The Global Fund

APPLICANT REQUEST FOR MATCHING FUNDS

IMPORTANT: *To complete this form, refer to the 'Instructions for Matching Funds Requests'.*

SUMMARY INFORMATION			
Applicant	Zimbabwe		
Funding request which this matching funds request relates to	TB/HIV		
Strategic priority area*	HIV: Key populations impact	**Amount available***	$10,000,000
		Amount requested	$9,909,957.57
Strategic priority area*	HIV: Adolescent girls and young women	**Amount available***	$8,000,000
		Amount requested	$7,982,126.60

** As communicated in the allocation letter*

1. Programming of allocation funding towards strategic priority areas

a) Referring to relevant modules and interventions within your allocation funding request,
- *Describe how programming of the allocation supports each strategic priority for which you are applying for matching funds;*
- *Specify whether the allocation budget invested in each strategic priority area is higher than for the previous allocation cycle (2014-2016).*

OR

b) For program continuation applicants,
- *Explain, as applicable, which modules and interventions within your existing program support each strategic priority for which you are applying for matching funds;*
- *Describe, as applicable, any reprogramming that you plan to undertake to increase the investment of allocation resources in the strategic priority areas.*

Describe how programming of the allocation supports each strategic priority for which you are applying for matching funds

Overall, catalytic funds intend to deepen and augment the within allocation request, which expressly amplifies Zimbabwe's focus on location and population as a strategy for maximizing impact.

Adolescent girls and young women

The prioritized allocation programming for adolescent girls and young women (AGYW), centres on a package of modified DREAMS (based on lessons from PEPFAR), scaling up existing investments from partner programs that have proven to be effective in Zimbabwe. There is specific emphasis on certain locations to achieve impact in 4 high-burden districts (Chimanimani, Mguza, Kwekwe and Umzingwane).

Activities provide a layered package of services addressing poverty, gender inequality, sexual violence, and the lack of education as structural drivers directly and indirectly increasing HIV risk. This tiered package provides a foundation and a springboard for activities budgeted in the matching funds that are indispensable to achieve reductions in HIV incidence among AGYW in Zimbabwe.

The matching funds to augment and expand the DREAMS modified package including the provision of PrEP and family planning commodities, and keeping girls in school (through provision of sanitary wear), all directly speak to scaling up PEPFAR-supported programmes and leveraging funds already invested.

The matching funds requested for Sista2Sista girls mentoring clubs are directly supportive of the allocation request for the modified DREAMS package, which reaches in-school AGYW and has strong components for keeping girls in school through provision of educational subsidies. Sista2Sista is an out of school program proven to support girls returning to school, and to reduce teen pregnancies (further supporting girls to remain in school). Reducing teen pregnancy and keeping girls in school are proven to reduce vulnerability to HIV.[1] This program therefore ensures girls benefit from both (proposed) Global Fund and (existing) PEPFAR investments in DREAMS. For example, program data from the current Sista2Sista implementation shows that 3% of AGYW report using a family planning method in 2016, up from 0.5% in 2014. The program also succeeded in enabling more than 450 out-of-school AGYW to return to school in the past three years.

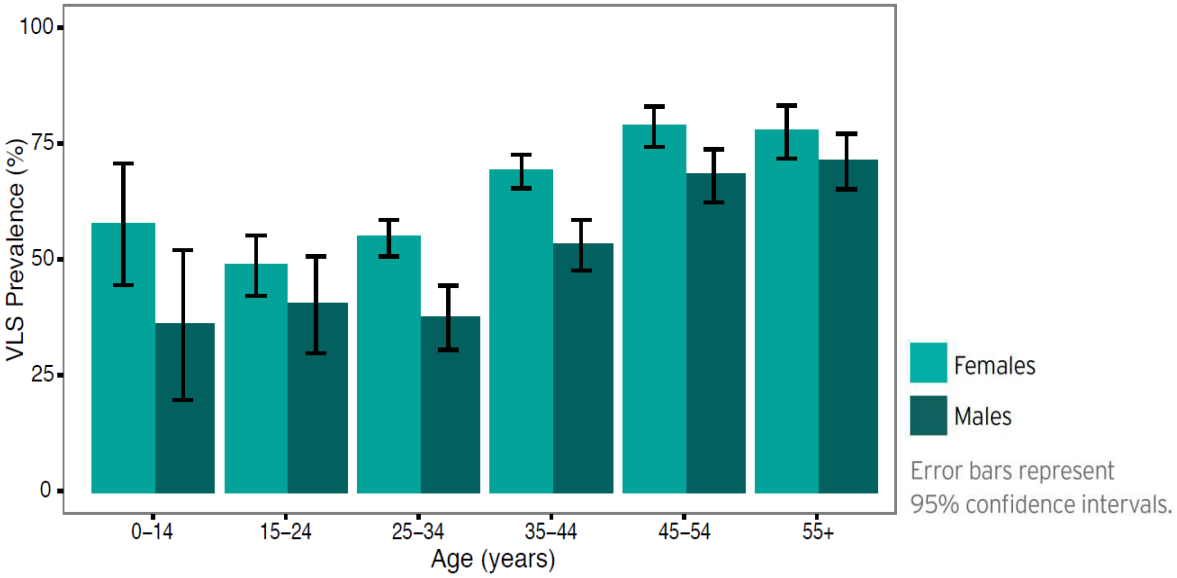
Piloting the evidence-based SASA! in 8 districts and realigning laws on child marriage further provide empowerment and mentorship to AGYW in and out of school and addresses primary prevention of violence against women. Among the 8 districts, 4 will be those supported by the within allocation request for the DREAMS modified package. Therefore, the SASA! intervention will further deepen the impact of the DREAMS package. In addition, the one-stop centres for GBV survivors are also going to be strategically placed in the 4 DREAMS districts, further layering the interventions for AGYW in these hot spot districts.

Layering the DREAMS modified package with intensified GBV interventions is grounded in national evidence demonstrating this as critical to reducing HIV incidence in AGYW. Gender-based violence is a serious issue in Zimbabwe where girls who experience violence are three times more likely to contract HIV. Violence against children (VAC) surveys in 11 countries, supported by PEPFAR, found an average of one in three young women reported their first sexual experience as forced. In Zimbabwe 33% of girls experience sexual violence; 64% experience physical violence; and 29% experience emotional violence.[2] Results from the Zimbabwe DHS (2015) show that 42% of ever-married women (36.8% among those who are married or living together and 47.6% among those who are divorced, separated or widowed) have experienced physical violence since the age of 15. Evidence shows that GBV exacerbates women's vulnerability to HIV.[3,4,5,6] The SASA! Model is a proven community mobilization approach preventing GBV and HIV, with randomized control trial findings associated with a 52% lower past year experience of physical intimate partner violence (IPV) and lower levels of past year experience of sexual IPV among women.[7]

Matching funds to provide peer education services to young women selling sex are essential given that the national response does not recognize girls below the age of 18 who sell sex as sex workers. This further bolsters AGYW investments (and key populations investments) and ensures that catalytic funding supports girls who are selling sex who are currently missed by the national sex worker program.

Prioritizing holistic support for adolescents on ART through community adolescent treatment supporters responds to distinctly lower levels of viral suppression among this age group. Only 48.6% of young women and 40.2% among young men (15-24) are virally suppressed (Figure 1).[8]

Figure 1: Viral Load Suppression among HIV-Positive People, by Age and Sex (2016)[9]



Community-based support has been shown to reduce virological failure among young people, with loss-to-follow-up was nearly halved after 6 months in the ZENITH trial.[10] Indeed, community adolescent treatment supporters are a well-documented success model in Zimbabwe.[11] In addition, the matching funds requested for adolescent treatment supporters will be critical to support adherence to PrEP, which is also requested for AGYW in the matching funds. Evidence from the VOICE trial shows that PrEP can be an effective HIV prevention tool for AGYW in Zimbabwe, but only if adherence support is part of the package. Trial results indicate that adherence support for PrEP is particularly needed among AGYW.

Key populations

The within allocation funding request for sex workers centers on a program of peer-education supported by a strong clinical service that is tailor made for sex workers and provided in a sex worker-friendly environment. This is a comprehensive package of care based on the international guidance for implementing comprehensive HIV/STI programmes with sex workers (the "SWIT").[12] Similarly, funding for MSM in the within allocation funding request supports the provision of a comprehensive package (emphasizing interventions that address stigma, discrimination, violence and advocacy for law and policy reform), through trained and supported peer-educators. This, too, is in line with international guidance for implementing comprehensive HIV/STI programmes with men who have sex with men (the "MSMIT").[13]

Matching funds requested for sex workers build on the within allocation request, by expanding the number of fixed sites from six (Harare, Karoi, Bulawayo, Masvingo, Gweru, Mutare) to add four new sites (Nyamapanda [Mudzi], Chirundu [Hurungwe], Victoria Falls and Beitbridge), reaching more sex workers and their clients with essential HIV and STI services. The four additional sites are all located in border towns of Zimbabwe and will provide services to sex workers along with truck drivers and migrant workers, who are common clients in these areas. Importantly, the matching funds also include procurement of essential commodities, including PrEP, STI treatment and HPV/cervical testing and treatment for sex workers. These commodities will help ensure that the package of care provided has even greater impact. Building on the training and support for peer educators and outreach workers, catalytic funds will ensure that peers can deliver a broader menu of services and link sex workers and their clients to a wider package of care. The PrEP requested for key populations is in line with targets articulated in the new ZNASP III (2018-2020) (Annex 2). Given that provision of PrEP is a new program focus for Zimbabwe, catalytic funds are critical for reaching 2020 targets among KPs (85%).

The matching funds requested for MSM center on expanding the quality of care by providing differentiated models of outreach (moonlight hours, peer educator outreach, fixed sites, etc.). Quality of care will also be improved by enhanced learning on how to scale MSM programs for greater coverage and impact (linked with the technical support unit [TSU], which also harnesses good practice from the region to enable greater scale up and impact in Zimbabwe). The scale up proposed under the MSM program with the matching funds is significant. With the award of catalytic funds, key populations networks aim to increase program reach from approximately 5000 at baseline (2017) to 7000 in 2018, 8500 in 2019 and 10,000 by 2020.

To enable this rapid scale up, the catalytic funding requested for establishing a TSU for key populations is absolutely vital. The TSU is essential both for enabling the rapid scale up of program coverage and for ensuring quality of care that is key population-friendly and key population-led. The proposed TSU is based on a good-practice model from Kenya (Annex 11) which has been shown to catalyze key populations programs there.

Specify whether the allocation budget invested in each strategic priority area is higher than for the previous allocation cycle (2014-2016)

In the 2017-2019 funding cycle the funding allocated ($5,619,260) for AGYW and key populations in Zimbabwe's within allocation funding request is a significant increase from the previous (2014-2016) cycle. In the country's current grant, approximately $858,262 is allocated to these key affected groups. This is respectively broken down as such: $12,450 allocated for MSM to procure condoms and lubricants;[14] $305,927 dedicated to perform a social mapping for young sex workers (allocated under the country's 2015 Incentive Funding award); and $539,887 specifically for the AGYW Sista2Sista clubs. The allocation funding dedicated for AGYW and key populations for the 2017-2019 funding cycle is 6.5 times greater than what was allocated in the country's current grant, representing rapid and intensified scale up and prioritization of these groups. This is reflective of the updated country context, which increasingly recognizes the disproportionate disease burden these groups face and the need to holistically address and the social and structural drivers through delivering a comprehensive package. It is also reflective of the new ZNASP III, which places increased emphasis on key and vulnerable populations.

2. Additional investments proposed and outcomes expected

Using the table below,

a) *Describe, for each strategic priority, the additional investments that you propose to undertake if the matching funds request is approved.*

b) *Explain how the proposed additional investments have the potential to contribute to maximizing the impact of the program. In your response, specify what program targets and/or improvements in program quality will be achieved.*

[Duplicate the table as needed, if your application includes more than one strategic priority area]

Strategic Priority Area				
Module	**Interventions**	**Brief description of activities to be undertaken**	**Outcomes expected** (e.g. expected increase in targets and/or program quality)	**Amount requested**
Prevention programs for adolescents and youth, in and out of school	Behavioral change as part of programs for adolescent and youth	**(1) Augment and expand the modified DREAMS package** in the 4 districts to include capacity building for AGYW on income and savings lending schemes and business management, support for parent child care (PCC) facilitators and PCC sessions in communities, outreach services using "stop the bus" model, in-school GBV clubs, training and support for DREAMS ambassadors, among other activities that will be additionally layered to boost impact (recall Figure 14 in section 1.3 on lessons learned which shows how additional layering of interventions increasingly reduces HIV incidence among AGYW).	• Reduce HIV incidence in AGYW (15-24) in high burden districts, contributing towards impact against a critical corporate key performance indicator for the Global Fund, and to the ZNASP III target of reducing new infections by 90% by 2020 (Annex 2). • The 4000 AGYW reached through the modified DREAMS package will increase the percentage of vulnerable girls reached with comprehensive HIV prevention packages (defined package of services) from 29.74% (n=7977) at baseline (2016) to 100% (n=12,000) by 2020 (see performance framework).	**$3,062,812.52**
	Pre-exposure prophylaxis (PrEP)	**(2) PrEP, HIV test kits and family planning commodities** for the vulnerable AGYW receiving the modified DREAMS package. Some additional PrEP is requested as part of this activity to reach other vulnerable youth, filling	• Contribute to the ESA commitment targets to reduce early and unintended pregnancies among young people by 75% by 2020. • Targets for PrEP are to reach 1032 young people in Y1, 6054 in Y2 and 13,107 in Y3.	**$1,068,493.08**[1]

[1] PrEP targets for vulnerable young people based on programmatic gap: 1032 in year 1, 6054 in year 2 and 13,107 in year 3. Assuming 6 months of use. $5.90/month + 20% PSM

		the programmatic gap.		
	Keeping girls in school	**(3)** Additional support to keep girls in school (the 4000 AGYW supported in the 4 DREAMS modified districts through the allocation and catalytic investments) through **providing reusable sanitary wear to in-school AGYW.**	• Keeping girls in school is directly linked to impact decreasing HIV incidence in AGYW. Evidence from the region shows that each additional year of secondary schooling leads to an absolute reduction in the cumulative risk of HIV infection by 11.6% among AGYW.[15]	**$144,000.00**[2]
	Community mobilization and norms change	**(4) Sista2Sista girls mentoring clubs** for out of school AGYW	• Increase the number of vulnerable girls referred by Sista2Sista mentors for HIV prevention services who received HTS reaching from 4086 at baseline (2016 to 6000 by 2020 (increasing reach to 12,000, maintaining % of those referred at 50%) (see performance framework). • Reduced teen pregnancies contributing to ESA targets. Program data from the current S2S implementation shows that 3% of AGYW report using a family planning method in 2016, up from 0.5% in 2014. • Increase the number of out of school AGYW who return to school. The program also succeeded in getting more than 450 out of school AGYW to return to school in the past three years. Reducing teen pregnancy and keeping girls in school are proven to reduce vulnerability to HIV.[16]	**$1,311,464.00**
	Other interventions for adolescent and youth (for young women selling sex)	**(5) Provide peer education services to young women selling sex (<18 years)**	• Improved coverage of testing, treatment and viral suppression among young women who sell sex (<18) (recall cascade presented in Figure 4 in main funding request), towards the 90-90-90 targets.	**$52,512.00**[3]

[2] $12/year for reusable sanitary wear x 4000 AGYW x 3 years
[3] $21,600 (peer educator allowances) + $30,912 training of peer educators

	Behavioral change as part of programs for adolescent and youth	**(6)** Provide holistic support for adolescents on ART, through **adolescent treatment supporters in communities** (training and retention of 120 adolescent treatment supporters in the four DREAMS modified provinces)**.**	• Improved viral suppression among young people, through evidence-based adolescent treatment supporters model, towards achieving 90% viral suppression among young people (up from 48.6% of young women and 40.2% among young men (15-24) [Figure 1]).	**$171,240.00**
Prevention programs for adolescents and youth, in and out of school	Gender-based violence prevention and treatment programs	**(7) Piloting the evidence-based SASA! Model** in 6 hot spot districts (including the 4 priority districts for the DREAMS modified package [Chimanimani, Mguza, Kwekwe and Umzingwane] plus 2 additional hot spot districts), for primary gender-based violence prevention programs (including prevention of gender-based and intimate-partner violence) to protect vulnerable AGYW. The program will include advocacy to realign laws on child marriage.	• Reduce the percentage of women (15-24) who experienced violence in the last 12 months by 50% in the target districts (from 16.4% in 2015[17] to 8.2% in 2020) (see performance framework). This is in line with the expected results of the SASA! Model, based on a recent randomized control trial which found the model is associated with a 52% lower past year experience of physical intimate partner violence (IPV) and lower levels of past year experience of sexual IPV among women.[18]	**$1,093,185.00**
	Gender-based violence prevention and treatment programs	**(8)** Establish **4 one-stop centres for post violence care for survivors of gender-based violence** (in the 4 priority districts for the DREAMS modified package). This investment will establish the centres (from partitioned prefab containers) and support functioning costs so that survivors of violence can access counselling and psychosocial support, legal services, health services (PEP, PrEP, emergency contraceptives, medical examination) and police services. Survivors will also be provided with a dignity pack (sanitary pads, towel, soap, toothpaste, toothbrush, whistle, underwear, food stuff).	• These 4 one stop centres aim to reach an additional 6000 survivors of gender-based violence over the three-year grant.[4] Increase access to post-violence care for AGYW through decentralized cites which overcome barriers of access to information and ease of mobility which currently limit access for younger women (by providing transfer tokens).	**$1,078,420.00**
			TOTAL Matching Funds requested for adolescent girls and young women	**$7,982,126.60**

[4] Target based on an estimated 30% increase from the average attendance of the existing 4 centers (33 survivors/month). Increased attendance is anticipated due to the decentralized nature of the four new proposed centers, which will be at district-level. The four existing ones are in provincial-level facilities (in Rusape General Hospital (Makoni), Harare and Gweru).

Comprehensive prevention programs for sex workers and their clients	Behavioral interventions for sex workers	(1) **Scale up to an additional 4 border static sites**, including support for additional peer educators and outreach, in Nyamapanda [Mudzi], Chirundu [Hurungwe], Victoria Falls and Beitbridge. These sites will be sustainably transitioned from the regional North Star Alliance program, also reaching clients of sex workers such as long-distance truck drivers, migrant workers and artisanal miners.	• Reduce the number of new HIV infections among sex workers and their clients. • Improve access to ART towards achieving the 90% target.	**$3,582,917.00**
	Community empowerment for sex workers	(2) **Establish 6 drop-in centers** where sex workers can have a safe space, access information, pick up condoms and lubricants, report incidents of violence and access social support. The Drop in Centres (DICs) will be established in the six major cities were sex workers congregated (Hot Spot clusters). The DICs will be manned by a counselor and will be furnished in order to provide a safe space for sex workers and place were mobile sex workers can drop in and get help if in distress.	• Expand access to condoms, increasing the percentage of sex workers who report using a condom with their last client from 66.8% in 2015 to at least 80% by 2020 (see performance framework).	**$425,637.00**
	Pre-exposure prophylaxis (PrEP)	(3) **Procure PrEP for sex workers** and deliver as part of the comprehensive combination prevention package out of the 10 fixed sites (Harare, Karoi, Bulawayo, Masvingo, Gweru, Mutare, Nyamapanda [Mudzi], Chirundu [Hurungwe], Victoria Falls and Beitbridge) as well as up to 20 outreach sites.	• Increasing coverage by 1377 in Y1, 9311 in Y2 and 13,183 in Y3.[5]	**$1,013,767.62**

[5] Targets worked out proportionally based on combined estimates for sex workers, MSM and prisoners. Without reliable size estimates for MSM, the country groups the need for key populations together based on estimated gapes.

	Diagnosis and treatment of sexually transmitted infections and other sexual and reproductive health services for sex workers	(4) **Procure essential STI medicines** and related commodities ensure STI prevention, treatment and care are part of the comprehensive package for sex workers. This will include Hepatitis B vaccinations, cervical cancer screening and referral for treatment as well as PMTCT services for sex workers (essential for Zimbabwe's eMTCT validation process).	• This will improve program quality by enhancing the integration of the comprehensive prevention package.	**$1,750,000**
	Other interventions for sex workers and their clients	(5) **Strengthening the national sex worker program** through implementation science, M&E and micro-planning.	• This will enhance program quality be improving monitoring and evaluation capacity and enhancing real-time learning for maximizing scale up.	**$256,705.00**
Comprehensive prevention programs for men who have sex with men	Behavioral interventions for men who have sex with men	(6) **Scale up delivery of the comprehensive package** to reach more vulnerable MSM and improve quality of service provision by offering peer education through differentiated delivery (including moonlight services). Quality of service provision will also be improved through learning visits to strengthen existing MSM programs.	• Reduce the number of new HIV infections among this vulnerable group and improve access to ART towards achieving the 90% target. • Increase program reach from approximately 5000 at baseline (2017) to 7000 in 2018, 8500 in 2019 and 10,000 by 2020.	**$1,413,002.10**
	Pre-exposure prophylaxis(PrEP)	(7) **Procure PrEP for MSM** and deliver as part of the comprehensive combination prevention package out of the 6 fixed sites (Harare, Bulawayo, Masvingo, Gweru, Mutare and Victoria Falls).	• Increasing coverage by 153 in Y1, 1035 in Y2 and 1465 in Y3.[6]	**$112,640.85**
	Diagnosis and treatment of sexually transmitted infections and other sexual health services for men	(8) **Procure essential STI medicines** and related commodities ensure STI prevention, treatment and care are part of the comprehensive package for MSM.	• This will improve program quality by enhancing the integration of the comprehensive prevention package.	**$250,000.00**

[6] Targets worked out proportionally based on combined estimates for sex workers, MSM and prisoners. Without reliable size estimates for MSM, the country groups the need for key populations together based on estimated gapes.

	who have sex with men			
Community systems and responses	Institutional capacity building, planning and leadership development	**(9) Establish a technical support unit (TSU) to deploy long-term capacity building and technical assistance to key populations' organizations** in order to support the scale up of quality service delivery to these groups. The TSU will serve organizations delivering services to sex workers, MSM, AGYW, and transgender communities. The unit will give preferential priority to women's organizations or organizations led by key populations. The TSU will also strengthen capacities of the National AIDS Council and the Ministry of Health and Child Care to program better around key populations. This will support implementation of the Service Provision Models and National Operational Plan for Sex Workers and other Key Populations (male sex workers, MSM, clients of sex workers as well as LGBTI) in Zimbabwe's HIV response, which NAC and MOHCC have begun developing. This investment will harness lessons from short- and long term technical assistance delivered through the Global Fund's community rights and gender special initiative (2014-2016), as well as lessons from the Global Fund's regional investments in key population network strengthening through the KP REACH grant.[19]	• The TSU is expected to dramatically improve program quality and support the significant scale up of activities for key populations and AGYW.	**$1,105,288.00**
TOTAL Matching Funds requested for key populations				**$9,909,957.57**
TOTAL AMOUNT OF MATCHING FUNDS REQUESTED FOR AGYW AND FOR KEY POPULATIONS				**$17,892,084.17**

3. Compliance with the minimum 1:1 funding match

For each strategic priority areas included in your application,

a) Confirm whether the total allocation funding invested in the strategic priority area matches by at least a 1:1 ratio the total amount that you are requesting for matching funds.
b) Provide a justification if this minimum matching ratio is not met. As applicable, specify any potential funding sources that will be mobilized to increase investments in the strategic priority area.

Following a rigorous prioritization exercise for the country's programmatic gaps, it must be acknowledged that the highly commoditized nature of Zimbabwe's funding request prohibits a 1:1 matching ratio for AGYW and key populations investments. There are two main reasons for this. First, Zimbabwe's current economic climate limits the country's ability to reliably procure essential medicines and related commodities with domestic resources, so these are prioritized for Global Fund support. Second, the country has deemed that directing the full 1:1 matching ratio from the within the allocation amount would significantly reduce the impact of the disease programs – both for the general population and for key and vulnerable populations. For instance, the impact of investments in AGYW and key populations cannot be maximized if essential medicines and commodities are not available for these groups as part of their comprehensive package.

That said, while the 1:1 matching ratio cannot rationally be made with the allocation amount, the country still requests that the full amount of the matching funds be awarded. Again, there are two reasons for this. First, despite extreme constraints on the country's allocation due to commodity needs, Zimbabwe has still prioritized the direction of $5,619,260 in allocation funding towards AGYW and key population programming. As stated above, this is a 6.5-fold increase from the 2014-2016 funding cycle, representing rapid and intensified scale-up. This effort reflects a high priority for the catalytic funding areas, especially given the country context. Indeed, all prevention programs for the general population have been placed in the PAAR, in order to ensure that AGYW, sex workers, and MSM are prioritized, as they are disproportionately affected by HIV and impact against the disease may be greater by investing in these populations. Second, the full amount of the available matching funds is requested on the back of known and anticipated PEPFAR investments in these areas in Zimbabwe. For AGYW, PEPFAR will invest approximately $21,356,999 in 2018. Broken down: as part of COP17, $15,310,785 will go towards DREAMS programming in 6 districts, plus an additional $3,376,537 outside of COP17 in DREAMS innovation, and $2,468,999 to enhance testing, initiation, retention, and adherence in children and adolescents aged 15-24 through community adolescent treatment supporters. PEPFAR will also invest $3,216,296 in sex workers and MSM. For 2018, the PEPFAR investments in DREAMS will continue full implementation of entire core DREAMS package in 6 districts (Mazowe, Makoni, Mutare, Chipinge, Gweru and Bulawayo), adding in activities to: identify barriers to reaching AGYW and accelerate achievement, particularly among older, out of school AGYW; expand education subsidies; and evaluate strategies for reaching men. The PEPFAR investments in sex workers and MSM will include expanding self-testing, supporting local civil society organizations, offering treatment in hotspots and through community care, offering PrEP to all HIV KPs and investing in TA to support key populations peer educators. Funding will also go towards strengthening the national KP program. The program aims to reach 10,273 sex workers and 2,973 MSM in 2018.

Assuming that the DREAMS investments may end in 2017, and that PEPFAR's other KP investments may continue, taken together, the country's Global Fund allocation investments and PEPFAR's anticipated investments total more than $36.6 million over 2018-2020 (Table 1) – well above the 1:1 ratio. As a result, Global Fund matching funds are requested to catalyze impact from the investments of both the Global Fund allocation and Zimbabwe's PEPFAR program.

Table 1: Anticipated Investments in AGYW and key populations that Matching Funds will Catalyse

	Amount (USD)
Global Fund Allocation	
Comprehensive prevention programs for men who have sex with men	$649,712
Prevention programs for adolescents and youth, in and out of school	$3,174,288
Comprehensive prevention programs for sex workers and their clients	$1,795,260
Anticipated PEPFAR investments	
DREAMS	$21,356,999
Sex workers	$4,824,444
MSM	$4,824,444
TOTAL	**$36,625,147**

References

[1] De Neve, J. W., Fink, G., Subramanian, S. V., Moyo, S., & Bor, J. (2015). Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment. *The Lancet Global Health*, *3*(8), e470-e477.
[2] https://www.cdc.gov/violenceprevention/vacs/
[3] Jewkes R, Dunkle K, Nduna M, Shai N. Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. Lancet. 2010;376(9734):41-8.
[4] WHO, UNAIDS. 16 ideas for addressing violence against women in the context of HIV epidemic: a programming tool. Geneva: WHO and UNAIDS, 2013
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[7] Abramsky, T., Devries, K., Kiss, L., Nakuti, J., Kyegombe, N., Starmann, E., ... & Michau, L. (2014). Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. *BMC medicine*, *12*(1), 122.
[8] https://www.cdc.gov/violenceprevention/vacs/
[9] The Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) 2016
[10] Ferrand et al. (2017). Community-based support reduces the risk of virological failure among children with HIV infection: results of the ZENITH trial. Abstract submitted to IAS 2017.
[11] Mavhu, W., Berwick, J., Chirawu, P., Makamba, M., Copas, A., Dirawo, J., ... & Mungofa, S. (2013). Enhancing psychosocial support for HIV positive adolescents in Harare, Zimbabwe. *PLoS One*, *8*(7), e70254.
[12] WHO; UNFPA; UNAIDS; NSWP; World Bank; UNDP (2013). Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. Online at http://www.who.int/hiv/pub/sti/sex_worker_implementation/en/
[13] UNFPA, MSMGF, UNDP, WHO, PEPFAR/USAID and the Bill & Melinda Gates Foundation. Implementing Comprehensive HIV and STI Programmes with Men Who Have Sex With Men: practical guidance for collaborative interventions. Online at: http://www.unfpa.org/press/new-unfpa-tool-implementing-hiv-and-sti-programmes-men-who-have-sex-men#sthash.gUarrMkg.dpuf
[14] This amount was topped up marginally, as it was not enough to procure the commodities.
[15] De Neve, J. W., Fink, G., Subramanian, S. V., Moyo, S., & Bor, J. (2015). Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment. *The Lancet Global Health*, *3*(8), e470-e477.
[16] De Neve, J. W., Fink, G., Subramanian, S. V., Moyo, S., & Bor, J. (2015). Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment. *The Lancet Global Health*, *3*(8), e470-e477.
[17] 2015 ZDHIS preliminary results report, page 43
[18] Abramsky, T., Devries, K., Kiss, L., Nakuti, J., Kyegombe, N., Starmann, E., ... & Michau, L. (2014). Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. *BMC medicine*, *12*(1), 122.
[19] The Principal Recipient – Hivos regional office for Southern Africa – is located in Harare, Zimbabwe.