

LIU LATHU MU COP 19

COMMUNITY PRIORITIES

PEPFAR COUNTRY OPERATIONAL PLAN 2019 – MALAWI





“We are Malawians. We know what our people want.”

Gift Trapence, Executive Director, Centre for Development of People, Malawi



HIV remains a public health threat for Malawi. Currently there are 1 061 459 people living with HIV in the country, yet only 796 100 are on life-saving HIV treatment, leaving a quarter of people without access¹. At the same time, we are not closing the tap of new infections fast enough.

According to the PEPFAR’s 2018 data, while 118 059 people initiated on treatment (TX_NEW) during the year, treatment rolls increased by only 69 197 (TX_NET_NEW) by the end of Q4. Analysis at a district level shows that many of the highest priority districts achieved less than 60% of their Net New goals including: Blantyre (60%), Mangochi (51%), Zomba (41%), Chikwawa (46%), Mulange (50%), Thyolo (44%), and Mzimba (32%), with other districts not doing much better. This points to both challenges in diagnosis and retention. Several priority districts saw 9% or more of their total people on treatment lost by the end of 2018 including Lilongwe (11%), Mzimba (11%), and Zomba (9%). Blantyre and Thyolo, on the other hand, seem to be doing better on retention but significantly lagging in identifying undiagnosed PLHIV. One question is what is Blantyre doing well to retain this percentage of people in care – and how can other districts learn from these successes?

In terms of linkage: Blantyre (74.95%), Chikwawa (76.02%), Machinga (69.42%), Mangochi (78.44%), and Zomba (77.48%) all fail to reach even 80% linkage to care from those testing positive (HTS_TST_POS) to those initiated onto treatment (TX_NEW). Focus needs to be put on these districts to improve these rates.

At the same time as facing these challenges in HIV, the country faces a major dual tuberculosis (TB) burden. According to the World Health Organization (WHO), Malawi remains in the top 20 countries with the highest estimated numbers of incident TB cases among people living with HIV - with 12,000 incidents of TB found in people living with HIV in 2017².

In December 2018, members of the Civil Society Advocacy Forum (CSAF) and other partners carried out an investigation into the state of HIV and TB services at eight PEPFAR supported Health Centres in the districts of Blantyre (Chikowa Health Centre, Chirimba Health Centre, South Lunzu Health Centre and Zingwangwa Health Centre) and Mangochi (Chiponde health Centre, Malembo Health Centre, Nankumba Health Centre, and Nangalamu Health Centre). The monitoring tool used has 45 questions that assess the state of HIV and TB services that a primary healthcare facility should offer and the quality of these services. The questions, developed in consultation with CSAF members, are designed to address the key concerns for people living with HIV and TB (including those facing barriers to HIV and TB services including key populations, adolescent girls and young women (AGYW) and men). This local level facility monitoring revealed both successes to be learned from and expanded upon, but also challenges that need urgently addressing in the provision of HIV and TB services. A detailed report compiled by the CSAF and partners has been developed and a number of issues have been unpacked in the demands below.

1. Malawi Integrated HIV Program Report 2018 - Q3 appendices.

2. Global TB Report, 2018. World Health Organization (WHO). Available at: <https://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf?ua=1>

PRIORITY INTERVENTIONS FOR COP19

1. Fund 100 community nurses and 1 000 community healthcare workers at the frontline of the HIV and TB response.

In recent years PEPFAR has shifted toward significant support for HRH in Malawi—which has been one of the key enablers for Malawi’s success compared to some neighboring programmes. However, data from 2018 shows that most of the PEPFAR priority districts struggled in both finding undiagnosed PLHIV and enrolling and keeping them in care. In Blantyre, Mongochi, Zomba, Chikwawa, Mulanje, Thyolo, and Mzimba the “new” enrollments on treatment were below 60% of the targets. Human resource shortages remain a major critical issue in Malawi which affects healthcare delivery.

The National Community Health Strategy 2017-22³ notes that over 7 000 additional community healthcare workers (CHWs) are needed, a significant portion of which is necessary for the HIV response. Ensuring access to quality healthcare services and ensuring everyone living with HIV and TB gets access to prevention, treatment and care depends largely on having a strong and effective health workforce in place. Malawi has only around 0.51 professional health workers per 1,000 inhabitants. This is only approximately one ninth of what the WHO calculates a country needs to realise Universal Health Coverage and the Strategic Development Goals (SDGs). The Malawi Human Resources for Health (HRH) Strategic Plan 2018-2022 identifies inadequate and unsustainable funding as critical bottlenecks for HRH in Malawi. Overall there is vacancy rate of 51% for all cadres. However, instead of filling in the vacant posts and ensuring that there are enough health workers to effectively provide services to those in need, freeze caps have been reported, created by Ministry of Finance in coordination with International Monetary Fund (IMF) which have halted recruitments in recent years. This has led to increased congestion in health facilities, long waiting times and increased pressure on the few staff in place, adversely impacting on quality HIV and TB service delivery.

Our recent fact-finding mission to eight facilities across the districts of Blantyre and Mangochi found that patients at the majority of facilities (6/8) thought there were not enough staff, while 2 sites were inconclusive. At the very least, this finding shows that a substantial number of people dependent on the public healthcare system perceive facilities as being understaffed. In terms of waiting times, patients at half the facilities (4/8) reported waiting more than two hours to access health services which is hugely disruptive for people, with two facilities having inconclusive data.

Further information gathered from members of HIV support groups in the districts painted a worse picture with one participant stating that “**we come to the health centre knowing full well that we may spend the whole day there. Of course, we stay for hours to get our medication**” and another stating that “it takes 3 to 7 hours to get medical help due to having one medical assistant”. Healthcare workers at the facilities confirmed the challenge of human resource shortages, explaining that both in facility and community-based healthcare workers were overwhelmed with work.

In addition to contributing to long waiting times to collect medicines and access healthcare services, the staff shortages

also detrimentally impact on HIV linkage and retention in care. Inadequate numbers of peer educators and counsellors mean that people who attend the facility for HIV testing fail to get adequate counselling and support. This can lead to challenges in retention, as people default on their treatment. While expert clients are being utilised for defaulter tracing in certain facilities, the shortage in community-based healthcare workers means that there is a gap in health promotion, HIV & TB prevention information and resource provision, and support for linkage and retention in care. Further, with shortages in staff, limited outreach can take place specifically to marginalised communities at higher risk of getting HIV such as female sex workers.

In order to ensure an effective HIV and TB response, we require a surge in the number of community-based healthcare workers, working in the frontline of healthcare delivery. This must include the maintenance of COP18’s 100 community nurses and the addition of a further 100 community nurses and 1 000 community healthcare workers (CHWs) in COP19. COP19 must clearly identify how many health workers are being funded by PEPFAR, at what level, and in what district.

PEPFAR must implement this surge of community-based nurses and healthcare workers in line with the National Community Health Strategy (NCHS) 2017-2022 to ensure quality, integrated community health services which are affordable, culturally acceptable, scientifically appropriate, and accessible to every household through community participation. The NCHS (2017-2022) focuses on multiple areas such as integration of health services; community engagement; sufficient and equitable distribution of well-trained community health workforce; sufficient supplies, transport, and infrastructure, and more. This will contribute effectively to the attainment of national and international goals in particular Sustainable Development Goal (SDGs) 3 of Universal Health Coverage.

COP19 must maintain the 100 community nurses committed to in COP18 and fund an additional 100 community nurses. In addition, COP19 must fund 1 000 community healthcare workers (CHWs) through the public healthcare system to work on the frontline of the HIV and TB response. These community nurses and CHWs should be prioritised in PEPFAR sites with the highest human resource shortages and prioritising larger sites. The health workers should be fully integrated into the facility and relieve the burden on existing staff.

3. National Community Health Strategy (NCHS) 2017-2022. Available at: https://www.healthynewbornnetwork.org/hnn-content/uploads/National_Community_Health_Strategy_2017-2022-FINAL.pdf

2. Improve linkage and retention rates by ensuring 100% of PEPFAR supported health centres are supporting functional community ART groups (CAGs) and have support groups in place by end of COP19 and funding an expansion of community lead treatment literacy efforts.

2a. Ensure 100% of PEPFAR supported health centres have functional CAGs and support groups.

COMMUNITY ART GROUPS: It is well known that each time someone is asked to return to the health centre or spend an extended time at a health centre, there is an increased risk of losing that person to care. Yet this is the case in most facilities in the country. People living with HIV report the inconvenience and cost of travelling long distances and then waiting many hours to be seen by health workers to simply collect ART refills. In some facilities people report travelling as far as 20 km (Nankumba Health Centre) or even 34 km (Nangalamu Health Centre). In a conversation with an HIV support group we heard that **“they walk for 3 hours to get to the clinic. They pass through a river and when it floods, they end up going to Mozambique then back to Malawi”**. For people who are stable on ART, there should be an option to utilise a community adherence group (CAG) for faster, more convenient and cheaper ART collection. With a more than 40% of people newly initiated on treatment in COP17 disengaging in care by the end of Q4, it is critical for PEPFAR programmes to address retention rates with community supported approaches.

In CAGs, which are managed by the recipients of care themselves, people living with HIV receive their ART refills in self-managed groups. The group usually meets outside of healthcare facilities and works on a roster system sharing pickup and distribution duties. It is made up of between four and 15 individuals. This is not a new idea. CAGs have been piloted in Mozambique with benefits including increased peer support, reduced time and costs associated with collecting ART refills, and stronger engagement of the community in HIV care. In Zimbabwe, an adaptation to the model was implemented based on feedback from PLHIV. The Community ART Refill Group (CARG) was changed according to the local context (wherein members had access to three-month refills and yearly clinical consultations) and in line with PLHIV preferences for bigger groups.

In Malawi, the CAG model has also been piloted by Médecins Sans Frontières (MSF) in the Thyolo district, reaching more than 5 000 people living with HIV. A study by UNAIDS, NAC, MSF, and Mothers 2 Mothers on the impact of CAGs in Thyolo found that retention in care rates (two years after the introduction of CAGs) was 96.8% for CAG members as compared to 94% for non-CAG patients in the study group (who were also stable patients)⁴. The introduction of CAGs reduced the number of ART refill visits per person per year from 8.02 to 4.58. With increased adherence and retention rates, the programme reduced the number of people defaulting or lost to follow up compared to the conventional ART programme outcomes. We are aware that the major concern against using CAGs is the so-called threat of ARVs being stolen - however based on the pilot projects run by MSF and in other countries, this threat is unfounded.

When we shared the concept of CAG during our focus group discussions, there was a great demand from the PLHIV support groups to join them. CAGs would in their opinion **“minimise**

missed appointments due to the long distances”, be **“less time consuming”**, and also be **“helpful as it’s not all the time one has transport [money] to come to the health centre”**.

We must consider the needs of people living with HIV when developing programmes, especially for people who are stable on ART. While Malawi is leading the way in terms of multi month scripting, collecting ART refills every three months is not a panacea to the challenges described above. In order to really address the losses associated with frequent and extended clinic visits, PEPFAR supported sites must adopt new approaches such as CAGs.

SUPPORT GROUPS: Effective pre and post-test counselling remains an essential part of the HIV treatment programme. Any expansion in treatment provision must be accompanied with a corresponding expansion of human resource capacity to ensure that effective counselling and treatment support services can be provided. Just like people have a right to access treatment, people also have a right to be accurately informed about all the risks and benefits of starting ART. It is also worth noting, in the context of same day ART initiation through “test and treat”, that many people will start ART with high CD4 counts, and may never have experienced any severe symptoms or illness related to HIV. Hence effective counselling is essential to ensure effective treatment adherence amongst this group of people.

At each facility there needs to be a streamlined system of preparation and counselling provided by healthcare workers and peer counsellors. In the context of “test and treat”, the emphasis must be shifted from pre-testing and pre-initiation preparation to strengthening post initiation support. Pre-initiation education can be limited to essential information needed to start treatment, subsequently followed by deeper counselling on adherence. This links back to the need for more health workers (including peer counsellors) to effectively take on this important burden. Especially true as more people are initiated. Individuals newly initiated should be immediately linked to expert recipients of care and mentor mothers, as well as a support group.

In terms of long-term adherence, much more needs to be done to provide counselling, mental health services and other adherence support to prevent people defaulting and being lost to follow up. Some of the reasons behind stopping treatment (outside of the logistical barriers) include anxiety, depression and stigma. Through our fact-finding mission, stigma at community level was reported repeatedly, causing people to either access services far from home, or default altogether. In terms of mental health, the reality is that there is limited support for people facing mental ill health within the health system. This is coupled with societal views that depressed people should simply pull themselves together and be positive – which is less than helpful advice to people experiencing sometimes devastating physical symptoms as a result of mental ill health.

Support groups linked to each public health facility are critical to bridge this gap, to provide counselling and support services to people newly initiated on ARVs as well as those struggling on treatment. Support groups provide a platform for people to share their experiences of living with HIV, talk about how

4. “Engaging the Community to Reach 90:90:90”. UNAIDS, NAC, MSF, and Mothers 2 Mothers. Available at: https://www.msf.org/sites/msf.org/files/engaging_the_community_to_reach_90-90-90.pdf



they are feeling, and find out more about HIV. This is critical to helping keep individuals both physically and mentally well. Support groups may at times need to be aligned to the specific needs of members who may be from different populations, backgrounds, ages etc. To be successful, where necessary, considerations should be taken to establish population specific support groups (youth, men, KP etc.) as required by the communities accessing these services. Further discussion with civil society groups should be held on this matter to support this implementation. Health surveillance assistants (HSAs) and community healthcare workers (CHWs) should be linked to support groups in order to ensure better linkage to healthcare services where needs arise and to provide updated information and training on the science of treatment and adherence.

By the end of COP19, PEPFAR must fill the human resources and other gaps to ensure 100% of sites in PEPFAR scale-up districts have functional community ART groups (CAGs) and support groups (including population specific groups such as male and youth where necessary) in place. These will reduce the burden on health centres, provide better access to treatment and support, and improve overall linkage and retention rates.

2b. Fund widespread community and peer led prevention and treatment literacy efforts.

Currently individuals are being lost in several places in the HIV cascade including between testing HIV positive and initiating on treatment, and between initiation on treatment and long-term adherence. In addition, we are still seeing large numbers of new infections. Strategies targeting these losses must be implemented; including through providing widespread treatment literacy in the country.

The teaching of the science and treatment of HIV/AIDS, STIs, TB and other diseases through a community and peer led prevention and treatment literacy programme will be critical to help people understand the importance of taking HIV and other treatment as prescribed. Treatment literacy is empowering for community members. Knowing that an undetectable viral load improves your long-term health and means you will not transmit HIV to sexual partners is empowering for people living with HIV to take control of their own lives. Being treatment literate helps keep individuals both physically and mentally well and reduces the likelihood of becoming treatment fatigued or defaulting on ART. In addition, the promotion of prevention information/ methods and the importance of testing will allow people to either remain negative, or to provide a link to care. It can also improve the uptake of services such as PrEP, self-testing, viral load testing and other new interventions that will arise.

Treatment literacy outreach should also take place amongst faith based organisations, faith healers and within churches. Often people are being fed incorrect information through the church platforms and from faith healers. It will be important for community groups to have resources to carry out this engagement effectively and promote correct HIV prevention and treatment literacy information in these platforms and publicly.

COP19 should fund trainings to take place at community and health centre level. In addition, accurate and informative materials related to prevention, adherence and treatment literacy should be developed by PLHIV led and community based organisations and also disseminated through localised social mobilisation campaigns.

COP19 must fund at least 15 community and PLHIV lead organisations in Malawi to develop prevention and treatment literacy programmes relevant to those communities across the country to include trainings (at community and facility levels) and the development and dissemination of easily accessible and understandable materials.

3. COP19 must support PLHIV to stop HIV transmission by supporting the roll out of T=T in Malawi. Every PLHIV must receive at least annual viral load, for which either PEPFAR or Global Fund resources are needed, and PEPFAR must support community based PLHIV organisations to engage in demand creation activities. PEPFAR must also support guidelines on DTG in line with WHO recommended language that allows women to make an informed choice on DTG based regimens.

It is empowering for PLHIV to understand their own viral load and what this means for their long-term health and their risk of transmitting the virus to another person through sexual intercourse. There is clear evidence that early treatment benefits the health of people living with HIV, as serious AIDS-related events like cancer and TB can be prevented. Research has also shown that people on ART with suppressed viral loads will not transmit HIV. It is imperative that all people living with HIV on ART should be given a viral load test at least annually and that they should be provided with their test results.

As Malawi begins the transition to a dolutegravir based regimen, it is critical to ensure that all the components are in place to ensure success. One such aspect, is to ensure that all people living with HIV receive a viral load (VL) test, that is shown to be undetectable, before the switch. The WHO recommends that people already taking another first-line regimen can be switched to tenofovir, lamivudine, and dolutegravir (TLD) if they have a viral load below 1000 copies/ml. However, if the regimen is failing and the individual has a higher viral load, resistance to lamivudine and tenofovir is likely to be present, weakening the antiviral potency of dolutegravir-based regimen. If the new regimen fails to suppress viral load, and keep it suppressed because of resistance to tenofovir and lamivudine, the consequence could be the development of resistance to dolutegravir too. That would remove the option of using dolutegravir in second-line treatment and require the use of a more expensive protease inhibitor instead. It is therefore imperative that all people be given a VL test ahead of switching to TLD.

The WHO currently recommends at least one viral load test per year, yet in Malawi people on ART are only receiving a test every two years, and we have varying reports on how many of these people actually receive these VL tests. Worse is that many people report waiting a long time or never receiving the results of these tests and losing enthusiasm to ever take a VL test again.

To better understand the state of our AIDS response, it is important that we do not only analyse the number of people who have initiated on ART, but also at whether these people remain in care and healthy with suppressed viral loads. Publicly reporting such figures will create greater accountability in the healthcare system and help flag underperforming districts or health facilities. At the moment much of this data is not publicly available – making it harder to hold underperforming health facilities and districts accountable. Retention in care, viral load coverage and viral load suppression rates must be published regularly for all health facilities and all districts.

More broadly in terms of the transition to TLD, Malawi is facing a further challenge in terms of guidelines. The current guidelines state that DTG-based regimens are not to be used as standard 1st line regimens for women within the fertility age range – and can only be given to women above 45 years old or those on permanent contraceptive. There is a caveat that DTG based regimens can be offered to women “on request”, however that the decision will remain with the healthcare worker and will be based on “sufficient information”

provided by the woman. This means currently in the transition, women of childbearing age are being denied access to a more efficacious medicine, and placing the final decision with the healthcare worker has removed the power from women to make independent choices. It remains unclear on what basis is the healthcare worker making the decision.

PEPFAR Malawi must support guidelines that state what sufficient information from women is needed to access DTG and develop a checklist that healthcare workers can use in making an assessment. The country needs to make it clear that the DTG based regimen (TLD) is also a preferred regimen. The guidelines should ensure that women are informed about their options and able to choose a DTG based regimen.

Finally, to ensure a successful transition it will be critical to ensure sufficient financing for community based PLHIV organisations to engage in demand creation activities at a local level, in order to promote uptake of DTG.

In COP19 PEPFAR must renew its commitment towards the T=T campaign including ensuring annual viral load testing in all PEPFAR supported districts and providing resources for community based PLHIV organisations to engage in demand creation activities. PEPFAR must also support national guidelines on DTG in line with WHO recommended language that allows women to make an informed choice on DTG based regimens.



4. Fund the procurement of HIV self-testing kits as part of a comprehensive HIV testing programme in Malawi.

In Malawi, while 796,100 people living with HIV are documented to be taking treatment, more than 265,359 people are still unable to access ARVs, many of whom are unaware of their HIV status. This is particularly true for marginalised groups of people who face various barriers to accessing HIV testing and treatment services and for men who are less likely to interact with the healthcare system.

The 2018/2019 development of National Guidelines for self-testing, PrEP and voluntary assisted partner notification (VAPN) creates an opportunity and necessity for Malawi to create a coherent testing strategy that takes full advantage of evidence, and takes what works to scale. Matching procurement of self-test kits, staffing of lay and peer counsellors, and programme designs that prioritise linkage with tailored programmes can only be done with a wholesale integrated plan. PEPFAR requires development of these three policies; it should support and participate the process that brings a cohesive testing strategy into focus.

This should do the following: focus on models and populations where self-testing can have an impact in the short-term (male partners of women in antenatal setting) with structured programming to learn how best to use kits amongst other groups including partners of sex workers, MSM, young men and possibly Malawian adolescent girls and young women. Take concrete steps to monitor and remediate any adverse impacts of index testing. Ensure peer- and CSO-based provision and linkage wherever possible and particularly for testing with key and vulnerable populations. The mix of testing modalities matched to the population should be presented and discussed with civil society organisations (CSOs) representing people living with HIV and key populations.

COP19 must support scaling up of HIV testing, as part of a comprehensive HIV testing programme, in young people, marginalised and key populations who are not up-taking these services with a variety of steps including procurement of additional self-test kits, training of peer educators and outreach workers at community level so that services are accessed at the point of need. The scale up must also target the missing men who do not uptake services and HIV testing at health centres. Those who test positive should be referred into the public healthcare system for further tests. While focus has also been on female sex workers (FSW),

little efforts/emphasis has been directed at the clients of FSW. COP19 must intensify testing of clients of FSW as these have the potential to transmit HIV if involved with multiple sexual partners. There is need to devise comprehensive approaches to reaching out to clients of FSW one of which is through expanding access to self-test kits and required support services. Our focus group discussions with FSWs in Blantyre showed a great demand for access to self-test kits.

COP19 must fund a comprehensive testing approach inclusive of systematic monitoring of and prompt reaction to any evidence of adverse events associated with index testing; procurement of HIV self-test kits in Malawi to saturate whole districts and/or populations with the procurement investment tied to tailored programme design that ensures “quick wins” e.g. with male partners in antenatal setting, self-test programmes that build the intervention into successful AGYW and youth health programmes, e.g. youth clubs or adolescent friendly health services, with a linkage to treatment and prevention metric as a requirement, and continued use of community partners for facility-based testing that meets the needs of key populations, AGYW and men. COP19 must ensure that HSAs, expert clients, and peer educators are engaged to monitor, document and respond to harms related to index testing (either to individuals or to the reputation of facilities where index testing is being delivered), to provide and support self-test, and to link T=T messages to testing messages, as well as supporting referral and transfer to public health facilities for secondary tests and interaction with HIV and broader sexual health treatment, care and support moving forward. We reiterate that this programme should be run through primary health services to ensure proper and adequate linkage to care. These HSAs must be clear on issues facing key populations and not perpetuate stigma and discrimination at a community level.

5. COP19 must fund a comprehensive HIV prevention programme including an expansion of VMMC and PrEP roll out.

5a. VMMC expansion costed and discussed in COP18 as part of a comprehensive primary prevention strategy.

PEPFAR must prioritise primary prevention with an analysis of gaps, incidence rate, impact and budget that ties self-testing, voluntary active partner notification (VAPN), voluntary medical male circumcision (VMMC) and Pre-Exposure Prophylaxis (PrEP). For VMMC, COP19 must include the USD 8 million funding previously discussed for expansion and

achieve saturation in key districts. The VMMC programme must be accompanied by a comprehensive social behaviour change communication (SBCC) approach to create more demand so that more people are reached. The current numbers could be improved with a more comprehensive demand creation approach that address barriers to VMMC.

COP19 must allocate additional resources of USD 8 million to allow for the expansion and saturation of the VMMC programme in all PEPFAR supported districts as previously agreed upon.

5b. Ensure that key populations and AGYW most at risk of HIV can start and stay on PrEP for prevention.

Oral tenofovir, alone or in combination with emtricitabine (PrEP), is the only prevention technology that does not require partner knowledge or co-operation. There is strong evidence from many contexts that initial uptake is strong, while retention, especially for AGYW, drops dramatically within 30 days of roll out. Malawi's PrEP programme is overdue; it has the opportunity to build on these lessons by ensuring user-centered design including provider training, community-outreach and youth- and key population friendly service delivery models that support both initiation and retention. Sex workers enrolled under Pakachere's Chirimba Drop in Centre (DIC) (LINKAGES Project) in Blantyre in particular expressed great demand for PrEP amongst their communities.

COP19 should support large scale PrEP distribution targeting key populations and AGYW in each of the districts where PEPFAR has focused. PEPFAR should commit to supporting both the commodities and the user-centered design including provider training, community-outreach and youth- and KP-friendly service delivery models that support both initiation and retention. Programmes should target those most vulnerable to and disconnected from services, but place no restrictions on who can access it, including key populations and AGYW (whether at university, college, school or not in education). This must include community education efforts through the PEPFAR-funded HSAs and CHWs and at drop in centres (DICs) – with emphasis on safe, easy access that accommodates the unique needs and vulnerabilities of these target populations.

6. Expand provision of TB preventive therapy (TPT) to all PLHIV newly enrolled into care, and expand provision of TPT to eligible household contacts of PLHIV with active TB, with a special emphasis on reaching young children.

TB preventive therapy (TPT) is proven to reduce morbidity and mortality among PLHIV, including PLHIV on ART. For this reason, TPT should be considered a routine and integral part of the HIV clinical care package.

Malawi has scaled up TPT coverage through the use of isoniazid preventive therapy (IPT) in five districts, reaching 92% of the target (251,119 out of 271,619 people). Although these figures show progress, there is much progress still to be made in PEPFAR supported targets more widely in scaling up TPT to ensure that all PLHIV who are eligible for TPT are reached.

Given Malawi's high HIV/TB co-infection rates, in COP19 the country should aim to reach 90% of PLHIV using either IPT, or, preferentially newer regimens such as 3HP. To reach this goal:

- + All PLHIV should be screened for TB with the outcome of this screening one of two mutually exclusive clinical decisions:
 - 1) diagnosis of active TB and initiation of TB treatment; or 2) initiation and completion of TB preventive therapy.
- + All PLHIV diagnosed with active TB should receive household contact investigation to identify TB in their families and among their close contacts, with TPT offered to household members who screen negative for TB. Household contact investigation is especially important for preventing TB in young children who living in the same household as an adult with TB.

PEPFAR Malawi should aim to put a significant proportion of PLHIV who receive TPT or 3HP. While currently more costly than IPT, the 3HP regimen is shorter, safer, easier for people to complete, and has been shown to be as effective in preventing TB as IPT. In contrast, people living with HIV have provided us with reports of painful and unpleasant side effects and other difficulties in using IPT which reduces its uptake. Generic producers of 3HP are expected to enter the market soon, making it important for PEPFAR Malawi to lay the groundwork for transitioning more PLHIV to rifampentine-based TPT as the cost of rifampentine comes down and information on the safety of its use with dolutegravir becomes available (expected March 2019). Anyone receiving IPT should receive the fixed-dose combination of isoniazid/cotrimoxazole/B6 (Q-TIB), which is available for USD 1.99.

Children receiving TPT should receive the 3HR regimen, which is available in a child-friendly dispersible tablet. Children with HIV requiring TPT can receive 3HR if they are on efavirenz-based ART; children on nevirapine, lopinavir/ritonavir, or dolutegravir-containing regimens should receive IPT to avoid drug-drug interactions with the rifampicin in 3HR.

COP19 should expand provision of TB preventive therapy (TPT) to all PLHIV newly enrolled into care, and expand provision of TPT to eligible household contacts of PLHIV with active TB, with a special emphasis on reaching young children.



SPECIFIC LANGUAGE REQUESTED IN COP19

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP17 & DATA	LANGUAGE TO INCLUDE IN COP18	TARGET
	<p>1. Fund 100 community nurses and 1 000 community healthcare workers at the frontline of the HIV and TB response.</p>	<p>"In accordance with Ministry of Health and Civil Society recommendations for COP18, PEPFAR will recruit approximately 100 community nurses support implementation of VAPN and community ART initiation." (p74)</p> <p>"PEPFAR will support sites through strategic deployment of human resources for health (HRH) who will be responsible for the oversight of index testing scale up at the site level and ART initiation in communities." p41</p> <p>"Shortage of skilled human resources for health continues to be a challenge affecting all aspects of the clinical cascade. In COP16, PEPFAR received \$1.8 million in supplemental funding to implement a health care worker salary support intervention to address the excessive HRH shortages in PEPFAR supported sites in Lilongwe, Blantyre, and Zomba districts. To support the smooth transition to the Test and Start policy, PEPFAR programmed resources to recruit approximately 462 HIV testing services and ART providers (nurses, clinicians, and pharmacy and laboratory staff). PEPFAR will support the health workers, who the GOM employs, for a period of three years. In COP17, PEPFAR increased its support for HRH through implementation of a 480 person HRH surge in the five acceleration districts. Through COP17 HRH surge support, PEPFAR continues progress towards hiring goals of 120 VMMC providers and 360 ART providers in the five acceleration districts." p70</p>	<p>While continuing support for the existing deployed human resources, COP19 will fund an additional 100 community nurses and 1 000 community healthcare workers (CHWs) through the public healthcare system to work on the frontline of the HIV and TB response.</p> <p>The majority of these workers, while linked to PEPFAR facilities, will be focused on work in communities--in support of community-based efforts to increase high-impact testing and linkage and to ensure differentiated models of care including community-based ART are scaled up at all sites.</p>
<p>2. Improve linkage and retention rates by ensuring 100% of PEPFAR supported health centres are supporting functional community ART groups (CAGs) and have support groups in place by end of COP19 and funding an expansion of community lead treatment literacy efforts.</p>	<p>"PEPFAR Malawi implements various differentiated service delivery models, including: three-month ART scripting for patients adherent and stable on ART; integrated TB/HIV clinics; Antenatal care/ART clinics; teen clubs; and Community ART Groups (CAGs)." p74</p> <p>"Lay cadres (such as Expert Clients) play a leading role in treatment literacy, adherence counseling, and active defaulter tracing – as well as directly linking newly diagnosed PLHIV to same-day treatment initiation." p75</p>	<p>By the end of COP19, PEPFAR will fill the human resources and other gaps to ensure 100% of sites in PEPFAR scale-up districts are supporting functional community ART groups (CAGs) and support groups (including population specific groups such as male and youth) in order to reduce the burden on health centres, provide better access to treatment and support, and improve overall linkage and retention rates.</p> <p>COP19 will fund community and PLHIV lead organisations in Malawi to develop prevention and treatment literacy programmes across the country which include trainings (at community and facility levels) and the development and dissemination of easily accessible and understandable materials.</p>	<p>Target: 100% of sites in PEPFAR scale-up districts will have Community ART Groups (CAG) as well as support groups running by end of COP19 and will report portion of stable patients in CAGs. Each district will have identified communities for targeted group models of care based on adherence levels.</p> <p>Target: Fund at least 15 community and PLHIV led organisations in Malawi to develop prevention and treatment literacy programmes.</p>

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	<p>3. COP19 must support the roll out of T=T (U=U) in Malawi including ensuring annual viral load testing and resources for community based PLHIV organisations to engage in demand creation activities. PEPFAR must also support guidelines on DTG in line with WHO recommended language that allows women to make an informed choice on DTG based regimens.</p> <p>"In a phased approach, Malawi will put the first patient on TLD in June 2018. It is expected that less than 5,000 PLHIV will be put on TLD between June and December 2018 after which it will scale-up to transition over 98% of the patient population from legacy ARVs to TLD by July 2019 (Figure 4.4.1). Our commodities forecast indicates that between July and December 2018, Malawi will build up enough stocks to implement the scale-up beginning January 2019. This forecast also demonstrates that TLE (and other legacy ARVs) stocks will decrease at steady rate to pave way for TLD and avoid legacy ARVs wastage at the same time." p67</p> <p>"Malawi also takes TLD introduction as an opportunity to promote viral load testing, results delivery, improved clinical decision making and patient literacy. PEPFAR is eager to work with other stakeholders to develop a transformative approach to patient centered care that harnesses the pivotal transition to TLD to empower ART patients to demand viral load results as a means of leading in their own disease management. This initiative (still under discussion) will employ resources across a public-private partnership with organization such as BMGF, the Global Fund, UNAIDS, PEPFAR, Civil Society and the Government of Malawi." p68</p>	<p>PEPFAR renews our commitment towards the national T=T (U=U) campaign including ensuring annual viral load testing in all PEPFAR supported districts, SMS system to ensure results reach PLHIV, and providing resources for community based PLHIV organisations to engage in demand creation activities.</p>	<p>100% of people living with HIV on ART uptake a viral load test during COP19. All women are able to make an informed choice on whether to switch to/or initiate on a DTG based regimen in COP19.</p>
<p>4. Fund the procurement of HIV self-testing kits as part of a comprehensive HIV testing programme in Malawi.</p> <p>"Acceleration districts (representing 51% of the saturation gap) include a surge investment with active index testing, self-testing, saturation of facility entry points, and a human resources for health supported pathway to treatment or prevention interventions [including Pre-exposure Prophylaxis (PrEP)]" p3</p> <p>"In COP17, PEPFAR...will procure around 200,000 Oraquick HIV self-test kits. In COP18, PEPFAR will provide additional resources for... Oraquick HIV self-test kits (\$450,000)." p67</p>	<p>COP19 will fund a comprehensive testing approach inclusive of systematic monitoring of and prompt reaction to any evidence of adverse events associated with index testing; procurement of HIV self-test kits in Malawi to saturate whole districts and/or populations with the procurement investment tied to tailored programme design that ensures "quick wins" e.g. with male partners in antenatal setting, self-test programmes that build the intervention into successful AGYW and youth health programmes, e.g. youth clubs or adolescent friendly health services, with a linkage to treatment and prevention metric as a requirement, and continued use of community partners for facility-based testing that meets the needs of key populations, AGYW and men. COP19 will ensure that HSAs, expert clients, and peer educators are engaged to monitor, document and respond to harms related to index testing (either to individuals or to the reputation of facilities where index testing is being delivered), to provide and support self-test, and to link T=T messages to testing messages, as well as supporting referral and transfer to public health facilities for secondary tests and interaction with HIV and broader sexual health treatment, care and support moving forward. This programme will be run through primary health services to ensure proper and adequate linkage to care. These HSAs and CHWs must be clear on issues facing key populations and not perpetuate stigma and discrimination at a community level.</p>	<p>Target: 15% of new positive targets will be sought through self-testing modalities.</p>	

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	<p>5. Fund a comprehensive HIV prevention programme by:</p> <p>a. Expanding VMMC as costed and discussed in COP18 as part of a comprehensive primary prevention strategy,</p> <p>b. Ensuring that key populations and AGYW most at risk of HIV can start and stay on PrEP for prevention.</p>		
	<p>"In terms of population focus, reaching men 25-40 and youth <25 with testing and treatment remains the program focus, with offer of VMMC prevention services to targeted 15-29 year old HIV negative men, and primary prevention interventions, including DREAMS and pre-exposure prophylaxis for vulnerable AGYW and FSW." p27</p> <p>"In accordance with the GOM-recommended prevention package, PEPFAR implementers will refer men that test HIV negative post-test counselling prevention services (e.g., condoms, information, and education) and VMMC services (15-29)." p38</p> <p>"In November 2017, the GOM began work on a "100 Day HIV Prevention Roadmap and Action Plan" to reduce new cases of HIV by 75% by 2020. The HIV Prevention Roadmap and Action Plan focuses Malawi's HIV prevention priorities and uses the UNAIDS "Five Prevention Pillars" as a basis for a new HIV Prevention Strategy. The five pillars are: combination prevention packages for AGYW and their male partners; combination prevention programs for key populations; strengthened national condom programs; VMMC; and PrEP." p48</p> <p>"In FY18, PEPFAR and the MOH will implement a protocol for PrEP demonstration in Lilongwe to determine the feasibility of integrating PrEP provision for high risk AGYW into routine services." p52</p> <p>"PrEP: In FY18, PEPFAR submitted a protocol to evaluate PrEP provision to 560 HIV negative FSWs enrolled in three drop-in centers in Blantyre for a period of one year as part of KP HIV service delivery platform and delivery package. The activity will provide the evidence-base necessary to access the feasibility, acceptability, and tolerability of PrEP as an additional HIV prevention method for FSW and inform future policy decisions around PrEP delivery among key populations in Malawi. Scheduled for implementation in FY18 and FY19, expansion of coverage for FSW in these sites or other districts will be determined in collaboration with DHA. PrEP is anticipated to be part of the National Guidelines by December 2018 as a targeted intervention for high risk individuals." p60</p> <p>"In FY18, PEPFAR put in place strategies to address demand creation challenges and seasonality of VMMC campaigns, including the scale-up of static sites for year-round VMMC service delivery. In FY18, PEPFAR is providing technical assistance to MOH to finalize revisions to the VMMC National Communication Strategy, National VMMC Standard Operation Procedures and the HIV Prevention Strategy. All implementers developed specific demand creation and communication strategies with messages focusing on reducing VMMC barriers (e.g., pain) and communicating positive factors such as hygiene and sexual appeal. PEPFAR developed a site level capacity assessment tools in FY17 and implementers will develop site specific capacity improvement plans. COP18 will focus on increasing and scaling up innovative demand creation strategies targeting 15- 29 year-olds and sustaining demand throughout the year; strengthening linkage of HIV negative males from all HIV testing delivery points; and scaling up use of VMMC devices." p61</p> <p>In COP17, PEPFAR also provided additional resources for procurement of VMMC commodities... In COP18, PEPFAR will provide additional resources for VMMC commodities (\$2,906,740)... " p68</p>	<p>COP19 must allocate additional resources of USD 8 million to allow for the expansion and saturation of the VMMC programme in all PEPFAR supported districts as previously agreed upon.</p> <p>COP19 will support large scale PrEP distribution targeting key populations and AGYW in each of the districts where PEPFAR has focused. COP19 will support both the commodities and the user-centered design including provider training, community-outreach and youth- and KP-friendly service delivery models that support both initiation and retention. Programs will target those most vulnerable to and disconnected from services, but place no restrictions on who can access it, including key populations and AGYW (whether at university, college, school or not in education). This will include community education efforts through the PEPFAR-funded HSAs and CHWs and at drop in centres (DICs) – with emphasis on safe, easy access that accommodates the unique needs and vulnerabilities of these target populations.</p>	<p>Target: USD 8 million to ensure expansion and saturation of VMMC programme in all PEPFAR supported districts.</p> <p>Target: Increase the PrEP target to 40 000 people on PrEP in Malawi through PEPFAR supported programs.</p>

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	<p>6. Expand provision of TB preventive therapy (TPT) to all PLHIV newly enrolled into care, and expand provision of TPT to eligible household contacts of PLHIV with active TB, including young children and HIV-negative adults.</p> <p>"All PLHIV in 5 priority districts on ART offered IPT" p131</p> <p>From PEPFAR Malawi data:</p> <p>TB_PREV</p> <p>Target: 271,619</p> <p>Result (thru Q4): 251,119</p>	<p>TPT for PLHIV: PEPFAR Malawi will support the scale-up of TB preventive therapy (TPT), ensuring that all PLHIV newly enrolled into care who screen negative for active TB disease initiate and complete a course of TPT. All PLHIV in PEPFAR Malawi programs newly diagnosed with active TB disease receive household contact investigations of their families and close contacts, with household contacts offered TPT.</p> <p>PEPFAR Malawi will pilot the use of the short-course, rifampin-based 3HP regimen as an alternative to isoniazid preventive therapy (IPT) for 50% of PLHIV started on TPT, pending confirmation that rifampin is safe to use with dolutegravir. Individuals receiving IPT will receive the fixed-dose combination of isoniazid/cotrimoxazole/B6 (Q-TIB).</p> <p>TPT for children: PEPFAR Malawi will support contact investigations for all PLHIV diagnosed with active TB disease. Children of PLHIV with TB identified by contact investigations will be offered TPT with the regimen determined by HIV status. HIV-negative children will be offered the 3HR regimen, which is available as a child-friendly FDC. Children with HIV will be offered 3HR (if on EFV-based ART) or IPT (if on nevirapine, lopinavir-ritonavir, or dolutegravir-based ART). IPT is also available in a child-friendly dispersible tablet.</p> <p>PEPFAR Malawi will integrate training on TPT initiation and adherence support into preparations to rollout dolutegravir-based ART, recognizing that TB prevention is a routine and integral part of the HIV clinical care package.</p>	<p>90% of eligible PLHIV initiate and complete TPT within COP19. Of these, 50% should receive 3HP and the rest should receive Q-TIB.</p> <p>100% of PLHIV diagnosed with active TB disease (TX_TB) receive household contact investigation of family and close contacts.</p> <p>All children <15 identified through household contact investigation (TX_TB x 2) screened for TB, and either placed on TB treatment or initiated on TPT.</p>

"Liu Lathu Mu COP19" is Chichewa for "Community Voices on COP19"