The Global Fund
To Fight AIDS, Tuberculosis and Malaria

STANDARD CONCEPT NOTE

Investing for impact against HIV, tuberculosis or malaria

A concept note outlines the reasons for Global Fund investment. Each concept note should describe a strategy, supported by technical data that shows why this approach will be effective. Guided by a national health strategy and a national disease strategic plan, it prioritizes a country's needs within a broader context. Further, it describes how implementation of the resulting grants can maximize the impact of the investment, by reaching the greatest number of people and by achieving the greatest possible effect on their health.

A concept note is divided into the following sections:

Section 1: A description of the country's epidemiological situation, including health systems and barriers to access, as well as the national response.

Section 2: Information on the national funding landscape and sustainability.

Section 3: A funding request to the Global Fund, including a programmatic gap analysis, rationale and description, and modular template.

Section 4: Implementation arrangements and risk assessment.

IMPORTANT NOTE: **Applicants should refer to the Standard Concept Note Instructions to complete this template.**

SUMMARY INFORMATION			
Applicant Information:			
Country	**ZIMBABWE**	**Component**	**Malaria**
Funding Request Start Date	**JANUARY 1, 2015**	**Funding Request End Date**	**DECEMBER 31, 2017**
Principal Recipient(s)	**MINISTRY OF HEALTH AND CHILD CARE**		

Funding Request Summary Table

A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including the disease epidemiology, the health systems and community systems setting, and the human rights situation. This description is critical for justifying the choice of appropriate interventions.

1.1 Country Disease, Health and Community Systems Context

With reference to the latest available epidemiological information, in addition to the portfolio analysis provided by the Global Fund, highlight:

a. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.
b. Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality.
c. Key human rights barriers and gender inequalities that may impede access to health services.
d. The health systems and community systems context in the country, including any constraints.

2-4 PAGES SUGGESTED

a. Malaria in Zimbabwe is undergoing an epidemiological transition. Transmission is heterogeneous and largely unstable, and transmission intensity ranges significantly; low lying districts to the east and north of the country experience moderate to high malaria transmission, while southern and central districts experience little to no malaria transmission.

Over the last 10 years, the country has recorded a steady annual decline in malaria morbidity, from an annual incidence of 155 cases per 1,000 in 2003, to 29 cases per 1,000 by the end of 20123[1] Malaria deaths have declined from an average of 3,000 deaths per year in the early 2000s to about 300 deaths in recent years. A marked decline in malaria burden has been seen in southern and central parts of the country. Incidence in some of the central regions now ranges between 0 and 3 cases per 1,000 population; in Matabeleland South Province specifically, incidence is less than 1 per 1,000, which suggests that the province should transition from control to the implementation of (pre-)elimination interventions. However, a greater proportion of the disease burden is concentrated and remains high in some districts (68 – 195 cases per 1,000 population); these districts are found along the border with Mozambique (to the east) and Zambia (to the north). The importation of malaria transmission from Zimbabwe's more malarious neighbours to the east and the north now contributes to persisting transmission in the border districts; poor access to health services in border districts also contributes to higher disease burden.

The patterns and seasonality of malaria transmission are primarily determined by rainfall (November to May); transmission peaks with the rainy season, and outbreaks are common between February and April. An estimated 50% of the population lives in transmission risk areas (a slight decline in the last few years). While all age groups are considered at risk of malaria, pregnant women, children under the age of five years, the malnourished as well as the immune-compromised have the highest risk of developing severe disease.

Figure 1 below illustrates the changes in epidemiology experienced in recent years.

[1] Ministry of Health and Child Care (MOHCC), 2013: Health Management Information System (HMIS).

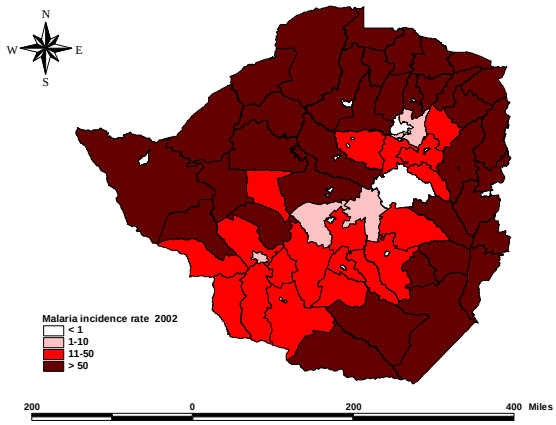
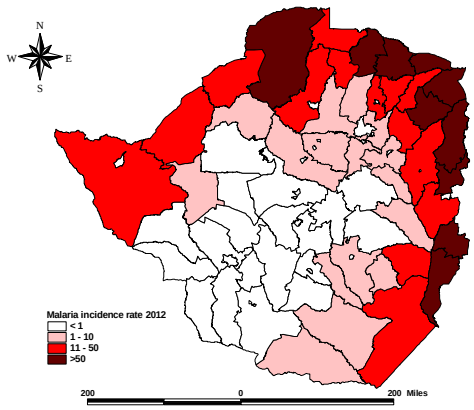
A. Malaria incidence 2002	B. Malaria incidence 2012
	

Figure 1: Evolving distribution of malaria transmission: 2002 and 2012

In addition to the evolving epidemiology of malaria, and the evolving pattern of the vector's distribution, as outlined below, there is need for a tailored approach to the vector control strategy, and enhanced efforts in routine entomological surveillance, as well as understanding of the efficacy of vector control strategies.

Anopheles arabiensis is the major vector for malaria transmission. Given that this vector rests both outdoors and indoors, and feeds on both humans and animals, it is difficult to eliminate this vector through indoor residual spraying (IRS). Recent entomological data also reveals the re-emergence of *Anopheles funestus* in Manicaland Province which borders with Mozambique (currently confirmed in Mutare and Mutasa districts, with additional surveys planned).[2] . In studies conducted in 2005[3] *Anopheles funestus* was only found in one lowveld district in Zimbabwe, suggesting that it had been driven out in areas where DDT was widely used, though not in most districts of Manicaland Province. It is also understood that An. *funestus* is prevalent in bordering Mozambique, where IRS is not done routinely, raising the suspicion that it may have migrated over the years to Zimbabwe (Manicaland).

An. funestus rests indoors, which makes it an easier target for effective vector reduction through IRS or long-lasting insecticide treated nets (LLINs). However this vector is demonstrating resistance to pyrethroids and carbamates, but remains susceptible to DDT, and organophosphates.

The predominant malaria parasite in Zimbabwe is *Plasmodium falciparum* which, is estimated to account for 98% of malaria cases; *Plasmodium ovale* and *Plasmodium malariae* account for the remaining cases. The first line treatment for uncomplicated malaria in Zimbabwe is currently Artmether-Lumefantrine (AL), while the second line is oral quinine; however, the country is currently planning the introduction of a second-line ACT treatment to gradually replace oral quinine. Therapeutic efficacy testing has been periodically carried out in Zimbabwe; the latest survey (2010) showed an overall treatment failure of only 3.3%[4].

The sustained and intensified scale up of malaria control interventions, guided by global guidance

[2] MOHCC, Abt Associates, 2014: Report on Insecticide Resistance Monitoring in Burma Valley (Mutare) and Honde Valley (Mutasa), Manicaland Province. pg.3 (Annex 18)

[3] Masendu et al (2005).Spatial and temporal distributions and insecticide susceptibility of malaria vectors in Zimbabwe, *African Entomology, vol 13, Issue 1* pg. 30 (Annex 33)

[4] Zimbabwe Therapeutic Efficacy Testing 2010, Report. However PCR methods were not used for this and previous years due to the non-availability of back up for the PCR. This year, therapeutic efficacy testing (TET) is currently being carried out and it is hoped that this time around, PCR correction will be carried out. pg.7 (Annex 3)

and use of proven tools, has resulted in a marked decline in malaria incidence, particularly between 2004 and 2012 (*See Figure 2* below). The introduction of malaria community case management in 2011, and training of community based health workers (CBHWs) on malaria diagnostics and treatment has significantly improved access to malaria treatment at community level.

The initial scale up of control interventions was made possible by increased funding from the Global Fund; the subsequent introduction of support and funding from the President's Malaria Initiative (PMI) in 2011, further expanded the reach and coverage of the control effort.

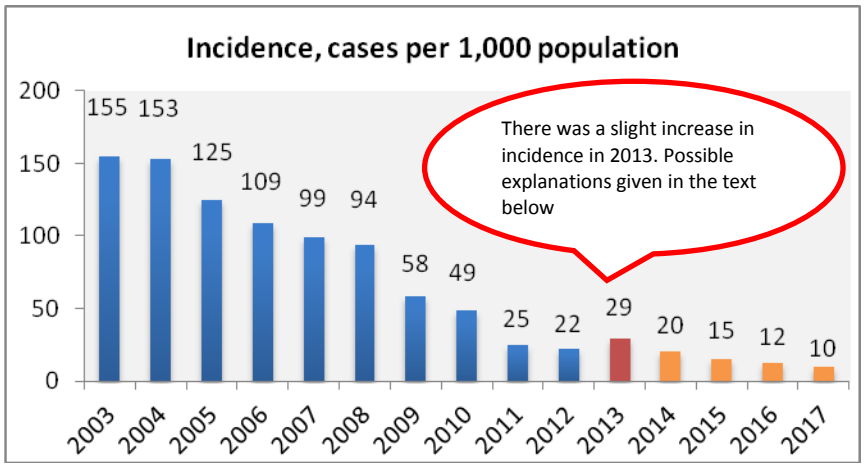


Figure 2: Zimbabwe malaria incidence, actual: 2003 - 2013, projected 2014 - 2017. Source, HMIS

An increase in incidence was noted in 2013 (largely driven by increases in cases along the Mozambique border), slightly reversing the strong gains that the country was making towards its 2015 goal of 15 cases per 1,000. The National Malaria Control Programme (NMCP) has investigated the reasons for the increase in this area, and engaged partner support in rapidly identifying the risks to continued increases and instituting robust measures to identify and rapidly respond to epidemics. The reasons for this increase were identified as a lack of vector control in rural service centres (which have urban infrastructure) where malaria transmission is known to occur, and sub-optimal outbreak detection and response, particularly because of limited reach of community case management and community mobilization to contain outbreaks.

In order to verify the true nature and drivers of the apparent decline in transmission, the NMCP and WHO collaborated on a rapid impact assessment exercise (RIA)[5] to determine the impact of the scale up interventions on transmission trends, as well as on disease burden and mortality. Using retrospective surveillance data (2003 to 2012) from a sample of health facilities, the impact assessment exercise concluded that the decline in malaria inpatient admissions and deaths was seen after the shift from chloroquine to its combination with SP, and the introduction of ITNs; however, a more dramatic decline resulted after the mass distribution of LLINs to the general population, as well as the introduction of ACTs in the public sector in 2008. *Figure 3* below highlights the declining contribution of malaria to all-cause outpatient mortality. Today, malaria is the 5th leading cause of morbidity (compared to 2nd leading cause in 2008). Declines in malaria admissions and deaths were significant in the high transmission areas compared to the low transmission areas. The assessment exercise also concluded that sustaining the gains which Zimbabwe has seen is dependent on sustained coverage of control interventions, and strengthened surveillance.

[5]Mberikunashe J, and Aregawi M, 2013. (Rapid Impact Assessment). *Antimalarial interventions and trends of malaria cases and deaths in hospitals, 2003-2012*, Zimbabwe (unpublished). pg.18 (Annex 4)

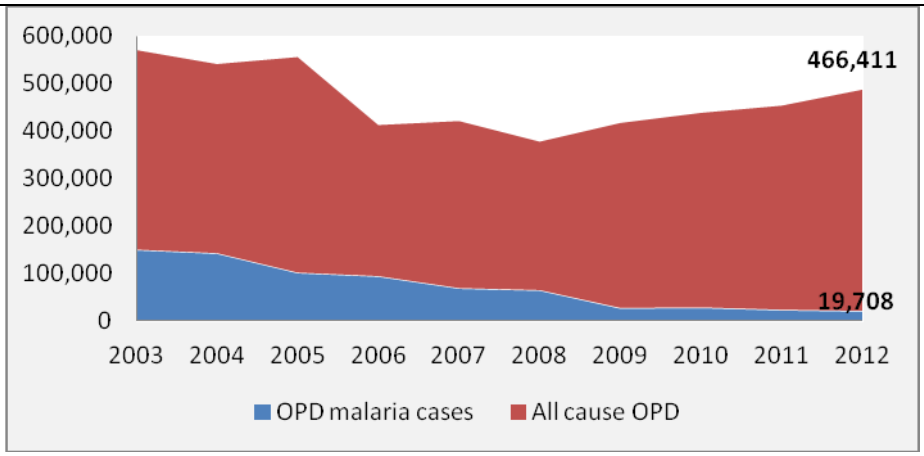


Figure 3: Declining contribution of malaria to all-cause outpatient morbidity. Source: Rapid Impact Assessment 2013.

b. As Zimbabwe continues to control malaria and suppress transmission, a transition has also been seen in the populations considered most vulnerable. This transition has also been in line with trends in other countries where adults (and men in particular) represent a greater proportion of cases (due to both the changing immunity and outdoor exposure) than they have in previous years when transmission was higher. Pregnant women and children continue to be considered the most vulnerable populations, but the malaria response will also evolve to consider the vulnerability to infection by outdoor workers (farming and mining communities), cross-border populations with limited access to health services, as well as the military.

c. The programming of malaria control in Zimbabwe is in line with national health policies on equitable access for all populations (universal access); malaria prevention and treatment services do not pose access challenges along lines of human rights or gender.

d. Key health systems and community issues serving as constraints to malaria are as follows:

Human Resources for Health: Malaria programme management is situated within the national health delivery system, which has structures from the national, provincial, district, health facility and community levels. Zimbabwe continues to face critical shortages of human resources for health; this was initially driven by high rates of migration to neighbouring countries, although the rate of migration to neighbouring countries has declined over the past few years. However, low wages in the public sector still contribute to movement of health workers from public to private sectors within the country. The ratio of 7.2 nurses per 10,000 population, and 12.3 health workers per 10,000 prevails in the public sector.[6] A 2010 assessment estimated that the health system is operating at 57% of staffing capacity, leaving existing healthcare workers overburdened, and facing multiple priority programs and interventions. In Zimbabwe's malaria case management strategy, there is a need to strengthen parasitological confirmation and provide support for differential diagnosis, while also introducing new treatment guidelines (additional ACT as second-line, IV-artesunate for severe malaria, and primaquine in elimination districts). As the workload on health workers increases, more responsibilities for case finding and case management will be transitioned to CBHWs (referred to as 'village health workers in Zimbabwe'. CBHWs have already begun to diagnose malaria using RDTs, and to treat with ACTS in most districts; however, the training of these cadres needs to continue and to be strengthened to optimize the numbers and reach of this cadre, and to achieve optimal case management coverage. Although the private sector gets updates on malaria policy issues, they are not supplied with public sector malaria commodities(RDTs and ACTs) which are intended for free distribution. Mechanisms to ensure there is no resale of free public sector commodities are in the early stages of development

[6] Ministry of Health and Child Care (MOHCC), 2009. National Health Strategy, 2009 – 2013. Equity and Quality in Health: A People's Right. pg96 (Annex 5)

***Quantification, Procurement and Supply Chain*:** Procurement, storage, and distribution of commodities in Zimbabwe are primarily managed by the National Pharmaceutical Company of Zimbabwe (NatPharm) – a parastatal organization. However, under additional safeguard measures, the procurement systems had been managed by the PR (UNDP). UNDP uses international procurement systems, which has caused challenges with delays of ordering and arrival of shipments. MOHCC leads quantification and forecasting of commodities in collaboration with implementing partners; quantification is informed by both morbidity and consumption data. Following quantification, procurement is managed in collaboration with the Government Tender Board. Antimalarial medicines and test-kits are distributed through the Zimbabwe Informed Push System (ZIP) – introduced as a response to economic and health system challenges in 2007 and 2008. The main objective of the system is to ensure timely delivery of commodities, as well as collection of essential logistics data. However, the system has resulted in health facilities not having full ownership over stock management, stockouts and losses due to expiry. Given these challenges, a new pull system is being reintroduced – Zimbabwe Assisted Pull System (ZAPS) – to allow greater ownership of stock management as well as to introduce cost-efficiency to the distribution system. This system will allow health staff and the district to collect their own consumption data and to use it for their decision-making, unlike the current situation where data is collected from the central level.

Sustainable Health Financing: Financing of the health system also remains a challenge. Zimbabwe is currently developing a National Health Financing Policy to guarantee access to a universal minimum health care package in an equitable manner. The NMCP will engage with the process to ensure the inclusion of malaria treatments and services as part of this policy, further supporting equitable access to malaria treatment.

Data, M&E: The National Monitoring and Evaluation Plan (M&E Plan) guides the monitoring of the National Malaria Strategic Plan. The routine reporting (monthly and weekly) is directly linked to the national Health Management Information System (HMIS) of the MOHCC. Routine reporting is decentralized, and data is reported from the primary source (health facilities) through Frontline SMS (weekly disease surveillance reporting) and a paper-based T5 (monthly reporting). The monthly reports are aggregated at district and province levels and transmitted electronically to the national level using the District Health Information System (DHIS, version 1.4) adapted in 2010, and later DHIS-2, which was adopted in 2012 and rolled out throughout the country in 2013. Following the adoption of the DHIS-2 database and Frontline SMS, the completeness and timeliness of the monthly and weekly disease surveillance reporting have improved significantly from around 50% in 2010 to above 90% in 2013. All rural and mission hospitals, districts offices and provincial offices were given laptops to improve data capturing form the lower levels. All the health facilities have been equipped with mobile phones for the frontline SMS. The CBHWs capture their data into a register, which they present to the health facility on a monthly basis for consolidation into a clinic report and resupply. Community reporting has now been integrated into DHIS-2 as a separate reporting system.

Data to assess the impact of the programme is derived from the Malaria Indicator Survey (conducted every 2 years), the Demographic and Health Surveys (conducted every 5 years) and the recently conducted Malaria Rapid Impact Assessment (RIA).
Some of the noted limitations of the sources of data relate to poor data quality; this has been due to the following:

- inadequate funding to train health care workers at the facility level on the proper use of new and revised data collection and reporting tools
- inadequate supervision and mentorship regarding data quality
- inability to publish the National Health Profile annually
- non-integration of vector control data into the HMIS
- non-disaggregation on community data (particularly case management) by the HMIS

1.2 National Disease Strategic Plans

With clear references to the current **national disease strategic plan(s)** and supporting documentation (include the name of the document and specific page reference), briefly summarize:

a. The key goals, objectives and priority program areas.
b. Implementation to date, including the main outcomes and impact achieved.
c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed.
d. The main areas of linkage to the national health strategy, including how implementation of this strategy impacts relevant disease outcomes.
e. For standard HIV or TB funding requests[7], describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes.
f. Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged.

4-5 PAGES SUGGESTED

a. The strategic direction of the current malaria control effort is based on the National Malaria Strategic Plan (NMSP, 2008 to 2015, extended to 2017). (The NMSP was originally developed for the period 2008 to 2015 (Annex 1), and was extended to cover the period up to 2017 (Annex 2), pending development of a new Strategic Plan.

Evolving Disease Patterns and Strategy

In response to the changing epidemiology and transmission patterns, Zimbabwe's malaria control strategy is similarly evolving, while also aiming to effectively manage risks to resurgence and reduced efficacy of current tools (i.e. emerging insecticide resistance and changing vector patterns [*see vector control section below*]). The NMSP interventions included in the extension of the strategic plan to 2017 build on the current strategies and the current gains in malaria control, while reaching for higher coverage targets, greater effectiveness of interventions, and ultimately greater impact. Zimbabwe aims to have reduced transmission from 22 per 1,000 in 2012, to 10 per 1,000 in 2017, while deaths are targeted at near zero. Currently, 7 of the 62 districts in the country are implementing malaria pre-elimination activities; in line with regional elimination ambitions, Zimbabwe also aims to expand the districts implementing pre-elimination/elimination strategies to 20 (approximately one-third of the country) by 2017.

The overarching goal of the strategic plan is: ***To reduce malaria incidence from 22/1000 in 2012 to 10/1000 in 2017 and malaria deaths to near zero by 2017.***

The following table summarizes the specific objectives of the current strategy, and any variations in strategy for different epidemiological zones.

Strategic Objective	Low-to-no transmission 16 districts (including urban metropolitan areas), 49% of pop	Moderate-to-high transmission 47 districts, 51% of pop

[7] Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB.

To ensure universal access of the population at risk to effective and appropriate malaria prevention interventions by 2017	No mass LLIN distribution No IRS Larval source management	Routine LLIN in ANC and EPI for PW and children <5 Mass LLIN distribution through campaigns IRS **in targeted wards of the 47 districts**, based on previous transmission patterns and incidence data Larval source management in selected areas
To ensure universal access to prompt and appropriate management of all malaria cases within 24 hours of onset of symptoms by 2017	Parasitological confirmation of all cases through RDT First line uncomplicated malaria – ACT Second line uncomplicated malaria: current transition from oral quinine to artesunate-amodiaquine Severe malaria: current transition from IV quinine to IV artesunate Pre-referral severe malaria: artesunate suppositories Single low-dose primaquine with ACT (to be introduced in 2014)	Parasitological confirmation of all cases through RDT First line uncomplicated malaria – ACT Second line uncomplicated malaria: current transition from oral quinine to artesunate-amodiaquine Severe malaria: current transition from IV quinine to IV artesunate Pre-referral severe malaria: artesunate suppositories
To detect 100% of epidemics within one week of onset and effectively manage 100% of malaria epidemics within two weeks of detection.	National HIS (currently under transition to electronic DHIS-2 monthly reporting) Weekly reporting of cases and use of thresholds to detect epidemics. Electronic reporting of all malaria patients through malaria notification form within 24h Active case investigation and active contact screening of household members within 3 days	National HIS (currently under transition to electronic DHIS-2 monthly reporting) Weekly reporting of cases, and use of thresholds to detect epidemics
To expand districts implementing pre-elimination activities from 7 to 20 by 2017.		
To strengthen monitoring and improve evaluation of malaria activities at all levels by 2017.		
To expand and maintain strong multi-sectorial partnerships for effective programme management and coordination by 2017		

Vector Control

IRS remains the primary vector control strategy in Zimbabwe and will be implemented in the 47 districts with ongoing malaria transmission. As per the WHO Global Plan for Insecticide Resistance Management in malaria vectors, Zimbabwe's strategy will include rotations of all four recommended classes of insecticides. Due to limited resources, the initial switch from pyrethroids to organophosphates will be carried out in only 4 of the border districts where An. *funestus* is showing resistance to pyrethroids and carbamates. During the following year, the number of

districts using the same effective insecticide will increase by 13 in order to effectively deal with resistant mosquito populations (with a total of 17 districts using organophosphates). During this period, entomological surveillance will be strengthened in these areas to inform future decisions. Susceptibility testing of mosquitoes was previously conducted but had been stopped due to resource limitations; however, there are now plans to reintroduce it bi-annually, starting in the 3rd quarter of 2014.

The Zimbabwe Malaria Strategic Plan, which is guided by global guidance on strategies for effectively reducing transmission, aims to **achieve universal preventive coverage in all moderate to high transmission areas** (47 districts, 50% of the population) with indoor residual house spraying. Zimbabwe has been implementing both IRS and LLINs in 30 districts (although not always overlapping in the same wards) targeting universal coverage for both. Mass distribution of LLINs in 47 districts is targeted for 2016 to enable synchronization of mass distribution following distributions in 2013 and 2014. Given the scarcity of resources, the programme will optimize targets by prioritizing LLINs for pregnant women, children under 5, and the immune-compromised through routine distribution mechanisms in these 47 districts in 2014 and 15. Given emerging insecticide resistance, nets which are impregnated with pyrethroids will only serve as barriers, especially in the areas where pyrethroid resistance has been confirmed. Beyond 2016, it is anticipated that IRS with an effective insecticide(as guided by an insecticide resistance management plan) will be the main intervention of choice in the moderate to high transmission areas, with LLINs restricted to routine outlets for special populations. In the (pre-) elimination areas the role of IRS will be limited to outbreak control whilst LLINs will serve as the main prevention tool. In addition larval source management will become more important in areas where breeding sites are few, fixed and findable.

Diagnosis and Treatment

Zimbabwe's malaria case management strategy aims to promptly manage malaria illness and to reduce its contribution to all-cause morbidity and mortality. All suspected cases should receive parasitological confirmation through RDTs in all health facilities and by CBHWs, whilst all admitting facilities should carry out slide microscopy in addition to RDTs. In pre-elimination areas, all RDT-positive cases will be confirmed by slide microscopy. First line treatment of confirmed cases is AL. Currently, oral quinine is the second line treatment but this will change with the introduction of a second artmesinin-based combination therapy, namely Artesunate-Amodiaquine (ASAQ). In addition, **radical cure of infections in (pre)elimination areas through the use of single low dose primaquine** will be introduced**.** Given the evidence on the enhanced efficacy of **IV-artesunate** over quinine as treatment for severe malaria, case management guidelines will also be adapted to introduce this new treatment, while pre-referral artesunate suppositories (particularly at community level) will be used. CBHW training will continue, with support from Global Fund and the Presidents Malaria Initiative (PMI).

In Zimbabwe, malaria mainly affects the rural communities; in the rural setup, more than 90% of health facilities are public sector facilities. For this reason, the malaria treatment strategies are centered on the public health sector, with no specific strategies to target the private sector. However, efforts are underway to update private practitioners on evolving treatment policies, and the NMCP is planning to develop systems for reporting of cases through the private sector.

Surveillance, EPR

In response to outbreaks and the threat of resurgence in areas where malaria transmission has been successfully suppressed, the NMCP aims to **strengthen surveillance and outbreak response**, while strengthening the coverage of **CBHWs to support case finding** and treatment at community level. In Zimbabwe's context (i.e. heterogeneous distribution of moderate-high and low transmission areas, combined with long porous borders with more highly endemic countries), surveillance will play an increasingly important role in **identifying foci of transmission, and rapidly responding** in order to limit onward transmission. Active case investigation and active detection

(which are currently implemented in one province) will be expanded to additional low transmission districts based on evidence of the technical and operational feasibility to implement these activities. This will enable the identification of more malaria cases (particularly those that may be asymptomatic) and effective treatment to limit onward transmission. With the recent rollout of the electronic DHIS-2 across the health system, more timely and complete data will be received and available at provincial and national levels to support more frequent analysis of incidence and to support outbreak monitoring. Data from the CBHW on malaria community case management will be incorporated into DHIS2. Electronic reporting of indoor residual spraying activities and mapping of sprayed households (which has already begun) will continue to be used to effectively monitor coverage, as well as to enhance supervision and the quality of spraying.

Social Behaviour Change and Communication

As IRS activities are dependent upon community acceptance, the effectiveness of the programme is therefore heavily reliant on successful community mobilization and awareness. The introduction of new chemicals in 17 districts necessitates an even greater awareness effort. The behavior change and **mobilization strategies will target community structures**, including community and traditional leader sensitization meetings. Although LLIN coverage in Zimbabwe has shown an upward trend, utilization has remained below targets (49%).[8] The programme will commence routine distribution for keep-up in 2015, while efforts will be made to deploy a multi-faceted approach to behavior change and increased uptake by engaging the Nursing Directorate, the Reproductive Health Department, and the Ministry of Education; these will be capacitated with SBCC skills to enhance community uptake of appropriate behaviours.

Monitoring and Evaluation

The NMSP intends to develop a higher level of rigour in data practices to improve the quality of data practices as part of the M&E strategy. An assessment will be conducted to determine data and database management capacity to inform the design of appropriate data management training modules. Collaboration with HMIS will be enhanced for provision and distribution of data capturing equipment (mobile phones, tablets) and appropriate data capturing tools (registers).

A package of standard malaria monitoring and evaluation activities will be continued; these include: annual and quarterly review meetings therapeutic efficacy tests, pharmacovigilance studies, entomological studies, case management audits, the Malaria Indicator Survey and the Malaria Programme Review.

Health workers will be trained in monitoring and evaluation management systems. The programme will conduct data driven supportive supervision visits at all levels, providing written feedback to peripheral levels. Selected indicators for pre-elimination/elimination will be incorporated into DHIS-2. Malaria routine data will be integrated with the HMIS. Data audits and data verification exercises will be conducted quarterly.

Post training follow-up will be carried out for all trainings conducted across all strategies.

Programme Management

Financing and sustainability of domestic malaria control efforts will be a key priority of the malaria strategy moving forward. MOHCC plans to lobby the Ministry of Finance and the Parliamentary Portfolio Committee on Health for increased and timely release of funds from the Treasury. An engagement strategy to map partners and develop a network of partners and potential funders will be used; this will include use of the Business Plan to solicit support and resources from the private sector and other partners.

[8] MOHCC, 2012. Zimbabwe Malaria Indicator Survey, 2012. pg.39, 29, 34 (Annex 6)

Another key feature of the programme management agenda over the remainder of the NMSP will be the development of health workers' capacity; this will be done through training, mentorship, provision of resources, and strengthening of supportive supervision tools and methods.

b. The 2012 Malaria Indicator Survey (MIS, Annex 6) provides estimates of the progress made in coverage of preventive and treatment services for malaria. The proportion of households with at least 1 Insecticide treated net (ITN) more than doubled between 2008 and 2012 (up from 22% to 46%). Utilization of ITNs amongst the population at risk of malaria also improved significantly; the proportion of children under-5 who slept under an ITN during the previous night grew five-fold between 2008 and 2012, from 9.2% to 49.6%. The proportion of women of child bearing age who slept under an ITN rose steeply, from 4.5% to 49.1% during the 5 year interval. (Note, the MIS is a national estimate, which does not take into account the fact that LLIN distribution is limited to selected districts). Programmatic coverage data demonstrates a high level of coverage of LLINs in the selected target areas (35 of the 47 moderate malaria transmission districts); by the end of 2013, the country had achieved about 80% coverage of LLINs[9] in these areas

According to programmatic data, IRS room coverage increased from 85% in 2008, to 91% in 2013. Likewise, the population protected by IRS (in selected IRS districts) increased from 80% in 2008 to 90% in 2013; these high coverage rates have since been maintained annually. The 2012 MIS estimates national IRS coverage at 48.6% (although this estimate does not take into account the fact that some sampled districts are not targeted for IRS). Similarly, data from the national health information system shows that IPTp2 coverage increased from 28% in 2009 to 60.5% in 2013[10].

Following successful scale up of prevention and treatment coverage to date, malaria incidence has fallen from 155 cases per 1,000 in 2003 to 22 per 1,000 in 2012; malaria mortality has declined from 16.5% in 2009 to 4.5% in 2012[11]. Parasitological testing rates increased from 60% in 2009 to 81.9% in 2012/2013 due to improved coverage of malaria diagnostics and training of health care workers, while the proportion of under-five year olds who received treatment within 24 hours of onset of fever increased from 40.5% in 2009[12] to 58.6% in 2013.

Table 1 below summarizes key indicators that demonstrate Zimbabwe's strong programme performance to date.

Table 1: Changes in Zimbabwe's malaria profile: 2002 - 2012

Indicator	2002	2008/2009	2012	Global/national target
Incidence: cases per 1,000 (HMIS)	116	58 (2009)	22	
Households owning at least 1 ITN, % (MIS, 2008 & 2012)	N/A	22	46.4	80%
% using ITN the previous night, % (MIS, 2008 & 2012)	N/A	4.5 (PW) 9(U5)	49.1 49.6	80%
Households sprayed by IRS, % (MIS, 2008 & 2012)	N/A	16	48.6	90%
IPTP coverage, % (Case Management Audit)		28	60.5	85%

[9] Plan Zimbabwe. Mass LLINs Distribution Report, 2013. pg3 (Annex 7)
[10] MOHCC, 2009: Malaria Case Management Audit 2013. (Annex 8)
[11] Ministry of Health and Child Care (MOHCC), 2013: Health Management Information System (HMIS).
[12] MOHCC, 2009: Malaria Case Management Audit 2009 (Annex 9)

More recently, sustained progress has been made, and it is expected that the results will be reflected in future surveys, and in the disease impact statistics. In 2013, 2,570,316 nets were distributed (supported by Global Fund, PMI, United Methodist Committee on Relief (UMCOR), and Econet Health); an additional 1,133,794 nets are planned for distribution in 2014. After this distribution, expected LLIN coverage in endemic areas is expected to be 100%. Therapeutic efficacy studies (20013/2014) are currently ongoing, which will also provide evidence on the parasitological response to treatment, and will continue to guide the treatment policy.

c.

IRS

The main issues challenging the performance of IRS are sub-optimal receptivity by the community, poor accessibility of certain areas during the spraying exercise, and delayed procurement of commodities. The re-emergence of An. *funestus*, which is resistant to pyrethroids (including synthetic pyrethroids) and carbamates[13] in areas where DDT may not be used for economic reasons further complicates the IRS strategy. It is encouraging however that this re-emergent vector is susceptible to organophosphates, although the relatively higher cost of organophosphates compared to other insecticides on the market makes them impractical for long term use. Regular insecticide susceptibility studies will continue to be very important for the vector control interventions. In the NMSP, entomological surveillance - and in particular regular susceptibility studies - is identified as a prerequisite to a good IRS program and will be implemented consistently. The adaptation and implementation of insecticide resistance management will also be given top priority, as the initial plan is to rotate insecticides as informed by susceptibility studies. The introduction of organophosphates, beginning with 4 districts in Manicaland, and scaling up to 13 border districts will be important in the short term to clear the pyrethroid and carbamate-resistant *An. funestus*.

LLINs

With the recent scale up of LLIN distribution for universal coverage, the country has reached over 80% net ownership (in the selected LLIN priority districts). However the LLIN utilization is still low at 49%[14]. The low utilization of LLINs may be due to declining incidence of malaria in some parts of the country, resulting in reduced risk perception among some communities. Social and behaviour change communication will be scaled up in all areas to reinforce the use of LLINs where they are available.

Prevention of malaria in pregnancy

The uptake of IPTp is still relatively low (60.5% in 2013, an increase from 28% in 2009)[15] despite an ANC coverage of more than 90%. Planned strategies for improving performance in this area include closer packaging of IPTp services within ANC and reinforcement of this in health worker training, including MCH trainings for implementers (both pre-service and in-service). The programme will continue to work closely with the reproductive and child health department to improve the uptake of IPTp; this will be done by contributing to the training of midwives in malaria case management (including IPTp), as well as through updating and widespread distribution of guidelines.

While it is appreciated that IPTp coverage has been low (and there is a need for interventions to improve programmatic performance in IPTp), there are also elements of the reporting of this indicator that will be revised to provide more accurate and meaningful estimates of IPTp coverage. One of the major challenges in IPTp has been the original source of data (HMIS), which underestimates actual coverage.[16] The program has since used Case Management Audit data as an

[13] Hunt R, and Wood O. (ICEMR). Field Work at Mutasa, Zimbabwe. February 2013. ICEMR. pg1-3 (Annex 10)
[14] Zimbabwe Malaria Indicator Survey (MIS) 2012 pg. 39,29,34 (Annex 6)
[15] MOHCC, 2013. Malaria Case Management Audit 2013 pg. 10 (Annex 8)
[16] HMIS data underestimates IPTp coverage because of the way the reporting forms and periods were structured

alternative, which better reflects actual coverage. In addition, a new approach to scheduling IPTp has been developed, leveraging on the set schedule for ANC nationwide. A package of services will be developed for each visit, including provision of IPTp at each of the four visits.[17] This allows the IPTp strategy to leverage the high ANC coverage, and to build on this foundation to improve IPTp.

Case management

Despite the high coverage and use of RDTs, the challenge of overprescribing of ACTs for unconfirmed cases remains. This results in overconsumption of ACTs, and a significant discrepancy between parasitologically confirmed cases and actual ACT consumption. This challenge is particularly pronounced in areas where incidence is declining, and health workers require enhanced training on differential diagnosis of fevers and management of fevers.

In addition, QA/QC for diagnostics is not routinely carried out at all levels of the health delivery system. Supervision and mentorship of both health facility staff and community-based health workers has been inadequate, limited primarily by the lack of comprehensive guidelines on CBHWs and their role in malaria, the lack of standardization of the CBHW programme across districts, as well as by limited resources. The extended NMSP (2014 – 2017) focuses on the expansion and strengthening of the role of community case management through Zimbabwe's system of CBHWs; guidelines on community case management will be developed to improve case detection and treatment rates. The use of community-based health workers in actively identifying potential infections in the community and in supporting management of fevers will also ease on the demands of health workers in facilities. Ongoing health worker training will focus on appropriate fever management as a malaria control strategy, yet simultaneously furthering efforts to improve management of fever in children.

Post-marketing surveillance of medicines is not routinely carried out and this results in possible side effects to medicines going undetected and unreported.

Cross-cutting Issues

Procurement and Supply Chain Management(PSM)

PSM challenges within malaria are more marked in vector control, where procurement of IRS commodities is done on an annual basis. Delays have been noted in the arrival of key commodities, leading to delays in implementation of interventions. PSM has been impacted negatively by the international procurement systems of the current PR, where there has been minimal involvement of the Ministry. Improvements in this area require the appreciation of the unique seasonal variations in malaria, and the need for more attention to the timing of procurement. Planned mitigation strategies to ease these challenges include improvements of forecasting and quantification processes; MOHCC will also plan to better coordinate timely submission of requirements by partners and implementing provinces, thereby having greater control over the procurement processes to expedite the arrival of commodities. In the case of other commodities such as RDTs and ACTs the consumption data has been unreliable; hence collection of consumption data will be reinforced and better quantification models will be developed with the purpose of more precise estimation of future requirements. The malaria program will also ensure that the national procurement agents receive specifications and quantification of procurements according to a pre-set annual calendar.

Cross border malaria control

A key challenge, whose significance will grow as malaria is successfully controlled in most of the country, is the persistent burden of malaria along the borders with Zambia and Mozambique. While Zimbabwe may continue to make progress in reducing malaria transmission in the central and southern parts of the country, the border regions will continue to facilitate continued transmission

[17] The indicator for estimation of IPTp coverage will also reference the number of IPTp visits as a proportion of all deliveries (not of first, second or third visit etc.).

unless effective cross-border mechanisms are put in place; this risks limiting the effectiveness and impact from Zimbabwe's investments into malaria control. A cross-border initiative between Zambia and Zimbabwe has recently been established, but is not yet fully operational. However no mechanism has been established with Mozambique. In recent months, efforts to coordinate a regional elimination initiative have been scaled up; this includes the eight countries within the Southern African Development Community (SADC) block – known as the Elimination 8 - that have committed to individual and collaborative regional elimination goals. The E8 countries have submitted an expression of interest (EOI) to the Global Fund, with the intent of taking advantage of the Global Fund's regional concept note opportunity. The EOI outlines three strategic pillars of the proposed regional approach; these are (i) strengthening regional surveillance systems, (ii) developing regional harmonized protocols on QA/QC, and (iii) incentivizing accelerated impact through regional collaboration.

This regional proposal is not duplicative of the activities represented in this funding request; it would not propose investments that could be included in national grants. Rather, it prioritizes activities that require regional and multilateral collaboration which would otherwise prohibit the individual country progress towards elimination. While the individual countries will continue to conduct their own resource mobilization efforts, additional funding for the regional initiative is critical to enable the gathering and analysis of regional surveillance data and regional transmission and risk trends. This is essential for the success of the countries' individual strategies and approaches to eliminating locally.

d. The National Health Strategy[18] (Annex 5) is intricately linked to the implementation of the malaria strategies and interventions; key aspects of the national strategy directly or indirectly further or reverse the gains in malaria control. . The following crosswalk summarizes the impact of the National Health Strategy on the national malaria goals.

National Health Strategy Objective	Linkage within Malaria Strategy
Medical products, vaccines, and technologies	The Medicines Authority of Zimbabwe (MCAZ), the National Microbiology Reference Laboratory (NMRL), and the Zimbabwe Quality Assurance National Program (ZINQAP) regulate and approve medical products, including drugs and devices. As new medicines for more effective case management of malaria are introduced, these bodies support the introduction and regulation processes. The Ministry of Agriculture, Mechanization, and Irrigation Development regulates the use of insecticides, while Ministry of Environment, Water and Climate oversees environmental management. The presence of additional insecticides on the global market also supports the insecticide rotation strategy, which is key to resistance management.
Health service delivery	Due to the comprehensive and wide-reaching coverage of health facilities in Zimbabwe, more than 85% of the population lives within 10 km of a health facility. In addition, the use of community systems also supports a strong health service delivery environment for malaria, including roles in BCC and case management. However, the community systems have not been fully optimized for malaria, and efforts proposed under this grant will train and equip more community-based health workers to play a larger role in malaria case management. A network of environmental health

[18] Ministry of Health and Child Care (MOHCC), 2009. National Health Strategy, 2009 – 2013. Equity and Quality in Health: A People's Right.

	technicians also complements facility-based service delivery, and this is leveraged for IRS and LLIN distribution activities.
Human resources for health	Currently, the health system is operating at approximately 57% of the health workforce as per MOHCC's established posts, with particular nursing shortages. The overburdening of nurses has been a challenge to the quality and robustness of care for patients; definitive differential diagnosis for malaria is not always given adequate attention. Through expanding the use of community-based health workers, the malaria program aims to mitigate some of these effects.
Partnerships for Health; Governance and leadership	Malaria technical sub-committees are in place and often meet to review progress, address bottlenecks, and ensure accountability of main partners in delivering their respective responsibilities. These committees are made up of a wide range of partners, including government, development partners, academia, civil society and faith-based organizations. Through their active participation in the Parliamentary Portfolio Committee on Health, the policy and political leadership has played a key advocacy role for malaria, and will also be involved in rolling out the Malaria Business Plan to solicit greater support from the private sector.
Health information	Monitoring and evaluation of strategic outcomes (coverage, morbidity, mortality) represents a key activity within the overall malaria strategy. Efforts to strengthen digital transmission of the national health information records will be an important advantage both for the quality of malaria data, as well as for the generation of more rapid data to guide response at provincial and national levels.

Table 2: National Health Strategy and impact on malaria strategy and outcomes

e. N/A

f. The Zimbabwe National Malaria Control Strategy (2008 – 2013) was developed through a consultative process involving multiple partners and public forums; the strategy was later extended to 2015 to align with the National Health Strategy and the MDGs. The strategy presented a pathway towards attainment of universal access of malaria control interventions and calls for scaling up of these interventions for impact. Through the implementation of this strategic plan, the country managed to achieve the 2010 Abuja targets of halving morbidity; it has also achieved Target 8 of MDG 6 (reducing the 2000 malaria burden by 75%).

Beyond the routine program monitoring activities highlighted in 1.2a, there are additional evaluation activities that are periodically conducted to monitor impact and progress at a higher level. Surveys - Zimbabwe Demographic Health Indicator Survey (ZDHS), MIS & RIA - and surveillance activities (case investigations and entomological investigations) are conducted to provide evidence of impact of the program interventions. Data and evidence generated from the HMIS, surveys and surveillance activities are used to monitor the implementation of the ZMSP and to inform its assessment.

A mid-term review exercise (of the 2008 – 2013 strategy) was conducted in 2012; operational and service delivery targets showed substantial increase and improvement, and incidence was reduced from 95 per 1,000 to 49 per 1,000 during this strategic plan cycle. The review found that deaths remained high, and that further efforts were needed to reduce mortality. In January 2014 during a technical meeting, the decision was taken to develop an addendum to the strategic plan, extending the Plan period to 2017, and allowing synchronization between the National Health Strategy (NHS)

and the Zimbabwe Malaria Strategic Plan.

The following timeline highlights the schedule of recent and upcoming review activities.

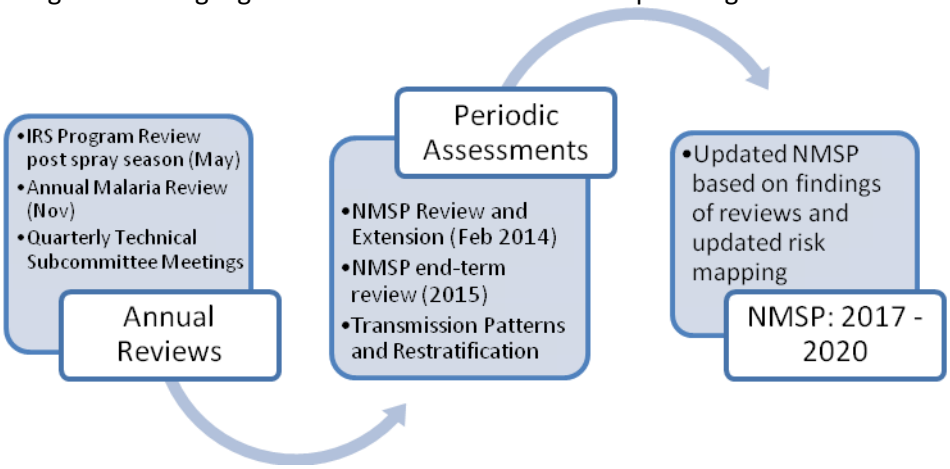


Figure 44: Schedule of country processes for reviewing ZMSP and evaluating progress against targets and impact

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the three diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources which are far from sufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the national program and how this funding request fits within this, briefly describe:

a. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).
b. How the proposed Global Fund investment has leveraged other donor resources.
c. For program areas that have significant funding gaps, planned actions to address these gaps.

1-2 PAGES SUGGESTED

The total cost of implementing the national malaria strategic plan for the next three years (2015-2017) is estimated at US$133,875,854. 58% ($77,860,076) of the required resources are available (including this funding request), supported by the following partners:

- PMI (approx. $16.8 million, which is 60% of the $28 million contribution for FY 2014/FY 2015 that represents direct implementation support)
- Government of Zimbabwe ($2,000,000), and
- The Global Fund allocation within the existing funding request ($59,460,076).

In order to sustain the gains made in the past 10 years, as evidenced by the steady decline in malaria incidence, the country has made a strategic decision to focus the entire funding allocation towards the existing gap in funding for programme implementation over the next two years i.e. 2015 and 2016 (rather than three years). This approach is expected to give the country additional

time to mobilize additional resources to address the identified funding gap for 2017. With this strategic approach, it is envisaged that the country will be on course to achieve its targets of reducing malaria incidence to 12/1,000 by 2016; this will position Zimbabwe well to ultimately attain its NMSP target of 10 cases per 1,000, and near zero deaths by 2017.

a. In recent years, the main funders of Zimbabwe's malaria control effort have been the Global Fund, the President's Malaria Initiative, and the Government of Zimbabwe – each representing 64, 28, and 7 percent of the total malaria budget between 2008 and 2012[19].

The vector control strategy is the largest cost driver of the malaria control effort (34 % of the national strategic plan budget), and 45% of this funding request. The priority intervention within vector control is full coverage of IRS in the selected 47 districts, while LLINs will complement IRS, primarily through routine distribution (to pregnant women and children under 5) as well as through mass distribution in the highest transmission areas. PMI support is expected to fund approximately 12% of the LLIN need over the funding request period (2015 and 2016), while this funding request will cover another 8%.

Through PMI commitments for 2015 and 2016, approximately 23% of funding for case management (including BCC) during the funding request period has been secured. (The decline in malaria cases and projected ACT consumption will likely result in fewer cases, and ACT requirements are largely covered by the committed PMI funds). This funding request includes a small proportion of projected ACT and RDT commodity costs, as well as severe malaria medicines and does not include IPTp (fully funded by PMI).

PMI is supporting the distribution system for commodities, including operational costs, technical assistance, trainings, quantification support and logistics, amounting to $1,834,000 over 2 years (this includes both administrative overheads and implementation costs for implementing partners).

b. Despite the resource constraints limiting the comprehensive malaria strategy, full coverage of IRS has been prioritized, and thus IRS has also been the focus of funding requests to other funders – namely PMI, as it is for this funding request. Domestic funding for malaria from the Government of Zimbabwe has also been prioritized for IRS, as this is recognized as a key intervention in the control effort. In 2015 and 2016, PMI will focus its IRS support on the 4 highest transmission districts in Manicaland, implementing a full package of IRS (spraying with organophosphate insecticide, waste management, entomological surveillance, and operational costs). Of the 47 spraying districts, 43 would then remain largely unfunded, and are thus the focus of this funding request. Investment in vector control is thus distributed among three main funders (Global Fund, PMI, Government of Zimbabwe), reducing the risks of funding volatility for this key intervention.

Given the declining transmission and case incidence, spending on treatment is projected to fall, compared to previous years, while spending on RDTs is expected to increase, as there is increased emphasis on parasitological testing of all fevers. This funding request leverages the commodity procurement which is largely supported by PMI. The requested amount under the case management module is therefore primarily constituted of operational activities to strengthen case management practice: parasitological confirmation of fevers, differential diagnosis support for health workers and training of community health care workers to support case management and active case finding).

Disease surveillance activities (including active surveillance) and therapeutic efficacy studies will be funded through this funding request, while entomological surveillance and studies will be

[19] WHO. World Malaria Report 2013: Funding for Malaria Control. (Annex 11)

funded through support from PMI. Activities related to elimination (active case investigation and detection) are also prioritized within the case management module of this funding request.

c. Assuming the success of this funding request, significant financing gaps still remain, which risk failure to maintain the strong malaria control gains that Zimbabwe has registered in the past 10 years. Mass distribution of LLINs, which is intended to complement the vector control strategy in areas of high transmission, is expected to further result in dramatic declines, particularly in areas with moderate-to-high transmission. Given the increasing evidence of insecticide resistance, it will be key to continue to monitor resistance patterns, IRS efficacy, and to manage resistance through insecticide rotation. While PMI funding, coupled with Global Fund support from this funding request does sufficiently fund the routine LLIN distribution strategy, mass distribution in 2016 remains unfunded.

The Malaria Business Plan: 2014 – 2017 (Annex 32) has therefore focused its efforts on strategies to leverage private sector resources to support all malaria efforts, but with some focus on LLINs in particular. Based on previous trends and the preferences of private sector partners, it is expected that efforts to attract private sector support for malaria will be more successful for LLIN commodity purchase, compared to other aspects of malaria control. However, the Business Plan will be widely used as a resource mobilization tool to facilitate outreach to the both the corporate sector, private philanthropists, and other external donors, and to develop lasting partnerships for a more coordinated approach to malaria control. In order to further enhance value for money and support prioritization of scarce resources, the NMCP will continue to develop its understanding of the evolving transmission risk around the country in order to better prioritize areas for mass distribution based on available funding which may become available in the future.

As part of long term sustainability planning, the Health Financing Policy (expected 2014) will provide strategic direction and principles for national efforts to reach universal health coverage, guaranteeing a minimum package of basic health services for all.

2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

a. Indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

Counterpart Financing Requirements	Compliant?	If not, provide a brief justification and planned actions
i. Availability of reliable data to assess compliance	☒ Yes ☐ No	Estimates of counterpart financing (for malaria specifically) are based on direct government contributions, particularly to the IRS program. However, these estimates likely underestimate the level of counterpart financing; beyond IRS, government has invested in other areas of malaria control, including infrastructure and service delivery systems, human resources, and appropriate case management. A dedicated resource tracking mechanism is needed to more accurately quantify this investment. Government allocations to the Ministry of Health and Child Care are reflected in the Budget Statements and Estimates of Expenditure Report – the Blue Book - which is published every year. Health expenditures are tracked through the National Health Accounts. The National Health Accounts is being institutionalized as the System of Health Accounts (SHA), which will be a real time tracking of health expenditures, beginning with public health institutions, and

		later to be rolled out to the private sector.
ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)	☒Yes ☐ No	Given the total allocation to Zimbabwe of US$478m, 15 % ($72m) is tied to 'willingness to pay'. Zimbabwe is required to put in an additional $18m into the three diseases in 2015 and 2016; an estimated additional $37m is expected to come from the Government of Zimbabwe through the AIDS Levy during the 2015-17 period, compared to 2012-14 period. This would be sufficient to meet the WTP requirements.
iii. Increasing government contribution to disease program	☒Yes ☐ No	(Recently, total spending on health has risen faster than government spending, driven by an increase in private and external funding). According to Blue Book estimates, expenditure on health by the Government of Zimbabwe is expected to grow at a rate of 7.5% and 6% respectively over the next two years. Within this budget allocation, government investments in human resources, commodities, and malaria activities are expected to grow at a similar rate of growth. As Zimbabwe continues to implement National Health Accounts, level of expenditure by government on specific budget items and programs will become clearer.

b. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.
c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

2-3 PAGES SUGGESTED

b. A Business Plan (finalized in early 2014 and to be launched later this year) also aims to facilitate investment partnerships with the private sector, further diversifying sources of funding and reducing funding risk. This initiative on sustainability will be supported by efforts within the Department of Policy and Planning to develop a framework to guide public-private partnerships within health programming in the MOHCC. Within the Business Plan, specific mechanisms for facilitating private sector partnerships have been proposed; given that the Business Plan focuses on public-private partnership (PPP) support of LLINs, the impact and progress of this initiative can be easily tracked through documentation of commodities supported/procured through this mechanism.

As the health care sector had been heavily supported by funding from development partners in recent years as a result of the economic challenges, government is committed to gradually increasing the financing responsibility for key areas of the health response. The key cadres responsible for delivering services within the malaria program – nurses, community-based health workers, environmental health technicians, laboratory scientists, and pharmacists – will increasingly become funded by the government This is recognized as a key priority for sustainability. As mentioned in 2.2.iii above, continued implementation of the NHA will enable better tracking of resources to allow more precise quantification of the investments into health

and malaria specifically. The source of this data will be the National Health Accounts (NHA); the last NHA was conducted for the 2010 financial year, and the next is planned to be conducted in 2014 (for the 2013 calendar year). This commitment has been demonstrated through the increasing budget projections for human resources within the Ministry of Health's allocated line item for employment costs (for preventive services in particular); it is also demonstrated through efforts to begin the re-hiring of previously frozen nursing posts. Regarding the direct contribution to malaria, the commitment to malaria (as per the published national budget projections) is estimated to grow as the national budget for health grows. The MOHCC is committed to increasing long term sustainability of health financing, and this will be done in a comprehensive manner. The MOHCC aims (in 2014) to complete the development of the country's first health financing policy; the Policy builds on the new Constitution's imperative to provide universal access to health services.[20] The Policy aims to develop a roadmap towards the provision of universal health coverage to all Zimbabweans, guaranteeing a basic package of health services, including some elements of care related to malaria.

Community share ownership trusts – which are designed to pool resources from the private sector for the benefit of the community – also present an opportunity to enhance sustainability of community development initiatives, including investments in health.

The Policy which is being developed aims to develop innovative methods of generating revenue (building on the existing AIDS Levy) to limit the reliance on external funding. Following the finalization of the Policy in 2014, implementation of financing arrangements is expected to begin in 2015 and 2016, introducing newer streams of revenue for the health sector.

c. Additional estimates on domestic malaria financing can also be found in the World Malaria Report (2013). Given the limited partner landscape in Zimbabwe, determining the contributions of various external funders is relatively simple; estimates of Global Fund, PMI, and WHO budgets are readily available from these partners. However, it is difficult to estimate the contributions which the government makes, beyond direct investments in IRS procurement. Much of the logistics related to service delivery for IRS is financed by the government, yet there has not been a dedicated effort to better quantify the level of this investment. It is also necessary to appreciate the support provided through human resources for health, health systems and infrastructure (e.g. community-based health workers who support case management and BCC, health care workers in facilities, environmental health technicians, storage and waste management infrastructure, as well as fuel and transportation).

A key assumption that is implicit in the malaria financial data is that budget information is a close estimation of expenditure information. However, there is often a significant variance between budget and actual expenditure on programs. There is therefore a need to conduct a resource tracking exercise to better understand the level of expenditure by the government and different partners, and the distribution of resources between key intervention areas within malaria. While some efforts have been conducted to understand partner investments across the broader health system, these are often conducted at a very high level and do not sufficiently disaggregate malaria information. Such an effort to better understand resources invested to date and how they link to outcomes would generate more accurate unit costs for malaria interventions, and support future costing and budgeting exercises. Through the National Health Accounts and the institutionalization of this process, MOHCC expects to be able to better track its investments as well as those of its partners into the health system.

[20] MOHCC, 2013. Terms of Reference for Developing Zimbabwe's Health Financing Policy: Resourcing Universal Health Coverage." (Annex 12)

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems**.** It requests an analysis of the key programmatic gaps, which forms the basis upon which the request is prioritized. The modular template (Table 3) organizes the request to clearly link the selected modules of interventions to the goals and objectives of the program, and associates these with indicators, targets, and costs.

3.1 Programmatic Gap Analysis

A programmatic gap analysis needs to be conducted for the three to six priority modules within the applicant's funding request.

Complete a programmatic gap table (Table 2) detailing the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps.

1-2 PAGES

SUGGESTED – *only for modules that are difficult to quantify*

One of the four key modules (not represented in the quantitative programmatic gap analysis) is Programme Management. Within the NMSP, programme management ensures an efficient and effective malaria response where implementation and activity is closely related to intended national targets of reducing morbidity and mortality, and expanding malaria-free zones. Beyond the national coordination and programme management responsibilities, the MOHCC (through the NMCP) plays an important role in supporting sub-national management and coordination structures within the health system such as provincial and district officers (This is due to the fiscal space and human resource challenges which the country has faced).

The following is a discussion of specific activities and related gaps within the programme management module.

Partnership coordination and planning meetings. Within programme management, effective coordination is paramount to ensure knowledge management, technical guidance, and the avoidance of duplication of efforts within the malaria partner landscape. In addition, sub-national levels require robust planning support to translate national strategy into implementation at their level, as well as to ensure clear and aligned targets. Between 2015 and 2017, there are plans for 2 partnership meetings, 2 cross-border meetings, as well as internal audits. In order to support decentralization of planning, 8 provincial and 47 district planning meetings are planned to occur once per year. None of these are currently funded, and so there is a 100% gap between 2015 and 2017.

Technical and coordination staff. At present, national staff responsible for technical guidance and operations management for malaria at the MOHCC are in place. These include the National Malaria Programme Manager, as well as national focal persons for case management, vector control, M&E (2 staff), data management, and BCC. Operations support is also provided through focal persons for Finance, Logistics and Administration. The MOHCC plans to maintain these 10 personnel. As the MOHCC takes on additional responsibilities related to grant management, there will also be a need for additional grant management and operations capacity. The MOHCC is advocating for the review of the staff establishment to create additional posts, some of which would support grant management within the NMCP; at the same time, resources will be requested through the Global Fund to support these positions in the interim.

At the sub-national level, malaria is primarily coordinated by a Provincial Epidemiology and Disease Control Officer (PEDCO). To date, these provincial officers play a lead role in coordination and technical input into malaria at the provincial level (although PEDCOs also coordinate activities for TB and HIV at provincial level). It is planned that these will continue to be supported through the national malaria programme. In addition, the MOHCC intends to introduce 47 district focal persons for each of the 47 moderate to high transmission districts; given the need to ensure detailed and quality execution of malaria control to maximize resources and to avoid resurgence, these focal persons will add operational capacity and support smooth operations. These positions are unfunded for 2015 to 2017.

Some budget has also been reserved to support unspecified technical assistance. The specific needs will be determined as and when the need arises.

Vehicles and other Operations Equipment. IRS is heavily reliant on a full fleet of lorries and vehicles; additional vehicles are required to support other program operations. Currently, 32 service vehicles and 32 lorries are available. It has been calculated that the successful execution of the NMSP will require the procurement of an additional 12 service vehicles and 14 lorries.

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request to the Global Fund, including both the proposed investment of the allocation amount and the request above this amount. Describe how it addresses the gaps and constraints described in questions 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

4-5 PAGES SUGGESTED

Introduction: Fifty percent of the total **funding gap** for ZMSP implementation from 2015 to 2017 ($118,463,163) is budgeted within the "allocation amount" of this funding request – i.e. $59 million. The remaining unfunded half ($59,003,087) is included as the above allocation. As mentioned in section 2.1, all available resources from the Global Fund for this grant have been allocated in the first 2 years of implementation of the strategic plan to ensure that the country sustains the gains already made. Of the total allocation amount, vector control has the largest share (45%). The relatively large share of the allocation dedicated to the vector control module is due to recognition of the high potential for vector control to contribute to the overall achievement of the national malaria control strategic goals.

Given that the amount allocated for this malaria funding request (combined with other secured resources from GOZ and PMI) funds approximately 50% of the total budget required for 2015 and 2016, an effort was made to strategically prioritize the activities included in the current funding request. The activities included in this funding request have been selected to allow the country to **(i) maintain the current gains in transmission decline and avert resurgence, and (ii) to further intensify the scale up effort of proven control strategies in areas with sustained moderate to high transmission**.

There are five key pillars of the strategic prioritization of the funds included in this funding request.

a) Bridging of the financing gap to allow execution of a comprehensive vector control strategy that effectively maintains IRS coverage in moderate to high transmission districts to progress towards **universal coverage with vector control**, and pre-emptively manages insecticide resistance through insecticide rotation. *(Vector control module).*

b) Enhancement of the case management strategy, including a focus on expanding **community case management, strengthening parasitological testing** and confirmation of fevers, introduction of IV-artesunate for severe malaria, as well as introduction of primaquine in areas of low transmission to support gametocidal clearance and progress towards elimination *(Case management, Surveillance/M&E module).*

c) **Scaling up of active surveillance in areas** of low malaria transmission to improve case management, and to actively identify and treat non-symptomatic cases. (Surveillance/M&E module).

d) Strengthening of real-time **reporting and data management practices** and use of data to understand evolving disease transmission risk, to identify and contain epidemics, and to drive decision-making and **targeted allocation of interventions** (and IRS and LLIN in particular). *(Surveillance/M&E module).*

e) **Effective coordination of partnerships** and implementation activities to ensure quality, robust execution of the malaria control strategy; enhanced management of cross-border initiatives to limit the risks of importation and outbreaks. (*Programme Management module).*

To this end, the modules included in this request are illustrated in *Figure 5* below, represented as a proportion of the total funding request:

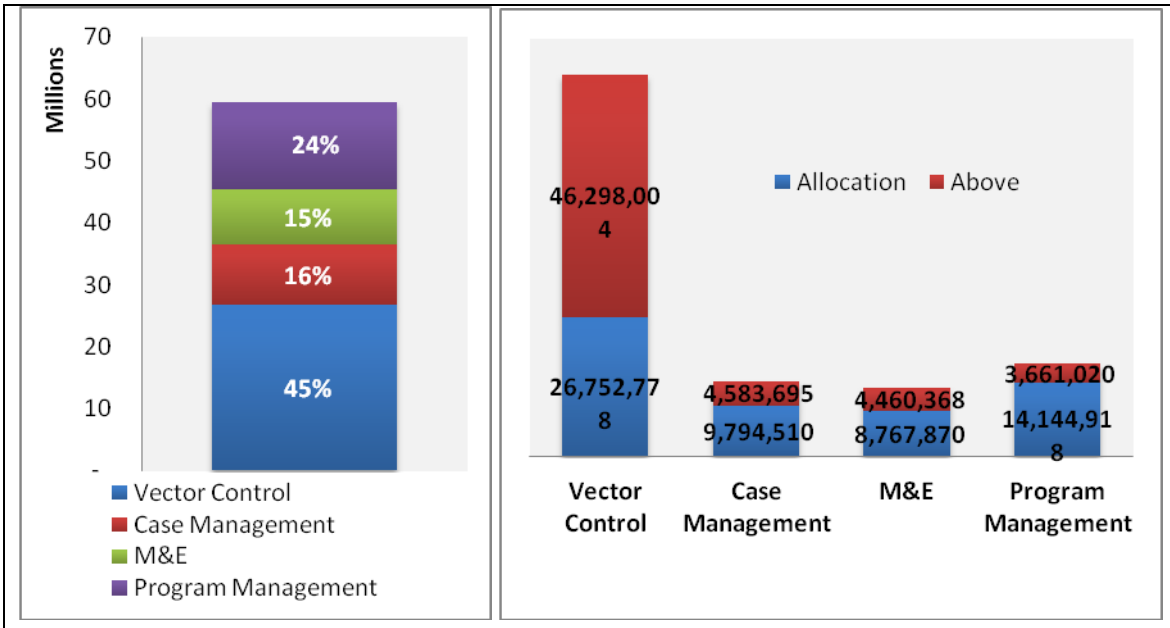


Figure 5: Funding request allocation amount, by module, and (b) funding request, including allocation and above amounts

The following table summarizes the key activities and targets represented in the allocation and above allocation budgets.

Module	Allocated	Above
Vector Control	• RS in 47 districts, universal coverage • LINs for PW, U5, immune-compromised • nsecticide resistance management • ommunity acceptance and behavior change to increase uptake	• ass distribution of LLINs in 47 moderate-to-high transmission districts
Case Management	• ommunity case management , training and guidelines • ome commodities (ACTs, RDTs, primaquine, artesunate, quinine) • ctive case finding in the community, diagnosis, and treatment • upport and supervision • A/QC of diagnostics and medicines. • ost-marketing surveillance	• V-artesunate and Primaquine commodities **(in part, expect limited consumption initially)** • SM, training for roll-out of assisted pull system • torage space expansion within health facilities • harmacovigilance
Surveillance, M&E	• lectronic reporting systems (IRS,	• perational research

	pre-elimination) and integration into DHIS-2 • evelopment of reporting systems for community case management • &E training and data quality for HWs, VHWs • urveys (MIS, MPR, ZDHS, Case Audit) • ntomological surveillance	• ssessment of M&E systems
Programme Management	• artnership coordination and program review • alaries and technical assistance • upport and supervision, all levels • ross-border, information gathering and sharing • esource mobilization • ommunity systems strengthening • rogram planning, data management, restratification, impact evaluation	• FPs in the 47 high transmission districts • ross-border, harmonized implementation of activities

Table 3: Key funding request activities, included in allocation and above allocation budget amounts

Each of the priority modules is discussed in detail below.

A. Vector Control.

Reflecting the key role of vector control in the current stage of the epidemic and the need to sustain recent gains in control, investment in vector control is the key priority of this funding request, representing 45% of the funding request. (The share of IRS within the vector control funding request is about 91%). The portfolio analysis of existing Global Fund investments (April 2014, Annex 13) similarly emphasizes the imperative for Zimbabwe to attain universal coverage of vector control interventions, and that "sustaining the gains made will require maintaining the current level of investment and prioritization of interventions".[21] Of the total needs for vector control over the next three years, about **37% ($26,752,777)** will be supported within the allocation request and 63% ($46,298,003) is included as above allocation.

Management of Insecticide Resistance. At the same time that Zimbabwe continues to expand vector control coverage (with a primary focus of IRS, followed by LLINs), there is a need to pre-emptively contain insecticide resistance, for which there is already some evidence (Annex 18).
A two-year insecticide rotational cycle will be employed as a resistance management strategy (See rationale as per ZMSP in Section 1.2). Although the use of an insecticide rotation strategy will increase the costs for the malaria control strategy (i.e. due to the use of organophosphates, estimated at $6.70 per structure sprayed, compared to $2 and $0.75 per structure sprayed for DDT

[21] GFATM, 2014 Zimbabwe Portfolio Analysis (Annex 13)

and pyrethroids respectively), the risks of failing to mitigate for insecticide resistance will render the main prevention and control tools (both IRS and LLINs) ineffective in the long term. This would result in resurgence and even higher costs for both malaria, and for the health system at large. This funding request therefore prioritizes the IRS strategy, adding to the existing investments (PMI and GOZ) to fund the programme for 2015 and 2016 at 100% of total need.

With this support, and with the attainment of universal IRS coverage in the 47 districts, the country expects to execute high quality IRS activities, and to witness the proven effect of this intervention in rapidly reducing transmission.

Integrated Vector Management. Given the challenges described earlier (lack of universal coverage, emerging insecticide resistance, and re-emergence of a vector that is resistant to pyrethroids and carbamates), the national program has adapted a multi-pronged approach to rapidly contain and control *An. funestus* on the eastern border, while maintaining control across the malaria endemic regions of the country, and making progress towards elimination in the southern parts of the country. In order to achieve this, the vector control activities supported through this funding request are as follows:

1. Rapid response to the re-emergence of *An. funestus* is currently being funded by PMI in four districts of Manicaland (Mutare, Mutasa, Nyanga and Chimanimani). However, history and evidence suggest that the vector will spread quickly, requiring additional entomological surveys and response in neighboring districts. These neighboring districts (12) will be funded, under this funding request; Global Fund support will be channeled towards IRS campaigns using lasting organophosphates, and the conduction of entomological surveys to determine the presence, distribution and susceptibility of the vectors to insecticides in these districts.
2. Control of *An. arabiensis* and *An. gambiae sensu stricto* in the remaining 31 districts with moderate to high malaria transmission will be attained through use of DDT funded through this request, which remains effective and is substantially less costly. It is important to note that districts do not conduct blanket IRS across the whole district, and most urban areas similarly do not receive IRS; rather, they target wards with highest transmission risk. For this reason, there is a need to complement this strategy with LLINs (particularly through routine distribution to ensure additional protection for vulnerable populations), particularly in areas with no IRS.
3. In addition, routine continuous distribution of LLINS will be funded under this allocation to protect the most vulnerable populations (specifically pregnant women, children under 5, and the immunocompromised) by delivering LLINs via public health facilities and opportunistic infection (OI) clinics.

IRS Operations. Beyond the procurement of LLINs and insecticides, the funding request will also support the hiring of spray teams (seasonal casual workers), training and field supervision, servicing of existing vehicles and replacement of consumables and equipment. Continued efforts to support training, quality control, and supervision will continue; the focus of these supporting activities will be to maintain a high quality and efficacy of IRS in order to optimize resources, and to maximize preventive impact on the disease and morbidity.

The unfunded “above allocation” amount primarily represents the gap in funding for a mass LLIN campaign (planned for 2016) to achieve universal coverage in moderate to high transmission districts.

SBCC for IRS. An integrated service package of vector control, along with behavior change messaging will be an important element of the vector control strategy; ensuring the uptake of IRS and consistent use of LLINs (beyond just coverage) is critical to maximizing the value of investments in IRS and LLIN. In order to promote high levels of IRS and consistent use of LLINs, a comprehensive social behavior change communication (SBCC) program will be implemented. The

SBCC activities will be conducted in line with the SBCC implementation guidelines. A multi-media approach will include community meetings, radio spots, road shows; branding of commuter buses and shops will be used to communicate IRS and LLIN strategies for malaria prevention and control.

Larval Source Management (LSM). Larval control will be prioritized as an important component of the integrated malaria control programme in pre-elimination/elimination areas and identified transmission foci. This strategy will use biolarvicides which are relatively low cost, environmentally friendly and highly sustainable if implemented in the context of community participation. **The larviciding activities within the national strategy have been included under the "above allocation" amount**; resource mobilization for larviciding will continue in order to facilitate the reduction of mosquito densities in pre-elimination districts, furthering the goals of expanding malaria-free zones.

B. Case Management

The case management module represents 16% of this funding request. Approximately 68% ($9,794,307) of total needs for case management between 2015 and 2017 have been budgeted under the allocation amount, while 32% is included as above allocation, mostly from the 2017 gap. Most of the needs for case management commodities in 2015 and 2016 (94%) are supported by PMI.

Community Case Management. Given the potential of community case management to improve the malaria response (also recommended in the Global Fund Portfolio Analysis), the funding proposed through this funding request will be used to update the Malaria Treatment Guidelines to align with current WHO Guidelines regarding case management for malaria and use of community case management. Training guidelines, facilitator and participant manuals, and associated behavior and change communication activities will be conducted in order to facilitate this transition of the case management strategy, and to ensure a high level of service provision led by health care workers. This will allow leveraging of the reach of CBHWs and their potential to support diagnosis and treatment.

Training. The changes in the case management treatment protocols will also be incorporated in the pre-service curriculum of health workers to reduce of the need for in-service training. However, health workers already in the workforce, who include doctors, nurses, environmental health workers, laboratory and pharmacy personnel, will receive in-service training in malaria case management through Global Fund support. Trainings in active case detection and use of primaquine for elimination districts will be conducted in line with the test treat and track mechanism. More community health workers from areas with no trained CBHWs need to be trained in all aspects of community case management, including practical aspects of malaria diagnosis and treatment. Refresher trainings will also be introduced for CBHWs who were not trained in the malaria-specific aspects.

A module on emergency preparedness and response (EPR) will continue to be part of the case management training and commodities for EPR are quantified as part of the buffer in the case management commodities. Outbreak response will require dedicated funds for the support and supervision, as this has posed challenges in the past. In the pre-elimination/elimination areas, health workers will continue to be trained in active case detection and enhanced surveillance, which is also targeted at the ward health team (WHT) members.

Parasitological Confirmation and Diagnosis QA. This funding request will also support quality assurance of malaria diagnostics; measures to be put in place include lot-to-lot testing of RDTs and microscopy reagents before distribution. In addition, external quality assurance (EQA) programme for malaria microscopy has been in place and needs to be strengthened. EQA for RDTs is being put in place to check performance of RDTs and competency of personnel performing tests, both at

health facility and community level. Furthermore, kit controls for RDTs will be procured and distributed for quality control to all levels of care. Quality assurance of medicines throughout the supply chain has been weak. Routine post marketing surveillance through the Medicines Control Authority of Zimbabwe (MCAZ) is proposed. Procurement of handheld Raman Spectrometers for use at key border posts will also assist in quality monitoring at port of entry.

Health systems strengthening is crucial for the implementation of the interventions. Routine support and supervision at all levels will include mentoring, quality and availability of medicines and diagnostics, storage conditions, recording and reporting and quality of records. On the job training will be conducted during support and supervision visits to support provincial, district, facility, and community structures.

SBCC for Case Management

The introduction of new medicines necessitates sensitisation of health workers on the new algorithms for treatment, including a delicate synchrony in the communications mix. In 2015, Zimbabwe will develop new training guidelines, treatment charts and toolkits for health facility workers across all the districts.

Mass media campaigns, using jingles, DJ mentions, and interactive call- in -shows to discuss the new innovations will be launched on radio across two stations with a combined reach of over 2 million listeners (largely in the rural areas most affected by malaria).

The introduction of the new case management protocols for community based case management and pre-referral treatment with rectal artesunate requires reorientation of the community to the malaria treatment protocol and the role of the CBHWs, as well as buy-in for this approach by the community. This will be secured through community meetings, while Ward Health Team (WHT) members will be oriented on the new treatment in order to facilitate continuous dissemination of information in the community. Community advocacy meetings will be conducted in all the wards in a stepwise manner that is aligned to the roll out plan for the new guidelines. An advocacy package with all the relevant information on the new interventions will also be produced and distributed to all stakeholders. A school health program focusing on child to child communication will be initiated in 2015, in the first 30 high transmission districts and eventually rolled out to all 47 malaria transmission districts.

The production and distribution of IEC materials remains important; this will be done to support the programme throughout the years. Training of community health workers and community volunteers on effective SBCC and community mobilization will be prioritised to ensure that right behaviour and early treatment seeking is promoted.

Consumption Verification and Commodity Quantification. Quantification of malarial commodities to follow international best practices is also a key priority under this funding request, which will contribute significantly to the effort to optimize limited resources and to limit expiry and waste. There is an apparent disconnect between consumption data and data from the health management information system and reasons for this discrepancy are not fully understood. End-user verification methods and data triangulation exercises will be conducted to better understand and mitigate any potential risks from the observed discrepancy. Through this, Zimbabwe expects to implement strengthened confirmation and case management practices to limit overprescribing of ACTs; this will reduce both ACT procurement needs, while also ensuring better management of fevers (which are not malaria but are still being treated with antimalarials).

Given the need to prioritize key commodities for equitable access to treatment, direct case management activities and commodities have been prioritized in this funding request. However, procurement and supply chain management is also paramount, and has been addressed to some

extent in this funding request. These activities include training of nurses on medicines management as recent surveys indicated a training gap of 60%.[22] General stock management is also poor with only 15.3% of facilities using stock cards correctly.[23] Other PSM-related needs have been identified (incinerators and expansion of storage space); these will be considered as part of the country's HIV and TB grants. .

C. Surveillance, M&E

The total needs for M&E over the three years are estimated at $13,228,238; 66% ($8,768,070) of this need is included within the allocation request. M&E represents 15% of this funding request.
Given the unstable nature of malaria transmission, the recent 2013 outbreaks and continued risk of high transmission along the borders, it is critical to have more rapid reporting and response to contain these risks. The funding request will support further development of the tools and systems necessary to mount better monitoring and response mechanisms.

***Integration with DHIS-2*.** A vector control system (which uses electronic means of reporting IRS activities in real time, and which was supported by previous Global Fund investments) has been in use, but this needs to be merged with the national DHIS-2 system, in order to synchronize the national health monitoring and evaluation platforms. Similarly, additional indicators and reporting systems have been developed for the unique context of pre-elimination districts (electronic PDA reporting/notification of case and surveillance data), and these will similarly need to be integrated onto the DHIS-2 platform.

***M&E in Community Systems*.** As the case management strategy takes a bigger focus on community systems, there is a critical need to rapidly develop reporting tools and systems to track this level of activity. Presently, CBHWs report their diagnosis and treatment data to the health facility, and this information is immediately merged within the facility reporting tools. As a result, the current system is unable to disaggregate diagnosis and treatment data from the facility and that from the CBHWs. This funding request includes support for the rapid development of community reporting systems and M&E training for CBHWs, as a critical pre-requisite for the scale up of community case management.

Routine Reporting and Data Quality. Funding request has also been made for routine support of monthly reporting through the DHIS-2, internet connectivity and monthly subscriptions, on-site data verification (OSDV) exercises, and technical support visits and mentoring. In addition, health workers and community health workers will be trained on the proper use of data collection tools and data management to help improve data quality. Further provision is made for M&E support within the case investigation strategy in pre-elimination districts, as well as routine entomological investigation.

Surveys. To assess the impact of the program, the funding request would also support conduction of the Malaria Indicator Survey (MIS), Malaria Program Review (MPR) and, and Malaria Case Management Audit in 2015. In particular, it is important to note that there will be a need to consider the objective and sampling of the MIS in order to generate estimates that are specific to the evolving epidemiological setting and low prevalence in much of the country. Evidence gathered from these sources will be essential to inform changes to implementation strategies and inform the new NSP in 2017. Baselines will also be conducted for the 13 new districts earmarked for pre-elimination by 2017 to establish benchmarks against which progress of pre-elimination interventions will be assessed.

Analysis, Review and Transparency. Routine Data Quality Audit (RDQA) will be institutionalized

[22] End Use Verification Reports. pg.1 (Annex 14)

[23] MOHCC. National Medicines Survey for Public Sector: 2013. pg. v (Annex 15)

and conducted annually to help improve data quality. Similarly, operations researches (Insecticide Resistance monitoring, entomological monitoring, Net Utilization Assessment, etc.) will be undertaken during the period. Annual conference, quarterly review meetings, documentation of best practices and dissemination of findings of surveys and assessments will be supported.

D. Programme Management

Of the total programme management need for 2015 to 2017 ($17,805,938), 79% ($14,144,918) will be supported under this allocation request. To support smooth implementation of the priority interventions, 24% of the total funding request will cover program management issues, including the following:

Salaries. Technical and coordination capacity – at national and provincial levels - will be critical during this stage of the malaria strategy in order to ensure a high quality of execution in order to maintain the gains made to date, and to sustain progress towards elimination in the coming years. Human resources supported through previous Global Fund support will continue to be supported through this funding request. As mentioned in 2.2b, it is recognized that the gradual re-absorption of salaries for technical and coordination staff ought to be a key priority to ensure sustainability. As the government investment in health increases, the GOZ is considering the incremental absorption of these resources into the government payroll.

Technical assistance and Capacity Development. TA will be sought from technical advisors; whereas most partners will be able to support the cost of TA, a small budget has been included for contingency purposes.

Supportive Supervision. National, provincial, and district health teams will be supported to conduct supportive supervision; some of these activities will be integrated with other disease grants to develop implementation efficiencies.

Administration Support. The funding request includes support for financial and grant management, including financial audits.

Cross border interventions. Some support has been requested to support cross-border initiatives, although a significant proportion of this remains "above" allocation; it will be necessary to confirm the buy-in from neighbouring countries and the establishment of an effective mechanism for collaboration, prior to investing significant resources for implementation.

Supply chain. The funding request will support storage, distribution, supply chain and logistics management and information systems (for lab and insecticide commodities), QA/QC for diagnosis and treatment, and waste management.

Partnership coordination and Resource Mobilization. Regular technical working groups and partnership forums will be held, and will serve as the main platform for partnership coordination and consultative planning. This will also be the forum for research and use of evidence-based malaria programming, including ongoing restratification of malaria zones based on evolving data. The Malaria Business Plan – finalized in 2013 –will be used to facilitate partnerships with the private sector; resources from this funding request will be used to catalyze the solicitation of additional funding partnerships with the private sector, through convening of meetings and outreach to industry.

Community systems strengthening. CBHWs and ward health teams will become an increasingly important element of the malaria strategy; outreach and partnership development with these cadres will be facilitated through joint activities between NMCP and the Department of Community Health. As the malaria control strategy evolves to increase the role of the community in control, there will be efforts to strengthen capacity for coordination among community structures, with a significant role for civil society.

3.3 Modular Template

Complete the modular template (Table 3). To accompany the modular template, for both the allocation amount and the request above this amount, briefly:

a. Explain the rationale for the selection and prioritization of modules and interventions.
b. Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

3-4 PAGES SUGGESTED

The rationale for the selection and prioritisation of modules and interventions for this concept note, takes into account the revised, extended Zimbabwe National Malaria Strategic Plan (2008 – 2017), the guidance of an inclusive group of stakeholders involved in malaria control including technical partners and civil society, and guidance from Global Fund (Portfolio Analysis). In addition, the recent discovery of evidence indicating a re-emergence of *An. funestus* resistant to pyrethroids on the eastern border with Mozambique, has further shaped and dictated an urgent need to adapt the interventions within these districts, as Zimbabwe heads towards a goal of near zero malaria deaths and 20 pre-elimination/elimination districts by 2017.

Given the limited resources available at this time, not only have interventions been prioritised during the 2015/2016 implementation period, but 2017 remains excluded from this concept note, providing time for additional resources to be mobilized from other donors. ***Through activities that will be supported by this funding request (complemented by existing committed funds provided by the Government of Zimbabwe and PMI) the expected impact is a maintained downward trajectory of declining malaria deaths to near zero and the reduction in malaria incidence from 22/1000 in 2012 to 12 per 1,000 by the end of 2016. With the additional support from the above allocation, the expected impact would be the full attainment of the stated goal of the NSP – i.e. 10 per 1,000 by 2017.***

The modules for Vector Control, Case Management, M&E, and Programme Management were selected by the team of stakeholders mentioned above. The selection of modules was an inclusive process, and it enabled the inclusion of all prioritised interventions within these modules. The rationale for the inclusion and prioritization of these particular modules is:

i) Vector control: Global guidance and experience confirms that vector control – and IRS in particular - is critical for the rapid reduction of transmission within the shortest possible time. IRS is also amendable to insecticide resistance management strategies, such as the rotation of insecticides. Furthermore, LLINs and IRS offer individual and household protection, thus playing a key role in the goal of reducing malaria morbidity.

ii) Case management: This intervention is central to any effort to reduce both morbidity and mortality, which is a stated aim of the national malaria strategy. The range of case management interventions focus on the benefits of adequate diagnosis and treatment, both from an individual and a public health perspective (i.e. reduction of parasite reservoirs and onward transmission potential).

iii) M&E: This intervention will enable stakeholders (including MOHCC) to evaluate progress against the stated national goals, and to develop corrective strategies based on evidence. Within the transition to (pre)elimination, M&E and surveillance also become increasingly important; beyond evaluation of progress, data is also used to identify and contain transmission foci.

iv) Programme Management: Given the widening landscape of interventions and partners, programme management is necessary to ensure coordination, effectiveness, as well as generation and use of evolving evidence and technical guidance. Coordination capacity is

essential at both national and sub-national levels.

A summary of the activities within the main programmatic modules - vector control and case management - modules and the prioritised interventions including justification is included below:

Vector Control

Intervention	Justification	Expected Impact / Outcome
IRS	Zimbabwe has systems and demonstrated capacity to effectively deliver IRS (a WHO recommended strategy) in its moderate and high transmission areas. Due to concerns related to evidence of insecticide resistance to pyretheroids in Zimbabwe, and given both the high levels of coverage of LLINS and the limited resources, Zimbabwe plans to focus on achieving and sustaining universal coverage of IRS. A mosaic of effective chemicals and robust entomological monitoring will be used to ensure effectiveness of the IRS, whilst remaining cost effective.	About 65% of households in designated targeted areas will be sprayed during IRS campaign by 2017. This is expected to rapidly reduce transmission in high malaria endemic areas whilst addressing insecticide resistance.
LLINs-mass campaigns	Given the current coverage levels, the limited resources, and guidance from GF, Zimbabwe does not plan to repeat another mass campaign until 2017, and as such, this is not funded under this concept note, but included as over-allocation in 2016 (for a 2017 campaign), once universal coverage of IRS has been achieved.	About 65% of the population in the targeted areas will sleep under LLINs. This is expected to contribute to reduction in malaria parasite prevalence in children and number of confirmed malaria cases.
Long-Lasting Nets (LLIN) – Continuous distribution	In order to provide additional protection to vulnerable groups, specifically pregnant women, children under 5, and the immune-compromised, this funding request includes the provision of LLINs, via ANC and EPI visits, as well as OI clinics.	Reduction in malaria parasite prevalence in children / pregnant women and Proportion of children / pregnant women under five years old who slept under an insecticide-treated net*
Entomological Monitoring	Monitoring to determine vector presence, behaviours and susceptibility to insecticides being used for IRS and on LLINS remains an essential supporting intervention, particular with the recent discovery of pyrethroid-resistant An. *funestus*. Entomological surveys will be conducted annually in the 16 sentinel sites under this funding.	Efficacy of interventions monitored to ensure intended impact, to maintain efficacy of IRS as a usable control tool, and to maximize value for money from continued deployment of the interventions.
IEC/BCC	Given the changes in chemical, frequency of spraying employed and possible likely side effects, it is essential that extensive BCC campaigns be delivered in the protected areas to ensure coverage.	To facilitate access to structures for spray team and appropriate response to any adverse reactions to ensure high coverage and impact from IRS.

Case Management

Intervention	Justification	Expected Impact / Outcome

Facility Based Treatment	In order to achieve near zero deaths, malaria case management must be optimised to a high coverage, promptness, and level of quality. Additional resources in this concept note are requested to compliment PMI current investments, with a focus on introducing new policies for second line treatment (artemisinin combination) and severe malaria treatment with artesunate. Commodity quantification is based on need (as per HMIS trends, and anticipated effectiveness of vector control and the strengthening of parasitological confirmation).	100% of all confirmed malaria cases receive 1st line anti-malaria treatment according to national policy guidelines; this will reduce mortality, and effectively reduce the parasite reservoir, contributing to sustained low transmission.	
Active Case Detection and Investigation (Elimination Phase)	Zimbabwe is rapidly approaching a phase of pre-elimination/elimination in 20 of its districts, and as such, this intervention is a vital part of that strategy, to both minimise the risk of epidemics and expand malaria-free areas, as well as for improved reporting.	100% of all cases detected fully investigated within the recommended time; this supports case finding (particularly of asymptomatic cases) and identification of transmission foci.	
Integrated Community case management	One of the major barriers to achieving near zero malaria deaths is prompt access to ACTs. In spite of the good coverage of health facilities in Zimbabwe, some patients are simply unable to travel (cost, availability or capacity. The scaling up of community case management addresses this concern. The trainings will be integrated with other diseases for improved cost effectiveness and will complement those already delivering ACTs at community level.	95% of all suspected cases will receive parasitological test in the community, and patients will receive more prompt care, reducing complication of cases, and supporting the identification of transmission foci.	
IEC/BCC	Given the new second line drug policy, the new policy for the treatment of severe malaria, the introduction of AS suppository, and the role out of ICCM, extensive BCC/IEC will be need to ensure acceptance and compliance with these interventions.	Community acceptance and uptake of the new treatment protocols is a critical step towards attainment of all diagnosis and treatment goals, and thus towards reduced morbidity and mortality.	

Given the importance of demonstrating outcomes and impact, special attention has been given to the M&E module in this proposal. The allocated funds will be used to support the introduction of malaria specific modules (LLINS, IRS) into the DHIS 2 and to contribute to 30% of the operational costs of the centralised reporting system which is shared between HIV, TB and malaria. Several surveys will also be funded through this funding request, including 25% for the MIS, and a malaria case management audit to verify performance of case management. Finally a pre-elimination survey will be undertaken to establish feasibility and to determine a baseline. Four operational research studies looking at intervention to generate evidence for improved effectiveness are also budgeted.

3.4 Focus on Key Populations and/or Highest-impact Interventions

This question is <u>not</u> applicable for low-income countries.

Describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below:

a. If the applicant is a lower-middle-income country, describe how the funding request focuses at least 50 percent of the budget on underserved and key populations and/or highest-impact interventions.
b. If the applicant is an upper-middle-income country, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions.

½ PAGE SUGGESTED

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

4.1 Overview of Implementation Arrangements

Provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s).
b. If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients.
c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified.
d. How coordination will occur between each nominated Principal Recipient and its respective sub-recipients.
e. How representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.

1-2 PAGES SUGGESTED

a. In recent years, Zimbabwe has been operating under the Additional Safeguard Policy (ASP); under this policy, the Global Fund selected United Nations Development Program (UNDP) as the principal recipient (PR) for the malaria Global Fund grant since Round 8. Following the annual review of the ASP in February 2014, and discussions with the CCM on removal of additional safeguard measures, the Global Fund and the CCM have agreed that the MOHCC would serve as the PR under this funding proposal. As the MOHCC previously served as the PR for Malaria under Round 5, it has been agreed to revert to this arrangement, following an assessment by the Global Fund that the MOHCC is able to play this role once more. *(See CCM Eligibility Requirements)*. A fund administrator will be appointed to manage and secure the funds.

The PR (MOHCC) will implement activities through its decentralized structures nationwide. Several sub-recipients will be selected to implement some of the activities. Dual-track financing remains a challenge in view of the ASP and the fact that MOHCC has been the sole SR in the existing grant. However the PR (MOHCC) will work with the selected SRs and build capacity for them to potentially serve as PRs in the future.

b. N/A (only one PR has been nominated).

c. Implementation of the activities proposed in this funding request will be coordinated through the national structures of the MOHCC (in its capacity as PR); this funding request also provides

support to government and civil society staff involved in the implementation of this grant, either as sub-recipients or sub sub-recipients .

The chart below summarizes the proposed implementation arrangements for this funding request.

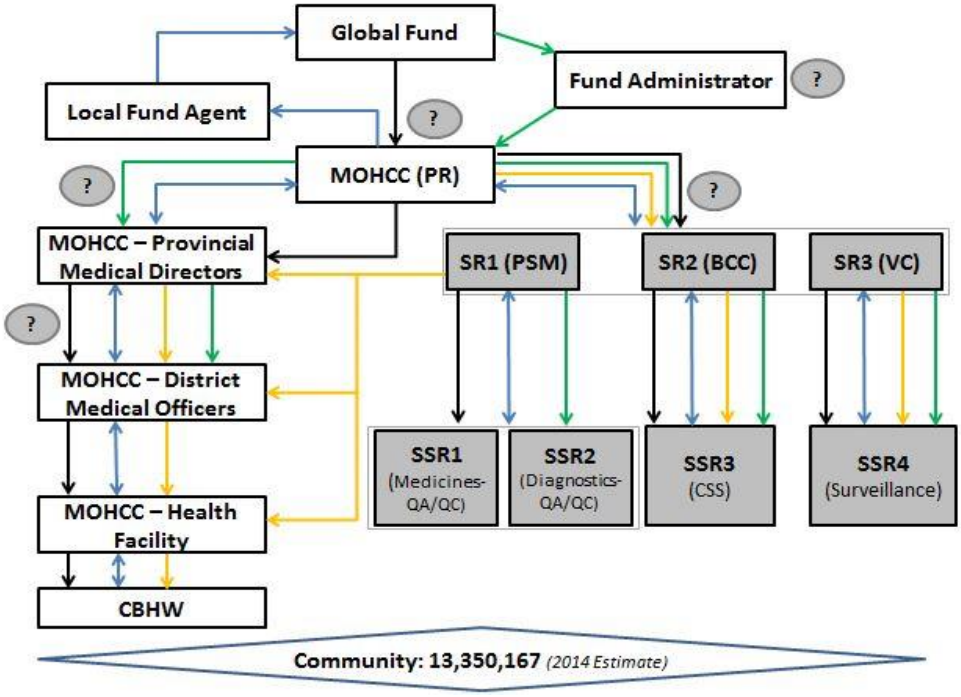


Figure 6: (Preliminary) proposed implementation arrangements for this funding request

At the time of submitting this funding request, Sub Recipients (SRs) and Sub-Sub Recipient (SSRs) have not been selected; the SRs and SSRs will be selected following the recommended procedures on transparency and fair selection laid down by the CCM. However, *Figure 6* above highlights some preliminary thinking on the broad categories of implementation partners that would be required. As the PR, the MOHCC will develop broad implementation plans for the execution of activities included in this funding request, and will sign SR agreements with specific responsibilities and activities to be managed by SRs. The SRs, on the other hand, will go through a transparent process to select SSRs and sign grant agreements with them. (Given the limited landscape of partners with experience implementing malaria and related aspects of malaria control, it is likely that previous SRs with a strong record of performance will be selected once more, while some new SRs and SSRs may be selected to support new elements of the evolving malaria strategy and to support aspects of implementation that require strengthening).

Following selection, MOUs and grant agreements that specify and outline the expectations in programme implementation will be signed, and rigorously monitored to ensure successful implementation, and contribution to the overarching country goals and targets. While the PR will lead the monitoring of effective and quality implementation of Global Fund resources, financial management will be supported by the fiduciary agent and the LFA. Supervision and accountability shall be enhanced through review meetings, joint preparation of progress updates, and joint verification of grant implementation.

At this point, only broad responsibilities have been identified for the PR, SRs, and SSRs and these will be refined at a later point. Preliminary roles are as follows.

- PR: programme management, monitoring and evaluation, implementation of activities
- SRs: IRS and LLIN implementation, storage and distribution of pharmaceutical and non-

pharmaceutical products
- SSRs: specific (pre-)elimination and surveillance systems, community mobilization and community case management, quality assurance

d. The MOHCC – in its capacity as PR - will provide overall management and guidance to the SRs and SSRs. The MOHCC will manage each SR individually on the basis of the standard conditions defined in the SR agreement that will be signed with each SR. The SR will in turn manage and coordinate SSRs under them. The MOHCC will have the responsibility to (i) manage the grant and provide technical guidance to SR/SSR (ii) coordinate with the fund manager and ensure timely disbursement of funds to the implementation of the approved activities; (iii) ensure budget monitoring of the SR/SSR activities and ensure that the funds are used as per the approved plan, (iv) coordinate and consolidate the periodic programmatic and financial reports, and (v) provide quality assurance on the periodic reports (both programmatic and financial) received from the SRs

The coordination between the MOHCC and SR/SSR shall be enhanced through scheduled monthly and quarterly meetings where progress and challenges in implementation are reviewed and remedial measures agreed upon to improve grant implementation and performance. As part of programme and financial monitoring and capacity building, joint on-site data verification (OSDV) and supportive supervision and mentoring will be carried out with SRs and SSRs. At grant initiation, and at periodic intervals, the PR (MOHCC) will conduct capacity assessments of the selected SRs and work with them to address identified gaps.

The CCM will continue to perform its oversight role and will approve all major changes. Regular updates on grant implementation will be provided to the CCM monthly.

e. Zimbabwe has adopted the universal access approach, which means everyone in malaria endemic areas, including key affected populations (immune-compromised, pregnant women children under-five and affected communities), has equal access to all malaria interventions. Communities will participate in the implementation of this grant through civil society SRs and SSRs, and through ward health committees (WHCs) and village health committees (VHCs). (These groups were also actively involved in the implementation of the previous grants, as well as in the processes leading to the development of this funding request). Representatives of key populations (Ward Health Teams, VHWs, FBO, etc.) participate in decision making and implementation. With regards to malaria specifically, prisons in malaria endemic areas will be sprayed during IRS campaign in the respective areas as has been done in the past. Pregnant mothers, children under five, and the immune-compromised will be receiving LLINs routinely.

4.2 Ensuring Implementation Efficiencies

Complete this question only if the Country Coordinating Mechanism (CCM) is overseeing other Global Fund grants.

Describe how the funding requested links to existing Global Fund grants or other funding requests being submitted by the CCM.
In particular, from a program management perspective, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

The existing single stream fund (SSF) grant was informed by the Zimbabwe National Malaria Strategic Plan (2008-2013, extended to 2015). The strategic plan – which has now been extended to 2017 - is being used to guide the prioritization of interventions in this current proposal. This application is more focused as it prioritizes high impact interventions identified in the ZMSP and is also guided by the National Malaria Business Plan. There are linkages which currently exist and the current grant will build on these.

In addition to the malaria grant, Zimbabwe is currently implementing three other Global Fund grants namely; TB, HSS (under the Round 8 Phase 2), and New Funding Model HIV grant. This proposal will support human resources costs which are specific to this grant, whilst TB and HIV grants will support the other HSS/CSS component.

Implementation efficiencies will occur through the following:

Planning and Supportive Supervision. MOHCC will harmonize and integrate supportive supervision at all levels of care, procurement and supply activities (storage and distribution, LMIS etc.). The MOHCC will conduct coordinated planning meetings, such as MODO, PHTs, DHTs, etc.

Monitoring and Evaluation. Zimbabwe is currently implementing the DHIS-2, which the malaria programme is benefiting in terms of M&E and surveillance. The NMCP will build on the existing investments in DHIS-2 by using this platform to manage additional electronic data collected from the pre-elimination districts. The Zimbabwe DHS (not funded through this funding request) will be leveraged by the malaria program to generate information on coverage and impact for particular malaria indicators.

Training. Training of community health workers will occur through an integrated approach to enable them to provide services to all three diseases. It is acknowledged that community-based health workers trained under the HSS grant have not been effectively used for malaria activities (as they were not trained in malaria case management). The malaria program, under this funding request, will build on those prior investments in training community health workers (both by previous Global Fund HSS grant and other donors).

Grant Coordination. The coordination of the grant will be done by MOHCC through NMCP, which is the implementing arm of the ministry. The main assumption is that the program will adopt one coordinating body (NMCP) and one malaria strategic plan. This helps to coordinate and integrate all available support from other partners in order to avoid duplication of services.

4.3 Minimum Standards for Principal Recipients and Program Delivery			
Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.			
PR 1 Name	Zimbabwe Ministry of Health and Child Care	**Sector**	Govt.
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?		☒ Yes ☐ No	
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		*Yes. The MOHCC will use national systems and structures to implement the proposed activities. Although the OIG report of 2013 revealed weakness in coordination and management, these are being addressed (See Section 4.4 above).*	
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)		*Yes. MOHCC has the requisite experienced human resources and,*	

	systems for effective management and oversight of SRs and SSRs. MOHCC has been PR under round 5 the sole SR under SSF malaria.
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	*Yes. In 2013 Capacity Development activities to strengthen the MOHCC Internal Audit Unit were implemented that resulted in successful formation and training of a Working Committee on internal audit.*
4. The financial management system of the Principal Recipient is effective and accurate	*Yes, in addition a Fiduciary Agent will be recruited to strengthen the financial management of the grant.*
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	*No. A plan to strengthen the supply chain management is being implemented to address the weaknesses identified. There is budget to strengthen Supply Chain Management through the HIV/AIDS grant*
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment/program disruptions	*Yes. NatPharm is the implementing agency for storage and distribution.*
7. Data-collection capacity and tools are in place to monitor program performance	*Yes. Standard reporting tools for data collection and templates for reporting have been developed and are being used.*
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	*Yes. A robust DHIS-2 has been rolled out nationally and provides the platform for all public health reporting systems to submit timely routine quality data from health facilities, through to districts and provinces and the national level.*
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	*Yes. A QA Programme has been developed, including activities to strengthen the current capacity and quality requirements.*

4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance
a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, Principal Recipient and key implementers' capacity, and past and current performance issues. b. Describe the proposed risk-mitigation measures (including technical assistance) included in the funding request.

a. The following risks to program delivery have been identified, and risk mitigation plans are under development.

Economic Context. Zimbabwe is emerging from a decade of hyperinflation and weak economic performance. However, since 2009 the economy has stabilized, and is registering considerable economic growth annually. Growth in national income has been registered, and a continued upwards trend is projected. Whereas hyper-inflation of the local currency previously eroded the value of external resources, the Government aims to maintain economic stability through maintenance of the USD currency in the medium term; it is therefore anticipated that over the duration of this grant, the USD will remain as the principal currency in use. The Government has also developed an economic blueprint to guide the growth of the economy in a sustainable manner – Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIMASSET).

Coordination and Management. Previous program evaluations (e.g. OIG report 2013) have shown weak coordination at all levels, which will need to be strengthened. The MOHCC has prioritized the provision of training in leadership and management, which will strengthen coordination at all levels of the Ministry of Health. Currently, an MOHCC-wide process is underway to build capacity in leadership and management; Global Fund Round 8 resources have been used to provide this capacity building for senior cadres in the Ministry of Health. Leveraging these resources, funding from the CDC is supporting training for provincial and district health executive teams as well. In addition, given the relatively small landscape of implementing partners and activities for malaria, it is believed that the management of the proposed grant for malaria can be successfully done within the current MOHCC structures.

Cross-Border Malaria Control and Importation of Cases
As referenced in the Global Fund portfolio analysis, the risks posed by the high incidence of malaria in Zimbabwe's eastern and northern neighbours potentially limit the disease impact and return on investment from Zimbabwe's current efforts. Zimbabwe's malaria control partners have actively participated in regional efforts to control malaria, including cross-border initiatives to limit the risks of importation along the eastern and northern borders. The Zambia-Zimbabwe cross-border initiative has been active, although timely implementation of activities has been limited by the flow of resources. While information sharing meetings do occur between Manicaland Province (Zimbabwe) and Manica Province (Mozambique), facilitated by a national-level MOU, implementation of any activities has been constrained by the lack of resources.

A key first step to addressing this challenge will be more accurate quantification of the challenge. Disease surveillance efforts in pre-elimination districts as well as in border districts will emphasize the categorization of imported and local cases through documentation of travel history among patients. NMCP and its key technical partners (PMI, Johns Hopkins University) collaborate on a research partnership (ICEMR) in Manicaland Province (the province bordering Mozambique) to better understand the drivers of transmission and the evolving disease context in that area.
Efforts are also underway (at the regional level) to develop a regional proposal for regional malaria collaboration, and this will further support coordination and resource mobilization.

Supply Chain Management, and Storage

ZIP coverage has been consistently above 95% of all health facilities per quarter and stock outs of all presentations of ACTs and RDTs have been below 10%. Institutions are also required to order products when stock levels fall below the emergency threshold, prior to another scheduled ZIP distribution. A logistic management information system is in use at NatPharm and health facilities remain largely manual. The central level maintains a database of all the logistics data collected during deliveries. Inequity in distributions has been observed and this has been attributed to failure to adhere to Standard Operating procedures by the delivery team leaders and the general

poor stock management at health facilities. Delays in deliveries have been one major challenge of the system. As a response, a revised pull system - Zimbabwe Assisted Pull System (ZAPS) - is being piloted in Manicaland and seeks to harmonize the distribution systems, possibly reducing cost and empowering facility staff to order through their involvement in the ordering process. If the pilot is successful, more funds will be needed for a full roll out to all the districts in the country.
As discussed earlier (section 3.2), there has been a noted difference between ACT consumption data and incidence data, resulting in significant challenges in quantification, and potential overstocking and expiry. In order to address this, a preliminary assessment was conducted, comparing data collected from the HMIS and the ZIP system.[24] It reviewed factors that contributed to a high variance between the two data sources. These were (i) high workload at facilities, which resulted in poor tallying, (ii) stockouts of some presentations for ACTs, resulting in combination or cutting of available presentations, and (iii) use of the daily tally as opposed to the RDT registers for compilation of monthly summaries. Recommendations developed following this assessment include quarterly data quality audits at provincial level, and redesign of the RDT register to include consumption of ACT data. Additional assessments and consultations will be held to finalize an approach to the choice of data used for quantification (i.e. HMIS or ZIP), building on the recommendations of this initial assessment. From this, models for more precise ACT quantification will be developed to improve on the quantification challenges that have been experienced in the past.

Issues of supporting infrastructure and storage space (especially for insecticides) have been identified by national assessments, as well as by the recommendations of the Global Fund Portfolio Analysis. Storage space is being compromised by increased volumes of anti-retroviral, TB medicines and old records.[25] An assessment of storage space and conditions was conducted in February 2013 for 52 facilities and recommendations were made and renovations are currently being made to those facilities[26] However, there is a need for expansion of storage space beyond these 52 sites. Following the assessments conducted on supply chain and storage capacity,[25,26] an Action Plan has been developed as a roadmap to guide multi-sectoral efforts to address this challenge (See Annex 17); some of these activities have been included within the HIV funding request, while some gaps remain (and are included in the above request of this proposal).

Human Resources for Health Financing and Retention. The Health Workforce Retention Scheme – supported by the Global Fund and Health Transition Fund- has been an effective tool for lowering staff attrition in the health sector, but the potential termination of this scheme may become a risk to the human resource situation. The retention scheme has contributed immensely to arresting the problem of staff attrition as Government has been unable to support competitive salaries for health professionals. The OIG report of 2013 noted that termination of the retention scheme before Government is able to support salaries at competitive levels has the potential of reversing current gains. Government has been consistently increasing salaries of civil servants. In 2014, civil servants were awarded a salary increment of almost 26%. Government is also working with partners to look at other options to deal with potential brain drain, and proposals of non-financial incentives to motivate and retain health workers are being considered.

b. As the PR of this grant, the MOHCC will receive support in financial management systems through a fiduciary agent. The costs of engaging this agent have been included under the program

[24] Data Survey: Report on ZIP and HMIS ACT Data (Annex 37)

[25] Comprehensive assessment of the supply chain for health commodities in the public sector in Zimbabwe, Euro Health Group. pg. 3 (Annex 16)

[26] Assessment of storage capacity and conditions of Health commodities in Zimbabwe, Progress Report: Ernst and Young February 2013. (Annex 17)

management module.

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

- ☒ Table 1: Financial Gap Analysis and Counterpart Financing Table
- ☒ Table 2: Programmatic Gap Table(s)
- ☒ Table 3: Modular Template
- ☒ Table 4: List of Abbreviations and Annexes
- ☒ CCM Eligibility Requirements
- ☒ CCM Endorsement of Concept Note