COP17 Overview and Review of Q2 Results
Overview of Malawi COP17

- **Improve geographic and population focus** to reach 70% of the national gap to saturation.
- Increase targeted testing strategies to reach men and youth
- Expand efficiencies modalities in service delivery
- Scale-up **evidence-based primary prevention strategies** and innovations
- Focus on **key populations prevention and treatment programming**, across the cascade
MPHIA shows Commendable Progress to 90-90-90 in Malawi

1st 90 Remains Greatest Challenge
Undiagnosed HIV Infection is the Main Reason for Non-suppressed Viral Load in Malawi

- Not suppressed because not diagnosed, 66%
- Not suppressed because not linked to treatment, 20%
- Not suppressed because not adherent to treatment, 14%

Index case testing important to reach our target age and gender groups efficiently with testing and treatment services
Index Case Testing Pilot in 41 Sites in Blantyre, Thyolo, Chiradzulu and Neno Districts (Q1 + Q2) demonstrated **26% yield**

All patients attending **41 ART clinics** were encouraged to bring family members (children, spouses, siblings, and parents) for testing during **“Family Testing Days”** usually on weekends.

Over **5 months** (October 2016 through February 2017), **7,567 contacts** of known positives were tested for HIV.

Of 7,567 tested, **1978 (26%) new HIV positives** identified.
74% of those tested\* were target populations (youth <20 and males 20+)

A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT

\*41 Sites in Blantyre, Thyolo, Chiradzulu and Neno Districts (Q1 + Q2)
High Diagnostic Yield among both Adults and Children

- High average yield among children (5-16%) despite low prevalence (1.6%)
- Very high yield among older adolescents (16%) despite prevalence of 3%
- Very high yield among adults (39%) vs. 10.6% prevalence

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Sexual Partner HIV Positivity Rates Very High with 57% of Positive Partners “Newly Identified”

*41 Sites in Blantyre, Thyolo, Chiradzulu and Neno Districts (Q1 + Q2)

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Linkage to ART Among New Positives Good (84%) but Short of the 90% Target

*41 Sites in Blantyre, Thyolo, Chiradzulu and Neno Districts (Q1 + Q2)

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Across the board **increases in community testing**, yield up in Blantyre, Lilongwe and Zomba with work remaining for Q3 across scale up districts.

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A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT
FY17 Q2 Data for 40 sites in 10 Scale-up Districts: Improvement in TX_NEW in Q2 versus Q1

- FY17 Q2 interventions that improved ART enrollment
- Scale-up of Index case testing
- Scale-up of same day ART initiation
- Enhanced implementer management

Extraordinary impact of Test and Start in the 4th quarter

39 of 40 sites showed improved Q2

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A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT

39 of 40 sites in 10 Scale-up Districts Improved TX_NEW in Q2 versus Q1

Largest acceleration in Q2 TX_NEW observed in QECH, a focus for PEPFAR Implementer remediation efforts and

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Q2 Progress* Means we are at 37% of Annual TX_NEW Target – current trend toward 96% achievement of FY17 TX_NEW targets

*EMRS data from 59 sites
**TX_NEW by District:** Urgent Continued Geographic Focus Needed Towards the 5 Acceleration Districts (data from 59 EMR sites)

- COP 17 Scale-up Districts (@32% of annual target)
- COP 17 Acceleration Districts (@79% of annual target)

**TX_NEW by District:**

- **Blantyre (MSH/COM):** 30%
- **Zomba (EQUIP):** 27%
- **Mangochi (EQUIP):** 22%
- **Chikwawa (EQUIP):** 23%
- **Machinga (EQUIP):** 21%
- **Mulanje (EQUIP):** 40%
- **Mzimba (EQUIP):** 24%
- **Phalombe (EQUIP):** 33%
- **Thyolo (MSH):** 61%
- **Ulongwe (LH + EQUIP):** 85%
- **Balaka (EQUIP):** 73%
- **Chiradzulu (MSH):** 83%
- **Dedza (EGPAF):** 67%
- **Dowa (EQUIP):** 43%
- **Machinga (EQUIP):** 31%
- **Nkhotakota (EQUIP):** 23%
- **Nchelere (EQUIP):** 31%
- **Nkhotakota (EQUIP):** 153%
- **Salima (EQUIP):** 77%
- **Mibaya (EQUIP):** 20%
- **Mchinji (EGPAF):** 67%
- **Nkhotakota (EQUIP):** 40%
- **Nkhotakota (EQUIP):** 80%
- **Nkhotakota (EQUIP):** 100%
- **Nkhotakota (EQUIP):** 120%
- **Nkhotakota (EQUIP):** 140%
- **Nkhotakota (EQUIP):** 160%
- **Nkhotakota (EQUIP):** 180%

A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT
Continued **Rapid Acceleration in current on treatment**, Reaching 203,621 (93%) of annual target by end of Q2*

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Increased focus on youth and males **not yet evident** in new on treatment (TX_NEW) population in Q2* versus Q1

Proportional increases in <25 needed, but observed the

Proportional increases in males aged 15-49 versus females 15-49 needed, but the proportion of male TX_NEW patients stayed constant

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Active Implementer Management Yielding Results
Implementing Partner Performance Management: EQUIP Remediation Case Study – Mangochi and Zomba

Site-level analysis with District and site staff

Develop & Implement site specific action plans

MER Quarterly Data - Low performing sites identified

Monthly progress review of remediation sites with IP

Monthly data capture of key indicators

Instituting a Continuous Process

REMEDIATION THRESHOLD:
Less than 70% quarterly target achievement – high volume sites
Less than 60% quarterly target - low volume sites

USG Team:
- Monthly Meeting with IPs
- Data analysis
- Technical Guidance and site visits
- Coordination with Community Partners

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Partner develops site specific remediation plans

CHALLENGES:

- Inadequate health workers
  - No CHWs
  - Not enough HDAs
  - Not enough nurses
- Inadequate testing room
- Inconsistent PITC and index testing
- Group counselling not done daily – linkage challenges

INTERVENTIONS:

- Feedback meeting with site
- Targeted mentorship and staff orientation
- Added an HTC room
- Collaboration with community partner for index testing established – services available - April 1
- New HDAs and CHWs started on April 1

NEXT STEPS:

- Negotiations with site regarding frequency of counseling
- Lobbying with DMO re: staffing (nurses)
- Strengthening linkage systems
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Why is Primiti Mission Hospital successful?

• Strong leadership (Hospital Director and facility ART Coordinator)
• Health Care Workers know PEPFAR targets and work towards them
• The facility is supported by a vibrant PLHIV Support Group, Solomeo
• HTS Services
  • 100% coverage of all entry points: In-patient wards (medical, Peds, NRU), Maternity, ANC and OPD.
  • 8 HTC Counselors available (4 PEPFAR supported HDAs, 3 HSAs and 1 patient attendant)
  • 2 dedicated rooms for HTS
  • Demand creation done by support group members at the community level
• Linkage to treatment
  • Transitioned all pre-ART patient to ART
  • Comprehensive counseling sessions offered before starting ART
  • Support Group members assist with adherence counseling, health talks, escorting clients to ART clinics and tracing of defaulters
Targeted remediation efforts improve TX_NEW trends - Continued efforts required

MANGOCHE: 80% of remediation sites improved TX_NEW in Q2

ZOMBA: 60% of remediation sites improved TX_NEW in Q2

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Stakeholder Review and Comments
COP17 Stakeholder Recommendations

• Increase investment in Human Resources for Health

• Ensure transparent coordination at the district level including leveraging District AIDS Committees

• Enhance the VMMC strategy beyond campaigns to reach targets

• Provide Malawi specific data through the proposed PrEP demonstration project (through the TWG)

• Ensure alert system on ART Commodities

• Continue close coordination in DREAMS/AGYW and Key Population activities with those funded through the Global Fund
Updates Made During COP Approval Meeting based on input from civil society, MOH and key stakeholders

• Shifting of resources to increase **HRH investment to 480 additive health care workers in the 5 acceleration districts** (120 focused on VMMC in scale-up districts)

• Ensuring ‘early alert’ system on ART – leveraging existing technical assistance focused on procurement and supply chain

*Other input incorporated into SDS prior and subsequent to submission*
Key Gaps & Solutions: COP17 Strategy
Improved Population & Geographic Focus

Utilizing MPHIA results
Evaluation of Progress in 10 Scale Up Districts: 5 Districts on Track but 5 Need to **Accelerate to Saturate**

<table>
<thead>
<tr>
<th>District</th>
<th>Classification</th>
<th>Current Coverage of PLHIV as of end of Q1 FY17</th>
<th>Projected saturation of the district at current average net new enrollment rates BY END OF FY17</th>
<th>Strategy for FY18 VS CURRENT AVERAGE NET NEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blantyre</td>
<td>ScaleUp Sat</td>
<td>55%</td>
<td>60%</td>
<td><strong>ACCELERATE</strong></td>
</tr>
<tr>
<td>Lilongwe</td>
<td>ScaleUp Sat</td>
<td>74%</td>
<td>80%</td>
<td><strong>SCALE-UP</strong></td>
</tr>
<tr>
<td>Mangochi</td>
<td>ScaleUp Agg</td>
<td>56%</td>
<td>62%</td>
<td><strong>ACCELERATE</strong></td>
</tr>
<tr>
<td>Zomba</td>
<td>ScaleUp Sat (DREAMS)</td>
<td>64%</td>
<td>69%</td>
<td><strong>ACCELERATE</strong></td>
</tr>
<tr>
<td>Mulanje</td>
<td>ScaleUp Sat</td>
<td>74%</td>
<td>82%</td>
<td><strong>SCALE-UP</strong></td>
</tr>
<tr>
<td>Thyolo</td>
<td>ScaleUp Sat</td>
<td>82%</td>
<td>88%</td>
<td><strong>SCALE-UP</strong></td>
</tr>
<tr>
<td>Mzimba</td>
<td>ScaleUp Sat</td>
<td>79%</td>
<td>86%</td>
<td><strong>SCALE-UP</strong></td>
</tr>
<tr>
<td>Machinga</td>
<td>ScaleUp Agg (DREAMS)</td>
<td>61%</td>
<td>66%</td>
<td><strong>ACCELERATE</strong></td>
</tr>
<tr>
<td>Chikwawa</td>
<td>ScaleUp Sat</td>
<td>59%</td>
<td>65%</td>
<td><strong>ACCELERATE</strong></td>
</tr>
<tr>
<td>Phalombe</td>
<td>ScaleUp Sat</td>
<td>72%</td>
<td>77%</td>
<td><strong>SCALE-UP</strong></td>
</tr>
<tr>
<td><strong>Total/Average</strong></td>
<td></td>
<td><strong>67%</strong></td>
<td><strong>72%</strong></td>
<td></td>
</tr>
</tbody>
</table>

**A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT**
A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT

MPHIA-informed Small Area Estimates Methodology to Isolate Geographic Distribution of the Gap to Saturation: Comparison of PLHIV Burden vs. Gap to Saturation by End FY2017

<table>
<thead>
<tr>
<th>District</th>
<th>% PLHIV</th>
<th>% GAP to Saturation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blantyre District</td>
<td>32%</td>
<td>14%</td>
</tr>
<tr>
<td>Lilongwe District</td>
<td>15%</td>
<td>12%</td>
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<tr>
<td>Mangochi District</td>
<td>10%</td>
<td>7%</td>
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<tr>
<td>Zomba District</td>
<td>7%</td>
<td>6%</td>
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<tr>
<td>Mulanje District</td>
<td>7%</td>
<td>6%</td>
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<tr>
<td>Thyolo District</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Mzimba District</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Machinga District</td>
<td>4%</td>
<td>4%</td>
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<tr>
<td>Chikwawa District</td>
<td>4%</td>
<td>4%</td>
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<tr>
<td>Phalombe District</td>
<td>3%</td>
<td>3%</td>
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<tr>
<td>Chiradzulu District</td>
<td>3%</td>
<td>3%</td>
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<tr>
<td>Balaka District</td>
<td>2%</td>
<td>2%</td>
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<tr>
<td>Nsanje District</td>
<td>2%</td>
<td>2%</td>
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<tr>
<td>Kasungu District</td>
<td>2%</td>
<td>2%</td>
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<td>Dedza District</td>
<td>2%</td>
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<td>Mchinji District</td>
<td>2%</td>
<td>2%</td>
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<tr>
<td>Salima District</td>
<td>2%</td>
<td>2%</td>
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<td>Dowa District</td>
<td>2%</td>
<td>2%</td>
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<tr>
<td>Karonga District</td>
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<td>2%</td>
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<tr>
<td>Nkhotakota District</td>
<td>2%</td>
<td>2%</td>
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<tr>
<td>Nkhotakota Bay District</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Neno District</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Rumphi District</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Chitipa District</td>
<td>1%</td>
<td>1%</td>
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<tr>
<td>Ntchisi District</td>
<td>1%</td>
<td>1%</td>
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<tr>
<td>Mwanda District</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Likoma District</td>
<td>0%</td>
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</tr>
</tbody>
</table>

A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT
Targeting men and youth and increasing yield

Addressing the first 90
Using MPHIA to Refine PEPFAR Malawi’s Geographic Focus: 15-24 Year Olds, and Males 25+ are Still Far from Target Suppression Levels in 10 Scale Up Districts
Reaching the first 90 Yield and Cost Per Positive:
Males 15-24 Year Old Have Lowest Yield and Highest Cost

A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT
Using District Gap Analysis, Cost, Yield, and Volume Analysis to Maximize Efficiency in FY18 vs. FY16: Scale-up of Index Case Testing, Earlier Identification of Positives

Decline in facility-based testing due to earlier identification of positives and reduced re-testing “worried well”

Aggressive Scale-up of high yield Index Case Testing

A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT
Efficient models of service delivery

Second 90: Focus on same day initiation (per policy)
Data-driven, evidence-based approaches to Differentiated Service Delivery: 5 Models Initiated

Triaging and tailoring services to optimize treatment:

- **Stable**: On ART, doing well, virally suppressed
- **Non-stable**: New clients with advanced HIV and suspected treatment failure

<table>
<thead>
<tr>
<th>Model</th>
<th>Progress update</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Facility-based Treatment Clubs (building on Teen Clubs)</td>
<td>• Expanded number of teen clubs to all districts</td>
</tr>
<tr>
<td></td>
<td>• Standardized package to improve retention and viral suppression</td>
</tr>
<tr>
<td>2 Community ART Groups</td>
<td>• Monthly refills through nominated group member</td>
</tr>
<tr>
<td></td>
<td>• Expansion underway in Thyolo, Chiradzulu, Salima, Chikwawa and Nsanje</td>
</tr>
<tr>
<td>Model</td>
<td>Progress update</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Pharmacy Fast Track                       | • Developed SOPs and EMRS module, SOPs to optimize VL testing  
• Established fast track “kiosks” at pilot sites  
• Initiated pilot in Q2 FY17 at 4 Lilongwe EMRS sites and 5 Zomba sites with paper based records |
| Nurse led ART                             | • Support groups in Lilongwe urban  
• **Enrolled 200 patients** - 132 patients in Q1 and 68 in Q2 |
| Advanced HIV management at Lighthouse     | • Enhanced prophylaxis: CTX +INH/B6+ fluconazole + azithromycin + albendazole  
• CD4 and screening for OIs – Cr Ag, TB LAM  
• CD4 < 100 in **23% of new ART initiations**; 21% serum CrAg +ve, 8% CM; 21% started TB treatment  
• Expect a 25% relative reduction in early mortality (REALITY trial) |
| Multi-month scripting                     | • Already doing 3 months with option for 6+ month |
Focusing on Retention, Adherence and VL Suppression

Third 90
Rapid expansion of viral load testing in FY 16: Focus on use of results for clinical decision making in COP 17
Using data to make clinical decisions - Optimizing routine and targeted viral load monitoring

<table>
<thead>
<tr>
<th>Date of VL was taken</th>
<th>ART regimen when last VL was taken</th>
<th>ART regimen at actual last visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/22/74</td>
<td>9/20/15</td>
<td>9/28/16</td>
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<tr>
<td>4/4/73</td>
<td>7/14/11</td>
<td>8/24/16</td>
</tr>
<tr>
<td>2/2/67</td>
<td>10/27/15</td>
<td>10/19/15</td>
</tr>
<tr>
<td>3/3/74</td>
<td>12/19/06</td>
<td>1/27/15</td>
</tr>
<tr>
<td>12/3/77</td>
<td>1/22/15</td>
<td>8/5/16</td>
</tr>
<tr>
<td>7/1/73</td>
<td>6/22/16</td>
<td>8/24/16</td>
</tr>
<tr>
<td>10/22/68</td>
<td>11/4/15</td>
<td>9/1/16</td>
</tr>
<tr>
<td>8/11/66</td>
<td>7/20/07</td>
<td>8/1/16</td>
</tr>
<tr>
<td>7/1/64</td>
<td>4/7/16</td>
<td>8/1/16</td>
</tr>
<tr>
<td>9/23/05</td>
<td>6/1/16</td>
<td>8/26/16</td>
</tr>
</tbody>
</table>

Malawi’s active approach in COP 16 to scale in COP 17:

- Support **clinical review** of patient records
- Develop SOPS for sorting and tagging patient files for VL testing
- Ensure **routine audit clinical data** to see if patients are appropriately managed

**Case review:** Patient was on 1st line regimen when her VL was taken, her VL was suppressed, and she stayed on 1st line

**Case review:** Patient was on regimen 2A when his VL was taken, VL was high and patient was appropriately switched to 2nd line
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PEPFAR-supported Facilities

Viral Load Laboratories

Strategic Viral Load Scale-up

TX_CURR

# planned VL tests

- <3282
- 32828-37603
- 37604-84190
- 84191-95785
A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT

VMMCC
VMMC Results: FY 17 Q2 shows improvement over FY 16 (Q1 & Q2) with anticipated seasonal spike

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At the district level, work remains with key focus on reaching 15-29 year olds for VMMC (Q2 data)

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VMMC Strategy to Improve Performance

Challenges Identified

1. Low Demand
2. Vertical Service Delivery

Support National VMMC Communication Strategy and IM specific plans
Increase and incentivize community mobilisers
Implement individual site capacity analysis

Strategic Shifts NOW

Increase from 11 to 35 service delivery teams
Create 2 high volume VMMC static hubs per district
Ensure provider Initiated VMMC via male health services
Mobilize private clinics

Priorities for COP17

A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT
DREAMS & AGYW Innovation
On track to meet FY17 target to reach 60% of vulnerable girls: Focus now on intensifying programmatic layering.

- **Vulnerable AGYW 15-24**
  - **Zomba**: FY16: 31,451 (34%), FY17: 22,162 (61%), FY18: 22,162 (79%)
  - **Machinga**: FY16: 5,000, FY17: 10,000, FY18: 15,000

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**Notes**

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A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT
FY16/17 DREAMS Site Selection Criteria:

- High HIV burden (TX_CURR)
- Low linkage rates
- Low retention in care (TX_RET)
- High HTS yield
- Physical site walks to map out FSW hotspots
- High rates of pregnancy in AGYW 10-24 based on baseline register review of selected facilities

<table>
<thead>
<tr>
<th>Zomba</th>
<th>Machinga</th>
<th>Blantyre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed expansion to 5 additional sites</td>
<td>Proposed expansion to 2 additional sites</td>
<td>Up to 3 highest burden facility catchment areas building on existing OVC/FSW/AGWY</td>
</tr>
</tbody>
</table>
Tracking Girls Access to DREAMS Comprehensive Package

Current
- Using DREAMS referral system (paper-based)
- Tracking club participation (age disaggregated)
- No unique ID

Actions Since DCCM
- Provision of regional to learn from other systems
- Coordinating with GF on Action Aid
- Planning a Unique ID review (May)
- DREAMS exchange planned (June)

Next Steps
- Survey clubs reach
- Establish DREAMS Passport for girls clubs
- Rollout COP 17 Unique ID
Building from the Botswana Study: Increasing AGYW access to secondary school to **decrease risk of HIV in Malawi**

**Intervention**

- **Increase secondary classroom space for AGYW** in Malawi by over 25%
- Provide approximately **17,225 new seats every year for AGYW**
- Measure the **impact**

**Anticipated Impact for AGYW**

- Reduced **HIV incidence**
- Reduced incidence of **pregnancy**
- Increased access to **education**
Orphans & Vulnerable Children
OVCs Served: Preliminary Data shows 58% Achievement of FY 17 Target

Increased implementer performance with all over 50% of annual targets:

- ASPIRE – School-based
- ASSIST – QI CBO capacity building
- One Community – Household case management

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Strategic Shifts in COP 17 OVC Portfolio

• Leverage facility-based linkage agents to improve case finding and tracking of HIV+ adolescents and children

• **Link underage girls** engaged in transactional sex and **children of FSW** with OVC support

• Integrate **HIV risk avoidance and GBV prevention** activities into school and community-based programming

• Target older OVC with Village Savings & Loans and school block grants
Key Populations
Key Population Results: Momentum building - FY 17 improved progress toward annual FSW targets

- Weekly contact with prevention/condoms/lube
- Quarterly HTS/STI screening and TX, FP, cervical cancer screening

74% of FY 17 target

41% screened had known HIV+ status – (584) tracked known positives re/initiated (30) on TX
- (176) receive ongoing ART through LINKAGES sites

767 TX new through peer navigators
- (115) LINKAGES sites & (652) supported public facilities

41% of FY 17 target

15% of FY 17 target

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While high reach and testing at midpoint - remediation strategies to reach older MSM started in Q2

39% of FY 17 target

High reach and testing uptake has not resulted in high # positives but reinforced importance of prevention

31% of FY 17 target

6% positivity rate in Q2 improved from Q1

Reach 1307 15 1292 836 26 9

Q1 1307 15 1292 836 26 9

Q2 350 0 350 333 21 29

FY16 2086 0 0 1300 106 61

Enrolled in clinical care
Initiated on ART
Enrolled in community care

Q2
350
0
350
333
21
29
0

Q1
1307
15
1292
836
26
9
9

FY16
2086
0
0
1300
106
61
61

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Building on Momentum to Improve Quality and Expand Coverage

• **Validated Hotspots and Size Estimates** Inform Expansion in 6 Current Districts

• **Enhanced clinical partnership** to provide same day ART initiation

• **Expand to six additional districts** coordinating with Global Fund Investments
Data Disaggregation to Refine and Target the Response
Starting in Q2 (now!), Ministry of Health/TWG collective agreement to:

- Report age/sex disaggregates for *treatment* indicators in all Electronic Medical Records System (EMRS) sites nationally
- Conduct manual collection & reporting of fine disaggregates for testing and TX-NEW indicators for non-EMRS facilities in 5.5 districts (capturing acceleration/DREAMS)

**Rapid scale-up of EMRS** – in 85 facilities currently, *covering 47% ART clients*

- Expand to 120 facilities by September 2017
- Expand to 270 facilities by September 2018
- Pilot of EMRS *testing* module in 4 facilities with subsequent scale-up
Direct Service Delivery:
Increasing HRH Investment & Delivering on Infrastructure
HRH: Preliminary DSD Audit Results 2017 demonstrate coverage continued shift to scale up districts

- HDAs increased by 330
- Reduced lay workers by 33 (shifting strategy from non-monetary to stipend)
- Increased ART providers by 211 (mostly in LLW)
- Increased staffing in Blantyre and Zomba - Lilongwe remains highest (Lighthouse as Center of Excellence)
- Preliminary data only
Snapshot: DSD Audit Results and trends in 2016 vs 2017

A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT
Hiring trained HRH in Malawi: PEPFAR & GF

- Of the 617, **462 will be hired** through the COP 16 investments
- **155 remaining + 98** graduating in June 2017 - all of whom will be hired through Global Fund recruitment (now)

<table>
<thead>
<tr>
<th>Students in pipeline</th>
<th>Expected Graduates 2017</th>
<th>Expected Graduates 2018</th>
<th>Expected Graduates 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,331</td>
<td>98</td>
<td>480</td>
</tr>
</tbody>
</table>

A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT
Surge Capacity Details: Additional 480 Health Care Workers in Five Acceleration Districts ($1.6M on COP17 – shift since meeting)

<table>
<thead>
<tr>
<th>District</th>
<th>Number of Facilities</th>
<th>Total Additive Health Care Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chikwawa</td>
<td>18</td>
<td>72</td>
</tr>
<tr>
<td>Mangochi</td>
<td>35</td>
<td>140</td>
</tr>
<tr>
<td>Machinga</td>
<td>17</td>
<td>68</td>
</tr>
<tr>
<td>Zomba</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Blantyre</td>
<td>18</td>
<td>72</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>90</strong></td>
<td><strong>360</strong></td>
</tr>
</tbody>
</table>

VMMC Surge: Lilongwe, Blantyre, Zomba, Mulanje, Thyolo, Chikwawa, Phalombe, Chiradzulu (including DOD sites) 120

Additive HRH surge support to COP 17 480

Providing an average of 4 additive HIV-focused healthcare workers in each PEPFAR supported site:
- 1 Nurse Midwife Technicians
- 1 Medical Assistant
- 1 Lab Technician
- 1 Pharmacy Assistant

For VMMC surge: Clinical Officers and Nurses
Infrastructure update: Pre-fabricated ART and HTS Space to address site level service delivery bottlenecks

Progress to date: In Consultation with MOH, Planning Directorate
- Space specifications developed
- Initial site level assessments conducted
- Solicitations underway

Next steps:
- MOU (Pharmacy in a Box as a model)
- Award of contracts – May-June
- Contractor site surveys
- Installation of 106 sites by October 1, 2017
Implementing the Blantyre Strategy
MPHIA and Program Data Indicate the Urgent Need to Respond to the Epidemic in **Blantyre**

- **HIV Prevalence**
  - North 7.3%
  - Central East 5.3%
  - Central West 5.8%
  - Lilongwe City 11.7%
  - South East 15.6%
  - Blantyre City 18.2%
  - South West 15.9%

- **VLS Prevalence**
  - North 66.9%
  - Central East 63.7%
  - Central West 70.4%
  - Lilongwe City 65.5%
  - South East 68.8%
  - Blantyre City 59.5%
  - South West 70.3%

- **Key Observations**
  - **Highest** adult HIV prevalence
  - **Lowest** levels of Viral load suppression
  - Accounts for **32%** of the national gap to saturation

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**A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT**
Blantyre Deep Dive

- **January 2017**: Implementer performance analysis to identify low performing sites and partners
- **February/March 2017**: Interagency workshop to identify challenges and opportunities to accelerate in Blantyre
- **April 2017**: Interagency visit to Blantyre with Ministry of Health. **Key changes needed:**
  - Improve coordination with DHO
  - Increase the number of sites (some private) and HCWs
  - Accelerate Index case testing **PLUS** mobile electronic device data capture
  - Expand same day ART initiation
  - Improve & expand key population services
  - Expand EMRS, data disaggregation, and outcome tracking

New center of excellence scheduled to open on WAD 2017
Results of Improved Implementer Performance Management – Acceleration in New Positives and New on Treatment in Q2 vs Q1

PEPFAR Malawi directed MSH to change sub-partner, and visited Blantyre twice with close coordination and follow up. As a result:

- Doubled Testing results (from under 5,000 in Q1 to over 11,000 in Q2)
- Increased positives identified by 40%
- 81% increase in treatment new results
- Began treatment initiation on the wards
- Began same day ART initiation

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Urgent Rollout of Planned Infrastructure and HRH Support in Blantyre By October 1st this Year

HRH Support

- 1-2 Pharm Assist
- 1-2 ART providers
- 3-4 ART providers
- 1-2 HDAs
- 3-4 HDAs

Infrastructure Support

- Pharm. In a Box
  - 1 clinic room
  - 2-4 clinic rooms
  - 5-7 clinic rooms
Budgeting the HIV Response
## Summary of COP 2017 Targets by District Prioritization

<table>
<thead>
<tr>
<th>COP17 Priority</th>
<th>COP17 Target (APR18) HTC_Test</th>
<th>COP17 Target (APR18) HTC_Pos</th>
<th>COP17 Target (APR18) Tx_New</th>
<th>COP17 Target (APR18) Tx_CURR</th>
<th>COP17 Target (APR18) OVC_Serv</th>
<th>COP17 Target (APR18) KP_Prev</th>
<th>COP17 Target (APR18) PP_Prev</th>
<th>COP17 Target (APR18) VMMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>3,118,578</td>
<td>190,223</td>
<td>185,629</td>
<td>779,250</td>
<td>129,313</td>
<td>22,530</td>
<td>304,839</td>
<td>145,342</td>
</tr>
<tr>
<td>Attained</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Saturation¹</td>
<td>1,520,415</td>
<td>116,668</td>
<td>113,910</td>
<td>456,146</td>
<td>87,018</td>
<td>14,790</td>
<td>192,018</td>
<td>138,226</td>
</tr>
<tr>
<td>Aggressive²</td>
<td>439,078</td>
<td>30,789</td>
<td>30,754</td>
<td>86,686</td>
<td>42,295</td>
<td>4,531</td>
<td>101,246</td>
<td>-</td>
</tr>
<tr>
<td>Sustained</td>
<td>1,118,621</td>
<td>40,408</td>
<td>38,877</td>
<td>227,768</td>
<td>-</td>
<td>3,209</td>
<td>1,850</td>
<td>2,068</td>
</tr>
<tr>
<td>Other (Military)</td>
<td>40,464</td>
<td>2,358</td>
<td>2,088</td>
<td>8,650</td>
<td>-</td>
<td>-</td>
<td>9,725</td>
<td>5,048</td>
</tr>
</tbody>
</table>

¹Blantyre, Lilongwe, Zomba, Mulanje, Thyolo, Mzimba, Chikwawa, Phalombe
²Mangochi, Machinga
Strong collaboration with Global Fund and full engagement in Funding Request development

• **Strong collaboration** in Global Fund Funding Request Development

• **Full participation** in all stakeholder meetings and development workshops

• **Concerns provided in writing** to Ministry of Health, CCM, Global Fund Secretariat, S/GAC and other stakeholders

• **Key issues:**
  - PrEP not in PAAR (TWG approval needed)
  - Maximizing commodities and building on strong performance
  - On-going coordination with AGYW activities
Commodities: PEPFAR (TX_Curr targets) create potential ARV gaps – portfolio optimization opportunities to cover
COP 16 Impact funding: What did we buy?

“...to support direct treatment activities and to support your negotiation with the host government for immediate implementation of WHO guidelines.”

Test and Start – National roll out

PEPFAR support:
- Site level in-service mentoring on new ART guideline
- HDAs, expert clients, and other lay cadres linked newly identified positives to treatment
- Defaulter tracing systems in place at all sites to bring people back to treatment

Result:
- Transition of pre-ART cohort nearly complete - 48% increase in new on treatment in FY16 Q4
- 100% of PEPFAR supported sites are implementing Test and Start
- FY 17 Q1 linkage rate of 87%

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Malawi: Opportunities to further explore treatment costs given relative low cost

- Average cost historically per patient on ART in Malawi per year **very low**: $137 in 2010
- Estimated to be about $200/person/year in 2016

*Source: Multi-Country Analysis of Treatment Costs for HIV/AIDS (MATCH): Facility-level ART Unit Cost Analysis in Ethiopia, Malawi, Rwanda, South Africa and Zambia, published November 2014*
What will the additional $10 million in acceleration funds achieve?

Analysis of what the additional $10 million in acceleration funds buys:

- An additional 39,451 net new on treatment
- Cost of about $253 per net new patient on treatment - slightly higher than current estimated costs ($200/person/year) due to surge in HRH & same day ART initiation

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>81,366</td>
<td>120,817</td>
<td>39,451</td>
<td>148%</td>
<td>$10,000,000</td>
<td>$253</td>
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</tbody>
</table>
A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT

COP16 vs COP17 Budget Code Totals

COP16 COP17

CIRC HBHC HKID HLAB HTXS HTXD HVCT HVMS HVOP HVSI HVTB IDUP MTCT OHSS PDCS PDTX HMBL HMIN HVAB

Budget Code Totals

- 5,000,000
10,000,000
15,000,000
20,000,000
25,000,000
30,000,000
35,000,000
40,000,000
45,000,000
## COP17 Agency Allocations and Pipeline

<table>
<thead>
<tr>
<th>Agency</th>
<th>New FY2017 Funding</th>
<th>Total Funding</th>
<th>Applied Pipeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHS/CDC</td>
<td>$46,129,817</td>
<td>$55,109,435</td>
<td>$8,979,618</td>
</tr>
<tr>
<td>USAID</td>
<td>$26,628,833</td>
<td>$53,062,947</td>
<td>$26,434,114</td>
</tr>
<tr>
<td>DOD</td>
<td>$1,079,795</td>
<td>$2,563,671</td>
<td>$1,483,876</td>
</tr>
<tr>
<td>State/PRM</td>
<td>$743,925</td>
<td>$743,925</td>
<td>$0</td>
</tr>
<tr>
<td>PC</td>
<td>$0</td>
<td>$1,644,802</td>
<td>$1,644,802</td>
</tr>
<tr>
<td>HRSA</td>
<td>$200,000</td>
<td>$251,165</td>
<td>$51,165</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$74,782,370</strong></td>
<td><strong>$113,375,944</strong></td>
<td><strong>$38,593,575</strong></td>
</tr>
</tbody>
</table>

*Minimum required pipeline applied*
Earmark Allocations: 100% Reached

• New FY 2017 funds allocated to care and treatment: $51,192,096
  ✓ COP17 requirement: $42,139,670

• New FY 2017 funds allocated to OVC: $5,101,097
  ✓ COP17 requirement: $5,041,956

• New FY 2017 funds allocated to water: $200,000
  ✓ COP17 requirement: $200,000

• New FY 2017 funds allocated to GBV: $1,397,159
  ✓ COP17 requirement: $898,000
CSO Remarks
In country processes

• 10th December CSOs invited to a stakeholders meeting with Ambassador Birx
• 11th January CSOs participated in a PEPFAR stakeholders engagement meeting
• 10th February PEPFAR multi-stakeholder engagement.
• On 17th February A written submission of the CSO COP priority areas was made before the country teams went to DC
• 13th March draft SDS shared with CSOs for input
• 15th March PEPFAR CSOs at MANASO, written feedback given
• 20th CSOs met PEPFAR to discuss outstanding issues before Joburg
Game changers

• Submitted two rounds of written feedback
  - February before SDS,
  - Draft SDS received March 13, feedback submitted March 15. we need more time in future
• PEPFAR-CSO meeting within CSO space
  - CSOs led the agenda
  - Enough time to go through all the issues
  - Had a chance to see the SDS, review the data
The things CSO asked for and were incorporated

- Increased investment in HRH
  - 480
- VMMC; demand creation and HRH
- Planning to intensify demand creation
- 120 HRH for VMMC
- PrEP
  - PrEP demonstration waiting MoH approval
• More CSO engagement beyond COP approval
• Monitoring of the program
  - CSO dedicated Dialogue, but would want to see IPs in this one
• Participation of AGYW in the process has been helpful
• Special thanks to Ministry for the leadership
THANK YOU!