

**COMMUNITY
COP20
ZIMBABWE**

COMMUNITY PRIORITIES

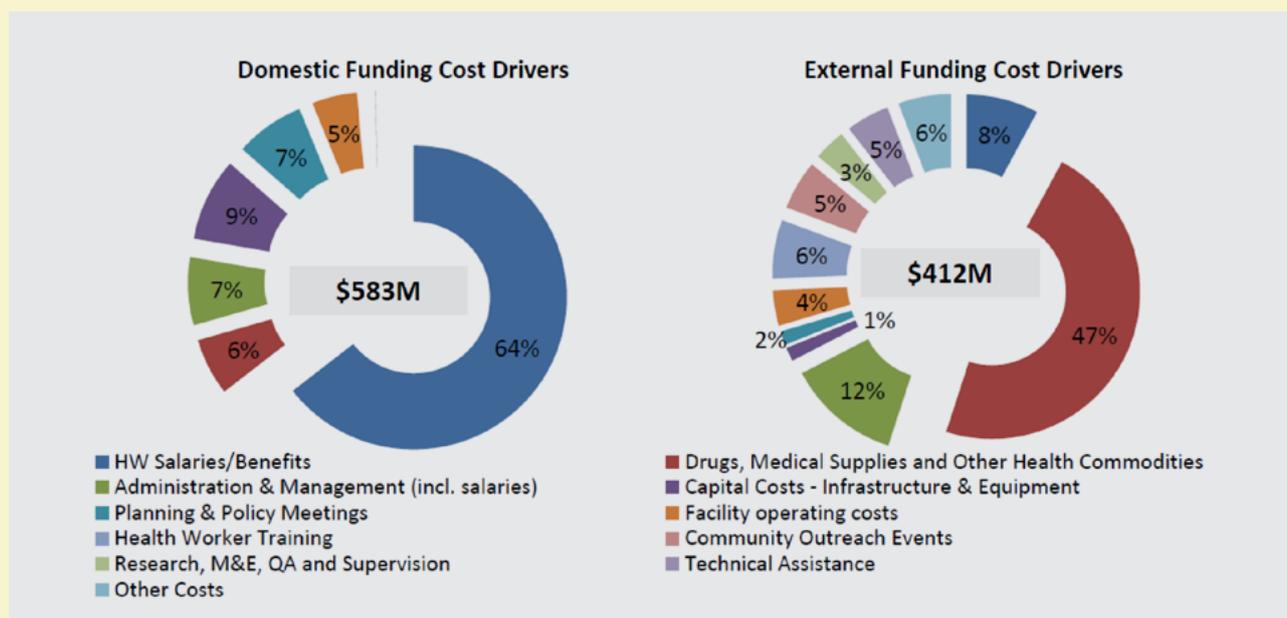
PEPFAR COUNTRY OPERATIONAL PLAN 2020

INTRODUCTION



Civil society and people living with and affected by HIV in Zimbabwe appreciate the increased PEPFAR budget support in COP20 by US\$63m. Zimbabwe remains committed to ending HIV/AIDS by 2030 despite its current social, economic and political challenges. While Zimbabwe is celebrated for achieving more with less, the operating environment has deteriorated significantly over the past 12 months. Power outage, cash and fuel shortages have made project implementation costly and unsustainable. Throughout this period, disbursements to health remained unpredictable and below budget allocation with just over 80% of the budget allocated being disbursed.

In 2018, 64% of the Government of Zimbabwe (GOZ) budget allocation for Ministry of Health and Child Care (MoHCC) was for salaries according to the Resource Mapping Report, 2019¹. This leaves the larger burden of important health system components (e.g. commodity needs and distribution, laboratory sample transportation, and health facility operational costs, etc.) in the hands of external funding from donors.



Domestic and External Funding Cost Drivers: Source Resource Mapping 2019

1. Resource Mapping 2019 Report



Despite support from Zimbabwe's health development partners, the consolidated total funding still falls short of projected requirements necessary to fully implement the national health strategy particularly supporting human resources for health.

As of December 2018, the GOZ's allocation to health was 7.3% of the national budget, well below the Abuja Target of 15%. In June 2019, a new monetary policy that removed the multicurrency system as the means of exchange and introduction of a new local currency (ZWL) led to exchange rate depreciation and reduction of purchasing power. This has worsened the challenges for procurement and importation of health supplies. While there are various explanations and opinions on the economic situation in Zimbabwe, ordinary poor citizens suffer collateral damage as the health delivery system is at its lowest since 1980.

Key challenges highlighted in this community COP with community solutions and suggestions for consideration in PEPFAR Zimbabwe's COP20 include:

- + Rapid scale up of access to routine viral load (VL);
- + Increased investments in Human Resources for Health (HRH) specifically to support retention in care to do community ART refills, contact tracing, scale up routine VL (both lab technicians and data clerks and lay community workers for psychosocial support) among other interventions hindering quality care support;
- + Elimination of user fees in all its forms and adoption of 6 months refill differentiated model of care among other policies;
- + Improve retention among men and children and adopt and scale up of community refill models (Out of Facility Community

Art Refill Distribution -OFCAD) and strategies of care as piloted by BHASO in partnership with MSF and MoHCC in Mwenezi District with excellent retention in care results;

- + Improve levels of stocks of commodities especially VL reagents, adult send line treatment, opportunistic infections drugs and paediatric treatment;
- + Support scale up of community-led treatment literacy;
- + Expansion of TB tools, diagnostics, preventive therapy (TPT), and treatment;
- + Expansion of prevention interventions in particular, PrEP, VMMC and Condom programming. VMMC and condoms remain the most sustainable methods for HIV prevention especially among men and sex workers in Zimbabwe, US\$17m VMMC commitment is greatly appreciated. However due to the ever rising operational costs, an additional US\$3m is recommended as finding men 15 years and older requires a range of strategies;
- + Fund the expansion of existing community-led monitoring models that are a combination of root cause analysis and advocacy follow-up at facility, district, provincial and national levels by investing an additional US\$2 million; and
- + Improve data management .

The decision to temporarily halt index case HIV testing among sex workers and MSM is greatly appreciated. Not setting and assigning targets to country teams has the potential to improve the quality of services. Mental health support is also highly recommended to psychologically prepare communities for new HIV services and policy changes that have been effected in the response, for instance TLD transition and long term adherence, VL Testing and the shift to targeting 15+yrs for VMMC.

PRIORITY INTERVENTIONS FOR COP20

1. Fund the expansion of Viral Load Testing (VLT) from the current 44% to the 74% as per government set targets.

In Q4 of 2019 only 44% of adult PLHIV received a viral load test result, well below the targeted 74%.²

Although the viral load coverage continues to improve from 28% in FY19 Q1 to 44% in FY19 Q4, viral suppression was only 88% putting Zimbabwe at risk of realising the 95.95.95 targets.³ The VL turnaround time (TAT) continues to be high and viral load coverage relatively low. Our community monitoring initiative found that TAT for VL testing using plasma for clients in Mt Hampden, Zvimba District hospital is 3 months, while that for DBS is up to 6 months.

Provincial and district VL testing labs have been affected by acute power cuts, which have worsened the turnaround time and burdened the labs while additionally fueled wastage of VL reagents and samples as these are lost when power cuts happen during processing of samples. Loss of samples at the lab also brings about additional costs for clients as they need to come back to the facility to get blood redrawn.

*"Ah ndoramba ndichidzoka kuzotorwa ropa. Rinopera ka!"
"Ah, cant keep coming back to get my blood drawn. It will run out." ART Client*

During the pre-COP20 community monitoring visit healthcare workers reported rider and fuel shortages which has resulted in facilities collecting viral load samples only once a week (plasma) to coincide with the rider's trip to the facility. Consequently, facilities resort to DBS testing for the rest of the week which has a much longer TAT as very few centralised labs process DBS samples nationally. In COP19, PEPFAR committed to addressing the transportation challenges through supporting an integrated specimen transport, laboratory information management (LIMS), and quality assurance (EQA) activities and this needs to be accelerated and finalised in COP20 if the impact of such investment is to improve VL coverage in the country.

From the health workers perspective, the sample transportation system is fragmented and inadequate to cater for the VL plasma transportation. Clinics at most have an average of 2 visits a week, whereas samples would need daily transportation within 6 hours to the separating/centrifuging laboratory. Opportunistic infection clinics would need to be equipped with centrifuges, fridges, and backup power, which is not the case nor functioning in most facilities visited during the community monitoring. Another alternative is the use of the DBS sample which is stable for 3 weeks, at the moment, only two platforms in Zimbabwe can process this kind of sample (BMX and ABBOTT).

Community driven advocacy, awareness raising and literacy is critical in ensuring demand creation for VL, monitoring for improved coverage and target achievements needed to improve health outcomes for PLHIV and requires adequate funding.

In COP19, PEPFAR committed to expanding its investments in VL

reagents to ensure that the over 1 million people in Zimbabwe on ART have access to viral load monitoring. PEPFAR needs to ensure that VL results for stable clients are timely available at the next refill. However, for pregnant and breastfeeding women, infants, adolescents and those clients suspected of clinical failure, PEPFAR needs to ensure initial results available within 2 weeks of testing, and a second VL is possible within a month.

In COP20, PEPFAR should :

- **Fund adequate resources to adopt and expand the use of Point of Care Viral Load or M-Health facilities such as the GX alert system used for Gene Xpert, for viral load result dissemination from lab to facility.**
- **PEPFAR should adopt and support the Scale up of models such as FTT (Find, Test and Treat 4000) paediatrics, and the PATA C3 (Pediatric AIDS Treatment Africa – Clinic CBO Collaboration) and IMBC (Integrated Mother-Baby Course) models to promote paediatric treatment and adherence.**
- **Support Private Sector Clinics/ Male Health Forums (for example by reaching the men in the workplace through partnerships with the private sector) to promote male demand for and access to health services. In support of the Solar for Health initiative.**
- **Fund the setup of solar power at all provincial Labs and some district facilities with large geographical catchment areas.**
- **Support with resources (medication, personnel, utensils) to treat opportunistic infections for PLHIV with high viral load.**
- **Purchase equipment and consumables based on need in every district. Training on use and utilisation of PEPFAR purchased existing 137 Gene-Xpert POC machines for the TB program approved for VL and early infant diagnosis (EID) as well as purchase of cartridges, and machine maintenance.⁴**
- **Purchase sample containers designed to carry different samples. PEPFAR must fund repair services of pre-existing motorcycles for sample transportation and riders per district and budget monitoring to curtail misuse of funds.**
- **Buy cartridges to allow the labs to use GeneXpert POC machines for VL and EID. Currently each cartridge costs US\$14.50 compared to the US\$17 for conventional testing.**
- **In COP20, PEPFAR will invest in Viral Load Testing and monitoring for 90% of Children, adolescents and young people living with HIV (CAYPLHIV) and their caregivers with high viral load.**

2. Annual PEPFAR Program Results 2019

3. Annual PEPFAR Program Results 2019

4. Children and AIDS. 2019. Integrated Testing for TB and HIV in Zimbabwe. https://www.childrenandaids.org/sites/default/files/2019-09/Integrated%20Testing%20for%20TB%20and%20HIV%20Zimbabwe_Eng_digital.pdf



2. Fund and increase the numbers of human resources for health from 14,133 in COP19 to 20,000 health care workers including lab technicians, CATs, data clerks, community, peer and lay workers, nurses and pharmacists among others in PEPFAR priority districts.

Zimbabwe has an acute shortage of human resources for health (HRH). The Government cites a lack of resources to support the mass recruitment of new health workers. Currently every district has at least 2 doctors, every primary healthcare centre has at least 2 qualified nurses, 59% of administrative wards are serviced by an Environmental Health Technician and 60% of villages have access to a village health worker.⁵ This current predicament makes Zimbabwe fall far short of the World Health Organisation's recommendation of the minimum threshold of 23 doctors, nurses and midwives per 10 000 population.⁶

Enough health workers are trained in Zimbabwe. However, the government alone is not able to absorb them citing the financial pressures and wage bill restrictions by the World Bank. For example, only 27% of nurses trained across the country's nursing schools in Zimbabwe between 2010 and 2019 were recruited by the Ministry of Health & Child Care (MoHCC). Zimbabwe is reported to be in need of approximately 10,000 more nurses yet currently produces over 1,000 nursing graduates every year, most of whom fail to find employment despite the gaps at the facility levels. The Mid Term Review of the National Health Strategy showed that the overall vacancy rate declined from 17% in 2014 to 15% in 2018. As of mid-2019, the MoCC reported the vacancy rate at 10% with 1735 vacant posts unfrozen by Treasury in 2018-2019.⁷

Junior doctors working in Zimbabwe's public hospitals⁸ have protested poor remuneration and unsatisfactory working conditions since March 2019. This has led to the closure of almost all central hospitals, children's units, provincial hospitals and the cessation of emergency life saving procedures throughout the country.⁹

Evidence from community monitoring exercises show a wide discrepancy between the number of staff physically present at facilities versus those in the staff establishment.

The overall vacancy rate masks the inequitable distribution of key professions such as doctors, pharmacists, radiographers and anaesthetists who are largely located at central hospitals and not in the rural areas where they are needed the most. There is also a need for PEPFAR with the government to share a skill mix aggregation plan, i.e. what skill mix and composition at facility level is needed to ensure the best HIV services, the gaps versus what PEPFAR and government is supporting and plans to fill the gaps.

In our community monitoring, clients reported long waiting times at facilities. Health workers on the other hand reported a lack of replacement when some existing staff members at the facility are transferred or retired, subsequently limiting their ability to deliver quality care.

"The same nurse who took our books is the same nurse who calls you to a room for consultation, brings your medication and sometimes we have to wait while she is called to attend to emergency cases at the maternity ward. There is just too much on their shoulders, no time and capacity to explain to people about their medications, results. Sometimes nurses don't know their medicines." ART Client

Often we found the combination of skills mix not enough or complementary, for example, a lack of technicians to

5. Ibid.

6. https://www.who.int/hrh/workforce_mdgs/en/

7. Zimbabwe Mid Term Review of the National Health Strategy

8. There are an estimated 300 junior doctors working in Zimbabwe's public hospitals.

9. Zimbabwe Junior Doctors Association

process VL results timely, few or no data clerks, and lack of adequate pharmacy staff, counsellors and peer workers.

In service training for frontline health workers was often cited as missing or inadequate. In one facility, only 5 had received any sort of training, and cited lack of support, tools and equipment. Some opportunistic infection nurses are not offered or included HIV/TB training and yet this is where the biggest needs are.

The government-funded Village Health Workers (VHWs) are enough but they receive limited support resulting in high turnover, that in turn, impact on the quality of care. While PEPFAR implementing partners have hired various community and lay worker cadres such as Community Referral Facilitators (CRF), Linkage Officers, Lead Father, Male mobilisers, Male Champions, Lead Mothers, there is a lack of harmonisation of these cadres.

According to PEPFARs HRH data¹⁰, it is clear that PEPFAR recognises the important role HRH plays across the treatment cascade and over time has incrementally recruited and supported full-time equivalents (FTEs) over the past three years from 1,516 in 2017 to 14,133 in 2019. While this increase has helped to address HRH shortages, huge gaps still remain.

Mental health is one of the factors contributing to poor retention in care. One notable investment in HRH is the Community Adolescent ART Supporter (CATS) led stigma and discrimination reduction interventions for caregivers, communities, religious and traditional leaders and stakeholders is currently being implemented in some PEPFAR districts.

In COP19, CATS-led mental health screening was scaled up to identify CAYPLHIV at risk of poor mental health. This initiative has been driven by Africaid's program and research data finding 51% of adolescents living with HIV have common mental disorders; only 63% of those are virally suppressed. Poor mental health among adolescents living with HIV (ALHIV) has been found to be closely linked to parental support, stigma and

discrimination. CATS engagement with caregivers has been found to improve parental support, communications and reduced stigma towards their CAYPLHIV. Lack of disclosure was found to be negatively impacting adherence as most children and their guardians do not know what the medication is for.

The ACT Site Level Monitoring project reported that "Transitioning Adolescents" are lost in the continuum of care as they struggle with social and biological changes. Layering of services by various players is essential particularly community-based youth-led organisations that work with youths out of school and teenagers, men's forums etc. Our monitoring also noted high turnover of CATs staff.

In addition to the ongoing government's Health Sector investment case and commitments to increase the numbers of human resources for Health, PEPFAR should in support and in the short term invest in additional lab technicians, pharmacy staff, data clerks at each facility level. Lab sample transporters need to be recruited for a smaller radius of clinics than 1 per district, and PEPFAR needs to invest in the increase of lay workers including a substantial increased investment in CATs as priority to ensure timely delivery and psychosocial support to clients. That entails an increase from the total HRH funded by PEPFAR from 14,133 to 20,000 health workers supported by PEPFAR in COP20.

In COP20, PEPFAR needs to support the increase of CATs to mitigate risk of high turnover but also to sufficiently provide quality services through scale up of information, counselling and support for caregivers of their CAYPLHIV caseloads and mental health screening. PEPFAR in COP20 needs to give civil society evidence of harmonisation and alignment of all its cadres to MoH standards.

3. PEPFAR should disburse funding contingent to the government of Zimbabwe adopting policies that support not inhibit HIV service scale up as per COP20 Guidance on Minimum Requirements.

Regarding policy adoption and implementation, civil society are concerned about the following:

- + There is an absence of a policy framework for expanding antiretroviral therapy services and regimen optimisation. PEPFAR plans to achieve 58% : 42% TLD:TLE ratio by March 2020¹¹, the transition pace is not equal for men as it is for women and there is a need to scale up provision of family planning as well as information and choices for women of reproductive and child bearing age. PEPFAR needs to support the monitoring and tracking of weight gain for people on DTG as well as possible transition back to EFV if necessary.
- + There exists weak links between testing and counselling services and services for EMTCT and antiretroviral therapy. The treatment of children and training guidelines for this need to be developed.
- + The reintroduction of user fees in January 2020 across government facilities has created a barrier to access for people living with HIV, who also have to worry about exorbitant transport costs to facilities leading to default by clients this was strongly revealed in the National Patient Cost survey 2017.
- + Civil society are concerned about the lack of clear strong evidence and commitment towards domestic resource mobilisation for HIV and related services in Zimbabwe.
- + Civil society are concerned about the lack of adoption and implementation of the 6 months multi refill differentiated delivery model.

As per COP Guidance Note regarding the minimum requirements, PEPFAR should reserve some resources contingent to the government showing clear commitments on, a policy framework for expanding ART services and regimen optimisation; expansion of testing and treatment for children; elimination of all forms of user fees; a plan and commitment towards domestic resources mobilisation and the adoption and implementation of 6 months multi refill differentiated service delivery model.

10. Submitted to OGAC over the past few years

11. PEPFAR Q3 Data



4. Expand alternate models of care to increase retention of PLHIV on treatment

The PEPFAR country program ended COP18 with 37,805 fewer patients than the previous year, despite a high level of enrollment.¹² While a proportion of this number is explained by poor data quality, the remainder makes clear a serious problem with retention that must be addressed. PEPFAR's own Q3 Data speaks of 50% of LTFU unreachable¹³ and reveals that MoHCC capacity for retention and loss to follow up tracing is weak at community level. Tools to track and record those disengaged from care are not standardised.¹⁴

The pre-COP community monitoring exercise found that the following issues were among the contributing factors to low retention rates: a lack of proper data collection and capturing tools and sufficient trained lay workers to do this, lack of targeted programming for men, religious beliefs, lack of comprehensive MIS, mobility and migration, inadequate preparedness of people for ARV on the test and treat model, GBV on retention, mental health, denial and a lack of the much needed psychosocial support.

The expansion and rollout of CAGs has not adequately taken off as a village health worker facilitates this at the facility level. This is a hindrance and a burden to clients seeking care as there is a huge burden of costs involved to get to the facilities as well as disclosure challenges. In our community monitoring, clients told us that while some sites are still actively trying to get people into CAGs, costs of transportation to get to the facility, (some clients in rural areas reported as much as US\$5 per one way trip and US\$10 return) as well as user fees at facility not for ARVs but to treat side effects and adverse events of US\$2 meant that each book that even the one client brings has to pay at facility and is individually charged and this is discouraging clients from utilising CAGs and limiting its impact.

Batanai AIDS Service Organisation (BHASO) conducted and documented a gap analysis which established that out of the 32 unserved Outreach Sites, there is imminent need for Out-of-Facility Community ART Distribution (OFCAD) model (which BHASO has piloted aligned to WHO community ART dispensing guidelines) to rollout to 9 most affected sites where clients are walking an average distance of 25km to the nearest Health Facility.¹⁵ Through the OFCAD pilot project, 259 ART clients (66.8% female, median age 44,

45.2% WHO stage 3 or 4 at their initiations) were enrolled in 2 sites in Mwenezi district with 11 OFCADs from September 2018 to September 2019 which was 37.1% of ART clients in the pilot site (cohort of Chovelele and Makugwe).¹⁶

In COP20, PEPFAR should support the expansion of the OFCAD model bringing medicines closer to the community as instead of clients going to the facility, a village health worker instead brings the medicines to the community eliminating transport and user fees costs for the clients.

In COP20, PEPFAR to support:

- *Scale up of the OFCAD model where implementing partners deliver ARVs to the clients.*
- *Review and development of tools so that they also capture social aspects.*
- *Expansion of options for differentiated service delivery (DSD).*
- *Online services to identify where the nearest facilities are to access ART Services (mobile applications).*
- *Increase and capacitation of the number of community cadres in the community (per population, sub population e.g. CATS for young people, people with disabilities).*
- *Support CATS model through motivation for adolescents and transition youths volunteering as CATS /Layering.*
- *Screening for common mental health conditions of 100% of CATS-supported children, adolescents and young people living with HIV.*
- *Scale up mental health interventions to cover 90% of CATS supported CAYPLHIV for improved mental health.*

12. PEPFAR 2019 Country Annual Progress Report

13. PEPFAR Q3 Data.

14. PEPFAR Q3 Data.

15. BHASO Gap Analysis

16. OFCAD project results



5. Invest in strengthening the procurement and supply systems to prevent stockouts

Over the past few years, ART coverage in Zimbabwe has expanded, facilitated by a rapid ART scale-up process involving the decentralisation of ART services, task shifting and involvement of the community in care delivery. However, these gains are under threat due to chronic shortages of generic and antiretroviral drugs, stock-outs, high medication costs, and long distances.

The procurement and supply process is slow owing to lack of accountability mechanisms particularly of people in leadership within Government and parastatals. Additionally supply chain system gaps evidenced by poor forecasting and quantification; budget constraints, delayed procurement and distribution of commodities of key commodities including ART medicines, laboratory consumables, test kits etc. There is also a lack of real time national inventory mechanisms for medicine supplies. Limited availability of equipment and consumables like reagents, GeneXpert machines, portable point of care viral load machines etc.

Our community monitoring found paediatric formulation availability and accessibility gaps at some sites. 2nd line treatment (abacavir/lamivudine) were out of stock completely with clients being told to go and buy from the pharmacies. The cost of one month's supply is about ZW\$1000, which many clients can not afford earning on average about ZW\$500 a month.

- COP20 must ensure PEPFAR procured vehicles provide support in transportation of commodities to improve last mile delivery.
- PEPFAR must provide technical assistance for correct forecasting of quantities of commodities and creation of buffer stocks as well as the mapping allocation of commodities proportional to need.
- PEPFAR must coordinate better with the Global Fund for timely release of approved budget support for ART medicines and other commodities.
- PEPFAR should support the establishment of a network that provides interface between Nat Pharm and other health service providers (public health centers, local authority health facilities and private health facilities including pharmacies).

6. Fund a widespread expansion of treatment literacy and communication to increase linkage, adherence and retention rates

While PEPFAR is committed to funding treatment literacy efforts in COP19, in December 2019 community monitoring showed us that there remains a lack of knowledge regarding HIV treatments among PLHIV and also healthcare providers. PEPFARs Q3 data acknowledges that treatment literacy tools need updating to include aspects of e.g. self-testing, index testing, treat all, adherence, viral load, faith healing, etc.¹⁷

17. PEPFAR Zimbabwe Q3 Data.

Community-led treatment literacy is an effective approach for teaching PLHIV and their communities the science of HIV, TB, STIs and other diseases. Raised consciousness on the importance of adhering to medicines as prescribed, therefore helping PLHIV stay both physically and mentally healthy.¹⁸

In an era of same day initiation, communities need an updated treatment literacy effort that is responsive to realities of people who are healthy and who have never been ill. As we shift to a dolutegravir based regimen, treatment literacy will be critical to ensure people are informed on the benefits and risks associated with TLD, in order for them to make an appropriate ART choice, having regard to the relevant information.

COP20 must financially and otherwise support efforts led by PLHIV to improve treatment literacy levels in the country through funding:

- a. Training of trainers (led by PLHIV and key population groups) to develop a cadre of PLHIV TL trainers to improve treatment literacy levels in the general population & amongst key populations;
- b. Subsequent trainings and health talks run by PLHIV at community and facility level – and outreach to marginalised populations;
- c. The inclusion of treatment literacy topics in the training and scope of work of all government funded healthcare workers;
- d. The development (by PLHIV groups) of accurate, informative, up to date and user friendly treatment literacy materials related to the science of HIV/ TB and related medicines, treatment adherence,

- the importance of early treatment initiation, treatment adherence to achieve an undetectable viral load, and mental health issues etc.; and
- e. The dissemination of these materials to all PEPFAR supported health facilities and through localised social mobilisation campaigns at a community level by PLHIV groups and by CHWs, where possible, in all PEPFAR supported districts.

- *In COP20, PEPFAR should fund an aggressive expansion of community-led treatment literacy across all PEPFAR supported districts run by, and for, communities living with HIV and key populations. This will include both a community lead component including: material development and dissemination to 100% of PEPFAR sites, training of trainers & subsequent trainings, social mobilisation campaigns at community level, as well as a healthcare worker component ensuring that community and facility-based health workers understand HIV and TB fully to offer up to date prevention and treatment literacy information – and offer HIV and TB education in facilities, support groups, and beyond.*
- *PEPFAR must fund at least 10 community lead PLHIV and KP organisations to engage PLHIV including key populations (including MSM, sex workers, transgender people, and people who use drugs) to target those groups more specifically.*
- *Adoption and scale-up of Psychosocial Support models such as PDHP and Family Centred Support.*

7. Scale up access to 3HP for TB preventative therapy (TPT) and urine-LAM as a point of care diagnostic at health facilities.

TB preventive therapy (TPT) is proven to reduce morbidity and mortality among PLHIV, including PLHIV on ART. For this reason, TPT should be considered a routine and integral part of the HIV clinical care package for early and effective TB case finding. In COP19, PEPFAR made commitments to scale up access to optimised TPT for all people living with HIV, specifically the newer 3HP regimen. Reports from community-led monitoring reveal many reports of toxicity amongst PLHIV currently taking Isoniazid Preventive Therapy (IPT). Following the safety data that 3HP is safe for use among PLHIV taking DTG, in COP20 it is critical for PEPFAR Zimbabwe to transition away from the use of IPT and 6H to ensure that all PLHIV are able to access the short-course, rifampentine based 3HP regimen as an alternative.

The community monitoring revealed a lack of available TB screening machines and as well as human resources for health to do contact tracing. Presumptive TB rate (15% of newly enrolling, ART-naive patients & 5% of previously enrolled patients) and there is need for all PLHIV with symptoms referred promptly for diagnosis. Integration of TB/HIV clinical & prevention services remains essential for

effective infection prevention and control activities.¹⁹

The TB LAM test is an affordable, quick and easy to use TB urine test that requires no electricity or reagents and where the results are ready in 25 minutes. Studies show that it allows earlier TB diagnosis in people with advanced HIV, and reduces TB mortality.²⁰ TB LAM testing has been recommended by the WHO for use in people with advanced

18. Perazzo, J., Reyes, D. & Webel, A. A Systematic Review of Health Literacy Interventions for People Living with HIV. *AIDS Behav* 21, 812–821 (2017). <https://doi.org/10.1007/s10461-016-1329-6>

19. World Health Organization, Compendium of WHO guidelines and associated standards: ensuring optimum delivery of the cascade of care for patients with tuberculosis, second edition. Available at:

<https://apps.who.int/iris/bitstream/handle/10665/272644/9789241514101-eng.pdf>

20. "Effect on mortality of point-of-care, urine-based lipoarabinomannan testing to guide tuberculosis treatment initiation in HIV-positive hospital inpatients: a pragmatic, parallel-group, multicountry, open-label, randomised controlled trial." *The Lancet*. Available at: <http://thelancet.com/journals/lancet/article/PIIS0140-6736%2815%2901092-2/fulltext>



HIV since 2015,²¹ and Global Fund and PEPFAR funding should be used for TB LAM procurement and implementation. A separate prospective observational cohort study of both ambulatory and hospitalized HIV-positive adults in Kenya indicated the utility of expanding TB-LAM testing to people with CD4<300/mm³ to increase diagnostic yield.²²

COP20 should ensure that TB LAM test is available for use in both inpatient and outpatient settings. In inpatient, hospital settings, PEPFAR Zimbabwe should use TB LAM as a screening test in all hospitalised patients with HIV. In outpatient, ambulatory settings, PEPFAR Zimbabwe should provide LAM testing to all people presenting to care with clinical signs of illness, or if CD4 testing is available, with CD4<200.

COP20 should procure and distribute LF LAM tests and related commodities (including urine cups) to all health facilities in PEPFAR supported districts together with information on correct use. COP20 should also provide funding for nutritional programmes for PLHIV at risk of TB. COP20 needs to ensure service integration so that those who come for HIV testing are screened for TB. COP20 must commit resources for CSOs to raise awareness about TB prevention in PLHIV and local clinics should be equipped to screen for TB e.g. GeneXpert machines.

8. Fund “Men and Boys Program” and wellness initiatives, rebrand condoms and strategically distribute them and expand PrEP scale up to all priority PEPFAR districts and populations.

While there has been a remarkable decline in HIV incidence, prevention efforts still trail far behind the HIV trajectory. Zimbabwe has made strides in rolling out PrEP. A lot of emphasis is placed on initiation with very little on PrEP continuation. PEPFAR has increased PrEP allocation to US\$3.7m however, there are certain aspects that need to be prioritized for PrEP to effectively contribute towards the reduction of new HIV infections. More efforts need to be made in supporting and tracking the continuation of clients on PrEP. To date the country has rolled out PrEP to about half of the districts — 31 out of 63.

Given that PrEP is a relatively new intervention, (with PrEP delivery starting in 2016), general uptake has been low. People who are likely to benefit from PrEP will ask their peers for confirmation. If the peers are not aware of PrEP, it is unlikely that the person will consider PrEP as an option. PrEP literacy is critical for Zimbabwe if we are to sustain PrEP delivery. Once communities are aware and understand what PrEP is, they will be able to support each other to continue on PrEP. As a country, we are seeing a sharp drop after the first couple of months after PrEP initiation likely attributable to lack of information, lack of support in the community and other myths and misconceptions on PrEP within the communities.

There is a need to invest in understanding more how different populations cycle on and off PrEP through implementation science to demonstrate feasibility. Understanding how people and communities would like to use PrEP will help the country in several ways including, forecasting for PrEP commodities and how to monitor those on PrEP.

PEPFAR must re-brand public sector condoms to create demand for them e.g. flavored condoms and fund the procurement of condom dispensers for strategic distribution of condoms e.g. placing condom

dispensers in places such as toilets, bars, clubs. PEPFAR should consider scaling up PrEP across all populations beyond the current key populations (KPs) and adolescent girls and young women (AGYW). PEPFAR must increase funding towards supporting demand creation of PrEP through mass and social media campaigns, provide funding for strategic rebranding and repackaging of PrEP; increase funding towards awareness through IEC materials; and increase in funding towards capacity building of skills of HCW regarding providing SBC communication. In COP20, resources must be put towards building community support mechanisms. PEPFAR to continue supporting PrEP surveillance to ensure that there is no resistance among the sero-converters. PEPFAR must ensure funding for a “men and boys” programme that will target issues surrounding HIV prevention, treatment and care e.g. within the workplace; fund wellness initiatives at workplaces to enhance behavior change towards an HIV response; ensure inclusion of a one stop shop with SRH services and fund outreach programmes for hard to reach audience e.g. mobile health clinics/centres.

21. World Health Organization, Lateral flow urine lipoarabinomannan assay (LF-LAM) for the diagnosis of active tuberculosis in people living with HIV Policy update (2019). Available at:

<https://www.who.int/tb/publications/2019/LAMPolicyUpdate2019/en/>

22. Huerga H, et al. Incremental Yield of Including Determine-TB LAM Assay in Diagnostic Algorithms for Hospitalized and Ambulatory HIV-Positive Patients in Kenya. PLoSOne. 2017 Jan 26;12(1):e0170976. doi: 10.1371/journal.pone.0170976

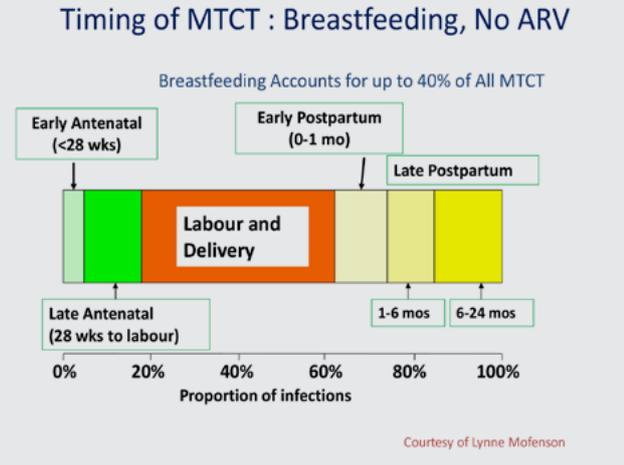


9. Fund optimal paediatric formulations and increase paediatric ART coverage

Despite progress in adult HIV treatment and testing, less children access treatment and worse, suboptimal antiretroviral formulations. Paediatric treatment has been suboptimal with foul tasting, cold chain formulations that are difficult to administer and mediums that are inaccessible for countries with a high burden. While there has been an increased push to get optimal treatment for paediatric cases, PEPFARs own Q3 data shows that paediatric ART coverage increased, yet still very low and below average. In COP19, PEPFAR planned to increase coverage from 44% to 55% as of Q3. In the same quarter, PEPFAR data shows that the highest rates of LTFU among 0-4 and 5-9 year olds (10%).

According to the National Health Strategy 2016 to 2020, Pregnant women in need of PMTCT is 63841, Six weeks MTCT rate is 4.4%, MTCT rate is 7,78% and Children LHIV (0-14 years) is 91164.

adhere to treatment and reduce transmission. POC-EID will go a long way in diagnosing HIV positive babies and DTG access for children will ensure those with a positive diagnosis have access to quality treatment. PEPFAR should also work with healthcare workers at the facility and communities of women living with HIV to increase early visits to the clinic, treatment and retention support for pregnant women living with HIV.



COP20 must ensure rapid transition from nevirapine based regimen to DTG based regimen for all infants and children living with HIV within dosing criteria of >20kgs. LPV/r based regimens must be made available for infants and children <20kgs using available syrup whilst making the pellets available for paediatrics who are struggling with taking the syrup or 4-in-1 ARV (ABC/3TC/LPV/r) fixed dose combination as soon as it is available. Health workers must be trained on the need to support treatment literacy for mothers of children living with HIV to improve case finding, treatment adherence and retention to care. COP20 must further strengthen the early infant diagnosis (EID) programs by funding POC-EID to improve early infant diagnosis across the country and ensure we catch those infants that need treatment.

PEPFAR needs to support mothers across the country to

10. Fund US\$2m to expand the existing community-led monitoring

We applaud the conscious effort that the COP20 Guidance has given for PEPFAR programs to develop, support and fund community-led monitoring of quality and accessibility of treatment services and the patient-provider experience at the facility level in close collaboration with independent civil society organisations and host country governments. We acknowledge the work of PEPFAR Zimbabwe that used COP19 resources to support a Community-led Monitoring pilot project — Community-led Monitoring Evidence-Based Advocacy Implementation approach focusing on increasing access to HIV services for hard to reach communities by interrogating “root causes” for lack of access.

Community-led monitoring has proved to be effective in flagging and revealing issues in a timely manner such as drug stockouts, poor staff establishment, high community cadre turnover among other challenges. Taking lessons from successful and useful community-led monitoring efforts to date, the scope needs to be expanded to cover more sites, specific population groups as well as issues and thematic. The monitoring exercise needs to be linked to a functioning rapid response mechanism that responds to challenges and gaps identified.

There is currently no national committee/ platform to collate, ensure data quality and enforce the four As (Acceptability, Affordability, Availability and Appropriateness) coming from community (Non-facility/Non-medical) entities. Previously the national monitoring platform was funded by the National AIDS Council and led by a national PLHIV monitoring team however was not effective, hence the need to strengthen the model. In the pilot Community based Monitoring the ACT would receive data from the five pilot implementing organisations collate and analyse it using a dashboard in tablet form which data is then used for policy level advocacy and engagement with donors. CSOs will continue to use this monitoring data and evidence to engage not only with

PEPFAR at the national level but use it to hold stakeholders accountable at the facility, district, provincial and national level targeting implementing partners, government and donors.

In COP20, PEPFAR should;

- *Support the scaling up of the Community Evidence-Based Advocacy Implementation approach expanding the community-led monitoring to non-PEPFAR districts as well as deliberately including marginalised groups in the process by investing US\$2m in this intervention;*
- *Support the establishment of a national health centre committee that looks at information coming from the PEPFAR supported community monitoring (made up of CSOs, CBOs, IPs, MoHCC and PEPFAR);*
- *Support the capacitation of Health Centre Committee (HCCs) (led by CSOs) in all the districts to develop a standard tool in consultation with all the players involved in community monitoring;*
- *Ensure SOPs are shared amongst the players involved in community monitoring;*
- *Build community capacity on data collection, packaging and analysis, data quality and effective use of tools.*

11. Invest in improving the data management platform and systems for accurate, reliable and timely data

Data quality ensures that strategic and programmatic decisions are relevant and informed. However, civil society organisations note that there has been a lack of supporting infrastructure of the various data management platforms, compromising the data capturing, analysis and hence utilisation. Real time data has been problematic because of power cuts at facilities, thereby compromising the ability to monitor client-centered data within and across facilities to enhance clinical care (e.g. retention, viral load suppression) that affect the clinical cascade.

In COP19, PEPFAR committed to ongoing above-site investments for expanding the Electronic Health Record (EHR) that is integrated into DHIS2, for care, surveillance, monitoring and evaluation, and there is a need to accelerate and finalise this process as it has a big impact on the quality of programmatic data and hence service delivery. There is still a heavy reliance on paper based systems that in turn require the time and attention of frontline health workers, who are already overstretched. There are limited facilities that are currently using the EPMS and with data personnel capable of capturing data into the EPMS system. There are no unique identifiers to address client duplication and a lot of clients are captured as lost to follow up as a result.

There is a need to improve the data linkage between facilities and community structures (community cadres, IPs) as referrals and other out of facility services are not fully captured at facility level, particularly in the absence of a paper referral slips. The data systems (EPMS, DHIS) are not fully utilised at local level (facility and district) to enhance clinical care.

In COP20, PEPFAR should accelerate the setting up and the roll out of an integrated database system, training of personnel on data capturing on EPMS, staff retention and motivation for EPMS focal persons, and invest in strengthening the surveillance system including the purchase of gadgets to sync to the national surveillance database. PEPFAR must upscale Unique identifier systems that do not infringe on the rights of the client. PEPFAR must capacitate community, workplace and facility based health care workers to collect, consolidate, interpret, analyse, document and utilise data. In addition, PEPFAR must conduct a Surveillance system audit to identify gaps/challenges hindering smooth reporting and accurate data; and integrate client satisfaction to enhance clinical care and retention, scale up the electronic health record (eHR) and recruit at least one data entry clerk for each facility within the PEPFAR districts.

SPECIFIC LANGUAGE REQUESTED IN COP20

PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS	COP20 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
	<p>1. Fund the expansion of Viral Load Testing (VLT) from the current 44% to the 74% as per government set targets.</p>	<p>In COP20, PEPFAR will :</p> <p>Fund adequate resources to adopt and expand the use of Point of Care Viral Load or M-Health facilities such as the GX alert system used for Gene Xpert, for viral load result dissemination from lab to facility.</p> <p>PEPFAR will adopt and support the Scale up of models such as FTT (Find, Test and Treat 4000) pediatrics, and the PATA C3 (Pediatric AIDS Treatment Africa – Clinic CBO Collaboration) and IMBC (Integrated Mother-Baby Course) models to promote pediatric treatment and adherence.</p> <p>PEPFAR will support Private Sector Clinics/ Male Health Forums (for example by reaching the men in the workplace through partnerships with the private sector) to promote male demand for and access to health services. In support of the Solar for Health initiative.</p> <p>PEPFAR will fund the setup of solar power at all provincial Labs and some district facilities with large geographical catchment areas.</p> <p>PEPFAR will support with resources (medication, personnel, utensils) to treat opportunistic infections for PLHIV with high viral load.</p> <p>PEPFAR will purchase equipment and consumables based on need in every district. Training on use and utilization of PEPFAR purchased existing 137 GeneXpert POC machines for the TB program approved for VL and early inf ant diagnosis (EID) as well as purchase of cartridges, and machine maintenance.²³</p> <p>PEPFAR will purchase sample containers designed to carry different samples. PEPFAR must fund repair services of preexisting motorcycles for sample transportation and riders per district and budget monitoring to curtail misuse of funds.</p> <p>PEPFAR will buy cartridges to allow the labs to use GeneXpert POC machines for VL and EID. Currently each cartridge costs 14.50 USD compared to the 17USD for conventional testing.</p> <p>In COP20, PEPFAR will invest in Viral Load Testing and monitoring for 90% of CAYPLHIV and their caregivers with high viral load.</p>	<p>Target: expansion of Viral Load Testing (VLT) from the current 44% to the 74% as per government set targets.</p>

23. Children and AIDS. 2019. Integrated Testing for TB and HIV in Zimbabwe. https://www.childrenandaids.org/sites/default/files/2019-09/Integrated%20Testing%20for%20TB%20and%20HIV%20Zimbabwe_Eng_digital.pdf

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP20 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
	<p>2. Fund and increase the numbers of human resources for health from 14,133 in COP19 to 20,000 health care workers including lab technicians, CATs, data clerks, community, peer and lay workers, nurses and pharmacists among others in PEPFAR priority districts.</p> <p>Major challenges to achieving high ART coverage and epidemic control continue to exist. These include insufficient funding for ARVs and lab commodities, human resource shortages, continued economic instability, weakening infrastructure, a deteriorating health system, and heavy reliance on donor funding. As an example of donor funding reliance, the Global Fund and PEPFAR currently finance the purchase of test kits, condoms, a majority of laboratory services, a majority of human resources at both central and site levels, and a significant portion of the efforts to strengthen the supply chain and logistics system.pg 18</p> <p>Key Population HTS programming in hot spots will also be supported in low ART gap districts, whilst HRH investments will be redeployed to activities that support adherence, retention and VL monitoringIn high gap districts. HRH will continue to be deployed to high volume facilities,, while in medium gap districts HRH will be redeployed to index testing modalities..pg 27.</p> <p>The plan will involve the selection of high gap districts, establishment of a USG task team, inter-agency This, together with the introduction of direct service delivery (DSD) HRH in facilities, has seen the linkage rate (proportion of PLHIV testing positive initiated on ART) increase from an average of 80% in COP 2016 to 85% at the end of COP 2017 and to 94% in Q1 of COP 2018 pg 30</p> <p>adaptation of an existing VL process monitoring tool and recruitment of highly skilled and well positioned human resource cadres (HRH) at national and district levels by PEPFAR partners. The HRH infusion will be strategically instituted to cover key gaps and areas of underperformance identified with the CLI cascade. SDS Pg 41.</p>	<p>In addition to the ongoing government's Health Sector investment case and commitments to increase the numbers of human resources for Health, PEPFAR should in support and in the short term invest in additional lab technicians, pharmacy staff, data clerks at each facility level. Lab sample transporters need to be recruited for a smaller radius of clinics than 1 per district, and PEPFAR needs to invest in the increase of lay workers including a substantial increased investment in CATs as priority to ensure timely delivery and psychosocial support to clients. That entails an increase from the total HRH funded by PEPFAR from 14,133 to 20,000 health workers supported by PEPFAR in COP 20.</p> <p>In COP 20, PEPFAR needs to support the increase of CATs to mitigate risk of high turnover but also to sufficiently provide quality services through scale up of information, counselling and support for caregivers of their CAYPLHIV caseloads and mental health screening.</p> <p>PEPFAR in COP20 needs to give civil society evidence of harmonisation and alignment of all its cadres to MoH standards.</p>	<p>Target: increased HRH from 14,133 in COP19 to 20,000 health care workers including lab technicians, CATs, data clerks, community, peer and lay workers, nurses and pharmacists among others.</p>
<p>3. PEPFAR should disburse funding contingent to the government of Zimbabwe adopting policies that support not inhibit HIV service scale up as per COP20 Guidance on Minimum Requirements.</p> <p>In COP19, PEPFAR will support the roll out of messages (drawing on Every Hour Matters) for timely reporting of sexual 3,477 62,296 80,220 66,144 145,334 COP 18 Age Distribution <1 1-9 10-14 15-17 18+ 3,477 63,196 120,072 67,679 103,147 COP 19 Age Distribution <1 1-9 10-14 15-17 18+ 58 P a g e violence and provide technical assistance in Child Safeguarding policy development to FBO umbrella bodies. (SDS, Page 57-8)</p> <p>PEPFAR will support the national VMMC SID, provincial, district and site level baseline assessments for sustainable VMMC service provision in FY 19 to ensure successful implementation of the strategy. This process involves site readiness assessments for provision of sustainable services, (considering the different strategic pillars) and the iterative development of district level work plans to ensure that the contextualized interventions at each district are implemented with fidelity (SDS, 69)</p>	<p>As per COP Guidance Note regarding the minimum requirements, PEPFAR will hold and reserve some resources contingent to the government showing clear commitments on, a policy framework for expanding ART services and regimen optimisation; expansion of testing and treatment for children; elimination of all forms of user fees; a plan and commitment towards domestic resources mobilisation and the adoption and implementation of 6 months multi refill differentiated service delivery model.</p>	<p>Target: PEPFAR disburses funding only on contingent to the government of Zimbabwe adopting policies that support not inhibit HIV service scale up as per COP20 Guidance on Minimum Requirements.</p>	

	COP20 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	5. Invest in strengthening the procurement and supply systems to prevent stockouts		
		<p>In COP20 will ensure PEPFAR procured vehicles provide support in transportation of commodities to improve last mile delivery. PEPFAR will provide technical assistance for correct forecasting of quantities of commodities and creation of buffer stocks as well as the mapping allocation of commodities proportional to need.</p> <p>PEPFAR will continue to coordinate better with the Global Fund for timely release of approved budget support for ART medicines and other commodities.</p> <p>PEPFAR will support the establishment of a network that provides interface between Nat Pharm and other health service providers (public health centers, local authority health facilities and private health facilities including pharmacies).</p>	<p>Target: resources for vehicle for commodities transportation to facilities, Funded TA capacity to support with forecasting and a clear plan shared by PEPFAR on who is buying what commodities agreed on by GF and government and an online tool connecting Natpharm to provincial, district and facility level on supply availability and needs.</p>
PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	6. Fund a widespread expansion of treatment literacy and communication to increase linkage, adherence and retention rates		
	<p>"In COP 19, PEPFAR will further scale up activities to improve treatment literacy among PLHIV to ensure that appropriate messages are delivered in appropriate ways to the various population subgroups. These messages will include the rationale for the Treat All approach, the benefits of testing and initiating ART prior to onset of symptoms, the superior efficacy and adverse event profile of dolutegravir (DTG)-based regimens, the importance of having all sexual partners on treatment or PrEP, the need for viral load monitoring and the meaning of viral load results, U=U (Undetectable = Untransmittable)." p38</p> <p>"Feedback from MoHCC, stakeholders, CSOs, and patients has impressed upon the PEPFAR team that treatment literacy tools need updating to include aspects of self-testing, index testing, treat 92 P a g e all, adherence, viral load, faith healing, and other important elements. In COP 19, PEPFAR clinical partners will partner with CSOs to implement community-level treatment literacy to improve uptake of VL, TLD, and TPT. Moreover, investments in FBOs will prioritize communication to improve adherence and retention and reduce stigmatization and IPV at the community-level." p91</p>	<p>COP20 will fund an aggressive expansion of treatment literacy across all PEPFAR supported districts run by, and for, communities living with HIV and key populations. This will include both a community lead component including: material development and dissemination to 100% of PEPFAR sites, training of trainers & subsequent trainings, social mobilisation campaigns at community level, as well as a healthcare worker component ensuring that community and facility-based health workers understand HIV and TB fully to offer up to date prevention and treatment literacy information – and offer HIV and TB education in facilities, adherence clubs and beyond. PEPFAR will fund at least 10 community lead PLHIV and KP organisations to engage PLHIV including key populations (including MSM, sex workers, transgender people, and people who use drugs) to target those groups more specifically.</p>	<p>Target: People friendly treatment literacy materials, developed with PLHIV and KPs, are available and HIV lead community based organisations deliver treatment literacy services through support groups and localised social mobilisation campaigns.</p>

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP20 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
	<p>7. Scale up access to 3HP for TB preventative therapy (TPT) and urine-LAM as a point of care diagnostic at health facilities.</p> <p>“The objective of the TPT program in Zimbabwe is to achieve full coverage among eligible PLHIV by the end of COP 20. During COP 19, the TPT target will be 458,389. In COP 19, the PEPFAR program will support the procurement and distribution of TPT medicines. PEPFAR support will complement the already existing Global Fund support which was the major contributor in COP18. A roll out to the new shorter TPT regimens, specifically 3HP (three months of rifapentine and isoniazid) will be supported through procurement and distribution. The rollout of 3HP is expected to address some of the mistrust that healthcare workers had about 6H (six months of daily isoniazid) causing hepatotoxicity. 3HP will also address patients’ high pill burden concern and improve adherence, as a once weekly regimen taken only for 3 months.” p46</p> <p>“- PLHIV on DTG based ART regimens: 6H plus Vit. B6 (FDC - INH/CTX/Vit. B6)</p> <p>- PLHIV on EFV based ART regimens: 3HP</p> <p>- HIV negative children and adolescents <15years TB contacts 3HR”.</p> <p>No mention of TB LAM in COP19 SDS.</p>	<p>TPT for PLHIV: PEPFAR Zimbabwe will support the scaleup of TB preventative therapy (TPT), ensuring that all PLHIV newly enrolled into care who screen negative for active TB disease initiate and complete a course of TPT. All PLHIV in PEPFAR Zimbabwe programs newly diagnosed with active TB disease receive contact investigations of their families and close contacts, with contacts offered TPT. PEPFAR Zimbabwe will transition away from the use of isoniazid preventive therapy (IPT) to ensure that all PLHIV are able to access the short-course, rifapentine based 3HP regimen as an alternative to IPT.</p> <p>TPT for children: PEPFAR Zimbabwe will support contact investigations for all PLHIV diagnosed with active TB disease. Children of PLHIV with TB identified by contact investigations will be offered TPT with the regimen determined by HIV status. HIV-negative children will be offered the 3HR regimen, which is available as a child-friendly FDC. Children with HIV will be offered 3HR (if on EFV-based ART) or 6H (if on nevirapine, lopinavir-ritonavir, or dolutegravir-based ART). 6H is also available in a child-friendly dispersible tablet. (3HR = three months of daily isoniazid + rifampicin; 6H = six months of isoniazid preventive therapy). PEPFAR Zimbabwe will ensure that TPT is a routine and integral part of the HIV clinical care package.</p> <p>PEPFAR Zimbabwe will make LAM testing available in all settings where PLHIV present for care, including both inpatient and outpatient settings. In inpatient, hospital settings, PEPFAR Zimbabwe will use TB LAM as a screening test in all hospitalized patients with HIV. In outpatient, ambulatory settings, PEPFAR Zimbabwe will provide LAM testing to all people presenting to care with clinical signs of apparent serious illness, or, if CD4 testing is available, with CD4<200. PEPFAR Zimbabwe will support training in the use of TB LAM and ensure the procurement of required commodities (TB LAM Ag urine assays, urine cups, pipettes, pipette tips, timers) within laboratory costs. PEPFAR Zimbabwe will also support sensitization of health care workers on the utility of TB LAM and its place in the TB diagnostic algorithm. Task sharing should be considered as the test is easy enough to be conducted by nurses. PEPFAR SA will preferentially support the use of more sensitive TB urine LAM tests, if they become available and are recommended by WHO within COP20.</p>	<p>Expand provision of TB preventative therapy (TPT), specifically 3HP, to all PLHIV newly enrolled into care, and expand provision of TPT to eligible household contacts of PLHIV with active TB, including young children and HIV-negative adults.</p> <p>Target: LAM testing provided to 100% of PLHIV who are hospitalized. LAM testing provided to all PLHIV presenting to care in outpatient settings with signs of advanced illness or with CD4<200 [i.e. XX% of TX_NEW target].</p>

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP20 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
	8. Fund “Men and Boys Program” and wellness initiatives, rebrand condoms and strategically distribute them and expand PrEP scale up to all priority PEPFAR districts and populations.	<p>In COP 19 PEPFAR will expand PrEP for priority populations, increasing the overall PREP_NEW target to 8,239 (78% of the national target and a 64% increase from COP 18). PEPFAR will continue to expand coverage among KP and AGYW and support service delivery for SDCs, pregnant and breastfeeding women in eight focus districts. (pg 50 SDS19)</p> <p>The COP 19 target for TX_NEW assumes identification of 75% of HIV positive MSM (within the 50% reached by the program), 95% linkage, all ART initiation at PEPFAR supported sites, and transition of 20% of the current TX_CURR cohort to KP friendly public sector sites in COP 19. The COP 19 PrEP target was set using the PrEP Implementer’s Toolkit which takes into account national and program data on population estimates, risk, acceptance and continuation on PrEP, as well as scale up patterns, cost and capacity.</p> <p>In COP 19 PEPFAR will engage stakeholders to use available information to estimate the size of the transgender (TG) population, at which time program targets and tailored interventions will be developed. In COP 19 PEPFAR will continue to pursue a saturation approach to reach, test, treat and retain key populations in the five largest urban cities of Harare, Bulawayo, Gweru, Mutare and Masvingo, focusing on the four key strategies (pg 63 SDS19)</p> <p>PEPFAR will continue to roll out differentiated models of care for key populations. Having different approaches is fundamental because meeting key populations where they are and with whom they trust is a cornerstone to engaging and keeping them in care. The types of services, frequency and location will also vary between FSW, MSM and LGBTI groups. (PG64 SDS19)</p> <p>COP 19 PEPFAR will continue to work closely with the Global Fund to leverage investments for key populations and ensure activities are complementary and not duplicative.</p>	<p>In COP20, PEPFAR will re-brand public sector condoms to create demand for them e.g. flavored condoms and fund the procurement of condom dispensers for strategic distribution of condoms e.g placing condom dispensers in places such as toilets, bars, clubs.</p> <p>In COP20, PEPFAR will scale up PrEP across all populations beyond the current key populations (KPs) and adolescent girls and young women (AGYW). PEPFAR will increase funding towards supporting demand creation of PrEP through mass and social media campaigns, provide funding for strategic rebranding and repackaging of PrEP; increase funding towards awareness through IEC materials; and increase in funding towards capacity building of skills of HCW regarding providing SBC communication.</p> <p>In COP20, PEPFAR will put resources towards building community support mechanisms. PEPFAR to continue supporting PrEP surveillance to ensure that there is no resistance among the sero-converters.</p> <p>Regarding VMMC, PEPFAR in COP20 will ensure funding for a “ Men and boys” programme that will target issues surrounding HIV prevention, treatment and care e.g within the workplace; fund wellness initiatives at workplaces to enhance behavior change towards an HIV response; ensure inclusion of a one stop shop with SRH services and fund outreach programmes for hard to reach audience e.g. mobile health clinics/ centres.</p>
9. Fund optimal paediatric formulations to increase paediatric ART coverage	<p>PEPFAR will support EID POC commodities for mPIMA devices procured under the UNITAID pilot in Zimbabwe. Through the POCs, EID TAT including result transmission to caregiver was within 7 days in 92% of the cases and this facilitated the early initiation of life-saving ART in HIV Exposed Infants (HEI) found to be HIV positive. (PG29 SDS)</p> <p>The PEPFAR program will support the procurement EID POC commodities, significantly reducing results turnaround time and enabling immediate linkage to treatment. In areas without POC EID testing, positive results will be treated with urgency and the patients will be followed up and initiated on ART as soon as possible. (PG36 SDS)</p>	<p>COP20 will ensure rapid transition from nevirapine based regimen to DTG based regimen for all infants and children living with HIV within dosing criteria of >20kgs. LPV/r based regimens must be made available for infants and children <20kgs using available syrup whilst making the pellets available for paediatrics who are struggling with taking the syrup or 4-in-1 ARV (ABC/3TC/LPV/r) fixed dose combination as soon as it is available. Health workers must be trained on the need to support treatment literacy for mothers of children living with HIV to improve case finding, treatment adherence and retention to care. COP20 will strengthen the early infant diagnosis (EID) programs by funding POC-EID to improve early infant diagnosis across the country and ensure we catch those infants that need treatment.</p>	<p>Target: All children >20kg will get dolutegravir 50mg; all children >10kg can swallow whole tablets will get lopinavir/ritonavir 100/25mg tablets; all children <20kh will get lopinavir/ritonavir granules / tablets/ syrup.</p> <p>Target: 70% of EID testing platforms situated at the point of care.</p>

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP20 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
	<p>10. Fund US\$2m to expand the existing community-led monitoring</p> <p>No language in SDS19</p>	<p>In COP20, PEPFAR will support the scaling up of the Community Evidence-Based Advocacy Implementation approach expanding the community-led monitoring to non-PEPFAR districts as well as deliberately including marginalized groups in the process by investing US\$2m in this intervention.</p> <p>In addition, PEPFAR will support the establishment of a national health centre committee that looks at information coming from the PEPFAR supported community monitoring (made up of CSOs, CBOs, IPs, MoHCC and PEPFAR)</p> <p>PEPFAR will support the capacitation of Health Centre Committee (HCCs) (led by CSOs) in all the districts to develop a standard tool in consultation with all the players involved in community monitoring; ensure SOPs are shared amongst the players involved in community monitoring; and lastly build community capacity on data collection, packaging and analysis, data quality and effective use of tools.</p>	<p>Target: US\$2m to expand the existing Community led monitoring</p>
<p>11. Invest in improving the data management platform aand systems for accurate, reliable and timely data</p>	<p>In COP20, PEPFAR will accelerate the setting up and the roll out of an integrated database system, training of personnel on data capturing on EPMS, staff retention and motivation for EPMS focal persons, and invest in strengthening the surveillance system including the purchase of gadgets to sync to the national surveillance database. PEPFAR will upscale unique identifier systems that do not infringe on the rights of the client. PEPFAR must capacitate community, workplace and facility based health care workers to collect, consolidate ,interpret, analyze, document and utilize data. In addition, PEPFAR must conduct a Surveillance system audit to identify gaps/challenges hindering smooth reporting and accurate data; and integrate client satisfaction to enhance clinical care and retention, scale up the electronic health record (eHR) and recruit at least one data entry clerk for each facility within the PEPFAR districts.</p>	<p>Target: one data entry clerk for each PEPFAR facility, an integrated database system, upscaled unique identifier system, and trained staff to use data effectively</p>	

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