Civil Society Engagement in PEPFAR COP16

UNAIDS PCB Meeting

AMB Deborah Birx, MD
June 2016
ENGAGING CIVIL SOCIETY ORGANIZATIONS

Ensuring nobody is left behind
Engaging Communities in PEPFAR

- PEPFAR is committed to engaging community at every stage of our planning processes and implementation:
  - Development and execution of our Country/Regional Operational Plans,
  - Quarterly data review through POART processes
- No longer will civil society simply hear about PEPFAR’s planned actions. They will be meaningfully involved in discussing what needs to be done to best control their local epidemics.
Engaging Communities in PEPFAR

• PEPFAR’s planning and programming is more strategic and successful due to the keen insight and unfailing advocacy of communities and key populations.

• Communities and key population groups are best positioned to support size estimation studies, offer input into, and verify prevention and treatment clinical cascades, and collaboratively plan, implement, and monitor investments with donors and local and national governments.
Announcing: Key Populations Investment Fund

PEPFAR launched $100M Key Populations Investment Fund at the UN High Level Meeting in June, 2016

- Supports multi-year and comprehensive approaches with **direct funding to key population-led community based organizations** to develop and improve their capacity for sustainable HIV responses at the local level **driven by data** and accountability.
- Supports innovative, tailored, **community-led approaches** to address critical issues and gaps that exist for key populations in the HIV/AIDS response.
- PEPFAR is committed to **engaging civil society in planning and implementation** of the Investment Fund.
Complex factors driving stigma & discrimination

- Identify
- Measure
- Change
Key Populations Investment Fund: **Addressing Specific Barriers**

In order to ensure **nobody is left behind**, we must address the lack of:

- Acceptance of **human rights of all persons**, without distinction;
- Systematic and **rigorous measurement** and monitoring of **stigma and discrimination** and clear actions to mitigate;
- Access to **quality services** for key populations;
- Availability of **disaggregated data** by key populations; and
- Focus on improving the **capacity of key populations-led community based organizations** not only to advocate for changes in policies but also directly implement services.
COUNTRY EXAMPLES OF COP CHANGES BASED ON CIVIL SOCIETY INPUT
Impact on PEPFAR Country Operational Plans

- **South Sudan** - as direct result of COP16 input, the country team reprogrammed $1.6 million in funding supporting PLHIV networks expansion of new service delivery models and innovations of index testing, community based ARV distribution, and adherence support.

- **Zimbabwe** - Both local and international CSOs were involved in COP review discussions and successfully advocated for a $6 million increase in funding to increase Direct Service Delivery activities to accelerate treatment coverage. Expanded Key Population services.

- **Thailand** — An incentive fund was developed through a community and civil society task force to enhance Thai leadership and sustain investments in community based organizations.

- **Malawi** - Civil society in Malawi has played a critical role in advocating for differentiated care models and increased human resources to support service delivery as well as expand investment in direct service delivery. COP16 will support community engagement facilitators to coordinate with community-based structures in order to achieve increase targeted testing, treatment and viral suppression.

- **Zambia** — Because of community involvement in the COP16 review, Zambia will have achieved 80% national coverage with 51 districts (includes scale up and sustained) above 80% coverage.

- **Swaziland** — Community Linkage Program - Model first implemented in one district in June 2015 with a goal to improve early enrollment in HIV care — especially targeting men. Implements a set of linkage-to-care services as recommended by WHO, IAPAC, and CDC for up to 90 days following diagnosis. Clinical services and case management delivered from MOH-registered mobile units, in the community. Early results: 91% linked to care Median time from diagnosis to first clinic visit: 6 days 95% of those that visited a facility still in care at 90 days.
National Epidemic Control End of FY 2017

80% National ART Coverage
Zambia District Classifications

<table>
<thead>
<tr>
<th>District Categories</th>
<th>Before Review</th>
<th>After Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale up to Saturation</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Aggressive Scale Up</td>
<td>0</td>
<td>23</td>
</tr>
<tr>
<td>Sustained</td>
<td>38</td>
<td>15</td>
</tr>
<tr>
<td>Central Support</td>
<td>21</td>
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</table>

By the end of FY17, Zambia will have achieved 80% National Coverage with 51 districts (includes scale up and sustained) above 80% coverage.
# Zambia COP 16 Targets

<table>
<thead>
<tr>
<th></th>
<th>Before Review</th>
<th>After Review</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment new</td>
<td>154,276</td>
<td>222,333</td>
<td>44%</td>
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<tr>
<td>Treatment net new new</td>
<td>56,572</td>
<td>121,253</td>
<td>114%</td>
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<tr>
<td>Treatment Current</td>
<td>852,050</td>
<td>914,276</td>
<td>7%</td>
</tr>
<tr>
<td>VMMC</td>
<td>228,177</td>
<td>308,177</td>
<td>35%</td>
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</tbody>
</table>
Community based Test and Start

154,276 TX New

30,855 LTFU

115,000 supported in community settings

Review T&S commodity requirements (Mar 2016)
Disseminate guidelines; capacity building (May 2016)
Expand T&S in priority districts (Oct 2016)

CHW ARV delivery and adherence support
Community ARV groups
Private courier delivery
Private pharmacies
Alternative clinic hours
Multi-month scripting

- Expand T&S in priority districts (Oct 2016)
- Disseminate guidelines; capacity building (May 2016)
- Review T&S commodity requirements (Mar 2016)
- 115,000 supported in community settings
- Private courier delivery
- Private pharmacies
- Alternative clinic hours
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30,855 LTFU
115,000 supported in community settings
SWAZILAND
Clinical Cascades — Key Populations

**MSM**

Swaziland Clinical Cascade and Targets for FY16 and FY17, MSM

- **Total PLHIV:** 972
- **PLHIV with Known Status:** 875
- **Current on ART:** 787
- **Viral Load Suppressed:** 709

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<tr>
<th>Category</th>
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<th>Target Status</th>
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<tr>
<td>PLHIV</td>
<td>972</td>
<td></td>
</tr>
<tr>
<td>PLHIV with Known Status</td>
<td>875 (63%)</td>
<td></td>
</tr>
<tr>
<td>Current on ART</td>
<td>787 (13%)</td>
<td></td>
</tr>
<tr>
<td>Viral Load Suppressed</td>
<td>709 (11%)</td>
<td></td>
</tr>
</tbody>
</table>

**FSW**

Swaziland Clinical Cascade and Targets for FY16 and FY17, FSW

- **Total PLHIV:** 8,592
- **PLHIV with Known Status:** 7,733
- **Current on ART:** 5,413
- **Viral Load Suppressed:** 2,320

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</tr>
<tr>
<td>Viral Load Suppressed</td>
<td>2,320 (11%)</td>
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- **Current National Status**
- **PEPFAR Target 2017**
- **PEPFAR Target 2018**
- **90-90-90**
ZIMBABWE
Key Changes this week since COP Submission

Real and honest engagement with stakeholders to transform the portfolio

- Major transition to direct service delivery in 25 districts to accelerate treatment coverage
- VMMC saturation projected in 5 districts (15-29)
- OVC targets maintained
- Key Population targets doubled
- Viral Load coverage increase from 6% to 33%
THANK YOU