

Prioritizing HIV services

The Malawi experience

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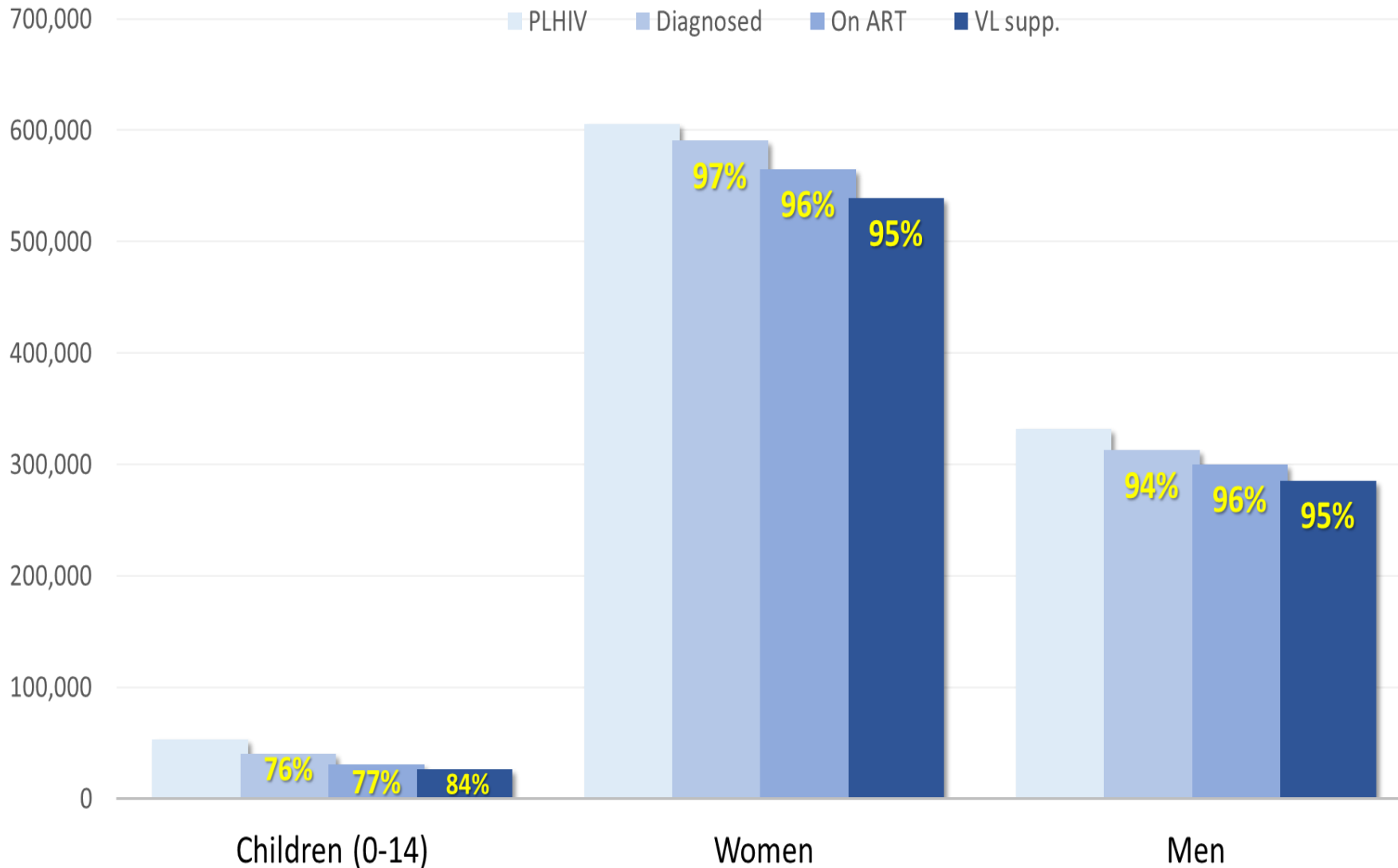
Directorate of HIV,STI and Viral Hepatitis, Malawi

The future of differentiated HIV services: Prioritize for impact

ICASA 2025



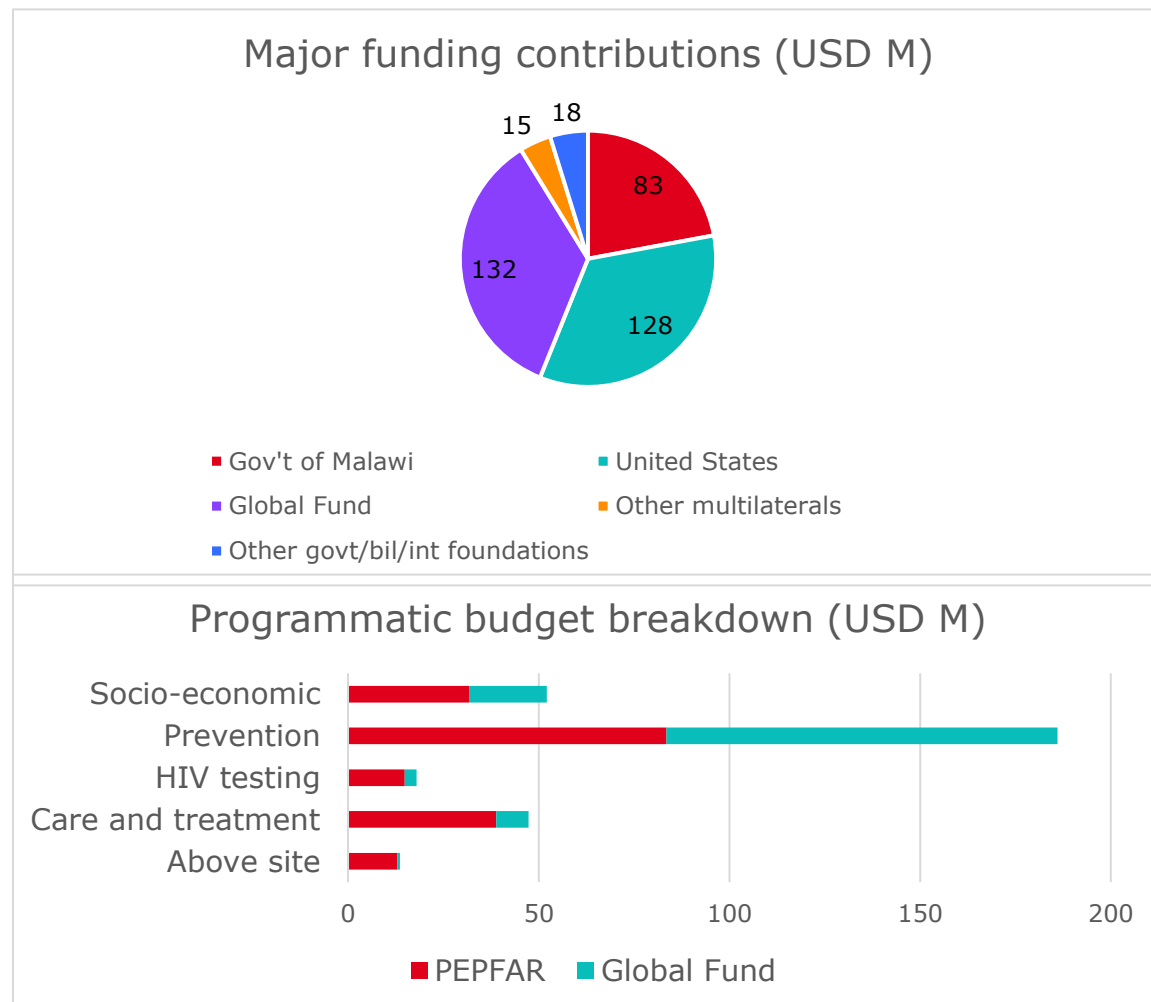
Spectrum Treatment Cascade (Dec 2024)



- **VLS target: 86% of all People living with HIV should be virally suppressed** ($95\% \times 95\% \times 95\% = 86\%$)
 - Exceeded for women: **89%**
 - Reached for men: **86%**
 - Off track for children: **49%**
- **Note uncertainty of estimated Children living with HIV:**
 - No population surveys since 2015
 - Several critical model parameters changed from default assumptions
 - CLHIV may be overestimated and ART coverage underestimated

National HIV programme funding for Malawi

- **Government of Malawi (22%)**
 - Human resources
 - Facility operations
 - ART co-financing
- **Global Fund (35%)**
 - >99% of ARVs, test kits and other medicines
 - Health system strengthening
 - Workforce, equipment, and digital solutions
- **PEPFAR (34%)**
 - Health systems
 - Human Resource
 - Data Systems
- **Agencies (WHO, UNAIDS, UNICEF, UNDP, etc.)**
 - Policy guidance
 - Coordination and advocacy
 - Emergency response
 - Technical Assistance




The stop work order (SWO) forced reprioritization


Immediate impact: Service disruptions	Immediate policy adjustment / guidance
HIV testing	<ul style="list-style-type: none"> • Prioritized facility-based testing; restricted testing to clinical entry points (ANC, OPD, TB, AHD)
ART provision	<ul style="list-style-type: none"> • Flexible multi-month dispensing for stable clients-6MMD
VL and EID sample collection, transportation and processing	<ul style="list-style-type: none"> • Targeted testing; Unsuppressed clients, pregnant/breastfeeding women, and children • Delayed routine VL for stable adults; adjusted sample routing
EMR system down in some facilities	<ul style="list-style-type: none"> • Temporary switch to paper registers • Use of ScanForm as a contingency data system • EMR restoration using MoH staff
Laboratory information systems were affected	<ul style="list-style-type: none"> • Temporary shutdown • Skills transfer to MOH staff to manage LIMS
Procurement and Supply chain Management	<ul style="list-style-type: none"> • Prioritized procurement of life saving commodities (ARVs, Test kits) • Overstocks due to reduced/halted services (self-tests, PrEP)


Immediate impact of SWO and Recovery-Daily Outputs


Average HIV service outputs	SWO Impact (Jan-Feb 2025)	Recovery (Up to June 2025)	Comment
HIV testing			Prioritized facility testing and client groups
Daily clients tested	-21%	-11%	Closed some testing points, fewer clients served
Daily new positives	-8%	-6%	Net decline in case finding
Positivity (“diagnostic yield“)	+19%	-3%	Evidence for more selective testing. Insufficient to offset drop in total tested
Syphilis			
Daily clients tested	-9%	+3%	Likely related to overall drop in clients tested (limited staff)
Daily new positives	-25%	-4%	
Positivity (“diagnostic yield“)	-9%	-3%	
HBV testing			
Daily clients tested	-12%	-6%	Likely related to overall drop in clients tested (limited staff)
Daily new positives	-20	-10	
Positivity (“diagnostic yield“)	-4	-1	
Viral load monitoring			
Viral load	-37%	-16%	Routine monitoring actively suspended; targeted VL prioritized

Planning the service prioritization exercise

 Internal MoH tools integrating data, cost-effectiveness, modelling & expert judgement

 Modelling & cost-impact evidence guided intervention prioritization

 MoH-led taskforce including IPs, technical experts & recipients of care

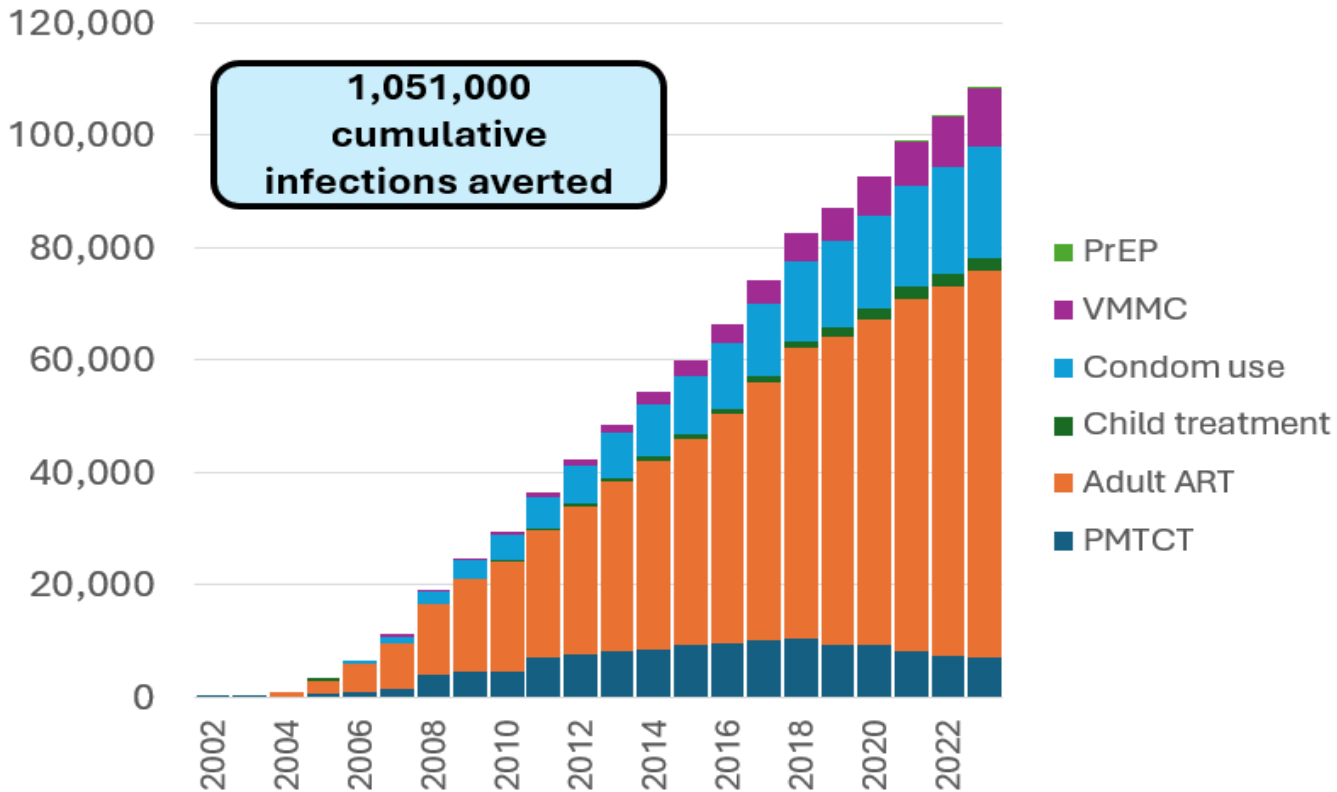
 Thematic working groups with iterative consensus-based reviews

 WHO tools, TIER system & scenario-based frameworks used in refinement

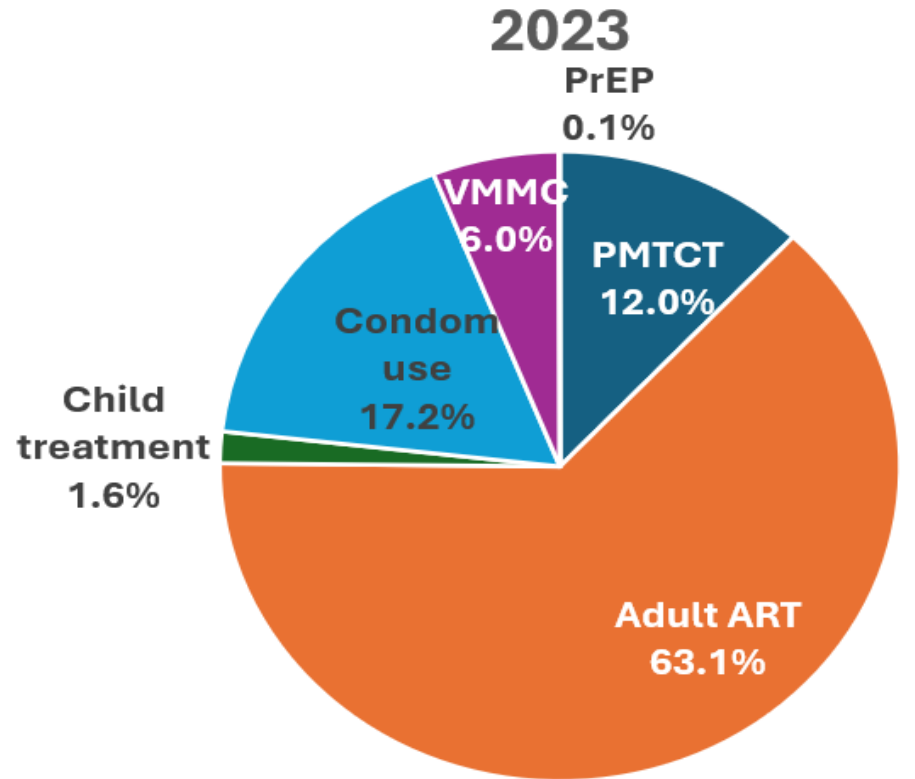
 Continuous adaptation based on facility feedback & evolving funding context

Review of evidence for minimum package of care (MPC): ART scale-up delivered 77% of the prevention impact

Annual HIV infections averted by the HIV programme

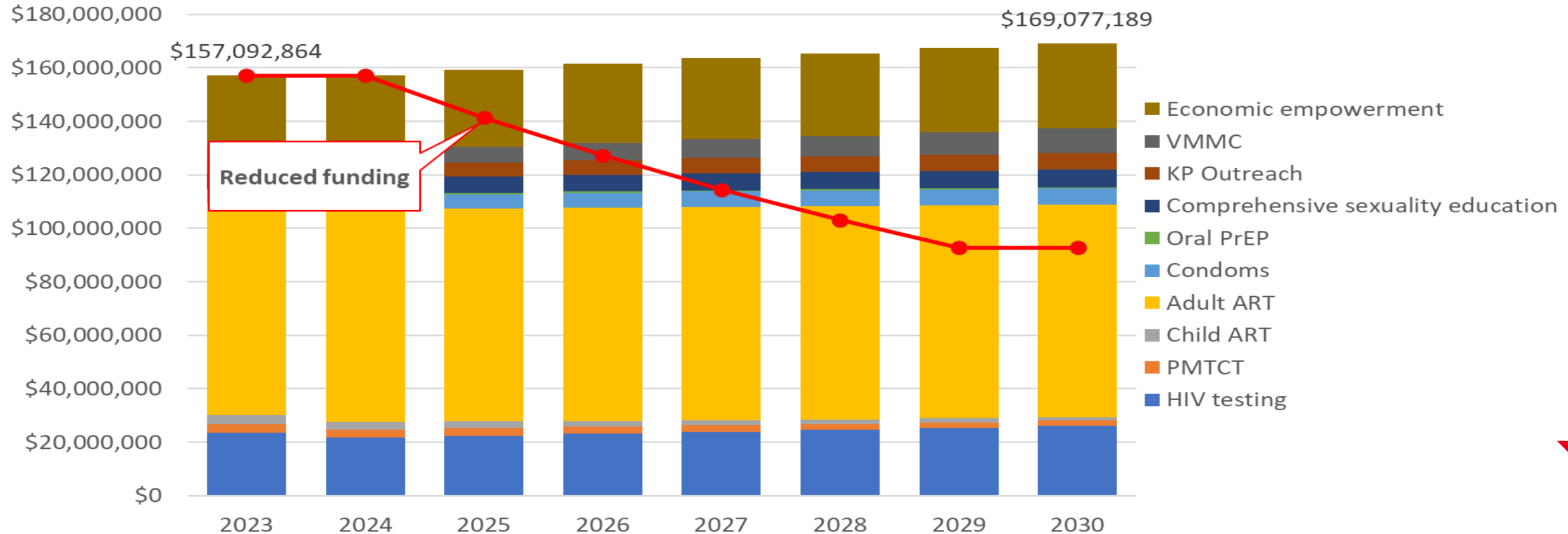


% of infections averted, 2002-2023





Intervention ranking by impact and cost-effectiveness and availability of resources



If only the most cost-effective interventions are prioritized and optimized, the total for running HIV program will reduce

Outcome of the prioritization exercise (1 - Clinical guidance and commodities)

Prevention	Testing	Care & Treatment
<ul style="list-style-type: none"> Facility-based condom distribution with community distribution via HSAs & CMAs 	<ul style="list-style-type: none"> Facility-based HIV testing in selected clinical points (ANC, IPD, OPD, etc) 	<ul style="list-style-type: none"> ART initiation
<ul style="list-style-type: none"> VMMC institutionalized and only done where capacity exists 	<ul style="list-style-type: none"> Reduced community testing points 	<ul style="list-style-type: none"> 6-month ART dispensing expanded nationwide; enabled by proactive supply chain management
<ul style="list-style-type: none"> Infant prophylaxis 	<ul style="list-style-type: none"> VL: routine testing paused; targeted VL maintained at all sites 	<ul style="list-style-type: none"> Emergency ART dispensing suspended
<ul style="list-style-type: none"> PEP maintained PrEP- Oral PrEP maintained, Injectable initially paused then resumed based on staff capacity 	<ul style="list-style-type: none"> EID DNA-PCR prioritized 	<ul style="list-style-type: none"> Increased AHD screening: CD4, LAM, CrAg
	<ul style="list-style-type: none"> Rapid HEI tests at 12 & 24 months continue 	<ul style="list-style-type: none"> Patient transfers used to rebalance workload
<p>13 – 17 July • Kigali, Rwanda</p>	<p>ias2025.org</p>	<ul style="list-style-type: none"> Self-testing for partners of PBW

Outcome of the prioritization exercise (2 - Systems)

System area	Interventions and Adaptations
Human Resources	<ul style="list-style-type: none"> • Transition to MoH-led staffing • Recruitment of MoH staff; redeployment to priority services. • staff retention planning; targeted TA support
Training and Capacity Building	<ul style="list-style-type: none"> • Simplified HIV training packages. • Mentorship & simplified training. • Training aligned with MPC simplification
Monitoring & Evaluation	<ul style="list-style-type: none"> • Simplified M&E tools; weekly performance checks. • Patient-level DQA • Backup paper/ScanForm workflows. • strengthened MoH analytic capacity
Supply Chain	<ul style="list-style-type: none"> • Increased domestic allocation for ART • Shifting towards MoH-led procurement and accountability
Laboratory Systems	<ul style="list-style-type: none"> • Integrated sample transport

Outcome of the prioritization exercise (3 – DSD models)

Prioritized/Scaled	Adjusted / Discontinued / Deprioritized
<ul style="list-style-type: none">• Most DSD models have been maintained, while some remain under review• Peer-led models prioritized — reduced provider workload and sustained reach (e.g., CAGs)• Teen Clubs (Modified, scheduled clinic days)• Facility-based service delivery• 6MMD – Expanded• High-Viral-Load management – strengthened• Mother-Infant Pair model – reinforced• Some models integrated into general clinics (Men’s clinic, Family clinic)	<ul style="list-style-type: none">• Provider-led Community ART Distribution• Youth-Friendly Services• Teen Mothers• Kindergarten model• Male/Youth-Friendly models• Other weekend DSD clinics — moved to weekdays• Adopt-a-Child — operational modifications

Donor vs. national priorities

Thematic Area	MoH	Donor / Implementing partner priority
HIS / M&E	Simplified reporting tools; minimal indicators; cost-efficient data systems	Maintain full EMR and digital tools even if costly & complex
Human Resources	Government-led staffing & recruitment; MoH staff in leadership roles	Partner-funded contractual workforce & vertical staffing models
Cadre Use and Roles	Multi-purpose, cross-functional government cadres	Dedicated HIV-specific cadres (HDA, EC, HIV nurse only)
Service Delivery Leadership	MoH-led planning, target-setting, accountability	Partner-driven planning & annual performance cycle
Intervention Breadth	Simplified Minimum Package; most cost-effective services	More intervention options (multiple PrEP modalities, frequent VL, multiple diagnostics)
DSD Models	Efficient, pragmatic, low-intensity models (CAGs, MMD)	Intensive client-centered individualized models
Program Focus	Long-term sustainability and local ownership	Short-term service volume & rapid impact

Key learning points and way forward

Many HIV services and systems are highly donor dependent

- Staffing, logistics, technical support
- Fragile data systems for ART
- VL monitoring chain has many weak links, accounts for 20-30% of annual treatment cost

MOH may currently not be able to sustain the gains

- The “invisible gap”: Redirecting MoH staff and resources to compensate for reduced DSD and TA support from IPs risks weakening other essential health services

Guidelines, protocols and tools must be optimized and simplified

- Define core HIV service package based on impact and cost-effectiveness
- Requires time and significant upfront investment: revision of guidelines, training curricula, M&E tools, data systems, re-training of health workers, supply chain management
- Need to utilize available resources NOW to prepare for the off-ramp