



Malawi Operational Plan
COP16
Strategic Direction Summary

July 1, 2016

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Goal Statement

Despite Malawi being among the poorest countries in the world, ranking 174 out of 187 on the UN Human Development Index, the country is a recognized leader for promoting a public health approach to address the significant national HIV/AIDS epidemic. Beyond having designed and been the first to implement Option B+, Malawi is also the first country to include Test and Start and the 90-90-90 objectives for epidemic control within its National Strategic Plan, initiating rollout in mid-2016. This commitment to adopt bold strategies has brought Malawi closer towards epidemic control: there are approximately 34,000 new HIV infections compared to the estimated 67,000 HIV-related deaths annually (Spectrum 2014). Reaching saturation (80% coverage) of HIV+ people on antiretroviral treatment (ART), however, remains a major challenge in the context of an increasingly fragile health system. Malawi has made significant progress in expanding ART access through task shifting and decentralization, but treatment scale-up in the highest burden areas is hampered by one of the severest health worker shortages in Africa, with only 28 nurses and 2 physicians per 100,000 population and a crumbling health facility infrastructure. Reaching missed populations, including men, will also require new strategies to accelerate ART coverage over the next two years.

Consistent with the principle that USG must maximize investments in areas of high HIV burden, the PEPFAR/Malawi program prioritized support to the Ministry of Health in 427 priority sites representing 60 percent of total sites in the country covering 88% of ART patients and HIV burden. This focused approach, which started in COP 2014 and was refined in COP15 is projected to result in 10 of 28 districts reaching 80% ART saturation by 2017, of which 6 are within the 10 scale up districts; by FY 18 half the districts (14 of 28) in Malawi, comprising 77% of the estimated PLHIV, will have reached saturation including Blantyre and Lilongwe. To achieve these targets, COP16 outlines an even more focused approach with additional aggressive interventions in the three highest HIV burdened districts (Lilongwe, Blantyre, and Zomba) and more intensive and targeted efforts in the remaining seven scale-up districts. Eighteen¹ districts will receive sustained PEPFAR support, a shift from 14 in COP 2015. COP16 outlines strategies for increased and targeted HIV testing; the roll out of differentiated care models to enhance efficiency and quality, and more active measures to improve adherence, retention in treatment, and viral suppression. There is an additional focus on community-based service delivery models to facilitate the decongestion of high burden facilities and to more effectively reach men and others who are not actively seeking services at health facilities. Saturation targets cannot be achieved through these programmatic interventions alone. Investment in health infrastructure and the health workforce, focused on the three highest HIV burdened districts, will be critical. PEPFAR/Malawi is submitting a supplementary request with this COP submission to address these challenging bottlenecks which will inhibit attainment of FY 17 and 18 targets. With COP16 resources and through strategic leveraging of a new high value Global Fund grant - particularly for HIV commodities, interventions reaching adolescent girls and young women and key populations, PEPFAR/ Malawi is well positioned to accelerate Malawi's progress toward achievement of 90-90-90 goals.

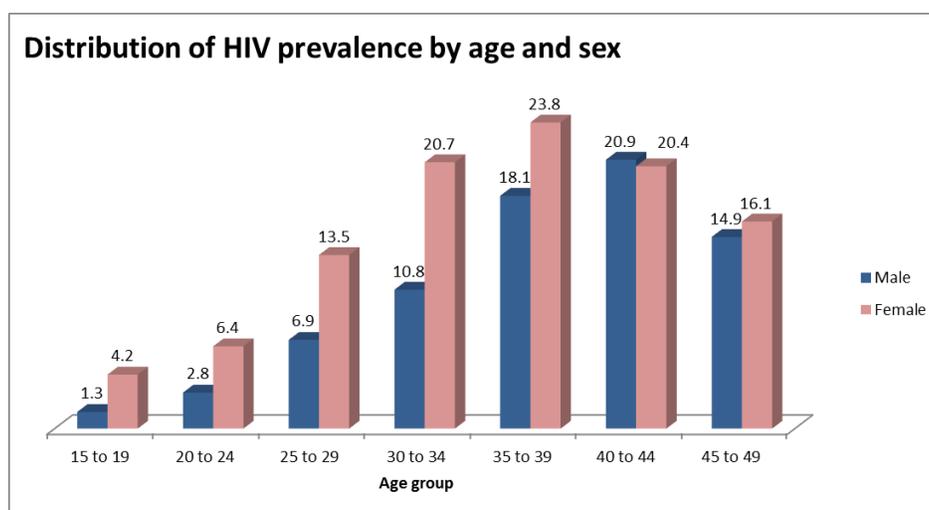
¹ Note that Chiradzulu receives only commodity support

1.0 Epidemic, Response, and Program Context

The Demographic and Health Survey (DHS) and Malawi Population HIV Impact Assessment (MPHIA), available by the end of 2016, will provide robust data for a more accurate picture of the HIV epidemic. In the absence of this updated information, data used to define intervention strategies and targets originated from older sources, and may not accurately reflect the current status of the HIV/AIDS epidemic in the country.

HIV prevalence among adults (15–49) increased sharply in Malawi in the 1990s, peaking at 16.4% in 1999 and declining to 10.6% by 2010. HIV prevalence is highest in the densely populated Southern region (14.5%), followed by Central (7.6%) and Northern regions (6.6%).² HIV ‘hot spots’ are found across all districts, primarily along major transportation routes, and in areas where large agricultural or business interests exist³. HIV prevalence varies considerably by gender, age, socio-economic characteristics, and geographic location., HIV prevalence in the 15-49 age group is higher among women (13%) than men (9%); 58% of PLHIV are female (Figure 1.1.1)

Figure 1.1.1 Distribution of HIV prevalence by age and sex



Source: MDHS 2010

Figure 1.1.2 shows the geographic distribution of HIV, which broadly aligns with the population density. This translates into a considerable concentration of PLHIV in the south and in a few urban and market centres in the north and central regions. In 2013, over 50% of the estimated 1 million PLHIV were living in six of Malawi’s 28 districts, which account together for 42% of the country’s population (all six in the

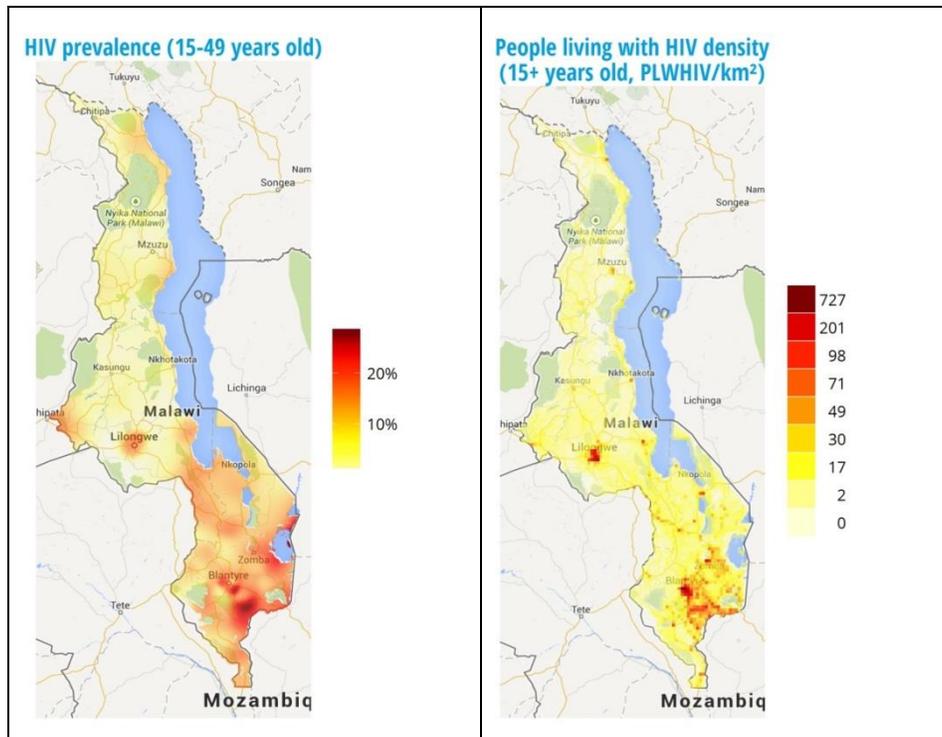
² National Statistical Office (NSO) and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010*. Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro.

³ St Johns Mission Hospital in Mzimba district has a HIV testing yield of 10% although the district prevalence is 5.1%. Dwangwa Matiki clinic. In Nkhhotakota has an HIV positive yield of about 9% whereas the district HIV prevalence is estimated at 3.1%.

south); Lilongwe and Blantyre account for 26% (279,369) of the total estimated PLHIV. Urban/rural differences in HIV prevalence are more pronounced in the northern and central regions.

Although there has been an observable decline in HIV prevalence, the absolute number of people infected with HIV has been offset by the rapid population growth combined with stable incidence and rapid ART scale up over the last decade, resulting in a modest reduction in the number of PLHIV, from an estimated 1.1 million in 1999 to 1.0 million in 2013.⁴

Figure 1.1.2 HIV Prevalence and PLHIV Population Density



Between 2010 and 2015, the number of patients on ART increased 232% from 251,000 to 585,660⁵. By 2015 over half of PLHIVs were receiving treatment. This rapid increase was in large part due to the integration of the ART and PMTCT program for Malawi’s Option B+ policy in 2011, an effort which required massive decentralization of ART/PMTCT services. Since the implementation of Option B+ in 2011, cumulatively about 85,000 pregnant and 30,000 breastfeeding women had started ART by the end of 2015; about 60% of HIV positive pregnant women were already on ART when getting pregnant⁶. The number of children infected through MTCT (including during the breast feeding period) has declined by

⁴ UNAIDS. The GAP Report. Geneva, 2014.

⁵ Integrated Quarterly HIV Program Report July-September 2015(MoH).

⁶ Option B+: A Stepping Stone to Universal Treatment; CROI Abstract 2016

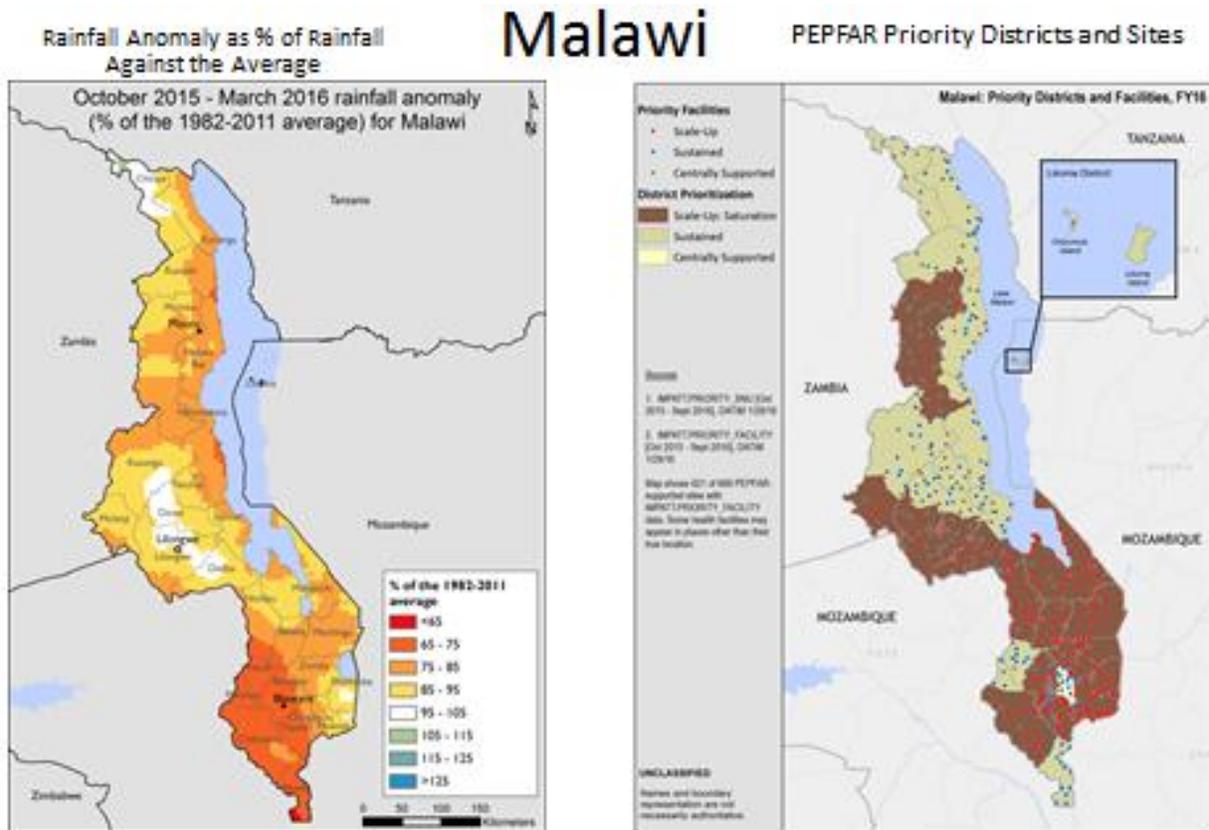
66% (from 30,000 in 2010 to 10,000 in 2014). In spite of ART scale-up, HIV remains the leading cause of death among adults. In 2013, 38,000 (66%) of 56,500 deaths in this age group were attributed to HIV.

Despite impressive gains in addressing the HIV epidemic, there are significant contextual concerns that are already affecting progress. Extreme poverty is pervasive with a per capita GDP of \$262. Eighty-five per cent of households are engaged in agriculture but they account for only 30% of GDP, a reflection of low productivity, which is rooted in small land holdings made smaller by population growth, degraded soils, uncertainty due to climate change and other economic and policy barriers. Poor domestic revenue generation at national level has constrained growth in domestic resources for the health sector. More recently the country instituted a hiring freeze for the civil service because the national budget can no longer effectively accommodate a constantly increasing wage bill, particularly in light of limited government revenues.

Emerging humanitarian crisis

Malawi, emerging from one of the worst food security crises in its history, is facing the prospect of an even worse humanitarian situation in the coming year as a result of severe El Niño effects. In 2015, unprecedented flooding in southern Malawi was followed by an early cessation of the rains nation-wide and considerably below average crop yields with maize production approximately 30-40% below last year's already reduced crop. As a result, 2.86 million Malawians required food assistance during all or part of the 2015/2016 "hungry" season from October through April. The GoM and USAID predict that between 6-8 million Malawians will require food assistance this year, beginning in July and extending through April, 2017. The area most affected is the southern part of Malawi which is also where the highest HIV burden is (see map below). It is likely that large numbers of households will actually require food assistance during May and June 2016, but resources for the response are depleted and no assistance is planned for this two-month interim period. The estimated total cost of the response for 2016/2017 is approximately \$400 million, but could well be significantly more. GoM declared a disaster declaration and humanitarian appeal with the need to import approximately 1.3 million metric tons of maize this year.

The USG country team is working across agencies and programs to develop contingencies for the emergency that will facilitate the protection of development gains to the extent possible during and after the crisis. The impact is already being felt in the HIV response with increased anecdotal reporting that transactional sex is on the rise as women seek additional income to purchase food and indications from partners that food assistance may be needed for ART patients in order to avoid defaults in treatment. The team notes for the record that it may be necessary to request support for limited reprogramming or supplemental funding to mitigate the impact of the crisis on our ability to meet targets during FY 16 and FY 17. (see Appendix D)



****Generally speaking, the impacts of El Nino on food security correspond geographically with rainfall deficits. Thus, these maps provide a geographic representation of the severity of El Nino on food security per country.**

The GOM spends only \$7.60 per capita per annum on health. Substantial donor resources bring Total Health Expenditures to \$39 per capita per annum, compared to an average of \$147 for the Southern Africa region. The HIV sector is heavily dependent on donor support, receiving 74% from Global Fund (GF) and PEPFAR and a further 12% from other donor resources. The GF principally supports the procurement and distribution of ARVs and other key commodities, supply chain management, minimal HRH pre- and in-service -training, and community interventions. Infrastructure and HRH remain critical gaps that have not been adequately supported. These areas require, therefore, the coordination of other donors, including USG, to meet the most critical needs. A request for reprogramming of GF grant savings (\$8.8 million) due to a reduction in the price of commodities to temporarily support salaries for 1,200 new health workers has yet to be approved.

Malawi's adoption of Test and Start in April 2016 demonstrates the national commitment to aggressively address the epidemic and to achieve the 90-90-90 goals nationally by 2020.

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		<15				15+				Source, Year
	N	%	Female		Male		Female		Male		
			N	%	N	%	N	%	N	%	
*Total Population	15,950,593	100	3,741,105	23.5	3,911,222	24.5	4,080,250	25.6	4,218,015	26.4	Spectrum estimates, 2015
Prevalence (%)		6.6		1.6		1.7		11.6		7.6	MoH, 2014
AIDS Deaths (per year)	29363		2,916		5,679		10,802		23,684		Spectrum estimates, 2015
PLHIV	1,065,491 ⁷		61,200		64,675		564,617		374,999		Spectrum estimates, 2015
Incidence Rate		0.21		0.11		0.11		0.35		0.26	Spectrum estimates, 2015
New Infections	34,000										Spectrum estimates, 2015
Annual births	651,700	4.1									UNICEF, 2013
% >= 1 ANC visit	43,866	95	NA	NA			NA	NA			UNAIDS, 2013; UNICEF, 2013
Pregnant women needing ARVs	59,703	9.2									Spectrum estimates, 2015
Orphans and Vulnerable Children	1,438,564 of which 958,740 are orphans ⁸	9%	NA		NA		NA		NA		DHS 2010 projection for 2015 for OVC
TB cases (Yr.)	17,779		NA		NA		NA		NA		WHO, 2013
TB/HIV Co-infection	9,998	56%	NA	NA	NA	NA	NA	NA	NA	NA	WHO, 2013
**Males Circumcised											
Males uncircumcised (10-34Yrs)	2,458,727	60%			901,824	37%			1,556,903	63%	DMPPT2.0 Modeling data 2014
Total MSM	38,734	1.84%									Wirtz et al. (2014) Final Report: HIV Prevalence and Socio Economic Characteristics among MSM across seven sites in Malawi
MSM HIV	6,700	17.3%									Wirtz (2014) IBID.

⁷PLHIV number used in our target setting was different from Spectrum value indicated in this table because the Spectrum did not have district-level estimates. Thus, MOH estimates were used instead.

⁸ An orphan is defined as having lost one or both parents

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
Prevalence											
Total FSW	55,000	1.5%									GFCN, 2014
FSW HIV Prevalence		62.7									IBBS 2015 for prev Size estimate GFCN 1.5% total pop 15-49*
Total PWID	NA	NA									
PWID HIV Prevalence	NA	NA									
Priority Populations											
AGYW (15-24)	1,610,902										Projected from Census 2008
AGYW Prev. (15-24)		4.2% (15-19) 6.4% (20-24)									UNAIDS 2014, DHS 2010: prev in AGYW was 5% and in all 15-49 was 11%
Female Estate Workers	NA	NA									
Female Estate Workers Prev.		22.7									
Male estate workers Prev		15.3									
Prisoners	12,000										GF-CN
Prisoner Prev.	3,642	19.7-41									Prisons Study, 2012
Police	14,717	100					2,765	19%	11,952	81%	NAC, unpublished data

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)*

				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	15,950,593	6.6	1,065,491	654,343	613,227	92,338	85%	2,055,254	122,316	101,377
Population less than 15 years	7,652,327	1.7%	125,875	51,496	51,496	7,885	85%	184,952	11,097	9,987
Pregnant Women	613,409	9.2%	59,703	41,115	41,115	21,697	85%	508,768	21,531	19,818
MSM	38,734	17.3%	6,700	NA	NA	NA	NA	NA	NA	NA
FSW	55,000	62.7%	34,485	NA	NA	NA	NA	NA	NA	NA
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

1.2 Investment Profile

A 2012 study calculated that Malawi would require almost 8% of GDP to maintain its entire HIV-positive population on ART, yet Malawi is one of the most donor-dependent countries in the world for its ART program.⁹ Government contributions to the HIV program are expected to increase from US\$ 10,557,083 in 2012-13 to US\$ 12,314,254¹⁰ in 2016-17, a 16.6% increase. Table 1.2.1 shows that 86% of total program expenditures in 2015 were from donors: 74% from combined PEPFAR and Global Fund resources and a further 12% from other donor sources.

⁹ Williams, B.G. and E. Gouws. Affordability, cost and cost-effectiveness of universal anti-retroviral therapy for HIV. ARXIV 2012 [cited 2014 13/08/2014]; Available from:

<http://arxiv.org/abs/1206.6774v2><http://arxiv.org/abs/1206.6774v2>

¹⁰ Extracted from CPF calculation

The majority of key commodities are procured through the Global Fund grant. It is not anticipated that PEPFAR will be required to provide any resources in COP16 for ARVs. Forecasts indicate that there are sufficient resources for ARVs until the end of 2018, inclusive of buffer stock.

Table 1.2.1. Investment profile by program area, GARPR indicator 6.1 data (2016 Malawi Country Report)

Program Area	PEPFAR Absolute*		Global Fund absolute	% GF	Govt absolute	% GRP	Others**	% Other	Total Expenditure
Clinical care, treatment and support	19,936,034	22%	69,783,001	77.8%		0%	7,712,541	9%	89,719,180
Community-based care	3,628,224	45%		0.0%	3,178,276	40%	1,223,457	15%	8,029,957
PMTCT	7,520,578	43%	10,000,145	57.0%		0%	9,855	0%	17,530,578
HTC	8,190,424	100%	0	0.0%	0	0%	0	0%	8,190,424
VMMC	10,909,429	92%	0	0.0%	0	0%	950,061	8%	11,859,490
Priority population prevention***	36,769	0%		0.0%	13,368,873	50%	11,174,321	42%	26,868,679
Key population prevention	375,014	46%		0.0%		0%	436,609	54%	811,623
OVC	2,548,810	100%		0.0%		0%	-	0%	2,548,810
Laboratory****	7,178,598	100%		0.0%		0%	-	0%	7,178,598
SI, Surveys and Surveillance	5,445,965	60%		0.0%	2,741,871	30%	930,816	10%	9,118,652
HSS****	22,801,541	49%	757,846	1.6%	11,723,579	25%	6,108,641	13%	46,815,432
Total	88,571,387	39%	80,540,992	35.2%	31,012,598	14%	28,546,446	12%	228,671,423

*Investment portfolio based on expenditure analysis for fiscal year 2015

** Others include Government of Germany, World Bank DFID, United Nations, private sector etc.

**** Includes other essential programs outside the core HIV/AIDS program (eg. AIDS-specific institutional development, policy dialogue, law reform etc)

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other	
ARVs	111,483,057	6.5	93.5	0	0	
Rapid test kits	7,027,706	28.5	71.5	0	0	
Other drugs	17,438,400	0	100	0	0	
Lab reagents*	13,219,150	0	76.1	0	23.9	
Condoms	2,674,856	12.9	76.1		11	USAID Central Contraceptive Procurement - 12.9% & UNFPA 11%
VMMC kits	3,344,726	0	58	0	42	World Bank
MAT	0	0	0	0	0	
Other commodities (Lubricant)	24,265	0	0	0	100	USAID Central Contraceptive Procurement
Total	155,212,160	47.9				

*Lab reagents includes VL commodities figures

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
ACT	-	-	-			
DREAMS	8,458,647	-	8,458,647	6		Linkages (FHI 360), One-C (JHU), Project SOAR (Population Council), SIFPO 2 (PSI), SIFPO 2 (BLM), ASPIRE, Project Concern International
DREAMS Innovation	-	-	-			
DREAMS Test & Start-Men	2,511,166	-	2,511,166	10	6,752,376	Project SOAR (Population Council); Dignitas International; FISH (PACT); Baylor; SIFPO 2 (PSI and BLM); Linkages (FHI 360); GHSC-PSM Management (Chemonics); MSH; COM
VMMC	10,112,512	-	10,112,512	7	1,967,550	Scaling up male circumcision (JHPIEGO/Sankhani), SIFPO 2 (PSI), ASSIST (URC), Supply Chain Management (Partnerships for Supply Chain Management), USAID), Project IQ (JHPIEGO-CDC), JHPIEGO (DOD)
Viral Load			-			
Other PEPFAR Central Initiatives	4,000,000	-	4,000,000	3	3,150,000	Baobab, NRB, EQUIP, HRH 2030
Other Public Private Partnership			-			
Total	22,082,325	-	22,082,325		11,869,926	

1.3 National Sustainability Profile

Country Overview: Malawi has a strong national HIV/AIDS response; however, the GOM continues to face chronic systems and services challenges to achieving sustained epidemic control. Eight-six percent of the national response is donor-funded, with the USG and Global Fund constituting the largest share of funding. Advocacy for increased GOM commitment to covering costs is ongoing; however, as Malawi is one of the poorest nations in the world, the likelihood of GOM contributing significant levels of additional funding towards the HIV response in the next few years is low.

SID Process: The Malawi SID Consultation was conducted jointly by UNAIDS and the USG on February 2016, and jointly-hosted. Each of the four domain working groups was co-facilitated by a USG and UNAIDS representative. The event was well-attended with representation from a cross-section of stakeholders including the GOM, civil society, private sector representatives, and external donors.

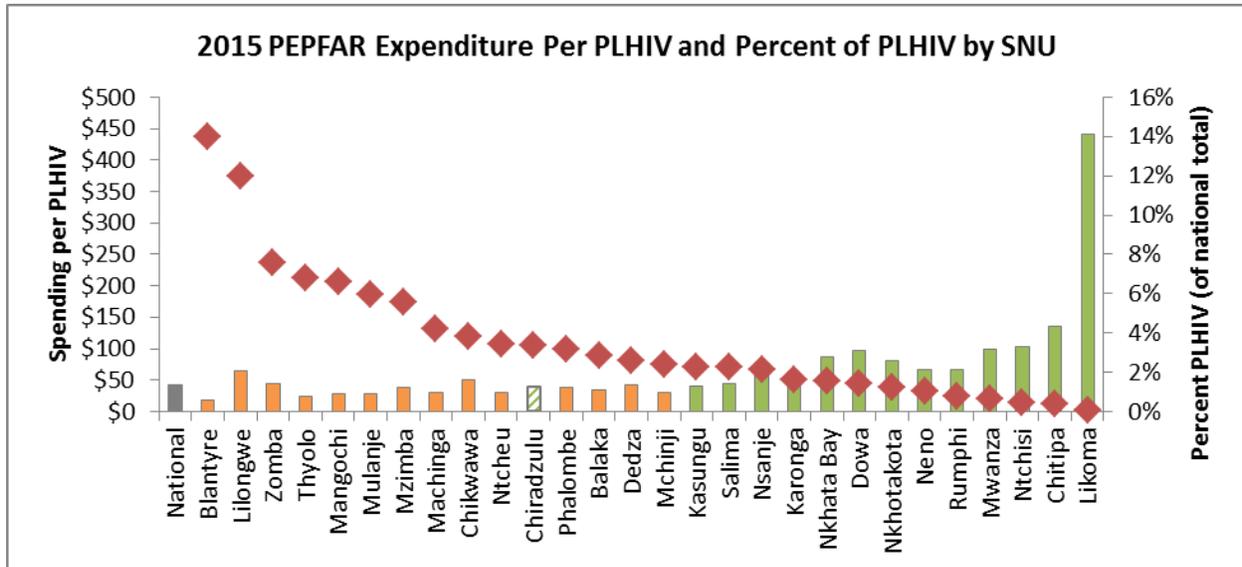
Sustainability Strengths: The two highest-scoring elements for 2016 are *Planning and Coordination*, and *Policies and Governance*. The national strategy, the participatory process for its development, the existence of a mechanism for coordination to track and map HIV/AIDS activities and convene planning and strategy meetings were identified as successes. The establishment of sub-national unit performance targets in 2015 was recognized as progress towards achieving goals. High scores in the *Policies and Governance* element are attributed to the existence of a wide range of policies to support the national response in HIV treatment initiation, service delivery, non-discrimination protection and recognition of the right to access services. Engagement of civil society and the private sector as key stakeholders to inform the national response are also strengths. Other noted successes include existing structures to promote community engagement in service delivery; incremental growth in domestic financing for HIV/AIDS; availability of HIV clinical data; regularity of surveys and surveillance; and the effectiveness of the government to collect expenditure data through the GARP, NASA and NHA.

Sustainability Weaknesses: The GOM continues to face chronic systems and services challenges in achieving sustained epidemic control and greater long-term planning and partnership is required. . The lowest-scoring elements are *Technical and Allocative Efficiencies* and *Epidemiological and Health Data* – both scoring as unsustainable. Limited accountability for how resources are tracked and monitored was noted as vulnerability. Under *Epidemiological and Health Data*, most surveys and surveillance rely on significant external TA. Nationally-approved data quality assurance policies and procedures were not in place and, while there is cost tracking, cost-effectiveness and cost-efficiency analyses are not done. Data analysis was an additional vulnerability as most results are not presented against targets to measure achievement

1.4 Alignment of PEPFAR investments geographically to disease burden

In FY 2015, PEPFAR spent on average \$19¹¹ per PLHIV in Malawi nationally. Individual district expenditures per PLHIV ranged from \$4.60 to \$170¹². The analysis showed that districts with the highest number of PLHIV received the largest amount of resources for care and treatment (Figures 1.4.1, 1.4.1b). This COP presents an intensified geographic focusing which will result in an even greater alignment of HIV burden and PEPFAR resources.

1.4.1 Alignment of PEPFAR investments geographically to disease burden ¹³

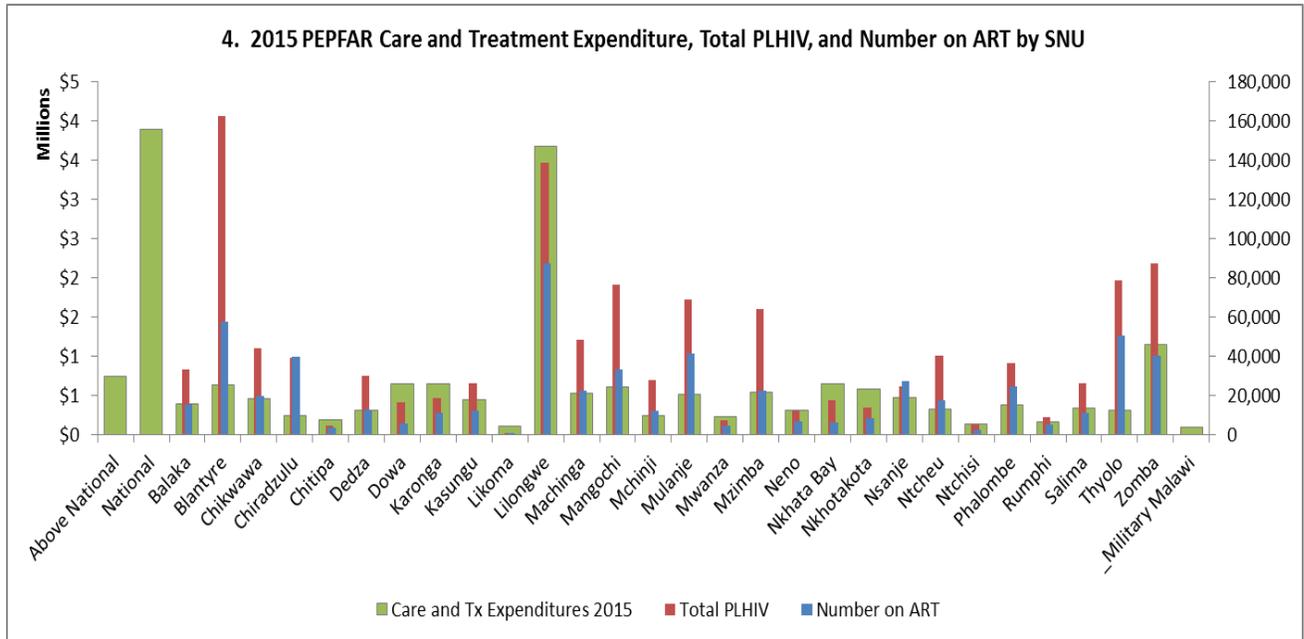


¹¹ This reflects cost to PEPFAR and therefore does not include ARVs purchased through the Global Fund

¹² Most districts do not exceed \$100; the highest cost is in Likoma District due to its difficult access.

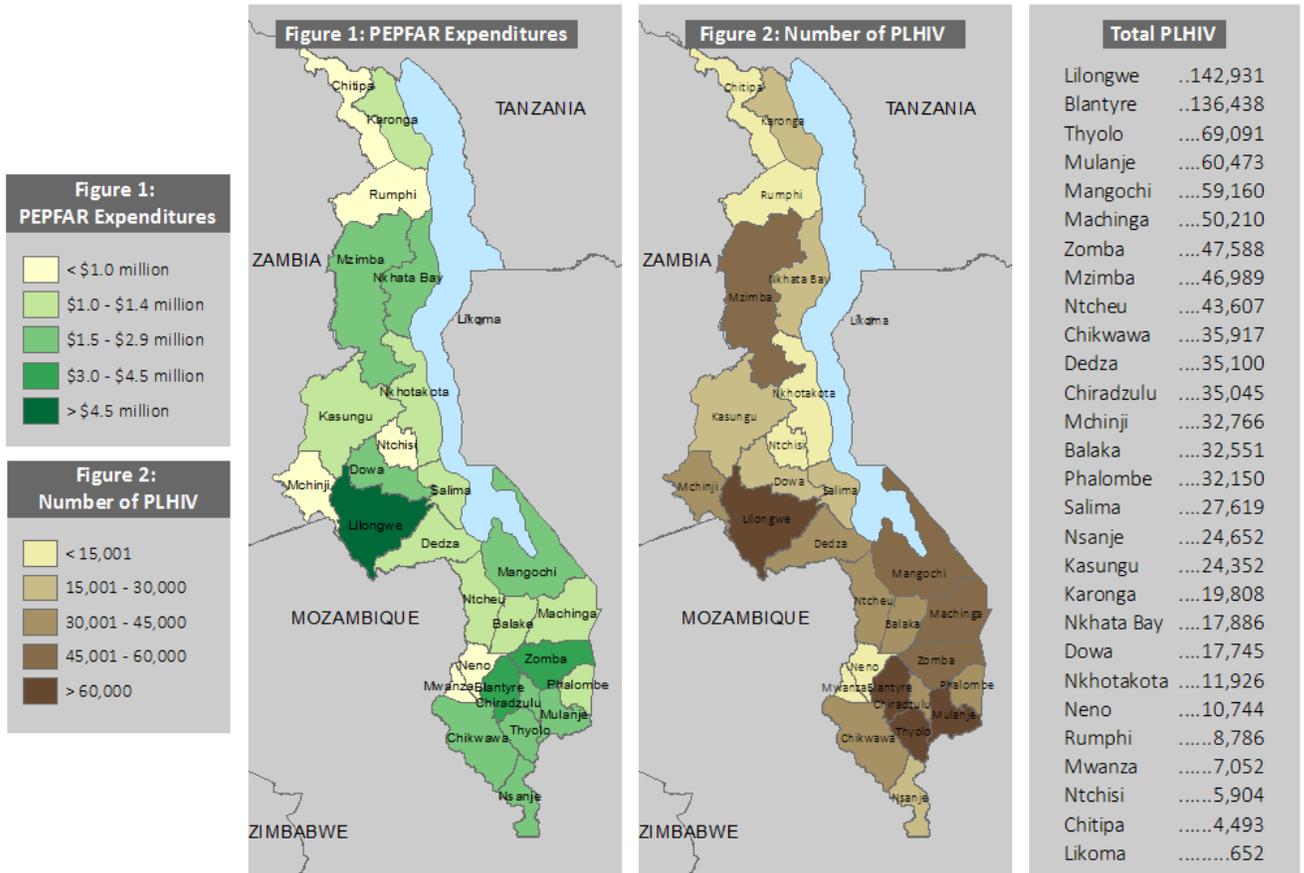
¹³ Triangles represent % PLHIV (of national level) and bars represent spending level per PLHIV

1.4.1b





Malawi: Total PEPFAR Expenditures and Number of People Living with HIV (PLHIV)



Source: PEPFAR (EA EPI Tool)

April 8, 2016

Figure 1.4.2 Total expenditure and PLHIV by District

1.5 Stakeholder Engagement

Government of Malawi

The PEPFAR/Malawi team principally interacts with the Department of HIV/AIDS (DHA) in the Ministry of Health (MoH). Regular meetings are held to review programmatic data and discuss programming plans. USG staff participate in GOM convened technical working groups (TWGs). Outcomes of the Washington, DC Management Meeting were shared and discussed with DHA. Further meetings have elaborated strategies for optimization addressing differentiated service delivery; identification of new sites for PEPFAR support, principally within Lilongwe and Blantyre; further definition by site of HRH and infrastructure barriers. It was decided to hold quarterly joint meetings with DHA, PEPFAR and Implementing Partners (IPs) to review programmatic performance, share successes and discuss concerns. PEPFAR/Malawi also engages with other key units in the MOH: Human Resources Department, Health Technical Support Services Department (includes Diagnostics and Supply Chain Management) and Department of Planning.

The USG PEPFAR team meets regularly with the National AIDS Commission (NAC), which is currently coordinating a National DREAMS Task Force and leading coordination of key populations and VMMC activities. NAC convenes prevention-related technical working groups.

Representatives from MoH DHA and Planning Department as well as NAC have been invited to attend the COP16 review meeting.

Global Fund and other External Donors

PEPFAR/Malawi team members actively participate in the monthly HIV/AIDS Donor (HADG) and Health Development Partners (HDG) Groups. USAID currently serves as the chair of HADG. Members include bilateral and multilateral donors. MOH and NAC participate in these fora from time to time.

USG engagement with GF in country is strong. USG staff were involved in supporting Concept Note development for the new award valued at over \$300 million and continue to support planning efforts with the Principal Recipients. The USAID Mission Director is currently the second Vice Chair on the Executive Committee of the CCM. PEPFAR/Malawi leadership is also directly consulted by Global Fund on key programming decisions.

Civil Society

Beginning with POART Q4 2015, PEPFAR Malawi will hold quarterly stakeholders meetings to engage civil society organizations (CSOs) to review of PEPFAR progress and planning efforts. PEPFAR/Malawi team fully engaged civil society in COP16 development. A meeting timeline was developed and invitations sent through network groups (Malawi Network of AIDS Service Organizations - (MANASO) and MSF. Civil society representatives took part in the Sustainability Index and Dashboard development process. Outcomes from the Washington DC Management Meeting were shared, providing an overall summary of the direction of COP 16. CSOs highlighted issues and provided feedback and input into COP16 , (e.g. establishing a practice of “twinning”

monitoring and accountability; use of expert clients for retention and defaulter tracing; key populations; and capacity building for CSOs). CSOs contributed to the SBOR exercise. Representatives from PLHIV groups (youth, journalists) and key populations participated and provided constructive input to improve service delivery and involvement of PLHIV. Written feedback was solicited and received, especially for community-based interventions and greater involvement of men in HIV prevention, care, and treatment. Another meeting was held with CSOs to discuss in greater depth the findings and recommendations submitted. There is an agreement to continue dialogue on issues of concern (limited direct funding to CSOs). An invitation has been extended to civil society to attend the COP16 review meeting. Prior to the COP review, the PEPFAR Malawi team will hold a stakeholders' meeting to solicit feedback on the COP submission.

Private Sector

There is limited private sector involvement. Children's Investment Fund Foundation (CIFF), as part of the ACT initiative, is co-funding activities to increase pediatric access to care and treatment services. Girl Effect Foundation, a global DREAMS partner, is working closely with PEPFAR/Malawi and the National DREAMS Task Force to develop a brand for girls and provide mass media communication support for implementation of AGYW interventions. PEPFAR supported partners work closely with private sector providers to deliver integrated HIV/FP services through social franchise. PEPFAR and the Elton John Foundation are coordinating to ensure complementarity in programs reaching out to MSM in PEPFAR supported districts.

2.0 Core, Near-Core and Non-Core Activities

(See Appendix A)

The following technical areas are core: improving the quality of pre-ART, ART, PMTCT, pediatric ART and TB through clinical and systems mentoring at the health facility level; increased focus on TB in urban settings and TB hotspots; support for neglected and hard-to-reach populations (AGYW, key populations); HTC for active case findings; VMMC; condom promotion and distribution; community-based prevention, care, OVC, and impact mitigation focused on linkage to care and treatment services, adherence and retention; targeted key population and youth services; bursary support for HRH and iHRIS to support PEPFAR bonding requirements and improved deployment, distribution, and tracking of human resources for health; strategic support for blood safety, labs, sample transport systems, and supply chain systems. New priorities in COP 16 are: expanding reach to underserved male populations through a range of strategies, implementation of differentiated care models to enhance efficiency and quality; salary support for HIV service providers, and targeted investments in infrastructure to support HIV service optimization

Near-core activities are: integration of HIV into maternal and child health services, STI screening and treatment; improving pre-service training institutions, KP GBV screening and treatment, capacity building

for CSOs, block grants to support schools and sub-grants to local CSOs, NACS, OVC national data base development, scaling up of SLMTA, HRH (curriculum development, strengthening HRH regulations). Procurement of laboratory equipment (hematology, chemistry) and consumables, procurement of bicycles and motorbikes, district support to conduct HIV outreach clinics targeting hard-to-reach communities have been moved from core to near core.

Non-core activities are: general population prevention; food packages and nutrition support to vulnerable households has been shifted to other USG technical areas and other development partners. However with the emerging humanitarian crisis this may need to be reconsidered, Cervical cancer screening and cryotherapy at PEPFAR high priority sites, CD4 testing systems, ensuring water and electricity are available at facilities, improved waste management and support for health care financing have been moved into the non-core category.

3.0 Geographic and Population Prioritization

Geographic Prioritization:

Data from multiple sources for population, PLHIV, and prevalence were reviewed (UNAIDS' Malawi 2008 Census projection data, MOH Department of HIV/AIDS (DHA) estimations and quarterly reported data, as well as OGAC SAE and DOM estimations). Estimates are based on data collected from 2010 DHS prevalence, ANC sentinel surveillance or before (last census conducted in 2008) and many assumptions have been used to arrive at these data points. Spectrum data is not available at the district level. Technical staff and leadership choose DHA estimations, which are available at district level and whose total was closest to UNAIDS Spectrum national estimates for 2016, as the foundation for COP16 planning. Currently, the country is conducting three national surveys: Sentinel surveillance, MPHIA and DHS. The results of these surveys will be available towards the end of 2016 and will undoubtedly result in more accurate figures and recalculation of targets and coverage based on these.

Further stratification analysis in Lilongwe and Blantyre for urban and rural populations indicated large gaps in testing and linkage into services in urban areas. This analysis did not affect the overall SNU achievement but highlighted programmatic challenges. The merging of SNUs based on population migration, specifically Chiradzulu, for health access also did not show significant improvements in coverage of ART for Blantyre District.

At the end of FY15, there was a 54.1% national coverage of PLHIV on ART. For COP16, Malawi has projected to reach 70% in FY17 and 78% in FY18. In order to maximally intensify progress towards saturation in the highest burden SNUs, COP16 will further concentrate efforts in 10 Scale up districts, of which 6 are predicted to achieve 80+% saturation in FY17 and a further 4 districts will reach saturation by FY 18. Nationally by FY18, 14 of 28 districts will have reached saturation, covering 77% of

estimated PLHIV. In COP16, the status of 4 districts was changed to sustain to reflect concerted efforts to move as rapidly as possible towards epidemic control. (See Table 3.1 of coverage rates.)

Upon review of the projected coverage rates of SNUs, PEPFAR/Malawi has chosen to intensify focus on three “fast track districts;” Lilongwe (SC-Sat), Blantyre (SC-Sat) and Zomba (SC-Sat). The estimated number of PLHIV in these three highest burden districts represents one third of all PLHIV in Malawi. These districts have distinct urban and rural populations and interventions will be refined to reach both groups. Prevalence rates vary between these different populations: Lilongwe urban - 11.6%, rural - 1.6%; Blantyre urban - 13%, rural - 5.3%; and Zomba urban - 14.4% and rural - 8.25%. In addition to increasing efforts to achieve greater efficiencies, it is critical in these three districts to improve the crumbling infrastructure and mitigate the dearth of health workers. Analysis of HRH and infrastructure needs within these districts form the basis of a supplemental request to be submitted with the COP document, which is intended to facilitate attainment of FY18 targets in the three “fast track” districts. In Zomba, which is now projected to achieve saturation at 80% by FY 2017, these investments will be accompanied by an aggressive outreach testing approach at community level, targeting adolescent girls and young women (AGYW) and their partners, and high prevalence groups including fishing communities, estate workers, and prisoners.

Table 3.1 Estimated coverage rates by SNU														
District	Prioritization	PLHIV	FY15		FY16		FY17				FY18		NATIONAL	
							PEPFAR		NATIONAL		PEPFAR			
Blantyre District	ScaleUp Sat	136,438	54,670	40%	73,365	54%	82,018	60%	92,349	68%	103,788	76%	115,128	84%
Lilongwe District	ScaleUp Sat	142,931	62,634	44%	83,263	58%	89,194	62%	96,795	68%	109,323	76%	118,459	83%
Zomba District	ScaleUp Sat	74,489	36,474	49%	43,567	58%	59,424	80%	61,932	83%	58,347	78%	62,912	84%
Thyolo District	ScaleUp Sat	69,091	40,985	59%	52,255	76%	51,721	75%	57,883	84%	54,049	78%	60,500	88%
Mangochi District	ScaleUp Agg	59,160	28,858	49%	39,104	66%	44,954	76%	50,731	86%	52,584	89%	59,618	101%
Mulanje District	ScaleUp Sat	60,473	38,173	63%	42,276	70%	45,345	75%	48,511	80%	50,656	84%	51,302	85%
Mzimba District	ScaleUp Sat	46,989	23,661	50%	31,734	68%	32,937	70%	41,516	88%	36,611	78%	47,280	101%
Machinga District	ScaleUp Agg	50,210	20,311	40%	23,667	47%	35,995	72%	37,592	75%	39,552	79%	42,687	85%
Chikwawa District	ScaleUp Sat	35,917	17,612	49%	20,105	56%	25,787	72%	27,373	76%	26,579	74%	28,358	79%
Ntcheu District	Sustained	43,607	15,582	36%	20,381	47%	17,179	39%	19,156	44%	17,739	41%	19,877	46%
Chiradzulu District	Sustained Com	35,045	34,887	100%	32,115	92%	32,408	92%	32,408	92%	33,088	94%	33,088	94%
Phalombe District	ScaleUp Sat	32,150	23,044	72%	26,641	83%	26,050	81%	26,686	83%	26,655	83%	27,671	86%
Balaka District	Sustained	32,551	12,665	39%	18,037	55%	14,963	46%	17,996	55%	15,189	47%	18,263	56%
Dedza District	Sustained	35,100	11,283	32%	15,511	44%	12,695	36%	15,612	44%	12,973	37%	16,107	46%
Mchinji District	Sustained	32,766	10,838	33%	12,595	38%	11,939	36%	12,678	39%	12,828	39%	13,720	42%
Kasungu District	Sustained	24,352	10,065	41%	13,747	56%	11,859	49%	14,616	60%	12,887	53%	16,059	66%
Salima District	Sustained	27,619	8,972	32%	12,082	44%	11,442	41%	12,682	46%	12,242	44%	13,490	49%
Nsanje District	Sustained	24,652	15,104	61%	17,203	70%	13,694	56%	14,002	57%	13,819	56%	14,113	57%
Karonga District	Sustained	19,808	10,125	51%	11,099	56%	10,298	52%	11,529	58%	11,117	56%	12,493	63%
Nkhata Bay District	Sustained	17,886	5,274	29%	7,952	44%	5,885	33%	7,681	43%	5,960	33%	7,981	45%
Dowa District	Sustained	17,745	6,708	38%	10,420	59%	5,735	32%	11,134	63%	6,284	35%	11,868	67%
Nkhotakota District	Sustained	11,926	6,786	57%	10,185	85%	6,687	56%	9,519	80%	6,828	57%	9,646	81%
Neno District	Sustained	10,744	5,892	55%	7,711	72%	6,262	58%	7,582	71%	6,286	59%	7,681	71%
Rumphi District	Sustained	8,786	4,363	50%	7,049	80%	4,618	53%	6,902	79%	4,637	53%	7,031	80%
Mwanza District	Sustained	7,052	3,777	54%	4,886	69%	4,182	59%	4,577	65%	4,129	59%	4,998	71%
Ntchisi District	Sustained	5,904	2,166	37%	3,960	67%	2,546	43%	3,825	65%	2,559	43%	3,892	66%
Chitipa District	Sustained	4,493	2,775	62%	4,800	107%	3,241	72%	4,134	92%	3,254	72%	4,202	94%
Likoma District	Sustained	652	446	68%	465	71%	425	65%	533	82%	459	70%	566	87%
National Totals		1,068,536	514,130	48%	646,175	60%	669,483	63%	747,934	70%	740,421	69%	828,990	78%

Population Prioritization:

Targeting populations most affected by and vulnerable to HIV is critical for rapid epidemic control. Prioritized population groups are identified based on analysis of districts with highest HIV prevalence, treatment gaps, estimated population size and contribution to new infections, profiles of specific at-risk groups, and known vulnerability for acquisition and transmission. Underserved populations include FSW, MSM/TG, OVC, AGYW, and OVP (i.e. prisons, military, police, estate workers, fishermen and women, and clients of FSW). Building on activities started in COP15, PEPFAR/Malawi is focusing additional efforts to reach adolescent girls and young women (AGYW) and men. AGYW interventions will saturate two DREAMS districts (Machinga and Zomba). These are complemented by GF supported AGYW activities (modeled on the Malawi DREAMS intervention package) in Mangochi, Mulanje and Lilongwe Urban. Data from the MOH DHA shows that women account for a significantly greater proportion of adults on ART, 66% versus 34% for men. As Malawi has a strong Option B+ program, HIV services have been strongly linked to ANC and maternity platforms, easy entry points for accessing women of reproductive age. Men on the other hand are often not routinely accessing/utilizing health services and tend to present at HF only when sick. Building on efforts that started in COP15, additional strategies will be initiated for finding HIV infected men and initiating them into treatment.

In COP15, PEPFAR/Malawi started a large integrated community prevention, impact mitigation, and care program to provide additional support for targeted, case finding, service linkages, and adherence support in the eight scale-up districts (Blantyre, Zomba, Mangochi, Machinga, Mulanje, Chikwawa, Phalombe, Balaka). With the increased focus on high burden districts in COP16, Balaka District has been re-classified as “sustained.” As a result, activities currently underway in Balaka will continue with a lighter footprint (without incurring longer term investments). The option for potential transition will be revisited in COP17. These districts have significant OVC populations and AGYW at risk, as well as priority subpopulations (estate workers, fishing communities, vendors, police, teachers, prisoners). Traditional Authorities in these districts were selected based on the location of PEPFAR rapid scale up treatment sites. Comprehensive interventions for AGYW are integrated in the community programs where OVC populations are high, early sexual initiation and childbearing are reported, there are high school dropout rates, high reported transactional sex, and damaging cultural norms and practices (MDHS 2010). DREAMS funding, in Machinga and Zomba districts complements these efforts to identify high risk male sexual partners for HTC and linkage to ART or VMMC services, based on their status. Intensive coordination efforts between PEPFAR, ActionAid (Global Fund PR), NAC, and other stakeholders will support the roll out of similar activities in Mangochi, Mulanje and Lilongwe Urban. We are hopeful that Malawi will receive DREAMS Incentive Fund resources to expand these efforts address HIV transmission to AGYW.

Due to shifts in district prioritization for an intensified focus on Blantyre, Lilongwe, and Zomba, the integrated community platform will be expanded to include priority Lilongwe treatment catchment areas for mobilization, linkage, targeted community-based HTC, and community care.

Key Populations (KPs) are targeted in Lilongwe, Blantyre, Mzuzu, and Mangochi where there is high population density, HIV prevalence, unmet need for treatment, and hot spots based on current data sources.

3.3. Voluntary Medical Male Circumcision (VMMC)

Since COP14, VMMC budget allocations were reduced in order to meet the treatment and care earmark. PEPFAR Malawi has relied heavily on central initiative funding to maintain direct service delivery in eight districts for the past three years. \$6.8M Central Initiative funds were received for continued scale up in these 8 districts in FY16, to reach a target of 101,000 circumcisions. The 8 districts are all scale up districts and include the DREAMS district of Zomba ,Machinga, the other DREAMS district will receive TA – see below).

Using pipeline FY16 VMMC central funds, three IPs will continue to provide VMMC services in Lilongwe (target 5,000), Blantyre (target 7,200) and Zomba (target 7,407) in FY17. As World Bank funds support Machinga District, PEPFAR will provide TA to strengthen MoH implementation and provide supplementary circumcisions to meet DREAMS targets. PEPFAR/Malawi is requesting an additional \$10,462,516 in central funding for providing direct service delivery in priority districts. Over 50% of the FY17 target will be realized in the two priority districts of Blantyre and Lilongwe, with a third of the annual circumcisions in Lilongwe alone

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

Table 4.1.1 Coverage in Scale up districts

Districts	Classification	PLHIV	Expected Current on ART (APR FY16)	Additional Patients Required for 80% ART Coverage	PEPFAR Target Current on ART (APR FY17) TX_CURR	PEPFAR Newly Initiated (APR FY17) TX_NEW	ART Coverage APR 17 (PEPFAR TX_CURR/National PLHIV)	National FY TX_CURR	National ART Coverage APR17
Blantyre	ScaleUp Sat	136,438	73,365	35,785	82,018	24,022	60%	92,349	68%
Lilongwe	ScaleUp Sat	142,931	82,263	32,082	89,194	20,017	62%	96,795	68%
Zomba	ScaleUp Sat	74,489	43,567	16,024	59,424	19,579	80%	61,932	83%
Thyolo	ScaleUp Sat	69,091	52,255	3,017	51,721	10,032	75%	57,883	84%
Mangochi	ScaleUp Agg	59,160	39,104	8,224	44,954	15,869	76%	50,731	86%
Mulanje	ScaleUp Sat	60,473	42,276	6,102	45,345	10,572	75%	48,511	80%
Mzimba	ScaleUp Sat	46,989	31,734	5,858	32,937	10,129	70%	41,516	88%
Machinga	ScaleUp Agg	50,210	23,667	16,501	35,995	15,248	72%	37,592	75%
Chikwawa	ScaleUp Sat	35,917	20,105	8,629	25,787	10,477	72%	27,373	76%
Phalombe	ScaleUp Sat	32,150	26,641	-921	26,050	4,024	81%	26,686	83%
Totals		707,848	434,977	131,302	493,425	139,969	70%	541,368	76%

4.1 Targets for Scale-up locations and populations

COP16 target setting combined multiple methodologies. The PEPFAR Malawi team reviewed, cleaned and modified the OGAC Datapack. Calculations used FY16 quarter 1 achievement as baseline. In a few circumstances where quarter 1 achievement was questionable for a specific site or the target was not reported in Q1, APR 15 was used as baseline. This methodology varied from the pre-set Data Pack baseline of FY16 targets. Malawi shifted the baseline in order to accurately account for trends and expected achievements based on the varied intensity of interventions to be implemented.

The second method conducted a detailed trend analysis of all MOH sites and SNUs since 2013. Multiple projection models were then applied to the historical trends to determine targets. The projection models differentiated rates of linkages, yields, coverage etc. for the different prioritization levels. The final projection model for district SNU and sites used the following assumptions:

1. Although Test & Start is planned to begin in April, initiations due to Test & Start are expected in July-Sept 2016- 70% of Pre-ART to initiate
2. 20% of Pre-ART to initiate in Oct-Dec 2016.
3. Calculated TX_NEW using Test & Start Assumptions and applied to TX_Curr projections (included lost to follow up and other interventions which varied by SNU prioritization.
4. Saturation districts: 80% linkage to treatment
5. Aggressive districts: 75% linkage to treatment
6. Sustained districts: 70% linkage to treatment

These projections were then reviewed with district saturation coverage rates and modified proportionally to match the Datapack SNU totals.

This is a significant change from target setting methodology in COP 15, where target setting started at the site level with testing numbers and concluded with district current on treatment.

The following assumptions and parameters were used to set site level targets from the modified Datapack:

Number of individuals tested for HIV (HTC TST)

District and site-level targets for HTC assumed that the HIV testing numbers will increase through the end of FY18 due to recent PEPFAR investments, by a quarterly growth value equal to the district median change, estimated using data on HIV testing from January 2013 to September 2015. HTC targets have been adjusted to increase in scale up districts while targets in sustained districts were reduced to reflect the more passive testing approaches implemented there. Community outreach testing is implemented only in scale up districts, reported at facility level, and expected to account for 4-12% of testing in “fast track” and saturation districts. Six percent community outreach was used for targeting in aggressive districts. Community testing targets at SNU level were set by incrementally increasing COP 15 targets. For the general population, index case testing was set at 5%, home based testing at 10%, mobile testing at 50% and other testing at 35%. In Key Population

centric testing, mobile testing is assumed to be 20% and other testing (drop-in centers, campaigns, etc.) is estimated to be 80%.

Number of HIV positive individuals identified (HTC Positives)

The estimated number of positives identified was calculated by applying site specific yields on the projected number of HTC_TST, reduced by an average decline in yield over time estimated from current data. The totals obtained for each site were adjusted to ensure that the district HTC_TST_POS totals are the same as in the Data Pack.

Number of pregnant women with known HIV status (PMTCT_Stat)

PMTCT_STAT was calculated using existing formulae in the Data Pack. Site-level PMTCT_STAT estimates were calculated by determining the proportion of pregnant women who were newly tested for each site using actual data. This proportion was applied to the number tested per site to determine the number of pregnant women newly tested for each site. This number was added to those previously tested to determine site specific PMTCT_STAT.

Number of pregnant women who are HIV positive (PMTCT_STAT_Pos).

Site specific targets for positive pregnant women identified were calculated by applying district level yields to the site level number of pregnant women tested. This was done to ensure that the total number of positive pregnant women for each district would align with Data Pack district totals.

Number of pregnant women who are on ART

The data pack PMTCT_STAT yield for district was used as an estimate for the yield for each facility in the district. Ninety five percent of the calculated PMTCT_STAT(pos) was taken as PMTCT_ART based on national data reports. The obtained value was adjusted for the district total in Datapack.

Number of Early Infant Diagnosis (PMTCT_EID)

An estimate of the number of HIV-positive pregnant women (DEN for PMTCT_ART) obtained by multiplying the PMTCT_STAT for each facility by the PMTCT yield for the district in which the facilities were located. An estimate of the proportion of HIV-exposed Infants tested for each district was obtained from Datapack. These were then multiplied to give PMTCT_EID targets.

New on Treatment (Tx_New)

Tx_New was calculated by incorporating the assumptions for accelerated case finding under HTC_TST and HTC_POS, and then by assuming that Test and Start is likely to start around July 2016 and that 70% of those who are currently in pre ART will be put on treatment by September 2016. A further 20% of those in pre-ART were assumed to start treatment by December 2016. It was also assumed that in Scale-up to Saturation sites, 80% of those who tested positive will start treatment; for sustained and centrally supported sites, linkage rates were assumed to be 75% and 70%. These linkage rates are considerably higher than current and assume programmatic improvements through PEPFAR investments. Review of site-level targets was conducted based on site-level data, and knowledge of facility, infrastructure, and expansion potential.

Current on ART (TX_Curr)

Calculation of the current number of PLHIV on ART took into account district specific averaged quarterly drop off rates plus TX_new calculated as described above. The numbers obtained were used to calculate district coverage. Site level targets for TX_Curr were calculated using the same assumptions as district TX_Curr but the district averaged drop-off rate was applied to site level. Notably, as the district level ART cohorts increase, the number lost to follow-up becomes greater relative to those new on treatment, resulting in decreasing marginal annual gains in TX_CURR.

Number Retained on Treatment (TX_RET)

TX_RET was obtained by dividing the expected FY16 TX-New by the estimated retention rate for each district. The estimated retention rate for each district was obtained from Data pack. The estimated TX-NEW for FY16 was obtained from the projections and the actual TX-New for the period October-December, 2015.

Number of TB patients with known HIV Status (TB_STAT)

The FY15 value for TB_STAT for each facility and district were used as baseline. Using the facility and district, the proportional contribution of each facility was determined in relation to the total FY15 TB_STAT. This was then multiplied against the total TB_STAT for each district obtained from data pack. The TB_STAT denominator was obtained by dividing TB_STAT from district in Datapack by the percent of TB_STAT who know status obtained from Datapack for each district.

Number HIV patients screen for TB. (TB_SCREENDX)

TB_SCREENDX was obtained by multiplying $.95 * TX_CURR$. The denominator for TB_SCREENDX was obtained by dividing TB_SCREENDX by $.95 = TX_CURR$.

Prevention Targets

KP_PREV and PP_PREV targets were set in consultation with partners based on current results, planned activities, and expected increase in achievement dependent of district prioritization. For most partners conducting PP_PREV activities, a 5-10% increase in targets was set. For KP_PREV, new preliminary site level estimations show a reduction in the denominator, and thus the targets were adjusted to reflect a smaller population.

OVC targets

With the start of a new integrated community program in COP15 and OVC guidance from HQ, OVC_SERV targets were set with a greater focus on comprehensive programming which is geographically focused.

4.1.2 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale up Districts	Tested for HIV (APR FY17)	Identified Positive (APR FY17)	Newly Initiated (APR FY17) TX_NEW
Entry Streams for ART Enrollment			
All	2,310,375	172,323	133,846
Clinical Care patients not on ART	N/A	N/A	N/A
HIV+TB Patients not on ART	N/A	681	N/A
HIV-positive Pregnant Women	306,605	41,844	39,752
Other Priority and key populations	138,696	N/A	N/A
Pediatrics	577,594	17,327	12,948

Data quality

Malawi has high quality program data that is obtained from national quarterly supervision of all HIV treatment sites. This country system reports at the end of each quarter exactly the number of people who are on treatment with very small margins of error. However, estimation of the number of people living with HIV has been challenging as noted earlier in section 3.0.

Target Populations	Population Size Estimate (scale-up SNU)	Coverage Goal (in FY17)	FY17 Target
Female Sex Workers	23,500 (Lilongwe, Blantyre, Mzuzu, Mangochi) ¹⁴	24%	5598
MSM	19,830	22%	4294
Females (15-24) Urban settings with high HIV prevalence¹⁵	Blantyre urban: 87,719 Lilongwe urban: 100,540	?	15,400 (4400)

¹⁴ Findings from UNC PLACE study are expected by June 2016 and will refine KP size estimations for FSW and MSM by SNU. Mwanza District was removed due to MSF coverage. DREAMS AGYW and Test and start funds support KP programming in Machinga, Zomba, and Blantyre (including male clients of FSW)).

¹⁵ AGYW: PEPFAR COP 15 funds support FP/HIV YFHS and 100 new Youth Alert Listener clubs in Lilongwe, and support 600 existing YA clubs within Lilongwe, Blantyre, Thyolo, Machinga, Mwanza, Neno, Ntchisi, Rumphi, and Mzimba due to leveraged FP resources provided by KFW. Size estimations are only provided for Lilongwe and Blantyre urban. ACT funds expand HTC across all SIFPO 2 supported districts through mobile/outreach and social franchise sites. DREAM funds support expansion of YFHS in Machinga and Zomba. DREAMS size estimations and targets for comprehensive girl centered programs in Machinga and Zomba are available separately. OVC households with adolescents (10-17) will be provided integrated impact mitigation and prevention services. These targets are reflected under OVC interventions.

¹⁵ Priority Populations in eight districts: Reach is calculated based on 75% coverage of populations in the 58 catchment TAs / eight districts over five years. COP 15 targets were calculated based on 15% reach of standardized packages for specific priority sub-populations specifically in the 12 TAs around rapid scale-up sites and where there are high numbers of OVC. Targeted normative change and stigma reduction interventions will be implemented through traditional leaders and community structures using standardized curricula to reach 20% coverage in all 58 sites. Since Balaka district is being reclassified as sustained, FY 17 targets will not increase by 5% as in other districts.

	Mzimba Thyolo Machinga Zomba		from urban priority sites)
> 15 priority populations (M and F) in 8 high prevalence Southern districts Priority Populations Subgroups: 1. Adolescent PLHIV 2. Adult PLHIV (20-49) in discordant relationships 3. OVC households 4. Estate workers, other hard to reach populations (i.e. fishing communities, teachers, and police) ¹⁶ 5. Men 6. Community leaders	Total >15 population: 3,011,505 Total PLHIV: 464,284 1. ALHIV: 17,100 2. Discordant couples: 117,458 3. OVC HH: 105,632 4. OVP: TBD Machinga, Mulanje, Zomba, Phalombe, Chikwawa, Blantyre, Balaka, Mangochi (and Lilongwe *) * ¹⁷ Lilongwe targets are not included at this time while contractual issues are being sorted out.	15%	PP Prev: 212,200
Military personnel and catchment areas	89,963 (MDF catchment areas)	35%	PPrev: 31, 898
Peace Corps will implement small scale HIV intervention in 22 districts across the country. Targeting both in school and out of school youth with more focused interventions on adolescent girls and young women. Age range (10 - 24) 25 to 49 years adults (parents) have been included to raise awareness of HIV risk among young people. Interventions will also address harmful gender social norms in 22 districts across the country	Balaka, Chiradzulu, Chitipa, Dedza, Dowa, Karonga, Kasungu, Lilongwe, Machinga, Mangochi, Mchinji, Mulanje, Mzimba, Nkhata Bay, Nkhotakota, Nsanje, Ntcheu, Ntchisi, Rumphu, Salima, Thyolo , Zomba	TBD % coverage will be determined from volunteer catchment areas	PPrev: 6000
Total			PPrev: 258,839 KPPrev: 9893

¹⁶ Due to the increased focus on treatment in Lilongwe, PEPFAR will explore expansion of community platforms in Lilongwe through One C and STEPS. Targets are not included at this stage while contractual issues around expansion of the activity are explored.

Program Area Summaries

4.2 Priority population prevention

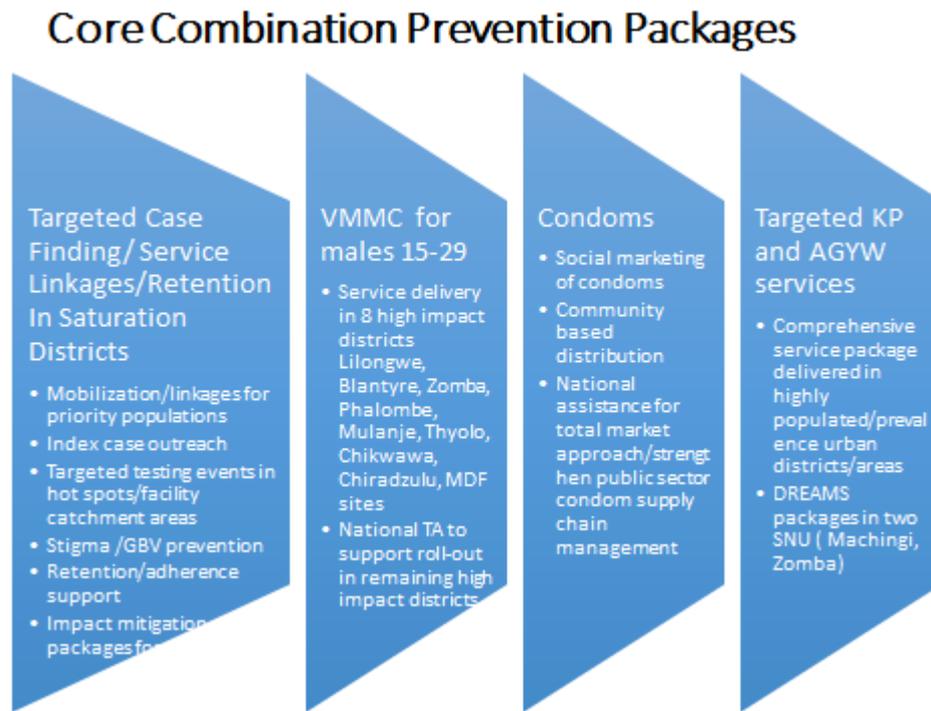
The NSP and GF Concept Note outline the importance of community models to support 90-90-90 targets and keep negative priority populations HIV free. Components of community platforms to address population needs across the cascade include condom programming, high yield HTC, VMMC, linkage to treatment and retention for positives, and community care. PEPFAR gender analysis recommendations are in alignment with the NSP. Interventions which address gender inequality, harmful cultural practices, discrimination, and other human rights violations should be prioritized in order to meet 90:90:90 treatment targets.

Close partnership between clinical and community platforms is essential to facilitate timely mobilization for service uptake, address gender barriers of specific target populations, provide linkage strategies across the cascade and deliver community retention and adherence programs. COP16 will employ a core set of combination prevention packages (Fig 4.2). These address targeted case finding, linkage into service and retention, VMMC for males 15-29, condoms, and focused activities for AGYW and key populations.

For the first “90,” PEPFAR will support targeted outreach HIV testing strategies using index clients, hot spot testing, and community open days for high risk children and families in PEPFAR priority districts. PEPFAR supports staff at facilities (HIV Diagnostic Assistants HDA, expert clients), community engagement facilitators, and KP peer navigators who will develop joint plans to follow-up on index client households, for family HTC, household visits, and testing events.

HTC and linkage are integrated into OVC household case management strategies through community case managers who will identify sick children for testing and treatment. PEPFAR will support comprehensive community packages which integrate impact mitigation interventions for vulnerable households, prevention services (i.e. outreach HTS, condom distribution), and child protection. Community platforms will use community engagement facilitators linked to facilities, community-based peer educators, and expert clients to facilitate linkage to HIV services (HTC, VMMC, PMTCT, ART), and deliver community-based services including condoms, child protection, education, nutritional support, and VSL. These community actors will work together to facilitate bi-directional referrals between facility and community while providing different components of the package through direct service delivery. Community leaders and structures (i.e. committees and CBOs) will also be strengthened to guide community plans, monitoring and evaluation

Fig 4.2 Schematic representation of Core Prevention Packages



Adolescent Girls and Young Women (AGYW):

Fifty percent of new HIV infections are anticipated among AGYW (15-24). The PEPFAR gender analysis and other studies confirm that AGYW remain a critical priority population to reach. Adolescent girls from an early age are exposed to early sex, childbearing, marriage and GBV; face barriers to health care services; and are more likely to be lost to follow-up¹⁸.

DREAMS funds, targeting two PEPFAR aggressive scale-up districts (Zomba and Machinga), provide an integrated platform to deliver targeted comprehensive interventions for high risk AGYW and their male partners in districts with high HIV burden, large treatment gaps, high burden of OVC, and poor indicators for early sexual debut, childbearing and school retention. DREAMS leverages COP funds and integrated HIV/FP/Education/Sustainable Economic Growth programs to reach 10-24 year old OVC populations, FSW, and vulnerable AGYW in hotspots to link them (and high risk male partners) to treatment and care services. Test and Start activities will complement existing PEPFAR strategies through profiling of high risk male partners and alternative service delivery models to reach men. DREAMS will also leverage Peace Corps volunteers for district coordination and

¹⁸ EZA 2014, Tewa et al 2014, VACS 2015, PEPFAR Gender Analysis 2016)

expansion of activities. Peace Corps health, education and environment volunteers will provide targeted interventions on HIV prevention and school retention to AGYW and male counterparts through camps, clubs and other activities in 23 districts. Strong partnership forged with GOM and Global Fund/ActionAid on coordination, synergistic program design and robust M&E will support expansion of the core DREAMS package to additional PEPFAR aggressive scale-up districts. Building on USG supported integrated HIV/FP youth friendly health services (YFHS) models and DREAMS investments, COP16 funds for YFHS and community packages will expand coverage of select DREAMS interventions to include scale-up districts of Lilongwe, Blantyre, Mangochi, and Mulanje. Targeted YFHS in urban areas of Lilongwe, Blantyre, Mzimba and Thyolo will continue to deliver HTC, FP, STI screening and treatment; ART; and linkage through a combination of social franchise sites and mobile outreach services. They will further provide peer support through youth clubs, and increase teen clubs for older children and adolescents living with HIV. ACT resources expand testing to identify HIV-positive adolescents and households, and link them into HIV care services. Complementary community-wide approaches will reach high-risk male partners with targeted male HTC, linkage to ART and VMMC.

Key Populations

Key Populations (KP) face a disproportionate burden of disease and known barriers to service access and utilization including criminalization of behavior, human rights abuses, stigma, poor health worker attitudes and GBV. The NSP and GF Concept Note highlight the need to reach these groups with targeted approaches and safe, non-stigmatizing services. KP standard operating procedures were incorporated into the following national guidelines currently under review: STI management guidelines, HTS guidelines and Malawi Clinical HIV guidelines.

In FY16, start-up activities for KP programming included district mapping; development of refined strategies for case identification (screening and linkage to HIV services), peer education curriculum, and M&E tools; training of peer educators/peer navigators; and capacity development of local partners. Districts prioritized for comprehensive KP models are Lilongwe, Blantyre, Mzuzu and Mangochi which have confirmed hot spots. Results for KP district size estimations, using PLACE, are expected by June 2016 and will validate denominators of both FSW and MSM in the priority districts as well as identifying additional geographic hot spots within the districts. Preliminary findings identified 2,100 FSW and 100 unique MSM hot spots in Lilongwe alone. Differentiated service delivery models for KP (FSW, MSM, TG) include drop-in centers, mobile/outreach, one stop shops, and hybrid models which link KPs to general clinical services through peer educators/navigators. DREAMS and Test and Start funds will expand program reach to FSW, male clients, MSM and TG in Zomba and Machinga districts. HIC-based services serve an estimated 80% of KPs targeted in the prioritized KP districts. PEPFAR service delivery partners working in the health facilities (HF) continue to promote services that reduce stigma and promote access to KP. First quarter data confirm that delivery models are acceptable to KP, showing a testing yield of 58% HIV positivity rate among FSW.

Other activities include a KP GBV and stigma study, PrEP assessment for KP, and expansion of activities to Machinga and Zomba districts with DREAMS and Test and Start funds. PEPFAR provides TA to ActionAid to adopt tested KP service delivery models and tools for planned expansion to unsupported districts and will continue to provide intensive TA and capacity development of GF sub-recipients in other PEPFAR priority districts.

COP16 will focus on strategies to facilitate immediate Test and Start for KP, address leakages in the clinical cascade based on enhanced M&E strategies, and capacity development of local partners. The

full range of services for KPs includes: STI screening, self-testing for HIV, routine peer educator/navigator support, regular quarterly checkups (SRH/STI services and transport) and linkage to impact mitigation programs for exploited children.

An MOU will be signed between our key KP implementing partner with a private laboratory to support VL scale up at HICs in Blantyre and potentially other KP districts. Strategies under Test and Start will also pilot ways to reach male clients of KP in hot spots through targeted peer educators, and linkage strategies. Operations research will compare at least two distinct KP service delivery modalities (HIC-based services vs. hybrid clinics) to determine effective strategies to optimize access to HIV services.

Health workers in HF around known hot spots will receive ongoing mentorship and supervision and KP issues will be integrated in health care worker in-service training. Linkage to existing HF will be promoted where there are no available comprehensive service models for KP. A national technical advisor for KP seconded by ActionAid will be placed at NAC to facilitate roll out of effective service delivery models, coordination of GF supported CSO capacity development and strengthening M&E system.

Leveraged PEPFAR KP investments by the Department of State, GF, and Elton John Foundation funded programs will strengthen documentation of rights violations, advocacy and linkage to protection and legal services for both LGBTI (principally MSM) and FSW.

Reaching Men

MoH DHA data shows that males are less likely to go for HTC, and initiate treatment when they are healthy. While roll-out of Malawi's universal Test and Start strategy will be an important enabler for testing among males who were not eligible for treatment before, there are other barriers (noted in the PEPFAR gender analysis and other regional studies) which impact timely service uptake and retention. These indicate poor knowledge and low risk perception in men, masculinity norms, and stigma, perceived access to services (i.e. distance to HIV services and challenges for working men to queue), perceived quality of health care (i.e. perception that facilities are female spaces, privacy/confidentiality, security of bicycles), and lack of effective community linkages or targeted service delivery models.

In COP16, proposes strategies to increase male reach to complement existing HTC and linkage strategies. DREAMS Test and Start funds will identify male-specific barriers and identify responsive service delivery models. Male oriented service delivery strategies for testing and initiation include expanded PITC (through male oriented entry points like STI, inpatient wards); flexible service delivery hours (weekend, extended hours, dedicated male days); targeted site-based infrastructure changes to improve privacy and security of bicycles; mobilization and outreach testing in KP and geographic hot spots; through integrated TB/HIV outreach case finding, and addressing norms of masculinity to encourage early service up-take. Expanded partnership with private sector as well as VMCC sites will further increase reach of targeted male populations.

Targeted male mobilisation efforts will focus on Test and Start for all, use of male PLHIV champions/role models for advocacy, and as community peer navigators. Other activities will reach male partners of HIV positive females through a combination of expanded community mobilization,

testing and linkage activities, as well as an increased proportion of male expert clients in PEPFAR supported facilities. Retention and adherence among men will be increased through targeted individual and group peer support, proposed alternative service delivery models, and active defaulter tracing. Strategies will be monitored for HTC yield, linkage rates, and retention over time. (See Fig 4.3)

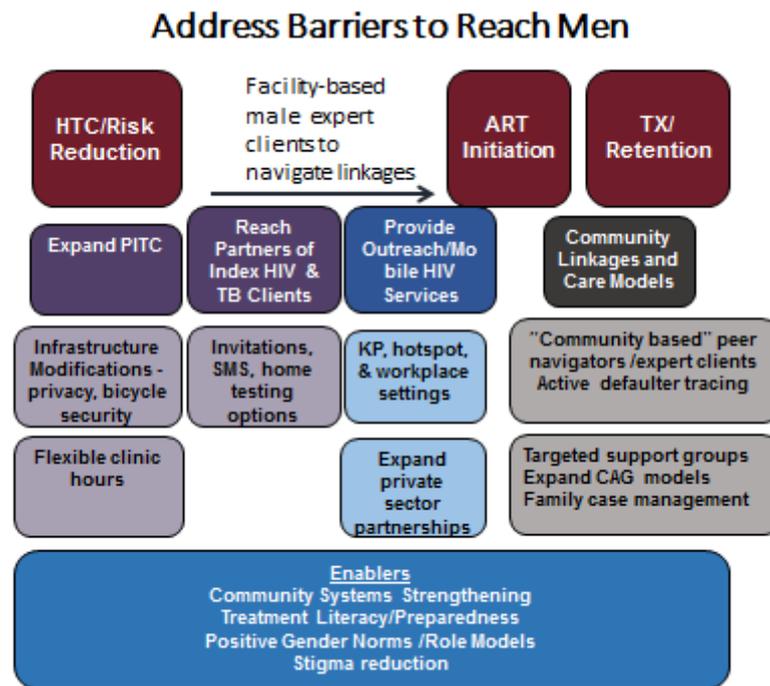


Fig 4.3

Prisons

Males and females in prison settings remain underserved despite high prevalence of HIV and co-TB infections. In FY16, PEPFAR prioritized active case finding and ART initiation in high volume prison settings in Lilongwe, Blantyre, and Zomba, and in other districts. Tools were developed for screening for TB and STIs, and PITC in prisons. Upon release, prisoners on ART and TB treatment will be transferred to a HF of their choice. The feasibility of tracing the referral and providing intensified adherence and retention for newly released prisoners is being explored. In COP16, PEPFAR will continue to provide HIV services within targeted high volume prisons in aggressive scale-up districts.

Condom Programming

Reinvigorating condom programming as a core HIV prevention intervention is a national priority. Within the NSP, strategies include emphasis on a total market approach for comprehensive condom programming and effective and efficient supply. Targets to reach 280 million condoms per annum were set to increase condom consumption using traditional and non-traditional platforms. Additionally, lubricant would be procured and distributed to KPs .

Nationally, condoms are procured, warehoused and distributed to service delivery partners by MoH. Recent improvements in LMIS reporting have strengthened supply chain management (SCM); nevertheless, condom availability, access and stigma associated with both male and female condoms remain challenges among priority populations. There are chronic stock outs of public sector condoms; socially marketed CHISANGO and CARE brands show record sales - CHISHANGO has already achieved 14,000,000. Public sector condom distribution, however, increased only slightly to 33,441,236. PEPFAR will work with GOM to strengthen SCM for procured public sector condoms and lubricant.

In COP16, PEPFAR will continue to champion a total condom market approach, mapping of condom distribution points and agents; technical assistance to operationalize national condom policy documents, and sharing of best practices for condom planning, programming, and monitoring, through public, private and socially marketing sectors.

Additional public sector condoms and lubricant will be procured as requested (Commodity Fund), warehoused and distributed to PEPFAR priority district community distribution. PEPFAR's community platform will distribute 12 million condoms in eight priority districts through community based condom distributors. Condom social marketing activities of CHISHANGO will expand coverage in urban areas and hotspots to reach 20 million condom sales. CARE and the new Whisper female condom brands will be marketed in urban settings, through salons, and by FSW Queens. Intensive demand generation activities at national and community levels will seek to increase demand for male, female condoms and lubricant among key and priority groups.

Gender Based Violence and Stigma and Discrimination

Responsive GBV prevention, impact mitigation, and comprehensive post-GBV services have been highlighted as a gap disproportionately affecting vulnerable children, AGYW, women, and key populations¹⁹. Although there are positive developments in gender related national policy, there is concern that there is not a sufficiently enabling environment to effectively operationalize responses to GBV, stigma and discrimination into district plans²⁰. While a combination of DREAMS and COP funded impact mitigation resources provides an opportunity to expand targeted community social behavior change interventions to address GBV, raising awareness of the new Marriage Act, and facilitating linkages, there are significant challenges to delivering comprehensive health, legal and

¹⁹ VACS 2015, PEPFAR Gender Analysis 2016

²⁰ Recent policy developments include the Divorce and Family Relations Act (2015) which raises the minimum age of marriage to 18, the National Plan of Action to Combat GBV in Malawi (2014-2020), the National Violence Against Children Plan of Action (still in draft) and the new National Gender and HIV Implementation Plan, which integrates priorities from NSP and National Gender Policy (still in draft)

psycho-social support services. While districts have victim support units (VSU) – managed under the National Police Service, post-GBV services are very limited and challenging to navigate. Coordination with HF for timely post-rape support is lacking, and reach is low. Past PEPFAR support expanded the number of trained social welfare/child protection officers in targeted districts to provide linkage for OVC to VSU and legal services; however, it is likely they reached only a fraction of GBV cases – with limited legal action against perpetrators of violence. Other challenges include limited capacity of health providers to respond to GBV cases and lack of direction within the national ART guidelines to provide comprehensive standard operating procedures for rape beyond post exposure prophylaxis (PEP).

In COP16, PEPFAR will provide more focused GBV responses and on-going monitoring particularly among highlighted vulnerable populations. PEPFAR’s community platform will address harmful gender norms (i.e. child abuse, child marriage, GBV, and sexual cleansing) and reduce stigma through community mobilization, with capacity development of district, CBO and community champions to strengthen policy awareness and focus on GBV monitoring and research. Although the revised national ART guidelines were finalized before additional GBV guidance could be included, PEPFAR-supported providers in priority districts will incorporate GBV sensitization and clinical protocols through mentorship to improve the quality of post-rape care within HFs. Under DREAMS, targeted approaches to expand comprehensive GBV programming will be developed to reach AGYW. Linkages between community, facility settings and VSUs will be better coordinated. Community resource persons, social welfare/child protection officers and HSAs will also be trained to improve screening and complete referrals of survivors to appropriate services.

KP GBV prevention and mitigation include documentation of human rights abuses, integration of State Department and USAID Democracy and Governance funding, and closer collaboration with the Malawi Human Rights Commission. Documentation of GBV/abuse and stigma reported by KP through PEPFAR supported activities will inform operational policies for HIV at national and district level. A targeted GBV prevention and response system with relevant standard operating procedures will be developed for KP.

4.3 Voluntary Male Medical Circumcision (VMMC)

GOM has an ambitious VMMC scale-up strategy for 2015-2020 implemented with financial resources from PEPFAR, World Bank (WB) and GF. For the last three years, PEPFAR/Malawi has provided technical leadership to GOM and contributes the majority of national results, cumulatively at 240,000 circumcisions²¹. WB resources, implemented in 10 districts, using MoH routine service delivery and small campaigns, have contributed only a small number of VMMCs to date due to difficulties faced by MoH in rolling out WB supported plans. This phenomenal growth in PEPFAR supported circumcisions will not be maintained without continued OGAC Central Funds and remains at risk of collapse.

In COP16, USG VMMC partners support eight priority districts with a target of 101,000 circumcisions. PEPFAR will prioritize clients aged 15-29 years reaching 80% coverage among this group over the

²¹ PEPFAR/Malawi Annual Program Report 2015

next five years (see Appendix E for an outline of the demand creation measures to be undertaken to increase the number of men between 15-29 undergoing VMMC). The FY17 target will be 70% of circumcisions among men aged 15-29 years. PEPFAR/ Malawi also provides MC in military settings as well as TA to MoH for the national VMMC program.

Carryover VMMC central funds will continue VMMC service provision in priority districts of Lilongwe, Blantyre, and Zomba. A new implementing partner will start in Lilongwe. COP16 VMMC funds are inadequate to maintain program investments in the priority PEPFAR districts. COP16 provides for minimal TA support to GOM in implementation of the VMMC program funded by the WB and GF, as well as moderate DSD support. Due in part to the very high care and treatment earmark, COP16 VMMC funds remain inadequate to maintain program investments in the priority PEPFAR districts.

Key activities will include: implementation of the VMMC minimum package of clinical and prevention services at every VMMC delivery point based on global guidance. PEPFAR/Malawi will continue procurement of VMMC supplies and commodities for PEPFAR supported sites). Ongoing provider training will be provided on adverse events/safety and surgery or devices. HIV positive males will be proactively linked to treatment and care services. IPs, TA to GOM will continue for Continuous Quality Improvement (CQI) and external quality assurance, training VMMC providers, clinical mentoring and supportive supervision. In scale-up districts, VMMC service-related data collection, reporting and Data Quality Assessments systems will document coverage trends. Commodities consumption forecasting and supply chain management support will also be provided.

Targeted demand creation will focus on reaching 15-29 year old males. PEPFAR will support the development of an updated national VMMC communication strategy.

Two WHO prequalified VMMC devices (PrePex and Shang ring) have successfully undergone acceptability and feasibility pilot studies in Malawi. MOH leadership endorsed PrePex and there are ongoing discussions to undertake active surveillance for 1,000 circumcisions for the PrePex device in FY16. PEPFAR/Malawi will continue partnership with UNICEF to lay the foundation for Early Infant Medical Circumcision (EIMC).

Target Populations	All Males Population Size Estimate (SNU)	Male Population (15-29 yr) Size Estimate FY17 (SNU)	Cumulative # of circumcised men 15-29 (end of FY16)	Current Coverage (15-29yrs) (FY16)	VMMC_CIRC (15-29 yrs) (in FY17)	Expected Coverage (15-29yrs) (in FY17)
Blantyre	677,867	199,821	34,775	31%	16,703	34.8%
Lilongwe	1,182,604	394,108	40,388	14%	24,500	17.3%
Zomba	399,166	134,094	26,248	45%	1,737	47.8%
Thyolo	313,732	117,073	16,611	34%	6,313	37.3%
Mulanje	273,555	104,671	15,689	36%	5,555	38.9%
Chikwawa	243,522	86,680	7,061	12%	11,098	18.5%
Chiradzulu	149,410	57,543	12,299	43%	1,450	46.2%
Phalombe	171,160	62,862	13,647	29%	5,892	34.3%

Total/ Average	3,411,016	1,156,852	166,718	National: 12.7%. Average across 8 PEPFAR supports Districts:30.5%	73,248	National: 14.2%. Average across 8 PEPFAR supported district:34.4%
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4.4 PMTCT

ART initiation for HIV positive pregnant women attending ANC is 90%. Stigma and low male engagement (only 22% of male partners test for HIV) impact HIV positive women's willingness to initiate treatment and adherence due to fear of disclosure, GBV or abandonment. IPs continue to work with communities to address stigma and GBV to increase identification of all pregnant women and families through targeted demand generation/gender normative change, and provide effective linkages through tracked referrals and support defaulter tracing. Priority populations – young mothers, OVC households, and sex workers -- may need additional strategies to improve access and effective linkage to services.

In COP16, USG will continue to strengthen core PMTCT services, including HIV case identification, provision of quality clinical services, linkages and retention systems. Interventions targeted to improve the quality of PMTCT services include:

- Addressing HRH gaps through hiring and deploying HIV diagnostic assistants (HDAs). HDAs increase access to routine PITC in MNCH settings. perform syphilis rapid tests in ANC, confirmatory testing before ART initiation and collect DBS samples for EID and VL monitoring;
- Deploying mentor mothers to improve PMTCT service uptake and retention;
- Increase HTC uptake of family members and couple testing through referral slips, family testing days and targeted community based HTS;
- Improving M&E systems and performance monitoring;
- Establishing model PMTCT and HIV-MNCH integration sites at rapid scale up sites;
- In-service training, mentoring and supportive supervision;
- Renovating HF; and
- Supporting young mothers' access through expansion of trained YFHS providers within targeted public health care facilities, social franchise and outreach service platforms, and targeted young HIV+ mother care groups.

Central initiatives that complement COP funded PMTCT include DREAMS, ACT, PMTCT/ART integration and Family Planning/HIV integration. With the exception of DREAMS, these central resources will end before COP16 implementation but approaches developed and lessons learned through these investments will be incorporated into the COP16. DREAMS funded activities will bring increased focus on AGYW to reduce HIV vulnerabilities and unintended pregnancy as well as increase access to key HIV services including FP, HTS, STI, and post-GBV care and treatment.

4.5 HIV Testing and Counselling

	Package of Services	“Fast track” Districts	Saturation	Sustained	Centrally Supported
First 90 :	Mentoring, QI for Facility based PITC with high yield (including EID)	Scale-up	Scale-up	Continue	x
	National level quarterly supportive supervision	X	X	X	X
	Linkage Systems – <i>SOPs, Linkage Experts</i>	Scale-up	Scale-up		
	HRH - <i>HDAs</i> - <i>Certified HTS supervisors</i>	Scale-up	Scale-up	No new investments beyond COP15	
	Infrastructure – N=new buildings – E= Expand/repurpose existing buildings; prefabs/ containers – R= minimal maintenance, renovations	N,E, R	E, R	R	
	Equipment and furniture to meet MOH basic minimum standards	X	X	X	
	Targeted outreach HTS with high yield (incl. pre-test screening)	Scale-up	Scale-up		

To reach 80% saturation of treatment coverage in scale up districts, 2,310,375 people need to be tested for HIV and effectively linked to treatment. COP16 will aggressively scale-up high yield HIV Testing Services (HTS) in facility and community settings. Priority interventions to reach missed populations will include expansion of PITC, targeted community based HIV Testing and Services, improved linkages, and quality assurance. All models will be monitored for impact and adjustments made based on evidence. Structural barriers to service uptake and quality will be addressed through infrastructure, expanded HRH and innovative service delivery models.

Expanded PITC, initiated in FY16, will continue in high yield settings. PEPFAR recruited 719 lay providers, HIV Diagnostic Assistants (HDA) in COP 15 to improve client identification through intensified PITC and linkage. Additional HDAs will be recruited in COP16 based on site specific analysis of HRH gaps. PEPFAR will strengthen implementation of confirmatory HIV testing, currently at 30%.

There are significant infrastructure and HRH issues impeding the scale up of PICT. These are addressed in a supplementary request focusing on the three “fast track” districts (Lilongwe, Blantyre and Zomba). Strategies to increase HTS space include minor renovations/refurbishments of existing infrastructure, rental space near facilities, procurement of repurposed containers, and use of tents.

Other priority population groups not reached through PITC include male partners, HIV-exposed children, KP, AGYW, and OVP. Malawi will scale up targeted community based testing where the yield will likely be high such as in key populations, hot spots, estate workers, truck drivers, fishing communities, adolescents, men, prisoners. Targeted mobilization, linkage and community based testing (CBHTS) strategies initiated in FY16, will be rolled out in COP16. Strategies will use index clients for partner and family testing, integrated HIV/TB mobile/outreach services, mobile/outreach testing in prisons, known hot spots, workplaces, schools, and youth clubs and geographically

targeted testing events to reach other priority populations. A three tiered approach for family index HTS will be used which include use of Family referral slips, followed by SMS reminders and then home based or targeted community HTS with the index client’s consent. In this case index testing can be classified as facility based testing under “other testing” or community based testing depending on where the testing was done. Some partners have established know your child status clinics where adults in ART program bring their children for testing (EGPAF and MSH are implementing this).

Expanded pediatric testing will be integrated into immunization campaigns, targeted HTS at under-five clinics, and dedicated days for Family HTS (Know Your Child’s Status campaign). Addressing specific bottlenecks in EID (reporting, long TAT, loss to follow up, missed opportunities, etc.) will improve the timing and coverage of testing among infants. PEPFAR will work with partners and the MoH to develop screening algorithms for testing among OVC and at high volume clinics where testing all children may not be feasible. Rapid test kits (RTK) are procured through GF resources; PEPFAR will support facilities to strengthen supply chain management of RTK by strengthening reporting of monthly RTK consumption data, ensuring use of daily activity registers and national SOPs to address stock outs.

SIMS results indicate adherence to QA for HIV testing remains a challenge. According to national guidelines, all HTS providers are supposed to undergo a proficiency test (PT) every six months and perform external quality control (QC) of the RTK upon opening a new kit and weekly to ensure its potency. PEPFAR/Malawi will work with MOH National Reference Laboratory and IPs to ensure that PT panels and QC materials are available and distributed to HTS sites; and that SOPs for HTS are available in all sites.

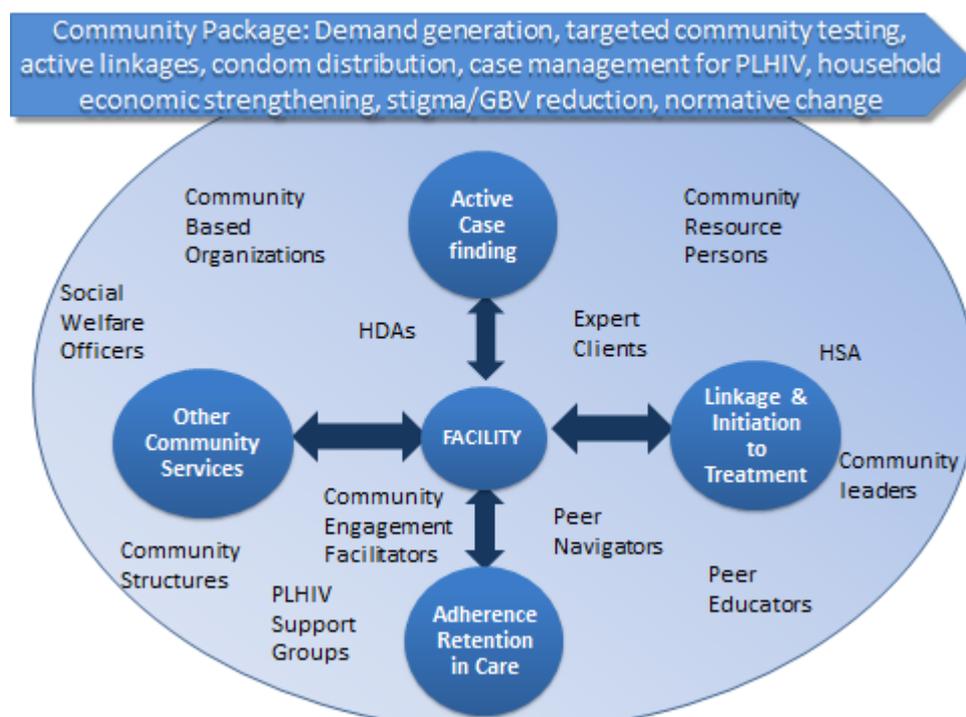


Fig : 4.4 Demonstrating community package and robust linkages through continuum of care

4.6 Facility and Community Based Treatment, Care and Support

In priority sites, all PEPFAR service delivery partners will implement a standardized package of DSD interventions (Table 4.6.1). In consultation with the MoH, a number of intensified approaches supporting the 90-90-90 cascade have been added in COP16. In line with Test and Start, facility-based activities will include evidence based interventions to address service delivery bottlenecks and improve treatment outcomes. An intensified emphasis on community systems is intended to improve retention efforts and reduce LTFU rates.

Various differentiated models of service delivery are already being implemented in Malawi, aligned with the WHO definition. The Malawi guidelines recommend 3 monthly visits for clinic and drug refills for patients who are adherent and stable on ART. Examples of differentiated care models already being implemented include integrated TB/HIV, ANC/ ART clinics, teen clubs, Community ART groups. ART service delivery has been task-shifted with nurses playing a key role in ART initiation and follow up, and lay cadres such as Expert Clients playing an increasingly leading role in treatment literacy, adherence counseling and active defaulter tracing. With the exception of viral load monitoring, stable ART patients do not routinely undergo any laboratory tests. Modelling has been undertaken to determine the impact differentiated care models would have in alleviating HR and Infrastructure gaps in COP 16. Although MOH has not endorsed pharmacy fast track and 6 monthly refill visits in the national guidelines, PEPFAR has endorsement to establish demonstration sites. On the basis of these projects PEPFAR will continue to advocate for scale up of these models, especially in the higher burden clinics. The considerations for differentiated care models are described in figures 4.2, 4.6.2, 4.8 and in appendix E.

Retention rates of ART cohorts are monitored on a quarterly basis. PEPFAR will scale up interventions at facility and community level to reduce loss to follow up (LTFU). Strategies are already being implemented in COP 15 with the development of operational guidance and tools for active patient tracing. The investment package to reduce LTFU includes low cost HRH support through the engagement of expert clients and volunteers, appointment reminders (registers, SMS technology, EMRS prompts, physical tracing), establishment and strengthening of support groups such as teen clubs. Expert clients and community models (see Fig.4.4) will address barriers to retention such as stigma and discrimination, facilitate disclosure, enhance treatment literacy, linkage with economic strengthening and psychosocial support programs. The investment package will be further refined with the findings of a HOP funded study to optimize retention in care, including screening tools to identify patients who are more likely to default.

In all of the facilities in the scale up districts PEPFAR will support at least one community engagement facilitator who will be charged with coordinating with Community based structures (including CSOs and support groups) in order to achieve increase targeted testing, treatment and viral suppression.

The following categories of patients will received additional support efforts for effective disease control:

- New Positive – Not yet linked to Care

- Patient with high viral load: patients with >1000 copies per ml
- Missed appointments: patient who missed 1 appointment
- Defaulter
- Positive DNA PCR

Table 4.6.1 Package of services by district classification

	Package of Services	“Fast track” Districts	Saturation	Sustained	Centrally Supported
Second 90	ARVs: No PEPFAR support needed. GF forecasts for FY 17 are adequate	Monitor	Monitor		
	District level clinical mentoring, QI and supportive supervision	X	X	Targeted remedial interventions only	
	National level quarterly supportive supervision	X	X	X	X
	ART service providers(HRH) – A= Additional Ask for salary support – D= recruit and deploy PEPFAR supported graduates	A, D			
	Rapid Infrastructure enhancements – N=new buildings – E= Expand existing buildings; add prefabs/containers (additional ask) – R= minimal maintenance, renovations	N,E, R (priority)	E,R	R	
	Equipment and furniture to meet MOH basic minimum standards	X	X	X	
	Facility based differentiated service delivery Models	X	X		
	Community based differentiated service delivery model	X			
	Active Defaulter Tracking (HRH) – EC, CHWs	X	X	HSAs	
	TB/HIV TA	X	X	X	
	TB diagnostics	X	X		
Third 90	Viral Load (lab systems)	X	X	X	X
	TA (clinical mentoring, QI and supportive supervision)	X	X		
	National level quarterly supportive supervision	X	X	X	X

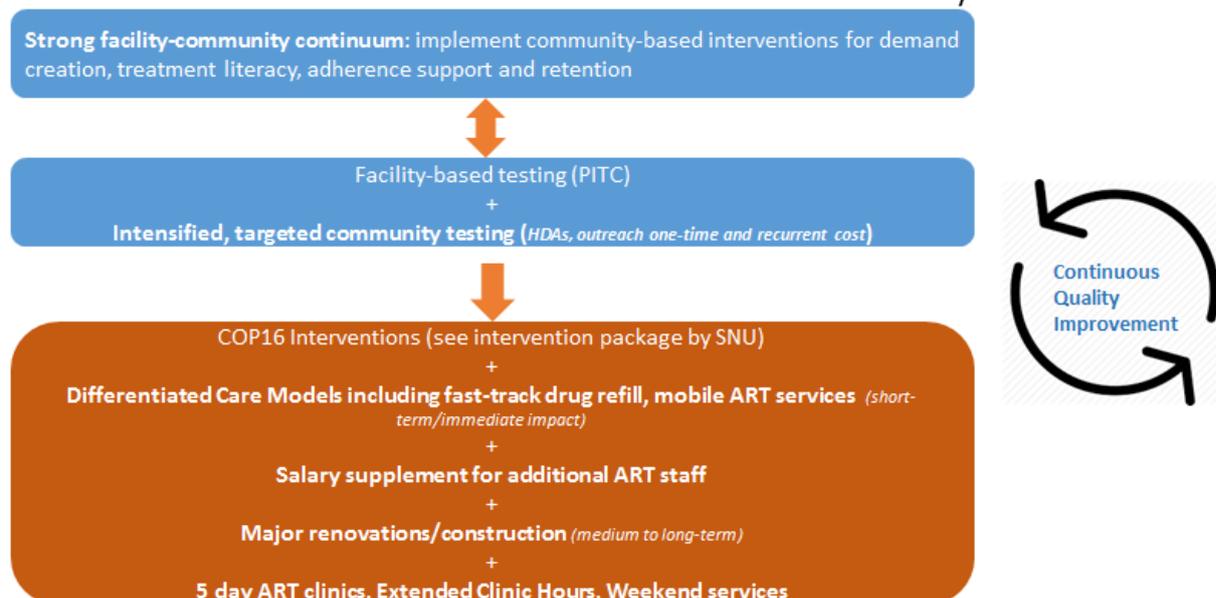
These include:

- Fast tracking ART initiation by decentralizing pre-initiation counselling using community based expert clients, increasing access to confirmatory HTC through deployment of dedicated HIV counsellors linked to or at the ART clinics prior to ART initiation and increasing the number of facility and community based service delivery points;
- Strengthening linkage and retention systems, including expert clients to improve enrollment and initiation at ART clinics, expand adherence counselling, and defaulter tracing;
- Bi-directional facility-community referral systems to support community based prevention, treatment and care models, supported by engagement of community health workers, support groups and CBOs for adherence and retention;

- Expanding the roles of clinical mentors to monitor workload, identify health systems bottlenecks to access and high quality care and treatment services, and develop site specific SOPs for differentiated models of care;
- Increasing access to confirmatory HTC through deployment of dedicated HIV counsellors linked to or at the ART clinics prior to ART initiation;
- Scaling-up QA/QI interventions to comply with national HIV guidelines.

Fig 4.6.2

“Fast-track” District Interventions - Summary



The following activities will be undertaken at sites anticipated to have a higher ART patient volume as a result of intensified and comprehensive interventions in the “fast track” districts. Salary support and infrastructure investments are dependent on a supplementary request to OGAC, which will support attainment of FY18 targets and service quality.

- **Assure service delivery standards for ART:**
 - Assure adequate HRH, infrastructure, and essential equipment (salary support for ART service providers at targeted sites in the “fast track” districts);
 - Use standard national tools for supportive supervision and monitoring of the quality of services and treatment outcomes.
- **Implement data-driven approaches:**
 - Define capacity thresholds for ART clinics and determine threshold for the implementation of differentiated service delivery models;
 - Monitor facility stock levels of ARVs, RTK, condoms, VL reagents, etc.;
 - Service delivery optimization as an immediate intervention; and
 - Any site with over 3,000 patients alive on ART be considered for:

- Rapid Investments in infrastructure (pre-fab or containers) and HRH recognizing the rate of cohort growth in these sites, and
- Enhancement of the facility-community continuum: implement community-based interventions for demand creation, treatment literacy, adherence support and retention.

Peace Corps Health volunteers placed in scale-up sites will collaborate with USG IPs for behavior change prevention activities. Additionally, PEPFAR/Malawi is exploring the possibility of leveraging additional Global Health Service Partnership Peace Corps health volunteers to be placed in large sites in Lilongwe, Blantyre and Zomba to provide service delivery and capacity building.

4.7 TB/HIV

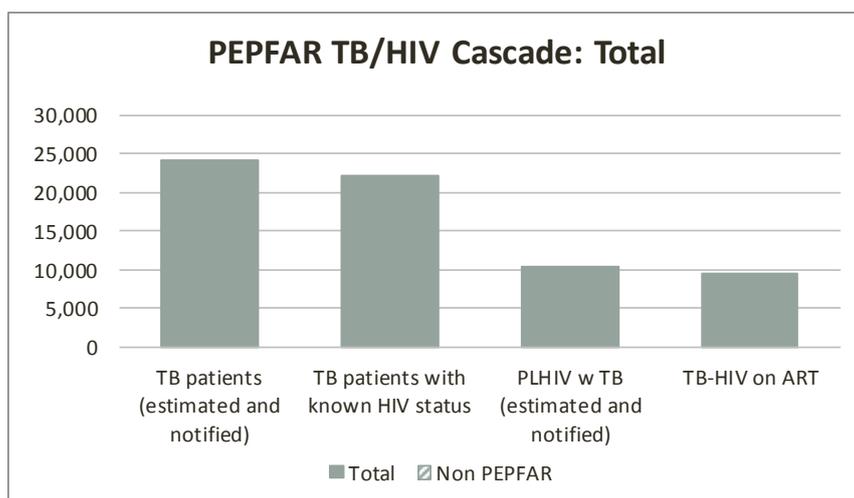
TB is a leading cause of mortality and morbidity among HIV positive patients but a 2014 survey indicated only half of expected TB cases were diagnosed. Most TB patients (91%) in clinics know their HIV status but TB case notification has been declining over the past decade, averaging 18,000 new and relapse cases per year. Diagnosing TB patients is a key challenge and priority. COP16 will focus on core TB/HIV activities aligned with the TB National Strategic Plan through:

- Hiring and training of dedicated HTC counselors for routine PITC for TB patients;
- Active case finding in the urban centers in Zomba, Blantyre, Lilongwe and Mzuzu where 55% of TB cases are notified (community mobilization, mobile clinics for screening, diagnosis and treatment),
- Increasing early ART and TB treatment initiation for co-infected patients,
- Enhanced case finding through systematic screening in HIV clinics and linkage e to diagnostic services. HSAs and expert clients trained at high burden sites to systematically screen for TB;
- Implementation of SOPs for TB/HIV integration,
- Improving M&E systems and performance monitoring;
- Technical support for in-service training, mentoring and supportive supervision;
- Review IPT policy to extend provision of IPT to patients on ART in whom TB has been ruled out;
- Renovating and equipping HF;
- Increasing access to TB diagnostic facilities including optimized utilization of GeneXpert platforms;
- Secondment of technical staff to the MoH to address capacity gaps for program management, commodity security and supply chain, monitoring and evaluation;
- Triaged approach for TB patients in high volume OPD and ART clinics and prisons;
- Supporting the national program to implement an electronic TB register and improve TB/HIV data recording and reporting;
- Decentralization of TB/HIV services through establishment of new TB diagnostic and TB treatment initiation services; and
- Supporting HF to develop and implement TB infection control plans.

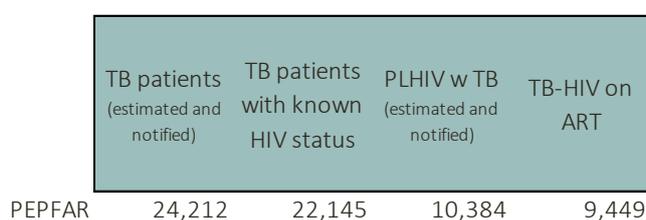
The bulk of TB resources are from Global Fund grants and continued funding is critical for an effective TB response. Integration of TB/HIV programs is expected to streamline and improve

management and implementation of activities including commodity procurement systems. Recently released MOH guidelines reflect this integration.

TB Cascade



PEPFAR TB/HIV Cascade



4.8 Adult ART

As of September 2015, there were 585,660 HIV positive adults on treatment nationally (68% coverage). Gaps in ART access are still evident among men, and there is limited data on treatment coverage among key populations. The 12-month retention rate is 78%, which is below the WHO target of 85%; however, this varies significantly by site.²² Viral suppression among adults (>81%) is much higher than children (61%)²³. However, viral load monitoring is not done consistently for all ART patients and the median result turn-around time is 30 days. One percent of the treatment cohort is on second line regimens.

COP16 will further intensify activities in districts with the highest burden; implement Test and Start, and address losses across the clinical cascade. In order to reach the aggressive target of adding 161,208 new patients, with a total of 670,407 patients on treatment, a number of new strategies will

²² MOH report estimates actual retention is 10% higher when “silent transfers” are taken into account.

²³ MOH quarterly report, September 2015

be implemented. Expanding access to HTC, improving yield, and ensuring linkage to treatment services are critical to reaching the COP16 targets. Differentiated care models will be needed to mitigate HRH and infrastructure constraints and ensure quality services.

As part of COP16 and using resources from the DREAMS male Test and Start initiative, PEPFAR/Malawi will implement targeted interventions addressing barriers that men encounter for HIV testing and treatment services (Fig 4.2). In Blantyre and Lilongwe, IPs will pilot alternative approaches to differentiated service delivery including pharmacy fast track visits for stable patients and community-based approaches such as mobile ART clinics.

Strategy 1: Differentiated Care and Treatment Services

BARRIERS: Client perspective • Long waiting times • Work hours • Stigma (actual/perceived) Provider perspective • HRH shortage • Constrained physical space • Unclear guidance on stigma reduction	Differentiated care models	Who provides the service? What is being done differently?	Where the service is provided?	How often are the services provided?
	Differentiated schedules	Expert clients, HDAs 1. Provide pre-initiation counselling after (confirmatory) HIV testing <i>(new)</i> 2. Start early or late opening hours +/- Saturday clinics <i>(new)</i>	Facility and/or community level	As needed
	Differentiated clinics	Certified ART providers 1. Provide integrated care • In ANC clinics • In TB clinics 2. Conduct dedicated clinics • Adolescent clinics/ teen clubs • Men friendly clinics/ clubs? <i>(new)</i> • Prisons	Facility level • Clinic days for adolescents, pregnant women and their children • Integrate ART services in Antenatal clinics; TB/HIV co-infected patients	To be determined at site level
	Differentiated client flows	Certified ART providers, expert clients 1. Triage follow-up visits • Nurse review of uncomplicated cases • Schedule VL milestone visits in the morning <i>(new)</i> • Fast-track drug refills for stable, adherent patients <i>(new)</i> 2. Task sharing to expert clients for core interventions: • TB screening, provider initiated FP <i>(new)</i> • Pill count and adherence counselling <i>(new)</i>	Facility level ART clinics	To be determined at site level

Fig 4.8 Differentiated Care and Treatment Services

Highlighted in the figure above are a number of new differentiated care models for COP16, including the agreement made by the Ministry of Health to fast track pharmacy refills in the three high burden districts of Blantyre, Lilongwe and Zomba. Through the National Care and Treatment TWG there is also a commitment to continue to explore other appropriate models and roll out timeframes.

Key treatment interventions include:

- Strengthening linkage and early enrollment into treatment;
- Recruitment and deployment of lay providers for linkage optimization and improved access to core HIV services;
- Targeted service delivery approaches to expand treatment access and quality for priority and key populations;
- Model ART clinics at scale up sites;
- Training, supervision, and clinical mentoring to improve comprehensive care and treatment services, monitoring of ARV side effects, identifying treatment failure, implementing family

centered chronic care models, bidirectional facility-community referral system to strengthen the care and treatment continuum;

- Coordination with communities, CBOs, FBOs and community health workers for awareness, stigma reduction and demand creation for ART services;
- Implementation of active defaulter tracing. Expert clients will play a central role in intensive post-test counseling, disclosure support, routine and targeted adherence counseling and defaulter tracing;
- Site-level M&E systems and data use for continuous QI;
- Renovating HF to increase clinic space and drug warehousing capacity;
- TA to implement NSP for viral loads scale-up support of viral load centers, sample transportation systems and Electronic Medical Record System (EMRS), VL module to improve clinical compliance;
- Identify first line regimen failures through VL, and certification of additional second line ARV prescribers;
- Procuring laboratory clinical monitoring commodities to complement the GF investment;
- National HIV Drug Resistance survey;
- Secondment of technical staff to MoH to address capacity gaps in program management, commodity security and supply chain, monitoring and evaluation; and
- Optimizing the National EMRS by extending its functionality as a point-of-care decision-support tool.

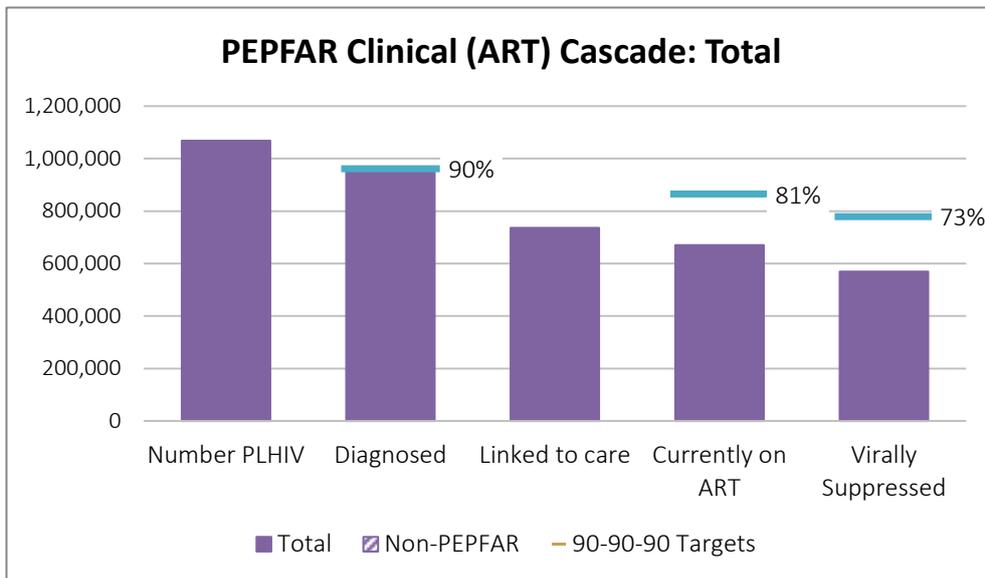
Demand creation for services will include mass media/communications design for treatment literacy, and intensive community mobilization by community partners will occur within the scale-up districts. Targeted community-oriented care interventions will support defaulter tracing and positive prevention dignity and health including adherence, partner testing and on-going linkage to services as well as stigma and discrimination reduction and GBV prevention. Close partnership with facility partners will facilitate expansion of community oriented adherence and treatment models pending MoH approval.

4.9 Pediatric ART

The number of children receiving ART increased from 42,220 in June 2014 to 50,533 by September 2015, coverage of 39%. COP16 follows-on from the ambitious ACT initiative which covered a two year period (FY15 and FY16). This strategy resulted in doubling the number of children tested by the deployment of HDAs and scaling-up of high-yield testing approaches.

In FY 17, 16,712 children will be newly initiated on treatment and 72,767 will be alive and on treatment.

Clinical (ART) Cascade



Number PLHIV	Diagnosed	Linked to care	Currently on ART	Virally Suppressed
1,068,536	950,087	736,741	670,407	569,846

Key interventions include:

- Site-level clinical mentorship, training and supervision, including differentiated care models such as integration into pediatric service delivery points, family centered approaches, synchronized mother-infant pair visits, decentralized treatment in high burden ART sites that exceed capacity, specialized clinic days, teen clubs;
- Assigning CHWs, including expert clients, and provider-initiated testing and counseling providers (HDAs) to actively link and/or refer to HIV care and treatment, including physical escort, and to rapidly trace children who default
- PITC in high-yield settings utilizing HDAs;
- Scale-up Community Testing - Immunization outreach posts to include EID;
- Continuous Quality Improvement (CQI) initiatives specifically for EID ;
- Scale-up facility and community index testing;
- An algorithm to screen and optimize yield for HIV in OPD and OVC settings;
- Scale-up Youth Friendly Health Services;
- Strengthen use of bi-directional linkage and referral tools;
- Support pediatric HIV technical advisors seconded to district hospitals in high burden districts;
- Scale-up the CQI approach for pediatric treatment;
- Active defaulter tracing systems at all priority facilities – Routine review of records to identify missed appointments, use of community workers (lay cadres, HSAs) for tracing and bringing patients back to care; and

- Support VL scale-up (sample collection and transportation, LMIS, HRH).
- Introduce LPVr regimen as per new ART guidelines with minimum requirement of at least one MOH certified level 2 (second line) prescriber as these are trained in the use of LPVr.

Interventions to address three key pediatric gaps identified through routine program performance review include:

(i) Low EID Coverage

- By May 2016 sample transportation will scale-up to all 28 districts;
- Reducing EID turnaround time for selected scale-up sites (Phone calls from lab to facility for all positive results, LMIS direct link for EMRS sites, SMS printers, etc.);
- Due to the format of the EID registers and exposed infant patient cards (“pink cards”) it is possible that a number of EID tests are not recorded and/or reported. PEPFAR/Malawi will work with MOH to improve current M&E tools including documentation of children on adult ART patient records to enhance identification, linkage and retention of family members of index client, and
- Opportunities for integrating EID services in community-based immunization points.

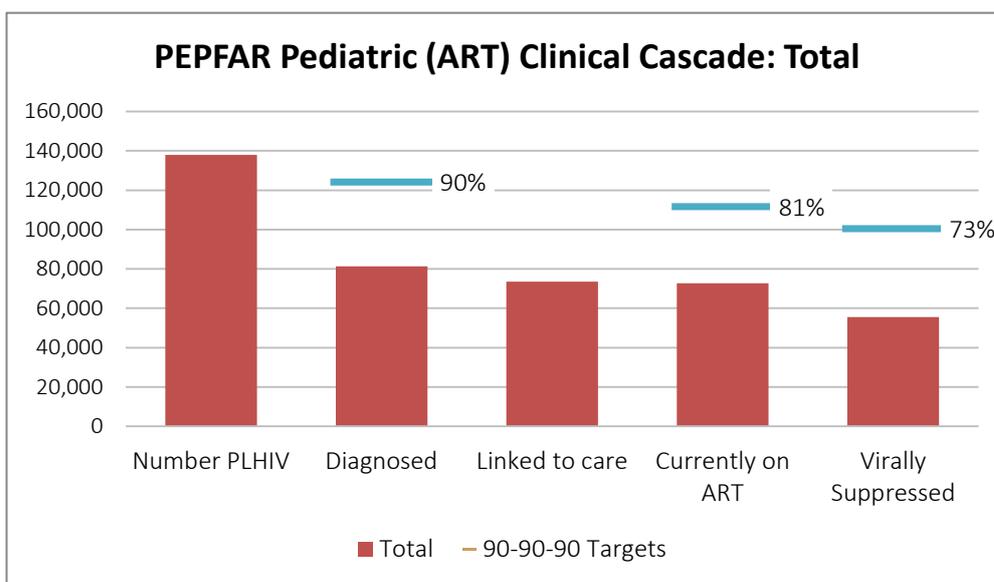
(ii) Gaps in linkage and treatment services for adolescents

Integration of HIV testing and treatment services in reproductive health clinics will be a key strategy. In line with suggestions received from CSOs, teen clubs and teen support hotlines will be expanded to more priority sites and districts. PEPFAR will work with DHA to improve current M&E systems for better age, sex and yield data. Some observed gaps are believed to be due to data quality issues. Utilizing PEPFAR community platforms, bi-directional referrals between community and facility-based HIV testing services and treatment facilities enhanced to maximize treatment services for adolescents.

(iii) Low VL coverage among children

IPs will work with sites to significantly increase VL coverage for children and adolescents with CQI initiatives). PEPFAR will advocate for inclusion of effective and well-tolerated pediatric regimen into the national guidelines.

Pediatric Clinical (ART) Cascade



Stage	Number
Number PLHIV	137,884
Diagnosed	81,335
Linked to care	73,502
Currently on ART	72,767
Virally Suppressed	55,590

4.10 Orphans and Vulnerable Children

Malawi has 1.4 million children affected by HIV/AIDS, 9% of the total population and 17% of the population of all children²⁴; of these, 770,000 have been orphaned due to AIDS-related deaths (UNAIDS, 2012). PEPFAR/Malawi will provide services to OVC and their households to ensure their well-being and provide comprehensive impact-mitigation and HIV prevention and treatment services. Activities will focus across five domains: case management; health (access to health/HIV services, psycho-social and mental health interventions); safety (child Protection/GBV, positive parenting); stability (economic strengthening, social protection access and support). Through direct service delivery, the OVC program will implement core activities including household vulnerability assessment, case management planning and implementation, food security/ nutrition services, caregiver/parenting programming, life skills education for children, and psychosocial support. Priority social welfare workforce capacity strengthening interventions and TA will improve community and school (education) and district level systems to support children. In FY17 PEPFAR/Malawi plans to engage “4Children”, implemented by Catholic Relief Services, to scale up OVC interventions to expand the reach of OVC core activities to other scale-up districts not currently covered by One C: Thyolo, Lilongwe and Mzimba.

²⁴ 2008 National Population Census projection for 2015

Table 4.1.5. Targets for OVC and Linkages to HIV Services

		Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY17 Target) OVC_SERV	FY17 Target OVC_SERV DREAMS	FY17 Target OVC_SERV (COP + DREAMS)
Lilongwe District	ScaleUp Sat	150,766	6,231		6,231
Blantyre District	ScaleUp Sat	123,417	8,660		8,660
Zomba District	ScaleUp Sat	78,784	25,032	26166	51,198
Mzimba District	ScaleUp Sat	72,872	3,304		3,304
Mulanje District	ScaleUp Sat	68,340	10,410		10,410
Thyolo District	ScaleUp Sat	63,865	3,708		3,708
Chikwawa District	ScaleUp Sat	58,844	7,595		7,595
Phalombe District	ScaleUp Sat	51,007	6,056		6,056
Mangochi District	ScaleUp Agg	105,924	20,206		20,206
Machinga District	ScaleUp Agg	60,146	12,980	19035	32,015
Balaka District	Sustained	40,151	8,114		8,114
TOTALS		874,116	112,296	45,201	157,497

**OVC_KNOWNSTAT will have targets in FY18*

PEPFAR/Malawi will provide system-level support to strengthen GOM system and structures, social workforce development, policy and case management. Working with communities, PEPFAR/Malawi will leverage new and existing mechanisms, and other initiatives - DREAMS and ACT. Interventions will focus across other service platforms to promote HTC and linkage of HIV-infected children and adolescents to care and treatment services. PEPFAR will collaborate with other development partners through new and existing activities to provide services to hard-to-reach populations of vulnerable children requiring alternative care, (e.g. children in institutions, children with disabilities, and street children). For COP16, direct service delivery OVC activities will be aligned with care and treatment scale-up sites located in eleven districts. In COP16, USG Malawi will roll out the MER 1.5 Essential Survey for OVC programs. Through Project SOAR, a baseline will be established to document the status of OVC households prior to interventions with subsequent outcome measurements biannually. Peace Corps volunteers will continue to engage OVCs in site level interventions including HIV prevention trainings, camps and clubs.

PEPFAR Malawi proposes to reach 75% of the OVC population in eight targeted districts by 2020 with a comprehensive package of interventions designed to 'graduate' vulnerable children from program support to self-sufficiency. This programming approach will saturate targeted traditional authorities to achieve district coverage over five years. Due to late award of the integrated community care/OVC platform ("One-C"), true implementation of this comprehensive approach has just begun. PEPFAR/Malawi anticipates providing comprehensive services to 355,899 beneficiaries from OVC households over a five year period in eight target districts covering 58 Traditional Authorities through this activity. In FY17 PEPFAR/Malawi also plans to engage "4Children", implemented by Catholic Relief Services, to scale up OVC interventions to expand the reach of OVC core activities to

other scale-up districts not currently covered by OneC: Thyolo, Lilongwe and Mzimba. In COP 16 PEPFAR Malawi expects to reach a total of 108,503 OVC with comprehensive services.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts

Sustained Support Volume by Group	Expected result APR 16	Expected result APR 17	Percent increase (decrease)
HIV testing in PMTCT sites	108,186	164,766	52%
HTS (only maintenance ART sites in FY 17)	416,757	756,271	81%
Current on ART	94,457	156,140	65%
OVC	20,484	26,607	30%

5.1 Maintenance package of services in other locations and populations

Approximately 50% of all national ART sites will no longer be intensively supported by PEPFAR; for these sites, a maintenance package negotiated with the MOH for COP 15 include:

In-service training – at priority sites with IPs coordinating with the DHOs for implementation.

Sample transportation (ST) – for EID and VL monitoring. Riders for Health (R4H) have developed a district collection schedule for at least weekly sample collection.

National Quarterly Supervision – The data which are validated and collected at each site during supervision is critical to ensuring that minimum quality standards are maintained, and ensuring that sites in need of urgent clinical mentoring are visited consistently.

Rapid Response Clinical Mentoring – 15-30 sites each quarter identified during supportive supervision as having one or more areas of sub-standard performance will be visited by an IP clinical mentoring team.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

The gains made in addressing the HIV epidemic in Malawi are threatened by key weaknesses in the health system. Malawi has one of the most severe health workforce crises in Africa with the lowest physician-to-population ratio at 2:100,000 population and second lowest nurse to population ratio

28:100,000; vacancy rates for nurses, lab staff, clinical officers and pharmacists range from 51% to 88%^{25,26}. Recently the country instituted a hiring freeze for civil service because the national budget can no longer accommodate a constantly increasing wage bill. Of the 719 functioning HF across the country, 81% are in rural areas and are unevenly distributed forcing many people to walk more than 10 km to access services.

Lack of access to health services is compounded by urban/rural disparities in staffing. Overall weak HRH management systems, poor enforcement of existing pre-service training, deployment and retention policies further compounds the poor HRH skill mix and unavailability across the country. There has been little infrastructure investment in HF since the 1980s. The population has doubled since then while the HIV epidemic has significantly increased service demand. Forty percent of public HF have no regular electricity supply, only half have running water, and two thirds do not have latrine facilities. From several surveys and SIMS visits, 68% of HF visited required increased space for counselling and testing. Three quarters of all facilities having inadequate pharmacy storage space for current needs. With a move toward multi-month prescribing options, increased pharmacy storage space is critical. While the national supply chain is functional, there have been challenges reported at facility/site level around commodity management. Although there is adequate stock of commodities nationally, facilities have reported stock-outs of EID and RTKs generally resulting from lack of, and poor, inventory commodity management skills. In FY 16, 11% of facilities reported a stock-out of “Determine” kits. The stock-out of these commodities directly affects the achievement of the 90-90-90 targets.

Laboratory systems are weak and cannot efficiently support the third “90” targets without considerable additional investments in sample transportation systems, information systems, commodity forecasting, equipment procurement, and improved laboratory staffing levels.

PEPFAR/Malawi has identified the following three key programmatic gaps in the care cascade that are critical for achieving PEPFAR epidemic control targets.

Programmatic Gap #1 Low identification of HIV positives at facility and community levels and linkage rates (testing to care/treatment).

Improving HIV testing strategies to identify specific groups of PLHIV is critical to increasing positivity yield. Initiation of Test and Start services is expected to reduce some linkage barriers for PLHIV however employing strategies that proactively identify PLHIV at facility and community level is necessary to increase number PLHIV eligible for treatment.

Systems are barriers affecting achievement of overall testing goals:

- Lack of private space for testing which limits acceptability of PITC and HCT and accessibility for men; 68% of sites had inadequate space for testing;

²⁵ EHRP evaluation report 2010

²⁶ HRH strategic plan 20102-2016

- Inadequate HRH to specifically focus on providing PITC at facility and at community level;
- Continued stock-outs of HIV test kits at facility level in spite of sufficient national stock;
- Lack of demand and health seeking behaviors for testing and services; and,
- Lack of standardized guidelines, operating procedures and monitoring tools for HTS linkage interventions.

Programmatic Gap #2 High defaulter rate and Low retention rate in treatment services

Retention in the national treatment program is 78% at 12 months, and 72% at 24 months. High rates of loss to follow-up will hinder capacity to accelerate new and current on treatment and reach viral suppression targets.

Systems barriers affecting retention rates:

- Inadequate space for providing optimal care and treatment services (consultation rooms, waiting areas, pharmacy space and space for physical integration of services); 58% of facilities had grossly inadequate space for ART delivery and 77% facilities had inadequate commodity storage space;
- Inadequate HRH to provide ART services through any given working day. Most facilities operate special ART clinic days or provide ART services for only half the day as a way of rationing staff time for service provision which affects service quality in cases of high patient volumes;
- Poor quality of ART services, affecting individual efficacy for treatment retention (long wait times, long distances to facilities, lack of alternative models of care to reach communities or decongest facilities, inadequate psychosocial counselling, limited recognition of treatment failure (1% of patients on second-line treatment);
- Weak community support and linkage systems at community level; and,
- Lack of a robust national pharmaco-vigilance system.

Programmatic Gap #3: Low coverage of Viral Load (27%) and EID testing (30% at 2 months, 48% at 12 months)

Viral Load testing coverage is 27% of ART patients; coverage of EID is 30% at 2 months and 48% at 12 months. Scale-up of VL is necessary to improve quality of care, recognition of treatment failure, and improve retention of patients in treatment. Low coverage of EID suggests that a high proportion of HIV-exposed infants are not receiving the care they need to prevent transmission of HIV; this is a lost opportunity to identify HIV positive children and initiate them on treatment.

Systems barriers affecting VL and EID testing:

- Shortage of lab sample kits;
- Lack of adherence to SOPs for documentation;
- Limited coverage of sample transport network; and,
- Limited demand for VL testing.

6.1 Proposed system investments for closing programmatic gaps

Table 6.1.1 Key Programmatic Gap #1: Low identification of HIV positives at facility and community levels and linkage rates (testing to care/treatment)						
Key Systems Barrier	Outcomes expected after three years of investment	Proposed COP16 Interventions	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Infrastructure limitations restrict facility capacity to offer confidential HTS	<ul style="list-style-type: none"> 80% of facilities have adequate space for all projected HIV testing services in prioritized sites in saturation and aggressive districts. 	<ul style="list-style-type: none"> - Increase testing facilities in priority sites in saturation and aggressive districts. - Procurement of additional vehicles and tents for targeted outreach HTS. 	OHSS	\$140,000 Supplemental Funding \$3,450,000	EQUIP, MSH,EGPAF, OneC	Service delivery
Inadequate HRH to implement targeted testing, systematic TB and STI screening in PLHIV and support for linkage at facility and community level	<ul style="list-style-type: none"> - 80% of people in saturation and aggressive catchment areas reached with HTS messages 	<ul style="list-style-type: none"> - Recruitment and salary support of HTC providers in saturation and aggressive districts. - In-service training of HTC providers and expert clients for all HTC entry points, TB/STI screening and linkage services. - Recruitment and salary support of expert clients and/or HDAs for community HTS. - Pre-service training of critical cadres for HTC service delivery. 	OHSS	\$1,028,000 Supplemental Funding \$1,000,000	EQUIP, MSH,EGPAF, Pivot, World Learning, CHAM, HRH 2030	Human resources for health
Limited capacity for test kit stock management at facility level	<ul style="list-style-type: none"> - 80% of people in saturation and aggressive catchment areas reached with HTS messages - 100% of the sites have incorporated HTS in their health education sessions in OPD, MCH and other service delivery points. 	<ul style="list-style-type: none"> - In-service supply chain training and ongoing supervision and mentorship for pharmacy personnel and other cadres to quantify, forecast, manage and account for stock at facility level. 	PDCS, HBHC, HTXS	\$425,800	EQUIP, MSH, EGPAF, Pivot, Lighthouse, GHSC-PSM,COM,	Commodity security and supply chain
Lack of Standard Operating Procedures and guidelines for patient tracking and	<ul style="list-style-type: none"> - 100% of scale-up sites have effective linkage systems between testing and treatment services (at facility and community level). 	<ul style="list-style-type: none"> - Develop standard operating procedures, guidelines and M&E tools for linkage from testing to care and treatment 	HVCT	\$10,000	EQUIP, MSH,EGPAF,COM, Pivot, Lighthouse	Quality management

linkage to care	<ul style="list-style-type: none"> ▪ 90% of clients testing HIV positive in HTS service delivery points linked to treatment ▪ Scale-up sites attain at least 90% linkage success rates for positive clients. 					
Lack of health seeking behavior and demand for testing services	<ul style="list-style-type: none"> - 80% of people in saturation and aggressive catchment areas reached with HTS messages - 100% of the sites have incorporated HTS in their health education sessions in OPD, MCH and other service delivery points. 	<ul style="list-style-type: none"> - Design targeted HTS services at facility level and community level. - Targeted community mobilization 	HVTC	\$5,000 \$10,000	EQUIP, MSH,EGPAF,COM,ONE C	Quality management
TOTAL				\$1,618,800 Supplemental Funding \$4,450,000		

Table 6.1.2 Key Programmatic Gap #2: High defaulter rate and Low retention rate in treatment services (78% at 12 months, 72% at 24 months)						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16 Interventions	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Lack of standard system for patient tracking and follow-up (including defaulters and transfers and adherence)	- Improved retention rates - 85% at 24 months	<ul style="list-style-type: none"> - Develop SOPs for patient tracking at the facility level to include patient transfers reporting and provision of unique patient identifier. - Introduce work flow efficiencies and alternative models to free time for health workers to conduct defaulter tracing. - Use of lay workers for active defaulter tracing (training, deployment, bicycles, supplies) - In-service training of health workers and expert clients on SOPs for patient tracking. 	HTXS	\$558,900	MSH,EGPAF,EQUIP,COM, Lighthouse	Quality Management
Inadequate HRH to implement targeted, systematic screening in PLWHA, and support for linkage at facility and community level	- 80% of facilities have adequate skilled HRH for systematic TB, and STI screening in prioritized sites in saturation and aggressive districts.	<ul style="list-style-type: none"> - Recruitment and salary support of 113 ART providers at priority sites in aggressive and saturation districts. - In-service training of ART providers for all sites. - Pre-service training of critical cadres for ART service delivery. 	HTXS, OHSS	\$970,000 Supplemental Funding \$1,000,000	EQUIP, MSH,EGPAF, World LEARNING, CHAM, light house, PIVOT. ONE C, HRH 2030	Human Resources for Health
Weak community support systems for ART adherence	- All of TAs covering scale up sites will have community based services for linkage, adherence and retention	<ul style="list-style-type: none"> - Sub-grant to local CSOs/CBOs to provide HIV/AIDS services at community level - Directly supporting CBOs within facility catchment areas to strengthen community care services - Recruitment and In service training of community based cadres for linkage and defaulter tracing 	HTXS,PDCS, HBHC	\$1,750,000	ONE C, MSH, EGPAF, EQUIP, STEPS	Quality Management

<p>No national pharmacovigilance system in place</p>	<ul style="list-style-type: none"> - One national reference lab has ability to test for drug resistance. - Existence of a functional national pharmacovigilance system in place for reporting and monitoring - System in place for reporting adverse reaction and monitoring drug quality surveillance at 2-3 sentinel sites 	<ul style="list-style-type: none"> - One national reference lab has ability to test for drug resistance. - Existence of a functional national pharmacovigilance system in place for reporting and monitoring - System in place for reporting adverse reaction and monitoring drug quality surveillance at 2-3 sentinel sites 	<p>HTXS, PDTX</p>	<p>\$100,000+</p>	<p>EQUIP, GHSC, COM</p>	<p>EQUIP, GHSC, COM</p>
<p>TOTAL</p>				<p>\$3,378,900</p> <p>Supplemental Funding</p> <p>\$1,000,000</p>		

Table 6.1.3 Key Programmatic Gap #3: Low coverage of viral load (27%) and EID testing (30% at 2 months 48% at 12 months)						
Key Systems Barrier	Outcomes expected after three years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Inadequate skilled HCWs at facility level to conduct quality VL sample collection and at lab to efficiently run VL tests	<ul style="list-style-type: none"> - 80% of facilities in prioritized sites in saturation and aggressive districts and 100% of labs have adequate skilled HRH for quality EID and VL services. - Turnaround time for results reporting decreased by 50%. 	<ul style="list-style-type: none"> - In-service training of HSAs, HDAs and other clinical cadres on quality and safe VL sample collection. - In-service training of laboratory technicians/technologists on molecular testing to allow efficient rotation of staff and reporting of results. 	HTXS	\$73,500	MSH, EGAPF, URC, EQUIP	Human Resources for Health, Laboratory, Quality management
Weak supply chain management at facility and district levels leading to stock-outs of DBS bundles	<ul style="list-style-type: none"> - Reduced stock-outs of DBS bundles at facility level to less than 5%. 	<ul style="list-style-type: none"> - Develop curriculum for stock management training for health workers and support roll-out of training on lab commodity management SOPs. 	HLAB	\$195,000	GHCS	Commodity Security and supply chain
		<ul style="list-style-type: none"> - In-service training of pharmacy and lab personnel, HDAs, HSAs in DBS bundle stock management. 	HTXS	See above	MSH, EGPAF, EQUIP, GHSC	Quality management, Commodity Security and supply chain
Poor adherence to VL SOPs and documentation of VL and EID results contributing to limited data availability for improved patient tracking and care	<ul style="list-style-type: none"> - 80% of eligible ART patients receiving VL testing and results. - Increased coverage of EID to 90% of exposed infants by 8 weeks. 	<ul style="list-style-type: none"> - In-service training of ART providers on VL SOPs. 	HTXS	See trainings above	MSH, EGPAF, EQUIP, URC	Quality management
		<ul style="list-style-type: none"> - Develop M&E tools and accountability systems for tracking number of eligible clients for VL against number of VL test done. - Development and distribution of SOPs, algorithms 	PDCS,HTXS, MTCT, HLAB	\$78,000	EQUIP, COM, URC, MSF, EGPAF	Service Delivery; Quality management

Limited coverage of sample transport network	<ul style="list-style-type: none"> - The sample transport network coverage is scaled-up to 100% of districts. - Turnaround time for dispatch of VL and EID results reduced to 3 weeks at a maximum 	<ul style="list-style-type: none"> - Maintain a functional nationwide sample transport system. 	HTXS,PDCS	See lab section	URC , EQUIP, COM	Laboratory
TOTAL				\$346,500		

6.2 Critical Systems Investments for Achieving Priority Policies

Table 6.2.1 Test and Start						
Key Systems Barrier	Outcomes expected after three years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Limited GOM capacity for evidence-based management of drug and commodity procurement and supply chain	<ul style="list-style-type: none"> - 90% of priority sites submit monthly LMIS report (including HIV/AIDS and related commodities) - 100% of pharmacy personnel trained in inventory management, drug requisition and reporting 	<ul style="list-style-type: none"> - Strengthen utility of LMIS for commodity procurement and supply and roll out of eLMIS. - Support deployment of eLMIS. - Train health facility staff on use of LIMS and LMIS data. - Expand EMRS coverage. - In-service training of pharmacy on data use, stock management and accountability. 	OHSS	\$2,890,666	GHSC, Baobab, URC	Commodity Security and supply chain
Inadequate HCWs to meet the increased patient volume as treatment coverage rises	<ul style="list-style-type: none"> - 80% of facilities in prioritized sites in saturation and aggressive districts have adequate trained ART providers for their volume of patients. - 100% of ART providers retrained to offer HIV treatment according to Test and Start. 	<ul style="list-style-type: none"> - Recruitment of additional ART providers, HTC providers and pharmacy personnel health care workers in three “fast track” districts to meet demand. - Implement differentiated care models such as 3 monthly fast-track drug refill with 6 monthly clinic visits for stable patients 		\$2,000,000	TBD, HRH 2030	Human Resources for Health
Limited GOM capacity for evidence based management of	<ul style="list-style-type: none"> - All PEPFAR prioritized Health information systems strengthened and generated data analyzed for 	<ul style="list-style-type: none"> - Providing TA to Department of HIV/AIDS for Strategic information and logistics 	OHSS	\$430,000	I-TECH	Epidemiological and Health data

national HIV program	timely decision-making and planning.	- Provide TA to MOH to develop supply chain database and Data Quality analysis.	OHSS	\$150,000	GHSC	Commodity security and supply chain
	- Supply chain management TAs recruited and seconded to HIV/AIDS department, HTSS-P, and zonal offices	- Place TAs at zones to support site level HIV/AIDS commodity management.				
	- Treatment optimisation – adoption of new efficacious and cost-effective drugs in pipeline.	- Provide TA to MOH for strategic HRH management.	OHSS	\$475,000		
Inadequate coverage and quality of HIV-related health information systems for decision support and management of patient volume and commodities	- 90% of PEPFAR supported students tracked through graduation and deployment - 90% of MOH cost centers providing updated staffing returns via electronic system at least quarterly	- Strengthen Health information systems (HRIS, TrainSmart, LIMS, EMRS, eLMIS).	OHSS	\$239,694	I-TECH, URC, MOH, Baobab, HR 2030, GHSC	Epidemiological and Health data
				\$860,000		
TOTAL				\$7,045,360		

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	Outcomes expected after three years of investment	Proposed COP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Lack of national guidelines and SOPs for new and efficient service delivery models	<ul style="list-style-type: none"> - National guidelines and SOPs developed for service delivery and approved by MOH 	- Develop nationally accepted SOPs and guidelines.	HTXS	Ref above	MSH, EGPAF, EQUIP, COM	Policies and governance
		<ul style="list-style-type: none"> - In-service training of pharmacists - Training modules developed for clinical mentors on differentiated HIV service delivery models (community and facility level). 	HTXS	\$289,200	MSH, EGPAF, EQUIP, COM, GHSC, LIGHTHOUSE, LINKAGES, SIFPO2	
		- Recruitment of additional staff.	HTXS	Ref above	MSH, EGPAF, EQUIP,	
		- Place TAs at zones to support site level HIV/AIDS commodity management.	OHSS	\$150,000	GHSC	
		- In-service training of pharmacists.	HTXS	Ref above	EQUIP, COM, GHSC	
Limited commodity storage capacity at national, district and facility levels	<ul style="list-style-type: none"> - 80% of facilities in prioritized sites in saturation and aggressive districts have adequate storage capacity for ARVs for routine needs - 100% of staff in prioritized sites in saturation and aggressive districts trained to appropriately manage stocks to avoid expiry. and stock outs 	<ul style="list-style-type: none"> - Install 34 prefabricated pharmacy units at prioritized high burden sites. - Recruit and provide salary support to 47 Pharmacy Assistants - Place supply chain TA at zone level to support HIV/AIDS 	OHSS	\$150,000	GHSC, MSH, EGPAF, EQUIP,	Commodity security of supply chain, HRH, Quality Management

<p>Limited MOH capacity to supervise and monitor community-based care and treatment models</p>	<ul style="list-style-type: none"> - Standards for quality community-based treatment established and incorporated within regular quality assurance monitoring for service delivery. - 100% of community based care models and treatment models to be supervised by PEPFAR or non-PEPFAR IP in collaboration with MOH 	<ul style="list-style-type: none"> - In-service training of staff on alternative models of care. - Standardize supervision approaches 	<p>HTXS</p>	<p>Ref above</p>	<p>MSH, EGPAF, EQUIP, COM</p>	<p>Quality management</p>
<p>TOTAL</p>		<p>\$589,200</p>				

6.3 Proposed system investments outside of programmatic gaps and priority policies.

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	Activity	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
HRH - Systems/Institutional Investments							
Inst & Org Development							
Organizational capacity development of HIV service CSOs	- Improve capacity of CSOs to manage, implement and sustain innovative and effective HIV/AIDS community care, prevention and OVC programs.	1 st 90; 2 nd 90; sustained Epi control	- Number of local HIV service organizations implementing community care, prevention and OVC programs with strengthened organizational capacity increased by 20%	\$ 1,000,000	OHSS, HBHC	STEPS, ONE C	Civil society engagement; Quality management
Supply Chain							
Weak capacity of supply chain management at central and district level	- Support national quantification/forecasting and supply planning for HIV/AIDS and related commodities - Support integrated supervision and mentorship visits to PEPFAR sites	Sustained Epi Control	- No stock-out of core commodities at national and district level - 100% of sites in scale-up districts receive quarterly visits	\$ 200,000	OHSS, PDTX	GHSC	
Laboratory							

Sample transportation	- Maintain national coverage of motorcycle based sample transportation system	1 st 90 (EID) and 3 rd 90 (viral load)	- Sample Transport offered at least weekly to all ART and PMTCT sites in the country	\$1,500,000	HTXS, PDCS	URC	10. Laboratory
Laboratory renovations	- Renovate laboratories in “saturation and aggressive” districts	2 nd 90	At least one laboratory able to provide drug resistance testing to all saturation and aggressive districts	\$750,000	HLAB	URC	10. Laboratory
Laboratory strengthening	- Laboratory information system	3 rd 90	All (10) labs connected to central LIMS data system Targeted scale up from 1-7 labs for comprehensive internal LIMS system	\$135,000	HLAB, HTXS	Baobab	Epi and health data
Strategic Information							
Strengthening M&E tools	- Strengthen data collection, monitoring and evaluation nationally	1 st , 2 nd and 3 rd 90; Sustained Epi control	High quality data originating at site level and disseminated through the reporting chain.	\$100,000	HTXS	MSH, EGPAF, EQUIP, COM	Epi and health data
Operational Research	- Utilize OR methods to explore barriers and successes to achieving the three 90s	2 nd 90, 3 rd 90	Understanding of barriers and development of interventions to reach the 2 nd & 3 rd 90s.	\$100,000		MSH, EGPAF, EQUIP, COM	Epi and health data
Surveillance and operational Research	- Surveillance and operational Research	1 st , 2 nd and 3 rd 90	Evidence based interventions.	\$1,400,000	HVSI	Surveillance Award	
Surveillance and Operational Research							
Health Information Systems Strengthening	- Civil Registration Vital Statistics	Sustained Epi control	CRVS maintenance plan from 4 to 28 Districts	\$400,000	HTXS	National Registration Bureau	Epi and health data
TOTAL				\$5,585,000			

*Reference Appendix C for a list of activity types that fit in each category.

7.0 Staffing Plan

Summary:

The interagency PEPFAR staffing pattern has grown and shifted to better reflect skill sets and adapt to the demands of PEPFAR 3.0. By early FY 17, the team will be better positioned to provide quality TA and project/activity oversight with enhanced capacity for data analysis

There has been significant growth in size and complexity of the CDC program as a result of increased PEPFAR funds, new initiatives, increased data processes and shifting interventions. CDC conducted a staffing review and determined an appropriate size and mix for staffing. Following the review, the staffing footprint increased in COP15 with the addition of seven technical staff (two USDH and five LES) to 41 employees. The consolidation of CDC and Embassy Motorpool has resulted in four fewer drivers to 37 employees in COP16. CDC does not propose any new positions for COP16.

USAID anticipates a full staff complement on board before the beginning of FY17. Once fully trained, this team, expanded through COP14 and 15, will be better positioned to meet the increased demands for data analysis, partner management, stakeholder engagement, and quality control. USAID proposes two new positions for COP16, detailed below.

Explain Long-term Vacant Positions:

CDC

Of seven vacant positions at CDC, (six LES and one USDH) six positions (five LES and one USDH) were approved in COP15. The hiring processes for one of the seven vacant positions (LES Key Populations) is in the advanced stage of recruitment; two of the LES positions will be filled by contractors (Epi and Stats), two are in the selection process (Lab-LES and Deputy of Programs-DH) and the remaining two LES positions (HIV/TB and Asset Mgmt) are being classified by State Department/Africa Bureau and are likely to be filled by end of June 2016.

The position of Epidemiologist-LES has been vacant for over two years. It has been decided that this position will be filled by one of the two Contractor positions mentioned above. In addition, CDC had a USDH Epidemiologist included in COP 15; this position is now filled.

The position of Statistician-LES has also not been filled because the local labor market does not offer a large enough pool of qualified personnel). CDC has planned to use the second Contractor for this position in COP16.

USAID

USAID is in the final stages of recruitment for the Quality Assurance/Quality Improvement Adviser that will provide technical support to the treatment and clinical services activities. This position, initially approved in COP 14, was previously advertised as a FSN position and reclassified in COP 15 as a third country national position when the recruitment process did not yield any acceptable candidates. Interviews have been conducted and final selections are being made for the following positions added in COP 15: pediatric specialist, monitoring and evaluation specialists (4).

3) Justify Proposed New Positions:

CDC has no new positions in COP16.

USAID proposes two new positions in COP16: DREAMS Manager, approved in the DREAMS proposal to support national- and district-level coordination of DREAMS activities and partner management. This position is DREAMS funded during FY16. Approval is sought in COP16 to add this position with possibility of requesting funding to continue this position FY17. Due to space constraints, USAID does not have capacity to add any future new staff positions..

The second position is a Strategic Information Adviser for the PEPFAR Coordination Office. This individual will report directly to the PEPFAR Coordinator, but USAID will manage the hiring mechanism. This individual will also take on some Deputy PEPFAR Coordinator responsibilities in the absence of the PEPFAR Coordinator. This profile is necessary to enhance coordination of strategic information activities including data collection, analysis and reporting.

Peace Corps has no new positions.

Explain major changes to CODB:

USG Staff Salaries and Benefits (Both Local and International hires): This increase is due to the fact that in COP15 New Positions were requested with nil budgets to avoid pipeline build-up due to approval and time lags in recruitment. Vacancies are now being budgeted in COP16.

USAID's budget for staff salaries has decreased due to reclassification of some benefits under other cost categories and availability of some pipeline due to longer than expected recruitment processes.

Computers IT: USAID experienced increases in IT cost recovery leading to a relative increase in this budget line in COP16.

ICASS: Consolidation of State and ASP ICASS costs led to a higher ICASS budget for USAID in COP16.

Capital Security Cost Sharing: Increases due to increased rate and net increases in Desk Positions. This is a cost outside Management control.

US Government renovations: Office renovation costs are not going to recur in COP16

Appendix A Core, Near Core, Non-Core

Table A.1 Program Core, Near-core, and Non-core Activities for COP 16

SITE LEVEL	Core Activities	Near-core Activities	Non-core Activities
	<p data-bbox="380 540 617 565">Counselling and Testing</p> <ul data-bbox="380 597 863 686" style="list-style-type: none"> <li data-bbox="380 597 863 654">• Increase access to PITC, Index family testing, targeted community based testing <li data-bbox="380 654 863 686">• Ensure adequate space for HTS <p data-bbox="380 719 583 743">Care and Treatment</p> <ul data-bbox="380 776 873 1068" style="list-style-type: none"> <li data-bbox="380 776 873 865">• Implement systems for improving adherence, bidirectional referral, linkage and retention in care <li data-bbox="380 865 873 922">• Implement systems for quality improvement and quality assurance for key HIV services <li data-bbox="380 922 873 1011">• Conduct clinical mentoring, supportive supervision Develop and implement site specific TB infection control plans <li data-bbox="380 1011 873 1044">• Scale up EMRS <li data-bbox="380 1044 873 1068">• Salary support for ART providers <p data-bbox="380 1101 457 1125">TB/HIV</p> <ul data-bbox="380 1190 890 1360" style="list-style-type: none"> <li data-bbox="380 1190 890 1271">• Conduct in-service training for prevention, care and treatment service providers including TB/HIV <li data-bbox="380 1271 890 1360">• Renovate infrastructure and procure medical furniture for integrated HIV service delivery models and TB infection control <p data-bbox="380 1393 457 1417">VMMC</p>	<p data-bbox="919 719 1123 743">Care and Treatment</p> <ul data-bbox="919 743 1251 979" style="list-style-type: none"> <li data-bbox="919 743 1251 833">• Increase access to integrated HIV/MNCH services, HIV/STI screening and TX <li data-bbox="919 833 1251 922">• Expand network of YFHS within public health care facilities. <li data-bbox="919 922 1251 979">• Strengthen capacity of pre-service training institutions 	<ul data-bbox="1291 597 1650 800" style="list-style-type: none"> <li data-bbox="1291 597 1650 630">• Patient transportation <li data-bbox="1291 630 1650 662">• Construct staff housing <li data-bbox="1291 662 1650 695">• Optimize CD4 testing systems <li data-bbox="1291 695 1650 743">• Ensure availability of water and electricity at facilities <li data-bbox="1291 743 1650 800">• Improve waste management systems

	<p>Condoms (priority districts and KPs)</p> <p>Community linkages</p> <ul style="list-style-type: none"> • Community support groups • Community mobilization to increase uptake of HIV services <p>Key populations</p> <ul style="list-style-type: none"> • Implement dedicated and comprehensive service delivery models for KP and vulnerable populations (e.g. prisoners, AGYW, FSW, ALHIV) including linkages to other HIV service • Implement community level interventions to facilitate normative change to protect key and vulnerable populations <p>OVC</p> <ul style="list-style-type: none"> • Establish community systems for tracked referrals/linkages to clinical and social services • Assessment of household vulnerability and child status outcomes • Provide comprehensive and needs based OVC services 	<p>Key Populations</p> <ul style="list-style-type: none"> • KP GBV screening and treatment, referral and linkages to broader health services, legal and other supportive services • Capacity development of CBOs, traditional structures, to manage community prevention, impact mitigation, care and linkage activities • Provide block grants support to schools and sub-grants to local CSOs 	
<p>SUB-NATIONAL LEVEL</p>	<p>Core Activities</p> <p>HTC</p> <ul style="list-style-type: none"> • Recruit, train and deploy HIV diagnostic assistants (HDAs) to increase access to HTC and other POC tests <p>Lab</p> <ul style="list-style-type: none"> • Conduct supportive supervision for diagnostic services • Fund sample transportation systems to 	<p>Near-core Activities</p> <p>Nutritional assessment</p> <ul style="list-style-type: none"> • Procure equipment for growth monitoring and nutritional assessments in HIV clinics and specialist services for chronic care <p>Lab</p> <ul style="list-style-type: none"> • Procure equipment, consumables and reagents for 	<p>Non-core Activities</p>

	<p>improve access to CD4, viral load, TB testing and improve results turnaround times</p>	<p>referral level HIV diagnostic platform (biochemistry, hematology)</p> <p>Care and Treatment</p> <ul style="list-style-type: none"> Support districts to conduct HIV outreach clinics targeting hard to reach communities 	
NATIONAL LEVEL	<p>Core Activities</p> <p>HRH/Training</p> <ul style="list-style-type: none"> Implement bonding systems for PEPFAR supported students In-service training for front line service providers and lay providers <p>Commodities</p> <ul style="list-style-type: none"> Procure bicycles and motorbikes to improve mobility of the service providers Procure commodities for KP, AGYW and VMMC services as required (PPT, HTC, syphilis tests) Provide TA to the HIV program, including Logistics and Supply Chain Management systems <p>Program oversight</p> <ul style="list-style-type: none"> Develop standardized operational guidelines and SOPs across clinical programs and community-based programs Improve M and E tools for the care cascade, including EMRS enhancements Conduct national quarterly supportive supervision <p>Condoms</p> <ul style="list-style-type: none"> Implement a total market approach for 	<p>Near-core Activities</p> <p>HRH/Training</p> <ul style="list-style-type: none"> Institutional and human capacity development support to GOM Strengthen in- and pre-service curriculum development Strengthen HRH management systems for HIV program, including Social Welfare staff <p>OVC</p> <ul style="list-style-type: none"> Develop operational guidance on NACS, KP, site level CSOs engagement, EIMC Developing/managing national data base for OVC Dissemination of national Plan of Action for Vulnerable Children (2015-2019) <p>Surveys/surveillance</p> <ul style="list-style-type: none"> Conduct KP population size assessment, TB Prevalence Survey, pharmacovigilance, DHS 	Non-core Activities

	<p>condoms</p> <p>Lab</p> <ul style="list-style-type: none"> • Scale up viral load and sample transport 	<p>Lab</p> <ul style="list-style-type: none"> • Scale up SLMTA program • Strategy support for HIV/AIDS and gender policies 	<p>Lab</p> <ul style="list-style-type: none"> • Integration of HIV/AIDS QA/QC with wider health systems • MOH development in leadership, organizational, and financial management • Provide support for Health and HIV/AIDS financing
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Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15			
	Core Activities	Near-core Activities	Non-core Activities
HTC	<ul style="list-style-type: none"> • PITC at all health care service delivery points- ANC, maternity, in patient wards, STI clinic, TB clinic, NRU, OPD, under five clinics • Index family testing- through a three tiered approach- 1)provision of referral slips home based testing 2) send reminder through SMS 3) household or community testing • Targeted community based testing for key and priority populations- testing in hot spots, work places, communities, households, schools, YFHS, and prisons • Recruitment and deployment of HIV diagnostic assistants (HDAs) to scale up PITC • In service training of the HDAs • Renovations of health facilities to increase HTC services delivery points • Procurement of containers, tents, trailers and vehicles 		

	<p>to increase HTC delivery points at the facility, and through mobile or outreach HTC services</p> <ul style="list-style-type: none"> • Systems for improving linkage and tracking linkages within the facility and between facility and community based HTC program • Systems for quality improvement at the site- like development of SOPs, establishment of QI teams, performance review meetings, support for transportation of PT panels from district hospitals to the sites thereby ensuring that all HTC counsellors undergo proficiency test; transportation of QC materials • Quality assurance activities- quarterly supervision, observing HTC sessions • Purchase of other supplies required for provision of HTC services apart from RTKs which are procured through GF • Logistic support for targeted outreach mobile testing ins saturation districts 		
<p>Care and Treatment</p>	<p>Core Activities</p> <p>Adult and pediatric care and treatment</p> <p>Effective comprehensive HIV care and treatment</p> <ul style="list-style-type: none"> • Conduct clinical mentoring, supportive supervision to improve compliance to clinical guidelines and efficiency in service delivery across the care cascade • Conduct in-service training for care and treatment service providers (standard and advanced HIV care training modules) to build competencies for case management • Recruit staff/ expand role of HDAs for POC HIV diagnostic tests:CD4, syphilis rapid tests • Develop operational guidelines and SOPS to improve linkage and defaulter tracing success rates, including early access to CD4/ clinical staging • Procure equipment and reagents for referral level HIV diagnostic platform (biochemistry, hematology) • Fund sample transportation systems to improve access to CD4, viral load, TB testing and improve results turnaround times 	<p>Near-core Activities</p> <p>Effective integration of NACS in HIV clinics</p> <ul style="list-style-type: none"> • Procure equipment for growth monitoring and nutritional assessments in HIV clinics • Develop operational guidance on linkage and referral for patients with moderate or severe malnutrition • Conduct clinical mentoring to ensure implementation • Support districts to conduct HIV outreach clinics targeting hard to reach communities 	<p>Non-core Activities</p> <p>Cervical cancer screening clinics</p>

	<ul style="list-style-type: none"> • Conduct supportive supervision to improve the quality of sample collection and specimen integrity for CD4, VL, TB <p>Effective linkage and retention</p> <ul style="list-style-type: none"> • Provide technical assistance to adapt site level SOPs to strengthen linkage and retention systems of consenting PLHIV to age-appropriate community support groups and structures (including OVC, teen clubs, M2M) <p>Efficient scale-up of integrated models of care</p> <ul style="list-style-type: none"> • Provide on-site technical assistance to scale up mother-baby care point model for PMTCT cascade; family centered care models and youth friendly services at targeted sites • Procure equipment, supplies other resources for community health workers, lay providers, expert patients providing linkage, adherence and retention support for consenting PLHIV (phones, bicycles, incentives for volunteers) • Establish community support groups to provide peer support and improve adherence and conduct defaulter tracing • Develop and implement standardized referral guidelines and SOPs across clinical programs (IMCI, MNCH, TB, OVC, nutrition) and community-based programs <p>Effective use information, data for decision making and quality improvement</p> <ul style="list-style-type: none"> • Establish QI teams and systems to improve the quality of comprehensive HIV care and treatment services • Renovate infrastructure and procure medical furniture for integrated HIV service delivery models • Procure equipment to ensure reliable power and water supply for HIV diagnostic services 		
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	<ul style="list-style-type: none"> • Improve M and E tools for the care cascade, including EMRS enhancements <p>TB/HIV strategy</p> <p>Effective integrated TB/HIV service delivery</p> <ul style="list-style-type: none"> • Provide technical assistance to develop operational guidelines and SOPs for integrated TB/HIV service delivery; TB/HIV linkage and referral systems (including for TB diagnostic “fast track” services); household contact tracing and PITC • Conduct supportive supervision and clinical mentoring to improve the quality of routinely TB screening in PLHIV; clinical management of TB/HIV and integrated service delivery • Train health workers on integrated TB/HIV service delivery • Develop and test new TB screening algorithms to improve TB case detection • Develop and implement site specific TB infection control plans • Renovate infrastructure for integrated TB/HIV service delivery and TB infection control including utilities • Procure equipment • Procure reagents (as a stop gap) • Provide technical assistance to sites to routinely analyze data to monitor and improve the quality of TB/HIV service delivery and case management 		
<p>Prevention</p>	<p>Core Activities</p> <p>Services</p> <ul style="list-style-type: none"> • VMMC service delivery and demand generation in targeted high impact districts • Total market approach for condoms: including national planning, social marketing of male and female condoms in hot spots, urban area, free community-based condom promotion, skills and distribution in priority areas for priority and key populations. • Dedicated KP service delivery model using trusted 	<p>Near-core Activities</p> <p>Services</p> <ul style="list-style-type: none"> • PEP • STI screening/TX • EIMC • Expand network of YFHS within public health care facilities. • KP near core service package: GBV screening and treatment, referral and linkages to broader health services, legal and 	<p>Non-core Activities</p>

	<p>network of trained providers, drop in centers, and mobile outreach. Core package includes peer led demand generation and risk reduction counselling, condom and lubricant distribution, quarterly HTC, STI, TB screening and treatment, FP, post-GBV care, treatment and care for HIV+, linkages to others services, case management, and support through CSO based support groups.</p> <ul style="list-style-type: none"> • Dedicated service package and approaches for AGYW including HTC, STI screening and treatment, FP, post-GBV, peer education, ART, care and support for ALHIV, linkages to PMTCT and VMMC. • Comprehensive services for prison settings including PITC, routine STI/TB screening, diagnosis and treatment, risk reduction, UTT pilot. • Integrated family planning counselling, education, screening for pregnancy risk and referral for long acting family planning methods- for FSW, AGYW and PLHIV • Blood safety • Commodities procured for KP, AGYW and VMMC services as required (PPT, HTC, syphilis tests) <p>Community</p> <ul style="list-style-type: none"> • Community mobilization for priority populations for access to HTC, care and treatment and other biomedical prevention services. • Normative change to protect children, AGYW. • Establish community systems for tracked referrals/linkages to clinical and social services • HR for HTC, care and linkages: In service training for the peers, expert clients and other community service providers • Procurement of bicycles, and motorbikes to improve mobility of the service providers 	<p>economic strengthening, stigma reduction, and national advocacy for rights</p> <ul style="list-style-type: none"> • Community: • GBV screening/referrals • Risk reduction <p>Systems</p> <ul style="list-style-type: none"> • Capacity development of CBOs, traditional structures, to manage community prevention, impact mitigation, care and linkage activities. • SI/implementation science to improve programming, tracking of services. • KP related national standards/guidelines for service delivery, training of public health care facility providers, capacity building of KP CSOs and operations research. 	
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<p>OVC</p>	<p>Core Activities</p> <ul style="list-style-type: none"> • Household vulnerability assessment • Care/Case management planning and implementation • Household Economic Strengthening • Village Savings and Loans • Food security/nutrition program • Linkages to health and nutrition programs • Facilitating access to Social Cash Transfer programs • Caregiver / parenting program • Enhancing access to education • Capacity building for teachers • Early Childhood Development program • Access to HCT, and referral for HIV services • Birth registration • Life skills building among children • psychosocial support services • Building capacity of the social welfare workforce 	<p>Near-core Activities</p> <ul style="list-style-type: none"> • Developing/managing national data base for OVC • Dissemination of national Plan of Action for Vulnerable Children (2015-2019) • Institutional and human capacity development support to GoM • Block grant support to schools 	<p>Non-core Activities</p>
<p>HSS</p>	<p>Core Activities</p> <p>Training/ HRH</p> <ul style="list-style-type: none"> • HRH: pre-service and in-service training of Care and Treatment and Testing cadres • Training and salaries for HTC and ART providers, bonding • iHRIS <p>Technical Assistance</p> <ul style="list-style-type: none"> • To Global Fund grant recipients • To MOH <p>Labs: Viral load and sample transport Infrastructure: Pre-fab facility drug/diagnostics storage space, ART clinics SI: EDS at priority sites, HIA QA/QI: clinical/systems mentoring, national quarterly supportive supervision SCM: quantification, eLMIS, and TA</p>	<p>Near-core Activities</p> <p>Training/HRH</p> <ul style="list-style-type: none"> • Curriculum Development • Strengthen HRH regulations • HRH Retention • HRH for Social Welfare • Improved training sites <ul style="list-style-type: none"> • SLMTA • DHS • TB Prevalence Survey • Pharmacovigilance • Operations Research • DHIS2/HMIS <ul style="list-style-type: none"> • Strategy support for HIV/AIDS 	<p>Non-core Activities</p> <ul style="list-style-type: none"> • Civil Service Reform • Patient Transportation • Commodity procurement and distribution • Integration of HIV/AIDS QA/QC with wider health systems • MoH and district government development in leadership, organizational, monitoring and financial management • Performance appraisal system • Water and electricity at

		<p>and gender policies</p> <ul style="list-style-type: none">• Health and HIV/AIDS financing• Capacity building of and sub-grants to local CSOs	<p>facilities</p> <ul style="list-style-type: none">• Incinerators/waste management• CD4 Testing
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APPENDIX B Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
\$US 7,475,825	\$US 87,524,175	\$US 95,000,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	2,930,299
HVAB	Abstinence/Be Faithful Prevention	-
HVOP	Other Sexual Prevention	1,970,600
IDUP	Injecting and Non-Injecting Drug Use	-
HMBL	Blood Safety	1,000,000
HMIN	Injection Safety	-
CIRC	Male Circumcision	755,000
HVCT	Counseling and Testing	2,851,888
HBHC	Adult Care and Support	5,469,663
PDCS	Pediatric Care and Support	2,975,340
HKID	Orphans and Vulnerable Children	4,911,274
HTXS	Adult Treatment	34,667,334
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	6,624,474
HVTB	TB/HIV Care	5,105,366
HLAB	Lab	1,473,512
HVSI	Strategic Information	1,954,212
OHSS	Health Systems Strengthening	4,054,477
HVMS	Management and Operations	10,780,736
TOTAL		87,524,175

Source: COP16 Budget Code Report – FACTS Info 7.1.2016

Appendix C

Acronyms and Abbreviations

AB – Abstinence and Be Faithful
 AFG – AIDS-Free Generation
 AGYW – Adolescent Girls and Young Women
 AIDS – Acquired Immune Deficiency Syndrome
 ANC – Antenatal Clinic
 APR – Annual Program Results
 ART – Antiretroviral therapy
 ARV – Antiretroviral
 CBO – Community-based Organization
 CCM – Country Coordinating Mechanism
 CDC – Centers for Disease Control and Prevention (part of HHS)
 CIFF – Children’s Investment Fund Foundation
 CN – Congressional Notification
 CODB – Costs of Doing the U.S. government’s PEPFAR Business
 COP – Country Operational Plan
 CQI – Continuous Quality Improvement
 CSO – Civil Society Organizations
 DHA – Department of HIV/AIDS
 DHS – Demographic and Health Survey
 DOD – U.S. Department of Defense
 DOS – U.S. Department of State
 EA – Expenditure Analysis
 EID – Early-Infant Diagnosis
 FP – Family Planning
 FSN – Foreign Service National
 FSW – Female Sex Worker
 FTE – Full-Time Equivalent
 FY – Fiscal Year
 GAP – Global AIDS Program (CDC)
 GBV – Gender Based Violence
 GDP – Gross Domestic Product
 GFATM – The Global Fund to Fight AIDS, Tuberculosis, and Malaria (also “Global Fund”)
 GHAI – Global HIV/AIDS Initiative (funding account; replaced by GHCS-State)
 GHCS – Global Health Child Survival funds (funding account)
 GHI – Global Health Initiative
 GoM – Government of Malawi
 HCN – Host Country National
 HCW – Health Care Workers
 HDG – Health Development Partners
 HHS – U.S. Department of Health and Human Services
 HIV – Human Immunodeficiency Virus
 HMIS – Health Management Information System
 HRSA – Health Resources and Services Administration (part of HHS)

HRH – Human Resources for Health
HTS – HIV Testing Services (formerly HIV Testing and Counseling – HTC)
ICASS – International Cooperative Administrative Support Services
ICF – Intensified Case Finding
ICPI – Interagency Cooperative for Program Improvement
INH – Isoniazid
IPT – Isoniazid Preventive Therapy
IP – Implementing Partner
LE – Locally Employed (Staff)
LGBTI – Lesbian, Gay, Bisexual, Transgender and Intersex
LOE – Level of Effort
LTFU – Loss to Follow-Up
MANASO – Malawi Network of Aids Service Organizations
M&E – Monitoring and Evaluation
MER – Monitoring, Evaluation and Reporting
M&O – Management and Operations
MC – Male Circumcision
MDHS – Malawi Demographic and Health Survey
MSF – Medicines Sans Frontiers
MSM – Men who have Sex with Men
MoH – Ministry of Health
MOU – Memorandum of Understanding
MPHIA – Malawi Population HIV Impact Assessment
NAC – National Aids Commission
NACS INH Nutrition Assessment Counseling and Support
NIH – National Institutes of Health (part of HHS)
NSO – National Statistical Office
OU – Operating Unit
OVC – Orphans and Vulnerable Children
PEPFAR – President’s Emergency Plan for AIDS Relief
PLHIV/PLWHA/PLWA – People Living with HIV/AIDS or People Living with AIDS
PMTCT – Prevention of Mother-to-Child HIV Transmission
POART – PEPFAR Oversight and Accountability Response
PPP – Public-Private Partnership
PR – Principal Recipient
PSE – Private Sector Engagement
PWID – People Who Inject Drugs
QA – Quality Assurance
RCNF – Robert Carr civil society Networks Fund
RFA – Request for Application
RFP – Request for Proposal
ROP – Regional Operational Plan
SAPR – Semi-Annual Program Results
SCMS – Supply Chain Management System
SDS – Strategic Direction Summary
S/GAC and S/GAC – Office of the U.S. Global AIDS Coordinator (part of State)
SI – Strategic Information
SID – Sustainability Index Dashboard
SIMS – Site Improvement through Monitoring System
TA/TC – Technical Assistance/Technical Collaboration
TB –Tuberculosis
TBD – To Be Determined
TCN – Third Country National

TTFs – Tools, Templates and Frameworks
TWG – Technical Working Group
UNAIDS – Joint United Nations Program on HIV/AIDS
UNDP – United Nations Development Program
UNICEF – United Nations Children’s Fund
USAID – U.S. Agency for International Development
USDH – U.S. Direct Hire
USG – United States Government
USPSC – U.S. Personal Services Contractor
VCT – Voluntary Counseling and Testing
VMMC – Voluntary Male Medical Circumcision
VL – Viral Load
YFHS – Youth Friendly Health Services
WHO – World Health Organization

Appendix D Humanitarian Crisis



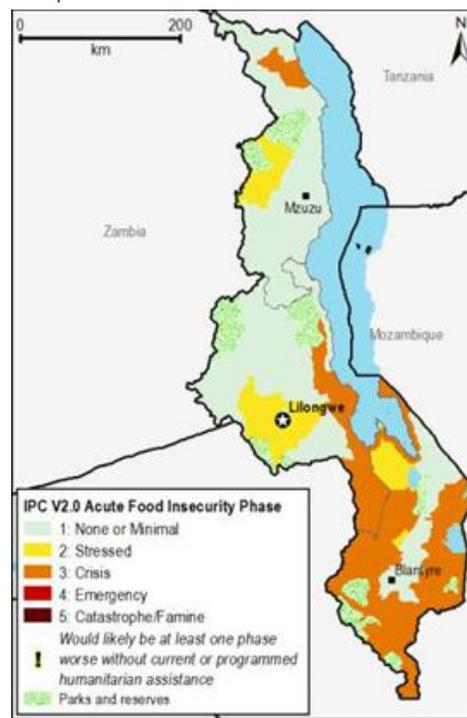
Lasting Impact of El Niño 2015-2016

Malawi is in the midst of a humanitarian crisis: last year 2.86 million people required humanitarian food assistance from October 2015 through April 2016. This upcoming year estimates are likely to double, however actual figures will be known early June 2016 when the Malawi Vulnerability Assessment Committee (MVAC) performs its annual assessment. Over recent years, Malawi has experienced a rapid escalation in the number people requiring humanitarian food distributions due to floods and drought, preventing vulnerable populations from adequately recovering from these more frequently occurring shocks.

The 2014 / 2015 agriculture season began with delayed rains, followed by unprecedented flooding, resulting in a poor harvest and the current 2.86 million humanitarian caseload. With the impact of El Niño, the 2015 / 2016 agriculture season experienced late-start and poor rains resulting in a second consecutive poor harvest and the anticipated doubling of the humanitarian needs. Poor households, which rely heavily on food purchases, also experienced unusually high staple food (maize) prices, which were almost double the five year average (FEWSNET). Poor rains compound water availability for winter cropping, hygiene and household use, and power supply. There are limited opportunities for day labor due to the poor harvest and the Government of Malawi's (GOM) Strategic Grain Reserve (SGR) is at an all-time low at less than 5,000 metric tons of maize, and grossly under-resourced to respond to the next humanitarian caseload. The southern Africa region was impacted, and countries that traditionally have surplus maize available are experiencing poor harvests as a result of El Niño, significantly impacting maize supplies in the region.

With the humanitarian assistance ended for the time being, poor households will face food shortages as early as June 2016. FEWSNET indicates over half a million people in 10 districts in the south will experience food security crisis conditions from June to September 2016. These households will face food consumption gaps or will only meet minimal food needs through unsustainable coping strategies. Some of these households registered completed crop failure, have very few prospects for labor, and have already depleted their sellable assets. These households have no choice but to

Projected acute food security outcomes, June – September 2016

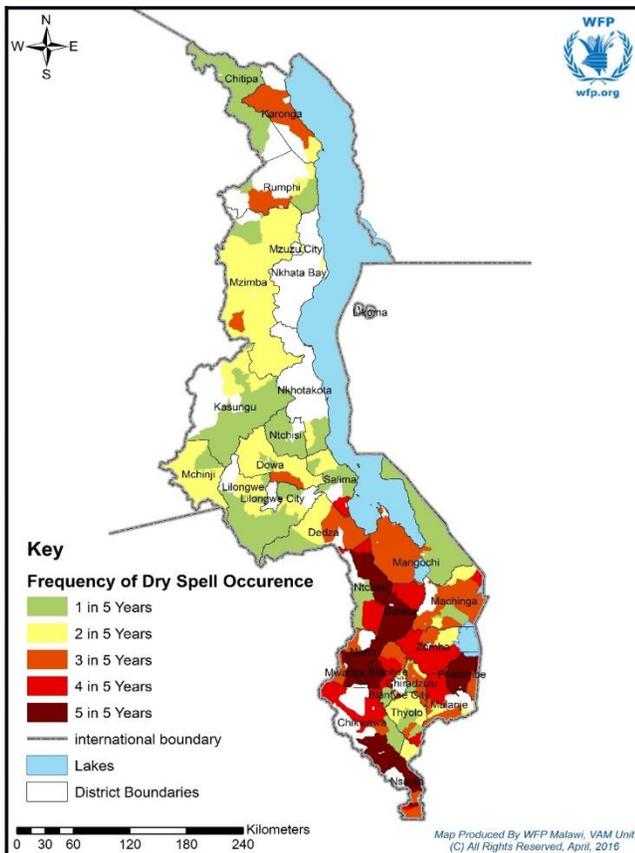
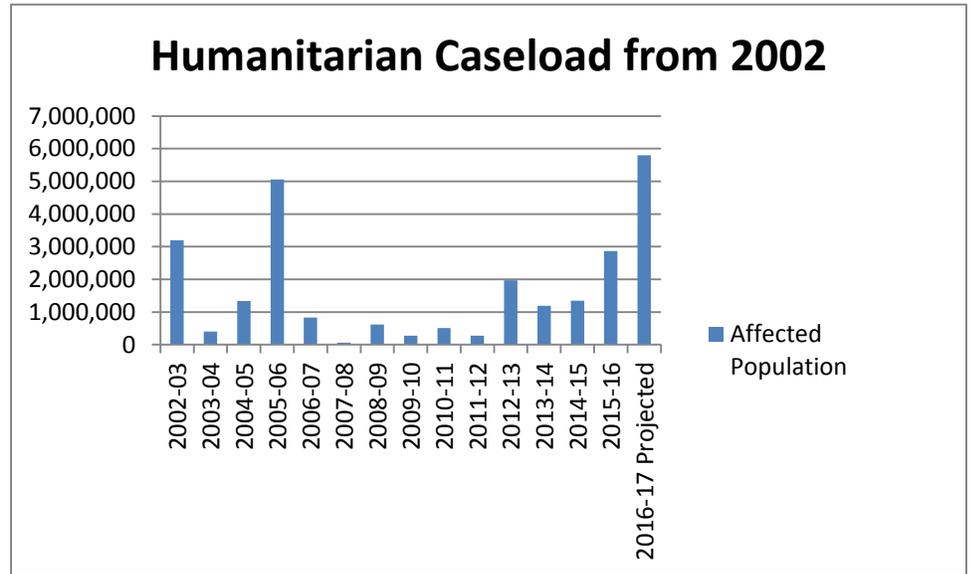


Source: FEWSNET / MALAWI Food Security Outlook

enter into negative coping behaviors including cutting firewood, making charcoal, migration for labor, transactional sex for food, and prostitution.

Increasing Food Insecure Populations

Malawi is experiencing increasingly poor harvests due to poor soil and water management, ineffective GOM programs including the Farm Input Subsidy Program (FISP) and the impacts of global climate change. These drivers of food insecurity have resulted in an increasing humanitarian caseload over the past 10 years. While the U.S. Government remains the primary humanitarian donor, the response needs are becoming prohibitively expensive and underfunded.



The USG Response

USAID responds to the humanitarian caseload through its Office of Food for Peace (FFP) with resources going directly to the World Food Program (WFP) to support food distributions. From fiscal year 2012, USAID/FFP has provided \$129 million in humanitarian assistance. Due to the concerns that El Niño may erode development gains, USAID is focusing more on resilience programs, which are currently a significant part of the portfolio. USAID is currently engaging development partners across the portfolio in a working group that looks at El Niño recovery as well as preparation for La Niña which is likely to result in heavy rains and flooding in the central and southern parts of Malawi. USAID is concerned that anticipated flooding will further compound vulnerability and push negative coping mechanisms as well as and result in significant loss of development gains.

Appendix E VMMC Demand Creation Strategy

Demand Creation is the bedrock for strengthening access and availability of VMMC for males aged 15-29years. PEPFAR Malawi initiated discussions and collaboration with implementing partners at the beginning of FY16 to address the age pivot and this resulted to an increase from 48% in APR'15 to 59% in Quarter 1 for males aged 15-29yrs. These efforts will continue in FY16 and FY 17.

Key next steps:

Objective	Strategy
Understand facilitators and obstacles faced by 15-29 population	Partners will conduct rapid assessment of age appropriate clients who are currently reached for services to better design communications to meet them Consider what other services clients would like to see delivered (i.e. HTC, STI, SRH information)
	Leverage Project SOAR planned profiling of males for treatment services (test and start funds) to include questions specific for VMMC uptake
	Revisit national communications strategy to refine strategies based on updated partner data (Previous data: PSI profile, BRIDGE II VMMC formative research, 2015 Blantyre study)
Improve service access	Train HDAs, expert clients, and community resource people/peer educators on VMMC to strengthen tracked referrals from HTS in public facilities and through community service delivery models. Promote "Provider initiated VMMC", by referring HIV negative males identified in all HTS setting, in priority districts with existing VMMC services for ease of access
	Refresher training for mobilizers – incentivize age appropriate referrals? Provide tools for active referral and data monitoring
	Promote other components of VMMC service package to bring in clients (i.e. STI screening/treatment, nutrition, health/well-being – weight/BP, sexual performance?)
	Strengthen partnership with private providers/clinics (i.e. Mobile Workplace VMMC service delivery) and in hotspots (through KP program)
	Link VMMC services more explicitly to alternative service delivery for males for TX (i.e. Extended/weekend hours, separate waiting areas for men,) –
	Use appointments /follow-up SMS/and expert clients to support older men's timely access to services
Refocus demand creation approaches/strategies	Highlight age appropriate male champions and their stories through mass media and revitalized interpersonal communications efforts (including female partners)
	Reinforce age appropriate counselling through IPC volunteers and targeted group education (based on barriers/benefits identified) i.e. Pain, HTS not mandatory, perceived benefits to female partners, etc.
	Targeted and more frequent media campaigns – call in shows to address questions, hotline, Bring in a friend campaign – incentivize client driven referrals?)
	Use of football platform and events for service delivery promotion (competitions, VMMC linked prizes, footballer champions?) -
	Target secondary schools and colleges for older young males – teacher engagement/as champions.
	Improve geographic targeting within scale up districts – aligned with other efforts, and monitoring of results.

Appendix F Considerations for Differentiated Care

1. SERVICE INTENSITY:

COP15:

- ART initiation
- Clinical monitoring
- Adherence support
- Viral load monitoring
- OI treatment
- Psychosocial support

COP16:

- As above (COP15)
- Interventions for advanced HIV:
 - Renal Function Test /Liver Function Test in district hospital
 - Screening for Cryptococcus antigen for
- Enhanced adherence support

2. SERVICE FREQUENCY: OPTIMISE CLINIC VISITS

COP 15:

- 3 monthly (all sites)

COP 16:

- Differentiated schedules, clinics and client flows (all high burden sites)
- Appointment spacing: 6 monthly (only stable patients at high burden sites)

3. SERVICE LOCATION: IMPROVE ACCESS

COP 15:

- Facility and community HTS
- Bidirectional linkages
- Facility based -treatment services
- Renovate facilities, repurpose space

COP 16:

- As above (COP 15)
- Add sites: pre-fab, new clinics
- Conduct mobile HTS and treatment services (fast track districts)
- Community based ART initiation
- Pilot community based drug delivery

4. HEALTH WORKER CADRE: ADDRESS HRH GAPS

COP 15:

- HDAs
- Expert clients

COP 16:

- As above (COP 15)
- Frontline ART providers
- Pharmacy assistants