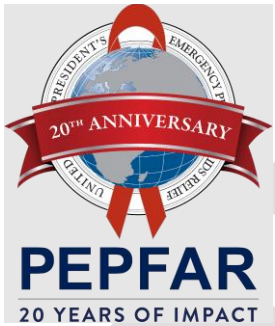
Zimbabwe
Country Operational Plan
(COP) 2023
Strategic Direction Summary (SDS)
April 27, 2023



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Acronym List

AE	Adverse Event
AGYW	Adolescent Girls and Young Women
AHD	Advanced HIV Disease
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARVs	Antiretroviral
BMGF	Bill and Melinda Gates Foundation
CAB-LA	Long Acting Cabotegravir
CARGS	Community ART Refill Groups
CBO	Community Based Organization
CBS	Case-based Surveillance
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CHW	Community Health Workers
CLHIV	Children Living with HIV
CLM	Community Led Monitoring
CODB	Cost of Doing Business
COP	Country Operational Plan
CQI	Continuous Quality Improvement
CSO	Civil Society Organizations
CTX	Cotrimoxazole
DBS	Dried Blood Spot
DHIS2	District Health Information System Version 2
DoS	Department of State
DPP	Dual Prevention Pill
DREAMS	Determined, Resilient, AIDS-free, Mentored and Safe
DSD	Direct Service Delivery or Differentiated Service Delivery
DTG	Dolutegravir
DPP	Dual Prevention Pill
EHR	Electronic Health Records
EID	Early Infant Diagnosis
eLMIS	Logistics Management and Information Systems
eMTCT	Elimination of Mother to Child Transmission
FAST	Funding Allocation to Strategy Tool
FP	Family Planning
FSW	Female Sex Workers
GBV	Gender Based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoZ	Government of Zimbabwe
HCD	Human Centered Design
HCW	Health Care Workers

HDP	Health Development Partners
HEI	HIV Exposed Infant
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HLMA	Health Labor Market Analysis
HMIS	Health Management Information System
HPV	Human Papillomavirus
HR	Human Resources
HRH	Human Resources for Health
HTS	HIV Testing Services
ICT	Index Case Testing
INH	Isoniazid (isonicotinylhydrazide drug)
IP	Implementing Partner
IPV	Intimate Partner Violence
IPT	Isoniazid Preventive Therapy
IST	Integrated Specimen Transport
KP	Key Population
KPIF	Key Populations Investment Fund
LEN	Lenacapvir
LPV/r	Lopinavir/ritonavir
M&E	Monitoring and Evaluation
M&O	Management and Operations
MCH	Maternal and Child Health
MER	Monitoring, Evaluation and Reporting
MMD	Multi-Month Dispensing
MoF	Ministry of Finance
MoHCC	Ministry of Health and Child Care
MoLSW	Ministry of Labor and Social Welfare
MoPSE	Ministry of Primary and Secondary Education
MoU	Memorandum of Understanding
MSM	Men who have Sex with Men
NAC	National AIDS Council
NCD	Non-Communicable Diseases
NGO	Non-Government Organization
OVC	Orphans and Vulnerable Children
PBFW	Pregnant and Breastfeeding Women
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PITC	Provider-initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post Natal Care
POART	PEPFAR Oversight and Accountability Response Team
POC	Point of Care

PrEP	Pre-Exposure Prophylaxis
PWID	People who Inject Drugs
QA	Quality Assurance
RBF	Results Based Financing
RITA	Recent Infection Testing Algorithm
RTK	Rapid Test Kit
RTRI	Rapid Test for Recent Infection
SBCC	Social and Behavior Change Communication
SDS	Strategic Direction Summary
SI	Strategic Information
SID	Sustainability Index and Dashboard
SIMS	Site Improvement through Monitoring System
SMS	Short Message Service
SNU	Sub National Unit
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SW	Sex Workers
TA	Technical Assistance
TAT	Technical Assistance for Treatment
TAT	Turn Around Time (Laboratory)
TB	Tuberculosis
TB LAM	TB urine lateral flow lipoarabinomannan
TBD	To Be Determined
TG	Transgender
TLD	Tenofovir Lamivudine Dolutegravir
TPT	TB Preventive Therapy
TSC	Technical Support Committee
TUTT	Targeted Universal Testing for TB
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USG	U.S. Government
VACS	Violence Against Children Survey
VL	Viral Load
VLC	Viral Load Coverage
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
YWSS	Young Women Selling Sex
ZDHS	Zimbabwe Demographic and Health Survey
ZIMPHIA	Zimbabwe Population-Based HIV Impact Assessment
ZNASP	Zimbabwe National AIDS Strategic Plan

Executive Summary

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Zimbabwe interagency team collaborated with key partners including the Government of Zimbabwe (GoZ), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), civil society organizations (CSOs), and other bilateral and multilateral health development partners to develop the 2023 Country Operational Plan (COP23) for FY 2024/25. The national antiretroviral therapy (ART) program and other critical HIV service delivery and prevention programs in Zimbabwe are implemented under the leadership of the Ministry of Health and Child Care (MoHCC), the National AIDS Council, the Ministry of Primary and Secondary Education (MoPSE), and the Ministry of Labor and Social Welfare (MoLSW) and are in line with the Zimbabwe National AIDS Strategic Plan (ZNASP) 2020-2025.

Zimbabwe is on the brink of ending the HIV/AIDS epidemic as a global health threat while sustainably strengthening public health systems; current estimates are at 93-100-95 under UNAIDS Fast Track Targets for all ages. However, despite commendable gains to date, Zimbabwe continues to operate in a complex operating environment with a tenuous relationship between the U.S. Government (USG) and Government of Zimbabwe. The national HIV/AIDS program is highly dependent on external resources to fund essential components of the HIV program including commodities, many aspects of service delivery, laboratory systems, strategic information systems, and human resources for health (HRH). The recent health labor market analysis (HLMA) highlighted major challenges in retention of health care workers (HCW) in the public health system and high migration to other countries, which poses a severe risk to the stability of Zimbabwe's health system. Additionally, significant inflation means that a flatline budget is analogous to a decrease due to the increasing costs of doing business, making continued progress more challenging. It is within this context that PEPFAR Zimbabwe has developed a balanced COP23 program that addresses gaps in prevention, case finding and treatment, as well as supports the much-needed HRH, commodity procurement, and national systems to sustain gains made to date in the HIV program.

In COP23, Zimbabwe must address gaps in pediatric case finding, beginning with accurate estimates of children living with HIV (CLHIV). Children (<15 years old) lag behind adults at 65-100-86 according to UNAIDS 2023 Spectrum estimates. In the past 6 years, Zimbabwe's PEPFAR program implemented robust strategies to close the 1st 95 gap in pediatric populations to little effect, suggesting the issue may stem from inaccurate estimates. In COP23, PEPFAR Zimbabwe will use LIFT funding to intensify case finding among children in targeted high-burden areas and improve CLHIV estimates through case-based surveillance.

While HIV incidence has declined significantly in Zimbabwe, there are still populations with elevated risk, including key and priority populations. PEPFAR will provide evidence-based combination prevention services to key populations (KP), including sex workers (SW), adolescent girls and young women (AGYW), men who have sex with men (MSM), transgender persons (TG), and people who inject drugs (PWID). PEPFAR Zimbabwe will also conduct size estimates and

biobehavioral surveys (BBS) for KP to fill gaps in data that are required for optimal planning and coverage.

Under new guidance from SGAC, the DREAMS program will be implemented in a more sustainable and streamlined way. The DREAMS program will maintain DREAMS in the 16 current districts, but the program will further reduce targets to focus on the most vulnerable AGYW, while scaling interventions to improve the enabling environment. At the same time, AGYW programming will be boosted in six new districts which were selected based on HIV incidence estimates.

Key measures in COP23 will be reinforced to reduce mortality. People starting treatment, re-engaging in treatment, or virally unsuppressed for ≥1 year will be evaluated for advanced HIV disease (AHD) and have CD4 T cells measured. PEPFAR will also help capacitate HCW to individualize AHD care.

Some program highlights included in COP23 that address primary gaps in prevention, testing, and treatment include:

- Expanding efforts to reach hidden subpopulations of KP through expansion of human-centered design (HCD) informed engagement and differentiated service delivery approaches, including scaling up digital innovations and intentionally engaging the private sector (e.g. pharmacies, private providers);
- Improving KP community led monitoring (CLM) metrics, rolling out a KP Friendliness Checklist and identifying other quick wins in making facilities more KP-friendly, while working with the MoHCC, KP CSOs and the National KP Technical Support Committee (TSC) to establish KP Centers of Excellence;
- Refreshing the social and behavior change communication (SBCC) strategy for improved reach and effectiveness of demand creation activities among priority populations and addressing HIV messaging fatigue by integrating a lifestyle approach that incorporates a range of health and wellness concerns;
- Increasing investment in KP CSO capacity building, interventions to address structural barriers and the enabling environment for KP-friendly and KP-competent service delivery;
- Transitioning the current practice of voluntary male medical circumcision (VMMC) cost-reimbursement for service and demand to a Results-Based-Financing (RBF)-like model in all districts, whilst maintaining accountability for resources and results, and supporting community-grown and led VMMC demand creation activities, rollout of reusable VMMC kits, and the Shang Ring method for a more sustainable VMMC program;
- Investing in interventions to move the needle on PrEP uptake among pregnant and breastfeeding women and leveraging centrally funded awards for the introduction of new PrEP products like CAB-LA;
- Improve tuberculosis (TB) case-finding through approaches such as Targeted Universal Testing for TB (TUTT) or through TB urine lateral flow lipoarabinomannan (TB LAM);
- Close the pediatric HIV case-finding gap through ethical index case testing;

- Employ a status neutral approach and continue to focus on ethical index case testing approach, alongside provider initiated testing and counseling (PITC), as the hallmarks for case-finding and testing for prevention;
- Explore offline functionality for the web-based Electronic Health Records (EHR) system as a solution for downtime due to power shortages or site level connectivity failure;
- Prioritize digitizing the laboratory integrated sample transportation (IST) system from paper-based systems for tracking and tracing samples to using the electronic sample tracking system;
- Supporting a country-led Sustainability Roadmap process, and aligning it to key national processes including implementation of the Health Resilience Fund, the HRH workforce assessment and strategy and broader health financing discussions;
- Increase investment in Community Led Monitoring (CLM) with a focus on KP-led organizations;
- Focusing on the management of AHD, capacitating HCWs, ensuring SOPs and guidelines are updated and differentiated care is available per clients' needs to optimize adherence;
- Integrating screening and referrals for non-communicable diseases (NCD) and mental health into HIV services and community support platforms.

The goals of COP23 are evident: 1) determine accurate CLHIV estimates with the objective of closing gaps in the pediatric cascade, 2) test and treat the most at risk and difficult to reach, including key and priority populations and men; 3) engage communities through CLM to ensure quality services are provided, ensuring people access services, remain on treatment, and sustain viral suppression. Based on current progress summarized in Tables 1 and 2 as well as Figure 1, by the end of COP23, PEPFAR Zimbabwe will ensure that 90% of the total expected 1,283,468 PLHIV on treatment will be virally suppressed, reaffirming that Zimbabwe is on a truly successful path to end AIDS by 2030.

Table 1: 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression

HIV Diagnosis, Treatment, and Viral Suppression										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	FY23 Total Population Size Estimate	FY24 PLHIV Estimate	FY24 HIV Prevalence	FY23 PLHIV Diagnosed	On ART	On ART Coverage	Viral Load Suppression	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
Total population	17,270,606	1,291,748	7.5%	1,299,202	1,217,247	96.2%	96.4%	1,191,692	67,193	64,289
Population <15 years	6,977,158	60,132	0.9%	56,387	50,415	72.1%	89.6%	65,817	2,209	2,394
Men 15-24 years	1,554,112	39,029	2.5%	36,320	32,592	71.2%	90.4%	80,544	2,046	1,778
Men 25+ years	3,452,173	440,678	12.8%	447,439	401,766	94.7%	96.6%	177,297	22,362	21,337
Women 15-24 years	1,559,434	64,059	4.1%	71,543	73,698	101.1%	93.2%	408,031	12,495	11,651
Women 25+ years	3,727,729	687,850	18.5%	687,513	658,359	95.7%	97.3%	459,957	28,081	27,135
MSM**	52,057	10,253	20%	7,186	6,928	68%	93%	14,250	1,421	1,364
FSW**	94,702	45,457	48%	41,237	38,703	94%	92%	35,210	3,585	3,343
TG**	8,007	2,145	27%	1,485	1,383	64%	87%	930	129	123

*These should be national data; if the data do not exist, PEPFAR data may be used if relevant. **New *national* consensus estimates based on available survey data (IBBS 2019; AMETHIST 2022)

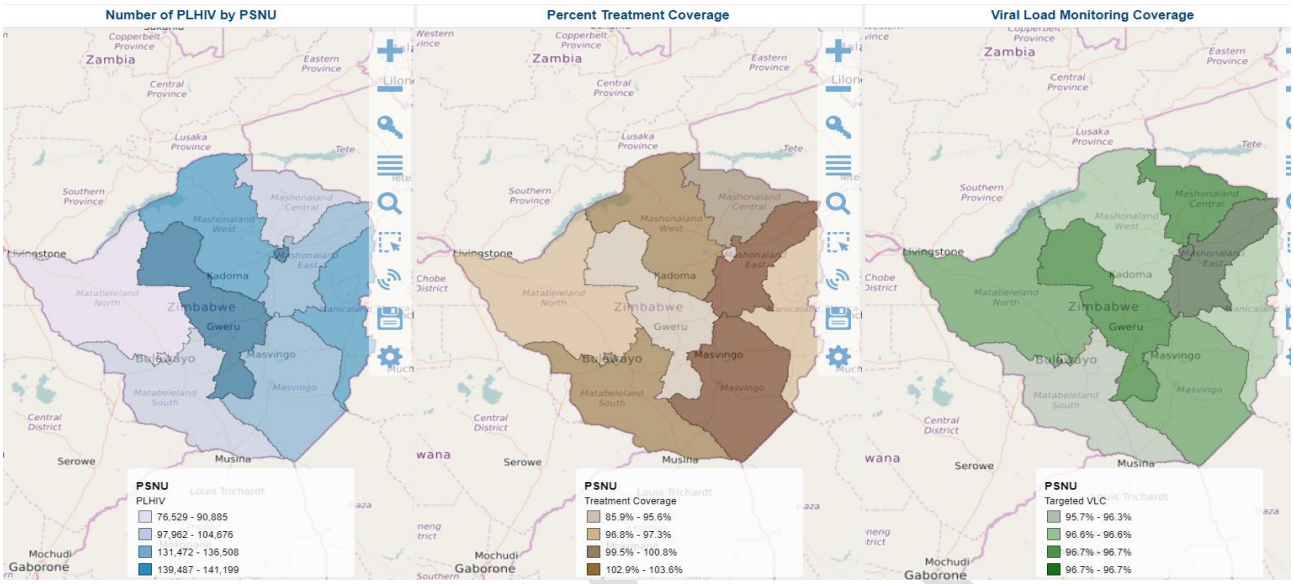


Figure 1: People Living with HIV, Treatment Coverage and Viral Load Monitoring Coverage

Table 2: Current Status of ART Saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP23	# Current on ART (FY22)	# of SNU COP22 (FY23)	# of SNU COP23 (FY24)
Attained	1,291,748	1,217,247	63	10
Total National	**1,291,748**	**1,217,247**	**63**	**10**

Pillar 1: Health Equity for Priority Populations

Using data, and informed by deliberations with stakeholders, in COP23 PEPFAR will ensure attention and resources are harnessed to effectively close the gaps and address inequities which are impeding Zimbabwe's sustained control of the HIV epidemic. Pillar 1 presents PEPFAR's strategy for reaching children, pregnant and breastfeeding women (PBFW), AGYW, and KP. In COP23 PEPFAR will continue to employ a strong public health approach, while ensuring innovative, person-centered HIV Testing (HTS) and treatment services, as well as a robust combination prevention approach. Additionally, PEPFAR will prioritize interventions to address key structural barriers that prevent priority populations from accessing services.

Plan to Close Gaps in the Pediatric Cascade

Finding children: As Zimbabwe inches closer to epidemic control, it is imperative to close the pediatric HIV case-finding gap. Mashonaland Central, East, and West have the largest, pediatric first 95 gaps. In COP23 PEPFAR will identify, and scale promising innovations and employ tried and tested effective case-finding strategies to reduce these gaps, as described below.

	PLWHIV Aware of Status																											
	Y000_004		Y005_009		Y010_014		Y015_019		Y020_024		Y025_029		Y030_034		Y035_039		Y040_044		Y045_049		Y050_054		Y055_059		Y060_064		Y065_999	
Provinces	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M
Bulawayo	78%	78%	84%	84%	88%	88%	99%	94%	99%	87%	99%	81%	99%	87%	100%	91%	99%	94%	100%	96%	100%	96%	100%	95%	100%	97%	99%	97%
Harare	42%	42%	50%	50%	47%	47%	71%	87%	68%	75%	79%	71%	91%	79%	93%	83%	92%	87%	96%	90%	96%	92%	94%	90%	95%	92%	93%	94%
Manicaland	78%	78%	80%	80%	72%	72%	93%	98%	91%	94%	91%	92%	96%	94%	97%	96%	96%	97%	98%	97%	98%	98%	97%	97%	98%	98%	97%	98%
Mashonaland Central	61%	61%	69%	69%	62%	62%	99%	98%	98%	94%	98%	92%	99%	94%	99%	96%	99%	96%	100%	97%	100%	97%	100%	97%	100%	98%	99%	98%
Mashonaland East	62%	61%	69%	69%	68%	68%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Mashonaland West	68%	68%	59%	59%	54%	54%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Masvingo	80%	80%	86%	86%	79%	79%	100%	99%	100%	99%	100%	98%	100%	99%	100%	99%	100%	99%	100%	99%	100%	100%	100%	99%	100%	100%	100%	100%
Matabeleland North	49%	50%	87%	86%	83%	83%	85%	96%	84%	91%	93%	88%	97%	91%	98%	93%	98%	95%	99%	96%	99%	97%	98%	96%	98%	97%	98%	98%
Matabeleland South	92%	92%	97%	97%	96%	96%	100%	93%	100%	83%	100%	78%	100%	83%	100%	87%	100%	91%	100%	93%	100%	94%	100%	92%	100%	94%	100%	95%
Midlands	68%	68%	86%	86%	83%	83%	92%	98%	89%	96%	90%	94%	94%	96%	96%	97%	95%	98%	98%	98%	98%	98%	97%	98%	97%	98%	96%	99%

Figure 2: First 95 Gaps in the Pediatric Population

Index case testing (ICT) continues to be an efficient testing modality among children; during COP21 the testing modality contributed 49% of new cases identified among children 0-14 years, while accounting for 34% of tests done. In COP23 PEPFAR will continue to support ethical ICT through building capacity of health workers and leveraging the OVC program's community platform for smart targeting and wider coverage, whenever possible. Specifically, PEPFAR will work with sites to conduct file audits to identify biological children of parents on ART who are eligible for testing, with the goal of achieving universal testing of child contacts. Discussions with the MoHCC to allow screening for children using HIV self-testing (HIVST) kits by caregivers and/or community health workers are ongoing; this innovation is expected to expand access to HTS, especially in hard-to-reach and remote locations. Provider-initiated testing and counseling (PITC) contributes about 35% of new cases identified and nearly half of all tests done, making the modality second in case contribution. In COP23 PEPFAR will continue to advocate and support use of the validated HIV screening tool before testing. This will enable efficiencies to be made between the available resources and the 'number needed to test' to identify one case.

The proportion of HIV exposed infants (HEI) tested using point-of-care (POC) platforms has been increasing over the last three years, and as a result, there has been an increase in early infant diagnosis (EID) coverage and linkage to ART. In COP23 PEPFAR will support the decentralization of conventional EID platforms and the Integrated Specimen Transport (IST) system. PEPFAR will also support expedited results transmission through electronic platforms (i.e., short message service (SMS) to reduce the turn-around time for results (TAT) for those tested on non-POC platforms.

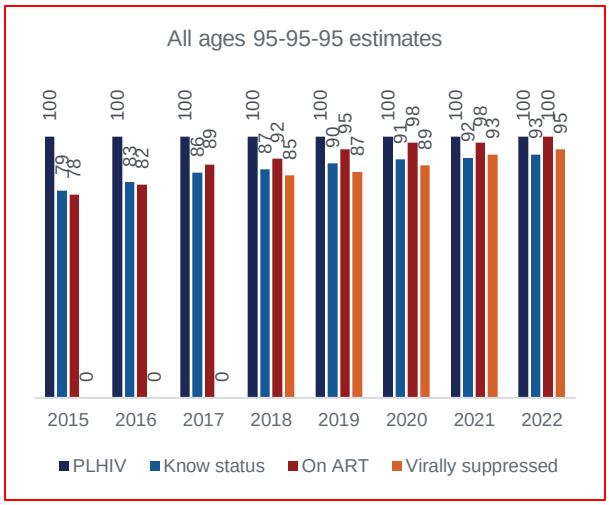
The PEPFAR program will support the procurement of EID POC commodities for mPIMA devices, which is expected to significantly reduce TAT and enable immediate linkage to ART initiation. To improve and maintain high EID coverage, and at least 95% linkage to treatment, PEPFAR will

expand use of EHR and the diary system, utilize longitudinal cohort monitoring, expand community ART initiation, and continue same day treatment initiation, and optimize child friendly regimens.

In COP23 PEPFAR will maintain the support to 90% of CLHIV in the 21 OVC focus districts by ensuring at least 80% coverage of CLHIV in all health facilities within the OVC coverage areas. Currently, 100% of health facilities in OVC catchment areas are covered by memorandums of understanding (MoUs) granting the IP permission to work within the facilities. The Community-Clinic Linkage Standard Operating Procedures (SOP) will remain the guiding document used to refine these agreements. PEPFAR will maintain support for case managers at high-volume clinics to ensure smooth coordination and referrals between health care workers and community case workers. In COP23 PEPFAR will continue to assess HIV-positive women in adult care who are pregnant and/or have children aged 0-19 to determine if their families should be enrolled in the OVC program. PEPFAR will continue to conduct home visits to all enrolled OVC to encourage HIV testing (if indicated based on risk assessment), including for children lost to follow up in the PMTCT cascade.

Improving children living with HIV estimates: UNAIDS' Spectrum model estimates that Zimbabwe has achieved 93-100-95 for all ages. Nevertheless, children less than 14 years old are lagging behind at 65-100-86. PEPFAR has implemented several strategies to address the case-finding and viral load gaps among children, with some degree of success, including pediatric surge activities focused on index testing among biological children of parents on ART, universal testing in high-risk entry points, HIV screening tools in outpatient departments, community case-finding, and collaboration with OVC programs.

Despite all these activities, case-finding and HIV positivity has remained low when compared to adults. Questions have been raised about the accuracy of CLHIV estimates, especially ANC and prevention of mother to child transmission (PMTCT) inputs into the Spectrum model. The 2020 Zimbabwe Population-based HIV Impact Assessment (ZIMPHIA) did not include children; therefore, there is no population-level surveillance data to provide better estimates.



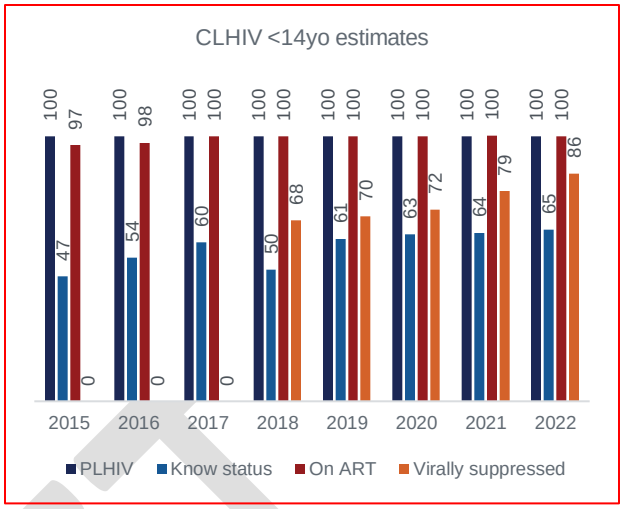


Figure 3: UNAIDS Spectrum model 95-95-95 Cascade for Children compared to all ages

In COP23 PEPFAR will improve the quality and completeness of ANC and PMTCT data in all health facilities using the EHR system and routine data quality assessments in all health facilities. A review of PMTCT data in the EHR has been conducted, and the modules will be improved in COP22.

Plan for Services for Pregnant and Breast-Feeding Women (PBFW)

Zimbabwe is one of the 12 countries which has committed to end AIDS in children by 2030 under the Global Alliance banner. PEPFAR is committed to working with the MoHCC to achieve this goal. In COP20, 99% of women booking for ANC had a documented HIV status. ART coverage among women with HIV positive status was 100% and EID coverage at 2 and 12 months of age were both above 100%. Linkage to ART for HIV infected infants was above 90%. However, despite this good program performance, most transmission of HIV to unborn babies is a result of women who do not access ART during pregnancy and breastfeeding. It is estimated that about 10 - 12% of pregnant women, due to various reasons, do not seek/receive ANC services at health facilities. Even among those women who do access services, there is a need to ensure they access the services early and do not interrupt treatment throughout pregnancy and after delivery until the end of the breastfeeding period.

To address vertical HIV transmission, PEPFAR will continue to support HIV retesting among HIV negative PBFW for early identification of new incident infections. In addition, PEPFAR will use the effective, universal PrEP counseling approaches and work with sites to expand the offer of PrEP to HIV negative PBFW who are at substantial risk of acquiring HIV. Program data shows high vertical HIV transmission among women delivering but not on ART, those who deliver with unsuppressed viral load (VL) and those starting ART late in pregnancy. PEPFAR will continue to prioritize early ART initiation and VL testing to ensure women deliver and continue breastfeeding with a suppressed VL. In collaboration with the MoHCC, PEPFAR will support the roll out of new national guidance recommending all HEI to receive triple therapy as prophylaxis.

Closing gaps among men and youth in Harare and beyond

According the 2023 HIV Estimates, there are gaps in the first, second and third 95s for specific age/sex groups in certain provinces as detailed in Figure 1 above. The largest gaps are among men and all age/sex groups in Harare. To address these gaps the program will implement context specific (geographic and population) targeted interventions as shown in Figure 4 below:

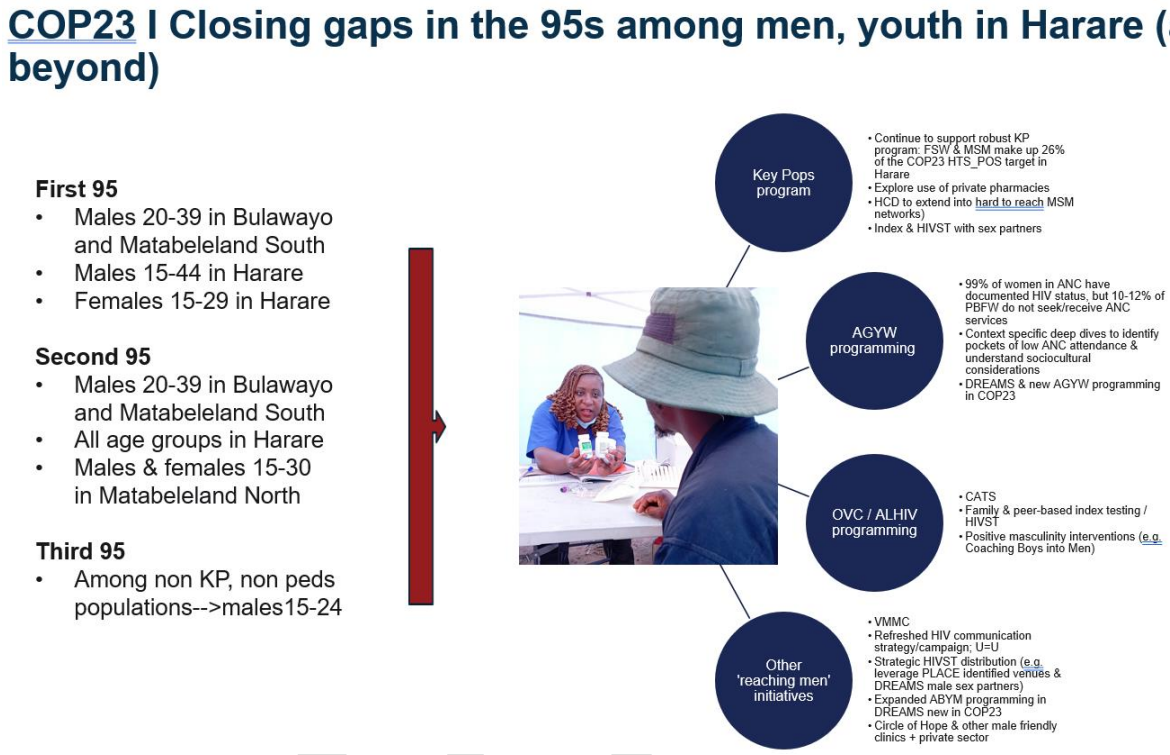


Figure 4: Interventions to close gaps in the 95s among men, youth in Harare and beyond

Additional work will be done to scale up and emphasize implementation fidelity in:

- Use of appointment registers and tracking/tracing registers for viral load monitoring to reduce missed opportunities particularly for youth and men;
- Targeted community outreach with services at soccer galas, workplaces, bars and other areas populated by men;
- Continue efforts to recruit and train male per counselors, treatment supporters and viral load champions;
- Expand work with Padare Men's Forum to improve access and outcomes for men across the clinical cascade;
- Male led/male only CARGS led my expert male clients who provide additional counseling, treatment and viral load literacy.

Combination Prevention

Summary

In COP23, PEPFAR will provide evidence-based combination prevention services to at-risk, priority, and KP guided by extensive stakeholder consultations and PEPFAR's 5X3 strategy, highlighting the importance of using a targeted, integrated, and person-centered approach to reduce new HIV infections. While HIV incidence has declined significantly in Zimbabwe based on current epidemic patterns and program coverage, there are still populations with elevated risk, including key and priority populations. KPs include sex workers (SW), AGYW, men who have sex with men (MSM), transgender persons (TG), and PWID. AGYW and HIV positive men age 18-24 years are considered priority populations for PEPFAR investments in COP23. Other important populations for combination prevention include HIV negative high-risk boys and men, including partners of SWs and AGYW, and pregnant and breastfeeding women (PBFW).

PEPFAR will seek to identify program efficiencies and deliver combination prevention services in a more sustainable way that considers short-term funding and longer-term financing, cost-effective approaches for capacity building, market development for condoms and PrEP products, evidence-based demand creation strategies, structural interventions, including violence prevention and norms change, and proven, as well as innovative, service delivery strategies. Through differentiated service delivery (DSD) models such as digital platforms, private sector engagement, strengthening youth-friendly services, PEPFAR Zimbabwe will increase access and choice to combination prevention products and services. Existing and new human-centered design (HCD) approaches will inform demand creation, program design, and implementation. Building off the MoHCC's ongoing work on standardizing HIV prevention packages, and the previously developed HIV Communication Strategy, PEPFAR will support a two-year campaign to reposition HIV alongside other sexual and reproductive health (SRH) and related health and wellness concerns, including refreshed, standardized, and linked biomedical prevention messages and updated communication channels. The combination prevention communication campaign will also tie into Undetectable=Untransmittable (U=U) messaging and tools, such as Flip the Script, to portray a comprehensive picture and show the interrelatedness of HIV prevention and treatment efforts.

HIV message fatigue is frequently cited as a challenge by stakeholders and communities. In COP23, PEPFAR will further integrate messaging and services that address other SRH needs (e.g. family planning, sexually transmitted infections (STI) prevention and treatment, post-violence care) to ensure HIV prevention programs remain meaningful and relevant and respond to users' expressed needs.

Several recent studies have documented elevated rates of STIs, particularly chlamydia and gonorrhea, among women less than 25 years old in eastern and southern Africa. SWs in Zimbabwe also experience high STI rates, as evidenced by the AMETHIST trial. In COP23 PEPFAR will strengthen STI screening, diagnosis, and treatment services for those most at risk including SWs, young women selling or transacting sex, and other high-risk young women.

HTS

The PEPFAR program has a defined HTS strategy that is based on a method mix designed to offer differentiated, person-centered services tailored to different subpopulations depending on their circumstances, need, and risk factors. In COP23 PEPFAR will employ a status neutral approach and continue to focus on ethical ICT approach, alongside PITC, as the hallmarks for case-finding and testing for prevention. In line with the status neutral approach to HTS, at-risk clients who test HIV negative will be offered a package of prevention interventions to choose from, depending on their circumstances, need and choice. HIVST distribution will continue to be scaled to maximize client choices and testing efficiencies. A blood based HIVST kit is being evaluated at National Microbiology Reference Laboratory (MNRL) for possible adoption by the start of COP23. This will widen clients' choices for HIVST. Through its clinical IPs, PEPFAR will regularly support capacity enhancement efforts for more efficient and robust SNU and facility level HTS commodities management interventions to ensure uninterrupted HTS service provision.

At the backdrop of continued attrition of the highly skilled and experienced health workers, the quality of HTS provided continues to be compromised across the country. Both PEPFAR and MoHCC are greatly concerned at the threat this poses to efforts at epidemic control. In line with regional practices for provision of high quality HTS, the need for sustained capacity building of HCWs cannot be emphasized enough. Regular Internal Quality Assurance activities at lowest performing sites is one area that MoHCC can do with PEPFAR support in COP23.

PEPFAR will engage with the MoHCC to update and review standard operating procedures and job aids for health care providers to offer holistic support to clients that address both their health and social needs. In particular, the revisions and updates will ensure the status neutral approach of service provision is adapted for the Zimbabwean context. The recently updated ART guidelines, as well as the Operational and Service Delivery Manual, will complement this process and form the basis for the provision of comprehensive HTS services and linkages to both preventive and curative services as needed by the clients.

PEPFAR implements a carefully monitored, safe, and ethical ICT program. Through on-the-job training, clinical mentoring, and supportive joint monitoring with the MoHCC, PEPFAR will continue to build the capacity of service providers, including newly appointed HCWs, to correctly offer ICT aligned with WHO's 5 Cs. PEPFAR will continue to strengthen service providers' capacity to routinely assess intimate partner violence (IPV) in a structured way, empower clients to report instances of violence, and offer appropriate referrals for services.

Voluntary Medical Male Circumcision (VMMC)

In COP23 PEPFAR will deploy district-specific strategies based on their progress toward saturation. Districts yet to achieve 90% VMMC coverage among the 15–29-year age group will continue with a "scale-up to saturation" approach, while districts that have reached or surpassed the 90% VMMC coverage will embark on a "transition to sustainability" initiative. The "scale-up to saturation" package will use a multi-pronged demand creation and service delivery strategy, that includes peer-to-peer, bring-a-buddy, reimbursement for lost wages, and moonlighting initiatives aimed at circumcising adolescent boys and young men in the 15–29 year age group. To drive the "transition-to-sustainability," PEPFAR will support community-grown and led VMMC

demand creation activities, the rollout of reusable VMMC kits, and the Shang Ring method—all of which will enable a more sustainable VMMC program. PEPFAR will support the decentralization of VMMC services to lower-level health facilities, as well as the private sector, through context–appropriate capacity building, holistic adverse events (AE) management, and ensuring the safety of both clients and frontline healthcare workers. Building on lessons learned from the Bill and Melinda Gates Foundation-funded INTEGRATE program, PEPFAR will transition the current practice of VMMC cost-reimbursement for service and demand to a Results-Based-Financing (RBF)-like model in all districts, whilst maintaining accountability for resources and results and adhering to USG funding and policy parameters in Zimbabwe. The RBF-like model builds on the MoHCC's RBF contracting, verification, support, and supervision tools. The model seeks to improve managerial capacity and ownership at provincial and district levels, data quality and reporting, community participation, and enhance program quality.

Pre-Exposure Prophylaxis (PrEP)

Oral PrEP is a proven, safe, and scalable intervention that can significantly reduce new HIV infections. PEPFAR has supported oral PrEP implementation in Zimbabwe since 2017, and despite challenges with periodic PrEP stock-outs (improved in COP22), ensuring there were adequately trained staff during high levels of attrition, and low uptake among PBFW, the program has consistently surpassed its targets each year.

Learning from the prior years of experience, COVID-19 adaptations, and community and PrEP recipients' feedback, PEPFAR will, in COP23, align national HIV prevention policies with the new WHO guidance on differentiated and simplified PrEP for HIV prevention and status-neutral service delivery considerations to streamline PrEP services and decrease barriers to PrEP use. In scaling up and integrating differentiated PrEP service delivery, all individuals testing negative for HIV, in all HIV service delivery points (including HTS, ART clinics, ANC/PMTCT clinics, DREAMS settings, STI testing and treatment, and KP services), should be linked to appropriate prevention interventions, including PrEP, using an informed choice and gain-framed approach alongside tailored counseling to support individuals in selecting the best combination prevention modalities for their needs. PEPFAR will support operationalization of SOPs to achieve seamless integration of prevention services. Careful counseling, using screening-in tools, will be provided to individuals before starting, during resupplies and while taking PrEP to ensure users adequately understand how to start and stop PrEP. Anyone directly requesting PrEP will be offered PrEP, even if they do not wish to disclose the reason for their request or risk context.

In COP23, PEPFAR, in collaboration with centrally funded implementation science projects MOSAIC and MATRIX and other stakeholders, such as AVAC, will continue to support a conducive enabling environment for the entry and rapid scale-up of new PrEP products including the PrEP Ring, CAB PrEP, Lenacapvir (LEN), and the Dual Prevention Pill (DPP). The Medicine Control Authority of Zimbabwe (MCAZ) approved both the PrEP Ring and CAB PrEP, under the brand name Apretude, in 2022; advanced studies are underway, but the introduction and access timelines for the DPP and LEN are still to be determined. Both the PrEP Ring and CAB PrEP have been included in Zimbabwe's updated HIV Guidelines and Operational and Service Delivery

manual. A standardized PrEP Training Manual was developed to ensure consistent training of healthcare providers. This manual contains a module on emerging PrEP modalities, including the PrEP Ring, CAB PrEP, the DPP, and event-driven PrEP (ED-PrEP).

PEPFAR will not procure the PrEP Ring outside PEPFAR-funded implementation science studies but will actively work with other donors (e.g. GFATM) that can procure the PrEP Ring; PEPFAR will fully support programmatic implementation when procured by these other parties. Findings from a PrEP Ring pilot funded in COP21 and implemented through the DREAMS platform suggest the Ring is acceptable by AGYW and it is feasible to implement in program settings. In addition, the PrEP Ring is one of three PrEP methods that will be assessed as part of the CATALYST study implemented by MOSAIC.

In COP21 PEPFAR supported a PrEP 2-1-1 pilot targeting the MSM community that demonstrated it is an acceptable prevention option and feasible to roll out in program settings. In COP23, ED-PrEP will be offered as an option for people who are assigned male at birth who do not use exogenous, estradiol-based gender affirming hormones. PEPFAR will explore PrEP service delivery in private pharmacies, which are settings beyond public and donor-funded health facilities. PEPFAR will support using HIVST to facilitate easier access to, and effective use of, PrEP for prevention.

PEPFAR will continue to support PrEP implementation and emphasize continuous quality improvement activities, such as internal quality assessments, site support visits, on-job mentoring, and external quality audits. In COP23, PEPFAR will strengthen the integration of STI management with PrEP delivery. Current guidelines rely on syndromic management, which is a sub-optimal strategy for women, especially those at high risk, who often experience asymptomatic STIs. PEPFAR will maximize the use of existing GeneXpert platforms to expand access to STI diagnostics and will continue to fill gaps in the national stock of STI commodities, focusing on the highest risk populations. It is important to note that additional funding, through the Government of Zimbabwe and/or other development partners, is needed to fully support the country's needs for STI diagnostics and treatment.

PrEP demand creation messaging will be tailored to the specific priority populations and integrated into existing prevention and treatment platforms, including DREAMS and KP programming, communications materials and strategies, and dissemination methods (including virtual platforms).

Post-Exposure Prophylaxis (PEP)

In alignment with WHO guidelines, PEP may be offered to anyone with a recent exposure to HIV (within 72 hours). However, PEP has been underutilized at health facilities in Zimbabwe and is largely reserved for high-risk, occupational exposures among healthcare workers and survivors of sexual violence. PEP uptake remains low among survivors of sexual violence due to access barriers to clinics (distance, cost of transport, limited capacity of providers at primary care level) following an incident of sexual violence. There is a need to increase PEP availability and accessibility both within and beyond formal clinical sites (i.e. One Stop Centers) and public sector

facilities so survivors of sexual violence, key and priority populations, and individuals with recent exposure can easily access it. In COP23, PEPFAR will support demand creation and marketing to increase community awareness about PEP use and availability and explore PEP availability in community settings, such as pharmacies and other accessible settings, identified by community members and within the parameters of MoHCC guidelines. PEPFAR will also collaborate with the MoHCC to support refresher training for healthcare providers on PEP dispensing and reduce the stigma associated with PEP use within and outside of health facilities. PEPFAR will strengthen PEP as an entryway to the full suite of prevention options, including PEP2PrEP linkage to ensure PEP users are offered PrEP as an additional prevention choice.

Condoms

In COP23, PEPFAR will continue to procure, promote, and distribute male and female condoms and lubricants. Guided by the 2022 Condom Market Segmentation study results, PEPFAR will deliver condoms through an integrated approach, across service delivery points including VMMC, HTS, HIV care and treatment, PrEP, DREAMS, KP-specific interventions, and other community interventions. PEPFAR will continue to use a total market approach in condom programming, promoting use across the public, social and commercial markets. PEPFAR will promote a mid-market condom type to appeal to the market segment that falls between the socially marketed and fully commercial condom markets, to encourage uptake among this population, while not crowding out either end of the market.

PEPFAR will support advocacy for greater public resource allocation for public sector condoms and will work with relevant stakeholders to reduce policy/regulatory barriers that minimize access to condoms such as classifying condoms and lubricants as essential commodities and advocating for the removal of import tax and VAT for condoms and lubricants.

Plan for Adolescent Girl and Young Women Services

Background

While Zimbabwe has made commendable progress in reducing HIV incidence, AGYW are still more likely to become infected than their male peers. Spectrum modeling from 2023 estimates HIV incidence to be 0.25 among AGYW 15-24 years, as compared to 0.07 among males. Multiple and interrelated factors contribute to AGYW's vulnerability to HIV, including low-risk perception, poor access to education and economic opportunities, biological susceptibility, high rates of GBV, child marriage and early childbearing, and social and gender norms that limit AGYW's agency. One in three Zimbabwean women was married, and one in four gave birth, before the age of 18 (https://www.unicef.org/zimbabwe/end-child-marriage-empower-women, UNICEF, 2020. Twenty-six percent of females reported experiencing sexual, physical, and/or emotional violence before age 18 (Young Adult Survey of Zimbabwe (VACS), 2019, 2nd edition). The prevalence of childhood sexual violence among females was 9.1%, and only 20.5% of females who experienced pressured or physically forced sex sought help. Nearly one in four females ages 13–24 (23.3%) who experienced pressured or physically forced sex became pregnant because of the first or the most recent incident. AGYW experiencing sexual violence face many barriers to receiving help,

including stigma, limited adolescent-friendly services, and long distances, resulting in sub-optimal access to PEP.

PEPFAR has implemented the Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe (DREAMS) program for AGYW since 2015 in 16 districts in Zimbabwe. DREAMS is PEPFAR's flagship approach to reducing AGYW's vulnerability to HIV infection. The program uses a multisectoral and comprehensive approach that layers interventions addressing individual, community, and structural factors that increase AGYW's HIV risk, including gender inequality, gender-based violence (GBV), and limited education and economic opportunities. Interventions provided to AGYW through DREAMS include HIV and GBV prevention, GBV response services, basic financial literacy and comprehensive economic strengthening, education assistance, and the provision of AGYW-friendly HTS, PrEP, SRH, inclusive of family planning (FP) and STI services. DREAMS services are delivered in schools, community safe spaces, health facilities, and outreach services. DREAMS also supports community norms change activities, and interventions targeting caregivers of adolescents and male sexual partners of AGYW. DREAMS is jointly led and coordinated by the MoHCC and National AIDS Council, and there are well-established coordination structures for sharing best practices and jointly planning, implementing, and troubleshooting challenges. PEPFAR provided one or more DREAMS services to 234,314 AGYW in COP21; 73% of AGYW completed the primary package (HIV and prevention education, financial literacy, and condom promotion) 72% also received one or more secondary services.

In line with the PEPFAR 5x3 framework, COP23 presents an opportunity to adjust the strategy for HIV prevention among AGYW, including using more nuanced approaches that respond to Zimbabwe's context. In COP23, the program will follow the DREAMS guidance, streamline the DREAMS core program in current districts that have achieved saturation, and extend the implementation of combination HIV prevention approaches in priority districts currently not covered by DREAMS (i.e., Phase III). These priority districts have the highest incidence levels after accounting for current DREAMS and GFATM districts. The program will maintain core programs in Phase I and Phase II, while scaling up interventions that promote an enabling environment, including expanding coverage of activities focused on adolescent boys and young men, community mobilization and norms change, and improving the availability and accessibility of adolescent-friendly health services. PEPFAR Zimbabwe will introduce combination HIV prevention interventions in Phase III districts by targeting the most at-risk AGYW with evidence-based interventions. Recognizing the current economic environment in Zimbabwe remains challenged, the program will continue to build the resilience of AGYW by providing economic strengthening support in Phase I, II, and III districts. Finally, in COP23 PEPFAR will focus on shifting approaches to promote more efficient programming and sustainability, including working through government entities, building capacity for health facilities to provide SRH services and capacity building of educational institutions to provide comprehensive sexuality education (CSE).

DREAMS Saturation

As of the end COP21, the program saturated 22 out of 48 age bands in the current 16 districts with primary package reach. By the end of COP22, the program anticipates saturating all current

DREAMS districts (Table 3). Once an age band/district reaches saturation, the focus will shift to reaching the most vulnerable (highest risk for HIV), maintaining saturation among the 10-14s to account for aging in, and priorities specific to the Zimbabwe context.

Table 3: DREAMS Zimbabwe Saturation Projections, end COP22

District	Age band		
	10 to 14	15 to 19	20 to 24
Beitbridge	129%	186%	138%
Bubi	91%	110%	111%
Bulawayo	171%	152%	242%
Bulilima	136%	163%	136%
Chipinge	111%	123%	197%
Gwanda	135%	162%	131%
Gweru	167%	157%	323%
Insiza	134%	161%	133%
Lupane	96%	124%	112%
Makoni	124%	109%	226%
Mangwe	138%	183%	191%
Matobo	137%	181%	145%
Mazowe	190%	148%	213%
Mutare	115%	125%	192%
Nkayi	98%	122%	120%
Tsholotsho	100%	122%	129%

AGYW Vulnerability and eligibility criteria in Zimbabwe

DREAMS targets the most vulnerable AGYW through standardized screening and enrollment tools: Form 1 (Eligibility Screening Tool) and Form 2 (Enrollment Tool, more comprehensive needs assessment). At present the program enrolls AGYW into DREAMS if they meet one or more of the standardized eligibility criteria.

Vulnerability estimates for AGYW in Zimbabwe derived from population-based survey data (e.g., PHIA, Violence Against Children and Youth Surveys (VACS)) range from 43% to 90% depending on district and age band, with an average of 67%. However, program data from more than 520,000 AGYW screened over 3 years show vulnerability rates between 83 to 100% depending on district and age band; an average of 98% of screened AGYW meet DREAMS eligibility criteria.

Vulnerability estimates for AGYW in Zimbabwe derived from population-based survey data (e.g., PHIA, Violence Against Children and Youth Surveys (VACS)) range from 43% to 90% depending on district and age band, with an average of 67%. However, program data from more than 520,000

AGYW screened over 3 years show vulnerability rates between 83 to 100% depending on district and age band; an average of 98% of screened AGYW meet DREAMS eligibility criteria (Figure 5). In COP 23 and 24 the program will be tightening the eligibility criteria by removing the risk of dropping out of school and no or irregular condom use in all the age bands. The removal of these eligibility criteria will strengthen the reach to the most at risk AGYW.

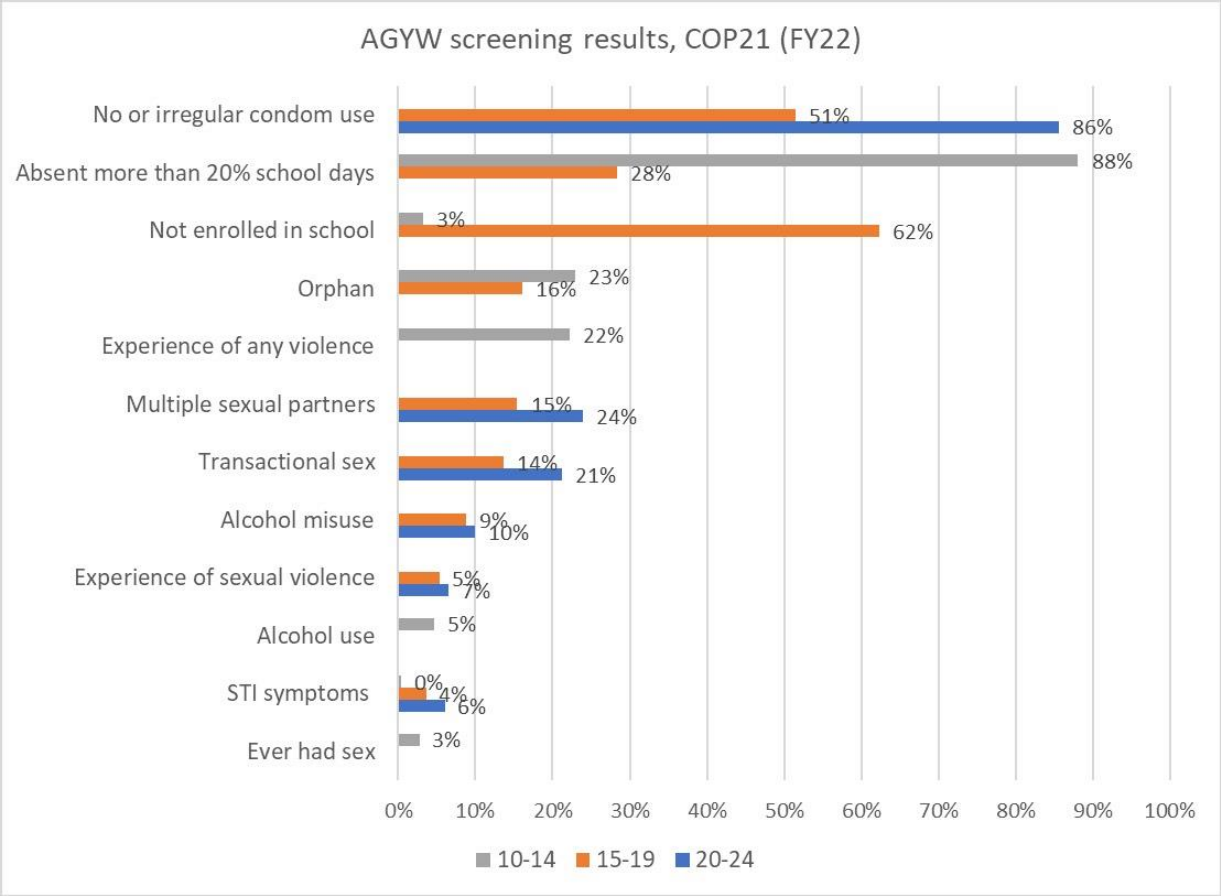


Figure 5: AGYW Screening Results, COP20-Present (FY21-FY23 Q1)

In COP23 the program will further focus on those at highest risk by revising the eligibility criteria to be more targeted and further refining strategies to identify and engage the most vulnerable (by eliminating poor school attendance and lack of condom use with a cohabitating partner as eligibility factors).

AGYW Programming in COP23

In COP23 PEPFAR will implement HIV prevention programming for AGYW in 22 districts (Figure 6) using a 3-pronged approach summarized below:

- DREAMS Phase I: streamlining DREAMS in the 6 original DREAMS districts of Bulawayo, Chipinge, Gweru, Makoni, Mazowe and Mutare, based on saturation estimates.

- DREAMS Phase II: streamlining DREAMS in the 10 additional districts that were added in COP20 in the provinces of Matabeleland North and South, based on projected saturation estimates by the end of COP22.
- Phase III: expanding programming to six additional districts (Seke, Mberengwa, Gokwe South, Zaka, Gutu, and Chivi) in COP23, with potential for further expansion in FY25. The selection of these districts was based on rank order of HIV incidence estimates, HIV burden, and size of the AGYW population. The selected districts have moderate 0.39% to low 0.25% HIV incidence.

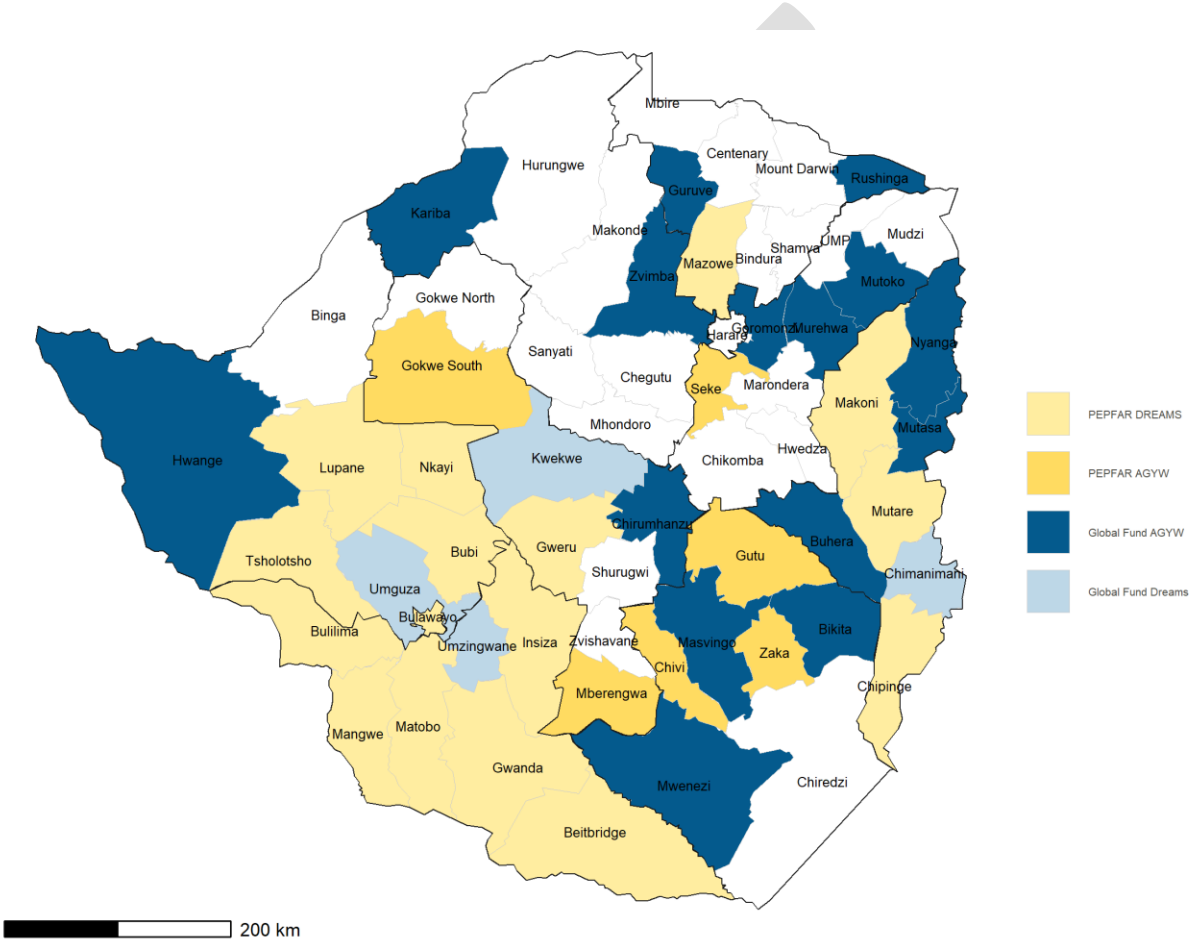


Figure 6: Distribution of Districts Where PEPFAR and GF Work

Table 4 illustrates the key shifts and strategies that will be employed as part of the 3-pronged implementation approach to AGYW prevention programming in COP23. These changes were identified during extensive consultations with stakeholders and are in line with COP23 guidance on streamlining, while intensifying focus on addressing barriers in the enabling environment and considering immediate measures that can be taken to enhance sustainability.

Table 4: Shifts in DREAMS and NextGen AGYW Programming in COP23

Phase I ***6 SNUs, started DREAMS in COP15***	**Phase II** ***10 SNUs started DREAMS in COP20***	**Phase III (NextGen)** ***6 new SNUs with AGYW programming in COP23***
10-14s		
Tighten the DREAMS eligibility and enrolment by excluding **poor school attendance** as a vulnerability criterion, which will reduce the number of 10-14s receiving the primary package+		AG in school to be reached through the MOPSE Comprehensive Sexuality Education (CSE) with lighter touch technical assistance from PEPFAR
Reduce educational subsidies by 50% and introduce Block Grant	Reduce educational subsidies by 50% and introduce Block Grant	Introduce Block Grant in place of Education Subsidies
Maintain primary package for AG aging in while supporting the MOPSE to take on CSE for sustainability		While not a target age group for clinical SRH services, AG 10-14 years will be provided with clinical services on demand
Reduce targets for parenting by 50%	Maintain parenting targets at COP22 levels	No caregiver programming
Reduce targets for caregiver Economic Strengthening (ES) by 50%	Maintain caregiver ES targets at COP22 levels	
15-19s		
To target the most at risk AGYW the program will tighten eligibility criteria to target AGYW with the following risks: those under 18 who are out of school or orphaned, survivors of sexual violence, multiple sexual partners, transactional sex, alcohol misuse, history of pregnancy or STIs, and inconsistent condom use with a non-cohabitating, non-marital partner. Maintain primary package; aging in targets will be retained at 20% of estimated number of vulnerable AGYW.		Target AGYW through hot spot mapping Offer primary package and sexual violence prevention interventions, and needs-based secondary services, in community settings
Maintain clinical outreach footprint		Establish clinical outreach footprint
ES according to reduced targets	ES according to reduced targets	ES according to targets
20-24s		
Remove primary package, for all groups except for YWSS Primary Pack (which includes young women engaged in transactional sex)		Target the most at risk YW: YWSS, mothers and GBV survivors Offer primary package and sexual violence prevention interventions, and

	needs-based secondary services, in community settings
Maintain clinical outreach footprint	Establish clinical outreach
Maintain ES for YWSS	ES according to targets
Community norms	
Maintain/expand Changing the Rivers Flow, SASA	Establish Changing the Rivers Flow, SASA
Boys & men	
NMN (new) / Coaching Boys into Men for Boys	
Enabling activities	
Youth friendly service capacitation for health facilities	
Digital platform for ongoing engagement and touch points	
Technical assistance for CSE in schools	

In addition to the shifts highlighted above, in COP23 PEPFAR will support the introduction of new PrEP products for AGYW (see Combination Prevention section) and leverage the DREAMS platform for demand creation, service delivery and support with PrEP continuation. Additional areas of focus include strengthening approaches for mental health and psychosocial support (MHPSS), including integrating drug and substance abuse mitigation; implementing a standardized mentorship program; expanding good practices in economic strengthening, including deepening private sector engagement; and incorporating innovations in how the DREAMS package is delivered according to AGYW feedback (such as the approach, time).

Enabling Activities

In all SNUs PEPFAR will work closely with the UN agencies (UNAIDS, UNESCO) to implement a realistic strategy for Comprehensive Sexuality Education (CSE) that can be fully managed by the MoPSE. PEPFAR will also pursue program sustainability through capacitating other key Government institutions including the MoHCC, Ministry of Women Affairs, Community, Small and Medium Enterprises, Ministry of Youth Sports Arts and Culture, and developing systems and accountability tools to support tracking of progress and implementation fidelity.

In COP23 PEPFAR will continue to offer HIV and violence prevention activities, as well as norms change interventions, to boys and men in all focus districts (Phase I, II, III), including male partners

of AGYW. PEPFAR will continue to use program data to understand the demographic characteristics of men who test HIV positive, as well as the type of partnerships/relationships they engage in, and venues where they can be reached with services. For violence prevention and norms change, the DREAMS program will expand the coverage of the evidence-based interventions Coaching Boys to Men and No Means No for adolescent boys and young men aged 10-24. As in past years, the program will link men and make referrals to services such as VMMC, HTS (including HIVST), ART or PrEP, and access to condoms. In collaboration with youth, PEPFAR will also explore utilizing virtual platforms for demand creation and providing HIV prevention education and linkage to services.

PEPFAR will continue and extend the Changing the Rivers Flow and SASA interventions to reduce GBV, address attitudes and beliefs about harmful gender norms, and engage men including partners of AGYW and community leaders in discussions about sexuality, gender and masculinity, and SRH.

In COP23 PEPFAR will continue to deliver HIV and sexual violence prevention education to adolescent boys (and girls) aged 10-14, who participate in the CSE general assembly and teacher-led classroom sessions in schools supported through the DREAMS platform. CSE programs reach both girls and boys aged 10-14 years in primary and secondary schools (focus is on Form 1 and 2). Form 1 and 2 is the aged band that would have transitioned from primary to secondary education. The curriculum and companion materials were revised previously based on the PEPFAR curricula review process and include the three PEPFAR Modules on Sexual Violence Prevention. In line with the DREAMS guidance for COP23, PEPFAR will support MoPSE to increase the coverage and quality of CSE in schools including training teachers on curriculum delivery.

The sexual violence prevention interventions aimed at caregivers of AG 10-14 years, which include male caregivers, (i.e., Families Matter Program, Sinovuyo) will continue into COP23 in the Phase I and II districts only, although on a smaller scale.

In COP23, DREAMS will continue to leverage the OVC and KP platforms to ensure AGYW who fall into those categories and meet the DREAMS eligibility criteria access the full DREAMS package. Likewise, AGYW (including their young children) identified through DREAMS entry points will be referred to OVC and KP services as required. Key DREAMS-OVC collaborative activities in COP23 include continued joint planning, implementation, and monitoring of DREAMS-OVC activities; aligning approaches for sexual violence and HIV prevention for adolescents and engagement with faith communities; and coordinating enhancements to the economic strengthening portfolio.

Plan for Key Populations Services

In FY22, the PEPFAR KP program performed well overall, particularly for SW and TG, and in the prevention cascade for MSM, as shown in Figure 7 below. The lower achievement in KP TX_CURR reflects a few data capture issues in the program. First, there are many KP who are receiving treatment in the public sector who are not recorded in the registers as KP. The second issue relates to transfers of newly diagnosed KP clients from private/non-government organization (NGO) provided services to the public sector, where some KP choose not to disclose their KP

status. The program noted challenges in the treatment cascade for MSM, with differences in model (community partners performed better), and an overall recognition of the need to refine approaches to reach new networks of MSM, especially those who do not self-identify and are not being reached.

	KP_PREV	HTS_SELF	HTS_TST	HTS_POS	TX_NEW	TX_CURR*	VLC	VLS	PrEP_NEW	PrEP_CT
FSW	148%	186%	183%	104%	103%	78%	90%	97%	195%	4,824
MSM	136%	155%	97%	58%	58%	67%	88%	95%	127%	1,446
TG	142%	243%	149%	152%	152%	64%	172%	100%	149%	91

Figure 7: Results Against Targets (FY22) by KP Type

As part of COP23 planning, the National KP TSC supported an inclusive process involving the National AIDS Commission (NAC), MoHCC, implementing partners, and the KP communities to review program and survey data, update 95-95-95 estimates, and set district level targets for COP23. Figures 8 through 10 below show estimated progress towards the 95s by KP type.

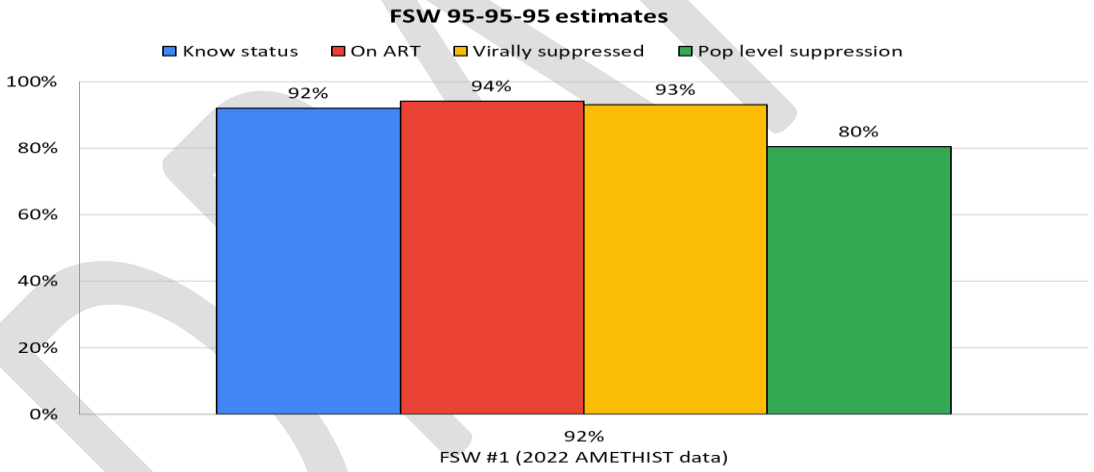


Figure 8: 95-95-95 Estimates for female sex workers

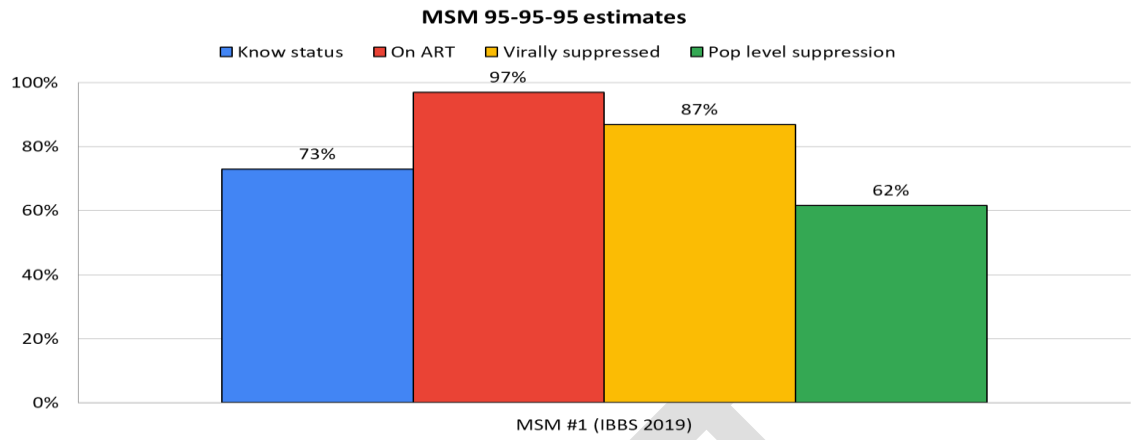


Figure 9: 95-95-95 Estimates for men who have sex with men

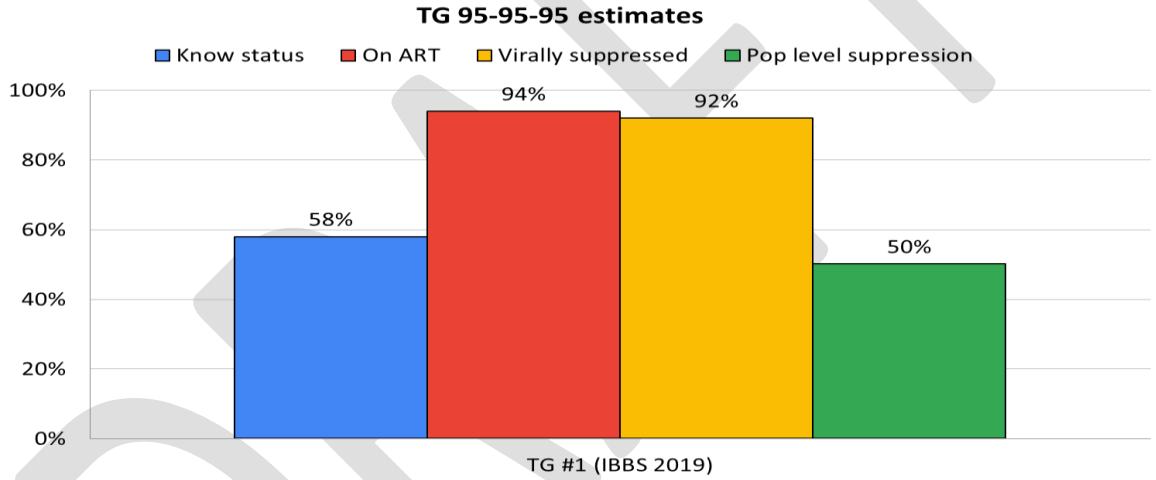


Figure 10: 95-95-95 Estimates for transgender persons

Progress among the MSM and TG communities is behind as compared to the FSW results, likely due to the maturity of the FSW program and higher levels of stigma and discrimination experienced by MSM and TG in the country. It is important to note that there are data limitations for the MSM and TG cascades: data for the last IBBS was collected in 2019 and only in Harare and Bulawayo.

Using surveys conducted with leveraged funding and program data, PEPFAR will provide technical assistance to update the FSW size and cascade estimates in COP22.

Supported by the GFATM, a Drug Use Situation Analysis was recently conducted in 2022. The assessment explored drug use in general (beyond injecting drug use) but it did reveal some important findings. One third of those interviewed, and more than half of the women, had injected drugs, mostly crystal meth and pharmaceuticals. The sharing of injecting materials,

unsafe discarding and injecting practices were frequently reported. Overlapping risk behaviors were also documented including associations between drug use, sex work, transactional sex, unprotected sex, sex with multiple partners and sexual violence. Zimbabwe lacks reliable size estimates and biobehavioral data for people who inject drugs (PWID), which presents a barrier to effectively planning and programming for this population.

In COP23, PEPFAR will support quality, person-centered approaches for HIV prevention, treatment, and retention for KP in the six largest urban districts in the country (Harare, Chitungwiza, Bulawayo, Gweru, Mutare, and Masvingo) in addition to the border districts for the FSW program (Beitbridge, Chirundu in Hurungwe district, Forbes in Mutare, Plumtree in Mangwe, and Victoria Falls in Hwange). In addition, PEPFAR will expand capacity building of healthcare providers in selected public sector sites to be competent in delivering KP friendly services in four peri urban priority sub national units (Goromonzi, Sanyati, Seke, and Marondera). PEPFAR will continue to support differentiated and integrated services to young women selling sex across DREAMS districts (see DREAMS above). PEPFAR will coordinate with GFATM, NAC, MoHCC and other stakeholders to ensure the high coverage of SW services in the country (currently estimated at 75%, including all urban areas and hotspots) is maintained. In addition, PEPFAR will continue to support the TSC to provide technical assistance in KP mobilization and KP-competent service delivery to existing PEPFAR will coordinate with GFATM, NAC, MoHCC and other stakeholders to ensure complementarity of investments and optimal coverage in the KP program, with defined packages of services, and contributing to national reporting. In addition, PEPFAR will continue to support the TSC to provide technical assistance in KP mobilization and KP-competent service delivery to existing NAC, MoHCC and community structures in 5 provinces, and advocate for additional resource mobilization to co-fund the TSC's activities in the remaining 5 provinces.

In COP23, PEPFAR will continue to build on what is working well in the KP program, highlights are summarized in Figure 11 below.

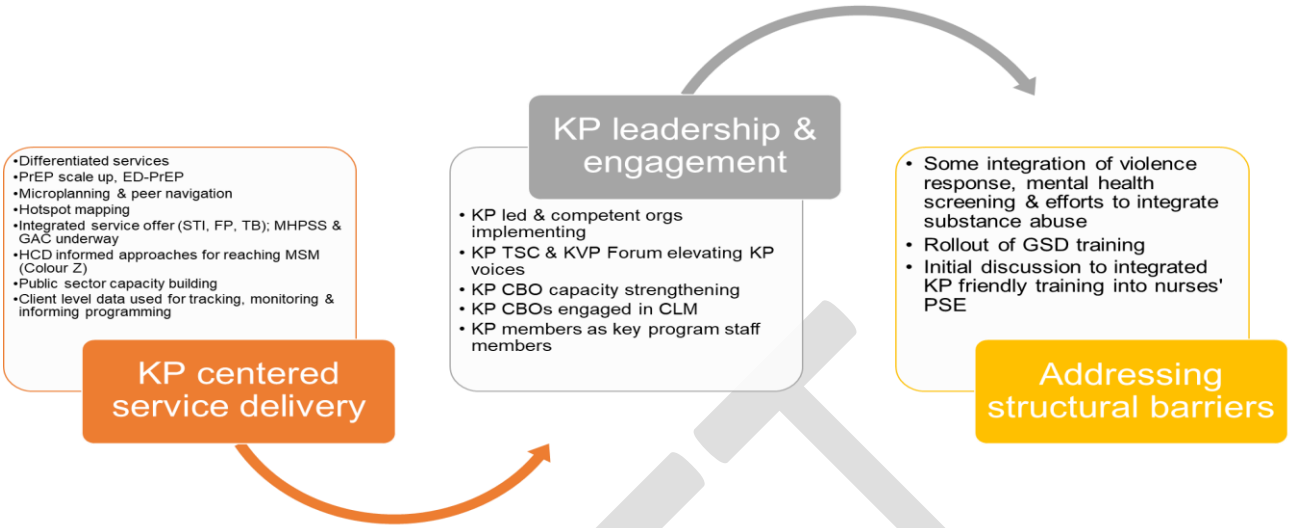


Figure 11: Approaches to key populations programming

Despite these positive achievements, there are several critical gaps in the KP program summarized below:

- High HCW attrition and turnover in public sector sites
- Sub-optimal engagement of the private sector
- Weak STI management: lack of availability of POC diagnostics and insufficient drugs for STI treatment
- PEP is not easily accessible
- Very limited access to HPV vaccination, cervical pre-cancer and cancer treatment
- No HCV treatment available
- Limited capacity for screening and treatment of alcohol and substance abuse; no harm reduction services available for PWID
- Limited capacity for MHPSS, mental health treatment
- Limited capacity for Gender Affirming Care (GAC)
- Limited behavioral science, including human centered design approaches, used to inform programming

Furthermore, the enabling environment for sustainable KP services remains constrained in Zimbabwe, as highlighted in Figure 12 below, and there are insufficient interventions geared towards reducing systemic stigma, discrimination, and violence. While engagement in the response has improved in recent years, with an opening of space for the LGBTQI community, there are wide gaps in KP empowerment and agency to advocate for services and reforms and successfully drive the change agenda on matters that are important to communities.

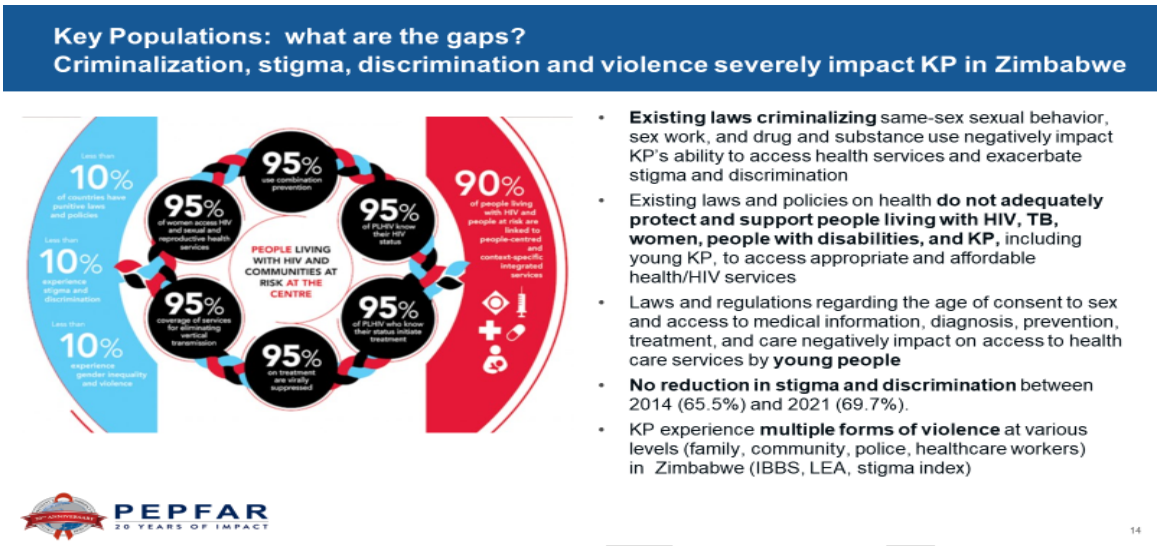


Figure 12: Key populations gaps in the form of criminalization, stigma, and discrimination

Based on extensive stakeholder consultations and prioritization, PEPFAR will prioritize the following activities in the KP program in COP23.

Expanding differentiated service delivery points for KP

PEPFAR will work hand in hand with the KP community and local CBOs to address obstacles to service uptake and retention and to meet KPs where they are with services that meet their needs. PEPFAR will innovate and diversify the provider mix (public, private, online/telehealth) to expand access points, prioritizing KP-led service delivery whenever possible (and ensuring KP-competent providers when it is not). In COP23 PEPFAR will continue to support service delivery through mobile and outreach services, One Stop Centers, venue-based, virtual and self-care approaches. PEPFAR will also work with KP communities to expand safe spaces, especially for underserved KP groups such as the TG and intersex communities, leveraging existing drop-in centers when possible. PEPFAR will expand efforts to reach hidden subpopulations, such as non-identifying MSM, through human-centered design (HCD) informed engagement and service delivery approaches, building off the successful ColourZ program for MSM. PEPFAR will intentionally engage the private sector (e.g. pharmacies, private providers) to provide KP relevant and friendly services, which will be discreetly signposted and advertised through a variety of channels.

In COP23 PEPFAR will refresh its social and behavior change (SBC) strategy for improved reach and effectiveness of demand creation activities in the KP program. PEPFAR will address HIV messaging fatigue by integrating a lifestyle approach that incorporates a range of health and wellness concerns. PEPFAR will adapt the Flip the Script (U=U) messaging for the KP communities specifically and integrate the treatment literacy materials and tools across community and facility platforms. Additionally, PEPFAR will prioritize digital messaging to reach hard-to-reach KPs including a chatbot for on-demand information and signposting, linked to self-screening services and a booking platform. PEPFAR will continue to support demand creation and engagement

through social media (e.g. Facebook, WhatsApp, Twitter), working with community influencers and online mobilizers to share co-created content and direct individuals to services.

PEPFAR will scale up the use of digital innovations to drive efficiencies including through the Workforce App, which is an open-source product developed under the VMMC program that addresses several efficiency challenges in the community mobilizer/facility provider/client engagement/service/follow up continuum. The app is configured to enable demand creation, e-referrals and reminders, service tracking, self-care messaging, refer a buddy, reporting and data verification and holds great potential for reducing provider burden, streamlining the work of KP DSD Assistants, peer mobilizers and microplanners, and promoting the practice of self-care.

PPEPFAR will support the KP TSC to engage in inclusive consultations with KP communities to review existing KP DSD models and support the process of adaptation, harmonization, and scaling as relevant.

Integrating services for improved quality and sustainability

In COP23, PEPFAR will continue to support comprehensive HIV prevention, care and treatment services for KP based on WHO normative guidance (Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations, WHO 2022), delivered through an integrated service model whenever possible. PEPFAR will offer a status neutral HIV testing approach to link individuals to both HIV prevention and treatment services as appropriate. In COP23, PEPFAR will identify and close gaps within HIV testing services utilizing effective public health approaches (HIVST with confirmatory testing, safe and ethical index testing with IPV screening, social network testing) and facilitating prompt linkage to treatment and prevention services. PEPFAR will continue to offer same day ART initiation for those newly diagnosed, both in facilities and community service delivery points. PEPFAR will continue to offer choice to KP communities and facilitate transfer of clients from community/private/NGO sites to public sector sites when desired and feasible. PEPFAR will implement an updated SOP to ensure efficient service delivery across facilities and community delivery points and strengthen referral pathways among them.

Considering recent survey data documenting inconsistent condom use, low rates of PrEP adherence and high rates of STIs among SWs, PEPFAR will reinforce and refresh its prevention activities and services (see Combination Prevention). PEPFAR will continue to support the delivery of oral PrEP and including demand creation and person-centered and differentiated strategies to facilitate PrEP continuation. Key to this will be using human centered design approaches to engage communities to co-create strategies and messaging.

Additional priority areas in COP23 include timely expansion of new PrEP products as they become available and strengthening STI diagnosis and management among KP. PEPFAR will continue to integrate strategies to identify, prevent and address gender-based violence, substance abuse and mental health issues faced by KP. As a strategy to promote adherence to prevention and treatment regimens, and to support mental health, PEPFAR will continue to integrate gender affirming care.

Strengthening KP-friendly services into the public health facilities

The KP program has not been spared the effects of health worker attrition, which has negatively affected efforts to build KP competent public facilities. In COP23, PEPFAR will continue to support integration of KP competent services across public sector sites and working with KP CSOs and TSC to establish KP Centers of Excellence in selected facilities in Harare, as well as strategic and targeted training and mentoring of HCWs in select priority sub national units. Key to this includes investing in more sustainable skills building approaches for HCWs through pre-service training, developing online modules for in-service training (IST), and expanding IST for more stable facility cadres like nurse aides. Additional strategies include structural changes in public facilities including assigning and training of KP peers to support counseling, outreach, and demand creation; establishing KP facility monitoring committees to discuss challenges around access to and quality of HIV services for KPs; forming strategic partnerships with KP-led organizations; and improving data collection (e.g. use of KP classification tool). Complementary to CLM, and led by the TSC, PEPFAR will support the finalization and roll out of a KP Friendliness Checklist that was recently drafted and piloted. The Friendliness Checklist is comprised of 38 performance criteria organized in 7 standards, covering service availability and accessibility, community participation and linkages, appropriateness of services for KP, provider competency, facility characteristics, non-discrimination practices and data and quality improvement.

Elevating focus on structural issues and human rights

In COP23, PEPFAR will continue to support the National Key Populations TSC to coordinate and provide technical leadership across KP programming in the country.

PEPFAR will coordinate with the TSC and other partners on evidence generation to support advocacy efforts on decriminalization, stigma and discrimination and the legal/policy impacts on the 10-10-10 goals. This will include development/use of monitoring and evaluation matrices, documentation tools, position papers, and advocacy training resources including the stigma index to monitor trends and guide efforts to address stigma and discrimination. PEPFAR will coordinate with other stakeholders, such as UNAIDS and UNDP, to advocate for legal and policy reform through support for mobilization of national and regional platforms and coalitions.

Additionally, PEPFAR will leverage other USG funding opportunities and relationships, such as the United States Agency for International Development's (USAID's) Democracy and Governance Rainbow Fund, to support advocacy initiatives and other activities that reduce stigma and discrimination experienced by the KP community. In addition, through one-time LIFT funding, PEPFAR will strengthen engagement, agency, and inclusion of marginalized TG and intersex communities in Zimbabwe through capacity strengthening and advocacy interventions aimed at fostering a more conducive enabling environment. Specifically, PEPFAR will improve equitable access of TG and intersex communities to HIV and related health/social services by supporting once off investments that address critical structural barriers that keep these communities on the margins. PEPFAR will apply human-centered design approaches to co-create and implement an advocacy strategy focused on GSD, inclusion, and rights in health policy to include context-appropriate communication and targeted sensitization activities. It will also strengthen the

capacity of TG and intersex-led and -serving organizations in advocacy and related skills, to include south to south TA visits for learning. The initiative will leverage technical assistance from UN partners supporting the Legal Environment Assessment and Stigma Index and complements the wider PEPAR KP program and planned COP activities, including routine operational expenses of a OSC that will be established and run by the same communities.

Strengthening the capacity of KP-led organizations

In COP23 PEPFAR will seek to increase funding managed by KP-led organizations for implementation (including smaller or nascent organizations), while continuing to ensure organizational capacity building for KP-led CSOs is included in awards implemented by a different prime IP. Additionally, PEPFAR will identify opportunities to integrate defined career pathways and employment creation opportunities for young KP and ensure fair remuneration for cadres implementing the program.

In COP23, PEPFAR will continue to support the national KP TSC to coordinate and provide technical leadership across KP programming in the country. The TSC will continue to play a lead role in convening KP constituencies in their diversity and ensuring their active engagement in priority setting and program implementation, monitoring and evaluation. In addition, the TSC will ensure complementarity across different funding streams, while monitoring progress towards closing equity gaps. In COP23 the TSC will ensure this approach is utilized in coordinating several new initiatives such as the KP BBS, inclusion of KP modules in pre-service training for nurses, scaling up of differentiated prevention innovations such as CAB-PrEP and Doxy-PEP, introducing programming for PWID and scaling up GAC, defining standard package of services, as well as finalizing/rolling out the public sector Centers of Excellence checklist (and together with CLM) working on how to action those findings at different levels.

Addressing data gaps in the KP program

In COP23 PEPFAR will conduct size estimates and BBS for KP (populations and geographies will be determined in consultation with stakeholders) to fill gaps in data that are required for optimal planning and coverage. Lack of data on the scope and scale of drug injecting, as well as services for PWID, have been identified as a major gap. In COP23 PEPFAR will consider the feasibility of integrating PWID programming, particularly among the current KP groups covered through the PEPFAR program, while considering PEPFAR co-funding programming in COP24. It is important to note that there are limitations in what PEPFAR can fund in terms of harm reduction and close collaboration with MoHCC, NAC, GFATM and to fully support PWID programming.

Pillar 2: Sustaining the Response

Sustainability Context

While Zimbabwe is at the cusp of achieving epidemic control, the national HIV/AIDS program remains highly dependent on external resources for commodity procurement, many aspects of service delivery, including human resources, and technical assistance required for reaching and sustaining epidemic control. Zimbabwe's heavy reliance on donor funding for the procurement,

management, and distribution of health commodities is a severe risk to the stability of the entire health system.

The macroeconomic environment remains significantly challenged, with high inflation rates, currency erosion, and stagnant economic growth. The health system struggles with deteriorating infrastructure, shortages of drugs and commodities, and low morale among HCWs. Civil servants are paid in local currency, which at a USD equivalent does not allow for a living wage. To appease HCWs, the GoZ has maintained a COVID-19 allowance and a danger zone allowance for frontline health workers. Still, several HCW industrial actions in recent years have led to facility closures and an absence of trained medical personnel to treat emergencies and health conditions that were deemed a lower priority. The number of nurses and doctors leaving the country continues to increase, and there is high attrition in the public sector. The impact on the public cannot be overstated. There is almost a complete lack of specialist services available for free or low cost in the public sector, patients are experiencing high ad hoc out of pocket costs, and the trust in the health system that was once affordable and high quality has eroded.

The GoZ has consistently led in the policy space, proactively adopting new public health approaches and technologies, such as differentiated and simplified pre-exposure prophylaxis for HIV prevention and status-neutral service delivery considerations. The commitment to financing the HIV response (and the health sector) remains unclear and is continually complicated by the ongoing currency erosion. In 2022, the GoZ increased the amount budgeted for health in the national budget to close to the 15% Abuja recommendation. However, the actual expenditure on this budget was reported to be less than 50%. The GoZ Ministry of Finance (MoF) and Economic Development reported that they are working to address the expenditure bottle necks in the MoHCC.

As shown in Figures 13, 14 and 15 below, the GoZ has struggled to absorb programs and services previously funded by development partners, and they have not been able to fill shortfalls in commodities, including those critical to the HIV response: viral load commodities, Anti Retroviral's (ARVs), PrEP, condoms, STI drugs, contraceptives, etc.

SID: Financing by Domestic Sources	2017 Response	2019 Response	2021 Response	Change Over Time
National HIV Response				
% financed with domestic public and private sector funding	Some (10-49%)	Some (10-49%)	Some (10-49%)	
Service Delivery				
% financing for service delivery from host country	Some (10-49%)	Some (10-49%)	Some (10-49%)	
% financing for service delivery to key populations from host country	Some (10-49%)	Some (10-49%)	Some (10-49%)	
Health Workforce				
% health worker salaries provided by host country institutions	All or almost all (90%+)	All or almost all (90%+)	l or almost all (90%	
Commodities				
% financing for ARVs from host country	Minimal (1-9%)	Minimal (1-9%)	Minimal (1-9%)	
% financing for rapid test kits from host country	Minimal (1-9%)	Minimal (1-9%)	Minimal (1-9%)	
% financing for condoms from host country	None	None	None	
Supply Chain Plan				
% financing for supply chain plan from host country	Some (10-49%)	Some (10-49%)	Some (10-49%)	
Laboratories				
% financing for laboratories from domestic public or private sources	Some (10-49%)	Some (10-49%)	Some (10-49%)	
Surveys and Surveillance				
% financing for general population surveys and surveillance from host country	Minimal (1-9%)	Minimal (1-9%)	Some (10-49%)	
% financing for key population surveys and surveillance from host country	None	None	Some (10-49%)	
Service Delivery Data				
% financing for service delivery data collection from host country	Some (10-49%)	Some (10-49%)	Some (10-49%)	

Figure 13: Financing by Domestic Resources (SID)

Tabulation of Responsibility Matrix Responses 2021

	Host Govt.			PEPFAR		
Functional Element	**Primary**	**Secondary**	**Nominal or None**	**Primary**	**Secondary**	**Nominal or None**
Total across elements	126	40	4	105	78	15
Above Site (Systems) Programs	52	0	0	35	15	2
Commodities	17	34	0	36	15	0
Health Workforce	17	0	1	5	13	6
Program Management	2	0	0	1	1	0
Site-Level Programs (excl. Commodities and Health Workforce)	38	6	3	28	34	7

Figure 14: Tabulation of Responsibility Matrix Responses

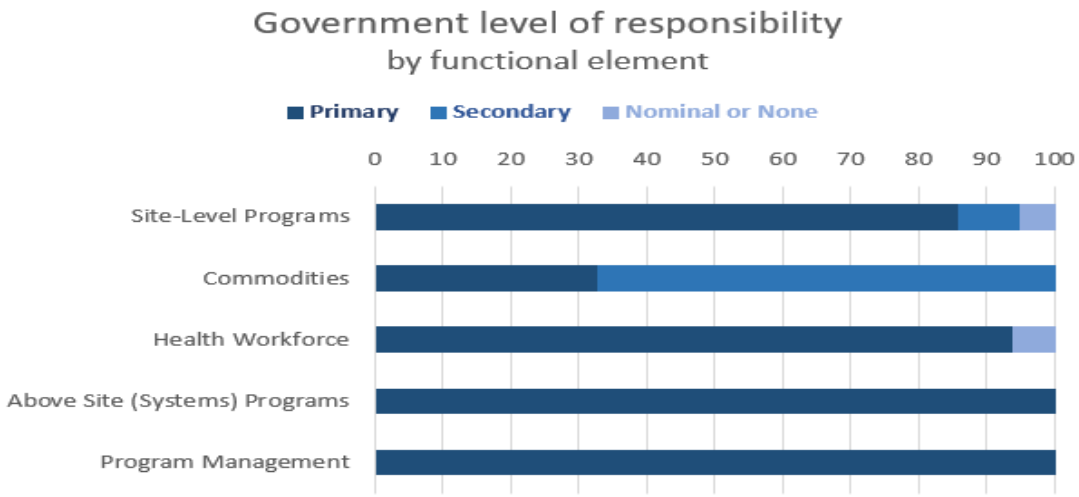


Figure 15: Government Level of Responsibility

The COP22 SDS highlighted these critical program gaps: adequate supplies of critical commodities, Viral Load Coverage (VLC), pediatric treatment and Viral Load Suppression (VLS), TB screening and reporting, coverage of prevention services for priority populations, and a variety of contextual and structural barriers that impede equitable access to HIV services. Progress has been made in VLC and VLS, coverage of prevention services for priority populations and consistent supplies of HIV drugs and commodities. The key gaps and challenges identified during the development of COP23 are highlighted in Figure 16 below.

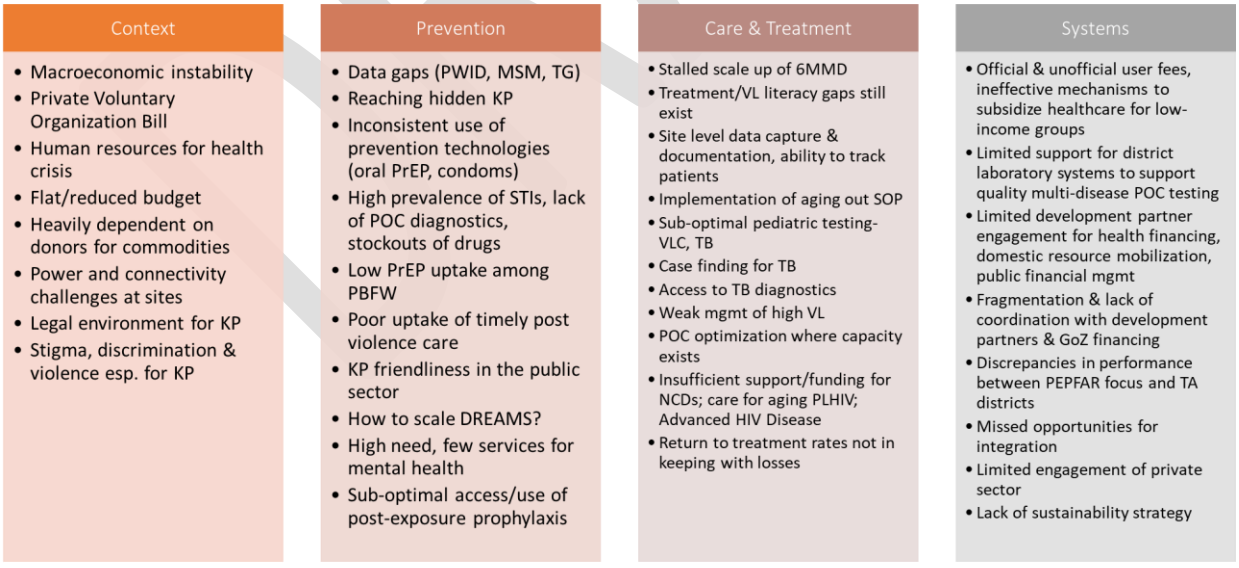


Figure 16: Key gaps and challenges in prevention, care & treatment, and systems

In the development of the Pillar 2 strategy for COP23, PEPFAR Zimbabwe worked closely with the National AIDS Council (NAC), MoHCC, UN Agencies, and development partners to review progress and challenges and identify opportunities and priorities to advance the following areas that are critical for sustained HIV epidemic control: 1) Sustainability Roadmap, 2) HRH, 3) Integration, and 4) Localization. Additionally, PEPFAR infused the themes of efficiencies and sustainability in all technical area planning discussions.

Developing a Country-Led Sustainability Roadmap

In COP23 PEPFAR will continue to support the Sustainability Roadmap process, allocating funding to UNICEF who will continue to work closely with NAC, which is the convening entity for this process. To date, a Steering Committee comprised of representatives from the following organizations has been formed: MoHCC AIDS & TB Unit, MoHCC Policy & Planning Unit, UNICEF, UNAIDS, UNDP, WHO, World Bank, Global Fund, Bill and Melinda Gates Foundation (BMGF). Initial discussions centered around how best to position the Roadmap within or alongside related efforts in the country such as development of the Health Resilience Fund, the HRH workforce assessment and strategy, and broader health financing discussions. The consensus building process for a shared vision of HIV sustainability and how to measure it, as well as the most important system gaps to address, has started and will continue throughout FY23 with a Sustainability Indaba. A broader technical working group (TWG), with full stakeholder representation including MoF, CSOs and private sector, will be constituted. A consultant was identified to conduct a desk review, consult with stakeholders, and coordinate future assessments, planning and engagement activities. The Sustainability Roadmap discussions are actively informing the Global Fund Grant Cycle Seven (GC7) development process and technical and UNAIDS and BMGF are contributing financial resources to complement PEPFAR investments in this effort.

Furthermore, the Zimbabwe National AIDS Strategic Plan (ZNASP) 2020-2025 has sustainability embedded into its mission: *To accelerate the scale-up of HIV programs and transition the HIV response into a sustainable phase through cost-efficient and effective strategies. T*he ZNASP contains many priorities, which if implemented fully, would strengthen the health system and community functions and capacities that support sustained epidemic control. The following strategies were shared to sustainably close the funding gap for the HIV response:

- Strengthen public-private partnerships to increase domestic resources for HIV. This will involve cooperation with the private sector to increase private pharmacies' access to low-priced HIV drugs, which will reduce the cost for clients accessing ARVs in the private sector and utilization of Corporate Social Responsibility (CSR) to support HIV interventions.
- Implement social contracting whereby government resources fund entities that are not part of the government to provide health / HIV services.
- Establish or participate in regionally coordinated pooled procurement of ARVs and other commodities.

- Increase allocative, technical and implementation efficiencies through HIV integration, improve coordination to minimize duplication of efforts, strengthen accountability, and invest in community response.
- Stretch the dollar--buy local products and invest in HIV prevention programs like KP and AGYW.

While COP22 focused primarily on identifying champions, consensus building and determining where and how to position the Sustainability Roadmap for maximum ownership, COP23 is expected to shift focus to strengthening the functional management capacity and systems, as well as financial management capacity and domestic resource mobilization. There is agreement among stakeholders that planning and advocating for financial sustainability is paramount. Pillar 2 deliberations during COP 23 preparation led to a set of priorities that are commonly shared by PEPFAR, GoZ, NAC, UNICEF and other development partners as shown in Table 6 below.

Table 5: Commonly shared sustainability priorities in COP23

Sustainability Priority	Strategy/Approach	Responsible Party
National consensus on high priority system gaps	● Sustainability Roadmap development process	NAC, MOHCC, PEPFAR, UNICEF
Advocate and plan for financial sustainability	● Leverage on existing platforms: Health sector coordination framework, HDPG, CCM, Sustainability TWG, Health Financing TWG. ● Launch and operationalize PPP framework	GoZ, NAC, Parliament of Zimbabwe, PEPFAR, UNICEF
Adopt program efficiencies and innovations that promote sustainability	● Task-shifting, facility to community ● Multi-plexing diagnostic tools ● Expand DSD models, Self-care ● Expand DHI for data collection efficiencies ● Virtual mentorship and training ● Expansion of IST system	NAC, MOHCC, UNICEF PEPFAR, CCM Implementing Partners, CSOs

Human Resources for Health (HRH)

PEPFAR investments in HRH have been essential in securing a more stable health care cadre in Zimbabwe. While HRH and health infrastructure are primarily funded by the MOHCC, PEPFAR has successfully leveraged and supplements this capacity with key commodities, site-level mentoring, and additional HRH support for HIV clinical services. The 2022 HRH inventory results show that PEPFAR has spent a total of $88 million to support 25,209 parttime and fulltime healthcare workers including nurses, laboratory scientists, and community health workers with salaries, stipends, or other forms of non-monetary support (e.g., airtime, transport). Further, PEPFAR supports secondments of senior-level technical experts to the national level of the MOHCC.

The recent health labor market analysis (HLMA) highlighted major challenges in retention of health workers in the public health system and high migration to other countries. The attrition rate for clinical health workers in the public sector was 11% in 2021. The number of healthcare workers declined by 10%- from 50,100 in 2019 to 45,500 in 2022, despite the recruitment of an additional 1,686 workers between 2021 and 2022. The HLMA presented an evidence base to support the development of a national HRH strategy and investment case that will be finalized in FY23.

COP23 co-planning with stakeholders identified the common priorities listed in Table 7 below. PEPFAR will position itself to align support to the new HRH strategy within the limits of PEPFAR and in country USG policy. The COP23 budget indicates the beginning of a shift towards more preservice training support. PEPFAR's FY22 and FY23 efforts to harmonize remuneration among service delivery (SD), facility and community cadres across implementing partners and agencies has positioned the program to respond to the national call for harmonization across development partners and with MOHCC. Harmonization efforts will continue once the new HRH strategy is finalized providing direction on levels of staff remuneration for the various cadres.

Stakeholders appreciate that stabilizing the national HRH crisis is a long-term effort and PEPFAR will need to continue current HRH support levels in the short to medium term in order to protect our progress towards HIV epidemic control.

Table 6: Commonly shared HRH priorities in COP23

Sustainability Priority	Strategy/Approach	Responsible Party
Finalize and align to national HRH strategy	● Continue participation in collaborative national HRH strategy formulation and investment compact ● Harmonization remuneration for health workers	GoZ, MOHCC NAC, PEPFAR, CCM and Private Sector
Continue to address current critical HRH shortages and protect gains in HIV epidemic control	● Maintain current HRH support at all levels of MOHCC ● Invest in training and production of HRH (pre-service and in-service). ● Update training curriculum ● Implement appropriate task-shifting/ task-sharing	MOHCC, PEPFAR, CCM

Integration

Zimbabwe's health delivery system is based on the primary health care approach. This calls for integration of services where a range of services are provided in one place. At the primary health facility providers provide services across a range of conditions. Based on this model, there is some integration between HIV, TB and Malaria at the primary health care level. In line with the WHO

Integrated People-Centered Health Services (IPHCS) framework focusing on empowering and engaging people and communities, strengthening governance and accountability, re-orienting the model of care, coordinating services within and across sectors as well as creating an enabling environment.

The integration focus for COP23 will work to achieve improved coordination across health and community services, with a focus towards maximizing efficiency of existing financial and human resources. An opportunity exists in the planning for pandemic preparedness funds as well as making use of the various community cadres to transfer non-complex facility-based services and reduce the burden on the narrow pool of health workers who are facility based.

Building Capacity of Local Institutions

PEPFAR/Zimbabwe continues to increase program leadership by local organizations. The proportion of the overall PEPFAR budget, excluding the USG agency management and operations and the commodities budget, that is directly funding local non-governmental organizations increased from 54% in COP21 to 65% in COP22 and is anticipated to further increase to 98% in COP23. PEPFAR/Zimbabwe is working through a growing number of KP-led organizations as sub recipients of PEPFAR funding and will continue to seek ways to grow their number and amplify their constituent voices in the national HIV program.

PEPFAR will continue to ensure that prime recipients of PEPFAR funds integrate robust activities to strengthen the institutional and technical capacity of smaller local CSOs (including youth and KP-led CSOs) into their awards, with specific targets for transitioning smaller local CSOs to direct funding where feasible.

As part of its overall Country Development Cooperation Strategy, USAID is increasing its focus on developing young leaders through the inclusion of specific pathways for developing young professionals in its awards and engaging youth advisory boards.

While USG agencies are unable to establish G2G grants with the GoZ due to policy considerations, PEPFAR will continue building the capacity of the MOHCC AIDS and TB program at all levels according to the jointly defined priorities in the different program areas described elsewhere in the SDS. PEPFAR will also continue to support the Key Populations National Technical Support Committee, comprised of NAC, MOHCC and CSO members.

Identifying Efficiencies

Among the Sustainability Roadmap Steering Committee there is consensus that identifying efficiencies in current programming should be a critical early step and efforts are underway to identify tools to facilitate this type of analysis. As part of COP23 stakeholder deliberations, several innovations and approaches to realizing program efficiencies were identified including task-shifting services from facility to community and community systems strengthening; expanding differentiated service delivery models and self-care approaches; scaling up digital information platforms at facility and community level; establishing virtual platforms for mentorship and training; multiplexing of diagnostic and laboratory tools and further expanding integrated sample transport. In addition, PEPFAR will shift resources from the traditional in-

service training approach, which has become costly due to high rates of health worker attrition, to a more sustainable and efficient approach to capacity building focused on pre-service education, linked to virtual or hybrid in-service training approaches. Please see the relevant Pillar areas for more details on the efficiencies that have been identified for COP23.

Pillar 3: Public Health Systems and Security

In COP23 PEPFAR will continue to support and strengthen critical infrastructure and practices that are both necessary for sustained HIV epidemic control and contribute to the Zimbabwe's ability to address ongoing and novel public health threats in the long term. Pillar 3 includes PEPFAR's strategy for modernizing the supply chain, strengthening the laboratory system and improving patient-centered care for PLHIV.

Supply chain modernization and adequate forecasting

To achieve a people-centered supply chain, PEPFAR will continue to support national forecasting and supply planning of commodities; procurement of commodities; and implementation, monitoring and strengthening of the national supply chain system. In addition, PEPFAR will continue to play a critical role in supply chain coordination.

The availability of HIV commodities is essential for the achievement of both PEPFAR and national HIV program objectives. In this vein, in COP23 PEPFAR will continue to coordinate with other funders, including the GFATM and the GoZ, to ensure the availability of all necessary HIV commodities. At the time of writing of the COP23 SDS, there were significant funding gaps for COP23 commodities because of the limited PEPFAR budget, ending of the current GFATM grant, and perennial GoZ budget constraints. PEPFAR will continue to engage with the GFATM and the GoZ to ensure that adequate resources are included in the new 2024-2026 GFATM grant cycle 7 (GC7) application to cover the COP23 commodity funding needs. PEPFAR will also engage with GoZ and CSOs to advocate for increased domestic funding towards critical HIV commodities in the short and long term.

To strengthen health equity, PEPFAR will continue supporting scaling up of multi-month dispensing (MMD) of TLD and transition to pediatric Dolutegravir (DTG) based regimens including other optimized regimens. The program will support decentralized drug delivery models as part of differentiated service delivery options to ensure that priority groups receive their medicines in the most convenient and efficient manner. In COP23 this includes a variety of approaches for community ART refill groups, community-based ART and PrEP distribution (e.g. Drop-In Centers, home delivery, community managed refill points), as well as retail pharmacy-based service delivery.

Currently, commodity reporting and ordering is done manually by facilities once every quarter. Over the last two years there has been significant attrition of HCWs from Zimbabwe, which has resulted in a high number of vacancies at both central and facility level and further degradation

of end-to-end visibility in the supply chain management system. During COP23, PEPFAR will continue to support the scale up of the Electronic Logistics Management Information System (eLMIS) and related supply chain strengthening activities. The use of the eLMIS is expected to increase pipeline visibility, timely and accurate reporting, and improve the current Zimbabwe Assisted Pull System (ZAPS) ordering and distribution system. Working with other development partners, PEPFAR will support the strengthening of National Pharmaceutical Company (NatPharm) through digitalization and optimization of warehousing processes. Throughout COP23, PEPFAR will support the implementation of the GS1 system that allows for individual primary pack identification at NatPharm to improve the track and traceability of commodities.

In COP23, PEPFAR-procured vehicles will continue to assist NatPharm by providing support for transportation of commodities to improve last mile delivery to service delivery points. PEPFAR will collaborate with GFATM and GoZ to support the implementation and strengthening of the distribution systems to ensure continuous commodity availability. PEPFAR will increasingly engage with the private sector on solutions to modernize the supply chain. PEPFAR will explore the use of vendor-managed inventory and/or services for viral load/EID commodities and TLD. PEPFAR aims to have a supply chain which is reliable, flexible, responsive, efficient, effective, and sustainable in the long term through use of digital solutions and other relevant innovations.

Laboratory systems

In COP23, PEPFAR will continue to support and prioritize VL testing to meet the national set target of 90% in FY24 and 95% in FY25. Transition from the older Roche CAPCTM and Abbott m2000 platforms to the newer Roche 5800/6800/8800 and Abbott Alinity platforms in COP22-COP23 will result in increased national VL testing capacity. Conventional testing will be complemented with a purposeful scale up of point-of-care (POC) diagnostics to offer equitable access and integrated testing for VL/EID/TB testing services, as well as increased coverage for priority populations. In COP23 the program will shift to enhance district laboratory systems, strengthening activities at select high impact district laboratory hubs to fully support implementation of:

- POC and rapid testing quality assurance
- POC VL/EID Testing
- AHD related laboratory tests (CD4, TB-LAM, CrAG,etc)
- EMTCT (Triple Elimination)
- Integrated sample transport (IST) systems
- Laboratory information management systems (LIMS) implementation
- Clinic community laboratory interface optimization

In addition, PEPFAR will support embedded full time program staff. The remaining hubs will continue to receive critical support for program implementation.

PEPFAR will continue to support the establishment of a national certification program aimed at improving quality of laboratory testing services at district level laboratories and POC sites using stepwise quality assurance through Strengthening Laboratory Management Toward Accreditation (SLMTA), HIV-RTCQI, and POC CQI. Support for ISO15189 accreditation at all VL/EID

testing laboratories and the national TB reference laboratory will be maintained. Newly established VL/EID testing laboratories will also be supported towards attaining accreditation. In addition, PEPFAR will continue to support the country to establish an integrated multi-disease national External Quality Assurance (EQA) program covering both conventional and POC testing.

Overall PEPFAR support in COP23 will address laboratory system gaps through the following key activities:

- Increased national IST oversight at district level by lab managers to ensure sustained ownership and accountability.
- Improving LIMS system capabilities, security, and data exchange capabilities with other Health Information Systems (HIS).
- Strengthening laboratory biosafety, equipment maintenance, and waste management
- Strengthening LIMS architecture to support POC network.
- Continuous laboratory workforce development through pre-service and in-service training strengthening.
- Strengthening reference labs for surveillance and pandemic preparedness, including integrated Genomic Surveillance Capacity.

During COP23 stakeholders' engagement the need for PEPFAR to engage MoHCC, GFTAM, and other stakeholders to address the following areas of concern was highlighted:

- Harmonization of internet connectivity to ensure adequate data support for LIMS and integration to other health information systems, i.e., EHR.
- The critical need for HRH support at national and subnational laboratories.
- IST review and ongoing optimization as the program endeavors to further reduce results TAT to less than 14 days.
- Establishment of genomic surveillance at the National Microbiology Reference Laboratory to support disease surveillance, outbreak investigations and disaster preparedness.
- Ongoing challenges with laboratory power back up and waste management support.
- HRH (priorities, national capacity to manage workforce, aligning to government planning, pay and cadres, etc.)

Key enablers for the program will be Diagnostic Network Optimization improvement through assessments, optimization, and continuous quality improvement; Clinic-Community-Laboratory Interface quality initiatives and SLMTA will ensure quality assured data are generated.

Improving Patient-Centered Care for PLHIV

Tuberculosis

Scaling up TB Preventive Therapy (TPT): Since COP19 when the PEPFAR program in Zimbabwe started supporting TPT capacity building and commodities, the country has experienced tremendous success in scaling access for PLHIV. 653,436 people have completed TPT in PEPFAR-supported health facilities (Figure 17).

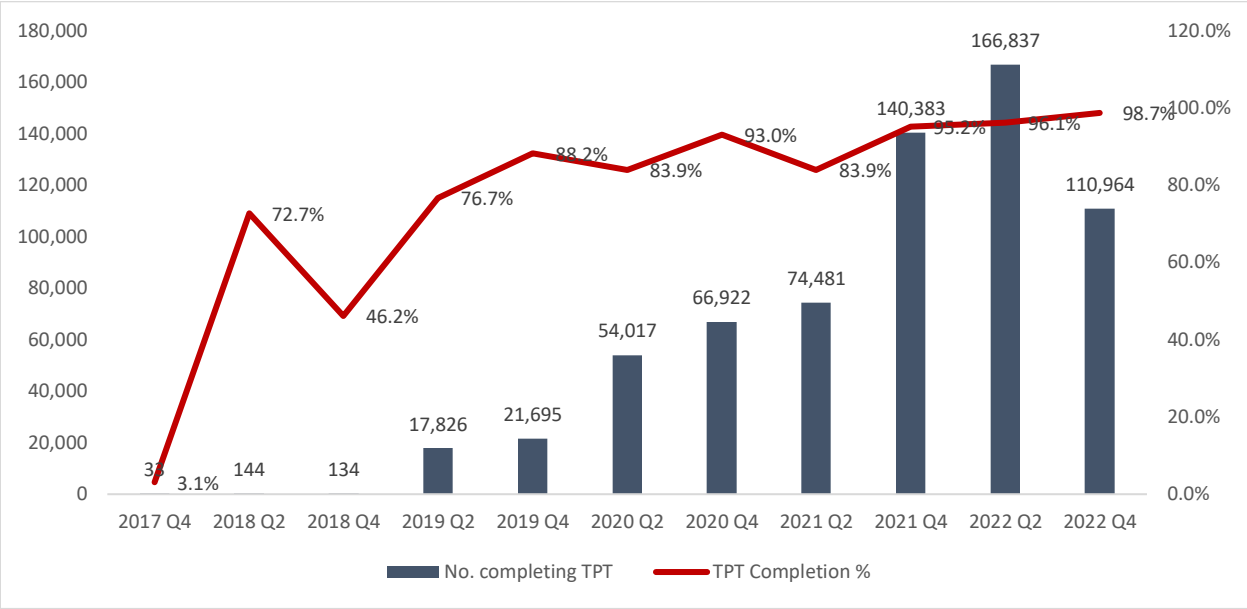


Figure 17: TPT Completion Rate Trends

In COP23, PEPFAR will support the procurement and distribution of TPT medicines, complementing investments of other donors (GFATM) and GoZ. Shorter TPT regimens, 3HP (three months rifapentine and isoniazid) and 3HR (3 months isoniazid and rifampicin) have better completion rates and they will be scaled up in COP23. As guided by PEPFAR and MoHCC guidelines the following groups will be prioritized in TPT scale up:

- PLHIV on DTG based ART regimens 6H plus Vitamin B6 (FDC - INH/CTX/Vitamin B6)
- PLHIV on EFV based ART regimens: 3HP
- HIV negative children and adolescents <15years TB contacts: 3HR

Integration of TPT into DSD models has already begun and will continue to be scaled in COP23 and monitored through standardized data collection tools that capture TPT uptake, duration, completion, outcomes, and adverse events. PEPFAR will continue to strengthen TPT M&E by adding a TPT module in the EHR and developing an electronic reporting system.

TB screening and diagnosis: Despite several interventions to improve screening, such as mentoring, supervision and regularizing chart reviews, the effectiveness of the tuberculosis symptom screening tool has remained suboptimal, as summarized in Figure 18 below. In 2022,

the WHO estimated that Zimbabwe missed 13,272 cases of TB. There is a need to innovative and devise new strategies to improve TB case-finding. One of the promising innovations from South Africa is TUTT, which requires all clients at higher risk of developing TB to be tested once a year using chest Xray, GeneXpert and/or LF-LAM. Implementation of TUTT in South Africa has increased TB case-finding by 17%, when compared with standard practice of the WHO recommended four symptom screening.

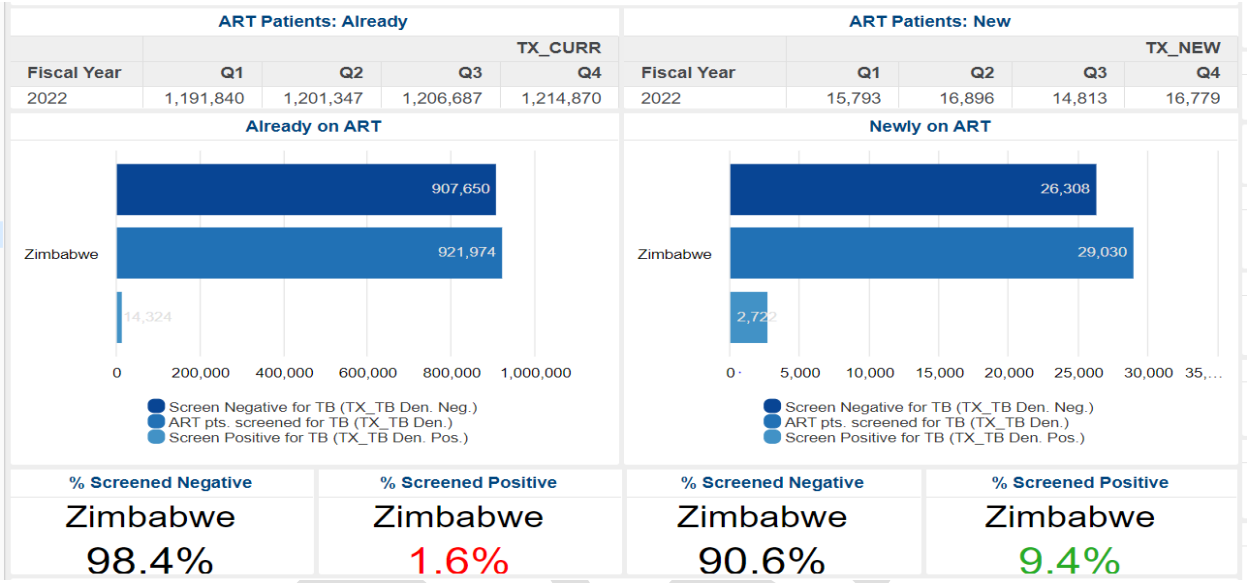


Figure 18: Sub-optimal TB Screening among patients already on ART

PEPFAR will support the MOHCC to roll out TUTT through technical assistance to revise guidelines rand data capture tools, procurement of LF-LAM and health worker capacity building.

PEPFAR has begun scaling up TB LAM as a tool to improve TB case-finding among clients with AHD and the strategy is showing promising results. Program data is documenting an increase in TB cases identified and linkage to appropriate treatment and increased convenience for HCWs and clients. The following challenges have been noted and are being addressed:

- Reliance on CD4 testing, which is not readily available
- Insecure pipeline, resulting in stock ruptures and short shelf life
- Overwhelmed nurses reluctant to task shifting
- Limited numbers of health workers trained
- Limited confidence and capacity of nurses to manage or offer AHD packages
- High MoHCC HCW turnover of trained staff leading to missed opportunities
- No community level LF-LAM testing resulting in missed opportunities

Currently there is optimal use of WHO molecular recommended rapid diagnostic tests (i.e., mWRD), with 95.7% of presumptive TB cases having a sputum sample collected and tested for TB (Figure 19). Going forward, the program will focus on strengthening sample testing using the WHO recommended molecular tests (i.e. GeneXpert). In COP21, 88% of the sputum samples collected were tested using GeneXpert. The program aims to increase this to 95%, and

significantly reduce testing using smear microscopy. TB TruNat, another molecular WHO-recommended rapid diagnostic tests for TB diagnosis, is being scaled up through support from other funding agencies. PEPFAR will leverage these resources and build capacity for implementation among health workers.

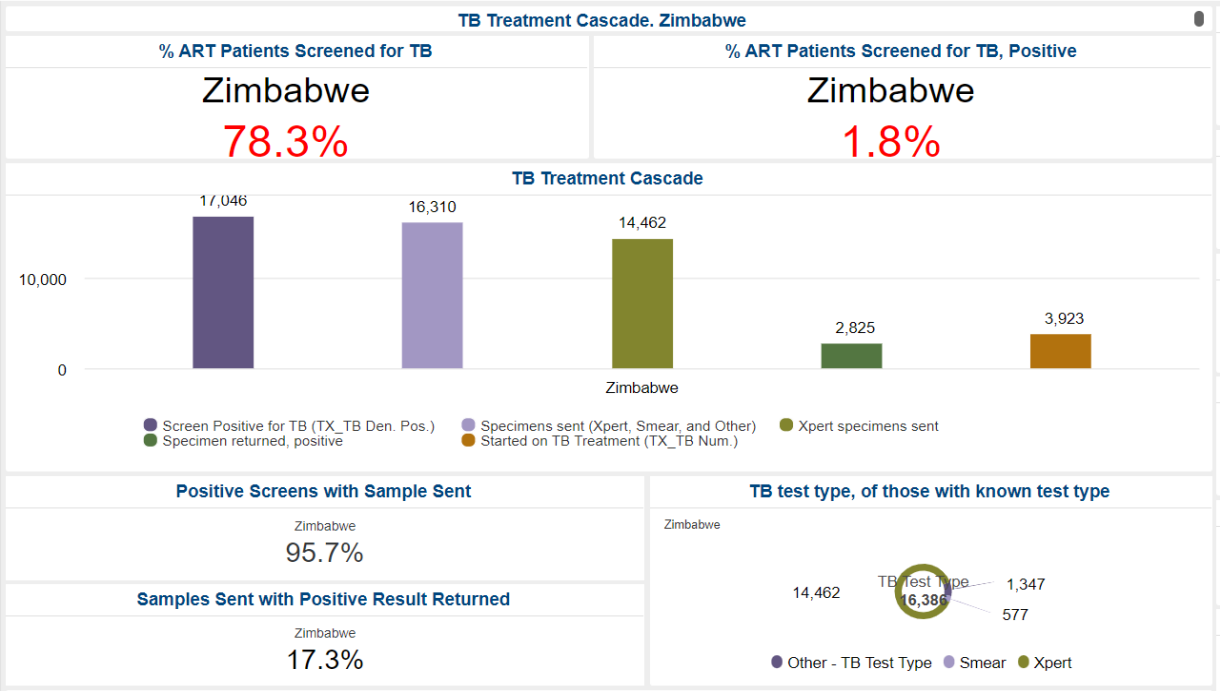


Figure 19: COP21 TB Treatment Cascade

Advanced HIV Disease (AHD)

In COP21, PEPFAR supported the re-prioritization of CD4 testing among newly diagnosed clients. Over 1,300 clients with AHD were diagnosed in the 18 initial high-volume sites, and of these, about 7% were children under 14 years of age (Figure 20).

This demonstrated the importance of routinized CD4 testing at all sites. Clinical staging alone was not enough to identify clients with AHD (Figure 21).

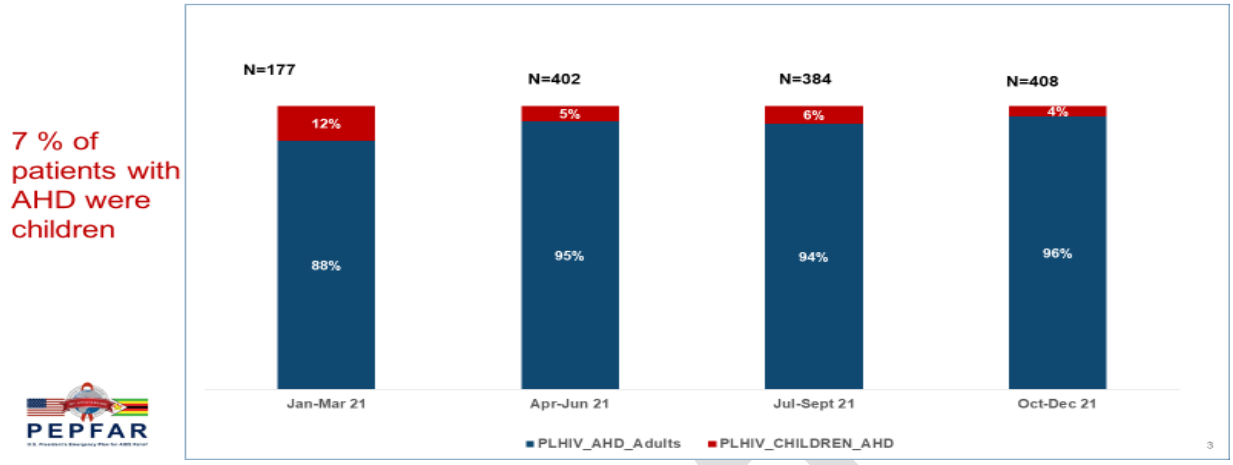


Figure 20: Patients with AHD in COP21

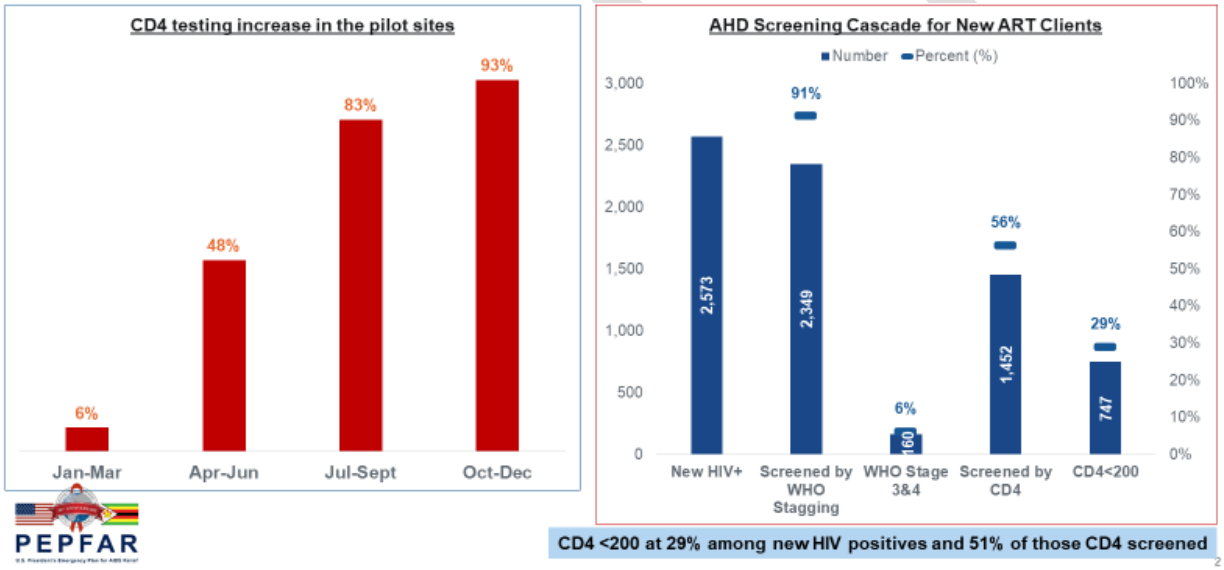


Figure 21: Screening with WHO Clinical Staging has the potential to miss clients with AHD

In COP23, PEPFAR will collaborate with GFATM and MoHCC to ensure that CD4 testing becomes mandatory for all newly diagnosed clients as well as all those who re-engage after having interrupted treatment. PEPFAR will ensure SOPs and other care guidelines are updated accordingly to include 1) screening for and diagnosis of TB and cryptococcal disease, 2) cotrimoxazole prophylaxis, 3) TPT, fluconazole therapy as needed, 4) rapid or delayed ART initiation depending on condition of the clients, and 5) ensuring differentiated care as per clients' needs to optimize adherence. Sensitization, supportive supervision, and mentorship for health care providers will be funded by PEPFAR in the supported districts.

Older adults and non-communicable diseases

In Zimbabwe, approximately 20% of the PLHIV on ART are 50 years old and above (Figure 22). Initial assessments in 18 PEPFAR-supported sites revealed a high proportion of clients with age-related comorbidities including uncontrolled hypertension (Figure 23) and diabetes mellitus (Figure 24).

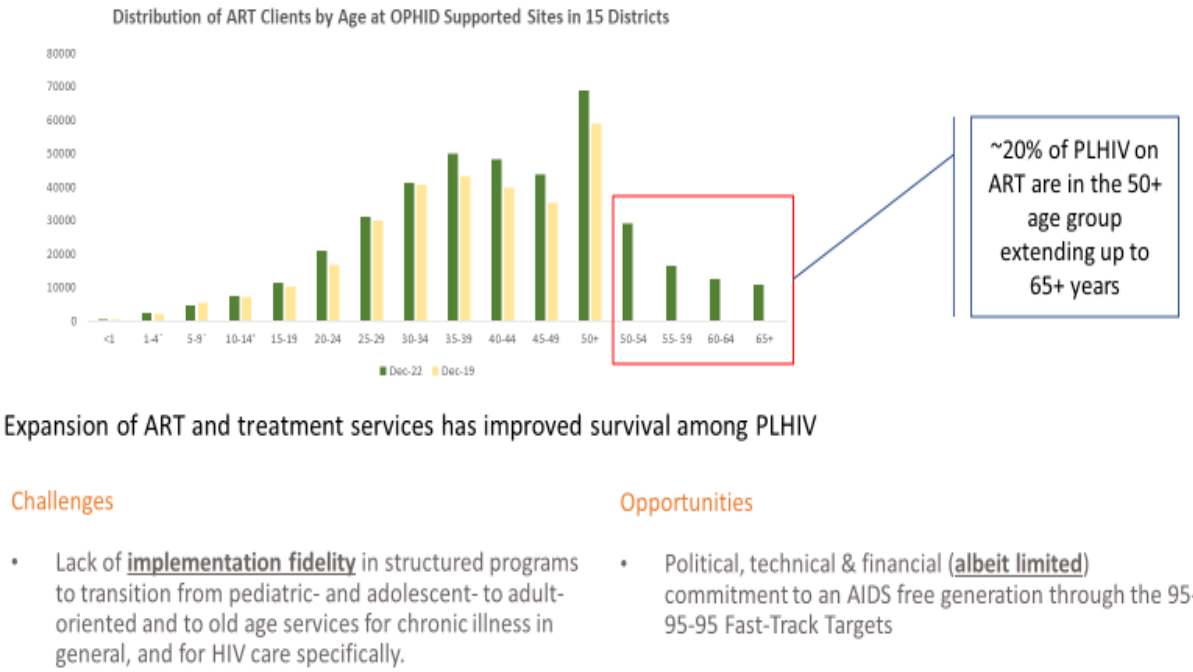


Figure 22: Age transition for PLHIV on ART

While some work has been done to expand/increase the age bands beyond 50-65 years, there is a need to adapt the HIV reporting tools to accommodate hypertension and diabetes, as well as additional indicators to track age-related co-morbidities.

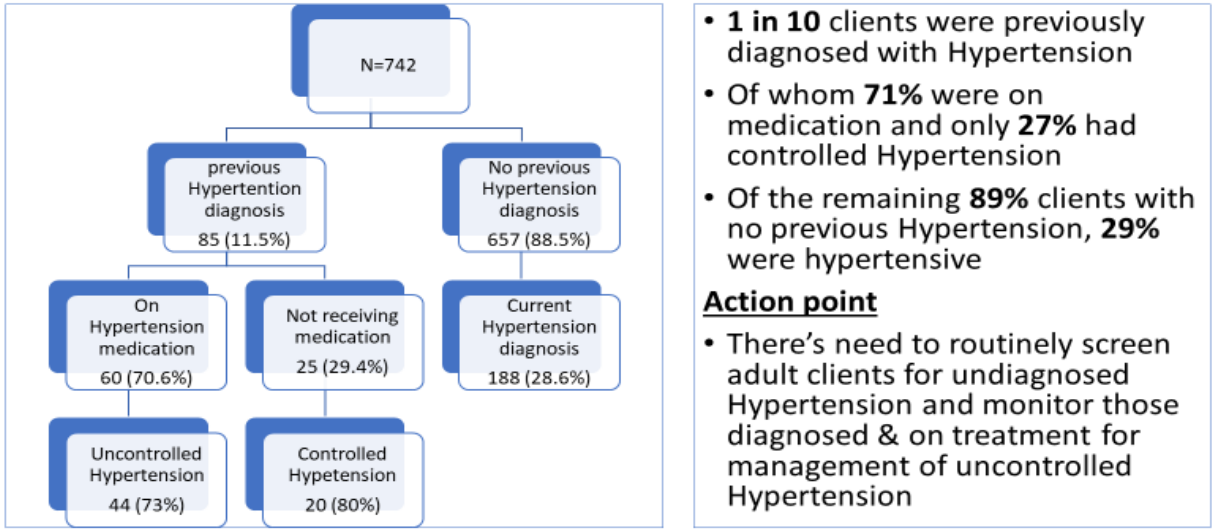


Figure 23: Previous hypertension diagnosis and treatment among screened PLHIV

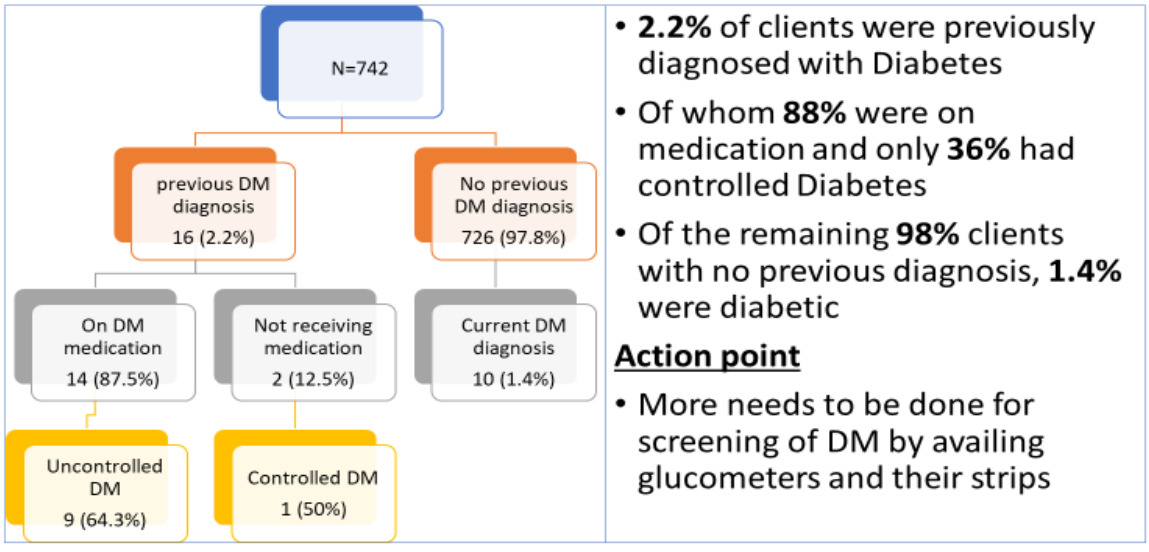


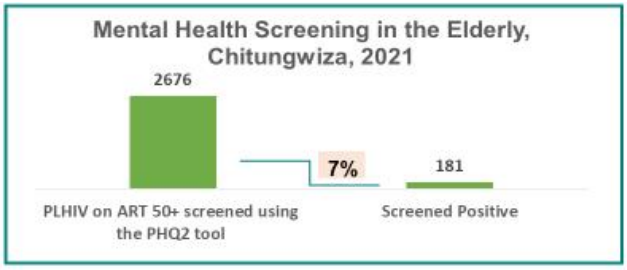
Figure 24: Previous diabetes mellitus diagnosis and treatment among screened PLHIV

In COP23, PEPFAR will continue to scale the screening of PLHIV for hypertension and diabetes to all supported sites, while strengthening referral systems and ensuring linkage to further management for these conditions using existing clinic/facility referral facilitators. Where feasible, facility general practitioners/physicians will rotate through the HIV clinics as well to enhance client convenience, and PEPFAR will provide technical assistance to these health care providers

to ensure they adhere to the National ART Guidelines as well as the National Operational and Service Delivery Manual.

Mental Health

Mental health challenges that impact negatively on ART adherence are well documented, particularly among adolescents and young people, although the elderly population is also affected. For example, in one PEPFAR support district, up to 7% of clients above 50 years screened positive for mental health issues (Figure 25).



OPHID Community Outreach Agent and Friendship Bench Grandmother reviewing referrals made

OPPORTUNITIES

- Mental Health screening by **community-based cadres** is possible.
  - **A standardized package** for capacity building has been developed
- Lay cadres can be trained to provide Cognitive Behavioral Therapy (CBT)
  - support the overburdened health system, leveraging on the existing community, traditional, and faith-based infrastructures.
- Referral pathways for **'higher level' Mental Health care** require support
  - To access specialist services such e.g., toll-free lines, transport fees
  - Capacity building for MH nurses – OPHID/FB

Figure 25: Mental Health Screening in the Elderly

There is a dearth of mental health capacity and services in Zimbabwe. In COP23, PEPFAR will continue to scale the "Friendship Bench" model to cover all age groups of clients. This model has already been implemented in select facilities and has shown positive results. The Friendship is a cost-effective and reliable system to provide psychosocial support and peer-to-peer counselling for "non-critical" issues that can be managed at primary health care level. The system is also designed to refer and /or escalate clients who need further support to the right level of care depending on the nature of the issue. PEPFAR will leverage on the counsellors, clinical psychologists, and psychiatrists who are currently available through other U.S.G. funding streams (e.g. COVID 19 funds) for complex cases. The COVID 19 funds will continue to be available through COP23 after which clients will be linked to other donor supported mental health activities (as available) for support. Through these COVID 19 funds, the health care providers themselves are also included through the "Caring for the carer" initiative. Problem solving and other cognitive therapies have been implemented with success. The PEPFAR program will continue to work with such initiatives to ensure health care workers minimize burnout and other morale issues.

Cervical Cancer Screening

PEPFAR will continue to support cervical cancer screening among women living with HIV, including through outreach services to ensure services get closer to the women. The "Test, Triage and Treat" approach is not yet universally available in Zimbabwe, but PEPFAR will prioritize its roll out in COP23, along with increasing HPV-DNA screening capacity. As highlighted in Figure 26 below, PEPFAR will continue to decentralize LEEP services, which will also continue to reduce waiting times for women who need the services.

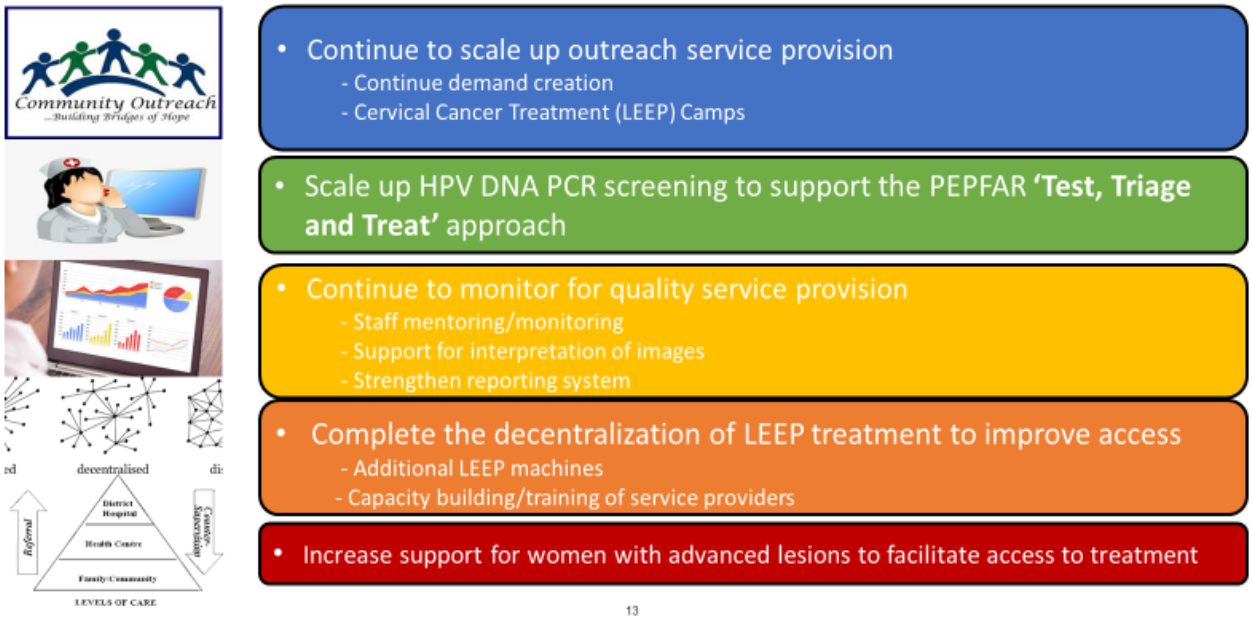


Figure 26: Cervical cancer screening strategies in COP23

A major challenge is the management of women with invasive lesions as the oncology services in the country remain centralized and the exorbitant costs associated with treatment are beyond the reach of most women.

Continuity of Treatment

PEPFAR Zimbabwe will continue to support interventions that 1) prevent loss or interruption in treatment, 2) activities that improve tracking and documentation, and 3) interventions targeting missed and lost clients and special populations in the program. Details of the COP23 strategy are shown in Figure 27 below. In addition, the PEPFAR program will continue to support the orientation of facility staff on respectful management of clients including being friendly and non-judgmental improving patient-provider communication using shared decision-making and providing linkages to available services that support the overall well-being of patients.

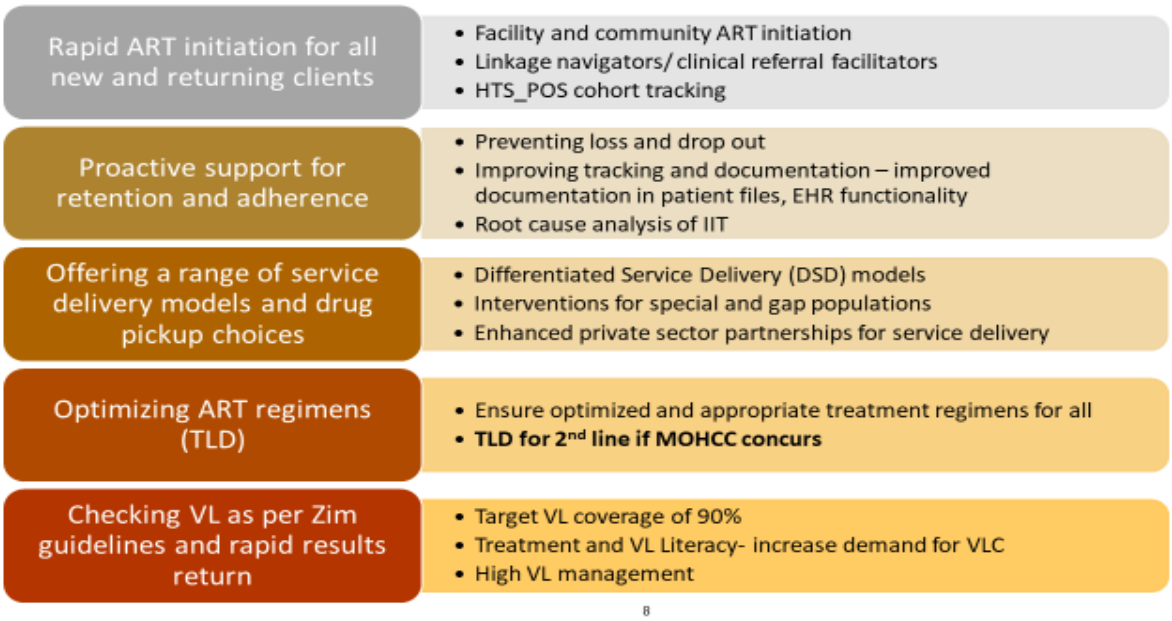


Figure 27: Continuity of treatment strategy for COP23

The PEPFAR program will continue to engage the MoHCC to develop enhanced differentiated service delivery models tailored to suit each individual and population group as defined in the MoHCC's recently revised Operational and Service Delivery Manual for HIV services. In COP23 PEPFAR will continue to strengthen the cross-border DSD model and focus on catching "sick returnees" early. TB program data shows unacceptably high levels of mortality in the border districts of the country. A rapid analysis of some of these deaths revealed that the majority are PLHIV who are returning residents from South Africa or Botswana who come back ill and present to the health care system late. PEPFAR will support the MoHCC to develop rapid referral protocols

to ensure such clients are fast tracked to the district or provincial level of care for management of AHD.

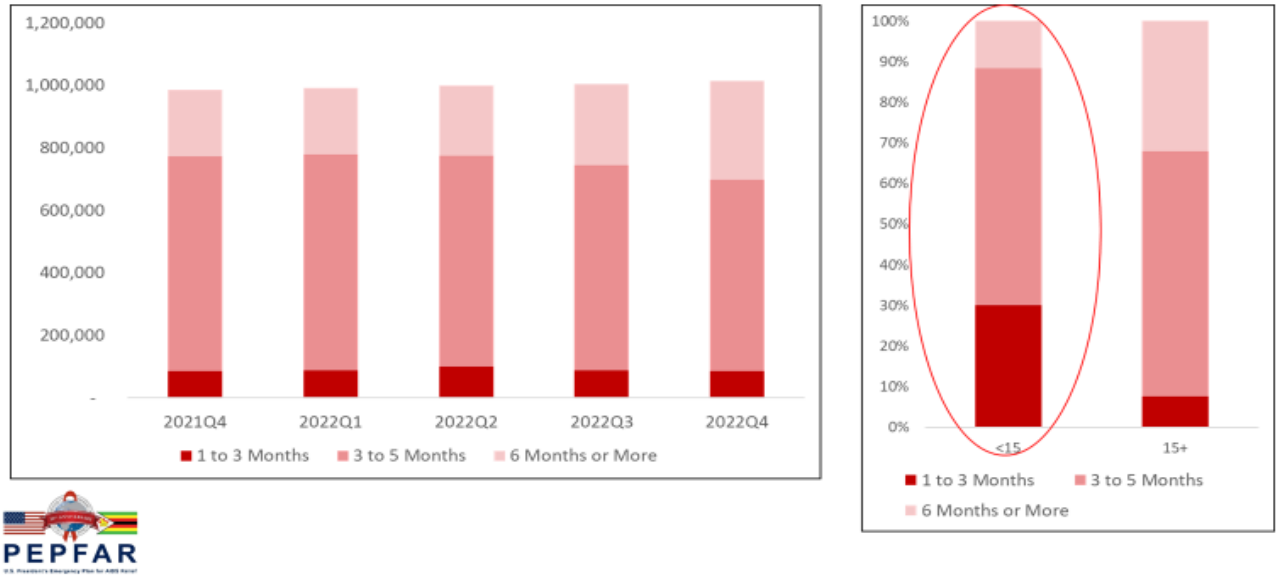


Figure 28: PEPFAR MMD trend shows improvement, though children are lagging

PEPFAR will continue to support the expansion of DSD models for children in COP23 (Figure 28). In addition, PEPFAR will work closely with the MoHCC and other stakeholders such as the Community Pharmacists Association to advance plans to offer re-supply of PrEP and ART through private pharmacies. Private pharmacies were identified during COP23 stakeholder consultations as an important, but underutilized, service delivery point for a range of HIV and related services such as blood pressure and blood sugar checks and referrals as appropriate.

Electronic Health Records

PEPFAR will support the GoZ's vision for a "One Zimbabwe" which includes use of the EHR system as the single electronic patient system as it is not siloed and disease specific. This aligns with PEPFAR's direction towards ensuring that "in sites with generalized systems across relevant programming, [we] work to ensure those systems support the capture and use of data necessary for PEPFAR reporting"[1].

PEPFAR will continue to support the EHR system improvements by leveraging the system's modules and functionality to track public health emergencies such as emerging pandemics and chronic conditions of interest such as mental health and hypertension among PLHIV. In COP23, PEPFAR will support significantly advancing the national integrated, longitudinal, person-level data repository, public health data automation, and Health Information Exchange. This will ensure that MoHCC progresses towards a cohesive, integrated, interoperable digital network to broker data that supports partner government, PEPFAR, and other stakeholders' data needs.

[1] FY 2024 PEPFAR Technical Considerations, pg. 405

Pillar 4: Transformative Partnerships

The PEPFAR interagency team collaborated with key partners including the GoZ, GFATM, CSOs, and other bilateral and multilateral health development partners to develop COP 2023. Representatives from the MoHCC, NAC, UNAIDS, WHO, UNDP, GF and seven representatives from local CSOs attended the Johannesburg Co-Planning Meeting in March 2023 essentially kick-starting the COP23 process. The meeting gave stakeholders ample opportunity to provide valuable input into the planning process and an agreement on the blueprint for the plan. The planning continued back in Harare during the third week of March with a larger Stakeholder Retreat resulting in agreed upon priority areas.

Host country government: The PEPFAR Coordination Office held bilateral meetings with the MoHCC and NAC to discuss the new PEPFAR 5-Year Strategy and the need for continued Ministry leadership throughout the COP23 planning process. MoHCC attended the PEPFAR Q4 POART call in December 2022, and many MoHCC representatives from the various technical units attended the 2-day Stakeholder Retreat in March 2023 where MoHCC led key presentations. MoHCC counterparts participated in key pillar discussions on ways to synchronize MoHCC priorities with PEPFAR's throughout the COP process. Two MoHCC representatives and one NAC representative participated as part of the official Johannesburg delegation March 06-10, 2023, and throughout the process to the approval meeting.

Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)and other external donors:
The GFATM Portfolio Manager and the local Principal Recipient, UNDP, attended the Johannesburg Co-Planning meeting, the PEPFAR Stakeholder's Retreat, and various other virtual planning meetings. PEPFAR/Zimbabwe hosts monthly meetings with Global Fund and UNDP and PEPFAR Zimbabwe colleagues serve on the CCM. PEPFAR Zimbabwe and UNDP conduct joint site visits and several PEPFAR Zimbabwe colleagues serve on the GC7 writing committee.

PEPFAR worked closely with the GFATM's CCM to ensure the alignment of programming with GFATM's current GC7 planning cycle coinciding with COP 2023 planning.

Civil Society/Community: Engagement with civil society kicked off in December 2022 when PEPFAR invited community representatives to the FY21 Q4 POART meeting. Ultimately, seven representatives were selected through various CSO advocacy forums to participate as part of the COP23 Johannesburg Co-Planning delegation. A CSO core group convened regional consultative meetings across the various geographical locations of the country to collect feedback from constituents receiving HIV prevention and treatment services in Zimbabwe. These consultations led to a list of community priorities that later culminated in a separate meeting in February 2023 with the U.S. Embassy Acting Deputy Chief of Mission and the PEPFAR team to deliver the COP23 Community COP list of priorities.

Pillar 5: Follow the Science

In COP23, the strategic direction of the program will follow the science within the context of the national HIV response. HTS programming will shift to status-neutral HIV testing based on emerging evidence on re-engagement with care among PLHIV experiencing interruptions in treatment. The program will maximize the use of point-of-care testing and work to ensure that updated diagnostic tools are used. PEPFAR will continue to support national HIV case-based surveillance with recency to inform program planning and enable a responsive and agile approach to HIV prevention and control. Other priorities include assessing the scope of AHD and how co-morbidities and chronic disease may influence HIV outcomes. PEPFAR will continue to support the UNAIDS HIV estimates process including ensuring high quality input data in the Spectrum model, KP size estimates, AGYW estimates, and VMMC estimates to measure progress towards these goals among general, key, and priority populations.

PEPFAR will address identified gaps in data on the status of the HIV epidemic in KP. In COP23, PEPFAR will conduct size estimates and a BBS for MSM, TG, and/or PWID to improve program targeting for those at most risk and to tailor KP programs to reduce stigma, increase affirming healthcare, and improve audience appropriate risk communications to enhance uptake and adherence to prevention and treatment programs.

PEPFAR and its partners will develop and expand service delivery approaches to reach gap and hidden populations using approaches informed by marketing, behavioral economics, and human centered design (HCD). COP23 condom promotion will be informed by the HCD market segmentation study on condom access and usage funded by PEPFAR in prior COPs. Condom market shaping activities in line with a total market approach will continue in COP23, including advocacy for elimination of import duties on commercial condoms. SBC approaches to advocacy will inform PEPFAR's activities addressing stigma and discrimination, particularly for KP. PEPFAR will apply SBC principles to refresh messaging around combination prevention to address increasing message fatigue among target audiences, which will be paired with U=U messaging using HCD informed tools such as *Flip the Script*. HCD will also inform updated approaches (including virtual and hybrid approaches) to engaging young women aged 20-24 and young women selling sex in the DREAMS program, considering their competing family commitments and economic engagements.

In the prevention space, PEPFAR will leverage three centrally funded awards MOSAIC, MATRIX, and Project Engage for the introduction of new PrEP products (namely, the Dapivirine ring and CAB-LA) under implementation science protocols. PEPFAR will also explore PrEP market development including private sector provision of PrEP to reach underserved populations using marketing and HCD approaches.

Strategic Enablers

Community Leadership

CLM is an integral part of the PEPFAR program in Zimbabwe. Communities present CLM data to PEPFAR in the interagency space at least once every quarter. These meetings are an opportunity

for PEPFAR to understand persistent problems, challenges, and barriers with service uptake at the site and facility level. This information is used by PEPFAR teams to inform discussions with IPs and the GoZ on how gaps can be addressed going forward. Examples of barriers that CLM has uncovered and collaboratively mitigated include drug stockouts, healthcare worker attitudes and VL results turnaround time.

CLM data was extensively used by communities in identifying gaps and making recommendations for priorities in the Community COP. PEPFAR TWGs also used CLM data in reviewing gaps and opportunities within program areas and triangulating this with monitoring, evaluation and Reporting (MER) data. For example, CLM data was key in understanding structural barriers for KPs based on community experiences.

As summarized in Figure 29, in COP23, PEPFAR will focus on strengthening the CLM program to improve the quality of data collected, analyzed and used, as well tracking the outcomes of program recommendations. CLM data will be additive to data collected through other routine PEPFAR programs and will be triangulated with data from SIMS and MER. In COP23 PEPFAR will also focus on ensuring that communities are empowered with the tools they need to bring quality to the program, that program design is made more robust to facilitate generation of quality data and that PEPFAR systems are made more receptive, and readier to act on CLM data.

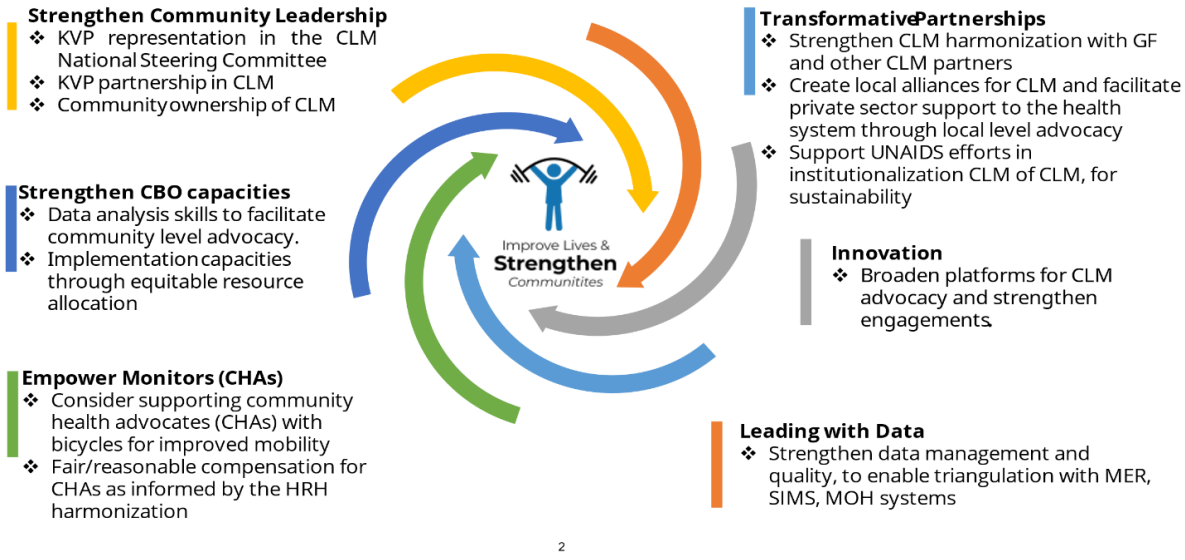


Figure 29: Community-led monitoring program activities in COP23

PEPFAR continues to prioritize community input and leadership in PEPFAR programs and processes. Engagement with civil society kicked off in December 2022 when PEPFAR invited civil society leadership and other community representatives to the Q4 POART virtual meeting. On December 21, 2022, PEPFAR took advantage of the CLM quarterly meeting with civil society to share the 5x3 strategy with civil society and community representatives for the first time. During this meeting, PEPFAR also shared the delegation list for the Joburg co-planning meeting and recommended civil society to start self-organizing in preparation for the COP23 planning season. This was followed by another meeting on January 18, where the PEPFAR Coordinator made a

detailed presentation on the 5x3 strategy. The objective was to ensure that CSOs and communities are well acquainted with the new PEPFAR strategy and are able to align their priorities to the strategic plan. Under the leadership of the Advocacy Core Team and the Zimbabwe AIDS Network, CSOs identified 7 representatives to lead engagements in the COP23 planning process. CSO representatives were drawn from networks of PLHIV, KPs, Youths, Mothers and broader CSO networks.

The identified CSO representatives convened regional consultative meetings across the various geographical locations of the country to collect feedback from constituents receiving HIV prevention and treatment services in Zimbabwe. They also interacted with CBOs implementing CLM to consolidate community priorities. These various meetings were a build up to the PEPFAR-CSO Town Hall held March 1, where the PEPFAR Coordination Office hosted CSOs at the embassy. This meeting presented an opportunity for CSOs and communities to present their Community COP23 to the acting Deputy Chief of Mission and PEPFAR. The meeting was attended by the Chargé d'Affaires who commended CSOs on the extent to which they used CLM data to propose evidence-based priorities in their community COP.

PEPFAR Zimbabwe with CSO and Community Representatives at the Community COP dialogue on March 1, 2023

Following their attendance at the Joburg co-planning meeting, Key and Vulnerable Population chairs, CSO representatives and leadership also attended the PEPFAR stakeholders meeting for the in-country consolidation of priorities in COP23. PEPFAR took time to review and respond to all priorities proposed by communities and these were shared back with civil society leadership. On April 19, another meeting was organized for CSOs to discuss PEPFAR responses to the

community COP. Dialogue on how PEPFAR may continue incorporating community priorities in routine programing will continue beyond the COP planning phase.

PEPFAR will strengthen community engagement to ensure that beyond planning, the role of communities as strategic partners in the implementation and continuous assessment of PEPFAR programs is realized. PEPFAR will continue leveraging on the various opportunities presented by the CLM program to interact with community feedback. These include the quarterly CLM output reporting meetings with PEPFAR, the monthly support meetings and other ad hoc engagements as informed by data coming out from the program. PEPFAR will also extend the CLM quarterly meetings to discuss other CSO priority and feedback issues, to ensure that interaction with communities goes beyond just CLM.

PEPFAR will also leverage on platforms supported by the KP TSC such as the key and vulnerable populations forum. These will be opportunities for PEPFAR to review and receive recommendations on how programming for key and vulnerable populations may continue to be strengthened. Similarly, for young people, PEPFAR will leverage on the National Adolescent and Youth Forum, USG agency youth advisory groups and other DREAMS platforms.

Innovation

In COP23, the PEPFAR Zimbabwe program will accelerate innovations that drive improvements in performance and sustainability, particularly interventions to reach priority populations and close prevention and treatment gaps, find and serve the most difficult-to-reach sub-populations, and increase coverage for all subpopulations and geographies. Some examples are highlighted below.

Adoption of new technologies to improve access to health care services.

To improve access and adherence to, and hence the effectiveness of PrEP, PEPFAR Zimbabwe will support the introduction and scale up of newer PrEP interventions such as event driven PrEP and long-acting medicines such as CAB LA. PEPFAR will also support the GoZ with adopting and implementing the WHO simplified and differentiated service delivery guidelines for PrEP to improve accessibility and adherence to PrEP. PEPFAR will explore PrEP service delivery in private pharmacies and support using HIVST to facilitate easier access to and effective use of PrEP.

To increase the availability of KP-friendly services in public sector clinics, PEPFAR will work closely with civil society and the GoZ to establish an accreditation process for KP Centers of Excellence, which can be replicated nationwide. In COP23, PEPFAR will support the MoHCC to launch at least two Centers of Excellence and plan to establish more centers in COP24.

In COP23, the VMMC program will scale up the availability and innovative use of the Shang Ring, which is more acceptable and more efficient in performing circumcisions. The ring does not require an injection of anesthetics and does not require advanced surgical skills. VMMCs can be performed by lower-level staff, enabling the program to reach more people.

PEPFAR will support the scale-up of the GS 1 Coding system to improve the tracking and tracing of commodities within the supply and distribution pipelines. This will be coupled with the rollout of the eLMIS to transition from paper-based to real-time electronic reporting.

In COP23 the lab program will prioritize digitizing the integrated sample transportation (IST) system from paper-based systems for tracking and tracing samples to using the electronic sample tracking system. This will be complemented by using the ECHO cloud conferencing platform to strengthen the clinic-lab interface. In addition, all PEPFAR-supported labs will transition to newer, high throughput testing technologies with multiplexing capabilities, which include HPV DNA testing, viral load, EID, Hepatitis B, molecular TB testing among others.

Performance models for efficiency

PEPFAR supported HIV testing programs will adopt the 'status neutral' approach to expand HIV testing approaches to give equal importance to both positive and negative results, with HIV-positive individuals actively linked to treatment and care services while HIV-negative individuals are actively linked to prevention services.

In COP23 DREAMS funding will be leveraged to create enabling environments for AGYW and young people to access HIV and sexual reproductive health services by improving adolescent-friendly health services in the public sector and innovating marketing approaches to increase demand for these services. Youths are major consumers of media, including social media. In COP23, the PEPFAR program will explore how to utilize these platforms to promote HIV prevention messages and uptake of services among this priority population.

To enhance continuity of treatment, the program will adopt the 'Flip the Script' concepts of using consumer marketing to reframe the language on treatment benefits to make it more friendly, simple, and compelling and ensure that U=U is well understood and resonates emotionally with PLHIV. Building on lessons learned from the Bill and Melinda Gates funded INTEGRATE program, PEPFAR will transition the current practice of VMMC cost-reimbursement for service and demand to a Results-Based-Financing-like model in all districts whilst maintaining accountability for resources and results and adhering to USG funding and policy parameters in Zimbabwe. The RBF-like model builds on the MOHCC's RBF contracting, verification, support and supervision tools. The model seeks to improve managerial capacity and ownership at provincial and district levels, data quality and reporting, community participation and ownership and enhance program quality.

In COP 23, the program will scale up the use of innovations and lessons learned during COVID-19 to bring services closer to communities and reach remote sites. These include comprehensive HIV services outreaches, blended learning techniques for capacity building, and virtual site support and supervision. The program will also scale up the successful Workforce App and introduce other digital innovations such as two-way texting (TWT) protocols to enhance bidirectional communication and interaction between healthcare workers and clients.

PEPFAR will support the MoHCC, thorough strategic information partners, in exploring offline functionality for the web-based Electronic Health Records (EHR) system powered by Bluetooth connectivity to connect facility level devices as a solution for downtime due to power shortages or site level connectivity failure. This innovation will allow users to continue consulting patients while offline without impacting service delivery.

The Laboratory Information Management System (LIMS) will adopt open health information exchange (HIE) frameworks to facilitate interoperability and data sharing between LIMS and other PEPFAR data platforms. To improve lab results turnaround times, PEPFAR will support the use of SMS and USSD platforms to transmit results among other communications and troubleshooting.

Enabling policy to scale up evidence-based programming.
The program will advocate and lobby for the amendment of the HIV testing policy to support the introduction of blood-based HIV self-testing to complement the currently used oral swab-based testing.

New partnerships to advance strategic priorities.
The OVC program will strengthen its partnership with the Office of Humanitarian Assistance, which offers food and nutrition supplements to pregnant and breastfeeding women, and children two years and below, to improve service delivery and longitudinal tracking of HIV-exposed and HIV-infected children.

In COP23 PEPFAR will increase collaboration with private sector health actors such as retail pharmacies, private providers, and private hospitals to expand capacity and increase equitable access to services while reducing the burden on the public sector. PEPFAR will also promote participation of the private sector in the Sustainability Roadmap and other routine MoHCC led TWGs. The MoHCC recently updated its Strategic Framework for Public Private Partnerships for TB/HIV Prevention, Care and Support; this presents an important opportunity for increasing private sector engagement and sustainability in the national HIV program.

In COP23, PEPFAR, in collaboration with donor agencies, will support the MoPSE to improve the quality and accessibility of comprehensive sexuality education in schools, which will help ensure that current and future generations of youth receive quality HIV prevention education.

Leading with Data
PEPFAR's overall strategy and plan for data systems (Figure 30) per COP23 guidance involves supporting country-operated or endorsed systems to also ensure that PEPFAR health information system and data management investments advance the vision of securely bringing together individual-level, longitudinal data in the form of a national data repository for appropriate in-country programmatic use and curated deidentified data sets for programmatic transparency.

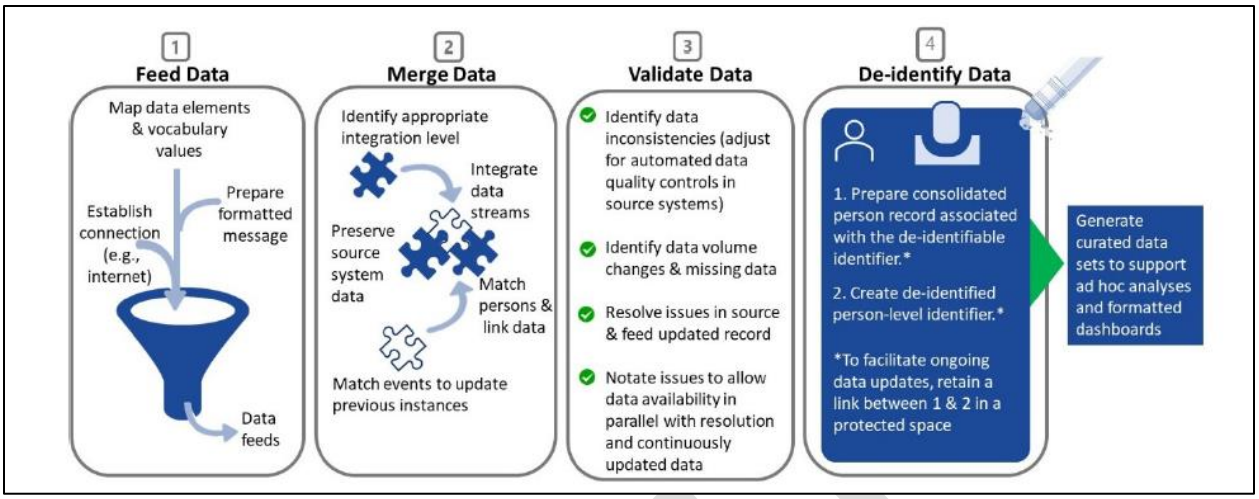


Figure 30: Leading with data through four steps

To that end, PEPFAR, in collaboration with GFATM and the Bill and Melinda Gates Foundation, supports the MoHCC efforts to build and deploy the digital health platform through Impilo Suite of Tools that seeks to enhance interoperability, integration, and data exchange with systems such as eLMIS, District Health Information System 2 (DHIS2), Laboratory Information Management System (LIMS), Electronic Health Record (EHR) as well as facilitate easy access to data. PEPFAR will also support continuous software and system improvement to ensure the EHR system modules collect patient data once that can be used for and across many program and donor use cases, and that will also help building of individual person-centered longitudinal data sets. A key facilitator to leading with data is a skilled workforce. PEPFAR will therefore provide support for capacity building through cost-effective and efficient methods such as on-the-job trainings and targeted technical assistance for MoHCC staff. These efforts will address areas like security to ensure data are captured, transmitted, and stored in a secure manner; data science and analytics to build in-country staff skills to be able to extract and package data for meaningful use; and data use trainings for site-level and above-site staff to routinize consumption and use of data to inform patient care and program strategies. These efforts are underpinned by having structures within MoHCC able to support and execute PEPFAR's vision. Hence in COP23 PEPFAR will continue to support secondments of strategic officers within MoHCC's structures.

To drive increased data utilization, PEPFAR will continue to support further enhancement of dashboards in the site level EHR system and the above-site Health Management Information System, with deliberate effort towards incorporating more user and program requirements to improve on visualizations availed in COP22.

PEPFAR will continue supporting MoHCC's implementation of case surveillance. We will however implement recency testing through a measured approach through Rapid Test for Recency Infection (RTRI) with Viral Load confirmation of RTRI recent result (i.e., Recency Infection Testing Algorithm (RITA)). PEPFAR will support recency testing in 17 districts that have a recency testing coverage of ≥75% and scale implementation in these districts to reach 100% saturation. For

general case surveillance program, PEPFAR has an ambitious goal of supporting MoHCC in reaching 100% of sites in the 44 PEPFAR-supported districts by end of COP23. All these efforts are aimed at ensuring our program continues to be led with data by providing robust case surveillance and recency data that translates into meaningful public health responses.

To reduce duplications and PEPFAR parallel systems we will continue to support data alignment activities and inclusion of all PEPFAR MER indicators in the MoHCC Impilo products of report.

PEPFAR will also support data systems that enhance strategic decision making for comprehensive community programming to close gaps for AGYW and OVC. The DREAMS database and OVC management information system (MIS) will continue to provide program managers and stakeholders real-time information on social protection and combination HIV prevention programs, using interactive visuals with disaggregation by geography, partner, and participant characteristics, as well as line lists of participants requiring programmatic follow-ups. In COP23, PEPFAR will promote data quality and data use through support for regular SI TWG coordination platforms, TA for OVC and DREAMS reporting, and training and TA on DREAMS and OVC SI and database use to PEPFAR partners and stakeholders. In addition, PEPFAR will promote system sustainability through support for updated program and SI documents (SOPs, protocols, guidance, etc.). PEPFAR also will support enhancements to the two systems to address programming needs and meet evolving PEPFAR DREAMS and OVC program guidance. The OVC MIS will be adapted to enable community-level data entry using electronic gadgets. In COP22, responsibility for the coordination and administration of the OVC MIS will be fully transitioned to a local Zimbabwean partner; responsibility for the DREAMS database will be transitioned to a local partner in COP23.

Target Tables

Target Table 1: ART Targets by Prioritization for Epidemic Control							
Prioritization Area	**Total PLHIV (FY23)**	**New Infections (FY23)**	**Expected Current on ART (FY23)**	**Current on ART Target (FY24) *TX_CURR***	**Newly Initiated Target (FY24) *TX_NEW***	**ART Coverage (FY24)**	**ART Coverage (FY25)**
Attained	1,291,748	16,906	1,282,703	1,283,478	42,397	99.4%	
Total	**1,291,748**	**16,906**	**1,282,703**	**1,283,478**	**42,397**	**99.4%**	

Target Table 2: VMMC Coverage and Targets by Age Bracket in Scale-up Districts							
Provinces	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (date)**	**VMMC_CIRC (in FY24)**	**Expected Coverage (in FY24)**	**VMMC_CIRC (in FY25)**	**Expected Coverage (in FY25)**
Bulawayo	15-19	29,423	58%	14,877	57%	5,949	80%
	20-24	31,931	65%	6,280	68%		80%
	25-29	32,746	63%	4,460	69%		80%
Harare	15-19	121,250	32%	84,052	34%	23,947	80%
	20-24	123,527	41%	53,682	47%		80%
	25-29	110,938	45%	43,051	49%		80%
Manicaland	15-19	105,778	64%	28,922	65%	15,414	80%
	20-24	97,231	63%	12,281	70%		81%
	25-29	81,835	48%	19,896	58%		80%
Mashonaland Central	15-19	79,760	90%	7,658	86%	7,459	84%
	20-24	72,599	102%	2,816	106%		106%
	25-29	61,420	79%	5,144	89%		102%
Mashonaland East	15-19	85,244	45%	46,493	52%	18,235	80%
	20-24	81,805	52%	26,009	60%		81%
	25-29	79,583	44%	27,399	54%		80%

Mashonaland West	15-19	89,270	68%	23,241	70%	14,081	80%
	20-24	80,877	85%	6,247	90%		92%
	25-29	77,729	73%	8,424	83%		94%
Masvingo	15-19	109,986	70%	26,940	68%	12,491	84%
	20-24	80,011	66%	15,100	73%		88%
	25-29	65,491	50%	20,148	60%		85%
Matabeleland North	15-19	45,757	101%	10,808	103%	4,909	109%
	20-24	37,726	92%	7,143	104%		118%
	25-29	38,752	68%	8,221	82%		105%
Matabeleland South	15-19	41,156	112%	1,813	107%	2,296	100%
	20-24	40,424	107%	278	113%		113%
	25-29	37,979	83%	563	94%		100%
Midlands	15-19	101,770	73%	30,295	72%	15,094	86%
	20-24	92,111	84%	12,059	88%		95%
	25-29	88,880	71%	16,222	79%		97%
	Total/ Average	**2,222,989**	**70%**	**555,644**	**76%**	**119,874**	**90%**

Target Table 3: Target Populations for Prevention Interventions to Facilitate Epidemic Control				
Target Populations	**Population Size Estimate* (SNUs)**	**Disease Burden***	**FY24 Target**	**FY25 Target**
[Specify target populations for focus, e.g., AGYW at risk of HIV acquisition, female sex workers] *Indicator Codes include PP_PREV, AGYW_PREV KP_PREV*				
PP_PREV Group 1: AGYW 15-24 vulnerable to HIV infection in DREAMS and Enabling DREAMS districts	Unreached with combination prevention interventions as of start COP23: **102,086**	Average HIV incidence among AGYW 15-24 in DREAMS + Enabling districts is 0.32% High viral load occurs in 10% of	**98,702**	**98,702**

PP_PREV Group 2: HIV positive youth (18-24) at risk for high viral load and transmission	YLHIV 18-24: 84,007	males and 7% of females 18-24		
AGYW_PREV: AGYW 10-24 vulnerable to HIV infection in DREAMS districts	Unreached by DREAMS as of start COP23: **81,492**	Average HIV incidence among AGYW 15-24 in DREAMS districts is 0.35%	Numerator: **55,612**	Numerator: **55,612**
			Denominator: **60,659**	Denominator: **60,659**
KP_PREV Group 1: Female sex workers	National FSW estimate: 94,702	FSW HIV prevalence estimated at 48%	**46,145**	**46,145**
KP_PREV Group 2: Men who have sex with men	National MSM estimate: 52,057	MSM prevalence at 20%	**30,487**	**30,487**
KP_PREV Group 3: Transgender individuals	National TG estimate: 8,007	TG prevalence at 27%	**3,792**	**3,792**
TOTAL				

*Include data sources in the text (i.e., not in the table itself)
**AGYW PSE from Spectrum 2023 NAOMI files and DREAMS saturation calculations*
**KP PSE from National KP Target Setting workshop held March 2023, based primarily on AMETHIST and BBS*

Target Table 4 is required, except for countries with no OVC investments or targets.

Target Table 4: Targets for OVC and Linkages to HIV Services (FY23 & FY24)					
District	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC** **OVC_SERV Comprehensive**	**Target # of OVC** **OVC_SERV Preventative**	**Target # of active OVC OVC_SERV DREAMS**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files. OVC_HIVSTAT**
FY24 TOTAL		187,146	**45,325**	**38,107**	187,146
Beitbridge		-	1,092	1,734	-
Bubi		-	-	202	-
Buhera		13,561	-	-	13,561

Target Table 4: Targets for OVC and Linkages to HIV Services (FY23 & FY24)					
District	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC OVC_SERV Comprehensive**	**Target # of OVC OVC_SERV Preventative**	**Target # of active OVC OVC_SERV DREAMS**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files. OVC_HIVSTAT**
Bulawayo		10,819	2,500	6,286	10,819
Bulilima		2,069	909	1,394	2,069
Chegutu		9,328			9,328
Chipinge		11,421	2,500	4,477	11,421
Chiredzi		3,296	-	-	3,296
Chitungwiza		3,938	-	-	3,938
Chivi		2,686	5,000	-	2,686
Gokwe South			5,000	-	
Goromonzi		10,372	-	-	10,372
Gutu		9,662	5,000	-	9,662
Gwanda		2,896	1,350	2,054	2,896
Gweru		5,847	1,569	2,956	5,847
Harare		24,670	-	-	24,670
Hurungwe		3,391	-	-	3,391
Insiza		4,284	1,206	1,760	4,284
Kwekwe		3,979	-	-	3,979
Lupane		3,161	-	328	3,161
Makonde		15,580	-	-	15,580
Makoni		11,739	2,500	4,203	11,739
Mangwe			780	1,221	
Masvingo	**162, 368**	3,996	-	-	3,996
Matobo			920	1,366	
Mazowe		2,431	2,500	4,128	2,431
Mberengwa			5,000	-	
Mutare		9,415	2,500	5,442	9,415
Mwenezi		3,311	-	-	3,311
Nkayi			-	297	
Seke		2,939	-	-	2,939
Tsholotsho		-	-	259	-
Zaka		-	5,000	-	-
Zvimba		12,355	-	-	12,355
FY25 TOTAL		187,146	**45,325**	**38,107**	187,146

Core Standards

1. **Offer safe and ethical index testing to all eligible people and expand access to self-testing**. Ensure that all HIV testing services are aligned with WHO's 5 Cs. Index testing services should include assessment of and appropriate follow-up for intimate partner violence. Offer HIV testing to every child under age 19 years with a biological parent or biological sibling living with HIV.
    - For the past 2 years, PEPFAR has implemented safe and ethical ICT in all SNUs and for all populations as part of the person-centered differentiated service delivery approach. All service providers have been, and continue to be, capacitated to correctly offer ICT aligned with WHO 5 Cs. This is complemented by a deliberately structured and supportive joint monitoring strategy by USG, IPs and MoHCC technical staff.
    - Service providers routinely assess IPV. PEPFAR will continue to strengthen service providers' capacity to routinely assess IPV in a structured way, empower clients to report instances of violence, and offer appropriate referrals for services.
    - To improve access to, and offer of, HIV testing to children under 19 years of a biological parent or biological sibling living with HIV, PEPFAR is maximizing the ICT modality. Currently, HIVST kits are only given to those over 16 years, while the MoHCC's current guidance is for a trained service provider to administer HIVST to children below the age of 16. PEPFAR will continue to leverage the OVC platform, with their strong community-clinic presence, to make ethical HIV testing services available to this age group.
2. **Fully implement "test-and-start" policies.** Across all age, sex, and risk groups, over 95% of people newly identified with HIV infection should experience direct and immediate linkage from testing to uninterrupted treatment.
    - The "test and start" strategy has been standard practice since 2018, with close monitoring of the linkage indicators to ensure implementation fidelity. Linkage to ART in COP21 was 96%. In the few instances where clients delay starting ART the most common causes are: client being investigated for TB, need to disclose HIV status to partner first and client not ready and/or coming to terms with the new diagnosis. The program is working with CSOs and advocacy groups to improve HIV treatment literacy for better outcomes.
3. **Directly and immediately offer HIV-prevention services to people at higher risk.** People at a higher risk of acquiring HIV must be directly and immediately linked with prevention services aimed at keeping them HIV-free, including PrEP and post-exposure prophylaxis (PEP).
    - PrEP is being scaled up targeting those at substantial risk of HIV acquisition. The initial focus was on KPs, AGYW and sero-discordant couples. Roll out to PBFW started during COP21 and expansion is ongoing. In COP23 PEPAR will strengthen the focus on PBFW by building the capacity of health workers who have not yet been trained and increasing procurement of PrEP commodities. There is a

standard PrEP screening tool which is guiding eligibility. AGYW are being reached through DREAMS and other prevention interventions.

- PEP implementation started in 2004 targeting health workers following needle stick and other occupational injuries. In COP23 PEPAR will increase access to PEP, focusing initially on populations at higher risk, by leveraging existing platforms and integrating the offer of PEP alongside other HIV prevention options. Targets in COP23 have not been set but will be set in COP24 following a better understanding of the program.

4. **Provide orphans and vulnerable children (OVC) and their families with case management and access to socioeconomic interventions in support of HIV prevention and treatment outcomes**. Provide evidence-based sexual violence and HIV prevention interventions to young adolescents (aged 10-14).
    - This core standard has been achieved and is being maintained in COP23. In COP22 the OVC Program expanded from 21 to 25 districts and case management is a cornerstone of program implementation. Individual case files are maintained for all enrolled children, which contains among other documents, an individualized Case Plan that defines the key issues and intervention areas jointly identified by the family and Case Worker during the Family Assessment. For CALHIV the Case Plan also includes health facility appointment dates for VL services and medicine collection.
    - The Family Assessment examines the broader household and identifies key issues and interventions that are important to ensuring a safe, healthy and stable environment for the child. PEPFAR will continue to support positive parenting and sexual violence prevention interventions targeting parents and caregivers such as Families Matter and Sinovuyo. PEPFAR will continue to support economic strengthening activities that benefit the full household including savings clubs. All caregiver programs are aimed at enhancing their knowledge in ensuring that CALHIV stay healthy, and for the HIV negative children and adolescents, they remain negative.
    - The program has provided evidence-based sexual violence and HIV prevention interventions to young adolescents through the OVC platform for several years, included the curricula Coaching Boys to Men and No Means No. These activities will continue in COP23.
5. **Ensure HIV services at PEPFAR-supported sites are free to the public.** Access to HIV services, medications, and related services (e.g., ART, cotrimoxazole, ANC, TB, cervical cancer, PrEP and routine clinical services for HIV testing and treatment and prevention) must not have any formal or informal user fees in the public sector.
    - Zimbabwe has a policy which stipulates access to primary health, TB and HIV services are accessed at no cost to the client. The challenge remains with some urban and rural local authorities, which are unable to finance their operations in the absence of user fees. Due to wider economic constraints the Central Government has been sporadic in providing drugs and commodities and paying grants and subsidies to local authorities, hence further limiting their fiscal space

and threatening the quality of care. PEPFAR continues to monitor the situation and advocate for waiver of user fees for HIV and TB services. Community Led Monitoring (CLM) has been a major proponent of ensuring PLHIV do not pay user fees.

6. **Eliminate harmful laws, policies, and practices that fuel stigma and discrimination, and make consistent progress toward equity.** Programs must consistently advance equity, repudiate stigma and discrimination, and promote human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, children, and other vulnerable groups. This progress must be evidence-based, documented, and included in program evaluation reports.
    - To eliminate harmful practices that fuel stigma and discrimination in KP, PEPFAR continues to build the capacity of frontline health workers through training in gender and sexual diversity (GSD). This enables health workers to provide KP-friendly services and ensures that health delivery points are safe spaces for KP. In COP23, PEPFAR will support additional efforts in the areas of advocacy, capacity building and SBCC (see Pillar 1).
    - To address harmful laws, policies, and practices that fuel stigma in AGYW, PEPFAR is implementing programs like DREAMS within safe spaces, educating parents and caregivers and supporting community mobilization and norms change activities targeting traditional and religious leaders. In COP23, PEPFAR will continue to build capacity of sites to be adolescent and youth-friendly and to provide first line support to all gender-based violence (GBV) survivors.
7. **Optimize and standardize ART regimens.** Offer DTG-based regimens to all people living with HIV (including adolescents, women of childbearing potential, and children) 4 weeks of age and older.
    - This core standard has been achieved. Currently in FY23 Q2, 96.3% and 87.7% of adults (including pregnant and breastfeeding women) and children on ART respectively are receiving DTG based regimens as part of first line treatment. PEPFAR ARV consumption data shows no children are taking nevirapine containing regimens and 9.3% are on LPV/r granules.
8. **Offer differentiated service delivery models.** All people with HIV must have access to differentiated service delivery models to simplify HIV care, including 6-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve ART coverage and continuity for different demographic and risk groups and to integrate with national health systems and services.
    - National policy allows implementation of 6MMD; nevertheless, implementation has slowed due to ARV supply chain challenges. In FY22 the MoHCC wrote a letter advising health facilities to temporarily suspend implementation of 6MMD due to an anticipated national stock rupture, and to date that suspension has not yet been lifted. PEPFAR will closely monitor the situation and continue to advocate for 6MMD.
    - In COP23 PEPFAR will support the expansion of other DSD models including peer, community and family led models. Community ART refill Groups (CARGs) have

been the major model implemented in most rural and peri-urban areas. In urban areas peer-led, family and 4-6MMD have been preferred by clients. It is imperative that implementation and enrolment remain client led. Clients must be allowed to choose a model they prefer and must never be coerced to join a model they do not prefer. Community-led monitoring will play a key role in ensuring this is achieved.

9. **Integrate TB care.** Routinely screen all people living with HIV for TB disease. Standardized symptom screen alone is not sufficient for TB screening among people living with HIV and should be complemented with more-sensitive and setting-specific, WHO-recommended screening tools. Ensure all people living with HIV who screen positive for TB receive molecular WHO-recommended diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TPT.
    - PEPFAR continues to support screening of clients at high risk of TB whenever they are in contact with health facilities. PLHIV are being screened using the WHO four symptom screening tool, with 93% screening coverage achieved in COP21. Currently we note issues with the quality of TB screening given the low presumptive cases reported, 9.4% and 1.6% screening positive among clients new and already on ART respectively. In COP23, PEPFAR will support the roll out of more sensitive screening tests like digital chest X-rays with computer aided diagnostics (CAD). Some health facilities will participate in the roll out of Targeted Universal TB Testing, an intervention show to improve TB case detection among PLHIV.
    - In COP21 89% of clients who screened positive for TB were tested using WHO recommended diagnostic and drug susceptibility tests, in this case GeneXpert. PEPFAR will support procurement and implementation of GeneXpert tests. Other diagnostic tests which will be implemented include TB LAM and TB TruNat which is supported through the Global Fund.
    - TPT universal coverage is in process with about 375,000 clients having completed TPT over the last 3 years. In COP21 Q2 and Q3 PEPFAR will support the MoHCC to roll out a TPT surge targeting eligible patients already on ART.
10. **Diagnose and treat people with AHD.** People starting treatment, re-engaging in treatment after an interruption of $\geq$ 1 year, or virally unsuppressed for $\geq$1 year should be evaluated for AHD and have CD4 T cells measured. All children <5 years old who are not stable on effective ART are considered to have AHD. The WHO-recommended and PEPFAR-adopted package of diagnostics and treatment should be offered to all individuals with AHD.
    - Achievement of this core will be achieved in COP23. In previous years there has been limited focus and support for AHD management. In COP21 PEPFAR and other stakeholders supported the MoHCC in the development of national AHD guidance. Training manuals, job aides and standard operating procedures were developed. Capacitation of health workers and managers was also done and will continue to be supported.

- In COP23 the program will focus on HCW training and ensure availability of AHD commodities to screen, diagnose, and treat. PEPFAR will support AHD prevention by conducting a deeper dive to understand the demographic of those with AHD (e.g., occupation, priority population, where they are seeking care) and to tease out contributors or drivers to AHD (e.g., is testing or retention or both, and at what proportion.

11. **Optimize diagnostic networks for VL/EID, TB, and other coinfections**. In coordination with other donors and the National TB Program, complete diagnostic network optimization (DNO) and transition to integrated diagnostics and multiplex testing to address multiple diseases. Ensure 100% EID and VL testing coverage and return of results within stipulated turn-around time.
    - Completion of diagnostic network optimization has been achieved, but this is a moving target given that technology keeps evolving. Performance of this MPR will be monitored continually. The focus will continue to be on diagnostic network optimization aimed at improving viral load coverage from 73% in FY2022 to 90% by FY2024, with key activities such as:
        - Transition from the older Roche CAPCTM and Abbott m2000 platforms to the newer Roche 5800/6800/8800 and Abbott Alinity platforms in COP22-COP23
        - Verification of VL/EID multiplex testing on Roche 5800/6800/8800 and Hologic panther molecular platforms
        - Optimization of POC testing on the GeneXpert and mPIMA platforms
        - Scale up integrated testing on GeneXpert (VL/EID, TB, Covid 19). Scale up of electronic results delivery systems to reduce total TATs
        - Diagnostic network assessment in collaboration with CHAI and other development partners in 2023 to review DNO recommendations from 2018
    - VL testing geographic coverage in FY22 was 100% (1619/1619 facilities) through a combination of conventional and POC integrated diagnostics; integrated sample transport network (IST); Laboratory Information Management System with remote login capability and multi-stakeholders' engagement through CLI.
12. **Integrate effective quality assurance (QA) and continuous quality improvement (CQI) practices into site and program management.** Program management must apply ongoing program and site standards assessment—including the consistent evaluation of site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including implementing partner agreements and work plans should align with national policy in support of QA/CQI.
    - Under policy and public health systems support, most MPRs have been achieved except for those that focus on equity, stigma reduction and promotion of human rights among those who are often left behind. PEPFAR commits to work with CSOs to ensure this MPR is achieved, leveraging CLM, among other efforts.
    - The National HIV Quality Improvement Strategy establishes indicators and guidelines for measuring the quality of service delivery and improving

performance towards those indicators. Importantly, this strategy considers client feedback to promote client-centered care. PEPFAR support towards the National HIV Quality Improvement program takes the form of secondees who provide technical guidance, ensuring that this program is aligned with the PEPFAR and UNAIDS strategy for achieving HIV epidemic control. Through this support, facilities implemented QI initiatives resulting in improved patient care, VL and TPT uptake. At the site-level, systems-level interventions to improve monitoring of patient satisfaction, linkage rates, same day initiation and improved M&E for PEPFAR treatment indicators, will be streamlined into the site-level support provided by the clinical partners.

13. **Offer treatment and viral-load literacy.** HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. U=U messaging and other messaging that reduces stigma and encourages HIV testing, prevention, and treatment should reach the general population and health care providers.
    - In COP21, PEPFAR will ensure ongoing activities to improve treatment literacy among PLHIV and ensure that appropriate messages are delivered in appropriate ways to the various population subgroups. These messages will include the rationale for the Treat All approach, the benefits of testing and initiating ART prior to onset of symptoms, the superior efficacy and adverse event profile of DTG-based regimens, the importance of having all sexual partners on treatment or PrEP, the need for viral load monitoring and the meaning of viral load results, U=U. PEPFAR will expand the use of the Flip the Script communication package to improve client's understanding of adhering to treatment and VL results interpretation. PEPFAR will continue to support the updating of counseling materials and guidelines to align with the current treatment recommendations and the shifts in the HIV program.
    - During COP 2019, PEPFAR Zimbabwe supported the development, printing, and dissemination of a "Comprehensive National HIV Communications Strategy for Zimbabwe 2019-2025". This document will be the basis for continued revitalization of prevention messaging as well as widespread treatment literacy. Working with CSOs and their constituents, treatment literacy messages tailored to specific population groups in specific areas will be guided by the strategy.
14. **Enhance local capacity for a sustainable HIV response.** There should be progress toward program leadership by local organizations, including governments, public health institutions, and NGOs. Programs should advance direct funding of local partners and increase funding of organizations led by members of affected communities, including KP-led and women-led organizations.
    - PEPFAR continues to increase program leadership by local organizations. The proportion of the overall PEPFAR budget, excluding the USG agency management and operations and commodities budgets, that is directly funding local NGOs increased from 54% in COP21 to 65% in COP22 and is anticipated to further increase to 98% in COP23 and COP24. PEPFAR is working through a growing

number of KP-led organizations as sub recipients of PEPFAR funding and will continue to seek ways to grow the number of KP-led sub partners and amplify their constituent voices.

15. **Increase partner government leadership.** A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects of the HIV response—including political commitment, building program capacities and capabilities, and financial planning and expenditure.
    - The GoZ has made significant efforts towards sustainability through development of relevant policy and strategy documents that are directed towards locally owned and accessible health services. With support from World Bank, the MoHCC developed a Health Financing Strategy which lays out guided steps towards ensuring affordable and equitable access to quality healthcare services, as well as strategic partnerships across government, private sector, and development partners. The Health Financing Strategy includes introduction of a new Health Levy, continuation of payments towards the National AIDS Trust Fund, and subsidized, and in some cases, free health services. More recently the Health Sector Coordination Framework was developed to coordinate all stakeholders, including government, donors, civil society, and private sector to work together in the financing, planning, implementation, monitoring and evaluation of all health-related interventions in the country. The MoHCC envisages efficiency in the management and coordination of available resources, reduction in duplication of efforts, stronger partner alignment and shared accountability for service provision. Implementation of the Health Sector Coordination Framework has begun with the convening of quarterly technical working groups. With UNICEF facilitation the government has developed a workplan for developing the HIV Sustainability Roadmap (see Pillar 2).
16. **Monitor morbidity and mortality outcomes.**
    - In collaboration with MoHCC and other stakeholders PEPFAR has been collecting and analyzing electronic and paper-based data to monitor causes of mobility and mortality among PLHIV. In COP23, investments in electronic health systems will improve quality of data and ability to monitor the following:
        - Newly identified HIV-infected persons and incident infections in defined geographic locations
        - MER & MoHCC monthly reports on all HIV/TB patients in all sub-populations
        - Mortality surveillance among ART patients, and
        - Outbreak response and utilization of data to inform policy
17. **Adopt and institutionalize best practices for public health case surveillance.** Transfer/deduplication processes and a secure person-based record should be in place for all people served across all sites. Unique identifiers should also be in place, or a plan and firm, agreed-upon timeline for scale-up to completion should be established.
    - EHR system, the main platform through which case surveillance is being implemented, is currently using a set of algorithms to uniquely identify patients.

MoHCC is working with Global Fund to develop and implement a biometrics solution in FY24 that will further enhance unique identification of patients, which should further strengthen existing algorithm-based deduplication and unique patient identification methods.

USG Operations and Staffing Plan to Achieve Stated Goals

For COP23 the PEPFAR team took a critical look across the entire interagency team to ensure it consisted of staff with an adequate mix of technical, management, and administrative skills to support the GoZ's goal of epidemic control.

The current proposed staffing plan put forth by USAID, CDC, and State equips the agencies to stay actively engaged in technical working groups and discussions, provide activity/project management oversight, conduct robust monitoring and analysis required to responsively adapt the program to ensure alignment with PEPFAR priorities, and conduct critical SIMS visits at the selected sites for the year.

USAID: Since April 2022, USAID has added one local hire position (SI Specialist) to the team. As of April 2023, USAID Zimbabwe has one local hire position pending recruitment (Program Management Specialist). This position has been vacant for less than 6 months and USAID anticipates filling it before the end of FY23.

USAID does not anticipate any staff changes in COP23 or COP24, however, USAID CODB will increase by $100,000 to cover ICASS and salary increases.

CDC: Since April 2022, CDC filled three vacancies, including:

- Communications Specialist (local hire)
- Strategic Information Branch Chief (US direct hire)
- HIV Services Branch Chief (US direct hire)

As of April 2023, CDC Zimbabwe has 5 vacant positions to be filled by the end of COP22, including:

- Public Health Specialist, Surveillance (local hire) – recruiting
- Cooperative Agreement Specialist (local hire) –recruiting
- Deputy Country Director (US direct hire) – recruiting
- Administrative Assistant (local hire) – pending reclassification
- Associate Director of Programs (local hire) – pending classification

In COP23, CDC is proposing to repurpose global health support budgeted through a CDC HQ fellowship mechanism ending in COP22 from three fellows to two Public Health Specialist positions (local hires) due to programmatic need. In COP23, CDC CODB will increase by $290K due to CSCS, ICASS, and the reallocation of one local-hire position from DOS.

State Department (DOS): As part of PEPFAR's CLM Initiative, PEPFAR Zimbabwe agreed in COP20 to fund a new local hire Grants Officer Representative position (informally known as the CLM Grants Specialist). The funding mechanism for CLM grants was shifted in COP 22 from PEPFAR Small Grants to UNAIDS, but the CLM Grants Specialist was retained under the Department of State. In COP23, State will transfer the CLM Grants Specialist position to a higher graded position under HHS/CDC. CLM is a country priority for Zimbabwe and moving the CLM Grants Specialist from State to CDC will allow PEPFAR Zimbabwe to compensate the CLM Coordinator at a level more commiserate with the qualifications. It will also ensure we keep this highly functioning position competitive. The move has interagency concurrence and has been approved by the Country Chair.

State will continue to fund one position: the PEPFAR Communications Specialist.

Operational Updates: Overall M&O needs were reviewed during budgetary discussions. Technical and non-technical staff are conducting SIMS visits. In alignment with COP guidance, the PEPFAR Coordination Office (PCO) will serve as the interagency point of contact for the oversight of the required Gender and Sexual Diversity Training (GSD) required for new staff within the first two months of arrival or hire at Post. The total COP23/24 CODB budget request of $18,662,043 is a 2% increase over the COP22 amount. The budget shift does not include an increased USG footprint in COP23, but are due to increases in the general Costs of Doing Business, including ICASS and salary increases for local and US Direct Hire staff.

APPENDIX A -- PRIORITIZATION

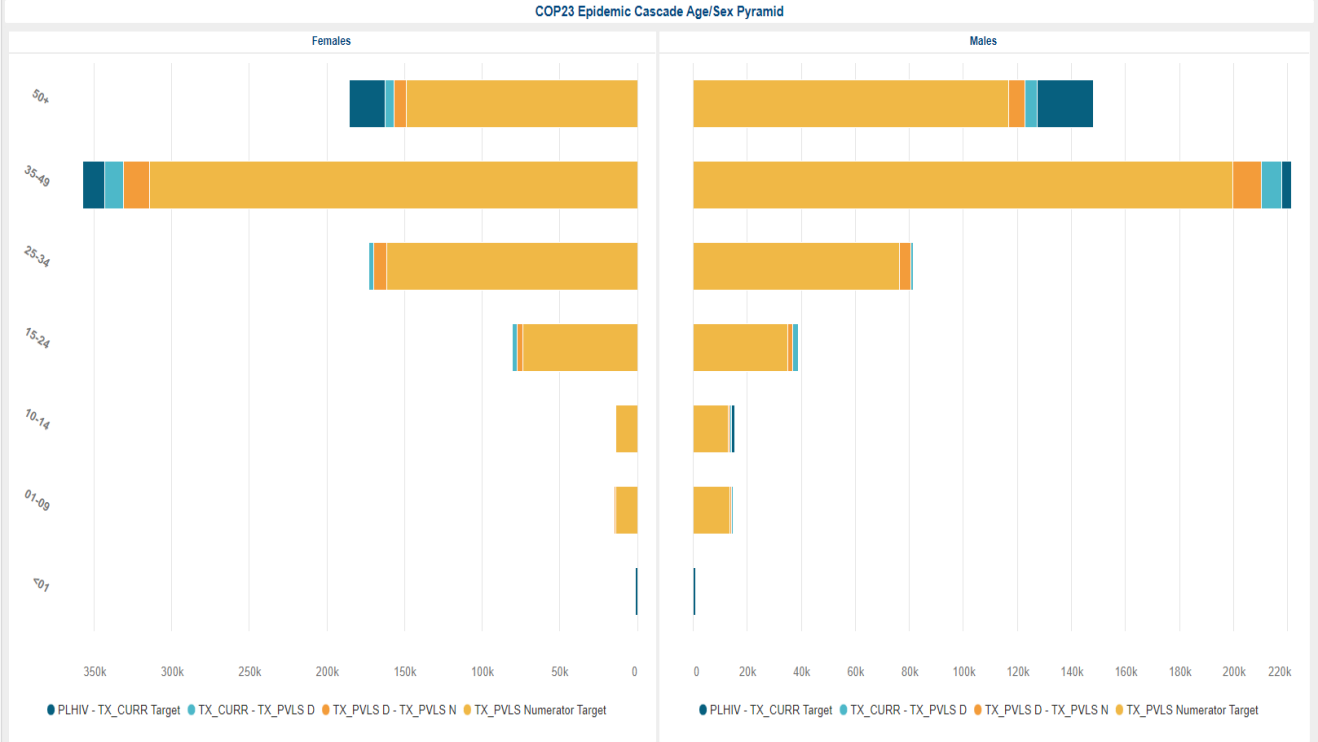


Figure 31: Epidemic Cascade Age/Sex Pyramid

APPENDIX B – Budget Profile and Resource Projections

Table B.1.1: COP22, COP23/FY 24, COP 23/FY25 Budget by Intervention

Intervention	COP 2022	COP 2023	COP 2024
ASP	**$12,505,555**	**$15,975,422**	**$13,405,422**
HMIS, surveillance, & research>Non Service Delivery>AGYW	$318,000		
HMIS, surveillance, & research>Non Service Delivery>Key Populations	$45,000		
HMIS, surveillance, & research>Non Service Delivery>Non-Targeted Populations	$2,678,480		
HMIS, surveillance, & research>Non Service Delivery>OVC	$374,999		
Health Management Information Systems (HMIS)>Non Service Delivery>AGYW		$318,750	$318,750
Health Management Information Systems (HMIS)>Non Service Delivery>Non-Targeted Populations		$1,967,530	$1,967,530
Health Management Information Systems (HMIS)>Non Service Delivery>OVC		$274,999	$274,999
Human resources for health>Non Service Delivery>Non-Targeted Populations	$1,128,962	$2,128,962	$2,128,962
Laboratory systems strengthening>Non Service Delivery>Non-Targeted Populations	$1,047,365	$1,047,365	$1,047,365
Management of Disease Control Programs>Non Service Delivery>AGYW		$874,750	$874,750
Management of Disease Control Programs>Non Service Delivery>Key Populations		$449,445	$449,445
Management of Disease Control Programs>Non Service Delivery>Non-Targeted Populations		$2,631,358	$2,666,358
Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$40,000		
Policy, planning, coordination & management of disease control programs>Non Service Delivery>AGYW	$1,197,750		
Policy, planning, coordination & management of disease control programs>Non Service Delivery>Key Populations	$528,759		

Policy, planning, coordination & management of disease control programs>Non Service Delivery>Non-Targeted Populations	$2,829,359		
Procurement & supply chain management>Non Service Delivery>Non-Targeted Populations	$2,316,881	$2,445,813	$2,445,813
Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Key Populations		$2,100,000	$0
Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Non-Targeted Populations		$1,266,450	$1,231,450
Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Pregnant & Breastfeeding Women		$470,000	$0
C&T	**$86,589,343**	**$81,735,090**	**$81,305,090**
HIV Clinical Services>Non Service Delivery>Children	$409,837	$409,837	$409,837
HIV Clinical Services>Non Service Delivery>Key Populations		$348,979	$348,979
HIV Clinical Services>Non Service Delivery>Non-Targeted Populations	$4,828,338	$15,264,215	$15,264,215
HIV Clinical Services>Service Delivery>AGYW	$254,799	$780,592	$780,592
HIV Clinical Services>Service Delivery>Children	$4,667,230	$5,943,865	$5,543,865
HIV Clinical Services>Service Delivery>Key Populations	$2,612,297	$2,177,944	$2,177,944
HIV Clinical Services>Service Delivery>Non-Targeted Populations	$28,422,596	$24,499,330	$24,499,330
HIV Clinical Services>Service Delivery>OVC		$177,701	$177,701
HIV Clinical Services>Service Delivery>Pregnant & Breastfeeding Women	$324,468	$902,625	$872,625
HIV Drugs>Service Delivery>Children	$512,200	$39,033	$39,033
HIV Drugs>Service Delivery>Non-Targeted Populations	$16,780,080	$14,322,285	$14,322,285
HIV Laboratory Services>Non Service Delivery>Non-Targeted Populations	$4,768,962	$4,768,962	$4,768,962
HIV Laboratory Services>Service Delivery>Children	$359,840	$1,222,295	$1,222,295
HIV Laboratory Services>Service Delivery>Non-Targeted Populations	$8,432,924	$6,061,283	$6,061,283
HIV/TB>Service Delivery>Non-Targeted Populations		$4,816,144	$4,816,144
Not Disaggregated>Non Service Delivery>Children	$2,029,194		

Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$8,070,943		
Not Disaggregated>Service Delivery>AGYW	$2,826,519		
Not Disaggregated>Service Delivery>Non-Targeted Populations	$1,289,116		
HTS	**$8,010,988**	**$8,545,292**	**$7,645,292**
Community-based testing>Non Service Delivery>Non-Targeted Populations		$205,458	$205,458
Community-based testing>Service Delivery>AGYW	$107,250	$87,500	$87,500
Community-based testing>Service Delivery>Children		$480,000	$0
Community-based testing>Service Delivery>Key Populations		$65,000	$65,000
Community-based testing>Service Delivery>Non-Targeted Populations	$907,257	$2,236,410	$2,236,410
Facility-based testing>Service Delivery>AGYW		$87,500	$87,500
Facility-based testing>Service Delivery>Children		$420,000	$0
Facility-based testing>Service Delivery>Key Populations		$217,206	$217,206
Facility-based testing>Service Delivery>Non-Targeted Populations	$1,472,767	$4,552,898	$4,552,898
Facility-based testing>Service Delivery>Pregnant & Breastfeeding Women		$193,320	$193,320
Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$329,750		
Not Disaggregated>Service Delivery>Key Populations	$42,206		
Not Disaggregated>Service Delivery>Non-Targeted Populations	$5,151,758		
PM	**$31,488,243**	**$34,170,927**	**$34,151,270**
IM Closeout costs>Non Service Delivery>Non-Targeted Populations	$1,241,508	$1,037,577	$687,577
IM Program Management>Non Service Delivery>AGYW		$2,084,752	$2,234,752
IM Program Management>Non Service Delivery>Key Populations		$648,855	$698,855
IM Program Management>Non Service Delivery>Non-Targeted Populations	$22,084,486	$21,878,592	$22,028,592
USG Program Management>Non Service Delivery>Non-Targeted Populations	$8,162,249	$8,521,151	$8,501,494
PREV	**$36,357,102**	**$46,372,968**	**$45,372,968**

Comm. mobilization, behavior & norms change>Non Service Delivery>AGYW	$578,043		
Comm. mobilization, behavior & norms change>Service Delivery>AGYW	$3,364,704		
Comm. mobilization, behavior & norms change>Service Delivery>Key Populations	$1,126,000		
Condom & Lubricant Programming>Service Delivery>Non-Targeted Populations	$4,114,690	$4,067,487	$4,067,487
Non-Biomedical HIV Prevention>Non Service Delivery>AGYW		$2,395,984	$2,395,984
Non-Biomedical HIV Prevention>Non Service Delivery>Key Populations		$2,258,933	$1,258,933
Non-Biomedical HIV Prevention>Service Delivery>AGYW		$1,818,365	$1,818,365
Not Disaggregated>Non Service Delivery>AGYW		$800,000	$800,000
Not Disaggregated>Non Service Delivery>Non-Targeted Populations		$60,000	$60,000
Not Disaggregated>Service Delivery>AGYW	$1,056,000	$3,960,989	$3,960,989
Not Disaggregated>Service Delivery>Key Populations	$2,077,573	$2,592,043	$2,592,043
Not Disaggregated>Service Delivery>Non-Targeted Populations	$217,511	$217,511	$217,511
Not Disaggregated>Service Delivery>OVC	$483,600	$408,108	$408,108
PrEP>Non Service Delivery>AGYW		$437,500	$437,500
PrEP>Service Delivery>AGYW	$3,299,200	$2,880,767	$2,880,767
PrEP>Service Delivery>Key Populations	$3,048,495	$1,987,916	$1,987,916
PrEP>Service Delivery>Non-Targeted Populations	$710,930	$1,573,837	$1,573,837
Primary prevention of HIV and sexual violence>Non Service Delivery>AGYW	$1,271,250		
Primary prevention of HIV and sexual violence>Non Service Delivery>Key Populations	$348,979		
Primary prevention of HIV and sexual violence>Service Delivery>AGYW	$1,589,543		
Primary prevention of HIV and sexual violence>Service Delivery>Pregnant & Breastfeeding Women	$359,994		
VMMC>Non Service Delivery>Non-Targeted Populations	$471,680	$421,680	$421,680
VMMC>Service Delivery>Non-Targeted Populations	$12,238,910	$11,896,629	$11,896,629

Violence Prevention and Response>Non Service Delivery>AGYW		$4,367,555	$4,367,555
Violence Prevention and Response>Service Delivery>AGYW		$4,142,664	$4,142,664
Violence Prevention and Response>Service Delivery>Key Populations		$85,000	$85,000
SE	**$28,848,769**	**$21,919,958**	**$21,919,958**
Case Management>Service Delivery>OVC	$4,852,067	$6,030,259	$6,030,259
Economic strengthening>Non Service Delivery>OVC	$483,600	$90,264	$90,264
Economic strengthening>Service Delivery>Key Populations	$277,500	$521,520	$521,520
Economic strengthening>Service Delivery>OVC	$758,100	$1,091,663	$1,091,664
Education assistance>Service Delivery>AGYW	$5,812,653	$3,586,287	$3,586,287
Education assistance>Service Delivery>Key Populations	$160,000	$211,708	$211,708
Education assistance>Service Delivery>OVC	$3,734,400	$4,053,506	$4,053,505
Legal, human rights & protection>Service Delivery>OVC	$879,300		
Not Disaggregated>Service Delivery>AGYW	$2,014,000		
Not Disaggregated>Service Delivery>Non-Targeted Populations	$60,000		
Not Disaggregated>Service Delivery>OVC	$685,733		
Psychosocial support>Service Delivery>OVC	$1,059,001	$1,089,262	$1,089,262
Grand Total	**$203,800,000**	**$208,719,657**	**$203,800,000**

Table B.1.2: COP22, COP23/FY 24, COP 23/FY25 Budget by Program Area

Program	COP 2022	COP 2023	COP 2024
C&T	$86,589,343	$81,735,090	$81,305,090
HTS	$8,010,988	$8,545,292	$7,645,292
PREV	$36,357,102	$46,372,968	$45,372,968
SE	$28,848,769	$21,919,958	$21,919,958
ASP	$12,505,555	$15,975,422	$13,405,422
PM	$31,488,243	$34,170,927	$34,151,270
Grand Total	**$203,800,000**	**$208,719,657**	**$203,800,000**

Table B.1.3: COP22, COP23/FY 24, COP 23/FY25 Budget by Beneficiary

Targeted Beneficiary	COP 2022	COP 2023	COP 2024
AGYW	$31,762,126	$33,869,444	$34,019,444
Children	$7,978,301	$8,515,030	$7,215,030
Key Populations	$10,266,809	$13,664,549	$10,614,549
Non-Targeted Populations	$139,797,502	$137,888,927	$137,669,270
OVC	$13,310,800	$13,215,762	$13,215,762
Pregnant & Breastfeeding Women	$684,462	$1,565,945	$1,065,945
Grand Total	**$203,800,000**	**$208,719,657**	**$203,800,000**

Table B.1.4: COP22, COP23/FY 24, COP 23/FY25 Budget by Initiative

Initiative Name	COP 2022	COP 2023	COP 2024
Cervical Cancer	$4,350,000	$4,350,000	$4,350,000
Community-Led Monitoring	$1,179,262	$1,423,247	$1,423,247
Condoms (GHP-USAID Central Funding)	$3,800,000	$3,800,000	$3,800,000
Core Program	$125,982,466	$133,841,893	$133,772,236
DREAMS	$40,277,472	$34,594,387	$34,644,387
KP Survey		$2,100,000	$0
LIFT UP Equity Initiative		$2,800,000	$0
OVC (Non-DREAMS)	$13,210,800	$13,038,061	$13,038,061
VMMC	$15,000,000	$12,772,069	$12,772,069
Grand Total	**$203,800,000**	**$208,719,657**	**$203,800,000**

B.2 Resource Projections

The PEPFAR COP23 two-year notional budget for Zimbabwe is $412,519,657 – Year 1 being $208,719,657 and Year 2 being $203,800,000. Year 1 is inclusive of a KP Survey at $2,100,000 and LIFT funding at $2,800,000.

The PEPFAR Zimbabwe team started with prioritization exercises at the Johannesburg Co-Planning Meeting and continued them during a 2-day in-country Stakeholder's Retreat, that looked at the various sub-program areas under each of the pillars. In addition, local civil society groups presented their "Community COP" priorities during a February 28 meeting with the PEPFAR team and the Acting DCM.

The PEPFAR Zimbabwe TWGs took an activity-based approach to budgeting that started by identifying priority activities for the implementation of the 5x3 strategy. The TWGs took the priorities cited from the above meetings and the Community COP recommendations under

consideration when deciding on two-year budgets. TWGs looked for efficiencies through rigorous assessment of program costs, especially program management, non-service delivery costs and HRH costs, with the aim of improving cost effectiveness of ongoing interventions. In a flat-budget scenario, the team understood that any increases in one program area must be matched with an equal decrease in another area(s).

Further refinements and efficiencies were found by examining above-site investments in this flat budget year, while maintaining focus on pillar one activities (esp. 1st and 3rd 95s), ongoing peds assessments, laboratory systems strengthening and viral load. In addition, the Commodities TWG worked with the Global Fund and MoHCC counterparts on an assessment of Zimbabwe's commodities needs and gaps, and further determined how gaps will be closed to enable a fully funded commodity procurement plan.

PEPFAR Zimbabwe is aware that the macroeconomic environment remains significantly challenged, with high inflation rates, currency erosion, and stagnant economic growth for the foreseeable future. A flat budget in COP23/24 is equivalent to a decrease given the increasing costs of doing business. Meanwhile, the national HIV/AIDS program remains highly dependent on external resources for commodities, service delivery, human resources, and technical assistance for reaching and sustaining epidemic control. USG is already the largest donor to the health sector in Zimbabwe, including through our contributions to the Global Fund, making our combined efforts at sustainability all the more important.

APPENDIX C – Above site and Systems Investments from PASIT and SRE

Funding Agency	Sub-Program	Activity Category	COP 23 Beneficiary	Status of Activity	Short Activity Description	Gap Activity Will Address	Measurable Interim Output by end of FY24	Measurable Interim Output by end of FY25	Measurable Expected Outcome from Activity	Activity Budget	Budget Continuation for Year 2
HHS/CDC	Management of Disease Control Programs	Oversight, technical assistance, and supervision to subnational levels	Non-Targeted Populations	Support secondees and LOEs within MOHCC that are supporting EHR and CBS activities	Support secondees and LOEs within MOHCC that are supporting EHR and CBS activities	Lack of skilled human resources within MOHCC	Increased availability of competent staff within MOHCC to advance policy and program implementation activities	Increased availability of competent staff within MOHCC to advance policy and program implementation activities	Increased MOHCC ownership, accountability, and capacity to manage the national HIV response utilizing EHR and CBS	$700,000	$735,000
HHS/CDC	Surveys, Surveillance, Research, and Evaluation (SRE)	Evaluations	Non-Targeted Populations	Enhanced monitoring of CBS implementation to closely monitor achievement of workplan outcomes and timely institution of corrective action	Enhanced monitoring of CBS implementation to closely monitor achievement of workplan outcomes and timely institution of corrective action	Need for M&E to improve program implementation	1. Data on sites implementing case surveillance per standard 2. Data on number of testers and quality of testing at sites doing recency testing 3. Recommendations to improve case surveillance program	1. Data on sites implementing case surveillance per standard 2. Data on number of testers and quality of testing at sites doing recency testing 3. Recommendations to improve case surveillance program	Improved capacity to effectively use case surveillance data for public health action	$100,000	$97,183
HHS/CDC	Surveys, Surveillance, Research, and Evaluation (SRE)	Evaluations	Non-Targeted Populations	Enhanced monitoring of CBS implementation to closely monitor achievement of workplan outcomes and timely institution of corrective action	Enhanced monitoring of CBS implementation to closely monitor achievement of workplan outcomes and timely institution of corrective action	Need for M&E to improve program implementation	1. Data on user satisfaction and barriers and facilitators to optimum system usage 2. Recommendations to improve EHR program implementation	1. Data on user satisfaction and barriers and facilitators to optimum system usage 2. Recommendations to improve EHR program implementation	Increased usage, functionality, and availability of EHR system	$76,000	$73,859
HHS/CDC	Surveys, Surveillance, Research, and Evaluation (SRE)	Surveillance	Non-Targeted Populations	Implement cased based surveillance tracking newly identified cases including recent infection surveillance to provide longitudinal patient level records to understand HIV	Implement cased based surveillance tracking newly identified cases including recent infection surveillance to provide longitudinal patient level records to understand HIV trends among PLHIV;	Lack of surveillance data for response actions	Increased usage of case surveillance data with submission of 4 case surveillance quarterly reports by September 2025; Increase the proportion of PEPFAR C&T MER indicators that can be reported from	Improved data quality, completeness, accuracy of case surveillance data to within 5% acceptable variance by September 2024; Increase integration of national data repository with	Improved capacity of MOHCC to use case surveillance data and respond to signals effectively; Increased quality of care and health outcomes for HIV patients using	$1,066,450	$1,036,408

				trends among PLHIV; additional work in Impilo EHR to enhance system functionality, modules, & reports	additional work in Impilo EHR to enhance system functionality, modules, & reports		EHR to 100% by September 2024; Update 100% of the MOHCC HTS and ART Monthly Return Form summary indicators by September 2024	other systems to 100% with patient level data available timely within 1 month of a patient encounter	evidence-based decision making		
HHS/CDC	Surveys, Surveillance, Research, and Evaluation (SRE)	Surveys	Key Populations	Conduct KP survey	Conduct KP survey	Lack of sufficient data on KPs	Measuring the prevalence of HIV, associated risk behaviors, barriers & facilitators to prevention, care & treatment services among KP	Measuring the prevalence of HIV, associated risk behaviors, barriers & facilitators to prevention, care & treatment services among KP	Data available on KP for better programming of interventions	$2,100,000	
HHS/CDC	Health Management Information Systems (HMIS)	Workforce training in systems or processes	Non-Targeted Populations	Work with SI partner in conducting site level EHR and CBS-recency activities that include: - user trainings and mentorship - continuous data quality activities - provision of optimization materials (user guides, job aides, algorithms) to increase EHR usage and performance of CBS activities - supporting data use activities at subnational level	Work with SI partner in conducting site level EHR and CBS-recency activities that include: - user trainings and mentorship - continuous data quality activities - provision of optimization materials (user guides, job aides, algorithms) to increase EHR usage and performance of CBS activities - supporting data use activities at subnational level	Site level EHR system & CBS data usage	1. Proportion of sites implementing recency testing routinely 2. Proportion of sites implementing CBS 3. Proportion of sites with functional EHR that are using it for reporting	1. Proportion of sites implementing recency testing routinely 2. Proportion of sites implementing CBS 3. Proportion of sites with functional EHR that are using it for reporting	Improved EHR data quality and system usage; Improved usage of CBS data for public health action	$173,450	
HHS/CDC	Health Management Information Systems (HMIS)	Workforce training in systems or processes	Non-Targeted Populations	Work with SI partner in conducting site level EHR and CBS-recency activities that include: - user trainings and mentorship - continuous data quality activities -	Work with SI partner in conducting site level EHR and CBS-recency activities that include: - user trainings and mentorship - continuous data quality activities - provision of	Site level EHR system & CBS data usage	1. Proportion of sites implementing recency testing routinely 2. Proportion of sites implementing CBS 3. Proportion of sites with functional EHR that are using it for reporting	1. Proportion of sites implementing recency testing routinely 2. Proportion of sites implementing CBS 3. Proportion of sites with functional EHR that are using it for reporting	Improved EHR data quality and system usage; Improved usage of CBS data for public health action	$693,800	$693,800

				provision of optimization materials (user guides, job aides, algorithms) to increase EHR usage and performance of CBS activities - supporting data use activities at subnational level	optimization materials (user guides, job aides, algorithms) to increase EHR usage and performance of CBS activities - supporting data use activities at subnational level						
HHS/CDC	Management of Disease Control Programs	Oversight, technical assistance, and supervision to subnational levels	Non-Targeted Populations	Secondments to the MOHCC to support policy, planning and coordination of TB/HIV programs & strengthen private sector involvement in HIV and TB services provision through PPPs	Secondments to the MOHCC to support policy, planning and coordination of TB/HIV programs & strengthen private sector involvement in HIV and TB services provision through PPPs	Lack of managerial capacity and HRH	Number of secondees supported and actively supporting the HIV program	Number of secondees supported and actively supporting the HIV program	1. Improved planning, coordination, monitoring and management of HIV service delivery	$536,365	$536,365
HHS/CDC	Health Management Information Systems (HMIS)	Workforce training in systems or processes	Non-Targeted Populations	Work with SI partner in conducting site level EHR and CBS-recency activities that include: - user trainings and mentorship - continuous data quality activities - provision of optimization materials (user guides, job aides, algorithms) to increase EHR usage and performance of CBS activities - supporting data use activities at subnational level	Work with SI partner in conducting site level EHR and CBS-recency activities that include: - user trainings and mentorship - continuous data quality activities - provision of optimization materials (user guides, job aides, algorithms) to increase EHR usage and performance of CBS activities - supporting data use activities at subnational level	Site level EHR system & CBS data usage	1. Proportion of sites implementing recency testing routinely 2. Proportion of sites implementing CBS 3. Proportion of sites with functional EHR that are using it for reporting	1. Proportion of sites implementing recency testing routinely 2. Proportion of sites implementing CBS 3. Proportion of sites with functional EHR that are using it for reporting	Improved EHR data quality and system usage; Improved usage of CBS data for public health action		
USAID	Management of Disease Control Programs	Oversight, technical assistance, and	AGYW	USAID RISE Activity assists the District AIDS Committee (DAC) to coordinate	USAID RISE Activity assists the District AIDS Committee (DAC) to coordinate	Lack of technical capacity	DREAMS program is well coordinated, and performance	DREAMS program is well coordinated, and performance	DREAMS program is well coordinated, and performance	$467,500	$467,500

		supervision to subnational levels		DREAMS activities (drafting integrated workplans, facilitate referral meetings, monthly/quarterly progress monitoring meetings). The RISE Activity is responsible for 9 of the 12 DREAMS districts.	DREAMS activities (drafting integrated workplans, facilitate referral meetings, monthly/quarterly progress monitoring meetings). The RISE Activity is responsible for 9 of the 12 DREAMS districts.		reviewed regularly at district level	reviewed regularly at district level	reviewed regularly at district level		
USAID	Management of Disease Control Programs	Oversight, technical assistance, and supervision to subnational levels	AGYW	USAID SMART Girls Activity assists the District AIDS Committee (DAC) to coordinate DREAMS activities (drafting integrated workplans, facilitate referral meetings, monthly/quarterly progress monitoring meetings). The SMART Activity is responsible for 3 of the 12 DREAMS districts.	USAID SMART Girls Activity assists the District AIDS Committee (DAC) to coordinate DREAMS activities (drafting integrated workplans, facilitate referral meetings, monthly/quarterly progress monitoring meetings). The SMART Activity is responsible for 3 of the 12 DREAMS districts.	Lack of technical capacity	DREAMS program is well coordinated, and performance reviewed regularly at district level	DREAMS program is well coordinated, and performance reviewed regularly at district level	DREAMS program is well coordinated, and performance reviewed regularly at district level	$250,000	$250,000
USAID	Procurement & supply chain management	Forecasting, supply chain plan, budget, and implementation	Non-Targeted Populations	Procurement and Supply Chain Management staff secondments for national quantification, supply planning, incountry commodity logistics. The project is supporting the Logistics Unit which is a key unit in managing the coordination of	Procurement and Supply Chain Management staff secondments for national quantification, supply planning, incountry commodity logistics. The project is supporting the Logistics Unit which is a key unit in managing the coordination of supply chain	Lack of technical capacity	Stockout rates of HIV commodities maintained below 5%	Stockout rates of HIV commodities maintained below 5%	Stockout rates of HIV commodities maintained below 5%	$1,445,813	$1,445,813

				supply chain activities in the country.	activities in the country.						
USAID	Management of Disease Control Programs	Oversight, technical assistance, and supervision to subnational levels	Non-Targeted Populations	Secondments to support the MOHCC: National ART Coordinator/Deputy Director AIDS & TB Unit, Deputy National ART Coordinator, National ART Officer, Deputy National PMTCT Coordinator, National PMTCT Training Officer, Senior M&E Officer, M&E Officer, Data Officer and admins.	Secondments to support the MOHCC: National ART Coordinator/Deputy Director AIDS & TB Unit, Deputy National ART Coordinator, National ART Officer, Deputy National PMTCT Coordinator, National PMTCT Training Officer, Senior M&E Officer, M&E Officer, Data Officer and admins.	Lack of technical capacity	National HIV program is well coordinated, and performance reviewed regularly	National HIV program is well coordinated, and performance reviewed regularly	National HIV program is well coordinated, and performance reviewed regularly	$769,593	$769,593
USAID	Health Management Information Systems (HMIS)	Systems development, operations, and maintenance	OVC	Maintain and upgrade OVC MIS to account for changes to OVC programming; provide training and TA on OVC SI and MIS use to OVC partners; conduct DQAs; TA for OVC reporting; and update OVC SI documents (SOPs, protocols, guidance, etc.)	Maintain and upgrade OVC MIS to account for changes to OVC programming; provide training and TA on OVC SI and MIS use to OVC partners; conduct DQAs; TA for OVC reporting; and update OVC SI documents (SOPs, protocols, guidance, etc.)	Lack of technical capacity	High quality DREAMS program data is used for quality improvement and program decision making	High quality DREAMS program data is used for quality improvement and program decision making	High quality OVC program data is used for quality improvement and program decision making	$274,999	$274,999
USAID	Management of Disease Control Programs	National strategic plans, operational plans and budgets	Non-Targeted Populations	HIV Program sustainability planning including domestic resource mobilization	HIV Program sustainability planning including domestic resource mobilization	Lack of technical capacity	1) Draft Roadmap developed which identifies critical opportunities and challenges, prioritizes short-, medium- and long-term areas for transition; and identifies key	1) Draft Roadmap developed which identifies critical opportunities and challenges, prioritizes short-, medium- and long-term areas for transition; and identifies key	1) Draft Roadmap developed which identifies critical opportunities and challenges, prioritizes short-, medium- and long-term areas for transition; and identifies key capacity,	$150,000	$150,000

							capacity, policy/legal and financial needs.	capacity, policy/legal and financial needs.	policy/legal and financial needs.		
USAID	Procurement & supply chain management	Forecasting, supply chain plan, budget, and implementation	Non-Targeted Populations	Supply Chain Incoutry Logistics and Technical Assistance	Supply Chain Incoutry Logistics and Technical Assistance	Lack of technical capacity	Stockout rates of HIV commodities maintained below 5%	Stockout rates of HIV commodities maintained below 5%	Stockout rates of HIV commodities maintained below 5%	$1,000,000	$1,000,000
USAID	Health Management Information Systems (HMIS)	Systems development, operations, and maintenance	AGYW	HMIS: Upgrade DREAMS layering database to account for changes to DREAMS programming; provide training and TA on DREAMS SI and database use to DREAMS partners; conduct DQAs; TA for DREAMS reporting; and leading development of program and SI documents (SOPs, protocols, guidance, layering tables, etc.)	HMIS: Upgrade DREAMS layering database to account for changes to DREAMS programming; provide training and TA on DREAMS SI and database use to DREAMS partners; conduct DQAs; TA for DREAMS reporting; and leading development of program and SI documents (SOPs, protocols, guidance, layering tables, etc.)	Lack of technical capacity	High quality DREAMS program data is used for quality improvement and program decision making	High quality DREAMS program data is used for quality improvement and program decision making	High quality DREAMS program data is used for quality improvement and program decision making	$318,750	$318,750
USAID	Management of Disease Control Programs	Oversight, technical assistance, and supervision to subnational levels	AGYW	Secondment of MOHCC and NAC DREAMS Coordinators. The two positions are responsible for leading internal/external DREAMS coordination meetings, quarterly progress monitoring and reporting, quarterly supportive supervision visits to districts, The MOHCC	Secondment of MOHCC and NAC DREAMS Coordinators. The two positions are responsible for leading internal/external DREAMS coordination meetings, quarterly progress monitoring and reporting, quarterly supportive supervision visits to districts, The MOHCC Coordinator also provides TA to the	Lack of technical capacity	1.) National level DREAMS meetings are facilitated by MOHCC and NAC Coordinator (100% of quarterly meetings take place); 2.) PEPFAR supported DREAMS activities are incorporated in MOHCC quarterly prevention partnership meetings; 3.) secondments act as PoC for all PEPFAR learning visits; 4.)	1.) National level DREAMS meetings are facilitated by MOHCC and NAC Coordinator (100% of quarterly meetings take place); 2.) PEPFAR supported DREAMS activities are incorporated in MOHCC quarterly prevention partnership meetings; 3.) secondments act as PoC for all PEPFAR learning visits; 4.)	1.) National level DREAMS meetings are facilitated by MOHCC and NAC Coordinator (100% of quarterly meetings take place); 2.) PEPFAR supported DREAMS activities are incorporated in MOHCC quarterly prevention partnership meetings; 3.) secondments act	$157,250	$157,250

				Coordinator also provides TA to the MOHCC's PrEP program for AGYW.	MOHCC's PrEP program for AGYW.		monitoring visits are conducted at least quarterly	monitoring visits are conducted at least quarterly	as PoC for all PEPFAR learning visits; 4.) monitoring visits are conducted at least quarterly		
USAID	Management of Disease Control Programs	Oversight, technical assistance, and supervision to subnational levels	Key Populations	Secondment of Key Populations Technical Steering Committee (TSC) to the MOHCC. TSC positions include: Clinical Officer, Communications Officer, and Monitoring and Evaluation Officer	Secondment of Key Populations Technical Steering Committee (TSC) to the MOHCC. TSC positions include: Clinical Officer, Communications Officer, and Monitoring and Evaluation Officer	Lack of technical capacity	1) Key secondments in place and holding monthly and quarterly coordination meeting, 2) conducting regular supportive and supervision visits to districts, 3) submitting timely reports, 4) providing sound technical program direction	1) Key secondments in place and holding monthly and quarterly coordination meeting, 2) conducting regular supportive and supervision visits to districts, 3) submitting timely reports, 4) providing sound technical program direction	1) Key secondments in place and holding monthly and quarterly coordination meeting, 2) conducting regular supportive and supervision visits to districts, 3) submitting timely reports, 4) providing sound technical program direction	$449,445	$449,445
USAID	Management of Disease Control Programs	Oversight, technical assistance, and supervision to subnational levels	Non-Targeted Populations	Secondment of National HIV Prevention Coordinator and National Advocacy and Communications Manager to MOHCC	Secondment of National HIV Prevention Coordinator and National Advocacy and Communications Manager to MOHCC	Lack of technical capacity	1) Key secondments in place and holding monthly and quarterly coordination meeting, 2) conducting regular supportive and supervision visits to districts, 3) submitting timely reports, 4) providing sound technical program direction	1) Key secondments in place and holding monthly and quarterly coordination meeting, 2) conducting regular supportive and supervision visits to districts, 3) submitting timely reports, 4) providing sound technical program direction	1) Key secondments in place and holding monthly and quarterly coordination meeting, 2) conducting regular supportive and supervision visits to districts, 3) submitting timely reports, 4) providing sound technical program direction	$145,000	$145,000
USAID	Human resources for health	Pre-service training	Non-Targeted Populations	National HRH Inservice Training Capacity Development	National HRH Inservice Training Capacity Development	Lack of technical capacity	1) Inservice training capacity building plans developed 2) Inservice training curriculum updated	1) Inservice training capacity building plans developed 2) Inservice training curriculum updated	1) Inservice training capacity building plans developed 2) Inservice training curriculum updated	$1,000,000	$1,000,000