**May 2015**
**Civil society priority recommendations to the 2015 Zimbabwe SDS**

We support the priority placed by the PEPFAR COP 2015 global guidance on epidemic control. This has caused civil society to focus attention on PEPFAR Zimbabwe's targets, priorities, and strategies as proposed in the 2015 SDS. We are also eager to offer feedback about how to ensure civil society engagement is as strong as possible. Zimbabwe has one of the highest burdens of HIV, with 15% national average adult prevalence; these issues could not be more crucial.

As the COP 2015 describes, no area of Zimbabwe has 'low' prevalence; the epidemic is generalized. Nevertheless, we feel that the approach used by PEPFAR Zimbabwe to geographic and/or population focus required by the COP 2015 guidance does not fully appreciate this reality. While PEPFAR cannot accelerate in all parts of the country with the resources available, withdrawing engagement completely from Districts suffering double digit prevalence and real disease burden will undermine efforts to achieve epidemic control. We have developed a number of recommendations:

• **APPROACH TO GEOGRPAPHIC AND/OR POPULATION FOCUS:** PEPFAR Zimbabwe approached the requirement for geographic and/or population focus in a manner that will not enable the critical analysis required to determine where PEPFAR needs to be accelerating high impact treatment and prevention interventions. Specifically, PEPFAR Zimbabwe first completed a District analysis of prevalence and burden, identifying the Districts where 80% of people with HIV live. They then examined HIV positivity yield among service delivery sites supported by PEPFAR only in the *priority* Districts that remained. Site level yield analysis was not completed among "non priority" Districts. In addition, it appears there was no projection of unmet need for service delivery, in particular HIV treatment—in fact, PEFPAR Zimbabwe assumes that 80% of the 129,000 people who represent the new national ART enrollment target for 2016 reside in the 36 priority districts. This assumption needs to be verified by actually modeling where the unmet need for service delivery actually is—overlap is not necessarily complete and unmet need is an important data point.

PEPFAR Zimbabwe should complete a site level analysis for the *entire* country, and ensure hot spots (with high volume and/or high positivity yield) within Districts of "low" prevalence (eg <14.7%--still extremely high) and/or burden are not left behind. PEPFAR Zimbabwe should also complete an assessment of unmet need among adults and children, and factor these data into their recommendations for strategic focus as well.

• **UNPACKING SITES WITH LOW YIELDS AND/OR LOW VOLUME:** Site level data are very important, and in Zimbabwe we need the country team to share information to map *where* low yield and/or low volume sites are in the country, *which* sites they are, and *which* services/type of technical support PEPFAR is supporting at these sites. There are many reasons why sites could have low yield—from saturation of services in a catchment area to poor performance by an implementing partner. We are suspicious of any low site yield data, for example, in an area with high burden and/or high prevalence. Currently we do not have access to detailed site yield data, so cannot provide meaningful or complete responses to the proposed prioritization.

• **NEED FOR SHIFT TO DIRECT SERVICE DELIVERY:** Unlike most other PEPFAR countries, the vast majority of Zimbabwe's almost $95 million PEPFAR funding is for technical support, not Direct Service Delivery, complicating concepts such as "acceleration." Apart from the clinical services of lab support for EID, HIV testing, and VMMC, PEFPAR in Zimbabwe is investing in technical support (see PEPFAR Zimbabwe Action Memo, October 24 2014 p. 3-4 and the Zimbabwe SDS p.19), with only 3,500 *existing* adult and pediatric patients *directly* supported on ART, and 30,000 *newly* enrolled people with HIV according to the 2014 COP. The 2015 SDS states that acceleration in ART by PEPFAR is entirely dependent upon how Government of Zimbabwe and the Global Fund expand and prioritize their investments in treatment—because virtually none of PEPFAR's support is for direct service delivery, despite the urgent need among Zimbabweans with HIV. It is time to consider changing this. Through national and Global Fund investments, as well as PEPFAR investments, Zimbabwe has been able to make huge strides, attaining 64% ART coverage and making important gains in prevention and care. However, serious gaps in coverage are looming, including a commodities gap coming as soon as 2016. PEPFAR Zimbabwe describes an ARV gap of approximately 22 million for 2015, 84 million for 2016, will looming stock outs and treatment interruptions in 2016 that will be averted only if the country "dramatically curtails enrollment" or raises more funding (Zimbabwe SDS p. 33).

Unfortunately, the 2015 SDS does not propose any increased investment in treatment or other high impact service delivery. Given Zimbabwe's strong track record in scale up, the prioritization by Government places on treatment scale up in order to save lives and prevent new infections, and the unmet national need for treatment initiation, we recommend PEPFAR begin to pivot away from technical support and toward high impact direct service delivery in Zimbabwe, in order to achieve epidemic control.

• **VMMC TARGETS:** We note the description in the SDS of a substantial reduction in VMMC targets and a $4 million reduction in budget for MMC, which the Zimbabwe PEPFAR team describes is being directly caused by implementation of PEPFAR's treatment earmark, implementation of SIMS and changes in Management and Operations. Because virtually no PEPFAR funding is being invested in treatment directly, we cannot understand why the earmark would displace funds for VMMC in COP 2015—only 13 sites provide direct service delivery and only 30,000 new HIV positive people were enrolled on treatment as directly supported patients in 2014. There does not have to be a trade off between VMMC scale up to at least maintain the current performance levels (in 2014 166,500 procedures were performed using PEPFAR funding) and treatment scale up in Zimbabwe.

• **KEY POPULATIONS:** We do not support the approach not to target MSMs with services until results from a size estimation study for MSMs are available. Men who have sex with men in Zimbabwe have an unmet need for treatment and prevention services. PEPFAR should support efforts to roll out service delivery in close partnership with trusted partners in the LGBTI community and their allies, while preparing for the results of the size estimation study. The SDS should be revised to set population specific sub targets for this and other key populations.

• **PROGRAM QUALITY, VIRAL LOAD AND RETENTION IN CARE:** The 2015 SDS identifies as an area of priority that "there is no formal referral, tracking and follow-up systems to increase retention in care or identification of those being lost to follow-up." This is a crucial priority that should receive increased attention and support in the 2015 COP. What is the budget PEPFAR proposes for improving treatment outcomes through efforts to reduce loss to follow up? What is the service delivery model and what is the minimum standard of non facility based inputs PEFPAR is supporting in Zimbabwe? We also note that investment in viral load roll out in Zimbabwe is not a feature of the SDS 2015—we believe investing in efforts to ensure all people with HIV in Zimbabwe on treatment have access to viral load monitoring and support to achieve sustained viral suppression should be an area of priority.

• **US FORWARD and Advancing Partners and Communities (APC) locally known as the LOCAL CAPACITY INITIATIVE (LCI):** While we acknowledge that PEPFAR has made important investments in communities through the LCI, it is biased towards the North, covering only ten communities as opposed to all provinces noting there has already been an effort to partner with non traditional CSO partners, including ZAN, ZLHR, SAT and Pangaea. This geographic restriction should be re examined. However the US FORWARD - which is the bigger strategy in building local capacity--is not very clear in terms of target expansion. While we acknowledge the graduation of Mavambo Trust (In Harare), HOSPAZ (in Harare) and FACT (in Mutare). it is worth noting that these are the same areas covered by the LCI yet the country has 8 more provinces with implementers. We recommend increased opportunities and a clearly defined criteria for non-traditional civil society partners to access PEPFAR support and graduation to receive and manage USG grants directly.

**COMMUNITY SYSTEMS STRENTHENING:** In recent years, a number of global processes have explicitly endorsed the strategy of community systems strengthening (CSS) to achieve both public health and human rights outcomes. In particular, the Global Fund's CSS Framework (2010, 2011 and 2013), the UNAIDS Investment Framework (2011), WHO's Consolidated Guidelines on the use of antiretroviral drugs for treating and preventing HIV infection (2013), and the Implementing Comprehensive HIV/STI Programmes with Sex Workers Tool (2013), provide global guidance for CSS to be an integral part of national programming. CSS delivers not just better access to services, but also meaningful and effective involvement of communities in health care, advocacy, health promotion and health literacy, health monitoring, home and community-based care and wider responses to disease burdens.

The Community and Home Based Care program came to an end in 2013 under Global Fund round 8 and since then the country has had concerns over low national ART coverage for children compared with adults. The IMPACT (now EIP) program needs to be scaled up to cover the gap in pediatric ART coverage. Adolescents

and youths are a target group that has been left behind, with high HIV deaths (even globally) Migrants, especially returning residents visiting during the Christmas break are a significant priority population that requires intervention—worse with the high STIs always recorded after the festive period, Ex convicts are another little-talked about group that is reached with HIV activities in the communities. The emergence of HIV and TB co-infection, MDR TB, non-communicable diseases (NCDs). Even with the reduction in bed-ridden clients there is still a huge scope for CSS in overall health promotion and saving lives. Engaging communities in health and social care, advocacy, health promotion and health literacy, and demand creation for HIV services can help ensure an enabling and supportive environment while improving program outcomes. How is PEPFAR prioritizing this approach in Zimbabwe in 2015?

**CSO ENGAGEMENT PLAN:** The PEPFAR team should link to the core team that has been established as part of their engagement plan; dialogue, meetings, and sharing data should always include HIV advocates, not only service providers from civil society. This will be critical as Zimbabwe prepares for quarterly data review meetings. The core team is currently developing an Engagement Action Plan and we will share this as soon as possible.

**PrEP FOR POPULATIONS IN NEED:** High impact prevention interventions should be explored in key populations in Zimbabwe, including through the DREAMS Initiative—beyond continuation of the sex worker demonstration project.

**PEDIATRIC TREATMENT:** Coverage among paediatrics is only 42%—closing this access gap should be a priority in 2015. Increased scale up of known best practices is needed. Furthermore retention is a major challenge for children, especially as children move into adolescence and the diagnosis of HIV-positive children is severely constrained by lack of decentralized laboratory and specimen transport capacity. How will this be addressed by PEPFAR?

**OVC TRANSITION:** We note the dramatic transition of many OVC services in ‘non priority’ Districts. We are extremely concerned that there will be negative implications for families and communities as a result. What is PEPFAR’s plan to ensure harm is not done to this vulnerable population. Case management implementation in USAID Districts is lagging behind and there are serious service gaps. Its not mentioned how the intervention will be delivered in the SDS, worse with the limitations in the newly formed Department of Child Welfare and Probation Services.

**Contributing Members:**

Zimbabwe Lawyers for Human Rights
Zimbabwe AIDS Network
Gays and Lesbians of Zimbabwe (GALZ)
Zimbabwe National Network of People Living with HIV/AIDS (ZNNP+)
F.A.C.T
BHASO
Jointed Hands Welfare Organisation (JHWO)

Midlands AIDS Caring Organisation (MACO)
Women's Health HIV and AIDS Southern Africa Harare Zimbabwe

Technical cooperation provided by Health GAP (Global Access Project) and Pangaea Zimbabwe AIDS Trust.