



COP 2017 Outbrief Malawi

Team Malawi

June 2017



COP17 Overview and Review of Q2 Results

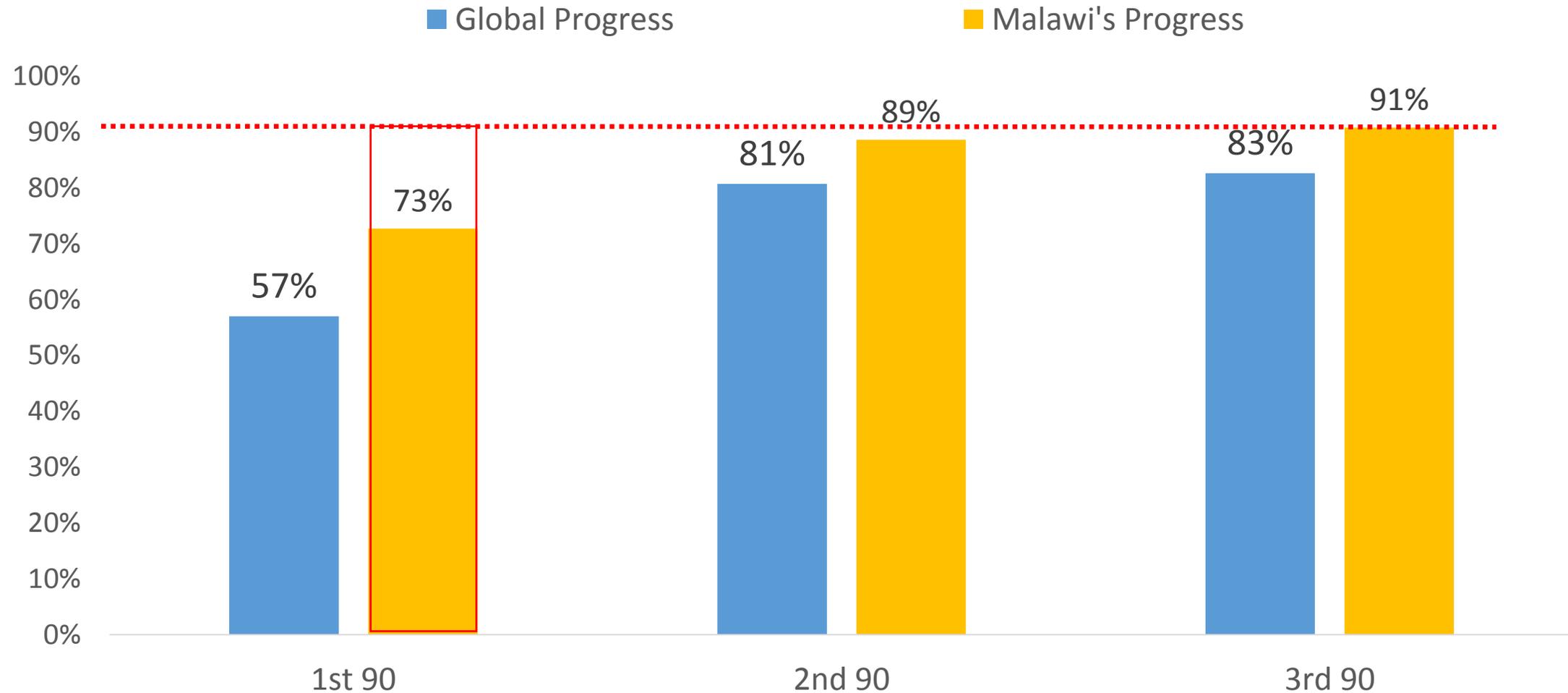
A New Era of Accountability, Transparency, and Solidarity to Accelerate IMPACT

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

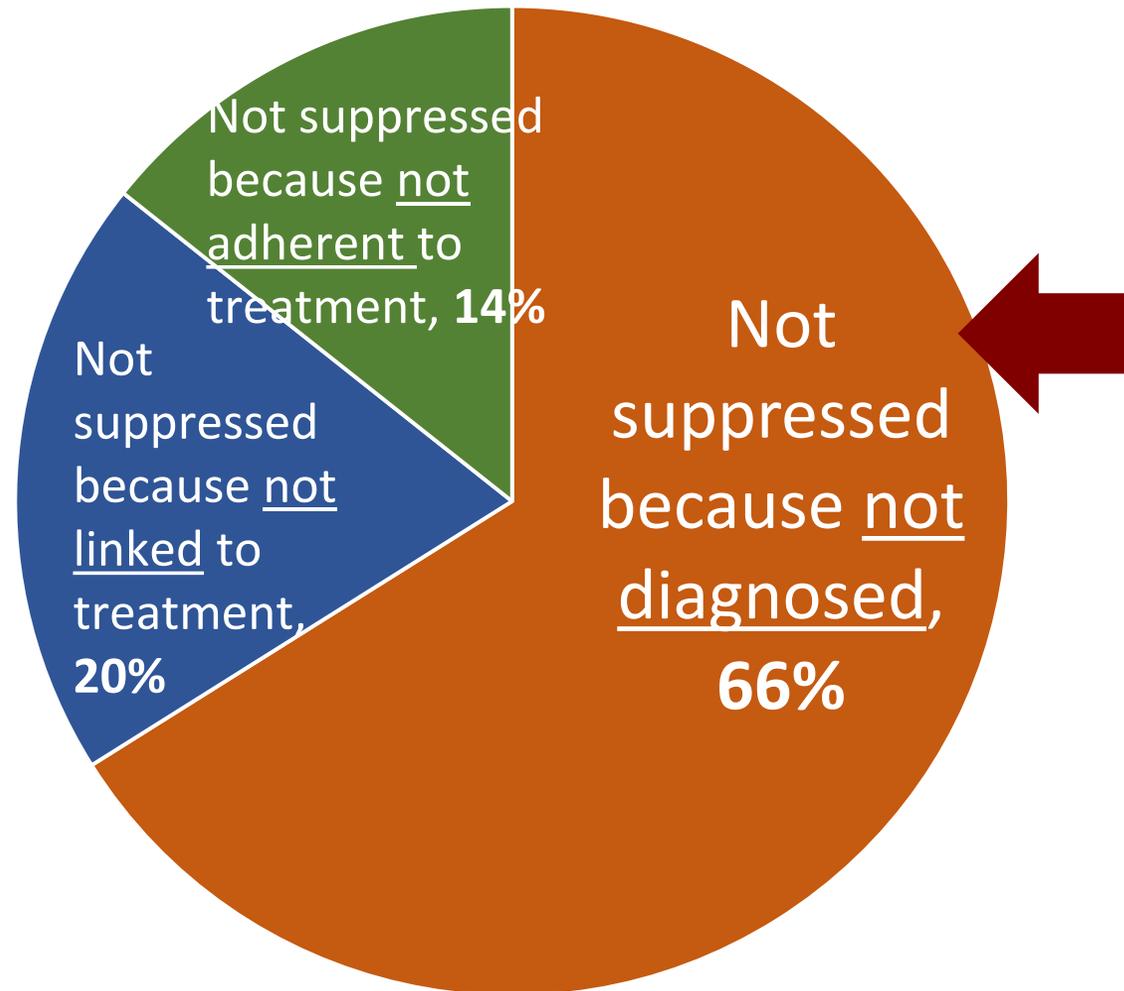
MPHIA shows Commendable Progress to 90-90-90 in Malawi

1st 90 Remains Greatest Challenge



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

Undiagnosed HIV Infection is the Main Reason for Non-suppressed Viral Load in Malawi



Index case testing important to reach our target age and gender groups efficiently with testing and treatment services

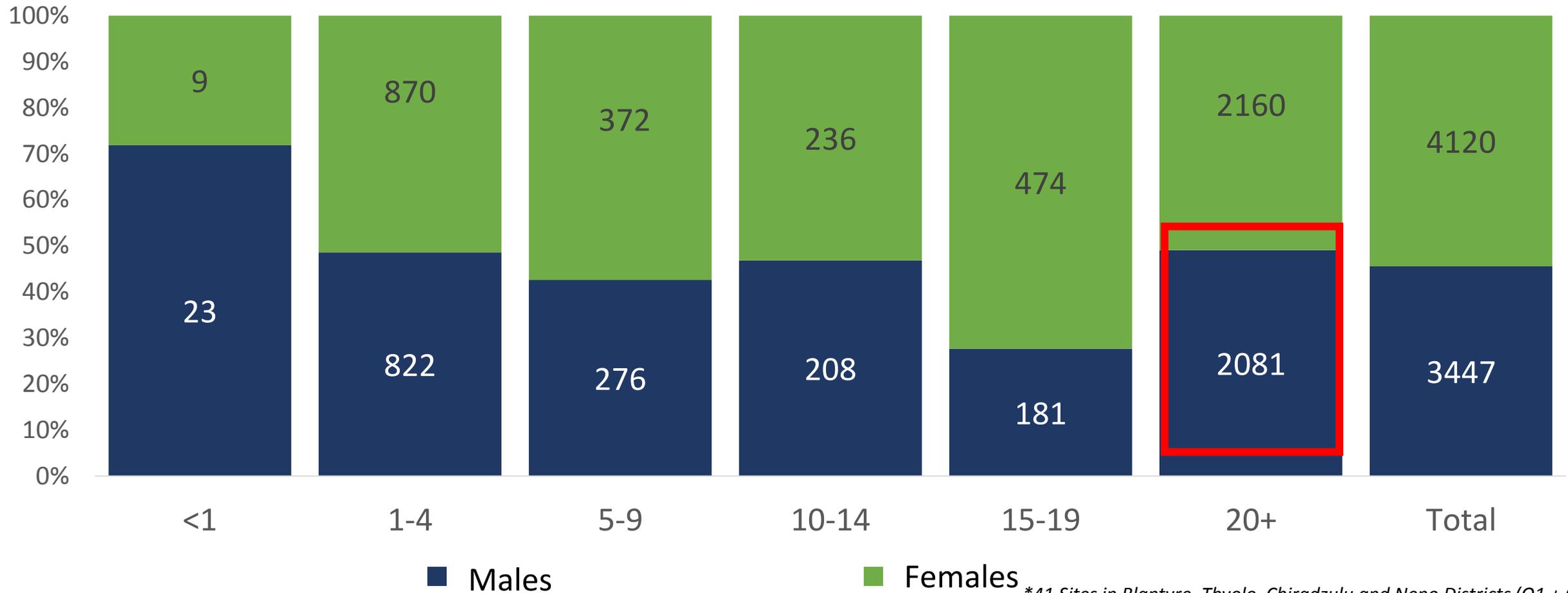
Index Case Testing Pilot in 41 Sites in Blantyre, Thyolo, Chiradzulu and Neno Districts (Q1 + Q2) demonstrated **26% yield**

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+)

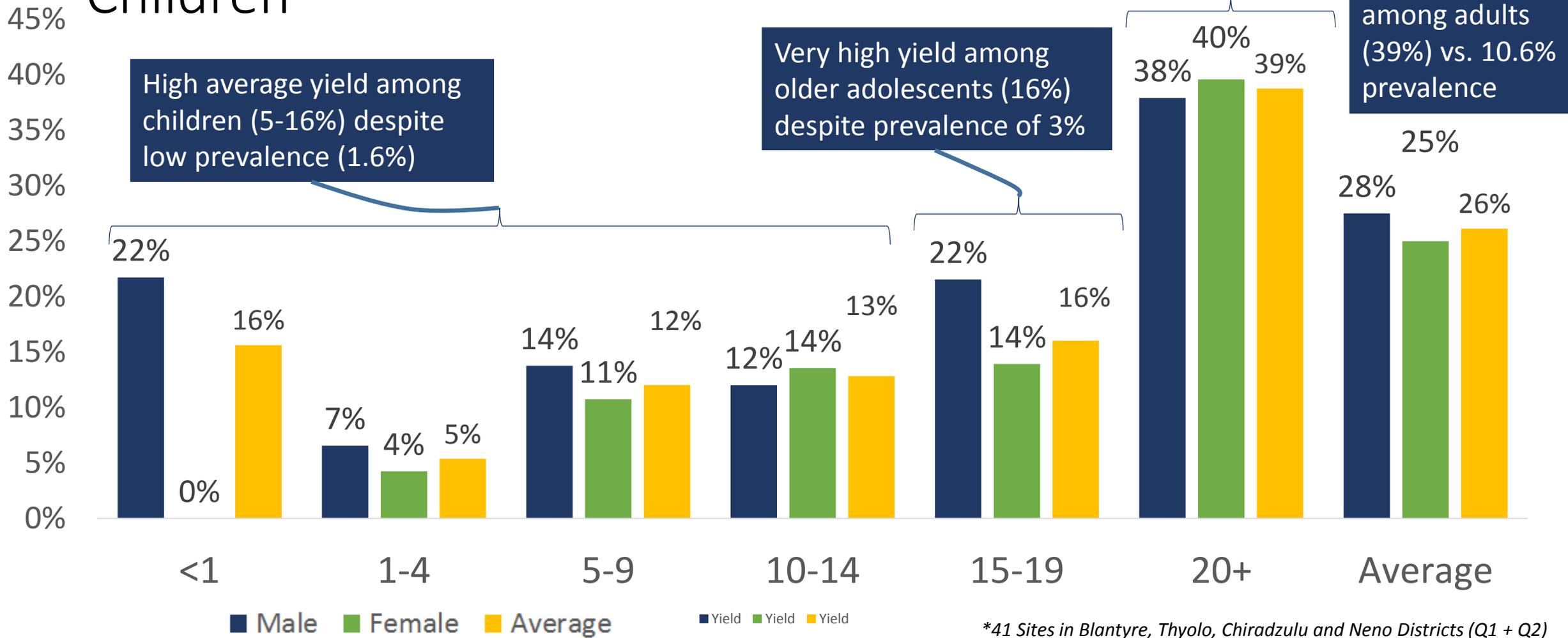


*41 Sites in Blantyre, Thyolo, Chiradzulu and Neno Districts (Q1 + Q2)

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

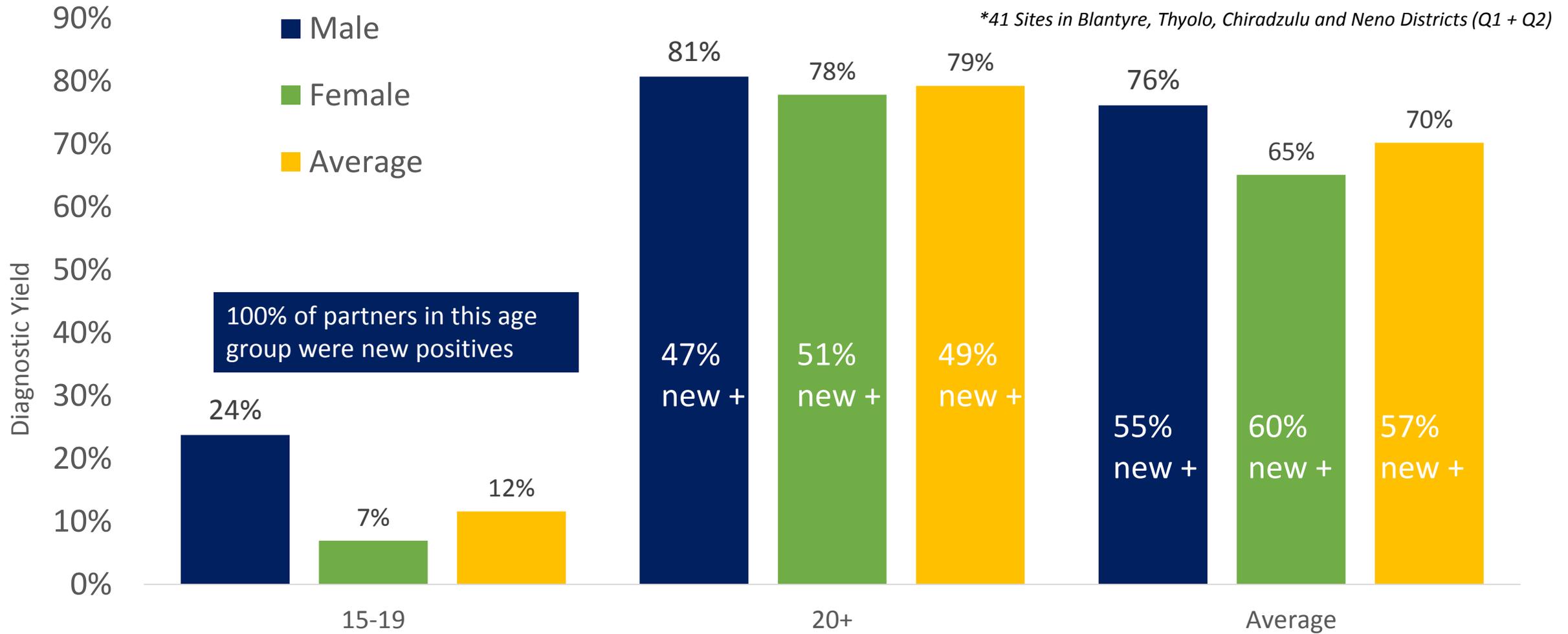
High Diagnostic Yield among both Adults and Children



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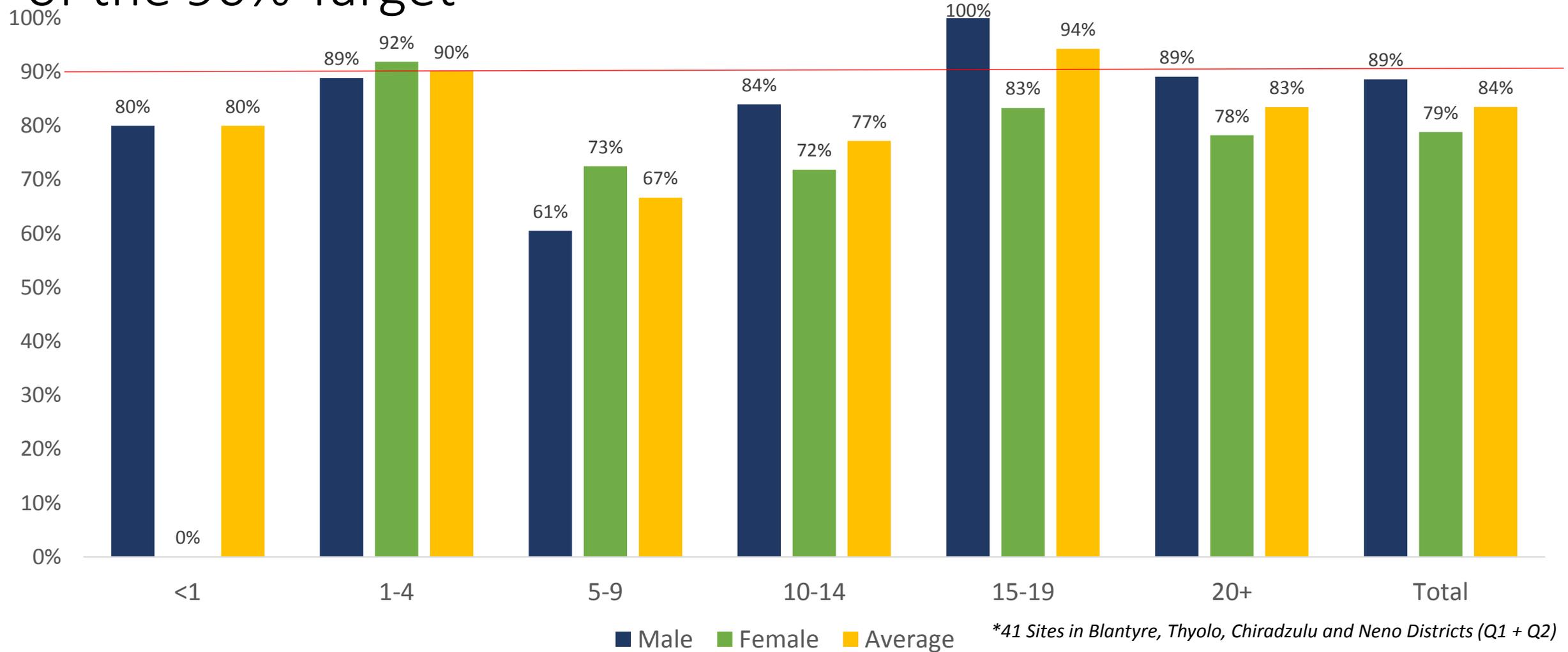
Sexual Partner HIV Positivity Rates Very High with 57% of Positive Partners “Newly Identified”



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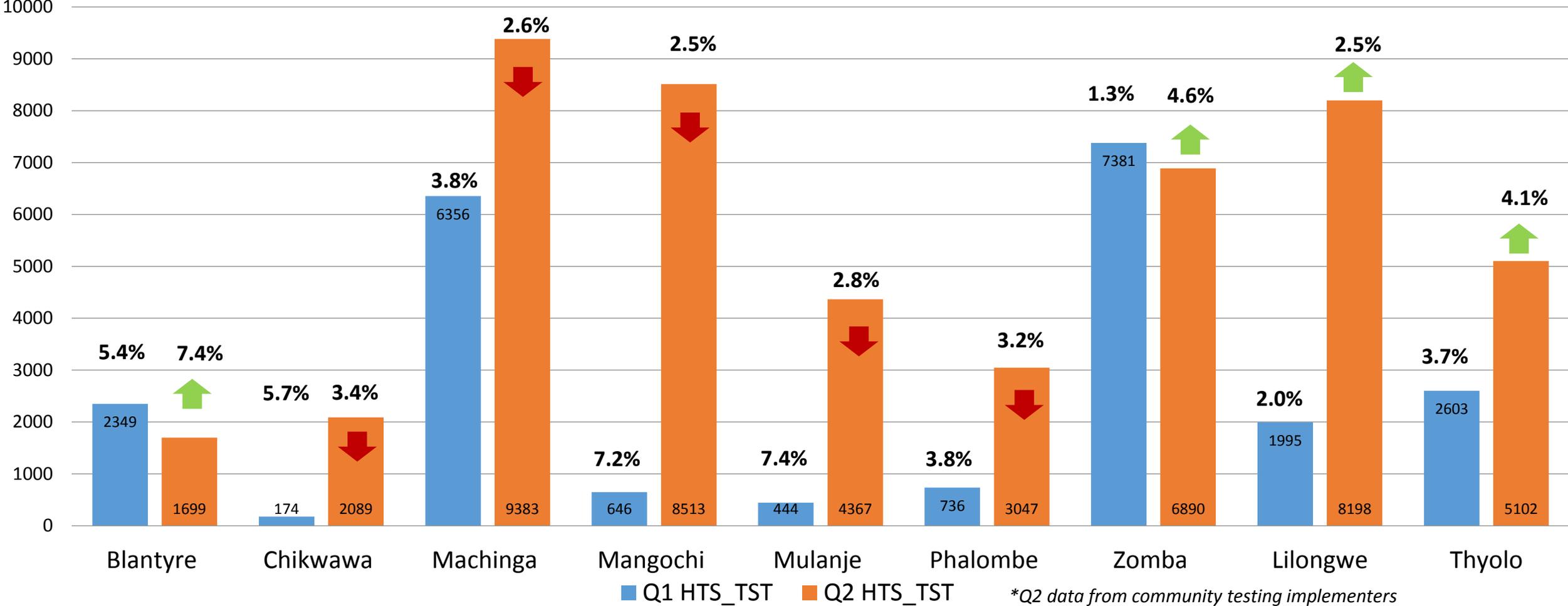
Linkage to ART Among New Positives Good (84%) but Short of the 90% Target



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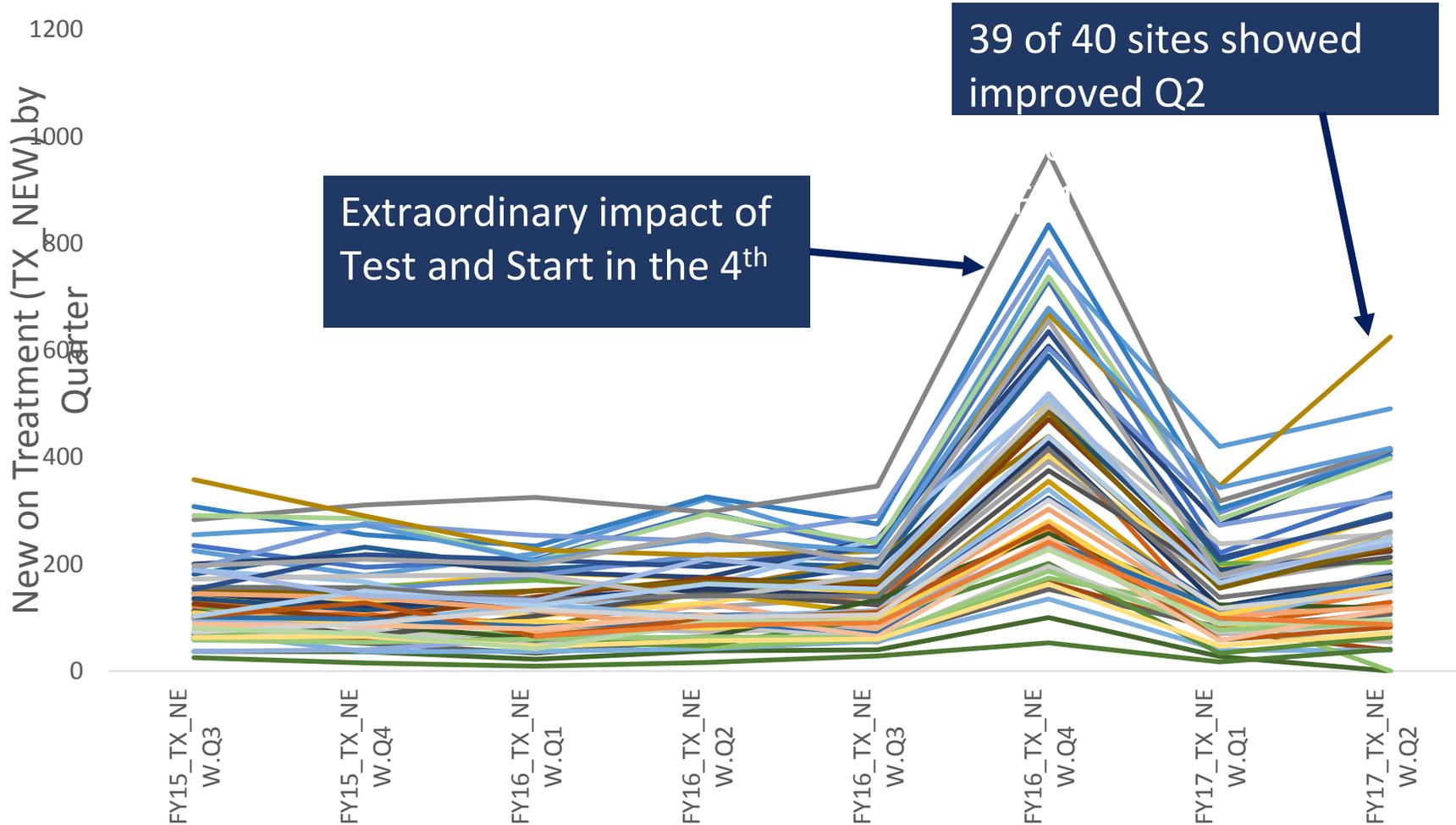
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Across the board increases in community testing*, yield up in Blantyre, Lilongwe and Zomba with work remaining for Q3 across scale up districts



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FY17 Q2 Data for 40 sites in 10 Scale-up Districts: Improvement in TX_NEW in Q2 versus Q1

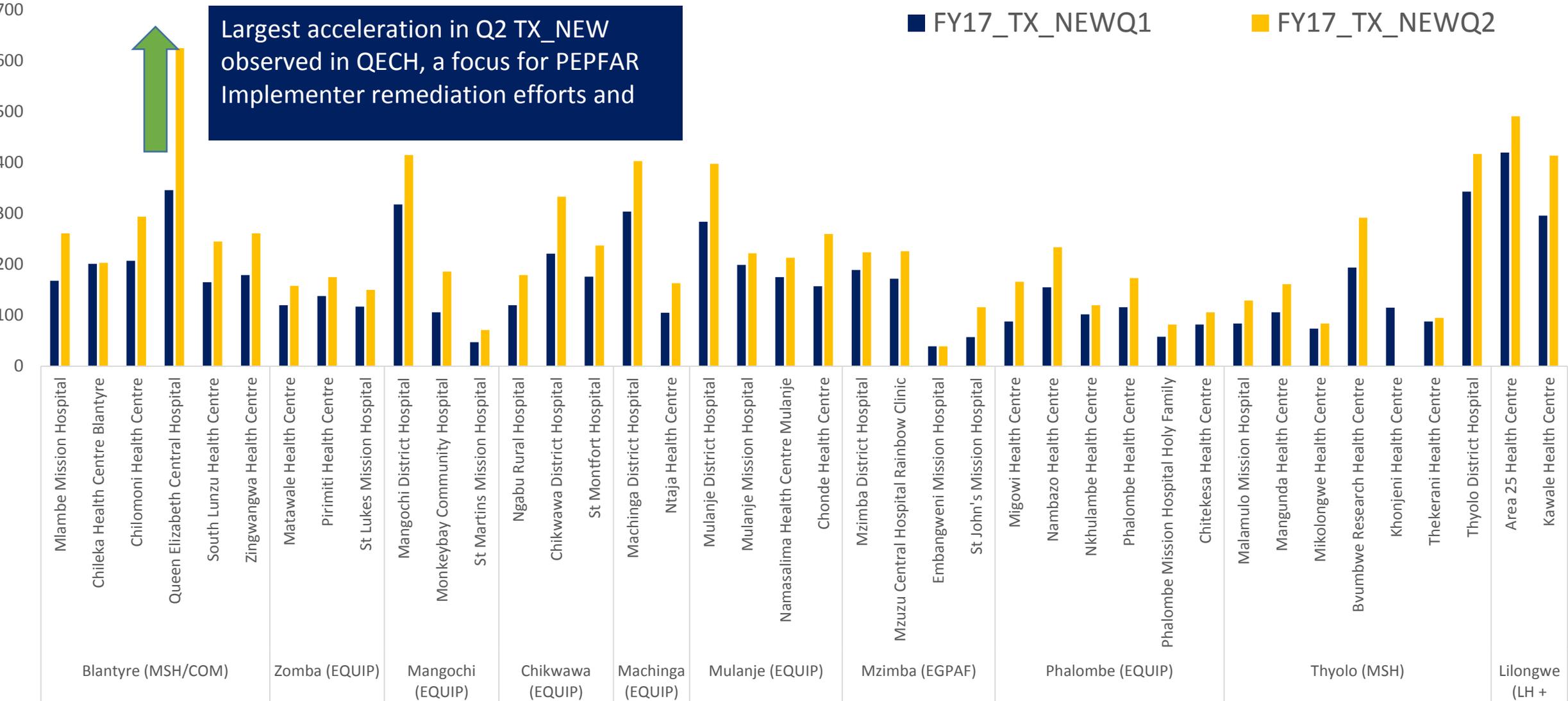


- **FY17 Q2 interventions that improved ART enrollment**
- Scale-up of Index case testing
- Scale-up of same day ART initiation
- Enhanced implementer management

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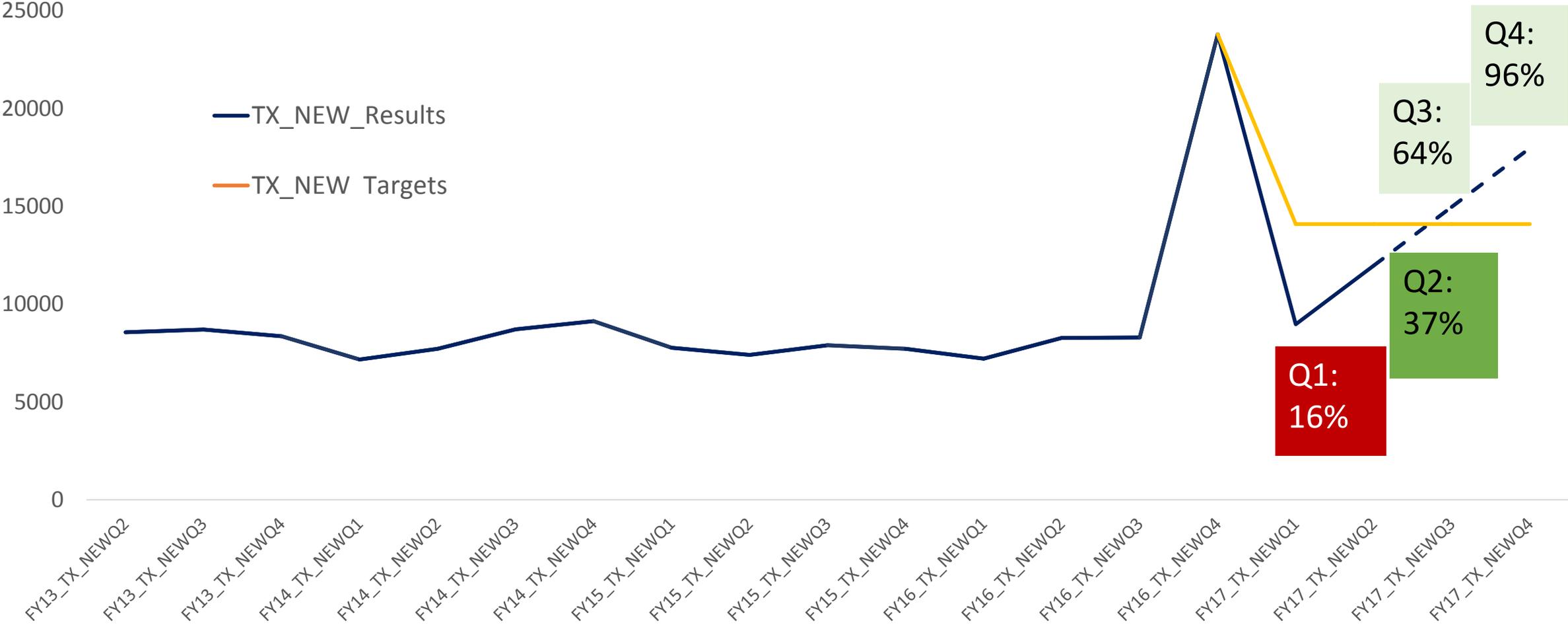
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39 of 40 sites in 10 Scale-up Districts Improved TX_NEW in Q2 versus Q1



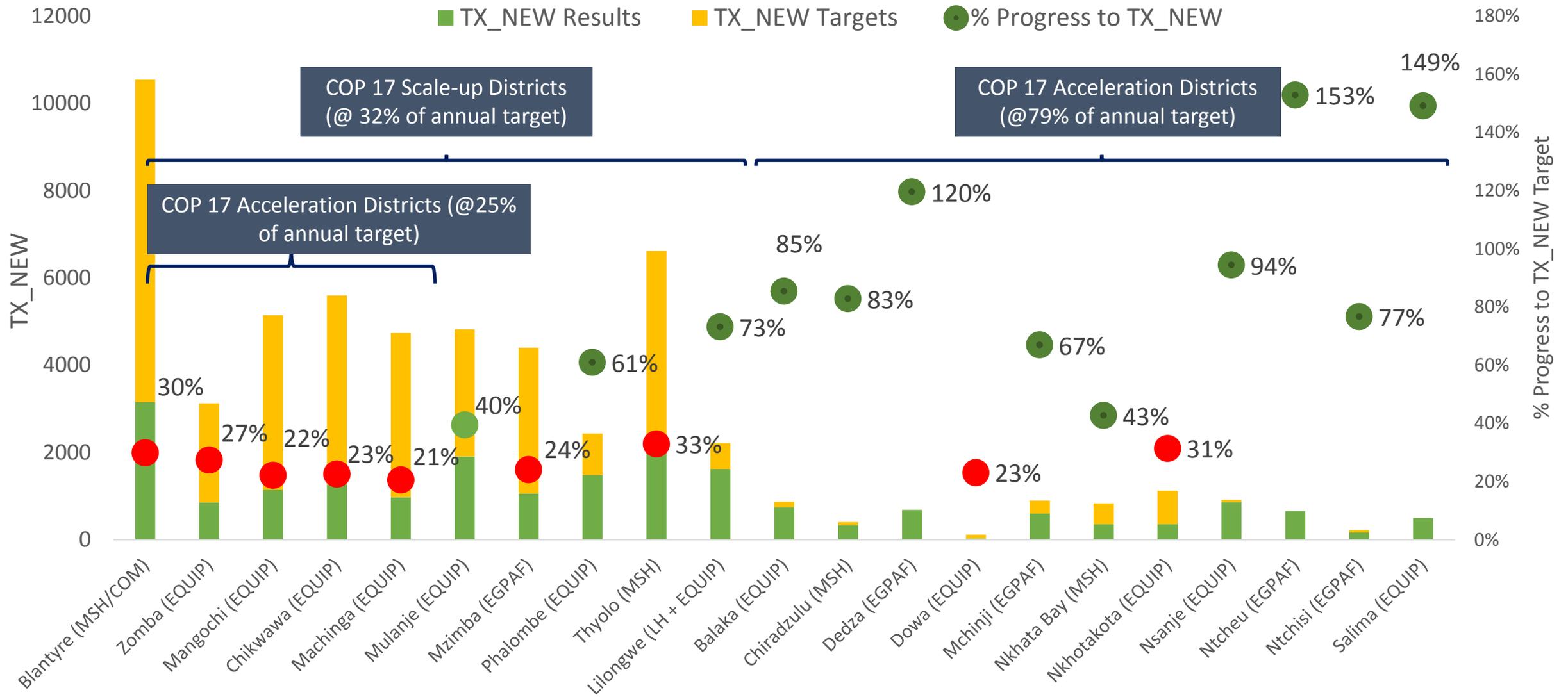
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Q2 Progress* Means we are at **37%** of Annual TX_NEW Target – current trend toward **96%** achievement of FY17 TX_NEW targets



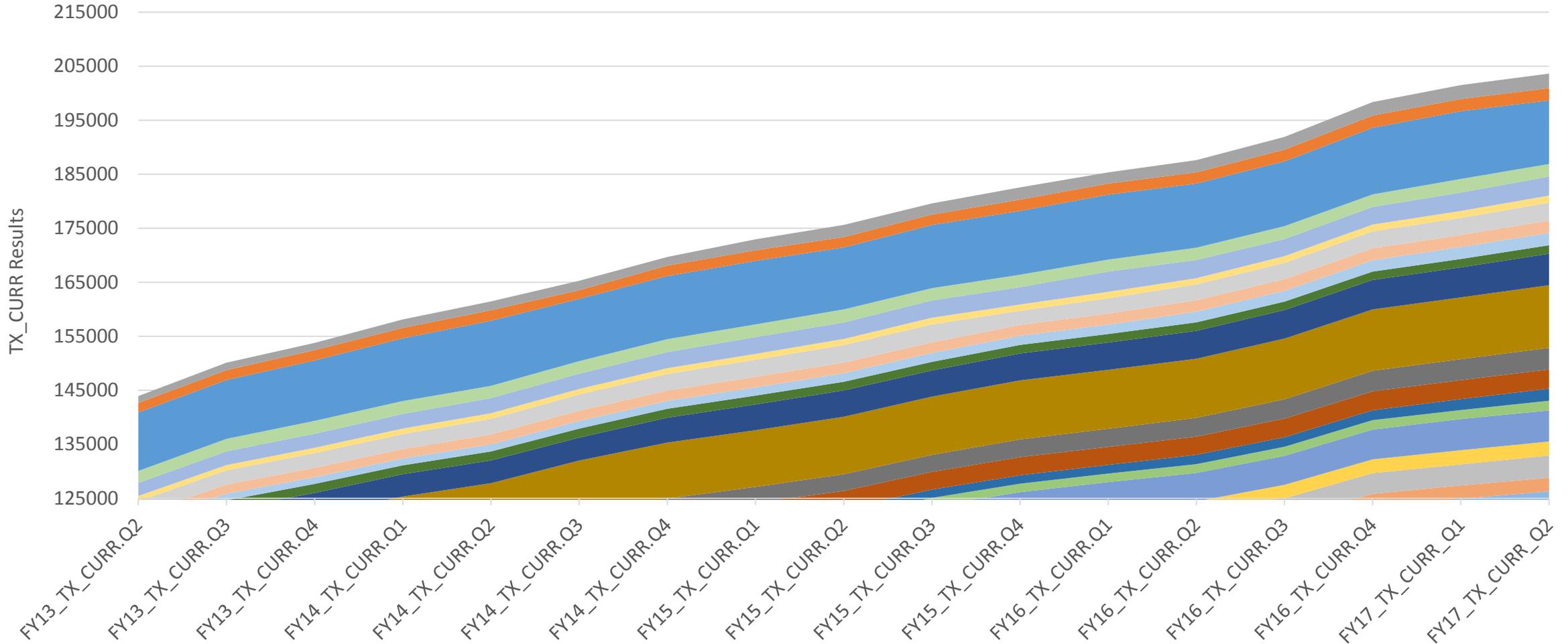
*EMRS data from 59 sites

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



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Continued Rapid Acceleration in current on treatment, Reaching 203,621 (93%) of annual target by end of Q2*

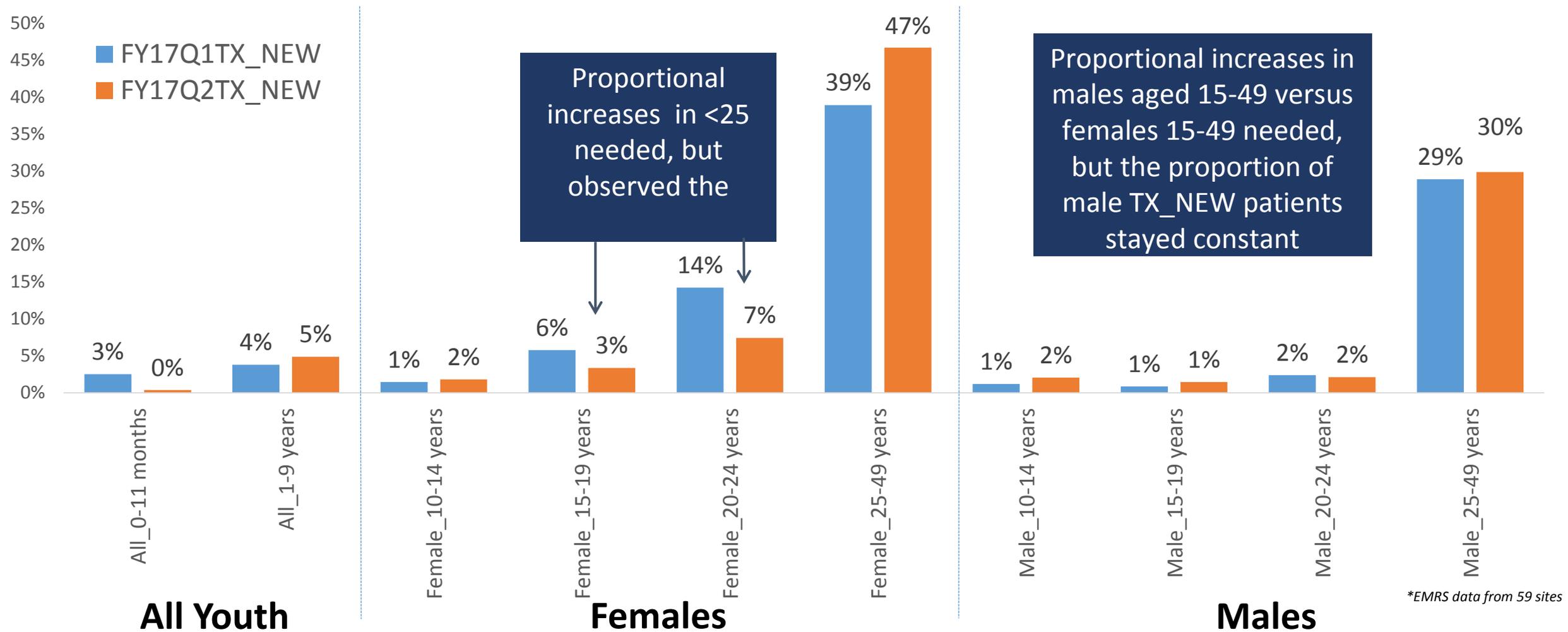


*EMRS data from 59 sites

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



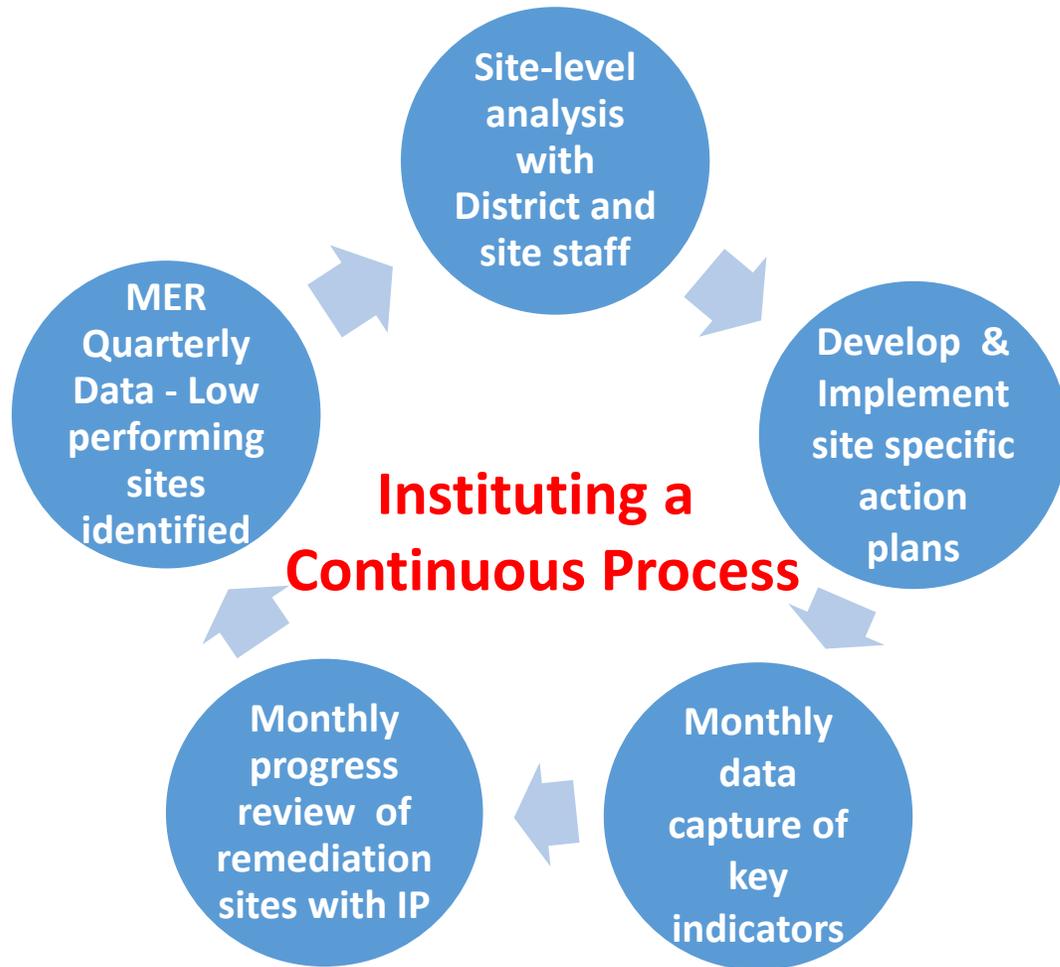
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Active Implementer Management Yielding Results

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Implementing Partner Performance Management: EQUIP Remediation Case Study – Mangochi and Zomba



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

Assalaam Clinic
Billy Riordan Memorial Clinic
Chikole Dispensary
Jalasi Health Centre
Katema Health Centre
Koche Community Hospital
Kukalanga Health Centre
Lugola health Centre
Lungwena Health Centre
Malembo Health Centre
Malukula Health centre
Mangochi District Hospital
Mase Health Centre
Monkeybay Rural Hospital
Mulibwanji Health Ceantre
Namalaka Health Centre
Namwera Health centre
Nankumba Health Centre
Nkope Health Centre
Phirilongwe Health Centre
St Martins Mission Hospital
Primiti Mission Hospital

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Partner develops site specific remediation plans

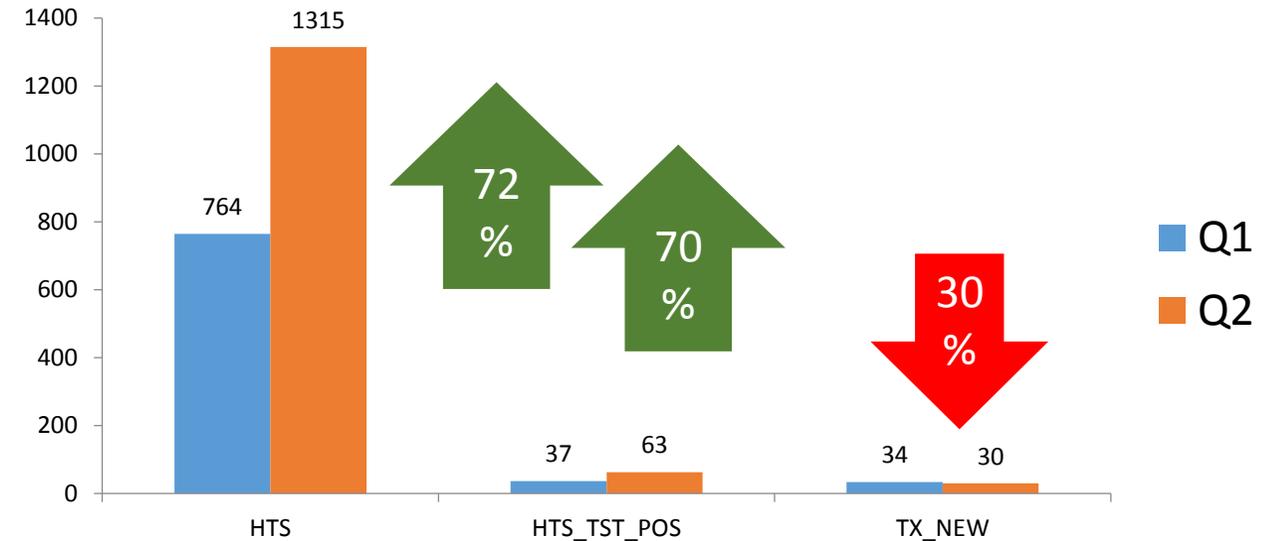
CHALLENGES:

- 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

Katema Health Center

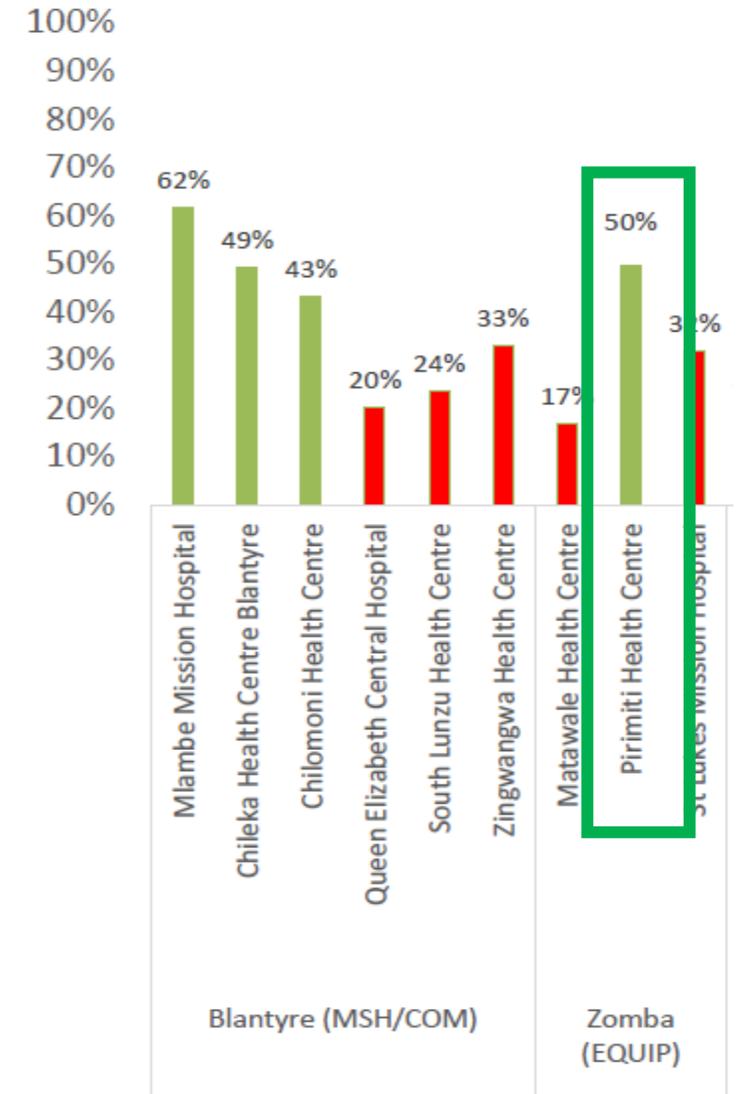


NEXT STEPS:

- Negotiations with site regarding frequency of counseling
- Lobbying with DMO re: staffing (nurses)
- Strengthening linkage systems

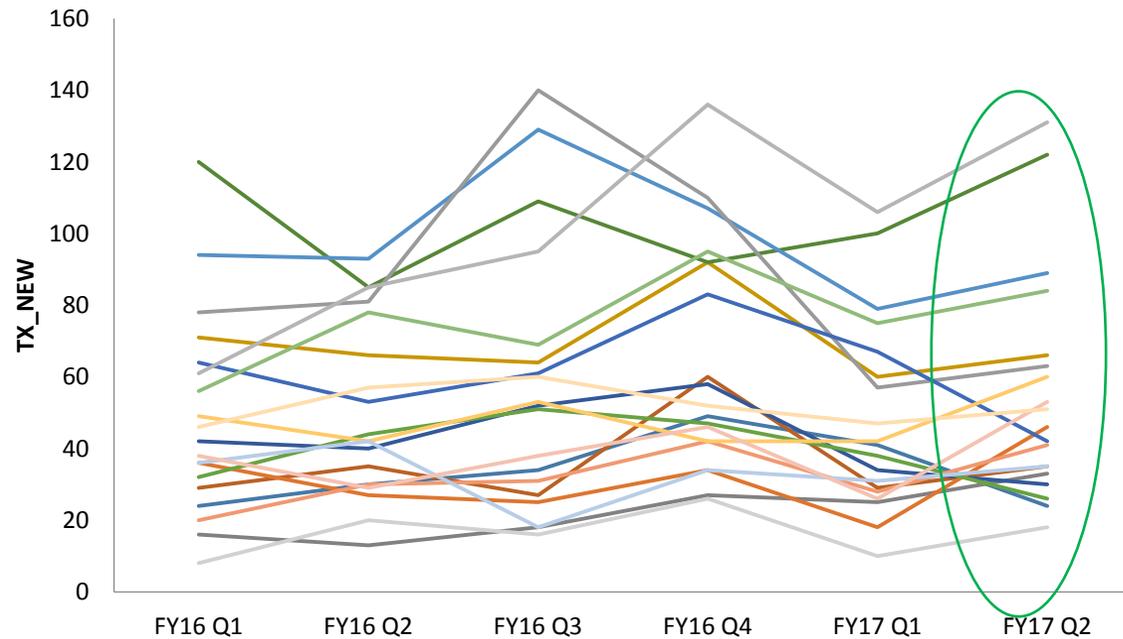
Why is Primiti Mission Hospital successful?

- 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, Peads, 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

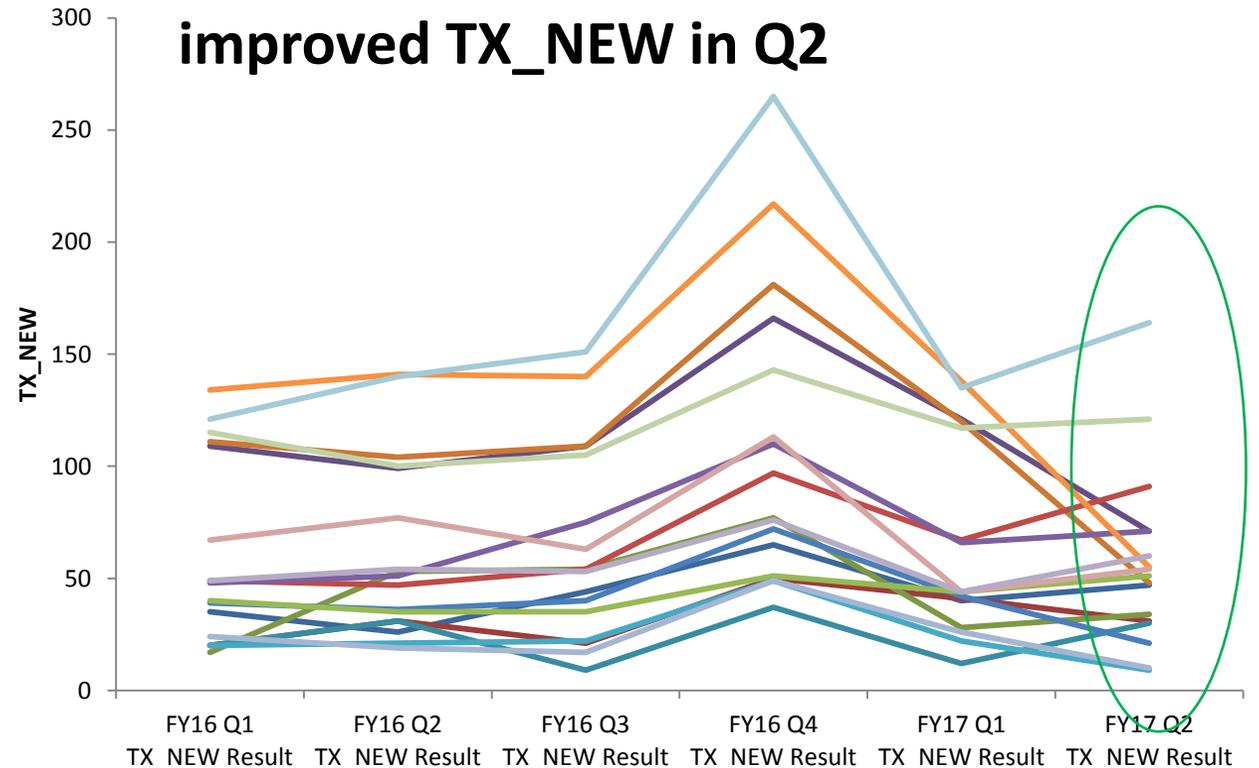


Targeted remediation efforts improve TX_NEW trends - Continued efforts required

MANGOCHI: 80% of remediation sites improved TX_NEW in Q2



ZOMBA: 60% of remediation sites improved TX_NEW in Q2



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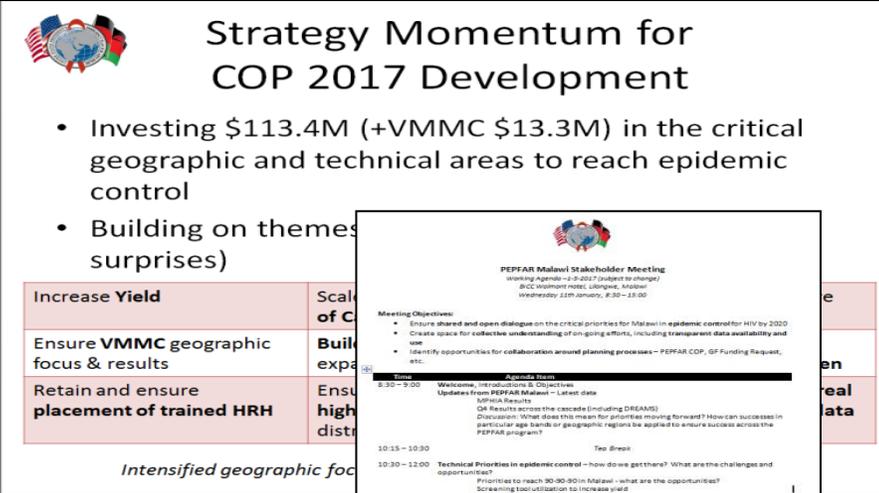


Stakeholder Review and Comments

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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



Strategy Momentum for COP 2017 Development

- Investing \$113.4M (+VMMC \$13.3M) in the critical geographic and technical areas to reach epidemic control
- Building on themes (surprises)

Increase Yield	Scale of C
Ensure VMMC geographic focus & results	Build exper
Retain and ensure placement of trained HRH	Ens high dist

Intensified geographic foc



PEPFAR Malawi Stakeholder Meeting
Working Agenda - 10-13-2017 (subject to change)
BCC: malawi@pepfar.org, Malawi
Wednesday 11th January, 8:30 - 12:00

Meeting Objectives:

- Ensure shared and open dialogue on the critical priorities for Malawi in epidemic control for HIV by 2020
- Create space for collective understanding of on-going efforts, including transparent data availability and use
- Identify opportunities for collaboration around planning processes – PEPFAR COP, GF Funding Request, etc.

Agenda Item

8:30-9:00	Welcome, Introductions & Objectives
9:00-9:30	Updates from PEPFAR Malawi – Latest data • HIV/AIDS • DR Results across the cascade (including DREAMS) Discussion: What does this mean for priorities moving forward? How can successes in particular age bands or geographic regions be applied to ensure success across the PEPFAR program?
10:15-10:30	Tea Break
10:30-12:00	Technical Priorities in epidemic control – how do we get there? What are the challenges and opportunities? Priorities to reach 90-90-90 in Malawi – what are the opportunities? Screening tool utilization to increase yield Site level analysis: Zomba example Discussion: How do we find the positives? How do we use data to target men and AGYW 55-64?
12:00-13:00	Collective planning, coordination & investment – how do we match the technical priorities with resources? COP 2017 – overview and priorities for Malawi GF Funding Request Opportunities to enhance District Coordination Discussion & Group Work: Opportunities moving forward
13:00-14:00	Lunch
14:00-15:00	Next Steps: Maintaining momentum and ensuring close collaboration Report back Key dates & insights, other opportunities and moving into development/planning processes



Logos for National AIDS Commission (NAC), MANASO, UNAIDS, and Bill & Melinda Gates Foundation.

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

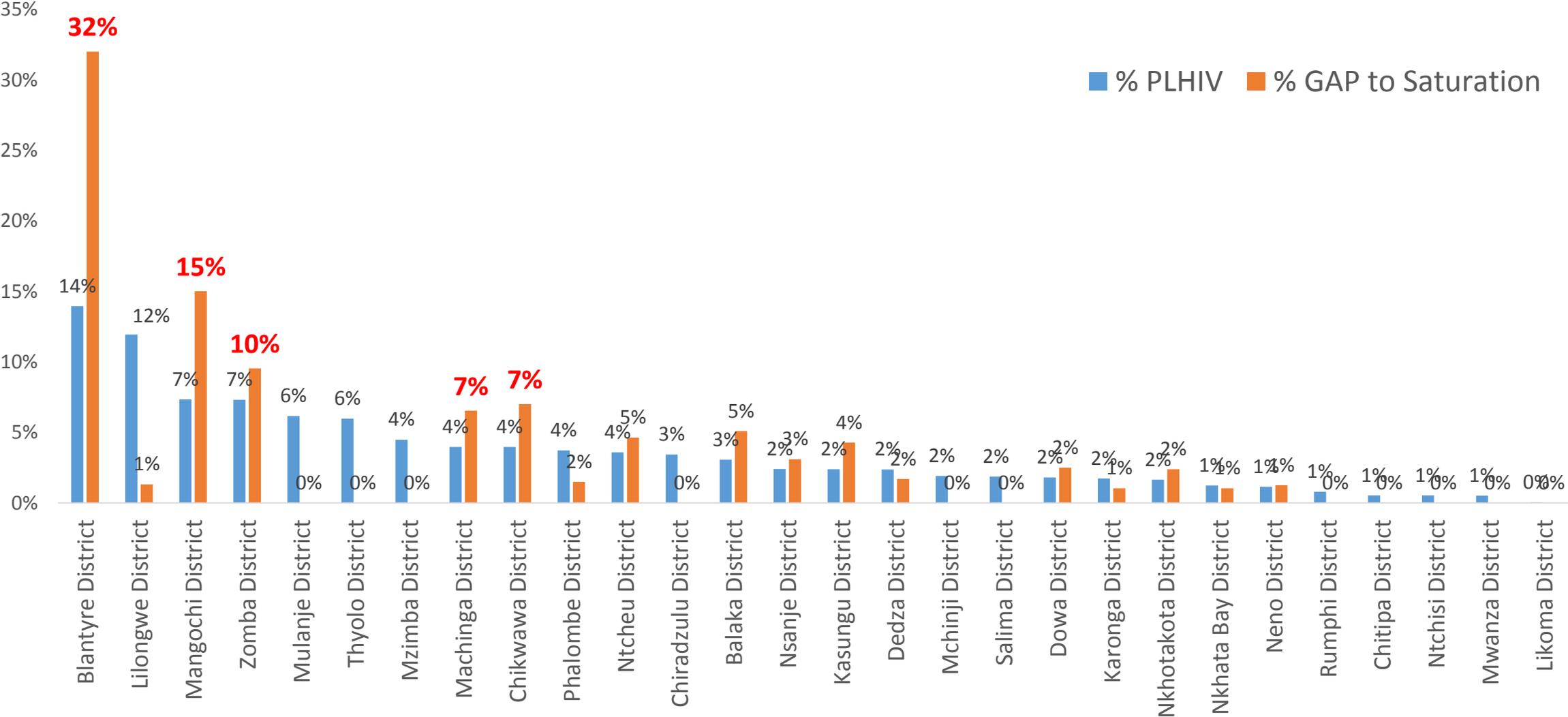
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Evaluation of Progress in 10 Scale Up Districts: 5 Districts on Track but 5 Need to Accelerate to Saturate

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

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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

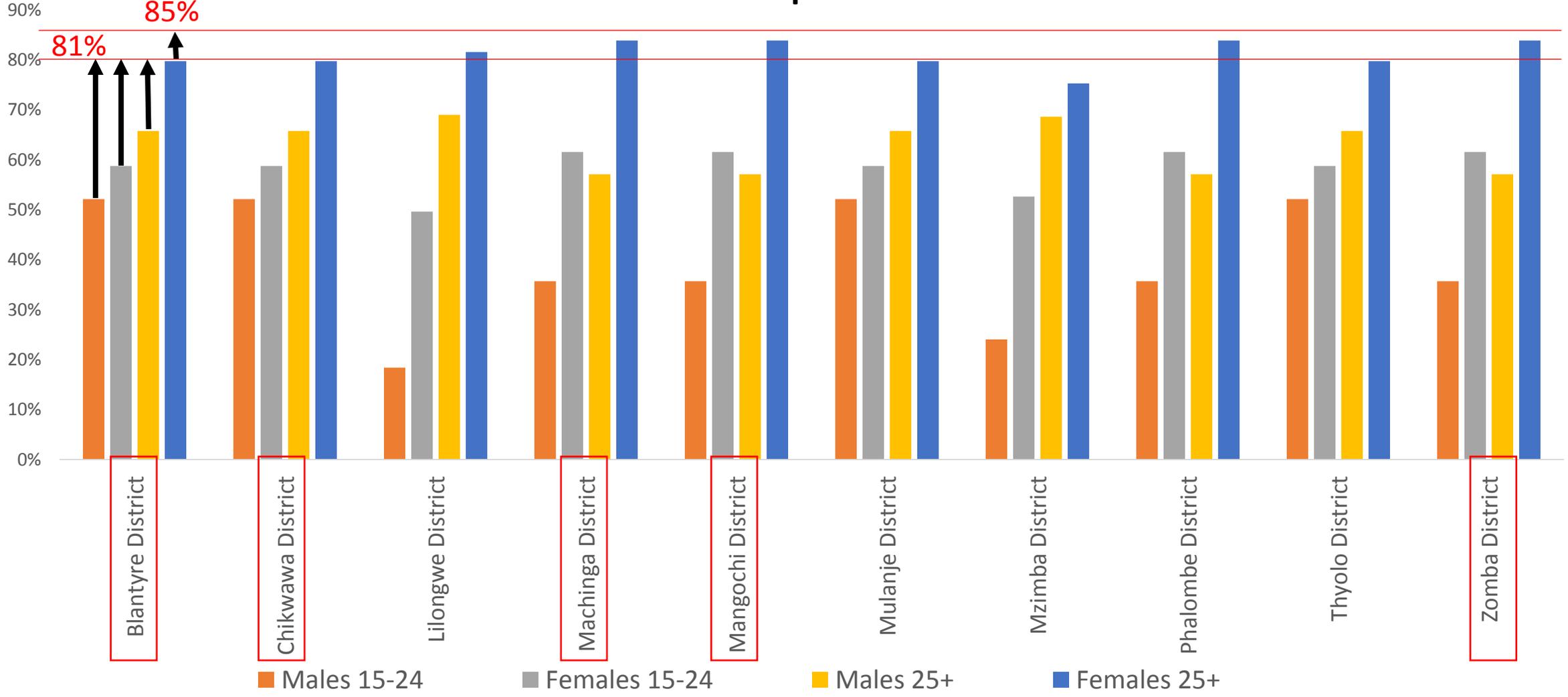




Targeting men and youth and increasing yield

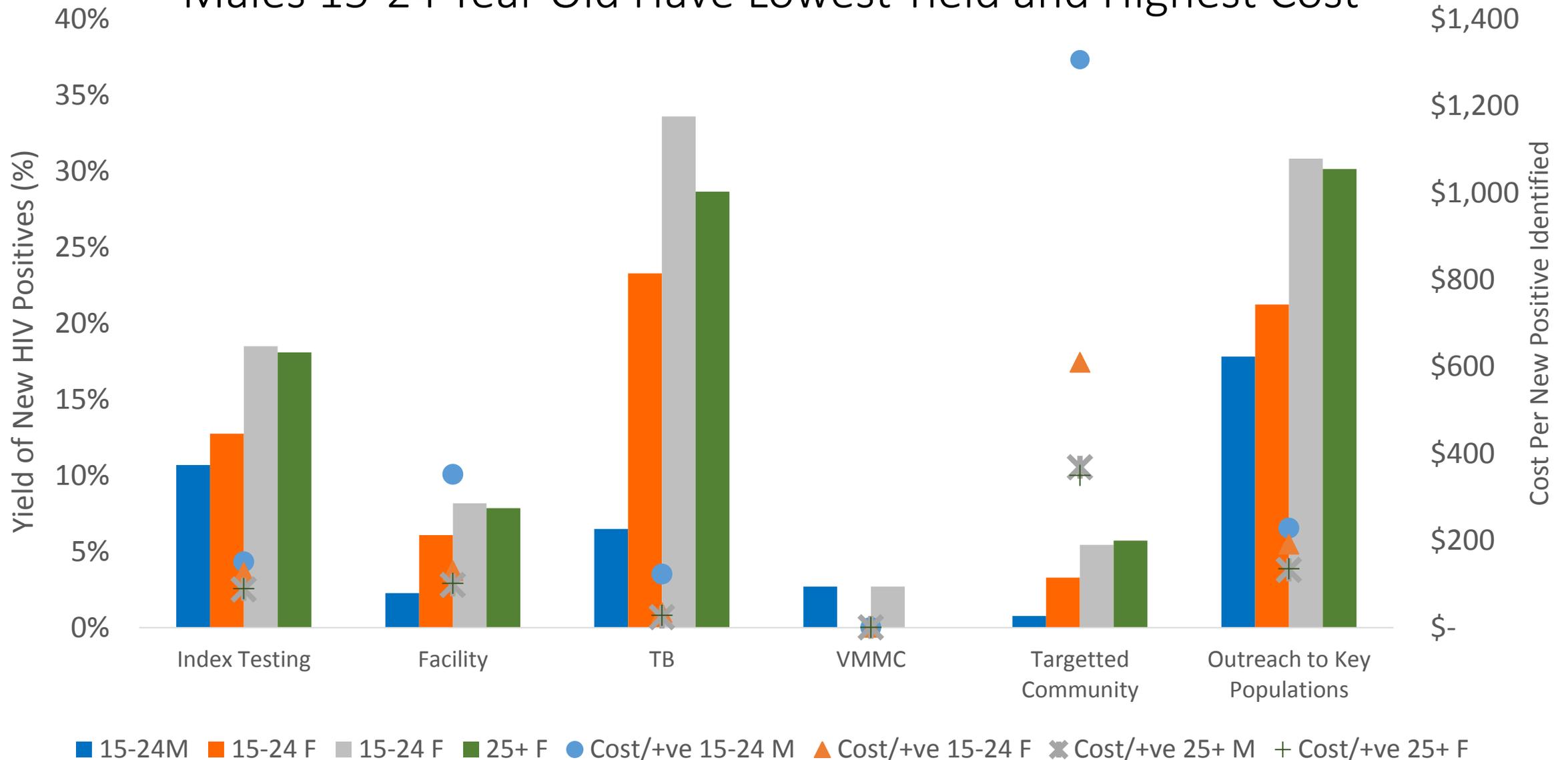
Addressing the first 90

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



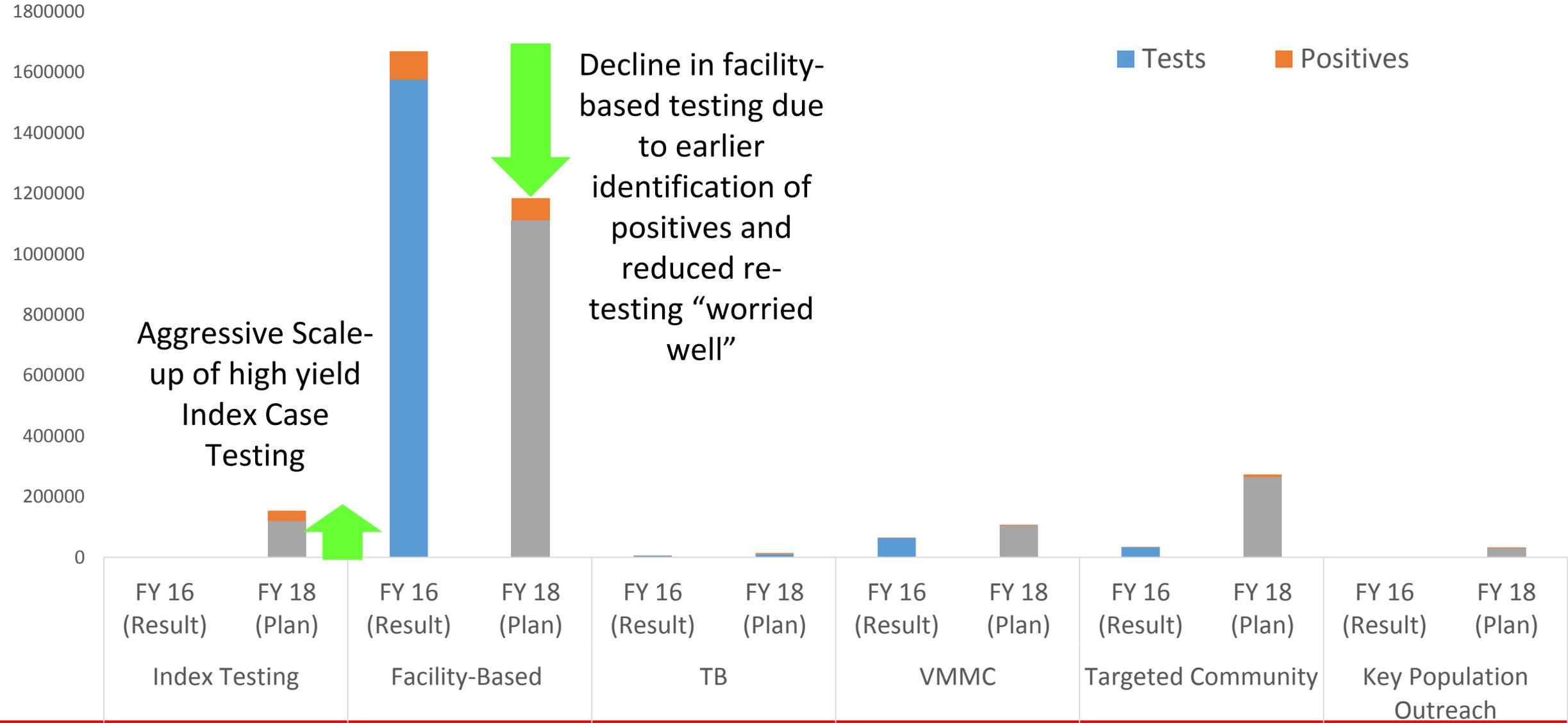
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Reaching the first 90 Yield and Cost Per Positive: Males 15-24 Year Old Have Lowest Yield and Highest Cost



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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



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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

	Model	Progress update
1	Facility-based Treatment Clubs (building on Teen Clubs)	<ul style="list-style-type: none">• Expanded number of teen clubs to all districts• Standardized package to improve retention and viral suppression
2	Community ART Groups	<ul style="list-style-type: none">• Monthly refills through nominated group member• Expansion underway in Thyolo, Chiradzulu, Salima, Chikwawa and Nsanje

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Scaling up Differentiated ART Service Delivery models

	Model	Progress update
3	Pharmacy Fast Track	<ul style="list-style-type: none"> • 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
4	Nurse led ART	<ul style="list-style-type: none"> • Support groups in Lilongwe urban • Enrolled 200 patients -132 patients in Q1 and 68 in Q2
5	Advanced HIV management at Lighthouse	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Already doing 3 months with option for 6+ month

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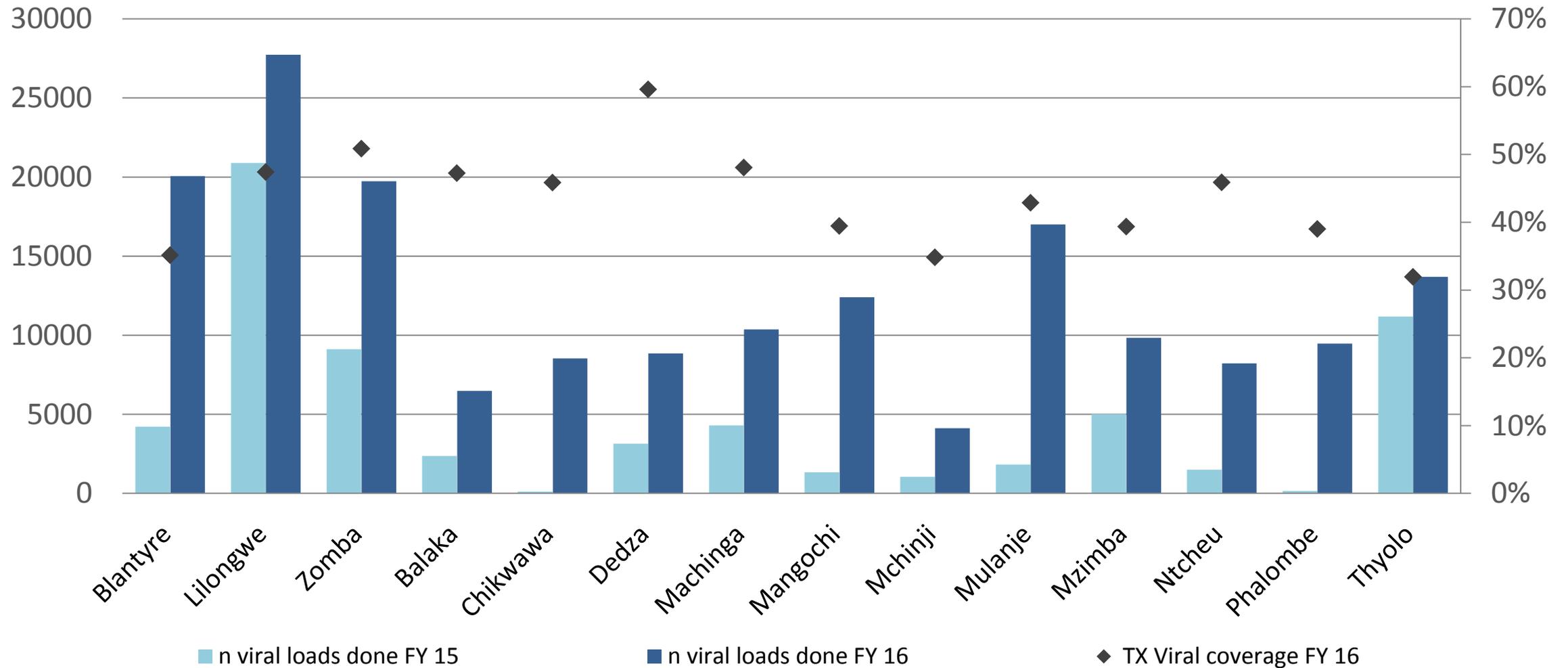


Focusing on Retention, Adherence and VL Suppression

Third 90

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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

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

site	artstartdate	visit_date	regimen	bleeddate	lab_value	visit_date_last	drug_name_last
1859	10/22/74	7/27/05	9/30/15 5A		9/30/15	40	9/28/16 5A
1860	4/4/73	7/4/11	7/16/15 5A		7/16/15	40	9/28/16 5A
1861	2/2/67	10/27/05	10/19/15 5A		10/19/15	40	10/14/16 5A
1862	3/3/74	12/19/06	1/27/15 5A		1/27/15	40	8/24/16 5A
1863	12/3/77	1/3/07	5/22/15 5A		5/22/15	40	8/8/16 5A
1864	7/1/73	1/9/06	6/22/16 5A		6/22/16	40	9/29/16 5A
1865	10/22/68	2/14/06	11/4/15 5A		11/4/15	40	9/1/16 5A
1866	8/11/46	7/20/07	6/25/15 5A		6/25/15	40	11/1/16 5A
1867	7/1/64	2/17/10	4/7/16 5A		4/7/16	40	10/10/16 5A
1868	3/11/73	9/23/05	5/18/16 5A		6/1/16	40	8/26/16 5A

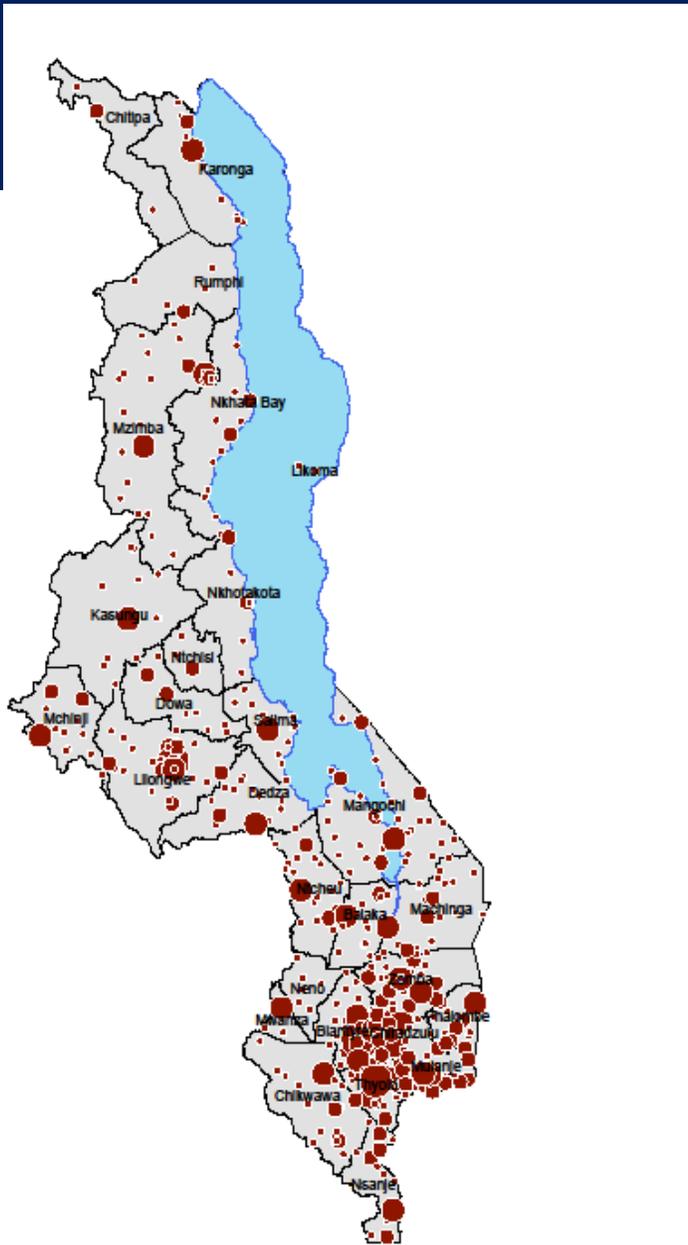
Case review: Patient was on 1st line regimen when her VL was taken, her VL was suppressed, and she stayed on 1st line

6/14/75	7/2/10	6/20/16 2A		6/20/16	31685	9/30/16 7A
6/26/67	9/21/05	10/20/15 2A		10/20/15	37324	10/4/16 7A
6/26/81	10/11/10	10/6/14 2A		10/6/14	51732	8/18/16 7A
8/8/03	10/1/15	4/22/16 2A		4/22/16	52779	10/28/16 7A
3/28/66	10/27/12	6/24/15 2A		6/24/15	54144	8/24/16 7A
7/1/83	12/19/12	6/15/16 2A		6/21/16	70760	10/11/16 7A
2/9/81	8/1/12	4/15/15 2A		4/15/15	94229	10/4/16 7A
9/2/72	4/14/09	2/9/15 2A		3/5/15	168735	10/13/16 7A
5/27/70	2/13/09	2/20/15 2A		2/20/15	289391	8/23/16 7A

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

Strategic Viral Load Scale-up

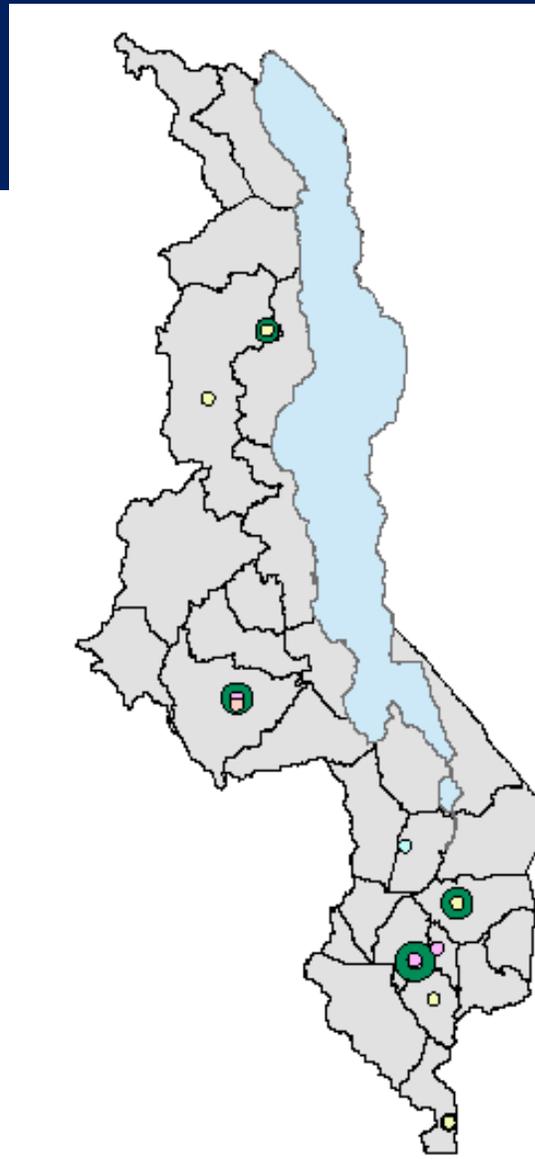
PEPFAR-supported
Facilities



TX_CURR

- 110-1419
- 1420-3511
- 3512-7734
- 7735-19929

Viral Load
Laboratories



planned VL tests

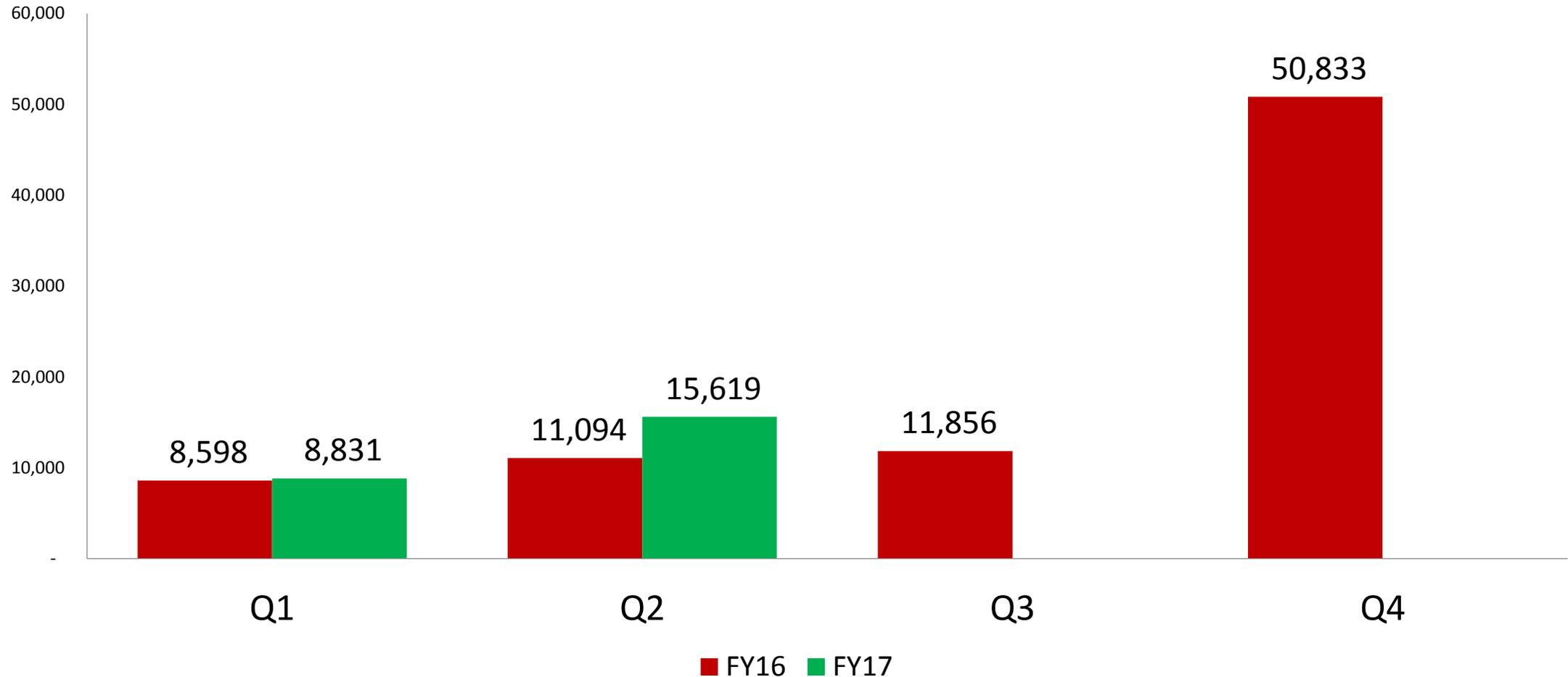
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VMMC

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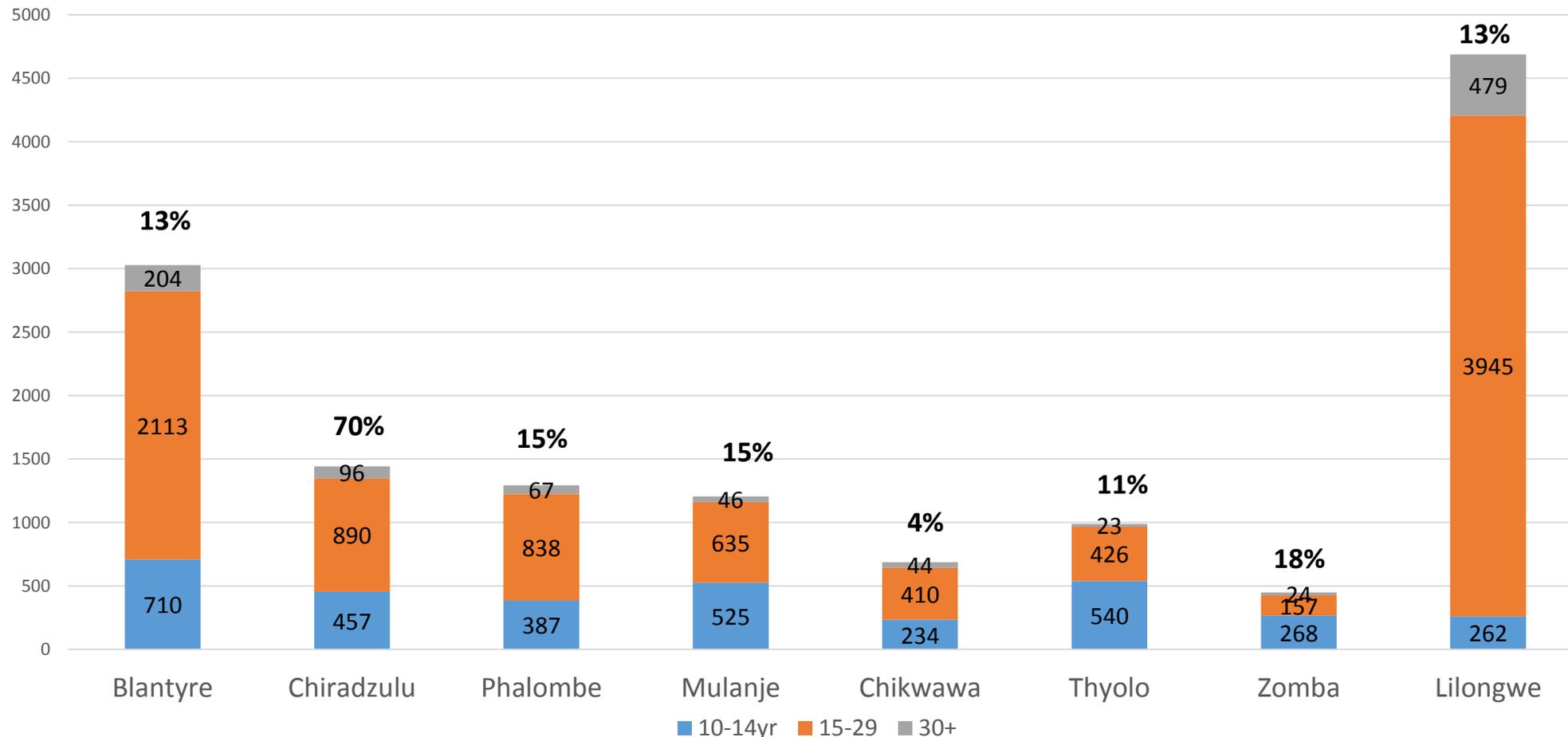
VMMC Results: FY 17 Q2 shows improvement over FY 16 (Q1 & Q2) with anticipated seasonal spike



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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



Strategic Shifts **NOW**



Priorities for COP17

- 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**

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**

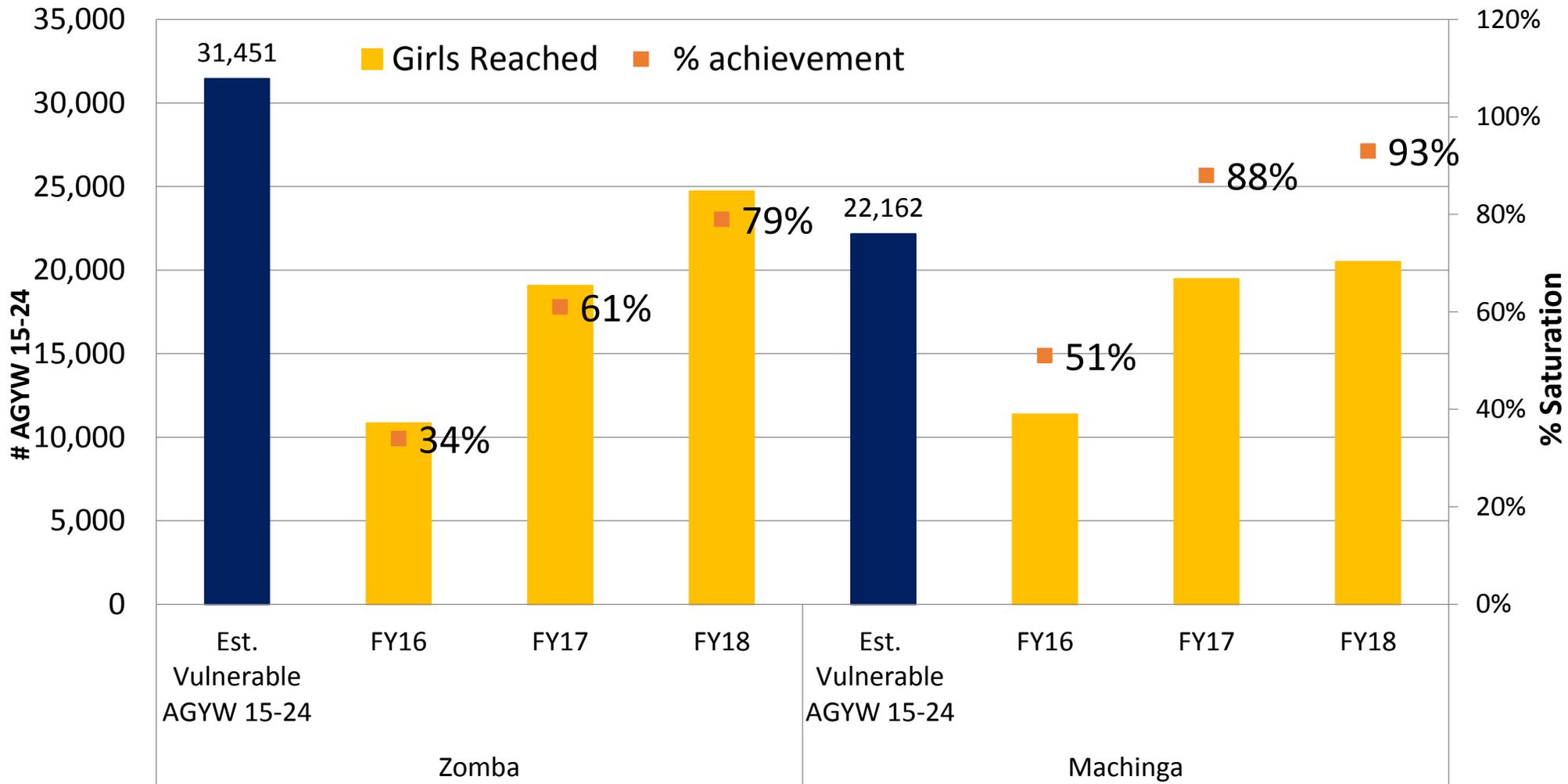
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DREAMS & AGYW Innovation

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

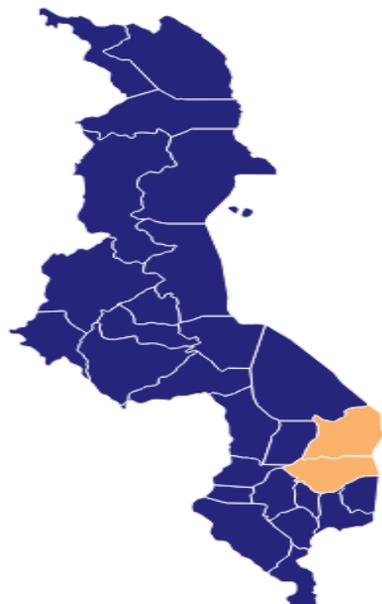
On track to meet FY17 target to reach 60% of vulnerable girls: Focus now on intensifying programmatic layering



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COP 2017 DREAMS Site and District Expansion

Based on Facility Data (burden high/coverage low) and MPHIA



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

Zomba	Machinga	Blantyre
Proposed expansion to 5 additional sites	Proposed expansion to 2 additional sites	Up to 3 highest burden facility catchment areas building on existing OVC/FSW/AGWY

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

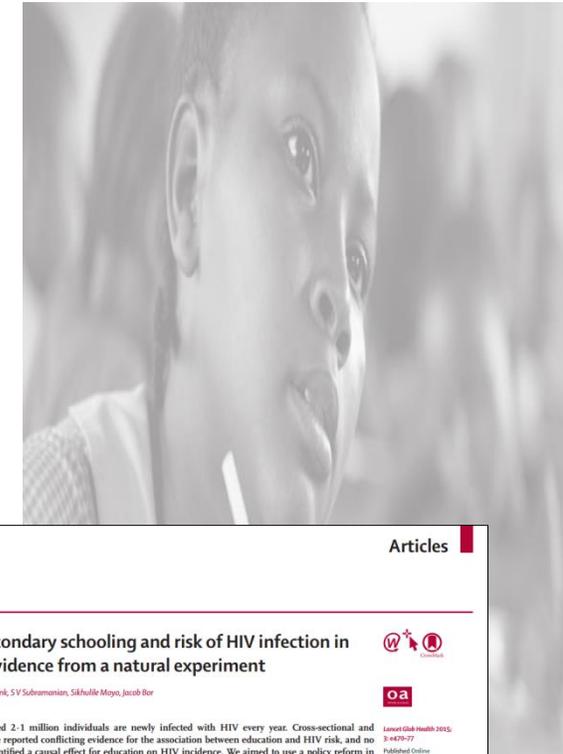
Building from the Botswana Study: Increasing AGYW access to secondary school to decrease risk of HIV in Malawi

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



Articles

Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment

Jim Walter De Neve, Günther Fisk, S V Subramanian, Sikhalile Moyo, Jacob Bor

Summary
Background An estimated 2.1 million individuals are newly infected with HIV every year. Cross-sectional and longitudinal studies have reported conflicting evidence for the association between education and HIV risk, and no randomised trial has identified a causal effect for education on HIV incidence. We aimed to use a policy reform in secondary schooling in Botswana to identify the causal effect of length of schooling on new HIV infection.

Methods Data for HIV biomarkers and demographics were obtained from the nationally representative household 2004 and 2008 Botswana AIDS Impact Surveys (N=7018). In 1996, Botswana reformed the grade structure of secondary school, expanding access to grade ten and increasing educational attainment for affected cohorts. Using exposure to the policy reform as an instrumental variable, we used two-stage least squares to estimate the causal effect of years of schooling on the cumulative probability that an individual contracted HIV up to their age at the time of the survey. We also assessed the cost-effectiveness of secondary schooling as an HIV prevention intervention in comparison to other established interventions.

Findings Each additional year of secondary schooling caused by the policy change led to an absolute reduction in the cumulative risk of HIV infection of 8.1 percentage points (p=0.008), relative to a baseline prevalence of 25.5% in the pre-reform 1990 birth cohort. Effects were particularly large in women (11.6 percentage points, p=0.046). Results were robust to a wide array of sensitivity analyses. Secondary school was cost effective as an HIV prevention intervention by standard metrics (cost per HIV infection averted was US\$27753).

Interpretation Additional years of secondary schooling had a large protective effect against HIV risk in Botswana, particularly for women. Increasing progression through secondary school could be a cost-effective HIV prevention measure in HIV-endemic settings, in addition to yielding other societal benefits.

Funding Takemi Program in International Health at the Harvard T.H. Chan School of Public Health, Belgian American Educational Foundation, Fernand Lazard Foundation, Boston University, National Institutes of Health.

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Introduction
HIV continues to be a major global health challenge with an estimated 2.1 million new infections each year. Formal education, particularly of girls, has been hailed as education might increase the size of an individual's sexual network, prolong the period of premarital sex,¹ and increase transactional sex among men.² In addition to the implication of this study for HIV prevention, we

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See Comment page e428

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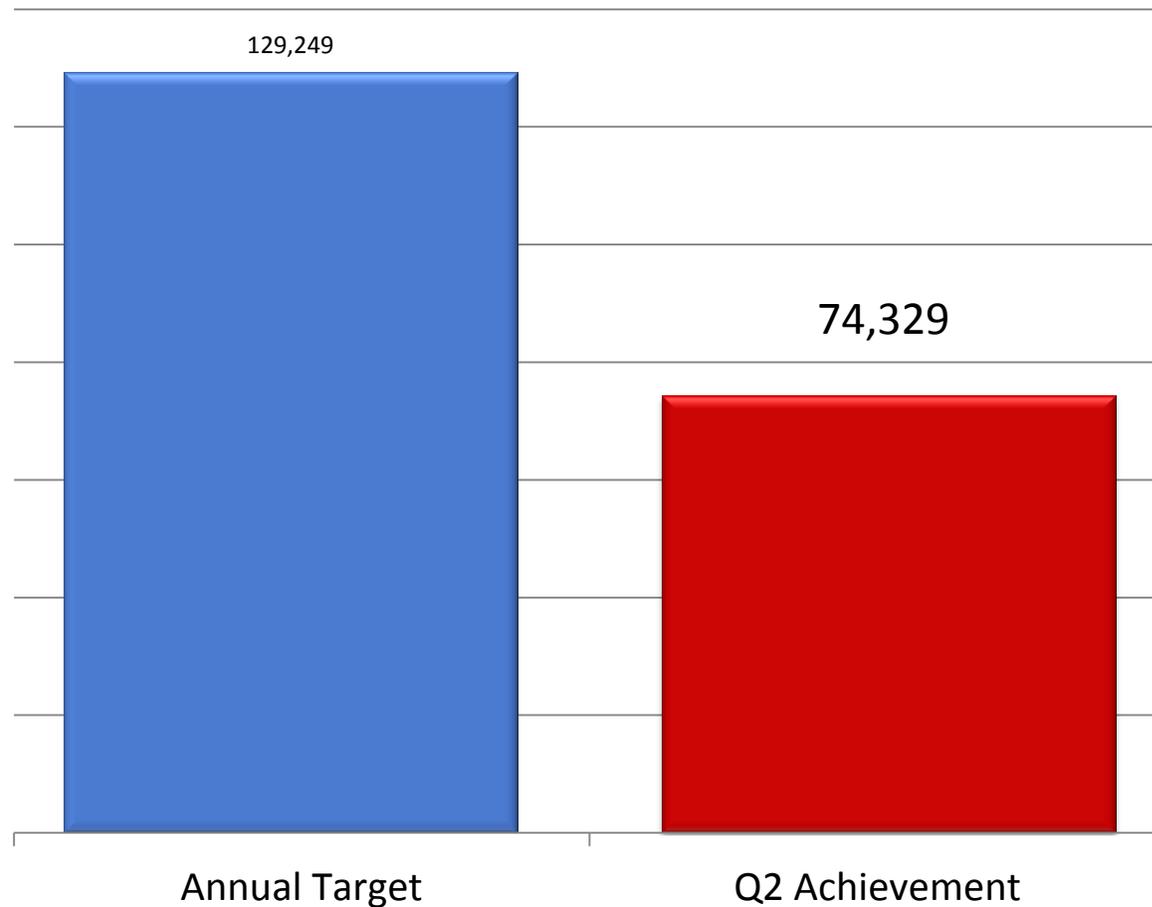
Correspondence to: Jacob Bor, Department of Global Health, Boston University School of Public Health, Boston, MA, 02118, USA (jacobbor@bu.edu)



Orphans & Vulnerable Children

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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

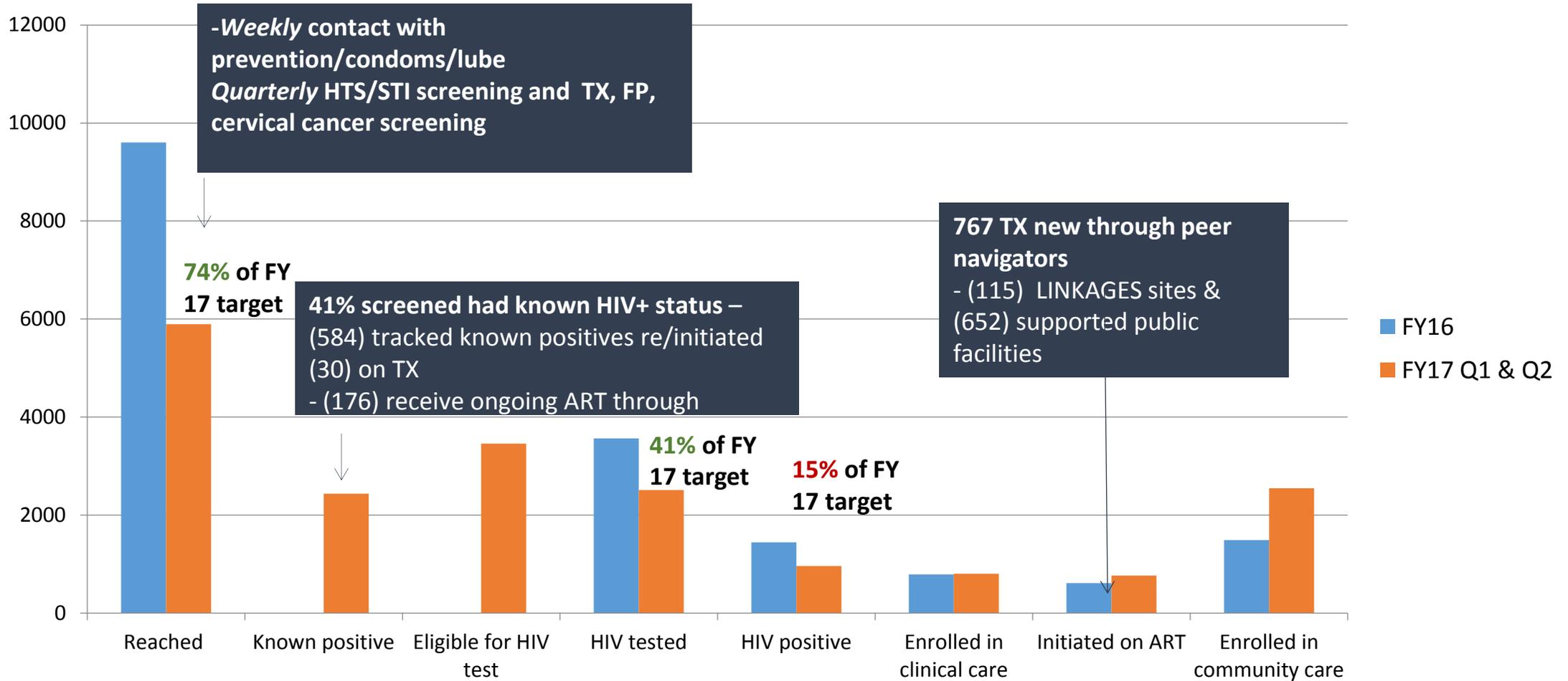




Key Populations

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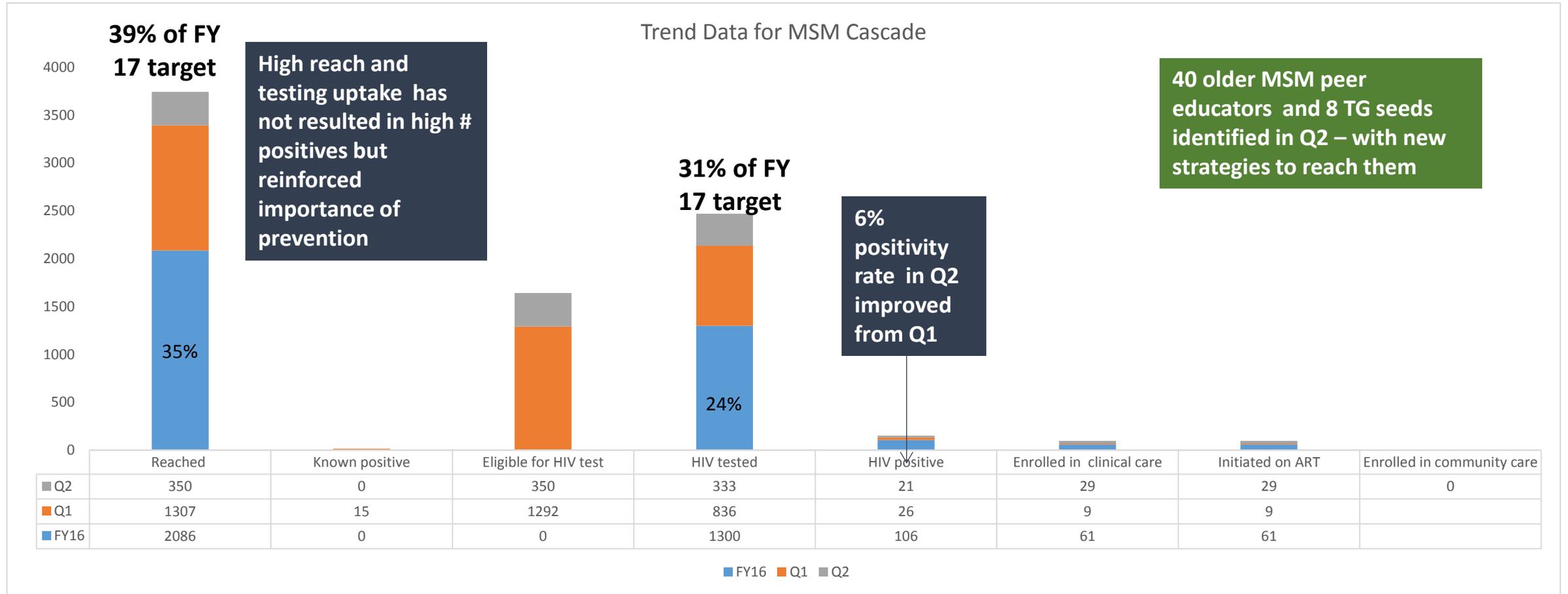
Key Population Results: Momentum building - FY 17 improved progress toward annual FSW targets



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

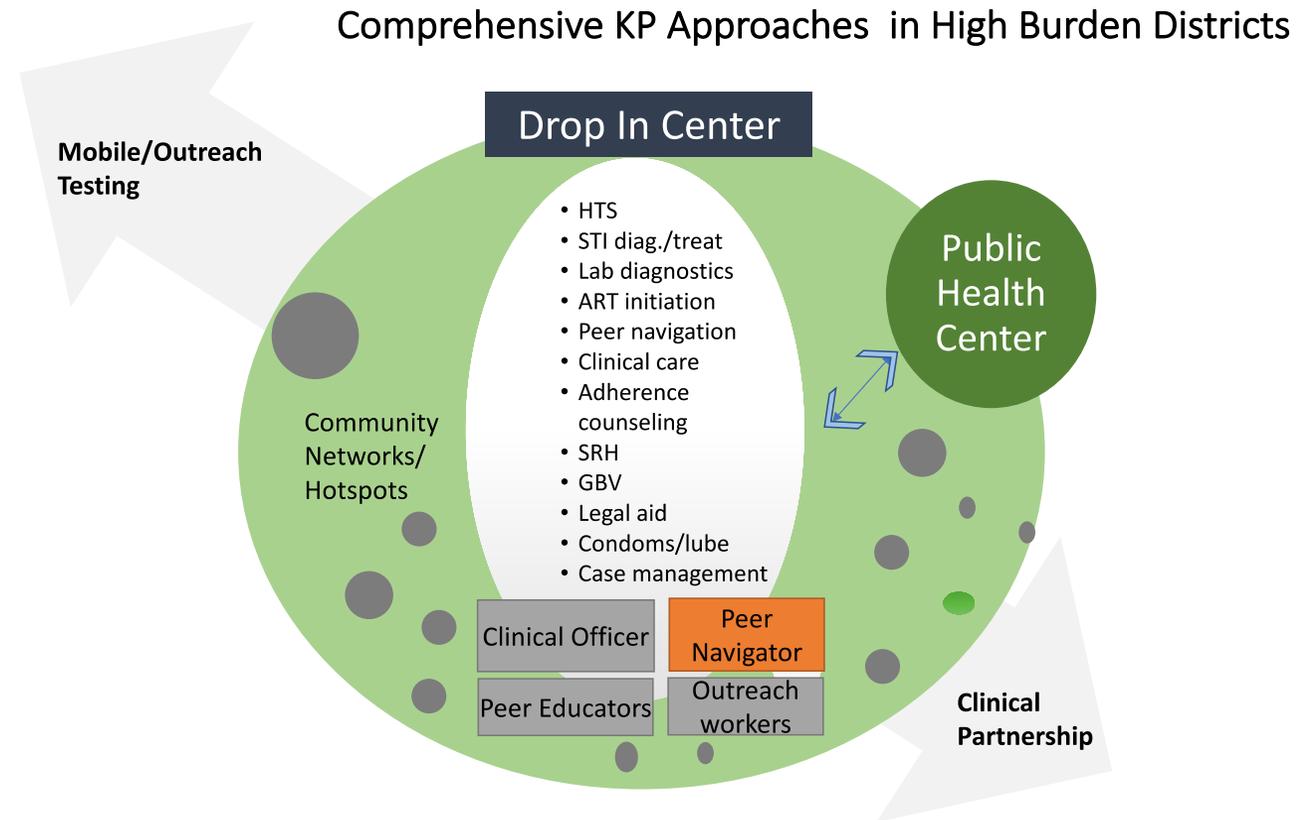


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Building on Momentum to Improve Quality and Expand Coverage

- **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

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Data Disaggregation to ensure collection, analysis and reporting for real time strategic shifts

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

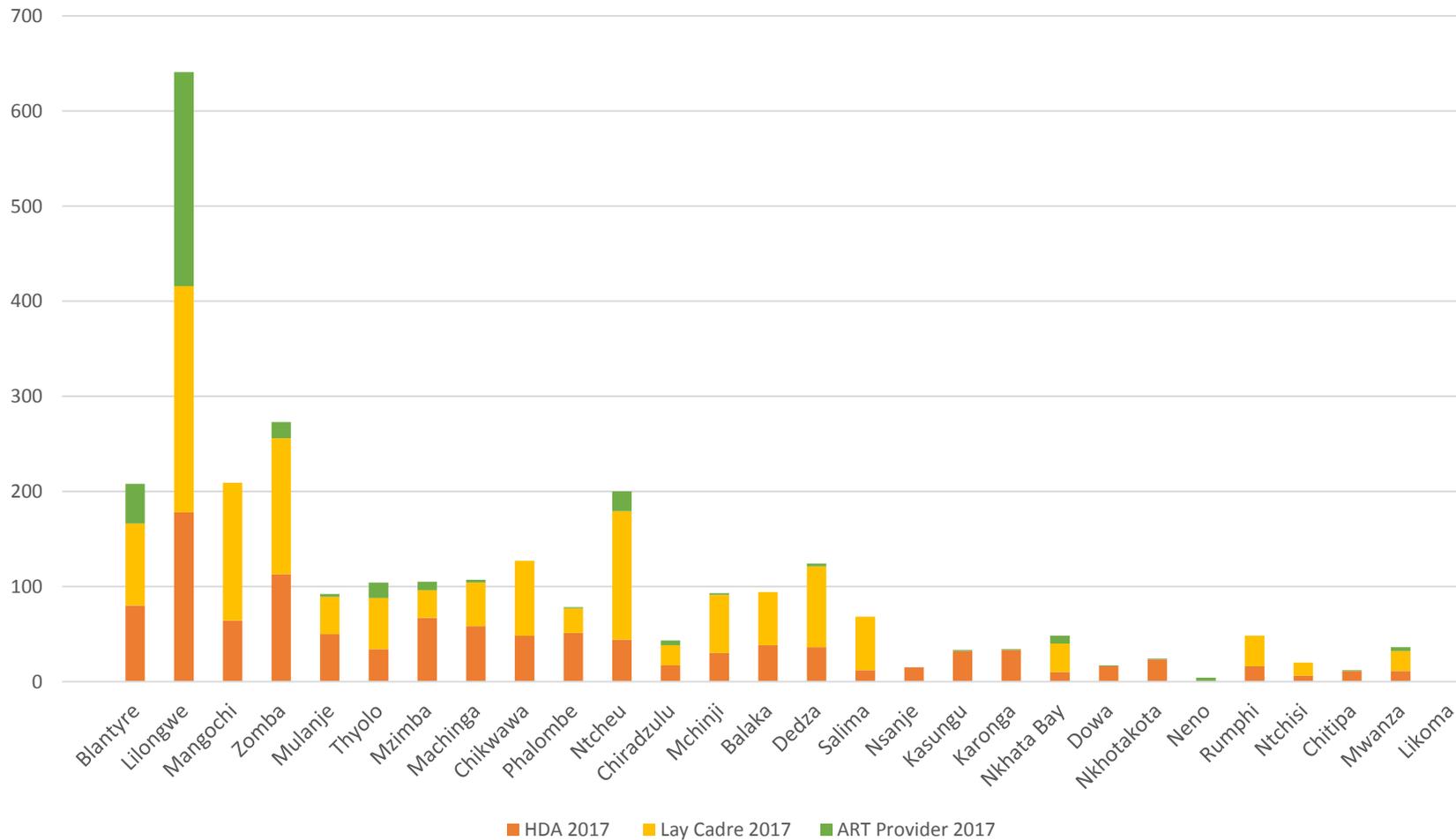


Direct Service Delivery: Increasing HRH Investment & Delivering on Infrastructure

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HRH: Preliminary DSD Audit Results 2017 demonstrate coverage continued shift to scale up districts

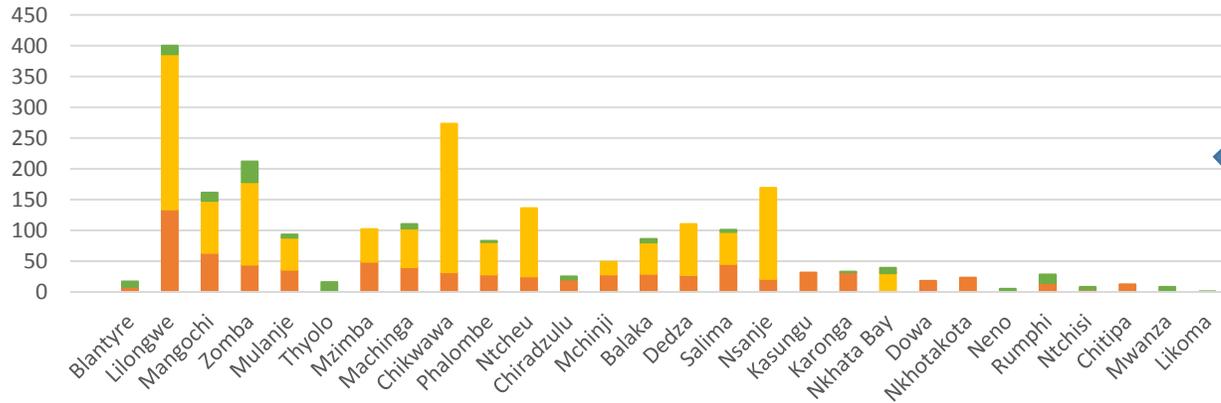
2017 DSD Results



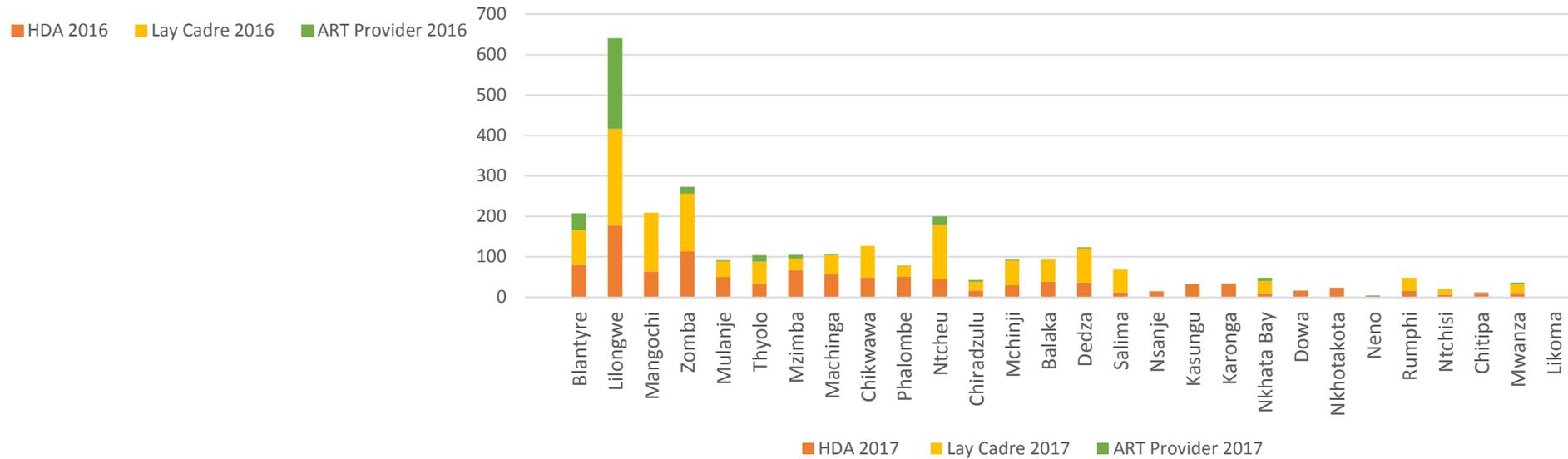
- **HDA**s increased by 330
- **Reduced lay workers** by 33 (shifting strategy from non-monetary to stipend)
- **Increased ART providers** by 211 (mostly in LLW)
- **Increased staffing in Blantyre and Zomba** - Lilongwe remains highest (Lighthouse as Center of Excellence)
- *Preliminary data only*

Snapshot: DSD Audit Results and trends in 2016 vs 2017

2016 DSD Results

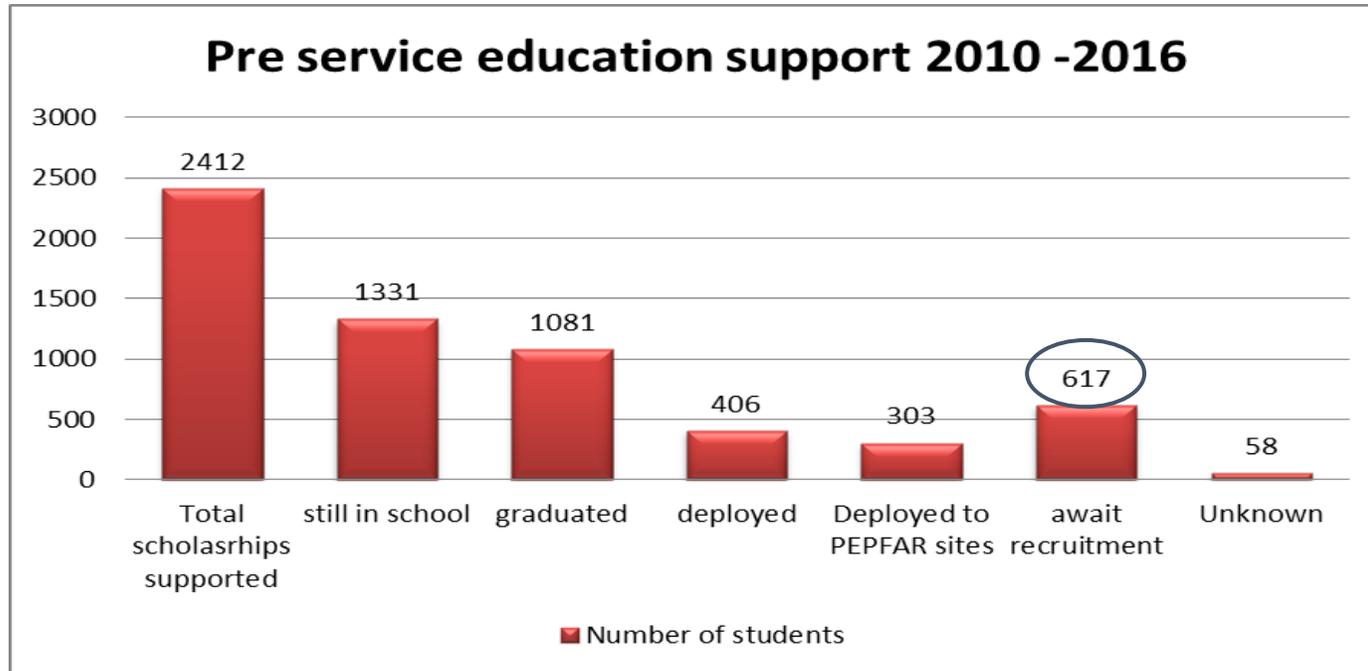


2017 DSD Results



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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)**

Students in pipeline	Expected Graduates 2017	Expected Graduates 2018	Expected Graduates 2019
1,331	98	480	753

Surge Capacity Details: Additional 480 Health Care Workers in Five Acceleration Districts (\$1.6M on COP17 – shift since meeting)

District	Number of Facilities	Total Additive Health Care Workers
Chikwawa	18	72
Mangochi	35	140
Machinga	17	68
Zomba	2	8
Blantyre	18	72
Total	90	360
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

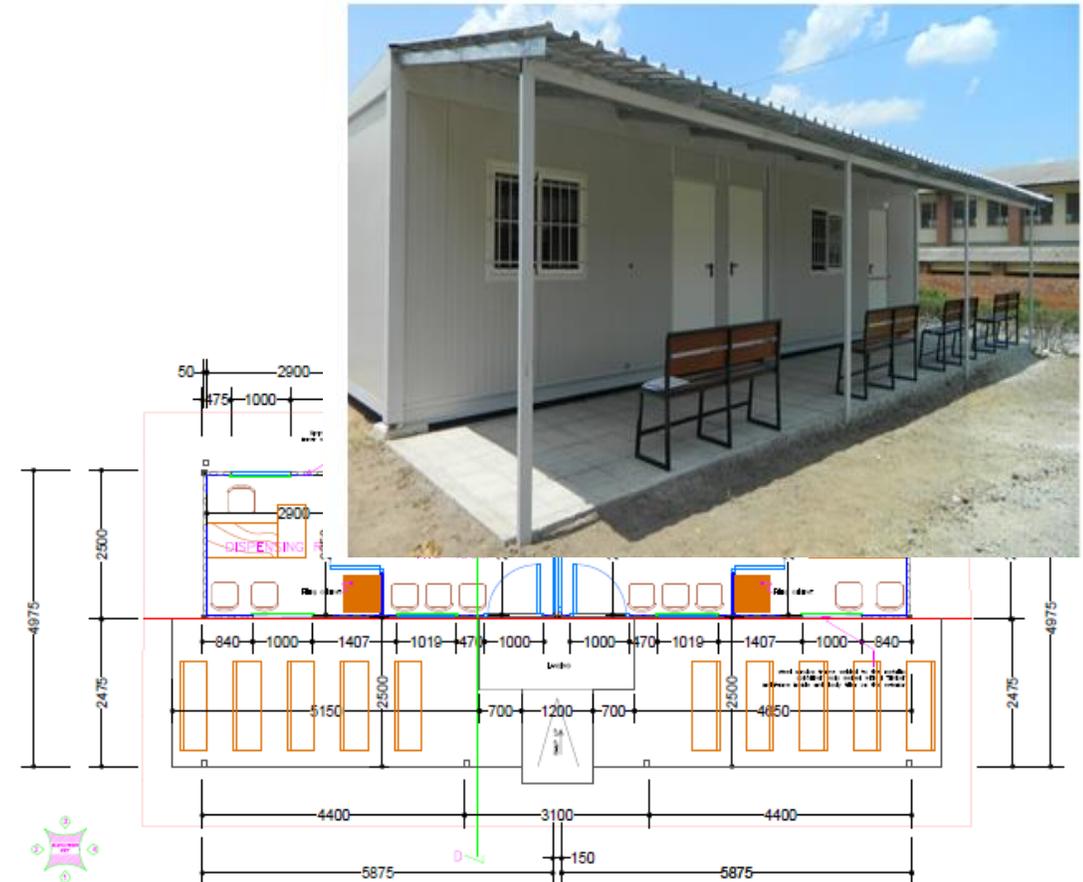
Infrastructure update: Pre-fabricated ART and HTS Space to address site level service delivery bottlenecks

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**

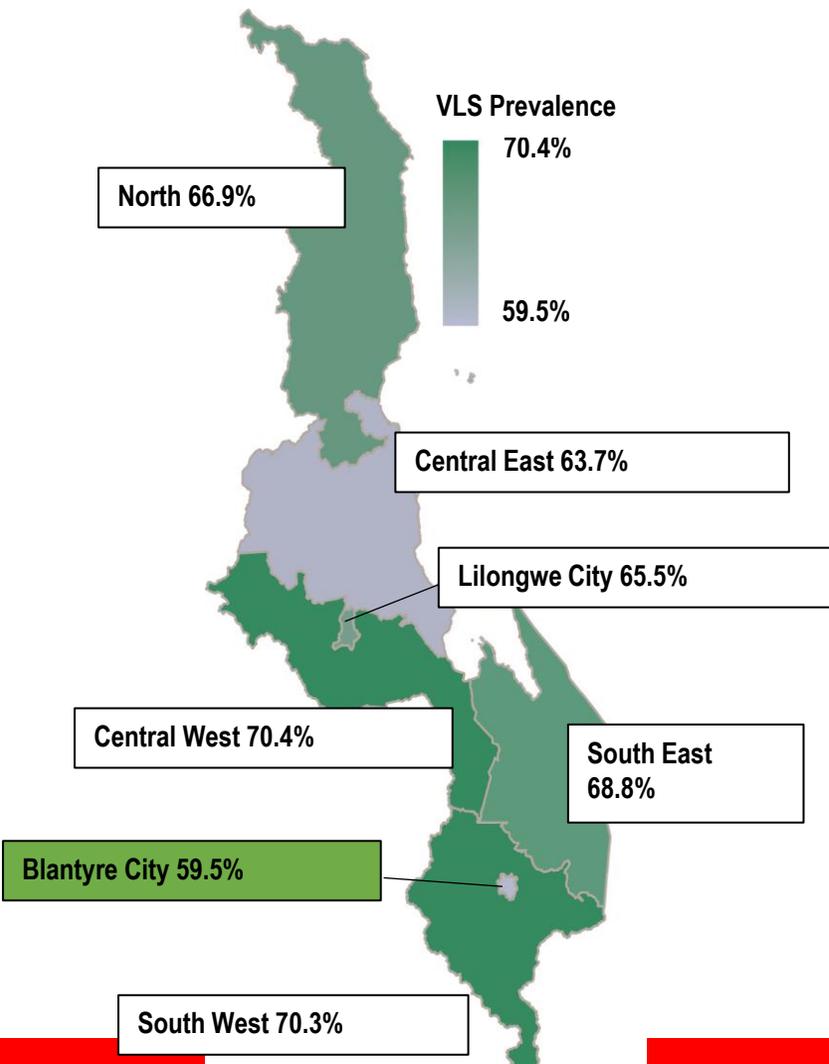
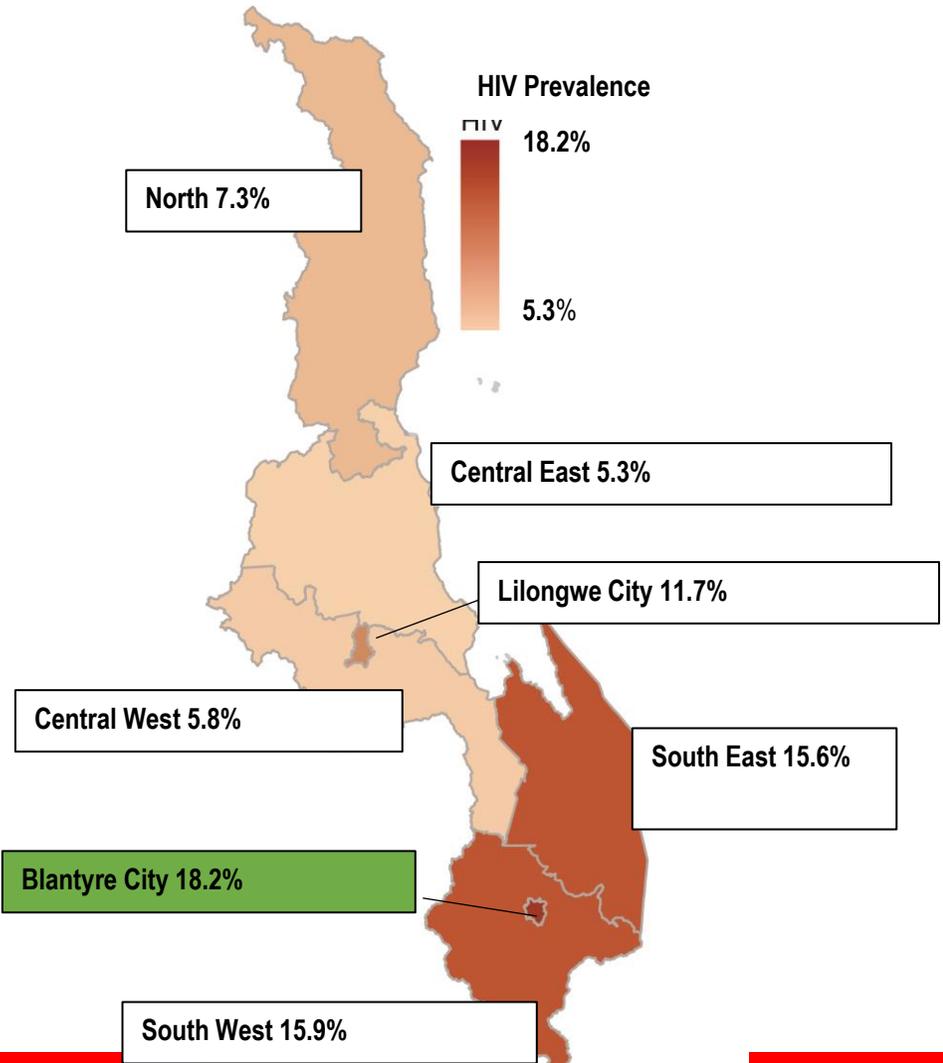




Implementing the Blantyre Strategy

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MPHIA and Program Data Indicate the Urgent Need to Respond to the Epidemic in **Blantyre**



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

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Blantyre Deep Dive

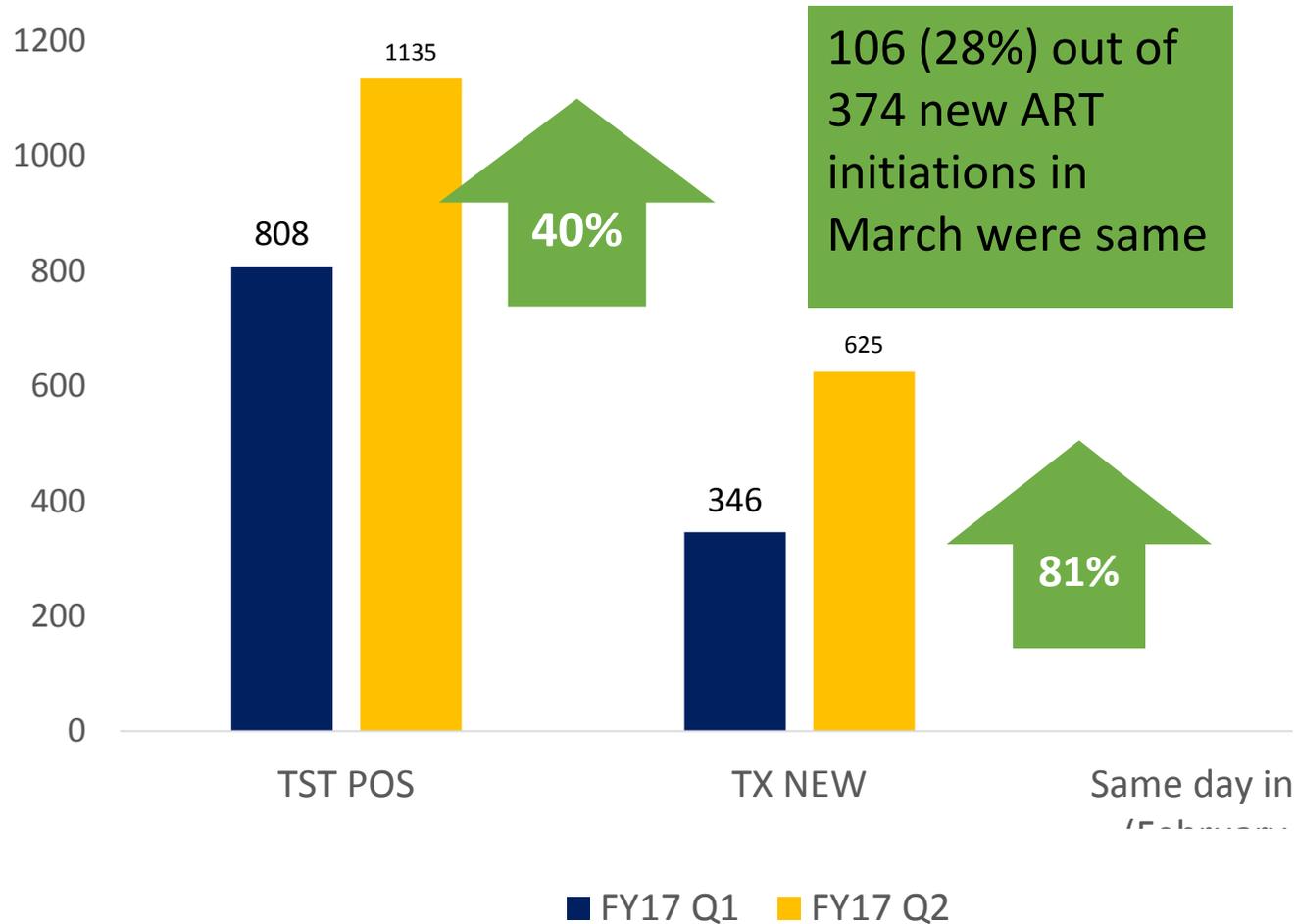
- **January 2017:** Implementer performance analysis to identify low performing sites and partners
- **February/March 2017:** Interagency workshop to identify challenges and opportunities to accelerate in Blantyre
- **April 2017:** Interagency visit to Blantyre with Ministry of Health. **Key changes 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

Umodzi HIV Clinic at QECH

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:

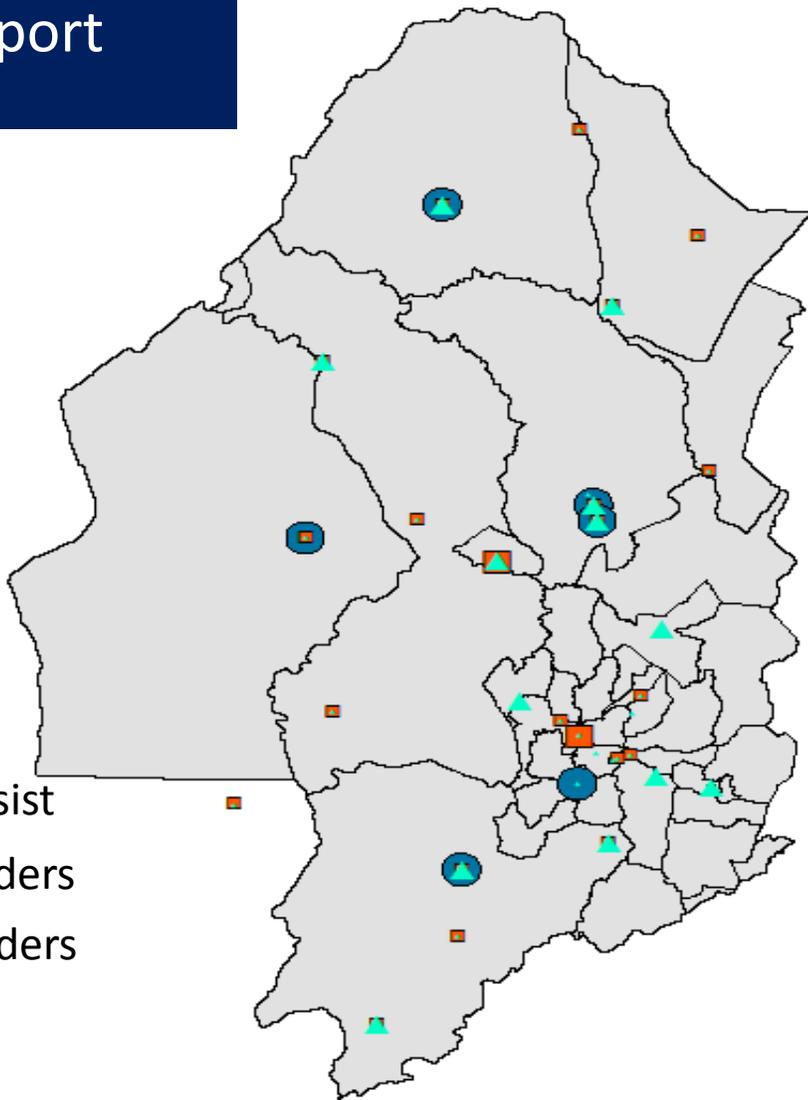
- **Doubled Testing results** (from under 5,000 in Q1 to over 11,000 in Q2)
- **Increased positives identified by 40%**
- **81% increase** in treatment new results
- **Began treatment initiation on the wards**
- **Began same day ART initiation**

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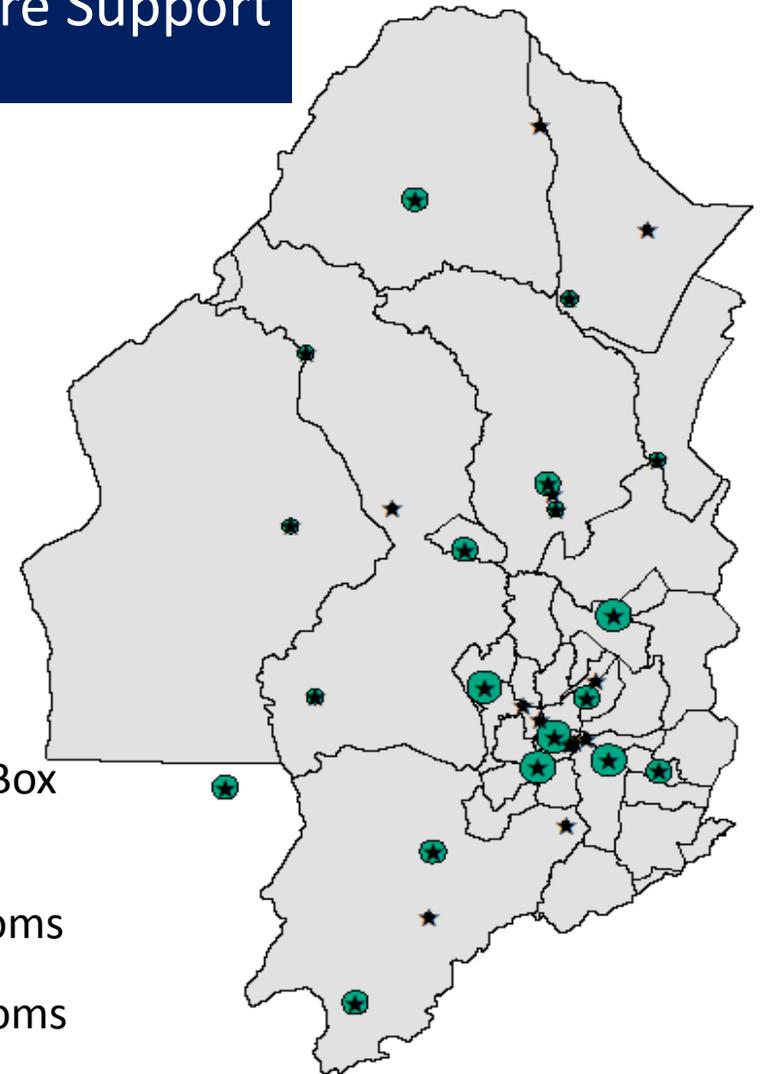
Urgent Rollout of Planned Infrastructure and HRH Support in Blantyre By October 1st this Year

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

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Summary of COP 2017 Targets by District Prioritization

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

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



PEPFAR Malawi Feedback on Global Fund HIV Funding Request

Submitted: March 13, 2017

Circulation: CCM Executive Committee, Department of HIV/AIDS, Program Implementation Unit, HIV Writing Team

PEPFAR/Malawi is pleased to participate in and support Malawi's Global Fund Funding Request for HIV. Based on information shared during the Country Team's recent visit to Lilongwe, PEPFAR/Malawi offers the following feedback on five key elements of the Funding Request:

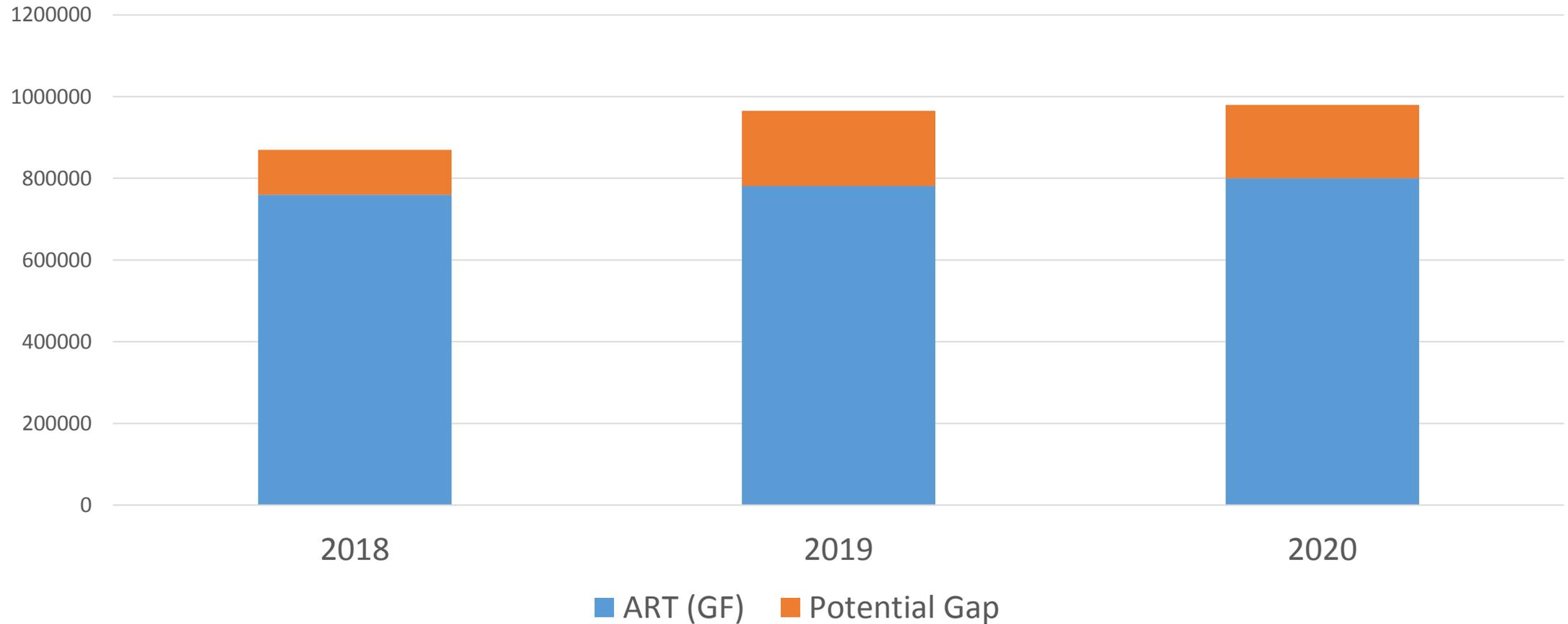
1. Commodities

- As discussed in previous meetings with the CCM and HIV writing team, PEPFAR strongly supports the HIV funding request's focus on commodities. Fully funding the basic commodity purchases for ARVs, HIV test kits, CPT, IPT, VL and EID is, and should continue to be, the top priority for the HIV funding request. Global Fund resources for commodities have historically been well-absorbed and managed by the disease programs in country - a success on which the new funding request can build.
- PEPFAR is very pleased to contribute \$6 million to support procurement of pediatric ARVs to expand treatment for children and young adults up to age 20. It is PEPFAR's expectation that this commitment of \$6 million is an additive contribution to Malawi's current Global Fund HIV Allocation of \$364,804,766 (2018-2020) and these funds will not be used to reduce the Global Fund HIV allocation, particularly for the purchase of HIV commodities.
- Self-test kits – Current WHO guidance recommends countries use epidemic and program data to determine the best use of HIV self-test kits as an additional approach to HIV testing services to reach people who may not otherwise test for HIV. Some suggested populations include men, partners of pregnant women, adolescents and key populations. Current guidance from PEPFAR headquarters estimates a cost of \$6 per test kit. PEPFAR recommends the HIV writing team add HIV self-test kits with an estimated cost of \$306,400 to the Prioritized Above Allocation request (PAAR).

Population	Total population	Estimated coverage	Test kits needed	Costs per test kit @ \$6 per kit
HIV+ pregnant women's partners	~ 4500 per quarter newly identified as HIV+ per MOH quarterly supervision report)	80%	3,600 x 4 = 14,400	\$86,400
Key Populations	Estimated 20,000 FSWs Estimated 5,000 MSM	80%	20,000	\$120,000
AGYW through DREAMS-like programming	Estimated 25,000 in the older age bracket and at risk	80%	20,000	\$120,000

1

Commodities: PEPFAR (TX_Curr targets) create potential ARV gaps – portfolio optimization opportunities to cover



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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.”

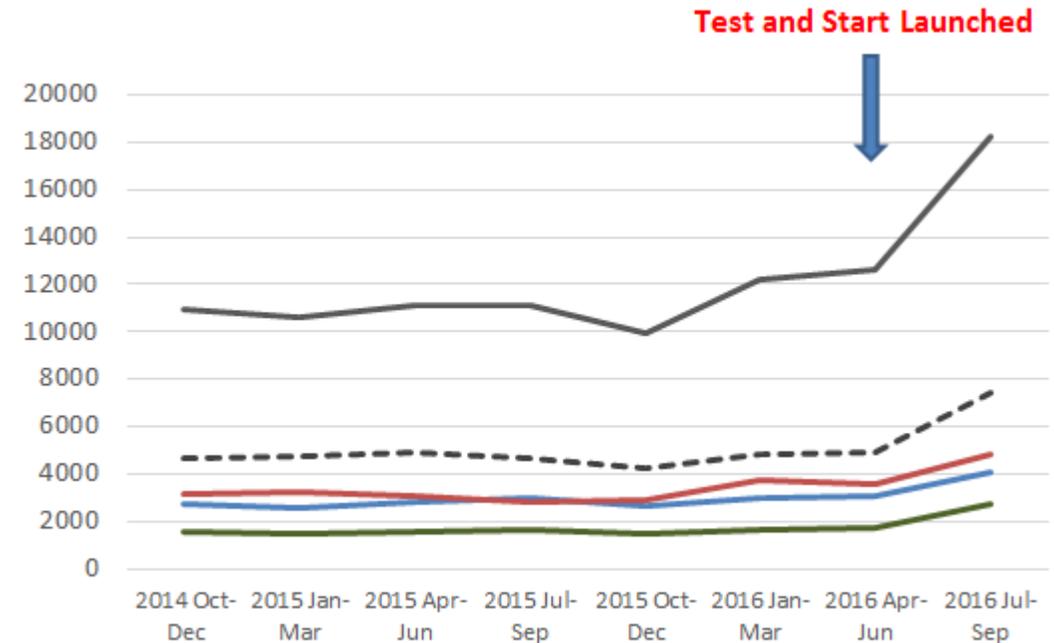
Test and Start – National roll out

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

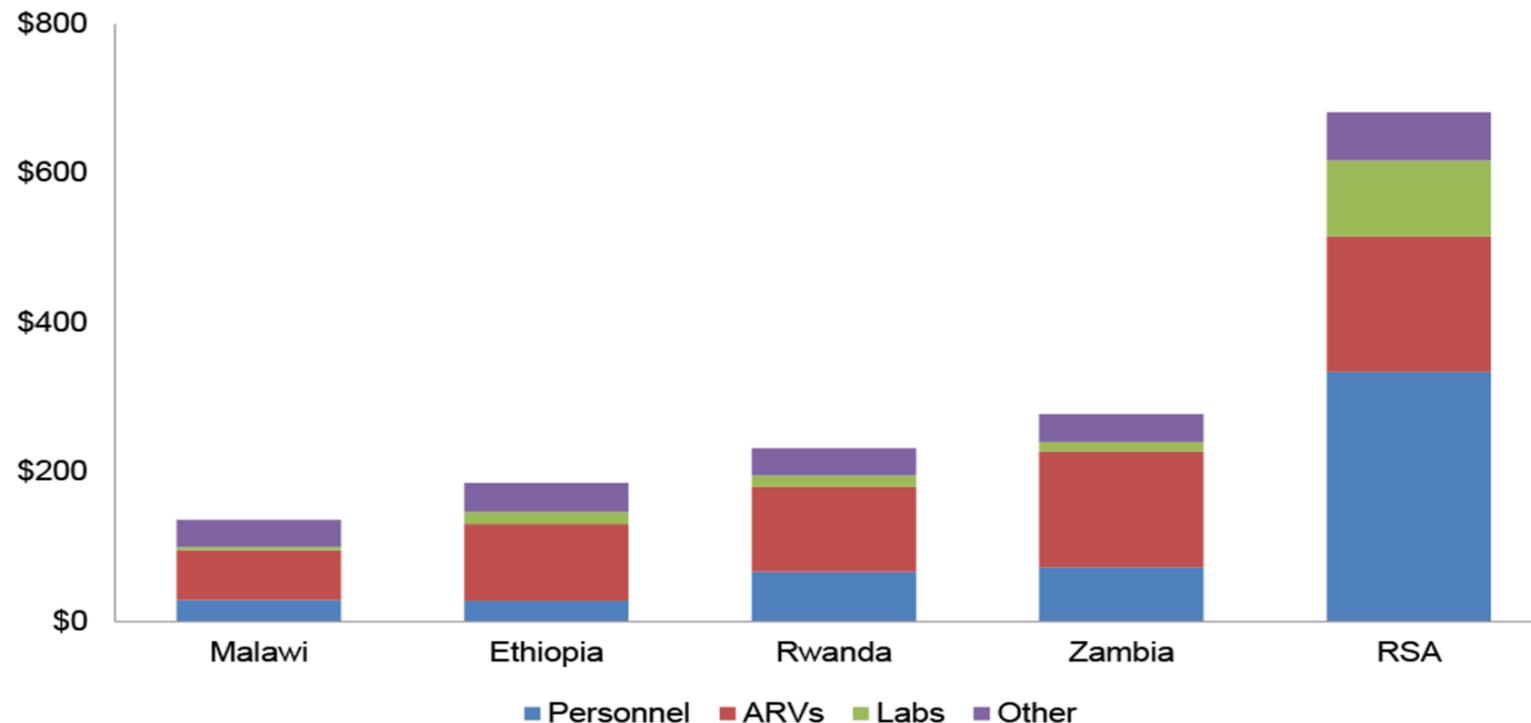
Result:

- 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%



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

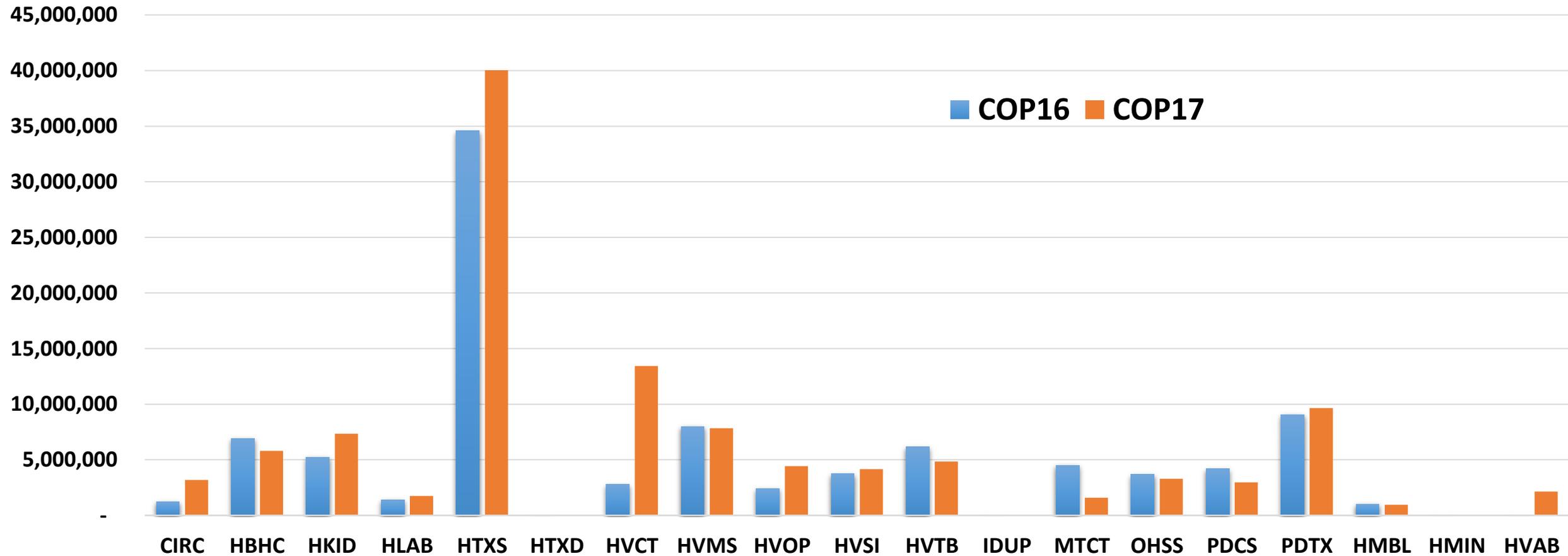
What will the additional \$10 million in acceleration funds achieve?

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

COP16 Net New Target	COP17 Net New Target	Difference in Net New Targets Between COP16 and COP17	% Increase in Net New Targets	Additional Funding	Cost / Net New
81,366	120,817	39,451	148%	\$ 10,000,000	\$ 253

COP16 vs COP17 Budget Code Totals



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COP17 Agency Allocations and Pipeline

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

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

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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!