ROUND 8 – HIV

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

PROPOSAL FORM – ROUND 8
(SINGLE COUNTRY APPLICANTS)

Applicant Name	Zimbabwe Country Coordinating Mechanism
Country	**Zimbabwe**
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 8 Guidelines)*	Low Income
Applicant Type	☑ CCM ☐ Sub-CCM ☐ Non-CCM

Round 8 Proposal Element(s):

	Disease	Title	HSS cross-cutting interventions section *(include in one disease only)*
☑	HIV[1]	Towards universal access: Addressing critical gaps in HIV Prevention, Treatment, Care and Support in Zimbabwe	☐
☑	Tuberculosis[1]	Towards universal access: Improving accessibility to high quality DOTS in Zimbabwe	☐
☑	Malaria	Towards universal access: Scaling up effective malaria control interventions in Zimbabwe	☑

Currency ☑ USD or ☐ EURO

Deadline for submission of proposals: **12 noon, Local Geneva Time, Tuesday 1 July 2008**

[1] In contexts where HIV is driving the tuberculosis epidemic, applicants should include relevant HIV/TB collaborative interventions in the HIV and/or tuberculosis proposals. Different HIV and tuberculosis activities are recommended for different epidemiological situations. **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/

ROUND 8 – HIV

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

'**+**' = A key attachment to the proposal. These documents **must** be submitted with the completed Proposal Form. Other documents may also be attached by an applicant to support their program strategy (*or strategies if more than one disease is applied for*) and funding requests. Applicants identify these in the 'Checklists' **at the end of** s.2 and s.5.

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)

+ Attachment C: Membership details of CCMs or Sub-CCMs

Complete the following sections for each disease included in Round 8:

3. Proposal Summary

4. Program Description

4B. HSS cross-cutting interventions strategy **

5. Funding Request

5B. HSS cross-cutting funding details **

** *Only to be included in one disease in Round 8. Refer to the Round 8 Guidelines for detailed information.*

+ Attachment A: '**Performance Framework**' (Indicators and targets)

+ Attachment B: '**Preliminary List of Pharmaceutical and Health Products**'

+ Detailed Work Plan: Quarterly for years 1 – 2, and annual details for years 3, 4 and 5

+ Detailed Budget: Quarterly for years 1 – 2, and annual details for years 3, 4 and 5

IMPORTANT NOTE:

Applicants are strongly encouraged to read the *Round 8 Guidelines* fully before completing a Round 8 proposal. Applicants should continually refer to these Guidelines as they answer each section in the proposal form. All other Round 8 Documents are available here.

A number of recent Global Fund Board decisions have been reflected in the Round 8 Proposal Form. The *Round 8 Guidelines* explain these decisions in the order they apply to this Proposal Form. Information on these decisions is available at:
http://www.theglobalfund.org/en/files/boardmeeting16/GF-BM16-Decisions.pdf.

Since Round 7, efforts have been made to simplify the structure and remove duplication in the Round 8 Proposal Form. The *Round 8 Guidelines* therefore contain the **majority of instructions** and examples that will assist in the completion of the form.

ROUND 8 – HIV

1. FUNDING SUMMARY AND CONTACT DETAILS

Clarified table 1.1.

1.1 Funding summary

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	33,911,829	52,909,901	65,090,613	68,555,682	76,284,045	296,752,070
Tuberculosis	18,989,498	10,549,154	10,131,069	9,360,552	9,268,024	58,298,297
Malaria	23,706,731	12,303,403	10,514,642	6,727,834	6,316,063	59,568,673
HSS cross-cutting interventions within the Malaria Proposal	18,065,343	16,918,995	15,587,972	15,587,972	15,587,972	81,748,254
					Total Round 8 Funding Request ➔:	496,367,294

1.2. Contact details

	Primary contact	Secondary contact
Name	Chiteure Rangarirai	Dr Gibson Mhlanga
Title	Coordinator	Principal Director Preventive Services
Organization	Country Coordinating Mechanism	Ministry of Health and Child Welfare
Mailing address	P.O. Box CY 1122 Causeway	P.O. Box CY 1122 Causeway
Telephone	+263-11-708099 +263-912-336663	+263-4-798537-60 +263-4-727951 +263-11-862600
Fax	+263-4-793634	+263-4-793634
E-mail address	secretariatccm@yahoo.co.uk	drgmhlanga@yahoo.com
Alternate e-mail address	chiteure@yahoo.co.uk	gmhlanga@comone.co.zw

1.3. List of Abbreviations and Acronyms used by the Applicant

Acronym/ Abbreviation	Meaning
AAA	Assessment Analysis Action
ABC	Abstain, Be faithful, Condomise
ACADA	Assessment, communication, analysis, design and action
AGM	Annual General Meeting
ANC	Ante-Natal Care
AOS	Administrative and Other Support (Costs)
ART	Antiretroviral Therapy
ARV	Antiretroviral Drug
ASMC	Advocacy and Social Mobilisation Committee
ASO	AIDS Service Organization
BC	Behaviour Change
BCC	Behaviour Change Communication
BEAM	Basic Education Assistant Module
BEM	Boys Education Movement
BFHI	Baby Friendly Hospital Initiative
BOT	Board of Trustees
CBD	Community Based Distributor
CBO	Community Based Organization
CHBC	Community Home-based Care
CHW	Community Health Workers
CITC	Client-Initiated Testing and Counselling
CMEIAST	Community Mobilization and Empowerment for Improved Access to Treatment
CPC	Child Protection Committee
CPCPZ	College of Primary Care Physicians of Zimbabwe
CR	Clinical Research
CSI	Child Status Index
CSO	Central Statistical Office
CTX	Cotrimoxazole

DAAC	District AIDS Action Committee
DAAO	District Accounting and Administration Officer
DART	Development of Antiretroviral Therapies in Africa
DBS	Dry Blood Spots
DEHO	District Environment Health Officer
DHE	District Health Executive
DHMT	District Health Management Team
DMO	District Medical Officer
DR	Drug resistance
EID	Early Infant Diagnosis
EMCOZ	Employers Confederation of Zimbabwe
EMLs	Essential Medicines Lists
EMS	Express Mail Service
EPI	Expanded Programme on Immunization
ESP	Expanded Support Programme
EXCOM	Executive Committee (National AIDS Council)
FAAC	Finance, Audit and Administration Committee (National AIDS Council)
FACT	Family AIDS Caring Trust Mutare
FP	Family Planning
FY	Financial Year
GBV	Gender Based Violence
GEM	Girls Education Movement
GF	Global Fund to Fight AIDS, TB and Malaria
GFR5	Global Fund Round 5
GFR8	Global Fund Round 8
GOZ	Government of Zimbabwe
HBC	Home-based Care
HDN	Health & Development Networks
HIPC	Heavily Indebted Poor Country
HMIS	Health Management and Information System
HMIS	Health Management Information System

HOSPAZ	Hospice Association of Zimbabwe
HQ	Head Quarters
HR	Human Resources
HTC	HIV Testing and Counselling
IA	Irish Aid
IDSR	Integrated Disease Surveillance and Response
IFIs	International Financial Institutions
INGO	International Non-Governmental Organization
IPC	Interpersonal Communication
LSU	Logistics Support Unit (Ministry of Health and Child Welfare)
MAC	Matebeleland AIDS Council
MASO	Midlands AIDS Service Organization
MCAZ	Medical Control Authority of Zimbabwe
MCSP	Malaria Control Strategic Plan of Zimbabwe 2008-12
MER	More Efficacious Regimen for PMTCT
MIS	Malaria Indicator Survey
Mmed/GMO	Master of Medicine/ General Medical Officer
MNCH	Maternal Neonatal and Child Health
MODO	MOHCW and Donors
MOESC	Ministry of Education, Sport and Culture
MOHCW	Ministry of Health and Child Welfare
MOPSLSW	Ministry of Public Service, Labour and Social Welfare
MOU	Memorandum of Understanding
NAC	National AIDS Council
NAP	National Action Plan
NAP-OVC	National Action Plan for Orphans and Other Vulnerable Children
NARF	National Activity Reporting Form
NATF	National AIDS Trust Fund
NatPharm	National Pharmaceutical Company of Zimbabwe
NCOI	National Core Output Indicators
NDTPAC	National Drugs and Therapeutics Policy Advisory Committee

NEC	National Employment Council
NHIU	National Health Information Unit
NMC	National Membership Council
NMCP	National Malaria Control Programme
NMRL	National Microbiology Reference Laboratory
NPF	National Partnership Forum
NVP	Nevirapine
ODF	Organisation Details Form
OR	Operational Research
ORDC	Operations, Research and Disbursement Committee (National AIDS Council)
PAAC	Provincial AIDS Action Committee
PAAO	Provincial Accounting and Administration Officer
PC	Primary Care Counsellor
PCN	Primary Care Nurse
PEC	Provincial Executive Committee
PEHO	Provincial Environmental Health Officer
PHE	Provincial Health Executive
PLC	Provincial Level Co-ordinator
PMD	Provincial Medical Director
POS	Programme of Support (to the National Action Plan on OVC)
PPAAT	Public Personalities Against Aids Trust
SAFAIDS	Southern Africa HIV and AIDS Dissemination Service
SHC	School Health Coordinator
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STG	Standard Treatment Guidelines
SW	Sex Worker
T&C	Testing & Counselling
T&S	Travel and Subsistence
TBA	Traditional Birth Attendant
TMA	Technical Management Assistance

TOT	Training of Trainers
UZ	University of Zimbabwe
VAAC	Village AIDS Action Committee
VL	Viral Load
VSO RAISA	Voluntary Services Overseas, Regional AIDS Initiative of Southern Africa
WAAC	Ward AIDS Action Committee
WPO	Working Party of Officials (on the National Action Plan for OVC)
YAS	Young Adult Survey
ZACH	Zimbabwe Association of Church Related Hospitals
ZAN	Zimbabwe AIDS Network
ZAPP	Zimbabwe AIDS Prevention Project
ZAPSO	Zimbabwe AIDS Prevention and Support Organisation
ZBCA	Zimbabwe Business Council on AIDS
ZCTU	Zimbabwe Congress of Trade Unions
ZDHS	Zimbabwe Demographic Health Survey
ZEDS	Zimbabwe Economic Development Strategy
ZICHIRE	Zimbabwe Community Health Intervention and Research Project
ZINERELA	Zimbabwe Network of Religious Leaders Living with or Personality Affected by HIV and AIDS
ZINQAP	Zimbabwe National Quality Assurance Programme
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZNFPC	Zimbabwe National Family Planning Council
ZNNP+	Zimbabwe National Network of People Living with HIV
ZRMCL	Zimbabwe Regional Medicines Control Laboratory
ZUNDAF	Zimbabwe United Nations Development Assistance Framework

2. APPLICANT SUMMARY (including eligibility)

CCM applicants: Only complete section 2.1. and 2.2. and DELETE sections 2.3. and 2.4.
Sub-CCM applicants: Complete sections 2.1. and 2.2. and 2.3. and DELETE section 2.4.
Non-CCM applicants: Only complete section 2.4. and DELETE sections 2.1. and 2.2. and 2.3.

IMPORTANT NOTE:
Different from Round 7, 'income level' eligibility is now set out in s.4.5.1 (focus on poor and key affected populations depending on income level), and in s.5.1. (cost sharing).

2.2. Members and operations

2.2.1. Membership summary

	Sector Representation	Number of members
☑	Academic/educational sector	1
☑	Government	6
☑	Non-government organizations (NGOs)/community-based organizations	3
☑	People living with the diseases	1
☑	People representing key affected populations[2]	1
☑	Private sector	2
☑	Faith-based organizations	2
☑	Multilateral and bilateral development partners in country	4
☐	Other *(please specify):*	
	Total Number of Members: *(Number must equal number of members in 'Attachment C'[3])*	20

[2] Please use the *Round 8 Guidelines* definition of *key affected populations*.
[3] **Attachment C** is where the CCM (or Sub-CCM) lists the names and other details of all current members. This document is a mandatory attachment to an applicant's proposal. It is available at: http://www.theglobalfund.org/documents/rounds/8/AttachmentC_en.xls

2.2.2. Broad and inclusive membership

Since the last time you applied to the Global Fund (and were determined compliant with the minimum requirements):

(a)	Have non-government sector members (*including any new members since the last application*) continued to be transparently selected by their own sector; and	☐ No	☒ Yes
(b)	Is there continuing active membership of people living with and/or affected by the diseases.	☐ No	☒ Yes

2.2.3. Member knowledge and experience in cross-cutting issues

Health Systems Strengthening

The Global Fund recognizes that weaknesses in the health system can constrain efforts to respond to the three diseases. We therefore encourage members to involve people (from both the government and non-government) who have a focus on the health system in the work of the CCM or Sub-CCM.

(a) Describe the capacity and experience of the CCM (or Sub-CCM) to consider how health system issues impact programs and outcomes for the three diseases.

Members of the Zimbabwe CCM have varying knowledge and experience of important crosscutting issues of health systems gaps that impact programmes and outcomes for the three diseases. The CCM secretariat conducted a rapid self-assessment of CCM members' knowledge and experience of cross-cutting health systems strengthening (HSS) issues (Annexe CCM 1) and found the following:

- Sixty-three percent (N=15) of CCM members were familiar with Round 8 guidelines of HSS.
- Thirty three percent were in need of training in HSS.
- Overall 86% agreed that critical HSS cross-cutting gaps should be included in the Round 8 proposal.
- Ninety-two percent of the CCM members identified health workforce as an example of HSS that can be included in round 8 proposals. Only one member identified an issue other than health workforce (supply chain management)

Members whose programmes of support include HSS interventions provide on-going technical assistance to the CCM. These include WHO, CDC, UNAIDS, EC, DfID, USAID and MOHCW. In addition technical experts are regularly invited to CCM and its subcommittee meetings to provide technical assistance on key HSS issues that impact on programme delivery.

During its meetings the CCM has often expressed its concern about the impact of weakened health systems, in particular health workforce, on programme performance. In 2007, realizsng the impact of the shortage of health workers on meeting agreed ART targets, the CCM collaborated with the National AIDS Council (NAC) and MOHCW to hire private doctors to initiate PLWHIV on ART at public sector hospitals. The CCM has continued to monitor the impact on programmes, of health workforce, procurement and supply chain among key HSS challenges.

Gender awareness

The Global Fund recognizes that inequality between males and females, and the situation of sexual minorities are important drivers of epidemics, and that experience in programming requires knowledge and skills in:

- methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and
- the factors that make women and girls and sexual minorities vulnerable.

(b) Describe the capacity and experience of the CCM (or Sub-CCM) in gender issues including the number of members with requisite knowledge and skills.

The CCM self-assessment on HSS (Annexe CCM 1) found the following:

- All the CCM members reported understanding of gender issues.
- Half of the members were in need of training gender issues within the context of the Global Fund thereby underscoring the need by members to move from being 'watchdogs' to more meaningful contribution to planning, programming, monitoring and decision-making on ways in which gender affects outcomes for the three diseases.
- All members agreed that gender issues should be included in the Round 8 proposal. The CCM secured technical assistance to ensure incorporation of strategies to reduce gender inequities in accessing services for the three diseases.
- Only 33% of the members knew the correct definition of gender in line with the round 8 guide-

lines.

The CCM includes representatives of Zimbabwe AIDS Network and National Association of Non Governmental Organisations (NANGO), whose work involves gender advocacy for the three diseases. On-going technical assistance is provided by UN agencies in particular UNFPA and UNICEF who participate in CCM sub-committees. On-going discussions in the CCM and MOHCW have included the need to strengthen linkages between gender, HIV and sexual and reproductive health in order to address the needs of sexually active men, women and young people more effectively. The Zimbabwe National Family Planning Council (ZNFPC) which is responsible for community adolescent and sexual reproductive health programming and family planning in adults and youth always is an SR in current HIV grants and attends CCM meetings.

Multi-sectoral planning

The Global Fund recognizes that multi-sectoral planning is important to expanding country capacity to respond to the three diseases.

(c) Describe the capacity and experience of the CCM (or Sub-CCM) in multi-sectoral program design.

The Zimbabwe CCM is a multi-sectoral body representing key sectors that are involved in the three diseases. Representatives of the key sectors involved in the three diseases base the CCM decision and operations on wide stakeholder consultation and consensus building through transparent processes that ensure active participation. Programme design for the three diseases is led by key government structures (MOHCW and NAC) in collaboration with civil society, private sector, technical partners, donors and other key stakeholders across all sectors. The CCM operates within the existing institutional framework that ensures multi-sectoral involvement e.g. HIV and AIDS programme design and implementation in line with the 'Three Ones' principle. In addition the CCM is represented by its secretariat in the various national coordination and planning fora for the three diseases. All the CCM members are also active members of these key coordination and planning structures.

The CCM has demonstrated extensive multi-sectoral planning during the development of Global Fund proposals. The experience that has been gained from these processes has been invaluable to the CCM members' understanding of multi-sectoral programme design. As a result the CCM self-assessment on HSS (Annexe CCM 1) found the following:

- Eighty percent (N=15) of the members reported understanding of multi-sectoral planning issues that are critical for effective response to the three diseases.
- Fifty-seven percent were in need of training in order to better understand the importance of multi-sectoral planning and support CCM decision-making, programme design and oversight.
- Over 90% of the members agreed to the inclusion of activities to strengthen multi-sectoral planning in the round 8 proposals.

2.3. Eligibility

2.3.1. Application history

'Check' one box in the table below and then follow the further instructions for that box in the right hand column.

☉	Applied for funding in Round 6 and/or Round 7 **and** was determined as having met the minimum eligibility requirements.	➔ ***Complete all of sections 2.2.2 to 2.2.8 below.***
○	Last time applied for funding was before Round 6 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' to and complete.*** *(Do not complete sections 2.2.2 to 2.2.4)* ➔ ***Then also complete sections 2.2.5 to 2.2.8 below.***

2.3.2. Transparent proposal development processes

➔ *Refer to the document 'Clarifications on CCM Minimum Requirements' when completing these questions.*

➔ *Documents supporting the information provided below must be submitted with the proposal as clearly named and numbered annexes. Refer to the 'Checklist' after s.2.*

(a) Describe the process (es) used to invite submissions for possible integration into the proposal from a broad range of stakeholders including civil society and the private sector, and at the national, sub-national and community levels. *(If a different process was used for each disease, explain each process.)*

In March 2008, the Zimbabwe CCM announced a national call for proposal/expression of interest (Annexe CCM 2) for possible integration into the Zimbabwe round 8 proposals. The national call was advertised in all the major newspapers in the country for a period of three weeks. In order to improve dissemination, CCM members also distributed copies of the national to their constituencies including communities, civil society, private sector and government institutions at all levels. Some CCM members placed the national call on their websites.

A supplementary call for proposal (Annexe CCM 3) was issued following poor response to the call for TB principal recipients and sub-recipients for special services including procurement, monitoring and evaluation and community systems strengthening.

(b) Describe the process (es) used to transparently review the submissions received for possible integration into this proposal. *(If a different process was used for each disease, explain each process.)*

During its meeting of the 19th March, 2008 (Annexe CCM 4), the CCM appointed a selection panel to review and recommend to the CCM potential sub-recipients and submissions into the round 8 proposal. The selection panel members were selected transparently during a full CCM meeting and included four CCM members, two representatives from each of the three CCM subcommittees and three MOHCW national programme technical staff for HIV and AIDS, TB and Malaria**.**

The selection panel agreed on a set of selection criteria (Annexe CCM 5) for reviewing the submissions for possible integration into the proposal. Members of the selection panel whose organisations submitted applications were asked to declare their interest and excused themselves from the selection meeting when their organisations' submissions were tabled. Recommended potential sub recipients and submissions were presented to and endorsed by the CCM meetings of April 30 and May 28 2008 (Annexe CCM 6) and (Annexe CCM 7) respectively.

All submissions were handed over to the writing teams for integration into the proposal based on the focus that was approved by the CCM. The nominated SRs were invited to participate in the technical writing team meetings and to assist provide specific information based on their knowledge and experience.

(c) Describe the process (es) used to ensure the input of people and stakeholders other than CCM (or Sub-CCM) members in the proposal development process. *(If a different process was used for each disease, explain each process.)*

The consultative process to develop the Zimbabwe round 8 proposal started when the CCM decided to submit round 8 proposals at its meeting on 17th January, 2008 (Annexe CCM 8). The CCM requested its three disease subcommittees to identify gaps in national programme priorities that could be considered for round 8 applications. The sub-committees conducted stakeholder consultations that informed the CCM decision on the overall focus of the round 8 proposal (Annexe CCM 9). The overall focus areas formed the basis of the national call for proposal/expression of interest described in section 2.2.2 (a) above.

The CCM then established proposal technical writing teams composed of multi-sectoral representation by non-CCM members from government institutions, civil society, private sector, technical partners and representatives of people living with the disease. The writing teams held several stakeholder consultations during the round 8 proposal development.

In order to ensure transparency and civil society involvement, the CCM through ZAN also engaged two consultants who conducted stakeholder consultations on gender and community involvement issues. The

input from the consultations (Annexe 10) was subsequently discussed with the writing teams and integrated into the HIV and AIDS proposal.

Experts from WHO, UNICEF, UNFPA and other partners also provided on-going technical assistance and input into the proposal. The CCM encouraged the writing teams to solicit peer review and input of local experts and people involved in the three diseases. The peer reviewers provided technical comments on the draft proposals during the months of May and June 2008. The malaria writing team participated at the Nairobi Regional Mock TRP in May 2008. Similarly the HIV writing team sent the HIV proposal to the East and Southern Africa peer review organized by WHO in June 2008.

(d)	**Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	**Annexe CCM 9**

2.3.3. Processes to oversee program implementation

(a) Describe the process (es) used by the CCM (or Sub-CCM) to oversee program implementation.

The CCM is responsible for overall programme oversight. A number of mechanisms are in place to ensure execution of the CCM oversight role.

(i) **CCM Meetings**: The CCM meets once every month. All CCM members, LFA, representatives PRs and SRs and other invited people including technical partners, attend the meeting. At this meeting all PRs present monthly updates on grant implementation. Issues affecting grant implementation are discussed and the CCM makes decisions to address key challenges. The CCM also holds extraordinary meetings to address emerging challenges that need urgent redress prior to scheduled meetings. The operations of the CCM in ensuring effective grant oversight are guided by the CCM terms of reference (Annexe 11).

(ii) **CCM sub-committees**: The CCM has established a sub-committee for each of the three diseases. Membership of the sub-committees is drawn from CCM, PRs, SRs and other key technical partners in the country. The sub-committees provide direct technical oversight to grant implementation on behalf of the CCM. Monthly and quarterly progress reports from the PRs are discussed at the sub-committee meetings before they are presented to the CCM. The sub-committees also provide technical advice to address implementation challenges. The sub-committees refer policy decision points to the CCM.

(iii) **CCM secretariat**: Day-to-day coordination of CCM operations is done by the CCM secretariat. The secretariat comprises three staff, a coordinator, deputy coordinator and programme assistant. The secretariat supports the CCM grant oversight role by managing administrative and logistical issues as well as regular liaison with the GF secretariat (FPM), PRs and LFA

(b) Describe the process (es) used to ensure the input of stakeholders other than CCM (or Sub-CCM) members in the ongoing oversight of program implementation.

Input of stakeholders other than CCM members into grant oversight is obtained largely through coordination meetings and reports. The CCM secretariat represents the CCM and shares reports on status of grants implementation in the country with stakeholders attending the following national coordination meetings for the three diseases:
HIV and AIDS: (i) National Partnership forum, **(ii)** PMTCT partnership forum, (iii) Treatment and Care Partnership forum, (iv) Testing and Counseling, (v) STI Technical Technical Advisory Committee, (vi) Technical Support Group on Behaviour Change which all meet bimonthly and (vii) the ESP working group which meets monthly.

Malaria: (i) Malaria Taskforce which meets monthly, (ii) Case Management, (iii) Vector control, (iv) IEC & Advocacy, and (v) Surveillance and M&E sub-committees which meet quarterly, and (vi) Annual malaria conference.

TB:
(i) TB Expert committee, and (ii) TB/HIV committee which meet quarterly.
Other coordination structures include

Donor funding: The Health Development Partners Group monthly meetings.

2.3.4. Processes to select Principal Recipients

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 8 Guidelines for further explanation of the principles.* .

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. *(If a different process was used for each disease, explain each process.)*	
The national call for proposal that is described in section 2.2.2 (b) above included the nomination of PRs for all three diseases. After the initial call, 12 applications were received for HIV, 4 for Malaria and 4 for TB. However the selection panel did not find any suitable potential PR for TB. The CCM at its meeting of April 30, resolved to issue a supplementary call for proposal for TB PR. The supplementary call yielded three applications from which a suitable PR was identified. The applications were reviewed by the selection panel comprising members who were appointed by the CCM meeting as described in section 2.2.2 (b) above. The selection panel agreed on a set of selection criteria (Annexe CCM 5) for reviewing the PR applications. Members of the selection panel whose organisations submitted applications were asked to declare their interest and recused themselves from the selection meeting. Recommended potential PRs were presented to and endorsed by the CCM meetings of April 30 for HIV and Malaria, and May 28, 2008 for TB (Annexe CCM 6) and (Annexe CCM 7) respectively.	
(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease.	Annexes CCM 6 and 7

2.3.5. Principal Recipient(s)

Name	Disease	Sector**
National AIDS Council	HIV and AIDS	Government
Zimbabwe AIDS Network	HIV and AIDS	Civil Society
Ministry of Health and Child Welfare – National Malaria Control Programme	Tuberculosis	Government
Ministry of Health and Child Welfare – AIDS and TB Unit	Malaria	Government

*** Choose a 'sector' from the possible options that are included in the Round 8 Guidelines at s.2.1.1.*

2.3.6. Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for each disease in this proposal.
The Zimbabwe CCM recognizes the aim of the Global Fund to ensure multi-sectoral programme implementation, sustainability and enhancement of equitable access to resources through dual track financing (DTF). After careful consideration of the country setting and submission of applications from potential PRs for the three diseases, the CCM recommended implementation of DTF for the HIV component only. DTF could not be implemented for the Malaria and TB components for the following reasons: • There was poor response to the call for potential PRs. Only four applications were received for

both malaria and TB after the initial call. The supplementary call only yielded three applications for TB.

- Most of the applications that were received did not meet the minimum criteria for PR nomination as assessed by the selection panel (Annexe CCM 5).
- Following a review of organisational priorities and capacity, the current round 5 PR for TB did not wish to continue as a PR in round 8 despite solicitation by the CCM (Annexe CCM 7).

The national call for proposal clearly stated that the CCM could consider two PRs for each disease. The CCM recognises the need to build the capacity of potential PRs for consideration in subsequent proposal rounds. In this regard, the CCM is requesting funding for technical and management assistance in this proposal in order to build capacity of SRs who can be considered as PRs in future proposals.

ONE PAGE MAXIMUM

2.3.7. Managing conflicts of interest

(a)	Are the Chair **and/or** Vice-Chair of the CCM (or Sub-CCM) from the same entity as any of the nominated Principal Recipient(s) for any of the diseases in this proposal?	☉ Yes ***provide details below*** ○ No ➔ *go to s.2.2.8.*
(b)	**If yes, attach** the plan for the management of actual and potential conflicts of interest.	☑ **Yes** ***[Insert Annex Number]***

2.3.8. Proposal endorsement by members

Attachment C – Membership information and Signatures	**Has 'Attachment C'** been completed with the signatures of all members of the CCM (or Sub-CCM)?	☑ Yes

3. PROPOSAL SUMMARY

3.1. Duration of Proposal

	Planned Start Date	To
Month and year: *(up to 5 years)*	1st July 2009	30th June 2014

3.2. Consolidation of grants

(a) Does the CCM (or Sub-CCM) wish to consolidate any existing HIV Global Fund grant(s) with the Round 8 HIV proposal?

☐ Yes *(go first to (b) below)*

x No *(go to s.3.3. below)*

'Consolidation' *refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 8 proposal.*

➔ *More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at: http://www.theglobalfund.org/documents/rounds/8/R8GC_Factsheet_en.pdf*

(b) If yes, which grants are planned to be consolidated with the Round 8 proposal after Board approval?
(List the relevant grant number(s))

3.3. Alignment of planning and fiscal cycles

Describe how the start date:

(a) contributes to alignment with the national planning, budgeting and fiscal cycle; and/or

(b) in grant consolidation cases, increases alignment of planning, implementation and reporting efforts.

The Zimbabwe national health annual planning, budgeting and fiscal cycle is from 1 January to 31 December to which the overall reporting and management cycle of the national HIV and AIDS response is aligned. As in previous rounds of Global Fund support, this proposal will follow the quarterly cycles following this directive. The Global Fund support will therefore be part of the integrated national planning at national, provincial and at district level and implementation will be aligned to components of the national HIV response and will feed into the National M&E System on this basis.

The proposed start date of 1st July 2009 comes at the start of the third quarter of the fiscal cycle for all activities undertaken under the national HIV/AIDS strategic plan. An important factor in considering the start date within the HIV component of this proposal is to ensure that activities that are already being implemented can be scaled up as rapidly as possible. Currently funding under Global Fund Round 5 phase 1 ends in July 2009 and phase 2 concludes in July 2010 if successful. However assistance from the Global Fund Round 5 only supports OI/ART services in 22 Districts and there is need to support a countrywide expansion of multiple interventions if universal access is to become a reality. Nationwide coverage of programmes that include Behaviour change (BC), Provider initiated testing and counselling (PITC), Prevention of mother to child transmission of HIV (PMTCT), antiretroviral therapy (ART) provision and home based care activities are urgently required to curtail the HIV epidemic in Zimbabwe and mitigate the impact of AIDS. These need to take advantage of the ongoing momentum to scale up interventions also being supported under GF round 5 as well as other efforts within the Expanded support programme (ESP) that are facilitating the national HIV responses. Furthermore, the start date has been selected to reflect the urgency of tackling the challenges the Zimbabwean population faces in terms of addressing the response to one of the world's most severe HIV epidemics.

ROUND 8 – HIV

3.4. Program-based approach for HIV

3.4.1. Does planning and funding for the country's response to HIV occur through a program-based approach?

☐ Yes. Answer s.3.4.2

X No. ➔ *Go to s.3.5.*

3.4.2. If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?

☐ Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism.***

☐ No. Do not complete s.5.5

3.5. Summary of Round 8 HIV Proposal

Provide a summary of the HIV proposal described in detail in section 4.
Prepare after completing s.4.

This proposal is designed to support a national multi-stakeholder response to reduce the number of new HIV infections in women, men, girls and boys as well as mitigating the impact of AIDS. It is based on an in-depth analysis of the HIV epidemic and the current HIV responses in Zimbabwe. The HIV proposal will build upon existing priority interventions that are being implemented within the national strategic framework. The focus will be on bringing best practices to scale to curtail the estimated 40,000 new infections occurring in adults and children on an annual basis and to bridge the gap to obtain universal access by scaling up OI/ART service delivery to address some of the needs of an estimated 479,796 adults and 24,194 infants and children annually who urgently require treatment[4]. By 2014, the proposal seeks to cover 58% of the national target for adults requiring ART treatment, contribute to reaching 71% of national PMTCT targets for pregnant women receiving more efficacious PMTCT regimens and complement current testing and counselling activities by covering 50% of the HIV testing targeted within the national programme. Behaviour change programmes will be scaled up to cover 60% of the districts. The aim is to reduce HIV prevalence rates to 8.3 % in young women aged 15-24 years and 3.5 % in young men. The proposal builds on the guiding principle that a multi-dimensional response is required involving public and private sector responses, community systems strengthening as well as strong community leadership and action with overall national leadership and coordination. Thereby the implementation of the proposals is expected to significantly contribute to a qualitatively better management of the response.

The behaviour change (BC) component will use proven successful models of community outreach and mass media to promote safer sexual practices and address underlying social and gender norms. While Zimbabwe's generalized HIV epidemic requires targeting the sexually active population at large, activities will take into account differences in needs by gender, age and location as well as ensure access of key affected populations. The BC response will address key drivers of the HIV epidemic based on the national strategy and ongoing review of epidemiological, behavioural and social trends. Provider initiated testing and counselling (PITC) will be scaled up to complement efforts already being supported to increase the numbers of women, men and children who know their HIV status with an expected 1,662,700 number of people tested for HIV over the course of the five years of this proposal. More efficacious prevention of mother to child transmission of HIV (PMTCT) regimens will be provided at 300 comprehensive PMTCT sites throughout the country to reduce the number of infants infected with HIV.

Furthermore management of opportunistic infections including co-infection with TB and provision of ART will continue to be decentralised through ongoing training, upgrading of sites and supervision and mentorship. Provision of adequate supplies of antiretroviral treatment for both adults and children will be ensured to complement existing government and donor contributions in both the private and public sector. This also necessitates the strengthening of laboratory capacity and procurement of essential diagnostic equipment and reagents to support service delivery which has been included as part of the overall proposal. Home based care activities at a community level are also an important component that will address capacity building of community initiatives to deliver a holistic package of services to HIV infected adults and children within their homes. Whilst there is a national programme to support orphans and vulnerable children supported by a multi-donor fund, critical coordination capacity is lacking and therefore coordination and accountability mechanisms will be strengthened. Similarly networks of people living with the virus remain isolated and need to be brought to the forefront of the national HIV response so that interventions can be tailored to meet the needs of those most affected.

To strengthen overall management of the national response, this proposal will contribute to improvement of monitoring systems in the public sector, private sector as well as at a community level. Currently the overall monitoring system remains fragmented and requires strengthened linkages and capacity building efforts to function efficiently. This will be addressed through improvement, development and application of standardised integrated systems and through capacity building of public, private and community cadres to collect and analyse strategic information within the national M&E framework.

[4] The number of infants and children requiring ART is likely to change based on the new recommendations from WHO (2008) that encourages all HIV positive infants to be started on ARVs earlier and not based on WHO staging with evidence from studies showing this improves overall morbidity and mortality outcomes.

Recognising that Zimbabwe faces critical shortages in human resources, this proposal will significantly contribute to a consolidated multi-stakeholder effort to retain and build capacity of the current public, private, civil society and community based services by supporting staff and by equipping different cadres of health care workers with the necessary skills to deliver high quality preventative, care and treatment services through training and mentorship.

The underlying rationale of this proposal is to close the most critical gaps in the national response through evidence-based programmes. In the spirit of moving towards universal access as soon as possible, a deliberate decision was made to focus on several of the most critical gaps in parallel. To ensure that this comprehensive approach can be effectively operationalised, a variety of partners with a comparative advantage in different areas were involved. This proposal, with guidance from the already established Country Coordination mechanism, will be better managed by two capable recipients, the National AIDS Council and the Zimbabwe AIDS network that will coordinate the responses of ten sub-recipients that have been chosen based on the previous track record. Within the HIV field, Zimbabwe has a long history of working in partnership with multiple stakeholders with common goals and priorities and this proposal builds upon this. Enhancing partnerships will enable the country to meet it's expected outcomes outlined whilst sustaining strong ownership of the programme at national level.

4. PROGRAM DESCRIPTION

4.1. National prevention, treatment, care, and support strategies

(a) Briefly summarize:

- the current HIV national prevention, treatment, and care and support strategies;
- how these strategies respond comprehensively to current epidemiological situation in the country; and
- the improved HIV outcomes expected from implementation of these strategies.

The overall national priorities for HIV and AIDS programming are defined in the National HIV/AIDS Policy of 1999. Strategic guidance to programming is provided by the Zimbabwe National HIV and AIDS Strategic plan 2006-2010 (ZNASP - ANNEX HIV 1). The National AIDS Council (NAC) is responsible for the coordination of a decentralised multi-sectoral HIV and AIDS response at national level and through AIDS Action Committees at village, ward, district and provincial levels. 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 overall goal of the ZNASP is to reduce the spread of HIV, improve the quality of life of those infected and affected, and mitigate the socio-economic impact of the epidemic in Zimbabwe. The thrust of the national response to the HIV epidemic for the past two decades has been prevention and mitigation of the effects of the disease through psychosocial support and home based care, with more recent development of health sector responses including HIV testing and counselling, PMTCT and OI/ART. The result has been that the adult HIV prevalence has significantly fallen to 15.6% for adults (age 15 to 49 years) in 2007 and an increasing number of people living with the virus have been able to access HIV services supported by private, public and community level initiatives (ANNEX HIV 7).

Behaviour change strategies: Zimbabwe developed and launched a National Behaviour Change Strategy 2006-2010 (ANNEX HIV 2) with the aim of reducing sexual transmission of HIV after a thorough epidemiological and behavioural science review and lessons learnt from the 2004 national AIDS conference. The strategy provides an evidence-based and systematic approach for multi-sectoral behavioural HIV prevention programming which focuses on key drivers and critical underlying factors of the epidemic such as concurrent sexual partnerships, age-disparate sexual relations, and long term discordant couples. Furthermore, the strategy calls for a multi sectoral response and outlines a focused approach towards addressing issues of leadership at all levels, gender imbalances, stigma associated with HIV as well as specific cultural practices. Despite increasing involvement and participation, the private sector remains largely marginalized with limited actions beyond behaviour change interventions. However Zimbabwe has developed the Zimbabwe National Strategic Framework for the Private Sector Response to HIV and AIDS for the period 2007-2010 (ANNEX HIV 3) which calls for aggressive advocacy campaigns to reach at least 80% of the private sector organisations with workplace policies and programmes by 2010. A key focus of this is to reduce work related stigma and discrimination and to improve access to HIV prevention, care, treatment and support services within the work place.

HIV testing and counselling: Since the introduction of HIV testing and counselling services in 1998, client initiated testing and counselling was the primary approach to HIV testing in Zimbabwe. Currently approximately 50% of all individuals tested for HIV in Zimbabwe are tested using this approach through static VCT centres and outreach services. According to the ZDHS 2005/2006 only 26% of women and 19% of men among the 1.1 million HIV positive adults in Zimbabwe, know their status. To increase early detection of HIV-infected individuals, the Government of Zimbabwe introduced provider-initiated testing and counselling (PITC) in health facilities in 2005; PITC was mainly offered in antenatal clinic (ANC) settings as part of PMTCT services. Since 2007, health care facilities primarily in the public sector and to some extent in the private sector have started to integrate the PITC approach within routine care at all entry points, including general outpatients, inpatients wards, STI, Reproductive Health and TB clinics. The National HIV Testing and Counselling Strategic Plan 2008-2010 (ANNEX 4) has recently been developed with the goal to increase the proportion of individuals tested and counselled for HIV from 20% to 85% by 2010 and to increase coverage of HIV testing and counselling ensuring access within a 10 km radius. The HTC strategy is guiding the implementation and wider roll out of PITC within both the private and public sector. PITC is complementing client initiated testing and counselling services which remains the primary approach outside the health facility settings

Comprehensive PMTCT services: including routine HIV testing of pregnant women and provision of ARV prophylaxis based on single dose Nevirapine has been the strategy used to reduce mother to child transmission of HIV as outlined within the PMTCT and Paediatric HIV prevention strategic plan 2006-2010 (ANNEX HIV 5). The PMTCT programme has been integrated within the broader framework of reproductive service provision. The programme has rapidly expanded in scope and quality and comprehensive PMTCT services[5] are currently offered in over 710 health care facilities with a further 850 sites providing routine antenatal and postnatal care including dispensing of single dose Nevirapine to HIV infected mother and their exposed infants but unable to provide on-site HIV testing. Routine 'opt' out HIV testing services have been integrated as part of reproductive health services, made possible due to the introduction of Primary care counsellors. Uptake of Nevirapine by HIV positive mothers at ANC sites is currently 60% translating to population coverage of 30%. The PMTCT curriculum uses an integrated model which includes strong emphasis on safe infant feeding practices, family planning, psychosocial support and creating linkages to care and treatment for both mothers, their partners and infants. The revision of the child health card has assisted in identifying HIV exposed infants to enable appropriate prescribing of Cotrimoxazole and linking infants at risk with other services however follow up and referral systems still remain weak. The programme is supported by strong technical partners who enhance national efforts by providing additional resources for training, site supervision, operational research and community mobilisation. Following the latest WHO recommendations (August 2006), short course combinations of ARVs have been piloted at six sites in two districts in Zimbabwe with great success and further roll out is planned (ANNEX 6: Interim report). Early HIV infant diagnosis to improve care and treatment outcomes of HIV exposed infants has also been piloted at 4 central hospitals with the intention to go to scale.

HIV care, treatment and support: Significant progress has been made in the provision of OI/ART services in Zimbabwe since April 2004 when the OI/ART programme was initiated (ANNEX HIV 22). OI/ART is implemented in the context of comprehensive treatment, care, and support. The goal of the national OI/ART programme is to reduce HIV related morbidity and mortality, and to improve the quality of life of people living with HIV infection in Zimbabwe. The number of patients accessing OI/ART in the country has increased from 5,000 in 2004 to 109,000 (99,000 from public sector and 10,000 from private sector) by March 2008 with 60% of these being women. According to the National HIV estimates of 2007 however, a total of 479,796 adults are in urgent need of OI/ART and require management of opportunistic infections (ANNEX HIV 7: Zimbabwe national HIV estimates 2007). Special focus has been on children living with HIV and AIDS and there has been a notable increase in the number of children accessing OI/ART from 2,100 in 2005 to 9,300 in 2008 with an estimated 18,475 receiving Cotrimoxazole prophylaxis in 2007. Training of health care workers on management of opportunistic infections and OI/ART is being rapidly rolled-out in all the country's provinces through partnership between the MOHCW, the University of Zimbabwe, WHO, CDC and UNICEF. The MOHCW has also embarked on an aggressive exercise to assess and support all major public health hospitals in the provision of OI/ART services and to date 101 health facilities across the country are OI/ART-initiating sites with a further 64 providing follow up care. Besides 300 companies also provide contributions to improve access to HIV care through a number of private health insurance schemes.

Support to PLWHIV has been provided by numerous community groups, NGOs and AIDS Support Organisations, who provide ongoing psychosocial support and home based care services with over 453,957 home based care (HBC) clients being reached by community care givers by 2007 (ANNEX 8: National activity report NARF Dec 2007). The coordination of these activities is managed by NAC with technical support form a multi-sectoral national CHBC task force. In recognition of the widespread importance of community home based care, the MOHCW and partners have developed national standards (ANNEX 9: National Standards for CHBC) to ensure a supportive environment for provision of quality services within all CHBC settings that are clearly linked to treatment services. Similarly a national strategic plan is under development to support further scale up at a national level (ANNEX 10: Draft CHBC strategic plan).

Orphans and vulnerable children: The complex psychosocial, educational and material needs arising due to the increasing number of orphans in the country are being addressed through the framework of the

[5] Zimbabwe defines **comprehensive** PMTCT services as being able to offer: routine ANC and PNC services; routine 'opt out' provider initiated HIV testing and counselling **and** providing on-site rapid HIV testing; counselling on HIV prevention, family planning, infant feeding options, PMTCT ARVs; **clinical** staging of HIV; dispensing of sdNVP to HIV infected pregnant women at time of diagnosis (recently changed from dispensing at 28 weeks only); providing HIV exposed infants with sdNVP; providing HIV follow up services including initiation of CTX at 6 weeks. Provision of more efficacious PMTCT regimens will now be included as part of the package.

National Action Plan for Orphans and Vulnerable Children and progress in terms of impact and outputs within this comprehensive programme are detailed (ANNEX HIV 11: National Action Plan for OVC). that Significant funds for activities are available under the NAP however coordination within government structures, which is the main player is weak & needs to be strengthened with support from the Global Fund.

PLWHIV: Meaningful involvement of people living with HIV is critical to ensure that HIV programmes remain responsive to those who are affected by the virus. Networks of PLWHIV have been advocating for greater access to treatment but their capacity to 'speak as one' has remained weak. To address these, a national strategic plan has been developed to guide enhanced efforts to attain the MIPA principles (ANNEX HIV 12: Zimbabwe National network for PLWHIV: strategic plan). However technical support and resources to implement many of the activities outlined in the strategic plan are still required.

The Global Fund Round 8 proposal for Zimbabwe therefore seeks to build upon the strategies that are already in place supported by the government, the private sector, CSOs and other donors and continue to prevent sexual HIV transmission focusing on evidence based interventions, proven to be effective addressing key drivers that fuel the epidemic in Southern Africa. It intends to enhance new PMTCT interventions in Zimbabwe through the scale up of more efficacious PMTCT regimens and increase coverage of PITC, including early infant diagnosis. The scale up of OI/ART will be strengthened through this proposal to strive towards universal access to treatment in Zimbabwe and community initiatives to provide home base care services will support these efforts at a household level. Finally improved coordination of OVC activities will complement efforts already being made under the National Action Plan for OVC and capacity building of PLWHIV networks will address gaps in the current overall HIV responses in Zimbabwe.

(b) From the list below, attach* **only those documents that are directly relevant** to the focus of this proposal *(or, *identify the specific Annex number from a Round 7 proposal when the document was last submitted, and the Global Fund will obtain this document from our Round 7 files).*

Also identify the specific page(s) (in these documents) that support the descriptions in s.4.1. above.

	Document	Proposal Annex Number	Page References
X	National Health Sector Development/Strategic Plan		
X	National HIV Control Strategy or Plan	ANNEX HIV 1	
X	Important sub-sector policies that are relevant to the proposal *(e.g., national or sub-national human resources policy, or norms and standards)*	ANNEX HIV 31, 32, 34, 38	
X	Most recent self-evaluation reports/technical advisory reviews, including any Epidemiology report directly relevant to the proposal	ANNEX HIV 6, 7, 8,10, 13, 14, 19, 20, 21, 36,37	
X	National Monitoring and Evaluation Plan (health sector, disease specific or other)	ANNEX HIV 27	
X	National policies to achieve gender equality in regard to the provision of HIV prevention, treatment, and care and support services to all people in need of services	ANNEX HIV 1, 2, 15, 23	

4.2. Epidemiological Background

4.2.1. Geographic reach of this proposal

(a) Do the activities target:

x Whole country ☐ Specific Region(s) ***If so, insert a map to show where* ☐ Specific population groups ***If so, insert a map to show where these groups are if they are in a specific area of the country*

(b) **Size of population group(s) targeted in Round 8**

Population Groups	Population Size	Source of Data	Year of Estimate
Total country population (all ages)	11,631,726	Central Statistics Office[6]	2002[7]
Women > 25 years	2,206,803	Central Statistics Office	2002
Women 20 – 24 years,	658,873	Central Statistics Office	2002
Women 15 – 19 years	766,890	Central Statistics Office	2002
Men > 25 years	1,976,437	Central Statistics Office	2002
Men 20 – 24 years	564,034	Central Statistics Office	2002
Men 15 – 19 years	736,686	Central Statistics Office	2002
Girls 0 – 14 years	2,364,911	Central Statistics Office	2002
Boys 0 – 14 years	2,357,092	Central Statistics Office	2002
Orphans and vulnerable children	1,600,000	ZDHS[8]	2005/2006

4.2.2. HIV epidemiology of target population(s)

Population Groups	Estimated Number	Source of Data	Year of Estimate
Number of people living with HIV *(all ages)*	1,320,739	MOHCW: National HIV Estimates	2007
Women living with HIV > 25 years	464,631	ZDHS[9]	2005-2006

[6] CSO data 2002
[7] 2002 Census figures have been used in this table. These figures will be updated as soon as figures from a 2007 Intercensal Survey have been analyzed. It was decided to use 2002 Census figures here, since projections would need to make a number of complex assumptions on issues such as the influence of informal and temporary migration. Scientifically valid updated population projections will only be possible based on figures from the Intercensal Survey.
[8] See ANNEX HIV 13: Zimbabwe Demographic Health Survey 2005-2006
[9] The number refers to women aged 25-49. For all figures taken from the DHS, prevalence rates for the specific age groups from the 2005/06 DHS+ were applied to the population in the respective age cohorts.

4.2.2. HIV epidemiology of target population(s)			
Population Groups	**Estimated Number**	**Source of Data**	**Year of Estimate**
Women living with HIV 20 – 24 years	107,396	ZDHS	2005-2006
Women living with HIV 15 – 19 years	47,547	ZDHS	2005-2006
Pregnant women living with HIV	56,950	MOHCW: National HIV Estimates	2007
Men living with HIV > 25 years	353,945	ZDHS[10]	2005-2006
Men living with HIV 20 – 24 years	32,714	ZDHS	2005-2006
Men living with HIV 15 – 19 years	22,837	ZDHS	2005-2006
Children living with HIV 0-14 years	132,938	MOHCW: National HIV Estimates[11]	2007
Boys (0-14) living with HIV	66,917	MOHCW: National HIV Estimates	2007
Girls (0 – 14 years) living with HIV	66,021	MOHCW: National HIV Estimates	2007
Number of new HIV infections Adults (15-49 years) Women (15-49 years) Children (0-14 years)	 22,367 10,199 17,370	MOHCW: National HIV Estimates	2007
Number of adults (15-49 years) needing ARVs Number of children (0-14 years) needing ARVs	479,796 24,194	MOHCW: National HIV Estimates	2007
Number of women (15-49 years) receiving ARVs Number of men (14-49 years) receiving ARVs Number of children (0-14 years) receiving ARVs Estimated nos. of adults and children receiving ARVs in the private sector[12] Other[13]	55,737 31,416 9,287 10,000 2,478	MOHCW: HMIS	2008
Orphans due to HIV (0-18 years)	1,265,473	MOHCW: National HIV Estimates	2007

[10] The number refers to men aged 25-54
[11] The 2007 national HIV and AIDS estimates were generated using the Epidemic Projection Package (EPP) software and HIV prevalence curves and projections were generated using the software package Spectrum.
[12] These are based on scanty reports that have been received from the private sector which are not disaggregated by age or sex.
[13] These figures are based on data received from public sector that have not been disaggregated by age or sex.

4.3. Major constraints and gaps

(For the questions below, consider government, non-government and community level weaknesses and gaps, and also any key affected populations[14] who may have disproportionately low access to HIV prevention, treatment, and care and support services, including women, girls, and sexual minorities.)

This summary of the gap analysis has been based on reviews of strategic documents, evaluations, assessments, and multiple consultations with stakeholders (ANNEX HIV 14: Consolidated gap analysis 2008). Furthermore, this gap analysis is based on the national Behavior Change strategy, the national Plan of Action on Women, Girls and HIV and AIDS (ANNEX HIV 15), the national strategic framework for the private sector response to HIV and AIDS 2006 -2010, the national HIV testing and counselling (HTC) strategic framework 2007- 2010, the National strategic PMTCT and Paediatric care and treatment plan 2006 -2010, the National care and treatment plan 2005 -2007 (ANNEX HIV 16), the draft CHBC strategic plan and the National Action plan for OVC which all fall under the overarching framework of the Zimbabwe National AIDS Strategic Plan 2006-2010.

HIV related stigma, lack of partner and community support as well as misunderstanding and misconceptions about HIV testing and counselling (HTC), PMTCT and HIV treatment and care services, including ART still prevent people from accessing HIV services. While communication strategies have been developed, there is still a gap in creating wider community preparedness to ensure that communities have adequate knowledge to enable them to make informed choices about HIV prevention, care, treatment and support services. In addition, while a number of programmes are underway to implement the national behavior change (BC) strategy, critical gaps remain in several areas including addressing concurrent sexual partnerships, broad-based leadership involvement, gender imbalances and stigma associated with HIV. Geographical expansion of decentralised implementation of the national BC strategy beyond the currently funded 26 districts, development and expansion of mass media approaches to address key drivers of HIV and implementation of the BC strategy in the private sector will address critical gaps.

The objective of the national HTC strategy is to increase the percentage of the Zimbabwean population that know their HIV status from 20% to 85% and to increase coverage of testing and counselling services in all districts by 2010. The main strategy to increase the number of people tested and counselled is provider initiated testing and counselling (PITC). While implementation of PITC beyond the ANC setting has been successfully implemented at 10 national pilot sites, a more coordinated approach is needed to introduce and expand PITC services at all levels of health care, including the private health sector as well as to ensure an uninterrupted HIV test kit supply.

The objectives of the national PMTCT programme is to provide 80% of pregnant women, their babies and families with comprehensive services to reduce MTCT rates to less than 10% by 2010. Currently single dose NVP has been the prophylaxis of choice, and continued efforts to capacitate sites to prescribe sdNVP at the time of diagnosis as well as provide safer motherhood practices including family planning is being supported largely through funding from USAID, DFID and UNICEF through a number of technical partners (ANNEX HIV 17: DFID mother and newborns programme). However the use of more efficacious PMTCT regimens has been piloted in 6 sites with a 95% uptake although national scale up of more efficacious PMTCT regimens has yet to be implemented on a wide scale and is a major gap within the programme[15]. Within this strategy, a focus on providing not only more effective ARV prophylaxis but also ART for HIV infected pregnant women who require it for their own health is being emphasised. However access to appropriate diagnostic services for pregnant and in particular HIV infected women remains poor with a need to support decentralisation of CD4 and routine haematology analysis. Efforts to strengthen critical follow up and referral services and safer infant feeding practices for HIV exposed infants are being addressed using the opportunity of revised child health card, development of national follow up registers for mother/infant pairs, breast feeding campaigns and integration of PMTCT messages within other outreach programmes e.g. EPI. However in view of the fact that by 12 months of age, approximately 30% of infants infected through MTCT will have died, it is essential that HIV testing be conducted within the first year of life. Early HIV infant diagnosis has been piloted in the 4 central hospitals in the country and further

[14] Please refer back to the definition in s.2 and found in the *Round 8 Guidelines.*

[15] CIDA, ESP and UNICEF are supporting phase one of roll out of more efficacious PMTCT regimens from 2008-2009 with additional support from technical partners.

support is needed for its national roll out, another critical gap in the programme.

The objective of the national care and treatment plan is to provide universal access to ART by 2010, which given the challenges required to meet the scale of the HIV epidemic, such as human resource constraints, inadequate ARV drug supplies, weak laboratory capacity to name but a few, is unlikely to be met. It is estimated that 479,796 adults and 24,194 children urgently need ART. The emphasis to date has been to equip high volume, central sites with the necessary capacity to deliver OI/ART services but clinics in these facilities have become overwhelmed with the demand and urgent decentralisation is required. The national programme has also identified the opportunities to enhance efforts being made within the private sector to deliver ART but provision of services within the private sector remains poorly monitored and de-linked from the national programme. The government of Zimbabwe as well as partners has been supporting these efforts but there still remains a gap of approximately 380,000 patients in need of ART (over 70,000 of whom are in the waiting list) and the necessary strengthening of health systems including monitoring to cope with the increasing demands that are being experienced. Furthermore, in planning for the future, it is recognised that managing the chronicity and complexities of HIV and AIDS will require enhanced skills which centres of excellence that are currently not supported, could be spearheading. Continuum of care is essential in HIV and AIDS care and the review of CHBC activities in 2006 revealed that the CHBC programme remains fragmented and needed to be standardised. The review therefore recommended the development of a national strategic plan, which is currently in draft form. Scale up of home base care activities are required to go beyond the currently supported districts under previous rounds of Global fund support, the ESP, Irish Aid and CDC being implemented with support from organisations such as HOSPAZ, Red Cross, PACT and others. There have been limited and short term resources to support CHBC activities, and this has hampered wider provision of services. ART literacy has also not kept pace with the increasing number of adults and children on or needing treatment, a matter that needs to be urgently addressed if the greatest impact from treatment is to be achieved.

The National Action plan for OVC intends to identify all orphans and vulnerable children and to have reached out with service provision to at least 50% of OVC in Zimbabwe considered to be the most vulnerable by December 2014. Critical gaps in the coordination structures for OVC programmes however exist at all levels and include limited human resource capacity as well as gaps in the infrastructure, equipment and transport which are necessary for the programme to reach its overall targets.

The ZNASP 2006-2010 encourages the further strengthening of participation of women and PLWHIV in HIV prevention, treatment and support programmes as well in coordination and M&E. Currently networks of PLWHIV lack capacity in terms of human resources, finances, infrastructure and equipment to better coordinate their activities in advocating and fostering meaningful involvement of PLWHIV at all levels. Whilst they are represented in the coordinating structures, representation becomes tokenistic because of this lack of capacity.

4.3.2. Health System

Describe the main weaknesses of and/or gaps in the health system that affect HIV outcomes.

The description can include discussion of:

- *issues that are common to HIV, tuberculosis and malaria programming and service delivery; and*
- *issues that are relevant to the health system and HIV outcomes (e.g.: PMTCT services), but perhaps not also malaria and tuberculosis programming and service delivery.*

For the nation to see a reduction in illness and death, the Ministry of Health and Child Welfare recognises that a well-remunerated health workforce with adequate tools to do what they do best is required. It is also recognised that the current existing workforce that has shown exemplary dedication, needs greater support and that a conducive environment needs to be created and nurtured for effective and efficient execution of duty. Despite the difficult operating environment, health care workers within the public, private and at community level continue to prioritise and address the needs of families infected and affected by HIV and AIDS.

Health work force: The human resource capacity is one of the major gaps in the health system which has great impact on HIV programme outcomes. The country's health system continues to be weakened by the exodus of skilled health workers which is reflected in the high vacancy rate among key health cadres such as nurses and medical doctors. The vacancy rate for health care personnel such as doctors,

pharmacists, nurses and laboratory scientists is as high as 50% (ANNEX HIV 14). The rural areas health facilities are only manned by 50% of the required skilled staff. Low salaries, lack of incentives, poor conditions of service and an unsatisfactory working environment have been identified as major causes of high attrition and migration. There is an urgent need to intervene to retain the existing staff in the health system and to prevent further exodus of the workforce. There is also need for task shifting to lower health care cadres, especially from medical doctors to nurses for initiation of ART, from nurses to lower cadres of health care in HIV testing and counselling and laboratory scientists to microscopists and nurses. Task shifting requires capacity building and training of health care personnel as well as ongoing supervision, mentoring and monitoring. Currently central, provincial and district level programme managers and coordinators are not available and the few existing staff of the DHE and the PHE are already overwhelmed with multiples tasks. This makes the integration of new approaches such PITC as well as the expansion of OI and ART treatment and PMTCT services difficult.

Service Delivery: Chronic under funding for health services against a background of adverse macroeconomic fundamentals and pressure to reduce public expenditure have resulted in severe weakening of public health infrastructure in the country. Assessments of health facilities for readiness to initiate or expand comprehensive HIV and AIDS services which were conducted by the MOHCW found lack of ideal space for confidential counselling, unsuitable laboratories and lack of laboratory equipment to be major barriers to effective delivery of comprehensive HIV and AIDS services (ANNEX HIV 18: Health facility assessment reports). Integration of PITC with routine care requires space to conduct counselling. The existing health infrastructure within outpatients and inpatients departments in both public sector and private sector only have limited capacity to provide privacy and confidentiality for HIV testing and counselling. Furthermore, lack of appropriate medical laboratory services are a key bottleneck to provision of OI/ART, PMTCT and PITC services. Robust equipment, sufficient numbers and adequately trained laboratory scientists and stronger monitoring and reporting are required as HIV services continue to expand. In addition, the private sector response remains de-linked from the main national efforts with lack of awareness on national protocols and guidelines, poor reporting and supervision being used within private clinics. There are weak referral and follow up systems to manage patients consistently across public and private sector and poor coordination and involvement of the private sector within the overall national efforts.

Medical products, vaccines and technologies: The weak supply chain management for both drugs as well as diagnostics are severely affecting HIV services throughout the country. Stock outs in Nevirapine as well as in HIV test kits have impacted on the PMTCT and the PITC programmes and inadequate supplies of Cotrimoxazole and other ART drugs could have severe implications on treatment outcomes for patients on treatment (ANNEX 14: Consolidated gap analysis). There is also stock out of CD4, haematology and chemistry reagents at most laboratories as these require foreign currency for procurement. The main weaknesses lie in the adequate forecasting and quantification at health facility level. Other weaknesses include the procurement, storage and proper distribution of health commodities as well as quality control at all levels. At health care facility level storage of expensive ART drugs is often not ensured because of failure to provide adequate levels of security.

Information: Currently there exist two parallel M&E systems in Zimbabwe which are currently not sufficiently linked (ANNEX HIV 42: HMIS assessment). Within the MOHCW, there is a national HMIS system and a parallel system for the HIV programme reporting. This is not only overwhelming health care workers at a site level but is also hampering effective integration and monitoring of the overall performance of the health system. The routine HMIS system was not set up initially to include important HIV indicators. The necessity to scale up HIV services rapidly meant that there was an urgent need to report on additional indicators specific to these services. In order not to delay the roll out of OI/ART care, treatment and support, an interim separate HIV reporting system was therefore devised. This now needs to become fully integrated within the HMIS system and be mindful not to overwhelm health care workers with additional duties of reporting and data collection, work that is ongoing as the programme moves towards meaningful integration. In addition, there are inadequate numbers of data clerks and poorly motivated District Health information officers to manage data coming in from facilities. To overcome some of these factors and because the current HMIS of the Ministry of Health is paper based, a computerised system is being developed with improvements being made on the data collection tools. There is however inadequate infrastructure and equipment such as telephone, radio-communication and e-mail and internet access to provide timely data collection and feedback at all levels. Furthermore, the capacity of site level and community health workers to monitor progress is weak and coordination of monitoring efforts needs to be strengthened. Similarly the national M&E system is not well connected with community initiatives or to private sec-

tor involvement and further effort is required to collect information from these multi-sectoral responses.

4.3.3. Efforts to resolve health system weaknesses and gaps

Describe what is being done, and by whom, to respond to health system weaknesses and gaps that affect HIV outcomes.

Currently Zimbabwe is reviewing and developing a continuation plan to build upon the National Health strategy 1997-2007 that has previously defined the direction of health services over the previous ten years. As part of this process, an assessment has been conducted to provide a detailed comprehensive human resource situation analysis. This comprehensive HRH situation analysis is intended to form the basis for the development of an evidence based HRH policy and plan for Zimbabwe (ANNEX HIV 19: Draft HSS situational analysis report) in order to harmonise contributions from partners and standardise salary support and retention packages to support the overall national health system. A multi-sectoral taskforce spearheaded by the MOHCW is in place and is now working on the development of the HRH policy and strategic plan.

Whilst the government of Zimbabwe has been providing the majority of resources to support personnel within the national health system, a number of partners through the MOHCW are also trying to respond to some of the critical health system weaknesses and gaps. The current political and economic climate has made planning particularly challenging given many uncertainties that are likely to be resolved by the time this Global fund round 8 proposal comes to fruition. Specific efforts have been made to strengthen the capacity of the MOHCW AIDS & TB Programme through secondment or funding of posts by bilateral, UN organisations, the ESP and international NGOs supporting the national HIV programme. These positions include a Chief Coordinator, Care and Treatment Coordinators (2), PMTCT Technical Officer, Training officers (3), T&C technical officer, two Monitoring and Evaluation Officer, Community Home Based Care officer, three Logistics Officers and a number of administration staff.

Through the EU funded, Vital Health Services Support Programme a number of cadres within the DHE are also being supported with remuneration and incentive packages although this is a short term proposal and only applies to certain districts. A number of different scenarios and packages have been presented to support the existing health work force in the short term, while long term solutions are being looked into. These short term packages are yet to be concluded and implemented. Similarly through Global Fund Round 5 a number of provincial and district HIV Coordinators, doctors, laboratory scientists, nurses and pharmacists are being supported in the 22. In order to address critical shortage of nurses and counsellors, the MOHCW has also created two generic mid-level health cadres; the Primary Care Nurse (PCN), and the Primary care Counsellor (PC) with the intention of task shifting various critical responsibilities to free up registered general nurses time. These cadres are individuals with minimum qualifications to perform focused primary clinical and nursing duties and basic HIV and AIDS counselling respectively. The reported impact of deployment of these cadres at district level has been very positive. Currently the Primary counsellors are being supported by a number of donor partners e.g. Clinton Foundation, ESP, UN agencies, GF but again this is only a short term proposal. Other broader task shifting duties and responsibilities e.g. enabling nurses to initiate ART, have yet to be agreed within the formal health system framework and preliminary discussions and advocacy following recommendations from the recent OI/ART assessment will bring these to the forefront over the coming year.

The procurement of HIV test kits, diagnostics (CD4, haematology, DNA PCR reagents), PMTCT, OI, ARV drugs and essential drugs are similarly being supported by a number of different donors, UN agencies and INGOs. Since mid 2007 through USG support, 40,000 patient doses of ARVs are being managed with support through JSI/Deliver. The Expanded support programme is supporting ART delivery including procurement of drugs in 16 Districts and similarly through the Global fund Round 5 grant ART services are being funded in an additional 22 districts. MSF is also providing ARVs to approximately 11,000 patients. The Clinton Foundation procures all paediatric ARVs and second line ARTs with Direct Relief International also supplying stocks to cover the number of patients on first line alternate treatment. Recently GOZ has also received support from CIDA and the ESP to procure ARV drugs to support the national PMTCT programme (more efficacious regimen) for the next two years. The Clinton Foundation and ESP is providing resources to scale up early infant diagnosis using DNA PCR testing. However all of these donations currently do not run beyond 2010 and it has been difficult to determine ongoing commitments after this period.

ROUND 8 – HIV

The European Commission (EC) is providing technical and financial support to the directorate of pharmaceutical services and NatPharm including the procurement of essential drugs including medicines for managing HIV and AIDS opportunistic infections. The NatPharm consortium which includes Crown Agents continue to harmonise all the national procurement systems and work closely with the MCAZ. To manage the growing procurement and supply chain management systems within the expanded HIV response in Zimbabwe, an HIV and AIDS logistics sub unit has been established, housed at Natpharm, supported by USG through JSI/Deliver.

Plans to strengthen M&E systems have been proposed under GFR5 which covers the development of indicator database for OI/ART. This has since been expanded to cover other programmes under AIDS and TB unit starting with VCT, PMTCT and consumption and requisition of commodities (ARVs) and other programmes e.g. workplace still need to be added. MOHCW does however not have funding for the deployment or roll out of this database although a rapid assessment of M and E systems for HIV/AIDS related diseases is planned. Technical input is also being provided by a number of partners and technical support for the development of this database is provided by ZVITAMBO and CDC. Efforts are also being made to integrate other aspects of the national programme including HIV prevention by revising routine monthly progress reports from sites and by developing integrated follow up registers for HIV exposed infants through technical support from EGPAF. No long term support is available for these efforts, therefore funds being sort under GFR8 are to expand and improve on the work done in GFR5 as well as meet new challenges such as patient based data monitoring and monitoring for HIV drug resistance.

4.4. Round 8 Priorities

Priority No:	1	Historical		Current		Country targets				
Intervention	**To scale up HIV Prevention Behaviour Change programmes through mass media and community outreach**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target (overall): Nos. of women and men of reproductive age reached with evidence-based behaviour change promotion		NA	100,000	1,147,998	1,721,997	2,295,996	2,869,995	3,443,993	4,017,992	4,591,991
B: Extent of need already planned to be met under other programs		NA	30,000	459,199	688,799	918,398	1,147,998	1,377,597	1,607,197	1,836,796
C: Expected annual gap in achieving plans		NA	70,000	688,799	1,033,198	1,377,597	1,721,997	2,066,396	2,410,795	2,755,195
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			103,320	551,039	1,291,498	2,066,396	2,410,795	2,755,195

Assumptions:

- This table focuses on the coverage target for inter-personal behaviour change communication (BC community outreach), since this target best illustrates the process of scaling up. Mass media coverage is not considered in this table because through mass media a large share of the population will already be reached in year 1 and this high-level of coverage will be maintained. There are other national targets at the impact level (HIV prevalence among young people aged 15-24 as a proxy for HIV incidence and various behavioural indicators). However, it was felt that the above coverage indicator better expressed the type of progress that is expected to be achieved through programming. It needs to be noted that the actual analysis of progress of behavioural HIV prevention interventions will always require a combined analysis of trends in HIV incidence, behaviours and intensity of BC programme exposure.
- Historical data: While a number of communication efforts have been ongoing, the historical baseline refers to persons reached with the key messages set out in the new evidence-based National BC Strategy, which was developed in 2006 and operationalised in 2007.
- The country targets are cumulative figures. They translates into the following annual targets for GF support: **2009:** 103,320; **2010:** 447,719; **2011:** 740,459; **2012:** 774,899; **2013:** 344,399; **2014:** 344,399
- Figures will be further disaggregated by sex, age and type of interpersonal communication activity (i.e. Nos. covered by IPC events and nos. covered by the standard BC community course).

ROUND 8 – HIV

Priority No:	2	Historical		Current		Country targets				
Intervention	**To scale up Provider initiated HIV testing and counselling**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target: **Nos. of adults and children (18 months – 49 years) to be tested for HIV**		180,000	250,000	512,000	606,920	679,000	763,000	848,000	862700	880000
A: Country target: **Nos. of HIV exposed infants (0-18 months) to be tested for HIV**		NA	400	3,000	8,372	14,700	20,160	25,200	27,200	27,916
B: Extent of need already planned to be met under other programs: **Nos. of adults and children (18 months – 49 years) to be tested for HIV**		180,000	250,000	512,000	606,920	530,000	400,000	400,000	400,000	400,000
B: Extent of need already planned to be met under other programs: **Nos. of HIV exposed infants (0-18 months) to be tested**			400	3,000	8, 372	14,700	0	0	0	0
C: Expected annual gap in achieving plans for: **HIV testing adults and children (18 months – 49 years)**					0	149,000	363,000	448,000	462,700	480,000
C: Expected annual gap in achieving plans for**: HIV testing HIV exposed infants (0-18 months)**					0	0	20,160	25,200	27,200	27,916
D: Round 8 proposal contribution to total need	*Gap for Nos. of adults and children (18months – 49 years)*				0	149,000	363,000	448,000	462,700	240,000
	Gap for Nos. of HIV exposed infants (0-18 months)				0	0	20,160	25,200	27,200	27,916

Assumptions:

- Country targets for 2006 -2007 based on historical data, estimates for 2008 based on existing national documents, estimates beyond 2008 are based on national targets and estimates for individuals presenting at health care facilities, increased uptake of testing and counselling services based on PITC scale up and increased acceptance rate by patients
- Estimates for extent of need already planned to be met under other programmes until 2010 is based on committed donor committed funding (including Global Fund Round 5, phase 2 (130 000 in 2009 and 130 000 in 2010), beyond 2010 it is assumed that of the need continuous support for 400 000 individuals tested is covered by other programs and the rest to be covered by Global Fund Round 8.
- Estimates for the contribution of Global Fund Round 8 for 2014 are only covering needs for 6 months as Global Fund Round 8 ends by 30th June 2014.Early infant diagnosis is being supported by Clinton Foundation who will continue to support the programme until end of 2010. Thereafter all early infant diagnosis will be factored under the Global Fund Round 8. Numbers in the implementation plan take into account the split between the years that have been proposed. Therefore GF8 will start to take over EID diagnosis activities at the beginning of January 2011 i.e. half way through year 2.

ROUND 8 – HIV

ROUND 8 – HIV

Priority No:	3	Historical		Current		Country targets				
Intervention	**To scale up the provision of more efficacious PMTCT regimens for the prevention of mother to child transmission of HIV**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target (overall): **Nos. of HIV infected pregnant women to receive more efficacious PMTCT regimens**		0	800	3,440	11,960	21,000	28,800	36,000	39,600	39,880
B: Extent of need already planned to be met under other programs		0	800	3,440	10,160	10,800	10,800	10,800	10,800	10,800
C: Expected annual gap in achieving plans			0	0	1,800	10,800	18,000	25,200	28,800	29,880
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			1,800	10,800	18,000	25,200	28,800	29,880

Assumptions:

- The targets that have been outlined make an assumption that the HIV prevalence rate amongst pregnant women will remain at approximately 18%.
- CIDA and ESP are currently providing ARVs for prophylaxis with donations pledged to the end of 2009. It is assumed that ongoing support for the programme will be maintained after this period.
- It is expected that GF round 8 would contribute to approximately 75% of the national targets with the further 25% being met by other donors by 2014. This would translate to an estimated 71% of population of pregnant HIV infected women to be reached by MER. This will complement the number of pregnant women who will continue to receive at least single dose NVP for PMTCT.

ROUND 8 – HIV

Priority No:	4	Historical		Current		Country targets				
Intervention	**To scale up the provision of ART to HIV infected adults**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target – Nos. of HIV infected adults to receive ARVs		150,000	250,000	170,000	210,000	260,000	310,000	350,000	380,000	410,000
B: Extent of need already planned to be met under other programs		60,403	116,601	160,864	174,864	116,500	116,500	116,500	116,500	116,500
C: Expected annual gap in achieving plans		89,597	133,399	9,136	35,136	143,500	193,500	233,500	263,500	293,500
D: Round 8 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			0	138,500	163,500	193,500	223,500	238,500

Assumptions:

- Targets for the national programme were changed during 2008 following review of progress and delays in obtaining global fund round 5 including scale up of training and infrastructure building required to expand the OI/ART programme. These have subsequently been revised and will be consolidated in the next strategic plan for the care and treatment component of the OI/ART programme that is in draft form but nearing completion.
- The targets take into account that by July 2010 84,000 patients will have been put on ART through support from GF round 5 as part of phase 2 and these patients will then be covered with support from GF round 8 in year 2 of this proposal.
- It is also assumed that GoZ will continue to support 10,500 patients per year on ARVs up to end of 2014; USG will maintain current level of ARV support for 40,000 patients yearly up to 2014; ESP will support ARVs for 56,000 patients yearly up to 2014; and private sector will provide ARVs for 10,000 patients yearly.
- There remains a gap in reaching the national targets and it is expected that the national HIV programme will continue to lobby the government of Zimbabwe and other donors to meet the gap that is required. Sites will be in position to initiate ARV treatment because of training, mentorship and supervision provided under this proposal.
- Need to be aware that these targets differ from the targets that have been put in the implementation plan. This is because the proposal starts mid-year in 2009, whilst the targets above are for a full year. A detailed breakdown of how the targets were derived is in the consolidated gap analysis, which is attached as an Annex 14.

ROUND 8 – HIV

Priority No:	5	Historical		Current		Country targets				
Intervention	**To scale up the provision of ART for HIV infected infants and children**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: Country target – Nos. of HIV infected infants and children to receive ARVs		5,000	10,000	15,000	20,000	25,000	30,000	36,000	45,000	55,000
B: Extent of need already planned to be met under other programs		5,000	10,000	15,000	20,000	25,000	0	0	0	0
C: Expected annual gap in achieving plans		0	0	0	0	0	30,000	36,000	45,000	55,000
D: Round 8 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			0	0	30,000	36,000	45,000	55,000

Assumptions:

- According to the HIV estimates 2007, the number of annual new infections in children is approximately 17,370. The majority of these are from mother to child transmission of HIV and have been modeled based on sdNVP being administered within the PMTCT programme. New models to appreciate the effect of introducing more efficacious regimens within PMTCT have not yet been developed so it has been difficult to understand the impact this will have. It is however likely that fewer children will become infected over the years if scale up of this PMTCT ARV prophylaxis regimen is successful.
- Similarly it is assumed that as early infant diagnosis is introduced as part of this proposal, more HIV infected infants will be diagnosed and channelled into treatment services.
- The 2007 HIV estimates, also approximate the number of children requiring HAART as 24,194, based on clinical/diagnostic staging with a total number of children infected with the virus as 132,938. Having just received the latest WHO recommendations to treat infants and children earlier, Zimbabwe recognises that it will need to adapt current treatment guidelines that base initiation of ARV treatment on clinical/diagnostic staging. This shift to earlier initiation of treatment for infants and children will have an affect on the current national targets that have been set which may change over the course of this five year grant.

4.5. Implementation strategy

4.5.1. Round 8 interventions

Explain: (i) who will be undertaking each area of activity (which Principal Recipient, which Sub-Recipient or other implementer); and (ii) the targeted population(s). *Ensure that the explanation follows the order of each objective, service delivery area (SDA) and indicator in the 'Performance Framework' (Attachment A) and work plan, and budget.*

Where there are planned activities that benefit the health system that can easily be included in the HIV program description (because they predominantly contribute to HIV outcomes), include them in this section only of the Round 8 proposal.

***Note**: If there are other activities that benefit, together, HIV, tuberculosis and malaria outcomes (and health outcomes beyond the three diseases), and these are not easily included in a 'disease program' strategy, they can be included in s.4B **in one disease proposal** in Round 8. The applicant will need to decide which disease to include s.4B (but only once). ➔ Refer to the Round 8 Guidelines (s.4.5.1.) for information on this choice.*

All the intended activities to be supported within this proposal are outlined in detail within the overall five year implementation plan.

Goal 1: Reduced number of new HIV infections in adults and children in Zimbabwe

This proposal is in support of critical gaps in HIV prevention strategies that are not already scaled up or supported. Social marketing and distribution of condoms is already catered for by other funding partners, while plans to introduce male circumcision as a prevention intervention are still under development and may be considered in future applications. Similarly distribution of family planning products is well established and has therefore not been included within this proposal.

Objective 1: Increased adoption of safer sexual behaviour and reduction in risk behaviour

Both the ***National AIDS Council*** and ***Zimbabwe AIDS Network*** will jointly manage the Behaviour change component as **PRs**; NAC will work with ***UNFPA, EMCOZ*** as ***SRs*** with ZAN managing **PSI/Safaids**. In advanced generalised epidemics like in Zimbabwe, sexual transmission of HIV in the general population is the major source of HIV infection. Consequently, behaviour change (BC) promotion targeting the entire sexually active population, but taking into account the important differences in exposure by age, sex, social factors and location, was identified as the core prevention strategy in the ZNASP 2006-2010 and the National BC Strategy[16]. The national strategy was based on comprehensive national reviews including an epidemiological review, a BC situation and response analysis, several national surveys, a national mapping of programmes and other key documents (ANNEX HIV 20: Evidence of HIV decline in Zimbabwe; a comprehensive review of the epidemiological data and ANNEX HIV 21: Comprehensive review of behaviour change as a means of prevention)[17]. The proposed support will contribute to scaling up implementation of this strategy using already existing implementation channels and modalities. The focus on mass media builds on the proven effectiveness of mass media approaches[18] in delivering key HIV prevention messages and promoting HIV service uptake. The focus on BC community outreach is complementary and equally essential, as the identified drivers of HIV (multiple concurrent partnerships, underlying gender issues, stigma and others) are complex social phenomena, which cannot be addressed through mass media alone as highlighted in the literature.[19]

SDA 1.1 describes **Prevention/ behaviour change through mass media**

[16] Population-level HIV declines in generalized HIV epidemics (Uganda, Kenya, Zimbabwe) have all been associated with behaviour changes in the general population, in particular partner reduction and in some settings condom use and delayed sexual debut. (See SADC: Expert Think Tank Meeting on HIV Prevention in High Prevalence Countries in Southern Africa, SADC 2006).
[17] UNAIDS 2005: Evidence for HIV Decline in Zimbabwe. A Comprehensive Review of the Epidemiological data. Harare; National AIDS Council/UNFPA 2006: Comprehensive Review of Behaviour Change as a Means of Prevention Sexual HIV Transmission. Harare. MOHCW, ZNFPC, NAC, CDC. 2004. Young Adult Survey 2001-2002; CSO, Macro International Inc. 2007. Zimbabwe Demographic and Health Survey 2005-2006. National AIDS Council/UNFPA 2006: HIV and AIDS District Atlas. Harare.
[18] WHO/ UNAIDS interagency task team on HIV and young people 2006: Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries: editors: David Ross, Bruce Dick, Jane Ferguson. Geneva.
[19] See for example: Wilson, David 2004: Partner reduction and the prevention of HIV/AIDS. *The most effective strategies come from within communities.* BMJ Volume 328, 10 April 2004.

The sub-recipient for SDA 1.1 will be a consortium of ***Population Services International (PSI) and SAFAIDS***. Both PSI and SAFAIDS have broad experience in the area of HIV prevention BC mass media communications, including as SRs under Global Fund Round 5. This consortium will work closely with local and international media experts, media agencies, producers, journalists, national television, radio and newspapers.

The overall target population for media programming is women and men aged 15-49. However, formative research will be utilised to make targeting of specific communications relevant to men and women of the different age and social groups. Mass media, community and work place-based BC promotion will encompass two major types of communication efforts: 1) BC communications focusing on prevention of sexual transmission of HIV taking into account broader issues of social change communications including gender issues and stigma as well as 2) HIV service communications promoting behaviour change in terms of uptake of PITC, PMTCT and OI/ART services.

Detailed concepts for communications will be developed in two consensus-building meetings (2009 and 2011) based on the national review documents, the national strategies and an update on the national epidemiological, behavioural and socio-cultural evidence-base. In terms of prevention of sexual HIV transmission, communication priorities will include: concurrent sexual partnerships, which have been identified as a key driver of HIV and are a priority in the National BC Strategy (target group: couples; women 15-39, men 20-39); gender norms that directly relate to HIV prevention including norms that condone risky behavioural patterns among men or prevent women from introducing safer sexual practices in relationships (target group: couples; women 15-39, men 20-39); issues of stigma reduction, positive prevention and prevention in discordant couples (target group: couples; women 15-39, men 20-39; PLWHIV); emerging issues including the benefits and risks of male circumcision (women and men 15-49).

In terms of service communications, the following priority areas have been identified: PITC, addressing aspects of risk perception and service availability, positioning testing as entry point to HIV treatment, care and support (target groups: sexually active men and women (age 15-49), caregivers of children, health care workers and general community); Prevention of Parent to Child Transmission addressing aspects of risk perception, benefits for families and male involvement (target groups: couples, pregnant women, and their families and the general community); OI/ART addressing aspects of treatment literacy, service availability and avoidance of risk compensation (target groups: PLWHIV and their families, persons who suspect they are infected and health care workers); and relationship of HIV and TB addressing importance of knowledge of HIV status in TB patients, awareness of TB symptoms and service availability (target groups: PLWHIV and their families, TB patients and their families, health care workers and the general community).

An overall multi-media plan will be developed to ensure the logical flow and complementary timing of the communications. The communications will include television programmes, radio programmes, newspaper adverts and dissemination of other print materials. The media campaigns will be complemented by interpersonal communication campaigns including road shows, drama in the workplace and at community level and other community mobilisation interventions (see SDA 1.2. below). To ensure that journalists and other media personnel have a good understanding of the ethical, medical and social issues around HIV and AIDS, a capacity-building component for journalists, producers, film and radio makers is included.

SDA 1.2 supports **Prevention/ behaviour change through community outreach**

BC community outreach will complement mass media communication and provide in-depth interpersonal communication on the thematic priorities outlined above. Particular focus will, however, be given to the more complex social aspects of the identified key drivers of HIV and the mentioned services. The approach and tools for IPC have been based on international best practices, which have proven effective at the level of behavioural and bio-marker evaluations. The effective Stepping Stones[20] approach has been adapted with a focus on key drivers identified in the national strategy. This approach will be used for community and work place based IPC. School-based IPC will build on the proven effectiveness of fo-

[20] Rachel Jewkes, Mzikazi Nduna, Jonathan Levin, Nwabisa Jama, Kristin Dunkle, Kate Wood, Mary Koss, Adrian Puren, Nata Duvvury: Evaluation of Stepping Stones, A Gender Transformative HIV Prevention Intervention. South Africa, 2007.
[21] For life-skills approaches, see: WHO/ UNAIDS interagency task team on HIV and young people 2006: Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries: editors: David Ross, Bruce Dick, Jane Ferguson. Geneva. For the school-based campaign see: Pascaline Dupas 2005: Relative Risks and the Market for Sex: Teenagers, Sugar Daddies and HIV in Kenya. Paris. The approach led to a 61 % risk reduction in teenage pregnancies by adult partners.
[22] The PMTCT programme is supported through other national proposals including: the USG support to EGPAF through the Family AIDS initiative; the DFID supported mothers and newborn programme; the Expanded support programme; a new grant from CIDA; UNICEF; and other partners including MSF, JICA, Plan etc.

cused gender and HIV life-skills education and a short-intensive exposure on HIV risk perception.[21]

There will be two SRs working on the different aspects of decentralised BC promotion under SDA 1.2:

a) ***UNFPA Zimbabwe*** will work with a consortium of local NGOs on **community-based and school-based HIV prevention**. Since 2007, UNFPA Zimbabwe manages overall implementation of the BC programme funded by the ESP and EC in 26 districts on behalf of the National AIDS Council. Through a competitive application process, 8 NGOs based in 8 provinces were selected for the actual implementation in 2006. The capacity of these 8 partners to manage evidence-based BC programmes has already been strengthened through ESP/EC support; wherefore the global fund support can focus on implementation in further 36 districts including Harare and Bulawayo. UNFPA will support the development of the capacity of as yet to be identified national organisations to become lead agencies for a multi-sectoral HIV prevention. It is proposed that after year 2 identified new organisations will then take on the managerial SR role, while UNFPA will focus on technical support. For that purpose a management unit with key functions on evidence-based prevention programming will be established.

A standard step-by step approach for development of localised HIV prevention BC responses will be used in communities and work places including: advocacy, sensitization and participatory action planning at district and community level using the approach tested in 26 districts and standard practices of Community-Centred Capacity Development (target group: 850 key district stakeholders including local authorities, traditional leadership, FBOs, NGOs, PLWHIV groups; 10,200 ward-level stakeholders); training of traditional, religious, business and other leaders as advocates and role models (target group: 4,080 leaders in 34 districts and Harare and Bulawayo); training of informal popular opinion leaders as behaviour change facilitators (target group: 4,080 BC facilitators; 2,040 females, 2,040 males); community sessions on HIV prevention BC provided by BC facilitators (target group for community-based IPC: sexually active population with sessions for the entire community and others for peer groups: adult women (24-49), adult men (24-49), young women (15-24), young men (15-24); specific sessions will be provided for key populations at higher risk such as women, OVC, PLWHIV and others).

These populations will also be involved through their active integration into ongoing community sessions such as: community video screening, condom distribution and referrals for services (target group: women and men of reproductive age); HIV prevention and gender life-skills education; school-based HIV risk perception campaign (target groups: teachers; adolescent boys and girls aged 12-19); and M&E and operational research.

b) *Employers' Confederation of Zimbabwe and the Zimbabwe Congress of Trade Unions (SR consortium)* will be responsible for **BC promotion in work places both the formal and informal in the private sector**. The consortium will be supported by ILO as technical manager in order to build their strength for policy and programme development and implementation in the first two years. The rationale for a separate focus on work place-based BC promotion is that large-scale enterprises in the mining, tourism, agriculture and other sectors are socially and geographically not fully integrated with local communities and face a different set of challenges often characterized by higher mobility and spousal separation. The same sequence of sensitisation, action planning and participatory sessions will be used with a focus on those key drivers of HIV, which are most relevant to the target group (target group: Male and female employers and workers aged 18-49). Treatment literacy campaigns within the workplace will be intensified. Advocacy for business leadership to commit resources for ARVs access for workers and their families will be scaled up through sensitization and awareness. Through private-public partnership between large corporates, SMEs and local authorities identified groups will be capacity built for community theatre and drama performances on HIV and AIDS education and awareness and creation of demand for services.

Objective 2: To increase the number of adults and children (18 months - 15 years) tested for HIV through the provider initiated testing and counselling approach (PITC).

Scale up of **HIV Testing and Counselling** is supported under **SDA 2.1.** In order to address the gaps in the wider roll out of PITC, the ***principle recipient NAC***, will allocate resources to ***the AIDS & TB unit within MOHCW and the College of Primary Care Physicians of Zimbabwe (CPCPZ) as sub-recipients*** with the overall responsibility of coordinating and implementing PITC activities in the public and private sector according to the national HIV testing and counselling strategic plan (HTC).

Activities will be undertaken to initiate and strengthen the integration of PITC at all levels of health care in the private and public sector. This will be ensured through initial cascade training of health care providers

through TOT training at provincial level and training of 3500 health care workers from the public and private sector at district level. Training will be carried out using the standardised national materials that cover issues pertinent to both adults and children. In addition, a total of 1500 health care workers will be trained in HIV rapid testing. Annual refresher training courses are included in the training strategy. Training will also include training of 180 Primary care Counsellor (PC) supervisors and a total of 800 PCs, who will be deployed at health facilities at all levels. Refresher courses for PC supervisors and PCs will be conducted on an annual basis. A one-day PITC sensitisation meeting in each district targeting district, mission, private hospitals and clinics in year 1, and all comprehensive PMTCT sites in year 2 will be conducted to ensure ownership and buy-in for PITC by all health workers and local decision makers. Sensitisation and training workshops will also be conducted for 9000 community based workers in all districts to enable community cadres to stimulate demand for HTC, to refer clients for HTC to the health facilities as well as to provide ongoing post-test supportive counselling for clients who have gone though HIV testing. Integration of PITC will include private sector providers including the workplaces and part of the strategy will consist of training peer educators in workplaces to discuss PITC with their peers and to increase uptake of T&C among workforces. A total of 500 peer educators at workplaces are expected to be trained through this strategy over the 5 years of the strategy.

The human resource crisis has adversely affected effective delivery of comprehensive HIV and AIDS services and other essential health services largely in the public and private sector in Zimbabwe. Human resources are needed at central level, as well as at provincial and district levels to coordinate the scale up of PITC at all levels of health care. The strategy is proposing to support Provincial and District health executive teams which have been included under Section 4B. The different senior health workers at provincial and district level e.g. PMD, PNOs etc already manage and coordinate each of the different components of HIV service delivery including PITC, PMTCT and OI/ART. In addition, one existing position that of the national T&C officer which is currently only supported until 2010 will be supported. Because of the scope of this large programme an additional assistant, who will be working with the national T&C officer, is proposed in this strategy. Primary Care counsellors (PCs) are the cornerstone of the PITC programme and the responsibilities of counselling on many different aspects of the HIV programme e.g. HTC, PMTCT, OI/ART adherence have been taken on by this cadre as task shifting has been recognised as a necessary health system strengthening strategy. In order to roll out PITC to the clinic level, an additional 800 PCs need to be recruited, trained and deployed. In addition allowances for 370 PCs currently supported by other programmes (270 through Global Fund Round 5), which will be coming to an end in 2010 will also be covered under this proposal.

Availability of appropriate physical infrastructure and equipment is critical for the delivery of quality HTC services. To conduct HIV counselling and testing according to national standards health care facilities need the necessary space and privacy to provide confidential services. To serve this purpose, health care facilities with limited capacity to accommodate and integrate PITC will be upgraded through minor renovations at identified facilities in the public sector. The same approach will be used in the private sector, where an assessment of the infrastructure of all health care facilities will be conducted to identify infrastructure gaps. The private sector health facility assessment will be supported by Global Fund Round 8 although it will be expected that private practitioners then use their own resources to upgrade properties and refurbishments have not been included.

In order to improve coordination and effectively manage procurement and supply management of HIV and AIDS related commodities the MOHCW has established an HIV and AIDS Logistics Sub Unit (LSU). The LSU is responsible for forecasting, quantification, procurement and distribution of HIV and AIDS commodities. A total of 1,662,700 HIV rapid test units over the course of five years will be procured in support of this component of the proposal. Similarly DBS bundles and reagents will be procured to support early infant diagnosis (see below). Plans are in progress to assess the performance of some rapid HIV test kits against the ELISA technology currently being used in the national ANC HIV sero-prevalence survey. The results obtained will also be used to decide on whether to adopt the serial testing algorithm for routine HIV testing. Serial testing will substantially reduce the number of HIV rapid test kits that are required to assess the HIV status of the 1,662,700 individuals to be tested with support from GF8. The surplus in funds will be used to test additional individuals or will be reprogrammed and used in other GF Round 8 programme areas.

The implementation of this strategy will require strengthening of programme management, coordination and monitoring capacity and skills among all key implementers and relevant stakeholders. Recognising

that prevention, care and treatment services come as an integrated package, a description of how this will be managed including strengthening of the M&E systems is described under Objective 4.

Although HTC services are increasingly becoming available the need to increase awareness of communities and individuals including specific target groups is an important determinant of utilisation of HTC services. The proposed intervention will continue and further expand on the communication activities implemented under Global Fund round 5. In close collaboration with the MoHCW the *SR SAFAIDS/PSI* will continue to develop communication strategies and campaigns to address primary and secondary target groups with the objective to build overall understanding on the critical issues of HTC as an entry point into HIV treatment care and support. All communication activities are integrated within the wider national HIV and AIDS communication strategy and are described under the BC component of this proposal.

Objective 3: To reduce transmission of HIV from mother to child by providing comprehensive PMTCT services.

SDA 3.1 supports the **Prevention of mother to child transmission of HIV**. The AIDS & TB unit within ***MOHCW* and *the College of Primary Care Physicians of Zimbabwe (CPCPZ)*** will be the two key SRs involved with ensuring implementation of activities under this objective and SDA 3.1. The main objective will be to continue reducing transmission of HIV from mother to child through provision of comprehensive PMTCT services in both the public and private sectors. Global fund round 8 activities will complement strengthening of maternal and child health services already being supported by other donors through technical partners[22]. These include efforts to continue to provide single dose NVP in ANC, scaling up family planning services, and strengthening of infant feeding practices as well as gender mainstreaming to promote greater male participation in reproductive health in general. MOHCW is supported by a number of strong INGO partners including EGPAF, JICA, Kapnek, MSF, OPHID, ZAPP and Zvitambo who will continue to assist through provision of both technical and additional funding to scale up and enhance PMTCT activities at a site level that will complement activities within this proposal. In addition NAC will support the *SR,* ***the College of Primary Care Physicians of Zimbabwe (CPCPZ),*** to implement PMTCT activities specifically to enhance efforts within the private sector.

Activities have been focused to ensure increased access for HIV-infected pregnant women to specifically receive more efficacious ARV prophylaxis to reduce the risk of mother-to-child transmission and to ensure eligible women receive ART for their own health. At national level, in order to ensure coordination, adequate supervision as well as effective monitoring, two programme officers will be recruited and retained to complement other senior managers within the AIDS & TB unit. To support scale up of more effective ARV prophylaxis within the already existing PMTCT programme, the Provincial and district health executive teams will provide technical, mentorship, coordination and routine monitoring of PMTCT at site level through integrated activities described under Objective 4 (refer to Section 4B). Specific preparatory capacity building visits will be undertaken by the District nursing officers to assist 60 comprehensive PMTCT sites within both the public and private sector to introduce the new ARV prophylaxis regimens each year. The pool of existing national and provincial trainers will undergo annual three day refresher courses each year to ensure scale up maintains quality, with a similar activity proposed for the district trainers. 300 health care workers from the public and 60 from the private sector will be trained (4 health workers per site) per year by the pool of national, provincial and district PMTCT trainers with additional support from collaborating technical partners. As well as the technical aspects of introducing more efficacious regimens e.g. drug protocols, side effects, training specifically will address improved assessment of WHO staging using both clinical and CD4 analysis, referral, follow up services and monitoring. As part of the national PMTCT curriculum, 360 health care workers will also be trained in infant feeding counselling each year an important step to encourage exclusive breast feeding. Integration of a module to support the introduction of MER will also be incorporated within the basic five day PMTCT course which will continue to be supported through complementary activities already covered by other donors. Training in adult and paediatric OI/ART management, which support a continuum of care and decentralised OI/ART provision including pregnant mothers are described under the care and treatment section. Exchange visits to encourage sharing of experiences and promote peer support will be undertaken in each district and the district nursing officers will carry out regular site support visits. Integrated national, provincial and district review meetings are planned as described below to provide a valuable platform for review of the PMTCT achievements and challenges.

Sites will be supported with the basic tools to deliver effective ANC and PMTCT services. This proposal

will support printing of the national registers used to support maternal child services as included under the M&E section under objective 4 within the implementation plan. These include printing of 2,000 ANC, 2,000 delivery and 1,000 follow up registers per year which will be distributed to all the national MCH sites. Printing of the hand held child health and ANC cards will also be undertaken. All these monitoring tools will be made available within both the private and public sector. In total, it is expected that over five years, 99,540 HIV infected pregnant women and their exposed infants will be supported by this grant to receive a course of the more efficacious ARV prophylaxis based on Zidovudine and sd-NVP to both mother and infant, with a post-partum Combivir® tail for the mother. Basic essential drugs will be procured for all attending pregnant women at the targeted sites. This will complement activities on MER undertaken through support of CIDA, ESP, INGOs and other bilateral and multilateral donors as well as the ongoing delivery of the PMTCT programme based on single dose Nevirapine. Hand held haemoglobin machines will be procured for all health facilities providing reproductive services to enable greater assessment of at risk pregnancies and thereby improved management. Procurement of ARVs and ANC basic drugs will be undertaken through the national logistics system who will be responsible for quantifying annual need, procuring and distribution to sites. Procurement of drugs will support the 60 comprehensive PMTCT sites that will be targeted on a yearly basis including the private sector. As the expansion of the programme is achieved, smaller volume sites will be targeted. Drugs will be distributed through the already existing delivery team top up system supported by other donors.

To ensure national ownership, wide acceptance and high uptake of the PMTCT programme, sensitisation of policy makers, partners, communities and all other stakeholders, including those in the private sector, will be an ongoing activity already supported within the PMTCT programme. Community sensitisation on PMTCT issues, gender disparities and increased male involvement have already been described within the BC component of the proposal. However additional specific community campaigns to mobilise support for the PMTCT that complement existing activities will also be undertaken spearheaded by the health promotion teams in each of the districts and will be carried out on a bi-annual basis.

Activities will also be undertaken to initiate and strengthen the integration of early infant diagnosis services within health care facilities that are providing HIV testing and counselling services (private and public sector). This includes targeting sites that provide routine reproductive and child health services such as EPI services as well as in-patient and out-patient services. In order to support scale up, two provincial laboratories will be refurbished in Mutare and Bulawayo and two new PCR machines will be procured. To process samples efficiently, the capacity of the National Microbiology Reference Laboratory (NMRL) will be expanded by retaining two HIV specialist laboratory scientists after 2010 (supported by CHAI) and recruiting six new HIV specialist laboratory scientists (including two each for Mpilo and Mutare). Five laboratory data officers will be retained/recruited to ensure effective turn around times ensuring results reach the clinics in a timely fashion. The NatPharm consortium will procure all the DBS bundles required and sufficient HIV DNA PCR reagents to run the tests. Quality assurance will be maintained by the NMRL and all machines will be serviced regularly. Samples will be collected from sites using the EMS system and funds will be used to ensure standardised recording at both a clinic and laboratory level by printing standardised national registers and forms. This will be done through sensitisation of provincial, district and site level decision makers, health care workers from both the public and private sector and the communities themselves. Two day training courses to equip health care workers (nurses, doctors and laboratory scientists) to properly collect dry blood spots (DBS) for HIV DNA PCR testing for infants will be undertaken facilitated by national trainers. 360 health care workers will be trained each year and 60 public and private sites will be targeted annually to provide early infant diagnostic services. Integrated training on DBS will also be included within the paediatric OI/ART and basic PMTCT training. It is expected that this proposal will enable a total of 86,708 tests to be run during the five years, a target based on the volume of HIV exposed infants to be followed up at the targeted sites. Information on the number of HIV exposed infants tested using HIV DNA PCR and this indicator will have been integrated within the national M&E reporting system.

SDA 3.2 supports the **Integration of family planning into HIV services (prevention of unintended pregnancies among women living with HIV)**

Coordinated by the ***Zimbabwe National Family Planning Council as sub-recipient,*** family planning is already an integrated part of the PMTCT curriculum and is taught as part of the basic PMTCT courses, recognizing this as an important prong within the WHO PMTCT framework. However wider integration within other programme areas has yet to occur. National integrated training materials that complement the OI/ART and PITC training and community counselling courses will therefore be developed using par-

ticipatory processes. Standardised materials will be printed to be used by tutors to train 1,500 community based health cadres on provision of family planning services within the context of HIV. Health care workers within the public and private sector will receive training on FP as part of the integrated OI/ART training that is mentioned within the care and treatment section. Training will be integrated as part of other training modules to cut down on the amount of time that health care workers need to go away from sites to attend courses. Job aides will be developed to be used during community counselling sessions and at health facilities. Regular supervisory visits will be carried out at provincial and district level by the national and provincial ZNFPC officers to support both district health teams and community supervisors to strengthen the quality of family planning services and to support integration and improved monitoring. A national review meeting will be organised on an annual basis with bi-annual provincial meetings to specifically address monitoring of progress and address technical issues.

GOAL 2: Reduced morbidity and mortality due to HIV and AIDS in Zimbabwe.

Objective 4: To expand the provision of comprehensive HIV and AIDS care, treatment and support including ART services in both private and public sector.

The ***National AIDS Council*** will be the ***PR*** responsible for overall programme management and coordination under **SDA 4.1 – 4.4** with ***MOHCW, University of Zimbabwe, Department of Medicine and the College of Primary Care Physicians of Zimbabwe*** managing direct implementation of activities as SRs. **SDA 4.1** refers to **Antiretroviral Therapy and OI Management.** The Global Fund round 8 treatment targets for this proposal (as outlined in appendix A) are paramount to attaining the overall national targets that have been set within the national HIV care and treatment programme. Specifically this proposal will support the provision of adult and paediatric first line, first line alternate and second line antiretroviral therapy as laid out in the implementation plan that: address the current gaps for adults and children given an appreciation of the Zimbabwe HIV epidemic; go hand in hand with efforts already described under the BC, PITC and PMTCT components; are mindful of previous rounds of Global fund support; appreciate the challenging operating environment; and that factor in contributions already being made by other donors and stakeholders (refer to ANNEX 14: Consolidated gap analysis). The proposal intends to initiate a total of 120,000 new adult HIV infected women (60% of the total number of adults) and men on treatment, maintaining a total of 208,500 adults on treatment by the end of year 5. In addition, provision of ARVs to infants/children will absorb the number being supported by the Clinton Foundation until the end of 2010 as well as initiate a further 25,000 new cases by the end of the grant. An additional 116,500 adult patients are assumed be maintained on ARVs through government, private sector and other donor support. The intention is to ensure initiation of treatment for children living with HIV and AIDS as well as PLWHIV with advanced disease, maintenance of treatment for PLWHIV initiated on treatment and clinical and laboratory monitoring of patients on treatment according to national guidelines. Linked with efforts to increase the number of HIV exposed infants tested, an increasing number of children on treatment are likely to be below 18 months and this has been factored into the quantifications. It is appreciated that an additional gap remains in terms of meeting national targets and continued complimentary resource mobilisation will be ongoing to leverage the efforts being made within this support and others e.g. ESP so that the maximum impact is obtained. Cotrimoxazole prophylaxis for adults will be provided to existing ART patients and for an additional registered number of adult patients receiving OI services. Global fund round 8 will also take over procurement of Cotrimoxazole for HIV exposed infants and children from year 2 onwards, as this is currently being donated by the Clinton Foundation.

The support these targets, activities will be implemented by health workers at accredited OI/ART sites, in collaboration with District Health Executive management teams, district laboratories and pharmacies, cadres whose necessary roles are included under Section 4B. It is also assumed that the level of additional support from technical partners in each district to supplement these activities will also be maintained. Mission Hospitals and private sector companies will also participate in overall district planning and service delivery including combined trainings. ***The College of Primary Care Physicians of Zimbabwe, University of Zimbabwe- Department of Medicine and private sector companies*** *as SRs* will be provided with ARVs and Opportunistic Infections medicines to deliver OI/ART services to their clients. A memorandum of understanding will be drawn up to ensure that patients are not charged for ARVs that are provided by the Global fund round 8 and this will form part of the sub-contractual agreement. A system whereby MOHCW takes over treatment for these clients will be developed. ARVs will be provided free of charge to patients within the public and private sector. The ***Ministry of Health and Child Welfare*** *as SR* will identify and assess 1,340 health facilities over five years for infrastructure, laboratory, and pharmacy service capacity in the public and private sectors to be able to provide either comprehensive and follow up

HIV/AIDS services. This proposal also seeks support for the minor refurbishments of health facility infrastructure to effectively deliver comprehensive HIV/AIDS services at 120 health care facilities in the public sector only. Most of the health facility renovations will target primary care clinics so as effect the plan to decentralise HIV care to clinics as a measure to improve geographic access to OI/HIV services. In addition, the capacity of the two quaternary referral OI/ART clinics based within Parirenyatwa hospital in Harare and Mpilo hospital in Bulawayo (both university teaching hospitals) will be strengthened, to provide leadership in the provision of quality clinical care. Activities will include mentorship, clinical attachments, continuing medical education, operational research and guidance on management of complicated cases.

ARV drugs (first and second line, for both adults and children including paediatric fixed dose combinations) will be procured by Natpharm and the Crown Agents consortium as the Procuring Agent using the most competitive quality products available, and as estimated in the attached detailed budget and implementation plan. Drugs to be purchased each year have been calculated based on the expected number of adults and children to be reached as outlined in section 4.2. Assumptions based on previous experience within the OI/ART programme have been made to forecast quantities of first line, second line and pediatric formulations. The programme will procure Cotrimoxazole for use as prophylaxis for patients: presenting with WHO clinical stages 2, 3 and 4 disease; patients with CD4 counts less than 200; and all infants born to HIV positive mothers to be prescribed from 6 weeks onwards until an HIV status is established upon testing. In addition adequate quantities of laboratory diagnostic reagents (CD4, haematology, chemistry, HIV DNA PCR, viral load and rapid HIV tests kits) will be procured to ensure effective monitoring of patients. Based on the gap analysis in Annex 14, an additional 24 CD4 machines, 19 chemistry machines, 18 haematology analyzers, 24 freezers and 24 refrigerators to strengthen diagnostic capacity in Districts and within the centres of excellence is proposed. The PCR machines are also capable of running viral load analysis and will double up to carry out these tests. Two coagulation machines to carry out coagulation studies will also be procured. These are required to monitor liver side effects and complicated cases. Lipid profiles, lipase, lactate and amylase reagents will be procured and run using equipment that already exists at Parirenyatwa and Mpilo hospitals. Regular quality control and servicing of equipment have been factored into the proposal.

Strengthening the management and coordination of all aspects of the HIV programme is critical to achieve greater impact are described under **SDA 4.2** which supports the **health workforce**. Key personnel at national level including a deputy ART coordinator and a finance/administrator will be supported within the AIDS & TB unit, positions already supported under GF round 5. Annual integrated national HIV/AIDS/TB/STI review meetings will be held to review all aspects of the HIV response along with 5 provincial review meetings which will complement activities already supported by other donors in Zimbabwe. The Provincial Medical Directors (PMDs) will be responsible for the smooth running of these meetings for HIV/AIDS, TB, PMTCT, HTC, FP and STI programmes aimed at strengthening programme linkages and coordination across HIV/AIDS and related programmes (support for these posts are included under Section 4B). Furthermore, in collaboration with the District AIDS Action Committees (DAAC), the 46 DHEs (excluding 16 ESP supported districts) will hold 2 1/2 day bi-annual meetings with other HIV and AIDS service providers and partners aimed at improving coordination, sharing progress and addressing challenges within each district. The forum will provide a platform for information sharing, peer reviews and updating on advances in best-practices with the view to improve overall service delivery including PITC and PMTCT. The MOHCW will provide support and supervision for health and non-health staff involved in HIV/AIDS prevention, care, and treatment. Office equipment and furniture, and vehicles for programme support will be required and procured. Vehicles for districts that have not received resources either through GF5, the ESP or other partners will be immediately procured with an expected need to replace existing HIV support vehicles in the third year of implementation.

In order to monitor the emergence of HIV Drug resistance (HIV-DR) patterns, Zimbabwe has adapted the WHO HIV-DR monitoring protocol and will conduct monitoring in selected sentinel sites in the country with support from WHO, CDC, ESP and GF. Laboratory capacity to monitor HIV-DR will be strengthened through additional staff, procurement of equipment (HIV DNA PCR machines already mentioned will carry out viral load testing) and reagents to conduct viral load testing and genotyping, and a strong element of training, supervision and site support visits will be undertaken. Further detailed description of activities to strengthen the national monitoring and evaluation system is described in Section 4.8.

For successful programme implementation, it is essential to have adequate number of health workers that are competent to provide OI/ART services to both adults and children. In order to improve competency in delivering OI/ART, the *Ministry of Health and Child Welfare, CPCPZ, University of Zimbabwe* and other

partners will conduct national training of training and refresher courses in OI/ART management in both public and private sector. The TOTs will be followed by in-service OI/ART training for health workers including doctors, clinical officers, nurses, counsellors, laboratory and pharmacy staff and other cadres to include 2,100 cadres from the public sector and 200 from the private sector. Follow up supervisory and mentoring visits will be conducted on a regular basis, building upon the establishment of a mentorship system due to be developed under Global fund round 5. Quality assurance monitoring visits will be conducted by experienced and senior health workers from higher levels so as to assure high quality of HIV services at ART sites and these will be combined with the mentoring visits.

SDA 4.3 supports **collaborative TB/HIV activities**. ***The College of Primary Care Physicians, University of Zimbabwe, and the Ministry of Health as SRs*** will conduct intensified TB case-finding among PLWHA through screening of all HIV positive patients for TB at each entry point in both public and private sector. Patients with dual TB and HIV infection will be commenced on Cotrimoxazole preventative therapy and TB patients eligible for ART will be initiated on ART. This will be achieved by developing national TB infection control policy and guidelines to be used by health workers at all facilities (budgeted under the TB proposal). Training of health workers in these and intensified TB case finding will be undertaken targeting 2000 health workers from the private and public sector each year. Infection control plans will be drawn up at each health care facility and improvements in air ventilation systems in waiting areas and wards will be carried out with procurement of personal protective devices (PPD)/respirators for staff in MDR wards (N95 masks) has been included under the TB disease component. Finally strengthened monitoring and supervision of infection control practices will be carried out during supervisory visits to hospitals as part of the overall support to sites.

The programme will be monitored to ensure that intended goals and objectives are met with specific aims to improve the quality of care, monitor HIV drug resistance, collect quality streamlined data in a timely fashion and carry out operational research to improve programme approaches and interventions. These fall under **SDA 4.4** which cover **Monitoring and Evaluation** activities. Currently there are three full time M&E officers supported by other donors within the AIDS & TB unit and a further two additional M&E officers will be recruited to complement this team to assist in spearheading the integration of the M&E systems. An additional M&E officer to strengthen monitoring in the private sector is also proposed which is incorporated into the administration support to CPCPZ. The Ministry of Health will train staff in both public and private sector in reporting on the national OI/ART M & E system. An electronic database will be developed and tools will be synchronized and piloted before scaling up. Finally the University of Zimbabwe in collaboration with other partners will train health workers on Operations Research using the ART Research Agenda for Zimbabwe. Operations Research will be carried out in public and private health institutions. The MOHCW and UZ will provide support and supervisory visits to sites conducting operations research. Research grants linked to the Harare centre of excellence will also be administered as part of this proposal.

Objective 5: Strengthen the involvement of communities in the provision of ART services.

SDA 5.1 describes **Care and support for the chronically ill**. ***HOSPAZ as SR*** with ***ZAN as the guiding PR*** will build the capacity of CHBC organisations in providing palliative care in the home setting as well as strengthen the capacity of other care providers in the continuum of care to support the home based care providers. HOSPAZ will conduct two TOTs; one for home based care officers to facilitate food security initiatives and the other to train additional trainers on basic HIV and AIDS and TB/HIV co-management focusing on prevention, care, treatment and support utilising the harmonised national training package. These trainings will then be cascaded down to involve community level workers including secondary and primary caregivers and village health workers, as well as their supervisors at the district levels who will be drawn from the Ministry of Health and Child Welfare and AIDS Service organisations. Districts to be targeted include those not already supported with similar activities that are ongoing under the ESP. To facilitate food security for CHBC clients on treatment, *HOSPAZ* will network with organisations specialising in agriculture to conduct the training to promote sustainability within the programme. To enable community health workers to implement these activities, provision of 4,800 home based care kits and 52,500 replenishment kits will provided yearly to the chronically ill. Supporting IEC materials will also be disseminated to beneficiaries. To complement, de-stigmatise and support these activities, *HOSPAZ* will also conduct district CMEIAST (Community Mobilisation and Empowerment for Improved Access to care, Support and Treatment) training workshops in the 46 districts including Harare and Bulawayo (excluding ESP districts) with a target of two trainers per district. Participants will be drawn from HOSPAZ membership as well as

other CHBC implementing organisations. Training will be cascaded to community leaders (who include, headmen, chiefs, religious leaders, traditional leaders, teachers, representatives of civil servants in the area, police and other influential people) and caregivers, targeting 20 community leaders and caregivers in 48 districts including Harare and Bulawayo. IEC materials to support care and ART literacy materials will also be distributed throughout the programme and treatment buddies will be supported to complement efforts.

Supporting the community based health care workers with remunerations, uniforms and bicycles have been included as an important part of the cross cutting health systems strengthening in section 4B. In addition, motorbikes will be procured to support supervision and coordination, by district CHBC supervisors in all districts. To oversee implementation of these activities, HOSPAZ will be supported by various salaried posts, as well as vehicles and office equipment including computers. HOSPAZ will be responsible for carrying out mentoring and monitoring visits to organisations implementing CHBC activities. To supplement monitoring activities already described in Section 4.8.3. annual review meetings will also be held.

Objective 6: To strengthen national institutional capacity to coordinate OVC interventions.

To enhance efforts under **SDA 6.1**, ***MoPSLSW as SR*** will be responsible for **strengthening the coordination of the national OVC programme**. The National Action Plan for Orphans and Vulnerable Children (NAP for OVC) was developed in 2005 and is being implemented in a collaborative multi-sectoral manner by both government and civil society organisations (CSO). Provision of support is described within this plan and is therefore not detailed here (ANNEX HIV 11 & 34) but implementation is already adequately supported by other donors. Additional resources are however required to support the coordination structures (Child Protection Committees) that are steered by core teams at national and sub-national levels. The National Core team comprises of the NAP for OVC Secretariat, NAC and UNICEF with the Provincial and District core teams comprising of MoPSLSW, another ministry, NAC, a local authority and two CSOs. The MoPSLSW will retain its critical posts of NAP for OVC coordinators (1 at national, 10 provincial and 63 district posts) responsible for coordinating, monitoring and providing supervision of OVC interventions. To equip the coordinators and strengthen the collaborative approach, training in programme coordination and management, M&E, right based programming and community centred capacity development will be undertaken facilitated by the national core team. The first national training of trainers will involve 30 participants, 3 per province drawn from provincial core teams (MoPSLSW, NAC and one CSO). These will be responsible for cascading training to district core teams – 4 per district drawn from MoPSLSW, NAC, Local Authorities and one CSO. From the 67 administrative districts, 268 officers will be trained. In turn, the district core teams will be responsible for working with community leaders and focal persons. They will monitor and mentor communities and promote the use of OVC village registers and the use of the Child Status Index (CSI) for communities to monitor the wellbeing of OVC. Core teams at all levels are also responsible for disseminating information and promoting functional relationships among stakeholders. This is managed through Working Party of Officials (this is the national OVC working group) at national level and Child Protection Committees at sub national level. Information sharing meetings are held quarterly.

Objective 7: To strengthen mechanisms for coordination, collaboration and accountability among PLWHIV networks in the mainstreaming of MIPA within the national response.

SDA 7.1 details activities in support of **strengthening of networks of PLWHIV and institutional capacity building**. ***The Zimbabwe national network of people living positively (ZNNP+) as SR*** will be responsible for strengthening networks of PLWHIV with technical support from NAC and additional management support from ***ZAN as the PR***. Mapping of support groups and organisations of PLWHIV will be undertaken in year one to establish a baseline of networks. This will involve the development of a computerised database to be managed at national and sub-national level. Based on needs assessments to be carried out in 15 PLWHIV organisations by end of year one. TOT workshops will be conducted at national level and cascaded to provincial and district levels where training of members of PLWHIV networks will be capacitated to be able to effectively represent their constituents in the coordinating structures. Capacity building initiatives will also be conducted for support groups including the private sector in strategic planning, organisational development and data collection and management skills. Development of national standard guidelines (which will be translated into vernacular languages) for support groups will be developed through participatory processes and subsequently 1000 copies of the guidelines will be printed and disseminated to organisations identified in year 1. Quarterly support and M&E visits by 3 na-

tional and 1 provincial officers to facilitate operationalisation of these guidelines and monitor their application by PLWHIV groups in communities and work places will also be undertaken. Through similar participatory consultations a national advocacy strategy will be developed, finalised and printed to guide national efforts to support more meaningful involvement of PLHWIV. This will then be disseminated to strengthen advocacy efforts at a district level. Exchange visits between support groups of people living with HIV will be organised to encourage greater harmonisation of efforts. One annual national general meeting and semi-annual provincial planning and coordination meetings will be undertaken. Quarterly district level review and monitoring meetings with PLWHIV support groups coordinated by the district PLWHIV representatives will support progress and data collection. In order to coordinate and strengthen the capacity of individual networks, ZNNP+ will procure national vehicles, computers and office equipment to enable activities to be supported effectively. These will be distributed accordingly to the four national networks for youth, women and ZNNP+ as well as support provincial offices. Remuneration of 7 national coordinators including an advocacy, M&E, finance/administrator and training officer, as well as youth and faith based and overall coordinators at national and provincial level have also been included.

4.5.2. Re-submission of Round 7 (or Round 6) proposal not recommended by the TRP

If relevant, describe adjustments made to the implementation plans and activities to take into account each of the 'weaknesses' identified in the 'TRP Review Form' in Round 7 (or, Round 6, if that was the last application applied for and not recommended for funding).

N/A

4.5.3. Lessons learned from implementation experience

How do the implementation plans and activities described in 4.5.1 above draw on lessons learned from program implementation (whether Global Fund grants or otherwise)?

The component on **HIV prevention behaviour change** promotion draws on experience from several previous and ongoing implementation efforts. A national response analysis conducted in 2005 summarised achievements, challenges and lessons learned[23]. Areas of successful programme implementation included condom distribution and social marketing as well as mass media programming. PSI/Zimbabwe and Safaids, the SR consortium for mass media have documented successful approaches of service communications in Zimbabwe, which evidently led to increased uptake of voluntary counselling and testing (VCT) and condoms. These effective campaign strategies will be replicated and applied to the planned campaigns on PITC, PMTCT, OI/ART and HIV/TB linkages. At the same time it was found that multi-media efforts on delayed debut were less successful and a new campaign focus was place around issues of concurrent sexual partnerships. Further lessons are currently being gathered by PSI and Safaids during implementation of GF Round 5. In the field of community outreach and interpersonal BC communication, the National BC Strategy integrated important lessons from the national BC review. Consequently, an approach focused on key drivers of HIV, a system to ensure more systematic coverage and evidence-based tools were developed and are currently in use in 26 districts. While in the previous national plans emphasis in BC community outreach had been placed on youth-to-youth peer approaches, it was found that age-disparate sex was the main entry for HIV infection among young women, which required involvement of adult men who make most decisions in such sexual relations affecting youth. As a lesson of this finding, a more comprehensive community approach to BC was developed building on proven effective community approaches involving adults and youths both in joint and separate sessions. Based on a documented best practice from the 2000-2004 District Response Initiative an approach of leadership involvement was developed, applied in 26 districts and currently being documented through operational research. The current approach involving careful advocacy, participatory planning and training of leaders proved useful in enhancing acceptability and ownership of BC promotion among local leaders and gatekeepers who have started speaking out for responsible practices and documenting their experiences.

A situation analysis conducted among large enterprises in support of the preparation of the Zimbabwe National Strategic Framework for the Private Sector Response to HIV and AIDS (2007-2010) showed that only 10% of private sector workplaces assessed had conducted research on the impact of HIV and AIDS,

[23] National AIDS Council/UNFPA 2006: Comprehensive Review of Behaviour Change as a Means of Prevention Sexual HIV Transmission. Harare. ANNEX 21.

43% had workplace policies. Stigma and discrimination were reported to be the most important barriers to HIV prevention, tackled by strengthened workplace policies. Most of those enterprises that had developed workplace policies needed technical assistance to formulate and implement programmes. For effective implementation, service providers will be accredited to ensure that organisations receive appropriate technical services. Studies on the situation in the transport[24], small and medium enterprise and informal sectors[25] have also shown the need for platforms for information sharing, improved working conditions, involvement of communities and improved access to health facilities for employees through referral systems.

The component on **HIV testing and counselling** draws on experience from successful implementation of PITC in the antenatal clinic setting where HIV testing has routinely been offered to all pregnant women since 2005. Uptake of HIV testing after routine offer among pregnant women is as high as 80-90% and a total of 710 health care facilities are currently offering PITC to pregnant women at the antenatal clinic. A key lesson has been to ensure that more than one nurse is trained at any one PMTCT site so under this grant further training in PITC and HIV rapid testing will be undertaken as well as including staff from lower level health care facilities in the roll out. In 2007 the MOHCW started a 6 month pilot phase of integration of PITC in settings other than ANC, where HIV testing was routinely offered to all patients accessing care at health facilities at all levels of health care including those from the private sector. A feasibility and acceptability study was conducted during the pilot phase. Qualitative assessments using focus group discussions and in depth interviews with service providers and patients showed that PITC was widely acceptable by both groups. Major recommendations from the providers suggested that the counselling and testing capacity needed to be increased to accommodate the PITC approach. Primary Care counsellors (PCs) were seen as the lynchpin in the roll out of PITC and additional PCs were needed at all level of health care. In addition all health care personnel needed to be trained and sensitised on PITC to ensure that HIV testing was offered to all patients entering the health system and a strong M&E supervisory system needed to be put in place to ensure that PITC was integrated in routine health care according to standard operating procedures. An uninterrupted supply of commodities such as HIV test kits was cited as another critical component of the scale up of PITC. Further recommendations included the need for ongoing post-test support services for patients who test HIV positive and to strengthen the capacity of community based organisations to provide ongoing counselling for these patients. These recommendations have been included in the implementation plan for the scale up of PITC and are included in this proposal. Acceptance of HIV testing after routine offer was especially high among pregnant women (100%) and in-patients (100%), but only 50% among outpatients and uptake of HIV testing and counselling after routine offer was especially low among men and youth. A comprehensive communication campaign using mass media and interpersonal communications will improve awareness about PITC, reduce HIV related stigma and address barriers of uptake of HIV testing and counselling especially among those target groups where uptake was low.

Within **the PMTCT programme** the focus of scaling up the two interventions described within this proposal are based on important lessons learnt from two national pilot initiatives that explored the feasibility of introducing both early infant diagnosis (EID) in 2007 and more efficacious PMTCT regimens in 2006 within the national context. Emerging results from the EID pilot highlight the need to include different cadres of health care workers e.g. laboratory staff, managers, nurses, counsellors at multiple entry points e.g. inpatients, EPI clinics, PMTCT sites. An important facilitator to enable rapid expansion of EID is to ensure that there is adequate capacity of the National Microbiology Reference Laboratory services to enable both quality assurance and quick turn around times of samples being received. The results from the pilot project supporting introduction of more efficacious regimen (draft final report available) highlighted critical areas to address which included adequate supervision, sufficient number of health workers trained both formally and on the job, the use of simplified integrated registers and reporting systems and a strong logistical system. Greater access to CD4 analysis was also seen as key to enable appropriate assessment for eligibility for HAART. Furthermore sensitisation about the more efficacious PMTCT regimens was found to be critical at both health facility and community levels. The national scale up plans have therefore been based on these important learning experiences with further input from technical experts from the PMTCT partnership forum as well as provincial and district medical and nursing officers to ensure that the processes that will be used remain practical and realistic. Expansion of both these initiatives will continue in 2008 and 2009 supported by other funding with technical partner support, whilst still maintaining

[24] Page, S. 2007. Planes, Trains and Automobiles: The Transport Sector Response to HIV and AIDS in Zimbabwe
[25] ILO and Ministry of Small and Medium Enterprises Development, Zimbabwe 2006. The Impact of HIV/AIDS on the SME sector in Zimbabwe. Harare, Zimbabwe.

single dose Nevirapine as the minimum package to be prescribed within the PMTCT programme. This will enable a phased introduction of these initiatives to continue which will continue to be documented and regularly reviewed.

A recent assessment of the **national care and treatment programme** has been undertaken during May 2008 (ANNEX HIV 22: Draft report national OI/ART assessment 2008). From the findings of this extensive review it was found that government commitment and leadership has been central to the success of the national OI/ART scale up achievements in Zimbabwe and that with adequate collaboration and coordination it is possible to scale up and attain universal access. The approaches so far have seen increasing access to ART services within OI/ART specific clinics with a few examples of good outreach and decentralisation models that now need to be emulated. Coordination, supervision and mentorship is still required based on the experiences gathered so far whilst paediatric HIV services particularly for young infants and adolescents need to be strengthened. All these areas will be addressed within this proposal by supporting not only some critical staff positions but by decentralising OI/ART services for adults and children both within the public and private sector through OI/ART preparatory assessments, training and provision of ARVs. Supporting a centre of excellence will assist in spearheading quality of care issues that need further attention according to the national assessment. Similarly it is clear that whilst the national programme has gone some way to start to strengthen M&E activities, further integration and deployment of computerised data based systems is required. In addition, whilst access to diagnostic services is improving, capacity building, ensuring ongoing quality assurance and procurement of further equipment has been recommended as priority areas to address. Models for delivery of community home base care activities similarly have been reviewed to harmonise national efforts. Based on these, national guidelines and training materials have been standardised to support further scale up of activities.

Coordination of OVC and PLWHIV activities: An audit of the MoPSLSW's capacity to coordinate the programme was undertaken in 2005 and established that MoPSLSW operated at 56% of its strength. The recommendations on creation and rationalisation of posts were attended to and all the 77 posts at sub-national level (10 provincial and 67 district coordinators) were filled over time. The brain drain caused by poor conditions of service has, however, negated the efforts and compromised the ministry's ability to oversee the implementation of the NAP for OVC hence the required payment of retention allowances, resourcing the structures and skills transfer. Currently there is a MIPA officer within NAC to coordinate activities to support PLWHIV. However operationalising plans and spearheading advocacy campaigns has been a challenge due to the low capacity of organisations such as the national network of PLWHIV to strengthen national initiatives. Strategies to address gaps that have been identified by networks of PLHWA are currently being developed.

4.5.4. Enhancing social and gender equality

Explain how the overall strategy of this proposal will contribute to achieving equality in your country in respect of the provision of access to high quality, affordable and locally available HIV prevention, treatment and/or care and support services.

*(If certain population groups face barriers to access, **such as women and girls, adolescents, sexual minorities and other key affected populations**, ensure that your explanation disaggregates the response between these key population groups).*

An HIV response built around equity and equality

The specific prioritisation of MDGs 1, 3 and 6 in Zimbabwe (see. 4.7.2.) has resulted in a strong emphasis on linkages of gender, social equality and HIV programming. Promoting gender and social equality are also key elements of the Zimbabwe National Strategic Plan on HIV and AIDS (2006-2010) as well as a number of its sub-strategies including a National Plan of Action on Women, Girls and HIV and AIDS and a Gender Based Violence Law (ANNEX HIV 23). While these policies are now in place, their implementation has only started in recent years. The proposed GF support will be one critical pillar in taking the implementation of these equity-focused policies to scale. Significant experience is being gathered in ongoing programmes such as a multi-sectoral NAC coordinated and EC/UNFPA supported initiative "Engendering HIV Prevention" implemented by 8 NGOs in 10 of 60 districts in Zimbabwe as part of the implementation of the National Behaviour Change Strategy. The GF support will be used to take such existing approaches to scale and further refine them.

Addressing gender imbalances as underlying factors for HIV transmission and to ensure equality

in access and involvement

Zimbabwe has experienced a clear trend towards feminization of the HIV epidemic. In the 2005/06, DHS HIV prevalence was found to be 21.1 % among women aged 15-49 and 14.5 % among men. Gender related norms increase HIV related vulnerabilities of Zimbabwean women, girls, men and boys in different ways. While women and girls are particularly affected at this stage of the epidemic, the underlying gender dynamics require a combined approach of building women's ability to protect themselves *and* strengthening male responsibility. A comprehensive review of survey data found that females consistently lag behind males in most areas of HIV related knowledge and tend to report lower levels of condom use. Girls are commonly raised to be submissive and unaware of sexual matters until marriage. The community, workplace and school-based HIV prevention approach will therefore address women's and girl's HIV prevention skills in specific sessions for adult and young women including aspects of risk perception, self-confidence, communication and safe sex negotiation. The difference in HIV prevalence between women and men is most pronounced between young women aged 15-24 (11.0 %) and their male peers (4.2%)[26]. This is mostly explained by the fact that age differentials at first sex and in subsequent sexual experience are particularly high in Zimbabwe and form an important epidemiological vector affecting young women, primarily because older men have higher infection rates than young men. This will be specifically addressed through interpersonal communication building on proven effectiveness of increasing young women's risk perception specifically on sexual relations with more experienced partners[27].

How men and boys are affected by HIV, is determined by several factors including concepts of masculinity, social expectations and labour relations, which separate them from their families. This is coupled with limited health-seeking behaviour such as lower and late uptake of HIV services by men leading to late diagnosis, late treatment and consequently high mortality. Men consistently report higher numbers of sexual partners and lower levels of uptake of HIV testing and counselling services. In 61% of the serodiscordant couples in Zimbabwe, the man is the HIV positive partner[28]. Analysis of behavioural data has, however, also shown that there has already been some positive behaviour change in men in Zimbabwe, including reduction in multiple partners and high condom use with non-regular partners. The approach towards involving men will build on such positive trends and use an approach currently being used in 26 districts. This involves training of leaders as advocates for and role models in responsible manhood. Interpersonal communication will be provided at community-level and in work places towards responsible sexual behaviour, uptake of HIV services, and greater male involvement in PMTCT.

Community-based HIV prevention will also include an element of Gender-based violence prevention. In addition, the HIV prevention approach includes a number of specific activities to promote gender equality. This includes a module to train leaders as advocates for gender equality, gender-focused life-skills education in schools, community sessions on gender equality, and advocacy with local authorities to ensure access of women to existing community resources. The tools for the behavioural change component - currently already being used in 26 districts - have a strong gender focus, as they are a local adaptation of the evidentially effective[29] Stepping Stones methodology, a gender-transformative HIV prevention approach. The gender and HIV life-skills component targeting boys and girls in secondary education institutions will contribute to gender equality-based socialisation. Furthermore, community-based HIV prevention and advocacy with leaders will focus on specific cultural practices, which expose women and men to HIV. After the assessments of the district contexts this will include practices such as widow inheritance, women's property rights, girl pledging, forced marriage, chiramu (the entitlement of a husband to have sexual relations with his wife's younger sister) and post-menopausal abstinence (which entitles the husband to look for another partner). A gender gap is currently commonly observed in provision of home-based care (HBC) services, as women carry the major burden of care. The HBC component will therefore make a specific effort to involve men as care givers. Within the workplace environment, activities will focus on sensitisation of enterprise leaders and managers, building women's ability to protect themselves *and* strengthening male responsibility on gender issues and how to address gender violence and reduce cases of sexual harassment in the workplace.

Equality in access to services including PITC, PMTCT, and OI/ART

[26] Central Statistical Office (CSO) [Zimbabwe] and Macro International Inc. 2007. *Zimbabwe Demographic and Health Survey 2005-06*. Calverton, Maryland: p. 230

[27] Pascaline Dupas 2005: Relative Risks and the Market for Sex: Teenagers, Sugar Daddies and HIV in Kenya. Paris.

[28] Central Statistical Office (CSO) [Zimbabwe] and Macro International Inc. 2007. *Zimbabwe Demographic and Health Survey 2005-06*. Calverton, Maryland.

[29] Rachel Jewkes, Mzikazi Nduna, Jonathan Levin, Nwabisa Jama, Kristin Dunkle, Kate Wood, Mary Koss, Adrian Puren, Nata Duvvury: Evaluation of Stepping Stones, A Gender Transformative HIV Prevention Intervention. South Africa, 2007

Equality in access is an overall principle of the National Strategic Plan and the underlying principle of this proposal for scaling up towards universal access. This approach will alleviate current geographical differences in access by taking critical OI/ART, PITC and PMTCT services to new rural, peri-urban and urban health facilities. While not creating parallel service delivery systems, this programme will build on a set of measures to ensure access of marginalised groups including adolescents, OVC, sex workers, PLWHIV and MSM. A specific training component on stigma reduction and non-discrimination of all the mentioned groups will be provided in all trainings of community behaviour change facilitators, health service providers, programme managers, media personnel and policy makers.

PLWHIV: PLWHIV will be a key target group not only for PITC, post-test, PMTCT and OI/ART services, but also for HIV prevention behaviour change including positive prevention. Equitable access to services will be closely monitored and ensured through transparent communication and systematic stakeholder involvement in the roll-out of services. Based on experience from 26 districts, one professional openly living with HIV was recruited as MIPA (Meaningful Involvement of PLWHIV) Support Officer in every district. These officers proved to be credible advocates, community mobilisers and experts in promoting positive prevention, stigma reduction, non-discrimination and service uptake among key affected populations. In the private sector workplace, PLWHIV will be trained and join the team of facilitators visiting enterprises.

Adolescents: Proven strategies of youth-friendly service delivery such as specific youth-friendly hours in existing health facilities, community-based communication events and mobilisation will be provided. As mentioned above, female adolescents, particularly those who are orphaned, are most affected and will therefore be specifically targeted in outreach and promotion of service uptake. An emerging affected group among adolescents are survivors of vertical transmission and other adolescents living with HIV. Within the context of post-test support specific support groups and structures will be set up for adolescents living with HIV.

OVC: Decentralised management structures for the OVC response will be strengthened in their capacity to advocate for full access of OVC to education, health and other basic services at community level. This will complement the large-scale provision of OVC support through the Programme of Support funded by several donors through UNICEF and Ministry of Public Service, Labour and Social Welfare.

Men having sex with men: While MSM are not highly visible as a public group, the national strategic plan acknowledges MSM as a target group for programmes. An approach to provide for improved access of MSM to PITC, PMTCT and OI/ART is under discussion and will be integrated as soon as it is available.

Sex workers: A number of HIV programmes have been implemented for SW in Zimbabwe. At present NAC, IOM and UNFPA work on a new strategic approach and programme, which is not part of this proposal. Nevertheless, access to PITC, PMTCT and OI/ART services shall be ensured by providing outreach and information on these services in sex work settings, including workplace sectors with high mobility and spousal separation such as transport, agriculture and mining.

4.5.5 Strategy to mitigate initial unintended consequences

If this proposal (in s.4.5.1.) includes activities that provide a disease-specific response to health system weaknesses that have an impact on outcomes for the disease, explain:

- the factors considered when deciding to proceed with the request on a disease specific basis; and
- the country's proposed strategy for mitigating any potentially disruptive consequences from a disease-specific approach.

All the activities within this proposal have been based on a detailed analysis of the gaps within the current health and HIV initiatives in Zimbabwe through consultations with multiple stakeholders including policy makers and review of key evaluations and assessments (ANNEX HIV 24 & 25: Minutes of meetings, SR proposals). They are cognisant of the fact that the government, other donors and organisations are already supporting the implementation of the Zimbabwe national AIDS strategic plan and activities have therefore been considered within this wider context. It is clear that there are gaps in the national responses as outlined in the gap analysis and whilst this is not exhaustive, prioritization of activities have

been made to ensure the greatest impact is achieved in meeting the intended national goals and objectives.

Activities outlined in this proposal have been planned in conjunction with HSS activities that cross cut the entire health system. However scale up of HIV interventions, requires additional capacity and technical expertise, to manage the multi-dimentional responses within the public and private sectors. Similarly civil society and AIDS service organisations bring a wealth of knowledge and experience which is uniquely relied upon to respond to the HIV/AIDS epidemic to bring added value beyond that provided within the formal health system. Therefore specific HIV related positions have been included under this proposal both for PRs and SRs to manage implementation of activities, provide technical support and mentorship as they relate to combating HIV and AIDS. These include technical, administration and M&E staff who will be supported with salaries. A number of salaried positions will be maintained from the previous Global fund round 5 including positions within NAC and MOHCW and additional specialised HIV positions, such as laboratory scientists to support centralised diagnostics for new interventions such as early infant diagnosis have been requested.

One of the key concerns given the unfavourable macroeconomic environment has been the potential inequity that has and may continue to be caused by supporting only a few number of selected health professional posts in a specific number of districts. Where only certain district staff have been supported, this has caused health workers from non-supported districts to become disgruntled and demotivated. In order to resolve this, an assessment of the human resource capacity has recently been undertaken and has recommended short term action to be taken to harmonise efforts and retain the current workforce. A number of different scenarios and standardised retention and remuneration packages have been drawn up for government and donors to consider. This has enabled clear priorities to emerge, to enable a transparent process to be discussed. Following on from higher level discussions, this proposal supports positions and cadres that have been identified by MOHCW to be a priority based on nationwide coverage. These are explained within section 4B. A proportion will be maintained by GOZ, with a contribution made by GF round 8 for cross cutting staff to manage all disease components. All staff within the public sector will therefore be supported in accordance with national guidelines, policy and within the overall strategic framework which is being updated. Decision making in this area has been made at the highest possible level and hence it is understood that support for staff remunerations and incentives will be endorsed and managed by senior management and government officials.

The proposal recognises that PHEs and DHEs, are instrumental for managing and coordinating HIV activities at these respective levels, but that they already have numerous responsibilities throughout the year in the management of various diseases. Whilst these positions will be included under the HSS cross cutting section, additional resources to carry out site support supervision, mentorship and meetings have been included because these are paramount to build confidence and monitor the HIV programme.

The proposal also recognises that training is an important component to be supported. This is because HIV service delivery urgently requires specialised knowledge and skills which are only now being introduced into pre-service curriculum and courses. More health workers need to be trained in HIV prevention, care, treatment and support to meet the massive demand, respond to decentralisation and to support task shifting which is urgently required. Trainings will be integrated wherever possible e.g. Family planning within OI/ART management. Furthermore, trainings proposed are all based on national training curriculum following national policies and protocols to ensure that there is standardisation throughout the programme within the public and private sector, as well as at community level.

Whilst major efforts to synchronise the different M&E systems, activities to strengthen specific HIV monitoring have been included within the HIV proposal for public, private and community health care workers to improve HIV data management. These are in response to major gaps which are hampering tracking, planning and resource mobilisation. Efforts to strengthen specific HIV monitoring systems such as HIV-DR monitoring have also been planned.

Furthermore, it has also been appreciated that supporting a disease specific area alone may further verticalize public health initiatives and system programming. Efforts however to integrate activities have been encouraged and planned for. For instance PMTCT is only one component of maternal health services offered and is already integrated at a clinic level so that activities that will strengthen PMTCT e.g. infant feeding counselling will naturally go to strengthen services for all pregnant women. Wherever possible, the use of vehicles that will be procured will also be used to assist other activities at a District level to be undertaken assisted by integrated district level plans.

4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

Describe any link between the focus of this proposal and the activities under any existing Global Fund grant. *(e.g., this proposal requests support for a scale up of ARV treatment and an existing grant provides support for service delivery initiatives to ensure that the treatment can be delivered).*

Proposals should clearly explain if this proposal requests support for the same interventions that are already planned under an existing grant or approved Round 7 proposal, and how there is no duplication. Also, it is important to comment on the reason for implementation delays in existing Global Fund grants, and what is being done to resolve these issues so that they do not also affect implementation of this proposal.

Current support being provided by Global fund round 5 will come to an end in May 2009 for phase one and May 2010 for phase 2, hence the intended start date of this new round of funding for July 2009 to enable the further scale up of activities in Districts not covered by global fund round 5 and to enable the transition of a number of activities already being supported within the Global fund round 5 activities, particularly ARV procurement. Activities within this proposal will be implemented in all districts nationwide where there is no current donor support and will transition many of the activities started under round 5. The proposal is mindful not to duplicate activities in the 16 districts currently supported by the expanded support programme, however where interventions such as early infant diagnosis have not been scaled up in these districts, nationwide coverage can be expected. A key focus is to scale up interventions that already exist e.g. provision of OI/ART and behaviour change components, community home based care. However in addition, GF round 8 will provide additional capacity to deliver new interventions such as more efficacious regimens for PMTCT, early infant diagnosis and expansion of the PITCT approach beyond ANC based on the pilot projects undertaken during 2006-2007. New innovations such as improving quality of care, supporting two centres of excellence, and monitoring HIV-Drug resistance have also been included.

The Behavior change activities for both mass media as well as community outreach with interpersonal communication interventions, with the goal to increase awareness about HIV services (T&C, OI/ART, treatment and care, TB/HIV), to increase treatment literacy, to reduce stigma and consequently increase uptake of services, that are currently implemented with support of Global Fund Round 5, will further be expanded and strengthened through Global Fund Round 8. The activities will be implemented by the same consortium of SRs and implementing partners as under Global Fund Round 5, which will ensure continuity and cohesion of the HIV services communication strategies. All communication activities are integrated with the wider HIV and AIDS communication strategy of the MOHCW and include mass media campaigns disseminated through TV, radio and the printed media as well as information materials for users and providers of the services.

Communication activities under Global Fund Round 5 were also including training and capacity building of journalists to ensure that these have good understanding of the ethical, medical and social issues around HIV and AIDS. The proposed intervention will expand activities involving training and debriefing meetings for journalists on HIV/AIDS issues including HIV services that are currently implemented under Global Fund Round 5.

Global Fund Round 1 and 5 supported the expansion of client initiated testing and counselling (CITC) services especially based on outreach T&C in 22 districts (12 in Global Fund Round 1 and 10 additional in Global Fund Round 5). It also included the expansion of T&C services in the public health sector through training and retention of primary care counsellors (PCs) and microscopists as well as the procurement of additional HIV rapid test kits needed for the expansion. This grant will build on the achievements within the previous Global Fund rounds and further expand the provision of provider initiated testing and counselling services aiming for nationwide coverage of PITC in all health facilities including the private and public sector to complement CITC services. Activities include further training of existing PCs in PITC currently supported by previous GF grants as well as training of additional PCs and other health care workers. The grant will also support retention of additional PCs to support the scale up of PITC at lower level health care facilities as well as in districts that were previously not receiving support through GF Round 1 or 5.

For greater cohesion and coordination of the HIV programme, a number of salaried positions have been

supported under global fund round 5, namely the HIV focal point personnel, a selected number of doctors, nurses, pharmacists and laboratory technicians. Salaries for all these positions will not be continued over the course of Round 8 as support for these positions, have been included within the health care personnel retention packages that have been included as a cross cutting component under the health systems strengthening section in Section 4B. The purpose of this is to harmonise salaries nationwide and support the national health infrastructure. Due to ongoing high staff attrition particularly among the experienced staff and because of the intended scale up of service provision in PITC, PMTCT and OI/ART, ongoing in-service training in comprehensive OI/ART management, PMTCT and PITC will be provided, targeting health workers not already trained in these areas under previous grants so as to build skills and competency in service delivery.

This proposal seeks to continue to increase access to ART and HIV treatment and care initiatives. Currently global fund round 5 is supporting this in 22 nominated districts only. Based on similar activities to those accepted within the round 5 grant, continued geographical expansion of OI/ART services are proposed and in addition, a proportion of the grant will be provided to support OI/ART delivery within the private sector. In line with the decentralisation drive to HIV treatment and care services, the programme will support renovation of health institutions particularly primary health care clinics to adequately store and manage ARVs and to improve and expand facilities for confidential counselling services. This will include health facilities not currently providing these services.

It is considered critical for GFR8 to continue to support Quality assurance practices for laboratories that were being supported under the previous grant (GFR5). The registration of laboratories for proficiency testing with ZINQAP and support and supervisory visits by senior laboratory staff will be supported so as to assure high quality lab diagnostic and monitoring capacity for effective delivery of HIV/AIDS services.

ZAN is an SR for Global Fund Round 1 and Round 5. Under Round 1 ZAN has been implementing the Community Home Based Care and Voluntary Counselling and Testing in 12 Global Fund districts that represent two of five components. Implementation of Round 1 activities was effected through sixteen sub sub recipients who are members of the ZAN network. The main objective for Community Home Based Care focused on strengthening provision of community and home based care for people living with HIV. Specific activities have been implemented targeting over 4800 clients by ZAN in Round 1 between 2005 to 2008. The activities included recruitment, training and support and incentives for 720-community home based caregivers. Direct nutritional support was provided to 1200 clients in 12 districts. Support to these clients also entailed basic nursing and 720 home based care kits were procured and replenished for this to be accomplished and in any endeavor to ensure that a holistic community care package was provided by the programme. The CHBC programme also served to provide continuum of care and support for the GF OI/ART component for both Round 1 and Round 5. In the case of ZAN's role in round 8, the emphasis will be on the continuation of the work that has been happening under rounds 1 and 5 with additional focus on advancing the work done regarding nutrition, the uptake of ART, and social mobilisation in communities with reference to PMTCT.

Support for Orphans and Vulnerable children was identified as an area of focus for GFR8 proposal, specifically the strengthening of existing coordinating structures for OVC programmes but an area that has not been supported in previous rounds. OVC activities and interventions are largely covered under the plan of support for OVC with 79% of the $84 million over 5 years going directly to support service delivery. Management and coordination of the programme have however remained lacking and therefore, GF round 8 will provide leverage funding to support the impact of this programme. Currently advocacy efforts to improve treatment literacy amongst PLWHIV are being undertaken through Round 5 funding. This is in the form of workshops and skills building using already established IEC materials. Activities within round 8 will ensure that capacity is built within already existing networks and support groups to enhance the impact of some of these already funded activities.

4.6.2. Links to non-Global Fund sourced support

Describe any link between this proposal and the activities that are supported through non-Global Fund sources (summarizing the main achievements planned from that funding over the same term as this proposal).Proposals should clearly explain if this proposal requests support for interventions that are new and/or complement existing interventions already planned through other funding sources.

Proposed Global Fund Support will complement a number of other existing funding channels and mechanisms towards scaling up for universal access. While there is no overall basket funding mechanism for support to the national HIV response, there has been considerable progress in terms of harmonization through the introduction of the Expanded Support Programme on HIV and AIDS (ESP) supported by five bilateral donors and implemented through UN agencies under the overall leadership of NAC and MOHCW (ANNEX HIV 26: Expanded Support Programme proposal). The following are the major linkages between GF, ESP and other funding streams along the continuum of care:

Prevention: The GF support will partially build on and partially expand existing HIV prevention programmes. Zimbabwe has functioning social marketing (PSI Zimbabwe) and public sector condom programmes (Zimbabwe National Family Planning Council), which will through support from USAID and DFID ensure availability of condoms in all facilities and areas covered by GF supported behaviour change, PITC, PMTCT and OI/ART activities. The same donors have supported the scaling up testing and counselling through a country-wide network of VCT sites and VCT outreach, which will continue to serve as referral point for community-based behaviour change, but also as entry point for service uptake, while PITC will be further scaled up with GF support. For both these strategies, USAID and DFID have committed to cover a 5 year period (2005-2010) to the amount of approximately $75 million. USAID and DFID have also provided technical as well financial support through the Partnership Project for PITC roll out such as the PITC pilot phase, the development of the national HTC strategy and PITC training guidelines as well as the training of health care providers and PCs. Several partners, including CDC and USAID through John Snow International (JSI), DFID and UNFPA are supporting the supply of HIV rapid test kits in the public sector and have expanded their commitment until the end of 2010 complementing the support received through GF Round 1, 5 and 8. In the area of BC community outreach, the Global Fund support will cover the 34 districts, Harare and Bulawayo, since those areas are not yet covered with ESP/EC support. The supervision and management system as well as programme tools already in place to implement decentralised behaviour change promotion activities in 26 districts through ESP/EC support can be utilised for the proposed GF supported work in order to scale up evidence and community-based gender-sensitive HIV prevention to nation-wide coverage. PMTCT service provision is supported by a number of INGOs and local NGOs at both national and site level implementation. Enhancement of PMTCT activities is being carried out countrywide, using support from USG through the EGPAF Family AIDS Initiative programme ($12.5 million over 5 years 2007-2012) and DFID through their maternal and newborn programme which is being implemented through UN agencies and other INGOs (ANNEX 17). UNICEF also provides technical and financial resources to the national PMTCT unit to address gaps in the programme. Recently MOHCW have received support from CIDA to support the initial scale up of more efficacious regimens and early infant diagnosis until the end of 2009. GF additional resources will build on these initial plans.

OI/ART Treatment and care: The proposed GF support will contribute to scaling up the national treatment programme for both adults and children, currently co-funded by the Government of Zimbabwe, the ESP, USAID, Clinton foundation, European Commission and a number of smaller partner organizations such as MSF (Refer to ANNEX 14). For 2008, procurement of over 160,000 patient doses is expected with support from bilateral donors, promised until the end of 2009. Donor support for ARV procurement beyond this period is currently uncertain as approved proposals cover the period until end of 2009 for ESP and USAID and 2010 for CHAI and EU. The USG donation through JSI/SCMS is also supporting the strengthening of the national logistic system and Natpharm. Additional resources are being provided for improving laboratory capacity from USG, CHAI, ESP and CIDA with procurement of diagnostic reagents, equipment and secondment of critical laboratory scientists to the NMRL. Currently no support for a centre of excellence is being received although expertise within the field of HIV has been maintained within the University of Zimbabwe.

Mitigation: The GF assistance for the support component will be directly linked to the implementation of the National Action Plan for OVC supported through the Programme of Support, a multi-donor, multi-year funding managed by UNICEF in close collaboration with the Ministry of Public Service, Labour and Social Welfare. Resource mobilisation has been successful and currently the Programme of Support boasts of having raised US$85 million to be accessed by CSOs. So far over 140 organisations are accessing resources and they have scaled-out interventions. Specific interventions to support OVC are therefore already largely funded through this mechanism. The co-ordination and management capacity of the MoPSLSW will however be strengthened through GF resources. UNAIDS is also providing technical and financial resources to build the capacity of the national network of PLHWA.

Health Systems Strengthening: In the framework of the development of a health sector human resource policy, a number of players have made contributions and pledges towards supporting key capacities in Zimbabwe's health system. In addition to above-mentioned support through GF Round 5, the ESP and the EC Vital Health Services Support are finalising agreed support to critical health sector capacities at decentralised levels, which have been considered in putting together this proposal, while UN agencies and INGOs e.g. CHAI, JSI, EGPAF, PSI support a number of key management functions at national level as has already been mentioned. The proposed GF support will complement these existing mechanisms and will work within the national human resource framework that is currently being finalised.

4.6.3. Partnerships with the private sector

(a) The private sector may be co-investing in the activities in this proposal, or participating in a way that contributes to outcomes (even if not a specific activity), if so, summarize the main contributions anticipated over the proposal term, and how these contributions are important to the achievement of the planned outcomes and outputs.

*(Refer to the Round 8 Guidelines for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.)*

The workplace offers an opportunity for private-public partnerships in improving access to HIV and AIDS prevention, care and treatment and support services to employees, their families and communities. Examples of such partnerships include the following:

- Coordination and facilitation of peer education programmes by urban authorities like the Mutare City Council through the hosting of weekly meetings for peer educators and focal persons from HIV and AIDS workplace programmes.
- Private - public sector partnerships in behaviour change awareness programmes, where local authorities provide venues; an informal sector association (ZCIEA) provides awareness messages through songs and drama; and large private sector corporates provide funding to promote industrial theatre and sports activities.
- Mining and agro-based industries' community programmes, for example, Hippo Valley Sugar Estates in Chiredzi, providing OIART treatment and other primary health care services to employees, their families and local communities.

Home-based care for PLWHIV is largely done by community-based volunteers and families of employees. There has been very little involvement of private sector businesses in the provision of home-based care. Enterprises have traditionally supported community-based development programmes as part of their corporate social responsibility but with little or no coordination within and between sectors. The new paradigm is that support for community programmes should not be considered as a responsibility but as an investment based on an assessment of risk of the enterprise. The national private sector framework in its broad based approach aims to achieve this in implementation. A coordinated approach to social investment could make a significant difference to provision of care and support to PLWHIV, their families and communities in which enterprises operate. Similarly, nutrition assistance is largely provided by NGOs rather than the private sector. This is another opportunity for public-private partnership. Experiences from elsewhere[30] will be used to promote private-public partnerships to improve access to HIV prevention, treatment and care and support services.

Information and education for the remote and geographically difficult to reach informal economy operators and workforce such as mine and farm workers will be through peer education and working with civil society and community groups for service provision. Business operators in these industries will be motivated to ensure personnel policies and conditions of work that reduce vulnerability to HIV infection and mitigate the impact such as provision of accommodation, access to transport to improve mobility to service points. The following activities will be implemented with funding from corporates, complemented by GF8:

- Sensitise and educate top company leadership of the value of community partnerships to business;
- Education and awareness sessions for the informal sector operators and working through their associations to ensure access of services and creating and strengthening partnerships, linkages and referrals to community based service providers;
- Scale-up the provision of drama and industrial theatre through partnerships between large companies, small and medium enterprise sector associations and local authorities;
- Use private sector health facilities for providing ART and OI treatment to surrounding communities;
- Involve large companies in supporting home-based care programmes for communities, through extending peer education programmes and provision of materials (gloves and kits);
- Provide education on safer sex to employee, spouses, other sexual partners and community members;
- Establish community-based nutrition training to family and community carers; and
- Promote the establishment of community-based social dialogue networks particularly with the informal sector operators and their associations.

In addition, the college of primary care physicians in Zimbabwe continues to ensure a high standard of delivery of HIV services to HIV infected adults and children within the private sector. With a membership of 460 private practitioners, services are provided to paying clients that support national initiatives such as provision of HIV testing and counselling, delivery of PMTCT services and management of OI/ART, care and support services. Whilst a gap within the private sector has been recognised in terms of standardised training and poor integrated monitoring of services, private practitioners still provide approximately 10,000 HIV positive patients with much needed care. Whilst this proposal will support a number of initiatives to improve delivery of these services, procurement of drugs and diagnostic regents; maintenance of functional clinics and ongoing clinical medical education will all be provided by the college.

[30] GTZ and Global Coalition on HIV/AIDS 2005. Making co-investment a Reality-Strategies and Experiences. Eschborn, December 2005.

(b) Identify in the table below the annual amount of the anticipated contribution from this private sector partnership. *(For non-financial contributions, please attempt to provide a monetary value if possible, and at a minimum, a description of that contribution.)*

Population relevant to Private Sector co-investment (*All or part, and which part, of proposal's targeted population group(s)?*) ➔	Men and women (18-49 years) in communities around workplaces in the mining, agricultural, transport SME and informal sectors.

Contribution Value (in USD or EURO)

Refer to the Round 8 Guidelines for examples

Organization Name	**Contribution Description** (*in words*)	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Turnal Holdings	Provision of ARVs and other drugs and to treat OIs. Provision of drama and Industrial theatre to employees and their families	164727	164727	164727	164727	164727	823635
Barclays	Awareness training, VCT and provision of OI/ART services to employees spouses and families	7353	7353	7353	7353	7353	36745
Polywaste Plastics	Developing in house training modules on HIV and AIDS as awareness campaigns	Not available	Not available	Not available	Not available	Not available	Not available
Hippo Valley	Provision of OI/ART services to employees, families and surrounding communities	Not available	Not available	Not available	Not available	Not available	Not available
ZBCA members	Provision of drama and industrial theatre to employees, families and communities and support for HBC	Not available	Not available	Not available	Not available	Not available	Not available

OK Zimbabwe, Dairiboard, Star Africa, Zimplats all provide some form of support although detailed analysis is not available.

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved HIV outcomes

The Global Fund recognizes that the relative capacity of government and non-government sector organizations (including community-based organizations), can be a significant constraint on the ability to reach and provide services to people (e.g., home-based care, outreach prevention, orphan care, etc.).

Describe how this proposal contributes to overall strengthening and/or further development of public, private and community institutions and systems to ensure improved HIV service delivery and outcomes. ➔ *Refer to country evaluation reviews, if available*.

This proposal involves strengthening a multi-sectoral approach to respond to the HIV epidemic in Zimbabwe. Integrated within a number of components within the proposal, community system strengthening will be conducted targeting community based organisations (CBOs), localised NGOs, as well as local leaders such as traditional leaders, local Councillors, leadership of community groups and church leadership. As part of this, the proposal aims to create an enabling environment for behaviour change to take place through capacitating leadership and communities to communicate, identify, address and plan to enhance behaviour change strategies and strengthen community initiatives. The component of HIV prevention BC builds on an approach of Community-Centred Capacity Development focusing on the steps of Assessment, Analysis and Action (AAA). Participatory review of drivers of the HIV epidemic at district and community-levels will be used as entry point for participatory development of district and community action plans. In parallel to the action planning, traditional, religious, business and other formal and informal opinion leaders as well as teachers will be capacitated and continuously supported to deliver evidence-based messages on HIV BC. Using multiple approaches e.g. outreach, mass media for a wide spectrum of target groups, the focus is to build the capacity of individuals to become agents of change to reduce prevalence of HIV. At national level, UNFPA will support the development of a unit with the capacity to guide and oversee implementation of evidence-based BC strategies.

Capacity building of community based organisations by enhancing a deeper analytical understanding of the pandemic and the national response; and by strengthening organisational systems focusing on financial management, programming, monitoring and reporting and management of information. Strengthening partnerships at the local level will improve coordination of initiatives to enhance impact and avoid duplication. Linkages and coordination systems between the formal health systems and community based initiatives. A key component of this is to ensure that the strengthening of standardised monitoring systems are employed so that these can feed into the overall national M&E system outlined within the ZNAPS. Through organisational development, civil society organisations skills on accountability, proposal writing and financial management will be addressed to encourage greater sustainability of local organisations. Similarly larger civil society groups at national, provincial and district level such as NZP+ will be supported to improve capacity and leadership for effective advocacy and implementation of HIV initiatives. They in term will be encouraged to transfer skills to other organizations and networks with whom they interact. Leadership in business will include trade unions and employer organizations and target sectors with mobile and more at risk populations in the mining, transport agriculture and SME and informal economy.

Another critical component of the proposal is to continue to strengthen the capacity of the public and private health care systems to deliver high quality HIV services. Within the HTC, PMTCT and care and treatment sections of the proposal, a considerable amount of training of health workers has been included to enhance the skills of multiple cadres within the national health system to enable scale up of activities in support of universal access. Training is necessary to prepare cadres to take on new responsibilities and confidence to manage patients, so that greater task shifting can be managed. Activities have been planned to strengthen the national pool of trainers to enable effective cascading of training skills and knowledge down to district and site level. Private practitioners and private sector health workers will participate in these training to ensure that standardised guidelines and protocols are applied routinely throughout the health system. Inclusion of the private sector is seen as an important opportunity to enhance critical human resources that are available. Acknowledging that training alone is insufficient to equip health care workers with all of the necessary skills to deliver effective services, supervision, mentorship and peer reviews have been included as important activities to support. Strengthening coordination mechanisms across the board will not only encourage better integration of services but help to improve overall reporting. The proposal through the inclusion of the University of Zimbabwe as SR, will also utilise the opportunity of having already established ‘experts’ in the field to mentor and coach medical

students and health care workers. Two centres of excellence for OI/ART management will be established to act as a resource for clinical attachments and training, and provide a benchmark for quality assurance.

Similarly the laboratory capacity within the public health system will be strengthened to enable greater access to diagnostic tests. The focus will be to continue to decentralise services to enable multiple entry points within the public health system e.g. maternity sites to appropriately access these services. A focus will be given to strengthen the national laboratory system to manage new diagnostic techniques such as HIV DNA PCR, viral load and HIV drug resistance testing through training, accreditation, mentorship and supervision.

Recognising that monitoring systems within the public and private sectors as well within civil society remain weak, activities have been planned to strengthen capacity to effectively monitor programme achievements. Opportunities to include innovations such as community level monitoring of service delivery will ensure sustained capacity is built for the future by CBOs and localised NGOs. Training, supervision and provision of standardised data collection tools have been included under all objectives within the proposal to ensure that overall reporting is strengthened to enable more efficient planning and distribution of resources. Computer equipment will be procured and communication systems improved to facilitate more effective capturing of information. Coordination at both district and community level will assist to strengthen flows of information from bottom up and top down and transport will be provided to enable this to happen.

4.7.2. Alignment with broader developmental frameworks

Describe how this proposal's strategy integrates within broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) initiative, the Millennium Development Goals, an existing national health sector development plan, and other important initiatives, such as the 'Global Plan to Stop Tuberculosis 2006-2015' for HIV/TB collaborative activities.

The main scope of this proposal is to scale up critical national programme components towards universal access within the context of the priorities identified in Zimbabwe's National Strategic Plan 2006-2010 (ZNASP). The ZNASP is embedded in and contributes to the broader framework of national and international development goals. The ZNASP goals and consequently the goals of this proposal are aligned to:

- The Millennium Development Goals (MDGs),
- The UNGASS Declaration of Commitment on HIV/AIDS (2001),
- Abuja framework for action for the fight against HIV/AIDS, TB and other related infectious diseases (2001),
- The Gleneagles G8 Universal Access Targets,
- The United Nations Political Declaration on HIV/AIDS (2006),
- The 'Global Plan to Stop Tuberculosis 2006-2015 and
- The Brazzaville Commitment on Universal Access of 2006.

The overall focus of this proposal is to close the most critical gaps for achievement of Universal Access. HIV and AIDS including related issues of gender and social equality are given high priority within the overall national development goals in Zimbabwe. Among the eight Millennium Development Goals (MDGs), the Government of Zimbabwe has made a deliberate choice to particularly prioritise three MDGs including MDG 1 (poverty), MDG 3 (gender equality) and MDG 6 (HIV, TB, and Malaria). Despite the challenging overall economic environment, the policy and programming environment in specific health and social sectors continues to allow for effective programming towards achievement of goals in the fields of health, HIV and AIDS and other social sectors. National and UN working groups and partnership fora ensure continued policy dialogue and joint programming in the areas of social sectors, health and HIV and AIDS involving government, civil society, multi-lateral and bilateral development agencies.

While Zimbabwe does not have a PRSP, a Zimbabwe Economic Development Strategy (ZEDS) is under development. The goals set out in the ZNASP will also be reflected in the ZEDS and elements of HIV and AIDS programming mainstreamed into the ZEDS framework, which also includes a specific Theme Group on HIV and AIDS. A National Health Sector Strategic Plan 2008-2018 and a Human Resources Policy for the Health Sector are also under development to replace the 1997-2007 Health Sector Strategic Plan. The support for Health Systems Strengthening under this proposal will be fully integrated in the Human

Resources Policy for the Health Sector.

4.8. Measuring impact

4.8.1. Impact Measurement Systems

Describe the strengths and weaknesses of in-country systems used to track or monitor achievements towards national HIV outcomes and measuring impact.

Where one exists, refer to a recent national or external evaluation of the IMS in your description.

Zimbabwe adopted the Three Ones Principles and has one national monitoring and evaluation system hosted by the National AIDS Council. A coordinated national effort has been ongoing in Zimbabwe to develop a comprehensive national monitoring and evaluation plan for implementation (ANNEX HIV 27: ZNAPS M&E plan). The aims of the national M&E framework are to allow Zimbabwe to evaluate in the context of implementing a comprehensive response to HIV and AIDS, which interventions make a difference and how they can be improved. Stakeholders including sector ministries, local government, civil society and the private sector, are meant to report on a monthly basis through decentralised offices of the NAC at district level. The National AIDS Council has adopted the CRIS database which has now been rolled out to district level. The database has been customised and has a set of core output indicators that were developed and adopted in a multisectoral and consultative process. Databases within the MOHCW, other line ministries, private sector and civil society do not however converge with the national M&E database at NAC.

The MOHCW is currently using a paper based M&E system, which makes data auditing, verification, storage and analysis difficult particularly at sub-national level. Two databases for both HIV and TB, a patient tracking and indicator database are being developed and will be decentralised to facility levels. An analysis of the data from the two databases will assist to measure the survival rates for people living with HIV who are either on OI prophylaxis or ART. Weaknesses including poor data auditing and verification, poor human capacity in terms of numbers and expertise have been highlighted in the Global Fund M&E assessments and it is envisaged that the national costed M&E plan will provide a roadmap on strengthening the M&E systems. There is also extremely poor reporting from the private sector on HIV activities. Capacity building in M&E is being strengthened with support from the Expanded Support Programme but there are still components that require additional technical input and resources.

ZAN is responsible for capacitating civil society organisations while NAC is responsible for the public sector. Civil society organisations are in a unique position being closest to the beneficiaries, to collect and utilise information to enhance interventions that directly support different target groups. However, CBOs are not familiar with standard reporting formats and so much of the work that is being done at community level is rarely informing planning or priority setting within the national framework. Similarly reporting of the private sector contributions have not been standardised nor are they regularly received. Critical weaknesses remain in data collection and submission from private practitioners involved in HIV service delivery with very few privately owned clinics feeding into the national M&E systems. The Zimbabwe Business Council on AIDS has been identified to carry out capacity building activities for the private sector in collaboration with the International Labour organisation and other key stakeholders to conform with national M&E systems.

In addition to service delivery reporting, HIV surveillance is conducted biennially, through unlinked anonymous surveys of pregnant women in antenatal care. The surveillance system serves as a basis for national estimates of trends in HIV prevalence, persons in need of ART and PMTCT as well as an estimate of new infections. The Central Statistical Office in partnership with international partners conducts population based surveys that comply with national and international standards. Impact and outcome indicators specified in this proposal are largely drawn from the Demographic and Health Survey which is commissioned and conducted by the CSO in collaboration with MOHCW and multiple stakeholders. Other partners also periodically carry out population based surveys and special surveys that boast the country's base of HIV and AIDS data. PSI/UNFPA/NAC (HIV prevention focused) and UNICEF (OVC) have periodic surveys that enable the country to triangulate data on HIV and AIDS outcomes. Other outcome indicators for special populations (PLWHIV) have no baseline information. This proposal includes contributions to PSI's annual nation-wide TRaC surveys and to a national impact evaluation survey, which will be

designed as a follow to the National BC Strategy Baseline Survey (a survey including HIV biomarkers and KAP). Thereby, the contributions through this proposed grant will co-fund existing impact evaluation surveys within the national M&E framework..

Zimbabwe has adapted the WHO HIV Drug resistance monitoring protocol and will conduct monitoring in 3 sentinel sites starting in the third quarter of 2008 (ANNEX HIV 28: Zimbabwe national HIV Drug resistance strategy 2008-2012). The plan is to set up give monitoring sites each year. Starting in 2009, there will be 6 sites conducting monitoring each year (3 new and 3 old sites which will be completing follow up). The current HIVDR Strategy (2008-2012) has 3 elements namely: Collection of Early warning indicators at site level; HIV Drug Resistance Threshold survey (HIVDR-TS) in drug naïve patients; and HIVDR cohort monitoring in populations on treatment. These 3 elements of the HIVDR Strategy are co-funded from various sources. The main sources of funding are GFTAM Round Five (2007–2009), ESP (2007-2009), CDC (undefined period) and the National AIDS Council (undefined funding period). It has been assumed that the ESP and other funding partners will maintain their current level of support beyond 2009 (refer to the consolidated gap analysis ANNEX HIV 14). Funding is therefore sought from GFR8 to support the 3rd element of the strategy i.e. HIVDR Cohort Monitoring which is not fully funded beyond 2009.

4.8.2. Avoiding parallel reporting

To what extent do the monitoring and evaluation ('M&E') arrangements in this proposal *(at the PR, Sub-Recipient, and community implementation levels)* use existing reporting frameworks and systems (including reporting channels and cycles, and/or indicator selection)?

National Monitoring and Evaluation System

A national M & E system was developed through a consultative and participatory process led by the national M&E task force during period 2006-2007. A draft M&E framework has been developed which will be costed during 2008. Data are collected on National Core Output Indicators (NCOI) and the national M&E system is decentralised at all levels. All implementing organisations from the civil society, public and private sectors should register and report through an Organisation Details Form (ODF). M&E activities that are included in this proposal are aligned to this National M&E Framework.

Indicator Selection for this proposal

Impact, outcome and output indicators that are identified in this proposal draw from the national M&E indicators, which are also aligned to internationally recommended indicators including the Global Fund. Zimbabwe having adopted the three ones principles has a national M&E system which draws from all implementers of HIV and AIDS projects. Selected PRs and SRs have been reporting on these indicators through the national monthly M&E reporting system. The national reporting forms clearly stipulate that the core output indicators will be used at community level for progress reporting. National core output indicators that will be reported by health facilities are in alignment with the HMIS indicators that are collected by all health providers and reported monthly to the MOHCW. The indicators that are proposed for some SDAs are currently not included in the National Core Output Indicators (NCOI). National AIDS Council will present these indicators to the Monitoring and Evaluation Advisory Group for inclusion in the NCOI to strength the national M&E data.

Reporting Channels and Cycles

Two reporting channels will be used for M&E reporting. Firstly, the current monthly reporting systems that is conducted through NAC decentralized offices i.e. implementing organizations reporting to district AIDS offices, then to provincial and national level, will be maintained. The NARF will be used to collate and report the data, and NAC's reporting timelines will be maintained. Secondly all organizations supported by the Global fund will report on a quarterly basis incorporating the quantitative indicators and other project specific information. The quarterly reports will be collated by SSRs then submitted to the SR for verification and further submited to the PR. Quarterly, biannual and annual reporting timelines that are used by the NAC will be used for SSR, SR and PR reporting.

The NAC staff at sub national level will verify and validate data together with SSRs, SRs and PRs. Data triangulation using monthly data reports from NAC database and quarterly reports to the SRs and PRs will also be conducted by M&E officers supported by the grant.

4.8.3. Strengthening monitoring and evaluation systems

What improvements to the M&E systems in the country (including those of the Principal Recipients and Sub-Recipients) are included in this proposal to overcome gaps and/or strengthen reporting into the national impact measurement systems framework?

➔ *The Global Fund recommends that 5% to 10% of a proposal's total budget is allocated to M&E activities, in order to strengthen existing M&E systems.*

A coordinated national effort has been ongoing in Zimbabwe to develop a comprehensive national monitoring and evaluation system yet gaps as outlined in section 4.8.1 still exist. M&E activities and the performance-based measurement in this proposal will build on and strengthen these existing systems and capacity; specifically they will enable programme managers and institutions and above all the country to make informed decisions, which should assist the achievements of the national goals. Strengthening monitoring and evaluation at all levels has been considered including the national M&E, private and community level systems through a comprehensive approach addressing process, output, outcome and impact levels.

Both PRs and SRs have M&E organisational structures with often inadequate personnel dedicated to M&E functions. The proposal will support human resources deployment and remuneration for M&E staff within each of the different organisations where required and these have been included within the implementation plan under the different SDAs. The M&E staff compliment of the MOHCW will be increased by the deployment of national, provincial and district level M&E staff who will boost the overall HMIS reporting and quality of data collection. Activities at this level will benefit overall health systems strengthening and have therefore been included within Section 4B. Additional M&E officers specifically involved with strengthening HIV output, outcome and impact levels have been included to support the AIDS & TB unit to integrate the HIV indicators within the broader frameworks. M&E officers at the different levels and within different organisations will be responsible for data collection, collation, auditing, analysis and utilisation of reports. They will also play a critical role in building overall capacity through training and mentorship at each respective level. Support for these establishments will ensure timely, accurate data reporting to the Global fund, the national M&E system and to other stakeholders.

Human capacity development will be strengthened through annual trainings at PR, SR, SSR, community and public/private facility level. Specific trainings on integrated national HIV M&E tools will be undertaken, cascading initially from national, provincial and district levels. Each PR in collaboration with the SR will update and standardise reporting tools and forms that will be used by the SSRs and at community or public/private facility level. Specific sets of indicators both quantitative and qualitative (measuring client satisfaction), disaggregating data by sex, age and other socio demographic characteristics will be included in the tools. Correct application of the tools and data analysis will be included as part of the training curriculum for M&E. Trainings have also been included to promote greater operational research to complement the more formalised routine M&E data collection.

All selected PRs and SRs will be supported to have electronic databases that are linked to the National M&E system to counteract dual reporting from community and facility levels. Mechanisms for extracting and transferring electronic data from databases at the sub national levels to the national level will be developed through technical assistance. The MOHCW proposes to decentralise its patient tracking and indicator electronic databases up to facility level and induction, mentorship and support visits in the new system will be done from national level. Analysed data from the databases will assist to measure the survival rates for people living with HIV who are either on OI prophylaxis, ART or on waiting lists. Connectivity and communication including intranet, internet and telephones will be put in place. IT equipment and supplies including computer hardware and software, printers, computer consumables for all SRs have been included in this proposal. Equipment at district level within MOHCW has been included under Section 4B. IT experts at national level will train and mentor SR, SSR and community and facility based staff in maintenance and use of the database. Quarterly M&E visits for MOCHW will include an IT expert who will provide support to the province, districts and health facilities.

ZAN proposes to train and mentor its SRs, SSRs and civil society organisations in M&E and in linking databases to ensure electronic and efficient reporting. NAC will train provincial level and districts level staff in M&E and the CRIS. M&E training and mentorship is also included in community systems strengthening to ensure that the country particularly CBOs and NGOs, develop a culture of data collection, collation and use, and report quality data to the National M&E system. Similarly, standardised M&E data collection tools and registers along with training on M&E will be introduced within the private sector. Printing

of national registers and monitoring tools have been included to support these activities.

It is proposed that supportive supervision and data auditing (validation and verification) will be carried out quarterly at each level. PRs will validate and verify data from SRs who will subsequently do so for SSRs. Field verification visits will be conducted before reports are further submitted to the next level to ensure that accurate data is reported. PRs in collaboration with SRs will develop a standardised data audit checklist and report to be used during these visits. Data audit reports will be disseminated to each organisation supervised. Dissemination of M&E reports will be done during quarterly review meetings and through quarterly newsletters that will be disseminated to stakeholders, these will also be used for sharing best practices. An annual report on the Global Fund will be produced and collated by all stakeholders with the leadership of the NAC. The report will detail quantitative and qualitative data from the field. Audio visual equipment will be procured to capture some graphical representations of activities on the ground.

To improve impact and outcome data a formative evaluation to provide project specific baseline data within the Behaviour change component of the proposal will be carried out in all new districts. Behaviour surveys will be carried out using different methodologies including focus group discussions, and participant observations with technical assistance from UNFPA. A summative evaluation will be done at the end of the five years. Population based data from the ZDHS and sentinel surveillance will be used to complement the programme specific survey results, to measure impact of the added funding from the Global fund.

PSI already has an established systematic system to track behavior changes following exposure to communication interventions. PSI's population based TRaC surveys (Tracking Results Continuously) complement the national Demographic and Health Survey and Behavioral Surveillance Survey by collecting data on behavioral determinants and by measuring behavioral outcomes in relation to duration, intensity and frequency of exposure to mass media and interpersonal communication (IPC) campaigns. An initial TRaC survey will be conducted in year 1 to measure baseline behaviours and HIV services knowledge levels in the population. Thereafter annual TRaC surveys will be conducted in year 2 -5 to track changes in behaviour, HIV services knowledge, attitudes and perception levels in relation to mass media and IPC exposure. Outcomes of TRaC surveys will be supported by qualitative studies using focus group discussions and in depth interviews with sub segments of specific target groups. For monitoring processes of BC community outreach the existing system utilised in 26 ESP/EC supported districts will be maintained (See ANNEX HIV 41: M&E framework for BC). This system includes simple monitoring tools for community facilitators, a calendar for leaders to track their advocacy and a summary form that directly feeds into the National Activity Reporting Form. This is complemented by qualitative process evaluation through participatory research techniques. Impact evaluation through surveys will be done in conjunction with PSI. In addition, EMCOZ will undertake a baseline KAPB survey in year one within the private sector to assist in implementing appropriate work place policies. An impact assessment will be carried out in year 4 to evaluate progress.

As also already described, resources will be availed to continue to support the HIV/DR strategy with monitoring at 5 sentinel sites on an annual basis. Potential sites will be assessed and sentinel staff trained in HIV DR monitoring protocols. Medical consumables for on-site laboratories will be procured. Cohort monitoring will include a baseline viral load and genotype testing. Endpoint genotyping will be conducted on patients showing signs of immunologic failure as characterised by viral load > 1000 copies, twelve months after initiating ART. Samples collected at sentinel sites will be transported to WHO accredited laboratory in Pune, India. In the meanwhile the capacity of local NMRL will be built with support from international TA to provide genotyping sequencing using a gene sequencer and accessories that were purchased using funding from GF round 5. A team of senior laboratory staff from NMRL will conduct quarterly support visits to sentinel sites to provide technical assistance and support to staff at HIV DR monitoring sites. An annual stakeholder review will be conducted with representatives from each sentinel site, key stakeholders and NMRL staff aiming at reviewing and strengthening cohort monitoring activities at site level. The HIVDR Working Group will be responsible for the preparation of an annual report summarising all HIVDR monitoring activities. This will complement activities that have been started during the implementation of GFATM Round 5. Sentinel staff will be trained using HIVDR monitoring protocols followed up with site support visits. Laboratory capacity will be strengthened to support viral load and genotyping analysis.

4.9. Implementation capacity

4.9.1 Principal Recipient(s)

Describe the respective technical, managerial and financial capacities of each Principal Recipient to manage and oversee implementation of the program (or their proportion, as relevant).

*In the description, discuss any anticipated barriers to strong performance, referring to any pre-existing assessments of the Principal Recipient(s) **other than 'Global Fund Grant Performance Reports'**. Plans to address capacity needs should be described in s.4.9.6 below, and included (as relevant) in the work plan and budget.*

PR 1	National AIDS Council (NAC)
Address	P.O. BOX MP1311, MT Pleasant, Harare, Zimbabwe,

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

NAC is run by 14 member non executive Board drawn from the different backgrounds to reflect the multi-sectoral nature of the national response. The Board functions through four Committees namely the Executive (EXCOM), Finance, Audit and Administration (FAAC), Operations, Research and Disbursement (ORDC) and the Advocacy and Social Mobilisation (ASMC). The Board structures are mirrored at Provincial, District, Ward and Village level to provide policy guidance and monitoring at each level. NAC has the Secretariat headed by the Chief Executive Officer, a team of Directors, National, Provincial and District Coordinators and other technical and administrative staff.

NAC operates within the framework of the "Three Ones" principle namely;

1. One National Coordinating Mechanism.
2. One Agreed Strategic Framework
3. One Monitoring and Evaluation System.

The organisation is guided by the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP 2006- 2010) which was developed through a broad consultative process. NAC is the current Principal Recipient of the Global Fund- HIV and AIDS grants for Round One Phase Two and Round Five. NAC has undergone the necessary assessments as required by the Global Fund hence the approval to manage the grants. The recommendations from these assessments have been operationalised through capacity building and systems strengthening. Through this capacity development and support NAC has managed to retain staff at managerial level and national programme co-ordinators in the areas of behaviour change, youth, gender, work place, MIPA, home-based care, OVC support and M&E. Furthermore, financial management capacity of NAC was strengthened. As a PR for Global Fund, NAC currently manages a portfolio of 6 million USD under Round 1 and 32 million USD in the first phase of Round 5. Furthermore, it administers the National AIDS Trust Fund. While NAC is not the principal recipient for ESP resources (45 million USD over 3 years), it has a programmatic oversight and chairs the ESP Working Group.

The National AIDS Council has the technical capacity, operational and relevant experience to effectively coordinate the national response in Zimbabwe. In its endeavour to achieve its mandate, NAC with various partners has developed the ZNASP and other sector strategies to ensure a coordinated national response. NAC is responsible for managing the National AIDS Trust Fund (NATF) commonly referred to as the AIDS Levy which is disbursed to communities through the District AIDS Action Committees (DAACs). Fifty percent of the AIDS Levy is currently channeled towards the procurement of ARVs for the national OI/ART programme. Furthermore NAC is coordinating the implementation of programmes funded under the Expanded Support Programme (grouping of donors), the United Stated Government (USG) through Centre for Disease Control (CDC) to support M&E and Home Based Care. A number of grants have also been received through the UN agencies to implement various programmes. The major challenge in effective programming and grant management has been the brain drain. Currently, efforts are being made to retain staff through mobilisation of resources from partners.

National AIDS Council has a Finance department headed by a Finance Director, who reports directly to the Chief Executive Officer. The department is manned by qualified and experienced personnel at National, Provincial and District levels. At national level the Finance Director is supported by an Accountant

and four (4) Accounting Officers who are responsible for funds from the National AIDS Trust Fund and other donor funded projects. Supporting the Finance Director also, is a Finance Officer and a Programme and Administrative Assistant responsible for managing funds from the Global Fund's HIV & AIDS grants. The Provincial Accounting and Administration Officer (PAAO) and District Accounting and Administration Officer (DAAO) are responsible for accounting and administration functions at provincial and district levels respectively.

Activities in the various departments of the Council are reviewed by Internal Audit Department and External Auditors for completeness, compliance with policies and regulations and international accounting standards. The Internal Audit Department is an essential internal control tool of the organization as it serves as an independent appraisal function, established to evaluate and control activities of the Council and make recommendations thereon. The Department is headed by the Audit Director who reports to the Chief Executive Officer and the Non-Executive Board. The Director is supported by one Senior Auditor, five Auditors and one Auditor dedicated to Global Fund (See Attachment for Full Description of NAC as a PR).

PR 2	Zimbabwe AIDS Network (ZAN)
Address	154 Samora Machel Avenue; Belvedere West; Harare

ZAN is a leading national HIV and AIDS network In Zimbabwe characterised by and known for its effective management of its contribution to the national response to the epidemic. The purpose of ZAN's programmes is to expand and improve the effectiveness of civil society (NGO, CBO) responses to the national response through resource mobilisation, capacity building, coordination, networking and information exchange activities between and among its members. ZAN supports the National AIDS Council that is the overall coordinating body for Zimbabwe by harnessing AIDS service organisations for multi sectoral coordination. ZAN's members work directly with communities at district level in a broad spectrum of prevention, care, support and support activities (including Orphan Care, Hospice, Home-Based Care, and Psychosocial Support). These activities target all population groups throughout the ten provinces of Zimbabwe and as such are expected to make a profound impact on the outcomes of the five-year Zimbabwe National AIDS Strategic Plan 2006 to 2010 (ZNASP).

ZAN governance structure: The governance structure of ZAN includes an Annual General Meeting (AGM) for ultimate accountability. This is followed by a National Membership Council (NMC), made up of the ten (10) chairpersons of the Provincial ZAN Chapter supported by Provincial Executive Committees (PEC) in each province. There is also a Board of Trustees (BOT) that plays a pivotal role in policy making for the network. ZAN is supported by a secretariat that includes a National Director and staff at the national office in Harare; and Provincial Level Coordinators (PLC) in each of the ten (10) provincial chapters. The network is currently supported by six (6) funding partners who include: GFATM, Irish Aid, GTZ, SIDA, HDN and the Africa Groups of Sweden. There is a total membership in excess 460 organisations throughout the ten provinces in the country.

ZAN strategic plan: The recently developed three-year Strategic Plan of ZAN for 2008 to 2010 complements the five-year Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) for 2006 to 2010. The current strategic plan seeks to strengthen and increase the funding base for the civil society response to HIV and AIDS at all levels. To this end, the Global Fund Round 8 presents an excellent opportunity for increased funding of the civil society response. The objectives are defined as the following:

- Resource mobilisation (financial, technical, material, human).
- Member competence strengthening in key areas.
- Improve programming and co-ordination for HIV and AIDS interventions
- Improve information flow and best practices uptake by members.
- Enhance advocacy competency among members.
- Enable ZAN members to effectively advocate on issues of: Prevention, Information, Care and Support, Treatment, Gender and HIV and AIDS, TB and HIV.

Given the emphasis on the Dual Track Financing mechanism, ZAN will work with and support community-based organisations, most of whom will require capacity strengthening in order to access and manage resources for effective community driven responses. ZAN is strategically placed to help ensure that civil society organisations focusing on gender and reaching other vulnerable groups have an equal chance of accessing funding for their programmes.

ZAN's Experience in Programme and Grant Management: ZAN has significant, documented experience in grant management. In February 2006, a Grants Capacity and Systems assessment study concluded that ZAN is the most relevant organisation to channel funds received from the Global Fund to NGOs and CBOs operating throughout the country. A major strength identified is the effectiveness of ZAN's broad based structures that go down to community level.

More specifically, ZAN has managed a mini-grants programme since 2003, funded out of core support and based on priorities identified by the PECs and NMC. Funds disbursed to members through the mini-grants project ranged from a minimum US$ 20,000 to a maximum US$ 120,000 throughout the six-year period. Every year the programme would disburse more than US$10,000 in small grants to strengthen emerging organisations (mainly for procurement of office and computer equipment). Over the five-year period, over ninety (90) member organisations have benefited from the programme. ZAN has also been providing support to Irish Aid (IA) Zambia CHBC partners who are also ZAN members and since 2003, the total grant size for the IA HBC partners in Zimbabwe has increased substantially from about US$1million per year to US$2,5 million in 2007. Over the five-year period, grants ranging in size from US$40,000 to US$155,000 were made to twenty-four (24) organisations with most of these grants being multi-year funding arrangements.

Finally, ZAN is a sub-recipient (SR) of Global Fund for AIDS, TB and Malaria (GFATM) Rounds 1 and 5. The programmatic and financial performance success rate has been over 80% for ZAN for Round 1 phase 1. ZAN has been implementing Rounds 1 and 5 funds through 26 organisations for both the CHBC and VCT components. Support to the implementation of the GF Round 1 and 5 has been through the ZAN operational structure with the M&E Officer taking the lead role in coordinating the programme. The budget is US$1,099,680, of which $380,280 is allocated to seven organisations for VCT, $695,400 to nine organisations for HBC, and $273,408 to ZAN for PMTCT social mobilisation activities and management costs. ZAN is a signatory to Zimbabwe's agreements with the GF for both Round 1 and 5.

4.9.2 Sub-Recipients

(a)	Will sub-recipients be involved in program implementation?	x Yes ☐ No
(b)	**If no**, why not?	
(c)	**If yes**, how many sub-recipients will be involved?	☐ 1 – 6 x 7 – 20 ☐ 21 – 50 ☐ more than 50
(d)	Are the sub-recipients already identified? *(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)*	x Yes See ANNEX 25 ☐ No **Answer s.4.9.4. to explain**

(e) **If yes**, comment on the relative proportion of work to be undertaken by the various sub-recipients. If the private sector and/or civil society are not involved, or substantially involved, in program delivery at the sub-recipient level, please explain why. ***In alphabetical order***

Under National AIDS Council as Principal recipient the following SRs are included:

College of Primary Care Physicians of Zimbabwe (CPCPZ) will be involved in strengthening private practitioner service delivery within the areas of PITC, PMTCT and OI/ART delivery and therefore implement activities under SDA 2.1, 3.1, 4.1, 4.2, 4.3 and 4.4. With over 460 members countrywide, activities will be undertaken to train health clinic staff throughout the country using standardised national training materials, IEC materials and tools. A key component will be to strengthen monitoring systems within the private sector so as to contribute to overall reporting within the national response. Practitioners registered with CPCPZ will be involved with directly providing PITC, PMTCT and OI/ART services through support given from this grant.

Employers' Confederation of Zimbabwe (EMCOZ) and Zimbabwe Congress of Trade Unions (ZCTU) are the national umbrella business organisations responsible for coordinating employers' and workers activities. Both EMCOZ and ZCTU are the representative bodies of the bipartite partners in the workplace, comprising employers and labour. EMCOZ/ZCTU will implement activities under SDA 1.3 to support workplace policy development within the behaviour change component of the programme. HIV responses will benefit employers and workers and, their families and communities to scale up HIV and AIDS responses in the private sector. Current responses remain limited and largely fragmented. The International Labour Organization (ILO) will continue to provide the technical backstopping partners and will provide the technical management assistance to the consortium during the first two year to prepare the organization for the more involving national coordination of the private sector response.

Ministry of Health and Child Welfare has the overall responsibility for the health of the nation and as a sub-recipient will spearhead and lead a large proportion of the implementation of activities within the public and private health sector that pertain to OI/ART delivery, scale up of PMTCT interventions and the PITC approach. These fall within SDA 2.1, 3.1, 4.1, 4.2, 4.3 and 4.4. MOHCW are uniquely positioned to promote and ensure that the integration of services remain the key focus of all public health interventions including those described under this HIV component to ensure positive impact that contribute to achieving the millennium goals. MOHCW works in close collaboration with a wide range of implementing and technical partners and has close links with the wider donor community. MOHCW coordinates overall activities for health service delivery at national, provincial and district level which are managed within the overall health system infrastructure. MOHCW are also responsible for the efficient procurement of all medical technologies, diagnostic equipment and reagents through the national logistics supply unit (LSU) and the national microbiology reference laboratory (NMRL). As SR for the HIV component, MOHCW will ensure through the AIDS & TB unit that implementation of PITC, PMTCT and OI/ART service provision will be scaled up on a national basis with support from the Global fund as well as other already contributing donors. Their responsibility will be to coordinate and manage the decentralisation of health services to ensure nationwide coverage. Routine monitoring and evaluation of the national health programme at all levels is undertaken by health care workers within the national health system which will continue to feed into the overall M&E system as laid out in the national HIV strategic plan.

Ministry of Public Service, Labour and Social Welfare (Support OVC) is the arm of government with statutory responsibility for the protection of vulnerable groups. As SR supporting SDA 6.1 in this grant, they will be responsible to coordinate the scaled-out implementation of the NAP for OVC. Resources will be allocated for improving assigned staff's conditions of service; provision of catalytic resources to ensure effective oversight role by the Ministry and coordination structures; capacity building (skills transfer – training) at sub national level and strengthening of linkages and networking among key stakeholders.

United Nations Population Fund (Prevention – BC): UNFPA Zimbabwe will offer its services in terms of implementation of the component on HIV prevention behaviour change under SDA 1.2. As a sub-recipient UNFPA proposes to provide programmatic oversight on decentralized implementation and provide funding to a number of sub-sub-recipients involved with carrying out behaviour change programmes. UNFPA Zimbabwe's involvement is designed **with the overall purpose of national and local capacity development**. For this purpose a programme management unit will be developed **in a local partner organization with the purpose of developing capacity in a national lead agency for behavioural HIV**

prevention. This programme management unit will have functions of: programme oversight and management; epidemiological review, evidence-based planning, monitoring and evaluation; communication (materials, tools and training in utilization of tools); finance, administration and cost-effectiveness analysis. It is envisaged that by end of year 1 this programme management unit is fully established and that after year 2 it will have the capacity to take on responsibility of managing the behaviour change programme. UNFPA will then hand over SR responsibility and continue to provide technical advice.

University of Zimbabwe Department of Medicine (improving quality of care and treatment) is linked with public health service delivery at one of the central hospitals in Harare and one in Bulawayo. A key role of the university is to train medical students and coordinate pre-service curricula and training. As an academic institution with the added value of drawing upon inter-departmental expertise, the university will spearhead improvements in quality of care through supporting a centre of excellence to use as a benchmark for clinicians, nurses and counsellors to learn from. Activities to be implemented will fall under SDA 4.1 and 4.4. which include implementation of operational research.

Zimbabwe National Family Planning Council With a strong background in training health service providers in comprehensive reproductive health services, ZNFPC will spearhead the development of integrated training materials to include FP within the broader STI/ HIV and AIDS frameworks under SDA 3.2, a missing element of the current integrated package of services. Training materials to enhance access to family planning services will be standardized and used to train provincial and district coordinators to further cascade skills and information to a network of community based cadres. The ZNFPC already offers clinic-based services through its 11 static clinics and community based services through a nationwide network of community based distributors who provide a wide range of reproductive health services at grassroots level.

Under Zimbabwe AIDS Network as Principal Recipient are the following SRs:

HOSPAZ (expanded community care) is a well established organisation in Zimbabwe and has been instrumental in scaling up of home based care activities, standardising palliative care services and strengthening linkages to provide a comprehensive package of care and support that goes beyond just health service delivery. These have been included under SDA 5.1 and 5.2. Their primary focus as SR will be to manage and implement community based activities in support of home based care activities and provide a holistic package of care and support that includes both practical medical care as well as psychosocial and nutritional support. HOSPAZ draws upon their experience in managing community initiatives that will be enhanced and scaled up during the course of this funding mechanism. Particular attention will be paid to a holistic approach to care that links necessary health care provision within the broader context of development and poverty reduction such as strengthening linkages with agricultural services to promote greater sustainability and community involvement in managing households affected by HIV and AIDS. Specifically through their already recognised leadership, they will continue to train community health workers on HIV and AIDS and TB/HIV co-management focusing on prevention, care, treatment and support utilising the harmonised national training package.

PSI and Safaids (social mobilisation for OI/ART, PMTCT and PITC),
In close collaboration with the MoHCW and HIV services implementing partners, SAFAIDS and PSI will continue to develop and implement communication strategies and campaigns that support the behaviour change component of the proposal under SDA 1.1. Mass media campaigns and professional interpersonal communication activities will aim to reducing multiple concurrent partnerships, increasing consistent and correct condom use and increasing awareness about male circumcision as a new emerging HIV prevention intervention for men. Implementation of the activities will be done in collaboration with several local partner organizations, PLWH and the existing national structures (MOHCW and NAC) at all levels. In addition, SAFAIDS and PSI will continue to develop communication strategies and campaigns with the objective to build overall understanding on the critical issues of HTC, on all components of PMTCT and on HIV treatment and care services, including ART. Increased knowledge and understanding of the services and their links will help to reduce stigma and create demand. The campaigns will address adults as well as caregivers of children as potential users of the services. All communication activities will be integrated with the wider HIV and AIDS communication strategy of the MOHCW and include mass media campaigns disseminated through TV, radio and the printed media as well as information materials for users and providers of the services.

Zimbabwe National Network of People living with HIV (ZNNP+): As the national umbrella network of PLWHIV support groups and chair of the PLWHIV Forum comprised of networks and institutions, ZNNP+ will implement activities under SDA 7.1. Networks including the Network of Positive Youths, Network of Zimbabwe Positive Women Public Personalities Against Aids Trust (PPAAT), the CENTRE, ZBCA, and Zimbabwe Network of Religious Leaders Living with or Personality Affected by HIV and AIDS (ZINERELA), ZNNP+ would play a central role in coordinating the activities for PLWHIV in conjunction with NAC in line with the meaningful involvement of people living with AIDS (MIPA) concept so that effective partnership are built and ensure avoidance of duplication within the national responses. ZNNP+ is seeking to create a supportive environment where there is the strengthening of PLWHIV involvement in the national response. PLWHIV will be actively involved in all the coordination structures and programmes, and they will also facilitate collection and sharing information around MIPA concept into reality in fulfillment of one of the eight guiding principles of the ZNASP. NAC and UNAIDS will play a pivotal role in supporting ZNNP+ to fulfill this role. ZNNP+ has in the past been managing smaller grants and in order to absorb funds from the Global fund will require management system strengthening. Organisations such as Skillshare International, VSO RAISA and Horizon 3000 will be approached to support the organisation. In the meantime, ZNNP+ continues to revisit its constitution to strengthen and differentiate further its roles and responsibilities as well improve on service delivery.

4.9.3. Pre-identified sub-recipients

Describe the past **implementation experience** of key sub-recipients. Also identify any challenges for sub-recipients that could affect performance, and what is planned to mitigate these challenges.

SRS UNDER NATIONAL AIDS COUNCIL (NAC)

College of Primary Care Phycicians of Zimbabwe (CPCPZ)

The CPCPZ is an independent and autonomous professional association of family practitioners in private practice in Zimbabwe. It is the largest professional association of doctors in Zimbabwe with a membership of 460 spread throughout the country.

The CPCPZ was established in 1985 and its major objectives as outlined in the constitution are:

- To foster and maintain the highest possible standards in general/ family medicine
- To establish and maintain regional faculties whether within or without the structure of the College designed to further the interests for which the College is established.
- To cooperate with other bodies in all matters relating to or connected with the attainment of the objectives for which the College is established.
- To undertake, accept, execute, perform or administer any lawful trusts and conditions affecting any real or personal property held or owned in trust for the College or any other charitable association, institution, society or body and any other charitable trusts.

The College is headed by a Council comprising of key office bearers (President, Vice President, Honorary Treasurer, Honorary Secretary and Council members drawn from the whole country). There are standing committees such as the Finance, Education, and Events/Programs. These committees are designed to supervise and ensure that the various functions of College are successfully achieved. CPCPZ is in the process of recruiting a finance and administration manager. Independent external auditors audit the College accounts annually.

While the members of the College have the required technical expertise to implement the proposed activities, its administrative capacity is proposed to be strengthened with GF support, so that the full potential of involvement of private practitioners in the national HIV response can be realized. Costs required for strengthening the administrative and managerial capacity of CPCPZ have been included in the work plan.

Employers' Confederation of Zimbabwe (EMCOZ) and Zimbabwe Congress of Trade Unions (ZCTU)

EMCOZ is the national umbrella business organisation responsible for coordinating employers' activities. It was registered with the Ministry of Public Service, Labour and Social Welfare (MOPSLSW) in 1980 as an employer federation. Its membership comprises national apex organisations such as the Zimbabwe Chamber of Commerce, the Confederation of Zimbabwe Industries, the Zimbabwe Chamber of Mines, the

Farmers' Unions, the Bankers' Association and the Hotel and Restaurant Association, 47 affiliated employer associations and individual corporate affiliates. Therefore, EMCOZ is the logical entry point for coordinating the scaling up HIV and AIDS responses in the private sector representing employers.

EMCOZ has a dedicated department which coordinates all HIV and AIDS activities. It works with its membership in formulating, developing and implementing workplace HIV and AIDS programmes. It works closely with the Zimbabwe Business Council on AIDS (ZBCA) and the International Labour Organisation (ILO) as technical backstopping partners, in addition to research institutions, universities, NGOs and government ministries. EMCOZ has the capacity to do financial reports to accepted international standards and regularly is audited annually by external auditors.

EMCOZ has worked on a number of related projects at the national level. These include the following:

- Through funding from ILO/ACTEMP, EMCOZ has implemented a project on combating child labour as part of the Fair Globalisation Project.
- EMCOZ sought and received assistance from the International Organisation of Employers (IOE) to carry out a project on Occupational Health and Safety in the Micro, Small and Medium Enterprises (MSME).

ZCTU was formed in 1980 and has 36 affiliates and a membership of over 300,000. They are a legally constituted body, with capacity to enter into legal contracts, to sue and be sued.

ZCTU has an HIV and AIDS department with a dedicated focal person for the national coordination of efforts of its affiliates. The union has the capacity to manage project funds, with a well developed financial management and reporting system. Recognising the impact of HIV and AIDS on their membership, the union has a draft policy on HIV and AIDS which is awaiting adoption by the ZCTU General Council. Education and awareness programmes and counselling workshops have been conducted for shop stewards but need scaling up. ZCTU and EMCOZ are currently working on a joint two-year (2007-2009) SIDA-funded project to scale up HIV and AIDS responses at the workplace in the private sector. EMCOZ and ZCTU are the representative bodies of the bipartite partners in the workplace, comprising employers and labour. The project activities are meant to benefit employees, their families and communities. Depending on the nature of activities, the two organisations will jointly coordinate and implement the programme.

While EMCOZ/ZCTU have the above-mentioned experience in HIV programming and strong overall administrative capacity, their current staffing levels would not be sufficient for developing and maintaining nation-wide action as outlined in this proposal. Therefore specific positions for HIV prevention programming and M&E have been included in the work plan to ensure that activities can be smoothly cascaded to all the identified work places throughout Zimbabwe.

Ministry of Health and Child Welfare

The MOHCW has experience as a sub-recipient that is implementing programmes supported by the Global Fund 1 and round 5. The programme overall goal for Rounds1 and 5 was to contribute to the lowering of transmission, improving care and thereby seeking to decrease national morbidity and mortality. The specific components to achieve the goal in round one were: to expand access to voluntary counselling and testing (VCT): to expand services for prevention of mother to child transmission of HIV/AIDS in 12 districts and to provide antiretroviral treatment to people living with HIV/AIDS at public health facilities (5 sites). Round 5 was designed to expand the services initiated under GF Round 1 in 22 districts including the original 12. The MOHCW adopted several strategies which included situational analysis and a mix of capacity building (individual and institutional), service delivery, networking information sharing and dissemination, social mobilization, advocacy and empowerment elements. The MOHCW through the AIDS and TB Unit provided the overall project coordination, but planning, organisation and implementation of activities, submission of monthly performance data and quarterly report submission was decentralized to the districts structures.

Challenges included delays in disbursement of funding with resultant high attrition rate of Primary Care Counsellors and stock out of commodities. The hyperinflation environment, which prevailed, for the most part of programme implementation put pressure on the limited phase one budget. The UN exchange rate adjustments were not in line with inflation and this affected planned renovation activities. Erroneous target setting for PMTCT and delays in approval of revised targets. ARVs procurement and supply management was affected by errors in forecasting and quantification resulting in over estimation of some drugs and underestimation of others. The system of follow up and tracking of clients was weak and so was linking

pregnant women to treatment.

Plans to mitigate challenges: Better targeting, to avoid interruptions due to lack of funds or stocks, spare parts and fuel among other things. Strengthening of human resources management and ensuring competitive procurement and supply management systems. Strengthening follow up system and community involvement.

Ministry of Public Service, Labour and Social Welfare

The Department of Social Services in the Ministry of Public Service, Labour and Social Welfare employs professional social workers who are appointed as probation officers in terms of the Children's Act (Chapter 5:06) to deal with children's issues including legal protection – foster and institutional care, adoption, and protection of children in conflict with the law. The Department has extensive experience in provision of material assistance, psychosocial support through officers trained in counseling and in the formulation and implementation of policies adhering to international, regional and national standards.

In order to respond to challenges faced by an increasing number of OVC as a result of HIV and AIDS, the Ministry, in collaboration with stakeholders in childcare and protection, engaged in a process of developing a National Action Plan for Orphans and Vulnerable Children (NAP for OVC). The plan is premised on the UNGASS on HIV and AIDS goals 65, 66, and 67 and contributes to the achievement of the Millennium Development Goals in regard to OVC. The goal of the plan is to provide a framework for coordinated implementation of interventions and increase access by OVC to basic services and improve their protection from all forms of abuse. It provides a structure that is all encompassing at all levels from communities to national level supporting OVC interventions by government, international and national NGOs, donors, FBOs and community based organisations.

The National Action Plan comprises of seven Activity Areas: 1. Co-ordination; 2. Birth Registration; 3. Child Participation; 4. Formal Education; 5. Extra-curricular Education; 6. Child Protection; 7. Provision of Social Services. Activity areas 2 to 7 are currently implemented by civil society organizations through the Programme of Support for the NAP for OVC financed by a multi-donor funded through UNICEF. Activity area 1 on co-ordination is currently not funded and structurally under the Department of Social Services. At sub-national level the Department has assigned officers to coordinate activities with support from multisectoral Child Protection Committees.

Over decades, the Department has fulfilled similar tasks of co-ordination and management. It has established systems and tools in the area of OVC programming. Furthermore, the Department has good working relations with civil society organizations, UNICEF and international funding partners. While the systems, tools, offices and other structures are available, human resource retention has been increasingly challenging. If human resources can retained through the proposed support, the Department will rapidly rebuild its capacity to better perform its core functions of coordination, overall management and provision of guidance at national, provincial and district levels.

United Nations Population Fund

UNFPA currently provides services in Zimbabwe at policy and implementation level in Zimbabwe:

- **Evidence-based policy and participatory programming:** UNFPA shares and disseminates information on HIV prevention research, supports reviews of evidence on HIV prevention and provides support to policy review and development, recently resulting in development of strategies in the areas of HIV prevention behaviour change, female condom and health sector prevention programming. UNFPA convenes supports and participates in fora to translate research and policy into evidence-based HIV prevention programmes.
- **Implementation of evidence-based programmes:** As a fund UNFPA currently supports scaling up of evidence-based HIV prevention programmes in the following areas:
  - Decentralized implementation of Zimbabwe's National HIV Prevention Behaviour Change Strategy in 26 districts (with support from the Expanded Support Programme and the European Commission) in collaboration with 8 partners including training of key stakeholders, interpersonal communication, material development and production, M&E*;*
  - Condom programming including technical reviews, support to nation-wide training of service providers, procurement of inputs;
  - Scaling up of HIV prevention services including testing and counselling, STI control and emerging prevention technologies such as male circumcision.

- Integration of HIV prevention in sexual and reproductive health is a cross-cutting priority for UNFPA.

UNFPA currently plays a similar role for the Expanded Support Programme and for a European Commission funded prevention programme implemented in 26 districts (12 million USD over 3 years). In the current set up UNFPA supports 8 provincial behaviour change support organizations:

- **Mashonaland West:** Batsirai Group
- **Manicaland:** FACT Mutare
- **Matebeleland North:** Matebeleland AIDS Council (MAC)
- **Midlands:** Midlands AIDS Service Organization (MASO)
- **Masvingo:** Regai Dzive Shiri
- **Matebeleland South:** World Vision Zimbabwe
- **Mashonaland Central:** Zimbabwe AIDS Prevention and Support Organization (ZAPSO)
- **Mashonaland East:** Zimbabwe Health Intervention Research Project (ZiCHIRe)

An implementation system including programmatic tools, management processes, M&E is already in place. UNFPA proposes that the existing functioning implementation system be used to scale up the decentralized implementation of the National BC Strategy to the 34 rural districts currently not covered and to Harare and Bulawayo.

University of Zimbabwe College of Health Sciences Department of Medicine

The University of Zimbabwe College of Health Sciences Department of Medicine is the premier teaching faculty for internal medicine in Zimbabwe. Its faculty is made up of highly qualified, and internationally recognized physicians, who are dedicated to training medical students and junior doctors, conducting both operational and basic science research and patient care primarily in the public health system.

In 2004 the Department of Medicine initiated the Parirenyatwa Hospital Opportunistic Infections (OI) clinic. At that time the primary function of the clinic was to mitigate the effects of HIV disease in HIV positive individuals through the provision of prophylaxis for and treatment of acute opportunistic infections. As antiretroviral (ARV) drugs became available through the national treatment program, the clinic transformed from being an OI clinic to becoming a leader in HIV/ART care. In January 2005 the clinic received its first ARVs, and has since then developed into one of the larger public institutions for the provision of ART, care and support services. In June 2006 the adult and the paediatric HIV/ART clinics are Parirenyatwa Hospitals serviced by the Departments of Medicine and Paediatrics respectively merged in order to provide family centred and comprehensive HIV care, and became known as the Parirenyatwa Family Care Centre. Through the leadership provided by the Department of Medicine, this institution has grown into one of the nations largest treatment and training facilities. To date over 5,000 adult patients, and 1,000 paediatric patients have received care at the facility. In addition the centre has become a major training ground for HIV treatment, care and support and has provided hands-on training for numerous junior doctors, nurses, professional and peer counsellors.

The Department of Medicine has the technical capacity to oversee the Centre of Excellence proposed for GF support. However, in order to retain highly qualified and specialized staff a human resource support component was included in the proposal.

Zimbabwe National Family Planning Council (ZNFPC)

ZNFPC, a parastatal organisation under Ministry of Health and Child Welfare is mandated to co-ordinate the provision of Family Planning/ Reproductive Health information and services in Zimbabwe and to collaborate with relevant key ministries, non-governmental organisations (NGOs) and private sector agencies.

ZNFPC is divided into service and support units, with financial and administrative units at both national and provincial levels. The Service Delivery Unit consists of clinic-based and community-based programmes. Support Units include Training; Information, Education and Communication (IEC) and Evaluation and Research. ZNFPC has operating offices in the eight provinces and has a total staff establishment of over 1200, the bulk of whom are Community Based Distributors (CBD). The ZNFPC Training Unit is responsible for training health service providers in comprehensive reproductive health services including STI/ HIV and AIDS, male motivation, youth reproductive health, and Provider Initiated Counselling Training. The ZNFPC offers clinic- based services through its 11 static clinics and community based services

through a nation- wide network of CBDs who provide a wide range of reproductive health services at grassroots level. The ZNFPC has over 30 Information Education and Communication (IEC) Officers at provincial level who are well experience in planning, designing and implementing IEC related activities which include advocacy, message and materials design, pre-testing and monitoring. The ZNFPC has an Audio Visual Unit at its Headquarters, which has the capacity to produce audio, video and graphic productions. The Evaluation and Research Unit has well trained Research Managers who can co-ordinate the research and evaluation component for ZNFPC. The unit is responsible for developing monitoring indicators and compilation of programme performance reports. The ZNFPC has almost two decades of experience in developing and implementing Adolescent Sexual and Reproductive Health. The ZNFPC has a logistics unit which, carries out the procurement and distribution of council commodities. At provincial level there are stores-men who carry out the distribution of commodities at that level.

Over the past two decades, ZNFPC has gathered extensive experience in management of donor resources. At the moment this includes a UNFPA/EC supported ASRH programme and a youth-centre based SRH programme under GF round 1, an area that is no longer included in GFR8. ZNFPC also collaborates closely with JSI/Deliver in implementing a Delivery Team Top Up System for nation-wide distribution of FP commodities including male and female condoms. With support from UNFPA, ZNFPC has trained over 1,000 service providers in the female condom and safer sex negotiation during 2006 and 2007. This recent experience in large-scale training programmes confirms the capacity of ZNFPC to implement the skills-building around FP integration into HIV prevention services.

While ZNFPC as an institution has the required experience to fulfil its role in the SDA of FP integration into HIV service delivery, high-levels of staff turn-over, which are currently experienced by the organization, may affect continuity of management of the programme. Therefore support to key programme management staff and ZNFPC M&E activities has been included in ZNFPC's work plan within SDA 3.2.

SRs UNDER ZIMBABWE AIDS NETWORK

Hospice Association of Zimbabwe (HOSPAZ)
HOSPAZ is a registered public voluntary organisation (PVO) whose mission is to provide national coordination, training and advocacy to support organisations in their provision of hospice and palliative care. All organisations describing themselves either as palliative care providers or home based care groups have been invited to register with HOSPAZ. Palliative care standards have been devised by HOSPAZ and approved by the Ministry of Health.

1. To provide national coordination of HOSPAZ member organisations that provide care and counselling of patients, families and bereaved
2. To determine and recommend standards of care to be provided by member organisations
3. To coordinate training and other educational activities of member organisations
4. To represent member organisations in Zimbabwe on matters of common interest in consultation, representation, and exchange of information with government departments and other national and international organisations.

HOSPAZ is currently providing trainings on palliative care throughout all provinces of Zimbabwe. HOSPAZ is also responsible for the integration of palliative care into the National Plan of Action for OVC. HOSPAZ has made important contributions to the development of the national guidelines and training manuals on HBC. Furthermore, HOSPAZ has extensive experience in building the capacity of community-based organizations in HBC and palliative care. Currently, the membership of HOSPAZ stands at 150 organizations.

Due to the high need for HBC and palliative care services, HOSPAZ has not been able to meet the entire demand for support to other organizations in HBC service provision. Therefore this proposal will include a component of support to HOSPAZ programme management capacity, which will allow for strengthened support to SSRs and scaling up of service delivery.

Population Services International
PSI/Zimbabwe (PSI/Z) is registered under local laws as a non-governmental trust and is a non-profit organisation. Since 1996, PSI/Z has implemented programmes in support of national public health priorities identified by the Ministry of Health and Child Welfare. PSI/Z has participated in both Global Fund Round

1 and 5 as an SSR and SR respectively for two components—behaviour change communications, which includes also communication activities focusing on TB/HIV collaboration, and testing & counselling which manages several implementing partners and SSRs. Quarterly targets for Global Fund Round 1 were exceeded and financial reports were satisfactory.

PSI/Zimbabwe has extensive experience in HIV/AIDS prevention, family planning and malaria control. All keys posts in the organisation are occupied by highly qualified and experienced staff. Made up of more than 240 staff members, the organisation promotes and distributes *Protector Plus* male condoms (since 1996), *care* female condoms (since 1997) and *Supanet* long-lasting insecticide treated bed nets (since 1998). Since 1999**,** PSI/Z has developed and implemented in collaboration with the MOHCW and 15 local partner organisations *New Start*: a network of centres providing high quality, affordable client initiated HIV testing and counselling (CITC) services. PSI/Z also provides technical support to MOHCW in the national roll out of provider initiated testing and counselling services. Since 2003, PSI/Z's *New Life* centre network has provided post-test support services for people living with HIV and AIDS through 13 local partners nationwide.

PSI/Z is a member of several technical working groups and committees including the CCM and the CCM technical subcommittees for HIV and AIDS and Malaria. PSI/Z has demonstrated the capacity to manage projects involving large budgets since 1996 with a comprehensive finance department with 7 staff members. It has a well-developed accounting system and comprehensive financial policies and procedures. PSI/Z's programmes are funded by two major donors, USAID and DFID as well as by UNICEF and the Global Fund. The organisation is able to comply with strict donor reporting requirements. PSI/Z has a central procurement unit with a decentralised distribution system reaching >15,000 retail outlets and warehouses in most provinces. The procurement system is capable of handling high value products and large volumes of goods.

PSI/Z has its own research department and has large experience in data collection and analysis. PSI/Z has a comprehensive M&E plan detailing timeframes and standardised indicators that are consistent with the Global Fund requirements, with international donor frameworks and with the national M&E framework of NAC.

Southern Africa HIV/AIDS Information Dissemination Service (SAfAIDS)

SAfAIDS is a regional NGO established in 1994. SAfAIDS mission is to promote effective and ethical development responses to the epidemic and its impact through HIV/AIDS knowledge management, capacity building, advocacy, policy analysis and research. SAfAIDS is a SSR of Round 5 global Fund involved with Behaviour Change Communication, Mass media and community outreach and a SR for the Workplace and Advocacy component. SAfAIDS core strengths are: building the capacity of other NGOs to produce a multiplier effect of good practice; information production and dissemination to a wider audience; documentation of Best Practice; building partnership and networking; leadership in identifying and addressing cutting edge issues; and gender and human rights advocacy.

SAfAIDS **primary target** group consist of service providers in intermediary organisations such as NGOs, FBOs, ASOs, CBOs, the media, academic and research institutions (NGO leaders, programme officers, field officers, community based volunteers, journalists, researchers in the field of HIV/AIDS, nurses and doctors. The **secondary targets** are individuals and communities that are at high risk of HIV infection to who are the target beneficiaries of the partners of being reached by SAfAIDS.

Over the years SAfAIDS has gained notable regional experience and can claim leadership and expertise in skills to interpret and repackage information from a variety of sources, including medical and technical, into formats that are more accessible to readers of different literacy levels. SAfAIDS' emphasis has been on disseminating HIV/AIDS prevention, care and supportive messages that is inspirational, effective and evidence-based. SAfAIDS' regional response to HIV/AIDS involves a three prong approach, including: 1) Design and development of high quality treatment literacy materials, which are adapted, translated and distributed throughout the southern African region and beyond; 2) Capacity development of AIDS Service Organisations (ASO), Community-based organisations (CBO) and private sector organisations; 3) Implementation of a cascading approach to reach communities with HIV information and documentation of best practices and experience sharing platforms.

SAfAIDS provides a variety of services that include; information packages, handbooks, toolkits, books,

and IEC materials, resource centers, training of trainers in the various packages, media training, capacity building on treatment literacy, stigma and discrimination, documentation of best practices, setting up and managing resource centres, workplace policy development, discussion forums, e-platforms and advocacy and policy platforms. SAfAIDS staff brings a broad range of skills and professional experience to their contributions to the organisation's work.

Zimbabwe National Network of People Living with HIV (ZNNP+)

ZNNP+ is an umbrella network founded in 1992 with membership of support groups of People Living with HIV (PLHIV) throughout Zimbabwe. Its current membership is estimated to be 50,000 PLHIV including OVC and women. The organization promotes empowerment of PLHIV through skills development, information sharing, community involvement in HBC, counselling and lobbying for the rights for PLHIV. The Secretariat is managed by a National Coordinator as the chief operating officer of the organization to manage the network's activities. The actual programming is overseen by the programme manager assisted by Provincial Coordinators who at the moment are volunteers. ZNNP+ also has a full-time finance and administration manager who is in charge of the day to day administrative business of the organization. ZNNP+' activities cover the whole continuum of HIV and AIDS programming, that is: prevention, treatment, care and support and endeavors to provide a supportive environment. Central to ZNNP+ programming is the concept of MIPA (Meaningful Involvement of People Living with HIV).

ZNNP+ has experience in managing funding from CDC and Action Aid for the establishment of support groups at community level as well as governance structures within these PLHIV communities. The major challenges being faced by the network relate to lack of effective coordination of the large number of grass root structures throughout the country to ensure adequate support, to local PLHIV groups and timeous flow of data to inform programmes within the network. The other challenge includes lack of community-owned guidelines to strengthen and sustain associations/ networks of PLHIV in Zimbabwe. In addition due to human capacity and financial resource constraints the network is currently strongly relying on volunteers who are frequently experiencing burnout.

In order to mitigate these challenges ZNNP+ is currently working with UNAIDS and NAC to solicit for support for a 6 month work plan (starting September 2008 to March 2009) which seeks to strengthen ZNNP+ governance structures at National and Sub National level. This 6month plan seeks to mobilise resources that would reinvigorate the strengthening of coordination and support to decentralized PLHIV groups. The proposed Global Fund support will build on this initial work plan to strengthen ZNNP+ national and decentralized capacity to co-ordinate and guide the development of PLHIV support groups.

4.9.4. Sub-recipients to be identified

Explain why some or all of the sub-recipients are not already identified. Also explain the transparent, time-bound process that the Principal Recipient(s) will use to select sub-recipients so as not to delay program performance.

NA

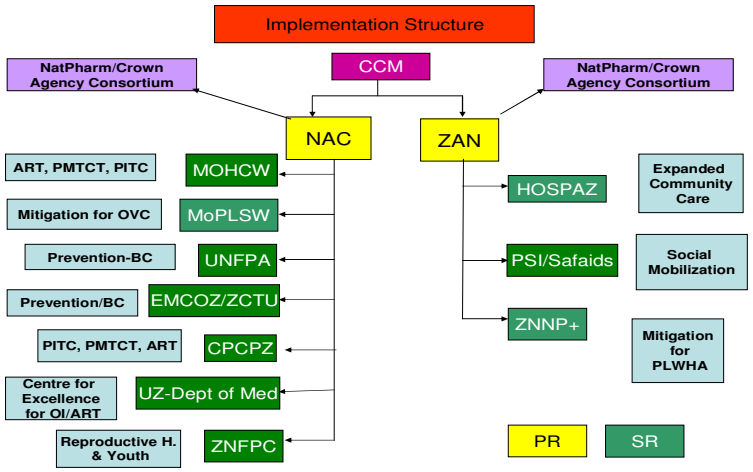
4.9.5. Coordination between implementers

Describe how coordination will occur between multiple Principal Recipients, and then between the Principal Recipient(s) and key sub-recipients to ensure timely and transparent program performance.

Comment on factors such as:

- **How Principal Recipients will interact where their work is linked** *(e.g., a government Principal Recipient is responsible for procurement of pharmaceutical and/or health products, and a non-government Principal Recipient is responsible for service delivery to, for example, hard to reach groups through non-public systems)*; and
- **The extent to which partners will support program implementation** *(e.g., by providing management or technical assistance in addition to any assistance requested to be funded through this proposal, if relevant)*.

The two principal recipients chosen to manage the HIV component will be the National AIDS Council (NAC) and the Zimbabwe AIDS network (ZAN) who will each be responsible for overseeing the implementation and reporting from the sub-recipients as depicted in the diagram below and as outlined in the previous section 4.9.2. Programme performance will be based on the detailed implementation plan meeting targets addressed in Appendix A with budget allocations outlined under each SR. In summary the majority of the health service delivery areas will be coordinated by NAC along with the behaviour change component of the proposal managed by UNFPA and EMCOZ. In addition, NAC will be responsible for coordinating the procurement of pharmaceutical and health products which will be directly managed by NatPharm and the Crown Agents consortium as described in section 4.10. and outlined in Appendix B. ZAN will be responsible for managing civil society organisations involved with components of behaviour change namely PSI/Safaids, community home based activities involved and strengthening of networks of PLWHIV.



Each PR will draw up a grant agreement with each of the SRs and ensure that these comply with global fund regulations. The PRs will hold regular coordination meetings between themselves and with individual SRs to ensure effective collaboration between all implementers (state and non state) and community systems and to address challenges that may emerge especially related to implementation and service delivery. The PRs joint roles will be to address:

- Coordination with reference to supply chain management challenges linked to commodity supplies, pharmaceutical supplies, deployment of service providers, appropriate spread (geographic) and mix of services;
- Collaboration with reference to scale-up strategies in communities and districts where there is unmet need and how state and non state comprehensive service delivery will be maintained as part of scale-up;
- Address challenges that threaten to slow down service delivery coverage and success;
- Joint engagement related to country policy, frameworks and strategies that directly impact on the

response to HIV and AIDS.

The PRs will collaborate in terms of feeding into a common national M&E reporting system such as the CRIS (managed by NAC), agree to standardised data collection (including financial management), analysis and verification modalities; and agreed national reporting templates. Timely and accurate return of financial and programme reports will be collected on a quarterly basis and consolidated by the respective PRs with overall consolidation of reports being the responsibility of NAC. Reports will be presented to the CCM, having collected and received these from each of the respective sub-recipients. A key part of this process is to monitor progress made regarding universal access to services and commodities. These will be reviewed through bi-annual meetings with the SRs and SSRs. ZAN will ensure that there is a constant focus on gender and social inequality, and supporting the strengthening of community systems.

Complementing these coordination activities are a number of national forum meetings where additional technical expertise and support is provided through established partnerships being supported by other donors such as the ART partnership forum, PMTCT partnership forum, Testing and Counselling sub-committee, M&E sub-committee, paediatric AIDS sub-committee to name but a few. National, provincial and districts reviews have also been built into this proposal, which will be organised by MOHCW as SR to inform progress against the stated targets.

4.9.6. Strengthening implementation capacity

The Global Fund encourages in-country efforts to strengthen government, non-government and community-based implementation capacity.

If this proposal is requesting funding for management and/ or technical assistance to ensure strong program performance, summarize:

(a) the assistance that is planned;**

(b) the process used to identify needs within the various sectors;

(c) how the assistance will be obtained on competitive, transparent terms; and

(d) the process that will be used to evaluate the effectiveness of that assistance, and make adjustments to maintain a high standard of support.

*** (e.g., where the applicant has nominated a second Principal Recipient which requires capacity development to fulfill its role; or where community systems strengthening is identified as a "gap" in achieving national targets, and organizational/management assistance is required to support increased service delivery.)*

Zimbabwe is fortunate to benefit from strong local technical capacity in many areas related to this proposal with multisectoral representation. Additional technical and implementation of strategies funded through support from other bilateral and multilateral partners have also been committed to complement the direct support that is outlined within this proposal.

Strengthening capacity: National AIDS Council

The National AIDS Council is already acting as Principle recipient to manage global fund round 5 activities and has gone through a process of capacity needs assessment resulting in reorganisation and strengthening of management structures and procedures. The focus of the initiative ranged from systems development, human resources, institutional support (finance, equipment and logistics) skills development and project management. NAC subsequently has put in place a strong technical and financial programme management team based on recommendations from these assessments who oversee implementation of the national responses as well as manage the global fund round 5 activities. This structure will continue to supported and expanded to increase capacity to manage this larger grant over the course of the five years. The issues of staff retention have been given priority given that without adequate and experienced human resources, the implementation of the Strategic Plan, ZNASP or the Global Fund Grants will remain problematic especially with regards to the absorption of resources earmarked for the national response to HIV and AIDS. Specifically NAC will recruit an additional programme manager, financial officer, compliance and grants officer and administration staff to effectively build capacity and support the seven SRs selected to implement activities within this HIV/AIDS component.

An important focus of this proposal is to address health and community systems strengthening and NAC

will contribute to this by building capacity of SRs and SSRs to manage and implement sustainable interventions on the ground. NAC will carry out capacity needs assessments for the SRs and address gaps through organisational development workshops to strengthen management, financial reporting, best business practices as well as monitoring and evaluation. NAC will familiarise all SRs on operational guidelines and compliance procedures being developed under GF round 5 to ensure transparent and accountable systems are upheld in managing global fund grants. Partnership review meetings for SRs and SSRs will be organised on a bi-annual basis to review programme performance progress against targets as well as financial expenditures and burn rates compared to budget allocations. These will be in addition to quarterly meetings to be undertaken on a regular basis.

In addition, specific attention will be given to strengthening monitoring and evaluation mechanisms to improve national reporting as well as financial management. Many of the activities already included within sections 4.8.1, 4.8.2 and 4.8.3 will be overseen with NAC support. NAC will strengthen their own data management capacity by purchasing a suitable data server to establish and maintain a comprehensive database that will be able to cope with the expansion of the programme. NAC also require additional support to operationalise resource tracking procedures as part of these M&E processes. From experience in administering previous global fund grants, NAC has also begun to carry out joint support visits for programmatic data verification and validation including financial returns resulting in improvements in data quality and reporting. These will provide an opportunity to monitor the impact of technical assistance provided to each of the SRs and ascertain their increasing capacity. These visits will be continued under GF round 8. Finally to support this larger grant, minimal additional equipment and one vehicle will be procured to strengthen the capacity of NAC to effectively manage this grant.

Strengthening capacity: Zimbabwe AIDS Network

ZAN is aware of the Global Fund facility for Health Systems Strengthening (HSS) and subsequent provision of Technical Management Assistance (TMA) for efficient and effective service delivery at all levels. ZAN as a PR will work with a selected technical management agency to further develop its capacity for PR status and that of sub recipients and sub sub recipients. The initial focus will be on further enhancing ZAN capacity with a subsequent focus on enhancing and building the capacities of SRs and SSRs. The capacity building of SRs, SSRs and other civil society organisations involved in Global Fund supported and other HIV and AIDS programmes, will remain as an ongoing process. ZAN will establish an adequate human resource operational structure at the national and provincial levels for its role as a PR, as the current human resource structure is more appropriate for its role as a SR. To this effect adequate human resources will be required for technical support, quality control and supervision, M&E support, financial management, auditing, information and communication. The Technical Management Assistance Agency that will be identified for Round 8 will work with ZAN as a PR to identify and support relevant HR and technical requirements and gaps that include:

- Improving the internal audit function by employing an internal auditor.
- Focusing on logistics and supply chain management by employing a supply chain manager.
- Improving grants management capacity by expanding the national team with an additional grants manager.
- Expanding the M&E unit at the ZAN national office with at least two M&E officers that will help with data validation, verification, reporting and uploading into the NAC database. These officers will also be seconded to SRs and SSRs where needed to offer mentorship support and training.
- Expanding the communications capacity of ZAN by employing a communications officer with information technology and knowledge management skills.

To enhance the capability profile of ZAN as a PR, the following skill areas will be the focus and content of capacity development for the organisation including the transfer of skills, knowledge development sessions and mentorship support:

- Financial management and auditing including statement of accounts, grantee spending reports, periodic balance sheets, and asset registers;
- Monitoring and evaluation with emphasis on indicator development, data collection and analysis, data quality audits; and reporting;
- Communications including all forms of reporting, managing mass media processes, web based (web sites, email and other) and other mediums;
- Management of information and knowledge;
- Effective grants management and skills to support and mentor SRs and SSRs of GF funds; but also effective management of grants of the other donors ZAN currently has;

- Supply chain management, project management and programme management skills; and
- Knowledge development of key staff with reference to all aspects of the pandemic; including issues, challenges and efficacy of all interventions with an emphasis on innovation.

In addition to the above ZAN will require support in expanding its infrastructure such as the following: 4 vehicles; computer, printing and audio-visual equipment; furniture and fittings. Finally specific technical and financial support has also been included to support ZNNP+ under SDA 7.1. A number of consultations and capacity needs assessments were carried out during 2007 and early 2008 to evaluate the strengths and weaknesses of networks of PLHWA. Based on these, ZNNP+ is requesting funding in the form of technical assistance especially in supply of vital key staff such as National training officer, M&E officer since these posts are vital to ensure strong program performance for the organization. In addition the organization also require support in terms of securing its infrastructure such as offices, equipment, communication and transport at all levels and is currently lacking.

Capacity building of SRs, SSRs and community systems strengthening

Similar to the intentions being under taken by NAC, ZAN will ensure health and community systems strengthening under the components of the grant, that they will manage. The expected outcome of the SR and SSR capacity building process is an increased number of organisations strengthened with the technical competencies to deliver services that improve the quality of HIV and AIDS and GFATM-funded services to the communities. ZAN will ensure that the TMA facility provides capacity building assistance potential SRs and SSRs. The key strategy will be to focus on the skills, knowledge base and capacities of these SRs and SSRs in order to position them to take a leading role in their contribution to the community driven response that is a key requirement for Round 8.

Key areas of competency strengthening for SRs and SSRs may include but are not limited to:

- Capacity building of SRs and SSRs in organisational development (leadership, governance, financial and programme management and accountability);
- Mentoring, training and twinning for SRs and SSRs in M&E and specialised programme areas;
- Support networking, documentation and information sharing activities for SRs and SSRs at different levels; and
- Enhance advocacy capacity SRs and SSRs to support vulnerable and most at risk groups such as women, girls, people with disabilities and the hard to reach at community level.

Implementation of the above interventions will improve the competency of Civil Society Organisations effectively contribute to community driven responses to the epidemic with special attention being given to vulnerable and most at risk groups.

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 8 proposal

Does this proposal seek funding for any pharmaceutical and/or health products?

☐ **No**
➔ ***Go to s.4B if relevant, or direct to s.5.***

x **Yes**
➔ ***Continue on to answer s.4.10.2.***

4.10.2. Table of roles and responsibilities

Provide as complete details as possible. *(e.g., the Ministry of Health may be the organization responsible for the 'Coordination' activity, and their 'role' is Principal Recipient in this proposal). If a function will be outsourced, identify this in the second column and provide the name of the planned outsourced provider.*

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)*	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	NAC will coordinate all procurements within this proposal including those required by ZAN as the other PR. NAC as PR will be responsible for this function and will outsource the procurement and supply chain management function to the NatPharm/Crown Agents Consortium, a private/public partnership which has already been established to perform the procurement function under Global Fund grants in Zimbabwe.	The NatPharm/Crown Agents Consortium as the Procurement Agent will conduct the procurement function. The Consortium has detailed written regulations which emphasise the need for transparency, fairness and competitiveness. The manuals are available for the LFA to review. To date the value of Consortium Procurements is as follows: National AIDS Council (NAC) - USD 2, 912,125.92; Zimbabwe Association of Church Hospitals (ZACH) - USD 2,351,125.92. NatPharm has conducted procurement to the value of USD 35 million whilst Crown Agents has procured to the value of USD264million. This makes a total of USD270million. The estimated total value of procurement to be conducted over the next 12 months is approximately USD9 million which is 3.3% of current procurement capacity. The Consortium has a dedicated experienced procurement team at the Consortium offices.	x No
Intellectual property rights	NAC as PR is responsible for adhering to national and international laws.	Zimbabwe is a member of the World Trade Organisation and is thus obliged to comply with the WTO trade rules such as the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The Patents Act (Chapter 26:03) gives effect to Zimbabwe's obligations under the TRIPS Agreement to ensure that appropriate provisions are provided which will cater for access to essential medicines among other issues. The amendment allows for parallel importation, compulsory	X No

		licensing, government use provisions and early working for generics. The NatPharm/Crown Agents Consortium as the Procurement Agent will adhere to international and national laws in its procurement processes.	
Quality assurance and quality control	The Medicines Control Authority of Zimbabwe (MCAZ) under The Ministry of Health and Child Welfare will be responsible for this function under the grant.	MCAZ is the national regulatory authority and will be the quality assurance and control agent under this function. Under the MCAZ the Zimbabwe Regional Medicines Control Laboratory (ZRMCL) acts as the WHO Regional Reference Control Laboratory. It has a functional laboratory. The laboratory is equipped to carry out QA tests on the full range of first and second line TB drugs. All pharmaceutical products imported into the country must be registered with MCAZ. MCAZ carries out post marketing surveillance of medicines imported into the country. In the case of product failure pharmaceuticals are destroyed in accordance with the National Drug Policy.	X Yes
Management and coordination	NAC as the PR is responsible for ensuring effective management and coordination of all PSM activities under this grant proposal.	Natpharm carry out national programme quantifications that are used by each donor e.g. ESP, EU, USAID to consolidate the pipeline analysis. Regular reviews are carried out through a number of coordinating e.g. procurement logistics sub-committee of the national ART forum, ESP coordinating meetings, Medicines and medical supplies coordinating team. These mechanisms ensure there is no duplication and allows for integrated planning.	X No
Product selection	NAC as PR will engage the NDTPAC and National ART Programme managers in product selection in accordance with the National ART Treatment guidelines and the national STGs.	NDTPAC under the Ministry of Health and Child Welfare is responsible for product selection and ensuring adherence to set national standard treatment guidelines (STGs) and standards.	X No
Management Information Systems (MIS)	The Procurement Agent will utilise the well established national existing management information systems.	There is a comprehensive Logistics Management Information System (LMIS) as well as a Health Management Information System (HMIS) in place. The LMIS (NAVISION) is a fully integrated financial, inventory management and procurement system whilst the HMIS is a computerised electronic information system that captures patient statistics from the treatment sites through monthly progress reports.	X No
Forecasting	Programme managers in the AIDS and TB Unit of the Ministry of Health and Child Welfare are responsible for forecasting ART, PMTCT and PITC requirements.	All forecasting and quantification will be done by the MOHCW in close collaboration with the PR and implementing partners. The medicines requirements were forecasted based on the expected numbers of patients (see priority tables). It is national policy that buffer stock will be three months at the District Lev-	X No

		el.	
Procurement and planning	Programme managers in the AIDS & TB unit, MOHCW will be responsible for this function in liaison with the Procurement Agent.	The Procurement Agent will utilise a variety of procurement methods from formal, restricted tender to direct procurement depending on the value, complexity, time and cost of the procurement with a view to gain maximum competition and facilitate the implementation.	x No
Storage and inventory management	The National Pharmaceutical Company of Zimbabwe (NatPharm) is the national medical store equivalent. All goods procured under the Global Funds will be stored and managed through the national NatPharm system.	NatPharm has six warehouses nationwide which are strategically located to reach the whole country whose storage capacity is more than 50 000m^2. The regional stores which will serve as the major international receiving stores together have a capacity of 30 000m^2. There is excess storage capacity which can accommodate all the health and non-health Global Fund Round 8 commodities without requiring any further expansion of physical space. The warehouses have reinforced cages for high security items, cold rooms and refridgerators for cold chain goods and 24 hour private security sysytem in place. Physical stock counts are carried out once a month and there are Standard Operating Procedures (SOPs) to ensure adherence to Good Wholeselling Practice. There is a computerised LMIS (NAVISION) which runs on WAN nationwide and generates inventory reports eg expiries , stock on hand etc At district levels, pharmacy departments have adequate storage facilities and all clinics have drug store rooms where the commodities will be stored.	X No
Distribution to other stores and end-users	The National Pharmaceutical Company of Zimbabwe (NatPharm) which is the national medical store equivalent is responsible for this function.	NatPharm has six branch stores strategically located throughout the country to cover all health centers. NatPharm has a fleet of 6 eight tonne trucks donated by the EU and this fleet is augmented by 3 eight tonne trucks from SCMS making a total of 9 eight tonne trucks dedicated to delivering health commodities monthly to all health centres.	X No
Ensuring rational use and patient safety (pharmacovigilance)	The National Drugs and Therapeutics Policy Advisory Committee (NDTPAC) is the multidisciplinary national body which co-ordinates policy on medicines is responsible for this function.	The Zimbabwe National Drug Policy aims at ensuring that drugs are prescribed dispensed and used rationally, in the public and private sectors. To this end the country has an essential drugs list and WHO approved standard treatment guidelines. The NDTPAC monitors adverse drug reactions and routinely reviews and updates the STGs and essential drugs list in conjunction with the MCAZ.	X No

4.10.3. Past management experience

What is the past experience of each organization that will manage the process of procuring, storing and overseeing distribution of pharmaceutical and health products?

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year *(Same currency as on cover of proposal)*
The National Pharmaceutical Company of Zimbabwe	Procurement Agent	USD 35 million
Crown Agents for Overseas Governments and Administration Limited	Procurement Agent	USD 264million

4.10.4. Alignment with existing systems

Describe the extent to which this proposal uses existing country systems for the management of the additional pharmaceutical and health product activities that are planned, including pharmacovigilance systems. If existing systems are not used, explain why.

The National Pharmaceutical Company of Zimbabwe (NatPharm) is a commercialized Government Medical Stores charged with the Procurement, Storage and Distribution of medical supplies to Public Health Institutions and the Private Sector. NatPharm is headed by a Managing Director (Pharmacist) who reports to a Board of Directors. The MD is supported by departments which include Operations, Procurement, Internal Audit, Finance, Information Technology, Business Development {Marketing} and Human Resources.

The Procurement department works in conjunction with the MOHCW, NDTPAC and MCAZ procuring only those medicines on the essential drugs list and registered in Zimbabwe. On receipt drugs are subjected to quality assurance tests by MCAZ, especially for new suppliers. Payment of supplies is through invoices raised to MOHCW.

NatPharm has six warehouses strategically located throughout the whole country to ensure coverage of all health centres. Their transport fleet has nine eight tonne delivery trucks. They operate a WAN on NAVISION, a LMIS which combines procurement, inventory and financial management information.

For the purposes of implementing Global Fund proposals, NatPharm has teamed up with Crown Agents to form The NatPharm and Crown Agents Consortium. Crown Agents is an international development organisation operating in more than 110 countries all over the world. Crown Agents delivers procurement and supply management, inspection, public sector transformation, revenue and expenditure management, banking, finance and training services. The Consortium team is housed at NatPharm headquarters and dedicated to Global Fund Procurement and Supply Chain Management. This public/private partnership ensures speedy delivery of commodities for effective and efficient implementation of Global Fund programmes.

4.10.5. Storage and distribution systems

(a) Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?

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

(b) For storage partners, what is each organization's current **storage capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be stored, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

NatPharm has excess storage facilities amounting to 50,000 square meters. The two regional receiving stores account for 30,000m^2 of this space. Further expansion of space is not required to accommodate goods under this proposal. There are reinforced cages for security items and 24 hour private security surveillance. NatPharm also has written Standard Operating Procedures (SOPs) which are adhered to.

(c) For distribution partners, what is each organization's **current distribution capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be distributed or the area(s) where distribution will occur, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

All districts in the country are covered by an eight tonne delivery vehicle once a month from each one of the six strategically located warehouses. There will be no need to increase coverage for the purposes of this proposal.

4.10.6. Pharmaceutical and health products for initial two years

Complete 'Attachment B-HIV' to this Proposal Form, to list all of the pharmaceutical and health products that are requested to be funded through this proposal.

Also include the expected costs per unit, and information on the existing 'Standard Treatment Guidelines ('STGs'). **However**, if the pharmaceutical products included in 'Attachment B-HIV' are not included in the current national, institutional or World Health Organization STGs, or Essential Medicines Lists ('EMLs'), describe below the STGs that are planned to be utilized, and the rationale for their use.

The National ART Treatment guidelines will be used. These are in line with the WHO STGs and EMLs.

Under Round 1 and 5 the Natpharm Crown Agents Consortium procurement, storage and distribution fee was pegged at 6 %. However, a recent study funded by the European Commission and carried out by Ernest & Young has determined that the actual cost of storage and distribution incurred by Natpharm is 8.62 %. However, given the large size of this proposal a fee of 6 % has been agreed. This will be reviewed if need arises. (Annex HIV 44 Review of Storage and Distribution Costs)

Clarified table below (meant to tick No).

4.10.7. Multi-drug-resistant tuberculosis

Is the provision of treatment of multi-drug-resistant tuberculosis included in this tuberculosis proposal?	☐ Yes *In the budget, include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services.* ☐ No *Do not include these costs*

5. FUNDING REQUEST

Clarified table 5.1.

5.1. Financial gap analysis - HIV

Financial gap analysis *(same currency as identified on proposal coversheet)*

Note ➔ Adjust headings (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**

	Actual		Planned		Estimated			
	2006	2007	2008	2009	2010	2011	2012	2013
HIV program funding needs to deliver comprehensive prevention, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	196,271,000	212,540,000	230,450,000	246,023,000	252,862,000	262,208,000	271,905,000	281,965,000
Line A.1 ➔ Total need over length of Round 8 Funding Request				*(combined total need over Round 8 proposal term)*				
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*arrears to IFI/bilateral creditors*)	5,400,000	5,400,000	5,400,000	5,400,000	5,400,000	5,400,000	5,400,000	5,400,000
Domestic source **B2** National funding resources	35,734,072	33,947,368	32,250,000	30,637,500	29,105,625	27,650,344	26,267,827	24,954,435
Domestic source **B3** Private Sector contributions (national)				1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	41,134,072	39,347,368	38,650,000	37,037,500	35,505,625	34,050,344	32,667,827	31,354,435
External source **C 1** Bilateral and EC donors: USG (PEPFAR), EC, DFID, CIDA, Norway, SIDA, Ireland	81,000,000	89,000,000	93,000,000	93,000,000	93,000,000	93,000,000	93,000,000	93,000,000
External source **C2** Other sources: UN, CHAI, I-NGOs	15,000,000	20,000,000	20,000,000	18,000,000	18,000,000	18,000,000	18,000,000	18,000,000

ROUND 8 – HIV

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
External source **C3** Private Sector contributions (International)	[redacted]							
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	96,000,000	109,000,000	113,000,000	111,000,000	111,000,000	111,000,000	111,000,000	111,000,000
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years	18,000,000	23,000,000	23,000,000	20,000,000				
Line E ➔ Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	114,000,000	132,000,000	136,000,000	131,000,000	111,000,000	111,000,000	111,000,000	111,000,000
Calculation of gap in financial resources and summary of total funding requested in Round 8 *(to be supported by detailed budget)*								
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)	**41,137,002**	**41,192,437**	**55,800,000**	**77,986,000**	**106,356,580**	**117,157,727**	**128,236,887**	**139,611,035**
Line G = Round 8 HIV funding request *(same amount as requested in table 5.3 for this disease)*				**33,911,829**	**52,909,901**	**65,090,613**	**68,555,682**	**76,284,045**

ROUND 8 – HIV

Part H – 'Cost Sharing' calculation for Lower-middle income and Upper-middle income applicants

In Round 8, the total maximum funding request for HIV in Line G is:

*(a) For **Lower-Middle income countries**, an amount that results in the Global Fund's overall contribution (all grants) to the national program reaching not more than 65% of the national disease program funding needs over the proposal term; and*

*(b) For **Upper-Middle income countries**, an amount that results in the Global Fund overall contribution (all grants) to the national program reaching not more than 35% of the national disease program funding needs over the proposal term.*

Line H ➔ Cost Sharing calculation as a percentage (%) of overall funding from Global Fund

$$\text{Cost sharing} = \frac{(\text{Total of Line D entries over 2009-2013 period} + \text{Line G Total}) \times 100}{\text{Line A.1}}$$

%

5.1.1. Explanation of financial needs – LINE A in table 5.1

Explain how the annual amounts were:

- developed *(e.g., through costed national strategies, a Medium Term Expenditure Framework [MTEF], or other basis);* and
- budgeted in a way that ensues that government, non-government and community needs were included to ensure fully implementation of country's HIV program strategies.

The financial needs are based on preliminary costing of a few national strategic plans including the Zimbabwe National Strategic Plan (ZNASP), national ART, testing and counseling, PMTCT and national behaviour change strategic plans. In addition an allocation of the total needs was done on a pro-rata basis for the costing of the Ministry of Health and Child Welfare health services which are not costed into the ZNASP.

Costing of this proposal also involvement key stakeholders, including Ministry of Health, donors and major NGOs. All costs were matched against the key national priorities as reflected in the key strategic plans. In the context of hyper-inflation, costs were converted into USD at a realistic market rate and it was assumed that the cost in USD would on average remain broadly stable over the period covered by the ZNASP.

In addition, a further 30% of the MOHCW total budget has been included to reflect the overall costs to the public health sector delivery which is not incorporated into the ZNASP costings. With MOHCW broadly no longer providing for the costs of drugs which are covered in the ZNASP and the majority now paid for by donors/Global Fund, this ensures minimal costing overlap. A further element was added to reflect the financing gap of the health system which has faced over 40% reduction in resources in nominal terms due to the economic situation when demand has increased due to the burden of HIV. This health systems' financing 'gap' is estimated at 30% of the USD120 million which would reflect the reduction in the MOHCW budget compared to its 2000 budget in current USD terms. The based year of 2000 is used as this is the last year that is generally accepted to be the point when Zimbabwe was still able to maintain an effective health system without significant external support.

For the funding needs beyond 2011, costs were increased by a further 5% per annum relative to previous year. This percentage is estimated to reflect continued increases in costs primarily driven by numbers on treatment and international (USD) inflation and reduced somewhat by an expected gradual fall in support costs. The increased financing gap despite an increase in donor and Global Fund support between 2006 and 2009 primarily reflects the objective of universal access of ARTs by 2010 and to a lesser but still significant extent, the steady decline in domestic resources available for the health sector.

5.1.2. Domestic funding – 'LINE B' entries in table 5.1

Explain the processes used in country to:

- prioritize domestic financial contributions to the national HIV program *(including HIPC [Heavily Indebted Poor Country] and other debt relief, and grant or loan funds that are contributed through the national budget)*; and
- ensure that domestic resources are utilized efficiently, transparently and equitably, to help implement treatment, prevention, care and support strategies at the national, sub-national and community levels.

Zimbabwe currently is unable to access most forms of international financing being in arrears to the major development banks and bilateral creditors, and is not currently eligible for debt relief under HIPC. It has a proud history of significant allocations to its health budget, and continues to prioritize a relatively high percentage of the national budget (9-10%) to health. An additional set up is the AIDS levy which takes 3% of all income tax which funds the National AIDS council.

High inflation and multiple exchange rates make estimates of the USD value of these funds challenging. Therefore the size of the budget is based on the World Bank estimate for the size of the total economy, and taking the Government estimates for the size of the budget (30%) as part of the total economy and the percentage allocation to the Health Sector (9%).

The domestic component has been assumed to steadily decrease at 5% per annum based on historic reductions in the size of the economy and therefore the purchasing power of the budget since 2000, and anticipated levels of the economy based on projects by the IMF assuming no major change in domestic policies. An economic turn-around would reduce the financing gap by an estimated USD2m to USD6m compounded per annum through increased domestic resources, with some additional savings efficiencies likely in a more stable economic situation.

Zimbabwe has also set up strong coordinating framework through ZNASP and associated national plans for HIV treatment, PMTCT, and the national Plan of Action for OVCs, to help ensure donor resources are well coordinated with domestic resources which help mitigate substantially the costs associated with the challenges faced by Zimbabwe. This also ensures that Zimbabwe's main asset in terms of ensuring efficient allocation of resources, especially in treatment, is the strong and still effective national publicly funded health systems which ensure resources placed through this system can be used effectively.

In addition, Zimbabwe receives international support to its domestic resource envelop through the non-payment of the majority of its debts to the International Financing Institutions (IFIs) and bilateral lenders, which is estimated at between USD200 million and USD300 million per annum. A figure of USD200 million has been used, of which in term 9% contributes to the MOHCW budget. This figure would also reflect similar amounts of debt relief which can be expected should Zimbabwe be able to re-engage with the major IFIs and potentially be eligible for HIPC debt relief.

5.1.3. External funding *excluding Global Fund* – 'LINE C' entries in table 5.1

Explain any changes in contributions anticipated over the proposal term (*and the reason for any identified reductions in external resources over time)*. Any current delays in accessing the external funding identified in table 5.1 should be explained (including the reason for the delay, and plans to resolve the issue(s)).

The resource figures for major bilateral donors in the HIV and health sector (USG, EC, and Expanded Support Programme (ESP) donors including DFID, CIDA, SIDA, Norway, and Irish Aid) have been assumed to remain steady for the period. This assumption is based on a strong continued commitment by donors to this sector, although in most cases the funds are committed at best on a three year basis, and in some cases reviewed on an annual basis. In the case of the EC which primarily supports the health system and essential drugs, as well as support by DFID/ECHO for vital drugs, the figures are based on an estimate of the proportion that can be attributed to the HIV sector (30%) ra-

ther than the total amount.

In addition, based on UNAIDS Zimbabwe estimates, a proportion of the allocation of donor funded safety net support provided to OVCs that corresponds to HIV infected and affected children, as well as a (smaller) proportion of humanitarian assistance which is provided that benefits chronically ill who require support due to HIV (rather than poverty in general).

The estimated figures for other sources including United Nations core funding, Clinton Foundation, international NGOs and other sources is based on comprehensive figures collated by UNAIDS for 2005 for these sectors, with a 25% increase since this period reflecting in particular the increase in support to treatment – most notably by MSF (ANNEX HIV 30: HIV expenditure profile).

5.2. Detailed Budget

Suggested steps in budget completion:

1. **Submit a detailed proposal budget *in Microsoft Excel format as a clearly numbered annex*.** Wherever possible, use the same numbering for budget line items as the program description.

   - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the budget information available at the following link:** http://www.theglobalfund.org/en/apply/call8/single/#budget

2. Ensure the detailed budget is consistent with the detailed workplan of program activities.

3. From that detailed budget, **prepare a '*Summary by Objective and Service Delivery Area*'** (s.5.3.)

4. From the same detailed budget, **prepare a '*Summary by Cost Category*'** (s.5.4.)

5. Do not include any CCM or Sub-CCM operating costs in Round 8. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available at: http://www.theglobalfund.org/en/apply/mechanisms/guidelines/

5.3. Summary of detailed budget by objective and service delivery area

Clarified table 5.3.

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	1.1 BCC Mass media	2,777,097.00	1,813,946.00	3,715,636.00	1,863,411.00	1,900,683.00	**12,070,773.00**
1	*1.2 BCC Community outreach*	4,494,455.00	5,263,286.00	4,360,449.00	3,593,638.00	2,794,166.00	**20,505,994.00**
1	*1.3 Work-place based HIV prevention behaviour change and work place policy development*	794,087.00	550,633.00	487,920.00	513,852.00	464,316.00	**2,810,808.00**
2	*2.1 HIV testing and Counseling*	1,549,750.00	2,903,431.00	3,138,794.00	2,814,407.00	2,924,212.00	**13,330,594.00**
3	*3.1 PMTCT*	2,622,730.00	1,909,410.00	2,323,884.00	2,587,300.00	2,739,857.00	**12,183,181.00**
3	*3.2 Integration of family planning into HIV services (prevention of unintended pregnancies among women living with HIV)*	305,562.00	438,361.00	268,170.00	273,531.00	117,520.00	**1,403,144.00**
4	*4.1 Antiretroviral treatment (ARV) and monitoring*	10,489,758.00	27,985,078.00	37,652,798.00	42,806,312.00	49,924,914.00	**168,858,860.00**
4	*4.2 HSS: health workforce*	255,360.00	458,755.00	286,755.00	451,670.00	272,210.00	**1,724,750.00**
4	*4.3 TB/HIV*	106,216.00	59,095.00	60,276.00	61,483.00	62,712.00	**349,782.00**
4	*4.4 Monitoring and evaluation*	1,842,993.00	1,086,170.00	1,405,662.00	883,687.00	1,336,146.00	**6,554,658.00**
5	*5.1 Care and support for the chronically ill*	2,277,272.00	2,164,717.00	2,158,073.00	2,201,235.00	2,245,258.00	**11,046,555.00**
5	*5.2 HSS: Leadership and government*	649,854.00	521,020.00	478,506.00	488,073.00	497,836.00	**2,635,289.00**

ROUND 8 – HIV

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
6	*6.1 Support for orphans and vulnerable children*	2,112,947.00	1,177,442.00	1,130,801.00	1,390,607.00	1,176,487.00	**6,988,284.00**
7	*7.1Strengthening of networks of PLWHIV and institutional capacity building*	979,810.00	1,050,990.00	477,151.00	512,926.00	503,174.00	**3,524,051.00**
7	*7.2Strengthening of civil society and institutional capacity building*	1,053,674.00	872,523.00	947,547.00	847,019.00	853,386.00	**4,574,149.00**
	Procurement costs	1,600,264.00	4,655,044.00	6,198,191.00	7,266,531.00	8,471,168.00	**28,191,198.00**
Round 8 HIV funding request:		**33,911,829.00**	**52,909,901.00**	**65,090,613.00**	**68,555,682.00**	**76,284,045.00**	**296,752,070.00**

ROUND 8 – HIV

5.4. Summary of detailed budget by cost category *(Summary information in this table should be further explained in sections 5.4.1 – 5.4.3 below.)*

Avoid using the "other" category unless necessary – read the Round 8 Guidelines.	*(same currency as on cover sheet of Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	2,484,873.00	3,710,513.00	4,545,056.00	4,826,961.00	4,814,400.00	**20,381,803.00**
Technical and Management Assistance	556,735.00	356,516.00	317,374.00	548,592.00	251,542.00	**2,030,759.00**
Training	6,111,286.00	8,506,971.00	5,663,918.00	4,575,238.00	3,758,355.00	**28,615,768.00**
Health products and health equipment	7,510,262.00	6,810,619.00	8,441,004.00	9,509,878.00	10,403,381.00	**42,675,144.00**
Pharmaceutical products (medicines)	2,936,522.00	24,181,443.00	32,338,758.00	38,945,277.00	46,026,812.00	**144,428,812.00**
Procurement and supply management costs	964,456.00	1,945,745.00	2,634,930.00	3,023,653.00	3,517,998.00	**12,086,782.00**
Infrastructure and other equipment	5,352,818.00	944,020.00	2,415,588.00	983,515.00	1,003,185.00	**10,699,126.00**
Communication Materials	3,364,530.00	2,049,078.00	3,918,433.00	1,940,095.00	1,923,915.00	**13,196,051.00**
Monitoring & Evaluation	2,321,093.00	1,990,737.00	2,289,786.00	1,951,954.00	2,361,729.00	**10,915,299.00**
Living Support to Clients/Target Populations	720,000.00	734,400.00	749,088.00	764,070.00	779,351.00	**3,746,909.00**
Planning and administration	493,154.00	501,487.00	468,445.00	477,812.00	487,370.00	**2,428,268.00**
Overheads	1,096,100.00	1,178,372.00	1,308,233.00	1,008,637.00	956,007.00	**5,547,349.00**
Other: *(Use to meet national budget planning categories, if required)*	-	-	-	-	-	**-**
Round 8 HIV funding request (*Should be the same annual totals as table 5.2)*	**33,911,829.00**	**52,909,901.00**	**65,090,613.00**	**68,555,682.00**	**76,284,045.00**	**296,752,070.00**

5.4.1. Overall budget context
Briefly explain any significant variations in cost categories by year, or significant five year totals for those categories.

Human resources: Costs for human resources are increasing over the first two years of the funding period and stabilize in year 3, 4 and 5. This trend reflects the capacity strengthening efforts and the expected impact of retention. In year two human resources supported by GF Round 5, which is ending by the second half of the first year of GF Round 8, will receive continued support through Global Fund Round 8, explaining the increase in the HR cost category between year one and year two. The increase in costs between year two and three are explained by the fact that some cadres are trained with GF resources in year 1 and 2 and will be deployed in year 3.

Technical & Management Assistance: The costs for technical and management assistance are higher in year 1 and year 4 than in the other years. The reason for the higher costs are explained by the fact that new documents, curricula and guidelines as well as communication materials will be developed through TA initially in year one and year 4. In addition there are a number of new PR and SRs who will require substantial TMA to strengthen their capacity.

Training: Training costs are higher in the first two years than in year 3, 4 and 5 as the majority of staff will be trained in the first two years. With the introduction and planned roll-out of new and best practices including use of more efficacious PMTCT ARV regimens, early infant diagnosis, HIV DR monitoring, and indicator and electronic databases for improved ART patient tracking, it is envisaged that most trainings will occur during the first year of implementation to build momentum for the roll-out. Training costs in years 3, 4 and 5 include refresher courses. In addition, smaller numbers of new staff will have to be trained in year 3, 4 and 5.

Health Products and Health Equipment: Most bulk and one-off procurements will occur in Year 1. Year 2 has a relatively lower budget allocation compared to Year 1, however, subsequent years 3 and 4 will experience a steady growth in budgetary allocation linked to scaling up of service delivery. This includes increases in lab tests, reagents and consumables associated with the ART scale up. In addition, HIV test kit requirements will gradually increase over the 5 year grant cycle in order to meet the increasing number of clients/patients to be tested for HIV.

Pharmaceutical Products (Medicines): The costs for pharmaceutical products and medicines are increasing over the five year funding period as increasing numbers of patients are initiated and then maintained on OI/ARV treatment. There is a steep increase in the costs for pharmaceutical products between year one and year two as a this proposal will take over funding of ARVs for the large number of patients who will have been initiated treatment under GF Round 5 which will come to an end in year 2. Thereafter a gradual increase in number of PLWHIV receiving ART peaking in year 5 is assumed.

Procurement and Supply Management Costs (PSM): The procurement and supply management costs are directly related to the costs of procurement of pharmaceutical products and medicines and health products. A PSM fee of 6% has been assumed to cover the procurement, storage and distribution services.

Infrastructure and Other Equipment: Costs for infrastructure and other equipment are highest in year 1 and in year 3 when the bulk of the equipment will be procured. Some of the equipment procured under GF Round 5 will be replaced in year 3.

Communication Materials: The costs for communication materials is higher in year one and in year three than in the other years. The higher costs are explained by the fact that new communication materials are produced in year 1 and updated in year 3. Production costs for TV, radio and the print media materials add on to the costs of placement and printing of materials in year 1 and year 3 and explain the higher costs in these two years.

Costs for M&E, Costs for Living Support to Clients/Target Population and Planning and Administration costs are stable over the 5 year funding period

Overheads: As overhead costs are calculated on direct costs without major variations over time, these costs are stable over the 5 year funding period.

5.4.2. Human resources

In cases where '*human resources*' represents an important share of the budget, summarize: (i) the basis for the budget calculation over the initial two years; (ii) the method of calculating the anticipated costs over years three to five; and (iii) to what extent human resources spending will strengthen service delivery.

(Useful information to support the assumptions to be set out in the detailed budget includes: a list of the proposed positions that is consistent with assumptions on hours, salary etc included in the detailed budget; and the proportion (in percentage terms) of time that will be allocated to the work under this proposal.

➔ *Attach supporting information as a clearly named and numbered annex*

Basis of calculation for Human Resources (HR) budget: Budget calculations for human resources were based on existing salary and compensation schemes. For the public health sector staff supported through this proposal, the national salary and top-up scale was applied. Thereby the HR unit costs have been aligned to a harmonized scheme, which is also being applied for other funding sources such as Expanded Support Programme, European Commission and Global Fund Round 5. Retention incentives for OVC programme staff salaries in MOPSLSW have been based on the UN National Professional Project Personnel scale and represent 20% of a salary in this scale at the respective level. Human resource contributions to civil society organizations have been based on existing salary levels in the respective organizations and the amounts paid by other programmes (ESP/EC).

Method of calculating the anticipated costs over years 3 to 5: All HR costs were expressed and calculated in USD. An annual increase of 2 % of all HR costs has been considered as compensation for inflation.

Contribution of Human Resources spending on service delivery: The human resources spending under the separate HSS component will primarily be supporting the health system at the client level. This will include Community Health Workers in every ward, clinical staff in Rural Health Clinics covering several wards, clinical and technical staff in Rural and Mission hospitals covering a sub-district, the clinical and technical staff in 62 District Hospitals, the referral Provincial Hospital and city health hospitals, and the tertiary referral central hospitals in Harare and Bulawayo. The areas where part of the proposed support will indirectly impact at client level will be top-ups received by District Health Executive and Provincial Health Executive as well as national programme co-ordinators who are key in management and coordination of the health system, and the clinical training schools who are key in ensuring a steady and high quality provision of clinical and technical staff into the public health system. The 800 Primary Care Counsellors supported in the SDA on PITC will be directly involved in HIV service delivery at health facility level in all districts of Zimbabwe. This is expected to contribute to increased service delivery capacity and service delivery quality. The HR support to the OVC programme will contribute to re-establishing decentralized management and co-ordination of the OVC response at all levels. Since in the past a tendency has been observed that HIV prevention behaviour change was given less priority than mitigation of immediate needs, the dedicated HR for behaviour change at district level are essential to take evidence-informed community-based action planning and implementation of behaviour change promotion activities to scale. 5,060 community volunteers directly working with target populations on HIV BC and PLHIV support will be supported in terms of a monthly allowance and other incentives, which shall contribute to continued motivation and retention.

5.4.3. Other large expenditure items

If other 'cost categories' represent important amounts in the summary in table 5.4, (i) explain the basis for the budget calculation of those amounts. Also explain how this contribution is important to implementation of the national HIV program.

➔ *Attach supporting information as a clearly named and numbered annex*

Other cost categories with significant amounts include Pharmaceutical products (medicines), Health products and health equipment, and Training.

Pharmaceutical products (medicines): Procurement of medicines mainly includes ARVs, Cotrimoxazole (both paediatric and adult formulations) and more efficacious PMTCT regimens. Budget calculations for medicines have been based on national targets and a gap analysis where GFR8 is expected to make a contribution towards the overall treatment gap (Refer to Appendix A and ANNEX HIV 14). ARV support from GFR8 will enhance the scale up the national OI/ART rollout programme that aims towards Universal Access to treatment. In order to reduce morbidity related to HIV/AIDS, GFR8 will support the procurement of Cotrimoxazole medicines and contribute to the overall national plan of providing Cotrimoxazole prophylaxis for PLWHIV in WHO clinical stage 2,3, and 4 and all infants born to HIV exposed babies from 6 weeks onwards until an HIV status is established. The PMTCT programme has adopted WHO's recommendations on the use of more efficacious regimens for MTCT of HIV. Also following feasibility studies from pilot studies conducted locally, the PMTCT programme envisions to rapidly rollout MER so as to effectively reduce MTCT of HIV in accordance with the revised national programme strategy.

Health products and health equipment: Laboratory equipment procured to strengthen laboratory capacity for effective diagnosis and patient monitoring includes HIV DNA PCR and CD4 machines, haematology analysers, chemistry analysers and service contracts which will be secured to maintain the equipment. Similarly, associated reagents and laboratory consumables including HIV test kits will be procured under GFR8 to cover gaps not fully supported by GOZ, local and external partners. The national HTC programme aims at increasing the proportion of individuals tested and counselled for HIV from 20% to 85% by 2010 and hence GFR8 will contribute towards the achievement of the HTC programme goal.

Training: A significant proportion of the budget is covered by training activities. Budget calculations were made using fixed unit costs for training at different levels of health care i.e. national, provincial, district, and community levels, which have been standardised across the three disease components based on existing country experience. Human resource development through training was identified as being key in building competence and the required skills of the overall health workforce within the public, private and at community level and at national, provincial, district, and community levels to effectively provide comprehensive HIV/AIDS services. With the introduction of new interventions such as the use of more efficacious ARV prophylaxis for PMTCT, early infant diagnosis, PITC, and the urgent need for a rapid scale up of HIV prevention, treatment, care, and support services as a whole, it was deemed imperative to build the capacity of health work force to fully deliver services and respond to the dynamic nature of the HIV response in line with the Zimbabwe national HIV goals and targets.

5.5. Funding requests in the context of a common funding mechanism

In this section, **common funding mechanism** refers to situations where all funding is contributed into a common fund for distribution to implementing partners.

Do not complete this section if the country pools, for example, procurement efforts, but all other funding is managed separately.

5.5.1. Operational status of common funding mechanism
Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners. ➔ *Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.*
5.5.2. Measuring performance
How often is program performance measured by the common funding mechanism? Explain whether program performance influences financial contributions to the common fund.
5.5.3 Additionality of Global Fund request
Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism. *If the focus of the common fund is broader than the HIV program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on HIV outcomes during the proposal term.*

HIV Proposal checklist

Section	Document description	Annex Number
4.1.	Zimbabwe National HIV and AIDS Strategic Plan 2006-2010	Annex HIV 1
4.1.	Zimbabwe National Behavioural Change Strategy for Prevention of Sexual Transmission of HIV (2006-2010)	Annex HIV 2
4.1.	Zimbabwe National Strategic Framework for the Private Sector Response to HIV and AIDS 2007-2010	Annex HIV 3
4.1.	National HIV Testing and Counselling Strategic Plan 2008-2010	Annex HIV 4
4.1.	PMTCT and Paediatric HIV prevention strategic plan 2006-2010	Annex HIV 5
4.1	Interim report: Alternative Regimens to single-dose Nevirapine for PMTCT in Resource Poor Settings: A Pilot Project to Explore Policy, Process and Practical Issues in Zimbabwe; June 2006 – August 2007	Annex HIV 6
4.1.	Zimbabwe National HIV and AIDS Estimates 2007	Annex HIV 7
4.1	National Activity Report Form (NARF Dec 2007)	Annex HIV 8
4.1.	Zimbabwe National Standards for CHBC	Annex HIV 9
4.1	Review of CHBC	Annex HIV 10
4.1	National Action Plan for Orphans and Vulnerable Children	Annex HIV 11
4.2.1	Zimbabwe National Network for PLWHIV: Strategic Plan	Annex HIV 12
4.2.1	Zimbabwe Demographic and Health Survey 2005/06 (only soft copy)	Annex HIV 13
4.2	Consolidated Gap Analysis Global Fund Round 8	Annex HIV 14
4.3	National Plan of Action on Women, Girls and HIV and AIDS (only hard copy)	Annex HIV 15
4.3	National care and treatment strategic plan 2005-2007	Annex HIV 16
4.3	Saving Maternal and Newborn Lives in the context of HIV and AIDS in Zimbabwe (Mothers and Newborns programme) DFID – Zimbabwe; October 2006	Annex HIV 17
4.3.2	Sample Health Facility Assessment on OI/ART	Annex HIV 18
4.3.3	Draft HSS situational analysis report	Annex HIV 19
4.5.1	Evidence for HIV Decline in Zimbabwe. A Comprehensive Review of the Epidemiological Data	Annex HIV 20

HIV Proposal checklist

4.5.1	Comprehensive Review of Behavioural Change as a Means of Preventing Sexual HIV Transmission	Annex HIV 21
4.5.3	Zimbabwe National OI/ART assessment report 2008	Annex HIV 22
4.5.4	Gender Based Violence Law	Annex HIV 23
4.5.5	Consolidated Consultative Meeting Reports	Annex HIV 24
4.5.5	SR proposals	Annex HIV 25
4.6.2	Expanded Support Programme proposal	Annex HIV 26
4.8.1	ZNASP M&E framework	Annex HIV 27
	Zimbabwe National Drug Resistance Strategy 2008-2012	Annex HIV 28
5.3.1	HIV Expenditure Profile 2005	Annex HIV 30
4.1b	Draft Early Infant Diagnosis Algorithm	Annex HIV 31
4.1b	PMTCT protocols for more efficacious regimens	Annex HIV 32
4.1b	Zimbabwe HTC Guidelines for Children	Annex HIV 33
4.1b	Programme of Support on the NAP for OVC	Annex HIV 34
4.1b	A Partnership Making a Difference – Zimbabwe's Programme of Support to the National Action Plan for OVC	Annex HIV 35
4.1b	The Impact of HIV and AIDS on the Small and Medium Enterprises Sector in Zimbabwe	Annex HIV 36
4.1b	PITC PSI Assessment Murambinda	Annex HIV 37
4.1b	National ART guidelines 2007	Annex HIV 38
	List of Acronyms	Annex HIV 39
	Zimbabwe Health Sector HIV Prevention Strategic Framework 2007-2010	Annex HIV 40
4.8.1	M&E Framework for BC	Annex HIV 41
4.3.2	HMIS Assessment	Annex HIV 42
	Draft National Care and Treatment Strategic Plan 2008-2012	Annex HIV 43
	Review of Distribution and Storage Costs	Annex HIV 44

Attachment A - HIV Performance Framework

Program Details

Country:	Zimbabwe
Disease:	HIV and AIDS
Proposal ID:	

Program Goal, impact and outcome indicators

	Goals
1	Reduced number of new HIV infections among adult and children
2	Reduced morbidity and mortality due to HIV and AIDS in Zimbabwe

Impact and outcome Indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
impact	% of young women and men aged 15-24 who are HIV infected	Female: 11.0 %, Male: 4.2 %	2006	DHS/DHS+ (Demographic and Health Survey)	Female: 10.2 %; Male: 3.9 %	Female: 9.7 %; Male: 3.8 %	Female: 9.2 %; Male: 3.7 %	Female: 8.8 %; Male: 3.6 %	Female: 8.3 %; Male: 3.5 %	In line with international practice, HIV prevalence in young people serves as a proxy for HIV incidence. Year 1 to year 5 data can be derived (ex post) from National Estimates Modeling based on ANC surveillance and population-based surveys; furthermore, a 2010/11 DHS, follow-up surveys on the National BC Strategy Baseline Survey will contribute to updating the data. In the interpretation of this indicator the emerging epidemic of survivors of vertical HIV transmission needs to be considered, particularly as the children born in the years of peak prevalence (late 1990s) will grow into the 15-24 year age cohort, wherefore there might be an increased number of young people living with HIV who were not infected through sexual transmission. New infections for children is being measured at output level and not at impact level.
impact	% of adults and children with HIV still alive at 12 months after initiation of ART	TBA		HMIS	86%	87%	88%	89%	90%	Estimates based on information from specific sites. National baseline still to be established before implementation of Global Fund Round 8. As of June 2008, 105,000 persons were on ART in Zimbabwe.
outcome	% of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Female: 9.0 %, Male: 28.4 %	2007	BSS (Behavioral Surveillance Survey)	Female: 8.3 %, Male: 26.4 %	Female: 7.8 %, Male: 24.5 %	Female: 7.2 %, Male: 22.8 %	Female: 6.7 %, Male: 21.2 %	Female: 6.2 %, Male: 19.7 %	The baseline information was extracted from the preliminary analysis of the National Behaviour Change Strategy Baseline Survey of 2007. This survey used ACASI (Automated Computer Assisted Self Interview), which was found to result in reduced desirability bias as compared to face-to-face interviews. This data will therefore be compared to future BC strategy surveys and not household survey data (such as DHS data), in which reporting of multiple partnerships is lower. Several other indicators including on risk perception and social norms as well as qualtitative research will be used to complement the quantitative trends expressed in these targets.

* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	To increase adoption of safer sexual behaviour and reduction in risk behaviour (National BC Strategy Outcome Area 2)	
2	To increase the number of children (18 months - 15 years) and adults tested for HIV	
3	To reduce transmission of HIV from mother to child by providing comprehensive PMTCT services	
4	Expand the provision of comprehensive HIV and AIDS care, treatment and support including ART services in public and private sectors	
5	Strengthen the involvement of communities in the provision of ART service	
6	To strengthen national institutional capacity to coordinate OVC interventions	
7	To strengthen mechanisms for coordination, collaboration and accountability among PLHIV networks in the mainstreaming of MIPA within the national response	

Attachment A - HIV Performance Framework

Program Details

Country:	Zimbabwe
Disease:	HIV and AIDS
Proposal ID:	

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4, and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
1.1	BCC - Mass media	Number of women and men reached through mass media BCC	2,000,000	2007	Health Facility survey	-	2,500,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	Y	N	N - not cumulative	ZAN	This indicator is adopted from GF round 5 and National AIDS Core output indicator. It will be collected monthly and reported quarterly using the National AIDS Reporting Forms
1.2	BCC - community outreach and schools	Number of adult women/men and young women/men reached with gender-sensitive HIV prevention interpersonal communication (disaggregated by single and repeat exposures)	15,700.00	2007	Reports (specify)	20,000	103,320	275,000	551,039	1,291,498	2,066,396	2,410,795	Y	N	Y - over program term	NAC	Baseline refers to IPC efforts specifically focusing on the new National BC Strategy key messages; data to be collected through NAC M&E system NARF reports
1.3	BCC - community outreach and schools	Number of wards and work places implementing community and work place action plans on HIV prevention behaviour change that include gender issues	108	2007	Reports (specify)	0	255	510	680	680	680	680	Y	N	Y - over program term	NAC	Baseline refers to 26 districts covered by other funding, for areas proposed under GF baseline = 0; collected through NAC M&E system NARF reports.
2.1	Testing and Counseling	Number of women and men above 15 years and children aged 18 months-15 years who received an HIV test (through the provider initiated approach) (UNGASS #7)	250, 000	2007	HMIS	37,250	74,500	202,500	330,500	736,000	1,191,350	1662700	Y	N	Y - over program term	NAC	This indicator is directly linked to the Global Fund Round 5 indicator is collected through the HMIS quartely.
3.1	PMTCT	Number of infants born to HIV infected women who received an HIV test within 12 months.	300	2007	Pilot project data	-	-		10,080	32,760	59,220	87,038	Y	N	Y - over program term	NAC	Quarterly data collection through the HMIS. Support for Early Infant diagnosis will be given up until the end of 2010 by Clinton Foundation when GF will then take over support for this strategy hence no targets for the initial period.
3.2	PMTCT	Number of HIV-infected pregnant women who received more efficacious ARV prophylaxis to reduce the risk of mother-to-child transmission	600	2007	Pilot project data	3,600	7,200	14,400	21,600	43,200	70,200	99540	Y	N	Y - over program term	NAC	HMIS: Quarterly data collection through revised monthly progress reports
4.1	Antiretroviral treatment (ARV) and monitoring	Number of children and adults with advanced HIV infection receiving antiretroviral therapy dissagregated by gender.	100,000	2007	HMIS	3,000 females adults; 2,000 male adults	6,000 female adults; 4,000 male adults	44,550 female adults; 29,700 male adults;	89,100 female adults; 59,400 male adults; 15,000 children	107,100 female adults; 71,400 male adults; 33,000 children	125,100 female adults; 83,400 male adults; 40,500 children	143,100 female adults; 95,400 male adults; 50,000 children	Y	N	Y - over program term	NAC	Indicator is directly linked to Global Fund Round 5 indiator and National AIDS Core Output Indicator.
4.2	Antiretroviral treatment (ARV) and monitoring	Health facilities that offer ART (i.e., prescribe and/or provide clinical follow up), Additional Recommended Indicator #2 (number and percentage)	151	2007	HMIS	27	54	98	142	230	318	406	Y	N	Y - over program term	NAC	HMIS: Quarterly data collection through revised monthly progress reports.
5.1	Care and support for the chronically ill	Number of people living with HIV receiving care at community level	41,888	2008	Reports (specify)	-	17,600	17,600	17,600	17,600	17,600	17,600	Y	N	N - not cumulative	ZAN	Quartely data collection by SSR and SR. The baseline data is a national figure, while the targets are for 44 districts. Number of chronically ill people receiving care at community level is expected to decrease as more people are intiated on ART.
6.1	Support for orphans and vulnerable children	Number of districts, in which revised OVC village registers has been rolled out	-	2008	Reports (specify)	-	10	20	30	67	67	67	Y	N	Y - over program term	NAC	Baseline = 0. Quarterly data collection. Indicator to be included in NARF and collected by MOPSLSW district and provincial level officers.
7.1	Strengthening of civil society and institutional capacity building	Number of NGOs, CBOs, FBOs and networks of PLWHIV reached with institutional capacity builiding services (training, IEC material).			Reports (specify)	-	50	100	125	150	175	200	Y	N	Y - over program term	ZAN	No baseline data. Baseline will be determined in year 1. New indicator advocayte for inclusion in the NARF.