HEALTH GAP
GLOBAL ACCESS PROJECT

Impact of Activism at 2016 Johannesburg PEPFAR COP Reviews

Preliminary Before & After Look at Malawi, Zambia and Uganda COPs[1]

MALAWI

Priority concern	COP review outcome
Move Money from TA to Increased investment in Clinical HRH: PEPFAR Malawi has received a significant increase in funding in recent year—but the bulk of funding has gone to indirect programs. CSOs asked in 2015 and again in the lead up to COP16,	For the first time COP16 will support direct salaries for both ART providers and pharmacy techs in 3 urban districts that account for 33% of the total HIV population. In addition, the COP will provide infrastructure in the form of "clinic in a box."
Community linkage: Linkage to care rates and retention in care (and viral suppression) rates are significantly low—which limits the epidemiologic impact of testing and treatment efforts. There is a small, but very underfunded, network of over 2,000 support groups.	PEPFAR agreed that every facility supported in "scale up" districts will receive at least one (often more) additional paid community health worker charged with helping facilitate linkage between clinics and PLHIV support groups/CBOs in each district with the goal of directly increasing testing, linkage, and viral suppression (retention). This will also prepare the groundwork for potentially support to community ART groups if Ministry approves the proposal to implement these groups at scale (per CSO request).
Testing: There is clear evidence that a high portion of people living with HIV who are *engaged* in the health system know their status in the highest burden districts. CSOs have asked for an increased focus of testing on community-based outreach and targeted key populations testing instead of just supporting facility-based testing—and fund increased HRH to accomplish this in the community.	PEPFAR has agreed to review its testing strategy and increase from 700 health diagnostic assistants currently being supported (a demand from CS last year) to an increased number based on need to be determined in the coming weeks.
Differentiated care: One critical need is to both a) decongest high volume clinics and b) reduce the burden on PLHIV in accessing treatment in order to improve retention. PEPFAR support has so far focused on clinical mentoring as the solution. CSOs instead asked for support directly to the HRH	Per above community health workers will be established. In addition, Ministry agreed to support "fast track refills" so stable patients do not need to see a clinician 2 out of 4 annual visits. To implement this, PEPFAR agreed to

[1] To be updated after publication of COPs

needed to implement differentiated care models both in the clinical and the community.	evaluate the need for both space and pharmacy techs to enable fast-track delivery to occur.
Direct vs. TA Delivery: PEPFAR has been counting nearly all people in all their scale up districts as "directly supported" even when PEPFAR is paying for neither the drugs nor the human resources. This matters because it means PEPFAR is setting targets for what it wants to achieve but is not accountable for investing in the game-changing interventions actually responsible for achieving those targets. In addition, it means the Ministry of Health cannot plan for exactly what PEPFAR interventions will occur in different parts of the country and identify their impact.	PEPFAR agreed to a comprehensive review of what counts as "DSD" given the changes above and to make it clear where its targets involve provision of commodities and HR vs where their investment is largely in technical assistance.

ZAMBIA

Priority concern	COP review outcome
Over-Focus & Targets for Treatment & VMMC: The PEPFAR team in recent years has focused on a sub-set of regions of the country—yet many of those districts will reach 80% coverage of all PLHIV on treatment by 2016. CSOs raised concern that the team was leaving out many of the districts that are most off track and most in need of support, noting only 61% of PLHIV are in PEPFAR covered districts and many high burden high prevalence districts with low coverage are left out—meaning reaching saturation will not have the epidemiologic impact hoped for. Overall this meant that the proposal by PEPFAR before the review was to scale up by 0 people next year, and the "net new" on treatment was dropping by nearly 30,000 fewer people than last year. CSOs asked for expansion in particular in districts including: Luanshya in Copper Belt, Mansa, Mwense, and Kasama in the North and Rufunsa in Lusaka province all have 12-14% prevalence. Masaiti, Mpongwe, Lufwanyama all have over 10%. Monze and Choma all have lower prevalence but high burden of PLHIV.	The final COP expanded significantly—adding 23 additional districts and increasing the "net new" on treatment 114%. VMMC targets in these new districts also expanded the total by 35%.

UGANDA

Priority concern	COP review outcome
Treatment targets: Despite including an aim of reaching the 90-90-90 targets before 2020, the 2016 Uganda COP contained less ambitious 'net new' treatment targets than the 2015 COP (cut by approximately 20,000 people). This was due to 2015 COP scale up targets already being reached in 11 out of 26 'Scale Up' Districts—those Districts were only assigned flat treatment targets.	After describing the problem in Uganda's Civil Society Recommendations letter to PEPFAR, civil society lobbied successfully for substantially expanded national "net new" (TX_NEW – 11% LTFU) FY2017 targets. Instead of a decrease of 19,000 people, our advocacy resulted in an increased treatment target by 68,012 people (from 241,091 to 310,103).
Key Populations: Criminalized populations, such as men who have sex with men and sex workers, are in need of scaled up access to treatment and high impact prevention services (including access to lubricant as well as condoms, targeted HIV testing, STD diagnosis and treatment, and PrEP). However, the 2016 COP contains only very vague language on how scale up will be achieved.	Civil society raised this concern, pointing out areas of weak program performance for key populations based on PEPFAR performance data. Because PEPFAR Uganda does not have expectations of minimum standards for service delivery, nor could one be generated on the spot at the COP review, civil society demanded ongoing technical team meetings between PEPFAR and key population networks to urgently finalize and roll out a new national approach to service provision. This outcome was reflected in the COP 2016 approval slides for presentation to Ambassador Birx on COP 2016 interventions for Key Population.
Roll-out of Test & Start: Despite strong technical support for implementing Test and Start among technocrats at the Ministry of Health, Executive Management at the Ministry of Health has not publicly endorsed Test and Start in part because of recurrent ART stock outs as well as a lack of political prioritization of HIV treatment scale up.	Civil society demanded release of a Ministry of Health circular rolling out guidance to implement Test and Start by end of May 2016, which representatives from the Ministry of Health expressed support for. In principle, the expedited roll out demanded by civil society would begin immediately with approximately 93,000 patients currently in pre-ART care—which would improve shockingly low Q2 TX_NEW numbers and would help Uganda achieve new, more ambitious COP 2016 treatment targets.
ART commodities gap: The ongoing ART commodities gap has been described as being triggered by treatment acceleration, the depreciation of the shilling, and multiple other factors—these are however not the cause. In fact, the inflated prices being paid by National Medical Stores (NMS) for first line ART (about 36- 42% higher	Civil society participants presented an analysis and commentary at the COP review that the only factor contributing to the ART gap was non competitive non transparent practices by NMS—not adoption of Test and Start as some were intimating. Once civil society made this

for 6 products) as well as non-competitive PSM costs and 28 million from GoU for ARV treatment not being released in full and on time are the main drivers of the gap. This in turn is triggering reluctance by MoH to roll out Test and Start.	argument, all stakeholders agreed—publicly and privately. All stakeholders committed to fighting for NMS 'reforms' in order to increase transparency, accountability, and value for money, as a corollary to COP 2016 approval.
PrEP targets: Civil society was told a new PrEP target of 3417 people for FY2017 was a 'typo' and would not be pursued; provisional targets were only 300 people total for three new implementation sites. This is due to a reticence to act before government policies are in place, as well as conflict among PEPFAR agencies about the need for PrEP.	Civil society worked at the COP review to demand retention of the target, based on urgent need for increased protection among communities at substantial risk of HIV infection, and the clear feasibility of this target in FY2017. The target was retained, and the projects are now framed as implementation projects, rather than merely pilots.
Quality of service delivery: PEPFAR Uganda has not implemented a plan of action agreed to in COP 2015 to improve the quality of service delivery at all levels—from the community-level to the facility-level.	Civil society secured a clear commitment by PEPFAR Uganda to accelerate completion of the plan of action, along with a re-doubling of efforts to engage people living with HIV and key populations in service delivery.
VMMC: National funding for VMMC was extremely low, despite substantial unmet need.	7 million in relatively low impact investments in health systems strengthening were re-invested in COP funding for VMMC.
Procurement and supply chain management: Global Fund supported HIV funding is about 90% for commodities, procured through external pooled procurement. But the Global Fund pays the National Medical Stores for procurement and supply chain management services at an inflated rate.	Global Fund representatives committed to negotiating more competitive procurement and supply chain management costs from the National Medical Stores, and investing those savings in commodities.