USAID | ZIMBABWE
FROM THE AMERICAN PEOPLE

Issue Date: May 20, 2015

Closing Date and Time: June 19, 2015 at 4:00 p.m. Zimbabwe time

Questions Due: May 27, 2015 at 4:00 p.m. Zimbabwe time

Subject: Notice of Funding Opportunity (NFO) Number: RFA-613-15-000005

Program Title: Zimbabwe Assistance Program in Malaria (ZAPIM)

The United States Agency for International Development's Mission in Zimbabwe (USAID/Zimbabwe) is seeking applications from organizations interested in implementing the **Zimbabwe Assistance Program in Malaria (ZAPIM)** as fully described in this NFO. Eligibility for this award is not restricted. See Section C of this NFO for eligibility requirements.

Subject to the availability of funds an award will be made to that responsible applicant whose application best meets the objectives of this funding opportunity and the selection criteria contained herein. While one award is anticipated as a result of this notice of funding opportunity (NFO), USAID reserves the right to fund any or none of the applications submitted.

For the purposes of this NFO the term "Grant" is synonymous with "Cooperative Agreement"; "Grantee" is synonymous with "Recipient"; and "Grant Officer" is synonymous with "Agreement Officer". Eligible organizations interested in submitting an application are encouraged to read this funding opportunity thoroughly to understand the type of program sought, application submission requirements and evaluation process.

To be eligible for award, the applicant must provide all information as required in this NFO and meet eligibility standards in Section C of this NFO. This funding opportunity is posted on www.grants.gov, and may be amended. Potential applicants should regularly check the website to ensure they have the latest information pertaining to this notice of funding opportunity. Applicants will need to have available or download the Adobe program to their computers in order to view and save the Adobe forms properly. It is the responsibility of the applicant to ensure that the entire NFO has been received from the internet in its entirety and USAID bears no responsibility for data errors resulting from transmission or conversion processes. If you have difficulty registering on www.grants.gov or accessing the NFO, please contact the Grants.gov Helpdesk at 1-800-518-4726 or via email at support@grants.gov for technical assistance.

The successful Applicant will be responsible for ensuring the achievement of the program objectives. Please read each section of the NFO.

Please send any questions to the point(s) of contact identified in section D. The deadline for questions is shown above. Responses to questions received prior to the deadline will be furnished to all potential applicants through an amendment to this notice posted to www.grants.gov.

Issuance of this notice of funding opportunity does not constitute an award commitment on the part of the Government nor does it commit the Government to pay for any costs incurred in preparation or

submission of comments/suggestions or an application. Applications are submitted at the risk of the applicant. All preparation and submission costs are at the applicant's expense.
Thank you for your interest in USAID programs.

Sincerely,

Leona Sasinkova
Agreement Officer
USAID Zimbabwe

Table of Contents

Abbreviations and Accroynms used in this NFO

ACT	Artemisinin Based Combination Therapy
AIDS	Acquired Immune Deficiency Syndrome
AIRS	Africa Indoor Residual Spraying
ANC	Antenatal Care
BCC	Behavior Change Communication
CBHW	Community-Based Health Worker
CDC	US Centers for Disease Control and Prevention
CDCS	Country Development Cooperation Strategy
DEHO	District Environmental Health Officer
DHIS	District Health Information System
DHIS-2	District Health Information System, Version 2
DHS	Demographic and Health Survey
DHMT	District Health Management Team
DMO	District Medical Officer
DO4	Development Objective 4
E8	Elimination 8 (countries in Southern Africa)
EHT	Environmental Health Technician
FP	Family Planning
GHI	Global Health Initiative
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOZ	Government of Zimbabwe
HIV	Human Immunodeficiency Virus
iCCM	Integrated Community Case Management
IEC	Information, Education and Communication
IPTp	Intermittent Preventive Treatment of pregnant women
IRS	Indoor Residual Spraying
ITN	Insecticide Treated bed nets
LLIN	Long-Lasting Insecticide treated bed nets
M&E	Monitoring and Evaluation
MCHIP	Maternal and Child Health Integrated Program
MOHCC	Ministry of Health and Child Care
MIMS	Multiple Indicator Monitoring Survey
MIP	Malaria in Pregnancy
MIS	Malaria Indictor Survey
MNCH	Maternal Newborn and Child Health
MOP	Malaria Operational Plan
MOZIZA	Mozambique, Zimbabwe and South Africa Cross-Border Malaria Initiative
MPH	Master in Public Health
Nat Pharm	National Pharmaceutical
NGO	non-governmental organization
NHISS	National Health Information and Surveillance System
NIHR	National Institute of Health Research
NMCP	National Malaria Control Programme
NMSP	National Malaria Strategic Plan
OPD	Out Patient Department
OR	Operations Research
PEDCO	Provincial Epidemiology and Disease Control Officer

PMI	President's Malaria Initiative
PMD	Provincial Medical Director
PMP	Performance Monitoring Plan
QA/QI	Quality Assurance/Quality Control
RBM	Roll Back Malaria
RH	Reproductive Health
RDT	Rapid Diagnostic Test
SADC	Southern Africa Development Community
SARN	Southern Africa Regional Network
SBCC	Social Behavior Change Communication
SP	Sulfadoxine-pyrimthamine
SMS	short messaging service
TB	Tuberculosis
TMZI	Trans-Zambezi Malaria Initiative
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization
WHT	Ward Health Team
ZAPS	Zimbabwe Assisted Pull System
ZAPIM	Zimbabwe Assistance Program in Malaria
ZIPS	Zimbabwe Informed Push System

SECTION A: PROGRAM DESCRIPTION

1. Overview

The United States Agency for International Development/Zimbabwe (USAID/Zimbabwe) presents the **Zimbabwe Assistance Program in Malaria (ZAPIM)**, an award for an implementing partner to provide comprehensive support for, and collaborative partnership with, the Zimbabwe National Malaria Control Program (NMCP) and to support the NMCP's established strategy and goals.

The overall objective of this health intervention is to contribute to attainment of the USAID Mission's 4th Development Objective - reducing morbidity and mortality related to Human Immunodeficiency Virus (HIV), Tuberculosis (TB), Malaria, and Maternal, Newborn, and Child Health (MNCH). This activity will support the two intermediate results outlined in the Mission's Country Development Cooperation Strategy (CDCS), Intermediate Result 4.1 health services delivery is improved, and Intermediate Result 4.2 health systems are strengthened.

There are five key objectives of ZAPIM envisioned by USAID that aim to strengthen the capacity of the NMCP at national, provincial, district, and/or community levels. These objectives are defined as having been successful in malaria control guidance by the World Health Organization (WHO) and the President's Malaria Initiative (PMI). However, in the interest of opening the door to innovation and advancement, responders to the ZAPIM notice of funding opportunity (NFO) are invited to expand upon this package in new and inventive ways to support NMCP.

1) Promote **quality malaria case management and prevention of malaria during pregnancy (MIP)**, specifically at health facilities but also with other cadres at the community level as indicated by NMCP priorities.

2) Formulate evidence-based national health policies, strategies, systems, and programs to prevent malaria through distribution, ownership, and correct, consistent, and increased use of **long-lasting insecticide treated nets**.

3) Develop and implement innovative and effective a **social behavior change communication** program to improve the prevention and treatment of malaria.

4) Support malaria **surveillance, monitoring and evaluation,** and **operational research activities** in conjunction with national malaria programs and other partners to assess the efficacy / effectiveness of currently deployed malaria control tools.

5) Conduct quality **therapeutic efficacy trials** together with the Ministry of Health and Child Care and partners on artemisinin-based combination therapy (ACT) medicines to monitor malaria drug resistance, a critical, sentinel task for Zimbabwe and for all malarious areas worldwide.

USAID anticipates awarding one cooperative agreement with a five-year period of performance. Applicants are encouraged to consider partnerships with relevant organizations with high-quality skills in malaria epidemiology, social and behavior change communications, monitoring and evaluation, surveillance, operational research, and drug therapeutic efficacy assessment.

Subject to the availability of funding, **USAID/Zimbabwe expects ZAPIM to receive an authorized funding level of $20 million dollars over the five-year period**. Funding will be planned and allocated through the PMI annual malaria operational plan (MOP) process. MOP14 and MOP15 have already planned for some initial funding for ZAPIM.

2. Zimbabwe Country Context

Zimbabwe has a population of approximately 13 million people, with an estimated 25 percent of the population between the ages of 15 and 24, and 41 percent of the population between the ages of 0 and 14[1]. Since 1990, the annual population growth has slowed from 3.5 percent to 1.1 percent[2]. Since 2008, high numbers of Zimbabweans (up to 4 million estimated by the International Organization for Migration), including health professionals, departed the country for economic, social, or political reasons[3]. Simultaneously, as the population growth has slowed, the percentage of the population living in urban areas increased from 29 percent to 33 percent with approximately two-thirds of Zimbabweans still living in rural areas. The percentage of Zimbabweans living below the total consumption poverty line was 55 percent in 1995, 72 percent in 2003 and 72 percent in 2011[4]. Zimbabwe's population can be described in short as **slow-growing with a majority rural population, but with increasing migration to urban areas in the face of recent loss of millions due to outward migration.**

Zimbabwe's turbulent political and present past, and recent economic decline, has left a weakened health system. From about 1999/2000, the country experienced negative economic growth, rising unemployment, declining exports and world record inflation rates. Many government health facilities closed their doors completely for a time in late 2008 and early 2009 during a period of severe hyperinflation. Staff abandoned their posts for lack of pay and many emigrated, hollowing out what had previously been well-trained cadres providing essential health services. Volunteer community-based health workers became inactive, as did non-governmental organizations (NGO). Drug stocks declined and essential equipment and infrastructure were not maintained.

The country has however been on a steady recovery path since the formation of the inclusive government in February 2009. At about the same time, the country dollarized the economy resulting in the use of major currencies with the US dollar being the main medium of exchange. This has halted the record-breaking inflation and to some extent has facilitated increased donor support to the health sector. Staffing levels have improved following a Harmonized Staff Retention Scheme put in place by the Ministry of Health and Child Care (MOHCC) with donor support from donors in January 2009.

There has been some decline in staff attrition rates particularly among primary care nurses and registered general nurses. There are still high vacancy rates for cadres such as midwives, medical doctors, pharmacists and laboratory scientists. Regular facility surveys have revealed that drug supplies have improved with 99 percent of facilities having at least 50 percent of the essential drugs in stock. However, the functionality of the national health commodities logistics system is largely funded by outside assistance using a push system.

Dollarization of the economy has, however, increased the cost of health care and the ability of the poor (particularly in rural areas) to access health services. Currency is difficult for the poor to obtain and quite scarce in rural areas. The government has not met the recommended national budget contributions to health and is unable to adequately finance the day-to-day operational costs of health facilities, consequently most facilities demand user fees from patients. In summary, Zimbabwe is experiencing high

[1] Zimbabwe Population Census 2012, Zimbabwe National Statistics Agency.
[2] Multiple Indicator Cluster Survey, Key Findings Report, 2014.
[3] International Organization for Migration, Zimbabwe Country Profile, www.iom.int. Accessed Dec. 23, 2014.
[4] Millenium Development Goals Progress Report, Zimbabwe 2012, United Nations Development Program.

morbidity and mortality from a severely weakened and under-resourced health delivery system with national government expenditure on health below recommended levels[5].

Table 1. Zimbabwe National Budget Health Sector Allocation, 2010-2014

	Allocated to Health Including Employment Cost (Million USD)	Percentage of National Budget	Disbursed/Spent (Million USD)	Compliance / Performance	USD per capita
2010	174	6.7%	149	86%	14 (11)
2011	256	9.3%	184*	72%*	20 (14)
2012	345	8.6%	289	84 %	27 (23)
2013	381	9.9%	236**	62%	29 (18)
2014	337	8.2%			26

* Up to October 2011
** Up to November 2013
( ) USD x Capita disbursement basis

3. Health Sector Landscape

In terms of the health situation, Zimbabwe suffers from a generalized HIV epidemic, which ranks as one of the most severe in the world and has the highest burden of disease in country. Estimates of the adult HIV prevalence rate have fallen from 24.6 percent in 2004 to about 14 percent currently, meaning that mortality from HIV and AIDS remains high, with about 2,200 deaths occurring each week. The HIV and AIDS burden increases the population's economic and social vulnerability, and jeopardizes Zimbabweans' health in general. Maternal and child health is compromised overall (rising maternal mortality from 555 per 100,000 live births in 2005 to 960 in 2010 but now showing a decline based on the 2014 released Multiple Indicator Cluster Survey (MICS) report of 614/100,000); and a great toll is taken by other diseases, including TB and malaria. Zimbabwe is considered a high TB burden country with a very low case detection rate of 27 percent. Historically, malaria has been a close third in mortality and morbidity as described later in detail.

Similar to the high maternal mortality rate, Zimbabwe historically has high infant mortality with under-five mortality rates increasing from 53 and 77 per 1,000 live births in 1994 to 57 and 84 per 1,000 live births in 2010, respectively[6]. However, the recent MICS indicates that infant (55/1,000) and under-five (75/1,000) mortality rates may be stabilizing. Nevertheless, basic management of sick newborns remains a challenge. Facilities lack basic equipment to resuscitate and manage newborns and knowledge of health workers on the management of newborn complications is as low as 41 percent assessed[7].

[5] MOHCC budget allocation in November 2013 was $337,005,000 equivalent to 26 USD per capita assuming an estimated population of 12.5 million. Out of the total national budget, the allocation to health decreased from 9.9% in 2013 to 8.2% in 2014 the result being far from the *Abuja Declaration (15%).*

[6] Zimbabwe Demographic Health Survey 2005/2006 and 2010/2011.

[7] Ministry of Health and Child Welfare 2012: National Integrated Health Facility Assessment.

According to the United Nations Human Development Index of 2009, life expectancy had fallen to 43 years for males and 44 years for females, the lowest recorded in the world in that year. Currently, the life expectancy has risen to 59.87, showing an increase, a trend which will hopefully increase if conducive contextual factors continue.

Zimbabwe has a decentralized health delivery system, with district health authorities fully responsible for health service planning and service delivery, from budget allocation decisions to hiring and firing of personnel. Zimbabwe is divided into ten provinces (two of which are considered urban), 65 rural districts and 1,200 wards. Forty-seven of the rural districts are considered malarious with 30 of those considered high malaria burden districts.

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

Malaria program management fits in the national health delivery system which has structures from the national, provincial, district, and community levels. Zimbabwe continues to face critical shortages of health personnel, though the rate of migration to neighbouring countries has reduced over the past few years. However, low wages in the public sector contribute to movement of health workers from public to private sectors within the country. The ratio of 7.2 nurses per 10,000 population, and 12.3 health care workers per 10,000 prevails in the public sector.[8] A 2010 assessment estimated that the health system is operating at 57 percent of staffing capacity, leaving existing healthcare workers overburdened, and facing multiple priority programs and interventions[9].

As the workload on health workers continues to increase, more responsibilities for malaria case-finding and case management will be transitioned to community-based health workers (CBHWs) who historically have included Village Health Workers and School Health Masters. In most districts, the CBHWs currently diagnose malaria using rapid diagnostic tests (RDTs), and treat with artemisinin combination therapy (ACT). However, to achieve optimal coverage, the training, supervision, and support of these cadres needs to continue and be strengthened. Though the private sector is updated on malaria policy issues, they are not supplied with malaria commodities (RDTs and ACTs) through the MOHCC and are not integrated into routine monitoring.

Procurement, storage and distribution of commodities are carried out by the National Pharmaceutical Company (Nat Pharm), a parastatal organization. The MOHCC works with Nat Pharm, and partners focusing on commodities support, to determine the national need through quantification and forecasting of commodities. Quantification is informed by morbidity and consumption data. Distribution of commodities is based on a push system, the Zimbabwe Informed Push System (ZIPS), with plans underway to re-introduce a modified (assisted ordering) pull system called the Zimbabwe Assisted Pull System (ZAPS).

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

The National Monitoring and Evaluation Plan (M&E Plan) guides the monitoring of the National Malaria Strategic Plan (NMSP). The routine reporting (monthly and weekly) is directly linked to the National

[8] National Health Survey, 2009 – 2013. Human Resources for Health – Country Profile: Zimbabwe.
[9] Zimbabwe Health System Assessment 2010, January 2011, Health Systems 2020, Abt Associates, Inc.

Health Information and Surveillance System (NHISS) of the MOHCC. Routine reporting is decentralized and reported from the primary source (health facilities) through *Frontline SMS* (weekly disease surveillance reporting) and paper based T5 forms (monthly reporting). The monthly reports are aggregated at district and provincial levels and transmitted electronically to the national level using the Demographic Health Information System 2 (DHIS-2) adopted in 2012 and rolled out throughout the country in 2013. Following the adoption of DHIS-2 database and *Frontline SMS*, the completeness and timeliness of the monthly and weekly disease surveillance reporting have improved significantly from approximately 50 percent in 2010 to above 90 percent in 2013. All rural and mission hospitals, as well as district and provincial offices possess laptops in order to improve data capturing from the lower levels. All the health facilities have been equipped with mobile phones for use of mobile applications and short message service (SMS). For example, the CBHWs capture their data into a register which they present to the health facility on a monthly basis for consolidation into a clinic report. Community reporting has now been integrated into DHIS-2 as a separate module or reporting system.

The Malaria Indicator Survey (MIS) is conducted every two years and is considered critical in showing the burden of malaria since it is so geographically specific in Zimbabwe. The Demographic and Health Survey (DHS) is a national-level exercise that is conducted every five years covering all heath areas, the next one expected to occur this year.

4. The Global Health Initiative

Malaria prevention and control is a major foreign assistance objective of the USG. In May 2009, President Barack Obama announced the Global Health Initiative (GHI), a six-year, comprehensive effort to reduce the burden of disease and promote healthy communities and families around the world. Through the GHI, the United States is investing $63 billion over six years to help partner countries improve health outcomes, with a particular focus on improving the health of women, newborns and children. The GHI is a global commitment to invest in healthy and productive lives, building upon and expanding the USG's successes in addressing specific diseases and issues.

The GHI aims to maximize the impact the United States achieves for every health dollar it invests, in a sustainable way. The GHI's business model is based on: implementing a woman- and girl-centered approach; increasing impact and efficiency through strategic coordination and programmatic integration; strengthening and leveraging key partnerships, multilateral organizations, and private contributions; encouraging country ownership and investing in country-led plans and health systems; improving metrics, monitoring and evaluation; and promoting research and innovation.

The USG, through the GHI, is pursuing a comprehensive, whole of government strategy to achieve significant health outcomes and foster a sustainable, effective and efficient public health program.

5. The President's Malaria Initiative

The President's Malaria Initiative (PMI) is a core component of the GHI, along with HIV/AIDS, maternal and child health, and TB. In June 2005, the USG announced the PMI, a five-year, $1.2 billion initiative to rapidly scale up malaria prevention and treatment interventions in high-burden countries in sub-Saharan Africa. PMI began in three countries in 2006 and expanded to include four more in 2007. Eight countries were added in 2008 for a total of 15 countries.

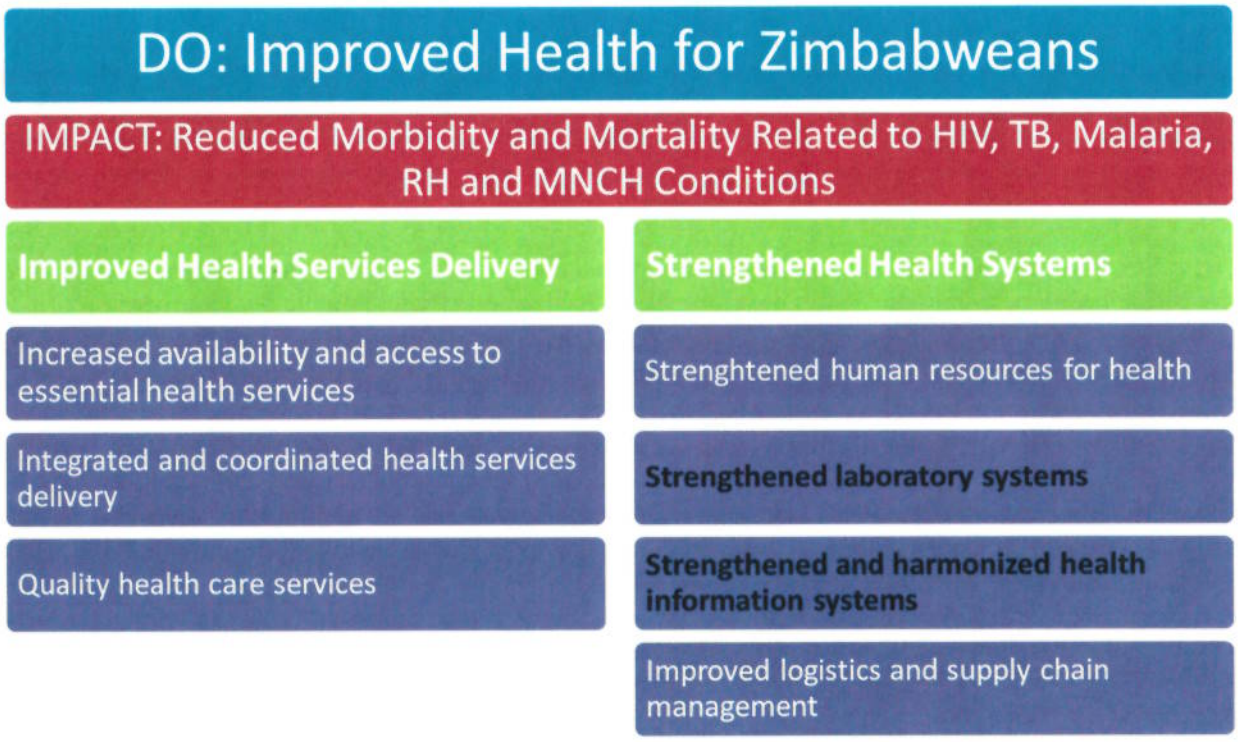
The PMI funding began with $30 million in fiscal year (FY) 2006 for the initial three countries, $135 million in FY 2007, and $300 million in FY 2008 and FY 2009. The funding level for FY 2010 was $500 million.

In 2008, the Tom Lantos and Henry J. Hyde Global Leadership against HIV/AIDS, Tuberculosis, and Malaria Act (Lantos/Hyde Act) authorized up to $5 billion in USG funding for malaria prevention and control. This act provides for continued support to the 15 PMI focus countries and an expansion to other endemic countries. It also called for the development of a comprehensive multi-year USG Malaria Strategy, which was released on April 25, 2010. The expanded malaria support of the Lantos/Hyde Act paved the way for Zimbabwe to be added as a PMI country in mid-2011.

The new USG Malaria Strategy also revised the original PMI goal upwards from 50 percent to 70 percent reduction in malaria morbidity and mortality by 2015. The new strategy continues to support the scale up of PMI's four highly effective interventions: 1) insecticide-treated mosquito nets; 2) indoor residual spraying (IRS); 3) intermittent preventive treatment of pregnant women (IPTp) with sulfadoxine/pyrimethamine (SP); and 4) correct diagnosis and treatment with artemisinin combination therapy (ACT).

6. Relationship to USAID/Zimbabwe Country Development Cooperation Strategy (CDCS) and Results Framework

The USAID/Zimbabwe health program identified effective evidence-based approaches to accelerate progress in reducing preventable deaths and decreasing the burden of disease within Zimbabwe, by developing the three-year CDCS approach. The strategy focuses on women and girls and improves the integration of a set of essential health services and systems. Development Objective Four (DO4) contributes to the Mission's goal of "strengthened democratic systems of governance contributing to sustained recovery." It is designed to assist in the re-establishment, initiation or expansion of key basic health services. USAID is working with the MOHCC to prioritize intervention areas, which will contribute to Zimbabwe's sustained recovery by reducing preventable deaths and lessening the burden of disease.



The CDCS Results Framework components encompass interventions that have the highest potential for greater public health impact within the general population. Due to the malaria disease burden being one of the leading causes of mortality in Zimbabwe, strengthening and improving health services link directly with comprehensive access to malaria prevention and timely, effective treatment is a priority.

ZAPIM will contribute to both intermediate results under DO4; Improved Health Services Delivery and Strengthened Health Systems. Improving the availability, quality of and access to essential health services for malaria is one of the critical components to achieving these results. Systems strengthening will build the national capacity to deliver prevention and treatment services as well as to improve the sustainability of service-delivery improvements in Zimbabwe.

7. USAID/Zimbabwe Health Portfolio

The focus of the Mission's health program in Zimbabwe is to support an array of essential health service interventions to reduce morbidity and preventable deaths, with a particular focus on women and children. This has been consistent with the goal outlined in both the GHI Strategy, which was developed and approved in August 2012, and the CDCS (DO4: 'Morbidity and Mortality related to HIV, TB, Malaria, RH and MNCH conditions reduced'). In formulating these strategies, the following factors were considered: 1) the major causes of deaths in Zimbabwe, which are HIV, TB, malaria, and conditions related to reproductive health (RH) and maternal, newborn and child health (MNCH); and 2) new assistance platforms that could help save lives. As part of the GHI, the USAID/Zimbabwe health program is placing increased emphasis on improving efficiencies by strengthening integration and coordination of health activities.

The resuscitation of Zimbabwe's primary health care remains a top priority for the USAID/Zimbabwe health program. Program interventions focus on: 1) improving the availability, quality, and utilization of essential health services; and 2) strengthening key health systems. The long-term expected results from USAID's program are improved maternal, neonatal, and child health indicators; reduction in unmet family planning (FP) needs; reduction in the transmission and impact of HIV and AIDS; reduction in deaths caused by TB and malaria; strengthened national, district and community health delivery systems; and improved public awareness on targeted health issues.

The Mission's health program is in line with the health priorities set in the Zimbabwean National Health Strategic Plan for 2009-2013 (extended to 2015) and contributes to the host government's plans to accelerate progress toward achieving Zimbabwe's health-related Millennium Development Goals. Currently, USAID/Zimbabwe implements a health program valued at approximately $97 million in FY 2012 with 14 percent spent on malaria. Most of USAID's funding is focused on HIV prevention, care, and treatment due to the impact of the AIDS pandemic in Zimbabwe. However in recent years, the Mission's health portfolio has expanded to include specific support to strengthen the NMCP, and MNCH services and FP.

A challenge for all the Mission's projects in Zimbabwe has been the political and economic environment. A number of U.S. legal limitations affect USG assistance to Zimbabwe, such as Brooke Amendment and Section 620q loan default provisions found in the annual appropriations act. Currently, USAID/Zimbabwe relies on a combination of legal authorities permitting certain types of assistance notwithstanding other provisions of law, waivers, and other exceptions included in statutes to carry out its activities in Zimbabwe. If new limitations on assistance to Zimbabwe are included in appropriation acts in the future, legal authorities are removed or if annual waivers are not approved, it may affect USAID/Zimbabwe's ability to implement some of the activities contemplated herein.

8. Women, Girls and Gender Equity

Women and girls issues are at the center of USAID/Zimbabwe's health program. Given the high levels of maternal mortality, unacceptable levels of gender-based violence, and the large percentage of women infected by HIV and AIDS, women and girls are the critical target population and primary intended beneficiaries for most of the essential health services supported by USAID. Pregnant women are also identified as a vulnerable group, more susceptible to contracting malaria and requiring immediate care if testing positive. Pregnant women are targeted for protection through the NMCP by receiving LLINs at their initial antenatal care visits. In addition, pregnant women in 30 highly malarious districts will begin to receive malaria prevention medication (SP) monthly after the first trimester up to delivery. ZAPIM will incorporate strategies for women, girls, and gender equity in annual work plans and advocate for targeted protection from malaria in pregnant women in line with the priorities of the NMSP.

9. USAID/Early Zimbabwe Malaria Assistance

Historically, USAID assistance to the health sector was oriented around specific diseases and largely vertical national programs structured to mitigate HIV and TB. Evidence from the past few years has increasingly shown that disease mitigation coupled with improved integration, linkage and coordination of essential health services and investments towards strengthened national health systems coupled with strong national ownership can lead to efficient and effective approaches that can accelerate progress towards sustainable impacts. These historical experiences formed the premise upon which the GHI Strategy was developed and approved in Zimbabwe in 2012.

In FY2009 and FY2011 before Zimbabwe became a PMI country and before GHI was initiated, there were some small-scale USAID activities for malaria funded in response to requests from MOHCC largely due to emergency circumstances.

FY09 - $200,000 Emergency Indoor Residual Spraying (IRS) funding

FY11 - $540,000 Quinine and SP + $1,000,000 ACTs
- $360,000 Operations/Technical Assistance

Following the early, ad hoc, malaria support, PMI/Washington announced Zimbabwe as a PMI country effective 2011. USAID/Zimbabwe used this opportunity, and the available funding that the PMI designation brought with it, to create a malaria program under PMI's Congressional mandate and incorporating GHI principles. The issuance of ZAPIM continues this trend and speaks to the GHI principles of comprehensive, quality support, integrating with other health programs as much as possible.

10. USAID/Zimbabwe Local Solutions

Due to the legal limitations on U.S. assistance to Zimbabwe discussed earlier, USAID/Zimbabwe is currently restricted from establishing direct government-to-government assistance. When considering the mechanism for this activity, USAID/Zimbabwe was informed by a national mapping exercise in October 2012, to identify local organizations working in the health field in Zimbabwe. Of the 70 organizations identified (out of 135 targeted), the vast majority (90 percent) of organizations carried out activities related to HIV, particularly in the area of HIV prevention and advocacy. A smaller number of organizations work in TB, MNCH, and FP/RH. The exercise identified no organizations working in

malaria; perhaps largely because historically malaria control has been largely managed by the MOHCC.[10] However, engaging communities to improve the reach of malaria prevention and treatment is important especially as Zimbabwe is facing a very serious problem with health service delivery and access/proximity to malaria treatment is critical within the first 24 hours. PMI/Zimbabwe and USAID/Zimbabwe strive to work with local organizations to provide services or technical assistance for health service delivery at national, provincial, district and community levels if quality organizations meet the procurement criteria.

11. National Malaria Control Program: Plan and Strategy

The MOHCC has three main divisions: Policy Planning, Monitoring, and Evaluation; Curative Services; and Preventive Services, plus the Provincial Medical Directorates. Under the Preventive Services directorate is the Epidemiology and Disease Control Department and the NMCP. The NMCP is led by a director, supported by a team of senior officers responsible for: case management; monitoring and evaluation (M&E); vector control; social behavioral change communication (SBCC); and finance and administration.

At the provincial level, the Provincial Medical Director (PMD) is responsible for all health activities, including malaria control, and has a team of managers responsible for epidemiology and disease control, nursing services, environmental health, administration, nutrition, health promotion and pharmacy. The Provincial Epidemiology and Disease Control Officer (PEDCO) also serves as the provincial focal person for malaria. The structure at the district level mirrors the province with a District Health Management Team (DHMT). The DHMT is led by the District Medical Officer (DMO), who is responsible for all health delivery services in the district including malaria. The DHMT works with ward health teams (WHTs) to coordinate and implement health programs. The District Environmental Health Officer (DEHO) manages IRS activities whereas the District Nursing Officer is responsible for case management related issues.

The primary health facility level is staffed by two or three nurses, one or two Environmental Health Technicians (EHTs), and nurse aides. There are approximately 1,500 primary health facilities in Zimbabwe and each primary health facility is linked to a WHT comprised of community members such as CBHWs, school health masters, headmen, chiefs, and religious leaders. The health facility staff is responsible for overseeing program implementation at ward level in conjunction with the WHT.

The NMCP collaborates with diverse partners and has linkages with the following parastatal, governmental, and nongovernmental organizations:

- National Institute for Health Research (NIHR), a government entity which operates a center for research, training, and service in the fields of disease control, biomedicine, and public health;
- Nat Pharm, a parastatal organization which is responsible for the procurement, storage and distribution of all health pharmaceutical commodities, including malaria medicines;
- Medicine Control Authority of Zimbabwe, which is responsible for registration of all medicines in the country;
- National Microbiology Reference Laboratory, a government entity which is responsible for internal quality assurance; and
- Zimbabwe National Quality Assurance Program, a nongovernmental organization responsible for external quality assurance for laboratories.

[10] Zimbabwe Health Sector Mapping Final Report, Psychosocial Support Research and Training Centre, November 2012.

The NMCP has ten national level staff and eight Provincial Malaria Focal Persons; all currently supported by the Global Fund malaria grant. In addition, there is one national level, local consultant supporting vector control as well as an MPH student attached to NMCP. At the national level, the NMCP develops policy, national guidelines and training materials. The national level also oversees program implementation, monitoring and evaluation, resource mobilization and coordinates partnerships. Due to Zimbabwe's economic collapse in 2008-09, all of the NMCP positions in Harare are currently supported by the Global Fund. The position of the Provincial Malaria Focal Person is also supported by the Global Fund, while the other workers receive allowances from the Zimbabwe Health Worker Retention Scheme. A Malaria Logistics Focal Person who is funded by PMI sits at the MOHCC under the pharmacy directorate and spearheads malaria supply chain activities at MOHCC headquarters level and coordinates with the NMCP.

PMI/Zimbabwe works in close collaboration with the MOHCC to design health activities, and engages with the MOHCC on a regular basis in donor forums and technical working groups. The creation of ZAPIM is aligned with the vision of the NMCP's 2008-2015 extended NMSP: a malaria-free Zimbabwe with the goal to "reduce malaria incidence from 95/1,000 in 2007 to 10/1,000 by 2015 and reduce malaria deaths to near zero by 2015." The advent of the addendum (2016-17) to the strategic plan resulted in the revision of the goal and reads as follows: "To reduce malaria incidence from 22/1000 in 2012 to 10/1000 by 2017 and malaria deaths to near zero by 2017."

The key approaches of the NMSP include:

- Universal access to malaria prevention and personal protection with: 90 percent of the population at risk covered by IRS and ITNs, and 85 percent coverage of monthly recommended dose of intermittent preventive treatment in pregnancy 2nd dose (IPTp2) attending antenatal care in medium-high transmission areas;
- Improve diagnosis and treatment of both uncomplicated and severe malaria;
- Improve detection and timely control of malaria epidemics, by detecting at least 100 percent of malaria epidemics within two weeks of onset;
- Expand districts implementing pre-elimination activities;
- Increase utilization of correct malaria prevention and control measures to at least 80 percent of the population at risk;
- Strengthen monitoring and improve evaluation of malaria activities at all levels; and
- Expand and maintain strong multi-sectoral partnerships for effective program management and coordination

All ZAPIM activities will be planned and implemented in collaboration with the NMCP and other major partners; such as, NIHR, Nat Pharm, etc.

The Zimbabwe NMCP participates in a number of sub-regional and cross-border initiatives, a priority for the program. NMCP is an active partner of the Roll Back Malaria (RBM) Southern Africa Regional Network (SARN) and with the Southern African Development Community (SADC) malaria network.

The NMCP is a member of the Malaria Elimination (E8) countries comprised of four front line countries: Botswana, Namibia, South Africa and Swaziland; and four second line countries: Angola, Mozambique, Zambia and Zimbabwe. Inaugurated in 2009, the E8 countries have a collective goal to eliminate malaria.

The program is also a member of the Trans-Zambezi Malaria Initiative (TZMI) with Zimbabwe, Zambia, Namibia, Botswana, and Angola. The TZMI is a convergence of five countries on the narrow Caprivi Strip with a total of 16 districts and a combined population of one and half million people at risk of

malaria. Its vision is to eliminate malaria in the Trans-Zambezi communities with social and economic prosperity by 2020.

The Mozambique, Zimbabwe and South Africa Cross-Border Malaria Initiative (MOZIZA) is a cross-border malaria initiative with Mozambique, Zimbabwe, and South Africa which began in 2003 and submitted an unsuccessful proposal to the Global Fund in 2010. The remote border area shared by Mozambique, Zimbabwe and South Africa contains a catchment population of over 2.3 million people within 9 districts – referred to as the MOZIZA region – of which 100 percent of the population is at risk for malaria.

Recently, last year on World Malaria Day 2013 in Victoria Falls, Zambia and Zimbabwe announced the Zam-Zim Cross Border Initiative along with a planning and coordination workshop.

12. Comprehensive Malaria Prevention & Treatment Technical Approach

As stated in Section II, General Description of the Funding Opportunity, PMI/Zimbabwe has worked with implementing partners in the past to provide a package of malaria control interventions that have been advocated by WHO and PMI. Through this NFO, USAID/Zimbabwe seeks another partner or group of partners to continue supporting the Zimbabwe NMCP toward a continuing decreasing trend of malaria incidence in Zimbabwe. Here are some guiding principles that PMI/Zimbabwe ascribes to ZAPIM.

- PMI/Zimbabwe will look to ZAPIM to provide a **comprehensive strategy for malaria control** in Zimbabwe and embrace internationally acceptable standards. The annual ZAPIM activities should represent a cohesive project strategy that is consistent and in support of the NMCP/Zimbabwe current strategy and priorities identified at their annual malaria conference. All ZAPIM activities should be managed and carried out with linkages between them that depict one strong program. For example, ZAPIM SBCC activities should have links with LLIN distribution and case management/malaria in pregnancy training and supervision.

- **Communication & Collaboration with PMI, NMCP and NIHR** are expected to be vital, routine practices for ZAPIM. ZAPIM should make a practice of communicating with PMI/ Zimbabwe staff (and when needed with U.S.-based PMI staff) including dialogue on planning, implementing, and proactive updating of activities and any challenges in implementation. NMCP Officers respond best if kept closely informed on the topics that they cover; case management, SBCC, M&E, and Vector Control.

  ZAPIM would be most successful by consulting closely with NMCP, NIHR, and other USG- and other donor-funded projects in Zimbabwe on activity planning, implementation and documentation/report sharing. ZAPIM should use creative approaches to work well and effectively with NIHR and bridge the communication gap between NIHR and other partners.

  ZAPIM should identify clear collaboration and consultation opportunities with partners in all areas of work – including PMI/Zimbabwe team and other partners. These should be planned for and featured in activity reports.

- ZAPIM is expected to have expertise in malaria **operations research, monitoring and evaluation, and survey design and implementation**. ZAPIM should ensure there is enough capacity on staff to design, conduct and analyze assessments, surveys, and any operational research included in the annual work plans with the goal of improving program research quality.

- ZAPIM is advised to ensure there is enough **knowledgeable and skilled staff** to manage activities and relationships with partners. Project staff should possess a solid background in malaria and

understand how malaria prevention, treatment, and control fit into the healthcare setting in Zimbabwe. Staff should also comprehend the evolving epidemiology of malaria in Zimbabwe and how resources and interventions should be targeted.

- PMI will look to ZAPIM to be a model of collection, dissemination, and use of high quality data for data driven advocacy to ensure malaria control measures are appropriate as transmission and epidemiology continues to change in Zimbabwe.

13. Project Activities

In response to the findings of the DHS, MIS, lessons learned from the PMI partners since 2012, and consultations with the MOP team, MOHCC/NMCP, and other donors, PMI/Zimbabwe designs ZAPIM to continue to support the NMCP strategy by scaling up and maintaining high-quality, effective prevention and treatment activities. This includes the scaling-up of new interventions (e.g., LLIN routine distribution), increasing the quality of malaria case management through training and supervision, strengthening the reliability and quality of national malaria surveillance data, actively managing high-quality operational research activities and therapeutic efficacy studies, and expanding to new activities to support malaria control in the context of changing malaria epidemiology in Zimbabwe.

Objective 1: Strengthen the capacity of the MOHCC/NMCP in implementing quality case management of malaria and malaria in pregnancy.

ZAPIM's role is to support NMCP/Zimbabwe in implementing **quality malaria case management** as well as providing a package of **prevention and treatment services specifically for pregnant women** in targeted high-risk malaria areas.

Part of this role will be to assist MOHCC/NMCP and partners, such as the Maternal and Child Health Integrated Program (MCHIP), to **create and maintain an accounting of cadres that have achieved a set of standardized skills in malaria case management/MIP** either through recent training and/or achievement of a set of knowledge/skills. ZAPIM will work with NMCP and partners to develop a standardized set of skills that can be measured via pre- and post-intervention tests and skills and knowledge observed during supportive supervision. Should the usage of Trainsmart database become fully functional and inclusively used by all MOHCC departments, ZAPIM will work with NMCP to make this transition and utilize Trainsmart.

One way of achieving quality case management/MIP is to **support training**. ZAPIM will support malaria case management training as needed and quantify when training events need to occur for which cadres. Each training event will be accompanied by an NMCP standardized pre- and post-test to determine cognition of training content internalized by participant. This should cover a wide variety of cadres that provide malaria service delivery in Zimbabwe including facility health workers, nurse aids and other community level care providers that the NMCP identifies as priority, such as: village health workers and SHMs. ZAPIM will work closely with NMCP, MCHIP and other partners to identify priorities in training and supportive supervision.

Another way of supporting quality case management/MIP is to practice **supportive supervision** of staff conducting malaria case management/MIP. ZAPIM will provide technical assistance to NMCP and partners in malaria case management/MIP supportive supervision. This includes identification of what constitutes quality achievement in malaria case management/MIP. ZAPIM will be active in the NMCP case management subcommittee in identifying/updating a set of parameters that **define quality practice achievement in malaria case management/MIP** appropriate for each cadre that participates in malaria case management (hospital and health facility nurses and doctors at all levels, nurse aids, village health

workers, and SHMs). ZAPIM will work with NMCP to plan and initiate a program of supportive supervision among staff that diagnose and treat malaria cases, including performance criteria, supportive supervision definitions and instructions, supportive supervision checklists and process of documentation of supportive supervision visits. Should NMCP policy change in the near future to incorporate malaria into universal supportive supervision (including all major health areas), ZAPIM will support NMCP in achieving this transition.

In addition, PMI will look to ZAPIM to provide advice and support on the **development and continuing revision of training curricula, training materials, facilitation guides, and job aids** as needed. Different materials may be needed to be adapted for different cadres, such as nurse aids and school health masters. MCHIP can be a resource and collaborator with ZAPIM on this task(s).

Illustrative Activities

- Develop a solution to keep track of health care professionals that have been trained in malaria case management/MIP
- Train health workers in malaria case management/MIP
- Begin a program of supportive supervision of malaria health care professionals under the guidance of NMCP

Illustrative Results

- Increase in the number of health workers trained and proficient in case management/MIP
- Increase in number of pregnant women receiving malaria IPTp doses per pregnancy in line with the latest WHO recommendations as NMCP policy adapts WHO new MIP guidelines) during ANC
- Initiate a program of supportive supervision of health professionals working in malaria case management and MIP

Objective 2: Strengthen the capacity of the MOHCC/NMCP at national and provincial levels to continue quality, targeted, LLIN campaigns in targeted districts; support the development and introduction of an LLIN routine distribution program; support the establishment of a rational vector-intervention policy that includes LLIN distribution and IRS use in Zimbabwe; support a program to promote a net culture of consistent use; and conduct a net durability study.

ZAPIM's second objective is to support and provide technical assistance for both **campaign and routine distribution of LLINs.** ZAPIM will benefit from working closely with NMCP to continue ongoing, periodic LLIN quantification exercises to determine appropriate distribution intervals and numbers of nets required for campaign distribution as well as the number and type of routine distribution outlets – all to maintain a high level of LLIN coverage (85 percent-90 percent coverage or as mandated by NMCP's malaria strategic plan) in malaria high-risk areas.

NMCP/Zimbabwe does not have depth of experience in the area of **routine distribution**. Therefore, ZAPIM will play a leadership role in assisting NMCP to establish policies, standard operating procedures, tools, and training curricula for a routine LLIN distribution system. ZAPIM will also provide technical advice and examples of international practices for routine distribution in antenatal clinics, immunization clinics, schools, and community settings. Other countries have piloted and launched different approaches to LLIN routine distribution and a supporting infrastructure (logistics, monitoring, creative methods for

outreach, etc.) that may be useful to NMCP/Zimbabwe. ZAPIM will assist NMCP to continuously learn from its own experiences and that of other countries.

In addition, PMI will look to ZAPIM to provide guidance and support to NMCP in thinking through a rationale and **establishing a policy on the geographic distribution of LLINs and use of IRS** – both currently major vector control activities in the country. Since the 1940s, IRS has been NMCP's dominate (or primary) vector control practice in Zimbabwe. Mosquito nets have traditionally played a much smaller role until the introduction of LLIN campaigns under the universal coverage goal over the past few years. When LLIN campaign distribution began, there was no clear rationale for the balance of LLINs and IRS coverage in Zimbabwe. ZAPIM will provide expertise, sharing WHO and PMI policies on the recommended balance of LLIN distribution and IRS use, considering the fact that LLINs are commonly imbedded with only pyrethroid-based insecticide and there is evidence of pyrethroid resistance in Zimbabwe. ZAPIM will also provide NMCP with examples of how other countries have defined this balance. NMCP will benefit from ZAPIM helping to determine what the current, ideal investment in LLINs and IRS is for Zimbabwe. ZAPIM can also use the Africa Indoor Residual Spraying (AIRS) Project as a partner and resource for this task.

Because, Zimbabwe has already embarked on a **net durability study** with 2014 being the first year of the study and data collection, PMI would like ZAPIM to continue managing the ongoing net durability study through to the three-year study end period. ZAPIM will work with NMCP, PMI/Zimbabwe staff, PMI U.S.-based staff including CDC entomologist(s), and partners to continue the study and analysis. ZAPIM will produce a final document with a full accounting of the study methods, results and recommendations on how the results should affect policy.

Finally, as described in more detail in Objective 3, ZAPIM's role will be to work with NMCP and other malaria partners, such as MCHIP, to attain a more **widespread net culture in Zimbabwe**. The ultimate goal of achieving a culture of consistent net use is that net use becomes valued and adopted by Zimbabweans in high-risk areas as a necessary daily practice, essential for good health.

Illustrative Activities

- Work with NMCP and partners to produce a standard operating procedure document on LLIN mass campaign and routine distribution in Zimbabwe
- Work with NMCP, Malaria Vector Control Project Staff, and partners to finalize documentation on LLIN quantification exercises and any planning documentation for LLIN routine campaign distribution (using previously created documentation led by the Networks project)
- Develop any necessary capacity development plans for partners (training, workshops)
- Establish relationships with relevant Ministries and local organizations and cadres that will have a role in LLIN routine distribution (for example, MOHCC Reproductive Health unit, Ministry of Education, etc.)
- Work with NMCP and partners to continue implementation of established plans for routine distribution roll out.
- Work with policy makers to establish a clearly written policy on vector control describing the rational for LLINs deployed and IRS and any complementary overlap.
- Build on SBCC messages and outreach using various media to promote a net culture in Zimbabwe.

- Continue and complete net durability study and documentation of process and results and completion of final report of study with recommendations.

Illustrative Results

- Maintenance of LLIN coverage of 85 percent or higher
- Strengthened LLIN distribution systems
- Rolled out routine LLIN distribution
- Change in targeted populations' knowledge, understanding, and acceptance of consistent LLIN use
- LLIN-IRS rationalization plan drafted for NMCP approval

Objective 3: Strengthen the capacity of the MOHCC at national, provincial, and district level to produce and disseminate SBCC materials that support strong prevention and timely, quality diagnosis and treatment of malaria.

Of all PMI/Zimbabwe partners, **ZAPIM will be in the lead role in supporting NMCP and partners in SBCC message development and dissemination**. ZAPIM must possess a repository of SBCC knowledge, approaches, and practices including an awareness of what has been successfully implemented in other PMI countries. There is a need to take stock of what messaging Zimbabwe has done using what media, and what has and has not worked well so far.

ZAPIM should consider novel approaches in SBCC including a platform approach for malaria with an overall theme/brand with specific message campaigns for specific areas of malaria intervention (early health care seeking/prompt treatment, MIP for every pregnant mother, taking appropriate malaria medications from trusted sources, etc.). ZAPIM should explore creative, culturally-appropriate ways to reach Zimbabweans and consider possibilities to integrate malaria messaging into other SBCC efforts, such as maternal, neonatal and child health, reproductive health, campaigns to reach out to men, or, food distribution programs.

In addition to creating novel malaria approaches, **ZAPIM will consider using a combination of outlets and media** that are most effective in reaching Zimbabweans in high-risk malaria areas. For medium- and low-risk malaria areas, ZAPIM will develop or continue to use existing, effective messages and outlets that continue to decrease or maintain lower malaria prevalence. ZAPIM will consider different SBCC delivery methods that are acceptable to different groups such as radio, drama, print media, billboards, mobile messages (on vehicles), and painted messages on static structures such as school buildings, community centres, churches, etc.

PMI will look to ZAPIM to coordinate with PMI-funded partners, such as DELIVER, MCHIP, and AIRS, to produce SBCC messages and choose delivery methods that are **based on evidence and will monitor campaigns to gauge effectiveness and progress**.

Illustrative Activities

- Provide technical assistance to the NMCP in documenting and understanding Zimbabwe's progress so far in malaria SBCC and promoting use of already available messages and tools that are proven to be effective
- Support malaria advocacy, communication, and social mobilization at provincial, district and community levels

- Explore ways to integrate malaria messages into other programs
- Improve NMCP's and partners' ability to creatively select SBCC delivery method(s) for different audiences
- Improve NMCP's and partners' ability to measure and monitor SBCC, through workshops, tools, etc.
- Play a leadership role in working with NMCP to develop malaria messages to encourage good malaria behaviors

Illustrative Results

- Improved systems/references to house malaria SBCC messages and delivery method options
- Increased effective use of malaria messaging and groups of messages to increase awareness of malaria prevention and treatment options and encourage good behaviors (such as, early treatment seeking and consistent net use)
- Increased use of malaria SBCC by partners
- Increased vehicles of SBCC, integrating with other programs

Objective 4: Increase the capacity of MOHCC/NMCP, NIHR, and partners to conduct quality therapeutic efficacy studies.

The NMCP, NIHR, and WHO have been conducting therapeutic efficacy studies on ACTs for several years now with a limited amount of resources. Consequently, there is a cadre of professionals that understand the basic methods and procedures of carrying out the studies. However, there are still opportunities for strengthening the study processes focusing on quality, uniformity, protocol compliance, and more extensive and timely documentation. ZAPIM will work with NMCP and NIHR and partners to invigorate the capacity of NMCP and NIHR to carry out quality therapeutic efficacy studies. ZAPIM will coordinate all planning and implementation activities with WHO and a therapeutic efficacy study technical working group which will include NMCP, NIHR, and PMI/Zimbabwe staff.

ZAPIM's role will be to work with the therapeutic efficacy study technical working group well in advance of the planned study for 2016 and create a series of preparations that will enhance the quality of the study and readiness of the team. ZAPIM will work with partners to assemble a therapeutic efficacy toolkit, including; a protocol template, standard operating procedures, tools for lab staff, tools for case management staff, tools for M&E staff, calendars, quick reference guides, lists of essential equipment to be mobilized for each study site, supervisory visit checklists, etc.

ZAPIM will have an influential and active role in the therapeutic efficacy studies of 2016 and 2018, for example as a co-Principal Investigator and secretariat on the technical working group under the guidance of the Principal Investigator.

Illustrative Activities

- Support the NMCP, NIHR, and partners to assemble the components necessary for a therapeutic efficacy study toolkit.
- Develop new materials in preparation for a therapeutic efficacy study toolkit, as necessary.

- Support the NMCP, NIHR and partners, especially WHO (another donor to this activity), to conduct therapeutic efficacy studies for 2016 and 2018.

- Support the NMCP and NIHR with data analysis and dissemination of therapeutic efficacy results for studies conducted in 2016 and 2018

Illustrative Results

- Improved systems and references to enhance therapeutic efficacy study performance.

- Improved performance of quality and processes of therapeutic efficacy studies.

Objective 5: Strengthen and support the MOHCC/NMCP in malaria surveillance, monitoring and evaluation; and operational research to assess the efficacy/effectiveness of currently deployed malaria control tools.

ZAPIM is expected to have strong monitoring and evaluation (M&E) expertise and capacity to work closely with the NMCP to enhance and increase the quality of routine malaria (including entomological) surveillance data and the M&E program, nationwide. In collaboration with appropriate partners, ZAPIM will ensure OR activities are conducted with scientific rigor and findings and recommendations are disseminated accordingly. ZAPIM will work with the NMCP and other partners, such as, the Clinton Health Access Initiative, to use evidence-based data for pre-elimination activities to advance the malaria control program as malaria epidemiology changes. In addition, ZAPIM will play a supportive role in the upcoming MIS scheduled for 2016 and any additional national or sub-national malaria-related surveys. Activities will include planning, implementation, collaborating with partners, analysis, presentation of results, and dissemination. ZAPIM will conduct training, refresher training, and/or workshops in M&E, as needed. ZAPIM will work with the NMCP and PMDs to introduce the process and production of monthly/quarterly malaria bulletins. ZAPIM will play a leadership role in displaying data effectively, for example use of layered mapping to illustrate findings.

Illustrative Activities

- Support the NMCP and partners to increase MOHCC/NMCP's capacity in M&E and surveillance

- Conduct evaluations of HMIS and DHIS2 malaria data to assess and improve the reliability, accuracy, timeliness, and quality

- Assist the NMCP to incorporate malaria data from VHWs and improve M&E of VHWs

- Work with the NMCP and partners to implement high-quality OR activities

- Conduct M&E, training, refresher training, and workshops

- Assist the NMCP and partners to publish and disseminate data on a monthly or quarterly basis, using graphics and maps to illustrate findings

- Support the NMCP and other partners to update a malaria risk stratification map of Zimbabwe

- Assist the NCMP and partners to conduct high-quality national or sub-national household surveys to collect key malaria indicators and/or biomarker data

- Identify and coordinate pre-elimination focused activities

Illustrative Results

- Increased MOHCC/NMCP's capacity in surveillance and M&E through improvements in national surveillance data and training and supervision activities
- Improvements in the data quality and reliability of national malaria data, including VHW
- Improvements in MOHCC/NMCP's capacity to analyze, present and disseminate M&E results in printed documentation
- Implementation of data-driven malaria prevention and control strategies and activities
- Strengthened NMCP and partners for pre-elimination approaches and activities

The description of these objectives has been informed by past successes in Zimbabwe and other malarious countries as well as recommendations from WHO and PMI. In response, interested, potential partners and consortia are invited to propose their vision of how to carry out Objectives 1-5 including novel and innovative approaches. Refer to Annexes I and II at the end of this document for more detailed information on malaria epidemiology in Zimbabwe and the PMI/Zimbabwe program.

14. Monitoring and Evaluation Requirements

USAID policy seeks to strengthen the way the Agency monitors and evaluates its activities in the field. ZAPIM will use MIS and DHS to monitor and evaluate the USG malaria impact in Zimbabwe along with other ad hoc surveys, such as the UNICEF Multiple Indicator Cluster Survey.

PMI impact evaluation methodologies follow the RBM Monitoring and Evaluation Reference Group guidance for malaria impact evaluations for comprehensive malaria country programs. PMI/Zimbabwe anticipates that PMI headquarters may initiate a malaria impact evaluation during the life of ZAPIM. ZAPIM may be asked to participate in the impact evaluation and project data and performance may be examined during this time.

MIS and DHS (with complete birth histories) are the preferred sources for baseline and endline data for outcomes and morbidity and mortality data for impact. The next Zimbabwe DHS is scheduled for 2015; and the next MIS is planned for 2016.

The following malaria program initial assessment and plans will help strengthen evidence-based program management for ZAPIM:

- ***Baseline Assessment***
- ***Monitoring and Evaluation Plan***

  In order to measure progress of implementation, a baseline assessment will be undertaken by ZAPIM at the beginning of the project in order to establish a foundation of malaria prevention and control progress, any identified gaps in programming and need in all the ZAPIM relevant areas of work. Depending on the protocol and timing of the DHS and/or MIS, some data collected in these surveys may be able to serve as a baseline data.

  In addition, a robust monitoring and evaluation plan will be developed by ZAPIM to outline both process and outcome indicators. The recipient will report on data and indicator progress during quarterly and annual reports.

The project will use various approaches and sources for program monitoring and evaluation including building on the existing, routine national health management information systems.

15. Environmental Compliance

USAID/Zimbabwe's health activities, including malaria activities, are covered under an Initial Environmental Examination (IEE) authorization, which was amended in 2012. The Mission has confirmed with the MEO that the IEE covers the ZAPIM activity. The IEE has a negative determination with conditions for procurement and management of health commodities; management and disposal of hazardous medical waste; rehabilitation of health facilities and schools; and blood screening or treatment for HIV, sexually transmitted illnesses, TB, and malaria programs.

In addition, the awardee selected to implement ZAPIM must suggest, in their submission, how they will put in place appropriate systems or management tools to ensure recommended mitigation and monitoring actions are taken to comply with the determinations of the IEE. The implementer will be expected to produce an environmental mitigation and monitoring plan (EMMP) and associated budget within the first 60 days of signing of the award. This plan will be reviewed annually in collaboration with the Agreement Officer's Representative, the Mission Environmental Officer, and the Regional Environmental Officer.

Any subsequent/new activities outside the scope of the approved IEE will need prior written approval from USAID/Zimbabwe. No such new activities shall be undertaken prior to receiving written USAID approval of environmental documentation amendments. Any on-going activities found to be outside the scope of the approved IEE shall be halted until an amendment to the documentation is submitted and written approval is received from USAID.

Monitoring of this plan will be expected on a quarterly basis as part of the written quarterly reporting and monitoring requirements.

SECTION B: FEDERAL AWARD INFORMATION

1. Estimate of Funds Available and Number of Awards Contemplated

Subject to funding availability, USAID intends to provide $20,000,000 in total USAID funding over a 5-year period. The ceiling for this program is $20,000,000. Actual funding amounts are subject to availability of funds.

USAID intends to award one Cooperative Agreement pursuant to this notice of funding opportunity.

USAID reserves the right to fund any one or none of the applications submitted.

2. Start Date and Period of Performance for Federal Awards

The period of performance anticipated herein is 5 years. The estimated start date will be upon the signature of the award, on or about September 1, 2015.

3. Substantial Involvement

USAID anticipates having substantial involvement throughout the implementation of this Cooperative Agreement in accordance with ADS 303.3.11. This substantial involvement will be through the Agreement Officer, except to the extent that the Agreement Officer (AO) delegates authority to the Agreement Officer's Representative (AOR) in writing. The specific areas of USAID's substantial involvement will include:

a. USAID approval of the recipient's annual implementation and monitoring and evaluation plans;
b. USAID approval of changes to the recipient's specified key personnel; and
c. USAID approval of all subawards.

4. Title to Property

Property title under the resultant agreement shall vest with the recipient.

5. Authorized Geographic Code

The geographic code for this program is 937 for the procurement of goods and services. This code includes the United States, the recipient country, and developing countries other than advanced developing countries, but excludes any country that is a prohibited source. .

6. Authorized Legislation and Applicable Regulations and Policies

The authorizing legislation for this award is the Foreign Assistance Act of 1961, as amended.

For U.S. organizations, 2 CFR 200, 2 CFR 700, applicable policies of ADS 303 and ADS 303maa, Standard Provisions for US Nongovernmental Organizations will apply. These standard provisions can be found at the following web address:
http://www.usaid.gov/ads/policy/300/303maa

For Non-U.S. organizations, applicable policies of ADS 303 and ADS 303mab, Standard Provisions for Non-U.S. Nongovernmental Organizations will apply. These standard provisions can be found at the following web address:
http://www.usaid.gov/ads/policy/300/303mab
Other References:

Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, 2 CFR 200 (http://www.ecfr.gov)

USAID Policy: Automated Directives System (ADS) 303, Grants and Cooperative Agreements to Non-Governmental Organizations: http://www.usaid.gov/ads/policy/300/303

7. Branding Strategy and Marking Plan

The applicant must submit a Branding Strategy and Marking Plan to be evaluated and approved by the Agreement Officer in coordination with the Development Outreach Communication Officer and the AOR. The Branding Implementation Strategy and Marking Plan shall be in accordance with USAID Branding and Marking requirements in ADS 320. (See http://www.usaid.gov/sites/default/files/documents/1868/320.pdf for detailed information.) This plan will be requested at a later date by the Agreement Officer.

8. Graphics Standards

The Recipient must comply with the requirements of the USAID Graphic Standards Manual, available at http://www.usaid.gov/branding, or any successor branding policy.

SECTION C: ELIGIBILITY INFORMATION

1. Eligible Applicants

In accordance with the Federal Grants and Cooperative Agreement Act, USAID encourages competition in the award of Grants and Cooperative Agreements in order to identify and fund the best possible applications to achieve program objectives. This is full and open competition, under which any type of organization is eligible to apply (to include U.S. non-federal (non-profit) entities, U.S. commercial (for profit) firms foregoing profit, faith-based organizations, foreign organizations and foreign public entities).

Pursuant to 2 CFR 200 and 2 CFR 700, profit, which is any amount in excess of allowable direct and indirect costs, is not allowed for recipients of USAID assistance awards. However, all reasonable, allocable, and allowable expenses, both direct and indirect, which are related to the grant program and are in accordance with applicable cost standards (2 CFR 200 Subpart E for non-profit organizations and universities, and the Federal Acquisition Regulation (FAR) Part 31 for-profit organizations), may be paid under the grant.

USAD encourages applications from potential new partners.

2. Cost Sharing or Matching

The applicant will not be responsible for cost share under this award. If the applicant wishes to propose cost share, it must be clearly detailed in the budget and budget notes. For more information about cost share and resource leveraging under USAID agreements, see ADS 303.3.10.2.

SECTION D: APPLICATION AND SUBMISSION INFORMATION

1. Agency Points of Contact

Leona Sasinkova
Agreement Officer
USAID/Zimbabwe
No. 1 Pascoe Avenue
Belgravia
Harare.
Email: lsasinkova@usaid.gov

Alfred Magudhu
Acquisition & Assistance Specialist
USAID/ Zimbabwe
No. 1 Pascoe Avenue
Belgravia
Harare
Email: amagudhu@usaid.gov
Land Lines: 250992/3 ext. 287

Questions and Answers:

All questions regarding this NFO should be submitted in writing to harareprocure@usaid.gov with a copy to Alfred Magudhu at amagudhu@usaid.gov **no later than May 27, 2015 at 4:00 p.m. Harare time** to provide sufficient time to address the questions and incorporate the questions and answers as an amendment to this solicitation. Any information given to a prospective Applicant concerning this NFO will be furnished promptly to all other prospective Applicants as an amendment to this NFO, if that information is necessary in submitting applications or if the lack of it would be prejudicial to any other prospective Applicant.

2. Content and Form of Application Submission

To facilitate the competitive review of the applications, the applications must conform to the format and submission requirements prescribed below. Applications must be submitted electronically in two separate volumes (technical and cost/business applications). Email submissions must include the following in the subject line:

Technical Application under RFA-613-15-000005, submitted by: (organization name)
Cost/Business Application under RFA-613-15-000005, submitted by: (organization name)

Applications must be submitted to the following email addresses: harareprocure@usaid.gov with a copy to Alfred Magudhu at amagudhu@usaid.gov.

Applicants are expected to review, understand, and comply with all aspects of the NFO. Failure to do so will be at the applicant's risk.

Each Applicant shall furnish the information required by this NFO. The applicant shall sign the application and certifications and print or type its name on the Cover Page of the technical and cost applications. Any erasures or other changes to the application must be initiated by the person signing the application. Applications signed by an agent on behalf of the Applicant shall be accompanied by evidence of that agent's authority, unless that evidence has been previously furnished to the issuing office.

Documents must be in Microsoft Word and Excel format. Signature pages must be converted to Adobe PDF format. Do **not** send files in ZIP format.

Applicants who include data that they do not want disclosed to the public for any purpose or used by the U.S. Government except for evaluation purpose, should mark the title page with the following legend:

"This application includes data that shall not be disclosed outside the U.S. Government and shall not be duplicated, used, or disclosed – in whole or in part – for any purpose other than to evaluate this application. If, however, a grant is awarded to this Applicant as a result of – or in connection with – the submission of this data, the U.S. Government shall have the right to duplicate, use, or disclose the data to the extent provided in the resulting grant. This restriction does not limit the U.S. Government's right to use information contained in this data if it is obtained from another source without restriction. The data subject to this restriction are contained in sheets {insert sheet numbers} and, mark each sheet of data it wished to restrict with the following legend:

"Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this application."

Applicants should retain for their records one (1) copy of the application and all enclosures that accompany it.

3. Application Submission Procedures

It is the Applicant's responsibility to ensure that all necessary documentation is complete and received on time. If you experience difficulty with submission please contact Alfred Magudhu at amagudhu@usaid.gov.

Our preference is that the technical application and the cost application be submitted as single email attachments, e.g. that you consolidate the various parts of a technical application into a single document before sending them. If this is not possible, please provide instructions on how to collate the attachments. USAID will not be responsible for errors in compiling electronic applications if no instructions are provided or are unclear. All applications received by the submission deadline will be reviewed for responsiveness to the NFO and the application format. No addition or modifications will be accepted after the submission date.

After you have sent your applications electronically, immediately check your own email to confirm that the attachments you intended to send were indeed sent. If you discover an error in your transmission, please send the material again and note in the subject line of the email that it is a "corrected" submission.

Do not send the same email more than once unless there has been a change, and if so, please note that it is a "corrected" email.

4. Technical Application Format

The technical application will be the most important factor for consideration in selection for award of the proposed Cooperative Agreement. The technical application should be specific, complete and presented concisely. The application should demonstrate the Applicant's capabilities and expertise with respect to achieving the goals of this program. The application should take into account the requirements of the program and evaluation criteria found in this NFO.

A lengthy application does not in and of itself constitute a well thought out proposal, nor do unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective application in response to this NFO.

The Technical Application must be written in English and limited to **30** pages. PAGES EXCEEDING THIS LIMIT WILL NOT BE EVALUATED. The application shall be typed on standard A4 sized paper with at least one-inch margins and with each page numbered consecutively. Fonts used must not be less than 12 points. The Annex and items such as the Cover Page and Table of Contents are not included in the 30-page limitation.

The technical application shall include the following sections:

(1) Cover Page

(2) Table of Contents

(3) Acronym List

(4) Program Abstract/Executive Summary

(5) Technical Application Body

(6) The Annex

(1) The ***Cover Page*** is not included in the 30-page limitation and should include the following:
   a. Solictation Number;
   b. Program title;
   c. Name of organizations/institutions involved; with the lead or primary applicant clearly identified;
   d. Contact person for the prime applicant, with individual's name, title or position, telephone number, email address and physical address. Also state whether the contact person has the authority to negotiate on behalf of the organization, or if not, include the contact information for the appropriate person with the authority to negotiate.

(2) The ***Table of Contents*** is optional and not included in the 30-page limitation should list all parts of the technical application, with page numbers and attachments.

(3) The ***Acronym List*** is optional and not included in the 30-page limitation.

(4) The ***Program Abstract/Executive Summary*** should be a maximum of 2 pages, and counts toward the 30-page limitation. The Program Abstract/Executive Summary should summarize the key elements of the applicant's technical strategy, management approach, implementation plan, expected results and

monitoring and evaluation plan. The Program Abstract/Executive Summary should provide no cost figures other than the Total amount of USAID funds requested.

(5) The ***Technical Application Body*** should contain the main parts of the technical application and shall include the following sections:

a. Technical Approach
b. Staffing and Management Capacity and Approach
c. Performance Monitoring and Evaluation

a. Technical Approach

This section should include information sufficient to properly evaluate the application under the program requirements set forth in the Program Description. This section should address the following:

- Proposed technical strategy and approach fully addressing how the applicant will achieve the results outlined in the Program Description over the 5-year life of the activity with particular attention to the Zimbabwe NMCP Strategic Plan, overall PMI goals, and ZAPIM's guiding principles explained in Section 12 of the Program Description.
- Comprehensive Malaria Prevention & Treatment Technical Approach.
- Plan for quality control in the production of intellectual work.
- Description of how gender will be included in the strategy.
- Comprehensive, yet concise summary of the proposed overall strategic and technical approach.

b. Staffing and Management Capacity and Approach

This section should include information sufficient to properly evaluate the application under the program requirements set forth in Section 13 of the Program Description.

USAID wishes to continue promoting the use of local and regional expertise, thus applicants are encouraged to include among staff qualified Zimbabweans and African professionals in their staffing plan. There are three key personnel positions envisioned under this project. They are outlined below with illustrative roles and responsibilities that may be considered as a starting point. ZAPIM will require a full and dynamic staffing plan designed to implement the desired activities.

Chief of Party:

- Responsible for project inputs, program strategy, external representation and coordination with project counterparts, USAID, host country contacts, other donors within the sector and other programs as necessary.
- Responsible for compliance with the agreement results and the oversight of project activities which will meet the stated objectives of the project
- A background in public health with 10 years of program management experience and 2-5 of malaria experience is required.
- MPH or degree in another health related field required.
- Must have strong English language skills, both oral and written.
- Preferred Qualifications: more than 10 years of experience managing and implementing health care programs in international settings, preferably in Africa.

Technical Director and Malaria Specialist:

- Responsible for technical oversight of malaria prevention and treatment activities.
- A minimum of 8 years experience in malaria prevention and treatment programs required.

- MD, DVM, or MPH/PhD with strong background in malaria epidemiology required.
- Ability to mobilize and coordinate partners around selected malaria intervention policies, approaches and indicators required.
- Must have strong English language skills, both oral and written.
- Experience with planning, implementation, data management, and research/study analysis and interpretation preferred.
- Strong experience in results dissemination and publication is preferred.
- Additional preferred qualifications: More than 10 years implementing malaria programs internationally, preferably in Africa.

Finance and Operations Manager:

- Responsible for ensuring project adherence to USG financial rules and regulations.
- Responsible for providing quarterly financial report, including pipeline analysis.
- Previous experience (5-10 years) managing financial and legal requirements of large donor-funded projects required.
- Previous experience working with local organizations as part of subawards/subcontracts required.
- Degree and certification in Accounting or other related field required.

Complete descriptions of key personnel roles, responsibilities, skills and experience must be included in the Technical Application. Applicants should also provide a clear description of how the cooperative agreement will be managed, and explain communication and synergies among staff. This should include the roles and responsibilities of each subrecipient and the lines of authority and communication among the prime and all proposed subrecipients in order to maximize efficiency and best utilize technical expertise/strengths of each partner.

Applicants should provide an organizational chart for the program as part of Annex III (see below).

*c. **Performance Monitoring and Evaluation***

See Annex II below.

(6) The ***Annex*** is not included in the 30-page limitation and consists of more than one section as described below:

*a. **Annex I: Work Plan** (including narrative and milestone chart)*

Applicants must submit a preliminary detailed work plan for the five-year period including a narrative as an annex to the application. A detailed, rapid start-up plan should be contained within the work plan. The first year of the implementation plan should be as detailed as possible. This preliminary work plan will include, but not be limited to, a timeline with major milestones for carrying out the various activities proposed under this project. The work plan should be linked to the proposed technical approach as outlined in the narrative, be logical, and demonstrate how the applicant would implement this activity in order to achieve the goals and objectives as described in the Program Description.

*b. **Annex II: Preliminary Monitoring and Evaluation (M&E) Plan***

Applicants should include a preliminary M&E plan for the life of the program. For each intermediate result and/or sub-intermediate result, the following should be provided: proposed indicators, definitions, units of measure, baseline, and target(s). Refer to Section 13 of the Program Description (Project Activities) for illustrative results and to PMI's Website that provides PMI indicators and M&E tools. http://www.pmi.gov/how-we-work/cross-cutting-technical-areas/monitoring-and-evaluation

c. *Annex III: Management and Staffing Plan and Key Personnel*

Management and Staffing Plan: The applicant shall submit a Management Plan with an explicit description of the distinctive roles and responsibilities of the prime recipient and subrecipients (as may be applicable) and how each recipient will work together and contribute to achieving impact and outcome priorities. The plan should include an overview of how activities will be managed and coordinated between the prime recipient and subrecipients.

The applicant shall submit a staffing plan that includes an organogram/organizational chart with projected positions (key and non-key) and reporting relationships. The plan must discuss the division of responsibilities between in-country project staff, home office support (if international organizations are chosen as subrecipients), and all proposed subrecipients. The proposed staffing plan should demonstrate clearly how the staff will support the proposed technical approach to achieve results.

Key Personnel: USAID requests applicants to identify (up to five) key personnel and any other staff the applicant deems critical to the project with the relevant knowledge, skills, and abilities in implementing ZAPIM as outlined in the Program Description.

Letters of commitment and curricula vitae (CV) of all key personnel shall be included in the annex. Curricula vitae should also be submitted for other proposed project staff members considered critical to the success of the project. The page limit for each proposed staff member's CV is three pages.

Applicants must also submit 3 recent (within the last 5 years) professional references for each of the proposed key personnel. Please include current contact information for each professional reference to include email addresses and telephone numbers.

Applicants should also include copies of any letters of commitment from proposed subrecipients and/or other stakeholders. The submitted letters should indicate an intention to pool resources and/or collaborate on the applicant's proposed initiatives. The proposed partnerships should reflect the technical approach described in the application.

d. *Annex IV: Past Performance*

Past performance is defined as relevant information regarding the applicants' performance under a previous award. Applicants shall provide detailed past performance information for the ten most relevant current or previous awards performed within the last three years that are similar in size, scope, and objectives to what is described in the Program Description. For each of these, Applicants must submit the following information:

- Agreement, Grant, contract, order or other identifying information
- Agency or entity providing the funding
- Description of the program or scope of work
- Primary location(s) of program or work
- Period of performance
- Skills/expertise required
- Dollar value
- Type of agreement, contract, order or grant, e.g. fixed-price or cost reimbursement
- Contact information for two persons, including name, job title, phone numbers and email address

Past performance information must be submitted for all proposed subrecipients. Each Applicant should submit no more than 10 past performance information data sheets for the entire prime/subrecipient team.

Relevant experience is defined as experience in one or more of the following technical areas:

- Malaria prevention and treatment;
- African experience in a country with heterogeneous malaria epidemiology;
- Social and behavior change communications;
- Monitoring and evaluation; and
- Survey and/or study management, analysis, and documentation.

The combined experience of the prime and subrecipient will be counted as relevant. Relevant past performance of the prime recipient and any subrecipients will be taken into consideration.

5. Cost/Business Application Format

The applicant must sign and submit the cost application standard form number SF-424 and SF-424A. Standard Forms can be accessed electronically at www.grants.gov.

The Cost Application should be submitted separately from the Technical Application. While there is no page limit for this portion, applicants are encouraged to be as concise as possible while still providing the necessary details. The cost application should conform to the specifications noted below:

1. The cost application should be for a period of 60 months.

2. An overall budget should be included in the cost application that provides, in detail to the individual line item, a breakdown of the types of costs anticipated. The types of costs should be organized based on the cost categories in the SF-424. All budgets shall include a sheet relating to the entire 60-month period. The budget shall include a summary and breakdown of the costs allocated to any subrecipient involved in the program as well as the breakdown of the financial and in-kind contributions of all such organizations (the applicant can also include separate sub-agreement or subcontract budgets for the sake of clarity). The electronic version of the budgets should be provided in the unprotected Microsoft Excel format.

3. Budget notes are required. These budget notes must provide an accompanying narrative by line item that explains in detail the basis for how the individual line item costs were derived.

4. The following section provides guidance on line item costs.

   Salary and Wages - Direct salaries and wages should be proposed in accordance with the organization's personnel policies. Details on the basis of estimate for each proposed salary should be sufficiently addressed in the budget narratives for all positions [key, consultants, short term technical assistance and non-key personnel]. Any proposed salary increase [initial or annual] must be sufficiently justified and supported with the organization's personnel policies (to be provided as annex to the cost application).

   Fringe Benefits - If the organization has a fringe benefit rate that has been approved by an agency of the US Government, such rate should be used and evidence of its approval should be provided. If a fringe benefit rate has not been so approved, the application should propose a rate and explain how the rate was determined. If the latter is used, the narrative should include a detailed breakdown comprised of all items of fringe benefits (e.g., unemployment insurance, workers compensation, health and life insurance, retirement, etc.) and the costs of each, expressed in dollars and as a percentage of salaries.

Travel and Transportation - The application should indicate the number of trips, domestic and international, and the estimated costs. Specify the origin and destination.

Other Direct Costs - This includes communications, report preparation costs, passports and visas fees, medical exams and inoculations, insurance (other than insurance included in the Applicant's fringe benefits), equipment (procurement plan for commodities), office rent abroad, branding/marking supplies, etc. The narrative should provide a breakdown and support for all and each other direct costs.

Indirect Costs –Local/ regional or other organizations that do not have a Negotiated Indirect Cost Rate Agreement (NICRA) letter with the US Government, these organizations should treat all indirect costs as direct costs and provide a fully- developed and supported rationale for allocating or estimating how much of the indirect costs should be allocated to the program.

Seminars and Conferences - The application should indicate the subject, venue and duration of proposed conferences and seminars, and their relationship to the objectives of the program, along with estimates of costs.

Foreign Government Delegations to International Conferences: Funds in this agreement may not be used to finance the travel, per diem, hotel expenses, meals, conference fees or other conference costs for any member of a foreign government's delegation to an international conference sponsored by a public international organization, except as provided in ADS Mandatory Reference "Guidance on Funding Foreign Government Delegations to International Conferences" or as approved by the AOR. http://www.usaid.gov/sites/default/files/documents/1868/350maa.pdf

Source and Origin Requirements - The authorized Geographic Code for this Agreement will be 937.

Training Costs - If there are any training costs to be charged to this agreement, they must be clearly identified.

5. The required Certifications, including the SF 424s, should be included with the Cost Application.

6. As written above, the proposed budget should provide separate cost estimates for the management of the program (including program monitoring) or "administrative" costs and a cost estimate for program or "programmatic" costs. The Applicant should provide a basis or explanation for how costs were categorized as one or the other. Applicants should attempt to minimize their administrative and support costs for managing the project to maximize the funds available for program activities.

7. The cost/business portion of the application should describe headquarters and field procedures for financial reporting, if applicable. Discuss the management information procedure you will employ to ensure accountability for the use of U.S. Government funds. Describe program budgeting, financial and related program reporting procedures.

8. Indicate if financial commitments were made among partners during the preparation of the application. Budgets shall indicate the amounts committed to each member of the team. Letters of commitments from partners should be included.

9. If requested by USAID after submission of applications, please provide information on the applicant's financial and management status, or that of major subcontractors and subrecipients, including:
   (a) Audited financial statements for the past three years,
   (b) Organization chart, by-laws, constitution, and articles of incorporation, if applicable,

(c) If the applicant has made a certification to USAID that its personnel, procurement and travel policies are compliant with applicable OMB circular and other applicable USAID and Federal regulations, a copy of the certification should be included with the application. If the certification has not been made, the applicant should submit a copy of its personnel (especially regarding salary and wage scales, merit increases, promotions, leave, differentials, etc.), travel and procurement policies, and indicate whether personnel and travel policies and procedures have been reviewed and approved by any agency of the Federal Government. If so, provide the name, address, and phone number of the cognizant reviewing official.
(d) If applicable, approval of the organization's accounting system by a U. S. Government agency including the name, addresses, and telephone number of the cognizant auditor.

10. The cost application should also address the Applicant's resources and capacity in the following areas in narrative form:
(a) Have adequate financial resources or the ability to obtain such resources as required during the performance of the Program;
(b) Has the ability to comply with the agreement conditions, taking into account all existing and currently prospective commitments of the Applicant, non-governmental and governmental;
(c) Has a satisfactory record of performance (only a brief discussion of this issue is required in the cost/business application since past performance is an evaluation factor – the Applicant may wish to discuss any notable issues regarding its record of performance that were not discussed in the technical application);
(d) Has a satisfactory record of integrity and business ethics; and
(e) Is otherwise qualified and eligible to receive a cooperative agreement under applicable laws and regulations (e.g., EEO).

If requested by USAID after submission of applications, please provide any additional evidence of responsibility considered necessary in order for the Agreement Officer to make a determination of responsibility. Please note that a positive responsibility determination is a requirement for award, and all organizations may be subject to a pre- award survey to verify the information provided and substantiate

NOTE: USAID will not reimburse potential applicants or the selected recipient for any pre-award cost

If the Applicant has established a consortium or another legal relationship among its partners, the Cost/Business application must include a copy of the legal relationship between the parties. The agreement should include a full discussion of the relationship between the applicant and sub-applicant(s) including identification of the applicant with whom USAID will work with for purposes of agreement administration, identity of the applicant which will have accounting responsibility, how agreement effort will be allocated and the express agreement of the principals thereto to be held jointly and severely liable for the acts or omissions of the other.

The Cost/Business Application should also include:

1. A signed copy of ADS 303mav, Certifications, Assurances, and Other Statements of the Recipient and Solicitation Standard Provisions (found online at http://www.usaid.gov/ads/policy/300/303mav), which includes:

- Assurance of Compliance with Laws and Regulations Governing Nondiscrimination in Federally Assisted Programs (This certification applies to Non-U.S. organizations, if any part of the program will be undertaken in the U.S.);
- Certification on Lobbying;

- Prohibition on Assistance to Drug Traffickers for Covered Countries and Individuals (ADS 206);
- Certification Regarding Terrorist Financing, Implementing Executive Order 13224; and
- Certification of Recipient.

2. Other certifications and statements found in ADS 303mav, Certifications, Assurances, and Other Statements of the Recipient and Solicitation Standard Provisions found online at http://www.usaid.gov/ads/policy/300/303mav):

- A signed copy of Key Individual Certification Narcotics Offenses and Drug Trafficking, when applicable;
- A signed copy of Participant Certification Narcotics Offenses and Drug Trafficking when applicable; and
- Other Statements of Recipients.

3. Unique Entity Identifier and System for Award Management (SAM)

Applicants for USAID funding (unless the applicant is an individual or Federal awarding agency that is excepted from those requirements under 2 CFR §25.110(b) or (c), or has an exception approved by USAID under 2 CFR §25.110(d)) **are required to:**

(i) Be registered in SAM before submitting an application;
(ii) Provide a valid unique entity identifier (Dun and Bradstreet Universal Numbering System (DUNS) number) in its application; and
(iii) Continue to maintain an active SAM registration with current information at all times during which it has an active award or an application or plan under consideration by USAID.

USAID may not make an award to an applicant until the applicant has complied with all applicable unique entity identifier and SAM requirements and, if an applicant has not fully complied with the requirements by the time USAID is ready to make an award, USAID may determine that the applicant is not qualified to receive an award and use that determination as a basis for making an award to another applicant.

It is the applicant's responsibility to ensure that all necessary documentation is complete and received on time.

SECTION E: APPLICATION REVIEW INFORMATION

1. Review and Selection Process

Responsive applications shall be reviewed in two parts: 1) A Selection Committee (SC) comprised of USAID employees and technical experts will review technical applications in accordance with the merit review criteria described in the following section; and 2) thereafter, the cost/business application of the apparently successful applicant will be evaluated to determine reasonableness and allocability of costs in the budget in accordance with ADS 303.3.12.

The Government may make award on the basis of the initial applications received, without further discussions or negotiations. Therefore, each application should contain the applicant's best terms from a cost and technical standpoint. However, the Government reserves the right (but is not under obligation to do so), to enter into discussions with one or more applicants in order to obtain clarifications, additional detail, or to suggest refinements in the activity description, budget, or other aspects of an application.

The award decision will be made by the Agreement Officer.

Upon the award decision and prior to the issuance of the award, USAID will conduct a risk assessment of the apparently successful applicant, to include a review of the applicant's capability and experience. The applicant will be assessed on the extent to which the Applicant demonstrates successful experience in the areas described below:

- How well an applicant performed on past projects,
- The relevancy of the work performed,
- Instances of good performance,
- Instances of poor performance,
- Significant achievements,
- Significant problems,
- Effectiveness of key personnel working on past projects,
- Cost control, including forecasting costs and accuracy in financial reporting, and
- Any indications of excellent or exceptional performance in the most critical areas.

When performing the pre-award risk assessment, the U.S. Government will consider the written qualifications and capability information provided by the apparently successful applicant, and any other information obtained by the Government through its own research (e.g., references, performance assessments, or other sources).

2. Merit Review Criteria

The Selection Committee (SC) will review technical applications in accordance with the merit review criteria described below. The merit review criteria listed below are presented by major category in order of descending importance, so that applicants know which areas require emphasis in applications.

These criteria have been tailored to the particular requirements of this NFO to allow USAID to choose the highest quality application. These criteria: a) identify the significant areas that applicants should address in their applications; and b) serve as the standard against which the Selection Committee (SC) shall

evaluate all applications. USAID will award to the Applicant whose application best meets the project description thus achieving the highest technical merit.

In descending order of importance, the merit review criteria are: Technical Approach, Staffing and Management Capacity and Approach, and Performance Monitoring and Evaluation. The Selection Committee will give each application a technical score out of a possible 100 points. Detailed information about the criteria is provided below:

a. Technical Approach (45/100)

The technical approach will be evaluated on the overall merit (creativity, clarity, analytical depth, prioritization, and responsiveness) and feasibility of the project approach and strategies proposed to achieve the project's objectives, and expected results. The following bullet points may be considered, but specific weights are not assigned to each bullet:

- Demonstrated understanding of the key opportunities as well as the issues and challenges of implementing malaria control interventions in Zimbabwe.
- Proposed approaches are feasible, efficient and have potential to be expanded and ultimately to be sustainable in terms of training methodologies, service delivery modalities, and environmental safety considerations.
- Proposed approach and illustrative activities are relevant and likely to achieve the expected results.
- Demonstrated understanding of issues in capacity building, replicating, adapting and implementing best practices in order to advance malaria control in Zimbabwe
- Demonstrated understanding of and a proposed approach for actively engaging a variety of stakeholders, leading to harmonization, integration and coordination/collaboration among parties.
- Proposed approaches build on prior and current successes of malaria control programs (USAID, PMI, and other) in Zimbabwe and/or Africa.
- Quality of environmental protection considerations of USAID and PMI.
- Quality of gender awareness related to activities and plans to manage current or potential gender issues.

b. Staffing and Management Capacity and Approach (35/100)

The SC will evaluate applicants' key personnel, staffing plan, work plans, management plan and organizational structure, subcontractors/subrecipients, rapid start up plan and proposed ZAPIM team capacity according to the following considerations (no specific weights are assigned to each bullet point):

- The Chief of Party demonstrates leadership capacity, strategic vision, ability to manage complex projects, and ability to effectively build and sustain positive working relationships and partnerships with governments, donors and partners.
- The Chief of Party and other key personnel demonstrate knowledge, skills, and abilities to implement this project, with past performance on malaria or primary health care projects, particularly in Africa. They have proven expertise in building the capacity of public and private service delivery providers and organizations in the region. They have a proven track record and significant relevant experience to achieve the objective and results of the project.
- Proposed project personnel demonstrate solid expertise in the area for which they are being considered. Proposed core staff and consultants demonstrate requisite expertise, skills and experience, and knowledge of the Zimbabwean or African context to implement the cooperative agreement.

- Staffing pattern is structured to respond to the diverse geographic and technical requirements of the project description. National origin, language, and gender diversity are taken into consideration.
- Proposed first year and five year work plans, including the capacity to design and implement activities are likely to contribute to the overall project results.
- The quality of the proposed management plan and organizational structure for accomplishing all aspects of cooperative agreement implementation in an effective and sustainable fashion.
- Proposed subcontractors/subrecipients, private sector, and local partners possess complimentary skills that are balanced and well utilized in project implementation.
- Efficient plans for rapid startup of the project in Zimbabwe; adequate plans for how the project will manage a complex set of activities and balance competing demands including reporting requirements and managing partners.
- The application demonstrates the Applicant's proposed ZAPIM team capacity, organizational systems and competence to creatively plan and implement the project.

c. Performance Monitoring and Evaluation (20/100)

The following bullet points may be considered upon evaluation of the Monitoring and Evaluation (M&E) Plan, however specific weights are not attached to each bullet: Plan will be evaluated according to the following criteria (bullet points do not have specific weights attached):

- The application presents a comprehensive, realistic M&E Plan that clearly outlines its approach to M&E and research. The PMP delineates ambitious but achievable performance targets and benchmarks for achieving the results outlined in the project description. Special attention should be paid to indicators that measure outcome and impact and not just process and outputs.
- The M&E Plan demonstrates what will be achieved by years one, three and by the end of the project. Indicators for targets, and benchmarks show how they lead to the achievement of results and are in line with those indicators advocated by PMI.
- The M&E Plan describes a methodology to be used for data collection that is cost effective and timely.
- Quality of planning for quality control in the production of all intellectual work.

SECTION F: FEDERAL AWARD ADMINISTRATION INFORMATION

1. Notice of Award

USAID reserves the right to make awards without discussions. Successful applicants can expect to receive a notice of award signed by the Agreement Officer which serves as the authorizing document. Unsuccessful applicants will be notified by letter sent electronically from the Agreement Officer. Notification will be sent electronically to the person indicated on the cover page of the application. Debriefings will be considered if requested in writing within 10 days of notification from the Agreement Officer.

Award of the agreement contemplated by this NFO cannot be made until funds have been appropriated, allocated and committed through internal USAID procedures. While USAID anticipates that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for the award. The Agreement Officer is the only individual who may legally commit the Government to the expenditure of public funds. No costs chargeable to the proposed Agreement may be incurred before receipt of either a fully executed agreement or a specific, written authorization from the Agreement Officer.

2. Deviations

No deviations are currently contemplated to the standard provisions for the cooperative agreement resulting from this NFO.

3. Reporting Requirements

The Recipient must adhere to all reporting requirements listed below. All reports shall be submitted by the due date for approval by the USAID Agreement Officer's Representative (AOR) designated by the Agreement Officer. The Recipient will consult the AOR on the format and expected content of reports prior to submission.

a. Financial Reporting:

The Recipient must submit quarterly financial reports to USAID within 30 calendar days following the end of each quarter using the Office of Management and Budget SF-425. Financial reports are due January 31, April 30, July 31, and October 31. The SF 425 (and SF 425a if necessary) must be submitted via electronic format to the Agreement Officer's Representative (AOR), the Agreement Officer (AO), and the USAID/Zimbabwe Financial Management Office. The Federal Financial Report (FFR/SF-425) is available in PDF or Excel format at the OMB website: http://www.whitehouse.gov/omb/grants_forms/.

b. Performance Monitoring and Reporting:

The Recipient shall submit copies of each report listed below to the Agreement Officer's Representative (AOR) with a copy to the Agreement Officer.

(1) <u>Annual Work Plan</u>

The Recipient is required to prepare and submit an annual work plan in accordance with the following schedule. A first draft of the Year One work plan will be due within forty five (45) days of the award of the cooperative agreement. This work plan will be reviewed and USAID written comments forwarded to

the Recipient within one month of submission, and then finalized by the Recipient no later than two (2) weeks after Recipient's receipt of USAID's written comments. USAID will collaborate closely with the Recipient as USAID funding, technical, and policy guidelines evolve to ensure necessary degrees of flexibility are built into all Work plans and strategies over the course of the cooperative agreement.

The Recipient will be encouraged to ensure that its work plans and budgets are (i) well-coordinated and mutually reinforcing with those of other USG and other donor partners working in the targeted health zones and provinces; (ii) explicitly linked to achievement of the USAID funded project; and (iii) prepared in a timely manner.

The Recipient should ensure that all research or data collection activities under the program are undertaken in collaboration and/or consultation with host countries' governments. Recipient should collaborate closely with USAID and other partners to avoid possible redundancies. The work plan will outline the:

- Proposed accomplishments and expected progress towards achieving planned results and performance targets tied to the M&E plan
- Timeline for implementation of the year's proposed activities, including target completion dates
- Information on how activities will be implemented and supervised
- Personnel requirements to achieve expected outcomes
- Major commodities and equipment to be procured when applicable
- Details of collaboration with other major partners
- Detailed budget
- Planned short term technical assistance

(2) <u>Quarterly and Annual Progress Reports</u>

On a quarterly basis, thirty (30) days following the close of each three month period (based on the USG fiscal year), the Recipient shall prepare and submit to USAID/Zimbabwe written status reports (Quarterly Reports) that:

- Identify and relate the benchmarks to the achievements, as identified in the applicant's annual monitoring and evaluation implementation plan, of the three month period of the approved implementation plan
- Provide status on relevant indicators identified in the performance monitoring plan
- Identify key problems or issues encountered, how they were or will be resolved, and, if/as required, recommended Mission-level intervention to facilitate their timely resolution;
- Include a brief summary of achievements during the concluding quarter towards planned targets
- Submit success stories
- Evolution of critical assumptions

The final quarterly status report of the fiscal year will serve as the annual status report for the concluding year (inclusive of all previous quarters of the year), and shall be submitted within thirty (30) days following the close of the fourth quarter (July-September). In addition to meeting the above requirements, the annual report shall include a discussion, supported with quantitative and qualitative evidence, (which evidence shall remain auditable under the terms of the agreement and USAID program implementation procedures), of impacts achieved during the appropriate fiscal year. This shall include clear identification of which impacts achieved were within the manageable interests of the Recipient and which were likely catalyzed by Recipient-supported initiatives, leading to substantial, sustained achievement of results. This discussion will be instrumental in helping the Mission to complete Annual Reports to USAID/Washington.

(3) Monitoring and Evaluation Plan

The Recipient must provide a comprehensive plan for project monitoring, evaluation, and reporting on achievements monitoring the critical assumptions data. Specific data required are of two types: (i) those that report on progress toward Recipient-proposed milestones and targets under the Cooperative Agreement (CA); (ii) those to measure USAID required indicators as established by USAID's Operational Plan and the MOP. The plan will also describe the established quality assurance system. It is emphasized that the indicators in this Project Description are illustrative and the Recipients may propose indicators more relevant to their proposed program in addition to the mandatory PMI indicators. The Monitoring & Evaluation plan is expected within 60 days of the award and is subject to approval by USAID.

(4) Branding and Marking Plan

The Recipient shall submit a Branding and Marking Plan 30 days after the award effective date, if it is not approved prior to finalizing the award.

(5) Final Report

No later than 90 days after the completion date of the agreement, the recipient must prepare a completion report and oral end-of project presentation which highlight accomplishments against work plans, gives the final status of the benchmarks and objectives, addresses lessons learned during implementation and suggests ways to resolve identified constraints. The report should provide recommendations for follow-on work that might complement the completed work and details of close out and transition plans. The recipient shall submit an electronic version, an original hard copy and two copies of the final report to the AOR. One additional copy must be sent to the USAID Development Experience Clearinghouse.

(6) Close-out Plan

Six months prior to the completion date of the agreement, the applicant will submit a close-out plan for AOR approval. The close-out plan will include, at a minimum, an illustrative property disposition plan, a plan for the phase-out of in-country operations, a delivery schedule for all reports or other deliverables required under the task order and a timetable for completing all required actions in the close out plan, including the submission date of the final property disposition plan to the Agreement Officer. A final project report will be due 90 days after project closeout.

4. Standard Provisions

Depending on the type of organization receiving the award, the following Standard Provisions will apply:

Standard Provisions for U.S. Nongovernmental Organizations found at
http://www.usaid.gov/ads/policy/300/303maa

Standard Provisions for Non-U.S. Nongovernmental Organizations found at
http://www.usaid.gov/ads/policy/300/303mab

Standard Provisions for Cost-Type Awards to Public International Organizations found at
http://www.usaid.gov/ads/policy/300/308mab

SECTION G: FEDERAL AWARDING AGENCY CONTACTS

The Agreement Officer for this award is:

Leona Sasinkova
Agreement Officer
USAID/Zimbabwe
No. 1 Pascoe Avenue
Belgravia
Harare, Zimbabwe
Email: lsasinkova@usaid.gov

The Financial Office for this award is:

Financial Management Office
USAID/Zimbabwe
No. 1 Pascoe Avenue
Belgravia
Harare, Zimbabwe
Email: harareinvoice@usaid.gov

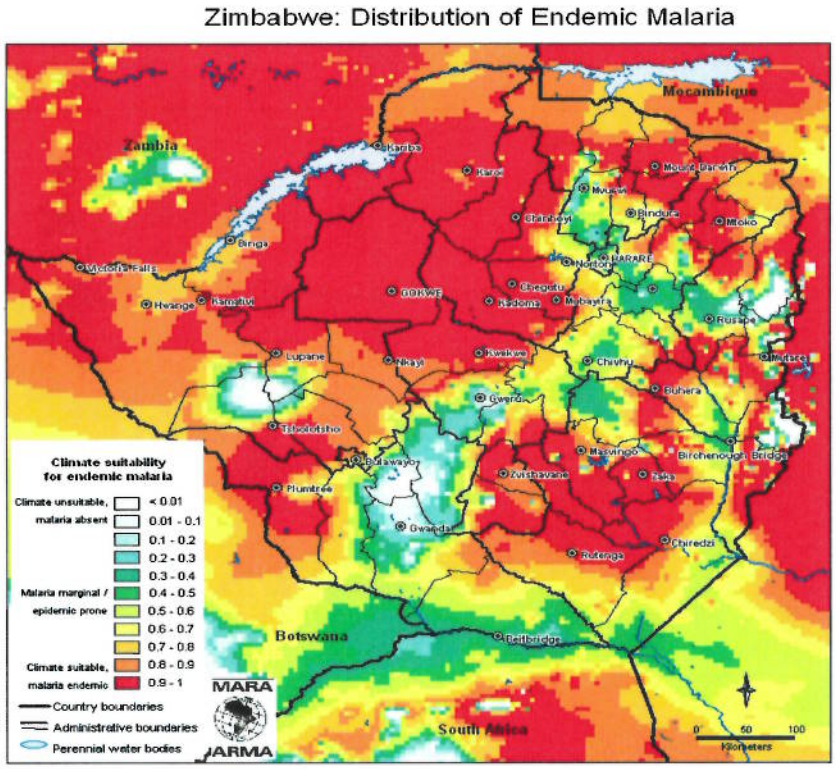
SECTION H: OTHER INFORMATION

Annex I. Malaria Burden & Epidemiology

In Zimbabwe malaria continues to be a major public health challenge with differing epidemiological patterns throughout the country that require an alert, well-prepared, and flexible public health and health service delivery system. Over half of the population of 13,061,239[11] is at risk of malaria. Zimbabwe has seen robust declines in transmission and disease burden. Today, malaria is the 5th leading cause of morbidity (compared to being the third leading cause at the start of the PMI Zimbabwe implementation period in 2011).

Zimbabwe has seasonal and geographic variation in malaria transmission that corresponds closely with the country's rainfall pattern (see Figure 1).

Figure 1: Distribution of Malaria in Zimbabwe, 2002



This map is a product of the MARA/ARMA collaboration (http://www.mara.org.za). July 2002, Medical Research Council, PO Box 70380, Overport, 4067, Durban, South Africa
CORE FUNDERS of MARA/ARMA: International Development Research Centre, Canada (IDRC); The Wellcome Trust UK; South African Medical Research Council (MRC); Swiss Tropical Institute, Multilateral Initiative on Malaria (MIM) / Special Programme for Research & Training in Tropical Diseases (TDR), Roll Back Malaria (RBM).
Malaria distribution model: Craig, M.H. et al. 1999. Parasitology Today 15: 105-111.
Topographical data: African Data Sampler. WRI. http://www.igc.org/wri/sdis/maps/ads/ads_idx.htm

In general, the major malaria transmission season occurs during the rainy season between November and April, with the average temperature ranging between 18 and 30 degrees Celsius. The annual rainfall varies from less than 700 mm in Matabeleland to more than 1,500 mm in Manicaland. Malaria transmission is lower in the low rainfall areas and higher in the high rainfall provinces (Figure 1).

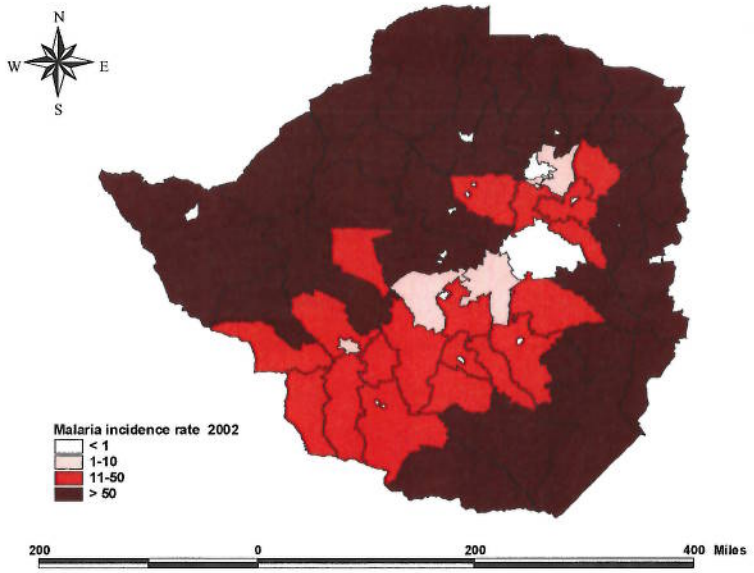
Geographically, Zimbabwe is divided by a central watershed lying higher than 1,200 meters above sea level and flanked north and south by low lying areas. In 1986, the country was divided into three malaria epidemiological areas: areas below 900 meters to the north and below 600 meters in the south have perennial transmission; areas between 900–1,200 meters north and 600–900 meters south have seasonal transmission and are prone to epidemics; areas above 1,200 meters north and 900 meters in the south normally does not experience malaria transmission.[12]

[11] Zimbabwe Population Census 2012, National Report, Zimbabwe National Statistics Agency.
[12] National Malaria Control Programme, Ministry of Health and Child Care, Zimbabwe.

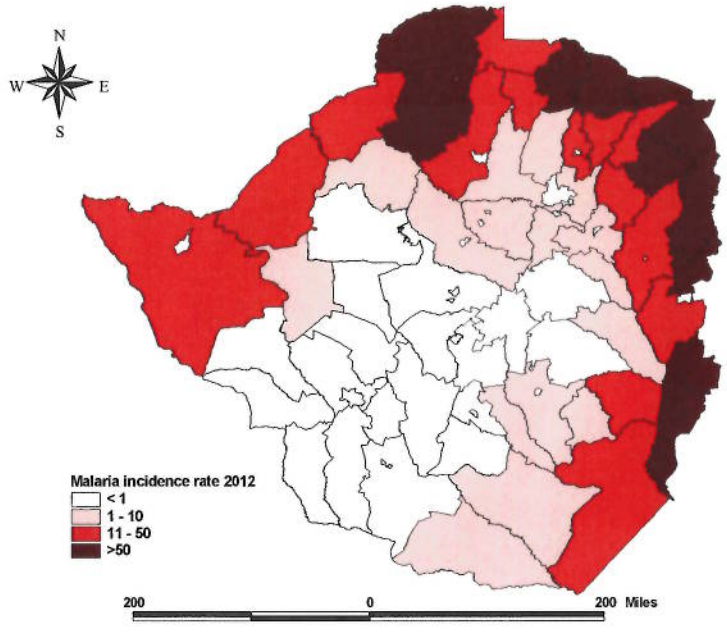
Plasmodium falciparum accounts for 98 percent of all reported malaria cases; *P. ovale* and *P. malariae* account for the remaining 2 percent. There are two important mosquito (vector) species responsible for transmission of malaria in Zimbabwe - *Anopheles gambiae* and *Anopheles funestus*. The Centers for Disease Control and Prevention (CDC) light traps and pyrethrum spray catches conducted at PMI-supported sentinel sites in 2013-14 showed the major malaria vector to be *Anopheles (An.) gambiae s.l.* in most parts of the country. *Anopheles funestus* was found to be prevalent in Mutasa and Mutare Districts of Manicaland Province. Other vectors such as *An. pretoriensis,* and *An. rufipes* are also present in low numbers (Source: Africa Indoor Residual Spraying (AIRS) Project Data, 2013). *Anopheles quadriannulatus,* a member of the *An. gambiae complex*, is commonly found in Zimbabwe, but is zoophilic and therefore not a malaria vector. A fourth member of the complex, *An. merus,* which is a vector in coastal areas of Eastern Africa, has also been reported in Zimbabwe; however, its role in malaria transmission is unclear.

Entomological surveillance is showing increasing vector resistance to pyrethroid insecticide in the highest burden districts in addition to the higher number of *An. funestus,* a species which is resistant to pyrethroids and sensitive to dichlorodiphenyltrichloroethane (DDT) and more expensive organophosphates (OPs), than noted in recent years.

Figure 2. Change in Malaria Incidence, 2002-2012, Zimbabwe



Malaria incidence rate, per 1000/pop, **2002**, Zimbabwe



Malaria incidence rate, per 1000/pop, **2012**, Zimbabwe

According to the NMCP's latest figures, malaria cases decreased from 1.8 million in 2006 to 377,872 cases in 2013[13]. Outpatient department malaria cases have decreased from about 1.53 million in 2005 to approximately 659,262 in 2013 (Figure 3 below); inpatient malaria

[12] Zimbabwe Malaria Program Review, Ministry of Health and Child Care (2012).

cases declined from 53,000 in 2005 to 26,000 in 2013 with case fatality rate for same period oscillating from 4.0 percent in 2005 to 1.4 percent in 2013.

Figure 3. All Cause Outpatient Department (OPD) Cases versus OPD Malaria Cases, 2003-2012, Zimbabwe

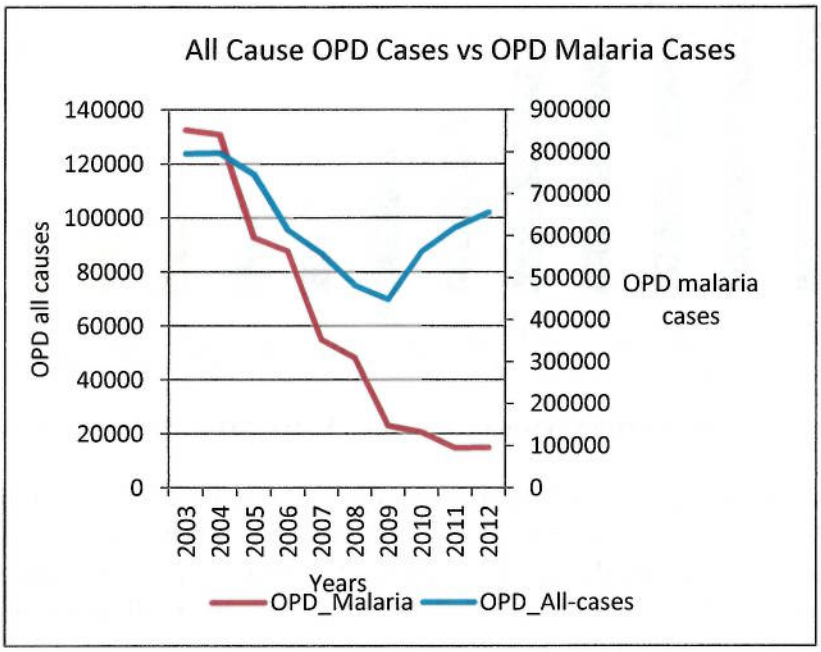
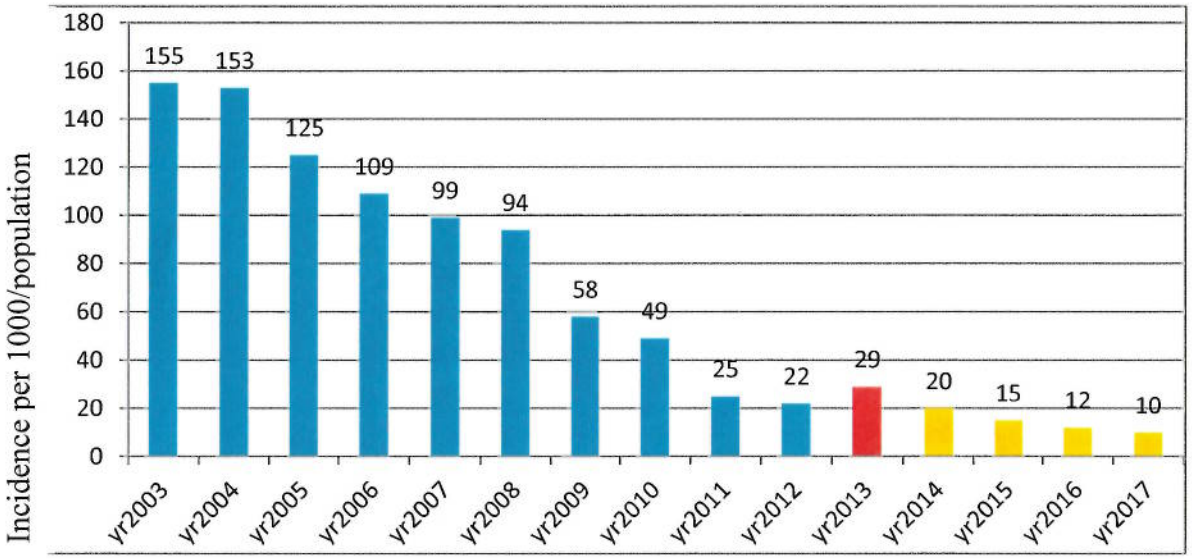


Figure 3 above highlights the declining contribution of malaria to all-cause outpatient mortality; Declines in malaria admissions and deaths were much greater in the high transmission areas rather than in the low transmission areas. Sustaining these gains which Zimbabwe has achieved is dependent on sustained coverage of control interventions and strengthened surveillance. By December 2013, Zimbabwe's reported malaria incidence rate was 29 cases per 1,000, indicating a decline of approximately 80 percent from the 2003 data – however also marking a 7 percent increase from 2012's low of 22 cases per 1,000. (Figure 4) It is difficult to know how much of the reduction in incidence is due to migration, changing weather patterns, oscillations in data quality, or if this represents a true reduction due to effective malaria control interventions. The NMCP and WHO collaborated on a rapid impact assessment exercise in 2013 to determine the impact of the scaled up interventions on transmission trends, as well as on disease burden and mortality. They concluded that the decline in malaria inpatient admissions and deaths was seen after the shift from choloroquine to its combination with sulfadoxine/pyremethamine (SP), and the introduction of insecticide-treated bednets (ITNs). In addition, a more dramatic decline resulted after the mass distribution of long lasting insectide-treated bednets (LLINs) to the general population, as well as the introduction of ACTs in the public sector in 2008.[14]

[14] World Health Organization (WHO), 2013. Rapid Impact Assessment: Antimalarial Interventions and Trends of Malaria Cases and Deaths in Hospitals, 2003-2012.

Figure 4. Malaria Incidence per 1,000 Population, by Year, 2003-2013, Projected to 2017



Source: Zimbabwe Health Information System (HIS) Note: Years 2014-2017 are projections

While overall malaria incidence in Zimbabwe is decreasing, it remains a major challenge in certain provinces, districts and wards. Approximately 86 percent of all malaria cases and 60 percent of all malaria death in 2013 originated from three provinces: Manicaland, Mashonaland East and Mashonaland Central, with 51 percent of all cases and 35 percent of all deaths coming from Manicaland. (Tables 2 and 3).

Table 2. Malaria Morbidity Data by Province, 2013, Zimbabwe

Province	Malaria Cases*	% Contribution
Manicaland	192,730	51.0
Mashonaland East	60,968	16.1
Mashonaland Central	70,749	18.7
Subtotal (3 provinces)	**324,447**	**85.9**
Other Provinces	53,425	14.1
National	**377,872**	**100**

***Diagnostically confirmed**

Table 3. Malaria Mortality Data by Province, 2013, Zimbabwe

Province	Malaria Deaths	% Contribution
Manicaland	**121**	**34.5**
Mashonaland East	48	13.7
Mashonaland Central	41	11.7
Subtotal (3 provinces)	**210**	**59.8**
Other Provinces	**141**	40.2
National	**351**	**100**

Annex II. PMI/Zimbabwe Program

The PMI/Zimbabwe program follows the PMI major implementation areas constituting a comprehensive malaria program.

Insecticide-treated nets (ITNs): PMI is supporting the MOHCC's goal of universal coverage of long-lasting insecticidal nets (LLINs) in 47 districts with moderate to high transmission of malaria.

Indoor residual spraying: Zimbabwe has a long history of IRS dating back to the 1950s. The NMCP IRS strategy focuses on 47 high-burden malaria districts throughout the country. With FY 2014 and FY 2015 funds, PMI will refocus its support for universal IRS from a limited support in all pyrethroid districts in Zimbabwe to a comprehensive support of four high burden districts of Manicaland Province (a province that contributes about 51 percent of malaria cases in Zimbabwe) using organophosphate (OP) insecticides to create a model spraying program in the four highest burden districts in Manicaland: Mutare, Chimanimani, Nyanga, and Mutasa. PMI IRS support includes the procurement of insecticide, equipment and personal protective equipment for spray operations, training implementation, and environmental compliance for IRS. In addition, PMI supports entomological monitoring to assure quality spraying and developments in insecticide effectiveness and resistance.

Malaria in pregnancy (MIP): Zimbabwe's malaria in pregnancy policy focuses on the high-burden malaria districts. In 2014, PMI and partners worked with NMCP to introduce the NMCP's adoption of the latest WHO recommendations for IPTp. The current policy calls for the administration of IPTp-sulfadoxine-pyrimethamine (SP) at each antenatal care visits (ANC) visit except during the first trimester and with doses ideally given under direct observation at least one month apart until the time of delivery. PMI supports the procurement of SP, ITN consistent use, early ANC visits and prompt malaria case management.

Case management: Since 2007, the first-line treatment for malaria has been the ACT drug, artemether-lumefantrine (AL). The NMCP policy requires that, where possible, all suspect cases of malaria undergo diagnostic confirmation by microscopy or a RDT. At the end of 2010, the pharmacy board and the laboratory regulatory council changed the policy to allow CBHWs to perform diagnosis using RDTs and dispense ACTs for positive cases. Village Health Workers (VHWs), a subgroup of CBHWs, are trained in integrated community case management (iCCM) as well as more comprehensive malaria community case management (MCCM) to deliver integrated care. School Health Masters used to teach about malaria prevention and dispensed chloroquine to school children but have not been a functional group for case management in the past five years but VHWs remain an active group. The NMCP has discussed plans to revive the SHMs to diagnose and dispense ACTs and possibly manage distribution of routine LLINs in the near future. In addition to supporting the drug management and distribution systems ZIPS and ZAPS), with FY 2015 funds: PMI will procure approximately 2 million RDTs and 450,000 ACT treatments for

uncomplicated malaria and distribute them to primary health facilities and CBHWs throughout the country. PMI will also support the recent NMCP adoption of the latest WHO-recommended guidelines for IPTp for control of malaria in pregnancy and use of ACTs for uncomplicated malaria and parenteral artemisinin products for the treatment of severe malaria. The support will include updating worker guidance materials and training of the workforce, (health workers and CBHWs), and providing monitoring and supervision.

Monitoring and evaluation (M&E): Prior to PMI support in Zimbabwe, the NMCP, with the support of Global Fund and other partners, developed a National Malaria M&E Strategy and Plan. The plan covered 2008–2015, but in 2014 was extended to 2017 to be more in line with the WHO pre-elimination strategies, and describes, by program area, the type of data needed, the indicators, data collection and flow, analysis, reporting, feedback and stakeholders' responsibilities. PMI anticipates that two national level health surveys will take place during 2015–2016. The MOHCC and partners are planning a DHS and an AIDS indicator survey in 2015. The sampling and timing of the DHS are not optimal for measuring malaria parasitemia (planned for June-December 2015 whereas malaria peak season in Zimbabwe is November-May); therefore, the NMCP has begun planning a Malaria Indicator Survey (MIS) to be conducted in 2016. PMI plans to support the planning and implementation of both the DHS and MIS with in-country partners.

With FY 2015 funding, PMI will continue to support malaria surveillance and national survey activities, M&E trainings at all levels including CBHWs, as well as supervisory and district health facility trainings. In addition, PMI support will be used to facilitate quarterly meetings for district-, provincial- and national-level representatives to meet and discuss surveillance and M&E related issues. PMI will continue to support four therapeutic efficacy monitoring sites every other year. PMI will continue supporting LLIN durability monitoring following the LLINs that were distributed in a mass campaign in 2014. PMI will contribute to the 2015 DHS as well as support the MIS in 2016.

Operations research (OR): In FY2015, PMI will support two operational research (OR) activities. One will assess the seasonal population movements, health care access, and malaria disease burden in Manicaland Province on the border with Mozambique. This two-phase activity will seek to better understand the changing burden and risk of malaria in this province and to understand the driving forces behind persistently high incidence levels and re-occurring outbreaks. Phase 1 will be an mixed qualitative and quantitative assessment to characterize the at risk populations and their access to care and evaluate health facility patient records conducted with FY 2014 funds and FY 2015 funds will support the research component of the activity to determine the determine the burden of malaria in the populations of interest. The second OR activity will support the testing of dried blood spots in order to better quantify national parasitemia levels using a more sensitive test. In addition, this is consistent with the 2014 WHO recommendation that the use of nucleic acid amplification methods by malaria programs should be considered for epidemiological research and surveys aimed at mapping submicroscopic infections at low transmission intensity.

Behavior change communication (BCC): Zimbabwe's 2008-2015 National Malaria Communication Strategy and Implementation Guidelines documents utilize advocacy, social mobilization, and BCC for malaria prevention and control through traditional and religious leaders and community volunteers organized into WHTs. The NMCP uses WHTs and community malaria committees to promote IRS campaigns and raise awareness about LLIN distribution and consistent use. During the last quarter of 2013, PMI supported extending the National Malaria Communication Strategy from 2013 to 2015 in line with the National Malaria Control Strategy, as well as development of Implementation Guidelines for partners. With funds from FY 14 MOP, a review of current BCC activities will be carried out and will inform plans for activities to be implemented with FY 15 funds. With FY 2015 funds, PMI will work with the NMCP and partners to strengthen BCC activities for malaria prevention and treatment, particularly working with CBHWs at the community level.

Capacity building: PMI will support capacity building by contributing to the Field Epidemiology Training Program, a successful, 21 year-old program in Zimbabwe, which is designed to train leaders in applied epidemiology while providing epidemiologic services to national and sub-national health care workers and supervisors. PMI's support will provide for a malaria-focused educational experience for selected participants to further enhance the workforce capacity in malaria control and prevention.

Current Status of Malaria Indicators

As in many African countries, PMI and the NMCP rely on nationally representative health surveys to track progress in coverage of malaria control interventions in Zimbabwe. There have been five such surveys since 2005. The most recent three surveys have been a Multiple Indicator Monitoring Survey (MIMS) conducted by UNICEF from August 2009 to October 2009, the DHS carried out from September 2010 to March 2011, and an MIS conducted from February 2012 to April 2012. The latter was conducted by NMCP with support from the Global Fund and PMI. Data from the 2012 MIS provided the baseline levels of key PMI indicators. The next DHS in 2015 will provide important malaria intervention coverage indicators and the next MIS in 2016 will provide updated malaria parasitemia measurements and sub-national data on malaria indicators.

Zimbabwe has achieved steady gains in many key malaria indicators. Between the 2005 and 2012 ITN ownership and use and the uptake of IPTp2 have increased significantly (Table 4). These data are encouraging but also suggest that efforts to scale up interventions must continue for Zimbabwe to achieve the RBM, PMI, and national targets.

The 2010 DHS shows national ITN ownership of one or more ITNs averaged 29 percent for the country compared to 9 percent in 2005, and the 2012 MIS found a higher proportion of ITN ownership (46 percent) in the 51 malaria endemic districts that were sampled. The 2010 DHS found that 10 percent of children under five reported sleeping under an ITN the previous night compared to 50 percent in the 51 malaria endemic districts sampled in the 2012 MIS.

Table 5. Estimates of Malaria Indicators, 2005-2012

Indicator	2005 DHS	2009 MIMS	2010 DHS	2012 MIS*
Proportion of households with one or more ITNs	9%	27%	29%	46%
Proportion of children under five years old who slept under an ITN the previous night	4%	17%	10%	57.9%
Proportion of pregnant women who slept under an ITN the previous night	NA	NA	10%	NA**
Proportion of women of child-bearing age who slept under an ITN the previous night	NA	NA	NA	44.6%
Proportion of women who received two or more doses of IPTp during their last pregnancy in the last two years	NA	NA	7%	35%
Proportion of children under five years old with fever in the last two weeks who received treatment with ACTs	5%	14%	2%	NA

*MIS was conducted in 51 malaria endemic districts of eight rural provinces
**Data was collected on net use by women of child-bearing age but not among pregnant women specifically

Integration, Collaboration, Coordination

Both USAID and CDC support programs in three key areas of GHI: HIV and AIDS, TB, and malaria. With FY 2015 funding, PMI/Zimbabwe will actively seek opportunities to collaborate with other USG health programs so as to ensure maximum impact for every health dollar the USG invests in the country. ZAPIM's role will include communication and collaboration with the MOHCC, NMCP, other partners working in malaria and other health areas but not duplicate services and products.

Opportunities to collaborate include the following:

Maternal and child health services and malaria: Since malaria prevention and control activities have been implemented as part of integrated maternal and child health services, PMI will make a significant contribution to strengthening capacity to deliver these services. PMI will work with other USG-funded programs and other partners to support the

comprehensive primary health care package, including the training and implementation of community-based diagnosis and treatment of fever, IPTp, and early treatment. PMI will continue to support universal coverage of LLINs via campaigns as well as the integration of LLIN distribution within routine ANC and expanded program on immunization services.

Integrated Community Case Management (iCCM): With increasing numbers of home births, falling household compliance to key child health household practices, and added barriers to care for women, newborns, and children (i.e., user fees and fewer rural health centers providing birthing and clinical care), the need is evident to focus increased attention on the community and households. PMI/Zimbabwe is supporting malaria prevention and treatment as a part of iCCM.

Beginning in early 2010, the MOHCC and its partners launched a training program to revitalize the CBHW cadres. Other partners are also supporting iCCM. UNICEF is currently supporting CBHWs training and providing other inputs such as bicycles, and the MOHCC is using Global Fund New funding model to expand CBHWs refresher training to all districts, provide CBHW kits, and once again offer a monthly stipend (approximately $15 per month) to each CBHW. The community-based maternal and newborn care manual, developed by WHO and UNICEF, comprises the primary content for the current CBHWs refresher training. The Health Transition Fund, a partnership of private and bilateral donors, is also supporting the CBHWs.

PMI has complemented other partner resources to integrate malaria community case management within the scope of the CBHWs program. PMI's partner is training CBHWs to provide an integrated package of care using a new community register as a job aid and to record visits on conducting comprehensive care. Village health workers have an important role to play in mobilizing their communities and identifying those women, infants, and sick children who require care.

Strengthening of supply chain system: PMI will also support the strengthening of supply chains, including support for the ZIPS or its successor, ZAPS, which includes TB commodities, primary health care packages, and malaria commodities, namely RDTs, SP, and ACTs.

HIV and malaria: The seroprevalence of HIV infections is high at an estimated 15.2 percent among individuals aged 15 to 49 years old.[15] Infection with HIV is higher among women (17.7 percent) than men (12.3 percent) and is higher in urban areas (7.0 percent) than in rural (4.8 percent) areas.

Areas where integration will be pursued between the MOHCC's HIV/AIDS Program and NMCP include: promoting adherence to universal precautions when taking blood samples, integrating laboratory quality assurance, providing LLINs to people living with HIV and AIDS, and ensuring appropriate malaria prevention services at integrated into the Prevention of Mother-to-Child Transmission platforms. At the community level, PMI will

[15] Zimbabwe 2010/11 Demographic and Health Survey.

support CBHWs who provide RDT and ACT services to also communicate important messages regarding HIV prevention and testing.

Tuberculosis and Malaria: The National Tuberculosis Program supports the activities of village health promoters to inform and support TB diagnosis and follow-up. Where these promoters are the same as the CBHWs that provide RDT and ACT services, PMI will work to integrate activities across HIV, TB, and malaria.

Routine partner collaboration and coordination: Commitment to reducing the malaria burden and continuing on the path of malaria elimination is evident at the highest levels of the MOHCC. The NMCP staff meets weekly to review work plans and monitor progress. The NMCP coordinates with partners through five malaria technical subcommittees: vector control, M&E, case management, BCC, and procurement and supply management. These sub-committees meet quarterly and are chaired by the NMCP or other MOHCC staff, and include the PMI Zimbabwe in-country team and PMI implementing partners.

The NMCP participates actively in the multi-sectoral Inter Agency Coordination Committee on Health "formerly Health Cluster" group meetings, chaired by the MOHCC's Director of Epidemiology and Disease Control. Also, the Health Partners Development Group meets on a quarterly basis to discuss issues of mutual interest. Currently, USAID chairs these meetings with WHO being the alternate chair.

PMI, led by the PMI in-country team, will work closely with the NMCP, RBM partners, Global Fund-funded, and other health-related programs in Zimbabwe to provide integrated services at the health facility and community level. PMI will work with others in USAID/Zimbabwe to ensure coordination of PMI-supported activities within the broader context of the health strategies. These approaches will ensure the most cost-effective implementation of prevention and treatment measures. PMI and NMCP have agreed on a quarterly PMI implementing partners meeting, which include PMI Resident Advisors, partners, and the NMCP.

In addition, PMI staff will provide leadership and technical assistance in other coordinating bodies such as the local RBM (including relevant RBM sub-committees). At the planning and implementation levels, PMI and other partners will work together to effectively fill commodity and human resource gaps.

Challenges, Opportunities, and Threats

The current USG restrictions prohibiting funding directly to the GOZ or any institution affiliated with the GOZ, make it challenging to implement NMCP-led activities in Zimbabwe. However, both major malaria donors (PMI and Global Fund) work through partners that operate under the leadership of NMCP; planning and working closely with NMCP staff throughout all activities.

District health staff, including EHTs, and health facility workers are responsible for malaria prevention and control activities implementation in communities, including the training

and supervision of CBHWs. Because of current USG policy in Zimbabwe, PMI is unable to support government staff per diem or allowances for routine visits to the field, such as monitoring, which are critical for a successful program implementation; and there are seldom funds available for supervision from GOZ. Global Fund has funded government staff per diem for some activities in the past. Nevertheless, ensuring that monitoring visits occur and that staff are compensated is a particular challenge. However, PMI does fund government staff per diem on an ad hoc basis providing support for some participation in training, monitoring and supervision events/visits.

Additionally, the need for a strong vector management strategy is increasing. Given the documented change in Anopheles species and insecticide resistance, a strategic approach to prevention using LLINS and IRS is warranted.

While Zimbabwe has made improvements in the use of parasitological diagnosis of cases to guide treatment, the diagnostic capacity needs a strong quality assurance (QA)/quality control (QC) system to maintain and advance gains made. Because of critical challenges in administration and management with a local designated partner, PMI was unable to fund a QA/QC program for diagnostics. However, PMI has prepared a description of detailed need in this area (supervision, tools, job aids, etc.) and recent collaborations with an international partner and/or new Global Fund resources provide potential opportunities for addressing this challenge.

The recent NMCP adoption of the latest WHO-recommended guidelines for IPTp and use of ACTs and parenteral artemisinin products for the treatment of uncomplicated and severe malaria, respectively, will require updating worker guidance materials and training of the workforce, in which there are training gaps, high turnover, hiring freezes. Additionally, the changes will lead to increased complexity in the supply chain management system. However, these policy changes provide opportunities for Zimbabwe to align with international and regional policies and enhance case management.

Zimbabwe is facing increased cross-border complexities as parts of the country near borders reach pre-elimination targets while others struggle with much higher disease burden. The frequent and consistent movement of populations across borders is a contributor and the fact that the provinces with vastly higher disease burden lie near areas in neighboring countries where the malaria burden is lower and less of a priority for those NMCPs. For example, as previously stated, Manicaland Province on the Zimbabwe-Mozambique border represents 51 percent of all of Zimbabwe's the malaria cases.

Zimbabwe's malaria burden may be highest in Manicaland, but provinces along the southern border with districts approaching pre-elimination raise the need for cross-border collaboration as part of Zimbabwe's malaria control strategy. Future plans will require balancing resources and priorities to address the heterogeneous malaria epidemiology and disease burdens patterns as the country works to achieve the goals in the revised strategic plan.

New PMI Guiding Principles

The new PMI strategy states that, "Malaria prevention and control is a major US foreign assistance objective and an important component of a comprehensive USG global health strategy to reduce the burden of disease and strengthen communities around the world, contributing to ending extreme poverty. This strategy is fully aligned with the USG's bold vision of ending preventable child and maternal deaths by 2035, as malaria continues to be a leading cause of child mortality, despite the progress of the last decade.[16] Because malaria also places a heavy financial burden on families and affected countries, this strategy's focus on reducing the burden of malaria further supports the USG's high-level development goal of Ending Extreme Poverty."

END OF NOTICE OF FUNDING OPPORTUNITY

[16] WHO currently estimates that malaria is the seventh leading cause of death in low-income countries.