

Optimizing HIV Services Beyond PEPFAR Support in Zimbabwe

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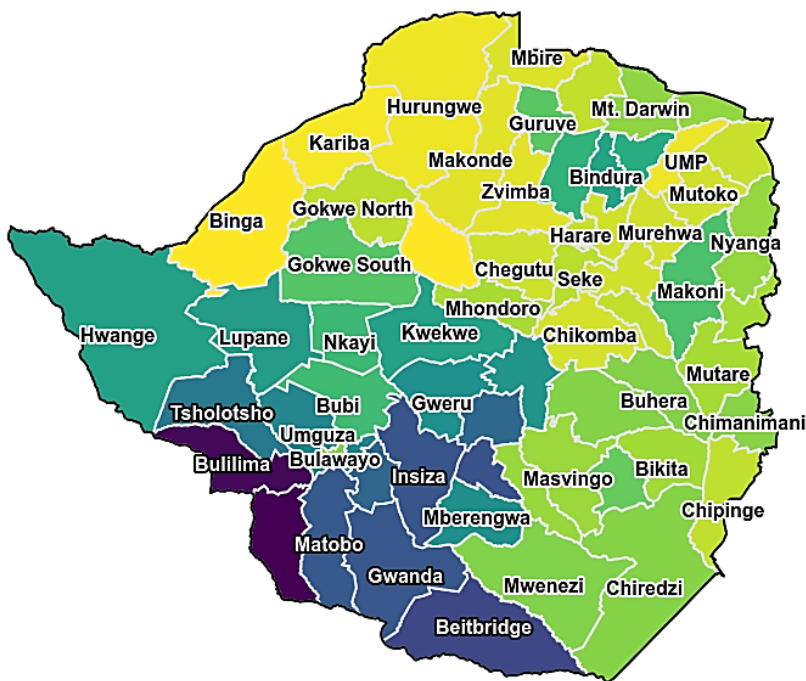
CQUIN 8th Annual Meeting | December 9-13, 2024 – Johannesburg, South Africa

Outline

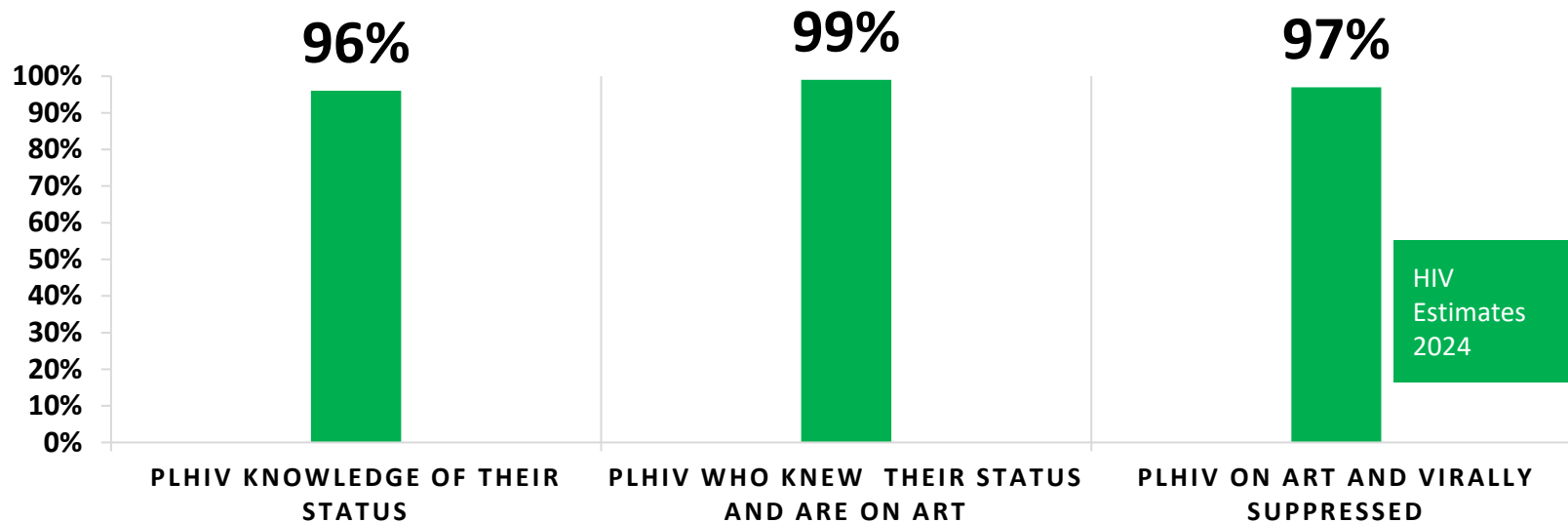
- Country context and sustainability roadmap development progress
- Optimizing HIV services beyond PEPFAR support in Zimbabwe as a sustainability agenda

Status towards reaching 2030 targets and epidemic control

HIV prevalence by district, 2023



DHIS2, 2023



- Zimbabwe has 1.3m PLHIV with HIV prevalence of **10.49** (15-49 years) and HIV incidence per 1000 uninfected population at **0.96** in 2023 (2024 estimates)
- As of 2023, Zimbabwe is in the **epidemic control phase** and has achieved **the three 95s**, whereby the total number of new HIV infections (15,474) is less than the total number of AIDS related deaths (19,417), with both the number of new HIV infections and AIDS related deaths on the decline.

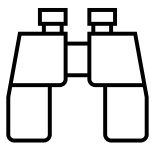
Vision and political leadership on HIV response sustainability

Definition of sustainability in Zimbabwe



The ability of Zimbabwe to achieve and maintain epidemic control, ending AIDS as a public health threat through an effective, functional, efficient, accessible, equitable, transparent and accountable national health system in an enabling environment, supported by adequate domestic resources

Zimbabwe vision of sustainability



A Zimbabwe where universal access to HIV prevention, treatment, and care is fully guaranteed and integrated into the health system, empowering communities to achieve an AIDS-free society by 2030, with sustainable domestic financing

Country ownership and engaging with the civil societies

Zimbabwe HIV Sustainability Technical Working Group

Functions

The TWG provides overall technical guidance to the process & direction including stakeholder engagement, support, sustainability assessment, development and implementation of the Roadmap.

Members

- MOHCC AIDS & TB (Co-Chair) and NAC (Co-Chair),
- MOHCC Policy & Planning
- UNICEF (Secretariat, Lead Tech Partner)
- UNAIDS, World Bank, UNDP/ GLOBAL FUND
- BMGF (TA through Genesis Analytics)
- WHO, USAID, CDC, PEPFAR, CHAI, FCDO
- CWGH, ZAN (aggregating body for HIV CSOs, Zimbabwe National Network of People Living with HIV and Key Population Groups Representative)

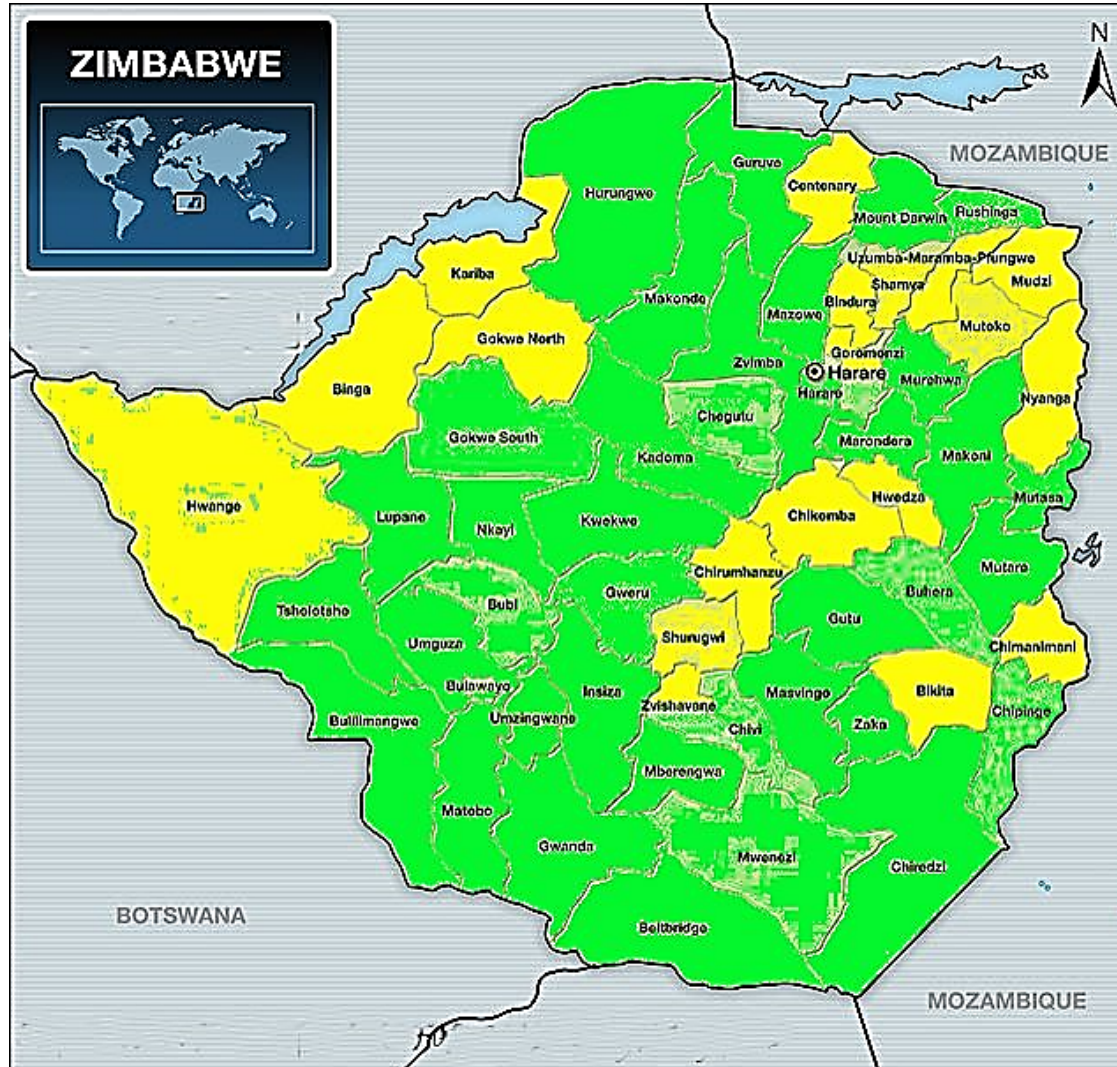
Stakeholder consultations guided by a comprehensive stakeholder mapping exercise



Outline

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In 2015, the PEPFAR Zimbabwe program pivoted to support 80% of PLHIV with Direct Service Delivery (DSD).



DSD: 44 Districts (~80% PLHIV)

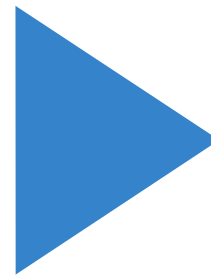
- Healthcare workers seconded by PEPFAR
- Intensive support from PEPFAR
- All relevant MER indicators collected

TA: 19 TA Districts (~20% PLHIV)

- No DSD support from PEPFAR
- Very light touch TA
- No seconded healthcare workers
- Report TX_CURR & TX_PVLS
- The TA sites are mainly supported by GOZ using GF funding for HIV/TB

What is the minimum package required to improve and sustain a high-quality care and treatment program?

Performance at DSD sites was much better, but not perfect either.



TA sites had significant gaps that threatened sustainable epidemic control.

Key aims and objectives

1

Understand Service Quality:

Assess the quality of services at DSD and TA sites.

Review the care and treatment cascade to identify areas for quality improvement.

2

Identify Gaps in Service Delivery:

Address gaps through sustainable interventions that improve viral load suppression rates and overall program performance.

3

Leverage Existing Resources:

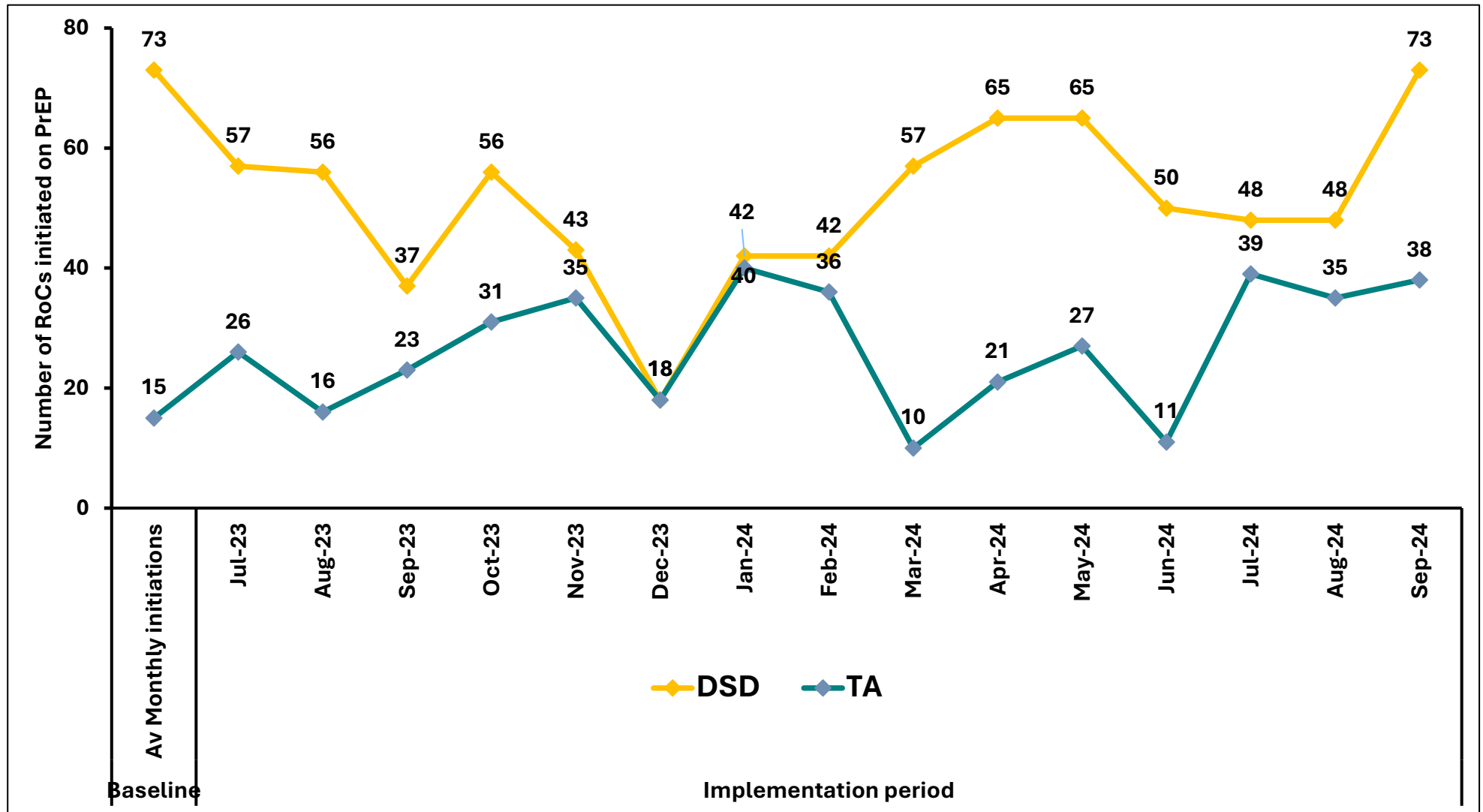
Optimize services throughout the clinical cascade by understanding the resources required, such as staff time and funding support.

Low-cost optimization package for 5 DSD sites and 5 TA sites

Interventions During Implementation Period	DSD sites	TA sites
Cell phones for viral load result tracking	Existing and continued	New
Airtime for tracking defaulters	Existing and continued	New
Provision of missing registers	Existing and continued	New
Establishing an ART focal person	Existing and continued	New
Monthly site support and mentorship	New	New
Monthly data abstraction and review with site staff	New	New

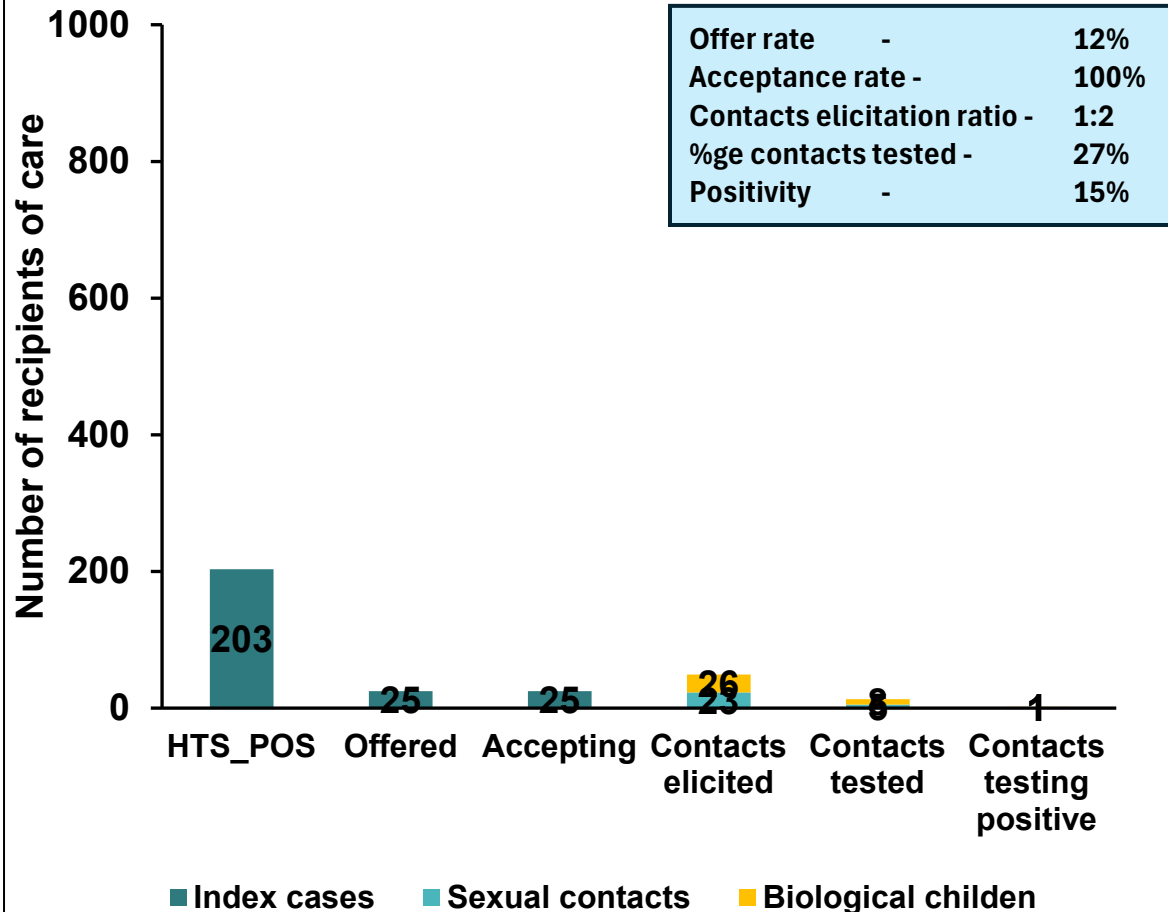
- Data at baseline and 15 months of implementation was collected and analyzed
- **Baseline** was April to June 2023 and **Implementation** was July 2023 to September 2024

Number of recipients of care initiated on PrEP by month at DSD and TA facilities

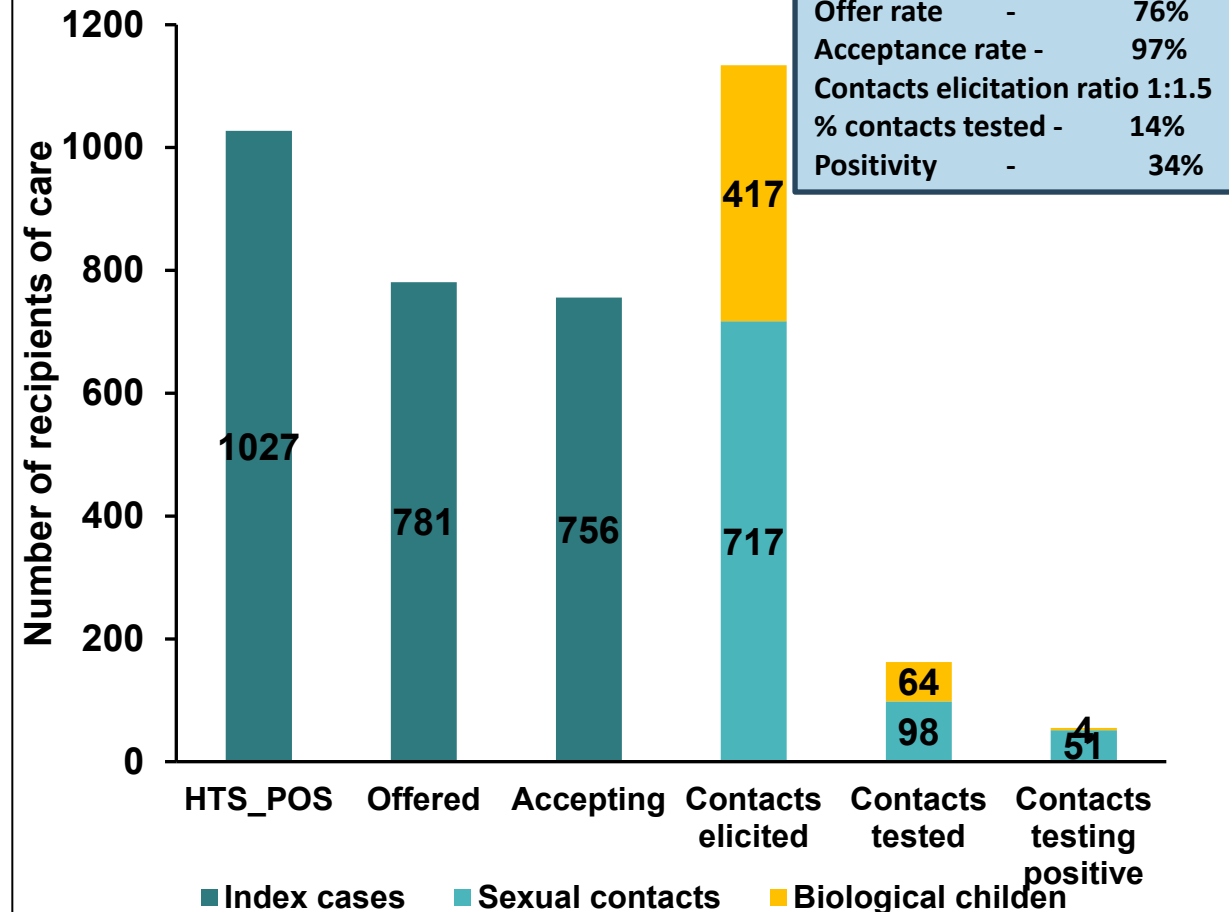


Index case testing cascade at TA facilities during baseline and implementation periods

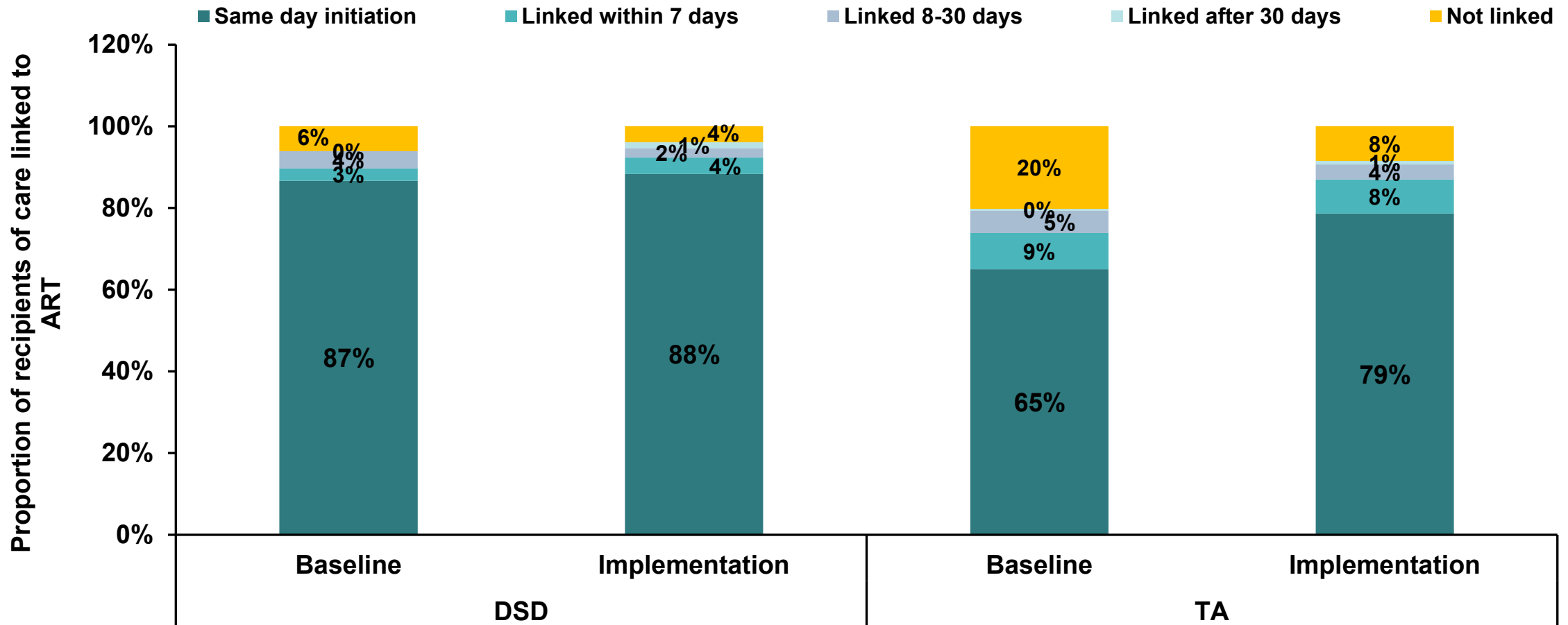
Baseline - TA



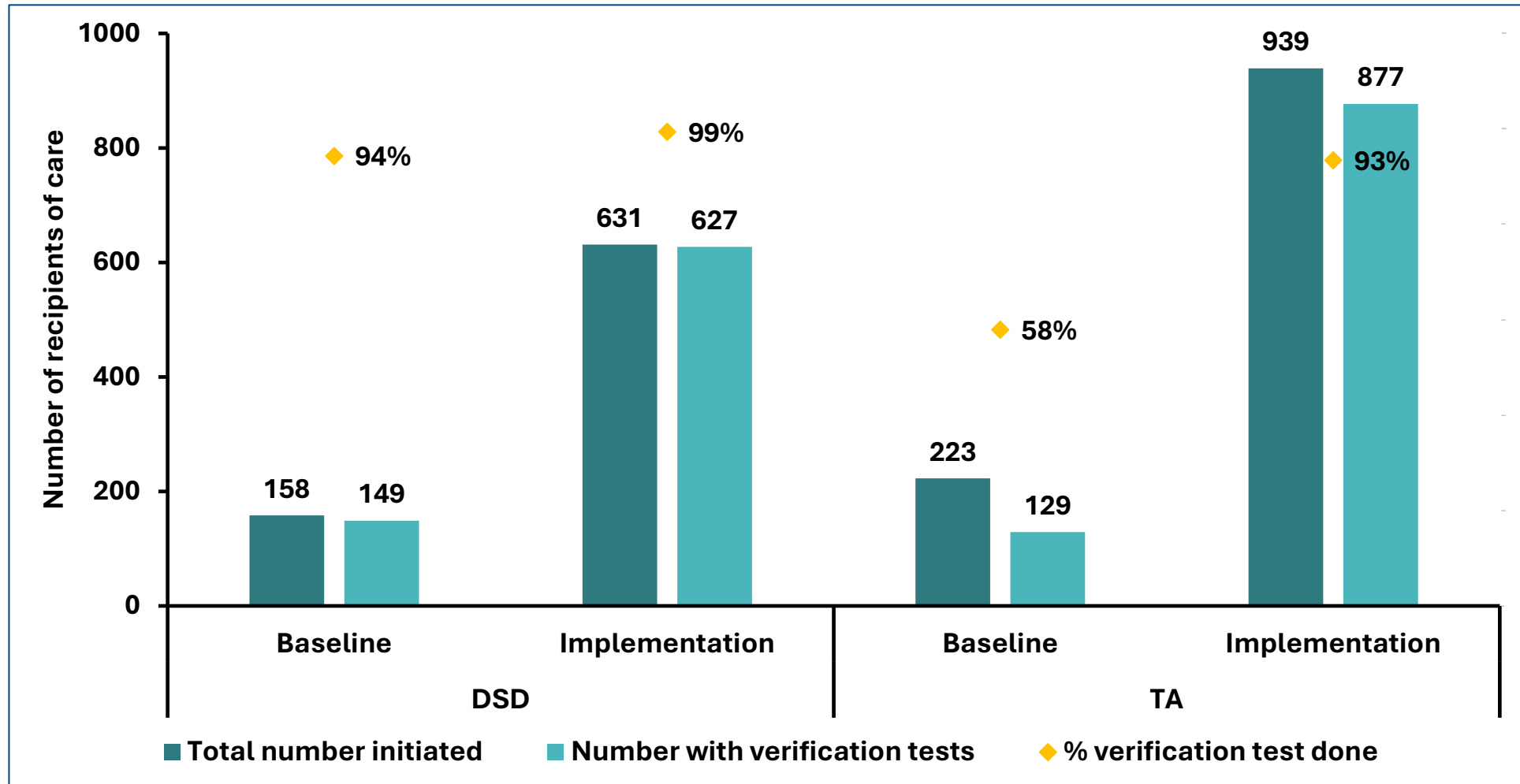
Implementation - TA



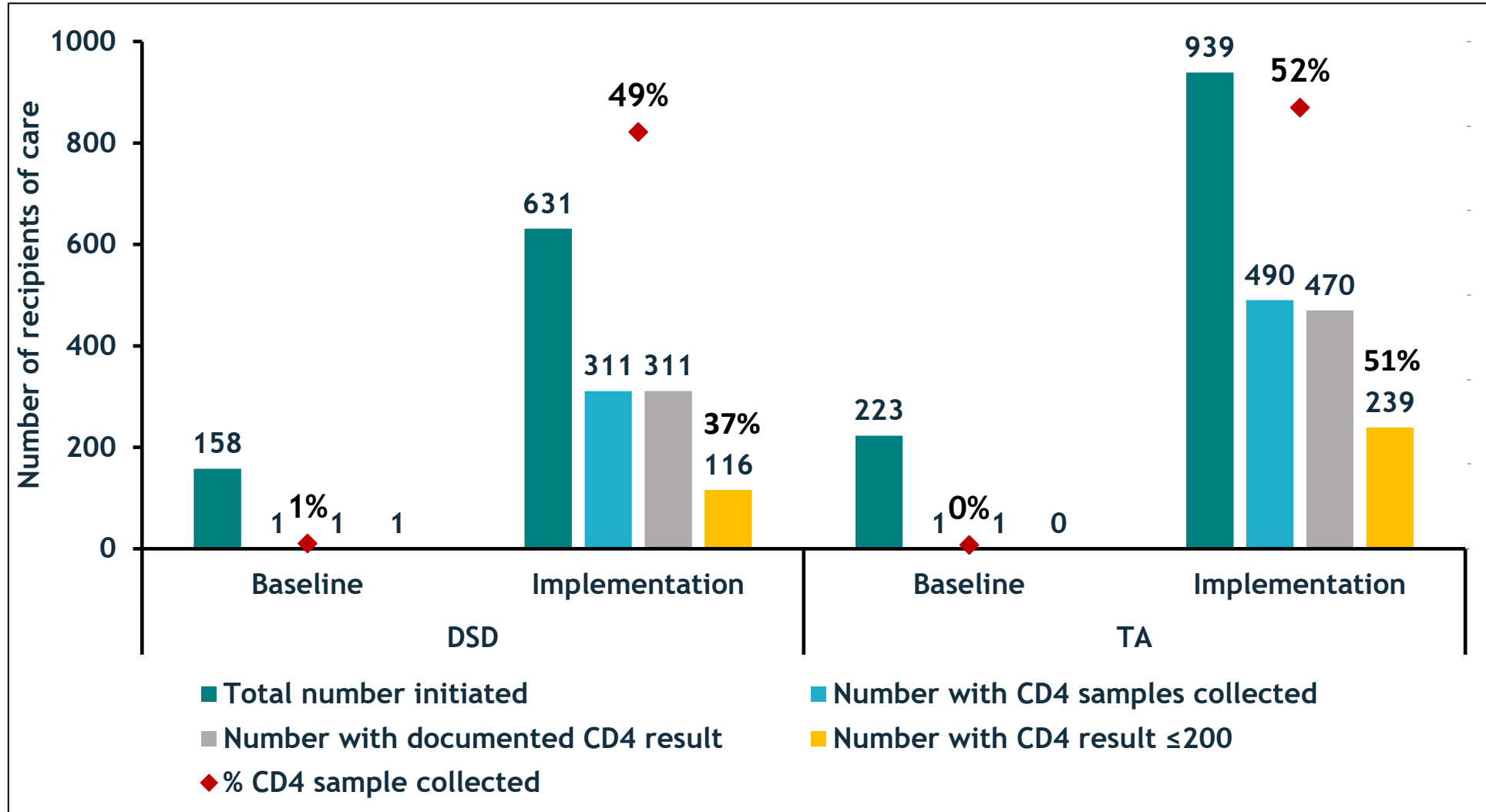
Linkage to ART at DSD & TA sites comparing baseline and implementation periods



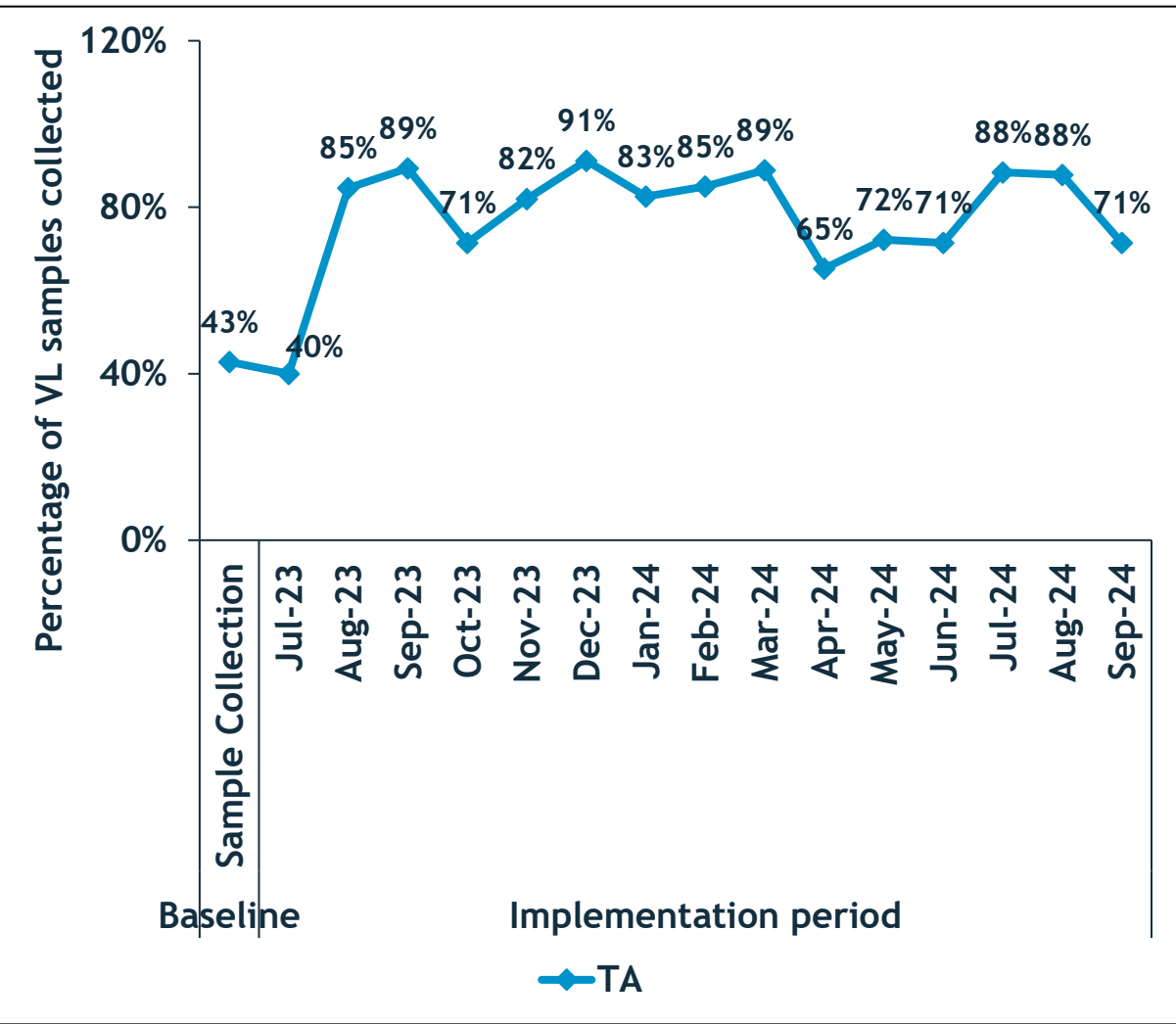
Verification testing among recipients of care initiated on ART at DSD and TA facilities



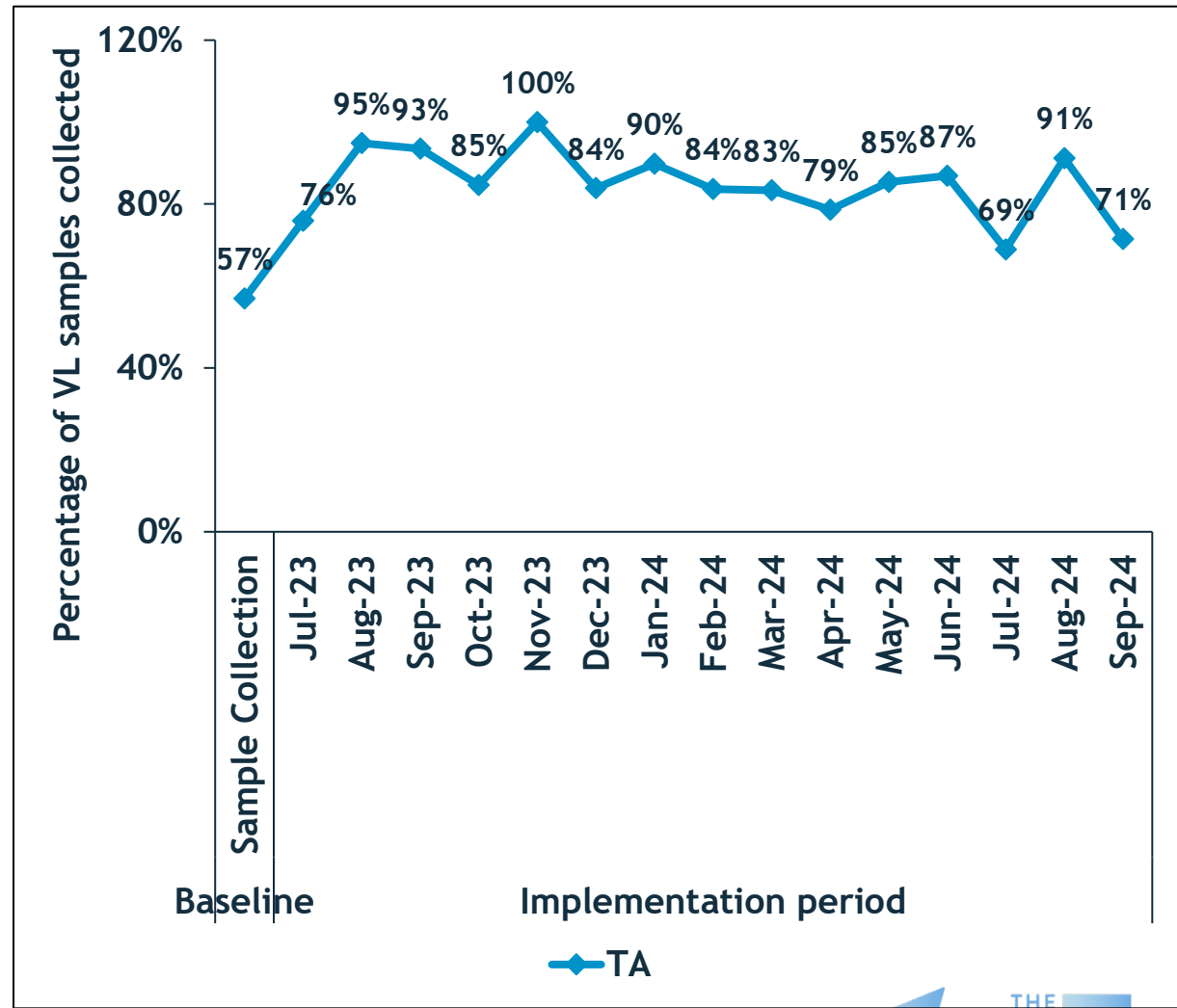
CD4 sample collection among recipients of care initiated on ART at DSD and TA facilities



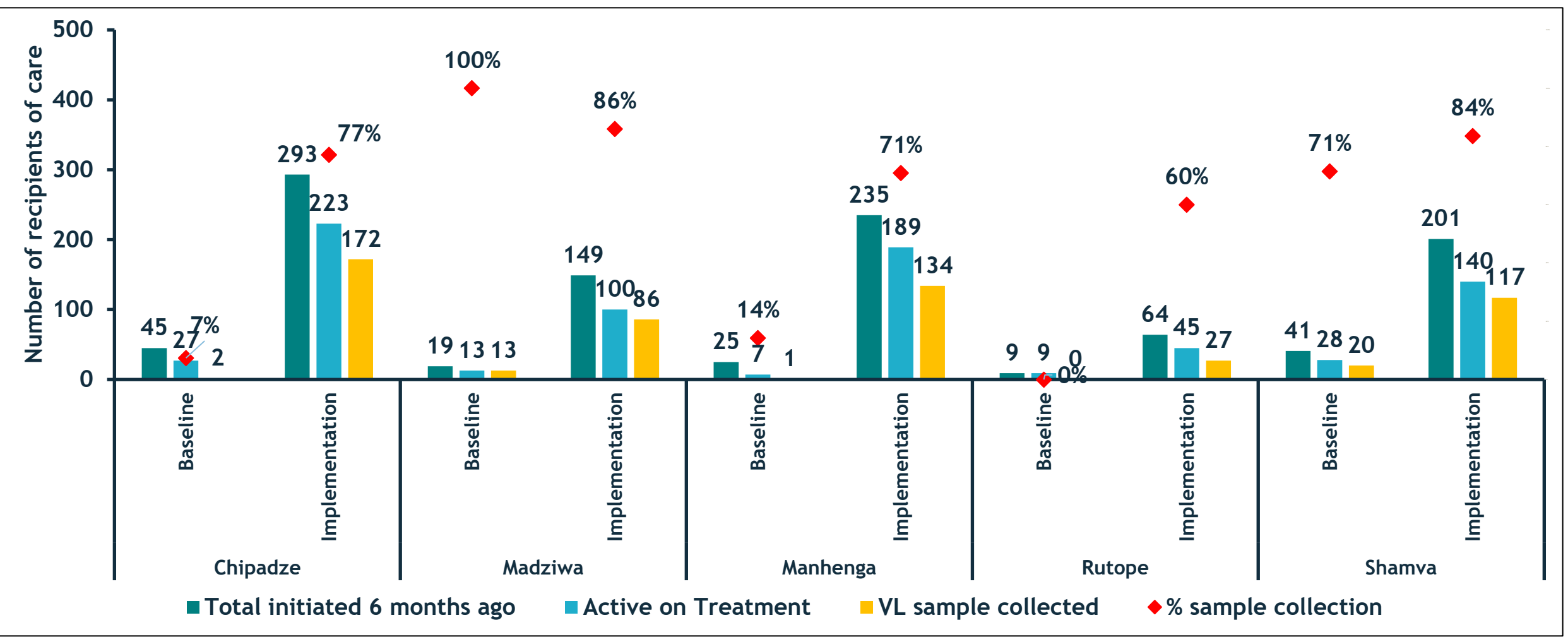
Proportion of recipients of care with a viral load sample collected according to algorithm at 6 months post initiation at TA facilities by month



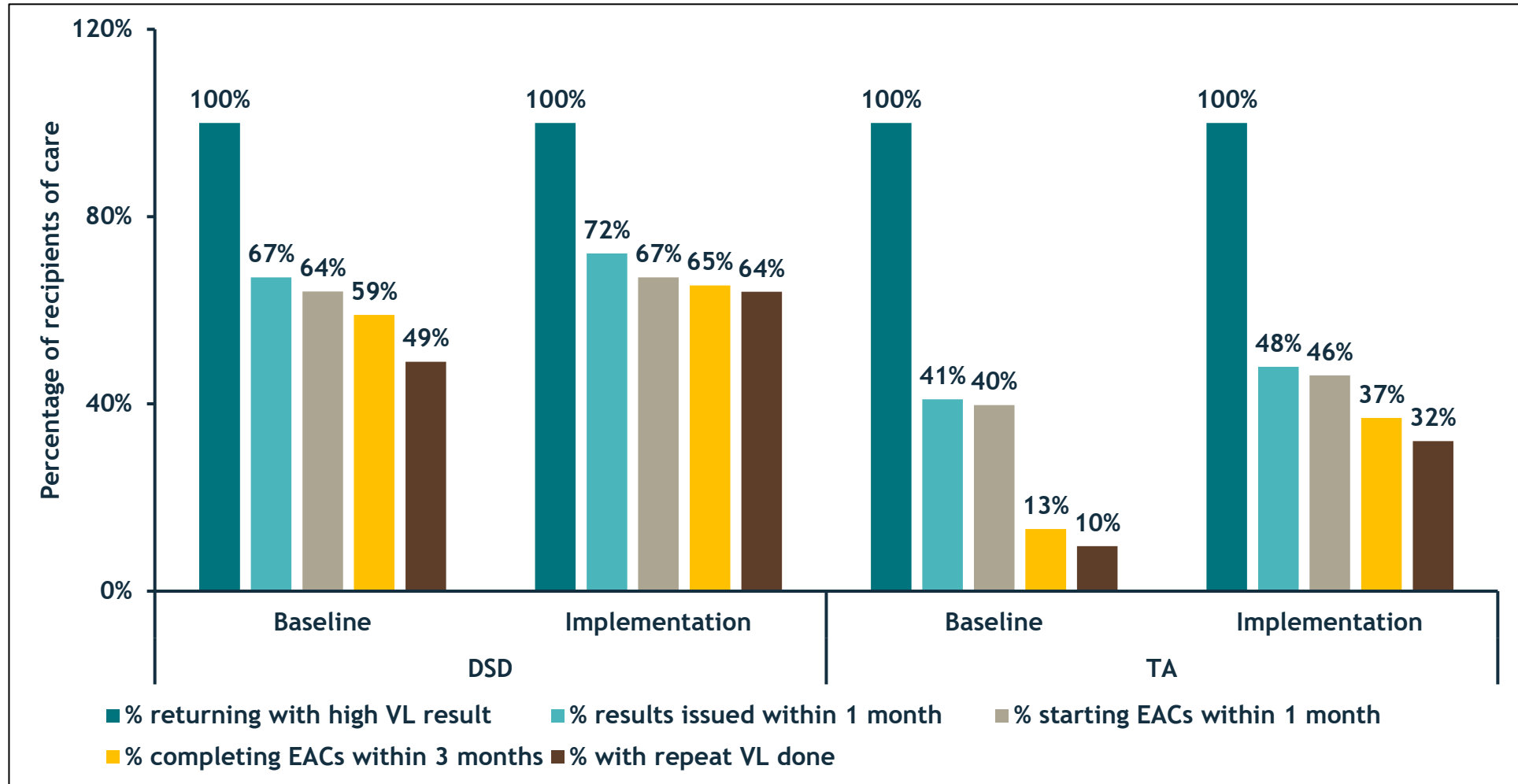
Proportion of recipients of care with a viral load sample collected according to algorithm at 12 months post initiation at TA facilities by month



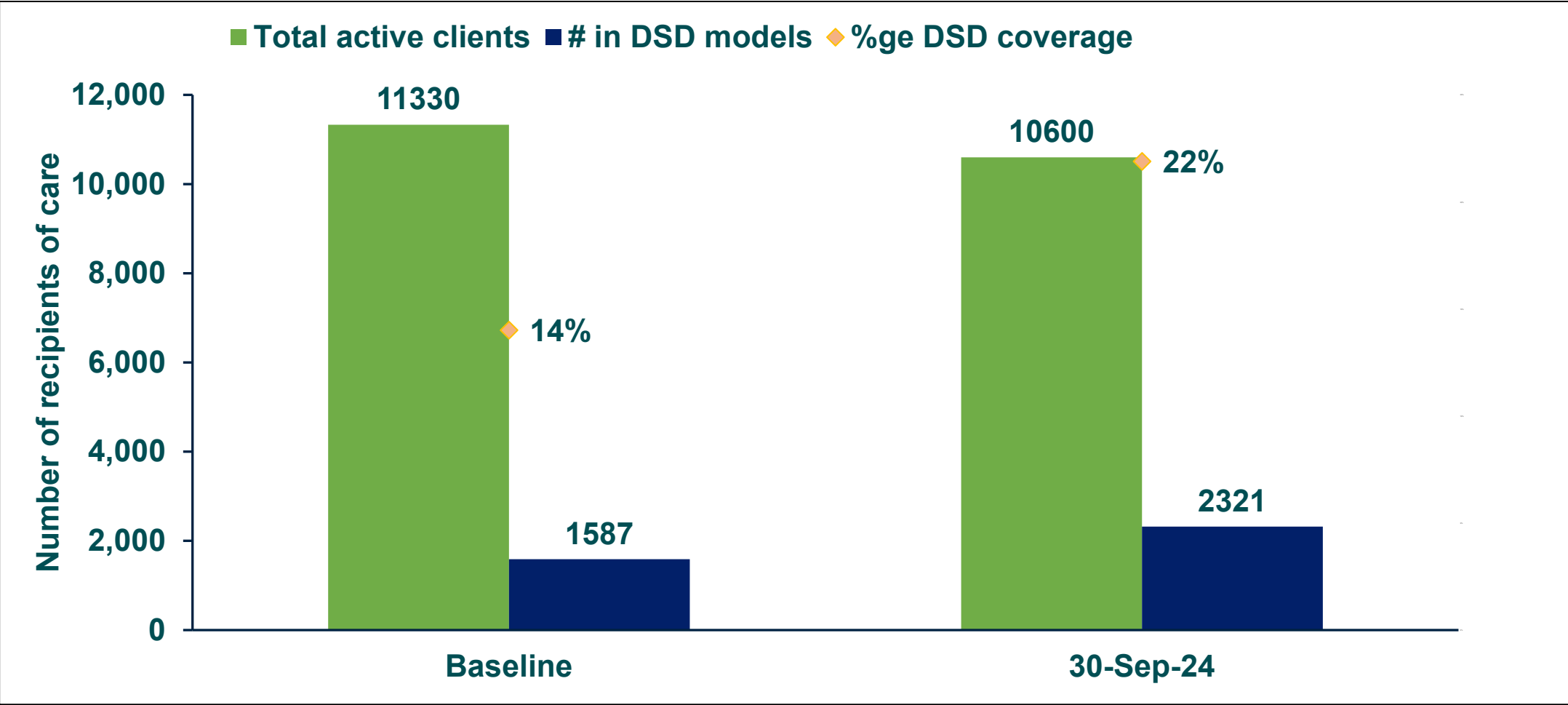
6 months cohort viral load monitoring at TA facilities comparing baseline and implementation periods



Management of high viral load clients among DSD and TA facilities



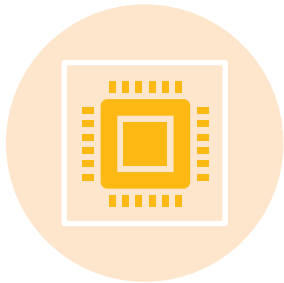
Proportion of recipients of care enrolled in DSD models at TA facilities comparing baseline and implementation periods



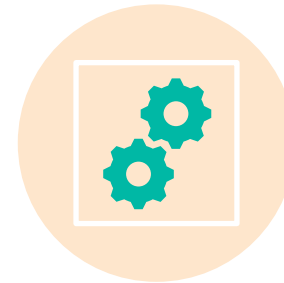
Defaulter tracking during baseline and implementation periods at DSD and TA facilities

	DSD (N=5 Facilities)		TA (N=5 facilities)	
	Baseline	Implementation	Baseline	Implementation
Number of clients with missed appointments	384	3,550	25	2,030
Number entered in defaulter tracking register	380 (99%)	3,381 (95%)	1	523 (9%)
Number followed up according to guidelines	380 (100%)	3,262 (96%)	-	241 (14%)
Number with documented final outcome	378 (99%)	3,175 (97%)	-	213 (88%)
Number active on treatment	342 (90%)	2,760 (87%)	-	194 (91%)
Number transferred out	9 (2%)	88 (3%)	-	9 (5%)
Number opted out	0 (0%)	7 (0.2%)	-	0
Number LTFU	29 (8%)	263 (8%)	-	3 (1%)
Number died	3 (1%)	26 (0.8%)	-	6 (3%)

Conclusion



Low-cost interventions implemented with fidelity can significantly enhance program performance



Program optimization can be a key in achieving and sustaining epidemic control.

Way forward on HIV treatment optimization

Review meetings done with all 10 facilities to share best practices, lessons learnt and areas of improvement

The districts to scale up treatment optimization to other TA facilities using domestic resources

Dissemination of the results to other HIV Stakeholders e.g., in the HIV/TB partnership forum whose stakeholders are all HIV partners, provincial cadres and PLHIV representatives

Adaptation and adoption by other HIV Partners

Acknowledgement

Recipients of care

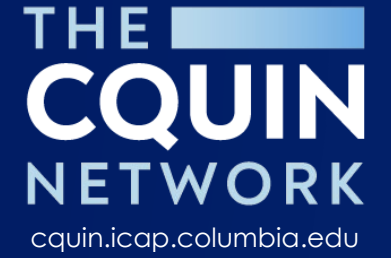
MoHCC, AIDS and TB Unit

DHEs

Facilities

Zim-TTECH

CDC



Thank You!

