

U.S. President's Emergency Plan for AIDS Relief

Fiscal Year 2015 Country Operational Plan

Strategic Direction Summary

Zambia

April 3, 2015

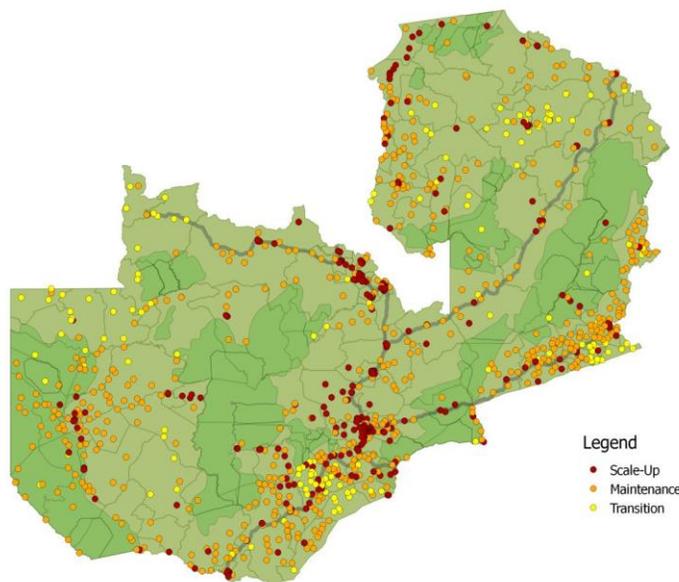


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Goal Statement

Over the last 11 years, the President's Emergency Plan for AIDS Relief (PEPFAR) program in Zambia has demonstrated that strategic allocation of resources aligned with the Zambian Government's National Health Strategic Plan and National AIDS Strategic Framework, paired with a USG team that unites in partnership, can achieve the impossible. When PEPFAR Zambia first launched in 2004, only 3,500 Zambians were receiving life-saving anti-retroviral therapy. Today, more than 600,000 Zambians are alive as a result of treatment. Over two million Zambians every year are counseled and tested for HIV. Over 700,000 orphans receive support and thousands of babies are born free from HIV every year because their mothers access prevention of mother to child transmission services. Programs focused on eliminating malaria, reducing maternal and newborn mortality in the hardest hit districts, and reducing deaths due to cervical cancer have benefitted from the sizeable PEPFAR investment in Zambia which has proven to be a strong platform for other health and economic sector gains.

The Zambian government's leadership of the national HIV/AIDS response, financial support from cooperating and multilateral partners, and an open dialogue with civil society and beneficiaries form the foundation of a functional and effective partnership that can be leveraged for future sustainability. Between 2001 and 2011, the rate of new HIV infections in Zambia dropped by 58 percent. The task at hand is clear: use program, financial, and epidemiological data to build on these successes and achieve epidemic control so that Zambia can be one of the first countries with a generalized epidemic to sustainably achieve an AIDS-free generation.

To achieve this goal, PEPFAR Zambia thoroughly analyzed a dozen data sources and proposes several programmatic pivots in the FY 2015 Country Operational Plan (COP). The USG team proposes to look beyond geopolitical provincial boundaries that shift periodically. We dug deeper to examine district and site-level data, unmet need, and unit costs. As a result, the PEPFAR Zambia team developed an algorithm, based on OGAC guidance and tailored to the country context, to determine which sites should receive additional support (scale-up), a maintenance package of support, and those sites where support for services should be transitioned to the GRZ, Global Fund, or other donors. This site-level analysis involved looking at data across 1,594 sites. As a result, we propose to saturate 353 sites, maintain services for 1,038 sites, and transition support from 203 sites. This combination will result in our ability to reach 80% of Zambians in need of critical HIV/AIDS services and is in line with the UNAIDS 90-90-90 global targets for arresting the AIDS epidemic by 2020.

Achieving sustainable epidemic control will require new and creative ways of working with our partners, including the Zambian government, to manage transitions, and make budgetary and programmatic shifts that harmonize coverage. The Sustainability Index and Dashboard has created a solid framework for engaging the Zambian government and partners on tangible aspects of a sustainably-led response.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Zambia is a lower, middle-income country (GNI: 3,810 per capita, PPP adjusted¹) with an estimated population of 15,473,905 in 2015 (population demographics: 49% male, 51% female; 58% rural, 42% urban). According to the 2013 Demographic and Health Survey (DHS) released on March 30, 2015, 13.3% of persons aged 15 – 49 years is infected with HIV (11.3% among adult males, 15.1% among adult females; 9.1% rural adults, 18.2% urban adults).² Detailed demographic and epidemiological data is presented in **Table 1.1.1** and prevalence data is displayed graphically in **Figure 1.1.1**.

In order to reach epidemic control, PEPFAR Zambia will focus on clinical treatment and core combination prevention interventions—specifically those reaching priority locations with elevated HIV burden, treatment gaps, and populations with the greatest unmet need. Accordingly, the PEPFAR ART program will increase the number of new patients enrolled in ART from 91,210 (2014 target) to 118,432 in 2015.

PEPFAR Zambia acknowledges, however, that a great deal of work is required to achieve epidemic control. At present, there is a need for more empirical evidence to better define the epidemic in Zambia. Some examples of data challenges include: 1) no data on viral suppression; 2) lack of pediatric HIV prevalence; 3) delay in availability of incidence data from the 2013 national level estimates of HIV/AIDS;³ 4) variations in data from multiple data sources (e.g., PEPFAR and DHIS); and 5) limited data on key populations (KPs) (e.g., female sex workers (FSW) and men who have sex with men (MSM)).⁴ These gaps in data quality and availability create challenges in identifying specific areas/hotspots and priority populations to reach epidemic control.

¹ World Bank, 2013 data.

² This estimation is derived from EIA testing; field-based rapid testing preliminarily reported in August 2014 yielded a national HIV prevalence rate of 10.3%.

³ National level estimates of HIV/AIDS are only available *after* the Health Impact Assessment (HIA).

⁴ While some targeted mapping and size estimations can tentatively guide PEPFAR Zambia in the size and location of high-risk populations, accurate HIV prevalence estimates among KPs will not be available until 2016 at the earliest.

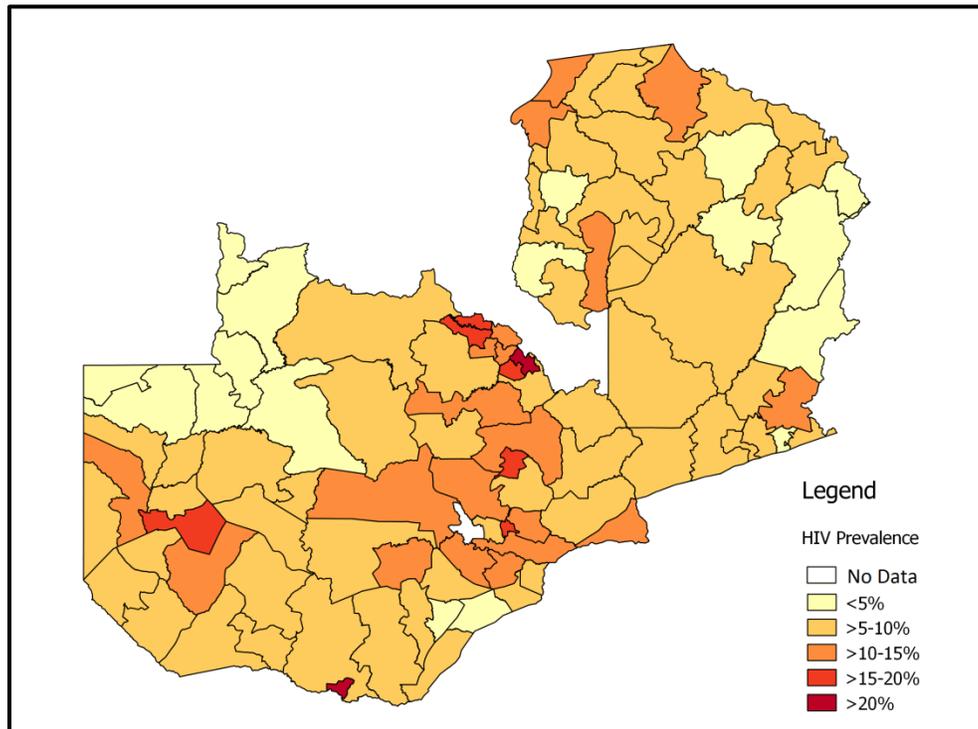
Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	15,023,315		3,453,164	23.0	3,484,984	23.2	4,138,028	27.5	3,947,139	26.3	Population and Demographic Projections 2013 (2014 estimates)
Prevalence (%)		13.3		1.96		1.98		15.1		11.3	DHS, 2013 [15-49], Total and 15+ HIV prevalence based on 2013 DHS EIA results. Under 15 based on Spectrum Projections point estimate 2014
AIDS Deaths (per year)	21,276		2,805		2,724		4,569		11,178		Spectrum,2015
PLHIV	1,145,649		67,834		69,005		527,604		481,207		Spectrum,2015
Incidence Rate (Yr.)		0.34		0.13		0.14		0.5		0.53	Spectrum,2015
New Infections (Yr.)	50,809										Spectrum,2015, 2014 estimate
Annual births	743,654	4.95									Calculation based on 4.95% of the total population
% >= 1 ANC visit	778,808	96	NA	NA			NA	NA			Calculation based on 96% of all expected pregnancies, DHS 2013
Pregnant women needing ARVs	97,351	12									Calculation based on 12% of all expected pregnancies. This percentage is based on the number of Positive women accessing ARV in APR 2014.
Orphans (maternal, paternal, double)	1,328,000		N/A		N/A		N/A		N/A		NACMIS, 2010

TB cases (Yr.)	45,793		1,623		1,726		16,678		25,766		MoH, 2013
TB/HIV Co-infection	25,676	63	NA	NA	NA	NA	NA	NA	NA	NA	MoH, 2013 [89% of all TB patients were tested and 63% were co-infected]
Males Circumcised	856,032	46			359,534	42			496,499	58	MoH 2014, 2007-2014. 2007-2011 (all ages); 2012-2014 (15-49)
Key Populations											
Total MSM*	5,076	NA									Size estimate in six towns (Population Council 2014)
MSM HIV Prevalence	NA	NA									No survey with biomarkers has been done
Total FSW	11,981	NA									Size estimate in six towns (Population Council 2014)
FSW HIV Prevalence	NA	NA									
Total PWID	3,435	NA									
PWID HIV Prevalence	NA	NA									
Military Prevalence ⁵	-	-	-	-	-	-	-	-	-	-	-

⁵ Due to confidentiality requirements, the Zambian military is unable to provide specific epidemiology data; however, the military is considered a priority population.

Figure 1.1.1 HIV Prevalence



The HIV epidemic in Zambia is generalized with heterosexual sex as the primary mode of transmission.⁶ Through Spectrum modeling data, HIV prevalence among children under 15 years is estimated to be 1.97%⁷. Spectrum data for morbidity and mortality also approximate the total number of deaths attributed to AIDS is 21,276, with 65% of AIDS deaths being male and 72% are adults. In Zambia, HIV disproportionately affects those living in urban areas and women. While only 42% of the population lives in urban areas, urban residents have an HIV prevalence of 18.2%, compared to 9.1% prevalence in rural areas. Equally, adult women have increased prevalence when compared to adult men in both urban (21% vs. 15%) and rural (9.9% vs. 8.1%) areas.

The Copperbelt province has the highest prevalence (18.2%), followed by Lusaka (16.3%), Western (15.4%) and Southern provinces (12.8%). Muchinga and North Western provinces have the lowest prevalence, estimated at 6.4% and 7.2% respectively. Because Lusaka, Copperbelt and Southern provinces have dense population centers, disease burden is highest in these provinces (230,614; 238,481; and 136,901 estimated cases, respectively). Data reflects most of the HIV positive individuals are residing in high-density areas (refer to map in **Figure 1.3.2**). Detailed data regarding the cascade of HIV diagnosis, care and treatment is presented in **Table 1.1.2**.

⁶ UNAIDS data estimated 90% of adult infections are attributable to heterosexual transmission. Limited data are currently available on transmission through MSM and IDUs.

⁷ Approximately 45% of individuals living with HIV are 15+ females while adult males account for approximately 42%.

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (Oct. 1, 2013 – Sept. 31, 2014)

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (Oct. 1, 2013 – Sept. 31, 2014)										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	15,023,315	13.3	1,145,645	400,394	613,922	74,394	NA	2,182,717	237,169	91,212
Population less than 15 years	6,938,148	1.97	136,839	27,154	29,083	5,436	NA	172,963	NA	6111
Pregnant Women	811,259	12	97,351	NA	NA	NA	NA	Target is 95% but PEPFAR is estimated to contribute 80% to national targets	NA	Target is 95% but PEPFAR is estimated to contribute 80% to national targets
MSM	5,076									
FSW	11,981									
PWID	3,435									
Military⁸	-	-	-	-	-	-	-	-	-	-

⁸ Due to confidentiality, the Zambian military is unable to provide specific epidemiology data; however, the military is considered a priority population.

1.2 Investment Profile

Through PEPFAR, the USG continues to be the largest contributor to Zambia's HIV response totaling approximately 60% of funding in 2014 with additional contributions from the Global Fund (27%)⁹ and GRZ (10%) (see **Table 1.2.1**).¹⁰ As in many countries, Zambia has seen a decline in overall donor activity in recent years, requiring GRZ to take on additional fiscal responsibility. The GRZ increased budget allocations for key commodities (such as ARVs) from \$6M in 2010 to \$59.6M in 2014 (see **Table 1.2.2**). Quantifying GRZ funding for infrastructure, salaries, and other overhead costs remains a challenge.

Table 1.2.1 Investment Profile by Program Area¹¹

Program Area	Total Expenditure	% PEPFAR	% GF	% GRZ	% Other
Clinical care, treatment and support	\$243,204,795	56%	27%	17%	0%
Community-based care	\$31,967,732	97%	3%	0%	0%
PMTCT	\$22,175,230	89%	10%	0%	1%
HTC	\$17,242,498	70%	21%	1%	9%
VMMC	\$20,421,299	87%	10%	0%	3%
Priority population prevention	\$272,517	0%	100%	0%	0%
Key population prevention	\$12,155,210	96%	4%	0%	0%
OVC	\$34,676,494	63%	35%	0%	2%
Laboratory	\$11,956,095	68%	21%	8%	3%
SI, Surveys and Surveillance	\$25,506,559	53%	32%	0%	15%
HSS	\$62,588,597	32%	52%	8%	9%
Total	\$482,167,026	60%	27%	10%	3%

Table 1.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRP	% Other
ARVs	\$166,382,795	27%	37%	36%	0%
Rapid test kits	\$5,248,800	52%	48%	0%	0%
Other drugs	\$3,810,674	56%	0%	44%	0%
Lab reagents	\$39,891,222	63%	30%	7%	0%
Condoms	\$4,888,693	31%	0%	23%	47%
VMMC kits	\$1,925,000	100%	0%	0%	0%
Other commodities	\$19,366,590	31%	0%	47%	22%
Total	\$241,513,774	35%	31%	31%	3%

The Revised National AIDS Strategic Framework (R-NASF) (2014-2016) estimates the overall funding gap for 2014-2016 at \$263,845,320 (see **Table 1.2.i**).

⁹ Contributions from the Global Fund are anticipated to decline in 2016 and 2017, since the majority of the New Funding Model resources will be spent in the first two years.

¹⁰ Other contributors include the Department for International Development of the United Kingdom (DFID), World Bank, Sweden, the European Union, and Irish Aid – all contributing less than 1% each to the response.

¹¹ Revised National AIDS Strategic Framework (R-NASF) 2014-2016 - Counterpart summaries

Table 1.2.i R-NASF Funding Projections: Macro Costing of the R NASF				
	2014	2015	2016	Total
Total Resource Needs	499,145,748	588,040,877	563,739,863	1,650,926,488
Total Funding Available	482,167,026	467,371,155	437,542,987	1,387,081,168
Annual Gap/Surplus	-16,978,722	-120,669,722	-126,196,876	-263,845,320

To reduce the aforementioned funding gap, PEPFAR Zambia plans to: a) increase dialogue with GRZ on viable, sustainable health financing mechanisms; b) identify local funding opportunities from the private sector through public/private partnerships (PPP) and within communities; c) mainstream HIV within other key social and development sectors (e.g., health, social protection, education, infrastructure, and transport);¹² d) continue to analyze the funding gap within specific line items in order to make sure that limited resources are directed towards the activities with the highest impact (see **Tables 1.2.1** and **1.2.2**); and e) continue to coordinate with other USG-funded health programs.

Complementary non-PEPFAR funded programs must also be leveraged for epidemic control. In high-burden areas, USAID-supported TB, family planning, maternal and child health, and nutrition programs complement health systems and improve quality of services rendered by health care providers supporting a continuum of care from the community to the facility. Integrated programs, and even complementary activities, will enhance the quality of life of patients and improve the clinical capacity of health care providers, ultimately improving multiple health outcomes.

¹² The GRZ has demonstrated commitment to reducing the incidence of HIV through sustained resource allocation for ARVs, OI drugs and HIV diagnostic commodities.

1.3 National Sustainability Profile

PEPFAR Zambia completed the Sustainability Index and Dashboard (SID) in collaboration with key GRZ representatives, multilateral and bilateral donors, international non-governmental organizations, and local civil society organizations. The analysis revealed weaknesses in some priority elements, ranked on the basis of element score and criticality to sustained epidemic control (Table 1.3.1).

Table 1.3.1 Sustainability Index and Dashboard Results		
Element/Score	Description	Notes on Sustainability
DRM: Resource Commitment (Score 7/20)		
	<p>Financial commitment is a critical component of country ownership and essential for sustainability of the national response. The SID indicates that domestic HIV expenditures finance 10 to 24 % of the national response. Additionally, there is paucity of information on the proportion of key population-specific interventions financed by domestic resources. Data used to determine proportions contributed by the GRZ were derived from the National AIDS Spending Assessment (NASA) of 2012 and the Revised National AIDS Strategic Framework (R-NASF) 2014-2016. In responding to this question in the SID, it was not possible to quantify other contributions made by the GRZ towards the response, including human resources, infrastructure, equipment and utilities. There are, however, clear indications that the GRZ's spending on the HIV response has increased significantly in recent years, including the almost ten-fold increase in the GRZ's budget for ARVs between 2010 and 2014.</p>	<p>A number of key stakeholders have invested in activities aimed at promoting sustainable health financing. These include the GRZ, World Bank, DFID, Japanese International Cooperation Agency (JICA), Swedish International Development Agency (SIDA), Irish Aid, EU, and USG/PEPFAR. Multilateral and bilateral donors have advocated for increased domestic resources through diplomatic channels and other forums such as the Health Sector Cooperating Partners' Group (CPG).</p> <p>PEPFAR is cognizant of the fact that GRZ has a limited resource envelope with other competing priorities, and that increasing the sustainability score for this element may not be possible in the near term.</p>
Access and Demand (Score 7.8/20)		
	<p>This element combines key components of the national response, including access to ART, access to PMTCT Option B+ services, services to KPs, and the right to access services/nondiscrimination. The SID indicates that less than 20% of healthcare facilities provide ART services and fewer than 40% provide PMTCT care in high-prevalence areas. Additionally, there is no information available about services accessed by KPs. Facilities with traditional laboratory infrastructure are too few in number for the population size and it is estimated that only 25% of health facilities offer laboratory services (Source: 2012 MOH List of Health facilities in Zambia).</p>	<p>Key stakeholders who have invested in activities to increase access to and demand for HIV prevention, care and treatment services include GRZ, PEPFAR, Global Fund, United Nations Development Program (UNDP), UNAIDS and UNICEF.</p> <p>Given the current level of investment in service delivery by key stakeholders, it is possible to improve the sustainability score of this element in the next two to three years.</p>
Epidemiological and Health Data (Score 9.8/20)		
	The timely availability of accurate and reliable	Key stakeholders that have invested in

<p>data to inform policy, financing and programming decisions is essential for achieving epidemic control. The SID indicates that the GRZ contributed less than 20% towards financing of the latest HIV epidemiological data survey. GRZ does not routinely engage stakeholders in data analysis in a timely fashion and does not systematically collect viral load data. Size estimate studies of KPs are limited.</p>	<p>activities to ensure the availability of high quality data include GRZ, PEPFAR, Global Fund, and European Union (EU). The EU has invested in strengthening the national Health Management Information System.</p> <p>Considering the level of investment in this element by key stakeholders, it is possible to increase the sustainability score in the next two to three years.</p>
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Human Resources for Health (Score 14.8/20)

<p>An adequate number of motivated health workers, with the appropriate skills mix, is critical to achieving epidemic control and a sustainable national HIV response. Zambia is facing a critical shortage of health workers with approximately 40% of positions in the health sector establishment remaining vacant. Laboratory staffing is compromised by deficiencies in pre-service training, which has limited practicum. When laboratory students are deployed for internship they are sometimes inappropriately assigned to perform routine testing to compensate for chronic shortage of assigned personnel and heavy workload. The SID demonstrates that there are insufficient numbers of health workers trained in HIV to meet the service delivery needs. Given the importance of this element to achieving sustainability of the national response, continued investment is warranted despite the relatively high sustainability score of 14.8.</p>	<p>Several key stakeholders have invested in HRH, including the GRZ, World Bank, DFID, EU, and Clinton Health Access Initiative (CHAI). DFID supported the training, deployment and salaries of the initial cohort of 300 community health assistants, while CHAI provides technical support to the Ministry of Health and has conducted a number HRH studies and assessments.</p>
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Commodity Security and Supply Chain (Score 15)

<p>The availability of life-saving antiretroviral medications and other HIV commodities is essential for epidemic control and a sustainable national response. While the GRZ's expenditure on ARVs has steadily increased over the past four years, the host government's contribution towards the procurement of rapid test kits is less than 30%. The country also faces challenges with storage space, and this is likely to be exacerbated by scale up of prevention, care and treatment services. GRZ provides less than 10% of the cost of lab commodities. PEPFAR supports the procurement of HIV-related commodities, but there is still a persistent \$10M shortfall in the overall estimated commodity costs for laboratory services. PEPFAR/Zambia feels that the importance to this element to achieving sustainability warrants continued investment despite the relatively high sustainability score.</p>	<p>Stakeholders that contribute towards commodity security and supply chain include GRZ, PEPFAR, Global Fund, World Bank, DFID, SIDA and EU. The Global fund procures 31% of key commodities for the national response (Table.1.2.2). PEPFAR and the World Bank are collaborating as they pilot a logistics management information system and an electronic inventory control system. SIDA provides technical assistance to Medical Stores Limited and provided funds to roll out the initial two regional commodity hubs. With the significant investments that have been made in this area, it is likely that the sustainability score will increase in the medium- to long- term.</p>
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1.4 Alignment of PEPFAR investments geographically to disease burden

Figure 1.4.1 shows PEPFAR expenditures per PLHIV and depicts how resources have been targeted to areas with the highest percentages of PLHIV (Copperbelt, 18.2%; Lusaka, 16.3%; Western, 15.4%; Southern, 12.8%; and Central Province, 12.5%). The highest cost per PLHIV occurred in Eastern, \$139.28, Western, \$112.02, Southern, \$107.54, and North Western Province \$102.35. Copperbelt, Central, and Luapula provinces had the lowest cost per PLHIV with \$48.19, \$78.89 and \$82.00, respectively. The figure also suggests a more efficient use of resources in the Copperbelt and Lusaka provinces, and as PEPFAR continues to prioritize, greater cost efficiencies in other provinces must be realized. This will require a better understanding of the cost drivers in every priority area and how they can be minimized.

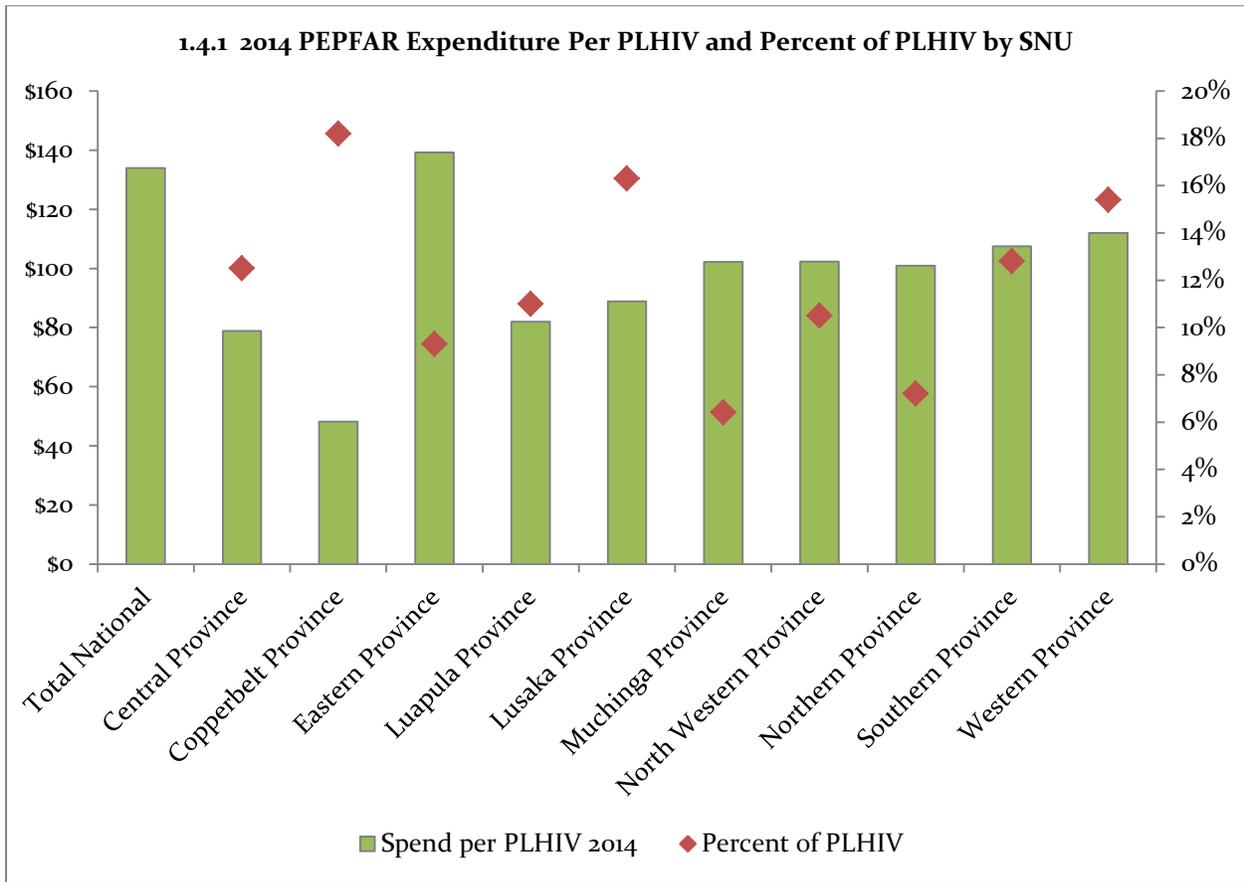
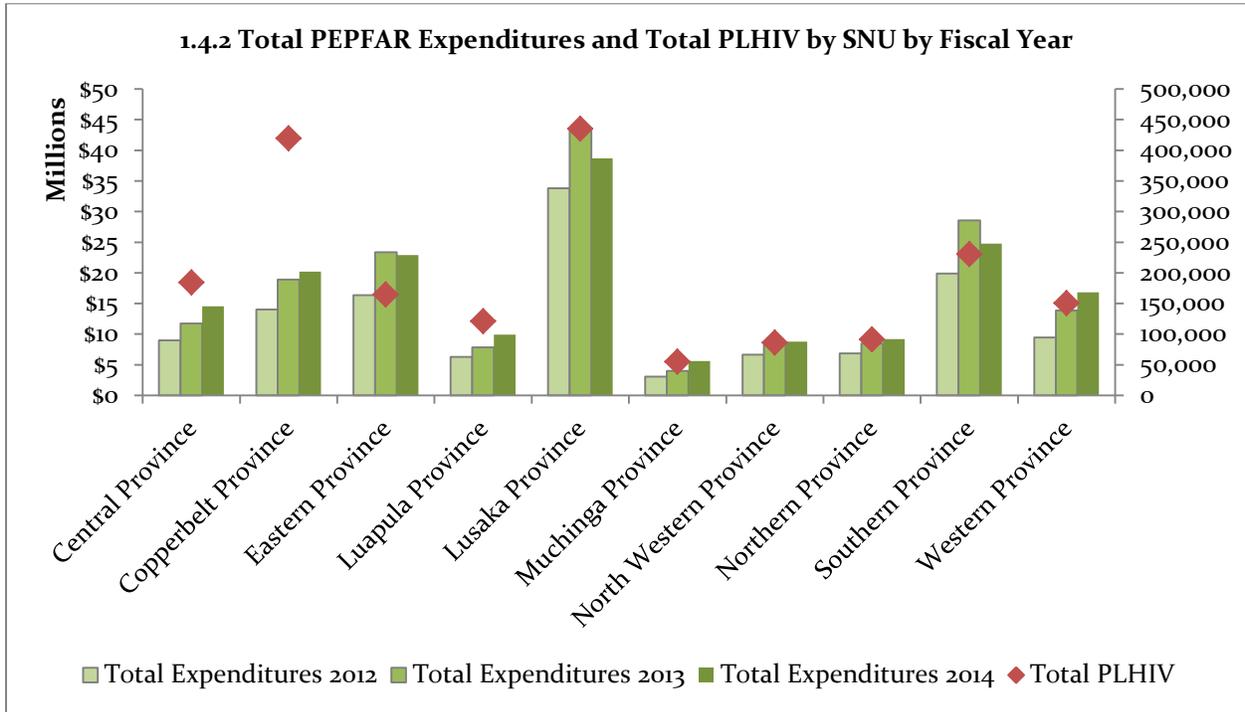


Figure 1.4.2 shows that in recent years, PEPFAR resources have been aligned with disease burden in Lusaka, Southern, Eastern and Copperbelt provinces.



Using 2014 expenditure analysis (EA) figures, R-NASF costing data, and 2012 HMIS data, PEPFAR and Global Fund expenditures generally align with the disease burden, when considered together (Figure 1.4.3).

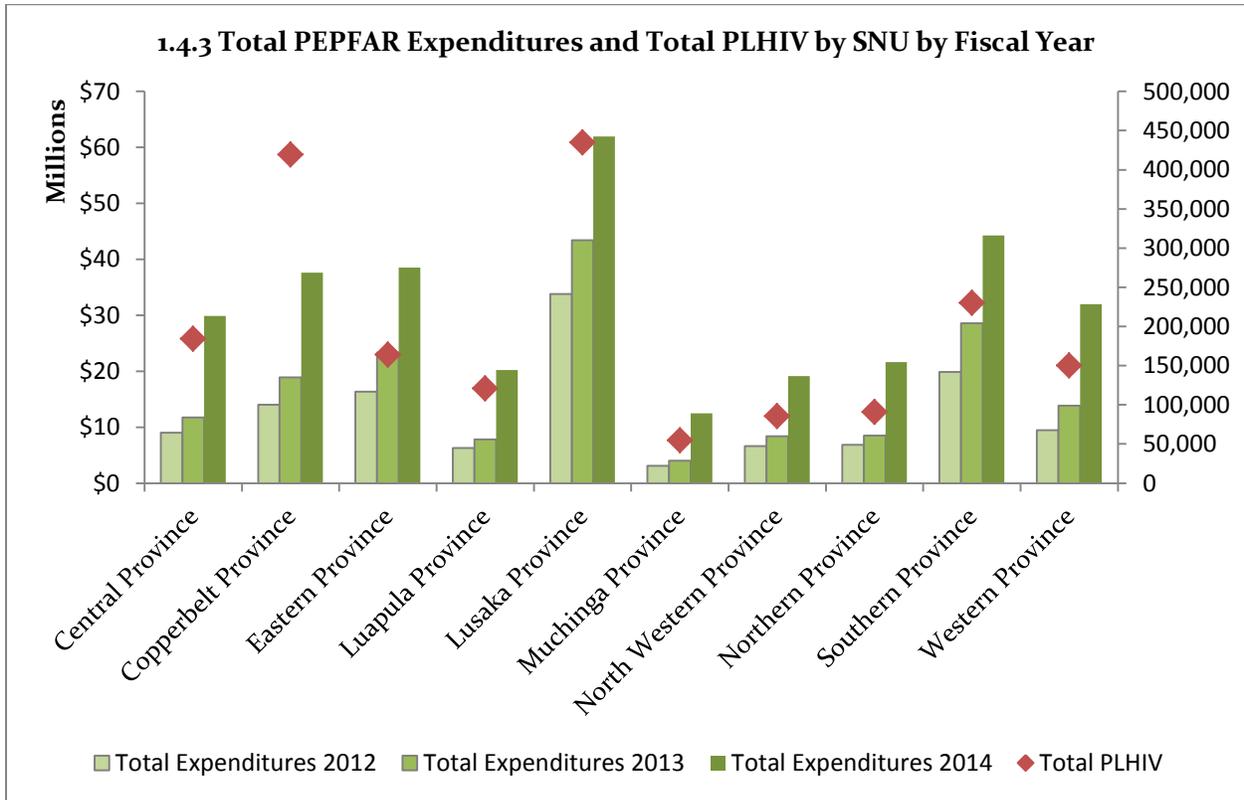


Figure 1.4.4 Total PEPFAR expenditures, PLHIV, and expenditure per PLHIV by province.

Figure 1.4.4i: Total PEPFAR Expenditures by Province

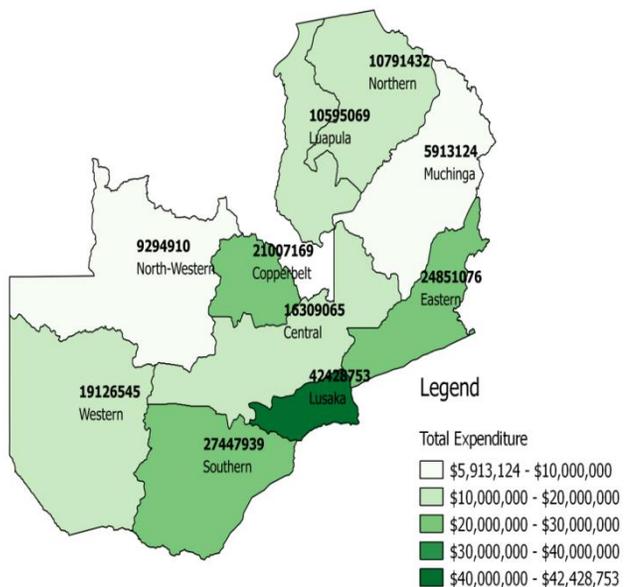


Figure 1.4.4ii: Number of PLHIV by Province

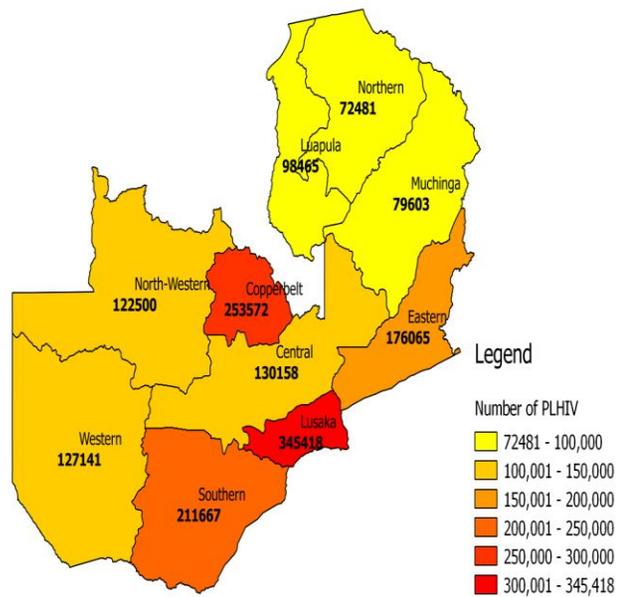
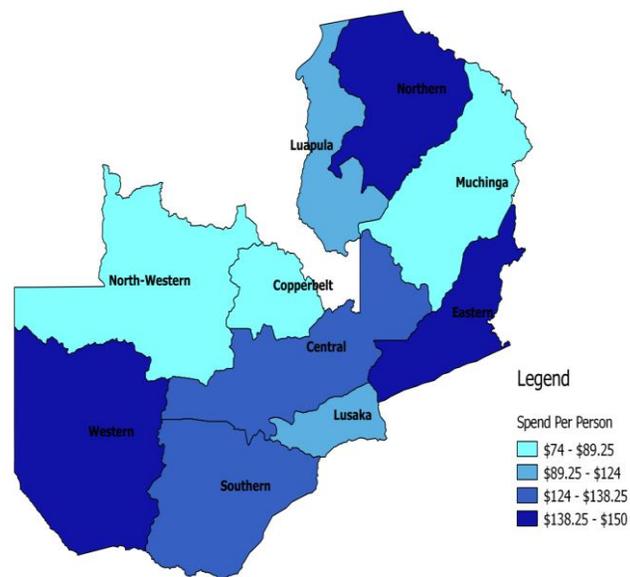


Figure 1.4.4iii: Unit Expenditure by Province



1.5 Stakeholder Engagement

After returning from an August 2014 PEPFAR meeting in Washington, PEPFAR Zambia met with the Ministry of Health (MOH), Ministry of Community Development Mother and Child Health (MCDMCH), and the National AIDS Council (NAC) to discuss the geographic priorities and core, near-core, and non-core activities. This created the foundation for continued dialogue throughout COP 2015 planning and development among all stakeholders. PEPFAR engaged with senior-level GRZ officials and GRZ technical experts to discuss funding, targets and priorities within their respective areas and worked with GRZ to develop and validate the SID. Finally, PEPFAR interagency leadership initiated discussions with the Ministry of Finance (MOF) focused on sustainable health financing. Dialogues with GRZ will continue throughout the implementation of COP 2015.

PEPFAR Zambia was actively engaged in the development of Zambia's New Funding Model application to the Global Fund—establishing a foundation for continued discussion through the COP development process. Team members participated in planning meetings and referenced the concept note as part of the overall review of Zambia's HIV funding landscape. Discussions with multilateral and bilateral donors were conducted through Zambia's HIV and Health Cooperating Partners' (HCP) platforms. Engagement with the Global Fund will continue through the Country Coordinating Mechanism (the USG through the PEPFAR Country Coordinator is a voting member), meetings with the Fund Portfolio Manager and through the position of the PEPFAR Global Fund Liaison. Discussions with HCPs will continue through regular cooperating partner meetings and one-on-one meetings as needed.

PEPFAR Zambia conducted ten separate civil society consultations, having unique discussions with PLHIV, youth, people with disabilities, local organizations, faith based organizations, and KPs that included a safe space meeting. Civil society was also included in the development of Zambia's SID. Further details on continued engagement are outlined in PEPFAR Zambia's Civil Society Engagement Strategy (attached with this submission).

In 2014, PEPFAR Zambia introduced the prospect of developing a Country Health Partnership to the GRZ to continue to strengthen joint decision-making through every COP development cycle. This includes increasing the frequency of meetings with senior-level GRZ officials, strengthening the relationship with the MOF and increasing engagement with NAC. Dialogue within all of these levels includes discussions on program results and financial data, including joint review of data used during the August 2014 meeting and the development of Zambia's SID. Zambia will develop a new National AIDS Strategic Framework in CY 2016, which will provide a vehicle for promoting mutually accountable measures of progress through clear indicators and benchmarks.

2.0 Core, Near-core and Non-Core Activities

PEPFAR Zambia considered the activities required to achieve sustained epidemic control, the current country investment portfolio, and the bottlenecks preventing program scale-up (as illustrated by the SID and SIMS data) in defining core, near-core, and non-core activities for program implementation in 2016. The following activities are considered core: a) prevention activities (e.g., scale-up of PMTCT Option B+, community linkages, and strengthening positive health, dignity, and prevention (PHDP)); b) implementation of intensified TB case finding among PLHIV; c) counseling and testing (e.g., quality HIV testing and counseling services and support for increased early diagnosis); d) care and support (e.g., strengthening family planning/HIV integration for PLHIV in care); e) treatment (e.g., targeted program evaluations to inform service delivery improvements and TB/HIV collaborative activities); f) laboratory capacity (e.g. quality systems, viral load scale-up); g) OVC; and h) prevention with priority populations. Some of the near-core activities include MOH policy support, retention of health care workers (HCWs) in high volume/yield sites, and ICT support. PMTCT Option A, water and sanitation, and palliative and end of life care have been categorized as non-core activities.

See Appendix A for full list of core, near-core, and non-core activities and transition plans.

3.0 Geographic and Population Prioritization

Epidemiologic and service provision data indicate that a substantial number of PLHIV are in *all* provinces and *all* districts in Zambia.

While nearly half of Zambia's estimated 1,145,649 PLHIV reside in two provinces, over 40% of the total PLHIV reside in four of the remaining eight provinces. When analyzed at the district level, 80% of PLHIV reside in 34 of the 74 districts for which population data are available.¹³ Provinces with high population density, including Lusaka and Copperbelt, comprise the majority of PLHIV since the majority of HIV-positive individuals on ART and/or in care live in urban centers. However, prevalence rates vary considerably within provinces and hotspots exist throughout the country, even in areas of lower population density. For this reason, rather than utilizing only provincial data, PEPFAR Zambia prioritized COP2015 programming based on district- and facility-level epidemiologic, program, performance, and financial/expenditure data.

Significant treatment gains will be made by reallocating resources to the areas of greatest need. PEPFAR Zambia will reallocate by: 1) scaling-up services (e.g., supporting active case finding, enhancing electronic and community linkages, extending clinic hours, extending mobile ART provision, and establishing community-based ART service provision) at sites in areas with the greatest estimated unmet need and at sites with the capacity to provide treatment to additional patients; 2) allowing existing GRZ structures to support low-volume sites and those with low estimated unmet need with only above-site/national-level support from PEPFAR Zambia ("transition" sites); 3) refocusing support through appropriate categorization and mix of services offered in maintenance sites, and 4) discontinuing PEPFAR support in individual clinics with low volume and unmet need.

To determine sites requiring scale-up, maintenance or transition of services, PEPFAR Zambia created district prevalence estimates and unmet ART need per district using ZDHS 2013 rapid test data. To determine district prevalence estimates, PEPFAR Zambia used provincial prevalence estimates, national data on the ratio of urban to rural prevalence, 2010 Census and 2014 Census projections, and proportion of each district population designated urban. Then, to determine unmet need, 2014 APR and DHIS data, specifically PEPFAR current on ART per district and national total on treatment per district, were taken into account. To determine PLHIV, the >15 population per district was multiplied by the district prevalence. To determine the number of PLHIV eligible for treatment, the number of PLHIV was multiplied by 73%, which is the proportion of PLHIV estimated to be eligible for treatment under national treatment guidelines. Finally, to determine unmet need, the national total on treatment in that district (DHIS) was subtracted by the PLHIV eligible for treatment.

Districts were then categorized into scale-up, maintenance and transition districts using unmet need alongside prevalence, existing knowledge of both gaps/quality issues in DHIS data and

¹³ Twenty-nine new districts (of a total 103 at present) have been created since the 2010 census and thus population data are not available for those districts.

special circumstances in specific areas (e.g., borders, key populations, and travel into population centers for better treatment). Next, APR 2014 data were used to ascertain whether sites met minimum-volume criteria. Specifically, if sites met a minimum threshold: HCT ≥ 4 positives or PMTCT ≥ 4 positive pregnant women, or any patient on ART, they were considered eligible for site-level support (maintenance or scale-up).

Using the 80/20 rule, PEPFAR Zambia classified sites as low- or high-volume based on their contribution to total volume of ART or PMTCT services. Specifically, 80% of the “Current on ART” volume came from sites serving >1415 patients (APR 2014); therefore, those sites were considered high-volume and sites serving fewer patients were considered low-volume. Eighty percent of the PMTCT volume came from sites serving >39 HIV positive pregnant women; therefore, those sites were considered high-volume, and sites serving fewer patients were designated low-volume.

Sites were categorized as transition, maintenance or scale-up using the following criteria: Sites in **transition or maintenance** districts that do not meet minimum volume criteria and are considered low-volume by the 80/20 rule are designated as transition sites. Sites in **transition or maintenance** districts that meet minimum-volume criteria (HCT, PMTCT, or ART), but are considered low volume according to the 80/20 rule are considered maintenance sites. Further, sites in **transition or maintenance** districts with high volume according to the 80/20 rule are considered hotspots, and thus classified as scale-up sites. Sites in **scale-up** districts that meet the minimum volume criteria for HCT, PMTCT or ART, but have low volume according to the 80/20 rule are considered maintenance sites. Finally, sites in **scale-up** districts with high-volume according to the 80/20 rule are classified as **scale-up sites** (see Figure 3.1).

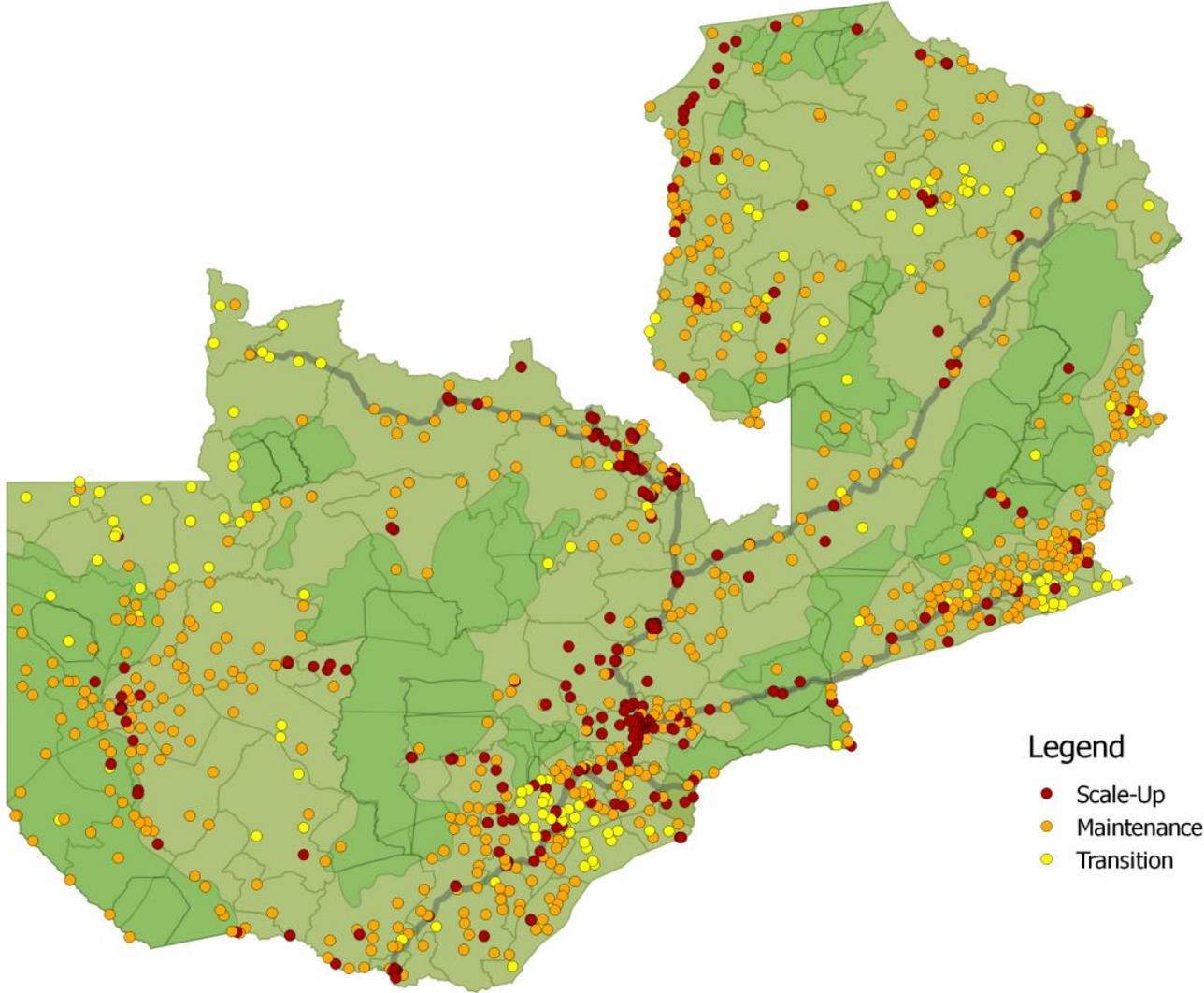
Finally, PEPFAR Zambia manually reviewed the allocations to recommend changes based on any additional knowledge about specific sites. This exercise produced 17 site-specific revisions. Specifically, 3 sites were changed from “maintenance” to “scale-up” (because these were new and/or newly supported facilities) and 14 sites were changed from “transition” to “maintenance” because they were high-volume relative to the underlying population.

In total, PEPFAR Zambia selected 203 of sites across the country for transition, 1,038 for maintenance and 353 for scale-up.

Table 3.1: Zambia Site Yield Analysis Summary

Province	Scale-Up	Maintenance	Transition	Total	Prevalence	Eligible Positives
Lusaka	72	97	8	177	16.30%	31,311
Copperbelt	66	79	6	151	18.20%	24,213
Southern	60	177	57	294	12.80%	14,335
Central	44	82	2	128	12.50%	12,261
Eastern	27	202	15	244	9.30%	10,255
Western	28	186	13	227	15.40%	7,731
Luapula	24	80	14	118	11.00%	6,495
Northern	14	56	19	89	10.50%	4,197
NorthWestern	8	67	39	114	7.20%	3,365
Muchinga	10	12	30	52	6.40%	2,778
	353	1,038	203	1,594		

Figure 3.1 Geographic Focusing of Sites: Scale-up, Maintenance, and Transition



4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

Given the geographic and population prioritizations made for COP 15, PEPFAR Zambia derived targets for all indicators by reviewing trend data, APR results, treatment cascade expectations, and site yield data analysis. Additionally, targeting requirements for the ACT Initiative and DREAMS Partnership were incorporated. Cost information from the PBAC and EA tool was used to guide the resource allocation to support these targets, while also adjusting for program efficiencies gained over several years of program implementation.

Targets for current on ART and ART enrollment (*newly initiated*) were determined based on the coverage required to attain saturation for both the adult and pediatric populations— as well as review of possible entry streams for ART from the pre-ART population, persons infected with TB, HIV infected pregnant women, and other priority and KPs. PEPFAR Zambia utilized the UNAIDS 90-90-90 framework in conjunction with epidemiologic data at the district level to set targets that represent coverage of 80% PLHIV on ART, thereby increasing targets from the expected FY15 result of 720,000 to 820,000. This target includes 95% coverage of all identified HIV infected pregnant and breastfeeding women, 85% early infant diagnosis (EID) testing coverage, and 80% final outcome documentation among HIV-exposed infants. All identified HIV infected infants will be initiated on ART. Additionally, treatment plus-up funding (\$19M) is expected to support the country's attainment of the ambitious treatment targets. Targets for clinical care were set based on the assumption that 80% of HTC clients testing positive would be referred to care.

To reach epidemic control, Zambia will focus on core combination prevention in priority districts with greatest treatment gaps and populations with the greatest need (i.e. pregnant women, youth, persons with TB/HIV co-infection, and KPs). The target coverage levels for general prevention are about 10% less than the previous year's target, due to the more stringent requirements for the indicator. The target for FSW represents a 10% increase from last year, while the target for MSM will increase due to a new KP project targeting MSM. Coverage levels for KPs are currently unknown, due to lack of data on population size. HTC targets represent a goal to reach saturation by covering 80% of the population in PEPFAR focus sites. Provider-initiated testing and counseling (PITC) for all patients in TB, STI, and ANC clinics, outreach mobile testing in focus provinces and hotspots, community mobilization and promotion of HTC will scale up HTC in priority settings. In all settings, strengthening linkages to treatment, care and support, and quality assurance for HIV testing will improve the HTC package. Gender-based violence (GBV) interventions will be prioritized in areas with high GBV prevalence. The overall targets for PMTCT represent a slight increase from previous years based on sustained universal HIV testing coverage and service utilization over the last 3 years.

There are several challenges that must be overcome in order to meet these impressive targets. HTC and treatment targets rely on commodity assurance, adequate facilities, and the presence of a skilled, stable workforce. To reduce facility congestion, implementing partners will provide new static and mobile treatment sites in areas with high unmet need and engage in strategic use of facilities by transitioning stable patients to community sites for ongoing care so that health facilities are available for initiating and stabilizing new patients. Attrition or instability among health care workers may affect service delivery, thus these targets assume that national capacity will be built and maintained at levels that will result in program implementation that is both sound and of high quality.

Other major challenges relate to the gathering and usage of data. Incidence and epidemiological data at the provincial, district, or ward level do not currently exist resulting in estimations being made at the national level. Similarly, there are no reliable estimates of HIV prevalence in pediatrics. Poor patient tracking systems have caused problems with linkage to care, and the care teams plan to implement better patient tracking in facilities to ensure follow-up and linkage to ART. With regard to KPs, there is little current information on key population size and the political environment is not very conducive to collecting KP data.¹⁴

To address some of the data challenges, PEPFAR Zambia is doing the following: 1) working with implementing mechanisms to collect epidemiological data at a more granular level; 2) training health workers on data verification (e.g., monitoring and evaluation, data analysis, and data use); 3) working with NAC to get KP data released to inform health programming; 4) funding a special evaluation of combination prevention involving bio-behavioral, service utilization, and post-service scale-up assessments; 5) seconding additional M&E staff to GRZ; and 6) conducting an HIV impact assessment.¹⁵

¹⁴ While there have been some size estimation and mapping data collected in several cities/towns for FSW (6 sites), intravenous drug user (IDU) (3 sites) and MSM (5 sites), there is no reliable estimate of HIV prevalence among these groups.

¹⁵ This assessment is tentatively proposed for late 2015 and will include children. As a result of this survey, PEPFAR Zambia is hoping to provide the first HIV prevalence estimates for pediatrics.

Table 4.1.1 ART Targets in Priority Sub-national Units for Epidemic Control					
Zambia District	Total PLHIV	Expected current on ART (2015)	Additional patients required for 80% ART coverage	Target current on ART (in FY16) TX_CURR	Newly initiated in FY 16 TX_NEW
Chibombo	25,763	7,144	15,126	17,447	10,303
Chiengi	-	1,865	(1,604)	729	(1,136)
Chingola	25,341	16,590	4,234	19,284	2,694
Chongwe	12,455	6,145	4,833	8,958	2,813
Kabwe	24,226	17,154	(2,063)	19,834	2,680
Kafue	22,665	10,207	6,567	13,686	3,479
Kalabo	11,999	3,441	3,818	5,720	2,279
Kaoma	9,757	4,108	3,683	5,139	1,031
Kapiri-Mposhi	23,112	13,327	5,580	16,204	2,877
Kawambwa	10,883	2,367	7,422	7,818	5,451
Kitwe	67,907	32,977	17,021	49,556	16,579
Livingstone	21,129	22,664	2,562	21,145	(1,519)
Luanshya	17,864	12,187	2,654	13,817	1,630
Lukulu	5,738	2,295	2,975	4,259	1,964
Lundazi	14,926	9,960	6,886	14,373	4,413
Lusaka	226,008	148,612	34,923	161,344	12,732
Mansa	19,193	7,811	8,750	14,092	6,281
Mazabuka	18,172	16,731	3,470	16,511	(220)
Mbala	10,474	4,285	4,692	7,161	2,876
Mongu	24,357	15,774	8,924	20,530	4,756
Mporokoso	7,512	1,887	4,617	5,096	3,209
Mpulungu	7,011	3,790	2,529	5,261	1,471
Mufulira	20,555	10,582	3,666	12,997	2,415
Total	627,047	371,903	151,265	460,960	89,057

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Priority Districts (FY 16)			
Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Clinical care patients not on ART	n/a	n/a	8,532
TB-HIV Patients not on ART	20,911	11,149	12,742
HIV-positive Pregnant Women	333,553	23,724	24,791
Other priority and key populations	872,404	84,890	49,576
Total	1,226,868	119,762	95,640

Table 4.1.3 VMMC Coverage and Targets by Age Bracket				
Target Populations	Population Size Estimate (priority SNUs)	Current Coverage (date)	VMMC_CIRC (in FY16)	Expected Coverage (in FY16)
Males 15-29	1,201,236	28.3%	125,812	54.4%
Total/Average	1,201,236		125,812	

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	Population Size Estimate (priority SNUs)	Coverage Goal (in FY16)	FY16 Target
Priority Population (All age groups)	2,317,432	80%	1,853,946
Total	2,317,432	80%	1,853,946

Table 4.1.5 Targets for OVC and Pediatric HIV Testing, Care and Treatment					
	Estimated # of Children PLHIV (<15)	Target # of active OVC (FY16 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target) OVC_ACC	Target # of children tested (FY16 Target)	Target # of children on ART
Chibombo	4,920	7,800	-		3,640
Chiengi	1,846	3,032	-		1,329
Chingola	3,099	13,465	-		2,250
Chongwe	3,140	6,179	-		2,211
Kabwe	2,625	7,573	-		1,957
Kafue	3,603	6,416	-		2,046
Kalabo	1,987	3,509	-		1,186
Kaoma	2,946	4,692	-		2,022
Kapiri-Mposhi	4,070	8,867	-		2,746
Kawambwa	2,185	3,899	-		1,631
Kitwe	8,112	26,617	-		5,628
Livingstone	1,803	4,897	-		1,500
Luanshya	2,150	8,137	-		1,586
Lukulu	1,448	2,274	-		1,159
Lundazi	5,215	7,652	-		3,948
Lusaka	26,292	39,149	-		16,113
Mansa	3,551	8,493	-		2,602
Mazabuka	3,329	12,982	-		2,488
Mbala	3,436	5,381	-		2,479
Mongu	2,620	8,410	-		2,329
Mporokoso	1,664	1,878	-		1,217
Mpulungu	1,676	2,852	-		1,221
Mufulira	2,341	8,642	-		1,436
TOTAL	94,059	202,794	-	64,723	94,059

Program Area Summaries 4.2-4.10

4.2 Priority Population Prevention

In FY 2016 the program will focus on reaching targeted groups in priority areas based on high HTC yield areas and the need for increased HTC uptake. Specific focus will be on high HIV prevalent groups including adolescent girls and young women (AGYW), female sex workers (FSW), MSM, and priority populations—namely transient populations, clients of sex workers, prisoners, military, and other uniformed service people. Through its implementing partners, PEPFAR Zambia will provide direct service delivery of comprehensive prevention packages or care referrals and linkages.¹⁶ The service delivery package includes targeted interventions reaching high-risk populations in scale-up sites. Technical assistance (TA) sites will receive above site level support and periodic targeted site-level TA. Partners based in low yield sites will transition their activities to high yield areas while increased engagement of the GRZ in site supervision and M&E will provide sustainability of activities.

The core prevention package includes condom promotion and distribution, community-based behavior change, mobilization and demand creation, support of community linkages to HIV care and support services, and PHDP programs. Promotion of gender equity, addressing sex/gender norms that contribute to the spread of HIV, and PHDP at community level are also prioritized as core activities. Near-core activities consist of integrated social and behavior change communication (SBCC) in PMTCT, HTC, VMMC and other programs, girls' empowerment, lubricant promotion and distribution for KPs, and improvement of documentation of community activities and linkages. Communities will be involved through community mobilization and community lay workers will conduct outreach to the general population and KPs. Hard to reach populations will be reached through mobile service provision and services in known hot spots.

Gender

The gender and gender-based violence (GBV) program will strategically target locations and populations with highest disease burden¹⁷. The gender activities are in line with PEPFAR's 2013 Gender strategy which encourages integration of gender issues and equality throughout the continuum of prevention, care, treatment and support.

Services provided under the GBV program have been classified as near-core and will be implemented in one stop centers (OSCs). Services provided include counseling, medical services and examinations, the provision of HTC and post exposure prophylaxis (PEP), legal services, strengthening GBV coordination efforts in the community, strengthening the capacity of service providers to better manage GBV cases through the engagement of boys and young men, and

¹⁶ World Health Organization, 2014. In order to be classified as “comprehensive,” service packages should include condom/lubricant provision, VMMC, HTC, access to ART, PMTCT, management of co-morbidities, provision of sexual reproductive health, STI screening and treatment and family planning to both priority populations and members of KPs (e.g., MSM and FSW).

¹⁷ Because of the correlation between HIV and GBV, the GBV program will focus on those geographic areas with the highest disease burden.

increasing community awareness of GBV. All OSCs will be transitioned to the government to ensure sustainability. With the increased number of PLHIV on treatment and the corresponding need to increase HTC, there is a possibility of commodity stock outs for testing in OSCs.

4.3 Voluntary Medical Male Circumcision (VMMC)

The VMMC program has experienced recent policy and funding challenges affecting Zambia's circumcision targets. WHO released two information notes in 2014, advising programs not to circumcise young adolescents less than 14 years old using the forceps-guided method and to intensify education and monitoring of tetanus. Major circumcision partners also closed due to funding reductions from a major partner, adversely affecting service delivery. FY 14 central supplemental funds have been allocated to Zambia to bridge subsequent gaps and to reach 56,801 additional men. Unfortunately, the funding has not yet been disbursed and targets may no longer be attainable in the remaining time period. Thus, there may be carry-over in VMMC targets to the following fiscal year.

The VMMC program will prioritize its efforts towards high HIV prevalent areas with uncircumcised men in the target age group (15-49 years). These populations will be reached through the use of mobile/outreach service delivery models. The core VMMC package will consist of a) demand creation activities; b) training, mentorship and supportive supervision; c) service delivery through the use of static and mobile models with extended hours; d) linkages to care and treatment for HIV infected clients; e) strengthening quality assurance; f) institutionalizing M&E; and g) engaging community health workers to support community mobilization and sensitization. The EIMC program will provide periodic TA to the government at targeted site level through September 2016. Implementing partners in low prevalence/burden geographic areas will provide periodic targeted regional and site level technical assistance and will transition their work to GRZ by September 2016. VMMC investments are consistent with the core framework and have been found efficacious for epidemiologic control.

Of concern to the program is the need to strengthen the distribution and logistics management of HIV rapid test kits to avoid stock outs and ensure a consistent supply available for testing all VMMC clients. This will be addressed by strengthening HIV RTK logistics management at all levels. Hard to reach communities in high HIV prevalence areas with high unmet VMMC need will access the services through outreach or mobile service provided by hubs set up at static sites.

4.4 Preventing Mother-to-Child Transmission (PMTCT)

In 2013, Zambia adopted WHO Option B+ for PMTCT, and PEPFAR funding supports operationalization of the B+ M&E framework, increased pediatric HIV case finding, and improvement in supply chain systems to improve program quality. Zambia will also receive Accelerating Children's Treatment Initiative (ACT) funds that will support pediatric HIV case finding and enrollment on treatment, which will result in increased EID of HIV exposed infants and enable reporting on the new mother-baby pair follow-up indicator.

The PMTCT program will tailor its response to high HIV burden areas with a goal of attaining 90% ART coverage among HIV positive pregnant women. The program will increase efforts in scale-up sites which are high yield, high volume, have high unmet need and maintain quality standards in maintenance low yield, low volume sites. The core package of services will include support for a) training for healthcare workers; b) HIV case finding among pregnant and breastfeeding women and HIV exposed infants; c) institutionalization of M&E systems for cohort monitoring; d) incorporation of quality assurance systems for HIV rapid testing; e) laboratory clinical monitoring; f) scale-up of Option B+; and g) support for adherence and retention of mother-baby pairs in Option B+ and through community lay workers. Hard to reach communities that reported at least one HIV infected pregnant women in the previous fiscal year will receive ART services through periodic mobile ART service delivery. The maintenance package in low yield, low burden sites will include above-site TA for purposes of quality assurance and provision of periodic targeted site-level TA; transition to GRZ for these sites will be completed by September 2016. Family planning/HIV integration is considered near-core. Option A is considered non-core and will not be funded in FY 2016. Reliable supply of EID testing commodities is of concern for program activities and targets although PEPFAR Zambia plans to support EID test procurement for adequate service delivery.

4.5 HIV Testing and Counseling (HTC)

The MoH 2014 HTC National Implementation Plan has a goal of 50% coverage by 2015 among Zambians age 15-49 who received an HIV test in the last 12 months and know their results. This is in line with the PEPFAR COP 15 plan to saturate the focus areas with 80% HTC by strategically targeting geographic locations with the highest burden of HIV to achieve the greatest impact. PEPFAR guidelines and the UNAIDS Gap Report emphasize the importance of location and population, focusing on populations that are underserved and at higher risk of HIV. Based on these guidelines, Zambia has an HTC target of 2,125,638 for COP 15.¹⁸ Zambia plans to leverage relationships with GRZ, bilateral partners, and central funding initiatives (ACT, DREAMS, and SMGL) to test an additional 1.2 million Zambians to reach targets in COP 15.¹⁹ The USG will encourage implementing partners to utilize innovative ways of scaling up testing in high yield settings.

The service delivery package for HTC will be comprised of quality HTC services to individuals, couples and families and to key and other priority populations in high prevalence areas and; mobile testing in high burden areas and hotspots; community mobilization and promotion of HTC; strengthening linkages to treatment, care and support in all settings; and enhanced monitoring of the completion of linkages to other services. Priority will also be on PITC for all patients in TB, STI and ANC clinics and improving linkages for HIV positive clients to enroll in care and treatment at ART sites (comprehensive HIV prevention strategy). In addition, USG

¹⁸ Historically, the Zambian HTC achievements have been increasing by an average of five percent per year. This target is much higher than previous years because of the increased treatment target and may, therefore, be challenging to reach.

¹⁹ Through the ACT Initiative, Zambia has to test 1,300,000 million children aged 0 to 19 years.

partners will develop and implement continuous QA/QI strategies, while providing TA at the provincial and district levels. The planned program activities align with the core framework as quality HTC services to individuals, couples, families and key and other priority populations in high prevalence areas and HIV hot spots and support for community linkages/systems to timely access services in HTC (and early diagnosis) are core activities. The near-core activity of generalized HTC will be continued in maintenance sites and coverage of PITC will be expanded. Partners in low yield sites will transition those sites to GRZ.

With the expected increase in numbers of people accessing HTC services potential challenges may occur such as commodity stock outs, logistical challenges, and delay in the movement of commodities from the district (where they are delivered) to facility level. The community will play an important role in increasing uptake and sustainability of services. Implementing partners will implement strategies for community mobilization and to increase awareness about the availability and benefits of HTC and ART services as well as the value of ART for all PLHIV. The community will be vital in sustainability of HTC activities beyond project implementation. Hard to reach populations will be serviced by mobile rapid HTC.

4.6 Facility and Community-Based Care and Support

In COP 15, PEPFAR Zambia's care and support program will focus on developing and implementing a high quality, cost-efficient package of integrated HIV care and support services consistent with PEPFAR guidance, GRZ national guidelines, and standards of care. This package underscores the importance of implementing care and support activities that have an impact on reducing morbidity and mortality amongst PLHIV. In alignment with the 90-90-90 strategy, the adult care and support program will ensure ART acceptability and adherence for PLHIV through adoption of a patient and family-centered approach at both facility and community sites in addition to retaining PLHIV who do not meet the ART initiation criteria.²⁰

The adult care and support program will strengthen multi-directional referral linkages, including linkages across different types of HIV/AIDS services and between facility-based and community-level services that promote retention in care and adherence to ART. One of the key activities to be implemented under COP 15 is the development and maintenance of functioning linkages and referral systems between caregivers at the community level as a means to guarantee quality care and ensure a continuum of care. Integration of HIV care and support services with other (non-HIV) health services at the community level will also improve efficiencies and access to services for PLHIV who may not seek out dedicated HIV services. Community-based programs will provide a mix of high quality behavioral interventions tailored to each priority population and partners will work to create demand for high impact HIV and health services (e.g., individualized risk assessments and condom use).

²⁰ These persons will receive a standard package of care that includes regular monitoring for HIV progression, condom provision and non-clinical services.

The core and near-core activities that will be implemented in COP 15 include:

- a. Providing Cotrimoxazole (CTX) prophylaxis to eligible HIV positive adults;
- b. Improving the TB/HIV care cascade;
- c. Introducing viral load (VL) testing as a gold standard for monitoring patients on ART in accordance with PEPFAR and the Zambian GRZ priority
- d. Scaling up nutrition assessment, counseling and support (NACS) services
- e. Strengthening linkage, engagement and retention (LER) of patients in care and strengthening referral mechanisms and other systems of linking clinical and social services;
- f. Scaling up adult care and support;
- g. Regular clinical and laboratory monitoring;
- h. Prevention and management of opportunistic infections;
- i. Improved case management of children and adolescents made vulnerable to or by HIV and AIDS; and
- j. Supporting community level child protection/GBV prevention and response activities and referrals to other services; and
- k. Facilitating group-based Household Economic Strengthening (HES) activities and access to social protection efforts.

All activities will be largely focused in both scale-up and maintenance sites with special attention to strengthening technical capabilities of district and community organizations to sustain quality services²¹.

Pediatric Care & Support:

The treatment of HIV-infected infants and children, when delivered appropriately, ensures that those children born with HIV have the opportunity to remain healthy into adulthood. In COP 15, the pediatric care and support program will provide comprehensive pediatric HIV care that includes prevention, early detection, and treatment through clinical and psychosocial support services. Through additive resources from the Accelerating Children's HIV/AIDS Treatment (ACT) Initiative, PEPFAR Zambia will double HIV services including screening and treatment to infected pediatrics and HIV exposed children. These services will be available to those with HIV/AIDS and their affected families in the scale-up and maintenance sites. Core and near-core focus will include:

- a. Scaling up EID, including support for provider-initiated testing and counseling, prompt

²¹ Specific interventions to be implemented in support of the identified core and near core activities include a) early identification of HIV-infected persons to connect them with the comprehensive system of HIV/AIDS services; b) psychological and spiritual support including group, individual, and adherence education and counseling; c) NACS support focused on corrective interventions to address malnutrition associated with the progression of HIV to AIDS and early ART²¹; d) integration with non-HIV services to improve efficiency and access to those with co-morbidities and other diseases; e) integration of palliative care services into all HIV ART and clinical care sites; f) multi-directional referral networks between the community and facility to strengthen all care and support services; and g) Implementation of quality, comprehensive services through community-based organizations (CBOs) in alignment with OVC Minimum Standards.

return of results to children and their designated caretakers, and links to appropriate care and treatment.

- b. Implementation of consolidated pediatric treatment guidelines and recommendations as well as alignment with the OVC Minimum Standards, National Plan of Action for Children, and forthcoming GRZ standards for vulnerable children.
- c. Appropriate clinical staging and laboratory monitoring to guide pediatric care and treatment.
- d. Promoting a comprehensive package of pediatric HIV care and treatment, including antiretroviral treatment, treatment of malnutrition and life-threatening infections, and pain and symptom management, all within a family-centered context.
- e. Developing and implementing strategies to decrease loss to follow-up through health facility- and community-based retention strategies.²²
- f. Training, mentoring, and supervision of health care workers to provide high quality pediatric care and treatment services, including those components outlined above.²³
- g. Provision of psychosocial support for children and their families, including the promotion of adherence and timely disclosure. School-based psychosocial support will include teacher support for children.
- h. Provision of targeted prevention efforts and age-appropriate psychosocial support for HIV-infected adolescents, including vocational training, intensive adherence support, and coping with stressors.
- i. Strengthening of GRZ monitoring and evaluation systems, including data collection for central reporting and data feedback for site level quality improvement
- j. Strengthening of systems to link CBOs with government health services for under-five, child and adolescent health programs, including ART and PMTCT services. Programs will emphasize the needs of children living with HIV by helping families and communities identify children and adolescents living with HIV and ensuring immediate access to ART for those under 15 years.
- k. Training, mentoring and support of CBOs to improve technical capacity in HIV prevention, care and support to scale-up evidence-based activities, including prevention with positives counseling by community caregivers, stigma education, alcohol education, Safe From Harm and other proven interventions.

²² Bi-directional referral networks between the community and facility will also be strengthened for pediatric ART. Programs will leverage the ability of CBOs to follow up with PLHIV at the household level, promoting retention in care.

²³ CBOs will improve quality delivery of HIV prevention information, such as implementing multi-dose, integrated prevention interventions and expanding HTC opportunities for families through strengthened referrals to HTC services.

4.7 TB/HIV

In line with the STOP TB Strategy and the recommendations of the 2010 Review of the TB Program, the TB/HIV program activities will include: 1) improving diagnosis of TB/HIV through the timely and effective use of new diagnostic tools, 2) reducing TB/HIV related morbidity and mortality through improved case management, 3) increasing access to high quality TB/HIV treatment and care to enhance the programmatic management of drug resistant TB, 4) strengthening the capacity of the health system to deliver quality TB/HIV care; and 5) enhancing community awareness and involvement in TB, TB/HIV and drug resistant TB management.

PEPFAR has provided support to the National TB/HIV program to provide HTC to TB patients. The TB patients tested and counseled for HIV increased from 86% in 2011 to 90% in 2013. The TB/HIV co-infected patients started on Cotrimoxazole prophylaxis increased from 87% in 2011 to 93% in 2013 and those initiated on ART increased from 53% in 2011 to 67% in 2013. Screening of HIV positive patients for TB has been implemented in the HIV program. Support has also been given to hire health care providers to complement government staff shortages, procurement of new diagnostics and other equipment and transport. Due to inadequate infrastructure to accommodate TB/HIV programs, minor renovations were done on selected facilities in order to improve on case identification, adherence and case holding, linkages and referral systems were strengthened between TB and HIV programs.

To address the many challenges in the TB and TB/HIV program, the National TB Program has the following objectives:

1. Increase case notification rate of all forms of tuberculosis from 321/100,000 in 2012 to 338/100,000 and screen 100 % of previously treated TB cases for MDR by 2016;
2. Increase treatment success of drug susceptible TB from 88% in 2012 to 90% by 2016;
3. Provide testing and counseling for HIV for 100% patients with presumptive TB and TB disease;
4. Successfully treat at least 70% of all MDR-TB patients initiated on treatment by 2016;
5. Reduce TB related morbidity and mortality among people living with HIV through the scale up of TB/HIV activities in at least 80% of TB and HIV sites by 2016;
6. Ensure that 100% of TB patients co-infected with HIV are initiated on ART by 2016;
7. Initiate 60% HIV + individuals with no signs of TB disease on Isoniazid Preventive therapy (IPT) by 2016;
8. Scale up TB prevention, diagnosis and care services for vulnerable and high risk populations by 2016;
9. Enhance TB surveillance and M&E; and
10. Strengthen the health system to deliver TB/HIV services through a primary health care approach at community level and the development of synergies.

PEPFAR is supporting the scale up of the 3Is project of Intensified TB case finding, TB infection control in HIV settings and Isoniazid Preventive Therapy among HIV positive individuals with no active TB disease in four provinces (Lusaka, Copperbelt, Central, and Southern) with a high burden of TB/HIV from 2012 to 2015. The objectives of this project are to:

- Increase TB case detection through development of national guidelines, screening of inmates from prisons and prison staff and community screening, strengthen existing laboratory networks and introducing new diagnostics like the genexpert
- Improve treatment success rate among TB patients diagnosed in HIV settings through supporting and strengthening DOTS, strengthen linkages and referral systems between TB and HIV and strengthen the monitoring and evaluation systems
- Implementation of Isoniazid Preventive Therapy among HIV positive individuals with no signs of active TB disease
- Improve TB infection control measures in HIV and prison settings at facility and prison levels
- Improve linkages for ART provision for TB patients diagnosed in HIV settings

The project is implemented by the Ministry of Health and PEPFAR partners, but support will end in September 2015. PEPFAR partners, the Global Fund and GRZ will then scale up the 3Is initiative to selected districts and health facilities with high HIV yields in 2015 and 2016. In COP 15, PEPFAR will support the following priorities identified as core or near-core activities in the scale-up sites:

1. Ensure that 100% of patients with presumptive TB or TB disease receive HIV testing and counseling and initiate 100% of those that are co-infected on ART.
2. Support integration of TB/HIV care and treatment to ensure linkages and retention
3. Ensure that HIV positive patients are screened for TB and refer those identified for TB diagnosis and treatment
4. Ensure to initiate 60% of HIV positive individuals who do not have TB disease on Isoniazid Preventive therapy
5. Expand interventions, including Xpert MTB/RIF assay to improve early diagnosis and treatment of TB among PLHIV. Support to laboratory networks, courier systems and quality control will be provided.
6. Support TB infection control measures to prevent transmission of TB in healthcare and community settings
7. Strengthen TB/HIV program monitoring and evaluation.
8. Ensure that children, pregnant women, prisoners, miners and other vulnerable groups are included in the TB/HIV programs.

PEPFAR will further support revisions of national guidelines, TB/HIV data review meetings, TB/HIV coordinating body meetings, technical support through training and mentoring of health care providers in maintenance sites.

4.8 Adult Treatment

FY 2015 represented the first year of a stepped-up level of implementation for the PEPFAR Zambia treatment program, representing the first budget with a 50% treatment earmark and the ACT Initiative. The stepped up activity resulted in a highly ambitious target of increasing the number of PLHIV on HIV treatment from the FY14 result of 613,000 to 720,000. PEPFAR Zambia

continues to support the national treatment program in order to reduce morbidity and mortality amongst PLHIV through increased and expanded ART access based on a thorough epidemiological analysis of the HIV epidemic in Zambia and the development of core and near-core packages as supported by the USG. In COP 15, the program will continue to a) consolidate a number of key strategies such as early ART initiation in all individuals with HIV with CD4 count of less than or equal to 500 cells/mm; b) continue ART initiation of HIV positive pregnant and breastfeeding women; and c) maintain viral load monitoring activities that were initiated in FY15 in order to sustain and further accelerate the up-take of new patients onto ART while driving increased quality and efficiency within the program for improved overall program out-comes toward attainment of an AIDS Free Generation. In COP 15, the budget treatment ear-mark of 54%, the additive resources based on a one-off plus-up funding of \$19m for HIV treatment, and the second year funding for the ACT initiative will be used for implementing the treatment program. In FY16 program targets are expected to increase the number of PLHIV on ART from the expected FY15 result of 720,000 to 820,000, out of which 98,575 will be children/adolescents up to the age of 19 years.

Based on the analysis of epidemiological data, the PEPFAR Zambia treatment program notes that the regions targeted for scale-up are home to the health facilities with the highest current patient load, with an estimation that these sites attend to 80% of PLHIV. In this regard, four provinces have been identified as scale-up provinces with the remaining six as maintenance provinces. No provinces at this point will be transitioned due to hotspots and the number of maintenance sites identified in these provinces. As PEPFAR Zambia has adopted the UNAIDS 90-90-90 strategy, the treatment program plans to scale-up ART service delivery by introducing new strategies and innovations targeting the identification of new ART clients, improve adherences and support, and suppress the viral load for over 90% of PLHIV enrolled in treatment while strengthening proven strategies such as early ART initiation of newly identified clients. Other strategies to be implemented will include: a) strategic static and mobile treatment sites that will be supported to operationalize in areas with high unmet need; b) limited/basic infrastructure improvements to support increased patient up-take; c) roll-out of more community HIV care and treatment model sites (including community linkages/systems to access HTC, ARV treatment and adherence, care and support, VMMC and PMTCT) as a means of decongesting the facilities that will primarily be maintained as treatment initiation and stabilization facilities for new patients; and d) transitioning stable patients on treatment to community units for on-going care. These activities are expected to improve accountability of each patient initiated on treatment, improve retention in care and provide better support for adherence.

PEPFAR Zambia will also provide support for the procurement of equipment for the existing large volume sites and new sites and mobile units to be established based on the epidemiology of disease. Considering that all ANC sites should be fully fledged option B+ sites in COP16, integration and decentralization of PMTCT and ART services will continue with a focus on quality assurance and consolidation of weaker, previously PMTCT-only sites. Similarly, provision of ART in TB treatment settings will be supported by developing ART capacity in each TB treatment site.

Support for CD4 and Viral Load monitoring will be improved to ensure all patients in PEPFAR supported treatment sites have access to these monitoring tests as per national guidelines. Activities will include supporting laboratory capacity (e.g., equipment and supplies and training), continuous quality improvement activities and accreditation in scale-up sites.

To drive increased up-take of ART patients, the PEPFAR Zambia team will be implementing integrated HTC and ART continuum of care service models to increase early case findings enhanced adherence/retention strategies, and strengthening linkage between HTC to care & treatment. This will mean existing implementing partners (IP) programs that previously only implemented one service component of the cascade will now also implement other services in the sites in which they operate to make linkages better coordinated. This strategy will also reduce over-lap of IP's and improve efficiency.

The PEPFAR country team plans to continue increasing access to ART by members of KPs by further expanding ART delivery to PEPFAR and other partner program platforms that have been reaching KPs with only “other prevention” interventions in prior years. In COP 15 programs will aim to reach commercial sex workers (CSW) and men who have sex with men (MSM).

4.9 Pediatric Treatment

Specific to pediatric HIV, the PEPFAR Zambia treatment program will emphasize implementation of activities by all implementing partners (IPs) to enhance early identification of HIV infected children through index adult patient linked family testing, routine implementation of PITC in all service points where children are accessed, and quality improvement of EID services. An additional focus area in COP 15 will be the implementation of adolescent specific HIV services that will involve training of health care providers based on best practice models that have been implemented in Zambia in limited settings during prior years.

In order to optimize patient monitoring and support strengthened adherence and retention interventions, roll-out of improved Information Communications technologies (ICTs) will be supported by the treatment program. This will include use of a single patient level electronic health record system (EHR) across the continuum of care and integration of Short Messaging System (SMS) technologies with the EHR for purposes of patient tracking and retention interventions as well as real-time process monitoring of service delivery sites.

Quality of care standards will continue to be based on current national guidelines and will be integrated with the Site Improvement Monitoring System (SIMS) as a tool for tracking service quality and informing improvements.

In view of the many lessons that are still being learned on how to effectively delivery services using highly decentralized service models, the PEPFAR Zambia treatment team has prioritized the inclusion of targeted program evaluations to inform service delivery improvements during FY16.

Over and above the core strategic direction described above that is targeted at the scale-up sites from which the PEPFAR program will draw 80% of its target results, the program will support the

following: technical assistance to supply chain systems at site level to assure commodity availability, procurement of HIV commodities including ARVs, EID, HIV test kits, viral load reagents, quality assurance/quality improvement (QA/QI) processes, and in-service trainings both to scale-up sites and maintenance sites. Site level in-service training and technical assistance (TA) and mentorship activities in maintenance sites will be necessitated by quality monitoring indicators. Supporting QA/QI for maintenance sites primarily through MOH provincial/district level TA will therefore form the foundation of PEPFAR support to maintenance sites.

As near-core activities, the PEPFAR Zambia program plans to support nutritional assessment counseling and support, training for community based support groups including safe mother action groups (SMAGs), traditional birth attendants (TBAs), Adherence Supporters and Youth Peer Educators, ART transition monitoring and evaluation, AIDS Indicator Survey implementation, Pre-service training, and HIV Drug resistance monitoring.

4.10 Orphans and Vulnerable Children

The OVC portfolio underwent major changes in FY14 and FY15. Per the geographic prioritization, the flagship OVC program (STEPS OVC) transitioned all program sites outside of the priority areas. Programs providing education and nutritional support remain active outside of the four priority provinces. All stand-alone education services will end in FY16; however, nutritional support focused on young PLHIV and referrals to other HIV services will remain in geographic hotspots in Eastern province which is a scale-up province for care and treatment.

Within hotspots and priority areas, there will be maintenance and scale-up sites for the OVC portfolio. GRZ data were used to determine districts with at least 20,000 orphans and treatment data were used to determine sites with highest volume (over 5,000 ART patients) as a first step to determine sites for OVC scale up. Catchment areas or constituency boundaries for the highest volume sites will be used to further geographically define scale-up OVC sites. In FY16, the new OVC flagship program, Zambia Family, will link with high volume ART facilities to assess the needs of families living with HIV to determine eligibility for enrolling in the program. A clinical-care partner will pilot the placement of a para-professional case worker to provide evidence on the value of such staff in facilitating clinical and community care linkages. As with STEPS OVC, the Child Status Index will be used to assess the children from families identified within the health facility.²⁴

Services in the scale-up and maintenance sites will include the Zambian core and near-core activities for OVC programs while all non-core activities will end in FY15. The primary difference between scale-up and maintenance sites will be the number of children served. As children move away or graduate from the program in maintenance sites, no new children will be added.²⁵

²⁴ The Index will be modified to better accommodate assessing the community care needs of children and adolescents living with HIV.

²⁵ Most maintenance sites are serving children that have been transitioned from the STEPS OVC program to the Zambia Family program.

As maintenance sites scale-down, more children can be added to the STEPS program from scale-up sites which will allow for increased support in scale-up sites to achieve saturation and the goal of enrolling 80% of eligible children in the OVC program. The pivot within the provision of services and support to OVC and their families will be the emphasis on epidemic control in scale-up sites.²⁶

The OVC portfolio will contribute to DREAMS through a focus on girls ages 10 to 14 to ensure they stay in school and successfully transition into adolescence. For the ACT initiative, Zambia Family will have a lead role in case finding (up to 30,000 new cases over two years), ART adherence and care retention. Nutritional support will include growth monitoring of young children under five that will be conducted at both facility and community level through USAID/Thrive and USAID/MAWA projects respectively. Following nutritional assessment the malnourished children will be referred to CCFLS for rehabilitation or the household taking care of the OVC will be linked to other livelihood activities within their communities. In addition to the above, DOD activities will provide technical support to the Ministry of Defense to strengthen their capacity to manage and coordinate OVC activities. OVC services in the military setting reaches children in and around the base through community schools established there.

USAID Zambia will seek expertise in programming for vulnerable adolescents, ages 10 to 19 to fill gaps in capacity and services across the care, prevention, and treatment partners to address the needs of youth in adversity. An existing youth mechanism will provide a platform for scaling up DREAMS and ACT in sites where these initiatives are not based and provide targeted support to vulnerable adolescents who are at risk of HIV or living with HIV often having limited or no access to services (this includes adolescents outside of family care and in exploitive work situations along with MSM).²⁷

Technical support will be provided to the GRZ social protection program²⁸ to increase their capacity to manage and coordinate activities for OVC and private sector resource leveraging will be increased to facilitate graduation from PEPFAR support. Capacity building support will be provided to existing government structures at the community, district and provincial levels to improve their ability to identify, refer and provide case management to OVC. Social service workforce development will remain a priority investment for the next three years and will address the need for government social protection structures to include paraprofessionals as well as adding case managers to health facilities who are trained in social service provision to bridge with

²⁶ Key interventions will include improved capacity of parents or guardians to mentor, protect and monitor their children; stronger referral systems to HIV and family planning services; elimination of GBV, and household economic strengthening.

²⁷ The intentions are to intervene early enough to prevent the on-set of risky behaviors or support alternatives for adolescents already engaging in risky behaviors in addition to providing support to help young PLHIV survive and thrive.

²⁸ The GRZ social protection program includes a household dependency burden with an emphasis on caring for orphans.

community care and provide a well-functioning continuum of care. Workforce development supports sustainability of PEPFAR investments and will involve resource leveraging with other donors and linkage with the GRZ social protection program.²⁹

SIMS visits found several areas for improvement. First, SIMS visits found there are gaps in meeting the needs of adolescents with HIV in part due to limitations of case management which is 100% handled by volunteers. Second, support for girls to successfully transition to and complete secondary school was not being covered by STEPS OVC. Lastly, timeliness of post-rape care was identified as an additional issue needing focused improvement. With the new OVC program, these issues will be discussed with the aim to resolve. The GBV program receiving HKID funds will continue to address the timeliness issue along with a new program focused on behavior-change communications.

²⁹ Programs providing technical support to GRZ are Zambia Rising and Community Rising.

5.0 Program Activities to Maintain Support for Other Locations and Populations

5.1 Maintenance package of services in other locations and populations

The expected volume of patients needing the minimum package of services in these areas has been calculated by district and overall (Table 5.1.1).

Maintenance Volume by Group	Expected result APR 15	Expected result APR 16	Percent increase (decrease)
HIV testing in PMTCT sites	179,657	197,994	10%
HTC (only maintenance ART sites in FY 16)	-	-	-
Current on care (not yet initiated on ART)	-	-	-
Current on ART	211,087	231,774	10%
OVC	115,774	144,717	25%

In addition to Table 5.1.1, the following tables describe the core maintenance package of services provided outside of priority areas in the following tables (5.1.2 through 5.1.9) by program area.

Table 5.1.2 PMTCT Maintenance Package

SCALE-UP	MAINTENANCE
- Training for PMTCT service providers, clinical mentoring, and supportive supervision of PMTCT sites; explore use of training modalities like e-learning	- Procurement of critical commodities and drugs and commodities and laboratory reagents
- Support active case finding along the continuum of care for pregnant and breastfeeding women as well as their sexual partners.	- Technical Assistance to PMO/ DMO
- Strengthen and expand early infant HIV testing; support DBS commodities, sample transportation and rapid return of results	- Targeted on-site clinical mentorship and training updates
- Support laboratory clinical monitoring including viral load testing	
- Support adherence, retention and tracking of mother-baby pairs through a) strengthening of paper-based and electronic systems, b) community health worker retention and c) mother mentoring programs.	
- Support site-level drug and commodities logistics management and distribution	
- Targeting funding for health care workers' salaries	
- Support institutionalization of M&E systems for cohort monitoring, <i>both electronic and paper based</i> , to enable tracking of outcomes of mother-baby pairs.	
- Support site level service and data quality improvement/assurance activities	
- Support incorporation of quality assurance systems for HIV rapid testing	
- Support operations of mobile ART services	
- Targeted infrastructural renovations	

Table 5.1.3 Care and Support Maintenance Package

SCALE-UP	MAINTENANCE
<p>Support to regular clinical and laboratory monitoring</p> <ul style="list-style-type: none"> - Procurement of equipment - Orientation on guidelines for HCWs 	<ul style="list-style-type: none"> - TA on WHO staging, CD4 and viral load counts HCWS and procurement of equipment - Support for updating and orientation on national guidelines to HCWs - TA to PMO/DMO/Facility staff
<p>Support for Cotrimoxazole procurement</p> <ul style="list-style-type: none"> - Support to training of health workers through mentoring, monitoring and oversight - Support the procurement of Cotrimoxazole for eligible HIV patients 	<ul style="list-style-type: none"> - TA to HCWs through training - Support for provision of Cotrimoxazole
<p>Support for adherence assessment</p> <ul style="list-style-type: none"> - Support for counseling services - Linkages with community structures - Condom provision - Support retention systems for patients on care and treatment 	<ul style="list-style-type: none"> - Support or referral for adherence counseling - Support for enrolling PLHIV to community structures (HBC, support groups, posttest clubs)
<p>NACS is critical to clients commencing Art due to the high burden the drugs put on the patients. And in most cases most clients get to begin ART after they fall very ill and that greatly requires nutrition support.</p> <p>In areas where NACS needs to be scaled up it is important that the NACS is integrated with HIV/AIDS and OVC services at the various following key interventions are planned and implemented.</p> <ul style="list-style-type: none"> - Procurement of NACS related job aids, BMI charts, counselling charts, counseling materials and performance standards - Coordination with government - NACS packages of services provided at both facility and community level - Training and mentorship supervision is provided to the clinical and community health workers - Specialized nutrition supplements are procured and distributed - Provide supplementary /therapeutic feeding for eligible clients - Integration with USAID programs already operating in the sites - Training facility teams in data capturing and reporting systems at facility - Training sites in quality improvement and quality assurance 	<p>In the maintenance sites NACS activities are almost established and with activities integrated into the health care system.</p> <p>These sites will still require regular follow up and support.</p> <p>Key follow up activities include:</p> <ul style="list-style-type: none"> - Continue with nutrition counselling and support - Specified training for health care providers - Procurement of Supplementary and therapeutic feeding - Continued engagement/ adherence /retention for clients - Scaling up HEPS commercialization with targeted free HEPS distribution - Provide support for community based NACS - Training facility teams in data capturing and reporting systems at facility - Training sites in quality improvement and quality assurance - Implementation of graduation strategy for both facility and community NACS activities. - Integration with USAID programs

Table 5.1.4 Orphans and Vulnerable Children Maintenance Package

SCALE-UP	MAINTENANCE
<ul style="list-style-type: none"> - ART and PMTCT scale up sites within 5 priority provinces will be scale-up sites for the OVC program. - Increase linkages with high volume facilities in order to reach children and adolescents living with HIV or at risk of HIV as well as families living with HIV. - Activities in the core and near-core categories for OVC will be undertaken with a primary focus on sub-populations noted above. - Support of DREAMS will be an additional consideration for designating scale-up sites for the OVC program. - Actions in support of ACT will occur in scale-up and maintenance sites. 	<ul style="list-style-type: none"> - The majority of services to OVC occur in five priority provinces for PEPFAR Zambia. Maintenance activities for these sites will include the OVC core and near-core activities for PEPFAR Zambia, with non-core activities phased out in FY15. - Assessment of children using criteria based on PEPFAR 3.0 priorities, meaning that not every child will be transitioned into the new program. - As children move away or graduate from the program, no new children will be added in the maintenance sites. - Technical support will be provided to GRZ to increase their capacity to manage and coordinate activities for OVC and private sector resource leveraging will be increased in the maintenance sites to facilitate graduation from PEPFAR support. - The education scholarship program (Time to Learn) has sites in all provinces which will be maintained until December 2016 when the last of the supported students will graduate from secondary school. No new students have been or will be added in FY 15. - The DOD program reaches OVC located in and around the military base. Selection of sites is based on the scale-up, maintenance and transition criteria; the community implementing partner will follow the scale and transition sites selected to implement OVC programs as these will be the densely populated high prevalent areas.

Table 5.1.5 TB/HIV Maintenance Package

SCALE-UP	MAINTENANCE
<p>Provider Initiated Testing and counseling for TB Presumptive and TB patients for HIV</p> <ul style="list-style-type: none"> - Strengthen recording and reporting system - Support smart care utilization - Support to referral and linkages between TB and HIV 	<ul style="list-style-type: none"> - TA to PMO/DMO/Facility staff - Support to volunteers and use of referral forms to strengthen referral systems between the two programs
<p>Screening PLHIV, prisoners, miners, children and Pregnant women for TB</p> <ul style="list-style-type: none"> - Support Screening PLHIV, Prisoners, pregnant women, pediatrics and miners for TB - Increased TB diagnostic facilities - Support to strengthened linkages/referral systems between TB/HIV programs 	<ul style="list-style-type: none"> - TA to clinicians on documentation on the screening forms - Support to strengthened referral systems- Volunteers participation and referral form with feedback information for diagnosis and treatment - Support to increased TB and HIV

	diagnostic facilities
<p>ART initiation for the TB/HIV co-infected individuals</p> <ul style="list-style-type: none"> - Integration of TB/HIV services - Support to minor renovations to accommodate TB/HIV services - Strengthened referral systems and linkages in between TB and HIV programs 	<ul style="list-style-type: none"> - Support TA to DMO/PMO/Facility - Integration of TB/HIV services where applicable - Support to strengthened referral systems- Volunteers participation and referral form with feedback information - Orientation of PMO/DMO and Facility staff on ART/TB management
<p>TB Infection control measures</p> <ul style="list-style-type: none"> - Support to minor renovations for PLHIV waiting areas, ART and screening rooms - -Support to procurement of Personal Protective equipment - -Support to triaging of patients with cough - Provide support on IEC materials, patient education/ triaging and PPE, 	<ul style="list-style-type: none"> - Support to provide IEC materials to promote TB infection control measures
<p>Monitoring and evaluation</p> <ul style="list-style-type: none"> - Support to updating the data collecting and reporting tools - Support to MER system - Support TB/HIV data review meetings 	<ul style="list-style-type: none"> - Support to update TB diagnostic/treatment registers, treatment/identity cards, and quarterly report forms - Support to smart care MER system to collect and report data - Support to regular TB/HIV data review meetings, clean, analyze and use data for policy, planning, implementation, monitoring and evaluation of the programs
<p>Laboratory support</p> <ul style="list-style-type: none"> - Support investment in new diagnostics-genexpert/cartilages - Support to increasing TB/HIV diagnostic centers - Support to specimen courier system - Support the scale up of new diagnostics-genexpert technology 	<ul style="list-style-type: none"> - Support to quality control - Support to specimen courier system from treatment to diagnostic facilities, from diagnostic facilities to culture laboratories
<p>TB/HIV Coordination</p> <ul style="list-style-type: none"> - Support to National, Provincial, District and facility TB/HIV Coordinating bodies 	<ul style="list-style-type: none"> - TA to Functional National, Provincial, District and Facility TB/HIV coordinating bodies Support to regular meetings with minutes documentation - Support to increased collaborations among partners
<p>IPT for PLHIV</p> <ul style="list-style-type: none"> - Support to Orientation on data collecting and reporting tools - Support to facility IPT data review meetings - Support for monitoring and evaluation of IPT uptake - Support to IPT guidelines updates including data collecting and reporting tools - Support to community structures in IPT uptake 	<ul style="list-style-type: none"> - Support to orientation of health care providers on the tools - Support for IPT data review meetings

Table 5.1.6 VMMC Maintenance Package³⁰

SCALE-UP	MAINTENANCE
- Provision of technical assistance to the VMMC program at all levels	- Quarterly technical assistance visits to sites

³⁰ The VMMC program will operate in all focus provinces, particularly in high population sites, and in HIV hotspot districts in other provinces. There are no maintenance sites or packages for the adult VMMC program, only a maintenance package for sites transitioned over to government support by the EIMC program.

of government i.e. National and subnational.	providing EIMC
- Support the development, implementation and coordination of strategies to link the highest at risk sub-populations of the VMMC eligible population (e.g. males in sero-discordant relationships with HIV-positive female partners, males attending STI clinics, military population) to VMMC services.	
- Support demand creation activities using a combination of communication approaches to communicate key VMMC messages	
- Support provision of the WHO prescribed minimum package of VMMC services (HIV counseling and testing, STI and general pre-operative screening, pre and post-operative counseling including wound care, risk reduction counseling, condom promotion and distribution) at static and mobile service delivery.	
- Strengthen linkages to care and treatment by providing counseling and referral of identified HIV-positive VMMC clients.	
- Support the community and facility staff in the provision of VMMC services offered in extended clinic hours.	
- Provide Technical Assistance to health workers in commodity management particularly Rapid Test Kit LMS at VMMC sites	
Support continuous quality improvement (CQI) activities for both VMMC static and mobile sites, with emphasis on quality indicators such as HTC coverage and AEs	
Support institutionalization of VMMC M&E systems, both electronic and paper based; strengthen M & E systems.	
Training, mentorship and supportive supervision of health workers in all aspects of VMMC service delivery including provision of HTC and emergency management of VMMC Adverse events.	

Table 5.1.7 HTC Maintenance Package

SCALE-UP	MAINTENANCE
- HTC training for HCWs & lay counselors in alignment with International standards	- RTK commodities procurement & distribution
- Provide HIV testing and counseling services to individuals, couples and families and to key and other priority populations in high prevalence areas and HIV hot spots;	- Targeted Technical Assistance to PMO/DMO
- Strengthen linkages from HTC to treatment, Care & support services.	- Support incorporation of quality assurance systems for HIV rapid testing
- Support site level service and data quality improvement/assurance activities	- Support the use of electronic and paper based systems to monitor linkages from HTC to care and treatment.
- Support incorporation of quality assurance systems for HIV rapid testing	
- Support the use of electronic and paper based systems to monitor linkages from HTC to care and treatment.	
- Support operations of mobile HTC services	

Table 5.1.8 Other Prevention Maintenance Package

SCALE-UP (activities tied to HTC sites yielding 80% of positives)	MAINTENANCE (activities tied to HTC sites with 5 or more positive yielding 20% of positive)
- Condom promotion and distribution, including; condom skills training, negotiation skills, and facilitate condom access (direct provision, linkages to social marketing outlets, and referrals)	- Condom distribution and targeted promotion to better reach key and priority populations
- Community-based behavior change/mobilization activities incorporating; targeted risk assessment and the provision of risk reduction information, education and/or counselling to correctly identify HIV prevention methods, reject transmission misconceptions, and accurately assess personal risk	- Targeted district and community level behavior change activities focusing on the highest risk groups with information on; HIV prevention, self-risk assessment information, and mitigation strategies
- Community and district level demand creation activities to increase	- Targeted district level demand creation activities

awareness, uptake, and acceptability of relevant clinical services (VMMC, PMTCT, TB, ARV treatment, and RH)	to increase awareness and uptake of clinical services
- Improved community linkages to facilities to increase access to HTC testing, VMMC, PMTCT, FP/HIV and treatment services, including; information sessions and active referrals	- Targeted activities to improve linkages between communities and facilities to increase access to testing and treatment services reaching the highest risk groups
- Community level activities that target adults to; raise awareness of HIV risks for young people, promote positive parenting/mentoring, and effective adult/child communication about sexuality and sexual risk reduction	
- Community level activities that promote gender equity, address harmful sex/gender norms, reduce HIV stigma, and prevent GBV	
- Lubricant promotion and distribution for key populations	

Table 5.1.9 Key Populations Maintenance Package

SCALE-UP (activities tied to HTC sites yielding 80% of positives)	MAINTENANCE (activities tied to HTC sites with 5 or more positive yielding 20% of positive)
- Condom promotion and distribution, including; condom skills training, negotiation skills, and facilitate condom access (direct provision, linkages to social marketing outlets, and referrals)	- Condom distribution and targeted promotion to better reach key and priority populations
- Behavior change activities incorporating; targeted risk assessment and the provision of risk reduction information, education and/or counselling to correctly identify HIV prevention methods, reject transmission misconceptions, and accurately assess personal risk	- Targeted district and community level behavior change activities focusing on the highest risk groups with information on; HIV prevention, self-risk assessment information, and mitigation strategies
- Prevention, testing, treatment and care of other infections (STIs, TB and Hepatitis)	- Targeted district level demand creation activities to increase awareness and uptake of clinical services
- Improved community linkages to facilities to increase access to HTC testing, ART, VMMC, PMTCT, FP/HIV and treatment services, including; information sessions and active referrals	- Targeted activities to improve linkages between communities and facilities to increase access to testing and treatment services reaching the highest risk groups
- Reproductive health services including family planning and PMTCT	
- Lubricant promotion and distribution for key populations	

Table 5.1.10 Treatment Maintenance Package

SCALE-UP	MAINTENANCE
- Targeted support for clinical staff positions	- Drugs and commodities procurement – National level
- Drugs and commodities procurement	- Technical Assistance to PMO/DMO for site maintenance
- Support site level Drug and commodities logistics management including distribution	- Targeted/periodic mentorship and on-site TA
- Laboratory support – equipment procurement & back-up supplies for CD4, VL	- Support patient tracking systems – electronic records, stationery, CHW's retention, equipment for CHW's
- Support for sample transport systems including but not limited to EID/DBS and VL samples" to the Saturation package	- Training/up-dates for attrition
- Support patient tracking systems – electronic records, stationery, CHW's retention, equipment for CHW's	- Support site level service and data quality improvement/assurance activities
- Support active case finding activities – PITC, targeted CBTC, index patient linked testing	
- Targeted infrastructural renovations	
- Support operations of mobile ART services	
- Support operations for extended clinic hours	

- Support implementation and operations of community ART services linked to supported sites
- Support site level service and data quality improvement/assurance activities
- On-site Mentoring & training

5.2 Transition plans for redirecting PEPFAR support to priority locations and populations

Prevention programs (apart from KPs) will transition maintenance areas to the GRZ over the period of one year and will move to areas of high yield by September 2016. Increased engagement of the GRZ in site supervision and M&E will provide sustainability of activities. The HTC program will be driven by the need to identify HIV infected persons in the communities and will move from areas of low positivity; thus, the HTC program will transition all low yield sites to the Provincial Health Offices within one year by September 2016. Anticipated challenges include the continuation of the same standard of services, including prevention services, which the USG was providing, the supply of HIV rapid test kits, the attrition of lay counselors, and the sustainability of community programs due to low levels of dedicated community staff and incentives.

The PMTCT and EIMC implementing partners will provide above site technical assistance in maintenance areas for purposes of quality assurance and provide periodic targeted site level technical assistance; transition to GRZ will occur by September 2016. Implementing partners in low prevalence / burden geographic areas will provide periodic targeted regional and site level technical assistance and will be transitioned to the government by September 2016.

For care and support, implementing partners providing palliative care have been advised to break out the components of their package of services; non-core components will not be supported by the end of FY15 and partners are to follow PEPFAR geographic refocusing in their implementation. Regarding cervical cancer, PEPFAR support will cease at the end of Sept 2015 for implementing partners using Pap smear and they will be advised to screen using VIA or refer to other partners that can support Pap smear.³¹ Clients requiring treatment will be referred to specialist treatment facilities. Additionally, on-going support will be limited to activities for quality assurance; no DSD support will be provided to transition or maintenance sites; TA will be reduced to leave only targeted TA support; no equipment procurement in these sites; and no renovations will be made in care and support sites.

All OVC sites receiving HKID funding under the Time to Learn education program of USAID are transition sites. As of FY15 no beneficiaries have been added and support to current beneficiaries will phase out through the end of the program in 2016. These beneficiaries receive support to complete secondary education. Non-core activities for OVC programming will cease in 2015, with the exception of a few remaining scholarship recipients who graduate at the end of 2016. All other OVC activities will occur in priority areas and top three hotspots in Eastern Province as scale-up or maintenance sites. As children graduate or move away for program sites that are maintenance, additional children will not be added which will allow for more resource allocation in scale up sites. DOD will transition out of 14 sites mostly located in the low prevalent areas in Luapula, Mansa, Northern and Northwestern. There are no activities classified as non-core for adult and pediatric treatment. As such, there are no plans for transitioning these activities.

³¹ PEPFAR does not fund cytologic screening such as pap smears or any prevention HPV vaccines but does support visual inspection with acetic acid or LEEP.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

Based on the results of the SID analysis and sustainability index, PEPFAR Zambia has examined those activities that must be included in laboratory strengthening to address access & demand, human resources for health, quality management, and commodity security and supply chain. In order to strengthen the laboratory infrastructure for improved access, quality, and coverage of HIV related diagnostic testing, PEPFAR Zambia will focus its core activities on:

- a. Provision of laboratory commodities
- b. Quality assurance programs for diagnosis of HIV, TB, other comorbidities, and opportunistic infections.
- c. Support for the enhancement of laboratory infrastructure
- d. Support for national equipment maintenance program
- e. Training and capacity building of staff
- f. Referral process improvement for laboratory specimens

6.2 Strategic information (SI)

Based on the results of the SID analysis and sustainability index, PEPFAR Zambia has examined those activities that must be included in strategic information (SI) to epidemiological and health data reporting, which is a priority for PEPFAR. In order to have an impact on the continuum of service cascade, PEPFAR Zambia will focus its core SI activities on:

- a. Strengthening M&E systems and improving data quality to inform data use in HIV program decision making including analysis and reporting;
- b. Providing technical assistance to build capacity of HRH to use Smart Care for HIV services;
- c. Improving HIV data quality and use by developing platforms to use national data from HMIS, SmartCare and vital registration; and
- d. Preparing for and conduct population based surveys that will contribute HIV epidemiologic data.

6.3 Health System Strengthening (HSS)

Based on the results of the SID, PEPFAR Zambia has examined those activities that must be included in health system strengthening to address access, demand, human resources for health, quality management, commodity security, and supply chain. HSS activities³² will include a

³² These activities will be implemented at national and sub-national levels. PEPFAR plans to expend substantially more resources supporting scale up HIV prevention, care and treatment services in high prevalence/disease burden locations compared to areas where maintenance packages of care will be provided. Notably, however, activities implemented in priority areas are likely to have positive spill over

sustainability strategy to ensure that investments are managed appropriately to help reach epidemic control by providing focused support in the following areas:

- a. Development of comprehensive electronic Human Resource Information System (eHRIS);
- b. Strengthening HR management to improve recruitment, deployment and retention of staff in high yield/volume sites³³;
- c. Implementation of quality management/improvement (QM/QI) methodologies;
- d. Strengthening national supply chain by improving commodity management systems;³⁴
- e. Supporting integrated procurement of commodities; improving distribution; and expanding storage capacity;
- f. Training and capacity building of staff;³⁵ and

effects in non-focus geographic areas. Additionally, PEPFAR will coordinate with and leverage resources of key stakeholders investing in health systems strengthening to promote efficiency and increase the impact of interventions.

³³ Recently, GRZ has made efforts to increase the health workforce by providing treasury authority for net recruitment of health professionals. Despite these efforts, the vacancy rate for clinical health worker positions is approximately 40 percent. Furthermore, pre-service training institutions have limited production capacity. PEPFAR will support pre-service training institutions to increase the production of new health workers by strengthening management capacity of schools, faculty development, procurement of teaching aids and training materials, and curriculum development and review. PEPFAR will work with GRZ to ensure that newly graduated health workers are recruited and preferentially deployed to high volume/yield sites in high prevalence geographic areas. This will include improvements to human resources through the development and roll out of an electronic human resource information system, training and orientations of HR staff, and implementation of task-sharing strategies. Additionally, PEPFAR will support needs-based in-service training, mentorship and supportive supervision of health providers and community health workers/volunteers.

³⁴ Technical area sustainability analyses identified stock-out of HIV commodities as a threat to achieving sustainable epidemic control, particularly for HTC, EID and VMMC activities that receive relatively low contribution from GRZ towards their procurement. PEPFAR will continue advocacy to GRZ to increase domestic financing on HIV commodities and support GRZ in conducting a national supply chain assessment to inform the National Supply Chain Strategy and Implementation Plan. USG will continue to support capacity building in commodity quantification and forecasting, warehousing, distribution, and expansion of storage space at sub-national level.

³⁵ One challenge faced by the PEPFAR team in formulating interventions to address the critical shortage of staff is the paucity of information on the staffing situation in high yield/volume sites. To address this, PEPFAR will use an existing mechanism (Emory University) to conduct an HRH assessment using FY 2014 funds. The assessment is expected to be completed before the end of FY15 so that the findings can inform investment decisions for COP 2016.

- g. Continuing to build on sustainable financing strengths³⁶ and relationships with civil society and GRZ³⁷.

Based on the results of the SID and technical area bottleneck/gap analyses, PEPFAR Zambia has identified priority health systems strengthening (HSS) activities that must be implemented to address weaknesses in domestic resource mobilization, access to and demand for HIV services, human resources for health, commodity security and supply chain, and stewardship and ownership. In addressing these, PEPFAR will coordinate with and leverage resources of key stakeholders to promote efficiency and increase the impact of interventions.

The SID indicates that less than 40% of health facilities in high-prevalence areas provide ART and PMTCT services. Existing high volume/yield facilities have insufficient space to provide services and only 25% of health facilities in Zambia have appropriate laboratory infrastructure to support service delivery. In FY16, PEPFAR will support targeted infrastructure improvements to increase access to services in these facilities. Furthermore, the SID and technical area analyses suggest that key populations may not be freely accessing HIV services. In response, PEPFAR will strengthen the capacity of civil society organizations to advocate for non-discriminatory rights for all persons to access HIV services.

³⁶ Despite recent increases in GRZ spending on HIV, domestic resources finance only 10 percent of the national response. Increased domestic resource mobilization and expenditure is required in order to assure sustainable results as the country progresses towards epidemic control. PEPFAR will support accelerating progress towards sustainable financing of the HIV response. Zambia is a Phase 2 country under USAID's Bold Vision Initiative. In FY16, PEPFAR will provide technical and financial support to conduct National Health Accounts and other health financing surveys that will be used to advocate for increased domestic resource commitment towards health and the HIV response. Additionally, PEPFAR will focus on increasing efficiency and promoting innovative financing methods that leverage private sector resources.

³⁷ The SID analysis revealed that formal channels for civil society participation have weakened significantly over the years. PEPFAR will focus on improving strategic capabilities of targeted local civil society organizations to enhance delivery, oversight and ownership of HIV service delivery, particularly in high prevalence/disease burden locations. Activities will focus on improving the ability of citizens to demand, and GRZ to deliver HIV services in a transparent, accountable manner through improvements to the HIV/AIDS policy and legal environment.

7.0 Staffing Plan

Given the greater emphasis on data, evidence, monitoring, and accountability, PEPFAR Zambia repurposed existing positions and added additional technical staff to support care (OVC), treatment, strategic information, and SIMS implementation. The additional human resources will strengthen the implementation of SIMS, foster routine data quality assurance checks, and promote thorough reviews of data to adjust programs across the interagency USG team. Presence at the provincial level would allow for greater coordination between the provincial and district government partners, donors, and USG-funded projects for implementation. Moreover, placement of staff at the provincial level will help ensure that PEPFAR funds are used efficiently and harmonized with GRZ and other donor activities to foster greater accountability and eventual country ownership of local programs. To support a growing team and increased monitoring visits, administrative staff will provide the necessary logistics for successful implementation.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15			
Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	X	X	
Sub-national level	X	X	
National level	X	X	X
Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15			
Prevention	<ul style="list-style-type: none"> a. Quality VMMC services targeting ages 15-29 through static and mobile sites; b. Scale up PMTCT Option B+ with emphasis on retention of mother-baby pairs “along the continuum of care” and establishment of M&E systems; c. Condom promotion and distribution; d. Targeted HIV prevention interventions reaching highest risk populations; e. Support community linkages/systems to timely access services in: ARV treatment and adherence, care & support, VMMC and PMTCT; f. Strengthen PHDP (positive health, dignity, and prevention) programs. 	<ul style="list-style-type: none"> a. Expand coverage of provider initiated testing and counseling (PITC) targeting high yield populations; b. Family Planning/ HIV integration; c. Integrated Social Behavior Change Communication in PMTCT, HTC, VMMC and other programs; including girls empowerment d. Lubricant promotion and distribution for key populations. 	<ul style="list-style-type: none"> a. Blood safety; b. Early infant male circumcision; c. PMTCT Option A d. General mass media prevention.
Counseling and Testing	<ul style="list-style-type: none"> a. Quality HIV testing and counseling services to individuals, couples and families and to key and other priority populations in high prevalence areas and HIV hot spots; b. Support community linkages/systems to timely access services in HTC (and early 	<ul style="list-style-type: none"> a. HTC for generalized population in maintenance sites; b. Expand coverage of provider initiated testing and counseling (PITC) targeting high yield populations; 	

	diagnosis).		
Care and Support	<ul style="list-style-type: none"> a. Strengthen FP/HIV integration for PLHIV on care; b. Continue providing support to GBV survivors; c. Improving patient record management; d. Early identification of HIV-infected persons, and improve linkage, adherence and retention in care using: <ul style="list-style-type: none"> - Community support groups, care givers and volunteers - Commodities which increase uptake of care-CTX; e. Point of Care (POC) CD4/VL testing, case management, IEC/BCC, care groups, patient tracking system(SMS)Clinical assessment and staging, measurement of CD4 count, and Dx and RX of OI; f. HIV testing of Children for early Identification; g. CTX prophylaxis and basic health interventions for HIV-exposed and –infected children; h. Elimination of new HIV infections among Children and keeping their mothers alive by improve the 	<ul style="list-style-type: none"> a. OI Prevention and Treatment; b. Cervical Cancer Screening; c. Strengthen community /facility referral system on nutrition; d. Training, capacity building, and institutional support activities to integrate nutrition in health facilities; e. Support the documentation of nutrition categorization and results in medical records; f. Strengthen community based support for HIV/AIDS-affected families who are suspected to be at greater risk of malnutrition; g. Develop national guidelines, training and reference materials, and job aids for the implementation of NACS; h. Incorporate pre-service training on the integration of NACS into HIV and TB care into medical and nursing education partnership initiatives; i. Strengthen the harmonization of the NACS approach and Integrated Management of Malnutrition (IMAM) 	

	<p>postnatal continuum of PMTCT care for HIV-infected mothers and their infants;</p> <ul style="list-style-type: none"> i. Strengthen the facility and community linkage and retention of infants, children and adolescents in life-long care and treatment; j. Strengthen EID including funding for DBS commodities; k. Improve infant feeding focusing on high impact interventions in the first 1000 days for pregnant mother and children; l. Improve basic child health interventions for HIV-exposed, -infected, and -affected children: PMTCT/Pediatric HIV/MNCH Integration; m. Provider Initiated Testing and Counseling to all patients with presumptive TB or TB disease for HIV; n. Providing Cotrimoxazole preventive therapy for HIV positive TB patients; o. Scaling up ART for PLHIV with TB: (Integration of TB and HIV services, strengthen linkages and referral systems between the two programs and training of staff); p. Providing TB infection control measures in HIV program areas: (Provide minor renovations to accommodate TB/HIV services, develop, print and distribute IEC materials, education of patients, 	<p>services;</p> <ul style="list-style-type: none"> j. Community-based nutrition support to strengthen the linkages between the health sector and the community in order to guarantee a continuum of care; k. Therapeutic /Supplementary feeding support for clinically wasted patients; l. Strengthen anthropometric assessments at the facility and community levels; m. Support to National, Provincial, district and facility TB/HIV coordinating bodies; n. Updating TB/HIV monitoring and evaluation tools (recording and reporting tools including electronic tools: presumptive TB and diagnostic/Treatment registers, treatment/identity cards and quarterly report forms); o. Evaluation of the updated recording and reporting tools; p. Conducting quarterly TB/HIV data review meetings; q. Providing technical support through Site Improvement Monitoring System; Semiannual and annual progress reports. 	
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	<p>procurement of Personal Protective equipment, Triaging of patients;</p> <p>q. Screening PLHIV for TB and other special populations: (Pregnant women, pediatrics, prisoners at entry and exit, miners and provide clinical care, strengthen linkages and referral systems between the two programs;</p> <p>r. Laboratory investments for TB/HIV (Increase TB/HIV diagnostic centers, provide diagnostics-genexpert, biosafety cabinets, AFB smear and culture;</p> <p>s. Provide Isoniazid Preventive Therapy to PLHIV with no signs of active TB: INH availability, orientation on data collecting and reporting tools, training of health care providers.</p>		
<p>Treatment</p>	<p>a. Clinical staging/CD4 measurement/Viral load</p> <p>b. Early identification of children for HIV treatment – including EID</p> <p>c. Focus on pediatric and adolescent ART initiation and retention</p> <p>d. Implementation of integrated HTC & ART continuum of care service models to increase early case finding, adherence/retention, and strengthening linkage between HTC to care & treatment</p> <p>e. Electronic Health Record roll-out for optimized patient monitoring and supporting strengthened</p>	<p>a. Nutritional Assessment counselling and support</p> <p>b. Management of opportunistic infections</p> <p>c. Support community linkages/systems to access HTC, ARV treatment and adherence, care & support, VMMC and PMTCT services</p> <p>d. Training for community based support groups including SMAGs, TBAs, HBC, Adherence Supporters and Youth Peer Educators</p> <p>e. Support ART transition monitoring and evaluation</p> <p>f. Pre-service training</p>	

	<p>adherence & retention interventions</p> <ul style="list-style-type: none"> f. PHDP (positive health, dignity and prevention) programs for PLHIV within treatment services g. Support ART service delivery targeting Key populations h. Scale-up ART service delivery via static, mobile and community care & treatment models, including targeted infrastructure improvement and equipment procurement i. Integration and decentralization of PMTCT and ART services j. Targeted program evaluations to inform service delivery improvements k. Provision of ART in TB treatment settings (TB/HIV collaborative activities) and ANC settings (B+) l. Support laboratory capacity, quality and accreditation m. Supply Chain TA to assure commodity availability at site level n. Procurement of HIV commodities: ARVs, EID, HIV test kits, viral load) o. Quality assurance/quality improvement - cross cutting across program areas p. In-service trainings 	<ul style="list-style-type: none"> g. AIDS Indicator Survey h. HIV Drug resistance monitoring 	
Lab	<ul style="list-style-type: none"> a. Work with stakeholders to identify laboratory gaps and address needs. b. Expand enrollment and number of analytes currently evaluated in Proficiency Test (PT) programs c. Continue and extend SLMTA training programs laboratories toward 	<ul style="list-style-type: none"> a. Establish capacity for evaluating new diagnostics b. Improve and re-establish diagnostic bacteriology services toward control of opportunistic infections and comorbidities in PLHIV in high impact Provinces 	

	<p>accreditation in high impact provinces and targeted facilities.</p> <p>d. Continue and expand EQA activities in high impact provinces and targeted sites for laboratory diagnosis of HIV, TB and other comorbidities and opportunistic infections.</p> <p>e. Address national deficiencies in biosafety training for laboratory staff and implementation of biosafety procedures in clinical laboratories</p> <p>f. Address national deficiencies in procurement and distribution of laboratory supplies</p> <p>g. Enhance QA/QI procedures for HIV RT in Zambia</p> <p>h. Build laboratory equipment maintenance capacity in Zambia</p> <p>i. Work with MOH to improve laboratory specimen referral systems in Zambia</p> <p>j. Provision of appropriate laboratory equipment</p>	<p>and targeted sites</p> <p>c. Support CDC HQ initiatives for broad health infrastructure improvements in Zambia</p> <p>d. Expand availability of Laboratory Information and Data Management Systems in high impact Provinces and at targeted sites.</p> <p>e. Work to improve and enhance curriculum development, pre-service training and staff retention for laboratory staff</p> <p>f. Continue to improve laboratory infrastructure to accommodate appropriate lab equipment.</p>	
HSS	<p>g. Support in- service training, mentorship/supervision and performance assessment to improve HRH performance and of quality HIV services in high volume/yield sites and high burden geographic areas.</p> <p>h. Strengthen national supply chain by improving national commodity management systems; supporting integrated procurement of HIV commodities; improving distribution; and expanding storage capacity</p>	<p>a. Support Development of comprehensive electronic Human Resource Information System (eHRIS) to improve HR management in high volume/yield sites and high burden geographic areas.</p> <p>b. Support pre-service training to increase the number and improve quality of HRH in high volume/yield sites and high burden geographic areas.</p> <p>c. Strengthen HR management to improve recruitment, deployment & retention of staff in high yield/volume sites.</p> <p>d. Support training and supervision of community health workers/volunteers to</p>	

		<p>increase linkages between facilities and communities in high burden geographic areas.</p> <ul style="list-style-type: none"> e. Support for implementation of the quality management/improvement (QM/QI) methodologies in high volume/yield sites and high burden geographic areas f. Targeted health infrastructure improvement and/or provision of equipment to increase access to quality HIV services in high volume/yield sites and high burden geographic areas. g. Strengthen oversight and management capacity of GRZ and local organizations to improve service delivery, transparency, accountability and efficiencies in the national HIV/AIDS response. h. Support efforts to accelerate progress towards sustainable financing of the national HIV/AIDS response. i. Build national capacity for epidemic control through support for the National Public Health Institute 	
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APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$US 12,397,274	\$US 313,297,357	\$US 325,694,631
Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	21,852,456
HVAB	Abstinence/Be Faithful Prevention	2,552,355
HVOP	Other Sexual Prevention	8,723,609
IDUP	Injecting and Non-Injecting Drug Use	0
HMBL	Blood Safety	783,644
HMIN	Injection Safety	0
CIRC	Male Circumcision	12,284,272
HVCT	Counseling and Testing	13,494,331
HBHC	Adult Care and Support	24,173,214
PDCS	Pediatric Care and Support	13,208,130
HKID	Orphans and Vulnerable Children	27,750,812
HTXS	Adult Treatment	52,515,339
HTXD	ARV Drugs	52,289,499
PDTX	Pediatric Treatment	16,568,941
HVTB	TB/HIV Care	15,669,377
HLAB	Lab	8,836,770
HVSI	Strategic Information	10,127,070
OHSS	Health Systems Strengthening	16,136,043
HVMS	Management and Operations	29,753,768
TOTAL		325,694,631

B.2 Resource Projections

Summary of Cost-Savings from Transition Sites*

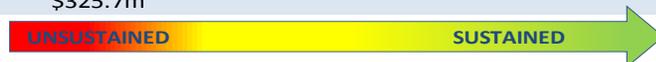
Transition	Transition	Cost/Unit	Est. Cost
HTC	96,252	8.67	834,505
ART	3,598	82.95	298,454
PMTCT	25,819	6.1	157,496
Total			1,290,455

Savings documented in Table B.2.1 are from 3 budget codes—HTC, ART, and PMTCT. Due to limited functionality of the PBAC and SEAT, PEPFAR Zambia made assumptions to manually generate cost savings from these budget codes.

APPENDIX C

Sustainability Analysis for Epidemic Control: ZAMBIA

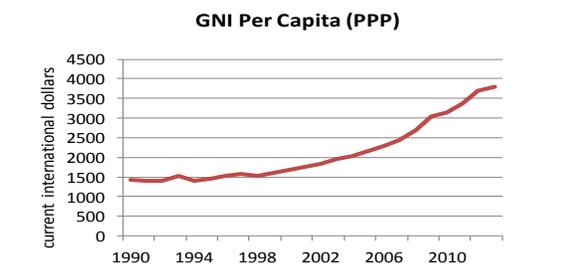
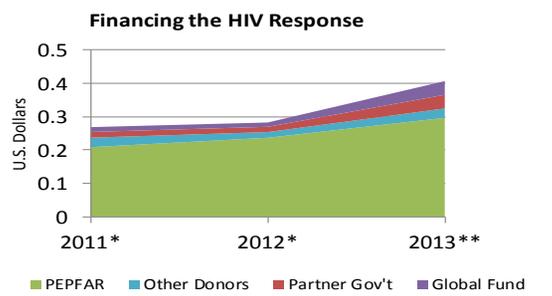
Epidemic Type: Generalized
Income Level: Lower Middle Income
PEPFAR Categorization: Long Term Strategy
COP 15 Planning Level: \$325.7m



SUSTAINABILITY DOMAINS AND ELEMENTS

Institutionalized Data Availability	Score
1. Epidemiological and Health Data	10.6
2. Financial/Expenditure Data	17.0
3. Performance Data	16.0
Domestic Program and Service Delivery	
4. Access and Demand	7.8
5. Human Resources for Health	14.8
6. Commodity Security and Supply Chain	15.0
7. Quality Management	14.0
Health Financing and Strategic Investments	
8. DRM: Resource Generation	9.0
9. DRM: Resource Commitments	7.0
10. Allocative Efficiency	16.0
11. Technical Efficiency	17.3
Accountability and Transparency	
12. Public Access to Information	11.0
13. Oversight and Stewardship	12.0
Enabling Environment	
14. Policies, Laws, and Regulations	10.0
15. Planning and Coordination	15.0

CONTEXTUAL DATA



CONTEXTUAL DATA

