



Concept Note for Early Applicants

This concept note template is to be completed by early applicants invited to request funding from the Global Fund in 2013 during the transition to the new funding model. For more information on how to complete the concept note, please refer to the Concept Note Instructions.

The concept note details the applicant's request for Global Fund resources in a disease area (and/or health and community systems strengthening) for the next three year period. The concept note should articulate an ambitious and technically sound response, drawing from the Health Sector Strategic Plan, National Strategic Plans and other appropriate documentation. It should include a prioritised full expression of demand to maximise impact against the disease(s).

There are five different sections of the concept note:

- Section 1:** How the application development process complies with CCM Eligibility Requirements.
- Section 2:** An explanation of the country's epidemiological situation and the current legal and policy environment, and how the National Strategic Plan responds to the country disease context.
- Section 3:** How existing and anticipated programmatic gaps of the National Strategic Plan have been identified.
- Section 4:** How the funds requested will be strategically invested to maximise the impact of the response.
- Section 5:** How the program will be implemented.

This concept note is specifically designed for early applicants and does not represent the final template to be used for the full roll-out of the new funding model. The concept note template will be revised to reflect feedback received during the transition phase.

OVERVIEW: Summary Information			
Applicant Information			
Country	Zimbabwe		
Applicant Type	CCM	Component	HIV
Funding Request Start Date	1 st January 2016	Funding Request End Date	31 st December 2016
Updated Incentive Funding Request	\$40,168,251.66		

Funding Request Summary			Currency of Funding Request	USD	
Component:			HIV and HCSS		
[Inset dates for annual period covered]	A= Existing (Global Fund grants)	B= Incremental Funding Request (Indicative)	C= Funding Request (above Indicative)	A+B= Existing and total Incremental Indicative Funding Request	A+B+C= Full Request
Insert Year 1	32,296,138.00	87,124,256.00		119,420,394.00	119,420,394.00
Insert Year 2		179,459,143.00		179,459,143.00	179,459,143.00
Insert Year 3		170,453,001.00	40,168,251.66	170,453,001.00	210,621,252.66
[Additional Yr]					
Years 1-3 Totals:	32,296,138.00	437,036,401.00	40,168,251.66	469,332,538.00	509,500,789.66

Confirmation of Program Split for Indicative Funding		
This question is only relevant for early applicants invited to submit funding requests for more than one disease.		
During country dialogue, the applicant will decide how best to distribute indicative funding across relevant disease programs and HCSS. Please provide the original indicative program split as communicated by the Global Fund and if relevant, the split approved by the Global Fund following country dialogue.		
Program	Original Indicative Program Split Amount (USD)	Approved Program Split Amount (USD)
HIV	278,880,000	374,116,131
Malaria		
Tuberculosis		
HCSS		62,920,270
Total Indicative Funding	278,880,000	437,036,401

Section 1. Executive Summary

Executive Summary

As an early applicant to the New Funding Model in 2013, Zimbabwe's experience with the NFM continues to be unique. The opportunity to submit a revised concept note for incentive funding, two years after the country's initial NFM application, is similarly distinct. It is also a significant advantage. Following more than a year of grant implementation, the country is able to root this revised application in lessons learned during NFM rollout to date, making it a more well-informed and well-considered request. The text from the original concept note remains in **black**, with the updated sections marked in **blue**.

This proposal seeks to enhance the impact of the final year of the NFM HIV grant through strategic strengthening of laboratory services and medicines provision focusing on remedial measures addressing bottlenecks identified in 2014 in relation to infants and children, address quality and impact of the current ART programme through support for viral load testing, strengthen community capacities to achieve greater impact of integrated HIV prevention and treatment programmes by applying successful experiences of programme implementation innovation, and enabling HIV response efforts to better focus on young people with a special emphasis on overcoming the vulnerabilities of young women and girls. Strategic enhancement of the national health information and electronic patient management systems will enable the national response to better track and target its impact.

The priority areas for this application were identified at a multi-stakeholder meeting held in Harare on 17 March 2015 and elaborated by working groups representing national stakeholders. Programme experience gained since the commencement of the NFM HIV grant from the beginning of 2014 was taken into account together with major new policy developments, the new National Strategic Plan (ZNASP III)¹, and national dialogue and drafting of a second generation investment case for HIV in Zimbabwe.

The total revised incentive funding request is for **US \$40,168,251.66**.

Paediatric ART: the Bottleneck Analysis (2014) and Rapid Assessment of Paediatric ART in Zimbabwe (2012) highlights low treatment coverage for children (46.12%)² compared to adult coverage (76.9%), chiefly related to weak downstream supply chain management and lack of decentralisation of paediatric ART, but also to parental knowledge and links between diagnosis and care. A key factor in the identified gap for paediatric ART is the decision made centrally by DfID to route its support for HIV through the Global Fund rather than through its bilateral programme for Zimbabwe. Half of the resultant gap has been filled through a reprogramming exercise reallocating savings made in overall ART procurement but this application seeks to address the remaining gap.

Laboratory services: Major national advances have been made since 2014 in the use of viral load testing, reflecting evolving global guidance and technical advances. Based on a new national plan for the progressive incorporation of viral load testing in the ART treatment programme, this application seeks support for increased access to viral load testing which is currently at very low levels and is a hindering factor in realizing quality ART outcomes. Reagents and equipment for improved patient monitoring and care are a third priority, building on existing Global Fund support for treatment and monitoring for adults, addressing gaps in reagent needs and enhancing the focus on children and young adolescents living with HIV.

Enhanced HIV prevention impact for youth and adolescents: this proposal identifies selective opportunities for increased HIV prevention impact on young people and adolescents. Male circumcision is the top priority for young adult men, which is directly in

¹ At the time of writing, ZNASP III was in its final draft stage.

² Government of Zimbabwe (2014) Global AIDS Response Country Progress Report (GARPR) 2014. Online at http://www.unaids.org/sites/default/files/country/documents/ZWE_narrative_report_2014.pdf pg. 4

line with ZNASP III's top priority. Capacity building of community-level cadres to offer comprehensive services to young people is also a prioritised activity with proposed Girls Mentoring Clubs along with school-based sexuality education. A mapping of young sex workers based on emerging evidence from the Sisters with a Voice programme is proposed, complementing other programme strengthening in this area. Innovations in HIV testing access will complement these HIV prevention activities, support a family and community orientation of services and enhance linkage to care, including the roll-out of community-based, family-centred, HIV testing, self-testing for young people and adolescents, non-facility HTC, all in line with the country's new HTC strategy. These interventions represent a deeper focus of the existing Global Fund grant which supports awareness campaigns for youth, emphasising adolescent vulnerabilities as well as their need for tailored care and support.

Innovative implementation delivery: Community ART Refill Groups (CARGs) are prioritised based on emerging evidence that they are cost-saving, time-saving and improve adherence in remote rural areas. Strategic opportunities to implement these groups in high priority districts will be supported. Community Adolescent Treatment Supporters (CATS) based on the successes of the Zvandiri model have also been identified for incentive funding

Opportunities for enhanced impact in key populations: Emerging evidence over the past two years has revealed key needs and weaknesses in key population responses including among sex workers. Sex worker network strengthening is a priority activity, building on existing Global Fund investments to train peer-educators and fund sex worker support groups. Evidence points to attitudes of service providers as key barrier to access for these groups.³ In order to address enacted stigma by health care providers the capacity of health care workers to deliver friendly, non-judgemental services to key populations will be built. Capacity building for health care workers on the use and implementation of the newly designed tools for treating people with disabilities is also proposed.

Better use of national information for quality and impact: The current investment in the national ePMS system and HMIS will be able to achieve greater impact through selective consolidation and analysis of information generated by these systems, and greater attention to the use of these data sources in programme quality improvement. An HIV data warehouse will consolidate patient level data at national level and enable analysis to link to quality improvement. Linkages between community-level data collection and the HMIS will be strengthened. The M&E activities will also evaluate current interventions, to generate further evidence to inform future programming. It will also include evidence generation for targeted groups such as adolescents and key populations (especially young key populations), in order to strengthen the implementation of ZNASP III through 2018.

Realisation of the incentive funding would contribute towards averting 18,365 AIDS deaths, saving the lives of 3,336 children living with HIV, preventing 45,500 new HIV infections and reaching an additional 469,769 young people.⁴ In addition to lives saved, these investments will also save money. Given current cost structures, annual resource needs are projected to increase to nearly \$600 million/year by 2018, expanding to over \$700 million/year from 2023 onwards. However, a more prioritised high-impact response based on the interventions in this incentive funding request

³ Mtetwa, S., Busza, J., Chidiya, S., Mungofa, S., & Cowan, F. (2013). "You are wasting our drugs": health service barriers to HIV treatment for sex workers in Zimbabwe. *BMC Public Health*, 13(1), 698.

⁴ Based on population estimates of 15-24 year olds in hot spots identified for youth interventions

could see resource needs stabilised at around \$550 million, if prevention gains and treatment and programme support efficiencies are realised.⁵

SECTION 2: Country Context

2.1 Country Disease Context

Explain the current and evolving epidemiological situation of the disease in your country. Refer as appropriate to the Performance and Impact Profile provided by the Global Fund, as well as other recent program reviews or relevant sources. Highlight the concentration of burden among specific population groups and/or geographic regions and any recent disease pattern changes (incidence or prevalence).

In your response, describe:

- a. **Key affected populations** that are epidemiologically important and may have disproportionately low access to prevention and treatment (and for HIV and TB, care and support services).
- b. Factors that may cause **inequity in access to services** for treatment and prevention, such as gender norms and practices, legal and policy barriers, stigma and discrimination, poverty, geography, conflict and natural disasters.
- c. **System-related constraints** at the national, sub-national and community levels in reducing the burden of the disease.

a. Epidemiological situation of HIV in Zimbabwe including Key Affected Populations

HIV prevalence, incidence and mortality

Zimbabwe has a generalised and feminised HIV epidemic, though progress to curb new infections and keep people alive has been significant. It is estimated that over the last 12 years - from 1997 to 2013 - adult HIV prevalence has almost halved and new infection declined by over 50%.⁶ HIV-related deaths have also been reduced by over 60% as a result of the very successful treatment and support programme.

According to the Zimbabwe National HIV and AIDS Estimates Report for 2013, HIV prevalence among adults (15-49) is 15% (14.24-15.70).⁷ Prevalence reached a peak in the late 1990s, declining steadily until 2010 when prevalence appears to be levelling off.

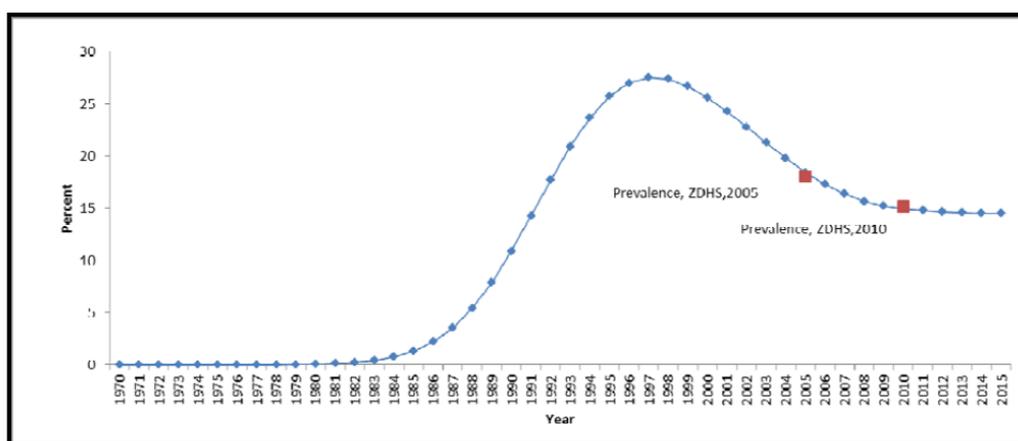
Figure 2.1.1: Trends in Adult (15-49) HIV Prevalence (1970-2015)⁸

⁵ National AIDS Council and UNAIDS (March 2015). Briefing note: resource availability and needs for the HIV Response in Zimbabwe.

⁶ MOHCC & NAT (2015). Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III), pg. 16. (In final stages of development at the time of writing)

⁷ Ministry of Health and Child Care (June 2014). Zimbabwe National HIV and AIDS Estimates Report 2013. AIDS and TB Programme. Online at <http://www.nac.org.zw/about/hiv-aids-situation>

⁸ Ibid.



The HIV prevalence among young people (15-24 years) was estimated at 5.31%, with prevalence among young women (6.55%) more than 1.5 times higher than among young men (4.06%).^{9,10} The total number of adults and children living with HIV was estimated at 1.4 million. The AIDS related deaths decreased from 66,052 in 2012 to 63,853 in 2013.

HIV estimates from modelling exercises show a declining HIV epidemic. There has been a sharp drop in HIV incidence from about 5.5% in adults in 1992 to approximately 0.98% in 2013.¹¹ The number of new infections among adults and children has declined from 85,724 in 2011, to 72,259 in 2012 to 69,105 in 2013. The decline in incidence is attributed to the successful implementation of prevention strategies especially behaviour change, high condom use, and reduction in multiple sexual partners^{12,13}. With continued efforts and strategic investments from government and other partners, it is projected that new infections will continue to fall, dropping to 48,999 in 2016.¹⁴

Table 2.1.2: Epidemiological context and progress (2011-2013)¹⁵

Indicator	2011	2012	2013
HIV incidence rate	1.29	1.25	0.98
Annual HIV related deaths	115,117	87,335	61,476
Total AIDS orphans	1,151,235	1,084,906	810,135
HIV prevalence among young pregnant women	12.5%	11.56%	9.85%
Deaths averted by ART (thousands)	40.42	48.22	45.7
Infections averted by PMTCT (thousands)	6.41	12.75	15.11
Life years gained by ART and PMTCT (thousands)	210.02	269.79	323.47
Deaths averted by PMTCT (0-4) (thousands)	2.91	4.06	5.4

Trends in HIV adult prevalence show initial increases with age and then a decline. For women, HIV prevalence increases to a peak of 29% in the 30-39 year age group while for men a peak of 30% is among those aged 45-49 years.

HIV prevalence is higher among individuals who are employed (17%) than among those

⁹ Ibid, pg. 15

¹⁰ Government of Zimbabwe (2014) Global AIDS Response Country Progress Report (GARPR) 2014. Online at http://www.unaids.org/sites/default/files/country/documents/ZWE_narrative_report_2014.pdf pg. 4

¹¹ Ibid, pg. 5

¹² Halperin, D. T., Mugurungi, O., Hallett, T. B., Muchini, B., Campbell, B., Magure, T. & Gregson, S. (2011). A Surprising Prevention Success: Why did the HIV epidemic decline in Zimbabwe?. *PLoS medicine*, 8(2), e1000414.

¹³ Gregson, S., Gonese, E., Hallett, T. B., Tarubekera, N., Hargrove, J. W., Lopman, B. & Mugurungi, O. (2010). HIV decline in Zimbabwe due to reductions in risky sex? Evidence from a comprehensive epidemiological review. *International Journal of Epidemiology*, dyq055.

¹⁴ Ministry of Health and Child Care (June 2014). Zimbabwe National HIV and AIDS Estimates Report. AIDS and TB Programme. Online at <http://www.nac.org.zw/about/hiv-aids-situation> page 19.

¹⁵ Ibid, pg. 2

who are unemployed (13%) and is modestly higher in urban than in rural areas (15.11% and 13.95% respectively).¹⁶ Differentials by province, on the other hand, are large. The prevalence is lowest in Harare Province (13%) and highest in Matabeleland South Province (21%), however there are some hotspots such as resettlements, mines and border towns.¹⁷

HIV Among Young People and Adolescents

Table 2.1.3 HIV Epidemiology among Adolescents in Zimbabwe¹⁸

Indicator	Estimate
HIV prevalence among older adolescent boys (aged 15-19), 2011	3.4%
HIV prevalence among older adolescent girls (aged 15-19), 2011	4.2%
Estimated number of adolescents (aged 10-19) living with HIV, 2013	110,000 [100,000 – 130,000]
Adolescent boys (aged 10-19) living with HIV, 2013	53,000 [47,000 – 58,000]
Adolescent girls (aged 10-19) living with HIV, 2013	61,000 [55,000 – 68,000]
Estimated adolescents (aged 15-19) newly infected with HIV, 2013	6,700 [4,600 – 8,900]
Adolescent boys (aged 15-19) newly infected with HIV, 2013	2,100 [1,400 – 2,700]
Adolescent girls (aged 15-19) newly infected with HIV, 2013	4,700 [3,200 – 6,200]
Percentage of new adolescent HIV infections among girls, 2013	69%
Estimated AIDS deaths among adolescents (aged 10-19), 2013	7,700 [6,200 – 9,300]
% of adolescents (aged 15-19) with comprehensive, correct knowledge of HIV	Boys – 42% Girls – 46%
% of adolescents (aged 15-19) reporting multiple sexual partners in the last 12 months	Boys – 3% Girls – 1%
% of adolescents (aged 15-19) reporting multiple sexual partners who reported condom use at last sex	Boys – 66% Girls – No Data
% of adolescents (aged 15-19) who were tested for HIV in the last 12 months and received the results of the last test	Boys – 7% Girls – 18%
% of adolescent boys (aged 15-19) who have been circumcised	5%
% of adolescent girls (aged 15-19) who have ever experienced sexual violence	18%
% of young women (aged 20-24) married or in union by age 18	31%

The figures in Table 2.1.3 show a significant adolescent epidemic in Zimbabwe (See Annex I). The country has the sixth highest total annual mortality for adolescent AIDS-related deaths globally; in 2013, 7,700 adolescents died from AIDS-related causes in Zimbabwe.¹⁹ The reason for this high mortality rate among adolescents is related to later initiation into care and poorer treatment outcomes. A recently published large cohort study of adolescents in Zimbabwe paints an epidemiology requiring urgent investment in improved prevention, treatment and care for 10-19-year-olds.²⁰ According to the study, adolescents registered at a more advanced disease stage than did adults (83% vs. 73%). This signals the need for an increased emphasis on early and routine testing among this age group, which is a key intervention in this revised request. Second, the median time for ART initiation was longer for adolescents than for adults (21 days vs. 15 days). In addition, once initiated mortality is higher, which is linked to delayed presentation to health care workers. This is related to the need for more routine testing of young people, but delayed entry into care is also related to lacking peer and social support structures, which are prioritised through BCF community support as well as girls clubs and CATS. Among the 138 adolescents and 942 adults who never commenced ART, 39 (28%) of adolescents and 135 (14%) of adults died, the remainder being lost to follow-up. Mortality among treatment-eligible adolescents awaiting ART was significantly higher than among adults (3% vs.

¹⁶ Ministry of Health and Child Care (June 2014). Zimbabwe National HIV and AIDS Estimates Report. AIDS and TB Programme. Online at <http://www.nac.org.zw/about/hiv-aids-situation> page 16.

¹⁷ MoHCC, NAC, CDC, UNAIDS & WFP (2015). Smart Investment to End HIV AIDS in ZIMBABWE based on Hotspot Analysis. Online at <http://www.nac.org.zw/sites/default/files/Hot%20spot%20Mapping%20Report.pdf>

¹⁸ UNAIDS & UNICEF (2015) All In Country Fact Sheet for Zimbabwe. Online at www.allintoendadolescentaids.org

¹⁹ Ibid.

²⁰ Shroufi, A., Ndebele, W., Nyathi, M., Gunguwo, H., Dixon, M., Saint-Sauveur, J. F., ... & Ferrand, R. A. (2015). Risk of death among those awaiting treatment for HIV infection in Zimbabwe: adolescents are at particular risk. *Journal of the International AIDS Society*, 18(1).

1.8%). Given these risks adolescents face, adherence is a key component which can help avert elevated adolescent AIDS deaths in Zimbabwe (see CATS Zvandiri model intervention in Section 4.2).

Further, the most recent HIV estimates (2013) show HIV prevalence among young women at 6.6% compared to 4.1% for men.²¹ It should also be noticed that the data show static HIV prevalence levels among young men (15-24 at 4.1% since 2007. Prevalence levels among young women have also been relatively static, decreasing at a very slow rate of 0.1% per year since 2007. Given stubbornly high prevalence levels paired with disproportionately poor treatment outcomes and mortality, evidence suggests a need for intensified focus on adolescent HIV prevention and care.

It should also be noted that at the time of writing there is a rapid assessment (through the All In initiative) being conducted by the MOHCC) which is ongoing. This assessment will provide further valuable data on adolescents and will shed light on the need for more comprehensive data collection on adolescents going forward (as prioritised in the M&E interventions in this request).

These trends signal the need for a serious re-focusing of the response on these populations in Zimbabwe. Indeed, this revised incentive funding request prioritises young people, particularly adolescents and young girls.

Modes of transmission and key affected populations

HIV transmission in Zimbabwe remains predominantly sexually driven. Sexual transmission accounts for over 90% of new infections. People practicing low-risk sex in the general population are the major sources of new HIV infections contributing 57.6% due to low condom use and high sexual networking. Table 1 shows estimates of contribution to new HIV infections by population group.

Table 2.1.4: Main outputs from the application of the UNAIDS HIV incidence by exposure group model

Exposure group by risk behaviour	Proportion of total adult population aged 15-49		Estimated HIV prevalence in the group	Model Outputs		
	Male	Female	Prevalence of HIV (%)	Incident infections	Percent of incidence	Incidence per 100,000
Low-risk heterosexual	37.83%	44.04%	14.30%	24183	54.79	1031
Partners Casual Heterosexual Sex	5.00%	12.00%	14.30%	5984	13.56	1229
Casual heterosexual sex	15.00%	6.00%	17.00%	4277	9.69	711
Clients of SWs	4.00%		19.30%	4251	9.63	3710
MSM	3.00%	0.00%	16.80%	2727	6.18	3172
Sex Workers	0.00%	1.44%	54.32%	912	2.07	2210
Partners of Clients		2.00%	20.90%	865	1.96	1510
Injecting Drug Use (IDU)	0.14%	0.05%	12.40%	626	1.42	11496
Female partners of MSM	0.00%	2.00%	20.00%	241	0.55	420

²¹ Ministry of Health and Child Care (June 2014). Zimbabwe National HIV and AIDS Estimates Report. AIDS and TB Programme. Online at <http://www.nac.org.zw/about/hiv-aids-situation> page 16.

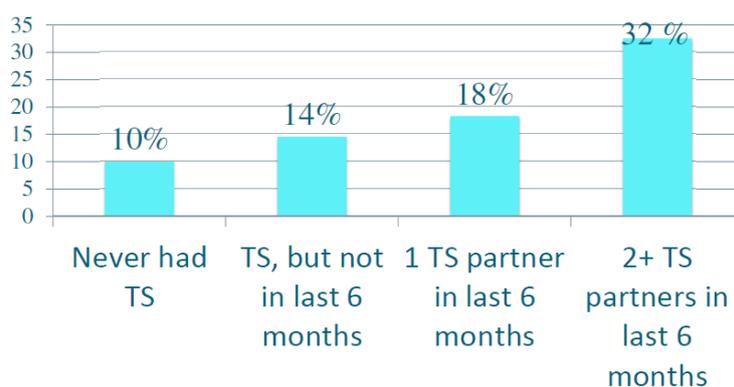
Medical injections	12.80%	28.20%	14.30%	39	0.09	3
Partners IDU	0.03%	0.07%	14.30%	30	0.07	1061
No risk	35.00%	32.40%	10.00%	0	0.00	0
Blood transfusions	1.00%	1.00%	14.30%	0	0.00	0
Total adult population	100%	100%	13.68%	44134		770

Source: Zimbabwe analysis of HIV epidemic, response and modes of transmission, August 2010

Some of the key populations at high risk of HIV infection and/or not adequately reached with HIV services (most-at-risk populations) include the following:

- Heterosexual **people in stable unions** or people considered to engage in low risk heterosexual sex are estimated to account for around 54.8%% of all new HIV infections.
- **People with disabilities** are twice as likely to self-report having HIV as those without disabilities (11.2% vs 6% for women, and 8.9% vs. 3.9% for men).²² HIV knowledge is also significantly lower among people with disabilities (72.6% among men and 76.9% among women) than among people without disabilities (83% among men and 85% among women).
- 11.3% of **married/cohabiting couples** are sero-discordant where in 6.7% the man is the HIV positive partner and in 4.5% the woman is the HIV-positive partner
- HIV prevalence in **young women** is significantly higher than in their male peers, (e.g. in 20-29 year age group 20% of women have HIV infection compared to 10% of men). Young women are infected earlier with HIV, although from a lifetime perspective, men and women face a similar level of risk.
- **Sex workers and their clients** together account for approximately 12% of new HIV infections. HIV prevalence in sex workers is particularly high (40–80%) due to the high numbers of partners, inadequate access to quality services, and a number of other factors. [Recent evidence from the Sisters with a Voice programme highlights the relationship between number of transactional sex partners and vulnerability to HIV, especially among young sex workers \(who are a focus for sex work interventions in this concept note\).](#)

Figure 2.1.2: HIV Prevalence among young women 18-24 who sell sex in Zimbabwe²³



- There are currently no local data on the population size estimate or HIV prevalence in **men who have sex with men (MSM)** in Zimbabwe. Behavioural data from a

²² Ministry of Health and Child Care (2013). Living Conditions Among Persons with Disability Survey: Key Findings Report. Online at [http://www.unicef.org/zimbabwe/National_Survey_on_Disability_2013\(1\).pdf](http://www.unicef.org/zimbabwe/National_Survey_on_Disability_2013(1).pdf)

²³ "Sisters" – the first four years of the Zimbabwe National Sex Work Programme. Online at www.unicef.org/zimbabwe/ZIM_resources_nationalsexworkprogram.pdf

small convenience sample of MSM surveyed by Gays and Lesbians of Zimbabwe (GALZ, 2009) indicated high HTC practice and suggested irregular condom use. The Blair Research and Training Institute of Zimbabwe (BRTI) is completing a regional size estimation study including MSM, its data is expected to provide more information on the HIV situation and behaviour patterns within this population group.

- A recent study indicated that HIV prevalence in **prison settings** is 26.8% for male inmates and 39% for female inmates; however, HIV status prior to incarceration is not known.²⁴

a. Factors that may cause inequity in access to services for treatment and prevention

Zimbabwe's HIV and AIDS Policy and strategic framework promote equity in access to services and effort is being made to ensure equitable access to prevention, care, treatment and support. However, barriers still exist.

Legal and policy barriers - Legal barriers to HIV prevention including illegal status of sex work between people of the same sex and prohibition of condom promotion in school settings still exist. Despite the current lack of legal frameworks for prevention activities with sex workers, prisoners and MSM, Zimbabwe has allowed the existence of informal lobby groups for these populations. In the meantime efforts are being made to scale up HIV services to most-at-risk populations using a public health approach. The primacy of customary law over the Bill of Rights has affected women's and girls' constitutional rights on protection and gender equality. While the Constitution includes a clause that promotes gender equality, it nonetheless maintains a "claw back clause" that undercuts the fundamental values by recognising the primacy of customary law over the Bill of Rights. A study in Zimbabwe demonstrated that married women who experience physical violence only, or both physical and sexual violence, are significantly more likely to be HIV-positive than those who have not experienced any physical or sexual violence. Further studies are needed to establish a causal relationship in the observed association.

Gender norms and practices - Domestic violence is widely acknowledged to be of great concern from the perspective of human rights, economic development, and public health. Despite existing legislation, much more can be done to protect the victims given 27% of Zimbabwean women have experienced sexual violence in their life-time with insignificant variation by wealth and education²⁵. Men's notions of masculinity, such as fear and denial of HIV, interfere with women's ability to achieve optimum antiretroviral therapy, particularly important for 'treatment as prevention' programmes. At the same time, social norms on masculinity serve as a barrier to men's uptake of HIV prevention and treatment services. Migration and mobility can increase individual risk behaviour and restrict access to HIV and health services. Higher HIV prevalence in some mining, commercial farming and border areas suggests the need to intensify HIV prevention services in those areas.

Geography – Access to services is geographically homogeneous due to the decentralised scale up of services through health and community structures at all levels. However some hard-to-reach populations remain including resettlement areas, mobile populations such as small-scale and informal miners, and areas distant from health facilities with geographical barriers to access varying on a seasonal basis e.g. restricted access due to rains.

Stigma and discrimination – The National HIV Policy promotes zero stigma and discrimination with a supporting legal framework including non-discrimination in relation to employment. Stigma in Zimbabwe has been decreasing, visible in communities with increasing openness and discussion of HIV; the ZDHS showed an increase in the percentage of men and women expressing accepting attitude towards PLHIV, from 17.1% and 10.8% women and men respectively in 2005-6, to 39.8% and 39.2% in 2010-11. The 2012 UNGASS report also showed that the stigma component of the NCPI has reduced to

²⁴ Center for Health Strategies (CHEST), 2012, 'Assessment of HIV Prevalence and Risk Behavior among the Prison Population in Zambia', Final report (unpublished).

²⁵ Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International, 2012, Zimbabwe Demographic and Health Survey 2010-11. Calverton, Maryland: ZIMSTAT and ICF International, Inc.

6.1. The recently launched Stigma Index Study will provide quality, up-to-date local information on the scope and scale of HIV-related stigma in Zimbabwe and inform further action as required.

Poverty – Zimbabwe is a low income country and is currently in recovery from an economic crisis under the guidance of the Government of Zimbabwe Mid Term Plan. Zimbabwe has experienced improved economic growth rate in recent years but this has not yet translated into increased productive employment and reduction of poverty. While ARV medicines are provided free of charge, economic access therefore remains a barrier to services including through out-of-pocket expenditures on user fees at health facilities, laboratory and X-ray charges, and transport to attend health facilities.

b) System-related constraints at the national, sub-national and community levels in reducing the burden of the disease

An efficient and effective health system is a pre-requisite for the HIV response. Without a functional system, scale up and integration of services cannot take place. The economic crisis had severely weakened the health system at all levels (national to primary care level) and within all building blocks of the health system. However, under the overall framework of the National Health Strategy (see Annexe 13 - Zimbabwe National Health Strategy 2009-2013: Equity and Quality In Health, A People's Right) the Ministry of Health and Child Welfare (MOHCC) is resuscitating the health sector and putting Zimbabwe back on track to meet the Millennium Development Goals (MDGs) in health. HIV is included in this strategy as one of the priority intervention areas and progressive efforts to integrate HIV within the broader health system continue in the hopes that each will strengthen the other going forward. Health financing and retention of a skilled health workforce remain key outstanding challenges to be addressed.

In responding to HIV, Zimbabwe's communities are organised around community based organisations, support groups and community networks and local level coordinating structures. These structures are intended to support and coordinate communities in community based health interventions including demand creation for services, adherence support and defaulter tracking. Strengthening community participation is an important element in order to ensure high standards of transparency, accountability of health service management and community ownership of health programmes. However, community responses have not been sufficiently defined and prioritised, and have suffered from lack of cohesion. The interface between community and health service delivery also requires continued strengthening.

Capacity within both health and community systems needs to be strengthened in order to better reach key and most-at-risk populations with services.

Future investment in health and community systems will focus on improving access and quality of services including for key populations, strengthening community service availability, generating demand and ensuring adherence.

2.2 National Strategic Plan

Briefly describe your National Strategic Plan and how it addresses the country disease context described in 2.1.

In your response, please describe:

- a. The **goals, objectives and priority interventions** of the National Strategic Plan, placing emphasis on their **on-going relevance** and any planned or needed revisions over the lifetime of the Funding Request.
- b. The **current stage of implementation** of the National Strategic Plan and the country processes for reviewing the Plan. If you are in the last 18 months of the period covered by the National Strategic Plan, please explain the process and

timeline for the development of a new plan.

- c. The **main findings of, and response to**, any recent assessments and/or program reviews.

a. Goals, priorities and interventions of the National Strategic Plan (NSP)

The Third Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III) 2015-2018 is a four-year multi-sectoral framework developed to inform and guide the national response towards achieving zero new infections, zero discrimination and zero AIDS related deaths.²⁶ It has been aligned to the ZIM Asset (2013-2018) priorities of the Government, in order to ensure that the HIV response contributes towards the national social and economic development agenda of the country.

The plan's foundation is a targeted approach in geographic hotspots and among key populations at elevated risk of HIV. Specifically, the plan prioritises children, adolescent, young people, girls, key populations and women to be targeted in 14 hotspot districts (Bindura, Buhera, Centenary, Chegutu Urban, Chipinge, Epworth, Hurungwe, Makonde, Makoni, Mhondoro- Ngezi, Mount Darwin, Mutasa, Mutare, Nyanga, Shamva and Chipinge).

ZNASP III includes three main indicators of success to be achieved by 2018:

1. To reduce HIV incidence among adults and adolescents reduced by 50% from 0.98 in 2013 to 0.49 % by 2018.
2. To reduce HIV-related mortality by 80% for both adults and children by 2018.
3. To increase domestic financing of the HIV response to 30% by 2018

To reach these targets, the plan has 14 guiding principles:

1. Results based management
2. Rights based approach
3. Equity for fairness and justice
4. Evidence Informed
5. Accountability
6. Shared Responsibility and Global solidarity
7. Gender sensitivity and responsiveness
8. Sustainable financing
9. Good Practices for learning
10. Positive Health, Dignity, and Prevention (PHDP)
11. Country ownership and partnership
12. Rights-based and gender transformative approaches
13. Efficiency, effectiveness and innovation
14. The importance of location and population

Integrated service delivery is a core theme of the strategy. ZNASP III includes the following integration matrix, outlining the country's new approach to increased efficiency through

Table: 2.2.1: Strategic Integration of HIV Prevention Services (ZNASP III 2015-2018)

	Key populations (sex workers, men and women in prison, mobile populations)	Behaviour change	Treatment and prevention	Condoms (and family Planning)	Male circumcision
PMTCT	Include PMTCT in programmes for key populations	Include MCP risk message in PMTCT; Include PMTCT message in SBCC	Couples testing & ART assessment, initiation & retention through PMTCT, including for the male partner	Offer condoms in PMTCT. Offer postnatal contraception (particularly long-term methods)	Offer early infant MC through MNCH

²⁶ MOHCC & NAT (2015). Zimbabwe National HIV an AIDS Strategic Plan (ZNASP III). pg. 16. (In final stages of development at the time of writing)

Male circumcision		Include MCP message in MC; Include MC message in SBCC	Offer HTC/ART referral during MC; Offer MC referral during HTC	Offer condoms during MC; Include MC message in condom interpersonal communications	
Condoms (family planning)	Provide condoms & contraceptives to programmes for key populations	Include condom messages in SCBC; Include MCP message in condom IPC (ensure that condom message does not undermine MCP message)	Offer condoms & family planning in HTC/ART (make sure ART does not undermine MCP); Refer to HTC/ART during condom interpersonal communications		
Treatment and prevention/ ARV-based strategies	Include ART in programmes for key populations; Explore use of other ARV based strategies	Include HTC/ART message in SBCC; Include MCP message in ART (make sure ART does not undermine MCP)		Integrate FP into HIV Treatment services; Offer condoms during ART	
Behaviour change	Ensure SW programs don't Undermine MCP message or make SW a more common choice among young women				

The development of the plan was premised on a human rights based planning approach complemented by evidence and results based management approaches. The strategic plan has mainstreamed gender dimensions in the response strategies, anticipated results and indicators that are used to measure performance. The plan provides meaningful opportunities for diverse stakeholders' participation in the implementation of the national response.

To achieve the anticipated results the implementation of the national response requires doing better and more of the right things at the right time in the right scale and intensity. For the four year period (2015-2018) covered by the ZNASP III, Zimbabwe has identified a set of 10 core national strategies in the fight against HIV and AIDS:

Core Strategy 1: Prevention

Zimbabwe will maintain combination prevention approach to reduce further the decline of new HIV infections. Awareness programs will be realigned to address the social and behaviour change required to adopt safer behaviour and to create demand for appropriate services. During the implementation of the ZNASP III, services for young people (All in) and key populations will be scaled up in target locations. It is critical to ensure that comprehensive treatment is provided to those who need it as part of indirect prevention benefits. There will be need to address self-stigma among HIV-positive individuals.

Core Strategy 2: Social Behaviour Change Communication (SBCC)

SBCC interventions will be intensified in the community, workplace and in schools, targeting most-at-risk and key populations while taking cognizance of the key findings and recommendation from the ZNASP II MTR of 2013. It is critical to note that SBCC is also a cross cutting intervention that cuts across a wide range of HIV and AIDS interventions. Therefore there will be need for coordination and harmonization of prevention strategies for impact.

Core Strategy 3: Youth-targeted prevention (in and out of school & tertiary)

The youth component in ZNASP II was considered under most at risk and key populations which compromised the response and focus on the youth as a specific target which needs specific targeted interventions (NAC, 2013). ZNASP III will focus on young people specifically and targeted interventions for an effective response and achievement of the national and global vision. Under HIV Treatment as Prevention, it is stated as a priority to address "Early diagnosis, referral to treatment and adherence support for adolescents living with HIV." Three bottlenecks are identified in this regard: (1) Parental/guardian bias towards HTC of their adolescent children; (2) Stigma within families, schools and communities affecting adolescents' adherence to ART; and (3) Health care workers consultation skills for

adolescents not supportive. The strategy identifies three ways forward to address these bottlenecks: (1) Identify entry points and engage with parents and guardians on HTC and referral to treatment (through schools, faith-based organisation, parent clubs); (2) Work with peer counsellors to address stigma and support adolescents' adherence; and (3) Emphasise adolescent counselling and treatment in integrated training for health care workers.²⁷ In line with this, incentive funding activities address all three issues and are in line with the proposed ways forward: (1) self-testing pilot for young people; (2) Zvandiri CATS for adherence and peer support; and (3) BCF training on youth-friendly HIV service provision.

Core Strategy 4: Condom Programming

Greater efforts will be made to ensure that male and female and specialised condom promotion and distribution is integrated in FP, STI services, VMMC, HTC, eMTCT and ART programmes, and in specific programmes that focus on most at risk and key populations e.g. young people, sex workers, migrant populations, people with disabilities and PLHIV and key populations.

Core Strategy 5: Voluntary Medical Male Circumcision

The country adopted VMMC as one of the key combination interventions for prevention of heterosexual transmission of HIV. A policy and strategy were adopted in 2009 AND Zimbabwe will up-scale the VMMC programme in the ZNASP III, maximising on the existing political commitment at all levels, including the highest office and parliament as well as involvement of traditional and religious leadership various partners. In order to improve VMMC coverage the country has now adopted the Prepex device as an approach.

Core Strategy 6: HIV Testing and Counselling (HTC)

HIV counseling and testing remains a key prevention strategy in the national response to HIV. The scaling up of HTC is both public health and human rights imperative and will be linked to achieve universal access to comprehensive HIV prevention, treatment care and support. The programme will continue targeting and working with priority populations including couples (formal and informal unions); partners of PLHIV on the national Pre-ART and ART programme; children (0-14 years), young people (aged 150-294 years) and key populations.

Core Strategy 7: Elimination Of Mother-to-Child Transmission (eMTCT)

The country's strategic thrust for eMTCT will be to enhance the implementation of the World Health Organisation 2013 Guidelines that include provision of lifelong ART to all pregnant and breastfeeding women living with HIV regardless of CD4 count, or, clinical stage (Option B+), and provision of ART to all HIV-infected infants and children under the age of 5 years regardless of the CD4 cell count. Simultaneously, ZNASP III will be responding to and addressing the existing gaps related to coverage, uptake and quality of integrated and comprehensive PMTCT services.

Core Strategy 8: Treatment Care and Support

Treatment, care and support remains at the core of provision of services. While ZNASP II focused on expansion of the ART programme, the strategic thrust of ZNASP III will be to maintain and periodically review the current ongoing programmes. These include integrated programmes such as HIV/AIDS, MNCH/SRH/TB with a focus on: implementation of Option B+ and CD4<500 cells/ml eligibility for ARV initiation, viral load testing, improving quality of care with emphasis on enrolment, adherence and retention on ART; targeted services for adolescent and youth, discordant couples, and key affected populations such as sex workers and OVCs.

Core Strategy 9: Community Care and Support

Community Care and Support will be an integral component of the continuum of care and

²⁷ ZNASP III pg. 28

support under ZNASP III. In addition to the continuum of care adherence and retention will be integrated in this ZNASP. Services provided in Zimbabwe include palliative care, nursing care, counselling and psychosocial support, spiritual support, and nutrition and referral services. Provision of community care and support these services is premised on the partnership between government, civil society organisations, support groups of PLHIV and the communities themselves.

Core Strategy 10: Response Management

Zimbabwe's National AIDS Council (NAC) continues to prioritise the successful streamlining and harmonization of policies, strategies and resources. This is critical for ensuring that appropriate and robust systems are applied so that the overall national response to the epidemic is delivered effectively and efficiently to achieve the ambitious targets. The response is managed with the internationally agreed "three ones" principles: a) One agreed HIV & AIDS Action Framework; b) One national AIDS authority and c) One agreed country-level Monitoring and Evaluation system.

Through the implementation of these core national strategies, ZNASP III has set sever ambitious national targets towards ending AIDS.

Table 2.2.2 Overview of National Targets in ZNASP III

Indicator	National Targets		
	2015 (baseline)	2018	2020
Coverage			
People living with HIV who know their serological status	66%	80%	90%
People living with HIV who know their status and are initiated in antiretroviral therapy	50% Adults 28.2% Children	80% Adults 79% Children	90% Adults 90% Children
Viral load suppression among people on ART	89% adults [2010]	95%	95%
Pregnant women living with HIV receiving antiretroviral therapy	66%	80%	90%
Children 0-15 years living with HIV receiving ART	55%	80%	90%
Access to services (including PrEP as appropriate) for female sex workers, transgender, men who have sex with men	TBD	TBD	TBD
Voluntary medical male circumcision for men aged 15-29 years (high prevalence countries with low MMC rates)	11%	TBD	TBD
Condoms and lubricants distributed and sold per adult (15–64 years old),	30		
Social and behaviour change programmes <ul style="list-style-type: none"> • Access to communication of prevention and demand generation (15-49 years) • Access to cash incentives for young girls (hyperendemic countries only) 	TBD	TBD	TBD
Expected Impact			
Reduction in new HIV infections (baseline 2010)	69%	81.7%	90%
Reduction in new HIV infections among children (baseline 2009)	12.75%	3%	1%
Reduction in Stigma (baseline 2010)	35%	60%	90%
Reduction in AIDS-related deaths (baseline 2010)	44%	82%	90%

Overall, the bedrock of ZNASP III is to promote smart investment on children, adolescent, young people, girls, key populations and women in prioritised geographical locations. In line with this core focus on ZNASP III, these populations have been chiefly prioritised in this incentive funding request. Some of the core interventions which target these groups include Pediatric ART, VMMC for young men, girls mentoring clubs, Community Adolescent Treatment Supporters (CATS) and for supporting Behaviour Change Facilitators (BCFs) to delivery youth-friendly services promoting self-testing for young people, sex worker network strengthening, training of health care workers to provide friendly services to key populations, among others (see Section 4.2). The following table highlights some of the key

areas of alignment between this request and ZNASP III:

Table 2.2.3 Critical Links Between ZNASP III and Incentive Funding Request

ZNASP III Priority Area of Focus	Proposed Intervention for Incentive Funding
<p>Rapidly scale up male circumcision using WHO’s implementation standards and guidelines to 80% coverage by 2018. If there are funding gaps for MC, other prevention activities that have less/no proof of efficacy (such as VCT, STI management) should be downscaled so as to be able to fully execute the male circumcision interventions.</p>	<p>The proposed intervention on promoting uptake of male circumcision (especially through PrePex procurement) is in line with this priority area of ZNASP III. It is indicated as the top priority in ZNASP III, and is similarly reflected as the top priority for youth interventions (with a focus on younger men 18-19, with a view to explore adolescent circumcision options) in this funding request.</p>
<p>Scale up comprehensive HIV prevention programmes for sex workers, adolescent and young people, both by creating the specific context for facilitating behaviour change, and by funding targeted and tailored services for these populations. Such a comprehensive programme for sex workers and other vulnerable and key populations consist of the following components: targeted HIV and STI testing and treatment, targeted condom promotion programmes, solidarity programmes, violence and abuse support, and protective policing.</p>	<p>The focus on young adolescent girls in this request is well-aligned with this priority area of ZNASP III. The girls mentoring clubs aimed at creating enabling environments for behaviour change through tailored gender-focused empowerment and HIV/SRHR/GBV integrated education and links to care. The interventions for Community Adolescent Treatment Supporters (CATS) and for supporting Behaviour Change Facilitators (BCFs) at community level to provide youth-friendly education and services are also congruent. Sex worker interventions on network strengthening are designed to encourage solidarity programmes in line with ZNASP III priorities. The strong focus of this funding request on health care worker training for key populations is also proposed in line with ZNASP III’s prioritisation on targeted HIV/STI treatment for key populations.</p>
<p>Regulate and rapidly distribute self-test kits for HIV at a subsidised cost so as to add an additional vehicle through which persons could know their HIV status, and to rapidly reduce the cost of such implementation.</p>	<p>This request includes interventions on building the capacity of BCFs to facilitate family-centred home-based self-testing among young people and adolescents, in line with this priority area of ZNASP III as well as the country’s new HIV testing guidelines.</p>
<p>Integrate social norm and behaviour change interventions into the delivery of social and HIV-related services, as opposed to stand-alone services, whilst continuing with an agreed minimum package of HIV prevention public health messaging at lower cost.</p>	<p>This request has a strong focus on building the capacity of community Behaviour Change Facilitators (BCFs) as well as health care workers to be able to deliver integrated HIV/SRHR/GBV services in a non-judgemental and friendly manner to young people as well as key populations such as men who have sex with men, sex workers and people with disabilities. These proposed interventions are in line with this priority area of ZNASP to improve integrated and effective HIV-related service delivery.</p>
<p>Conduct operational research in order to identify potential efficiency gains and Conduct impact evaluations.</p>	<p>ZNASP III has a strong focus on monitoring and evaluation, especially disease trend monitoring, research and impact evaluations. In line with this, Zimbabwe’s revised incentive funding request places equally critical importance on M&E. This request includes proposed interventions to implement patient-level data monitoring through the HIV Data Warehouse, as well as strengthening to the existing ePMS system. There are also activities for monitoring the impact of pilot projects which are part of this request (youth self-testing and innovative integrated sample transport system). Lastly, this request includes M&E interventions which will gather critical data (especially on adolescents) to inform</p>

b. Current stage of implementation of the National Strategic Plan and the country processes for reviewing the Plan.

Mid-Term Review of ZNASP II

ZNASP II underwent its Mid-Term Review (MTR) in August and September 2013.²⁸ ZNASP II had four main impact level results. Those overarching impact indicators, and their status to date according to the country's 2014 Global AIDS Response Progress Report, are:

Impact Indicator 1: HIV incidence reduced by 50% by 2015

Status: More than 50% reduction in adult incidence for the past decade. The target of achieving 50% reduction as stated in the ZNASP 2011-15 seems achievable with the current gains that have been made.

Impact Indicator 2: HIV incidence reduced among children from 30% in 2010 to less than 5% by 2015

Status: 73% reduction in the HIV incidence among children. The country is likely to meet its elimination target of <5% by 2015

Impact Indicator 3: HIV and AIDS related mortality reduced by 38% by 2015

Status: 47% reduction in HIV and AIDS related mortality. The country has already achieved the stated target in the ZNASP due to high coverage of ART and PMTCT programme.

Impact Indicator 4: The national multi-sectoral response improved

Status: The NCPI rating has improved from 6.2 in 2010 to 8.0 in 2013. This reflects an improvement in policy, political commitment and overall strategic environment required for a multi-sectoral national response.

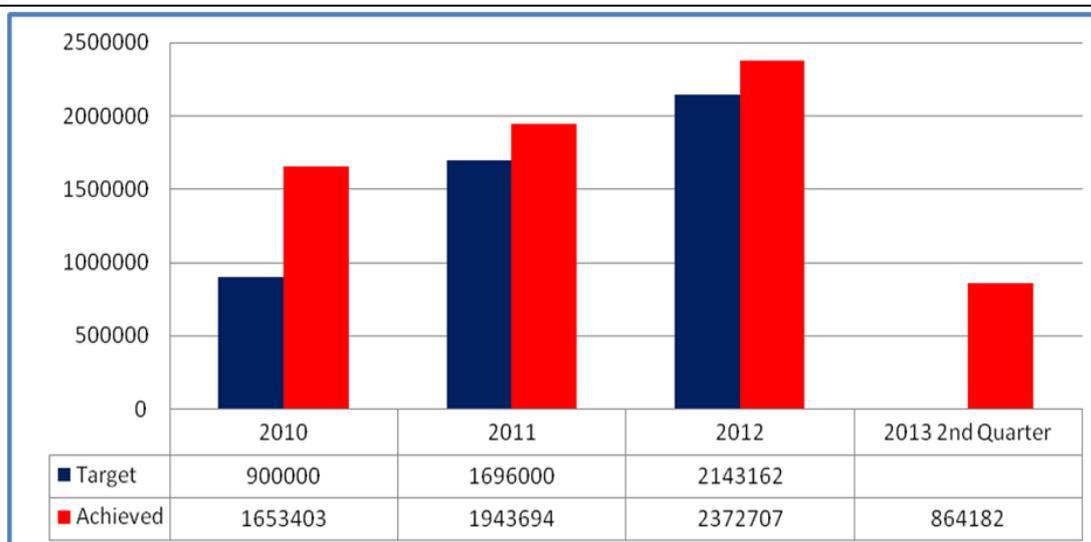
For prevention indicators, the mid-term review findings indicate that SBCC, HTC, and Blood Safety targets were achieved, with some surpassing set targets for 2013 (based mainly on process outputs). For example, the total cumulative number of people reached through SBCC interventions was 14,600,000 in 2011-2012, against a target of 9,700,000.

Other prevention interventions such as condom distribution achieved results of 85-90% based on targets set. For the first quarter of 2013, 22,735,108 male condoms were distributed against a target of 25 million, while 1,184,073 female condoms were distributed against a target of 1,375,000. The numbers of both male and female condoms distributed has maintained an upward trend from 2010 to 2012.

The number of clients who accessed HTC increased from 1,653,403 in 2010 to 2,372,707 in 2012 (Figure 2.2.1). Demand was created through the SBCC programme and campaigns in Manicaland, Mashonaland East and Harare for ten days in 2011 and in Bulawayo, Masvingo, Matabeleland North and Matabeleland South in 2012. The second quarter of 2013 saw 846,182 clients tested and counselled.

Figure 2.2.1: HCT Targets and Achievements 2010-2013

²⁸ All data in this section are drawn from the ZNASP II Mid-Term Review (October 2013).



However VMMC has attained only 10% of the target making it most unlikely to reach the expected result by 2015. Among the reasons cited for low VMMC achievement were slow and insufficient integration of VMMC into the district health delivery system and delayed disbursement of funds from partners. HTC and prevention and control of STIs experienced challenges of intermittent stock-outs of test kits and medicines respectively.

Post-exposure prophylaxis (PEP) has been decentralised to district hospitals nationwide. Sites offering PEP have increased from 510 in 2010 to 1,060 in 2013. Eighty one percent and 62% of health workers reporting work related injuries in 2011 and 2012 completed the treatment respectively, giving an overall coverage of 71% for the 2 years. The main challenge for PEP is the obstacles faced by survivors of sexual abuse to access services within 72 hours.

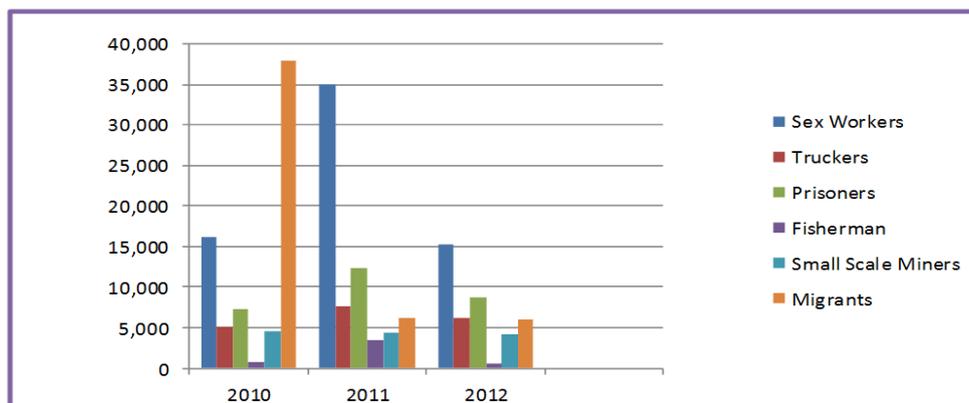
The MTR registered a decrease in the number of young people exposed to HIV and AIDS education from 276 814 in 2011 to 139 315 in 2012. It also noted a decrease on the number of peer educators who were active in 2012 (13 520) compared to 2011 (19 666) due to inadequate funding.

The Mid-Term Review revealed that the PMTCT programme was on track towards attainment of the set targets for elimination of new paediatric HIV infections in the country by 2015. A number of indicators show significant progress from 2010 towards the targets for 2013: Functional ANC facilities providing both on-site HIV testing and PMTCT ARVs rose from 77% to 92%; Pregnant women tested for HIV and knowing their results rose from 82% to 95%; HIV-positive pregnant women receiving ARV drugs to reduce risk of MTCT rose from 84% to 93%. Other indicators reflect more stunted progress: women living with HIV assessed for ART eligibility using CD4 count (31% to 45%); and HIV exposed infants provided with cotrimoxazole prophylaxis within the first two months of age (53% to 57%). Key challenge remained around the low access to paediatric HIV diagnosis and ART, which informs the re-prioritization of this intervention within this incentive funding request.

The most at risk population reached with HIV prevention programmes include sex workers, cross boarder traders, fishermen, truck drivers, MSM, prisoners and small scale miners. Major implementers targeting MARPS include ZAPP, Batsirai Group, PSI, Hope Humana, Kariba AIDS Project, North Star Alliance, SAT, and IOM. There are noticeable fluctuations in the number of most at risk and key populations reached between 2010 and 2012, with more clients reached in 2011 (Figure 2.2.2). For the sex work programme, this could be attributed to scaling up of interventions by the Zimbabwe AIDS Prevention Project (ZAPP) which were rolled out to a number of sites with funding support from UNFPA, and the expansion of the “Sisters with a Voice” Programme under CeSHHAR. The decline in 2012 is attributed to scaling down of activities by some major implementers due to funding

challenges.

Figure 2.2.2: Key Populations Reached with HIV and AIDS Services 2010-2012



Treatment Care and Support indicators also showed progress. The number of adults receiving ART increased from 298,092 in 2010 to 565,675 and this translated to ART coverage for 2012 of 68%, using the estimate of 836,384 PLHIV in need of ART by 2012 according to the 2012 HIV Estimates Report. The relatively increased number of adults on ART was facilitated by the decentralization of both ART initiation and follow up services and task shifting of ART initiation from medical officers to nurses and decentralization of planning, target setting and capacity-building. The number of PLHIV who remained on ART 12 months after initiation of ART was relatively high, on average 78% (80% for females and 75% for males) with calculated survival rates of 78% in 2011 and 89% in 2012. A continuous decline of clients on community home based care as well as the percentage of those who were bed-ridden has been reported and attributed to the increased access to and country-wide coverage of ART. The number of HIV/TB co-infected clients who received treatment for both HIV and TB in line with the guidelines increased significantly from 30% in 2010 to 60% in 2011. The review, however, noted slow progress in enrolling children on ART with coverage of only 42% by 2012.

Although the MTR showed an increase of the AIDS levy from \$26.4 million in 2011 to \$32.5 million in 2012, more than 70% of ZNASP II expenditure up to mid-2013 has been met from external resources. The development partners who have provided the much needed funding support for the HIV and AIDS response and some of the critical interventions within the public health sector include the Global Fund, USG, EU and some of its member countries and other bilateral organizations and the United Nations. While MOHCC, NAC and partners have successfully secured a \$311 million funding from the Global Fund to support mainly the national ART program for the period 2014-2016, more innovative strategies are required to ensure sustainability of resources for ZNASP II and beyond.

Some of the key recommendations from the ZNASP II Mid-Term Review which have informed the development of ZNASP III as well as this revised application for incentive funding include:

- Strengthen community systems since prevention and other HIV and AIDS interventions are dependent on community ownership and buy-in.
- Accelerate combination HIV prevention interventions with focus on appropriate integration to enhance service provision and demand creation.
- Due to the changing scope of the CHBC programme, the community health workers must be multi-skilled to offer a uniform basic package to clients.
- Specific interventions targeting key populations such as sex workers, MSM and People Living with Disability (PLWD) need to be developed. Skills training for service providers to enable them to offer friendly services to PLWD needs to be prioritised as well as the development of user-friendly IEC material.

- Advocate for a statutory instrument to improve reporting of HIV & AIDS program performance data among stakeholders so as to strengthen monitoring of the national response and availability of key strategic information.
- Intensify programming for adolescents and other key population and remove barriers for them to access services such as HTC and other prevention interventions for the remainder of ZNASP II.
- Intensify efforts to strengthen health systems with special focus on human resources for health and overall health and HIV financing.

c. The main findings of, and response to, any recent assessments, program reviews and emerging data

The Zimbabwe Demographic Health Survey 2010-11 – This survey showed the HIV prevalence has reduced amongst men and women of all age groups, and an increase in knowledge and accepting attitudes around HIV. Condom use remains low amongst those in stable relationships, condom use amongst high knowledge of HIV among young people. This survey has provided important data for baseline purposes, providing clear denominators for outcome and impact.

Sex worker study – In 2011, the Zimbabwe AIDS Prevention Project (ZAPP) supported by GIZ and in collaboration with NAC and the MOHCC conducted a survey of selected sex work populations using respondent driven sampling in the towns of Mutare, Victoria Falls and Hwange²⁹. In the 804 women tested, HIV prevalence was found to be 59.8% (around 4 times higher than among antenatal clinic attenders and general population) and SWs experienced low access to services and high stigma and discrimination by health providers. This evidence highlights the need to scale up services for prevention and treatment services for sex workers. There is also need to generate appropriate data on other key populations for better programming.

Impact evaluation for eMTCT – In 2012 Zimbabwe conducted an evaluation of the PMTCT program with sampling of survey participants designed to measure transmission rates in 2011 prior to wide-scale accelerated implementation of Option A (2010 WHO guidelines). This was an external evaluation conducted by University of California Berkeley in collaboration with CeSHHAR Zimbabwe and funded by the Children's Investment Fund Foundation (CIFF). The objectives of this two serial cross-sectional community-based survey were to determine:

- MTCT rate at 9-18 months
- HIV-free survival among infants exposed to HIV at 9-18 months; and
- Uptake of PMTCT services

Preliminary results with unweighted data and with final laboratory results still to be confirmed show an MTCT rate of 8.8%. This has given the country confidence that the goal of eMTCT and reducing MTCT to <5% by 2015 is attainable. In addition, the country is conducting a facility based PMTCT effectiveness survey, collecting blood samples at primary care clinics as infants come for routine immunization. Data collection is in process with preliminary results available in July 2013. Results from this survey will indicate 6-week MTCT rates. These will be triangulated with data from the community based survey and Spectrum modeling to give the country an accurate picture of the MTCT rate as we march towards eMTCT by 2015.

More recent research based on the 2012 impact evaluations shows that of 8,800 women, 94% attended at least one antenatal care (ANC) visit, 92% knew their HIV status during

²⁹ Survey of selected sex work populations conducted using respondent driven sampling in the towns of Mutare and Victoria Falls and Hwange, Zimbabwe AIDS Prevention Project, University College London and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) August 2012

pregnancy, 77% delivered in a health facility, and 92% attended the 6-8 week postnatal visit.³⁰ Among 1,075 (12%) HIV-infected women, 59% reported ART/ARV prophylaxis and 63% of their HIV-exposed infants received ARV prophylaxis. The study found that there were three main factors associated with receipt of maternal ART/ARV prophylaxis: four ANC visits, institutional delivery, and disclosure of serostatus.

Paediatric ART review – In 2012 a multi-country paediatric HIV assessment was conducted with support from UNICEF and WHO to determine major policy, health systems and structural bottlenecks that hampered access to Early Infant Diagnosis (EID), ART and retention to paediatric HIV treatment and care. Major findings included: limited linkage between EID and ART, centralised PCR testing and a long turnaround times of laboratory results (2.2 months). The median time from diagnosis to ART initiation was 61 days for children <2 years of age while the median age at ART initiation was above 7 years. In addition, the proportion of children remaining in care 12 months after initiation was below 75% and high rate of lost to follow-up was more observed among the under-fives (Rapid Assessment of Paediatric HIV in Zimbabwe, October, 2012). Efforts to increase uptake of EID and linkages to, and retention in care are required to improve child survival.

HIV Testing Counselling Strategy Review - The MOHCC, supported by WHO and NAC, commissioned a review of implementation of the National HTC Strategic Plan (2008-2011) in selected sites in all provinces. Findings informed the development of the current HTC Strategic Plan (2013-2015). The review revealed existing gaps and missed opportunities for identifying PLHIV which need to be addressed, including low couple testing (16%) and adolescent testing and counselling. The country is addressing these gaps by strengthening the skills of health workers in couple counselling, child and adolescent counselling and through prioritization of partner/couple testing within ANC, STI, HIV, TB and in-patient settings using the opt out strategy. The review also found sub-optimal referrals and linkages of HTC services and post-test services, resulting in significant loss to follow up and the need to strengthen this going forwards. The review also recommended innovative strategies such as self-testing, community based testing and counselling to increase awareness, demand and utilization for HTC with more emphasis on couple/partner counselling and testing, adolescents, young people and high risk populations.

Modes of Transmission Study - A comprehensive analysis of the HIV epidemic in Zimbabwe was conducted in 2010 to strategically address the drivers of the epidemic with better HIV prevention programmes and a more focused allocation of resources to avert the most number of new infections³¹. The analysis described the epidemiological situation and the HIV prevention response, synthesized and linked the epidemic and response data, and recommended improvements in HIV prevention policies, programmatic action and resource allocation. The results were used to formulate the ZNASP II and inform the Combination HIV Prevention approach.

Reducing transmission in stable unions and SW settings continues to be important in order to reduce heterosexual transmission of HIV. Since there is no single HIV prevention intervention suitable for all populations and situations, a combination HIV prevention approach is being adopted in order to maximise the effect of complementary prevention interventions³².

Sex Workers and to a lesser extent MSM have benefitted from specifically targeted interventions. The 2008 sex work situation analysis highlighted that programmes for sex workers were limited and underfunded (MOT 2011). Current sex worker interventions comprise of HIV prevention education, condom distribution, STI treatment, peer education, micro-credit and other measures that facilitate exit from sex work.

³⁰ Mccoy, S. I., Buzdugan, R., Padian, N. S., Musarandega, R., Engelsman, B., Martz, T. E. & Cowan, F. M. (2015). Uptake of services and behaviors in the prevention of mother-to-child HIV transmission (PMTCT) cascade in Zimbabwe. *JAIDS Journal of Acquired Immune Deficiency Syndromes*.

³¹ Zimbabwe Analysis of HIV Epidemic, Response and Modes of Transmission, National AIDS Council and Government of Zimbabwe with MOHCW, World Bank and UNAIDS, August 2010

³² Combination HIV Prevention: An Implementation Approach For Zimbabwe, Zimbabwe National AIDS Council and Ministry of Health and Child Welfare, 2012

The Military has an HIV policy and focuses on condom promotion and distribution, uptake of HTC and male circumcision (MOT 2011).

Emerging Data - As the epidemic unfolds, new social, economic, political and technological challenges emerge that transcend institutional and often national boundaries. These challenges demand a revolutionary rather than evolutionary approach with built in flexibility for periodical review, re-orientation, and strengthening of operational strategies.

For example, recent research showing that with safer, less toxic and more effective drug regimens available, earlier HIV diagnosis and treatment delivers substantial benefits to the individual and the successive impact at the population level is drastic reduction in transmission of the virus³³ – treatment as prevention – requires a paradigm shift in Zimbabwe’s approach to both its treatment and prevention efforts. A delicate balance weighs the potential prevention and clinical benefits of early initiation against the potential complications (ARV toxicity, emergence of ARV drug resistance) and limited capacity of health and community systems to deal with a dramatically increased patient load.

The expanded analysis of the HPTN 052 study is revealing that individual patient outcomes are also greatly enhanced by the early initiation of ART. Data show that the overall incidence of clinical events – both AIDS and non-AIDS – was much lower in study participants in the early therapy arm³⁴. In line with this new data, some countries in East and Southern Africa are initiating all pregnant women living with HIV on ART immediately - an approach known as Option B+. In Zimbabwe, MOHCC is taking steps to transition to Option B+ following a February 2013 national consultation in Harare where a majority of stakeholders recommended this move (see Annexe 15: Report of PMTCT Option B+ Stakeholder Consultation). The move to Option B+ is likely to have a greater impact in reducing infant HIV infections, increasing maternal survival and reducing transmission to HIV negative male sexual partners. These benefits will have a continuing positive impact, both during future pregnancies and in protecting HIV negative male partners.

A complementary intervention to PMTCT is the immediate treatment of the infected partner in a discordant relationship (where one member of the couple is HIV infected and the other is not). With couples representing only 16% of people tested, Zimbabwe is considering a pilot study looking at the dynamics of the prevalence in discordant couples and strategies for testing, counselling and immediate treatment of the negative partner.

Regular viral load monitoring is crucial to assess virological suppression and is more effective than CD4 count in monitoring treatment response for patients on ART, enabling identification of treatment failure much earlier. Zimbabwe therefore plans to introduce viral load testing in a phased manner to improve quality of care. The report of the Office of the Inspector General (OIG) found patients were not always receiving regular CD4 counts as per national guideline, and this will be addressed going forwards.

Zimbabwe and Rwanda participated in a study to assess the feasibility of using the Pre-pex device for VMMC. WHO is currently considering the device for pre-qualification. Approval of these devices will expedite scaling up of VMMC as the device can be used by non-doctors.

Scaling up of Zimbabwe’s electronic patient tracking system will greatly improve the quality of data for HIV programmes and enable further analysis to determine outcomes of patients on ART. Zimbabwe will be introducing the eSystem starting with HIV as the entry point. However the future vision of the country is to include other health related programmes.

National Survey on Disability and Health (2013) – The first ever national survey on the health of people with disabilities in Zimbabwe was conducted in 2013 by the Ministry of

³³ Cohen, MS, et al., 2011, Prevention of HIV-1 infection with early antiretroviral therapy. *NEJM*, 2011, 365: 493-505 PMID

³⁴ HIV Prevention Trials Network (HPTN), 2012, Additional benefits of early HIV treatment revealed. *ScienceDaily*. [Accessed on 20 March 2013 from <http://www.sciencedaily.com/releases/2012/07/120726180255.htm>].

Health and Child Care, in partnership with UNICEF and the Swedish Embassy (See Annexe J).³⁵ The Survey covered 15,368 households and 15,274 individuals (7781 of whom were living with a disability) in all ten provinces. This study found that people with disabilities were twice as likely to self-report having HIV as those without disabilities (11.2% vs 6% for women, and 8.9% vs. 3.9% for men). Further, the survey revealed that HIV knowledge was significantly lower among people with disabilities (72.6% among men and 76.9% among women) than among the control sample (83% among men and 85% among women). The findings also indicate that households containing people with disabilities were marginally more likely to indicate that AIDS was the major cause of death (20.6%) than households without disabled family members (19.7%). This new data signals the need to prioritise access to HIV services for people with disabilities in Zimbabwe.

PLHIV Stigma Index (2014) – The Zimbabwe PLHIV Stigma Index brings new information to bear about human rights barriers faced by many key and marginalised populations (See Annexe K).³⁶ A total of 1905 respondents participated in the study, including several from key populations: 6% (n=104) were people living with disabilities, 2% (n=42) were sex workers and 2% were men who have sex with men (n=36). Overall, the study found that 65.5% of respondents reported experiencing one or more forms of HIV-related stigma and discrimination. Over half (51.4%) reported that they had been gossiped about, and close to a third (31.2%) reported that they had been verbally insulted, harassed and/or threatened. Encouragingly, 91.8% of the people living with disabilities, 75% of men who have sex with men, 53.3% of prison inmates and 46.2% of sex workers reported that they knew of support organisations that they could go to if they experience stigma and discrimination. Other results shone a light on issues with voluntary testing. More than half (51.1%) of the respondents reported that they underwent HIV testing due to pressure from other individuals; just 42% said they had tested on a voluntary basis. The majority (91%) of respondents reported that they had received pre and post-test counselling when they went for testing. The report results also highlight relatively good access to ART, even for key populations: All prison inmates reported that they had access to ART, 70% of sex workers had access to ART and 82% of MSM also reported that they have access to ART. However, these populations were also more likely to experience stigma than the general population, due to double stigma of being both HIV positive and a member of a marginalised or criminalised group. 100% of prison inmates reported experiencing stigma and discrimination, along with 90.8% of sex workers, 77.8% of MSM and 64.5% of people with disabilities.

Zimbabwe Multiple Indicator Cluster Survey (2014) - For the 2014 MICS, the sample had 682 clusters, 229 in urban areas and 453 in rural areas. A representative sample of 17,047 households was selected for the survey (See Annexe L). The survey revealed that the percentage of young people age 15-24 years who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission was 56.4% among young women and 51.7% among young men.³⁷ Similarly to the stigma index results, this survey also highlighted the low levels of acceptability towards people living with HIV (43.2% among women and 43.8% among men). Other indicators showed that knowledge about HIV services was fairly high. Ninety-five percent women and 93.5% of men (15-49) knew where to be tested for HIV. Despite high knowledge, just 51% of women and 40.3% of men been tested in the last 12 months. Among women who had given birth in the last two years, 77.7% reported that they received counselling on HIV during ANC, and about 89% reported being tested for HIV. Age disparate relationships were commonly reported, with 17.9% of young women (15-24) reporting a sexual partner who was 10 or more years older.

³⁵ Ministry of Health and Child Care (2013). Living Conditions Among Persons with Disability Survey: Key Findings Report. Online at [http://www.unicef.org/zimbabwe/National_Survey_on_Disability_2013\(1\).pdf](http://www.unicef.org/zimbabwe/National_Survey_on_Disability_2013(1).pdf)

³⁶ ZNNP+ (December 2014). The Zimbabwe People Living with HIV Stigma Index. Online At <http://www.stigmaindex.org/zimbabwe>

³⁷ Zimbabwe National Statistics Agency (ZIMSTAT). 2014. Multiple Indicator Cluster Survey 2014, Key Findings. Harare, Zimbabwe: ZIMSTAT. Online at www.childinfo.org/files/Zimbabwe_2014_KFR.pdf Page 38.

Investment Case (2015) – Though not yet finalised, the draft Investment Case for Zimbabwe speaks to the possible savings of a more efficient and targeted approach (See Annexe D). Annual resource needs are projected to increase to nearly \$600 million by around 2018, and over \$700 million each year from 2023 onwards, given current cost structures. However, a more prioritised high-impact response could see resource needs stabilised at around \$550 million annually in the second half of the coming decade if prevention gains and treatment and programme support efficiencies are realised.³⁸ In addition to these cost savings, the IC also highlights the potential impact on the epidemic of strategic investment. The IC projects that by 2025, an enhanced more efficient response to AIDS in Zimbabwe will see 100,000 fewer HIV infections annually compared to simply maintaining the existing response, and 70,000 fewer AIDS deaths per year.³⁹

Hotspot Mapping (2015) – This recent mapping of high-risk geographical regions for HIV in Zimbabwe informs the targeted approach of the new National Strategic Plan (ZNASP III) (See Annexe E).⁴⁰ A composite index derived from four indicators was used to identify geographic hotspots: HIV prevalence; HIV Incidence; risk factors (defined by a combination of condom use, multiple sexual partners, high risk sexual intercourse and young people fertility as a proxy for pregnancy); service coverage data. The analysis found Bubi, Nkayi, Mazowe, Marondara and Buhera in Matabeleland South to be HIV hotspots. To a lesser extent, Manicaland, Mashonaland East and Central provinces were identified as having the potential of becoming hotspots if special attention is not taken according to reduce risk factors there. The rest of the country falls in the medium range, except for Sanyati and Mbire which are in the low range.

2.3 Implementation of the National Strategic Plan

Please describe the **implementation progress** of your National Strategic Plan, referring as appropriate to the Performance and Impact Profile provided by the Global Fund as well as any recent evidence from program reviews, evaluations and relevant surveillance surveys.

In your response, include:

- a. The **priority interventions** that are currently being implemented.
- b. The **outcome and impact** achieved to date by these priority interventions.
- c. The **key stakeholders** involved in the implementation.
- d. Any **limitations** of the response to date and the **lessons learned** informing the design of future interventions.
- e. Any **limitations in national data systems** to measure and demonstrate impact.

The Zimbabwe Analysis of the HIV Epidemic, Response and Modes of Transmission (2011) provided the evidence base for the development of ZNASP II. With this understanding of the epidemic and response, all interventions and strategies were prioritised against Zimbabwe's two overarching goals of preventing new infections and keeping people alive.

Preventing new infections: implementation of priority interventions

- **Social and Behaviour Change Communication**

Implementing Partners: World Vision; Regai Dzive Shiri; ZiCHIRe; Batsirai; FACT Mutare; Zimbabwe AIDS Support Organisation (ZAPSO); Matabeleland AIDS Council; Midlands AIDS Support Organisation, UNFPA

³⁸ National AIDS Council and UNAIDS (March 2015). Briefing note: resource availability and needs for the HIV Response in Zimbabwe.

³⁹ Draft Investment Case for Zimbabwe (April 2015).

⁴⁰ MoHCC, NAC, CDC, UNAIDS & WFP (2015). Smart Investment to End HIV AIDS in ZIMBABWE based on Hotspot Analysis. Online at <http://www.nac.org.zw/sites/default/files/Hot%20spot%20Mapping%20Report.pdf>

The Zimbabwe National Behaviour Change Programme (NBCP) is operative in all 65 districts of the country and is well integrated into different sectors. Outreach includes prisons and prison officers and prisoners have been trained in behaviour change course. NBCP coverage at a population level is striking with over 45% of people having attended a meeting with a Behaviour Change Facilitator (BFC) and a remarkable 14% of people were visited by BCFs in their homes⁴¹. Progress is also evidenced by the significant increase in the percentage of men and women with a comprehensive knowledge of HIV and the number of women and men who know HIV can be transmitted through breastfeeding and that this risk can be reduced by taking special medicines⁴². Sex work interventions are being implemented in selected sites in the country focusing mainly on peer education and condom distribution.

Lessons Learned: data suggest a continuing gap between people's perception and actual risk of HIV infection. Limited data exist on key population especially MSM and IDU.

- **Promotion and distribution of male and female condoms**

Implementing Partners: ZNFPC; MOHCC ;PSI Social Marketing; UNFPA

The focus of the Comprehensive Condom Programme is to increase consistent and correct use of both male and female condoms. A comparison of the ZDHS results from 2005/6 and 2010/1 suggests that while there have been essentially no changes in the percentage of Zimbabwean men who paid for sex in the 12 months preceding the interviews, 88% of those who did engage in paid sex used a condom. In 2011, 91.7 million male condoms and 5.3 million female condoms were distributed from approximately 1,600 service delivery points, with less than 1% (male condoms) and 2% (female condoms) stock outs. Sex workers access female and male condoms in selected sites and health facilities.

Lessons Learned: Gaps in consistent condom use persist, particularly within concurrent sexual relationships. Additionally, levels of condom use among PLHIV are low despite high levels of sexual activity.

- **Voluntary male medical circumcision (VMMC)**

Implementing Partners: PSI; ZAPP, ZACH/ITECH; UNFPA; MOHCC, WHO

Zimbabwe's combination prevention strategy includes adult male circumcision because of its potential for rapid epidemiological impact. Achieving the National Male Circumcision strategy's ambitious goal of reaching 1.3 million men aged 15-49 with circumcision services by 2015 would avert 600,000 new infections by 2025⁴³. As of December 2012, over 100,000 men had been circumcised. A total of 806 providers are trained in VMMC, (491 nurses 138 doctors, 101 receptionists, 76 theatre assistants). These services are available for clients of sex workers and MSM, although the M&E system is not able to capture the service utilization data at the moment.

Lessons Learned: The MC programme has reached only 7% of its target of 1.3 million by 2015. Limited funding for social mobilization and advocacy has resulted in low uptake of VMMC services. Integrating early infant male circumcision in a horizontal approach as part of routine care of mothers and infants would make this programme more sustainable in the long term.

- **Prevention of mother to child transmission of HIV (PMTCT)**

Implementing Partners: Organization for Public Health Interventions and Development (OPHID); MSF; Kapnek Trust; EGPAF; WHO; UNICEF; CHAI; ZVITAMBO; NAC; SafAIDS; ZAN; MOHCC

High quality, comprehensive PMTCT services are currently provided in 95% of the 1,560

⁴¹ Zimbabwe, Department of Community Medicine, 'National Behavior Change Programme Surveys', 2012, Final Report

⁴² Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International, 2012, *Zimbabwe Demographic and Health Survey 2010-11*. Calverton, Maryland: ZIMSTAT and ICF International, Inc.

⁴³ Njeuhmeli E, Forsythe S, Reed J, et al. VMMC: modeling the impact and cost of expanding male circumcision for HIV prevention in eastern and southern Africa. *PLoS Med.* 2011;8:e1001132.

health facilities in Zimbabwe. To accompany this rapid expansion, 2219 Health Care Workers received IMAI/IMPAC training in taking a holistic approach to the management of positive, pregnant women particularly. This concerted effort by government and partners resulted in an increase in the proportion of infants receiving prophylaxis (85%) and the number of sites performing DBS collection (from 379 to 1440) in 2012. PMTCT services are accessible to all pregnant women including pregnant sex workers.

Lesson Learned: Strengthening mother-baby follow-up strategies can increase retention across the PMTCT cascade. Expanding integration of family health should be a continuing priority to achieve cost efficiencies and improve service quality. Exploring ways to increase male involvement and achieve greater gender balance in the provision and use of services is recommended.

- **HIV testing and counselling**

Implementing Partners: PSI; OPHID; MOHCC; ZAPP, WHO

HIV testing is a crucial first step in the cascade of HIV treatment and an entry point to other prevention and care interventions including male circumcision, prevention of mother-to-child HIV transmission, and treatment of opportunistic infections. The DHS 2010/11 shows a marked increase in HIV testing coverage among both men and women. Furthermore, 91% of women and 88% of men knew where to access HTC services. In 2012 a total of 2.2 million adults aged 15-49 accessed HTC in Zimbabwe through a total of 1,456 health care facilities, either in Antenatal Clinic (ANC), TB and STI care settings or through opportunistic infections clinics and HIV treatment centres. HTC services are available to all citizens that need, inclusive of key populations.

Lessons Learned: The linkages and referral systems between HIV testing and subsequent interventions in the continuum of care are sub-optimal. Attrition at the “gateway” must be addressed if Zimbabwe is to achieve universal access. Emerging issues including community based HIV testing and counselling and the potential introduction of self-testing to reach the difficult to reach populations needs to be explored.

Keeping people alive: implementation of priority interventions

The benefit of antiretroviral therapy (ART) to individual health outcomes is well understood. ART keeps people alive. Recent research has further demonstrated two important concepts: 1) that early initiation of ART delivers considerably greater health outcomes to the individual as opportunistic infections are held at bay; and 2) ART, when taken consistently, reduces a patient’s viral load to almost non-transmissible levels (HTPN 052) which contributes significantly to the reduction of new infections.

The scale up of comprehensive HIV prevention, treatment, care and support has resulted in the decline of both the prevalence and incidence rates from a peak of 26.4% and 5.19% in 1994 to 13.49% and 0.81% in 2012 respectively (2011). Despite this significant progress, the number of new HIV infections and the number of HIV and AIDS related deaths is still unacceptably high.

- **Antiretroviral Therapy (ART)**

Implementing Partners: MSF; Private Sector; SAfAIDS; ZAN; MOHCC, CDC

The total number of PLHIV receiving ART in Zimbabwe is 578,450 including 531,136 adults and 47,314 children with more than 8,000 PLHIV initiating treatment each month (LMIS data 2012). Preliminary results from an ART outcome study by the MOHCC indicate survival rates of about 91%, 78% and 69% at 6, 12 and 24 months respectively. Zimbabwe’s plan to phase out the current stavudine-based regimen for the less toxic, patient-friendly TDF combination is underway with 64% of those accessing ART already on TDF as of 2012. Full transition to TDF is expected to be completed by first quarter of 2014. There is no limitation on key and most-at-risk populations accessing services but there is need to better link people with the services.

Lessons Learned: PLHIV are lost at every step along the continuum of care with the

highest rates of Loss To Follow Up (LTFU) occurring between HIV testing and enrolment in care. Paediatric ART coverage remains at 42% (based on 2011 estimates) – significantly below the universal access target of 85%.

- **HIV/TB control and therapy**

Implementing Partners: Private Sector; MOHCC

Zimbabwe continues to experience a major HIV driven TB epidemic with co-infection rates of 82%. Considerable progress has been made towards addressing the 12 point WHO collaborative TB/HIV activities. As of 2011, 92% of all TB patients notified during the year had an HIV test result, 85% of the HIV positive TB patients received cotrimoxazole and 60% received ART. Although ART uptake among HIV+TB patients is increasing it remains below the ART coverage among the general population of PLHIV who do not have TB. Progress on implementation of the 3I's has been very slow especially Isoniazid preventive therapy (IPT). Intensified case finding among PLHIV has been on-going but not recorded. TB infection control needs to be strengthened. TB/HIV services are available to all key populations that need it.

Lessons Learned: Task-shifting needs to be expedited so that more nurses can be allowed to initiate ART among stable TB co-infected patients. Delay in implementation of policies e.g IPT denies beneficiaries from accessing interventions that has an impact on their lives.

- **Diagnostic services**

Implementing Partners: CHAI, EGPAF, CDC, UNICEF, National Microbiology Reference Laboratory (NMRL)

The introduction of point-of-care CD4 cell count machines is significantly improving patient management as transport constraints no longer contribute to loss to follow up in these sites⁴⁴. The National Microbiology Reference Laboratory, currently the only laboratory offering HIV DNA PCR testing, has observed a marked increase in the number of tests performed per year and the number of sites submitting specimens, from 12 in 2007 to 1,440 in 2012⁴⁵.

Lessons Learned: One of the major draw backs in early infant diagnosis is the turnaround time for lab results (currently transported by Fedex). With lives in the balance, a need to identify new technologies that can address this challenge is critical.

Health and community systems strengthening

Strengthening the interface between the health facility and the community it serves improves uptake and access to services (facility and community-based) and quality of care and retention. The notion of health and community systems strengthening is a not top-down activity for stakeholders in capital cities, but a locally-owned, context-specific and inclusive process, one that is built on the tenets of equity, evidence and efficiency.

Socio-cultural factors, beliefs about health, and health care utilization certainly play a role in community-level medicine whether the community is urban, rural or peri-urban. Zimbabwe's investment in health and community systems seeks first to understand what factors motivate and drive behaviour at the local level (for the service provider and the client – supply and demand), then to address these drivers through behavioural incentive changes, not just through technology.

For example, the adaptation and roll out of the Stigma Index by ZNNP+ and partners measures perceived stigma among PLHIV and will provide a more nuanced contextual understanding of the root drivers. NAC decentralised structure ensures that the voices of people living with HIV are heard and that key populations are included in the HIV response.

⁴⁴ UNICEF operational research, Unpublished Report, 2012

⁴⁵ National Microbiology Reference Laboratory, end of the year report 2012,

Communities are designing and implementing community-based models for ART delivery, patient tracking, adherence support and home based care with great potential. With the anticipation of over 300,000 people rapidly entering the treatment ranks as the threshold to treatment eligibility is raised, piloting these innovative community models will be a fundamental and worthy investment for Zimbabwe to alleviate the burden on the health systems..

For example, Southern African AIDS Trust (SAT) has supported the construction of 'Waiting Mother's Shelters' for pregnant women, HOPSAZ has developed quality standards for palliative care, and community home-based care, and partners such as PADARE, SAfAIDS, SAT, ZNNP+, ZAN, AFRICARE, Community Working Group on Health (CWGH) are empowering community leaders to promote the uptake of HIV prevention, care and treatment services in their communities.

ZAN and ZNNP+, two apex organizations, provide support to their members through capacity building opportunities and small grants. ZAN currently has 275 civil society members working on HIV while ZNNP+ has 6000 support groups spread across the country. SAT provides skills-building opportunities, grants, networking and joint planning for HIV and TB initiatives to 25 civil society organizations.

A number of key partners such as SAT, SAfAIDS, ZAN, PSI, ZNNP+, SAYWHAT, PADARE, utilise their structures to build their constituencies' capacity to advocate not only for issues concerning HIV services and care, but also for synergistic interventions that can reduce vulnerability to HIV. For example, SAT successfully petitioned the government for the reintroduction of student grants in higher and tertiary institutions to prevent students from adopting risky sexual behaviours as a result of poverty. UNICEF's support for child protection and poverty reduction contributed to communities playing a leveraged role in HIV impact mitigation.

Acknowledging the challenging socio-cultural and legal environment for MARPS (specifically MSM), but based on the need to ensure access to HIV prevention, care and treatment, a number of small-scale initiatives are being initiated in Zimbabwe from which lessons can be learned. For example, SAfAIDS has hosted national and regional advocacy platforms on policy issues affect people living with HIV and LGBTI (Lesbians, Gays, Bi-sexual, Transexual and Intersexed). SAfAIDS is currently implementing community-based transformative approach aimed at lifting social barriers and improving access to HIV prevention services in Zimbabwe. Lessons learned from these (and other organisational) approaches can be integrated into prevention and treatment programs.

Retention of health staff has improved largely due to increased remuneration through the GF and HTF supported retention scheme. Vacancy rates have been declining especially after the GoZ lifted the freeze on over 2000 health worker posts; however, more health workers will be required as more patients initiate ART. Plans are underway to look into non-monetary incentive schemes and a transition from post qualification individual skills training where health workers are absent from their posts for long periods to pre-qualification training and integration of curricula. This integration of training curriculum has already started with HIV and TB case management training.

While essential medicine coverage has improved significantly, the rapid initiation of new patients on ART poses significant challenges to national procurement and supply management systems, including storage facilities. National Pharmaceutical Company (Natpharm) has not been recapitalised since the introduction of multi currencies making the ability to draw down on tenders and restock difficult. The practice of parallel sourcing and procurement of commodities by donors does not build capacity of the national system. Zimbabwe's rapid scale up of coverage and services has also impacted on the quality of care in health facilities. Different strategies are being implemented to improve the quality of services provided in health facilities, including decentralization and integration.

The use of front line SMS for the weekly surveillance has improved the completeness and timeliness of reporting from below 50% to above 90%. M&E data collection tools are being harmonised to avoid duplication and overlaps. The country is piloting an electronic patient

monitoring system for HIV which will feed into the upgraded DHIS.

A package of M&E tools has been developed for village health care workers to monitor performance. In addition, District AIDS Action Committees (DAACs) collect information from the community partners working on HIV and AIDS and report through one central M&E system. While monitoring and evaluation of community engagement, empowerment and participation is complex, qualitative evidence shows that community systems' strengthening increases the uptake of various HIV prevention, care and treatment services.

e) Limitations of national data systems to measure and demonstrate impact

Patient data is collected using a paper based system. Increased data requirements and growing numbers of people accessing services has resulted in reduced data quality and health workers being overburdened with heavy data recording and reporting requirements. This lack of timely transmission of data from health facility to district, province and national levels disrupts the communication infrastructure.

The lack of patient follow-up mechanisms in some districts as ART is decentralised from ART initiating sites to ART follow-up sites leads to an increase in the number of patients lost to follow up. This is compounded by the multiple registers at service delivery points and overall inadequate M&E capacity.

Efforts to address these challenges are underway and include the roll out of ePMS to all high volume ART health facilities, integrated Monitoring and Evaluation (M&E) data collection tools, development of indicator guidelines and Standard Operating Procedures (SOPs), among others.

2.4 Enhancing TB/HIV Collaborative Activities

If you are submitting a **TB and/or HIV concept note(s)**, you must describe the scope and status of on-going TB/HIV collaborative activities.

a. How the funding requests will strengthen TB/HIV collaborative activities.

b. The linkages between the respective national TB and HIV programs in your country.

a) How the funding request will strengthen TB/HIV collaborative activities

Zimbabwe faces a major HIV driven TB epidemic (82% co-infection). About 50% of deaths among PLHIV are due to TB. The government since 2007 adopted and implemented the WHO collaborative TB/HIV strategy with varying levels of success. In 2011, 92% of all TB patients notified during the year had an HIV test result, 85% of the HIV positive TB patients received cotrimoxazole and 60% received ART. However from the HIV care clinics, although PLHIV enrolled in care were screened for TB, the recording tools were unable to capture such information. Isoniazid preventive therapy (IPT) was only introduced towards the end of the year in 10 pilot sites despite the proven effectiveness of the intervention. This application therefore focusses on the accelerated implementation of the Three I's for TB/HIV as this remains an outstanding weak area of the National response.

The pre-ART/ ART registers were recently revised to accommodate ICF/ IPT indicators. Use of these revised tools started early 2013. For assessing eligibility for IPT the country is using the screening tool. When it comes to diagnosis of TB among PLHIV, Sputum smear microscopy (SSM) has a particularly low sensitivity for detecting TB among PLHIV and PLHIV with a negative smear microscopy result but who are still presumed to have TB, a better option is the GeneXpert since bacterial culture is out of reach. y. Currently the main diagnostic tool for TB is smear microscopy and notification rates for TB show a downward trend within the past 3 years. This application will expand the availability of GeneXpert to an

additional 30 secondary level health facilities from the indicative funding and an additional 30 machines from the incentive funding, the remaining 60 machines will be sought from the upcoming TB application and other sources. This will translate into additional case identification of all types of TB especially in PLHIV. Preliminary findings from one district supported by MSF indicate an increase in case detection, reduced need for CXRs, reduced time between diagnosis and treatment for clinic cases and more TB initiations by nurses. Treatment needs for these additional patients are covered in the current TB grant and NAC.

Prevention of TB disease in PLHIV is a weak area of the National TB/HIV Response because of negative perceptions around its utility and fears of generating more drug resistance common to both policymakers and implementers. The MOHCC introduced IPT in a phased approach starting in December 2012, with implementation currently piloted in 10 selected sites. Due to the short implementation time not much data on performance had been gathered at the time of this concept note. TB Infection control (IC) measures are sub-optimal due to the absence of a National Policy Framework and Guidelines and in addition, many health facilities were constructed before TB/HIV IC was fully appreciated. In 2012 the Ministry received a CDC grant to develop policy framework/guidelines and renovate 100 health facilities. This proposal requests support to renovate an additional 40 centres out of the 1564 health facilities in the country.

Zimbabwe hopes to meet its targets i.e. increasing Cotrimoxazole uptake in TB/HIV patients to 100%, and ART in TB/HIV to 100% by the end of the support period.

b) **Collaboration between the National TB and the HIV programmes**

In 2008, a National Collaborative TB/HIV committee was formed with subsequent committees formed by expanding the TORs for existing committees at provincial and district levels. At the health facility level, TB/HIV collaboration is even better as the same health worker offers both TB and HIV services. Where the TB and HIV clinics are separate, referral of patients is taking place with the aim of a “one-stop-shop” for TB/HIV co-infected patients to minimise loss of patients between the two programmes and create greater efficiencies.

At national level the NTP and HIV programmes co-chair the collaborative TB/HIV meetings. Joint planning is in place and so are joint work-plans for implementation. Both programmes have focal points responsible for the collaborative activities. The former national level HIV/AIDS Treatment and Care Partnership Forum has been transformed into a TB/ HIV Prevention, Treatment and Care Partnership forum with meetings held quarterly. The two programmes worked closely in the development of the 2009-2013 NTP Strategic plan and guidelines for co-management of TB/HIV, including the revision of the cough screening tool used to screen for TB in PLHIV. Integrated TB/HIV training materials have been developed and both programmes are using these materials to train health workers. M&E tools have been revised by both programmes to accommodate missing indicators on HIV and TB indicators. Both programmes remain under the overall leadership of one director which further aids collaboration.

SECTION 3: Programmatic Gap

Please complete the **Programmatic Gap Table** in Attachment 2 by identifying the gaps in coverage for three to six priority program areas consistent with the National Strategic Plan, and which will be addressed through the applicant’s funding request.

All numbers in this table should relate to the size of the population groups targeted by the priority program areas, and not the financial need for the program areas.

3.1 In accordance with the **Programmatic Gap Table** in Attachment 2, describe the **assumptions, methodology and sources** used in estimating the programmatic gaps.

In addition to the programmatic gap tables in the Modular Template, Zimbabwe has developed a full programmatic gap analysis based on detailed understanding of activities already supported by GOZ and partners. These tables provide complementary, supplementary information and can be seen in Annex 16 – Zimbabwe Detailed Programmatic Gap Tables.

Zimbabwe has prioritised five programme or service delivery areas: Adult and paediatric ART (including TB/HIV), PMTCT, VMMC, HTC and BCC, with additional supportive programming in the areas of health and community systems strengthening. These areas were determined through a series of consultative processes, including a meeting with Provincial Medical Directorate (PMD), a Gap analysis workshop with national stakeholders; and consultations with Gender Technical Working Group and Sex Worker Technical Working Group. Additional consultations were made through telephone/email and review of existing reports, evaluations and assessments. A specific effort was made to ensure that key populations, including women and girls, people with disabilities, men who have sex with men, sex workers, people living with HIV, and adolescents participated in the consultative process of analysing the programmatic gap. Additional information on the justification for the prioritisation of these areas is included in Section 4.1.

Methodology. Information was gathered from different programmes on estimates of need, targets and partner support. Projected commitments were also solicited from partners in various programme areas. Reflecting on the ZNASP II, stakeholders were then asked; 1) to highlight progress made to date and analyse activities that are outstanding; 2) prioritise the programmatic gaps and justify with existing evidence. The information collected through the consultative processes was analysed. Data from national targets and estimates were used in the programmatic gap table, and contrasted with the financial gaps. Overall analysis confirmed the programme areas selected for this request.

Key Assumptions. A number of program areas receive support from non-Global Fund partners, including USG/PEPFAR, DFID, UNICEF, EGPAF/CIFF. Where commitments have been made for future year funding, the funding estimates have been included.

Sources. The targets and estimates used to determine the programmatic gaps in the six program areas included: 2011 HIV estimates; preliminary 2013 HIV estimates, Zimbabwe Global AIDS Response Report 2011; Zimbabwe National Voluntary Male Circumcision Strategy (2010-2015); National Strategic Plan for Eliminating new HIV infections in Children and Keeping Mothers and Families Alive (2011-2015).

SECTION 4: Funding Request to the Global Fund

Please complete the questions below together with the **Modular Template** in Attachment 3.

4.1 Funding Request within the Indicative Funding Amount

Please describe how indicative funding requested and any existing Global Fund financing will be invested (or reprogrammed) during the funding request period to maximise impact. In your response, include:

- a. The
objectives and expected outcomes of the funding request, and how the outcomes have been estimated and will contribute to achieving greater impact. Please refer to available local evidence of effectiveness of the programs being proposed.

- b. The
proposed modules and interventions of the funding request in order of priority, in addition to the rationale for their **selection** and **prioritization**.

c.

For

consolidated funding requests, explain how current interventions will be adapted, discontinued or extended to maximise impact.

a) Objectives and outcomes of funding request

In arriving at the objectives and outcomes of this application the national stakeholders took into account the priorities and targets for the national response as outlined in the ZNASP II. Analysis of the current level of achievement was made and the programmatic and financial gaps determined using the methodology described in section 3.1, which resulted in the programmatic gaps documented in attachment 2. Zimbabwe has also taken into account recent evidence on effectiveness of various HIV interventions. The impact and outcome targets of the ZNASP II continue to the end of 2015, but an assumption has been made to maintain them at the same level in 2016 to cover the 3-year period of this request.

The total amount of the April 2013 request was \$555,540,629 of which \$311,175,241 was the indicative funding amount and \$244,365,388 is for additional gains beyond indicative funding. Following the approval of the \$311,175,241, along with an additional \$126,055,782 awarded, the within allocation funding currently sits at \$437,231,023. This section describes those already-approved interventions, with the remaining incentive funding request of \$40,168,251.00 outlined in Section 4.2.

The aim of this request is to sustain the trajectory of declining HIV infections and increased access to AIDS treatment for Zimbabwe to reach the tipping point where the number of new HIV infections per year becomes less than the number of people being initiated on ART. This will be a major contribution to improving health, the economy and human capital in Zimbabwe. This request will contribute to Zimbabwe’s two main goals:

- 1) Reduce HIV related mortality by 38% from 2009 to 2016; and
- 2) Reduce new HIV infections in adults (15-49) from 0.81% (59,260) in 2012 to 0.6% (44,910) by 2016; and reduce % of infants born to women with HIV who are infected from 18% in 2010 to 7% in 2013 and to less than 5% by 2016.

a. The objectives and expected outcomes of the funding request, and how the outcomes have been estimated and will contribute to achieving greater impact.

The objectives and expected results are shown in the table below:

GF NFM investment objectives	National Outcomes/Targets
To support ART provision for 364,363 clients in 2014; 381,112 clients in 2015; 381,112 clients in 2016	Number of PLHIV receiving ART increased from 518,801 in 2012 to 984,401 for adults in 2016 and from 46874 in 2012 to 112,869 in 2016 for children
To support provision of IPT in PLHIV in 115,000 clients in 2014 125,000 clients in 2015; 175,000 clients in 2016	Number of PLHIV on IPT increased from 365 (pilot Feb 2013) to 350,000 by end 2016
To support ART provision for 31177 pregnant women in 2014 55260 pregnant women in 2015 59451 pregnant women in 2016	Number of HIV pregnant women on ART provision increased from 7305 (11%) in 2012 to 59,451 (97%) in 2016
To support circumcision of	Number of males circumcised increased from

17,800 in 2014 (13-49 year old males), 47,290 in 2015 (13-49 year old males) 38,433 in 2016 (13-49 year old males)	100,000 (7%) at end 2012 to 949,000 (73%) by end 2016
To support HTC for: 687,489 adults and children in 2014, 933,429 adults and children in 2015 1,109,500 adults and children in 2016	HTC provision increased from 2,240,000 clients per year in 2012 to 2,777,000 per year by end 2016
To support adoption of safer sexual practices and uptake of HIV prevention services in: 180,000 people in 2014, 220,000 people in 2015, 250,000 people in 2016	Number of people reached through community based messages on HIV prevention services including key populations increased from 400,000 in 2013 to 500,000 by end 2016
To increase Health worker retention from 16/100,000 in 2012 to 17/100,0000 To scale –up rollout of ePMS from 83 in 2013 facilities to 534 HF by 2016 To improve on data timeliness and completeness from 80% in 2012 to 95% by 2016	Service delivery is managed and coordinated effectively and efficiently

Approaches to estimating outcome targets – The outcomes have been estimated at national level by assessing the current need (using epidemiological analysis of Zimbabwe’s epidemic), taking into account the current programme achievements and capacity, and modelling the potential impact of various high impact interventions. The country has also used preliminary 2013 HIV estimates and anticipated WHO guidelines on use of ARV medicines to calculate numbers of people in need.

There is also a small but emerging body of local evidence supporting prioritisation of these interventions for expanded implementation in Zimbabwe as described below.

ART - An ART outcomes evaluation study conducted in Zimbabwe (2012) demonstrated that in spite of the difficult macroeconomic environment experienced by the country, patient retention on treatment was similar to that seen in other countries within the region. It also highlighted the need to start clients on treatment early as well as develop specific services targeting males⁴⁶. An end-term review of the HIV Care and Treatment ART and opportunistic infections programme will be carried out in April this year. It will assess effectiveness, efficiency, equity, relevance and sustainability of the programme. It will also assess the characteristics of people accessing ART, including disaggregation by sex, age, key population groups and geographic locations. The review will also consider factors contributing to quality of the ART and OI services provided in the country. It is hoped that the review will inform the formulation of the new National ART Strategy including pointing to ways of improving targeting, demand and quality of the services.

PMTCT - Cost-effectiveness modelling research on PMTCT in Zimbabwe by Ciaranello, A. et. al in 2012 concluded that replacing sdNVP with Option A or Option B will improve maternal and infant outcomes and save money; Option B increases health benefits and

⁴⁶ Zimbabwe MOHCW, Evaluation of ART Outcomes in Zimbabwe, 2012

decreases costs compared with Option A in the longer term. Option B+ further improves maternal outcomes. The majority of local evaluations have focused on programmatic and process indicators. To assess the long-term impact of the PMTCT program, two evaluations of the PMTCT program are currently being undertaken with results available in the next two years.

VMMC – A study on VMMC acceptability in Zimbabwe conducted in Harare in 2004, demonstrated that 45% of respondents expressed a wish to be circumcised if the practice was confirmed to reduce the risk of contracting HIV or STIs, and if it was performed safely and was affordable⁴⁷. A situation analysis undertaken in 2008 found that cost, pain and potential of complications were concerns that needed to be taken into account in the MC scale up (MOHCC, 2008). A further study in 2008 did not appear to demonstrate significant barriers to the acceptability of MC in the majority of the population⁴⁸. Zimbabwe has also carried out an evaluation study of the use of devices for VMMC exploring safety, total operative time and field implementation by trained nurses⁴⁹. The results have contributed to the global pre-qualification process of the device by WHO for use on male clients 18 years and above.

HTC - HIV testing and counselling (HTC) is the entry point to prevention, treatment and care, The overall goal of Zimbabwe's HTC strategy is to ensure 85% of people know their HIV status by 2016. The recent ZDHS 2010-11 indicated that 36% of men and 57% of women reported to have been tested in the country and a discordance rate of 12 % among couples. A review of the HIV Testing and Counselling Strategy in 2012 showed that there are limited testing and counselling services for pregnant women during labour, delivery and also that training in HTC for children and adolescents living with HIV is inadequate and needs strengthening. The review thus recommended innovative strategies to increase awareness, demand and utilization for HTC with more emphasis on couple/partner counselling and testing, adolescents, young people and high risk populations.

BCC - Zimbabwe launched the National Behaviour Change programme to reduce HIV transmission through behaviour change in 2006, and it has been extensively rolled out across the country. According to the UNAIDS World AIDS Report 2011, behaviour change interventions are one of the high priority high impact programs for Sub Saharan Africa. An impact study was conducted in Zimbabwe in 2010-11⁵⁰ comparing BC focus districts with BC non-focus districts. The findings supported the rationale for behaviour change programming to include multiple partner messaging by showing positive associations between programme exposure, knowledge/attitudes/self-efficacy, fewer non-regular partners and HIV status. The majority of adults report having at least some exposure during the period. There have been important and significant changes in knowledge, attitudes, norms and behaviours between 2007 and 2011, which are likely to have contributed to the decline in HIV prevalence over this period (and noted in various other national bio-behavioural surveys)⁵¹.

Community Systems Strengthening – Local reviews and studies have demonstrated important approaches to strengthen the community response, including establishing that home based care by community volunteers enables the continuum of care from the health facility to the community (ref: Looking Back, Mapping Forward – Research findings on Home Based Care, Irish AID & SAfAIDS). Support groups of people living with HIV have also enabled treatment adherence and improved quality of life for those affected and their families (Zimbabwe National Network of People Living with HIV – Annual Report 2011). An

⁴⁷ Halperin et al (2005) Acceptability of adult male circumcision for STD and HIV prevention in Zimbabwe. Sexually Transmitted Diseases, 32(4) 238-239

⁴⁸ Samkange C et al (2008) Male Circumcision – Report on the feasibility of MC Roll Out

⁴⁹ Gwinji G et al (2012) Randomized Clinical Trial on PrePex Device, unpublished

⁵⁰ National Behaviour Change Programme Surveys, University of Zimbabwe Department of Community Medicine, 2012

⁵¹ Gregson, S., et al., HIV decline in Zimbabwe due to reductions in risky sex? Evidence from a comprehensive epidemiological review. Int J Epidemiol, 2010. 39(5): p. 1311-23.

evaluation of the PMTCT programme in Zimbabwe baseline survey (preliminary results) also demonstrated that community mobilisation and education has enabled more women to access services and reduced defaulter rate of mother-infant pairs.

Health Systems Strengthening: Human Resource Support. There is increasing evidence that the retention scheme allowance, supported by Global Fund and more recently combined with the Health Transition Fund, has significantly impacted on improving the recruitment and retention of health workers in Zimbabwe’s public health institutions⁵². Annual retention rates for 2012 show a significant improvement in both doctors (75%) and nurses (96%) when compared to 2009 rates (before the retention scheme was introduced)⁵³. The GF Office of the Inspector General (OIG) report highlighted that failure to pay retention allowances directly impacts programme implementation and is likely to result in a loss of gains registered in this area. Zimbabwe is therefore requesting continued investment in this scheme in order to continue provision and enhance access to quality health services, with the intention of improving broad health outcomes as well as HIV-specific and other GF supported diseases (TB and malaria).

c) The proposed modules and interventions of the funding request in order of priority

Modules for implementation have been selected and prioritised from within the much wider scope of the ZNASP II (which addresses all the components of a holistic multisectoral response) based on the rationale described above. The modules have been prioritised through wide stakeholder consultation (see Section 1.3 of Concept Note), programmatic gap analysis (see Attachment 2 and section 3.1 of Concept Note) and emerging global and local data on their potential impact on Zimbabwe’s strategic goals of preventing new infections and keeping people alive. Availability of cost-effectiveness data at national and local level for decision making remains limited, although selection of these services is increasingly supported by global cost-effectiveness data.

The modules and interventions selected for inclusion in this request are as follows:

Module	Interventions	Amount in Original Application (April 2013)	Adjusted amount following grant making and including additional \$126m awarded (2014)
Treatment, care and support	Pre-ART	\$45,800	\$32,150
	ART	\$151,268,889	\$273,194,157
	Treatment Monitoring	\$9,991,160	
	Treatment adherence	\$1,493,100	\$773,000
	Community systems strengthening for specific HIV interventions	\$331,600	

⁵² DFID Zimbabwe Impact Assessment of Health Worker Retention Scheme 2012

⁵³ Zimbabwe Health Services Board Report 2012

	TB/HIV collaborative interventions	\$5,892,234	\$2,436,875
PMTCT	Prong 1: Primary Prevention of HIV infection among women of childbearing age	\$525,000	\$525,000
	Prong 2: Prevention of unintended pregnancies among women living with HIV	\$605,000	\$262,500
	Prong 3: Preventing vertical HIV transmission	\$7,534,180	\$119,650
	Prong 4: Treatment, care and support to mothers living with HIV and their children and families	\$1,247,000	\$344,000
Male Circumcision (“HIV other 3”)	Male circumcision (MC activities)	\$6,373,250	\$4,455,461
HIV Testing and Counselling (“HIV other 2”)	Other intervention (HTC activities)	\$6,908,026	\$15,186,237
Behaviour Change (“HIV other”)	Other intervention (BC activities)	\$1,601,050	\$6,405,645
HCSS: Community groups and networks	Advocacy, communications and social mobilisation	\$2,054,125	\$347,766
	Equity and enabling environment	\$1,168,450	\$2,105,715
	Health and other rights	\$389,500	\$21,840
HCSS: Procurement and supply chain management	Operationalisation of PSM system	\$1,026,512	\$1,648,133
	PSM infrastructure	\$8,409,177	\$22,427,353
HCSS: Health and community workforce	Retention of workforce	\$34,753,980	\$35,871,564
HCSS Information System	Routine reporting	\$230,000	\$497,900
M&E (HIV)	Analysis, review and transparency	\$1,178,040	\$1,298,060
	Routine reporting	\$16,899,168	\$14,624,864
	Surveys	\$1,250,000	\$386,633

Programme management (HIV)	Planning, coordination and management	\$50,000,000	\$54,071,898
Grand Total		\$311,175,241	\$437,036,401

Rationale for prioritisation

The Global Fund three-year investment in the proposed complement of interventions comprising ART, elimination of mother to child transmission and combination prevention services supported by HCSS effort will result in⁵⁴:

- Averting an average of 60,000 deaths annually among PLHIV
- Averting an average of 20,000 new infections annually in infants
- Averting about 5,000 deaths annually in children exposed to HIV

The country has made strident efforts and significantly expanded access to ART to current levels of around 95% of the treatment needs for adults (based on 2011 estimates and 2010 WHO ART guidelines). While paediatric ART has lagged behind at 42% and there is need to step up interventions targeting children, success in coverage has been largely due to the leadership of the Government of Zimbabwe and significant resource commitments from the National AIDS Trust Fund (NATF), the Global Fund, USG, DFID and other partners. However, it is critical to acknowledge that ART is treatment for life. Failure to provide regular ARVs can halt the decline in AIDS mortality in the country and result in development of HIV drug resistance threatening the individual, the community and the national programme at large. Maintaining people on ART is therefore both a programmatic and an ethical imperative. It is for this reason that ART is made the first priority in this request, especially given that the Global Fund is currently one of the largest funders of ART in the country.

As described in the preceding sections, Zimbabwe has seen steady decline in new HIV infections since the onset of the 21st century. This trend has been associated with increase in coverage of HIV prevention interventions such as behaviour change communication, testing & counselling and targeted services for some high risk groups such as sex workers. Zimbabwe would like to sustain this downward trend in new HIV infections by scaling up high impact interventions and ensuring greater focus of efforts on the most affected population groups. Zimbabwe has adopted the strategy of combination prevention to intensify efforts towards further reducing new HIV infections. Combination prevention refers to a systematic approach to implementing a range of HIV prevention interventions: behavioural (e.g. communication to promote reduction in the number of sexual partners) and biomedical (such as condoms and male circumcision), in synergy with structural interventions (for example, increasing girls’ access to education). In this request Zimbabwe is prioritizing the scale up of PMTCT, male circumcision, HIV testing and counselling and targeted behaviour change interventions. Efforts will be made in each of these priority areas to tailor the interventions to the requirements of the most affected populations groups.

In addition, the country has experienced major systems constraints in the delivery of services which have been largely resulted from the economic crisis that the country has been experiencing. The work of rebuilding health and community systems to ensure that there are able to support efficient and effective delivery of the HIV prevention, treatment and care services, will need to continue. This request includes efforts to strengthen health systems by ensuring availability of sufficient human resources, improved supply chain and adequate information systems to implement and monitor the HIV services.

C) Consolidated funding requests

Global Fund is one of the major investors in HIV (including ART and PMTCT) in Zimbabwe. HIV grants were awarded in Rounds 1, 5 and 8 and have contributed significantly to the country’s achievements in addressing HIV. The Round 8 grant awarded to Zimbabwe for

⁵⁴ Preliminary 2013 HIV Estimates, MOHCW

HIV has been implemented since 2010, with over 200 million USD disbursed by the end of 2012. Grant performance has also been strong, recording two A ratings and two B1 ratings in 2012. GF has contributed to HIV testing, counselling and provision of results to over 1.5 million people and to Zimbabwe's attainment of universal access to treatment in adults by September 2012 based on the 2011 HIV estimates, including direct support of ARV medicines for 203,440 patients (about 42% of patients currently on treatment in Zimbabwe) and ARV prophylaxis for 44,638 pregnant women living with HIV. A Round 8 Health Systems Strengthening grant has also provided critical support for retention of health workers that has enabled ambitious treatment and prevention targets to be met⁵⁵.

With the exception of MC, all modules for this application were included in the GF R8 grant. All of these modules will therefore be adapted and extended to maximise the impact of this new investment. Male circumcision will essentially be added as a new module from Round 8, as policy and programme strategy were not yet in place at the time of applying for Round 8 and activities of R8 implementation only included a small amount of mass media communications.

ART – Investments will be used to scale up treatment coverage and maintain existing patients on treatment. Paediatric ART will be scaled up to reach universal access. The intention in this request is to support 364,363 patients in 2014; 381,112 in 2015; and maintain same level of support through to sustain the level of attainment by 2016. The number of patients in need of treatment was adjusted to include HIV-positive pregnant women in the context of PMTCT Option B+. This will further contribute to reduction in AIDS mortality. This funding request is aimed at supporting further decentralization of HIV Care and Treatment services and integration of ART into primary health care from the current 61% of all health facilities in 2012 to 90% in 2016. Decentralization will help improve treatment access by bringing ART services closer to where patients live. However, mobile teams will continue to be supported by the National AIDS Council to offer outreach services to the hard to reach areas.

Current systems and structures for TB/HIV collaboration will be strengthened and maintained, with emphasis on intensified TB case finding and implementation of IPT for PLHIV following results of pilot study. The country will also implement an electronic patient monitoring system to address data quality and improve provision of care.

Quality of services will also be improved including through regular monitoring of ART patients, improving patient adherence and retention. The requested funding will support the capacitation of site staff, district, and provincial managers in utilizing quality monitoring indicators and tools and to identify interventions for quality improvement. The selected quality indicators are meant to address patient retention issues, patient adherence to treatment, CD4 monitoring and TB screening for PLHIV. Through this support, health workers will be trained using the Integrated Training approach to improve competencies and skills in HIV Management. Clinical Mentorship and attachment programmes will be supported by other funders including PEPFAR, UNICEF and EGPAF.

PMTCT - Zimbabwe has committed itself to the global goal of eliminating new HIV infections infants and children by 2015. The overall approach is to scale up the provision of quality and comprehensive PMTCT services, transition the provision of Option A to Option B+, improve the quality and scale up early infant diagnosis (EID) and early infant treatment (EIT) and attain the universal access. The PMTCT programme is currently receiving substantial support for programmatic activities, therefore requested support from GF will contribute to the procurement of commodities and programme activities to support the transition. PMTCT will also be used as an entry point for reaching women and men in stable unions and sero-discordant couples with HIV testing, couple counselling, behaviour change interventions and

⁵⁵ The Global Fund In Zimbabwe – 2012 In Review. United Nations Development Programme (UNDP) supported by the GFATM, 2012

treatment as prevention.

VMMC – Investments in VMMC will support the scale up of the national VMMC programme through procurement of VMMC kits, training and capacity building of health workers in the use of both surgical methods and devices. The New Funding model will support VMMCs in 17,800 in 2014 and 47,290 in 2015. Expansion of service delivery will be supported through outreach and static site support. Extensive demand creation is also included, given Zimbabwe's traditional status as a non-circumcising country. This funding request will contribute to an increase in the rate of male circumcision from the 2011/2012 level of 7% of males targeted to 73% by end 2016. This target is achievable considering the accelerated pace of scale up observed for other interventions when special effort is made. Zimbabwe has embarked on ambitious VMMC targets based on the current initiatives to reach more men through demand creation efforts and expansion of VMMC services. The expansion of services is anchored on the increased number of VMMC sites to all the districts countrywide with each district providing outreach services to sub-district levels. Further, the service expansion will be achieved through the broadening of scope of nursing practice to provide both surgical and device male circumcision services. Consultations with relevant regulatory authorities, (Nurses Council, Medical and Dental Practitioners` Council and the Health Professions` Council) are at an advanced stage. The effect of the all these initiatives is to increase availability and accessibility of male circumcision services. Male circumcision is another prevention intervention that will be used to reach males in stable heterosexual unions and discordant couples. They will also be provided with other services such as condoms, testing, counselling and behaviour change interventions.

HTC – In 2012, 2.2 million people were tested for HIV. This request seeks funding support to test a total of 2.7 million individuals by 2016. Expansion of the existing PITC model supported in R8 will continue, with capacity building and support of the Primary Counsellors. Testing and counselling will also be linked to other services such as PMTCT (aiming to cover as many ANC services as possible), couple counselling, male circumcision and for specific key populations. The assumption is that with increased demand creation for uptake of VMMC, PMTCT, ART services there will be increased uptake of HTC services as the entry point for prevention, treatment and care. This application will also place stronger emphasis on building capacity to undertake couple counselling which will help in identification and of sero discordant couples that will be linked to treatment, and counselling of children and adolescents.

BCC – The new GF investments will fill gaps in promotion of safer sexual practices and promotion of uptake of HIV services and commodities. This will complement efforts of other implementers involved in demand generation e.g. male circumcision and HTC. Interventions will focus on the general population and targeted interventions for specific populations, including sex workers to ensure that they have access to information and HIV preventions services. Young people will be targeted to receive messages with capacity building of School Health Masters in HIV prevention.

Behaviour change interventions will aim at reducing risk of HIV transmission and increase demand for other HIV services including VMMC, condoms (supported and distributed by PEPFAR). BCC interventions will be better tailored to needs of specific population groups, with priority being placed on males and females in stable unions (aim to integrate BCC into and cover as many ANC services as possible), young people (including schools), sex workers, men who have sex with men and people in prisons. In working with other key populations such as sex workers and men who have sex with men, efforts will aim at extending services to these population groups. Since these most-at-risk populations access services from the existing public facilities, healthcare workers will need to be trained to be more sensitive to the needs of these special groups.

The NAC is working with the Zimbabwe Prison Services, and with support from United Nations Office of Drug and Crime (UNODC) has developed a strategy for HIV and TB

prevention among people in prison settings. UNODC is committing USD 2 million to this programme which will include peer education, testing, counselling and HIV treatment.

Community Systems Strengthening will also be extended with a focus on community based advocacy, communications and social mobilisation, equity and an enabling environment and attention to health and other rights. Particular attention will be paid to ensuring that key populations, including MARPs, are informed of and have access to prevention, treatment and care services. This will be done through:

- Social and behaviour change communication and community outreach to key and most-at-risk populations
- Peer education
- Referral of key populations to existing services, including STI screening and treatment

Procurement and Supply Management: NatPharm is now focusing on providing procurement services of pharmaceuticals apart from storage and distribution functions. The funding and anticipated increase in revenue inflows (National AIDS Trust Fund) as well as annual allocations from the health budget will continue to support new and existing patients on treatment. Capacity of health staff at national and sub national levels will be strengthened through Inventory management trainings (including on-job), mentoring, and supportive supervision. NatPharm and 52 health facilities were assessed in relation to storage capacity and conditions for health commodities and capacity requirements identified. Storage and distribution of antiretroviral medicines will be decentralised to all the four NatPharm branch stores and the remaining 1,508 facilities will also be assessed and the identified areas for improvement will be supported through this proposal. The improvements will address issues of inadequate storage conditions at facilities.

The Health Workforce will be supported through continuation of the successful Health Worker Retention Scheme from the R8 Health Systems Strengthening grant. For this application the contribution of GF will be 60% of its current level (2013) in order to remain within budget allocations, applied to the same categories of staff (C5 and above).

Monitoring and evaluation will focus primarily on improving data quality and integration of the HIV/TB M&E into the routine national health information system. Critically, an Electronic Patient Monitoring System will be expanded across the country to high volume ART sites in order to strengthen monitoring and quality of patient care and treatment, and further analysis of outcomes.

4.2 Funding Request above the Indicative Funding Amount

Building on the applicant's funding request in 4.1, please describe and prioritise the funding request above the indicative amount, including:

- a. With reference to the country context, disease epidemiology and existing programs, describe the above allocation request. What are the **goals, objectives, impact and outcomes** you expect to achieve? In addition, describe the main programmatic and funding gaps the above allocation request will address.
- b. What the **additional proposed modules and interventions are in order of priority**. Explain the rationale for the selection and prioritization of interventions requested and how these are positioned for the highest impact. Please explain the budget amounts by year for each.
- c. Describe whether and how the above allocation request meets the Global Fund's focus of the funding requirement on **key populations** and/or **highest-impact interventions** (This question is not applicable for low-income countries).

- a. With reference to the country context, disease epidemiology and existing programs,

describe the above allocation request. What are the **goals, objectives, impact and outcomes** you expect to achieve? In addition, describe the main programmatic and funding gaps the above allocation request will address.

Many of the activities in this section are aligned to the country's initial request (April 2013) and will reduce Zimbabwe's current unfunded quality demand. However, given Zimbabwe's unique position as an early applicant, there are also some well-reasoned exceptions. New evidence and experience brought to bear during NFM rollout to-date warrants the inclusion of some additional incentive funding requests, particularly for programing targeting young people and key populations.

Zimbabwe's request for incentive funding is focused on high-impact activities in three strategic areas:

- (1) Laboratory and Pharmaceuticals**
- (2) Youth and Adolescent**
- (3) Community and Key Populations**

Based on lessons learned during nearly two years of NFM grant implementation, this request has been revised to reflect identified opportunities for increased efficiency, cost-saving and impact. These activities represent an opportunity to strategically invest minimal additional resources that will maximise the impact of the existing Global Fund grant. More critically, investment in these activities will provide a platform to demonstrate value, which will foster increased government and partner commitment to these programmes through the implementation of ZNASP III (2015-2018), creating a more sustainable HIV response.

The main objective of the incentive funding request is to **(1) improve quality of care** and **(2) reduce new infections among young people and key affected populations**.

Towards these objectives, there is a basis for a more highly prioritised response in light of the new National Strategic Plan (ZNASP III 2015-2018), the development of Zimbabwe's Investment Case, and the national hot-spot mapping (see Annexes C, D and E). Though closely linked to the current Global Fund programme, this request for funding has also been revised in line with these three documents, and Zimbabwe's aim to contribute to the 90-90-90 goals, fostering a more targeted approach aimed at increasing impact among high-risk populations in high-transmission areas. In short, this request is a deeper focus of the existing Global Fund NFM grant, informed by recent epidemiological and policy developments.

The Modules, interventions and activities include in this request for incentive funding are as follows:

Table 4.2.1: Overview of Revised Incentive Funding Request (in priority order)

Module	Intervention(s)	High-Impact Activity/Activities	Amount
Strategic Area 1: Laboratory and Pharmaceuticals			
Treatment Care and Support	Anti-retroviral Therapy	Pediatric ART	\$7,544,394.38
	Treatment Monitoring	Viral load testing, integrated sample transportation system, HIV test kits, other lab reagents, EQA, and HIV DR	\$11,946,683.04
Sub-total			\$19,491,081.42
Strategic Area 2: Youth and Adolescents			
Prevention programs for general population	Male Circumcision	PrePex, Surgical Kits and Consumables	\$5,919,368.00
Prevention programs for adolescents and youth, in and out of school	HIV Testing and Counselling	PC training; HTC campaigns for young people and adolescents	\$1,118,800.00
	Behaviour change	BCF capacity building to support community self-testing; BCF support on gaps; girls mentoring clubs; Peer-education (tertiary inst.); in-school sexuality education	\$2,007,140.00

	RMNCH Linkages and GBV	Training of HCW to provide adolescent-responsive integrated HIV/SRHR/GBV minimum package of services	\$150,000.00
Treatment Care and Support	Other interventions for treatment (adolescent adherence support)	Community adolescent treatment supporters (CATS) (Zvandiri model)	\$57,080.00
Prevention Programmes for Sex Workers and Their Clients	Other Interventions (evidence gathering for young sex workers)	Mapping Study to Inform Future Provision of Integrated SRHR Services to Young Sex Workers	\$750,000.00
Sub-total			\$10,002,388.00
Strategic Area 3: Community and Key Populations			
Prevention Programs for other vulnerable populations (people living with disabilities)	Other (social mapping)	Social mapping for people with disabilities living with HIV	\$40,600.00
	Behavioural change	Treatment literacy, peer-counsellors and social mobilisation strategy, sign language, sensitisation meetings.	\$1,320,875.00
Prevention Programs for MSM and TG	Behavioural change	Training of peer-educators for HIV-positive LGBTI community	\$60,375.00
Prevention Programs for other vulnerable populations (prisoners)	Behavioural change	Stigma reduction in prisons	\$37,745.00
Treatment Care and Support	ART	Community adherence refill support groups (CARGs)	\$625,188.00
Prevention Programmes for Sex Workers and Their Clients	Other (sex worker network strengthening)	Formalisation of the sex workers association, including trainings, exchange visits and micro-planning.	\$641,440.00
Sub-total			\$2,726,223.00
Overarching Strategic Area: M&E			
Health Information Systems and M&E	Routine Data Monitoring	Strengthening the current ePMS (LAN and power back-up); HIV data warehouse	\$3,673,524.00
	Surveys	Modes of Transmission; National AIDS Spending Assessment; Adolescents in-depth analysis	\$370,000.00
	Other (Linkages)	Information system linkages between community and HMIS	\$125,950.00
Sub-total			\$4,169,474.00
Programme Management	Grant Management	7% PR; 3% SR	\$3,594,823.94
Total			\$40,168,251.00

Further, there is a recognition that all intervention-based approaches need to begin streamlining towards delivering an integrated package of services, especially for young people. As such, there remains great scope for achieving additional gains, objectives and outcomes with incentive funding from the Global Fund as opportunities for efficient, innovative high-impact interventions have been refined in the last two years. A revised incentive funding budget has been developed and prioritised, totalling **US \$40,168,251.00**

Realisation of the incentive funding would thus contribute towards Zimbabwe's attainment of desired outcomes and contribute to the goals of reducing new infections and keeping people alive. The potential impact of the incentive investment will contribute towards:⁵⁶

- Averting 18,365 AIDS deaths
- Saving the lives of 3,336 children living with HIV
- Preventing 45,500 new HIV infections
- Reaching an additional 469,769 young people⁵⁷

Zimbabwe's Investment Case highlights the need to invest in these strategies now, to save money in the future. Given current cost structures, annual resource needs are projected to increase to nearly \$600 million/year by 2018, expanding to over \$700 million/year from 2023 onwards. However, a more prioritised high-impact response based on the kinds of

⁵⁶ Based on 2016 projections from 2013 HIV Estimates, MOHCC. (At the time of writing, 2014 estimates are still undergoing formal review). Online at <http://www.nac.org.zw/sites/default/files/Zimbabwe-National-HIV-and%20AIDS-2013%20Estimates.doc>

⁵⁷ Based on population estimates of 15-24 year olds in hot spots identified for youth interventions

interventions below could see resource needs stabilised at around \$550 million, if prevention gains and treatment and programme support efficiencies are realised.⁵⁸

- a. What the **additional proposed modules and interventions are in order of priority**. Explain the rationale for the selection and prioritization of interventions requested and how these are positioned for the highest impact. Please explain the budget amounts by year for each.

The prioritisation of intervention areas remains in alignment with the original application from April 2013. Under each intervention area, the updated activities have been described.

ART

Priority 1: Paediatric ART (\$7,544,394.38)

Paediatric ART coverage lags significantly behind adult ART in Zimbabwe. There are approximately 133,520 children (0-15 years) living with HIV in Zimbabwe, of which 107,771 will be in need of antiretroviral therapy in 2016.⁵⁹ Where the previous request for incentive funding prioritised treatment for discordant couples, recent changes in the funding landscape in Zimbabwe means that there will be a gap in paediatric ART come 2016, intensifying the current crisis where only 46.12% of children in need are receiving treatment.⁶⁰ Other evidence suggests this estimate may even be too high, with one provincial study showing that as few as 25% of HIV-positive children in Zimbabwe are aware of their status, and just 23% of those who did were enrolled on treatment.⁶¹ The MOHCC Bottleneck Analysis also shows coverage is highly uneven, and as low as 10% in some districts.

Zimbabwe has embraced recent global initiatives like the Double Dividend, All In and ACT. These initiatives focus on children from 0-19 years and most of the activities under these initiatives focus on demand creation for HIV treatment and care for children and adolescents. The results of the recent evidence from the Bottleneck Analysis conducted by the MOHCC, show that parents and guardians are not always informed of the importance of testing children. However, demand must also be met with the ability to treat those in need. The bottleneck analysis also points to issues associated with lack of decentralisation for distribution of medicines as a key challenges related to low paediatric treatment coverage. In addition, sample transportation challenges are noted to contribute to the problem in Bottleneck Analysis. Further, the 2012 Rapid Paediatric ART Assessment in Zimbabwe cites limited linkage between EID and ART and centralised PCR testing as critical issues related to low treatment coverage.⁶² The country acknowledges these challenges associated with paediatric ART coverage, which is why this request for medicines is also paired with a request to pilot an innovative sample transport system for EID results (see Priority 2 under Lab Support below), which will improve diagnostic capacity and linkages to care for children. Incentive funding is requested to support providing ART to 86,345 children (based on national target of 80% coverage) as a top priority. This request complements the approved reprogramming of savings (\$7 million) from existing Global Fund grants to support paediatric treatment for the first six months of 2016, with this request covering the latter six of the year. This intervention is a paramount priority because it has the potential to make

⁵⁸ National AIDS Council and UNAIDS (March 2015). Briefing note: resource availability and needs for the HIV Response in Zimbabwe.

⁵⁹ Based on 2016 projections from 2013 HIV Estimates, MOHCC. (At the time of writing, 2014 estimates are still undergoing formal review). Page 17 and 32. Online at <http://www.nac.org.zw/sites/default/files/Zimbabwe-National-HIV-and%20AIDS-2013%20Estimates.doc>

⁶⁰ Government of Zimbabwe (2014). Global AIDS Response Country Progress Report. Page 3. Online at http://www.unaids.org/sites/default/files/country/documents/ZWE_narrative_report_2014.pdf

⁶¹ Pufall, E. L., Nyamukapa, C., Eaton, J. W., Mutsindiri, R., Chawira, G., Munyati, S., ... & Gregson, S. (2014). HIV in Children in a General Population Sample in East Zimbabwe: Prevalence, Causes and Effects. *PloS one*, 9(11), e113415.

⁶² UNICEF & WHO (2012). Rapid Pediatric ART Assessment in Zimbabwe. October 2012.

the biggest impact in terms of lives saved, averting an estimated 3,336 AIDS-related deaths among children in 2016.⁶³

Recognising sustainability challenges, the Government of Zimbabwe has made concerted efforts to increase local revenue for paediatric ART. Based on the 2015 budget, the AIDS Levy will be expanded to include the mining sector, bringing in additional domestic resources which can be directed towards this area. Additionally, it is important to note that the country is also pursuing discussions with CIFF (Children's Investment Fund Foundation) towards mobilising resources for paediatric ART. In the event that paediatric ART can be supported by CIFF, this request for incentive funding will proceed with Viral Load Testing (next priority below) as the top priority intervention in the application.

Laboratory Support towards monitoring PLHIV on ART

Priority 1: Viral Load Testing (\$2,766,600)

The ART programme has prioritised strategic use of laboratory services for patient monitoring in addition to clinical monitoring of patients on treatment. The previous above allocation request focused heavily on CD4 count tests, requesting support for six monthly CD4 tests for 50,000 patients (2014), 75,000 patients (2015) and 150,000 patients (2016), with mention of the country's intention to begin phasing in viral load (VL) testing. Since then, evidence has emerged that viral load testing is a cost-saving measure in terms of CD4 monitoring, reducing expenditure by approximately 30%. Based on realised efficiencies in VL testing over the last two years, and strategic VL planning by government, this incentive funding request has been amended to reflect this updated focus.

The MOHCC's effort to phase in viral load testing to monitor the ART response has demonstrated significant potential. The VL algorithm is aligned to the 2013 WHO guidelines, and is now steered by the country's new Viral Load Implementation Plan (2015-2017) (See Annexe H). Ambitious targets have been set. The plan aims to achieve 21% coverage (213,709 VL tests) in 2015, 50% coverage (577,990 tests) in 2016, and reach 90% coverage (871,008 tests) by 2017.

Incentive funding will be used towards maximally using the existing VL testing machines, recognising that additional resources are required to reach the targets in the plan. Acknowledging these constraints, funding is requested to procure the reagents needed to perform an additional 83,439 viral load tests in 2016 (\$2,002,536). Current resources exist to perform 174,940 tests in 2016, and efforts to mobilise resources for the VL Implementation Plan are still ongoing. Incentive funding will also be used for leasing/buying six viral load machines at provincial laboratories (\$600,000). Lastly, incentive funding will contribute towards retaining six lab scientist and four data officers to do the VL tests (\$164,064).

Priority 2: Innovative Sample Transport System (\$440,072)

The previous request focused on scaling up of the GPRS system for expedited delivery of DNA PCR results to facilities; improvement of the current sample transportation system. In this revised request, incentive funding will support the development of an innovative integrated transport system of samples, to combine EID and viral load specimens and results to maximise efficiency and reduce transport costs. Evidence shows that many children born with HIV are only diagnosed in their teenage years, indicating a delay in diagnosis of more than decade and highlighting the gross inadequacies of current HIV case-finding strategies among children.⁶⁴ This request also addresses this through an innovative EID sample transport system, to improve early detection among children

⁶³ Based on 2016 projections from 2013 HIV Estimates, MOHCC. (At the time of writing, 2014 estimates are still undergoing formal review). Page 22. Online at <http://www.nac.org.zw/sites/default/files/Zimbabwe-National-HIV-and%20AIDS-2013%20Estimates.doc>

⁶⁴ Shroufi, A., Ndebele, W., Nyathi, M., Gunguwo, H., Dixon, M., Saint-Sauveur, J. F., ... & Ferrand, R. A. (2015). Risk of death among those awaiting treatment for HIV infection in Zimbabwe: adolescents are at particular risk. *Journal of the International AIDS Society*, 18(1).

(\$200,000). Based on an evaluation done by PEPFAR on the Ministry's integrated transport system, this request has been updated to reflect the country's intention to include both the design and the piloting of the integrated system (transporting all EID, VL and TB samples to district level) in some sites, while at the same time maintaining the existing transport system for combined VL/EID sample transportation. Incentive funding will also be used for Fedex of VL/EID samples (\$240,072). The reason for this priority is based on maximising existing investment and efforts of sample transportation. The MOHCC acknowledges the Global Fund support of 75 motorcycles to the existing infrastructure of collecting samples from the over 1500 health facilities in the country. They assist in the delivery of the samples and results to the 276 Fedex collection sites. This funding request for Fedex delivery will reduce sample turnaround time, enhancing the efficiency of the existing Global Fund-supported programme and improving quality of services. Further, incentive funding will be used for piloting a more integrated and cost-effective sample transport system, including other samples (TB).

Priority 3: Other lab reagents, EQA, and HIV DR (\$8,740,015.04)

A quantification and forecasting exercise for laboratory commodities required for the HIV programme was conducted in 2014, well after the signing of the HIV NFM grant. This exercise revealed a gap between the forecasted and budgeted volumes in the grant and the real requirements on the ground. Additional funding then covered part of the gap at the end of 2014. The functionality of the Zimbabwe Laboratory Commodities Distribution system depends highly on commodity availability, hence the revised request in this area. Further, there are a number of reagents and diagnostics which are needed in parallel with other interventions prioritised in this application.

First, POC Cartridges and EID reagents are necessary in tandem with the pediatric ART intervention (\$2,545,649.60). CD4 reagents are needed in order to ensure accurate treatment initiation and treatment efficacy for PLHIV while VL scale-up is still ongoing (\$1,058,780). Rapid HIV test kits are critical in order to leverage the opportunities of community demand creation campaigns (i.e. DREAMS), especially for populations which have been under-targeted to date (such as young people and key populations) (\$2,566,665.62). Syphilis test kits are required as part of the comprehensive package of HIV/SRHR services to be delivered to young people at tertiary institutions and at community level (\$866,524.82).

Global scale-up of ART will inevitably be accompanied by the emergence of HIV DR, as has been observed in countries where antiretroviral therapy is routinely utilised. There is therefore a need to upgrade the HIV drug resistance equipment at the National Microbiology Reference Laboratory from a 6 capillary ABI 3130 Genetic analyser to a 3130XL, 16 Capillary in order to increase the testing capacity to cover 10% failing patients (\$200,000). This will help inform decisions around changing patients on ART to the more expensive second or third line drugs, and will assist the institution in getting the much needed accreditation as a centre of excellence for managing ART failures and patient switching. HIV drug resistant reagents must be available alongside community efforts to improve adherence, both among adults and adolescents (\$60,000). Biochemistry Reagents, Haematology Reagents and Microbiology/Serology reagents complement existing efforts to deliver quality treatment and care (\$558,608).

Lastly, the routine tests being carried out throughout the public health laboratory network needs to be monitored in terms of quality. This safeguards the quality of results and helps provide remedial action to labs facing challenges. As such, this request includes support for laboratory EQA, which forms a back-bone of quality testing as it provides a way of monitoring laboratory tests being used for ART, i.e. CD4, FBC and chemistry, to make sure correct results are given to clients leading to correct diagnosis and treatment (\$329,840). There is a need to replace four MCAZ quality assurance machines (and procure relevant reagents), two of which are past their 10-year warranty and experience frequent breakdowns (\$553,947).

VMMC

Priority 1: PrePex, Surgical Kits and Consumables (\$5,919,368)

Procurement of the PrePex device has emerged as opportunity to enhance current investments in outreach teams to allow service delivery in geographically remote areas as services reach saturation point around static sites. In 2016, Zimbabwe aims to circumcise 291,538 males, but recent developments indicate the current support will be reduced to cover 33 out of the previous 64 supported districts (approximately 103,000 circumcisions). The country will continue to resource mobilize to support this gap, however for this incentive funding, incentive funding is requested to cover cost for PrePex devices (\$1,504,000) and related PrePex consumables (\$797,872), as well as surgical devices (\$2,222,160) and related consumables (\$1,395,336). With this investment, the country will be able to achieve a total of 188,000 circumcisions (75,200 PrePex, 112,800 surgical), significantly contributing towards the ambitious targets set in the MOHCC's Accelerated Strategic and Operational Plan on VMMC (2014-2018) (see Annexe G). This will be rolled out strategically and targeted in Manicaland and Matabeleland South, which have been identified as priority areas for young people in the hotspot mapping.⁶⁵ The rationale for the prioritisation of this activity is based on robust impact modelling which shows that the VMMC Plan will result in 212,000 infections averted by 2025, an additional 3% reduction in HIV prevalence. Further, the achieved target of circumcising 1.3 million men is an investment that is estimated to result in more than \$1 billion in financial savings.⁶⁶ This intervention complements the existing Global Fund programme which is already supporting VMMC for the general population (and through PrePex procurement). However, given evidence of the very low levels of MC among young men (only 5% of adolescent boys have been circumcised – see Table 2.1.3), as well as persistent levels of HIV prevalence among this age group (plateau of 4.1% among young men 15-24 since 2007) VMMC as an intervention has been re-prioritised to focus on younger men (18-29 years old), in line with the VMMC Accelerated Strategic and Operational Plan.

Integrated HTC

Priority 1: Training and support for PCs (national programme) (\$718,800)

Incentive funding will go towards training 150 primary counsellors (PC) and retaining them to provide quality counselling HTC, male circumcision, adherence counselling for ART, child counselling and for eMTCT as the country rolls out Option B+. Refresher courses for PC supervisors will also be included for continued quality assurance.

Priority 2: Accelerated Provision of Non-Facility Based HTC for Young People (\$840,060)

Closely linked with Priority 1, incentive funding will support provision of a comprehensive HTC package including condom provision, family planning, and IEC through different approaches including outreach (conducted by health facility staff, integrated with existing outreaches), testing campaigns and service provision in tertiary institutions. This intervention will cover the existing gaps in the 35 districts, including demand generation (\$28,080), training (\$210,180), printing and ID material (\$151,800) and transportation (bicycles) (\$450,000) gaps. This will complement the existing investment through which the Global Fund supported once-a-year campaigns in all ten provinces. With incentive funding, these campaigns will be translated into uptake of services with a strong focus on attracting young people in specific hot spots according to the mapping.

BCC

Priority 1: Capacity Building of Behaviour Change Facilitators (BCFs) to Provide

⁶⁵ MoHCC, NAC, CDC, UNAIDS & WFP (2015). Smart Investment to End HIV AIDS in Zimbabwe based on Hotspot Analysis. Page 13. Online at <http://www.nac.org.zw/sites/default/files/Hot%20spot%20Mapping%20Report.pdf>

⁶⁶ Ibid. p. iv.

Comprehensive Adolescent-Responsive Services, Including Youth Self-Testing (\$569,590)

Incentive funding will also go towards training of 1,000 existing behaviour change facilitators (BCFs) to provide counselling and support at community level for young people who wish to self-test (\$169,590), as well as provide training materials (\$14,750). The need for the focus on self-testing is based on evidence which shows that in a recent cohort study among adolescents in Zimbabwe, it was found that most adolescents underwent HIV testing following an HIV associated illness, with far fewer accessing HIV testing through VCT services compared to adults (3.3% vs. 18.2%).⁶⁷ Further, evidence from the MICS (2014) survey shows testing rates among female 15-19 years is higher (49%) than among adolescent boys (24%), indicating the need to potentially focus and target home self-testing accordingly.⁶⁸ The prioritisation of BCFs to support adolescent-responsive community based HIV testing and Counselling which includes self-testing as experience to date shows that community-level support is a key opportunity to reach more young people, especially through a community based approach. Of note is that self-testing is being piloted in the country and the pilot and rollout is supported by NIH and UNITAID and this support includes the self-test kits. The previous request noted that new innovations like self-testing will be piloted with support from the incentive funding and will inform policy development followed by national scale up of self-testing. The incentive funding is requested to also support a 10-day HTC campaign once a year to generate demand among adolescents and youth in each of the 20 target districts (\$400,000).

Priority 2: Girls Mentoring Clubs (\$450,190)

Incentive funding is requested to train an additional 10 BCFs per each of the 20 target district (identified for young people, based on hotspot mapping). Each BCF will run two girls mentoring clubs for vulnerable girls age 10-19, with a curriculum of 40 sessions/year covering a life skills approach and broader support for health and personal development (diary and journal keeping). They also promote peer-led integrated HIV/SRHR BCC among young women, including condom promotion, broader SRHR and GBV information. The rationale for this intervention is ground in evidence which shows that in Zimbabwe, 56% of HIV-positive adolescents reported psychosocial problems due to lack of support structures.⁶⁹ There is also emerging evidence that these kinds of mentoring club programmes for young girls are effective at reducing risk behaviours to prevent HIV. A systematic review showed that the frequency of protected sex increased by 19% as a result of peer-group education on HIV risk reduction.⁷⁰ Evidence from the SHAZ! Project in Zimbabwe, which includes gender-focused HIV education, guidance counselling and integrated social support for adolescent girls, shows that young women in the intervention arm (as compared to the control) showed statistically significant reductions in risk of transactional sex as well as significant increases in the likelihood of using a condom with their current partner.⁷¹ Further, a recent systematic review (including programmes from Zimbabwe) found that interventions which include aspects of gender or power were five times more likely to be effective than those which do not. Of those which did include gender or power, 80% of them were associated with a significantly lower rate of sexually transmitted infections. In contrast, among the programs that did not address gender or power, only 17% had such an association.⁷² This review provides strong rational for including girls mentoring clubs which address these issues.

⁶⁷ Shroufi, A., Ndebele, W., Nyathi, M., Gunguwo, H., Dixon, M., Saint-Sauveur, J. F., ... & Ferrand, R. A. (2015). Risk of death among those awaiting treatment for HIV infection in Zimbabwe: adolescents are at particular risk. *Journal of the International AIDS Society*, 18(1).

⁶⁸ ZIMSTAT (2014) Multiple Indicator Cluster Survey: Key Findings Report. Online at

<http://www.zw.one.un.org/resources/publication/2014-multiple-indicator-cluster-survey-mics-key-findings-report>

⁶⁹ Ferrand RA, Lowe S, Whande B, Munaiwa L, Langhaug L, et al. (2010) Survey of children accessing HIV services in a high prevalence setting: Time for adolescents to count? *Bull World Health Organ* 88(6): 428–434.

⁷⁰ Salam, R. A., Haroon, S., Ahmed, H. H., Das, J. K., & Bhutta, Z. A. (2014). Impact of community-based interventions on HIV knowledge, attitudes, and transmission. *Infectious diseases of poverty*, 3(1), 26.

⁷¹ Dunbar, M. S., Dufour, M. S. K., Lambdin, B., Mudekunya-Mahaka, I., Nhamo, D., & Padian, N. S. (2014). The SHAZ! Project: Results from a Pilot Randomized Trial of a Structural Intervention to Prevent HIV among Adolescent Women in Zimbabwe. *PLoS one*, 9(11), e113621.

⁷² Haberland (2015) The Case for Addressing Gender and Power in Sexuality And HIV Education: A Comprehensive Review Of Evaluation Studies.

With incentive funding it will be possible to reach an additional 10,000 vulnerable girls, who face HIV risk related to running child-headed households, GBV, child-marriage, early pregnancy, etc. This investment will complement existing efforts under the UNFPA's ISP programme (sista2sista clubs) which is a sub-component of the BCFs initiative. Since then, resources for development of a youth-centred home-visit approach curriculum have already been secured, and this request is for roll-out to train 1,430 BCFs in 20 districts in a youth-targeted home visit approach. Again, this training will focus on an integrated package of services for young people, with condom promotion and other SRHR information accompanying home testing support.

Social media is also a key component of reaching young people. However, recent data from ZIMSTAT's Multiple Indicator Cluster Survey (2014) show that only 21.6% of young women (15-24) and 30.8% of young men used the internet in the last twelve months.⁷³ For this reason, it is recognised community-based BCF outreach is a more strategic approach at this time.

Priority 3: & Peer-Education in Tertiary Institutions and Community Level (\$201,300)

Combination prevention and creating demand for increased access to services is the key for successful HIV prevention. The rationale for this priority is related to preliminary data from the 2015 GARPR which shows that incidence may have risen in 2014 for the first time since 2011 (from 0.98 in 2013 to 1.1 in 2014).⁷⁴ Complementing existing initiatives around mass media (led by PSI and SAT), incentive funding will be used to conduct interpersonal communication BCC through peer-educators (18-24) in tertiary institutions and at the community level. Incentive funding is requested to train 100 peer educators across four tertiary institutions and equip them with the same standard package as the BCFs. Through the youth hotspot mapping, eight of the 20 districts have been identified for intensive efforts for this intervention.⁷⁵

Demand creation for VMMC among young men will be a key component of this peer-education intervention. While HIV prevalence among the general population is projected to be falling, prevalence among young men is projected to be on the rise (4.06% in 2013, 4.07% in 2014, and 4.11% in 2015). Further, the Hotspot Mapping highlights recent evidence of STI increases among youth.⁷⁶ The rationale for this intervention is based on these rising statistics, and also in response to the Mid-Term Review of ZNASP II, which registered a decrease in the number of young people exposed to HIV and AIDS education from 276 814 in 2011 to 139 315 in 2012. The MTR also noted a decrease on the number of peer educators who were active in 2012 (13 520) compared to 2011 (19 666) due to inadequate funding.⁷⁷ For these reasons, peer-education for young people has been prioritised for incentive funding.

Priority 4: In-school Sexuality Education for Primary and Secondary Students (\$346,000)

The MoPSE has developed teacher's manual for implementing the Guidance and Counselling Programme to Strengthen the Life Skills, Sexuality, HIV and AIDS Education in Zimbabwe. The manual aims at providing information and methodologies for equipping teachers with age appropriate, culturally acceptable and comprehensive knowledge on life skills, sexuality, HIV and AIDS education. The education is intended to instil positive values of *unhu/ubuntu*, attitudes and responsible behaviour among the 4 million learners in Zimbabwe. Through the manual teachers should be able to provide the learner with up-to-date, correct and relevant information related to Life Skills, Sexuality, HIV and AIDS

⁷³ ZIMSTAT (2014) Multiple Indicator Cluster Survey: Key Findings Report. Online at

<http://www.zw.one.un.org/resources/publication/2014-multiple-indicator-cluster-survey-mics-key-findings-report>

⁷⁴ Government of Zimbabwe (2015). Global AIDS Response Country Progress Report. Page 5. Not yet published.

⁷⁵ Bindura, Gwanda, Hwange, Lupane, Makonde (Chinhoyi), Matobo, Mutasa and Nyanga.

⁷⁶ MoHCC, NAC, CDC, UNAIDS & WFP (2015). Smart Investment to End HIV AIDS in Zimbabwe based on Hotspot Analysis. Online at <http://www.nac.org.zw/sites/default/files/Hot%20spot%20Mapping%20Report.pdf>

⁷⁷ ZNASP II Mid-Term Review (October 2013). Pg. 22.

Education. The manual also provides the teacher with suggested methodology and media in the teaching of Life Skills, Sexuality, HIV and AIDS Education. Ensuring the success of this existing investment, incentive funding is requested to train the school health teachers in order for them to effectively deliver the Life Skills, Sexuality, HIV and AIDS Education to learners under their care. This will be implemented in 20 focus districts for youth interventions.

Priority 5: Behaviour Change Programmes for Key Populations (Excluding Sensitisation of HCW) (\$106,120)

Incentive funding will go towards a social mapping on people with disabilities (PWD) and HIV, particularly seeking to establish robust national data on *young* people with disabilities (\$8,000). The results of the 2013 Living Conditions Among Persons with Disability Survey show that young people (up to age 20) have significantly higher activity limitations than do adults living with disability.⁷⁸ As a result, they may face additional challenges in accessing health services. These barriers need to be better-understood, and incentive funding will be utilised accordingly. Incentive funding will also go towards community dialogues, peer-education and IEC among MSM (\$60,375). Recognising that condom and lubricant procurement and promotion for MSM are part of the existing Global Fund support to Zimbabwe, recent challenges with procuring 54mm condoms over 53mm ones led to changes in price and quantity, which informs this revised request. Among prison populations, recent evidence from the December 2014 PLHIV Stigma Index in Zimbabwe shows that 100% of prison inmates surveyed reported experience stigma and discrimination.⁷⁹ Further, recent evidence from The Zimbabwe Prisons and Correctional Service (ZPCS) shows that HIV prevalence in prisons is nearly twice as high as in the general population (39% for female prisoners and 26.8% for male prisoners).⁸⁰ As such, treatment literacy, adherence and stigma reduction among prisoners will be addressed (\$37,745). Support and M&E from the SR will be critical for these interventions. This will work in tandem with existing Global Fund support for 180 support groups for prisoners living with HIV in 72 prisons, and awareness campaigns to stimulate demand for services. Without stigma reduction (the need highlighted in the recently published Stigma Index), the success of these other programmes will be hampered.

Priority 6: Mapping Study to Inform Future Provision of Integrated SRHR Services to Young Sex Workers (\$750,000)

Building on the existing Sisters with a Voice programme, this priority intervention will bring focus to young key populations, especially given recent evidence from the Sisters with a Voice programme which shows the acute relationship between number of transactional sex partners and rising HIV prevalence among a nationally representative sample of 18-24-year-old sex workers in Zimbabwe (see Figure 2.1.2 in Section 2.1). Further, the focus on young sex workers is rooted in recent evidence which shows that the overlapping experience of being an adolescent and a sex worker shaped young women's health and access to services in Zimbabwe.⁸¹

Community Systems Strengthening

Priority 1: Establish community adolescent treatment supporters (CATS) (\$57,080)

Based on the successes of the community-based Zvandiri model (Shona word meaning "As I Am"), developed by Africaid, incentive funding is requested to go towards an approach which coordinates and links community adolescent treatment supporters (CATS) to provide youth-led adherence monitoring and counselling. CATS are HIV-positive adolescents who

⁷⁸ Ministry of Health and Child Care (2013). Living Conditions Among Persons with Disability Survey: Key Findings Report. Online at [http://www.unicef.org/zimbabwe/National_Survey_on_Disability_2013\(1\).pdf](http://www.unicef.org/zimbabwe/National_Survey_on_Disability_2013(1).pdf)

⁷⁹ ZNNP+ (December 2014). The Zimbabwe People Living with HIV Stigma Index. Online At <http://www.stigmaindex.org/zimbabwe>

⁸⁰ Mugurungi, O. (2013). HIV wreaks havoc in Zimbabwean prisons (Originally Published in The Standard). Ministry of Health and Child Care. Online at <http://bulawayo24.com/index-id-news-sc-national-byo-30096.html>

⁸¹ Busza, J., Mtetwa, S., Chirawu, P., & Cowan, F. (2014). Triple jeopardy: Adolescent experiences of sex work and migration in Zimbabwe. *Health & place*, 28, 85-91.

become peer mentors and counsellors to other children, adolescents and young people living with HIV. The funding will support the training and retention of 40 CATS (20 in Mat South and 20 in Manicaland). The innovative and cost-effective model has proven its ability to reach over 5000 HIV-positive adolescents (in 2014), through 30 community support groups and 60 CATS. Incentive funding will go towards training an additional 40 CATS (\$33,080) and retaining them through monthly allowances (\$24,000), reaching thousands more vulnerable HIV-positive adolescents with important support on treatment literacy, adherence, and broader integrated SRHR information. The rationale for this priority is based on documented evidence from Zimbabwe which clearly highlights the importance of peer-support among HIV-positive adolescents.⁸² In that study, it was documented that many adolescents did not learn much when they were first told about being HIV-positive. Instead, most turned to support from peers to share experiences and learn about HIV/AIDS. In addition, there is direct evidence which shows that the wider psychosocial support provided to adolescents through the Zvandiri model in Zimbabwe is associated with improved adherence to ART among young people in Zimbabwe.⁸³ This intervention complements the existing Global Fund investment to conduct awareness campaigns targeting adolescents LWHIV [1000 x 10 provinces] done through ZNNP+. Building on these awareness campaigns, support for the Zvandiri model will empower adolescents living with HIV to support others in their communities and to improve adherence among young people. Comprehensive peer support must be available for those made aware of their risk and/or status through the existing campaigns. This will improve the linkages to care as well as retention.

Priority 2: Establish community adherence refill support groups (CARGs) (\$625,188)

Incentive funding will go towards improving adherence through establishing community adherence refill support groups (CARGs) in 20 hard to reach districts in 8 rural provinces. The following 5 districts have already been identified and consultations are on going to identify the remaining 15 districts. These include Beitbridge, Plumtree, Victoria Falls, Kariba, Mbire and Mudzi districts. CARGs are comprised of seven-ten people who take turns traveling to facilities to refill ARV prescriptions for the entire group. The community models of care are a way to simplify treatment access, with the primary goal of CARGs being improved patient retention on ART. CARGs have emerged as a viable way to reduce the cost-burden of ART refills, limiting access-related adherence challenges and maintaining more people on first line treatment. Recently documented evidence from UNAIDS and NAC on the impact of CARGs in Zimbabwe shows significant gains in efficiency and health outcomes. Each CARG saves its group members approx. \$128/year in travel costs and 570 hours of time. Each CARG also saves approximately 150 hours/year of health care worker time. In addition to time and cost savings, there is promising evidence from the monitoring pilot for improved treatment adherence. The 9 months pilot phase review done in 2014 in Gutu District showed that there was 100% retention in CARGs after 9 months of follow up. They had good virological suppression with 99% of patients eligible for viral load testing being below the threshold of 1000 copies/ ml. No loss for follow up was recorded and there were no patients returning to individual care.⁸⁴ Incentive funding for CARGs will build on existing efforts by government and partners (MSF) which have initiated the formation of 65 CARGs in nine rural health facilities in Buhera district. Though the groups are self-forming, incentive funding go towards supporting 16 CARG leaders in five districts, to be trained on record keeping and documentation.

Priority 3: Support Network Formalisation and Capacity Building for Sex Worker Association (\$707,315)

Sex workers in Zimbabwe have recently gathered significant momentum towards organising

⁸² Kidia, K. K., Mupambireyi, Z., Cluver, L., Ndhlovu, C. E., Borok, M., & Ferrand, R. A. (2014). HIV Status Disclosure to Perinatally-Infected Adolescents in Zimbabwe: A Qualitative Study of Adolescent and Healthcare Worker Perspectives. *PLoS one*, 9(1).

⁸³ Mavhu, W., Berwick, J., Chirawu, P., Makamba, M., Copas, A., Dirawo, J. & Cowan, F. M. (2013). Enhancing psychosocial support for HIV positive adolescents in Harare, Zimbabwe. *PLoS one*, 8(7), e70254.

⁸⁴ UNAIDS & NAC (2015). "Bringing Treatment Closer to Home": Community Antiretroviral Therapy – experiences and lessons learned for scaling up in Zimbabwe. Second Draft – 11 May 2015.

and formalising their networks. Support through the Sisters with a Voice programme (implemented through CeSHHAR with support from UNFPA) has jump-started the formation of a nascent sex worker association called Women Against All Forms of Discrimination (WAAD). The Sisters with a Voice programme is an example of successful community empowerment-based scale-up that is now present in 36 sites in Zimbabwe. Along with sustained resources the country recognises that strategies which address social and structural determinants are needed for maximum prevention effect.⁸⁵ This intervention will catalyse the existing Global Fund which established 260 support groups for sex workers living with HIV and trained 20 people in each province as sex worker peer educators. With network formalisation, these gains can be solidified in a sustainable way, as sex worker will be better placed to advocate for improved service delivery and legal and policy change going forward.

With further support from the Global Fund NFM grant for sex worker peer-education (through NAC), WAAG has recently galvanised to formalise their association and build peer-led capacity and with an aim to become a registered trust in the near future. With incentive funding, the country will build the capacity of sex workers to deliver peer-led outreach, research and advocacy. This request is based on emerging evidence that strong community systems and strong networks for key populations significantly improve health outcomes for these groups in the context of HIV. A recent qualitative study found that strong and functioning networks for key populations were a vital source for accessing information about HIV.⁸⁶ Further, a 2014 systematic review of community responses to HIV among key populations (including sex workers) found that strong network characteristics (including social support, social cohesion, participation and inclusion) were significant determinants of health for these groups.⁸⁷ Further evidence shows that strong a supportive network and peer support for sex workers are associated with willingness of sex workers to engage in testing, care, treatment initiation, as well as adherence.⁸⁸ This is highly important given that studies show only 30–40% of sex workers who are eligible for ART were actually accessing treatment and that fewer than a quarter of those who are HIV-negative reported testing in the previous 6 months.⁸⁹

The amount requested will be dedicated towards two participatory meetings to consult and build the vision for the WAAG Strategic Action Plan (looking to 2018) (\$32,500) and towards developing a strategic action plan and a resource mobilisation plan for the sex worker association (\$33,375). The funding will also go towards general network support, including a leadership programs for sex workers, capacity building on organisational development and management training (\$641,440). As a pilot, Gweru, Bindura and Masvingo will be considered for entry points to set up hubs.⁹⁰ This intervention has synergies with regional Global Fund programming with the Hivos-led KP REACH initiative, which seeks to strengthen regional sex worker networks to support associations at the national level. . Support and M&E from the SR will be critical for these interventions.

Health Workforce

Priority 1: Training of healthcare workers to provide adolescent-responsive integrated HIV/SRHR/GBV service to young people (\$150,000)

Linked with Priority 1 under the Integrated HTC component, training of healthcare workers

⁸⁵ Bekker, L. G., Johnson, L., Cowan, F., Overs, C., Besada, D., Hillier, S., & Cates, W. (2015). Combination HIV prevention for female sex workers: what is the evidence?. *The Lancet*, 385(9962), 72-87.

⁸⁶ Schneiders, M. (2014). Values and preferences of transgender people: a qualitative study. *World Health Organization*. Online at http://apps.who.int/iris/bitstream/10665/128119/1/WHO_HIV_2014.21_eng.pdf?ua=1

⁸⁷ Baral, S., Holland, C. E., Shannon, K., Logie, C., Semugoma, P., Sithole, B. & Beyrer, C. (2014). Enhancing Benefits or increasing harms: community responses for HIV among men who have sex with men, transgender women, female sex workers, and people who inject drugs. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 66, S319-S328.

⁸⁸ Brown B, Dube Z, Bekker LG. Sex workers: an introductory manual for health care workers in South Africa. Cape Town, South Africa: Desmond Tutu HIV Foundation, 2012.

⁸⁹ Cowan FM, Mtetwa S, Davey C, et al. Engagement with HIV prevention treatment and care among female sex workers in Zimbabwe: a respondent driven sampling survey. *PLoS One* 2013; 8: e77080.

⁹⁰ Selected based on programme data from the national sex workers programme.

to deliver a comprehensive and integrated package of HIV and other health services is a high priority for incentive funding. Chiefly, this includes sensitisation for a minimum package of services for sexually abused young people, complete with, PEP, emergency contraception, HTC and appropriate referrals & linkages to additional services. The training will be based on the existing ASRH Training manual for service providers. With incentive funding, greater focus will be placed on promoting the Sexual and Reproductive Health Rights of young women living with HIV. HIV prevalence among young women (15-24) has been steadily declining in Zimbabwe, from 12.5% in 2011, to 11.56% in 2012, to 9.85% in 2013.⁹¹ Promoting an integrated HIV/SRHR/GBV package of friendly services for young people has been identified as a top priority for sustaining and accelerating these gains. Incentive funding will go towards training 200 HCWs in the 20 districts identified in the youth hotspot mapping.⁹² Capacity building for GBV service provision under the incentive funding focuses on provision of clinical services for survivors of sexual and gender-based violence, with strong referral links to existing victim-friendly support units, legal aid, and community-based support.

Priority 2: Training of healthcare workers to provide friendly HIV service to key populations (MSM, sex workers and people with disabilities) (\$1,287,600)

Evidence shows that the attitudes of health care workers are one of the biggest barriers to access for young people and key populations.⁹³ As such, sensitisation and training for healthcare workers to provide friendly, non-judgmental services is the dominant proportion of this incentive funding request for these two strategic areas. People with disabilities are prioritised as a population for HCW training, in light of new evidence from the Living Conditions Among Persons with Disability Survey (2013). The report highlights that the leading cause of the death was reported to be HIV/AIDS-related (as high as 20.6%), signalling an acute barrier to accessing life-saving HIV services. Materials have already been developed to support HCWs to deliver improved services to people who are visually and orally impaired, but with incentive funding they will be trained in their use and application. Incentive funding will go towards training 100 TOTs and 100 Peer-educators on providing treatment literacy to PWD (\$194,050). It will also be used for conducting a provincial level training of trainers (TOT) for 43 TOTs in basic sign language (\$47,300), as well as training 1000 HCWs to communicate information about HIV prevention and treatment to patients with disabilities (\$550,000).

Allocated Global Fund support through SAT is already going towards trainings for HCW on provision of MSM-friendly services at the national and provincial level. However, based on lessons learned from this there is an opportunity to augment this impact by conducting trainings at more basic levels of care. Evidence from the region also demonstrates the potential impact of sex-worker-friendly clinics to attract and retain female sex workers for HIV prevention and care.⁹⁴ Additionally, recent evidence reveals that the need among these groups may warrant increased investment. The Sexual Minorities and HIV in Zimbabwe For the NACs in SADC (July, 2013 Report) indicate that HIV prevalence among MSM in Zimbabwe could be higher than previously believed.⁹⁵ As such, incentive funding is requested to hold two national planning meetings (\$16,250) to roll out four workshops each sensitising 120 TOTs around the needs of MSM, as well as sex workers and people with disabilities (\$180,000) and four workshops each sensitising 800 district and clinic staff. Lastly, incentive funding will go towards PMD Stakeholder and HCW Sensitisation (\$300,000).

⁹¹ 2014 GARPR pg. 2.

⁹² Bindura, Buhera, Bulilima, Chimanimani, Chitungwiza, Chivi, Gwanda, Harare, Hwange, Insiza, Lupane, Matobo, Makonde (Chinhoyi), Mangwe (Plumtree), Makoni, Mhondoro-Ngezi (Mine), Mutasa, Nyanga, Mudzi, Umzingwane.

⁹³ Mtetwa, S., Busza, J., Chidiya, S., Mungofa, S., & Cowan, F. (2013). "You are wasting our drugs": health service barriers to HIV treatment for sex workers in Zimbabwe. *BMC Public Health*, 13(1), 698.

⁹⁴ Chersich M, Luchters S, Ntaganira I, et al. Priority interventions to reduce HIV transmission in sex work settings in sub-Saharan Africa and delivery of these services. *J Int AIDS Society* 2013; 16: 17980.

⁹⁵ It should be noted that this study is not yet published and is still under review.

PMTCT

Priority 1: HIV/SRHR integrated services for young people (see Health Workforce Priority 2 and BCC Priority 1)

M&E

Priority 1: ePMS Strengthening (\$2,947,413)

The current HIV NFM was planned to cover 534 sites (accounting for 80% of ART coverage) in a phased approach: Lot 1 – 83 HF; Lot 2 – 267 HF; and Lot 3 – 184 HF. The costing of this was based on estimates, which, upon implementation was able to cover Lot 1 & 2 only in LAN installations. Incentive funding is requested to cover Lot 3, which remains outstanding (to cover 152 health facilities) (\$2,051,013). In addition, incentive funding will be used for power back-up for the 534 health facilities still outstanding, with a targeted approach to be explored (\$896,400). Third, as a result of decentralisation of ART services, some of which do not yet have ePMS, incentive funding will also go towards supporting the outreach model for data collection and entry for DECAs (including Fuel [2 visits per month], leveraging the already existing transport system, and logging in system for records).

Priority 2: HIV Data Warehouse (\$726,111)

In order to effectively monitor and analyse the impact of the above interventions, incentive funding is requested to design an HIV Data Warehouse to store and process patient-level data at the central level. Incentive funding is requested for the development of the Data Warehouse (\$320,261), hold a training on its use (\$246,250) as well as setting up the data centre, roll-out the ETL and administration costs (\$159,600). This is a much needed request that has the potential to yield enormous impact for improving quality of care. Currently, patient level data is only available at facility level. To be able to conduct patient-level analysis of patient data⁹⁶ at national level, teams from national level are periodically sent out to health facilities to collect the data and bring it to national level. Establishment of this HIV Data warehouse enables transmission of patient-level data electronically to the national level. To that effect, the MOHCC, in partnership with Futures Group, have developed a concept note (see Annexe F) for the design of a data warehouse to collect data from the EPMS software. The system will also be extensible to other EMR systems including the Newlands system and EMR systems (which may be developed in future for other health program areas). Establishing the HIV data warehouse has been identified as an M&E priority because of its potential to improve treatment outcomes and save lives through informed data-driven decisions. It also has the ability to maximise impact of the current investment, gathering more accurate and informed data on lives saved and infections averted based on current Global Fund-supported initiatives.

Priority 3: Creating Linkages Between Community and HMIS (\$125,950)

DHIS2 has provision to incorporate community initiatives. Database available is partly supported through NAC & ISP (BCF), but there is a need for new IT equipment (such as handheld tablets) to fully realise the potential of linking the community data collection with national level databases.

Priority 4: Generation of Further Evidence to Guide Programmes (\$370,000)

The final M&E priority is to conduct a modes of transmission study and protocol (\$100,000). This should take approximately 6 months to conduct. In addition, incentive funding is requested to conduct a National AIDS Spending Assessment (NASA) for 2013/14 (\$120,000). Thirdly, incentive funding will be used to evaluate the two pilots proposed in this application – self-testing for youth and the integrated sample transportation system – to monitor efficacy and impact, combined with conducting a related rapid assessment on

⁹⁶ Patient data confidentiality will be addressed through the following measures: i) Data centre room security reinforcements; ii) Network based file and file transfer encryption (VPNs, VLANs and encryption certificates), iii) Software security (Security Policy, antivirus, Access level controls) and iv) Hardware based security measures (Firewalls, IPS and IDS).

adolescents (\$150,000). Qualitative operations research will be conducted to give in-depth analysis of drivers of epidemic and factors associated with this among adolescents.

- b. Describe whether and how the above allocation request meets the Global Fund's focus of the funding requirement on **key populations and/or highest-impact interventions** (This question is not applicable for low-income countries).

The emphasis of this incentive funding request is considerably more focused on key populations than the country's previous application. Based on lessons learned from existing Global Fund-supported programming for key populations, it is possible for increased coverage among these groups despite the legal and policy environment. Further, if Zimbabwe is able to demonstrate high-impact results, these interventions may be considered part of core programming going forward for the implementation of ZNASP III. The previous request outlined the need for size estimates of key populations. With this underway with support from Global Fund and PEPAR (approved for sex workers, pending approval for MSM), there are even greater opportunities for informed key populations' programming through incentive funding in 2016.

4.3 Commitment to Sustainability and Additionality

Financial sustainability is important to ensure continuity of impact. In particular, implementing country governments must fulfill their obligations to sustain and increase contributions to the national response. The counterpart financing requirements of the Global Fund are set forth in the Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization (ECFP).

Please complete the **Financial Gap Analysis and Counterpart Financing Table** in Attachment 4.

- a. Indicate whether the **counterpart financing requirement** has been met. If not, provide a justification that includes actions planned during implementation to reach compliance.
- b. Describe whether and how this funding request to the Global Fund will be complemented by **additional funding commitments from the Government**.
- c. Describe how this funding request to the Global Fund can leverage **other donor resources**.

a. Counterpart financing:

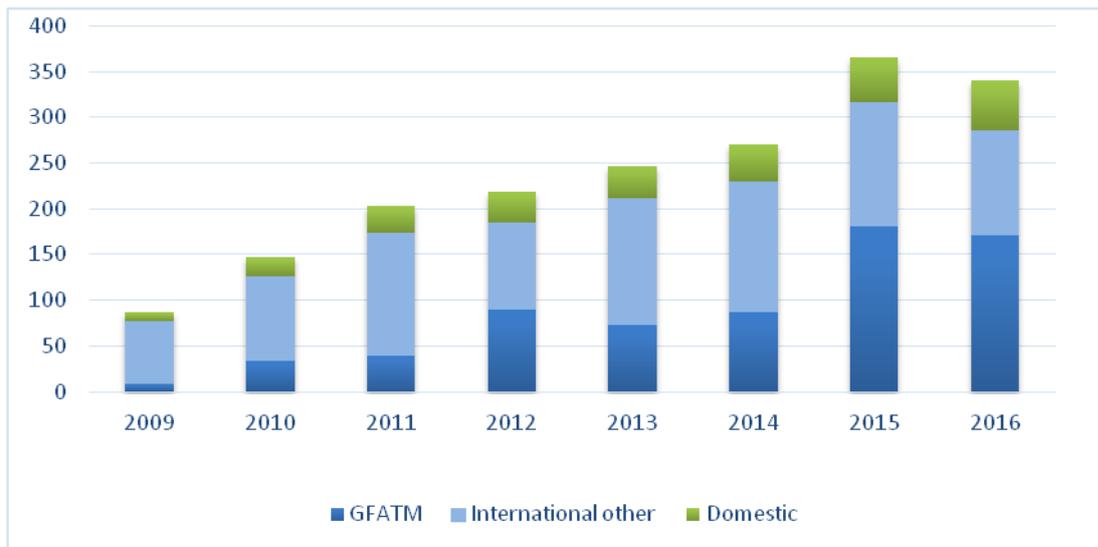
The Government of Zimbabwe has demonstrated commitment to the national response in HIV/AIDS. This is evidence through a) putting in place legislative provision to ensure 3% of both individual income tax (PAYE) and Corporate Income Tax (CIT) is wholly earmarked for HIV responses, b) there are specific votes in general treasury annual budgets, which allow certain funds in the health budget to be allocated for the HIV/AIDS response e.g. ARVs and related commodities, HIV programme support, and HIV research. The total of these allocations yields an estimated counterpart threshold of 17%. Political commitment provided the tax provision, now the country's economic performance will determine the extent of future commitments. As noted in the Financial Gap Analysis and Counterpart Financing Table (Attachment 4), a general increase in the absolute contribution of the Government of Zimbabwe to the HIV budget is evident. The economy is growing at 5%; therefore, it is anticipated that the level of pooled domestic resources will also increase and bring about an increase in percentage of counterpart financing, in addition to a national sense of ownership and sustainability.

c. Additional funding commitments from the Government

The government of Zimbabwe has demonstrated increasing commitment towards raising domestic resources to fund its national AIDS program (Figure 4.3.1). Domestic spending increased by 40% from 2011 to 2014.⁹⁷

In 1999, Zimbabwe introduced an AIDS levy – a 3% tax on income and corporate revenue - which has grown from \$5.7 million in 2009 to \$26.5 million in 2012. Projections indicate that it will grow to \$47 million in 2016, partially related to the government’s decision to expand the levy to include revenue from the country’s mining sector.⁹⁸ Overall, the Levy has raised more than \$200 million in domestic resources for Zimbabwe’s AIDS response.⁹⁹ The Levy continues to contribute towards the government’s target to increase domestic financing of the HIV response to 30% by 2018 (ZNASP III).

Figure 4.3.1: Resources Available for AIDS in Zimbabwe (US \$ millions, 2009-2016).



Despite this effort towards shared responsibility, significant challenges remain. A recent analysis of African countries’ ability-to-pay projected that even in a maximum effort scenario, countries with similar wealth and disease burden as Zimbabwe will only be able to cover 20-50% of their AIDS programmes needs with domestic resources.¹⁰⁰ This means that external support remains critical, but also that efficiencies must be harnessed to use limited resources to maximum effect.

Though the bulk of Zimbabwe’s AIDS funding (85%) is from international sources, on a per-person living with HIV basis, Zimbabwe receives one of the lowest per capita allocations globally from the combined funding of the two largest international funders (the Global Fund and PEPFAR).¹⁰¹

In light of the country focus demonstrated in this application, there is complementarity between GF resources and the domestic pool, particularly in the area of treatment and care and health/community systems strengthening. The Government of Zimbabwe has demonstrated its commitment to retaining and maintaining human resources in general for

⁹⁷ NAC and UNAIDS (March 2015). Briefing note: resource availability and needs for the HIV Response in Zimbabwe.

⁹⁸ Friends of the Global Fight against AIDS, Tuberculosis and Malaria (2015). Innovation for Greater Impact: Exploring Resources for Domestic Health Funding in Africa. Page 8. Online at http://theglobalfight.org/wp-content/uploads/Innovation_for_Greater_Impact.pdf

⁹⁹ ZNASP II Mid-Term Review (October 2013). Page 70.

¹⁰⁰ Resch, S., Ryckman, T., & Hecht, R. (2015). Funding AIDS programmes in the era of shared responsibility: an analysis of domestic spending in 12 low-income and middle-income countries. *The Lancet Global Health*, 3(1), e52-e61.

¹⁰¹ National AIDS Council and UNAIDS (March 2015). Briefing note: resource availability and needs for the HIV Response in Zimbabwe.

the health sector through the payment of basic salaries and maintaining facilities infrastructure. It is evident that these are key to delivering HIV services to all those who need it. The government of Zimbabwe has also committed to ensuring in-service training to all medical personnel at the University of Zimbabwe, College of Health Sciences. The Government of Zimbabwe has been able to commit to purchasing of ARVs through the National AIDS Trust Fund (NATF - an earmarked tax), the additionally here demonstrated is that of a synergistic effect. The funding request to GF will cater for the remaining gap, especially for paediatric ART.

d. Process of developing the financial gap analysis and leverage with other donors

As noted in the development of the programmatic gap, emphasis has been placed on high impact interventions (those which maximise outcomes/outputs from a given investment), creating a synergistic effect with other donors as well. Donors or partners in HIV responses in Zimbabwe were consulted and interviewed to assess their previous expenditures, current areas of focus, and future commitments and areas of focus. This helped to identify the areas within the gap that will be addressed through the donor activities. The final funding request presented was developed taking into consideration both domestic and donor funding currently available and committed. Experts project the growth of the Zimbabwean economy at 5%, which will subsequently increase the treasury 'pot', hence both the NATF collections and specific budgetary allocations will increase. A commitment is not a guaranteed future disbursement; it is with this thinking that the figures from donors here presented needed to be judged with caution, particularly commitments from the donor community. There is a possibility that these figures could be low subject to changing international policies from the partners. Also considered was the fact that current Global Fund Round 8, Phase 2, is coming to an end hence there is an expected gap left thereafter.

4.4 Focus of Proposal

This question is **not** applicable for Low Income Countries.

If the applicant is a **Middle Income Country**, describe how this request meets the Focus of Proposals requirement according to the threshold based on the income classification for the country.

Not applicable.

SECTION 5: Implementation Arrangements

5.1 Principal Recipient Information

Complete this section for each nominated Principal Recipient. For more information on Minimum Standards refer to the Concept Note Instructions.

PR 1 Name	UNDP	Sector		UN Agency	
Does this PR currently manage a Global Fund grant(s) in this disease/HCSS area?		✓ <input type="checkbox"/> Yes		<input type="checkbox"/> No	
Minimum Standards		CCM assessment			
1. The Principal Recipient demonstrates effective management structures and planning		Yes			

2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)	Yes
3. There is no conflict-of-interest for the selection of the Principal Recipient(s) and Sub-Recipients	Yes
4. The program-implementation plan provided in the concept note is sound	Yes
5. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	Yes
6. The financial-management system of the Principal Recipient is effective and accurate	Yes
7. The central warehouse and the warehouses for key regions have capacity, appropriate conditions and security to store health products, and to maintain their quality	No
8. The distribution process can handle the requisition of supplies to avoid treatment / program disruptions	Yes
9. Data-collection capacity and tools are in place to monitor program performance	Yes
10. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	Yes
11. The CCM actively oversees the implementation of the grant, and intervenes where appropriate	Yes
12. A quality-assurance plan is in place to monitor product quality throughout the in-country supply chain	No

5.2 Current or Anticipated Risks to Program and PR(s) Performance

In reference to the Minimum Standards above and risk assessments conducted (if applicable), describe current or anticipated risks to the program and nominated PR(s) performance, as well as the proposed mitigation measures (including technical assistance) included in your funding request.

UNDP as the PR to the Zimbabwean grants poses no envisaged risks to programme implementation and grant performance. The PR has also designed and implemented a capacity development programme to enhance capacities of current SRs under round 8. This will mitigate any potential risks at SR level.

There is need however to address warehousing and storage services from central to regional to site level with the view to improve on security and conditions of storage for health products. The PR, working with other partners, are assisting NatPharm and the MOHCC to address these challenges. Within this current application some budgets have been allocated toward addressing storage issues.

5.3 Overview of Implementation Arrangements

Please provide an overview of the proposed implementation arrangements for the funding request. In your response, please describe as appropriate:

- a. If more than one PR is nominated, how co-ordination will occur between PR(s).
- b. Whether Sub-Recipients (SRs) have been identified and the type of management arrangements likely to be put into place.
- c. How coordination will occur between each nominated PR and its respective SR(s).

a) Coordination between PRs

UNDP currently works as the nominated PR under the general guidance of the CCM, and is responsible for programme management, financial accountability, procurement of goods & services and Monitoring and Evaluation. It is anticipated that the current institutional arrangement will continue during the life of the grant as there has been no review of the ASP. The grant will thus be implemented by a single PR (UNDP) hence the issue of coordination among PRs is not applicable.

b) Identification and management of sub-recipients

The existing grant will be consolidated with the new grant and this includes reprogramming of the existing budget. While the selection of SSRs will be a transparent and open process, it is anticipated that the current SRs, depending on capacity, may continue. However this will entail conducting further capacity assessment by the PR in light of the changing focus of the grant.

The current grant has 4 SRs namely MOHCC, NAC, NatPharm and a civil society organisation. UNDP expect to re-engage as Sub Recipients the National AIDS Council (NAC), the Zimbabwe Ministry of Health and Child Welfare, a civil society organisation and the National Pharmaceutical Company of Zimbabwe (NatPharm). UNDP also expects to engage the Health Services Board (HSB) as a new sub-recipient for management of the health worker retention scheme, then undertake a transparent process to engage the civil society organisation. NAC and the Ministry of Health and Child Welfare will be responsible for the implementation of the programmatic activities and NatPharm will be the implementing agency for storage and distribution without having to replicate or have parallel structures to support UNDP's role as PR in Zimbabwe. The PR has already developed guidelines for SR management through the SR Manual (see Annexe 18: Implementation Manual for Global Fund Grant Sub-Recipients).

The Ministry of Health and Child Welfare - operates within the functions mandated to the office of the Minister of Health and Child Welfare. The ministry's national head quarter's role is regulatory, policy setting and provision of a legally enabling environment for the operation of the various health services and funders.

The Zimbabwe National AIDS Council (NAC) - is a Parastatal established by an Act of Parliament, Chapter 15:14 of 1999 mandated to coordinate and facilitate the multi-sectoral response to HIV and AIDS Prevention, Care, Treatment and Support.

NatPharm is the implementing agency for storage and distribution for major donors and UN Agencies such as UNICEF, UNFPA and WHO. NatPharm was the result of the promulgation of the Government Medical Stores (Commercialization) Act, 2000. It was established as an autonomous not-for-profit organisation registered in terms of Section 26 of the Companies Act (Chapter 24:03) with an independent Board appointed by the Minister of Health and Child Welfare. NatPharm has six warehouses nationwide with storage capacity of approximately 12, 812 sqm. The regional store in Harare which will serve as the major international receiving store has a capacity of 6,621 sqm.

The civil society organisation will be responsible for the implementation of programmatic activities. The organisation will support the implementation of this programme by harnessing AIDS service organisations for multi-sectoral coordination. Specifically, the civil society organisation will be strategically placed to ensure that civil society organisations focusing on gender and reaching other vulnerable groups are included in implementation of related activities.

The Health Services Board (HSB) is directly responsible for all staffing and service matters in the health sector with the aim for an overall improvement of the sector in order to attract and retain professional staff. HSB manages the Retention Scheme and works closely with donor partners, including the Global Fund, to ensure effective implementation of the Scheme. HSB is the result of the Health Services Bill, which passed through parliament in 2004, effectively removed all health service personnel from the employ of the Public Service Commission (PSC) and placed them under the Health Services Board.

c) How coordination will occur between each nominated PR and its respective SRs
Zimbabwe is currently under Additional Safeguard Policy (ASP) and the Global Fund has nominated UNDP as the Principal Recipient. No other PR was nominated therefore coordination is led by UNDP with the SRs. As the PR, UNDP is supporting capacity development of individuals (skills building) within SR organisations and institutional systems, in the areas of coordination and management, accountability and risk management, including the country's Health Information System.

Each SR is managed individually by the PR, who in turn manages and coordinates with their own SSRs. UNDP has a project management unit with the mandate to manage all Global Fund grants in Zimbabwe. The PMU has various units – disease units (HIV, TB, Malaria) and support (finance and admin, M&E and PSM). Each grant has a manager who ensures budget monitoring of all SR activities, avoiding duplication, ensuring appropriate integration of activities and budgets, enforcing budgetary and policy compliance and ensuring money is used according to plan. Reports are made to the Global Fund on a semester basis (six-monthly) which consists of financial and programmatic progress linked to the Performance Framework (links performance to targets) and this is the basis of grant rating. The manager has monthly meetings with the SRs and quarterly review meetings with each SR and their SSRs. At these meetings progress and challenges in implementation are reviewed and improvements to implementation proposed. Verification of data is done by M&E officers going to the field to verify reports submitted, undertake spot checks and to ensure activities being implemented according to the plan and ensure no problems in implementation. The findings of these missions form part of the agenda of the monthly meetings. This can result in reallocation of budgets to maximise efficiency of implementation.

As a manager of the main source of funding to the health sector UNDP also plays an important role in the coordination with donors to avoid duplication and maximise the impact of the interventions. In the implementation of the project, UNDP Country Office will coordinate closely with Government, bi-lateral development partners, civil society and private sector to harmonise and coordinate the response in supporting the implementation of Global Fund grants and in the establishment of a strong communication policy and ways of sharing lessons of implementing in this dynamic environment. Moreover the UNDP Country Office will work with these stakeholders to strengthen national capacity in the implementation of the project activities. Bi-lateral partners include DfID, EU, USAID (CDC, PEPFAR) and UN agencies (UNAIDS, UNFPA, UNICEF, UN Women, ILO and WHO).

5.4 Addressing Links to other Concept Notes and/or Existing Grants

If you are requesting funds for more than one component (including stand-alone HCSS) during the transition or have an on-going Global Fund grant (for another component), describe how the interventions being requested link to existing Global Fund grants or other concept notes being submitted, in particular as they relate to human resources, staffing, training, monitoring and evaluation and supervision activities.

The existing Round 8 Phase 2 grant was informed by the current Zimbabwe National HIV and AIDS Strategic Plan (2011-2015). The National Strategic Plan (NSP) is being used to guide the prioritization of interventions in this current proposal. This application is more focused as it prioritises high impact interventions identified in the NSP and is also guided by the investment framework currently under development. The existing grant will be consolidated with the new grant and this includes reprogramming of the existing budget

In addition to the HIV/AIDS grant, Zimbabwe is currently implementing three other Global Fund grants namely; TB and HSS under the Round 8 Phase 2 grant and the SSF Malaria. In addition to the support for human resources costs which are specific to this grant, this proposal provides for support to government and civil society staff involved in the implementation of other existing grants. Both categories of staff provide service to the three diseases at the community and institutional levels. Training for health personnel is cross cutting and complementary particularly as it relates to TB/HIV collaborative activities. Other training targeting community health workers is also focusing on enabling the cadre at that level to provide services to all diseases and not just HIV related activities. A major component of this proposal relates to the establishment of an Electronic Patient Monitoring and Management system. The e-PMS will be used to monitor and manage all ART and TB patients and will use the national Health Information Management System platform. Whilst the HMIS is currently being supported under the three diseases, there is a gap which is provided for in this proposal.

5.5 Women, Communities and other Key Affected Populations

Please describe how representatives of women's organizations, people living with the three diseases and other key affected populations will actively participate in the implementation of this funding request, including in interventions that will address legal or policy barriers to service access.

Representatives of women's organizations, people living with HIV/TB and other key affected populations will participate in the implementation of the funding request, including conceptualization, implementation and evaluation. While the legal and policy environment remains challenging for the full, open participation of sex workers and men who have sex with men (MSM), efforts have been made for representatives of these networks to participate in the conceptualization, implementation and evaluation of this funding request.

Conceptualization - Representatives of PLHIV (specifically ZNNP+ - Zimbabwe National Network of PLHIV and ZHAAU – Zimbabwe HIV and AIDS Activists Union) are represented on the CCM, as well as on the core writing team for the concept note. Representatives of women's organizations (specifically Women AIDS Support Network, UN Women), and key populations (specifically Sex worker technical working group and Gays and Lesbians of Zimbabwe (GALZ)) participated in the Program Gap Analysis workshop, and in consultative processes leading up to the development of the concept note. These groups had been actively involved in national dialogue on building an Investment Case for Zimbabwe through UNAIDS and NAC, prior to the invitation from GFTAM to develop a concept. Focal people from within these networks will also participate in the stakeholder review of the concept note before finalization and submission. These representatives ensure that the concept is technically sound and in line with the interests of their

constituency (i.e. concerns about pill burden, introduction of Option B+ and phasing out of toxic regimens).

Implementation- The engagement with women, communities and key affected populations is an ongoing process embedded within the national HIV response and emphasised in the ZNASP II. Representatives of women's organizations and people living with HIV are included as sub-recipients and sub-sub-recipients. Throughout the National AIDS Council's coordination structure at Provincial, District and Ward level, representatives of women's organizations, youth and people living with HIV are represented. They are also represented on existing Health Centre committees, child protection committees. At national level, there are also structures through which continued engagement takes place, including the PMTCT Partnership Forum, national TWG on Gender, Global Power Women network Africa-Zimbabwe Chapter and Young People's Network.

Evaluation- Representatives of women's organizations, people living with HIV/TB and other key affected populations will participate in routine reviews and evaluations.

5.6 Major External Risks

Please describe any major external risks (beyond the control of those managing the implementation of the program) that might negatively affect the implementation and performance of the proposed interventions.

The general elections are planned for 2013 in Zimbabwe. Previous elections in Zimbabwe in the last 10 years have resulted in social unrest and political violence which presented challenges in programme implementation particularly as it relates to implementation of activities by civil society at community level. Whilst there is a risk of disruption of implementation of activities in the existing grants, there is no risk to the implementation of activities in this proposal unless the dates of the elections change to 2014. In the event that there is no absolute winner, there is a potential risk of protracted period of uncertainty in policy direction hence a risk to the implementation of all programmes including treatment disruptions, low HTC uptake, etc.

Currently there is economic stability due to the adoption of the multi-currency regime in early 2009 with the USD as its currency and therefore significant changes in commodity prices, inflation and exchange rates are not anticipated. However in the event that the outcome of the election results in significant departure from the current economic policies there is a potential risk of economic instability.

To address the above risks, the country will maintain the current PR (UNDP) to safeguard the flow of Global Fund resources into the country with minimal disruptions to activities and mitigate against potential loss and misuse of GF resources. UNCT/UNDP has developed a risk plan to address possible eventuality.