

FUNDING REQUEST APPLICATION FORM

Full Review

SUMMARY INFORMATION			
Applicant	Zimbabwe		
Component(s)	TB/HIV		
Principal Recipient(s)	United Nations Development Programme (UNDP) (HIV) Ministry of Health and Child Care (MOHCC) (TB)		
Envisioned grant(s) start date	January 2018	Envisioned grant(s) end date	December 2020
Allocation funding request	\$432,294,735*	Prioritized above allocation request	\$196,966,334

*Amount reflects Zimbabwe's HIV allocation + TB allocation + \$2 million from malaria allocation for cross-cutting RSSH interventions.

IMPORTANT:

To complete this funding request, please:

- Refer to the accompanying **Funding Request Instructions: Full Review**;
- Refer to the Information Note for each component as relevant to the funding request, and other guidance available, found on the [Global Fund website](#).
- Ensure that all mandatory attachments have been completed and attached. To assist with this, an application checklist is provided in the Annex of the *Instructions*;
- Ensure consistency across documentation.

Applicants are encouraged to submit a joint funding request for eligible disease components and resilient and sustainable systems for health (RSSH).

Joint TB/HIV submissions are compulsory for a selected number of countries with highest rates of co-infection. See the related [guidance](#) for more information.

This funding request includes the following sections:

- Section 1:** Context related to the funding request
- Section 2:** Program elements proposed for Global Fund support, including rationale
- Section 3:** Planned implementation arrangements and risk mitigation measures
- Section 4:** Funding landscape, co-financing and sustainability
- Section 5:** Prioritized above allocation request

SECTION 1: CONTEXT

This section should capture in a concise way relevant information on the country context. Attach and refer to key contextual documentation justifying the choice of interventions proposed. To respond, refer to additional guidance provided in the *Instructions*.

1.1 Key reference documents on country context

List contextual documentation for key areas in the table provided below. If key information for effective programming is not available, specify this in the table ("N/A") and explain in Section 1.2 how this was dealt with within the context of the request, including plans, if any, to address such gaps.

Applicant response in table below.

Key area	Applicable reference document(s)	Relevant section(s) & pages nb.	N/A
Resilient and Sustainable Systems for Health (RSSH)			
Health system overview	1. MOHCC & UNFPA (2016) Community Based Cadre Mapping Exercise		<input type="checkbox"/>
	2. Zimbabwe Economic Policy Analysis Research Unit (for MOHCC) (2014). Desk Review of institutional arrangements for health financing in Zimbabwe		<input type="checkbox"/>
Health system strategy	3. National Health Strategy for Zimbabwe (2016-2020)		<input type="checkbox"/>
	4. MOHCC (2016). Community Systems Strengthening Framework for Health in Zimbabwe (Draft)		<input type="checkbox"/>
	5. MOHCC & NAC. Private Sector Response to HIV/AIDS, TB and Wellness. National Strategic Framework (2014-2018)		<input type="checkbox"/>
	6. Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset) (2013-2018).	Pg. 66-67 (Social Service Delivery); Pg. 75 (Gender)	<input type="checkbox"/>
	7. MOHCC Draft ePMS Strategic Plan (2018-2020)		<input type="checkbox"/>
	8. SADC (2015) Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region		<input type="checkbox"/>
	9. MOHCC Clinical Mentorship Comprehensive prevention, care and treatment services for HIV, TB STI and related conditions Operational Scale Up Plan (2016-2018)		<input type="checkbox"/>
	10. MOHCC. Quality Assurance and Quality Improvement Strategy (2016-2020)		<input type="checkbox"/>
	11. Zimbabwe National Family Planning Strategy (ZNFPS) (2016-2020)	Pg. 32-33 (Strategy 3)	<input type="checkbox"/>
	12. MOHCC (2017). Zimbabwe Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition Strategy (2017–2021)		<input type="checkbox"/>
Program reviews and/or evaluations	13. MOHCC & World Bank (2015) Health Public Expenditure Review – Zimbabwe		<input type="checkbox"/>
	14. European Union (2016) Assessment and redesign of the systems for RBF, Human Resources for Health and Pharmaceuticals in Zimbabwe (Draft)		<input type="checkbox"/>
	15. Costed recommendations from the comprehensive laboratory assessment (2017)		<input type="checkbox"/>
	16. MOHCC (2014) The Electronic Patient Monitoring System (ePMS) Assessment		<input type="checkbox"/>

	17. MOHCC (2011) Zimbabwe National Rapid Assessment on SRH and HIV Integration and Linkages		<input type="checkbox"/>
	18. PWC (2012) Global Fund Round 8 HSS Grant - Community Systems Strengthening (CSS) Evaluation		<input type="checkbox"/>
Human rights and gender considerations (cross-cutting)	19. Constitution of Zimbabwe Amendment No.20 14-05-2013	Pg. 23 (health services); 30 (right to privacy); 37-38 (right to health).	<input type="checkbox"/>
	20. ZimStat (2016). Understanding Gender Equality in Zimbabwe: Women and Men Report	Pg. 18-22 (RMNCH & HIV); Pg. 58-62 (GBV)	<input type="checkbox"/>
	21. Global Fund priorities of Zimbabwean women and girls across age and diversity (2017)		<input type="checkbox"/>
	22. Zimbabwe National Action Plan and Communication Strategy on Ending Child Marriage (2016–2018)	Pg. 1 (HIV, STIs, SRHR and sexual violence)	<input type="checkbox"/>
	23. The National Cancer Prevention And Control Strategy For Zimbabwe (2013–2017)	Pg. 8, 19-20 (Sections on HIV, HPV and cervical cancer)	<input type="checkbox"/>
	24. Ministry of Primary and Secondary Education. Education Sector Strategic Plan (2016-2020)	Pg. 44-45 (School Health, Life Skills, Sexuality, HIV)	<input type="checkbox"/>
	25. MOHCC (2013). Living Conditions Among Persons with Disability Survey		<input type="checkbox"/>
Disease-specific			
Epidemiological profile (including interventions for key and vulnerable populations, as relevant)	26. The Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) (2016)		<input type="checkbox"/>
	27. Government of Zimbabwe (2016) Zimbabwe Demographic and Health Survey 2015	Pg. 33-46 (HIV, cervical cancer, GBV and maternal mortality)	<input type="checkbox"/>
	28. WHO (2016). Rapid HIV Epidemiology and Impact Review		<input type="checkbox"/>
	29. National AIDS Council (2015). Smart Investment to End HIV AIDS in Zimbabwe based on Hotspot Analysis		<input type="checkbox"/>
	30. NAC (2017). The HIV Epidemic in Zimbabwe: Epidemiological review and Modes of Transmission (Draft)		<input type="checkbox"/>
	31. MOHCC (2014). The Zimbabwe National Population Based TB Prevalence Survey		<input type="checkbox"/>
	32. Zimbabwe Prisons and Correctional Services & UNODC (2016). Assessment of TB Prevalence and Factors with TB among the Prison Population in Zimbabwe		<input type="checkbox"/>
Disease strategy (including interventions for key and vulnerable populations, as relevant)	33. MOHCC & NAC. Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III) 2015-2018		<input type="checkbox"/>
	34. MOHCC & NAC. Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III) 2015-2020 (Draft)		<input type="checkbox"/>
	35. UNAIDS (2015). Zimbabwe HIV Investment Case		<input type="checkbox"/>
	36. MOHCC National Tuberculosis Program Strategic Plan (2017-2020) (Draft)		<input type="checkbox"/>

	37. MOHCC (2014) National Guidelines for Community Engagement in TB Prevention and Care		<input type="checkbox"/>
	38. MOHCC (2013) National HIV Care and Treatment Strategic Plan (2013-2017)		<input type="checkbox"/>
	39. Zimbabwe Prison and Correctional Service HIV and AIDS Strategic Plan (2016-2018)		<input type="checkbox"/>
	40. MOHCC National Strategic Plan for Eliminating New HIV Infections in Children and Keeping Mothers and Families Alive (2014–2018) (Draft)		<input type="checkbox"/>
	41. MOHCC HIV Testing Services Strategy (2016-2020)		<input type="checkbox"/>
	42. MOHCC National Strategy and Implementation Plan for the Prevention and Control of Sexually Transmitted Infections in Zimbabwe (2017–2021)		<input type="checkbox"/>
Operational plan, including budgetary framework	43. MOHCC Accelerated Strategic and Operational Plan on Voluntary Medical Male Circumcision (2014-2018)		<input type="checkbox"/>
	44. MOHCC, NAC & UNAIDS (2016). Roadmap to Revitalise HIV Prevention in Zimbabwe		<input type="checkbox"/>
	45. NMTPAC & MOHCC (2016) Guidelines for Antiretroviral Therapy for the Prevention and Treatment of HIV in Zimbabwe		<input type="checkbox"/>
	46. MOHCC National Guidelines for TB/HIV Co-Management		<input type="checkbox"/>
	47. MOHCC Zimbabwe Viral Load Scale Up Plan (2015-2018)		<input type="checkbox"/>
	48. MOHCC National Comprehensive Condom Programming Operational Plan (2017-2020) (Draft)		<input type="checkbox"/>
	49. MOHCC (2015) Operational and Service Delivery Manual for the Prevention, Care and Treatment of HIV in Zimbabwe		<input type="checkbox"/>
	50. Accelerated Action Plan for the Nationwide Scale-up of Infant, Paediatric and Adolescent ART in Zimbabwe (2015-2018)		<input type="checkbox"/>
	51. MOHCC & Partners. Start Free Stay Free AIDS Free: A Super Fast-Track Framework for Ending Aids among Children, Adolescents and Young Women by 2020.		<input type="checkbox"/>
Program reviews and/or evaluations	52. WHO External TB Program Review (2016)		<input type="checkbox"/>
	53. UNICEF (2015) Synthesis Report of the Rapid Assessment of Adolescent and HIV Programme Context in Five Countries		<input type="checkbox"/>
	54. Office of the Inspector General (2016). Audit Report: Global Fund Grants to the Republic of Zimbabwe		<input type="checkbox"/>
Human rights and gender considerations (disease-specific)	55. Ministry of Women Affairs, Gender and Community Development - National Gender Policy (2013-2017)		<input type="checkbox"/>
	56. Draft Gender and HIV Implementation Plan (January 2017)		<input type="checkbox"/>
	57. Zimbabwe National Network of PLHIV (2014). Zimbabwe People Living with HIV Stigma Index		<input type="checkbox"/>
	58. Ministry of Women Affairs, Gender and Community Development (2014). Girls' and Young Women's Empowerment Framework		<input type="checkbox"/>
	59. Zimbabwe DHS (2015) Key Findings Gender-Based Violence		<input type="checkbox"/>

All key reference documents listed above have been catalogued and numbered and are accessible at the following link: [Key Reference Documents on Country Context](#)

1.2 Summary of country context

To complement the reference documents listed in Section 1.1 above, provide a summary of the critical elements within the context that informed the development of the funding request. The brief description of the context should cover disease-specific and RSSH components, as appropriate, as well as human rights and gender-related considerations.

Introduction and Background

Zimbabwe has made considerable progress in its HIV and TB responses and in building resilient and sustainable systems for health (RSSH). HIV prevalence has decreased by 28% over the last decade,¹ TB incidence has dropped by nearly 60% over the same period,² and an integrated electronic patient tracking system has been put in place to monitor quality of care.³

Building on these successes, the country has embraced ambitious global targets. Zimbabwe has aligned to the HIV Fast-Track targets and the goals of the End TB Strategy and the Global TB Plan, and ratified most fundamental conventions designed to achieve gender justice across sectors. The country is committed to rapidly scale up prevention, treatment and support services over 2018-2020 to end the diseases as public health threats by 2030.

This funding request is a vital opportunity to consolidate gains made and accelerate progress towards ending the diseases. It is aligned with the National Health Strategy (2016-2020) (Annex 1), the Extended National HIV and AIDS Strategic Plan (ZNASP III) (2015-2020) (Annex 2) and the National Strategic Plan (NSP) for TB (2017-2020) (Annex 3). The piloting of HIV self-testing, adoption of "Treat All" (December 2016), the plan for viral load scale-up (2015-2018) and commensurate community-based support make 90-90-90 a near reality. Early TB case finding through expanded use of Xpert MTB/Rif as the initial diagnostic test, optimization of CXR for TB screening, targeted TB screening among high risk groups and intensified community TB care can ensure Zimbabwe is on track to achieve the goals and objectives of the End TB strategy. However, there is no room for complacency. With continued high risk and gaps in care, gains made may be lost without sustained investments.

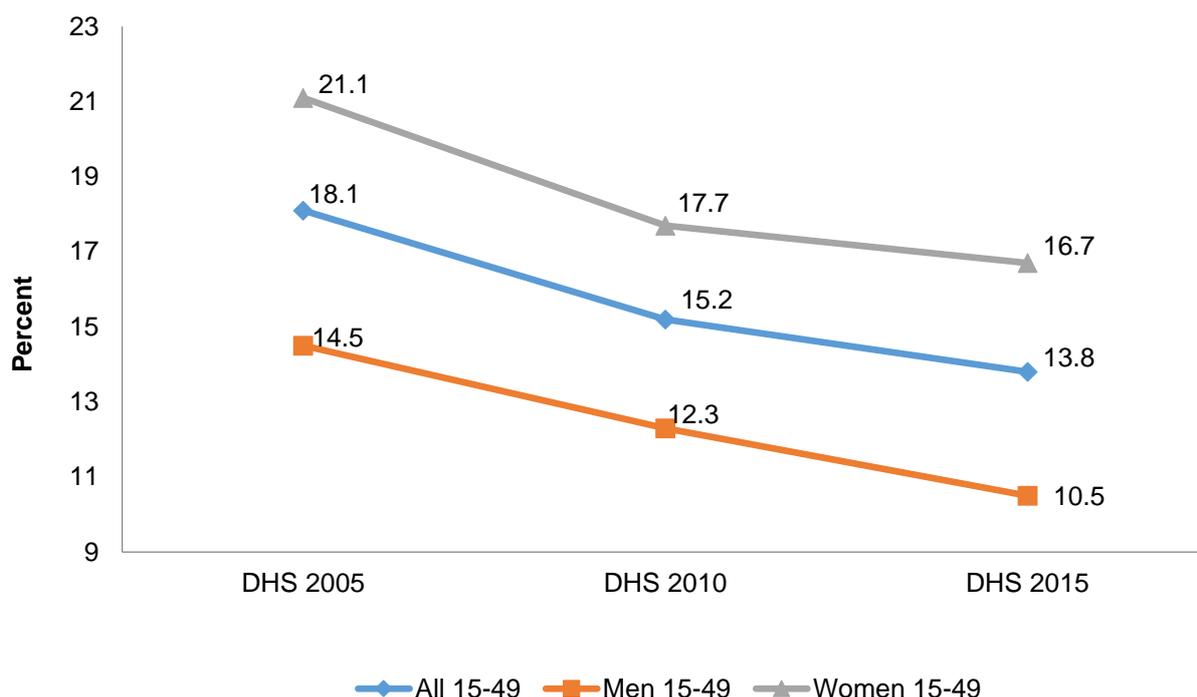
Following detailed NSP reviews and an extensive country dialogue process (Annex 4), the context of this funding request emanates from three critical opportunities:

1. **Entrench the national HIV and TB response within a comprehensive and integrated health framework.** This is Zimbabwe's first integrated HIV, TB and RSSH funding request, deepening the country's commitment to providing comprehensive packages of care in an efficient and effective manner. Exploiting programmatic and systems-related synergies across the three components will maximize impact and increase value-for-money.
2. **Focus for impact by targeting the response on locations and populations at greatest risk.** This means rapidly scaling-up programs for HIV prevention and active TB case finding among key and vulnerable populations in geographic hotspots. The approach will centre on the tailored and differentiated delivery of a comprehensive package of health and empowerment services, employing location-specific strategies including intensified efforts in provinces and districts with higher disease burden and other risk factors.
3. **Improve quality across the entire continuum of care.** This includes ensuring the effective implementation of combination prevention, accurate and timely diagnosis, early treatment initiation and strong systems for patient monitoring and support. Bolstering human resources for health (including community health workers) through strategic retention schemes, strengthening procurement and supply chain management, enhancing community-centred monitoring and responses, and collecting and using strategic information are key priorities.

Overview of the HIV Epidemic in Zimbabwe

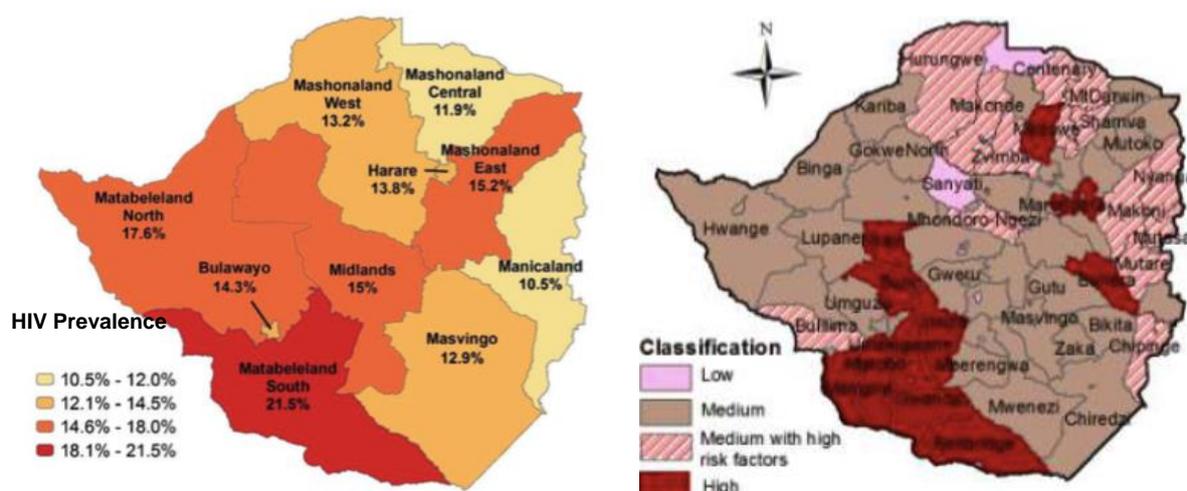
Zimbabwe has an estimated 1.4 million people living with HIV (PLHIV), 1.2 million of whom are between the ages of 15 and 64.⁴ Adult HIV prevalence has steadily decreased over the last ten years, declining from 18.1% in 2005 to 13.8% in 2015 (Figure 1).⁵ Prevalence among children (0-14) is estimated at 1.6%. While the epidemic has declined among both men and women (15-49), women continue to bear disproportionate burden with prevalence levels of 16.7% compared to 10.5% among men in 2015. The same gender disparity is true for new infections, where women have an HIV incidence of 0.67%, compared to 0.28% among men (15-49).⁶

Figure 1: Prevalence of HIV among adults (15-49) in Zimbabwe, DHS 2005, 2010 and 2015⁷



HIV prevalence varies substantially by region and by district. According to the 2015 Demographic and Health Survey (DHS), Matabeleland South has the greatest burden, with adult prevalence of 21.5%. Comparatively, Manicaland has the lowest prevalence at 10.5% (Figure 2). However, Manicaland has high estimated incidence, making it an important region to focus prevention efforts.⁸ Zimbabwe’s 2015 Hot Spot Analysis (Annex 5) helps explain these variations by overlaying HIV prevalence data with epidemic drivers such as STI prevalence, teenage pregnancy and condom knowledge, to create risk profiles for each district. The analysis shows that all districts of Matabeleland South as well as Bulawayo, Bubi, Nkayi, Mazowe and Marondera are HIV risk hotspots.

Figure 2: Adult HIV Prevalence (Left)⁹ and Hot Spot Risk Analysis (Right) (2015)¹⁰

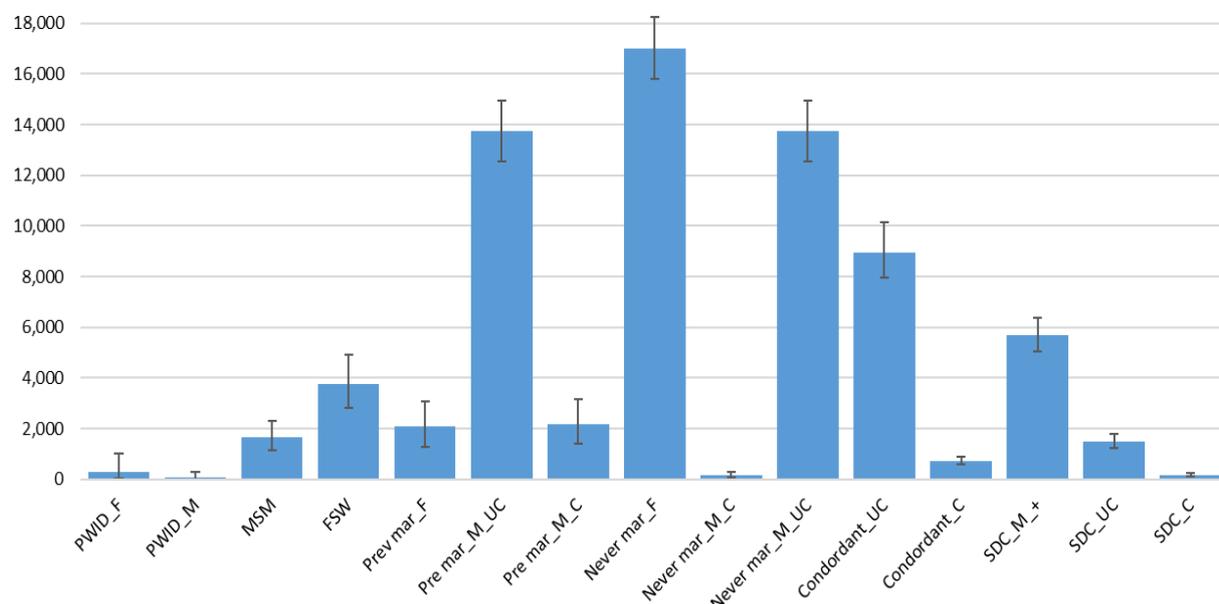


Recent vertical transmission estimates show considerable progress made, with the early 2016/2017 data indicating 5.2% transmission at 18 months.¹¹ This is a significant decline from 30% in 2009. This early data suggests Zimbabwe has the potential to achieve the international threshold for virtual elimination of vertical transmission (eMTCT) (<5% at 18 months), if strategic investments are sustained over the next three years. The Government of Zimbabwe has made a commitment to get to validation of eMTCT of both HIV and syphilis. However, early infant diagnosis (EID) remains a challenge, with EID by 6 weeks among HIV-exposed infants estimated as low as 45%.¹² Linkages to TB services for exposed infants are also a persistent challenge, and better integration is required to improve this aspect of Zimbabwe’s response.

Zimbabwe's modes of transmission study (ongoing) shows that the greatest number of new infections – more than 16,000 a year – occur among never married women. Adolescent girls and young women (AGYW) in particular experience dramatically disproportionate burden and risk factors. For example, young women (20-24) have HIV prevalence 2.78 times greater than their male peers. 17.1% of women aged 15-19 who had sex in the last year did so with a partner that was ten or more years older (up from 15.2% in 2010 and 7.5% in 2005).¹³ Further, 41% of girls report sexual debut before 18 years as unwanted¹⁴ and rates of transactional sex are high, and increasing.¹⁵ The HIV prevalence among young women (18-24) with two or more transactional sex partners in the last six months is estimated at 32%, compared to 10% among those who have never had transactional sex.¹⁶ Interventions which address the social and structural factors that fuel intergenerational, forced and/or transactional sex - particularly gender inequality and sexual and gender-based violence (GBV) - are critical for preventing HIV among AGYW. Given that less than half of young people in Zimbabwe are knowledgeable about HIV prevention methods (46% among women and 47% among men), improved comprehensive sexuality education (CSE) is also critical.¹⁷

HIV sub-epidemics among other key and vulnerable populations in Zimbabwe also signal the need for a more targeted response.¹ Preliminary results from the modes of transmission study show nearly 4000 new HIV infections a year among female sex workers (with a prevalence around 57.1%) and nearly 2000 new infections each year among men who have sex with men (MSM) (with a prevalence of about 23.5%) (Figure 3).^{18,19} HIV prevalence among the wider LGBT community has been linked to risks associated with forced sex, a key gender-related consideration.²⁰ People with disabilities are twice as likely to self-report having HIV as those without disabilities.²¹ Among prisoners, HIV prevalence is estimated at 28% in 2015 (26.8% among male detainees and 39% among female detainees).²² Criminalization, stigmatization and marginalization drive both higher rates of infection and lower uptake of services. Indeed, the 2014 PLHIV Stigma Index found that 90.8% of sex workers, 77.8% of MSM, 64.5% of people with disabilities and 100% of prisoners reported experiencing stigma and discrimination.²³ Interventions for key populations must include activities to remove human rights barriers to access, creating more enabling environments to scale HIV services.

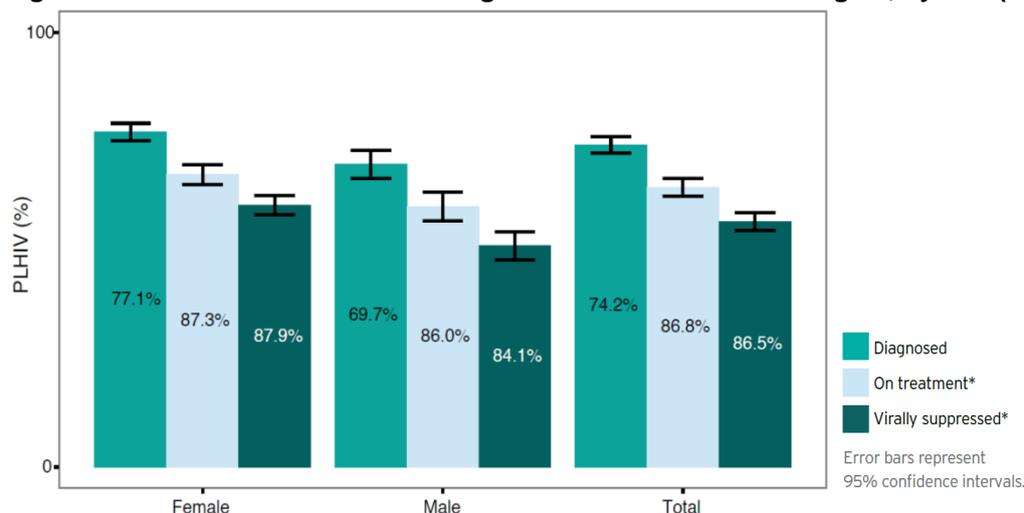
Figure 3: Number of New HIV Infections in Zimbabwe, by Sub-Group and Key Population²⁴



Though prevention gaps persist, the treatment cascade in Zimbabwe suggests the country is on track to achieve the 90-90-90 targets if current investments are sustained and strategies to scale-up testing uptake are explored, particularly among young people, men and key and vulnerable populations. As of 2016, 74.2% of all PLHIV know their status, 86.8% of those are on treatment (translating to 909,508 people as of 2016) and 86.5% of people on treatment are virally suppressed (Figure 4).²⁵ Although the country has achieved high treatment coverage, issues of quality and retention in care remain a challenge. Investments in treatment, care and support must respond to these gaps.

¹ UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs as the four main key population groups, but it acknowledges that prisoners and other incarcerated people also are particularly vulnerable to HIV and frequently lack adequate access to services. Figure 3 makes it clear that the number of new infections among people who inject drugs in Zimbabwe is extremely low, therefore they are not considered a key population in this country and disease context.

Figure 4: Treatment Cascade and Progress Towards 90-90-90 Targets, by Sex (2016)²⁶

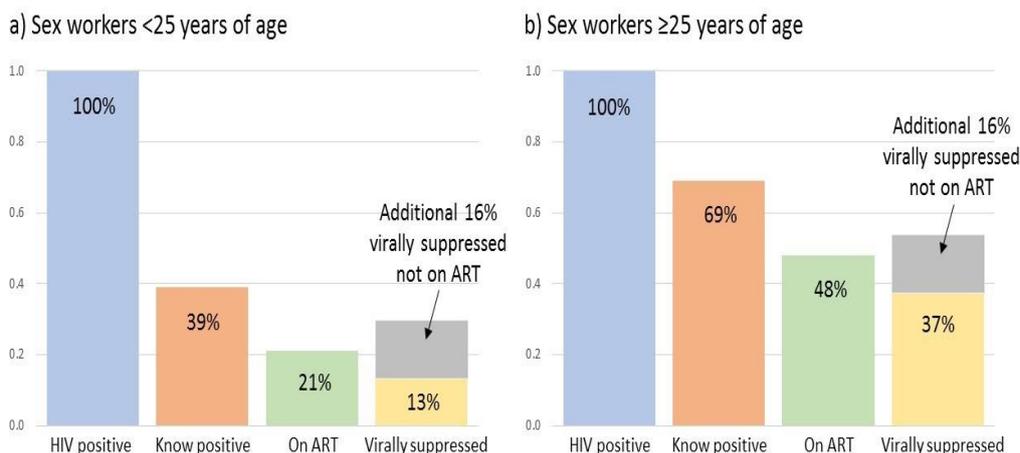


National (Figure 4) and provincial-level 90-90-90 analyses (see Annex 6) clearly indicate that the largest “leak” in Zimbabwe’s treatment cascade is ensuring that PLHIV know their HIV status. Therefore, strategies to increase testing are a key focus of this funding request. Removing stigma and other human rights barriers to accessing HIV testing services (HTS) are critical considerations.

Progress towards 90-90-90 among adolescents and young people in Zimbabwe is distinctly lagging compared to the adult population cascade. This is largely driven by a significant gap in achieving the first 90; among young people aged 15-24, just 52% know their HIV status. Further, the ZIMPHIA survey results indicate that prevalence of viral load suppression is markedly lower among youth aged 15-24, at 48.6% among HIV-positive females and 40.2% among HIV-positive males.

Treatment cascades for sex workers also reveal significant gaps that are particularly pronounced for young sex workers (<25 years of age) (Figure 5). While gaps exist across the cascade for sex workers of all ages, young HIV-positive sex workers require urgent attention given that only 21% access treatment.

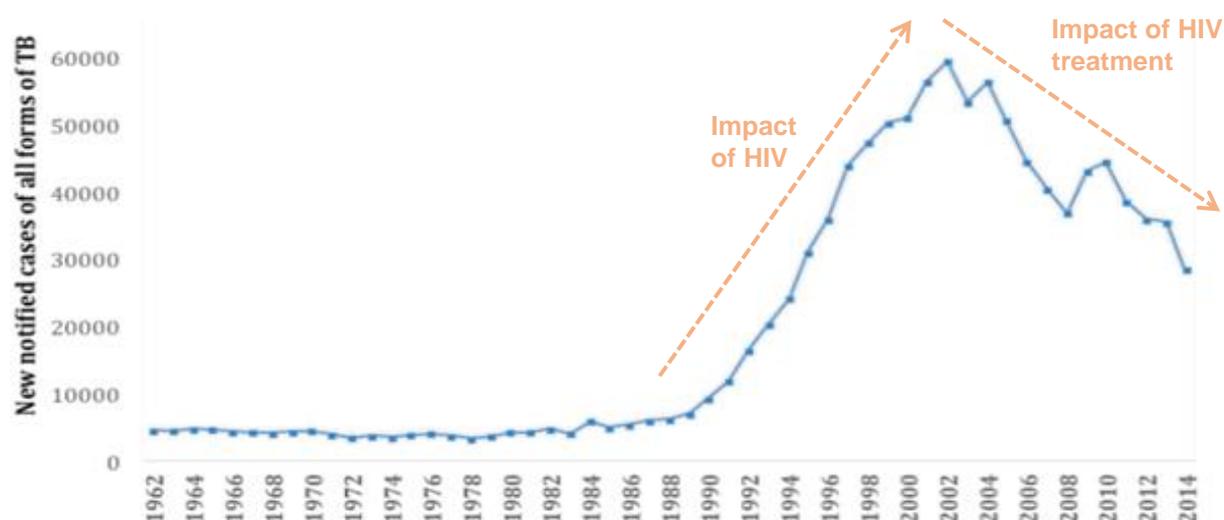
Figure 5: Treatment Cascade for HIV Positive Sex Workers in Zimbabwe, by Age Group²⁷



Overview of the TB Epidemic in Zimbabwe

Zimbabwe’s TB incidence has sustained a downward trajectory from as high as 799/100,000 population in 2005²⁸ to 242/100,000 population in 2015.²⁹ TB mortality excluding HIV has declined by 50%, from 22/100,000 in 2005 to 11/100,000 in 2015, and TB mortality including HIV has significantly declined by 75% from 158/100,000 in 2005 to 40/100,000 in 2015. These gains are largely due to increased investment in TB diagnosis and treatment and stronger TB/HIV collaboration such as the scale up of antiretroviral therapy (ART) in the general population (Figure 6). Despite this progress, the country remains among the World Health Organization’s (WHO) list of 14 countries that are considered high-burden for TB, MDR-TB as well as TB/HIV coinfection. Further, latest treatment coverage data (72%) indicates nearly a third of TB cases go undetected and continue to act as a reservoir for community transmission, making intensified TB case finding a top priority.

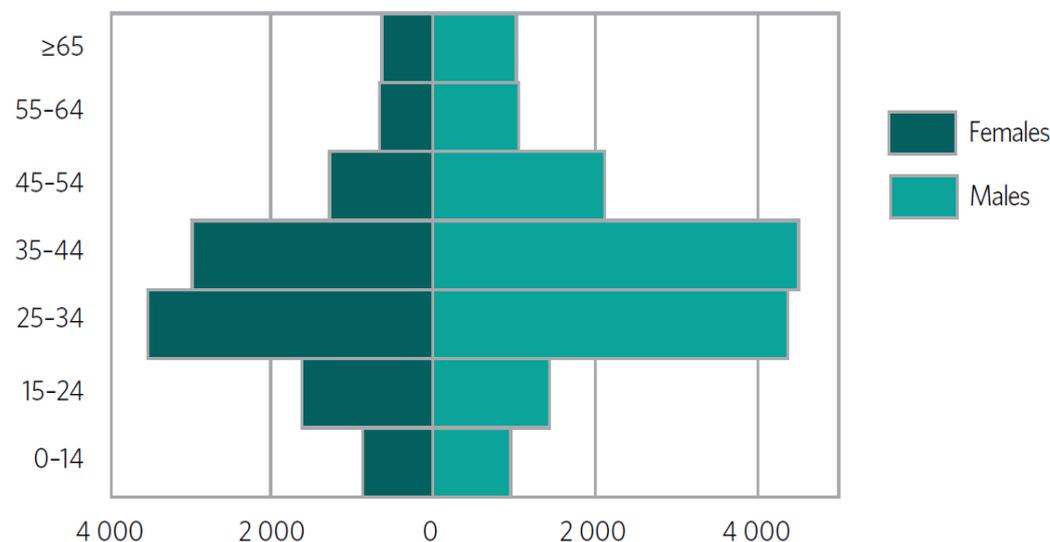
Figure 6: New Notified Cases of All Forms of TB over Time in Zimbabwe³⁰



Results from Zimbabwe's first National TB Prevalence Survey show the estimated TB prevalence for all forms of TB among all age groups was 292/100,000 population in 2014. Childhood TB (<15 years) notifications constituted 8% of all notifications in 2015, against a national target of 15%. Improved integration with reproductive, maternal, newborn child and adolescent health (RMNCAH) and school health programs are required to improve access to childhood TB services and address TB in women.

TB/HIV co-infection rates in Zimbabwe have declined from 86% in 2009 to 72% in 2015, largely due to the effective rollout of ART and TB preventive therapy. 86% and 94% of HIV-positive TB patients are reported to be on ART and cotrimoxazole prophylaxis, respectively.

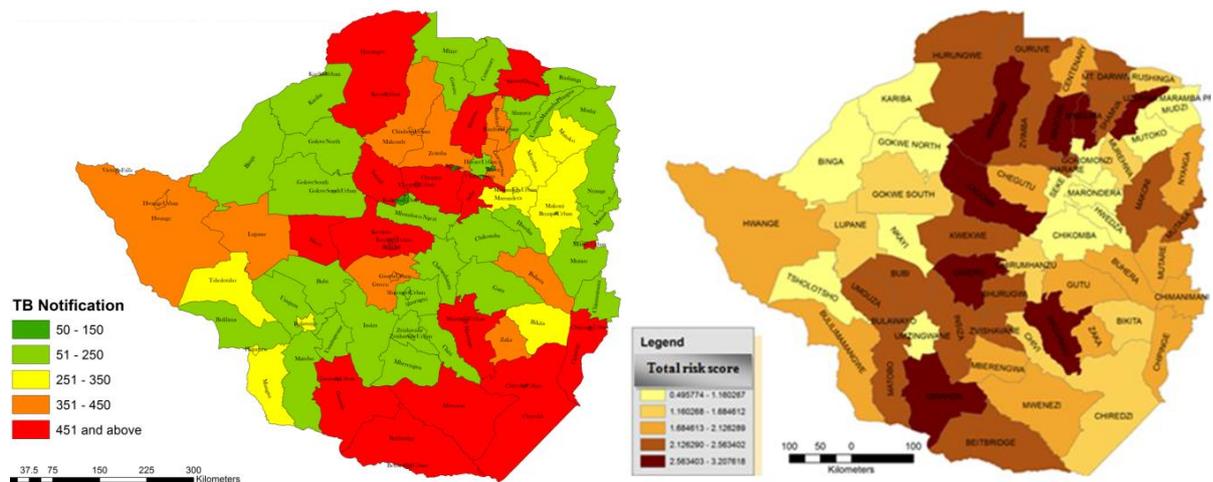
Figure 7: Notified TB Cases by Age Group and Sex in Zimbabwe, 2015³¹



The greatest numbers of new TB cases occur among men aged 35-44, while men aged 25-34 also bear a significant burden (Figure 7). Gender dynamics expose more men to TB than women in all age brackets, except for AGYW (15-24), who had more case notifications than their male peers in 2015. This may be linked with disproportionate HIV burden among this age group as compared to their male counterparts. Importantly, results from the TB prevalence survey found that women were less likely to visit a health facility with TB symptoms than men, with one of the top reasons cited being that the participants could not afford medical care.³² This is an important gender consideration linked to gender inequality in Zimbabwe. Further, a number of studies have found that TB progresses more quickly in women of reproductive age than in men of the same age group.³³ This underscores the need for RMNCAH/TB integration, particularly at community level.

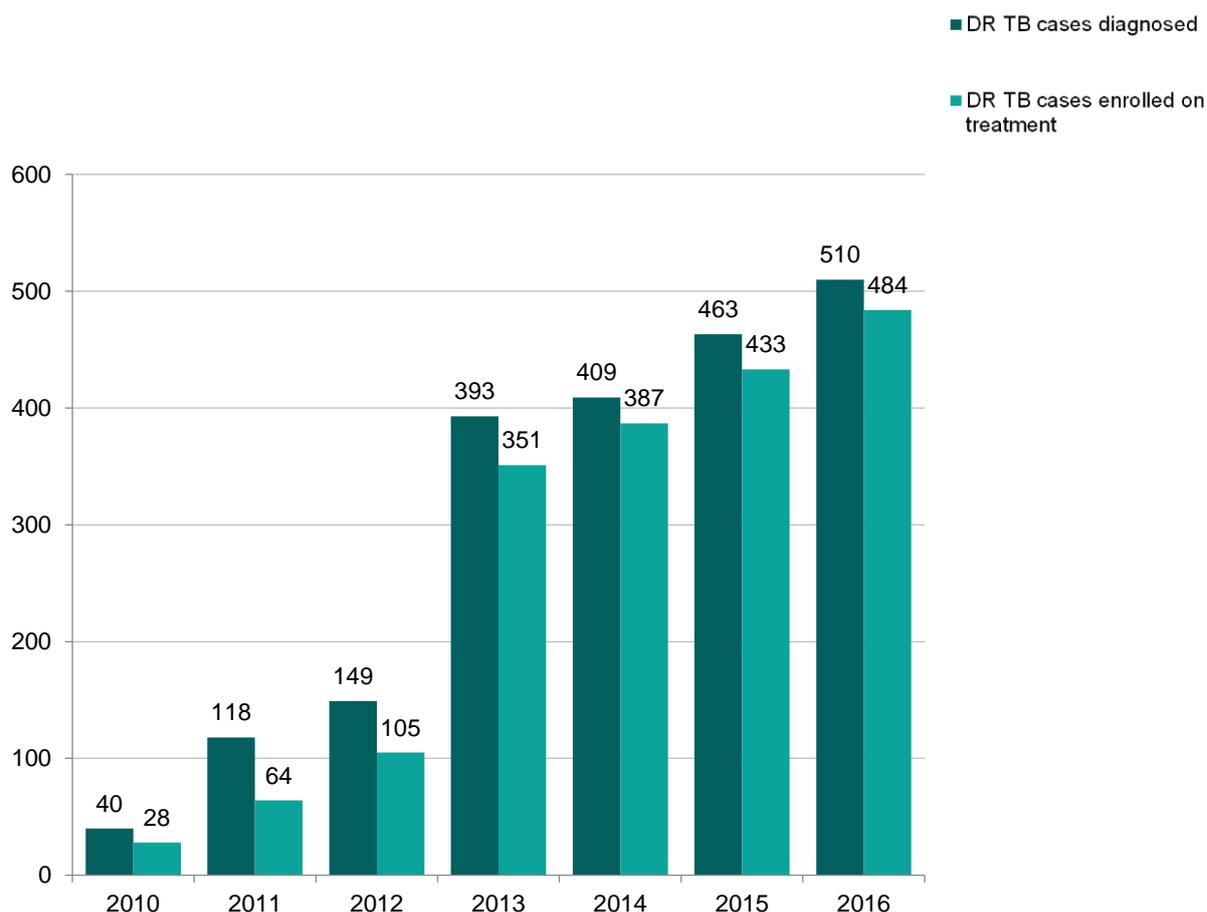
As with HIV, TB is also not evenly distributed across the country. There are hot spots with high TB prevalence in the Southern region of the country and in mining communities (Figure 8).

Figure 8: TB Case Notification Rates (Left) & Distribution of High Risk Groups (Right) (2015)³⁴



The introduction of new diagnostic tools, strengthening laboratory capacity and decentralization of services contributed to increased drug-resistant TB (DR-TB) case detection. WHO estimates show that 3.2% and 14% among new and retreatment patients respectively are infected with rifampicin- or multidrug-resistant TB (RR/MDR-TB). The country has managed to reduce the diagnosis and treatment initiation gap (Figure 9). In 2016, 95% of diagnosed RR/MDR cases initiated treatment, up from 70% in 2010. This was mainly due to decentralization and increased access to services through support of specimen transport systems and community involvement. However, treatment outcomes have continuously declined from 81% in the 2011 cohort to 59% in 2013, against a target of 75%. This can be attributed to increased workload, decreased quality of care as more cases are identified and care is decentralized to lower levels. The program therefore needs to reinforce quality of care by improving clinical and laboratory monitoring of DR-TB cases as well as psychosocial support systems.

Figure 9: Trends in DR-TB Notifications and Treatment Initiation in Zimbabwe³⁵



Several high risk groups bear disproportionate TB burden in Zimbabwe.² PLHIV, children, miners, prisoners, smokers, the elderly and people living in high density areas are particularly vulnerable (Table 1).

Table 1: Distribution of TB in Zimbabwe, by High Risk Group³⁶

Risk Group	% of population in risk group	% of TB Cases	# TB Cases
Children u15 suffering from severe malnutrition	0.8%	0.60%	265
Adults with low BMI	0.6%	0.43%	191
Smoking	6.5%	2.58%	1,133
Alcohol dependence	2.0%	1.06%	468
Diabetes	2.9%	1.65%	726
Elderly	3.1%	0.79%	347
Prisoners	0.15%	0.14%	61
Miners	4.9%	2.70%	1,187
Persons living in high density areas	20.0%	9.17%	4,037
PLHIV	*	68.00%	29,920
TB not found in a high risk group	**	12.88%	5,666

² The Stop TB Partnership defines key populations as children, miners, mobile populations, urban populations, prisoners, rural populations and people who use drugs.

Total	100.00%	44,000
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* determined with TIME Estimates

** not directly modelled, but as 100% (sum of high-risk groups)

Pilots of targeted mobile screening among high risk groups found TB prevalence around 4%, which is 14 times greater than among the general population (see Section 1.3 for lessons learned from this new case finding approach). Preliminary results from a study in Midlands also shows high risk sexual behavior (high rates of STIs) among artisanal miners, signaling the need for integrated TB, HIV and STI services for this high risk group. Indeed, there is a significant overlap among these high risk groups, with many PLHIV placed at additional heightened risk for TB based on where they live and work.

As with other Sub-Saharan African countries, Zimbabwe has a high burden of TB in mining communities. Through the Southern African Development Community (SADC) TB in the mines framework, the country is making progressive efforts and strategies for active TB case finding to address TB in the mining communities and workplaces including exposure to silica dust.

An assessment of TB prevalence in prisons in 2016 found prevalence to be 574/100,000 population screened, which is much higher than the national prevalence.³⁷ Overcrowding of detention facilities is a critical human rights consideration which drives high rates of TB among inmates in Zimbabwe. For example, current holding capacity as of March 2016 was as high as 125.1% in Mashonaland and 135.5% in Manicaland.³⁸

Overview of Zimbabwe's Systems for Health

Zimbabwe has 30,697 out of 37,602 health care workers in post, representing a vacancy rate of 18%, though this is vastly understated due to outdated benchmarks.³⁹ The current situation is an improvement from 2009, when critical shortages existed in human resources for health (HRH) across all cadres of health care workers and the vacancy rate was as high as 60%. Development partners have supported retention of health workers, augmenting allowances through the comprehensive Human Resources Retention Scheme.

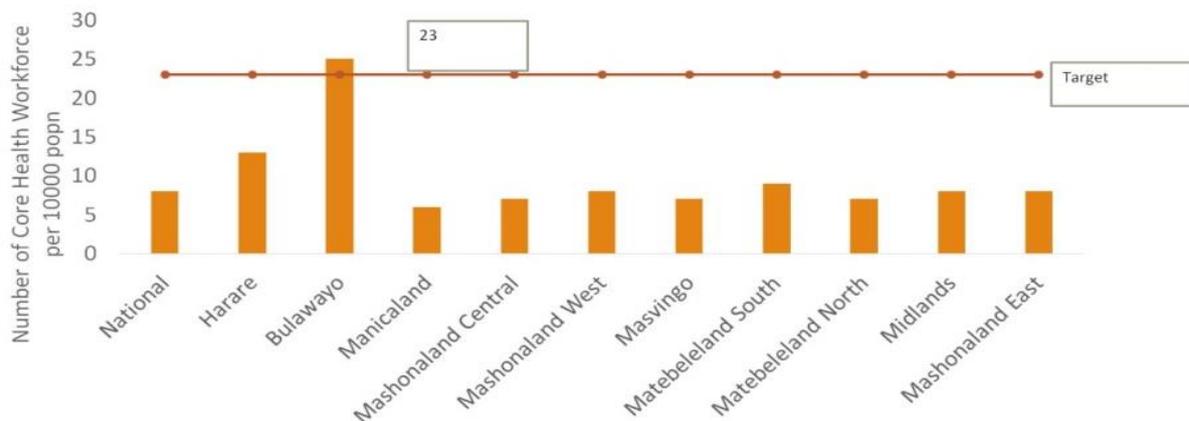
However, HRH gaps remain critical for certain cadres including laboratory scientists, physiotherapists, radiographers, pharmacists, medical doctors and specialists whose vacancy rates remain unacceptably high (Table 2).⁴⁰ Without increased and sustained investments in HRH, impact against the diseases will falter.

Table 2: Vacancy Rates for Select Health Care Workers (as of November 2016)⁴¹

Cadre	Vacancy Rate
Laboratory scientists	44%
Physiotherapists	35%
Radiographers	36%
Pharmacists	41%
Pharmaceutical technicians	11%
Xray Operators	62%
Nurse Tutor	41%
Port Health Technicians	60%
Environmental health Officers	36%
Environmental Health Technicians	54%
Nurses	12%
Doctors (Overall)	27%
Medical Specialists	63%
District TB Coordinators	45%
Clinical Officers	63%

The current national average is approximately 8 health care workers for 10,000 people, well below the WHO target of 23/10,000. Currently, only Bulawayo meets the target (Figure 10).

Figure 10: Provincial Distribution of Human Resources for Health, Against WHO Target⁴²

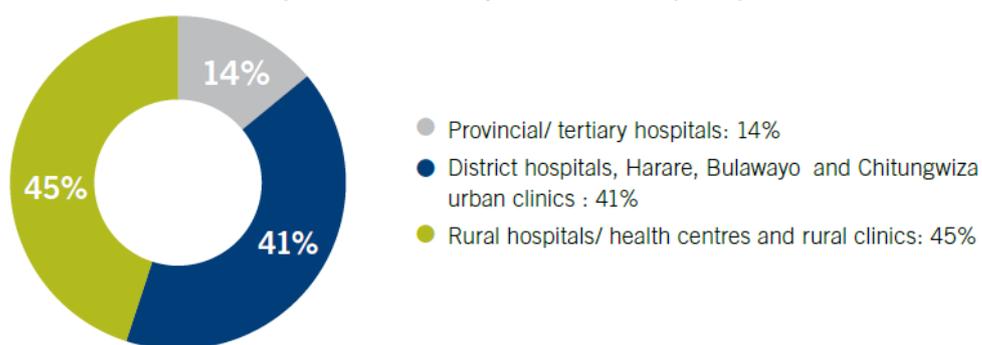


Given constraints on HRH, task shifting is a key strategy alleviating burden in the health system. The country has finalized the task sharing policy that allows nurses to conduct voluntary medical male circumcision (VMMC),⁴³ and primary counsellors (PCs) to offer HIV testing services. The HIV Testing Strategy (2016-2020) aims to support additional PCs for providing HIV testing in facilities.⁴⁴

Community cadres including behavior change facilitators, expert patients, village health workers, community-based distributors for sexual and reproductive health (SRH) services, PLHIV support groups, among others, exist to drive Zimbabwe's community systems and responses. While these community structures have the potential to be highly effective, they must be strengthened and capacitated to track and monitor diseases. Though nascent networks of key and vulnerable populations exist, these require additional investment and capacity building. Many of these community cadres lack adequate structures and are poorly resourced and coordinated. Village health workers submit data to facilities but better data disaggregation and counter verification is required, as are exercises under the performance-based financing program. A recent community mapping exercise highlighted approximately 77 different types of community health cadres, which require further scaffolding and coordination for more coherent community responses.

The number of health facilities providing ART initiation services has steadily increased from 1,163 in 2014 to 1,472 in 2015, with a total of 1,434 (97.4%) of them also offering paediatric ART services. By the end of 2016, there was a total of 1550 sites providing ART across the country, representing (near) full decentralization.⁴⁵ Guided by a decentralization strategy⁴⁶, multi-disciplinary outreach teams of health personnel at district hospitals travel to peripheral clinics and provide all services at those sites. In other cases, patients are initiated at a district hospital and are referred to local clinics for follow up.

Figure 11: Breakdown of ART patient cohort by level of care (2014)⁴⁷

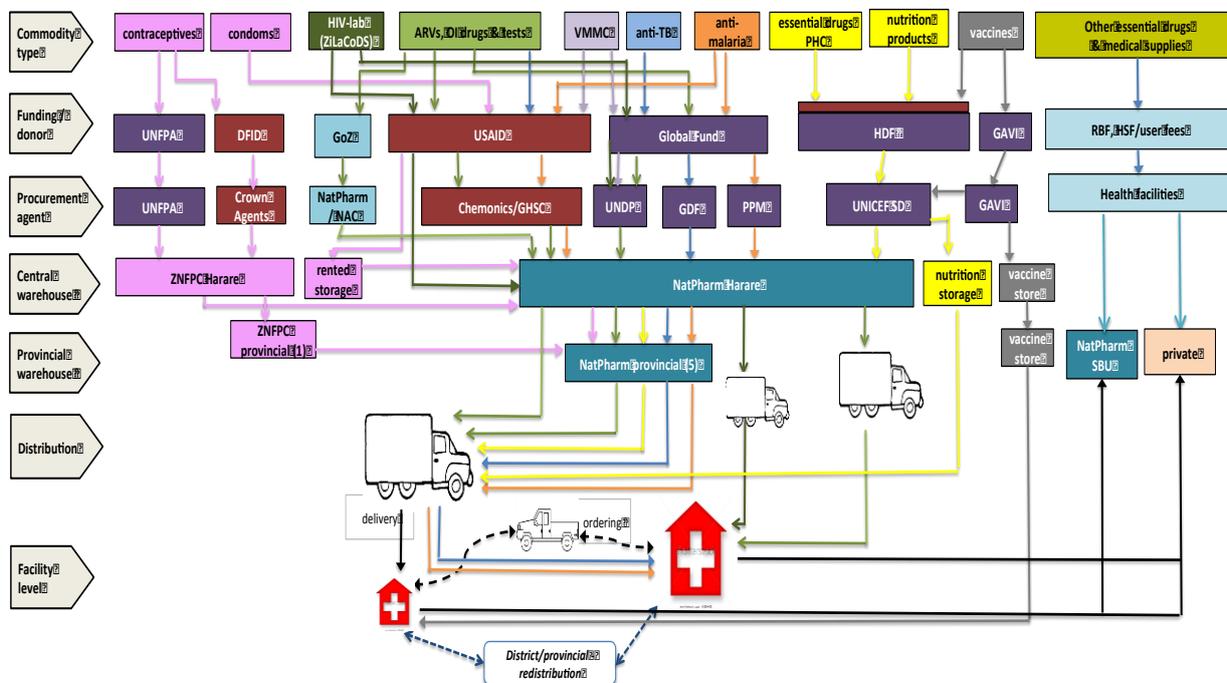


In 2011, the Ministry of Health and Child Care (MOHCC) resolved to establish electronic systems to collect and manage TB/HIV data at patient level. While the MOHCC acknowledges a long-term need to establish a more integrated system, the electronic patient management system (ePMS) for HIV/TB was established first as an entry-point. The ePMS has been rolled out in a phased approach, with 634 sites functioning as of December 2016. The ePMS Strategic Plan (2018-2020) aims to implement the ePMS system in 1039 health facilities and 184 health posts/ART follow up sites by December 2020.⁴⁸ The 2014 ePMS assessment notes that tracking quality of care indicators has improved since transitioning from a paper based system, with more accurate monitoring, tracking and reporting of patients accessing HIV services.⁴⁹ However, significant opportunity remains to strengthen and link patient level information systems, unique identifiers, and district level information systems to support HIV, TB and health programs in more integrated ways. Work on addressing the long term needs of a more comprehensive

integrated electronic health system has started with the piloting of the Electronic Health Record system (EHR).

In terms of procurement and supply chain, Zimbabwe has improved coherence of the system with respect to quantification of commodities required, partially pooled procurement through the Health Development Fund (HDF), joint warehousing and more harmonized distribution chains (Figure 12).

Figure 12: Harmonization and Coherence of Zimbabwe’s Procurement and Supply Chain



However, challenges with procurement and supply chain management (PSM), particularly specimen transport, persist as a weak point in the health system. A PSM quality assurance (QA) plan is available but only partially implemented. Implementation of quality management systems for labs is needed for accreditation of laboratories. Improving these aspects of Zimbabwe’s systems for health is imperative to maximize HIV, TB and malaria investments and ensure gains are more sustainable.

1.3 Past implementation and lessons-learned from Global Fund and other donor investments

- List recent disease-specific Global Fund grants from the 2014-16 allocation period and summarize key lessons learned from their implementation.
- Include lessons-learned from specific HSS grants or any HSS investments embedded in the disease-specific grant(s) from the 2014-16 allocation period as applicable.
- Outline lessons learned from investments by other donors as applicable.

For each of the above, explain how these lessons learned are taken into account in this funding request.

Several important program and impact reviews have been conducted which reveal critical areas for evolving and refining Zimbabwe’s HIV and TB responses. This funding request is cognizant of these findings and directly responds to identified gaps and opportunities. Key lessons learned from Zimbabwe’s two active HIV and TB Global Fund grants (ZIM-H-UNDP and ZWE-T-MOHC), cross-cutting RSSH investments, and the investments of other funding partners are summarized below.

Lessons Learned from Current HIV Global Fund Grant Implementation

A comprehensive evidence and impact review of Zimbabwe’s HIV program (Annex 7) highlights seven key lessons which guide and inform this funding request:

- **Focus on scaling up HTS**, particularly among young people, older men and key populations, Innovate with partner, lay and self-testing that is delivered by community and peer workers.

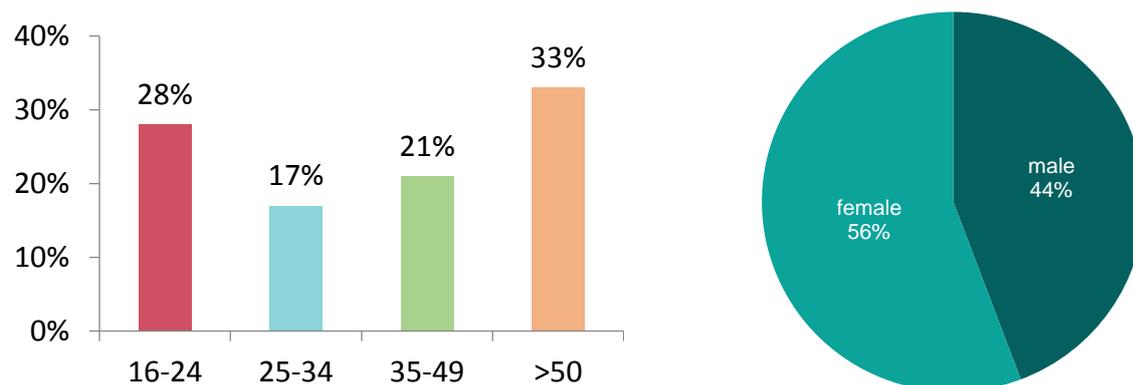
- **Older men have been missed with prevention.** Non-facility-based prevention including workplace prevention, peer education, and targeted media requires a dedicated focus.
- **Prevention for AGYW is more effective with a layered approach,** which goes beyond health to address poverty, gender inequality, sexual violence, education and family support.
- **Comprehensive packages for key populations** should include prevention, treatment and empowerment components, delivered through a peer-driven approach.
- **Strong impact on eliminating vertical transmission (eMTCT) can be sustained** with a shift towards individual case reporting and follow-up and targeted engagement with local leaders in key provinces (ie. Manicaland).
- **Further impact on VMMC** is possible by focusing on older men and low-coverage districts.
- **Address cross-cutting RSSH issues** to strengthen strategic information, human resources for health, one-stop-shop service delivery and integration of eMTCT and RMNCAH platforms.

Elaborating on the above, there are several more specific lessons learned from implementation:

Self-testing can scale up HTS among young people and among men

ZIMPPIA survey data suggest the largest gap in the treatment cascade is in HIV testing coverage, with a particular need to adjust testing strategies for reaching youth (<25) and men. Lessons from Zimbabwe's HIV self-testing pilot suggest this may be an effective strategy to boost testing among these groups (Figure 13). To date, 65,000 test kits have been distributed in pilot sites, primarily through community-based distributors, with a 65-70% return rate. 28% of all self-testers were young people age 16-24 and 44% of were men. 21% of those who self-tested were first time testers.

Figure 13: HIV Self-Testing Uptake at Pilot Sites in Zimbabwe, by Age and Sex⁵⁰



To reach young sex workers a comprehensive package and delivery model must be tailored

Implementation lessons from the national sex worker program (Sisters with a Voice⁵¹) show that despite successes in engaging adults, reaching young sex workers has proved challenging. A survey among 2722 sex workers in 14 sites found younger women had significantly lower levels of HIV testing and engagement with care.⁵² Yet, in 2013 less than 1% of sex workers engaged by the national program were under the age of 18.⁵³ Further scoping revealed that the priorities of young sex workers centre on protection from violence, client negotiation, gaining confidence to use clinical services, and accessing education or income-generating opportunities.⁵⁴ The comprehensive package in this request is tailored to amplify these particular aspects to reach young women who sell sex.

Peer-to-peer models are effective prevention and treatment strategies to reach AGYW

Through Global Fund investments, the National AIDS Council (NAC) introduced the sista2sista (S2S) program, reaching 9,882 vulnerable girls in 20 hotspot districts. 7,957 girls completed the five-module curriculum, and more than half accessed HIV testing services. These successes suggest that the S2S initiative has the potential to significantly increase HIV testing uptake among vulnerable AGYW. In addition, the Africaid Zvandiri Community Adolescent Treatment Supporters (CATS) model⁵⁵ has been successful in providing peer adherence support to young PLHIV. An evaluation of the CATS model found that those in the program are 3.9 times more likely to adhere to treatment.⁵⁶ With incentive funding from the Global Fund, a total of 11,060 young people were mobilized through the CATS model to receive HTS through index case finding and were linked to care for accessing ART and a range of other integrated services.⁵⁷ Matching funds are requested for both these models.

To reach saturation, VMMC should focus on older men and low-coverage districts

VMMC as part of combination prevention has increased. As of 2016, 839,681 procedures have been done, representing 65% of the 1.3 million target. However, lessons show that coverage is highly inconsistent, with some districts already at saturation levels among the target group (15-29)⁵⁸ while others lag far behind.⁵⁹ Significant gaps also exist among older men. VMMC coverage among men age 15-29 is 33%, but this drops to 16% among men in their thirties and 12% in men older than 40. Lessons learned from PEPFAR implementation further underscore the need to scale up VMMC among older men in DREAMS districts, linked with reducing HIV incidence among AGYW.⁶⁰

Better integration of RMNCAH, SRH and HIV would improve quality of care along the life cycle

Previous Global Fund funding requests have not effectively integrated RMNCAH with HIV services. Consequently, lessons learned point to low quality of care at all levels, despite high service coverage. This is linked with persistently weak program integration resulting in missed opportunities and a fractured continuum of care along the life cycle and across service delivery levels.⁶¹ Further, a recent evaluation⁶² recommends that the MOHCC revise existing policies⁶³ to further address SRHR/HIV linkages and integration and continue to ensure their operationalization. The evaluation also urges greater efforts are required, ensuring training of trainer (TOT) activities are cascaded down to lower levels and that SRHR/HIV integration happens in all training curricula used by facilities. The National Health Strategy for Zimbabwe (2016–2020) makes a key recommendation to strengthen integration of family planning services with MCH and selected SRH and HIV services.⁶⁴

Lessons Learned from Current TB Global Fund Grant Implementation

The 2016 WHO External TB Programme Review (Annex 8) highlights key lessons from implementation of the National TB Program which guide and inform this funding request:

- **GeneXpert machines are grossly underutilized.** This is largely linked with inconsistent supply and distribution of cartridges.
- **Exemplary response to TB/HIV co-infection is linked with one-stop-shop models**
- **Continue processes and approaches to improve TB diagnosis in children** including developing the clinical capacity to suspect TB in children and to carry out procedures such as Naso-Gastric (NG) and Naso-Pharyngeal (NP) aspiration and appropriate Tuberculosis skin testing (TST) administration and reading/interpretation of results.
- **The quality of MDR-TB care can be enhanced and made safer** through routine use of available line probe assays, enhanced provision of psychosocial support, and better screening and monitoring of patients on treatment with second line drugs for adverse events.
- **Scale up systematic screening of vulnerable groups** while monitoring and documenting active case finding activities to identify high yielding, effective and efficient approaches.
- **Advocacy, communication and social mobilization (ACSM) is working well**, with communities increasingly being engaged in the TB response through local civil society organizations (CSOs). This will be continued and enhanced with this funding request.

Elaborating on the above, there are several more specific lessons learned from implementation:

Expanded use of more sensitive diagnostics for TB

Scaling up Xpert MTB/Rif technology during the current Global Fund TB grant has significantly reduced the laboratory turn-around time (TAT) for TB diagnosis and increased the identification of bacteriologically confirmed TB cases. As the general notifications decline, there are increased numbers of bacteriologically confirmed cases from 40% in 2014 to 43% in 2015. However, this technology has not been optimally utilized due to challenges with specimen transportation, delays in the relay of results, infrastructure (power cuts, air conditioners), weak PSM and limited health worker knowledge. The diagnostic algorithm has since been revised with the new National TB Guidelines to include Xpert MTB/Rif use as an initial test for all presumptive TB clients in line with the current WHO recommendations. This funding request prioritizes this new approach to improve TB diagnosis.

Importance of chest X-rays as a more sensitive screening tool for TB

The National TB Prevalence Survey demonstrated that field chest x-ray screening was more sensitive in identification of TB compared to symptom screening. This has informed review of National TB Treatment Guidelines to promote use of chest radiography as a more sensitive screening tool for TB.

Targeted TB screening is an effective strategy to increase case finding in high risk groups

Zimbabwe initiated targeted TB screening among high risk communities in 2016 using a mobile screening model. The first six priority districts in three provinces were covered over two months. Of 11,870 people screened for TB, 185 bacteriologically confirmed patients (of which 3 were RR-TB) were diagnosed with TB (1,558/100 000 clients screened). Based on the promising yield of this intervention,

the new TB NSP (Annex 3) prioritizes this approach to target hard to reach high risk community groups. This funding request prioritizes activities that are in line with the new approach.

Lessons Learned from Embedded RSSH Interventions in Current Global Fund Grants

For the HIV program, lessons from the 2016 WHO epidemiology and impact review (Annex 7) point to key RSSH investments that contribute to greater impact:

- **Health and community workers capacity, retention and training.** Going forward these need to include differentiated care and sensitization to adolescent and key population services to improve service uptake.
- **Procurement and supply chain capacity,** including rolling out access to viral load testing and integration of its data into routine monitoring.
- **Program monitoring and evaluation.** Comprehensive implementation of initiatives in this area must be consolidated to improve patient retention and quality of care.
- **Community systems capacity,** including peer educator capacity to deliver and monitor prevention, testing and initiate treatment, with point of service delivery.

For the TB program, the 2016 WHO External TB Programme Review (Annex 8) highlights specific RSSH lessons learned:

- **Clinical and laboratory efficiencies should be enhanced through adequate investments in the national sputum transport system** including eHealth innovations and information management system for real-time data capture and monitoring at the national level.
- **Move to electronic recording and reporting for TB data** and develop a system enabling supervision through adherence to supervisory schedules, routine check lists, creation of a standardized supervision reporting system, a data base of supervision recommendations and utilization of feedback loops.
- **Develop and implement plans to enhance research capacity** through targeted staff training and mobilize resources to conduct relevant TB research.

In a third assessment, the 2016 Office of the Inspector General (OIG) Report on Zimbabwe flags two key systems-related areas for improvement: **quality of care** (deemed in need of significant improvements) and the **supply chain** (deemed partially effective). More specifically:

Strategic investments in HRH are vital to improve quality of care

The scale up of services – including the commendable 30% increase in the number of people on ART in 2014 and 2015 – has not always been accompanied with corresponding increases in the quality of services. About one third of HIV positive cases receive no confirmatory tests to mitigate false diagnoses.⁶⁵ The OIG report largely attributes this issue to economic challenges in Zimbabwe (alongside diagnostic capacity), acknowledging that quality of care is directly linked with the availability of health workers at facilities. HRH are jeopardized by the country's challenges in paying health workers salaries, its freeze on employment in the public sector and health worker migration to other countries. Investments in critical front line cadres including nurses, doctors, laboratory and pharmacy personnel, have been critical for impact against the diseases and it is imperative that the Global Fund and its partners continue to support retention schemes to incentivize and retain workers at health facilities. The recent EU review on HRH found that the 25% staff bonuses provided under the performance-based financing program helped to improve staff performance and job satisfaction, and proposed that the current level of bonuses either be maintained or increased to 30%.⁶⁶ The 2016 WHO External Program Review of the National TB Program (NTP) concluded that lack of continued investments in health care worker retention schemes would result in devastating effects on health service delivery.⁶⁷ The national results-based financing model been prioritized as the most cost-effective health financing mechanism to improve health outcomes in the new National Health Sector Strategy (2016-2020). Performance-based financing for HRH is therefore prioritized in this request.

A strong PSM will improve delivery/accountability of medicines, samples and health products

Since 2012, the country's supply chain management system has improved with well outlined, coordinated PSM activities including integrated multidisciplinary selection and quantification process, partially pooled procurement system, harmonized distribution systems, increased capacity of NatPharm and improved management of expired medicines. Expansion of the laboratory network from 110 microscopy sites in 2010 to 230 in 2015 has brought diagnosis closer to communities. Investment in the specimen transportation system has ensured optimized access for more patient oriented service provision for TB diagnosis and decentralizing DNA/PCR to the provincial level has contributed to a significant reduction in turnaround time of EID results (from 3-6 months to 2 weeks, in many districts). However, challenges with an uncoordinated specimen transportation system (there is a need to

strengthening integrated sample transportation for HIV, TB and malaria samples), inaccurate and/or incomplete record keeping, storage constraints and government debt to NatPharm (\$23 million) hamper the country's ability to effectively store and distribute health commodities in a timely manner. The importance of establishing and supporting the Logistic Management Information Systems (LMIS) at the health facility level cannot be overstated. LMIS data is collected and transmitted manually from facility level to central level where it then captured into electronic systems.

Community-based interventions improve awareness and responses to health issues

Community structures are an important interface with the health delivery system. Formation of community ART refill groups (CARGS) and other community support structures have contributed to differentiated models of care for treatment adherence for patients on ART, access to treatment in malaria prone areas, and identification of presumptive TB cases. However, engagement of the communities has been fragmented and disease specific. This has resulted in the community-based cadres being overwhelmed by demands from the various programs. Each disease program has developed disease specific recording and reporting tools with potential duplication of tracked indicators. Opportunities exist for integration at community level through the development of simplified and integrated recording/reporting tools which cater for the various programs.

Engage civil society and communities as partners to reach key populations

Zimbabwe's NFM grant delivered progressive results through the behaviour change program, led by NAC and implemented by partners in all 10 provinces. Given the importance of community systems and responses for this intervention, civil society organizations (CSOs) should be more closely engaged as implementing partners. Key population programming was initiated under this grant and this saw trainings to health care workers on how to engage and care for people with disabilities, sex workers and other key populations. Further, trainings for community structures such as the Tongogara Refugee Camp and Mashonaland West Artisanal miners capacitated PLHIV and TB patients as peer educators which led to increased awareness and adherence. The recent WHO epidemiology and impact review highlighted peer educators for key populations as a lynchpin of success for achieving HIV impact. Yet, a task force (set up by the CCM TB Committee) found that recognition of the importance of community-based workers to improve case finding and treatment success rated did not match with allocation of adequate resources, training, and mentoring.

Electronic record and reporting systems improve access to and use of health information

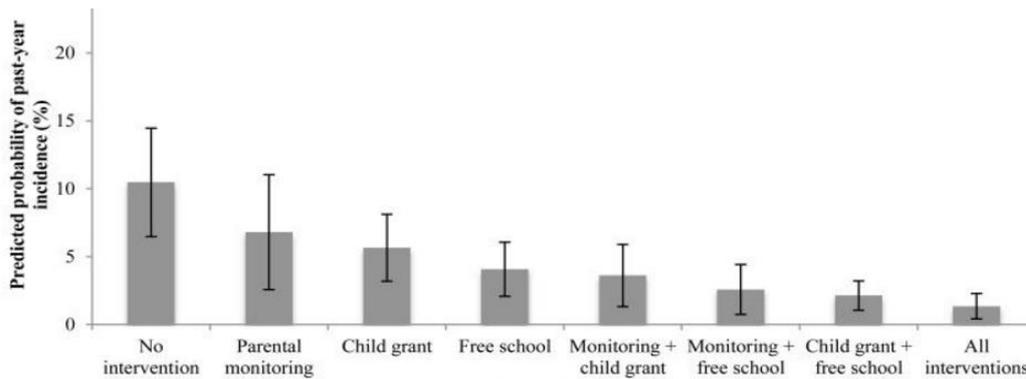
There has been significant Global Fund investment to develop an electronic patient monitoring system (ePMS), primarily designed for PLHIV in care. It has, however, not fully integrated the reporting requirements of other health conditions such as TB and malaria as HIV positive status is the key entry point to the system. There are efforts to pilot a more comprehensive electronic health record (EHR) for all health conditions within the broader context of a robust national health information system. The pilot has demonstrated successes so far in providing health workers with one system that is capturing data for all diseases and conditions. The system has been able to reduce the number of registers in use at the clinic level, and has greatly reduced time required for producing aggregated reports (from as much as a 2-3 days to as low as a few minutes). Lastly, the system offers improved quality of data by offering health workers feedback through an end of day data quality report, range checks and guidelines for completing simple tasks such as TB screening. The investments proposed in this funding request build on the existing Global Fund investments in ePMS, DHIS2 and LMIS to support the Ministry's decision to integrate the several existing electronic health information systems (Zimbabwe EHR roadmap) and also support the completion and roll-out of other specialized information tools. In addition, while there is significant investment in electronic patient management systems, there has not been a commensurate investment in electronic logistics management information systems, which this funding request seeks to address.

Lessons Learned from Investments of Other Major Funding Partners

The layered approach as a success factor for reducing HIV incidence among AGYW

The success of DREAMS is hinged upon layering of interventions, targeting most vulnerable AGYW with education subsidies, HTS, family planning commodities, post-violence care, livelihoods programs and family strengthening. This layered approach has demonstrated direct impact on reducing HIV incidence in AGYW (Figure 14). PEPFAR's experience shows that educational subsidies are essential as part of the layered approach and that condom funding must be available to sustain social marketing programs. Educational subsidies are a core component of the AGYW funding requested.

Figure 14: The Effect of Layering Interventions on Reducing HIV Incidence (Girls, 12-18)⁶⁸



Youth-responsive interventions boost impact of gender and behavior change interventions

The European Union invests in a school-based and community HIV and GBV prevention program called Young4Real, implemented by SAfAIDS. An evaluation of the program showed an increase from 26.7% to 47.7% of adolescent girls 15-19 years who indicated that they were confident that they would insist on condom use every time they had sex. It also showed a decrease from 36.8% to 9.5% of young females who reported having multiple concurrent sexual partners. In addition, GIZ invests in an approach called the Join-In Circuit on HIV, Love & Sexuality (JIC), implemented among youth aged 15-24 years. Because service providers have improved to be more youth-friendly, 97.9% of targeted youth would visit the health facility again.

Integrated TB/HIV Care (ITHC) “one-stop-shop” increases uptake of HIV and TB service

The high TB/HIV co-infection (>70%) has justified the need to promote a one-stop-shop integrated TB/HIV patient care model. The 46 existing ITHC sites in the USAID-supported Challenge TB program have achieved 98% coverage for HTS, slightly higher than the national average (96%).⁶⁹ These one-stop-shop centres have also achieved 82% ART coverage among HIV positive TB patients, 10% above the national average.⁷⁰ Further, co-trimoxazole preventive therapy (CPT) coverage among HIV positive TB patients was 91% for ITHC sites compared to 81% nationally in 2016. This funding request prioritizes capacitating district teams to roll out this model to more sites.

Bi-directional screening among TB and diabetic patients is a crucial integration opportunity

Given the evidence of Diabetes Mellitus (DM) as an important risk factor for TB and the WHO recommendation to implement bi-directional screening, Zimbabwe initiated a pilot in 10 high volume primary care urban clinics which was supported by the World Diabetic Foundation. In the first six months of implementation, 10% (67/661) of TB patients were newly diagnosed with DM, while 2% (3/154) of known DM patients were newly diagnosed with TB. Early identification of DM and appropriate management among TB patients increases positive treatment outcomes and quality of care. Systematic screening models may also contribute to early identification of additional TB cases.

SECTION 2: FUNDING REQUEST (Within Allocation)

This section should describe and provide a rationale for the program elements proposed for this funding request. Attach and refer to completed **Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework and Budget**, and refer to national strategy documents as applicable.

To respond, refer to additional guidance provided in the *Instructions*.

Ensure that the funding request as described in questions 2.1 and/or 2.2 meets the focus of application requirement as outlined in section 2.3.

2.1 Disease-specific funding request

Not applicable if the application is a standalone RSSH request.

Given the context and lessons learned outlined in Section 1,

- a) Describe the disease-specific funding request(s), the rationale for prioritizing modules and interventions, and how these choices ensure the highest possible impact with a view to ending the three diseases and removing human rights and gender-related barriers to accessing services.
- b) For any priority modules for which gaps are difficult to quantify in the programmatic gap tables, explain here the barriers being addressed, the proposed interventions and the population or groups involved.
- c) Explain how the funding request addresses the key funding gaps reflected in the Funding Landscape Table(s) for the disease program(s) in the current allocation cycle, and specify other actions planned to cover remaining gaps.

For funding requests including both HIV and TB components:

- a) Describe the coordination of joint TB and HIV strategies, policies and interventions at different levels of the health system, including community systems, and expected impact and efficiencies from the joint programming.

This funding request represents a targeted investment within a comprehensive response. Based on a full review of the country's approach and strategic priorities, the requested investment harnesses disease and systems-related opportunities to maximize impact and value-for-money.

As highlighted in Section 1.2, the thrust of this funding request is threefold: **(1) enhance integration** and efficiencies, **(2) focus for impact** by prioritizing key and vulnerable populations and geographic hotspots; and **(3) improve quality** across the continuum of care.

Table 3 provides an overview of the prioritized funding request, presented by module.

Table 3: High-Level Overview of Integrated HIV/TB/RSSH Funding Request, by Module

Module	Amount (USD)
Treatment, care and support	\$314,953,679
HIV Testing Services	\$23,074,707
Prevention of mother-to-child transmission	\$1,761,900
Prevention programs for adolescents and youth, in and out of school	\$3,174,288
Comprehensive prevention programs for sex workers and their clients	\$1,795,260
Comprehensive prevention programs for men who have sex with men	\$649,712
TB/HIV	\$4,923,144
TB care and prevention	\$9,549,916
Multidrug-resistant TB	\$6,792,626
Human resources for health, including community health workers	\$17,376,000
Health management Information system and monitoring and evaluation	\$4,035,122
Procurement and supply chain management systems	\$750,000
Program management	\$43,458,381
TOTAL	\$432,294,735³

³ Total reflects Zimbabwe's HIV allocation + TB allocation + \$2 million of the malaria allocation for cross-cutting RSSH.

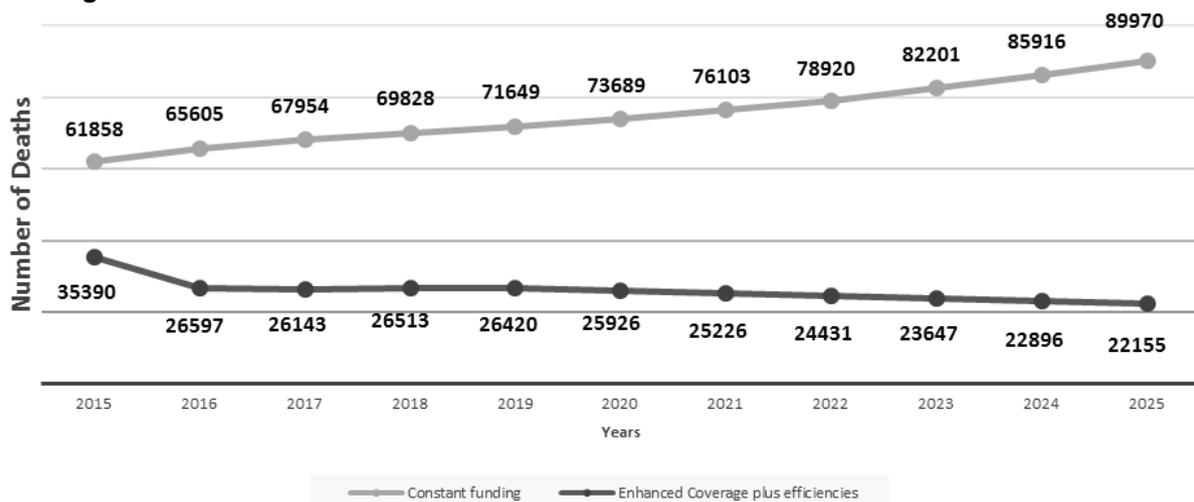
It is important to note that a rigorous prioritization exercise was performed to arrive at the within allocation request. Due to the unique country context, it is acknowledged that this is necessarily a highly commoditized grant. This is based on the country's programmatic gaps and the identified opportunities to maximize impact. That said, the country has given considerable effort to define the prioritized above allocation request (PAAR), with many activities described in great detail within specified Annexes (14-16). The reason for this is to demonstrate the country's equal weighting to programmatic activities, and the seriousness with which the country intends to implement these activities if additional funding becomes available.

Module: Treatment Care and Support

Zimbabwe's top priority for the next three years is to scale-up the number of people receiving sustained ART. As the most high impact intervention, funding is requested to ensure that the country meets its treatment targets, as contained in ZNASP III (2015-2020). The proposed investment maintains all patients that are currently receiving treatment through Global Fund for the next three years. But, combined with the anticipated \$60 million investment for adult ART from PEPFAR and the \$30 million investment from the National AIDS Trust Fund, the proposed investment from Global Fund will enable Zimbabwe to scale up treatment access ensure that by 2020, at least 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.

Specifically, funding is requested to **procure adult and pediatric antiretroviral medicines** to scale up ART coverage to achieve 90% coverage by 2020, in conjunction with the anticipated investments from other partners (PEPFAR and the National AIDS Trust Fund [NATF]). This will be done using differentiated models of care, and rolled out in line with the "Treat All" national policy which Zimbabwe adopted in 2016 and took to scale nationally as of January 2017. The funding requested is inclusive of 20% PSM costs, covering storage of medicines at NatPharm, transport to facilities (in line with the country's decentralization strategy) and quality assurance. The proposed treatment investment is in line with the "enhanced coverage plus efficiency" scenario in Zimbabwe's HIV Investment Case. This scenario is modelled to avert an additional 540,000 AIDS related deaths over a ten year period, compared to the "constant funding" scenario (Figure 15).

Figure 15: Zimbabwe AIDS deaths in 2 Scenarios 2015-2025: Business as Usual vs. Enhanced Coverage with Efficiencies⁷¹



Second, funding is requested to enhance treatment monitoring and improve quality of care for those supported on treatment, including strengthening the monitoring of toxicity, preventing and monitoring HIV drug resistance (HIV DR) and conducting operational research on aging and HIV. The rationale for prioritizing this intervention is in line with the recent (2016) OIG recommendation for Zimbabwe that the country needs to prioritize consistent delivery of the tests required prior to and after initiation of treatment.

Specifically, funding is requested for **expanded and decentralized viral load (VL) testing capacity**. In line with the country's Viral Load Scale-up Plan (2015-2018), viral load testing is being scaled up in a phased approach. The phased approach targets patients from throughout the country, with differing timing to launch routine VL testing for selected patients and routine VL testing for all patients depending on patient location.

Currently in Phase 3 (in 2017) of the viral load scale up plan, rural clinics/health centres have started offering routine testing to selected patients for monitoring, prioritising children and pregnant women, with a gradual scale-up of routine testing for all patients at all levels by 2018. Given that VL scale up is being done in a phased approach, funding will also support **conventional and point-of-care CD4 testing** to complement VL testing. Funding is also requested for **early infant diagnosis, hematology, serology** and related chemistry and consumables.

It should be noted here that the identification and management of common opportunistic infections and related morbidities aimed at holistic service provision are captured in the TB/HIV module. It is also noteworthy that the National AIDS Council has prioritized allocation of savings from the NATF to address issues of kaposi sarcoma.

Lastly, funding is requested to **provide integrated adherence support** through differentiated models of care, including community models and one-stop services. This includes adapting to decentralization by expanding to community settings and prioritizing same-day initiation and integrated services for key populations (see comprehensive packages of care prioritized for key populations below).

Strengthening adherence and retention among children and adolescents is prioritized in the matching funds request, to catalyze comprehensive investments in AGYW. Enhancing skills and capacities of health workers to provide integrated care (including adherence support) is prioritize in the TB/HIV module (see activities on the blended learning program).

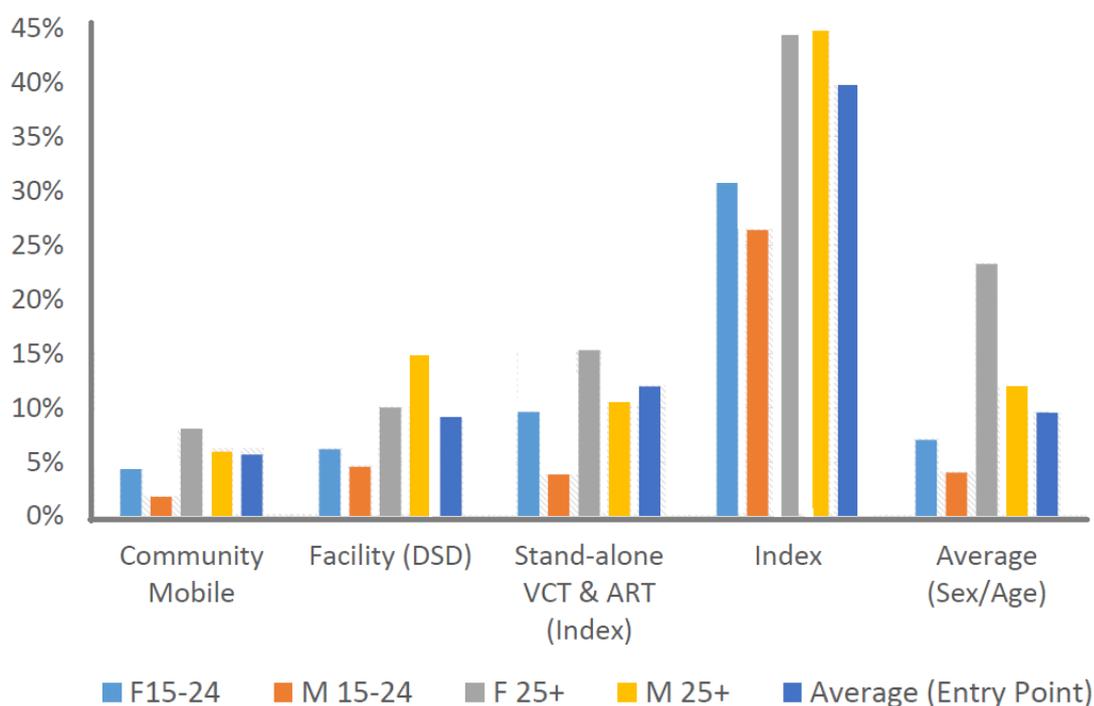
Module: HIV Testing Services

In order to support the scale up of treatment illustrated above, the HIV testing module will achieve the first 90 with this grant, with innovations in test-and-treat and enhanced linkage to care.

Specifically, funding is requested to **scale up innovative and differentiated HIV testing models** to achieve the first 90, including lay testing, partner testing and index testing, focusing on high yield populations (including key populations and presumptive TB cases). Chiefly, the funding will fill critical gaps in the procurement of test kits, ensuring complementarity between Global Fund and PEPFAR investments in testing. Self-testing as an additional innovation has been prioritized in the PAAR.

HIV testing models will be facility- and community-based, and also include index testing. The rationale for including index testing is based on lessons learned from PEPFAR programs that this method may be especially effective at ensuring more PLHIV are aware of their HIV-status, with large increases in yield as a result of a targeted approach (sexual partners and networks) and working flexible hours and weekends (Figure 16).

Figure 16: HIV Positive People per 100 Tests Done in Each Entry Point, By Age and Sex⁷²



In addition, funding under this module is requested to **support the retention of 1200 Primary Counselors** to deliver quality HTS. Recall from Section 1.2 that PCs have played a key role in task-shifting HTS and ensuring that more people are aware of their HIV status. This request is in line with the country's HIV Testing Strategy (2016-2020) which aims to support additional PCs for providing HIV testing in facilities.⁷³ Investments in PCs are a key aspect of improving the quality of HIV testing services with implementation of the latest guidelines, and strengthening internal and external quality systems to reduce misdiagnosis, upholding rights and confidentiality.

Linkages with RMNCAH platforms and STI services will be exploited to scale up testing, based on evidence which shows this can be a high-yield approach. For instance, results from rapid assessment at Kwekwe district hospital assessing facility-based HIV testing services by entry point found a 40% HIV positivity rate among STI clients, much higher than general outpatients, medical in patients or surgical inpatients.⁷⁴ Importantly the National AIDS Council has prioritized funding through the NATF for the procurement of some dual HIV/syphilis tests, leading the country to place these in the PAAR.

Module: Prevention of mother-to-child transmission (PMTCT)

Investment in Zimbabwe's vertical transmission efforts has the potential to achieve key targets of elimination in this program area. This is possible over the next few years by closing gaps in eMTCT and ANC coverage in priority districts, and shifting to a case finding, response and elimination approach. The major gaps to be addressed are: (1) Focused activities among hard-to-reach communities in specific geographical locations (i.e. Manicaland); (2) Case surveillance, finding and response linked to M&E components of patient and case monitoring, to ensure feedback to facilities allowing individualized responses to close gaps. Specifically, the PMTCT module will fill gaps in implementation across the following areas:

Prong 1: Primary prevention of HIV among women of childbearing age, including screening and treatment of HIV, and referrals and linkages for STIs (especially syphilis) and cervical cancer (in all HIV-positive women) through visual inspection with acetic acid and cervicography (VIAC). Activities under this prong will also aim to increase couples/partner counselling and promoting use of dual protection especially post-delivery and use of condoms in pregnancy. Delivery of PrEP for sero-discordant couples is prioritized in the PAAR to complement this module. In the focused geographical locations (focusing for impact in Manicaland), this will include a comprehensive package with provision of multiple integrated screening and tests (including enhanced post-test counselling for HIV-negative women), safe delivery and related commodities, and links to the school program.

Note: Prong 2 activities are prioritized in the RSSH module on integrated service delivery and quality improvements in the above allocation request.

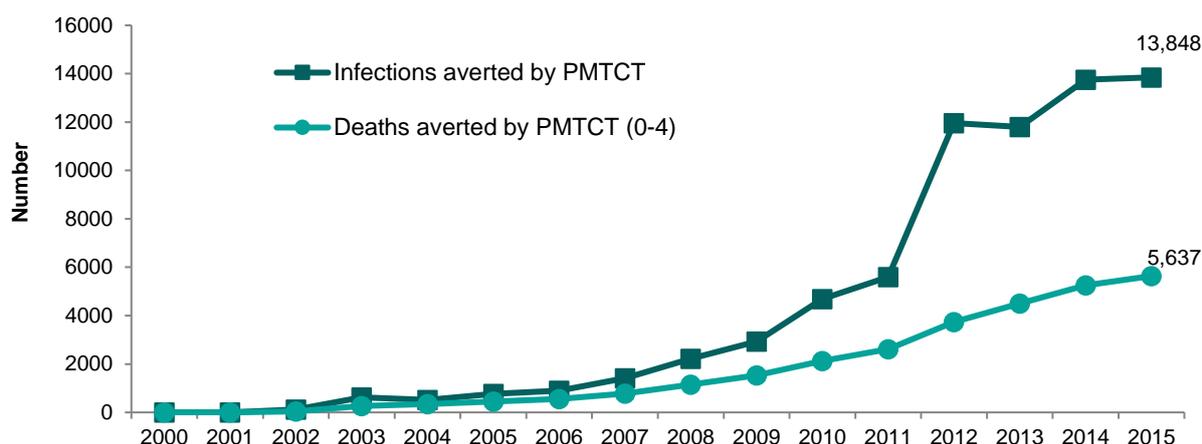
Prong 3: Preventing vertical transmission; Provide ART to women living with HIV, ARVs to HIV exposed infants and promoting safe infant and young child feeding practices. Create demand for uptake of HIV/TB services and institutional delivery and breastfeeding.

Prong 4: Treatment, care and support to mothers living with HIV, their children and their families, including EID and linkages to pediatric care and treatment, mentor mothers, and keeping in-care. This will also provide point-of-care EID and scale-up of birth NAT/PCR, with strategic community-level activities to scale-up/ensure routine testing at nutrition and inpatient wards to ensure post-natal transmission is addressed as a top priority. These community platforms can also be used for TB case identification and for referrals.

Lastly, funding is requested for three other PMTCT activities linked to improved case surveillance, finding and response (in line with the recommendations in the WHO epidemiology and impact review): (1) to train PMTCT male mobilisers at district level in targeted priority districts; (2) to train and support health care workers on PMTCT cascade analysis to identify and address gaps; and (3) to conduct knowledge, attitudes and practices survey on PMTCT interventions.

The rationale for prioritizing PMTCT interventions in this funding request is based on impact indicators demonstrating high numbers of new infections and deaths averted as a result of the program. In 2015, 13,848 HIV infections and 5,637 deaths were averted due to PMTCT (Figure 17). Continued investments in these interventions will achieve even greater impact on these key indicators as the country approaches virtual elimination of vertical transmission.

Figure 17: Rationale for Continued Investment Based on PMTCT Impact Indicators⁷⁵



Module: Prevention programs for adolescents and youth, in and out of school

Given the disproportionate HIV burden, number of new infections, and social and structural risk factors outlined in Section 1.2, this module centers entirely on high-impact prevention programs for adolescent girls and young women. The funding requested builds on key, sustainable components of the DREAMS package. School and tertiary activities focusing on delivering peer-driven approaches to address issues around gender, power, violence and linkages to services will buttress this package.

First, funding is requested for core interventions **modified from the DREAMS package**, applied to 4 additional districts outside of PEPFAR support (Chimanimani, Mguza, Kwekwe and Umzingwane, identified based on Zimbabwe’s hot spot analysis – Annex 5).⁷⁶ This package will include health, education and social protection enablers with a focus on vulnerable AGYW aged 10-24 (the delivery will be specific to the needs of the different age groups of AGYW). It will include empowering AGYW with support for condom negotiation and use (using gender transformative models), demand generation for health services, addressing social norms within communities, school-based HIV prevention, peer and community mobilization support, and educational subsidies to keep girls in school and address structural drivers of the epidemic.

The **educational subsidies** will target 4000 extremely vulnerable AGYW (roughly 15% of the total number of adolescent girls per district) with \$180/year in financial support for school fees, school uniforms, and other school-related needs. Paying for school fees and providing cash transfers that make money available for families to afford school fees are evidence-based strategies for keeping girls in school, preventing child marriage and reducing HIV and STI.^{77,78} Recent evidence from Zimbabwe shows that when orphan girls are provided with school support of fees, uniform and school supplies, the cumulative school dropout rate is reduced by about one third.⁷⁹ This is directly linked to impact against HIV incidence among AGYW. Evidence from the region shows that each additional year of secondary schooling can lead to an absolute reduction in the cumulative risk of HIV infection by 11.6% among AGYW.⁸⁰

Core activities within the modified DREAMS package include conducting two district-level teacher trainings on the **new comprehensive sexuality education (CSE) curriculum**, being rolled out by the Government of Zimbabwe. While CSE is an important objective in its own right, the aim of including this activity in the modified DREAMS package is that it will enable teachers to conduct vulnerability assessments for girls, establish in-school girls’ clubs and make referrals for the educational subsidies and other identified issues. Following the CSE curriculum trainings, funding is requested to conduct household identifications and vulnerability assessments in the four districts to **map households with vulnerable AGYW**. This will support the direction of educational subsidies (and related interventions contained in the expanded DREAMS package, described in the matching funds request) to the AGYW with the greatest need, where the impact will be greatest.

As an added impact, the roll out of the CSE curriculum will support the achievement of the ESA commitment target to increase to 95% the number of adolescents and young people, aged 10-24, who demonstrate comprehensive HIV prevention knowledge levels.⁸¹ This directly responds to the country context, where the recent DHS data reflects low and declining knowledge of HIV prevention among young people (recall Section 1.2).

The proposed interventions are in line a key HIV prevention strategy to scale up interventions that empower young women and girls, as outline in the new ZNASP III (Annex 2). Further, expanding the DREAMS package is informed by the funding landscape to ensure complementarity of PEPFAR and Global Fund investments.⁸² The rationale for the layering of interventions as part of a comprehensive package for young people, and AGYW in particular, is based on evidence which shows this model to be more effective at reducing HIV incidence. As interventions are added, there is an incremental reduction in the predicted probability of past year HIV incidence among adolescent girls (12-18) (recall Figure 14 in Section 1.3).

Note: See attached matching funds request for a description of the additional proposed activities for adolescent girls and young women through catalytic investments.

Module: Comprehensive prevention programs for sex workers and their clients

Prioritizing prevention among sex workers is critical to control the epidemic in Zimbabwe. HIV incidence among sex workers is estimated at 10%, more than 22 times the general population (0.45%).⁸³ As a result, sex workers and their clients together account for approximately 12% of new HIV infections in Zimbabwe. As such, funding is requested to deliver a **comprehensive package of prevention, treatment and support services** through a peer-led model, with outreach conducted from six fixed sites, to provide a comprehensive package of care based on the international guidance for implementing comprehensive HIV/STI programs with sex workers (the “SWIT”).⁸⁴ Importantly, the proposed program targets sex workers in their diversity, including female, male and transgender sex workers. The investment will maintain support to the six existing fixed sites in Harare, Karoi, Bulawayo, Masvingo, Gweru, Mutare. See the attached matching funds request for the proposed scale up to four new border static sites to be sustainably transitioned from the regional North Star Alliance program (Nyamapanda [Mudzi], Chirundu [Hurungwe], Victoria Falls and Beitbridge), which also target the clients of sex workers such as long-distance truck drivers, migrant workers and artisanal miners.

The comprehensive package will include condom programming, HTS that includes diagnosis and treatment of STIs (with catalytic funds), syndromic management and cervical cancer screening and linkage to care, among other RMNCAH services (including PMTCT) for sex workers and their children. Linkage to PMTCT for sex workers is an important part of the country’s aim to achieve eMTCT validation. Links to TB services will also be provided. As part of the program, PrEP will be offered, combined with intensified adherence activities such as support groups and mobile phone follow-ups. Harm reduction services as well as **interventions to address stigma, discrimination and violence** against sex workers will be included. These services will be combined with **legal support and legal literacy**, and **service to prevent and respond to sexual, physical and GBV**. The comprehensive package will be tailored to the priorities of young sex workers, amplifying protection from violence, client negotiation, gaining confidence to use clinical services, and accessing education or income-generating opportunities, since evidence shows these are their priorities.⁸⁵ Efforts to reach clients of sex workers will happen in close collaboration with the indexed HTS as described in that module.

Equally, given high prevalence rates (>60%), **ensuring treatment access for sex workers** living with HIV is critical for effective treatment as prevention. Where 87.3% of women living with HIV in the general population know their status and are on ART (recall Figure 4), just 48% of HIV positive sex workers (>25 years) are accessing treatment. For younger sex workers (<25), just 21% are on ART. These figures are much improved if sex workers are linked to support through CSOs (where ~70% of sex workers are on ART).⁸⁶ Given this, the integrated package for sex workers will build on the proven outreach activities and strengthening the service package to include onsite treatment initiation with one-stop delivery, where feasible. It is pertinent to note that a size estimation study of sex workers is currently ongoing in the country, so it is anticipated that these interventions will be guided by that forthcoming information.

Note: See attached matching funds request for a description of the additional proposed activities for prevention among sex workers and their clients through catalytic investments.

Module: Comprehensive prevention programs for men who have sex with men

Given high HIV prevalence (23.5%) and high numbers of new infections (~2000 year), funding is requested to deliver a **comprehensive package of services** tailored to the specific vulnerabilities and lived realities of MSM. In line with international guidance on implementing comprehensive HIV and STI programmes with MSM (the “MSMIT”)⁸⁷, the package will be offered through peer-led models, out of six existing fixed sites (Harare, Bulawayo, Masvingo, Gweru, Mutare and Victoria Falls), building on a

strong community empowerment foundation that includes community mobilization. Combination prevention interventions will include the provision of condoms and lubricant, STI screening, VMMC⁸⁸, PrEP, PEP, links to TB services, comprehensive HTS, including point-of-service treatment initiation, where possible.

The rationale for increasing for **point-of-service treatment** (for HIV, STIs, mental health and substance use) is based on evidence which suggests linkage to care may be lower for MSM than among men in the general populations. ZIMPHIA data show that 86% of men in the general population know their status and have access to ART, while the PLHIV Stigma Index highlights that ART coverage among MSM living with HIV is slightly lower, at 82%.⁸⁹ This figure is likely an overestimate for the wider MSM population, since sampling for the Stigma Index was done through those already linked to support services and community networks. Access to treatment and adherence support is critical to ensure viral suppression – a proven prevention strategy.

Alongside clinical services, the program will also work to reduce human rights-related barriers to HIV services for MSM, including **interventions that address stigma, discrimination and violence** against MSM through legal support and legal/patients' rights' literacy trainings. Additionally, funding will be dedicated towards following up on the recommendations of the Legal Environment Assessment⁹⁰ and **conducting advocacy for law and policy reform**. This set of interventions will build on the successes of long-standing and effective civil society and community groups, especially those which are MSM-led, to improve service quality by linking outreach, testing and treatment services. As with sex workers, it is pertinent to mention that the research protocols for an MSM size estimate study are currently in the approvals process, so it is anticipated that these interventions will be guided by that forthcoming information.

Note: See attached matching funds request for a description of the additional proposed activities for prevention among MSM through catalytic investments.

Module: TB/HIV

Supporting mechanisms for TB/HIV integrated services is critical to maximize impact against both diseases. First, funding is requested to **procure the necessary cartridges for the existing GeneXpert machines** in order to optimize their use and improve timely and accurate diagnosis and to increase the case detection rate from 72% in 2015 to 85% by 2020 (NSP target). Use of Xpert will be expanded to any presumptive TB client regardless of HIV status as per current global best practice. It is expected that this will minimize missed opportunities for Xpert testing for the most vulnerable PLHIV, who are likely to be smear negative and misdiagnosed as not having TB disease. While the Xpert MTB/RIF technology in the country has expanded to 120 instruments by 2016,⁹¹ recall from the lessons learned (Section 1.3) that the existing GeneXpert machines are grossly underutilized and that this is largely linked with inconsistent supply and distribution of cartridges. This intervention aims to address this critical gap and support the achievement of the sub-objective in Zimbabwe's TB NSP (Annex 3) which aims to increase and strengthen laboratory capacity for diagnosis of TB including drug resistance by 2020, through strategic interventions to ensure access, operation and utilization of Xpert MTB/RIF testing for all presumptive TB cases.

Second, funding is requested to **procure and deliver Isoniazid Preventive Therapy (IPT) for PLHIV**. Leveraging on lessons learnt and experiences shared from the phased roll out of IPT in the previous grant which was scaled up from 10 pilot sites in 2013 to 634 high volume OI/ART sites by end of 2016, investments will be directed towards further decentralization of the program to the remaining 900 plus OI/ART sites. Funding will also support demand creation and strengthening surveillance of adverse drug reactions (pharmacovigilance). IPT will be offered to all PLHIV (both adults and children) who are eligible, with re-dosing only extended to those on ART for at least 3 years and are not doing well (CD4 threshold less than 450 cells/ul).

Third, funding is also requested to **procure Cotrimoxazole Preventive Therapy (CPT) as a critical OI medicine**. There is an upward trend in TB/HIV service coverage in Zimbabwe, with 96% of TB/HIV co-infected patients accessing Cotrimoxazole (CTX) in 2015. This funding request aims to catalyse this positive trajectory and achieve the objective in the TB NSP (2017-2020) to initiate all TB/HIV co-infected patients on CPT (and ART) by 2020.

Fourth, funding is requested to **facilitate co-location of TB and HIV services to support one stop shop service delivery approaches** with a focus to promote the provision of HIV services within TB settings and vice versa by the same nurse, on the same day and under one roof. Capacity building of

health care workers on TB/HIV will be undertaken through practical attachments and mentorship support and renovations of physical infrastructure will be undertaken to co-locate services where feasible. This responds to key lessons learned that one-stop services improves HIV and TB impact.

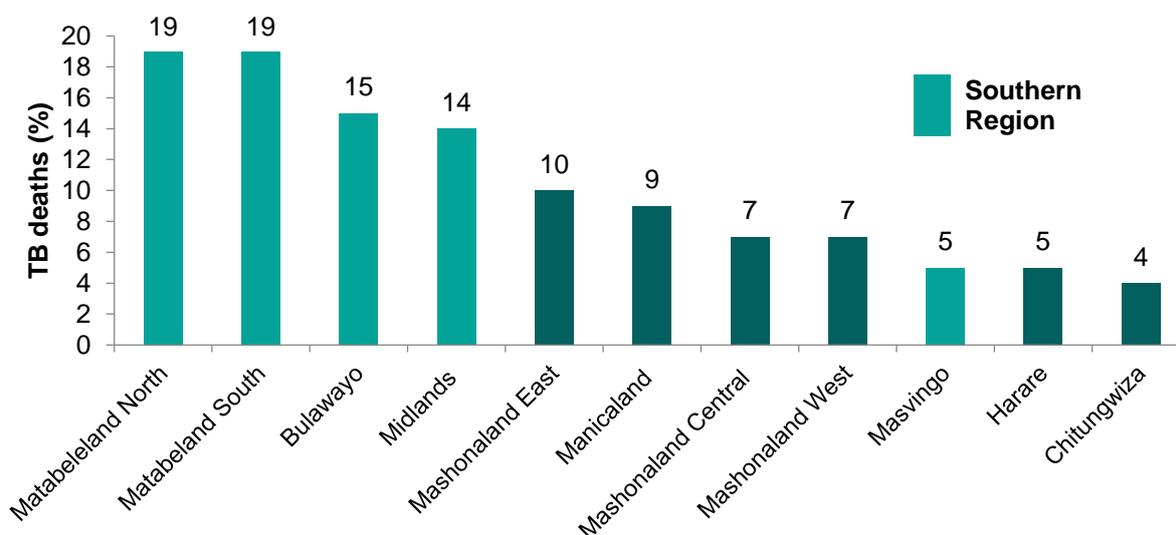
Also aiming at improved integration, funding is requested to **enhance skills and capacity of health workers to deliver quality integrated care through mentorship and blended learning**. This will improve health care workers to deliver a comprehensive care package, grounded in human rights. Funding will support a training of health care workers within the public health system, including members of the uniformed forces and health workers in tertiary institution (to reach young people, especially AGYW). The training will centre on a blended learning package for integrated TB/HIV prevention, treatment, care, TB/HIV/RMNCAH and related comorbidities. Following the training, funding will support the practical attachments of 200 trained health care workers at learning sites to cascade the blended learning package down to facility level.

Lastly, also responding to the need for better integrated care, funding is requested to **strengthen existing mechanisms for providing better coordination of TB/HIV service delivery and minimizing duplication of efforts**, such as TB/HIV partnership forum engagements. Recall that enhancing integration is positioned as a critical opportunity for this funding request. This activity will also support TB/HIV technical working groups to track implementation of TB/HIV collaborative interventions and steer integration. Strengthened joint planning, training and monitoring will enhance TB/HIV collaboration. It is expected that these efforts will ensure improved coordination among TB/HIV collaborative activities. Strengthening coordination stems from the increasing presence of partners with diverse approaches and interests whose activities and reporting requirements may not be in line with the national needs and standards. The coordination meetings will provide a platform to share experiences and influence policy based on local evidence.

Module: TB Care and Prevention

First, funding will support the **procurement of essential first line TB medicines and laboratory reagents** for laboratory treatment monitoring, including support for quality assurance. Provinces and districts in the southern region, as illustrated in Figure 18 contribute the highest number of deaths and loss to follow up and this funding will prioritize improving treatment outcomes in these areas.

Figure 18: Proportion of TB Deaths by Province, 2014 Cohort²



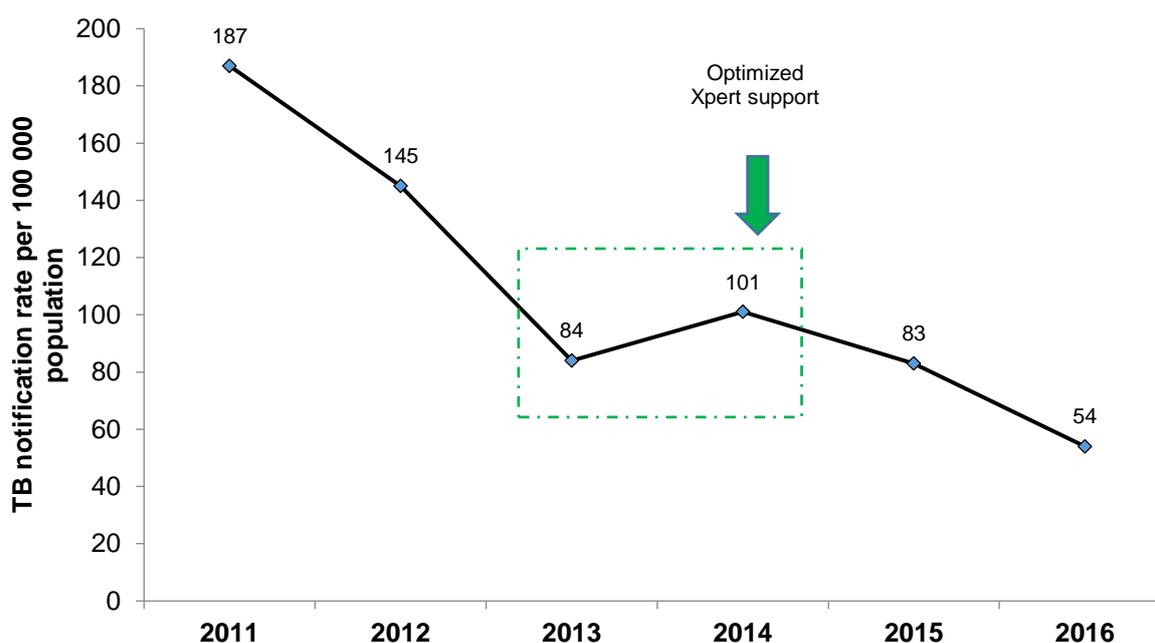
Efforts will address: bottlenecks related to case holding and engagement of community health systems for treatment adherence and support, debilitating costs related to TB services and care, lack of information on patients’ rights and barriers to patient centred care. This investment will contribute to improved treatment outcomes from 81% treatment success in 2014 to 90% by 2020.⁹² Notably, other provinces in the northern region with high rates of adverse outcomes will be prioritized for support through other development partners.

Second, funding is requested to **procure and deliver Isoniazid Preventive Therapy (IPT) for children under 5 years** who are contacts of bacteriologically confirmed TB. Emphasizing the need to reach children with IPT is in line with strategic interventions prioritized in the TB NSP (2017-2020). Indeed, a

child's risk of developing tuberculosis (TB) can be reduced by nearly 60% with administration of a 6 months course of IPT after exposure to TB.

Third, given the country context of concentrated burden of TB among certain high risk groups (recall Section 1.2) and the lessons learned about how effective targeted case finding can be (recall Section 1.3), funding is requested **for intensified TB case detection and diagnosis among key populations**. The funds will support expanded use of Xpert MTB/RIF technology as first line testing for TB diagnosis and digital radiography screening for presumptive TB cases. The capacity of health care workers to diagnose childhood TB and implement contact investigation for bacteriologically confirmed TB will be enhanced. The investment will leverage on the current grant to procure six additional trucks equipped with digital X-rays and GeneXpert machines - increasing systematic TB screening among underserved high risk groups (prisoners, miners, migrant workers and refugees). The investment will leverage existing regional Global Fund grants implementing HIV related activities through static centers established at border posts targeting migrant populations (Northstar Alliance initiative) as well as through intensified TB case finding through the entry point of HIV testing services (in line with the 2016 WHO HTS guidelines). Comprehensive TB services will be integrated in these centers within the context of strengthening cross border collaboration for TB care and prevention. It is envisaged this investment will contribute to increasing treatment coverage from 72% in 2015 to 90% by 2020. In just 6 months of implementation a USAID grant in Mutare (2014) which focused on optimizing use of Xpert MTB/RIF technology particularly among PLHIV, demonstrated promising yield in bending the declining trend in case notifications (Figure 19). This gain however was not sustained beyond the 6 month support. Investing in Xpert use as initial test, complimented by innovative case finding approaches among high risk groups is likely to optimize treatment coverage.

Figure 19: Trends in TB Notification Rates, all Forms, Mutare District, 2011-2014⁹³



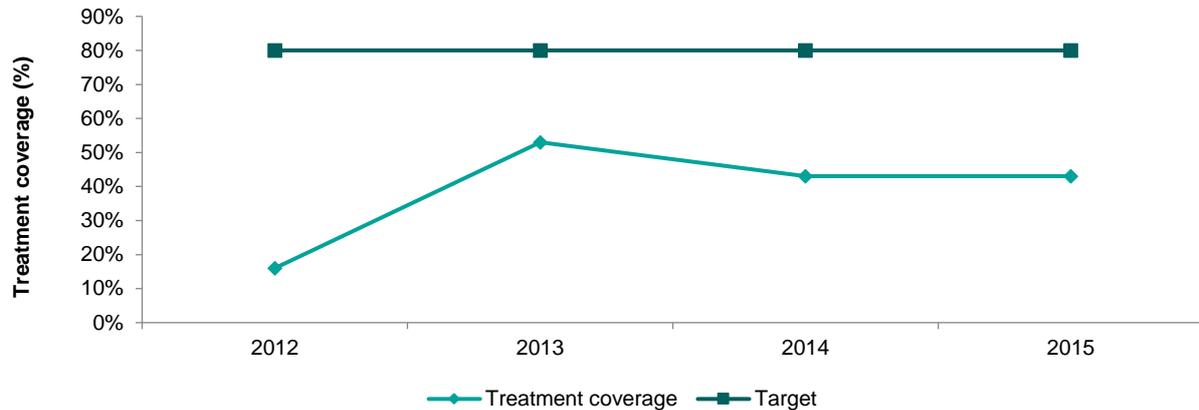
Lastly, funding is requested to **strengthen community TB care delivery**. Key community interventions will be to conduct systematic targeted TB case finding, building capacity of community health workers, strengthening CSOs in TB and TB/HIV, advocacy and communication through mass media (32 district awareness campaigns, bi-annually), IEC materials for community mobilization during systematic targeted TB screening, social media campaigns (among other platforms) to enhance TB case finding. The rationale for heightened focus on community responses is the missed opportunity for significant community contribution to TB referrals currently at 7%.⁹⁴ Strengthening community TB care delivery in line with strategic interventions prioritized in the TB NSP (2017-2020) (Annex 3) to strengthen the involvement of community health care workers in support of contact investigation and facilitate links with health facilities to improve IPT uptake among children in particular.

Module: Multidrug-resistant TB

The top priority for this module is to **improve case detection and diagnosis of MDR-TB**. Funding will support procurement of cartridges for Xpert MTB/Rif, reagents for Line Probe Assay (LPA), culture, 1st

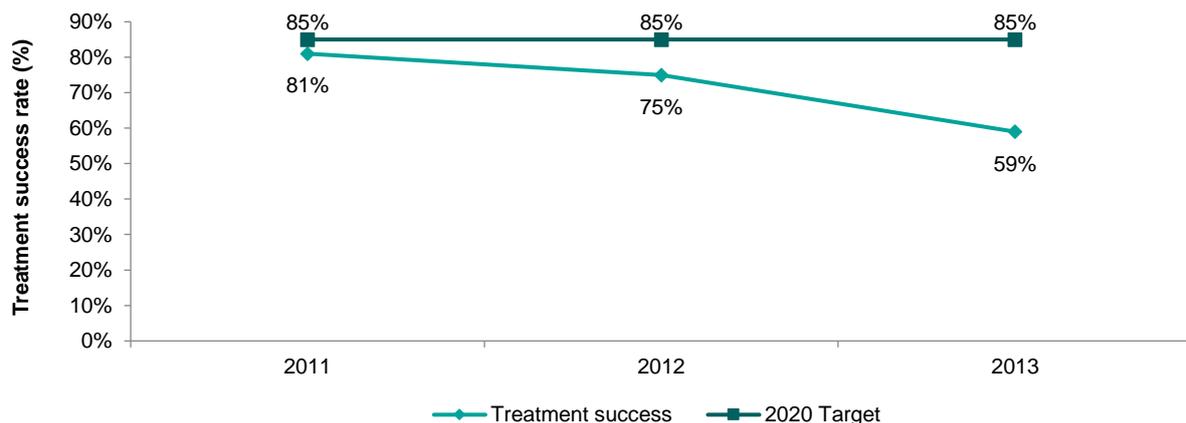
and 2nd line Drug Susceptibility Testing (DST) including institutional support for the two reference laboratories. Laboratory personnel from the reference laboratory will be supported to attend international short courses on 2nd line DST and quality management systems and relevant international conferences to strengthen knowledge/capacity of new drugs and short course regimen for drug resistant TB. This investment will improve treatment coverage for drug resistant TB from 43% in 2015 to the country's target of 80% by 2020 (Figure 20). This needs to be urgently addressed through more targeted on-site mentorship support and investigative appraisal of determinants of adverse outcomes for remedial redress.

Figure 20: Trends in treatment coverage (case detection) for drug resistant TB (2012-2015)⁹⁵



Second, funding will support the **procurement of second line TB medicines** for the treatment of MDR-TB and community care delivery. Following the recent WHO recommendation to introduce new drugs and regimens (ND&R) for drug resistant TB, this funding request will support procurement of second line (including ND&R) and ancillary medicines, targeted on-site mentorship on DR-TB, and supportive supervision. Patients on treatment will be supported with monthly treatment enablers and psycho-social support. The decentralization of PMDT from the initial 2 centres in 2010 to district level has resulted in lapses in quality of care over time characterized by a sustained deterioration in treatment outcomes (Figure 21). Funding is also requested to support Green Light Committee monitoring visits to monitor the use of second line TB medicines in the country.

Figure 21: Trends in treatment success rate for drug resistant TB in Zimbabwe (2011-2013)⁹⁶



This investment will deliberately prioritize quality of patient care. ECG machines and thyroid function test analysers will be procured for patient monitoring and hearing aids for patients with hearing loss. Pharmaco-vigilance for second line TB medicines will be enhanced for timely redress of adverse drug effects. The investment will also leverage community responses for drug sensitive TB to empower communities to better provide treatment adherence, palliative care and psycho-social support for DR-TB in a non-stigmatizing manner. This investment could contribute to reversing the negative outlook of trends in treatment outcome towards 85% treatment success rate by 2020.

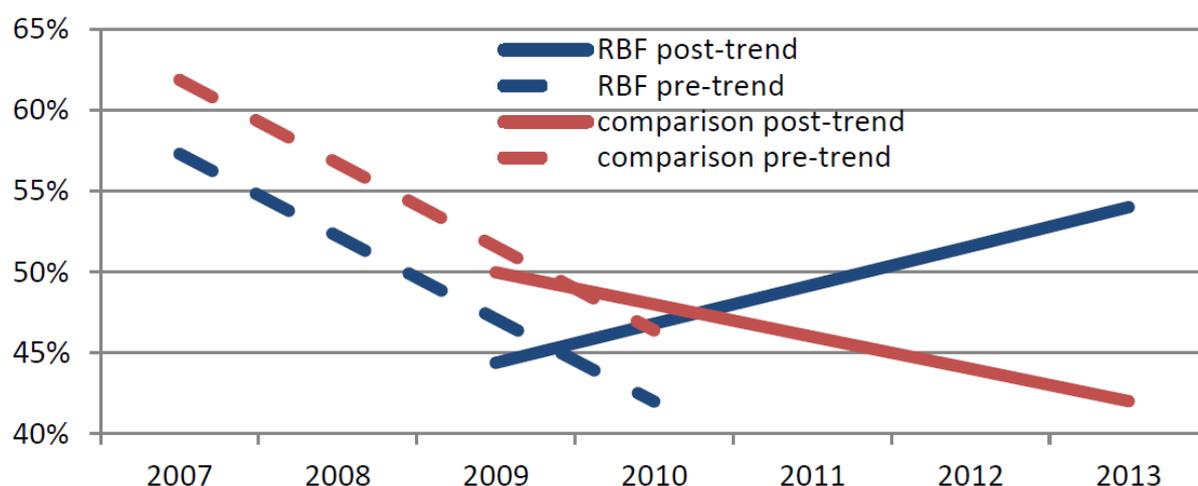
2.2 RSSH funding request	
The Global Fund strongly encourages funding requests for RSSH investments to be submitted within a <i>single</i> application, and preferably to be requested in the first submission.	
Does this funding request include an RSSH component? ⁴	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>If yes, describe the request below and how it is strategically targeted.</p> <p>Referring to the national health strategy, gaps and lessons learned outlined in the previous section, describe the funding request for RSSH and how the investment is strategically targeted to strengthen systems for health and achieve greater impact on the diseases. In your explanation, refer to the Funding Landscape Table on government health spending, Performance Framework and Budget as appropriate. It is optional to complete a Programmatic Gap Table for RSSH.</p>	

To maximize the impact of the funding requested for HIV, TB and malaria programs, Zimbabwe has developed an integrated funding request to also build resilient and sustainable systems for health (RSSH). This request is aligned to the National Health Strategy (2016–2020) (Annex 1) and crafted to respond to the strategic plans for the diseases (Annexes 2-3). The country context and lessons learned point to key weaknesses in Zimbabwe’s systems for health which require strategic investments to resolve problems and create better service delivery. This will optimize investments in the three diseases. The National Health Strategy identifies TB and HIV-related illness among the top causes of mortality in the country, seeking to prevent HIV new infections and to reduce HIV related deaths by 50% and to reduce TB mortality, morbidity and transmission by 90%.

Module: Human resources for health, including community health workers

Based on acute under-staffing of many critical posts (highlighted in Section 1.2) and given lessons learned about how critical Zimbabwe’s HRH retention schemes have been to achieve impact (as highlighted in Section 1.3), funding is requested for continued strategic investments in health and community workers. Informed by the recommendations of the recent EU review on HRH, funding will **ensure that strategic performance-based retention schemes are maintained** at the current levels for facility level staff at 1600 sites. Close coordination with the Health Development Fund will be critical to maximize efficiencies and synergies of these HRH investments (see Annex 9).

Figure 22: Performance-based Retention Scheme Impact on Yearly Differences in Receipt of Urine Test during ANC Care⁹⁷



⁴ It should be noted that due to the unique country context and the resulting highly commoditized nature of this funding request, flexibilities are requested in terms of meeting the minimum allocation to be dedicated to RSSH. Based on the rigorous prioritization exercise which emphasized the filling of critical medicine and commodity gaps, the resultant RSSH investments focus on the efficient and effective delivery of those services prioritized in the HIV, TB and malaria modules. However, as with the TB and HIV modules, the country has given considerable effort to define the prioritized above allocation request (PAAR) for RSSH, with many activities described in great detail within specified Annexes (Annex 16). This is meant to communicate the country’s serious intention to increasingly fund these activities if additional funding becomes available.

The proposed performance-based retention scheme for health workers is in line with the recommended approach in the country's National Health Strategy (2016-2020) (Annex 1). The scheme is output-based funding that uses both quantity and quality indicators to measure results, leveraging Global Fund resources by increasing accountability at all levels of the health system and leading to quality improvements in the outputs.

The rationale for including investments in the performance-based retention scheme is based on evidence of improved impact on key indicators. For instance, yearly percentage changes in urine tests receipts during an ANC visit before and after the implementation of the performance-based retention scheme show a declining trend was reversed for performance-based sites but only slowed in the non-performance-based group (Figure 22). Further, pregnant women in performance-based districts experienced a relative gain of 13.6% in the likelihood of delivering in a facility compared to those non-performance-based districts.

Funding is also requested to **maintain support for community-based health care workers** (7620 community health workers, to be classified according to the new Community Systems Strengthening Framework [CSS] [Annex 10]). Funding will support capacity development, leadership, technical support, curriculum review and preservice training. Evidence presented in the country's draft CSS framework shows that there is a sustainability component for this investment, as communities are keenly involved in supporting the work of the community health workers, in communication of health information using traditional and indigenous community associations, and community-based organizations such as schools, women and youth associations and religious institutions.

This request complements the over 8,000 community-based health care workers which the HDF supported in 2016. However, this is still shy of the recommended 23,700 community health workers (1 for every 100 households) in the CSS framework, hence the PAAR request to support 5800 additional community health workers, contributing to the new targets of the CSS Framework.

Third, funding is requested to **maintain support for the eight Provincial Medical Officers on TB/HIV and DR-TB**. These officers play a critical role in catalyzing integrated planning, implementation and supervision around HIV, TB and RMNCAH. As integration is a key opportunity with this funding request, support for these officers is a key way in which the country intends to deepen its commitment to maximizing impact through integrated service provision.

Module: Procurement and supply chain management systems

Despite significant improvements in procurement and supply chain management systems over the past few years with support from the Global Fund and other partners, there are still challenges that need to be addressed to ensure availability of health commodities needed for HIV, TB and malaria, reproductive health, maternal, neonatal, child and adolescent health, non-communicable as well as other diseases and health conditions. In response to the gaps mentioned in section 1.3, funding is requested to strengthen Zimbabwe's PSM in order to **strengthen the integrated sample transport system** as the top priority for the within allocation request.

Module: Health management information system and monitoring and evaluation

Low coverage of electronic data systems, uncoordinated data analysis (with limited discussion across programmes and communities), and "verticalized" program-specific M&E and data quality activities compromises data quality and data utilization for decision-making. In order to improve the collection and use of strategic information, funding is requested to **scale up patient monitoring** and **continue the transition to electronic reporting in facilities** (clinics and hospitals, including linking patient and case reporting to tests, lab data and mortality). Specifically, funding will support 267 data entry clerks and support the scale up and maintenance of the ePMS and DHIS2 systems.

This will build on Global Fund's previous investments, scaling up of the comprehensive eHMIS. This aims to ensure facilities covering 90% of people on treatment report into electronic patient monitoring systems. Support is also needed for similar key population and community monitoring, improved DHIS2 data quality, dashboards, data and impact analysis capacity. The MOHCC has made the strategic decision to integrate all electronic health systems (Zimbabwe EHR roadmap) and ensure that the Electronic Health Record (EHR) is the backbone of electronic health systems and all other disease specific systems. Funding is therefore being requested to strengthen the integration of the electronic reporting systems with the ultimate aim of having EHR as the main system into which ePMS and other systems shall be incorporated as modules. This approach will not compromise data reporting requirements for HIV program through ePMS as it will be an integral part of EHR.

SECTION 3: OPERATIONALIZATION AND RISK MITIGATION

This section describes the planned implementation arrangements and foreseen risks for the proposed program(s). Applicants are encouraged to **attach an updated Implementation Arrangements Map**. To respond, refer to additional guidance provided in the *Instructions*.

3.1 Implementation arrangements summary

Do you propose major changes from past implementation arrangements, e.g. in key implementers, flow of funds or commodities?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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If **yes**, provide an overview of the new implementation arrangements and elaborate how these changes affect the operationalization of the grant.

If **no**, provide a summary of high-level implementation arrangements focusing only on lessons learned for the next period.

In **both cases**, detail how representatives of women's organizations, key populations and people living with the disease(s), as applicable, will actively participate in the implementation.

Include a description of procurement mechanisms.

Zimbabwe is subject to additional safeguard measures by the Global Fund. As such, the anticipated impact associated with the proposed investments can only be realized with strong partnerships (among government, civil society, UN agencies and the private sector), innovative service delivery arrangements, and the necessary flexibilities to achieve maximum results within Zimbabwe's unique country context. The interventions proposed, targets set and implementation arrangements specified in this funding request reflect the most strategic investment case for the country's current situation.

Based on the additional safeguard measures in place for Zimbabwe, UNDP will remain the fiduciary agent for all three disease components, with MOHCC as the PR for TB and malaria and UNDP as the PR for HIV.

Though there are no major changes from past implementation arrangements, the proposed program does significantly prioritize the capacity building of other organizations to deliver services, particularly in terms of reaching a greater number of key and vulnerable populations.

For instance, the matching funds request includes establishing a Technical Support Unit (TSU) to deploy both short-term technical assistance and long-term capacity building to key populations' organizations in order to support the scale up of quality service delivery to these groups. The TSU will serve organizations delivering services to sex workers, MSM, AGYW, transgender communities, and other key and vulnerable groups. The unit will give preferential priority to women's organizations or organizations led by key populations, but will also strengthen capacities of the National AIDS Council and the Ministry of Health and Child Care to program better around key populations.

The proposed TSU in this investment will harness lessons learned from the short- and long-term technical assistance and capacity building delivered through the Global Fund's Community Rights and Gender Special Initiative (2014-2016), as well as lessons from the Global Fund's regional investments in key population network strengthening through the KP REACH grant (with the PR located in Zimbabwe).⁹⁸

The TSU will play a critical role in ensuring that representatives of women's organizations, key populations and people living with the disease(s), as applicable, will actively participate in the implementation of this grant. It is modelled after the Kenyan example (Annex 11), which has helped in ensuring that the role of key populations in the HIV epidemic in Kenya has been recognised, understood, and included in designing Kenya's HIV response.

3.2 Key implementation risks

Using the table below, outline key risks foreseen, including those that were provided in the *Key Program Risks* table shared by the Global Fund during the Country Dialogue process. You can also add key operational and implementation risks, which you identified as outstanding over the previous implementation period, and the specific mitigation measures planned to address each of these challenges/risks to ensure effective program performance in the given context.

Risk Category (Functional area)	Key Risk	Mitigating actions	Responsible	Timeline
Key Programmatic, Monitoring and Evaluation and Performance Related Risks	<p>Sub-optimal quality of health services due to significant brain-drain of qualified staff in the health sector as a result of:</p> <ul style="list-style-type: none"> (1) Deteriorating economic situations (2) Inability of GoZ to pay health workers salaries (3) Freeze on employment by the public sector 	<ul style="list-style-type: none"> (1) Prioritize retention of critical health workers in the current application (2) Continue to resource mobilise for more resources for the health sector (3) Unfreeze all health posts especially for pharmacists and lab technologists as the vacancy rate 47%. (4) Carryout a WISN to inform the new establishment 5) Targeted mentoring and support supervision to underperforming centres 	<p>CCM</p> <p>GoZ (MOF)& Dev Partners</p> <p>GoZ (MOF)</p> <p>MOHCC (HSB)</p>	<p>During grant making</p> <p>On-going</p> <p>Q4 2017</p> <p>Q4 of 2017</p>
Key Programmatic, Monitoring and Evaluation and Performance Related Risks	<p>Gaps in M&E and Data Quality due to challenges faced by HMIS including high turnover rate of the key leadership in MOHCC and other key implementers due to economic situation, overstretched staff capacity at service delivery level affecting quality of data.</p>	<ul style="list-style-type: none"> (1) Recruit M&E director and HMIS deputy director (GF supported) (2) Finalize the next M&E Strategy (2016 – 2020). (3) Scale up electronic patient data health information system to replace paper registers (approved system is the EHR and e-PMS will be a module of the EHR) 4) Data analysis and utilization capacitation for district managers 	<p>MOHCC -HR</p> <p>MOHCC – PPM&E</p> <p>MOHCC -EDC</p>	<p>Q3 of 2017</p> <p>Q4 of 2017</p> <p>Two district by Q4 2017, Share roadmap for EHR</p>
Key Programmatic, Monitoring and Evaluation and Performance Related Risks	<p>Not achieving Program Outcome and Impact Targets due to:</p> <ul style="list-style-type: none"> (1) Inadequate resources impacting achievement of outcomes (2) possible resurgence of Malaria especially across the border with Zambia and Mozambique; 	<ul style="list-style-type: none"> (1) Ensure all funds allocated for MOHCCC programs are released on time and in full (2) Strengthen rapid outbreak investigation teams and cross border interventions with support from E8 grant 	<p>MOF</p> <p>MOHCC-NMCP</p> <p>MOHCC-NTP</p>	<p>Ongoing</p> <p>Q4 of 2017</p> <p>Q2 of 2017</p>

	(3) TB: large numbers of smear negative TB cases, extra-pulmonary and paediatric TB undiagnosed; (4) HIV: slow-down in ART enrolment especially paediatric and PMTCT	(3) Review and implement TB diagnosis algorithm and make Gene-Xpert one of the first diagnostic test (4) Strengthen the sample transport system (this should be integrated) Pilot is in progress	MOHCC-DLS	Ongoing To share road map of sample transportation roll out
Key PSM Risk	Treatment Disruptions due to inadequate PSCM arrangements contributed by: (1) Poor and inadequate storage space for medicines at health facilities (2) Irregular supply of anti-malaria medicines to facilities without an effective re-distribution mechanism resulting in under/overstocking and expiries at facility level; (3) Inadequate record keeping that affects accountability of commodities; (4) Large outstanding government debt of US\$23M to NatPharm, affects implementation of the new distribution system (OIG, 2016)\Risk for quality assurance (5) Delays in procurement of critical diagnosis machines and sub-optimal deployment of available machines that affect service quality (OIG, 2016) (6) Commodity gaps (ARV and Reagents) resulting in stock outs (7) Delayed flow of funds to NatPharm for distribution of commodities	(1) Resource mobilise for renovation and building storage at health facilities including Harare and provincial warehouses. (2) Develop eLMIS for MOHCC which is interoperable with NatPharm ERP system (3) Support employment of district pharmacists qualified to do optimal stock management; (4) Rollout ZAPS distribution system to all provinces and procure additional distribution trucks (5) Procurement of incinerator to support waste management; (6) Support solar systems for the health facilities for improved storage conditions and (7) Procurement of IT hardware for NATPHARM and (8) Support MCAZ (Medicine Control Authority of Zimbabwe) With upgrading of microbiology lab to attain WHO prequalification (31 December 2017); (9) Conduct a lab assessment and deploy lab equipment appropriately (10) Implementation of Quarterly Provincial Pharmacist support supervision	CCM/MOHCC DPS MOHCC/UNDP MOHCC DPS MOHCC DPS NATPHARM /UNDP DPS/UNDP DPS/UNDP MCAZ/UNDP DLS/UNDP	Ongoing December 2018 December 2017 March 2017 May 2017 September 2017 Ongoing December 2017 December 2017
Key Finance and Fiduciary Risks	Inadequate internal control system at implementers that affect effective utilization and accountability of funds contributed by: (1) Non-compliant costs of US\$0.4m;	(1) Support recruitment of 4 additional auditors (2) Track advances on monthly basis and conduct quarterly spot checks. (3) Revise SOPs to clarify further application of DSA timelines for liquidation of advances	GF CT MOHCC -PR MOHCC -DF	Q4 subject to approval by GF On-going

	(2) Gaps in management of advances with over 40% of advances			Done SOP to be shared with GF
Key Finance and Fiduciary Risks	Low rates of absorption and funding flows for the all program. The implementation of the Global Fund NFM grants has been characterized by a low rate of absorption of budgeted funds. Program review found that “funding flows to the program have been slow, risking program and grant performance. There was no clarity of where the bottlenecks could be although the additional safe guard policy under which this grant is operating may be contributing. It is also possible that acquittal challenges by implementing teams at the provincial level may also be contributing to the slowing down of fund flows.” Given that allocations can no longer roll over from one funding cycle to the next, low grant absorption could mean that Zimbabwe will have to send money back to the Global Fund.	(1) Disbursements be made separately for each SR that has reached the 80% threshold. (2) Timely FA verifications of procurements (3) Make all players accountable by defining deliverables for each player. (4) Decentralise implementation activities to subnational level and build the necessary capacity	FA FA/MOHCC MOHCC-PR MOHCC-PD Preventive	Ongoing On-going Ongoing Ongoing
Key Finance and Fiduciary Risks	Low rates of domestic financing for health. The 2016 OIG report highlights that the government’s per capita expenditure on health service delivery declined from 9.9% in 2013 to 8.2% in 2014. As a result, the equipment for TB screening in children was not available in over 50% of facilities visited by the OIG due to limited government funding. Further, the national programs are unable to scale up quality assurance under the HIV program due to limited funding of this intervention by the government.	(1) Develop resource mobilization strategic documents: - Costed NHS - Health Financing Policy (2) Engagement with the private sector and strengthen participation of private sector.	MHOCC-PDPPM&E MOHCCPDPPM&E	Q3 2017 Q4 2017

Other	Challenging legal environment. Laws and policies which criminalize certain key populations (sex workers, men who have sex with men, etc.) could limit the effective scale up of key population interventions and activities.	(1) Develop Service Provision Models and National Operational plan for Sex Workers and other Key Populations (Male Sex Workers, Men who have Sex with men, Clients of Sex Workers as well as LGBTI) in Zimbabwe's HIV Response.	NAC	On going
		(2) Rollout of comprehensive packages of HIV prevention, treatment and support to key populations.	MOHCC-ATP	Ongoing
		(3) Complete the legal environment for health assessment and adopt recommendations.	NAC	Ongoing

SECTION 4: FUNDING LANDSCAPE, CO-FINANCING AND SUSTAINABILITY

This section details trends in overall health financing, government commitments to co-financing, and key plans for sustainability. Refer to the Funding Landscape Table(s) and supporting documents as applicable. To respond, refer to additional guidance provided in the *Instructions*.

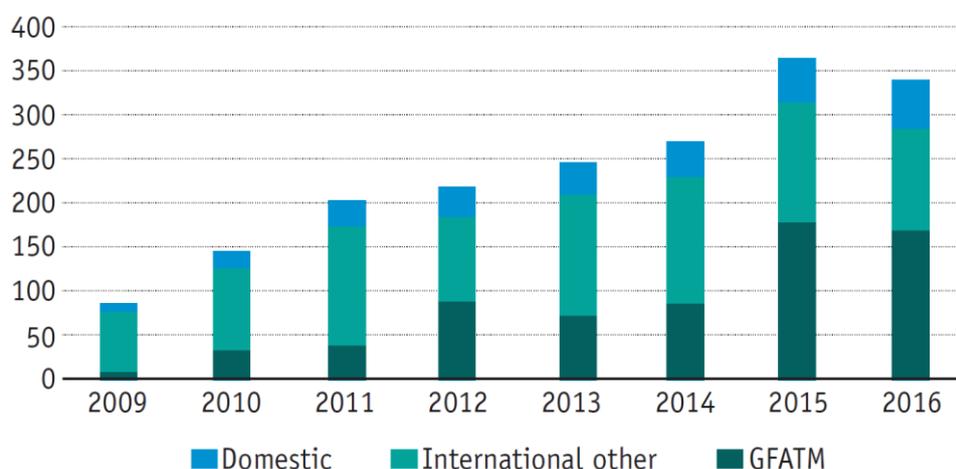
4.1 Funding Landscape and Co-financing		
a) Are there any current and/or planned actions or reforms to increase domestic resources for health as well as to enable greater efficiency and effectiveness of health spending? If yes , provide details below.	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
b) Is this current application requesting Global Fund support for developing a health financing strategy and/or implementing health-financing reforms? If yes , provide a brief description below.	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
c) Have previous government commitments for the 2014-16 allocation been realized? If not , provide reasons below.	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
d) Do current co-financing commitments for the 2017-19 allocation meet minimum requirements to fully access the co-financing incentive, as set forth in the Sustainability, Transition and Co-financing Policy? ⁹⁹ If not , provide reasons below.	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
e) Does this application request Global Fund support for the institutionalization of expenditure tracking mechanisms such as National Health Accounts? If yes or no, specify below how realization of co-financing commitments will be tracked and reported.	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No

a) Current and planned actions to increase domestic resources for health and enable greater efficiency and effectiveness of health spending

Two core strategies will be employed to stimulate greater domestic resource mobilization in Zimbabwe: continued revenue generation through the National AIDS Trust Fund (NATF) and increased private sector engagement.

The government of Zimbabwe has demonstrated increasing commitment towards raising domestic resources to fund its national AIDS program (Figure 24). While 80-85% of the response remains externally funded, domestic spending has increased by 40% from 2011 to 2014.¹⁰⁰ In 1999, Zimbabwe introduced an AIDS levy (the NATF) – a 3% tax on income and corporate revenue. The domestic funding generated by the NATF has grown from \$5.7 million in 2009 to \$26.5 million in 2012,¹⁰¹ reaching nearly \$40 million in 2014.¹⁰² Overall, the NATF has raised more than \$200 million in domestic resources for Zimbabwe's AIDS response.¹⁰³ The NATF continues to generate substantial resources of around \$35 million annually. By policy, at least 50% of funds are used for purchase of antiretroviral medicines. Other spending includes administration and capital costs, HIV prevention, and monitoring and evaluation. The NATF is a cornerstone of the government's target to increase domestic financing of the HIV response to 30% by 2018 (ZNASP III target).

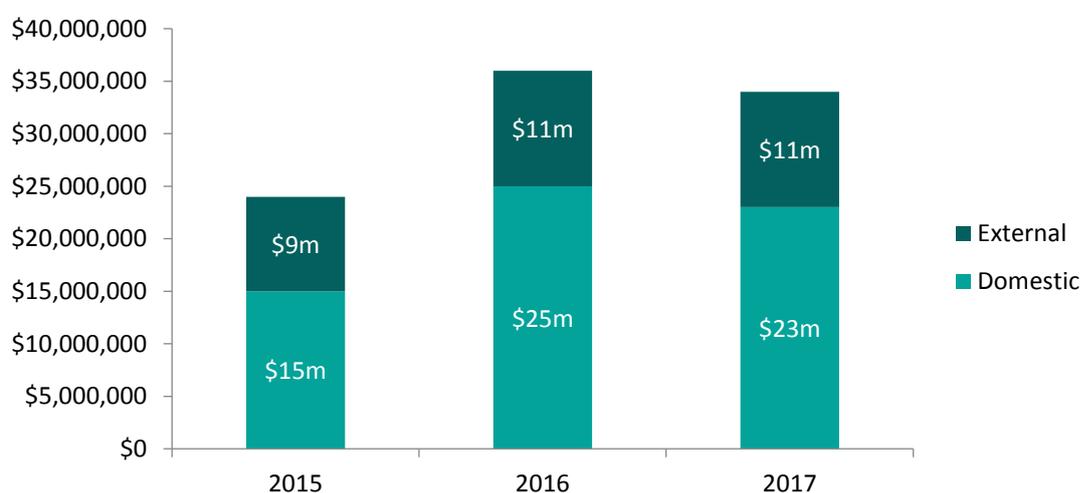
Figure 24: Domestic vs. External HIV Funding in Zimbabwe (US\$ millions)¹⁰⁴



Increasing domestic funding for TB has been challenging, with Figure 25 revealing the inconsistent nature of domestic investments year on year. The total national TB budget is \$36 million in 2016, with 31% funded by international partners.¹⁰⁵ The TB program has been supported by the Global Fund with a total of \$62.6 million allocated during 2003-2013, \$38.8 million of which was allocated as part of the NFM for the 2015-2017 implementation period. Apart from Global Fund investments, the TB program has also been supported by USAID through the funding mechanisms TB Care I & II and now Challenge TB. The government of Zimbabwe has supported human resources and infrastructure necessary for TB control. Furthermore, through the National AIDS Trust Fund government supports the program with resources for procurement of TB program commodities.

Private medical care is available in most settings at a fee, often with the support of medical insurance/aid. The private health sector supports the National TB Program mainly in the diagnosis of TB and referral for follow up care. Some large corporations, mainly agro-based and the mining sector, have company-based health services including for TB, in line with national standards. The extent of private sector engagement, however, remains limited. The Ministry is committed to ensure that private sector involvement in TB control is expanded as highlighted in the National Health Strategy (Annex 1). The AIDS and TB programs have developed a framework for public-private sector engagement and is in the process of operationalizing it. This is expected to boost domestic resources for both diseases.

Figure 25: Domestic vs. External TB Funding in Zimbabwe (US\$ millions)¹⁰⁶



b) Global Fund support for developing a health financing strategy and/or implementing health-financing reforms

This funding request is in aligned with the National Health Strategy (2016-2020), which includes a scenario-based health financing strategy. Among the three scenarios that are modelled (Scenario 1: Baseline, Scenario 2: High impact interventions and Scenario 3: Optimal scenario), the preferred scenario for the country is Scenario 2, which focuses on reducing mortality associated with the 20 established leading causes within limits of the proposed financial space.¹⁰⁷

In line with the National Health Strategy, to move from the baseline to the high impact interventions scenario, five specific investment reforms will take place:

- Scale-up of RMNCH, Malaria, HIV, Nutrition and NCDs interventions with emphasis on lower levels of care
- Shift provision of preventive services at the primary health level
- Infrastructure improvements at the primary level only
- Investments to improve availability and security of medicines and supplies
- Capacitation of skilled Human Resources

This funding request is geared in support of these strategic health-financing reforms.

In addition, findings from the recent EU health systems assessment (document 14 in the catalogued folder for Section 1.1) have guided and informed this funding request, particularly in terms of maintaining the strategic investments in performance-based retention schemes for HRH.

c) Realization of government commitments for the 2014-2016 allocation

Over the 2014-2016 allocation period the Government of Zimbabwe has committed nearly \$850 million to its national health response (Table 4). Further, over the same period, the NATF brought in more than \$100 million (Table 5).

Table 4: Government of Zimbabwe Contribution to the Health Sector 2014-2016

Year	Amount
2014	\$276,462,589
2015	\$300,891,844
2016	\$272,335,357*
TOTAL	\$849,689,790

**As of 22 November 2016 and not audited*

Table 5: National AIDS Trust Fund (NATF) Income for 2014-2016

Year	Amount
2014	\$39,665,883
2015	\$36,657,663
2016	\$24,567,034* projected to be \$34,000,000
TOTAL	\$100,890,580 projected to \$110,323,546

**As of 17 November 2016*

Letters from the Ministry of Finance and Economic Development and the National AIDS Council (Annex 13) confirming these domestic investments are attached to this funding request.

d) Current co-financing commitments for the 2017-19 allocation meeting the minimum requirements to fully access the co-financing incentive

The minimum amount of additional co-financing investments Zimbabwe has to make in order to access its full co-financing incentive is \$36,298,538 over the 2018-2020 implementation period. Given that the NATF alone is anticipated to raise approximately \$30 million each year, Zimbabwe is expected to meet and surpass the minimum co-financing requirements.

e) Global Fund support for the institutionalization of expenditure tracking mechanisms and how co-financing commitments will be tracked and reported

The government conducts National AIDS Spending Assessments (NASA), with the most recent report available for 2015. Conducted annually, the NASA is a key tool for specifying the contributions from government as well as from external funding partners.

4.2 Sustainability

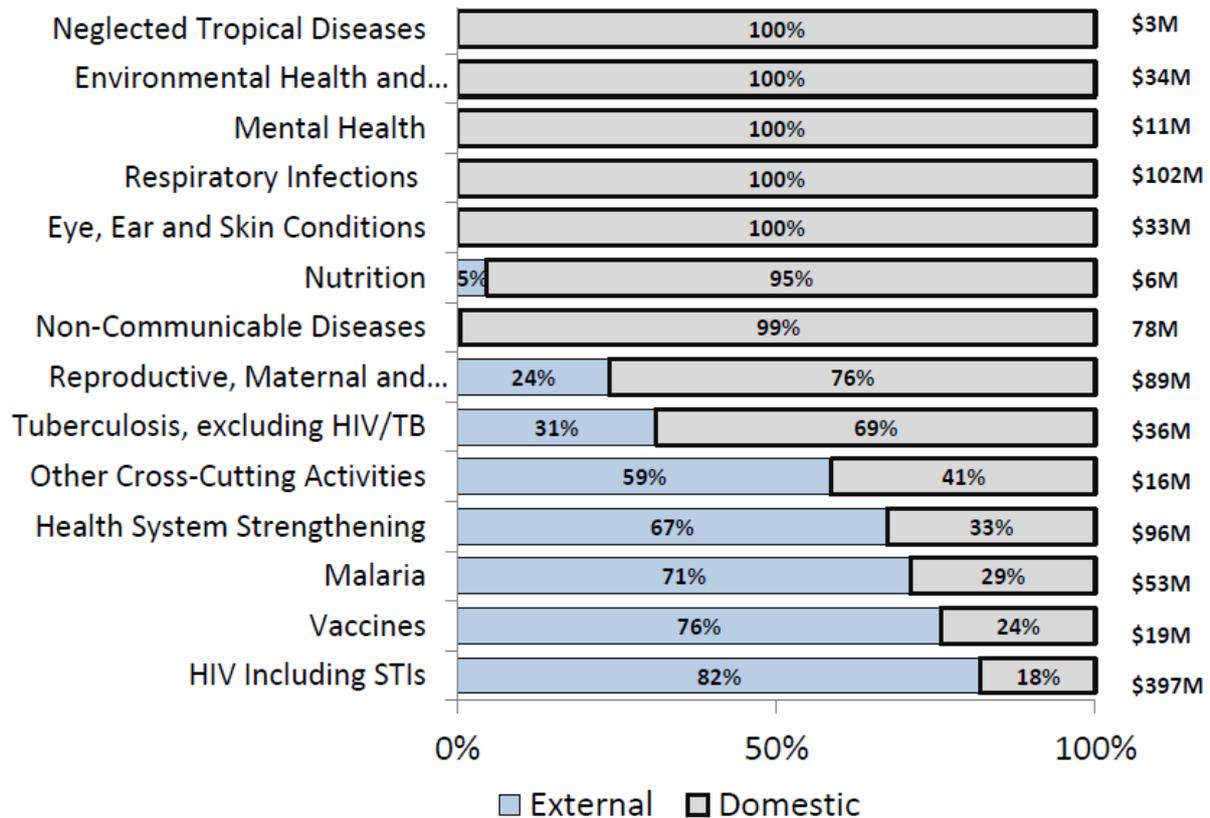
Describe below how the government will increasingly take up health program costs, and actions to improve sustainability of Global Fund financed programs. Specifically,

- Explain the costs, availability of funds and the funding gap for major program areas. Specify in particular how the government will increasingly take up key costs of national disease plans and/or support health systems; including scaling up investments in programs for key and vulnerable population, removal of human rights and gender-related barriers and enabling environment interventions.
- Describe actions to improve sustainability of Global Fund financed programs. Specifically, highlight key sustainability challenges of the program(s) covered by the funding request, and any current and/or planned actions to address them.

a) Costs, availability of funds and the funding gap for major program areas⁵.

Overall, there is large variance in the domestic funding proportion for different aspects of Zimbabwe's health response. For instance, the government is increasingly funding its own TB response (69% in 2016, up from 63% in 2015), though HIV and systems for health remain largely donor dependent (Figure 26). Across all areas, domestic resources mostly support systems costs while donors mainly support discrete program costs like drugs and commodities. This funding landscape informs the country's Global Fund program, as a significant proportion of this funding request is dedicated to filling gaps in essential medicines and related commodities.

Figure 26: Government and External Partners Funding Breakdown, by Program Area (2016)



The gap between available resources for Zimbabwe's HIV response (domestic and external) and the total program costs was around \$125 million in 2016. This gap is expected to grow to \$290.4 by 2020, largely driven by the country's move to implement the new "Treat All" policy, which came into effect in January 2017 (Table 6).

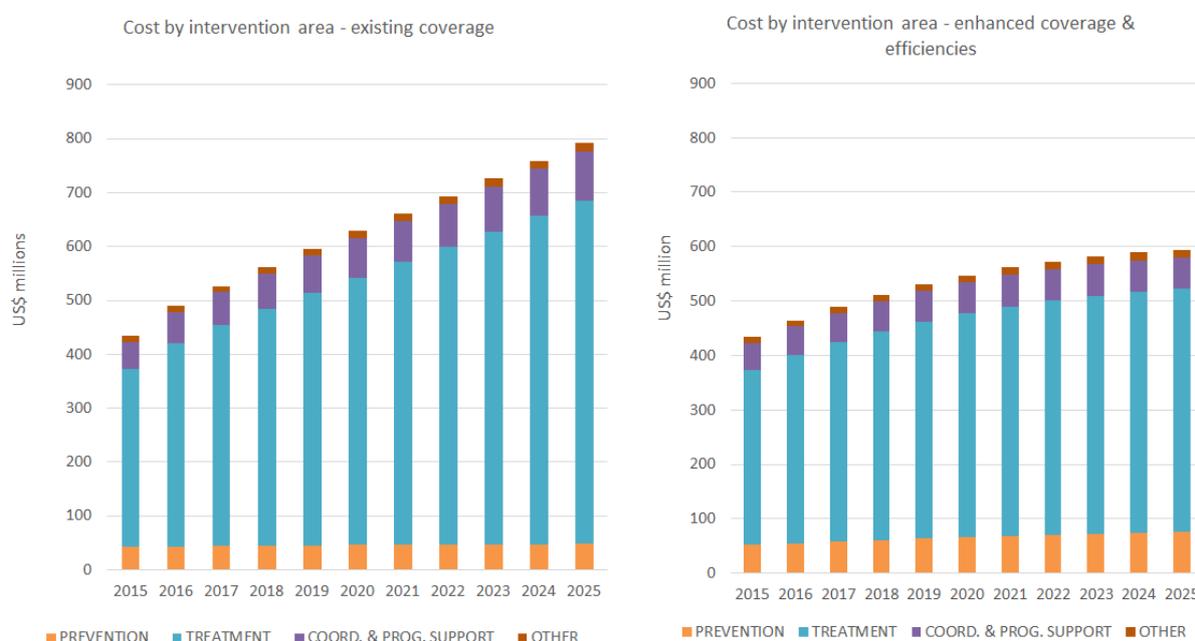
⁵ See Annex 12 for an additional external funding partner historical spending mapping for HIV, TB and malaria over the 2015-2017 period. **NB:** The total funding need for HIV in the Funding Landscape Table (NSP cost areas) is preliminary, as costing of the new ZNASP III is currently ongoing.

Table 6: Preliminary Costing for ZNASP III (Annex 2): Available Resources and Gaps

Year	2018	2019	2020
Total ART Care and Support	\$288,047,014.03	\$309,981,130.28	\$328,859,481.63
Total PMTCT	\$26,209,635.39	\$26,805,881.64	\$27,552,745.27
Total Prevention costs	\$108,626,534.42	\$105,212,863.47	\$99,089,350.22
Policy management and coordination	\$63,492,287.00	\$64,444,671.31	\$65,411,341.37
Strategic Information and System strengthening	\$7,057,908.00	\$7,107,313.36	\$7,157,064.55
Total Resources Required (Cost)	\$493,433,378.84	\$513,551,860.05	\$528,069,983.05
Resources available (indicative)	\$237,628,869.00	\$237,628,869.00	\$237,628,869.00
GAP	\$255,804,509.84	\$275,922,991.05	\$290,441,114.05

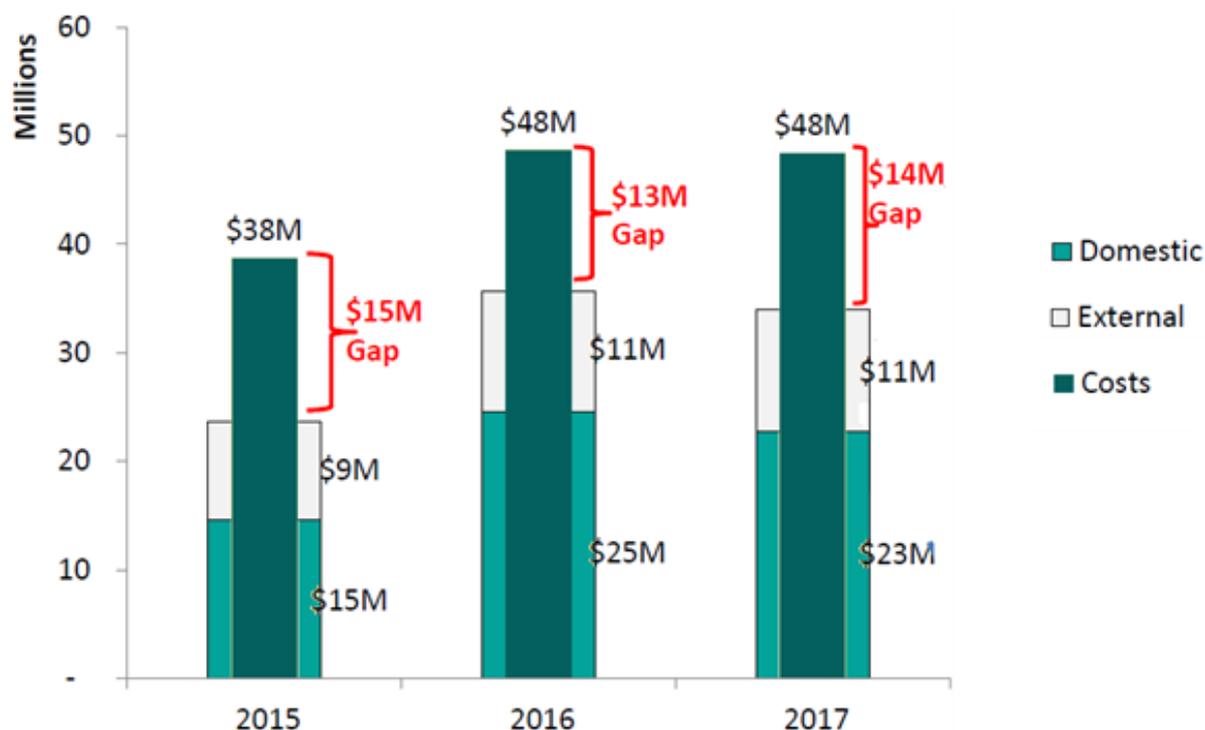
However, the anticipated HIV funding needs are significantly reduced if enhanced coverage and efficiencies are realized. Figure 27 makes it clear that increasing spending on prevention in particular, including scaling up investments in prevention programs for key and vulnerable populations (as this funding request has strategically prioritized), has the potential to reduce long-term spending needs from nearly \$800 million by 2025 to less than \$600 million.

Figure 27: Resource Needs for HIV in Zimbabwe (2015-2025) in Two Different Scenarios¹⁰⁸



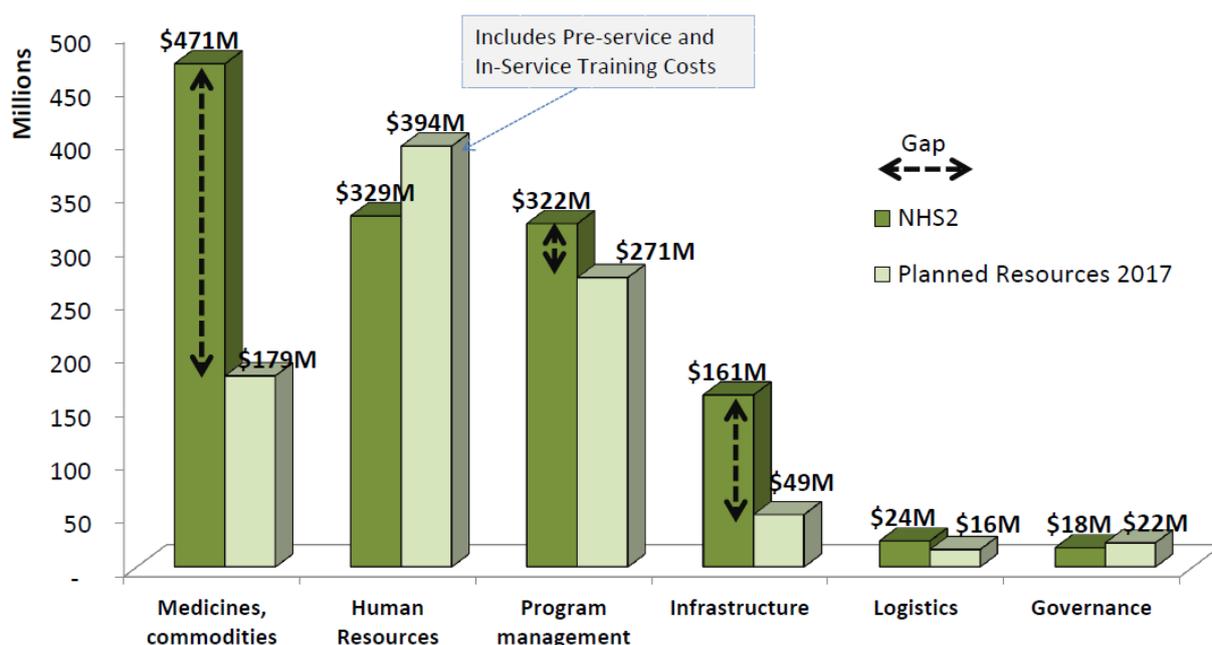
For TB, the funding gap is expected to remain around \$14 million in 2017, about the same as it has been for the past two years (Figure 28). The major gaps are around drugs and medical supplies, which consumed 35% of external TB funding in 2017 and just 3% of domestic funding. The TB NSP (2017-2020) (Annex 3) has been costed (for programmatic activities, only), expected to require \$111,187,970.08 to fully implement over the four years.

Figure 28: Planned TB Spending and Funding Gap in Zimbabwe, 2015-2017¹⁰⁹



For RSSH, approximately 67% of the response is externally funded. External funding for RSSH is allocated directly (53%) or through specific diseases areas (47%) with the largest being HIV and malaria. An RSSH gap analysis for 2017 reveals significant gaps for medicines and commodities (\$292 million), as well as for infrastructure (\$112 million) and program management (\$51 million) (Figure 29). If pre-service and in-service training costs are deducted, the funding gap for human resources for health is significant, which informs this funding requests prioritization of strategic retention schemes for critical facility- and community-based cares.

Figure 29: RSSH Resources, Costs and Projected Funding Gap in Zimbabwe for 2017¹¹⁰

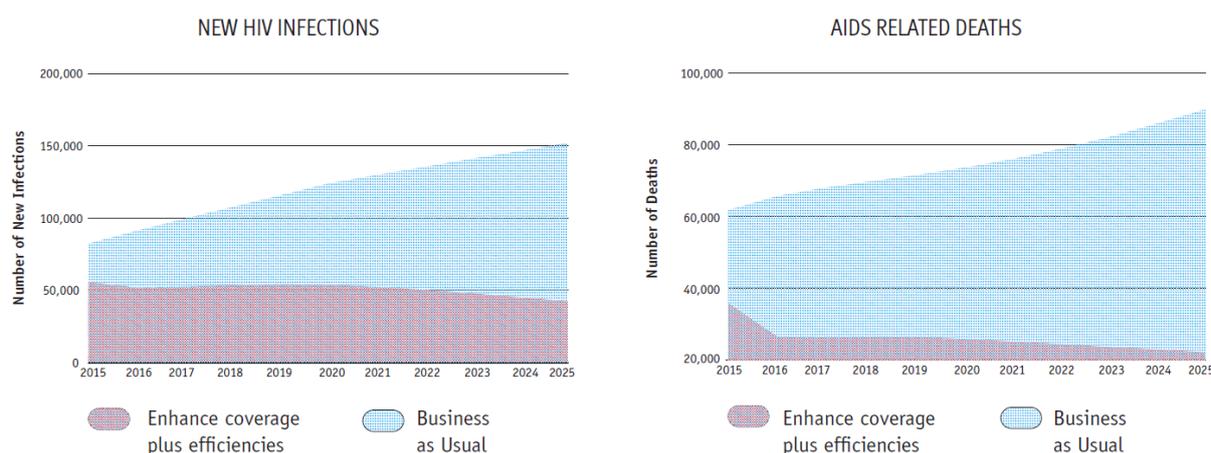


**Resource needs are based on Scenario 2 in Zimbabwe's National Health Strategy (2016-2020) (Annex 1)*

b) Actions to improve sustainability of Global Fund financed programs

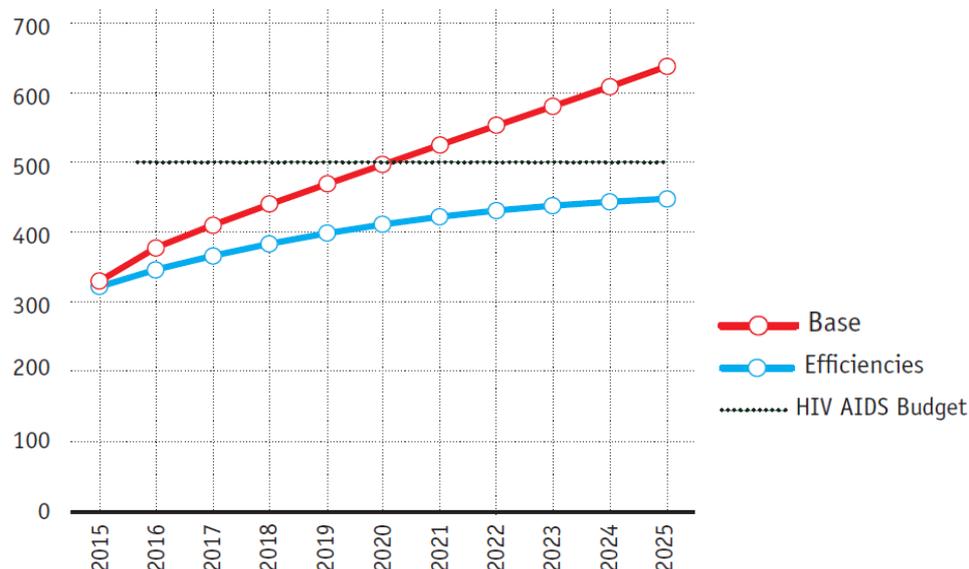
To improve sustainability of Zimbabwe’s Global Fund program, this funding request employs second generation investment thinking, in line with the country’s HIV investment case: interventions with the highest impact are brought to scale and resource allocation decisions prioritize geographic areas and populations with the highest burden of disease. This has been termed “focus for impact” in the introduction of this funding request. This approach is expected to significantly reduce the number of new infections and deaths from HIV and TB, contributing to epidemic control and a more sustainable and affordable response (Figure 30).

Figure 30: Zimbabwe Investment Case Modelling of Enhanced Coverage and Efficiencies¹¹¹



Further, investments in building resilient and sustainable systems for health are also expected to continue to enhanced sustainability of Zimbabwe’s HIV, TB, malaria and integrated RMNCAH programs. For example, coherence around procurement processes including investing in a single, integrated and consolidated national supply chain have the potential to save millions of dollars over the next decade.¹¹² These efficiencies are modelled to bend the cost curve of ART in Zimbabwe (Figure 31), without which these would soon exceed the country’s total HIV budget.

Figure 31: ART Costs Out of Total HIV Costs in Zimbabwe, Base and Efficiencies Scenarios¹¹³



The recent EU Health Systems Assessment (HSA) found that integration of parallel systems as well as streamlining and developing national capacity can contribute to value-for-money and sustainability in both the short and longer terms.¹¹⁴ These sustainability considerations are embedded with Zimbabwe’s national health and disease strategies, to which this funding request is aligned. As noted above, the National Health Strategy and this funding request prioritize a “high impact interventions” scenario which focuses on maximizing results within the limits of the proposed financial space.¹¹⁵

SECTION 5.1: PRIORITIZED ABOVE ALLOCATION REQUEST

All applicants are requested to detail a prioritized above allocation request. To respond, refer to guidance in the *Instructions* and fill in the table below.

Provide in the table below a prioritized above allocation request which, following the TRP review, could be funded using savings or efficiencies identified during grant-making or put on the register of UQD to be financed should additional resources become available. The above allocation request should include clear rationale and should be aligned with programming of the allocation for maximum impact. In line with the Global Fund's Strategy to maximize impact and end the epidemics, the prioritized above allocation request should be ambitious (i.e representing at least 30-50 percent of the within allocation amount).

See Annexes 14-16 for more detailed narrative descriptions of the PAAR activities described below.

See attached Prioritized Above Allocation Request (PAAR) Template for the detailed PAAR. In addition, a detailed PAAR budget has been provided at this early stage to provide greater clarity on the planned activities.

References

- ¹ Draft Modes of Transmission study, page 15 (Key Reference Document No. 30)
- ² The Epidemiological review of TB disease and surveillance (May 2016) (Annex 8)
- ³ ePMS Data Reporting Analysis Report (30 September 2016) (not yet publicly available)
- ⁴ Zimbabwe DHS 2015 (Key Reference Document No. 27)
- ⁵ Zimbabwe DHS 2015 (Key Reference Document No. 27)
- ⁶ ZIMPHIA 2016 Fact Sheet (Key Reference Document No. 26)
- ⁷ Draft Modes of Transmission study (Key Reference Document No. 30)
- ⁸ Hot spot analysis (2015), page 27 (Annex 5)
- ⁹ Zimbabwe DHS 2015 (Key Reference Document No. 27)
- ¹⁰ HIV Hotspot Analysis 2015 (Annex 5)
- ¹¹ Spectrum Estimates (updated Feb 2017)
- ¹² Zinyowera, S et al. The Zimbabwe HIV Early Infant Diagnosis (EID) Program for the period 2007-2012. Zimbabwe Ministry of Health and Child Care.
- ¹³ WHO Epi and Impact Review, page 7 (Annex 7)
- ¹⁴ National Baseline Survey on the Life Experiences of Adolescents (NBSLEA-ZimStat)
- ¹⁵ According to DHS trend data 2005-2015, see Draft Modes of Transmission study, page 15 (Key Reference Document No. 30)
- ¹⁶ "Sisters"– the first four years of the Zimbabwe National Sex Work Programme. Online at www.unicef.org/zimbabwe/ZIM_resources_nationalsexworkprogram.pdf
- ¹⁷ Zimbabwe DHS 2015, Page 35 (Key Reference Document No. 27)
- ¹⁸ 2015 Programme Data; <http://aidsinfo.unaids.org/>
- ¹⁹ BRTI Sexual Minorities and HIV in Zimbabwe Draft Report (2013); PEPFAR Zimbabwe Country Operational Plan (COP) 2016, Strategic Direction Summary. Online at <https://www.pepfar.gov/documents/organization/257623.pdf>
- ²⁰ Sandfort, T. G., Baumann, L. R., Matebeni, Z., Reddy, V., & Southey-Swartz, I. (2013). Forced sexual experiences as risk factor for self-reported HIV infection among southern African lesbian and bisexual women. *PLoS One*, 8(1), e53552. Online at <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0053552>
- ²¹ 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)
- ²² Zimbabwe Prison Service (2011). Assessment of HIV Prevalence and Risk Behaviours among the Prison Population in Zimbabwe. NAC & UNODC. Online at: http://www.centreforhealthstrategies.co.zw/hiv_prison.htm
- ²³ ZNNP+ (December 2014). The Zimbabwe People Living with HIV Stigma Index. Online At <http://www.stigmaindex.org/zimbabwe>. Page 43.
- ²⁴ Draft Modes of Transmission study (Key Reference Document No. 30)
- ²⁵ ZIMPHIA 2016 Fact Sheet (Key Reference Document No. 26)
- ²⁶ ZIMPHIA 2016 Fact Sheet (Key Reference Document No. 26)
- ²⁷ Cowan FM, Davey C, Napierala Mavedzenge S, Mushati P, Mtetwa S, Chiyaka T, et al. Estimation of the HIV care cascade for female sex workers in Zimbabwe: baseline results of the SAPH-Ire trial. 20th International AIDS Conference; Melbourne, Australia 2014. Online at: <http://pag.aids2014.org/Abstracts.aspx?AID=11297>
- ²⁸ WHO (2014) Global TB Report 2013, page 159 Online at http://apps.who.int/iris/bitstream/10665/91355/1/9789241564656_eng.pdf
- ²⁹ The Epidemiological review of TB disease and surveillance (May 2016) (Annex 8)
- ³⁰ Ministry of Health and Child Care (2014). The Zimbabwe National Population Based TB Prevalence Survey. Page 18. (Key Reference Document No. 31)
- ³¹ WHO (2016) Global TB Report. Page 169. Online at http://www.who.int/tb/publications/global_report/en/
- ³² Ministry of Health and Child Care (2014). The Zimbabwe National Population Based TB Prevalence Survey. Page 48. Key Reference Document No. 31)
- ³³ UNDP (2015). Gender and Tuberculosis: Making the investment case for programming that addresses the specific vulnerabilities and needs of both males and females who are affected by or at risk of tuberculosis. Discussion Paper. Online at [http://www.undp.org/content/dam/undp/library/HIV-AIDS/Gender%20HIV%20and%20Health/Gender%20and%20TB%20UNDP%20Discussion%20Paper%20\(1\).pdf](http://www.undp.org/content/dam/undp/library/HIV-AIDS/Gender%20HIV%20and%20Health/Gender%20and%20TB%20UNDP%20Discussion%20Paper%20(1).pdf)
- ³⁴ MOHCC. National Tuberculosis Program –Strategic Plan (2017-2020). Page 24. (Annex 3)
- ³⁵ Routine programme data (February 2017)
- ³⁶ Draft cost-effectiveness analysis of the National Strategic Plan for the National TB Program of Zimbabwe
- ³⁷ University of Zimbabwe and UNODC (2016). Assessment of TB Prevalence and Factors with TB among the Prison Population in Zimbabwe. Page 49-50. (Key Reference Document No. 32)
- ³⁸ University of Zimbabwe and UNODC (2016). Assessment of TB Prevalence and Factors with TB among the Prison Population in Zimbabwe. Page 24. (Key Reference Document No. 32)
- ³⁹ It should be noted that this is based on the 1980 staff establishment which is not matched to the current disease burden.
- ⁴⁰ External Program Review 2016 (Health care Policy Document 2016, page 15)
- ⁴¹ MOHCC Human Resources Department
- ⁴² National Health Strategy for Zimbabwe 2016-2020 (Annex 1)
- ⁴³ 2016 GARPR Page. Online at http://www.unaids.org/sites/default/files/country/documents/ZWE_narrative_report_2016.pdf
- ⁴⁴ MOHCC HIV Testing Services Strategy (2016-2020). Page vii. (Key Reference Document No. 41)
- ⁴⁵ Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III) 2015-2020 (Draft). Page 55. (Annex 2)
- ⁴⁶ Ministry of Health and Child Welfare Zimbabwe. ART Decentralization Guidelines. 2013. Online at [http://www.nac.org.zw/sites/default/files/2013%20Zimbabwe%20ARV%20Guidelines%20%20Main%20Document%20\(1\).pdf](http://www.nac.org.zw/sites/default/files/2013%20Zimbabwe%20ARV%20Guidelines%20%20Main%20Document%20(1).pdf)
- ⁴⁷ MOHCC (2014). Zimbabwe HIV Viral Load Scale Up Plan (2015-2018). Page 9. (Key Reference Document No. 47)
- ⁴⁸ MOHCC Draft ePMS Strategic Plan (2018-2020). Page 22. (Key Reference Document No. 7)
- ⁴⁹ MOHCC (2014) The Electronic Patient Monitoring System (ePMS) Assessment. Page 7. (Key Reference Document No. 16)
- ⁵⁰ PEPFAR Zimbabwe FY2016 Q4 POART (13 December 2016). Not publicly available.

- ⁵¹ Sisters is implemented by CeSHHAR on behalf of the National AIDS Council, reaching over 24,000 female sex workers in 36 sites with clinical services, health education, and community mobilization
- ⁵² Napierala Mavedzenge S, Fearon E, Hargreaves J., Mushati, P., Mtetwa, S., Chiyaka, T., ... Cowan F. (2015, July). Estimating engagement in HIV care among young female sex workers in Zimbabwe. IAS 2015, Vancouver. As cited in Busza, J., Mtetwa, S., Mapfumo, R., Hanisch, D., Wong-Gruenwald, R., & Cowan, F. (2016). Underage and underserved: reaching young women who sell sex in Zimbabwe. *AIDS care*, 28(sup2), 14-20. Online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4991229/>
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- ⁵⁵ Community Adolescent Treatment Supporters (CATS) have been trained and mentored since 2009 to provide counselling and supporting a cohort of HIV positive children, adolescents and young people in communities through home and clinic visits. CATS identify adherence challenges, traced treatment defaulters, and proactively identifies and refers children, adolescents and young people in need of further investigation for possible opportunistic infections, treatment failure, child protection issues and their psychosocial support, sexual and reproductive health needs.
- ⁵⁶ Willis, N. (2016). Findings from a community peer support treatment intervention. Presentation delivered at the International AIDS Conference 2016 in Durban, South Africa. Online at http://programme.aids2016.org/PAGMaterial/PPT/4636_6533/2016_07_06%20IAS%20Clinical%20Models%20of%20Service%20Delivery%20N%20Willis.pptx.
- ⁵⁷ Including referrals for cancer screening, dry blood spot screening (DBS), STI screening, VMMC, PrEP, ART reinitiating, emergency shelter (as necessary), and support groups in order to improved adherence and mental health among this group.
- ⁵⁸ Beitbridge (95%), Bulawayo (81%), Matobo (114%), Seke (114%), Umguza (73%), Umzingwane (82%) and Lupane 123%.
- ⁵⁹ Including Chimanimani (31%), Kariba (16%), Binga, (15%), Bikita (28%), Umguza (73%), Rushinga (21%), among others.
- ⁶⁰ DREAMS districts for COP 17 (FY18): Mazowe, Makoni, Mutare, Chipinge, Gweru and Bulawayo.
- ⁶¹ National Health Strategy for Zimbabwe (2016 – 2020), page 34 (Annex 1)
- ⁶² UNAIDS & UNFPA (2016). Evaluation of the United Nations Population Fund (UNFPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Project on Sexual and Reproductive Health and Rights and HIV Linkages in Seven Countries in Southern Africa: Country Report—Zimbabwe.
- ⁶³ MOHCC (2013). Service Guidelines on HIV and SRHR Linkages. Online at <http://www.integrainitiative.org/wp/wp-content/uploads/2015/04/Zim-Linkages-service-guidelines.pdf>
- ⁶⁴ National Health Strategy for Zimbabwe (2016 – 2020), page 34 (Annex 1)
- ⁶⁵ 2016 OIG report, page 6 (Key Reference Document No. 54)
- ⁶⁶ European Union (2016) Assessment and redesign of the systems for RBF, Human Resources for Health and Pharmaceuticals in Zimbabwe (Draft) Page 109. (Key Reference Document No. 14)
- ⁶⁷ WHO (2016) External National Tuberculosis Control Program Review. Page 2. (Annex 8)
- ⁶⁸ Cluver, L. D., Orkin, M. F., Yakubovich, A. R., & Sherr, L. (2016). Combination social protection for reducing HIV-risk behavior amongst adolescents in South Africa. *Journal of acquired immune deficiency syndromes (1999)*, 72(1), 96. Online at <https://www.ncbi.nlm.nih.gov/pubmed/26825176>
- ⁶⁹ WHO (2016) Global TB Report, 2016, page 169 Online at http://www.who.int/tb/publications/global_report/en/
- ⁷⁰ WHO (2016) Global TB Report 2016 page 169 Online at http://www.who.int/tb/publications/global_report/en/
- ⁷¹ Zimbabwe HIV Investment Case (2015) (Key Reference Document No. 35)
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- ⁸⁰ De Neve, J. W., Fink, G., Subramanian, S. V., Moyo, S., & Bor, J. (2015). Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment. *The Lancet Global Health*, 3(8), e470-e477. Online at <https://www.ncbi.nlm.nih.gov/pubmed/26134875>
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- ⁸³ Extended ZNASP III page 25 (Annex 2)
- ⁸⁴ WHO; UNFPA; UNAIDS; NSWP; World Bank; UNDP (2013). Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. Online at http://www.who.int/hiv/pub/sti/sex_worker_implementation/en/
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- ⁸⁶ The 2014 Zimbabwe PLHIV Stigma Index found that 70% of sex workers surveyed had access to ART, though this survey was conducted through a sampling exercise which was driven by sex workers who were already engaged in key populations and civil society support networks. (Key Reference Document No. 57).
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- ⁸⁸ Acknowledging that VMMC is not recommended as an intervention to prevent HIV transmission in sex between men, MSM may still benefit from circumcision if they also engage in vaginal sex. Further, it is important that VMMC is offered as part of the comprehensive combination prevention package because it can serve as an entry point for additional services, and exclusion from VMMC services might lead to their being publically identified as MSM and expose them to greater stigma and discrimination.
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- ⁹⁷ RBF Project Impact Evaluation 2014, initial results, as cited in MOHCC & World Bank (2015). Health Public Expenditure Review Zimbabwe. Page 38
- ⁹⁸ The Principal Recipient – Hivos regional office for Southern Africa – is located in Harare, Zimbabwe.
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