evidence action

# Syphilis-Free Start Zambia: Y3-5 Top-Up Proposal

*2 May 2025*

In 2022, GiveWell awarded a 5-year grant to Evidence Action in the amount of $7,046,250 to implement its Syphilis-Free Start program in Zambia. The primary objectives of the program were to: (1) support the Government of Zambia with adopting and scaling the dual test to achieve parity between syphilis screening and HIV screening rates during antenatal care, and (2) strengthen and increase syphilis treatment coverage in pregnant women testing positive.

As we entered the second half of the program, we conducted a financial runway analysis to determine the financial health of the program and to assess our planned expenditures relative to the remaining budget.[1] **Based on our financial analysis, we have determined that in order to implement all activities as planned through the end of Year 5, we will require an additional $665,654**. This total does not include the $142,515 additional funding which GiveWell approved in March to fill funding gaps for syphilis training left after the USG withdrawals. **We also request that the contingency fund for filling dual test availability gaps be increased to $2,184,715** (an additional $1,280,695 on top of the $904,020 GiveWell approved in March)

The content contained in the proposal is as follows:



[1] At this point in time, we are uncertain as to whether we will need a 6th year of programming to successfully transition program ownership to the government.Training is still underway, and the first phase of training was only completed ~6 months ago. The full effect of the US administration's funding cuts have also yet to be understood, which may also change our perspective on a responsible exit. We plan to monitor this carefully over the next year to assess whether or not we can exit responsibly within the current grant timeframe.

## Overview of Program Progress & Successes To-Date

Together with the Government of Zambia, the Syphilis-Free Start program is playing a critical role in the broader national strategy for achieving elimination of mother-to-child transmission of syphilis. As we approach the end of Year 3 of the program, we want to highlight the tremendous progress achieved across key program areas. Detailed updates can be found in the six-monthly progress updates here. The following highlights major achievements to-date:

**Program Area 1: Strengthening policy, program management, and coordination**

- We established Evidence Action as a key government partner on congenital syphilis, by integrating ourselves into key technical working groups. Through these groups, we increased visibility for the syphilis program and strengthened relationships with other key partners in the space.
- We supported the integration of dual testing in the '2022 Zambia Consolidated Guidelines for Treatment and Prevention of HIV Infection,' paving the way for dual test scale-up nationally.
- We supported the Ministry of Health as a key partner in the development of the '2025-2030 National Operational Plan for the Elimination of Vertical Transmission of HIV, Syphilis and Hepatitis B Virus', published in December of 2024, ensuring that syphilis continues to be a high priority agenda item for the Government of Zambia.

**Program Area 2: Ensuring quality training and supervision of healthcare providers**

- We developed and iterated on a program package of curricula, job aids, training and supervision checklists, and reporting tools that enabled consistent, quality training and supervision by master trainers and delivery of high quality antenatal care services by healthcare providers
- We integrated dual testing into the National Curriculum for the HIV Rapid Test Continuous Quality Improvement Program, such that all new staff certified in HIV rapid testing will be trained on the dual test moving forward, supporting the long-term sustainability of the program.
- We completed Phase 1 of training (reaching ~50% of all ANC-going women), and are currently achieving significant progress in Phase 2 of training. At the time of writing, we have trained 1,582 health facilities, and over 18,000 frontline healthcare workers. By the end of Phase 2, we will have trained facilities which reach ~80% of ANC-going pregnant women.
- We designed and are implementing a data-driven supportive supervision strategy using routine data from DHIS2, to identify the lowest performing sites in each province and facilitating visits to address identified issues. To date, we have funded 189 supportive supervision visits, where trainers provided mentorship to reinforce the skills and knowledge of healthcare workers to ensure high-quality syphilis screening and treatment services.

**Program Area 3: Improving supply chain management**

- We provided critical, gap-filling donations of 120,000 doses of benzathine penicillin in November 2023, 60,000 syphilis-only rapid tests in January 2024, and 138,000 doses of benzathine penicillin in October 2024, all of which enabled the rapid acceleration of dual test adoption.

- We coordinated a commodity push ahead of Phase 1 and leveraged the national supply chain systems ahead of Phase 2 to ensure last mile delivery to health facilities of HIV/syphilis dual tests, syphilis only rapid tests, and benzathine penicillin in advance of on-site training and where required to address stock out challenges;
- We successfully added the Standard Q HIV/syphilis dual test to the electronic Logistics Management Information System to ensure health facilities can requisition dual tests using the established supply chain.
- Together with CHAI, we successfully advocated and secured commitments from Global Fund for ~400,000 dual tests annually and from PEPFAR for ~600,000 dual tests annually (prior to the USG funding freeze), ensuring there were no national stock outs of dual tests until recent global events.
- Together with the MoH, we successfully lobbied USAID and CDC to contribute to the training-of-trainers cascades, until recent global events, which expanded the collective buy-in and ownership of the congenital syphilis program within Zambia (see below for the amounts contributed by partners).

**Program Area 4: Strengthening data collection and program monitoring**

- We succeeded in revising a key national data tool, the monthly HIA reporting form and DHIS2, to appropriately capture syphilis treatment data, which was previously missing and now enables the MoH to generate insights that can be used to drive program decisions;
- We revised the HIV Daily Activity Register to capture whether a syphilis test was done and the results alongside HIV testing, creating an additional data resource for understanding screening coverage;
- We implemented the first Comprehensive Facility Survey in Feb-Mar 2025 in 44 health facilities sampled from the 840 health facilities trained in Phase 1, from which we attained rich data on program quality and impact, including estimating coverage of syphilis screening and treatment services (findings shared here).
- We developed a program monitoring dashboard within DHIS2 utilizing real-time health facility data to assess facility progress and gaps in syphilis screening and treatment. By integrating it within DHIS2, the national, provincial, and district health staff can all monitor program progress and identify gaps.
- We provided targeted, data-oriented supervision visits to health facilities where there was significant over- and/or under-reporting of key indicators to improve data accuracy and quality in DHIS2 and support usage of DHIS2 data in the long-term.

**Program Area 5: Identifying and securing sustainable funding**

- We built relationships with PEPFAR-funded implementing partners (USAID sub-recipients and CDC) and leveraged their resources to expand the amount of support devoted to syphilis screening and treatment. CDC contributed ~$40,000 toward Phase 1 training. We had also secured a commitment from CDC and USAID to support training across 456 facilities (~40% of the overall target for Phase 2). Approx. 233 of these were trained prior to the funding cuts.

- We coordinated with the MoH to leverage Global Fund resources toward the training-of-trainers cascade, securing ~$20,000 toward training in Phase 1 and further resources toward Phase 2 (amount still unknown).

# Budget

## Initial Commitment

The initial grant to Evidence Action totalled $7,046,250 for Zambia (overall grant value was $15,153,121 as the grant included funding for Cameroon too). In GiveWell's cost-effectiveness modeling, the Zambia program was estimated to be 30 times as cost-effective as unconditional cash transfers via GiveDirectly.

## Y3 - Y5 Shortfall

As of December 31, 2025 (4 months into Year 3), we have spent $2,958,843. Therefore, we remain with $4,087,407. Table 1 below summarizes our initial budgeted amounts for each program year, and our actual spend for Year 1, Year 2, and the first four months of Year 3. The table also shows the forecasted spending for the remaining 8 months in Year 3, Year 4, and Year 4. A more detailed breakdown of the revised Years 3 - 5 budget can be found here. In total, we are currently projecting a $665,654 shortfall for the remainder of the program.

**Table 1: Budget vs Actuals / Updated Forecasts for Years 1 -5**

| | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Total |
|---|---|---|---|---|---|---|
| Original Program Budget | $1,671,721 | $1,616,375 | $1,513,301 | $1,073,714 | $1,171,139 | $7,046,250 |
| Actual Expenditure | $549,200 | $1,653,110 | $756,533 | -- | -- | $2,958,843 |
| Forecasted Expenditure | -- | -- | $1,555,613 | $1,609,013 | $1,588,435 | $4,753,061 |
| Variance Between Budgeted & Expenditure | + $1,122,521 | - $36,735 | - $798,845 | - $535,299 | - $417,296 | - $665,654 |

# Proposal Rationale

## Why is Additional Funding Needed for Years 3 - 5?

When developing the initial budget in 2022, Evidence Action sought to make a best guess on what a 5-year program would cost, leveraging learnings and experience from our program in Liberia. However, we had never worked in Zambia prior, and the scale of Zambia is much larger than Liberia, so it was difficult to accurately predict certain costs. Beyond this, we faced changing government requirements for the training-of-trainers cascade and program implementation, driving significant cost overages in training and supportive supervision activities. Table 2 breaks down, by spending category, how the initially predicted budget compares to our cumulative spending in Years 1-5 (actuals from the beginning of the grant through Dec 2024; forecasted expenditures from Jan 2025 to Aug 2027). A breakdown year-on-year is included in the shared revised budget.

**Table 2: Budget Analysis by Spending Category Across the Entire Grant**

| | Entire Grant Period (Years 1-5) | | |
|---|---|---|---|
| | Originally Budgeted | Actuals + Projected Spend | Variance |
| Global Personnel and Fringe | $667,698 | $866,266 | - $198,569 |
| Local Personnel and Fringe* | $2,262,877 | $1,185,120 | + $1,077,757 |
| Travel | $204,000 | $213,093 | - $9,093 |
| Operations | $491,025 | $837,928 | - $346,903 |
| Program Implementation | $1,751,125 | $2,337,217 | - $586,092 |
| Monitoring and Evaluation | $594,674 | $966,692 | - $372,018 |
| Global IDC | $1,074,852 | $1,305,587 | - $230,735 |
| **Total** | $7,046,250 | $7,711,903 | - $665,654 |

*We are anticipating a significant under-spend in local personnel and fringe. We developed the budget before we had done formal salary benchmarking for Zambia and had instead based our salary assumptions on what two local partners had informally shared about their own pay scales. In the end, the salaries we assumed for budgeting were much higher than our final salary ranges and so we have found significant cost-savings on this budget line.

The need for additional funding in Years 3 - 5 is driven by increased spending in earlier years in some budget categories combined with revised, increased spending in other budget categories for later years. The most significant cost categories where we saw deviations are: (1) global personnel; (2) program implementation, namely training and supportive supervision costs, stakeholder meetings, and printing, (3) monitoring and evaluation, and, (4) operating costs. In addition, our original budget did not include the sub-grantee agreement that we made to CHAI in the first half of the program to support initial program launch. Below is a more detailed description of each of the key drivers in spending overages.

### *1. Global Personnel*

We initially underestimated the level of global LOE required for the start up phase of the syphilis program in Zambia. Our total level of effort from the global team exceeded our original expectations for two main reasons: (1) our first Country Director in Zambia left the organization within ~eight months, necessitating more hands-on support to the country team from our global program lead in Year 2 before the vacancy could be filled, and, (2) the Zambia team was understaffed for the scale of training that was undertaken in Phase 1, which required significant allocations of LOE from the global team in Years 2 - 3. Going forward, we expect our spending in this category to more closely mirror what we had originally budgeted for Years 4 - 5.

### *2A. Program Implementation, Training and Supportive Supervision Costs*

For **training**, we had initially planned to implement a similar training model that was used in Liberia, with **each health facility training delivered in one afternoon, by a single trainer**. However, the **MoH asked us for three key changes to the model**, based on the unique context of Zambia:

- **Increase the number of days of training from one to two-and-a-half**. In Zambia, HIV rapid testing is done by community-based volunteers (CBVs) rather than nurses/midwives as in Liberia. CBVs are lower skilled health staff, akin to community health workers in other countries, and are only in the facility to support counseling and testing for HIV. Based on experiences with other programs, the MoH felt it was important to design a curriculum specific to CBVs which only covers counseling and testing vs. the broader curriculum delivered to skilled healthcare workers, such as nurses, midwives, and lab staff. Thus, there would need to be two different afternoon trainings -- day one for the skilled healthcare workers and day two for CBVs. Additionally, the MoH felt it was important to do real-time observation of how facility staff implemented the dual test and so a half day was added where trainers would go and observe antenatal care in the morning to provide hands-on feedback about how the tests are being used post-training. We initially tried to curtail the number of days of training, but recognizing that the MoH knows its own context better than we do, we adopted their recommendations to ensure that the right knowledge was imparted to the right healthcare workers.
- **Increase the number of trainers from one to two**. The MoH felt strongly that there should be one trainer with clinical expertise and one trainer with lab expertise delivering each training and supportive supervision visit. The Zambian MoH is highly technical and technocratic. Additionally, the dual testing program in Zambia is co-implemented between the MoH PMTCT Team and the Lab Team. As a consequence, the MoH would only allow training to move forward if there was one trainer with clinical expertise and one trainer with lab expertise delivering the training together; a trainer with clinical expertise did not feel comfortable delivering the portion of the training about using the dual test, and vice versa.
- **Integrate significant supervision from the Provincial Health Team**. The MoH insisted that there be more consistent and frequent supervision of the district trainers by the provincial trainers. Our initial assumption was that the district trainers in Zambia would be treated similarly to county trainers in Liberia, where only a ~week of in-person supervision was required after the trainers were trained. However, we learned that there was little confidence in the skills / knowledge of the district trainers and a greater insistence at the national and provincial levels to fund more significant supervision by the provincial trainers. Without this level of supervision, we could not get buy-in from the MoH to implement a training-of-trainers cascade. Because the provincial trainers were traveling outside of their designated working area for this supervision, they were entitled to per diem for each day, increasing our costs more significantly.

On top of changes to the overall implementation model, we underestimated the operational unit costs related to the training-of-trainers cascade and supportive supervision. This consisted of:

- We assumed that district trainers would <u>not</u> require a per diem to reach health facilities within their district, regardless of the distance of the health facility. However, as we better understood the MoH's policies, we learned that **we *would* need to pay a per diem if the facility was more than 50km from the District Health Office**. Given the geographic expanse of the country, a significant proportion of health facilities are more than 50km from the District Health Office. For these facilities, the trainers are entitled to ZMW 1,100 per person per day and a travel day needs to be added vs. the ZMW 150 lunch allowance per person per day that we had assumed initially.
- We assumed an average transport allowance of ZMW 600 on the basis that district trainers would use public transport to reach health facilities as is the norm in Liberia. Instead, we learned that the Zambian government generally forbids their staff from traveling via public transport when the

distance they are traveling is more than 50km; instead, **government staff are required to travel via an official vehicle** which necessitates per diem payments for a third person (the driver) and covering the cost of fuel. Additionally, **with inflation and shocks to the price of fuel, the average facility required ~ZMW 1,200 for fuel alone**

As a consequence of all of the changes, we have a significant increase in the realized costs for each facility that we target for training and for each supportive supervision visit. See below:

| | Initially Budgeted | Realized Costs |
|---|---|---|
| Average cost per facility trained | ZMW 4,500 | ZMW 13,000 |
| Average cost per facility supportive supervision visit | ZMW 750 | ZMW 5,000 |

### *2B. Stakeholder Meetings*

Our initial estimate for stakeholder meetings was an annual spend of ~$5,000 per year, based very roughly on what we spend in Liberia annually. In reality, the true cost of this has been triple that of our budgeted amount (~$15,000 per year). This has been driven by the need to continuously build and strengthen our relationship with the Ministry of Health; our experience in Zambia has shown that there is immense value and need in investing / building strong relationships at every level of the Ministry of Health (national, provincial, and district) to ensure multiple channels are available to use when facing roadblocks. In 2024 for example, the National PMTCT Coordinator (who is our main program partner), was working from Canada, and was less responsive and available to us in moving approvals through the government system. This resulted in delays and challenges to maintaining progress and momentum in the program, pushing us to strengthen our relationships with other key government stakeholders at the national level. Additionally, we felt it was critical to build program ownership at the provincial level, not just the national level, necessitating periodic in-person meetings where representatives from each province attend. Specifically, we involved representatives from each province in meetings to validate the training-of-trainers approach and tools and we are holding biannual progress meetings involving national and provincial MoH representatives.

### *2C. Printing*

We initially estimated that we would spend a total of $55,000 across five years to print various program tools (job aids, registers, training manuals, etc), based very roughly on what we spent in Liberia. Our realized costs were approx. twice as high at $114,133 ($54,686 of which we've spent to-date and a further $59,447 that we have budgeted to spend going forward). We encountered higher printing costs for two main reasons: (1) we developed more tools in Zambia which required printing than we had in Liberia, most important was the participant's reference manuals which are small hand-held booklets given to all trained healthcare workers to serve as reference guides in case they forget any aspects of the training; and, (2) we needed to print more total units of every tool because there were more trainers and more healthcare providers than we had initially estimated.

### *3. Monitoring and Evaluation*

Our original estimate for the cost of a comprehensive facility survey in Zambia was based on the cost of implementing the same survey in Liberia (~$80,000). We anticipated the sample sizes to be the same and both countries are known for high transport costs and so we took the Liberia survey costs as the best point

estimate for Zambia. However, upon soliciting proposals from survey enumeration firms in early 2023, we realized we had significantly underestimated the cost of surveying in Zambia as the two most qualified survey firms, CIDRZ and IDinsight both quoted survey costs around ~$145,000. This was further exasperated by recent inflation, which has driven up the cost of fuel / transport (a significant cost driver in data collection).

### *4A. Operating Costs, In-Country*

Our initial budget constituted our best attempt to estimate operating costs in Zambia. However, due to inflation, combined with an overall underestimation of key cost categories, our overall operating costs have been higher than anticipated. There were three main cost drivers that we did not account for, or underestimated initially:

- **Office rent:** In our initial budget, we estimated that we would spend ~$1,500 per person per month toward office rent, based on what partners shared about the costs of using a co-working space. As our team size grew substantially relative to what we had initially predicted (10 staff vs. 6 staff), it was more cost-efficient to move into a formal office space vs. continuing to use a co-working space. Our current office costs approx. $4,000 per month, driven in part by inflation and an increase in our monthly office service charge due to frequent power outages driving an increase in generator costs.
- **Vehicle purchase & maintenance**: Our initial budget did not include the purchase of a vehicle, nor the costs associated with the vehicle (fuel, repairs, etc). However, in mid-2023, we decided to purchase a vehicle, with GiveWell's approval, following a costing analysis of various ground transportation options. Specifically, that analysis found that purchasing a vehicle would have an up-front cost, likely not to exceed $50k, and then we anticipate we'll spend ~$1,800 monthly toward fuel, a driver, insurance, etc, which is in comparison to ~$3,000 to ~$5,000 monthly toward car rentals, leases, etc if we were unable to buy a car.
- **Support contracts:** These include a legal firm, tax consultant, and audit firm. In our initial budget, we entirely neglected to account for these costs, which run ~$33,000 annually. Ultimately, these are mandatory expenditures to maintain our program office in Zambia and ensure we are compliant with local regulations and Evidence Action policies.

### *4B. Indirect Rate*

Starting January 1, 2025, Evidence Action's indirect cost (IDC) rate has increased to 22% (note: it was 18% at the time of our original Zambia budget submission). The higher rate is reflected in the revised budget. This adjustment reflects the growing complexity of our work and ensures we can continue supporting programs, like Syphilis-Free Start, at the highest level. Several key factors contributed to the increase in our IDC rate:

- **Improved talent management:** We're investing in our People and Culture team to strengthen recruitment, retention, and talent development—critical to maintaining high-quality program delivery.
- **Governance, compliance, and reporting requirements:** We've hired a General Counsel and are building an internal audit function to better meet donor expectations and uphold rigorous standards for stewardship and accountability.

- **Expansion of global operations functions:** As our programs grow in size and complexity, we're investing in global operations and finance to ensure strong execution, financial oversight, and responsiveness to a more diversified funding environment.

We are committed to ensuring that every dollar is spent efficiently and effectively to achieve the greatest possible impact for the Syphilis-Free Start program. This IDC adjustment allows us to maintain the infrastructure, compliance, operational, and leadership support necessary to deliver on our shared goals.

***5. CHAI Sub-Grant Agreement***

Our initial budget did not include the sub-grant we gave to CHAI Zambia. In late 2022, we decided to move forward with the sub-grant to enable CHAI Zambia to extend their national-level technical support to the MoH. Throughout 2021-2022, CHAI had provided very specific and targeted support to the MoH labs team to coordinate the adoption of dual testing - this included acting as the secretariat for the biweekly dual test working group calls, supporting the registration of the various HIV/syphilis dual test brands, and supporting the investigation of false positives due to the Bioline dual test. We felt it was more efficient to continue to leverage the CHAI / labs teams engagement rather than replacing it. This allowed Evidence Action to focus on the overall strategic planning and management of the maternal syphilis program and prioritize its relationship with the National PMTCT team at the outset. In all, the partnership proved useful -- CHAI was able to maintain the dual test working group, helped manage the dual test brand transition, advocated together with our team to lift the 2023 hold on dual test procurement which had prevented PEPFAR from donating test kits, ensured adequate annual quantification of test kits, and worked with the Labs team to develop stronger tools for dual test usage at the health facility. The agreement ended, as planned, in December 2024. In total, we transferred $394,228 to CHAI.

## Contingency Pool for Gap-Filling Dual Test Procurement

HIV commodities in Zambia, including HIV/syphilis dual tests, are funded via PEPFAR and Global Fund. The decisions made by the Trump Administration to freeze foreign aid and to dismantle USAID have put the availability of dual tests in Zambia at risk. Going forward, we anticipate that Zambia may face shortfalls in dual tests, but whether these shortfalls emerge in reality remains uncertain -- dual tests are still being bought via Global Fund and, recently, the MoH placed an order using domestic resources.

In March, GiveWell approved up to $904,020 for Evidence Action to purchase up to 600,000 dual tests to fill availability gaps in 2025. So far, we have not utilized this funding. Based on our current assessment of the situation, we predict that we may only need to utilize half of this funding this year; that said, we will continue monitoring in case the situation changes.

Going forward, **we request that the overall contingency for dual test procurement be increased to a total of $2,184,715 to cover the following procurement scenarios in future years**. See Table 3 below.

**Table 3: Projections of Dual Test Gap-Filling**

| | **# of Dual Tests Needed** | **Total Budget** (including IDC) |
|---|---|---|
| Gap filling in Year 3;<br>*takes into account that half of the initial gap of 600,000 was filled by GRZ (Gov't of Zambia)* | 300,000 | $452,010 |
| Gap filling in Year 4;<br>*assumes 1,300,000 dual tests are needed annually, Global Fund commits to 425,000 dual tests, and GRZ commits to 300,000 dual tests* | 575,000 | $866,353 |
| Gap filling in Year 5;<br>*same assumptions as Year 4* | 575,000 | $866,353 |
| Total | 1,450,000 | **$2,184,715**<br>*already committed $904,020*<br>***additional amount: $1,280,695*** |

As with the original amount agreed to with GiveWell ($904,020), we will only purchase the dual tests if we have high confidence that a gap is likely and we will make that decision in consultation with GiveWell.