Zimbabwe Lawyers for Human Rights
Zimbabwe AIDS Network
PATAM – Pan African Treatment Access Movement
Gays and Lesbians of Zimbabwe (GALZ)
Zimbabwe National Network of People Living with HIV/AIDS (ZNNP+)

17 April 2012

Ambassador Eric Goosby, MD
Office of the Global AIDS Coordinator
2100 Pennsylvania Ave NW
S/GAC SA-29 2nd Floor
Washington DC 20037

Dear Ambassador Goosby,

We are organisations representing a coalition of Zimbabwean civil society groups working to turn the tide of the AIDS crisis in Zimbabwe and we are contacting you regarding Zimbabwe's draft 2012/13 Country Operational Plan (draft COP) submitted March 2012.

Zimbabwe is a country that has made tremendous strides in fighting HIV despite incredible systems challenges and one of the highest burdens of HIV infection—as well as TB mortality—in the world. However, this progress is facing serious threats, particularly in the areas of treatment scale up, prevention of mother to child transmission, and high impact prevention interventions such as medical male circumcision—primarily because of funding shortfalls. Despite the catastrophic burden of HIV disease and HIV/TB co infection, Zimbabwe only receives $4 in funding per person with HIV from donors—meaning it receives less per person with HIV than any other SADC country.[1] An increase in funding from PEPFAR for treatment and other high impact interventions is long overdue—and is consistent with President Obama's pledge to begin to end the AIDS epidemic by doubling new patients on HIV treatment to reach 6 million total directly supported by PEFPAR by 2013.

While we requested a meeting with Zimbabwe's PEPFAR Country Team on 6 March 2012 to discuss the targets and goals of the draft COP, unfortunately we were only provided with a meeting by the Country Team on April 3—*after* the deadline for submission of the draft COP. While we immediately requested that the Country Team reschedule our meeting for an earlier

[1] National HIV/AIDS Estimates, Ministry of Health and Child Welfare 2009

date, before the COP deadline, we did not receive a response to our request. We eventually met with the Country Team on April 3 and we hope for ongoing engagement between indigenous civil society representatives and PEPFAR, in order to meaningfully impact COP reprogramming for 2012 and the COP development for 2013-2014.

However, we understand that draft COPs are being reviewed **right now** in Washington DC, and we would therefore like to formally submit our concerns and recommendations. We have reviewed Zimbabwe's draft COP, and we feel that it does not adequately reflect President Obama's promise and the need for dramatically scaled up ambition among all partners contributing to the AIDS response. Specifically, we have the following concerns:[2]

1. End ongoing use of suboptimal regimens

We are extremely concerned that, because of funding shortfalls, Zimbabwe will continue enrolling patients on suboptimal, toxic first line therapy in 2012, while potentially further delaying implementation of the stavudine phase-out plan beyond 2013.[3] The COP indicates that USG funding will *not* be used to procure stavudine but other funding sources (which outstrip the US in size). This choice will come with substantial additional costs. Stavudine-based regimens will end up being more costly than tenofovir-based regimens—accruing costs triggered by everything from increased hospitalization and loss to follow up to earlier switching to more costlier line treatment.[4] **Recommendation: We strongly believe that PEPFAR must increase investments to help defray the costs of phasing out stavudine by 2012 while enrolling new patients on non-stavudine based combinations, so that continued scale up uses less toxic, more durable regimens. This is the true cost of scaling up to end AIDS.**

2. Virtual elimination of pediatric HIV

The use of Option A in Zimbabwe, a country facing a preventable epidemic of pediatric HIV, is extremely concerning to us. We note that Namibia, South Africa, Uganda, Kenya, Malawi, Rwanda, Zambia, Mozambique, Swaziland, Haiti and Cameroon are all exploring use of Option B+ (access to HIV treatment for life regardless of CD4 count for pregnant women) or are already pursuing implementation of Option B+. WHO recently published country guidance indicating that Option B/B+ are "likely to prove preferable to Option A for operational, programmatic and strategic reasons."[5] The guidance also instructs that Option B+, while more expensive in the short term, has "benefits gained for the costs expended are likely to be much greater" than for Option A.[6] Furthermore, Option B+ would provide an important opportunity to begin operationalizing treatment as prevention, since pregnant women CD4 >350 would include sexually active women whose risk of transmitting HIV through sex would be reduced through access to treatment. In addition, we note that recent data from Zimbabwe reveal troublingly high

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[2] Note: the version of the draft COP that was reviewed by civil society had all budget line items and several partner names redacted.

[3] See Zimbabwe draft COP p. 57: "The MOCHW had initially planned to put all new patients on Tenofovir-containing regimens and switch 20% of existing patients from Stavudine to Tenovofir and/or Zidovudine regimens in 2011, 50% in 2012, and 100% by the end of 2013. However, resources…were limited. The MOHCW with support from the donor group revised the transition plan. The new plan allowed for transition of 20% of existing clients, pregnant women, children and patients with severe side effects…with continued use of Stavudine for all new adult patients."

[4] See for example: Bygrave H et al. 2011. Implementing a tenofovir-based first line regimen in rural Lesotho: clinical outcomes and toxicities after two years. J Acquir Immune Defic Syndr. 2011 Mar 1;56(3):e75-8.Jouquet et al. Cost and cost-effectiveness of switching from d4T or AZT to a TDF-based first-line regimen in a resource limited setting in rural Lesotho. JAIDS Publish Ahead of Print. DOI: 10.1097/QAI.

[5] Programmatic Update: Use of Antiretroviral Drugs for treating Pregnant Women and Preventing HIV infection in Infants. Executive Summary 2012. WHO. Available at: http://www.who.int/hiv/PMTCT_update.pdf

[6] *Ibid*. p. 5

rates of maternal deaths among HIV positive women at high CD4 counts,[7] while access to treatment for HIV positive mothers is critical to save the lives and protect the health of children born to HIV positive mothers. Family health depends on the health of the mother—even when a child is HIV negative, if a mother is not receiving the treatment she needs for her health, the family's health will suffer. **Recommendation: PEPFAR should work with the MOHCW to modify national PMTCT guidelines to support Option B+, and raise additional funds through PEPFAR, additional Global Fund resources, other bilateral donors, and through national investments accordingly.**

3. Treatment coverage and treatment as prevention

We are extremely concerned by the draft COP's proposed increase in directly supported patients on treatment—only 24,000 additional patients. Considering current waiting lists for treatment initiation and the huge potential Zimbabwe has to turn the tide against HIV, particularly by operationalization of the findings of HPTN 052 through earlier initiation of treatment for serodiscordant couples, we believe this target must be increased. Zimbabwe has the third highest HIV burden in the world and an impressive demonstrated track record in successful, rapid HIV treatment scale up—the country initiated more people on treatment in 2010 than any other country, after considerable economic, political and public health turmoil. In 2011, 8,000 people were initiated on treatment monthly. This acceleration must be maintained and intensified. Furthermore, Zimbabwe is an HPTN 052 study site—it is unethical for a country to contribute to such groundbreaking research and not derive benefits from the findings. Currently Zimbabwe does not have the resources to systematically pursue treatment as prevention. **Recommendation: the COP ART direct support targets should be increased to reflect a strategy of pursuing treatment as prevention.**

4. Key populations

We note with concern that the COP has no investment indicated for men who have sex with men, despite listing them as a key population.[8] Men who have sex with men are identified by the Zimbabwe National HIV and AIDS Strategic Plan II (ZNASP II 2011-2015) as a key population in need of intensified prevention services;[9] PEPFAR has also recently developed guidance for programming targeting men who have sex with men.[10] **Recommendation: PEPFAR should amend this draft COP to include investment in support and service delivery targeting men who have sex with men.**

5. Circumcision

The reduction in targets for MMC contained in the COP is a major concern to us—an increase from 56,880 circumcisions in 2011 to 60,000 circumcisions in 2012 is too little, too slow, particularly in a country with bold national commitment to reaching 50% coverage by 2013 and 80% coverage by 2015. **Recommendation: the COP should be amended to support a bold USG target, leveraging national support and support from other donors.**

6. Other Issues

We are extremely concerned that the new MNCH-focused Health Transition Fund (HTF) does not currently contain any HIV focused activities, despite the inextricable link in Zimbabwe between maternal and infant mortality and the AIDS crisis. **Recommendation: PEPFAR**

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[7] http://journals.lww.com/aidsonline/Fulltext/2010/01280/Mortality_among_HIV_positive_postpartum_women_with.2.aspx
[8] See: draft COP page 73.
[9] See: Zimbabwe National HIV and AIDS Strategic Plan II (ZNASP II 2011-2015) p. 28
[10] http://www.pepfar.gov/documents/organization/164010.pdf

(together with civil society) should publicly advocate with DfID, UNICEF and other HTF supporters to include funding for key interventions that address preventable maternal death, such as access to ART.

We recognize that these recommendations come at an increased upfront cost. But the data clearly indicate that investing in accelerated scale up now--including initiating treatment earlier—using better tolerated regimens, as actually *cost saving* in the medium term.[11] We are actively engaged in national resource mobilization efforts, such as lobbying Parliament to expand the allocation for HIV treatment within in the National AIDS Trust Fund, lobbying bilateral donors to include HIV specific investments in the HTF and lobbying Government of Zimbabwe to expand its investment in the health budget. But an expanded investment from PEPFAR—particularly in HIV treatment—is urgently needed to ensure the country begins to end the AIDS crisis and rises to the challenge that has been set by President Barack Obama.

Sincerely,

Chamunorwa Mashoko
on behalf of the Coalition

cc: Peter Halpert, Director, Health, USAID Zimbabwe
Captain Peter H Kilmarx, MD, Director, CDC Zimbabwe

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[11] Bernhard Schwartländer: Towards an improved investment approach for an effective response to HIV/AIDS *The Lancet,* Vol 377: 03 June 2011, available at www.thelancet.com/journals/lancet/article/PIIS0140--6736(11)60702--2/abstract and Global Webinar: The Impact of Treatment as Prevention—Models to Guide Ending the Epidemic www.avac.org/ht/display/EventDetails/i/41814/TPL/MatDetails/pid/351