Investing in our future

The Global Fund

To Fight AIDS, Tuberculosis and Malaria

Fifth Call For Proposals

Proposal Form

Proposal to provide ART in 22 districts, strengthen the National TB control programme and make ACT available for treatment of malaria in Zimbabwe

ZIMBABWE

The Global Fund to Fight AIDS, Tuberculosis and Malaria is issuing its Fifth Call for Proposals for grant funding. This proposal form should be used to submit proposals to the Global Fund. Please read the accompanying Guidelines for Proposals carefully, before filling out the proposal form.

Timetable: Fifth Round

Deadline for submission of proposals: **June 10, 2005**
Board consideration of recommended proposals: **September 28-30, 2005**

Resources available: Fifth Round

As of the date of the Fifth Call for Proposals, US$ 300 million is available for commitment for the Fifth Call for Proposals. It is anticipated that additional resources will become available prior to the Board consideration of proposals. The amount available will be updated regularly on the Global Fund's website. Any information submitted to the Global Fund may be made publicly available.

Geneva, 17 March 2005

How to use this form:

1. Ensure that you have all the documents that accompany this form—the Guidelines for Proposals, and Instructions on how to use the PDF version of the form. Please read the Instructions on how to use the PDF version of the form before using the PDF form.

2. Please read ALL questions carefully. Specific instructions for answering the questions are provided.

3. Where appropriate, indications are given as to the approximate length of the answer to be provided. Please try to respect these indications.

4. To avoid duplication of effort, we urge you to make maximum use of existing information (e.g., program documents written for other donors/funding agencies).

5. Instructions are printed in blue and marked with an I symbol. Guidelines are printed in blue and marked with a G symbol

6. Lists of Impact and Coverage Indicators (incl. glossary of terms) are available as Annex A for the MS Word version of this form. Annex B for the MS Word version of this form contains information on Green Light Committee Applications.

Name of applicant	Zimbabwe Country Coordinating Mechanism	
Proposal Title:	Proposal to provide ART in 22 districts, strengthen the National TB control programme and make ACT available for treatment of malaria in Zimbabwe	
Country/Countries:	Select	ZIMBABWE

Type of Application:

- [x] **National Country Coordinating Mechanism**
- [ ] **Sub-National Country Coordinating Mechanism**
- [ ] **Regional Coordinating Mechanism (including Small Island Developing States)**
- [ ] **Regional Organization**
- [ ] **Non-Country Coordinating Mechanism**

[Please tick one of the boxes to categorize your application type; refer to Guidelines for Proposals, section II, paragraphs C1 to C4.]

Proposal Component(s)

- [x] HIV/AIDS[1]
- [x] Tuberculosis[2]
- [x] Malaria
- [ ] Health system strengthening

[Please tick the appropriate box or boxes for your proposal target; refer to Guidelines for Proposals, section III, A.]

Currency in which the Proposal is submitted

- [x] **USD**
- [ ] **EURO**

[Please tick the appropriate box. Please note that all financial amounts appearing in the proposal should be denominated in the selected currency only.]

1 In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

2 In contexts where HIV/AIDS is driving the tuberculosis epidemic, tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/

1. Eligibility

[Countries classified as "lower-middle-income" or "upper-middle-income" by the World Bank are eligible to apply only if they meet additional requirements (see the Guidelines for Proposals, section II.A.).]

Country/Countries	ZIMBABWE

- [x] **Low Income**
- [ ] **Lower-Middle Income**
- [ ] **Upper-Middle Income**

1.2. CCM functioning - eligibility criteria

[To be eligible for funding National/Sub-National/Regional (C)CM applications have to meet the requirements outlined in 1.2.1 to 1.2.3.] If you need additional space please attach document(s) for you text aside of the field(s)

1.2.1. Demonstrate CCM membership of people living with and /or affected by the diseases.

[This may be done by demonstrating corresponding CCM membership composition in section 3.6.3 'Membership Information.']

The CCM has two seats for people living with the diseases. The two seats are occupied by two PLWAs, one representing an umbrella body of people living with HIV and AIDS and the other from a community based AIDS support group. (CCM annex 1)

1.2.2. Provide evidence that CCM members representing the non-governmental sectors have been selected by their own sector(s) based on a documented, transparent process developed within each sector.

[Please summarize the process and attach documentation as described in the instructions.]

The CCM embarked on a self-restructuring exercise after the requirements came into place since the 9th board meeting. The new structure of the CCM HAS 20 seats, see details on attachment. A CCM guide for constituency member selection was also developed to facilitate the transparent and consultative process for selecting new members as per the new guidelines. All CCM members representing non government sectors in the old CCM were tasked to facilitate the selection process in respective constituencies, for example the bilaterals members in the old CCM facilitated the selection process of all new members from the bilaterals constituency. In most constituencies meetings were held and new members elected and minutes submitted to the CCM secretariat and members endorsed by the CCM at the next meeting (CCM Annex 2).

1.2.3. Describe and provide evidence of a documented and transparent process to:

a. Solicit submissions for possible integration into the proposal

[please summarize and attach documentation as described in the instructions].

In its first meeting of 2005 the CCM set up a committee to develop a process for the preparation of round five proposals. The committee presented its recommendations on the various options that the CCM could use to ensure a trasnparent and all inclusive process. The CCM made a decision that a call for proposals/concept papers be flighted in the print media and in addition each CCM member was tasked to inform their constituency to submit proposals/concept papers for consideration. Attached is the CCM call for proposals.(CCM Annex 3).

b) Review submissions for possible integration into the proposal

[please summarize and attach documentation as described in the instructions].

All proposals and concept papers that were received after the CCM call for proposals and concept papers were registered by the CCM secretariat. The proposals were then given to the writing teams, which were composed of members from all sectors, government, private sector, NGOs. The writing teams reviewed all proposals and incorporated activities considered important and within the focus of the round five proposal. Some of organizations that submitted proposals were also invited to a discussion on the focus of the proposal and asked provide more information where necessary. Some organizations that did not submit proposals were contacted and invited to a discussion on the proposal and to assist provide specific information based on their knowledge and experience. Specific groups like PLWAs and private sector companies were invited to make some contributions to the proposal and to review the extent to which the proposal addressed their areas of concern and interest.(Proposal Annex 17).

b) Nominate (the) Principal Recipient(s) and oversee program implementation

[please summarize and attach documentation as described in the instructions].

A committee of five CCM members from the public sector, private sector, bilateral, NGO sector and secretariat was set up to develop a criteria for review of principal recipient applications. The criteria included legal status, institutional & programmatic, financial management, procurement and supply management and comparative advantage. The criteria were applied and principal recipients were proposed to the entire CCM for discussion and finalization. At the 2 June 2005 meeting the CCM deliberated on the report of the committee and decided on multiple principal recipients and went on to nominate principal recipients from different sectors, private sector, public sector and civil society (CCM Annex 4). In its 4th meeting of 2005 on 8 April, the CCM after a feedback on the Zambia CCM capacity building workshop resolved to develop memorandum of understandings with principal recipients as part of a mechanism of program oversight. The CCM is still in the process of finalizing a document on programme oversight after the publication of new guidelines on CCM oversight by the Global Fund Board at the 10th Board meeting in April 2005.

2.1. Executive Summary

[Please include quantitative information, where possible (4–6 paragraphs total)]:

2.1.1. Briefly describe the (national) disease context, existing control strategies and programs as well as program and funding gaps. Explain how the proposed interventions complement existing strategies and programs, particularly where funding from the Global Fund has been received or approved.

2.1.2. Describe the overall strategy by referring to the goals, objectives and service delivery areas for each component, including expected results and associated timeframes. Specify for each component the beneficiaries and expected benefits (including target populations and their estimated number).

2.1.3. If there are several components, describe any synergies expected from the combination of different components—for example, TB/HIV collaborative activities (by synergies, we mean the added value that the different components bring to each other, or how the combination of these components may have broader impact).

2.1.4. Indicate whether the proposal is to scale up existing efforts or initiate new activities. Explain how lessons learned and best practices have been reflected in this proposal and describe innovative aspects to the proposal.

The prevalence of HIV infection in Zimbabwe is still one of the highest in the world, and HIV/AIDS associated morbidity and mortality continues to rise. This results in adverse social and economic consequences such as growing number of orphans and vulnerable population sub groups, and reduced economic outputs. Despite major efforts made in form of a comprehensive response, the critical areas of antiretroviral treatment and HIV Testing Counselling need substantial additional funding for scale up. The current proposal is building on already existing strategies, such as the national PMTCT, TB and ART program as well as HIV Testing and Counselling services. Currently about 10% of the Zimbabwean population have received HIV Testing and Counselling and only 4% of those in need of treatment are accessing ART. This proposal will support scale up of ART and T&C services in 22 districts, which include expansion of services in 12 districts covered by Global Fund Round1.

The goal of the HIV/AIDS component is improved quality of life and reduced mortality from HIV and AIDS amongst PLWHA. The proposal aims to increase awareness and commitment among policy makers, leaders, communities and PLWHA that AIDS is a treatable disease, and increase the number of people with advanced HIV disease receiving ART as part of a comprehensive treatment and care package. The main strategy will be implementation of a decentralised, district response to ART roll out. The first objective will be achieved through development of a supportive environment for HIV interventions through creation of advocacy initiatives and improved workplace policy programs, and improving HIV awareness through BCC using mass media and community outreach. The second objective will be achieved by enhancing coordination and partnership for ART roll out, and developing health infrastructure and human resource capacity. It will also support procurement and supply management for HIV related medicines and commodities and strengthen Monitoring & Evaluation and operational research. Services to be expanded include T&C, HIV/TB collaboration, nutritional guidance, ART treatment and monitoring, and care and support for the chronically ill and families affected by HIV and AIDS. Expected results of this proposal include the provision of testing and counselling services to 1,090,000 people and ART to 70,000 PLWHA by the end of the third year. The main beneficiaries of this proposal will be people living with advanced HIV/AIDS infection, including tuberculosis patients, local communities, women and children.

In 2003, Zimbabwe ranked 19th in the world by the estimated number of TB cases. It is among the group of 22 `high disease burden' countries. Disease incidence increased dramatically in recent years. The biggest factor for this increase is the HIV/AIDS epidemic. Zimbabwe has a national TB control program (NTP) which formally adopted the DOTS strategy in 1997. The NTP uses two regimens for treating TB and there is a plan to introduce fixed-dose combination tablets (FDCs) in the very near future. Treatment success was 71% in the 2001 cohort and fell to 67% for 2002. In the latter, 11% of patients died and 22% defaulted. The latest survey (1994) estimated an MDR prevalence rate of 1.4%. As a result and combined with the current adverse economic climate, there is no national regimen for MDR-TB. Recent reviews of the TB program identified the major shortcomings inadequate management and supervisory capacity and limited coordination at all levels, deteriorating laboratory infrastructure and insufficient community based support services for patients. Consequently the performance of the TB program has been poor with a decline in case detection and treatment success rates.

The goal of the TB component is reduced TB morbidity and mortality in Zimbabwe. The proposed interventions are designed to support and strengthen the existing NTP efforts. It focuses on 5 areas; strengthening programme management and supervisory capacity, strengthening laboratory diagnostic capacity (achieving 70% diagnosis) improving treatment outcomes (80% success) and patient support and coordination between TB and HIV services and strengthening M&E capacity. The programme will benefit the disadvantaged poor and PLWHA as these groups are disproportionately affected by TB. It will contribute to the fight against AIDS by offering all TB patients the opportunity to know their HIV status. TB clinics will thus become a major entry point for HIV/AIDS care. The combined activities of both the HIV and TB components can be expected to result in synergistic enhancement of care and treatment for patients with TB and HIV co-infection, both in the 22 focus districts of the HIV proposal, and in other areas across the country.

ZIMBABWE

Th Global Fund
To fight AIDS, TB, Malaria

2.2 Component and Funding Summary

Funding Summary in ITable 2.2 Total Funding Summary

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS	15,996,545	19,934,614	26,547,732			62,478,891
Malaria	9,779,800	11,437,669	8,780,932			29,998,401
Tuberculosis	6,716,826	3,370,450	3,384,650			13,471,926
HSS	-	-	-			-
TOTAL	32,493,171	34,742,733	38,713,314			105,949,218

2.2. Component and Funding Summary

Funding Summary in USD

Table 2.2. Total Funding Summary

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS	0	0	0	0	0	0
Malaria	0	0	0	0	0	0
Tuberculosis	0	0	0	0	0	0
HSS	0	0	0	0	0	0
Total	0	0	0	0	0	0

3. Type of Application: National Country Coordinating Mechanism

[Complete section 3 as appropriate. Please note that - without these details, and in particular the information requested in section3.6 the proposal cannot be reviewed.]

3.1. National CCM Section

Table 3.1 - National CCM: Basic Information

Name of the National CCM	Date of Composition
ZIMBABWE COUNTRY COORDINATING MECHANISM	1 March 2002

3.1.1. Describe how the National CCM operates—in particular, the extent to which the CCM acts as a partnership between government and other actors in civil society, including non-governmental organizations, the private sector and academic institutions, and how it coordinates its activities with other national structures (such as National AIDS Councils) (2 paragraphs).

[For example, decision-making mechanisms, constituency consultation processes, structure of subcommittees, frequency of meetings, implementation oversight, etc. Provide statutes of the organization, organizational diagram and terms of reference as attachments.]

The CCM has recently been restructured to meet the new CCM requirements from the Global Fund. The CCM has two technical committees, HIV and AIDS, and malaria. The CCM uses the best efforts to reach all decisions by consensus. If all practical efforts by the CCM and the Chair have not led to consensus, any member of the CCM with voting powers can call for a vote. If in the exceptional circumstances, the secretariat, the CCM Chair and the Vice chair determine that a pending issue cannot wait until the next scheduled CCM meeting, the CCM Chair and Vice Chair communicate with members through electronic mail to help the Chair make informed decisions.

The CCM meetings are held every month to discuss and deliberate on grants management. Occasionally the CCM meets on an adhoc basis if there are urgent issues requiring decisions to be made. When there are complex issues that require informed decisions adhoc CCM committees are set up for specific tasks to recommend decisions to the CCM. The CCM has an established secretariat responsible for managing all CCM business and supporting and advising all players in the Global Fund Grants.

On constituency consultation processes, the various sector representatives in the CCM are responsible for consulting and sharing information with their respective constituencies. In the 5th meeting of 2005 the CCM resolved that each constituency members facilitate the development of constituency consultation plans and present them to the CCM (CCM Annex8). The process is currently underway. The CCM has also developed a plan of action which details on how the various constituencies including, the private sector, PLWAs and civil society will be engaged to ensure they are fully involved in the Global Fund programmes (CCM Annex 7).

3.6. Proposal Endorsement and Membership Section

3.6.1. National CCM Membership Section

NATIONAL CCM CONTACT DETAILS

[Applicable to submissions fr	Zimbabwe Country Coordinating Mechanism
One of the tables below must	1 March 2002
Regional (C)CMs must demo	Zimbabwe
	Africa

Please provide full contact details for the national CCM leadership and for each national CCM member.

National CCM leadership details *Table 3.6.1 - National CCM Leadership Information*

	Chairperson	Vice Chairperson
Name	Dr P.D Parirenyatwa	Dr Everist Njelesani
Title	Minister of Health and Child Welfare	World Health Organisation Representative
Mail address	Ministry of Health and Child Welfare	World Health Organisation
	P.O. Box CY 1122, Causeway	Box CY 348, Causeway,
	Harare	Harare
	Zimbabwe	Zimbabwe
Telephone	263 4 729208	263 4 253724
Fax	263 4 720110	263 4 253732
Email address	dparirenyatwa@yahoo.com	njelesanie@whoafr.org

3.6.3. National CCM member details *Table 3.6.2 - National CCM Member Information*

Member			
Agency/Organization	Centres for Disease Prevention and Control- USG	Website	www.zimcdc.co.zw
Type	Bilateral	Mailing Address	CDC Zimbabwe
Sector Represented	Multilateral and Bilateral Development Partners		P.O. Box 3340
Name of Representative	Dr Shannon Hader		Harare
Title in Agency	Director	Email Address	haders@zimcdc.co.zw
Role in CCM	Review & Technical Input	CCM member since	1 March 2002
		Fax	263 4 796032
		Telephone	263 4 796040

Member			
Agency/Organization	UNAIDS	Website	www.unaids.org
Type	Multilateral	Mailing Address	UNAIDS
Sector Represented	Multilateral and Bilateral Development Partners		P.O. Box 4775
Name of Representative	Dr Karl-Lorenz Dehne		Harare
Title in Agency	UNAIDS Representative	Email Address	Karl-Lorenz.Dehne@undp.org
Role in CCM	Review &Technical Input	CCM member since	1March 2002 re-elected March 2005
		Fax	263 4 250691
		Telephone	263 4 792681-5
			263 91267963 Mobile

Table 3.6.2 - National CCM Member Information (continued)

Member			
Agency/Organization	Zimbabwe Associon of Church related Hospitals	Website	none
Type	Religious/Faith Based	Mailing Address	Zimbabwe Association of Church related Hospitals P.O. Box 1556 Harare
Sector Represented	Religious/Faith-Based Organisations		
Name of Representative	Vuyelwa Chitimbire		
Title in Agency	Executive Director	Email Address	chitimbire@zach.org.zw
Role in CCM	Review &Technical Input	CCM member since	June 2002, re-elected March 2005
		Fax	263 4 724371
		Telephone	263 4 790597

Member			
Agency/Organization	Zimbabwe AIDS Network	Website	www.zan.co.zw
Type	Civil Society	Mailing Address	Zimbabwe AIDS Network P.O. Box CY 3006, Causeway Harare
Sector Represented	NGOs/Community-Based Organisations		
Name of Representative	Lindiwe Chaza-Jangira		
Title in Agency	National Coordinator	Email Address	lchaza-jangira@zan.co.zw
Role in CCM	Review &Technical Input	CCM member since	20 January 2005
		Fax	263 4 775520
		Telephone	263 4 700832/795337/ 263 91220579

Member			
Agency/Organization	Syngenta	Website	www.syngenta.co.zw
Type	The Private Sector	Mailing Address	Syngenta P.O. Box Harare
Sector Represented	Private Sector		
Name of Representative	Martha Mpisaunga		
Title in Agency	Regional Manager	Email Address	martha.mpisaunga@syngenta.co.zw
Role in CCM	Review & Technical	CCM member since	1 March 2002, Re-elected April 2005
		Fax	263 4 661505
		Telephone	263 4 663590 263 91402474 Mobile

Member			
Agency/Organization	UNILEVER	Website	www.
Type	The Private Sector	Mailing Address	UNILEVER P.O. Box A1290 Avondale Harare
Sector Represented	Private Sector		
Name of Representative	Noah Matibiri		
Title in Agency	Human Resources Director	Email Address	cps@zol.co.zw
Role in CCM	Review	CCM member since	8 April 2005
		Fax	263 4 753705
		Telephone	263 4 753700

Table 3.6.2 - National CCM Member Information (continued)

Member			
Agency/Organization	National AIDS Council	Website	NONE
Type	Government	Mailing Address	National AIDS Council P.O. Box MP 1131 Harare
Sector Represented	Government		
Name of Representative	Dr Tapuwa Magure		
Title in Agency	Executive Director	Email Address	tmagure@nac.co.zw
Role in CCM	Review& Technical Input	CCM member since	July 2004
		Fax	263 4 791243
		Telephone	263 4 791170-2 263 91415143 Mobile

Member			
Agency/Organization	Ministry Of Education and Culture	Website	None
Type	Government	Mailing Address	Ministry of Education and Culture P.O. Box CY 121, Causeway Harare
Sector Represented	Government		
Name of Representative	J.Z Muchovo		
Title in Agency	Deputy Director	Email Address	none
Role in CCM	Review	CCM member since	20 January 2005
		Fax	263 4 797027
		Telephone	263 4 734051-9 263 91309406 Mobile

Member			
Agency/Organization	Ministry of Public Service and Social Welfare	Website	None
Type	Government	Mailing Address	Public Service Labour and Social Welfare P.O. Box 7707, Causeway Harare
Sector Represented	Government		
Name of Representative	S.G. Mhishi		
Title in Agency	Director	Email Address	mishi@sdf.org.zw
Role in CCM	Review	CCM member since	1 March 2002
		Fax	263 4 796080
		Telephone	263 4 720692

Member			
Agency/Organization	Association of Rural District Councils of Zimbabwe	Website	None
Type	Local Government	Mailing Address	Association of Rural District Councils P.O. Box BE 411,Belveredere Harare
Sector Represented	Government		
Name of Representative	Solomon Chikate		
Title in Agency	Secretary General	Email Address	ardcz@africaonline.co.zw
Role in CCM	Review	CCM member since	1 March 2002
		Fax	263 4 732904
		Telephone	263 4 726526/725433

Table 3.6.2 - National CCM Member Information (continued)

Member			
Agency/Organization	Batanai AIDS Support Group	Website	None
Type	People Living with HIV/AIDS	Mailing Address	Batanai AIDS Support Group
Sector Represented	People living with HIV/AIDS,TB and/or Malaria		P.O. Box 38
Name of Representative	Evelyn Sharon Mashamba		Masvingo
Title in Agency	Member	Email Address	emashamba2001@yahoo.co.uk
Role in CCM	Review	CCM member since	12 April 2005
		Fax	263 39 52199
		Telephone	263 39 52199
			263 91349533 Mobile

Member			
Agency/Organization	Zimbabwe National Network of People Living with AIDS	Website	None
Type	PeopleLiving with HIV/AIDS	Mailing Address	ZNNP+
Sector Represented	People living with HIV/AIDS,TB and/or Malaria		9 Newport Road, Greencroft
Name of Representative	Believe Dhliwayo		Harare
Title in Agency	Interim Committee Member	Email Address	none
Role in CCM	Review	CCM member since	8 April 2005
		Fax	None
		Telephone	263 4 333917
			263 23693050 Mobile

Member			
Agency/Organization	Ministry of Finance	Website	None
Type	Government	Mailing Address	Ministry of Finance
Sector Represented	Government		P. Bag 7705, Causeway
Name of Representative	W. M Gonera		Harare
Title in Agency	Finance Officer	Email Address	None
Role in CCM	Review	CCM member since	8 April 2005
		Fax	263 4 250615
		Telephone	263 4 794571-7
			263 11766432

Member			
Agency/Organization	Population Services International	Website	www.psi.org
Type	Non-Governmental Organisation	Mailing Address	Population Services International
Sector Represented	NGOs/Community-Based Organisations		P.O. Box EH 306, Emerald Hill
Name of Representative	Michael Chommie		Harare
Title in Agency	Country Director	Email Address	mchommie@psi-zim.co.zw
Role in CCM	Review & Technical	CCM member since	17 February 2005
		Fax	263 4 339632
		Telephone	263 4 334631
			263 11605306 Mobile

Table 3.6.2 - National CCM Member Information (continued)

Member			
Agency/Organization	European Union	Website	www.eu.org.zw
Type	Bilateral	Mailing Address	European Union P.O. Box MP 620 Harare
Sector Represented	Multilateral and Bilateral Development Partners		
Name of Representative	Marc De-Bruycker		
Title in Agency	Head of Social Sector	Email Address	marc.de-bruycker@cec.eu.int
Role in CCM	Review & Technical	CCM member since	4 March 2005
		Fax	263 4 338165
		Telephone	263 4 338158 263 338158

Member			
Agency/Organization	Midlands State University	Website	www. msu.
Type	Educational	Mailing Address	Midlands State University P. Bag 9055 GWERU
Sector Represented	Academic/Educational		
Name of Representative	Dr Doreen Zandile Moyo		
Title in Agency	Lecturer	Email Address	zandilemoyo2000@yahoo.co.uk
Role in CCM	Review	CCM member since	2 June 2005
		Fax	263 54 260753
		Telephone	263 54 260450/260417 Ext 260

Member			
Agency/Organization	National Association of NON -Governmental Organisations	Website	www.nango.org.zw
Type	Non Governmental Organisation	Mailing Address	NANGO P.O. Box CY 250, Causeway Harare
Sector Represented	NGOs/Community-Based Organisations		
Name of Representative	Jonah Mudehwe		
Title in Agency	Executive Director	Email Address	jonahm@nango.org.zw
Role in CCM	Review	CCM member since	12 May 2005
		Fax	263 4 794973
		Telephone	263 4 708761/703579732612 263 4 708761/7035797

Member			
Agency/Organization	INTERFAITH	Website	NONE
Type	Faith Based	Mailing Address	3 Roamer Road Highlands Harare
Sector Represented	Religious/Faith-Based Organisations		
Name of Representative	Matilda Jambgja		
Title in Agency	Chairperson	Email Address	mca@zol.co.zw
Role in CCM	Review	CCM member since	12 May 2005
		Fax	None
		Telephone	263 4 498233

3.6. Proposal Endorsement and Membership Section

3.6.4. National CCM Endorsement of Proposal

[Please note: The entire proposal, including the signature page, must be received by the Global Fund Secretariat before the deadline for submitting proposals. The minutes of the RCM meetings at which the proposal was developed and endorsed must be attached as an annex to this proposal.]

"We, the undersigned, hereby certify that we have participated in the proposal development process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and support it. If the proposal is approved we further pledge to continue our involvement in the Coordinating Mechanism during its implementation."

Table 3.6.4 - National CCM Endorsement

Proposal Title:	Proposal to provide ART in 22 districts, strengthen the National TB control programme and make ACT available for treatment of malaria in Zimbabwe			
Agency / Organization	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Health & Child Welfare	Dr. P.D. Parirenyatwa	Minister of Health & Child Welfare	08/06/2005	
World Health Organisation	Dr. e. Njelesani	World Health Organisation Representative	08/06/2005	
UNAIDS	Dr. Karl-Lorenz Dehne	UNAIDS Representative	08/06/05	
Centres fir Disease Prevention and Control-USG	Dr. Shannon Hader	Director	08/06/2005	
European Union	Marc De-Bruycker	Head Social Sector	08/06/2005	
NANGO	John Mudehwe	Executive Director	08/06/2005	
INTERFAITH	Matilda Jambga	Chairperson	08/06/2005	
Batanai AIDS Support Group	Evelyn Sharon Mashamba	Member	08/06/2005	
Zimbabwe National Network of People Living with HIV/AIDS	Believe Dhliwayo	Interim Committe Member	08/06/2005	
Ministry of Finance	W.M. Gonera	Finance Officer	08/06/2005	
Population Services International	Michael Chommie	Country Director	08/06/2005	
Zimbabwe Association of Church Related Hospitals	Vuyelwa Chitimbire	Executive Director	08/06/2005	
Zimbabwe AIDS Network	Lindiwe Chaza-Jangira	National Coordinator	08/06/2005	
Syngenta	Martha Mpisaunga	Regional Manager	08/06/2005	
UNILEVER	Noah Matibiri	Human Resources Director	08/06/2005	
Midlands State University	Dr. Doreen Zandile Moyo	Lecturer-Head of Departmnent	08/06/2005	

4. Component: HIV/AIDS

4.1. Indicate the estimated start time and duration of the component

[Please take note of the timing of proposal approval by the Board of the Global Fund (described on the cover page of the proposal form), as well as the fact that generally, disbursement of funds does not occur for a minimum of two months following Board approval. Approved proposals must have a start date within 12 months of proposal approval.]

Table 4.1.1. Proposal start time and duration

	From	To
Month and Year	Jan-2006	Dec-2008

4.2. Contact persons for questions regarding this component

[Please provide full contact details for two persons; this is necessary to ensure fast and responsive communication. These persons need to be readily accessible for technical or administrative clarification purposes.]

Table 4.2. Component contact persons

	Primary contact	Secondary contact
Name	Dr Owen Mugurungi	Dr Christine Chakanyuka
Title	National AIDS & TB Programme Coordinator	National AIDS and TB Programme HIV Care and Treatment Technical Coordinator
Organization	National AIDS and TB Programme, Ministry of Health and Child Welfare	National AIDS and TB Programme, Ministry of Health and Child Welfare
Mailing Address	Causeway, Harare	Causeway, Harare
Telephone	+263 45 726 803	+263 45 726 803
Fax	+263 4 795 191	+263 4 795 191
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4.3. National Program Context and Gap Analysis for this Component

[The context in which proposed interventions will be implemented provides the basis for reviewing this proposal. Therefore, historical, current and projected data on the epidemiological situation, disease-control strategies, broader development frameworks, and resource availability and gaps need to be clearly documented.]

[Proposals to the Global Fund should be developed based on a comprehensive review of the capacity of health systems, disease-specific national strategies and plans, and broader development frameworks. This context should help determine how successful programs can be scaled up to achieve impact against the three diseases.]

4.3.1. Epidemiological and Disease-Specific Background

Describe, and provide the latest data on, the stage and type of epidemic and its dynamics (including breakdown by age, gender, population group and geographical location, wherever possible), the most affected population groups, and data on drug resistance, where relevant. (Information on drug resistance is of specific relevance if the proposal includes anti-malarial drugs or insecticides. In the case of TB components, indicate, in addition, the treatment regimes in use or to be used and the reasons for their use.)

Zimbabwe continues to experience one of the most severe epidemics of HIV and AIDS in the world. The Ministry of Health and Child Welfare (MOHCW) in its last HIV and AIDS estimates reported that in 2003 the prevalence of HIV in the adult population (age 15-49 years) was 24.6% (ANNEXE 1 - National HIV and AIDS Estimates 2003). At the end of 2003 the total number of adults and children living with HIV/AIDS was estimated to be 1.8 million, of whom 342

4.3.2. Health Systems, Disease-Control Initiatives and Broader Development Frameworks

a) Describe the (national) health system, including both the public and private sectors, as relevant to fighting the disease in question.

Zimbabwe is situated in Southern Africa and has a population of 11.6 million people. The country is experiencing a generalised, high prevalence HIV epidemic. There are ten administrative health provinces, sixty districts and at least twenty wards per district. The public health system is anchored on primary health care services which are provided through rural health centres and rural hospitals in each of the rural districts. Rural health centers are usual

b) Describe comprehensively the current disease-control strategies and programs aimed at the target disease, including all relevant goals and objectives with regard to addressing the disease. (Include both existing Global Fund-financed programs and other programs currently implemented or planned by all stakeholders and existing and planned commitments to major international initiatives and partnerships).

The HIV and AIDS health sector response is led by the National AIDS & TB Programme within the Ministry of Health and Child Welfare (MOHCW). The National AIDS Council (NAC) is responsible for the coordination of a decentralised multisectoral national HIV and AIDS response through its AIDS Action Committees at community, district and provincial levels. The strategic framework, developed by NAC and MOHCW is currently under review. This has

c) Describe the role of AIDS-, tuberculosis- and/or malaria-control efforts in broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) Initiative, the Millennium Development Goals or sector-wide approaches. Outline any links to international initiatives such as the WHO/UNAIDS '3-by-5 Initiative' or the Global Plan to Stop TB or the Roll Back Malaria Initiative.

Zimbabwe, being a high HIV/AIDS burden country, enthusiastically welcomed the WHO/UNAIDS-led 3-by-5 initiative. To that end the Minister of Health and Child Welfare wrote to the Director General of WHO requesting support to enable Zimbabwe scale up antiretroviral treatment (ART) in line with the 3-by-5 target. A 3-by-5 scoping mission visited Zimbabwe in February 2004 to assess existing capacity and potential for scaling up ART. One of the

4.3.3. Financial and Programmatic Gap Analysis

[Interventions included in the proposal should be identified through an analysis of the gaps in the financing and programmatic coverage of existing programs. Global Fund financing must be additional to existing efforts, rather than replacing them, and efforts to ensure this additionality should be described Use Table 4.3.3.a to provide in summarized form all the figures used in sections 4.3.3.1 to 4.3.3.3.] [For health systems strengthening components the financial and programmatic gap analysis needs to provide information relevant to the proposed health systems strengthening intervention(s).]

4.3.3.1. Detail current and planned expenditures from all relevant sources, whether domestic, external or from debt relief, including previous grants from the Global Fund.

[List the financial contributions dedicated to the fight against this disease by all domestic and external sources. Indicate duration and amount, and ensure that the amount for domestic sources is consistent with Table 1.1.]

For the purposes of this proposal, funds available for both a comprehensive response to HIV and AIDS (including prevention, care and treatment) AND specifically for ARV treatment had to be quantified. This was necessary as many HIV and AIDS activities and funding sources are not specifically divided into those for different elements, due to the cross cutting nature of activities involved. Table 4.3.3 shows the estimated funds available SPECIFICALLY FOR ART. Note that this table is expressed in thousands of dollars. Bilateral partners have estimated that in 2004, less than one percent of HIV and AIDS

4.3.3.2. Provide an estimate of the costs of meeting overall (national) goals and objectives and provide information about how this costing has been developed (e.g. costed national strategies).

The costed national strategic plan for ART roll out indicates that US $247,176,000 are required to initiate and maintain 250,00 patients on treatment (73% of the total number of persons estimated to be requiring treatment) by December 2008. This estimate, which takes into account the cost of drugs, reagents and many of the associated health infrastructure and systems costs, were estimated by MOH/CW with technical support from WHO 3x5 in advance of proposal writing.

4.3.3.3. Provide a calculation of the gaps between the estimated costs and current and planned expenditures.

During the development of this GF proposal, this estimate was verified and further detail was obtained after definition of objectives, strategies and activities relative to the overall goal. Recent epidemiological surveillance, health services, demographic and other available data were combined to produce appropriate national targets for each service delivery area for scaling up ART. Budgets were developed in USD using current auction exchange rates, utilizing costing information obtained from the Ministry of Health and Ministry of Finance and local budgeting experience of NGOs. This provided an

Table 4.3.3 - Financial Contributions to National Response in: *USD*

	2004	2005	2006	2007	2008	2009	2010
Domestic (A)	3,787	7,380	6,989	7,338	7,705		
External (B)	2,998	12,431	16,479	20,550	28,758	0	0
External source 1							
Bilateral Organizations	1,832	5,368	7,657	11,443	15,258		
External source 2							
UN Agencies	666	1,650	2,800	3,500	5,000		
External source 3							
International NGOs	500	4,070	4,070	5,600	8,500		
External source 4							
Global Funds 1st round	0	1,343	1,952	7	0		
External source 5							
(to be named)							
Total resources available (A+B)	6,785	19,811	23,468	27,888	36,463	0	0
Total need (C)	25,000	52,000	72,874	122,000	160,000		
Unmet need (A+B) - (C)	(18,215)	(32,189)	(49,406)	(94,112)	(123,537)	0	0

4.3.4. Confirm that Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources, and explain plans to ensure that this is the case.

Table 4.3.3 shows a total funding gap of between 2006 and end 2008 of US $267,055,000 in the Zimbabwe ART plan. The total need for 2008 has been estimated based on the fact that most of the pre-requisites for ART will have been put in place, and that most of the funds will be required for procurement of ARVs in line with the targeted number of patients for that year. Over the past two years, the contribution and commitment of government, NAC and donor partners towards the ART programme has increased. The government of Zimbabwe has demonstrated its commitment to the program by making $3.8 million available to the program during 2004. This financial commitment increased to $7.4 million in 2005. The MOHCW started its ART roll-out plan in April 2004 and by May 30, 2005, 27 public health institutions were already offering ART services. The program is predominantly funded by the Government of Zimbabwe. The National AIDS Council is already providing additional domestic funding to the ART program from the funds which are collected through the National AIDS Trust Fund (AIDS Levy), and plans to increase this support over the coming years.

A number of development partners and bilateral donors are also supporting the National ART program. The major ART partners include the US Government and MSF, with imminent scale-up from EU and UNAIDS/DFID support, amongst other donors. The Global Fund round 1 grant was signed in April 2005. An additional US$3.3 million for ART is available from this source. The private sector is also actively involved in provision of ART services. Some corporate organizations have contracted with medical aid schemes for employees to access ART benefit through private insurance. Other companies have started providing ART services to their employees through private industrial clinics. The commitments to the ART programme described demonstrate that any funding obtained from5th Round Global Fund will be additional to current funding in the country.

UNAIDS in collaboration with the MOHCW has also started tracking all financial resources that are available in the country for the national HIV response, including division into programme categories. Information from this on going exercise will allow ongoing demonstration that any Global Fund resources received will be additional to existing and planned resources.

It should also be noted that the funds requested in this proposal are directed towards ART; other elements of a comprehensive HIV and AIDS response (including prevention, mitigation and care) have not been requested. The national AIDS & TB Programme already promotes widespread prophylaxis and treatment of opportunistic infections, through provision of comprehensive guidelines for HIV Management (ANNEXE 14 – Zimbabwe HIV and AIDS Standard Treatment Guidelines), roll-out of training in HIV Care includnig ART (ANNEXE 15 - OI Management and ARV Drug Therapy; a training course for healthcare workers) and PMTCT (ANNEXE 16 - Clinical Protocols for PMTCT), and provision of donated commodities (e.g. Fluconazole). These activities have been funded using domestic resources, with support from technical and financial partners including the US Centers for Disease Control. In addition, support for basic drug purchase from the national essential drugs list (including cotrimoxazole for prophylaxis) comes from additional donors such as the EU and PMTCT partners. Ongoing OI activities in Zimbabwe include maintenance of cotrimoxazole prophylaxis for PLWHA already initiated on prophylaxis, further development of guidelines and definition of eligibility criteria for INH prophylaxis in PLWHA, initiation of treatment for common OIs in eligible patients (TB, cryptococcal meningitis, PCP) and clinical, laboratory and radiological monitoring of patients on OI treatment according to national guidelines. Community care and support interventions (including for Orphans and Vulnerable Children according to the National Plan of Action continue to be supported through National AIDS Council Funds and other domestic and external sources.

While drug shortages and challenges towards a comprehensive response may remain, this Global Fund HIV and AIDS proposal does not request additional funds for these activities. Cotrimoxazole prophylaxis for TB/HIV co-infected patients is requested in the TB Component of the Fifth Round proposal, and other existing supports will continue with efforts at scaling up continued to ensure that appropriate management of OIs and other prevention, care and support services will occur in conjunction with ART roll-out.

4.4. Component Strategy

4.4.1. Description and justification of the program strategy

[This section must be supported by a summary of the Program Strategy section in tabular form.

- Tables 4.4a and b (following section 4.4.1) are designed to help applicants clearly summarize the strategy and rationale behind this proposal. For definitions of the terms used in the tables, see Annex A. (See Guidelines for Proposals, section V.B.2, for more information.)

- In addition, please also provide a detailed quarterly work plan for the first 12 months and an indicative work plan for the second year. These should be attached to the proposal form as described in the instructions.

Narrative information in section 4.4.1 should refer to Tables 4.4a and 4.4b, but should not consist merely of a description of the tables.]

4.4.1. Description and justification of the program strategy

Table 4.4a. Goals and Impact Indicators over Life of Program

Goal No.	Goals over five years
1	Improved quality of life and reduced mortality from HIV and AIDS amongst PLWHA
2	
3	

Goal No.	Impact Indicator	Baseline Value	Baseline Year	Source	Year 1 Target	Year 2 Target	Year 3 Target	Year 4 Target	Year 5 Target	Source and comments
1	Other: Percentage of PLWHA reporting improved quality of life as measured by validated tools eg Karnofsky Score	To be determined	2005	Baseline Survey	20% increase	40% increase	60% increase			
1	Impact: Increased percentage of people still alive after 6,12, and 24 months after initiation of ARV	To be determined	2005	HIV literature	20% increase	40% increase	40% increase			

Table 4.4b. Objectives, Service Delivery Areas and Coverage Indicators over Life of Program

Objective No.	Objective description	Linked to Goal No.
Objective 1	To increase awareness and commitment among policy makers, leaders, communities and PLWHA that AIDS is a treatable chronic disease	1
Objective 2	To increase the number of people with advanced HIV disease receiving ART as part of a comprehensive treatment and care package	1
Objective 3		

Table 4.4b. Objectives, Service Delivery Areas and Coverage Indicators over Life of Program

Objective	Service delivery area	Tied to TGF	Level	Indicator description *	Baseline		Year 1 target	Year 2 target	Year 3 target	Year 4 target	Year 5 target	Frequency of data collection
					Value	Year						
1	Supportive Environment: Advocacy Initiatives	Yes	1	Other: Number of workshops conducted on treatment advocacy	Negligible	2005	33					Bi-annual
1	Supportive Environment: Advocacy Initiatives	Yes	1	Other: Number of people trained in treatment advocacy	Negligible	2005	660	660	0			Bi-annual
1	Supportive Environment: Advocacy Initiatives	Yes	2	Other: Number of community groups carrying out treatment advocacy	Negligible	2005	22	22	22			Bi-annual
1	Prevention: Behavioral Change Communication (BCC) — Community Outreach	Yes	2	Other: Number of community groups actively disseminating IEC messages	20	2005	110	110	110			Bi-annual
1	Prevention: Behavioral Change Communication (BCC) — Community Outreach	No	3	Other: Number of people reached by community groups	20,000	2005	100,000	100,000	100,000			Bi-annual
1	Prevention: Behavioral Change Communication (BCC) — Mass Media	Yes	1	Other: Number of journalists trained on HIV and AIDS Reporting including ART	0	2005	50	50				Bi-annual
1	Prevention: Behavioral Change Communication (BCC) — Mass Media	Yes	2	Other: Number of mass media materials disseminated	2,800	2005	140,000	240,000	80,000			Bi-annual
1	Prevention: Behavioral Change Communication (BCC) — Mass Media	Yes	3	Other: Number of people reached by mass media on stigma reductions, C&T, TB/HIV and treatment literacy campaigns	100,000	2005	1,000,000	2,000,000	3,000,000			Bi-annual
1	Supportive Environment: Workplace Policy Programme	Yes	2	Number of large enterprises/companies capable of providing advanced interventions for prevention and medical treatment for HIV-infected persons	15	2005	10	12	12			Bi-annual
1	Supportive Environment: Workplace Policy Programme	No	3	Other: Number of employees (including spouses, children and community members) benefiting from comprehensive workplace programs	6,750	2005	4,500	5,400	5,400			Bi-annual
2	Supportive Environment: Coordination and Partnership Development	No	1	Other: Number of HIV/AIDS coordination meetings held that discuss ART	80	2004	132	132	132			Quarterly
2	Supportive Environment: Coordination and Partnership Development	Yes	2	Other: Number of partners/organisations attending coordination meetings	10	2004	50	100	160			Quarterly
2	Health Systems Strengthening: Health Infrastructure Development	Yes	1	Other: Number of health facilities assessed to support ART	5	2004	550					Bi-annual
2	Health Systems Strengthening: Health Infrastructure Development	Yes	2	Other: Number of facilities renovated	36	2005	52	44				Annually

2	Health Systems Strengthening: Health Infrastructure Development	Yes	2	Other: Number of laboratories that can provide basic tests to support ART (haemotology and chemistry)	5	2005	20	20	20			Bi-annually
2	Health Systems Strengthening: Human Resources	Yes	1	Other: Number of PCCs trained and deployed	50	2005	150	120	120			Bi-annual
2	Health Systems Strengthening: Human Resources	Yes	2	Other: Number of doctors/lab scientists and pharmacy technicians and health officers recruited and working in the selected 22 districts	40	2005	96	96	96			Bi-annually
2	Health Systems Strengthening: Monitoring and Evaluation (M&E)	Off	1	Other: Number of people trained in ART M & E	0	2005	170		170			Bi-annually
2	Health Systems Strengthening: Monitoring and Evaluation (M&E)	No	2	Other: Existence of a computerized ART M&E system	No	2005	Yes					Annually
2	Health Systems Strengthening: Monitoring and Evaluation (M&E)	No	2	Other: Number and percentage of health facilities submitting complete and timely reports	5	2005	10	22	22			Quarterly
2	Health Systems Strengthening: Operational Research	Yes	2	Other: Number of people trained in OR at district level	Negligible	2005	60					Annually
2	Health Systems Strengthening: Operational Research	Yes	2	Other: Number of Operations research studies carried out	0	2005	2	4	4			Annually
2	Health Systems Strengthening: Operational Research	Yes	2	Other: Number of samples analysed for ART drug resistance	0	2005	400	400	400			Quarterly
2	Health Systems Strengthening: Operational Research	Yes	3	Other: Number of ART resistance sentinel surveillance reports	0	2005	3	4	4			Quarterly
2	Health Systems Strengthening: Procurement and Supply Management System	Yes	1	Other: Number of people trained in supply chain management of HIV related medicines	25 National	2005	44					Bi-annual
2	Prevention: Counseling and Testing (CT)	No	1	Other: Number of health care workers trained in HIV testing	100	2005	220	220	220			Bi-annual
2	Prevention: Counseling and Testing (CT)	No	2	Number of service delivery points providing counseling and testing with minimum conditions to provide quality services	36	2005	63	103	138			Bi- annual
2	HIV/TB Collaborative activities: Prevention of HIV in TB Patients	No	1	Other: Number of service deliverers trained on intensified TB case finding among PLWHA	250	2005	440	440				Quarterly
2	HIV/TB Collaborative activities: Prevention of HIV in TB Patients	No	2	Other: Number of service delivery points conducting intensified TB case finding	15	2005	88	110	110			Quarterly

2	HIV/TB Collaborative activities: Prevention of HIV in TB Patients	No	3	Other: Number of PLWHA screened for TB symptoms when receiving HIV testing and counseling or HIV treatment and care services	5000	2005	25,000	40,000	50,000			Quarterly
2	Other: Nutrition	Yes	0	Other: Existence of National guidelines on targeted food assistance to PLWHA	No	2005	Yes					Annual
2	Other: Nutrition	Yes	2	Other: Number of guidelines on targetted food assistance programs disseminated	0	2005	2,000					Bi-annual
2	Other: Nutrition	Yes	2	Other: Number of national nutritional guidelines for counselors and care providers disseminated	1,000	2005	2,000					Bi-annual
2	Care and Support: Care and Support for the Chronically ill and Families Affected by HIV/ AIDS	No	1	Other: Number of primary and secondary caregivers trained in CHBC/ART	50	2005	2,000	2,000	2,000			Quarterly
2	Care and Support: Care and Support for the Chronically ill and Families Affected by HIV/ AIDS	No	1	Other: Number of health workers and secondary care givers trained in PSS for children on ART	0	2005	1,600	1,540	770			Quarterly
2	Care and Support: Care and Support for the Chronically ill and Families Affected by HIV/ AIDS	No	2	Other: Number of chronically ill and OVC provided with care and support	500	2005	30,000	60,000	100,000			Quarterly
2	Treatment: Antiretroviral Treatment and Monitoring	No	1	Other: Number of health workers trained in OI/ART	50	2005	220	220	110			Quarterly
2	Treatment: Antiretroviral Treatment and Monitoring	No	2	Other: Number of health facilities providing ART services	6	2005	22	44	44			Quarterly
2	Treatment: Antiretroviral Treatment and Monitoring	No	3	Other: Number and percentage of health facilities providing ART services with no stock-outs of 1st line ARV medicines	80%	2005	90%qUAR	100%	100%			Quarterly
2	Treatment: Antiretroviral Treatment and Monitoring	No	3	Number and percentage of people with advanced HIV infection receiving antiretroviral combination therapy	1,500	2005	15,000	25,000	40,000			Quarterly

4.4.1.1. Provide a clear description of the program's goal(s) and objectives and service delivery areas (provide quantitative information, where possible).

The programme has one overall goal, that of improved quality of life and reduced mortality among people living with HIV and AIDS (PLWA). There are two main objectives in reaching this overall goal:

1. To increase awareness and commitment among policy makers, leaders, communities and PLWHA that AIDS is a treatable chronic illness. This objective will be achieved through implementation of integrated activities in the following service delivery areas: Advocacy Initiatives, Behaviour Change Communication (BCC), Community Outreach, Behaviour Change Communication (BCC), Mass Media, and Workplace policy

4.4.1.2. Describe how these goals and objectives are linked to the key problems and gaps arising from the description of the national context. Demonstrate clearly how the proposed goals fit within the overall (national) strategy and how the proposed objectives and service delivery areas relate to the goals and to each other.

The main goal and objective are designed to address the huge treatment gap being experienced in Zimbabwe as described in sections 4.3.1c, and 4.3.3.

The overall goal of the program is to improve the quality of life and reduced mortality among people living with HIV and AIDS (PLWHA). This will be achieved through comprehensive, integrated activities aimed at scaling up access to and utilization of antiretroviral therapy, linkages to antimycocic prophylaxis, improved TB/HIV management and nutritional counselling and support. The program aims to treat 15000 PLWHA

[For health systems strengthening components only:]

4.4.1.3. Describe in detail how the proposed objectives and service delivery areas are linked to the fight against the three diseases. In order to demonstrate this link, applicants should relate proposed health systems interventions to disease specific goals and their impact indicators. To demonstrate the contribution of the proposed health systems strengthening intervention(s) in fighting the disease(s) include at least three disease relevant indicators with a baseline and annual targets over the life of the program.
[This may be done in form of an annex based on the format of table 4.4.b.]
Clearly explain why the proposed health systems strengthening activities are necessary to improve coverage in the fight against the three diseases.
[When completing this section, applicants should refer to the Guidelines for Proposals, section III.B.&F.]

4.4.1.4. Provide a description of the target groups, and their inclusion during planning, implementation and evaluation of the proposal. Describe the impact that the project will have on these group(s).

The overall target group is people living with advanced HIV infection. Specific sub-groups will be targeted to receive enhanced care and treatment services for HIV, including vulnerable groups (women, children, youth, rural populations) and patients identified through a wide range of entry points (PMTCT services, TB clinics, STI clinics, CHBC services, out-patients, in-patients etc).

The proposal was written collaboratively through the workings of multiple stakeholders in HIV/AIDS under the coordinating umbrella of the National AIDS & TB Unit, Ministry of Health and Child Welfare (including representation from vulnerable groups, Women's Action Groups, PLWA

4.4.1.5. Provide estimates of how many of those reached are women, how many are youth, how many are living in rural areas. The estimates must be based on a serious assessment of each objective.

Table 4.4.1.5. Objectives

	Estimated percentage of people reached who are:		
Objectives	**Women**	**Youth**	**Living in rural areas**
Objective 1:	70%	40%	60%
Objective 2:	55%	20%	80%
Objective			

4.4.1.6. Provide a clear and detailed description of the activities that will be implemented within each service delivery area for each objective. This should provide reviewers with a clear understanding of what activities are proposed, how these will be implemented, and by whom.

NOTE: A DETAILED NARRATIVE OF ALL ACTIVITIES IS INCLUDED AS APPENDIX 3
Objective 1: To increase awareness and commitment among policy makers, leaders, communities and PLWHA that AIDS is a treatable disease SDA 1 – Advocacy: Implemented by key civil society organizations including ZAHA, ZNNP+, ZAN, SAFAIDS,PPAAT, NAC, WASN. Activities include sensitisation of policy makers at all levels on the need for HIV treatment and strengthening of treatment advocacy in 22 districts. SDA 2 – BCC: Community Outreach: Implemented through experienced partners (MOHCW, SAfAIDS, PSI) , activities are focused on providing

4.4.1.7. Outline whether these are new interventions or existing interventions that are to be scaled up, and how they link to existing programs.

The major focus of this proposal is to scale up access to ART and other related services including testing and counseling, TB/HIV services and the overall continuum of care. Tuberculosis services are a critical component of this treatment and care program and are largely addressed as a separate component of the proposal. As described, Zimbabwe currently has very low coverage of ART, and this is available mainly in the larger urban centres. The provision of ART in public facilities has been expanded to more than 20 hospitals, but now needs to be scaled up to ensure coverage across the country and into rural and vulnerable populations.

4.4.2. Describe how the activities initiated and/or expanded by this proposal will be sustained at the end of the Global Fund grant period.

Long term sustainability of antiretroviral therapy programmes in resource poor settings remains an unresolved issue. Nonetheless, the overwhelming right of individuals to access treatment means we cannot wait to roll-out life saving treatment due to concern over sustainability. In recent years there has been increasing acknowledgement of this, with the 3x5 initiative spearheaded by WHO and supported by multi and bilateral donor agencies across the world. At the same time however, it is necessary to implement programmes in such a way as to promote long term sustainability through local ownership and strengthening of existing health systems.

4.4.3. Describe gender inequities regarding program management and access to the services to be delivered and how this proposal will contribute to minimizing these gender inequities (2 paragraphs).

The significant momentum and funding opportunities surrounding HIV and AIDS should be harnessed to provide a platform for addressing the wider agenda of gender inequality and empowerment of women, in order to address the gender inequalities that facilitate the spread of HIV. Women are the main carers of those affected and infected by HIV in Zimbabwe (both in and out of health facilities). They also experience disproportionately high rates of infection when compared with men. Migrant labour results in congregation of men in urban and commercial centres while women remain in rural areas; male utilization of Commercial Sex services is a consequence of this social structure. Gender

4.4.4. Describe how this proposal will contribute to reducing stigma and discrimination against people living with HIV/AIDS, tuberculosis and/or malaria, and other types of stigma and discrimination that facilitate the spread of these diseases (1–2 paragraphs).

Stigma surrounding HIV and AIDS has remained one of the biggest obstacles to effective treatment and care of people infected and affected by HIV. The Zimbabwe National HIV/AIDS policy states clearly the guiding principles that should be followed to combat stigma and discrimination (ANNEXE 19 - National HIV/AIDS Policy 1999). Despite extensive HIV/AIDS training in all sectors and establishment of community based psychosocial support groups, stigma, discrimination, shame and "cultural silence" remain in many parts of the country. Ignorance and fear around the modes and mechanisms of transmission underpin much of this stigma. Those affected by HIV are often ostracized both socially and

4.4.5. Describe how principles of equity will be ensured in the selection of patients to access services, particularly if the proposal includes services that will only reach a proportion of the population in need (e.g. some antiretroviral therapy programs) (1–2 paragraphs).

Equity is an important principle in access to all health services, but in particular to antiretroviral treatment. The strengthening of the Treatment Advocacy Network in Zimbabwe as proposed in this programme is critical in ensuring existence of a body that can ensure development of a rights-based approach to ART roll out, through debate on equity issues in access to treatment (with specific focus on vulnerable groups including women and children), advocating for policy amendments and advising on policy implementation.

4.5. Program and financial management

[In this section, CCMs should describe their proposed implementation arrangements, including nominating Principal Recipient(s). See the Guidelines for Proposals: section V.B.3, for more information. Where the applicant is a Regional Organization or a Non-CCM, the term 'Principal Recipient' should be read as implementing organization).]

4.5.1. Indicate whether implementation will be managed through a single Principal Recipient or multiple Principal Recipients. ☐ Single ☑ Multiple

[Every component of your proposal can have one or several Principal Recipients. In Table 4.5.1 below, you must nominate the Principal Recipient(s).]

Responsibility for Implementation

Nominated Principal Recipient(s)	Area of responsibility	Contact person	Address, telephone and fax numbers, e-mail address
The Zimbabwe AIDS, TB and Malaria Funding Trust	Private Sector and Civil Society Components of HIV/AIDS	Mr. James Maposa Managing Director	C/O Anglo American Zimbabwe Limited Broadlands Park Broadlands Road Emerald Hill Harare, Zimbabwe P.O. Box 1168 Harare, Zimbabwe Tel: +263 4 336802

4.5.2. Describe the process by which the CCM, Sub-CCM or Regional CM nominated the Principal Recipient(s).

[Minutes of the CCM meeting at which the Principal Recipient(s) was/were nominated should be included as an annex to the proposal. If there are multiple Principal Recipients, questions 4.5.3 – 4.5.6 should be repeated for each one.] [Question not applicable to Non-CCM and regional Organization applications].

[Question not applicable to Non-CCM and regional Organization applications].

A committee of five CCM members from the public sector, private sector, bilateral, NGO sector and secretariat was set up to develop a criteria for review of principal recipient applications. The criteria included legal status, institutional & programmatic, financial management, procurement and supply management and comparative advantage. The criteria were applied and principal recipients were proposed to the entire CCM for discussion and finalisation. At the 2 June 2005 meeting the CCM deliberated on the report of the committee and decided on multiple principal recipients and went on to nominate principal recipients from different sectors, private sector, public sector and civil society. (CCM Annex 6- Minutes of 2 June).

4.5.3. Describe the relevant technical, managerial and financial capabilities for each nominated Principal Recipient.

[Please also discuss any anticipated shortcomings that these arrangements might have and how they will be addressed, please refer to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).]

The Zimbabwe AIDS, TB and Malaria Funding Trust will be administered by Anglo American Zimbabwe Limited. This long established mining and natural resources company will provide financial and administrative services using its existing systems and expertise. The services will include financial and management accounting, foreign exchange management, investment, procurement and supply management, disbursement of funds, expenditure control, internal audit, reporting and legal services. Existing financial management and information technology systems and existing professional staff will be used for the provision of these services. Anglo American has undertaken to provide these services free of charge to the Trust for a minimum period of five years.

To the extent that the existing capacity might not meet all the needs of a fully functioning Principal Recipient for the Global Fund, additional capacity will have to be contracted in or trained to serve the Trust. The cost of these additional services will have to be provided for in any Grant Agreement. It is anticipated that additional technical capacity will be required for the monitoring and evaluation of health specific programmatic data. Maximum possible use of development partners such as UNDP, UNAIDS, WHO and other multilateral and bilateral development agencies will be made.

4.5.4. Has the nominated Principal Recipient previously administered a Global Fund grant? Yes No

4.5.5. If yes, provide the total cost of the project and describe the performance of the nominated Principal Recipient in administering previous Global Fund grants [1–2 paragraphs].

NOT APPLICABLE

4.5.6. Describe other relevant previous experience(s) that the nominated Principal Recipient has had:

[Please describe in broad terms the relevant programs, as well as their objectives, key implementation challenges and results [2–3 paragraphs].]

The financial and administrative infrastructure of The Zimbabwe AIDS, TB and Malaria Funding Trust will be provided by Anglo American Zimbabwe Limited. This company has extensive and well developed financial management infrastructure which deals with the complexity of managing and consolidating the financial performance of numerous subsidiaries and associates. This experience includes the financial management of health services provided by mining and industrial companies and the administration of charitable grants.

4.5.7. Describe the proposed management approach and explain the rationale behind the proposed arrangements.

[Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM [2–3 paragraphs].]

Three Principal Recipients have been nominated with multi-sectoral representation, in recognition of the importance of diversifying management of funds to increase absorptive capacity and assist in ensuring timely progress towards the overall goal. Each PR will manage funds to sub-recipients (SRs) whose activities are broadly related to the existing structures and strategies of that PR. The PR will manage funds to selected sub-recipients, who will undertake direct implementation of activites as SRs, and through further sub-awards to Sub-sub recipients (SSRs).

NAC will therefore manage funding to sub recipients for human resources, training, infrastructure and ART delivery, advocacy and community outeach, mass media, monitoring and evaluation support. ZACH will manage funding to Mission Hospitals within the 22 districts for human resources, training, infrastructure, and additional sub-recipients for issues around care of children living with HIV and AIDS, technical support to district health teams and operational research. The Zimbabwe AIDS, TB and Malaria Funding Trust will manage funding to sub-recipients for Quality Assurance of drugs and other medical products, quality assurance of laboratory services, mass media and community outreach at national level, client initiated T&C, workplace policies in 22 districts, and several private sector SRs for training and ARV delivery.

The SSRs will be accountable to the SRs, and the SRs to the PRs, for all implementation, monitoring and financial accounting activities. The Principle Recipients will be accountable to the CCM and to the Global Fund secretariat for the overall management of all Global Fund resources they will handle. The PRs will be responsible for monitoring implementation and producing accounts and progress reports through the Local Fund Agent.

Funds for UN Volunteers may be negotiated to flow straight from Global Fund to UNDP in Genvea in order to maximise efficiency. Procurement and distribution of all medical and non-medical commodities will be managed by the Natpharm/Crown Agents consortium as desribed in section 4.7. It is important to note that all ARV drugs will be procured and managed centrally, and distributed to districts and health facilities through existing (strengthened) structures and mechanisms. Therefore all funds for ARV procurement will either flow directly to the procurement agents, or via a single Principal Recipient, and this mechanism will be fully defined when the outcome of the submission is known.

The proposed arrangments for potential implementation of activities is shown in APPENDIX 20 - Potential Implementation Structure. In keeping with the ongoing initiatives to strengthen the CCM, the CCM will play an increasingly critical role in monitoring and review of all activities of the PRs to ensure appropriate progress towards the overall goal.

4.5.8. Are sub-recipients expected to play a role in the program? ✓ Yes No

4.5.9. How many sub-recipients will be, or are expected to be, involved in the implementation? 6-20

4.5.10. Have the sub-recipients already been identified? ✓ Yes No

4.5.11. Describe the process by which sub-recipients were selected and the criteria that were applied in the selection process (e.g. open bid, restricted tender, etc.) [2–3 paragraphs).]

An open call for proposals for the Fifth Round Global Fund was issued in the national media and through existing information exchange channels in March 2005. Any organization was eligible to submit a proposal to the national CCM for consideration as a potential Principal or Sub-Recipient, according to the broad guidelines and format set out in the call for proposals (CCM Annexe).

A committee of five CCM members from the public sector, private sector, bilateral, NGO sector and secretariat was subsequently established, to develop criteria and review all proposals submitted for the Fifth Round Global Funding cycle. The criteria for review included legal status of the applicant organization, track record and experience, programmatic management capacity, current service coverage at district, provincial or national level, and comparative advantage. The criteria were applied by the committee, and a list of sub-recipients was proposed to the entire CCM for discussions and finalisation. At the CCM meeting on 2nd June, the CCM deliberated on the report of the committee to produce a final shortlist. This list was then matched with the list of selected districts to determine which organizations operated in the selected districts, and against the proposed activities for the 5th Round submission, in order to define the final list of potential sub-recipients. The final sub-recipients, sub-sub recipients and other implementing agencies will be confirmed when the outcome of this Fifth Round submission is known.

4.5.12. Where sub-recipients applied to the CCM, but were not selected, provide the name and type of all organizations not selected, the proposed budget amount and reasons for non-selection as an attachment to the proposal [1–2 paragraphs].

About sixty proposals for potential sub-recipients were received by the CCM. Each proposal was reviewed and discussed individually by the CCM committee tasked to review proposals. A detailed list of those proposals that were not selected as potential Sub-recipients is provided as an attachment (ATTACHMENT - Proposals not selected as potential SR). The total budget requested by these proposals was over $760 million USD.

Stemming from the main review criteria described above, four main reasons for the decision not to select proposals emerged from the review process:

1. The proposal application focused on implementation of activities outside the the geographical focus of the round five proposal (twenty two districts selected by the CCM) and were therefore excluded from consideration
2. Most of the activities proposed were outside the scope of the national CCM proposal, for example all proposals on orphans and vulnerable children (OVC) were referred to UNICEF which had mobilised resources for OVC programmes in the country. Some on home based care (HBC) were reffred to the National AIDS Council which has substantial funding for this activity,
3. Proposal submission did not follow the specified format for submissions
4. Capacity of organisation was not consistent with role as SR
5. Budgets were too high and over ambitious. The amount requested were not comensurate with planned activities.

Organisations who submitted proposals that were not selected as sub-recipients may still be eligible to take on the role of Sub-Sub recipient if 5th Round funds are awarded. If this submission is succesful, a wide stakeholder meeting will be called to address this issue in more detail, including provision of more specific direction on the activity scope and geographical location for activities to be implemented. SSR awards would then be made through the identified sub-recipients to ensure activity support for organizations operating at grassroots level who have major contributions to make to the work of implementing the proposal.

4.5.13. Describe the relevant technical, managerial and financial capabilities of the sub-recipients.

G [Describe anticipated shortcomings or challenges faced by sub-recipients and how they will be addressed (e.g., capacity-building, staffing and training requirements, etc.).]

A number of potential sub-recipients have been identified through the process described above. The final sub-recipients, sub-sub-recipients and other implementing agenencies will be confirmed when the outcome of this Fifth Round Submission is known.

Please see ATTACHMENT 10 for narrative on the capabilities of potential sub-recipients.

4.5.14. Describe why sub-recipients were not selected prior to submission of the proposal.

4.5.15. Describe the process that will be used to select sub-recipients if the proposal is approved, including the criteria that will be applied in the selection process [1–2 paragraphs].

4.6. Monitoring and Evaluation (M&E)

[The Global Fund encourages the development of nationally owned monitoring and evaluation plans and M&E systems, and the use of these systems to report on grant program results. By answering the questions below, applicants should clarify how and in what way monitoring the implementation of the grant relates to existing data-collection efforts].

4.6.1 Describe how this proposal and its Monitoring and Evaluation plan complements or contributes towards existing efforts (including existing Global Fund programs) to strengthen the national Monitoring & Evaluation plan and/or relevant health information systems.

The MOH already operates a health information system. Specified indicators are gathered from the district levels and passed through the provincial to the national level periodically. Data collected are collated, analyzed and used by management at each level before reporting to the next level. The above routine information system is complemented by information from the Demographic Health Surveys and HIV surveillance surveys (ANC, Young Adults, HIV Estimates – see Annexe). A coordinated national effort has been ongoing in Zimbabwe to develop a comprehensive national monitoring and evaluation plan for implementing AIDS service organizations receiving funds through NAC (either funds from GFATM or National AIDS Levy). The aims of this initiative are to allow Zimbabwe to evaluate 1) What works and does not work in the conext of implementing a comprhensive response to HIV and AIDS, 2) Which interventions make a difference and 3) How can interventions be improved. This effort includes a National Indicators Task Force led by MOHCW and NAC, and supported by the University of Zimbabwe Center for Evaluation of Public Health Interventions. The tools developed include a NAC monthly activity report form for programme implementers, a computerized database for district and national level aggregation of statistics, and an overall summary document of monitoring by strategic and programme area. Substantial effort has gone into the development of these tools to date, with participation of a wide variety of technical and financial partners, and oversight by the MOHCW. This process has ensured consistency and coordination with existing health sector disease surveillance systems, and coordinated the selection of indicators for scaling up of activities such as ART and treatment of opportunistic infections. Distribution and training in the final tools will take place to ensure that appropriate monitoring and evaluation of all HIV&AIDS activities, objectives and goals takes place on a widespread national scale. The final drafts of monthly activity report form and overall summary document are attached (ANNEXE 21 - NAC Monitoring Tools). The M&E activities proposed here will build on and strengthen these existing systems and capacity, specifically they will enable programme managers, in collaboration with all stakeholders to identify in the context of ARV treament, whether or not: 1) The programme is being implemented as planned, and 2) The programme is having the desired effect.

The M&E plan described for this Fifth Round GFATM has been developed in accordance with the guidelines and terminology for the fifth round global fund proposal form, which defines strategic and indicator levels as impact, coverage and process indicators. Streamlining of the draft NAC monitoring and evaluation tools and fifth round global fund proposal will take place in the next six months to ensure one overall, integrated monitoring and evaluation plan to accompany the national strategic plan for HIV and AIDS. Having selected relevant indicators, the M&E Unit will examine the existing systems to identify which can be monitored using data from the existing systems - the NAC system, but including the HMIS, vital statistical systems and periodic surveys such as DHS+. Where this is not the case additional data items will be included in the various collection tools as appropriate to obtain the necessary information. As a last resort special surveys will be carried out to obtain information not otherwise available.The Principal Recipients will report quarterly to the CCM for review of output. Oversight responsibilities on data review lies with the PR. Quality assurance and validation of data related to monitoring and evaluation will be the responsibility of NAC and MOHCW and other specialized agencies depending on the activity. Monitoring teams will co-opt technical experts, if need be, to address specific monitoring issues. All M&E activities wil be under the control of the NAC M&E UNit, working closely with the MOHCW, and guided by the National Task Force. Given the multitude of complimentary activities in this area, process/activity/output indicators will largely be used to monitor Global Fund supported activities whilst outcome and impact indicators will monitor the results of all efforts combined. Data collected from the National HMIS and the NAC M&E system will be transmitted from service facilities to the District Information / M&E officers and then through Province to the National Offices through pre-existing channels. The NAC M&E Unit will be responsible for overseeing the routine management of the system and prepare routine and ad hoc reports as required by Programme Managers and the CCM.

Substantial capacity has been developed within NAC in order to address some of the capacity issues. NAC has developed and begun to implement a comprehensive M & E plan. Activities include: modification of organizational structure to include a full M&E unit; hiring and placement of computer/data specialists at all provincial offices to oversee data collection and data input; identification of a senior M &E officer with postings for additional M&E support officers; development of a program plan that includes finalization and implementation of a NAC M&E curriculum based on the national indicators; trainings in M&E down to district level; and ongoing collaboration with technical consultants including UNAIDS, CDC, and University of Zimbabwe.

Additional capacity-building will relate to full roll-out of M&E trainings and database down to District level, with modification and quality improvement based on process evaluation. In addition, ongoing capacity-building with implementing organzations, such that data are reported consistently and correctly, will be needed. As staff turnover in many of these organizations may be high, repeated trainings and technical assistance from NAC will be needed over time to maintain high quality reporting capacity. Once the national indicators are finalized and trainings to district and implementor level have been carried out (anticipate full nation-wide implementation within one year), it is likely that disbursement of all funds through NAC (not just GFATM funds/including AIDS-levy funds) will be dependent on reporting by implementers receiving these funds. Beneficiaries of the programme will be on two levels: those whose capacity in M&E per se is improved and those PLWHA who benefiot directly or indirectly from the programmes activities. PLWHA will be involved in programme monitoring and evaluation in that several of the indicators relate directly to their inclusion in the programme or their perceived benefit from the programm e.g. Quality of life measurement using validated tools eg Karnofsky Score

4.7. Procurement and Supply Management

[In this section, applicants should describe the management structure and systems currently in place for the procurement and supply management (PSM) of drugs and health products in the country]

[When completing this section, applicants should refer to the Guidelines for Proposals, section V.B.5.]

4.7.1. Briefly describe the organizational structure of the unit currently responsible for procurement and supply management of drugs and health products. Further indicate how it coordinates its activities with other entities such as National Drug Regulatory Authority (or quality assurance department), Ministry of Finance, Ministry of Health, distributors, etc.

The National PharmaceuticalCompany (NatPharm) is currently responsible for procurement and distribution of drugs and medical supplies to Public Health Institutions in Zimbabwe. NatPharm is a commercialized Goverment Medical Store tasked with Procurement, Storage, Sale and Distribution of Pharmaceuticals and Medical supplies to Public Health Institutions. In line with commercialization it also procures and sells to the Private Sector. The Company is headed by a Managing Director (pharmacist) who reports to a Board of Directors. Supporting departments include Operations, Procurement, Finance, Information Technology, Human Resources and Internal Audit. NatPharm has six Warehouses or Distribution centers which are strategically placed to ensure coverage of the whole country. Each Store/warehouse is headed by a Pharmacist. The distribution is undertaken by six 8 – ton delivery trucks. NatPharm recently adopted a new Software package – Navision - which has enhanced its Inventory and Financial management systems. Health facilities also provide NatPharm with essential logistics information such as stock on hand at time of ordering.

Payment for supplies is through invoices submitted to Ministry of Health and Child Welfare. NatPharm's procurement takes into consideration drugs registered with the National Regulatory Authority (the Medicines Control Authority of Zimbabwe - MCAZ). On receipt, drugs are further subjected to Quality Control analytical tests by MCAZ, particularly for new suppliers.

For purposes of implementing Global Fund Round 5 proposals Natpharm is teaming upwith Crown Agents. CROWN AGENTS is an International Organization Operating in more than 110 countries all over the world. Crown Agents delivers Procurement and Supply Management Services, Public Sector transformation, revenue and expenditure management, banking, finance and training services.

4.7.2. Procurement Capacity

a) Will procurement and supply management of health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient or will sub-recipients also conduct procurement and supply management of health products?

- [x] Principal Recipient only
- [ ] Sub-recipient only
- [ ] Both

b) For each organization involved in procurement, please provide the latest available annual data (in Euro/US$) of procurement of drugs and related medical supplies by that agency (Attach to the proposal)

4.7.3. Coordination

a) For the organizations involved in section 4.7.2.b, indicate in percentage terms, relative to total value, the various sources of funding for procurement, such as national programs, multilateral and bilateral donors, etc.

	NatPharm	CROWN AGENTS
NATIONAL PROGRAMS	58%	14%
MULTILATERAL DONORS	0	36%
BILATERAL DONORS	42% (EU)	32%
NGO & OTHER DONORS	0	18%

b) Specify participation in any donation programs through which drugs or health products are currently being supplied (or have been applied for), including the Global Drug Facility for TB drugs and drug-donation programs of pharmaceutical companies, multilateral agencies and NGOs, relevant to this proposal (1 paragraph).

NatPharm is currently involved in storage and distribution of donations (medical and non-medical) from the following Organizations: WHO - HARPUNICEF (HBC Kits & other donations); Global Fund – Round I Malaria commodities; Red CROSS - Various commodities. Crown Agents does not participate in any drug donations programs, however Crown Agents purchases ARVs through the access pricing agreements and also Coartem through the WHO supply schemeThe National AIDS & TB Programme benefits from donations of Diflucan (Pfizer), Nevirapine (Boehringer-Ingelheim) and Determine HIV rapid test kits (Abbot Laboratories) which support both national OI and PMTCT services across the country. These donations are currently managed by Geddes Pharmaceutical Wholesaler, but plans are underway to transfer management to Natpharm to ensure one overall management system for all HIV associated drugs and commodities.

4.7.4. Supply Management (Storage and Distribution)

a) Has an organization already been nominated to provide the supply management function for this grant? Yes/No

b) Indicate, which types of organizations will be involved in the supply management of drugs and health products.

[If more than one of these is ticked, describe the relationships between these entities (1 paragraph)]

- [x] National medical stores or equivalent
- [ ] Sub-contracted national organization(s) () (specify which one[s])
- [ ] Sub-contracted international organization(s) () (specify which one[s])
- [ ] Other (specify)

c). Describe the organizations' current storage capacity for drugs and health products and indicate how the increased requirements will be managed.

The organization currently has six warehouse whose storage capacity is more than 50,000m2. The two regional stores which will serve as the major international receiving stores have a combined capacity of approximately 30,000m2. The organization currently has excess storage capacity and will therefore accommodate all health and non-health commodities purchased with Fifth Round Global Funds without requiring any further expansion of physical space.

Natpharm are currently reinforcing security at two of the six warehouses to accommodate Round 1 ARV drugs. This proposal will support renovation of the remaining four warehouses (including burglar bars, metal doors, lockable storage units etc).

d) Describe the organizations' current distribution capacity for drugs and health products and indicate how the increased coverage will be managed. In addition, provide an indicative estimate of the percentage of the country and/or population covered in this proposal.

The six stores are strategically placed to ensure coverage of the whole country. Each store has an eight-ton delivery truck to service the surrounding districts, and these trucks are in good condition (less than one year old). All districts are covered by deliveries every month. Deliveries are now on a door-to-door basis (covering every service delivery point, including rural health centres). Therefore the coverage will not need to expand to enable supporting supply of ARV drugs for the 22 districts, as the institutions are already covered on a monthly basis.

Overall management of storage and distribution will be enhanced through the procurement of two sets of computer hardware for each store, and the provision of service costs to the consortium for Procurement and Supply Chain management.

Approximately one third of the country will be covered for the HIV and AIDS proposal.

[For HIV/AIDS and tuberculosis components only:]

4.7.5. Does the proposal request funding for the treatment of multi-drug-resistant TB? ☐ Yes ☑ No

[Applicants should be aware that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee (GLC) of the Stop TB Partnership. Proposals must therefore indicate whether a successful application to the Committee has already been made. If not, a Green Light Committee application form must be completed and included with this proposal (see Annex B).]

4.8. Technical Assistance and Capacity-Building

[Technical assistance and capacity-building can be requested for all stages of the program cycle, from the time of approval onwards, including Technical Review Panel Clarifications, development of M&E or Procurement Plans, etc.]

4.8.1. Describe capacity constraints that will be faced in implementing this proposal and the strategies that are planned to address these constraints. This description should outline the current gaps as well as the strategies that will be used to overcome these to further develop national capacity, capacity of principal recipients and sub-recipients, as well as any target group. Please ensure that these activities are included in the detailed budget.

Zimbabwe is fortunate to benefit from strong local technical capacity in many areas related to this proposal. The writing team for this proposal are all permanently resident in Zimbabwe, and are composed of technical and community experts with multisectoral representation. Each step of proposal development was overseen by the relevant technical officer in the National AIDS & TB Unit, and comperhensive consensus and understanding of the content of this proposal has been developed amongst many stakeholders. In additon Zimbabwe is evolving its expertise in Global Fund procedures and mechanisms as a result of recent disbursement of Round 1 funds. It is therefore anticipated that this local capacity will be drawn upon for any TRP clarifications and inital planning for implementation if succesful. Capacity building of Principal Recipients, Sub-recipients and the identified Procurement and Distribution agent will be an ongoing process, that has already commenced through the development of this Fifth Round proposal. Funds to support this capacity building have been included in the operational costs for the PRs, with enhanced security at storage warehouses and traning in PSM for MOHCW and Procurement & Distribution agent personnel included in the direct budget.

Nonetheless, Zimbabwe faces several key capacity constraints in implementation of this proposal. The primary constraint is that of inadequate human resource shortages at all levels, and in many cadres. These issues are described in detail in ANNEXE 3 - Detailed Programm Description. In the public sector the MOHCW has reported vacancy rates of 60% and 55% among doctors and nurses respectively. None of the country's district hospitals has a pharmacist and the majority lack trained laboratory scientists. There is also a critical shortage of counselors at most of the public health institutions. This is the result of a combination of migration, misdistribution and mortality of the country's well trained and highly qualified staff and represents the single most challenging issue in scaling up ART services within the country. In order to ensure the implementation of ART services takes place as proposed, a combination of local and international technical assistance is requested in order to fill immediate gaps, at the same time as developing approaches that are integrated and potentially sustainable in the longer term. Local capacity building will take place through creation, training and deployment of Primary Care Counselors, District and Provincial HIV and AIDS Health Officers, while the immediate technical needs at site and district level will be addressed through deployment of UN Volunteers for the duration of the project, each of the 22 districts will benefit from one UNV medical doctor, one pharmacy technician and one laboratory scientist.

The current National Health Information System (NHIS) is well established, but currently suffers from lack of quality computer hardware and subsequent limitations on reporting. Global Funds will therefore be utilized to purchase new computer equipment to support monitoring activities within each district. However, both the HIV&AIDS monitoring system implemented by national AIDS Council (NAC) and the HMIS in the Ministry of Health and Child Welfare (MOHCW) are weak on ART program and patient monitoring. As the number of patients on treatment increase, a robust and efficient M&E system becomes critical. The situation is even more urgent in the private sector where approximately 50% of the patients are accessing ART and no known system for patient monitoring exists. With support from WHO, the MOHCW will conduct a rapid assessment of the monitoring system within the next 6 months. This will be inclusive of the public and the privates sectors and should come up with a plan for addressing the weaknesses of the existing system. Global Funds will assist in addressing some of the gaps identified, specifically in the development and implementation of a computerized M&E system for ART integrated into the National Health Information Management System (HMIS), and training of key personnel in its use to ensure ongoing capacity for monitoring patients on treatment.

With increasing use of ARV medicines, resistance to the drugs is inevitable. It is hoped that development of resistance will be slowed by ensuring high adherence to treatment by patients receiving treatment. This will be achieved through capacity building and strengthened collaboration with the networks of PLWHA, community based support structures such as NGO facilities, Community Based Organizations and primary and secondary care givers, in conjunction with intensive community outreach and intensified treatment literacy efforts through mass media campaigns. To inform clinicians, policy makers and users of the services, and to inform treatment decision making, the MOHCW has set up a task force of experts in HIV/AIDS (an epidemiologist, a clinician, a laboratory scientist and a surveillance expert) to lead the development of a system for resistance surveillance. There are currently no facilities for resistance monitoring in the country. However, opportunities are available in neighboring countries with capacity for resistance testing (South African and Botswana), and Zimbabwe plans to utilize Global Funds to take advantage of these opportunities for international technical assistance in resistance testing, at the same time as building national capacity to undertake resistance monitoring locally by the third year of the programme.

Specific technical assistance will also come from local organizations with key expertise in a number of areas, including training of journalists, mass media campaigns, workplace programme mapping and development of targeted food assistance policy as described in the detailed narrative and implementation plan (ANNEXE 3 and Required Attachment 3 - Detailed Implementation Plan).

5 Budget Section

[Please note that this section is to be completed for each component. Throughout, 'year' refers to the year of proposal implementation. For example, if Table 4.1.1 indicates that the proposal starts in June, year 1 would cover the period from June to the following May.

Financial information can be provided either in Euro or US$, but must be consistent throughout the proposal. Please clearly state denomination of currency.]

Currency selected for this proposal is USD

All budget breakdowns requested in the following sections are to be provided as an attachment to the hard and soft (electronic) copies of the proposal form.

5.1. Component Budget

[The budget should be broken down by year and budget category. The budget categories and allowable expenses within each category are defined in detail in the Guidelines for Proposal, section V.B.7. Costs that do not fall within the above-mentioned categories can be allocated under 'other' but must be specified. The total requested for each year, and for the program as a whole, must be consistent with the totals provided in section 5.1.]

Table 5.1 – Funds Requested from the Global Fund in USD

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human resources	2,688,600	3,480,600	3,429,000			9,598,200
Infrastructure and equipment	2,366,100	44,000	0			2,410,100
Training	2,002,883	1,757,092	2,074,296			5,834,271
Commodities and products	1,595,100	1,738,850	2,155,100			5,489,050
Drugs	3,473,048	8,858,198	15,374,934			27,706,180
Planning and administration	2,616,414	2,378,074	2,607,402			7,601,890
Other (please specify): Information and Publicity	1,254,400	1,677,800	907,000			3,839,200
Total funds requested from the Global Fund	15,996,545	19,934,614	26,547,732	0	0	62,478,891

The component budget must be accompanied by a detailed year 1 and indicative year 2 workplan and budget. This should reflect the main headings used in section 4.4. (component strategy) and should meet the following criteria, (please attach this information as described in the instructions):

a) It should be structured along the same lines as the component strategy—i.e. reflect the same goals, objectives, service delivery areas and activities.

b) It should be detailed for years 1 and 2, stating all key assumptions, including those relating to units and unit costs, and should be consistent with the assumptions and explanations included in section 5.1.2.

c) It should provide more summarized information and assumptions for the balance of the proposal period (year 3 through to conclusion of proposal term).

d) It should be integrated with a detailed workplan for year 1 and an indicative workplan for year 2.

e) It should be fully consistent with the summary budgets provided elsewhere in the proposal, including in this section 5.

5.1.1. Breakdown by functional areas

[Provide the budgets for each of the following three functional areas—monitoring and evaluation; procurement and supply management; and technical assistance. In each case, these costs should already be included in Table 5.1. Therefore, the tables below should be subsets of the budget in Table 5.1., rather than being additional to it. For example, the costs for monitoring and evaluation may be included within some of the line items in Table 5.1 above (e.g., human resources, infrastructure and equipment, training, etc.).]

Monitoring and evaluation:

[This includes: data collection, analysis, travel, field supervision visits, systems and software, consultant and human resources costs and any other costs associated with monitoring and evaluation.]

Table 5.1.1a – Costs for Monitoring and Evaluation in USD

	Funds requested from the Global Fund for monitoring and evaluation					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Monitoring and evaluation	2,747,083	1,939,942	2,324,196			7,011,221

Procurement and supply management:

[This includes: consultant and human resources costs (including any technical assistance required for the development of the Procurement and Supply Management Plan), warehouse and office facilities, transportation and other logistics requirements, legal expertise, costs for quality assurance (including laboratory testing of samples), and any other costs associated with acquiring sufficient health products of assured quality, procured at the lowest price and in accordance with national laws and international agreements to the end user in a reliable and timely fashion; do not include drug costs.]

Table 5.1.1b – Costs for Procurement and Supply Management in USD

	Funds requested from the Global Fund for procurement and supply management					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Procurement & supply management	3,153,100	2,202,850	2,419,100			7,775,050

Technical assistance:

[This includes: costs of consultant and other human resources that provide technical assistance on any part of the proposal—from the development of initial plans, through the course of implementation. This should include technical assistance costs related to planning, technical aspects of implementation, management, monitoring and evaluation and procurement and supply management.]

Table 5.1.1.c – Costs for Technical Assistance in USD

	Funds requested from the Global Fund for Technical assistance					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Technical assistance	1,704,200	1,504,800	1,366,200			4575200

5.1.2. Breakdown by Service Delivery Area

[Please estimate the percentage allocation of the annual budget over service delivery areas. The objectives and service delivery areas listed should resemble, as closely as possible, those in Table 4.4b.]

Table 5.1.2: Estimated Budget Allocation by Service Delivery Area and Objective.

		Year 1	Year 2	Year 3	Year 4	Year 5	Total
	Value per year	15,996,545	19,934,614	26,547,732			NaN
Objective	**Service delivery area**	**Estimated percentage of budget**					
1	Supportive Environment: Advocacy Initiatives	2.1	1	0.7			
1	Prevention: Behavioral Change Communication (BCC) — Community Outreach	4.8	6.2	1.7			
1	Prevention: Behavioral Change Communication (BCC) — Mass Media	3.2	2.3	1.6			
1	Supportive Environment: Workplace Policy Programme	1.5	0.9	0.2			
2	Supportive Environment: Coordination and Partnership Development	5.8	5.8	5.7			
2	Health Systems Strengthening: Health Infrastructure Development	19.7	1.7	1.1			
2	Health Systems Strengthening: Human Resources	18.2	18.6	14.4			
2	Health Systems Strengthening: Monitoring and Evaluation (M&E)	0.7	0.1	0.1			
2	Health Systems Strengthening: Operational Research	4.6	1.7	0.3			
2	Health Systems Strengthening: Procurement and Supply Management System	2	2.7	3.5			
2	Prevention: Counseling and Testing (CT)	9.6	9.5	8.2			
2	HIV/TB Collaborative activities: Prevention of TB Disease in PLWHA	0	0.5	0.4			
2	Other: Nutrition	0.6	0	0.1			
2	Care and Support: Care and Support for the Chronically Ill and Families Affected by HIV/AIDS	2.4	1.2	0.7			
2	Treatment: Antiretroviral Treatment and Monitoring	24.8	47.8	61.3			
Total		100%	100%	100%	0%	0%	

5.1.3. Breakdown by Partner Allocations

[Indicate in Table 5.1.3 below how the requested resources in Table 5.1 will, in percentage terms, be allocated among the following categories of implementing entities.]

Table 5.1.3. Partner Allocations

	Fund allocation to implementing partners (in %)				
	Year 1	Year 2	Year 3	Year 4	Year 5
Academic/educational sector	0.50	2.00	0.30		
Government	41.00	43.00	51.00		
Nongovernmental/community-based org.	17.00	15.00	8.00		
Organizations representing people living with HIV/AIDS tuberculosis and/or malaria	1.00	1.00	0.40		
Private sector	16.00	23.00	13.00		
Religious/faith-based organizations	24.00	15.00	27.00		
Multi/bilateral development partners	0.50	1.00	0.30		
Other (please specify):					
Total	100.00%	100.00%	100.00%	0.00%	0.00%

5.2. Key Budget Assumptions for requests from The Global Fund

Without limiting the information required under section 5.1, please indicate budget assumptions for year 1and year 2 in relation to the following:

5.2.1 Drugs, commodities and products

[Unit costs and volumes must be fully consistent with the detailed budget. If prices from sources other than those specified below are used, a rationale must be included.]

a) Provide a list of anti-retroviral (ARVs), anti-tuberculosis and anti-malarial drugs to be used in the proposed program, together with average cost per person per year or average cost per treatment course. If prices from sources other than those specified below are used, a rationale must be included. *(Please attach).*

b) Provide the total cost of drugs by therapeutic category for all other drugs to be used in the program. It is not necessary to itemize each product in the category. *(Please attach).*

c) Provide a list of commodities and products by main categories e.g., bed nets, condoms, diagnostics, hospital and medical supplies, medical equipment. Include total costs, where appropriate unit costs. *(Please attach).*

(For example: Sources and Prices of Selected Drugs and Diagnostics for People Living with HIV/AIDS. Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, June 2003, (<http://www.who.int/medicines/organization/par/ipc/sources-prices.pdf>): Market News Service, *Pharmaceutical Starting Materials and Essential Drugs*, WTO/UNCTAD/International Trade Centre and WHO (http://www.intracen.org/mns/pharma.html); *International Drug Price Indicator Guide on Finished Products of Essential Drugs*, Management Sciences for Health in Collaboration with WHO (published annually) (<http://www.msh.org>): *First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility (*http://www.stoptb.org/GDF/drugsupply/drugs.available.html*).)*

5.2.2. Human resources costs

[In cases where human resources represent an important share of the budget, explain how these amounts have been budgeted in respect of the first two years, to what extent human resources spending will strengthen health systems' capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over [1–2 paragraphs].]

Due to the extreme human resource capacity constraints currently experienced in Zimbabwe, a substantial proportion of the proposed budget for decentralized scale up of ART is allocated for human resources. The challenge is to implement responses to the acute human resource crisis in the health sector in order to effectively scale up a human-resource intensive service such as ART, whilst at the same time retaining approaches that are sustainable and integrated in the longer term. Detailed information on the challenges and medium-longer term solutions proposed in Zimbabwe are found in ANNNEXE 3 - Detailed Programme Description. For this proposal, and to ensure adequate HR to deliver the proposed interventions, three main approaches have been taken. Additional managerial personnel (HIV and AIDS Health Officers at Provincial and District level) counseling personnel (Primary Care Counselors) and UN Volunteers (pharmacists, laboratory scientists and medical doctors) will be recruited and deployed for the 22 districts. Numbers and salary costs of these essential personnel have been calculated as shown in the detailed budget and implementation plan over the three years of the programme, with salary allocations calculated relative to existing health personnel remuneration scales in the country.

The human resource capacity increases proposed are critical in strengthening the health system at health facility and community level, to enable the proposed interventions (testing and counseling, ART) to be delivered effectively to PLWA. Whilst substantial Global Fund support is required to recruit and sustain these personnel over the three years of the programme, the approaches proposed have also followed the existing, integrated structures and cadres of the MOHCW, increasing the potential for long term sustainability. In itself, increasing access to treatment can be expected to increase human resource capacity over time, as individuals in the health sector workforce receive treatment themselves and return to productive work. Sustainability is also increased by the innovative approaches proposed in this Fifth Round submission, to build the capacity of primary and secondary caregivers of PLWA at community level through revision of training curricula and training for these community members at district level. The extensive efforts to educate and inform communities through advocacy, community outreach and mass media approaches proposed will also contribute to reduced burden on the formal health sector, as capacity of communities and individuals to manage ART grows. Nonetheless, given the scale of the HIV crisis in Zimbabwe, combined with such a severe human resource challenge, it may be necessary to apply for further Global Funds in future rounds to continue supporting human resources in the medium term, while the longer term solutions proposed by the GoZ take effect, and community capacity grows.

5.2.3. Other key expenditure items

With respect to other expenditure categories (e.g. infrastructure and equipment), which form an important share of the budget, explain how these amounts have been budgeted for the first two years [1–2 paragraphs].

With the exception of human resources, the single biggest expenditure proposed is for Antiretroviral drugs ($27.7 million USD). These amounts have been calculated and budgeted according to treatment targets and assessment of accompanying capacity to deliver the drugs, as outlined in the detailed budget and implementation plan and the accompanying attachment detailing ARV drug assumptions.

Other major expenditures include Training ($4.2 million), Planning and Administration ($7 million) and Commodities and Products ($5.4 million). Training costs are extensive due to the considerable cross-cutting technical capacity building required to scale up ART, combined with the high staff turnover necessitating frequent training. Training activities have been budgeted according to a phased approach over time, which takes into account realistic targets and existing training capacities within the country, balanced against the reality of extensive training requirements to ensure delivery of quality services. For this reason, training costs are higher during the first year of the programme as capacity is established. Planning and administration costs represent combined monitoring and evaluation, coordination and partnership development as well as administrative costs of managing the project, and are therefore budgeted consistently throughout all three years of implementation activities. Commodities and products include rapid HIV test kits, which have been calculated and budgeted for across all three years of the project taking into account evolving testing and counseling capacity (including training and deployment of Primary Care Counselors) and testing requirements to meet accompanying treatment targets. Therefore these costs gradually increase throughout the three years of the programme.