ENDING TB AND AIDS AN INTEGRATED MULTISECTORAL RESPONSE THE MALAWI EXPERIENCE

MALAWI

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Secretary for Health
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Presentation outline

- Background
- Key governance issues
- Key programmatic interventions

Background – Malawi

- Population – 18 million
- 1.1 million people living with HIV
- In 2016, TB incidence 29 000, of whom 15 000 occurred among people living with HIV
    - 2900 TB deaths among people who were HIV negative plus an additional 6000 TB deaths among people living
    - 78% of TB patients were living with HIV in 2006, now down to 49% in 2016
- ProTEST studies in 1996/1997 (Malawi, South Africa and Zambia)
    - formed the evidence base for WHO policy on collaborative TB/HIV activities.
    - studying TB/HIV integration, IPT, CPT and community involvement in care –

Key governance issues

- Malawi Growth and Development Strategy III
  - Health and Nutrition are core pillars.
- Workplace HIV programmes 2% of budget in all government departments.
- HIV governance structures at levels
  - national level TWGs develop and review policy and undertake technical review
- District level TB/HIV coordinator
- Policy documents at all levels
  - National Strategic Plans (HSSP),
  - Costed National Community Health Strategy,
  - TB/HIV operational framework;
  - Community and Treatment Guidelines
- CHWs are on government payroll
- Partner collaboration through national reviews, TWGs, research dissemination fora, district implementation etc

Access to care

- 732 health facilities (private and public sector)
  - TB services in 342 facilities mostly public sector
- TB and HIV services provided in a '**one-stop shop**' by environmental health officer (CHW), who supervises health surveillance assistants (HSA)
- TB/HIV/Malaria treatment and care is free at public facilities
- Private facilities have a Malawi Business Coalition on HIV Care

Key programmatic interventions

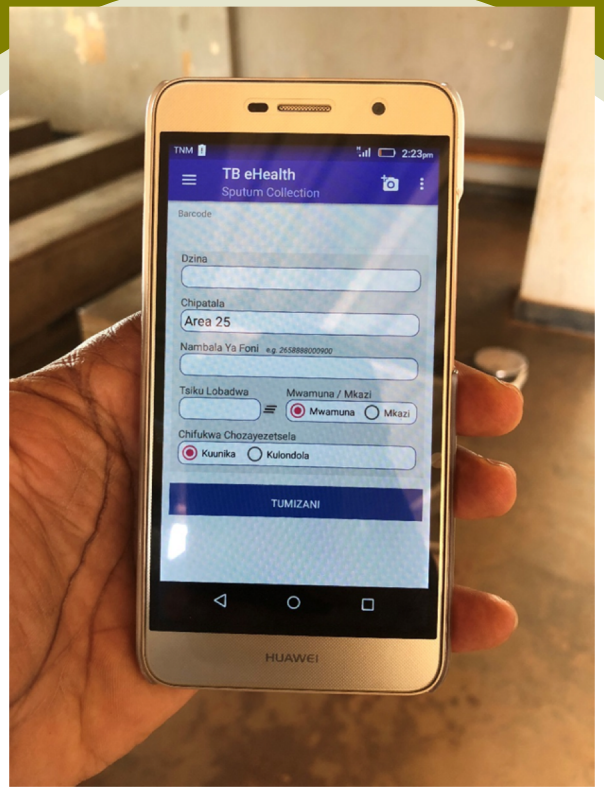
- Joint TB and HIV planning
  - Development of NSPs
  - Funding concepts (Global Fund)
  - Guidelines
- Joint TB/HIV supervision at facility and community levels
- Joint TB/HIV mentorship programs which follow on supervisions targeting specific areas of need
- Isoniazid Preventive Therapy (IPT) for children and adults
  - NTP leading in the former while DHA leads in the latter

Mobile health vans

- Health education
- TB screening with presumptive cases going to digital Xray and GeneXpert TB testing
- HIV testing and counselling
- Patient referral
- Service urban areas with high TB prevalence (1000/ 100,0000)
- Reduce patient cost by bringing the services to communities.
- District level coordination with community structures to create demand

eHealth intervention

- Community volunteers screening at door step
- Information transmitted to next level at facility
- Facility expects specimen within a recommended period otherwise follow ups are made
- Laboratory linked and reports back to referring volunteer and client through sms
- HIV module is being piloted



e-Health Innovation linked to mobile van

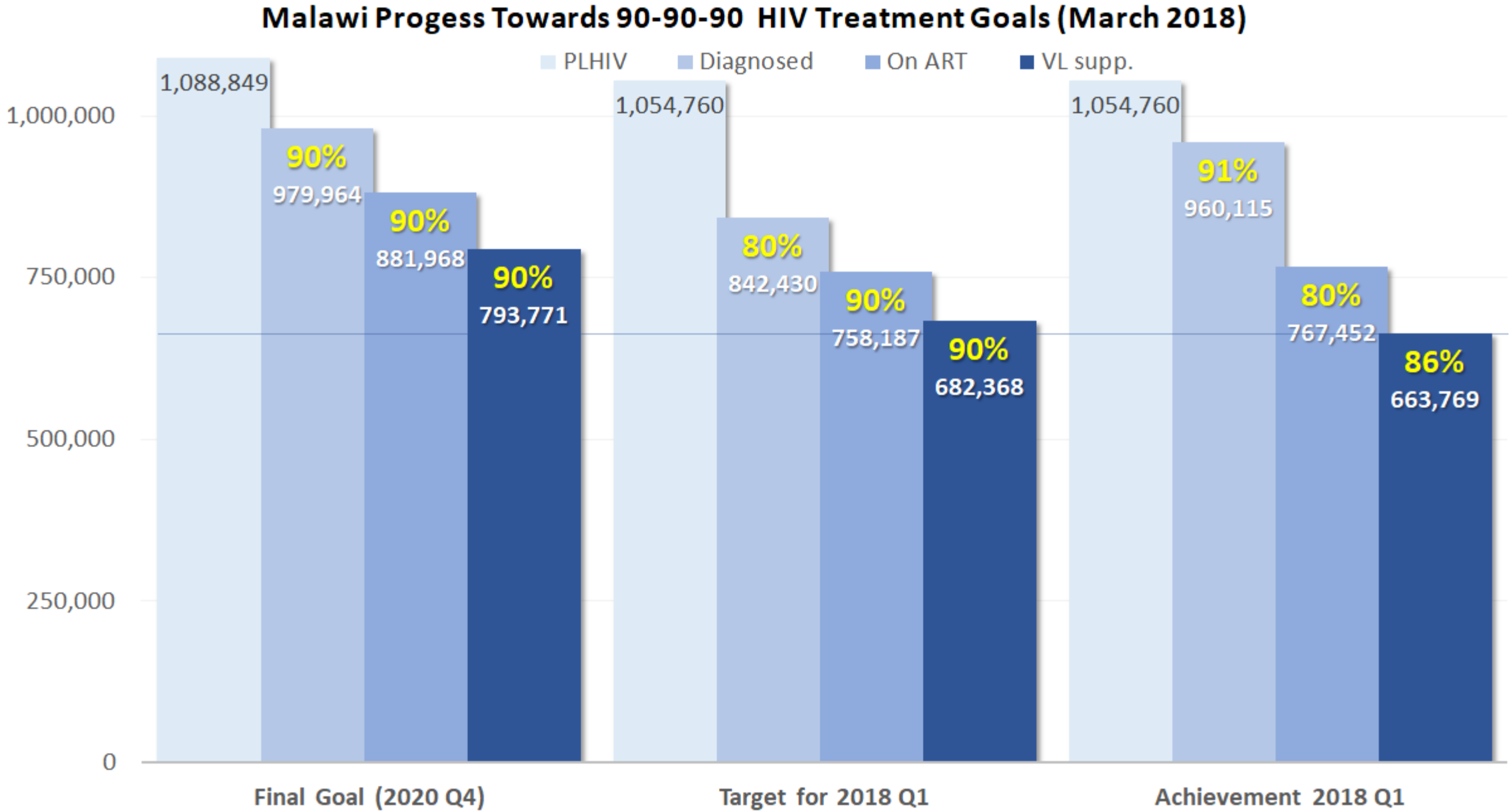
- Visiting World Bank mission being taken through the app by an elderly volunteer at one rural area

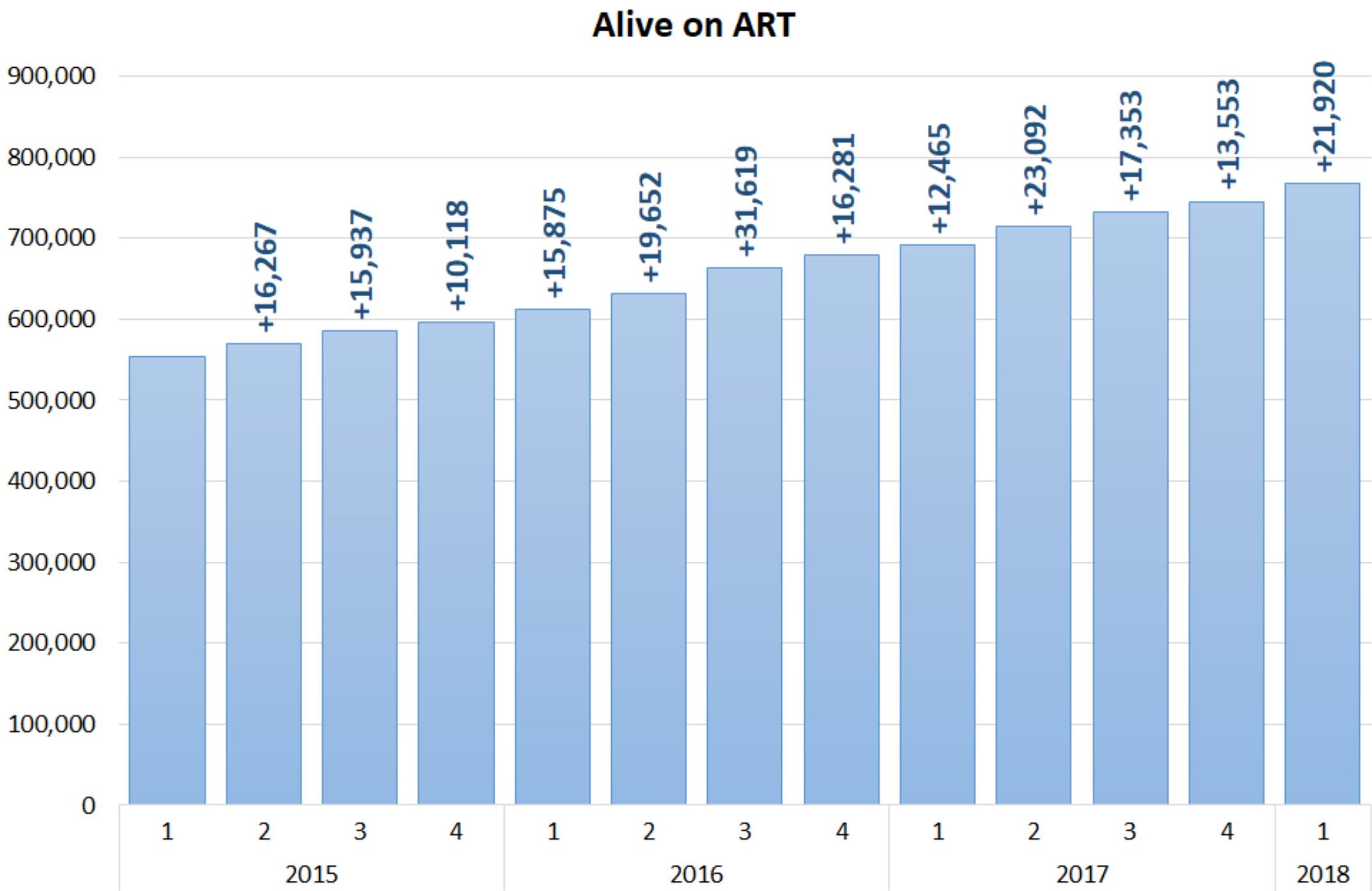
Stakeholder engagement

- Anti-microbial resistance (AMR) - Africa CDC
- TB in the mines, cross-border disease surveillance, one-stop border clinics
  - SADC, NEPAD and Economic Community of East and Southern Africa (Zambia, Mozambique, Lesotho, Malawi)
  - Engagement between mine owners, miners and mining communities promoting TB and HIV- screening and referrals
- Community level activities - ActionAid, PARADISO patient trust, MANASO
- Media trainings and fora on TB and HIV
- Education - primary school teachers and teaching materials on TB and HIV
- Engaging of private providers and traditional healers

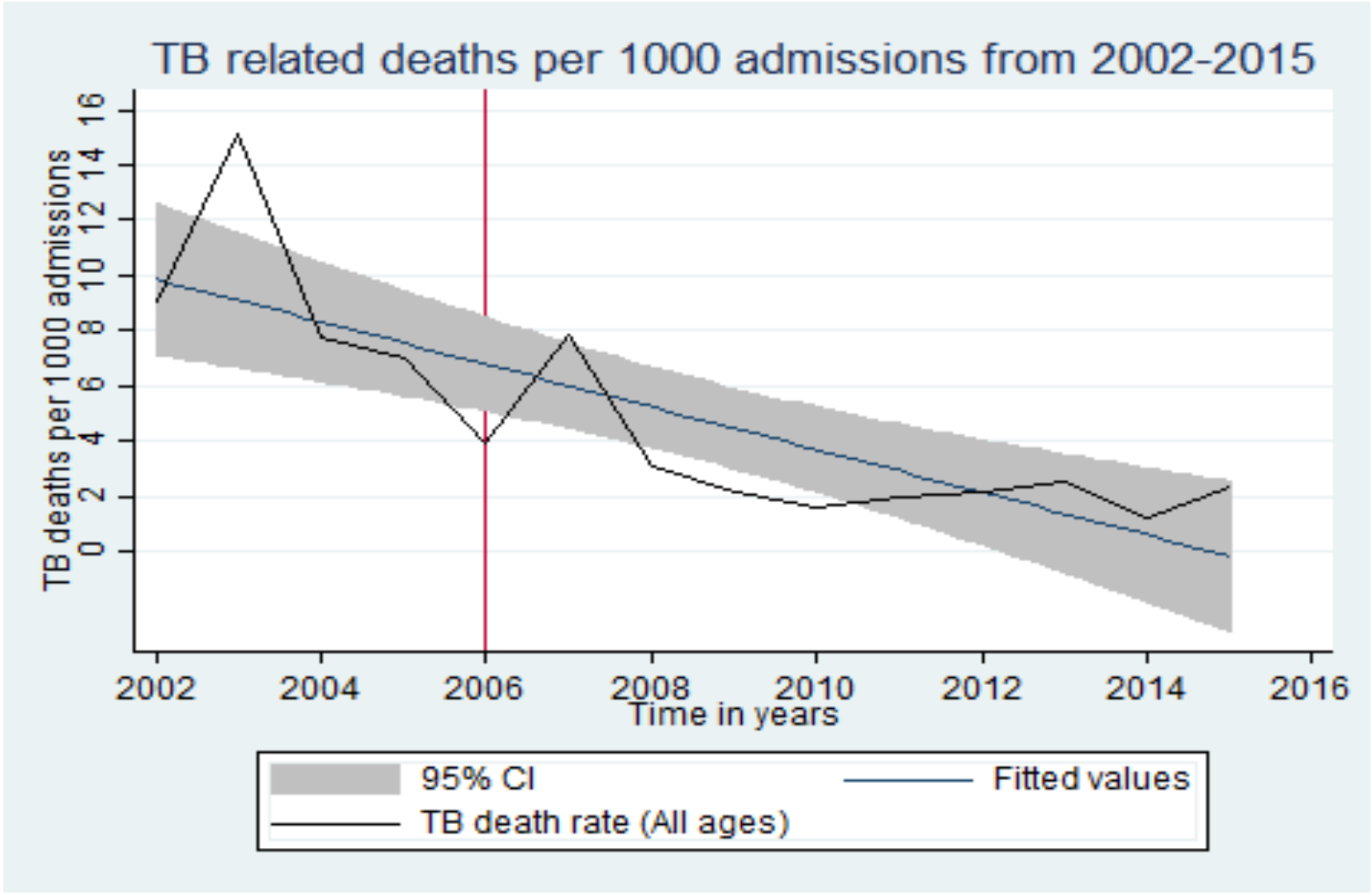
Selected results …

- TB screening among PLHIV - 98%
- Rapid rise of community referrals
- TB/HIV coinfection at around 49% a decline from over 70% in 2008
- HIV testing among presumptive TB cases is at 85%
- TB incidence declined by 40% over the last 4 years of implementation of these initiatives (without the vans) and community referrals improved thereby narrowing the gap in missed TB patients among PLHIV (<40%).
- HIV testing among TB patients is at 99% (TB cases with documented HIV status)

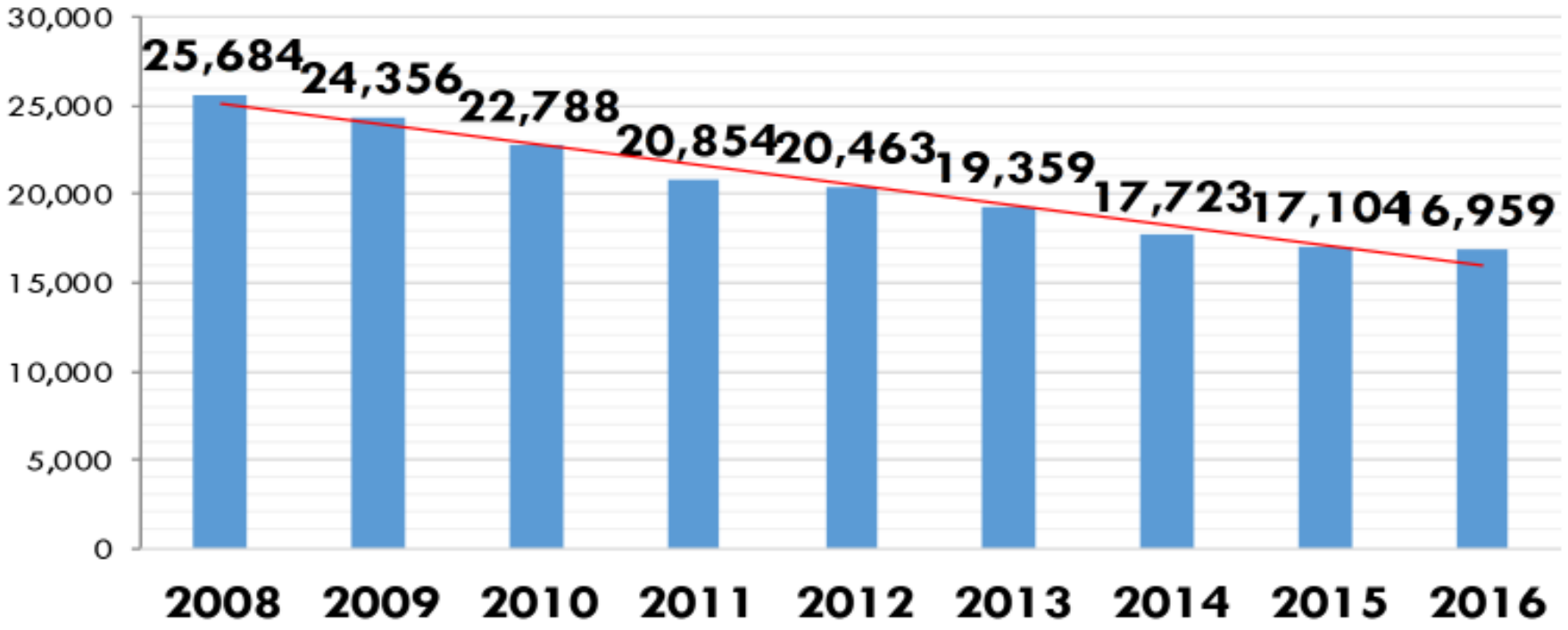

Malawi Progess Towards 90-90-90 HIV Treatment Goals (March 2018)
PLHIV
Diagnosed
On ART
VL supp.
1,000,000
750,000
500,000
250,000
0
1,088,849
90%
979,964
90%
881,968
90%
793,771
1,054,760
80%
842,430
90%
758,187
90%
682,368
1,054,760
91%
960,115
80%
767,452
86%
663,769
Final Goal (2020 Q4)
Target for 2018 Q1
Achievement 2018 Q1


Alive on ART
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
+16,267
+15,937
+10,118
+15,875
+19,652
+31,619
+16,281
+12,465
+23,092
+17,353
+13,553
+21,920
1
2
3
4
1
2
3
4
1
2
3
4
1
2015
2016
2017
2018

As ART coverage increases and integrated services improve TB mortality declines



Trends in TB Case Notification Malawi 2008-2016



Key lessons

- TB/HIV integration is key to mplementation of TB and HIV services and reaching populations left behind
- Government leadership is critical in the success of TB/HIV integrated delivery
- Partner support is key
  - technical, donor, academic and civil society
- Communities and facility staff welcome the community integrated implementation; patient costs reduced
- Strong governance structures at all levels

Finally

Ending TB and AIDS by 2030 is possible only through closer collaboration between TB/HIV programs and strengthening community engagement and empowerment

Thank you very much

Zikomo kwambili

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