THE GLOBAL FUND
To Fight AIDS, Tuberculosis and Malaria
Interim Secretariat

Geneva, 31 January 2002 **GFATM/B1/6A**

GUIDELINES FOR PROPOSALS

PROPOSAL FORM

Guidelines for Proposals **set out detailed conditions of support and criteria for review of proposals. Reference is made in this form to relevant sections of the Guidelines.**

For the use of the Global Fund Secretariat: *Date Received:* *ID No:*

This form is divided into 3 sections:
SECTION A seeks summary information on the overall proposal, total funding sought and information related to general eligibility criteria, including details of the Country Coordinating Mechanism;
SECTIOB B seeks further detail on the overall proposal, its objectives, how it will be monitored and demonstration of additionality;
SECTION C seeks detail, including budgetary information, separately on each component of the proposal.

For additional pages, please mark clearly whether SECTION A, B or C.

SECTION A: OVERVIEW INFORMATION

A.1. Country (or region): **Republic of Zimbabwe**
A.2. Proposal Title: **Proposal to strengthen and scale up disease prevention and care for HIV/AIDS, TB and Malaria in Zimbabwe (2002)**
A.3. Spell out which of the three health problems or combination of them this proposal aims to address (HIV/AIDS, TB and/or malaria) (*Guidelines para.4*) : **1. HIV/AIDS - Prevention and Care 2. TB - DOTS Expansion 3. Malaria- Vector Control and Case Management**
A.4 What are the additional outcomes expected from this proposal? (*Guidelines, para. 8 and Annex 1, II 3*). **1. Strengthening of the Health System. 2. Community Empowerment. 3. Partnership building**

A.4. Total Amount Requested from the Global Fund: (in US$, by year)

Components (described in Section C)		Year 1 (Budget)	Year 2 (Estimated . . . . . .)	Year 3	Year 4	Year 5
Component 1	**HIV/AIDS**	5,300,000	5,000,000	3,800,000		
Component 2	**Tuberculosis**	**820,700**	**1,842,600**	**750,500**		
Component 3	Malaria	**4,746,250**	**1,970,000**	**2,161,250**		
Component 4	**Adminstration**	**289 500**	**318450**	**350295**		
TOTAL (outlined in Section B)		**11,156,450**	**4,131,050**	**7,062,045**		

A.5. Disease burden (Refer to official documentation or sources of epidemiological data on the prevalence and magnitude of HIV/AIDS, TB and/or malaria in the country/region/area) **or potential disease burden** (indicators such as incidence of new infections etc) *(Guidelines para.6)*

HIV/AIDS in Zimbabwe

The population of Zimbabwe is estimated at 11 529 000 of whom 5 768 000 or 50% are aged 15 - 49 years (Source: UNPOP 1999 estimate). Sixty one percent (61%) of the residents live in the "districts" in the rural areas.

Estimated Prevalence and Incidence of HIV/AIDS

The first case of AIDS in Zimbabwe was officially reported in 1985. Since then HIV infection has spread rapidly throughout the country in both urban and rural areas. By the end of 1999 an estimated 1 500 000 were living with HIV/AIDS and 160 000 persons died of AIDS in the same year. 93% of the PLWHIV/AIDS were adults between 15-49 years. During the same period an estimated 800,000 women of reproductive age and 56 000 children 0-15 years were living with HIV/AIDS (Source: UNAIDS/WHO Update 1999, Zimbabwe Epidemiological fact sheet).

Ministry of Health records show that women are affected five times as many as men in the age group 15-19 years and about one and half times in the age 20-29 years.The current seroprevalence rate is 35%, based on the year 2000 sentinel survey of pregnant women. This represents a large and rapid increase from the 29% recorded in the 1997 survey. Reports to the MOH show that 70% of all reported cases of HIV disease are in the 20-49 year age group. The peak age of HIV infection in adults is reported to be 20-29 years for females and 30-39 years for males (Zimbabwe National Health Profile, 1997). Among the young persons 15-24 years in both urban and rural areas 32% are HIV positive. These are the actively reproductive population groups with young families. High HIV prevalence in these ages results not only in high prevalence of HIV infected young children but also in the tragedy of young orphans, some of whom are also HIV infected. This group also constitutes the majority part of the country's workforce, and high mortality in the group has adverse effects on the country's economy.

In the 2000 sentinel surveilance 27.8% of young pregnant women aged 15-19 years were HIV positive. This suggests a high incidence of recent infections. Viewed together with the 20% increase in the seroprevalence rate between 1997 and 2000 the epidemic is firmly on the increase. It is projected that the number of persons living with HIV/AIDS will rise to 2 million by 2005; those who have progressed to AIDS will rise to 1. 3 million; and cumulative deaths are estimated to number 1.2 million by 2005.(Source: Zimbabwe National HIV/AIDS Strategic Framework, November 1999).

The leading mode of HIV transmission in the country is sexual contact between men and women. This accounts for 92% of the infection. The next most common mode of transmission is from mother to child during pregnancy, at delivery or through breast milk. This is the method of transmission in approximately 7% of the infections. All other modes of transmission together account for only about 1% of infections.

Impact of HIV/AIDS

"AIDS Orphans" The number of known "AIDS orphans" has increased rapidly, from a small number in 1990 to about 200 000 in 1995. UNAIDS/WHO have estimated that by 1999 some 900 000 children under 15 years had lost their mother or both parents and there were 623 883 living orphans under 15 years of age. These children face numerous problems among which are inadequate basics such as food and accommodation, inadequate care from overworking widowed mothers, movement from household to household and caring for sick surviving parents.In addition to the personal problems faced by the orphans their large numbers in society is causing a severe strain and burden on extended families; many grand parents, who themselves are in need of support have been forced to revert to supporting and caring for young children. There is already an increased burden on society and social systems to provide such as health care support and education services for the orphans.

Child survival

Infant and child mortality has been rising since the early 90's and there is no doubt that AIDS is a major factor in this increased mortality. This has effectively reversed the health gains achieved in the 80's.The National AIDS Council estimates that Infant mortality rate is presently 72% higher than what it woud be without AIDS. The National AIDS Coordination Programme (NACP) estimates that the AIDS has been responsible for 5% of the childhood deaths during the 1986-90 period, and is estimated to rise to 60% of child deaths between 2000 - 2005. AIDS Impact on Health Care study in 1996 found over 70% of patients in the country's hospitals to have underlying HIV infection. The demand for and pressure on hospital beds has led to the unprecedented phenomenon of discharging very sick and dying patients to the care of relatives. These relatives in most cases have never been exposed to the care of sick persons, let alone the chronically and terminally ill. The HIV epidemic has resulted in a parallel Tuberculosis epidemic and an increase in hospital bed days.Because of the large and increasing numbers of HIV/AIDS patients who are often seriously ill, relative expenditure on other conditions is rapidly declining. This, together with the high demand on the already depleted staff, is hastening the decline in the quality of care offered in health institutions.

Tuberculosis (TB)

Zimbabwe is ranked number 21 out of the 23 countries that together are responsible for 80% of the global burden of TB. The national estimated incidence of all forms of TB in 2000 was 584 per 100,000 populations while notification for the same year was 411 per 100,000 giving a Case Detection Rate (CDR) of 70%. Notification is increasing at the rate of 7% mainly due to HIV co-infection but also due to changing socioeconomic circumstances. In 2000 it was estimated that 30,000 new cases of infectious TB (smear positive) would occur in Zimbabwe. However the system could only pick up 15,455 giving a DOTS detection rate of 52%. For all patients with pulmonary disease last year, 25% did not received sputum smear.

The TB epidemic in Zimbabwe is HIV driven. Of the 74,000 cases of all forms of TB expected in 2000, about 30,000 (41%) were attributable to HIV. The patient female to male ration was 1: 1.2 between 15 – 35 year of age otherwise men tend to dominated in later ages. On the average over 80% of the patients are between 15 – 50 years, the period when they are most productive. TB patients on treatment are likely loose 3 to 4 months of work period about 25 – 30% of the annual working time. This constitutes a significant economic opportunities lost taking into account the high numbers of TB patient in Zimbabwe – 51,000.

TB is only second to AIDS as a major cause of deaths in Zimbabwe. Institutional figures are not

quite accurate as many particularly those with co-infection are discharge to die home within the Home Based Care program. It is estimated however about 20,000 could have died of TB in 2000.

The DOTS strategy has been adopted and implemented countrywide with varying degree of efficiency and quality. In 2001 the NTP achieved a TS of 73%, death rate of 10%, transfer out 11% and default rate of 7%.

There is thus a good TB delivery system in Zimbabwe, with services reaching the smallest echelons of society as free public good but of declining quality and equity as the epidemic outstrip the coping capacity. Major challenges facing the control program include,

1. Scaling up DOTS to bring to halt the current rapid increase.
2.Tackling TB and HIV together to mitigate the impact of their synergy
3. Building partnership to maximize and coordinate control efforts
4. Monitoring and improving response to the dual epidemic
The proposal is an effort to secure additional funds to implement strategies to address the challenges.

Malaria Prevention and Control

Malaria remains one of the major public health problems in Zimbabwe causing high morbidity and mortality. In high endemic districts, malaria is responsible for between 30 and 50 percent of fever cases and 30 percent of all outpatient consultations and 10-15 percent of hospital admissions. Malaria is responsible for over 2 000 deaths per year and every year between 1 and 1.85 million people suffer from clinical malaria in Zimbabwe. The incidence rates of malaria in the ten most affected districts range from 310 to 984 per 1000. Malaria incidence has been increasing steadily since 1996. This could be attributed to recent changes in the weather patterns in the Southern Africa region as well as improved reporting systems. Pregnant women and children under five years of age are the most vulnerable population groups to malaria in Zimbabwe. Pregnant women are four times more likely than non-pregnant women and men to suffer from malaria attacks. Malaria infections in pregnant women can result in abortions, still births, low birth weight babies etc.

Malaria in Zimbabwe is a dynamic disease in terms of time and place. The country is stratified into three transmision zones' follows:

1. Zone A - Areas that are free from malaria or have sporadic transmision and high epidemic potentials and situated north of the country 1200m+ above seas level and the south of the country 900 m + above sea level.

2. Zone B - Areas of low to moderate seasonal transmission with high epidemic potentials and found in the north of the country between 900 m and 1200 m above sean level and below 600m above sea level in the southern part of the country.

3. Zone C: - Areas of high high endemicity with low possibilities of epidemics found in the northen part of the country below 900m above sea level and in the southern part of the country

Malaria top 20 districts in Zimbabwe (1996)

Rank	District	Incidence (per 1000 population)
1	Hwangwe	984
2	Lupane	599
3	Binga	559
4	Tsholotsho	454
5	Centenary	399
6	Guruve	375
7	Mudzi	372
8	Gokwe	372

9	**Mt. Darwin**	**326**
10	**Mutasa**	**311**
11	**Nyanga**	**306**
12	**Chipinge**	**258**
13	**Chimanimani**	**239**
14	**Mutare**	**226**
15	**Chiredzi**	**221**
16	**Nkayi**	**215**
17	**Hurungwe**	**149**
18	**Kwekwe**	**137**
19	**Kadoma**	**123**
20	**Makoni**	**111**

A.6. Economic situation: (Refer to official indicators such as GNP per capita, HDI or other information on resource availability) (*Guidelines para.6*)

Zimbabwe is a 390,759-km2 land locked republic, sharing borders with South Africa and Botswana to the south, with Zambia to the west and Mozambique to the east. The national average life expectancy is estimated at 45.4 years for males and 46 years for females (World Health Report 2001). The estimated GDP per capita is US$ 720 (World Bank 1997) - 25% atributable to manufacturing, 15% to agriculture and 6% to the mining sector.

The country is currently experiencing a three digit inflation and highlevels of poverty. About 61% of households live in poverty while 45% are in extreme poverty (1995 Poverty Assessment Study Survey (PASS)-1995. In the same study the incidence of poverty was found to be higher in female (85%) as against male-headed households with levels of 72 per cent respectively. Zimbabwe's HDI value increased from 0.397 in 1992 to 0.513 in 1997, representing an average annual growth rate of 4,87 per cent over the six year period. This compares well with the world annual increases of 4,38 per cent and is high compared to other countries in the region.

Zimbabwe fairs well on global scale for women empowerment, ranking 45 in the UNDP's Gender Empowerment Measure (GEM). Nevertheless in all the ten provinces males have a higher HDI than females.

Government allocations to the health under structural adjustment fell from 2.6 per of GDP in 1980 to about 2.2 per cent by 1997. Since 1990, there has been a steady decline in real capita spending on health. The ZHDR (1999) showed in greater detail, that the HIV/AIDS epidemic has immensely increased the burden on the health sector (reffer to HIV section).

HIV/AIDS has significantly increased costs and demands on the health sector and placed heavy demands on insured benefits. The health sector therefore is operating under a tremendous strain as it seeks to cope with patients with AIDS-related illnesses. A National AIDS Levy has been launched to source urgently needed resources to supplement these costs of prevention and care of HIVAIDS.

Structures to facilitate district response and coordination have been established ie. the National AIDS Council (NAC), Provincial AIDS Action Council (PAAC), District AIDS Action Committee (DAAC), Ward AIDS Action Committee (WAAC) and Village AIDS Action Committee (VAAC). This was followed by a District Planning Process for HIV/AIDS which led to the production of 80 District Strategic Plans and 2002 Work plan and budget. The district is thus the focal point for coordination, facilitation, planning and resource mobilization and disbursement in support of community based HIV/AIDS response development. NAC allocated ZW$20 million to each district for the year 2002. This is inadequate given the magnitude of the problem and additional

resources are requested in this proposal to address the districts financial gaps.

A.7 Political commitment: (government contribution to the financing of the proposal or public spending on health or existence of supportive national policies or presence of a national counterpart in the proposal, or other indicator) (*Guidelines para. 6*).

The GOZ is committed to health as a key sector to enhance development and alleviate poverty. The country spends over 10% of her GNP and about 15% of her recurrent expenditure on health.

Further commitment to this course is demonstrated by :

1. The establishment of the National AIDS Council (NAC) with mandate to develop and guide implementation of appropriate strategies to combat HIV/AIDS and ameliorate the effects of the disease.

2. The establishment of the National AIDS Trust Fund (NATF) and introduction of AIDS levey to support the operation of the National AIDS Council in the fight against HIV/AIDS.

3. The establishment of the sub-committee on Health/HIV/AIDS at Cabinet Level to advise Cabinet on necessary action required for the intensification and acceleration of the national response to HIV/AIDS. This sub-committee on Health /HIV/AIDS is to be enlarged into a Multisectoral Co-ordination Committee (MCC) and will eventually govern implementation of the GFATM proposal in the event that it is funded.

Zimbabwe is signatory to the Abuja, Amsterdam, Washington Declarations in support of acceleration and expansion of DOTS to tackle the TB epidemic. Local funds to the tune of Z$ 90 miilion have been set aside for TB/HIV control. The organizational structures and HR necessary for disease control is in place but the numbers could be better. Malaria like TB and HIV is among the priority diseases in Zimbabwe. Through GOZ own source and RBM case management and vector control in terms of IRS and personal protection using ITN are conducted. However coverage is limited due to inadequate resources.

A.8 Links with existing activities: (What links are there between this proposal and other current activities supported, for example, through, national health strategies, Poverty Reduction Strategies and Sector-Wide Approaches? Provide copies of these as supporting documentation, noting them in Attachment 1)

The Ministry of Health and Child Welfare (MOHCW) is currently implementing the National Health Strategy for Zimbabwe 1997 – 2007 (Working for Quality and Equity in Health) through a three year rolling plan. It envisions achievement of the highest possible level of health and quality of life for its citizens through the combined efforts of individuals, communities' organizations and the government. Guaranteed access to comprehensive and effective social services will allow every Zimbabwean to participate fully in the country's socio-economic development.

To operationalize the Strategy, NAC has produced the following documents:-
1.Strategic Framework for a National Response to HIV/AIDS: 2001 – 2005.
2.National AIDS Council/NAC) Year 2002 (See copies attached).
3. Handbook for District Planning Process . A total of 80 Districts (57 rural and 23 urban) prepared a Strategic plan and 2002 workplan for HIV/AIDS with the participation and involvement of village and ward communities. Some of the district proposals are submitted in this CCP for

possible funding. On the bilateral front a country district management training program is ongoing through the Government of Italy/Zimbabwe cooperation. Twenty three districts are already trained and the rest will be covered by 2003.

A.9 Profile of the Country Coordinating Mechanism (CCM) – If not submitted by a CCM, please move directly to A.12. *(Guidelines para. 9-14)*

Various agencies and partners (including NGOs and Research Institutions) that are supporting this proposal are co-ordinated and organised through a country coordinating mechanism which is referred to in this document as CCM.

1. Name of the CCM:

Multisectoral Coodinating Committee

2. Date of constitution of the current CCM:

March 2001 but expanded in February 2002 to include private sector, buisness sector, bilateral cooperation agencies, UN Team and private citzens.

3. Organizational structure (e.g., secretariat, sub-committee, stand-alone):

Cabinet Sub committee

4. Frequency of meetings (e.g. monthly, quarterly):

Monthly and Quarterly

5. Major functions and responsibilities of the CCM:

a) Mobilize additional resources and for control of TB,HIV from variety of sources including GFATM .
b) Reviews and approves proposal from stakeholders and implementors for Global Fund support.
c) Manages the Global Fund.
d) Disburses the Global Fund to implementors and stakeholders.
e) Reviews implementation progress.
f) Coordinates planning, implementation, monitoring and evaluation of activities.

6. Major strategies to enhance CCM's role and functions in the next 12 months:

1. Draw up the Terms of Reference (TOR) and Operational Guidelines for the MCC and its sub-committees.
2. Employ the GFATM Programme Management Unit staff and establish an office.
3.Hold orientation meetings and workshops.
4.Form sub-committees or technical teams to carry out specialized tasks.
5.Open a Trust Account for TB/HIV and Malaria control in Zimbabwe.
6.Call for proposal, review, approval and disburse funds and support implementation.

A.10. Please provide the total number and composition of members of CCM:

People living with HIV/TB/malaria	1
NGOs/Community-based organisation	3

Private Sector	5
Religious/Faith groups	1
Academic/Educational Sector	0
Government Sector	5
Other (explain)	2 (Association of Local Authorities)
TOTAL	17

A.10. Signatures:

Members of the Country Coordinating Mechanism (CCM – see following page) sign below to endorse this proposal. Endorsement of this proposal does not imply any financial (or legal) commitment on the part of the partner agency or individual:

Signature,

Deleted: ¶ ¶

Chair of Country Coordination Mechanism: _____

Chair Name and Contact Information: **Hon. Dr,D.Parirenyatwa - Dupty Minister of Health and Child Welfare & Chairperson of the MCC.**

CCM Member Signatures

Deleted: ¶

Agency/Organization	Name/Title	Date	Signature
PLWAIDS/HIV	**J.M.Mxotshwa**		
NGO/CBO	**K.Mhambi**		
Religious/FaithGroup	**V.S.Chitimbire**		
Private Sector	**Mpisaunga M** **Ciaran Sharwood**		
Ministry of Health and Child Welfare	**Hon. D.Parirenyatwa** **E.Marowa**		
Ministry of Public Services, Labour	**S.G.Mhishi**		
Ministry of Education **Ministry of Finance**	**G.A.Jumbe** **M.Dzinotizei**		

Ministry of Youth, Gender	**I.Mandaza**		
Association of Local Authorities	**J.Zowa Chikate**		
WHO and UNAIDS	**G.Tembo E.K.Njelesani**		
DFID and CDC Atlanta	**Carole Presern Michael St. Louis**		

A.11. In case the Global Fund Secretariat has queries on this submission, please contact:
Name:
Dr. D.Parirenyatwa - Hon Deputy Minister of Health and Child Welfare & Chairman of MCC
Title/Address:
Ministry of Health and Child Welfare P.O.Box CY 1122 Causeway Harare
Tel.No.: + 263 4 729208

Fax No.: +263 4 720110

E-mail:
parirenyatwad@yahoo.com or dgdhlakama@healthnet.zw

A.12. If submitting not under a CCM, but as an individual or a partnership of non-governmental organizations (NGOs) or from private sector, please explain clearly the circumstances, conditions and/or reasons why not applying under a CCM.

NOT APPLICABLE

SECTION B: OVERALL PROPOSAL

B.1 Summary of overall proposal: (Synopsis of proposal, describing overall objectives, who will be involved, the beneficiaries, listing the major health components and the synergies between the different components. [more detail on separate components is sought in section C]).

Synopsis. Zimbabwe requests support from GFATM for expansion of the national response for each of HIV/AIDS, TB, and malaria. For each disease, Zimbabwe is currently pursuing the recognized, international best practice model for technical and organizational response, that is, an intensive local (district) response initiative for HIV/AIDS; DOTS for TB; and RBM for malaria). Each of these organizational responses was designed to allow for expansion to national scale. However, for each of these programs, constraints in essential resources have limited the scale of an expansive national response. Zimbabwe's application for GFATM proposes to systematically attack selected of these resource constraints for each of the three diseases, carefully using GFATM resources to supplement rather than supplant existing national and international resources. This has been done principally in a "bottoms up" approach for each of the three diseases, as detailed in Section C for each disease and component of the application. However, what has been particularly exciting in development of this application has been to see powerful cross-cutting themes emerge across the three disease areas, and large potential synergies in the responses, as explained below.

Goals and Objectives. The overriding goal of Zimbabwe's application to GFATM is lowering transmission, improving care, and thereby decreasing morbidity and mortality related to 3 infectious diseases: HIV infection, tuberculosis, and malaria. The overall objective and theme of Zimbabwe's application is "scaling up." Each program element, with the exception of ARV treatment, has already been piloted, adopted as policy, and implemented to a certain level of national implementation. For HIV/AIDS, the key objectives reflected in this application are:

1. Expand behavior change efforts in youth.
2. Expand voluntary counseling and testing (VCT) for HIV, especially to rural areas.
3. Expand efforts to prevent mother to child transmission (PMTCT) of HIV.
4. Support an expanding program of operational research that will set the stage for broad implementation of programs in highly active antiretroviral therapy (HAART) in Zimbabwe within 2-3 years.

For TB, the key objectives are:

1. Scale up the DOTS program and improving its quality nationally
2. Increase partnerships, social mobilization, and community response to TB
3. Increase coordination and collaboration between HIV and TB program
4. Build a comprehensive system to monitor and evaluate program coverage and quality, as well as disease trends for TB

For malaria, the key objectives are:

1. Strengthen and expand prevention of malaria transmission in the worst affected districts.
2. Strengthen diagnosis and management of malaria at community and primary health care levels, especially in children (through IMCI) and pregnant women.

Partners involved. The partners who will be involved in Zimbabwe's efforts include a broad range of national organizations in both public sector and civil society. Reflecting the major role of the Ministry of Health and Child Welfare in disease prevention and provision of health care, this coalition will be led by MOHCW. However, Zimbabwe has sought intensive input from other Ministries, from many Zimbabwean nongovernmental organizations, from UN agencies, from international NGOs, and from

bilateral donors. Moreover, all of these groups are seen as essential in the needed, expanded national response. The largest share of resources will go to commodities, training, logistics, or services that will "lighten the load" and facilitate the actions of each of these organizations, allowing them to apply their own already available resources more efficiently and to greater impact. The next share of resources will go to shore up critical elements of the health sector infrastructure, mainly at the district level and below. However, resources will also be directly shared with other Ministries and with Zimbabwean NGOs to support their efforts. For international NGOs and bilateral agencies, strategic uses of GFATM resources will allow channeling of those agencies own resources to core commitments and will allow them to leverage their own continuing (and hopefully expanding) commitments greater impact.

Beneficiaries. The primary beneficiaries of resources from GFATM will be the Zimbabwean people, especially rural people and those who suffer the greatest burden from these three diseases, namely, women, children, and persons vulnerable by reason of economic, social, or political disadvantage of any type. Secondary beneficiaries include front-line health and social service providers, from home-based care providers for HIV patients to doctors struggling to get a proper diagnosis on a perplexing case of TB, who so often are faced with dealing with problems of the intended primary beneficiaries, but who face the demoralizing circumstance of not having resources to really help the persons they are trained and committed to help. Additional beneficiaries include the organizations noted above as partners in utilization of GFATM resources, whose work and impact will all benefit by the strategic injection of resources, and the synergies to be recovered from considering and acting in an integrated way in efforts across these three disease areas.

Major Health Components and Synergies between Components. Substantial synergies and opportunities for collaboration and integration across program elements have already been identified in the process of developing this application, including, but not limited to:

1. Laboratory. Integrated focus on enhancing district-level laboratory capacity, especially strengthening microscopy for TB and malaria (and possibly CD4+ cell counting), rapid tests for HIV and malaria, and laboratory information systems to promote quality assurance and improved timeliness of reporting.
2. Antenatal Care. Integrated focus on strengthening systems of antenatal care, newly enhanced by thoroughly integrating HIV prevention and malaria control into all aspects of antenatal care, and probably using VCT services introduced into ANC for PMTCT as the entry point for VCT services available at the district level.
3. Monitoring, evaluation, and use of health information to strengthen services at local level. This major component of each of the proposed program elements in part C can be reviewed and approached in a common way, to promote optimal use of staff, training resources, and information technology (IT) at the local level.
4. Procurement and distribution of commodities. Improved, coordinated efficiency of procurement, including careful stewardship of GFATM foreign exchange resources, ranging from residual insecticides to ARVs, combined with strengthened distribution of drugs, laboratory reagents, and other commodities through a strengthened NatPharm and related, streamlined procurement agencies.
5. Human Capacity. Each of the program component in part C direct new or expanded responsibilities, training requirements, M&E tasks, quality performance expectations, and duties to the same cadre of front-line health staff, or very thin layer of supervisors or managers at the provincial and national levels. The biggest responsibility hidden amongst these program components is the time and skill involved in carefully, caringly, and supportively providing HIV counseling for a nation where 25-33% of all adults will be found infected, or 80-90% in TB clinics. Zimbabwe pledges to match this request for support from GFATM by a renewed, intensified effort at achieving Health Sector Reform that will allow for improved conditions of service for health care workers, and through other policy and personnel actions that will allow for rapid expansion of the number of key cadres that will otherwise be a bottleneck on overall program expansion such as HIV counselors, microscopists and rapid test technicians, and informatics officers with basic data and IT training.
6. Multisectoral, Local Planning for Health. The biggest health systems event of the past year in Zimbabwe has been the rapid and effective organizing of District AIDS Action Committees (DAACs) in nearly all 82 rural and urban districts of the country, and development of local district response plans that have been funded by Zimbabwe's own domestic resources through the National AIDS Trust Fund. NGOs that previously operated at the level of making national or international applications for support are now increasingly involved with their DAACs locally. However, National

AIDS Council funding of the multisectoral response at the district level has often left the resource-constrained health sector unable to respond as effectively as it might to the new (and positive) expectations from these local coalitions. GFATM resources should allow some parallel building of the health sector in Zimbabwe to allow it to be a more effective response agent within the local, multisectoral response. Conversely, GFATM resources utilized synergistically (as described in #1-5 above) are likely to draw TB and malaria even further into the local, multisectoral planning process that has been set in motion so intently and comprehensively by the District Response Initiative for HIV/AIDS.

B.2 Programmatic monitoring and evaluation: (*Guidelines para. 34-37*) (The proposal needs to include an outline of the monitoring and evaluation process that will be followed in relation to the overall proposal, including timelines, and baseline data, responsibility for collection, proposed/anticipated use of the information to be collected and involvement of target population with monitoring and evaluation. [Section C requests monitoring and evaluation information on major components])

B.2 Programmatic Monitoring and Evaluation

Overview of Monitoring and Evaluation Approach. Three major technical components for programmatic monitoring and evaluation are proposed for the GFATM in Zimbabwe.

Part 1. M&E for core Ministry of Health Programs. TB and malaria control programs are core Ministry of Health activities, and key indicators recommended for the DOTS approach to TB control and for Roll Back Malaria are already incorporated into reporting through the National Health Information System (NHIS) of Zimbabwe and/or through programmatic reports of the TB and malaria programs of the MOHCW. AIDS and STI surveillance is also conducted through the NHIS, and HIV surveillance is conducted through annual or biannual, unlinked anonymous surveys of pregnant women in antenatal care. The main NHIS form for reporting of notifiable diseases and related indicators (the T5 form) is currently being revised to incorporate four key programmatic indicators for PMTCT efforts and for HIV VCT. Details of monitoring and evaluation procedures (e.g., indicators, data sources) for each component of this application are presented in part C of this application.

Part 2. Database of National Indicators for Progress Against AIDS, TB, and Malaria. For the past year, a Technical Working Group on Monitoring and Evaluation (TWG-M&E) of the National AIDS Council (NAC) has been developing guidelines and tools for monitoring and evaluation of funds disbursed from the National AIDS Trust Fund (NATF) of Zimbabwe to Districts under the District Response Initiative. These guidelines are based on the Measure/UNAIDS/WHO consensus indicators for HIV/AIDS program, and was adapted to the purpose of monitoring the UNGASS goals for HIV/AIDS prevention and care. The first product of this process has been the implementation of the Zimbabwe Young Adult Survey (YAS+) 2001, which was recently completed by the MOHCW and ZNFPC, which will provide population-based data on many of the prevention and care HIV/AIDS indicators at a national level among males and females 15-29 years of age. The YAS will be repeated in 2005, at which time it will be possible to monitor progress in many critical outcome and impact indicators, such as critical HIV prevalence among young persons 15-24 yrs of age, sexual behaviors important to sustaining HIV transmission, and coverage and quality of key clinical services that Zimbabwe proposes to expand through this GFATM application, including VCT, PMTCT, and home-based care. Through this program of repeated national surveys of young adults, Zimbabwe will be distinctive in being able to precisely measure national outcome and impact indicators for the central HIV/AIDS interventions proposed in this application.

It will be important to include indicators for TB and malaria, drawn primarily from sources represented in Part 1, and indicators for progress against HIV/AIDS, drawn primarily from sources represented in Part 2, can be combined in an indicator database for the GFATM. The multidisciplinary process and representation of the TWG-M&E of NAC, plus the fact that many or most of the output and impact indicators in the NAC indicator database are also drawn from MOHCW sources (that is, Part 1 sources), suggests that it will not be difficult to add TB and malaria indicators to those in the current HIV/AIDS indicator database, to produce a summary GFATM indicator database for AIDS, TB, and malaria.

Part 3. Monitoring of programmatic activities funded by GFATM resources. The TWG-M&E has been developing guidelines and tools for the second major component of the overall M&E approach, which is a set of guidelines and standards for reporting process, outcome, and (where available) impact measurement for specific projects funded by individual Zimbabwe-NATF grants. The same (or slightly adapted) procedures and tools should be able to be used by individual grantee organizations that receive GFATM funds. Such grantees will report to the Zimbabwe MCC for GFATM on a quarterly basis. The TWG-M&E has begun developing a request for contract for a software firm to develop a database of programmatic efforts funded by the NATF and by other national and international resources – GFATM resources will be specified as one such source for international assistance. This will have

three special advantages for GFATM programmatic accountability: 1) other national HIV/AIDS programs funded by national and international assistance will be represented in the same database, so that the relationship between GFATM funding and activities funded by other donors can be transparently understood, and 2) much of the preparatory work has already been done on the guidelines and database, so this can proceed more quickly than would otherwise be true.

Overall Process for Programmatic M&E. GFATM resources that are allocated to Ministry of Health or other Ministries (e.g., Education) will be reported through normal GOZ accounting procedures, according to the types of processes outlined for Part 1 above. GFATM resources allocated to NGOs, to other civil society organizations, to District AIDS Action Committees, or to other entities for programmatic work (e.g., research organizations, etc.) will be subject to programmatic accountability as suggested in Part 3. An integrated indicator database for GFATM (Part 2) will be assembled from the key indicators from Parts 1 and 3 above, plus from periodic national surveys. In addition, external evaluations will be done on a subset of selected grantees, especially for programs that appear to be either problematic or to be unusually promising. Additional technical resources and staffing for external evaluation are already being developed through a new program at the University of Zimbabwe Department of Community Medicine called the "Center for Evaluation of Public Health Interventions (CEPHI)." The Multisectoral Coordinating Committee (MCC) will review progress per national indicators, periodic reports from all grantees, in standardized format with indicators, and reports of external evaluations conducted as a key part of its overall responsibilities.

B.3. Financial management (*Guidelines para. 19-22, 38-40*) (Describe arrangements in place for financial management, including suggested disbursement mechanisms and plans)

B.3 Financial Management.
Receipt and Holding of Funds. The GFATM will be retained in its own special Trust Fund Account administered by the Ministry of Health and Child Welfare. Because of the peculiar monetary environment of Zimbabwe, with high inflation and an acute shortage of foreign exchange, this will be maintained predominantly as a foreign currency account (FCA), with a linked domestic currency account to which funds can be transferred only when needed for disbursement of domestic currency. Purchases that require or are advantageous when made in foreign currency (such as drugs, equipment, laboratory reagents, and the like) will be purchased directly from the FCA.
Decisions regarding Allocations and Disbursements. Disbursements are intended predominantly along the lines reflected in this application, although priorities and budget lines may need to change for reasons out of the control of the MCC. For example, an international partner might suddenly decide to start funding purchase of HIV test kits that were envisioned in the proposal as needing to be purchased by GFATM resources, or vice versa, such an organization that was expected to provide a key input might suddenly discontinue its support to that area. The MCC needs the authority to rapidly shift planned allocations around to meet agreed upon key objectives for the program. Substantial funding has been requested for key programmatic and commodities support for Ministry of Health and Child Welfare in the areas of HIV/AIDS, TB, and malaria. In addition, substantial support in the area of behavior change for youth is committed to the Ministry of Education, Sport, and Culture (MOESC), and other Ministries may also present to the MCC a strong proposal to address one or more of the targeted diseases. In addition, funding will be made to NGOs and civil society organization with documented competence and relevant, high priority proposals submitted to the MCC.
Funding of NGOs and Civil Society. Although no funding formula or ratios has been developed, a substantial proportion (perhaps 25% of the total funding) is expected to be committed to NGOs and other organs of civil society for their direct support to expand the national response to AIDS, TB, and malaria. Although program guidance for the GFATM appeared to seek specific funding

commitments to named organizational partners, the solicitation of proposals in Zimbabwe to date was clearly very partial and perhaps quite biased in nature. For example, fewer than 10 of the more than 160 NGOs registered as AIDS Service Organizations with the Zimbabwe AIDS Network (ZAN) submitted proposals, with widely varying requests. A more deliberate process for solicitation of proposals with substantial information sharing and provision of technical assistance to understand how to develop and submit proposals would establish a more equal footing. One additional option that will be considered by the MCC to assure that a fair share of resources goes to NGOs and civil society is target NGO partners proposed and approved by District AIDS Action Committees in the District Response plans for funding, but for which available funding was insufficient. However, one special area for emphasis of NGO partners in GFATM is that of national organizations, since many such organizations were for obvious reasons underrepresented in commitments of the NATF, since the later focused almost exclusively on district-based plans.

Financial Accounting and Audits. The MOHCW and Ministry of Education, Sport, and Culture (MOESC) have well-established procedures for receiving funds from external donors and for full accounting including external audit. Generally, there have not been major shortfalls identified with these accounting procedures in Zimbabwe; identified problems have been more likely to fall into the domains of either slow uptake and programming of funds, or of less than full impact evaluation of funded programs, rather than of fraud that might have been detected through more stringent and duplicate accounting or audit review. For NGO partners, full financial accounting backed by a recognized accounting firm, plus external audits, will be required and will be eligible for funding as a use of the grant resources themselves. For the GFATM as a whole, a financial accounting and consulting firm will be retained to provide guidance to MCC on how to maintain the highest possible transparency and accountability, without introducing requirements that are unduly burdensome on grantees or that compromise the rapid application of the resources to address critical issues in AIDS, TB, or malaria in Zimbabwe.

B.4 Statement of Budget Requirements, Financial Commitments and Unmet Needs 2002 *(Guidelines para. 8, Annex III.2) (Demonstrate the additionality of the proposal)*

(US$)

	Budget Categories (please fill in according to plan)							
	Human Resources	*Logistics & supplies*	*Training & Supervision*	*Outreach Services*	*Commodities or products**	*Data & information systems*	*Other (explain)*	*TOTAL*
BUDGET REQUIREMENTS								
Financial commitments, by source								
Government								
Civil Society	Data not readly available							
Private sector								
Donors								
Other								
TOTAL COMMITMENTS	Incomplete data							
UNMET NEEDS	CI - C5	CI - C5	C1-C5	C1-C5	C1 -C5	C1- C5	C1 C5	CI - C5

**including drugs*

B.3 Duration (provide an estimate):

Beginning and end dates:

From: June/July 2002 To: December 2004

Period to be covered by this request for financing:

From: June/July 2002 To: December 2004

SECTION C: MAJOR COMPONENTS

(separate Section C pages should be prepared for each major component of the proposal i.e. make more copies if needed.)

PROPOSAL COMPONENT ---- (Number separate components 1 to xx)

C.1 Description: (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

PLEASE SEE ATTACHED PAPERS CI - C5

C.2 Objectives and indicators (Provide information on objectives for this component.)

- **Main objective** (Describe the expected end situation)

FOR CI - C5 PLEASE SEE ATTACHED PAPERS

- **Specific objectives:** (Related to indicators, including baseline data, current situation and annual targets) (*Guidelines para. 34-37*)

INDICATOR	Baseline	Targets				
	2001	2002	2003	2004	2005	2006

C.3 Programmatic monitoring and evaluation plans: (An outline of the monitoring and evaluation process that will be followed for this component.) (*Guidelines para. 34-37*)

C.4 Duration: (provide an estimate)

Beginning and end dates:

From: To:

Period to be covered by this request for financing:

From: To:

C.5 Implementation Plans including resource allocations to partners *(Guidelines para. 40)*

(US$)

	Budget Categories (please fill in according to your plan)							
Implementing Partner	*Human Resources*	*Logistics and supplies*	*Training & Supervision*	*Outreach Services*	*Commodities or Products**	*Data & information systems*	*Other (explain)*	***TOTAL***
Government								
Civil Society								
Private sector								
Donors								
Other								
TOTAL								

**Including drugs*

Attachment 1: List of Supporting Documents

Please note which documents are being included with your proposal by indicating a document number

General documentation:	**Attachment #**
1. Poverty Reduction Strategy Paper (PRSP)	X
2. Medium Term Expenditure Framework	
3. Sector strategic plans	X
4. Any reports on performance	

HIV/AIDS specific documentation:	**Attachment #**
5. Situation analysis	X
6. Baseline data for tracking progress[1]	X
7. National strategic plan for HIV/AIDS, with budget estimates	X
8. Results-oriented plan, with budget and resource gap indication (where available)	X

TB specific documentation:	**Attachment #**
9. Multi-year DOTS expansion plan and budget to meet the global targets for TB control	X
10. Documentation of technical and operational policies for the national TB programme, in the form of national manuals or similar documents	X
11. Most recent annual report on the status of DOTS implementation, expansion, and financial planning (routine annual WHO TB Data [and Finance] Collection Form)	X
12. Most recent independent assessment/review of national TB control activities	X

Malaria specific documentation:	**Attachment #**
13. Situation analysis	X
14. Baseline data for the tracking of progress	
15. Country strategic plan to Roll Back Malaria, with budget estimates	X
16. Result oriented plan, with budget and resource gap indication (where available)	

Crosscutting documents/activities	**Attachment #**

[1] Where baselines are not available, plans to establish baselines should be included in the proposal.

MAJOR COMPONENTS

Introduction

Zimbabwe has responded resolutely to the HIV/AIDS epidemic since 1997. The response has been scaled up considerably in recent years. A national AIDS policy was adopted in 1999. Parliament in 1999 established a multisectorall National AIDS Council with responsibilities to fight the epidemic enshrined in the Act. A National HIV Strategic Framework for the period 2000 - 2004 is in place and operational. In a demonstration of the importance and priority accorded to HIV/AIDS government in 1999 established a National AIDS Trust Fund (NATF) to partly finance the national response to the epidemic. The fund's steady source income is a 6% (3% employer and 3% employee) levy on all taxable incomes. In 2001 an ambitious and successful district response initiative was launched through he creation of District AIDS Action Committees (DAACS) to spearhead district action in a decentralised national response. Strategic plans for all 23 urban districts and 57 rural districts have been prepared, however operationalisation has been limited by inadequacy of funds. Government has allocated a sum of US$ 364000 per district for the year 2002 to start decentralised response. Additional funds are necessary to expand and strengthen HIV/AIDS activities.

On interventions Zimbabwe has adopted the recognised key interventions recommended by the WHO regional member states as having potential to reduce the HIV/AIDS problem (Youth, VCT, PMTCT, Blood safety, Care, STI, Safe injection practices, Workplace, TB, Surveillance). However the scale of some of the interventions has been severely limited by inadequate funding and therefore the impact on the epidemic has not been realised.

Zimbabwe has also taken strong measures to improve surveillance. Sentinel Surveillance has been strengthened and more reliable and useable results were obtained from the 2000 survey. In 2001 the first and comprehensive Young Adult Survey (YAS+) combining behaviour change with HIV prevalence and service provision, was conducted, and the results are expected in May 2002. This will afford the country a critical tool in the prevention of HIV infection in young persons and baseline data for most of the key interventions.

All funds requested from the Global Fund are for ongoing and sustainable interventions, but will are critical in scaling up the response in a timely fashion and appropriate magnitude.

PROPOSAL COMPONENT 1: ***PREVENTION OF HIV TRANSMISSION AMONG YOUNG PEOPLE WITH A FOCUS ON SEXUAL AND REPRODUCTIVE HEALTH SERVICES***

This component is prompted by the high prevalence of HIV infection (32%) among young persons in the country, using pregnant women 15-24 years as a proxy for the age group. In addition this is a large population group (15-24 = 20.6%, 10-24 >30%) with marked influence on the course of the epidemic. Effective interventions that are directed at preventing infections in the youth are certain to pay off well.

The following interventions/innovations are taking place in the country to address the problem of youths and HIV infections:

Existing programmes directed at the youth are mainly the following:

In school youth

- In service teacher training in HIV/AIDS (health) and life skills. Some 30000 teachers out of 108000 have had the training. The balance is yet to be trained and UNICEF will fund the training. UNICEF has also supported production of AIDS in Action books for grades 7 to 6th form. What is required is funds for developing supplementary teaching materials such as wall charts for primary and secondary schools (4668 primary schools with 2537475 pupils and 1800 secondary schools with 863636 pupils).
- UNAIDS sponsored programme "Towards improved reproductive health and promotion of safer sex among the youth in urban areas of Southern Africa" being piloted in 3 urban centres

Out of school youth

- Numerous NGOs are involved in programmes for the youth out of school including peer education programmes, skills training, theatre, religious and income generation programmes
- Science-based behaviour change communication strategy involving mass media and community level reinforcement activities supported by CDC-Zimbabwe
- Youth friendly corners have been established in some health facilities
- Each of the 80 DAACs in Zimbabwe is currently examining various behaviour change initiatives relevant to their communities.

The above interventions have not had adequate impact largely because of the insufficient scale of the services. Scaling up of the activities will contribute towards the reduction of HIV/AIDS among the youth.

This proposal is restricted to **in school youth Material Development and Procurement for HIV/AIDS and Life Skills Education.**

Activities:

1. Development, production and distribution of appropriate materials

The beneficiaries are the approximately 3.5 million school children and the youth out of school.

Implementation partners

The key implementing partners in this component are the public sector i.e. Ministries of Health & Child Welfare (OHCW), Ministry of Education Sports and Culture (MOESC), and Ministry of Higher Education; NGOs; CDC; Turner Foundation, Curriculum Development Unit. Printing of materials will be subcontracted to the private sector.

The HIV/AIDS and life skills department in the MOESC will take a leading role in the implementation working with regional coordinators, DEOs, headmasters and school health masters. The finance and administration section of the ministry will continue to provide services.

Main Objectives

Lower the HIV infection rate in young adults (males and females 15-29 years) from the baseline established in the Zimbabwe Young Adult Survey (YAS+) in 2001.

Specific Objectives

- Improving the quality and coverage of school programmes that include HIV/AIDS and related issues
- Promote activities to engage youth in non risk activities
- Provide information, raise awareness and stimulate discussion among young adults
- Encourage the development of safe behaviour to minimise the risk of infection

Output indicators

- Drop out rates of the girl child
- Number of schools with anti-AIDS clubs
- Number of children actively involved in anti-AIDS clubs

Outcome indicators

Indicator	**Base line**	**Annual Target (see * below)**				
	2001	**2002**	**2003**	**2004**	**2005**	**2006**
Number of health institutions with Youth friendly programmes	YAS+ conducted				Repeat YAS+	
% young people having pre-marital sex	YAS+ Conducted				Repeat YAS+	
% young people using a condom during pre-marital sex	YAS+ Conducted				Repeat YAS+	
Age-mixing in sexual relationships	YAS+ Conducted				Repeat YAS+	
% of young people with multiple partners	YAS+ Conducted				Repeat YAS+	
% condom use at last higher risk sex	YAS+ Conducted				Repeat YAS+	
Median age at first sex	YAS+ Conducted				Repeat YAS+	

*****The Zimbabwe Young Adult Survey (YAS+), a comprehensive national survey of HIV prevalence, behaviour, and health services for persons aged 15-29 years, was conducted for the first time in 2001 and will be conducted every 4 years for 4-5 cycles. It was designed to be a comprehensive monitoring tool for all facets for all facets of youth oriented services, and especially behaviour change and provision of key services such as VCT and PMTCT to young persons. Because of the YAS+ Zimbabwe will be able to precisely measure the progress towards the key UNGASS goal of lowering infection rates in persons aged 15-24 years by the year 2005. Targets for 2003 and subsequently will be determined after the results of the baseline are known.

Programmatic Monitoring and Evaluation

The monitoring and evaluation will be done through the existing education system with the HIV/AIDS and Life Skills Education secretariat taking a leading role. Impact evaluation will be conducted through regular Young Adult Surveys.

Duration:

From: July 2002
To: December 2004

Implementation Plan including resource allocation to partners, Young People.

Implementing partner	**Budget Categories**							
	Human Resources	Logistics and supplies	Training & supervision	Outreach services	Commodities & products, incl. drugs	Data & information systems	Other/explanation	Total
Government		400000						400000
Civil society				200000				200000
Curriculum Development Unit					400000			400000
Total								**1000000**

PROPOSAL COMPONENT 2**:** ***EXPANSION OF VCT SERVICES TO THE RURAL AREAS***

C.1 Description

The component seeks to increase access to voluntary counselling and (VCT) to the public as a preventive strategy as well as an entry point to HIV prevention and behaviour change, prevention and treatment of TB and other opportunistic infections, psychosocial support and improved medical care of PLWHA and support of those affected.
Currently all VCT services in the country are provided mainly by the non-governmental trust PSI Zimbabwe, an affiliate of Population Services International (PSI). The trust runs a network of 12 VCT centres concentrated in urban areas and carries out about 5000 tests per month nation-wide. **This figure can be substantially increased by expanding the service to the rural districts.**

It is proposed to expand VCT services to 20 districts. The target group is the adult population (15-49 years) of approximately 1.9 million in the 20 districts.
Strategies for implementation
The first 12 districts will be the same district as for the PMTCT expansion. The services will be based at the same facilities in order to share the scarce human and financial resources and minimise costs. Coverage will be gradually expanded to a total of 20 districts (12 mission hospitals and 8 government hospitals).
The main input is rapid HIV tests, outreach costs for community mobilisation and training o health workers, and a health facility survey.

The testing service will be attached to the existing district hospital and open to all members of the public. Existing or upgraded laboratory facilities will be utilised for testing. HIV positive clients will be referred systematically for further interventions namely, testing for TB, medical care, post-test clubs, home based care, and mitigation interventions. Where appropriate clients will be referred for MTCT prophylaxis. DAACS will play a central role in community mobilisation, follow-up psychosocial care and mitigation through post-test clubs/support groups and orphan care.

District focus, training of health workers, community mobilisation, participation of the DAACS are the main considerations.

Main implementing partners:
- Government (Ministry of Health and Child Welfare).
- (Zimbabwe Association of Church-related Hospitals (ZACH)
- NGOs
- Local communities represented by multisectoral District AIDS Action Committees (DAACS)

Objectives and Indicators

Main Objective

To expand access to VCT to rural areas in Zimbabwe and establish a formalised link with prevention and care interventions

Specific Objectives

- To build health worker skills to carry out effective and quality counselling and HIV testing and care.
- To work in collaboration with the DAACS to provide effective psychosocial care and mitigation services to PLWHA in the districts
- To provide VCT services at 20 health care facilities
- To conduct a facility baseline survey and periodic.

Indicator	**Base line**	**Annual Target**		
	2001	**2002**	**2003**	**2004**
1. Number of health workers trained in Counselling and Care of HIV-related conditions including TB	Baseline survey	300	200	400
2. Number of districts with VCT services	4	12	14	20
3. Number of VCT centres with minimum conditions to provide quality services	Baseline survey	Health facilities survey	Health facilities survey	Health facilities survey
4. Number requesting a test	Negligible	55000	75000	95000
5. Number receiving a test	Negligible	50000	70000	90000
6. Number receiving test results	Negligible	30000	50000	70000

Expected additional outcomes

- Reduction in risk behaviour
- Improved referral for care

C.3 Programmatic Monitoring and Evaluation

Programme supervisor will be designated for the purpose of keeping track of the implementation process against the plans.
All districts will plans for regular monitoring and support visits to ensure correct conduct of counselling and testing.
An annual internal project review is planned in all districts, followed by an external mid-term evaluation and a final external evaluation at the end of the project.

C.4 Duration

From: July 2002
To: June 2005

C.5 Implementation Plan including resource allocation to partners, VCT.

Implementing partner	**Budget Categories**							
	Human Resources	Logistics and supplies	Training & supervision	Outreach services	Commodities & products, incl. drugs	Data & information systems	Other/explanation	**Total (US$)**
GOVERNMENT	104000	31,636	175,500	214,036	135,142	250000	0	910,314
ZACH	104000	31,636	175,500	214,036	135,142	30,000	0	690,314
CIVIL SOCIETY/NGO		50000	0	461,538	184,615	30000	0	726,153
Total	**208000**	**113,272**	**351,000**	**889,610**	**454,899**	**310,000**	**0**	**2,326,781**

PROPOSAL COMPONENT 3: ***SCALING UP PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV (MTCT)***

An estimated seven percent (7%) of HIV infection the country is transmitted vertically from mother to child during pregnancy, delivery and breastfeeding.

The number of HIV positive women with access to ARV prophylaxis against MTCT in the country is currently minimal. The intervention is confined to the private sector in the main urban centres and a few mission hospitals in the rural areas. Therefore the overall impact is understandably negligible at present. However government has adopted PMTCT as an important intervention in the fight against HIV/AIDS. Pilot studies have been conducted in three urban centres and, based on lessons learnt, the service is being expanded nation-wide. A national workshop attended by provincial and district representatives was held in May 2001, at which the modalities of expansion to the districts was agreed. Laboratory personnel in all the 58 district hospitals have since been trained to perform rapid HIV tests.

A UNICEF sponsored pilot project recently concluded a successful 2 years. CDC has supported the training of laboratory scientists nationally and provision of 65000 rapid HIV test kits for initiation of new PMTCT programmes around the country. The MOHCW successfully petitioned Boehringer Ingelheim for donation of Nevirapine for PMTCT. An active PMTCT Partnership Forum (PPF) has functioned successfully since August 2001 to promote greater coordination and communication for scaling up the national response, and a consensus approach to national monitoring and evaluation of the programme has been developed by the PPF. Funding has been secured from the WHO/Italian initiative for four districts in 4 provinces (Mt. Darwin, Kwekwe, Nkayi and Bulilimamangwe) for two years. **Funds are requested from the GFATM to scale up PMTCT to 12 more districts.** The expansion will be done in partnership with the Zimbabwe Association of Church Related Hospitals (ZACH), whose members run most mission hospitals in Zimbabwe. The services will be based at 8 mission hospitals and surrounding rural health centres, and 4 government hospitals and surrounding rural health centres. The distribution will be such that each of the 8 provinces has 2 districts offering PMTCT supported by different partners namely Government, ZACH, and WHO/Italian initiative.

Strategies for implementation

The planned key strategy for PMTCT is antiretroviral (ARV) prophylaxis in pregnancy using Nevirapine, supported by primary prevention, VCT and obstetric-based interventions. Community mobilisation and training of health workers in HIV/AIDS in general, PMTCT and counselling will be major elements of the programme. The programme will be based at the district with the strong involvement of the DAACS.

Counselling will be an integral part of **antenatal care** in the health facilities but testing will be voluntary. **Rapid HIV test** kits and existing or modified laboratory facilities will be utilised.

In addition to **ARV preventive therapy** HIV positive mothers will be **referred** for TB testing, medical care, post-test clubs, home based care, and mitigation interventions. **Exclusive breastfeeding** will be encouraged for 4-6 months only. The **baby** will be monitored and tested for HIV infection after 18 months of age. The non-medical follow up activities (eg Post-test clubs and Support groups) will be coordinated by the DAACS.

The project will start at the district hospitals and expand to the peripheral areas as rapidly as experience is gained and as capacity permits.

The counselling and testing services will also serve as a V**CT** service for the general public.

The main areas of activity and cost are:

- training seminars and refresher sessions for about 25 health workers in each district
- outreach meetings with various sections of the community
- IEC and other supplies
- video equipment for supporting education in antenatal clinics
- rapid HIV test kits for pregnant women and exposed infants
- salaries for district Counselling/MTCT coordinators
- support to local NGO/CBO to carry out psychosocial post-test care

Main implementing partners:

- Government (Ministry of Health)
- Zimbabwe Association of Church-related Hospitals (ZACH)
- NGOs, especially Kapnek Trust, CESVI, and Zvitambo
- UN Agencies, especially UNICEF
- CDC
- Local communities represented by multisectoral District AIDS Action Committees (DAACS)

Main Objective

To reduce the vertical spread of HIV infection by increasing access to ARV prophylaxis to HIV infected pregnant women.

Specific Objectives

- To build health worker skills to carry out effective and quality counselling and HIV testing.
- To strengthen the capacity of district health institutions to provide effective PMTCT.
- To provide ARV prophylaxis to HIV positive pregnant women
- To provide follow-up programme for HIV positive women

Indicator	Base line	Annual Target		
	2001	2002	2003	2004
Number of health workers trained in PMTCT	Negligible	300	100	200
Number of Pregnant women counselled and tested for HIV	Negligible	30000	65000	70000
Number of pregnant women provided with ARV therapy in pregnancy	Negligible	21000	48000	56000
Number of districts with PMTCT services	4	12	12	12
% of health institutions offering or referring for PMTCT	Negligible	80	90	100
% HIV positive women referred for care	Negligible	80	90	100

Programmatic Monitoring and Evaluation

Programme supervisor will be designated for the purpose of keeping track of the implementation process against the plans.
Monitoring and evaluation of the PMTCT programme will be as simple as possible so that it does not retard the delivery of PMTCT services. As far as possible existing registers such as the MCH register will utilised after appropriate modifications.
All districts have made plans for regular monitoring and support visits to ensure correct conduct of counselling, testing, administration and stocking of nevirapine and management of HIV positive women and their infants.
An annual internal project review is planned in all districts, followed by an external mid-term evaluation and a final external evaluation at the end of the project.

Duration

From: July 2002 to December 2004

Implementation Plan including resource allocation to partners, PMTCT.

Implementing partner	Budget Categories							
	Human Resources	Logistics and supplies	Training & supervision	Outreach services	Commodities & products, incl. Drugs*	Data & information systems	Other	Total (US$)
Government	$432,000	$46,636	$175,500	$214,036	$135,142	$30,000	$0	**$1,033,314.00**
ZACH	$0	$93,273	$351,000	$428,073	$270,284	$60,000	$0	**$1,202,630.00**
Civil Society/NGO	$140,000	$830,769	$0	$692,308	$276,923	$553,846	$0	**$2,493,846**
Total	$572,000	$925,678	$526,500	$1,334,417	$682,349	$643,846	$0	**$4,729,790**

* Boehringer Ingelheim will provide all Nevirapine required for the until end 2004
*CDC Zimbabwe will purchase and supply 100 000 HIV rapid test kits

PROPOSAL COMPONENT 4: ***PROVIDING A HOLISTIC CONTINUUM OF CARE FOR THE INFECTED***

Description

There are at least 1.5 million people living with HIV/AIDS who are at different stages of the infection and require various levels of care - from institutional care to CHBC. Health institutions are overwhelmed and patients are discharged to the care of relatives at home and the rate of death in the country is unprecedented and alarming. The main challenges Zimbabwe is facing in the area of care are CHBC and specialised drugs for opportunistic infections and drugs for antiretroviral (ARV) therapy.

COMMUNITY HOME BASED CARE (CHBC)

Extensive Home-based care activities have been undertaken in the country for several years, largely as private and government hospital outreach programmes, community initiated, NGO and other schemes. A CHBC policy has now been adopted and guidelines for referral are in place. The district plans drawn up by the DAACS contain a provision for systematic and coordinated CHBC; however the financial provision is far below requirement has been drawn up but lacks funding. Needs were identified by district planning teams after extensive consultations at village, ward, district and at the national consultative meeting with the private sector, NGOs, CBO and government agencies. Assessed needs are: -

- Scaling up to make CHBC accessible within the catchment area of every rural health centre or urban municipal clinic.
- Improving the quality of CHBC, currently being provided.

The programme will be implemented in eight selected districts as a pilot project.
The main elements of the planned expanded programme are:

- Community mobilisation of men and women done by district planning teams and partner NGOs and the private sector in the administrative wards.
- Training for CHBC.
- Provision of information and training to family members about HIV/AIDS and home care
- Support visit by village health workers
- Provision of resources - HBC kits and refills, basic drugs for pain relief and simple infections.
- It is proposed that DOTS will in due course be integrated into the CHBC programme.
- Supplementary feeds.
- Provision of bicycles for village health workers
- Monitoring and Evaluation

Training and support of family caregivers will become a major activity as the demand for home-based care increases.
The family will play a major role in home based care in partnership with the nurse at the periphery in counselling, information dissemination and supervising care that is given by the village health workers and families. This will ensure the continuum of

care hospital to home. Special attention should be made to prevent burnout syndrome for volunteers who are mainly women in care provision.
Attention will be made to improve the human resources in the selected district to ensure that their capacity to manage discharge plans and provide physical and psychosocial home care.
Training of village health worker and support of care providers within the families with logistics and supplies. The programme should enable the care providers to carry out outreach work providing care giving and supervision of care.
For sustainability of the programme, the government structures as per district strategic plans will ensure that local authorities, government and NGOs work together on care provision and other mitigating strategies that will allow for sustainability.
Organisations and agencies providing support to household and communities for prevention and mitigation and care provision will work together. Effective co-ordination will ensure that there is good communication and networking.

Main Objective

To reduce the impact of HIV/AIDS on PLWHA by providing systematic medical and psychosocial care.

Specific Objectives

- To conduct a survey of support given to households
- To provide effective management of patient care within and between health institutions, communities and households
- To establish a well resourced and supported Home Based Care Programme
- To support families in caring for sick relatives at home with information and logistics

Indicator	**Base line**	**Annual Target**		
	2001	**2002**	**2003**	**2004**
% of clinics equipped to give support to households		Baseline survey		70
% households receiving help in caring for chronically persons		Baseline Survey		50
% households helped with care of orphans		Baseline survey		60

Programmatic Monitoring and Evaluation

Process will consist of:

- Monthly meetings between the programme co-ordinator at district and all community stakeholders
- Monthly and quarterly and annual reports on finance and activities
- Annual external evaluation

Duration

July: 2002
To: December 2004

Implementation Plan including resource allocation to partners, CHBC.

Implementing partner	Budget Categories							
	Human Resources	Logistics and supplies	Training & supervision	Outreach services	Commodities & products, incl. drugs	Data & information systems	Other/ explanation	Total
Government	628363	579200	226091	200000	0	3000	0	1636654
Civil society	628363	579200	226091	200000	0	2000	0	1635654
Total	**1256726**	**1158400**	**452182**	**400000**	**0**	**5000**	**0**	**3272308**

ANTIRETROVIRAL THERAPY (ARV)

Antiretroviral therapy has been available in the private sector for some years. This has reached only a small number of people, and pressure for expansion of the service is very high due to demand and developments on the international arena regarding ARVs. As a way forward government has taken the following action:

- The existing National Drugs and Therapeutics Policy Advisory Committee (NDTPAC) set up a special Antiretroviral Therapy Subcommittee (ARTS)
- Guidelines for antiretroviral therapy in Zimbabwe have been developed by the ARTS and are ready for production and distribution.
- The DART study, with reaserch sites in Uganda and Zimbabwe, will be implemented in 2002 with support from Rockerfeller Foundation. More than 1000 patients will be treated with ARVs in Harare according to a fixed HAART protocol, testing different strategies for monitoring response to therapy and side effects.

- **ARV operational research:**

Planning for an ARV operational research involving MOHCW, CDC and other partners has commenced. The purpose of the initiative is to implement and evaluate an antiretroviral treatment programme based on the new guidelines for ARV in Zimbabwe, in order to support development of expertise in the guidelines by health care providers and the development of standardised simplified treatment and monitoring algorithms.
Several partners have committed themselves to support an operational research initiative. Costs include the purchase of drugs and the remainder for laboratory monitoring, training, information and monitoring and evaluation. It is requested that the GFATM fund US$ 2.2 million worth of drugs for scaling up of HAART in Zimbabwe in 2002. The amount will enable Zimbabwe to scale up of the intervention from the previously planned 300 to 900 life years.

Main Objective

To develop expertise in the implementation of a nation wide ARV programme

Specific Objectives

- To provide ARV therapy on an operational research basis with a view to scaling up towards the beginning of broad coverage of HAART in urban Zimbabwe by 2004, along with pilot implementation of rural district-based HAART programmes.
- To establish clinical reference centre of excellence and national referral centre
- To establish a national HIV reference laboratory with capacity to conduct viral load measurement; CD4+ measurement; quality assurance for all HIV-related testing.
- To develop an ARV training programme for health workers
- Produce algorithms for ARV treatment of patients with HIV infection
- Develop capacity for health facilities to provide ARV therapy
- To train health workers in ARV therapy

Indicator	**Base line**	**Annual Target**		
	2001	**2002**	**2003**	**2004**
Number of medical personnel trained in the care of ARV therapy	-	20	200	200
% health facilities with capacity to deliver appropriate HIV care to patients	-	-	-	80
Number of patients started on ARV treatment	-	100	400	500
% patients on treatment adhering to treatment	-	Monitor	Monitor	Monitor

Programmatic Monitoring and Evaluation

Clinical monitoring and laboratory follow up will be strict and in accordance with the guidelines for ARV therapy in Zimbabwe.

Duration

From: July 2002
To: December 2004

Implementation Plan including resource allocation to partners, ARV.

Implementing partner	**Budget Categories**							
	Human Resources	Logistics and supplies	Training & supervision	Outreach services	Commodities & products, incl. drugs	Data & information systems	Other/explanation	**Total**
Government	0	500000	1000000	0	2200000	0	0	**3700000**
Civil society								
Donors								
other								
Total								**3700000**