

# **Malawi Country Operational Plan 2020**

## **Strategic Direction Summary**

**March 27, 2020**



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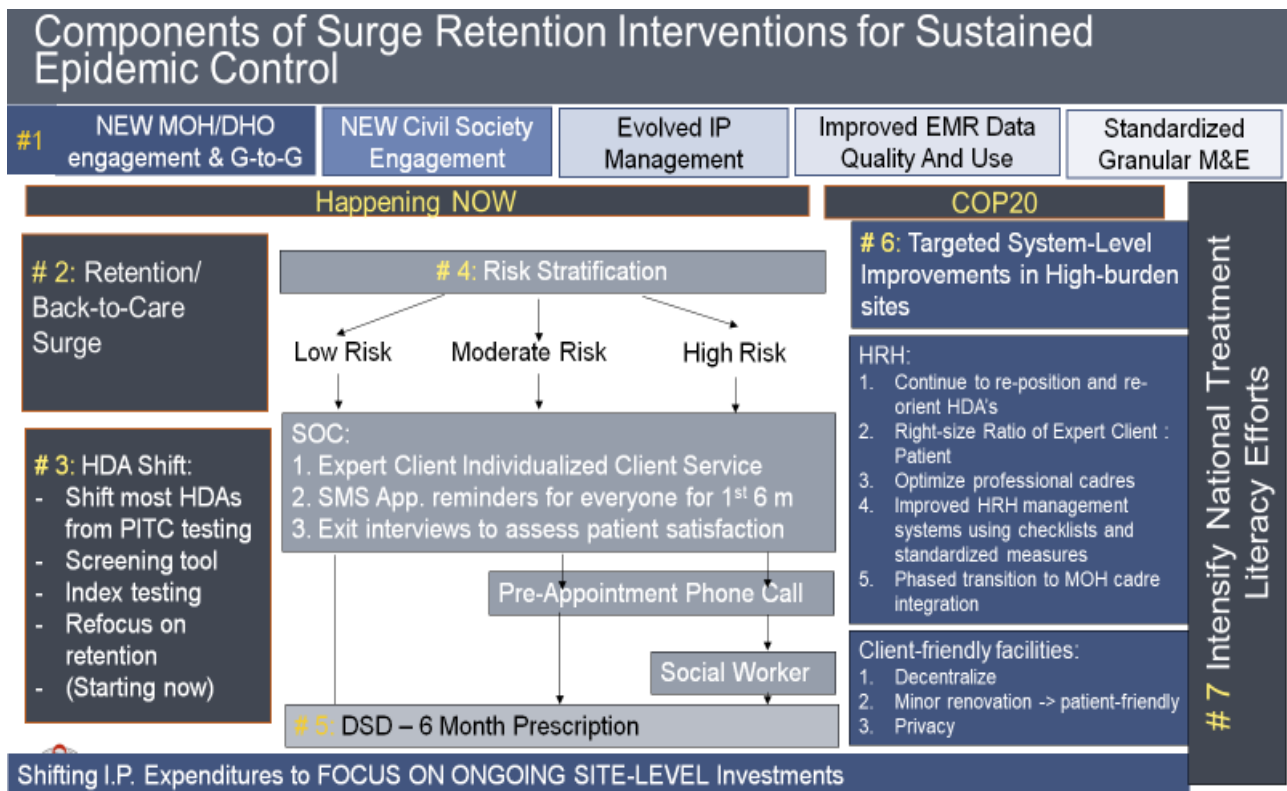
# 1.0 Goal Statement

Through the President’s Emergency Plan for AIDS Relief (PEPFAR) Country Operational Plan 2020 (COP20), the United States government (USG) will rapidly implement a direct service delivery model to improve client-centered care and support the government of Malawi (GoM) in both attaining and sustaining HIV epidemic control.

With Malawi estimated to have achieved 93-80-92 of the 95-95-95 UNAIDS goals, the PEPFAR Malawi program will need to reach 160,000 people living with HIV (PLHIV) with antiretroviral therapy (ART), retain the over 800,000 clients currently in care with client centered services and prevent transmission through accelerated treatment literacy efforts and scale high impact prevention programs.

Rigorous analyses of patient level data and partner performance has identified the retention of clients as the single greatest threat to a sustainable HIV response in Malawi. Over the past three years, PEPFAR Malawi has been successful in identifying and initiating over 380,000 clients on ART, but only retained 125,000 clients in care.

**To improve retention, return clients back to care, and prevent new infections, PEPFAR Malawi will implement the surge retention strategy presented at the Regional Planning Meeting with seven key components highlighted in the below figure and subsequent summary.**



## ***Components of Surge Retention Interventions to Sustain Epidemic Control:***

1. **New and evolved partnerships:** In COP20, PEPFAR will directly fund the GoM through new government-to-government-agreements (Ministry of Health, Ministry of Finance, National AIDS Commission (NAC), and two District Councils) to strengthen efficient service delivery, district coordination, and deployment of human resources for health (HRH). PEPFAR will also directly fund civil society organizations to conduct community-led monitoring of HIV services with the intent of identifying and addressing challenges clients face in accessing care.
2. **Back to care surge and differentiated service delivery models:** PEPFAR will actively address barriers clients face in adhering to treatment by modifying service delivery models to include adaptations of the MenStar Strategy to the Malawian context, accelerate six-month dispensing, and recruit professional healthcare workers (HCW) to provide advanced disease care. PEPFAR will also work with civil society organizations to identify and respond to issues pertaining to stigma and discrimination.
3. **Optimized human resources for health (HRH):** PEPFAR will redirect HIV diagnostic assistants (HDAs) from low yield outpatient settings towards index testing, recency and retention support, rightsizing existing HRH to align with site volume. Additionally, PEPFAR will recruit and deploy additional HCWs and lay cadres (e.g. patient supporters/ expert clients) to reduce waiting times and address psychosocial needs.
4. **Incorporating a risk stratification strategy:** Patients newly identified as HIV positive will be assessed to ensure that clients at a higher risk of defaulting receive a more tailored package of services.
5. **Shift from technical assistance to direct service delivery models:** Implementing partners will increase their level of effort at the site level by shifting from a rotational mentorship structure to deploying full time clinical mentors and staff at the site level as part of a pivot away from a technical assistance model.
6. **Intensified national treatment literacy efforts:** PEPFAR will work through civil society and government platforms to disseminate “Messages of Hope” to improve treatment literacy at the individual, community and national level.
7. **Quality data for patient management:** In COP20, PEPFAR will support efforts to increase provider utilization of electronic medical record (EMR) systems at site, district, and national levels to efficiently track patient outcomes, increase data utilization for decision-making and evaluate quality of care.

To complement retention efforts, COP20 will expand implementation of high impact prevention interventions targeting men, key populations (KP) including men who have sex with men (MSM), female sex workers (FSW), male sex workers (MSW), transgender persons, and adolescent girls and young women (AGYW). PEPFAR will aim to accelerate voluntary medical male circumcision (VMMC) saturation goals, by focusing investments in Blantyre, Lilongwe, and Chikwawa to reach 157,421 men ages 15-29. PEPFAR Malawi will also increase access and demand for Pre-Exposure

Prophylaxis (PrEP) which will be provided to 16,000 new clients including AGYW, pregnant and breastfeeding women, sero-discordant couples, and KP.

HIV testing services at the site level will become more streamlined through the consolidation of provider-initiated testing counseling (PITC) testing points, expansion of HIV self-testing (HIVST), continued validation of screening tools, and task-shifting of HDAs to identify high risk clients and reduce over testing. Case-finding efforts will be targeted in antenatal care (ANC), tuberculosis (TB), and sexually transmitted infections (STI) settings with index modalities targeting men and high-risk individuals. Adherence to the 5Cs (consent, confidentiality, counseling, correct test results and connection to prevention/treatment) will be a key requirement to index testing modalities, in addition to, site certifications, intimate partner violence (IPV) screenings and referrals. PEPFAR's testing strategy and investments align with the strategic priorities in the National Strategic Plan (NSP) and interventions proposed in the Global Fund grant application submitted March 23,2020.

The orphans and vulnerable children (OVC) portfolio will strengthen collaborative efforts with clinical partners and health facilities to ensure that prevention services are delivered to 9-14-year old boys and girls and children living with HIV are enrolled into the OVC program. DREAMS programming will be scaled to reach saturation goals in Blantyre, Zomba, and Machinga with an expanded social asset building and gender-based violence (GBV) prevention activities, economic strengthening, and employment opportunities for beneficiaries. The DREAMS database will enable the program to track layering of services and completion of the minimum package while investments via the Secondary Education Expansion for Development (SEED) and the Historically Black Colleges and University (HBCU) Initiative will also complement efforts to increase opportunities for AGYW.

Mapping and social networking approaches will be scaled to reach untested key populations while strengthening the continuum of care for KP living with HIV to include orientation for health workers, law enforcement, and communities to address stigma and discrimination, and institutional strengthening of KP-led networks.

Case-based surveillance including recency, HIV drug resistance (HIVDR) testing, birth defect monitoring, and point of care (POC) EMR platforms will remain critical to ensure near real-time program monitoring for sustained epidemic control. PEPFAR Malawi is committed to ensuring that HIV epidemic control is both achieved and sustained with the greatest efficiency, continuous data analyses, and close collaboration with the government and other stakeholders.

## 2.0 Epidemic, Response, and Program Context

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### 2.1 Summary Statistics, Disease Burden, and Country Profile

Malawi is a low-income country (GNI: 320 per capita<sup>1</sup>) with a population of more than 19.5 million people<sup>2</sup>. Although a small country, Malawi's HIV prevalence, at 6.3% overall and 10.6% among adults, is among the highest in the world<sup>3</sup>.

1.1 million Malawians are living with HIV; of which, 57% of are women, 38% men, and 5% are children under 15. Malawi has made good progress toward reaching the 95-95-95 UNAIDS goals, and at the end of September 2019, an estimated 93% of all PLHIV knew their HIV status, 80% of PLHIV with known status were on ART, and 92% of PLHIV on ART were virally suppressed. Despite the progress, some critical disparities by geography and populations persist. The greatest gaps to reaching 90% ART coverage are in Blantyre, Lilongwe, and Zomba.

Within Malawi, HIV prevalence varies widely by region, with prevalence among adults ranging from 4.9% in the Central-East to 17.7% in Blantyre City. Prevalence is highest in the urban centers of Blantyre and Lilongwe (14.2% among adults aged 15-64 with urban residence) and differs significantly by age and sex. HIV prevalence is nearly twice as high among females 15-24 years old (3.4%), and nearly three times as high among females 25-29 years old (13.6%) than among males in the same age brackets (1.5% and 4.7%, respectively). Prevalence peaks among females 40-44 years old at 24.6% and among males 45-49 years old at 22.1%. The migration of youth to urban centers, a growing youth bulge, and sub-optimal levels of viral suppression in urban areas has contributed to higher incidence and prevalence among young people.

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<sup>1</sup> World Bank. GNI per capita, Atlas method (current USD\$). <https://data.worldbank.org/indicator/NY.GNP.PCAP.CD?locations=MW>. 2017. Accessed March 18, 2019

<sup>2</sup> Spectrum 2020 estimates, for 2020

<sup>3</sup> Government of Malawi National Statistical Office. 2018 Population and Housing Census: Preliminary Report. [http://www.nsomalawi.mw/images/stories/data\\_on\\_line/demography/census\\_2018/2018%20Population%20and%20Housing%20Census%20Preliminary%20Report.pdf](http://www.nsomalawi.mw/images/stories/data_on_line/demography/census_2018/2018%20Population%20and%20Housing%20Census%20Preliminary%20Report.pdf). December, 2018.

**Table 2.1.1 Host Country Government Results**

| Table 2.1.1 Host Country Government Results  |            |      |           |    |           |    |           |      |           |      |           |      |           |      |  |
|--|------------|------|-----------|----|-----------|----|-----------|------|-----------|------|-----------|------|-----------|------|--|
|  | Total      |      | <15       |    |           |    | 15-24     |      |           |      | 25+       |      |           |      | Source, Year   |
|  |            |      | Female    |    | Male      |    | Female    |      | Male      |      | Female    |      | Male      |      |  |
|  | N          | %    | N         | %  | N         | %  | N         | %    | N         | %    | N         | %    | N         | %    |  |
| Total Population                             | 19,536,180 | 100  | 4,118,393 | 21 | 4,188,283 | 21 | 2,049,632 | 10   | 2,041,149 | 10   | 3,734,313 | 19   | 3,404,408 | 17   | Spectrum 2020 estimates, for 2020  |
| HIV Prevalence (%)                           |            | 5.7  |           | .8 |           | .8 |           | 4.1  |           | 1.5  |           | 18.2 |           | 13   | Spectrum 2020 estimates, for 2020  |
| AIDS Deaths (per year)                       | 12,667     |      | 713       |    | 733       |    | 956       |      | 772       |      | 4,545     |      | 4,948     |      | Spectrum 2020 estimates, for 2020  |
| # PLHIV                                      | 1,077,268  |      | 26,014    |    | 26510     |    | 75,801    |      | 40,017    |      | 539,176   |      | 369,747   |      | Spectrum 2020 estimates, for 2020  |
| Incidence Rate (Yr)                          |            | 0.39 |           | NA |           | NA |           | 0.40 |           | 0.05 |           | 0.61 |           | 0.42 | MPHIA, 2015-16   |
| New Infections (Yr)                          | 32,211     |      |           |    |           |    |           |      |           |      |           |      |           |      | Spectrum 2020 estimates, for 2020  |
| Annual births                                | 630,187    | 100  |           |    |           |    |           |      |           |      |           |      |           |      | Spectrum 2020 estimates, for 2020  |
| % Pregnant Women with at least one ANC visit |            | 99.4 |           | NA |           |    |           | 99.6 |           |      |           | 99.2 |           |      | MPHIA, 2015-16   |
| Pregnant women needing ARVs                  | 41,574     | NA   |           |    |           |    |           |      |           |      |           |      |           |      | Spectrum 2020 estimates, for 2020  |
| Orphans (maternal, paternal, double)         | 1,085,900  |      | NA        |    | NA        |    | NA        |      | NA        |      | NA        |      | NA        |      | OVC rates from MDHS 2015-16 applied to 2019 projection of the population (2010 population census projections). |
| Notified TB cases (Yr)                       | 16,791     |      | NA        |    | NA        |    | NA        |      | NA        |      | NA        |      | NA        |      | National TB Program Quarterly Data, FY2019   |

|                                     |                |                  |    |    |         |     |    |    |         |      |    |    |    |         |     |  |
|-------------------------------------|----------------|------------------|----|----|---------|-----|----|----|---------|------|----|----|----|---------|-----|--|
| % of TB cases that are HIV infected | 7,878          | 47               | NA | NA | NA      | NA  | NA | NA | NA      | NA   | NA | NA | NA | NA      | NA  | National TB Program Quarterly Data, FY2019 |
| % of Males Circumcised              | 503,934 (0-64) | 9.2 (adults 15+) |    |    | 123,753 | 3.2 |    |    | 207,232 | 12.8 |    |    |    | 172,949 | 6.9 | MPHIA, 2015-16                             |
| Estimated Population Size of MSM*   | 10,376         |                  |    |    |         |     |    |    |         |      |    |    |    |         |     | Spectrum 2020 estimates, for 2020          |
| MSM HIV Prevalence                  |                | 14               |    |    |         |     |    |    |         |      |    |    |    |         |     | Spectrum 2020 estimates, for 2020          |
| Estimated Population Size of FSW    | 27,312         |                  |    |    |         |     |    |    |         |      |    |    |    |         |     | Malawi Place Report, May 2018              |
| FSW HIV Prevalence                  |                | 15               |    |    |         |     | NA | NA |         |      | NA | NA |    |         |     | Spectrum 2020 estimates, for 2020          |

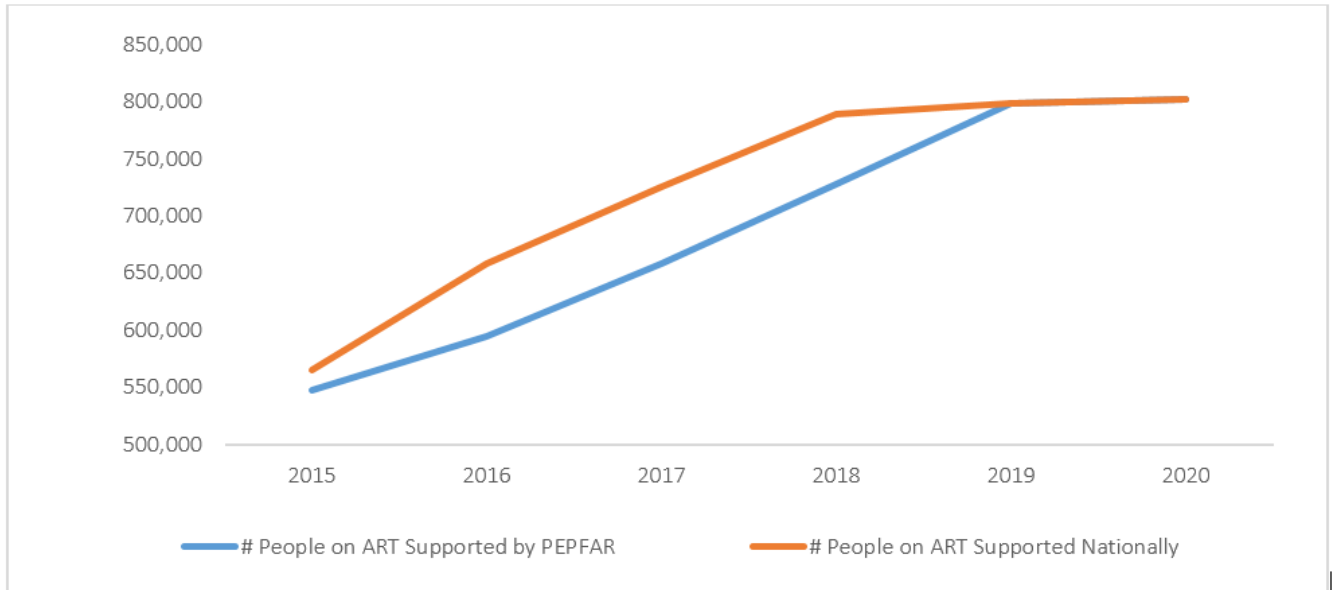


Table 2.1.2 95-95-95 Cascade: HIV Diagnosis, Treatment, and Viral Suppression

| Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression |                                       |                       |                              |                        |                                     |                     |                          |   |                               |                         |
|--|---------------------------------------|-----------------------|------------------------------|------------------------|-------------------------------------|---------------------|--------------------------|---|-------------------------------|-------------------------|
| Epidemiologic Data   |                                       |                       |                              |                        | HIV Treatment and Viral Suppression |                     |                          | HIV Testing and Linkage to ART Within the Last Year |                               |                         |
|  | Total Population Size Estimate<br>(#) | HIV Prevalence<br>(%) | Estimated Total PLHIV<br>(#) | PLHIV diagnosed<br>(#) | On ART<br>(#)                       | ART Coverage<br>(%) | Viral Suppression<br>(%) | Tested for HIV<br>(#)                               | Diagnosed HIV Positive<br>(#) | Initiated on ART<br>(#) |
| Total population   | 19,536,180                            | 6%                    | 1,077,268                    | 944,826                | 925,139                             | 86%                 | 85%                      | 4,099,366   | 114,335                       | 107,413                 |
| Population <15 years   | 8,306,678                             | 1%                    | 52,527                       | 44,491                 | 44,491                              | 85%                 | 66%                      | no data   | no data                       | 10,072                  |
| Men 15-24 years  | 2,041,148                             | 2%                    | 40,019                       | 22,602                 | 27,958                              | 70%                 | 54%                      | no data   | no data                       | 4,283                   |
| Men 25+ years  | 3,404,410                             | 11%                   | 369,747                      | 322,446                | 293,558                             | 79%                 | 69%                      | no data   | no data                       | 34,922                  |
| Women 15-24 years  | 2,049,630                             | 4%                    | 75,800                       | 52,340                 | 57,358                              | 76%                 | 56%                      | no data   | no data                       | 16,423                  |
| Women 25+ years  | 3,734,314                             | 14%                   | 539,175                      | 502,947                | 501,774                             | 93%                 | 83%                      | no data   | no data                       | 41,714                  |
|  |                                       |                       |                              |                        |                                     |                     | no data                  | no data   | no data                       | no data                 |
| MSM  | 10,376                                | 14%                   | 1,327                        |                        | 1310                                | 99%                 | no data                  | no data   | no data                       | no data                 |
| FSW  | 27,312                                | 15%                   | 3,613                        |                        | 3156                                | 87%                 | no data                  | no data   | no data                       | no data                 |
| Priority Pop (specify)   | 15,785                                | 17%                   | 2,683                        |                        | 2,279                               | 85%                 | no data                  | no data   | no data                       | no data                 |

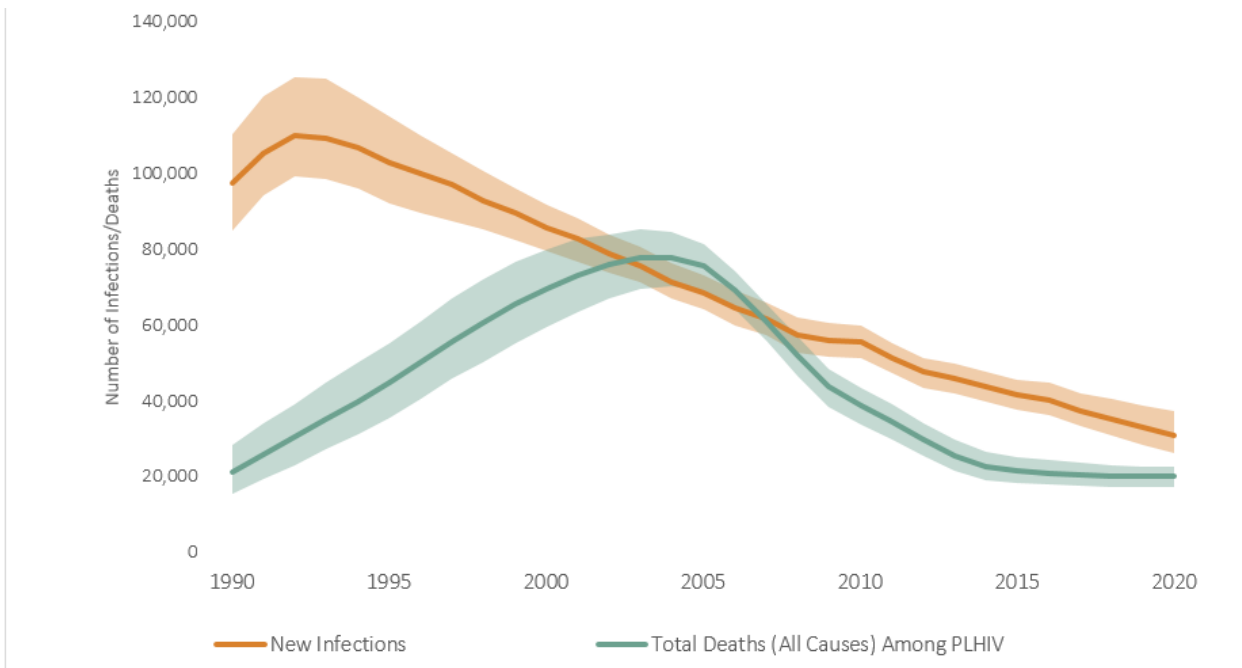
Source: COP20 Datapack

**Figure 2.1.3 Updated National and PEPFAR Trend for Individuals Currently on Treatment**

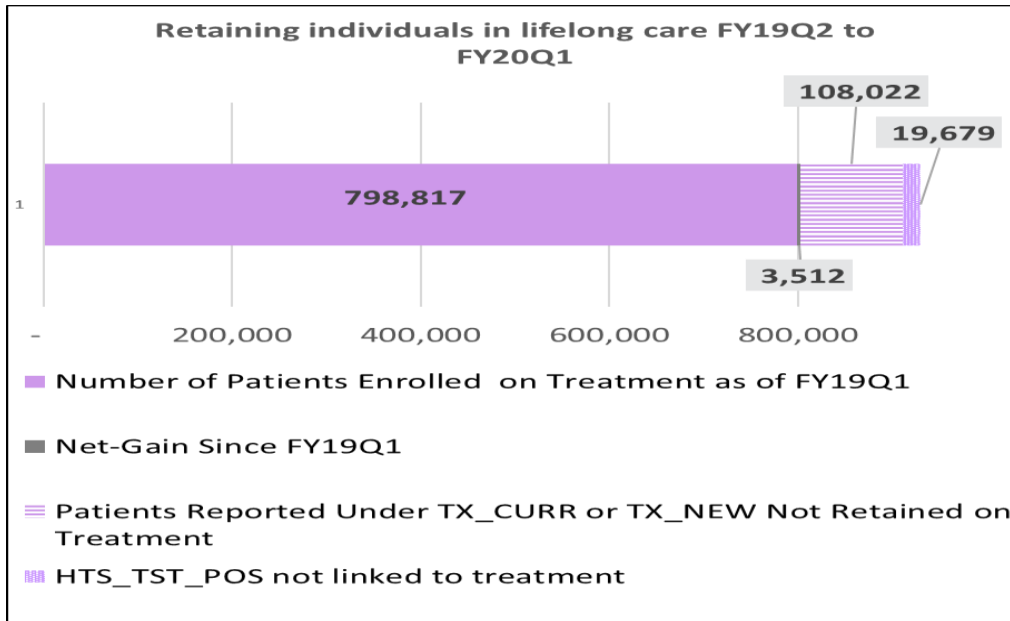


Source: FY20 Q1 TX\_CURR in Panorama

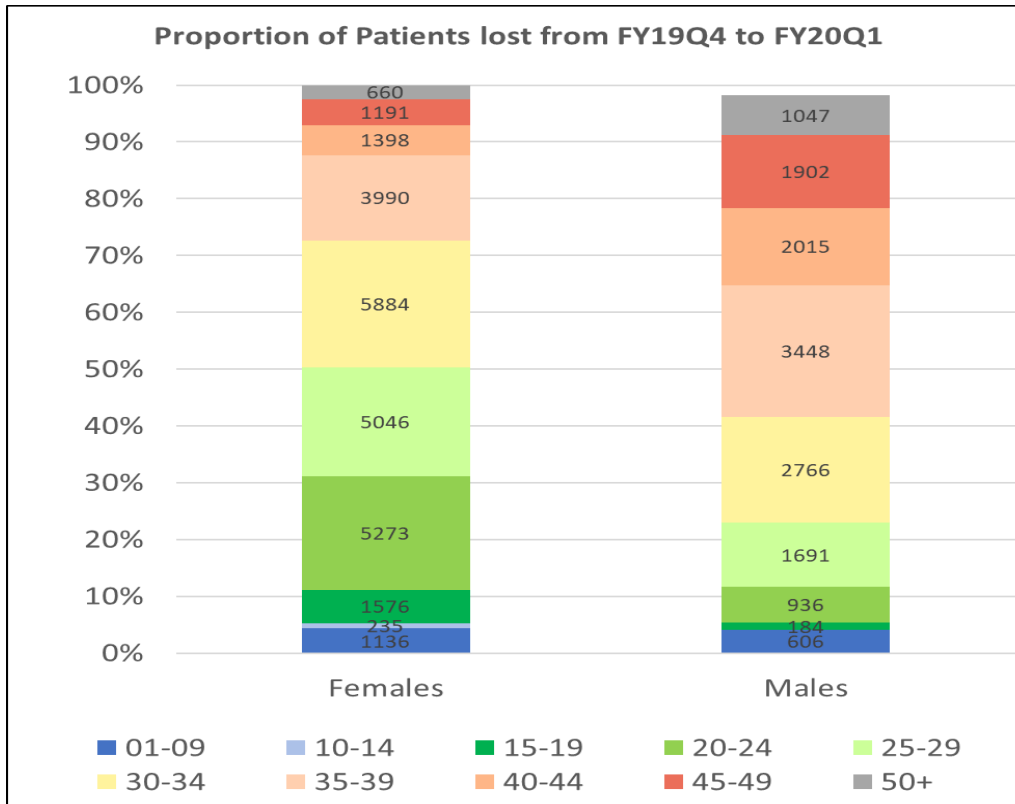
**Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality among PLHIV**



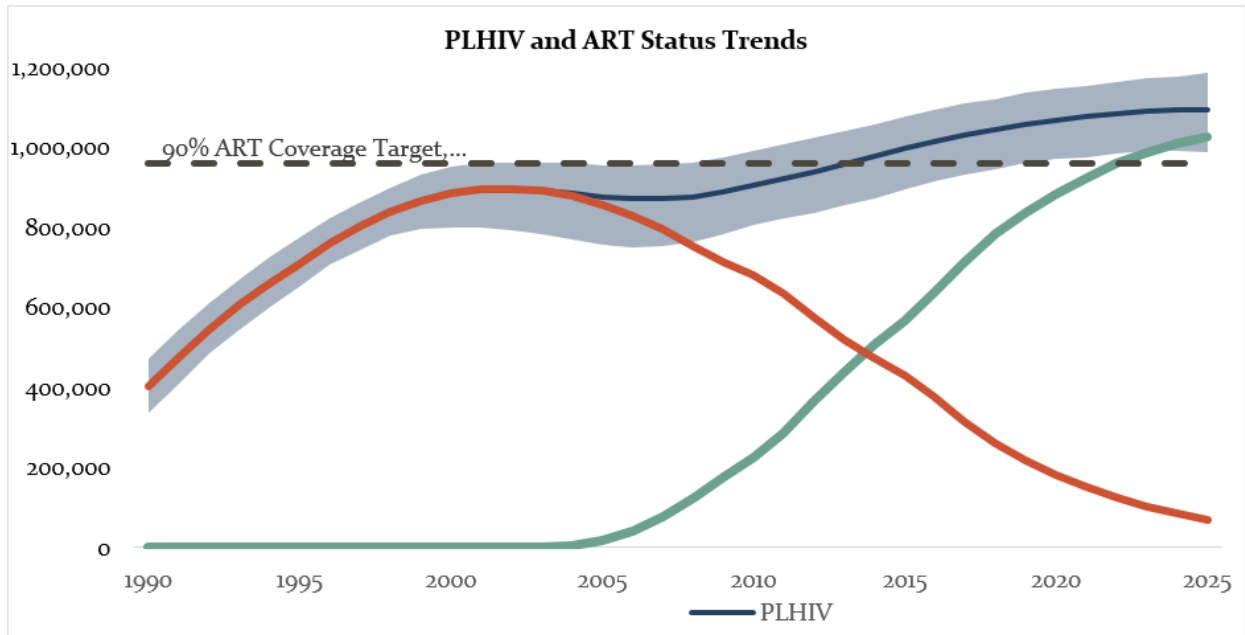
**Figure 2.1.5 Progress Retaining Individuals in Lifelong ART in FY19 and FY20 Q1**



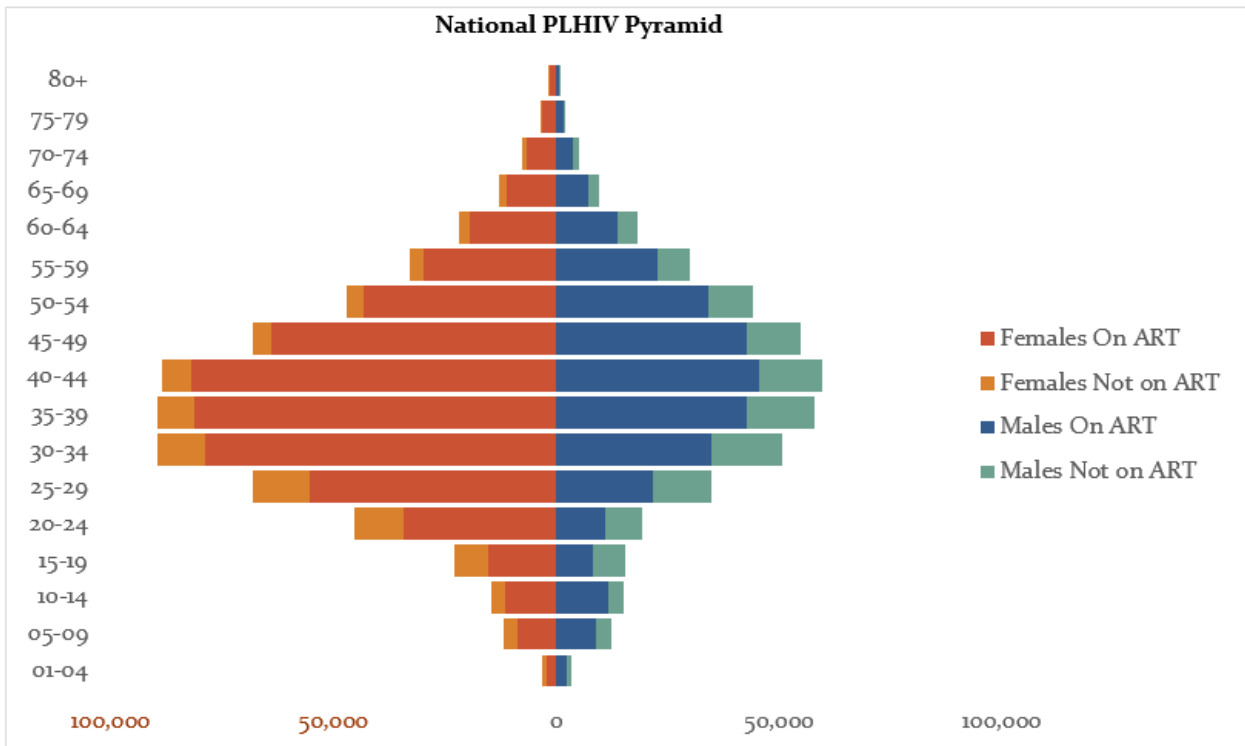
**Figure 2.1.6 Proportion of Clients Lost from ART FY19 Q4 to FY20 Q1**



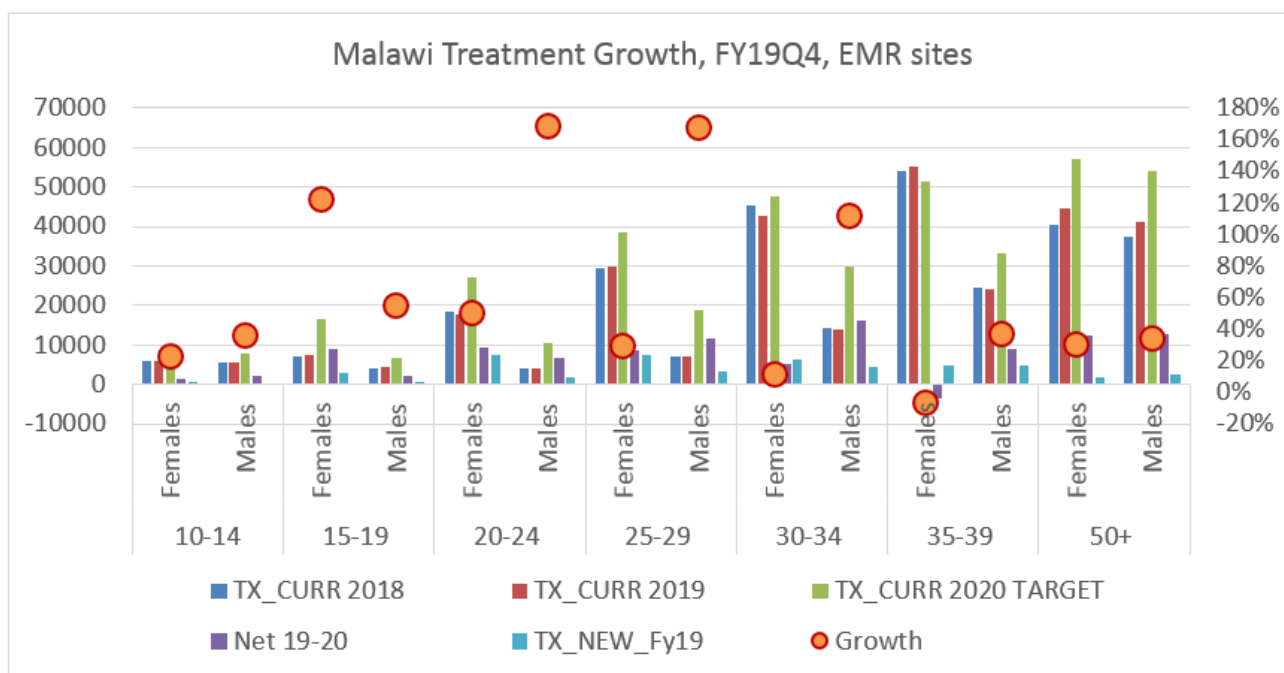
**Figure 2.1.7 Epidemiologic Trends and Program Response**



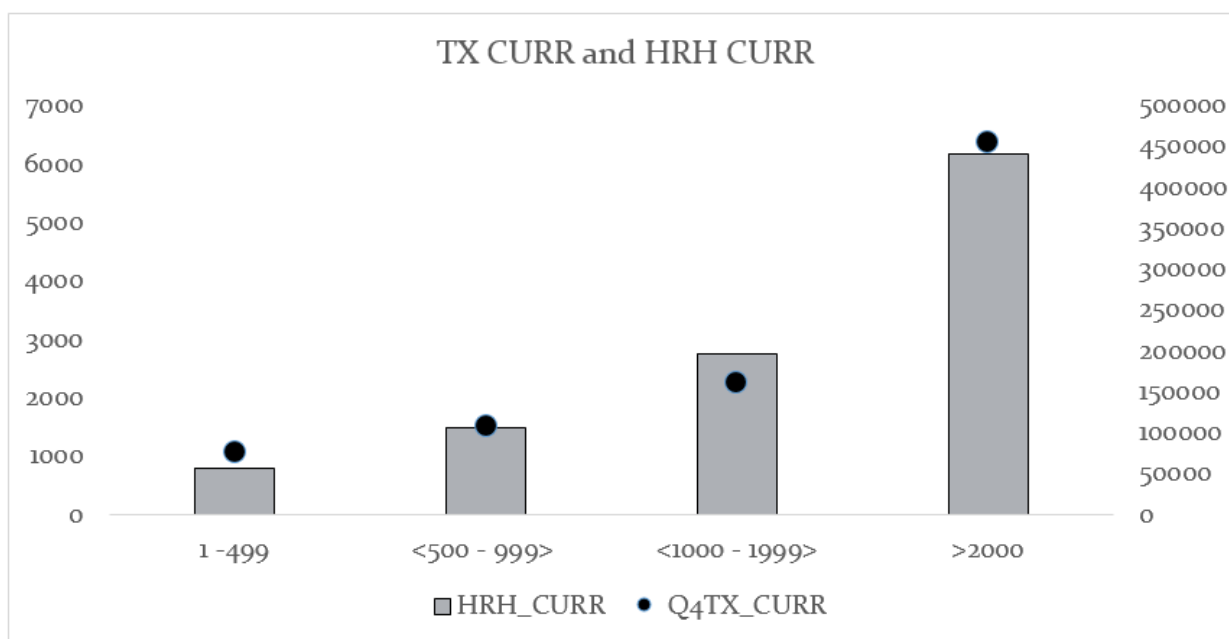
**Figure 2.1.8 ART Coverage by Age/Sex**



**Figure 2.1.9 Net Change in HIV Treatment by Sex and Age Bands 2018 Q4 to 2019 Q4**



**Figure 2.1.10 Staffing Deployment Stratified by Site Volume**



**2.2 New Activities and Areas of Focus for COP20, including Focus on Client Retention**

With the aim of addressing critical gaps in client retention, PEPFAR Malawi will introduce the following new interventions in COP20:

- **Community-led monitoring:** PEPFAR will provide funding to civil society organizations (CSOs) for community-led monitoring of the national HIV/AIDS response in line with national and PEPFAR strategic priorities. PEPFAR Malawi will work with CSOs to establish effective feedback mechanisms that enable timely resolution of problems and/or broader application of good practices.
- **Patient stratification:** PEPFAR Malawi will work with the Department of HIV/AIDS (DHA) to devise standardized approaches to categorize patients based on outcome and/or risk for loss to follow up in order to provide tailored client centered services.
- **Optimizing HRH:** PEPFAR Malawi’s major input for site-level direct service delivery is human resources. PEPFAR will recruit and deploy clinicians (not currently employed through the government establishment) to scale up advanced disease care and management of high viral load. Individuals with strong psychosocial or counseling skills (i.e. social workers) will be hired and deployed to selected high-volume facilities to improve access to quality counseling for clients at a higher risk for attrition. Significant reductions in COP20 testing targets will enable HDAs to support retention interventions. Based on a careful review of expenditure reporting data, PEPFAR Malawi will shift IP-level resources from non-service delivery activities to service delivery. This will enable the program to address HRH gaps at the site-level and deploy additional resources to retention efforts, as well as, re-engagement of clients brought back into care.
- **Client exit interviews:** Client-centered care, which is at the core of PEPFAR’s COP20 strategy, requires understanding clients’ preferences, concerns, and fears. PEPFAR Malawi will work through CSOs funded to support monitoring activities to facilitate exit interviews among ART clients. Information collected through this process will be used to inform real- time programmatic and service adjustments that are responsive to concerns raised by clients.
- **Strengthening local ownership:** In COP20, PEPFAR will initiate direct funding agreements with the Ministry of Health, Ministry of Finance, National AIDS Commission, and two District Councils.
- **Use of unique IDs:** PEPFAR Malawi will work the Ministry of Health to use unique IDs for the HIV program. Unique IDs will complement other retention interventions by enabling tracking of movement of patients across sites in the national program. Understanding patient movement across sites will help the program grasp the number of “true defaulters” and channel tracing efforts to those groups, as opposed to “silent transfers.”
- **Timely transmission of viral load/early infant diagnosis (EID) results:** PEPFAR Malawi will collaborate with the Bill and Melinda Gates Foundation to establish an electronic results transmission system for viral load and EID results. This system will transmit an alert with the availability of results from labs directly to sites and clients simultaneously. Timely receipt of viral load and EID results by providers and clients will assist appropriate actions to be taken immediately in the event of a high viral load or positive EID result.

### **2.3 Investment Profile**

The Malawian health sector relies heavily on funding from external sources. The National HIV program is almost entirely funded through international donors (95%). Based on 2019 preliminary HIV expenditure data, PEPFAR contributed 49% of total available HIV resources, the Global Fund contributed 45% while other external and domestic resources contributed 6% and 0.1% respectively. Between 2018 and 2019, multilateral donor contributions to the HIV response dropped from \$9 million to approximately \$1.9 million. Additionally, the country's contribution to the Abuja Declaration fell short of the 15% promised.

While Malawi has limited fiscal space, the GoM is commended for investments in health systems strengthening including HRH, health infrastructure, essential medicines, and prevention efforts. The Global Fund finances the procurement of health products, paying for 99% of all HIV-related commodities.

Since 2004, PEPFAR has invested over \$1 billion in HIV service provision to efficiently identify PLHIV, ensuring all newly diagnosed PLHIV are immediately linked to treatment, retained on treatment, and are virally suppressed. In partnership with the GoM, PEPFAR and USAID Education are currently implementing the Secondary Education Expansion for Development (SEED) project, a \$90 million initiative to build up to 200 new secondary schools where educational access has been limited. In COP20, PEPFAR Malawi will invest over \$195 million, continuing its support to the HIV program implementation and maintaining epidemic control.

The COP20 development cycle provided an opportune time for both PEPFAR and Global Fund (GF) to reaffirm commitments to support the national HIV response in Malawi and to harmonize investments for the greatest impact. As the country develops the GF application for 2020-2022, the complementary nature of the two investments remains critical to ensuring coordination and efficient use of resources. PEPFAR's significant investment in service delivery including human resources, and the Global Fund's grant ensures a secure commodity supply chain to with access to ARVs, lab monitoring, and HIV testing commodities. Close coordination between PEPFAR and Global Fund prevents investment duplication and leverages comparative advantages to reach more districts with quality services.

**Table 2.3.1 Annual Investment Profile by Program Area**

| Table 2.3.1 Annual Investment Profile by Program Area |                    |           |           |                |           |
|---|--------------------|-----------|-----------|----------------|-----------|
| Program Area  | Absolute Total     | % PEPFAR  | % GF      | % Host Country | % Other   |
| Clinical CTS  | 134,662,014        | 28        | 72        | 0.1            | 1         |
| Community-based CTS                                   |                    |           |           |                |           |
| HTC   | 37,602,023         | 50        | 33        | 0.0            | 17        |
| VMMC  | 13,249,817         | 94        |           | 0.1            | 6         |
| Prevention ( AGYW, PMTCT, Priority Population)        | 23,280,099         | 34        | 65        |                | 1         |
| Key Population Prev.                                  | 1,852,732          | 100       |           |                |           |
| OVC   | 4,842,563          | 100       |           |                |           |
| Laboratory  | 4,251,127          | 83        |           | 0.0            | 17        |
| SI, Surveys and Surveillance                          | 7,190,974          | 100       |           |                |           |
| HSS   | 10,689,799         | 38        |           | 1.9            | 60        |
| PM  | 34,354,356         | 100       |           |                |           |
| <b>TOTAL</b>  | <b>271,975,504</b> | <b>49</b> | <b>46</b> | <b>0.1%</b>    | <b>6%</b> |

Source: PEPFAR 2019 Expenditure Report and MoH Resource Mapping 2019

**Table 2.3.2 Annual Procurement Profile for Key Commodities in COP19**

| Table 2.3.2 Annual Procurement Profile for Key Commodities in COP19 |                    |          |      |                |
|---|--------------------|----------|------|----------------|
| Commodity Category  | Total Expenditure  | % PEPFAR | % GF | % Host Country |
| ARVs  | 85,782,826         | 0        | 100  | 0              |
| Rapid test kits   | 4,553,899          | 3        | 97   | 0              |
| Other drugs   | 0                  |          |      |                |
| Lab reagents  | 8,503,470          | 0        | 100  | 0              |
| Condoms   | 1,652,939          | 51       | 49   | 0              |
| Viral Load commodities  | 22,421,058         | 0        | 100  | 0              |
| VMMC kits   | 3,545,107          | 47       | 53   | 0              |
| MAT   |                    |          |      |                |
| Other commodities (STI + OIs)                                       | 13,122,414         | 0        | 100  | *              |
| <b>Total</b>  | <b>139,581,713</b> |          |      |                |



**Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration**

| Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration |                                |  |                 |                                    |  |
|--|--------------------------------|--|-----------------|------------------------------------|--|
| Funding Source   | Total USG Non-PEPFAR Resources | Non-PEPFAR Resources Co-Funding PEPFAR IMs | # Co-Funded IMs | PEPFAR COP Co-Funding Contribution | Objectives   |
| USAID MNCH   | 17,500,000                     | 2,900,000                                  | 2               | 1,550,000                          | To reduce maternal and child morbidity and mortality, strengthen health systems to deliver primary health care services. |
| USAID TB   | 2,500,000                      | 644,000                                    | 1               | 470,929                            | To strengthen TB screening prevention, diagnosis, and treatment among PLHIV, including IPT delivery.                     |
| USAID Malaria  | 24,000,000                     | 350,000                                    | 1               | 275,000                            | To strengthen health systems to deliver primary health care services.  |
| Family Planning  | 11,000,000                     | 1,550,000                                  | 2               | 1,050,000                          | These co-funded mechanisms provide support to strengthen health systems to deliver primary health care services.         |
| Nutrition  | 7,500,000                      | 450,000                                    | 2               | 675,000                            | To strengthen health systems to deliver primary health care services.  |
| <b>Total</b>   | <b>62,500,000</b>              | <b>5,894,000</b>                           | <b>8</b>        | <b>4,020,929</b>                   |  |

#### 2.4 National Sustainability Profile Update

In September 2019, PEPFAR Malawi and UNAIDS co-convened a two-day stakeholder Sustainability Index and Dashboard (SID) workshop to identify key areas for collaborative strategic planning ahead of COP20 and the Global Fund 2021 grant writing process.

Sustainability Strengths:

- **Quality management:** The GoM has institutionalized quality management systems through existing budget commitments to lead pre- and in-service trainings, and implementation plans for quality improvement. Although the Quality Management (QM) program has no specific HIV Quality Improvement (QI) projects funded, the country has a QM strategic plan and QI checklist which includes HIV specific elements.
- **Planning and coordination:** Malawi’s multi-year, costed National Strategic Plan for HIV/AIDS (NSP) 2020-2025 includes strategies to minimize the impact of HIV and addresses social vulnerabilities. Through the National AIDS Commission’s (NAC) leadership, consultative efforts were put in place to ensure a fully inclusive NSP process

with opportunities for active participation by grassroots CSOs, business cooperatives, private providers, and medical insurance companies.

- **HRH:** Malawi has a National Human Resource for Health Strategic Plan, Community Strategy (not yet funded), and in the NSP, a delineated community-based health workers' role and responsibilities for HIV/AIDS service delivery plan which is well defined. In order to better support Malawi's decentralization approach, there is a need to develop a multi-year strategy and strengthen and leverage existing community and traditional structures to anchor and sustain HIV programs and services. The GoM provides almost all health worker salaries, but inadequate quantity and poor distribution of health workers compromises the quality of service delivery; although many donor contributions aim to expand HRH and promote task shifting to lower level cadres (e.g. HDAs, mentor mothers, expert clients, and community facilitators). The country's pre-service education institutions have updated HIV/AIDS content within the last three years but struggle to produce an adequate supply and mix of skilled clinical health care providers. The Department of Human Resource Management manages and monitors the health workforce with an insufficient budget and lacks a Human Resource Information System (HRIS) to track existing HRH and recent student graduates. While the MoH collects and uses available health worker employee data (e.g. inventories) with plans underway for donor-supported workers to transition to the government system, there is a need for a comprehensive assessment of cadres by service provision category.
- **Financial and expenditure data:** The GoM partially finances the collection of service delivery data and leads the National AIDS Spending Assessments (NASA) and resource mapping exercises. Implementing a harmonized system to routinely track HIV related expenditures remains a priority. Malawi is currently in the process of conducting a new NASA.

#### Sustainability Vulnerabilities:

- **Epidemiological and health data:** There is a need to strengthen routine data collection and monitoring, maximizing its use for surveillance and addressing chronic data-related staffing and skills gaps. Most epidemiological surveys and surveillance activities are donor funded. The MoH should consider including HIV-specific surveys under the National Statistical Office strategic plans to increase technical capacity.
- **Commodity security and supply chain:** In 2018, Malawi adopted new policies including annual VL testing, transition to DTG based regimens, PrEP, and HIV Self-Testing. While a national supply chain strategic plan is available and the GoM manages processes and systems to ensure appropriate commodity stocks, Malawi relies solely on the GF for ARV and HIV test kit procurements. Although no recent ARV stockouts and thefts have been confirmed, these have been reported by various channels including communities and there is room for improvement in assessment, management, and monitoring of supply chain at all levels. PEPFAR will continue to provide technical assistance and support for forecasting and quantification of medicines to reduce stock outs and shortages.

- **Domestic resource mobilization:** The GoM budget is constrained by a low GDP and limited fiscal opportunities. New approaches to increase domestic resource mobilization, allocation, and expenditures remain critical to sustainable financing.
- **Technical and allocative efficiencies:** Malawi routinely collects, analyzes, and makes data available on the HIV/AIDS epidemic and its effects on health outcomes. However, epidemiological data is not always used to inform resource decisions by geography and or by burden of disease. Tracking of unit costs for domestic resources and taking steps to improve HIV/AIDS outcomes within the available resource envelope is critically important.
- **Malawi Responsibility Matrix (RM) 2019:** Findings from the RM show the GoM/MoH hold the primary responsibility of oversight for the HIV response and funding of health personnel. Commodity procurement and implementation support currently lies with the Global Fund and PEPFAR.

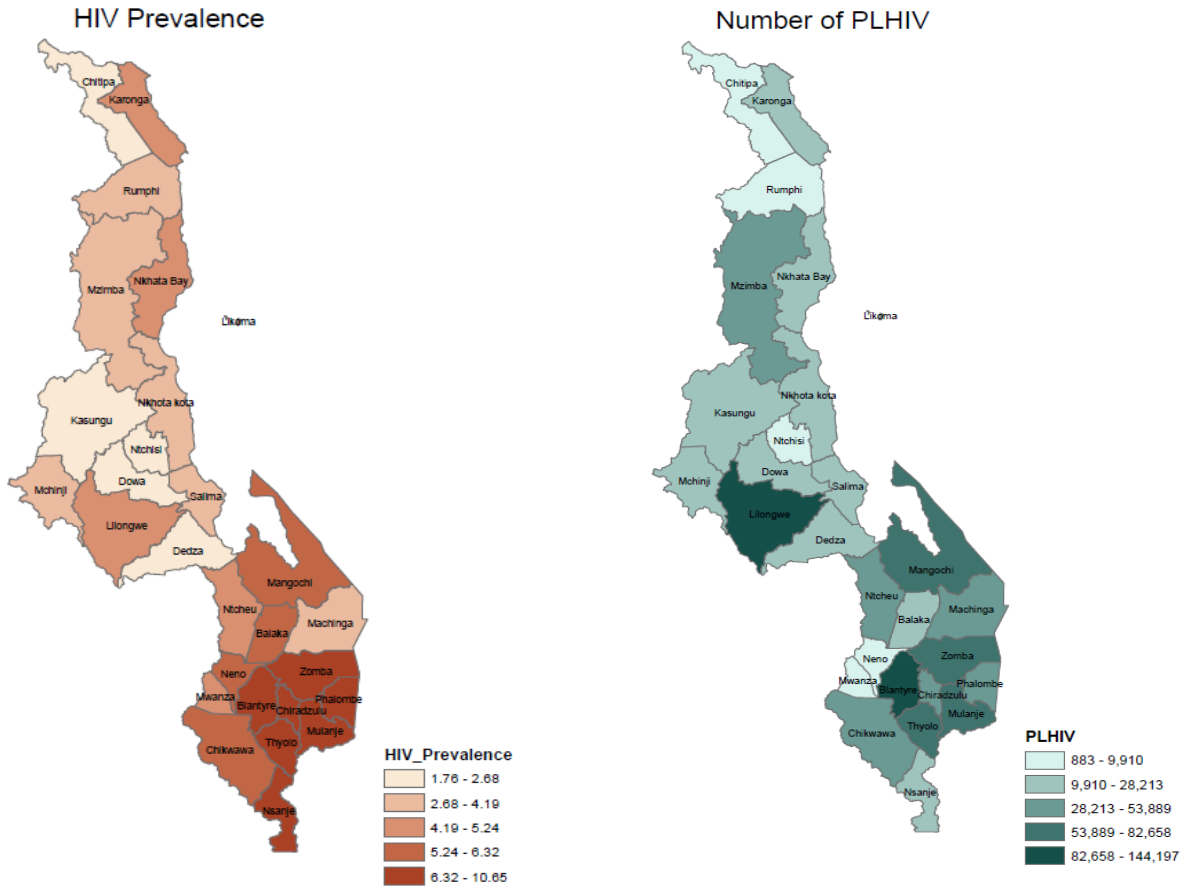
Global Fund proposed investments for the next funding cycle will cover ARV, lab, point of care and EID commodities, programming for AGYW, sexual and reproductive health service integration, STI drugs and essential medicines, in addition to, systems strengthening investments which will compliment PEPFAR COP20 activities.

PEPFAR Malawi is also working towards an accelerated transition to indigenous partnerships. COP20 will highlight new investments in government-to-government mechanisms to support sustainable programming, capacitate national systems, and maximize efficiencies and costs. Over \$1 million will be allocated in COP20 to support community-led monitoring, treatment literacy, advocacy, and oversight efforts to ensure that recipients of care have access to client-friendly services, a feedback loop to report stigma, discrimination, and support district-level coordination efforts. Umbrella awards will also be developed to help graduate local organizations from sub to prime partners.

## 2.5 Alignment of PEPFAR Investments Geographically to Disease Burden

Figure 2.5.1 below outlines district-level HIV burden, ART coverage, and viral load coverage. PEPFAR strategically focuses investments in high-burden scale-up districts. In COP20, PEPFAR will focus on the 11 scale-up districts with the greatest PLHIV burden and largest remaining gaps to 90% ART coverage in Blantyre, Chikwawa, Chiradzulu, Lilongwe, Machinga, Mangochi, Mulanje, Mzimba, Phalombe, Thyolo, and Zomba.

**Figure 2.5.1 HIV Prevalence, People Living with HIV, Treatment Coverage, and Viral Load Monitoring Coverage**



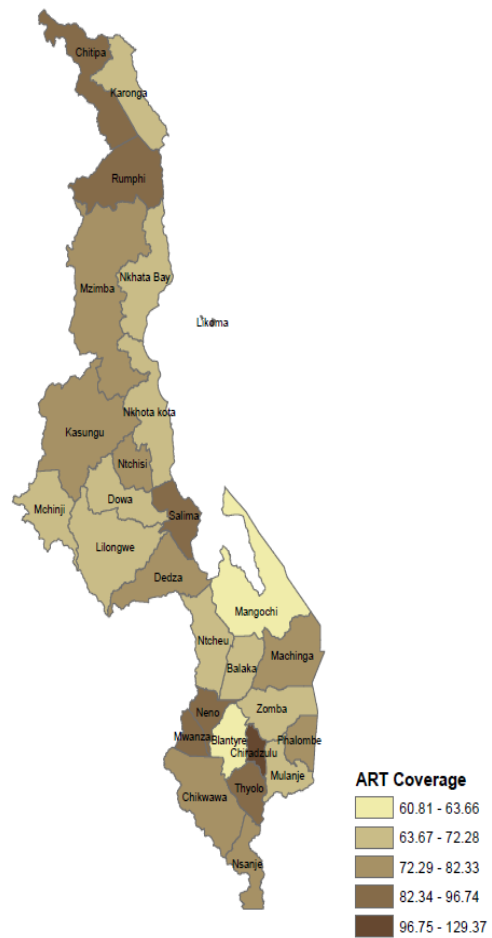
Source: Spectrum v6, Fine age/sex calibrated Naomi output

**Figure 2.5.2 ART Coverage, FY20 Q1 ART Coverage, COP20 Viral Load Coverage**

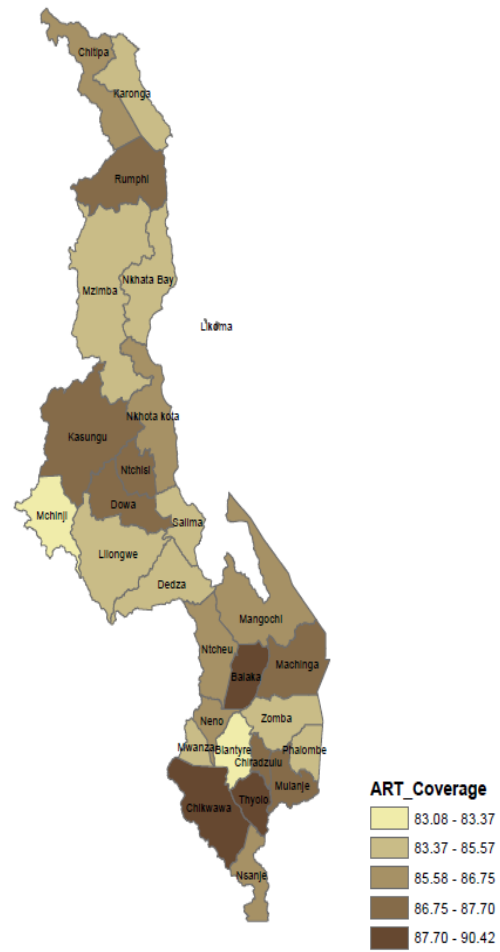
ART Coverage, FY20 Q1

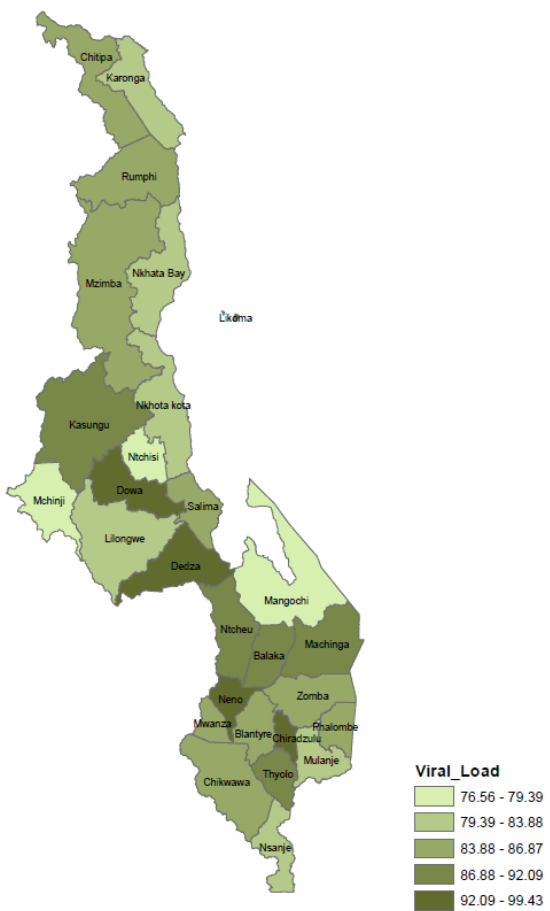
ART Coverage, COP20

Viral Load Coverage



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Source: Spectrum v6, DATIM

## 2.6 Stakeholder Engagement

Recent stakeholder engagements leading up to and including the COP20 development include:

January 10, 2020: Faith and Community Initiative (FCI) – PEPFAR convened FCI partners to review workplans by geographic and programmatic focus to facilitate coordination and ensure there are no duplication of efforts.

- **January 24, 2020:** Civil society hosted a presentation of CSO Forum findings on HIV and related conditions in selected PEPFAR supported scale-up districts.
- **January 27 – 29, 2020:** PEPFAR hosted a stakeholder retreat to kick off the Country Operational Planning 2020 (COP20) planning process. Participants included Ministry of Health, multilateral institutions, implementing partners, and CSOs. The objective was to review critical progress to reach epidemic control, COP20 policy directives, and technical approaches.
- **February 12, 2020:** PEPFAR met with CSOs to discuss COP20 strategy and community-led monitoring.
- **February 21, 2020:** NAC hosted a technical team meeting to discuss the COP20 agenda and share the Government of Malawi's priorities. Participants included MOH - Department of HIV and AIDS, and Quality Management Directorate - UNAIDS, and the PEPFAR interagency.
- **February 26, 2020:** PEPFAR met with RPM external participants (UNAIDS, WHO, Ministry of Health, CSOs, and Global Fund's Project Implementation Unit) to review the RPM agenda, key messages from S/GAC, high-level overview of targets, and strategy and budget directives.
- **March 9-22, 2020:** PEPFAR held extensive planning and joint strategy discussions (NAC, Global Fund's Country Team, Project Implementation Unit and writing teams) to inform prioritization of TB-HIV activities, assure adequate ARV commodities funding in allocation and build consensus on key revisions to HIV testing approaches and budget, AGYW and KP-related targets in non-PEPFAR districts with high burden of disease.



**Figure 2.6.1 COP 20 CSO Funding Allocation**

| <b>Amount</b> | <b>Activities</b>   |
|---------------|---|
| \$725,000     | <p><b>COP20 CSO Community-led Monitoring</b><br/> <b>Mechanism: UNAIDS</b></p> <p>PEPFAR will provide funding to CSOs for community-led monitoring of the HIV/AIDS response in 11 PEPFAR scale-up districts. In line with the national and PEPFAR strategic priorities, monitoring of client-centered care at the site- and community-levels will be central to this effort. CSOs will analyze and collect quantitative and qualitative data about HIV services with a focus in getting input from recipients of care. PEPFAR Malawi will work with CSOs to establish effective feedback mechanisms that enable timely resolution of problems and/or broader application of good practices.</p> |
| \$300,000     | <p><b>Treatment Literacy</b><br/> <b>Mechanism: USAID CSO Prime</b></p> <p>PEPFAR Malawi will support civil society to implement education and treatment literacy efforts related to the science of HIV/TB and related medicines, treatment adherence, the importance of early treatment initiation, treatment adherence to achieve an undetectable viral load, and mental health issues. Any developed materials will need to align with MoH guidelines and will be disseminated within communities.</p>   |
| \$25,000      | <p><b>COP19 CSO Community-led Monitoring</b><br/> <b>Mechanism: State Small Grants</b></p> <p>PEPFAR Malawi will make COP19 funding available to support tool development for community-led monitoring and coordination grants through the Embassy Small Grants Mechanism.</p>  |

NOTE: Activities will require coordination between DHA, NAC, UNAIDS and CSOs.

### 3.0 Geographic and Population Prioritization

PEPFAR Malawi will shift its geographic focus for VMMC services to three high priority ART districts (Blantyre, Chikwawa, and Lilongwe), including military facilities with high HIV burden, incidence, and unmet VMMC needs. Chikwawa and Blantyre received VMMC Ambition Funds to scale up VMMC to 80% saturation in the 15-29 age group. PEPFAR will work with the Global Fund and the GoM to ensure the VMMC program aligns with the revised HIV National Strategic Plan 2020-2025 that prioritizes VMMC in 12 districts with the aim of achieving 50-80% coverage among men aged 15-49, with a focus on 25-39 years.

**Table 3.1 Current Status of VMMC Saturation, 15-29-years**

|                | Lilongwe   |            | Blantyre   |            | Chikwawa   |            |
|----------------|------------|------------|------------|------------|------------|------------|
|                | FY20       | FY21       | FY20       | FY21       | FY20       | FY21       |
| 15-19          | 58%        | 71%        | 78%        | 81%        | 78%        | 84%        |
| 20-24          | 64%        | 71%        | 68%        | 74%        | 66%        | 74%        |
| 25-29          | 52%        | 66%        | 55%        | 67%        | 52%        | 65%        |
| <b>Average</b> | <b>58%</b> | <b>69%</b> | <b>67%</b> | <b>74%</b> | <b>65%</b> | <b>74%</b> |

*Decision-Makers Program Planning Tool (DMPPT)*

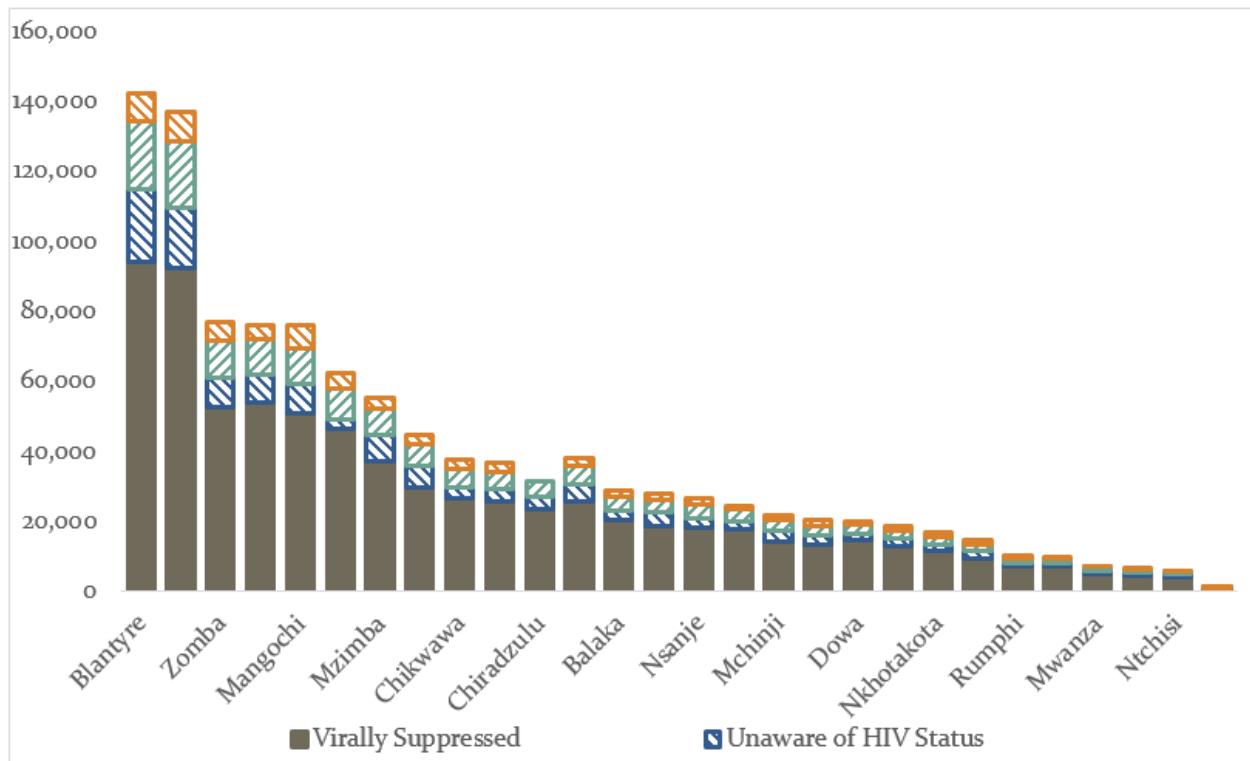
PEPFAR Malawi’s analysis of gaps and barriers by geography and population group guide COP20 interventions. Table 3.2 shows the current status of ART saturation by subnational units (SNU). Roughly three of four PLHIV reside in PEPFAR prioritized scale up districts.

**Table 3.2 Current Status of ART Saturation**

| <b>Table 3.2 Current Status of ART saturation</b> |   |                                |                              |                              |
|---|---|--------------------------------|------------------------------|------------------------------|
| <b>Prioritization Area</b>                        | <b>Total PLHIV/% of all PLHIV for COP20</b> | <b># Current on ART (FY19)</b> | <b># of SNU COP19 (FY20)</b> | <b># of SNU COP20 (FY21)</b> |
| Scale-up Saturation                               | 786,661 (73%)                               | 602,568                        | 10                           | 11                           |
| Scale-up Aggressive                               | -   | -                              | -                            | -                            |
| Sustained   | 290,607 (27%)                               | 221,542                        | 18                           | 17                           |

s

**Table 3.3 Prioritized District Support where Greatest Gaps to 90% ART Coverage**



As shown in Table 3.4 below, significant gaps in treatment coverage remain among men. Case finding, treatment, and retention activities both in COP19 and 20 will intensify interventions that reach and meet the needs of men.

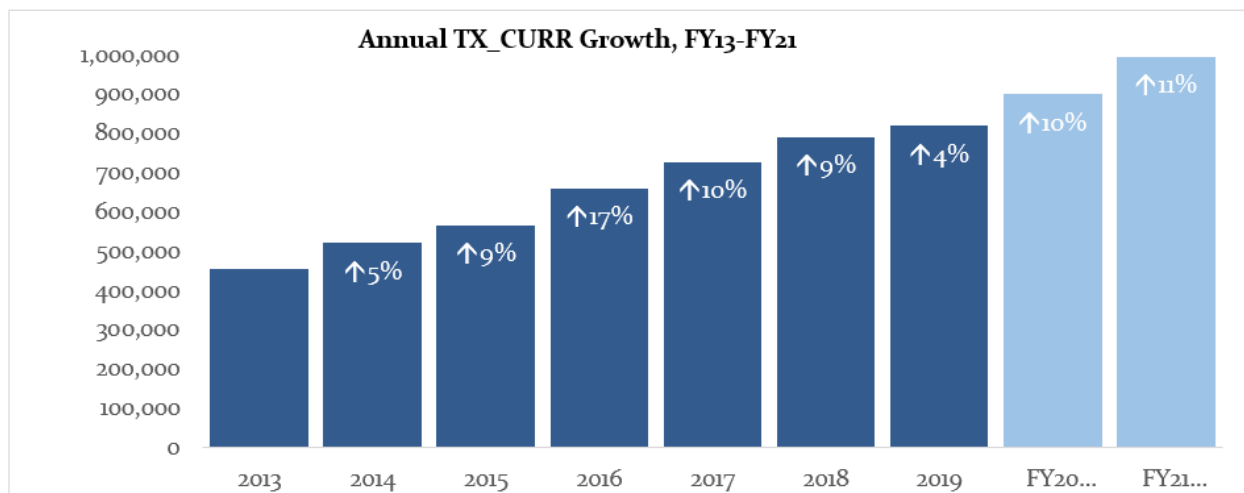
**Table 3.4 Greatest Treatment Gap Still Men**

|                 |              | <15    | 15+ Female | 15+ Male | Total     |
|-----------------|--------------|--------|------------|----------|-----------|
| Spectrum        | PLHIV        | 52,524 | 614,976    | 409,764  | 1,077,264 |
|                 | On ART       | 46,310 | 497,250    | 258,719  | 802,279   |
| Program Results |              |        |            |          |           |
|                 | ART Coverage | 88%    | 81%        | 63%      | 74%       |

Investments will support patient centered approaches to retain patients on ART, through differentiated service delivery models, improvements in the quality of care, and interventions

tailored to patients’ risk profiles will ensure a minimized rate of missed appointments. There is a need to aggressively increase the growth in TX\_CURR to achieve and sustain epidemic control. PEPFAR Malawi is targeting an 11% increase in the TX\_CURR growth in FY21, as depicted in Figure 3.5 below in order to reach 160,000 PLHIV with ART by the end of COP20.

**Figure 3.5 Annual TX\_CURR Growth, FY13-FY21**



In COP20, PEPFAR Malawi will focus on a concrete shift to direct service delivery. A new MOH cooperative agreement will oversee 283 sites accounting for 10% of TX\_CURR across all 28 districts. (See Figure 3.6 below).

**Figure 3.6 Shifting to Direct Service Delivery**

## 4.0 Client Centered Program Activities for Epidemic Control

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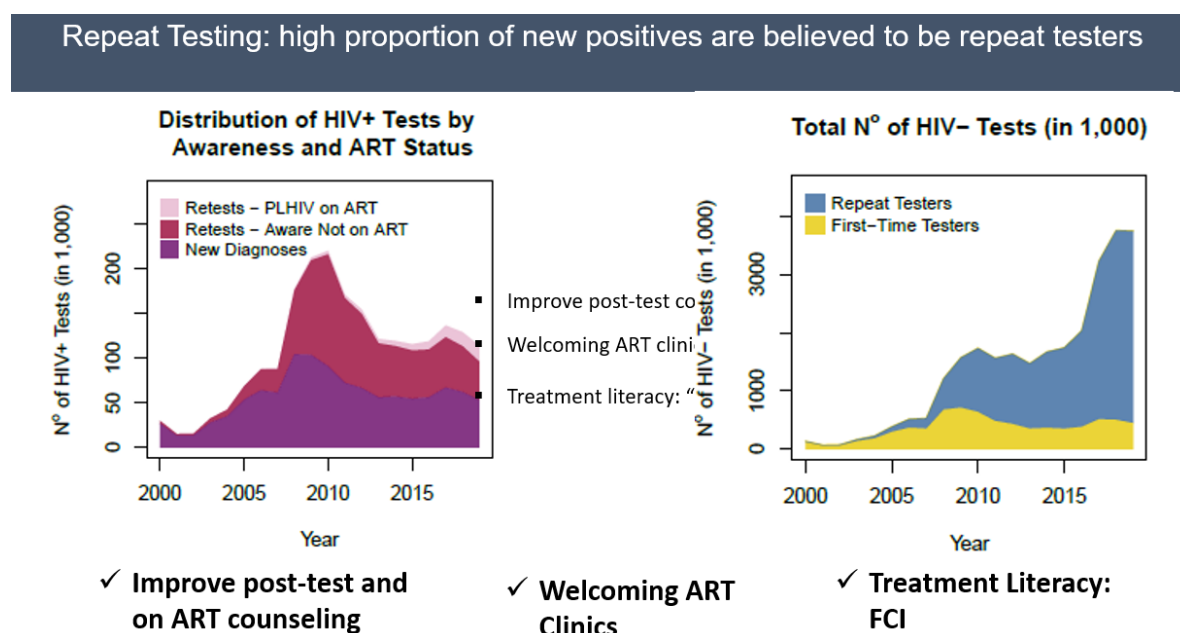
### 4.1 Finding the Missing and Getting Them on Treatment

PEPFAR Malawi is intensifying HIV testing strategies to find HIV positive men, key populations, and children who do not yet know their status and get them on treatment. Active index testing has been rolled out in all sites in scale-up districts while expansion to high volume sites in sustained districts is currently underway. All facilities implementing index testing will be re-assessed after certification criteria are established to ensure compliance with the 5Cs, effective

adverse event monitoring, and adequate training. Remediation plans will be put in place for sites that do not meet criteria until they are able to meet certification standards.

Outpatient department (OPD) testing contributes to most of the new cases identified, while also being the primary source of “over-testing” across districts. PEPFAR implementing partners are working with the MoH to implement screening approaches to increase yield and reduce testing volumes. As indicated in the figure below, programmatic data highlights that many new positives are not actually new, but are clients who previously tested positive and either did not initiate ART or dropped out of care. Screening and literacy efforts will be deployed to minimize repeat testers.

**Figure 4.1.1 Are New Positives Actually New?**



It is acknowledged that some clients who have never initiated ART or who previously dropped out of care utilize re-testing as a route back onto treatment and efforts will be employed to ensure that clients ready to return back into care do not face additional obstacles. In COP20, PEPFAR Malawi’s HTS investments will be reduced and more focused. Figure 4.1.2 shows investment changes and Figure 4.1.3 summarizes COP20 testing modalities, targets, and proportional contribution to new cases identified. Compared to COP19, testing targets have reduced by 28% (from 2,720,256 tested in COP19 to 1,956,679 in COP20) whereas the contribution of index testing to overall new positives has increased.

**Figure 4.1.2 COP20 HTS Budget Trends by Agency**

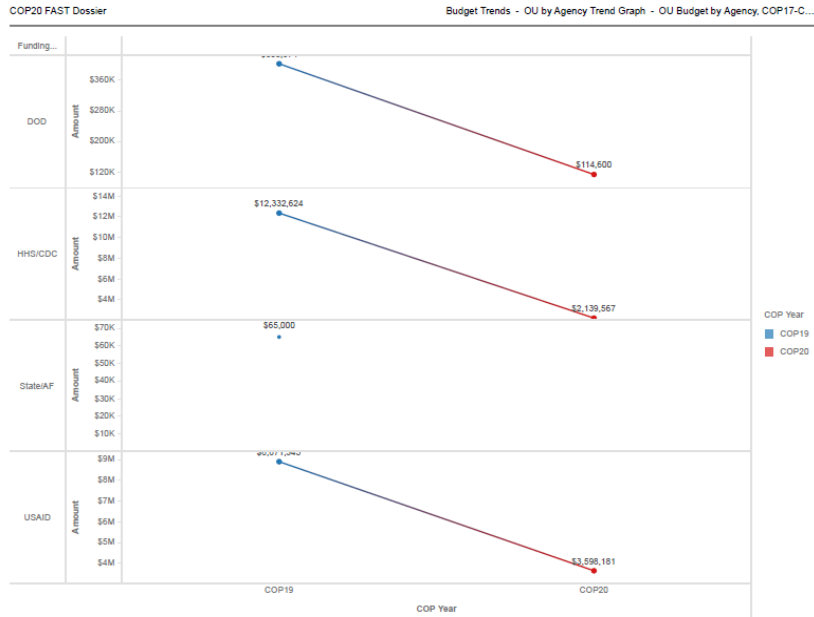


Figure 4.1.3 COP20 HTS Targets per Modality and Expected Yield

| TESTING MODALITY        |                                | HTS_POS       | HTS_TST          | YIELD       | % HTS_TST_POS from modality |
|-------------------------|--------------------------------|---------------|------------------|-------------|-----------------------------|
|                         |                                | FY21 Target   | FY21 Target      | FY21 Target | FY21 Target                 |
| Index Testing           | Community Index                | 5,300         | 21,764           | 24.4%       | 5.4%                        |
|                         | Facility Index                 | 50,484        | 236,951          | 21.3%       | 51.7%                       |
| Community based testing | Mobile                         | 682           | 40,944           | 1.7%        | 0.7%                        |
| Facility based testing  | Pediatric                      | 99            | 5,198            | 1.9%        | 0.1%                        |
|                         | PMTCT ANC1                     | 10,899        | 613,735          | 1.8%        | 11.2%                       |
|                         | Facility-Based PMTCT Post-ANC1 | 898           | 602,873          | 0.1%        | 0.9%                        |
|                         | STI Clinic                     | 47            | 1,174            | 4.0%        | 0.0%                        |
|                         | TB                             | 1,085         | 9,856            | 11.0%       | 1.1%                        |
|                         | VCT                            | 236           | 3,939            | 6.0%        | 0.2%                        |
|                         | VMMC                           | 1,431         | 152,801          | 0.9%        | 1.5%                        |
|                         | Other PITC                     | 26,439        | 256,012          | 10.3%       | 27.1%                       |
| <b>Total target</b>     |                                | <b>97,600</b> | <b>1,956,679</b> | <b>5%</b>   | <b>100%</b>                 |

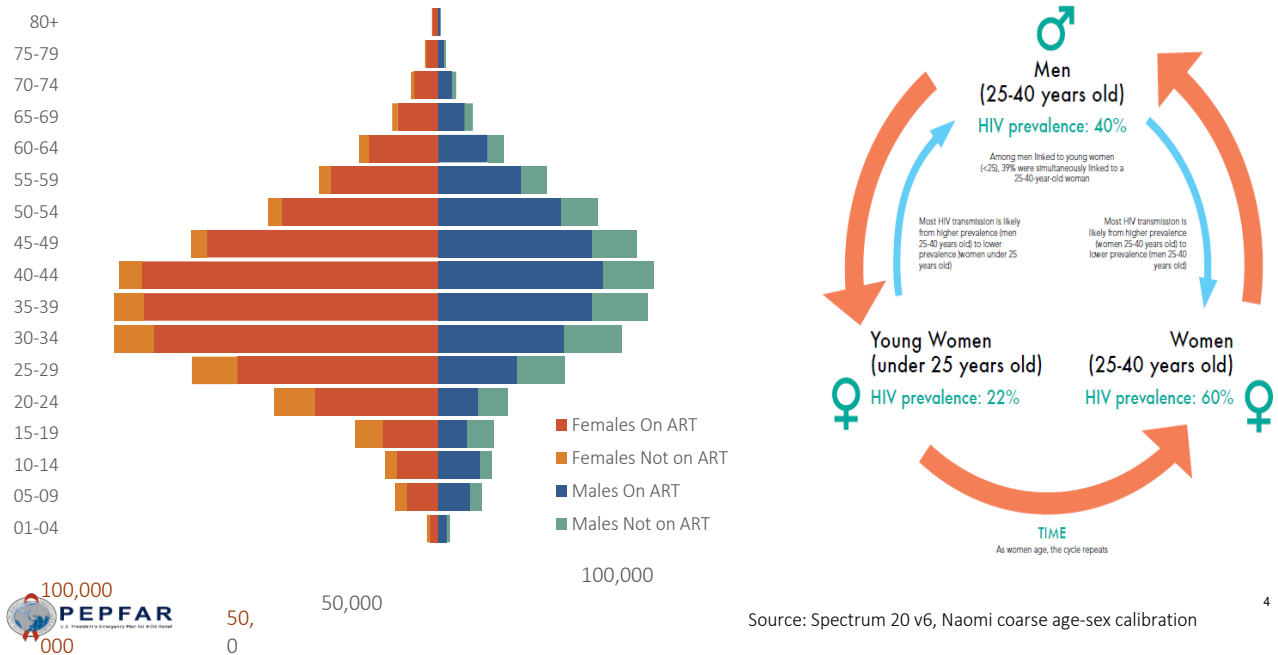
PEPFAR Malawi developed a mathematical model to define an optimal mix of testing strategies that accelerate progress towards the 95-95-95 targets. Implementing partners will use the projected contribution of various HIV testing modalities to find the new positives to guide COP20 work plan development with index testing as the dominant strategy. The development of index testing certification processes is underway with emphasis on WHO's 5Cs principle.

## **Men**

Spectrum Malawi 20 v6 (Figure 4.1.4) reports sub-optimal reach of men (especially 15-40-years) with testing and treatment services and this continues to fuel the HIV transmission cycle. In COP20, additional male-friendly integrated strategies will be implemented in major cities to promote reach with HTS, including male friendly clinics, HIVST, and extended clinic hours. Targeted mobile testing to reach MSM through social network strategies (SNS) will continue in COP20. Moreover, clients of FSW in geographic hotspots will be reached through secondary HIVST distribution and index testing.

**Figure 4.1.4 National PLHIV Pyramid & Men vs Women Transmission Cycle**

**Sub-optimal Reach of Men, especially Men 15-40, with Testing and Treatment this Continues to Fuel the Transmission Cycle**



Source: Spectrum 20 v6, Naomi coarse age-sex calibration

4

### Implementing Active Index Testing with Fidelity

As previously noted, PEPFAR partners will strategically shift HDAs from low yield OPD testing to active index and recency testing. PEPFAR will work with the MoH and CSOs to establish an adverse event monitoring system and response as part of index testing implementation. Index clients who screen positive in intimate partner violence screenings will be linked to supportive post-violence care services within the district. Ambition Funding resources will be used to target active index testing among children in Nsanje, Chikwawa, and Lilongwe districts. Activities are expected to result in the identification and initiation of 1,587 children living with HIV (CLHIV) on treatment.

### HIV Self-Testing (HIVST)

HIV prevention programs will prioritize HIVST distribution as its primary modality for HIV testing. Assisted HIVST distribution will be promoted in DREAMS, KP, and VMMC programs. Integration of HIVST into active index testing targeting sexual partners will continue to be implemented in COP20. HIVST kits will also be distributed to HIV negative pregnant women with partners of unknown status for secondary distribution. All individuals screening positive will be referred to ART facilities for confirmatory tests prior to ART initiation, according to National Guidelines. PEPFAR partners will ensure active linkage of all clients screening HIV positive.



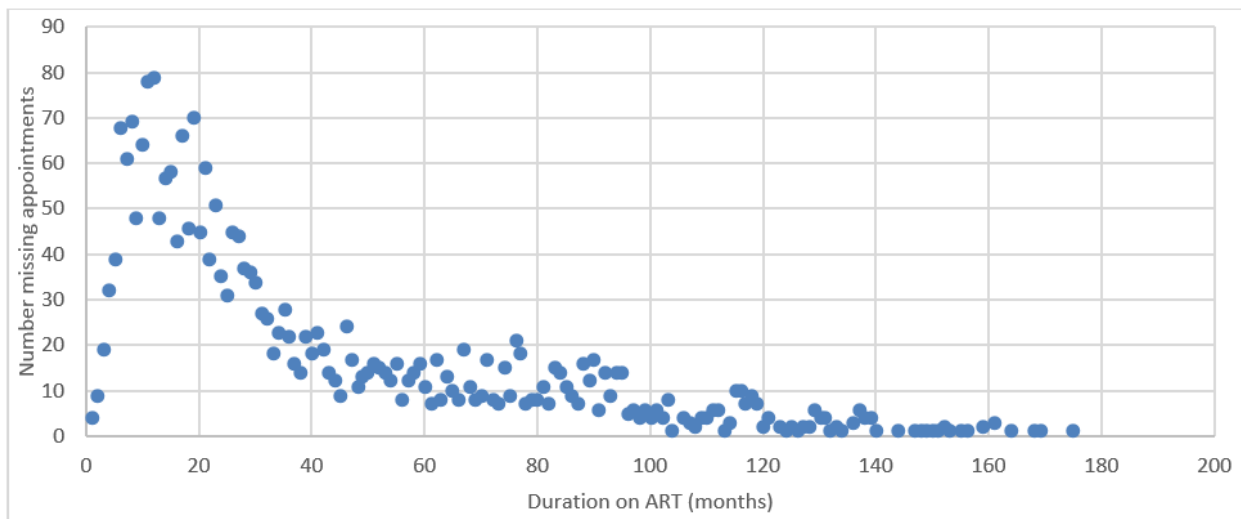
**Military Testing:** PEPFAR will strengthen HIV testing in military settings for soldiers and sexual contacts, as well as a focused pre- and post-deployment packages to facilitate testing and linkage to treatment for those testing positive.

## 4.2 Retaining Clients on Treatment and Ensuring Viral Suppression

### Retaining Clients on Treatment

Improving retention and bringing individuals back to care ensures that 85% of PLHIV are virally suppressed. The growth of the treatment cohort in Malawi has slowed over time, and a substantial drop was noted in TX\_CURR in FY20 Q1 which was attributed to: the change in definition for lost to follow up from 60 days to 28 days, data quality issues, and program loss. In COP19, PEPFAR Malawi is intensifying efforts to prevent missed appointments, early loss to follow up, as well as, return clients back to care. At site level, the use of weekly, monthly, and quarterly program data is guiding IPs to refine and adjust interventions. As shown in the figure below, a larger number of patients miss their appointments early in treatment (within 12 months). Patients on ART for at least five years are less likely to miss appointments.

**Figure 4.2.1 Most Patients Miss their Appointments Early in Treatment**

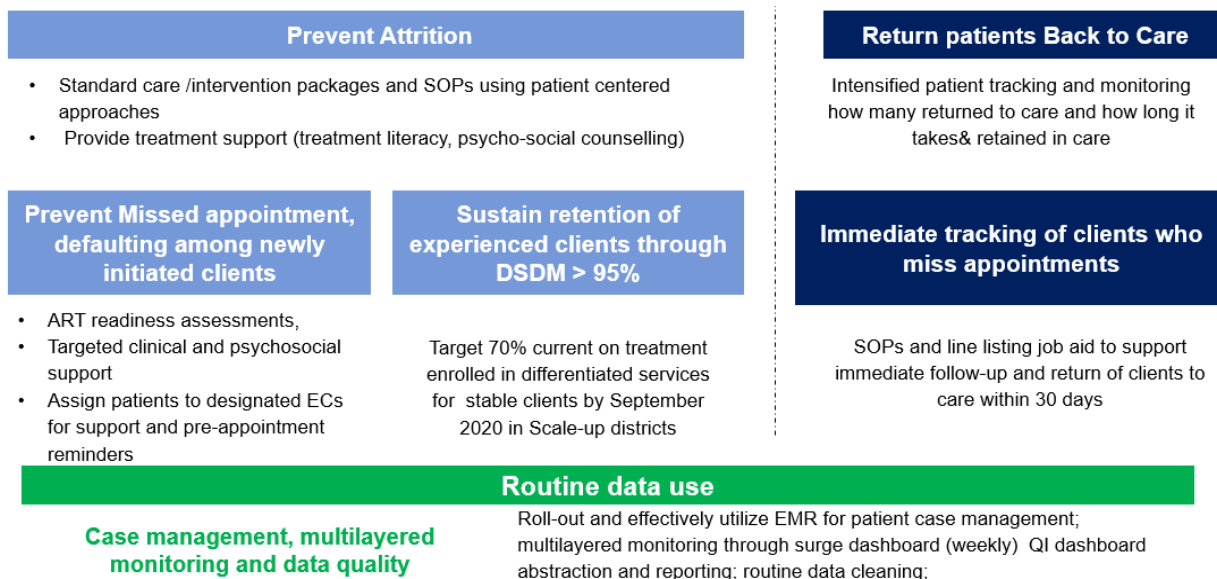


Source: EGPAF program data

To arrive at higher levels of retention, PEPFAR Malawi will follow the three-pronged approach depicted in Figure 4.2.2 below. At all scale-up sites, IPs will implement activities that are designed to: 1) prevent attrition by addressing reasons why patients miss their appointments and default, improving retention on ART through differentiated service delivery models 2) return patients back to care through responsive measures to identify missed appointments and establish tracing outcomes within a 30-day period, and 3) support re-engagement in care for those that stopped treatment and update patient records for those that were incorrectly identified as defaulters. This case management approach for retaining patients in care will be monitored routinely using site

level data from EMR and paper-based records. In COPs 18 and 19, several direct service delivery models were developed and tailored to specific patient needs. In addition to multi-month dispensing, differentiated models to improve retention and treatment outcomes include teen clubs, male friendly clinics, pediatric clinics, and nurse-led community ART clinics (a community outreach model). Ambition Funding resources will be used to expand teen clubs for adolescents living with HIV (ALHIV) in Nsanje, Chikwawa, and Lilongwe districts.

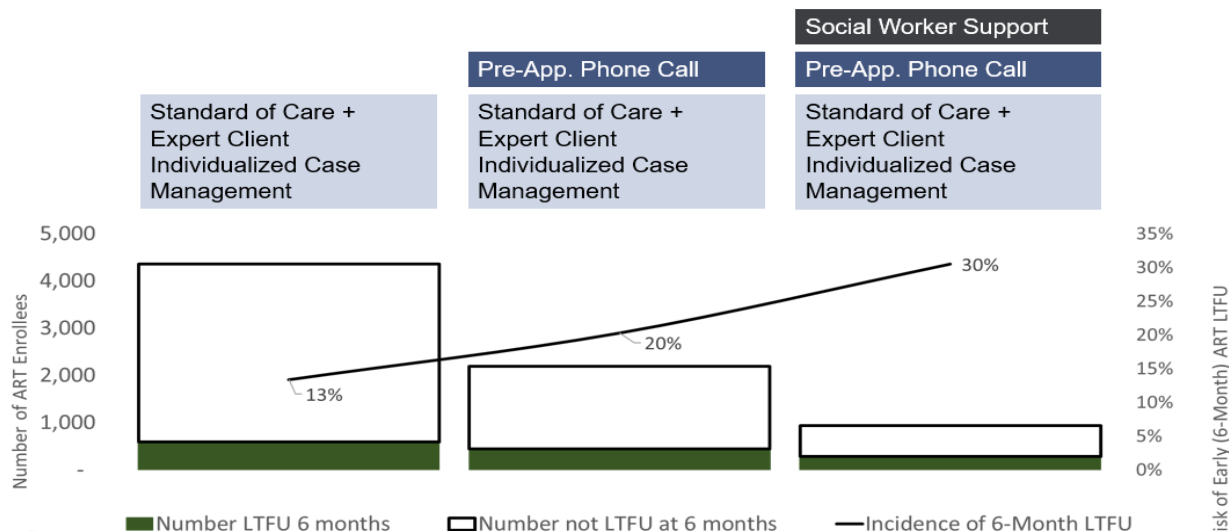
**Figure 4.2.2 Three-pronged Approach to Retaining Clients in Care**



In FY19, IPs piloted successful interventions to improve early retention on ART by providing frequent psychosocial counselling for patients newly initiated on ART. More tailored interventions were provided using a case management approach with more experienced psychosocial counsellors providing support to patients assessed as being most likely to fall out of care. Community-led monitoring strategies, designed to improve quality and patient satisfaction, along with complementary systems supported by IPs to periodically obtain patient feedback about services, will be used to adjust implementation approaches.

In COP19 and COP20, these tailored approaches, depicted in Figure 4.2.3 will be scaled up.

**Figure 4.2.3 Stratified Approach to Case Management to Improve Early Retention**



**Treatment for Late Presenters:** National program data shows that approximately 16% of new ART clients started treatment either in WHO stage three or four<sup>4</sup>. Patients with advanced HIV have a higher likelihood of opportunistic infections and early mortality, especially due to TB co-infection. In COP20, PEPFAR Malawi will build on FY20 interventions to intensify the implementation of the national guidelines to conduct urine LAM and cryptococcal antigen screening in district and central hospitals (currently not available universally) to patients with advanced HIV (i.e. CD4 < 200, WHO Stage III/IV, “seriously ill” patients). In smaller health centers, access to these services will depend on a functional referral system to district hospitals and other referral facilities that have the required diagnostic and treatment capacities. Implementation of proven retention and adherence strategies (e.g. active defaulter tracing and adherence support through lay providers such as Expert Clients) will be key to reduce the number of ART patients failing on treatment. This model will include case management approaches for active follow up.

**TB/HIV:** PEPFAR implementing partners will implement a three-pronged TB strategy at site level aiming to: detect TB cases early and effectively through systematic symptomatic screening using a dedicated cadre; optimize TB/HIV care by ensuring all symptomatic patients are promptly referred for TB diagnostic work-up at sites with efficient laboratory diagnostic tools such as GeneXpert and LF-LAM, with those diagnosed with TB or HIV initiated on appropriate treatment regimens; and scale-up of TB Preventive Therapy using the MoH preferred TB Preventive Regimen of 3HP when it is available in-country. PEPFAR implementing partners will mentor health facility staff in managing adverse events arising from TB and HIV treatment and TB preventive Therapy, monitor treatment completion, and completion of the associated data as per PEPFAR requirements.

<sup>4</sup> MOH July-September 2018 Quarterly Report

Figure 4.2.4 Patient Centered Approaches for TB/HIV



**Find TB among PLHIV: HTS for presumptive TB & TB patients**

- Strengthened systematic TB screening and contact tracing, facilitate quality sample submission, repurposing HRH to optimize & improve quality in TB screening
- Maintain HTS for TB patients at 99% or higher,
- Integration of services: e.g. combine TB screening with HIV index testing



**Prevent TB among PLHIV: optimize TPT and IC practices**

- Scale-up TPT nationwide
- Optimize TPT for pregnant women, CLHIV, u5C contacts, prisoners
- Strengthened M&E through a TPT dedicated register, including adverse event tracking



**Optimize TB treatment and ART for TB/HIV co-infected patients**

- Early TB treatment & ART for HIV infected TB patients
- Treatment adherence support
- Treatment literacy activities



**Optimize TB Diagnostics**

- GeneXpert use optimization, optimize sample transportation, nationwide scale-up of urine-LAM
- Strengthen child TB diagnostics through other forms of samples e.g. stool on top of high clinical suspicion

**Ensuring Viral Suppression:**

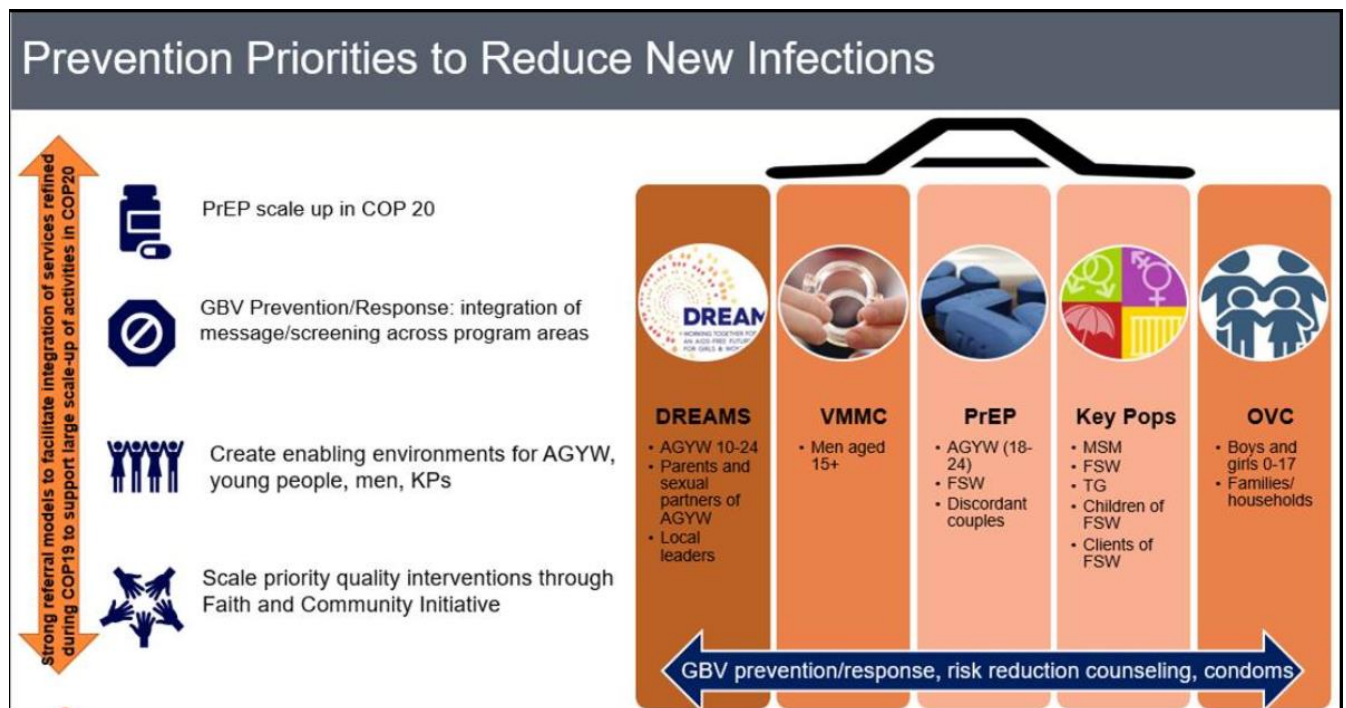
PEPFAR Malawi is striving to reach 95% viral suppression across SNU and population groups. In order to achieve this goal (suppression level FY20Q1 is 88%), the following key interventions will be implemented in COP20:

- **ART optimization:** PEPFAR Malawi will build upon COP19 successes in ARV optimization to ensure adult and pediatric clients have access to the most efficacious regimens in line with national guidelines. Over 75% of the ART cohort is on tenofovir/lamivudine/dolutegravir (TLD), though 57% of children were still on a non-nucleoside reverse transcriptase inhibitors (NNRTI) as of February 2020. These optimized ARVs will contribute to better viral suppression, especially among CLHIV. Clinicians will be mentored and supervised to ensure compliance with national guidelines. The transition to optimal ARVs will be supported through training and mentorship of providers, deployment of clinical staff, and close monitoring of progress and timely resolution of issues.
- **Treatment literacy:** Through individual and group approaches, PEPFAR Malawi will ensure clients are reached with key treatment literacy messages focused on adherence, retention, and viral load monitoring. Additionally, key messages addressing clients' concerns and misconceptions both at the facility and community level and messages of hope via the Faith and Community Initiative will be central to PEPFAR Malawi's

treatment literacy efforts in collaboration with civil society organizations, the Ministry of Health, and NAC.

- **Case management:** PEPFAR Malawi will implement a case-management approach for patients with high viral load and clients known to be at a higher risk for poor adherence or retention. As part of this intervention, patient supporters, such as Expert Clients and Community Health Workers, will provide group and individual counseling, reminders for clinic appointment, as well as link clients to community care services. Patient supporters will also facilitate timely communication of high viral load (VL) results to clients either through a phone call or through a home visit. PEPFAR Malawi will collaborate with the Bill and Melinda Gates Foundation and MoH to explore a sustainable utility of SMS or other technologies to facilitate communication of results to clients.
- **Differentiated care models:** In COP20, PEPFAR Malawi will scale up differentiated models of care such as viremia clinics to ensure client’s with high viral load receive timely care across the HIV VL cascade including intensified adherence counseling, repeat VL tests, and shift to second line ARVs as appropriate. Advanced HIV disease services will be supported at facilities with high ART cohorts (such as at district hospitals) and PEPFAR will continue to support teen clubs and other youth-friendly approaches to ensure ALHIV have the support they need to stay in care and achieve durable viral suppression.

### 4.3 Prevention, Specifically Detailing Programs for Priority Programming



In COP20, HIV primary prevention will guide efforts to ensure that individuals facing a substantially higher risk for HIV infections are reached with PrEP, VMMC, OVC, KP and

DREAMS programs and services in high burden SNUs. Although the number of new HIV infections has declined, HIV incidence among certain populations, such as AGYW and KP remains high, if not increasing. As Malawi moves toward epidemic control, the NSP 2020-2025 set the target of new infections at 11,000 in 2025 from 33,000 in 2019. Achieving these ambitious targets set by the NSP to reduce new HIV infections will be possible through the right mix of biomedical interventions, including “treatment-as-prevention” achieved through viral suppression and evidence-based prevention strategies. In addition, a robust strategy for addressing social and structural determinants, social behavior change communication, and customized interventions for key and vulnerable populations for HIV and TB are all underpinned by a rights-based approach and central to success.

As a crucial prevention strategy for reaching and maintaining epidemic control, PEPFAR IPs are poised to implement PrEP services in 11 districts following the finalization of national guidelines and tools. The roll-out plan will include investments in multi-level communications that promote PrEP messages validated by civil society, and place PrEP in the context of comprehensive prevention including couples testing, male and female condoms, lubricants for women and men, and treatment leading to undetectable viral load in PLHIV.

#### **4.3.1 HIV Prevention and Risk Avoidance for AGYW and OVC**

AGYW in Malawi continue to be disproportionately affected by HIV and violence compared to their male peers. Malawi’s National AGYW Strategy highlights this, and while resource constraints for the strategy remains a challenge, coordination structures and referral/linkage processes will be implemented at the district level in 2020. The USG continues to work with other donors and stakeholders through the AGYW Strategy Secretariat, Core Team, and sub-technical working group to support implementation of the strategy and ensure USG programming aligns with the goals and objectives of the strategy. Evidence suggests that multi-layered approaches to HIV prevention among AGYW are most effective. Data from the 2019 World AIDS Day modeling highlights that all DREAMS districts in Malawi have demonstrated a >30% reduction in new diagnoses among AGYW between 2015-2019, with an over 40% decline observed in Blantyre. Ensuring AGYW receive a full prevention package based on their unique needs and vulnerabilities is key to reaching and maintaining epidemic control.

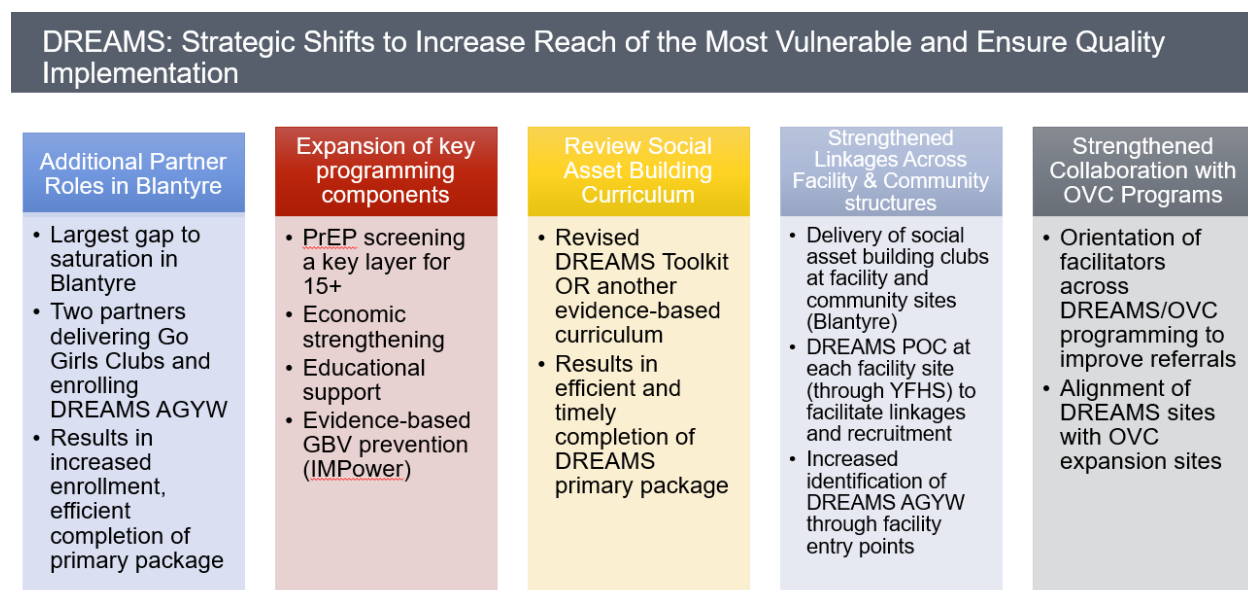
**DREAMS:** An analysis of FY19 data indicated that AGYW in DREAMS Malawi districts complete the primary package within 7-12 months and that Machinga has the largest percentage of AGYW who received at least the primary package. This is likely due to the provision of mobile services and Machinga being one of the first two districts where DREAMS was implemented. Of all the components of the primary package, completion of the DREAMS toolkit (social asset building curriculum), which includes HIV and violence prevention modules, takes the longest time to complete. With the operationalization of a DREAMS database in FY20 to track service layering and referrals, data quality and understanding of the primary and secondary package completion rates will significantly improve in FY20 and FY21.

In FY21, PEPFAR Malawi will continue to reach the most vulnerable AGYW in the three DREAMS districts (Zomba, Machinga, and Blantyre) with comprehensive and layered risk reduction



services at the individual and community levels. An eligibility screening tool to identify the most vulnerable girls will be updated to screen AGYW for alcohol use and current/prior STI status (per COP20 guidance) and apply a Malawi-specific weighted vulnerability score for each age band. In FY21, the Malawi DREAMS program will expand to additional sites to ensure a full geographic footprint. Each site will provide a complete service package, facilitate Go Girls! Clubs, and ensure set up of YFHS/GBV care at facilities within the catchment areas. In COP20, a total of 46,263 new DREAMS AGYW will be targeted, with 36,404 in Blantyre, 2,073 in Machinga, and 7,786 in Zomba. Across the three districts, 29% of DREAMS AGYW will be 10-14, 47% 15-19 and 24% 20-24. Moreover, a total of 35,000 DREAMS AGYW who were enrolled in COP19 will complete the primary and secondary interventions in FY21 (7,931 in Blantyre, 12,374 in Machinga, and 14,695 in Zomba; 43% will be 10-14, 47% 15-19 and 10% 20-24). The largest increase in enrollment in DREAMS will be in Blantyre, given that the program is currently only in five sites in the district. These efforts will result in 68% progress toward saturation by the end of FY21 (164,266 AGYW will be reached out of 242,043 of the most vulnerable AGYW in DREAMS districts).

**Figure 4.3.1 DREAMS Priorities in COP20**



PEPFAR Malawi’s COP20 DREAMS strategy is responsive to expansion needs while also strengthening key components of the DREAMS package: PrEP, evidence-based GBV prevention programming- specifically IMPower, economic strengthening, and educational support. PrEP education and information will be part of the primary package, while screening for 15-24-year-olds eligible/interested girls will be referred to YFHS (community initiation is not currently permitted in Malawi’s national policy). In COP20, PEPFAR Malawi aims to reach 4,493 DREAMS AGYW with PrEP. Findings from the PrEP pilot conducted among AGYW in Lilongwe demonstrate high uptake and retention across a six-month period and lessons learned from this pilot will inform the implementation and outreach strategy. Community and facility partners will work together to

improve awareness, generate demand, and facilitate PrEP screening and initiation for those who are eligible. Facility staff will initiate clients onto PrEP until national policy permits community initiation of ART. Facilities will integrate PrEP into youth-friendly health services, ANC, STI, and other service delivery points that AGYW often access. Findings from a UNC study conducted on PrEP uptake in Malawi among AGYW found that AGYW prefer to access PrEP in youth friendly spaces. Partners will also engage peer educators and DREAMS Ambassadors to build awareness of and generate demand for PrEP. PEPFAR routinely engages with Global Fund to share implementation challenges, solutions, joint learning and coordinate with national TWGs. Evidence and best practices from the DREAMS program will be used to implement interventions for high risk AGYW in Mulanje, Thyolo, Chikwawa, Mangochi, and Lilongwe in the next grant cycle.

PEPFAR Malawi will continue to provide a contraceptive mix to AGYW to reduce the number of unwanted pregnancies and track data on AGYW released from early child and forced marriages. Continued scale-up of HIVST will be a key strategy to reach all DREAMS AGYW with HIVST distribution facilitated through clubs, mobile integrated service delivery teams, and youth friendly health services at facilities. In addition to direct service delivery to the DREAMS clubs, active linkage strategies such as having a club leader escort AGYW to facilities and clustering AGYW from different clubs to go to health facilities or mobile clinics in groups, will be applied. Activities to strengthen linkages across facility and community structures will also be applied including the delivery of social asset building clubs through both facility and community structures to meet AGYW where they are, designating a DREAMS POC at each facility site (based in YFHS center) to facilitate linkages and recruitment, and increased identification of DREAMS AGYW through facility entry points. Facility entry points include STI, YFHS, ANC, and family planning clinics. Entry points within communities continue to include schools, OVC, and community structures (e.g. mother groups, CBOs, and faith structures). Interventions targeting the parents of 10-14 and 15-19 (like Families Matter!) year olds will continue in COP20, both building off current programming and expansion through the FCI in FY20 as parents play a key protective role for AGYW.

In COP20, PEPFAR Malawi will also expand economic strengthening programming in DREAMS with a focus on a bridge to employment, financial literacy, and savings and loan groups. The Department of Health and Human Services will fund a pathway to employment activity through a Historically Black Colleges and Universities Initiative, replicating and adapting successful initiatives from the United States to the Malawi context. These efforts will be informed by the labor market assessment to determine viable employment opportunities for AGYW in Malawi. PEPFAR Malawi and USAID's Sustainable Economic Growth office will also explore employment opportunities for DREAMS AGYW as HDAs, Peer Navigators, and HIVST distributors.

Strengthened collaboration with OVC programming is a key component of the COP20 DREAMS approach. Facilitators across DREAMS/OVC programming will be cross-trained to improve referrals; expansion of DREAMS sites in Blantyre will be aligned with OVC expansion sites; and



educational support through DREAMS will focus on DREAMS AGYW who also meet criteria for the OVC program.

As a cross-cutting issue across prevention programming, the expansion of evidence-based GBV prevention and response strategies at community and facility levels remains a critical to epidemic control. Continued synergies across DREAMS, OVC, KP, and FCI programming will increase awareness, access to, and quality of comprehensive GBV prevention and response services, establishing a coordinated data driven and multi-level prevention and response strategy. Priorities include reducing the time between an experience of violence and receiving care, strengthened tracking of cases across program and geographic areas, building facility and community level capacity to respond to violence, and implementing gender and social norms change interventions for long-term impact. Several activities implemented at the community level and initiated during FY20 through the FCI will continue in DREAMS districts in COP20, in an effort to strengthen community mobilization and norms change activities. These evidence-based programs aim to create a supportive and enabling environment for AGYW include the following: SVAC101/SASA Faith (targeting faith and traditional leaders and their communities), IMPower (targeting boys and girls 9-14 years old), mobile courts (in Zomba and Blantyre), the Families Matter! Program, and Coaching Boys into Men. The Every Hour Matters campaign will also be launched in FY20 with continued efforts in FY21.

COP20 will have a fully operational DREAMS database with unique identifier codes (UICs) to effectively track referrals, service layering, and program delivery. Partners will enter and utilize layering data to track referrals, completion time of the primary package, and ensure AGYWs are accessing services specific to their risk.

DREAMS Ambassadors are key agents for change in the DREAMS programs and therefore will be more actively involved in COP20. DREAMS Ambassadors will continue to mobilize AGYW for post-violence services uptake, PrEP initiation, and other key service layers. Additionally, DREAMS Coordination Ambassadors will be hired to work alongside Peace Corps Response Volunteer DREAMS Coordinators at the district level to strengthen programming and coordination across partners, ensure DREAMS AGYW are receiving the complete package based on their unique needs, and facilitate collaboration across District Health Office counterparts and other stakeholders. These coordinators will continue to be supported by CDC and USAID DREAMS POCs and the dedicated PEPFAR DREAMS Coordinator.

In COP20, Peace Corps Response Volunteers will continue to coordinate with District Health Office counterparts to ensure continued collaboration among all AGYW stakeholders and implementers within the three DREAMS districts. Peace Corps will also place Health and Education Volunteers in DREAMS districts to support education and health services for youth, with a particular focus on AGYW. Peace Corps will place six Education Specialists to help Headmasters in the SEED and AMAA schools to set up administrative and management systems but also to introduce gender-sensitive pedagogy to create gender equitable learning opportunities

for all students. Peace Corps Volunteers and their counterparts will target 10-14-year old girls with school and community-based HIV and violence prevention interventions. The program will use Grassroots Soccer and evidence-based HIV prevention curricula life skills to help delay sexual debut and support healthy decision making. PCVs and their counterparts will equip youth aged 15-19 with information and skills to help reduce the risk of HIV infection and prevention of sexual violence. In these interventions, the Volunteers and their counterparts will refer youth to access HIV-related services at both the facility and community level that includes HIV testing, VMMC, ART, and youth friendly health services. Peace Corps Volunteers will support the delivery of youth friendly health services.

**OVC Program:** PEPFAR Malawi will provide HIV impact mitigation, prevention, and treatment services to 161,249 ( 140,409 <18 and 20,840 >18 ) OVC ages 0-17 and their households to address contributing factors to vulnerability with particular focus on: 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV. Activities will be implemented in at least 90 high burden (with highest numbers of TX\_CURR for pediatric clients) health facility catchment areas in nine districts: Machinga, Mangochi, Zomba, Blantyre, Chikwawa, Phalombe, Mulanje, Thyolo, and Lilongwe (Mulanje, Phalombe and Thyolo are new districts in COP20, selected because of high TX\_CURR amongst pediatric clients).

**Comprehensive: 92,667 (71,827 <18 and 20,848 >18)** OVC will be reached through the comprehensive model targeting enrollment of children 0-17 years in priority sub-populations including children and adolescents living with HIV, HIV exposed infants, sexual violence survivors, children of HIV+ mothers, children of HIV+ FSW, AGYW, child-headed households, and their caregivers. Activities will span four main domains of healthy, safe, stable, and schooled, coordinated through tailored, comprehensive case management efforts. The OVC program will provide age-appropriate activities as needed, including risk assessment; linkage to HIV services and support; facilitate EID; psychosocial support; group-based interventions promoting positive parenting and norms change; child protection and GBV services; savings and loans groups; work readiness; market-based income-generating activities; market driven vocational training; and, school block grants and material support to ensure OVC attend and progress in school.

In COP20, PEPFAR will support keeping children in school through community mobilization, material support, school block grants and facilitation of readmission for dropouts; life-skills training with integrated health messaging to children, both in- and out-of-school; and market driven vocational training for older adolescents. COP20 will strengthen efforts to ensure 30% of the OVC\_SERV <18 cohort are C/ALHIV, while ensuring 90% of TX\_CURR <15 in the OVC catchment area are offered enrollment into the OVC comprehensive program. With priority enrollment given to newly identified HIV+ children, those with poor viral suppression, and those who are lost to follow up/returned to care. The program will intensify risk assessment efforts to find “well” HIV positive children outside of clinical settings and link them to care by assessing

HIV+ women on ART to identify biological children for index testing and possible enrollment into the OVC Comprehensive program. The program will also work to ensure children already enrolled in the program are risk-assessed and linked to appropriate HIV services. Strengthened collaboration with at least 90 health facilities through MOUs between clinical and OVC IPs, placement of OVC staff at health facilities, facility-based case management and case conferencing will lead to better outcomes for CLHIV. In these facilities, PEPFAR will train facility-based cadre to assess, recruit, and ensure referral completion of children living with HIV into the OVC program. Viral load monitoring services will be scaled up, to reach all the CLHIV enrolled in the program. PEPFAR will provide CLHIV with appropriate services and support to ensure viral suppression.

To provide high-quality social support and age-appropriate information about HIV infection, treatment, adherence, HIV status disclosure, positive living and life skills needed for growing into healthy adults, PEPFAR will intensify enrollment of children and adolescents living with HIV ages 10–17 (especially those with high viral load or newly enrolled on ART) into Y+ (Youth Living Positively with HIV) support groups based in the communities and the facility based adherence clubs in COP20. PEPFAR will provide a comprehensive package of services using the case management approach. Peace Corps Volunteers and their counterparts will also support adolescents living with HIV (and their caregivers) through teen clubs that provide guidance on nutrition and well-being, life skills, ART adherence, hygiene, and psychosocial support. Peace Corps Volunteers will also link ALHIV from the health center to OVC service providers in the community. COP20 will emphasize support to mothers/caregivers and HIV-exposed children 0–24 months old to assure early diagnosis, adherence and retention on treatment, and provide holistic parenting support to optimize HIV-exposed children’s developmental outcomes. The OVC program will expand Families Matter! and Sinovuyo to reach more beneficiaries in Blantyre, Zomba, Machinga, Lilongwe, Chikwawa, and Mangochi while introducing the curricula in Phalombe, Mulanje, and Thyolo in FY21. In COP20, strengthened linkages with implementers serving KP will reach more children of FSW through the OVC program.

**Preventive: 62,000 (50,000 9-14 years and 12,000 AGYW 10-17)** OVC will be reached under the preventive model leveraging the FCI initiative. Preventing sexual violence and HIV for 9-14 year old girls and boys (50,000) and reducing risk for adolescent girls (12,000 AGYW in non -DREAMS districts only) through leveraging schools, community groups, and faith-based networks will be a key focus in COP20 in line with the Malawi National Intervention Framework, as identified within the priority responses to VACS (noted below in Figure 4.3.2).

### **Figure 4.3.2 Malawi National Intervention Framework**

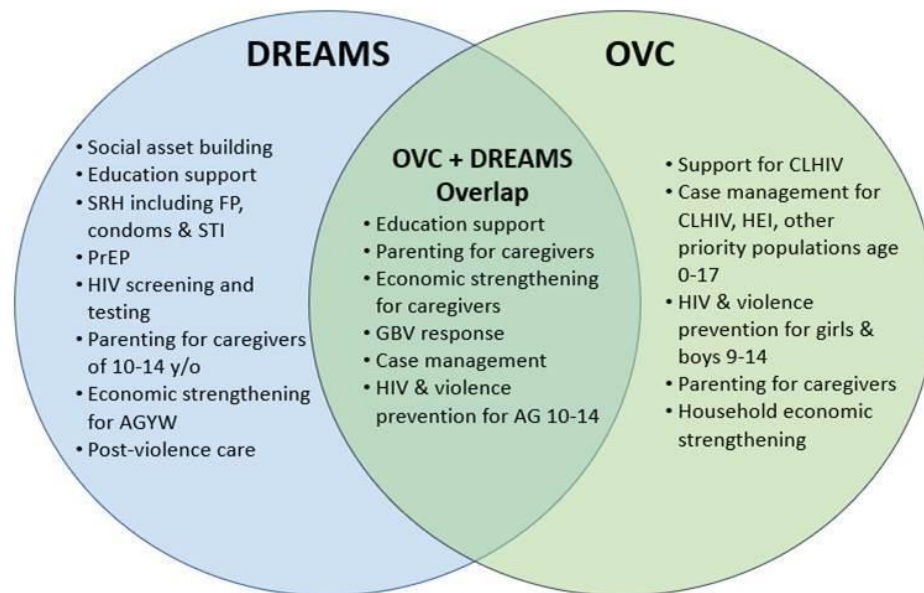


Through evidence-based and developmentally appropriate activities, COP20 will focus on preventing sexual violence and HIV risk before it happens (i.e., preventing any form of coercive/forced/nonconsensual sex and preventing early sexual debut) help youth reduce risk or consequences of exposure to risk (i.e., reduce number of partners, condoms, PrEP, access to post-violence care). For the 9-14 age group, activities will focus on preventing youth from exposure to risk (primary prevention) and for the 15-17 age group, activities will focus on a combination of preventing risk and reducing risk. COP20 will continue to prioritize and target the 9-14 age group (at least 50,000 to be reached in COP20) with age-specific evidence-based curricula with skills building components such as Families Matter!, Sinovuyo Teens, and Grassroots Soccer.

The integration of S/GAC-developed modules (namely Module 1: Healthy and Unhealthy Relationships, Module 2: Making Healthy Decisions about Sex and, Module 3: Understanding Non-consensual Sex) will continue in COP20. PEPFAR will intensify collaboration with FBOs and community-based organizations through expansion in Lilongwe, Blantyre, Machinga, Mangochi, Zomba, and Chikwawa) and introduction of community mobilization/norms change interventions (e.g. SASA! Faith and Coaching Boys into Men) in Phalombe, Mulanje, and Thyolo. Implementation will be sensitive to sexual violence and other factors shaping adolescent sexual behaviors (such as initiation rites, forced sex, and transactional sex for survival). Programming will not blame youth or make them feel ashamed for factors outside of their control, but will provide them with accurate information on the benefits of delaying sexual debut when they have the ability to do so and employ comprehensive safe sex practices..

In partnership with the GoM, PEPFAR will ensure that new CBOs, FBOs, and faith communities engaged in COP20 have child protection policies in place to prevent abuse and exploitation of minors within their structures. PEPFAR will ensure IPs have standard operating procedures to refer beneficiaries reached under the preventive model for services under the comprehensive model when necessary.

**OVC/DREAMS Collaboration:** OVC and DREAMS programs overlap in three districts (Blantyre, Machinga, and Zomba; in these districts the OVC program will not implement activities targeting AGYW 10-17 years as they will be reached through DREAMS programming. Referrals between OVC and DREAMS will be strengthened in order to achieve enhanced outcomes for the AGYW. To better align with DREAMS in Blantyre, the OVC program will expand to 5 additional facility catchment areas and to promote efficiencies, OVC and DREAMS will implement joint planning where appropriate, especially with trainings.



**Professionalizing the Social Welfare Workforce:** In COP20, PEPFAR Malawi will continue to work with the GoM to build a strong national social welfare and well-coordinated case management system capable of preventing and responding to violence. A major shift in COP20 is the professionalization of the community-based social welfare workforce which will result in the movement from “voluntarism” to full time employment of at least 72 child protection workers and 1,200 case workers. In addition, focus will be on strengthening the capacity of voluntary community-based child protection structures (community-based organizations, child protection committees and mother groups). These voluntary structures are crucial in ensuring that children and adolescents are protected from violence, exploitation, and abuse. A local partner to be engaged at the end of COP19 will in COP20 enroll its first cohort of students in social work. In addition to strengthening local capacity in Malawi, this initiative will continue to inject much-needed, qualified social workers into the child protection system, resulting in better protection for children and adolescents.

The USAID Health office is working on a government-to-government mechanism to engage Zomba District Council to implement health programs, including the strengthening of case management, and supervision and coordination support for OVC programming through PEPFAR funding. In CO20, the OVC program will be implemented largely through local partners as a new

follow on award mandated building local capacity to compete as prime partners through transition awards.

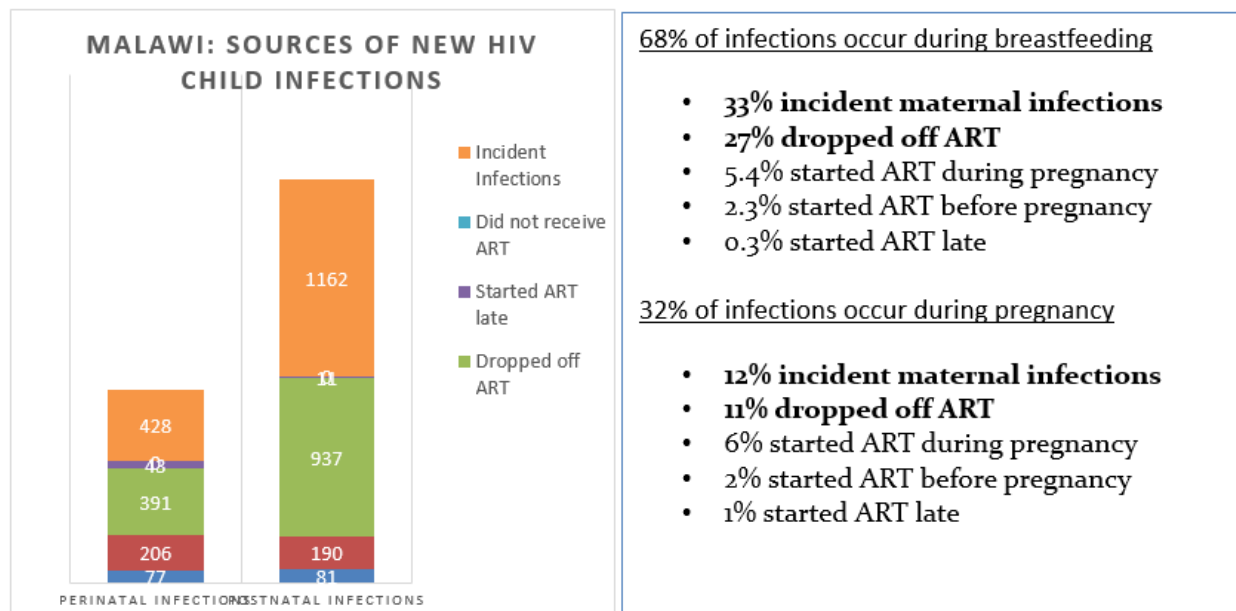
#### **4.3.2 Children and PMTCT**

Prevention of mother-to-child transmission of HIV is one of the core programs to prevent HIV in children. The PMTCT program in Malawi is a model to many countries for implementation of Test and Start for pregnant and breastfeeding women. The 2019 PEPFAR annual progress report indicates high service coverage with 98% HIV status ascertainment and 99% ART coverage among pregnant women attending ANC. Additionally, PEPFAR partner performance on PMTCT indicators has consistently been high. Transmission rates have remained below 2% in MER reports for infants who are two months of age.

Despite having made significant progress, Malawi is not yet on any tier on the WHO path to elimination framework until further reduction in overall transmission rates can be realized. WHO criteria for validation of eMTCT require high service coverage indicators (>95% ANC attendance, status ascertainment, and ART coverage), transmission rates of <5%, and a case rate of <50 cases per 100,000 live births. Spectrum estimates for 2019 indicate a prevalence rate of 7.1%, a final transmission rate of 7.8%, and an estimated case rate of 551 per 100,000 live births.

The 2019 Spectrum estimates indicate that the major sources of new infections in children have changed since roll out of the treat all approach. Previously, most infections occurred due to failure to diagnose and put women on antiretroviral treatment. Now most transmissions occur during the breastfeeding period, and mainly from incident infections among women who were previously HIV-negative and women living with HIV who drop off antiretroviral treatment (Figure 4.3.2.1).

Figure 4.3.2.1 Malawi Sources of New HIV Child Infections (Spectrum 2019)



PEPFAR Malawi will continue to implement interventions to strengthen the PMTCT program to address key barriers to attaining elimination of mother-to-child transmission of HIV in Malawi in COP20 including:

- Prevent/address incident infections during breastfeeding
  - Retesting during breastfeeding at nine months (new guidelines)
  - PrEP for high-risk pregnant and breastfeeding women, including discordant couples, as part of a comprehensive prevention package according to national guidelines
  - Health education among pregnant and breastfeeding women and risk reduction messaging
- Improve retention
  - Data use and CQI approach
  - Mentor mothers
  - Active tracing of missed appointments
  - Mother-infant-pair clinics
  - Community engagement to understand and address challenges faced by clients at site level
- Point of care viral load (Gene Xpert) at the first ANC visit for pregnant women. An unsuppressed VL will result in the woman being enrolled on intensive adherence counselling immediately
  - Incorporated into daily health talks at maternal child health (MCH) services
- Tailored interventions for AGYW in PMTCT program
  - Young mentor mothers
  - Young mothers' clubs
  - YFHS training in MCH

- Flexible ANC schedules for young mothers
- POCs/champions for the youth among the staff

Activities supported by the Global Fund will also contribute to progress toward the elimination of mother to child transmission. Similar to PEPFAR, Malawi's Global Fund grant application will ensure that 95% universal PITC maintained at ANC, maternity, and STI, in addition to, support for peer mentor mothers to carry out active tracing that results in returning mothers back to care.

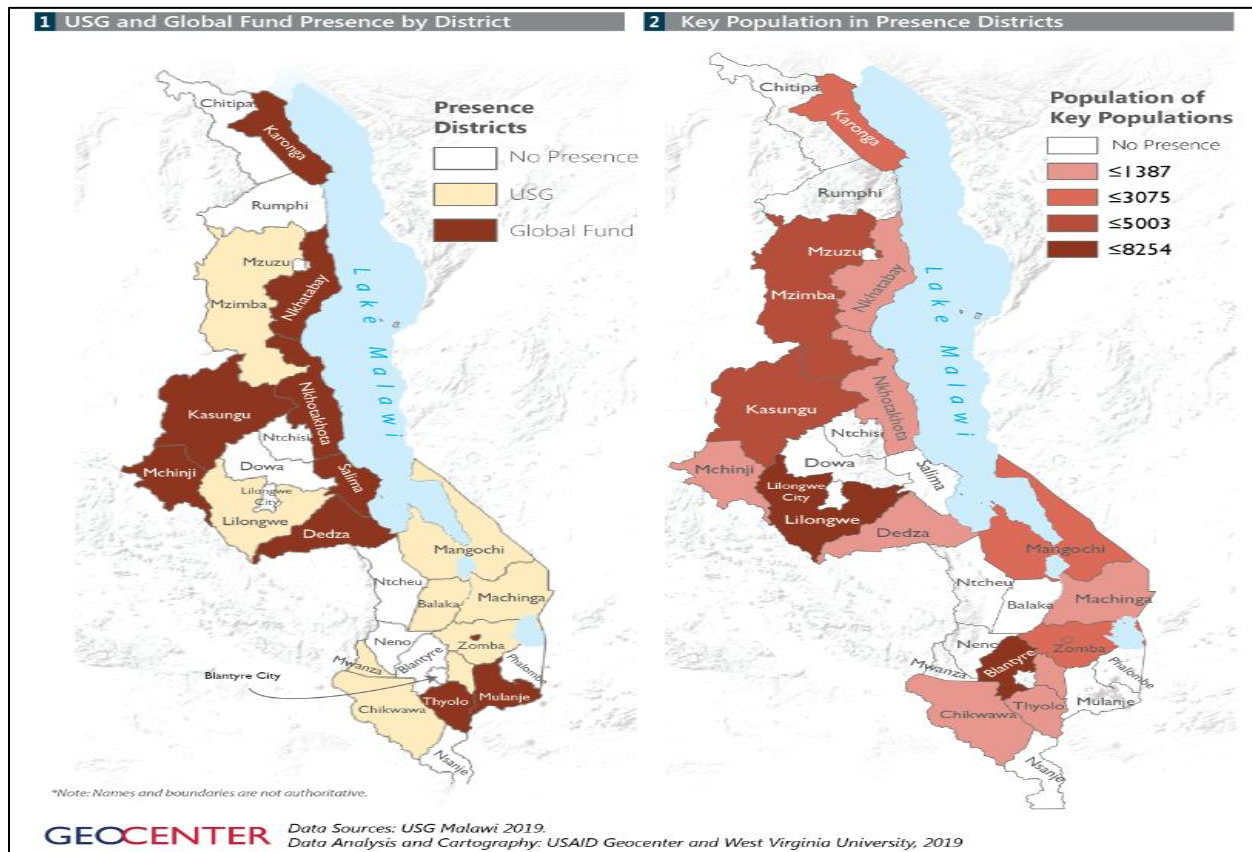
### 4.3.3 Key Populations

Over the years, PEPFAR Malawi and the Global Fund have been the main KP program implementers. However, six new KP-led community organizations were registered at the end of FY19 to accelerate HIV Prevention and service delivery for KP, especially for the hardest to reach and in districts where PEPFAR and Global Fund do not have presence. Implementation through KP-led organizations builds trust and eliminates fear, stigma, and discrimination at all stages of the KP continuum of care, improving the performance of the KP HIV cascade indicators. The timely introduction of Key Population Investment Funds (KPIF) in COP19 has been a great resource for capacity building of these KP-led organizations and enabled them to provide comprehensive prevention and treatment services to KP in two additional districts: Phalombe and Balaka. The Diversity Forum is a KP-led organization coordination structure which ensures that there are coordinated efforts in the KP programming with PEPFAR, the Global Fund, UNAIDS, MoH, NAC, and all other relevant stakeholders. PEPFAR consults with the Diversity Forum and will aim for quarterly meetings in COP20 to improve quality services for KP, including indicator performance, especially in testing strategies, ART adherence, treatment as prevention, and tracking of mobile FSW wherever they may be. High-level stakeholder engagement continues to improve with increased dialogue at national, district, and local levels.

**PEPFAR's Package of Services for KPs by Geographic Prioritization and Interventions:** In eight high-burden districts - Blantyre, Machinga, Zomba, Mangochi, Lilongwe, Chikwawa, Chiradzulu, and Mzimba - the KP program continues to provide a cascade of comprehensive HIV prevention, care, and treatment services through 17 drop-in centers, mobile hotspot outreach, and supported KP-friendly public facilities. Key approaches include well-trained health care workers to provide KP-friendly and sensitive clinical services, KP lay personnel (peer educators and HIV positive peer navigators), and direct service delivery to beneficiaries. Peer-led activities increase self and community efficacy to adopt healthy behaviors and access services addressing the continuum of care for HIV positive individuals. Through direct, referrals, or service-providing centers, the comprehensive KP package will include: condoms/lubricant, quarterly HIV testing, STI screening and treatment, family planning, cervical cancer screening and treatment services, TB, PMTCT, and post-GBV services treatment and care. PEPFAR will continue to provide these services through the KP platform including targeted HTS, condoms, and prevention messages to clients of FSW. Children of sex workers will be targeted with 5C compliant index testing and underage girls (<18) that are exploited and found in hotspots will be referred to DREAMS and social welfare departments in the districts.



**Figure 4.3.3.1 Geography of KP program in Malawi: Targeting Burden of Disease**



**Reaching Key Populations with Services:** The KP investment will continue to optimize strategies to reach HIV negative and HIV positive KP with comprehensive prevention, treatment, and care services, address leakages in the clinical cascade, and expand hotspot coverage based on annual revalidated hotspot assessments. Well-trained and trusted peers will reach MSM, male sex workers and transgender people with expanded services, especially among hidden MSM through virtual platforms (e.g., SMS-based and leveraging social media). Community led outreach approaches in transgender specific safe spaces will continue to focus on empowerment of transgender leaders (peer educators/peer navigators). The Peer Educator Microplanning approach will continue to ensure that KP are tracked through the cascade and will drive treatment literacy efforts.

Strategies below are currently being implemented in COP19 and will be scaled up in COP20:

- **Reaching the most at risk and hard to reach KPs with HIV testing services:** Training of Peer Educators in HIV Self Testing will promote confidentiality by accessing services in comfort zones, reducing facility waiting time as well as health care worker burden. HIV yield will also improve as only those that are at most risk will be tested in facilities. Self-testing blends well in the social network strategy aimed at reaching MSM in particular.

For children and clients of FSW, PEPFAR will continue to reach FSW family members and clients with HTS, STI, family planning, and GBV screening.

- **PrEP:** Continue to expand access and use of PrEP to all eligible HIV negative KPs in all PEPFAR supported KP districts.
- **Strengthened HCW and Peer Educator capacity:** KPs may experience self-stigma which makes it difficult for them to visit care centers especially when the HCW are not trained in KP-specific issues. Provision of HCW KP sensitive trainings will continue in COP20 to ensure the existence of KP friendly facilities. HCW trainings are key to PEPFAR's 5As KP program model of implementing KP centered and focused program. Peer educators are often the first contact of KP in their own settings, hence the need for their capacity building too.
- **Scale up the T=T campaign:** This campaign will build on education sessions to address the existing knowledge gap in order to prevent HIV transmission cause by unsuppressed viral load in KP.
- **Prisons:** in COP20, PEPFAR will continue to provide a prevention service package to approximately 14,000 prison inmates in 19 prisons across scale-up and sustained districts. Sustained districts were included because the increased risk of HIV for prison inmates is the same regardless of prison geographical location (situational MSM).

#### 4.3.4 Voluntary Medical Male Circumcision

The GoM continues to prioritize VMMC as part of its biomedical prevention strategies as shown in the revised NSP 2020-2025 and in the National HIV Prevention Strategy (2018-2020). The revised NSP emphasizes the need to prioritize men aged 25-39 for VMMC as HIV incidence peaks up among sexually active men in this age group. The revised NSP further indicates that VMMC services should target men aged 15-49 years in the high HIV burden districts. This aligns well with the PEPFAR COP20 guidance which stipulates that circumcision should not be performed in boys younger than 15 years, and that country programs should use survey data to inform VMMC prioritization by targeting men with highest HIV incidence. PEPFAR Malawi has been the main funder of the VMMC program in Malawi, supporting 692,345 out of 842,851 (82%) circumcisions nationwide since the program started seven years ago. With COP19 funds and leveraging Global Fund resources for VMMC commodities, PEPFAR is providing VMMC direct service delivery in eleven districts. Three of these districts, formerly supported by World Bank resources, are earmarked to reach 80% saturation for 15-29 years old by the end of FY20.

In COP20, VMMC programming will receive \$9.5 million in base funding and \$6.5 million in Ambition Funds totaling \$16 million. PEPFAR Malawi will implement VMMC in Lilongwe, Blantyre, and Chikwawa districts and military sites due to high HIV burden, high unmet need for VMMC, and good performance in achieving the age pivot. A target of 157,421 has been set for the three districts plus military settings which includes males >15 years of age and older. The target setting process took HIV incidence among men into consideration. Unlike previous years where 70% of the target was men aged 15-29, in COP20, 89% of the target is men aged 20-44 as HIV

incidence is higher among these age groups compared. The updated decision makers program planning tool (DMPPT) shows that at the end of COP20, these three districts will reach 80% saturation for 15-19 and over 60% for the 20-34-year-old.

The VMMC program continues to gain momentum in the country and the number of annual circumcisions is still rising. In FY19, 139,129 circumcisions were performed across PEPFAR supported districts. Increased numbers of VMMC providers, community mobilizers, mobile and static sites, and consistent demand creation activities contributed to the high number of circumcisions. FY20 Q1 results show an increase in results achieved when compared to FY19 Q1 with 74% aged >15 years, with some district level variations. Successful strategies to improve the uptake of VMMC services among older men will be scaled in COP20, including: flexible hours for services (weekends and after hours), enhancing linkage to VMMC from other services like STI and HTS clinics, using client centered demand creation approaches, and improving collaboration with private clinics.

PEPFAR partners will continue to implement continuous quality improvement activities to ensure adherence to standards and quality of services are provided. The Department of HIV and AIDS will conduct periodic supervision to VMMC sites and lead the annual external quality assurance activity. PEPFAR will continue to work with the implementing partners and MOH to ensure that well trained providers are engaged in the program and that team's complete refresher trainings using the online training hub.

In FY19, PEPFAR Malawi, with guidance from the Ministry of Health, implemented the Shang Ring active surveillance at ten sites. A total of 1,862 men were circumcised using the Shang Ring device and all clients had the removals within the window period. There was one case of moderate adverse event of bleeding and pain, but the ring was removed, and conventional circumcision was performed. The Shang Ring method has shown potential in reaching older men as 88% of circumcisions performed were in males above age 15. In addition, active surveillance results indicate that the device can safely be used among 10-14-year-old boys. 227 boys aged 10-14 received the Shang Ring method with none reporting any adverse event.

PEPFAR partners are transitioning to reusable kits in FY19, with staff trainings and procurements underway. In COP20, PEPFAR has increased the number of circumcisions to be conducted using reusable kits from 64,000 to 91,000 (58% of total circumcisions).

Key COP20 activities will include:

- Provision of the minimum package of required services including age appropriate risk reduction counselling, STI screening and treatment, HIV screening/testing, and linkage to ART for those testing positive, condom promotion, and distribution and post-surgery follow-up including management of adverse events.
- Age appropriate comprehensive sex education for boys aged 10-14 who are not eligible for immediate VMMC.
- Scale-up of HIVST.

- Scale-up of human centered design for VMMC communication and demand creation.
- Continued use of the Shang Ring device.
- Tracking of referrals of clients testing positive in VMMC settings using ART linkage registers.
- Linking HIV negative males to VMMC services through collaboration between testing and treatment partners and VMMC partners. High-risk settings like STI clinics will be prioritized.
- Provision of integrated male-friendly services in selected VMMC static sites, e.g., general medical examination, STI screening and treatment, HIV self-testing, and sexual and reproductive health services.

#### **4.4 Additional Country-specific Priorities Listed in the Planning Level Letter**

In response to the COP20 planning level letter and significant retention challenges reflected in COP18 performance, the PEPFAR Malawi team will not wait to commence critical program adjustments. Programmatic shifts starting before COP20 implementation will include rightsizing HRH to align with high burden facilities, availing small grants funding to support civil society community-led monitoring efforts, as well as, partner improvement plans for redirecting HRH to sites. The USG team will continue actively supporting the Global Fund Grant development process to ensure critical commodities including ARVs, STI and RTKs align with service delivery strategies. PEPFAR will gain efficiencies by increasing funding to indigenous organizations including the GoM and civil society to deliver quality services in sustained sites and districts, as well as increase partner expenditures in direct service delivery at the patient and site level. To optimize client centered care, differentiated service delivery modalities including 6MMD, pharmacy fast-tracking and nurse-led community ART clubs (see Appendix E for additional information on CACs). Recency testing will enable the program to monitor the rise of micro-epidemics and lessons learned from MenStar will be adapted to the Malawian context to reach and retain men in ART.

Given Malawi's > 80% ART coverage, COP20 will have a significant reduction in PITC and will focus efforts in STI, TB, and ANC settings. In alignment with WHO Five C's of HTS, PEPFAR Malawi will work with the MoH to develop and implement a site certification to prevent IPV and adverse events associated with index testing modalities while ensuring implementing partners and providers are both familiar and trained on the 5Cs. Agencies are also ensuring that partners understand that there will be no specific target on the percentage of positive clients identified from PNS.

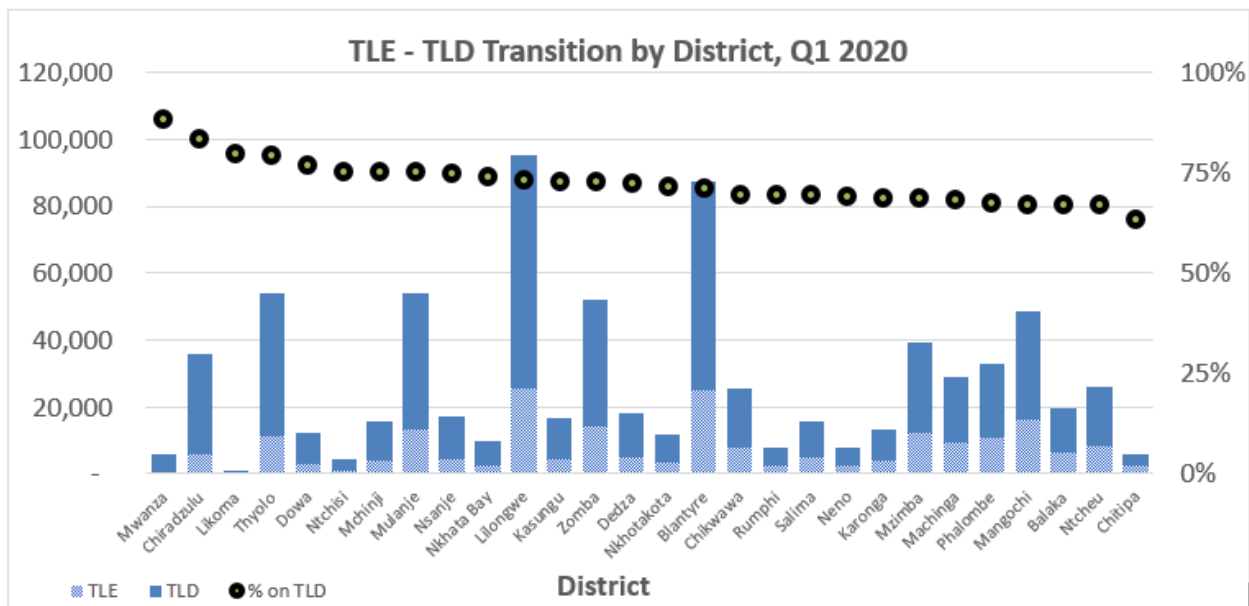
#### **4.5 Commodities**

Over 90% of key HIV/AIDS commodities are procured through the Global Fund grant and effectively managed by the MoH with support from PEPFAR technical assistance. In COP19, PEPFAR supported quantification, supply planning, and monitoring of HIV/AIDS commodities

and procurement of: Oraquick self-test kits (\$157,500), VMMC commodities (\$1,656,603), condoms, and lubricants (\$843,713). PEPFAR will leverage USAID’s Commodity Fund and will continue to fund Malawi’s lubricant needs, socially marketed condoms, and female condoms to prevent gaps in condom supplies. The MoH through the Global Fund procures commodities for STIs, however, national gaps in essential commodities at the facility level oftentimes results in stock-outs limiting the availability and access to STI treatment. While PEPFAR will continue advocating for STI commodities to be available, significant shortages of essential medicines for the treatment of illnesses (pneumonia) and other diseases will continue to draw upon these commodities until additional resources from the GoM are allocated.

**DTG Transition:** Malawi began transitioning clients to DTG-based formulations in January 2019 after the pilot that began in mid-2018. PEPFAR will support the country’s complete transition to DTG for those eligible, including women of childbearing age. Malawi is scaling up the transition of all eligible PLHIV with 71% (554, 815) of those on first line ART on TLD by end of Q1 of COP19. In COP20, PEPFAR will continue supporting quantification, supply planning, and monitoring of stock availability of TLD and all other HIV commodities to avoid stock outs, overstocks, and expirations. PEPFAR will support implementation for pediatric ART optimization as recommended by WHO and will support the country to optimally use Global Fund resources to ensure a seamless transition and availability of HIV/AIDS commodities. PEPFAR will also support the implementation of multi-month prescriptions and the transition to 90 pills per bottles for around two-thirds stable PLHIV.

**Table 4.5.1 TLE-TLD Transition by District, FY20 Q1**



The PEPFAR team continues to work closely with the Ministry of Health, clinical implementers, and civil society to accelerate the transition to DTG. Following the COP19 policy decisions in Johannesburg, the PEPFAR team ensured the procurement plan for DTG reflected new policies, including six-month refills. This is monitored through a bi-weekly monitoring plan, as well as, quarterly sit visits.

#### **4.6 Collaboration, Integration and Monitoring**

COP20 demonstrates a concerted paradigm shift to increase collaboration with the Government of Malawi through direct funding agreements and increase accountability measures through community-led monitoring frameworks. The simultaneous timeline of the Global Fund grant application with COP20 planning presented a timely opportunity to strategically align investments in HRH, EMR, commodities, testing strategies, as well as, safeguard against duplicative investments. The USG team scheduled the COP20 strategic planning kickoff the same week as the GF Geneva-based country team was in Malawi, enabling more stakeholders to present solutions required to overcome implementation challenges. Moreover, recurrent meetings held with CSOs, FBOs, international organizations, UNAIDS, WHO, implementing partners, and health donor groups provided feedback and insight on challenges in COP20 and related programmatic considerations. PEPFAR will utilize various avenues including newsletters, quarterly in-person meetings, POARTs, and virtual fora to disseminate information and keep constituents well-informed.

As the PEPFAR program fully transitions to a direct service delivery model, key programmatic shifts will include increased investments in both professional and lay HCWs to address retention, decongest facilities, offer an increased menu of differentiated service delivery models and, create a more friendly and enabling environment for clients to interface with at site and community level. PEPFAR will also work with the MoH to address HRH related barriers such as poor HCW attitudes towards clients returning back to care. Above site investments including laboratory strengthening, case-based surveillance, and supply chain management will enable PEPFAR to strengthen national structures required to reach the third 95 and monitor the epidemic.

#### 4.7 Targets by Population

Table 4.7.1 ART Targets by Prioritization for Epidemic Control

| Table 4.7.1 ART Targets by Prioritization for Epidemic Control |                  |                                    |   |   |  |                       |
|--|------------------|------------------------------------|---|---|--|-----------------------|
| Prioritization Area  | Total PLHIV      | Expected current on ART (APR FY20) | Additional patients required for 80% ART coverage | Target current on ART (APR FY21) <i>TX_CURR</i> | Newly initiated (APR FY21) <i>TX_NEW</i> | ART Coverage (APR 21) |
| Scale-Up Saturation  | 786,661          | 647,505                            | 0   | 727,606   | 72,393                                   | 90%                   |
| Sustained  | 290,607          | 234,165                            | 0   | 252,724   | 18,273                                   | 90%                   |
| <b>Total</b>   | <b>1,077,268</b> | <b>881,670</b>                     | <b>0</b>  | <b>980,330</b>                                  | <b>90,666</b>                            | <b>90%</b>            |

\*Military not included

Table 4.7.2 VMMC Coverage and Targets by Age Bracket in Scale-Up Districts

| Table 4.7.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts |                    |                                 |                         |                     |                             |
|--|--------------------|---------------------------------|-------------------------|---------------------|-----------------------------|
| SNU  | Target Populations | Population Size Estimate (SNUs) | Current Coverage (date) | VMMC_CIRC (in FY21) | Expected Coverage (in FY21) |
| Blantyre   | >15 years          | 290200                          | 38%                     | 43,865              | 43%                         |
| Chikwawa   | > 15 years         | 129700                          | 32%                     | 30,000              | 39%                         |
| Lilongwe   | >15 years          | 605400                          | 29%                     | 72,000              | 36%                         |

Table 4.7.3 Key Population Prevention Interventions to Facilitate Epidemic Control

| Table 4.7.3 Target Population for Prevention Interventions to Facilitate Epidemic Control |           |   |                          |                         |             |
|---|-----------|---|--------------------------|-------------------------|-------------|
| District  | Indicator | Target Population                             | Population Size Estimate | Coverage Goal (in FY21) | FY21 Target |
| Blantyre  | KP_PREV   | FSW   | 6,700                    | 95%                     | 6,365       |
|   |           | MSM SW  | 640                      | 95%                     | 608         |
|   |           | MSM not SW                                    | 2,560                    | 95%                     | 2,432       |
|   |           | TG  | 200                      | 95%                     | 190         |
|   |           | People in prisons and other enclosed settings | 2,600                    | 100%                    | 2,600       |
| Balaka  | KP_PREV   | FSW   | 410                      | 95%                     | 390         |
|   |           | MSM SW  | 250                      | 19%                     | 48          |
|   |           | MSM not SW                                    |                          |                         | 190         |
| Chikwawa  | KP_PREV   | FSW   | 900                      | 95%                     | 855         |
|   |           | MSM SW  | 700                      | 19%                     | 133         |
|   |           | MSM not SW                                    |                          |                         | 532         |
|   |           | Non-Disaggregated                             |                          |                         | 778         |
| Chiradzulu  | KP_PREV   | FSW   | 400                      | 95%                     | 380         |
|   |           | MSM SW  | 100                      | 19%                     | 19          |
|   |           | MSM not SW                                    |                          |                         | 76          |
|   |           | MSM SW  |                          |                         | 16          |
|   |           | MSM not SW                                    |                          |                         | 4           |
|   |           | Non-Disaggregated                             |                          |                         | 195         |
| Lilongwe  | KP_PREV   | FSW   | 7,050                    | 95%                     | 6,698       |



|                 |         |   |       |      |       |
|-----------------|---------|---|-------|------|-------|
|                 |         | MSM SW  | 2,950 | 19%  | 561   |
|                 |         | MSM not SW                                    |       | 51%  | 2,242 |
|                 |         | TG  | 300   |      | 285   |
|                 |         | People in prisons and other enclosed settings | 4,400 | 100% | 4,400 |
|                 |         | Non-Disaggregated                             |       |      | 3,890 |
| <u>Machinga</u> | KP_PREV | FSW   | 1,500 | 95%  | 1425  |
|                 |         | MSM SW  | 290   | 19%  | 55    |
|                 |         | MSM not SW                                    |       |      | 221   |
|                 |         | Non-Disaggregated                             |       |      | 552   |
| <u>Mangochi</u> | KP_PREV | FSW   | 1,000 | 95%  | 950   |
|                 |         | MSM SW  | 280   | 19%  | 53    |
|                 |         | MSM not SW                                    |       |      | 213   |
| <u>Mwanza</u>   | KP_PREV | FSW   | 800   | 95%  | 760   |
|                 |         | MSM SW  | 186   | 19%  | 35    |
|                 |         | MSM not SW                                    |       |      | 142   |
|                 |         | TG  | 330   | 100% | 330   |
| <u>Mzimba</u>   | KP_PREV | FSW   | 3,227 | 95%  | 3,066 |
|                 |         | MSM SW  | 900   | 19%  | 171   |
|                 |         | MSM not SW                                    |       |      | 684   |
|                 |         | TG  | 70    | 96%  | 67    |
|                 |         | People in prisons and other enclosed settings | 1,400 | 100% | 1,400 |
|                 |         | MSM SW  |       |      | 143   |
|                 |         | MSM not SW                                    |       |      | 36    |
|                 |         | TG  |       |      | 14    |
|                 |         | Non-Disaggregated                             |       |      | 1,924 |
| <u>Phalombe</u> | KP_PREV | FSW   | 350   | 95%  | 333   |

**Table 4.7.4 Target Populations for Prevention Interventions**

**Table 4.7.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control**

| District      | Indicator                   | Target Population | FY21 Target |
|---------------|-----------------------------|-------------------|-------------|
| Blantyre      | PP_PREV                     | AGYW              | 42,309      |
|               |                             | Non-Disaggregated | 22,316      |
|               | GEND_GBV-Physical emotional | AGYW              | 990         |
|               | GEND_GBV-Sexual             | AGYW              | 1,845       |
|               | <u>PrEP_NEW</u>             | FSW               | 1,315       |
|               |                             | MSM SW            | 508         |
|               |                             | MSM not SW        | 127         |
|               |                             | TG                | 40          |
|               |                             | AGYW              | 3,859       |
|               |                             | Non-Disaggregated | 2,040       |
|               |                             | <u>PrEP_CURR</u>  | FSW         |
|               | MSM SW                      |                   | 330         |
|               | MSM not SW                  |                   | 83          |
|               | TG                          |                   | 26          |
| <u>Balaka</u> | <u>PrEP_NEW</u>             | FSW               | 80          |
|               |                             | MSM SW            | 40          |
|               |                             | MSM not SW        | 10          |
|               |                             | Non-Disaggregated | 130         |
|               | <u>PrEP_CURR</u>            | FSW               | 52          |

|                 |                             |                   |        |
|-----------------|-----------------------------|-------------------|--------|
|                 |                             | TG                | 59     |
|                 |                             | Non-Disaggregated | 3,352  |
|                 | <u>PrEP_CURR</u>            | FSW               | 899    |
|                 |                             | MSM SW            | 305    |
|                 |                             | MSM not SW        | 76     |
|                 |                             | TG                | 39     |
|                 |                             | Non-Disaggregated | 3,890  |
|                 |                             |                   |        |
| <u>Machinga</u> | PP_PREV                     | AGYW              | 29,234 |
|                 | PP_PREV                     | Non-Disaggregated | 6,477  |
|                 | GEND_GBV-Physical emotional | AGYW              | 1,097  |
|                 | GEND_GBV-Sexual             | AGYW              | 887    |
|                 | <u>PrEP_NEW</u>             | FSW               | 294    |
|                 |                             | MSM SW            | 46     |
|                 |                             | MSM not SW        | 11     |
|                 |                             | AGYW              | 150    |
|                 |                             | Non-Disaggregated | 702    |
|                 | <u>PrEP_CURR</u>            | FSW               | 191    |
|                 |                             | MSM SW            | 30     |
|                 |                             | MSM not SW        | 7      |
|                 |                             | AGYW              | 424    |
|                 |                             | Non-Disaggregated | 552    |
| <u>Mangochi</u> | PP_PREV                     | Non-Disaggregated | 300    |
|                 | GEND_GBV-Physical emotional | Non-Disaggregated | 158    |
|                 | GEND_GBV-Sexual             | Non-Disaggregated | 68     |
|                 | <u>PrEP_NEW</u>             | FSW               | 196    |
|                 |                             | MSM SW            | 44     |
|                 |                             | MSM not SW        | 11     |
|                 |                             | Non-Disaggregated | 1,169  |

|                  |                   |                             |                   |     |
|------------------|-------------------|-----------------------------|-------------------|-----|
|                  | <u>PrEP_CURR</u>  | FSW                         | 127               |     |
|                  |                   | MSM SW                      | 29                |     |
|                  |                   | MSM not SW                  | 7                 |     |
|                  |                   | Non-Disaggregated           | 1,261             |     |
| Mwanza           | PP_PREV           | Non-Disaggregated           | 50                |     |
|                  |                   |                             |                   |     |
|                  | <u>PrEP_NEW</u>   | FSW                         | 157               |     |
|                  |                   | MSM SW                      | 30                |     |
|                  |                   | MSM not SW                  | 7                 |     |
|                  |                   | Non-Disaggregated           | 194               |     |
|                  | <u>PrEP_CURR</u>  | FSW                         | 102               |     |
|                  |                   | MSM SW                      | 19                |     |
|                  |                   | MSM not SW                  | 5                 |     |
|                  |                   | Non-Disaggregated           | 221               |     |
|                  | Mzimba            | PP_PREV                     | Non-Disaggregated | 151 |
|                  |                   | GEND_GBV-Physical emotional | Non-Disaggregated | 90  |
| GEND_GBV-Sexual  |                   | Non-Disaggregated-          | 38                |     |
| <u>PrEP_NEW</u>  |                   | FSW                         | 633               |     |
|                  |                   | MSM SW                      | 143               |     |
|                  |                   | MSM not SW                  | 36                |     |
|                  |                   | TG                          | 14                |     |
|                  |                   | Non-Disaggregated           | 1,924             |     |
| <u>PrEP_CURR</u> |                   | FSW                         | 411               |     |
|                  |                   | MSM SW                      | 93                |     |
|                  |                   | MSM not SW                  | 23                |     |
|                  |                   | TG                          | 9                 |     |
|                  | Non-Disaggregated | 2,120                       |                   |     |
| <u>Phalombe</u>  | <u>PrEP_NEW</u>   | FSW                         | 69                |     |
|                  |                   | MSM SW                      | 43                |     |

|                |                             |                   |        |
|----------------|-----------------------------|-------------------|--------|
|                |                             | MSM not SW        | 11     |
|                |                             | Non-Disaggregated | 122    |
|                | <u>PrEP_CURR</u>            | FSW               | 45     |
|                |                             | MSM SW            | 28     |
|                |                             | MSM not SW        | 7      |
|                |                             | Non-Disaggregated | 122    |
|                |                             |                   |        |
| <u>Zomba</u>   | PP_PREV                     | AGYW              | 23,086 |
|                | PP_PREV                     | Non-Disaggregated | 10,116 |
|                | GEND_GBV-Physical emotional | AGYW              | 1,043  |
|                | GEND_GBV-Sexual             | AGYW              | 1,181  |
|                | <u>PrEP_NEW</u>             | FSW               | 343    |
|                |                             | MSM SW            | 56     |
|                |                             | AGYW              | 484    |
|                |                             | MSM not SW        | 14     |
|                |                             | Non-Disaggregated | 1251   |
|                | <u>PrEP_CURR</u>            | FSW               | 223    |
|                |                             | MSM SW            | 36     |
|                |                             | MSM not SW        | 9      |
|                |                             | TG                | 9      |
|                |                             | AGYW              | 759    |
|                |                             | Non-Disaggregated | 766    |
| <u>Thvolo</u>  | PREP_NEW                    | Non-Disaggregated | 165    |
|                | PREP_CURR                   | Non-Disaggregated | 245    |
| <u>Mulanje</u> | <u>PrEP_NEW</u>             | Non-Disaggregated | 203    |
|                | <u>PrEP_CURR</u>            | Non-Disaggregated | 203    |
| <u>Ntchisi</u> | PP_PREV                     | Non-Disaggregated | 150    |
| <u>Ntcheu</u>  | PP_PREV                     | Non-Disaggregated | 50     |
| <u>Rumphi</u>  | PP_PREV                     | Non-Disaggregated | 50     |

|                    |                |                          |            |
|--------------------|----------------|--------------------------|------------|
| <b>Dedza</b>       | <b>PP_PREV</b> | <b>Non-Disaggregated</b> | <b>100</b> |
| <b>Salima*</b>     | <b>PP_PREV</b> | <b>Non-Disaggregated</b> | <b>100</b> |
| <b>Chitipa*</b>    | <b>PP_PREV</b> | <b>Non-Disaggregated</b> | <b>100</b> |
| <b>Dowa*</b>       | <b>PP_PREV</b> | <b>Non-Disaggregated</b> | <b>100</b> |
| <b>Kasungu*</b>    | <b>PP_PREV</b> | <b>Non-Disaggregated</b> | <b>150</b> |
| <b>Mchinji*</b>    | <b>PP_PREV</b> | <b>Non-Disaggregated</b> | <b>150</b> |
| <b>Nkhotakota*</b> | <b>PP_PREV</b> | <b>Non-Disaggregated</b> | <b>100</b> |

\* Peace Corps-only districts

Table 4.7.4 Targets for OVC and Linkages to HIV Services

| Table 4.7.4 Targets for OVC and Linkages to HIV Services |   |                |   |  |  |
|--|---|----------------|---|--|--|
| SNU/District   | Estimated # of Orphans and vulnerable children ** | Total OVC_SERV | Target # of Active OVC (FY21 target) OVC_SERV | Target # of graduated OVC (FY21 target) OVC_SERV | Target # of Active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in the program files (FY21 target) OVC |
| Blantyre   | 70,021  | 15,367         | 13,369  | 1998   | 12,627   |
| Chikwawa   | 34,399  | 12,879         | 11,205  | 1,674  | 11,441   |
| Lilongwe   | 118,143   | 34,459         | 27,568  | 6,891  | 30,895   |
| Machinga   | 41,536  | 11,477         | 9,985   | 1,492  | 9,730  |
| Mangochi   | 70,859  | 15,565         | 13,542  | 2,023  | 13,540   |
| Mulanje  | 44,615  | 19,551         | 19,355  | 196  | 16,472   |
| Phalombe   | 27,580  | 17,061         | 16,890  | 171  | 14,567   |
| Zomba  | 49,468  | 16,702         | 14,531  | 2,171  | 13,649   |
| Thyolo   | 46,979  | 16,738         | 16,571  | 167  | 14,324   |
| Chitipa *  | 12,309  | 100            | 99  | 1  | 100  |
| Rumphi *   | 11,397  | 150            | 148   | 2  | 150  |
| Mzimba *   | 54,497  | 250            | 248   | 2  | 240  |
| Kasungu *  | 38,921  | 151            | 149   | 2  | 151  |
| Nkhotakota *   | 20,927  | 100            | 99  | 1  | 100  |
| Ntchisi *  | 13,830  | 149            | 147   | 2  | 149  |
| Dowa *   | 36,321  | 100            | 99  | 1  | 100  |
| Salima *   | 27,583  | 100            | 99  | 1  | 100  |
| Mchinji *  | 26,387  | 150            | 148   | 2  | 150  |
| Dedza *  | 50,580  | 99             | 98  | 1  | 99   |
| Ntcheu *   | 40,698  | 51             | 51  | 0  | 51   |
| Mwanza *   | 7,031   | 50             | 50  | 0  | 50   |
| <b>Totals</b>  | <b>844,081</b>                                    | <b>161,249</b> | <b>144,451</b>                                | <b>16,798</b>                                    | <b>138,685</b>   |

\* Peace Corps-only districts

\*\* Malawi Population and Housing census Report 2018



## 4.8 Cervical Cancer

Cervical cancer is the number one cancer killer in sub-Saharan Africa. Women living with HIV (WLHIV) are four to five times more likely to develop persistent precancerous lesions that progress to cervical cancer, often with more aggressive forms and with higher mortality<sup>5</sup>. PEPFAR Malawi implemented cervical cancer screening and treatment for pre-cancerous lesions for WLHIV in FY19 at 39 high-volume ART facilities and reached 39,235 women with screen and treat (representing 92% achievement of the FY19 target of 42,827). In these 39 sites, the program served approximately 32% of WLHIV aged 25-49 years and by FY19 Q3, all 39 sites were implementing cervical cancer screening and treatment services with cryotherapy and thermocoagulation. PEPFAR leveraged Global Fund resources for the procurement of key equipment and consumables. PEPFAR also worked closely with the MoH to ensure that equipment distribution was rationalized and revised monitoring and evaluation tools aligned with PEPFAR clinical reporting requirements. PEPFAR Malawi strengthened service delivery through in-service training of providers and deploying at least one cervical cancer lead per site to coordinate screening and treatment services.

Between FY19 and FY20, PEPFAR seconded two technical assistants to MoH to strengthen coordination and improve the quality of data collection, analysis, and utilization. Standard operating procedures for quality assurance were also developed. Despite achieving 92% of the OU CXCA\_SCRN target in FY19, a third of WLHIV with precancerous lesions were not treated due to untrained staff (funding was delayed) and delayed availability of treatment equipment at most facilities. The availability of loop electrosurgical procedure (LEEP) for treatment of large lesions is limited across the country resulting in women travelling very long distances to access these services where priority is given to other emergency surgical procedures.

In FY20 Q1, Malawi's cervical cancer program continued its strong performance with an achievement of 25% of the annual CXCA\_SCRN target (101,507 WLHIV). Same-day treatment of precancerous lesions has improved from 64% in FY19 Q4 to 85% in FY20 Q1. PEPFAR implementing partners have been able to account for the remainder of the 15% as those referred for LEEP due to large lesions and are able to track these referrals for accountability.

PEPFAR will continue working with the MoH to introduce LEEP services to all district hospitals (secondary referral level), and strengthening referral networks for WLHIV in need of LEEP and specialized care for those presumed to have cervical cancer. In COP20, PEPFAR Malawi will further improve access to cervical cancer screen and treat services by scaling up to an additional 41 sites, bringing the number of PEPFAR supported cervical cancer sites to 80, while reaching 50% of WLHIV aged 25-49 years. PEPFAR aims to screen 103,650 WLHIV in COP20 from the 80 designated facilities. PEPFAR Malawi will also employ a hub and spoke model to expand services to facilities surrounding the district and other large mission hospitals. This allows for minimal investments for high impact through outreach clinics in facilities that are otherwise smaller in

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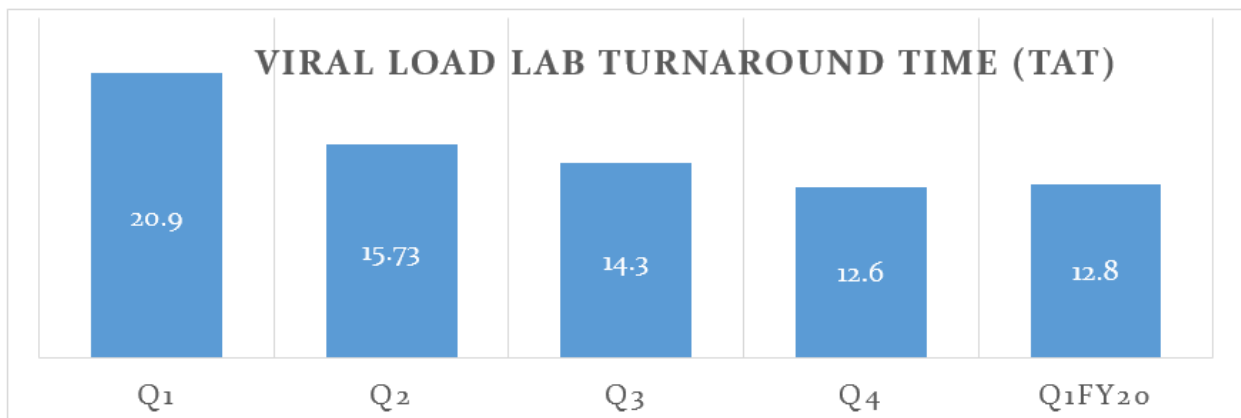
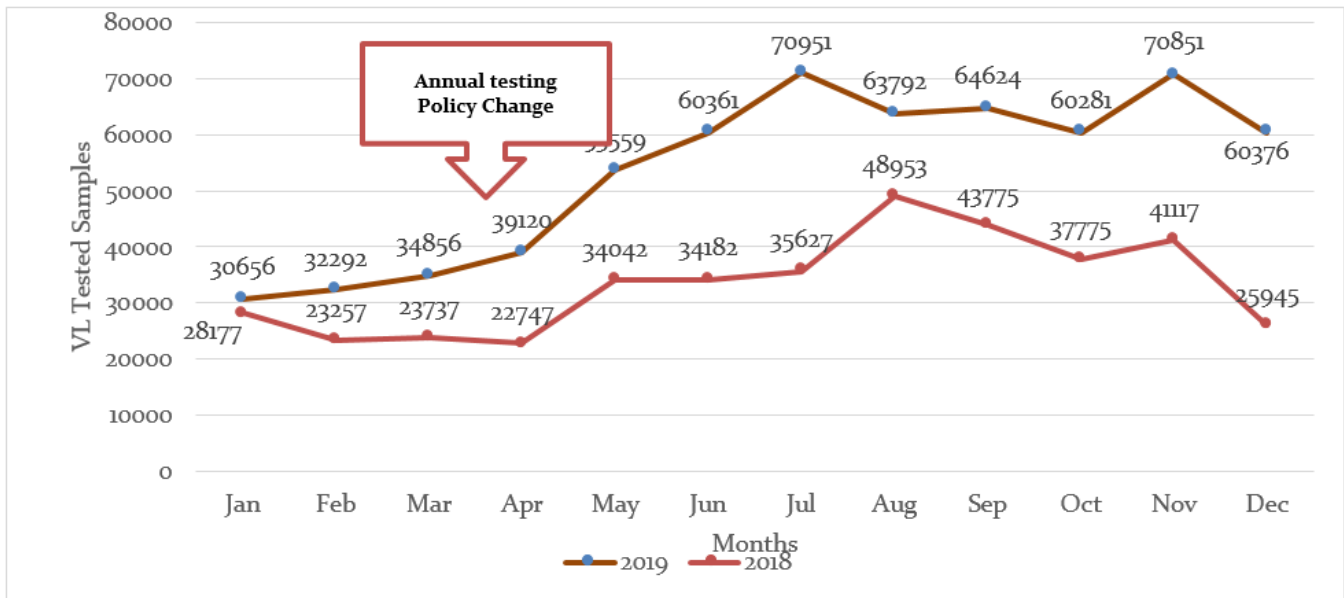
<sup>5</sup> COP 20 guidance

their WLHIV volume. The innovative use of portable thermocoagulators makes service delivery through an outreach model more feasible.

#### 4.9 Viral Load and Early Infant Diagnosis Optimization

Following the annual VL policy change in April 2019 and site-level interventions by implementing partners, the number of viral load samples tested doubled with viral load coverage now national.

**Figure 4.9.1 Viral Load Samples Tested Doubled, Coverage Now at 100%**

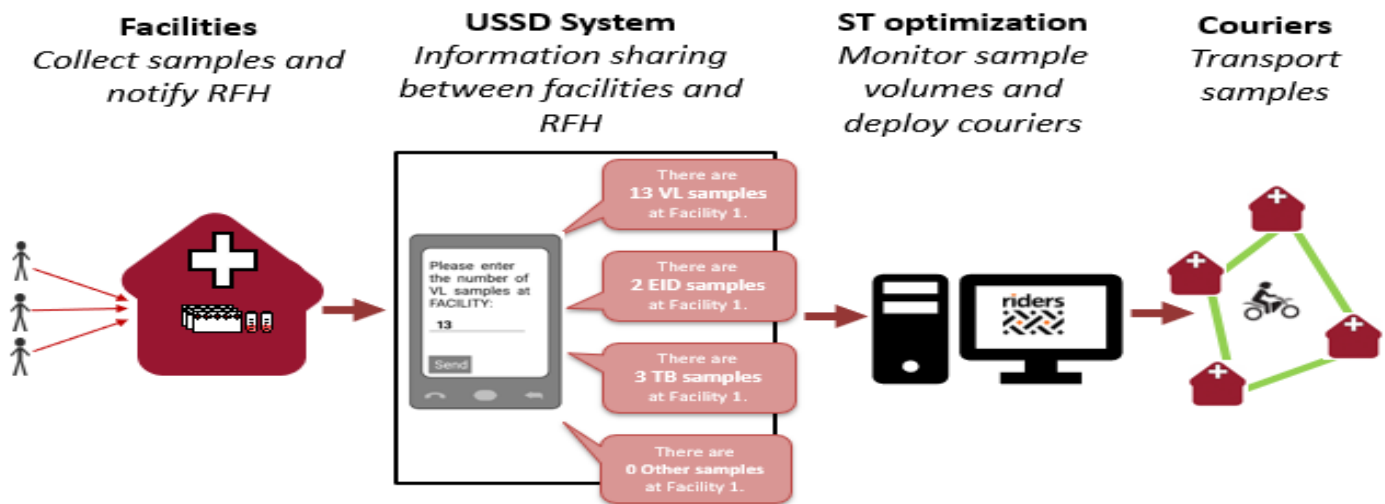


Another major achievement in FY19 was the reduction in turnaround times from 21 days in FY19 Q1 to 13 days by FY20 Q1 (from sample collection to dispatch from the molecular lab), as shown in Figure 4.9.2. This was achieved through: 1) sample transport (ST) optimization; 2) hub automation and 3) additional shifts of HRH in labs.

**Figure 4.9.2 Viral Load Lab Turnaround Time**

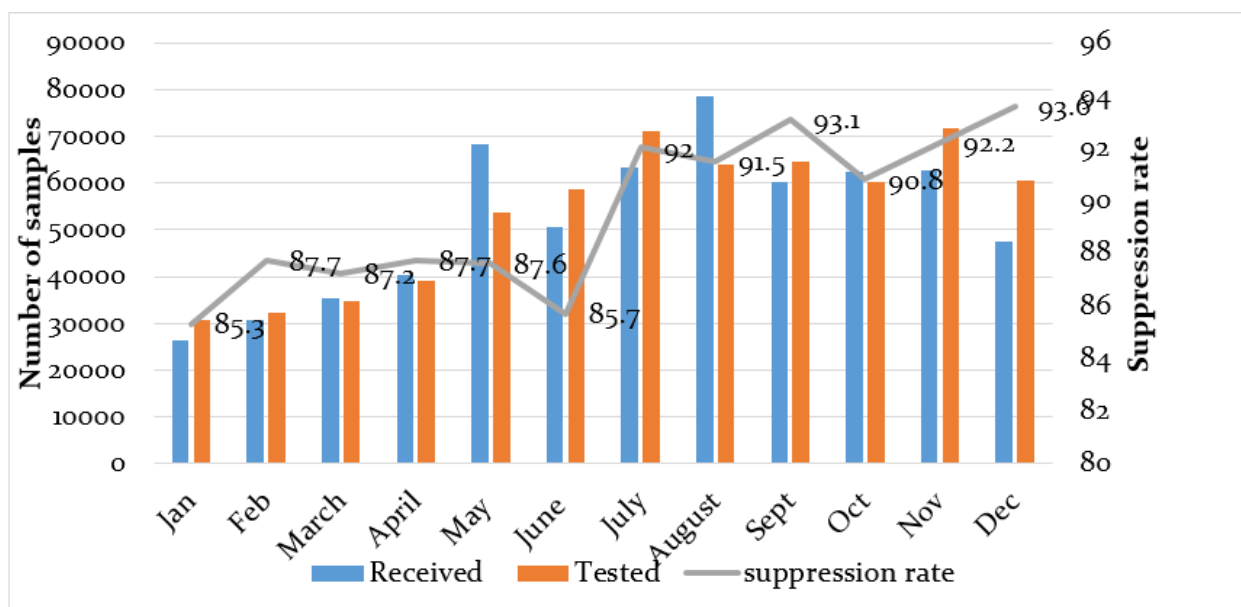
In FY19 going into FY20, sample transportations optimization will continue. A pull system using SDS phone messaging will reduce unnecessary trips by couriers improving the efficiency of results return, per Figure 4.9.3. The Bill and Melinda Gates Foundation has committed to funding a SMS results alert pilot in Malawi in 2020 which will be sustained, improving turnaround time and empowering PLHIV to know and receive their viral loads in a timely manner.

**Figure 4.9.3 Improving Efficiency of Results**



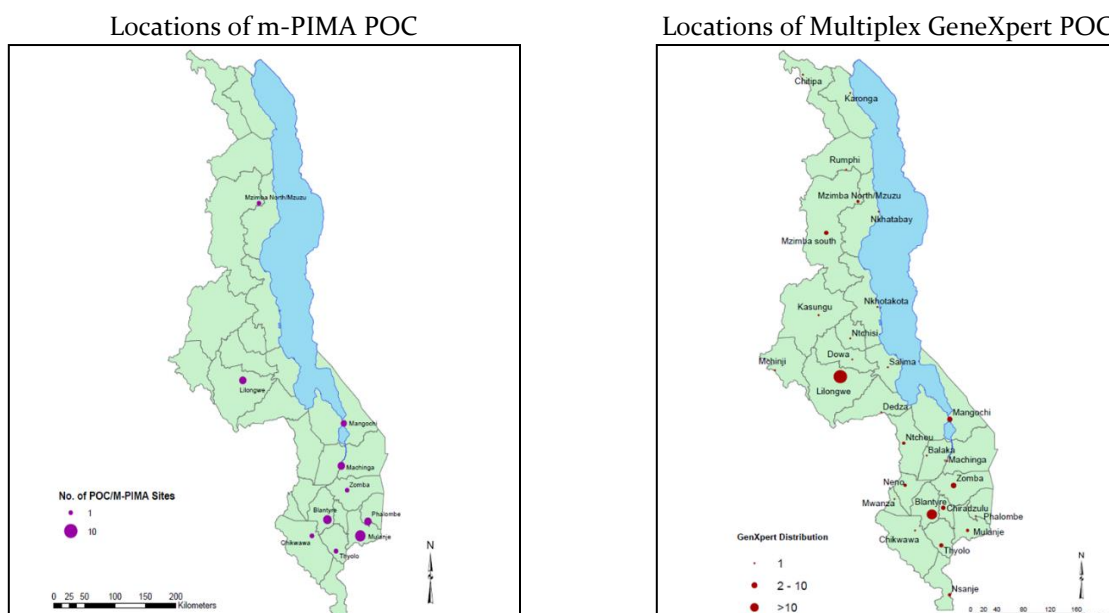
As of December 2019, viral load suppression rates improved to over 90% (Figure 4.9.4) and are most directly attributed to the DTG transition. Patient centered approaches, such as viremia clinics and psychosocial counselling for patients who have sub-optimal adherence continue to demonstrate a positive impact on health outcomes.

**Figure 4.9.4 Improvement of Viral Suppression Rates**



In COP20, PEPFAR Malawi will continue supporting the national VL program, which will include scale up of plasma sample collection in urban centers, optimal use of POC machines, enhancing effective sample and results transfer, and ensuring molecular labs meet quality assurance standards. Malawi has a total of 92 GeneXpert Machines with 48 available for EID and VL testing<sup>6</sup> at sites eligible for TB/HIV integration (with integrated testing beginning in FY20). National policies are already in place to decentralize EID and targeted VL testing at the district level utilizing GeneXpert. Currently, POC EID is only being done at selected high-volume facilities including central hospitals. As the National TB program moves towards the WHO recommendation of using GeneXpert as the primary test for all presumptive TB patients, an increase in TB testing is expected. GeneXpert is primarily used for EID and targeted VL but not routine VL testing.

**Figure 4.9.5 Locations of m-PIMA POC and Multiplex GeneXpert POC**



Malawi does not have a specific VL policy in place for pregnant and breastfeeding women. In COP20, PEPFAR Malawi will work together with the MOH to develop and implement this policy and increase utilization of existing GeneXpert machines.

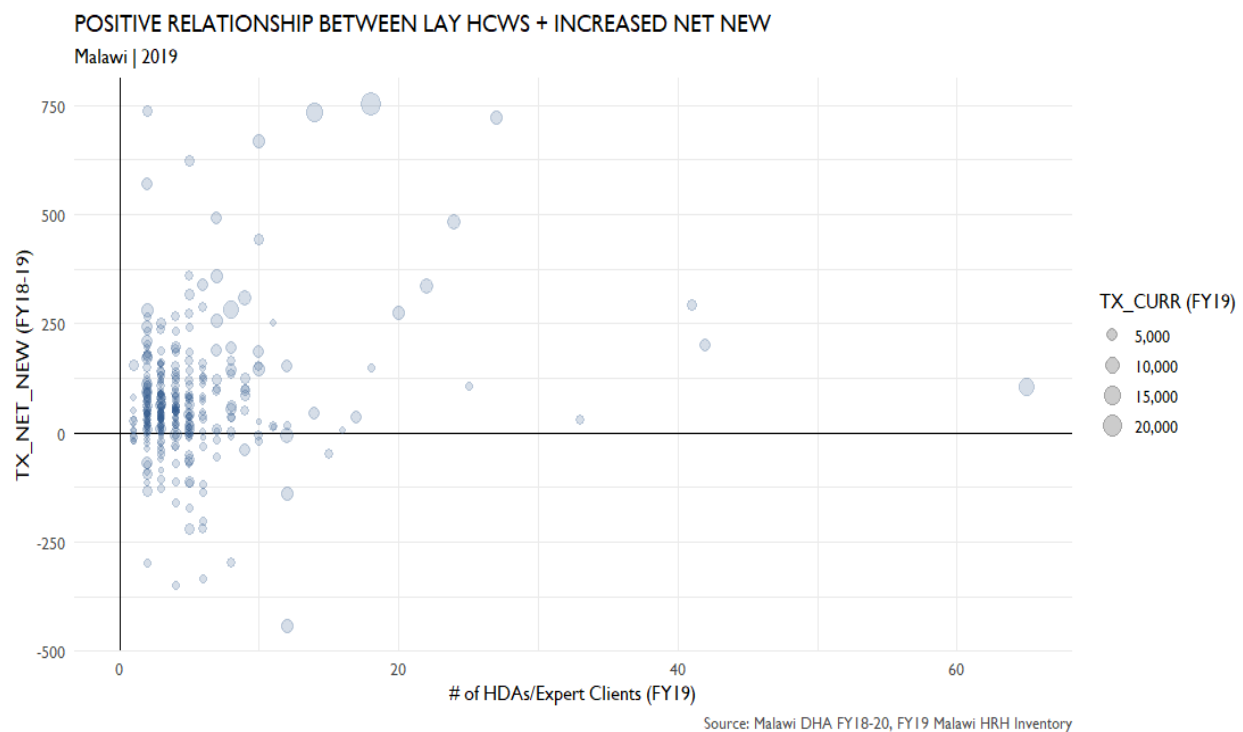
<sup>6</sup> MOHP 2019; HIV Early infant diagnosis & Viral load scale up and implementation plan 2019-2020

## 5.0 Program Support Necessary to Achieve Sustained Epidemic Control

As Malawi moves toward achieving epidemic control, six key barriers that require particular attention in COP20 include: (a) the evolving and suboptimal policy environment; (b) weak information systems; (c) inadequate human resources for health for HIV (and broader) health service delivery; (d) limited host country institutional capacity; (e) limited commodity management and storage capacity, and (f) poor optimization of lab mechanisms. Each has the potential to stall implementation of HIV interventions across the cascade.

The 2019 Sustainability Index Dashboard (SID) identified technical and allocative efficiencies; commodity security and supply chain issues; epidemiology and health data; and, important laboratory-related issues as posing the greatest threats to the country's progress. In conjunction with the SID, information and insights gleaned from MER and SIMS data all point to the need for PEPFAR investments to focus on improved service delivery and broader health systems strengthening, including increasing the number of skilled professional cadres, advancing the quality and depth of national, district, and site level leadership, management of HIV services, and recognizing that data eco-systems genuinely inform decision making as well as the gains made in HIV prevention, treatment, and viral load interventions.

### 5.1 Evolving and Suboptimal Policy Environment



From a policy and enabling environment perspective, PEPFAR Malawi will work with technical working groups, health, and the HIV donor community to strengthen national policies to align with global guidance and strengthen coordination and governance structures.

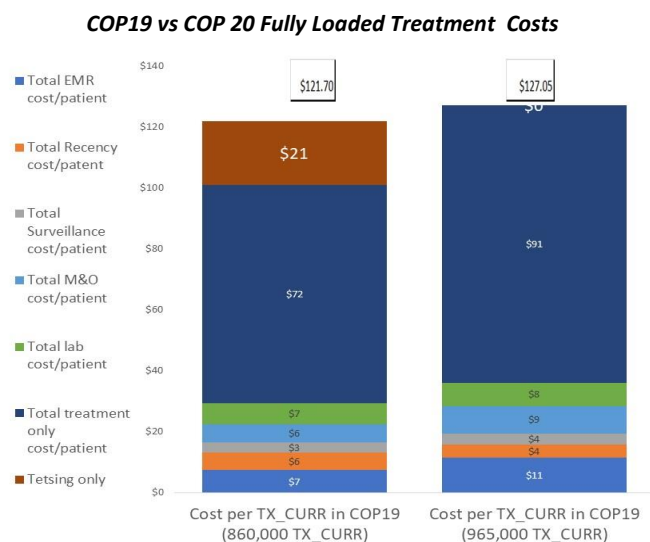
A key focus on policy-level HRH engagement with MOH will also ensure that the remaining 50% of supported HCWs are fully absorbed in the MOH establishment as per the signed MOU, while PEPFAR maintains surge salary support for 552 HCWs. Other areas of joint planning will be prioritized through regular engagement with Global Fund’s Project Implementation Unit to track progress made in the proposed increase of primary health facility and community level health workforce in the Funding Request who will deliver HIV, TB services alongside other diseases in a multi-disciplinary manner, In COP20, engagement with district-level leadership to improve HRH planning and management capacities will be essential. PEPFAR Malawi has seen a positive relationship between lay HCWs and an increase in NET\_NEW. Sustainability of PEPFAR site-level HRH investments is dependent on the capacity of decentralized governance structures and the health sector’s ability to plan for and retain facility-based HRH in an evidence-based and equitable manner.

## 5.2 Weak Information Systems to Efficiently Collect Accurate, Real-Time Epidemiological and Health Data

### Health Information Systems

To improve program monitoring and allow for rapid strategic shifts at the district and site-level, successful program implementation requires near real-time individual-level data. PEPFAR Malawi has established different types of electronic information systems to facilitate availability of real time quality data. At \$7 per patient or 9% of the total cost per TX\_CURR in COP19, this buys appointment reminders, lists of clients missing appointments, patient level risk stratification, and clinical care algorithms. At national and district levels, this also allows for the integration of data in multiple ways without increasing the reporting burden for clinic staff.

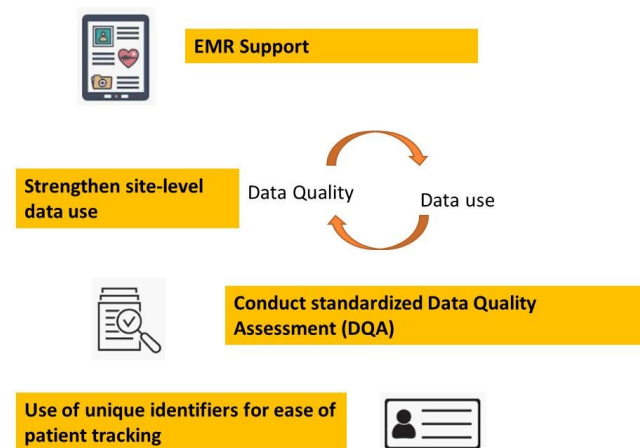
Previously, PEPFAR Malawi used aggregated data from MOH or published studies to inform management decisions – a practice PEPFAR has shifted away from. To ensure availability of near real-time individual-level data, PEPFAR will continue strengthening sustainable electronic solutions that include differentiated models based on the needs of the site and a centralized data repository (CDR), as well as systems for laboratory information management and mortality surveillance.



Electronic solutions in Malawi continue to evolve in response to the needs of the PEPFAR program and technological advances. At the facility level, PEPFAR is supporting a POC EMR system in 206 high and medium volume sites and an electronic HIV treatment system (eMasterCard) for retrospective data capture in 506 medium and low volume sites. The POC EMR has modules for ART, HIV testing services, antenatal care, and outpatient services, as well as features that allow integration of laboratory information systems and drug tracking distribution. Smaller direct service delivery and technical assistance sites supported by PEPFAR enter data retrospectively using the eMasterCard application, which captures the HIV testing and treatment cascade for patients ever registered at each site. Together the systems cover 712 sites. An additional 19 sites have private EMR systems that report disaggregated site level data which are available for MoH and PEPFAR reporting.

A key component to ensuring real-time access to individual level data for client centered program management is the CDR. By consolidating patient-level databases across the country, greater insight into program effectiveness can be achieved. For example, de-duplication can identify patients classified as defaulters but who have silently transferred to another facility. Currently, the CDR consists of separate secure environments - staging and analytical databases and a case-based surveillance database (CBS) to trace the cascade at the patient level. The process to move data to the CBS removes personally identifiable information and inserts a unique CBS de-identifiable identifier for each patient to protect their confidentiality. Preformatted reports provide authorized access to the de-identifiable data. In addition, the CDR will feed its data into existing site-level and other aggregated systems, such as the Malawi DHIS2 installation.

In COP19, PEPFAR continues to provide system level support by improving connectivity,



***Using the EMR data at the site, ensuring quality data for better patient retention.***

replacing end-of-life hardware, and providing short-term power backup systems at the sites. PEPFAR will also maintain the software and expand reporting capabilities at site and central levels to facilitate program monitoring and resource allocations. In COP20, PEPFAR will maintain its longstanding support for the Ministry of Health and other government entities to build and sustain these electronic solutions to maintain quality ART services and availability of individual-level data, while staying apprised of current and future Global Fund support to address the existing EMR system in 210 high burden facilities and other HMIS investments. To introduce greater

flexibility for provider, point of care data collection and a smaller hardware footprint, PEPFAR will pilot tablet apps and other technological advances. With respect to the CDR, after exploring

options for optimization in COP19, PEPFAR will implement recommended optimizations in COP20.

In addition to facility based electronic systems (i.e., POC EMR and eMasterCard) installation, PEPFAR continues to address delays in reporting test results by improving and expanding electronic integration of the POC EMR and the National Laboratory Information Management System (NLIMS) with other laboratory related systems, including the Viral Load/EID LIMS, private LIMS, and electronic tracking systems used by Riders 4 Health (R4H). This facilitates same or next day return of lab results to the facility and specimen tracking. With improved connectivity, this integrated information technology and communications approach will be widely implemented in COP20.

PEPFAR will continue to utilize a DHIS2 based system to track the clinical cascade, prevention, and referral services provided to KP clients through a generated UIC. The system will track periodic repeat testing, linkage to treatment, referral to other supportive services and facilitate real time monitoring of services accessed by this population.

With support from PEPFAR, the GoM through the National Registration Bureau (NRB) and MoH has established and rolled out a national birth and death registration system. Birth registration is in 583 health facilities in all 28 districts, of which 35 facilities have electronic birth registration systems (eBRS). NRB also installed eBRS in all district offices, which pushes data to the central database. The birth registration process is also integrated with the National ID system to ensure that each newborn is assigned an ID that will be printed on their National ID card when issued at the age 16. This integration is a foundation for identity management within the health sector. In COP19, PEPFAR worked with MoH to approve the use of National IDs for unique patient identification in health facilities, and in COP20, will continue working with MoH to operationalize this policy. This will include ensuring the use of National IDs as unique identifiers to track patient movements and outcomes, including mortality, to better quantify default, loss to follow up, and the current cohort on ART. In addition, to improve efficiencies, eBRS will be integrated into POC EMR sites having maternity wards.

Universal and compulsory facility-based death registration, including Medical Certification of Cause of Death (MCCoD), is implemented in 12 districts and uses the electronic death registration system (eDRS). Community death registration is implemented in seven districts. Implementation of eDRS mirrors the birth registration process and ensures availability of individual level mortality surveillance data. eDRS is being used in four district and central hospitals and the remaining districts register deaths on demand without MCCoD. By the end of COP19, compulsory death registration is expected in additional eight districts, and in COP20, death registration quality will continue to improve the quality of death registration with emphasis on cause of death classification and linkage to information from other PEPFAR supported individual level electronic systems. Infrastructure at eMasterCard sites will be leveraged to expand electronic capture of death (and birth) registrations. Data from the death registration

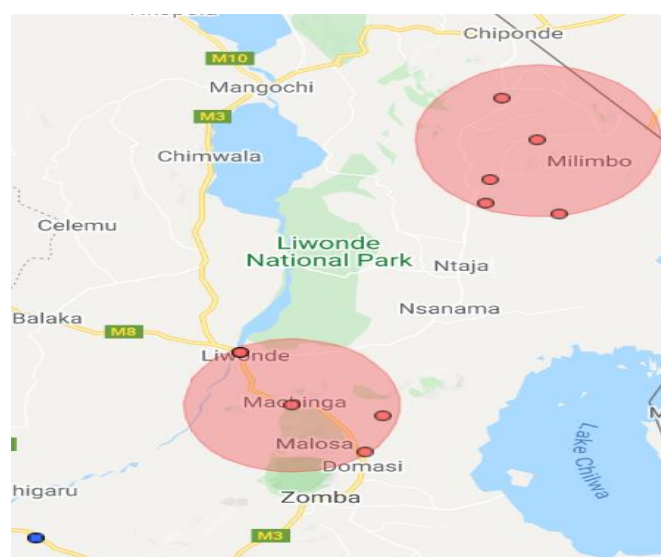


system and linked to the HIV case-based surveillance system, forms the basis of mortality surveillance in the country.

## Surveillance and Surveys

In addition to the health information system activities described above that support routine surveillance, PEPFAR Malawi will continue to support the MoH in conducting targeted sentinel- and survey-based surveillance to monitor HIV epidemiology and ART outcomes, including adverse birth outcomes. In COP20, PEPFAR Malawi will support mortality, recency, birth defects, and drug resistance surveillance. PEPFAR will also continue to support CDC's Field Epidemiology Training Program (FETP) to support quality data review, resolution, and emergency preparedness to respond to emerging diseases that affect PLHIV.

**Recency:** In COP17, PEPFAR supported early implementation of a recency study to estimate HIV incidence and detect recent infections among pregnant AGYW at ANC clinics in Blantyre, Lilongwe, Zomba, and Machinga. In COP18, the scope was broadened to establish a surveillance system among newly diagnosed populations beyond AGYW to monitor recent HIV infection by age, sex, and geography; and multiple HIV testing service delivery points. The near real-time data from this surveillance system helps PEPFAR and the National Program respond to clusters of infections with targeted HIV prevention and treatment efforts. In COP19, the recency surveillance system is expanding to cover 80% of newly diagnosed PLHIV nationally with select participating health facilities in 27 districts. In COP20, recency surveillance will be implemented more broadly in these 27 districts and will target all facilities that contribute to 80% of newly identified positives in the country for testing, while also responding to potential outbreaks to identify recent infections. Areas with high numbers of recent infections are being identified by applying data analyses and hotspot mapping and then prioritized for hotspot investigation through collaborations with MOH and IPs. Findings of the investigations will guide enhanced prevention, treatment, and retention activities.



Example of HIV Recent Infection Surveillance SatScan map identifying two 20 km clusters having higher than expected number of recent infections in Machinga, Mangochi, Zomba areas – Feb 28, 2020

**Drug Resistance:** In January 2019, Malawi transitioned its first line treatment combination from tenofovir/lamivudine/Efavirenz (TLE) to TLD, due to exceptional performance of dolutegravir based regimens in clinical trials. Malawi has the highest patient volumes of PLHIV taking DBR in Africa, however, within the first six months of DBR introduction in MSF-supported districts,

Malawi reported two cases of DTG resistance in patients with baseline NNRTI resistance. It is unclear whether PLHIV having baseline NNRTI are prone to integrase resistance, and with limited data available on DBR resistance, Malawi presents a unique opportunity to address this and related urgent programmatic and epidemiological questions. In COP20, PEPFAR Malawi will implement drug resistance surveillance in selected sentinel sites.

**Birth defects:** In COP17, Malawi began implementing birth defects surveillance to estimate prevalence of birth defects in sentinel sites, targeting four hospitals in Lilongwe, Blantyre, Mangochi, and Ntcheu. The study is also designed to examine the association of maternal use of ART and birth defects outcomes. In COP18, the protocol was modified to include establishment of a pregnancy registry and monitoring birth outcomes as required in transition plans for DTG. In COP19, birth defects surveillance continues to monitor birth outcomes as DTG continues to be scaled up and use the data to inform treatment policy and guidelines. DTG monitoring will continue in COP20, as well as data analysis and dissemination of results.

**Case Based Surveillance:** In COP18, the International Training and Education Center for Health (I-TECH), in partnership with the MoH, piloted a CBS system in selected sites. In leveraging routinely collected data from existing systems (like POC EMR), as well as, HIV recency and mortality surveillance, CBS is generating data for an individual-level, de-identified longitudinal cohort. Such a cohort allows for the tracking of sentinel events such as HIV diagnoses and ART initiations, as well as other individual-level health outcomes, and provides robust surveillance data on a real-time basis. In COP20, the CBS system will expand in conjunction with CDR expansion and refined to improve data use and sustainability.

**Capacitation:** Although increasing, Malawi has limited personnel with epidemiological skills to effectively monitor HIV programs. CDC introduced FETP in 2016, as a three-month frontline in-service training to strengthen collection and analysis of epidemiological and surveillance data. This facilitates timely responses to HIV program needs, diseases, and events of public health importance. By the end of COP19, PEPFAR/CDC expects a total of 164 surveillance officers trained in FETP. In COP20, PEPFAR/CDC plans to train 48 more people in FETP.

### **5.3 Inadequate Human Resources for Health for HIV (and Broader) Health Service Delivery**

HRH remains the single greatest health systems challenge to implement targeted HIV services and reach epidemic control. The HRH strategic plan of 2018-2022 estimates a 58% vacancy rate across all cadres and Malawi remains far from meeting the WHO standard by 2040.<sup>7</sup> To address existing HRH gaps, PEPFAR will continue to support HCWs recruited in COP19, noting that as some cadres are professionalized and work full time, less of certain cadres may be required in COP20 (i.e., OVC case care workers). Current high-level PEPFAR data show a good HRH alignment between TX\_CURR and site volume in PEPFAR target sites, but granular data analysis

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<sup>7</sup> HRH Strategic Plan 2018-2022

revealed that there are inconsistencies with insufficient numbers of health diagnostic assistants (HDAs) and Expert Clients at larger sites and some smaller sites with larger numbers. The pervasive loss of clients at greatly understaffed high volume facilities highlights the need for a site-specific approach to right-sizing and performance monitoring of HRH. To rectify the underlying HRH issues at site level, PEPFAR investments in COP20 will optimize staffing allocation (right-size Expert Client to patient staffing ratios), repurpose existing HDAs from testing to retention efforts, deploy data clerks to assist health care workers to use data for patient management, and increase placement of professional cadres while professionalizing lay cadres to fill critical gaps at site level. Resources will also improve HRH management systems using checklists and standardized measures, professionalize and employ a phased transition approach to MoH cadre integration for sustainability. This approach should result in better retention for those on ART, bring people back to care, improve viral suppression and expand delivery and access to DSD services.

To further increase HRH investments at site level, PEPFAR Malawi will redirect program management costs to increase site level investments in HRH. This approach will commence during the remaining quarters of COP19 with an accelerated shift in COP20. Besides rationalization of existing HRH, PEPFAR will add more psycho-social counselors (or comparable cadres), Expert Clients, and Community Health Workers (CHWs) to support client retention in care in the high-volume sites. The program will further strengthen HRH planning, management, and coordination capacities at district-level through above site mechanisms (government-to-government and CHAM) in scale up districts to ensure close monitoring of all supported HRH at site level. Building on the COP19 successes of U.S.-based programs of the HBCUs that train youth to enter the health field as community health workers, COP20 will work with HBCUs through HRSA to target AGYW graduates of DREAMS with a pathway to employment.

As part of pre-service training, the program will continue to support 45 specialists and 30 specialists already enrolled at the College of Medicine to strengthen advanced HIV care. The program will also support a degree program for social work to increase the skill level of existing district level social protection workers. Peace Corps will recruit five Health Professionals to support in pre-service training through mainstreaming HIV and AIDS in the Nursing and Clinical Medicine curriculum. Support capacity building of fellow lecturers and staff in the partner institutions in student centered teaching approaches, curriculum design, improvement of skills laboratory training, research methodology, and improved clinic protocols and procedures in order to strengthen education and training of health workers.

Long term planning and sustainability are essential to epidemic control preparedness. To sustain the gains made through HRH investments, PEPFAR Malawi will establish a direct government-to-government agreement with MoH to oversee 283 sites accounting for 10% of TX\_CURR across all 28 districts. The approach will facilitate coordination of data-driven learning between CSO representatives, GoM, PEPFAR, and implementing partners. District -level agreements and the establishment of a direct government-to-government agreement with the Ministry of Finance will further capacitate districts with HRH and system support. Furthermore, future directions for

granular site management of HRH will be accomplished through an online dashboard visualization with weekly updates accessible from mobile phones at health facilities or district health offices.

#### **5.4 Host Country Institutional Capacity**

To continue improving the enabling policy environment for HIV service delivery, PEPFAR will support MoH to strengthen regulatory control of herbal medicines, which can have a negative impact on adherence. Other technical assistance to MoH will help facilitate rapid adoption of new WHO recommendations and the development of accompanying tools to monitor implementation to ensure improved case finding and linkage to care. Finally, to ensure lab optimization, PEPFAR will build the capacity of laboratory EQA programs, develop strong mentorship strategies, and strengthen the national system for collecting and monitoring VL reagents and lab commodity stock status.

PEPFAR Malawi continues to work closely with the Global Fund to leverage collective impact and investments. With continued focus on procurement of commodities (24 months currently), the proposed funding allocation of \$353,704,332 for the next grant cycle in tandem offers an opportunity to capitalize on joint planning and alignment with COP20 and accelerate the pace at which we address the key barriers to epidemic control in Malawi, including action and contingency planning in relation to the Malawi Coronavirus response. Specifically, the resilient and sustainable systems for health systems priorities of HRH recruitment, retention, performance and planning, procurement and supply chain management, community response and monitoring, and smart integrated service delivery approaches, illustrate areas where the USG can monitor progress, compliment activities, and avoid duplication. HRH investments currently being considered for the upcoming Global Fund request includes remuneration, deployment, skills development and production of HDAs, HSAs, nursing/midwife assistants, and other priority community health worker cadres.

#### **5.5 Commodity Management and Storage Capacity**

With national implementation of Test and Start, transition to DTG, and the rollout of multi-month prescription options to improve service delivery, some facilities have reported commodity management challenges at the site-level, particularly stock-outs of condoms and rapid test kits generally resulting from weak inventory commodity management skills.<sup>8,9</sup> The stock-out of these commodities directly effects the achievement of the PEPFAR goals and targets. With Global Fund resources and significant technical assistance from PEPFAR, Malawi is operating a well-functioning parallel supply chain for HIV/AIDS commodities, ensuring HIV commodity availability at service delivery points. In COP20, PEPFAR Malawi will work with district and health facility staff to strengthen monthly reporting of inventory data into OpenLMIS and improve accuracy of inventory records through mentorship and supportive supervision. This will

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<sup>8</sup> Supply Chain Data Quality Assessment in Malawi, GHSC-PSM, January 2018

<sup>9</sup> Monthly Logistics Management Information System (LMIS) Report, MOH-HTSS, 2017

increase visibility into inventory levels, consumption, and facilitate a triangulation between clinical and stock data at site-levels (facility) at more regular intervals.

Building on successes from COP19, PEPFAR will continue to support critical supply chain activities including national quantification, forecasting, monitoring, and supply planning for HIV and related commodities. PEPFAR will provide supply chain technical assistance to health facility staff and MOH to manage the programmatic shifts and related commodity requirements. PEPFAR will support implementation for pediatric ART optimization as recommended by WHO. In COP20, by ensuring timely procurements, distribution, and monitoring, PEPFAR will provide targeted support for the management of other key commodities such as VMMC commodities, lubricants, and condoms for KP. To ensure availability of logistics data and visibility of national supply chain, PEPFAR will continue to provide technical support for maintenance and roll-out of Open LMIS, the national platform for collection and reporting of supply chain data for decision-making. Support will include troubleshooting, provision of internet bundles to health facilities, equipment, on-the-job training, systems updates, and the establishment of additional data hubs for direct data entry. This system enables national, district, and site level staff to closely monitor stocks and respond proactively to low stocks through movement of commodities between facilities and emergency deliveries as needed. In COP20, PEPFAR intends to ensure that stock outs of key commodities, including laboratory commodities, do not exceed five percent through investment in continued targeted site level monitoring and supervision to address key bottlenecks in the supply chain.

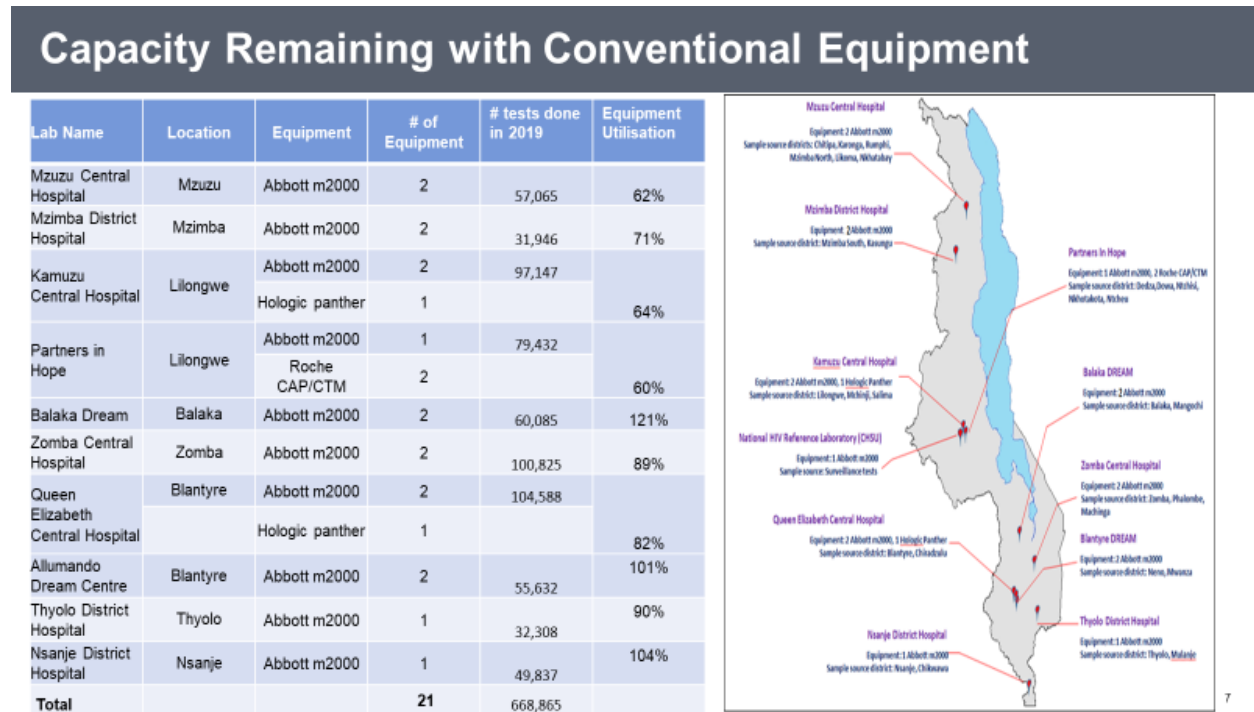
## **5.6 Poor Optimization of Lab Mechanisms**

Laboratory systems in Malawi were stretched in FY19 when the annual viral load policy went into effect but were able to cope with the increased volume due to sufficient conventional platforms and an increase in HRH provided by PEPFAR. Viral load coverage has reached 100% and viral load suppression is 88%.

Malawi has a strong conventional laboratory backbone in ten molecular labs with 22 devices (18 Abbott, 2 Roche, and 2 new Hologic devices procured in COP18). There are 25 Pima POC machines for EID and 48 POC GeneXpert platforms running TB/EID and targeted viral load. The Zomba Central Hospital lab renovation was completed in FY20 Q1.

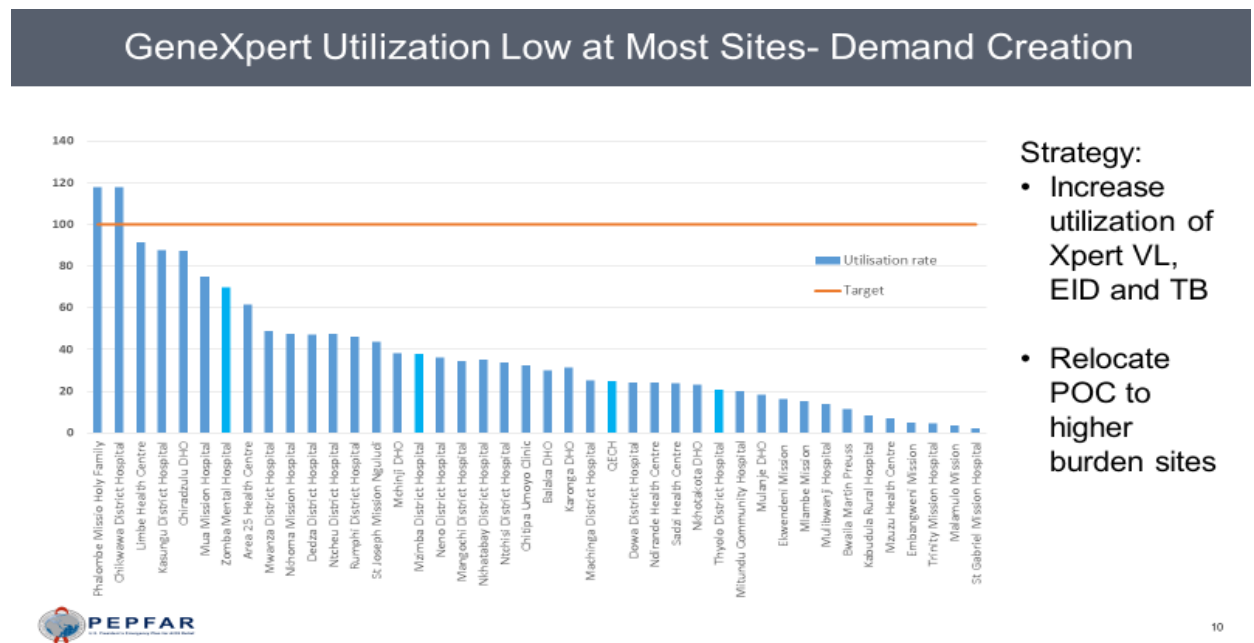
For the conventional labs, per the graphic below, most labs are able to increase their utilization. Two Hologic machines were added in FY19 though utilization have been insufficient due to difficulties in expanding the use of plasma for viral load. The lack of phlebotomists and insufficient nurses are a limitation to expanding plasma, but this will be overcome with additional HRH investments from PEPFAR. The PEPFAR lab partner will continue to work with the MoH on troubleshooting to optimize laboratory services.

Figure 5.6.1 Capacity Remaining with Conventional Equipment



The utilization of POC GeneXpert for VL/EID is at 36% overall utilization with only a few health facilities reaching maximum capacity. A service agreement was put in place between MOH and Cepheid, but down time was an issue. Additional machines are not needed until existing machines are optimally utilized.

Figure 5.6.2 GeneXpert Utilization Low at Most Sites – Demand Creation



For the last four years, PEPFAR has supported the national sample transportation system reaching over 700 sites. While the system is effective, there are areas for improvement as described in Section 4.9. The new lab partner is developing a sample transportation web application and mobile application called STaRT (Sample Tracking and Results Return Reporting System) for monitoring, tracking, decision making, and reporting of sample transportation and turnaround time.

The Lab Information Management System (LIMS) is implemented in ten molecular laboratories for viral load and EID testing. LIMS is linked to the national EID and viral load dashboard, which needs consistent internet connection for real-time data transfer and timely national-level decision-making. PEPFAR will continue to support two MOH staffs' salaries to centrally coordinate LIMS implementation, data flow, and 28 hubs and staff to sustain the linkages. PEPFAR will support the expansion of national LIMS to an additional 10 clinical laboratories and linking LIMS to EMRs to minimize TAT and facilitate a results based tracking system. PEPFAR will train laboratory staff on proper utilization and management of LIMS, which will ensure high quality and real-time data sharing. The new SMS results alert system will be integrated in the LIMS and EMR systems.

Malawi does not yet have an internationally accredited lab in the public health system. In FY19 and in early FY20, three labs achieved four stars and three labs achieved three stars from the ASLM (African Society of Lab Management). With that, the first six labs qualified for ISO accreditation in COP19 with a goal of achieving accreditation in COP19, expanding to more labs in COP20.

Human resources for health are an important contribution by PEPFAR to the laboratory systems to optimize and strengthen lab systems. In COP19, there were 12 data clerks, 19 lab technicians and 20 lab technologists hired and seconded by PEPFAR to support the labs. An additional 15 lab technicians and 15 lab technologists will be supported in COP20.

## 6.0 USG Operations and Staffing Plan to Achieve Stated Goals

For USAID, PEPFAR Malawi flatlined its COP20 Management and Operations budget from COP19. Any shifts needed to align with COP20 program priorities including government-to-government agreements, and an increase in staffing for management of local partner organizations, will need to come from finding efficiencies within the current agency staffing patterns. Increased time will need to be spent out in the field monitoring implementation of activities as the number of awards and agreements with local entities increases.

CDC has aligned its staffing footprint towards supporting critical PEPFAR COP20 priorities. A staff compliment of fifty (50) has been determined to be adequate to provide leadership, technical assistance, and program management support in the key HIV/AIDs technical areas and to conduct the robust monitoring and data analysis required to responsively adapt the program to

epidemic response priorities. CDC is proposing two additional positions over COP19 approved positions which will be funded within the existing budget envelope and pipeline.

*Long-term Vacant Positions:*

For USAID, long-term vacancies including the M&E supervisory specialist and HRH specialist awaiting security clearances. Other vacancies include the community support specialist, the SI fellow, and the additional staff included in USAID's COP19 request to support with local partner transition are under final approvals for recruitment. Unfilled positions will be filled by COP20 implementation.

For CDC, there are five (5) vacant positions that were previously approved: Cooperative Agreement Specialist, Biomedical HIV Prevention Specialist, Financial Specialist, Laboratory Team Lead, and the Grants Financial Specialist. The Cooperative Agreement Specialist and the Biomedical HIV Prevention Specialist will be filled in the third quarter of FY20. The applications for these positions are being shortlisted for interviews. The recruitment of the Financial Specialist (long-term vacancy) and the Grants Financial Specialist is delayed because the position descriptions are not yet classified as HROE is currently backlogged up to one year. The position of the Laboratory Team Lead has been repurposed to Laboratory Specialist to meet the need for more staff providing technical assistance and leadership for laboratory services. There was no attrition in FY19 among technical staff, presumably due to an exception rate range (ERR) that the Mission received in FY18 on selected technical series. The implementation of exceptional rare range has also facilitated recruitment of four technical staff due to improved competitiveness in recruiting highly qualified technical locally engaged staff. There are four encumbered HCN positions whose position descriptions were revised and need to be appropriately classified. Classification freeze on encumbered positions and delays in classifying new positions by the Department of State is the major challenge CDC faces to maintain staff and fill vacant positions.

*New Positions:*

For USAID, there are no proposed new positions in COP20.

For CDC, the two proposed new positions are: Adolescent Girls and Young Women (AGYW) Specialist (Contractor), and Executive Assistant (HCN). The new positions will be located in the existing USAID/CDC building and there is enough space and sufficient support for the positions.

The Adolescent Girls and Young Women (AGYW) Specialist (Contractor) will be responsible for designing, implementing, coordinating, and evaluating HIV care and treatment and prevention program activities directed at AGYW. The position will also be key in learning more about comprehensive HIV prevention interventions to enhance the efforts of PEPFAR Malawi. The position will also collaborate with MOH, development agencies, USG implementing partners, and those funded by the Global Fund and other non-governmental organizations (NGOs) implementing HIV care and treatment and prevention program activities and studies directed at AGYW.



The Executive Assistant will be the administrative manager in the office of the Country Director. The jobholder will be responsible for office management, administration, and provision of complex and wide ranging administrative and program coordination support to the Director. The position portfolio will include communications, procurement, logistics, travel, and transportation that support of the Director. The jobholder will support the Director by coordinating administrative arrangements for VIP visitors, including U.S. Congressional and Executive Branch visitors, Department of Human Health Services and the United States Centers for Disease Control and Prevention officials.

*Cost of Doing Business (CODB):*

For USAID, while COP20 overall management and operations budgets remained the same as COP19, implementing agencies in COP20 are shifting to greater implementation through local entities, including increased government-to-government modalities. USAID's CODB will ensure adequate staffing to design, award, and effectively manage new implementing mechanisms. The budget includes resources to provide targeted technical assistance to support local organizations to meet rigorous PEPFAR results and expenditure reporting requirements, as well as USAID award compliance guidelines. USAID will continue to support staffing costs for three offshore hire positions in the PEPFAR Coordination Office in COP20.

CDC has flat lined the budget for management and operations. A total of 83% of the CODB is comprised of priority costs including salaries, benefits, capital security cost sharing, ICASS, and computers and IT services. Proposed positions will be funded through the current budget envelope.

# APPENDIX A -- PRIORITIZATION

Table A.1

| SNU        | COP    | Prioritization      | Results Reported | Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall |       |      |       |      |       |     |       |     |       |     |       |      |       |      |      |      |      | Overall TX Coverage |
|------------|--------|---------------------|------------------|---|-------|------|-------|------|-------|-----|-------|-----|-------|-----|-------|------|-------|------|------|------|------|---------------------|
|            |        |                     |                  | Treatment Coverage at APR by Age and Sex  |       |      |       |      |       |     |       |     |       |     |       |      |       |      |      |      |      |                     |
|            |        |                     |                  | 0-9   | 10-14 |      | 15-19 |      | 20-24 |     | 25-29 |     | 30-34 |     | 35-39 |      | 40-49 |      | 50+  |      |      |                     |
|            | F      | M                   | F                | M   | F     | M    | F     | M    | F     | M   | F     | M   | F     | M   | F     | M    | F     | M    |      |      |      |                     |
| Balaka     | COP 15 |                     | APR 16           | 38%   | 68%   | 71%  | 29%   | 45%  | 34%   | 20% | 43%   | 17% | 67%   | 36% | 68%   | 51%  | 73%   | 71%  | 74%  | 79%  | 57%  |                     |
|            | COP 16 | Sustained           | APR 17           | 50%   | 64%   | 74%  | 43%   | 43%  | 53%   | 20% | 59%   | 18% | 79%   | 37% | 81%   | 51%  | 71%   | 61%  | 66%  | 66%  | 60%  |                     |
|            | COP 17 | Sustained           | APR 18           | 52%   | 72%   | 84%  | 45%   | 53%  | 58%   | 28% | 62%   | 23% | 82%   | 36% | 86%   | 54%  | 75%   | 64%  | 70%  | 72%  | 64%  |                     |
|            | COP 18 | Sustained           | APR 19           | 61%   | 88%   | 85%  | 59%   | 112% | 62%   | 50% | 59%   | 29% | 84%   | 49% | 94%   | 70%  | 79%   | 86%  | 63%  | 94%  | 73%  |                     |
|            | COP 19 | Sustained           | APR 20           | 88%   | 88%   | 88%  | 87%   | 87%  | 87%   | 87% | 87%   | 87% | 87%   | 87% | 87%   | 87%  | 87%   | 87%  | 87%  | 87%  | 87%  |                     |
|            | COP 20 | Sustained           | APR 21           | 89%   | 92%   | 92%  | 76%   | 86%  | 80%   | 66% | 87%   | 62% | 91%   | 67% | 94%   | 76%  | 97%   | 86%  | 98%  | 93%  | 89%  |                     |
| Blantyre   | COP 15 |                     | APR 16           | 40%   | 74%   | 73%  | 37%   | 46%  | 45%   | 21% | 50%   | 21% | 80%   | 41% | 75%   | 57%  | 61%   | 66%  | 50%  | 68%  | 57%  |                     |
|            | COP 16 | Scale-Up Saturation | APR 17           | 42%   | 78%   | 80%  | 45%   | 53%  | 50%   | 25% | 54%   | 22% | 81%   | 41% | 84%   | 59%  | 67%   | 71%  | 54%  | 71%  | 61%  |                     |
|            | COP 17 | Scale-Up Saturation | APR 18           | 43%   | 77%   | 78%  | 54%   | 63%  | 58%   | 32% | 59%   | 28% | 82%   | 46% | 91%   | 67%  | 70%   | 75%  | 55%  | 76%  | 66%  |                     |
|            | COP 18 | Scale-Up Saturation | APR 19           | 72%   | 118%  | 116% | 65%   | 137% | 69%   | 62% | 77%   | 38% | 108%  | 65% | 116%  | 96%  | 84%   | 106% | 62%  | 97%  | 87%  |                     |
|            | COP 19 | Scale-Up Saturation | APR 20           | 88%   | 88%   | 88%  | 91%   | 87%  | 91%   | 87% | 91%   | 87% | 91%   | 87% | 91%   | 87%  | 91%   | 87%  | 91%  | 87%  | 89%  |                     |
|            | COP 20 | Scale-Up Saturation | APR 21           | 85%   | 90%   | 90%  | 68%   | 75%  | 74%   | 58% | 82%   | 55% | 87%   | 62% | 91%   | 71%  | 94%   | 83%  | 95%  | 90%  | 83%  |                     |
| Chikwawa   | COP 15 |                     | APR 16           | 61%   | 75%   | 71%  | 48%   | 44%  | 69%   | 26% | 74%   | 31% | 94%   | 45% | 77%   | 57%  | 60%   | 62%  | 52%  | 69%  | 63%  |                     |
|            | COP 16 | Scale-Up Saturation | APR 17           | 70%   | 85%   | 82%  | 56%   | 51%  | 74%   | 36% | 79%   | 34% | 100%  | 53% | 88%   | 68%  | 67%   | 76%  | 54%  | 77%  | 71%  |                     |
|            | COP 17 | Scale-Up Saturation | APR 18           | 73%   | 93%   | 91%  | 66%   | 67%  | 83%   | 46% | 82%   | 39% | 101%  | 55% | 102%  | 75%  | 78%   | 84%  | 61%  | 84%  | 78%  |                     |
|            | COP 18 | Scale-Up Saturation | APR 19           | 90%   | 92%   | 89%  | 57%   | 106% | 70%   | 75% | 101%  | 47% | 125%  | 71% | 117%  | 96%  | 83%   | 100% | 61%  | 91%  | 89%  |                     |
|            | COP 19 | Scale-Up Saturation | APR 20           | 100%  | 100%  | 100% | 96%   | 98%  | 96%   | 98% | 96%   | 98% | 96%   | 98% | 96%   | 98%  | 96%   | 98%  | 96%  | 98%  | 97%  |                     |
|            | COP 20 | Scale-Up Saturation | APR 21           | 96%   | 98%   | 98%  | 77%   | 87%  | 81%   | 67% | 87%   | 63% | 91%   | 68% | 94%   | 76%  | 97%   | 87%  | 98%  | 93%  | 89%  |                     |
| Chiradzulu | COP 15 |                     | APR 16           | 69%   | 133%  | 128% | 55%   | 83%  | 47%   | 26% | 73%   | 25% | 131%  | 53% | 156%  | 85%  | 151%  | 119% | 156% | 157% | 109% |                     |
|            | COP 16 | Sustained           | APR 17           | 63%   | 142%  | 137% | 59%   | 87%  | 49%   | 30% | 67%   | 24% | 118%  | 49% | 150%  | 80%  | 148%  | 115% | 146% | 149% | 105% |                     |
|            | COP 17 | Sustained           | APR 18           | 57%   | 151%  | 143% | 74%   | 110% | 62%   | 35% | 68%   | 26% | 118%  | 48% | 162%  | 82%  | 156%  | 121% | 158% | 159% | 113% |                     |
|            | COP 18 | Sustained           | APR 19           | 101%  | 145%  | 140% | 94%   | 179% | 99%   | 80% | 94%   | 46% | 134%  | 78% | 150%  | 111% | 125%  | 137% | 101% | 150% | 117% |                     |
|            | COP 19 | Scale-Up Saturation | APR 20           | 100%  | 100%  | 100% | 80%   | 87%  | 80%   | 87% | 80%   | 87% | 80%   | 87% | 80%   | 87%  | 80%   | 87%  | 80%  | 87%  | 83%  |                     |
|            | COP 20 | Scale-Up Saturation | APR 21           | 77%   | 83%   | 83%  | 73%   | 82%  | 78%   | 63% | 85%   | 60% | 90%   | 65% | 93%   | 74%  | 96%   | 85%  | 97%  | 92%  | 87%  |                     |
| Chitipa    | COP 15 |                     | APR 16           | 80%   | 112%  | 121% | 64%   | 106% | 75%   | 37% | 103%  | 36% | 136%  | 78% | 123%  | 82%  | 139%  | 113% | 119% | 169% | 108% |                     |
|            | COP 16 | Sustained           | APR 17           | 87%   | 120%  | 136% | 77%   | 94%  | 93%   | 54% | 106%  | 48% | 146%  | 82% | 135%  | 91%  | 138%  | 114% | 126% | 152% | 114% |                     |
|            | COP 17 | Sustained           | APR 18           | 96%   | 130%  | 169% | 89%   | 98%  | 123%  | 79% | 112%  | 58% | 154%  | 97% | 160%  | 117% | 148%  | 125% | 138% | 180% | 130% |                     |
|            | COP 18 | Sustained           | APR 19           | 94%   | 136%  | 131% | 87%   | 165% | 91%   | 74% | 87%   | 43% | 124%  | 72% | 139%  | 103% | 116%  | 127% | 93%  | 138% | 108% |                     |
|            | COP 19 | Sustained           | APR 20           | 89%   | 89%   | 89%  | 89%   | 88%  | 89%   | 88% | 89%   | 88% | 89%   | 88% | 89%   | 88%  | 89%   | 88%  | 89%  | 88%  | 89%  |                     |
|            | COP 20 | Sustained           | APR 21           | 72%   | 78%   | 79%  | 73%   | 81%  | 78%   | 62% | 85%   | 59% | 90%   | 65% | 93%   | 74%  | 96%   | 85%  | 97%  | 91%  | 86%  |                     |
| Dedza      | COP 15 |                     | APR 16           | 36%   | 57%   | 44%  | 32%   | 33%  | 54%   | 26% | 48%   | 22% | 64%   | 30% | 56%   | 37%  | 46%   | 46%  | 40%  | 47%  | 45%  |                     |
|            | COP 16 | Sustained           | APR 17           | 40%   | 61%   | 49%  | 42%   | 34%  | 58%   | 33% | 56%   | 30% | 71%   | 40% | 60%   | 43%  | 53%   | 52%  | 42%  | 53%  | 51%  |                     |
|            | COP 17 | Sustained           | APR 18           | 39%   | 66%   | 64%  | 46%   | 48%  | 57%   | 35% | 58%   | 33% | 69%   | 42% | 67%   | 43%  | 55%   | 53%  | 43%  | 57%  | 53%  |                     |
|            | COP 18 | Sustained           | APR 19           | 75%   | 108%  | 104% | 69%   | 131% | 72%   | 59% | 69%   | 34% | 98%   | 57% | 110%  | 81%  | 92%   | 100% | 74%  | 110% | 86%  |                     |
|            | COP 19 | Sustained           | APR 20           | 88%   | 88%   | 88%  | 84%   | 87%  | 84%   | 87% | 84%   | 87% | 84%   | 87% | 84%   | 87%  | 84%   | 87%  | 84%  | 87%  | 86%  |                     |
|            | COP 20 | Sustained           | APR 21           | 82%   | 86%   | 87%  | 69%   | 77%  | 75%   | 59% | 83%   | 57% | 88%   | 63% | 92%   | 72%  | 95%   | 84%  | 96%  | 90%  | 85%  |                     |

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| SNU      | COP    | Prioritization      | Results Reported | Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall |      |       |      |       |      |       |      |       |      |       |      |       |      |       |      |                     |      |     |
|----------|--------|---------------------|------------------|---|------|-------|------|-------|------|-------|------|-------|------|-------|------|-------|------|-------|------|---------------------|------|-----|
|          |        |                     |                  | Treatment Coverage at APR by Age and Sex  |      |       |      |       |      |       |      |       |      |       |      |       |      |       |      | Overall TX Coverage |      |     |
|          |        |                     |                  | 0-9   |      | 10-14 |      | 15-19 |      | 20-24 |      | 25-29 |      | 30-34 |      | 35-39 |      | 40-49 |      |                     |      | 50+ |
| F        | M      | F                   | M                | F   | M    | F     | M    | F     | M    | F     | M    | F     | M    | F     | M    | F     | M    |       |      |                     |      |     |
| Dowa     | COP 15 |                     | APR 16           | 35%   | 97%  | 92%   | 49%  | 53%   | 54%  | 27%   | 46%  | 19%   | 72%  | 29%   | 71%  | 45%   | 76%  | 89%   | 80%  | 121%                | 65%  |     |
|          | COP 16 | Sustained           | APR 17           | 47%   | 78%  | 78%   | 44%  | 65%   | 62%  | 33%   | 55%  | 31%   | 82%  | 42%   | 77%  | 51%   | 76%  | 81%   | 79%  | 114%                | 69%  |     |
|          | COP 17 | Sustained           | APR 18           | 50%   | 91%  | 58%   | 52%  | 88%   | 59%  | 25%   | 60%  | 36%   | 81%  | 44%   | 79%  | 61%   | 77%  | 83%   | 76%  | 110%                | 71%  |     |
|          | COP 18 | Sustained           | APR 19           | 62%   | 90%  | 87%   | 57%  | 110%  | 60%  | 49%   | 58%  | 28%   | 82%  | 48%   | 92%  | 68%   | 77%  | 84%   | 62%  | 92%                 | 72%  |     |
|          | COP 19 | Sustained           | APR 20           | 88%   | 88%  | 88%   | 73%  | 87%   | 73%  | 87%   | 73%  | 87%   | 73%  | 87%   | 73%  | 87%   | 73%  | 87%   | 73%  | 87%                 | 73%  | 79% |
|          | COP 20 | Sustained           | APR 21           | 103%  | 103% | 103%  | 73%  | 81%   | 78%  | 62%   | 85%  | 59%   | 90%  | 65%   | 93%  | 74%   | 96%  | 85%   | 97%  | 92%                 | 88%  |     |
| Karonga  | COP 15 |                     | APR 16           | 49%   | 81%  | 74%   | 39%  | 52%   | 33%  | 21%   | 42%  | 17%   | 71%  | 34%   | 78%  | 52%   | 81%  | 72%   | 71%  | 99%                 | 62%  |     |
|          | COP 16 | Sustained           | APR 17           | 48%   | 87%  | 89%   | 42%  | 46%   | 39%  | 19%   | 39%  | 17%   | 73%  | 31%   | 84%  | 50%   | 84%  | 77%   | 73%  | 98%                 | 64%  |     |
|          | COP 17 | Sustained           | APR 18           | 54%   | 94%  | 104%  | 47%  | 56%   | 47%  | 25%   | 43%  | 21%   | 76%  | 33%   | 89%  | 53%   | 90%  | 83%   | 81%  | 105%                | 70%  |     |
|          | COP 18 | Sustained           | APR 19           | 68%   | 99%  | 95%   | 66%  | 126%  | 69%  | 57%   | 66%  | 33%   | 94%  | 55%   | 106% | 78%   | 88%  | 96%   | 71%  | 105%                | 82%  |     |
|          | COP 19 | Sustained           | APR 20           | 88%   | 88%  | 88%   | 88%  | 87%   | 88%  | 87%   | 88%  | 87%   | 88%  | 87%   | 88%  | 87%   | 88%  | 87%   | 88%  | 87%                 | 88%  | 88% |
|          | COP 20 | Sustained           | APR 21           | 71%   | 77%  | 77%   | 72%  | 80%   | 77%  | 62%   | 85%  | 58%   | 89%  | 64%   | 93%  | 73%   | 96%  | 84%   | 97%  | 91%                 | 85%  |     |
| Kasungu  | COP 15 |                     | APR 16           | 42%   | 83%  | 76%   | 34%  | 45%   | 34%  | 13%   | 44%  | 18%   | 79%  | 35%   | 79%  | 52%   | 73%  | 72%   | 56%  | 84%                 | 59%  |     |
|          | COP 16 | Sustained           | APR 17           | 44%   | 89%  | 92%   | 41%  | 63%   | 38%  | 20%   | 47%  | 19%   | 77%  | 38%   | 85%  | 58%   | 82%  | 79%   | 59%  | 88%                 | 64%  |     |
|          | COP 17 | Sustained           | APR 18           | 44%   | 96%  | 97%   | 50%  | 70%   | 43%  | 28%   | 48%  | 19%   | 74%  | 39%   | 98%  | 59%   | 89%  | 86%   | 69%  | 100%                | 70%  |     |
|          | COP 18 | Sustained           | APR 19           | 60%   | 87%  | 84%   | 55%  | 106%  | 58%  | 48%   | 56%  | 28%   | 79%  | 46%   | 89%  | 66%   | 74%  | 81%   | 60%  | 89%                 | 69%  |     |
|          | COP 19 | Sustained           | APR 20           | 88%   | 88%  | 88%   | 85%  | 87%   | 85%  | 87%   | 85%  | 87%   | 85%  | 87%   | 85%  | 87%   | 85%  | 87%   | 85%  | 87%                 | 85%  | 86% |
|          | COP 20 | Sustained           | APR 21           | 98%   | 99%  | 99%   | 73%  | 81%   | 78%  | 62%   | 85%  | 59%   | 90%  | 65%   | 93%  | 74%   | 96%  | 85%   | 97%  | 92%                 | 87%  |     |
| Likoma   | COP 15 |                     | APR 16           |   |      |       |      |       |      |       |      |       |      |       |      |       |      |       |      |                     |      |     |
|          | COP 16 | Sustained           | APR 17           | 56%   | 124% | 100%  | 61%  | 87%   | 52%  | 26%   | 50%  | 24%   | 87%  | 44%   | 118% | 75%   | 130% | 121%  | 121% | 187%                | 95%  |     |
|          | COP 17 | Sustained           | APR 18           | 57%   | 125% | 100%  | 73%  | 100%  | 56%  | 29%   | 50%  | 30%   | 93%  | 43%   | 122% | 80%   | 127% | 122%  | 129% | 193%                | 100% |     |
|          | COP 18 | Sustained           | APR 19           | 201%  | 290% | 279%  | 124% | 237%  | 130% | 106%  | 124% | 61%   | 177% | 102%  | 199% | 147%  | 166% | 181%  | 134% | 198%                | 161% |     |
|          | COP 19 | Sustained           | APR 20           | 88%   | 88%  | 88%   | 91%  | 87%   | 91%  | 87%   | 91%  | 87%   | 91%  | 87%   | 91%  | 87%   | 91%  | 87%   | 91%  | 87%                 | 89%  |     |
|          | COP 20 | Sustained           | APR 21           | 78%   | 100% | 100%  | 75%  | 83%   | 78%  | 62%   | 86%  | 60%   | 91%  | 65%   | 93%  | 75%   | 96%  | 85%   | 97%  | 92%                 | 87%  |     |
| Lilongwe | COP 15 |                     | APR 16           | 44%   | 62%  | 48%   | 28%  | 33%   | 55%  | 17%   | 67%  | 21%   | 101% | 39%   | 82%  | 59%   | 66%  | 72%   | 52%  | 70%                 | 62%  |     |
|          | COP 16 | Scale-Up Saturation | APR 17           | 44%   | 68%  | 52%   | 33%  | 41%   | 60%  | 22%   | 67%  | 25%   | 96%  | 47%   | 90%  | 67%   | 72%  | 80%   | 55%  | 79%                 | 67%  |     |
|          | COP 17 | Scale-Up Saturation | APR 18           | 33%   | 53%  | 47%   | 39%  | 47%   | 59%  | 28%   | 66%  | 31%   | 92%  | 50%   | 95%  | 77%   | 77%  | 86%   | 56%  | 87%                 | 70%  |     |
|          | COP 18 | Scale-Up Saturation | APR 19           | 84%   | 117% | 110%  | 47%  | 112%  | 78%  | 76%   | 96%  | 40%   | 128% | 67%   | 129% | 101%  | 98%  | 105%  | 65%  | 95%                 | 94%  |     |
|          | COP 19 | Scale-Up Saturation | APR 20           | 88%   | 88%  | 88%   | 91%  | 87%   | 91%  | 87%   | 91%  | 87%   | 91%  | 87%   | 91%  | 87%   | 91%  | 87%   | 91%  | 87%                 | 89%  |     |
|          | COP 20 | Scale-Up Saturation | APR 21           | 77%   | 83%  | 83%   | 70%  | 78%   | 76%  | 60%   | 83%  | 57%   | 88%  | 63%   | 92%  | 72%   | 95%  | 84%   | 96%  | 91%                 | 84%  |     |
| Machinga | COP 15 |                     | APR 16           | 44%   | 58%  | 61%   | 24%  | 29%   | 36%  | 9%    | 49%  | 13%   | 77%  | 25%   | 70%  | 41%   | 57%  | 48%   | 48%  | 58%                 | 49%  |     |
|          | COP 16 | Scale-Up Aggressive | APR 17           | 48%   | 70%  | 77%   | 33%  | 40%   | 46%  | 19%   | 56%  | 15%   | 80%  | 26%   | 86%  | 46%   | 64%  | 58%   | 53%  | 64%                 | 56%  |     |
|          | COP 17 | Scale-Up Aggressive | APR 18           | 50%   | 79%  | 73%   | 39%  | 49%   | 50%  | 18%   | 56%  | 16%   | 80%  | 27%   | 95%  | 47%   | 71%  | 61%   | 58%  | 71%                 | 60%  |     |
|          | COP 18 | Scale-Up Saturation | APR 19           | 81%   | 98%  | 108%  | 61%  | 144%  | 77%  | 67%   | 82%  | 31%   | 110% | 51%   | 124% | 94%   | 82%  | 113%  | 64%  | 114%                | 89%  |     |
|          | COP 19 | Scale-Up Saturation | APR 20           | 89%   | 89%  | 89%   | 97%  | 101%  | 97%  | 101%  | 97%  | 101%  | 97%  | 101%  | 97%  | 101%  | 97%  | 101%  | 97%  | 101%                | 98%  |     |
|          | COP 20 | Scale-Up Saturation | APR 21           | 90%   | 93%  | 93%   | 73%  | 82%   | 78%  | 63%   | 85%  | 60%   | 90%  | 66%   | 93%  | 74%   | 96%  | 85%   | 97%  | 92%                 | 87%  |     |

| SNU      | COP    | Prioritization      | Results Reported | Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall |      |       |     |       |     |       |      |       |      |       |      |       |      |       |     |      |     | Overall TX Coverage |
|----------|--------|---------------------|------------------|---|------|-------|-----|-------|-----|-------|------|-------|------|-------|------|-------|------|-------|-----|------|-----|---------------------|
|          |        |                     |                  | Treatment Coverage at APR by Age and Sex  |      |       |     |       |     |       |      |       |      |       |      |       |      |       |     |      |     |                     |
|          |        |                     |                  | 0-9   |      | 10-14 |     | 15-19 |     | 20-24 |      | 25-29 |      | 30-34 |      | 35-39 |      | 40-49 |     | 50+  |     |                     |
|          | F      | M                   | F                | M   | F    | M     | F   | M     | F   | M     | F    | M     | F    | M     | F    | M     | F    | M     |     |      |     |                     |
| Mangochi | COP 15 |                     | APR 16           | 64%   | 108% | 75%   | 38% | 50%   | 60% | 17%   | 69%  | 17%   | 100% | 35%   | 96%  | 48%   | 81%  | 66%   | 72% | 86%  | 69% |                     |
|          | COP 16 | Scale-Up Aggressive | APR 17           | 77%   | 131% | 92%   | 53% | 57%   | 71% | 26%   | 80%  | 21%   | 108% | 41%   | 109% | 60%   | 91%  | 74%   | 78% | 91%  | 79% |                     |
|          | COP 17 | Scale-Up Aggressive | APR 18           | 90%   | 130% | 100%  | 70% | 72%   | 80% | 34%   | 87%  | 30%   | 119% | 49%   | 124% | 68%   | 101% | 83%   | 85% | 103% | 89% |                     |
|          | COP 18 | Scale-Up Saturation | APR 19           | 82%   | 122% | 82%   | 54% | 131%  | 68% | 57%   | 95%  | 31%   | 117% | 55%   | 122% | 82%   | 92%  | 93%   | 73% | 106% | 89% |                     |
|          | COP 19 | Scale-Up Saturation | APR 20           | 99%   | 99%  | 99%   | 98% | 102%  | 98% | 102%  | 98%  | 102%  | 98%  | 102%  | 98%  | 102%  | 98%  | 102%  | 98% | 102% | 99% |                     |
|          | COP 20 | Scale-Up Saturation | APR 21           | 94%   | 96%  | 96%   | 73% | 82%   | 78% | 63%   | 85%  | 60%   | 90%  | 65%   | 93%  | 74%   | 96%  | 85%   | 97% | 92%  | 87% |                     |
| Mchinji  | COP 15 |                     | APR 16           | 40%   | 60%  | 41%   | 23% | 27%   | 28% | 14%   | 33%  | 14%   | 51%  | 29%   | 51%  | 38%   | 53%  | 54%   | 48% | 67%  | 43% |                     |
|          | COP 16 | Sustained           | APR 17           | 41%   | 65%  | 47%   | 33% | 34%   | 33% | 17%   | 34%  | 16%   | 54%  | 33%   | 58%  | 45%   | 56%  | 60%   | 53% | 71%  | 48% |                     |
|          | COP 17 | Sustained           | APR 18           | 39%   | 66%  | 54%   | 32% | 42%   | 36% | 22%   | 36%  | 16%   | 52%  | 34%   | 60%  | 47%   | 57%  | 63%   | 53% | 76%  | 50% |                     |
|          | COP 18 | Sustained           | APR 19           | 83%   | 120% | 116%  | 76% | 146%  | 81% | 66%   | 77%  | 38%   | 109% | 63%   | 123% | 91%   | 102% | 112%  | 83% | 122% | 96% |                     |
|          | COP 19 | Sustained           | APR 20           | 88%   | 88%  | 88%   | 88% | 87%   | 88% | 87%   | 88%  | 87%   | 88%  | 87%   | 88%  | 87%   | 88%  | 87%   | 88% | 87%  | 88% |                     |
|          | COP 20 | Sustained           | APR 21           | 82%   | 87%  | 87%   | 67% | 74%   | 74% | 57%   | 82%  | 55%   | 87%  | 61%   | 91%  | 71%   | 94%  | 83%   | 95% | 89%  | 83% |                     |
| Mulanje  | COP 15 |                     | APR 16           | 56%   | 71%  | 57%   | 46% | 31%   | 64% | 24%   | 87%  | 27%   | 111% | 61%   | 103% | 63%   | 86%  | 70%   | 75% | 71%  | 74% |                     |
|          | COP 16 | Scale-Up Saturation | APR 17           | 65%   | 108% | 81%   | 57% | 50%   | 73% | 26%   | 91%  | 31%   | 124% | 57%   | 117% | 70%   | 92%  | 79%   | 80% | 75%  | 82% |                     |
|          | COP 17 | Scale-Up Saturation | APR 18           | 55%   | 99%  | 87%   | 59% | 55%   | 73% | 35%   | 82%  | 34%   | 121% | 61%   | 128% | 85%   | 101% | 90%   | 82% | 90%  | 87% |                     |
|          | COP 18 | Scale-Up Saturation | APR 19           | 85%   | 132% | 108%  | 64% | 127%  | 71% | 70%   | 91%  | 43%   | 125% | 81%   | 126% | 102%  | 91%  | 104%  | 71% | 92%  | 94% |                     |
|          | COP 19 | Scale-Up Saturation | APR 20           | 88%   | 88%  | 88%   | 91% | 92%   | 91% | 92%   | 91%  | 92%   | 91%  | 92%   | 91%  | 92%   | 91%  | 92%   | 91% | 92%  | 91% |                     |
|          | COP 20 | Scale-Up Saturation | APR 21           | 75%   | 81%  | 81%   | 75% | 85%   | 80% | 65%   | 86%  | 62%   | 91%  | 67%   | 94%  | 75%   | 97%  | 86%   | 98% | 93%  | 87% |                     |
| Mwanza   | COP 15 |                     | APR 16           | 54%   | 96%  | 85%   | 47% | 47%   | 67% | 32%   | 93%  | 35%   | 114% | 61%   | 96%  | 79%   | 74%  | 73%   | 60% | 75%  | 75% |                     |
|          | COP 16 | Sustained           | APR 17           | 55%   | 106% | 96%   | 56% | 56%   | 77% | 25%   | 103% | 39%   | 123% | 70%   | 105% | 82%   | 81%  | 82%   | 62% | 80%  | 82% |                     |
|          | COP 17 | Sustained           | APR 18           | 57%   | 96%  | 96%   | 67% | 51%   | 85% | 34%   | 95%  | 43%   | 126% | 67%   | 119% | 89%   | 85%  | 86%   | 63% | 81%  | 85% |                     |
|          | COP 18 | Sustained           | APR 19           | 79%   | 114% | 109%  | 72% | 138%  | 76% | 62%   | 73%  | 36%   | 103% | 60%   | 116% | 86%   | 97%  | 106%  | 78% | 115% | 90% |                     |
|          | COP 19 | Sustained           | APR 20           | 93%   | 93%  | 93%   | 99% | 95%   | 99% | 95%   | 99%  | 95%   | 99%  | 95%   | 99%  | 95%   | 99%  | 95%   | 99% | 95%  | 97% |                     |
|          | COP 20 | Sustained           | APR 21           | 81%   | 85%  | 86%   | 71% | 80%   | 77% | 61%   | 84%  | 58%   | 89%  | 64%   | 93%  | 73%   | 95%  | 84%   | 96% | 91%  | 86% |                     |
| Mzimba   | COP 15 |                     | APR 16           | 53%   | 118% | 107%  | 57% | 79%   | 59% | 24%   | 58%  | 23%   | 95%  | 44%   | 95%  | 58%   | 95%  | 81%   | 83% | 121% | 76% |                     |
|          | COP 16 | Scale-Up Saturation | APR 17           | 49%   | 113% | 95%   | 58% | 86%   | 59% | 30%   | 62%  | 27%   | 93%  | 50%   | 100% | 67%   | 97%  | 86%   | 83% | 123% | 79% |                     |
|          | COP 17 | Scale-Up Saturation | APR 18           | 49%   | 115% | 93%   | 69% | 97%   | 68% | 37%   | 67%  | 29%   | 92%  | 50%   | 108% | 71%   | 103% | 90%   | 89% | 132% | 85% |                     |
|          | COP 18 | Scale-Up Saturation | APR 19           | 75%   | 145% | 124%  | 68% | 153%  | 69% | 55%   | 80%  | 35%   | 112% | 60%   | 131% | 84%   | 112% | 100%  | 88% | 129% | 97% |                     |
|          | COP 19 | Scale-Up Saturation | APR 20           | 88%   | 88%  | 88%   | 90% | 87%   | 90% | 87%   | 90%  | 87%   | 90%  | 87%   | 90%  | 87%   | 90%  | 87%   | 90% | 87%  | 89% |                     |
|          | COP 20 | Scale-Up Saturation | APR 21           | 67%   | 69%  | 69%   | 73% | 80%   | 78% | 62%   | 85%  | 59%   | 90%  | 65%   | 93%  | 74%   | 96%  | 85%   | 97% | 91%  | 85% |                     |
| Neno     | COP 15 |                     | APR 16           | 53%   | 95%  | 82%   | 46% | 46%   | 66% | 32%   | 91%  | 35%   | 111% | 60%   | 94%  | 77%   | 72%  | 71%   | 58% | 73%  | 73% |                     |
|          | COP 16 | Sustained           | APR 17           | 52%   | 101% | 90%   | 53% | 52%   | 72% | 23%   | 97%  | 37%   | 116% | 66%   | 99%  | 78%   | 76%  | 77%   | 59% | 76%  | 77% |                     |
|          | COP 17 | Sustained           | APR 18           | 52%   | 88%  | 88%   | 62% | 47%   | 77% | 31%   | 86%  | 39%   | 115% | 61%   | 109% | 81%   | 77%  | 78%   | 57% | 74%  | 77% |                     |
|          | COP 18 | Sustained           | APR 19           | 64%   | 92%  | 89%   | 58% | 112%  | 62% | 50%   | 59%  | 29%   | 84%  | 48%   | 94%  | 69%   | 78%  | 85%   | 63% | 93%  | 73% |                     |
|          | COP 19 | Sustained           | APR 20           | 88%   | 88%  | 88%   | 85% | 87%   | 85% | 87%   | 85%  | 87%   | 85%  | 87%   | 85%  | 87%   | 85%  | 87%   | 85% | 87%  | 86% |                     |
|          | COP 20 | Sustained           | APR 21           | 67%   | 73%  | 73%   | 75% | 84%   | 79% | 65%   | 86%  | 61%   | 91%  | 66%   | 94%  | 75%   | 96%  | 86%   | 98% | 92%  | 86% |                     |



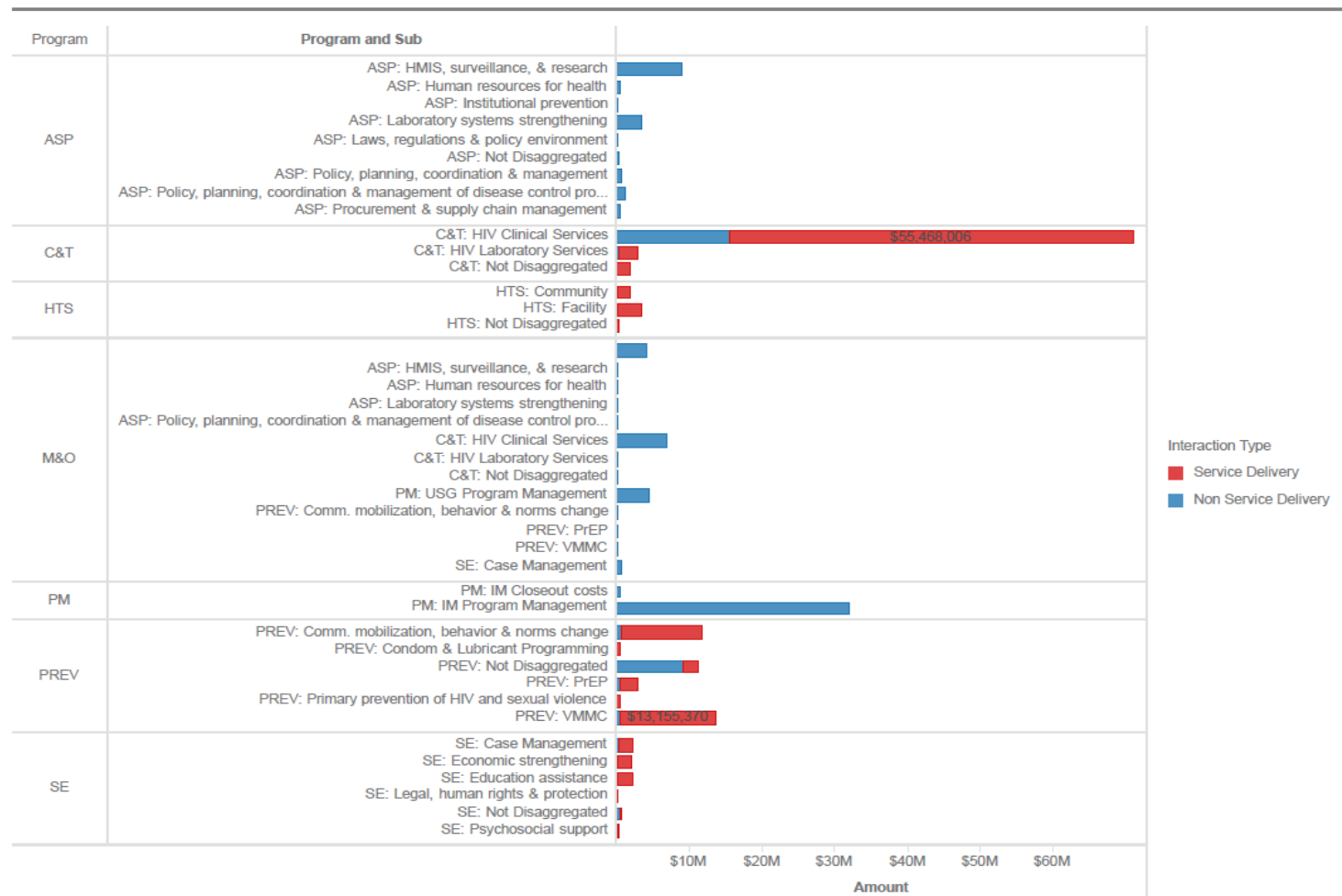
| SNU         | COP    | Prioritization      | Results Reported | Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall |      |       |     |       |      |       |      |       |      |       |      |       |      |       |     |                     |      |     |     |
|-------------|--------|---------------------|------------------|---|------|-------|-----|-------|------|-------|------|-------|------|-------|------|-------|------|-------|-----|---------------------|------|-----|-----|
|             |        |                     |                  | Treatment Coverage at APR by Age and Sex  |      |       |     |       |      |       |      |       |      |       |      |       |      |       |     | Overall TX Coverage |      |     |     |
|             |        |                     |                  | 0-9   |      | 10-14 |     | 15-19 |      | 20-24 |      | 25-29 |      | 30-34 |      | 35-39 |      | 40-49 |     |                     | 50+  |     |     |
| F           | M      | F                   | M                | F   | M    | F     | M   | F     | M    | F     | M    | F     | M    | F     | M    | F     | M    | F     | M   |                     |      |     |     |
| Nkhata-bay  | COP 15 |                     | APR 16           | 26%   | 63%  | 46%   | 24% | 40%   | 20%  | 13%   | 24%  | 12%   | 47%  | 22%   | 55%  | 36%   | 64%  | 61%   | 60% | 94%                 | 46%  |     |     |
|             | COP 16 | Sustained           | APR 17           | 29%   | 68%  | 55%   | 32% | 44%   | 27%  | 13%   | 26%  | 12%   | 46%  | 23%   | 62%  | 40%   | 68%  | 64%   | 64% | 98%                 | 50%  |     |     |
|             | COP 17 | Sustained           | APR 18           | 32%   | 69%  | 57%   | 38% | 53%   | 30%  | 16%   | 27%  | 15%   | 49%  | 23%   | 65%  | 42%   | 67%  | 65%   | 69% | 104%                | 53%  |     |     |
|             | COP 18 | Sustained           | APR 19           | 73%   | 106% | 102%  | 67% | 129%  | 71%  | 58%   | 68%  | 33%   | 96%  | 56%   | 108% | 80%   | 90%  | 99%   | 73% | 108%                | 84%  |     |     |
|             | COP 19 | Sustained           | APR 20           | 88%   | 88%  | 88%   | 83% | 87%   | 83%  | 87%   | 83%  | 87%   | 83%  | 87%   | 83%  | 87%   | 83%  | 87%   | 83% | 87%                 | 83%  | 87% | 85% |
|             | COP 20 | Sustained           | APR 21           | 69%   | 75%  | 75%   | 73% | 81%   | 78%  | 62%   | 85%  | 59%   | 90%  | 65%   | 93%  | 74%   | 96%  | 85%   | 97% | 92%                 | 85%  |     |     |
| Nkhota-kota | COP 15 |                     | APR 16           | 61%   | 87%  | 81%   | 39% | 68%   | 44%  | 26%   | 62%  | 18%   | 105% | 55%   | 112% | 80%   | 106% | 118%  | 87% | 171%                | 88%  |     |     |
|             | COP 16 | Sustained           | APR 17           | 58%   | 126% | 92%   | 41% | 74%   | 50%  | 27%   | 60%  | 21%   | 100% | 57%   | 127% | 92%   | 120% | 127%  | 92% | 185%                | 96%  |     |     |
|             | COP 17 | Sustained           | APR 18           | 61%   | 118% | 91%   | 46% | 83%   | 56%  | 28%   | 66%  | 22%   | 100% | 58%   | 131% | 94%   | 130% | 129%  | 94% | 194%                | 101% |     |     |
|             | COP 18 | Sustained           | APR 19           | 63%   | 91%  | 88%   | 59% | 112%  | 62%  | 50%   | 59%  | 29%   | 84%  | 49%   | 94%  | 70%   | 78%  | 86%   | 63% | 94%                 | 73%  |     |     |
|             | COP 19 | Sustained           | APR 20           | 88%   | 88%  | 88%   | 82% | 87%   | 82%  | 87%   | 82%  | 87%   | 82%  | 87%   | 82%  | 87%   | 82%  | 87%   | 82% | 87%                 | 82%  | 87% | 84% |
|             | COP 20 | Sustained           | APR 21           | 102%  | 102% | 102%  | 70% | 78%   | 76%  | 60%   | 83%  | 57%   | 88%  | 63%   | 92%  | 72%   | 95%  | 84%   | 96% | 91%                 | 86%  |     |     |
| Nsanje      | COP 15 |                     | APR 16           | 67%   | 90%  | 83%   | 47% | 42%   | 61%  | 20%   | 68%  | 23%   | 108% | 44%   | 100% | 62%   | 84%  | 78%   | 74% | 86%                 | 74%  |     |     |
|             | COP 16 | Sustained           | APR 17           | 78%   | 94%  | 85%   | 52% | 57%   | 61%  | 19%   | 74%  | 26%   | 104% | 40%   | 106% | 65%   | 85%  | 80%   | 71% | 84%                 | 76%  |     |     |
|             | COP 17 | Sustained           | APR 18           | 82%   | 95%  | 109%  | 67% | 69%   | 75%  | 24%   | 81%  | 30%   | 109% | 43%   | 124% | 73%   | 96%  | 91%   | 80% | 93%                 | 85%  |     |     |
|             | COP 18 | Sustained           | APR 19           | 64%   | 93%  | 89%   | 66% | 125%  | 69%  | 56%   | 66%  | 33%   | 94%  | 54%   | 105% | 78%   | 88%  | 96%   | 71% | 105%                | 81%  |     |     |
|             | COP 19 | Sustained           | APR 20           | 91%   | 91%  | 91%   | 92% | 96%   | 92%  | 96%   | 92%  | 96%   | 92%  | 96%   | 92%  | 96%   | 92%  | 96%   | 92% | 96%                 | 92%  | 96% | 93% |
|             | COP 20 | Sustained           | APR 21           | 74%   | 80%  | 80%   | 75% | 84%   | 79%  | 64%   | 86%  | 61%   | 90%  | 66%   | 94%  | 75%   | 96%  | 86%   | 98% | 92%                 | 86%  |     |     |
| Ntcheu      | COP 15 |                     | APR 16           | 41%   | 64%  | 67%   | 31% | 44%   | 37%  | 14%   | 39%  | 18%   | 66%  | 28%   | 69%  | 38%   | 63%  | 55%   | 55% | 64%                 | 50%  |     |     |
|             | COP 16 | Sustained           | APR 17           | 43%   | 68%  | 77%   | 42% | 52%   | 40%  | 21%   | 44%  | 23%   | 69%  | 37%   | 77%  | 43%   | 66%  | 63%   | 59% | 71%                 | 56%  |     |     |
|             | COP 17 | Sustained           | APR 18           | 40%   | 74%  | 77%   | 48% | 53%   | 44%  | 22%   | 44%  | 24%   | 67%  | 38%   | 82%  | 49%   | 72%  | 64%   | 62% | 78%                 | 59%  |     |     |
|             | COP 18 | Sustained           | APR 19           | 68%   | 98%  | 95%   | 63% | 120%  | 66%  | 54%   | 63%  | 31%   | 89%  | 52%   | 100% | 74%   | 84%  | 91%   | 68% | 100%                | 78%  |     |     |
|             | COP 19 | Sustained           | APR 20           | 88%   | 88%  | 88%   | 89% | 88%   | 89%  | 88%   | 89%  | 88%   | 89%  | 88%   | 89%  | 88%   | 89%  | 88%   | 89% | 88%                 | 89%  | 89% | 89% |
|             | COP 20 | Sustained           | APR 21           | 77%   | 82%  | 82%   | 73% | 81%   | 78%  | 62%   | 85%  | 59%   | 89%  | 65%   | 93%  | 74%   | 96%  | 85%   | 97% | 92%                 | 86%  |     |     |
| Ntchisi     | COP 15 |                     | APR 16           | 43%   | 54%  | 100%  | 45% | 60%   | 37%  | 34%   | 52%  | 20%   | 83%  | 43%   | 87%  | 53%   | 87%  | 89%   | 87% | 111%                | 70%  |     |     |
|             | COP 16 | Sustained           | APR 17           | 50%   | 68%  | 104%  | 49% | 82%   | 46%  | 35%   | 48%  | 30%   | 85%  | 41%   | 92%  | 54%   | 98%  | 93%   | 87% | 109%                | 75%  |     |     |
|             | COP 17 | Sustained           | APR 18           | 49%   | 87%  | 89%   | 45% | 92%   | 52%  | 35%   | 46%  | 29%   | 87%  | 42%   | 94%  | 65%   | 97%  | 94%   | 90% | 109%                | 77%  |     |     |
|             | COP 18 | Sustained           | APR 19           | 76%   | 110% | 106%  | 70% | 134%  | 74%  | 60%   | 70%  | 35%   | 100% | 58%   | 113% | 83%   | 94%  | 102%  | 76% | 112%                | 88%  |     |     |
|             | COP 19 | Sustained           | APR 20           | 88%   | 88%  | 88%   | 73% | 87%   | 73%  | 87%   | 73%  | 87%   | 73%  | 87%   | 73%  | 87%   | 73%  | 87%   | 73% | 87%                 | 73%  | 87% | 79% |
|             | COP 20 | Sustained           | APR 21           | 94%   | 97%  | 96%   | 74% | 82%   | 78%  | 63%   | 85%  | 59%   | 90%  | 65%   | 93%  | 74%   | 96%  | 85%   | 97% | 92%                 | 88%  |     |     |
| Phalombe    | COP 15 |                     | APR 16           | 78%   | 92%  | 73%   | 48% | 43%   | 79%  | 32%   | 94%  | 41%   | 124% | 70%   | 113% | 83%   | 88%  | 77%   | 74% | 79%                 | 84%  |     |     |
|             | COP 16 | Scale-Up Saturation | APR 17           | 90%   | 116% | 96%   | 63% | 48%   | 89%  | 49%   | 99%  | 52%   | 137% | 76%   | 131% | 99%   | 98%  | 90%   | 77% | 84%                 | 95%  |     |     |
|             | COP 17 | Scale-Up Saturation | APR 18           | 89%   | 132% | 105%  | 73% | 71%   | 100% | 56%   | 104% | 60%   | 139% | 87%   | 141% | 101%  | 105% | 98%   | 79% | 89%                 | 101% |     |     |
|             | COP 18 | Scale-Up Saturation | APR 19           | 92%   | 105% | 85%   | 51% | 82%   | 68%  | 80%   | 101% | 55%   | 131% | 77%   | 128% | 99%   | 86%  | 85%   | 62% | 75%                 | 89%  |     |     |
|             | COP 19 | Scale-Up Saturation | APR 20           | 92%   | 92%  | 92%   | 93% | 101%  | 93%  | 101%  | 93%  | 101%  | 93%  | 101%  | 93%  | 101%  | 93%  | 101%  | 93% | 101%                | 93%  | 96% |     |
|             | COP 20 | Scale-Up Saturation | APR 21           | 58%   | 65%  | 65%   | 76% | 85%   | 80%  | 65%   | 87%  | 62%   | 91%  | 67%   | 94%  | 75%   | 97%  | 86%   | 98% | 93%                 | 85%  |     |     |

| SNU    | COP    | Prioritization      | Results Reported | Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall |      |       |     |       |      |       |     |       |      |       |      |       |      |       |     |                     |     |     |
|--------|--------|---------------------|------------------|---|------|-------|-----|-------|------|-------|-----|-------|------|-------|------|-------|------|-------|-----|---------------------|-----|-----|
|        |        |                     |                  | Treatment Coverage at APR by Age and Sex  |      |       |     |       |      |       |     |       |      |       |      |       |      |       |     | Overall TX Coverage |     |     |
|        |        |                     |                  | 0-9   |      | 10-14 |     | 15-19 |      | 20-24 |     | 25-29 |      | 30-34 |      | 35-39 |      | 40-49 |     |                     |     | 50+ |
| F      | M      | F                   | M                | F   | M    | F     | M   | F     | M    | F     | M   | F     | M    | F     | M    | F     | M    |       |     |                     |     |     |
| Rumphi | COP 15 |                     | APR 16           | 63%   | 116% | 122%  | 52% | 70%   | 47%  | 30%   | 54% | 31%   | 91%  | 55%   | 94%  | 64%   | 101% | 110%  | 86% | 142%                | 82% |     |
|        | COP 16 | Sustained           | APR 17           | 45%   | 73%  | 103%  | 43% | 75%   | 56%  | 52%   | 49% | 33%   | 85%  | 51%   | 106% | 67%   | 98%  | 109%  | 93% | 149%                | 83% |     |
|        | COP 17 | Sustained           | APR 18           | 52%   | 116% | 116%  | 71% | 119%  | 66%  | 40%   | 57% | 37%   | 78%  | 52%   | 112% | 78%   | 104% | 113%  | 98% | 157%                | 90% |     |
|        | COP 18 | Sustained           | APR 19           | 89%   | 128% | 124%  | 78% | 150%  | 83%  | 67%   | 79% | 39%   | 112% | 65%   | 126% | 93%   | 105% | 115%  | 85% | 125%                | 98% |     |
|        | COP 19 | Sustained           | APR 20           | 88%   | 88%  | 88%   | 80% | 87%   | 80%  | 87%   | 80% | 87%   | 80%  | 87%   | 80%  | 87%   | 80%  | 87%   | 80% | 87%                 | 80% | 87% |
|        | COP 20 | Sustained           | APR 21           | 92%   | 95%  | 95%   | 73% | 82%   | 78%  | 63%   | 85% | 59%   | 90%  | 65%   | 93%  | 74%   | 96%  | 85%   | 97% | 92%                 | 92% | 87% |
| Salima | COP 15 |                     | APR 16           | 45%   | 48%  | 47%   | 31% | 35%   | 34%  | 11%   | 42% | 10%   | 70%  | 31%   | 70%  | 43%   | 62%  | 62%   | 44% | 66%                 | 50% |     |
|        | COP 16 | Sustained           | APR 17           | 50%   | 64%  | 45%   | 37% | 41%   | 37%  | 20%   | 41% | 17%   | 72%  | 32%   | 76%  | 47%   | 69%  | 67%   | 48% | 72%                 | 55% |     |
|        | COP 17 | Sustained           | APR 18           | 51%   | 57%  | 53%   | 40% | 46%   | 43%  | 24%   | 41% | 18%   | 71%  | 32%   | 83%  | 49%   | 71%  | 70%   | 53% | 78%                 | 58% |     |
|        | COP 18 | Sustained           | APR 19           | 79%   | 114% | 110%  | 73% | 139%  | 77%  | 62%   | 73% | 36%   | 104% | 60%   | 117% | 86%   | 97%  | 106%  | 78% | 116%                | 91% |     |
|        | COP 19 | Sustained           | APR 20           | 88%   | 88%  | 88%   | 90% | 89%   | 90%  | 89%   | 90% | 89%   | 90%  | 89%   | 90%  | 89%   | 90%  | 89%   | 90% | 89%                 | 90% | 89% |
|        | COP 20 | Sustained           | APR 21           | 75%   | 81%  | 81%   | 69% | 77%   | 75%  | 59%   | 83% | 56%   | 88%  | 63%   | 92%  | 72%   | 95%  | 83%   | 96% | 90%                 | 85% |     |
| Thyolo | COP 15 |                     | APR 16           | 44%   | 73%  | 83%   | 41% | 45%   | 46%  | 19%   | 58% | 23%   | 93%  | 39%   | 93%  | 54%   | 88%  | 66%   | 79% | 78%                 | 67% |     |
|        | COP 16 | Scale-Up Saturation | APR 17           | 50%   | 82%  | 90%   | 52% | 52%   | 59%  | 29%   | 67% | 32%   | 98%  | 48%   | 105% | 63%   | 92%  | 71%   | 81% | 76%                 | 74% |     |
|        | COP 17 | Scale-Up Saturation | APR 18           | 42%   | 91%  | 93%   | 54% | 69%   | 53%  | 26%   | 59% | 25%   | 88%  | 39%   | 112% | 67%   | 102% | 86%   | 84% | 94%                 | 77% |     |
|        | COP 18 | Scale-Up Saturation | APR 19           | 78%   | 131% | 134%  | 95% | 162%  | 103% | 68%   | 72% | 38%   | 105% | 62%   | 126% | 104%  | 102% | 119%  | 79% | 117%                | 98% |     |
|        | COP 19 | Scale-Up Saturation | APR 20           | 88%   | 88%  | 88%   | 90% | 87%   | 90%  | 87%   | 90% | 87%   | 90%  | 87%   | 90%  | 87%   | 90%  | 87%   | 90% | 87%                 | 89% |     |
|        | COP 20 | Scale-Up Saturation | APR 21           | 107%  | 106% | 106%  | 78% | 88%   | 81%  | 67%   | 88% | 63%   | 92%  | 68%   | 95%  | 76%   | 97%  | 87%   | 99% | 93%                 | 90% |     |
| Zomba  | COP 15 |                     | APR 16           | 53%   | 73%  | 71%   | 35% | 48%   | 49%  | 22%   | 57% | 20%   | 90%  | 42%   | 83%  | 54%   | 70%  | 63%   | 66% | 74%                 | 62% |     |
|        | COP 16 | Scale-Up Saturation | APR 17           | 58%   | 79%  | 76%   | 43% | 50%   | 52%  | 25%   | 61% | 25%   | 91%  | 42%   | 95%  | 55%   | 79%  | 64%   | 76% | 73%                 | 67% |     |
|        | COP 17 | Scale-Up Saturation | APR 18           | 57%   | 94%  | 93%   | 49% | 66%   | 52%  | 30%   | 57% | 26%   | 86%  | 39%   | 103% | 61%   | 86%  | 71%   | 79% | 85%                 | 71% |     |
|        | COP 18 | Scale-Up Saturation | APR 19           | 79%   | 107% | 102%  | 57% | 117%  | 60%  | 55%   | 76% | 35%   | 108% | 54%   | 123% | 81%   | 94%  | 91%   | 84% | 98%                 | 87% |     |
|        | COP 19 | Scale-Up Saturation | APR 20           | 89%   | 89%  | 89%   | 89% | 88%   | 89%  | 88%   | 89% | 88%   | 89%  | 88%   | 89%  | 88%   | 89%  | 88%   | 89% | 88%                 | 89% | 89% |
|        | COP 20 | Scale-Up Saturation | APR 21           | 86%   | 90%  | 90%   | 70% | 79%   | 76%  | 61%   | 84% | 58%   | 89%  | 64%   | 92%  | 73%   | 95%  | 84%   | 96% | 91%                 | 86% |     |

# APPENDIX B – Budget Profile and Resource Projections

## B1. COP20 Planned Spending in Alignment with Planning Level Letter Guidance

Table B.1.1 COP20 Budget by Program Area





**Table B.1.2 COP20 Total Planning Level**

| Applied Pipeline | New Funding    | Total Spend   |
|------------------|----------------|---------------|
| \$18,413,203     | \$ 177,163,966 | \$195,577,169 |

**Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)**

| PEPFAR Budget Code                | Budget Code Description                 | Amount Allocated (\$) |
|-----------------------------------|---|-----------------------|
| MTCT                              | Mother to Child Transmission            | 1,704,244             |
| HVAB/Y                            | Abstinence/Be Faithful Prevention/Youth | 568,449               |
| HVOP                              | Other Sexual Prevention                 | 21,773,109            |
| HMBL                              | Blood Safety                            | 222,760               |
| CIRC                              | Male Circumcision                       | 16,131,735            |
| HVCT                              | Counseling and Testing                  | 4,627,897             |
| HBHC                              | Adult Care and Support                  | 193,552               |
| PDCS                              | Pediatric Care and Support              | 2,903,260             |
| HKID                              | Orphans and Vulnerable Children         | 9,005,635             |
| HTXS                              | Adult Treatment                         | 86,290,670            |
| HTXD                              | ARV Drugs                               | -                     |
| PDTX                              | Pediatric Treatment                     | 3,964,299             |
| HVTB                              | TB/HIV Care                             | 6,121,717             |
| HLAB                              | Lab                                     | 4,248,601             |
| HVSI                              | Strategic Information                   | 10,874,931            |
| OHSS                              | Health Systems Strengthening            | 3,867,743             |
| HVMS                              | Management and Operations               | 4,656,364             |
| <b>TOTAL (excluding pipeline)</b> |   | <b>\$ 177,163,966</b> |

## B.2 Resource Projections

PEPFAR Malawi COP20 program has been designed to address retention challenges through back to care efforts to ensure clients return to care by supporting client-centered priorities. Over \$108.5 million budgeted for care and treatment services to support direct service support at facility level. Based on 2019 partner performance (treatment target achievement), PEPFAR Malawi received \$30 million in performance funding. The team used a program-based, incremental budget approach to support high performing mechanisms to scale up impactful innovation and best practices. PEPFAR Malawi implemented a phased health information system to support quality patient care with real-time and near real-time electronic medical records (EMR) system to improve patient outcomes. In COP20, PEPFAR will continue investing in EMR to maintain the system and will work with partners to support data utilization at facility level to inform decision making. S/GAC has commended PEPFAR Malawi for successfully implementing the DREAMS program to support AGYW. In COP20, the DREAMS budget has been increased from \$8.5 million to \$20 million to

expand and saturate interventions, hire DREAMS Ambassadors, further develop the DREAMS database to monitor layering of services, and to address implementation challenges in the three districts (Blantyre, Machinga, and Zomba) where DREAMS is currently being implemented. These funds will complement Malawi's Global fund DREAMS investment in other non-PEPFAR districts currently budgeted at \$6.4 million and additional \$20.3 million for AGYW over the 3-year grant period (2020-2022). One of the challenges noted for Malawi was partners continue to over-test. To address this challenge PEPFAR Malawi will shift from inefficient testing modalities. The COP20 budget has drastically reduced from \$ 12.5 million to \$4,6 million to support testing for key populations, DREAMS AGYW and ANC testing support services.

PEPFAR Malawi also demonstrated good results in reaching the 15-29-year-old males with VMMC programming. To saturate VMMC services for the specified age group in three PEPFAR districts (Blantyre, Chikwawa, Lilongwe), the Malawi team applied for Ambition Funding in addition to the \$9.5 million allocated for COP20. The applications were approved bringing the total COP20 VMMC budget to \$16,131,735. In COP20, PEPFAR Malawi will fund CSOs for community-led monitoring to help PEPFAR to diagnose and pinpoint persistent problems and barriers to effective services and client outcomes at the site level. PEPFAR Malawi received \$2m for support towards implementation of a new program whereby students in Malawi will graduate with certification in community health work under the HBCU initiative that is implemented by the Health Resources and Services Administration (HRSA). HRSA will continue to jointly plan activities together with the country team.

## APPENDIX C – Tables and Systems Investments for Section 6.o

| Table 6-E (Entry of Above Site Programs Activities) |  |  |   |   |  |                    |              |   |
|---|--|--|---|---|--|--------------------|--------------|---|
| Funding Agency                                      | PrimePartner                               | COP20 Program Area                                   | COP20 Beneficiary                         | COP20 Activity Category                             | Key Systems Barrier  | Intervention Start | Intervention | COP20 Benchmark   |
| HHS/CDC   | MALAWI BLOOD TRANSFUSION SERVICE           | ASP: Institutional prevention-NSD                    | Non-Targeted Pop: Not disaggregated       | Blood supply  | Poor optimization of lab mechanisms to effectively and efficiently utilize lab resources                                   | COP17              | COP19        | Develop sustainability strategy   |
| HHS/CDC   | MALAWI BLOOD TRANSFUSION SERVICE           | ASP: Laboratory systems strengthening-NSD            | Non-Targeted Pop: Not disaggregated       | Lab quality improvement and assurance               | Poor optimization of lab mechanisms to effectively and efficiently utilize lab resources                                   | COP17              | COP19        | Develop sustainability strategy   |
| HHS/CDC   | CHRISTIAN HEALTH ASSOCIATION OF MALAWI     | ASP: Human resources for health-NSD                  | Non-Targeted Pop: Adults                  |   |  | COP16              | COP19        |   |
| HHS/CDC   | The Lighthouse Trust                       | ASP: HMIS, surveillance, & research-NSD              | Females: Young women & adolescent females |   |  | COP18              | COP20        |   |
| HHS/CDC   | University Research Co., LLC               | ASP: Laboratory systems strengthening-NSD            | Non-Targeted Pop: Not disaggregated       |   |  | COP16              | COP19        |   |
| HHS/CDC   | UNIVERSITY OF WASHINGTON                   | ASP: HMIS, surveillance, & research-NSD              | Non-Targeted Pop: Not disaggregated       |   |  | COP17              | COP19        |   |
| HHS/CDC   | UNIVERSITY OF WASHINGTON                   | ASP: Human resources for health-NSD                  | Non-Targeted Pop: Not disaggregated       |   |  | COP16              | COP19        |   |
| HHS/CDC   | UNIVERSITY OF WASHINGTON                   | ASP: Policy, planning, coordination & management-NSD | Non-Targeted Pop: Not disaggregated       |   |  | COP18              | COP19        |   |
| HHS/CDC   | NATIONAL REGISTRATION BUREAU               | ASP: HMIS, surveillance, & research-NSD              | Non-Targeted Pop: Not disaggregated       |   |  | COP16              | COP19        |   |
| HHS/CDC   | UNIVERSITY OF MALAWI COLLEGE OF MEDICINE   | ASP: HMIS, surveillance, & research-NSD              | Non-Targeted Pop: Not disaggregated       |   |  | COP16              | COP19        |   |
| HHS/CDC   | UNIVERSITY OF MALAWI COLLEGE OF MEDICINE   | ASP: Human resources for health-NSD                  | Non-Targeted Pop: Not disaggregated       | Pre-service training                                | Inadequate HRH to implement quality targeted HIV service delivery at the site and community level                          | COP16              | COP19        | NA  |
| HHS/CDC   | UNIVERSITY OF WASHINGTON                   | ASP: HMIS, surveillance, & research-NSD              | Non-Targeted Pop: Not disaggregated       | Surveillance  | Weak Information Systems to efficiently collect accurate, age/sex disaggregated, real-time epidemiological and health data | COP17              | COP21        | Integration of recency surveillance into routine HTS  |
| HHS/CDC   | UNIVERSITY OF WASHINGTON                   | ASP: Human resources for health-NSD                  | Non-Targeted Pop: Not disaggregated       |   |  | COP16              | COP19        |   |
| HHS/CDC   | UNIVERSITY OF WASHINGTON                   | ASP: Laboratory systems strengthening-NSD            | Non-Targeted Pop: Not disaggregated       |   |  | COP18              | COP19        |   |
| HHS/CDC   | UNIVERSITY OF WASHINGTON                   | ASP: Policy, planning, coordination & management-NSD | Non-Targeted Pop: Not disaggregated       |   |  | COP17              | COP19        |   |
| HHS/CDC   | JHPIEGO CORPORATION                        | ASP: Policy, planning, coordination & management-NSD | Non-Targeted Pop: Not disaggregated       |   |  | COP19              | COP21        |   |
| HHS/CDC   | Elizabeth Glaser Pediatric Aids Foundation | ASP: HMIS, surveillance, & research-NSD              | Non-Targeted Pop: Not disaggregated       | HMIS systems  | Weak Information Systems to efficiently collect accurate, age/sex disaggregated, real-time epidemiological and health data | COP16              | COP20        | NA  |
| HHS/CDC   | Elizabeth Glaser Pediatric Aids Foundation | ASP: Policy, planning, coordination & management-NSD | Non-Targeted Pop: Not disaggregated       | Assessing impact of policies and regulations on HIV | Limited host country institutional capacity for evidence-based management of HIV program                                   | COP18              | COP20        |   |
| HHS/CDC   | UNIVERSITY OF MARYLAND                     | ASP: Laboratory systems strengthening-NSD            | Non-Targeted Pop: Not disaggregated       | Lab quality improvement and assurance               | Poor optimization of lab mechanisms to effectively and efficiently utilize lab resources                                   | COP20              | COP21        | 10 Laboratories accredited; Renovate 3 laboratories; sustain waste management system; sustaining EQA schemes/programs in all Laboratories |
| State/AF  | DEPARTMENT OF STATE                        | ASP: HMIS, surveillance, & research-NSD              | Non-Targeted Pop: Not disaggregated       | Assessing impact of policies and regulations on HIV | Limited host country institutional capacity for evidence-based management of HIV program                                   | COP20              | COP21        | Functional data center in place   |

|         |                                   |  |                                     |  |  |       |       |   |
|---------|-----------------------------------|--|-------------------------------------|--|--|-------|-------|---|
| USAID   | Unicef                            | ASP: Policy, planning, coordination & management-NSD                             | OVC: Not disaggregated              | Oversight, technical assistance, and supervision to subnational levels | Limited host country institutional capacity for evidence-based management of HIV program                                   | COP17 | COP19 | 10 Case Management Coordination meetings held at National and district level  |
| USAID   | Palladium International, LLC      | ASP: Policy, planning, coordination & management-NSD                             | Non-Targeted Pop: Not disaggregated | Oversight, technical assistance, and supervision to subnational levels | Limited host country institutional capacity for evidence-based management of HIV program                                   | COP18 | COP19 | Improvements in AGYW outcomes documented through M&E framework and routine reporting by stakeholders through mechanism established by AGYW Secretariat  |
| USAID   | Palladium International, LLC      | ASP: Policy, planning, coordination & management-NSD                             | Non-Targeted Pop: Not disaggregated | Oversight, technical assistance, and supervision to subnational levels | Limited host country institutional capacity for evidence-based management of HIV program                                   | COP18 | COP19 | QA SOPs disseminated nationally and monitored routinely; indicators for screening and treatment improve from baseline   |
| USAID   | Palladium International, LLC      | ASP: Policy, planning, coordination & management-NSD                             | Non-Targeted Pop: Not disaggregated | National strategic plans, operational plans and budgets                | Limited host country institutional capacity for evidence-based management of HIV program                                   | COP17 | COP20 | TA to MOF maintained for on-track GF grant performance; quarterly financial reviews conducted and submitted to PEPFAR   |
| USAID   | FHI Development 360 LLC           |  |                                     |  |  |       |       |   |
| USAID   | Chemonics International, Inc.     | ASP: Laboratory systems strengthening-NSD  | Non-Targeted Pop: Not disaggregated | Forecasting, supply chain plan, budget, and implementation             | Limited commodity management and storage capacity at national, district, and facility levels                               | COP16 | COP20 | Maintain an average of 5% or lower stock out rate for all HIV commodities   |
| USAID   | Chemonics International, Inc.     | ASP: Procurement & supply chain management-NSD                                   | Non-Targeted Pop: Not disaggregated | Lab quality improvement and assurance                                  | Poor optimization of lab mechanisms to effectively and efficiently utilize lab resources                                   | COP17 | COP20 | 100% of Molecular labs submitting a monthly LMIS report for VL and key lab commodities  |
| USAID   | Chemonics International, Inc.     | ASP: Policy, planning, coordination & management-NSD                             | Non-Targeted Pop: Not disaggregated | Oversight, technical assistance, and supervision to subnational levels | Inadequate HRH to implement quality targeted HIV service delivery at the site and community level                          | COP16 | COP20 | District HRH technical team develop a management plan that includes timelines and actionable work plans and set up a system for monitoring implementation and addressing bottlenecks to ensure timely delivery of HRH milestones. |
| USAID   | Partners In Hope                  |  |                                     |  |  |       |       |   |
| USAID   | Partners In Hope                  |  |                                     |  |  |       |       |   |
| USAID   | Population Services International |  |                                     |  |  |       |       |   |
| USAID   | Family Health International       | ASP: Policy, planning, coordination & management of disease control programs-NSD | Non-Targeted Pop: Not disaggregated | Oversight, technical assistance, and supervision to subnational levels | Limited host country institutional capacity for evidence-based management of HIV program                                   | COP17 | COP20 | Quarterly data review and validation conducted at national level stakeholder meetings   |
| USAID   | Family Health International       | ASP: Not Disaggregated-NSD   | Non-Targeted Pop: Not disaggregated | Oversight, technical assistance, and supervision to subnational levels | Limited host country institutional capacity for evidence-based management of HIV program                                   | COP17 | COP20 | Organizational and financial capacity built.  |
| HHS/CDC | UNIVERSITY OF WASHINGTON          | ASP: HMIS, surveillance, & research-NSD  | Non-Targeted Pop: Not disaggregated | Surveillance   | Poor optimization of lab mechanisms to effectively and efficiently utilize lab resources                                   | COP18 | COP21 | 500 drug resistance tests done on patients failing DTG-based regime; completion and dissemination of final HIVDR report   |
| HHS/CDC | UNIVERSITY OF WASHINGTON          | ASP: HMIS, surveillance, & research-NSD  | Non-Targeted Pop: Not disaggregated | Surveillance   | Weak Information Systems to efficiently collect accurate, age/sex disaggregated, real-time epidemiological and health data | COP16 | COP21 | Implementation of second phase that looks at association of birth defects with DTG  |
| HHS/CDC | UNIVERSITY OF WASHINGTON          | ASP: HMIS, surveillance, & research-NSD  | Non-Targeted Pop: Not disaggregated | Surveillance   | Weak Information Systems to efficiently collect accurate, age/sex disaggregated, real-time epidemiological and health data | COP17 | COP20 | N/A   |
| HHS/CDC | UNIVERSITY OF WASHINGTON          | ASP: HMIS, surveillance, & research-NSD  | Non-Targeted Pop: Not disaggregated | Program and data quality management                                    | Weak Information Systems to efficiently collect accurate, age/sex disaggregated, real-time epidemiological and health data | COP16 | COP21 | 212 Frontline surveillance officers trained   |

|         |   |  |  |                      |  |       |       |   |
|---------|---|--|--|----------------------|--|-------|-------|---|
| HHS/CDC | Regents of the University of California, San Francisco, The | ASP: HMIS, surveillance, & research-NSD              | Non-Targeted Pop: Not disaggregated                | Surveillance         | Weak Information Systems to efficiently collect accurate, age/sex disaggregated, real-time epidemiological and health data | COP19 | COP20 | N/A   |
| HHS/CDC | Elizabeth Glaser Pediatric Aids Foundation                  | ASP: HMIS, surveillance, & research-NSD              | Non-Targeted Pop: Not disaggregated                | Surveillance         | Weak Information Systems to efficiently collect accurate, age/sex disaggregated, real-time epidemiological and health data | COP17 | COP21 | Inclusion of recent infection as a sentinel event in the case surveillance platform   |
| PC      | Peace Corps   | ASP: Human resources for health-NSD                  | Non-Targeted Pop: Adults                           | Pre-service training | Inadequate HRH to implement quality targeted HIV service delivery at the site and community level                          | COP18 | COP21 | 500 nursing students received quality nursing education through improved skills lab training via placement of PC volunteers in 5 partner institutions<br><br>55 Institution staff trained in continuous professional development to meet identified needs |
| DOD     | Project Concern International                               | ASP: HMIS, surveillance, & research-NSD              | Priority Pops: Military & other uniformed services |                      |  | COP18 | COP19 |   |
| USAID   | Family Health International                                 |  |  |                      |  |       |       |   |
| USAID   | Palladium International, LLC                                | ASP: Policy, planning, coordination & management-NSD | Non-Targeted Pop: Young people & adolescents       |                      |  |       |       |   |
| USAID   | Population Council, Inc., The                               | ASP: HMIS, surveillance, & research-NSD              | Females: Not disaggregated                         |                      |  |       |       |   |
| USAID   | Population Council, Inc., The                               | ASP: HMIS, surveillance, & research-NSD              | Males: Not disaggregated                           |                      |  |       |       |   |
| USAID   | Population Council, Inc., The                               | ASP: HMIS, surveillance, & research-NSD              | Non-Targeted Pop: Not disaggregated                |                      |  |       |       |   |

\*Please note the PDF attachments of Table 6-E and SRE Tool-E for easier reading, as well as the SRE Excel workbook, are all attached.

## APPENDIX D– Minimum Program Requirements

|                    | Policy  | Status for COP 20 Implementation  |
|--------------------|---|---|
| Care and Treatment | 1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. <sup>10</sup>   | Test and Start services available in all 750 ART sites.   |
|                    | 2. Rapid optimization of ART by offering TLD to all PLHIV weighing $\geq 30$ kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing $\geq 20$ kg, and removal of all <u>nevirapine</u> -based regimens. <sup>11</sup> | DTG transition ongoing in all Malawi ART sites. So far, 70% of the national treatment cohort is on DTG-based regimen. By end of COP19, we expect to reach 90%.<br>Pediatrics ARV optimization:<br>Transition to DTG based regimen for children weighing at least 20kgs is underway at all ART sites.<br>Transition to LPV/r- based regimens is underway at 74 sites. Shortage of LPV/r granules and tablets has slowed the pace of scale up. Additional shipment expected in March 2020. Scale up to all ART clinics expected by June 2020. |
|                    | 3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents. <sup>12</sup>   | All PEPFAR supported sites will implement MMD6. Technical assistance will be provided to MOH to support differentiated service delivery models in non-PEPFAR supported facilities.  |
|                    | 4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP20, and <u>cotrimoxazole</u> , where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. <sup>13</sup>                                  | Five districts already implementing 6H (six-month INH). TPT commodities are expected to be delivered in June (IPT) and July (3HP).<br>Relocation of excess IPT from the five initial districts is underway. Scale up will be intensified as soon as commodities are available.  |



|                    |   |   |
|--------------------|---|---|
|                    |   | All 28 districts will be rolling out TPT mostly 3HP in COP20.   |
|                    | 5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.  | <p>As of Q1 FY20, 70% VL coverage, 94% viral load suppression. Expand coverage through patient education efforts.</p> <p>Reduce TAT from 13.6 days to 10 days.</p> <p>Continue conventional lab optimization through current and additional Hologic and increased utilization of existing multiplex GeneXpert POC.</p> <p>Sample transportation optimization scaled and transition from URC to University of Maryland in progress.</p> <p>By COP20, 85% viral load coverage expected with 95% viral suppression. Additional Hologic devices will also be procured to increase lab capacity.</p> |
| Case Finding       | 6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV. <sup>44</sup>   | Policy adopted; implementation in progress in PEPFAR supported community and facility sites. IPV screening and testing of children integrated into index testing procedures.  |
| Prevention and OVC | 7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) <sup>45</sup> | Implementation and reach will increase from 8 to 11 Districts (Balaka, Blantyre, Chikwawa, Chiradzulu, Lilongwe, Machinga, Mangochi, Mulanje, Mwanza, Mzimba, Phalombe, Thyolo and Zomba) reaching over 16,000 clients.   |
|                    | 8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and  | The OVC program is currently being implemented in 6 districts: Chikwawa, Blantyre, Lilongwe, Mangochi, Machinga, and Zomba. In COP20, OVC program to be implemented in 9 districts: Chikwawa, Blantyre, Lilongwe, Mangochi, Machinga, Zomba, Mulanje, Phalombe, and Thyolo, reaching a  |

|  |   |  |
|--|---|--|
|  | adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.  | population of over 150,000 OVCs including caregivers with services for children living with HIV, AGYW who are also DREAMS recipients, and prevention services for OVC.   |
| Policy & Public Health Systems Support | 9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention. <sup>66</sup>                             | Malawi's policy does not allow user fees to be charged for HIV services.<br><br>GOM to expand SLA to include new elements of HIV services including TB treatment, cervical cancer screening and treatment, and GBV services at CHAM facilities where user fees for these services exist.               |
|  | 10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy. <sup>67</sup>  | CQI will remain an integral approach to identifying and addressing bottlenecks that hamper Malawi's progress towards achieving and sustaining epidemic control.  |
|  | 11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention. | U=U messaging is integrated into the Faith and Community Initiative component of Finding Men messaging. COP20 will include funding for national treatment literacy campaigns including funding for CSO demand creation and coordination via NAC.   |
|  | 12. Clear evidence of agency progress toward local, indigenous partner direct funding.  | COP20 will include three new government-to-government agreements with NAC, MOH, and MOF to increase government capacity to implement and deliver HIV services. Mechanisms to directly fund civil society organizations will also increase in COP20 as funding shifts from international organizations. |
|  | 13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.  | Through willingness to pay agreements as part of the Global Fund application process and investments in human resources for health via CHAM, the GOM continues to demonstrate an increasing commitment to investing in the HIV response.   |



|  |   |  |
|--|---|--|
|  |   | Malawi is expected to meet its Global Fund 2020-2022 co-financing requirement of \$76,940,862.   |
|  | 14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. | PEPFAR Malawi is using EMRS and active <u>tracing</u> systems for PLHIV who missed their appointments or defaulted from care to monitor morbidity and mortality outcomes. Mortality surveillance is being expanded through the national civil registration and vital statistics (CRVS) program. 12 out of the 28 districts will be covered by mortality surveillance as part of CRVS by end of FY20. |
|  | 15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.                       | National policy on using the national ID in health is being tested as part of the EMR rollout.   |

PEPFAR Malawi expects to fully implement retention-related PEPFAR Minimum Program Requirements at every PEPFAR-supported site, as these have a known impact on continuity of ART. Implementing partners will be assessed on site level implementation of the below four elements:

Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.

Rapid optimization of ART by offering TLD to all PLHIV weighing  $\geq 30$  kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing  $\geq 20$ kg, and removal of all nevirapine-based regimens.

Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.

Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.

## APPENDIX E– Malawi CSO Priorities being Addressed by PEFPAR

| CSO Priority  | How is this being addressed in COP 19  | HOW will it be addressed In COP 20  |
|---|--|---|
| <p>1. Fund</p> <ul style="list-style-type: none"> <li>i) 1,500 Expert Clients,</li> <li>ii) 50 Community Health Nurses,</li> <li>iii) 800 Sputum Collectors,</li> <li>iv) 50 Lab Assistants</li> <li>v) and standalone ombudsman in every facility in the 11 districts</li> </ul> | <ul style="list-style-type: none"> <li>✓ Currently funding over 1,500 expert clients</li> <li>✓ 13 Community Health Nurses, with 664 Nurse Midwife Technicians</li> <li>✓ No sputum collectors in current program, both Global Fund and World Bank have investments in this cadre</li> <li>✓ Currently supporting 49 Lab Technologists, 18 Lab Technicians and 25 Data Clerks in the labs</li> <li>✓ Improve HRH data quality and sharing</li> </ul> | <ul style="list-style-type: none"> <li>✓ Plan to increase the number of expert clients in COP20</li> <li>✓ Plan to add 15 more lab technicians and 15 more lab technologists at the request of MOH</li> <li>✓ Plan to maintain 372 surge support HCWs under CHAM and add 180 more (including the 30-lab staff mentioned above)</li> <li>✓ Plan to add 200 health workers through new <u>GoM</u> government-to-government mechanism</li> <li>✓ No ombudsmen planned</li> <li>✓ Harmonize TORs, share site level data, improve curricula (counselling)</li> </ul> |
| <p>2. Reduce Turnaround time to 15 days of a test being taken from ROC to LHIV receiving the results and improve Viral load counselling</p>   | <ul style="list-style-type: none"> <li>✓ Reducing TAT through hub automation and LIMS to EMR connectivity</li> <li>✓ Improving VL counseling through a) increased expert clients with improvements in counseling skills; b) standardized messaging developed with input from CSOs</li> </ul>   | <ul style="list-style-type: none"> <li>✓ Commitment from BMGF to develop SMS results alerts to further reduce TAT</li> <li>✓ Monitor VL counseling and concerns from PLHIV through CSO monitoring and hotline</li> <li>✓ Institute VL/EID POC at sites for sample tracking and patient communication</li> </ul>   |

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| 3a. Make urine-LAM and Xpert MTB/RIF Ultra testing as first line available in all settings | <ul style="list-style-type: none"> <li>✓ Advanced HIV roll out: 294 providers trained in all districts.</li> <li>✓ TB LAM kits and Xpert reagents procured through the Global Fund and supplied to prioritized facilities (district hospitals)</li> </ul> | <ul style="list-style-type: none"> <li>✓ There are currently 99 Xpert platforms, POC network optimization. Reagents procured by Global Fund.</li> </ul>   |
| 3b. Fund the procurement of optimal Cryptococcal meningitis drugs                          | <ul style="list-style-type: none"> <li>✓ Drugs are in the pipeline, procured through the Global Fund and sites will start implementing as soon as they receive the commodities</li> </ul>   | <ul style="list-style-type: none"> <li>✓ Global Fund procures commodities for advanced disease</li> </ul>   |
| 3c. Fund community led case finding, demand creation and contact tracing on TB (AHD,       | <ul style="list-style-type: none"> <li>✓ Community case finding of TB is a Global Fund activity through Action Aid in rural areas and NTP in urban areas with the outreach vans</li> </ul>  | <ul style="list-style-type: none"> <li>✓ Global Fund activities continue</li> <li>✓ USAID TB investment will support enhanced case finding and civil society engagement</li> </ul>  |
| 4. Ensure all PEPFAR facilities have cervical cancer screening and treatment equipment     | <ul style="list-style-type: none"> <li>✓ 184,973 WLHIV have received cervical cancer screening through PEPFAR at 39 of the highest volume facilities.</li> </ul>  | <ul style="list-style-type: none"> <li>✓ PEPFAR will expand cervical cancer screening in 41 additional sites, for a total of 80 facilities in 24 districts</li> <li>✓ Outreach screening efforts and referral for treatment to expand reach</li> </ul>  |
| 4a. PEPFAR should therefore fund procurement of STI drugs to avoid the stock outs          | <ul style="list-style-type: none"> <li>✓ PEPFAR supports OpenLMIS and is supporting digitization of stock data at 680 sites, as well as supports quarterly site level stock management supervisions (costs shared with non-PEPFAR funds).</li> </ul>      | <ul style="list-style-type: none"> <li>✓ STI drugs included in the 2021-2024 Global Fund grant application; commodities procured by MOH/Global Fund.</li> </ul> <p><b>Note:</b> While commodities for treatment of STI drugs are quantified and procured based on number of cases expected, these medicines are routinely used for other conditions due to overall shortage of antibiotics.</p> |

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| 4c. Support training of staff on cervical cancer screening and treatment    | <ul style="list-style-type: none"> <li>✓ Training support is underway through clinical partners targeting 39 PEPFAR supported sites with the highest volume of women living with HIV</li> </ul> | <ul style="list-style-type: none"> <li>✓ Training will continue with site expansion</li> <li>✓ A limited number of rained providers are present in sites not supported under PEPFAR.</li> </ul> |
| 5. Increase KP target by 50% of FY 2019 results with a new target of 64,590 | <ul style="list-style-type: none"> <li>✓ Agreement to meet KP constituencies to review KP program progress quarterly.</li> </ul>  | <ul style="list-style-type: none"> <li>✓ In recognition of the multiple risk factors facing MSW in Malawi, PEPFAR Malawi has committed to MSW targets for the first time in COP2020.</li> </ul> |