Once every year, PEPFAR brings together different stakeholders in PEPFAR recipient-countries to input into its annual Strategic Direction summary also known as the Country Operational Plan (COP). Civil Society and Communities in their diversity as Adolescent Girls and Young Women (AGYW), People Living With HIV (PLHIV) and Key Populations (KPs) are one of the key stakeholders to this process as they provide lived experiences and insights on program successes and best practices as well as the existing gaps and challenges in services delivery and quality.

Liu Lathu (Our Voices) is a consolidation of community priorities for the national HIV and TB program and facility level services developed out of a nexus of CSO and community-led consultation processes including; community-led monitoring findings and stakeholder engagement at community, facility, district and national level. Liu Lathu aims at amplifying the voices of AGYW, PLHIV and KPs as Recipients of Care (ROC) in the realm of their priorities and needs.

The purpose of this document is to inform and influence the PEPFAR COP process to address gaps in the HIV response and other related conditions. The intention is that quality HIV service and HIV program activities accrued from this process, should directly benefit Recipients of Care (ROC).

Who is the target audience for this document

PEPFAR's COP development process provides a unique opportunity for different stakeholders and players in the HIV response to jointly plan, coordinate and strategize on the most viable interventions. The target audience for this document are all stakeholders involved in the COP planning process including PEPFAR, Global Fund and Ministry of Health and other partners with the expectation that the community priorities outlined in this document and categorized by stakeholder would be addressed accordingly by all relevant stakeholders.
The Development of Liu Lathu Mu COP23

Community-led monitoring (CLM) by CSOs and HIV and TB affected communities continues to play a pivotal role in identifying gaps and challenges on access and delivery of health services. Through quantitative and qualitative data collection, analysis and interpretation, civil society and communities are able to bring to light the challenges behind different program outcomes as well as provide recommendations for program improvement.

Liu Lathu mu COP23 was developed out of a series of data collection exercises under the PEPFAR funded CLM program targeting PLHIV, AGYW, KP and other affected populations, followed by engagement with different stakeholders at grassroots/community, district and national level. In total there were three rounds of data collection at community and facility level conducted between January and September 2022 followed by facility, district and national level stakeholder consultation to present findings and recommendations, and discuss a way forward. Prioritization was made out of the many findings discovered. Priorities and recommendations included in this document were also informed by findings from the COMPASS CLM program. Development of the Liu Lathu report is further informed by analysis of policy documents and reports including; the SDS 21 & 22, PEPFAR POART Q4 data, the Global Fund Funding request, MOH HIV program data and other national policies and strategies.
1. Routine Viral Load Monitoring

Although evidence shows that viral load testing in PLHIV on ART is an important measure of treatment outcomes, CLM findings from (Q1: Oct - Dec, 2022) indicated a high viral load testing turnaround time (TAT). Thirteen percent (13%) of respondents during this period (Q1-October-December, 2022) reported having received results in 6 months. This statistic contributes to the low viral load testing coverage in Malawi, for which COP 22 records indicate as being at 66%.

This is likely influenced by several factors including inadequate human resource like laboratory technologists/technicians and data clerks; transportation of plasma samples; stock out of reagents and test kits; breakdown of a testing platform; provider inability to follow up on referred test results; provider inability to communicate and interpret the status of the test result to the recipient of care on time; providers only targeting recipients of care with high viral load when communicating results; and providers not timely filing the results.

Although Malawi has 19 viral load testing laboratories and 75 GeneExpert machines covering 56 sites of the 28 districts and the HIV EID & Viral Load Scale and Implementation Plan 2022-2024 stipulating 21 days as ideal; the 2022 Q4 CLM program data reports a TAT range of 21 days to 3 months. The national HIV program data further show that only about 60% of the VL results were dispatched to health facilities within the desired TAT of 21 days. Turn Around Time therefore remains a challenge for recipients of care in Malawi, and this needs improving.
Respondents indicated to have waited for as long as 5 months for their viral load results:

“I waited for my viral load results for close to 5 months only to be told that they are lost and I need to retake the VL test.” – PLHIV at Mpemba Health Centre, Blantyre.

This trend of long TAT for VL test results and missing results also having been reported in COP22, continues to have detrimental effects on PLHIV including: delays in necessary interventions especially when the PLHIV has an unsuppressed VL; and a likely loss of trust in the public health system.

Recommendations for PEPFAR

+ PEPFAR should in consultation with the government recruit targeted laboratory technologists/technicians and data clerks as per the HIV EID & Viral Load Scale and Implementation Plan 2022-2024 annual phased approach.

+ Increase the number of motorbikes fleet and associated cold chain equipment to respond to increasing numbers of samples. Also procure 5 vehicles to transport samples from a testing platform that has broken down at one laboratory to another laboratory in a different region. This is also known as cross region sample transportation links.

+ Conduct refresher training and quarterly mentorship visits to laboratories to address the problem of provider inability to communicate test results and interpret them to the recipient of care. Providers to identify and target recipients of care with high viral load and ensure timely filing of results.

+ 100% of PLHIV on ART should receive an annual VL test with results delivered to the PLHIV in a maximum of 14 days.

+ Support scale up of T=T interventions and dissemination of messages

Recommendations for Global Fund

+ Make GENX machines accessible: GENX are ideal and should be considered for smaller institutions. It is cheaper and doesn’t require complex infrastructure. It is further ideal for decentralization.

+ Sustain funding and procurement of viral load testing reagents and test kits and, + Support regular supervision and maintenance of machines for quality results at all times

Recommendations to MoH, DHA

+ For sustainability, incorporate T=T messages in service delivery packages. Health workers should consistently provide information and education on treatment adherence, viral load testing, interpretation of test results, cervical cancer screening, prevention among positives and TPT to PLHIV waiting in line to be seen by a health provider.
2. Services for Key Populations (FSW, MSM, TG)

There are gaps in Lubricant and Condoms which were reported as out of stock at Kawale, Kafukule, Mphelembe, Makhwila, Nathenje, Ekwendeni, Mzuzu Health Centre and Mikolongwe (CLM October-December, 2022 findings). Based on CLM findings at Health facility level, these issues not only affect KPs but also affect the entire population and threaten progress made in HIV prevention.

Additionally, there are gaps in common understanding of what KP friendly services should look like. Though some facilities like Limbe Health Centre, St. Montfort, Makhwila and Mapelela identified health care providers for KP service delivery that are yet to be trained in Sexual Orientation Gender Identity and Expression (SOGIE) as recommended in COP22/SDS. Limitations also exist in human rights observance for KPs, and KP programming such as Hormone Therapy for Transgender persons and Outreach Services for Transgender Persons, Men who have Sex with Men and Female sex workers as shown in the Charts below.

“Knowledge on human rights and where to report abuse still remains a challenge because the focus in KP programming is on the biomedical aspect and not the structural barriers that hinder key populations from accessing services.” – According to the KP-Led Organizations

### Specific Services for TG

- Gender affirming STI testing and treatment: 11
- Lubricant and Condoms: 11
- PrEP: 14
- Gender affirming HIV testing and counselling: 12
- HIV treatment and care: 15
- TG outreach services: 5

### Specific Services for FSW

- Contraception: 17
- Cervical cancer screening: 18
- STI testing and treatment: 20
- Condoms and Lubricants: 18
- Access to PrEP: 19
- Friendly HIV testing and counselling: 21
- HIV treatment and care: 22
- Outreach services: 11

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"When an MSM/TG with anal ailments comes to the facility, we refer them to those trained in handling those issues, it is in this process where other MSM feel we’re showing another HCW their condition.“ – HCW Nathenje Health Centre

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<thead>
<tr>
<th>Does your facility have specific services for any of the following populations?</th>
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<tbody>
<tr>
<td>Men who have sex with men</td>
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</tr>
<tr>
<td>Transgender people</td>
<td>15</td>
</tr>
<tr>
<td>Female sex workers</td>
<td>23</td>
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<tr>
<td>Adolescent girls and young women (10-24)</td>
<td>27</td>
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<tr>
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<table>
<thead>
<tr>
<th>Specific Services for MSM</th>
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<td>MSM Friendly STI testing and counselling</td>
<td>13</td>
</tr>
<tr>
<td>Lubricant and Condom</td>
<td>11</td>
</tr>
<tr>
<td>PrEP</td>
<td>13</td>
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<tr>
<td>MSM friendly HIV testing and counselling</td>
<td>13</td>
</tr>
<tr>
<td>HIV treatment and care</td>
<td>14</td>
</tr>
<tr>
<td>MSM outreach services</td>
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</tr>
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Recommendations for PEPFAR

+ PEPFAR to work with the Government to update and fast track roll out of KP Service SOPs which were developed by NAC over 10 years ago. PEPFAR to scale up KP programming including education (Human Rights and Abuse) across all facilities
+ Health care providers and police in all PEPFAR supported sites to be trained in SOGIE
+ PEPFAR to scale up DSD models such as KP led outreach services
+ PEPFAR to adequately fund the National KP Network for a minimum time period of 2-years, so they may coordinate KP-led organizations in responding to Structural barriers (criminalization of KPs, police arrests, hatred speeches, gender based violence and stigma and discrimination that hinders smooth implementation of programs).

Recommendations for MoH, DHA

+ Expand a DSD model for KPs enabling them to access a continuum of MoH to scale up HIV and SRH service delivery points
+ For sustainability, MOH should incorporate SOGIE in the training curriculum of all Healthcare workers and ensure that all student finalists are well equipped with information and skills in providing health services to KVPs. This may be done by ensuring that all student health care providers have had a part of their internship working with KVPs.
+ MOH should enroll KP representatives on the drafting team developing guidelines for KP Friendly Services.
+ MOH should adopt the 10-10-10 societal enabler targets of the 2021 Political Declaration which commit to ensuring that:
  » Less than 10% of women, girls, and people living with, at risk of, and affected by HIV experience gender-based inequalities and sexual and gender-based violence by 2025
  » Less than 10% of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services by 2025
  » Less than 10% of people living with, at risk of and affected by HIV experience stigma and discrimination by 2025.
+ MOH and partners should further commit to ensuring that community-led organizations deliver 60% of programs to support the achievement of societal enablers.
3. ART Retention/Treatment continuity

FY22 POART records that there has been significant improvement in retention rate from 51% in FY22Q1 to 71% in FY22Q4. However, it further says, 29% of those who experienced interruptions in treatment were still not retained. CLM findings for Jul-Sep 2022 depict that 32% missed their appointment because they were busy, 20% forgot their appointment which shows that there is a lack of knowledge/value on the importance of treatment.

Secondly, is the long distance to the facility. A study by Lam and Eaton, 2021 on Priority locations for additional ART facilities to reach PLHIV with long travel time to existing facilities shows that there were an estimated total 207,000 PLHIV residing greater than 60 minutes from an existing ART facility and 74,000 PLHIV living at a distance greater than 90 minutes from an existing ART facility. According to Mpingajira et. al, in Malawi, loss to follow-up (LTFU) of HIV-positive pregnant and postpartum women on Option B+ regimen greatly contributes to sub-optimal retention, estimated to be 74% at 12 months postpartum. The reasons were, lack of support from husbands or family members; long distance to health facilities; poverty; community-level stigma; ART side effects; perceived good health after taking ART and adoption of other alternative HIV treatment options. Lack of follow up and contacting service user is also prevalent, and showing a disengagement of staff towards persistence to improve retention.

Reasons for loss to follow-up include long distance to health facilities; poverty; community-level stigma; ART side effects; perceived good health after taking ART and adoption of other alternative HIV treatment options.

Recommendations for PEPFAR

+ PEPFAR to scale up T=T interventions and dissemination of messages in high burden districts with limited interventions
+ PEPFAR to scale up community ART distribution (nurse led community ART Pick up point)
+ PEPFAR should support IP interventions towards bringing DSD closer to recipient of care (community ART Groups)
+ PEPFAR should make sure that case managers follow up on clients and remind them to stay engaged in their treatment.

Recommendations for MoH, DHA

+ DHA to fasttrack the finalization and operationalization of the National DSD policy and guidelines
+ MOH should ensure that ROC receiving TPT are aligned to the MMD for ART for proper follow up and monitoring

If you miss a facility visit to collect your ARTs which of the following happens?

- SMS from healthcare worker: 43
- Visited by healthcare worker: 108
- Get a phone call: 163
- Not contacted by the clinic: 422
- Don’t know: 24

If it was an option, would you like to collect your ARTs closer to home?

- 2 weeks: 1410
- 1 month: 1410
- 2 months: 10

What were the reasons for missing the appointment?

- Was busy with other things: 232
- Was sick: 157
- Had no money for transport: 92
- Forgot my appointment: 144
- Had just moved to another area: 81
- Other: 87
4. Stockouts

CLM programs have noted the following strides towards addressing the issue of persistent drug stockouts; The Ministry of Local Government circulated a circular on drug budget devolvement to local councils through the National Local government finance committee on 29th March, 2022. District Health Offices are now utilizing the 10% devolved drug budget to procure drugs from private pharmacies when Central Medical Stores Trust (CMST) has some drugs out of stock. Recapitalization of Central Medical Stores Trust (CMST) commenced to give it capacity to procure and supply. Efforts have been made to deal with drug theft and pilferage through the Drug Theft Investigations Unit (DTIU). The Buy Malawi Strategy was suspended to ensure that CMST is not procuring drugs that have inflated prices.

Though positive impact has been observed due to various efforts to address the gap, District Health Offices (DHO) are still experiencing drug stock outs. 11 out of 15 health centers monitored by JONEHA in Q4 of 2022 reported experiencing drug stock outs. Antibiotics such as amoxicillin, ciprofloxacin, metronidazole and ceftriaxone are among drugs that are in short supply at CMST causing stock outs in health facilities. This is because of the following reported reasons; DHOs observed that CMST does not stock most drugs they need. DHOs reported that rising costs of prices due to devaluation have negatively affected procurement of drugs. CMST has not been fully recapitalized and unable to stock all essential drugs as only 22.5 Billion Malawi Kwacha of the targeted 30 Billion was allocated to CMST. DTIU is still facing financial challenges and challenges of equipment such as vehicles for prosecution and investigations.

“It is difficult and challenging to conduct raids on drug theft and pilferage due to limited operations equipment such as vehicles” – Head of DTIU Ministry of Health Lilongwe.

The process to review and approve procurement of drugs by Public Procurement and Disposal of Assets (PPDA) takes long which affects supply of drugs.

“For instance 10% of funds in the devolved drug budget is meant for emergencies but it takes 7 days for PPDA to review the procuring process which doesn’t reflect an emergency response.” – Health Provider

| Did the facility experience drug stockouts in the previous month? |
|-----------------|-----------------|
| Yes             | 22              |
| No              | 8               |

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<thead>
<tr>
<th>Which, if any, of these commodities were still out of stock at the time of data collection?</th>
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<tbody>
<tr>
<td>Lubricants</td>
</tr>
<tr>
<td>Male condoms</td>
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<tr>
<td>Female condoms</td>
</tr>
<tr>
<td>Self-testing kits</td>
</tr>
<tr>
<td>TB LAM</td>
</tr>
<tr>
<td>CrAg</td>
</tr>
<tr>
<td>Other</td>
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Recommendations for PEPFAR:
+ Allocate funds towards drug procurement under the 10% drug budget devolvement plan

Recommendations for MoH and Ministry of Finance
+ Increase allocation of funds for procurement of essential drugs, cotrimoxazole in health facilities
+ Complete the recapitalization of CMST

Recommendations for Local Government Finance Committee:
+ Adequately resource DTIU for investigations and prosecutions of people that steal drugs.
+ Increase percentage of drug budget devolvement to district health offices.
+ Install mechanisms to ensure that resources for procurement of drugs are released timely by treasury
+ The LGFC must liaise with the treasury to release resources timely and as per budget allocated.
5. HIV Prevention

POART FY 22 Q4 report states an overachievement on PrEP enrollment for individuals with substantial risk which indicates that targets set did not match the actual need. Despite the fact that there are known barriers hindering access and utilization of PrEP services, there is much more demand than the targets set to achieve the prevention objectives. As such, utilization statistics have surpassed the targets.

However, community data on the other hand suggest that barriers to PrEP use are still persistent. For example, while CDC guidelines indicate that people on PrEP should be monitored for side effects and be tested for HIV, the government of Malawi has not yet scaled up laboratory investigations and structures on Creatinine and hepatitis test before initiation of PrEP and the follow up measures for those put on PrEP have been a challenge. (MOH 2022 Q2 PrEP outcomes summary). Additionally, stigma related to PrEP affects access and use, and further leads to misconceptions, myths and non-adherence.

TARGETED PREVENTION FOR KEY POPULATIONS

Number of key populations reached with individual and or small group-level HIV prevention interviews designed for the target population.

Result: 53,417 (through Q4)
Target: 52,108
Achievement: 102.51%

Stigma related to PrEP affects access and use, and further leads to misconceptions, myths and non-adherence.
Achieving epidemic control will require a significant reduction in new infections, the DHA program report shows 2500 new child infections from mother to child transmission, and the MPHIA 2021 demonstrates high new infections in AGYW attributed to sexual transmission from PLHIV who are not aware of their HIV status and viral suppression. It is important that AGYW are provided a wide spectrum of prevention tools including but not limited to biomedical HIV prevention like DVR and long acting PrEP.

**Recommendations for PEPFAR**

+ PEPFAR to Support the government to fast track roll out of long lasting injectable PrEP and Dapivirine ring to increase the PrEP options among the priority populations.
+ Set ambitious PrEP targets while maintaining the COP22 roll out strategy and ensure that all population sub-groups, especially KVPs (e.g. people in prisons, discordant couples, young people and people who inject drugs) have real access.
+ PEPFAR to fund community based initiatives aimed at reaching the priority population, Faith communities, traditional leaders and local communities to eliminate the structural barriers, deconstruct gender norms, myths and misconceptions that limit PrEP enrollment and Use.
+ PEPFAR to support MoH/DHA with setting up Community based access points for PrEP, condoms, lubricants and VMCC and other SRHR services (integration).
+ PEPFAR to scale up KP programming including Education on PrEP across all KP Led organizations and all facilities
+ PEPFAR to support and empower AGYW and women led organizations to reach out to this sub-population at risk

**Recommendations for MoH, DHA**

+ GoM to fast-track the issuance of guidance on Creatinine and Hepatitis B to align with WHO guidelines
+ MoH to fast track the Review for the submission made for the Dapivirine Vaginal ring
+ MoH to train service providers on PrEP guidelines across all facilities administering PrEP.
+ MOH to coordinate and collaborate with CSOs in raising awareness and supporting community rights and gender issues (social contraction)

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**INDIVIDUALS NEWLY ENROLLED ON PrEP**

Number of Individuals who have been newly enrolled on (oral) antiretroviral pre-exposure prophylaxis (PrEP) to prevent HIV infection in the reporting period.

Result: 30,807 (through Q4)
Target: 17,729
Achievement: 173.77%
Facilities reporting: 169

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<td>4,174 to 8,241</td>
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6. Community Led Monitoring

CLM has improved HIV, TB, SRHR service delivery in the 30 targeted facilities through advocacy and engagement with Service providers, recipients of care, and implementing partners. CLM has played a role in reducing stigma related barriers faced by PLHIV in accessing ART services (advocated for fences which were constructed at Kawale, Nathenje and Zingwangwa); There is significant improvement in retention rate from 51% in POART FY22Q1 to 71% in FY22Q4; Treatment interruption has decreased from 20% in FY22Q1 to 13% FY22Q4; CLM interventions have triggered the introduction of female nurses in cervical cancer screening rooms in some facilities which has contributed to increased uptake of cervical cancer screening services; Reduced stock outs of a select drugs including gentamicin, Bactrim, and STI drugs: contributed to a policy guideline for the allocation of 10% devolved budget to cushion DHOs when Central Medical Stores Trust is not able to supply essential drugs.

To support the continuity of high-quality and impactful CLM programming, there will be a need for increased and sustained financial commitment to CLM initiatives. We recommend that PEPFAR considers increasing investments in CLM from $ 725,000 and to $1,000,000 as originally requested for CLM programming in Malawi. The initial total funds received by MANASO as host organization on behalf of Civil Society Advocacy Forum (CSAF) was MK 469,700.600 representing $576,319 at an exchange rate of MK 815 as of year 1. And in years 2 and 3 Mk 473,804,400 was received thereby representing $ 457,340.00 at a non-negotiable exchange rate of 1036 CLM approach of funding, contractual obligations including the 15% admin costs (higher than 8% that was discussed in the start of the project) have affected timely implementation and achievement of overall program goals.

The current funding arrangement has created difficulties to implement the CLM full cycle (data collection; facility, district and national engagements including the education component) as current funds are inadequate coupled with funding modality of receiving funds in the local currency, faced with unforeseen circumstances such as devaluation of Malawi Kwacha currency. In view of inadequate resources, the CLM program is failing to expand to additional facilities and districts with high HIV burden as per its initial plan on the onset in 2020.

Recommendations for PEPFAR
+ PEPFAR should live up to its commitment by funding $1,000,000.00 to implement a complete CLM cycle and scale up interventions in additional sites, high HIV/ TB burden districts and additional prisons.
+ PEPFAR should ensure that the current funding arrangement with UNAIDS should be reviewed to accommodate funding CLM in USD instead of Malawi Kwacha so that saved resources benefit additional Recipients of Care (ROC).

Recommendations for GoM
+ Commit to the continuity of CLM programming and scale up to non-PEPFAR sites as well.
+ Commit to adhere to, and uphold CLM principles.

To support the continuity of high-quality and impactful CLM programming, there will be a need for increased and sustained financial commitment to CLM initiatives.