Major Civil Society Themes for Review of 2015 COPs

Civil society groups in a dozen PEPFAR countries are currently reviewing COP elements and draft SDSs, and three COP/ROP reviews have already taken place. The following questions have surfaced in multiple countries as cross cutting priority concerns. As CS groups prepare country-specific recommendations and requests, we present these concerns to OGAC as important recurrent issues we request OGAC address as a matter of priority as reviews get underway.

1. **Geographic prioritization**: A variety of different methods have been used in countries to implement geographic and/or population focus required by the COP 2015 guidance, as part of the "pivot" toward focusing resources on scaling up high-impact interventions where they are needed most. We support the core concept of pivoting to achieve 80% ART coverage in places and/or communities most in need by 2017, especially where there are significantly underserved communities with high unmet need for treatment or high transmission rates. It is appropriate that countries are not applying a "one size fits all" approach given the diversity of the epidemics in different countries and the differences in how fully and successfully countries have been able to mount a response.
   However, we raise the following as concerns about the approach in some countries:
   a. **Cut-off points and epidemiology limits:** Several countries are clearly developing a thorough, thoughtful, flexible, strategic and common-sense strategy in their decisions about where and how to focus. Other countries, however, are relying only on a small sub-set of epidemiological and site-level data that are not sufficiently robust to drive all program decisions. Especially near cut-off points for burden and prevalence, it is very hard to justify why some districts or sites should not be scaled up if the goal is truly epidemic control. Some countries began by identifying 'high priority' geographic areas and then only subjected those areas to more robust analyses—which almost certainly ignores areas of critical epidemiologic importance. Best country practice seems to require an holistic analysis in which a range of data including unmet need for adult and pediatric treatment, ANC data, mobility of target populations, site level yield and volume analysis, expert opinion, presence of key populations, and advice from communities are combined to identify prioritization of limited resources rather than arbitrary cut-offs, or
   b. **Low epidemic/need or just bad programs?:** Some countries propose moving out of low-yield sites that are in comparatively high burden and/or prevalence areas or very near high-yield sites. We are very concerned that the most likely issue facing these sites is poor programming, not saturation or low need—poorly performing programs that do insufficient outreach, are unwelcoming to key populations, are poorly administered, etc. lead to low yield and may drive people to nearby programs. No COP we have seen has accounted for this likelihood effectively. One country has described 1) verifying the sites actually exist and then 2) disaggregating sites according to multiple factors such as when they were accredited (for ART sites) and how far they are from another facility providing similar services.
      PEPFAR's site level analyses in particular have never been undertaken on such a scale, and many of our partners are concerned about the veracity of the data and about PEPFAR country teams COPs over-interpreting or over-relying on these data separate from the local context.
   c. **"Transition" of programs:** We see plans in several countries to "transition" ART, eMTCT, OVC, VMMC, and other programs—yet no COP we have seen has put forward a clear, costed transition plan that includes identifying exact responsibility for ongoing service delivery and scale up, tracking patients, monitoring continued quality,

and ensuring a PEPFAR partner is responsible for intervening if problems arise. As we saw in South Africa, a lack of such specifics means patients lost to follow up, diminished program quality, and wasted investment. In some COPs, in fact, countries are stating that transition will happen with no plan for continuation.

d. **Overlap between PEPFAR and the Global Fund and/or government-funded responses:** While geographic focus can make sense and PEFPAR cannot provide all of any country's response, there is also a core need to avoid duplication. In several countries GFATM and PEPFAR propose focus on exactly the same places—which would leave other areas with relatively smaller but still very significant epidemics with near zero support. This is a recipe for failure, especially when populations are mobile and significant populations at high risk are in areas of lower prevalence and/or burden. In countries where the Global Fund has already released results of the application, it is important that PEPFAR looks into the gaps as well as the unfunded quality demands to avoid duplication. The same needs to apply to government funded responses gaps.

2. **Meeting the needs of key populations and priority populations:** Key affected populations—in particular criminalized and marginalized groups such as men who have sex with men, sex workers, and people who inject drugs—appear as a priority in all countries, a focus by PEPFAR that is especially important and welcome. Overall, however, we see very little detail in the COPs about exactly what will be different for MSM, CSWs, and people who use drugs in FY2016 because of PEPFAR investments. IDUs seem neglected completely in some COPs. In addition, reaching key populations in de-prioritized geographic areas does not appear to be a consideration in some COPs—but epidemic control requires extending prevention and treatment services to them. Overall many COPs seem to lack:
    a. Details about how exactly key populations will be reached and with what services, including services designed to address the discrimination and criminalization they experience
    b. Budgets for key population-specific programs
    c. Key population service delivery sub targets
    d. Attention to how existing services will be made accessible to key populations and how systemic barriers to access will be addressed, and
    e. Indicators of success in this area.

In addition, we note that surveys and estimates of populations are missing in many countries, even where work has been done and funded by the USG. In two countries data have been collected using USG funding but are being withheld by country governments; we strongly urge PEPFAR to work with civil society to plan to make these data available through other channels.

Several countries present lack of data as a reason for not scaling up key populations programs—this should not be acceptable anywhere. There is no need to wait for data before planning initial scale up—which itself will help illuminate need and population sizes.

Especially in the context of geographic and/or population focus, there is a real danger that key populations facing high burdens of HIV but living in lower-burden geographies will be ignored—they are often not captured by ANC data. Low yield sites, in fact, may be situated amidst high key population need but marginalization, stigma, and lack of training result in no uptake among the right population. No COP we've seen has addressed this issue sufficiently.

3. **HIV treatment adherence, viral suppression & community-based programs:** Quite a few countries mention the goal of helping reach 90/90/90 targets and increase adherence toward viral suppression. We also know that community based client focused service delivery models of care have been proven effective and widely recognized as key in the HIV response. A few countries have specifics about an actual plan or strategy on how the patient groups and civil society organization will be involved and engaged in programmatic response that impact retention in care/adherence and viral load suppression.

   Most, however, do not:
   - **a.** Address targets and indicators to track success, including measures such as community-viral load suppression and improved retention in care/reduction in LTFU rates.
   - **b.** Include specifics in the COP about **how** the program will address this—what specific programs, community client focused models for introduction of viral load monitoring, at what scale, and where.

   We urge PEPFAR to significantly strengthen its focus across all countries on requiring all implementing partners to invest significantly and partner with local civil society organizations and PLHIV groups in programming and strategies that are patient focused and adapted to the realities and needs of the clients closer to their communities. Adherence support and treatment literacy with the goal to reaching viral load undetectable should be a top priority of PEPFAR funding. Counselling and peer support both at initiation and long term retention in care are particular areas where PEPFAR could focus on through investment in lay counsellors (community based health workers, peer and expert clients) .

4. **Technical assistance vs. direct service delivery:** A subset of PEPFAR countries seem significantly overinvested in technical assistance over direct services. Some countries, for example, invest far more of their "clinical" program funds in TA than in direct services. This includes countries where more than a decade of TA has already been provided. At this stage we are not even sure what it means to "rapidly scale up" technical assistance in COP 2015.

   We therefore have the following questions we would like to see answered for each COP:
   - **a.** What are the commodities PEPFAR is purchasing and in what quantity?
   - **b.** How many direct-service staff salaries & retention incentives is PEPFAR paying for?
   - **c.** **What proportion of people newly enrolled are predicted DSD/indirect/TA?**
   - **d.** In the geographic areas where you plan to focus, what % of the total cost of direct program is each person PEPFAR plans to claim as "reached" being covered?
   - **e.** What is the justification for technical assistance as the biggest priority?
   - **f.** How will the success of TA be measured?

   TA has a clear role in many places—it can make a significant difference when it is directly linked to expanding direct service delivery and improving quality in measurable ways. Nonetheless there is a trade-off for funds that could otherwise go to addressing the unmet need of PLWHAs for treatment or marginalized people for effective prevention tools—considerations that should be far clearer in many COPs.

5. **VMM Circumcision:** Several countries seem to be reducing targets or failing to accelerate VMMC sufficiently for FY16. In several countries it seems that the end of central funds allocated specifically for VMMC in the last two years is not being made up for in national funds—resulting in substantially lower targets proposed, including in countries with huge opportunity for impact. In other countries, larger budgets for treatment are described as displacing VMMC funding. This is especially confusing in countries that are significantly invested in technical assistance and health systems work that, while important, is unlikely to

have the more urgent impact of investment in VMMC in the coming two years. In each COP we would like to see the 2015 expendiures and targets compared with the 2014 expenditures and targets, as well as a mapping of how the geographic prioritization which, in most cases, is driven by scale up of ART, is affecting VMMC programming. Are there SNUs that are high performing for VMMC but low priority for ART? COPs should identify these areas, provide a clear statement on the budgetary and target gaps, a justification for these reductions, where they exist, and a plan for how to support immediate efforts to fill these gaps—such as working to reprogram funds and identify other donors and national VMMC support where possible..

6. **Health workforce:** For many PEPFAR countries, lack of sufficient, trained, motivated, and equipped health workers is among the biggest barriers to scale up of HIV testing, treatment, prevention, and care services. This issue is addressed in several countries, however we are concerned because:
    - **a.** Several COPs lack a substantive analysis of skilled and lay community based health worker shortages as a barrier to care and acceleration which are essential to achieving the ambitious scale up plans
    - **b.** Most COPs do not make clear how many staff are needed to achieve scale up and what PEPFAR will do beyond training—including salaries, top-ups, transport needs, etc. for professional as well as non professional staff.
    - **c.** Others actually plan to "transition" staff from PEFPAR support within the next year to two years without clear evidence government can pick them up, and without analysis of what this would mean to scale up efforts. It may be that this is an appropriate and important strategy—moving more trained, competent health workers into the public health system—but it requires greater attention and planning.

7. **Defining "direct" and Global Fund vs. PEPFAR investments accurately:** The issue of "counting" contributions is complex and duplication in "counts" is inevitable since at the facility a mix of PEPFAR, Global Fund, national government, and other donor funds all support the care of many of the same people. COPs seem to still be using very different understanding of what it means to support a person on treatment, however. The PEPFAR definition of direct service delivery (DSD) which is services that are both critical and routinized does not seem to figure clearly in the COPs and is, perhaps, insufficient for clarifying these issues.
   An analysis of treatment budgets (minus TA, percent of which is often not clear) divided by targets for treatment suggests that in some countries PEPFAR is supporting far less than half the cost of each person "claimed." This is problematic for disease control and planning since it suggests that no one has a clear picture of just how many actual, additional people will be enrolled on ART in a country on a given year since PEPFAR + GFATM + Govt targets all overlap—and are sometimes *less* than the sum of their parts. This needs to be addressed. PEPFAR cannot and should not be counting every person on treatment in a country or region as "supported" if there's no direct connection of that patient to PEPFAR funds. Some countries do a good job of making this clear, but for others it is not clear in the COP.

8. **Engagement of civil society:** Several countries have done a thoughtful job under complex and changing circumstances to bring civil society to the table in a meaningful way. Those country teams engaged CSOs early, were transparent, made it clear what questions were on the table, shared data in real time even when it wasn't finalized (making caveats), erred on the side of including more civil society rather than fewer, and sought input on the key decisions being made. They then shared back the draft plans, targets, and SDS before it

was submitted for direct feedback from CSOs and incoporated changes, making clear to everyone that it was not finalized but instead open for negotiation. No country did this perfectly, but several showed clear signs of trying hard and of moving beyond an understanding of civil society engagement as 'sharing updates' to seeking concerns, analysis, and even constructive disagreement.

Unfortunately, quite a few countries seem to have resisted meaningful engagement or proved ill equipped to engage effectively to ensure that the COPs process was transparent, accountable and actually gathered important insights from civil society that made the COP stronger. There was no compliance with the minimum standards described in the 2015 COP global guidance. Specifically we saw countries that:

- **a.** Refused to share the data for months because it was not yet "approved"
- **b.** Refused to share the list of geographic focus locations, especially sites, until they were "finished deciding" or "agreed with government"—meaning that insights from civil society could not inform them. Knowledge such as, for example, which sites might be underperforming because of poor programs or whether key pops were accessing services in poor-performing sites was not incorporated into the COP.
- **c.** Held sessions in which only broad generalities were shared—a broad generic "PEPFAR 3.0" slide deck, for example. Feedback at that level might be a starting point, but without details CSOs cannot meaningfully comment on what PEFPAR is actually planning in country. Several CSOs report they did not receive targets, goals, budgets, or central activities *ever*, or in some cases until it was too late. Input gathered only at the most generic level is likely to be of little use in actually informing the COP and improving PEPFAR programs.
- **d.** Ran out of time—details came last minute and therefore feedback was not able to be given beforehand
- **e.** Unnecessarily restricted which groups could have access to data, rather than engaging diverse groups of civil society.
- **f.** Applied different standards of civil society engagement to planning for the COP versus for DREAMS – in some instances, civil society were told that the DREAMS plans were only being shared with implementing partners; that they had already been submitted and that their contents were final. Given the potential for DREAMS to introduce innovative comprehensive SRH services and to explore PrEP, it is essential for civil society engagement in these plans to parallel the openness, collaboration and iterative consultation that characterizes COP processes at their best.

In many countries information was only made available verbally or via in-person presentation and **data and drafts were not shared ahead of time or after the fact.** This made it nearly impossible for CSOs to consult their colleagues and gather information from communities and talk with each other to develop meaningful high level feedback. Successful coordinators shared data openly and in advance in order to avoid a situation where civil society had to react essentially on the spot, with individual opinions rather than considered, more representative positions.

In addition, and worryingly, some PEPFAR staff designated only some CSOs to receive input from—directing all others to go through the selected few in order to get information and/or submit input. PEPFAR should **not** be in the business of talking only to a select group, especially when members of that select group **hopes to** or **is currently** receiving PEPFAR funds. They should also not place the burden of sharing PEPFAR's information with CSOs on some small group of other CSOs. Effective coordinators shared information with all who asked (which was

in no case a prohibitively large number of groups) and created clear, easy pathways for any CSO with input to provide it (via email, through a designated staff person) without creating gate-keepers out of other CSOs.

Most importantly, effective coordinators came to the process with a clear intention and spirit of collaboration, and a willingness to change course where something was not working. It was neither a one-way conversation in which PEPFAR presented information nor that PEPFAR simply listened. Instead it is in an attempt at dialogue, with give and take and negotiation, that meaningful engagement occurs.

9. **COP Review Process:** The COP Reviews are more open in the current round than they have been historically. This is a welcome change. Yet, there are still substantial improvements to the process and structure of the agenda that could be made to address civil society concerns regarding the level and sincerity of engagement. Initially, civil society representatives at the COP Reviews have a very limited time to engage with country teams regarding the content of the SDSs and this time comes at the very end of the review – after country teams have already had their final review meetings with Amb. Birx and OGAC.

   Additionally, some presentations for civil society from the country teams have dominated the time available for engagement and presented only the information that civil society representatives already knew from having read the SDSs distributed prior to the review. This was especially true in the case of Kenya. Given the tight window of opportunity to engage, this time would be better spent only going over the changes to the SDSs that have been made over the course of the week and responding directly to the concerns that were presented by civil society groups in advance of the Review. Ideally, these presentations should also be kept very short to preserve as much time for questions, clarifications and more substantive engagement as possible.

   Finally, the final plenary occupied 3 hours of time at which very little of substance was produced. We believe this time could be better spent extending the period of engagement with civil society. Additionally, the final plenary calls for a presentation on the concerns expressed by civil society throughout the COP Review, but this presentation is made not by a civil society representative who can better frame the concerns but by an OGAC representative. At Frankfurt, civil society was also given a slot in which to provide comments alongside an OGAC representative, but this slot was only made available at the last second and created a difficulty for developing a consensus civil society statement as well as occupying more time than was necessary.

10. **COP Guidance Development:** Ultimately, the content of COPs and SDSs are defined and determined by the COP Guidance that is developed by OGAC. After its publication, the strategy and content of what will be contained in country SDSs are essentially already determined, even if local context can still amend some of the specifics. Thus, given the critical nature of the COP Guidance documents, we believe civil society groups should be actively engaged throughout the development of the Guidance document prior to it being finalized and distributed to country teams to develop their COPs.

We therefore suggest several corrective actions:

1. Work with global partners to gather as much input as possible even after COPs have been submitted leading up to the COP review, especially in countries where feedback was non-specific. Provide CSOs who ask for it a copy of the submitted

SDS. Provide contact information for formal comments to be submitted to both country teams and country chairs in advance of COP review sessions.

2. Establish a clear way in which the new quarterly reviews can become meaningful, engaging opportunities for dialogue—open to those who want to engage, and applying the lessons from the COP reviews.
3. Plan for a new way of doing business going forward in which staff are in place in each country with clear competencies in dialogue, negotiation, and civil society engagement.
4. For future COP Reviews, move the 2 hour block of time for civil society to engage with country teams from Friday to Thursday. We believe it is essential that civil society's comments are heard before the final review by OGAC.
5. Advise country teams that the opening presentations for civil society during the Review should be limited to 20 minutes and focus only on: A) Critiques of the submitted SDS made by OGAC over the course of the week and the changes that are being made as a result; and B) Point by point responses to any input that's been provided by civil society organizations prior to the COP Review.
6. Allow a civil society representative to present the consensus concerns during the final plenary, rather than them being presented by OGAC.
7. In the future, work with civil society groups at the global and local level to develop the COP Guidance. Ensure that civil society can substantively comment on the Guidance prior to its finalization.