COMMUNITY COP22 ZIMBABWE

COMMUNITY PRIORITY RECOMMENDATIONS

FOR PEPFAR COP22


HOSPITAL VISITING HOURS
MONDAY TO FRIDAY
06:00-07:00 MORNING 13:30-14:00 AFTERNOON 16:30-17:30 EVENING
SATURDAY TO SUNDAY
06:00-07:00 MORNING 13:00 AFTERNOON -14:00 EVENING
HOLIDAYS
06:00-07:00 MORNING 13:00 AFTERNOON -14:00 EVENING
HW


D27
VOLUNTARY
COUNSELLING
AND TESTING...

INTRODUCTION

In Zimbabwe, an estimated 1.3. million people are living with HIV.[1] The effort to reach 95-95-95 is catalyzing energy and the country is now at 91.89 85 and 93.2 for adults and 74.8 and 79.3 for children.

In the midst of these milestone achievements, COVID 19 crept in to destabilize the progressive gains leaving not only Zimbabwe but the Global HIV programme retrogressing. While huge progress was made in 2019, the knock-on effects of the COVID-19 pandemic in 2020 and beyond have derailed decades of progress in the fight against HIV, TB and other diseases. PEPFAR's COP22 commitments for increased Viral Load coverage and HIV Testing Services especially among children and Key Populations is greatly appreciated. The directive to optimize human resources allocation and staffing support is most welcome as it ensures alignment of HRH investments with program priorities and guides future transitions.

Challenges include:

+ Viral load coverage
+ Pediatric viral load suppression
+ TB screening and reporting
+ HRH depletion
+ The lack of a mental health centered approach amidst Covid19 challenges
+ Cervical cancer screening for PLHIV women
+ Person-centered prevention
+ Prioritizing Advanced HIV Disease, people with Disabilities
+ Centering KP needs beyond treatment and care, but a KP-friendly holistic approach for effective prevention
+ Stigma and discrimination
+ Sustainable Local Partner transition – Change definition of local Organisation

The impact of COVID-19 has had far reaching consequences, and evidence-based assertions and testimonies, among others include:

1. The Planning Level Letter contends that, "The PEPFAR program has faced many challenges during this period. Nevertheless, the PEPFAR family and partners have carried the mission forward while enduring significant personal impacts of COVID-19. Despite these challenges, what remains true is the strength and resilience of PEPFAR in partnership with countries and communities – through our teams, and our programs in the midst of dueling pandemics"
2. "Modeling analysis projects an additional 6.3 million cases of TB and an additional 1.4 million TB deaths attributable to COVID-19 pandemic between 2020 and 2025. Global TB incidence and deaths in 2021 were projected to increase to 2013 and 2016 levels respectively – a setback of 5-8 years in the fight against TB. COVID-19 has affected the whole cascade of care and prevention for TB.[2]
3. Mental health was shaken by COVID-19 at a time when research showed that "It is increasingly acknowledged that mental health is a risk factor for HIV and TB and can negatively impact on the course of the disease and treatment, and that living with HIV and/or TB is a significant risk factor for a decline in an individual's mental health and developing psychiatric illness.[3]
4. The Community Rights and Gender Assessment (MoHCC-NTP & Jointed Hands 2021), and the Stigma Index (ZNNP+) preliminary results show that Stigma and Discrimination increased during the period under review.
5. The period has seen a massive brain drain and depletion of Human Resources for Health, an area which calls for increased advocacy, with it the need for domestic resource Mobilization.
6. Overall, access to services declined, forced disclosures, GBV and other barriers to quality health services were witnessed.

Be it as it may, COP22 brings opportunities to ensure gains that were made before COVID-19 are sustained and epidemic control is achieved. The priorities set out below by Civil Society and communities in Zimbabwe through a robust consultative process carried out by the Advocacy Core Team through the support from COMPASS, CLM, Health GAP, amfAR, and O Neill Institute gives PEPFAR the opportunity to implement solutions from lived experiences. Selected Civil Society Representatives from 4 population groups engaged with communities whose demands if implemented, will turn the tide.

1. World health organization HIV Country profile Zimbabwe 2017.
2. COVID-19 Information Note: "Catch-up" Plans to Mitigate the Impact of COVID-19 on Tuberculosis Services, 23 October 2020, Global Fund
3. https://unitedgmh.org/sites/default/files/2021-06/The%20impact%20of%20integrating%20mental%20health%20services%20on%20HIV%20%26%20TB%C6%92%20%281%29.pdf

PRIORITY INTERVENTIONS FOR COP22

1. Case Finding and Other Screening Programs

1.1. HIV Testing

The shortages of health care workers in Zimbabwe due to among other reasons brain drain, attrition and insufficient government and donor resources to recruit and retain adequate numbers has negatively impacted case finding among other program interventions. These shortages further risk the Program's trajectory to achieve epidemic control if not urgently and comprehensively addressed not only by PEPFAR, but by the government and other developing partners as an emergency. Figure 1 of Q4 POART data shows worrying missed targets for COP21 on index testing and contact tracing. In order to course correct the low performance on case finding in COP21 with the existing health workforce, civil society strongly recommends that in COP22, PEPFAR innovates and implements case finding interventions that reach the largest targets, i.e. move from facility based to community based HTS and screening methods. For example, the Head to Toe school health screening is an efficient community screening initiative with demonstrated impact in reaching and accessing schools. PEPFAR could also close the gaps in collaboration and coordination in testing and screening programs amongst programs and partners. For example, OVC partners vs clinical partners, non PEPFAR but USAID funded partners all intervening separately but often targeting the same population and clients.

Figure 1: Q4 POART Data- Index Testing

HTS_INDEX	30,268	28,656	14,553	18,141	18,028	21,333	23,512	20,553		164,548	51%
HTS_INDEX_NEWPOS	6,733	6,255	2,721	4,040	2,514	3,385	3,968	3,313		33,042	40%
HIV Testing Yield Index	22%	22%	19%	22%	14%	16%	17%	16%		20%	

+ **COP22 Target:** Create District Technical Working Groups for PEPFAR and USAID but non PEPFAR grants in District e.g. in the 8 districts where the TB-LON is in existence the PEPFAR specific TWGs facilitate integrated screening and testing across PEPFAR (OVC/Clinical) partner and TB partner.
+ **COP22 Target:** PEPFAR to fund capacity building/ training of VHWs, CCWs on case findings and referral systems.
+ **COP22 Target:** PEPFAR to fund and support media and community engagement on case management and violence prevention related to targeted case-finding and possible human rights derives.
+ **COP22 Target:** PEPFAR to collaborate with MOHCC in the Reintroduction of the Head to Toe school health assessment and related referrals in 13 OVC districts.
+ **COP22 Target:** PEPFAR to Increase investments by 30% in mobile units (E.g. GF Trucks) to support quarterly provincial integrated outreach programmes to underserved population groups such as KPs, artisanal and small-scale mining communities.
+ **COP22 Target:** PEPFAR should expand the availability of self-test kits for targeted populations including young people, MSMs and Men during specific populations/community gatherings, mobile testing closer to the villages and communities. This was done under the FCI and is planned to end without clear commitment of programmatic follow up.
+ **COP22 Target:** PEPFAR will partner with MOHCC and faith-based communities to promote and resource places of worship with HIV self-tests and use these as possible points of outreach by clinical and community health workers in order to expand testing services.

1.2. Cervical Cancer – Screening

Despite evidence-based guidelines for screening and prevention of cervical cancer, the majority of WLWH in LMICs lack access to cervical cancer screening.4 Accessibility to the service is affected by the exclusive operational schedule. For instance, in Bulawayo, there are only nine free screening centers. Provincial Hospitals which are also screening centers, have a maximum ceiling of appointments per week that can be attended to, and only open five days a week, excluding a lot of others in need of screening. Furthermore, screening is only limited to those women living with HIV between 25-49 years, yet there are prevalent cases in the other excluded age groups. These barriers are further compounded by the shortage of VIAC trained health personnel and consumables. The disruption in service provision due to power outages, affect access and operationality of services, the sterilization of reusable consumables such as speculums and forceps.

+ **COP22 Target:** PEPFAR should scale up provision of free cancer screening services to 1 more PEPFAR site per province and extend services to open during the weekends to enhance access.
+ **COP22 Target:** PEPFAR should expand the target population to include those below 25 and those above 49 among the persons living with HIV who are at risk, as has been done in other countries.
+ **COP22 Target:** PEPFAR should establish self-testing for HPV as the first step, and have only those testing positive reports for VIAC screening at facilities.

4. Mungo Chemtai, Barker Emily, Randa Magdalene, Ambaka Jeniffer, Ogollah Osongo Cirilus (2021) Integration of cervical cancer screening into HIV/AIDS care in low income countries: a moral imperative ecancer 15 1237

+ **COP22 Target:** PEPFAR should support training of nurses on VIAC screening (at least 1 nurse per PEPFAR facility).
+ **COP22 Target:** PEPFAR should procure and install power backup systems at all PEPFAR funded facilities that suffer chronic power shortages and also promote usage of disposable consumables.

1.3. PMTCT

At a time when Zimbabwe is progressing towards the elimination of Mother to Child Transmission (PMTCT), pregnant and lactating women face a number of barriers in accessing services, resulting in low viral load coverage for this population. Examples of these barriers include: limited viral load diagnostic platforms, reagents and other consumables and a lack of full utilization of these platforms; long turnaround time for DNA PCR results of about between 3 to 4 weeks; user fees required to access services resulting in women giving birth at home. In some instances, women are asked to buy and bring their own consumables- gloves, cotton etc. Civil Society observes that there has been some progress made by some local authorities to remove informal user fees, and note the commitment made by the MoHCC during the COP21 meetings to address the issues as they emerge.

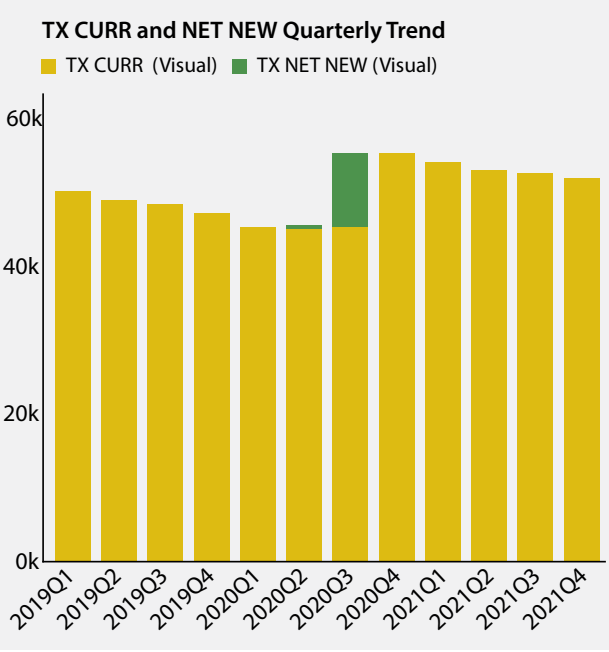
There is an urgent need to prioritize VL testing among PBF women and to prioritize use of point of care, early infant diagnosis (POC-EID) machines.

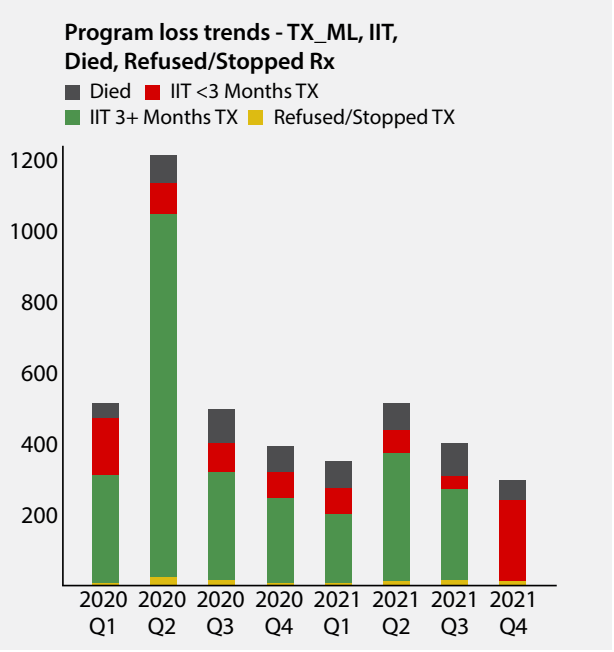
+ **COP22 Target:** PEPFAR should procure and distribute Point of Care machines for DNA PCR tests in local facilities in all PEPFAR priority districts especially those that are far away from the Provincial sites.
+ **COP22 Target:** PEPFAR should increase investments in consumables for ANC programs to attract more women to deliver at facilities in order to increase access to PMTCT programs.

1.4. Pediatrics

Q4 POART data shows a worrying decline in pediatric ART cohort, (see figure 2). As was in COP21 Community COP priorities, in COP22, CSOs are calling for the use of piloted models such as Find Test and Treat pediatrics the Community Clinic Collaboration (c3) that have demonstrated results but were never fully implemented by PEPFAR programs, in a bid to address; testing, linkage rates, viral load coverage and viral load suppression @ 55% (Q4 POART page 38), treatment literacy on children , home deliveries in rural areas and disjointed sample transportation (TB, COVID-19, VL, Malaria), among other barriers to accessing services.

Figure 2: Decline in Pediatric Cohort





+ **COP22 Target:** PEPFAR should pilot DSD models in 6 provinces that have worked for Pediatric interventions such as "call to action by ZAP", the Find Test and Treat, the Pediatric AIDS Treatment Association (PATA) and C3 model.
+ **COP22 Target:** PEPFAR should Integrate the pediatric program with the Expanded Program on Immunization (EPI) to reach and test pediatrics in all PEPFAR supported districts.

+ **COP22 Target:** PEPFAR should double supply of new regimens for pediatrics pDTG to ensure facilities still dispensing NVP move to pDTG and give 6 MMD to stable clients and fund treatment literacy.
+ **COP22 Target:** Facilitate the consultation with 3 groups of adolescents and young adults aged 15 to 20 years old PLHIV to identify best programmatic design to respond to their needs.

2. Person Centered Prevention

2.1. VMMC

Implementation of VMMC in COP21 was slowed down by COVID-19 especially in Q3 of 2020 but resumed with adaptations in Q4 of 2020. While there has been progress made, the program has only achieved 51% of its FY21 targets. Loss of potential income during the healing process contributes to hesitancy for VMMC uptake.

+ **COP22 Target:** PEPFAR should expand the rollout of reusable kits to all PEPFAR facilities that were planned for in COP21 but not implemented.
+ **COP22 Target:** PEPFAR should support the training of a minimum one clinical staff per PEPFAR facility offering VMMC.
+ **COP22 Target:** PEPFAR should expand/further rollout the Shang Ring to eligible population in all PEPFAR sites.
+ **COP22 Target:** PEPFAR should incentivize VMMC clients with a stipend to compensate for the loss of revenue during the healing process. Stipend can also be used as an incentive to lower barriers related to hesitancy to partake in VMMC.

2.2. Key Populations

Stigma and discrimination persist for gender and sexual minorities. Most KPs social spaces at KP institutions are being converted to clinical/office spaces without replacement (effect on mental health and continuity in treatment and viral load suppression). Policy and law are still discriminatory and targeting human rights of LGBTI population, impeding of the progress toward 95-95-95.

Structural interventions are a vital component of controlling the KP HIV epidemic in Zimbabwe. Despite community requests of the previous COPs, PEPFAR continues to disregard the impact of structural barriers to the implementation of the KP programme. It is important to note that our gains in the program will likely not survive without the necessary investments in eliminating all legal political and social barriers that impede access to quality and competent KP services.

+ **COP22 Target:** PEPFAR should designate a budget of USD 2,000,000 towards the implementation of KP structural interventions as follows PEPFAR should fund KP-led CSOs to undertake interventions to eliminate punitive and repressive policy and laws from statute.
+ **COP22 Target:** PEPFAR should increase KP friendly centers by financially supporting 1 KP center (social space) in each district to carry out prevention (not treatment) activities.
+ **COP22 Target:** PEPFAR should expand support for KP centered DSDs by 25%.
+ **COP22 Target:** PEPFAR should support trans and intersex identities in rural areas by providing KP centers with micro grants to carry out community empowerment activities targeting these specific populations.
+ **COP22 Target:** PEPFAR should conduct a size estimate study for transgender populations.

2.3. OVC

The OVC program receives limited social welfare support from the government. Resources are not enough especially given -BEAM, NAC, Online, and needs to include support for food and clothing. Within the same PEPFAR-funded programs, different levels of community incentives exist among partners. This causes confusion and competition instead of complementarity and collaboration.

+ **COP22 Target:** PEPFAR should standardize incentives for community volunteers and similar cadres working in the OVC program across all PEPFAR partners
+ **COP22 Target:** PEPFAR should increase the budget allocation for social welfare support to allow for at minimum all transport fees, a basic universal stipend to cover nutrition needs. Transport fees should account for distance to the facility and unlike nutrition fees, it should not be a flat rate.
+ **COP22 Target:** PEPFAR should bring back the school health program (Head to Toe screening) as this was an impactful entry point in schools in higher burden districts such as Harare, Bulawayo, Seke, Mutoko, Hwange, Goromonzi, Zvishavane and Kwekwe.
+ **COP22 Target:** PEPFAR should engage, include and fund local Partners in the implementation of DREAMS – FHI/ZHI has taken local Partner models and eliminated the local CBOs in implementation.

2.4. Condom Programming

The condom program suffers from disruption in the supply chain. This results in an ongoing consistent condom shortage. Condoms are part of priority prevention interventions, particularly for key populations.

+ **COP22 Target:** PEPFAR should expand its condom supply to all KP CBO and youth programming and artisanal mining spaces in PEPFAR districts with a consistent and considerable amount of condom stock to cover 110% of needs.
+ **COP22 Target:** PEPFAR should retain a budget for buffer stocks of condoms to ensure supply chain constrains do not adversely impact the condom programme.
+ **COP22 Target:** PEPFAR should increase knowledge about condoms using DREAMS, CATS and other adolescent programs. Using these programmatic pathways, collect

data about young people behavior patterns in matters of SHRH using appropriate surveys. This will allow future analysis of risk and condom use assessment.

+ **COP22 Target:** PEPFAR should engage and collaborate with the MOHCC, faith-based communities and administrate leaders at the community levels such chiefs, in expanding availability and distribution of condoms and on the importance of this protective method so that they are available and accessible to teenagers, youths and others.

2.5. PrEP

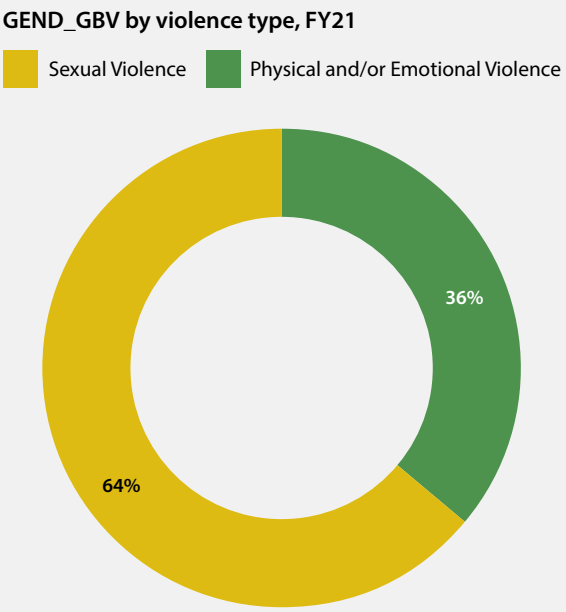
PrEP targets were surpassed in Q4, indicating a good appetite for the program, however reach within KP shows 0% among transgender communities, 9% MSM, 32% FSW and 59% non KP, implying there is need to reach these underserved population groups. Post violence care interventions show an upward trend in FY21 as opposed to FY20, creating a need to increase GBV/IPV interventions and PrEP access. There were 36% sexual violence cases in Q4 2021 but PEP completion needs improvement in all SNUs. The following, however, remain as key gaps in PrEP implementation:

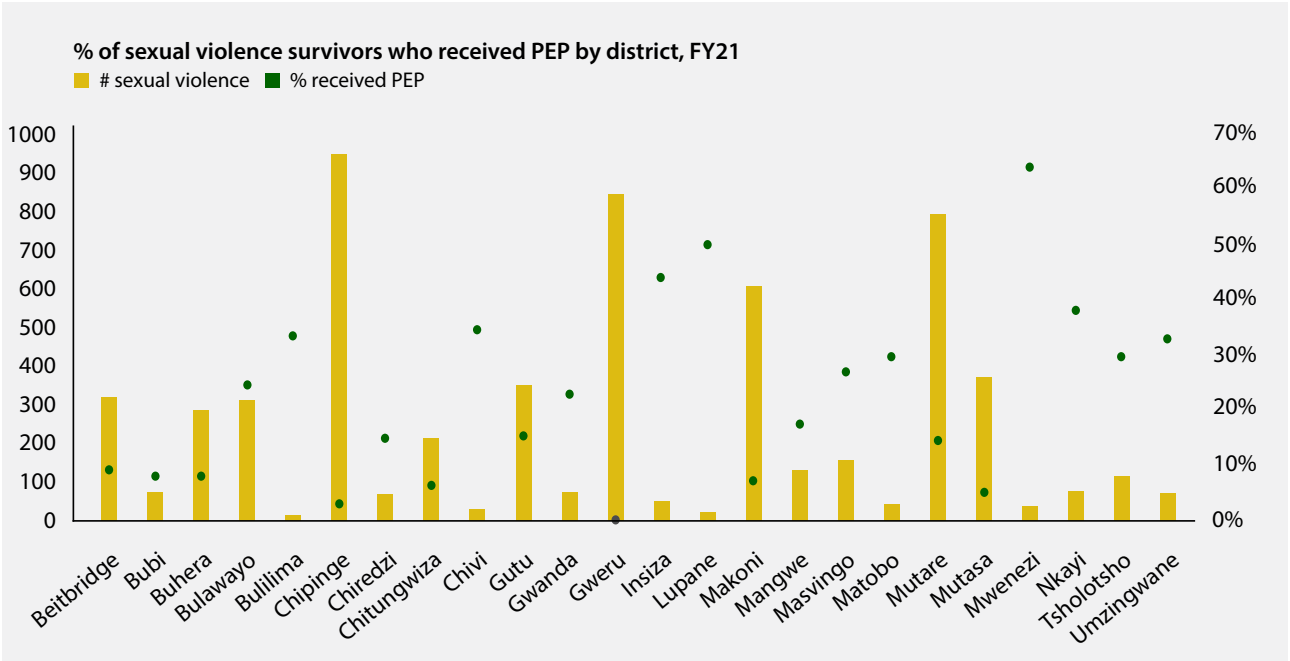
+ Limited stocks coupled with poor targeting
+ Inadequate information around PrEP

+ **COP22 Target:** PEPFAR should increase PrEP coverage to 100% of targeted KP, AGYW eligible non AGYW OVC and young men aged 15 to 25.
+ **COP22 Target:** PEPFAR should prioritize and set specific targets for high risk population groups such as artisanal and small-scale miners and urban slum dwellers and ensure it is able to cover 100% of their PrEP demands.

+ **COP22 Target:** PEPFAR must fund/scale up its investment in CSOs/CBOs, FBOs led PrEP literacy initiatives that includes the dapivirine ring and already invest in literacy for the upcoming CAB-LA.
+ **COP22 Target:** PEPFAR should invest in Increased IPV /GBV awareness raising and PEP literacy especially in family and risk settings, by funding and promoting community-based outreach via PLHIV organizations, youth led organizations, FBOs and KP CSOs. PEPFAR needs to make sure PLHIV, KP CSOs and FBOs receive grants and a work plan to do so.

Figure 3: Q4 2021 PEP





3. Continuity of Treatment

3.1. ART Services

Affordability and accessibility of ART is limited to public service delivery points but expensive in the private sector which affects access for people who may not be comfortable with the public sector but cannot afford to access medicines in the private sector. Most pediatric clients remain on suboptimal ART regimens, with clinics still dispensing nevirapine (NVP). There still remain unacceptably high rates of defaulting among children due to caregivers withdrawing or refusing consent to treatment. Even though the test and treat mechanism has been progressive, there is a need to monitor and strengthen psycho-social support services. The focus has been on initiating treatment and adherence resulting in limited psycho-social support services. Years into the HIV pandemic, disclosure in discordant couples remains a major challenge which requires intervention, while stigma and discrimination persists as an important barrier.

+ **COP22 Target:** PEPFAR to fully fund upscaling of DSD models including Out of Facility ART-Distribution (OFCAD)- dedicate 50% of the DSD fund to upscale OFCAD to cover the hard to reach areas, least serviced populations (miners, farm workers) and pilot the same to serve KPs in the PEPFAR supported districts; CARGs and FARGs as well as the SAFAIDs Clinic-Community Collaboration (C3) model as well as other effective, community-based models.
+ **COP22 Target:** PEPFAR should expand the roll out of pediatric dolutegravir for all children and newborns in all PEPFAR sites.
+ **COP22 Target:** PEPFAR should expand funding for disclosure support programs for adolescents and children.
+ **COP22 Target:** PEPFAR should support PLHIV designed and led programs for treatment literacy, identification of people who have been lost to follow up and treatment adherence support.
+ **COP22 Target:** PEPFAR should support advocacy efforts to change the age of consent to access SRH services in Zimbabwe, in order to facilitate access to essential health services for young people.
+ **COP22 Target:** PEPFAR should work at the community level with faith organizations and traditional healers to promote evidence regarding HIV treatment, disclosure support at churches and mosques, fighting stigma, and comprehensive knowledge about HIV. These efforts would include health sessions, including during fellowship sessions held by women.
+ **COP22 Target:** In all PEPFAR sites, people living with HIV should have support for using separate OI units where people can start treatment discreetly, without the fear of being seen.
+ **COP22 Target:** PEPFAR should expand the target percentage of clients accessing multi-month dispensing of ART for young people and adults in all its sites

3.2. Persons with Disabilities

In COP20, CSOs requested for a size estimation study of the burden of HIV among persons with disability and this was included in the SDS, however implementation ended up with a sharing of the protocol and ended there. It is prudent that this study be conducted with disability organizations leading this study for sustainability. Lack of available evidence on the level of HIV burden for persons with disabilities has resulted in the constituency not being prioritized during planning, resource allocation, implementation, monitoring, evaluation and learning initiatives in the HIV response. The size estimates will play a critical role in covering the evidence gap. Current precise and reliable statistics on disability in Zimbabwe are not available. However, approximate statistics can be deduced from the WHO and World Bank world report on disability[5] which states that 15% of the world population consists of persons with disabilities.

5. World Health Organisation and World Bank (2011). *World report on disability.* Malta: World Health Organisation. http://www.who.int/disabilities/world_report/2011/accessible_en.pdf,site

It can therefore be estimated that approximately 15% of Zimbabwe's population of about 15 million people comprises persons with disabilities which is estimated to be 2 250 000 people. The causes of disability in Zimbabwe are categorized as follows; congenital (23.2%), illness/disease (47.4%), injury/accident (11.2%) and violence including domestic violence (5.5%). It is imperative to note that one of the leading causes of disability is illness or disease and HIV is one of the ailments of concern. According to a report published by the United Nations in (2017), through increased access to antiretroviral therapy, AIDS-related deaths have declined, leading to an improvement in life expectancy. Living longer with chronic HIV, however, may occur alongside other co-morbidities and the risk of disability increases. In addition, antiretroviral medicine regimens may cause adverse effects, potentially causing long-term damage to bodily functions. Diverse aspects of disability are experienced by a high number of people living with HIV. The United Nations report also alludes that people with disabilities have been excluded and neglected in all of the sectors responding to HIV. While data on HIV prevalence and incidence among people with disabilities is scarce, evidence from sub-Saharan Africa suggests an increased risk of HIV infection of 1.48 times in males with disabilities and 2.21 times in females with disabilities compared with male and females without disabilities.

Persons with disabilities face limited access to comprehensive information on treatment. For example, there are other components of disability that need adaptations to improve access to information on health literacy.[6] There are limited psycho-social support services that are disability responsive and there are limited disability Inclusive and Sensitive Care-strengthen capacity building initiatives and support for providing quality care for persons with disabilities.

+ **COP22 Target:** PEPFAR should involve the Disability sector in the ongoing size estimate study of the burden of HIV among this population in all its districts and co-design a programmatic response to the gaps and barriers to accessing care faced by this population in all PEPFAR sites.
+ **COP22 Target:** Intervention models particularly those targeting Adolescent Girls and Young Women should directly reach persons with disabilities.
+ **COP22 Target:** PEPFAR should ensure that it makes available to the Deaf community, sign language interpretation and braille to the visually impaired on demand in all PEPFAR supported sites.
+ **COP22 Target:** PEPFAR needs to ensure that parents for children and adolescent with disabilities are targeted and included in OVC program and provided with additional support (technical and financial) care-givers.

3.3. Advanced HIV Disease (AHD), TB and TPT

Despite high and better quality ART coverage, life threatening opportunistic infections most notably, tuberculosis and cryptococcal meningitis continue. According to the COP21 SDS, Zimbabwe has an estimated 21,909 preventable AIDS related deaths despite availability of prevention, diagnosis and treatment tools for AHD (See 20 point checklist https://msfaccess.org/20-tool-checklist-diagnosing-treating-and-preventing-aids.)

The inclusion of AHD in the Minimum Program Requirements in the PEPFAR COP Guidance is a step towards the right direction. Prioritizing critical hospitalization and care to PLHIV critically ill with AHD/AIDS is of great importance.

In Zimbabwe, only 382 POC CD4 machines were reportedly available in selected high- volume primary care facilities, which have since become obsolete. Other supply chain challenges include stockouts of CD4 testing reagents and sub-optimal sample transportation system for laboratory samples. Resource challenges include limited availability of medicines (such as Cotrimoxazole and Flucytosine) and an incapacitated HRH to provide quality AHD services. There are also gaps in data points to adequately record and report AHD at all levels of the public health system. Overcoming barriers to testing and adherence through the development of differentiated care models and providing psychosocial support will be key in reaching populations at high risk of presenting with advanced HIV.[7]

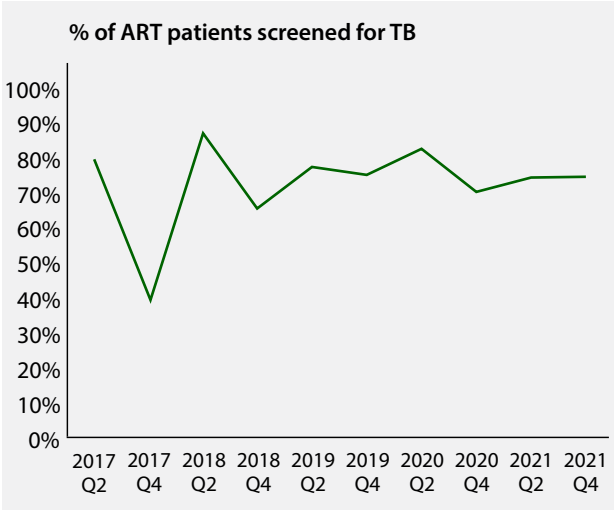
3.3.1 TB screening

While the PEPFAR program increased the number of PLHIV screened for TB and put on treatment, (see figure 4), COVID-19 heavily impacted the TB program and the program faces competing diagnostic capacity with the use of the same diagnostic platform with HIV VL testing as well as COVID-19.

The USAID TB LON (KNTB) grant conducted a Community Rights and Gender Assessment and preliminary results show that stigma and discrimination is still an issue, there still remains underserved population groups such as those living in informal settlements, overcrowded and mining settlements, including cross boarder and public transport, late presentation of males in facilities, among other key factors.

Some clinics are still using the lab-based tests for TB screening and this affects the turnaround times for results and in some cases, specimens get lost. Limited X-ray machines for TB screening, as well as diagnosis for people with Advanced HIV disease in public health centers — in some hospitals either the X-ray malfunctioned years back or requires licensing. The table below shows a decline in ART patients screened for TB.

Figure 4: Proportion of ART Patients Screened for TB



6. Banks LM, Zuurmond M, Ferrand R, Kuper H. Knowledge of HIV-related disabilities and challenges in accessing care: Qualitative research from Zimbabwe. PLoS One. 2017;12(8): e0181144. Published 2017 Aug 9. doi: 10.1371/journal.pone.0181144
7. Stop TB Partnership. Tuberculosis Situation in 2020 Zimbabwe. [Online] 2021. [Cited 2022 Jan 31]. Available from: https://www.stoptb.org/static_pages/ZWE_Dashboard.html

3.3.2 TPT

CSOs applaud PEPFAR for the results for TPT as outlined in the Planning Level Letter in Table 6 page 7 from 214,864 COP20 Target to 275,844 COP21 results. PEPFAR had high TPT completion rates at 92.2% against the National Completion rate of 58.3% giving a national average of 63.3%. The following continue to be a major barrier to access to TPT services; myths and misconception on the adverse events during the IPT era affecting uptake of TPT.

Tuberculosis preventive treatment (TPT)

+ **COP22 Target:** PEPFAR must prioritize increasing TPT literacy and awareness, availability, and uptake. This must include a stronger focus on scaling up among children living with HIV and through the integration of TPT into all service deliver models (i.e. DSD models and AHD packages).
+ **COP22 Target:** PEPFAR must in partnership with the government of Zimbabwe, and Global Fund must agree and develop a plan to procure TPT commodities and close the gap and provide resources to train and capacitate all clinicians in TPT.

Tuberculosis Diagnosis

+ **COP22 Target:** PEPFAR must increase its targets of TB screening in all PLHIV in all PEPFAR sites through the roll-out of non-lab-based screening or diagnosis like TB LAMPEPFAR must ensure that broken X-ray machines in all District Hospitals are repaired in the next 6 months
+ **COP22 Target:** Tuberculosis care must be fully integrated into HIV services. PEPFAR must require all its implementing partners to ensure that a minimum package of TB services, including TB diagnosis and TPT, be available in HIV clinics
+ **COP22 Target:** PEPFAR must roll out digital X-rays with an aim to replace 70% of X-ray machines by the end of COP22. PEPFAR should additionally implement a coupon system by the end of Q2 to provide free X-rays to patients with advanced HIV disease (AHD)
+ **COP22 Target:** In COP22 commit resources for diagnostic such as Visitech for CD4 testing as per commitment in the COP Guidance
+ **COP22 Target:** PEPFAR must ensure that its partners deliver TB-LAM tests to 1) every PLWHA, including children, receiving care in hospitals; 2) all PLWHA, including children, with TB symptoms, or severely ill, or with AHD receiving care in outpatient settings; and, 3) must be available in all inpatient and outpatient facilities.

Tuberculosis Treatment

+ **COP22 Target:** Programs must ensure the full transition from isoniazid-based regimens to rifapentine-based regimens 3HP and 1HP by the end of COP22 (as per WHO guidance).

Advanced HIV Disease

+ **COP22 Target:** To reduce mortality among patients with cryptococcal meningitis, and with the aim of 100% of people with CM, PEPFAR to support procurement, training, and provision of combination infusion and oral therapy (L-AmB with flucytosine and fluconazole) by Q2.
+ **COP22 Target:** Increased support for Visitech platforms and reagents for CD4 for advanced HIV disease, including baseline CD4 testing for people entering or reentering ARV care and for those with virologic failure.
+ **COP22 Target:** PEPFAR must deliver cryptococcal antigen lateral flow assay (CrAg LFA) tests as a screening tool for all PLWHA with CD4 cell count <200 cells/mm3 or WHO HIV stage 3 or 4 in adults and adolescents. Tests should be available and administered at all healthcare system levels, including primary healthcare.
+ **COP22 Target:** At a minimum, PEPFAR should include data on CD4 < 200 identified, CrAg screening done, positive CrAg tests, confirmed CM (this is complex given the challenges with Lumbar punctures); pre-emptive therapy given, and number of CM treated and AIDS related deaths in all PEPFAR sites. PEPFAR must integrate this data in its routine M&E Electronic systems and move from paper-based reporting.
+ **COP22 Target:** PEPFAR must invest resources for civil society and community led treatment literacy for the prevention, diagnosis and treatment of advanced HIV and ensure this is integrated in all other PEPFAR funded community and CSO led treatment literacy programs.

3.4. CATS Community Adolescent Treatment Supporters (CATS)

Adolescents receiving the CATS service had improved linkage to services and retention in care, improved adherence and psychosocial well-being compared to adolescents who did not have access to such services.8However, adolescents living with HIV face challenges with adherence and retention on treatment leading to lower viral suppression rates when they transition out of the CATS program. In COP22 PEPFAR should adopt models that provide clear pathways for empowerment and treatment adherence. Based on Q4 POART the proxy coverage of existing PEPFAR OVC programs in Zimbabwe is 107% for TX_CURR <15 and 61% for TX_CURR <20 in OVC PSNUs. True coverage falls somewhere in between these two estimates since the OVC program enrolls C/ALHIV 17 years of age and younger.

+ **COP22 Target:** PEPFAR expands the eligibility to the CATS program beyond 18 years old for already enrolled adolescent, part of a transition pathway (i.e. life skills training)
+ **COP22 Target:** PEPFAR ensure that all adolescents that are transitioning into adult life have a transition plan that includes cognitive behavioral therapy to avoid a possible gap, as they transition out of CATS.

8. Willis, N., Milanzi, A., Mawodzeke, M. et al. Effectiveness of community adolescent treatment supporters (CATS) interventions in improving linkage and retention in care, adherence to ART and psychosocial well-being: a randomized trial among adolescents living with HIV in rural Zimbabwe. BMC Public Health 19, 117 (2019).

4. Third 95, Viral Load Scale Up & Laboratory Programming

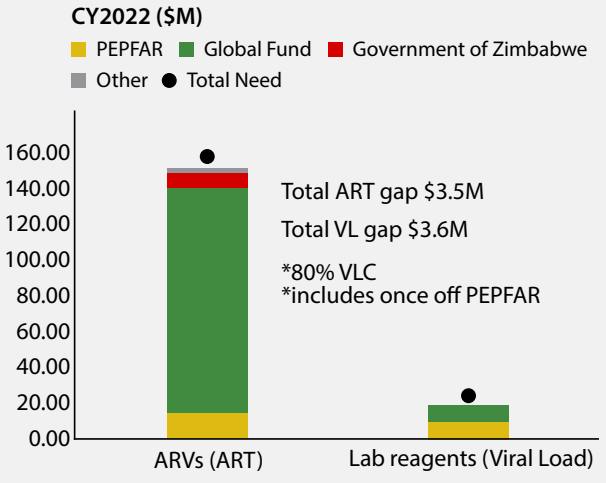
Trends in the third 95 have generally been low, with improvements in COP20 and COP21 through the strengthening of the Integrated Specimen Transportation (IST) and lab support. Low turnaround time remains problematic coupled with client fatigue of numerous blood drawings without results leading to weak adherence and limited appetite to have viral load, worse still results at times come when it is too late. Transport for viral load samples to labs and back to facilities, though improved remains a major issue, coupled with a shortage of HRH for frequent communication with clients for testing and results. Communication and follow up support network, airtime, data for communication remains a major bottleneck along the continuum.

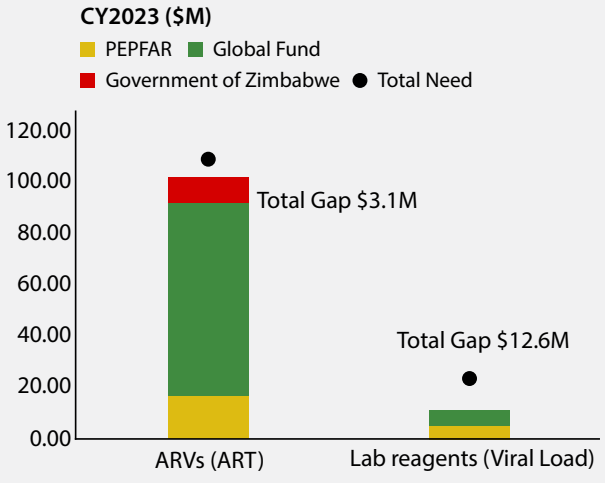
+ **COP22 Target:** PEPFAR must ensure in all sites that viral load collection/testing is decentralized. Health facilities should receive equipment for localized testing and reporting particularly high gap districts (patient testing gaps >10,000) such as Harare, Bulawayo, Seke, Mutoko, Hwange, Goromonzi, Zvishavane and Kwekwe.
+ **COP22 Target:** In COP22, PEPFAR should scale up of community health model; decentralized to provide ART and VL interpretation at community level.
+ **COP22 Target:** PEPFAR should fund an increase in lab staff and DBS EID machines at district level and facility level.
+ **COP22 Target:** PEPFAR should improve efficiency and collection times for sample transport.
+ **COP22 Target:** In COP22, PEPFAR should plan and include resources for a refresher courses for Adherence Counselors.

5. People Centered Supply Chain

Q4 POART indicated the falling of 6MMD as a sign of stock challenges, with close to 86,097 clients not on MMD and 685,153 on 3 to 5 months MMD and only 213,085 on 6 MMD. This signals the need for interrogation of the stock status, right from the quantification, to storage space of clinics as well as the supply chain as a whole. CLM data notes the administration of NVP in some facilities at a time when the country is rolling out pediatric dolutegravir. The funding gap for VL commodities has been noted, not only in the Planning level letter but in the supply chain and has led to fatigue by clients after multiple pricks without results.

Figure 5: Funding Landscape ARVs and VL Commodities





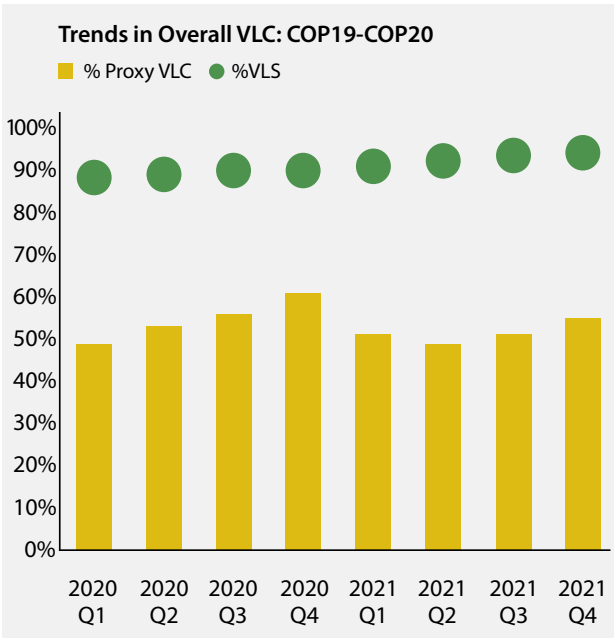
+ **COP22 Target:** PEPFAR should expand its targets for transition to DTG based regimens.
+ **COP22 Target:** PEPFAR should increase budgetary allocation for HIV drugs (both adult and pediatric ARV budgets).
+ **COP22 Target:** Integrate into existing electronic platforms and or dashboards a tracking of platform granular information up to district and facility levels information on meds and drug needs stockouts.
+ **COP22 Target:** In COP22, PEPFAR should invest in training and capacity building of Health Center Committees and CLM focal persons to monitor supply chain and any stock raptures.
+ **COP22 Target:** In COP22, PEPFAR should support Buffer Stocks and adequate storage space at facility level.
+ **COP22 Target:** PEPFAR should support/ fund procurement of OI phones.

6. Human Resources for Health (HRH)

In COP21, civil society asked PEPFAR to conduct the HRH Inventory. This inventory revealed inadequate numbers of health workers, and extremely worrying high attrition rates to migration and other pull factors. The directive from PEPFAR HQ therefore not to expand HRH beyond current levels comes as a blow to Zimbabwe at a time when the country's macroeconomic environment is yet to stabilize. Health workers are facing a number of massive challenges, including:

+ Insufficient tools and equipment to perform their work;
+ Lack of decent working conditions;
+ No feedback on quality of care received by clients;
+ Poaching of staff due to high discrepancies in pay between PEPFAR implementers; particularly brought about by new quasi- "local partners";
+ High staff turnover in particular amongst Nurses;
+ Insufficient numbers of adherence Counselors;
+ Uneven distribution of allowances e.g. COVID-19 allowances;
+ There is no path to real sustainability without an expanded investment in HRH in Zimbabwe, given its severe effects on HIV and TB treatment and prevention scale up.

Figure 6: Trends in Overall VLC: COP19-COP20



+ **COP22 Target:** PEPFAR allocates resources for nurses' accommodation infrastructure at facilities
+ **COP22 Target:** PEPFAR should invest in equipping of Standard of Care requirements at all facilities
+ **COP22 Target:** PEPFAR should as much as possible harmonize and standardize remuneration across all PEPFAR partners to reduce the poaching and competition for the limited health care workers from the public pool but also from one implementing partner to another.
+ **COP22 Target:** In COP22, as PEPFAR thinks of transitioning its health workforce, it should develop a robust HRH transition plan with clear plans and timelines and negotiate with the ministries of health and finance among others the formalization, recognition and absorptions of salaries of these health workers, in particular the community and lay workers to ensure sustainability of program results
+ **COP22 Target:** PEPFAR should remove the policy that prohibits incentives being given to Community Health Workers. They play a critical role in service delivery, and must be given at minimum a stipend that there were getting previously while Government implements the Community Health Strategy. Removing this small stipend is destroying the only stable workforce left.

7. CSO Thoughts on Sustainability

In COP18, PEPFAR set global targets to ensure that by FY20 about 70% of its funding should go to local implementing partners (such as women led organisations, KP led, AGYW led, PLHIV led, CBOs and community led organisations including FBOs in order to sustain epidemic control and program gains.

Civil society organizations note with extreme concern that international NGOs formerly American and other NGOs have now changed names or rebranded and re-registered as local NGOs and organizations in order to continue accessing PEPFAR funds. What is of concern to CSOs is the lack of integrity, transparency and accountability by PEPFAR in allowing organizations that are recently registered and even in less than one year to access funds that were with good intention by OCAG meant for real local indigenous organizations.

These INGOs have taken over space in communities leaving indigenous CSOs without roles within the communities they once served. These new "local organizations" will unfortunately leave the communities they are serving when resources end. Local indigenous organizations will always remain in their communities hence provide sustainability to the programs they run. This new state of affairs has increased competition between CSOs and International NGOs but the question that remains is how did PEPFAR award grants to organizations that are less than 1 year old and haven't even had their first audit, and have no local systems. This manipulation of the COP Guidance has to be addressed by ensuring that these Pseudo local organizations do not qualify for upcoming grants.

International organizations to work with indigenous CBOs for sustainability purposes, it has been noted that those pseudo locals no longer work with local IPs since they are now getting into communities directly and because they pay INGO salaries, they are taking employees from local genuine CSOs.

+ **COP22 Target:** PEPFAR should change the definition of "local organization" to apply only to reflect indigenous organizations that have been founded and bred in Zimbabwe. These must be registered local PVOs with clear MoUs and proof of existence and track record in local authorities spanning 5 years and above.
+ **COP22 Target:** PEPFAR should fund capacity building that will enable local CSOs to receive and manage PEPFAR funds as originally intended
+ **COP22 Target:** PEPFAR to ensure that grants are not awarded to pseudo local organizations and instead that international organizations work with authentic local organizations by providing technical assistance.
+ **COP22 Target:** PEPFAR to share its transitional plan with communities and the expected SOPs (Ring Fence resources across different thematic areas for genuine local organizations).

8. COVID-19

The COVID-19 pandemic has had a devastating impact on HIV and TB PEPFAR funded and Global Fund funded as well as government programs overall. Notable is the lack of access to good information for PLHIV and the further leaving behind in both responses populations such as people living with disabilities, key populations, AGYW exposing them to further risks and harm such as SGBV/IPV and sexual violence, further exacerbating their multiple intersecting vulnerabilities in accessing health services.

+ **COP22 Target:** Increasing number of free COVID-19 testing facilities with a focus of facilitating access for PLHIV and marginalised communities as key populations, AGYW, people living with disabilities.
+ **COP22 Target:** Fund community led education, awareness and literacy campaigns among PLHIV especially targeting populations often left behind such as under 16s, AGYW, people living with disabilities and key populations among others (in braille, local languages and sign language etc.) PEPFAR should in COP22 commit to integrated testing services for TB, HIV and COVID in all its sites.
+ **COP22 Target:** PEPFAR should invest in, complement and or use its position to negotiate and leverage existing and new resources such as of GF C19RM, ACT-A, World Bank, IMF and other funders to address wider health systems and other infrastructural issues that would enhance the delivery of HIV and TB programs.

9. Key Populations

The 2022 Country Planning Letter acknowledges the need to pay closer attention to KP needs and tailor programs accordingly. It notes, "structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and strengthening the KP competency of HIV service providers."

In COP22, PEPFAR should focus on models and approaches to support the sustainability of KP-led CSOs, expanding the menu of options available to strengthen and support the long-term viability and strength of these organizations. While we acknowledge the recent gains, and PEPFAR's increasing commitment toward KP, serious gaps persist.

Low targets set in COP20 and 21 for KP_PREP resulting in overachievement. In COP21, PrEP targets went up 68% among SW, 77% among MSM and 201% among TG, compared to COP20. The 2021 Q4 results for PREP coverage amongst KPs shows an achievement of these targets of 114% for PrEP_NEW and 95% for PrEP_CURR despite COVID 19 related obstacles. Nonetheless, that overachievement depicts a need to adjust targets to ensure all KPs have access to PrEP.

In adapting clinical services to fit KP needs, many KP organizations got converted into clinics, with members of the community suffering loss of gathering spaces. We recognize the need of KP specific DDPs and the importance of community involvement in the HIV response for specifically marginalized populations. But it should not come at the expense of social support spaces. This is particularly relevant in times of COVID where isolation and mental health challenges created a need for greater social networks and psycho social support. PEPFAR acknowledged the importance of KP CBO capacity development in the strategic priorities of COP21. We look forward to a renewed engagement in the light of aforementioned challenges.

KP programming in Zimbabwe was being funded by KPIF and KP pot under PEPFAR. Since KPIF ended there has not been any additional funding to match the gap left by KPIF. The end of the KPIF program in 2020 is still leaving a gap in programming. We acknowledge the investment made in KP programs last year, and the renewed commitment in this year's planning letter, we want to stress areas of concerns related to KP services. The main area of tension is the absence of structures of coordination of KP services. This result is the persistence of solid gaps in multiple areas.

Lack of streamlined and targeted psychosocial support programs for key affected populations. There is a need to strengthen the capacity of service providers including community cadres and peer to peer service providers on mental health. The emergence of COVID-19 has since exacerbated mental health challenges, the nexus between COVID-19 and access to HIV treatment, care and support needs to be explored to inform implementation of mental health services

+ **COP22 Target:** Increase target for KP_PREP increase KP funding and cover programming gaps left by KPIF.
+ **COP22 Target:** PEPFAR should fund and support the setting up of KP clinics with KP led organisations in all PEPFAR sites without changing social spaces.
+ **COP22 Target:** PEPFAR should fund KP CBOS to lead the work around the legal and policy environment, evaluation and review, to address structural barriers that threaten sustaining the gains. PEPFAR should provide KP led CSOs with advocacy grants to carry this important mission.
+ **COP22 Target:** PEPFAR should invest in the training of all PEPFAR funded HCW and social workers on KP issues and health service provision.
+ **COP22 Target:** PEPFAR should strengthen and support YKP, KP PWD in programming at national level by ensuring their direct engagement, representation in decision making around PEPFAR funded KP programs, co-creation and co-implementation with IPs.
+ **COP22 Target:** PEPFAR should strengthen case management of defaulters, by providing a KP friendly welcome back package that includes automatically a supporting peer and access to mental health services.
+ **COP22 Target:** PEPFAR should document, recognize and dissemination of success stories of MSWs by creating a champion program of undetectable MSW.
+ **COP22 Target:** PEPFAR should pilot Gender Affirming Care services in 2 provinces, including Hormonal replacement therapy for transgender people as part of HIV prevention treatment and care and risk reduction
+ **COP22 Target:** PEPFAR should scale up and decentralize ColourZ and other KPs programming within and without PSH to CBOs.

10. Mental Health

New research commissioned by United for Global Mental Health (UGMH) demonstrates that integrating basic mental health and psychosocial services into HIV and TB programmes will not only help millions of vulnerable people with ill mental health, but contribute to ending these pandemics much quicker. The research shows that between now and 2030 this approach would speed up the reduction of HIV infections by 10-17% while decreasing TB infections by 13 - 20%. Almost 1 million people would avoid contracting HIV - the equivalent to the total number of new infections currently predicted for 2026, while as many as 14 million TB infections could be prevented — more than the total number of global TB infections in any given year. Integrating mental health treatment does not need to be expensive and it is certainly cost-effective: evidence shows benefits outweigh the investment required.

A salient issue that has spread across age groups particularly adolescents and young people in Zimbabwe is substance abuse. The COVID-19 induced national lockdown led to an alarming rise in substance abuse among young people in both high- and low-density areas. One of the country's biggest hospitals, Sally Mugabe Hospital, reported that a larger proportion of patients seen at the psychiatric unit are substance users. The hospital attended 150 substance abuse cases in 2019, and numbers spiked to 850 in 2020 and continued to rise in 2021.[9] A high number of cases recorded at the unit are schizophrenia, depression, bipolar disorders due to drug use and abuse and psychiatric complications of HIV infection.

Research has shown that impairment in mental health leads to negative health outcomes at each step in the HIV care continuum, from diagnosis all the way to achieving viral suppression.[10] MOHCC needs to ensure that all ART clients are provided with counseling services before initiation and during therapy. Integration of mental health and HIV services and basic skills-building in provision of MHPSS for all types of healthcare workers including clinicians is recommended as a starting point to ensure early detection and early support before referral to trained personnel. The emergence of COVID-19 has since exacerbated mental health challenges, the nexus between COVID-19 and access to HIV treatment, care and support needs to be explored to inform implementation of mental health services. Early detection and support are crucial as mental health issues may affect health seeking behaviors, adherence, retention in care and other clinical outcomes.[11]

Currently, the functional facilities for mental health are 2 psychiatric hospitals, 2 psychiatric inpatient units, and 7 outpatient mental health facilities in all of Zimbabwe. Mental health services are mainly limited to General and Central hospitals. The health system has a staff complement of an estimated 18 psychiatrists (17 of them in Harare) that is approximately 0.1 per 100,000 population, 917 psychiatric nurses (6.5 per 100,000) and 6 psychologists (0.04 per 100,000)[12]. The health delivery system needs to be equipped with all necessary elements to address mental health issues. Currently nurses do not have the capacity to provide optimized care and service to those in need due to high attrition rates within the Ministry of Health. Staff members are strained and rehabilitation centers at public health facilities are few. Thus, the reduced staffing levels feature a demotivated human resource in need of mental health support thereby resulting in a reduced capacity of the health system. Civil society should continue lobbying the government to reinforce human resources for health.

While political support of the government has been mainly through a 0.42% budget allocation and development of the National Mental Health Policy and Strategic Plan (2019-2023) and Zimbabwe National Drug Masterplan (2020-2025), key components such as the decentralization and primary health care integration of mental health services are yet to be fully achieved. A few primary health care facilities have been implementing the Friendship Bench problem-solving therapy intervention. Not much was included in COP21 on drug use and abuse and there remains a need for enhanced programming on drug abuse management and provision of mental health and psychosocial support services (MHPSS) at all levels of the health system, particularly at the primary health care level which is the first point of call for the community. A youth mobilization model exists that is used by a local civil society organization, ORAP Zenzele, in which dialogues are held with young people from community level through to national level which proved to be a very beneficial community engagement model. This model can be piloted to address drug use among adolescents and young people. OVC Partners also utilize the Cognitive Behavioral Therapy (CBT) model which can be scaled up to other settings.

+ **COP22 Target:** In COP22, immediately placed at the center of PEPFARs through full integration of training of frontline health workers, case managers and peer service providers; decentralized mental health care at all health facilities, supported by adequate funding.
+ **COP22 Target:** PEPFAR should focus protection of the rights of key populations and others who are most vulnerable to mental illness health, as part of fighting inequity, and strengthen capacity of service providers to provide quality mental health care through models from concerned KP groups such as Looking In Looking Out Connect (LILO Connect).
+ **COP22 Target:** PEPFAR should fund prevention programs for drug and substance abuse. (refer to community COP21) while centering harm reduction approaches in programs. Hormonal Therapy for transgender individuals, anonymous self-testing for sex workers, syringe exchange programs for drug user etc.
+ **COP22 Target:** In COP22, PEPFAR should support a pilot of the ORAP Youth Mobilization Model for prevention of drug use.

9. Zimbabwe grapples with substance abuse problems in pandemic - ABC News (go.com)
10. Mental health and HIV/AIDS: the need for an integrated respo... : AIDS (lww.com)
11. ZIMPHIA 2020
12. who-special-initiative-country-report---Zimbabwe---2020_a183c028-2abd-4380-a2ad-f5e923146f9f.pdf

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