



Baylor College of Medicine Children's Foundation Malawi

Tingathe CORE Program

Fiscal Year 22 Quarter 3 Progress Report

April 1- June 30, 2022



Viral Load Sample Collection at Mpsa Health Centre in Phalombe District

Tingathe CORE Program

Client Oriented Response for HIV Epidemic Control (CORE) Program

Award No: 72061221CA00011

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AHD	Advanced HIV Disease
ALHIV	Adolescents Living with HIV
ANC	Ante-Natal Care
APA	Ana Patsogolo
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
CAD	Community ART Distribution
CHAI	Clinton Health Access Initiative
CECAP	Cervical Cancer Prevention
CHAM	Christian Health Association of Malawi
CHPO	Community and HTS Program Officer
CHW	Community Health Worker
CLHIV	Children Living Client-Oriented Client Oriented Response for HIV Epidemic Control
CPD	Continuous Professional Development
CQI	Continuous Quality Improvement
DHA	Department of HIV/AIDS
DHMT	District Health Management Team
DHO	District Health Office/Officer
DREAMS	Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe initiative
DSD	Differentiated HIV Service Delivery
EID	Early-Infant Diagnosis
EMR	Electronic Medical Record
EQA	External Quality Assurance
FP	Family Planning
FRS	Family Referral Slip
FY	Fiscal Year
GBV	Gender-based Violence
HDA	HIV Diagnostic Assistants
HTS	HIV Testing Services
HIV	Human Immunodeficiency Virus
HIV-STK	Human Immunodeficiency Virus Self-Test Kit
HIVST	Human Immunodeficiency Virus Self-Test
IAC	Intensive Adherence Counseling
ICAC	Intensified Care ART Clinic
ICT	Index Case Testing
INH	Isoniazid
IPC	Infection Prevention and Control
IPT	Isoniazid Preventive Therapy

IPV	Intimate Partner Violence
KCH	Kamuzu Central Hospital
LIVES	Listen, Inquire, Validate, Enhance safety and Support approach
LPV/r	Lopinavir/ritonavir
M&E	Monitoring and Evaluation
MIP	Mother-Infant Pair
MMD	Multi-Month Dispensing
MOH	Ministry of Health
MOU	Memorandum of Understanding
NVP	Nevirapine
ONSE	Organized Network of Services for Everyone
OPD	Out-Patient Department
OTP	Outpatient Therapeutic Program
PACT	Pediatric and Adolescent Clinical monitoring Tool
PEPFAR	President's Emergency Plan for AIDS Relief
PHEMC	Public Health Epidemic Management Committees
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother-To-Child HIV transmission
PPE	Personal Protective Equipment
PrEP	Pre-Exposure Prophylaxis
PSC	Psychosocial Counseling
PSS	Psychosocial Services
Q1	Quarter 1
Q2	Quarter 2
QI	Quality Improvement
QM	Quality Management
SAPR	Semi-Annual Performance Report
SFP	Supplemental Feeding Program
SOP	Standard Operating Procedures
SS	Site Supervisor
STI	Sexually Transmitted Infection
TAT	Turnaround Time
TB	Tuberculosis
TPT	TB Preventative Therapy
TWG	Technical working group
USAID	U.S. Agency for International Development
VAPN	Voluntary Assisted Partner Notification
VL	Viral Load

EXECUTIVE SUMMARY

The Tingathe program is implemented under the CORE Project, a five-year (2021-2026) bilateral cooperative agreement between Baylor-Malawi and USAID Malawi. The program's goal is to reduce new HIV infections, HIV morbidity and mortality in Malawi through implementation of cost-effective and innovative interventions to increase HIV case finding, linkage to treatment for HIV, management of associated conditions including Tuberculosis (TB), and viral load suppression among People Living with HIV (PLHIV). Tingathe CORE Program is implemented in Mangochi, Machinga, Phalombe, Balaka and Salima districts covering 95 health facilities (sites) including the Baylor Center of Excellence in Lilongwe. This report describes program achievements of the fiscal year (FY) 22 from April to June 2022 [Quarter 3 (Q3)] and the continued implementation of innovative strategies to support Malawi to achieve sustained HIV epidemic control.

There was sustained reduction in the number of COVID-19 cases and deaths in the country. The program effectively utilized infection prevention and control measures and emphasized strict adherence to COVID-19 Standard Operation Procedures(SOP), and as a result, there was no disruption of essential HIV service provision. Tingathe continued to implement innovations and best practices within routine programming that ensures persons living with HIV receive high-quality care while our staff remain protected from COVID-19 infection. Support to scale up access to vaccines remained a priority, and the program supported the Ministry of Health (MOH) COVID Vaccine mobilization activities to continuously increase vaccine uptake, by providing health education to address vaccine hesitancy among ART clients with CHW-assisted linkage to vaccination for willing clients. Further, a vaccine coverage survey conducted amongst program staff showed an increase in proportion of fully vaccinated staff from 70% in Q4 FY21 to 85% in Q3 FY22; with a 98% of clinical staff being fully vaccinated. Section III of this report provides details of the program's COVID-19 response.

Tingathe continued to assist MOH and influence national health policies to improve pediatric and adult HIV and TB prevention, care and treatment services in Malawi. The program participated at various national level forums in collaboration with MOH, USAID and other partners, including national technical working groups and task forces. In particular, Baylor provided technical expertise in the development of training materials for the 2022 Integrated HIV Testing services guidelines spearheaded by Department of HIV & Aids and viral hepatitis (DHA). The program continued to support ART provider trainings and rollout of the 2022 Clinical Management of HIV in Children and adults. In May, USAID team visited Senga-bay Hospital and Lifuwu Health Centers in Salima district to appreciate environmental waste management processes in HIV testing services. The two sites were commended for proper handling and disposal of waste in resource limited environment.

Tingathe continued to implement essential HIV prevention, care and treatment service provision at all supported sites. The national stock out of Dry Blood Spot (DBS) bundles and VL testing reagents due to supply chain disruptions continued to affect routine VL coverage as available stocks were prioritized for particular groups of PLHIV outlined in the issued DHA circular of May 2022; EID, targeted and follow up VL. Despite an improvement in supply of DBS bundles in May, low stocks of VL reagents at molecular labs continued to disrupt VL testing services. To cope, VL testing was

limited to targeted and follow up for individuals in HVL cascade, pregnant and breastfeeding women, and children.

Site level performance analysis was conducted on a regular basis to identify and promptly address identified hinderences to performance as informed by weekly and monthly datadashboards. Program adaptations across the HIV cascade continued to result in improved performance on key indicators as illustrated in the table below. The program results section of this report provides a detailed description of implementation activities under corresponding objectives to support Q3 performance progress.

Table 1: Tingathe FY22 Q1-Q3 achievement by indicator – CORE Program

Indicator	Annual Target (FY22)	Q1-Q3 Target	Q1 Results	Q2 Results	Q3 Results	% of Q1-Q3 target achieved
HTS_TST	287,459	215,594	150,127	155,332	159,048	215%
HTS_TST_POS	6,001	4,501	3,147	3,212	2,968	207%
Yield	2.1%	2.1%	2.1%	2.1%	1.9%	96%
HTS_SELF	97,839	73,379	67,565	64,397	55,872	256%
TX_NEW	5,902	4,427	3,233	3,147	3,023	212%
TX_CURR	156,260	156,260	151,607	152,928	154,563	99%
PMTCT_STAT N	118,747	89,060	34,163	35,749	32,682	115%
PMTCT_ART N	8,870	6,653	1,932	1,847	1,905	85% (100% coverage among PVLHIV)
PMTCT_EID*	9,178	6,884	4,010	3,834	2,179	146%
TX_PVLS, D	156,216	156,216	97,756	90,761	90,900	58% vs PVLS target 60% vs cohort (92% suppression)

I. IMPLEMENTATION HIGHLIGHTS OF CORE INNOVATIONS

This section provides a brief progress snapshot of implementation of key innovations under CORE program; additional information can be found in the relevant technical sections under objectives 1-6.



TINGATHE DIGITAL APPLICATION: Baylor-Malawi, working with its sub partner D-Tree, continued to make progress on development of the Tingathe digital Application (Tingathe App) which aims to improve workflow across the 95-95-95 cascade and to supplement paper-based data collection with digitized systems. In Q3, detailed development of Tingathe application(app) content continued including clinic visit functionality with automated individual screening for relevant services based on age and gender. A number of tasks were completed as follows; 1) Creating workflows that are converted into forms for the application. 2) Supporting the development team in creating forms for the application. 3) Testing the registration and clinic visit components of the application.

A guide was developed for the software development team which details what the Tingathe application encompasses, its functionalities including interdependencies of functions. The guide will be updated accordingly depending on design choices and methods of execution.

Two Health Information Systems (HIS) Officers joined the team in April and visited Salima district to gain a deeper understanding of the CORE program implementation at health facility level. Some internal task shifting was done to HIS officers to allow Engineers focus more on technical work.

In Q4, Dtree will create and execute internal and field-testing plan for the registration and visit components of the application, conduct baseline surveys, draft the first version of the application manual covering the registration and visit components as well as an application support and maintenance plan and recruit two new Software engineers to expedite the development of Tingathe App.



CORE VIDEO AND ANIMATION PLATFORM: Through its sub partner In Tune For Life (ITFL), Baylor-Malawi continued production work for development of video and animation-based counselling and education tools. The platform aims to improve and streamline client counseling and education as well as HCW professional development while relieving some of the counseling burden from health workers. Q3 focused on finalizing the production of *“Taking your ART”* and amendments of *“Viral Load”* videos which was necessitated by findings from user insights and changes in ART guidelines 2022; prior to releasing the videos for use In Q3, content gathering for *Pediatric Care and Welcome Care Services* videos was done. Baylor and ITFL teams developed scripts for both of these videos and reviews are ongoing, including revision of content into more succinct pieces. The completion and sign-off of the two videos will spill over to Q4.

Early in Q3, ITFL team traveled to Malawi, to provide in-person training and capacity building of local collaborating artists, including capacity building of current local designer on the digital animation techniques for the CORE project animations.

In Q4 activities will be focused on amending all the videos produced so far to incorporate feedback as well as producing the final video for the year focusing on “welcome care”. The preparatory productions stages for this video were concluded towards the end of Q3. In Q4 the videos will upscale testing for local acceptability through focused group discussions with sites staff and end users and feedback used to adjust as applicable.



TAKULANDIRANI WELCOME SERVICE: Tingathe continued to offer client-centered supportive services for PLHIV through the Takulandirani service, with a focus on developing tailored approaches to care for clients newly diagnosed with HIV, those with high viral load, and those who had recently returned from interruptions in treatment. This service is offered at all supported facilities by Baylor staff and is designed to enhance the standard of care by empowering clients to co-create their own approach to adherence and retention in care through identification of anticipated challenges that might lead to treatment interruption or high viral load and jointly with CHW developing a treatment approach that will lead to good clinical outcomes.

In the reporting period, the program continued to enhance its client-targeted and service-stratified approach to providing counselling and clinical services to ART clients through welcome care by using uniquely color-coded client flagging cards that outline essential services for clients newly initiating ART, returning from treatment interruption, or addressing challenges with viral load suppression. The cards prompt the CHWs and clinical staff on the package of services to be provided for these individual categories at each visit including gender-sensitive (gender-matched) counselling and support that systematically identifies barriers to adherence and retention in a proactive, emphatic and nonjudgmental manner and prompts client-tailored approaches to addressing barriers. All sites are using this approach to follow up the client for 6 months or until they have overcome their treatment challenges. In Q3, the client cards were updated to indicate services provided if a client sent a guardian to collect medication on their behalf; which was informed by feedback on realities of clinic attendance. The program will continue to use feedback received from site level implementation and documentation on the cards to make necessary revisions to the client flagging cards.



CORE YOUTH ARE THE FUTURE (YATF): YATF is a package of services specifically tailored to youth to promote engagement and retention through creation of an enabling environment for youth to access high quality health services in line with the Malawi CDCS 2020-2025 IR2. During Q3, YATF programming continued to support adolescents living with HIV through the Teen club DSD model providing Youth friendly ART and SRH care with ongoing engagement of youth and guardians through guardian sessions as well as complementary delivery of prevention services with support to provision of HPV vaccine for cervical cancer prevention to eligible ALHIV. Support for the youngest adolescents was bolstered with a disclosure training to ensure all facilities now have at least two lay providers trained to delivery developmentally appropriate disclosure counseling to children. They are supported by clinical providers and psychosocial counselors who continue to be available for counseling support. Care for all youth at the facility continues with support from youth ambassadors at each facility who have been busy providing counseling to all pregnant AGYW as well as youth PMTCT mothers at the facility while

navigating all youth to needed services. YATF continues to strengthen YFHS at all sites to include clinical service provision with ongoing support.

II. PROGRAM RESULTS

OBJECTIVE 1: INCREASED UPTAKE OF OPTIMIZED HIV CASE FINDING STRATEGIES

In Q3, Tingathe provided 159, 048 HIV tests to clients, and 2,968 People Living with HIV (PLHIV) were identified, achieving 201% of the quarterly HTS-POS target with a positivity yield of 1.9% as illustrated in Figure 1. This testing yield includes all tests performed at all service delivery points, including high-volume, and lower-yield medically required testing places like prenatal clinics and maternity wards. High-yield case-finding approaches such as index case testing and HIV self-testing were used while PITC was used to ensure that all eligible clients at all entry points received HIV testing. The distribution of HIV self-kits (STKs) remained high during this period to maximize access to testing for populations at risk and decongest facilities where possible due to COVID-19. CHWs (Community Health Workers)/Community Health Worker Counsellors (CHWC) trained and certified in HTS provision continue to provide HTS services in all supported districts to increase access to comprehensive HIV services. Tingathe program continued to screen clients for testing eligibility and provided targeted testing and counseling services in addition to the provision of retention support.

With a stable supply of PPE for staff/HCW during this reporting period, Tingathe continued to provide targeted community tracing and testing for index client contacts. The program continued to implement facility-specific case-finding best practices with excellent performance in case identification. Newly identified HIV-positive clients were rapidly linked to ART and those testing negative were linked to prevention services.

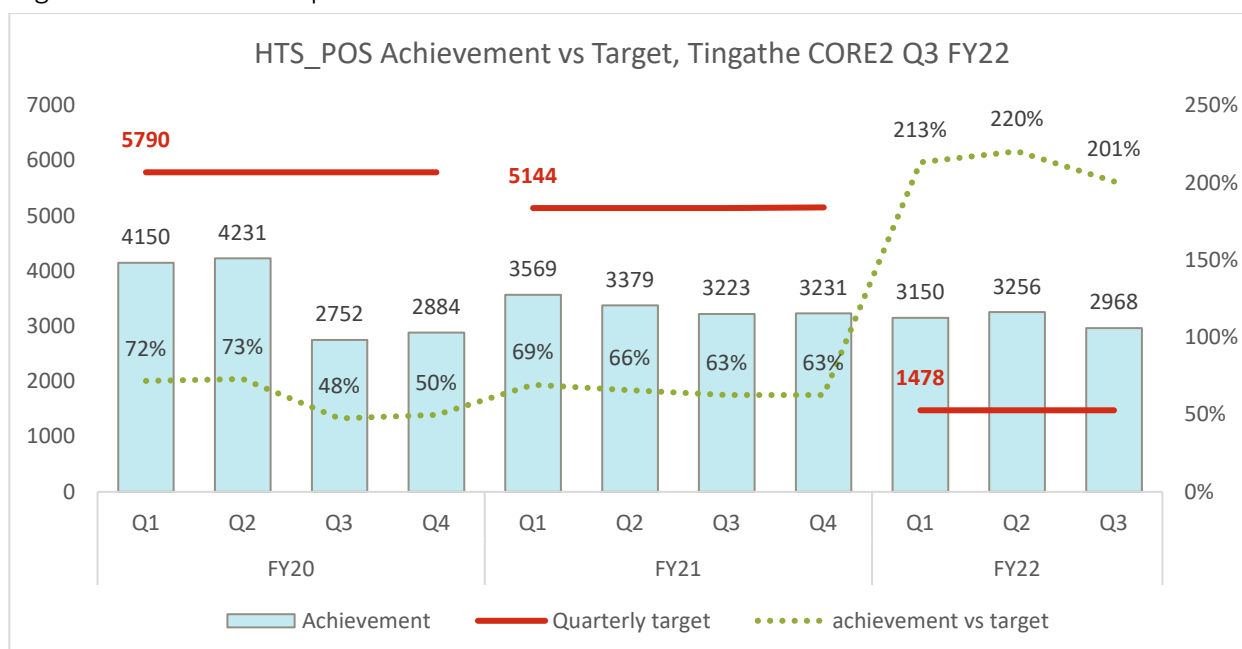


Figure 1: HTS_POS achievement against target Q3 FY 22

As part of ongoing data review and supportive supervision, weekly performance dashboards for each site were shared with cluster/site coordinators and CHPOs to discuss case-finding performance and improvement plans with respective site staff. Three key HTS staff attended the

MOH master trainers training for the New Integrated HIV, Syphilis and HepB testing guidelines in readiness for HTS provider trainings to begin in Q4.

1.1 Index Case Testing: Implementation progress

During Q3, CHWs/CHWCs (HDAs) continued to provide passive and active ICT services to clients in HTS rooms and the ART clinic. Clients newly diagnosed with HIV, those with a high viral load (HVL), and those returning after a treatment interruption were prioritized for ICT services. Stable ART patients were rescreened on their annual VL collection day to assess if they had new contacts or untested children despite VL not being collected in all clients due to DHA adjusted eligibility criteria following limited DBS bundles and lab supplies. Documentation was done in the client's health pass book to serve as a record that ICT screening had been conducted for the client, despite VL samples not being collected due to revised client prioritization following VL commodity shortages. HIV self-test kits (HIV-STK) were provided to ICT clients who requested them for their contacts. To maintain quality of ICT services, Tingathe continued to focus on the following interventions;

- **ICT health talks** were conducted at ART clinics and HTS waiting areas to increase awareness about the availability of HIV testing services for partners and family members.
- **ICT screening criteria** were reinforced to ensure screening for all clients newly diagnosed with HIV, all clients with unsuppressed viral load, all clients with interruption in treatment, annual screening for stable (virally suppressed) clients and all women for untested children.
- The **Child ICT tool** was used at all facilities to systematically document the HIV testing status of all children of WHLIV in care; this simple screening tool is attached to the MasterCard of all women in ART clinic to document all children <18 years and their HIV status and facilitate review of testing status of previously untested children upon every visit to ART clinic to ensure status of all children is known.
- Designated **ICT experts/best counsellors** were scheduled full-time for ICT screening to optimize ICT counselling particularly for sexual contact elicitation. Where possible, gender-matched counselling was provided.
- ICT providers continued to **screen for IPV**, and offer first-line response using the Listen, Inquire, Validate, Enhance safety and Support (LIVES) model for those who screen positive as well as provide appropriate referrals.
- CHWs and CHWCs **followed up index contacts** through phone (for clients with phones ~<40%) to offer HIV testing and at home including home testing for clients opting to be tested at home.
- Supervision was intensified at all sites with in-person visits at sites and virtually via **use of supervision tools on google forms**.

ICT Highlights

99% of potential index clients were screened

21% of reported contacts needed follow up (were eligible for testing)

93% of contacts who needed follow-up tested

9% yield overall (14% adults, 2% peds)

The google tools cover all program areas (ICT, EID, VL, AHD, and YATF) and are designed to help district implementation staff identify gaps and take immediate action by responding to questions, provide guiding actions/prompts to address the gaps and develop quality improvement actions to be tracked overtime using CQI forms. Using these virtual tools, program managers and supervisors guide staff on sites and intervention areas with performance and/or quality care gaps, and facilitate a discussion on solutions to identified gaps

- **Client-centered tracing**; following up clients during mutually agreed appointment date and times for clients' convenience. Strategies for testing and optimizing yield were **tailored to each site's needs**
- **CHW tracers by motorbikes to expand tracing coverage and reach**: Motorbike riding training for this team continued through Q3. Fourteen (14) motorbikes were procured and distributed to the trained staff in Q3. A total of 74 motorbikes have been distributed to trained staff to facilitate client tracing.
- **Weekly listing and prioritizing contacts** for follow up to enable swift tracing of contacts and prioritizing adults contacts; men and sexual partners
- CHWs and CHWCs continued to **listen to voice notes and watch videos illustrating best practices for contact elicitation** to improve their skills in providing ICT services.

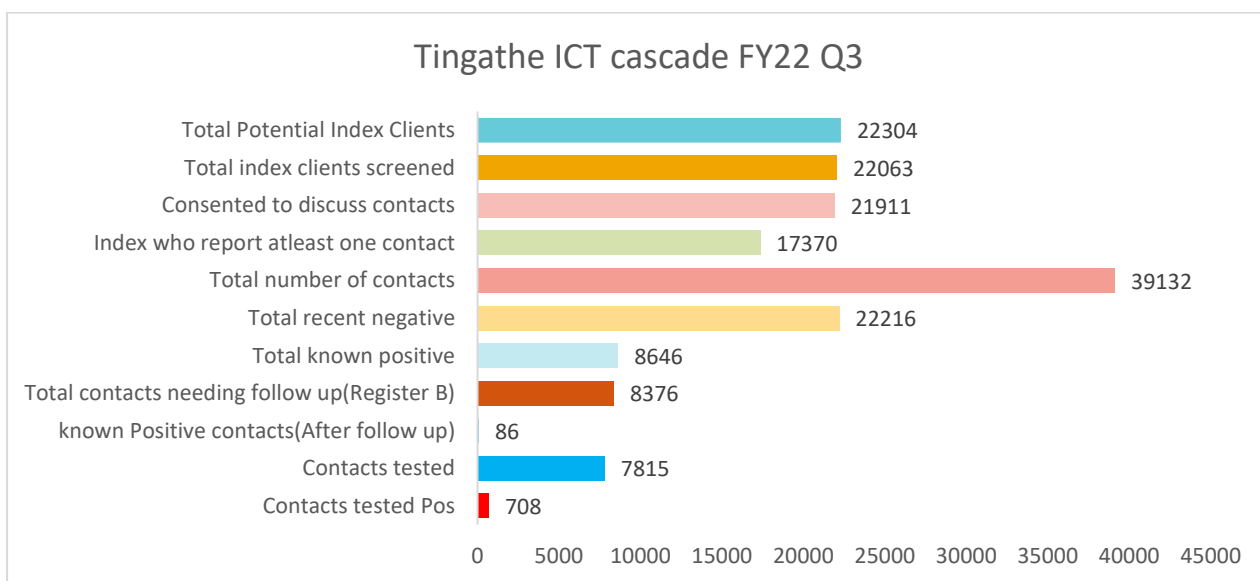


Figure 2: ICT Cascade Q3 FY22

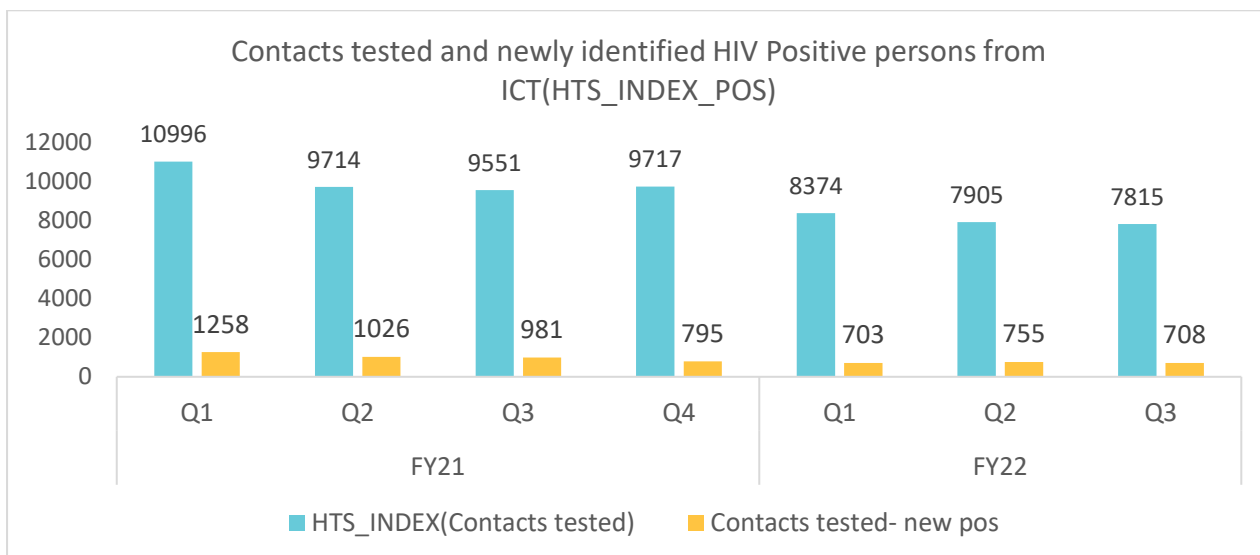


Figure 3: ICT and Case Identification, Q3FY22

In Q3, Tingathe continued to use client and provider feedback to design site-specific plans to improve ICT provision, screening coverage, contact elicitation, and contact tracing and testing in a safe and confidential manner. Ensuring sufficient numbers of CHWs were assigned for tracing was

critical to reach more clients who needed tracing both through the phone and physically. Motorbikes were used to transport CHW/CHWCs to reach clients residing at significant distances from facilities to expand reach and tracing hours, maintaining high number of ICT contacts tested and new positive clients identified through ICT. This resulted in the identification of 708 new PLHIV out of 7,815 contacts tested as shown in Figure 2 and 3 above, achieving an average yield of 9 %; **an impressive 14% among adult contacts** which is above the recommended minimum positivity from index testing *for adults (>15 years)* of 10%; and 2% among pediatric contacts.

Figure 4 below shows number of ICT clients screened and tested by contact type (adults and pediatrics).

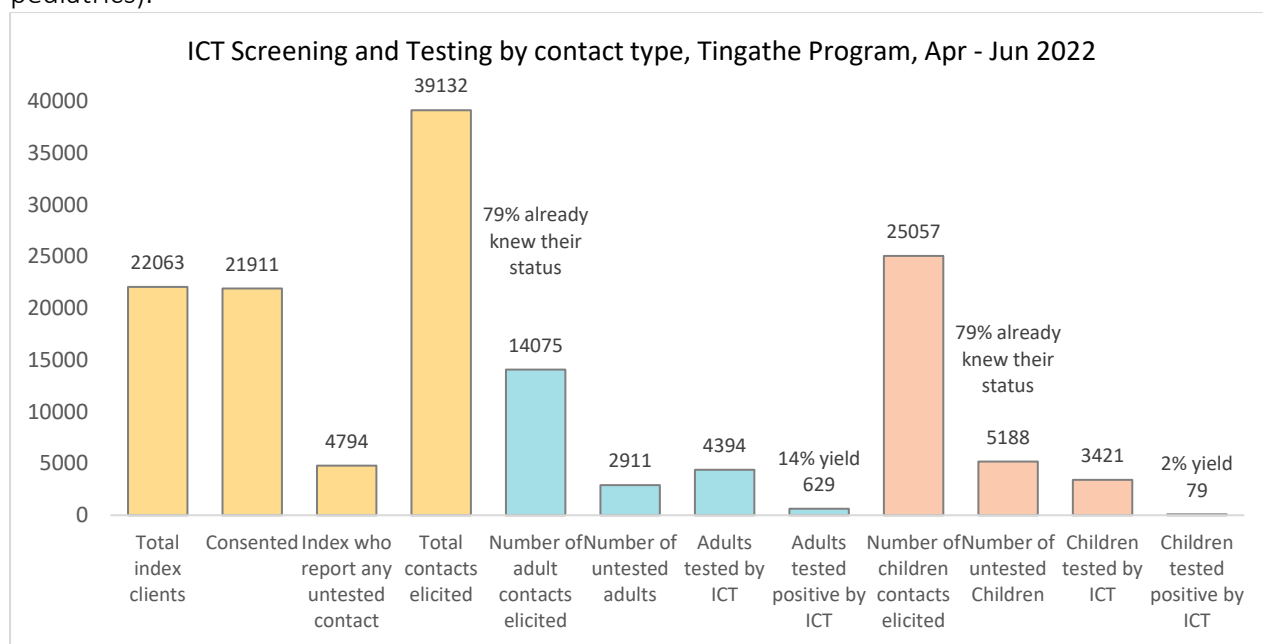


Figure 4: ICT Cascade (pediatrics and adults), Q3 FY22

Tingathe continued to register high ICT yield at 9% at the end of Q3. The extreme cold weather during this reporting period influenced facility attendance, resulting in fewer clients receiving ICT and contacts elicited and tested. Nonetheless, ICT continued to contribute a large proportion of total newly identified PLHIV, with overall positivity from ICT remaining above 20%, as seen in Figures 5 and 6.

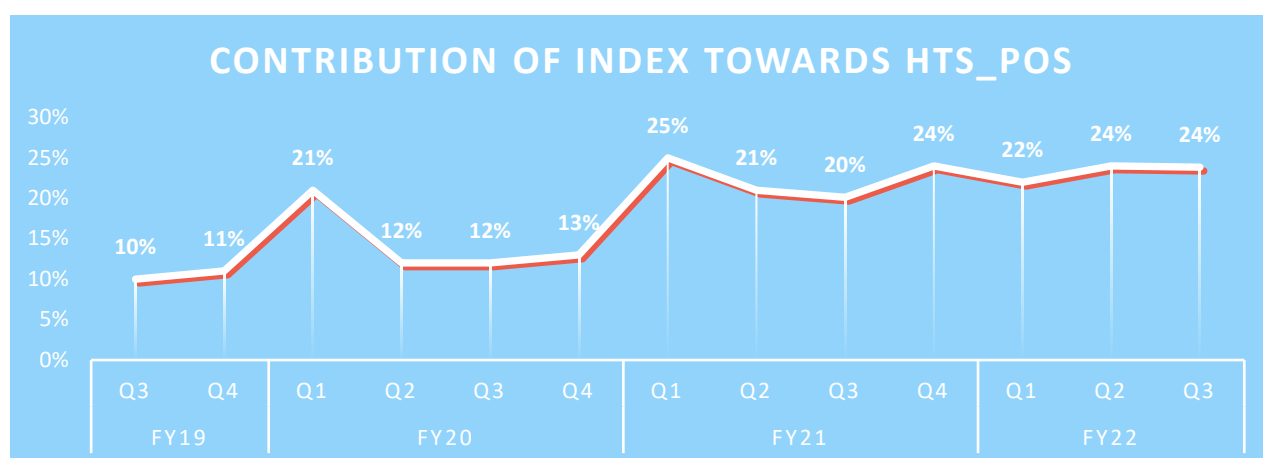


Figure 5: Contribution of Index testing towards HTS pos Q3FY19- Q3FY22

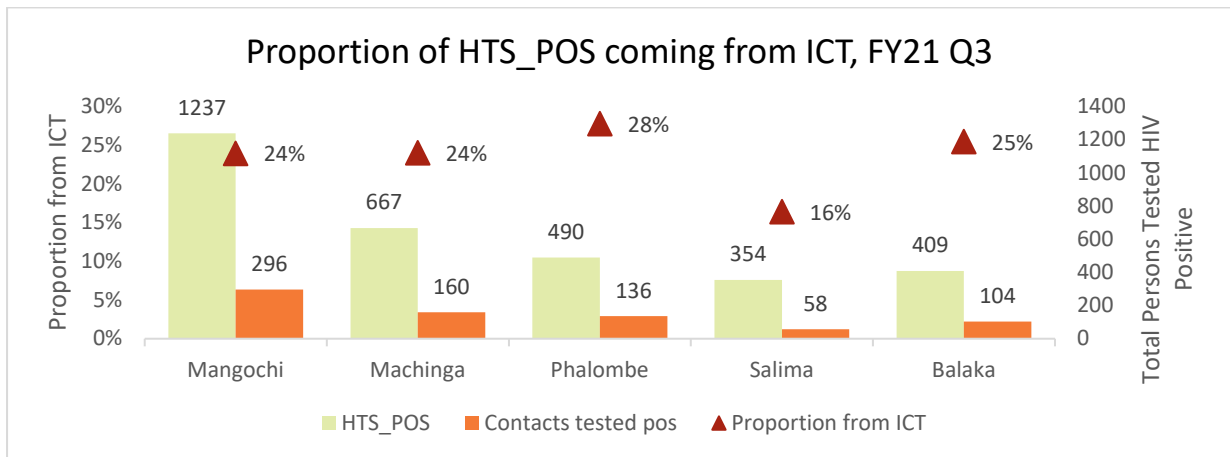


Figure 6: Proportion of positive cases coming from ICT by district, Q3 FY22

ICT yield across districts ranged between 7 - 12% as illustrated in Figure 7 below.

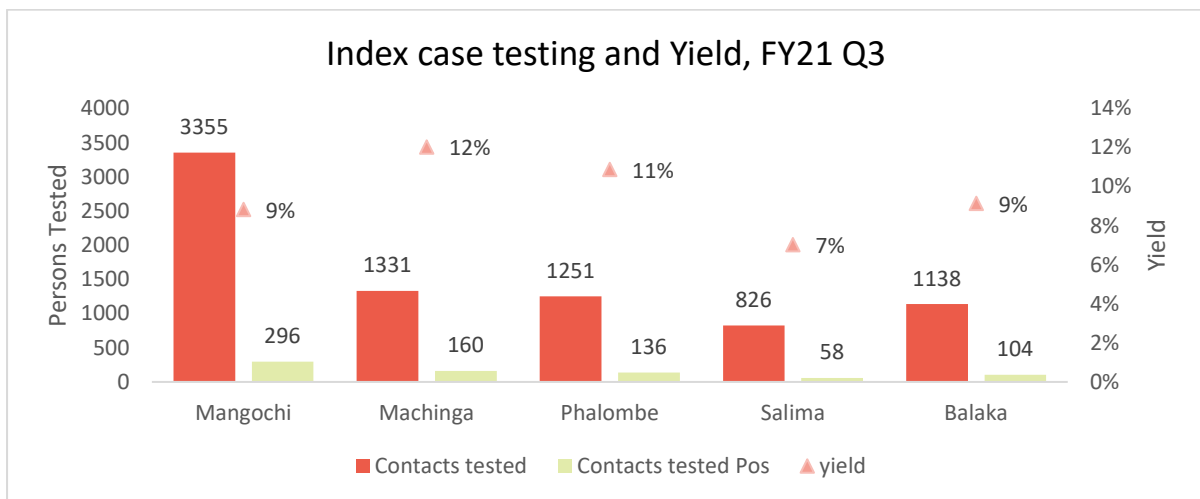


Figure 7: Index Case Testing and Yield by district, Q3 FY22

Figure 8 below illustrates that more female than male contacts were tested through ICT, with high proportion of HIV positivity yield recorded in men between 30-49 years.

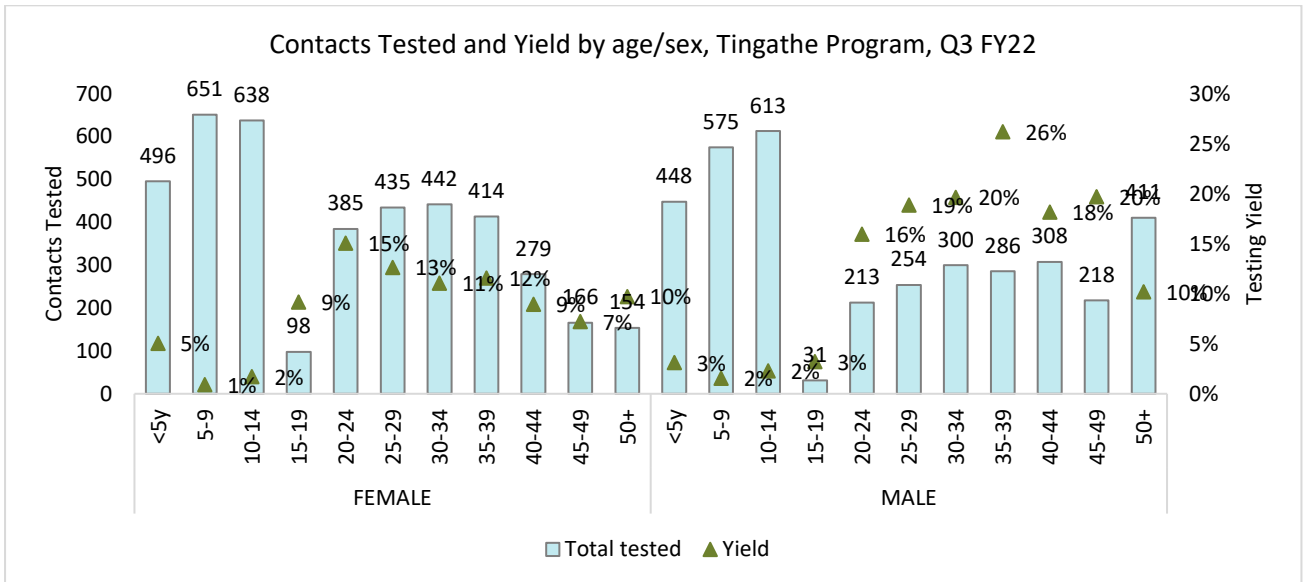


Figure 8: Age and sex distribution of contacts tested and yield, Q3 FY22

Tingathe Site Supervisors and Community and HTS Program Officers (CHPOs) continued to provide supportive supervision through sit-in observations of ICT counseling sessions, monitoring of documentation, monitoring supply chain of HIV test kits and coordinating testing of ICT contacts to ensure quality of ICT services. To avoid missed opportunity for ICT screening and counselling, screening tools and color-coded client flagging cards were used to identify clients for ICT. Virtual and WhatsApp-based support continues to be provided to sites on a daily basis where gaps identified are immediately addressed and best practices replicated across sites; which assures fidelity of ICT implementation.

Voluntary Assisted Partner Notification (VAPN) services were provided at all 95 sites. Recently elicited adult sexual contacts were prioritized as the highest-yielding category and were grouped by geographical locator information for priority tracing. Site staff contacted clients via phone calls beforehand to set up appointments for home tracing, with many clients identifying evening, weekend, and early morning hours as appropriate times for home testing/tracing. This client-centered approach and facilitated motorbike tracing increased the number of successful home tracing visit aligned to ICT contacts' availability, resulting in an average return rate of 49.6 % across all ICT techniques (an increase from 41.8% reported at SAPR), as shown in Figure 9.

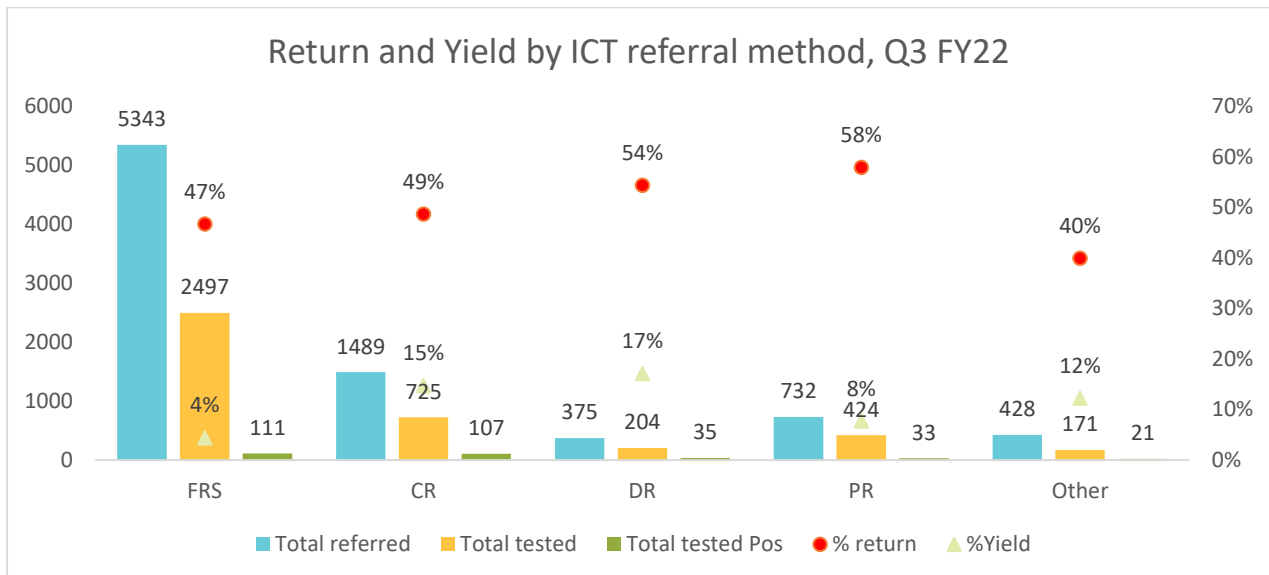


Figure 9: Return and yield by ICT referral method, Q3 FY22

Family Referral Slips (FRS) had the highest return rate (47 %) of all ICT referral techniques (mainly due to child contacts), followed by dual referral (DR) at 17% , with contact and provider referrals at 15 % and 8% respectively. Out of all the ICT referral strategies, dual referral registered the highest yield at 17 %. All contacts, both adults and children, were actively followed up based on index clients consent for this follow up.

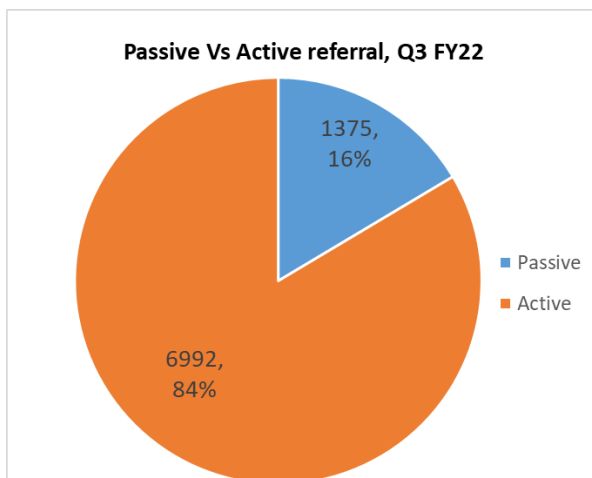


Figure 10: Passive vs Active Referral, Q3 FY22

Out of the 8,367 clients offered ICT 84% received **active referral/follow up**, whereas 16% received passive referral, as shown in Fig. 10. This proportion of active referrals includes clients who received FRS and consented to follow up and testing at home if they didn't return to the facility for testing. ICT health talks and ICT counseling to clients at the ART waiting area and individually during screening enabled clients to understand and choose their preferred ICT method.

Tingathe continued to prioritize male case identification throughout Q3 of FY22. Figure 11 shows the highest HIV testing yield at 4% among men over 25 years and females over 50 years. The lower yield among women of reproductive age is primarily due to the high volume of HIV tests administered to women, particularly those receiving antenatal (ANC) services. It is notable, however, that despite a lower testing yield, the higher volume of tests conducted resulted in identification significantly more women in this age group than men. There was no difference in testing yield among males and females under the age of 15 years.

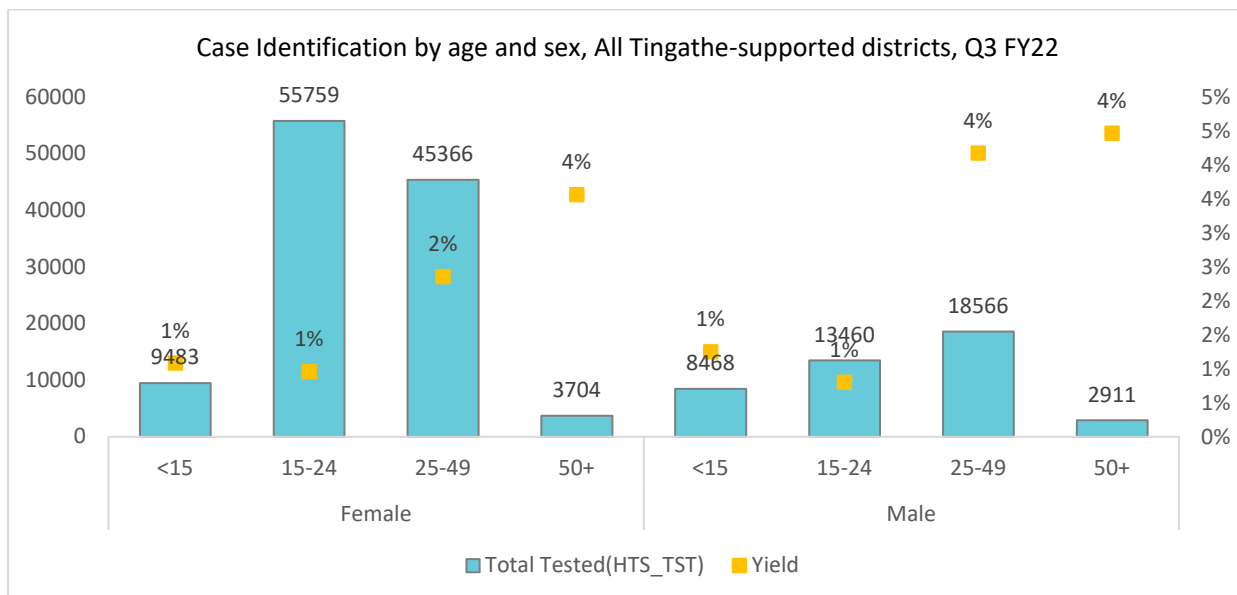


Figure 11: Case identification by age and sex, all Tingathe supported districts, Q3 FY22

Interventions targeting men included;

- Provision of HTS and HIV-STK to all men at OPD above 25 years who had not tested for HIV in the previous 3 months
- Targeted health talks provided just outside health facilities for bicycle taxi riders and male guardians are conducted to encourage men to access self-testing and/or other services.
- Fast-tracking men who accompanied their partner during ANC,
- HIV-STK distribution to women in the ANC who did not bring a partner during their second ANC visit for provision to their male sexual partners.
- Gender-matched HIV testing and counseling - aligning men's testing and counseling to a male provider and for health education about access to HTS and HIV STKs, with linkage to welcome care
- Continued monitoring and support to enhance CHW and HDAs' ability to successfully trace men with VAPN approaches
- Clinic adaptations to provide specific clinics and/or flexible clinic hours to offer services for men

1.2 Provider Initiated Testing and Counseling Optimization

In this reporting period, Tingathe registered a high PITC coverage (above 95%) in STI, OTP, SFP, NRU and pediatric ward as shown in the figure 12 below. PITC was offered in high-yield settings, such as STI, adult female and male wards, OTP and NRU with prevalence rate of 10% and above, as well as areas where universal testing is provided for essential prevention of mother to child transmission (PMTCT) interventions like ANC and maternity. Targeted PITC was also provided in high volume, low yield settings such as OPD. CHWs and CHWCs screened clients at OPD and offered HIV testing to clients who had never tested for HIV in the past year or had risk factors suggesting the need for HIV testing. All men above 25 years and youth presenting at OPD who had not had an HIV test in the previous three months were offered testing as an approach to improve access to services for men and youth. Health care providers in OPD were encouraged to refer all clients with risk factors suggesting need for HIV test including STI clients.

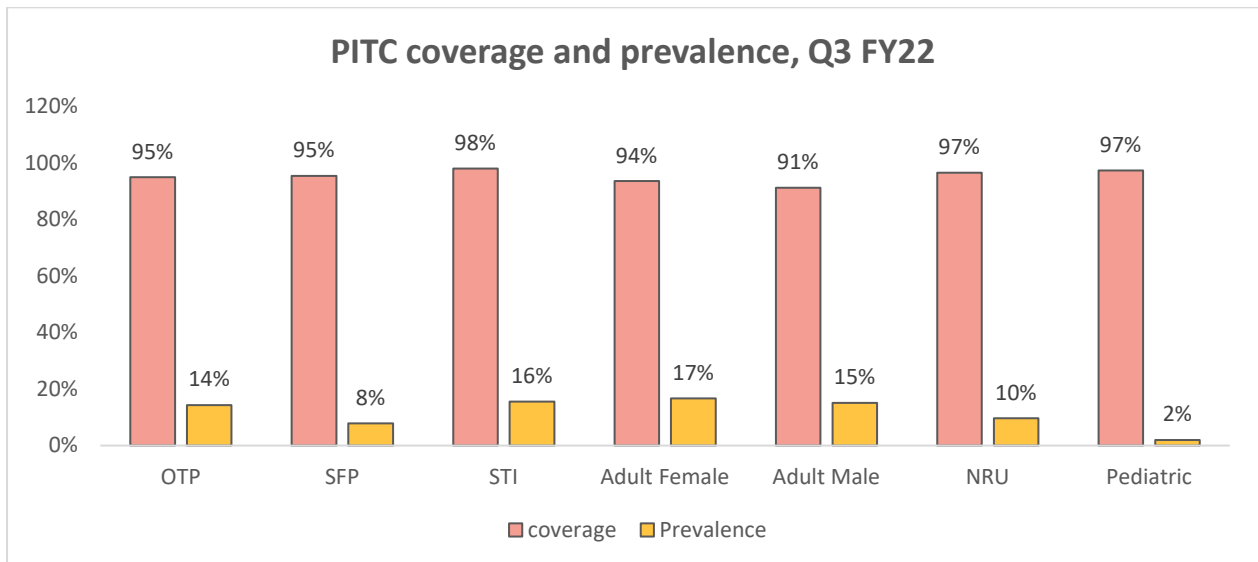


Figure 12: PITC coverage in all entry points, Q3 FY22, Tingathe program

To ensure early detection and prompt linkage to ART for pregnant WLHIV, Tingathe continues to offer HIV testing to all pregnant women throughout the first trimester, third trimester, labor, or before discharge from the maternity ward. Exposed children were also provided HIV testing at the 6 week, 12 month, and 24 month milestones. More information on maternity HIV testing and early infant diagnosis (EID) coverage is described in [Section 3.3](#)

Assurance of HTS quality at facilities

During Q3 FY2022, Tingathe ensured the following HTS quality assurance measures were implemented in all its supported sites;

- Tingathe program and MOH jointly conducted mentorship and implemented corrective actions from RTCQII and National HTS supervision to address issues identified.
- Conducted quality controls on all HIV test kits used
- Site supervisors and CHPOs conducted counseling session sit-in observations for HTS providers to ensure quality of HTS with a focus on ethical, client-centered delivery of VAPN services
- ICT exit interviews were conducted to assess client experience with ICT provision, with a focus on VAPN services; responses were fed back to district teams to inform program improvements.

Recency testing

The Tingathe Program is supporting the roll-out of HIV recency testing. In Q3, there were 2269 clients tested for recent HIV infection at 54 sites. Of the newly tested clients, 184 were identified as recent infections (8%). Data are compiled and shared by the recency partner I-TECH. Tingathe continues to engage with MOH and I-TECH in reviewing recency data to inform programming.

1.3 HIV Self-Testing

During this reporting period, a total of 55, 872 HIV Self-Test Kits were distributed from 95 Tingathe supported sites. Tingathe CHWs continued to promote HIV-STK as a facility-based screening test that men can use or collect and give their sexual partners and friends. STKs were given to pregnant women attending ANC for provision to their partners, some OPD clients who needed an HIV test and chose STK, and ICT clients from all service delivery sites (STI, TB, etc.) who wanted STK for their contacts. Clients receiving an HIV-STK to use at the facility were directed to a private space to do the test, with or without the assistance of a provider, as desired, after which they could access confirmatory HIV testing if the HIV self-test result was positive. HIV-STK stock challenges were addressed by close monitoring of stocks and intra-and inter-district relocations.

HIV-STK were also supplied to patient escorts, truck drivers, and bicycle taxi drivers to increase HIV testing access for men. This was combined with provision of education on the benefits of HIV testing and partner notification targeted specifically to men.

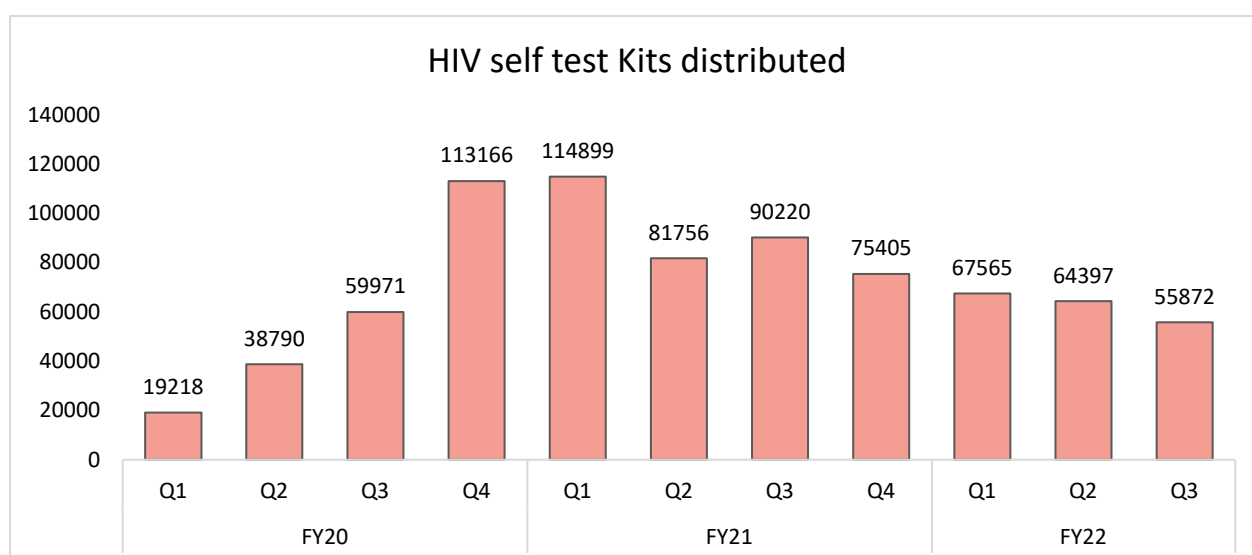


Figure 13: Number of HIV-STK distributed, Q1 FY20– Q3 FY22

Figure 14 below shows the highest number of STKs was distributed to the age group 20-24 years in line with prioritization of this age group. Providers reminded clients to return to the facility for confirmatory testing if their self-test result was positive. HTS providers were encouraged to enquire if clients had used a self-test recently in order to document appropriately in dedicated HTS registers.

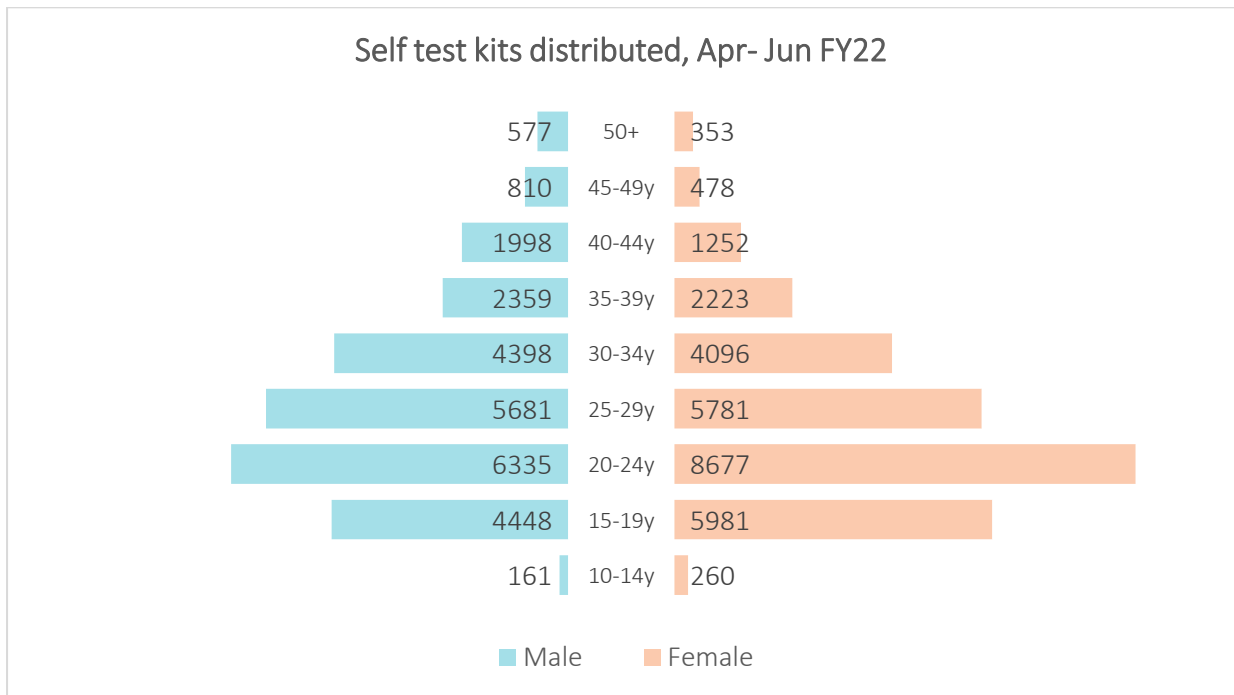


Figure 14: STKs distributed by age and sex, Q3 FY22

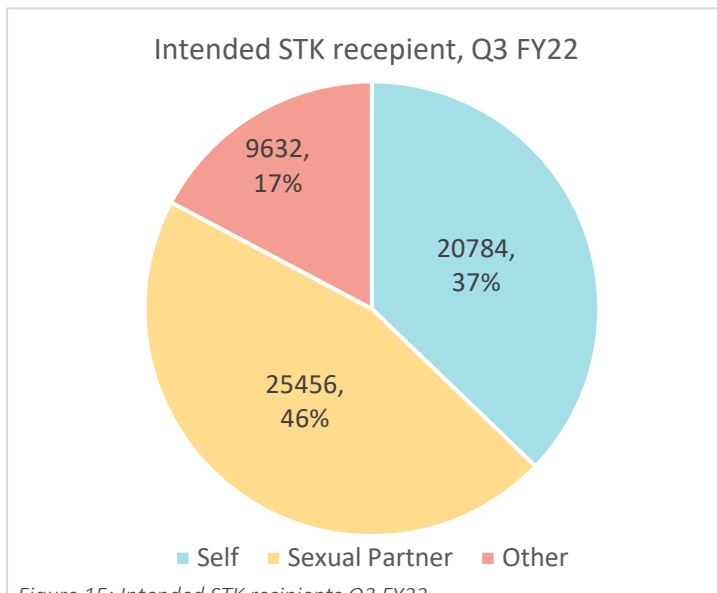


Figure 15: Intended STK recipients Q3 FY22

Most (46%) of test kits were distributed for sexual partners as the intended end users, followed by 37% for self, and 17% for other contacts as illustrated by Figure 15 below.

All sites maintained a dedicated HTS register for clients who came for confirmatory HIV rapid test after a positive HIV result outcome following use of HIV-STK. All clients accessing HTS were screened by HTS providers to establish their previous use of HIV STK and document them in the dedicated HTS register.

1.4 Finding and Engaging Men and Boys

To ensure client-centered care, Tingathe continued to implement improved male case-finding and linkage interventions derived from feedback from routine client exit interviews conducted by the program. The interventions included;

- Prioritizing **male sexual contacts** for ICT tracing,
- Offering **“on-site” supported STK testing**,
- Establishing **male hours or physical spaces for testing**,
- Using **male HDAs/CHW counsellors** whenever possible to test males who prefer a male provider (gender-matched services).

- Male-only clinics were operated by **male staff with flexible hours** to increase HIV testing, ART initiation and retention in care,
- TB screening and early diagnosis, and **STI management in sexually active men.**
- Through collaboration with community partners to **generate demand for testing and ART services** in the community,
- **Targeted community testing (through ICT)** was effective in finding HIV+ men. Across the program, 46% of the tests performed were provided for men, while 56% of the PLHIV identified were men. The male testing yield was higher at 11% than the female testing yield at 7%.
- Tingathe will continue to **intensify efforts through ICT** as one of the key approaches to identifying HIV positive men.

Active Case Finding challenges and responses

- Test kit shortages (Determine test kits). **Tingathe worked closely with district Pharmacists and central DHA logistics team to do relocations to sites with low supply and prevent stock-outs.**
- **Low or stock out of DBS bundles up to mid-May. Tingathe supported stock monitoring and facilitated relocations to sites with low supply to prevent stock-outs. Sites were encouraged to reserve low stocks of DBS bundles for EID**
- Tingathe program recognizes the need to continue testing in certain higher-volume, lower-yield settings such as ANC, maternity, inpatient wards and OPD for critical HIV prevention activities. While continuing these important testing efforts, **Tingathe continues to work hand in hand with providers in OPD to refer STI clients, clients at high risk, and those with symptoms to HTS. OPD screening is done to offer targeted HIV testing.**
- ICT clients are reluctant to disclose all of their sexual partners for many valid reasons, however an avoidable barrier is the lack of privacy due to lack of confidential space for ICT counseling. **Construction of drop boxes** in some sites during prior performance periods provided **additional private space for ICT screening.**
- Developing trusting relationships with clients is also critical; thus **client flow during ART Clinic was reviewed to maximize screening opportunities such as ICT screening being done by the same person providing welcome service for newly diagnosed clients, clients with HVL, and those with treatment interruption. ICT screening is also done during routine VL collection, annually for stable clients on ART.**
- At some sites **tents were set up to create additional room for STK use, with or without provider support and allow clients who test positive conveniently access confirmatory testing before leaving the site.**
- Very few clients are reachable via phone tracing; the majority needed physical tracing due to establish low phone ownership amongst clients in the districts coupled with poor network in rural areas and change in phone contact details. **CHWs continued to update client phone numbers to increase chances of reach by phone tracing and follow-up.**
- To increase ICT testing for contacts from far to reach areas, **Tingathe trained motorbike riders and provided motorbikes and vehicles to CHW Counselors to increase case identification among contacts of PLHIV**

- Index clients often report no or one adult sexual contact and/or provide false names and/or locator. **Expert ICT counselors (CHWs with good ICT counseling skills) were allocated for ICT counseling to enhance quality counseling to promote the listing of sexual partners as contacts and provision of correct locator information for successful ICT.**
- Tingathe continued to address factors that affect clinic attendance including COVID-19 through the delivery of **health talks on COVID-19 to dispel myths, provide vaccine education and encourage care-seeking behaviors** as well as **intensified facility testing through different approaches (OPD screening, ICT, PITC, and STKs).**

Active Case Finding activities in the next quarter

- The program is poised to support rollout of refresher trainings in the new integrated testing guidelines in collaboration with support from the HTS department at the DHA. As at submission of this report, the trainings had commenced on July 22 after completion of trainings of trainers, however, one challenge is the large number of providers DHA has requested partners to train which may not be realistically covered by available resources; hence prioritization of key/practicing HTS providers to attend initial training sessions. Unlike previous training, the Global fund support is limited to TA sites.
- Continued efforts to enhance client-centered, confidential, and voluntary ICT services through role play practice, recorded voice notes, supervision and feedback to improve contact elicitation, particularly for sexual partners.
- Continue to provide HIV-STK to women at ANC, STI, and newly diagnosed HIV positive clients for their untested partners and to all clients seeking HTS without a defined risk during the COVID-19 pandemic period.
- Continued delivery of site-specific male interventions informed by exit interviews, with collaboration with faith-based groups.
- Fast track testing service for men who present with FRS/VAPN
- Focus on continued development of client-centered approaches to disclosure
- Continue enhanced weekly facility-based case review and data feedback meetings with APA partner to optimize cross-referrals and ensure all eligible clients are receiving optimal services from all stakeholders.
- Continue monitoring of stocks and coordinate relocations following stock outs to ensure consistent availability of HIV testing services
- Conduct HTS providers proficiency testing to monitor their technical skills and take corrective actions for those who performed poorly

Site level performance analysis

In Q3 Tingathe Program conducted biweekly data deep dives aiming at reviewing site level performance. Deep dive sessions focused on zooming into the site level performance for a selected indicator, highlighting the high and low performing sites and engaging sites in discussions to identify the reasons for both levels of performance. The high performing sites shared their experiences and interventions they have in place to achieve the high performance. Sites with low performance were engaged further by supporting them to develop action plans for improvement.

A total 6 site performance deep dives were conducted during the quarter in Child ICT, continuity of treatment in adolescent and children, Viral Load Coverage, Cervical cancer prevention services, PMTCT EID and AHD. The table below summarizes two of the analyses.

Area of focus	Performance overview	Reasons for poor performance	Action points for addressing the gaps
<p>Early Infant Diagnosis Tingathe program seeks to achieve 100% testing coverage for all infants of WLHIV, at 2,12 and 24 months milestones</p>	<p>Q3 data analysis highlighted sites with suboptimal performance of EID at all milestones. 16%, 14% and 7% of the Tingathe sites had suboptimal performance at 2, 12 and 24 months milestones respectively. Namanolo and Machinga Health Centres were highlighted for low EID testing coverage at 2months, Machinga DHO and Malukula HC at 12 months milestone and; Nyambi Ngokwe, Katuli and Machinga DHO at 24 months milestone</p>	<p>Factors that contributed to the sub optimal performance included mothers interrupting care, mother and infant appointment dates were not aligned and there were challenges in filling the monthly EID report submitted by MOH which in most cases was under reported.</p>	<p>All sites with suboptimal coverage developed CQI plans to improve the coverage. Specifically, sites addressed some of the gaps by ensuring that reports are written collaboratively with MOH staff, conducting pink card Audit every third week of the month to ensure all infants due for milestones have a documented outcome. In addition, sites flagged all mothers' charts with HCC information and testing milestones for their infants for easy identification for service provision</p> <p>CQI projects were initiated in May and June 2022 in selected sites in Mangochi and Machinga Districts to improve EID coverage</p>
<p>Index case testing for children Tingathe uses a child ICT card (CICT) which is designed to improve pediatric case finding by documenting the HIV status of all children of WLHIV in Baylor-supported ART clinics throughout Malawi. The goal of Tingathe Program is to have 95% of all women receiving ART screened for untested children during their clinic visit. This is done by opening a CICT card, attach to mothers Mastercard and entered in Baylor reporting Survey CTO tool for monitoring performance</p>	<p>The analysis covered the period from Q3, FY21 to Q2 FY22. It was observed that; out of the 95 Baylor supported sites, 23 had CICT coverage below 70% with very low coverage in high volume sites i.e. Nambazo and Salima DHO (49%), Salima Lifeline (37%) and Mangochi DHO (61%)</p>	<p>It was observed that some women who visited the clinics were missed due to gaps in client flow that created loopholes for opening child cards for ICT testing, many CICT cards that were opened were not entered in the Survey CTO and Cards were not often used during community ART distribution Clinics</p>	<p>The 23 sites developed CQI plans to improve child index testing. Actions included: Clearing the backlog of cards not entered in Survey CTO, reorganizing the card flow process to ensure that all women 15Yrs+ have a CICT card opened and Integrating CICT tool during community ART Distribution clinics.</p>

OBJECTIVE 2: IMPROVED TREATMENT COVERAGE AND RETENTION SERVICES

Tingathe continues to utilize the Takulandirani Welcome Service to provide client-centered support for all clients to access and remain on life-saving antiretroviral therapy (ART). The Welcome Service strives to address structural, clinical, and emotional barriers that prevent patients from starting, sticking with, and staying on treatment. Clients with high viral loads, treatment interruptions, and new initiations are supported by CHWs, clinical staff, and psychosocial counsellors with counselling tailored to their needs.

The Welcome Service uses a "handshake" model to help patients stay on treatment by welcoming them, normalizing their treatment challenges, acknowledging their challenges with engagement in care, supporting them, providing client-centered care and counseling, and empowering them to restart and stay on treatment. Tingathe team members continued to identify clients' needs and deliver targeted, client-centered counseling sessions using the welcome counseling tool. The program employs a continuous approach to refining and enhancing fidelity in implementation based on feedback from the sites. Further, the program commenced the process of developing an animated video on welcome care, initial content gathering and video script development was done with the aim of further refining and video production in the subsequent quarter.

Tingathe continued to focus on incorporating Takulandirani Welcome Service into all HIV services, particularly for clients with high Viral Load, those who have recently interrupted treatment, and newly diagnosed clients. Color-coded client flagging cards were used to track delivery of a package of services for each client during the first six clinic visits and prompt development of client-centered approaches to barrier. At the time of the clinic visit, the CHW in charge of the client ensures that the appropriate service is performed and recorded on the card. A comment is included when a service is not provided during a visit as a reminder to ensure that this information is delivered during the next visit. During this reporting period, Tingathe conducted a meeting with Site Supervisors to enhance their knowledge and skills on use, documentation and reporting on the client flagging cards. Client flagging cards ensure that clients have access to services that meet their needs in order to stay in care, and act as prompts for facility staff to offer the listed package of services for these clients in a friendly and sensitive manner.

2.1 Treatment Growth/New Clients

Tingathe identified 2,968 HIV-positive people in Q3 FY22, and 3,023 of them were put on treatment, achieving 102% linkage rate which include some new clients from the previous performance period, likely identified at the end of the quarter and did not immediately start treatment. Figure 16 shows that all supported districts recorded high linkage rates (>100%) except for Lilongwe district. Baylor COE on KCH campus supports testing of all children and guardians on pediatric wards. Children initiating treatment are linked to care at COE, while adults are referred to Light House to initiate treatment which explains the variation in proportion of newly identified individuals to those starting treatment at the facility.

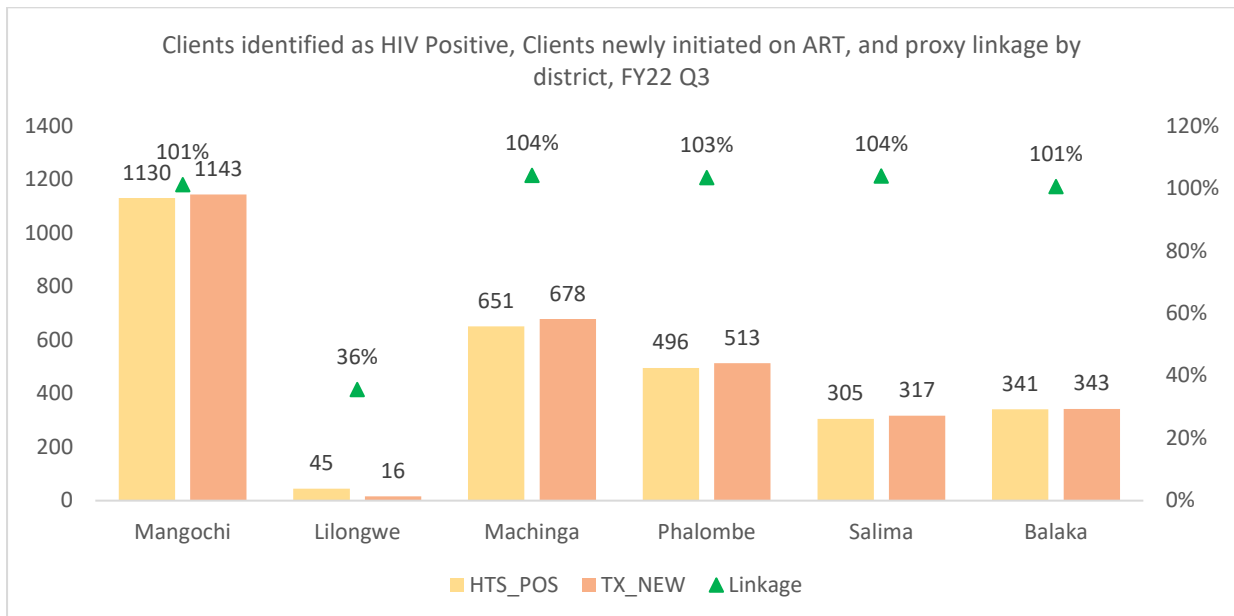


Figure 16: ART linkage per district, Q3 FY22

CHWs continue to physically escort newly diagnosed clients to start ART and provided pre-ART counseling to help patients make informed decisions about starting ART and developing a personalized plan to stay in care. Selected clients were further referred for counselling by a psychosocial counsellor (PSC). The Takulandirani (Welcome) Service significantly enhanced provision of client-centered care to new ART clients. The program has placed clinical staff at sites and ensures ART clinics are patronized by ART providers during all clinic days, to ensure newly diagnosed clients are started on treatment during the day of their diagnosis having gone through counselling sessions. The test and start approach has resulted in high ART linkage rates across the program. For clients who were not ready for same-day ART initiation, their home location information was collected allowing for follow-up via home visits and phone conversations to better understand and address their ART linkage barriers. Each week, the linkage focal persons (a selected CHW at each site) recorded and reported the number of clients initiated on ART out of the total number of HIV-positive clients identified which enable the site supervisor to keep track of this linkage data. The site supervisor assigned and ensured CHWs followed up clients opting not to start ART on the same day.

High linkage rates were recorded across all age bands and sex. Site and Cluster Coordinators discussed with their respective site staff the linkage performance and developed improvement plans based on data from site performance dashboards produced and shared weekly by the M&E team to monitor any person that was not linked to care. Some common factors in clients who fail timely linkage includes community testing especially among key populations, who are highly mobile and move out of district.

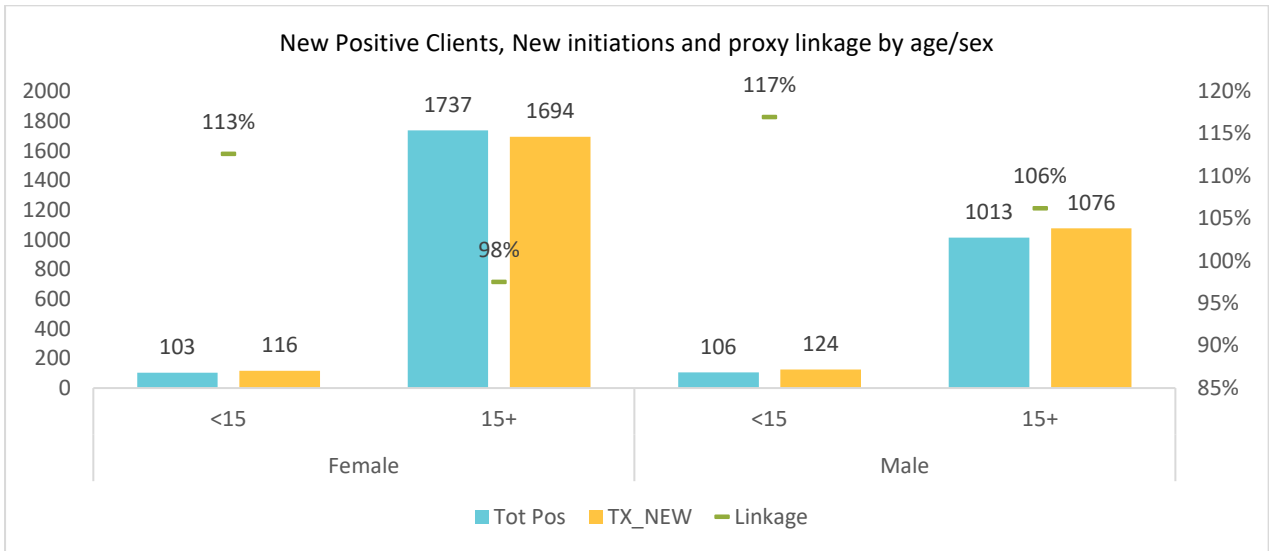


Figure 17: ART linkage by age per district, Q3 FY22

CHWs updated phone and geographic locator information of all clients during ART clinic visit to ensure successful tracing of clients who needed tracing. Those who have access to a phone but do not know the number are given a CHW phone number to "flash" for a call-back; many of these clients contacted site-level staff after returning home to provide updated information on a family member or friend's phone number at which they could be reached. Only 28% of clients attended in the quarter had access to phones, limiting the impact of phone tracing, the rest required physical tracing via home visits; 62% of the clients traced returned to clinic within the reporting period. Overall, <40% of the total client cohort served by the program has access to a phone.



28%
of clients needing tracing have phones

CHWs routinely reviewed appointment registers and electronic medical record (EMR) data to identify clients who missed appointments. Those who did not attend clinic were identified within a day of their missed appointment and called the next day, as well as seven days later if they had not yet attended clinic. Clients who missed an appointment were documented in a tracing register, and tracing was initiated through phone calls, and home visits for clients without phones. Clients with phones who were not reached after two phone attempts were sent text messages. Figure 18 shows that over half of people who needed tracing had missed a clinic appointment (50%) or had an interruption in treatment (19%). People with a high viral load result who needed tracing were about 8% of the total number needing tracing.

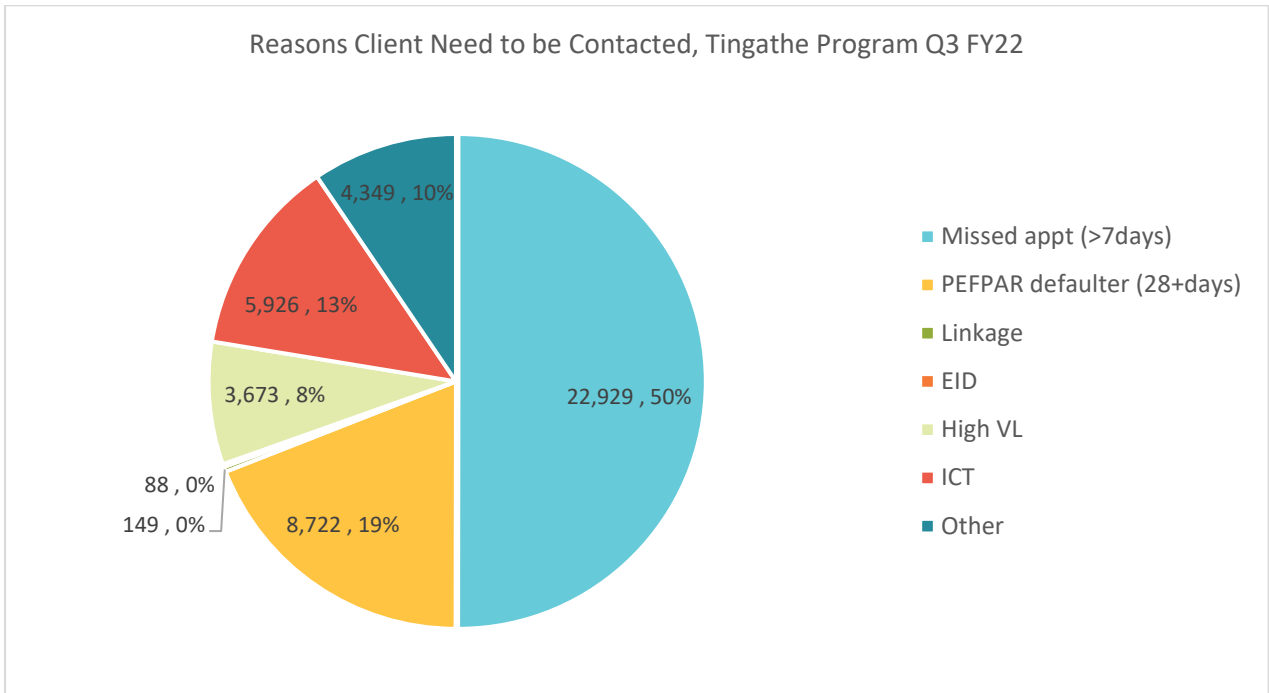


Figure 18: Reasons for client tracing, Q3 FY22

Client movements across the border for business and farming activities have been identified as some of the primary reasons for missed appointments especially at sites along the border. Rotas (work allocation schedules) were adjusted to create rotational schedules to maximize efficiency and allow for daily CHW tracing to follow these clients. Motorcycles were used to trace clients at distant location and CHWs tracing on motorcycle were allocated more tracing days to increase reach of more clients at a given time. Figure 19 illustrates increasing rate of clients who miss appointments at boarder facilities and decreasing rate of missed appointments at non-boarder facilities towards the end of Q3, a period with increased trade after the harvest season.

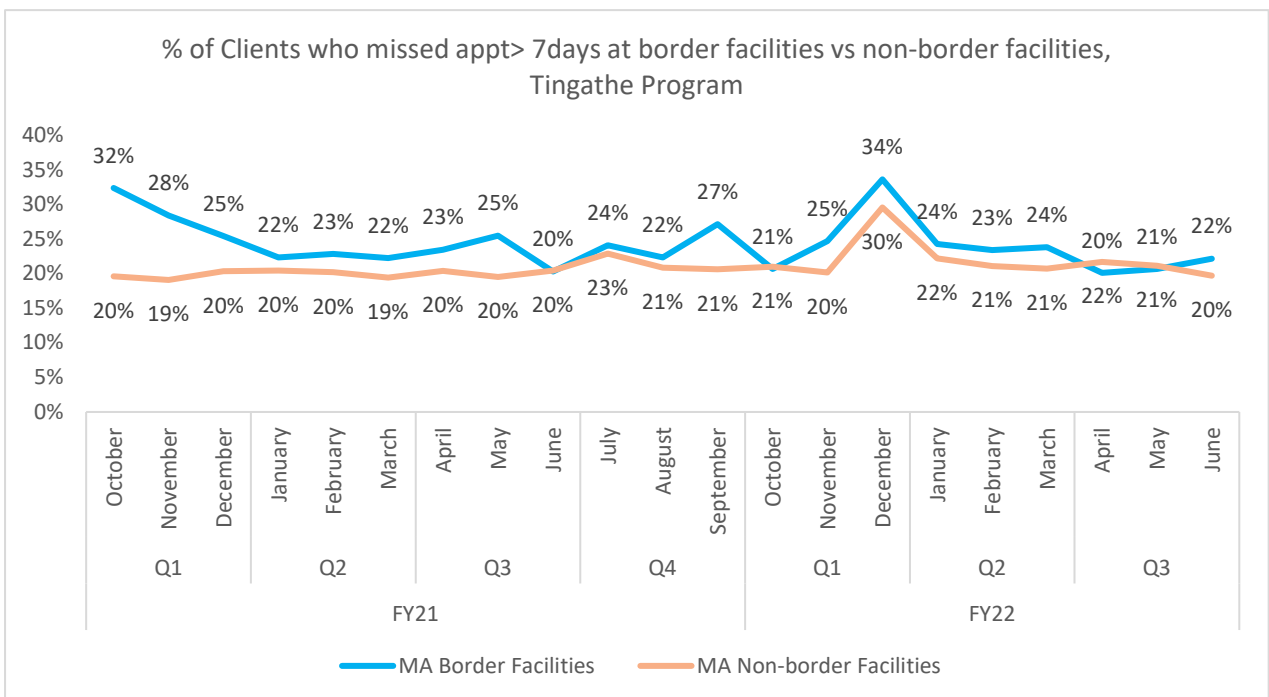


Figure 19: Missed appointment rates at border vs non-border facilities from Q1 FY 21- -Q3 FY22

Stable clients on ART were given a multi-month supply (MMS) of ART in all supported districts, allowing for flexible ART attendance to clinic and improving retention. Figures 20 show the number of clients by age who received medication for <3 months, 3-5 months, or 6+ months. As of Q3 FY22, 90% of ART clients received at least a three-month supply of ART (Figure 21).

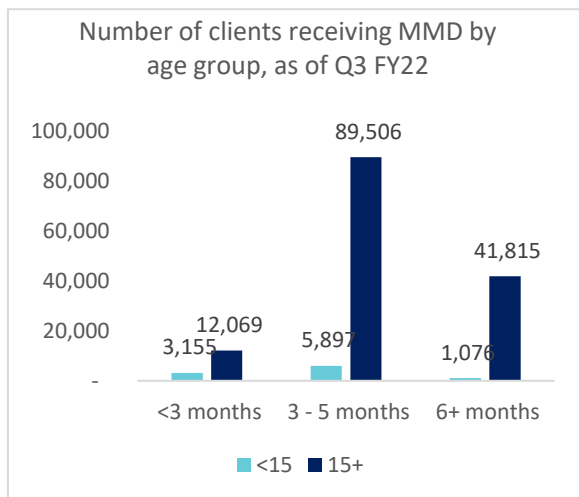


Figure 20 : Proportion of clients receiving MMD by age group as of Q3 FY22

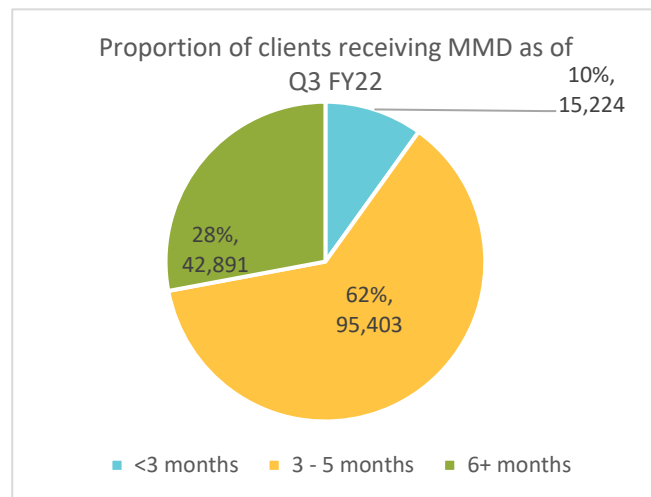


Figure 21: No. of clients receiving MMD by age group as of Q3 FY22

2.2. Continuity of Treatment: Implementation progress

Tingathe supports PLHIV from diagnosis of HIV infection through lifelong ART services, which include high-quality, client-focused education, counselling, and support. Tingathe delivers high-quality pre-ART and ART counseling by expert counselor community health workers with excellent counseling skills to ensure linkage by offering client-centered linkage support and same-day ART initiation in all supported facilities. This counselling sessions are provided during the first 180 days of ART initiation on months 1,2,3 and 6 were to address potential barriers to adherence and treatment interruption, as described in previous sections. Tingathe continued to implement a variety of client-centered retention interventions during this reporting period, as summarized in the green box.

Intensified, targeted counselling sessions were provided to newly diagnosed HIV clients who face multiple challenges including dealing with a chronic illness with its required daily medication administration, clinic visits, time and travel costs in addition to realities of coping with their diagnosis, disclosure and fears of stigma and discrimination as well as overcoming myths and misinformation about ART and HIV.

A range of services are provided including health education and counselling support; treatment literacy, adherence support, and support for disclosure to partner and family, and index testing.

By implementation of these services, Tingathe continues to maintain a high retention rate. Figure 22 illustrates continued improvement in one month and three month retention that has increased from 71 to 83% and 63 to 79%, respectively.

Retention Support

- Health talks
- Welcome Care services
- Pre-test and ART counselling
- Calling clients within a day of missed appointment
- Review and update of client contact information at each visit
- Enrolment of all new and HVL clients in ICAC
- Enrolment of all new clients and clients who have returned to care in Welcome Care (new in Q3)
- Pre-ART and counselling videos
- DSD models (MMD, teen club, nurse-led ART, extended hours, Men's Clinic, Community ART Distribution (CAD))
- Psychosocial Support (in person and by phone)
- Tracing of missed appointments, clients who have interrupted treatment, HVL, EID

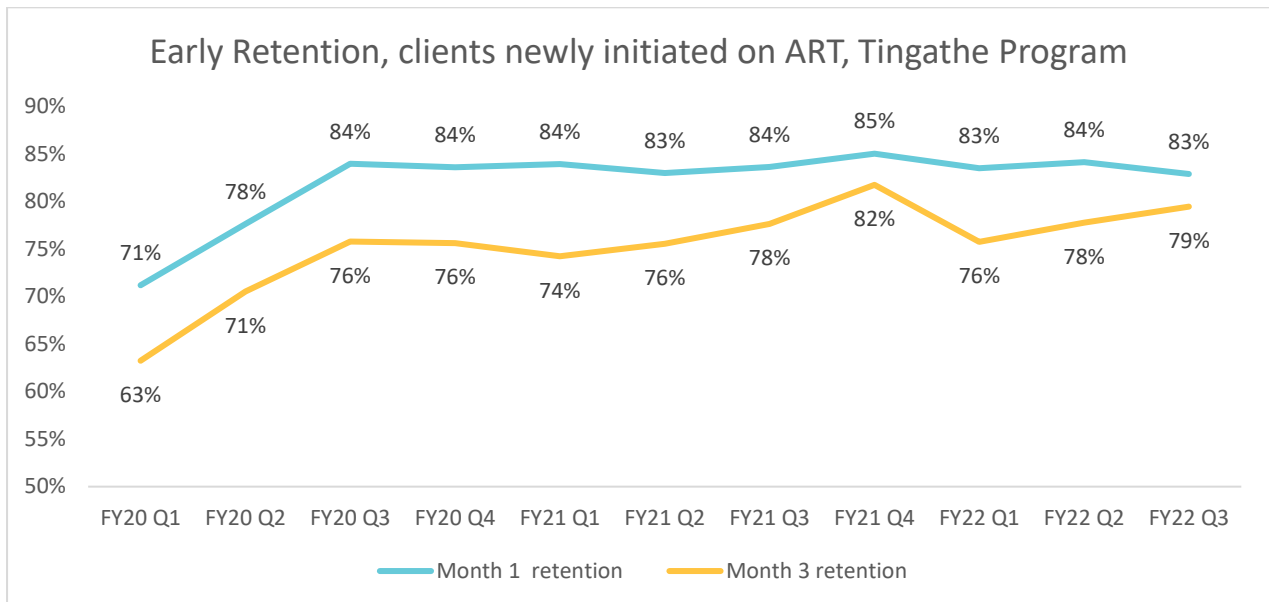


Figure 22 : One- and three-month Retention in newly initiated ART Clients, Q1 FY20 to Q3 FY22

Welcome care counselling sessions were conducted with clients newly initiated on treatment and those returning from treatment interruption to determine what challenges may hamper or hampered their timely clinic attendance and together generate solutions that work for them, including MMS, appointment reminders, CAD clinic and linkage for community support among others. Clients newly initiated on treatment were prioritized for tracing immediately. CHW counselor and expert psychosocial counsellors provide individual counseling sessions augmented by video-based counseling. CHW support new clients to navigate the health care system and empower them to manage their ART care.

Voluntary clinic exit interviews were conducted with clients from various demographic groups, including men, youth, pregnant and non-pregnant women, to determine client-level needs to inform programming adjustments that promote retention.

Differentiated Service Delivery

Tingathe continued to implement Differentiated Service Delivery (DSD) models to promote retention by addressing client barriers to clinic attendance such as distance and cost of travelling to the health facility. These include running 49 Community ART Distribution clinics, 35 Men’s clinics, 109 Teen clubs at 64 facilities and MIP clinic implemented in all facilities as a separate clinic or in cooperated in the normal clinic/ pediatric or family clinic, in addition to the availability of MMD at all supported facilities.

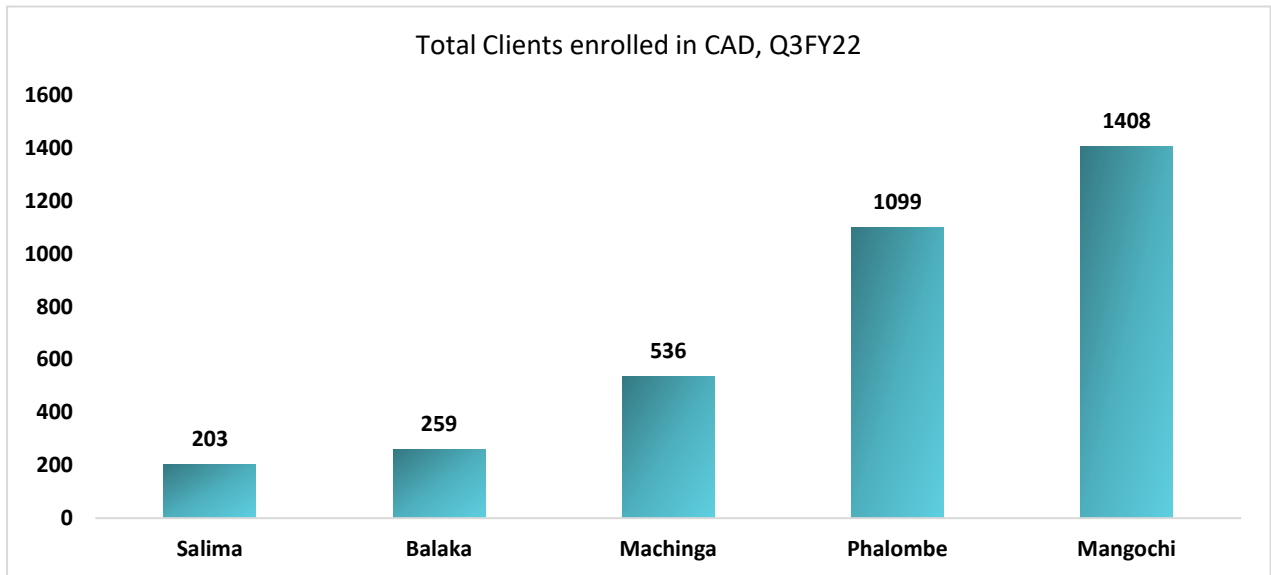


Figure 23: Total clients enrolled in CAD, FY22

During this reporting period, 3,505 clients were enrolled in CAD clinics in 5 districts and Tingathe registered high retention (96%) rate of all clients attending a CAD (94% in CAD, 1% back to general clinic, 1% transferred out) as shown in Figure 23 and 24 respectively.

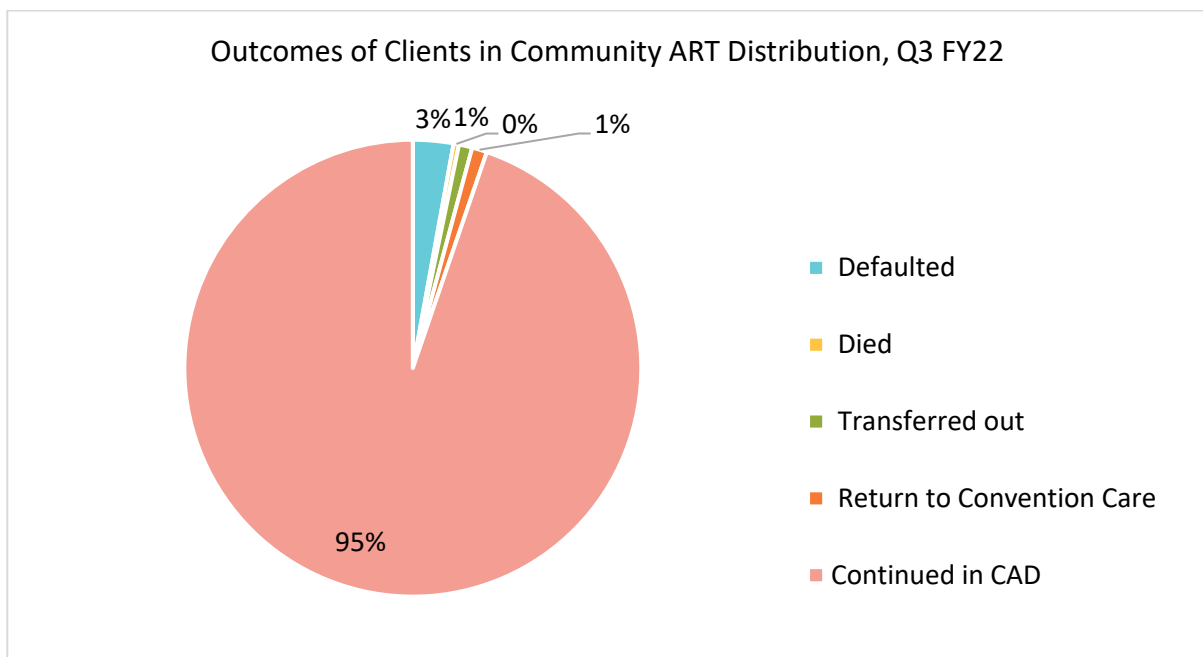


Figure 24: Outcomes of Clients in Community ART Distribution, Q3 FY22

In Q3 of FY22, Tingathe reported high early retention rates among newly diagnosed clients across supported districts ranging from 81-87% at month one and 78-80% at month three.

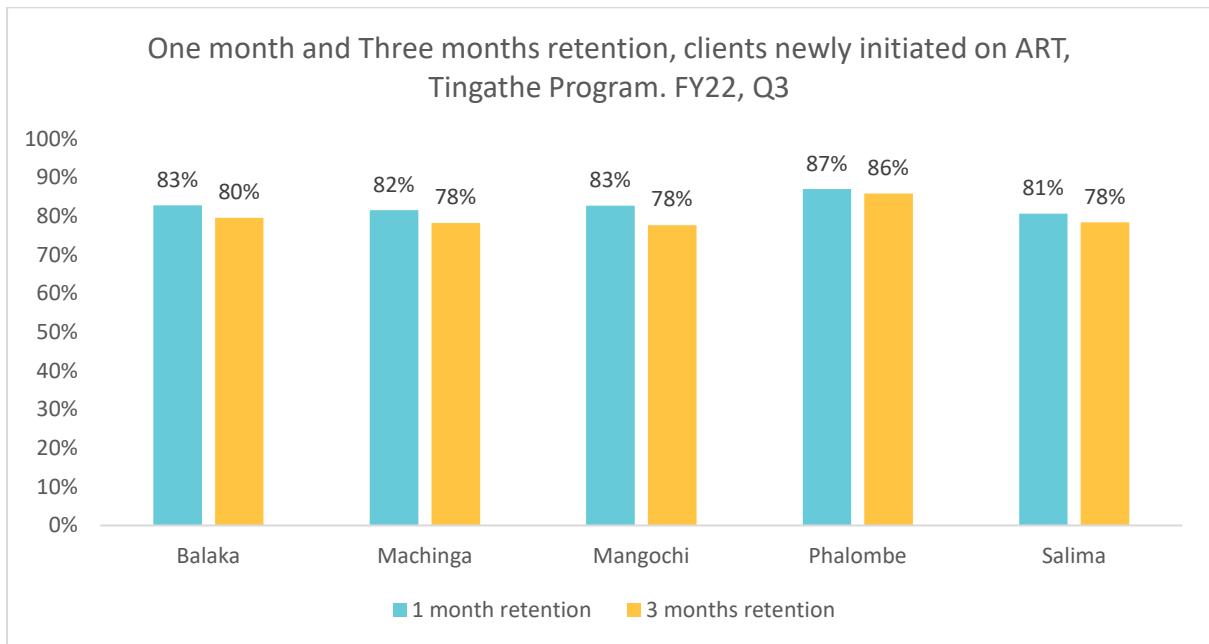


Figure 25: Retention in care at months 1 and 3 for new ART clients, Q3 FY22

Psychosocial Support

Psychosocial Counsellors (PSC) continued to provide psychosocial support to all clients with psychosocial needs at all program supported sites. These included newly HIV diagnosed clients, clients with adherence challenges, clients who declined to start ART, clients who were struggling with their diagnosis, disclosure, survivors of gender based violence (GBV)/intimate partner violence (IPV), and those with mental health concerns. Clients who were identified as having a severe mental health concern, for example severe depression, suicide, abuse and also those that had other clinical needs (e.g. side effects) were referred for a clinical review and/or a mental health expert for specialist evaluation and appropriate treatment.

In Q3, the referral criteria and referral process to PSC was revised to expand reach and improve access for more clients with psychosocial services. Facilities were encouraged to

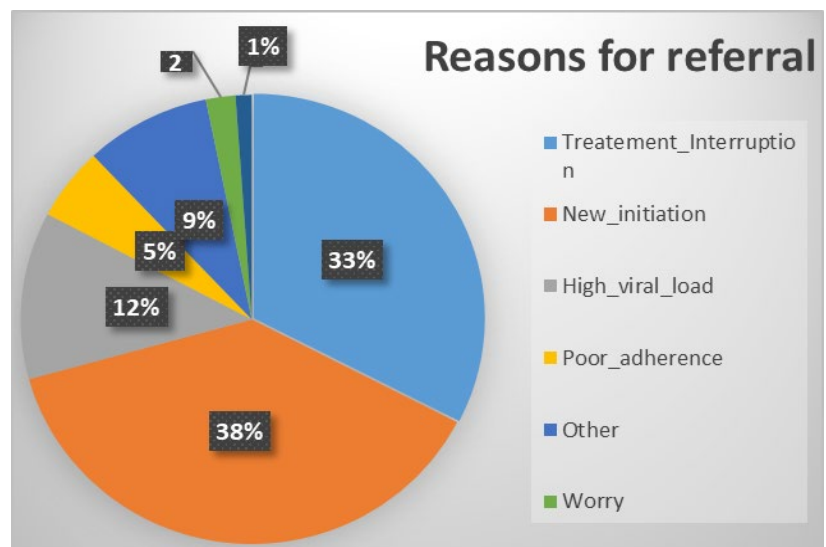


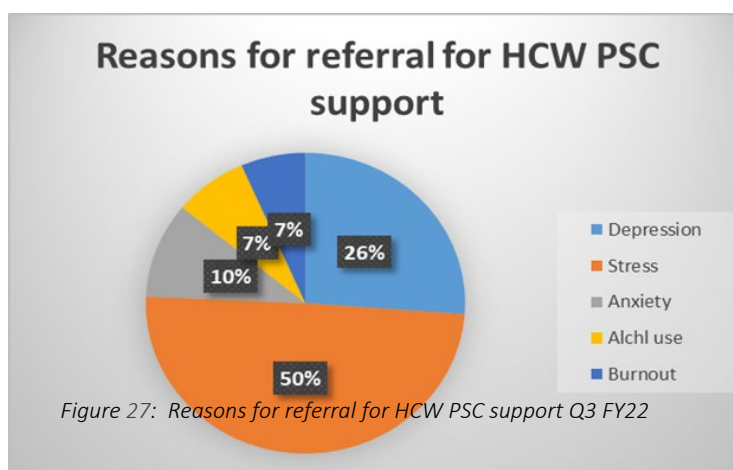
Figure 26: Reasons for PLHIV referral to psychosocial counsellors, Q3FY22

refer clients to PSC as early as 7am when clients arrive to clinic and are waiting for service provision to start which also offloads the busiest times of day from 8am e. Clients who preferred could opt to talk to the PSC during the next clinic visit, or be called later at home on their personal phone. The nineteen Psychosocial Counsellors are all based at high-volume facilities including district hospitals, and provide expert psychosocial consultations to clients in person or remotely over the phone. During this reporting period, a total of 5146 psychosocial encounters were made for a variety of reasons. Figure 26 illustrates that the most common reasons that clients were referred

to a Psychosocial Counsellor which included people newly initiated on treatment (38%), with a treatment interruption (33%) and with a high viral load (12%).

Through American Rescue Plan Act (ARPA) funds, a psychosocial counsellor designated to support healthcare workers psychosocial needs was hired in the preceding quarter. The program provided orientations to HCW on basic mental health needs of clinical staff and mental health support to reduce the psychological impact of COVID-19 on health care workers/ staff to ensure continued provision of high-quality health services to clients and self-care for health care workers. Over 90 sites were oriented during this reporting period.

These sensitization activities raised awareness of HCWs on mental health needs and available treatment via HCW psychosocial counsellor. During Q3, the HCW psychosocial counsellor had a total of 107 encounters and the most commonly occurring psychosocial issues that HCW were supported on included stress (50%) depression (26%) and anxiety (10%) as shown in Figure 27.



Infrastructure and supplies to support HTS and ART services

Tingathe had 3 construction projects undertaken during this reporting period in Phalombe and Mangochi districts. In Phalombe, pharmacy and HTS building renovations were done at Sukasanje and Mpsa Health Centres respectively while in Mangochi, HTS building extension was done at Koche Health Centre. Details of works done are included in the EMMR.

Treatment Coverage and retention challenges and responses

- In this reporting period, Tingathe trained 71 CHWs in Motorbike ridings and allocated them moto bikes at 62 supported facilities in 5 supported districts. CHW motorbike tracers will be able to reach more clients through physical tracing addressing **distance as a major barrier to finding clients who need to be traced for various reasons to improve retention in care.**
- **Commodity relocations:** in Q3 commodity distribution slightly improved than had been in the previous 2 quarters. Despite such an improvement, some commodity particularly DBS bundles and VL reagents was inadequate to maintain undisrupted service delivery. Tingathe facilitated relocations of the following commodities in the 5 supported districts; MTB Cartilages, Unigold, Cotrimoxazole 120mg, TB drugs and EID cartilages
- **TB LAM for AHD screening is now supplied by CMST, the system has not taken a full grip to maintain a stable supply to last a quarter.** The pharmacy team continue to engage CMST on the stock status and keep checking with their office to replenish supplies. Testing for TB using TB LAM has been on and off over the period.

- **The migration of clients;** FSW, Fishermen, and farmers, has been influencing clients' disruption of treatment. CHWs engage clients through welcome counseling to discuss clients' challenges affecting adherence and work out solutions such as multi-month supply, and emergency supply and empower clients to demand such services whenever necessary.
- **Silent transfer out (unofficial);** especially sex workers and fishermen has been affecting data on treatment current. Clients were provided information on the need to obtain a transfer whenever they are shifting places.
- **Clients from Mozambique giving false locators.** The program is using Welcome Care services targeting clients that reside in Mozambique or travel to Mozambique for business and target them with MMs
- **Clients missing appointments and defaulting because of playing their businesses in Mozambique.** CHWs have been continuously updating locators to keep record of any changes in the current locations.
- **One- and three-month retention is low** in some sites due to the following reasons 1) people need time to start treatment, 2) clients from Mozambique are not able to come back every month and 2) people already know their status. The program has intensified follow up and tracing of clients who do not start ART immediately; prioritized tracing for new clients on ART who miss appointments, scheduling three-month appointments for some new clients from Mozambique if they are clear that they cannot come back monthly. The program is also using expert clients tracing new clients in Mozambique.
- **Long distance from home to facility** has been noted as a challenge to some clients. We are offering MMS to eligible clients and continues to asses for suitable areas to establish new Community ART Distribution clinics, 2 new CADs were established in Salima. Site continue to provide information on existing CADs and encouraging stable clients from far to reach areas to attend CAD clinics within reach.

Treatment Coverage and retention activities in the next quarter

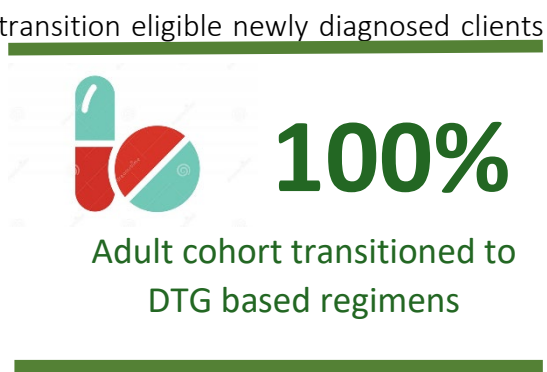
- Non-disclosure of HV status to sexual partner in case of a couple and that affects subsequent visits. Welcome Service and referral to our PSC is ongoing to address this issue
- Frequent change of location of clients especially due to nature of economic activities that they are doing. We are updating locator information routinely during clinic visits and encouraging clients to notify the clinic in case they are changing locations.
- Continue providing enhanced support to clients newly initiated on ART, which includes welcome service, assignment of a CHW to all new HIV+ clients for follow-up, enrolment in intensified care ART clinic, and a special counselling curriculum.
- Continue ART counselling sessions for all new clients on ICAC days at month 1, 2, 3 & 6, in person or via phone/video counseling.
- Continue to use EMR to generate a monthly list of all clients who have interrupted treatment at EMR sites, confirm accuracy of data, and assign all clients who have truly interrupted treatment for tracing.
- Continue intensified phone follow-up systems at site level including health talks, updating of phone numbers, appointment reminders, and phoning all clients one day after missed appointment and again at 7 days.

- Build capacity of site supervisors to supervise retention activities at site level including focal person reports and prompt implementation of remedial actions.
- Continue to obtain good locator and active phone number for clients to facilitate effective tracing.

OBJECTIVE 3: IMPROVED AND OPTIMIZED HIV CARE AND TREATMENT SERVICES FOR ADULTS, CHILDREN, ADOLESCENTS AND KEY POPULATIONS

3.1 ARV Optimization

During Q3 of FY22, Tingathe continued to initiate and transition eligible newly diagnosed clients and clients already on ART to optimized HIV treatment regimens in all supported sites, with a particular focus on transitioning children <20kgs to DTG-based regimens. Clients continued to receive health education and individual counseling on ART treatment and DTG transition. CHWs and CHWCs used Tingathe-developed talking points on ART treatment and DTG to ensure counseling sessions had standardized information given across sites. Tingathe site/cluster coordinators continued to work side by side with MOH providers to strengthen their capacity in providing optimized regimens to clients. Tingathe supported a refresher training for Clinical Coordinators and MOH ART providers from all supported districts to be updated on the new Integrated TB/HIV guidelines. Tingathe Site Supervisors were briefed on key updates which were shared with their respective teams of CHWs and EMR Clerks to effectively support client care following the updated HIV clinical care.



At the end of this reporting period, all eligible adult clients (100%) in all supported facilities were receiving Tenofovir, Lamivudine, and Dolutegravir (TLD), the adult formulation of 1st line DTG-based regimen, in each of the six supported districts as shown in Figure 28 below.

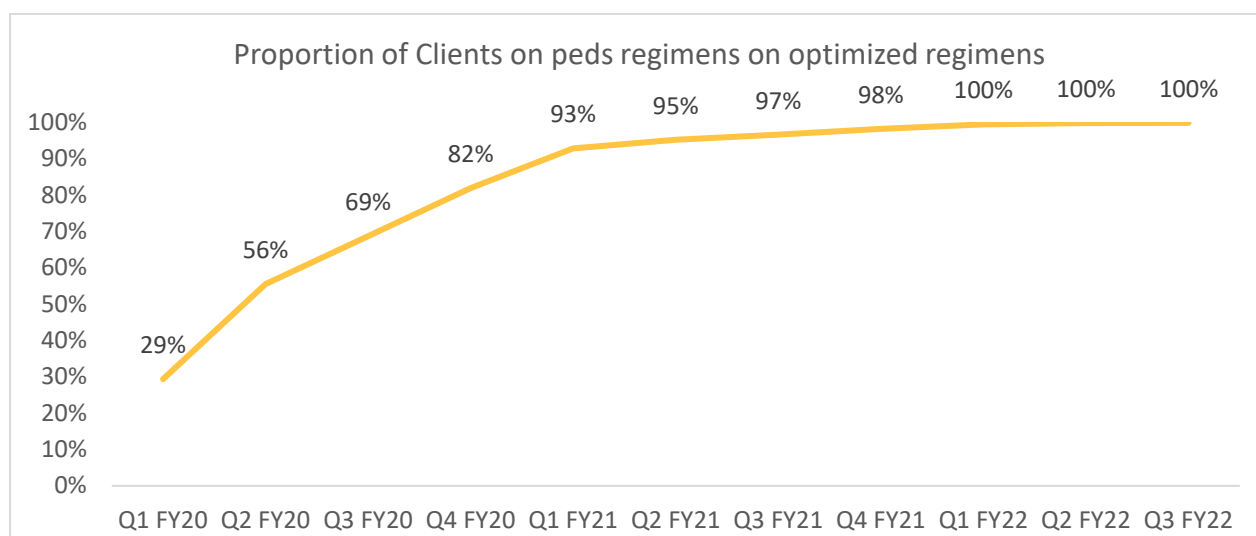


Figure 28: Proportion of Cohort on DTG-based regimens Q1 FY20 – Q3FY22

Tingathe CORE Q3 FY22, April- June 2022



Pediatric Clients by Regimen

LVP/r (9/11)	<1%
DTG (13/14/15)	99%
NVP/EFV (0/2/4)	<1%

By Q3 of FY22, all sites have transitioned all eligible children <20kgs to pDTG. All supported sites in 6 districts have been receiving supply of pDTG. Pediatric clients weighing 3-19kg continue to be initiated or transitioned to pDTG regardless of VL results, registering 100% of eligible pediatric clients transitioned to optimized regimens by the end of Q3 FY22. The Pediatric Optimization Tracking Tool continued to guide regimen optimization with a focus on drawing VL 6-month post-switch to ensure suppression on the optimized ART regimen.

Since this tool focused on outstanding clients only, Tingathe introduced a Pediatric and Adolescents Clinical Management tool (PACT) during Q3 to track HIV clinical management of children and adolescents (<19years) including 6 months VL testing. Site and Cluster Coordinators entered all children <19years from their respective facilities and developed a plan for follow up for any gaps requiring client’s corrective actions such as delayed VL testing and inaccurate pediatric dosing.

Continuous stock level monitoring of all pediatric regimens including pDTG was done, along with drug relocations where needed, to ensure adequate drug availability. By the end of Q3 of FY22, a total of 4,455 pediatric clients were receiving pDTG.

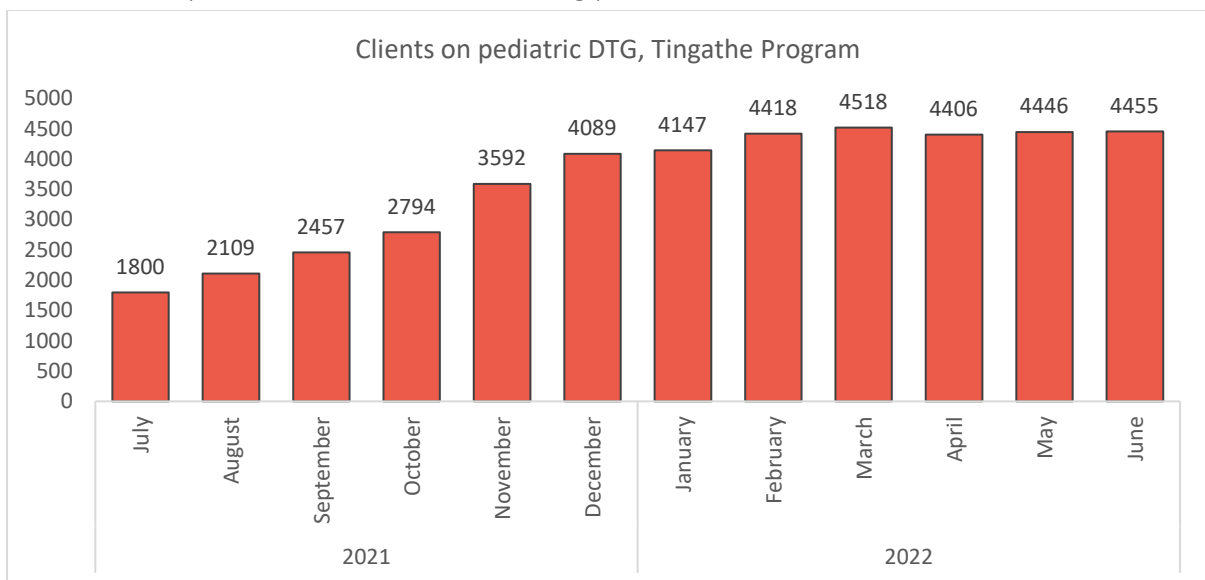


Figure 29: Clients on pediatric DTG, Tingathe Program FY21- FY22

To continue the progress in transition to optimized ART regimens, Tingathe maintained focus on the following interventions during this reporting period:

- **Close monitoring of pediatrics/adolescents with multiple previous ARV exposure for DTG resistance.**

- Tingathe **continue** providing pDTG mentorship to **Baylor employees, MOH facility staff and APA staff**
- Tingathe is providing **mentorship to MOH staff on advanced HIV disease (AHD) screening and treatment** in the supported districts.
- **Mentorship focused on adherence support, transition to optimized regimens, viral load monitoring and viral load results interpretation**
- **All newly diagnosed clients from 3kgs above were optimized to DTG** with drug formulations based on weight.
- Supported refresher trainings and initial ART Training of Clinical Coordinators and MOH ART providers on the 2022 Integrated TB/HIV Clinical Guidelines. Lay cadres were updated through a brief of key highlights provided to Site Supervisors who briefed site specific teams.
- Continued use of **Tingathe-developed training and counseling materials** to support the transition to optimized pediatric regimens.
- Reinforced use of **updated DTG talking points** guide education to clients provided by CHWs. The talking points highlights the benefits of DTG, eligibility, potential side effects, how the drug is taken.
- Tingathe supported **high viral load cascade monitoring with viral load audit and intensified lab support and supervision** to facilitate as possible timely return of sample results to clients.
- Tingathe sites **encouraged clients with children to come to family days or ICAC clinic. Takulandirani Welcome Care Service was provided along with the expansion of DSDs for children (baby/kids club, ICAC, community ART distribution (CAD) and MMD for children to improve and optimize care and treatment services for clients (as described above). Stock monitoring and relocations** to ensure adequate drug availability; this was done in consultation with MOH district pharmacy managers.

3.2 Pediatric, Adolescent, and Youth HIV

Youth Are the Future

Tingathe continued implementing the new Youth are the future (YATF) program which aims at improving care to youth within Baylor's catchment areas. In addition to Baylor's well-established work in caring for exposed infants and children and adolescents living with HIV, YATF expands on previous work with all youth including support for AGYW those who are pregnant and all youth accessing HTS or clinical services at the health facility. District adolescent officers work with each district team to help reinforce, strengthen and support all youth focused activities with active linkage to community and ministry of Health agencies. During the period under review, a total of 29, 050 adolescent clients received YATF services in 5 supported districts as illustrated in Figure 30 below.

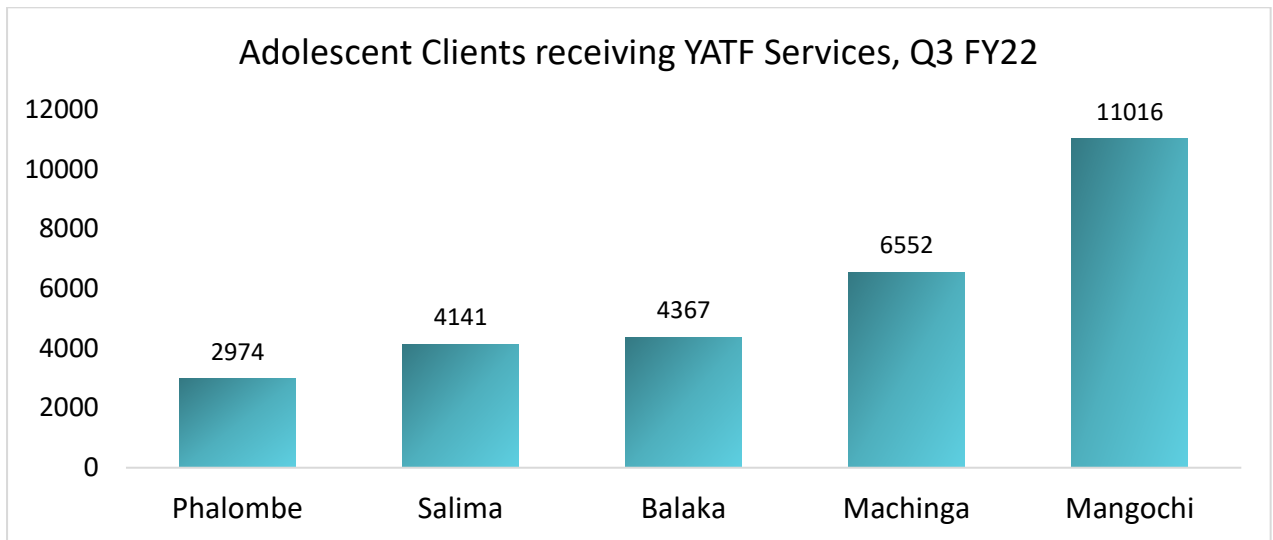


Figure 30: Adolescent clients receiving YATF services, Q3 FY22

Under the umbrella of Tingathe’s YATF services, the following activities were implemented;

Teen Club:

During the period under review, Tingathe supported 126 teen club (TC) sessions of which 61 were guardian sessions and 6410 ALHIV attended. Through these teen club and guardian sessions, Tingathe provided ALHIV with comprehensive treatment with HIV/ART and SRH care and psychosocial support in a safe and adolescent friendly environment.

At all TC sessions, clinical teams attended to clinical needs of ALHIV and provided HIV care with ART refills, adherence support and viral load monitoring whilst following COVID-19 preventive measures. SRH education was provided at all teen club sessions and a dedicated SRH nurse provided SRH education at 101 teen club sessions. Psychosocial counseling services and peer support were provided through activities and discussion about adherence challenges and skills, resiliency and self-efficacy development building on strengths of ALHIV, and peer learning. Psychosocial counselors provided expert counselling to both ALHIV and their families though in person interaction and virtually via phone. Eligible ALHIV received multi-month scripting (3MMS or 6MMS as supply chain allowed) in line with updated DHA guidelines which decreases visits to the health facility as one way of decongesting health facilities as we worked to minimize risks of COVID 19. Tingathe recognizes the critical importance of guardians in the life of ALHIV and engages them throughout adolescence during guardian sessions at teen club. The 61 guardian sessions conducted across the Baylor supported districts were used to engage guardians on how to identify and support strengths of ALHIV and their role in supporting adherence throughout adolescence.

Baylor continued working collaboratively with partners such as Emmanuel International and APA in serving ALHIV. We collaborated to support the clinical and psychosocial needs of ALHIV at overlapping facilities. We provided clinical support to all Baylor sites including the teen clubs supported by these partners. In Mangochi and Balaka districts Emmanuel International supported teen clubs psychosocial programming at 10 sites and in Mangochi and Machinga, APA supported 4 teen clubs where Baylor supports clinical services as well. APA has enrolled eligible ALHIV at supported facilities into their program and provide community support and teams discuss enrolled ALHIV at site level meetings to coordinate support.

Tingathe continued providing both virtual and in person Teen Club supportive supervision and mentorship to all TC sites in the 5 supported districts. Tingathe provided clinical and programmatic support during these supportive and mentorship sessions including reinforcing the importance of verifying disclosure before enrolling teens into teen clubs. Preparation and reporting on teen club sessions is done after each session to allow close monitoring of services, gaps and make timely interventions. Registers and follow-up are supervised between teen club sessions.

Family Clinic:

Implementation of family clinic DSD to care for CLHIV and their guardians continued in all districts. Alignment of child and guardian visits for families is prioritized to facilitate care for the families, minimize facility visits and allow family centered adherence support. CHWs trained in disclosure continued engaging families of children and young adolescents on the importance of disclosure and support the process. Disclosure registers have been rolled out at all sites to monitor the disclosure process of the cohort to full disclosure, and sites have started to complete to monitor progress of the cohort through to timely full disclosure, and to date information on some of the cohort is available. To date, as in figure 31, over 70% of CLHIV have documentation of disclosure and ongoing support to document disclosure status is ongoing as they attend scheduled appointment.

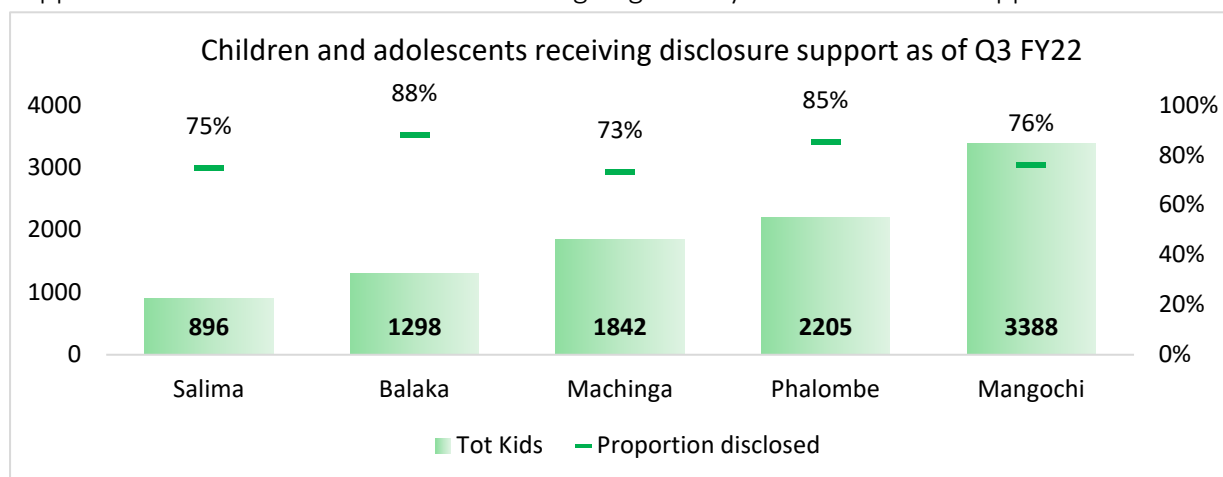


Figure 31: Children and adolescents receiving disclosure support Q3 FY22

Figure 31 below illustrates by end of Q3, over 70% of children and adolescents received disclosure counseling in each of the 5 supported districts.

At sites supported by APA, facility meetings occur weekly to discuss and assign follow-up for children supported by APA who have needs to address including VL follow-up, ICT and back to care support.

Care of Youth Living with HIV - Tinyade Clinic: Tingathe continued initial Tinyade clinics in all the supported districts. Tinyade clinics aim to attend to the needs of newly diagnosed youth 16-24 year old youth. Youth are clustered on the same day for ART refills with 15 Tinyade sessions and 107 Youth participated in all districts to date. ART care is provided including support for newly diagnosed and treatment experienced youth who support each other and get support from HCWs. Youth direct design of the clinical services as they are established. For older youth in teen club, focus group discussions and exit interviews demonstrated that many prefer to remain in teen club sessions, and many have been interested to act as teen club mentors and accommodations are ongoing to attend to their unique needs as they grow out of adolescence into young adulthood with

a long standing chronic illness. Ongoing engagement of ALHIV to design clinical service delivery after completing teen club is ongoing.

Support for Youth Friendly Health Services: YATF programming actively supports provision of youth friendly health services in youth are the future clinical spaces or incorporated into routine service delivery at sites. To date 71 sites are running YFHS clinics and the sites without trained providers are set to be trained next quarter. CHW Youth ambassadors have been trained from each facility to engage and navigate all youth who access the facility for any service and are active at all supported sites. District adolescent officers work with district teams to support strengthening delivery of clinical services with YFHS at all sites. Teams are striving to deliver same day services to all youth

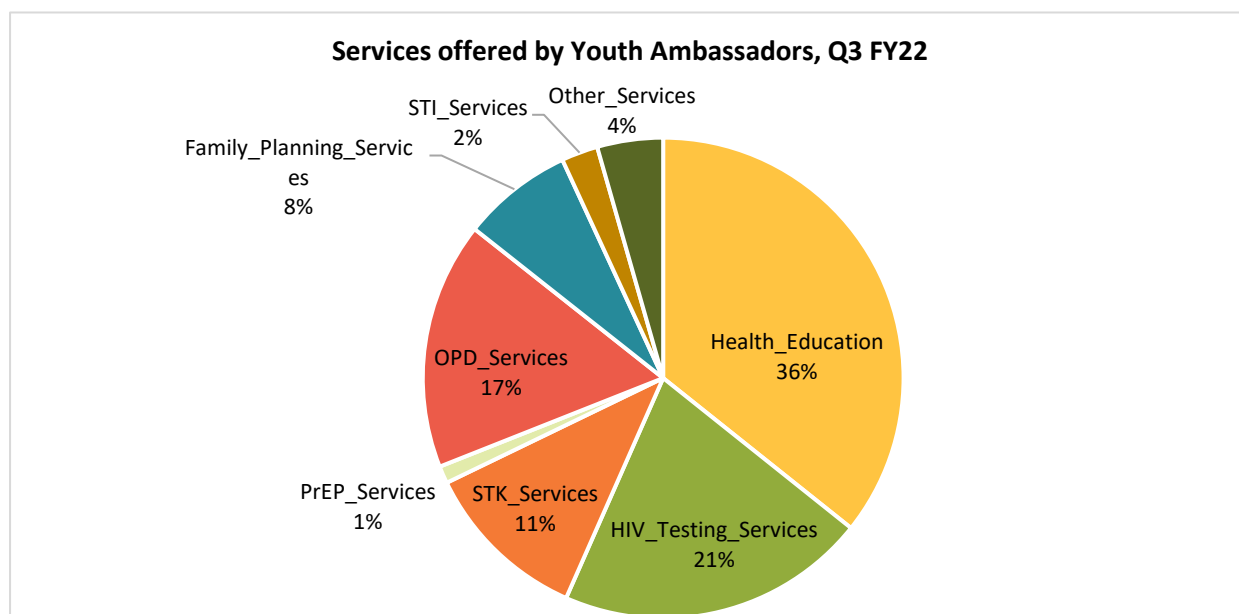


Figure 32: Services offered by Youth ambassadors, Q3 FY22

and continually engaging youth on needs and getting their input on program design. Figure 32 shows that most youths were supported to access the following services; health education (36%), HIV testing (21%), OPD services (17%).

Disclosure Training: During this reporting period, 33 Baylor Staff were trained in intentional disclosure to continue to support developmentally appropriate disclosure sessions at all supported sites including reinforcing the importance of verifying disclosure before enrolling teens into teen clubs. They also engage guardians for ALHIV on the importance of disclosure and support the disclosure process if they are ready.

Support for Pregnant Adolescent Girls and Young Women:

Dedicated care and support for pregnant AGYW occurred at all facilities during this reporting period to attend to the needs of pregnant AGYW. Intentional support for pregnant AGYW at ANC has been expanded with counseling of all pregnant AGYW on important information regarding pregnancy, safe delivery, HIV testing, treatment and prevention. An audio message for AGYW at ANC reviewing common concerns and challenges for pregnant AGYW guides discussions with youth

supporters for all pregnant AGYW at ANC during ANC visits. Pregnant AGYW after HTS are linked to primary and secondary HIV prevention as indicated including linkage to PrEP and ART respectively. AGYW meet with Youth Ambassadors who provide education and link them to needed services or care providers as well as providing an opportunity for peer support amongst the group. After delivery of infants, AGYW who are living with HIV receive continued support after delivery at ART at MIP clinics with youth friendly HIV care including VL suppression, peer support, and early childhood development counseling. All eligible infants at APA supported sites are linked to OVC services.

Pediatric, Youth and adolescent care challenges

- While progress has certainly been made through expansion of eligibility criteria for MMD, supply chain barriers of pediatric regimens limit implementation. This is particularly important in light of the aim to align children's ART refill visits with those of their guardians.

Adolescent care activities in the next quarter

- Continue providing logistical support to all Teen clubs and guardian sessions
- Begin planning for and scheduling for new teen clubs in all districts
- Train staff from facilities on YFHS to support active YFHS clinical services at all facilities
- Continue supportive supervision and mentorship of YATF services at all sites
- Continue engaging youth at Tinyade clinics to refine psychosocial support and self-efficacy skill building for youth

3.3 Prevention of Mother to Child Transmission

Tingathe collaborated with MOH staff to continue provision of HIV testing and counseling for all pregnant women in the first and third trimesters, as well as during labor and before discharge from the maternity ward. Figure 33 illustrates excellent testing coverage for ANC women in all districts above 95%. High-volume supported facilities operated a flexible rotation schedule, which allowed for maternity testing and ART initiation on weekends, as well as same-day ART initiation for newly diagnosed clients. CHWs offered pre-ART counseling to newly diagnosed pregnant women before beginning ART, as well as adherence counseling to pregnant women who were already on ART. ANC appointments were aligned with ART refill days and master cards of pregnant women on ART are flagged to enable timely VL monitoring. CHWs offered adherence support during ANC/ ART refill appointment days. HIV-infected pregnant women were given NVP syrup to administer to their newborn baby for 6 weeks after birth.

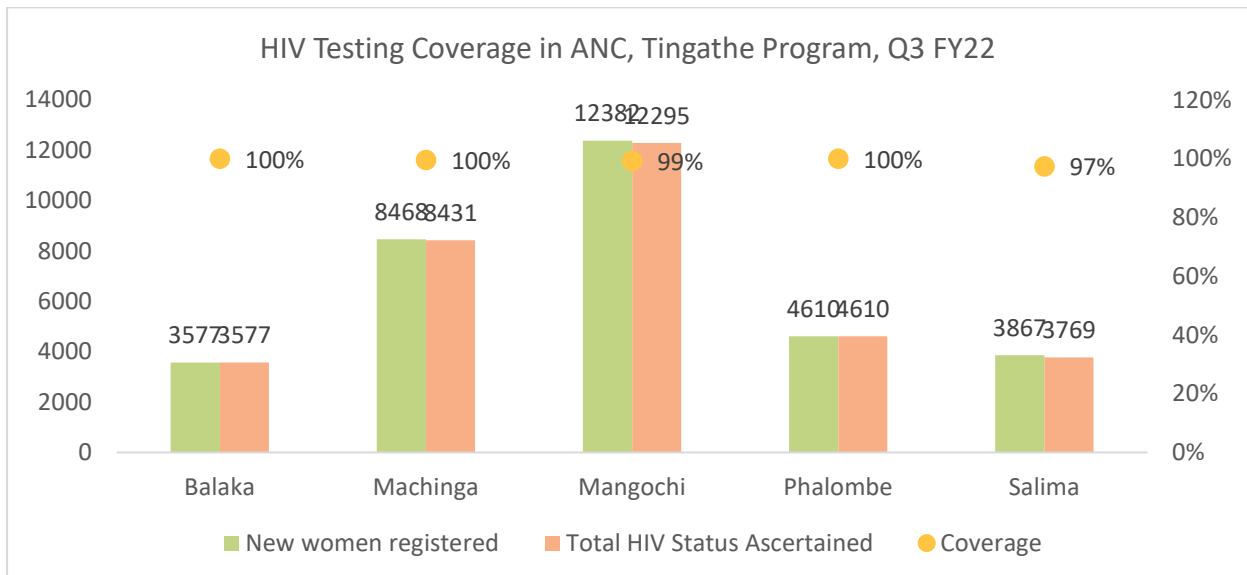


Figure 33: HIV testing coverage at ANC, Tingathe program, Q3 FY22

All infants born to HIV-positive pregnant women were enrolled in the HIV Care Clinic (HCC) to facilitate early infant diagnosis, follow-up, and ongoing support for maternal antiretroviral therapy (ART). The importance of scheduling mothers and infants together for all clinical review visits starting with the infant’s 6-week DNA-PCR test was emphasized in order to ensure children received testing at appropriate milestone and remain retained in care. Children with positive HIV DNA PCR results were traced urgently in order to facilitate return to clinic for confirmatory HIV testing and rapid ART initiation. At Tingathe-supported sites, mothers and their exposed children were enrolled in the MIP clinic/family clinic or the Intensified ART Care ART Clinic (ICAC) for maternal counseling on ART adherence and refills, as well as growth monitoring and EID testing and counseling, with family-centered care. Clinic appointments for mothers/guardians were purposefully scheduled to coincide with HIV testing milestones for these exposed children. During this reporting period, CHWs traced guardians of exposed infants for clinic reminders, after missed appointments, and for DNA PCR positive results. Any tracing possible by phone was done first before physical home visits in the community were conducted.

In Q3, Tingathe-supported districts achieved excellent (>90%) EID testing coverage at both 2 and 12 months as shown in Figure 34. Documentation challenges on HIV tests conducted and results provided to clients but not documented on pink cards contributed to some EID coverage gaps; EID “pink card” audits were conducted regularly at site level to allow correction of any documentation gaps as well as identify children who had truly missed testing milestones or defaulted to fast-track assignment for tracing and follow-up.

In Q3, the program experienced stock outs of DBS bundles leading to supply shortages in almost all the sites. The few DBS bundles available were prioritized for EID with multiple relocations across sites/districts. Tingathe kept track of infants who missed milestones due to this stock outs to have them brought back to clinic for testing as soon as stocks were replenished.

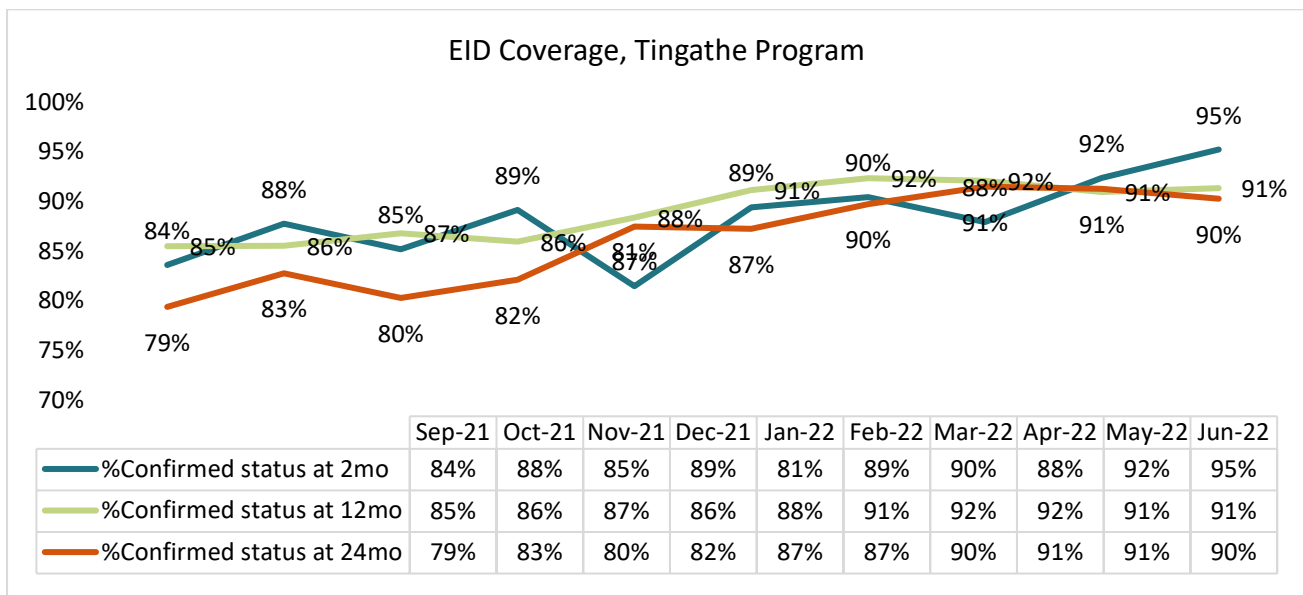


Figure 34: EID coverage at 2 and 12m, Tingathe Program FY22

3.4 TB and HIV

Baylor is providing integrated TB/HIV services in all the 95 supported health facilities in 6 districts. Out of this, 82 sites are equipped as TB registration sites where TB diagnosis, treatment initiation and follow up is happening. All the supported sites offer a range of TB/HIV services including TB screening, sample collection, TB diagnosis and treatment, referrals, refills, HIV testing and ART treatment for TB/HIV co-infected patients.

Table 2: TB/HIV Facilities in Baylor Supported Districts

District	TB Registration Sites	Facilities with GeneXpert	with X-ray	TB-LAM
Balaka	13	2	1	1
Machinga	17	2	1	2
Mangochi	30	7	2	6
Phalombe	10	2	1	2
Salima	11	2	1	5
Lilongwe (COE/KCH)	1	1	1	1
Total	82	16	7	17

TB screening coverage among HIV clients remained high (100%) in all supported sites. Tingathe continued to incorporate COVID-19 screening into routine TB screening for ART clients, which is performed by CHWs or HDAs as well as ART providers during each clinic. Baylor has been rapidly adjusting programming to ensure that existing systems were optimized for COVID-19 detection, in addition to maintaining robust infection control practices to keep clients and providers healthy, including increased PPE availability and use. For more information, please see the COVID-19 section.



All individuals who screened positive for TB or COVID-19 were referred for further evaluation. Clients with tuberculosis were treated with TB medication as alongside their ART, whereas those with COVID-19 were referred to designated COVID-19 clinic for further investigation and management according to MOH guidelines. Tingathe has been collaborating with DAPP TB LON2 program in Machinga and Mangochi districts with an objective to provide TB service through facility-based cough surveillance, treatment initiation (FAST). The collaboration with Baylor is through data sharing at ART clinic, where all Tb presumptive clients are referred for TB screening. Similarly, clients isolated from OPD for TB screening are referred for HTS.

Tingathe continued to mentor MOH providers in managing TB/HIV coinfection and to address drug interactions between ART and TB drugs. Sputum testing for HIV-infected clients with suspected TB from all supported sites is done using GeneXpert at district hospitals and select Christian Health Association of Malawi (CHAM) institutions in all supported districts according to the NTP protocol. AHD service activated sites with testing commodities available, performed sputum for microscopy, Urine LAM, and gene expert to screen for TB in newly diagnosed patients with HIV before ART initiation per AHD screening guidance.

Tingathe supported TB infection prevention and control practices including the use of cough booths, one-on-one mentorship on infection prevention control (IPC), triaging of presumed cases, ventilation, use of N95 masks, and ensuring adequate ventilation, among others. Tingathe clinicians played an active role in the TB Technical working group and on several TB and TPT task forces.

The program is also involved in TB commodities forecast to ensure the availability of TPT and other essential commodities such as TPT, sputum collection bottles and AHD test kits in the supported districts.

Overall, TB indicator performance demonstrates strong HIV testing and treatment coverage among TB patients with 100% HIV testing coverage in TB clinic and initiation of ART to co-infected clients.

TB Preventive Therapy

TB preventive therapy (TPT) is provided for all newly diagnosed non-pregnant PLHIV without active TB. Currently, two formulations are recommended: isoniazid (INH) and rifapentine (3HP). Tingathe continue to implement 3HP for new ART clients.

Baylor's support towards TPT implementation include training of HCWs on screening for TPT, initiation, dosing and follow up of clients. Baylor coordinators conduct regular mentorship and supervision to the sites and strengthen the capacity of staff through side-by-side mentorship and the use of job aides. M&E staff provide support on documentation and reporting in registers and the EMR system.

There has been challenges in TPT initiation mainly related with provider's attitude and confidence in initiating pediatric clients and also on the new 3HP formulations. The lengthy procedure in ruling out TB in presumptive cases also affect initiation of clients once TB is ruled out. In addition, documentation of TPT initiations and refills during the subsequent visit remain challenging. Our

coordinators are continuing the side-by-side mentorship, site level data analysis and continuous quality improvement as well as troubleshooting the challenges as they arise.

3.5 Family Planning Integration

Tingathe continues to provide family planning services to WLHIV in order to meet their family planning needs. Family planning services are provided directly to ART patients at the ART clinic in the majority of facilities. CHWs screen WLHIV patients at the ART clinic to identify potential family planning (FP) needs and link them with providers on the same day. During adolescent clinics, a sexual and reproductive health care nurse is present to provide health education, STI treatment, and FP supplies to all ALHIV attendees.

Optimized HIV care and treatment services challenges and responses

1. **Adherence challenges across all age groups; in person and virtual support for psychosocial counseling** and mentorship, an **increase in multi-month scripting**, provision of DSD including MIP, family clinic, flexible clinic hours and adherence support through Takulandirani service contributed to achieving excellent linkage and remarkable progress in treatment optimization.
2. **Drug stock-outs** of ART, CPT, and TPT made it difficult to prescribe 6MMS for clients despite their eligibility. **Relocations** from nearby districts were done and supply was limited to 1 month so that no client should go back completely without their specific drugs
3. Pediatric TB diagnosis remains a challenge. Tingathe coordinators continue to **provide mentorship** to ART providers on **TB management** and to provide continuous professional development on pediatric TB management.
4. **Challenges with TPT reporting** due to lack of streamlined reporting procedures for TPT in the EMR limited reporting of TPT performance. Continued to **lobby with HIS partner** for use of this data and work closely with DHA to align definitions.
5. Few sites are not prescribing 3HP due to knowledge gaps. Tingathe will continue to provide mentorship to MOH providers
6. **Access to TB LAM testing** has been a challenge for some clients from the health centers as they are not AHD activated sites. ART Providers were encouraged to refer the clients to AHD activated sites for evaluation, and ongoing discussion on further expansion of AHD services is ongoing.

Optimized HIV care and treatment services activities in the next quarter

- Continue Pediatric Optimization and follow-up on transition all eligible clients to DTG regimens, including support for viral load monitoring after switch to optimized regimens in particular for children
- Continued close monitoring of clients using treatment optimization tool and in-person supervision to ensure appropriate pediatric dosing and regimen transition according to milestones, including capturing viral load 6-month post regimen transition to confirm post-optimization viral suppression
- Continue to expand access to TB preventive therapy
- Continue to engage with HIS partner to improve TPT reporting in the EMR
- Continue to enhance combined TB and COVID-19 screening and referrals for diagnostic assessment and linkage to treatment or prophylaxis.

OBJECTIVE 4: INCREASED VIRAL SUPPRESSION FOR PLHIV

Excellent viral load testing coverage and suppression are critical for HIV treatment service delivery. Tingathe maintained intensive supervision of VL coverage throughout ensuring best practices were implemented in all supported facilities to provide clients with access to viral load testing and to ensure optimal viral suppression rates. Daily supervision was conducted via WhatsApp to promote real-time troubleshooting of site-level issues affecting access to VL testing, as well as rapid sharing of best practices across program facilities. Figure below illustrates an overall program VL coverage of 59% with viral load suppression of 90% in Q3 FY22.

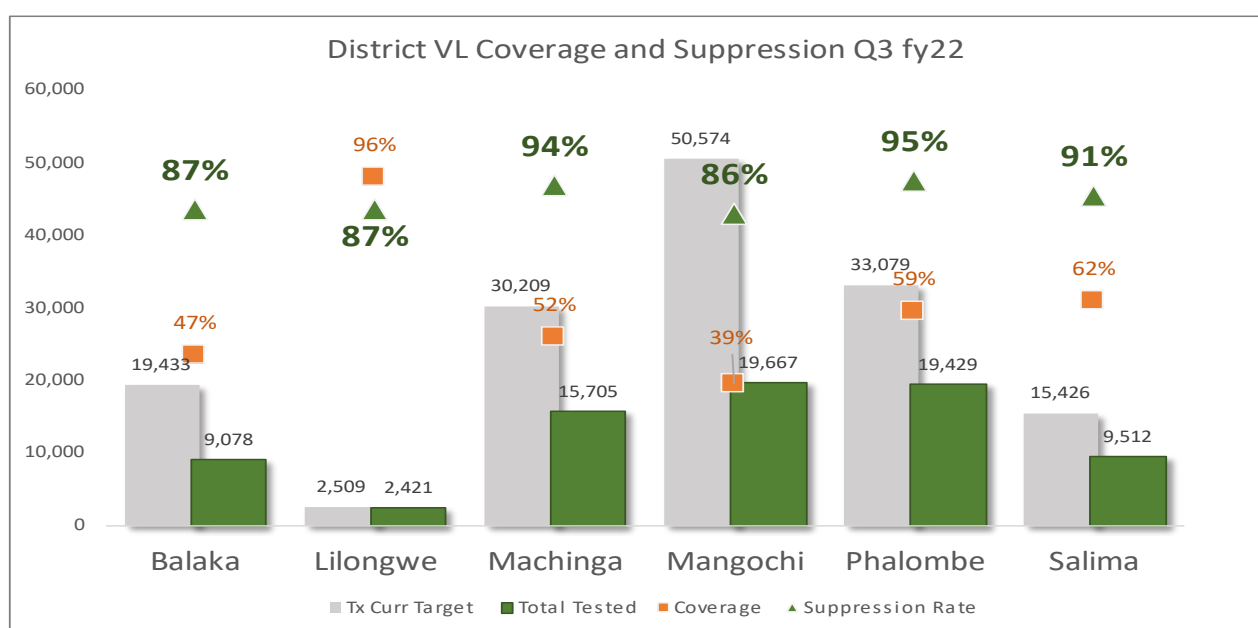


Figure 35: Overall program 12-month VL coverage and suppression, Q3 FY22 (Data source: LIMS)

Due to the national stock out of DBS bundles and VL reagents ; routine viral load testing was halted at most sites level where priority was given to EID for the limited stock of DBS bundles, pregnant and lactating women, and follow up VL testing for those with High VL . The lack of reagents at laboratories delayed the processing of routine VL samples, resulting in an accumulating backlog of VL samples and pending results in the districts. Sites had backlogs, many clients' lab results were delayed longer than their result validity, requiring clinical teams at facilities to redraw VL samples for clients with missing results. Intensive support for the entire viral load process, including numerous collaborative meetings with laboratory partners, was maintained in an attempt to address some of the lab and transport-related challenges discussed further later in this section. Sites began to collect VL samples for all eligible clients towards the end of May when supplies of DBS bundles and laboratory reagents were delivered to sites and molecular labs respectively.

As highlighted earlier in this report, there was increased client transition to DTG-based regimens, and with it, a closure of the previously existing gap between female and male viral suppression In regard to VL suppression as illustrated in the figure below. Rates of viral suppression remain higher among men and women above 25yrs, with significant improvements among adolescents and older children, as clients are initiated on and transitioned to DTG-based regimens. Tingathe is implementing additional interventions for pediatric and younger clients through YATF activities to

provide intensive adherence support and ART optimization for improved and sustained viral suppression. Close monitoring for adolescents with multiple previous ARV exposure for DTG resistance is being done with referral for genotyping for those not suppressed.

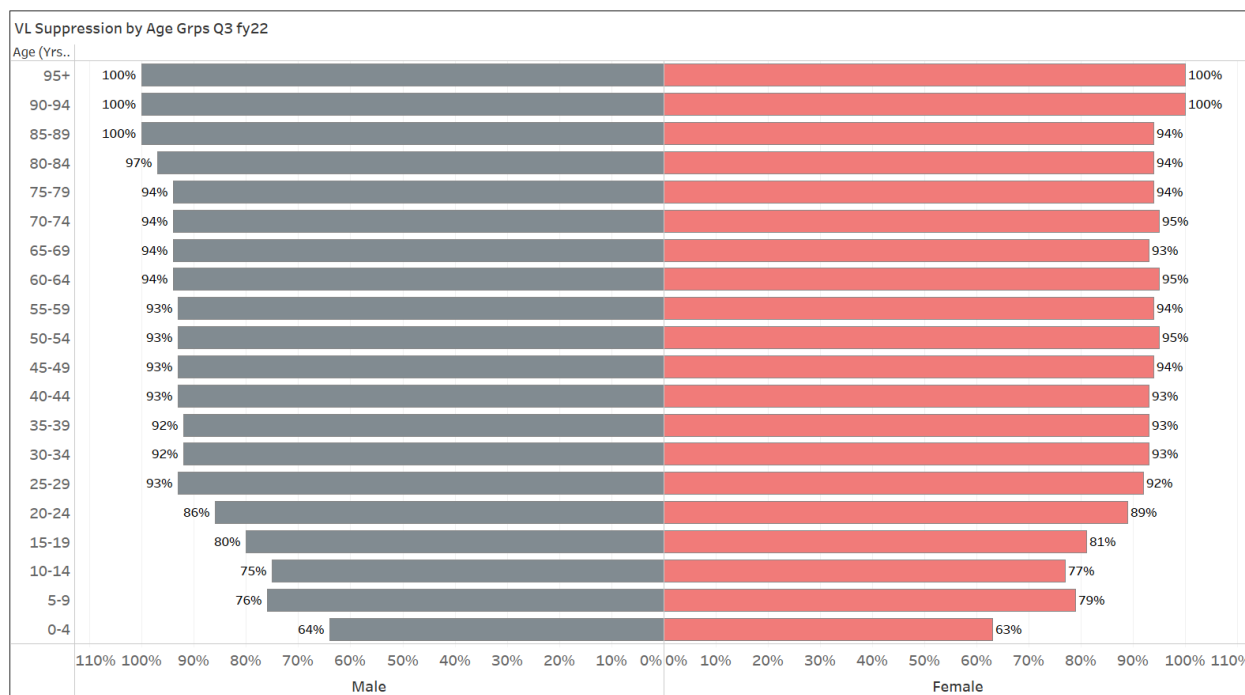


Figure 36: Tingathe Program VL Suppression rates by age group, Q3 FY22

4.1 VL testing coverage

Tingathe continued to implement a number of strategies to improve VL testing coverage as follows;

- **Early morning viral load sample** collection (before official services begin) was maintained in all supported sites, to ensure clients’ waiting time was used appropriately and duration in clinic was not extended due to VL collection.
- CHWs continued to **screen** clients’ health passports and master cards during clinic days and refer eligible clients for viral load sample collection. Where practical, **Master Cards** of all clients booked for clinic and due for VL **were pulled** and set aside a day prior to clinic in order to fast-track them for VL sample collection as soon as they arrive at the clinic. These changes minimized the chances of clients leaving the clinic before getting a viral load drawn.
- Site/cluster coordinators continued to conduct an **additional screening of Master Cards** while clinically reviewing clients in the ART rooms, to ensure clients who were missed by the CHW screening process for routine VL accessed blood draw prior to drug refill.
- **Daily ART clinic WhatsApp reporting** to facilitate virtual site supervision by site/cluster coordinators and district leadership was sustained. Through this reporting, site supervisors shared daily number of clients attending clinic, those eligible for VL draw, and those who had VL drawn, among other indicators, in order to monitor daily uptake of viral load and make ongoing adjustments as necessary.

- **Data feedback meetings** and **viral load audits** were conducted in all supported sites to identify and address loopholes in the VL cascade including identification of clients with a missed routine VL, missing results, missing action for clients with a HVL result, and regimen optimization; which facilitated the development of site-specific plans to improve VL coverage and management of clients with high viral load. Site supervisors used a **monthly high VL checklist** to identify and implement actions to address VL cascade gaps on a monthly basis but began to submit progress on the cascade weekly as part of the enhanced supervision efforts.
- **Supervision** was intensified at all sites with **in-person visits** at sites and **virtually** via use of newly developed supervision tools on google forms, alongside other virtual supervision processes introduced since the onset of COVID-19. Tingathe used a hybrid of both supervision approaches based on COVID-19 waves. Virtual CPD, supportive supervision and reporting continues to be operationalized throughout the program.

Factors that contribute to VL Coverage

Factors leading to lower viral load coverage: CHAM sites that do not allow early AM VL collection; sites with “private” clients who skip routine clinic procedures and screening; clients who travel to South Africa or other parts of Malawi and send guardians to collect medication; low stocks/ stock outs of DBS bundles and VL reagents

Factors leading to higher viral load coverage: consistent flow of VL results, consistent performance monitoring with rapid introduction of mitigation strategies; implementation of best practices; strong and attentive clinical staff and experienced site supervisors

Pediatric VL Suppression

The Tingathe program maintained its emphasis on intensified programming to increase viral load suppression in children. The program continued to refine and implement the use of practice materials, curricula, job aids, and videos on pediatric ART regimen optimization, adolescent training, and supportive supervisions remotely and in person, with a focus during the reporting period on scaling up to all sites pediatric

DTG transitions and initiations following arrival of enough stock in the country. Tingathe has continued to innovate in order to improve the health of children living with HIV by introducing and expanding family clinics, and other programs with “youth are the future” package.

Implementation of these activities to support care for children living with HIV has resulted in maintaining a VL suppression rate among children <15years above 79% throughout Q3 FY22 as illustrated in figure 37.

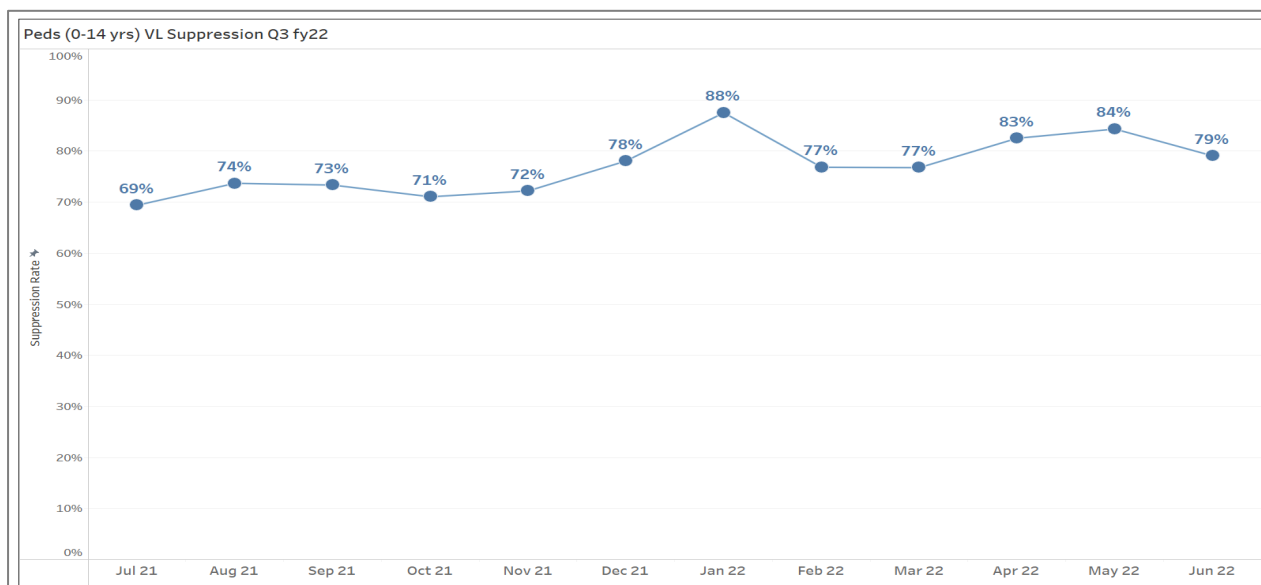


Figure 37: Average pediatric routine VL suppression, Tingathe program Q3 FY22 (Data source: LIMS)

Tingathe mentored MOH providers on treatment optimization with pDTG regimens. Pediatric optimization tracking sheets were used to track progress on ART optimization in children. During this reporting period, a thorough review of CLHIV (children below 19years) was done using an internal tool (Pediatric Adolescent Care Tool) to review the clinical care cascade particularly VL monitoring. Master cards of clients requiring actions were flagged, and actioned noted in client flagging cards to ensure necessary tracing and/or action implementation with overdue VL testing were flagged and followed up for VL sample collection and CHWs followed up results with the lab for kids with pending VL results. After full disclosure, adolescents were enrolled in teen club clinics, to ensure close clinical monitoring and that regimens/dosages are adjusted as weight changes with adolescent-focused care for ALHIV in teen clubs. To avoid dosing errors, guardians are continually empowered to request a weight check and dose adjustment evaluation at any time during a clinic visit. During teen clubs and ICAC, clients received age-appropriate counseling, VL was monitored, and regimens were changed as needed. The scaling up of pediatric DTG, a formulation that is better tolerated in all facilities during this reporting period, is expected to result in better viral suppression and treatment outcomes for pediatric clients as these children reach their 6-month milestone in the coming quarters.

To optimize treatment support for C/ALHIV, the program continues to work closely with OVC IP APA in 3 focus districts (Mangochi, Machinga and Phalombe), to ensure at-risk children receive a broad complement of services to set them up for ART adherence success. Teams jointly support CLHIV with high viral load, reviewing clients documented in the bidirectional forms at weekly site meetings to discuss progress and identify follow up actions (clinical and community level) to support these children to achieve and maintain viral suppression. As earlier highlighted, Tingathe provided an orientation for APA staff on pediatric care including pDTG regimen and disclosure.

Lab service support

Tingathe continues to assist laboratories by seconding lab technicians and lab data clerks in supported districts to improve viral load and EID turnaround time. Access to the LIMS network at

the district laboratory in Mangochi, Machinga, and Phalombe districts aided in the turnaround time for VL and EID results. Riders for Health transported samples to molecular labs for processing, and approved results were made available for direct printing in hospital labs using thermal papers. Tingathe staff at district labs contacted facility focal persons to communicate all HVL and EID+ results through phone as soon as they were received to avoid delays in tracing and clinical interventions.

Tingathe invested significant time and resources to help address lab system challenges either through direct support or extensive collaboration with multiple stakeholders including the MOH Diagnostics Department, Department of HIV and AIDS and partners such as UMB (University of Maryland, Baltimore), DREAM labs, Chemonics (procurement of supplies) and Bollore (logistics). In particular, Dream lab Baraka which serves Mangochi and Baraka districts had multiple machine breakdowns and lab contamination events that led to erroneous results and delayed sample processing, exacerbated by lab reagent stock outs which disrupted VL testing.

A lab issue tracking log was completed every week to facilitate timely identification and resolution of challenges. Baylor continues to retain full-time laboratory technicians and data clerks (engaged since March 2021) at molecular labs to process VL samples, which is expected to improve clearing of VL sample backlogs. Figure 38 shows significant reduction in sample processing at the molecular labs due to in availability of sufficient lab support.

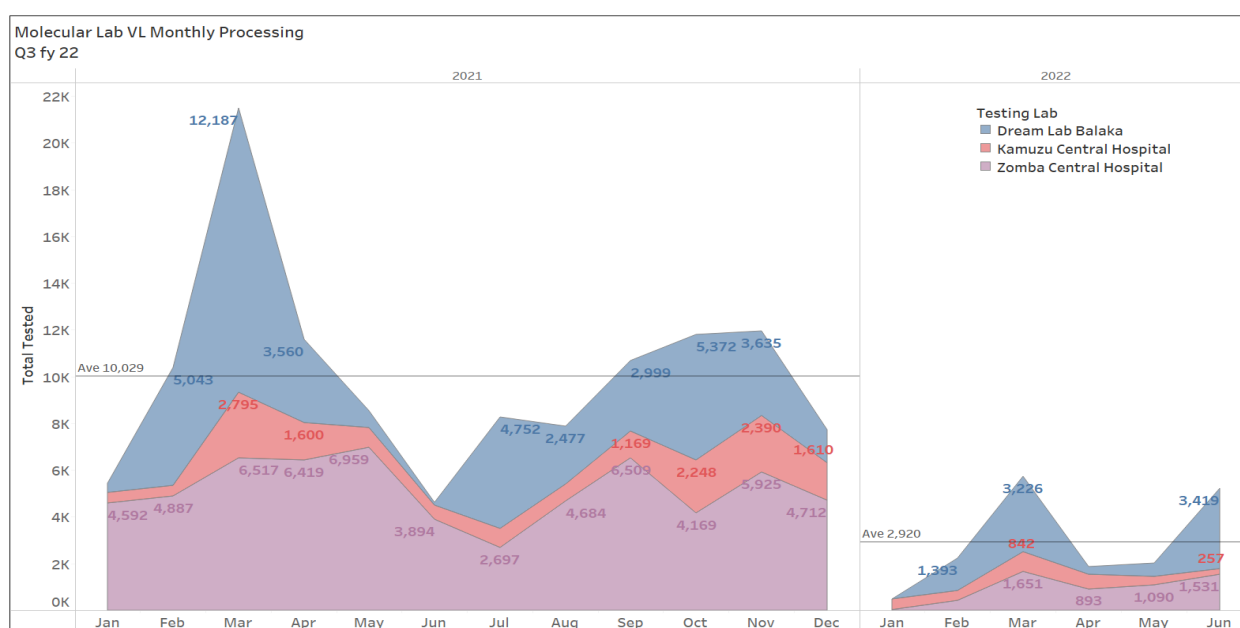


Figure 38: Molecular lab VL testing performance Q3, FY22

LIMS failure/Network Issues

LIMS faced challenges due to shortages of supplies and machine malfunctions. The program is closely monitoring the issues and adapting to the processing capacity by prioritizing sample collection to targeted VL samples, HVL follow-up and children and PMTCT women. Tingathe continued the support to district and molecular labs with prompt notification of issues to the MoH Diagnostics and HTSS and other lab partners. Specific issues that were addressed are as follows.

- Shortage of supplies and reagents

- Abbott machine malfunctions and lab contamination
- Power issues resulting from adverse weather in the southern districts

Tingathe addressed these challenges with constant monitoring using a laboratory issues tracking log, liaising with the lab supporting partners through reporting and follow up of notifications for assistance or repairs. Re-routing of samples for data entry and prompt processing with the assistance of our lab clerks and lab techs seconded in the district's labs, and participating in meetings to address these concerns.

4.2 High Viral Load Management

Tingathe maintained its focus on closely monitoring the HVL cascade through the use of the Site Supervisor HVL checklist, which ensures that both adults and children with HVL progress through the care cascade as quickly as possible and that issues are addressed in real time. Ongoing mentorship and education for clinical providers was provided to ensure that client-centered intensified adherence counseling was provided using the welcome service approach and that clients with persistently high viral loads were referred for review by the genotyping committee to determine the need for genotyping as appropriate. The HVL checklist tool follows HVL clients through the IAC cascade until a decision is made on the viral load result. HVL clients who missed intensive adherence counselling (IAC) sessions, repeat/follow up VL after IAC, and those awaiting VL results are identified and followed up on. When results are not received in four weeks, the laboratory is contacted, and clients are evaluated for a switch to second line based on repeat VL results. At each stage, actions are noted and ticked off as they are completed. However, progress through the HVL cascade was delayed due to halting of VL testing due to stock outs of DBS kits and lab supplies. The supervisory team met once a week to review progress.

Additional activities implemented to improve VL cascade management, as described above, included continued provision of welcome service with quality IAC using the Information, Motivation, and Behavior Change (IMB) approach focusing on needs of different age groups and sex, ICAC for clients requiring additional clinical reviews/care – high VL cascade, suspected clinical failure, management of co-morbidities such as chronic diseases and malnutrition, etc., and support for adolescent health. MOH providers and lay health care workers were mentored on an ongoing basis to help them understand the eligibility criteria for VL testing, enrolment, and client management in ICAC. Daily WhatsApp reporting on viral load coverage from facilities allowed for real-time remote supervision and troubleshooting to address a gap in daily VL uptake.

Finally, Baylor technical experts continued to take part in multiple care and treatment subcommittees of the HIV technical working group at DHA, including the 3rd line, viral load, and pediatric subcommittees to guide policy and ensure quality treatment is available.

4.3 Advanced HIV Disease Management

Tingathe continued to provide advanced HIV disease screening and treatment services in 95 facilities in all Baylor-supported districts through a hub-and-spoke model. Hub sites have CD4 Pima machines for CD4 testing as well as LAM and CrAg testing capability, while spoke sites conduct clinical staging and refer eligible clients to Hub sites for testing as needed. The program is working with DHA and NTP to expand access to LAM and CrAg testing to spoke sites, however supply shortages present a barrier currently.

Sites provided targeted screening in newly diagnosed HIV patients prior to ART initiation to identify patients with advanced HIV disease (defined by CD4 count 200, clinical stage 3 or 4, or 5 children not on ART or less than a year on ART; and patients seriously ill including those on ART, those with virologic failure, and those PLHIV with danger signs). Many hub sites do not have capacity to do CSF CrAg, and therefore, all serum CrAg positive clients in hub sites with no capacity to do CFS analysis are referred to the hub sites with well-established laboratories. A Tingathe-developed advanced HIV disease register is used as a clinical tool to facilitate accurate screening, diagnosis, and treatment plans for eligible clients. The figures below illustrate overall AHD testing cascade for Tingathe 5 supported districts and district AHD testing cascade.

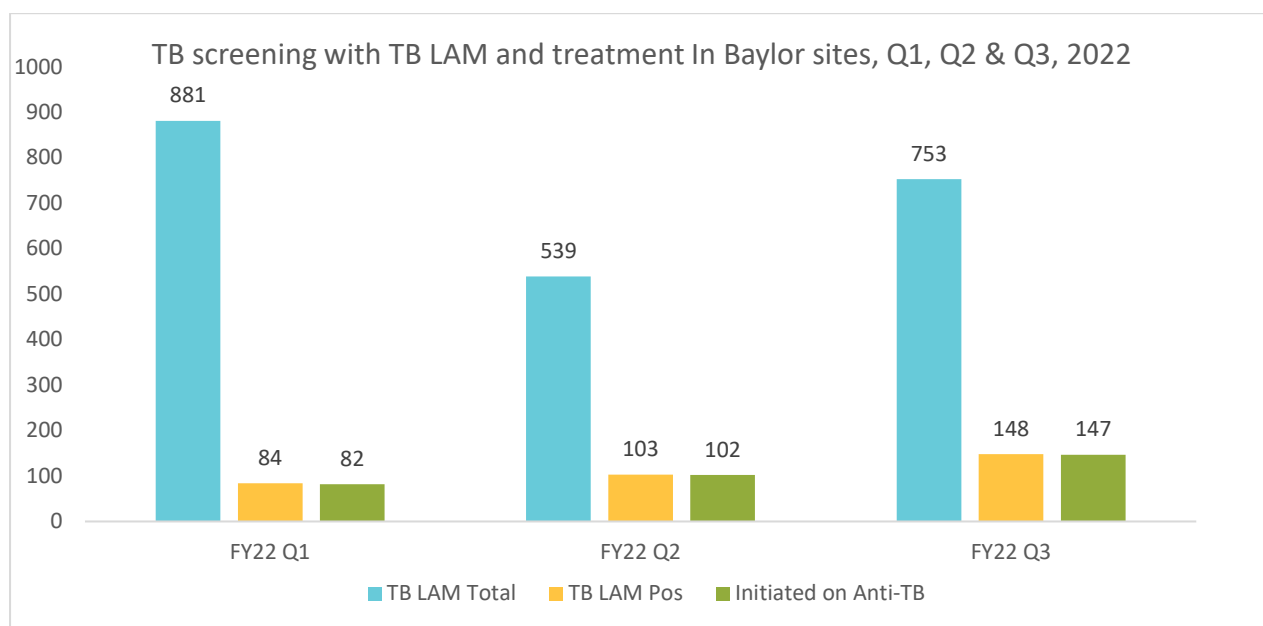


Figure 39: TB screening with TB LAM and treatment in Baylor sites, Oct 2021 to Jun 2022

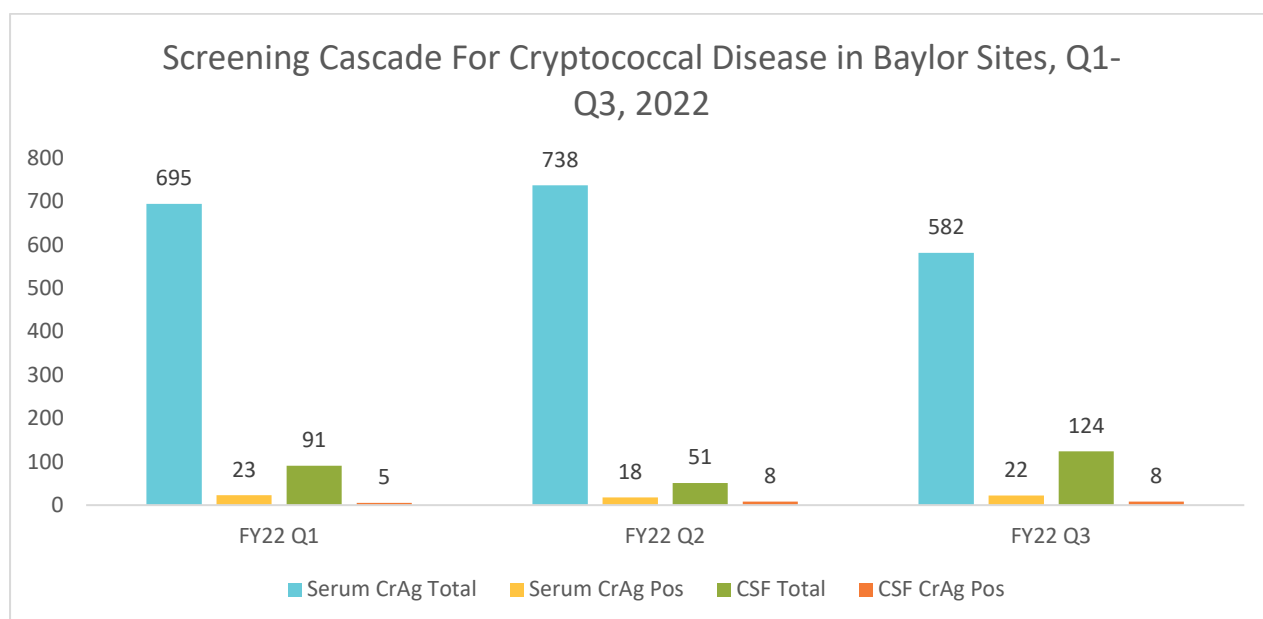


Figure 40: Screening Cascade for Cryptococcal Disease in Baylor Sites, Oct 2021 to Jun 2022

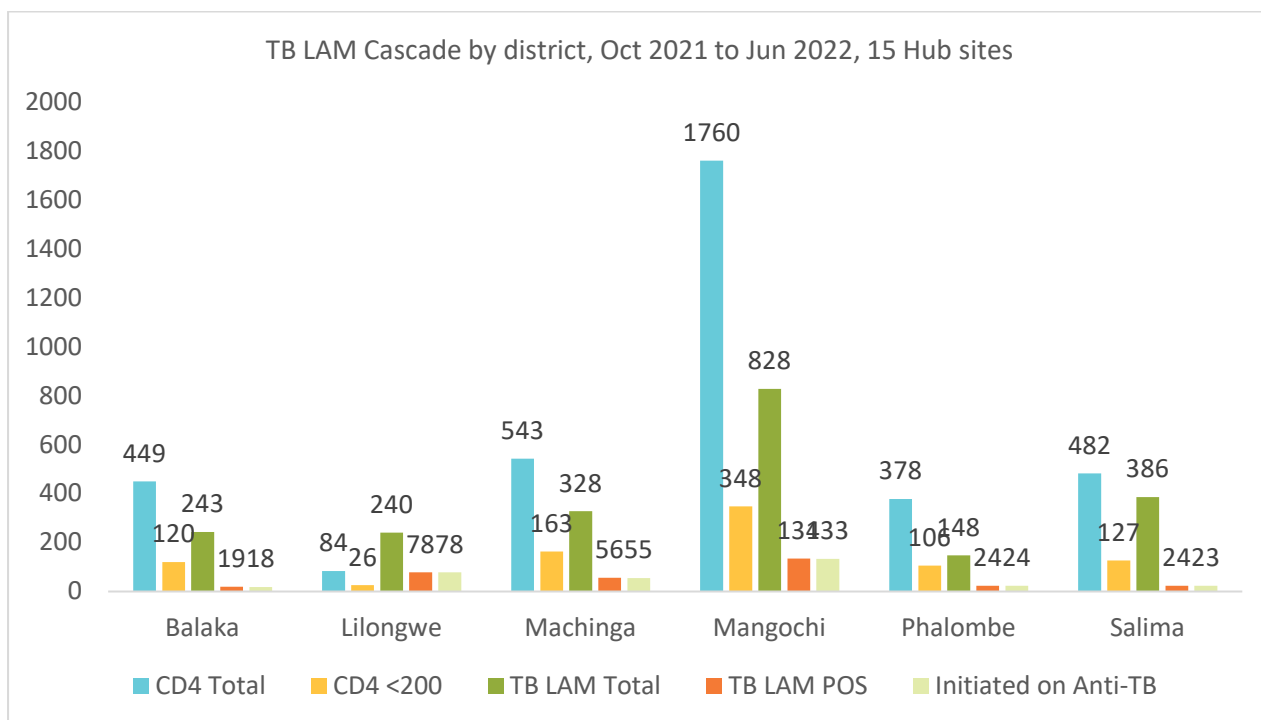


Figure 41: TB LAM Cascade by district, Oct 2021 to Jun 2022

Following a clinical AHD CPD conducted in Q2 for Coordinators and CHPOs to support implementation of AHD service provision; including AHD screening and documentation in the Tingathe clinical AHD register, in Q3 the program scaled up AHD QI projects in the following Mangochi DHO, Namwera, Mulibwanji health center, Machinga DHO, Phalombe Health Centre, Balaka DHO and Salima DHO. Dissemination of CQI project results by all sites demonstrated improvements in AHD screening in the respective sites, refer to CQI section ender Section III. The next step is for the rest of the sites to do the same to improve AHD screening.

Challenges to AHD service provision and proposed solutions

- People who are eligible for TB LAM or Serum CrAg test are unable to access these tests. Most of those referred to a hub site are unable to go to these hub sites due to lack of transport because most spoke sites are far from the hub sites. In districts, like Phalombe, where Tingathe through collaboration with APA children 17 years old and below from spoke sites who require AHD evaluation are provided transport to go to hub sites to access the services. Challenge still remains for Adults who are not eligible to be provided transport money from APA in Phalombe, and the rest of our clients from spoke sites in other districts who cannot afford to travel to hub sites.
- Rapid CD4 test kits, TB LAM and Serum CrAg kits are still not yet available in spoke sites. This would be the lasting solution to resolve the transportation barrier. Tingathe continue to engage DHA to consider distributing these kits to spoke sites for easy access of the services for eligible clients.
- Shortage of AHD commodities- CD4 cartridges, LAM and CrAg test kits, due to under supply relative to the demand for the kits. Baylor is in constant communication with district

pharmacy technicians and DHA logistics to replenish supplies in time; forecasting, relocating and transportation of reagents and drugs as required.

Activities planned for the next quarter.

- Expand the AHD CQI projects to all our supported site that have low AHD screening coverage. Initial AHD CQI was implemented in a few selected sites from our all our supported districts.
- Supportive supervision to and continued mentorship to our site teams by the district and central office team.
- Systems strengthening to prevent missing clients that require AHD evaluation, accurately documenting people who have received the services.

ART regimen optimization

Refer to Objective 3 [Section 3.1](#)

Increased viral suppression challenges and responses

- Guardian visits continue to contribute to missed opportunities for viral load collection. To address these issues, client empowerment education on timing and purpose of VL testing was intensified; clinic flow was continually optimized; and ongoing capacity building for clinical providers continued. In addition, client health education includes advising guardians that the client may come to clinic any day, at any time, for a “fast tracked” viral load draw and they need not queue.
- Challenges with documentation on master cards and in HVL registers persist. Continued supervision and mentorship by site supervisors, Site/cluster coordinators and CHPOs to ensure VL focal persons are identifying and documenting all HVL clients’ results daily. Clients with HVL are flagged for welcome care and documented for follow-up by CHWs. SS monthly HVL checklist addresses gaps in documentation every four weeks allowing any gaps to be closed in more timely fashion.
- Farming and harvesting and the festive season contributed to clients missing their appointments- a multifactorial approach utilizing client-centered Takulandirani counseling and phone tracing was used to bring clients back and identify tailored appointment approaches to help them schedule more conveniently, including introduction of additional community ART distribution clinics (CADs) for clients, and expansion of MMS to align with clients’ harvesting seasons and reduce the frequency of ART visits.

Increased viral suppression activities in the next quarter

- Conduct VL cascade audit and continue monthly HVL monitoring using the SS HVL checklist at all sites to identify barriers and gaps in the cascade and link to immediate reparative action.
- Ensure clinic flow is optimized; where it is not, change client /patient flow to allow for VL samples to be drawn prior to seeing clinicians and before antiretroviral (ARV) refills.
- Continue mentorship on management of HVL and 2nd line clients to ART providers with site/cluster coordinators performing regimen switches at facilities without a second-line provider. Encourage submission of genotyping samples for clients with HVL on DTG- or PI-based regimens.
- Continue technical support to and participation in 3rd line / genotyping subcommittee of care and treatment TWG and as part of third line review committee, providing feedback and guidance on client management.
- Supervise focal persons and site supervisors to ensure all clients with HVL are enrolled in welcome care, followed up, receive IAC, a second VL draw and scheduling for the next available clinic for switching.
- Continue to provide support to labs processing viral loads
- Continue to meaningfully engage clients in their treatment and disease management through takulandirani approach, including explaining why VL monitoring is important during health talks. Discourage providers from taking on “private clients” that circumvent routine VL monitoring and remain documented as “clients who have interrupted treatment.”

OBJECTIVE 5: INCREASED UPTAKE OF PREVENTION SERVICES FOR TARGETED POPULATIONS

5.1 Cervical Cancer Screening and Treatment

Tingathe continued providing cervical cancer screening and treatment services at 25 static sites and 10 outreach sites in 5 districts targeting women living with HIV (WLHIV) who are at high risk of

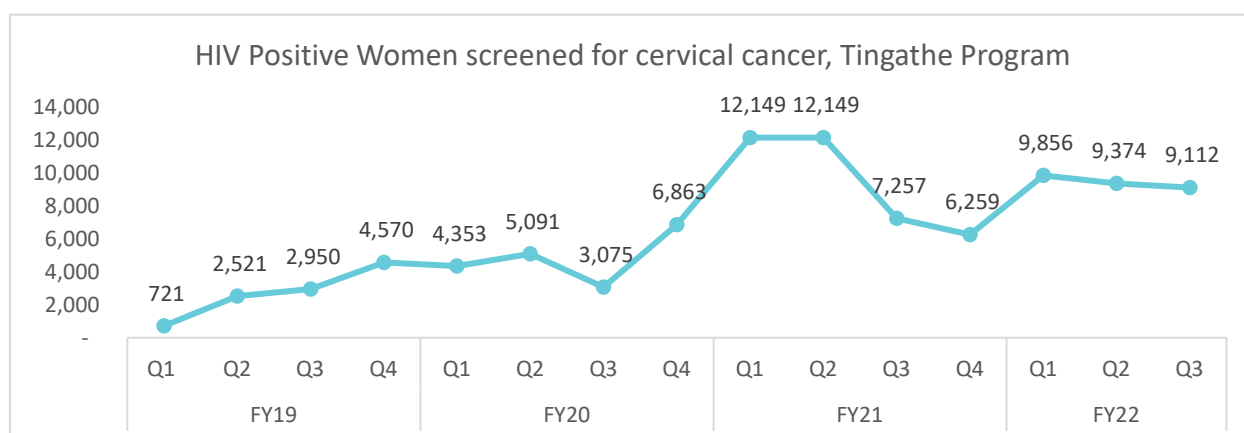


Figure 42: HIV Positive Women screened for cervical cancer

developing cervical cancer. During this quarter, 9112 women living with HIV (WLHIV) were screened achieving 142% of the quarterly target (9112/6409) as illustrated above.

In this reporting period, Tingathe recorded excellent performance with over 90% of women with treatment eligible lesions receiving same day treatment as shown in figure 43 below. The majority of women not treated the same-day were referred for large lesions or suspect cancer, and a few deferred treatments due to both personal and clinical reasons.

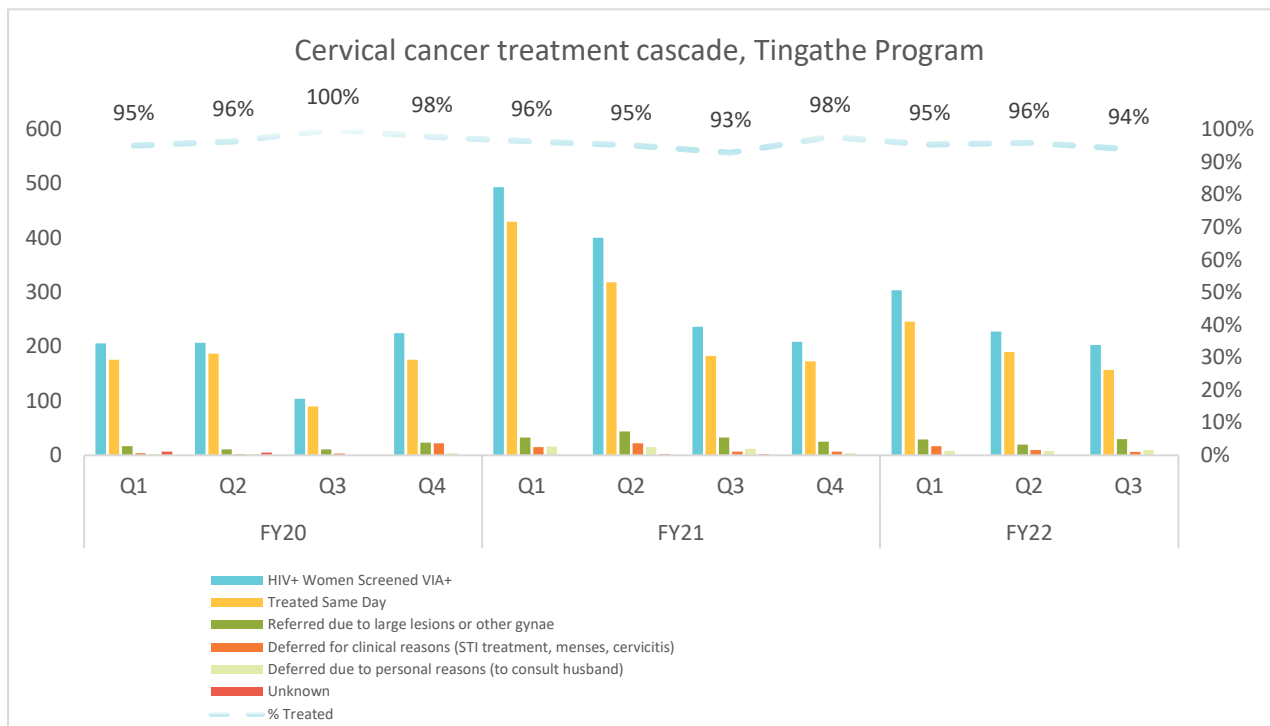


Figure 43: Cervical cancer treatment cascade

To achieve this sustained strong performance, Tingathe continued utilizing best practices for CECAP service delivery implementation to optimize CECAP delivery at all the supported sites. This was done through the following;

- Active linkage (assigning 1 dedicated CHW every month to link and escort women from ART to VIA clinic),
- Active screening by CHW and ART provider (conducting routine screening for WLHIV coming for ART refills and those eligible be fast tracked to access VIA services before getting their meds and also ART providers link clients to VIA clinic and check if women need follow up),
- Empowering ART clients to seek CECAP services (CHWs conduct health talks at multiple service points including at ART, FP and STI clinics. Engage both men and women about why to seek CECAP care),
- Engaging MOH staff at all service delivery points (link up with clinical staff (MAs/Nurses) at OPD, FP and STI clinics to refer WLHIV to CECAP) and
- Advocating for women (arranging with MoH staff to do VIA on busy ART days sometimes if not all the time to allow more WLHIV to access CECAP services).

HPV DNA testing

Tingathe continued to provide CECAP screening through expansion of access to HPV DNA testing, with services now available at Mangochi DHO, Kukalanga, Machinga DHO, Balaka DHO, and Balaka OPD. All women are offered HPV screening at the ART clinic, with same-day VIA and treatment as needed for those who have a positive HPV result.

Figure 44 illustrates that, in Q3, 503 women had CECAP screening with HPV testing and 399 of these women (79%) of women completed same day CECAP screening (HPV negative result or HPV positive result with VIA done).

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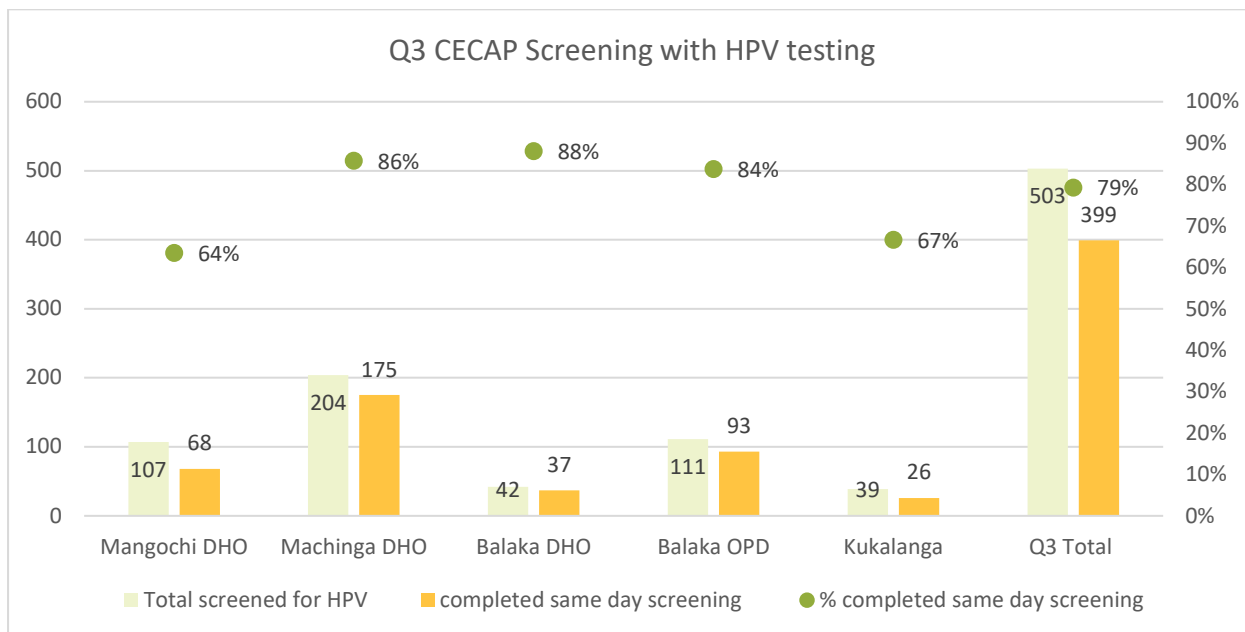


Figure 44: CECAP screening with HPV testing

As was the case during last quarter, the variability in the number of women who completed screening was mostly affected by the turnaround time of HPV testing from the lab and the availability of testkit/reagents to allow both screening and completion of testing. Delays in processing HPV samples do occur from time to time due to multiple samples requiring priority on the GeneXpert machine on site, as well as women who arrive by late morning prefer to go home and not wait until late afternoon if the samples for the day were already completed. To address these challenges, Tingathe continued to use phone follow-up to inform clients of their HPV results and to encourage women found to have HPV to return for VIA. Women are given the CECAP nurse's phone number and asked to flash or call it within two days of their visit if they do not receive their HPV result the same day. This enables women who do not have a phone to contact the nurses by borrowing one. CECAP nurses also directly call all women who provide a phone number. CHWs also check the next appointment date for all women who have a HPV+ result and flag them to be fast tracked and referred to CECAP nurse for VIA. Additionally, women who have an appointment in the distant future are assigned to CHWs for home tracing using their locator information. As was the case last quarter, HPV screening was also interrupted at all sites due to shortages of HPV cartridges and sample collection kits. By the end of the quarter, HPV DNA testing had not resumed due to lack of these HPV commodities.

Referral of Women with suspected cervical cancer or large lesion for treatment

Tingathe continued to advocate for women with large cervical lesions or lesions that were possible cervical cancer. Women are referred to district LEEP providers wherever possible and then further evaluation if needed at MSF at Queens or KCH for further evaluation. During this quarter, MOH LEEP for Balaka completed his mentorship program after being trained. Tingathe supported the district with LEEP supplies including formalin solution and Lugols iodine to help the provider to start providing the LEEP services. By end June, MOH-trained LEEP providers in Mangochi and Machinga and Balaka completed their training and started providing LEEP services to women. This has made it easier for women to access these services without having to go outside of their district. LEEP providers in Salima and Phalombe have left and Baylor working with RHD to determine the way forward to support women from these districts who need LEEP services. Tingathe continued

Tingathe CORE Q3 FY22, April- June 2022

supporting the processing of biopsy samples collected by these LEEP providers, which are sent to UNC lab for evaluation

Inadequate or lack of LEEP supplies, such as Lugol's iodine and Monsel paste, is a major challenge that this initiative faces, as supply chain constraints exist in the country. Baylor is collaborating with sites and district CECAP coordinators to support LEEP services in the districts. Tingathe has maintained the established relationship for referring women with suspected cervical cancer or large lesions to MSF in Blantyre or Kamuzu Central Hospital Ob/gyn if services are not available in their district or if a higher level of care is required following consultation with LEEP providers.

Primary Prevention of cervical cancer: HPV Vaccine Scale up initiate

During the same period, Tingathe engaged MOH to start providing HPV vaccine to 9-14yo girls in teen clubs at some selected sites in Phalombe and Balaka districts. Tingathe focused on facility-based vaccination targeting girls at teen club on guardian session days. District EPI coordinators were involved in planning for this. HSAs and nurses gave health talk to create demand for the vaccine and vaccines were provided on the same day during the teen club guardian session. At teen club guardian sessions, nearly 60% of eligible girls were vaccinated with their first dose of HPV vaccine (154 of 270 eligible).

Other achievements

- Rolled out HPV vaccine initiative in Phalombe and Balaka districts. The other districts have started now in q4.
- Improved linkage of clients from multiple service points to VIA clinic. A CHW is assigned to support CECAP services daily at high volume sites
- Uninterrupted provision of VIA supplies and equipment
- Close supervision and following data with weekly and monthly reporting assisted in identifying gaps and provided timely remedial action.

Challenges

- Gaps in service provision when Baylor providers are away from site continue affecting VIA services at some sites. We continue to work closely with MoH providers to ensure clients are not turned away or miss VIA screening.
- HPV screening commodities and testing has challenges. Competing lab priorities and short staffing affecting TAT for HPV samples that affects completion of VIA same day for those who need it
- Stock out of HPV commodities affected service delivery and program adjusted to return to VIA only when HPV commodity is out of stock and supporting districts and supply chain management as able to ensure adequate commodity. MMS has resulted in many women now accessing the facility less frequently and program is adjusting to make sure all women can be screened on days when they are in clinic and flagging charts when women are back to clinic.

Activities for the next quarter

- Conduct CPD CECAP Nurses to share best practices and build capacity to maximize site level performance. HPV vaccination support through engagement of EPI program to support sensitization of health facility attendees, women accessing CECAP and family clinic/teen club participants and guardians on benefits of HPV vaccination and provision during GS teen club days
- Continue supporting pathology/biopsy samples at UNC from sites that are providing biopsy and/or LEEP services (Mangochi, Machinga, Salima and Balaka DHOs) Considering other possible sample processing as UNC has had some delays in their processing of samples due to their staffing changes.
- Continue providing support to women with suspect cervical cancer or large lesion referred to MSF-Blantyre or KCH

5.2 Pre-Exposure Prophylaxis (PrEP)

Tingathe has continued supporting PrEP service delivery in supported districts. Trained PrEP providers continued providing PrEP services in their respective sites and the number of clients accessing PrEP services has been increasing overtime and this has helped the program to reach its semiannual target as highlighted in figure below. During this reporting period, Tingathe made tremendous improvement in initiating eligible people on PrEP, registering a total of 1,498 people initiated on PrEP during this reporting period exceeding semiannual target overall and achieving a cumulative total of 3,488 people on PrEP.

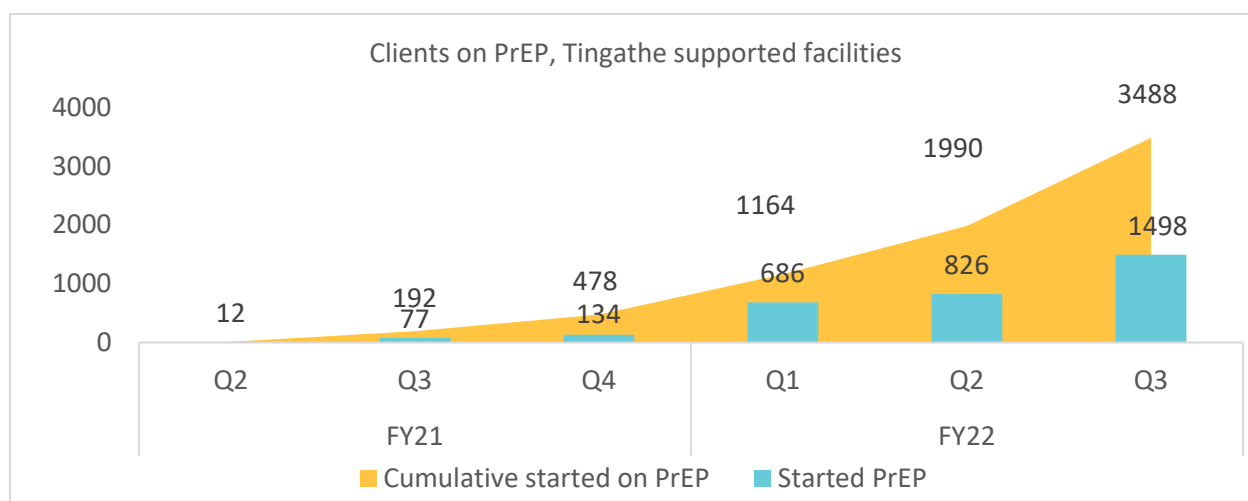


Figure 45: Clients on PrEP, Tingathe supported sites Q2 FY21- Q3 FY22

Sites provided health talks throughout the health facility to sensitize people at the facility about availability of PrEP services. Post-test counseling given to people with HIV negative test results included counseling on PrEP services to allow informed choice on prevention services and create demand for the service. Active linkage was done for interested clients after HTS to evaluate for eligibility and provision of PrEP to eligible clients. With very limited creatinine testing in labs, lab testing continues to be a bottleneck in services, and work to strengthen this service is ongoing. POC hepatitis B testing is available, allowing for testing at the site level, although stocks remain a challenge.

Challenges

- Long queues at the lab to get HepB testing remains a barrier; teams are negotiating with laboratory staff with an aim to allow the testing to be done by a provider in the PrEP initiation room as the test is a point of care rapid test. Lab staff have been engaged from central, district and facility level regarding lab challenges.
- Some facilities worry of long queues therefore they don't sell the service to every potential user. Baylor continues to engage with the STI coordinators to provide a separate room next to STI room so that clients should be sent to that room to get the knowledge and do the rest of the procedures then just go in the STI room for initiation
- Some clients not coming back for refills or transferred out or quit.

Plans for the next quarter

- Continue providing mentorship and supportive supervision to the trained PrEP providers
- Continue sensitization to people at the facility and with partners working in the community for demand creation
- Support safe initiation and testing per DHA guidelines for eligible clients.

5.3 GBV Clinical Response

Tingathe continued providing the minimum package of care for survivors of gender-based violence (GBV). All the Baylor supported districts have been oriented on the minimum package of care for survivors of GBV. To improve active referral of survivors of GBV to access clinical services, Tingathe is working in collaboration with other partners and stakeholders in the districts. During the period under review 1,790 survivors of GBV accessed the minimum package of care for survivors of GBV as shown in Figure 46 below.

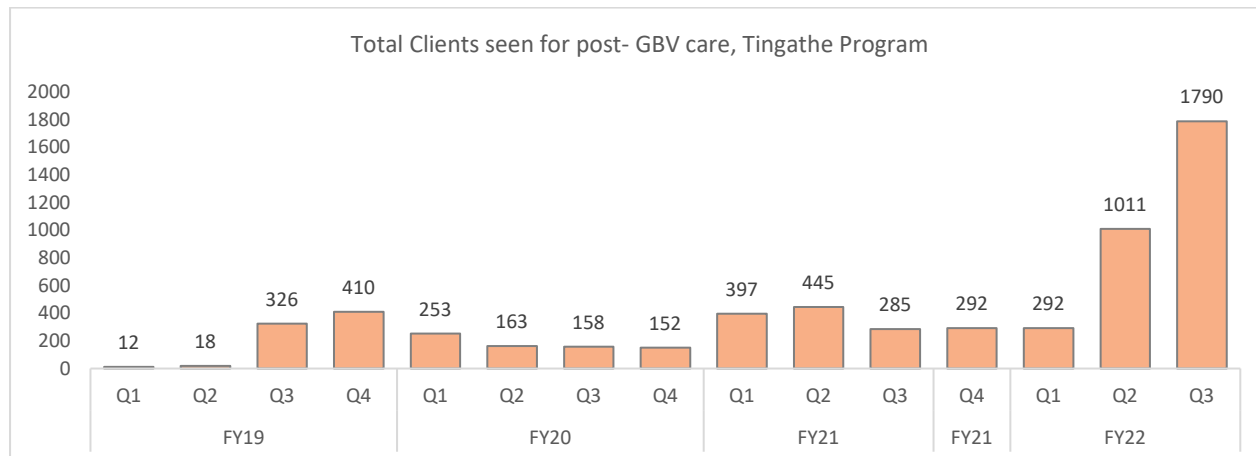


Figure 46: Total clients seen for post-GBV care, Tingathe program Q1 FY 19-Q3 FY22

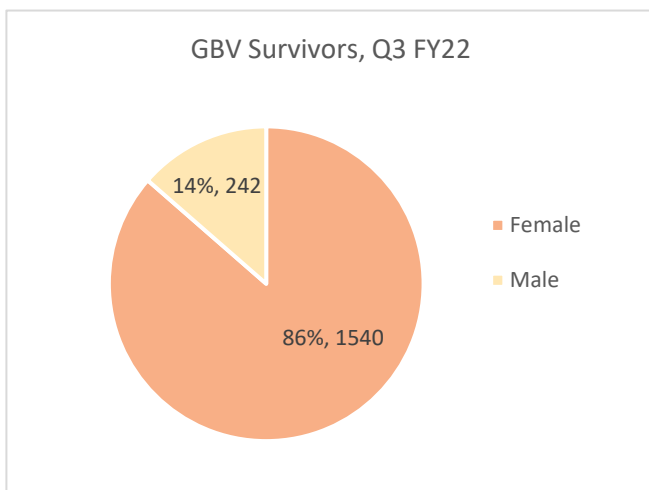


Figure 47 illustrates that more women (86%) than men (14%) aged received the minimum package of services for survivors of GBV, all of whom were between 15-39years old.

Figure 47: Post-GBV care by gender Q3 FY22

Challenges and potential solutions

Increased uptake of prevention service challenges and responses

- Limited number of people accessing timely services for survivors of GBV. Tingathe continues to work with EMPOWER and APA partners and other community partners to sensitize individuals and communities to the availability of services particularly acute timely care for survivors of sexual violence. Active screening at ICT is ongoing.

Activities for the next quarter

- Continue to work with EMPOWER and APA partners and other community partners to sensitize communities about GBV, availability of care for survivors of GBV and actively refer survivors of GBV for care
- Continue screening of all ICT clients for IPV and link survivors to care

OBJECTIVE 6: HEALTH SYSTEM STRENGTHENING / STRENGTHENED CAPACITY FOR HIV RESPONSE

6.1 Human Resources for Health

The program completed and submitted to USAID the PEPFAR HRH inventory tool which is used to collect and collate data on individuals funded through PEPFAR. The Inventory template captured all types of PEPFAR-funded individuals, from health workers delivering direct services to clients at health facilities to program and sub partner staff supporting program management and operations, and technical assistance or non-service delivery (NSD) activities. The submission captured data from two mechanism implementing the program in FY21 period – TSP and CORE. Over 85% of individuals constituted site level staff providing direct services to clients, while the rest were above site staff. Prior to this, relevant program staff attended OHA training for FY22 HRH reporting and Baylor-M acquired DATIM credentials for the new HRH portal in DATIM.

Baylor continued to participate in the PEPFAR Malawi HRH interagency taskforce meetings aimed at standardizing lay staff cadres across partners to maximize efficiencies with a vision of

sustainability as the country moves toward epidemic control. The meetings focused on implementation actions outlined in the standardization road map, with discussion pegged on engaging various government stakeholders to appraise them on proposed actions. In Q3, the taskforce continued to hold discussions with DHA concerning standardization guidelines for cadre naming, which tentatively will be rolled out by October 2022.

Staff recruitment and onboarding was done to ensure the right mix of talent and capacities for CORE program implementation at both above site and service delivery levels in the 5 supported districts. This recruitment also aimed to fill vacant positions due to attrition. As such, seventeen (17) staff were hired and ten (10) separated with the program during this reporting period, as shown below;

Table 3: Staff recruitment and attrition Q3 FY22

New recruits – Q3 FY22	
Position	Total #
Programs	14
Operations /HR	1
Finance	0
M&E	2
Research	0
TOTAL	17
Resignations – Q3 FY22	
Positions	Total #
Programs	5
Operations/HR	2
M&E	2
Research	1
TOTAL	10
Death –Q3FY22	
Programs	Total #
TOTAL	1

Baylor continues to conduct in -person trainings/meetings with strict adherence to COVID-19 prevention measures for number of a participants considering spacing, aeration and IPC as per revision of government guidelines as infection rates dipped in the previous quarter. Virtual trainings, CPD and meetings continued to be conducted using a variety of methods, including video and audio messages, followed by comprehension assessments via Google forms. The following trainings were conducted during the reporting period (April- June 2022):

Table 4: Trainings conducted in Q3 FY22

Training	Number trained	Districts
HTS Guidelines CPD	42 (Baylor –Cluster coordinators, CHPOs, DCs and DLs)	Balaka, Lilongwe, Machinga, Mangochi, Phalombe and Salima
SS Meetings	183 (Site supervisors, EMR data clerks, CHPOs, DAOs, DCs and DLs)	Balaka, Mangochi, Machinga and Phalombe and Salima.
Molecular supply chain management training in Mangochi	1 (Baylor Lab technician)	Lilongwe (COE)
Motorbike training	23 (CHWs, CHW/Counsellor and nurse (Expert tracers)	Balaka, Mangochi, Machinga, Phalombe and Salima.

Training	Number trained	Districts
Disclosure Training (Baylor)	35 (SS and CHWs)	Balaka, Mangochi, Machinga, Phalombe and Salima.
ARPA Mental health orientations	1,561 MOH (Nurses and clinicians) 1,127 BAYLOR (PSC counselors, DCs, nurse, clinicians)	Balaka, Lilongwe (COE), Mangochi, Machinga and Phalombe and Salima.
ART initial Training	26 MoH (Nurse, NMT, Clinician, MA and NO) 1 Baylor (Cluster Coordinator)	Balaka, Mangochi, Machinga, Phalombe and Salima.

6.2 Coordination with MOH and other partners

From April – June 2022, Tingathe continued to work closely with the Department of HIV and AIDS (DHA) at the national and district levels to ensure the quality delivery of HIV care and treatment services. PEPFAR and DHA provided guidance on implementation of essential HIV services, including routine VL draw, while ensuring clients and HIV service providers were kept safe from COVID-19. DHOs provided the necessary support to enable continuity of HIV services at health facilities. Baylor continued to implement the Vaccine Express Strategy (VES) which was re-launched in previous quarters to accelerate vaccine uptake in the country.

Tingathe continues to participate in COVID-19 prevention and preparedness meetings through Public Health Epidemic Management Committees (PHEMC) in all supported districts, as well as national level cluster and partners COVID-19 forums. Details can be found in the COVID-19 section below.

Pharmacy stock monitoring: In this reporting period Tingathe program in collaboration with district ART and HTS Coordinators and Pharmacy Managers monitored HIV commodities stock levels for sustained supply to support ARV regimen optimization, MMS, VL tests and HTS. Tingathe addressed challenges of frequent stock outs of DBS bundles, CD4 Cartilages, ART drugs (like pediatric DTG, DTG 50mg and Adult ABC/3TC), syphilis and HIV Test kits through stock monitoring and relocation of supplies within and from other districts in collaboration with DHA.

Lab monitoring: Due to supply chain issues, there was a nationwide stock out of DBS bundles and VL reagents. Tingathe encouraged sites to use the last few bundles for EID testing and follow up VL testing for those with High VL for limited VL reagents., children and pregnant/breast feeding women. Please refer to viral load section above for additional information.

With consistent high demand for Gene pert machines to test for COVID-19 in addition to TB, VL, EID, and HPV samples, during this reporting period, Tingathe continued to actively monitor the processes to ensure that timely TAT for all HIV tests, particularly EID, was not compromised. DHA emphasized the testing of all EID samples at district labs.

Viral load processing support: As described above, Tingathe undertook many activities at national, district, and facility level to provide intensive support to laboratories to deliver essential HIV services. Tingathe lab technicians and lab data clerks worked hand in hand with MoH laboratory staff to ensure smooth and timely processing of VL and EID samples. Priority was given to EID to cover for the limited stock of DBS bundles.

Support to MOH Technical working groups: Baylor staff participated in the HIV care and treatment technical working group meeting as well as pediatric subgroup meetings. In addition, Baylor staff participated in several DHA-led meetings about TPT, EMR upgrades, 3rd Line ART and genotyping, Differentiated Service Delivery (DSD) Model progress and Advanced HIV Disease support.

Baylor and KCH Pediatric ward collaboration

Baylor and the Pediatric ward at KCH hold regular meetings to discuss the best way to manage HIV-infected patients admitted to the hospital. Baylor consultants also provide specialized care for non-infected pediatric patients who are critically ill on the wards at odd hours. Furthermore, KCH consultants support the provision of specialized care to HIV-infected patients admitted to the Pediatric ward.

Collaboration with other Implementing Partners: The program continues to support combined ART/PMTCT/TB and HTS review meetings in the 5 supported districts including joint ART and HTS supervisions with the ART and HTS Coordinators. Coordination among partners during planning of HIV program activities was encouraged to avoid duplication of efforts. Further, Baylor continues to jointly work with APA OVC program in Mangochi, Machinga and Phalombe to provide comprehensive support to CLHIV and their families. Particular attention is provided to CLHIV with HVL through joint site level meetings; clinical reviews, regimen optimization and social support. Other notable (but not exhaustive) collaboration initiatives are listed below;

Table 5: Collaboration with implementing partners, Q3 FY22

Implementing partner	Areas of collaboration
MOH	<ul style="list-style-type: none"> • Baylor in collaboration with GAIA is implementing in Mangochi under TA Nankumba which falls under the following health facilities, Billy Riordan, Monkey Bay, Nope, Nankumba, Malembo, Nankhwali, and Chilonga. In the just ended quarter GAIA has been conducting formative visits to implementing partners to gain insights for their implementation. Mangochi has 21 CAD points of which 3 fall under TA Nankumba. • Outreach HTS- Mangochi District council through the office of the DHSS has opened 3 new health centers in the district namely Njeleza, Nsaka and Cape Maclear. • Baylor worked with DHO to relocate HIV commodities within and outside the district on the following items – DBS bundles, CD4 Cartilages, ART drugs (like pediatric DTG, DTG 50mg and Adult ABC/3TC), syphilis and HIV Test. • In Balaka, Salima, Machinga Phalombe and Mangochi districts, Tingathe supported HIV review meetings where MOH HTS, ART, STI, and TB service providers from all supported facilities reviewed performance of the HIV care and treatment program. Other participants included the DACC from the District Council and DHMT members. • Promoting and scaling up PrEP services through engagement meetings and collaborative health talks • Ongoing in person and Virtual ART/PMTCT/HTS supportive supervision and mentorship • Establishment of new CADs in Balaka, Machinga, Mangochi and Salima districts.

Implementing partner	Areas of collaboration
BULAMO and STAR Fish	<ul style="list-style-type: none"> • COVID-19 response and vaccination uptake activities in all supported districts. Baylor continued providing health talks on COVID vaccines in all supported districts and referred all eligible clients for vaccination. • In Salima, Tingathe worked with BULAMO, and Starfish to conduct CADs.
UMB	<ul style="list-style-type: none"> • Lab training gene expert- UMB organized an initial GeneXpert end user training concentrating on VL and EID tests. In addition, Mangochi DHO lab will receive a new 4 module GeneXpert for TB (10 colour), which will be able to detect resistance in other drugs.
OVC PARTNER APA	<ul style="list-style-type: none"> • Baylor continued to work in collaboration with OVC partner APA in Phalombe, Machinga and Mangochi districts to support children and adolescents living with HIV and their families
EMPOWER	<ul style="list-style-type: none"> • Monthly district meetings to discuss PrEP and referral of DREAMS girls for facility-based services
JENOVA	<ul style="list-style-type: none"> • In Phalombe, Baylor in collaboration with JENOVA provide checks and balance in service provision especially ART and Cervical cancer.

Health systems strengthening for HIV response challenges and responses

- Supply chain challenges: DBS, AHD commodities and pDTG among other ARVs commodity shortages remained a persistent challenge in this reporting period. Tingathe supported relocation of drugs and HIV test kits from the main pharmacy to peripheral sites and across districts as well as provided data to inform commodity distribution planning.
- Lab challenges: Shortage of VL supplies and reagents and machine breakdowns resulting in an accumulating backlog of VL samples and pending results in the districts. Tingathe addressed these challenges with constant monitoring using a laboratory issues tracking log, liaising with the lab supporting partners through reporting and follow up of notifications for assistance or repairs.

Health systems strengthening for HIV response activities in the next quarter

- Continued support for EMR/HIS, laboratories -with escalation to relevant IP and MOH departments
- Continued participation in technical working groups and subgroups
- Continued engagement of ART and HTS Coordinators on planned activities to promote ownership
- Support for ART and HTS review meeting to improve HIV service delivery
- Work collaboratively with other partners to strengthen HIV service delivery
- Commence the 1st step of lay cadre standardized naming with PEPFAR country office guidance

CORONAVIRUS DISEASE (COVID-19) RESPONSE

There was sustained reduction in the number of COVID-19 cases and deaths in the country with 960 new infections and 20 deaths reported in Q3 (Apr-Jun). Nonetheless, Baylor employed a heightened caution on infection prevention and control measures and emphasized strict adherence to COVID-19 SOPs at health service delivery points, offices and vehicles. Resultantly, there was no disruption of essential HIV service provision or program activities, with significant resumption of in-person trainings and meetings with virtual options where possible. There was no reported case of COVID 19 infection among Baylor staff in the reporting period.

Through Tingathe CORE program, Baylor continued to work with MOH to coordinate COVID-19 response by participation in district-level prevention and preparedness meetings through Public Health Epidemic Management Committees (PHEMC) as well as national Health Cluster and the USAID COVID-19 Partners forum. These forums bring together different stakeholders and partners to review and discuss strategic actions needed to adequately prevent COVID-19 spread, and to respond to and manage infections and scale up vaccination. The program coordinated its support with other district level partners, such as Organized Network of Services for Everyone (ONSE) and community-based organization (CBOs) through regular meetings to harness support and avoid duplication of efforts in response to district level needs to address COVID-19. Following ONSE project closed out at the end of Q3, Tingathe has reached out to Right to Care and Break through action for resource sharing and activity coordination in overlapping districts of implementation.

Cumulatively, 86,600 COVID-19 confirmed cases had been reported nationally by end of June 2022 with 2,646 deaths and 83,202 recoveries. People reported to have received first COVID-19 vaccine dose were 1,658,304, while 1,663,519 had been fully vaccinated and 41,842 received booster doses.



Cumulative data (2 April 2020 to 3 July 2022)

Confirmed cases	Recoveries	Admissions	Deaths	Tests conducted	Vaccines administered		
					First dose	Fully vaccinated	Booster
86,600	83,202	6,977	2,646	593,797	1,658,304	1,663,519	41,842

Epidemiological Week 26, 2022 (27 June to 3 July 2022)

190	186	14	1	2,631	67,569	50,301	10,718
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Source: National data on COVID-19 from PHIM

Following a series of national vaccination campaigns and MOH Vaccine Express Strategy (VES), there was a 45% (515,883) of the number of people who received a first vaccine dose in Q3 compared to Q2. Similarly, the proportional quarterly increase of people fully vaccinated was 86% (771,105) while booster doses increased to 41,842 in Q3 from 766 in Q2. Malawi, however still remains far behind other sub-Saharan countries in COVID vaccine update. Baylor, alongside other partners, participate in vaccination campaign activities to address vaccine readiness and hesitancy among

communities and staff to sustain vaccine coverage across supported districts and stem wastage by ensuring the vaccine doses are used up within their shelf life.

Baylor worked in partnership with district health promotion officers and EPI coordinators at district levels to sustain vaccination activities and ensure maintenance of adequate vaccine supply and vaccinators (HSAs) at the health facilities. At national level, the program continued to participate in bi-weekly USAID implementing partners and health cluster meetings to strategize and share lessons to increase COVID vaccine uptake in the country. The integration of COVID vaccination with Polio vaccination campaign that took place within the quarter was extensively discussed with the aim of optimizing time and HRH (HSAs) efforts as they administered both vaccines to people at communities and within health facilities. However, this integration idea was vacated following the guidance of Malawi Immunization Technical Advisory Group.

Tingathe CHWs continued providing COVID vaccine health talks at intervals throughout the day with a particular focus on PLHIV and families attending ART clinics. CHWs counselled and escorted those who expressed interest to the vaccination center within the health facility (and referral to community vaccination when facility-based vaccination is not available). The number of referrals made was then tallied and reported on a weekly basis. These referrals contributed to the overall vaccination numbers at sites as reported on EPI records (not exclusively ART clients, but all people vaccinated at sites). Overall, 16,318 clients from ART clinic were referred for facility-based vaccination; which contributed to the total number of people vaccinated at supported sites at 96,537. The program did not collect vaccination data specific to ART clients, rather overall site vaccination data as shown below. The program will start reporting specific data on number of PLHIV receiving COVID-19 Vaccines in the subsequent quarter (Q4).

Month	Total ART Clients Referred for COVID Vaccination						Total People Vaccinated against COVID-19 (Total at the facility)					
	Balaka	Machinga	Mangochi	Phalombe	Salima	Total	Balaka	Machinga	Mangochi	Phalombe	Salima	Total
April	883	1524	1595	29	411	4442	3633	9137	3787	1430	3710	21697
May	1096	2095	1339	40	277	4847	2987	16439	4314	1225	3392	28357
June	1784	2864	1887	28	466	7029	7360	25914	8453	1018	5198	47943
Q3 Total	3763	6483	4821	97	1154	16318	13980	51490	16554	3673	12300	97997

Tingathe Program data on COVID-19 Vaccination Referrals and Uptake, Q3

Some facilities experienced challenges emerged due to absence of HSAs to administer the vaccines within the facilities during ART clinics when clients were escorted to get vaccinated. Where HSAs were available at sites, they were reluctant to open vaccine vials if there are few clients than the number of doses in a vial leading to some clients missing vaccines despite their willingness to get vaccinated. The program continues to engage EPI coordinators to resolve this, but it remained a barrier to facility-based vaccine uptake for ART clients. In addition, vaccine hesitancy remained high amongst clients, the program intensified vaccine education at health facilities and within communities working with chiefs/community leaders to address misinformation and drive correct messaging to community groups; this was done in collaboration with other partners working within

Tingathe CORE Q3 FY22, April- June 2022

Tingathe supported districts. Further Tingathe reached out to Breakthrough Action program for adaptable communication materials on COVID vaccination to enhance health education delivered at facility waiting areas.

In addition to activities mentioned above, Tingathe program's COVID-19 response includes the following:

ARPA COVID Vaccine Uptake (CN31): In May 2022, Baylor submitted to USAID a twelve-month scope of work and budget for implementation of COVID vaccine uptake activities among PLHIV in ART clinics. With this additional Global Health funding, the program will aim to increase access to COVID vaccination services and address vaccine hesitancy to increase vaccine uptake among PLHIV, Healthcare workers (HCWs) and lay cadres. The support will be provided at 95 PEPFAR supported facilities in 6 Districts (Salima, Mangochi, Machinga, Balaka, Lilongwe and Phalombe). The activities will include training of HCWs and lay cadres, health education and assigning lay cadres to physically escort clients from ART clinics to the vaccination rooms. Following the scope of work approval, Baylor and USAID held discussions on activities and indicators to be reported in DIS.

ARPA Mental Health/ Psychosocial activities(CN30): Through phone-based counselling services, a psychosocial counsellor continued to attend to needs of health care workers and their families. Facility level orientations on Mental Health were conducted targeting health care workers to sensitize them on self-care, mental health needs and resources available to them including access to phone based counseling by psychosocial counselor for health care workers. As was reported last quarter, 1058 health care workers were trained; this continued in Q3 with an additional 675 trained, out of which 540 were MOH staff and the rest Baylor staff. With exception on 3 sites in Mangochi districts, all Tingathe supported sites have been trained. This training was extended to KCH staff, who requested for it following orientation of Baylor COE HCWs.

Implementation of essential HIV services: The program sustained to implement innovative approaches and best practices to continue providing essential HIV services to clients without any service disruptions. HIV service delivery at health facilities continued with strict adherence to infection prevention measures while paying close attention to trends of COVID 19 infections and making necessary adjustments. Activities incorporated in routine programming include: remote psychosocial support (phone-based counselling); remote supervision using google forms, daily WhatsApp reporting and weekly phone calls; expanded tracing on phone and in-person; continued support for ART optimization and HVL management for CLHIV; enhanced supply chain support to address supply chain challenges related to commodity shortages; enhanced and integrated TB/COVID screening and referral, enhanced infection control protocols, provision of PPE, development and deployment of COVID-related training for providers as well as health talks/education for clients about COVID and importance of COVID vaccination; remote and video-based counselling. A hybrid model of in-person and virtual methods of training was used to maintain quality standards in HIV service provision. Our clinical team patronized ART clinics for service provision, mentorship and supervision activities with strict adherence to COVID-19 prevention protocols. There were no major COVID-19 restrictions from DHA in the quarter which facilitated uninterrupted service delivery to all PLHIV clients, nonetheless Baylor continues to adapt

and adjust programming in alignment with DHA and OHA guidance on HIV service provision during COVID-19 pandemic.

Personal Protective Equipment and COVID-19 supplies: The program prioritized guaranteeing the safety and protection of frontline program staff as they delivered HIV services. Tingathe continued to procure and distribute PPE for its staff and COVID-19 prevention commodities for all supported sites at intervals and based on need. The program extended non-PPE support to MOH at all supported districts to particularly promote hand washing and decontamination of high touch services at health facilities. Table below shows PPE quantities supplied in the period.

District	Surgical (pieces)	Masks	Soaps (pieces)	Bleach (Jik 750ml)	Sanitizer (Litres)
Balaka	<i>Stocks available</i>		350	<i>Stocks available</i>	70
Machinga	5000		700	155	220
Mangochi	<i>Stocks available</i>		850	200	250
Salima	<i>Stocks available</i>		<i>Stocks available</i>	30	60

Awareness on COVID-19 at ART clinic: Messages about COVID-19 were integrated into routine health education including: signs and symptoms, how to prevent spread, what to do if a client is concerned, they might have COVID-19, preventing stigma and discrimination. Health education with COVID-19 messages was given each morning at the ART clinic waiting area. Information on vaccine benefits and access was provided to staff and clients, with those accepting to be vaccinated being escorted to receive a vaccine at the site as explained earlier.

COVID-19 triaging: patients exhibiting COVID-19 symptoms were separated from others at the waiting areas for further investigation by assigned MOH clinicians/nurses. Some sites, particularly district hospitals, maintained isolation spaces (tents, wards/rooms) while smaller sites with space challenges set up aerated spaces outside the buildings/under a shade to assess patients exhibiting COVID-19 symptoms. Surgical masks were provided to unmasked patients with a cough.

Promoting infection prevention and control practices: Tingathe maintained handwashing stations through provision of hand washing soap and filling of buckets with water at all supported sites. Tingathe site level team actively wiped surfaces multiple times in a day with 0.5% chlorine/bleach solution as one of infection prevention and control measures of COVID-19.

III. MONITORING AND EVALUATION

In the FY22 Q3 period, Tingathe M&E team continued supporting all health facilities to ensure complete, accurate, and timely data. The following are key activities supported by M&E to strengthen data quality and use:

Quality Management/Improvement (QM/QI)

- **Routine Monitoring and Data Review:** Daily, weekly, and monthly reports are generated and shared by site teams for data review. Weekly performance is monitored towards targets and

address gaps. Weekly dashboards are produced and shared with site, district, and central office for performance review.

- **Weekly Site-Level Monitoring:** Sites generate reports on weekly performance of key indicators (HTS_TST, HTS_POS, HTS_INDEX, TX_NEW, TX_CURR and Viral load). Reports are reviewed at site level regularly assess performance and identify site-specific gaps. Data are shared with district and central office team for further review and analysis to guide program improvement. Weekly reports are also generated to identify clients who miss appointments and who interrupted treatment to facilitate assignment to Community Health Workers for tracing.
- **Supporting EMRS Use and Enhanced EMR data quality:** M&E staff (EMR data clerks, Data Officers and M&E Officers) continue to support EMR system usage in all DSD-supported and TA-supported facilities, which has led to improved data quality. All client records are updated in the system, clearing of backlog (after system downtime) is done systematically, and reports are generated timely facilitating monitoring of progress. Reports generated from EMR are shared with site staff for further review and action. All EMR system issues are documented, communicated to district M&E and EGPAF HIS Officers and reported to the EMR helpdesk for further assistance.
- **Central M&E Support:** Central M&E team continues with quarterly district and site supervision where site and district M&E staff are supported in various areas from data collection, reporting, documentation checks and review of weekly dashboards. Data cleaning tools were discussed and practiced during the supervision. The team also participate in district data review meetings and supervision feedback is given to the staff at site and district level. This exercise is sometimes done collaboratively by both HIS Officers and Baylor M&E Officers.
- **Enhancing Monitoring and Supervision:** District and central M&E teams continue to provide enhanced monitoring and supervision support to all the sites by conducting site data review meetings where performance feedback is shared to site staff. Data verification on monthly and quarterly basis is conducted before DHA supervision starts. M&E prepares site team before DHA supervision by making sure that all sites have cleaned data, updating clients' records in the EMR system, and writing site reports prior to supervision.
- **Site-Level Data Use:** Each site team generates list of clients who missed appointments weekly and interrupted treatment quarterly and uses this to trace clients who need to be brought back to care.
- **Improved Data Quality through Data Audits:** To improve the quality of data and reports, M&E team continue to conduct data audits in collaboration with EGPAF HIS Officers and site staff where thorough, patient-level data cleaning occurs. Teams verify data in the EMR using paper-based sources such as client MasterCard records and ART registers. Duplicates are merged and 'ghost' clients are cleaned from the system.
- **Engagement in various M&E meetings:** Program M&E engaged in monthly USAID Data Rooms and TB/HIV meetings, and quarterly PEPFAR task force meetings. Baylor is serving the role of co-chair in the PEPFAR M&E task force this quarter.
- EMRs backend and get site data dump and run queries on elements specific to that site.
- **TB_PREV and TX_TB reporting challenges:** The National EMR system has challenges with how TB_PREV completion rate is calculated. Notable issues with TB_PREV report from the EMRs

include; some clients reported as not completed yet consumed more than enough pills as per recommendation, clients starting TPT outside reporting period wrongly included in the denominator, TPT history of transfer-in clients TPT drugs not added in the system hence results into not completed etc. **TX_TB** indicator is compiled from several sources: EMRS, MOH ART cohort data, and TB_HIV program data. Because of this we have noted that only TB Initiation sites are reported in TX_TB(N) even though TX_TB(D) includes all facilities supported regardless of whether is a TB initiation site or not. This results into poor TB screening coverage reported in DATIM when in actual sense TB screening coverage in all Baylor supported sites is above 95%.

Continuous Quality Improvement (CQI)

To maintain CQI across all Baylor supported sites, the M&E team continues to provide support through the data feedback loop process which facilitates identification of CQI interventions at site level. The M&E team assists by:

- Generating list of missed appointments and verifying with client records
- Generating list from EMR of clients who have interrupted treatment >28 days
- Crosschecking the list of clients who have interrupted treatment generated with hard-copy records such as master cards and registers
- Updating the client records in the system with current ART status based on paper-based records or client tracing/ follow-up.
- Supporting site team with list of clients who need follow up for clients who have truly interrupted treatment. Priority to those with phone numbers and updating tracing outcomes in client records and EMR system.
- Ensuring clients' outcomes in the system are updated after follow-up
- Regularly (weekly) producing EMR reports to monitor the progress of TX_CURR
- Supporting facility staff in clearing site backlog of un-entered patient records.
- Submitting Tingathe program weekly, monthly reports into SurveyCTO for programs reporting.
- Reporting and following up all EMR issues with district HIS officers and through "EMR help desk" and issue reporting log.
- Conducting virtual and physical supervision to support sites on reporting through WhatsApp and phone calls. Data queries of irregular submissions followed up.
- Data reviews sent to sites weekly through WhatsApp on progress of key indicators

In Q3 of FY22, Tingathe CORE program continued to support sites to use the Tingathe CQI model to identify gaps in program performance and working to address them. The support was done through virtual as well as in-person coaching sessions to all sites implementing CQI projects. This helped to strengthen the capacity of staff in using the CQI tools.

One key component of the Tingathe CQI model is the root cause analysis which dives into the problem to identify its root causes. The program supported the site teams to build their skills, and experience in using root cause analysis tools such as the fishbone diagram and the 5 WHYS, as they worked to improve their sites' performance. The program also supported the teams through the development of site-specific interventions which they implemented to achieve improved performance.

The Tingathe program also collaborated with EGPAF to support sites that are implementing the Malawi AHD collaborative that aims at reducing mortality caused by AHD. The project is implemented by EGPAF with support from Bill and Melinda Gates Foundation. Five Tingathe project supported sites are part of the collaborative, and Tingathe staff joined the supportive supervision sessions which were conducted in June 2022.

In June 2022, the program conducted a virtual learning session to share lessons and experiences from the implementation of the AHD CQI project that was initiated in Q2 of FY22. This session enabled knowledge sharing across the 95 Tingathe supported sites as a means of facilitating spread of best practices. The six participating sites also shared action plans for further improvement or sustaining their achieved performance. Sites that had poor performance in AHD were encouraged to initiate CQI projects in their sites.

Summary of CQI projects implemented during this reporting period

Two major CQI projects were implemented in this quarter aiming at improving AHD screening in new ART clients and improving EID testing coverage. A total of 15 sites are part of the program led CQI projects. The aim is to facilitate rapid spread of effective interventions where the few sites gather best practices into a package of effective interventions that are shared to other sites at district level. The sites then initiate CQI projects and use the package of the consolidated effective interventions to improve performance in their sites.

The two key CQI projects implemented in the quarter are described below:

1. Improving AHD screening in New ART clients

A total of 6 sites are implementing this project in four Tingathe supported districts. In Q3, these sites engaged in implementing the interventions they developed to address the root causes for low AHD screening in new ART initiations. Some of the most effective changes they made were to build capacity of MOH partners through AHD orientation meetings, changing the client flow to have clients assessed for AHD before receiving medication and allocating CHWs to escort eligible clients through the screening process. The graph below shows the results observed.

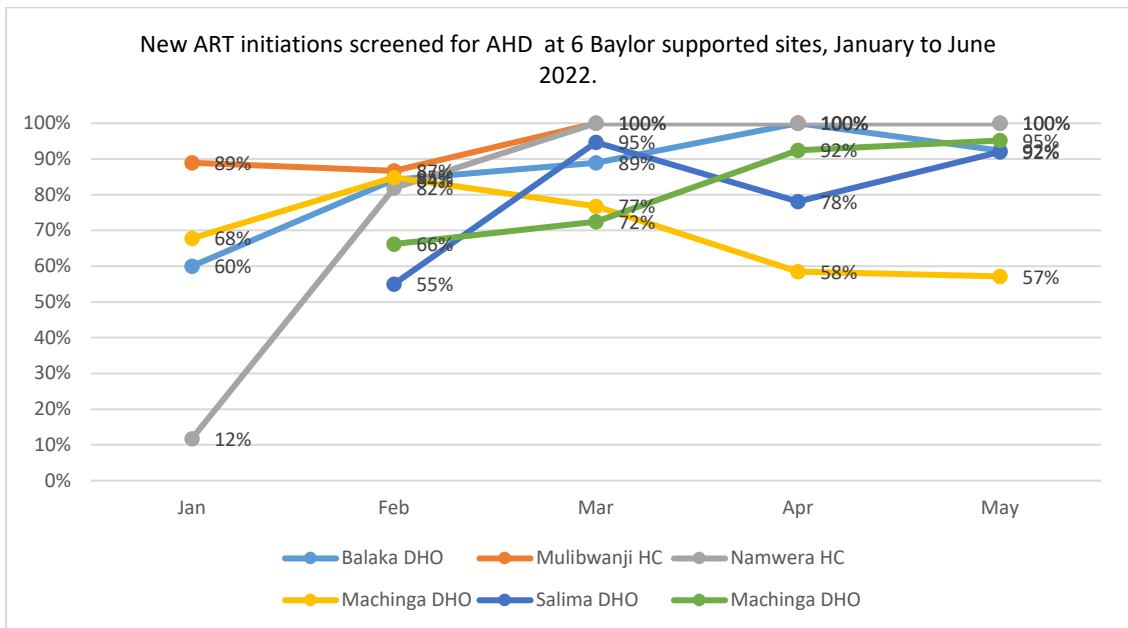


Figure 48: CQI - New ART initiations screened for AHD at 6 Baylor supported sites, January to June 2022

As observed in the graph, Mangochi District Hospital did not improve screening despite making changes to the clinic processes. A key lesson that was learnt from this site was the importance of conducting a comprehensive root cause analysis and the importance of partner collaboration that strengthens the multidisciplinary team QI activities. In June 2022, the site conducted another in-depth root cause analysis and it is currently testing suggested changes for improvement, preliminary data shows an improved trend which will be reported in the subsequent quarter.

2. Improving EID coverage in two districts

A total of 8 sites are implementing this project in two (Machinga and Mangochi) of the five Tingathe supported districts. Both districts have 4 sites with Mangochi District initiating the CQI project from April, and Machinga District from May. The teams conducted root cause analysis to identify the main causes of low EID coverage for 2, 12 and 24 months. Some of the causes identified were related to 1) documentation of test results in pink cards and registers, 2) un-synchronized appointment dates of mother and exposed infant, 3) Mothers coming to clinic without the infant, 4) providers missing clients who came during days other than Mother Infant Pair clinics, and 5) mothers defaulting care or moving to Mozambique especially in sites close to the borders. The teams progressed to testing the changes they suggested for addressing the root causes. There is indication that EID coverage in these sites will improve however, the sites need more time to implement the suggested changes and observe the results for meaningful conclusions.

SIMS Assessments

In May and June 2022, USAID conducted SIMS assessments at 3 sites both in Balaka and Mangochi Districts and impressive results were observed with all assessed sites achieving more than 95% of the standards. A few gaps were observed of which the most common were beyond the program control, i.e. malfunction of air conditioner in pharmacy, commodity stock outs and viral load sample

collection issues. The sites developed remedial plans to improve all standards that were not achieved, including monitoring commodity stock levels weekly and timely commodity relocation.

Activities for the next quarter

In the next quarter the core program staff plan to implement the following:

- Virtual learning session on EID
- Initiating CQI project to improve ICT testing, EID and TB/TPT
- Conducting site quality assurance assessments using the SIMS tool in districts and develop site level improvement plans.

IV. OPERATIONAL RESEARCH

Articles published from April to June 2022

- Masiano SP, Yu X, Tembo T, Wetzel E, Mphande M, Khama I, Mkandawire A, Chitani M, Liwimbi O, Udedi M, Mazenga A, Nyasulu P, Abrams E, Ahmed S, Kim MH. The relationship between adverse childhood experiences and common mental disorders among pregnant women living with HIV in Malawi. *J Affect Disord.* 2022 Sep 1;312:159-168. doi: 10.1016/j.jad.2022.06.028. Epub 2022 Jun 22. PMID: 35752220.
- van Oosterhout JJ, Chipungu C, Nkhoma L, Kanise H, Hosseinipour MC, Sagnò JB, Simon K, Cox C, Hoffman R, Steegen K, Matola BW, Phiri S, Jahn A, Nyirenda R, Heller T. Dolutegravir Resistance in Malawi's National HIV Treatment Program, *Open Forum Infect Dis:* 2022 May; 9(5):ofac148. PMID: 35493118; PMCID: PMC9045949.
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ABSTRACTS

There were no abstracts presented during this reporting period

V. MANAGEMENT & OPERATIONS

Program Operations

In the reporting period (April to June 2022), Tingathe achieved the following key management activities;

- Licensed 14 new motorbike riders
- Procured and received 14 new motorbikes for use in the 5 supported districts (Balaka, Machinga, Mangochi, Phalombe and Salima).
- Received 8 new Land Cruisers to be deployed for program support in the 5 supported districts.

Financial Management

From April- June 2022, Tingathe had adequate funding to support implementation of program activities. Tables A and B below show summary by budget line item and location respectively.

A) By major budget Line Item

Budget line item	April- June 2022			
	Budget	Expense	Balance	% Spending
Salary	1,784,887.47	1,500,505.04	284,382.42	84%
Benefit	269,052.73	239,085.82	29,966.92	89%
Equipment				
Sub awards	589,694.43	582,267.37	7,427.06	99%
Construction	-	27,783.93		
Training	143,014.77	221,219.78	- 78,205.01	155%
Travel	133,917.50	128,542.96	5,374.54	96%
Supplies	24,719.38	10,209.45	14,509.92	41%
Other direct cost	320,973.77	418,729.28	- 97,755.51	130%
Total Direct cost	3,266,260.05	3,128,343.63	165,700.36	96%
Indirect cost	267,656.56	201,820.29	65,836.27	75%
Total cost	3,533,916.61	3,330,163.92	203,752.69	94%

B) By Location

Location	April- June 2022			
	Budget	Expense	Balance	% Spending
Head Office	1,161,020.15	1,175,844.69	- 14,824.54	101%
Balaka	282,524.20	230,656.90	51,867.30	82%
Machinga	469,519.28	466,143.70	3,375.57	99%
Mangochi	772,050.48	736,449.38	35,601.10	95%
Phalombe	361,455.27	316,344.61	45,110.66	88%
Salima	219,690.67	202,904.35	16,786.32	92%
Total cost	3,266,260.05	3,128,343.63	165,700.36	96%
Indirect cost	267,656.56	201,820.29	65,836.27	75%
Total cost	3,533,916.61	3,330,163.92	203,752.69	94%

VI. SUCCESS STORY

Nalisiwe supports daughter fight high viral load.

Nelia* is a 2 ½ year old who lives with her parents and two siblings. Her mother Nalisiwe** found out she was living with HIV during Nelia’s pregnancy and started ART. Nelia was enrolled in care with her mom and initially had a negative HIV test at 6 weeks old however at one year old Nelia tested HIV positive and started ART.

Nelia was initially started on pediatric ART regimen 9p with LPV/r granules that have a very bitter taste and are difficult to administer to children. Like many guardians, Nelia’s mother struggled to give Nelia her medication even though she tried very much. Despite all of her mother’s efforts, Nelia had a high viral load which was very disappointing to her mom who was trying so hard to take good care of her.

Nelia started losing weight and her mother felt she was letting down her daughter and that that all the efforts were for nothing. “The results were really disappointing. I knew that that the high viral load means that the fight against the virus is a long way for me and my daughter” narrated Nalisiwe.

When she received the high viral load results, her mother met with a psycho-social counsellor who supported her as she cared for her daughter. She also was started on pediatric dolutegravir that was now available to her in Malawi and is much better tasting and less challenging to administer. She started the new medications and felt empowered and happy as Nelia did not mind the taste of the new pDTG and took it much more easily.



Nelia stopped losing weight and her follow up viral load on her new ART regimen showed that her virus was undetectable. This was the exciting moment especially for her mom who had been working so hard to care for her daughter. Today Nalisiwe is a very happy mother witnessing Nelia continuously getting better and growing stronger. “I am very happy my child (Nelia) is growing like any other child and my gratitude to Baylor-Tingathe team for the support. I am able to concentrate on my business and farming since Nelia is not getting sick the way she used to”, she narrates

Nalisiwe continues to honour Nelia’s appointments and supporting her adherence as she watches her child grow. She is confident and feels that that through the knowledge and the support she got from the Tingathe team she hopes to share her experience and support other women who are facing similar challenges in administering drugs to their children. At family clinic days guardians are offered an opportunity to meet other guardians and share experience with their peers.

* Both Nelia and Nalisiwe are pseudonyms