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January 14, 2020

**INFORMATION MEMO FOR AMBASSADOR SCOTT, Malawi**

**FROM: S/GAC – Ambassador Deborah L. Birx, MD**

**SUBJECT: FY 2020 PEPFAR Planned Country Allocation and Strategic Direction**

Dear Ambassador Scott:

First, I wanted to personally thank you and Deputy Chief of Mission for your dedication to PEPFAR and working every day to achieve the most possible with the United States taxpayers' dollars. The ability to translate these resources into effective and impactful programming has and continues to be core to our collective progress. Your PEPFAR team in country is extraordinary and we are fortunate to witness their passion and compassion. We remain impressed about your progress in:

- Malawi is commended for good performance overall in COP 18. It has steadfastly pursued epidemic control by curbing the growth of new infections and reducing AIDS-related deaths through 2019. This is possible because of a strong, reliable and evidence-based partnership with the leadership in the Malawi Ministry of Health and its Department of HIV/AIDS;
- We are encouraged by the efforts to implement an Electronic Medical Record System (EMRS) this past year, evidenced by complete clinical records for clients in the dHIS2 system and in PEPFAR-Panorama. We applaud the effort despite development challenges to deliver consistent power, connectivity, integrated and interoperable systems;
- We continue to be pleased about the work done with and for adolescent girls and young women through the DREAMS program and the success recruiting and serving more 10 – 14-year olds.

Together with the Government of Malawi and civil society leadership we have made tremendous progress together. Malawi should be proud of the progress made over the past 16 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

We did want to highlight both overarching issues we see across PEPFAR and a few specific to Malawi. Full details will follow in a more comprehensive letter from your S/GAC Chair and PPM.

Throughout the PEPFAR family of supported countries and communities, five gaps are shared across the globe holding us collectively back from achieving Sustainable Development Goal 3 related to controlling the HIV AIDS epidemic:

1. Continued new HIV infections in adolescents and young women
2. Supporting key populations with prevention and treatment services
3. Ensuring men are diagnosed and treated early (testing positive and new on treatment (linkage surrogate))
4. Ensuring 15-35-year-old asymptomatic clients are maintained on treatment and virally suppressed (net new on treatment and treatment current growth, (retention surrogate))
5. Ensuring all children are diagnosed and are on the best treatment regimens and virally suppressed

Moreover, we note the following challenges in the PEPFAR Malawi program:

- Partners continue to over test, conducting more than 4.2 million tests in COP 18. Partners must shift away from inefficient modalities, especially PITC, and improve contact tracing. Case finding in men and youth is lagging, and it will not be possible to achieve targets for clients on treatment without reaching these populations through tailored, client-centered services.
- We have not solved the challenge of maintaining young 15 – 35 year olds who are asymptomatic, on treatment and not virally suppressed, in quality services. This is particularly evident in urban sites and among men and youth. Dolutegravir-based regimens have not fully rolled out due to in-country challenges including concerns of TLE stock wastage. Malawi's achievement and sustained support of 95-95-95 goals by 2020 will be constantly under threat until as a collective, with our clients, we find needed solutions.
- Seventy percent of children are still on Nevirapine-based regimens with poor viral load suppression, partly due to lack of pediatric ARVs in country and Malawi remains under-capacitated for the needed viral load tests to be conducted per year.

In a recent Office of Inspector General audit around PEPFAR coordination there were four draft preliminary recommendations based on their discussions with PEPFAR staff in the field from four countries, three of their recommendations are relevant to this Country Operational Plan planning cycle related to target setting, tool development, and timelines. Although we just received the draft report a few days ago we did not want to wait another COP cycle to make substantive changes related to the recommendations. The first was around targets and target-setting and the need for a clear and transparent understanding and dialogue in establishing targets. PEPFAR targets are not PEPFAR's but flow directly from the UNAIDS Fast Track Strategy of 2016. Since 2016, both the PEPFAR strategy and targets were directly derive from the global communities of UNAIDS, WHO, and specifically Heads of State in their commitment to SDG 3 and are aligned to support the country's specific ambition towards those goals.

The global community in 2015 through their Heads of State committed to achieving SDG 3.3 by 2030 which for HIV is ending the HIV/AIDS epidemic as a public health threat. This was followed by a United Nations High Level Meeting on HIV/AIDS in June 2016, whereby these Heads of State committed to the 90/90/90 Fast Track Strategy. Essential to the strategy was 73% community viral load suppression (VLS) by 2020 and 86% community VLS by 2030 combined

with increased prevention interventions and zero stigma and discrimination to ensure all ages, genders and risk groups have access to life saving prevention and treatment services. Also, in 2016, 22 PEPFAR-supported high HIV burden countries committed to the three Frees of Start Free, Stay Free, AIDS Free with 2020 targets of a decrease in new infections in children to 20,000, 85% of pregnant women on ART, AGYW new infections to < 100,000, 90% of children on ART and 25 million VMMCs. Since 2016 PEPFAR and the GF resources have been focused on achieving these global goals that have been translated to each country by UNAIDS and subsequently supported financially and technically by the PEPFAR family. Since 2016, PEPFAR has utilized these global commitment targets as PEPFAR targets with the commensurate increased funding to countries in 2016, 2017, and 2018 to achieve the goals set out by the Heads of State. Many countries have made tremendous progress towards these targets and others need to accelerate. Malawi is on track to achieve and sustain the 2020 and 2030 goals if some key program gaps are addressed.

Over the past 4 years, PEPFAR resources were allocated based on need, performance, and specifically on the country's and communities' desire to achieve the SDG, Fast Track Strategy, and Three Free goals and country specific targets. Based on the OIG recommendation, S/GAC will take a different approach this year to target-setting. Our collective hope is that together we use this moment of reflection on progress and challenges along with the realization that the end of 2020 is only 11 months away to address these overarching challenges this year through COP 2019 implementation and use COP 2020 to maintain our progress, address any ongoing challenges and finally fund ambition for greater impact. Thus, S/GAC will not assign targets to countries but only provide notional budget levels. After the PEPFAR country team submits their targets the notional budget will then be adjusted to the presented level of ambition. Additional funding is available as ambition funding for treatment and VMMC.

The PEPFAR Country/Regional Operational Plan (COP/ROP 2020) notional budget is **\$184,034,169** inclusive of all new funding accounts and applied pipeline and reflects the following:

1. Sustaining the gains in treatment services based on your projected COP 2019 treatment result (FY2020 treatment current funded in COP19)  
\$124,600,000
  - a. The care and treatment budget is determined by all of your FY18 C/T expenditure services and commodities (no RTK commodities), including all aspects of the health system inclusive of human resources, laboratory and systems, commodities (exclusive of RTKs), an upward adjustment from FY19 treatment current to the FY2020 treatment current fully burdened cost of treatment services and commodities, and 100% of partner program management costs and data needs
  - b. This Budget is broken down by
    - i. Care and Treatment services including partner program management costs, FY2020 upward adjustment, EMR and data with surveillance, recency \$105,000,000

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- ii. ARV drugs and treatment commodities (everything except RTKs) \$0
  - iii. TB preventive treatment \$5,900,000
  - iv. Cervical cancer \$3,000,000
  - v. HBCU Tx support \$2,000,000
  - vi. For earmark purposes 50% of M/O costs \$8,700,000
  - vii. Care and Treatment qualifies for ambition funds if addresses gap #3-5
2. Continued orphans and vulnerable children funding to include DREAMS vulnerable girls less than 20-year-old. \$24,740,000
    - a. HKID or \$6,000,000 dollars for continued historical OVC services
    - b. DREAMS funding of \$20,000,000 of which 85% is for vulnerable girls under 20 \$17,000,000
    - c. 10% of M/O or \$1,740,000
  3. Continued VMMC funding based on your percent of VMMC in the appropriate age band of >15 years old
    - a. Total VMMC \$9,500,000
    - b. VMMC qualifies for ambition requests
  4. Dramatic expansion of DREAMS programming \$20,000,00 as noted above
  5. Continued expansion of Key Populations prevention and expansion of PrEP depending on country submitted targets
    - a. Key Population (non-treatment) \$2,600,000
    - b. PrEP total: \$1,600,000 dollars
  6. RTK and service support to ANC HIV testing \$1,400,000
  7. Remaining 40% M/O based on COP19 \$6,960,000

Total COP2020 notional budget of **\$184,034,169** (comprised of **\$165,620,966** new and **\$18,413,203** pipeline).

Overall, across the PEPFAR portfolio, we have dramatically increased DREAMS funding to address prevent new infections in adolescent girls and young women. For the first time we find across all districts implementing DREAMS, declines in new diagnoses of HIV in young women. These funds should be used to expand to the highest burden districts not current covered and saturate in urban areas.

Teams will develop their own targets across PEPFAR program areas described above, with the treatment current target no less than the result that was to be achieved in COP 2019. Testing support outside of ANC should be consistent with any targets above FY2020 treatment current and be submitted with any ambition funding. Targets reflecting continued and sustained OVC programming and KP programming. For DREAMS, PrEP, cervical cancer and Preventive TB, increased targets consistent with the level of increased budgets.

Again, the team has received a notional budget as noted above and a final budget approval will be contingent on the team's desired targets. As always funding is associated with a performance target that will be achieved with those resources. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team in collaboration with the Government of

Malawi and civil society of Malawi believes is critical for the country's progress towards controlling the pandemic and maintaining controlling.

Additionally, country teams and specifically agencies independently can request additive ambition funds in the OU FAST to be submitted, based on their stated increased ambition in Treatment and VMMC, with commensurate increased partner level targets. This funding is available to agency partners with the highest performance with evidence that they are addressing the one of the critical gaps outlined above. Budget requests must be consistent with the cost of expanded targets and address one of the gaps in programming #3-5 above. These requests should be discussed with the S/GAC chair and PPM during the January strategy retreat and tentatively approved and be submitted with the DataPack and FAST tool. The final budget and associated country level targets will be discussed and approved during the Johannesburg meeting.

We are hoping this new approach to target-setting and budget will establish an open dialogue on target-setting and empower teams to work with all stakeholders to plan a strategic and impactful COP. The expectation is for country teams and agencies to propose to S/GAC the targets they believe are achievable and feasible and hold their partner's accountable to that achievement. In addition, this new approach to target-setting gives high performing partners and agencies with additional aspirations the opportunity to do more to achieve even greater impact with additional ambition resources.

In the next 48 hours, more detailed descriptions of OU's programmatic successes and challenges will be conveyed to your wider PEPFAR team by the S/GAC Chair and PPM in a phone call, after which the detailed planning level letter will be immediately released.

Again, thank you for your work and we are looking forward to working with you to achieve your Fast Track Strategy and ultimately the SDG 3 goal.

Together we can.

Deborah Birx

Subject to COP Development Approval



## United States Department of State

Washington, D.C. 20520

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January 17, 2020

COP 2020 Planning Level Letter | PART 2

### **INFORMATION MEMO FOR AMBASSADOR SCOTT**

**SUBJECT: Fiscal Year (FY) 2020 PEPFAR Planned Allocation and Strategic Direction**

With input from the field teams through the quarterly POARTs and from Headquarters Country Accountability and Support Teams, we have thoroughly reviewed progress of the program in your country over time and specifically the end of year results of the Country Operational Plan (COP) 2018 and current COP 2019 implementation as we plan for COP 2020. We have noted the following key successes and specific areas of concern:

#### **Malawi's Key Successes**

Malawi is commended for good performance overall in COP18. It has steadfastly pursued epidemic control, curbing the growth of new infections and reducing AIDS-related deaths through 2019. This has been possible because of a strong, reliable and evidence-based partnership with the leadership in the Ministry of Health and the Department of HIV/AIDS, and coordination with civil society, the Global Fund and UNAIDS. The partnership is on course to achieve 95-95-95 at a national level and 90-90-90 in each age-stratified gender group by geographic catchment area. Population-level HIV incidence is on course to decline to <1/10,000 population. We are confident that the country can close the outstanding gaps in reaching men, key populations, AGYW and children, including achieving viral suppression for pediatric clients and implementing U=U with community assistance.

Malawi is commended for implementing a phased health information system strategy in spite of development challenges to deliver consistent power, connectivity, integrated and interoperable systems. We want to note with pride the dedicated problem-solving demonstrated by the entire OU to be able to support quality patient care with real-time and near real-time EMR to improve patient outcomes. We urge the government to dedicate resources provided both by the US government and other external partners to finish the platform that supports complex HIV care, and use that system as its gateway to managing the array of health challenges confronted by its people, including ending TB and cervical cancer epidemics among clients living with HIV.

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Malawi has led the path to near real-time HIV epidemic surveillance for “hot spots” using recency tests to characterize, respond to, and end micro-epidemics, going from testing in 17 districts to all 28 districts by the end of the current implementation period. The team has already begun to see critical elements including fewer recent infections amongst males, 35+, indicating late presentation for HIV testing, towards the end of FY2019. This path will enable the country through its partnership with PEPFAR and the Global Fund, to achieve and sustain existing gains, and maintain the 3<sup>rd</sup> 95 viral suppression goal.

We continue to be pleased about the work done with, and for, adolescent girls and young women through the DREAMS program, and the success recruiting and serving more 10 – 14-year olds. However, challenges remain which could be due to incomplete capture of layered services offered but not recorded. We know that we are in need of greater investment in high burden districts and have every expectation that as a country, Malawi’s Global Fund investments in this area and in the correct interventions, will be a high priority for the GF resources sought in the 2020 – 2022 funding cycle. We want to acknowledge your team’s efforts in VMMC programming to target 15 – 29 year old males, and prioritize saturating that population, as is our guidance.

We have provided funding to PEPFAR Malawi for the HBCU expansion activities in the 2020 COP. This integration will ensure greater synergy between HBCU activities and other country COP activities. HRSA will transition the HBCU partnership from a HOP activity in FY 2020 to a COP activity in FY 2021. Year 2 is included in the COP 2020 budget and joint planning with the country team is required.

### **Malawi’s Key Challenges**

With all our incredible successes, challenges remain for PEPFAR and the Department of HIV/AIDS. Prior to COP 18, Malawi’s achievement of 95-95-95 by 2020 was threatened when we failed to adequately grow TX-CURR in FY18 despite spending our budget fully. As a result, we started COP 18 in a deficit. So, as we consider COP 2020, Malawi not only must achieve its FY20 targets, but must also grow the TX-CURR we expected from COP 2018, in COP 2019. So, Malawi’s NSP 2020 goal in development with support from UNAIDS and as the basis of the Global Fund submission in March must be the 991,000 target set by UNAIDS. COP 2019 needs to make up the backlog and grow TX\_CURR as expected. This will allow COP 2020 to be on schedule and well positioned to execute the client-centered priorities in the COP 2020 guidance.

Partners continue to over-test, conducting more than 4.2 million tests in COP 18. Partners must shift away from inefficient modalities, especially PITC, and improve contact tracing. While adult females are being over tested, case finding in men and youth is lagging, and it will not be possible to achieve targets for clients on treatment without reaching these populations through tailored, client-centered services.

We have not solved the challenge of maintaining young 15 – 35 year olds who are asymptomatic, on treatment and not virally suppressed, in quality services. This is

particularly evident in urban sites and among men and youth. Dolutegravir-based regimens have not fully rolled out due to in-country challenges including concerns of TLE stock wastage. Malawi's achievement and sustained support of 95-95-95 goals by 2020 will be constantly under threat until as a collective, with our clients, we find needed solutions. Seventy percent of children are still on Nevirapine-based regimens with poor viral load suppression, partly due to lack of pediatric ARVs in country and Malawi remains under-capacitated for the needed viral load tests to be conducted per year.

Subject to COP Development and Approval



**SECTION 1: COP/ROP 2020 PLANNING LEVEL**

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total COP/ROP 2020 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

**Table 1. MALAWI 2020 Total Budget including Applied Pipeline**

**\*\*Based on agency reported available pipeline from EOFY 2019.**

**SECTION 2: MALAWI 2020 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS\*\***

Countries should plan for the full Care and Treatment (C&T) level of \$124,600,000 and the full Orphans and Vulnerable Children (OVC) level of \$24,740,000 from Part 1 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

**Table 1. MALAWI 2020 Total Budget including Applied Pipeline**

TABLE 1 : All COP 2020 Funding by Fiscal Year

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
Total New Funding	\$ 165,620,966	\$ -	\$ -			\$ 165,620,966
GHP- State	\$ 164,108,466	\$ -	\$ -			\$ 164,108,466
GHP- USAID	\$ -	\$ -	\$ -			\$ -
GAP	\$ 1,512,500	\$ -	\$ -			\$ 1,512,500
Total Applied Pipeline				\$ 5,276,034	\$ 13,137,169	\$ 18,413,203
DOD				\$ 61,600	\$ -	\$ 61,600
HHS/CDC				\$ 4,138,464	\$ -	\$ 4,138,464
HHS/HRSA				\$ -	\$ -	\$ -
PC				\$ 279,006	\$ -	\$ 279,006
State				\$ -	\$ -	\$ -
USAID				\$ 796,964	\$ 13,137,169	\$ 13,934,133
TOTAL FUNDING	\$ 165,620,966	\$ -	\$ -	\$ 5,276,034	\$ 13,137,169	\$ 184,034,169

**Table 2. MALAWI 2020 Earmarks by Fiscal Year**

TABLE 2 : COP 2020 Earmarks by Fiscal Year \*

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	\$ 90,000,000	\$ -	\$ -	\$ 90,000,000
OVC	\$ 18,500,000	\$ -	\$ -	\$ 18,500,000
GBV	\$ 1,397,159	\$ -	\$ -	\$ 1,397,159
Water	\$ 200,000	\$ -	\$ -	\$ 200,000

\* Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. These earmark controls above represent the minimum amounts that must be programmed in the given appropriation year.

**Table 3. MALAWI 2020 Initiative Controls**

TABLE 3 : All COP 2020 Initiative Controls

	COP 20 Total
Total Funding	\$ 70,500,000
VMMC	\$ 9,500,000
Cervical Cancer	\$ 3,000,000
DREAMS	\$ 20,000,000
HBCU Tx	\$ 2,000,000
COP 19 Performance	\$ 30,000,000
HKID Requirement	\$ 6,000,000

\*\*See Appendix 1 for detailed budgetary requirements and other budgetary considerations.

**Table 4 – Acceleration 20 Applied Pipeline is not applicable to Malawi**

## SECTION 3: PAST PERFORMANCE – COP/ROP 2018 Review

Table 5. COP/ROP OU Level FY19 Program Results (COP18) and FY20 Targets (COP19)

Indicator	FY19 result (COP18)	FY20 target (COP19)
TX Current Adults	771,390	928,641
TX Current Peds	46,766	62,721
VMMC among males 15 years or older	95,748	132,202
PrEP (NEW/CURR)	762 / 376	6,549 / 4,573
DREAMS (AGYW_PREV_N)	11,252	----
Cervical Cancer Screening	37,505	101,451
TB Preventive Therapy	28,948	46,896

*\*All FY 2020 targets are sourced from the Malawi COP 19 Approval Memo.*

Table 6. COP/ROP 2018 | FY 2019 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP/ROP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
<b>OU</b>	<b>165,393,619</b>	<b>126,491,257</b>	<b>38,902,362</b>
DOD	2,632,726	2,355,590	277,136
HHS/CDC	68,696,627	59,056,216	9,640,411
HHS/HRSA	100,252	191,042	(90,790)
PC	1,893,053	1,369,495	523,558
State	992,422	181,416	811,006
State/AF	776,243	917,764	(141,521)
USAID	63,386,777	60,129,835	3,256,942
HHS/CDC (Central)	4,324,890	-	4,324,890
USAID (Central)	22,590,629	2,289,899	20,300,730
<b>Grand Total</b>	<b>165,393,619</b>	<b>126,491,257</b>	<b>38,902,362</b>

*\*All figures are sourced from the Malawi EOFY Tool*

*\*Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

**Table 7. COP/ROP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget**

Mech ID	Prime Partner	Funding Agency	COP/ROP18/FY19 Budget (New funding + Pipeline + Central)	Actual FY19 Outlays (\$)	Over/Under FY19 Outlays (Actual \$ - Total COP/ROP18 Budget \$)
18246	Regents of the University of California, San Francisco, The	HHS/HRSA	100252	191,042	(90,790)
18256	Department of State	State/AF	576243	811,289	(235,046)
17585	FHI Development 360 LLC	USAID	4460663	5,258,039	(797,376)
15888	UNICEF	USAID	535227	614,113	(78,886)
18028	World Learning	USAID	790000	905,577	(115,577)
70189	Population Services International	USAID	5599247	6,269,254	(670,007)
14441	The Lighthouse Trust	HHS/CDC	5865974	5,919,251	(460,803)

*\*Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

**Table 8. COP/ROP 2018 | FY 2019 Results & Expenditures**

Agency	Indicator	FY19 Target	FY19 Result	% Achievement	Program Classification	FY19 Expenditure	% Service Delivery
DOD	HTS_TST	43,030	34,463	80.1%	HTS Program Area	\$96,819	34%
	HTS_TST_POS	2,428	3,163	130.3%			
	TX_NEW	2,144	2,448	114.2%	C&T Program Area	\$407,794	0%
	TX_CURR	10,057	8,349	83.0%			
	VMMC_CIRC	5,050	10,477	207.5%	VMMC Subprogram of PREV	\$394,294	98%
HHS/CDC	HTS_TST	1,384,216	2,178,468	157.4%	HTS Program Area	\$11,698,677	74%
	HTS_TST_POS	75,720	71,131	93.9%			
	TX_NEW	75,917	65,791	86.7%	C&T Program Area	\$19,418,017	59%
	TX_CURR	577,480	480,455	83.2%			

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	VMMC_CIRC	50,015	52,062	104.1%	VMMC Subprogram of PREV	\$3,454,602	100%
Peace Corps	OVC_SERV	330	160	48.5%	OVC Major Beneficiary	-----	-----
USAID	HTS_TST	1,137,603	2,045,936	179.8%	HTS Program Area	\$7,346,064	77%
	HTS_TST_POS	60,766	56,091	92.3%			
	TX_NEW	58,063	49,012	84.4%	C&T Program Area	\$17,522,975	59%
	TX_CURR	394,684	336,790	85.3%			
	VMMC_CIRC	89,970	78,050	86.8%	VMMC Subprogram of PREV	\$9,916,711	85%
	OVC_SERV	126,234	123,761	98.0%	OVC Major Beneficiary	\$4,316,286	91%
Above-Site Programs						\$15,196,435	
Program Management						\$26,669,801	

*Note:\* An error was corrected. The target discrepancy for USAID's TX\_CURR was due to double-counting of TX\_CURR targets in Panorama under two different mechanisms (EQUIP and OHSEC/PIH). These targets were for the same sites. Panorama has 541,173 which is an impossibility. For HTS TST, achievement under 90% is coded green; achievement over 150% is coded orange.*

**COP 2018 | FY 2019 Analysis of Performance OU-Level Analysis**

Above Site

The entire team and its implementing partners, especially EGPAF, are strongly commended for their tremendous and admirable efforts that resulted in the deployment of EMRS to 731 sites. As a result of their work, the full set of Malawi data is now available in DATIM, fulfilling a key priority for OGAC. The team is also commended for transitioning more than 230 health care workers to the Ministry of Health payroll. The team continues to maintain a strong relationship with the Government of Malawi that has allowed for the institution of key policy changes that will be critical to the achievement of epidemic control. However, it will be important to ensure that these policies are implemented and scaled rapidly.

Case Finding

Overall, the program demonstrated excellent performance on case finding, with all agencies showing great improvement over the previous COP cycle. At the OU level, the program achieved 94% of its target for new positives. However, over-testing by USAID and CDC, particularly among adult females, is a significant concern. The OU tested at 166% of its HTS target, with USAID testing at 180% and CDC at 154% of their targets. Performance on finding men and youth has faltered, with Malawi falling short on male case finding targets.

Performance on self-testing has been strong. While index testing has been scaled up, it still represents only 15% of new positives. Malawi has not scaled index testing for

pediatrics, although it is the most efficient modality for case finding in this population. The OU has met or exceeded all of its PMTCT targets.

### Care and Treatment

Malawi has failed to adequately grow the number of clients on treatment. Early loss to follow up among children, men, and pregnant women remains the biggest challenge to Malawi's HIV treatment program, with up to 25% of all ART enrollees LTFU by 12 months of follow up.

Prior to COP 18, Malawi's achievement of 95-95-95 by 2020 was threatened when we failed to adequately grow TX\_CURR in FY18 despite spending our budget fully. As a result, we started COP 18 in a deficit. So, as we consider COP 2020, Malawi not only must achieve its FY20 targets, but must also grow the TX\_CURR we expected from COP 2018, in COP 2019.

The program struggled to meet targets for initiating clients on treatment and retention, with OU- level achievement of TX\_CURR at 84% and TX\_NEW at 85%. It should be noted, however, that COP18 performance on TX\_NEW across all agencies is greatly improved from COP17, when it stood at 64%. Transitioning children from NVP-based regimens has lagged.

### Viral Load

The OU demonstrated satisfactory performance on viral suppression, making gains over performance the prior year. A total of 29% of PLHIV living with non-suppressed viral load are on treatment but not suppressed. Even with the roll out of optimal ART, viral load suppression for children <15 remains unacceptably low at 55% as compared to 89% for those 15+. While recent policy changes have allowed for the scale up of viral load testing, Malawi is not fully capacitated to conduct over a million viral tests each year.

### Prevention

On the whole, Malawi continued to demonstrate excellent performance in its prevention program. On the indicators OVC\_SERV, VMMC\_CIRC, and KP\_PREV the program achieved 96%, 98%, and 158% of its respective targets. As compared to the prior year, Malawi also showed significant improvement in reaching clients with GBV clinical care, but still achieved just 49% of its target. While there is a high demand for PrEP, just 750 people were placed on PrEP vs. the target of 1,060, representing an achievement of 72%.

### **Agency and Partner Performance**

#### Overall

- Nearly all partners failed to meet targets on TX\_CURR, TX\_NEW or both.
- The largest partners EGPAF and Baylor are generally performing well on case finding but are both significantly overspending on testing.
- All partners but PCI spent more than 100% of their HTS budget, with most spending more than 130% of their budgets. Four partners spent more than 200% of their HTS budget. Conversely, very few partners expended their full care and treatment budget.

DOD:

DOD is strongly commended for demonstrating much higher achievement across the board as compared to the previous COP cycle. DOD succeeded in targeted testing, did not over test, while at the same time achieving 130% of its target for new positives. DOD needs to find and retain 1,705 clients in addition to its COP 2020 targets.

- *JHPIEGO*: DOD's VMMC partner, JHPIEGO had very satisfactory performance in COP18, reaching 112% of its target.
- *Project Concern International*: PCI's performance is greatly improved over last year's with respect to finding new positives (130% of target) and putting new clients on treatment (114% of target). This is particularly impressive given that testing was only at 67% of the target for this indicator and spending on HTS was just 50% of this budget. However, results on TX\_PVLS were low at just 43%.

HHS/CDC:

CDC partners performed very well on finding new positives, but significantly over tested (157% of target). With the notable exception of the Lighthouse Center for Excellence, no IMs met their retention targets. While achievement of retention targets dropped as compared to COP17, the agency greatly improved its performance with respect to initiating new clients on treatment (from 62% to 87% in COP18). CDC needs to find and retain 97,025 clients in addition to its COP 2020 targets.

- *EGPAF*:  
EGPAF did an excellent job taking the lead in rapidly rolling out the EMR to all ART sites, and generally demonstrated good performance. While commended for reaching 93% of its target for new positives, it also expended 213% of its HTS budget.  
Performance on self-testing was low at 24%.
- *Lighthouse*:
  - The mechanism in Lilongwe stands out as the only high performing treatment partner, at 94% of TX\_NEW and 96% of TX\_CURR. Its success in this area should be analyzed and lessons learned applied across the OU. However, its achievement on case finding was 76%, while it expended 159% of its HTS budget. While demonstrating very good performance on TB, achievement on PMTCT was low.
  - The mechanism in Blantyre has shown dramatic improvements over the prior year's performance across nearly all indicators. It exceeded targets for PMTCT, TB, and viral load suppression. However, performance on self-testing was low.
- *JHPIEGO*:
  - IM 18244 achieved 98% of its new positives target but overspent at 386% of its HTS budget.
  - IM 18247, focused on VMMC, performed well and achieved all of its targets.

- *University Research Co.:* Performance was good; 553,067 or 89% of the TX-PVLS target was reached, and represents the volume of VL testing achieved supported by the lab IP

USAID:

USAID partners performed very well on finding new positives, but significantly over tested (180% of target). No partners met their retention targets. While achievement of retention targets dropped as compared to COP17, the agency greatly improved its performance with respect to initiating new clients on treatment (from 68% to 84% in COP18). USAID needs to find and retain 57,894 clients in addition to its COP 2020 targets.

*Baylor:* On the whole, Baylor's performance was good, with especially strong achievements on PMTCT and TB. While commended for reaching 94% of its target for new positives, it also expended 162% of its HTS budget.

- *Johns Hopkins University:* JHU performed well, meeting its targets for OVCs and priority populations, and reaching 308% of its self-testing target. While JHU did not over test, it spent 494% of its HTS budget but achieved 71% of its new positives target.
- *FHI360:* LINKAGES performed well on a number of program areas. While exceeding its target for case finding (110%), it also expended 631% of its HTS budget. It reached 247% of its target for self-testing and showed very strong results on prevention interventions for KPs.
- *Partners in Hope:* PIH performed very well, exceeding targets on self-testing, PMTCT, TB, and viral suppression. While it achieved just 78% of its case finding target, its expenditures as a percentage of its HTS budget was among the lowest at 107%
- *John Snow International:* JSI performed well, reaching 108% of its VMMC target.
- *PSI:* PSI performed very well with respect to case finding, reaching 109% of its target. At 74% of the target, achievement on VMMC needs improvement.
- *EQUIP:* EQUIP performed well on PMTCT and TB. Performance on HST\_TST\_POS was 102%. TX\_CURR and TX\_NEW were both 87%.

Peace Corps:

Peace Corps fell short on their OVC target, reaching only 160 OVC against a target of 330, representing just 45% achievement of target. However, going forward, the potential for Peace Corps to be an incubator for largest partners is strong, and we are excited about this opportunity.



*Subject to COP Development and Approval*

## SECTION 4: COP/ROP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives. The COP 2020 directives include targets for Treatment Current and TB Preventive Therapy. Targets for VMMC, DREAMS, cervical cancer and PrEP should be set based on FY19 performance. Funds for these programs have been allocated based on FY19 performance (see Table 5).

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements in place no later than the beginning of COP/ROP 2019 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs.

For COP/ROP 2020, the failure to meet any of these requirements will result in reductions to the Malawi's budget. (See Section 2.2. of COP Guidance)

**Table 9. COP/ROP 2020 (FY 2021) Minimum Program Requirements**

	Minimum Program Requirement	Team Reported Status	Outstanding Issues Hindering Implementation
Carmen And Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. <sup>1</sup>	Test and Start services are available in all ART sites.	None. However, team must incorporate COP 2020 guidance in this area.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens. <sup>2</sup>	Nearly 60% of all patients were on DTG as of September 30, 2019.	Phase out of NVP- based formulations in progress although there has been a slow transition to optimized pediatric regimens. Only 50- 60% of children on treatment are virally suppressed and most (70%) are still on NVP- based regimens due to delayed issuance of MOH guidance to sites and related training, that would allow TLD for children >30kgs. LPV/r-pellets or granules have been available in Malawi since January 2019 for the majority of CLHIV <20kg. There was a delay in arrival of ABC-3TC-DTG for

<sup>1</sup> Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

<sup>2</sup> Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

Case Findings			children 20-30 kg, but these stocks have been in country since Oct 2019.
	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents. <sup>3</sup>	Malawi has been offering three-month dispensing for nearly a decade with more than 70% of patients estimated to be on 3-month MMD. Six-month multi-month dispensing services began April 2019 at 23 high volume sites. In FY 20 Q1, MOH guidance allows for 6-month MMD at all sites which demonstrate capacity through a standard site assessment process. Other differentiated service delivery models such as Teen Clubs, Drop-In centers for key populations, nurse provided community ART, and Advanced Patient Care are already underway.	Team must incorporate COP 2020 guidance in this area.
	4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by the end of COP 2020; cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. <sup>4</sup>	All eligible PLHIV are expected to be reached with TPT by end of COP 20	Malawi will scale TpT to 23 new districts to achieve national coverage. The country is eager to adopt 3HP, however, may need to implement with INH pending global stock availability of 3HP.
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	Access to and expansion of viral load testing continues to scale as a result of a viral load policy circular that went into effect April 2019. Extended work hours and additional HR have improved lab capacity.  GeneXpert optimization efforts underway (92) to improve current 50% utilization rate of GeneXpert. Use of GeneXpert also being used for EID and targeted VL. All machines connected to GxAlert for real time monitoring of functionality and stock status.	Efforts ongoing to optimize sample transportation for TB including plans to transition from a “push” to “pull” collection schedule.
	6. Scale up of index testing and self-testing, ensuring consent	Policy Adopted; implementation in progress in PEPFAR supported	Revision of revised national testing guidelines delayed

<sup>3</sup> Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

	procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV. <sup>4</sup>	community and facility sites. IPV screening and testing of children integrated into index testing procedures.	pending WHO guideline release. Standard tools for index testing and contact tracing not yet final. Standardized implementation and approach to monitoring/reporting of active index testing across IP's is still needed.
Prevention and	7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) <sup>5</sup>	Policy Adopted; but limited implementation in progress with focus on AGYW and FSW at sites in Lilongwe and Blantyre, due to delayed release of national guidelines and training.	National PrEP roll-out expected in Q2 pending dissemination of guidelines, which include other populations at elevated risk.
	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	Implementation in progress. Case management approach in place including high HIV ascertainment among OVC. Prevention activities for OVC 9-14 in place, to be bolstered through the Faith and Community Initiative.	Current OVC cohort being graduated where possible to ensure capacity to enroll new OVC, with focus on CLHIV.
Policy &	9. Elimination of all formal and informal user fees in the public sector for access to all direct	Malawi's policy does not allow user fees to be charged for HIV services.	User fees exist at select CHAM sites for services including with PrEP, GBV

<sup>4</sup> Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016

<https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/>

<sup>5</sup> Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV.

Geneva: World Health Organization; 2015 (<http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en>).

	HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention. <sup>6</sup>		services and Cervical Cancer screening. There has been success with negotiating these at select sites.
10.	OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy. <sup>7</sup>	CQI is integrated into service delivery programs and monitored regularly.	Team must incorporate COP 2020 guidance in this area.
11.	Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Tizirombo Tochepa= Thanzi T=T activities to increase treatment literacy, viral load coverage and suppression levels have been proposed; faith and community initiative platforms are being utilized to.	MOH has requested further time to develop messaging that is adapted to the local context.
12.	Clear evidence of agency progress toward local, indigenous partner prime funding.	CDC is on track towards this objective. USAID improved from 4% in COP 17 to 43% at beginning of COP 19.	Team must incorporate COP 2020 guidance in this area.
13.	Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	Malawi met Co-Financing and Willingness to Pay Obligations under the 2018-2020 grant period. US\$33,785,636 was allocated demonstrating the commitment to increase domestic resources for health, within the limited fiscal environment.	Team must incorporate COP 2020 guidance in this area.
14.	Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	PEPFAR Malawi is using EMRS and active tracing systems for PLHIV who missed their appointments or defaulted from care to monitor morbidity and	Only 12 of 28 districts will be covered by mortality surveillance as part of CRVS by end of FY20.

<sup>6</sup> The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

<sup>7</sup> Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

		mortality outcomes. Mortality surveillance is being expanded through the national civil registration and vital statistics (CRVS) program.	
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	PEPFAR scaled up EMR to 712 facilities in COP18, bringing total sites with EMR to 730 (96%) of 760 sites. A central data repository is functional and proceeding with case-based surveillance protocols for 10 large sites. By end of FY20, CBS is scheduled to be nation-wide at all EMR facilities. Point of Care EMR uses a Demographic Data Exchange that can use the national ID to track patients across sites once connectivity is fully established. Connectivity should be in place by end FY20.	National policy on using the national ID in health is still needed.

In addition to meeting the minimum requirements outlined above, it is expected that Malawi will:

**Table 10. COP/ROP 2020 (FY 2021) Technical Directives for PEPFAR/Malawi**

<u>Malawi Specific Directives for COP 2020</u>
<b>Prevention of New Infections in AGYW</b>
<ul style="list-style-type: none"> <li>▪ PEPFAR Malawi must continue to invest in and expand evidence-based prevention interventions, including DREAMS. For 9 to 14-year olds, implementation must focus on evidence-based primary prevention of HIV and sexual violence. These interventions must be integrated into OVC programs and seek to prevent coerced sex and early sexual debut, while increasing HIV prevention knowledge and improved sexual activity decision making.</li> <li>▪ <u>We must determine if Malawi has data quality issues related to AGYW_PREV</u>, complicated by a lack of layering data. No client in the DREAMS program enrolled for less than 6 months appears to have completed the primary package, and a majority of AGYW in DREAMS programs for 7-12 months in each age band have not completed the primary package.</li> <li>▪ Improving economic strengthening should be a focus in Malawi—the team should look at the resources linked in the COP guidance to improve existing programs.</li> </ul>
<b>Support for KPs with prevention and treatment</b>

- PEPFAR Malawi must continue to invest in and expand evidence-based prevention interventions including PrEP. KP programming must be expanded geographically while ensuring that in targeted areas, the KP demographic must achieve 95/95/95 in addition to increasing KP access to PrEP.
- Additionally, PEPFAR Malawi must continue to advocate for a conducive KP policy environment through a public health approach, justice for children, and lowering the age of consent to increase adolescent HIV testing.
- Improve service delivery for KPs, delivering services in a way that serves KPs well.
- Refine case finding through index and social network testing.
- Scale up self-testing.

**Diagnose and Treat Men**

- Between FY18Q4 and FY19Q4, the percentage of males 15+ years on treatment in your program increased by 79%. While most of the percentage increase in FY19 was in the 25-29-year-old age band, a smaller percentage was in the 30-34 year age band. In addition, in the first three quarters of FY19, your program put half the number of men on treatment than women ages 15+ years. UNAIDS 2019 data shows significant gaps in the 2nd 90 (68%) and 3rd 90 (61%) among males 15+ years in Malawi. Therefore, in COP20, your program should continue focusing on adding men to treatment, specifically within the 25-34-year age band, and attaining viral suppression among this group.
- Meeting clients where they are with what they need at each stage of the treatment cascade will be critical to advancing life-long continuity of ART. This requires a better understanding of client needs in order to remove barriers to treatment. MenStar is a coordinated effort to clearly understand obstacles to testing and treatment and differentiate service delivery for men. Leveraging the insights garnered through MenStar, and as a priority MenStar country, your program should implement a core package of services that meet men where they are with what they need. Please see the newly released MenStar Guidance Document and Compendium for recommended strategies, interventions, and examples.

**Maintain 15-35 year old asymptomatic clients on treatment and virally suppressed**

- Perhaps our most significant challenge is in ensuring 15-35 year old asymptomatic clients are maintained on treatment and virally suppressed (TX\_NET\_NEW and TX-CURR growth, and retention surrogates). We need to address this.

**Children on the best regimen and virally suppressed**

- The Malawi program must rapidly scale up index testing for children (<15) to  $\geq 15\%$  HTS\_TST from index and  $\geq 30\%$ -50% TST\_POS from index. Expansion of teen clubs may bear fruit.
- Team must focus on pregnant and breastfeeding mothers (especially

those who are LTFU) - ensuring there is MMD available and that the children are being tested.
<b>Case Finding</b>
<ul style="list-style-type: none"><li>Per the 2020 Guidance, active index testing and contact referral tracing must be the norm and a shift from PITC implemented in accordance with the COP guidance allowances.</li></ul>
<b>Care and Treatment</b>
<ul style="list-style-type: none"><li>We anticipate that the Malawi program will achieve its goal of epidemic control by the end of COP 19. COP 20 PEPFAR resources must support Malawi to maintain 95-95-95 gains and offer support for quality client services across all DSD and TA sites. PEPFAR must ensure sites are supported to provide quality client-centered services for the TX_CURR population of ~1.2 million people. IPs must ensure implementation of the minimum program requirements and ensure 100% client retention for ~1.2 million PLHIV. Services supported will include TB care, cervical cancer, annual viral load, and 6-month MMD aligned to the COP2020 guidance. This includes our HRH investment at DSD sites.</li><li>Due to the small proportion of unmet need at the close of COP 19, for COP 2020, high- performing IPs in Blantyre, Lilongwe and Mangochi must be funded to find the outstanding clients. Not every clinical or community partner should be part of this operation, which should focus on finding the pediatric cases, the adolescents/youth (including KPs) with unsuppressed viral load and not on ART, and the missing men who will impact our prevention success in young women. The goal of this effort is to saturate high burden urban areas and other epidemic hotspots.</li></ul>
<b>OVC</b>
<ul style="list-style-type: none"><li>Implement care and treatment and prevention services in a highly strategic manner through OVC programming. Funding must be directed purposefully, and for impact.</li><li>In COP20, OVC and clinical implementing partners in Malawi must work together to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC SNU are offered the opportunity to enroll in the comprehensive OVC program.</li></ul>
<b>VMMC</b>
<ul style="list-style-type: none"><li>Implement prevention services in a highly strategic manner through VMMC programming. Funding must be directed purposefully, and for impact.</li></ul>
<b>DREAMS</b>



- Implement prevention services in a highly strategic manner through DREAMS programming. Funding must be directed purposefully, and for impact. PrEP must be offered to for high risk groups and we must saturate DREAMS districts where we have gaps in programming. Malawi should leverage GF financing wisely for this population.
- The data system that would allow a cross-stakeholder review of DREAMS data is not fully rolled out and easily analyzable to understand the DREAMS program's progress. We are therefore recommending that Malawi stakeholders and the interagency have access to a populated DREAMS database with information on >60,000 AGYW. An update must be provided at the February Planning Meeting. As is announced in this letter, expansion of DREAMS to additional catchment areas in existing DREAMS districts with increased access to PrEP for vulnerable AGYW in COP20 is funded

**Cervical Cancer, PrEP and TB**

- Cervical Cancer - Malawi must leverage the MoH release of new cervical cancer screening guidelines to increase awareness of the need for screening for women living with HIV and increase demand. It must establish clear referral and accountability systems to track women who are referred for treatment services and work closely with other cervical cancer screening programs, including the USAID FP screening research program, to avoid duplication of services and ensure efficiency. Include cervical cancer questions on the PHIA2 if possible.
- PrEP - Malawi's PrEP targets are low to begin with and the program is barely reaching 25% of those targets. Malawi has a national policy in place, but country-wide implementation is slow. Advocating for wider PrEP distribution must continue. Data from Blantyre and Lilongwe show a high demand for PrEP and reasonable retention. However, by mid FY20 Q1, only 750 persons are enrolled on PrEP, while the COP19 target is >6,000. Therefore we are recommending the team accelerate PrEP rollout given high levels of demand among vulnerable AGYW, FSW, and other target populations in COP19.
- TB/HIV - Only about 250,000 of nearly 1.1 million PLHIV received TB preventive therapy, due to restriction of TPT policy to 5 of 28 districts therefore we are recommending support for rapid expansion of the TPT program through purchase of both 3HP and 6IPT for nation-wide rollout (per new guidelines) to reach >90% of PLHIV on treatment with TPT by end of COP19. This effort needs to be adequately resourced at site level.

**Above Site**

<ul style="list-style-type: none"><li>▪ The interagency HIS strategy endorsed by the Embassy front office is approved to advance contingent on the chair-approved governance plan being implemented. PEPFAR IPs need to be funded to expand to support EMR in the 264 non-presence (TA) sites (in COP19)</li><li>▪ Redistribute agency and partner support for EMR.</li><li>▪ Integrate DREAMS layering database and KP tracking across partners and with GoM and improve EMR governance and increased resources and accountability for clinical partners.</li><li>▪ Expedite SEED implementation.</li><li>▪ HRH alignment and professionalization of community cadres is supported.</li></ul>
<b>Community Response</b>
<ul style="list-style-type: none"><li>▪ As agreed to with our partners, acknowledge the role communities play, and pledge to jointly support and strengthen their capacity</li></ul>
<b>Peace Corps</b>
<ul style="list-style-type: none"><li>▪ Deploy Peace Corps Volunteers to address gaps in Youth Friendly Health Services and Teen Clubs to enhance critical health seeking behavior</li><li>▪ Leverage PCVs to support linkages and referrals to services</li><li>▪ Leverage PCV to advance the skills of health professionals to provide more patient centered care focused on behavior change for boys.</li></ul>
<b>HBCU Partnership</b>
<ul style="list-style-type: none"><li>▪ PEPFAR Malawi is funded in COP 2020 to roll its funding for current HBCU community health worker certification activities into their broader 2020 COP. This integration will ensure greater synergy between HBCU activities and other country COP activities. Funding will continue to support programs for high school students to graduate with a certification in community health work, building from best practices and lessons learned from HBCUs' domestic work in this area.</li></ul>

**COP/ROP 2020 Technical Priorities**

Client and Family Centered Treatment Services

COP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, must require long-term, continuous ART for a population that is often young and asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site- level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient

ARV pick-up arrangements, and community and client participation in design and evaluation of services. OU's must ensure 100% "known HIV status" for biological children of TX\_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

#### Community-led Monitoring

In COP 20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

#### Pre-Exposure Prophylaxis (PrEP)

Groups to be prioritized for PrEP include those testing negative in index testing but remaining at increased risk of HIV acquisition by virtue of unprotected exposure to a PLHIV with unsuppressed viral load, key populations including sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls and young women, including pregnant and breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified serodiscordant couples. (Groups will be tailored to country context).

#### TB Preventive Treatment (TPT)

TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP20; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

#### DREAMS

DREAMS funding is allocated within your COP 2020 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNU's in accordance with all DREAMS and COP 2020 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP20 DREAMS implementation include: systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition, improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR), and accelerating PrEP uptake for AGYW.

#### Malawi Specific

DREAMS is receiving an increase in new funding which should be used for the following:

- PrEP: Significantly scale-up PrEP for AGYW in all DREAMS districts.
- Minimum Requirements for new funds: To receive additional funds, Malawi must present a strategy and a timeline at the COP meeting for the following:
  - Hire a dedicated DREAMS Coordinator (100% LOE)

- Hire a DREAMS ambassador for each district to support DREAMS coordination and oversight
- Implement approved, evidence-based curricula in line with the current DREAMS Guidance
- Ensure a fully operable layering database with unique IDs across IPs and SNU
- Ensure a full geographic footprint in all districts
- Address challenges and ensure DREAMS implementation in all districts with fidelity (e.g. education subsidies, community mobilization and norms change)

In addition, DREAMS Malawi should focus on the following:

- Layering: Malawi seems to have a significant data quality issue with AGYW\_PREV. Nobody in DREAMS for less than 6 months has completed the primary package, and a majority of AGYW in DREAMS for 7-12 months in each age band have not completed the primary package.

### OVC

To support the Minimum Program Requirement described above, in COP 20 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, case conferencing, shared confidentiality, and joint case identification. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

### VMMC

Funds have been provided to conduct VMMC for males 15 years or older. The team is reminded of the revised guidance which allows surgical VMMC under the age of 15 only by the dorsal slit method and only for those who have attained Tanner stage 3 or higher of development and are able to provide full informed consent for the procedure. While Shang ring may be considered for those below age 15 regardless of Tanner stage, the same informed consent issues apply. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

### Cervical Cancer Screening and Treatment:

Funding for cervical cancer screening and treatment of pre-invasive lesions. The target for screening must be equal to half of the TX\_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance. Basic treatment should be available for pre-cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results.

### PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0 or complement Global Fund or other donors financing implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma and can inform future HIV program planning. If the revised Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 20, whether supported by PEPFAR or other resources.

### **COP/ROP 2020 Stakeholder Engagement** (see section 2.5.3 of COP Guidance)

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP/ROP 2020 remains a requirement for all PEPFAR programs, and as such the COP/ROP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP/ROP 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2020. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, GA where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Specific guidance for the 2020 meeting delegations have been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP/ROP 2020 development and finalization process. As in COP/ROP 2019, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP/ROP 2020 Guidance for a full list of requirements and engagement timelines.

**APPENDIX 1: Detailed Budgetary Requirements****Table 11. MALAWI New Funding Detailed Controls by Initiative**

TABLE 11 : New Funding Detailed Initiative Controls

	COP 2020 Planning Level			COP 20 Total
	FY2 0			
	GHP-State	GHP- USAID	GAP	
Total New Funding	\$ 164,108,466	\$ -	\$ 1,512,500	\$ 165,620,966
Core Program	\$ 128,108,466	\$ -	\$ 1,512,500	\$ 129,620,966
COP 19 Performance	\$ 30,000,000			\$ 30,000,000
HKID Requirement ++	\$ 6,000,000			\$ 6,000,000

++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia

Care and Treatment: If there is no adjustment to the COP/ROP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.

Orphans and Vulnerable Children (OVC): Countries must program to the full OVC amount from Part 1 of the planning across all funding sources. Your OVC requirement is made up of the HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.

HKID Requirement: OU's COP/ROP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your COP/ROP 2020 HKID requirement is derived based upon the approved COP/ROP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The COP/ROP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): OU's COP/ROP 2020 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total new FY 2020 funding programmed to the GBV cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 GBV earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.

Water: OU's COP/ROP 2020 minimum requirement for the water earmark is reflected in Table

2. Your water earmark requirement is calculated as the total new FY 2020 funding programmed to the water cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 funds for water can be above this amount; however, it cannot fall below it.

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs.

PEPFAR has set a 70% goal **by agency** by the end of FY20 and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services.

Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP/ROP 2019 submission.