5 May 2016

Dr. Carmela Green-Abate, PEPFAR Country Coordinator
PEPFAR
Via email.

Dear Dr. Green-Abate,

We want to thank you for sharing the Strategic Direction Summary with us. Seeing the document has provided us important insights about PEPFAR's plans for next year including budgets and activities, so we appreciate that. We also appreciate seeing several of the key CSO recommendations in the SDS.

Below in this file please find a set of further recommendations, questions, requests, and notes we hope you will consider in the lead up to the Johannesburg reviews, which build off the original CSO submission before we had seen the SDS. That is also attached here. We have organized this feedback along the same themes, though we do ask you to refer back to the original document for a fuller set of feedback.

Thank you for your time and engagement.

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1. Treatment & Viral Suppression: Further Move to Direct Services

Direct Services for Treatment: We appreciate the move within PEPFAR over the last few years to increase funding for treatment. As described below, we are especially glad to see moves in COP2016 toward increasing attention to salaries & human resources for ART providers and community health workers. We as well see much more mention of adherence support, expert clients, and other services that wrap-around the existing overstretched ART programme. We applaud the move to include many more of these activities than just a few years ago. Can PEPFAR make clear what portion of funds will go into direct, front-line services for PLHIV?

We are concerned that we still see that a majority of the SDS activities listed seem to include the main outputs as: "train," "provide mentoring," "provide technical assistance," "develop operational guidelines," "develop standard operating procedures," "provide capacity building," and other activities that seem a step removed from the critical inputs that make the difference whether PLHIV get quality services and eliminating barriers to access like long wait times, long travel times, insufficient staffing for follow up, etc.

We reiterate our concern that when we review the mechanisms in COP2015 (not available yet for COP16) PLHIV were claimed as "supported" when PEPFAR funds seemed to contribute less than $30 per patient in many cases and with the major intervention only quarterly visits. *We suggest PEPFAR should focus on quality and investment in critical barriers over numbers.*

Viral Load: This is a key priority for Malawi—low viral load testing means most PLHIV cannot use ARVs as an effective prevention tool or whether their ARV regimen is working. We are glad to low VL coverage levels listed as a key gap in the health system (p55) and that sample transport is an important element of PEPFAR's plan. We were confused, though, about why PEPFAR's main contribution seems to be technical assistance (p47) and in-service training (p60).

- Is it true that there is no commodity gap?
- PEPFAR should consider recruitment and salary support for lab techs. PEPFAR finds at least 41 are short in clinics (MTM presentation) but we understand the need is likely far higher.
- We understand that there are 150 trained lab techs that currently cannot be deployed by ministry because of lack of salary support.

Linkage & Retention Remain a Major Concern, especially in Blantyre, Lilongwe, and Chikwawa Districts: The data pack indicates that in Blantyre 20,820 people tested positive in Blantyre in FY2015. Yet, only 12,092 (58.08%) were linked to care and 11,009 (52.88%) were linked to treatment; in Chikwawa only 50% (55%) of those enrolled in care (34,956) identified as currently on treatment (17,612 tx_curr; 19.387 tx_curr_subnat); In Lilongwe District: 22,344 tested positive in 2015, yet only 10,036 (44.92%) were newly enrolled in treatment. As noted

below the move to include Blantyre & Lilongwe as "fast track" districts make sense, but this data suggests other districts (including Chikwawa) should also be fast-tracked.

OI Drugs: ARVs are only one part of effective antiretroviral therapy—there is still need for OI drugs. Yet stock-outs of basic OI drugs continue to be a significant problem for PLHIV in Malawi. We therefore request that PEPFAR engage with GoM to identify whether there is a significant commodity gap before moving money out of the drugs budget.

Stopping Stock-Outs: As we note below, there is an important role that civil society and PLHIV networks can play in helping monitor the effectiveness of the ARV programme. While groups started a "stop stock outs" campaign in partnership with Airtel, the effort is having much less impact than it could because of the lack of capacity among CSOs to support it. We therefore request that PEPFAR consider support to monitoring and stop-stock-outs efforts as a key way PEPFAR can help address quality in the ARV programme.

2. Human Resources for Health: Supporting & Expanding Front-Line Workforce

Direct investment in health workers in facilities and the community: We are very glad to see that COP 2016 holds the prospect of an important shift from past practice by placing a new emphasis on direct investment—including salary support—in health workers. This has been a major barrier—perhaps the single largest—to improving quality and speed of scale up that we have identified for the last few cycles and are very glad to see PEPFAR taking it up. We strongly voice our support for the inclusion (p 28, 41) of salary support for 113 ART providers and 47 Pharmacy Assistants. Continued scale up of HTC providers is also important.
We request that PEPFAR further consider:

1. Expanding the investment beyond 113 ART providers & 47 Pharm Assistant. This number will make a difference, but the need identified in PEPFAR's MTM materials says there is a gap of 923 health workers including lab techs, pharmacy techs, HSAs, and ART providers in high yield clinics and hospitals. (MTM presentation)
2. Specifically increase the number of districts where salary support will be available beyond the current three "Fast Track" districts.
3. Currently US$1.8 million is included in the SDS for this purpose. We believe this should be considered a core activity for the treatment program and significantly more should be invested.
4. If needed, we suggest above a review of TA, mentoring and training funding to re-prioritize where this is most critical and to free up funding to expand health workforce.
5. Being clear about the model through which IPs will work directly with the Ministry of Health to ensure these are truly additional and will be placed directly in public sector facilities and do not simply move staff from the public sector around.
6. Expanding the important commitment (p59) to recruitment and training of community based cadres for linkage and defaulter tracing to include other key costs and stipends

4. Geographic-Specific Issues

Reducing focus districts from 14 to 10: We are concerned by the move to reduce the number of focus districts from 14 to only 10—for which we do not see a clear rationale. Ntchewu, Dedza, Mchinji, and Balaka districts are all moved to 'sustain' but they include a large number of people living with HIV (each more than 30,000). Looking back at the COP15 targets we also note that they are all off-track from the targets set last year—each fell below the 2015 coverage levels expected and each is now projected to miss the targets for 2016 set then. Why is PEPFAR further restricting its focus, then? It seems all are seeing many new infections and most are below 50% coverage.

We are especially concerned since the dropped districts seem to be those most off track. COP projections suggest these districts are not on course to reach saturation, even by 2020 (p21).

District	COP 15 PLHIV	COP16 PLHIV	FY15 ART Expected (COP15)	FY15 ART Achieved (COP16)	FY16 ART Target (COP15)	FY16 ART Estimate (COP16)
Ntcheu	40,039	43,607	17,624	15,582	21,923	20,381
Dedza	30,138	35,100	12,366	11,283	15,582	15,511
Mchinji	27,540	32,766	11,642	10,838	14,069	12,595
Balaka	33,239	32,551	13,419	12,665	19,063	18,037

Source: COP16 p 21, COP15 p 28.

Fast Track" All Scale Up Districts: Lilongwe, Blantyre and Zomba have been designated "fast track districts" and a strong model seems to be being developed for how PEPFAR can address scale up in these districts. The key difference (p41) seems to be recruitment, deployment, and salary support for health workers (including ART providers) and the use of community-based differentiated service delivery models. <u>These are among two of the biggest priorities in Malawi to address quality and scale up and we strongly support this shift by PEPFAR. We urge it go further.</u> We suggest:

1. these two elements should be central to all PEPFAR districts
2. PEPFAR to review other activities to consider repurposing a portion of TA, training, mentoring, and QI funds to make this possible.

<u>3. Support Community Oriented Service Delivery Models</u>

Community-based models—including ART delivery, including rural areas: We applaud the inclusion in much clearer and stronger terms this year of support for community-based service delivery models. This is a clear area where PEPFAR funding could support GoM to improve the ART programme. We suggest that it be much clearer in the plan how and what PEPFAR will fund along these lines. We are still a bit unclear if PEPFAR will support ARV programmes directly in communities (p47)?

We are worried that these models are only being considered for the urban "fast track" districts—when issues like distance to clinic, transport costs, etc. are even more acute in the rural areas.

We are not sure why (p42) clinics would need thresholds to implement community-based models? PLHIV benefit from community based models even when clinics are not

overcrowded—indeed sometimes lack of community engagement is *why* they are not more crowded.

Overall we suggest that the COP explicitly include funded efforts to:

1. Partner with existing local networks to establish and fund community-based ART programs for stable patients in all saturation districts—building off the existing pilots and done in close collaboration with Ministry of Health.
2. Fund the training and moderate monthly stipends for lay cadres to do adherence support, defaulter tracing, and support local support and ART groups.
3. Fund the tools these lay cadre need—a transport stipend, written materials, and mobile phones and airtime to send SMS follow ups.
4. Focus on adolescents - support should be provided for mobilization of youths to form teen clubs and to train expert clients among them. Additional support could be needed for monthly stipends and transport for their expert clients.
5. Key opportunities exist to integrate PMTCT/SRH services including through mother infant pair management, which will also require lay worker stipends and transport.
6. Support the position of Technical Assistant in the Ministry of Health to coordinate the community of practice efforts and scale up in saturation districts.

5. Prevention

VMMC: We are concerned that the VMMC programming in Malawi is being undermined by reliance on central funds. Last year a significant part of these funds seems to have arrived quite late and lack of reliability makes it very hard for providers to plan.

OGAC should reverse this trend and make these funds available as COP funds. We reiterate our note from our pre-SDS that PEPFAR should also identify gaps where limited funding exist so it is clearer where other funding will be needed to secure the VMMC plan.

LINKAGE & CONDOMS: We are also concerned about the number of reports of how many HIV- people leave HIV testing without condoms. The aggressive HTC efforts outlined in the COP need to be linked directly to condom distribution to maximize their impact and we suggest PEPFAR clarify its plan along these lines since condom promotion and HTC IPs are often separate groups.

6. Testing & reaching men

Testing Budget Cuts?: From what we can see the testing budget has gone from $5,780,309 in FY15 to $2,992,026 in FY16. What accounts for this change? It seems very substantial.

Testing & Community Based Platforms: We are glad to see a clear focus on testing and using community-based platforms (p30). We are still confused about these platforms, which were first mentioned in COP15. Can PEPFAR clarity how these platforms will be created? What type of partners will be funded and how these will link to existing PLHIV and CBO networks?

7. Key Populations

Key Populations: Can PEPFAR please clarify what exact services are being funded and how this relates to existing gaps. We are not clear whether PEPFAR is directly funding all of the interventions listed (drop-in centers, mobile/outreach, one stop shops, etc… p 32). This is an

important area where PEPFAR can have a serious impact—though we have also taken note of service overlaps where PEPFAR implementing partners seem to plan duplicated services with GF and other funded groups. We therefore suggest a more explicit analysis of what is/is not being provided that PEPFAR is seeking to bridge.
We are very glad to see PEPFAR expand KP services to include Zomba and Machinga and to include a focus on documentation of rights violations and legal services (p32-33). We reiterate that there are other key population groups in important districts such as Karonga, Chitipa, Mchinji, Dedza, Salima and Thyolo which are border towns and/or near the lake which need attention.

8. Civil Society

Support CBOs for Advocacy & With Core Support: We note the plan to coordinate with CBOs (p47) and the plan to both strengthen CBO capacity and to sub-grant to CBOs (p59). We applaud these moves and urge they be carried out. We also suggest more specificity in the COP will help. We wish to point out that the major area of limited capacity for many Malawian CSOs is lack of staff and lack of resources. In this context, trainings and technical assistance is often of limited value. There are reports that current PEFPAR-funded TA efforts have shown limited value because of unrealistic expectations of under-resourced groups and those who lack sufficient staff to make full use of the TA that may be targeted with a different kind of group in mind.

We also suggest that PEFPAR include a specific focus on advocacy and monitoring as key activities, rather than only for service delivery. Some of the most important impact civil society has, comes in efforts to monitor, report, advocate, coordinate and advance critical policy change. While significant funding is currently being spent on technical assistance for the HIV response, accountability is often still lacking and CSOs can help provide that accountability. But we currently lack sufficient resources to do so—indeed several key CSO networks have faced serious financial shortfalls that undercut even the existing efforts, which are insufficient to start.

Therefore we urge PEPFAR to:

1. Combine any technical assistance with direct funding for salaries and core costs of CBOs
2. Include “advocacy” and “monitoring” as a key element of the work CBOs are funded to take on, not just direct services (p59).

9. Cross Cutting Issues

Global Fund: All of the discussion above should be considered based on the Global Fund’s financing in Malawi. The vast majority of that funding is going into commodities, largely drugs but also condoms etc. Our worry is that grant will not be successful without significant further investment in programmes that can wrap around the commodities. In addition, Global Fund funding for key populations and young women are also important—and overlap with some of the geographies and activities mentioned in the PEPFAR SDS.

Given this reality, the COP does not seem to take enough attention to the exact synergies with the Global Fund grant. We suggest that PEPFAR consider:

- A fuller analysis of the gaps left by Global Fund (apart from ARVs were are mentioned p11) funding.
- Greater clarity on how geographic focus and activity focus of PEFPAR and Global Fund avoid duplication and over-focus on some districts when other areas are left out despite high levels of HIV.