United States Department of State

Washington, D.C. 20520

FY 2015 Malawi Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Malawi.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

Malawi Country Operational Plan (COP) 2015
Strategic Direction Summary

Revised 28 August 2015

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Goal Statement

In order to reduce the burden of the HIV epidemic by preventing transmission and achieving the UN's 90-90-90 goals, PEPFAR Malawi will saturate in high burden districts and will support epidemic control in Malawi by ensuring 80% ART coverage for PLHIV in 14 Scale Up districts by 2017. In the remaining 14 Sustained districts, PEPFAR will support the national HIV Strategic Plan's goal to increase epidemic control and accelerate progress towards attainment of the national 90-90-90 objectives by 2020. In COP 15, PEPFAR will maintain COP14's pivot to focus on 305 Saturation Sites in the Scale Up districts and provide a standardized package of interventions across implementing partners, and implement site-level quality improvement approaches.

Achievement of this goal will entail significant scale up of routine testing in health facilities and targeted HIV testing for key populations, optimizing the continuum of care and treatment to increase retention and improve HIV outcomes, and scaling up viral load monitoring. Targeted interventions for priority populations will facilitate identification of unknown HIV positive individuals within targeted communities, increase access to condoms and comprehensive HIV prevention programming, linkage to HIV services, and impact mitigation programs.

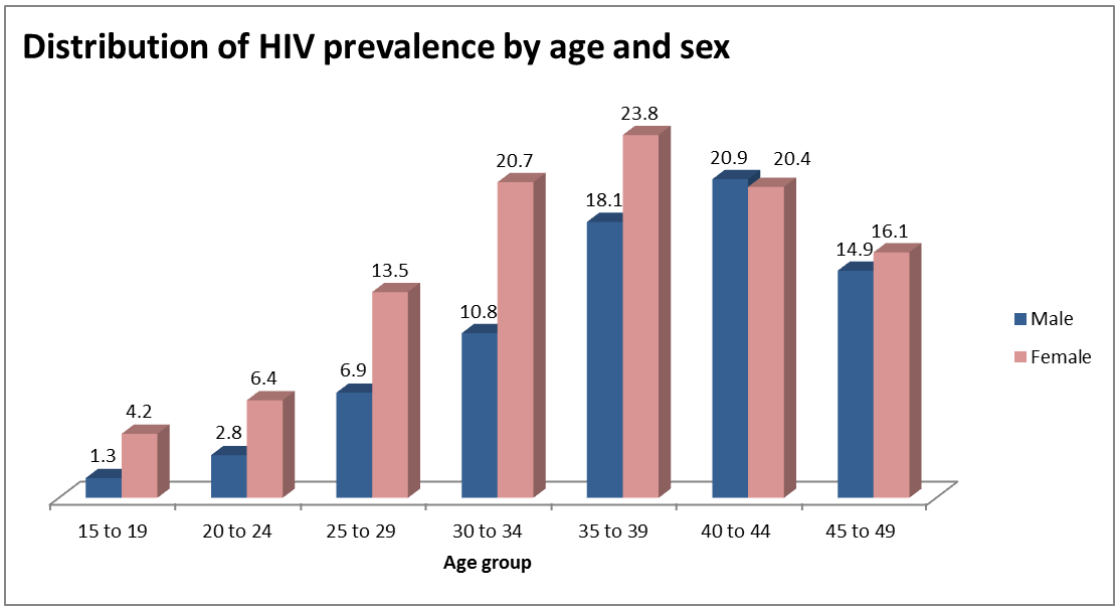
The PEPFAR team used expenditure analysis (EA) data to calculate the site-level costs necessary to implement a standard package of interventions that was jointly developed with the MoH. Quarterly site level data collected by MoH will be used by partners to measure progress towards coverage, identify program areas and providers in need of clinical mentoring, and develop quality improvement interventions where needed.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

HIV prevalence among adults (15–49) increased sharply in Malawi in the 1990s, peaking at 16.4% in 1999 and declining to 10.6% by 2010.[1] According to DHS 2010, HIV prevalence is highest in the densely populated Southern region (14.5%), followed by the Central region (7.6%) and Northern region (6.6). Despite these regional disparities, HIV 'hot spots' are found across all districts, primarily along major transportation routes, and in areas where large agricultural or business interests exist. Rumphi district for example has estimated 6.7% HIV prevalence, but Lura health centre in the same district has prevalence of 16.2% in ANC. Another high prevalence health facility is St Johns Mission Hospital in Mzimba district, which has 15.1% prevalence although the district prevalence is relatively low at 5.1%. HIV prevalence varies considerably by gender, age, socio-economic characteristics, and geographic location. Based on 2010 MDHS data, HIV prevalence in the 15-49 age group is higher among women (13%) than men (9%); 58% of PLHIV are female. Figure 1.1.1 below shows age and sex distribution of HIV prevalence.

Figure 1.1.1 Distribution of HIV prevalence by age and sex

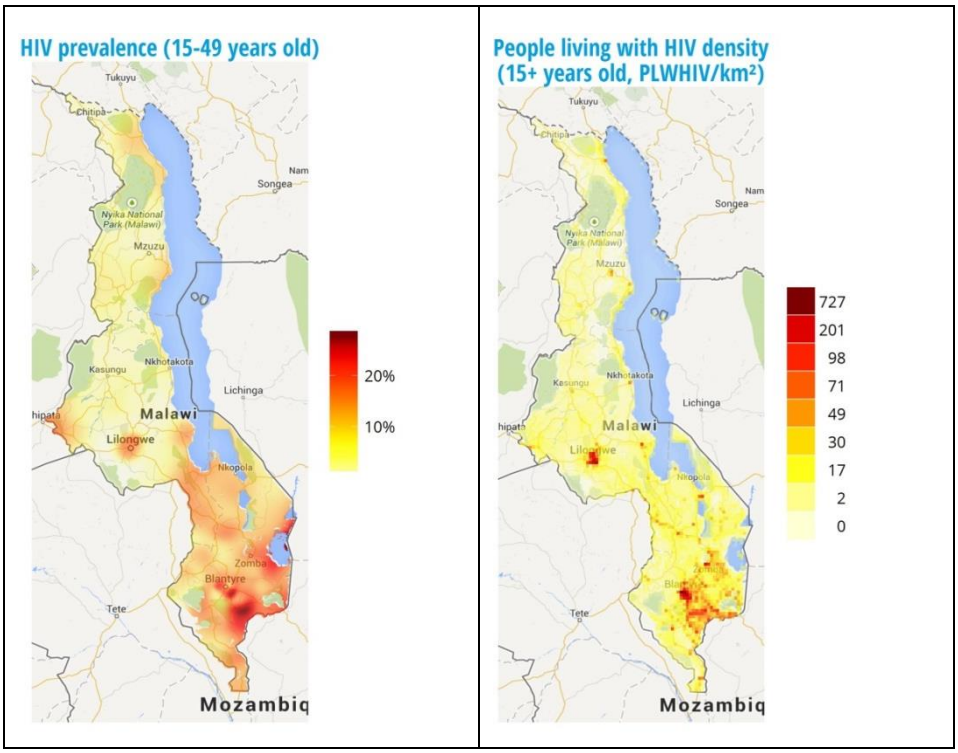


Source: MDHS 2010

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

The maps in Figure 1.1.2 below show the geographic distribution of HIV throughout the country, which broadly aligns with the population density. This translates into a considerable concentration of PLHIV in the south and in a few urban and market centres in the north and central regions. In 2013, over 50% of the estimated 1 million PLHIV were living in six of Malawi's 28 districts, which account together for 42% of the country's population (all six are in the south), while 82% of PLHIV are in 14 of the 28 districts. Urban/rural differences in HIV prevalence are more pronounced in the northern and central regions than in the Southern region.

Figure 1.1.2 HIV Prevalence and PLHIV Population Density



Although there has been an observable decline in HIV prevalence, the absolute number infected with HIV has remained stable at 1.1 million because of the rapid population growth combined with stable incidence.

The stable HIV population size is also a result of the decline in AIDS deaths due to rapid ART scale up over the last decade. By June 2014, half of all PLHIV were on ART.[2] Between 2010 and 2014 alone, the number of patients on ART doubled from 251,000 to 505,123[3]. This rapid increase was in large part due to the integration of the ART and PMTCT program for Malawi's Option B+ policy in 2011, an effort which

2 Integrated Quarterly HIV Program Report April-June 2014 (MoH).

3 Integrated Quarterly HIV Program Report April-June 2014 (MoH).

required massive decentralization of ART/PMTCT services. ART coverage in HIV positive pregnant and breastfeeding women increased from around 30% in 2010 to 75% in 2013. The number of children infected through MTCT (including during the breast feeding period) has declined by 66% (from 30,000 in 2010 to 10,000 in 2014).

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

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	16,084,486	100%	3,721,665	23.2%	3,735,187	23.2%	4,466,526	27.8%	4,161,108	25.9%	MoH Projections, 2014
Prevalence (%)		10.6%		1.8%		1.7%		12.9%		8.7%	MoH, 2014
AIDS Deaths (per year)	67,000		NA		NA		NA		NA		UNAIDS, 2013
PLHIV	1,067,896		67,086		62,966		576,218		361,626		MoH Projections, 2014
Incidence Rate (2014)		0.48		NA		NA		NA		NA	NAC 2014
New Infections (2013)	34,000										UNAIDS, 2013
Annual births	651,700	4.1%									UNICEF, 2013
% >= 1 ANC visit	43,866	95%	NA	NA			NA	NA			UNAIDS, 2013; UNICEF, 2013
Pregnant women needing ARVs	11,825	20.4%									UNAIDS, 2013
Orphans and Vulnerable Children	1,438,564	9%	NA		NA		NA		NA		DHS 2010 projection for 2015 for OVC
TB cases (Yr.)	17,779		NA		NA		NA		NA		WHO, 2013
TB/HIV Co-infection	9,998	56%	NA	NA	NA	NA	NA	NA	NA	NA	WHO, 2013
Males Circumcised	150	6%			60,000	40%			90,000	60%	PEPFAR Malawi projections
Males uncircumcised (10-34Yrs)	2,458,727	60%			901,824	37%			1,556,903	63%	DMPPT2.0 Modeling data 2014
Total MSM	38,734	1.84%									Wirtz et al. (2014) Final Report: HIV Prevalence and Socio Economic Characteristics among MSM across seven sites in Malawi

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		<15				15+				*Source, Year*
			Female		Male		Female		Male		
MSM HIV Prevalence	6,700	17.3%									Wirtz (2014) IBID.
Total FSW	55,000	1.5%									GFCN, 2014
FSW HIV Prevalence		62.69%									IBBS 2015 for prev Size estimate GFCN 1.5% total pop 15-49*
Total PWID	NA	NA									
PWID HIV Prevalence	NA	NA									
Priority Populations											
AGYW (15-24)	1,610,902										Projected from Census 2008
AGYW Prev. (15-24)		4.2% (15-19) 6.4% (20-24)									UNAIDS 2014, DHS 2010: prev in AGYW was 5% and in all 15-49 was 11%
Female Estate Workers	NA	NA									
Female Estate Workers Prev.		22.73 %									
Male estate workers Prev		15.26 %									
Prisoners	12,000										GF-CN
Prisoner Prev.	3,642	19.7-41% (30.35 %)									*Prisons Study, 2012*
Police	14,717	100%					2,765	19%	11,952	81%	*NAC, unpublished data*

* N.B. Data on FSW does not include sex workers under the age of 18 as they are considered exploited minors

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

				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	16,084,486	10.6%	1,067,896	691,738	519,311	91,814**	85%****	1,804,627	150,231	107,788
Population less than 15 years	7,456,852	1.7%	130,052	142,540	80,433	8,217	85%****	152,825	12,722	11,104
Pregnant Women	613,409	9.5%	58000	36,989	36,989	22,507***	85%****	603,193	39,980	26,751
MSM	38,734	17.3%	6,701	NA	NA	NA	NA	NA	NA	NA
FSW	55,000	62.7%	34,485	NA	NA	NA	NA	NA	NA	NA
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

*MDHS 2010

**This is out of new initiations per year and not out of current on ART

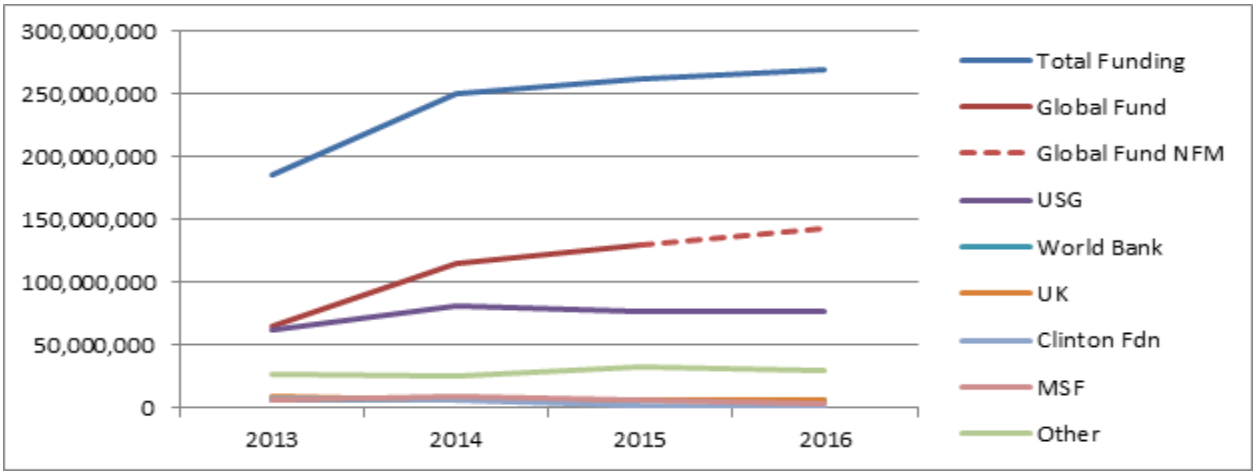
***Includes pregnant and lactating women

**** MoH Program data indicates that 85% of patients who received viral load test reached viral suppression. Age disaggregated data is not readily available

1.2 Investment Profile

With Malawi government and donor commitments, Malawi's HIV program has logged tremendous achievements. The majority of funding in recent years has come from the Global Fund and the US Government, and this trend is projected to continue through the near future. Figure 1.2.1 below demonstrates the increasing need for additional resources to sustain the gains of the national HIV program and support achievement of the NSP 90-90-90 targets. It will be critical for the Government of Malawi to explore new and sustainable financing mechanisms during this period to ensure a sufficiently funded HIV response moving forward.

Figure 1.2.1 External Resources by Donor for HIV, Projection Post-2014 (in USD)[4]



Government contributions to the HIV program are expected to increase through 2017, from USD 10,557,083 in 2012-13 to USD 12,314,254[5] in 2016-17, marking a 16.64% increase. A 2012 study calculated that Malawi would require almost 8% of GDP to maintain its entire HIV-positive population on ART, making Malawi the most donor-dependent country in the world for its ART program.[6] Although donor commitments could potentially change, Malawi's HIV donors have tentatively committed to the main activities listed in Table 1.2.1.

4 Malawi Resource Mapping Round 3 Master Database

5 Extracted from CPF calculation

6 Williams, B.G. and E. Gouws. Affordability, cost and cost-effectiveness of universal anti-retroviral therapy for HIV. ARXIV 2012 [cited 2014 13/08/2014]; Available from: Link to: http://arxiv.org/abs/1206.6774v2 Link to: http://arxiv.org/abs/1206.6774v2

Table 1.2.1 Main Donor Commitments by HIV Activity (in USD)[7]

Main Funding Source	Fiscal years 2014 – 2017 Total**	Main Activities Funded
GoM	39,601,257	ART, VMMC, Cross-cutting HSS
GF (dispersed)	73,285,288	HIV Commodities, Cross Cutting HSS
GF (excl. NFM; incl. forecasts up to June 2015)	112,861,013	HIV Commodities, cross-cutting HSS, HTC, OIs, Labs
USG	236,342,654	HTC, Priority & Key Population Prevention, Condoms, HIV Commodities, ART, TB/HIV, PMTCT, OVC, Clinical care, treatment and support, Cross-cutting health systems strengthening and Community based care
World Bank	18,360,000	VMMC, Cross-cutting HSS
MSF	20,710,126	VL, ART, HTC, Cross-cutting HSS
UKAID/DfID	19,746,880	EID, HTC, PMTCT
CHAI	9,749,523	ART, CD4 testing

**Please note that this excludes GF NFM because it is not yet confirmed (Concept Note under technical review by GF)

7 Data taken from HIV-TB JCN Financial Analysis, version GF Final.

Table 1.2.2 Investment Profile by Program Area (NASA 2012 Expenditure Data – Pre COP 14 Pivot)

Program Area	PEPFAR Absolute	% PEPFAR	GF absolute	% GF	GoM absolute	% GRP	Other	% Other	Total Expenditure
Clinical care, treatment and support	9,010,865	19.1%	22,751,994	48.2%	6,391,175	13.5%	9,056,594	19.2%	47,210,628
Community-based care	48,537	1.4%	465,627	13.9%	133,066	4.0%	2,713,115	80.7%	3,360,345
PMTCT	9,606,079	73.1%	1,167,724	8.9%	324,282	2.5%	2,050,151	15.6%	13,148,236
HTC	3,651,987	37.4%	-	0%	-	0%	6,117,424	62.6%	9,769,411
VMMC	2,905,467	100%	-	0.0%	-	0%	-	0.0%	2,905,467
Priority population prevention*	8,406,835	53.3%	4,069,460	25.8%	1,387,460	8.8%	1,902,013	12.1%	15,765,768
Key population prevention	79,253	2.5%	135,862	4.3%	377,294	12%	2,558,838	81.2%	3,151,247
OVC	4,374,107	80.5%	362,631	6.7%	100,704	1.9%	597,707	11.0%	5,435,149
Laboratory**	967,129	70.1%	258,712	18.7%	71,846	5.2%	82,400	6.0%	1,380,087
SI, Surveys and Surveillance	4,760,416	59.8%	716,429	9.0%	198,992	2.5%	2,283,112	28.7%	7,958,949
HSS	14,448,148	40.8%	6,874,558	19.4%	2,832,993	8.0%	11,281,449	31.8%	35,437,148
Total	58,258,823	40.0%	36,802,997	25.3%	11,817,812	8.1%	38,642,803	26.6%	145,522,435

* Others includes the following Governments of Canada, Denmark, German, Ireland, Norway, Sweden, UK, EU, FAO, UNAIDS, UNICEF, UNDP, UNESCO, UNODC, UNFPA, World Bank, WFP, WHO, Action Aid, WVI, Caritas International (CRS), Red Cross, IPPF etc.

** Figure based only on blood safety but other lab expenses are included PMTCT, Outpatient care, operations research, information technology, biomedical research.

Table 1.2.3 Procurement Profile for Key Commodities in FY 14

Commodity Category	Total Expenditure US Dollars	% PEPFAR (Oct 2013-2014)	% GF (2014)	% GoM	% Other	% Total
ARVs	70,129,869	0%	100%	0%	0%	100%
Rapid test kits	1,243,188	0%	100%	0%	0%	100%
Lab reagents	6,234,348	12.24%	73.00%	0%	14.72%*	100%
Other drugs	15,999,415.36	0%	31.26%	68.74%	0%	100%
Condoms	2,886,141	38.59%	37.55%	0%	23.87%**	100%
VMMC kits and related commodities	1,803,326	61.00%	0%	0%	39%***	100%
Other commodities	NA	NA	NA	NA	NA	NA
Total	98,296,287					

* Contribution from CHAI covering EID and CD4, ** UNFPA *** World Bank

Table 1.2.4 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives for FY 14

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	IM's/Objectives
USAID MCH	14,500,000	7,290,000	5	8,626,724	SSDI - Jhpiego, Abt (SSDI - Systems), Deliver - Task Order no 4, STEPS, ASPIRE
USAID TB	1,500,000	1,398,000	2	1,100,000	TBCare II
USAID MALARIA	22,000,000	3,180,000	3	5,895,829	SSDI - Jhpiego, Abt (SSDI - Systems) and STEPS
USAID Family planning	12,700,000	4,320,000	5	9,026,724	HPPSSDI – Jhpiego, Abt (SSDI, Systems), Deliver - Task Order no 4 and STEPS
USAID Nutrition	5,000,000	1,750,000	2	5,895,829	SSDI – Jhpiego, Abt, (SSDI - Systems)
VMMC (central funds)	7,907,800 (Oct 2014-Sept 2015)		5	5,305,250	VMMC scale up in selected high priority districts
CDC NCD	250,000	0	2	0	Integration of hypertension screening and mgmt. in HIV care clinics
Peace Corps	350,000				GHSP Volunteers
DOD Ebola	0	0	0	0	N/A
MCC	N/A	N/A	N/A	N/A	N/A
Private Sector	N/A	N/A	N/A	N/A	N/A
FAMILY PLANING/HIV (central funds)	3,970,000	3,970,000	9	0	Family planning integration
CDC MALARIA	174,000	174,000	1	0	Modules for Electronic Medical records for Malaria program
CDC HYPERTENSION	205,000	205,000	2	0	HIV/Hypertension
PMTCT (central funds)	-	-	-	-	Received in FY 15
NATIONAL REGISTRATION/VITAL STATISTICS (central funds)	3,050,000	3,050,000	2	0	NRVS support
ACT*	N/A	N/A	N/A	N/A	N/A
DREAMS**	N/A	N/A	N/A	N/A	N/A
Total	**71,606,800**				
	* ACT to begin May 2015 ** DREAMS to begin FY 16				

1.3 National Sustainability Profile

Malawi has a strong national HIV/AIDS response; however, the GoM continues to face chronic systems and services challenges in achieving sustained epidemic control and long-term planning and partnership is required to ensure success. While GoM leads and oversees the national response, 95% of the national HIV response is donor-funded, with the USG and Global Fund constituting the largest share of funding to the 2015-2020 National Strategic Plan. Advocacy for increased commitment from GoM to covering costs is ongoing; however, as Malawi is one of the poorest nations in the world according to the IMF, the

likelihood of GoM contributing significant levels of additional funding towards the HIV response in the next few years is low.

Ten of the fifteen elements examined for the Sustainability Index and Dashboard were noted as "unsustainable" or "emerging". Of these ten elements, two were scored "red" and eight scored "yellow." The analysis revealed the following critical issues by data element:

1. *Epidemiological and Health Data*:
    a. Less than 5% of the total cost of the HIV/AIDS national response is financed by the GoM
    b. There is collection and analysis of viral load data by age, sex, and children; however, specific viral load information is not collected for key populations
    c. There is collection, analysis and available data on HIV prevalence by age, children, sex, key population, sub-national data, but HIV incidence data is not collected
    d. While there are preliminary key population size estimates for MSM and FSW, there are no size estimates for other vulnerable population categories available.
2. *Financial/Expenditure Data*
    a. While there is a system for collecting HIV/AIDS expenditure data by program area, it is not done annually or sub-nationally
    b. There have been no special health economic studies or analyses for HIV/AIDS i.e. costing, cost-effectiveness, efficiency and cost-benefit analysis
3. *Access and Demand*
    a. 52% of PLHIV are receiving ART services at public service delivery points
    b. No data is available on the proportion of key populations HIV/AIDS prevention program clients receiving services at public service delivery sites
4. *Human Resources for Health*
    a. HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand
    b. Pre-service training institutions have updated the HIV/AIDS content of their curricula; however, the content is not by cadre of service provider and institutions do not track their graduates
    c. While there is a strategy to institutionalize donor supported in-service training, it has not yet been implemented
    d. A functional Human Resource Information System is not in place
5. *Commodity Security and Supply Chain*
    a. The entire supply chain management plan for the national response is donor supported with no funds obligated from domestic public revenues for ARVs, test kits and condoms
    b. As proposed in the GF New Funding Model Concept, the GoM has committed to purchasing $8.5M in ARVs under the Willingness to Pay requirement
6. *Quality Management*
    a. There is no national HIV/AIDS related QM/QI strategy
    b. While there is quality monitoring at Centrally Supported sites, it does not include review of service outcomes, client feedback or a QI action plan

7. *Resource Commitment*
    a. The GoM is not meeting the 15% Abuja commitment for government health expenditure and is contributing less than 8% of domestic HIV expenditure financing towards the annual national HIV response (GoM expenditure for health currently at 6%)
    b. Information is not available on domestic expenditures on key populations
8. *Technical Efficiency*
    a. There is expenditure data or cost analysis to estimate unit costs of HIV/AIDS services (HIV testing, care and support, ART, PMTCT, VMMC), however this is not done annually; and it is not done for OVC and key populations
    b. There is no integration of HIV/ AIDS into national or subnational insurance, nor is there a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery
    c. Average costs for providing ART in the country have not reduced within the last two years due to shift in regimens
9. *Public Access to Information*
    a. The Open Budget Index (OBI) and Public Expenditure and Financial Accountability Assessment (PEFA) scores are low
    b. No audit is conducted of the national HIV/AIDS program
10. *Oversight and Stewardship*
    a. There are no formal channels and opportunities for diverse civil society groups to engage and provide feedback on the HIV/AIDS policies, programs and services
    b. There is a weak enabling environment for civil society engagement.

Six of these ten elements were identified as most critical to ensuring sustained control of the epidemic:

1. Epidemiological and health data
2. Financial and expenditure data
3. Access and demand for treatment and care services
4. Human resources for health
5. Commodity security and supply chain
6. Quality management.

Improvements in these six priority elements can be realized through PEPFAR's core and near core activities for PMTCT, care and treatment, community, and health systems strengthening, and efforts will be intensified in COP15.

Contributors to the Malawi Sustainability Index and Dashboard agreed that the scoring would look very different (worse) if donor supported programs had been excluded from consideration. In fact, in Malawi, **the Index is considered more of an assessment of efficiency than a sustainability tool**. To date, PEPFAR and other donors have invested financially and technically in all six priority areas. As noted previously, 95% of the national response is donor funded with the USG and Global Fund constituting the largest share of funding to the 2015-2020 NSP. DfID was the largest contributor to the national donor pool for health and HIV/AIDS and would have been a key contributor to closing gaps; however, because of the GoM "Cashgate" corruption scandal, where millions of dollars were noted to

have been pilfered by civil servants, DfID funding has been retracted. As a result, there is a limited number of donors and resources available to address those priority elements which are not already receiving support.

1.4 Alignment of PEPFAR investments geographically to disease burden

In FY 2014, PEPFAR spent, on average, $66 per PLHIV in Malawi nationally. District specific expenditures per PLHIV ranged from $14 to $112; Ntcheu and Mwanza were the districts with the lowest and the highest unit expenditures respectively (Figure 1.4.1). Differences in the unit expenditure varied by district and by implementing mechanism. The analysis of the data showed that there was efficient use of resources where districts with highest number of PLHIV received largest amount of resources on care and treatment as shown in Figure 1.4.2; Blantyre and Lilongwe have the highest number of PLHIV and received the largest proportional share for care and treatment.

Spending per PLHIV in the high burden districts is the highest in Blantyre and Lilongwe, but still too low in relation to the burden of disease. In Nkhata Bay, Dowa, Nkhotakota, Neno, Mwanza, and Chitipa spending per PLHIV is high compared to HIV burden. This is most likely explained by transportation costs, with fuel at $8/gallon, these rural districts are more expensive to support. Also, these districts have fewer PLHIV per site in those districts due to the lower population density. It should be noted that the expenditure analysis (EA) data reflected here is from our COP13, *before* site prioritization took place. We would anticipate in the next round of EA data to show a different picture, now that we have refocused the program to Scale Up districts.

Figure 1.4.1 PEPFAR FY14 Expenditure per PLHIV and Percent of PLHIV by SNU

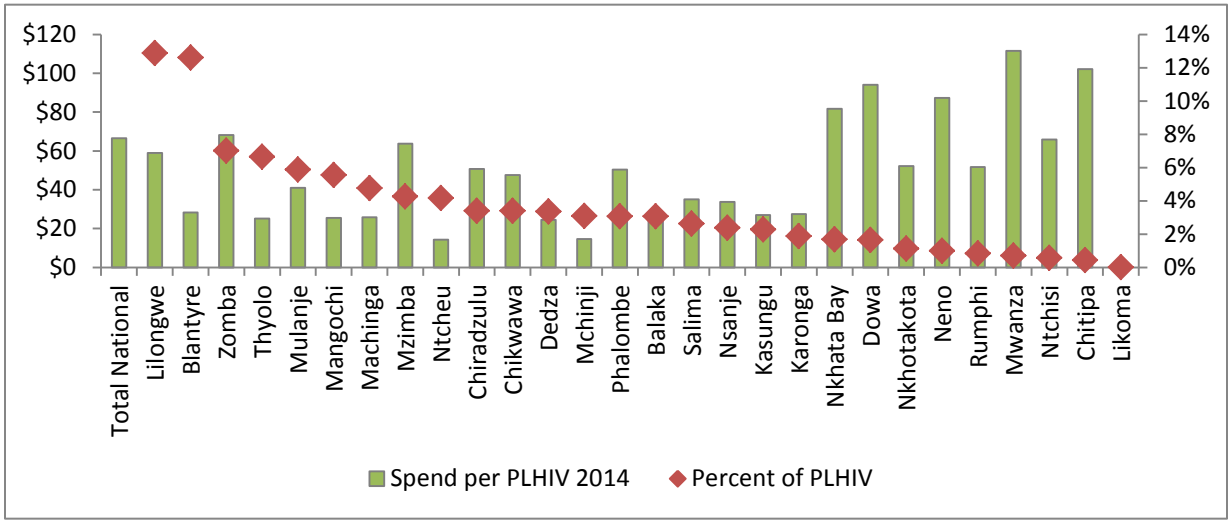
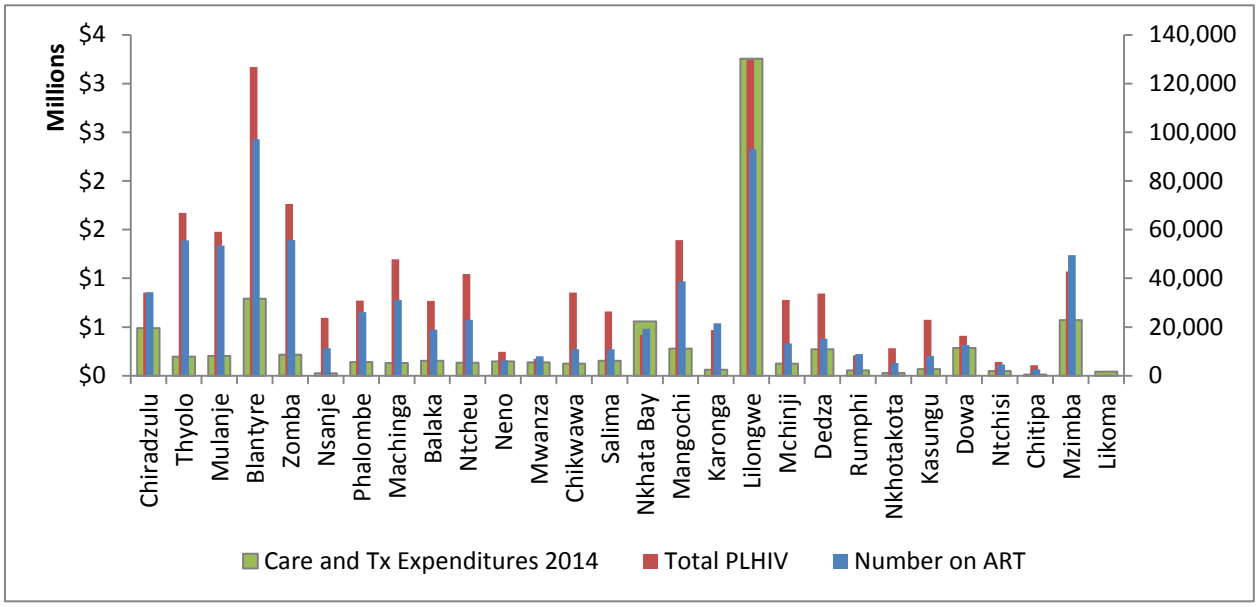


Figure 1.4.2 PEPFAR FY14 Care and Treatment Expenditure, Total PLHIV, and Number on ART by SNU



Lilongwe expenditures tend to be high because they include all above-site/central costs of the PEPFAR program.

1.5 Stakeholder Engagement

Since the submission of COP14, GoM, with the support of UNAIDS, USG and CHAI, has focused on the development of a new National Strategic Plan for HIV/AIDS to form the central tenet of the GoM's Concept Note (CN) to the Global Fund. Civil society, the private sector, implementing partners and multilateral donors were all engaged in the Concept Note writing process, which concluded with the submission of the CN on January 30, 2015. Since that time, USG has continued to formally engage with these stakeholders for the COP15 preparation, including:

1. Meetings with the MoH Department of HIV/AIDS over the COP14 pivot, prioritization of sites, development of standard and maintenance packages of support, and COP15 planning
2. Conferences with implementing partners and district health officers over the COP 14 pivot and finalization of the priority sites for COP15
3. Participation of representatives from government, multilateral donors and CSOs in the Sustainability Index and Dashboard development confirming the Core/Near Core decisions
4. Participation in Gender and Sexual Diversity Training as part of the USG Human Rights Agenda
5. Separate meetings specifically for CSOs and HIV advocacy organizations representing networks of PLHIV:
    a. CSOs were able to highlight issues and provide feedback and input into COP programmatic design, much of which is included in the overall COP plan (e.g. establishing a practice of 'twining" CSOs to priority sites for retention, monitoring and accountability, the use of Expert Clients for retention and defaulter tracing; support of

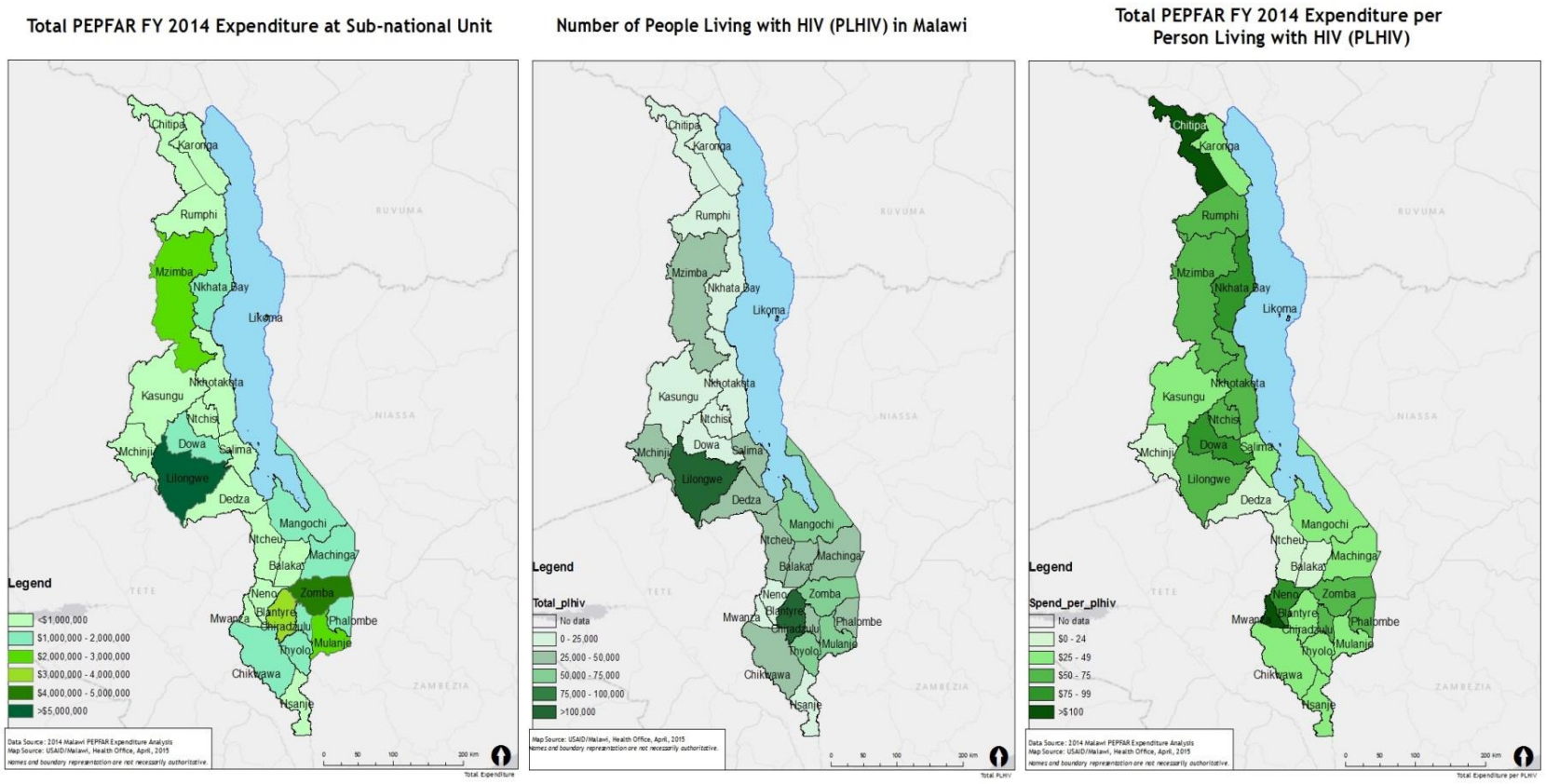
pre-service health care worker training; special attention and outreach to key populations, and development of drug storage facilities at the health facility level.)

b. Information on Resource Mobilization and Capacity building, two big issues for CSOs, as the pool of resources available for civil society from the Global Fund grants will decrease significantly in 2016. PEPFAR Malawi also provided Information on the USAID STEPS (Supporting the Efforts of Partners) program, a USAID program with partial PEPFAR funding. Through STEPS, USAID is building the organizational capacity of Civil Society Organizations across the entire portfolio. This activity is designed to improve organizations' financial skills, strategic planning, program management, monitoring and evaluation, research, and advocacy capabilities. Interventions will strengthen organizations' long-term sustainability and help them deliver even stronger results.
c. Meetings held March 19, April 9, April 16, April 23, June 4 prior to COP Review in Namibia and July 27 prior to the submission of the revised SDS.

The meetings and interactions were important to USG and stakeholders, and a plan for formal quarterly meetings and reporting has been developed. Engagement with the private sector was primarily with CIFF, as part of the ACT initiative. Other private sector engagement outside of the GF CN preparation has not been conducted. Appendix C has the complete list of organizations which participated in COP15 development.

Figure 1.5.1 Total PEPFAR FY 14 Expenditure, PLHIV, and Expenditure per PLHIV

District (number of sites)	Total PLHIV
Likoma (2)	689
Ntcheu (21)	41,830
Mchinji (12)	31,063
Balaka (14)	30,794
Dedza (14)	33,795
Thyolo (24)	66,935
Mangochi (34)	55,753
Machinga (18)	47,828
Kasungu (12)	22,927
Karonga (9)	18,761
Blantyre (29)	126,849
Nsanje (13)	23,780
Salima (12)	26,428
Mulanje (22)	59,107
Chikwawa (17)	34,160
Phalombe (13)	30,867
Chiradzulu (12)	34,161
Rumphi (5)	8,340
Nkhotakota (9)	11,328
Lilongwe (33)	129,651
Mzimba (24)	42,882
Ntchisi (3)	5,636
Zomba (30)	70,589
Nkhata Bay (9)	16,805
Neno (8)	9,803
Dowa (8)	16,394
Chitipa (3)	4,330
Mwanza (3)	6,934



2.0 Core, Near-Core and Non-Core Activities

PEPFAR/Malawi reviewed and analyzed the following documents to determine core, near-core, and non-core activities: the current investment portfolio; gaps analysis done for development of new National HIV Strategic Plan and Global Fund Concept Note; and the Sustainability Index and activities which are required to achieve sustained epidemic control. Because of how funding priorities for the Global Fund, the GoM and the pooled donors have developed over the years, PEPFAR serves as the primary funder of various aspects of the national response. As such the following technical areas are considered core: improving the quality of pre-ART, ART, PMTCT, pediatric ART and TB through clinical and systems mentoring at the health facility level; increased focus of TB in urban settings and TB hotspots; support for neglected and hard to reach populations such as pediatrics, adolescent girls and key populations; HTC for active case findings; condom promotion and distribution; community based prevention, care, OVC, and impact mitigation activities especially focused on linkage to care and treatment services, adherence and retention; targeted key population and youth services; bursary support for HRH; strategic support for labs, sample transport systems, and supply chain systems.

Near-core activities are: cervical cancer screening and cryotherapy in PEPFAR focus districts and services for victims of gender based violence. Non-core: prevention programming for general population; food packages and nutrition support to vulnerable households has been shifted to other USG technical areas and other development partners.

3.0 Geographic and Population Prioritization

PEPFAR 3.0 urges countries to adopt data driven epidemic control strategies, through the use of targeted, geographic, and population prioritization. Malawi is uniquely positioned to respond to this call because of availability of site level HIV program data. Malawi is renowned for the excellent paper-based HIV M&E system, in which data is collected and validated at every site, every quarter.

In a country with wide variation in HIV prevalence both between and within districts, this site level data enables a super-targeting of the HIV epidemic at the smallest possible sub-national unit (SNU), the health facility and its catchment area. During the PEPFAR 'pivot' in COP14 planning, the PEPFAR Malawi team chose to maximize the available data in prioritizing populations and geographic areas. This was done by identifying Sites in need of services based on ART unmet need (treatment gap), expected HIV-positive pregnancies and current on ART patient volumes. In COP 15, this population prioritization was further refined by geographic prioritizations at the district level.

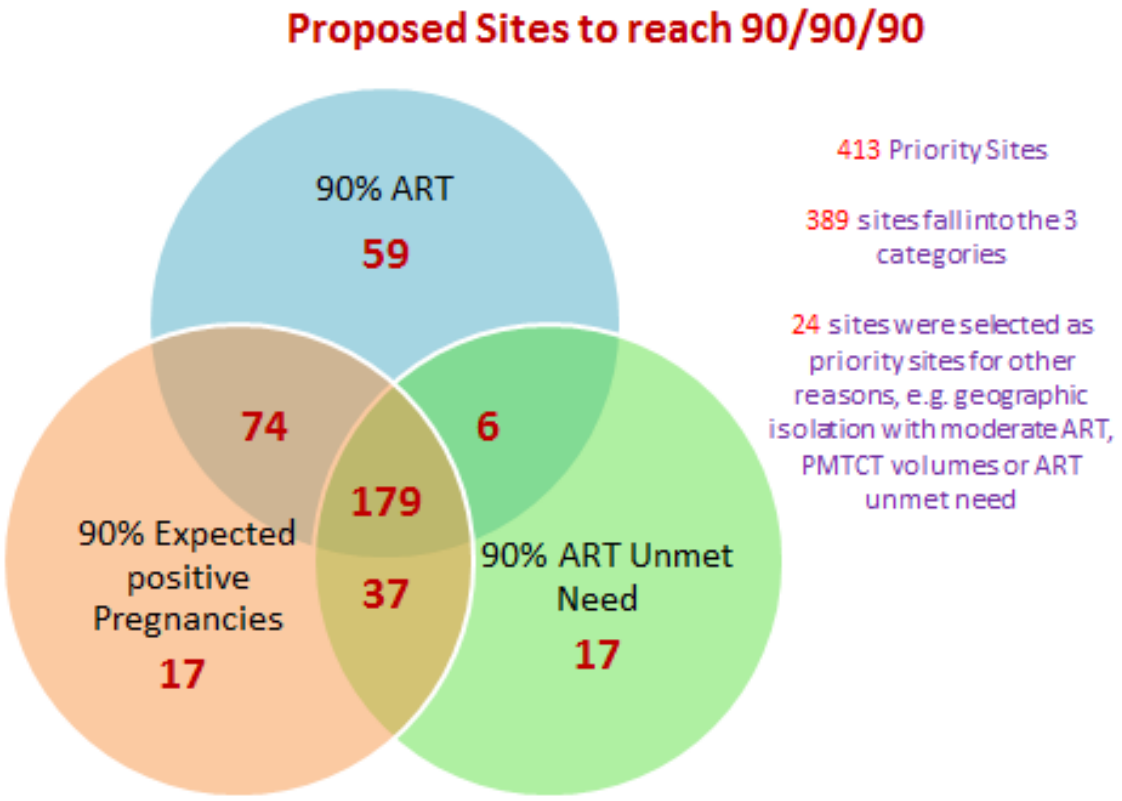
First Stage-Population Prioritization

Three prioritization parameters were used to select sites which would reach:

- 90% of ART Unmet need (PLHIV - Current on ART)
- 90% of expected HIV-positive pregnancies
- 90% of current on ART patient

This population prioritization process resulted in 413 priority Sites as illustrated in Figure 3.0.1 below and these represent about 57% of total sites in the country covering 90% of ART patients and HIV burden.

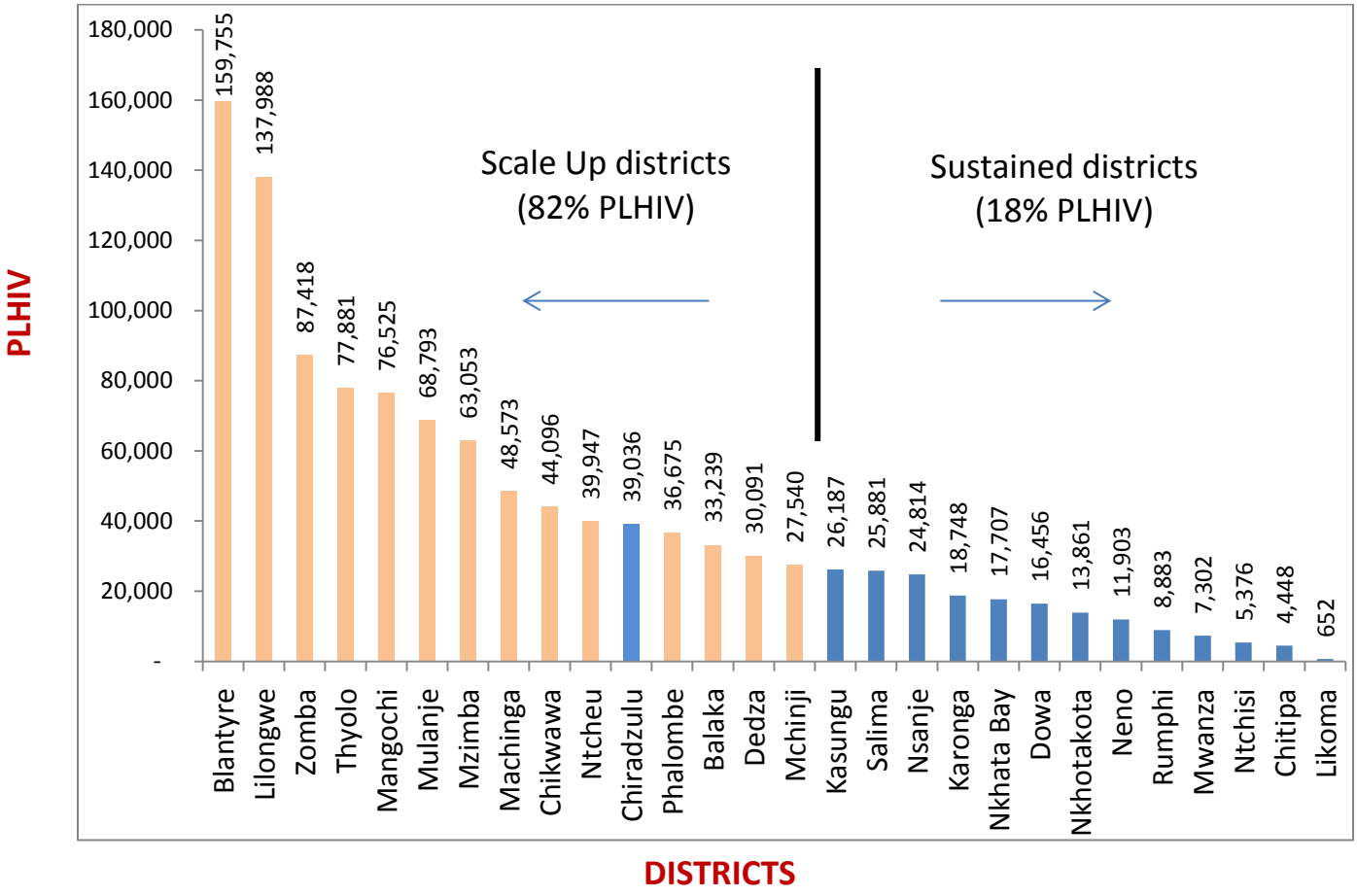
Figure 3.0.1 PEPFAR Malawi Priority Sites



Second Stage- Geographic Prioritization by District

The 28 districts were ranked in descending order of number of PLHIV. As seen in the figure below, 82% of PLHIV were located in 14 districts. These 14 districts were prioritized as Scale Up districts. (Although Chiradzulu district has a high number of PLHIV, it was not included in Scale Up districts for COP 15 due to other support mechanisms.) In combining the population and geographic prioritizations by district, 305 sites were identified for Scale Up services, 108 sites were identified for Sustained services. The remaining 284 sites are defined as Centrally Supported sites.

Figure 3.0.2 PEPFAR Malawi Scale Up and Sustained Districts



3.1 Facility-based care and treatment

In COP15, OGAC increased the Malawi budget by $10 million in treatment funds to further intensify progress towards epidemic control. These funds are to be focused on acceleration of treatment in a defined geographic area to reach 80% coverage on ART by 2017; this is ahead of the 2020 schedule endorsed in the NSP. After multiple iterations of district and site level data review and analysis, and extensive discussions with the OGAC, MoH Planning Department and Department of HIV and AIDS, civil society groups and UNAIDs, the decision was made to focus on the 14 districts which cover 82% of total PLHIV. Within these Scale Up districts there will be 305 Saturation sites which were selected using the criteria described in section 3 above, to achieve coverage of 80% of PLHIV on ART by 2017. In the 14 Sustained districts there will be 108 sites where facility level interventions will be implemented to retain patients in care with district and national level quality monitoring activities.

A standardized package of comprehensive program interventions will be implemented in the 14 Scale Up districts with active case identification, optimizing the clinical cascade and the continuum of care. Malawi will use an intensive approach to iteratively saturate all high yield community- and facility-based

HTC entry points, and will also use the national quarterly M&E system to regularly follow progress towards saturation, and of course, correct as necessary.

In Sustained districts, PEPFAR programs would support provision of quality care and treatment services for current HIV patients and new ART patients based on passive enrollments. As opposed to Scale Up districts, in Sustained districts, PEPFAR's investment on active case finding and linkage will be limited to key populations and children.

3.2 Community

In the Scale Up districts, linkage systems will be strengthened to ensure retention along the care continuum, including targeted testing for active case identification. Targeting the populations most affected and vulnerable to HIV with comprehensive HIV services is critical to facilitate epidemic control. Prioritization of specific sub-populations was based on analysis of districts with highest HIV prevalence, treatment gaps, estimated populations and contribution to new infections, profiles of specific at-risk groups, behavioral and biological surveillance surveys (BBSS) vulnerable population data etc. High HIV prevalence in marginalized populations such as sex workers (63%), men who have sex with men (17%), and vulnerable populations such as estate workers (23%), fishing communities (12%), prisoners (20-41%), and female vendors (24%) reflects the imperative to increase targeted HTC, service linkages, community prevention, and care and treatment activities.

The integrated impact mitigation, prevention and community care platform is focused on 8 of the highest prevalence districts: Mangochi, Machinga, Zomba, Mulanje, Chikwawa, Balaka, Blantyre, and Phalombe. These districts, which account for 177 Saturation Sites and 71 Centrally Supported Sites for care and treatment, also have low treatment coverage, significant OVC populations and adolescent girls and young women (AGYW) at risk, as well as priority subpopulations such as estate workers, fishing communities, vendors, police, and teachers. Traditional Authorities (TAs) in these districts will be selected based on the location of PEPFAR Saturation sites for treatment. The identified priority population will be targeted for community-based mobilization and testing activities. Other vulnerable populations identified include uniformed military, police and prisoners will also be reached in the Saturation sites through targeted service delivery activities. Peace Corps Health Volunteers placed within Saturation sites will provide technical assistance in core and near-core activities in 17 districts, with supplementary prevention activities in an additional 8 districts.

Key Populations (KPs) and AGYW will be targeted in urban areas where there is high population density, HIV prevalence, unmet need for treatment and hot spots based on current data sources. Community based services for KPs will focus in Blantyre, Lilongwe, Mzuzu, Mangochi (along the lakeshore), and Mwanza (border areas). Community-based testing within hotspots around these areas will reach clients of sex workers who are identified as priority populations based on the preliminary BBSS results. Comprehensive interventions for AGYW are integrated in the community programs where OVC populations are high, early sex initiation and childbearing are reported, there are high school dropout rates, high reported transactional sex, and damaging cultural norms and practices (MDHS 2010). Female

sex workers will also be reached with the comprehensive package in two DREAMS districts and exploited children will be linked to impact mitigation interventions. DREAMS funding will also be utilized to identify high risk male sexual partners and target them for HTC and linkage to ART or VMMC services based on their status.

3.3 Voluntary Medical Male Circumcision (VMMC)

The PEPFAR/Malawi VMMC budget was reduced during the COP14 pivot to meet the 54% treatment and care earmark. However, in COP14, PEPFAR/Malawi received central initiative funding so we were able to maintain direct service delivery in eight districts. Based on the analysis of current prevention funding in Malawi, and in the absence of further central initiative funding this year, PEPFAR Malawi will pivot its VMMC portfolio during FY16 from a direct service delivery (DSD) to a Technical Assistance (TA) model to support the GoM implement a VMMC program funded by the World Bank and Global Fund, except for DSD support for the Malawi Defense Forces (MDF). The CIRC budget for COP15 will be $1,132,825 with $550,000 going to the MDF VMMC program for DSD targets of 5,583 at a unit expenditure of $98.5 per MC; $78,800 for national coordination support to the MoH; $400,000 for TA to the GoM and $104,025 for M&O.

With VMMC central funds received in FY15, two implementing partners will continue to provide VMMC services in Lilongwe and Blantyre District until March and June 2016, respectively. PEPFAR Malawi has requested an additional $10M in central funding for 5 years to ensure fulfillment of the new VMMC demand generated by the PEPFAR and MoH VMMC program. It is critical that this funding be for multiple years, and a minimum of 3 years so that agreements with implementing partners can be secured. All current VMMC implementing partners have expiring agreements in FY16.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

Having identified the 413 sites for PEPFAR support, with 305 of them as Scale Up sites, care and treatment targets were set based on varying assumptions by sites type, whether Centrally Supported, Sustained or Scale Up. In order to reach the second 90 (on ART), the first 90 (HIV Testing) is key. Different streams of HIV testing were identified of which out-patient department (OPD) and in-patients were potentially high HIV test yield. Targets were set for a period of 5 years, in line with the National Strategic Plan (NSP) in which Malawi seeks to treat 81% of PLHIV by 2020. An annual growth rate of 3.17% STI, TB and Family Planning clinics as well as in-patient and Other Outpatient (OPD) departments plus a 1.51% annual growth rate for ANC were applied to project the possible targets in the years after FY15. The Government of Malawi considers the targets and objective of the NSP to be very optimistic;

the idea of reaching 80% coverage by 2017 required extensive (and on-going) negotiations with the government to ensure that there be improvements to infrastructure and health systems to handle the accelerated program. The table 4.1.1 below summarizes the targets per site type.

Table 4.1.1 HIV Testing and Treatment Targets

Indicator	Prioritization Level	# of Districts	Total # of Sites		Total Targets		Target Total
			# Facility Sites	# Community Sites	DSD	TA	
Number of individuals who received HIV Testing and Counseling	Scale Up	14	305	11	2,676,927		3,148,354
	Sustained	14	108	4	471,427		
Number Current on Treatment	Scale Up	14	305		520,321		653,107
	Sustained	14	108		132,786		
Number of individuals newly initiated on treatment	Scale Up	14	305		151,964		173,090
	Sustained	14	108		21,126		
Number of pregnant women with known HIV status	Scale Up	14	305		373,392		488,118
	Sustained	14	108		114,726		
Number of positive pregnant women put on ARV	Scale Up	14	305		32,072		39,587
	Sustained	14	108		7,515		
Number of infants born to HIV-positive women who had a virologic HIV test done within 12 months of birth	Scale Up	14	305		27,008		33,337
	Sustained	14	108		6,329		

4.1.1. Orphans and Vulnerable Children

The proposed reach of OVC programming is based on population size estimates provided at district level to achieve 75% coverage in targeted Traditional Authorities of each district over five years. Coverage within each TA will be defined by the number of OVC reached by the activity, based on a denominator of population size estimations provided at baseline. In FY14, PEPFAR Malawi, through two different projects, reached 209,777 OVC with services (i.e. Case Management, Health and Nutrition, Child Protection, Family Stability and Schooling). In COP15, there will only be one implementing partner, which will begin providing services in FY16. Given the current lean OVC portfolio and extended time required for new activity startup, USG is proposing to provide services to 188,072 beneficiaries in OVC

households through direct services delivery and technical assistance. Of those OVC receiving direct service delivery, 85,927 will receive HIV services (Table 4.1.6). Within the next five years, PEPFAR Malawi anticipates providing services to 355,899 beneficiaries from OVC households (75% of total OVC population).

Additional support to OVC is provided by Peace Corps Community Support activities and the Small Grant program. COP 15 targets have not been established as of yet for these two smaller programs. (In COP14, PC reached 1233 OVC, while the Small Grants program reached 1275 (APR 14)).

4.1.2. VMMC

As seen in Table 4.1.2 below, there are estimated 2,458,727 males aged 10-34 years in the nation's 28 districts requiring circumcision to reach the GoM's target of 60% in the period 2015-2019. However, the GoM prioritized 14 districts for scale up of VMMC during this 5 year period. Based on the 60% target, this translates to 1,300,568 men in this age group needing circumcision. PEPFAR has been scaling up VMMC in 8 of these priority districts with an estimated 1,063,501 uncircumcised men aged 10-34years. The coverage in these 8 districts as at APR15 is projected to be 19%.

With the COP 15 VMMC strategic pivot to the Technical Assistance model, DSD target estimates have been reduced to 26,866 which are coming from the military VMMC program (5,583) and carry over VMMC central initiative funding (21,283) in FY 15 , bringing the national coverage to an estimated 21% by APR16 in the eight previously PEPFAR focus districts.

The current central funding expires in Q3 of FY 16 so additional central funds were requested in early July 2015. To reach 60% of the 15-29 year old group, PEPFAR would require $50M over 5 years. With an annual budget of $10,000,000, at a unit cost estimate of $98.5/MC, and within the absorptive capacity of current systems, PEPFAR could circumcise 101,522 males per year. To achieve this, PEPFAR Malawi will need to make multi-year awards to implementing partners as routine service delivery by the MoH cannot achieve desired targets. A minimum commitment of 3 years of funding is therefore is necessary for us to proceed with this plan.

Table 4.1.2 Estimated Population size of 10-34 year old males – National and current coverage and estimated coverage in priority SNUs

Target Populations	Population Size (priority SNUs)	Current Coverage (APR 15)	*VMMC_CIRC* (in FY16)	Expected Coverage (in FY16)
Targeted 60% uncircumcised males 10-34 years in 28 Districts	2,458,727			
Targeted 60% uncircumcised males 10-34 years in 14 priority Districts	1,300,568			
Targeted 60% uncircumcised males 10-34 years in 8 PEPFAR supported Districts COP14	1,063,501	201,554 (19%)	26,866 (5,583 under COP 15 funding & 21,283 under central funding)	21%

Table 4.1.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (priority districts)	Coverage Goal (in FY16)	FY16 Target
Female sex workers	24,300 (5 districts)[8]	32%	7,776
MSM	19,830 (4 districts)	30%	5,963
Females (15-24)[9] Urban settings with high HIV prevalence	Blantyre urban 87,719 Lilongwe urban 100,54	2%	14,000 (4000 from urban priority sites
> 15 priority populations (M and F) in 8 high prevalence Southern districts Priority Populations Subgroups: 1. Adolescent PLHIV 2. Adult PLHIV (20-49) in discordant relationships 3. OVC households 4. estate workers, other hard to reach populations (i.e. fishing communities, teachers, and police)[10]	Total 15> population: 2 008 196 Total PLHIV: 369,598 5. ALHIV: 14,149 6. Discordant couples: 90,182 7. OVC HH: 88,577 8. OVP: TBD Machinga, Mulanje, Zomba, Phalombe, Chikwawa, Blantyre Balaka, Mangochi.	15%	PP Prev: 31,936 • ALHIV: 2,122 • Discord couples: 13,527 • OVH HH: 13,287 • OVP: 3,000 • Gen-Norm: 186,224
Military personnel and sites	30,469 (MDF sites)	64%	Prev: 14,385

8. Priority KP districts are Lilongwe, Blantyre, Mzuzu, Mangochi and Mwanza (FSW only)

9. AGYW: PEPFAR COP funds will primarily support YFHS and 100 new Youth Alert Listener clubs in Lilongwe, and support to 600 existing YA clubs within Blantyre , Mwanza, Neno, Thyolo, Dedza, Ntsisi, Rumphi, Machinga and Mzimba due to leveraged FP resources provided by KFW. Size estimations are only provided for Lilongwe and Blantyre urban. OVC households with adolescents (10-17) will be provided integrated impact mitigation and prevention services. These targets are reflected under OVC interventions.

10. Priority Populations in 8 districts: Reach is calculated based on 75% coverage of populations in the 58 catchment TAs / 8 districts over five years. COP 15 targets were calculated based on 15% reach of standardized packages for specific priority sub populations specifically in the 12 TAs around Saturation sites and where there are high numbers of OVC. Targeted normative change and stigma reduction interventions will be implemented through traditional leaders and community structures using standardized curriculums to reach 20% coverage in all 58 sites

Peace Corps will implement small scale HIV intervention in 25 districts across the country. Targeting both in school and out of school youth with more focused interventions on adolescent girls and young women. Age range (10 - 24) 25 to 49 years adults (parents) have been included to raise awareness of HIV risk among young people. Interventions will also address harmful gender social in 23 districts across the country	Balaka, Chiradzulu, Mangochi, Chikwawa, Nsanje, Machinga, Blantyre, Thyolo, Zomba, Phalombe, Mulanje, Nkhata Bay, Rumphi, Mzimba, Karonga, Chitipa, Nkhotakota, Salima Mchinji, Dowa, Lilongwe, Ntcheu, Kasungu, Dedza, Ntchisi	TBD % coverage will be determined from volunteer sites	HVOP: 3750 Gen-Norm: 1376
Peace Corps will place within the high burden HIV Facility sites will work with Health facility and Community based organization to promote treatment adherence and retention.	Balaka, Ntcheu, Chiradzulo, Karonga, Mangochi Mzimba, Nkhatabay, Rumphi, Machinga, Mulanje, Chikwawa, Nsanje, Chitipa, Lilongwe, Nkhotakoata, Salima, Mchinji	TBD	HBHC: 500
Total COP			KP and PP Prev: 89,795 Gen-Norm: 187,600

Table 4.1.4 ART Targets in Scale Up Districts (Saturation Sites) for Epidemic Control

District	Total PLHIV	Expected current on ART (2015)	Additional patients required for 80% ART coverage	Target current on ART (in FY16) TX_CURR	Newly initiated in FY 16 TX_NEW	Target current on ART (in FY17) TX_CURR	Newly initiated in FY 17 TX_NEW
Balaka	33,239	13,419	7,528	19,063	4,893	26,591	7,528
Blantyre	162,314	59,804	41,152	88,699	30,450	129,851	41,152
Chikwawa	44,272	17,198	10,216	25,202	7,937	35,418	10,216
Dedza	30,138	12,366	8,528	15,582	3,860	24,110	8,528
Lilongwe	138,583	70,146	15,755	95,111	26,177	110,866	15,755
Machinga	48,579	20,823	11,965	26,898	7,578	38,863	11,965
Mangochi	76,525	31,998	22,354	38,866	9,890	61,220	22,354
Mchinji	27,540	11,642	7,963	14,069	3,920	22,032	7,963
Mulanje	68,793	41,775	9,163	45,871	13,748	55,034	9,163
Mzimba	64,209	28,552	14,054	37,313	10,158	51,367	14,054
Ntcheu	40,039	17,624	10,108	21,923	5,553	32,031	10,108
Phalombe	36,675	23,310	1,925	27,415	6,892	29,340	1,925
Thyolo	78,394	42,978	10,719	51,996	11,677	62,715	10,719
Zomba	87,432	37,475	17,693	52,253	16,250	69,946	17,693
Grand Total	**936,732**	**429,112**	**189,125**	**560,261**	**158,983**	**749,386**	**189,125**

Figure 4.1.0 COP 15 Scale Up and Sustained districts with Sites

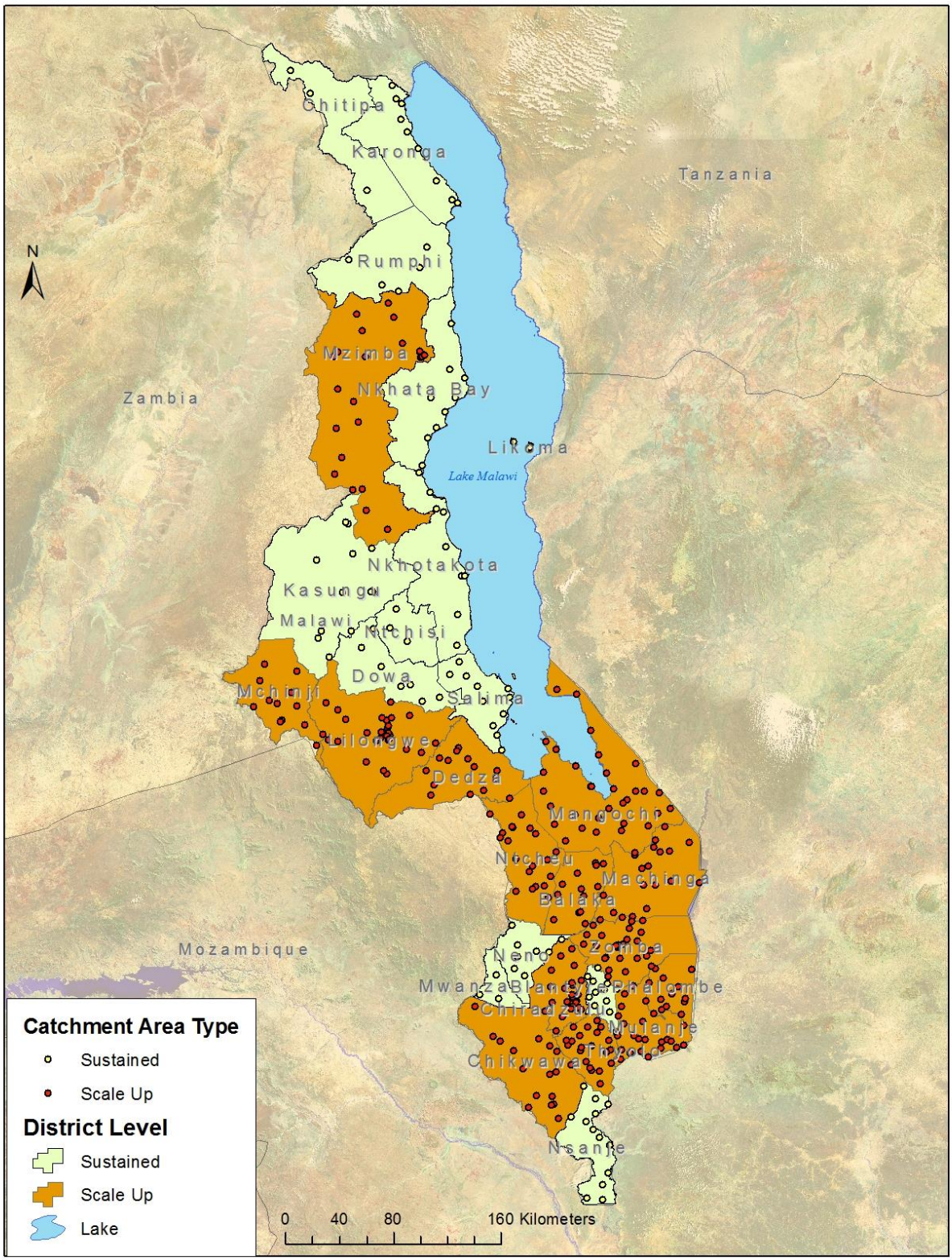


Table 4.1.5 Entry Streams for Newly Initiating ART Patients in Priority Districts (FY 16)

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Clinical care patients not on ART	2,414,807	156,973	141,276
TB-HIV Patients not on ART	16,306	3,816	3,434
HIV-positive Pregnant Women	499,787	31,539	28,385
Other priority and key populations	67,169	6,272	5,645
Total	2,998,069	198,600	178,740

Figure 4.1.1 PMTCT, ART and VMMC Coverage by District, 2014

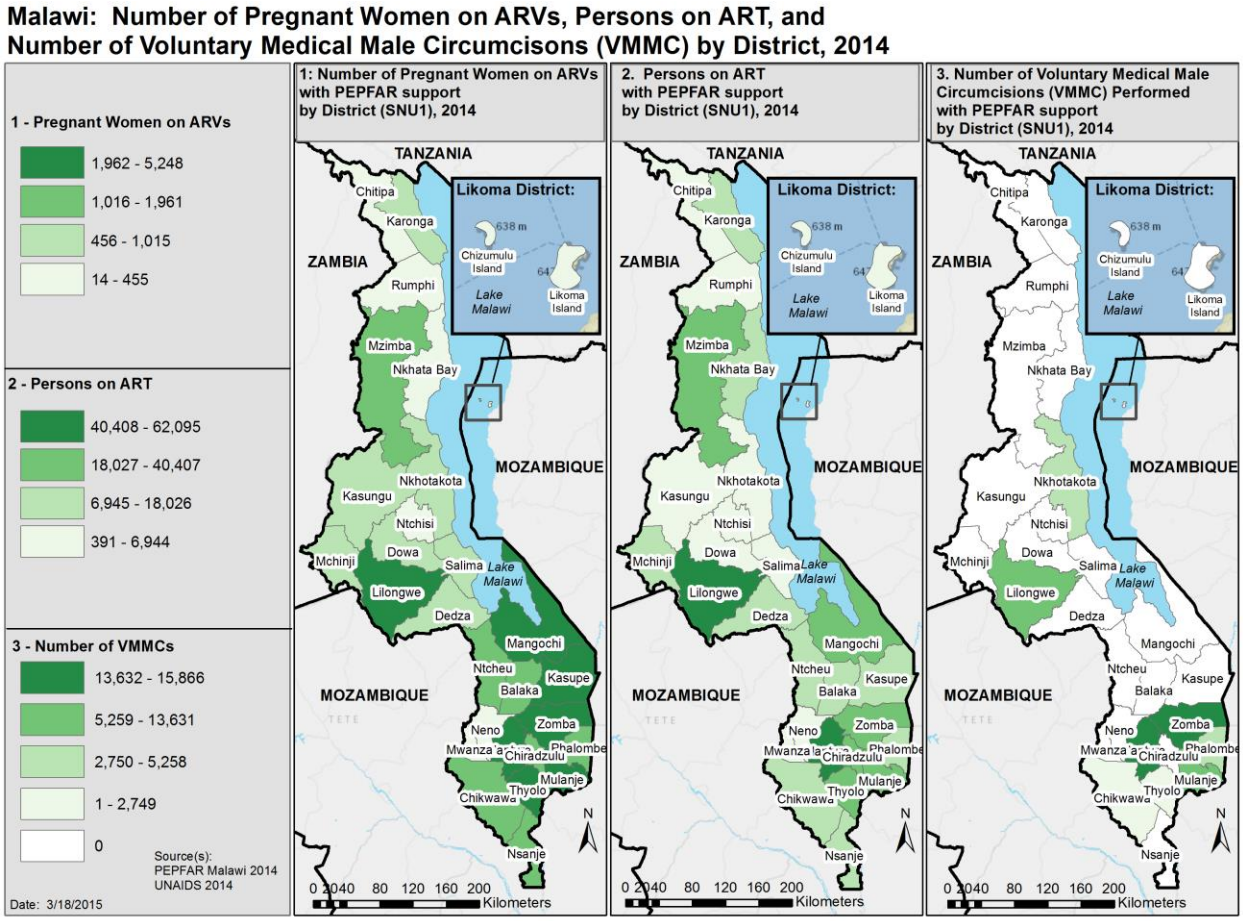
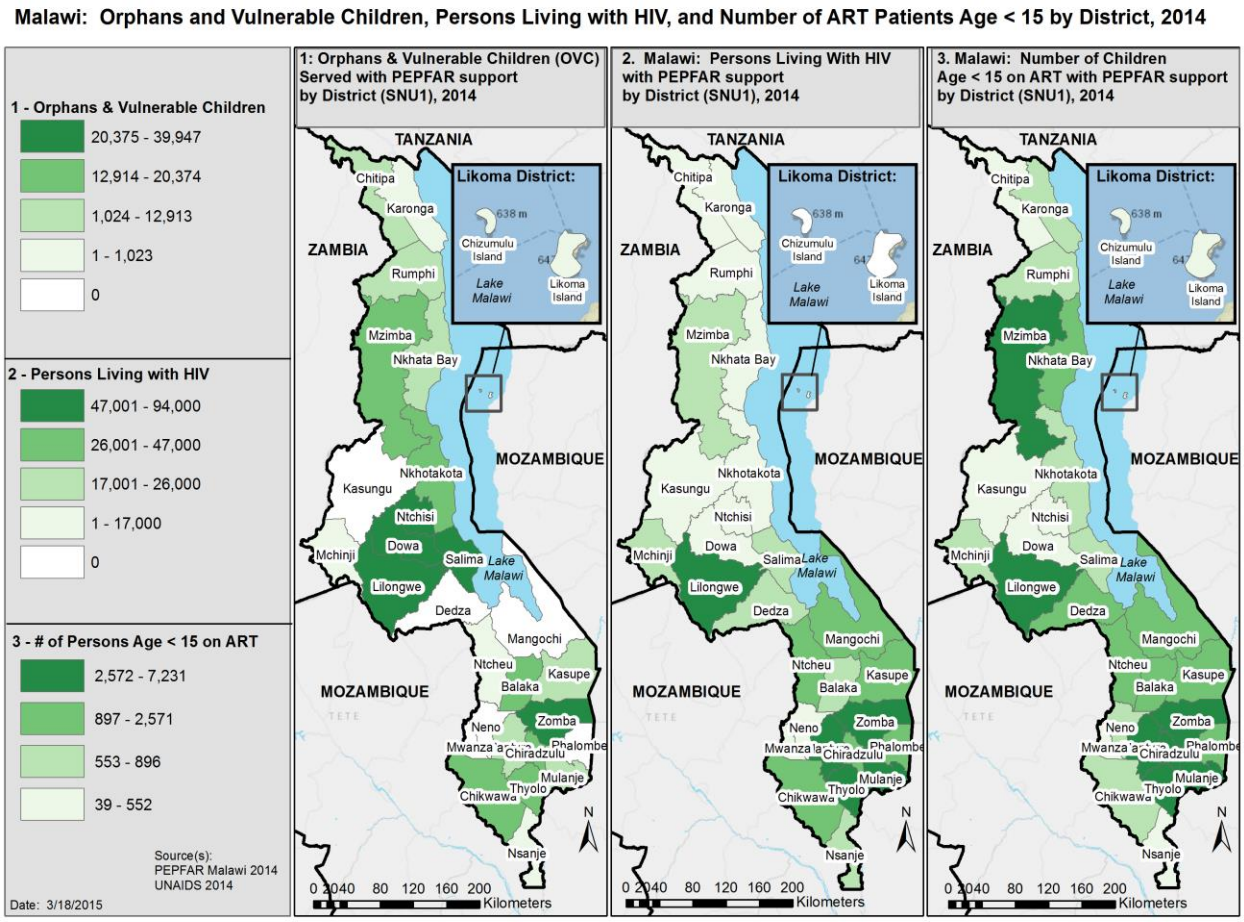


Table 4.1.6 Targets for OVC and Pediatric HIV Testing, Care and Treatment

District *(Scale Up Districts in Italics)*	Estimated # of Children PLHIV (<15)	Target # of active OVC (FY16 Target)	Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target)	Target # of children tested (FY16 Target)	Target # of children on ART
		OVC_SERV	OVC_ACC		
Balaka	*4,706*	*20,284*	*8,849*	*2,004*	*27,807*
Blantyre	*28,138*	*9,533*	*4,752*	*6,943*	*94,863*
Chikwawa	*4,996*	*18,984*	*9,473*	*2,671*	*33,472*
Chiradzulu	4,737	46*	NA	2,925	18,551
Chitipa	694	21*	NA	420	6,492
Dedza	*4,933*	*NA*	*NA*	*1,574*	*27,633*
Dowa	2,251	NA	NA	1,000	17,309
Karonga	2,868	21*	NA	1,414	13,105
Kasungu	3,452	NA	NA	1,227	20,847
Likoma	92	NA	NA	58	1,107
Lilongwe	*30,810*	*23**	*NA*	*8,107*	*111,231*
Machinga	*7,625*	*18,920*	*9,446*	*2,910*	*37,981*
Mangochi	*8,517*	*50,516*	*23,394*	*4,239*	*51,446*
Mchinji	*4,845*	*23**	*NA*	*1,309*	*20,514*
Mulanje	*8,563*	*30,143*	*15,057*	*3,868*	*40,919*
Mwanza	1,061	NA	NA	485	5,854
Mzimba	*10,898*	*35**	*NA*	*3,108*	*55,146*
Neno	1,359	NA	NA	1,030	16,371
Nkhatabay	2,390	21*	NA	806	14,062
Nkhotakota	1,674	21*	NA	872	12,706
Nsanje	3,708	NA	NA	1,781	20,051
Ntcheu	*6,297*	*21**	*NA*	*2,220*	*33,910*
Ntchisi	905	NA	NA	351	6,545
Phalombe	*4,813*	*15,140*	*7,570*	*2,627*	*27,600*
Rumphi	1,142	21*	NA	731	8,592
Salima	4,331	23*	NA	1,164	16,101
Thyolo	*10,044*	*NA*	*NA*	*3,968*	*38,881*
Zomba	*19,360*	*24,276*	*12,138*	*4,770*	*58,931*
TOTAL	**185,209**	**188,072**	**85,927**	**64,582**	**838,029**

* Asterisked figures are technical assistance facilitated services to vulnerable children and their households by US Peace Corps volunteers. These figures are minimal as it represents OVC and/or households in the sites of Peace Corps' volunteers' location.

Figure 4.1.2 OVC, PLHIV and Pediatric ART by District



4.2 Priority population prevention

The NSP and GF CN highlight specific priority populations and community packages needed to address epidemic drivers and the care cascade. Reponses need to be strategic to support 90/90/90 targets and continued risk reduction through efficient and effective integrated approaches. Nevertheless, limited GF resources necessitate sustained PEPFAR leadership in developing national standards and providing evidence based approaches to achieve scale.

In COP 15, tightly focused core community packages delivered in Saturation sites will strengthen priority population demand for and linkages with condoms, FP, HTC, PMTCT, VMMC, and ART. Interventions will also promote and increase demand for community-based HTC and other HIV related services; treatment literacy and adherence; and positive, health, dignity and prevention (PHDP) activities through age-appropriate PLHIV support groups. Community volunteers and expert clients will promote and distribute condoms, provide tracked referrals to HIV and impact mitigation services, and conduct household visits. Community-wide mobilization of traditional and faith leaders and structures will

address damaging gender norms and practices that impact on risk behavior, service uptake, disclosure and retention.

Despite high HIV prevalence, risk profiles and vulnerability, specific populations, including sex workers, MSM, and AGYW face barriers to public health care facilities due to structural barriers or stigma. The NSP and Global Fund Concept Note (CN) highlight the need to reach these groups with targeted approaches and *safe* non-stigmatizing services. Incarcerated populations also require targeted approaches.

Adolescent girls and young women (AGYW)

Recent studies confirm the need to strengthen targeting of service packages designed for high risk Adolescent Girls and Young Women (AGYW), aged 15-24. A national Youth Friendly Health Services (YFHS) evaluation (2014) identified gaps in YFHS coverage and barriers to effective utilization[11]. HIV-infected young mothers are more likely to be lost to follow-up (Tewa et al 2014). PEPFAR will expand integrated HIV/FP YFHS in high burden urban areas using outreach and social franchise sites, provide peer support through youth clubs, and increase teen clubs for older children and adolescents living with HIV. Community platforms will provide vulnerable adolescent girls and households with integrated prevention, impact mitigation and community care activities. ACT resources will expand testing to identify HIV-positive adolescents and households, and link them into HIV care services in 10 districts. The DREAMS initiative will provide additional resources and strategic vision to reach the most vulnerable AGYW in three districts through layered prevention and impact mitigation strategies. Complementary community-wide approaches will reach high-risk male partners with expanded HTC, linkage to care and VMMC.

Key populations (KP)

Despite increased emphasis on reaching KP for treatment and prevention within the NSP and GF concept note, GF resources are limited, so PEPFAR technical leadership is critical to reaching these population groups. Definitive KP size estimations remain challenging. Recent studies estimate 38,000 MSM and 12,000 sex workers, which are lower than previous estimations and regional modelling. Also noted in the studies were high HIV prevalence, risk behavior, and low ART coverage and condom use. Recent consultations also highlighted legal restrictions, such as criminalization of consensual same sex intercourse, are stigmatizing and affect service utilization.[12]

Data gaps will be addressed with GF and PEPFAR resources. COP 14 resources support a rapid assessment currently underway within the five prioritized PEPFAR sites to refine district size estimations, gaps, and strategies. Core KP service packages will use strong peer networks and trusted providers to provide intensive services including HTC, STI screening and treatment, GBV post care, FP, condoms and

11 Evaluation of Youth Friendly Health Services in Malawi Report (2014) by Evidence to Action (E2A) for Strengthened Reproductive Health and Centre for Social Research, University of Malawi, USAID

12 Consultation Report for KP 2014

lubricant as well as risk reduction counselling. A dual approach to provide services in safe spaces, and build capacity of public health care providers will be implemented to address short-term needs for KP responsive services and transition to longer-term integrated public service delivery. USG will support government with national Standard Operating Procedures, and effective service delivery models. District mapping and robust tracking of the KP service package delivered will support program implementation. Targets for treatment and care are reflected under adult ART section.

Prisons

Prisoners are the first priority population to have had Treatment as Prevention (TasP) approved by the MoH ART/PMTCT TWG due to high HIV prevalence and challenges in primary prevention including condom provision. PEPFAR is working with Prison Health Services to standardize prison-specific M&E tools and services, including routine testing at entry; retesting according to the high-risk category in the HTC guidelines; universal ART eligibility for those who test HIV positive, and TB screening, diagnosis and treatment. To strengthen linkage systems between the prisons and ART clinics, upon release, prisoners on ART and TB treatment will indicate which treatment clinic they want to be formally transferred to and these referrals will be monitored. The feasibility of tracing the referral and providing intensified adherence and retention interventions for newly released prisoners will be explored in COP15. Targets for treatment are reflected under adult ART.

Condom programming

Increasing national condom availability and utilization remains core with a particular emphasis on addressing low and inconsistent condom use by key and priority populations. Annual consumption was reduced at 31 million and recent studies report continued trends in low condom use at last risky sex with increased unprotected anal sex among MSM (1.5%).[13] Low condom availability, misconceptions and gender inequalities contributed to low and/or inconsistent condom use. While condom stock-outs are reduced, supply chain management challenges remain. In COP14, PEPFAR supported condom social marketing and free distribution played a critical role in expanding the total market approach.

USG will continue procurement and distribution of condoms for community-based distribution in the 14 focus districts and lubricant for KP to address gaps identified in the GF concept note. New activities will support condom social marketing in urban areas and hot spots to increase targets to 18 million condom sales, community-based condom distribution and focus on national and local efforts to strengthen and improve the sustainability of the national condom program and the supply chain.

4.3 VMMC

Although VMMC remains a core activity in our core/near core exercise, current COP resources remain inadequate to achieve significant impact in the PEPFAR VMMC focus districts without additional central

13 BSSS 2014, MSM size estimation study (2014)

funding. COP 15 funds will only support DSD for VMMC services in the military program, and will transition to a TA model for supporting the MoH in implementing the Global Fund and World Bank (WB) supported programs.

GoM has included VMMC services in all strategic documents, with plans for significant program expansion in 2015–2019. In part due to PEPFAR's technical assistance and advocacy on the issue, the GoM has endorsed an ambitious VMMC scale up for 2015 - 2020. With reduced PEPFAR funding, WB investments of $23.1 million over three years will further support VMMC scale up in all district hospitals and through saturation in the remaining nine VMMC priority districts to achieve 241,200 circumcisions. WB support will also provide training, equip health facilities, procure commodities and generate demand.

In this TA model, PEPFAR will provide ongoing support for service delivery improvement including training of VMMC service providers; clinical mentoring and supportive supervision of HCW at VMMC sites; support of VMMC service-related data collection, reporting, data quality assessments (DQA); CQI/EQA of VMMC services at point of service delivery; and commodities consumption forecasting and supply chain management support.

Positive Prepex study outcomes have led to VMMC TWG endorsement of device use. Procurement of Prepex for active surveillance will be included in plans after formal MoH approval. PEPFAR Malawi will provide TA to MoH for rolling out of EIMC.

4.4 PMTCT

Since 2011, Malawi implemented Option B+ strategy: universal eligibility for lifelong ART for HIV positive pregnant and breastfeeding women. The number of newly infected infants was estimated to have decreased by 67%, from nearly 23,000 in 2009 to 7,405 in 2013. This strategy coupled with rapid decentralization and high ANC attendance rates dramatically accelerated PMTCT scale up and ART coverage increased from around 30% in 2010 to 75% in 2013. With rapid increase of ART coverage among HIV positive women in the reproductive age range, 47% of women in need of PMTCT are already on ART when getting pregnant.

Despite high coverage of testing (80%) through PITC, early ART initiation (75%) and retention of HIV positive pregnant women (73% after 12 months), the performance of the care cascade needs to improve. 123,621 women were not tested in 2013, missing a potential 9,889 HIV positive women that year based on an 8% positivity rate. A further 3,935 HIV positive women were not initiated on treatment, and another 3,190 were not retained after 12 months -total estimated 17,014 missed positives that year. Further gaps are seen in diagnosing and treating infants of HIV positive mothers and other children within their families and few of their partners are ever treated because of high remaining levels of stigma. There is a high loss to follow-up of both mother and infant pairs and missed opportunities for identifying unknown HIV positive pediatric cases. Low male engagement impacts identification of unknown positive male partners for HIV- pregnant women, HIV+ women's willingness to initiate treatment and adherence due to fears of disclosure, GBV or abandonment. Other key systems gaps to be addressed include shortage of HRH, infrastructure challenges within ANC which affect quality and confidentiality of HIV service delivery as well as storage of commodities and delays in diagnosis due

to long turnaround time for DNA PCR. Increased access to family planning for both HIV+ and HIV negative females is another important strategy to support PMTCT outcomes.

Community responses need to increase identification of all pregnant women and families at risk through targeted demand generation/gender normative change, provide effective linkages through tracked referrals and support defaulter tracing (in collaboration with treatment partner efforts). Priority populations – young mothers, OVC households, and sex workers may need additional strategies to improve access and effective linkage to services.

In COP 15, USG will strengthen core PMTCT services, including HIV case identification, provision of quality clinical services, linkages and retention systems. Interventions will be targeted to address key PMTCT service delivery bottlenecks identified during site assessments (quarterly supportive supervision, SIMS, SMS and SQA visits). These include:

- Hiring and training dedicated HTC counselors for Scale Up districts to increase access to routine PITC in Maternal, New Born and Child Health (MNCH) settings, including repeat testing after delivery and during immunization clinic visits for mother infant pairs. To increase HTC uptake of family members, referral slips and targeted community based HTC will be conducted. The dedicated HTC counsellors will also perform syphilis rapid tests in ANC.
- Supporting implementation of HTC quality assurance including confirmatory HIV testing for all HIV positive pregnant and breast feeding women before initiation of ART.
- Deploying mentor mothers to improve PMTCT service uptake and retention.
- Supporting the implementation of SOPs for EID.
- Improving M&E systems and performance monitoring.
- Establishing model PMTCT and HIV-MNCH integration sites in Saturation sites
- Funding and providing technical support for in-service training, mentoring and supportive supervision.
- Renovating health facilities to increase clinic space and storage capacity.
- Supporting young mothers' access through expansion of trained YFHS providers within targeted public health care facilities, social franchise and outreach service platforms, and targeted young HIV+ mother care groups.

To complement COP funded PMTCT activities, Malawi will receive additional resources from the ART/ PMTCT and DREAMS central initiatives. DREAMS focuses on prevention of new HIV infections among adolescents and young women. Both of these initiatives will complement PMTCT activities funded through the COP. The PMTCT/ART integration funds focus on implementing site-level quality improvement activities that will help to identify critical bottlenecks and develop remedies with the aim of optimizing enrollment, retention, viral suppression and reduction of MTCT. DREAMS funded activities will bring increased focus on AGYW to reduce HIV vulnerabilities and unintended pregnancy as well as increase access to key HIV services including FP, HTC,STI, post GBV care, and treatment.

4.5 HIV Testing and Counselling

PEPFAR Malawi has a strong strategy for high-yield, high-volume HIV testing to meet the 90/90/90 targets in Saturation sites. The national HTC guidelines are currently under review and aligned with the goals stated in Malawi's NSP, which aims to meet the UNAIDS 90-90-90 goals by 2020. HIV testing for high yield returns will be the main focus as highlighted in these two strategic documents and delivered through a strategic mix of facility and targeted community based models. During the COP14 pivot, PEPFAR Malawi developed a PITC strategy relying on recruitment and secondment of lay counselors. Although Malawi adopted the PITC policy in 2010, its implementation has been suboptimal. This is due to HRH constraints where Health Surveillance Assistants (HSAs), responsible for HTC, have multiple roles at facility and community level where provision of HTC services also takes a lower priority to vaccinations and other primary health care services. The MoH HIV and AIDS Department has advocated for a special cadre of HTC counselors to scale up PITC and PEPFAR is committed to addressing this need.

Increasing HTC coverage, yield, quality and referrals are top priorities in order to reach the targets under the first 90 of the 90-90-90 goals. PEPFAR Malawi will continue to increase HTC coverage by demand generation; community activities; facility-based testing; site, district and national level quality monitoring. HTC service delivery points will be increased within the Saturation sites in the Scale Up districts. Expansion of PITC will continue in ANC, maternity, STI clinic, TB wards, in-patient wards, NRU, OPD and under five clinics. Implementing partners will recruit and train more HTC counselors (known as HIV diagnostic assistants or HDAs) to ensure consistent availability of HIV testing in strategic services delivery points. Those testing HIV positive will be given referral slips for family testing to increase high yield testing of family members and other sexual partners. Client initiated HIV testing and counseling will continue to take place at HTC sites.

The Saturation sites will implement a three tiered approach for family index testing which include use of referral slips, followed by SMS reminders, and then home visits or community testing with the index client's consent. Targeted high yield community based testing will be conducted in hot spots, work places, communities, households, schools, orphanages, Youth Friendly Health Services, and prisons to reach other key and priority populations. Bidirectional referral between facilities and community will be strengthened through the expert clients to improve linkage to testing, care and treatment among the key and priority populations. Linkage of identified HIV positive to care and treatment services will be strengthened through use of expert clients and referral slips.

The COP 15 target for HTC is 3,148,354, almost double the number reported during APR 14 and even higher than the national target as indicated in NSP. At this time the MoH states that the number of Rapid Test Kits (RTK) is sufficient for the scale up. Other challenges that PEPFAR Malawi anticipates with this HTC saturation include infrastructure, as most health facilities do not have adequate space for increasing the HIV testing points within the health facility. PEPFAR Malawi is considering innovative ways to increase space for HTC services like minor renovations/refurbishment of the existing infrastructure, procurement of repurposing containers and tents. Other programs areas like VMMC, PMTCT, ART and dedicated KP and youth services will contribute to the HTC numbers.

A renewed emphasis on quality assurance and quality control for HTC is imperative as PITC rapidly scales up. According to the national guidelines, all HIV testers are supposed to undergo a proficiency test (PT) twice a year. PEPFAR Malawi will work with MoH National reference laboratory and implementing partners to ensure that PT panels and quality control materials are distributed to the testing sites and that SOPs for HTC are available in all testing sites.

PEPFAR Malawi also supports national quarterly supervision of the MoH team to selected HTC sites per quarter to monitor the quality of testing and conduct session observation of HTC. In 2014, Malawi joined the Rapid Test Quality Improvement Initiative (RTQII) which is currently in 5 districts will be further rolled out to one more district within COP 14 implementation. National reference laboratory will provide stewardship of national coverage of RTQII in collaboration with the laboratory partner; and district implementing partners at facility level.

4.6 Facility and Community Based Care and Support

In the Scale Up districts, all PEPFAR service delivery partners will implement a standardized package of DSD interventions. Core interventions include HTC, CPT, IPT, ARVs, management of OIs, viral load testing. In line with the 90-90-90 strategy, facility and community based packages will include evidence based interventions to improve treatment outcomes and address service delivery bottlenecks:

- Increasing access to HTC through PITC, targeted community based testing and deployment of dedicated HIV counsellors to address staffing gaps
- Scaling up quality assurance and quality improvement interventions (supportive supervision, clinical mentoring) to ensure priority prevention, care and support interventions are provided consistently and according to the national HIV guidelines.
- Strengthening linkage and retention systems, including engagement of expert clients to increase access to HIV testing, ART eligibility assessment, adherence counselling and defaulter tracing
- Strengthening bi-directional facility-community referral systems to support community based prevention, treatment and care models, supported by engagement of Community Health Workers, support groups and CBO along the care continuum.

4.7 TB/HIV

In COP 15, PEPFAR Malawi will focus on the core TB/HIV activities aligned with the TB National Strategic Plan goals to reduce both the TB related mortality and TB/HIV prevalence by 50% from the 2014 baseline by the end of 2020. These include providing integrated TB/HIV services and improved case finding and management through:

- Routine and enhanced TB screening of PLHIV and linkage of patients screening positive to diagnostic services.
- Hiring and training dedicated HTC counselors to increase access to routine PITC for TB patients in Scale Up districts.

- Increasing early ART and TB treatment initiation for co-infected patients.
- Supporting the implementation of SOPs for TB/HIV integration.
- Improving M&E systems and performance monitoring.
- Establishing model TB/HIV integration services at high volume sites in Scale Up districts and high volume prisons
- Funding and providing technical support for in-service training, mentoring and supportive supervision to provide preventive and curative TB services, including isoniazid preventive therapy (IPT).
- Renovating and equipping health facilities to improve case finding, patient flow and infection control
- Increasing access to TB diagnostic services. 40 LED microscopes and 10 GeneXpert machines will be procured. Linkage to GeneXpert platforms will be strengthened through sample transportation systems scale up and improved turnaround times
- Secondment of technical staff to the MoH to address capacity gaps for program management, commodity security and supply chain, M&E.
- Institute FAST approach for MDR TB clinics, prisons and rapid scale up ART clinics

The bulk of TB resources have been from Global Fund grants and continued funding is critical for an effective TB response. Integration of the TB/HIV programs is expected to streamline and improve management and implementation of activities including commodity procurement systems. Decentralization of TB/HIV services and TB infection control are priority activities for PEPFAR support.

4.8 Adult ART

Currently there are approximately 400,000 HIV positive adults that are not yet on treatment. According to the most recent MoH quarterly report, the 12-month retention rate is 78%, well below the WHO target of 85%. Close to a third of ART patients are started in either WHO stage 3 or 4.There is limited data on treatment coverage among key populations. In many facilities, SIMS visits revealed absence of standardized, functional defaulter tracing systems. Viral load monitoring is not done consistently for all ART patients that reached their VL monitoring milestones. For PHDP, most sites scored over 50% red or yellow during SIMS because the national M&E systems do not require routine documentation of all PHDP interventions on the paper based tools.

PEPFAR Malawi aims to initiate 173,090 new patients in FY 16 and support a total of 653,107 patients on treatment by APR 16, an increase of 45% from APR 2014. The PEPFAR program will focus on increasing ART coverage by targeting geographic locations and population groups with the highest unmet need for ART. As part of the comprehensive intervention package, special focus will also be made on diagnosing and treating specific key and vulnerable populations.

In COP 15, USG will strengthen core care and treatment services, including early ART initiation, provision of quality clinical services for OI management, linkage and retention. Interventions will be targeted to address key care and treatment service delivery bottlenecks. Interventions include:

- Strengthening enrollment into care and early ART initiation in Scale Up sites; expanding access to CD4 monitoring, building providers' clinical competence, and facilitating linkage across services.
- Recruitment and deployment of lay providers for linkage optimization and improved access to core HIV services.
- Scaling up sample transportation systems, HIV diagnostic support, with focus on CD4 and VL monitoring and TB.
- USG will implement targeted service delivery approaches to expand treatment access for key and vulnerable populations.
- Improving site-level M&E systems and performance monitoring.
- Establishing model ART clinics at high volume Scale Up sites
- Renovating health facilities to increase clinic space and drug warehousing capacity [14]
- Improving care and treatment service delivery through the implementation of QI interventions.
- Supporting Scale Up and Sustained sites to implement an active defaulter tracing system. Lay workers such as expert clients will play a central role in intensive post-test counseling, disclosure support, routine and targeted adherence counseling and defaulter tracing.
- Strengthening viral load monitoring through technical support to develop a national strategic plan for scale up of VL monitoring, clinical mentorship, supporting a viral load center, scaling up of sample transportation systems and EMRS VL module to improve clinical compliance.
- Procuring laboratory clinical monitoring commodities to complement the GF investment.
- Continuing funding for the national HIVDR survey.
- Providing training, supervision, and clinical mentoring to improve provision of comprehensive care and treatment services, monitoring of ARV side effects, monitoring treatment failure, implementing family centered and chronic care models, bidirectional facility community referral system to strengthen the care and treatment continuum.
- Continuing secondment of technical staff to the MoH to address capacity gaps for program management, commodity security and supply chain, M&E.
- Implementation of alternative and innovative service delivery models to mitigate the growing patient volumes and increase access for key and vulnerable populations, including prisoners
- Optimizing the National EMRS by extending its functionality as a point-of-care decision-support tool, for improving patient flows, for linkages and patient transfers and for facility-based QI programs. Modules have been developed for the cascade in ART, OPD, ANC, HTC/EID settings and for pharmacy stock status reporting.
- Strengthening coordination with communities, CBOs, FBOs and community health workers for awareness, stigma reduction and demand creation for ART services.

ARVs needed for the Malawi treatment program are largely procured using Global Fund resources. In COP15, PEPFAR will procure ARVs worth $6.6 million to meet the increased demand expected as a result of the PEPFAR acceleration in Scale Up districts.

In FY15, PEPFAR Malawi has received $7 million as part of the PMTCT/ART integration (central) funds. Similarly, Malawi is one of the 10 countries receiving DREAMS funding that focuses on prevention of

[14] Using COP 14 funding, 35 Pre-fabricated "Storage units in a box" will be erected. During FY 16, PMI will be building 5 units and PEPFAR has leveraged approximately $6M from DfiD to erected another 75 units during FY 16

new HIV infections among adolescents and young women. Both of these initiatives will complement adult treatment activities funded through the COP.

4.9 Pediatric ART

With the implementation of Option B+, the number of children infected through MTCT (including during the breastfeeding period) has declined by 66% (from 30,000 in 2010 to 10,000 in 2014). Pediatric care and treatment is provided at all ART sites. The number of children receiving ART has increased from 35,887 in 2012 to 42,220 in June 2014.

Malawi will receive additional funding through the ACT Initiative and plans to double the number of children receiving treatment by the end of FY 2016.

In COP 15, USG will strengthen core care and treatment services for pediatric HIV, including early ART initiation, provision of quality clinical services for OI management, linkage and retention systems. Interventions will be targeted to address key care and treatment service delivery bottlenecks identified during site visits. These include:

- Improving clinical management and monitoring of children and adolescents with HIV through supervision, clinical mentoring, QI and EMRS module enhancements
- Monitoring and improving the performance of the diagnostic cascade for EID and older children.
- Improving the availability of basic equipment for routine growth monitoring and nutritional assessments, strengthening linkage and referral systems to therapeutic or supplementary feeding support and building provider capacity to provide counselling on infant and young child feeding (IYCF).
- Strengthening adherence support will include services for adolescents living with HIV, including teen clubs for adolescents on ART.
- Supporting community based structures to improve facility-community based linkages across the care continuum.
- Recruitment and deployment of lay providers for linkage optimization, improved access to core HIV services and to improve family and adolescent adherence counselling
- Scaling up sample transportation systems, with focus on EID, VL monitoring and TB.
- Improving M&E systems and performance monitoring.
- Establishing model pediatric ART clinics at Saturation sites
- Renovating health facilities to increase clinic space and drug warehousing capacity.
- Strengthening bidirectional facility community referral systems to reduce attrition along the care and treatment continuum. This will include integration with other childhood health programs, e.g. EPI and IMCI and to improve early case identification and referral to health facilities[15]
- Supporting sites to implement an active defaulter tracing system.
- Continuing funding for the national pediatric HIVDR survey.

[15] Bhalakia, A. et al., One-Year Outcomes Of HIV-Infected Malawian Infants Started On Antiretroviral Therapy In The Hospital Setting, 2014 Link to: http://pag.aids2014.org/EPosterHandler.axd?aid=6567

- Secondment of technical staff to the MoH to address capacity gaps for pediatric HIV.

PEPFAR has supported the MoH to optimize the national pediatric ARV formulary. Funding flows from the GF interim funding mechanism and transition to the new funding model may affect pediatric HIV service delivery and attainment of PEPFAR treatment targets if the supply chain is negatively affected by delays in approvals or disbursements. Given the accelerated treatment strategy over the next two years, provision has been made within the ACT initiative to address any scale up in pediatric ART coverage not projected by the national program.

4.10 OVC

Malawi has 1.4 million children affected by HIV/AIDS, accounting for 9% of the total population and 17% of the population of all children (2008 National Population Census projection for 2015); of this, 770,000 have been orphaned due to AIDS-related deaths (UNAIDS, 2012). In FY16, given the OVC earmark and emphasis on core and near core interventions (see Appendix A.2), PEPFAR Malawi will provide services to OVC and their households to ensure their well-being and provide them with double benefits of HIV prevention and impact mitigation. Utilizing PEPFAR and GoM guidance documents for OVC program, activities will focus on evidence-based interventions across five domains: case management (identifying/developing customized interventions for OVC households); healthy (access to health/HIV services, psycho-social and mental health interventions); safe (child Protection/GBV, positive parenting); stable (economic strengthening, social protection access and support); schooled (education).

In addition, PEPFAR will provide system-level support to strengthen GoM system and structures, social workforce development, policy and case management. Working with communities, PEPFAR will leverage new and existing mechanisms, and other initiatives - DREAMS and ACT. Interventions will focus across other service platforms to promote HTC and linkage of HIV-infected children and adolescents to care and treatment services. PEPFAR will also collaborate with other development partners through new and existing programs to provide services to hard-to-reach populations of vulnerable children requiring alternative care, e.g. children in institutions, children with disabilities and street children. For COP15, direct service delivery OVC activities will be aligned with care and Saturation sites located in eight districts. USG will provide technical assistance in core and near-core activities in 17 districts through its Peace Corps Volunteers.

In COP15, USG Malawi will roll out the MER 1.5 Essential Survey for OVC program. Through Project SOAR FIELD Support, baseline will be established in a new award (to be made out late COP14/early COP15) to document the status of OVC households prior to interventions. The outcome of the interventions on the beneficiaries will be measured every two years, going forward.

5.0 Program Activities to Support other Locations and Populations outside of Scale Up districts

5.1 Service packages for other locations and populations

In COP15, the PEPFAR Malawi program will have 108 Sustained sites. These sites will receive a package of interventions focused on maintaining current ART expansion rates and improving adherence and retention. District and site-level quality monitoring systems will be implemented including SIMS, regular site supervisions and district program reviews. A key difference between Saturation and Sustained sites will be the absence of PEPFAR investment for active case finding in the latter. Hence, ART expansion will be based on passive enrollments as opposed to scaled-up high yield facility and community testing strategies.

The components of the package at Sustained districts and sites are:

In-service training – IPs supporting training at priority sites will work directly with the DHOs to implement. There will be no prioritization of supported site staff over centrally supported site staff, as trainings will be planned in a way which saturates each district and ensures coverage at sites while staff are in training

Sample transportation – Sample transportation (ST) is critical for EID and VL monitoring. Riders for Health (R4H) is scaling up their ST to national level in COP14, and this system is designed to be implemented at district level: all sites within a given district will be on an established schedule for at least weekly sample collection. The national cost of implementing ST is already shouldered by PEPFAR, and will be maintained in COP15

National Quarterly Supervision – The MoH has been directly supported since 2009 to implement this national exercise. The data which is validated and collected at each site during supervision is critical to ensuring that minimum quality standards are maintained, and ensuring that sites in need of urgent clinical mentoring are visited by a team

Rapid Response Clinical Mentoring – Sites identified during supportive supervision as having one or more areas of sub-standard performance will be visited by an IP clinical mentoring team. There are estimated 15-30 sites each quarter which will need this response, which provides key support to the national program and adds minimal additional expense and clinician time to the PEPFAR IPs.

5.2 Transition plans for redirecting PEPFAR support to other locations and populations

Direct Service Delivery: After the COP14 pivot in August 2014, the process of implementing changes became very complex and mired in political sensitivities nationally. These challenges were resolved after multiple meetings between the PEPFAR team members and the Ministry of Health leadership and DHA, and concluded with a meeting in March 2015 which involved all service delivery IPs and DHA. The final 'pivot' details of Saturation sites selected for intensive support, and standardized service delivery package components were also subsequently finalized through an iterative process between DHA and

PEPFAR TWGs. Peace Corps Health volunteer placements were realigned during FY2015 to correspond with communities surrounding high priority sites.

IPs have been given the COP14 implementation year to modify the intensity of support in Sustained districts, where facility level activities will center around adherence and retention of patients on ART and continued support to national level quality assurance activities.

The performance of those districts and sites which are shifting to centrally supported status will be monitored by IPs and DHA. If a situation emerges in which sites encounter challenges in providing quality HIV services, with a focus on adherence and retention after transitioning, the PEPFAR team has agreed to hold further discussions with the MoH team to review the level of support needed ensure minimum service delivery quality standards are maintained.

Orphans and Vulnerable Children: Previous Orphans and Vulnerable Children programs of USAID/Malawi were designed taking the HIV prevalence and OVC burden into consideration. Two of the major interventions closed out in FY14 while the nutrition-focused program will close out in FY15. With PEPFAR 3.0's focus on integrated programming with measurable outcomes for impact, USG new award and plans target programs in and around facility-based interventions. USG/Malawi uses sites as its sub-national unit for care and treatment program, prioritizing 413 health facilities, spread across all 28 districts. Two hundred and twenty four of these prioritized sites are located around the eight priority community programming districts, with OVC services planned out within the sites. Other OVC interventions especially being implemented by US Peace Corps volunteers will continue in catchment communities of the Saturation sites in 12 districts. There are no ongoing OVC interventions in the remaining eight districts (ref. Table 4.1.8).

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Non-priority Sites

Transition Volume by Group	Expected result APR 15	Expected result APR 16	Percent increase (decrease)
HIV testing in PMTCT sites	*	81199	NA
HTC (only maintenance ART sites in FY 16)	*	329574	NA
Current on care (not yet initiated on ART)	*	61640	NA
Current on ART	*	57995	NA
OVC	*	NA	NA

**COP 14 targets were not set by site so we are unable to calculate the Expected results in APR 15.*

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

In COP14, PEPFAR maintained its focus on strengthening the laboratory infrastructure in Malawi to support scale–up of the ART programs. In COP 15, the laboratory focus will be tailored to intensively support the pivot, expanding sample transportation and lab capacity to bring VL monitoring to all ART sites.

PEPFAR will conduct an evaluation of the national public health laboratory system network to assess the infrastructure and equipment and determine the potential need to enhance not only facility performance but to improve the capabilities of the whole system. Priority will be given to performing minor renovations and equipping within the Scale Up districts. PEPFAR will also equip the prioritized laboratories with the capacity for patient monitoring (Chemistry, Hematology and CD4) and opportunistic infection diagnosis.

PEPFAR will improve quality by supporting the central reference laboratory to produce and distribute dry tube samples (DTS) for proficiency testing and quality control for HTC. PEPFAR will develop capacity for Malawi to develop a TB microscopy external quality assurance program. Laboratories will also be assisted to enroll on GeneXpert and CD4 EQA programs. All clinical laboratories will be maintained or enrolled on the SLMTA program and PEPFAR Malawi will continue to expand the Rapid Test Quality Improvement Initiative (RTQII).

PEPFAR will achieve national coverage of Sample Transportation (ST) in the COP15 implementation period and will aim to maintain the system for maintenance and high priority site while optimizing the number of visits to the high priority site as needed. ST is strategically important for the scale up of early infant diagnosis (EID), viral load monitoring (VL) and GeneXpert MTB RIF for HIV positive presumptive TB patients. PEPFAR will also continue to support diagnostic platform maintenance contracts, training of laboratory, nursing and clinical staff as well as procure specimen collection materials and other laboratory consumables as contributions towards the scale up these programs.

In order to improve the availability of laboratory data, PEPFAR Malawi has invested in a standardized paper-based system for all laboratories and has distributed it to all testing facilities. A pilot for Laboratory Information Management Systems (LIMS) in 2 laboratories is currently underway. The results are to inform how the LIMS system will be rolled out to all district level and central level facilities in COP 14 and COP 15. Once rollout is completed, PEPFAR will ensure there is interface and intra-operability with other existing data systems including EMRS, HMIS and IHRIS.

As part of a long-term plan to improve HR in laboratories, PEPFAR will fund 25 Diploma level scholarships. In the short term, PEPFAR will support salaries for 3 Technical Assistants at the Diagnostics Department and Central Reference Lab to steward national Quality Improvement/Quality Assurance (QI/QA) programs and assist with diagnostic aspects of USG funded surveillance and other studies. PEPFAR will also support up to 10 SLMTA mentors to assist with the QI/QA programs at facility level.

PEPFAR will assist the Ministry of Health in providing reagents, in-service training and technical assistance to Mzuzu Tuberculosis Laboratory and the Central Tuberculosis Reference Laboratory in

performing referral microscopy, culture and sensitivity. PEPFAR will continue to support the Malawi Blood Transfusion Services to achieve access to safe blood transfusion for Malawian patients.

Table 6.1.1 COP deliverables and contribution to epidemic control

Brief Activity Description	Deliverables		Budget codes and allocation		IM ID number	Relevant Sustainability Element and Score	Impact on epidemic control				
	2015	2016	2015	2016			HIV Testing	Linkage to Care (LTC)	ART up take	*Other Combination prevention	Viral suppression
Lab Infrastructure	Complete and equip 5 district laboratories, increase Viral Load high throughput machine testing sites to 8	Conduct an evaluation of the national public health laboratory network in terms of infrastructure and equipment. Prioritize 3 for renovations and equipping. Buy equipment for patient monitoring and opportunistic infection diagnosis	HLAB: 800,000	HLAB: 500,000	17949	1.1 Epi and Health Data (11/20)	X	X			X
Lab QI/QC (SLMTA, HTC PT)	Support the central reference laboratory to produce and distribute Dry tube samples for proficiency testing for. Enroll labs with GeneXpert on EQA. Support SLMTA	Support the central reference laboratory to produce and distribute Dry tube samples for proficiency testing for HTC and slides for TB microscopy. Enroll labs with GeneXpert on EQA. Support SLMTA, expand RTQII	HLAB: 900,000	HLAB: 450,000 HTXS: 500,000 HVTB: 300,000 MTCT: 350,000	17949 12111	1.1 Epi and Health Data (11/20) 2.6 Commodity Security &Supply Chain (9.7/20)	X	X			X
Specimen Transportation	Maintain specimen transportation in 15 districts and enroll a further 12 districts for full national coverage	Maintain the National coverage of Specimen transportation and standardize transportation of samples between district facility and central testing facilities	HLAB: 600,000	PDCS: 1000,000 HTXS: 1000,000	17949 14113 16678 12105 12638 12107	2.6 Commodity Security &Supply Chain (9.7/20)					X

Brief Activity Description	Deliverables		Budget codes and allocation		IM ID number	Relevant Sustainability Element and Score	Impact on epidemic control				
	2015	2016	2015	2016			HIV Testing	Linkage to Care (LTC)	ART up take	*Other Combination prevention	Viral suppression
Blood Safety	Support the Malawi Blood Transfusion services in expanding access to safe blood transfusion	Support the Malawi Blood Transfusion services in expanding access to safe blood transfusion	HMBL: 1,760,000	HMBL: 1,000,000	10427						
LIMS	Standardize the paper-based system and distribute to all testing facilities. Implement a pilot for Laboratory information management systems for 2 laboratories. Ensure interface with existing VL LIMS, EMRS and HMIS	Rollout the LIMS system to all central hospitals and district hospitals.	HLAB: 600,000	OHSS: 450,000	17949 1442 12111	1.1 Epi & Health data					
Technical assistance	Support salaries for 1 Technical assistant at Central reference Laboratory and 1 Technical assistant at Kamuzu Central Hospital.	Support salaries for 3 Technical Assistants and diagnostics and Central reference lab to steward national QA/QI and surveillance support. Support salaries for SLMTA mentors	HLAB: 100,000	HLAB: 350,000	17949						
Reagents	Supply reagents for HIV patient monitoring including, CD4, Viral load (backstop measure), Haematology and Chemistry.	Supply reagents for HIV patient monitoring including, Viral load (backstop measure), Haematology and Chemistry.	HLAB + HTXS + PDCS: 250,000	HTXS: 500,000	17949 14441 12111	2.6 Commodity Security & Supply Chain (9.7/20)			X		X

6.2 Strategic information

In COP15 Malawi will continue to fund strategic information activities that will include HIV drug resistance, birth defects surveillance activities (as required by OGAC under COP 14) and support for site-level M&E, and data quality assessments. Analysis of the Sustainability Index revealed that Malawi is performing well in regard to performance data however this was attributed to the routine quarterly supervision system which is funded by PEPFAR. This financial and technical support for the routine MoH quarterly supervision system will be maintained and further improved through iteratively linking partner clinical mentoring data with quarterly site performance data. With the introduction of the POART and the quarterly reporting, systems will need to be established to increase the MoH data collection, cleaning and analysis. In COP15 we will continue to provide support to the Ministry of Health Department of HIV and AIDS and will increase technical assistance to ensure surveys are taking place at scheduled regular intervals. The birth defects surveillance will use pipeline funds, so does not have any allocated any funds in COP15.

Table 6.2.1 Strategic Information activities to achieve sustained epidemic control

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Continue to support coordination of surveillance and research activities	birth defects and HIVDR surveillance projects initiated	birth defects and HIVDR surveillance projects successfully implemented	HVSI 200,000	HVSI	MoH	Epidemiological and Health Data 9.7		x	x		x
Birth Defects surveillance to assess impact of ARVs on the newborns	Report on progress of BD surveillance	Preliminary BD surveillance report	HVSI 0	HVSI		Epidemiological and Health Data 9.7		x			
HIV drug resistance surveillance (transmitted, acquired)	Report on progress of BD surveillance	Surveillance report	HVSI 500,000	HVSI	TBD	Epidemiological and Health Data 9.7			x		x
Data Quality assessments	1 Data quality assessment per IM	1 Data quality assessment per IM	HVSI 92,552	HVSI	TBD	Performance Data 19.5	x	x	x	x	x
M&E Quarterly Supervision	Quarterly supervision reports	Quarterly supervision reports	HTXS: TBD PDTX: TBD MTCT: TBD HVCT: TBD OHSS: TBD	HTXS: TBD PDTX: TBD MTCT: TBD HVCT: TBD OHSS: TBD	MoH PIH, SSDI-Services, Dignitas, Baylor SSDI-Systems	Performance Data 19.5	x	x	x	x	x
One-C baseline survey	Baseline survey report	Routine M&E reports	HVSI: TBD	HVSI	TBD-One-C	Epidemiological and Health Data 9.7 HRH 5.7	x	x	x	x	x
Continue to conduct SIMS visits to Implementing Partners to ensure quality of support provided to sites	Number of sites visited in Q1	Number of sites visited in Q2-4	HVSI 424,837.17	HVSI	M&O	Performance Data 19.5					

6.3 Health System Strengthening

In a multi-country 2014 analysis by Harvard University and the Clinton Health Access Initiative, Malawi was the only country that lacked the basic health systems requirements to scale up HIV Treatment without negatively affecting other health priorities.[16] Malawi has the third lowest GDP per capita in the world[17] and the GoM expends only $7.60 per capita per annum on health[18]. Substantial donor resources bring Total Health Expenditures to $39 per capita per annum, compared to an average of $147 for the Southern Africa region. As a result of such extreme resource constraints, the country's HRH, infrastructure, and Supply Chain capacity are not yet adequate to meet the 90-90-90 goals. Malawi is tied with Niger for 190th among 193 countries with data on physicians per capita and 174 of 189 on nurses per capita.[19] Fifty-two percent of established positions in the health sector are vacant, with substantial gaps at both MoH headquarters and service delivery points. In addition, the majority of health facilities are inadequate to accommodate the increase in patient volume resulting from the country's rapid population growth, together with scale up of HIV testing and treatment. Stockout rates for essential medicines to treat opportunistic infections were as high as 45 percent in the most recent LMIS report.

PEPFAR HSS programming focuses on critical gaps identified in the SID and Core/Non-Core exercise, with HSS funding targeted to sustainable epidemic control through activities where the USG has a comparative advantage. PEPFAR will continue to address the severe HRH gap by providing pre-service training scholarships to HIV Treatment cadres who are bonded to PEPFAR priority sites. These scholarships are complemented by Technical Assistance and volunteer faculty assignments through Peace Corps GHSP[20] program (HOP funded) to improve HRH management including updating HIV/AIDS curricula, improving quality of teaching, and clinical mentorship for students and hospital staff. Technical assistance will also be provided to strengthen the country's new integrated Human Resource Information System, which will allow the MoH to ensure that health workers are deployed to sites most critical to the HIV/AIDS response. PEPFAR further improves HRH performance by funding supportive supervision of pharmacy and clinical staff at PEPFAR priority sites. Supply Chain Management activities will reduce stockouts by improving data use in supply planning through seconding a Supply Chain Management M&E Advisor to MoH headquarters, maintaining the Logistics Management Information System, and providing technical assistance to the national quantification exercise for HIV commodities. In addition, PEPFAR will renovate and expand

16 Harvard University, Clinton Health Access Initiative, Malawi Ministry of Health, Zambia Ministry of Health, Rwanda Ministry of Health, Swaziland Ministry of Health. "The Implications of Treatment Scale-Up Strategies on National Health Systems: Phase II Report to DfID." April 2014.

17 IMF World Economic Outlook 2015.

18 Malawi National Health Accounts 2009-2012.

19 WHO website accessed 1/28/15. Link to: http://apps.who.int/gho/data/node.main.A1444?lang=en&showonly=HWF

20 The GHSP is a collaboration of the Peace Corps, PEPFAR, Seed Global Health to implement a three-year pilot medical teaching and training project in Malawi, Tanzania and Uganda. This public-private partnership addresses critical shortages in qualified health care providers and educators where the need is greatest in resource -limited countries by placing qualified American nurses, physicians, and other health professionals as adjunct faculty in medical and nursing schools. In Malawi they are placed at the University of Malawi - College of Medicine, Kamuzu College of Nursing in Lilongwe and Blantyre and Mzuzu University. These doctors and nurses bring a range of talent, experience and clinical specialties including Pediatrics, Obstetrics/Gynecology, Psychiatry, Infectious Diseases and Internal Medicine. In July 2015, Malawi received its third group of 11 new Volunteers.

infrastructure at high-priority sites to enable HIV Treatment scale up. Where necessary, PEPFAR will place technical advisors and fellows in key offices within the MoH and other affiliated organizations to improve management and performance on PEPFAR-related activities.

The PEPFAR Malawi HSS budget has decreased from COP 14 to COP 15 despite the growing need to scale up system strengthening to support the accelerated treatment program and increased data collection requirements. Strengthening health information systems through the National DHIS 2.0 architecture has resulted in improved electronic transmission, storage and integration of MoH data and information for timely reporting, access and use. However, budget support to HSS must continue, at a minimum, at current levels to improve the efficiency of the supportive supervision to the field and the development of enhanced standard reporting tools for the HIV response and quality improvement programs. Central funding for HSS should be provided to countries to ensure that data collection and the systems required are achieved within the OGAC timeframes.

Malawi lacks official population-based, vital statistics derived from birth and death certificates to support HIV program planning, treatment compliance, mortality measurement and cause of death reporting, and assurances for orphans and vulnerable children. Malawi's Civil Registration Vital Statistics initiative builds upon 2012-2014 OGAC Central Strategic Information funding through which national standards for birth and death notification, registration, and certification were introduced. Benefitting from an existing ART National EMRS investment, the next phase aims to accelerate and scale electronic birth and death systems in HIV high burden sites and manual methods in other facilities and communities.

Non-core HSS activities were transitioned off of PEPFAR support in COP14 or are part of a multi-year transition plan. PEPFAR is working with the GoM, non-PEPFAR USG programs, and other donors to fill this gap where possible.

Table 6.3.1 Health Systems Strengthening activities to achieve sustained epidemic control

Brief Activity Description	Deliverables		Budget codes and allocation ($)		IM ID number	Relevant Sustainability Element and Score	Impact on epidemic control				
	2015	2016	2015	2016			HIV Testing	Linkage to Care (LTC)	ART uptake	.*Other Combination prevention	Viral suppression
HRH: Pre-Service Training of core cadres for delivery of HIV/AIDS services at priority sites, particularly NIMART	• Scholarships for 1083 health workers from cadres required for HIV treatment • Scholarships for ▪ 26 nurse mentors and masters nurse-tutors ▪ 30 faculty in pre-service training institutions ▪ 14 OB/GYN registrars • Training for HCT counsellors • Support curriculum revisions for nursing, medical, and lab cadres	•Graduate approximately • 191 nurses • 83 clinical officers •Sustain the OB/GYN program and complete planning for its transition to sustainability •Deploy 1239 HCT Counselors • Scholarships and bonding for 1184health workers from cadres required for HIV Treatment	OHSS 2508982	OHSS 2503093 HTXS 495000	12131 12119 14113 16678 17451 World Learning 9266 17488 17341	2.5 HRH (11.8/20)	x	x	X (NIMART)	X	x
HRH: Improve operability and use of iHRIS system to track HR resources, estimate needs, and monitor bonding.	•iHRIS system customized to produce vacancy analysis and retirement projection reports •Rapid assessment of system requirements to link iHRIS to in-service training database (TRAINSMART) and incorporate pre-service and bonding data • District and Central Hospital Management Teams trained on operability and application of iHRIS.	•iHRIS utilized to produce vacancy analysis and retirement projection reports •iHRIS system linked to TRAINSMART and pre-service and bonding data incorporated •District and Central Hospital Management Teams mentored on operability and application of iHRIS	HVSI OHSS $50,000 HKID $200,000	OHSS 400000 HVSI	14246 12111	2.5 HRH (11.8/20)	X	X	X	X	
Information: DHIS/HMIS	• 29 District connectivity to National level • Standard Reporting tools • Mobile based version for HMIS/DHIS • Archiving HIV quarterly supervision data, TB, MNCH and other program data. • Village health clinics	•Standard Reporting tools •Mobile based version for HMIS/DHIS •Archiving HIV quarterly supervision data, TB, MNCH and other program data.	OHSS 39,000	OHSS 1462429	12111	1.1 Epi & Health Data (11/20) 1.3 Performance Data (20) 2.7 Quality Mgmt (12.5/20) 4.1 Public Access to information(6/20) 4.2 Oversight & Stewardship(9/20)	x		x		

Brief Activity Description	Deliverables		Budget codes and allocation ($)		IM ID number	Relevant Sustainability Element and Score	Impact on epidemic control				
	2015	2016	2015	2016			HIV Testing	Linkage to Care (LTC)	ART uptake	.*Other Combination prevention	Viral suppression
Information: National Electronic Medical Record System: National Scale-up of HIV high burden, High Yield sites. (Includes ACT funding)	• 6 sites for ANC modules • 30 sites for ART drug monitoring modules • 30 sites for HTC/EID modules • 64 sites for Viral Load modules • 64 sites for maintenance	• 10 sites for ART/OPD • 26 ANC • 26 sites for ART Drug Monitoring Dashboards • 26 sites for HTC/EID • 84 sites for Maintenance • 26 sites for IT Architecture • 94 sites for decision-support tools and enhancements. • 84 sites for EMRS DQA/TQM	1300000	1300000	12111	1.1 Epi & Health Data (11/20) 1.3 Performance Data (20) 2.7 Quality Mgmt (12.5/20) 4.1 Public Access to information(6/20) 4.2 Oversight & Stewardship(9/20)	x	x	x	x	x
Supply Chain/ Commodities: Provide Technical Assistance to MoH, Service Delivery Points, and Pharmacy, Medicines, and Poisons Board to improve pharmaceutical and supply chain management of HIV/AIDS-related commodities	• Logistics system designed for lab commodities, SOPs updated, and data collected, cleaned and validated for national quantification • 480 integrated supportive supervision and peer mentorship visits conducted • TB commodity SOP manual developed, 3 NTP staff trained in SCM, National TB supportive supervision for 120 sites completed, Logistics data collection at all TB registration & treatment sites; TB guidelines updated • Post-marketing surveillance: Reports on quality of pharmaceuticals in circulation disseminated to MoH & USG	• Thirty lab personnel from PEPFAR priority sites trained on LMIS for HIV lab reagents and commodities • Integrated supportive supervision and peer mentorship quarterly visits conducted at all PEPFAR priority sites • National quantification and supply planning workshop including HIV and OI medicines facilitated • Final report of 2016 National quantification and supply planning exercise disseminated to stakeholders • Monthly LMIS report collated, analyzed and shared with stakeholders • Post-marketing surveillance: Reports on quality of STI and OI pharmaceuticals in circulation disseminated to MoH & USG • National Pharmacovigilance Plan developed and costed	OHSS 880,895	OHSS $1,225,981 HLAB 150,000	9266 GHSP (2016) 7166 (2015)	2.6 Commodity Security & Supply Chain (9.7/20) 2.7 Quality Mgmt (12.5/20) 3.11 Technical Efficiency (8.5/20)	X	X	X	X	

Brief Activity Description	Deliverables		Budget codes and allocation ($)		IM ID number	Relevant Sustainability Element and Score	Impact on epidemic control				
	2015	2016	2015	2016			HIV Testing	Linkage to Care (LTC)	ART uptake	.*Other Combination prevention	Viral suppression
Financing: Provide technical assistance to the MoH to increase domestic resource generation and improve accountability for health and HIV/AIDS resource use	Concept note on establishment of health fund submitted to MoH	• Cabinet Paper on establishment of health fund developed and submitted to Office of the President and Cabinet • Cost analysis of systems requirements for ART scale up completed		OHSS $366,784	14246 MSH EGPAF	3.8 Resource Generation (14/20) 3.9 Resource Commitment (0/20)	X	X	X	X	
Civil Society: train and mentor civil society organizations to strengthen capacity to provide HIV Care and Treatment services	• HIV and AIDS care services at community level and community linkages with HIV and AIDS treatment programs at health facility level strengthened by CSO grantees • Organizational Capacity of HIV/AIDS CSOs strengthened	• HIV and AIDS care services at community level and community linkages with HIV and AIDS treatment programs at health facility level strengthened by CSO grantees • Organizational Capacity of HIV/AIDS CSOs strengthened	OHSS Pipeline only	OHSS 200,000 Care & TX 843,000	16716	4.3 Oversight & Stewardship (9/20)		X	X		
Information: Civil Registration Vital Statistics (CRVS)	• Scale up of birth notification/registration/certification in 15 facilities • Scale up of death notification/registration/certification in 18 facilities • Standard Forms and Protocols • Training Materials • CRVS IEC Campaigns • National Vital statistics Report • M&E and response	Scale up of death notification, registration, and certification.	OHSS	OHSS 300,000	17487	1.1 Epi & Health Data (11/20)		x		x	
Leadership/Policy Capacity Building: • Lab Strategy • VL Scale Up • NSP Revision • Bonding and Scholarship Policy	• Health Surveillance Assistant Task-Shifting Guidelines finalized and approved • TA and operational support provided to gender affairs department for management and coordination of gender programming at national level • Develop National Lab Strategic Plan		OHSS $200,000 HTXS $100,000 HKID $100,000	2093082	14246 17341	3.11 Technical Efficiency (8.5/20) 5. 15 Planning & Coordination (14/20)	X	X	X		

Brief Activity Description	Deliverables		Budget codes and allocation ($)		IM ID number	Relevant Sustainability Element and Score	Impact on epidemic control				
	2015	2016	2015	2016			HIV Testing	Linkage to Care (LTC)	ART uptake	.*Other Combination prevention	Viral suppression
Technical Assistance to GoM	Embedded Advisor within National AIDS Commission: • Global Fund's NFM Concept Note strengthened and submitted • National Strategic Plan and National HIV Prevention Strategy finalized Embedded advisors within dept of HIV/AIDS, MoH Planning Directorate, Global Fund, TB program, etc. Supply chain management advisor recruited and seconded to MoH • National supply plan developed for ARVs , OI medicines and other essential medicines Support GoM service delivery sites with top-up pay, local supply chain management, minor renovations, and other short-term gap filling to sustain service at high-priority areas	Embedded Advisor to National AIDS Commission: • Capacity Building Strategy for local organizations developed • HIV/AIDS National Operational Plan developed • Integrated Annual Work Plan developed Embedded supply chain management advisor (PSM) in MoH: • National supply plan developed for ARVs , OI medicines and other essential medicines • MoH/GF PSM plan developed • GF supply chain condition precedents and management actions completed. Embedded HRH Advisor in MoH Department of Human Resources • iHRIS work plan developed and costed and donors coordinated to support implementation • iHRIS utilized to produce vacancy analysis and retirement projection reports	OHSS 705,000	OHSS 1545194	14246 9266 GHSP (2016) 14113 16678 ITECH	2.5 HRH (11.8/20)	X	X	X	X	
Infrastructure/Renovation: renovate and expand PEPFAR priority sites to scale up HIV Treatment and Testing capacity	• 35 prefabricated pharmacy units procured and installed at priority sites • Construction of drug stores for two high volume ART sites • Construction of two ART clinics Minor renovations at 40 Priority PEPFAR sites renovated	• Minor renovations at 30 Priority PEPFAR sites Construction of one ART clinic	OHSS 4,005,000	OHSS 800,000	RPSO 9266 12107 12105 12638 12130		X		X		

7.0 Staffing Plan

All agencies, USAID, CDC, Peace Corps, DoD and DoS, have conducted staffing review, skills assessment, and programmatic alignment of staff towards sustained epidemic control and the ability to successfully implement the new PEPFAR business model. We found that overall PEPFAR staff percent of time and number of FTEs are aligned closely to the core and near core activities described in this document. This includes an emphasis on staff support especially in technical areas that are primarily supported by PEPFAR such as OVC, community care, clinical care, and treatment, PMTCT, HTC and Lab. All PEPFAR Malawi technical and support staff, regardless of their position description, are expected to participate in SIMS and data driven programming. Due to an increase in the number of PEPFAR initiatives such as SIMS, ACT, DREAMS, POART, Expenditure Analysis, quarterly data collection, DATIM and data driven programming for the epidemic control, the current staffing level under PEPFAR (60 full time employees and 19 partially funded)[21] is inadequate to manage the program and requires additional support in the management of this growing portfolio in the areas of management, site level data management, and technical areas.

PEPFAR Malawi is in the process of hiring 5 vacant positions approved through COP 14 and together with proposed 16 new positions, PEPFAR Malawi will be able to ensure full SIMS implementation in line with OGAC reporting requirements and new emphasis on data collection/analysis, and use of data in programming, high level coordination with GF and MoH, and successful implementation of expanded COP, ACT, DREAMS initiatives.

The PEPFAR Coordination office identified the need for two new positions: (1) PEPFAR Communications Specialist – Part time EFM position (20 hours) to prepare communication briefs, brochures, flyers, stories, social media posts, etc. on PEPFAR interagency programs and activities. (2) Global Fund Liaison – This position will be full time expat PSC or LES. This position is critical to successful monitoring of the Global Fund operations in Malawi and to providing assistance to the Country Coordination Mechanism (CCM) and the CCM Secretariat. The position will also serve as a liaison between the USG PEPFAR office, Inter-agencies, Geneva and the GoM.

USAID/Malawi has completed a skills assessment of the current staff to determine current in-house capabilities to, *inter alia*, conduct advanced quality analysis and interpretation of data. As a result of this analysis, USAID is requesting the following six additional positions: Deputy Team Leader, Pediatrician, and four Monitoring & Evaluation Specialists.

Among the six new positions, USAID is proposing to purpose the M&E positions to SIMS coordination. This will ensure full SIMS implementation in line with increased OGAC reporting requirements and that all support staff, who are funded by PEPFAR at 100%, fully participate in SIMS.

The Pediatrician position will specifically focus on the implementation of the ACT initiative in line with the Malawi national HIV response. The Deputy Team Leader will assist in providing overall support in the management of the whole portfolio. USAID/Malawi also has two vacant positions - an Epidemiologist and a Treatment Specialist - which will manage the increasingly data-driven PEPFAR processes and oversight of expanding programs.

[21] Full time staff: CDC – 34. USAID – 18. DoD – 1. PC – 4. DoS – 3.

The CDC portfolio has grown significantly in size and complexity as a result of increased PEPFAR funding to Malawi, and the multitude of new processes and initiatives. CDC conducted a staffing review and determined an appropriate size and mix for staffing with respect to HIV programming and budget allocations. The conclusion reached is current staffing level under PEPFAR is inadequate to manage the program.

It is anticipated that the additional accountability processes through the implementation of the quarterly reporting surrounding the POART will require additional staff hours and skills. CDC is also participating in the ACT initiative, and there is an additional demand for staff time to assist with Global Fund processes, and coordination with the MOH HIV Department. All CDC Malawi technical staff, regardless of their position description, are expected to be engaged in data driven processes including the ones stated above, and to be actively providing direct Technical Assistance to the Ministry of Health. It will be impossible to institute these additional measures without additional staffing.

CDC is seeking two new US Direct Hire positions and five additional technical Locally Employed Staff positions. The additional positions will enable CDC to have the right number and appropriate technical mix of staff to adequately manage an increasingly complex and growing portfolio, and more effectively engage with the Government of Malawi, Multilateral and Bilateral partners, Global Fund processes and implementing organizations. These positions will also improve accountability over the technical programming of USG funds. The hiring of senior level technical LES supports country ownership of PEPFAR initiatives, as these LES will work at a high level with national counterparts and ensure continuity and context appropriateness of programming in specialized technical areas, as well as, improve health impact through improved quality of programming.

The new positions include: Deputy Director of Programs (USDH), Epidemiologist (USDH), Physical assets/lab equipment Specialist, Monitoring and Evaluation Specialist, HIV/TB Specialist, Clinical Specialist for Priority populations, and Laboratory Specialist. This will bring to a total number of staff under PEPFAR from 34 (7 USDH and 27 LES) to 41 (9 USDH and 32 LES[22]). The addition of these staff results in a relatively small budget implication, which CDC will be able to absorb. We anticipate that CDC will not need additional space as we will reconstruct and redesign the existing office space to accommodate additional staff.

The Deputy Director of Programs position is a norm among CDC country office of comparable size or complexity[23], and allows for the CDC Country Director to have a single technical backup and representative in key fora, better coverage of the office in times of absence, and the ability to focus on higher level strategic, diplomatic, partnership and management issues, without becoming overly engaged in technical issues. The CDC office is in need of a senior Epidemiologist to provide technical expertise to the Surveillance and Data use Branch. It is envisioned that these candidates would not deploy to Malawi until February, 2016, and possibly not until July 2016 depending on the recruitment process. Both of these positions would require additional NSDD-38s. These positions have been discussed with the Embassy Executive Office and CDC has received support for this request.

22 Note that these numbers include four drivers though a motorpool consolidation is planned and starting in FY16 where the CDC drivers will transition to USAID , the alternate service provider for Motorpool in Malawi - ICASS.

23 CDC offices in Zambia, Zimbabwe, Mozambique, Kenya, Uganda, each have this position

Peace Corps is seeking to hire a Deputy Director of Programming and Training, with non-PEPFAR appropriated funds, to support PEPFAR and other programmatic priorities. Peace Corps has removed an unfilled Response Coordinator position from the budget as a result of programmatic changes and realignment. SIMS requirements for Peace Corps are under review and will be managed by the MER specialist with existing program staff.

DOD is requesting approval of additional Public Health Specialist (LES) position which will support Malawi Defense Force HIV prevention and treatment programs as part of the DHAPP team for the uniformed services. This position will be primarily responsible for, coordinating and implementing M&E activities of the DOD/ PEPFAR partners. The position will support the implementation of program M&E strategies and methodologies including POART processes such as SIMS, EA, as well as quarterly reporting.

Over the fiscal year, it is estimated that the overall cost of doing business to increase due to three main factors (i) SIMS scale up; (ii) Increase in staffing; and (iii) USAID LE staff pay freeze has been lifted so there are anticipated pay increases beginning in FY 16. This will have an impact on the CODB areas of program travel, ICASS and salaries & benefits.

Appendix A Core, Near Core, Non-Core

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
Site level	• Increase access to PITC, Index family testing, targeted community based testing • Implement systems for improving adherence, bidirectional referral, linkage and retention in care • Implement systems for quality improvement and quality assurance for key HIV services • Establish community support groups to provide peer support and improve adherence and conduct defaulter tracing • Conduct clinical mentoring, supportive supervision • Conduct in-service training for prevention, care and treatment service providers including TB/HIV • Develop and implement site specific TB infection control plans • Conduct VMMC service delivery and demand generation in targeted high impact districts • Conduct condom distribution in priority areas for priority and key populations • Implement dedicated and comprehensive service delivery models for KP and vulnerable populations (e.g. prisoners, AGYW, FSW, ALHIV) including linkages to other HIV service • Conduct community mobilization to increase uptake of HIV services • Implement community level interventions to facilitate normative change to protect key and vulnerable	• Increase access to integrated HIV/MNCH services, HIV/STI screening and TX • Expand network of YFHS within public health care facilities. • KP GBV screening and treatment, referral and linkages to broader health services, legal and other supportive services • Capacity development of CBOs, traditional structures, to manage community prevention, impact mitigation, care and linkage activities. • Optimize CD4 testing systems • Improve pre-service training institutions • Ensure availability of water and electricity at facilities • Improve waste management systems • Provide block grants support to schools and sub-grants to local CSOs	• Patient transportation • Construct staff housing

	populations • Establish community systems for tracked referrals/linkages to clinical and social services • Conduct a household vulnerability assessment for OVC • Provide comprehensive and needs based OVC services • Renovate infrastructure and procure medical furniture for integrated HIV service delivery models and TB infection control • Scale up EMRS		
Sub-national level	**Core Activities** • Recruit, train and deploy HIV diagnostic assistants (HDAs) to increase access to HTC and other POC tests • Procure equipment, consumables and reagents for referral level HIV diagnostic platform (biochemistry, hematology) • Conduct supportive supervision for diagnostic services • Support districts to conduct HIV outreach clinics targeting hard to reach communities • Fund sample transportation systems to improve access to CD4, viral load, TB testing and improve results turnaround times	**Near-core Activities** • Procure equipment for growth monitoring and nutritional assessments in HIV clinics and specialist services for chronic care	**Non-core Activities**
National level	**Core Activities** • Develop standardized operational guidelines and SOPs across clinical programs and community-based programs • Improve M&E tools for the care cascade, including EMRS enhancements • Implement a total market approach for condoms: including national planning, social marketing of male and female condoms in hot spots, urban area, free community-based condom promotion, skills and • Conduct in-service training for front line service providers and lay providers • Procure bicycles and motorbikes to improve mobility of the service providers	**Near-core Activities** • Develop operational guidance on NACS, KP, site level CSOs engagement, EIMC • SI/implementation science to improve programming, tracking of services. • Developing/managing national data base for OVC • Dissemination of national Plan of Action for Vulnerable Children (2015-2019) • Institutional and human capacity development support to GOM • Strengthen in- and pre-service curriculum development • Strengthen HRH management systems for HIV program, including Social Welfare staff • Scale up SLMTA program	**Non-core Activities** • Integration of HIV/AIDS QA/QC with wider health systems • MOH development in leadership, organizational, and financial management

	• Procure commodities for KP, AGYW and VMMC services as required (PPT, HTC, syphilis tests) • Implement bonding systems for PEPFAR supported students • Provide TA to the HIV program, including Logistics and Supply Chain Management systems • Scale up viral load and sample transport • Conduct national quarterly supportive supervision	• Conduct KP population size assessment, TB Prevalence Survey, pharmacovigilance, DHS • Strategy support for HIV/AIDS and gender policies • Provide support for Health and HIV/AIDS financing	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
HTC	• PITC at all health care service delivery points- ANC, maternity, in patient wards, STI clinic, TB clinic, NRU, OPD, under five clinics • Index family testing- through a three tiered approach-1)provision of referral slips home based testing 2) send reminder through SMS 3) household or community testing • Targeted community based testing for key and priority populations- testing in hot spots, work places, communities, households, schools, YFHS, and prisons • Recruitment and deployment of HIV diagnostic assistants (HDAs) to scale up PITC • In service training of the HDAs • Renovations of health facilities to increase HTC services delivery points • Procurement of containers, tents, trailers and vehicles to increase HTC delivery points at the facility, and through mobile or outreach HTC services • Systems for improving linkage and tracking linkages within the facility and between facility and community based HTC program • Systems for quality improvement at the site- like development of SOPs, establishment of QI teams, performance review meetings, support for transportation of PT panels from district hospitals to the sites thereby ensuring that all HTC counselors undergo proficiency test; transportation of QC materials • Quality assurance activities- quarterly supervision, observing HTC sessions • Purchase of other supplies required for provision of HTC services apart from RTKs which are procured through GF		

	Core Activities	Near-core Activities	Non-core Activities

Care and Treatment	**Adult and pediatric care and treatment strategy:**
	• **Effective comprehensive HIV care and treatment**
	  • Conduct clinical mentoring, supportive supervision to improve compliance to clinical guidelines and efficiency in service delivery across the care cascade
	  • Conduct in-service training for care and treatment service providers (standard and advanced HIV care training modules) to build competencies for case management
	  • Recruit staff/ expand role of HDAs for POC HIV diagnostic tests:CD4, syphilis rapid tests
	  • Develop operational guidelines and SOPS to improve linkage and defaulter tracing success rates, including early access to CD4/ clinical staging
	  • Procure equipment and reagents for referral level HIV diagnostic platform (biochemistry, hematology)
	  • Fund sample transportation systems to improve access to CD4, viral load, TB testing and improve results turnaround times
	  • Conduct supportive supervision to improve the quality of sample collection and specimen integrity for CD4, VL, TB
	• **Effective linkage and retention**
	  • Provide technical assistance to adapt site level SOPS to strengthen linkage and retention systems of consenting PLHIV to age-appropriate community support groups and structures (including OVC, teen clubs, M2M)
	• **Efficient scale up of integrated models of care**
	  • Provide on-site technical assistance to scale up mother-baby care point model for PMTCT cascade; family centered care models and youth friendly services at targeted sites
	  • Support districts to conduct HIV outreach clinics targeting hard to reach communities
	  • Procure equipment, supplies other resources for community health workers, lay providers, expert patients providing linkage, adherence and retention support for consenting PLHIV (phones, bicycles, incentives for volunteers)
	  • Establish community support groups to provide peer support and improve adherence and conduct defaulter tracing
	  • Develop and implement standardized referral guidelines and SOPs across clinical programs (IMCI, MNCH, TB, OVC, nutrition) and community-based programs
	• **Effective use information, data for decision making and quality improvement**
	  • Establish QI teams and systems to improve the quality of comprehensive HIV care and treatment services
	  • Renovate infrastructure and procure medical furniture for integrated HIV service delivery models
	  • Procure equipment to ensure reliable power and water supply for HIV diagnostic
		Effective integration of NACS in HIV clinics:
		•Procure equipment for growth monitoring and nutritional assessments in HIV clinics
		•Develop operational guidance on linkage and referral for patients with moderate or severe malnutrition
		•Conduct clinical mentoring to ensure implementation
		
		Effective integration of cervical cancer screening
		• Renovate infrastructure to integrate cervical cancer screening in HIV clinic settings
		• Procure equipment, medical furniture and consumables for cervical cancer screening (VIA)
		• Train HIV service providers in VIA and LEEP
		• Develop operational guidance and SOPS for cervical cancer screening services
		• Conduct supportive supervision and clinical mentoring of staff providing cervical cancer screening services
		• Develop referral guidelines and SOPS to district and central hospitals
		• Provide sample transportation for biopsies	

	services • Improve M &E tools for the care cascade, including EMRS enhancements **TB/HIV strategy:** • **Effective integrated TB/HIV service delivery** • Provide technical assistance to develop operational guidelines and SOPs for integrated TB/HIV service delivery; TB/HIV linkage and referral systems (including for TB diagnostic "fast track" services); household contact tracing and PITC • Conduct supportive supervision and clinical mentoring to improve the quality of routinely TB screening in PLHIV; clinical management of TB/HIV and integrated service delivery • Train health workers on integrated TB/HIV service delivery • Develop and test new TB screening algorithms to improve TB case detection • Develop and implement site specific TB infection control plans • Renovate infrastructure for integrated TB/HIV service delivery and TB infection control including utilities • Procure equipment • Procure reagents (as a stop gap) • Provide technical assistance to sites to routinely analyze data to monitor and improve the quality of TB/HIV service delivery and case management		
Prevention	**Core Activities** **Services** • **VMMC service delivery** and demand generation in targeted high impact districts • **Total market approach for condoms:** including national planning, social marketing of male and female condoms in hot spots, urban area, free community-based condom promotion, skills and distribution in priority areas for priority and key populations. • **Dedicated KP service delivery model** using trusted network of trained providers, drop in centers, and mobile outreach. Core package includes peer led demand generation and risk reduction counselling, condom and lubricant distribution, quarterly HTC, STI, TB screening and treatment, FP, post-GBV care, treatment and care for HIV+, linkages to others services, case management, and support through CSO based support groups. • **Dedicated service package and approaches for AGYW** including HTC, STI screening and treatment, FP, post-GBV, peer education, ART, care and support for ALHIV, linkages to PMTCT and VMMC. • **Comprehensive services for prison settings** including PITC, routine STI/TB screening, diagnosis and treatment, risk reduction, UTT pilot. • **Integrated family planning** counselling, education, screening for pregnancy risk and referral for long acting family planning methods- for FSW, AGYW and PLHIV	**Near-core Activities** **Services:** • PEP • STI screening/TX • EIMC • Expand network of YFHS within public health care facilities. • KP near core service package: GBV screening and treatment , referral and linkages to broader health services, legal and economic strengthening, stigma reduction, and national advocacy for rights **Community:** • GBV screening/referrals • Risk reduction **Systems:** • Capacity development of CBOs, traditional	**Non-core Activities**

	Community: • **Community mobilization for priority populations** for access to HTC, care and treatment and other biomedical prevention services. • **Normative change to protect children, AGYW.** • **Establish community system**s for tracked referrals/linkages to clinical and social services • **HR for HTC, care and linkages: In service training** for the peers, expert clients and other community service providers • **Procurement of bicycles, and motorbikes** to improve mobility of the service providers **Commodities procured for KP, AGYW and VMMC services as required** (PPT, HTC, syphilis tests)	structures, to manage community prevention, impact mitigation, care and linkage activities. • SI/implementation science to improve programming, tracking of services. • KP related national standards/guidelines for service delivery, training of public health care facility providers, capacity building of KP CSOs and operations research.	
OVC	**Core Activities** • Household vulnerability assessment • Care/Case management planning and implementation • Household Economic Strengthening • Village Savings and Loans • Food security/nutrition program • Linkages to health and nutrition programs • Facilitating access to Social Cash Transfer programs • Caregiver / parenting program • Enhancing access to education • Capacity building for teachers • Early Childhood Development program • Access to HCT, and referral for HIV services • Birth registration • Life skills building among children • psychosocial support services	**Near-core Activities** • Developing/managing national data base for OVC • Dissemination of national Plan of Action for Vulnerable Children (2015-2019) • Institutional and human capacity development support to GoM • Block grant support to schools	**Non-core Activities**
HSS	**Core Activities** • HRH: pre-service and in-service training of Care and Treatment and Testing cadres, training and salaries for HTC providers, bonding • TA to MoH • Labs: Viral load and sample transport • Infrastructure: Pre-fab facility drug/diagnostics storage space, ART clinics • TA to Global Fund grant recipients	**Near-core Activities** • Curriculum Development • Strengthen HRH regulations • HRH Retention • HRH for Social Welfare • SLMTA • CD4 Testing	**Non-core Activities** • Civil Service Reform • Patient Transportation • Commodity procurement and

	• SI: EDS at priority sites, HIA • QA/QI: clinical/systems mentoring, national quarterly supportive supervision • SCM: quantification, eLMIS, and TA	• Improved training sites • Water and electricity at facilities • Incinerators/waste management • DHS • TB Prevalence Survey • Pharmacovigilance • Operations Research • DHIS2/HMIS • iHRIS • Strategy support for HIV/AIDS and gender policies • Health and HIV/AIDS financing • Capacity building of and sub-grants to local CSOs	distribution • Integration of HIV/AIDS QA/QC with wider health systems • MoH and district government development in leadership, organizational, monitoring and financial management • Performance appraisal system

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Food supplementation program for OVC in north and central Malawi	To USAID Maternal and Child Health/Nutrition Team	$0	$0	1	NA	The transition was initiated and completed in COP14
OB/GYN training Preservice Training Of OB/GYN residents	To College of Medicine And MoH	$250,000	$220,000	1	2018	CDC committed to 5 years at conception
Leadership & Management training of district and central staff	TO USAID	$0	$0	0		
TA for quarterly progress reviews by district government	Priority districts transitioned To USAID; seeking other Donor support on remaining districts	$0	$0	0		
Financial Management Coaching of district staff	USAID partially absorbed Seeking other donor support	$0	`$0	0		
TA for performance Appraisal Systems	To MoH	$0	$0	0		
Totals		$250,000	$220,000	2		

APPENDIX B Budget Information

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$374,279	**$94,625,721**	**$95,000,000**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated ($)***
MTCT	Mother to Child Transmission	5,195,920
HVAB	Abstinence/Be Faithful Prevention	0
HVOP	Other Sexual Prevention	3,117,166
IDUP	Injecting and Non-Injecting Drug Use	0
HMBL	Blood Safety	1,009,628
HMIN	Injection Safety	0
CIRC	Male Circumcision	1,132,825
HVCT	Counseling and Testing	5,780,309
HBHC	Adult Care and Support	6,577,274
PDCS	Pediatric Care and Support	2,869,245
HKID	Orphans and Vulnerable Children	5,041,956
HTXS	Adult Treatment	27,985,281
HTXD	ARV Drugs	6,754,489
PDTX	Pediatric Treatment	6,179,927
HVTB	TB/HIV Care	5,670,178
HLAB	Lab	2,371,381
HVSI	Strategic Information	1,974,657
OHSS	Health Systems Strengthening	8,024,014
HVMS	Management and Operations	4,941,471
TOTAL		**94,625,721**
Care and Treatment earmark	**61%**	

* Budget codes include M&O applications

Table B.2 Resource Projections

PEPFAR Malawi used unit expenditures from Expenditure Analysis 2014 and targets by running the PBAC tool as a main source for resource projection. We costed treatment and care package per each of the sites (PMTCT/FBCTS): Maintenance site, Low/Medium Volume Priority sites, and High volume priority hospital sites. Each intervention in the care and treatment package was costed using EA 2014 data, the NSP costing tool and additional information collected from the partners. Costing for the rapid scale up sites for additional $10M has been conducted separately. Similarly community intervention package has been costed per traditional authority. As the number of current community programs, including priority population prevention, OVC and Key Population are phased out during the current year and new follow-up programs are more integrated and comprehensive interventions, we had to reflect all of these programmatic changes in the costing of these programs. Efficiency gains are taken into consideration especially for VMMC and prevention programs. Every TWG worked closely with our assigned OGAC EA advisor when costing the interventions and running the PBAC tool.

APPENDIX C Civil Society Organizations Engagement

Malawi Civil Society Organizations Involved in COP 15 Development
Malawi Network of PLHIV (MANET +)
Malawi Network of Religious Leaders with or Affected by HIV/ AIDS (MANERELA)
Malawi Network of AIDS Service Organizations (MANASO)
National Association of PLHIV in Malawi (NAPHAM)
Centre for the Development of People (CEDEP)
National Association of Youth Living with HIV (NAYPLHIV)
National Sex Workers Alliance
Centre for Human Rights and Rehabilitation (CHRR)
Malawi Interfaith AIDS Association (MIAA)
Health and Rights Education Programme (HREP)
ISAMA HIV/AIDS Project
Malawi AIDS Counselling and Resources Organization (MACRO)
Journalists Network of PLHIV (JONEHA)
Child Rights Information and Documentation Centre (CRIDOC)
DREAM (Community of Sant'Egidio)
Family Planning Association of Malawi
Paradiso Home Based Care & Outreach for HIV Affected Communities in Malawi
Global Hope Mobilization (GLOHOMO)
Coalition of Women Living with HIV and AIDS in Malawi (COWLHA)
Teachers Living Positively with HIV/AIDS in Malawi (TILIPO)
Health Care Workers Living Positively (HECAWLP)
National Organization of Nurses and Midwives of Malawi (NONM)
Development from People to People in Malawi (DAPP Malawi)
Global AIDS Interfaith Alliance (GAIA)
Community Partnership for Relief and Development (COPRED)
Youth Act Alliance
AIDS Vaccine Advocacy Coalition (AVAC)
Medecins Sans Frontieres/Belgium
Malawi Business Coalition Against AIDS

APPENDIX D Site-Level ART Targets in Priority Sub-national Units (Sites) for Epidemic Control

Site name ***(Saturation Districts Italicized)***	**Total PLHIV**	**Expected current on ART (2015)**	**Additional patients required for 80% ART coverage**	**Target current on ART (in FY16) TX_CURR**	**Newly initiated in FY 16 TX_NEW**
Bowe Health Centre	770	347	269	341	43
Chankhungu Health Centre	553	324	118	338	40
Dowa District Hospital	1000	1129	0	1,251	174
Dzaleka Health Centre	865	286	406	330	94
Madisi Mission Hospital	1254	1385	0	1,492	166
Mponela Rural Hospital	2578	1494	568	1,527	343
Mvera Mission Health Centre	990	311	481	314	68
Bua Health Centre	1200	502	458	479	70
Chulu Health Centre	767	418	196	404	61
Kaluluma Rural Hospital	1744	397	998	358	110
Kasungu District Hospital	6026	5862	0	6,269	891
Kawamba Health Centre	1029	594	229	594	129
Khola Health Centre	986	237	552	202	62
Mtunthama Health Centre	1167	109	824	115	37
Nkhamenya Community Hospital	661	837	0	947	86
Ofesi Health Centre	873	138	560	125	21
Santhe Health Centre	1626	582	719	682	143
Simlemba Health Centre	1229	263	721	245	51
St. Andrews Health Centre	1270	1242	0	1,086	106
Alinafe Community Hospital	559	746	0	798	88
Dwambazi Rural Hospital	863	617	74	656	87
Dwangwa Matiki Clinic	1383	1350	0	1,459	95
Malowa Health Centre	550	116	324	137	42
Msenjere Health Centre	758	300	306	338	66
Ngala Health Centre	808	332	314	360	73
Nkhotakota District Hospital	2605	2148	0	2,572	610
Nkhunga Health Centre	2143	780	934	632	114
St. Annes Hospital	260	1069	0	1,252	165
Kansonga Health Centre	596	369	107	365	43
Malomo Health Centre	1065	725	127	644	90
Ntchisi District Hospital	1245	1565	0	1,852	364
Chinguluwe Health Centre	906	202	523	266	94
Chipoka Health Centre	1720	704	672	781	186
Khombedza Health Centre	2926	961	1380	1,080	185

Life Line Salima Health Centre	1115	1117	0	1,234	151
Lifuwu Health Centre	1237	534	456	528	84
Maganga Health Centre	1983	487	1099	563	210
Makioni Health Centre	1173	212	726	293	83
Mchoka Health Centre	1642	522	792	397	117
Salima District Hospital	7234	5302	485	5,624	910
Senga Bay Baptist Medical Clinic	1412	549	580	572	184
Thavite Health Centre	1222	215	762	266	50
Bembeke Health Centre	927	523	218	537	100
Chikuse Health Centre	1107	234	651	370	183
Chiphwanya St Joseph Health Centre	883	309	398	346	109
Chitowo Health Centre	1368	145	950	273	162
Dedza District Hospital	3860	3805	0	4,384	1,010
Dzindevu Health Centre	832	698	0	218	94
Golomoti Health Centre	1409	397	730	567	240
Kaphuka Health Centre	1095	1160	0	837	188
Kasina Health Centre	1202	463	498	507	140
Lobi Health Centre	1633	811	495	978	226
Mayani Health Centre	1960	764	804	739	197
Mtakataka Health Centre	740	441	151	567	167
Mtendere Health Centre	2318	1426	428	1,533	323
Mua Rural Hospital	852	1190	0	1,287	126
African Bible College Clinic	774	1056	0	1,042	125
Area 18 Health Centre	14258	2448	8958	3,489	1,234
Area 25 Health Centre	11103	3586	5296	5,385	2,254
Area 30 Police Clinic	384	537	0	587	174
Baylor Children's Centre Of Excellence In Malawi	0	2557	0	3,507	967
Bwaila Hospital Martin Preuss Centre	31528	17551	7671	19,516	4,187
Chileka Health Centre	1988	615	975	714	263
Chitedze Health Centre	1637	476	833	562	215
Chiwamba Health Centre	1181	438	507	418	90
Daeyang Luke Hospital	4736	1185	2604	1,718	663
Dr David Livingstone Memorial Clinic	652	291	231	359	118
Dzenza Health Centre	1986	364	1224	704	570
Kabudula Rural Hospital	1034	796	31	1,075	331
Kamuzu Central Hospital	2645	949	1167	3,087	2,284
Kawale Health Centre	19211	2619	12750	4,492	2,088
Khongoni Health Centre	1072	435	422	469	109
Lighthouse Clinic	0	9944	0	10,493	880
Likuni Mission Hospital	8132	3126	3380	4,447	1,547
Lilongwe City Assembly Chinsap	0	595	0	497 533	66

Lumbadzi Health Centre	6678	861	4481	2,312	1,698
Macro Lilongwe Clinic	0	1471	0	2,508	1,171
Malingunde Health Centre	1331	573	492	483	117
Mitundu Community Hospital	4319	2083	1372	2,234	480
Mlale Mission Hospital	603	921	0	994	292
Mtenthera Health Centre	1601	492	789	607	216
Nathenje Health Centre	1578	1152	111	1,175	184
Nkhoma Mission Hospital	1869	2095	0	2,388	562
Nsaru Health Centre	1067	283	571	296	87
Nthondo Health Centre	990	335	457	365	136
Partners In Hope Clinic Moyo Clinic (public)	0	5257	0	5,100	269
SOS Clinic	103	1015	0	1,160	131
St Gabriel Mission Hospital	1476	2823	0	3,655	897
Chiosya Health Centre	1311	363	686	387	156
Guillime Mission Hospital	1183	496	450	597	236
Kaigwazanga Health Centre	1668	562	773	586	243
Kapanga Health Centre	1985	238	1350	289	160
Kapiri Mission Hospital	3062	2109	340	2,667	614
Kochilira Rural Hospital	1853	731	752	894	311
Ludzi St Joseph's Health Centre	1487	436	754	528	157
Mchinji District Hospital	4791	3663	170	4,416	1,128
Mikundi Health Centre	2239	523	1268	624	166
Mkanda Health Centre	2875	1282	1018	1,480	297
Nkhwazi Health Centre	1955	747	817	670	237
Tembwe Health Centre	1629	493	810	589	127
Bilila Health Centre	2239	1083	708	1,069	244
Biliwiri Health Centre	911	637	91	601	170
Bwanje Health Centre	2021	544	1073	686	201
Champiti Health Centre	444	478	0	477	97
Chikande Health Centre	1206	363	602	469	170
Ganya Health Centre	705	663	0	782	155
Gowa Health Centre	1069	246	610	187	61
Kandeu Health Centre	1715	327	1045	372	213
Kapeni Health Centre	1238	232	758	417	242
Kasinje Health Centre	3228	1783	799	1,497	350
Katsekera Health Centre	1330	830	234	941	202
Lake View Health Centre	691	382	171	415	77
Lizulu Health Centre	1480	801	383	1,014	279
Mlangeni Health Centre	1251	323	677	369	118
Mtonda Health Centre	774	375	244	415	95
Nsipe Health Centre	2072	560	1098	693	206
Nsiyaludzu Health Centre	2349	848	1031	1,067	444
Ntcheu District Hospital	6576	4763	498	6,175	1,516

Senzani Health Centre	1485	392	796	392	94
Sharpe Valley Health Centre	1483	355	831	446	148
Sister Theresa Community Hospital Mikoke	538	1637	0	1,893	199
Chitipa District Hospital	1552	2948	0	2,323	298
Kameme Health Centre	738	411	179	417	60
Nthalire Health Centre	577	497	0	463	34
Atupele Community Hospital	1476	426	755	496	181
Chilumba Rural Hospital	1441	3660	0	818	135
Iponga Health Centre	1285	612	416	562	83
Kaporo Rural Hospital	2737	1825	365	1,804	167
Karonga District Hospital	4593	3610	64	4,337	665
Kasoba Health Centre	1275	471	549	519	96
Lupembe Health Centre	663	255	276	286	64
Nyungwe Health Centre	1791	878	555	1,063	107
St. Anne's Health Centre	638	145	366	163	65
St Mary's / Chizumulu Health Centre	155	113	11	114	18
St Peters Mission Hospital	497	316	82	411	98
Bulala Health Centre	906	243	482	277	86
Ekwendeni Mission Hospital	2792	2069	164	2,522	416
Embangweni Mission Hospital	1656	1020	304	1,360	284
Endindeni Health Centre	392	596	0	537	82
Engucwini Health Centre	622	567	0	438	119
Euthini Rural Hospital	743	834	0	875	178
Jenda Health Centre	1051	558	283	628	176
Kafukule Health Centre	574	406	53	450	86
Kamwe Health Centre	597	812	0	303	77
Katete Community Hospital	550	501	0	597	138
Luwelezi Health Centre	538	375	55	396	84
Mabiri Health Centre	530	181	243	223	41
Macro Mzuzu Clinic	0	2301	0	3,233	1,221
Manyamula Health Centre	448	495	0	370	43
Mkoma Health Centre	434	232	115	138	46
Mpherembe Health Centre	1079	1329	0	581	182
Mzambazi Community Hospital	572	204	254	306	147
Mzimba District Hospital	8296	3601	3035	4,619	1,400
Mzuzu Cental Hospital Rainbow Clinic	7690	4986	1166	6,782	2,058
Mzuzu Health Centre	14021	3604	7612	3,133	1,438
Mzuzu University Clinic	0	311	0	406	65
St. Johns Mission Hospital	5699	2149	2411	2,527	568
Thunduwike Health Centre	496	764	0	451	77
Chintcheche Rural Hospital	2238	1695	95	2,002	286
Kachere Health Centre	1354	453	630	499	96

Kande Health Centre	1104	350	533	367	109
Liuzi Health Centre	749	282	317	219	39
Maula Health Centre	1058	236	611	211	40
Mpamba Health Centre	1464	246	925	256	81
Mzenga Health Centre	1145	330	586	350	69
Nkhata Bay District Hospital	3934	2185	962	2,600	400
Usisya Health Centre	849	397	282	349	37
Bolero Rural Hospital	1631	1221	84	970	150
Katowo Rural Hospital	615	515	0	507	72
Lura Health Centre	692	103	451	110	46
Mhuju Rural Hospital	666	596	0	519	93
Rumphi District Hospital	1849	2622	0	2,854	389
Balaka District Hospital	7684	3978	2169	4,741	1,097
Balaka Opd Health Centre	0	1257	0	1,344	460
Chiendausiku Health Centre	1131	528	376	649	242
Kalembo Dispensary	3130	1873	631	2,151	641
Kankao Health Centre	1950	343	1217	407	211
Kwitanda Health Centre	1306	419	626	660	282
Mbera Health Centre	3109	1188	1300	1,396	401
Namanolo Health Centre	2627	425	1676	605	258
Namdumbo Health Centre	1100	550	330	679	286
Phalula Health Centre	1964	1099	473	1,138	245
Phimbi Health Centre	1928	688	854	962	255
Ulongwe Health Centre	1670	431	905	455	132
Utale 1 Health Centre	1747	46	1352	116	112
Utale 2 Health Centre	1446	594	562	686	131
Chamba Dispensary	2092	0	0	186	152
Chikweo Health Centre	3858	1233	1854	1,418	342
Gawanani Health Centre	882	575	130	550	162
Machinga District Hospital	6426	6778	0	8,896	2,578
Machinga Health Centre	1248	564	434	834	340
Mangamba Health Centre	2640	776	1336	1,033	327
Mkwepere Health Centre	1340	330	742	419	153
Mpiri Health Centre	3125	415	2085	520	230
Mposa Health Centre	1724	594	785	750	221
Namandanje Health Centre	1481	1198	0	1,299	176
Namanja Health Centre	2165	878	854	1,051	205
Nayinunje Health Centre	1395	694	422	829	228
Nayuchi Health Centre	1698	921	438	1,106	228
Ngokwe Health Centre	2482	690	1295	807	265
Nsanama Health Centre	3365	1304	1388	1,723	392
Ntaja Health Centre	3915	2519	613	3,076	766
Nthorowa Health Centre	1161	465	464	522	169

Nyambi Health Centre	2831	890	1375	1,156	382
Assalaam Clinic	1429	490	653	746	277
Billy Riordan Memorial Health Clinic	0	745	0	837	122
Chikole Dispensary	899	231	488	286	112
Chilipa Health Centre	2135	825	883	1,084	454
Chilonga Health care	1273	289	729	340	163
Chiponde Dispensary	740	522	70	422	138
Chiunda Dispensary	2429	172	1771	292	196
Jalasi Health Centre	1948	992	567	974	218
Katema Health Centre	1450	715	445	650	119
Katuli Health Centre	2609	1396	691	1,279	229
Koche Health Centre	4126	1504	1796	1,584	531
Kukalanga Dispensary	3082	1898	567	1,483	438
Lugola Health Centre	942	392	362	379	79
Lulanga Health Centre	2534	365	1662	438	149
Lungwena Health Centre	2063	757	893	883	326
Makanjira Health Centre	2376	1533	367	1,520	248
Maldeco Fisheries Clinic	0	1564	0	1,403	42
Malembo Health Centre	2062	900	750	1,022	248
Malombe Dispensary	1210	550	418	596	145
Malukula Health Centre	616	310	183	466	197
Mangochi District Hospital	9993	6174	1820	7,615	1,834
Mase Health Centre	1869	283	1213	391	138
Mkumba Health Centre	2245	472	1324	464	141
Monkeybay Community Hospital	3789	2248	783	2,507	618
Mtimabi Health Centre	1844	314	1161	434	226
Mulibwanji Hospital	2276	1215	606	1,541	348
Namalaka Health Centre	765	389	223	586	98
Namwera Health Centre	2470	711	1265	1,034	349
Nangalamu Health Centre	1196	171	786	284	137
Nankumba Health Centre	1767	846	568	924	221
Nkope Health Centre	2151	830	891	848	167
Phirilongwe Health Centre	1016	374	439	402	126
St. Martins Mission Hospital	1924	1145	395	1,449	355
Bondo Health Centre	2070	898	758	1,042	330
Chambe Health Centre	4434	1238	2310	1,327	435
Chinyama Health Centre	2423	1076	862	1,190	424
Chisitu Health Centre	2028	910	713	1,081	313
Chonde Health Centre	5596	2536	1940	3,292	1,369
Dzenje Health Centre	734	505	83	449	134
Kambenje Health Centre	3032	2128	297	1,422	531
Lujeri Health Centre	624	770	0	1,306	680
Mbiza Health Centre	3854	1634	1449	1,907	497

Milonde Health Centre	1577	1653	0	1,674	456
Mimosa Dispensary	2767	1746	468	1,699	444
Mkomaula Health Centre	989	0	791	195	157
Mpala Health Centre	4917	2174	1759	2,413	782
Mulanje District Hospital	5869	7391	0	9,054	2,237
Mulanje Mission Hospital	5451	5512	0	6,285	1,404
Mulomba Health Centre	3720	1491	1485	1,097	323
Muloza Heath Centre	5608	2317	2169	2,350	886
Namasalima Health Centre	3298	3207	0	3,166	465
Namphungo Health Centre	2979	1247	1136	829	340
Namulenga Health Centre	1369	386	709	588	302
Naphimba Health Centre	1825	1143	317	1,229	480
Thuchila Health Centre	3629	1814	1089	2,086	641
Chiringa Maternity	2232	412	1374	481	208
Chitekesa Health Centre	3113	2223	267	2,356	402
Kalinde Health Centre	2610	1288	800	1,517	465
Migowi Health Centre	3257	2223	382	3,214	928
Mpasa Health Centre	2967	884	1490	1,173	506
Mwanga Health Centre	1457	715	451	762	248
Nambazo Health Centre	4283	3611	0	4,052	853
Nazombe Health Centre (GoGo)	1197	1329	0	1,418	269
Nkhulambe Health Centre	2691	2342	0	2,831	448
Nkhwayi Health Centre	2802	1205	1036	1,334	355
Phalombe Health Centre	4831	1679	2186	2,361	1,065
Phalombe Mission Holy Family Hospital	2655	3385	0	3,972	696
Sukasanje Health Centre	2008	2015	0	1,841	368
Bimbi Health Centre	1746	868	529	1,022	366
Chamba Health Centre	1465	603	569	795	300
Chilipa Health Centre	1212	430	540	529	115
Chingale Health Centre	1340	663	409	972	352
Chipini Health Centre	4916	1618	2314	1,914	419
City Clinic Zomba	2617	433	1660	1,047	782
Domasi Rural Hospital	2128	1602	101	2,029	733
Lambulira Health Centre	1718	788	586	894	186
Likangala Health Centre	4236	2229	1160	2,422	638
Machinjiri Health Centre	850	381	299	478	204
Magomero Health Centre	1539	693	538	767	176
Makwapala Health Centre	2398	1287	631	1,402	330
Matawale Health Centre	5850	2833	1847	3,780	1,226
Matiya Health Centre	3874	2001	1098	2,065	405
Mayaka Health Centre	4249	1493	1906	1,724	390
M'mambo Health Centre	937	465	285	613	234
Naisi Health Centre	825	643	17	833	294

Namasalima Health Centre	1843	739	735	1,069	401
Namikango Health Centre	3117	438	2056	599	257
Nasawa Health Centre	2403	630	1293	914	528
Ngwelelo Health Centre	2699	789	1370	1,115	488
Nkasala Health Centre	1114	561	330	612	127
Pirimiti Rural Hospital	3414	0	2731	3,491	565
Police College Hospital	453	853	0	1,497	637
Sadzi Health Centre	2751	527	1674	789	597
St. Lukes Mission Hospital	3898	3469	0	3,723	574
Thondwe Health Centre	2344	1891	0	2,101	803
Zomba Central Hospital Tisungane Clinic	6865	6931	0	9,630	3,129
Zomba Central Prison Clinic	144	596	0	473	134
Bangwe Health Centre	16285	4938	8090	5,824	1,595
Blantyre Adventist Hospital	2151	1244	477	1,201	95
Blantyre City Assembly Clinic	1291	811	221	864	59
Chavala Health Centre	513	165	246	196	82
Chichiri Prison	0	432	0	497	193
Chikowa Health Centre	1704	509	855	669	225
Chileka Health Centre	3381	2910	0	2,125	701
Chilomoni Health Centre	10783	3467	5159	4,724	1,662
Chimembe Health Centre	796	231	406	297	119
Chirimba Health Centre	4927	662	3280	1,316	962
Dziwe Health Centre	1546	356	881	521	263
Kadidi Health Centre	4777	528	3294	751	493
Limbe Health Centre	17776	5405	8816	7,248	2,744
Lirangwe Health Centre	2931	1064	1281	1,189	290
Lundu Health Centre	1563	634	616	669	189
Macro Blantyre Clinic	0	3334	0	4,453	1,452
Madziabango Health Centre	998	422	376	538	207
Makata Health Centre	2027	320	1302	318	180
Makhetha Clinic	3255	1345	1259	1,234	522
Malabada Health Centre	1334	252	815	180	45
Masm Medi Clinic Limbe	536	1032	0	920	69
Mdeka Health Centre	2752	1238	963	1,280	340
Mlambe Mission Hospital	3734	5043	0	5,455	705
Mpemba Health Centre	3829	1203	1860	1,662	603
Mtengoumodzi Private Hospital	356	684	0	693	15
Ndirande Health Centre	24531	4608	15017	6,401	2,169
Queen Elizabeth Central Hospital	8089	10917	0	19,924	9,662
South Lunzu Health Centre	12537	1787	8242	3,731	2,338
Zingwangwa Health Centre	17228	4265	9517	3,146	1,578
Chapananga Health Centre	1051	560	281	691	215
Chikwawa District Hospital	6698	4608	750	4,865	1,213

Chipwaila Health Centre	2437	459	1491	572	258
Dolo Health Centre	2314	446	1405	586	212
Gaga Health Centre	1227	470	512	558	165
Kakoma Health Centre	1059	474	373	571	216
Kalulu Health Centre, Chikwawa	373	517	0	535	142
Makhwira Health Centre	4191	0	3353	1,947	632
Mapelera Health Centre	2111	0	1689	832	303
Mfera Health Centre	1182	543	402	719	275
Misomali Health Centre	903	208	515	351	213
Ndakwera Health Centre	1840	445	1027	629	251
Ngabu Rural Hospital	6958	3131	2436	3,937	1,043
Ngabu SDA Health Centre	648	748	0	1,783	1,293
Nkumaniza Health Centre	1241	491	502	647	216
St Montfort Hospital	6046	3520	1317	3,727	689
Sucoma Clinic Illovo	1682	579	767	998	433
Bilal Clinic	2294	3868	0	3,774	172
Chiradzulu District Hospital	4543	5194	0	5,549	561
Chitera Health Centre	1640	1930	0	1,093	183
Mauwa Health Centre	2115	2258	0	2,399	261
Mbulumbuzi Health Centre	2451	2312	0	2,332	239
Milepa Health Centre	3768	3804	0	4,061	413
Namadzi Health Centre	2908	2436	0	2,675	299
Namitambo Health Centre	6219	6505	0	4,694	455
Ndunde Health Centre	2053	1984	0	2,177	243
Nkalo Health Centre	3748	3314	0	3,492	390
St. Joseph Mission Hospital	4238	2964	426	2,738	368
Thumbwe Health Centre	3059	1969	478	1,998	252
Mwanza District Hospital	4302	3235	206	4,012	996
Thambani Health Centre	1458	528	639	644	189
Tulonkhondo Health Centre	827	320	341	310	54
Chifunga Health Centre	1055	519	325	709	245
Ligowe Health Centre	974	570	209	659	134
Lisungwi Community Hospital	1404	1186	0	1,341	287
Magaleta Health Centre	627	235	267	319	77
Matope Health Centre	1161	828	101	979	216
Neno District Hospital	1656	1261	64	1,473	333
Nsambe Health Centre	1047	440	398	463	79
Zalewa PIH Clinic	1335	1097	0	1,126	134
Kalemba Community Hospital	2377	2096	0	2,094	338
Lulwe Health Centre	741	0	593	262	69
Makhanga Health Centre	1417	0	1134	1,368	278
Masenjere Health Centre	1362	0	1090	985	263
Mbenje Health Centre	1661	721	608	668	120

Ndamera Health Centre	2101	1449	232	1,539	247
Nsanje District Hospital	6257	3578	1428	4,477	1,074
Nyamithuthu Health Centre	597	340	138	359	84
Phokera Health Centre	892	408	306	488	156
Sankhulani Health Centre	998	1561179	0	490	114
Sorgin Health Centre	1241	751	241	828	175
Tengani Health Centre	1998	1043	555	1,076	200
Trinity Mission Hospital	2491	2050	0	2,429	446
Bvumbwe Research Health Centre	7363	3432	2458	3,694	449
Changata Health Centre	1990	1533	59	1,512	200
Chimaliro Health Centre	4457	2116	1450	2,261	569
Chimvu Health Centre	2453	501	1461	635	253
Chipho Health Centre	1684	547	800	709	203
Chisoka Health Centre	2155	690	1034	915	400
Dzimbiri Health Centre (DiDi)	1821	382	1075	440	286
Gombe Health Centre	1463	663	508	704	193
Khonjeni Health Centre	5607	3014	1472	3,955	729
Makapwa Health Centre	1078	554	308	660	204
Makungwa Health Centre	1833	1238	228	1,737	381
Malamulo Mission Hospital	5913	4196	534	5,072	912
Mangunda Health Centre	6328	2529	2533	2,906	888
Mapanga Clinic	1403	697	426	477	229
Mianga Health Centre	1974	457	1122	460	166
Mikolongwe Health Centre	3094	2208	268	2,446	349
Mitengo Health Centre	1098	366	512	358	114
Satemwa Clinic	1576	707	554	651	90
St Martins Molere Health Centre	2458	490	1476	531	151
Thekerani Rural Hospital	3537	2333	496	3,208	774
Thomasi Health Centre	989	622	169	761	112
Thunga Health Centre	2432	832	1113	836	151
Thyolo District Hospital	10599	11965	0	15,079	3,164
Zoa Health Centre	2179	906	838	1,111	351
Malawian Defense Forces	1,880	4,522	0	4,728	654

Malawi COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Balaka District	95,905	4,958	16,056	4,839	15,914
Blantyre District	353,629	32,874	86,173	30,537	83,481
Chikwawa District	135,581	8,305	25,077	7,769	23,946
Chiradzulu District	52,829	4,493	41,274	4,205	39,720
Chitipa District	16,143	418	3,276	392	3,203
Dedza District	104,814	3,624	14,955	3,391	14,430
Dowa District	37,473	992	5,893	928	5,593
Karonga District	35,798	1,669	10,333	1,562	10,048
Kasungu District	59,861	1,888	11,808	1,767	11,506
Likoma District	2,910	124	542	116	525
Lilongwe District	487,256	27,233	91,397	24,970	85,838
Machinga District	169,136	8,152	29,192	7,380	26,175
Mangochi District	199,561	10,065	35,586	9,150	36,015
Mchinji District	101,746	4,095	14,199	3,832	13,727
Mulanje District	176,293	15,670	50,951	13,864	46,731
Mwanza District	22,412	1,348	5,128	1,251	4,966
Mzimba District	253,326	10,042	32,404	9,298	31,458
Neno District	30,591	1,631	7,396	1,519	7,069
Nkhata Bay District	26,657	1,238	7,311	1,157	6,853
Nkhotakota District	39,513	1,432	8,403	1,340	8,204
Nsanje District	59,776	3,810	17,846	3,564	17,064
Ntcheu District	113,989	5,957	23,125	5,575	22,685
Ntchisi District	18,359	600	3,003	533	2,861
Phalombe District	107,612	7,178	30,216	6,811	27,312
Rumphi District	23,095	847	5,167	774	4,960
Salima District	44,169	2,408	12,063	2,254	11,605
Thyolo District	163,226	13,289	60,916	12,347	56,190
Zomba District	258,611	16,355	51,828	15,624	49,472
Other_ Malawi	20,642	698	6,587	653	4,727
Total	**3,210,913**	**191,393**	**708,105**	**177,402**	**672,278**

Malawi COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Balaka District	4,188	-	20,284
Blantyre District	6,183	5,281	8,112
Chikwawa District	4,154	-	18,987
Chiradzulu District	196	-	20
Chitipa District	124	-	20
Dedza District	1,104	-	-
Dowa District	72	-	-
Karonga District	124	-	20
Kasungu District	94	-	-
Likoma District	-	-	-
Lilongwe District	2,198	4,493	40
Machinga District	30,025	-	32,450
Mangochi District	4,193	770	50,516
Mchinji District	119	-	40
Mulanje District	4,172	-	26,024
Mwanza District	1,000	233	-
Mzimba District	2,124	2,963	60
Neno District	1,000	-	-
Nkhata Bay District	135	-	20
Nkhotakota District	124	-	20
Nsanje District	162	-	20
Ntcheu District	132	-	40
Ntchisi District	1,104	-	-
Phalombe District	4,175	-	15,140
Rumphi District	1,124	-	20
Salima District	136	-	20
Thyolo District	2,184	-	-
Zomba District	39,050	-	41,720
Other_ Malawi	13,535	-	-
Total	**122,931**	**13,740**	**213,573**

Malawi COP15 Targets by District: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Balaka District	14,545	1,316
Blantyre District	33,588	4,350
Chikwawa District	18,591	1,946
Chiradzulu District	12,505	1,657
Chitipa District	4,784	118
Dedza District	20,949	860
Dowa District	10,574	303
Karonga District	9,080	488
Kasungu District	15,364	609
Likoma District	529	28
Lilongwe District	62,041	3,979
Machinga District	31,514	2,298
Mangochi District	39,434	3,354
Mchinji District	20,033	793
Mulanje District	24,577	3,216
Mwanza District	4,690	355
Mzimba District	26,052	1,364
Neno District	4,269	373
Nkhata Bay District	5,692	379
Nkhotakota District	9,136	471
Nsanje District	14,464	1,539
Ntcheu District	18,617	1,263
Ntchisi District	5,081	125
Phalombe District	15,708	1,787
Rumphi District	5,047	269
Salima District	14,070	907
Thyolo District	22,908	2,930
Zomba District	28,769	3,013
Other_ Malawi	617	31
Total	**493,228**	**40,121**

Malawi COP15 Targets by District: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Balaka District	468	230
Blantyre District	4,691	2,312
Chikwawa District	1,161	572
Chiradzulu District	933	460
Chitipa District	129	64
Dedza District	877	431
Dowa District	355	175
Karonga District	341	168
Kasungu District	308	153
Likoma District	4	2
Lilongwe District	6,201	3,054
Machinga District	48	22
Mangochi District	85	42
Mchinji District	468	232
Mulanje District	62	32
Mwanza District	407	200
Mzimba District	1,543	760
Neno District	233	115
Nkhata Bay District	284	139
Nkhotakota District	379	188
Nsanje District	823	407
Ntcheu District	487	240
Ntchisi District	143	70
Phalombe District	30	14
Rumphi District	174	86
Salima District	679	335
Thyolo District	1,346	663
Zomba District	92	47
Other_ Malawi	-	-
Total	**22,751**	**11,213**

Malawi COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Balaka District	-
Blantyre District	-
Chikwawa District	-
Chiradzulu District	-
Chitipa District	-
Dedza District	-
Dowa District	-
Karonga District	-
Kasungu District	-
Likoma District	-
Lilongwe District	-
Machinga District	-
Mangochi District	-
Mchinji District	-
Mulanje District	-
Mwanza District	-
Mzimba District	-
Neno District	-
Nkhata Bay District	-
Nkhotakota District	-
Nsanje District	-
Ntcheu District	-
Ntchisi District	-
Phalombe District	-
Rumphi District	-
Salima District	-
Thyolo District	-
Zomba District	-
Other_ Malawi	5,583
Total	**5,583**