had >50% red or yellow scores. However, one concern emerged across the country as a whole: there is no formal referral, tracking and follow-up systems to increase retention in case or identification of those being lost to follow-up. The MOHCC is well aware of these issues and TA is being provided at several levels to strengthen facility-community linkages, incorporate appointment/patient tracking systems, and strengthening adherence counseling as core activities in the scale-up districts. The role of community systems and structures cannot be underestimated in this effort, and all methods for capitalizing on existing community efforts will be employed.

Efficiency Analysis

Figure 4.5.1 represents 1,345 integrated treatment sites PEPFAR supported in COP 2014. Nationally there are over 748,000 clients on treatment and 80% of patients are in 31% of the sites (421). There were no sites reporting less than four clients. Please see section 5.1 for methodology to prioritize sites in geographic areas for saturation.

Figure 4.8.1



4.9 Pediatric Treatment

The MOHCC has developed a Framework for the Accelerated Plan for Pediatric and Adolescent ART in Zimbabwe, which aims to scale identification of HIV-exposed and infected infants, children and adolescents, using facility and community based approaches and all available entry points, including campaigns and universal HIV testing. PEPFAR Zimbabwe aims to test approximately 323,000 children, in order to identify approximately 19,000 positives and to initiate approximately 15,000 children on ART in the 36 scale-up districts in FY16. This is based upon 81% linkage from diagnosis to treatment, and an assumption of 6% positivity given that much of the testing will be targeted (e.g. index tracing and improvements in EID). As part of the national acceleration program, PEPFAR will focus TA to improve EID results transmission and specimen handling, as well as index tracing and linkage to care for identified HIV+ positive children in the community. Current challenges include weaknesses in data collection, monitoring and reporting, paper-based registers, lack of longitudinal tracking of mother baby pairs, user fees, denial and non-disclosure by guardians who end up not bringing children forward for HTC.

In COP 2015, PEPFAR will procure ~\$2 million EID commodities and will train HCWs to:

- Collect EID samples and to follow up results as well as track mother baby pairs to give results when received;
- Initiate and maintain on ART, babies and children under 5 years as per new 2013 ART guidelines
- Provide integrated HIV services (e.g. EID during immunization sessions) including cotrimoxazole

4.9 OVC

The key Government Department that the PEPFAR OVC program primarily works with is the Department of Social Services, which is housed in the Ministry of Labor and Social Welfare (MOLSW). In 2014, the Department of Social Services split into two Departments: Department of Social Services and the Department of Child Welfare and Protection Services. Last year, the Government of Zimbabwe introduced a new policy that allowed social workers working outside of government to serve as probation officers and filled many previously vacant social welfare positions. These two initiatives aim to improve the quality of services for children as the case load will be reduced for each social worker.

The OVC program has been redirected to align with the 36 scale-up districts and implement interventions that impact epidemic control. OVC activities are in 23 high burden districts with an estimated OVC population of 678,066, 16 of which are scale-up districts (with an estimated OVC population of 607 528 and 7 sustained districts (with an estimated OVC population of 70 537). For COP 2015 due to budgetary constraints there are no plans to implement the comprehensive program in all 36 scale-up districts; as the program phases out from sustained districts resources will be reinvested in the scale-up districts.

In order to minimize potential negative impacts on OVC currently being served, there will be a carefully planned phase-out plan from the seven sustained districts. Past experience has shown that PEPFAR can start graduating households benefitting from household economic strengthening activities after a minimum period of two years. Beneficiaries in sustained districts will therefore be maintained for a minimum period of two years and graduated thereafter depending on the results of the annual partner vulnerability assessments. For those still in need of care, efforts will be made to transition them into Government Social Protection Programs or other donor programs. Reduction in numbers due to attrition set at 5% (historical data indicates attrition levels of 4% to 6 %) will not be replaced. At the end of FY16 the program will move out of six sustained districts (Bubi, Umzingwane, Zvishavane, Nyanga, Mutasa and UMP). A final shift from sustained districts is anticipated at the end of FY 17, enabling the OVC program to re-invest in more scale-up districts in FY18.

The program aims to have all the OVC served know their status by the end of FY17. PEPFAR aims to reach at least 28% in FY15, 50% in FY16 and the remaining 22% in FY17. This will be achieved through working within the Ministry of Health's accelerated plan for pediatric and adolescent ART framework, which aims to scale up identification of HIV-exposed and infected infants, children, and adolescents. From October 2014 to March 2015, the program contributed to over 28,000 children tested.

The OVC service delivery package to a child or a household consists of health services, educational support, child protection and household economic strengthening. This package will be delivered in both scale-up and sustained districts. In delivering the package of services, partners work within a community site and visit various intervention points (e.g., meetings, schools, households, centers and facilities) within the district. All services received by individual children are tracked through a database which includes bio-data, child location within the site, as well as services received (both PEPFAR and non PEPFAR). Program sustainability efforts are targeted at national, community, household and individual levels. These include systems strengthening of the MOLSW, strengthening community structures which take care of and

respond to children's issues (such as the child protection committees) and supporting the scale up of case management.

One SIMS visit was carried out in September 2014. The partner scored green on most of the CEEs with the exception of a red score on the gender norms questions. To address this issue, the partner will train staff on gender norms and maintain individual training records which will allow tracking of an individual's participation in trainings over time.

The program made a conscious effort to target hard-to-reach areas, such as Chipinge, Insiza, Makonde, Chiredzi, Bubi, UMP, and Umzingwane and to engage closed religious sects who often have harmful practices towards children. Out-of-school children will be reached through various programs that include community learning centers. Special efforts will be made to ensure that the package of services is accessed by children living with disabilities and their households.

5.0 Program Activities to Maintain Support for Other Locations and Populations

5.1 Package of services for sustained sites in other locations and populations

Once the 36 districts which contribute to 80% coverage of the PLHIV population were identified, the team began to define both the facilities which would continue to receive PEPFAR support, as well as the most efficient package of treatment and care services (including pregnant women) that would have the highest impact, and that could be provided within the budget available. It was clear that a tiered approach would be necessary to define our "touch", and a broad array of criteria to help delineate these tiers was examined.

Tier assignment decisions were made based on volume (i.e. total ART enrollment) as decentralization proceeds over the coming months. High-volume (>680 ART patients) clinical facilities outside the scale-up districts will continue to receive a maintenance package, including procurement and TA for forecasting and distribution of commodities, and mentoring and supportive supervision TA (as outlined in Appendix A), but without efforts for active enrollment of patients. By establishing the tier criteria as such, PEPFAR will be able to maintain a strong presence (through sustained sites) in all 60 of Zimbabwe's districts. Low-volume sites (<200 patients in scale-up districts and <680 patients in sustained districts) will be considered "sustaining commodity sites," only receiving distribution of ARV and lab commodities as an extension of the national system. On a case-by-case basis, PEPFAR may respond to specific requests by MOHCC for extra support in sustained or lower tier facilities. Section 5.1.1 captures details of the Tier designations and broadly delineates the services to be provided at each level.

Site Level Tiers

Number ART patients per site	Scale-up (36 districts)	Sustained (24 districts)	Row Total
Tier 1 (>680)	197	53	250
Tier 2 (>200)	344	159	503
Tier 3 (<200)	375	217	592
Column Total	916	429	1345

Dark Blue=Scale-up
 Light Blue=Sustained
 All other are centrally supported sites

Sustained site costs were estimated based upon the projected cost of the service package (including distribution of HIV commodities), and a presumption of quarterly visits. These same parameters (service package cost, site-visit cost) were utilized to determine the cost-projections for scale-up districts, bearing in mind the expanded service package and quarterly visits. The combination of reducing the number of sites and limiting the service package outside of the scale-up districts will allow for intensified TA in the scale-up areas, facilitating improved quality of care and progress towards ambitious epidemic control targets. This goal must be contextualized, within the reality of the ARV gap which is the rate-limiting step for achieving these targets.

The Tier structure only applies to facility-based Treatment (including PMTCT) and Care activities. . Mobile and static HTC services will continue in sites that are yielding at least 9% positivity rates. Sites yielding less than 9% positivity (excepting in the context of VMMC) will be discontinued. The OVC package of services will remain unchanged from COP 2014, and during the transition period the package provided to OVC in the scale-up and sustained districts will be the same. While current OVC investments are only in 15 of the 36 scale-up districts, the plan is for the majority of OVC activities to be transitioned to the scale-up districts by 2018. This will not be accomplished by discontinuing any of the OVC currently receiving care, but rather through natural attrition as a result of ageing out and/or “graduating” as a result of economic empowerment activities and other targeted services.

5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Districts

Sustained Volume by Group	Expected Result APR15	Expected Result APR16	Percent increase (or decrease)
HIV testing in PMTCT sites	90,141	79,949	-11%
HTC (only sustained ART sites in FY 16)	1,863,011	409,514	-78%
Current on care (not yet initiated on ART)	158,356	187,022	+18%
Current on ART	142,521	168,321	+18%
OVC	51,217	41,424	-19%

Facility type	36 Scale-up Districts	Sustained Districts
Tier 1: more than 680 enrolled on ART	<ul style="list-style-type: none"> Quantification, forecasting, purchase, and delivery of ARVs, lab reagents, EID and CD4 POC bundles Condom programming, provision, and delivery to service outlets Lab monitoring including SLMTA Lab transport EPMS Training Supportive supervision Clinical mentorship Quality improvement At least quarterly visits 	<ul style="list-style-type: none"> Quantification, forecasting, purchase, and delivery of ARVs, lab reagents, EID and CD4 POC bundles Condom programming, provision, and delivery to service outlets Lab monitoring without SLMTA PITC Lab transport EPMS At least quarterly visits
Tier 2: 200-680 enrolled on ART	<ul style="list-style-type: none"> Quantification, forecasting, purchase, and delivery of ARVs, lab reagents, EID and CD4 POC bundles Condom programming, provision, and delivery to service outlets Lab monitoring without SLMTA Lab transport Training Supportive supervision Clinical mentorship Quality improvement At least quarterly visits 	<ul style="list-style-type: none"> Quantification, forecasting, purchase, and delivery of ARVs, lab reagents, EID and CD4 POC bundles Condom programming, provision, and delivery to health facilities Lab monitoring without SLMTA Lab transport
Tier 3: less than 200 enrolled on ART	<ul style="list-style-type: none"> Quantification, forecasting, purchase, and delivery of ARVs, lab reagents, EID and CD4 POC bundles Condom programming, provision, and delivery to health facilities Lab monitoring without SLMTA Lab transport 	<ul style="list-style-type: none"> Quantification, forecasting, purchase, and delivery of ARVs, lab reagents, EID and CD4 POC bundles Condom provision and delivery to health facilities Lab monitoring without SLMTA Lab transport

5.2 Central Support plans for redirecting PEPFAR support to scale-up locations and populations

With greater prioritization and focus, all activities considered 'non-core' will be transitioned over 12 months to either the relevant line ministry or other NGOs supporting the national HIV response. For HIV prevention, activities targeting the general population will be phased-out in sustained districts over the course of 2015. PEPFAR is in discussions with the NAC to see if HIV prevention activities funded by NAC could concentrate in these sustained districts. For VMMC, 34 districts previously supported by PEPFAR will be transitioned over to the MOHCC. PEPFAR will however continue to deliver MC commodities to these districts. If NAC revenues increase, there may be an opportunity for them to start supporting VMMC. For PMTCT, Care and Treatment PMTCT sites in sustained districts, a maintenance package will be implemented excluding PITC, only supporting passive enrollment. For the OVC program, there will be a carefully planned phase out from the 8 sustained districts over the course of a two year period. Supportive supervision, monitoring, QA and QI, and other TA to public facilities for Treatment and Care in the sustained districts will largely be discontinued by the USG.

Two key commodities--ARVs and condoms--will continue to be provided nationwide, and support will continue for related quantification, forecasting, purchase, and delivery. ARV provision will remain essentially unchanged, as will quantification, forecasting and distribution of lab reagents, and lab transport and non-SLMTA lab monitoring. Condom provision will continue to all districts, but condom programming will not be as intensive, and delivery will only be to Health Facilities at the sustained sites (all Tier 3 and Tier 2 in sustained districts).

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

In order to strengthen Zimbabwe's laboratory infrastructure for improved access, quality, and coverage of HIV related diagnostic testing towards epidemic control, PEPFAR Zimbabwe will focus its core activities on:

1. Mentoring and supporting laboratory scientists in the provision of laboratory tests for HIV patients through scale-up district laboratories with a supported referral network. PEPFAR Zimbabwe currently supports strengthening of laboratory services to 4 provincial laboratories, 16 district labs, and 166 referral clinics. The plan for the COP 2015 period is the alignment of laboratory support to the 36 scale-up districts. PEPFAR is one of three laboratory partners working within the MOHCC and leverages GF funding for implementation of laboratory testing services. A viral load implementation plan for the country is available and funding is primarily covered by GF with limited support from MSF. GF is the procurer of reagents generally, but a gap remains for viral load reagents. Viral Load needs additional donor funding in order to scale up. Global Fund allocation is tapped and reprogramming within the current cycle is not feasible. While the treatment can be scaled up without viral load testing it will not be possible to verify if the viral suppression is being achieved due to the low access to viral load testing.
2. EQA for HIV related tests to ensure reliable results in scale-up district laboratories.
3. PEPFAR Zimbabwe will continue to support the development of a laboratory logistics system which will provide the country with timely and accurate information to quantify, procure, plan shipments and distribute laboratory reagents to all laboratories in the country through support of national laboratory commodity quantification and nationwide distribution logistics. PEPFAR has stepped back from procurement of commodities and equipment maintenance but leverages against GF to quantify and distribute the required laboratory commodities for the national laboratory system. The GF is the main supplier of laboratory reagents, consumables and equipment maintenance.
4. Procurement of rapid HIV test kits under the PMTCT/ART integration funds.

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Mentoring and supporting laboratory scientists in scale-up districts to increase capacity of the current laboratory testing services to provide access to quality testing services that support diagnostic testing and management of persons living with HIV/AIDS	Lab testing performed for HIV diagnosis and monitoring tests for patients in on ART in 20 scale-up districts.	Lab testing performed for HIV diagnosis and monitoring tests for patients in on ART in 36 scale-up districts	HTXS [REDACTED]	HTXS [REDACTED]	APHL	#5: Quality management Score: 15.0	X	X	X	X	

Supporting laboratory sample transport network in scale-up districts	Transport of all ART patient monitoring laboratory specimens from 20 scale-up districts with results return from referring sites	Integrated laboratory transport system for all referring laboratory specimens (HIV, TB, EID) within the 36 scale-up districts.	HTXS [REDACTED]	HTXS [REDACTED]	APHL	#5: Quality management Score: 15.0	X	X	X	X	
Strengthen quality testing in laboratories through continuous quality improvement	Training/mentoring/supervision of scientists on quality management systems for reliable testing results in 20 scale-up districts.	Training/mentoring/supervision of scientists on quality management systems for reliable testing results in 36 scale-up districts.	HLAB [REDACTED]	HLAB [REDACTED]	APHL	#5: Quality management Score: 15.0	X	X	X	X	
External Quality Assurance (EQA) for HIV related tests to ensure quality testing results in scale-up district labs.	External Quality Assurance (EQA) for HIV related tests for 20 scale-up districts	External Quality Assurance (EQA) for HIV related tests for 36 scale-up districts	HTXS [REDACTED] HVCT [REDACTED]	HTXS [REDACTED] HVCT [REDACTED]	APHL	#5: Quality management Score: 15.0	X	X	X	X	

Support the national level laboratory logistics system	Will conduct 2 national quantification exercises for laboratory commodities to inform the procurement for the laboratory logistics system	Fully functional logistics system will distribute laboratory commodities to 120 laboratories nationwide.	HLAB [REDACTED]	HLAB [REDACTED]	JSI-SCMS	#6: Commodity Security and Supply Chain Score: 15.0	X	X	X	X	
Training of laboratory scientists in PIMA POC testing.	• 24 laboratory scientists trained.	• 24 laboratory scientists trained.	HTXS [REDACTED]	HTXS [REDACTED]	PSI	#5: Human resources for health Score: 10.7	X	X	X		
QA training for laboratory scientists.	• 18 laboratory scientists trained on quality assurance.	• 18 laboratory scientists trained on quality assurance.	HTXS [REDACTED]	HTXS [REDACTED]	PSI	#5: Human resources for health Score: 10.7	X	X	X		

6.2 Strategic Information: Health Information System (HIS) and Monitoring and Evaluation

PEPFAR Zimbabwe has supported the strengthening Ministry of Health's capacity to collect and utilize health information from facilities using the aggregate level District Health Information Software (DHIS 2) and cell-phone based data transmission of EID results using the SMS platform which was initially developed for rapid diseases notification. In COP 15, PEPFAR will support the finalization of ICT and E-Health policies with initial developments of Frameworks that ensure collaboration between Ministry of Information Communication and Technology (ICT) and Ministry of Health. The support will focus on harmonization of indicators collected from DHIS 2 into DATIM and work on improvements in data quality from source. The country has several program-specific data collection systems, as an example HIV testing registers are separate from the pre-ART and treatment registers. This has resulted in double counting and poor quality of data collected. In addition, the absence of a longitudinal register has made it difficult to track and refer individuals from the identification phase through referral to care. This problem is especially highlighted in the PMTCT program where the absence of a longitudinal record makes it difficult to track mother-baby pairs into treatment. Another challenge is the existence of a separate paper and limited electronic TB register. This has made it difficult to track HV/TB co-infections. Although Global Fund has made investments in trying to develop an electronic patient record, the lack of focused systems development has resulted in a heavy reliance on paper. PEPFAR has received ART/PMTCT integration funds which will be critical in the start-up, but more resources are required to ensure that the system is brought to scale. We will collaborate with GF and local partners to ensure full development of electronic patient level record. This information must feed into aggregate level DHIS 2 with ability to report on critical gender and age disaggregation. As a priority, the team will assist in the correct identification and location of health facilities, through Geographic Information Systems (GIS) mapping and Service Availability Mapping (SAM) firstly in scale-up districts and later for sustained districts.

PEPFAR will focus its work on building and strengthening the 12 components of a functional M&E system as defined by the UNAIDS Framework. At the national level, PEPFAR support will support sound monitoring and evaluation systems including the collection of appropriate and critical care, treatment and community indicators for tracking. A major activity will be capacity building of M & E units at the provincial and district levels in order to ensure availability of quality data.

To measure progress towards epidemic control and generate a strong evidence base for informed decision making, PEPFAR will continue to support the MOHCC to conduct key HIV prevalence surveys, HIV drug resistance, TB drug resistance, STI surveillance and HIV incidence studies. A commercial sex workers study is currently underway and in COP 15, special focus will be placed on size estimates and behavioral surveillance among MSM and other high risk groups. PEPFAR will continue to support the PMTCT Effectiveness study as a key activity for measuring progress in the elimination of mother-to-child (e-MTCT) transmission and monitoring for Pediatric HIV drug resistance. We will expand the Cryptococcal Antigen pilot study from 8 sites in and around Harare to a routine programme with data collection activities.

To support accuracy, validity and quality data collection and reporting at the site level by partners, PEPFAR will conduct ongoing SIMS visits, biannual Data Quality Assessments and Onsite Data Verifications at site. The SI team will also participate in national level M/E TWG to guide then national M/E plan through building strong data collection tools and collection systems.

Support to Monitoring and Evaluation (SI)

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
1. Organizational structures for HIV M/E functions											
1. PEPFAR will support Ministry of Health and the National AIDS Council to establish M/E units at the national, provincial and district levels to oversee M/E activities	1. Existence of a functional National Monitoring and Evaluation Advisory Group	1. Existence of a functional National Monitoring and Evaluation Advisory Group	HVSI [REDACTED]	HVSI [REDACTED]	TBD	19.0	X	X	X	X	X
	2. Functional National level M/E unit in MOHCC	2. Functional National level M/E unit in MOHCC				19.0					
	3. Eight Provincial M/E units* receive T/A from national M/E officers	3. Eight Provincial M/E units receiving T/A from National M/E officers				19.0					
	4. Sixty District M/E units receiving T/A from provincial level	4. Sixty District M/E units receiving T/A from provincial level									
2. Human capacity for HIV M/E											
1. Provide Human Resource for the National M/E	1. Six national Officers on the MOHCC M/E organogram	1. Six national Officers on the MOHCC M/E organogram	HVSI [REDACTED]	HVSI [REDACTED]	TBD	9.5	X	X	X	X	X

Unit	supported	supported									
2. Capacity building M/E Officers at the provincial and district level units in data recording, analysis and utilization	2. T/A provided for training 8 Provincial M/E officers & 36 district Health Information Officers and HIV focal persons	2. T/A provided for training 8 Provincial M/E officers & 36 district Health Information Officers and HIV focal persons	[REDACTED]	[REDACTED]	TBD	9.5	X	X	X	X	X
3. Partnerships to plan, coordinate and manage M/E systems											
1.Coordinate the national M/E stakeholder meetings that will guide and lead M/E activities in Zimbabwe	1. Two national M/E stakeholder meetings per year	1. Four national M/E stakeholder meetings per year	HVSI [REDACTED]	HVSI [REDACTED]	TBD	9.5	X	X	X	X	X
2. Technical assistance to multi-stakeholder M/E meetings at provincial and district level to plan and coordinate M/E activities	2.T/A for Eight M/E meetings at Provincial offices	2.T/A for Eight M/E meetings at Provincial offices	HVSI [REDACTED]	HVSI [REDACTED]	TBD	9.5					

4. National M/E workplan											
Lead development of an annual Ministry of Health M/E plan with quarterly and annual targets for M/E activities involving key stakeholders such as National AIDS Council, UN and PEPFAR teams	Annual national M/E workplan developed	Annual national M/E workplan developed	HVSI [REDACTED]	HVSI [REDACTED]	TBD	9.5	X	X	X	X	X
5. Support development of an annual costed M/E workplan											
Support costing & resource allocation for M/E workplan	Annual national M/E workplan costed	Annual national M/E workplan costed	HVSI [REDACTED]	HVSI [REDACTED]	TBD		X	X	X	X	X
6. Advocacy, communications and culture for HIV M/E											
Provide T/A to relevant officers in the M/E units to ensure discussion and dialogue around M/E	Bi-annual provincial level meetings to discuss M/E development issues	Bi-annual provincial level meetings to discuss M/E development issues	HVSI [REDACTED]	HVSI [REDACTED]	TBD	9.5	X	X	X	X	X
7. Surveys and surveillance plan											
Provide Technical & materials support for	2016 PMTCT/ANC sero-prevalence data collection and analysis	2017 PMTCT/ANC sero-prevalence data collection and analysis	HVSI [REDACTED]	MTCT [REDACTED]	TBD	7.2	X	X	X	X	X

surveys and surveillance											
	2016 Cross-sectional HIVDR survey completed	2017 Cross-sectional HIVDR survey completed	HVSI [REDACTED]	HVSI [REDACTED]	TBD	7.2	X	X	X	X	X
This is annual data collection at sentinel sites	2016 HIVDR Early Warning Indicators survey completed	2017 HIVDR Early Warning Indicators survey completed	HVSI [REDACTED]	HVSI [REDACTED]	TBD	7.2			X	X	X
GF & MOHCC are currently completing the TB survey. Establishment of surveillance system will ensure continual monitoring	2016 TB Surveillance	2017 TB Surveillance	HVTB [REDACTED]	HVTB [REDACTED]	TB	7.2	X	X	X	X	X
	2016 PMTCT Effectiveness survey initiated	PMTCT Effectiveness survey completed	MTCT [REDACTED]	MTCT [REDACTED]		7.2	X	X	X	X	X
An implementation science protocol is currently being implemented at 8 facilities in and around Harare. Programmatic implementation with data collection will be supported in	Cryptococcal antigen prophylaxis pilot	Cryptococcal antigen scale up	HTXS [REDACTED]	HTXS [REDACTED]	TBD	7.2	X	X	X	X	X

COP 15 & 16											
A CSW protocol is currently being implemented to estimate size of CSW	Key population studies with focus on MSM & other groups	Key population studies with focus on MSM & other groups	HVSI [REDACTED]	HVSI [REDACTED]	TBD	7.2	X	X	X	X	X
	Zimbabwe and Demographic Health Survey ZDHS Completed	Extended Analysis of ZDHS data	OHSS [REDACTED]	[REDACTED]	ICF Macro	7.2	X	X	X	X	
8. Routine data collection											
1. Provide T/A in updating HMIS indicators	1. Updated indicator reference sheets	Updated indicator reference sheets	HVSI [REDACTED]	HVSI [REDACTED]	TBD	19.0	X	X	X	X	X
2. Provide technical assistance in development and updating of routine data collection tools	2. Timely and complete monthly HIV and AIDS reports	2. Timely and complete monthly HIV and AIDS reports									
3. Support distribution of data collection tools	3. Annual AIDS and TB Report with data on key indicators produced	3. Annual AIDS and TB Report with data on key indicators produced									
9. Databases											

1. Provide T/A for maintenance of national, sub-national HIV databases on the Health Information System (HIS)	1 National office DHIS2 databases & 8 Provincial & 62 District & 3 City Health with aggregate HIV and AIDS indicators 2. Pilot linkage of Electronic patient level Medical Records to DHIS2 in one district	1 National office DHIS Databases & 8 Provincial & 62 District & 3 City Health with aggregate HIV and AIDS indicators 2. Functional EMR patient level feeding into DHIS2 in all high volume sites in the 36 scale-up districts	HVSI [REDACTED]	HVSI [REDACTED]	TBD	19.0	X	X	X	X	X
10. Data quality audit											
Provide technical leadership and coordination for data quality audits and supportive supervision	Annual AIDS and TB Data quality audit report produced	Annual AIDS and TB Data quality audit report produced	HVSI [REDACTED]	HVSI [REDACTED]	TBD	19.0	X	X	X	X	X
11. HIV Research plan											
Support NAC to conduct multi-stake holder meeting to provide a Research Priority Plan	Updated Research priority document	Updated Research priority document	HVSI [REDACTED]	HVSI [REDACTED]	TBD	7.2	X	X	X	X	X
12. Data dissemination use											

Support various strategies for data dissemination and use	1. Two reports distributed 2. Four National data dissemination meetings held	1. Two Reports distributed 2. Four National data dissemination meetings held	HVSI [REDACTED]	HVSI [REDACTED]	TBD	19.0	X	X	X	X	X
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Health Information Systems (HIS)

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
1. Technical assistance to build and maintain a health facility registry											
1. Technical support to Ministry of Health for GIS mapping of facilities 2. Technical support a Service Availability Mapping (SAM)	1. Facility registry with GIS coordinates for all facilities in the 36 scale-up districts 2. Facility Registry with SAM in 36 scale-up districts	1. Facility registry with GIS coordinates for all facilities in all districts 2. Facility Registry with SAM in all districts	HVSI [REDACTED]	HVSI [REDACTED]	TBD	19.0	X	X	X	X	X
2. Technical support to MOHCC in coordinating and conducting effective HIS strengthening activities											
TA to MOHCC to develop integrated Health Information Management workplan	Annual costed HMIS workplan developed	Annual costed HMIS workplan developed	HVSI [REDACTED]	HVSI [REDACTED]	TBD	19.0	X	X	X	X	X

3. Support MOHCC and partners to develop policies and standards for interoperable HIS											
Provide Technical support to MOHCC and partners to develop policies and standards for interoperable HIS	1. Draft E-Health strategic framework; 2. Draft standards for coding and sharing data 3. ICT SOPs on basic use of MOHCC ICT resources(security; email; internet; equipment distribution) 4. SOP for health facility registry	1.Final E-Health Strategic Framework 2.Draft E-Health policy 3.Final Standards for coding and data sharing 4.Final ICT SOP on basic use of MOHCC ICT resources(security; email; internet; equipment distribution 5.Updated Health facility registry	HVSI [REDACTED]	HVSI [REDACTED]	TBD	19.0	X	X	X	X	X
4. Technical assistance for national, provincial, district and facility level in data collection, analysis and utilization											
Provide technical support for data collection at health facilities through supportive supervision	1.Eight Provincial M/E committee members and 36 district officers trained in data collection, supportive supervision 2.Monthly and Annual HIV reports available	1.Eight Provincial M/E committee members and 62 district officers trained in data collection, supportive supervision 2.Monthly and Annual HIV reports available	HVSI [REDACTED]	HVSI [REDACTED]	TBD	19.0	X	X	X	X	X

5. Technical support strengthening an integrated DHIS-2 system that is capable of providing high quality aggregate and patient level data elements (electronic patient monitoring systems) EPMS

Technical support for the development and roll out of an enhanced DHIS2	1.Support to HR MOHCC secondments	Support to HR MOHCC secondments	HVSI [REDACTED]	HVSI [REDACTED]	TBD	19.0	X	X	X	X	X
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	<p>2.Laboratory information systems at 4 Central Hospital integrated into DHIS 2</p> <p>3. Pharmacy information systems integrated in DHIS2 at 4 central hospitals</p> <p>4.Pilot electronic medical record integrated into DHIS2 in 1 district with capacity to provide a longitudinal record for PMTCT clients and ART patient outcomes</p>	<p>2.Laboratory information systems at 4 Central Hospital and 36 district hospital laboratory integrated into DHIS</p> <p>3.Pharmacy information systems integrated in DHIS2 at 4 Central Hospital and 36 district hospital laboratory integrated into DHIS</p> <p>4. Functional electronic medical record integrated DHIS2 and rolled out at high volume sites in the 36 districts</p>	<p>HVSI</p> <p>[REDACTED]</p>	<p>HVSI</p> <p>[REDACTED]</p>	<p>TBD</p>	<p>19.0</p>	<p>X</p>	<p>X</p>	<p>X</p>	<p>X</p>	<p>X</p>
	<p>5. Development and integration of e-TB into DHIS 2</p>	<p>5. Development and integration of e-TB into DHIS 2</p>	<p>HVTB</p> <p>[REDACTED]</p>	<p>HVTB</p> <p>[REDACTED]</p>	<p>TBD</p>	<p>19.0</p>	<p>X</p>	<p>X</p>	<p>X</p>	<p>X</p>	<p>X</p>
	<p>6. Development of pediatric data system and integration on DHIS 2</p>	<p>6. Development of pediatric data system and integration on DHIS 2</p>	<p>PDCS</p> <p>[REDACTED]</p>	<p>PDCS</p> <p>[REDACTED]</p>	<p>TBD</p>	<p>19.0</p>	<p>X</p>	<p>X</p>	<p>X</p>	<p>X</p>	<p>X</p>

6.3 Health System Strengthening (HSS)

In order to align activities with the PEPFAR strategic direction to achieve epidemic control, as well as the PEPFAR human resources for health (HRH) Strategy, PEPFAR Zimbabwe will focus the following HRH strengthening activities in scale-up districts:

- In service training of HCWs on OI/ART/PMTCT
- Clinical mentoring and supportive supervision of HCW on OI/ART/PMTCT
- Training of Health workers in Rapid Testing for HIV
- Facility level QI initiatives
- Training of Social Workers and the sub-district community structures

PEPFAR Zimbabwe's health system strengthening (HSS) initiatives and strategies have led to better health through improvements in access, coverage, quality and efficiency. Some of the HSS activities support national level activities and are not necessarily limited to the scale-up districts; however, they are essential to ensuring functionality of critical systems such as the supply chain management system as well as information management systems. In COP 2015, key HSS strengthening activities include: 1) comprehensive human resources information system (HRIS) development and HRH financing at national level for selected posts in the MOHCC, including Logistics, e-MTCT and ART positions.

The USG will continue in-service training for both facility- and community-based workers as this is essential in achieving epidemic control. Health workers are key to making sure that people living with HIV access the appropriate services at the right time, ensuring effective linkages across HIV services and clients' continuum of care. Within the framework, non-core activities will be transitioned to other donors.

PEPFAR will continue to engage the GoZ to plan for transition of PEPFAR-supported health workers, however in the current economic climate, it is unclear how feasible this will be in the near to medium-term. PEPFAR plans to conduct a HRH assessment in 2017; as such, this will be included in the COP 2017 HSS log-frame.

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
HRH (To Ensure adequate supply and quality of human resources for health to expand HIV/AIDS services in PEPFAR-supported moderate- and high-volume sites and/or high HIV-burden areas)											
Training of health care workers in integrated HIV management (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> 60 new HIT trainers 1315 Health care workers trained in integrated HIV mgt. 25 integrated HIV mgt. trainings conducted 55 HIT trainers oriented on the revised HIT curriculum 120 health care workers trained as part of option B+ mop-up trainings. 	<ul style="list-style-type: none"> 60 HCW trained 	HTXS HTXS MTCT 770,000	HTXS HTXS MTCT 770,000	ITECH OPHID	#5: Human resources for health Score: 10.7	X	X	X		

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Training of health care workers in integrated HIV management focusing on sex workers and other vulnerable populations. (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> Seven health care workers trained in one new site 	<ul style="list-style-type: none"> 7 health care workers trained 	HTXS \$2,000	HTXS \$2,000	PSI	#5: Human resources for health Score: 10.7	X	X	X		
Training of health care workers in rapid testing. (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> 50 Lab scientists trained 375 other HCW trained 180 HCWs (staff on admission wards, OPD, EPI etc.) trained for expanded PITC for children 	<ul style="list-style-type: none"> 375 HCW trained 	HTXS HLAB PDCS \$700,000	HTXS HLAB PDCS \$700,000	ITECH APHL OPHID	#5: Human resources for health Score: 10.7	X	X	X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Support clinical attachments for HCWs to pediatric ART initiating sites to strengthen management of children on ARVs. (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> 100 HCW attachments supported. 	<ul style="list-style-type: none"> 120HCW attachments supported 	PDTX \$600,000	PDTX \$600,000	OPHID ITECH ZACH	#5: Human resources for health Score: 10.7	X	X	X		X
Training of health care workers in targeted content (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> 240 HCW complete distance targeted content modules 100 Auxiliary HCW trained on targeted content 200 Primary counselors trained 	<ul style="list-style-type: none"> 240 HCW trained 	HTXS \$20,000	HTXS \$20,000	ITECH OPHID ZACH	#5: Human resources for health Score: 10.7	X	X	X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
Support salaries and the provision of strategic direction and guidance for the PMTCT program. (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> Second six personnel for key positions in the PMTCT unit at national level 	<ul style="list-style-type: none"> Second six personnel for key positions in the PMTCT unit at national level 	MTCT \$35,000	MTCT \$35,000	OPHID	#5: Human resources for health Score: 10.7	X	X	X		X
Support salaries and the provision of strategic direction and guidance for the ART program (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> Second three personnel for key positions in the national ART program 	<ul style="list-style-type: none"> Second three personnel for key positions in the national ART program 	HTXS \$25,000	HTXS \$25,000	JSI-SCMS to OPHID	#5: Human resources for health Score: 10.7 #6: Commodity security and supply chain Score: 10.7	X	X	X		X

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
Facilitate supportive supervision (SS) of ART/PMTCT sites. (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> 594 facilities supported Option B+ implemented as per national guidelines. 	<ul style="list-style-type: none"> 594 facilities supported for Option B+ implementation 	HTXS \$3,000,000	HTXS \$3,000,000	OPHID ITECH ZACH	#5: Human resources for health Score: 10.7	X	X	X		X

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
In-service refresher training for VMMC providers on dorsal slit and prepex methods. (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> 685 HCWs trained on dorsal slit method. 164 nurses trained on prepex method. 124 nurses trained on rapid HIV testing. 258 people trained on basic life skills and emergency mgt. 400 VHWs trained on HIV combination prevention. 18 Demand creation field assistants trained 100 Community VMMC mobilisers trained 	685 HCWs trained on dorsal slit method	CIRC CIRC CIRC \$2,000,000	CIRC CIRC CIRC \$2,000,000	ITECH PSI ZACH	#5: Human resources for health Score: 10.7	X		X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
Quarterly supportive supervision for QA of VMMC at static and outreach sites in VMMC scale-up districts. (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> Visit 98 teams quarterly 	<ul style="list-style-type: none"> Visit 98 teams quarterly 	CIRC CIRC CIRC \$275,000	CIRC CIRC CIRC \$275,000	PSI ITECH ZACH	#5: Human resources for health Score: 10.7 #7: Quality management Score: 15.0	X	X	X		
Strengthen MOHCC capacity in HIV prevention through secondment of HIV Prevention Coordinator to National AIDS & TB Program (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> One HIV prevention coordinator seconded 	<ul style="list-style-type: none"> One HIV prevention coordinator seconded 	CIRC \$30,000	CIRC \$30,000	PSI	#5: Human resources for health Score: 10.7	X	X		X	

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
Strengthen MOHCC monitoring of VMMC related activities through secondment of a VMMC M&E officer (PEPFAR HRH Strategy: Objective 4)	• One M&E officer seconded	• One M&E officer seconded	CIRC \$45,000	CIRC \$45,000	ITECH	#5: Human resources for health Score: 10.7 #7: Quality management Score: 15.0	X	X		X	
Strengthen MOHCC capacity in implementing VMMC through secondment of two officers to the National AIDS & TB Program (PEPFAR HRH Strategy: Objective 5)	• One VMMC communications officer and one VMMC training officer seconded	• One VMMC communications officer and one VMMC training officer seconded	CIRC \$28,000	CIRC \$28,000	PSI	#5: Human resources for health Score: 10.7	X	X		X	

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
HIV testing and prevention combination refresher training. (PEPFAR HRH Strategy: Objective 5)	• 230 HIV testing and prevention counselors trained	• 230 HIV testing and prevention counselors trained	HVCT \$10,000	HVCT \$10,000	PSI	#5: Human resources for health Score: 10.7	X	X	X	X	
Training of laboratory scientists in PIMA POC testing. (PEPFAR HRH Strategy: Objective 5)	• 24 laboratory scientists trained.	• 24 laboratory scientists trained.	HBHC \$7,500	HBHC \$7,500	PSI	#5: Human resources for health Score: 10.7	X	X	X		
Training in laboratory QA laboratory scientists. (PEPFAR HRH Strategy: Objective 5)	• 18 laboratory scientists trained on quality assurance.	• 18 laboratory scientists trained on quality assurance.	HBHC \$6,300	HBHC \$6,300	PSI	#5: Human resources for health Score: 10.7	X	X	X		

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
Support quality improvement (QI) in health facilities (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> 172 sites supported to implement quality improvement activities and of these, 65 of them elevated to centers of excellence for QI. 260 health workers trained in QI related activities 	<ul style="list-style-type: none"> 250 sites supported to implement quality improvement activities 400 health workers trained in QI related activities 	HTXS HTXS [REDACTED]	HTXS HTXS [REDACTED]	Health Qual/EG PAF OPHID	#5: Human resources for health Score: 10.7 #7: Quality management Score: 15.0	X	X	X		X
Provide Human Resource for the MOHCC National Strategic Information/M&E Unit (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> Second 12 personnel to the MOHCC for M&E and HMIS activities Project management support 	<ul style="list-style-type: none"> Second 12 personnel to the MOHCC for M&E and HMIS activities Project management support 	HVSI [REDACTED]	HVSI [REDACTED]	TBD	#5: Human resources for health Score: 10.7	X	X	X	X	X

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
Provide technical assistance for capacity building M&E units at the provincial and district level in data recording, analysis and utilization (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> TA provided for training eight provincial M&E officers and 36 district HIO/HIV focal persons 	<ul style="list-style-type: none"> TA provided for training eight provincial M&E officers and 36 district HIO/HIV focal persons 	HVSI \$7,000	HVSI \$7,000	DCM-SEAM	#5: Human resources for health Score: 10.7 #7: Quality management Score: 15.0	X	X	X	X	X
Training to equip implementing partner staff on gender to ensure minimum service standards and for effective monitoring of community cadres. (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> 64 implementing partner staff trained 	<ul style="list-style-type: none"> 64 implementing partner staff trained 	HKID \$3,200	HKID \$3,200	WEI FACT Mutare Hospaz Mavambo	#5: Human resources for health Score: 10.7		X			

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
Case Management training child community case workers (CCW) to equip them with knowledge and skills to roll out the case management program for children's protection (PEPFAR HRH Strategy: Objective 5)	• 1,333 CCWs trained	• 1,333 CCWs trained	HKID \$7,500	HKID \$7,500	WEI FACT Mutare Hospaz Mavambo	#5: Human resources for health Score: 10.7	X	X	X		
Teachers and community facilitators trained on gender-based violence (GBV) to ensure quality delivery of gender norms interventions to children and parents. (PEPFAR HRH Strategy: Objective 5)	• 210 Teachers and community facilitators trained	• 210 Teachers and community facilitators trained	HKID \$2,000	HKID \$2,000	WEI FACT Mutare Hospaz Mavambo	#5: Human resources for health Score: 10.7		X			

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
Household economic strengthening training to improve community and local service provider capacity to sustainably care for vulnerable children and families. (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> 5,176 Primary and secondary care givers trained 	<ul style="list-style-type: none"> 5176 Primary and secondary care givers trained 	HKID \$15,000	HKID \$15,000	WEI FACT Mutare Hospaz Mavambo	#5: Human resources for health Score: 10.7		X			
Teachers and youth peer-educators trained on adolescent sexual and reproductive health to effectively support adolescents on sexual and reproductive health issues. (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> 853 Teachers and youth peer-educators trained 	<ul style="list-style-type: none"> 853 Teachers and youth peer-educators trained 	HKID \$7,265	HKID \$7,265	WEI FACT Mutare Hospaz Mavambo	#5: Human resources for health Score: 10.7	X	X	X	X	

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
Training on counseling and psychosocial skills to ensure that teachers and CCWs can provide adequate counseling services to children for psychosocial support services and GBV support. (PEPFAR HRH Strategy: Objective 5)	<ul style="list-style-type: none"> 1,283 teachers and CCWs trained 	<ul style="list-style-type: none"> 1,283 teachers and CCWs trained 	HKID \$7,500	HKID \$7,500	WEI FACT Mutare Hospaz Mavambo	#5: Human resources for health Score: 10.7	X	X	X		

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
Training of district level department of social services staff to enable them to give maximum support to the needy children in health and education through assisted medical treatment order and basic education assistance module. (PEPFAR HRH Strategy: Objective 5)	• 81 District department of social services staff trained	• 81 District department of social services staff trained	HKID \$5,000	HKID \$5,000	WEI FACT Mutare Hospaz Mavambo	#5: Human resources for health Score: 10.7	X	X	X		
Early childhood development trainings to build capacity on disability identification and support as well as day-to-day roles and responsibilities and teaching. (PEPFAR HRH Strategy: Objective 5)	• 204 Early childhood development teachers trained	• 204 Early childhood development teachers trained	HKID \$2,500	HKID \$2,500	WEI FACT Mutare Hospaz Mavambo	#5: Human resources for health Score: 10.7		X			

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
<p>Trainings on child protection to equip child protection committees (CPC) with knowledge and appreciation on child protection issues and equip families with knowledge and skills to care for children with disabilities. (PEPFAR HRH Strategy: Objective 5)</p>	<ul style="list-style-type: none"> 4,000 CPCs, both adult and child-led committees, trained 	<ul style="list-style-type: none"> 4,000 CPCs, both adult and child-led committees, trained 	HKID \$13,200	HKID \$13,200	WEI FACT Mutare Hospaz Mavambo	#5: Human resources for health Score: 10.7		X			

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
Support for staff in the MOHCC national Directorate of Pharmaceutical Services (DPS) logistics unit (PEPFAR HRH Strategy: Objective 4)	<ul style="list-style-type: none"> Second personnel to the DPS to manage the supply chain system for essential medicine commodities to maintain a functional pharmaceutical and laboratory logistics system 	Second personnel to the DPS to manage the supply chain system for essential medicine commodities to maintain a functional pharmaceutical and laboratory logistics system	OHSS/HTXS/HLAB [REDACTED]	OHSS/HTXS/HLAB [REDACTED]	JSI-SCMS	#5: Human resources for health Score: 10.7 #6: Commodity security and supply chain Score: 10.7	X		X	X	X

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
Strengthen HRIS and health workforce registries (PEPFAR HRH Strategy: Objective 3)	<ul style="list-style-type: none"> Roll out of HRIS to 36 scale-up districts Incorporation of GIS mapping of health facility locations into HRIS Joint regulatory collaborative (JRC) established Increased linkage of HRIS with council websites 	<ul style="list-style-type: none"> Enterprise architecture artefacts defined and documented Increased online tracking and management of continued professional development Increased standards of quality assurance, training of HRIS supervisors, and improve data validation 	OHSS [REDACTED]	OHSS [REDACTED]	Development of an HRIS in Zimbabwe	#5: Human resources for health Score: 10.7	X	X	X	X	X

7.0 Staffing Plan

In preparation of the 2015 COP, the PEPFAR team conducted an interagency staffing analysis of current and vacant staffing positions to ensure an adequate mix of technical, management and administrative staff to monitor program pivots and to monitor investments in Care and Treatment towards epidemic control. PEPFAR staff are largely aligned with core and near core activities described in Appendix A and no new staff are being requested in COP 2015. Seven previously vacant positions (two CDC and five USAID) are in the negotiation phases and are expected to be filled before the end of Q4 of FY 2015. Five of the seven positions will focus specifically on Care and Support, Treatment and TB/HIV and will help support SIMS visit requirements.

SIMS requirements and overall Management and Operations (M&O) needs were reviewed during budgetary discussions. Due to geographic pivots, the number of sites requiring SIMS visit dropped from approximately 1345 to 415 sites. Although the MOHCC granted PEPFAR access to conduct SIMS visits, concerns remain around the duplication of other quality monitoring and improvement efforts and PEPFAR has agreed with the MOHCC to use the remainder of FY2015 to find ways of coordinating and harmonizing monitoring activities already underway.

[REDACTED]

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	<ul style="list-style-type: none"> • HTC: intensified PITC; community-based HTC focused on high risk populations; strengthened linkages into HIV prevention, care and treatment. • HIV Prevention: PEPFAR guided HIV prevention activities to priority populations • VMMC: WHO-prescribed minimum package of VMMC services to 10-29 yr olds; community-based demand creation. • Care/Treatment: Scale up ART, pediatric and PMTCT service delivery; intensified TB/HIV case finding and management; community outreach to improve adherence and retention; lab specimen transport; forecasting and distribution of HIV commodities. 	<ul style="list-style-type: none"> • Ongoing supportive supervision and mentorship on ad hoc/PRN basis to low volume sites and in sustained districts 	<ul style="list-style-type: none"> • Blanket (non-targeted) HIV testing and counseling • Direct service delivery of early infant male circumcision • Non-targeted prevention activities to general population • Providing food packages • Directly supporting IGAs with funds and other inputs • Providing micro-credit
Sub-national level	<ul style="list-style-type: none"> • HTC: Distribution of RTKs; demand creation to increase uptake of HTC. • HIV Prevention: distribution of male and female condoms. • VMMC: Demand creation; distribution of commodities. • Care/Treatment: TB infection control activities; strengthen district supportive supervision and mentorship; forecasting and distribution of HIV commodities. • Laboratory: Lab EQA and mentoring of lab staff for diagnostics. • Strategic Information: capacity building for district-level M&E teams to improve data quality • OVCs: Identification, assessment and case management of OVCs; GBV, nutrition, and child protection referrals; linkage to PMTCT and pediatric ART services and adherence counseling; establish and train parenting clubs and support for ECD centers; household economic strengthening; succession planning and reintegration activities 	<ul style="list-style-type: none"> • Identify new models for community based testing to reach at-risk populations • Strengthen community systems to provide psychosocial and other support to clients. • Promote cross referrals between schools and clinics • Training of community-based child protection structures • Set up community places of safety • Value chain assessments and market linkages • Child friendly school creation and training of school/ECD committees 	<ul style="list-style-type: none"> • Strengthening birth registration programs

National level	<p>Care/Treatment: Development and dissemination of national guidelines and plans; coordination of national HIV activities; supply chain management, forecasting and procurement.</p> <ul style="list-style-type: none"> • Strategic Information: Support for implementation of ePMS; integration of data collection systems; epidemiological surveys (e.g. key pop size estimation, PMTCT impact evaluation, HIVDR) 	<ul style="list-style-type: none"> • Work with government and civil society to reduce discrimination • Provide technical support towards the development of a national sustainability plan for VMMC • Support for scale up of national case management system • Support training of social and para-social workers 	<ul style="list-style-type: none"> • National Leadership and Management Training • Support to the National Blood Safety and Transfusion Department • MPH Program • Rebranding of male and female condoms
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Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

HTC	Core Activities	Near-core Activities	Non-core Activities
HIV Testing and Counseling (Community, Facility, PITC)	<ul style="list-style-type: none"> • Strengthen PITC at public health facilities- multiple entry points and in-patient services • Provide community based integrated HTC services to ‘at-risk’ and vulnerable populations e.g. mining areas, trucking routes, sex workers, AGYW • Provide HTC services at both static sites and during outreach activities as part of a package for VMMC to boys and men • Strengthen index patient partner and family testing • TB Screening integration within HTC activities • Strengthen linkages from testing into care, treatment and other prevention services through SMS, peer support counseling and existing community-based structures • Distribution of HIV rapid test kits (RTKs) • Carry out demand creation to increase uptake of HTC in prioritized districts and within at-risk, vulnerable and high priority groups e.g. key populations • Address barriers men and women may face accessing HTC services by improving HTC availability (e.g. outreach services, mobile testing sites, workplace) • Immediate provision of CD4 results by expanding access to mobile POC CD4 	<ul style="list-style-type: none"> • Rapid test quality improvement initiative • Identify new models for community based testing e.g. door to door, self-testing targeted to reach at-risk populations • Activities that address dynamics of gender norms and inequities in decisions related to disclosure and encouragement of couples counseling • Training HTC service providers in how to counsel and appropriately refer women and men who report experiencing GBV 	<ul style="list-style-type: none"> • Procurement of HTKs except to cover emergency gaps • Blanket (Non-Targeted) Testing and Counseling • PITC in sustained districts

<p>Care and Treatment</p>	<p>Core Activities</p> <ul style="list-style-type: none"> • Training, mentoring and supportive supervision to strengthen clinical management of ART and PMTCT (including the incorporation of viral load testing and interpretation) to improve performance in the following areas: <ul style="list-style-type: none"> ○ Support to develop SNU-level IPC committees; ○ Increased screening, intensive case-finding for TB/HIV patients ○ Patient tracking and strategies to improve retention ○ Adherence counseling and partner disclosure ○ Prevention counseling for PLHIV ○ OI screening and STI management • Intensified efforts to increase pediatric enrolment: <ul style="list-style-type: none"> ○ Training on EID sample management, results communication, and integration into EPI ○ Intensified PITC in pediatric wards, nutrition centers, and index tracing • Mentoring and supervision of primary care counselors (for HIV testing and counseling at facilities) • Support community health workers to track and refer clients to care. • Lab EQA for diagnostics (RTKs, CD4, VL, EID, etc.) • Mentoring of lab staff (EID, PITC, CD4, VL – sample collection, results transmission/interpretation) • Laboratory specimen transport • Forecasting, procurement and distribution of HIV commodities • HIV QI activities and HMIS support (at high-volume sites only) 	<p>Near-core Activities</p> <ul style="list-style-type: none"> • Ongoing supportive supervision and mentorship on ad hoc/PRN basis • Strengthen community systems to provide psychosocial and other support to clients. 	<p>Non-core Activities</p> <ul style="list-style-type: none"> • <i>None</i>
<p>Prevention Condoms</p>	<p>Core Activities</p> <ul style="list-style-type: none"> • Male and female condom distribution to public health facilities and through social franchising network • As part of an integrated package for HIV 	<p>Near-core Activities</p> <ul style="list-style-type: none"> • Capacity building of Natpharm/ZNFPC to forecast and distribute condoms 	<p>Non-core Activities</p> <ul style="list-style-type: none"> • Rebranding of male and female condoms • Procurement of condoms

prevention, provide vulnerable populations e.g. AGYW, Sex workers, discordant couples, with information about consistent condom use

GBV Prevention

- Interventions designed to prevent GBV and provide linkages to non-clinical post-violence care such as psychosocial and legal services through community-based platforms.
- Interventions to empower young women and adolescent girls and engage men and boys to promote positive norms and behaviors using a rigorously evaluated curriculum that have shown a significant impact on changing gender norms and related HIV risk behaviors.
- Work with government and civil society to reduce stigma and discrimination

VMMC

- Provide WHO-prescribed minimum package of VMMC services to 10-29 yr olds
- Procure and distribute VMMC commodities to all districts scaling up VMMC
- Strengthen demand creation including interpersonal counseling and community mobilization focused on increasing demand among 15-29 yr olds
- Provide WHO-prescribed minimum package of services to ≥30 yr old men
- Provide technical support towards the development of a national sustainability plan for VMMC
- Research
- Direct service delivery of early infant male circumcision

Other Prevention

- Community mobilization, health communication, and small group activities, to increase demand for and uptake of VMMC, HTC, HIV care and treatment, TB services
- Referrals and tracking of clients to HTC, VMMC and care and treatment services.
- Condom promotion and condom skills training to at risk and vulnerable populations
- Targeted risk assessment and provision of sexual risk reduction strategies and skills
- Treatment as prevention
- Activities that reduce harmful norms, reduce stigma and discrimination and prevent gender based violence.
- Work with district and ward level established structures e.g. DACs to strengthen coordination of HIV prevention services
- Refine established mapping techniques to identify at risk and vulnerable groups and based on results continue to align HIV prevention activities to these groups
- Non-targeted prevention activities to general population
- Self-Help Small Grants Program

- Curriculum based, age appropriate HIV prevention skills and sexuality education to prevent HIV acquisition and encourage safer sex strategies for sexually active youth both in and out of school

OVC	Core Activities	Near-core Activities
Case Management Identification of OVC	<ul style="list-style-type: none"> • Identification of OVC • Vulnerability Assessments • Development of Case management plans 	<ul style="list-style-type: none"> • National scale up of case management system
Healthy (Access to Health and HIV Services)	<ul style="list-style-type: none"> • Support community structures to engage and mobilize communities for Accelerated Pediatric ART • Promoting adherence, assessment, counseling • SRH services for adolescents • School/community gardens • Referrals for nutrition and food security 	<ul style="list-style-type: none"> • Promoting cross referrals e.g. between clinics and schools
Safe (Protection)	<ul style="list-style-type: none"> • Psychosocial support • Succession planning and re-integration • Establish Parenting Clubs • GBV response • child protection responses and referrals 	<ul style="list-style-type: none"> • Training of community based child protection structures • Training social and para-social workers • Setting-up of Community Places of safety
Stable,(Economic Strengthening)	<ul style="list-style-type: none"> • household economic strengthening (ISALS) • Emergency fund for short term economic support 	<ul style="list-style-type: none"> • value chain assessments • Market linkages
Education	<ul style="list-style-type: none"> • Access to education • Supporting early childhood development, linkages with PMTCT and pediatric ART 	<ul style="list-style-type: none"> • Creating child friendly schools • Training of school and ECD development committees

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP15	Estimated Funding in COP16	# of IMs	Transition End Date	Notes
Procurement of HTKs except to cover emergency gaps	Transition to other donors	\$0	\$0		2015	Currently funded by Global Fund and other donors
Blanket (Non-Targeted) Testing and Counseling	Phase out	\$0	\$0		2015	
Rebranding of male and female condoms	Phase out	\$0	\$0		2015	
Procurement of condoms	Leverage USAID non-PEPFAR	\$0	\$0		2015	
Direct service delivery of early infant male circumcision	Transition to Government	\$0	\$0		2015	covered by USAID through central commodity fund
Procurement of PrePex commodities	Transitioned to other donors	\$0	\$0		2015	
Non-targeted prevention activities to general population	Transition to local partner	\$0	\$0		2015	Covered by GlobalFund
Providing food packages	Strengthen nutrition gardens in selected ECDs and schools	\$0	\$0		2015	
Strengthening birth registration systems	Transition to UNICEF	\$0	\$0		2015	
Directly supporting IGAs with funds and other inputs	Focus is now on ISALs to generate money within savings groups	\$0	\$0		2015	
Support to the National Blood Transfusion Program	Transitioned to other donors	\$0	\$0		2015	
Leadership, Management, Training for District Health Teams	Phase out	\$0	\$0		2015	Support will be provided by the Donor Health Transition Fund
Providing Micro-credit	Link mature ISAL groups to MFIs (Steward Bank and Micro plan)	\$0	\$0		2015	Trainings will be transitioned to the GF and World Bank
Tuition support for University of Zimbabwe MPH program	Phase out	\$0	\$0		2015	
Pre-service training	Phase-out	\$0	\$0		2015	

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
\$0	\$95,000,000	\$95,00,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$4,140,785
HVAB	Abstinence/Be Faithful Prevention	\$4,780
HVOP	Other Sexual Prevention	\$ 1,788,554
IDUP	Injecting and Non-Injecting Drug Use	\$0
HMBL	Blood Safety	\$0
HMIN	Injection Safety	\$0
CIRC	Male Circumcision	\$ 16,838,414
HVCT	Counseling and Testing	\$ 3,160,011
HBHC	Adult Care and Support	\$ 1,845,032
PDCS	Pediatric Care and Support	\$ 2,545,964
HKID	Orphans and Vulnerable Children	\$ 7,589,019
HTXS	Adult Treatment	\$ 17,065,798
HTXD	ARV Drugs	\$ 21,971,822
PDTX	Pediatric Treatment	\$ 3,819,395
HVTB	TB/HIV Care	\$ 3,272,070
HLAB	Lab	\$ 469,125
HVSI	Strategic Information	\$ 2,012,516
OHSS	Health Systems Strengthening	\$ 1,017,437
HVMS	Management and Operations	\$ 7,459,278
TOTAL		\$95,000,000

B.2 Resource Projections

PEPFAR expenditures and unit expenditures (UEs) from the most recent available data (2014) were used to calculate the required resources to support targets for HTC, care and treatment, PMTCT, VMMC, priority and key population prevention, and OVC. The team used the Zimbabwe overview Data Navigation tool as well as Program Area and IM specific Data Nav tools to better understand the expenditure structures of various IMs, program areas, and IP models. Additionally, the team used the EA-Epi tool to examine historical expenditures in relation to program and national indicators. Based on this data, the team was able to assemble a number of maps to assist in analyzing country data. The team used the PEPFAR Budget Allocation Calculator (PBAC) for certain program areas with UEs such as VMMC due to some inaccurate partner reporting of UEs to the wrong district or program area. For example, in Figure 1.4.1 partners reported expenditures for Harare in Seke due to the close intersecting of district lines. Adjustments to UEs were made to account for anticipated changes to the program in the coming implementation year, including geographic and site focus among scale-up and sustained districts, IM workplans, and changes to models/packages of service delivery and support. In order to facilitate budget allocations to partners (according to the new geographic de-duplication), a package of facility-based services (across budget codes) was costed using EA and programmatic data, and agreed upon per-patient costs were used to develop targets related to budget. The combined budget for facility-based activities was then divided between the agencies based upon the number of PLHAs in the districts assigned to them. The two agencies have allocated those resources in different manners to capitalize on the varying strengths of their partners and based on their organizational philosophies. They both will adhere to the agreed-upon package of services and related targets. Strict adherence to national policies and guidelines will ensure equitable delivery of services across partners.

B. 2.1 VMMC EXAMPLE

Based on the EA and MER reporting from the two IMs performing VMMC, the team was able to closely examine the cost drivers of the program. Additionally, the team considered external resources (i.e. DfID) that are not projected to exist in COP15 implementation period. Based on these assumptions, the team came up with a UE for sustained districts at \$94, and the UE for scale-up districts at \$150 (as per CHAI).

	UE Estimate	Sustained UE Estimate		Scale Up UE	
Training	\$ 2.90	\$ -	no training in mtnc	\$ 2.90	
Construction/Renovation	\$ 0.01	\$ 0.01		\$ 0.01	
Vehicles	\$ 3.79	\$ -	no purchasing vehicles in mtnc	\$ 3.79	
Equipment/Furniture	\$ 6.30	\$ 3.15	equip will reduce, potentially some small repairs	\$ 6.30	
Other Investments	\$ 0.01	\$ -		\$ 0.01	
Personnel	\$ 20.11	\$ 20.11	same	\$ 20.11	
ARVs	\$ -	\$ -		\$ -	
Non-ARV Drugs/Reagents	\$ 0.07	\$ 0.07	same (for adverse events)	\$ 0.07	
HIV Test Kits	\$ -	\$ -		\$ -	
Condoms	\$ -	\$ -		\$ -	
Other Supplies	\$ 23.22	\$ 30.00	^ \$7 due to new commodity (dorsal slit)	\$ 30.00	^ \$7 due to new commodity (dorsal slit)
Food Supplements	\$ -	\$ -		\$ -	
Building Rental/Utilities	\$ 0.79	\$ 0.79	same (generators)	\$ 0.79	
Travel/Transport	\$ 10.92	\$ -	no outreach, only static sites-MOH to use own vehicles	\$ 15.00	^ due to more outreach
Other Recurrent Exp.	\$ 17.23	\$ 17.23		\$ 17.23	
Program Management	\$ 20.27	\$ 20.27		\$ 20.27	
Strategic Information	\$ 2.31	\$ 2.31		\$ 2.31	
Demand Creation to Reach 15-29				\$ 30.00	^ \$30.00 Hard to reach pops
	\$ 107.94	\$ 93.96		\$ 148.80	

Note: will use \$150 as per CHAI costing

Zimbabwe COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Beitbridge	10,407	5,776	42,509	1,045	11,932
Bikita	3,244	166	1,604	544	3,626
Bindura	11,308	1,266	6,862	1,363	5,725
Binga	1,984	219	2,119	264	1,738
Bubi	2,395	264	2,557	319	2,097
Buhera	17,296	5,144	37,876	1,574	17,756
Bulawayo	96,089	9,983	69,898	10,360	67,597
Bulilima	27,277	2,577	18,969	2,987	7,999
Centenary	2,143	236	2,288	285	1,876
Chegutu	39,726	2,896	22,043	3,457	17,547
Chikomba	4,648	514	4,963	619	4,070
Chimanimani	1,512	234	2,265	231	1,538
Chipinge	64,711	2,789	20,534	6,243	18,175
Chiredzi	16,442	3,539	26,044	2,108	23,203
Chirumhanzu	3,636	488	4,720	1,049	6,995
Chivi	31,980	2,975	21,912	3,101	11,442
Gokwe North	11,145	325	2,619	802	3,771
Gokwe South	55,790	1,829	13,460	5,520	15,360
Goromonzi	31,529	2,624	17,751	3,132	14,056
Guruve	49,393	3,585	18,328	4,292	13,713
Gutu	65,841	5,055	37,224	6,270	16,992
Gwanda	21,137	2,591	19,032	2,200	14,877
Gweru	36,373	2,908	21,411	3,372	37,189
Harare	150,202	18,619	155,106	18,911	117,984
Hurungwe	65,236	5,056	27,595	6,029	20,848
Hwange	12,770	1,272	12,301	1,532	10,084
Hwedza	2,063	228	2,203	274	1,806
Insiza	42,805	2,136	18,815	3,417	13,132
Kadoma	31,091	2,836	21,136	3,377	16,950
Kariba	5,313	336	3,255	405	2,669
Kwekwe	90,171	3,090	22,725	8,567	27,229
Lupane	25,649	1,777	14,964	2,134	11,728
Makonde	23,619	1,924	20,736	2,298	16,763
Makoni	74,426	2,730	20,097	6,901	19,056
Mangwe	9,801	522	4,810	862	4,357
Marondera	75,132	6,050	17,463	7,206	12,325
Masvingo	25,265	4,441	29,350	3,219	28,986
Matobo	26,236	1,123	8,452	2,200	11,479
Mazowe	14,894	1,362	24,835	1,676	20,423
Mberengwa	50,102	463	3,380	4,631	13,224
Mt. Darwin	15,867	1,172	17,597	1,420	14,686
Mudzi	3,838	424	4,099	511	3,361
Murehwa	31,946	2,586	19,754	3,098	15,186
Mutare	63,488	2,570	15,299	6,645	24,889
Mutasa	38,026	1,267	9,327	3,708	11,234
Mutoko	5,738	633	6,127	763	5,024
Mwenezi	17,836	1,218	8,952	1,956	10,192
Nkayi	29,801	2,527	12,989	3,016	9,860
Nyanga	3,603	273	2,642	542	3,612
Rushinga	966	107	1,032	129	846
Seke	5,271	581	5,628	701	4,616
Shamva	5,841	644	6,237	777	5,114
Shurugwi	3,834	371	3,587	692	4,615
Tsholotsho	20,012	1,519	17,565	1,833	14,099
Umguza	1,707	188	1,823	227	1,495
UMP	980	108	1,046	130	858
Umzingwane	1,566	137	1,321	253	1,682
Zaka	40,190	4,039	29,736	3,871	14,220
Zvimba	40,360	3,487	25,653	4,179	20,338
Zvishavane	8,192	809	7,834	748	4,988
Total	1,669,843	136,608	1,022,459	169,975	839,232

**Zimbabwe COP15 Targets by District: Key, Priority,
Orphan and Vulnerable Children Indicators**

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Beitbridge	44,556	700	-
Bikita	-	-	-
Bindura	6,677	100	-
Binga	-	-	-
Bubi	-	-	10,325
Buhera	14,520	500	15,982
Bulawayo	150,300	1,470	2,191
Bulima	43,928	600	-
Centenary	-	-	8,626
Chegutu	10,170	500	17,669
Chikomba	-	-	-
Chimanimani	-	-	-
Chipinge	9,165	628	22,752
Chiredzi	13,685	900	9,100
Chirumhanzu	-	-	-
Chivi	2,901	600	-
Gokwe North	-	-	-
Gokwe South	3,600	700	-
Goromonzi	4,706	450	19,694
Guruve	8,284	750	-
Gutu	2,162	600	16,200
Gwanda	45,122	600	-
Gweru	52,140	1,322	8,823
Harare	378,883	2,000	37,690
Hurungwe	46,599	600	-
Hwange	639	135	-
Hwedza	-	-	-
Insiza	600	50	9,809
Kadoma	9,143	750	10,150
Kariba	3,207	100	-
Kwekwe	50,302	700	-
Lupane	4,239	-	-
Makonde	13,713	700	29,070
Makoni	48,478	731	25,641
Mangwe	-	-	-
Marondera	48,978	500	-
Masvingo	17,623	700	-
Matobo	5,993	500	-
Mazowe	4,409	778	14,462
Mberengwa	5,453	335	-
Mt. Darwin	47,721	750	-
Mudzi	-	-	-
Murehwa	47,927	800	-
Mutare	16,622	978	33,490
Mutasa	2,015	600	13,500
Mutoko	-	-	-
Mwenezi	45,180	700	-
Nkayi	4,677	300	-
Nyanga	-	-	2,477
Rushinga	-	-	-
Seke	-	-	5,000
Shamva	-	-	-
Shurugwi	-	-	-
Tsholotsho	2,134	500	-
Umguza	-	-	-
UMP	-	-	3,896
Umzingwane	-	-	8,550
Zaka	4,204	500	-
Zvimba	4,068	500	15,848
Zvishavane	5,832	150	2,550
Total	1,230,555	24,777	343,495

**Zimbabwe COP15 Targets by District:
Breastfeeding and Pregnant Women**

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Beitbridge	5,256	988
Bikita	2,581	246
Bindura	5,563	738
Binga	2,005	266
Bubi	3,076	408
Buhera	7,984	794
Bulawayo	13,787	2,392
Bulilima	2,559	639
Centenary	3,218	427
Chegutu	4,470	593
Chikomba	1,613	214
Chimanimani	975	86
Chipinga	7,373	688
Chiredzi	6,305	738
Chirumhanzu	2,561	278
Chivi	4,920	578
Gokwe North	3,574	448
Gokwe South	7,345	636
Goromonzi	3,738	495
Guruve	7,252	961
Gutu	5,677	647
Gwanda	4,655	924
Gweru	4,678	691
Harare	42,980	5,238
Hurungwe	6,241	827
Hwange	4,677	620
Hwedza	2,492	331
Insiza	8,428	1,418
Kadoma	3,581	475
Kariba	1,085	144
Kwekwe	6,468	850
Lupane	5,207	692
Makonde	4,023	534
Makoni	6,534	733
Mangwe	1,408	324
Marondera	4,628	615
Masvingo	6,826	843
Matobo	2,115	406
Mazowe	12,244	1,624
Mberengwa	3,024	580
Mt. Darwin	6,573	871
Mudzi	2,088	277
Murehwa	5,163	686
Mutare	6,669	619
Mutasa	3,829	459
Mutoko	2,168	288
Mwenezi	4,912	557
Nkayi	4,238	562
Nyanga	2,503	203
Rushinga	2,179	289
Seke	6,814	905
Shamva	2,548	338
Shurugwi	2,528	321
Tsholotsho	5,929	785
Umguzha	1,779	236
UMP	1,455	193
Umzingwane	1,163	200
Zaka	7,112	792
Zvimba	8,482	1,124
Zvishavane	4,061	638
Total	315,319	41,472

**Zimbabwe COP15 Targets by District: Tuberculosis
(TB)**

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Beitbridge	886	546
Bikita	100	59
Bindura	430	241
Binga	102	57
Bubi	123	69
Buhera	792	458
Bulawayo	2,174	1,099
Bulilima	534	328
Centenary	209	126
Chegutu	497	278
Chikomba	171	96
Chimanimani	41	22
Chipinge	630	372
Chiredzi	661	399
Chirumhanzu	102	57
Chivi	521	319
Gokwe North	141	61
Gokwe South	600	347
Goromonzi	403	231
Guruve	189	108
Gutu	622	369
Gwanda	764	459
Gweru	665	370
Harare	6,531	3,487
Hurungwe	836	516
Hwange	469	290
Hwedza	72	43
Insiza	603	368
Kadoma	1,403	865
Kariba	187	105
Kwekwe	817	403
Lupane	642	398
Makonde	811	483
Makoni	710	398
Mangwe	173	96
Marondera	438	247
Masvingo	793	462
Matobo	393	235
Mazowe	787	459
Mberengwa	540	297
Mt. Darwin	567	327
Mudzi	136	76
Murehwa	364	221
Mutare	561	317
Mutasa	425	244
Mutoko	360	440
Mwenezi	549	331
Nkayi	529	318
Nyanga	83	46
Rushinga	89	50
Seke	933	553
Shamva	149	84
Shurugwi	122	72
Tsholotsho	451	258
Umguzo	138	77
UMP	71	40
Umzingwane	76	50
Zaka	732	448
Zvimba	649	377
Zvishavane	226	122
Total	34,772	20,074

**Zimbabwe COP15 Targets by District: Voluntary
Male Medical Circumcision (VMMC)**

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Beitbridge	5,520
Bikita	-
Bindura	-
Binga	-
Bubi	-
Buhera	-
Bulawayo	10,524
Bullima	-
Centenary	-
Chegutu	6,028
Chikomba	-
Chimanimani	-
Chipinge	-
Chiredzi	-
Chirumhanzu	-
Chivi	-
Gokwe North	-
Gokwe South	3,507
Goromonzi	-
Guruve	6,028
Gutu	-
Gwanda	3,500
Gweru	6,228
Harare	21,575
Hurungwe	5,000
Hwange	-
Hwedza	-
Insiza	2,180
Kadoma	2,740
Kariba	-
Kwekwe	3,293
Lupane	7,125
Makonde	3,668
Makoni	3,500
Mangwe	3,068
Marondera	3,500
Masvingo	5,000
Matobo	6,028
Mazowe	-
Mberengwa	4,932
Mt. Darwin	4,223
Mudzi	-
Murehwa	1,333
Mutare	3,500
Mutasa	-
Mutoko	-
Mwenezi	3,500
Nkayi	-
Nyanga	-
Rushinga	-
Seke	-
Shamva	-
Shurugwi	-
Tsholotsho	3,500
Umguzo	-
UMP	-
Umzingwane	-
Zaka	2,521
Zvimba	-
Zvishavane	-
Total	131,521