

Grant Confirmation

1. This **Grant Confirmation** is made and entered into by **the Global Fund to Fight AIDS, Tuberculosis and Malaria** (the "Global Fund") and **The Ministry of Health and Child Care of the Republic of Zimbabwe** (the "Principal Recipient") on behalf of the Republic of Zimbabwe (the "Grantee"), as of the date of the last signature below and effective as of the start date of the Implementation Period (as defined below), pursuant to the Framework Agreement, dated as of 17 November 2014, as amended and supplemented from time to time (the "Framework Agreement"), between the Global Fund and the Grantee, to implement the Program set forth herein.
2. **Single Agreement.** This Grant Confirmation, together with the Integrated Grant Description attached hereto as Schedule I, sets forth the provisions (including, without limitation, policies, representations, covenants, Program Activities, Program budget, performance framework, and related implementation arrangements) applicable to the Program, and forms part of the Grant Agreement. Each capitalized term used but not defined in this Grant Confirmation shall have the meaning ascribed to such term in the Framework Agreement (including the Global Fund Grant Regulations (2014), available at <http://www.theglobalfund.org/GrantRegulations>). In the event of any inconsistency between this Grant Confirmation and the Framework Agreement (including the Global Fund Grant Regulations (2014)), the provisions of this Grant Confirmation shall govern unless expressly provided for otherwise in the Framework Agreement.

3. **Grant Information.** The Global Fund and the Grantee hereby confirm the following:

3.1	Host Country or Region:	Republic of Zimbabwe
3.2	Disease Component:	Malaria
3.3	Program Title:	Moving Zimbabwe Towards Malaria Elimination: Strengthening Evidence-Based Programming
3.4	Grant Name:	ZWE-M-MOHCC
3.5	GA Number:	1932
3.6	Grant Funds:	Up to the amount of USD 62,862,864 or its equivalent in other currencies
3.7	Implementation Period:	From 1 January 2021 to 31 December 2023 (inclusive)
3.8	Principal Recipient:	The Ministry of Health and Child Care of the Republic of Zimbabwe Ministry of Health & Child Care Causeway Kaguvu Building, 5th Floor

		Cnr 4th / Central Avenue PO Box CY 1122 Harare Republic of Zimbabwe Attention: Dr. Jasper Chimedza Permanent Secretary Telephone: +263242798620 Email: chimedzaj@gmail.com
3.9	Fiscal Year:	1 January to 31 December
3.10	Local Fund Agent:	PricewaterhouseCoopers Advisory Services (Private) Limited Arundel Office Park, Building 4, Norfolk Road, Mount Pleasant Harare Republic of Zimbabwe Attention: Esther Antonio Partner Telephone: +41 587929100 Email: antonio.esther@zw.pwc.com
3.11	Global Fund contact:	The Global Fund to Fight AIDS, Tuberculosis and Malaria Global Health Campus, Chemin du Pommier 40 1218 Grand-Saconnex, Geneva, Switzerland Attention: Linden Morrison Department Head Grant Management Division Telephone: +41587911700 Facsimile: +41445806820 Email: linden.morrison@theglobalfund.org

4. **Policies.** The Grantee shall, and shall cause the Principal Recipient to, take all appropriate and necessary actions to comply with (1) the Global Fund Guidelines for Grant Budgeting (2019, as amended from time to time), (2) the Health Products Guide (2018, as amended from time to time), and (3) any other policies, procedures, regulations and guidelines, which the Global Fund may communicate in writing to the Grantee and the Principal Recipient, from time to time.
5. **Representations.** In addition to the representations set forth in the Framework Agreement (including the Global Fund Grant Regulations (2014)), the Principal Recipient hereby represents that the Principal Recipient has all the necessary power, has been duly authorised by or obtained all necessary consents, approvals and authorisations to execute and deliver this Grant Confirmation and to perform all the obligations on behalf of the Grantee under this Grant Confirmation. The execution, delivery and performance by the Principal Recipient on behalf of the Grantee of this Grant Confirmation do not violate or conflict with any applicable law, any provision of the Grantee's and Principal Recipient's constitutional documents, any order or

judgment of any court or any competent authority, or any contractual restriction binding on or affecting the Grantee or the Principal Recipient.

6. **Covenants**. The Global Fund and the Grantee further agree that:

6.1 Personal Data

(1) Principles. The Principal Recipient, on behalf of the Grantee, acknowledges that Program Activities are expected to respect the following principles and rights ("Data Protection Principles"):

(a) Information that could be used to identify a natural person ("Personal Data") will be: (i) processed lawfully, fairly and transparently; (ii) collected for specified, explicit and legitimate purposes and not further processed in a manner not compatible with those purposes; (iii) adequate, relevant and limited to what is necessary for the purposes for which they are processed; (iv) accurate and, where necessary, kept up to date; (v) kept in a form which permits identification of the individuals for no longer than is necessary for the purposes for which the Personal Data is processed; and (vi) processed in a manner that ensures appropriate security of the Personal Data; and

(b) Natural persons are afforded, where relevant, the right to information about Personal Data that is processed; the right to access and rectify or erase Personal Data; the right to data portability; the right to confidentiality of electronic communications; and the right to object to processing.

(2) Limitations. Where collection and processing of Personal Data is required in order to implement Program Activities, whether by the Principal Recipient, a Sub-recipient, or Supplier, the Principal Recipient should respect the Data Protection Principles:

(a) to the extent that doing so does not violate or conflict with applicable law and/or policy; and

(b) subject to the Principal Recipient balancing the Data Protection Principles with other fundamental rights in accordance with the principle of proportionality, taking into account the risks to the rights and freedoms of natural persons.

6.2 With respect to Section 7.6 (Right of Access) of the Global Fund Grant Regulations (2014), (1) the Global Fund may collect or seek to collect data, and it is possible that such data may contain Personal Data, and (2), prior to collection and at all times thereafter, the Principal Recipient shall take all necessary actions to ensure that the transfer of such information to the Global Fund does not violate any applicable law or regulation.

6.4 The Program budget may be funded in part by Grant Funds disbursed under a previous Grant Agreement, which the Global Fund has approved to be used for the Program under the current Grant Agreement ("Previously Disbursed Grant Funds"), as well as additional Grant Funds up to the amount set forth in Section 3.6. hereof. Accordingly, the Global Fund may reduce the amount of Grant Funds set forth in Section 3.6. hereof by the amount of any Previously Disbursed Grant Funds. Previously Disbursed Grant Funds shall be governed by the terms of this Grant Agreement.

6.5 The procurement of health and non-health products with Grant Funds shall be carried out through the Global Fund's Pooled Procurement Mechanism (PPM), the Global Drug Facility (GDF) or a suitably qualified procurement agent, subject to Global Fund approval in its sole discretion, until the Global Fund has agreed in writing that procurement of these items can be managed by the Grantee or the Principal Recipient using a different process.

6.6 Fund Administrator

(1) The United Nations Development Programme (the "Fund Administrator") is expected to perform certain functions in order to safeguard Grant Funds, including financial management and support with the procurement of health and non-health products to be sourced through the PPM or GDF. Throughout the Implementation Period, the Principal Recipient acting on behalf of the Grantee shall fully cooperate and work with the Fund Administrator and shall provide all the requested documents and information to the Fund Administrator and/or the Global Fund as are considered necessary by the Global Fund in its sole discretion. For the avoidance of doubt, the Principal Recipient acting on behalf of the Grantee shall submit all the document and reports required under Section 6.2 of the Global Fund Grant Regulations (2014) to the Global Fund with the copy to the Fund Administrator.

(2) Expenditures, for which the Fund Administrator's recommendation is required, as notified by the Global Fund to the Principal Recipient acting on behalf of the Grantee, shall be deemed ineligible if the Principal Recipient fails to comply with the notification of the Global Fund or the relevant recommendation from the Fund Administrator and, under such circumstances, the amounts equal to such expenditures shall be promptly refunded to the Global Fund.

(3) The Principal Recipient acknowledges and agrees that the Global Fund reserves the right to classify any expenditure of Grant Funds, regardless of pre-verification or endorsement by the Fund Administrator, as ineligible and in breach of this Agreement, in which case Section 11.1 of the Global Fund Grant Regulations (2014) shall apply and, under such circumstances, the amounts equal to such expenditures shall be promptly refunded to the Global Fund.

6.7 Notwithstanding any amounts provided in the Program budget, no severance payment shall be paid to any staff members from Grant Funds unless and until an adequate legislative basis for such severance payments is provided and approved by the Global Fund in its sole discretion; any severance payments for a particular budget year that are not adequately substantiated and/or paid in the Global Fund's sole discretion prior to end of such calendar year shall be reprogrammed for a subsequent year, subject to approval by the Global Fund in its sole discretion.

6.8 In accordance with the Global Fund Board Decision on additional support for country responses to COVID-19 (GF/B42/EDP11), the Program budget includes USD 11,178,531 in funding granted under the Global Fund COVID-19 Response Mechanism ("C19RM Funds") programmed towards activities to respond to the COVID-19 pandemic ("Approved C19RM Activities"). Notwithstanding anything to the contrary in the Grant Agreement, C19RM Funds must remain invested in the Approved C19RM Activities and may only be reprogrammed upon prior written approval by the Global

Fund, provided that C19RM Funds are not used after 30 June 2021, unless otherwise expressly agreed in writing by the Global Fund.

[Signature Page Follows.]

IN WITNESS WHEREOF, the Global Fund and the Principal Recipient, acting on behalf of the Grantee, have caused this Grant Confirmation to be executed and delivered by their respective duly authorized representatives on their respective date of signature below.

**The Global Fund to Fight AIDS,
Tuberculosis and Malaria**

By: M.A. Eldon Edington

Name: Mark Eldon-Edington

Title: Head, Grant Management Division

Date: 2/12/2020

**The Ministry of Health and Child Care of the
Republic of Zimbabwe**

on behalf of the Republic of Zimbabwe

By: Jasper Chimedza

Name: Jasper Chimedza

Title: Permanent Secretary

Date: 30/11/20

Acknowledged by

By: Jasper Chimedza

Name: Jasper Chimedza

Title: Chair Country Coordinating Mechanism of Republic of Zimbabwe

Date: 30/11/20



By: Walter Chikanya

Name: Walter Chikanya

Title: Civil Society Signatory Country Coordinating Mechanism of Republic of Zimbabwe

Date:

Schedule I

Integrated Grant Description

A. PROGRAM DESCRIPTION

1. Background and Rationale for the Program

Despite the numerous and on-going economic challenges in Zimbabwe, the malaria program has consistently managed to achieve high level of performance driving the impact. The Zimbabwe malaria control program is one of the strongest performing on the African continent, with malaria mortality having reduced by 75% and malaria incidence by 83.8% over the past two decades. Despite the progress made, a lot of effort is still needed for the program to achieve the target of reducing malaria incidence to 5/1000 and reaching 90% decline in malaria mortality from 2015 baseline according to the National Malaria Strategic Plan (2021–2025). The national malaria program is at an advanced stage of implementing activities that are targeting high burden areas with a plan to expand the elimination districts from current 6 to 28. The goal is to ensure that Zimbabwe is malaria-free by 2030, hence contributing to the efforts of SADC regional Malaria Elimination 8 initiative.

This new grant is aligned with the Zimbabwe National Malaria Control Program and Elimination Strategic Plan (ZMCESP) 2021-2025. The choice of interventions is based on the principle that the case management builds on epidemiology surveillance and that there is no overlap of vector control interventions. Capacity building in entomologic monitoring and a focus on the quality of IRS will complement targeting of the interventions to maximize impact, and a strategic shift has been made to move away from one-time LLINs mass campaign to rolling campaign that addresses issues of LLINs durability, potency and overall operational costs and demand. The strategy is underpinned by HRH resources retention and strong health management information systems. Investing more than 56% of the funds into the malaria prevention efforts consisting of the IRS, LLINs, IPTp and the associated SBCC interventions has greatly helped in increasing the population protected. The focus is to use the most effective interventions and technologies to drive down the disease mortality and morbidity while investing in the right tools and technologies for the malaria response based on home-grown evidence and appropriate global best practices and guidance. Importantly, the procurement of key commodities for this grant through Global Fund's PPM will ensure that >50% investment in health products will be from quality assured sources at the lowest possible costs.

The malaria program will continue to be implemented in Zimbabwe through the Ministry of Health and Child Care, with the United Nations Development Programme acting as Fund Administrator, an arrangement established in 2015 that has provided stable operational mechanisms for the implementation of Global Fund funding.

2. Goals, Strategies and Activities

Goal: To reduce the malaria incidence to 5/1000 and malaria deaths by at least 90% of the 2015 figure by 2025.

Objectives:

- To protect at least 85% of population at risk of malaria with an appropriate malaria prevention intervention
- To provide prompt and quality assured diagnosis for all malaria suspected cases and treatment to all confirmed cases

- To achieve zero malaria transmission in 20 districts and increase the elimination districts to 36 by 2025
- To increase utilization of malaria interventions to at least 85% of the targeted population by 2025
- To strengthen surveillance, monitoring and evaluation and operational research
- To foster an enabling environment for optimal program implementation and impact

Strategies:

- Build active case detection capacity in 8 new districts;
- IRS: differentiated geographical tailoring of insecticides; focus on quality; timing of interventions for impact; transitioning of IRS to LLIN in low prevalence districts;
- Capacity building in entomologic monitoring; improved epidemic preparedness and response;
- LLINs: shift from mass campaign to rolling campaign

Planned Activities:

- Vector Control: IRS; LLIN mass campaign (universal coverage); LLIN continuous distribution; entomological monitoring and surveillance; IEC/BCC
- Case management: quality assured malaria diagnosis; quantification and procurement of ACTs; health worker capacity building for quality case management including trainings, supervision and audits; integrated community case management (iCCM) including training and procurement of RDTs for CHWs; training for private sector case management; elimination activities and surveillance; epidemic preparedness, IEC/BCC; IPTp

3. Target Group/Beneficiaries

- General population;
- Children; and
- Pregnant women.

B. PERFORMANCE FRAMEWORK

Please see attached.

C. SUMMARY BUDGET

Please see attached.

Country	Zimbabwe
Grant Name	ZWE-M-MOHCC
Implementation Period	01-Jan-2021 - 31-Dec-2023
Principal Recipient	The Ministry of Health and Child Care of the Republic of Zimbabwe

By Module	01/01/2021 - 31/03/2021	01/04/2021 - 30/06/2021	01/07/2021 - 30/09/2021	01/10/2021 - 31/12/2021	Total Y1	01/01/2022 - 31/03/2022	01/04/2022 - 30/06/2022	01/07/2022 - 30/09/2022	01/10/2022 - 31/12/2022	Total Y2	01/01/2023 - 31/03/2023	01/04/2023 - 30/06/2023	01/07/2023 - 30/09/2023	01/10/2023 - 31/12/2023	Total Y3	Grand Total	% of Grand Total	
Case management	\$176,433	\$502,689	\$522,494	\$599,087	\$1,800,703	\$681,472	\$766,992	\$707,291	\$748,438	\$2,904,194	\$321,036	\$520,511	\$609,231	\$365,822	\$1,816,600	\$6,521,496	10.4 %	
COVID-19		\$11,178,531			\$11,178,531											\$11,178,531	17.8 %	
Program management	\$848,345	\$874,152	\$977,889	\$895,623	\$3,596,009	\$801,933	\$836,414	\$560,744	\$555,037	\$2,754,128	\$477,838	\$401,345	\$371,945	\$391,971	\$1,643,100	\$7,993,238	12.7 %	
RSSH: Financial management systems					\$17,775	\$17,775				\$17,775						\$35,550	0.1 %	
RSSH: Health management information systems and M&E	\$86,031	\$177,490	\$344,905	\$43,850	\$652,276	\$758,323	\$1,322,293	\$48,230	\$34,925	\$2,163,771	\$1,001,400	\$3,525	\$17,200	\$3,525	\$1,025,650	\$3,841,698	6.1 %	
RSSH: Human resources for health, including community health workers																	0.0 %	
RSSH: Integrated service delivery and quality improvement										\$17,850	\$17,850		\$9,440		\$9,440	\$27,290	0.0 %	
Specific prevention interventions (SPI)					\$20,475		\$20,475		\$34,100	\$120,040		\$5,940	\$160,080				\$180,555	0.3 %
Vector control	\$126,105	\$435,076	\$7,849,197	\$2,480,235	\$10,890,614	\$480,005	\$304,408	\$13,311,531	\$1,803,397	\$15,899,341	\$301,089	\$95,534	\$4,137,881	\$1,760,048	\$6,294,552	\$33,084,507	52.6 %	
Grand Total	\$1,236,914	\$13,167,938	\$9,714,960	\$4,036,571	\$28,156,383	\$2,755,834	\$3,350,147	\$14,645,572	\$3,165,587	\$23,917,139	\$2,101,363	\$1,030,356	\$5,136,258	\$2,521,366	\$10,789,342	\$62,862,864	100.0 %	

By Cost Grouping	01/01/2021 - 31/03/2021	01/04/2021 - 30/06/2021	01/07/2021 - 30/09/2021	01/10/2021 - 31/12/2021	Total Y1	01/01/2022 - 31/03/2022	01/04/2022 - 30/06/2022	01/07/2022 - 30/09/2022	01/10/2022 - 31/12/2022	Total Y2	01/01/2023 - 31/03/2023	01/04/2023 - 30/06/2023	01/07/2023 - 30/09/2023	01/10/2023 - 31/12/2023	Total Y3	Grand Total	% of Grand Total
Human Resources (HR)	\$316,015	\$316,015	\$316,015	\$2,344,576	\$3,292,620	\$328,033	\$348,331	\$189,727	\$1,856,014	\$2,722,104	\$177,796	\$177,796	\$177,796	\$1,844,083	\$2,377,473	\$8,392,197	13.4 %
Travel related costs (TRC)	\$446,537	\$953,661	\$1,363,142	\$1,016,864	\$3,780,204	\$1,331,077	\$970,379	\$1,282,894	\$378,859	\$3,963,208	\$210,901	\$182,098	\$311,188	\$154,526	\$858,713	\$8,602,126	13.7 %
External Professional services (EPS)	\$394,354	\$305,671	\$589,245	\$357,419	\$1,646,689	\$553,260	\$303,661	\$232,187	\$268,437	\$1,357,545	\$415,544	\$137,756	\$144,006	\$137,756	\$835,063	\$3,839,297	6.1 %
Health Products - Pharmaceutical Products (HPPP)		\$267,481	\$124,894	\$68,275	\$460,650	\$283,775	\$338,092	\$60,281	\$56,364	\$738,512	\$158,469	\$425,368			\$583,837	\$1,782,999	2.8 %
Health Products - Non-Pharmaceuticals (HPNP)		\$8,794,246	\$3,977,242	\$72,638	\$12,844,125	\$29,268		\$10,518,183	\$371,814	\$10,919,264	\$64,904		\$3,367,964	\$205,900	\$3,638,767	\$27,402,157	43.6 %
Health Products - Equipment (HPE)					\$1,593,502					\$430,767					\$430,767	\$2,455,036	3.9 %
Procurement and Supply-Chain Management costs (PSM)		\$2,327,072	\$718,356	\$56,654	\$3,102,081	\$29,256	\$12,668	\$1,729,666	\$139,967	\$1,911,557	\$24,673	\$10,494	\$614,557	\$121,802	\$771,527	\$5,785,165	9.2 %
Non-health equipment (NHP)	\$47,204	\$104,417	\$868,404	\$47,204	\$1,067,229	\$89,554	\$1,289,522	\$70,290	\$34,890	\$1,484,256	\$1,035,390	\$34,890	\$34,890	\$34,890	\$1,140,060	\$3,691,546	5.9 %
Communication Material and Publications (CMP)		\$33,972	\$98,758	\$6,550	\$139,280	\$78,808	\$11,030	\$77,406	\$3,750	\$170,994	\$2,800	\$41,970	\$35,106	\$2,150	\$82,026	\$392,300	0.6 %
Indirect and Overhead Costs	\$32,804	\$65,403	\$65,403	\$66,391	\$230,001	\$32,804	\$76,464	\$54,171	\$55,494	\$218,932	\$10,886	\$19,983	\$20,258	\$71,110	\$520,042		0.8 %
GrandTotal	\$1,236,914	\$13,167,938	\$9,714,960	\$4,036,571	\$28,156,383	\$2,755,834	\$3,350,147	\$14,645,572	\$3,165,587	\$23,917,139	\$2,101,363	\$1,030,356	\$5,136,258	\$2,521,366	\$10,789,342	\$62,862,864	100.0 %

By Recipients	01/01/2021 - 31/03/2021	01/04/2021 - 30/06/2021	01/07/2021 - 30/09/2021	01/10/2021 - 31/12/2021	Total Y1	01/01/2022 - 31/03/2022	01/04/2022 - 30/06/2022	01/07/2022 - 30/09/2022	01/10/2022 - 31/12/2022	Total Y2	01/01/2023 -
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Country	Zimbabwe
Grant Name	ZWE-M-MOHCC
Implementation Period	01-Jan-2021 - 31-Dec-2023
Principal Recipient	The Ministry of Health and Child Care of the Republic of Zimbabwe

Reporting Periods	Start Date	01-Jan-2021	01-Jul-2021	01-Jan-2022	01-Jul-2022	01-Jan-2023	01-Jul-2023
	End Date	30-Jun-2021	31-Dec-2021	30-Jun-2022	31-Dec-2022	30-Jun-2023	31-Dec-2023
	PU includes DR?	No	Yes	No	Yes	No	No

Program Goals, Impact Indicators and targets

- 1 To reduce malaria incidence to 5/1000 and malaria deaths by at least 90% by 2025 and accelerate towards malaria elimination.

	Impact Indicator	Country	Baseline Value	Baseline Year and Source	Required Dissagregation	Responsible PR	2021	2022	2023	
	Malaria I-10 M Annual parasite incidence: Confirmed malaria cases (microscopy or RDT): rate per 1000 persons per year (Elimination settings)	Zimbabwe	N: .56 D: P:	2019 HMIS	Source of infection	The Ministry of Health and Child Care of the Republic of Zimbabwe	N: 1.09 D: P: %	N: .8 D: P: %	N: .58 D: P: %	
Comments										
1	The Malaria Strategic Plan (2021-2025) recognises movement of districts to elimination phase from 28 districts in 2018 to 36 districts by 2025. This indicator is calculated for the elimination setting only. The indicator measures the progress made towards achieving the goal of reducing the annual parasite incidence of malaria (API) in the 9 elimination districts during the 3 year grant period. The indicator is measured as a rate per 1000 population. The baseline 0.56/1000 (2794 local cases /5018040 population) in 2019 will be used. Numerator: Number of laboratory (microscopy or RDT) confirmed cases (local cases) reported during the year X 1000 in elimination settings. Denominator: Population at risk (number of people living in areas targeted for malaria elimination). i.e the projected annual population (in targeted districts) using the 2012 Population Census. Data source: HMIS/DHIS2 The numerator excludes imported cases identified in the areas targeted for malaria elimination. The baseline was determined from the 20 pre-elimination districts as proxy. The strategic targets are specific for 9 proposed elimination districts hence the bigger margin between baseline and target. PR notes - based on latest situation monitored by the MoH due to covid, there has been an up-surge in malaria cases due to this and other factors, hence the 2021-2023 targets have been adjusted higher. When reporting, the numerator, denominator and the percentage completeness of reporting will be provided. Furthermore, the data (for the numerator) will be disaggregated by age and sex. Data are obtained through the routine information system and the source for reporting on the indicator is the HMIS using the T5 as the data source feeding into DHIS-2.									
2	Malaria I-2.1 Confirmed malaria cases (microscopy or RDT): rate per 1000 persons per year	Zimbabwe	N: 22 D: P:	2019 HMIS	Age,Species	The Ministry of Health and Child Care of the Republic of Zimbabwe	N: 27 D: P: %	N: 21 D: P: %	N: 20 D: P: %	
Comments										
3	Malaria I-3.1 M Inpatient malaria deaths per year: rate per 100,000 persons per year	Zimbabwe	N: 1.14 D: P:	2019 HMIS (hospital data)	Age	The Ministry of Health and Child Care of the Republic of Zimbabwe	N: .58 D: P: %	N: .36 D: P: %	N: .13 D: P: %	
Comments										

3 The indicator assesses malaria mortality in the general population through data collected in clinical settings. In Zimbabwe, inpatient data remains a huge challenge across all diseases. With this in mind, NMCP created an excel based database so as to mitigate the challenges of malaria inpatient data unavailability. Hospitals submit populated excel sheets of inpatient data to national level (NMCP) on quarterly basis. This database is used as data source for this indicator. The annual targets are 0.58 (2021), 0.38 (2022), 0.13 (2023) against baseline of 1.14 (2019) Numerator: Number of inpatient malaria deaths Denominator: Population at risk (number of people leaving in areas where malaria transmission occurs) Data source: HMIS/hospital records The baseline is derived from 160 deaths/14003420 pop (1.14/100,000pop) in 2019.

	Malaria I-6 All-cause under-5 mortality rate per 1000 live births	Zimbabwe	N: 65 D: P:	2019 MICS	Gender	The Ministry of Health and Child Care of the Republic of Zimbabwe	N: D: P: %	N: 53 D: P: %	N: D: P: %
							Due Date:	Due Date: 01-Mar-2023	Due Date:

4	Comments Malaria is an urgent public health priority. Monitoring trends in all-cause under five mortality rates is a useful exercise and will be done using data from nationally representative household survey- Demographic Health survey (DHS) scheduled for 2022. It is the responsibility of RMNCH in MOHCC to track this indicator through either MICS or DHS. Baseline of 65 /1000 live births (2019 MICS) is used as benchmark of this indicator and target of 53 /1000 live births measured through DHS in (2022). Indicator will be reported once during the life of the grant, as this is based on survey and not vital registration system. However, this indicator can be influenced by several factors and does not provide specific information on malaria mortality trends. To assess whether the malaria control program have had an impact on all-cause mortality rates, it will be possible for the program to examine all-cause childhood mortality trends over a clearly defined time interval. For the same time interval, observe changes in malaria intervention coverage, the prevalence of other factors influencing malaria and non-malaria childhood mortality (vaccination coverage, malnutrition, etc.) and morbidity indicators (anemia and parasite prevalence). If statistically, significant reductions in mortality and morbidity are found and malaria intervention coverage has increased to high levels conclusion can be drawn that malaria control activities caused or contributed to reductions in malaria-associated mortality.
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Program Objectives, Outcome Indicators and targets

- 1 To protect at least 85% of the population at risk of malaria with an appropriate malaria prevention intervention for the period 2016-2020.
- 2 To provide prompt and quality assured diagnosis for all malaria suspected cases and treatment to all confirmed cases.
- 3 To achieve zero malaria transmission in 20 districts and increase the elimination districts to 36 by 2025
- 4 To detect all outbreaks within one week of onset and control them within two weeks of detection
- 5 To increase utilization of malaria interventions to at least 85% of the targeted population by 2025
- 6 To strengthen surveillance, monitoring and evaluation and operational research for all malaria interventions for the period 2021-2025.
- 7 To foster an enabling environment for optimal program implementation and impact.

	Outcome Indicator	Country	Baseline Value	Baseline Year and Source	Required Dissagregation	Responsible PR	2022
1	Malaria O-1b Proportion of children under five years old who slept under an insecticide-treated net the previous night	Zimbabwe	N: D: P: 33.0%	2016 MIS		The Ministry of Health and Child Care of the Republic of Zimbabwe	N: D: P: 65.00%
Comments							
Children under 5 years are a vulnerable group. This indicator provides a direct measure of ITN use by children under five years of age at the time of the survey. The next MIS will be conducted in 2022. Numerator: Number of children under five years old who slept under an ITN the previous night Denominator: Total number of children under five years old who spent the previous night in surveyed households The baseline of 32.5% is extracted from MIS 2016. The target of 65% is informed by MSP 2021-2022.							
2	Malaria O-1c Proportion of pregnant women who slept under an insecticide-treated net the previous night	Zimbabwe	N: D: P: 36.0%	2016 MIS		The Ministry of Health and Child Care of the Republic of Zimbabwe	N: D: P: 70.00%
Comments							
Pregnant women are a vulnerable group for malaria. This indicator provides a direct measure of ITN use by pregnant women at the time of the survey. Numerator: Number of pregnant women who slept under an ITN the previous night Denominator: Total number of pregnant women who spent the previous night in surveyed households The baseline of 36% is extracted from MIS 2016. The target of 70% is informed by MSP 2021-2022.							

	Malaria O-3 Proportion of population using an insecticide-treated net among those with access to an insecticide-treated net	Zimbabwe	N: D: P: 54.0%	2016 MIS	Gender	The Ministry of Health and Child Care of the Republic of Zimbabwe	N: D: P: 65.00%
Comments							
This indicator measures the use of existing ITNs. It defines the behavioral gap in use of ITNs (i.e. the population with access to an ITN, but not using it) and distinguishes it from the ownership gap (i.e. non-use because there are not enough nets in the household). It is useful for assessing the utilization of ITNs among the population with access to ITNs. The indicator will be reported once in the life of the grant through MIS in 2022 as source of data. The target is lower than the MSP of 80% considering changes in net types and minimal SBCC net usage campaigns over from 2017 to date. Numerator: Number of individuals who slept under an ITN the previous night Denominator: Number of individuals with access to an insecticide-treated net To avoid seasonality bias data collection is appropriate during the wet season when net use high. This indicator provides a direct measure of use of ITNs by the population with access to ITNs at the time of the survey. It also identifies behavioral deficiencies of ITN use. There was a change in the type of the nets from conical to rectangular but SBCC was poorly funded. It is assumed that SBCC activities will gradually increase net utilisation.							

	Malaria O-8 Proportion of households sprayed by IRS within the last 12 months	Zimbabwe	N: D: P: 62.0%	2016 MIS	The Ministry of Health and Child Care of the Republic of Zimbabwe	N: D: P: 80.00%
Comments						
Zimbabwe conducts IRS campaign as part of the national strategy. This indicator assesses the extent to which IRS is available to populations. It measures the proportion of households covered by IRS. The indicator will be reported once in the life of the grant through MIS in 2022 as source of data. Target 80% (2022). Baseline 62% (MIS 2016) Numerator: Number of households that have been sprayed by IRS in the last 12 months Denominator: Total number of households surveyed The data for the numerator are obtained from information on which households have been protected by IRS in the last 12 months. The denominator is simply the total number of households in the survey.						

Coverage indicators and targets										01-Jan-2021 30-Jun-2021	01-Jul-2021 31-Dec-2021	01-Jan-2022 30-Jun-2022	01-Jul-2022 31-Dec-2022	01-Jan-2023 30-Jun-2023	01-Jul-2023 31-Dec-2023
CI Number	Population	Coverage Indicator	Country and Scope of Targets	Baseline Value	Baseline Year and Source	Required Dissagregation	Include in GF Results	Responsible PR	Cumulation Type						
Vector control															
		VC-6.1 Proportion of population protected by IRS within the last 12 months in areas targeted for IRS	Country: Zimbabwe; Coverage: Geographic Subnational, 100% of national program target	N: 3,164,344 D: 3,388,358 P: 93.4%	2019 Program activity report		Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative – other	N: D: P:	N: 3,500,743 D: 3,500,743 P: 100.0%	N: D: P:	N: 3,253,940 D: 3,253,940 P: 100.0%	N: D: P:	N: 3,124,861 D: 3,124,861 P: 100.0%
Comments															
10															
The program targets 100% in 2021, 2022 and 2023 respectively. The baseline for this indicator is pegged at 93% in 2019. The Indicator measures the proportion of the population residing in targeted malaria transmission areas (32 moderate-high transmission districts) that are protected by IRS annually. For the past seasons, the program experienced challenges beyond its control such as delay in the procurement and delivery of the insecticide in the country. As such the targets are based on the following assumptions: Timely delivery of IRS commodities to mitigate perennial procurement bottlenecks, adequate funding of SBCC for pre-spraying awareness activities, community acceptance. Numerator: Population residing in households that were sprayed with an indoor residual insecticide during a national IRS campaign in the last 12 months within the targeted areas. Denominator: Total number of population residing in the IRS targeted areas. The denominator is decreasing in year3 (2023) because the program expects to drop 6 districts from IRS and move them to pre elimination. These districts will not be targeted for IRS.															
		VC-1 ^M Number of long-lasting insecticidal nets distributed to at-risk populations through mass campaigns	Country: Zimbabwe; Coverage: Geographic Subnational, 100% of national program target	N: 2,020,946 D: P:	2019 Program activity report	Target / Risk population group	Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative	N: 928,629 D: P:	N: 1,769,258 D: P:	N: 281,686 D: P:	N: 281,686 D: P:	N: 281,686 D: P:	N: 281,686 D: P:
Comments															
7															
Consistent with the policy of universal access every person residing in targeted malarious areas is eligible to receive at least a net for every 2 people or per sleeping space. The MSP (2021-2025) requires that mass campaigns carried out every three years to replace absolute LLINs. Mass LLIN distribution campaign is regarded as a once off activity. A distribution plan will be developed to guide the distribution process. Nets for mass campaign in 2021 (n=928,629) replaces nets distributed in 2018, while 2022 nets (n=1,769,258) and 2023 (n=281,686) nets replaces nets distributed in 2020, and 2021. However, we note that mass campaigns are once off activity and directly not comparable for the targeted years/ periods, therefore, the baseline is only provided to appreciate a trend. Key directly linked activities include procurement of nets and logistics, training and orientation of staff and community awareness campaigns, storage and security services.															
		VC-3 ^M Number of long-lasting insecticidal nets distributed to targeted risk groups through continuous distribution	Country: Zimbabwe; Coverage: Geographic Subnational, 100% of national program target	N: 139,229 D: P:	2019 Program activity report	Target / Risk population group	Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative	N: 472,972 D: P:	N: 472,972 D: P:	N: 408,823 D: P:	N: 408,823 D: P:	N: 432,259 D: P:	N: 432,259 D: P:
Comments															
8															

	Beyond mass distribution campaigns, Zimbabwe plans to channel LLINs to households on a continuous basis to help sustain vector control coverage levels. The channels planned for continuous distribution (CD) include: EPI, ANC and community channels. Continuous distribution approach is demand driven implying that when communities are saturated with ITNs the movement of nets through CD is very low and this denotes level of program success, as beneficiaries are adequately covered and there is no demand for ITNs. Numerator: Number of insecticide-treated nets distributed to targeted risk groups through continuous distribution (2021-2023 breakdown by type: ANC - 207621,223145,233204; EPI - 173696, 198351, 219487, community channel/coupon - 564628, 396150, 411827) Denominator: Not applicable for this indicator. The indicator needs to report six-monthly. The reporting system is currently paper based and there are proposals under this grant to switch to an electronic reporting system that which is integrated with the DHIS2 platform. Health workers will be capacitated on CD data collection, analysis and use of the information. The CD targets for this grant are set as 945,944 (2021), 817,646 (2022) and 864,518 (2023). Please note that the NMCP is increasing the number of districts using LLIN as core intervention from 35 to 41 districts per NSP 2021-2025. Some lessons drawn after the roll out of the continuous distribution in 2018 included (a) Regular stock outs at peripheral sites (b) Poor reporting system (paper based) where consolidation of data to national level was a challenge (c) Poor supportive systems to capacitate lower level cadres on the CD programme (d) The CD nets will therefore cover new sleeping spaces, gaps created by LLIN wastage (losses) gaps and additional sleeping spaces as need may arise. Covid 19 response (isolation/quarantine facilities), IDPs, Refugees, disasters etc). Going forward, the PR will strengthen supportive activities, regular stock checks at peripheral sites and intensify community engagements to market CD. PR will also roll out electronic reporting to address gaps in reporting systems and hopefully this will improve in accounting for all LLINs distributed through this channel. Key directly linked activities include procurement of nets, delivery and distribution of LLINs through the channels stated above, support supervision and reporting.														
8		VC-5 Proportion of households in targeted areas that received Indoor Residual Spraying during the reporting period	Country: Zimbabwe; Coverage: Geographic Subnational, 100% of national program target	N: 2,151,375 D: 2,448,561 P: 87.9%	2019 Program activity report	Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative – other	N: D: P:	N: 2,756,491 D: 2,756,491 P: 100.0%	N: D: P:	N: 2,562,157 D: 2,562,157 P: 100.0%	N: D: P:	N: 2,460,520 D: 2,460,520 P: 100.0%	
9	Comments Non-cumulative indicator measuring operational performance of Indoor Residual Spraying that is carried out once a year between October and November. In line with strategic plan, Zimbabwe's IRS program is oriented to use rooms as the unit of analysis from which the planning of implementation logistics, insecticides and operational targets (as in the Gap Analysis) are based. The program does not use households for measurement of IRS performance. While the standard indicator in the PF indicates households, the calculation of performance for this indicator assessing the 3 rounds of IRS (one round per year in 2021, 2022, 2023) will use rooms in both numerator and denominator as below; Numerator: Number of rooms in targeted areas that received spraying during the reporting period Denominator: Number of rooms in targeted areas Baseline 87.86% (2019) Program data is collected during routine spraying activities in order to capture whether IRS activities reached all the targeted households. While the WHO recommends target of 85% for minimum impact level, the program targets 100% to match the country needs where malaria incidence 5 per 1000 population and above. Assumptions for IRS performance: insecticides are delivered on time, operational and transport logistics are available on time, and adequate funding for SBCC to garner for program acceptance.														
RSSH: Health management information systems and M&E															
11		M&E-2b Timeliness of facility reporting: Percentage of submitted facility monthly reports (for the reporting period) that are received on time per the national guidelines	Country: Zimbabwe; Coverage: Geographic National, 100% of national program target	N: 14,666 D: 21,336 P: 68.7%	2019 HMIS	Type of report	Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative	N: 9,068 D: 10,668 P: 85.0%	N: 9,068 D: 10,668 P: 85.0%	N: 9,281 D: 10,668 P: 87.0%	N: 9,281 D: 10,668 P: 87.0%	N: 9,601 D: 10,668 P: 90.0%	N: 9,601 D: 10,668 P: 90.0%
12	Comments Timeliness refers to the time expectation for accessibility and availability of reports on time. In tracking this indicator, timeliness can be measured as the time between when reports are expected from health facilities (HF) and when T5 and OPD data set general reports are readily available for use in the main District Health Information System 2 (DHIS2). Health facilities submit reports to district by the 7th of following month and district captures reports into DHIS2 up to the 21st of that month. Thus all reports captured in the DHIS2 system by the 21st are regarded as received on time. The total count of reports received on time constitute the numerator of this indicator. 2019 baseline report was 14,666 based on criteria hence % timeliness of 68.74%. Numerator: Number of monthly reports that were received on time per national guidelines for the reporting period. Denominator: Number of monthly reports submitted from health facilities for the reporting period. Annual denominator is the number of expected reports based on number of total HFs ($1778 * 12 = 21336$). Data source: HMIS/DHIS2. Timeliness of facility reporting will be measured semi-annually against semester performance targets of 85% Year 1 (2021), 87% Year 2 (2022) and 90% Year 3 (2023). Target setting conforms with WHO recommendations of 85% timeliness of system effectiveness. The success of DHIS2 applications relying on master OPD data general, depends on consistent and timely reporting. Through this indicator the service levels (HFs) specifying how quickly the T5 reports must be propagated through the centralized repository (DHIS2) will be defined so that compliance with those timeliness constraints can be measured. While the limitations to this indicator are noted, the program is not directly in control of the factors driving this RSSH indicator. These include frequent power outages that may affect part of the network connectivity (or the components of the aggregate part of the network), affecting individual districts resulting in delays of capturing data at district level. Added to challenges are fears of systems breakdown, natural disasters. Regardless of challenges there is optimism for system resilience to meet the expected performance.														
12		M&E-6 Percentage of districts that produce periodic analytical report(s) as per nationally agreed plan and reporting format during the reporting period	Country: Zimbabwe; Coverage: Geographic National, 100% of national program target	N: D: P:			Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative – other	N: 62 D: 62 P: 100.0%	N: 62 D: 62 P: 100.0%	N: 62 D: 62 P: 100.0%	N: 62 D: 62 P: 100.0%	N: 62 D: 62 P: 100.0%	N: 62 D: 62 P: 100.0%
Specific prevention interventions (SPI)															
6		SPI-1 Proportion of pregnant women attending antenatal clinics who received three or more doses of intermittent preventive treatment for malaria	Country: Zimbabwe; Coverage: Geographic National, 100% of national program target	N: D: P: 69.8%	2019 Case management audit (% only)	Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative	N: 101,791 D: 127,238 P: 80.0%	N: 101,791 D: 127,238 P: 80.0%	N: 103,012 D: 128,765 P: 80.0%	N: 103,012 D: 128,765 P: 80.0%	N: 104,208 D: 130,260 P: 80.0%	N: 104,208 D: 130,260 P: 80.0%	
	Comments														

6 This indicator assesses the proportion of women attending antenatal clinics who receive 3 or more doses of IPTp under direct observation of a health worker (in line with WHO guidelines 2015, IPTp). This indicator provides an alternative measure of IPTp delivered through ANC. The actual values for the numerator/denominator will be determined by the methodology to be used which also determines sample size. The country will be working with the GF team to find a way to capture this indicator more frequently than is at least annually. Baseline: please note this is based on a small sample of case audit - hence N/D not provided in the fields to avoid misleading interpretation. The N/D of the sample: (340/487) 69.82%. Numerator: Number of pregnant women attending antenatal clinics who received three or more doses of intermittent preventive treatment for malaria during the reporting period Denominator: Number of first antenatal clinic visits during the reporting period Source of data for reporting this indicator is Case Management Audits (CMA). CMA was as per agreement in NFM2. Next CMA will be conducted in 2022 and analyses is confined to IPTp targeted districts where the intervention is implemented . However, CT will explore during implementation readiness review the situation and to provide needed support to identify solutions to achieve the goal of getting this data from routine data sources which should be reported to GF every 6 months as a standard service delivery indicator (increasing frequencies of the audit and/or strengthening IPTp routine collection). The target in 2022 is 80% set in view of trends in IPTp over years. The result of 2019 CMA of 69.8% provides the baseline. Key activities linked include- Training of HWs in IPTp especially on the changes, provision of IPTp to pregnant women in targeted districts, on job follow ups , commodity supply

Case management													
		CM-1a□M□ Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities	Country: Zimbabwe; Coverage: Geographic National, 100% of national program target	N: 911,486 D: 911,486 P: 100.0%	2019 HMIS	Age,Type of testing	Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative				
								N: 789,324.83 D: 789,324.83 P: 100.0%	N: 338,282.07 D: 338,282.07 P: 100.0%	N: 627,617 D: 627,617 P: 100.0%	N: 268,979 D: 268,979 P: 100.0%	N: 587,620.25 D: 587,620.25 P: 100.0%	N: 251,837 D: 251,837 P: 100.0%

1 Comments

The indicator measures the test rate in public sector i.e the proportion of suspected malaria cases that are tested by either an RDT or microscopy to confirm the diagnosis of malaria at public health facility. Baseline: total annual suspected and tested cases that were reported in 2019, 911486 (100%). Numerator: Number of Suspected Malaria Cases presenting at either public health facility that are tested (RDT/Microscopy) for malaria. Denominator: All suspected malaria cases presenting at public health facility. The targets are informed by the baseline and aligned to the M&E Plan and the National Treatment Guidelines (NTGs). According to the NTG every suspected malaria case should receive a parasitological test to confirm presence of malaria parasites before proceeding with treatment. In setting a target of universal access (100%) it has been assumed that there will be a constant supply of Rapid Diagnostic Test Kits in the public health facilities. Data source: District Health Management Information System (HMIS)- DHIS2. T5 as the data source. NB: The data will be disaggregated by age and sex but not by testype of test. Key directly linked activities : Training of health workers, On job support and supervision, Post market surveillance of RDTs and reagents- Sampling of RDT kit at testing facilities for QA/QC.

		CM-1b□M□ Proportion of suspected malaria cases that receive a parasitological test in the community	Country: Zimbabwe; Coverage: Geographic Subnational, 100% of national program target	N: 385,711 D: 412,813 P: 93.4%	2019 HMIS	Age,Type of testing	Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative				
								N: 321,368 D: 338,282.07 P: 95.0%	N: 137,729 D: 144,978.03 P: 95.0%	N: 255,530 D: 268,979 P: 95.0%	N: 109,513 D: 115,277 P: 95.0%	N: 239,245 D: 251,837.25 P: 95.0%	N: 102,534 D: 107,930.25 P: 95.0%

2 Comments

The indicator measures the proportion of suspected malaria cases that are tested by RDT to confirm the diagnosis of malaria at community level (by Village Health Workers (VHWs). Baseline: 93% (385711/412813) was obtained from DHIS2. Numerator: Number of Suspected Malaria Cases presenting to CHWs/VHWs in the community who are tested using RDT. Denominator: All suspected malaria cases presenting to CHWs/VHWs in the communities. Data source: District Health Management Information System (HMIS). National data collection system does not disintegrate this indicator by age nor by type of test. Geographical scope - this is provided in 7 rural provinces: Matebeleland North, Mashonaland West, Mashonaland East, Mashonaland Central, Midlands, Masvingo, and Manicaland. Key directly linked activities : Training of community health workers in case management, On job support and supervision, community based workers support by health facility level.

		CM-2a□M□ Proportion of confirmed malaria cases that received first-line antimalarial treatment at public sector health facilities	Country: Zimbabwe; Coverage: Geographic National, 100% of national program target	N: 184,269 D: 186,050 P: 99.0%	2019 HMIS	Age	Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative				
								N: 189,437.92 D: 189,437.92 P: 100.0%	N: 81,187.68 D: 81,187.68 P: 100.0%	N: 150,627.96 D: 150,627.96 P: 100.0%	N: 64,554.84 D: 64,554.84 P: 100.0%	N: 141,028.86 D: 141,028.86 P: 100.0%	N: 60,440.94 D: 60,440.94 P: 100.0%

3 Comments

This indicator measures the adherence to malaria treatment guidelines in the management of confirmed malaria cases at public sector health facilities. Numerator: Number of confirmed malaria cases treated that received first-line antimalarial treatment at public sector health facilities. Denominator: Number of confirmed malaria cases at public sector health facilities. Data Source: HMIS/DHIS2. According to Treatment Policy ACTs are used for 1st line treatment. The baseline of 99.04% (184269/186050) in 2019 was extracted from the DHIS2. The targets have been aligned to the strategic plan 100%,(2021), 100% (2022) and 100% (2023). The assumptions are adequate stocks of malaria commodities, maintaining a high coverage of case management training among health care workers in the public health sector. Key directly linked activities : training public and private sector health workers in case management and VHW logistics system.

		CM-2b□M□ Proportion of confirmed malaria cases that received first-line antimalarial treatment in the community	Country: Zimbabwe; Coverage: Geographic Subnational, 100% of national program target	N: 120,040 D: 122,123 P: 98.0%	2019 HMIS	Age	Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative				
								N: 81,187.68 D: 81,187.68 P: 100.0%	N: 34,794.72 D: 34,795 P: 100.0%	N: 64,554.84 D: 64,554.84 P: 100.0%	N: 27,666.36 D: 27,666.36 P: 100.0%	N: 60,440.94 D: 60,440.94 P: 100.0%	N: 25,903.26 D: 25,903.26 P: 100.0%

4 Comments

"This indicator measures the adherence to malaria treatment guidelines in the management of confirmed malaria cases at community level by community based health workers. Baseline of 98% (120140/122123) in 2019, extracted from the DHIS2. Numerator: Number of confirmed malaria cases treated that received first-line antimalarial treatment in the community. Denominator: Number of confirmed malaria cases in the community. According to Treatment Policy ACTs are used for 1st line treatment. The targets have been aligned to the strategic plan 100%,(2021), 100% (2022) and 100% (2023). Geographical scope - this is provided in 7 rural provinces: Matebeleland North, Mashonaland West, Mashonaland East, Mashonaland Central, Midlands, Masvingo, and Manicaland. Key directly linked activities : training of community case management and VHW logistics system.VHW data collection tools do not disaggregate by age. The assumptions are adequate stocks of malaria commodities, maintaining a high training coverage in case management among community based health care workers. "

		CM-5□M□ Percentage of confirmed cases fully investigated and classified	Country: Zimbabwe; Coverage: Geographic Subnational, 100% of national program target	N: 4,472.01 D: 5,521 P: 81.0%	2019 HMIS		Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative				
								N: 7,885 D: 9,499.52 P: 83.0%	N: 1,971 D: 2,374.88 P: 83.0%	N: 6,460 D: 7,599.616 P: 85.0%	N: 1,615 D: 1,899.904 P: 85.0%	N: 5,472 D: 6,079.6928 P: 90.0%	N: 1,368 D: 1,519.9232 P: 90.0%

Comments

5 The indicator is measured for districts that have implemented elimination with different starting years. During the period of the 2021-2023 grant, the aim is to increase elimination districts by adding 4 districts in 2021 and 4 districts in 2022 to the elimination setting. Hence, this grant seeks the need for capacity building to allow for the achievement of the required performance of this elimination indicator. The targets are slightly lower than those in the National Malaria and Elimination Strategic plan due to the fact that the activities for supporting the elimination are not fully funded to give the required results. Numerator: Number of confirmed cases fully investigated and classified during the reporting period *100 Denominator: Total number of confirmed cases during the reporting period. The baseline of 81% (4472/5521) was extracted from DHIS2 Tracker as source of data. Data Source: HMIS/DHIS2 tracker. The strategic plan provides the national need for malaria elimination which is expected to be funded by GoZ and all supporting partners including Global Fund. The assumption is that other budget needs not provided for by GoZ and Global Fund will be covered by other partners. Key activities directly linked : Conduct trainings for enhanced surveillance-preelimination for both health workers and community, Conduct capacity assessment in each of the districts marked for preelimination, field case investigations & classification, on the job training and follow up on use of the DHIS2 Tracker/case based surveillance systems

RSSH: Health products management systems																						
13		PSM-3 Percentage of health facilities providing diagnostic services with tracer items available on the day of the visit or day of reporting	Country: Zimbabwe; Coverage: Geographic National, 100% of national program target	N: 1,485 D: 1,560 P: 95.0%	2019 ZAPS Reports	Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative – other	N: D: P:	N: 1,600 D: 1,684 P: 95.0%	N: D: P:	N: 1,600 D: 1,684 P: 95.0%	N: D: P:	N: 1,600 D: 1,684 P: 95.0%								
Comments																						
14		PSM-4 Percentage of health facilities with tracer medicines for the three diseases available on the day of the visit or day of reporting	Country: Zimbabwe; Coverage: Geographic National, 100% of national program target	N: 1,516 D: 1,580 P: 96.0%	2019 ZAPS Reports	Yes	The Ministry of Health and Child Care of the Republic of Zimbabwe	Non cumulative – other	N: D: P:	N: 1,633 D: 1,684 P: 97.0%	N: D: P:	N: 1,633 D: 1,684 P: 97.0%	N: D: P:	N: 1,633 D: 1,684 P: 97.0%								
Comments																						
PF targets are set annually for this indicator at PU2, PU4 and PU6. However, the PR will submit the reports to CT every six months regardless of whether there is an official target in the PF for the period concerned. For information, the 6-monthly targets are 95% for the full grant duration. This indicator measures availability of the Malaria Rapid Diagnostic Test Kits on the day of reporting. The indicator will be tracked quarterly although the reporting will be done annually using ZAPS reports. The RDTs were selected because of the country's test and treat policy which makes availability of RDTs essential. The indicator is monitored to ensure continuous access to life saving diagnosis for patients and enhance quality outcomes. Numerator: number of health facilities with malaria RDTs available at the time of reporting. Denominator: total number of health facilities that offer malaria diagnostic testing. Data source: ZAPS reports.																						

Workplan Tracking Measures

Population	Intervention	Key Activity	Milestones	Criteria for Completion	Country	

Comments

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