Civil Society Engagement in PEPFAR COP16

UNAIDS PCB Meeting

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June 2016

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ENGAGING CIVIL SOCIETY ORGANIZATIONS

Ensuring nobody is left behind

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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 meaning-fully involved in discussing what needs to be done to best control their local epidemics.

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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.

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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

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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.

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COUNTRY EXAMPLES OF COP CHANGES BASED ON CIVIL SOCIETY INPUT

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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.

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Epidemic Control End of FY 2015

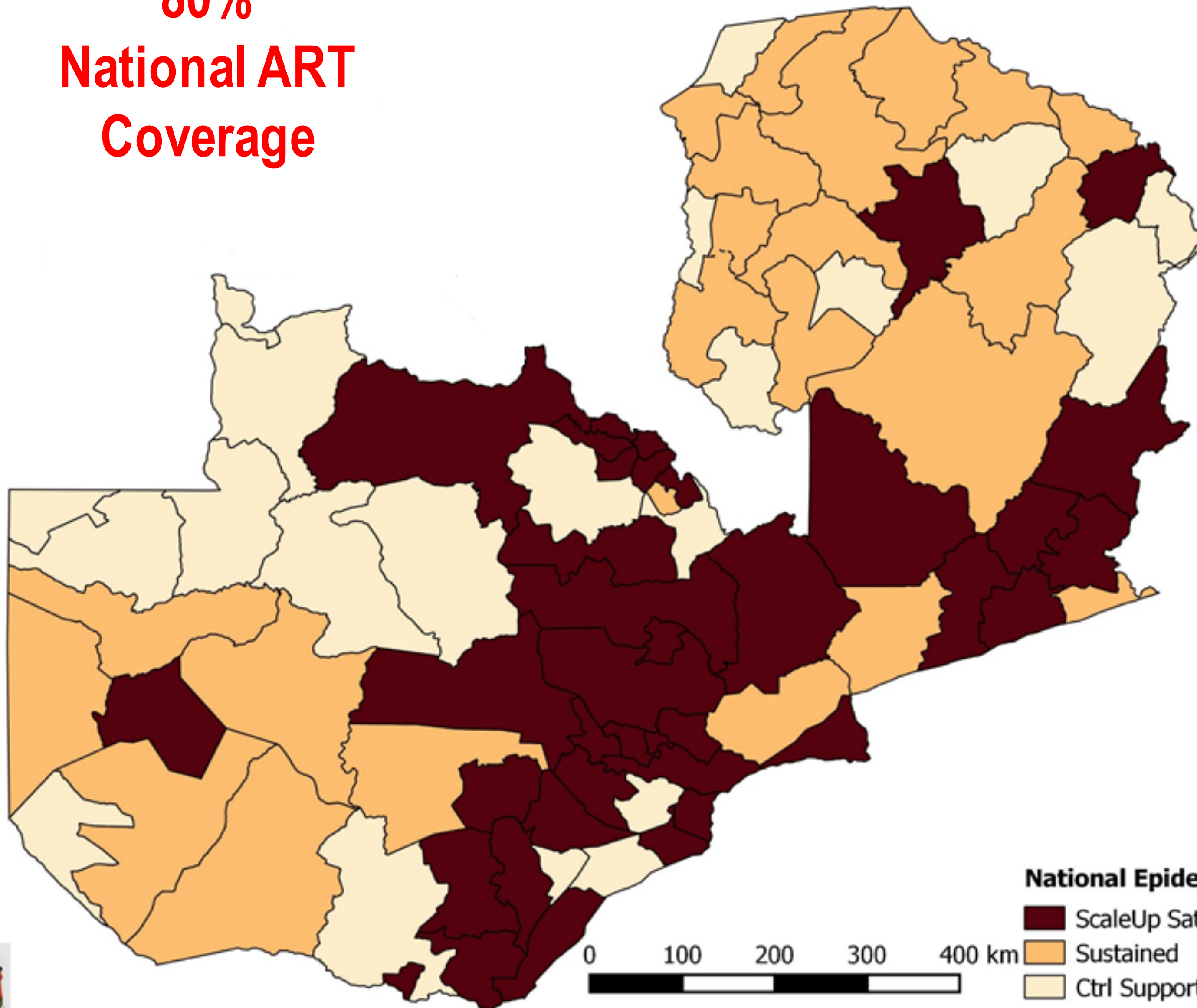
Epidemic Control End of FY 2015

- ScaleUp Sat
- ScaleUp Agg
- Sustained
- Ctrl Supported

0 100 200 300 400 km

National Epidemic Control End of FY 2017

80%
National ART Coverage



National Epidemic Control End of FY 2017

- ScaleUp Sat
- Sustained
- Ctrl Supported

Zambia District Classifications

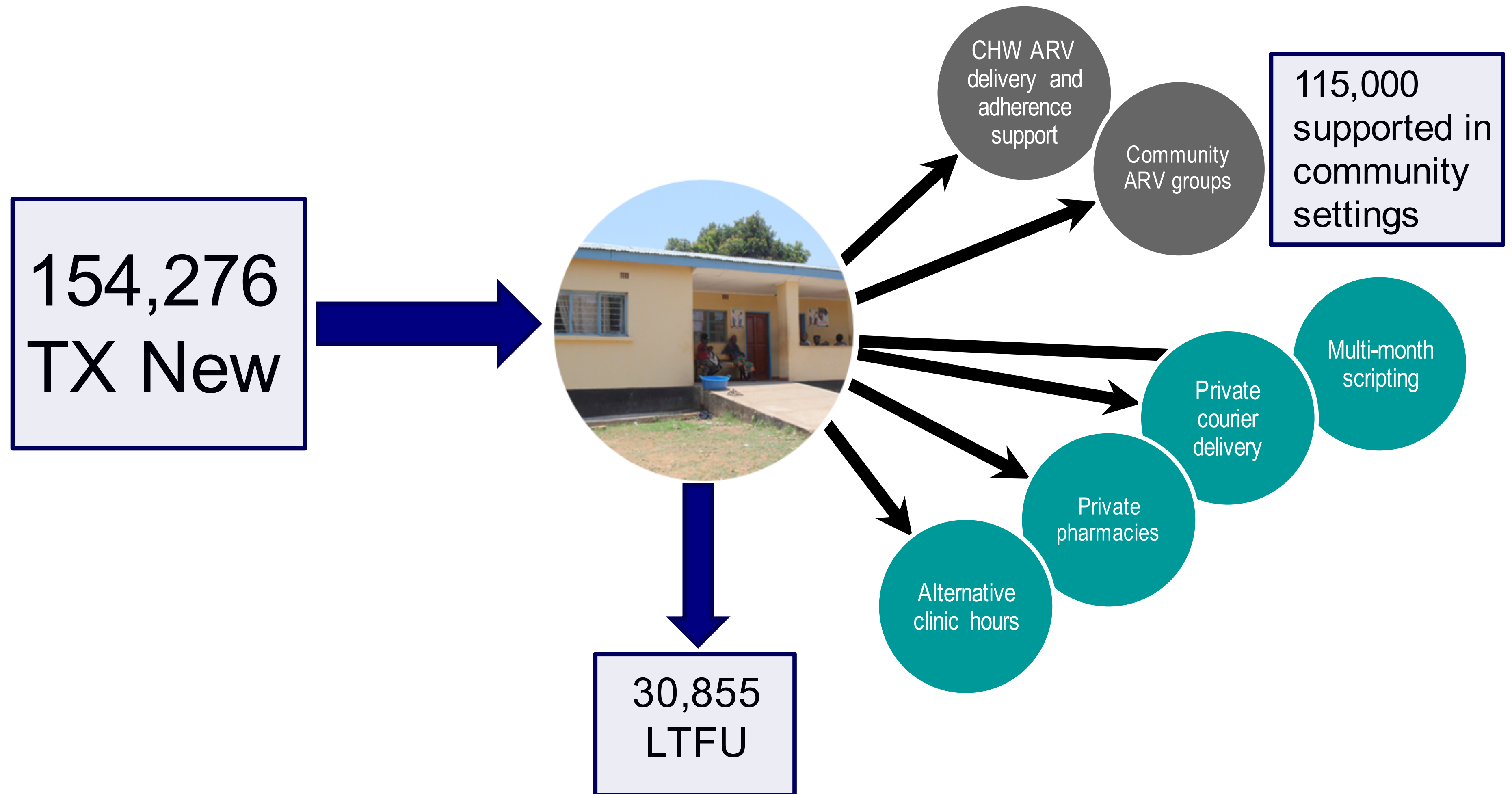
District Categories	Before Review	After Review
Scale up to Saturation	23	23
Aggressive Scale Up	0	23
Sustained	38	15
Central Support	21	21

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

	Before Review	After Review	% Increase
Treatment new	154,276	222,333	44%
Treatment net new	56,572	121,253	114%
Treatment Current	852,050	914,276	7%
VMMC	228,177	308,177	35%

Community based Test and Start

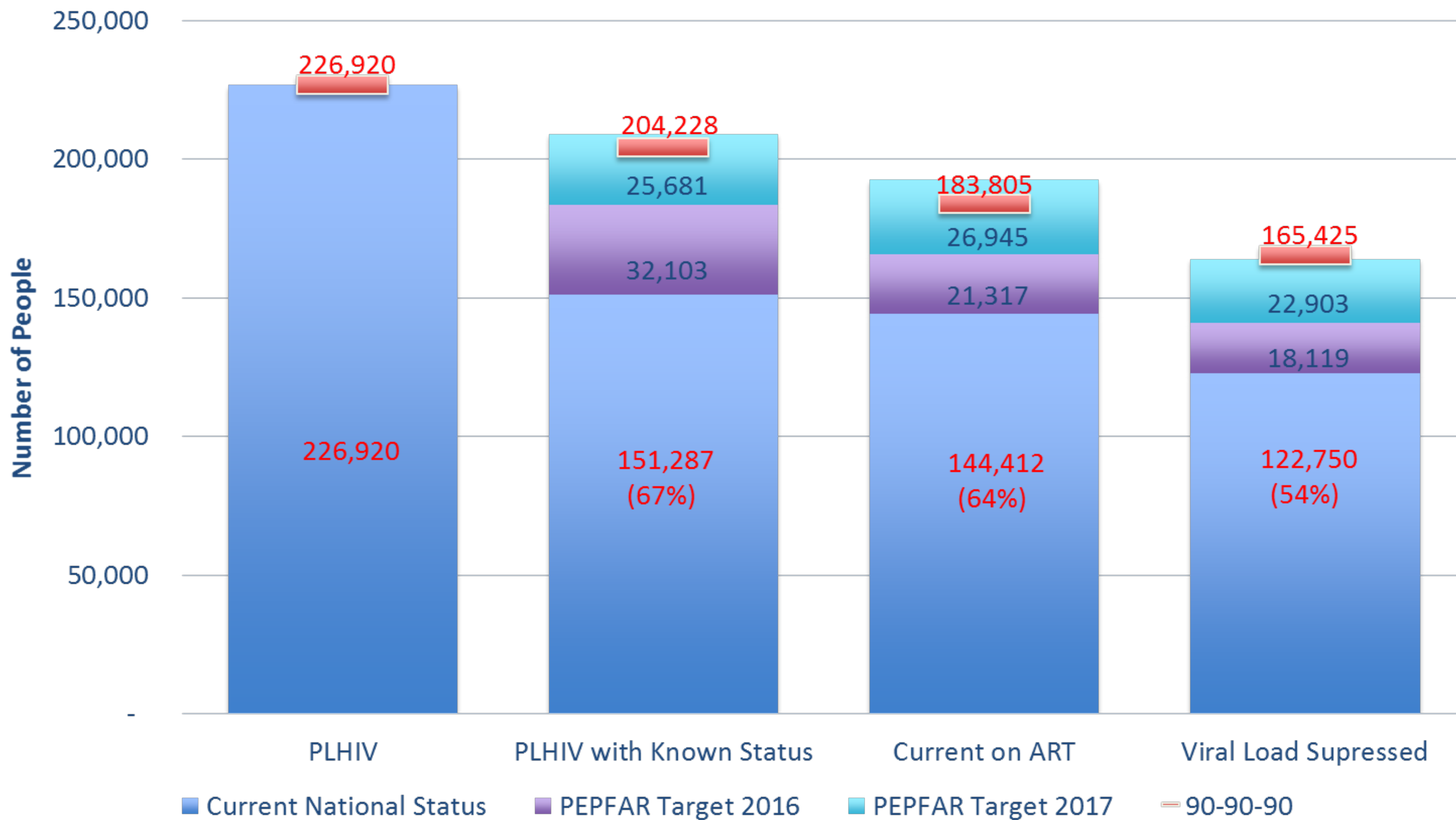


Review T&S commodity requirements (Mar 2016)

Disseminate guidelines; capacity building (May 2016)

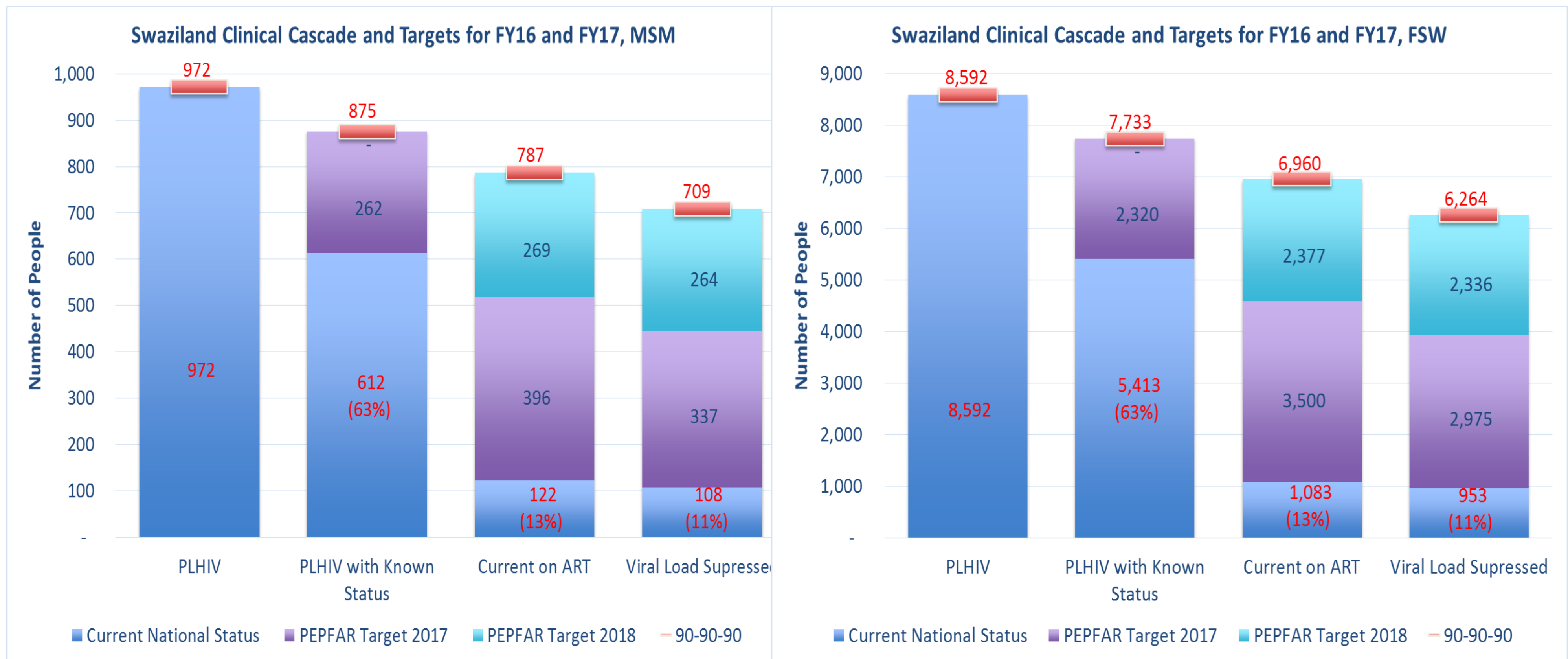
Expand T&S in priority districts (Oct 2016)

SWAZILAND



Clinical Cascade – Overall
250,000
200,000
150,000
100,000
50,000
-
Number of People
226,920
226,920
204,228
25,681
32,103
151,287
(67%)
183,805
26,945
21,317
144,412
(64%)
165,425
22,903
18,119
122,750
(54%)
PLHIV
PLHIV with Known Status
Current on ART
Viral Load Supressed
Current National Status
PEPFAR Target 2016
PEPFAR Target 2017
90-90-90

Clinical Cascades – Key Populations



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