2016 Zimbabwe Civil Society HIV Treatment and Prevention Priorities

Materials reviewed: PEPFAR Zimbabwe Country Operational Plan (COP) 2016

Strategic Direction Summary

Background: We appreciate efforts by PEPFAR Zimbabwe to engage with civil society in shaping the COP 2016 and in ensuring PEPFAR’s approach to scaling up prevention and treatment in Zimbabwe reflect the recommendations and concerns of communities that are most heavily impacted by HIV. This note describes several provision priorities regarding HIV treatment and prevention for your consideration.

1). Maintained Level Funding

Zimbabwe has shown enormous strides in reaching people with life saving services, using relatively limited funding from the public sector, PEPFAR, the Global Fund and other funders. Zimbabwe has a generalized HIV epidemic from 6.5% to as high as 70%. We are gravely concerned that PEPFAR’s allocation for Zimbabwe remains level at $95 million\(^1\). Combined funding from PEPFAR and the Global Fund per PLHIV is lowest for Zimbabwe among ten sub-Saharan African countries classified as low income by the World Bank. Annual PEPFAR support grew by approximately 74% between 2011 and 2012 and is now maintaining level funding ($95 million COP support). This is unacceptable. While the geographical focus was premised on reaching HIV high-risk districts we strongly feel that the case of Zimbabwe is unique. Treatment gap for example is generalized across all the 60 districts. We appreciate the continued support over the years from the USG besides the political differences between Zimbabwe and the US government. However, politics cannot be allowed to take precedence over people’s lives. ARV funding for future years is uncertain for Zimbabwe given that planning for the Global Fund beyond 2016 is currently unknown. Furthermore, as ART coverage is expected to increase with the introduction of Test and Start, ARV needs will increase while overall funding is expected to remain level.

**Recommendation:** As civil society in Zimbabwe we expect PEPFAR to do more by reconsidering its funding policy on Zimbabwe and commit to cover the $19.5 million treatment gap projected in 2017.

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\(^1\) INFORMATION MEMO FOR AMBASSADOR HARRY K. THOMAS, JR., ZIMBABWE FROM: S/GAC – Ambassador Deborah L. Birx, MD
SUBJECT: FY 2016 PEPFAR Planned Country Allocation
2). 90-90-90 Test and Start & Further Move to Direct Services

Zimbabwe is yet to adopt and implement Test and Start. Zimbabwe’s MOHCC is in the process of revising the national treatment guidelines to align with the 2015 WHO recommendations to initiate ART for all PLHIV irrespective of CD4 count. This will require additional support to an already strained health care infrastructure and will further strain the ARV supply. In terms of the UNAIDS Fast Track Strategy, reaching the “first 90” requires heavy investment ($165 million in FY16 and $165 million in FY17) and strengthening of HIV testing service (HTS) strategies. PEPFAR according to the Zimbabwe-Specific Technical Direction for COP 2016 is committed to the adoption of Test and Start. As described below we need significantly greater investment in core direct services to support Test & Start than is currently found in COP2016. Realistically, we know that the government of Zimbabwe is not in a position to fund Test and Start due to years of an underperforming economy. Government health spending has slowly declined with currently expenditures at 7.6% of the total GOZ budget. Funding for MOHCC continues at $330 million per year in the 2014 and 2015 budget. While these funds are primarily allocated for MOHCC personnel costs, a critical component of the national HIV response, the actual funding disbursement is only approximately 10% of the budgeted amount. In line with the above, from discussions with MoHCC, GoZ is reluctant to fully commit to Test and Start unless funding is promised from other funding sources. Furthermore, GoZ cites covering treatment gap (approximately $19.5 million) as priority. Zimbabwe like any other HIV burdened country will gain significantly form Test and Start. According to UNAIDS Achieving the Fast-Track Targets would reduce future direct treatment expenditures by 43% as a result of new infections averted. The gains in human terms are even more profound. In less than two generations (35 years), ending the AIDS epidemic will lead to 760 million life-years gained—75% of them in sub-Saharan Africa. It would mean that 7.9 million African children would avoid orphanhood. Expenditures for HIV prevention, treatment and other services are strategic investments to save lives, avert new infections and achieve the end of the AIDS epidemic as a public health threat by 2030. With an increase in financing, international donors can help realize the end of the AIDS epidemic. PEPFAR should commit to invest in the Test and Start approach otherwise this will remain a pipe dream. Moreover, this is a human rights issue. The UNAIDS says:

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2 Zimbabwe-Specific Technical Direction for COP 2016
3 UNAIDS 2015 IMPLICATIONS OF THE START STUDY DATA
QUESTIONS AND ANSWERS
“Every person living with HIV should have immediate access to life-saving antiretroviral therapy. Delaying access to HIV treatment under any pretext is denying the right to health.”" Michel Sidibé, Executive Director of UNAIDS

Recommendation: A significant investment should be made on the part of PEPFAR as an unsupported push for the adoption of Test and Start will not bear fruits in Zimbabwe in the near future. It is programmatically impossible for GoZ to implement Test and Start while currently experiencing a treatment gap in both ARVs of $19.5 and in service delivery, human resources, etc..

Treatment & Direct Service Delivery

In 2015 Civil Society raised a strong concern about how small a portion of PEFPAR’s funding was going to direct treatment services or other high impact service delivery. We are concerned that this continued throughout 2015—with targets of just 4,100 people supported on treatment and 3,600 newly initiated through direct service delivery in COP15.

It is clear that in 2016 some important changes are under consideration in this area. Those changes are to be applauded, but they do not go far enough in addressing the core limiting factors that PEFPAR identifies for scale up: HRH and resources for facility based and community based care as well as linkage and retention through defaulter tracing and community based models. These activities are critical to scale up and we applaud the move to focus there in Harare/Chitungwiza. This model should be significantly expanded to reach throughout PEPFAR’s 36 districts.

An analysis of the “Program Support Necessary to Achieve Sustained Epidemic Control” section of the COP (p46-54) shows that significantly more is still being spent on non-DSD activities. Specifically we notice that:

- DSD support including for PITC in Harare & Dreams Districts, community based testing, ART initiation through nurse teams in Harare, and expanded sample transport totals $6,715,913.
- Support for implementation of CARGS and alternative service delivery models (we are unclear if this includes funding HRH to support?) is an additional $3,189,143

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4 UNAIDS 2015 IMPLICATIONS OF THE START STUDY DATA QUESTIONS AND ANSWERS
• By comparison activities including technical assistance, training, mentoring, M&E, tool creation, process implementation, information systems, surveys, etc. is budgeted for $30,367,997

RECOMMENDATION We therefore suggest that
• All current scale up districts be identified for DSD service delivery that provides the kind of interventions identified for Harare.
• The “aggressive scale up” districts are especially important given the current low coverage rates—which we suggest will not see sufficient scale up only with focused TA and quarterly visits. Instead human resources and other direct service investments are critical.
• Support community-based service delivery like CARGs etc in all of these districts, not just Harare are.

What ‘counts’ as DSD?

As shown on p15 of the SDS, it seems in 2015 that PEPFAR Zimbabwe spent very small amounts of money per person “supported” by the program in most districts, with only 3-4 exceptions where PEPFAR spending accounts for anywhere approaching half the cost of keeping a person alive on treatment. In the past, however, this has been justifiable insofar as the difference between TA and “direct” service delivery was clearly and fairly accounted for.

However, we are gravely concerned that PEPFAR has now changed the way Zimbabwe ‘counts’ people on ART supported by PEPFAR to make it even easier for PEPFAR to achieve its program targets. It now will include people enrolled on ART in sites where PEPFAR merely supports mentoring and supportive supervision (see PEPFAR 2015 APR PoART Zimbabwe, slide 27) as supported by PEPFAR. This definition is so broad it means almost nothing.

Page 20 of the SDS gives a clear indication about what types of services will be provided in different districts. In the DREAMS and Harare areas it seems clear PEPFAR will provide what has historically been considered “direct” services—human resources, commodities, space, etc. In scale up to saturation districts, however, this seems much less clear.
RECOMMENDATION: We strongly suggest that activities such as mentoring, QI visits, and TA for PITC are not “direct” service—as much as they may be important interventions—and should not “count” for as DSD patients.

3) Community Level Support: Investing in indigenous community support and advocacy

A major civil society concern over the past years is the lack of direct support to local community HIV prevention and treatment support. PEPFAR does not commit support to community based care efforts in Zimbabwe. This is worrisome considering that Zimbabwe recorded a 60 000 PLHIV loss to follow up in the FY2015. In addition, the targeted 12.500 per month ART initiation target plummeted to 4000 in the FY15. We strongly believe that if community efforts are supported directly, ART initiation targets will be improved and maintained. Historically, community based efforts have recorded significant success in HIV care and treatment, the case of Home-based care model. The COP16 SDS draft acknowledges the role of community based efforts and PEPFAR has proposed to “In COP 2016, PEPFAR Zimbabwe will pilot direct-service delivery community-based adherence and retention models using lay cadres, expert patients, and leveraging the presence of existing community cadres such as village health workers (VHWs) and community case care workers (CCCWs)”\(^5\). For this process to be successful communities should be engaged from the onset and rigorous support procedures should be limited as community lack of compliance may be mistaken for inability to implement. Political will to community based care support is high evidenced by the MOHCC’s incorporation of the concept of differentiated service delivery packages within its Operational Service Delivery Manual. Unfortunately, while this approach has been endorsed, it has not yet come to fruition in most facilities due to resource challenges. Supporting community-based care efforts directly has long-term benefits as it is cheaper and structures are permanent. Furthermore, 90-90-90 Test and Start cannot be successful without involving Communities play an important role in supporting public health systems, linking people to services, reaching people not accessing public health services, providing testing and supporting people in adhering to treatment.

Recommendation: PEPFAR should commit a significant amount ($1million) support to communities in building demand for prevention, testing, treatment and viral load suppression, in particular for key populations, who have too often been left behind in the AIDS response.

\(^5\) PEPFAR Zimbabwe Country Operational Plan (COP) 2016 Strategic Direction Summary Draft
4) Geographic areas of concern

A major civil society concern during the COP 2015 planning process was the arbitrary cut-offs that assigned Districts either to ‘Sustain’ or ‘Scale up (Saturation)’/‘Scale up (Aggressive).’ In a country such as Zimbabwe, with double digit prevalence and substantial unmet need for treatment and prevention spread throughout the entire country, geographic focus runs the risk of leaving behind substantial numbers of people—for example ‘low’ prevalence in Zimbabwe is <14.7%. We need information about the impact of this pivot so far—contained only in 2016 quarter 1 data that have not yet been made available. This is even more concerning considering the fact ‘Sustain’ Districts will from 2016 only receive Central/‘above site’ support.

We note with particular concern that linkage is a major problem in some districts, including Buhera where the datapack shows only 618 (23.32%) of those testing positive newly enrolled on treatment and, including new on care (510), linkage to care or treatment is still only 42.6%. Bulawayo, where 9,572 people tested positive and only 3,247 (33.92%) newly enrolled on treatment. Chiredzi, where 2,768 tested positive but only 1,337 (48.3%) newly enrolled on treatment and Mutare where 3,277 tested positive but 1,435 (43.79%) newly enrolled on treatment. Bulawayo and Mutare are dreams districts and so are set for further DSD expansion—we suggest that Buhera and Chiredzi should be a starting point for further DSD expansion.

In addition, we note that of the “centrally supported” districts, the datapack shows that Umguza and Chikomba have very high “unmet need”—larger even than many of the scale up districts.

**RECOMMENDATION:** PEPFAR should consider including at least these two districts in scale up—and should be committed to reviewing districts such as these for scale up. PEPFAR should also continue to report and focus on scale up in what will be the “centrally supported” districts to at least provide for surveillance and clarity about how far behind these districts may be falling.

5) Key populations focusing on PWDs

The full enjoyment of the right to health remains a distant goal for PWDs. Due to social isolation, exclusion from the mainstream schools, negative assumptions about their
sexuality and communication barriers (i.e. the unavailability of information by sign language, in Braille, on tape or in other accessible formats), PWDs are not receiving adequate HIV services. Strategies to improve especially women and girls with disabilities rights to health must take full account of the underlying determinants of health, particularly gender inequality and discrimination, and must address the specific structural, socioeconomic and cultural barriers that hamper women and girls with disabilities in protecting and improving their health. These strategies must be placed in the broader context of government and broader society recognizing, acknowledging and safeguarding the inherent dignity and equal worth of women and girls with disabilities, as a fundamental pre-requisite to women and girls with disabilities realizing their right to health. Women and girls with disabilities are less likely to receive information on SRH, including information on STI, HIV, cancer, safe sex practices and effective birth control.

Lack/inadequate access to HIV and AIDS prevention, treatment, care, support and mitigation services by PWDs
Programmes and services are designed, planned and implemented in the context of the non-disabled. Disability sensitive and friendly services are inadequate or non-existent. In other words, most prevention, treatment, care, support and mitigations services are not accessible to people with disabilities. For example, facilities lack provisions such as elevators, ramps and wide doors to facilitate access for the physically handicapped; Braille translation for the blind; service providers who are able to communicate in sign language to serve the deaf. Policies that promote disability friendly provisions do not exist or are inadequate. Where such policies exist in the absence of supportive legislation to enforce policy implementation, policies are unhelpful.

PEPFAR Zimbabwe COP16 shows no commitment to investing in PWDs citing lack of data. This is unacceptable. We demand that COP16 allocate a significant amount towards data collection on PWDs. No commitments have been made to provide funding for HIV treatment and prevention services for PWDs. Lack of data is cited as a hinderance. While this should be a collaborative effort especially led by GoZ, it is clear that even the government does not seem committed to ending AIDS among PWDs. This is tantamount to discrimination.

**Recommendation: PEPFAR should commit a significant investment in data collection on HIV prevention, care and treatment for PWDs.**