

Approved



**Malawi**

**Country Operational Plan**

**FY 2014**

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.



## Operating Unit Overview

### OU Executive Summary

COUNTRY CONTEXT: The Republic of Malawi has a population of over 16 million people in an area of 45,747 square miles. Although the economy has grown considerably over the past five years, Malawi is still one of the poorest countries in the world, ranked 170 out of 187 on the UN Human Development Index. Index Mundi states that GDP growth is estimated at 1.9%, down from approximately 6.5% in 2010 and over 50% of the population lives below the national poverty line (World Bank data).

HIV prevalence has reduced from 14% in 2004 to 10.6% in 2012. The National AIDS Commission (NAC) reports 1.1 million Malawians living with HIV, with an estimated 46,000 HIV-related deaths in 2012, contributing to Malawi's low life expectancy of 54 years. Malawi has one of the highest Total Fertility Rates in the world at 5.7 and the population is expected to treble by 2040. Malawi is well known in the region for its innovations in streamlining 'the public health approach' to service delivery, which has contributed to the remarkable success of Antiretroviral Therapy (ART) scale-up. In 2011, Malawi switched to Option B+, which places all HIV-positive pregnant and breastfeeding women on ART for life regardless of CD4 count or clinical staging. Option B+ has provided a platform to aggressively scale-up ART access under a programmatically-sustainable approach with the number of sites providing ART increasing from just over 350 in 2011 to 675 in 2013. In a four-country analysis of HIV treatment programs, Malawi was found to have one of the lowest costs for Tenofovir-based first line regimen treatment at \$230 per person per year. As of September 2013, 459,261 patients of the 602,000 estimated in need (74%) were reported alive and on ART. In FY13 it is estimated that 66,000 people were newly infected and 103,421 people were newly enrolled on ART, providing a tipping point ratio of less than 1.0 ( $66,000/103,421 = 0.64$ ). While this is a positive metric of progress in the treatment program, there are still many challenges facing Malawi. Tuberculosis (TB) continues to be a challenge and co-morbidity with HIV is high. While there has been a significant increase in TB treatment success rate of 87%, the overall case detection rate remains about 66%. An estimated 770,000 children have lost at least one parent due to AIDS, representing 59% of the children who have lost one or both parents to all causes. The national HIV response is managed by NAC which falls under the Office of the President and Cabinet's (OPC) Department of Nutrition, HIV and AIDS. NAC is the Principal Recipient for the main HIV Global Fund (GF) grant that is the prime funder of all HIV commodities, including antiretrovirals (ARVs). The HIV commodities are channeled to the Ministry of Health's (MoH) public health system, which is a sub-recipient under NAC, although the supply chain is parallel to that of the Essential Health Package (EHP) commodities. Malawi maintains a well-coordinated health donor environment, under the leadership of MoH. USG and other donors coordinate closely on the national HIV response through the HIV/AIDS and the Health Donor Groups. These two donor groups are effective fora to coordinate donor and government inputs, ensure awareness of critical political developments, and address pressing issues.



USG serves as the chairs of both donor groups. USG is one of two development partners (DP) representing the bilateral DPs on the GF Country Coordinating Mechanism (CCM). The PEPFAR Malawi team works very closely with the local UNAIDS office on policy development and implementation. The PEPFAR Malawi team also actively participates in all national health TWGs convened by the GoM. According to the 2013 National AIDS Spending Assessment (NASA), approximately 95% of the national HIV response is funded by donors, and 4.9% and 0.2% is covered by GoM and private sector funds respectively. Approximately 80% of the GoM's overall health program is supported by donors. The austere GoM budget, more than 40% funded by donors, negatively affects the ability of the MoH and other health organizations to plan and implement a complete and comprehensive health program. Increasing the financial ownership of the GoM in order to reduce Malawi's donor dependence in health is an issue of growing importance, but one that will likely take many years to resolve. A UNAIDS financing study estimated that if all possible domestic resources (i.e. special tariffs and taxes) were mobilized, it would cover only 30% of the HIV resource gap. In 2013, the GF approved an HIV interim proposal worth \$114M. The majority of funding from this proposal will be applied to procurement and distribution of ARVs and other commodities necessary for the implementation of the public health program. USG will continue to support non-commodity costs for the implementation and quality improvement of the HIV treatment programme. GF currently contributes 25% of public health sector financing and fully funds drugs needed for both HIV and TB treatment – none of these programs will survive a loss of GF funding and any such loss would fundamentally undermine USG efforts to combat HIV/AIDS in Malawi. In 2014, Malawi will submit a proposal under GF's New Funding Model (NFM) to fund the TB/HIV program beyond 2015.

**USG SUPPORT TO THE NATIONAL RESPONSE:** USG assistance plays a major role in Malawi's progress in health. Including PEPFAR funding, USG provided no less than \$150 million in health assistance to Malawi in 2013. The USG health portfolio is aligned with Malawi's Health Sector Strategic Plan (HSSP) for 2011-2016, through its programs in HIV, TB, maternal and child health (MCH), nutrition, reproductive health, malaria, and health systems strengthening (HSS). The PEPFAR team actively engages in the biannual reviews of the HIV national response coordinated by NAC, as well as Health Sector Reviews led by the MoH. PEPFAR and other USG investments are reported and analyzed as part of the government-led national planning cycle. All USG agencies have developed strong relationships within and across multiple sectors and TWGs, resulting in improved programming. Examples of such integration include collaboration between the MCH-HIV programming, FP-HIV programming, and increased integration with the Education and Sustainable Livelihoods sectors. USG and the GF are the two major HIV donors, and are intricately linked in support of the MoH's HIV programs. USG provides crucial financial and technical support to the MoH's HIV Department, the main implementer of the national HIV response. USG programs could not exist without the ARVs supplied by the GF, and the GF's investment in Malawi would not be effective without the fundamental support provided by USG. PEPFAR is the largest single donor supporting the scale up of Voluntary Medical Male Circumcision (VMMC)



services, and is the primary funder of other critical prevention and care services including community systems strengthening, peer counseling, support groups, and home-based care. To support the national expansion of the provision of HTC, ART, Prevention of Mother to Child Transmission (PMTCT) and VMMC, the USG ensures quality, equity, linkages and integration of services across all levels of care through innovative service co-location models and referral systems. The USG supports pre-service and in-service training and strengthens health care worker (HCW) regulation. The USG is strengthening health information systems, building MoH capacity for SCM and will expand pharmaceutical warehousing at facility level to improve commodity management. The USG provides assistance to MoH to develop and implement Malawi's first health financing strategy, and supports institutionalization of the National Health Accounts to ensure availability of fiscal data for decision making. The USG strengthens the leadership and management skills of senior and mid-level MoH managers to analyze and utilize program data and encourage evidence-based programming; strengthens financial management at national and district level; provides coaching and mentoring for program directors; builds the organizational and technical capacity of CSOs; and reviews and monitors key policies to reduce bottlenecks to service delivery. Malawian civil society is still generally nascent with limited capacity to implement health programs at scale, or to sustain itself through resource mobilization and effective program management. USG will fund an integrated capacity development activity for CSOs, including HIV network organizations, HIV service delivery organizations, and advocacy organizations at all levels. Leveraging multiple USG funding streams both within and beyond health, the activity will provide CSOs with organizational and technical capacity building in addition to grants to implement HIV activities. USG will support local Community Based Organizations (CBOs) through prime partners to implement a wide range of community level interventions for HIV prevention and treatment as well as condom and family planning (FP) commodities distribution, establishment of community referral systems and implementation of HIV impact mitigation interventions. During the COP planning process, USG has engaged with CSOs and faith based organizations to share information and discuss expanded collaboration opportunities as part of the country ownership dialogue. USG Malawi has five major areas of focus: 1) Continue scale-up of Option B+ along with integration of services as part of a standard comprehensive package. The focus will be on the quality of HIV care and treatment services program services with improved retention and adherence, and standardizing linkages with FP and MCH, 2) Accelerate momentum of the VMMC program, 3) Address the health worker shortage, strengthen laboratory services, undertake infrastructure upgrades, and improve management of supply chains and the security of HIV commodities, 4) Strengthen intentional integration of the community based care and support platform with the facility based care and treatment platform, and expand FP-HIV prevention, care, and treatment programming for adolescents through public and private sector approaches, and 5) As a follow on to the successful Partnership Framework (PF), work with the GoM, CSOs, UNAIDS and the GF to establish a new framework and sustainability plan for collaboration and shared responsibility.

**PROGRESS AND FUTURE:** USG developed a GHI strategy for Malawi in 2011 that prioritizes



investments in three key areas of HSS: 1) Human Resources for Health (HRH), 2) Leadership, governance, management and accountability, and 3) Infrastructure. USG has leveraged its resources with other programs to operationalize the GHI strategy. USG will continue to support and embolden HRH, strengthen capacity and improve infrastructure that support the full array of USG health programming. Through leveraging of PEPFAR funding with non-HIV health funding, PEPFAR will continue to implement integrated health service delivery that enables a strong response to the epidemic while also addressing other systemic priorities beyond HIV.

USG integrates HIV and non-HIV services to reduce new HIV infections as well as reducing maternal and child morbidity and mortality. This is one of USG Malawi's smart investments and these achievements correspond directly with the goals of the GHI strategy. Infrastructure is a critical bottleneck to health service delivery. Scale-up of programs is not possible without a focus on infrastructure support that will address security and management of commodities, adequate space for laboratory testing, improved patient flow in health facilities, and the privacy needs of women and youth through family friendly facilities. As infrastructure development is expensive, USG will seek to leverage multiple funding streams, as well as non-traditional or private health partners, to focus on sustainable and fundamental improvements such as provision of electricity and water.

COUNTRY OWNERSHIP (CO): Malawi has made progress in expanding both the scale and quality of its national response to HIV/AIDS, maximizing GF, PEPFAR, and other donor investments to improve health and bolster the health system in the near-term while making long-term systems strengthening investments. These successes are due to the MoH coordinated health sector and a willingness to use scientific evidence to introduce and evaluate innovative new policies and service delivery programs. USG has a very strong relationship and trusted partnership with the GoM, and remains committed to GoM continuing its progress. The USG has aligned its programming to address Malawi's health and development goals in an integrated manner through participation in the design of the 2011-2016 HSSP. HRH challenges constrain progress in ownership (planning, programming, and implementation). MoH leadership is dependent on a small cadre of key senior managers and program managers who are pulled in too many directions, over-burdened with both on-going work and new initiatives, both internal and external. Below this level, the country is suffering from what a previous Secretary for Health called an "80% vacancy rate" in health facilities. Many central level MoH program managers are seconded from tertiary care facilities. While there is no disagreement among the USG team that building leadership capacity should be a priority, the health sector is truly saturated with countless initiatives, including many leadership capacity initiatives and GF demands. Proposing new management structures when the older structures are still weak is not a prudent approach. Malawi was the first PEPFAR country to sign a PF in 2009. The Malawi PF has been a useful guide and reference in the achievement of the primary purpose to fully align the PEPFAR program with GoM national health and HIV strategic plans. This has been successful as there is one national response and no parallel PEPFAR programs, activities, or facilities. The PF expired at the end of 2013, but the principles of collaboration enshrined in it continue on. The



PEPFAR team recognizes the need to develop an agreement with the GoM in follow-up to the PF. USG will work with all stakeholders to establish a plan to critically analyze the commitments and shared responsibility of the various governmental and non-state HIV actors. While there are structures in place that could allow the GoM to meet some of the four dimensions of CO as outlined in the PEPFAR Sustainability Guidance, there are contributing factors this year that affect this achievement in the health sector. The economic and political situation does not lend itself to a robust CO initiative at this time. The concepts of political ownership and stewardship with a maturing partnership between GoM and PEPFAR will be potentially influenced by the tripartite elections in May 2014, which could see a new government in place and drastic changes in leadership, and perhaps policy, at all levels. Developing a full Country Health Partnership (CHP) in FY 2014 is neither strategic nor viable in the immediate term and will need to evolve and grow over time out of an in-country process and a more basic Sustainability Plan under COP14. The additional management and oversight structure proposed under a CHP, when added to the dozens of health sector structures already in place, would likely have a paradoxical effect, causing distraction within the context of limited capacity and competing priorities. The Malawi CCM is not an effective body, lacking leadership and strong GoM political support. The CCM needs to reduce its current and numerous conflict of interest opportunities and it requires structural changes to have more effective oversight capacity over the grants, proposal development and a transparent PR selection process. Improving the management capacity of the CCM is a USG priority, and this is particularly important as Malawi prepares NFM concept notes. The creation of any other governing body at the same time as this transition would not be prudent, may send the wrong message on CO, interfere with other high priority efforts, or damage USG credibility with GoM and other partners. Consistent with accepted international norms for aid effectiveness as well as donor coordination expectations in Malawi, establishing a new structure based on a single disease and single donor should be avoided. Corruption negatively affects the running of the GoM. In September 2013, a situation (known as "Cashgate") developed, exposing government officials who stole millions of dollars from GoM accounts through fraudulent transactions exploiting loopholes in the GoM's electronic payments system. The revelations of theft led international financial institutions and many of the bilateral budget support donors to suspend assistance to the GoM. While the health sector was broadly protected by the GoM and donors providing project support, the impact of the suspension of assistance has been felt across the country, especially in the delivery of social services. The GoM's response to Cashgate thus far has been seen as positive by donors, and in January the IMF agreed to disburse \$20 million under its extended credit facility. The true impact and fallout of Cashgate will be clearer after the elections and the donor's response. Technical collaboration with MoH directors and staff are strong and productive. The NASA was released in February 2014, and the UNAIDS Investment Case is due to be finalized in April. The work already done on the Investment Case confirms that PEPFAR's support for FP-HIV integration is sound, as modeling indicates no decrease in the total cost of the HIV response is possible in Malawi, despite very optimistic assumptions of coverage of key HIV interventions, before 2050 without significantly reducing the high fertility rate or



ART costs. The GF will announce its NFM allocation for Malawi and the PEPFAR-Gates collaboration on a Strategic Information (SI) project will begin its year-long planning phase in March 2014. USG participated in an Expenditure Analysis Exercise at the end of 2013 and received the cost analysis report in early February 2014. During the upcoming months, USG will use the results in conjunction with other financial and program tools to inform resource allocation to programs and implementing partners (IPs), promote accountability and assist planners at all levels to improve efficiency in service delivery and support. USG was also notified in February that Malawi was selected by the S/GAC to be a pilot country for DHIS 2 (District Health Information System) for the 2014 APR cycle for both expenditure and indicator data capture. Malawi has also been selected by S/GAC as a pilot country for a joint data collection/analysis process, which would seek to capture congruent full HIV data spent by all sources—PEPFAR, GF, GoM and other donors—and feed into national planning discussions. These are all critical pieces to the Sustainability Plan process that will gain traction following the May elections.

#### PROGRAM REVIEW

**TREATMENT:** In July 2011 Malawi implemented revised integrated HIV guidelines following the WHO recommendations for ART and PMTCT. Malawi pioneered Option B+ and this provided a platform to aggressively scale-up ART access in HIV+ pregnant and breastfeeding women, making significant strides towards elimination of MTCT and the attainment of the tipping point ratio. A PEPFAR HIV Testing and Counselling (HTC) TDY in 2012 identified several critical areas of protocol drift which were likely reducing the sensitivity of rapid HIV tests. COP13 HTC programming began addressing these weaknesses and emphasis was placed on improving the quality of testing by strengthening the competency of HTC counsellors and improving the security of the HIV test kit supply chain. USG will continue this support as well as complement treatment interventions with a focus on pediatrics. Technical assistance will be provided to strengthen M&E systems for exposed infants' follow up and quarterly analysis of birth cohorts as well as pediatric ART cohort outcome survival analysis. One major goal of the national HIV program is to increase access to a continuum of quality HIV treatment. Since the introduction in 2011 of integrated HIV guidelines, the number of ART sites has more than doubled from just over 300 in June 2010 to 675 by the end of September 2013. USG is aligned with the national HIV strategic plan priorities and IPs support ART service delivery in all 28 districts, prioritizing sites with high patient volumes where HIV services are provided for children, adolescents and adults through an integrated service delivery model. As of September 2013, 73% of patients were transitioned from the Stavudine-based adult first line regimen to Tenofovir-based regimen with PEPFAR technical and financial support. USG provides support to the National TB Control Program (NTP) to strengthen NTP's capacity to implement, supervise and monitor a comprehensive TB program. USG supported the NTP to update and implement strategic plans, develop job aids, and improve M&E systems. The scale up of TB diagnostic and treatment sites has lagged behind the number of ART clinics which limits the possibility of service delivery integration and operationalizing a "one stop shop" model for TB-HIV. USG will continue to fund renovations prioritizing high volume sites including the identification of cough corners to reduce transmission risk. Operational



guidance to fast track TB suspects, improve TB screening and linkages to diagnosis and treatment will be provided by partners. USG will work with the MoH and stakeholders to improve the quality of TB screening and ensure that WHO's screening tool is optimally utilized. PEPFAR will undertake routine review of partner activities aimed at strengthening HIV service delivery quality. These include Quality Assurance activities for HIV diagnostics (HTC and GeneXpert). Support for the national pharmacovigilance system development will increase in COP14. Other interventions include collaboration with the Pharmacy, Medicines and Poisons Board to track adverse events and preparatory activities to support a national birth defects surveillance system. USG will continue to support implementation of Provider Initiated Testing and Counselling (PITC) among those who are suspected of having TB. Family members and contacts of TB patients will be offered HTC and linked to follow-up services as necessary. USG IPs will pilot and replicate models for linkage and retention, with a focus on PITC clients, Option B+ and Early Infant Diagnosis (EID) to inform the national HIV program operational guidance and policies. At facility level, USG will continue to build capacity of health workers and facility managers to continually address infection control gaps, and fund minor renovations of selected sites to facilitate infection control. USG will continue support for a pediatric HIV program evaluation. Malawi has set a target to achieve 83% ART coverage among eligible children by 2015. USG's key priorities include continued assistance for the implementation of revised national HIV clinical guidelines to increase ART coverage, including support to trainings on the new guidelines and clinical mentoring of service providers. USG will strengthen the linkages between PMTCT and Orphans and Vulnerable Children (OVC) and care programs to HIV services through interventions both at the facility and community levels. USG IPs will integrate Nutritional Assessment, Counseling and Support (NACS) interventions as part of their mentoring and broader support. Health systems challenges are addressed by scaling up the coverage of sample transportation systems and improving operational guidance to reduce the long turn-around time for DNA-PCR results. In COP14 continuous quality improvement (CQI) activities will be scaled up. USG support for clinical mentoring will improve the confidence and competence of service providers to clinically manage pediatric HIV including providing age-appropriate counseling.

**PREVENTION:** USG's Prevention Portfolio aligns with GoM priorities to reduce new infections through a combination of biomedical, behavioral and structural interventions. USG will expand access to high impact biomedical interventions for priority populations, with an emphasis on strengthening quality HTC, linking HIV-positives to ART, ensuring HIV-negative men are referred to VMMC, and screening for and referring to FP and STI services.

With 66,000 new infections each year, prevention is a national priority. The 2013 Modes of Transmission (MOT) study modeled distribution of new infections by specific populations, stating the majority of new infections will occur through heterosexual sex within discordant, married or co-habiting sexual relationships and among partners of people who have multiple and concurrent sexual partnerships (MCP). Key drivers of the epidemic include MCP and low or inconsistent condom use. Studies show that MCP is generally accepted and less than 50% of adults have accurate comprehensive knowledge about



HIV prevention. Provision of comprehensive HIV clinical and preventive services designed for Key Populations (KP) will be addressed. HIV prevalence is 15-21% in men who have sex with men and 71% in Sex Workers. Other priority groups for sexual prevention include adolescents, prisoners and people with STIs. Tailored clinical and behavioral interventions will be developed to meet the unique needs of all these priority populations. USG will target KP in four initial districts with high density and high risk concentrations. Deliberate efforts will be made to expand KP access to stigma-free health services through provider training.

Because of the large population and increased vulnerability to HIV, STIs, and unintended pregnancy, adolescents (15-24), particularly girls and young women are a new priority. The primary intervention will be expansion of youth friendly health services (YFHS) with development of a youth-specific communications strategy, and expansion of teen clubs for older children and adolescents living with HIV. USG will leverage FP and education resources to offer a robust approach to addressing adolescent health and providing appropriate services. USG will renew emphasis on reaching adolescent girls with comprehensive prevention interventions that will seek to delay early marriage, reduce unwanted pregnancies, and reduce risk of HIV acquisition. Peace Corps Volunteers will continue to focus on key prevention efforts through the use of HOPE Kits, Go Girls!, and Grassroots Soccer methodologies aimed at adolescent girls. High HIV, TB and STI prevalence among prisoners is perpetuated by coercive and voluntary same-sex activity and substandard living conditions. USG will increase HIV service support to all 12 prisons in Malawi. The prevention package includes HTC, STI screening and treatment, access to pre-ART services and ART and TB screening and treatment. Technical assistance will be provided at the national level to adopt national policies, guidelines and standard operating procedures to support HIV-TB service delivery, and ensuring that the needs of patients are addressed. Assistance will be provided to prison health officials to implement HIV-TB care interventions in prison settings, including age and gender appropriate interventions. Condom availability in prisons is being negotiated at the National Prisons TWG level. USG priorities in HTC will improve case finding by increasing PITC in health facilities, scaling-up home-based testing for family members of ART and pre-ART patients, and targeted HTC for priority populations. EID and pediatric HTC have improved in recent years, but systemic barriers remain, including HR and sample transportation. USG will support healthcare training, specimen transportation, laboratory information management systems (LMIS) and SMS technology to increase uptake of EID and reduce the turn-around time of the results and appropriate care interventions. IPs will support Option B+ retention through improved health education in MCH, expansion of patient tracing, and clinical mentoring to ensure quality of HIV care and treatment services. USG will also leverage FP, mass media and community prevention and care platforms to support service utilization through community mobilization, referrals, and tailored Positive Health Dignity and Prevention (PHDP) interventions. USG will sustain the scale up of MC services in priority districts identified in the National VMMC Strategic Plan. IPs in each targeted district will collaborate with Christian Health Association of Malawi (CHAM) and MoH, creating demand and providing services in static and outreach sites, utilizing efficient high-volume service-delivery



models and campaigns. District coordination will be through the District Health Offices to minimize duplication. Severe HRH constraints limit rapid scale-up of VMMC and partners need to explore innovative HR solutions with GoM to ensure VMMC is not delivered at the expense of other key services. Malawi has adopted task-shifting of VMMC to registered nurses, and task-sharing through implementation of the MOVE model. USG will support additional operations research to identify efficiencies to be gained, as well as an assessment of the feasibility and acceptability of Early Infant Male Circumcision. USG will work closely with GoM to advocate for a total market approach to condom programming, and support coordination of condom logistics and multi-sectoral promotion. Access and acceptability of male and female condoms will be expanded through continued condom social marketing and expansion of outlets to ensure adequate condom availability in communities, facilities, hotspots, and targeted condom and lubricant availability for KP. By leveraging FP funds, new approaches will be introduced to meet the needs of women and girls, including introduction of an improved female condom. Linkages between community-wide structures, OVC committees and PLHIV support groups will ensure group members have access to community-based male and female condom distribution, and receive tailored positive prevention messages. The Malawi Blood Transfusion Services (MBTS) currently meets 73% of the national need, though its quality system is not fully implemented. USG will support expansion of MBTS operations to meet 80% of the need for safe and quality-assured blood products. M&E will be strengthened with procurement and installation of new blood safety software and a manual system for all transfusing hospitals. Technical assistance will support development of a comprehensive quality system extended to cover all 87 blood banks. With the expiration of the National Prevention Strategy in 2014, USG is providing technical assistance to NAC to develop a revised plan which outlines annual milestones for biomedical, behavioral and structural prevention.

**CARE AND OVC:** USG Care and Support activities are well aligned with priorities of the GoM as identified in the National HIV Strategic Plan, which identifies three expected outcomes: reduced HIV infection and transmission rates; improved dietary practices of PLHIV, OVC, and affected individuals and households; and, improved quality of life for PLHIV, OVC and affected households. The most essential services in the continuum of HIV care are integrated with treatment and PMTCT in one cohesive, family-centered and patient-focused model known as the HIV Care Clinic (HCC). Key elements of a standardized PHDP package are in the HCC and include STI management, condoms, and FP. USG supports limited provision of specialized services like cervical cancer screening, water and sanitation related activities and palliative care. At the community level, USG supports use of innovative approaches, such as expert clients, to improve patient retention, and PLHIV community groups further augment facility treatment and care. Support groups link PLHIV to services, information and to economic strengthening activities like Village Savings and Loans (VSLs) and implement components of the PHDP. Health promoters train care group volunteers on hygiene and sanitation, breastfeeding, complementary feeding, maternal health and nutrition. USG will strengthen linkages between the community care and facility-based care and treatment platforms; monitoring of PLHIV retention in care; scale-up of TB case



finding; integration of FP/HIV services; and coverage of ART for TB/HIV co-infected patients. Malawi has adopted the universal test-and-treat approach for HIV+ children under five years. Through clinical supervision and mentorship, USG will support MoH in the implementation of the new treatment eligibility criteria. USG IPs will intensify active case finding through PITC in pediatric in-patient wards, Nutrition Rehabilitation Units and under-five clinics. Expert clients and other lay workers will link HIV-infected children with care and treatment services. USG IPs will integrate NACS services in pre-ART and ART clinics. In FY 2013 there was a 31.7% increase in the number of eligible adults and children receiving a minimum of one care service. Care services include community led complementary feeding and learning sessions, household economic strengthening, secondary school support, early childhood development (ECD), child protection, birth registration and Community Integrated Management of Childhood Illnesses (C-IMCI). OVC programming will include child focused family-centered interventions to ensure provision of care services and improve linkages between the community-based care and facility-based treatment. USG will build one community platform that will provide care group and support services for vulnerable children and their families. USG will build upon the existing platforms of service delivery in the core dimensions of services for OVC: protection, education including ECD, health, nutrition, psychosocial support and capacity building. USG will further bolster support for ECD through Community Based Child Care Centers, parenting groups and community based educational “drop in” centers that have provided educational support and counselling to over 60,000 in- and out-of-school youth. Scholarships have enabled 2,634 children to attend secondary schools. To improve efficiencies, USG will now provide school block grants instead of individual bursary support. USG will address adolescents’ barriers to social and health services. Access to life skills, FP and sexual/reproductive health information and services will be improved while addressing gender norms and improving self-efficacy. USG will strive to ensure children and teens that are HIV-negative remain negative and facilitate linking HIV+ children and adolescents to care and follow up support services. USG is supporting the Ministry of Gender, Children and Social Welfare (MoGCSW) to develop two major health systems components: a social welfare degree course, and a human resource information system that will improve the planning, recruitment and deployment of the social welfare workforce. USG will continue to work with UNICEF on strengthening the child protection system and will expand the PEPFAR Small Grants fund to support more CBOs working with people with disabilities and their families.

**GOVERNANCE & SYSTEMS:** The USG Malawi portfolio complements support for health service delivery with crosscutting HSS activities for long term sustainability. Critical shortages of personnel across all professional cadres undermine the ability of MoH to manage a complex HIV/AIDS program and any scale-up of the program requires a bolstering of the HR capacity. MoH identifies HRH as the most critical component of the health system in Malawi. Current HCW staffing levels in MoH do not meet the minimum WHO requirements to support the health system. USG investments in capacity building are largely focused on front-line HIV service providers through pre- and in-service activities. USG will support strategic deployment and bonding of graduates who received bursaries. USG will increase



pre-service training support through provision of bursaries for 1,266 new students across a variety of cadres over five years. USG will identify two CHAM schools to receive a holistic package of support to increase student in-takes including renovation of training school infrastructure. The decentralization of the health sector remains incomplete. Local Councils are mandated to manage the health budget at district level but do not fully manage HCWs or other health policies, hindering the delivery of services at district level. District Health Management Teams will receive training in financial management conducted jointly with Local Council staff to increase ownership of the health budget at district levels. USG will provide support to teams to mobilize non-governmental partners for joint District Implementation Planning to improve resource leveraging and coordination. USG will also continue to support MoH to strengthen supervision of health services including thorough scale-up of mobile technology based integrated supportive supervision systems. USG IPs will continue to strengthen referral, feedback and patient tracking systems to improve the facilitation of patient access to a continuum of HIV services in clinics and communities and reduce loss to follow-up by using care group models such as mother infant pairs to facilitate EID, referrals and adherence. USG will continue to work with the GoM to link PLHIV to impact mitigation interventions such as economic strengthening, agriculture and food security. USG will bring effective programs to the rural communities where Peace Corps Volunteers serve and seek opportunities for the integration of programs with the President's Malaria Initiative. The availability of state-of-the-art lab services at all levels of care is critical to the diagnosis, treatment and surveillance of HIV. With the scale-up of pre-ART and ART, PMTCT, HTC, TB/HIV and malaria services, the demand for lab services has increased in scope and complexity. The National Lab Strategic plan is in its final year of implementation and USG is working with MoH to develop a new strategic plan. USG will continue to prioritize laboratory workforce training and improve Quality Management Systems through strengthening laboratory management through accreditation processes. USG will maintain its focus on strengthening laboratory infrastructure in Malawi to support scale-up of ART and care programs. To improve availability of services for EID, viral load, GeneXpert and CD4, USG will support expansion of the sample transportation network to all districts in Malawi. Supply chain management (SCM) of public health commodities is a critical component in need of systems strengthening. Several disease-specific parallel supply chains operate outside of Central Medical Stores Trust (CMST), due in part to weaknesses at CMST and increased volume of commodity procurements. One of the overarching GoM supply chain priorities for SCM is to strengthen CMST and consolidate parallel supply chains into nationally-operated systems. USG will support the implementation of the joint strategy for supply chain integration once the priority gaps are identified and agreed upon by CMST and stakeholders. USG will also strengthen the GoM capacity to manage HIV and other health program supply chains, through improved human resources for SCM, increased availability of quality supply chain data for decision making, secondment of experts to critical GoM departments and increased storage capacity at service delivery points. Over 75% of public health facilities in Malawi lack adequate storage space for health commodities in appropriate and secured conditions. This is a major threat to program implementation, considering the risk to product



quality and security. USG, in collaboration with stakeholders, will support the expansion of storage capacity for ARVs and other health commodities at selected health facilities, taking into consideration best practices from other PEPFAR countries.

SI: USG is committed to a unified M&E reporting system to measure national success as well as measuring PEPFAR's contribution toward national goals. USG provides technical and financial support to the Health Management Information Systems, national electronic medical record systems, vital registration, and surveys, surveillance, and M&E activities at the national and district levels. USG adopted the new S/GAC Monitoring, Evaluation and Reporting (MER) guidance during COP14 and it is being implemented by all USG agencies and IPs. USG provides financial and technical support with the aim of ensuring quality SI activities while also building long term capacity within the MoH. USG is supporting several HIV surveillance activities, including Incidence Surveillance, Behavioral Surveillance Survey including population size estimation of female SW, Service Provision Assessment, Mother-to-Child Transmission evaluation, HIV drug resistance monitoring in adults and pediatric patients. USG will fund the evaluation of the pediatric program, a Demographic Health Survey (DHS) and a birth defects surveillance system. An AIDS Indicator Survey (AIS) will be supported in collaboration with relevant stakeholders as a means of monitoring and evaluating the impact of the national program response on the epidemic. In Malawi, information is collected through USG-funded routine quarterly HIV program monitoring and specialized HIV surveillance and surveys yet sufficient data are still lacking on the population-level outcomes and impacts of HIV programs. Implementation of AIS will answer questions that cannot be answered using the current surveys such as HIV prevalence, HIV incidence, CD4 cell counts, viral load, and known HIV status. USG leads in strengthening the national health information systems (HIS) framework. Priority areas are developing HIS policies and sustaining TWGs responsible for advancing data standards, e-health, IT architecture and national scale up of DHIS 2.0. Sample vital registration with verbal autopsy (SAVVY) methods will be used to estimate the level and extent of cause of death and also create a baseline measure of the impact of scaled-up initiatives that aim to reduce mortality and acts as an interim step to a civil registration system. Findings from SAVVY and demonstration evaluations will be used to inform national registration and vital statistics policy.

CHALLENGES: Malawi's HIV response cannot survive a failed GF NFM application. USG's engagement is comprehensive and intensive on corruption, governance, health sector management and GF mechanisms. The strength of Malawi's economy, governance structures and capacity, CSOs, HRH workforce and health systems are much weaker than in most other countries in the region. The continued need to rapidly scale up PMTCT/ART and VMMC programs, while maintaining quality across all health services, has in the past two years collided with this reality. Lack of adequate space for drugs, testing and patients, lack of healthcare workers, and rapid population growth combined with almost 500,000 patients currently on treatment, translate into a relentlessly strained health system. While the GoM is leading Malawi's HIV response, it is at, or beyond, capacity already. Any new or additional mechanisms to further expect GoM leadership will likely be met with efficacy losses elsewhere. PEPFAR

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is increasingly challenged to address these issues. Building civil institutions and health systems is a multi-year process, and while the value of such investment may be self-evident, it may not be immediately and quantitatively tied to service delivery targets. Because of this, USG Malawi is challenged to ascribe value for money within the existing reporting framework, using primarily service delivery indicators on an annual basis for multi-year health systems interventions. In this context and with the prevailing global economic situation, USG is extremely appreciative of the additional \$10 million to PEPFAR's base funding and the opportunity it provides to respond better to GoM priorities by tackling strained structural components of the Malawi health system. USG is also grateful for the opportunity to apply for one time VMMC, OVC, as well as PMTCT/ART integration funding, which are essential to reaching our goals. Success will depend on the ability of the USG to recruit staff into our currently-approved positions to handle our growing portfolio. USG will then be better positioned to accelerate progress in addressing today's HIV service delivery needs and tomorrow's health system for a more sustained and aggressive response to the epidemic.