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

Concept Note for Early Applicants

This concept note template is to be completed by early applicants invited to request funding from the Global Fund in 2013 during the transition to the new funding model. For more information on how to complete the concept note, please refer to the Concept Note Instructions.

The concept note details the applicant's request for Global Fund resources in a disease area (and/or health and community systems strengthening) for the next three year period. The concept note should articulate an ambitious and technically sound response, drawing from the Health Sector Strategic Plan, National Strategic Plans and other appropriate documentation. It should include a prioritized full expression of demand to maximize impact against the disease(s).

There are five different sections of the concept note:

Section 1: How the application development process complies with CCM Eligibility Requirements.

Section 2: An explanation of the country's epidemiological situation and the current legal and policy environment, and how the National Strategic Plan responds to the country disease context.

Section 3: How existing and anticipated programmatic gaps of the National Strategic Plan have been identified.

Section 4: How the funds requested will be strategically invested to maximize the impact of the response.

Section 5: How the program will be implemented.

This concept note is specifically designed for early applicants and does not represent the final template to be used for the full roll-out of the new funding model. The concept note template will be revised to reflect feedback received during the transition phase.

CCM Zimbabwe
Country : Zimbabwe
Start Date : Wed Jan 01 00:00:00 GMT 2014
Last Modified Date : Wed Apr 03 01:01:14 GMT 2013
Last Modified By : Matthews Maruva

OVERVIEW: Summary Information

Applicant Information

Component	HIV	**Modules**	Treatment, care and support;PMTCT;Prevention general population;Program Management (HIV);M&E (HIV);Other (HIV);HCSS: Community groups and networks;HCSS: Health and community Workforce;HCSS: Information systems;HCSS: Procurement & Supply Chain Mgmt;Other 2 (HIV);Other 3 (HIV)
Indicative Amount		**Proposed Split Status**	Not yet submitted
Funding Request Start Date	01.01.2014	**Funding Request End Date**	

Funding Request Summary			**Currency of Funding Request**		USD
Component:			HIV		
Year	**A= Existing (Global Fund grants)**	**B= Incremental Funding Request (Indicative)**	**C= Funding Request (above Indicative)**	**A+B= Existing and total Incremental Indicative Funding Request**	**A+B+C= Full RequestInsert**
2014	32296138	80446825	44481031	112742963	157223994
2015		98217263	88216423	98217263	186433686
2016		100215015	111667934	100215015	211882949
Total	32296138	278879103	244365388	311175241	555540629

SECTION 1: CCM Eligibility Requirements and Dual Track Financing

Two of the six CCM Eligibility Requirements relate to application development and Principal Recipient (PR) selection processes and will be assessed as part of the concept note:

a. **Requirement 1** – Application development process
b. **Requirement 2** - The Principal Recipient(s) selection process.

For each Requirement, applicants must provide evidence of compliance and attach relevant supporting documentation. Please also fill in and attach the **CCM Endorsement** (Attachment 1).

1.1 Application Development Process (Requirement 1)

Please describe:

a. The **documented and transparent process** undertaken by the CCM to **engage** a broad range of stakeholders, including non-CCM members, in the application development process.

b. The efforts made to engage **key population groups**[1], including most-at-risk populations[2], as active participants in the country dialogue and application development process.

a. Documented and transparent process to engage broad range of stakeholders

Involvement of stakeholders prior to development of the Concept Note

The Zimbabwe national response to HIV has long been multisectoral in character encompassing efforts of a wide range of stakeholders including government, civil society, private sector, academia, faith groups, local communities and international organisations. The National HIV and AIDS Policy and the Zimbabwe National HIV and AIDS Strategic Plan 2011-2015 (ZNASP II – see Annex 1) articulate a participatory approach to the national response. The National AIDS Council was established to promote broad participation and coordinate efforts of all stakeholders. Various structures and processes are in place to facilitate on-going consultations and engagement at national, provincial, district and community levels. This participatory approach also applied in the process of developing this Concept Note.

The ZNASP II was developed in 2010-2011 through a highly participatory process which involved broad consultations and consensus on the status of the response, national priorities, targets, costs and implementation arrangements. The priorities contained in this Concept Note are all derived from the ZNASP II.

[1] **Key population groups** include: women and girls, men who have sex with men, transgender persons, people who inject drugs, male and female and transgender sex workers and their clients, prisoners, refugees and migrants, people living with HIV, adolescents and young people, vulnerable children and orphans, and populations of humanitarian concern. In addition to these groups: internally displaced persons, indigenous persons, people living with TB and malaria and people working settings that facilitate TB transmissions should also be considered as key affected populations.

[2] For the purpose of the transition to the new funding model (GF/B28/DP5), most-at-risk populations will be defined as subpopulations, applying to HIV, malaria and tuberculosis, within a defined and recognized epidemiological context:

1) That have significantly higher levels of risk, mortality and/or morbidity;
2) Whose access to or uptake of relevant services is significantly lower than the rest of the population; and
3) Who are culturally and/or politically disenfranchised and therefore face barriers to gaining access to services.

In addition, Zimbabwe established various Partnership Forums on HIV and TB where stakeholders meet on a quarterly basis to address issues in implementation of the response. These forums provide a platform for on-going country dialogue on key issues related to the HIV and AIDS response. The main Partnership Forums that meet consistently are: (see Annexe 2: Minutes of Partnership Fora meetings)

- Elimination of mother-to-child transmission
- Laboratory Services
- TB and HIV Care

These are supplemented by broader health systems fora and working groups including the Health Transition Fund (HTF) Steering Committee which meets monthly and addresses broad Maternal, Newborn and Child Health (MNCH) and the pillars of the health system (see Annexe 3: Health Transition Fund: A Multi-donor Pooled Fund For Health In Zimbabwe. October 2011), and the Integrated Support Programme (ISP) addressing HIV prevention, Sexual and Reproductive Health Rights (SRHR) and Gender based violence (GBV). All the foregoing processes contributed significantly to ensuring adequate consultations and participation of stakeholders in developing this funding application despite the very tight timelines to complete the process.

Stakeholder involvement during development of the Concept Note

The Zimbabwe Country Coordinating Mechanism (CCM) ensures that funding applications to the Global Fund are developed with broad stakeholder participation and in an open and transparent manner (see Annexe 4: CCM Guidelines).

Upon receiving notice of Zimbabwe's selection as an early applicant for HIV and AIDS under the New Funding Model (NFM), the CCM's HIV and AIDS Committee hosted a meeting on 5th March 2013 to begin preparations and identify gaps and focus areas for the application. The twelve members of the HIV and AIDS Committee are drawn from CCM constituencies, though they are not necessarily CCM members. Meetings of the Committee are open to and attended by a variety of stakeholders from all sectors (see Annexe 5: Membership and Minutes of CCM HIV & AIDS Committee 5 March 2013).

The HIV and AIDS Committee, tasked with the responsibility of drawing up an evidence-informed preliminary list of priority areas for inclusion in the proposal and proposing the composition of a writing team, consulted with their respective constituencies to develop the initial suggestions for priority activities and the composition of the writing team.

The writing team comprised 25 individuals representing a wide range of stakeholders from different constituencies including People Living with HIV (PLHIV), the Ministry of Health and Child Welfare (MOHCW), the National AIDS Council (NAC), civil society and international development partners. The CCM appointed Ms. Tatiana Shoumilina, a CCM member from UNAIDS, and Dr Owen Mugurungi, a Director in the MOHCW responsible for HIV and TB, to oversee the proposal development. In addition to the oversight leadership, two technical persons (one from MOHCW and the other from NAC) were tasked to lead the writing team to ensure a multisectoral approach. Guiding principles and working arrangements were documented and circulated to all members, and writing team members signed a declaration of interest form to ensure inputs were given in the interests of Zimbabwe's HIV response and not along narrow organizational priorities of individuals (see Annexe 6: Writing Team Composition, Roles and Responsibilities, and Sample Declaration of Interest).

Members of the writing team continuously interacted with key constituencies during the proposal development process, gathering input on overall perspectives, gaps and priority activities for inclusion in the proposal and feeding these into the writing process itself.

Two CCM meetings were held specifically to discuss the NFM. In the first meeting, held on 6 March 2013, the Global Fund Secretariat briefed members on Zimbabwe's selection as an Early Applicant and the requirements for NFM. Following this meeting, the CCM accepted the offer to participate as an early applicant and to develop a Concept Note for a new HIV and AIDS grant. The second CCM meeting was held on 27 March 2013 to discuss and approve the final Concept Note (see Annexe 7: CCM Minutes 6 and 27 March 2013). These two CCM meetings were uniquely well attended by both CCM and non-CCM members. This strategy was used to ensure broad engagement in the process despite the limited time available for sector-by-sector consultations.

The CCM also hosted a number of specific consultations to further solicit contributions from stakeholders. Between 5th and 7th March a series of inclusive, constituency based consultations were held with the Global Fund (GF) country team to introduce the New Funding Model (NFM) and familiarise stakeholders with the new application processes. On 12 March 2013 the CCM Secretariat discussed the NFM with the International Non-Governmental Organisation (INGO) forum and encouraged them to participate in the process given their place as a key constituency in the response. On 13 March 2013, members of the writing team and CCM secretariat attended a one day meeting with Provincial Medical Directors (PMDs) and key officials from the MOHCW to introduce the NFM and solicit inputs for the application. The PMD's meeting is a regular in-country dialogue and is held quarterly bringing together Provincial Medical Directors, key MOHCW Head Office Departments (laboratory services, Pharmacy Services, and HIV and TB programmes), City Health Departments from major towns, and Central Hospitals. The discussion was focused on identifying programmatic gaps on the ground and proposing priority interventions and activities for the new application (Annexe 8: Minutes of the PMD Consultation).

On 14 March 2013, the CCM held a one day consultative workshop to identify gaps in the HIV and TB responses and discuss focus areas for consideration in the NFM. Over 80 stakeholders representing a broad range of interests responded to the open invitation circulated widely by email and attended the workshop. Meeting evaluations documented the broad consultation and wide participation as a key positive aspect of the workshop (see Annexe 9: Stakeholder Workshop Report 14 March 2013).

The PLHIV representatives of the writing team also held consultations within their constituencies of key affected populations including women's groups and Sex Workers (SWs). Issues explored during these consultations included barriers in accessing services, suggestions to overcome these barriers, and recommendations of activities for inclusion in the new application (see Annexe 10: Documentation of PLHIV Writing Team Members' Consultations with Key Populations).

All information was consolidated into a format to enable the writing team to review and incorporate the identified issues into the writing of the proposal.

Stakeholder involvement in reviewing the Concept Note

The draft Concept Note was circulated for review on 23rd March 2013 (see Annexe 11: Distribution List for Review of Draft Concept Note circulated 23 March 2013). Groups reviewing the document included all CCM members, the Technical Review Panel (TRP) in Geneva, pre-selected technical reviewers, the UN family (country, regional and global), United States Government (USG) and other bilateral donors and all stakeholders who had participated in the process of developing the application. Each group consulted further with its respective constituencies and provided feedback to the writing team. Civil society groups with support from UNAIDS, the International HIV/AIDS Alliance and Pangaea Global AIDS Foundation organized a separate workshop to review the draft on 26 March 2013.

a. **Efforts made to engage key population groups**

Key populations as active participants in country dialogue

In the Zimbabwe context, key populations most affected by HIV and AIDS include heterosexual couples in stable unions, orphans and vulnerable children, mobile workers (e.g. truckers, small scale miners, informal traders) and young people. People living in hard to reach geographical locations are also underserved and have to adopt various strategies to access services including group collection of periodic medicines. Most-at-risk populations include sex workers, people living with disabilities, prisoners and men who have sex with men (MSM).

ZNASP II is built on 8 guiding principles, three of which inform the engagement with key populations:

Putting human rights at the centre of the national response to HIV and AIDS Addressing gender inequalities in the national response to HIV and AIDS Meaningful participation of those for whom HIV and AIDS interventions are planned

Beginning with the President's directive that enabled the establishment of local government structures reaching down to the village level, Zimbabwe's structures are designed to accommodate engagement by communities in the national effort to reduce new infections and keep people alive. PLHIV have a guaranteed seat on each of the NAC structures from the national to the ward level. In addition, engagement takes place through national structures including a Technical Working Group on Gender,

GlobalPOWER Women Network Africa-Zimbabwe Chapter, PMTCT and ART Partnership Forums, Community and Home Based

Care (CHBC), Meaningful Involvement of PLIHV (MIPA) and Young People's Network.

Key populations as active participants in proposal development process

Representatives of key population groups, including the most at risk populations, were active participants in country dialogues on the development of the Concept Note. Representatives of PLHIV (specifically ZNNP+ and ZHAAU) were represented on writing team for the Concept Note. One of their specific roles was to reach out to key populations. Representatives of women's organizations (specifically Women AIDS Support Network, UN Women), and other key populations such as Gays and Lesbians

of Zimbabwe (GALZ) participated in the Program Gap Analysis workshop on 14 March 2013 in Harare. UNFPA hosted a meeting on 15 March 2013 in Harare for the Sex Worker Technical Working Group to discuss the development of the Concept Note and garner their input.

Focal people from within networks and organizations working with key populations also participa the stakeholder review of the draft Concept Note before finalization and submission. T representatives aimed to ensure that the Concept Note is technically sound and adequately re their aspirations.

1.2 Principal Recipient (PR) Nomination and Selection Process (Requirement 2)

Please describe:

a. The documented and transparent **process and criteria** used to nominate any new or continuing PR(s).

b. How any **potential conflict of interest** that may have affected the PR(s) nomination process was **managed**.

a. Documented and transparent process and criteria used to nominate continuing PR

The Zimbabwe CCM has developed and adopted guidelines for the selection of Principal Recipients (PRs). They are contained in a document entitled 'Standard Procedures for National Call and Principal Recipient (PR)/Sub Recipient Selection Process for Global Fund Proposals' (see Annexe 12: Standard Procedures for National Call and Principal Recipient (PR)/Sub

Recipient Selection Process for Global Fund Proposals). This document guides the CCM in the selection of potential implementers of Global Fund supported programmes in Zimbabwe, in a transparent manner. However for the current application, the provisions of the PR selection guidelines were not relevant because Zimbabwe is under additional safeguard measures from the Global Fund (GF). The GF in consultation with the CCM has nominated UNDP as the Principal Recipient for all GF grants to Zimbabwe since Round 5 Phase II in 2009, and this is expected to continue as long as safeguard measures are in place. In 2012 the GF reviewed the safeguards but retained the condition that the PR for GF grants will be nominated by GF. The CCM therefore did not go through a PR selection process but maintained UNDP as the PR under NFM for HIV and AIDS, which has also been performing well.

b. How potential conflict of interest in PR selection was managed

The Zimbabwe CCM has a conflict interest policy that is applicable to all its processes including PR selection. However, since the country is still under the additional safeguard Policy, the CCM did not go through a process of selecting the PR. UNDP remains the PR for all GF grants to Zimbabwe.

1.3 Dual-track Financing

Dual-track financing refers to a proposed implementation arrangement that involves both government and non-government sector PRs. If this funding request does not reflect dual-track financing, please explain why. If your funding request includes dual-track financing, please leave this section blank.

No. The principle of dual-track financing at PR level does not apply to Zimbabwe at the moment given that the PR is not selected by the CCM. As described above, the country is currently under the Additional Safeguard Policy and UNDP, which is neither government nor civil society, was nominated by the GF in consultation with the CCM as the preferred PR for all GF grants to Zimbabwe. The Zimbabwe CCM commits itself to implement dual track financing when the opportunity to select PRs is availed. The CCM will however work with the PR to ensure that dual track financing is reflected in the selection of implementers (Sub-Recipients – SRs, and Sub-Sub Recipients - SSRs).

SECTION 2: Country Context

2.1 Country Disease Context

Explain the current and evolving epidemiological situation of the disease in your country. Refer as appropriate to the Performance and Impact Profile provided by the Global Fund, as well as other recent program reviews or relevant sources. Highlight the concentration of burden among specific population groups and/or geographic regions and any recent disease pattern changes (incidence or prevalence).

In your response, describe:

a. **Key affected populations** that are epidemiologically important and may have disproportionately low access to prevention and treatment (and for HIV and TB, care and support services).
b. Factors that may cause **inequity in access to services** for treatment and prevention, such as gender norms and practices, legal and policy barriers, stigma and discrimination, poverty, geography, conflict and natural disasters.
c. **System-related constraints** at the national, sub-national and community levels in reducing the burden of the disease.

a. Epidemiological situation of HIV in Zimbabwe including Key Affected Populations

HIV prevalence, incidence and mortality

Zimbabwe, one of the countries hardest hit by the AIDS epidemic in sub-Saharan Africa, has a projected population of 12.9 [2] million people[1]. The prevalence of HIV among adults 15-49 years is 15%, 18% for women and 12% for men . Trends in HIV adult prevalence show initial increases with age and then a decline. For women, HIV prevalence increases to a peak of 29% in the 30-39 year age group while for men a peak of 30% is among those aged 45-49 years.

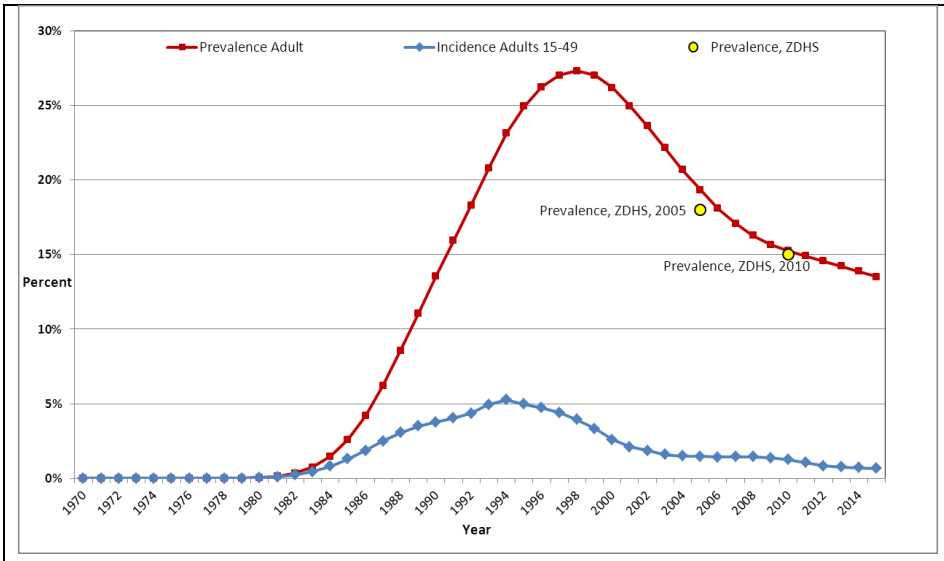
HIV prevalence is higher among individuals who are employed (17%) than among those who are unemployed (13%) and is modestly higher in urban than in rural areas (17% and 15% respectively). Differentials by province, on the other hand, are large. Matabeleland South has the highest prevalence estimate (21%), followed by Bulawayo (19%). Harare has the lowest prevalence estimate (13%), followed by Mashonaland Central, Manicaland, and Masvingo (14%).

By the end of 2012, an estimated 1.2 million people (1,053,535 adults and 189,233 children) were living with HIV and an [3] estimated 597,293 adults and children were in urgent need of antiretroviral therapy by the end of 2011.

In 2011, there were an estimated 46,250 new HIV infections, 63,765 AIDS related deaths and 946,547 children were orphaned [4] due to AIDS-related deaths.

HIV estimates from 2005, 2007, and 2009 modelling exercises show a declining HIV epidemic. The results correspond with trends in the ANC surveillance data from 1998-2008 and are consistent with epidemiological reviews and studies in Zimbabwe. The decline in incidence is attributed to the successful implementation of prevention strategies especially behaviour change, high condom use, and reduction in multiple sexual partners[5],[6]. High mortality due to low ART coverage contributed to a lesser extent to this decline. Overall ART coverage has now increased from 36% in 2009, 51% in 2010 to 86% (42% in children and95% in adults) by end 2012 (MOHCW).

Figure 1 (attached) : Estimated prevalent and incident HIV infections and AIDS mortality in Zimbabwe (1990-2009)



Modes of transmission and key affected populations

HIV transmission in Zimbabwe remains predominantly sexually driven. Sexual transmission accounts for over 90% of new infections. People practicing low-risk sex in the general population are the major sources of new HIV infections contributing 57.6% due to low condom use and high sexual networking. Table 1 shows estimates of contribution to new HIV infections by population group.

Table 1: Main outputs from the application of the UNAIDS HIV incidence by exposure group model

Exposure group by risk behavior	Proportion of total adult population aged 15-49		Estimated HIV prevalence in the group	Model Outputs		
	Male	Female	Prevalence of HIV (%)	Incident infections	Percent of incidence	Incidence per 100,000
Low-risk heterosexual	37.83%	44.04%	14.30%	24183	54.79	1031
Partners Casual Heterosexual Sex	5.00%	12.00%	14.30%	5984	13.56	1229
Casual heterosexual Sex	15.00%	6.00%	17.00%	4277	9.69	711
Clients of SWs	4.00%		19.30%	4251	9.63	3710
MSM	3.00%	0.00%	16.80%	2727	6.18	3172
Sex Workers	0.00%	1.44%	54.32%	912	2.07	2210
Partners of Clients		2.00%	20.90%	865	1.96	1510

Injecting Drug Use (IDU)	0.14%	0.05%	12.40%	626	1.42	11496
Female partners of MSM	0.00%	2.00%	20.00%	241	0.55	420
Medical injections	12.80%	28.20%	14.30%	39	0.09	3
Partners IDU	0.03%	0.07%	14.30%	30	0.07	1061
No Risk	35.00%	32.40%	10.00%	0	0.00	0
Blood transfusions	1.00%	1.00%	14.30%	0	0.00	0
Total adult population	100%	100%	13.68%	44134		770

Source: Zimbabwe analysis of HIV epidemic, response and modes of transmission, August 2010

Some of the key populations at high risk of HIV infection and/or not adequately reached with HIV services (most-at-risk populations) include the following:

- Heterosexual people in **stable unions** or people considered to engage in low risk heterosexual sex are estimated to account for around 54.8%% of all new HIV infections.
- 11.3% of **married/cohabiting couples** are sero-discordant where in 6.7% the man is the HIV positive partner and in 4.5% the woman is the HIV-positive partner
- HIV prevalence in young women is significantly higher than in their male peers, (e.g. in 20-29 year age group 20% of women have HIV infection compared to 10% of men). Young women are infected earlier with HIV, although from a lifetime perspective, men and women face a similar level of risk.
- There is no recent estimate of the proportion of new HIV infections in young people in Zimbabwe, but global data suggest that around 36% of new infections are in this group
- **Sex workers and their clients** together account for approximately 12% of new HIV infections. HIV prevalence in sex workers is particularly high (40–80%) due to the high numbers of partners, inadequate access to quality services, and a number of other factors.

- There are currently no local data on the population size estimate or HIV prevalence in men who have sex with men (**MSM)** in Zimbabwe. Behavioural data from a small convenience sample of MSM surveyed by Gays and Lesbians of Zimbabwe (GALZ, 2009) indicated high HTC practice and suggested irregular condom use. The Blair Research and Training Institute of Zimbabwe (BRTI) is completing a regional size estimation study including MSM, its data is expected to provide more information on the HIV situation and behaviour patterns within this population group.
- A recent study indicated that HIV prevalence in **prison settings** is 26.8% for male inmates and 39% for female inmates; however, HIV status prior to incarceration is not known[7].

a. Factors that may cause inequity in access to services for treatment and prevention

Zimbabwe's HIV and AIDS Policy and strategic framework promote equity in access to services and effort is being made to ensure equitable access to prevention, care, treatment and support. However, barriers still exist.

Legal and policy barriers - Legal barriers to HIV prevention including illegal status of sex work sex between people of the same sex and prohibition of condom promotion in school settings still exist. Despite the current lack of legal frameworks for prevention activities with sex workers, prisoners and MSM, Zimbabwe has allowed the existence of informal lobby groups for these populations. In the meantime efforts are being made to scale up HIV services to most-at-risk populations using a public health approach. The primacy of customary law over the Bill of Rights has affected women's and girls' constitutional rights on protection and gender equality. While the Constitution includes a clause that promotes gender equality, it nonetheless maintains a "claw back clause" that undercuts the fundamental values by recognising the primacy of customary law over the Bill of Rights. A study in Zimbabwe demonstrated that married women who experience physical violence only, or both physical and sexual violence, are significantly more likely to be HIV-positive than those who have not experienced any physical or sexual violence. Further studies are needed to establish a causal relationship in the observed association.

Gender norms and practices - Domestic violence is widely acknowledged to be of great concern from the perspective of human rights, economic development, and public health. Despite existing legislation, much more can be done to protect the victims given 27% of Zimbabwean women have experienced sexual violence in their life-time with insignificant variation by wealth and [8] education . Men's notions of masculinity, such as fear and denial of HIV, interfere with women's ability to achieve optimum antiretroviral therapy, particularly important for 'treatment as prevention' programmes. At the same time, social norms on masculinity serve as a barrier to men's uptake of HIV prevention and treatment services. Migration and mobility can increase individual risk behaviour and restrict access to HIV and health services. Higher HIV prevalence in some mining, commercial farming and border areas suggests the need to intensify HIV prevention services in those areas.

Geography – Access to services is geographically homogeneous due to the decentralised scale up of services through health and community structures at all levels. However some hard-to-reach populations remain including resettlement areas, mobile populations such as small-scale and informal miners, and areas distant from health facilities with geographical barriers to access varying on a seasonal basis e.g. restricted access due to rains.

Stigma and discrimination – The National HIV Policy promotes zero stigma and discrimination with a supporting legal framework including non-discrimination in relation to employment. Stigma in Zimbabwe has been decreasing, visible in communities with increasing openness and discussion of HIV; the ZDHS showed an increase in the percentage of men and women expressing accepting attitude towards PLHIV, from 17.1% and 10.8% women and men respectively in 2005-6, to 39.8% and 39.2% in 2010-11. The 2012 UNGASS report also showed that the stigma component of the NCPI has reduced to 6.1. The recently launched Stigma Index Study will provide quality, up-to-date local information on the scope and scale of HIV-related stigma in Zimbabwe and inform further action as required.

Poverty – Zimbabwe is a low income country and is currently in recovery from an economic crisis under the guidance of the Government of Zimbabwe Mid Term Plan. Zimbabwe has experienced improved economic growth rate in recent years but this has not yet translated into increased productive employment and reduction of poverty. While ARV medicines are provided free of charge, economic access therefore remains a barrier to services including through out-of-pocket expenditures on user fees at health facilities, laboratory and X-ray charges, and transport to attend health facilities.

a. **System-related constraints at the national, sub-national and community levels in reducing the burden of the disease**

An efficient and effective health system is a pre-requisite for the HIV response. Without a functional system, scale up and integration of services cannot take place. The economic crisis had severely weakened the health system at all levels (national to primary care level) and within all building blocks of the health system. However, under the overall framework of the National Health Strategy (see Annexe 13 - Zimbabwe National Health Strategy 2009-2013: Equity and Quality In Health, A People's Right) the Ministry of Health and Child Welfare (MOHCW) is resuscitating the health sector and putting Zimbabwe back on track to meet the Millennium Development Goals (MDGs) in health. HIV is included in this strategy as one of the priority intervention areas and progressive efforts to integrate HIV within the broader health system continue in the hopes that each will strengthen the other going forward. Health financing and retention of a skilled health workforce remain key outstanding challenges to be addressed. In responding to HIV, Zimbabwe's communities are organised around community based organisations, support groups and community networks and local level coordinating structures. These structures are intended to support and coordinate communities in community based health interventions including demand creation for services, adherence support and defaulter tracking. Strengthening community participation is an important element in order to ensure high standards of transparency, accountability of health service management and community ownership of health programmes. However, community responses have not been sufficiently defined and prioritised, and have suffered from lack of cohesion. The interface between community and health service delivery also requires continued strengthening.

Capacity within both health and community systems needs to be strengthened in order to better reach key and most-at-risk populations with services.

Future investment in health and community systems will focus on improving access and quality of services including for key populations, strengthening community service availability, generating demand and ensuring adherence.

[1] Zimbabwe Census 2012 Preliminary Report, Zimbabwe National Statistical Agency (ZIMSTAT)

[2] Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International, 2012, Zimbabwe Demographic and Health Survey

2010-11. Calverton, Maryland: ZIMSTAT and ICF International, Inc.

[3] Ministry of Health and Child Welfare 2011 National HIV Estimates Report, 2011 [4] Ibid.

[5] Halperin, D.T., et al., A surprising prevention success: why did the HIV epidemic decline in Zimbabwe? PLoS Med, 2011. 8(2):

p. e1000414

[6] Gregson, S., et al., HIV decline in Zimbabwe due to reductions in risky sex? Evidence from a comprehensive epidemiological review. Int J Epidemiol, 2010. 39(5): p. 1311-23.

[7] Center for Health Strategies (CHEST), 2012, 'Assessment of HIV Prevalence and Risk Behavior among the Prison Population in Zambia', Final report (unpublished).

[8] Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International, 2012, Zimbabwe Demographic and Health Survey

2010-11. Calverton, Maryland: ZIMSTAT and ICF International, Inc.

2.2 National Strategic Plan

Briefly describe your National Strategic Plan and how it addresses the country disease

context described in 2.1.

In your response, please describe:

a. The **goals, objectives and priority interventions** of the National Strategic Plan, placing emphasis on their **on-going relevance** and any planned or needed revisions over the lifetime of the Funding Request.

b. The **current stage of implementation** of the National Strategic Plan and the country processes for reviewing the Plan. If you are in the last 18 months of the period covered by the National Strategic Plan, please explain the process and timeline for the development of a new plan.

c. The **main findings of, and response to,** any recent assessments and/or program reviews.

a. **Goals, priorities and interventions of the National Strategic Plan (NSP)**

ZNASP II is a five-year 2011 to 2015, multi-sectoral framework developed to inform and guide the national response towards achieving zero new infections, zero discrimination and zero AIDS related deaths by 2015. The development of the plan was premised on a human rights based planning approach complemented by evidence and results based management approaches.

The strategic plan has mainstreamed gender dimensions in the response strategies, anticipated results and indicators that are used to measure performance. The plan provides meaningful opportunities for diverse stakeholders' participation in the implementation of the national response.

To achieve the anticipated results the implementation of the national response requires doing better and more of the right things at the right time in the right scale and intensity. For the five year period (2011-2015) covered by the ZNASP II, Zimbabwe has identified the following two national priorities in the fight against HIV and AIDS.

Prevention of new adult and children HIV infections

Reduction of Mortality amongst PLHIV

These priorities are being achieved through the implementation of prioritised interventions that contribute to specific impact, outcome and output results. The ZNASP II has articulated three impact and twenty-four outcome level results. A results framework is attached as Annex 14. The following are the three impact level results in ZNASP II based on 2009 estimates:

Impact 1. HIV incidence reduced by 50% from 0.85% (48, 168) for adults (2009) to 0.425% (24,084) by 2015

Impact 2. HIV and AIDS related mortality reduced by 38% from 71299 (2010) for adults and 13,393 for children (2009) to 44,205 for adults and 8,304 for children by 2015

Impact 3. National HIV and AIDS response is effectively coordinated and managed: the NCPI rating is improved from 6.2 in 2010 to 9.0 in 2015

ZNASP II is supporting efforts that consolidate mainstreaming of human rights and gender responsive approaches in HIV and AIDS planning and service delivery mechanisms. Strategies are targeting most at risk and key populations. To ensure better outcome results efforts are being made to integrate services, and strengthen health and community systems to support efficient and effective services delivery.

National Priority 1: Prevention of new HIV infections in adults and children

Reduction of new HIV infections in adults and children is being achieved through intensified delivery of combination prevention interventions. Based on the KYE/KYR and MOT evidence ZNASP II prioritises reduction of sexual and vertical transmission of HIV.

In addressing **sexual transmission** of HIV, ZNASP II has prioritised interventions around social and behaviour change; increased condom promotion and distribution, coupled with intensified awareness on correct and consistent use; voluntary medical male circumcision (VMMC); HIV, testing and counselling; prevention and control of sexually transmitted infections.

These strategies are addressing the key drivers of the epidemic which include multiple and concurrent partnerships, inter-generational sex, discordant couples and low circumcision rates. HIV Testing and Counselling (HTC) has been identified as a strategic entry point for both ART and HIV prevention services. Provider initiated testing and counselling (PITC) services are being scaled up and have been rolled out to 94% of health facilities.

Zimbabwe has committed itself to elimination of new HIV infections in children and keeping their mothers and families alive, with an aim of **eliminating mother to child transmission** of HIV and reducing maternal mortality by 2015. This is being achieved through the implementation of all four PMTCT prongs. PMTCT services are being scaled up, including provision of Antiretrovirals (ARVs) to pregnant women to prevent mother to child transmission and Antiretroviral Therapy (ART) for the woman's own health, accelerating paediatric HIV testing, and provision of ART/Cotrimoxazole prophylaxis to infants. Similarly primary prevention interventions are being scaled up and integrated into other relevant health care services including Maternal, Newborn and Child Health (MNCH). Male involvement in the eMTCT agenda is being strengthened.

Zimbabwe continues to intensify its efforts on blood safety through capacity building and technical support to the National Blood Transfusion Services. Zimbabwe has attained a 100% screening of blood for transfusion transmissible infections (TTIs), including Sexually Transmitted Infections (STIs) and HIV in accordance with national guidelines.

ZNASP II seeks to improve availability and access to Post Exposure Prophylaxis (PEP) services countrywide. The country developed national PEP guidelines in 2009, and all health facilities continue to adhere to these guidelines and provide PEP for both occupational and non-occupational exposures.

Zimbabwe is also committed to addressing the needs of key populations within the contextof prevention, treatment, care and support. In the context of ZNASP II key populations are groups of people considered to be at most risk of HIV infection due to their behaviours, the nature of their duty and or their lifestyle practices. In many cases lack of empirical data on the extent of HIV prevalence or key population size estimation prevents effective planning and service delivery, and hence access to services is often compromised. Efforts will be made to address these challenges from a policy and service delivery perspectives.

ZNASPII will support efforts that will consolidate mainstreaming of human rights and gender responsive approaches in HIV and AIDS planning and service delivery mechanisms. Strategies will target most at risk and key populations.

National Priority 2: Reduction of Mortality among People Living with HIV

Zimbabwe is committed to the provision of **antiretroviral therapy** for all PLHIV who meet the national eligibility of CD4 350 criteria. For adults the country had reached universal access by December 2012 based on the 2011 HIV estimates; however scaling of paediatric ART needs to be strengthened as the current coverage is 42%. Additionally, preliminary 2013 estimates have significantly increased the total need for adult ART. Isoniazid Preventive Therapy (IPT) has recently been introduced in 10 pilot sites to help reduce the prevalence of TB among PLHIV and subsequent reduction in TB related mortality. Capacity building of health care service providers in quality assurance of ART services is in

progress.

Diagnostics and monitoring of patients on ART – Laboratory capacity is being improved with refurbishment to acceptable standards. Additional CD4, biochemistry and haematology machines are being procured and distributed according to requirements. District level laboratories are expected to participate in proficiency testing with Zimbabwe National Quality Assurance Programme (ZINQAP) as part of external quality assurance to improve the quality of HIV diagnostics.

Procurement and supply chain management - Systems for medicines and other consumables are being strengthened as part

of the broader health systems strengthening and integration of service delivery systems. A roadmap for the strengthening of the National Pharmaceutical Stores has been developed and partners requested to contribute in addressing the action plan. In addition the Global Fund through UNDP has conducted an assessment on the storage capacity at various levels of the health system, and the country has started to address some of the key deficiencies identified.

Pharmacovigilance systems of ART, anti-TB and opportunistic medicines in adults and children including those under PMTCT are in place but need continuous review and strengthening in order to ensure early detection of adverse effects. The Medicines Control Authority of Zimbabwe (MCAZ) plays a key role in conducting post-marketing surveillance activities for medicines but requires strengthening.

Community and home based care (CHBC) services have been reviewed to incorporate new approaches in light of improved access to ART. The new focus is on community systems strengthening and meaningful involvement of PLHIV. Partners have been supporting malnourished PLHIV with therapeutic and supplementary feeding in selected sites.

Mitigating the Impact of HIV

Zimbabwe has approximately 1.6 million **orphans** and vulnerable children (OVC) based on 2011 esimtates. In response to this a national plan of action to guide care and support services for OVC has been developed. The Ministry of Labour and Social Services is coordinating OVC service providers to ensure equitable distribution of services, synergy, efficient use of resources, and elimination of duplication of efforts. The Government of Zimbabwe (GOZ) has also revamped the Basic Education

Assistance Module (BEAM) that provides educational assistance for OVC in Zimbabwe.

Coordination, management and M&E

The National AIDS Council provides **coordination and management** of the multi-sectoral national response through its decentralised structures. This coordinating structure has ensured inclusion of the hard to reach communities, PLHIV, other government sectors, the private sector, faith based communities and the traditional leadership.

Zimbabwe continues to mobilise resources from both domestic and international sources to support the national HIV response. The country is currently developing an HIV investment case to ensure sustainable financing of the national response.

The National **Monitoring & Evaluation (M&E) system** has been decentralised down to

district level and is linked with the MOHCW HIV M&E systems. These systems have provided the evidence necessary to support “evidence and results based” management of the response as well as indicator values and baselines of the ZNASP II. Quality of data needs to be improved.

The ZNASP II aims to achieve an enabling policy and legal environment in order to address key barriers to HIV service provision and access. The ZNASP ii has articulated strategies that promote and support HIV, gender and human rights mainstreaming in the workplace and in development projects. Technical assistance and policy guidance has been provided to sectors establishing HIV and AIDS work place programmes and mainstreaming HIV in development projects. The overall consideration in HIV mainstreaming is how sectors address the impacts of HIV and prevent sector’s development work from influencing the spread of epidemic.

b. **Current stage of implementation of the National Strategic Plan and the country processes for reviewing the**

Plan.

ZNASP II is currently at the mid-point of its implementation and Zimbabwe is preparing for the mid-term review in 2013. The review will dovetail with the Global AIDS Response Progress Report 2013, Mid Term Review of the ten targets of the 2011

United Nations (UN) Political declaration on HIV and AIDS, and the Review of the Implementation of the Plan for the Nationwide

Rollout of Antiretroviral Therapy 2008-2012.

Based on programme and response monitoring data there is evidence that the country is on-track to meet the planned targets of ZNASP II. The mid-term review of ZNASP II will specifically assess progress towards reaching set targets. Therefore, full assessment of the extent to which the objectives and priorities of the strategic plan are being met will be accomplished through an array of periodic reviews, evaluations, operations research, and M&E data generated by the national system.

The ZNASP II was developed taking into account both the current epidemiological situation and potential future directions of a comprehensive HIV response: as such it remains highly relevant. However the mid-term review will also provide an opportunity to adapt national strategies and targets to reflect emerging evidence, prioritise high impact interventions, address global guidelines, local implementation experience and best practices for the remainder of the plan.

c. **The main findings of, and response to, any recent assessments, program reviews and emerging data**

The Zimbabwe Demographic Health Survey 2010-11 – This survey showed the HIV prevalence has reduced amongst men and women of all age groups, and an increase in knowledge and accepting attitudes around HIV. Condom use remains low amongst those in stable relationships, condom use amongst high knowledge of HIV among young people. This survey has provided important data for baseline purposes, providing clear denominators for outcome and impact.

Sex worker study – In 2011, the Zimbabwe AIDS Prevention Project (ZAPP) supported by GIZ and in collaboration with NAC

and the MOHCW conducted a survey of selected sex work populations using respondent driven sampling in the towns of Mutare, Victoria Falls and Hwange[1]. In the 804 women tested, HIV prevalence was found to be 59.8% (around 4 times higher than among antenatal clinic attenders and general population) and SWs experienced low access to services and high stigma and discrimination by health providers. This evidence highlights the need to scale up services for prevention and treatment services for sex workers. There is also need to generate appropriate data on other key populations for better programming.

Impact evaluation for eMTCT – In 2012 Zimbabwe conducted an evaluation of the PMTCT program with sampling of survey participants designed to measure transmission rates in 2011 prior to wide-scale accelerated implementation of Option A (2010

WHO guidelines). This was an external evaluation conducted by University of California Berkeley in collaboration with CeSHHAR Zimbabwe and funded by the Children's Investment Fund Foundation (CIFF). The objectives of this two serial cross-sectional community-based survey were to determine:

- MTCT rate at 9-18 months
- HIV-free survival among infants exposed to HIV at 9-18 months; and
- Uptake of PMTCT services

Preliminary results with unweighted data and with final laboratory results still to be confirmed show an MTCT rate of 8.8%. This has given the country confidence that the goal of eMTCT and reducing MTCT to <5% by 2015 is attainable. In addition, the country is conducting a facility based PMTCT effectiveness survey, collecting blood samples at primary care clinics as infants come for routine immunization. Data collection is in process with preliminary results available in July 2013. Results from this survey will indicate 6-week MTCT rates. These will be triangulated with data from the community based survey and Spectrum modeling to give the country an accurate picture of the MTCT rate as we march towards eMTCT by 2015.

Paediatric ART review – In 2012 a multi-country paediatric HIV assessment was conducted with support from UNICEF and WHO to determine major policy, health systems and structural bottlenecks that hampered access to Early Infant Diagnosis (EID), ART and retention to paediatric HIV treatment and care. Major findings included: limited linkage between EID and ART, centralized PCR testing and a long turnaround times of laboratory results (2.2 months). The median time from diagnosis to ART initiation was 61 days for children <2 years of age while the median age at ART initiation was above 7 years. In addition, the proportion of children remaining in care 12 months after initiation was below 75% and high rate of lost to follow-up was more observed among the under-fives (Rapid Assessment of Paediatric HIV in Zimbabwe, October, 2012). Efforts to increase uptake

of EID and linkages to, and retention in care are required to improve child survival.

HIV Testing Counselling Strategy Review - The MOHCW, supported by WHO and NAC, commissioned a review of implementation of the National HTC Strategic Plan (2008-2011) in selected sites in all provinces. Findings informed the development of the current HTC Strategic Plan (2013-2015). The review revealed existing gaps and missed opportunities for identifying PLHIV which need to be addressed, including low couple testing (16%) and adolescent testing and counselling. The country is addressing these gaps by strengthening the skills of health workers in couple counselling, child and adolescent counselling and through prioritization of partner/couple testing within ANC, STI, HIV, TB and in-patient settings using the opt out strategy. The review also found sub-optimal referrals and

linkages of HTC services and post-test services, resulting in significant loss to follow up and the need to strengthen this going forwards. The review also recommended innovative strategies such as self-testing, community based testing and counselling to increase awareness, demand and utilization for HTC with more emphasis on couple/partner counselling and testing, adolescents, young people and high risk populations.

Modes of Transmission Study - A comprehensive analysis of the HIV epidemic in Zimbabwe was conducted in 2010 to strategically address the drivers of the epidemic with better HIV prevention programmes and a more focused allocation of resources to avert the most number of new infections[2]. The analysis described the epidemiological situation and the HIV prevention response, synthesized and linked the epidemic and response data, and recommended improvements in HIV prevention policies, programmatic action and resource allocation. The results were used to formulate the ZNASP II and inform the Combination HIV Prevention approach.

Reducing transmission in stable unions and SW settings continues to be important in order to reduce heterosexual transmission of HIV. Since there is no single HIV prevention intervention suitable for all populations and situations, a combination HIV prevention approach is being adopted in order to maximise the effect of complementary prevention interventions[3].

Sex Workers and to a lesser extent MSM have benefitted from specifically targeted interventions. The 2008 sex work situation analysis highlighted that programmes for sex workers were limited and underfunded (MOT 2011). Current sex worker interventions comprise of HIV prevention education, condom distribution, STI treatment, peer education, micro-credit and other measures that facilitate exit from sex work.

The Military has an HIV policy and focuses on condom promotion and distribution, uptake of HTC and male circumcision (MOT

2011).

Emerging Data - As the epidemic unfolds, new social, economic, political and technological challenges emerge that transcend institutional and often national boundaries. These challenges demand a revolutionary rather than evolutionary approach with built in flexibility for periodical review, re-orientation, and strengthening of operational strategies.

For example, recent research showing that with safer, less toxic and more effective drug regimens available, earlier HIV

diagnosis and treatment delivers substantial benefits to the individual and the successive impact at the population level is drastic

[4]

reduction in transmission of the virus – treatment as prevention – requires a paradigm shift in Zimbabwe's approach to both its

treatment and prevention efforts. A delicate balance weighs the potential prevention and clinical benefits of early initiation against the potential complications (ARV toxicity, emergence of ARV drug resistance) and limited capacity of health and community systems to deal with a dramatically increased patient load.

WHO will release updated treatment guidelines in June 2013. These are expected to raise the ART initiation threshold to include patients with a CD4 count of <500 cells/μ and may recommend immediate therapy regardless of CD4 count for pregnant women with HIV and patients at risk of transmitting HIV to a sexual partner. An increased threshold for treatment initiation will significantly increase the numbers of people eligible for treatment in Zimbabwe and thus raise the universal access target. The country will therefore require additional investment to achieve and sustain universal access to treatment.

The expanded analysis of the HPTN 052 study is revealing that individual patient outcomes are also greatly enhanced by the early initiation of ART. Data show that the overall incidence of clinical events – both AIDS and non-AIDS – was much lower in study participants in the early therapy arm[5]. In line with this new data, some countries in East and Southern Africa are initiating all pregnant women living with HIV on ART immediately - an approach known as Option B+. In Zimbabwe, MOHCW is taking steps to transition to Option B+ following a February 2013 national consultation in Harare where a majority of stakeholders recommended this move (see Annexe 15: Report of PMTCT Option B+ Stakeholder Consultation). The move to Option B+ is likely to have a greater impact in reducing infant HIV infections, increasing maternal survival and reducing transmission to HIV negative male sexual partners. These benefits will have a continuing positive impact, both during future pregnancies and in protecting HIV negative male partners.

A complementary intervention to PMTCT is the immediate treatment of the infected partner in a discordant relationship (where one member of the couple is HIV infected and the other is not). With couples representing only 16% of people tested, Zimbabwe is considering a pilot study looking at the dynamics of the prevalence in discordant couples and strategies for testing, counselling and immediate treatment of the negative partner.

Regular viral load monitoring is crucial to assess virological suppression and is more effective than CD4 count in monitoring treatment response for patients on ART, enabling identification of treatment failure much earlier. Zimbabwe therefore plans to introduce viral load testing in a phased manner to improve quality of care. The report of the Office of the Inspector General (OIG) found patients were not always receiving regular CD4 counts as per national guideline, and this will be addressed going forwards.

Zimbabwe and Rwanda participated in a study to assess the feasibility of using the Pre-pex device for VMMC. WHO is currently considering the device for pre-qualification. Approval of these devices will expedite scaling up of VMMC as the device can be used by non-doctors.

Scaling up of Zimbabwe's electronic patient tracking system will greatly improve the quality of data for HIV programms and enable further analysis to determine outcomes of patients on ART. Zimbabwe will be introducing the eSystem starting with HIV as the entry point. However the future vision of the country is to include other health related programmes.

Strong leadership by the National AIDS Council and Ministry of Health and Child Welfare, with continued commitment of stakeholders, will ensure Zimbabwe is well placed to continue meeting the challenges and take the emerging opportunities to further reduce HIV infections and keep people alive.

[1] Survey of selected sex work populations conducted using respondent driven sampling in the towns of Mutare and Victoria Falls and Hwange, Zimbabwe AIDS Prevention Project, University College London and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) August 2012

[2] Zimbabwe Analysis of HIV Epidemic, Response and Modes of Transmission, National AIDS Council and Government of

Zimbabwe with MOHCW, World Bank and UNAIDS, August 2010

[3] Combination HIV Prevention: An Implementation Approach For Zimbabwe, Zimbabwe National AIDS Council and Ministry of

Health and Child Welfare, 2012

[4] Cohen, MS, et al., 2011, Prevention of HIV-1 infection with early antiretroviral therapy. *NEJM*, 2011, 365: 493-505 PMCID

[5] HIV Prevention Trials Network (HTPN), 2012, Additional benefits of early HIV treatment revealed. *ScienceDaily*. [Accessed on 20 March 2013 from http://www.sciencedaily.com-/releases/2012/07/120726180255.htm].

2.3 Implementation of the National Strategic Plan

Please describe the **implementation progress** of your National Strategic Plan, referring as appropriate to the Performance and Impact Profile provided by the Global Fund as well as any recent evidence from program reviews, evaluations and relevant surveillance surveys.

In your response, include:

a. The **priority interventions** that are currently being implemented.
b. The **outcome and impact** achieved to date by these priority interventions.
c. The **key stakeholders** involved in the implementation.
d. Any **limitations** of the response to date and the **lessons learned** informing the design of future interventions.
e. Any **limitations** in **national data systems** to measure and demonstrate impact.

The Zimbabwe Analysis of the HIV Epidemic, Response and Modes of Transmission (2011) provided the evidence base for the development of ZNASP II. With this understanding of the epidemic and response, all interventions and strategies were prioritised against Zimbabwe's two overarching goals of preventing new infections and keeping people alive.

Preventing new infections: implementation of priority interventions

Social and Behaviour Change Communication

Implementing Partners: World Vision; Regai Dzive Shiri; ZiCHIRe; Batsirai; FACT Mutare; Zimbabwe AIDS Support

Organisation (ZAPSO); Matebeleland AIDS Council; Midlands AIDS Support Organisation, UNFPA

The Zimbabwe National Behaviour Change Programme (NBCP) is operative in all 65

districts of the country and is well integrated into different sectors. Outreach includes prisons and prison officers and prisoners have been trained in behaviour change course. NBCP coverage at a population level is striking with over 45% of people having attended a meeting with a Behaviour Change Facilitator (BFC) and a remarkable 14% of people were visited by BCFs in their homes[1]. Progress is also evidenced by the significant increase in the percentage of men and women with a comprehensive knowledge of HIV and the number of women and men who know HIV can be transmitted through breastfeeding and that this risk can be reduced by taking special medicines[2]. Sex work interventions are being implemented in selected sites in the country focusing mainly on peer education and condom distribution.

Lessons Learned: data suggest a continuing gap between people's perception and actual risk of HIV infection. Limited data exist on key population especially MSM and IDU.

Promotion and distribution of male and female condoms

Implementing Partners: ZNFPC; MOHCW ;PSI Social Marketing; UNFPA

The focus of the Comprehensive Condom Programme is to increase consistent and correct use of both male and female condoms. A comparison of the ZDHS results from 2005/6 and 2010/1 suggests that while there have been essentially no changes in the percentage of Zimbabwean men who paid for sex in the 12 months preceding the interviews, 88% of those who did engage in paid sex used a condom. In 2011, 91.7 million male condoms and 5.3 million female condoms were distributed from approximately 1,600 service delivery points, with less than 1% (male condoms) and 2% (female condoms) stock outs. Sex workers access female and male condoms in selected sites and health facilities.

Lessons Learned: Gaps in consistent condom use persist, particularly within concurrent sexual relationships. Additionally, levels of condom use among PLHIV are low despite high levels of sexual activity.

Voluntary male medical circumcision (VMMC)

Implementing Partners: PSI; ZAPP, ZACH/ITECH; UNFPA; MOHCW, WHO

Zimbabwe's combination prevention strategy includes adult male circumcision because of its potential for rapid epidemiological impact. Achieving the National Male Circumcision strategy's ambitious goal of reaching 1.3 million men aged 15-49 with

[3]

circumcision services by 2015 would avert 600,000 new infections by 2025. As of December 2012, over 100, 000 men had

been circumcised. A total of 806 providers are trained in VMMC, (491 nurses 138 doctors, 101 receptionists, 76 theatre assistants). These services are available for clients of sex workers and MSM, although the M&E system is not able to capture the service utilization data at the moment.

Lessons Learned: The MC programme has reached only 7% of its target of 1.3 million by 2015. Limited funding for social mobilization and advocacy has resulted in low uptake of VMMC services. Integrating early infant male circumcision in a horizontal approach as part

of routine care of mothers and infants would make this programme more sustainable in the long term.

Prevention of mother to child transmission of HIV (PMTCT)

Implementing Partners: Organization for Public Health Interventions and Development (OPHID); MSF; Kapnek Trust; EGPAF; WHO; UNICEF; CHAI; ZVITAMBO; NAC; SafAIDS; ZAN; MOHCW

High quality, comprehensive PMTCT services are currently provided in 95% of the 1,560 health facilities in Zimbabwe. To accompany this rapid expansion, 2219 Health Care Workers received IMAI/IMPAC training in taking a holistic approach to the management of positive, pregnant women particularly. This concerted effort by government and partners resulted in an increase in the proportion of infants receiving prophylaxis (85%) and the number of sites performing DBS collection (from 379 to 1440) in

2012. PMTCT services are accessible to all pregnant women including pregnant sex workers.

Lesson Learned: Strengthening mother-baby follow-up strategies can increase retention across the PMTCT cascade. Expanding integration of family health should be a continuing priority to achieve cost efficiencies and improve service quality. Exploring ways to increase male involvement and achieve greater gender balance in the provision and use of services is recommended.

HIV testing and counselling

Implementing Partners: PSI; OPHID; MOHCW; ZAPP, WHO

HIV testing is a crucial first step in the cascade of HIV treatment and an entry point to other prevention and care interventions including male circumcision, prevention of mother-to-child HIV transmission, and treatment of opportunistic infections. The DHS

2010/11 shows a marked increase in HIV testing coverage among both men and women. Furthermore, 91% of women and 88% of men knew where to access HTC services. In 2012 a total of 2.2 million adults aged 15-49 accessed HTC in Zimbabwe through a total of 1,456 health care facilities, either in Antenatal Clinic (ANC), TB and STI care settings or through opportunistic infections clinics and HIV treatment centres. HTC services are available to all citizens that need, inclusive of key populations.

Lessons Learned: The linkages and referral systems between HIV testing and subsequent interventions in the continuum of care are sub-optimal. Attrition at the "gateway" must be addressed if Zimbabwe is to achieve universal access. Emerging issues including community based HIV testing and counselling and the potential introduction of self-testing to reach the difficult to reach populations needs to be explored.

Keeping people alive: implementation of priority interventions

The benefit of antiretroviral therapy (ART) to individual health outcomes is well understood. ART keeps people alive. Recent research has further demonstrated two important concepts: 1) that early initiation of ART delivers considerably greater health outcomes to the individual as opportunistic infections are held at bay; and 2) ART, when taken

consistently, reduces a patient's viral load to almost non-transmissible levels (HTPN 052) which contributes significantly to the reduction of new infections.

The scale up of comprehensive HIV prevention, treatment, care and support has resulted in the decline of both the prevalence and incidence rates from a peak of 26.4% and 5.19% in 1994 to 13.49% and 0.81% in 2012 respectively (2011). Despite this significant progress, the number of new HIV infections and the number of HIV and AIDS related deaths is still unacceptably high.

Antiretroviral Therapy (ART)

Implementing Partners: MSF; Private Sector; SAfAIDS; ZAN; MOHCW, CDC

The total number of PLHIV receiving ART in Zimbabwe is 578,450 including 531,136 adults and 47,314 children with more than

8,000 PLHIV initiating treatment each month (LMIS data 2012). Preliminary results from an ART outcome study by the MOHCW indicate survival rates of about 91%, 78% and 69% at 6, 12 and 24 months respectively. Zimbabwe's plan to phase out the current stavudine-based regimen for the less toxic, patient-friendly TDF combination is underway with 64% of those accessing ART already on TDF as of 2012. Full transition to TDF is expected to be completed by first quarter of 2014. There is no limitation on key and most-at-risk populations accessing services but there is need to better link people with the services.

Lessons Learned: PLHIV are lost at every step along the continuum of care with the highest rates of Loss To Follow Up (LTFU) occurring between HIV testing and enrolment in care. Paediatric ART coverage remains at 42% (based on 2011 estimates) – significantly below the universal access target of 85%.

HIV/TB control and therapy

Implementing Partners: Private Sector; MOHCW

Zimbabwe continues to experience a major HIV driven TB epidemic with co-infection rates of 82%. Considerable progress has been made towards addressing the 12 point WHO collaborative TB/HIV activities. As of 2011, 92% of all TB patients notified during the year had an HIV test result, 85% of the HIV positive TB patients received cotrimoxazole and 60% received ART. Although ART uptake among HIV+TB patients is increasing it remains below the ART coverage among the general population of PLHIV who do not have TB. Progress on implementation of the 3I's has been very slow especially Isoniazid preventive therapy (IPT). Intensified case finding among PLHIV has been on-going but not recorded. TB infection control needs to be strengthened. TB/HIV services are available to all key populations that need it.

Lessons Learned: Task-shifting needs to be expedited so that more nurses can be allowed to initiate ART among stable TB co-infected patients. Delay in implementation of policies e.g IPT denies beneficiaries from accessing interventions that has an impact on their lives.

Diagnostic services

Implementing Partners: CHAI, EGPAF, CDC, UNICEF, National Microbiology Reference Laboratory (NMRL)

The introduction of point-of-care CD4 cell count machines is significantly improving patient management as transport constraints no longer contribute to loss to follow up in these sites[4]. The National Microbiology Reference Laboratory, currently the only laboratory offering HIV DNA PCR testing, has observed a marked increase in the number of tests performed per year and the number of sites submitting specimens, from 12 in 2007 to 1,440 in 2012[5].

Lessons Learned: One of the major draw backs in early infant diagnosis is the turnaround time for lab results (currently transported by Fedex). With lives in the balance, a need to identify new technologies that can address this challenge is critical.

Health and community systems strengthening

Strengthening the interface between the health facility and the community it serves improves uptake and access to services (facility and community-based) and quality of care and retention. The notion of health and community systems strengthening is a not top-down activity for stakeholders in capital cities, but a locally-owned, context-specific and inclusive process, one that is built on the tenets of equity, evidence and efficiency.

Socio-cultural factors, beliefs about health, and health care utilization certainly play a role in community-level medicine whether the community is urban, rural or peri-urban. Zimbabwe's investment in health and community systems seeks first to understand what factors motivate and drive behaviour at the local level (for the service provider and the client – supply and demand), then to address these drivers through behavioural incentive changes, not just through technology.

For example, the adaptation and roll out of the Stigma Index by ZNNP+ and partners measures perceived stigma among PLHIV and will provide a more nuanced contextual understanding of the root drivers. NAC decentralised structure ensures that the voices of people living with HIV are heard and that key populations are included in the HIV response.

Communities are designing and implementing community-based models for ART delivery, patient tracking, adherence support and home based care with great potential. With the anticipation of over 300,000 people rapidly entering the treatment ranks as the threshold to treatment eligibility is raised, piloting these innovative community models will be a fundamental and worthy investment for Zimbabwe to alleviate the burden on the health systems. For example, Southern African AIDS Trust (SAT) has supported the construction of 'Waiting Mother's Shelters' for pregnant women, HOPSAZ has developed quality standards for palliative care, and community home-based care, and partners such as PADARE, SAfAIDS, SAT, ZNNP+, ZAN, AFRICARE, Community Working Group on Health (CWGH) are empowering community leaders to promote the uptake of HIV prevention, care and treatment services in their communities.

ZAN and ZNNP+, two apex organizations, provide support to their members through capacity building opportunities and small grants. ZAN currently has 275 civil society members working on HIV while ZNNP+ has 6000 support groups spread across the country. SAT provides skills-building opportunities, grants, networking and joint planning for HIV and TB initiatives to 25 civil society organizations.

A number of key partners such as SAT, SAfAIDS, ZAN, PSI, ZNNP+, SAYWHAT, PADARE, utilise their structures to build their constituencies' capacity to advocate not only for issues concerning HIV services and care, but also for synergistic interventions that can reduce vulnerability to HIV. For example, SAT successfully petitioned the government for the reintroduction of student grants in higher and tertiary institutions to prevent students from adopting risky sexual behaviours as a result of poverty. UNICEF's support for child protection and poverty reduction contributed to communities playing a leveraged role in HIV impact mitigation.

Acknowledging the challenging socio-cultural and legal environment for MARPS (specifically MSM), but based on the need to ensure access to HIV prevention, care and treatment, a number of small-scale initiatives are being initiated in Zimbabwe from which lessons can be learned. For example, SAfAIDS has hosted national and regional advocacy platforms on policy issues affect people living with HIV and LGBTI (Lesbians, Gays, Bi-sexual, Transexual and Intersexed). SAfAIDS is currently implementing community-based transformative approach aimed at lifting social barriers and improving access to HIV prevention services in Zimbabwe. Lessons learned from these (and other organisational) approaches can be integrated into prevention and treatment programs.

Retention of health staff has improved largely due to increased remuneration through the GF and HTF supported retention scheme. Vacancy rates have been declining especially after the GoZ lifted the freeze on over 2000 health worker posts; however, more health workers will be required as more patients initiate ART. Plans are underway to look into non-monetary incentive schemes and a transition from post qualification individual skills training where health workers are absent from their posts for long periods to pre-qualification training and integration of curricula. This integration of training curriculum has already started with HIV and TB case management training.

While essential medicine coverage has improved significantly, the rapid initiation of new patients on ART poses significant challenges to national procurement and supply management systems, including storage facilities. National Pharmaceutical Company (Natpharm) has not been recapitalized since the introduction of multi currencies making the ability to draw down on tenders and restock difficult. The practice of parallel sourcing and procurement of commodities by donors does not build capacity of the national system. Zimbabwe's rapid scale up of coverage and services has also impacted on the quality of care in health facilities. Different strategies are being implemented to improve the quality of services provided in health facilities, including decentralization and integration.

The use of front line SMS for the weekly surveillance has improved the completeness and timeliness of reporting from below

50% to above 90%. M&E data collection tools are being harmonized to avoid duplication and overlaps. The country is piloting an electronic patient monitoring system for HIV which will feed into the upgraded DHIS.

A package of M&E tools has been developed for village health care workers to monitor performance. In addition, District AIDS Action Committees (DAACs) collect information from the community partners working on HIV and AIDS and report through one central M&E system. While monitoring and evaluation of community engagement, empowerment and participation is complex, qualitative evidence shows that community systems'

strengthening increases the uptake of various HIV prevention, care and treatment services.

e) Limitations of national data systems to measure and demonstrate impact

Patient data is collected using a paper based system. Increased data requirements and growing numbers of people accessing services has resulted in reduced data quality and health workers being overburdened with heavy data recording and reporting requirements. This lack of timely transmission of data from health facility to district, province and national levels disrupts the communication infrastructure.

The lack of patient follow-up mechanisms in some districts as ART is decentralized from ART initiating sites to ART follow-up sites leads to an increase in the number of patients lost to follow up. This is compounded by the multiple registers at service delivery points and overall inadequate M&E capacity.

Support and supervision in data compilation and validation processes is insufficient, including irregular supervisory visits and data quality audits.

Efforts to address these challenges are underway and include the roll out of ePMS to all high volume ART health facilities, integrated Monitoring and Evaluation (M&E) data collection tools, development of indicator guidelines and Standard Operating Procedures (SOPs), among others.

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[4] UNICEF operational research, Unpublished Report, 2012

[5] National Microbiology Reference Laboratory, end of the year report 2012

2.4 Enhancing TB/HIV Collaborative Activities

If you are submitting a **TB and/or HIV concept note(s)**, you must describe the scope and status of on-going TB/HIV collaborative activities.

a. How the funding requests will strengthen TB/HIV collaborative activities.
b. The linkages between the respective national TB and HIV programs in your country.

a. How the funding request will strengthen TB/HIV collaborative activities

Zimbabwe faces a major HIV driven TB epidemic (82% co-infection). About 50% of deaths among PLHIV are due to TB. The government since 2007 adopted and implemented the WHO collaborative TB/HIV strategy with varying levels of success. In

2011, 92% of all TB patients notified during the year had an HIV test result, 85% of the HIV positive TB patients received cotrimoxazole and 60% received ART. However from the HIV care clinics, although PLHIV enrolled in care were screened for TB, the recording tools were unable to capture such information. Isoniazid preventive therapy (IPT) was only introduced towards the end of the year in 10 pilot sites despite the proven effectiveness of

the intervention. This application therefore focusses on the accelerated implementation of the Three I's for TB/HIV as this remains an outstanding weak area of the National response.

The pre-ART/ ART registers were recently revised to accommodate ICF/ IPT indicators. Use of these revised tools started early

2013. For assessing eligibility for IPT the country is using the screening tool. When it comes to diagnosis of TB among PLHIV, Sputum smear microscopy (SSM) has a particularly low sensitivity for detecting TB among PLHIV and PLHIV with a negative smear microscopy result but who are still presumed to have TB, a better option is the GeneXpert since bacterial culture is out of reach. y. Currently the main diagnostic tool for TB is smear microscopy and notification rates for TB show a downward trend within the past 3 years. GeneXpert was introduced on a pilot basis in a few centres in 2011 and to date with support from other partners the country has 29 machines and an additional 29 will be installed in 2013. This application will expand the availability of GeneXpert to an additional 30 secondary level health facilities from the indicative funding and an additional 30 machines from the incentive funding, the remaining 60 machines will be sought from the upcoming TB application and other sources. This will translate into additional case identification of all types of TB especially in PLHIV. Preliminary findings from one district supported by MSF indicate an increase in case detection, reduced need for CXRs, reduced time between diagnosis and treatment for clinic cases and more TB initiations by nurses. Treatment needs for these additional patients are covered in the current TB grant and NAC.

Prevention of TB disease in PLHIV is a weak area of the National TB/HIV Response because of negative perceptions around its utility and fears of generating more drug resistance common to both policymakers and implementers. The MOHCW introduced IPT in a phased approach starting in December 2012, with implementation currently piloted in 10 selected sites. Due to the short implementation time not much data on performance had been gathered at the time of this concept note. TB Infection control (IC) measures are sub-optimal due to the absence of a National Policy Framework and Guidelines and in addition, many health facilities were constructed before TB/HIV IC was fully appreciated. In 2012 the Ministry received a CDC grant to develop policy framework/guidelines and renovate 100 health facilities. This proposal requests support to renovate an additional 40 centres out of the 1564 health facilities in the country. Zimbabwe hopes to meet its targets i.e. increasing Cotrimoxazole uptake in TB/HIV patients to 100%, and ART in TB/HIV to 100% by the end of the support period.

b. **Collaboration between the National TB and the HIV programmes**

In 2008, a National Collaborative TB/HIV committee was formed with subsequent committees formed by expanding the TORs for existing committees at provincial and district levels. At the health facility level, TB/HIV collaboration is even better as the same health worker offers both TB and HIV services. Where the TB and HIV clinics are separate, referral of patients is taking place with the aim of a "one-stop-shop" for TB/HIV co-infected patients to minimize loss of patients between the two programmes and create greater efficiencies.

At national level the NTP and HIV programmes co-chair the collaborative TB/HIV meetings. Joint planning is in place and so are joint work-plans for implementation. Both programmes have focal points responsible for the collaborative activities. The former national level HIV/AIDS Treatment and Care Partnership Forum has been transformed into a TB/ HIV Prevention, Treatment and Care Partnership forum with meetings held quarterly. The two programmes worked closely in the development of the 2009-2013 NTP Strategic plan and guidelines for co-management of TB/HIV, including the revision of the cough screening tool used to screen for TB in PLHIV. Integrated TB/HIV training materials have been developed and both programmes are using these materials to train health

workers. M&E tools have been revised by both programmes to accommodate missing indicators on HIV and TB indicators. Both programmes remain under the overall leadership of one director which further aids collaboration.

SECTION 3: Programmatic Gap

Please complete the **Programmatic Gap Table** in Attachment 2 by identifying the gaps in coverage for three to six priority program areas consistent with the National Strategic Plan, and which will be addressed through the applicant's funding request.

All numbers in this table should relate to the size of the population groups targeted by the priority program areas, and not the financial need for the program areas.

3.1 In accordance with the **Programmatic Gap Table** in Attachment 2, describe the **assumptions, methodology and sources** used in estimating the programmatic gaps.

In addition to the programmatic gap tables in the Modular Template, Zimbabwe has developed a full programmatic gap analysis based on detailed understanding of activities already supported by GOZ and partners. These tables provide complementary, supplementary information and can be seen in Annex 16 – Zimbabwe Detailed Programmatic Gap Tables.

Zimbabwe has prioritised five programme or service delivery areas: Adult and paediatric ART (including TB/HIV), PMTCT, VMMC, HTC and BCC, with additional supportive programming in the areas of health and community systems strengthening. These areas were determined through a series of consultative processes, including a meeting with Provincial Medical Directorate (PMD), a Gap analysis workshop with national stakeholders; and consultations with Gender Technical Working Group and Sex Worker Technical Working Group. Additional consultations were made through telephone/email and review of existing reports, evaluations and assessments. A specific effort was made to ensure that key populations, including women and girls, people with disabilities, men who have sex with men, sex workers, people living with HIV, and adolescents participated in the consultative process of analysing the programmatic gap. Additional information on the justification for the prioritisation of these areas is included in Section 4.1.

Methodology. Information was gathered from different programmes on estimates of need, targets and partner support. Projected commitments were also solicited from partners in various programme areas. Reflecting on the ZNASP II, stakeholders were then asked; 1) to highlight progress made to date and analyse activities that are outstanding; 2) prioritise the programmatic gaps and justify with existing evidence. The information collected through the consultative processes was analysed. Data from national targets and estimates were used in the programmatic gap table, and contrasted with the financial gaps. Overall analysis confirmed the programme areas selected for this request.

Key Assumptions. A number of program areas receive support from non-Global Fund partners, including USG/PEPFAR, DFID, UNICEF, EGPAF/CIFF. Where commitments have been made for future year funding, the funding estimates have been included.

Sources. The targets and estimates used to determine the programmatic gaps in the six program areas included: 2011 HIV estimates; preliminary 2013 HIV estimates, Zimbabwe Global AIDS Response Report 2011; Zimbabwe National Voluntary Male Circumcision Strategy (2010-2015); National Strategic Plan for Eliminating new HIV

infections in Children and Keeping Mothers and Families Alive (2011-2015).

Program Area 1:Treatment and Care	Metric:Number of adults receiving ART			
Current coverage:	**518801**	**68 %**	**Comments:**	

Specification	2014	2015	2016	Assumptions
Country Target	745601	864401	984401	Preliminary 2013 HIV estimates
How much will be met with existing resources…				
Under Non-GF programs	298438	308005	308005	Commitments from NATF, USG and DFID
Under existing approved GF grants				Existing Round8 Phase 2 funds for 2014 were rought forward to 2013 to support ARV buffer stock procurements
Expected Annual Gap	447,163	556,396	676,396	
How much will this funding request contribute to the full need…				
Indicative Request	364363	381112	381112	Funding is being requested to support scale up of new and maintenance of existing Round 8 Phase 2 clients on treatment using 2010 WHO Guidelines
Above Indicative Request	82800	175284	295284	The country is considering raising eligibility criteria from CD4<350 to CD4<500. The adoption of CD4 500 threshold will increase the treatment gap by 27% for all people in need of ART, including treatment as prevention for serodiscordant couples, HIV positive pregnant women and key populations.

Program Area 2:Treatment and Care	Metric:Number of children receiving ART

Current coverage:	46874	37 %	Comments:	

Specification	2014	2015	2016	Assumptions
Country Target	76869	93669	112869	Preliminary 2013 HIV Estimates
How much will be met with existing resources…				
Under Non-GF programs	76869	87224	95785	All exisitng and new children to be intiated on treatment will be supported by NATF and DFID
Under existing approved GF grants				
Expected Annual Gap	0	6,445	17,084	
How much will this funding request contribute to the full need…				
Indicative Request				All existing and new children to be intiiated on treatment will be supported by NATF and DFID hence there is no treatment gap using current eligibility criteria
Above Indicative Request		6445	17084	The country is considering widening the eligibility criteria for initiation of ART in children. This will result in a treatment gap when compared to current WHO 2010 guidelines.

Program Area 3:PMTCT	**Metric:**Number of pregnant women recieving ART			
Current coverage:	**7305**	**11 %**	**Comments:**	**Programme data**

Specification	2014	2015	2016	Assumptions
Country Target	31177	55260	54260	Source: Programme targets

How much will be met with existing resources…				
Under Non-GF programs	31177	37630	37130	Commitments from NATF, USG and proportion (50%) covered under general ART targets
Under existing approved GF grants				
Expected Annual Gap	0	17,630	17,130	
How much will this funding request contribute to the full need…				
Indicative Request		17630	17130	This request will support initiation of HIV positive pregnant women on treatment. The annual gap for 2016 will include pregnant women initiated on treatment in 2015 (17,630). Total support by end 2016 will be 34,760
Above Indicative Request				

Program Area 4:HTC	**Metric:**Number of clients tested and recieving results

Current coverage:	**2240244**	**104 %**	**Comments:**	**Programme targets exceeded due to succesful campaigns**

Specification	2014	2015	2016	Assumptions
Country Target	2467246	2521525	2777000	
How much will be met with existing resources…				
Under Non-GF programs	1779757	1588096	1667500	Commitments from NATF, USG and DFID
Under existing approved GF grants				
Expected Annual Gap	687,489	933,429	1,109,500	
How much will this funding request contribute to the full need…				

Indicative Request	687489	933429	1109500	HTC is the entry point to prevention, treatment and care, hence the funding being requested to support scale up of HTC (MC, PMTCT, PITC)
Above Indicative Request				

Program Area 5:VMMC	**Metric:**Number of adult males circumcised			
Current coverage:	**91335**	**7 %**	**Comments:**	

Specification	2014	2015	2016	Assumptions
Country Target	217800	239580	263538	
How much will be met with existing resources…				
Under Non-GF programs	200000	145000	130000	Partners will continue supporting the MC programme as per the commitments stated (USG, DFID, NATF)
Under existing approved GF grants				
Expected Annual Gap	17,800	94,580	133,538	
How much will this funding request contribute to the full need…				
Indicative Request	17800	47290		The country is considering use of MC devices for scale up of services
Above Indicative Request		47290	133538	The additional funding will enable the programme to reach 73% of the targeted population

Program Area 6:BC	**Metric:**Number of people to be reached with Interpersonal Communication

Current coverage:		%	Comments:	

Specification	2014	2015	2016	Assumptions
Country Target	200000	240000	250000	The country expects to reach more people with BC to generate demand for all prevention
How much will be met with existing resources…				
Under Non-GF programs	20000	20000		Commitments from Integrated Support Programme (ISP) for two years in selected districts
Under existing approved GF grants				
Expected Annual Gap	180,000	220,000	250,000	
How much will this funding request contribute to the full need…				
Indicative Request	180000	220000	250000	The support will cover the number of people to be reached with interpersonal communication to increase the uptake of HIV prevention, treatment and care services.
Above Indicative Request				

SECTION 4: Funding Request to the Global Fund

Please complete the questions below together with the **Modular Template** in Attachment 3.

4.1 Funding Request within the Indicative Funding Amount

Please describe how indicative funding requested and any existing Global Fund financing will be invested (or reprogrammed) during the funding request period to maximize impact. In your response, include:

a. The **objectives and expected outcomes** of the funding request, and how the outcomes have been estimated and will contribute to achieving greater impact. Please refer to available local evidence of effectiveness of the programs being proposed.
b. The **proposed modules and interventions** of the funding request in order of priority, in addition to the rationale for their **selection** and **prioritization**.
c. For **consolidated funding requests**, explain how current interventions will be adapted, discontinued or extended to maximize impact.

a) Objectives and outcomes of funding request

In arriving at the objectives and outcomes of this application the national stakeholders took into account the priorities and targets for the national response as outlined in the ZNASP II. Analysis of the current level of achievement was made and the programmatic and financial gaps determined using the methodology described in section 3.1, which resulted in the programmatic gaps documented in attachment 2. Zimbabwe has also taken into account recent evidence on effectiveness of various HIV interventions. The impact and outcome targets of the ZNASP II continue to the end of 2015, but an assumption has been made to maintain them at the same level in 2016 to cover the 3-year period of this request.

The total amount of this request is USD 555,540,629 of which USD 311,175,241 is the indicative funding amount and USD 244,365,388 is for additional gains beyond indicative funding. This funding will be invested to maximise impact on the strategic goals of Zimbabwe's HIV response: prevention of new adult and child HIV infections and reduction of mortality among PLHIV.

The aim of this request is to sustain the trajectory of declining HIV infections and increased access to AIDS treatment for Zimbabwe to reach the tipping point where the number of new HIV infections per year becomes less than the number of people being initiated on ART. This will be a major contribution to improving health, the economy and human capital in Zimbabwe. This request will contribute to Zimbabwe's two main goals:

1. Reduce HIV related mortality by 38% from 2009 to 2016; and

2. Reduce new HIV infections in adults (15-49) from 0.81% (59,260) in 2012 to 0.6% (44,910) by 2016; and reduce % of infants born to women with HIV who are infected from 18% in 2010 to 7% in 2013 and to less than 5% by 2016

a. The objectives and expected outcomes of the funding request, and how the outcomes have been estimated and will contribute to achieving greater impact.

The objectives and expected results are shown in the table below:

Approaches to estimating outcome targets – The outcomes have been estimated at national level by assessing the current need (using epidemiological analysis of Zimbabwe's epidemic), taking into account the current programme achievements and capacity, and modelling the potential impact of various high impact interventions. The country has also used preliminary 2013 HIV estimates and anticipated WHO guidelines on use of ARV medicines to calculate numbers of people in need. There is also a small but emerging body of local evidence supporting prioritisation of these interventions for expanded implementation in Zimbabwe as described below.

ART - An ART outcomes evaluation study conducted in Zimbabwe (2012) demonstrated that in spite of the difficult macroeconomic environment experienced by the country, patient retention on treatment was similar to that seen in other countries within the region. It also highlighted the need to start clients on treatment early as well as develop specific services targeting males**1**. An end-term review of the HIV Care and Treatment ART and opportunistic infections programme will be carried out in April this year. It will assess effectiveness, efficiency, equity, relevance and sustainability of the programme. It will also assess the characteristics of people accessing ART, including disaggregation by sex, age, key population groups and geographic locations. The review will also consider factors contributing to quality of the ART and OI services provided in the country. It is hoped that the review will inform the formulation of the new National ART Strategy including pointing to ways of improving targeting, demand and quality of the services.

PMTCT - Cost-effectiveness modelling research on PMTCT in Zimbabwe by Ciaranello, A. et. al in 2012 concluded that replacing sdNVP with Option A or Option B will improve maternal and infant outcomes and save money; Option B increases health benefits and decreases costs compared with Option A in the longer term. Option B+ further improves maternal outcomes. The majority of local evaluations have focused on programmatic and process indicators. To assess the long-term impact of the PMTCT program, two evaluations of the PMTCT program are currently being undertaken with results available in the next two years.

VMMC – A study on VMMC acceptability in Zimbabwe conducted in Harare in 2004, demonstrated that 45% of respondents expressed a wish to be circumcised if the practice was confirmed to reduce the risk of contracting HIV or STIs, and if it was performed safely and was affordable2. A situation analysis undertaken in 2008 found that cost, pain and potential of complications were concerns that needed to be taken into account in the MC scale up (MOHCW, 2008). A further study in 2008 did not appear to demonstrate significant barriers to the acceptability of MC in the majority of the population3. Zimbabwe has also carried out an evaluation study of the use of devices for VMMC exploring safety, total operative time and field implementation by trained nurses4. The results have contributed to the global pre-qualification process of the device by WHO for use on male clients 18 years and above.

HTC - HIV testing and counselling (HTC) is the entry point to prevention, treatment and care, The overall goal of Zimbabwe's HTC strategy is to ensure 85% of people know their HIV status by 2016. The recent ZDHS 2010-11 indicated that 36% of men and 57% of women reported to have been tested in the country and a discordance rate of 12 % among couples. A review of the HIV Testing and Counselling Strategy in 2012 showed that there are limited testing and counselling services for pregnant women during labour, delivery and also that training in HTC for children and adolescents living with HIV is inadequate and needs strengthening. The review thus recommended innovative strategies to increase

awareness, demand and utilization for HTC with more emphasis on couple/partner counselling and testing, adolescents, young people and high risk populations.

BCC - Zimbabwe launched the National Behaviour Change programme to reduce HIV transmission through behaviour change in

2006, and it has been extensively rolled out across the country. According to the UNAIDS World AIDS Report 2011, behaviour change interventions are one of the high priority high impact programs for Sub Saharan Africa. An impact study was conducted in Zimbabwe in 2010-115 comparing BC focus districts with BC non-focus districts. The findings supported the rationale for behaviour change programming to include multiple partner messaging by showing positive associations between programme exposure, knowledge/attitudes/self-efficacy, fewer non-regular partners and HIV status. The majority of adults report having at least some exposure during the period. There have been important and significant changes in knowledge, attitudes, norms and behaviours between 2007 and 2011, which are likely to have contributed to the decline in HIV prevalence over this period (and noted in various other national bio-behavioural surveys)6.

Community Systems Strengthening – Local reviews and studies have demonstrated important approaches to strengthen the community response, including establishing that home based care by community volunteers enables the continuum of care from the health facility to the community (ref: Looking Back, Mapping Forward – Research findings on Home Based Care, Irish AID & SAfAIDS). Support groups of people living with HIV have also enabled treatment adherence and improved quality of life for those affected and their families (Zimbabwe National Network of People Living with HIV – Annual Report 2011). An evaluation of the PMTCT programme in Zimbabwe baseline survey (preliminary results) also demonstrated that community mobilisation and education has enabled more women to access services and reduced defaulter rate of mother-infant pairs.

Health Systems Strengthening: Human Resource Support. There is increasing evidence that the retention scheme allowance, supported by Global Fund and more recently combined with the Health Transition Fund, has significantly impacted on improving the recruitment and retention of health workers in Zimbabwe's public health institutions7. Annual retention rates for 2012 show a significant improvement in both doctors (75%) and nurses (96%) when compared to 2009 rates (before the retention scheme was introduced)8. The GF Office of the Inspector General (OIG) report highlighted that failure to pay retention allowances directly impacts programme implementation and is likely to result in a loss of gains registered in this area. Zimbabwe is therefore requesting continued investment in this scheme in order to continue provision and enhance access to quality health services, with the intention of improving broad health outcomes as well as HIV-specific and other GF supported diseases (TB and malaria).

a) The proposed modules and interventions of the funding request in order of priority Modules for implementation have been selected and prioritised from within the much wider scope of the ZNASP II (which addresses all the components of a holistic multisectoral response) based on the rationale described above. The modules have been prioritised through wide stakeholder consultation (see Section 1.3 of Concept Note), programmatic gap analysis (see Attachment 2 and section 3.1 of Concept Note) and emerging global and local data on their potential impact on Zimbabwe's strategic goals of preventing new infections and keeping people alive. Availability of cost-effectiveness data at national and local level for decision making remains limited, although selection of these services is increasingly supported by global cost-effectiveness data.

These modules and interventions selected for inclusion in this request are as follows:

Module	Interventions	Amount
Treatment, care and support	Pre-ART	$45,800
	ART	$151,268,889
	Treatment Monitoring	$9,991,160
	Treatment adherence	$1,493,100
	Community systems strengthening for specific HIV interventions	$331,600
	TB/HIV collaborative interventions	$5,892,234
PMTCT	Prong 1: Primary Prevention of HIV infection among women of childbearing age	$525,000
	Prong 2: Prevention of unintended pregnancies among women living with HIV	$605,000
	Prong 3: Preventing vertical HIV transmission	$7,534,180
	Prong 4: Treatment, care and support to mothers living with HIV and their children and families	$1,247,000
Male Circumcision ("HIV other 3")	Male circumcision (MC activities)	$6,373,250
HIV Testing and Counselling ("HIV other 2")	Other intervention (HTC activities)	$6,908,026
Behaviour Change ("HIV other")	Other intervention (BC activities)	$1,601,050
HCSS: Community groups and networks	Advocacy, communications and social mobilisation	$2,054,125
	Equity and enabling environment	$1,168,450
	Health and other rights	$389,500
HCSS: Procurement and supply chain management	Operationalization of PSM system	$1,026,512
	PSM infrastructure	$8,409,177
HCSS: Health and community workforce	Retention of workforce	$34,753,980
HCSS Information System	Routine reporting	$230,000
M&E (HIV)	Analysis, review and transparency	$1,178,040
	Routine reporting	$16,899,168
	Surveys	$1,250,000
Programme management (HIV)	Planning, coordination and management	$50,000,000
Grand Total		$311,175,241

Rationale for prioritisation

The Global Fund three-year investment in the proposed complement of interventions comprising ART, elimination of mother to child transmission and combination prevention services supported by HCSS effort will result in9:

• Averting an average of 60,000 deaths annually among PLHIV

• Averting an average of 20,000 new infections annually in infants

• Averting about 5,000 deaths annually in children exposed to HIV

The country has made strident efforts and significantly expanded access to ART to current levels of around 95% of the treatment needs for adults (based on 2011 estimates and 2010 WHO ART guidelines). While paediatric ART has lagged behind at 42% and there is need to step up interventions targeting children, success in coverage has been largely due to the leadership of the Government of Zimbabwe and significant resource commitments from the National AIDS Trust Fund (NATF), the Global Fund, USG, DFID and other partners. However, it is critical to acknowledge that ART is treatment for life. Failure to provide regular ARVs can halt the decline in AIDS mortality in the country and result in development of HIV drug resistance threatening the individual, the community and the national programme at large. Maintaining people on ART is therefore both a programmatic and an ethical imperative. It is for this reason that ART is made the first priority in this request, especially given that the Global Fund is currently one of the largest funders of ART in the country.

As described in the preceding sections, Zimbabwe has seen steady decline in new HIV infections since the onset of the 21st century. This trend has been associated with increase in coverage of HIV prevention interventions such as behaviour change communication, testing & counselling and targeted services for some high risk groups such as sex workers. Zimbabwe would like to sustain this downward trend in new HIV infections by scaling up high impact interventions and ensuring greater focus of efforts on the most affected population groups. Zimbabwe has adopted the strategy of combination prevention to intensify efforts towards further reducing new HIV infections. Combination prevention refers to a systematic approach to implementing a range of HIV prevention interventions: behavioural (e.g. communication to promote reduction in the number of sexual partners) and biomedical (such as condoms and male circumcision), in synergy with structural interventions (for example, increasing girls' access to education). In this request Zimbabwe is prioritizing the scale up of PMTCT, male circumcision, HIV testing and counselling and targeted behaviour change interventions. Efforts will be made in each of these priority areas to tailor the interventions to the requirements of the most affected populations groups.

In addition, the country has experienced major systems constraints in the delivery of services which have been largely resulted from the economic crisis that the country has been experiencing. The work of rebuilding health and community systems to ensure that there are able to support efficient and effective delivery of the HIV prevention, treatment and care services, will need to continue. This request includes efforts to strengthen health systems by ensuring availability of sufficient human resources, improved supply chain and adequate information systems to implement and monitor the HIV services.

C) Consolidated funding requests Global Fund is one of the major investors in HIV (including ART and PMTCT) in Zimbabwe. HIV grants were awarded in Rounds 1, 5 and 8 and have contributed significantly to the country's achievements in addressing HIV. The Round 8 grant awarded to Zimbabwe for HIV has been implemented since 2010, with over 200 million USD disbursed by the end of 2012. Grant performance has also been strong, recording two A ratings and two B1 ratings in 2012. GF has contributed to HIV testing, counselling and provision of results to over 1.5 million people and to Zimbabwe's attainment of universal access to treatment in adults by September 2012 based on the 2011 HIV estimates, including direct support of ARV medicines for 203,440 patients (about 42% of patients currently on treatment in Zimbabwe) and ARV prophylaxis for 44,638

pregnant women living with HIV. A Round 8 Health Systems Strengthening grant has also provided critical support for retention of health workers that has enabled ambitious treatment and prevention targets to be met10.

With the exception of MC, all modules for this application were included in the GF R8 grant. All of these modules will therefore be adapted and extended to maximise the impact of this new investment. Male circumcision will essentially be added as a new module from Round 8, as policy and programme strategy were not yet in place at the time of applying for Round 8 and activities

of R8 implementation only included a small amount of mass media communications.

ART – Investments will be used to scale up treatment coverage and maintain existing patients on treatment. Paediatric ART will be scaled up to reach universal access. The intention in this request is to support 364,363 patients in 2014; 381,112 in 2015; and maintain same level of support through to sustain the level of attainment by 2016. The number of patients in need of treatment was adjusted to include HIV-positive pregnant women in the context of PMTCT Option B+. This will further contribute to reduction in AIDS mortality. This funding request is aimed at supporting further decentralization of HIV Care and Treatment services and integration of ART into primary health care from the current 61% of all health facilities in 2012 to 90% in 2016. Decentralization will help improve treatment access by bringing ART services closer to where patients live. However, mobile teams will continue

to be supported by the National AIDS Council to offer outreach services to the hard to reach areas. Current systems and structures for TB/HIV collaboration will be strengthened and maintained, with emphasis on intensified TB case finding and implementation of IPT for PLHIV following results of pilot study. The country will also implement an electronic patient monitoring system to address data quality and improve provision of care.

Quality of services will also be improved including through regular monitoring of ART patients, improving patient adherence and retention. The requested funding will support the capacitation of site staff, district, and provincial managers in utilizing quality monitoring indicators and tools and to identify interventions for quality improvement. The selected quality indicators are meant to address patient retention issues, patient adherence to treatment, CD4 monitoring and TB screening for PLHIV. Through this support, health workers will be trained using the Integrated Training approach to improve competencies and skills in HIV Management. Clinical Mentorship and attachment programmes will be supported by other funders including PEPFAR, UNICEF and EGPAF.

PMTCT - Zimbabwe has committed itself to the global goal of eliminating new HIV infections infants and children by 2015. The overall approach is to scale up the provision of quality and comprehensive PMTCT services, transition the provision of Option A to Option B+, improve the quality and scale up early infant diagnosis (EID) and early infant treatment (EIT) and attain the universal access. The PMTCT programme is currently receiving substantial support for programmatic activities, therefore requested support from GF will contribute to the procurement of commodities and programme activities to support the transition. PMTCT will also be used as an entry point for reaching women and men in stable unions and sero- discordant couples with HIV testing, couple counselling, behaviour change interventions and treatment as prevention.

VMMC – Investments in VMMC will support the scale up of the national VMMC programme through procurement of VMMC kits, training and capacity building of health workers in the use of both surgical methods and devices. The New Funding model will support VMMCs in

17,800 in 2014 and 47,290 in 2015. Expansion of service delivery will be supported through outreach and static site support. Extensive demand creation is also included, given Zimbabwe's traditional status as a non-circumcising country. This funding request will contribute to an increase in the rate of male circumcision from the 2011/2012 level of 7% of males targeted to 73% by end 2016.

This target is achievable considering the accelerated pace of scale up observed for other interventions when special effort is made. Zimbabwe has embarked on ambitious VMMC targets based on the current initiatives to reach more men through demand creation efforts and expansion of VMMC services. The expansion of services is anchored on the increased number of VMMC sites to all the districts countrywide with each district providing outreach services to sub-district levels. Further, the service expansion will be achieved through the broadening of scope of nursing practice to provide both surgical and device male circumcision services. Consultations with relevant regulatory authorities, (Nurses Council, Medical and Dental Practitioners` Council and the Health Professions` Council) are at an advanced stage. The effect of the all these initiatives is to increase availability and accessibility of male circumcision services. Male circumcision is another prevention intervention that will be used to reach males in stable heterosexual unions and discordant couples. They will also be provided with other services such as condoms, testing, counselling and behaviour change interventions.

HTC – In 2012, 2.2 million people were tested for HIV. This request seeks funding support to test a total of 2.7 million individuals

by 2016. Expansion of the existing PITC model supported in R8 will continue, with capacity building and support of the Primary Counsellors. Testing and counselling will also be linked to other services such as PMTCT (aiming to cover as many ANC services as possible), couple counselling, male circumcision and for specific key populations. The assumption is that with increased demand creation for uptake of VMMC, PMTCT, ART services there will be increased uptake of HTC services as the entry point for prevention, treatment and care. This application will also place stronger emphasis on building capacity to undertake couple counselling which will help in identification and of sero discordant couples that will be linked to treatment, and counselling of children and adolescents.

BCC – The new GF investments will fill gaps in promotion of safer sexual practices and promotion of uptake of HIV services and commodities. This will complement efforts of other implementers involved in demand generation e.g. male circumcision and HTC. Interventions will focus on the general population and targeted interventions for specific populations, including sex workers to ensure that they have access to information and HIV preventions services. Young people will be targeted to receive messages with capacity building of School Health Masters in HIV prevention.

Behaviour change interventions will aim at reducing risk of HIV transmission and increase demand for other HIV services including VMMC, condoms (supported and distributed by PEPFAR). BCC interventions will be better tailored to needs of specific population groups, with priority being placed on males and females in stable unions (aim to integrate BCC into and cover as many ANC services as possible), young people (including schools), sex workers, men who have sex with men and people in prisons. In working with other key populations such as sex workers and men who have sex with men, efforts will aim at extending services to these population groups. Since these most-at-risk populations access services from the existing public facilities, healthcare workers will need to be trained to be more sensitive to the needs of these special groups. The NAC is working with the Zimbabwe Prison Services, and with support from United Nations Office of Drug and Crime (UNODC) has developed a strategy for HIV and TB prevention among people in prison

settings. UNODC is committing USD 2 million to this programme which will include peer education, testing, counselling and HIV treatment.

Community Systems Strengthening will also be extended with a focus on community based advocacy, communications and social mobilisation, equity and an enabling environment and attention to health and other rights. Particular attention will be paid to ensuring that key populations, including MARPs, are informed of and have access to prevention, treatment and care services. This will be done through:

• Social and behaviour change communication and community outreach to key and most-at-risk populations

• Peer education

• Referral of key populations to existing services, including STI screening and treatment

Procurement and Supply Management: NatPharm is now focusing on providing procurement services of pharmaceuticals apart from storage and distribution functions. The funding and anticipated increase in revenue inflows (National AIDS Trust Fund) as well as annual allocations from the health budget will continue to support new and existing patients on treatment. Capacity of health staff at national and sub national levels will be strengthened through Inventory management trainings (including on-job), mentoring, and supportive supervision. NatPharm and 52 health facilities were assessed in relation to storage capacity and conditions for health commodities and capacity requirements identified. Storage and distribution of antiretroviral medicines will be decentralised to all the four NatPharm branch stores and the remaining 1,508 facilities will also be assessed and the identified areas for improvement will be supported through this proposal. The improvements will address issues of inadequate storage conditions at facilities.

The Health Workforce will be supported through continuation of the successful Health Worker Retention Scheme from the R8 Health Systems Strengthening grant. For this application the contribution of GF will be 60% of its current level (2013) in order to remain within budget allocations, applied to the same categories of staff (C5 and above).

Monitoring and evaluation will focus primarily on improving data quality and integration of the HIV/TB M&E into the routine national health information system. Critically, an Electronic Patient Monitoring System will be expanded across the country to high volume ART sites in order to strengthen monitoring and quality of patient care and treatment, and further analysis of outcomes. Please see the attached Technical Assistance Plan (Annex 17) summarising the Technical Assistance activities proposed for this request.

[1] Zimbabwe MOHCW, Evaluation of ART Outcomes in Zimbabwe, 2012

[2] Halperin et al (2005) Acceptability of adult male circumcision for STD and HIV prevention in Zimbabwe. Sexually Transmitted

Diseases, 32(4) 238-239

[3] Samkange C et al (2008) Male Circumcision – Report on the feasibility of MC Roll Out

[4] Gwinji G et al (2012) Randomized Clinical Trial on PrePex Device, unpublished

[5] National Behaviour Change Programme Surveys, University of Zimbabwe Department of Community Medicine, 2012

[6] Gregson, S., et al., HIV decline in Zimbabwe due to reductions in risky sex? Evidence from a comprehensive epidemiological review. Int J Epidemiol, 2010. 39(5): p. 1311-23.

[7] DFID Zimbabwe Impact Assessment of Health Worker Retention Scheme 2012 [8] Zimbabwe Health

Services Board Report 2012

[9]Preliminary 2013 HIV Estimates, MOHCW

10] The Global Fund In Zimbabwe – 2012 In Review. United Nations Development Programme (UNDP) supported by the GFATM 2012

4.2 Funding Request above the Indicative Funding Amount

Building on the applicant's funding request in 4.1, please describe and prioritize the funding request above the indicative amount, including:

a. The **additional gains, objectives** and **outcomes** that could be realized to achieve specific national goals or objectives.
b. What the **additional proposed modules and interventions** are in order of priority. Explain the rationale for this prioritization.

a. Additional proposed modules and interventions are in order of priority. Explain the rationale for this prioritization.

The modules and programme areas to be funded with incentive funding are the same as for the indicative funding request, and have been prioritised in the same order. They include implementation of strategies that are expected to act synergistically with the indicative funding investment, and with each other, in order to accelerate impact.

ART - The MOHCW is guided by global recommendations, and is therefore likely to adopt the pending revised 2013 WHO guidelines of increasing the CD4 threshold for initiation of ART to <500. This will increase the need for ART among adults by about 28% annually. There is in-country dialogue on how to address the low paediatric ART coverage which stands at 42% by considering a pragmatic approach towards widening the ART eligibility criteria for children. In addition ART has also been proven to be efficacious in preventing transmission between sero-discordant couples and would significantly add to the impact of the programme, as the 2010/2011 ZDHS data show the bulk of infections come from stable heterosexual unions with sero-discordance rates of 12%. Under the incentive funding, the country is requesting support for the additional treatment needs based on the preliminary revised 2013 WHO guidelines and the need to cover sero-discordant couples and all TB/HIV co-infected patients i.e 82 800 (2014), 175,284 (2015) and 295,284 (2016) and an additional 6,445 (2015) and 17,082 (2016) children.

Cotrimoxazole and Isoniazid medicines are required for the prophylaxis of Opportunistic Infections, including TB among PLHIV and would be procured for 300,000 patients using incentive funding, with resulting benefits on overall health status of these patients.

As part of improved pharmaco-vigilance, cohort event monitoring training and supportive supervision will be conducted to selected health facilities based on set criteria.

The incentive funding will contribute towards the end-term review of the National HIV Prevention, Treatment and Care programme in 2016 to inform the development of a comprehensive Health Sector HIV Prevention, Treatment and Care Strategy.

Laboratory Support towards monitoring PLHIV on ART – The ART programme has prioritized strategic use of laboratory services for patient monitoring in addition to clinical

monitoring of patients on treatment. According to current 2010 ART guidelines, patients being initiated on ART should have a baseline CD4, FBC and biochemistry tests. However in the absence of baseline laboratory tests, the WHO clinical staging criteria are used to assess eligibility for ART. Patients already on ART should have six monthly CD4, FBC and biochemistry tests and yearly Viral Load tests. However, optimal provision of laboratory services is impeded due to inadequate qualified laboratory personnel, weak supply chain management of laboratory reagents and commodities, and lack of regular servicing of equipment.

The incentive funding will provide additional support for six monthly CD4 tests for 50,000 patients (2014), 75,000 patients (2015) and 150,000 patients (2016). Six monthly FBC and biochemistry tests for 100,000 patients yearly for the three years will also be supported.

MOHCW is considering phasing-in Viral Load testing to monitor ART response. The VL algorithm will be aligned to the 2013

WHO guidelines anticipated in mid-2013. Based on the current guidelines, the incentive funding will support yearly VL tests for 100,000 patients (2014), 150,000 patients (2015) and 200,000 patients (2016) using the conventional VL platforms. As POC Viral

Load technology becomes available globally, the country intends to invest in such technology. This proposal seeks to support additional patients to benefit from VL testing using the POC VL technology i.e an additional 100,000 patients (2014), 150,000 patients (2015) and 200,000 patients (2016). The incentive funding will also contribute to the scaling up of the GPRS system for expedited delivery of DNA PCR results to facilities; improvement of the current sample transportation system; employment of additional 6 laboratory scientists to support increased VL demand; external quality assurance and servicing of existing laboratory equipment.

PMTCT - PMTCT and Paediatric Care and Treatment will be further strengthened across all four prongs of the approach. With incentive funding, greater focus will be placed on promoting the Sexual and Reproductive Health Rights of women living with HIV through community based road shows reaching 130,000 people per year with information and providing mobile HIV testing and FP counselling services. The national programme will design and disseminate messages through bulk SMS facilities to promote uptake of testing and treatment services for infants. For timely transportation of DBS samples, an additional ten motorbikes will be procured and maintained for EHTs in ten hard to reach districts. This will reduce the turn-around time for DNA PCR results. Six messages will be released yearly with the intended audience for the SMS messages are mothers (pregnant and non-pregnant) and their partners and community leadership. An innovative model of peer–to peer support will be established with the aim of reducing loss to follow-up in the ANC and Post-natal Care cascade to reach 62,000 pregnant women per year. Capacity building of 1,050 health workers on provision of comprehensive HIV prevention, treatment and care services for pregnant women and their partners including key populations will be conducted and immediately followed up with continued clinical mentorship.

VMMC - Demand creating through innovative Information, Communication and Technology (ICT) platforms will be covered with this additional funding. The National Office will engage an Advocacy and Communication person to strengthen demand creation. Transport for mobile services will be provided including the purchase of eleven vehicles for these outreach teams to allow service delivery in geographically remote areas as services reach saturation point around static sites. Costs for fuel and maintenance of the eleven MC outreach vehicles and 50% of the commodities will be supported by the incentive funding, enabling another 180,828 clients to be reached with MC services.

HTC - Zimbabwe has adopted the Combination HIV Prevention Strategy and Male Circumcision and eMTCT are high impact interventions strategies. HTC is the critical entry point in all these strategies hence incentive funding will train an additional 300 Primary Counsellors (PC) and retain them to provide quality counselling for male circumcision, adherence counselling for ART, child counselling and for eMTCT as the country moves to Option B+. For the hard to reach communities, mobile outreach activities will be conducted monthly per each of the 65 districts. Recognising that the highest prevalence of HIV is among married couples, a focus will be placed on couple counselling and testing. Within ANC, a focus will be placed on encouraging testing and counselling among couples. New innovations like self-testing will be piloted with support from the incentive funding and will inform policy development followed by national scale up of self-testing.

BCC - Additional funding will be required to reach youths in school and out of school with comprehensive HIV prevention, treatment and Care services by training 108 trainer of trainers (TOTs) behaviour change facilitators. This will be followed by cascade training to all 65 districts. Additional incentive funding is being requested to procure one vehicle for outreach activities in each of the ten provinces, twenty printers and ten LCD projectors to support training activities of BCC facilitators in tertiary and higher learning institutions.

Community Systems Strengthening – With incentive funding there will be provision of OVC support to enhance access to health and reduce their vulnerability to HIV infection. Child care workers will also be trained in psychosocial support for children living with HIV. Village Health worker capacity building programme, strengthening of an electronic data base for the National Network of PLHIV as well as incentives for the data collectors for the data base will also be supported. Community strengthening for PMTCT will take place in the form of community ambulances to ensure transport is readily available for pregnant women in communities that are hard to reach and thus reduce home deliveries.

Health Workforce – The indicative funding amount may be insufficient to support all of the health workers at a desirable rate. Therefore incentive funding would allow payment of 100% of the current retention allowance to further support the country to retain sufficiently qualified and experienced personnel. Allowances for an additional 1000 Environmental Health Technicians who are currently being trained with support from other partners, will also be supported to increase community based access to health care services including HIV, TB and malaria. Salaries for four additional HR auditors will also be supported to conduct spot checks for the retention scheme at every health facility.

PSM- Funding requested in the indicative budget is not adequate to improve storage capacity at all facilities, therefore the incentive funding will be required to support health facility assessments and improvement of storage capacity at 1,353 health facilities within the health delivery system. For effective and efficient management of medicines, capacity building of 2,550 health workers will be conducted. Monitoring and supportive supervision at all levels of the health care will be carried out.

M&E - The additional request beyond the indicative amount will support the complete expansion of the ePMS into all 534 high volume ART health facilities and cater for greater than 90% of the ART patients.

Funding will also support size estimates of key populations to determine the magnitude of the problem for key population groups and design appropriate interventions for the groups.

Supportive supervision visits and capacity building in M&E will also be supported.

[1] Zimbabwe Draft Combination HIV Prevention Strategy 2013-2015, Unpublished

Clarified Section 4.3- Government contributions towards health sector as shown in Financial Gap Analysis Table

4.3 Commitment to Sustainability and Additionality Financial sustainability is important to ensure continuity of impact. In particular, implementing country governments must fulfill their obligations to sustain and increase contributions to the national response. The counterpart financing requirements of the Global Fund are set forth in the Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization (ECFP).
Please complete the **Financial Gap Analysis and Counterpart Financing Table** in Attachment 4. a. Indicate whether the **counterpart financing requirement** has been met. If not, provide a justification that includes actions planned during implementation to reach compliance. b. Describe whether and how this funding request to the Global Fund will be complemented by **additional funding commitments from the Government.** c. Describe how this funding request to the Global Fund can leverage **other donor resources**.
a. Counterpart financing: The Government of Zimbabwe has demonstrated commitment to the national response in HIV/AIDS. This is evidence through a) putting in place legislative provision to ensure 3% of both individual income tax (PAYE) and Corporate Income Tax (CIT) is wholly earmarked for HIV responses, b) there are specific votes in general treasury annual budgets, which allow certain funds in the health budget to be allocated for the HIV/AIDS response e.g. ARVs and related commodities, HIV programme support, and HIV research. The total of these allocations yields an estimated counterpart threshold of 24%. Political commitment provided the tax provision, now the country's economic performance will determine the extent of future commitments. As noted in the Financial Gap Analysis and Counterpart Financing Table (Attachment 4), a general increase in the absolute contribution of the Government of Zimbabwe to the HIV budget is evident. The economy is growing at 5%; therefore, it is anticipated that the level of pooled domestic resources will also increase and bring about an increase in percentage of counterpart financing, in addition to a national sense of ownership and sustainability. **b.** Additional funding commitments from the Government In light of the country focus demonstrated in this application, there is complementarity between GF resources and the domestic pool, particularly in the area of treatment and care and health/community systems strengthening. The Government of Zimbabwe has demonstrated its commitment to retaining and maintaining human resources in general for the health sector through the payment of basic salaries and maintaining facilities infrastructure. It is evident that these are key to delivering HIV services to all those who need it. The government of Zimbabwe has also committed to ensuring in-service training to all medical personnel at the University of Zimbabwe, College of Health Sciences. The Government of Zimbabwe has been able to commit to purchasing of ARVs through the National AIDS Trust Fund (NATF - an earmarked tax), the additionally here demonstrated is that of a synergistic effect. The funding request to GF will cater for the remaining gap amounting to $310 million. **c.** Process of developing the financial gap analysis and leverage with other donors As noted in the development of the programmatic gap, emphasis has been placed on high impact interventions (those which maximize outcomes/outputs from a given investment), creating a synergistic effect with other donors as well. Donors or partners

in HIV responses in Zimbabwe were consulted and interviewed to assess their previous expenditures, current areas of focus, and future commitments and areas of focus. This helped to identify the areas within the gap that will be addressed through the donor activities. The final funding request presented was developed taking into consideration both domestic and donor funding currently available and committed. Experts project the growth of the Zimbabwean economy at 5%, which will subsequently increase the treasury 'pot', hence both the NATF collections and specific budgetary allocations will increase. A commitment is not a guaranteed future disbursement; it is with this thinking that the figures from donors here presented needed to be judged with caution, particularly commitments from the donor community. There is a possibility that these figures could be low subject to changing international policies from the partners. Also considered was the fact that current Global Fund Round 8, Phase 2, is coming to an end hence there is an expected gap left thereafter.

As described in the preceding sections, Zimbabwe has seen steady decline in new HIV infections since the onset of the 21st century. This trend has been associated with increase in coverage of HIV prevention interventions such as behaviour change communication, testing & counselling and targeted services for some high risk groups such as sex workers. Zimbabwe would like to sustain this downward trend in new HIV infections by scaling up high impact interventions and ensuring greater focus of efforts on the most affected population groups. Zimbabwe has adopted the strategy of combination prevention to intensify efforts towards further reducing new HIV infections. Combination prevention refers to a systematic approach to implementing a range of HIV prevention interventions: behavioural (e.g. communication to promote reduction in the number of sexual partners) and biomedical (such as condoms and male circumcision), in synergy with structural interventions (for example, increasing girls' access to education). In this request Zimbabwe is prioritizing the scale up of PMTCT, male circumcision, HIV testing and counselling and targeted behaviour change interventions. Efforts will be made in each of these priority areas to tailor the interventions to the requirements of the most affected populations groups.

In addition, the country has experienced major systems constraints in the delivery of services which have been largely resulted from the economic crisis that the country has been experiencing. The work of rebuilding health and community systems to ensure that there are able to support efficient and effective delivery of the HIV prevention, treatment and care services, will need to continue. This request includes efforts to strengthen health systems by ensuring availability of sufficient human resources, improved supply chain and adequate information systems to implement and monitor the HIV services.

4.4 Focus of Proposal

This question is **not** applicable for Low Income Countries.

If the applicant is a **Middle Income Country,** describe how this request meets the Focus of Proposals requirement according to the threshold based on the income classification for the country.

Not applicable.

SECTION 5: Implementation Arrangements			
5.1 Principal Recipient Information			
Complete this section for each nominated Principal Recipient. For more information on Minimum Standards refer to the Concept Note Instructions.			
PR 1 Name	UNDP	**Sector**	Multilateral
Does this PR currently manage a Global Fund grant(s) in this disease/HCSS area?		☒Yes	☐No
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		Yes	
2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)		Yes	
3. There is no conflict-of-interest for the selection of the Principal Recipient(s) and Sub-Recipients		Yes	
4. The program-implementation plan provided in the concept note is sound		Yes	
5. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud		Yes	
6. The financial-management system of the Principal Recipient is effective and accurate		Yes	
7. The central warehouse and the warehouses for key regions have capacity, appropriate conditions and security to store health products, and to maintain their quality		No	
8. The distribution process can handle the requisition of supplies to avoid treatment / program disruptions		Yes	
9. Data-collection capacity and tools are in place to monitor program performance		Yes	
10. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately		Yes	
11. The CCM actively oversees the implementation of the grant, and intervenes where appropriate		Yes	
12. A quality-assurance plan is in place to monitor product quality throughout the in-country supply chain		No	

5.2 Current or Anticipated Risks to Program and PR(s) Performance

In reference to the Minimum Standards above and risk assessments conducted (if applicable), describe current or anticipated risks to the program and nominated PR(s) performance, as well as the proposed mitigation measures (including technical assistance) included in your funding request.

UNDP as the PR to the Zimbabwean grants poses no envisaged risks to programme implementation and grant performance. The PR has also designed and implemented a capacity development programme to enhance capacities of current SRs under round 8. This will mitigate any potential risks at SR level.

There is need however to address warehousing and storage services from central to regional to site level with the view to improve on security and conditions of storage for health products. The PR, working with other partners, are assisting NatPharm and the MOHCW to address these challenges. Within this current application some budgets have been allocated toward addressing storage issues.

5.3 Overview of Implementation Arrangements

Please provide an overview of the proposed implementation arrangements for the funding request. In your response, please describe as appropriate:

a. If more than one PR is nominated, how co-ordination will occur between PR(s).
b. Whether Sub-Recipients (SRs) have been identified and the type of management arrangements likely to be put into place.
c. How coordination will occur between each nominated PR and its respective SR(s).

a. Coordination between PRs

UNDP currently works as the nominated PR under the general guidance of the CCM, and is responsible for programme management, financial accountability, procurement of goods & services and Monitoring and Evaluation. It is anticipated that the current institutional arrangement will continue during the life of the grant as there has been no review of the ASP. The grant will thus be implemented by a single PR (UNDP) hence the issue of coordination among PRs is not applicable.

b. Identification and management of sub-recipients

The existing grant will be consolidated with the new grant and this includes reprogramming of the existing budget. While the selection of SSRs will be a transparent and open process, it is anticipated that the current SRs, depending on capacity, may continue. However this will entail conducting further capacity assessment by the PR in light of the changing focus of the grant.

The current grant has 4 SRs namely MoHCW, NAC, NatPharm and a civil society organisation. UNDP expect to re-engage as Sub Recipients the National AIDS Council (NAC), the Zimbabwe Ministry of Health and Child Welfare, a civil society organisation and the National Pharmaceutical Company of Zimbabwe (NatPharm). UNDP also expects to engage the Health Services Board (HSB) as a new sub-recipient for management of the health worker retention scheme, then undertake a transparent process to engage the civil society organisation. NAC and the Ministry of Health and Child Welfare will be responsible for the implementation of the programmatic activities

and NatPharm will be the implementing agency for storage and distribution without having to replicate or have parallel structures to support UNDP's role as PR in Zimbabwe. The PR has already developed guidelines for SR management through the SR Manual (see Annexe 18: Implementation Manual for Global Fund Grant Sub-Recipients).

The Ministry of Health and Child Welfare - operates within the functions mandated to the office of the Minister of Health and Child Welfare. The ministry's national head quarter's role is regulatory, policy setting and provision of a legally enabling environment for the operation of the various health services and funders.

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

NatPharm-is the implementing agency for storage and distribution for major donors and UN Agencies such as UNICEF, UNFPA and WHO. NatPharm was the result of the promulgation of the Government Medical Stores (Commercialization) Act, 2000. It was established as an autonomous not-for-profit organisation registered in terms of Section 26 of the Companies Act (Chapter 24:03) with an independent Board appointed by the Minister of Health and Child Welfare. NatPharm has six warehouses nationwide with storage capacity of approximately 12, 812 sqm. The regional store in Harare which will serve as the major international receiving store has a capacity of 6,621 sqm.

The civil society organisation will be responsible for the implementation of programmatic activities. The organisation will support the implementation of this programme by harnessing AIDS service organisations for multi-sectoral coordination. Specifically, the civil society organisation will be strategically placed to ensure that civil society organisations focusing on gender and reaching other vulnerable groups are included in implementation of related activities.

The Health Services Board (HSBis- directly responsible for all staffing and service matters in the health sector with the aim for an overall improvement of the sector in order to attract and retain professional staff. HSB manages the Retention Scheme and works closely with donor partners, including the Global Fund, to ensure effective implementation of the Scheme. HSB is the result of the Health Services Bill, which passed through parliament in 2004, effectively removed all health service personnel from the employ of the Public Service Commission (PSC) and placed them under the Health Services Board.

c. How coordination will occur between each nominated PR and its respective SRs

Zimbabwe is currently under Additional Safeguard Policy (ASP) and the Global Fund has nominated UNDP as the Principal Recipient. No other PR was nominated therefore coordination is led by UNDP with the SRs. As the PR, UNDP is supporting capacity development of individuals (skills building) within SR organisations and institutional systems, in the areas of coordination and management, accountability and risk management, including the country's Health Information System.

Each SR is managed individually by the PR, who in turn manages and coordinates with their own SSRs. UNDP has a project management unit with the mandate to manage all Global Fund grants in Zimbabwe. The PMU has various units –

disease units (HIV, TB, Malaria) and support (finance and admin, M&E and PSM). Each grant has a manager who ensures budget monitoring of all SR activities, avoiding duplication, ensuring appropriate integration of activities and budgets, enforcing budgetary and policy compliance and ensuring money is used according to plan. Reports are made to the Global Fund on a semester basis (six-monthly) which consists of financial and programmatic progress linked to the Peformance Framework (links performance to targets) and this is the basis of grant rating. The manager has monthly meetings with the SRs and quarterly review meetings with each SR and their SSRs. At these meetings progress and challenges in implementation are reviewed and improvements to implementation proposed. Verification of data is done by M&E officers going to the field to verify reports submitted, undertake spot checks and to ensure activities being implemented according to the plan and ensure no problems in implementation. The findings of these missions form part of the agenda of the monthly meetings. This can result in reallocation of budgets to maximise efficiency of implementation.

As a manager of the main source of funding to the health sector UNDP also plays an important role in the coordination with donors to avoid duplication and maximize the impact of the interventions. In the implementation of the project, UNDP Country Office will coordinate closely with Government, bi-lateral development partners, civil society and private sector to harmonize and coordinate the response in supporting the implementation of Global Fund grants and in the establishment of a strong communication policy and ways of sharing lessons of implementing in this dynamic environment. Moreover the UNDP Country Office will work with these stakeholders to strengthen national capacity in the implementation of the project activities. Bi-lateral partners include DfID, EU, USAID (CDC, PEPFAR) and UN agencies (UNAIDS, UNFPA, UNICEF, UN Women, ILO and WHO).

The CCM will continue to perform its oversight role and will approve all major changes in implementation plans as necessary.

5.4 Addressing Links to other Concept Notes and/or Existing Grants

If you are requesting funds for more than one component (including stand-alone HCSS) during the transition or have an on-going Global Fund grant (for another component), describe how the interventions being requested link to existing Global Fund grants or other concept notes being submitted, in particular as they relate to human resources, staffing, training, monitoring and evaluation and supervision activities.

The existing Round 8 Phase 2 grant was informed by the current Zimbabwe National HIV and AIDS Strategic Plan (2011-2015). The National Strategic Plan (NSP) 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 NSP and is also guided by the investment framework currently under development. The existing grant will be consolidated with the new grant and this includes reprogramming of the existing budget

In addition to the HIV/AIDS grant, Zimbabwe is currently implementing three other Global Fund grants namely; TB and HSS under the Round 8 Phase 2 grant and the SSF Malaria. In addition to the support for human resources costs which are specific to this grant, this proposal provides for support to government and civil society staff involved in the implementation of other existing grants. Both categories of staff provide service to the three diseases at the community and institutional levels. Training for health personnel is cross cutting and complementary particularly as it relates to TB/HIV collaborative activities. Other training targeting community health workers is also

focusing on enabling the cadre at that level to provide services to all diseases and not just HIV related activities.

A major component of this proposal relates to the establishment of an Electronic Patient Monitoring and Management system. The e-PMS will be used to monitor and manage all ART and TB patients and will use the national Health Information Management System platform. Whist the HMIS is currently being supported under the three diseases, there is a gap which is provided for in this proposal.

5.5 Women, Communities and other Key Affected Populations

Please describe how representatives of women's organizations, people living with the three diseases and other key affected populations will actively participate in the implementation of this funding request, including in interventions that will address legal or policy barriers to service access.

Representatives of women's organizations, people living with HIV/TB and other key affected populations will participate in the implementation of the funding request, including conceptualization, implementation and evaluation. While the legal and policy environment remains challenging for the full, open participation of sex workers and men who have sex with men (MSM), efforts have been made for representatives of these networks to participate in the conceptualization, implementation and evaluation of this funding request.

Conceptualization - Representatives of PLHIV (specifically ZNNP+ - Zimbabwe National Network of PLHIV and ZHAAU – Zimbabwe HIV and AIDS Activists Union) are represented on the CCM, as well as on the core writing team for the concept note. Representatives of women's organizations (specifically Women AIDS Support Network, UN Women), and key populations(specifically Sex worker technical working group and Gays and Lesbians of Zimbabwe (GALZ)) participated in the Program Gap Analysis workshop, and in consultative processes leading up to the development of the concept note. These groups had been actively involved in national dialogue on building an Investment Case for Zimbabwe through UNAIDS and NAC, prior to the invitation from GFTAM to develop a concept. Focal people from within these networks will also participate in the stakeholder review of the concept note before finalization and submission. These representatives ensure that the concept is technically sound and in line with the interests of their constituency (i.e. concerns about pill burden, introduction of Option B+ and phasing out of toxic regimens).

Implementation- The engagement with women, communities and key affected populations is an ongoing process embedded within the national HIV response and emphasized in the ZNASP II. Representatives of women's organizations and people living with HIV are included as sub-recipients and sub-sub-recipients. Throughout the National AIDS Council's coordination structure at Provincial, District and Ward level, representatives of women's organizations, youth and people living with HIV are represented. They are also represented on existing Health Centre committees, child protection committees. At national level, there are also structures through which continued engagement takes place, including the PMTCT Partnership Forum, national TWG on Gender, Global Power Women network Africa-Zimbabwe Chapter and Young People's Network.

Evaluation- Representatives of women's organizations, people living with HIV/TB and other key affected populations will participate in routine reviews and evaluations.

5.6 Major External Risks

Please describe any major external risks (beyond the control of those managing the implementation of the program) that might negatively affect the implementation and performance of the proposed interventions.

The general elections are planned for 2013 in Zimbabwe. Previous elections in Zimbabwe in the last 10 years have resulted in social unrest and political violence which presented challenges in programme implementation particularly as it relates to implementation of activities by civil society at community level.

Whilst there is a risk of disruption of implementation of activities in the existing grants, there is no risk to the implementation of activities in this proposal unless the dates of the elections change to 2014. In the event that there is no absolute winner, there is a potential risk of protracted period of uncertainty in policy direction hence a risk to the implementation of all programmes including treatment disruptions, low HTC uptake, etc.

Currently there is economic stability due to the adoption of the multi-currency regime in early 2009 with the USD as its currency and therefore significant changes in commodity prices, inflation and exchange rates are not anticipated. However in the event that the outcome of the election results in significant departure from the current economic policies there is a potential risk of economic instability.

Attachments

Document Name	Section	Uploaded by	Size
COMPLETE SECTION 4.1_Final_Zimbabwe_HIV_CN.pdf	Funding Request to the Global Fund	Matthews Maruva	268 kb
FINAL_Attachment 4_ZIM_HIV_CN_Financial_Gap_Analysis.xls	Funding Gap and Counterpart Financing	Anna Miller	157 kb
Figure 1_Section 2.1a_Zimbabwe_HIV_CN.pdf	Country Context	Matthews Maruva	43 kb
FINAL_Zim_HIV_CN_List_of_Annexes_in_Concept_Note.pdf	CCM Eligibility Requirements	Matthews Maruva	153 kb
Attachment 5_List of Acronyms_Zim_HIV_CN.pdf	CCM Endorsement and List of Abbreviations	Anna Miller	162 kb
Annex 14 ZNASP II M & E plan 2011 to 2015 Final_ 2012doc.pdf	Country Context	Anna Miller	1436 kb
Attachment 1b_Zim_HIV_NFM_Concept Note Zinyengere Endorsement letter.pdf	CCM Eligibility Requirements	Anna Miller	369 kb
Annex 17_Zimbabwe_Technical_Assistance_Plan_NFM_Request.pdf	Funding Request to the Global Fund	Matthews Maruva	238 kb
Annex 6 Roles_Responsibilities_NFM_Concept_Zimbabwe.pdf	CCM Eligibility Requirements	Anna Miller	630 kb
Annex 10a Sex Workers and stakeholders Consultations.pdf	CCM Eligibility Requirements	Anna Miller	630 kb
Annex 8 NFM PMDs consultative meeting report 13 March 2013.pdf	CCM Eligibility Requirements	Anna Miller	332 kb
Attachment 1a_Zim_HIV_CCM_Endorsement.pdf	CCM Eligibility Requirements	Anna Miller	325 kb

Global Fund Indicators not uploading.xlsx	CCM Eligibility Requirements	Matthews Maruva	14 kb
Annex 9 NFM Stakeholder consultative meeting report 14 March 2013.pdf	CCM Eligibility Requirements	Anna Miller	1134 kb
Annex 1 ZNASP II Final.pdf	CCM Eligibility Requirements	Anna Miller	4562 kb
Annex 7b CCM Meeting minutes 27 March 2013.pdf	CCM Eligibility Requirements	Anna Miller	202 kb
Annex 13 Zimbabwe National Health Strategy 2009-2013.pdf	CCM Eligibility Requirements	Anna Miller	1071 kb
Annex 5 CCM HIV & AIDS committee minutes 5 March 2013.pdf	CCM Eligibility Requirements	Anna Miller	260 kb
Annex 2a PMTCT Partnership Forum PPF February 2013.pdf	CCM Eligibility Requirements	Anna Miller	286 kb
Annex 15 eMTCT Option B+ consultative meeting draft report.pdf	CCM Eligibility Requirements	Anna Miller	1842 kb
Annex 16_Zimbabwe_HIV_Programmatic_Gap_Analysis.xls	CCM Eligibility Requirements	Anna Miller	80 kb
Annex 18_Implementation_Manual_for_Global_Fund_Grant_Sub-Recipients.pdf	CCM Eligibility Requirements	Matthews Maruva	1211 kb
Annex 4 Zimbabwe CCM Guide Documents May 2009 Final.pdf	CCM Eligibility Requirements	Anna Miller	320 kb
Annex 2b Lab Services Partnership Forum meeting of the 5th of Sept 2012.pdf	CCM Eligibility Requirements	Anna Miller	403 kb
Annex 12 Zimbabwe CCM Procedures for National Call & PR Selection.pdf	CCM Eligibility Requirements	Anna Miller	318 kb
Annex 7a CCM Meeting minutes 6 March 2013.pdf	CCM Eligibility	Anna Miller	199 kb

	Requirements		
Annex 11 Zimbabwe NFM Application Circulation Lists for Consultations.pdf	CCM Eligibility Requirements	Anna Miller	252 kb
Annex 2d HTC PARTNERSHIP FORA 2 November 2012 minutes.pdf	CCM Eligibility Requirements	Anna Miller	248 kb
Annex 2c TB and AIDS Care Partnership Forum 4 October 2012 minutes.pdf	CCM Eligibility Requirements	Anna Miller	363 kb
COMPLETE SECTION 5.5_Final_Zimbabwe_HIV_CN.pdf	CCM Eligibility Requirements	Matthews Maruva	69kb
Annex 10b Gender TWG consultations for the NFM.pdf	CCM Eligibility Requirements	Anna Miller	208kb
Annex 3 Health Transition Fund MOHCW 2010 - 15 Final.pdf	CCM Eligibility Requirements	Anna Miller	623kb