REPUBLIC OF MALAWI

Malawi National Strategic Plan for HIV and AIDS 2020-2025

Sustaining gains and accelerating progress towards epidemic control

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Foreword

As Malawi strives to meet the aspirations of the Agenda 2063 through the development of its own long-term development plan, the National Transformation Framework 2063; my Government recognizes that HIV is one of the major development risks that has to be mitigated. Therefore, through this National Strategic Plan (NSP) the country is committed to ensure that all necessary HIV and AIDS control measures are implemented so that we reduce the impact of HIV and AIDS and eliminate HIV as a public health threat by 2030 in line with the 2016 United Nations General Assembly Political Declaration on HIV and AIDS. We have favourable legal, policy and political environment to achieve this goal. My Government enacted the HIV and AIDS (Prevention and Management) Act number 9 of 2018 in order to create the conductive legal environment to prevent and manage HIV and AIDS; and HIV and AIDS prevention and management is one of the key priorities in the 2017-2022 Malawi Growth and Development Strategy III.

The development of NSP could not have happened at a more opportune time than this: Malawi has just successfully made significant achievements towards achieving the global 90:90:90 Fast-Track Targets set out in the predecessor NSP; there are a lot of new products and new evidence on strategies that can be used for the elimination of AIDS as a public health threat; and there has never been more commitment to end AIDS both nationally and globally.

This NSP comes at a time when there are some challenges. Despite achievements on the treatment targets, Malawi has lagged in its response to some key and vulnerable populations and still has unacceptably high numbers of new infections and AIDS related deaths. Malawi has not taken full advantage of the opportunities presented to it by the more advanced tools to combat HIV and AIDS. As such, this NSP calls for critical game changers that are cost-effective and targeted to achieve tangible impact on prevention, treatment and care services for HIV and AIDS and related infections. It requires building blocks at all levels of the health system from the national, local authority to community levels to be able to win and sustain the fight. This is the hallmark of this NSP. Using available evidence, program implementation experience and knowledge, it builds up on the emphasis of and achievement of scale that characterized the previous NSP, to focus on the delivery of targeted, high impact interventions and leaving no-one behind; while building a resilient and sustainable health system.

This NSP demonstrates the commitment of the Government of Malawi through the Ministry of Health, National AIDS Commission (NAC) and all partners and stakeholders in the fight against HIV and AIDS. It is a useful resource and provides guidance on the priorities of the government, the strategies recommended and the resources required to implement them. It will help to coordinate and consolidate all the efforts by all players in the HIV and AIDS sector for greater impact.

Honourable Khumbize Kandodo Chiponda, MP

Minister of Health

Acknowledgements

The Ministry of Health (MoH) and the National AIDS Commission (NAC) wish to express their gratitude to the various organizations working in HIV and AIDS sector from Government Ministries, Departments and Agencies, Civil Society Organisations, local and international Non-Governmental Organisation and Development Partners that contributed to the development of this NSP for HIV and AIDS 2020-2025.

The NSP was informed by comprehensive end-term internal and external review of the predecessor NSP; stakeholder consultations, literature review as well as mathematical modelling and economic analysis to come up with cost-effective health programs that will ensure that we efficiently and effectively meet our planned targets.

The development process of the NSP was fully participatory and consultative; it was coordinated by a National Steering Committee that was chaired by the Chief of Health Services in the MoH; and a Technical Team that was co-chaired by the Director of the Department of HIV and AIDS in the MoH and the NAC acting Chief Executive officer. A team of three technical consultants led by Dr Erik Schouten put this NSP together and the MoH Senior Management Team and the NAC Board of Commissioners inputted into and approved the final NSP.

We would like to thank all members of the Steering Committee and the Technical Team for their enduring commitment to the development of this NSP. Special appreciation should also go to the co- chairs of the Technical Team, Mrs Rose Nyirenda, Director of Department of HIV and AIDS in MoH, and Dr Andrew Gonani, Acting Chief Executive Officer of NAC for providing effective leadership and directing the process. Your passion, dedication and commitment to *'sustaining gains and accelerating progress towards HIV epidemic control'* in Malawi is acknowledged.

Finally, we would like to thank all partners that funded the process of developing the NSP, and those that provided technical assistance; in particular UNAIDS and the Clinton Health Access Initiative.

Dr Dan Namarika
Secretary for Health

Abbreviations and Acronyms

ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
CCI	Child Care Institution
CHW	Community Health Worker
CMST	Central Medical Stores Trust
CSO	Civil Society Organisation
DHA	Department of HIV and AIDS
DSD	Differentiated Service Delivery
EHP	Essential Health Package
EID	Early Infant Diagnosis
EMR	Electronic Medical Records
e-MTCT	Elimination of Mother to Child Transmission of HIV
EQA	External Quality Assurance
FAO	Food and Agricultural Organisation
FSW	Female Sex Worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoM	Government of Malawi
HCV	Hepatitis C Virus
HCW	Health Care Worker
HDA	HIV Diagnostic Assistant
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HRH	Human Resources for Health
HSA	Health Surveillance Assistant
HSSP	Health Sector Strategic Plan
HTS	HIV Testing Services
IEC	Information Education and Communication
KP	Key Population
LGBTI	Lesbian, Gay, Bisexual, Transgender, and/or Intersex
LMIS	Logistics Management Information System
LTFU	Lost to Follow Up
M&E	Monitoring and Evaluation
MBCA	Malawi Business Coalition Against HIV and AIDS
MBTS	Malawi Blood Transfusion Services
MDHS	Malawi Demographic and Health Survey
MDR	Multi-Drug Resistance
MoHP	Ministry of Health and Population
MoGCDSW	Ministry of Gender, Children, Disability and Social Welfare
MPHIA	Malawi Population-based HIV Impact Assessment

MSM	Men who have Sex with Men
MSW	Male Sex Worker
NAC	National AIDS Commission
NAF	National HIV and AIDS Framework
NCD	Non-Communicable Disease
NCHS	National Community Health Strategy
NGO	Non-Governmental Organisation
NSC	National Steering Committee
NSO	National Statistical Office
NSP	National Strategic Plan
OPD	Outpatient Department
PEPFAR	US President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission of HIV
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
POC	Point of Care
PrEP	Pre-Exposure Prophylaxis
PPM	Global Fund Pooled Procurement Mechanism
PSM	Procurement and Supply Management
SBCC	Social Behaviour Change Communication
SDG	Sustainable Development Goals
SRHR	Sexual and Reproductive Health Rights
SRHS	Sexual and Reproductive Health Services
STI	Sexually Transmitted Infection
TAT	Turn-Around-Time
TB	Tuberculosis
TF	Task Force
TMA	Total Market Approach
TPT	TB Preventive Therapy
TWG	Technical Working Group
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
VAPN	Voluntary Assisted Partner Notification
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
YFHS	Youth Friendly Health Services

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Executive summary

The Malawi National Strategic Plan (NSP) for HIV and AIDS 2020–2025 is the guiding document for the multi-sectoral response to the HIV epidemic for the next five years. It succeeds the 2015-2020 HIV NSP, building on previous achievements and addressing areas that need improvement with the goal of meeting 95:95:95 targets and eliminating HIV as a public health threat by 2030. Implementation of the previous NSP contributed to the dramatic decline in the number of new infections from 111,000 in 1992 to 33,000 in 2019 and the decline in AIDS deaths from 71,000 in 2004 to 13,000 in 2019.[1] As of September 2019, progress on the 90:90:90 UNAIDS Fast-Track targets was 93:84:92.

The vision of the new strategy is "*A health and prosperous nation free from HIV and AIDS*." This document outlines the mission, objectives, strategic interventions, activities, implementation arrangements and resources required over the period 2020-2025 to realise this long-term vision.

The strategy is aligned to various global frameworks including, but not limited to, the Sustainable Development Goals, the UNAIDS Fast Track Strategy, and the 2017 Global HIV Prevention Road Map. The strategy is also linked to local frameworks including, but not limited to, the Constitution of the Republic of Malawi, the HIV and AIDS (Prevention and Management) Act, the Malawi Growth & Development Strategy 2017-2022, the National Health Policy, the Health Sector Strategic Plan 2017-2022, and the National Gender Policy 2012-2017.

This NSP recognizes the ten Sustainable Development Goals (SDGs) that are key for ending the HIV epidemic (No Poverty; Zero Hunger; Good Health and Well-Being; Quality Education; Gender Equality; Decent Work and Economic Growth; Reduced Inequality; Sustainable Cities and Communities; Peace, Justice and Strong Institutions; and Partnerships for the Goals). Strong leadership and governance in all relevant sectors and strong, resilient and sustainable health systems are critical to the HIV response. Thus, this NSP prioritises a multisectoral response by highlighting the contributions needed from other sectors in order to achieve elimination.

To accelerate progress, this NSP continues to implement cost-effective and evidence-based interventions through the public health approach – the hallmark of Malawi's HIV program. While implementation of this NSP will target the entire population of Malawi, some prevention interventions will target geographies of high incidence and/or high-risk populations such as AGYW, men (including the elite), key populations, and vulnerable groups including migrant labourers. This NSP also prioritises integration and retention across HIV prevention, treatment, and care cascades and across diseases and conditions (in particular: Tuberculosis, Sexual Reproductive Health, Non-Communicable Diseases, Viral Hepatitis and Mental Health).

The NSP highlights ***game-changing strategies*** that will not only be key to achieving set targets in the next five years, but also put Malawi on the path to reach SDG Target 3.3 to end the AIDS epidemic by 2030 and contribute to National Health and Development goals. Key strategic interventions for the next five years include: (i) Expanding access to HIV services, especially to men, youths, and KPs; (ii) Strengthening district and community capacity for epidemic response; (iii) Strengthening private sector engagement in service delivery, workplace policies, and funding contributions; (iv) Improving HIV and STI surveillance, toxicity and drug resistance monitoring; (v) Improving the quality of prevention, treatment, care and support for

HIV and related diseases; (vii) Revitalizing workplace HIV and AIDS programmes; (vii) Implementing integrated service delivery and multi-sectoral approaches to governance and programming; (viii) Distributing condoms to the last mile using the Total Market Approach (TMA); (ix) Social, economic and legal empowerment of key and vulnerable populations; and (x) Increasing domestic private sector funding towards HIV epidemic control.

This NSP has eight thematic areas: (i) Combination Prevention; (ii) Differentiated HIV Testing Services; (iii) Treatment, Care and Support for HIV/AIDS and Related Diseases; (iv) TB/HIV; (v) Vulnerable Children; (vi) Reducing Human Rights and Gender-Related Barriers; (vii) Social and Behaviour Change Communication; and (viii) Resilient and Sustainable Systems for Health. Implementation of the NSP relies on a wide range of implementing partners including the public and private sectors, CSOs, FBOs, traditional leaders and development partners. The NAC will exercise its role as the coordinating body for the national response and will thus be responsible for monitoring and evaluating the implementation of the NSP. In order to put Malawi on the path towards elimination, implementation of this NSP will cost an estimated $1.22 billion US dollars over the five-year period.

1. Introduction

Malawi remains one of the countries with the highest HIV burden in Southern Africa: prevalence among adults 15 years and above is 9.3% and there are over one million people living with HIV (PLHIV). Disaggregated by sex, prevalence is 10.8% for women and 7.7% for men.[2] However, Malawi has made great strides towards epidemic control through a well-coordinated multi-sectoral response, including adoption of several policies such as the rapid scale-up of ART through the universal test and treat in 2016, continued scale up of Option B+ for prevention of mother to child transmission of HIV (PMTCT), introduction of HIV self-testing in 2018, the transition to Dolutegravir-based regimens in 2019 and strengthened efforts to increase voluntary male medical circumcision (VMMC). Malawi has also implemented primary prevention and structural interventions for adolescent girls and young women (AGYW) and key populations in selected districts. As of December 2019, over 850,000 people were on ART.

These efforts have contributed to a dramatic decline in the number of new infections from 111,000 in 1992 to 33,000 in 2019 and AIDS deaths from 71,000 in 2004 to 13,000 in 2019.[3] This new NSP focuses on sustaining these tremendous gains and accelerating progress through adoption of the latest evidence-based interventions.[4] The NSP prioritises game-changing strategies that will make a key contribution to Malawi's health and development goals, with an impact beyond SDG Target 3.3 to end the AIDS epidemic by 2030.

Malawi developed the first comprehensive National HIV and AIDS Strategic Framework for the period 2000-2004. Malawi followed this with the National HIV and AIDS Action Framework (NAF) 2005-2009, the Extended NAF 2010-2012, the NSP 2012-2016, and then the NSP 2015-2020. Malawi has used these strategic plans to guide the national response to the HIV and AIDS epidemic and mobilize resources for effective implementation of interventions. In pursuit of a healthy and prosperous nation free from HIV and AIDS, this new NSP provides the rationale and direction for key interventions that stakeholders and funding agencies should prioritize. The NSP 2020-2025 focuses on the following thematic areas:

1. Combination Prevention
2. Differentiated HIV Testing Services
3. Treatment, Care and Support for HIV/AIDS and Related Diseases
4. TB/HIV
5. Vulnerable Children
6. Reducing Human Rights and Gender-Related Barriers
7. Social and Behaviour Change Communication (SBCC)
8. Resilient and Sustainable Systems for Health (RSSH)

There is an urgent need to sustain and accelerate the national response between 2020 and 2025 in order to put Malawi on the path towards ending AIDS as a public health threat in Malawi by 2030. This can only be achieved by strengthening resource mobilisation, programmatic innovation, removing human rights barriers, political commitment and sustained leadership towards the response.

2. Situation analysis

2.1 Malawi context

Malawi is a relatively small (94,280 km^2 land area), densely populated (186 people/km^2) country in Southern Africa that borders Tanzania, Zambia, and Mozambique. Per the 2018 Population and Housing Census, Malawi has a population of 17.6 million. The total population increased by 35% between 2008 and 2018, representing an average annual growth rate of 2.9%.[5] The country is divided into three regions and 28 administrative districts, one of which is further divided into two health districts. Districts are further divided into a total of 433 Traditional Authorities (TAs) and then villages. Sixteen percent (16%) of the population resides in the four urban areas, 44% live in the Southern Region, 43% in the Central Region and then 13% in the Northern Region. The population is young – 51% of the population is under 18.[6] Eleven percent of this underage population are orphans – 39% of these orphaned children were orphaned by the HIV and AIDS epidemic. Ten percent of the population age five and older have at least one type of disability. Orphanhood and disability both increase vulnerability to poverty, gender-based violence (GBV), and other forms of structural violence, resulting in elevated risk of HIV infection in these subpopulations.[7]

Malawi is ranked 171 out of the 189 countries and territories on the 2019 Human Development Index.[8] Literacy is not yet universal– in 2018, an estimated 72% of males and 66% of females above age 5 are literate.[9] Poverty is widespread– 52% of the general population has consumption below the poverty line. Poverty is also concentrated in rural areas– 60% of people in rural areas experience poverty compared to 18% of people in urban areas. The prevalence of poverty is highest in the Southern Region at 65%, followed by the Northern Region at 60% and then the Central Region at 54%.[10] Malawi's GDP is estimated at US$381 per capita. Agriculture dominates Malawi's economy– it accounts for a third of GDP,[11] employs 64% of the workforce,[12] and constitutes over 80% of national export earnings.

Health services are free at the point of delivery in public facilities. Over the last decade, there has been a significant improvement in the health status of Malawians as demonstrated by various health outcomes. In the period from 2010 to 2015/16– as measured by the Malawi Demographic and Health Survey– the infant mortality rate decreased from 66 deaths per 1,000 live births to 42 deaths per 1,000 live births; the under-five mortality rate decreased from 112 to 63 deaths per 1,000 live births; and the maternal mortality rate decreased from 675 to 439 deaths per 100,000 live births. These declining trends in mortality among under five children and pregnant women have been observed since 2004.[13] Malawi was one of the few countries that achieved the MDG 4 target for child mortality well ahead of schedule.[14] The number of AIDS deaths has also significantly reduced from 32,000 in 2010 to 13,000 in 2019.[15] Despite this decline, AIDS remains the leading cause of death.[16]

2.2 HIV Epidemiology

The first HIV infection in Malawi was confirmed from stored blood samples collected in Karonga District in 1982[17] and the first AIDS case was documented in 1985. In 1987, an HIV prevalence survey among 30,000 workers in South African gold mines found 4% of Malawian men were HIV infected, while prevalence among workers from all other countries in the region (Botswana, Lesotho, Mozambique, Swaziland, South Africa) was still 0.03% or less.[18] **Table 1** provides a summary of the epidemiological estimates for the general population and for key populations at the end of 2019.

Table 1: HIV epidemic estimates at end of 2019. Source: 2020 Spectrum Model / UNAIDS Key Population Atlas.

Population	Age group	Gender	Pop. Size	PLHIV	Prevalence	New HIV infections	Incidence	AIDS deaths	AIDS mortality
General	All	All	18,748,000	1,060,000	5.7%	32,700	0.18%	13,100	70
General	15+	All	10,649,000	992,000	9.3%	30,000	0.31%	11,100	104
General	15+	Female	5,488,000	594,000	10.8%	17,000	0.35%	5,400	98
General	15+	Male	5,161,000	398,000	7.7%	13,000	0.27%	5,700	110
General	15-49	All	8,884,000	791,000	8.9%	28,600	0.35%	8,500	96
Pregnant	15-49	Female	622,000	43,000	6.9%	2,000	0.35%	NA	NA
General	15-24	Female	1,952,000	81,000	4.1%	8,400	0.45%	1,000	51
General	0-14	All	8,099,000	68,000	0.8%	2,700	0.03%	2,000	25
General	0-1	All	1,179,000	4,000	0.3%	2,700	0.23%	700	59
FSW	18+	Female	36,400	20,000	55%	NA	NA	NA	NA
MSM	15-49	Male	42,600	3,000	7%	NA	NA	NA	NA

2.2.1 HIV Infections

The latest epidemiological model estimates show that the number of new infections increased exponentially from 1980 and reached a maximum around 111,000 in 1992.[19] From 1994, new infections started to decline by approximately 3,000 each year reaching approximately 33,000 in 2019. The incidence decline started several years before prevention interventions reached any meaningful scale and before the introduction of free ART. This decline was likely driven by the saturation of high-risk networks and changes in sexual behaviour that are not well documented. Epidemiological models predict a continued, although slowing decline through 2025 and beyond. The projected decline shown in **Figure 1** implies that Malawi may miss the UNAIDS target of a 75% reduction in new infections between 2010 and 2020 – latest estimates show a 45% reduction of new infections from 56,000 in 2010 to 33,000 in 2019. An extrapolation of the current trend predicts around 17,000 new infections in 2030, which is equivalent to a 70% decline from the 2010 baseline. This suggests that the 90% UNAIDS target for the reduction of new infections might only be reached with significant scale-up of ART and other effective prevention interventions.

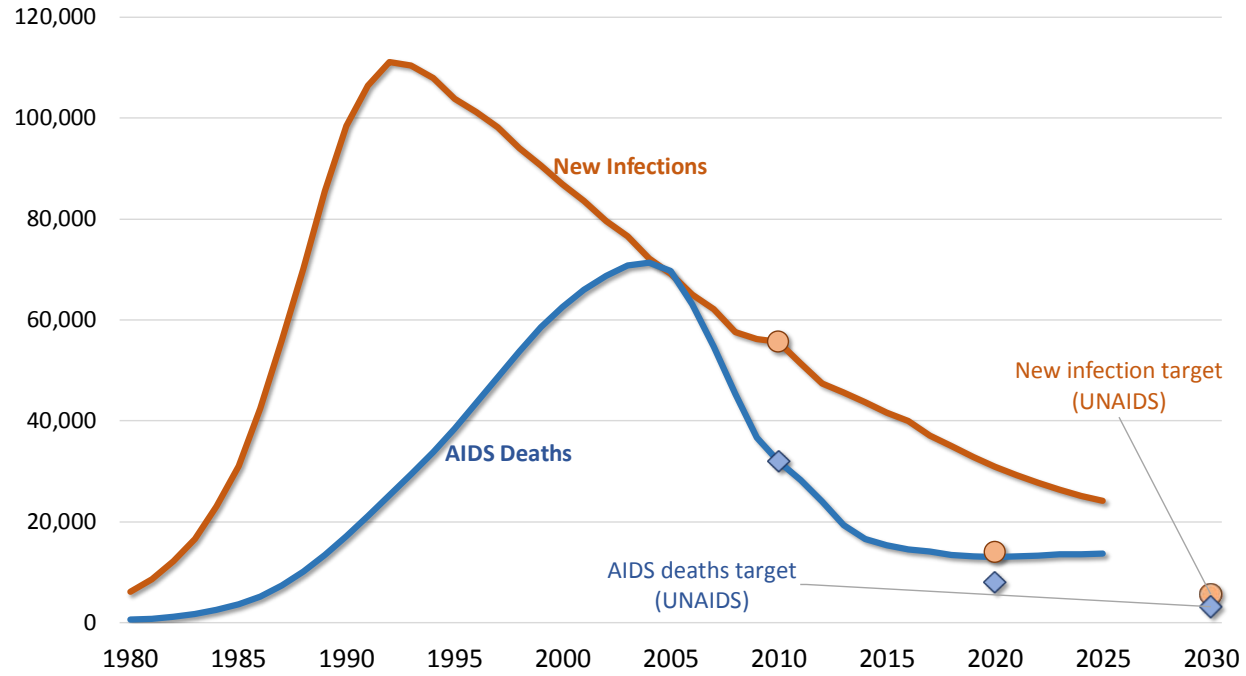


Figure 1: New HIV infections and AIDS deaths (all ages, 1980-2025).

The UNAIDS "elimination targets" are defined as a 75% and 90% reduction from the 2010 baseline by 2020 and 2030, respectively. Source: 2020 Spectrum estimates.

High HIV incidence among women in the late 1990s, coupled with high fertility, resulted in a wave of children who were infected by their mothers. Before the scale-up of routine HIV testing and PMTCT prophylaxis, over 25,000 new child infections occurred each year between 1997-2002. **Figure 2** shows the profound effect of the introduction of Malawi's "Option B+" policy in 2011 on the number of new child infections. Since the beginning of the HIV epidemic, a total of 569,000 children have been infected in Malawi and an estimated 95,000 infections have been prevented by PMTCT / Option B+.[20]

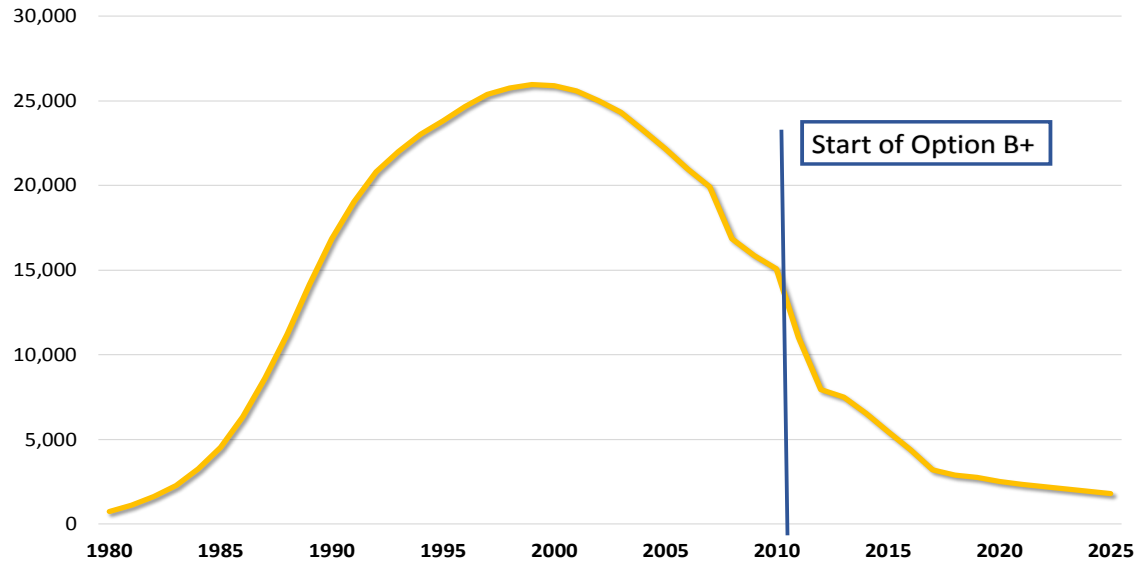


Figure 2: Number of children infected with HIV by their mothers (1980-2025). Source: 2020 Spectrum estimates.

2.2.2 Determinants of HIV Infection

HIV transmission in Malawi, like most other countries, is influenced by an interaction of structural, economic, social, biological, and cultural factors. Studies identify the following as key determinants of HIV infection in sub-Saharan Africa: background factors (e.g. age, gender, education, region of residence, circumcision, wealth/poverty, religion, and exposure to media), proximate HIV and AIDS factors (e.g. HIV and AIDS awareness, stigma, and discrimination), and sexual behaviour factors (e.g. condom use, number of sex partners, marital status).[21] The section below describes determinants and inequalities that increase vulnerability to HIV infection– all of which result in increased susceptibility of women, girls, transgender and key population groups to HIV.[22]

Poverty: Malawi is one of the lowest income countries in the world. About 50.7% of the population lives below the poverty line.[23] As mentioned above, Malawi's economy is primarily dependent on agriculture. The sector accounts for 38% of GDP[24] and over 80% of employment.[25] Tobacco, tea and sugar dominate exports – tobacco alone constitutes 60% of the total exports from Malawi.[1] Malawi's heavy dependency on agriculture creates economic vulnerabilities to factors like poor/heavy rains or fluctuating prices of agricultural commodities on the international market. High levels of unemployment, poverty, and low earnings often lead to transactional sex– situations in which condom use is inconsistent and low.[26] Further, the sizable proportion of workers employed in the informal sector creates additional barriers to reaching this high-risk population through their place of work.

Age mixing: Experts hypothesise that age disparities in sexual relationships are one of the main drivers of ongoing transmission between successive age-cohorts of younger women and older men. The 2015/16 Malawi Demographic and Health Survey (MDHS) estimated that on average, men in regular relationships are 5.1 years older than their female partners.[27] Reported age differences in previous surveys were comparable. There is little data on age disparities among non-regular partners, but it is plausible that differences are greater. An early sexual debut is associated with an increased risk of STIs– including HIV– and pregnancy. The percentage of young people (15-24) who have had sex by age 15 has decreased only slightly between 2000 and 2015/16 for both females (from 17% to 14%) and males (from 25% to 19%).[28] Particularly among girls, an early sexual debut is more common in rural areas and in the southern region. There is also a strong association with education levels: while 26% of those with no education had sex before age 15, this measure is only 3% amongst those with education beyond secondary school. **Figure 3** shows the estimated age distribution among the estimated 33,000 new infections in 2019.[3] About 25% of all new infections occurred among AGYW and 20% among men aged 20-29 years. Adults ≥30 years contributed 35% of all new infections.

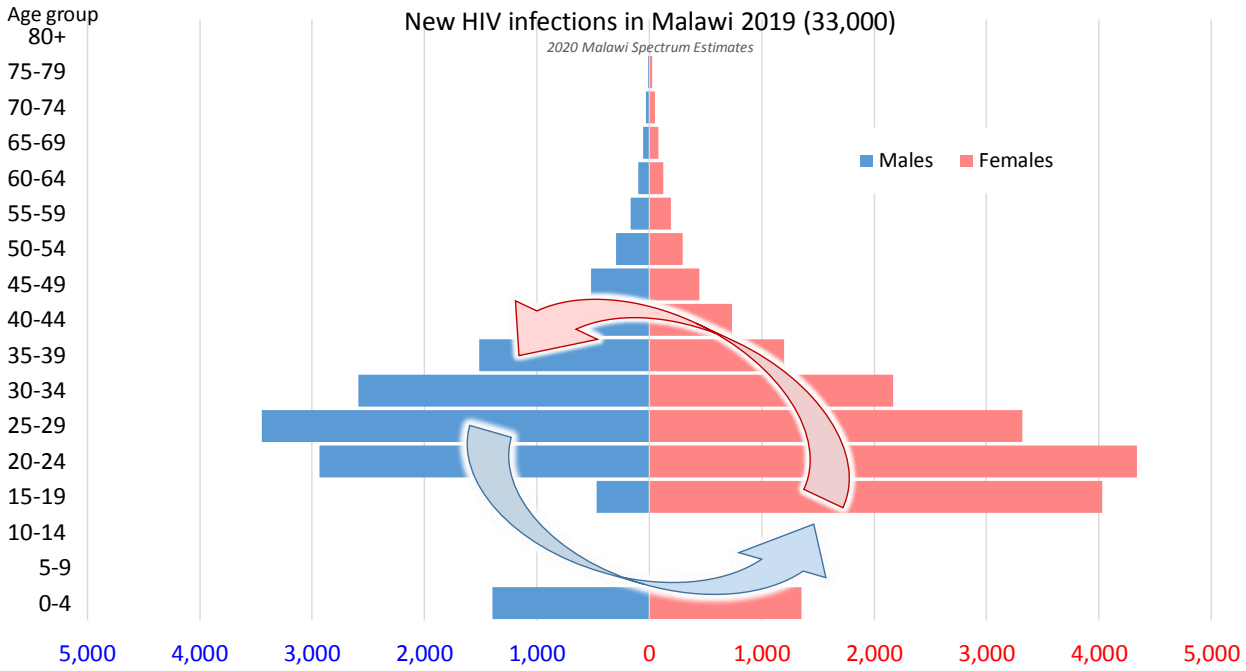


Figure 3: Age and sex-distribution of new HIV infections in 2019. Source: 2020 Spectrum estimates.

Key Populations (KPs): Over the last decade, Malawi has increased the amount of information collected on key populations from specialised surveys and service data. This has resulted in improved estimates for population size, HIV prevalence, and access to services. However, due to the stigma surrounding Men who have Sex with Men (MSM), transgender persons (TGs), and Female Sex Workers (FSWs), considerable uncertainty remains about the representativeness and generalizability of the subset reached. HIV prevalence was estimated at 55% and 7% among FSWs, and MSM, respectively. [29] Based on these latest estimates, around 4% of 33,000 new infections in the 2019 population were among FSWs, 3% among clients of FSWs and <1% among MSM.[30] Considering new HIV infections among clients of SWs and female partners of bisexual men, as well as the continued onward transmission in the future, the proportion of new HIV infections associated with KP transmission dynamics is likely substantially greater.

Geographical variation*:* HIV burden varies considerably by geographical area. Prevalence is overall closely associated with population density, which is much greater in urban areas and in the Southern region. In **Figure 4**, the map on the left shows incidence (the lighter the colour, the higher the rate) and the number of new infections in 2019 (size of the balloon), indicating that incidence is much higher in the cities and in the southern districts. However, the total number of new infections is strongly influenced by the district population size – large populous rural districts such as Mangochi, Mulanje, Chikwawa, and Zomba contribute a disproportionately large proportion of total new infections.[31] The map in the centre shows a consistent trend of higher prevalence in the cities and in the south of the country. The map on the right shows that the estimated ART coverage among PLHIV is high and remarkably similar in all districts, signifying equitable access.

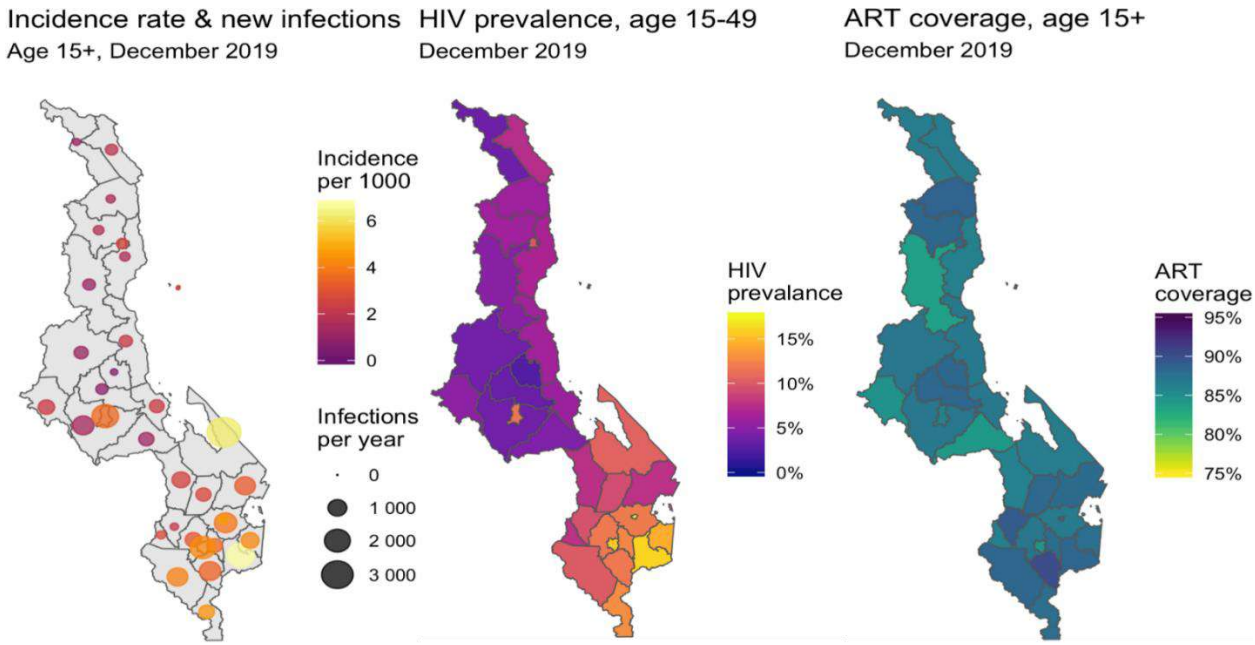


Figure 4: HIV incidence, prevalence, and ART coverage. Source: 2020 Spectrum estimates.

Gender inequality: Gender norms influence access to HIV prevention, testing, treatment, care and support for women and girls, men and boys, other genders, and key populations.[32, 33] In Malawi, many women have limited power over their own sexual health– a substantial barrier to access to care. While there has been a drastic increase in the percent of married women who report participation in decision-making about their own health care (68% in 2015/16, up from 55% in 2010),[34] there are still far too many women who do not have a say in their own health. If a woman's husband has an STI, 12% of men disagree that she is justified in asking that they use a condom. Gender-based violence is both a cause and consequence of HIV and a critical barrier to access to services.[35] Among all women aged 15-49 who have experienced physical violence since age 15, nearly half (46%) report that their current husbands were the perpetrators of the violence, and 26% report that former husbands were the perpetrators. Among females age 18-24 years, 55% report experiencing some form of violence– sexual, physical, or emotional– during their childhood.[36] It is only when we begin to understand these gender inequalities as determinants of HIV transmission that we can prioritize interventions that tackle these underlying causes.

2.2.3 AIDS Deaths

Since the start of the epidemic in the 1980s, an estimated 1.2 million Malawians have died of AIDS. **Figure 5** shows the number of annual AIDS deaths among men, women, and children between 2007 and 2017. The AIDS death wave peaked at 71,000 in 2004 and started to decline rapidly with the introduction of free ART later that year. Malawi's rapid and successful scale-up of ART between 2004 and 2019 averted an estimated 500,000 AIDS deaths and gained 4.1 million life-years, primarily among young adults in their peak productive life period. As shown below, the Institute for Health Metrics and Evaluation estimated that AIDS mortality decreased by 72% between 2007 and 2017 but remained the leading cause of death in Malawi in 2017.[37]

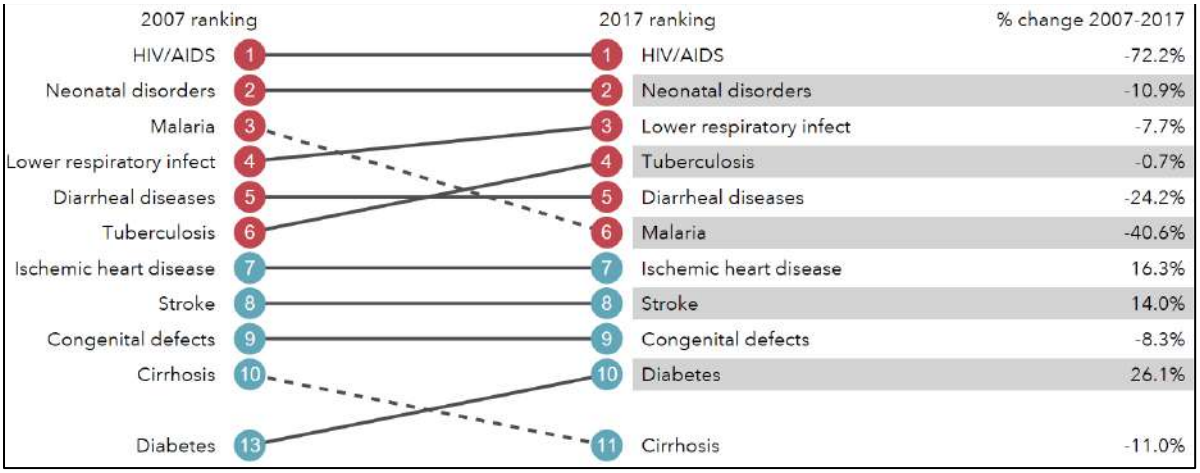


Figure 5: Top 10 causes of death in 2017 and percent change in Malawi, 2007-2017, all ages. Source: Institute for Health Metrics and Evaluation.

Malawi's population is projected to increase by 2.7 million in this NSP period, from 19 million in 2020 to 21.7 million in 2025.[38] Due to this rapid population growth, HIV incidence and prevalence have declined much more rapidly than the absolute number of new infections and PLHIV. The growing (HIV negative) population potentially at risk of HIV infection from PLHIV not on ART will pose a considerable challenge for primary prevention interventions as the declining number of new infections will be "hidden" in a large and growing HIV negative population. The expected relationship between PLHIV, ART, population growth, and new infections is captured in **Figure 6** below.

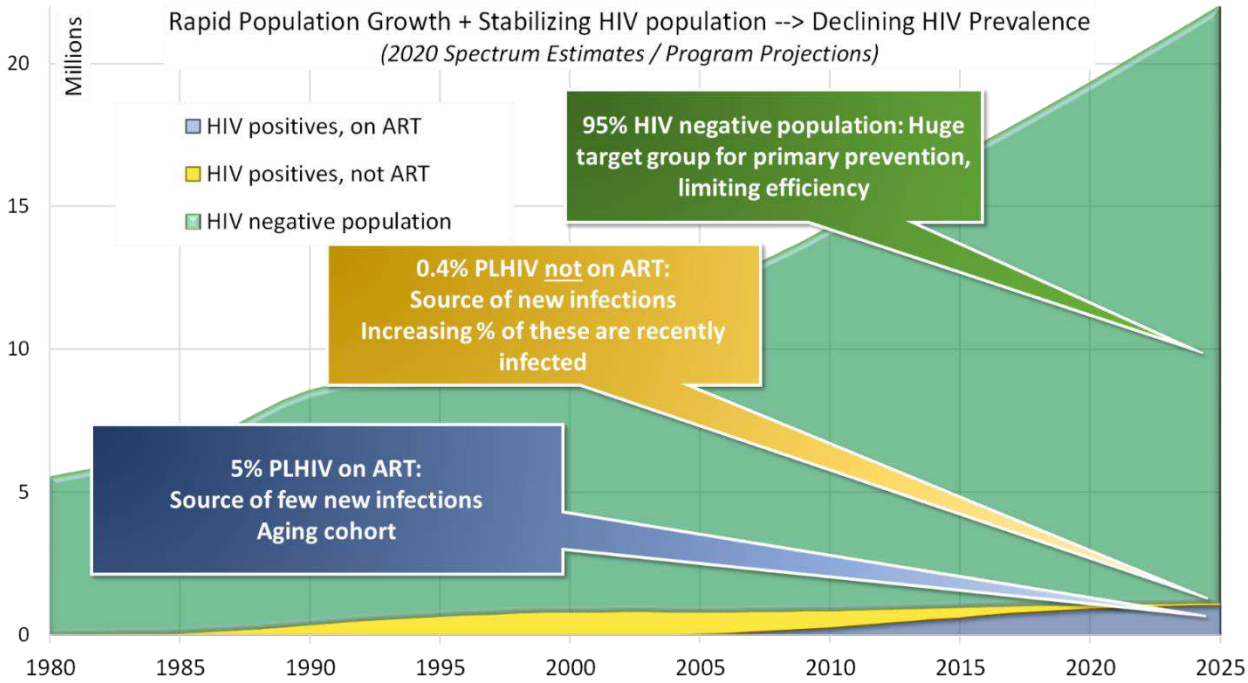


Figure 6: Rapid population growth and a stabilizing HIV population result in declining HIV prevalence. Sources: 2020 Spectrum estimates and program projections.

The total number of PLHIV (men, women, and children) over the period 1980-2025 is illustrated in **Figure 7** below.

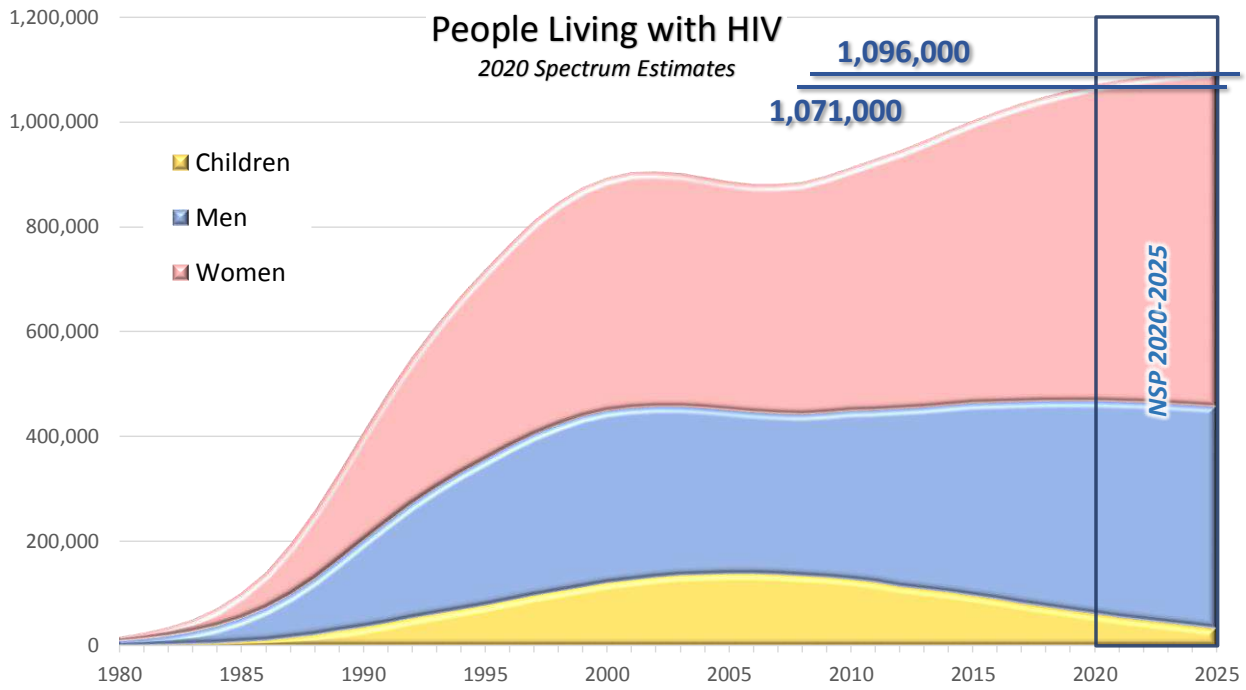


Figure 7: Number of PLHIV 1980-2025. Source: 2020 Spectrum estimates.

The latest epidemiological models estimate that the annual number of deaths among PLHIV will increase and reach over 20,000 in 2025. Over 95% of these deaths will be among patients in care. This is due to the aging of the ART patient cohort, bringing about long-term treatment complications: delayed diagnosis of treatment failure from adherence problems and emerging drug-resistance leading to deaths from opportunistic infections such as TB, cryptococcal meningitis, bacterial sepsis, and malignancies such as cervical cancer. A significant mortality burden is exacted by undiagnosed and poorly managed non-communicable diseases (NCDs) such as hypertension, dyslipidaemia and diabetes. In order to curb this second wave of deaths in the next 5 years and beyond, it will be critical for Malawi to ensure the availability of basic medical commodities and services and increase staffing numbers, clinical expertise, and diagnostic capacity.

2.3 Progress during the NSP 2015–2020

This section provides a situation analysis of the successes and challenges of Malawi's efforts in prevention of HIV transmission, 90:90:90 targets, and health systems strengthening during the NSP 2015-2020 period.

2.3.1 Prevention of HIV Transmission

Malawi is determined to meet the prevention goals required to end HIV/AIDS as a public health threat in the next decade. The 2015-2020 NSP aimed to reduce new infections from 56,000 in 2010 to 25,000 in 2020. With the nation's commitment to the Global HIV Prevention Coalition, Malawi revised this 2020 target to be even more ambitious – 11,000 new infections in 2020. However, the latest epidemiological model estimates that there were 33,000 new infections in 2019,[39] indicating that Malawi may not meet either target. While Malawi has made tremendous progress towards the 90:90:90 testing and treatment targets, the country has fallen far short of its prevention goals. Despite unprecedented scale-up of many

prevention programs, thus far Malawi has not achieved any of the targets set in the five prevention pillars defined by the Global Prevention Coalition.

Reflecting back and looking ahead, Malawi will continue to build on existing efforts from the past NSP to strengthen leadership, governance, and financing for prevention; scale-up high-impact cost-effective interventions to targeted populations; and identify new ways of doing business[40] in order to accelerate progress in HIV prevention. Malawi will also prioritise collaboration with the private sector, which recently made global commitments to ending AIDS.[41] This was a strategy not highlighted in the past NSP but is one that features prominently in this new NSP.

The sections below provide a situation analysis of the successes and challenges in the past NSP period for prevention programming.

***Condom and Lubricant Programming*:** Condoms are a simple, low-cost intervention that when used correctly and consistently, are highly effective at reducing sexual transmission. In the 2015/16 MDHS, 27% of men and 10% of women reported having sex with a non-regular partner and 13% of men and 1% of women reported having more than one partner in the 12 months preceding the survey. [42] The 2015/16 MDHS also found that 18% of men have paid for sex at least once in their lifetime, and 7% have done so in the 12 months preceding the survey.[43] Given that unprotected sex is the primary mode of transmission in almost all populations – including sero-discordant couples, MSM and FSWs – condoms are one of the most cost-effective methods that reduce the risk of infection from high-risk sexual behaviour.

Since the publication of the National Condom Strategy in 2015 and the Revised National HIV Prevention Strategy in 2018, Malawi has significantly expanded its condom and lubricant programming. Malawi distributed 102 million male condoms in 2019, a 73% increase from the 59 million condoms distributed in the one-year period from mid-2016 to mid-2017.[44] Malawi also distributed 1.5 million lubricant sachets in 2019, nearly doubling the number distributed in 2017.[45] Knowledge has increased as much as distribution: in 2015/16, 70% of the men and women knew that using condoms and limiting sexual intercourse to one uninfected partner reduces HIV risk, compared to 63% of men and 47% of women in 2004.[46] Condom use among men reporting paying for sex increased from 61% in 2010 to 75% in 2015/16.[47]

The key successes from the past NSP period that have led to this progress include: the launch of the Revised National Condom Strategy, which provides a framework for a Total Market Approach (TMA) using the comparative advantages of all sectors such as public, non-profit, and commercial, to strengthen programs that distribute condoms for the prevention of HIV; the use of parallel distribution channels to the public sector supply chain system, including community-based distribution agents (CBDAs) and a dedicated distribution channel for condoms and lubricants for KP service providers; and the introduction of lubricants into ongoing KP programs.[48] There is still progress to be made, however – while the number of female condoms distributed increased 14% from 470,000 in a one-year period (mid-2016 to mid-2017)[49] to 538,000 in 2019, both knowledge and use of female condoms remains unacceptably low.[50] Uptake of non-branded condoms has remained lower. In order to achieve incidence reduction goals, condom programming must further increase community knowledge, access, and acceptability.

Condom use in the populations with the highest HIV burden remains a significant challenge. Condom use at last high-risk sex was lowest in the Southern region where the HIV burden is the highest.[51] Condom use at last high-risk sex was also lower among both females and males residing in rural areas, compared to those in urban areas.[52] Condom use at last high-risk sex is lowest among women with no education (27%).[53] While condom use at last high-risk sex is highest among women 15-19 years (60%) and 20-24 years (46%),[54] future condom programming efforts must continue to improve uptake amongst AGYW.

***Pre-Exposure Prophylaxis (PrEP*)**: Based on evidence from clinical trials as well as WHO recommendations, the MoHP approved PrEP in 2018 as an additional prevention intervention for individuals at substantial risk of acquiring HIV, such as key and vulnerable populations including FSWs and MSM. PrEP is currently available for KPs at selected service delivery points in Lilongwe and Blantyre districts. Malawi has incorporated PrEP (TDF/3TC) into Clinical HIV Guidelines, written a PrEP guidance for the targeted population and developed an implementation plan which proposes a phased implementation approach based on HIV incidence and facility readiness. Challenges in the implementation of the PrEP programme include adherence to the daily regimen, inadequate laboratory capacity, and demand generation.[55]

Voluntary Medical Male Circumcision (VMMC): Medical male circumcision reduces the risk of female-to-male sexual transmission of HIV by approximately 60%. In contrast with any other available intervention, VMMC provides lifelong partial protection against HIV and other STIs. Based on this evidence, in 2007, WHO recommended VMMC as a high-impact cost-effective method for HIV prevention, particularly in settings with high HIV prevalence and low levels of male circumcision.[56]

Malawi initiated an expansion of its VMMC program in 2012 in response to the recommendation from WHO.[57,58] The MoHP and its partners currently provide VMMC services through two different approaches:[59] (1) Support to district health councils to integrate VMMC services in static public health facilities; and (2) The deployment of dedicated teams that provide VMMC services on designated days at health facilities, in communities, or other priority institutions. At each VMMC service delivery point, VMMC is provided as part of a comprehensive package of clinical and preventive services.[2]

Nationwide, the prevalence of reported male circumcision in Malawi increased slightly from 22% in 2010 to 28% in 2015/16,[60] although the district prevalence varied widely. Circumcision rates were lowest in the North (6%) and highest in the South East (58%), due to higher rates of traditional male circumcision[61] practiced by some ethnic and religious groups in Malawi. Traditional male circumcision accounts for roughly two-thirds of all reported circumcisions.[62] Muslims have the highest rate at 80%.[63]

Circumcision is much more common among men with more than secondary education compared with men with no formal education (22% vs. 2.5%). Circumcision coverage was highest in the 15-24 years age-group,[64] implying that the peak HIV incidence age groups are yet to benefit from this intervention. Program data indicate that demand for VMMC is high among boys under 15 years but lower among older

[2] The VMMC minimum package includes group education, HIV testing and counseling, STI management, and age-appropriate reproductive health services including risk reduction counseling, post-operative care, and provision of condoms.

men, where impact would be greatest. In the 2015/16 MPHIA, only 10% of males aged 15-64 years reported receipt of VMMC.[65]

While the NSP 2015-2020 set a target for 2,458,727 circumcisions conducted among males aged 10-34 years over the five years,[66] only 939,573 VMMCs (38%) had been performed by December 2019, falling far short of the target.[67] However, several recent successes have moved Malawi closer to its coverage target set in the NSP 2015-2020. The level of awareness of VMMC intervention in the community is significantly higher and there has been success in piloting and implementation of new devices.

The key challenges identified in previous VMMC scale-up included: (i) inadequate funding (ii) inadequate demand generation activities, (iii) cultural and biological misperceptions about the procedure, including the link between male circumcision and cultural identity (iv) inadequate space in health facilities, (v) the fact that VMMC is not integrated and routinized into service delivery and HIV prevention programs,[68] and (vi) perceived complications and inconveniences associated with the procedure.[69]

Adolescent Girls and Young Women (AGYW): AGYW account for 74% of new HIV infections among adolescents in sub-Saharan Africa.[70] There are 1,952,000 females aged 15-24 in Malawi, representing 10% of the total population, but accounting for an estimated 25% of all new HIV infections in 2019. Structural gender inequalities and discriminatory cultural norms lead to lower enrolment in schools, unsafe sexual relations, gender-based violence (GBV), inadequate access to SRH, early pregnancy and marriage, and high-risk sexual behaviour by their male sexual partners. These conditions put AGYW at great risk for violence, abuse, and exploitation – all of which are risk factors for HIV infection.

Driven by age disparities in sexual relationships, HIV incidence is eight times higher among AGYW at 0.40% than among adolescent boys and young men (ABYM) at 0.05%.[71] HIV prevalence is almost five times higher among AGYW at 5% than in ABYM at 1%. Epidemiological models suggest the primary source of infection for AGYW age 20-24 are men age 30-34,[72] and treatment and prevention efforts targeting middle-aged men may have the most significant impact on reducing new infections among AGYW.

Alcohol and substance abuse in adolescents contribute substantial range of risks with adverse effects including crime, sexual risk taking, sexual abuse, mental health problems and accidents. Prevalence of heavy episodic drinking in 15-19-year olds (consuming at least 60 grams or more of pure alcohol on at least one occasion in the past 30 days) is at 60% in males and 24% in females. Adolescents living with HIV and AIDS are likely to have depression.

Malawi increased focus on AGYW in 2016, coinciding with the launch of the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) program in October 2016 and also the Global Fund support towards AGYW. In eight districts, PEPFAR and Global Fund support provision of a comprehensive package of services that go beyond the health sector to address the structural inequalities that impact both AGYW and ABYM vulnerability to HIV. The comprehensive package of interventions are delivered in high burden districts consisting of information and delivery of HIV prevention interventions, reproductive health services, post-GBV care, violence prevention and perceived HIV risk determination, social asset building, back to school support, and village savings and loans programming. In medium and low burden

districts, GoM will implement a referral system to ensure that AGYW have access to broad-based services across different sectors.

GoM has also committed to cross-sectoral coordination and collaboration among the Ministry of Education Science and Technology; Ministry of Health and Population; Ministry of Gender, Children Disability and Social Welfare; and Ministry of Youth, Sports and Culture. These core Ministries are collaboratively addressing the needs of AGYW and in 2018 they directed and launched the National AGYW Strategy. The launch of this strategy and a functional secretariat have already improved multi-sectoral coordination of GoM and partner activities. Key challenges in the implementation of the AGYW strategy include inadequate funding, limited effective coordination and sub-optimal awareness about the existence of the Strategy.

Key and Vulnerable Populations: In Malawi, FSWs, male sex workers (MSWs), MSM, TGs, and people who use inject drugs (PWIDs) are considered key populations while prisoners, migrant labourers, persons displaced due to emergencies, uniformed personnel, AGYW and persons with disabilities are considered vulnerable populations.

Key and vulnerable populations constitute a small proportion of Malawi's population, but they are at disproportionate risk of acquiring and transmitting HIV. Stigmatization, discrimination, and criminalization of same-sex relationships, sex work, and drug use constitute a major barrier to access and uptake of HIV prevention and treatment services by the KP community.[73] Due to prevailing stigma and discrimination, many KPs especially MSM and TGs are hidden while FSWs continue experiencing sexual violence which is often unreported. Meanwhile, the practice of men having sex with men puts male inmates at risk of HIV infection.[74] The delivery of services in a stigma free environment with active involvement of the KP community increases the uptake of HIV services.

Stigma and discrimination associated with their identity, sexual orientation and behaviour have led to undercounting and underreporting, making it difficult to ascertain accurate population sizes, incidence, and prevalence estimates. One survey estimated that there are about 36,700 FSWs and 9,698 MSM reachable in venues where people meet new sexual partners.[75] However, the UNAIDS KP Atlas estimates that there are between 36,400 and 42,600 MSM in total.[76] In 2017, HIV prevalence among FSWs residing in six high burden districts of Blantyre, Lilongwe, Mzimba North, Mangochi, Machinga and Zomba was at 60%.[77] An earlier nationwide study found an HIV prevalence of 63% among FSWs.[78]Among MSM, HIV prevalence was at 18% in a study conducted between 2011 and 2014.[79] In contrast, in 2017 the LINKAGES project found a lower than expected HIV prevalence of 7% among MSM residing in four high burden districts of Blantyre, Lilongwe, Mzimba North and Mangochi.[80] While prevalence is lower in medium and small prisons, it is 41% among male and 42% among female inmates in central prisons. A lack of national population estimates for MSW, TGs, and PWID make it difficult to develop programming to support these key populations.

The Government of Malawi has demonstrated robust political will and commitment to bring to scale effective and efficient tailored high impact interventions for key and vulnerable populations. To enhance the delivery of quality of service to key and vulnerable populations, the GoM with participation of the KPs has developed policy documents and tools such as the HIV Prevention Strategy, the National Key

Populations Standard Operating Procedures, the Condom Strategy, Pre-exposure Prophylaxis Guidelines, the integrated prevention reporting tools and proposed prevention database.

Currently, the Global Fund, MSF, and PEPFAR provide support to enable delivery of KP interventions in the country. Some public facilities also support key populations, the majority of which are FSW. In 2019, there were 19 drop-in-centres (DICs) operating in six districts– Blantyre, Lilongwe, Machinga, Mangochi, Mzimba North, and Zomba. Four of these DICs are for MSM and TG persons and the remaining 15 are for FSWs and clients of FSWs.

Structural challenges limit the impact of KP programming. While the national KP technical working group (TWG) is well-organized, district and sub-district level coordination mechanisms have yet to effectively replicate this success. Furthermore, the KP community is loosely organized and limited in its advocacy capacity – it will be necessary to empower the community to maximize its impact in the HIV space. Finally, the paucity of KP data limits the ability of government and partners to base decisions on evidence.

***Vulnerable Children*:** Malawi's definition of a vulnerable child considers four vulnerability factors: (i) children living in a household in the bottom three wealth quintiles; (ii) children not living with either parent; (iii) children living in households with adults with no education; and (iv) children who have lost one or both parents. The definition of a vulnerable child also includes children with disabilities and those living with HIV, who can also have any of the four vulnerability factors.[81] Based on this definition, there are about 1.8 million vulnerable children in Malawi– 53% of them are girls and 47% are boys. These factors significantly contribute to high levels of child labour, teenage pregnancy, child marriage, early sexual debut, placement of children in orphanages and other childcare institutions, children living in the street, low education and poor health outcomes, among children.

High poverty levels contribute to child labour practices: 38% of the children aged 5-17 are involved in child labour.[82] Many children are trafficked for labour and sexual exploitation.[83] Orphans may be exploited to engage in child labour or transactional sex in order to earn a living.[84] While deaths of adults due to AIDS have significantly declined, Malawi still has many orphans, half of whom are orphaned from AIDS. The prevalence of violence against children, both girls and boys, across the country is quite high: two thirds of Malawian children experience extreme forms of violence in their lifetime. The 2013 national survey on violence against children and young women found that one in five females and one in seven males experienced at least one incident of sexual violence before turning 18.[85] High rates of child marriage also persist in Malawi.[86] It is common for girls to marry men much older (transgenerational marriages), which puts girls at risk of contracting STIs including HIV.

There are also some harmful practices that enhance the transmission of HIV. A 2018 harmful practices survey found that while initiation ceremonies are practiced nationwide, they primarily occur in the southern region: 47% of the respondents acknowledged that sexual instruction is a regular activity during girls' initiation ceremonies and that at the end of the initiation ceremonies a man performs sex to conclude an initiation ceremony, activities that may enhance the transmission of HIV.[87]

In addition to child labour, orphanhood and child marriage, children in institutions are also vulnerable: there are 169 childcare institutions (CCIs) in Malawi which care for nearly 9,000 children. Orphanages and

other CCIs primarily emerged in the 1990s as a way of responding to the orphan crisis primarily caused by HIV and AIDS. While Malawi's policy on orphans and other vulnerable children recommends that children should grow up in families and socialize with other children in the wider community, institutionalization is the first resort for some families. Studies have generally shown that while CCIs provide the material needs of children, challenges include cases of sexual abuse of children by CCI staff and fellow children in some CCIs, the meting out of corporal punishment and other physical, verbal and emotional forms of violence against children. In 2017, 105 children living with HIV in institutions who needed special care. In addition to this, girls especially are vulnerable as they may be at risk of contracting HIV.[88]

Vulnerable children experience a wide range of challenges including lack of food, clothing, shoes, school materials and shelter. This has negative impacts on school enrolment and attendance and these children can drop out of school and seek work, engage in sex work or even engage in child marriage. Due to the high poverty level they may experience, vulnerable children may also fail to timely access health services.

The 2015/16 MDHS found that about 25% of the children lived with foster parents.[89] Children also experience different forms of violence and it is mostly girls and women who experience more violence compared to boys. For example, in 2013 about 23% of the females and 13% of the males aged 13-17 reported that they experienced sexual violence in the 12 months prior to the survey. This survey also found that 41% of females and 60% of the males aged 13-17 reported experiencing physical abuse in the 12 months prior to the survey.

Throughout the country, there are weak referral and complaint pathways for victims of violence within communities as well as violence prevention strategies. The recurrent humanitarian crisis in Malawi has resulted in an increased caseload on existing service providers (social workers) and consequently an additional strain in the delivery of social services. This is compounded by the absence of competent and well qualified personnel to be able to prevent and respond to victims of violence, abuse, exploitation, neglect and impacts of HIV and AIDS. Although the GoM has established One Stop Centres and the national child protection system which, among other things, ensure that children who are HIV positive have access to counselling services, GoM has yet to roll out the system to all districts.

Elimination of Mother to Child Transmission (e-MTCT): e-MTCT is a priority program and the means for eliminating paediatric HIV in Malawi. The introduction of lifelong ART for all HIV+ pregnant and breastfeeding women regardless of clinical staging or CD4 count in 2011 (Option B+) led to a significant reduction in MTCT transmission rates and a significant decrease in the number of new infections in children. Since the introduction of Option B+ in 2011, 76,420 paediatric infections have been averted.[90] By 2019, the transmission rates decreased to 2% at six weeks after birth and 7.6% at the end of the breastfeeding period, resulting in 3,336 new infections among children. A major component of PMTCT is the universal access to HIV Testing Services (HTS) for mothers at antenatal clinics (ANC) and maternity wards. By the end of 2018, 93% of the eligible women attending ANC and 50% of eligible women attending maternity services were tested for HIV. Almost all known HIV infected women (98%) in ANC and 99% HIV infected women admitted to maternity received ART. In addition, 87% of the women attending ANC were screened for syphilis.[91] HIV prevalence among ANC clients has declined to around 7% and over 95% of HIV positive pregnant women were on ART. The proportion of pregnant HIV positive women that is already on ART before conception increased to 70% and could reach 85% by 2025, as seen in **Figure 8**.

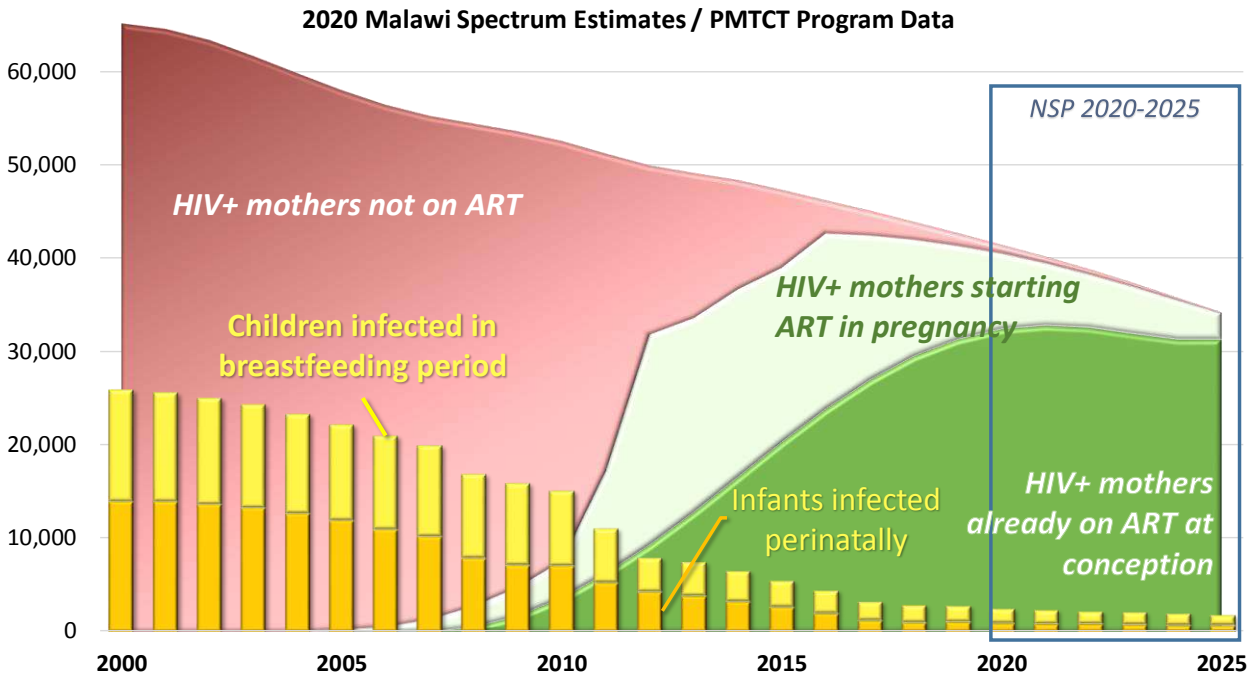


Figure 8: Progress made in the e-MTCT program and projections for 2020-2025. Source: 2020 Spectrum estimates and PMTCT program data.

Figure 9 shows that in 2019, over 50% of MTCT occurred during the breastfeeding period, either from mothers infected during the breastfeeding period or mothers who discontinued their medication.

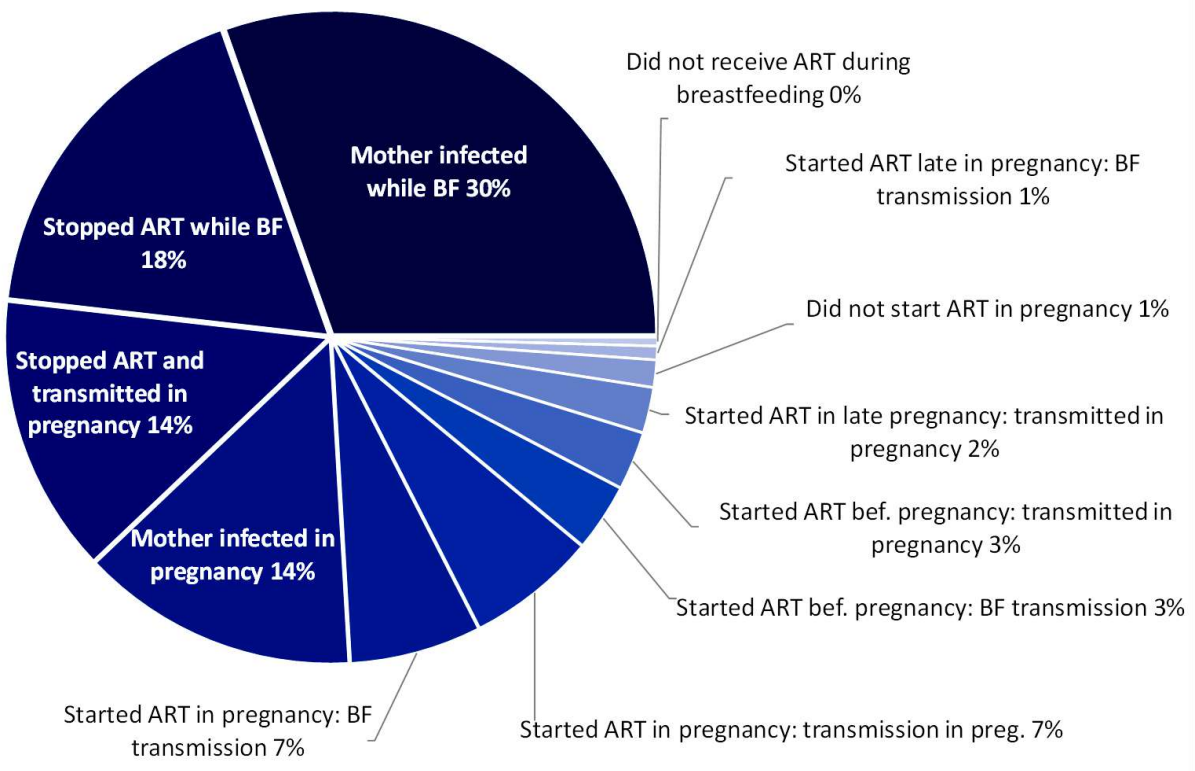


Figure 9: Sources of the 2500 children infected by their mothers in 2019. Source: 2020 Spectrum model estimates

While Malawi has made significant progress in the prevention of MTCT of HIV, the following challenges delay the achievement of the international goal of virtual e-MTCT:

1. Mothers presenting to ANC late in pregnancy, delaying HIV testing and linkage to ART and HIV prevention.
2. Poor maternal retesting coverage around birth and during the breastfeeding period;
3. More children getting infected during breastfeeding than during the pregnancy period;
4. Sub-optimal uptake of syphilis screening among pregnant women compared to HIV;
5. Insufficient HIV testing coverage of male partners of AGYW, pregnant and breastfeeding women within the PMTCT program;
6. Lack of routine viral hepatitis screening among pregnant and breastfeeding women.
7. High proportion of unintended pregnancies in HIV-positive women.[92,93]

***Sexually Transmitted Infections (STIs) and Sexual and Reproductive Health Services (SRHS)**:*

The presence of an untreated STI can enhance both the acquisition and transmission of HIV and viral hepatitis by a factor of up to 10.[94] Hence, WHO recommends STI services as part of a comprehensive HIV prevention package.[95] The 2015/16 MPHIA indicated that there is significant under diagnosis of STIs in Malawi: among HIV-positive males aged 15-64 years, 16% reported to have had a genital ulcer, 5% have had abnormal discharge from the penis, but only 6% had been diagnosed with an STI in the 12 months preceding the survey. Among HIV-positive females aged 15-64 years, 12% reported to have had a genital ulcer, 11% to have had abnormal discharge from the vagina, but only 7% had been diagnosed with an STI in the 12 months preceding the survey.

Program data has shown an increasing demand for STI services. In 2018 the recorded cases of STIs were 395,583, from 267,862 in 2016, an increase of 48%.[96] The rate of HIV status ascertainment among STI clients increased from 69% in 2016 to approximately 87% in 2018, representing an 18% increase and nearly meeting the 90% target. HIV yield among STI clients halved between 2016 (6%) and 2018 (3%). Coverage of syphilis screening among antenatal women increased from 2016 (75%) to 2017 (84%), followed by a minimal decrease in 2018 (82%).[97]

Women on ART in Malawi report high rates of unintended pregnancy (69%) and mistimed pregnancy (61%).[98] For women using contraception, 79% were using contraception at the time of conception, with condoms as the most popular form (91%), followed by injectables (9%), and the implant (9%).[99] Women living with HIV are also at a five times higher risk of developing cervical cancer, yet among HIV positive women aged 30-49 years, only 19% have ever been screened for cervical cancer.[100]

The STI program brought M&E tools, reporting forms, and mentorship to private facilities, which led to the ability to perform intensified quarterly STI supervisions targeting private health facilities. This capacity building and monitoring of private health facilities resulted in the first comprehensive program report on STIs that includes data from private facilities. Challenges experienced in STI management include stockouts of medicines and laboratory reagents for STI treatment and testing in public facilities, limited training in the private sector, inadequate resources to perform supervision and mentorship to all sites, and emerging antimicrobial resistance (AMR). During this NSP 2015-2020 period, integration of HIV testing and STI services with SRH services is key to ensuring comprehensive coverage and person-centred care.

***TB-HIV Co-Infection*:** Tuberculosis (TB) is the most common co-infection in PLHIV and the most common cause of HIV-related death. Forty eight percent (48%) of TB cases in Malawi are also HIV-positive; hence, systematic symptom screening for TB is a cornerstone of the HIV care package. The NSP 2015-2020 set a target that 83% of the HIV+ TB patients should be on ART and that 85% of the TB patients should have their HIV status ascertained. By December 2018, Malawi achieved both indicators at 93% and 97%, respectively. In 2019, 99% of new TB patients had their HIV status ascertained. Ninety five percent (95%) of those found HIV-positive were already on ART at the time of TB initiation.[101] The proportion of new ART initiations during TB treatment is 7%. Total ART coverage among co-infected patients at the end of TB treatment has consistently been more than 99%. Almost all (99%) patients on ART were screened for TB during their last visit, and 2% classified as presumptive TB cases. While 2020 targets for TB-HIV co-infection have been achieved, challenges remain including delayed diagnosis of TB, delays in providing results due to high workloads in microscopic laboratories and absence of microscopy, GeneXpert platforms and Urine LAM in most facilities and the limited skills among service providers in screening for TB.

***HIV-Viral hepatitis Co-infection*:** Viral hepatitis is a significant public health problem in sub-Saharan Africa. Several studies indicate that Hepatitis B is highly prevalent in Malawi with an estimated sero-prevalence of 8% among the general population.[102] Data on Hepatitis C is scarcer; the prevalence is estimated to be around 1% in the general population. Currently, Malawi Blood Transfusion Services (MBTS) screens for both HIV and viral hepatitis, however there is no clear linkage and access to treatment and care for those who are found to be Hepatitis B or C positive.

The NSP 2020-2025 aligns with the National Viral Hepatitis Strategy which adopts the WHO formulated targets of 30% reduction of new infections and 10% related deaths by 2020 in an effort towards elimination of viral hepatitis by 2030. HIV Clinical Guidelines have included Tenofovir and recently incorporated Entecavir. GoM plans to make ARVs accessible to HIV–Hepatitis B co-infected patients and HIV negative patients. GoM will also integrate Viral Hepatitis programming into existing HIV diagnostic and service delivery platforms.

***Blood Safety*:** The NSP 2015-2020 set a target that 99% (from a 93% baseline) of the donated blood in Malawi should be screened for HIV, Hepatitis B and syphilis. MBTS collected about 80% of the estimated 100,000 blood units collected in 2018. Sixty hospitals in Malawi also collected about 20,000 units. Over 99% of all units collected in the country were screened for Transfusion Transmittable Infections (TTIs), HIV, Hepatitis B and Syphilis.[103] However, in order to fully decentralize blood collection, screening and distribution, MBTS requires infrastructure, human resources, equipment and commodities to set up sentinel sites at all major hospitals.[104]

2.3.2 Progress towards the 90:90:90 targets

The NSP 2015-2020 focused on meeting the 90:90:90 treatment targets released by UNAIDS in 2014. This was in preparation to end the HIV and AIDS epidemic as a public health threat by 2030. This section summarizes the progress that Malawi has made towards these and other related targets. **Figure 10** below shows the progress that Malawi has made on the 90:90:90 targets set for 2020.

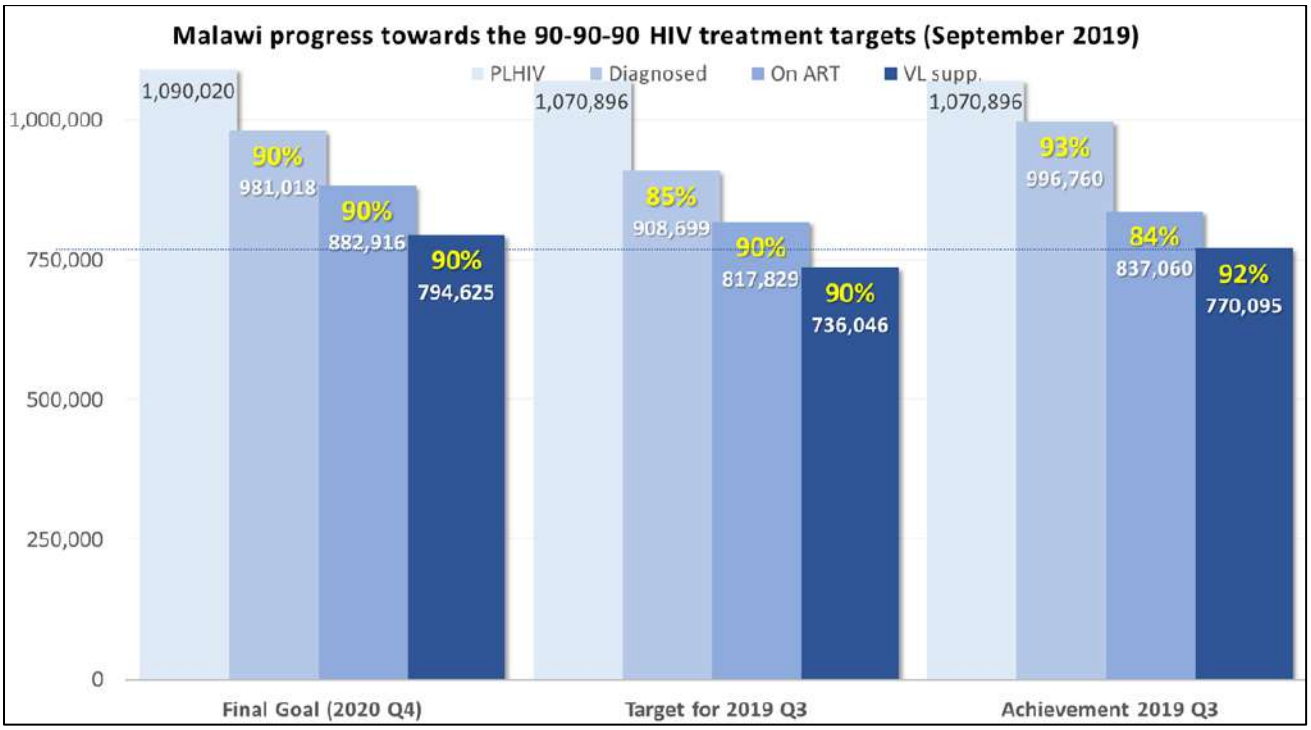


Figure 10: Malawi progress towards the 90:90:90 HIV treatment targets. Source: Department of HIV and AIDS.

Ninety percent of the PLHIV know their status: In December 2018, there were 758 static and 225 outreach sites offering HTS in Malawi.[105] The number of people tested for HIV increased over the period 2015-2019 as can be seen in **Figure 11** which shows the trends in HIV tests performed and new diagnosis by year. This has, however, put a strain on the health system, including human resources, commodities, quality assurance and monitoring and evaluation systems.

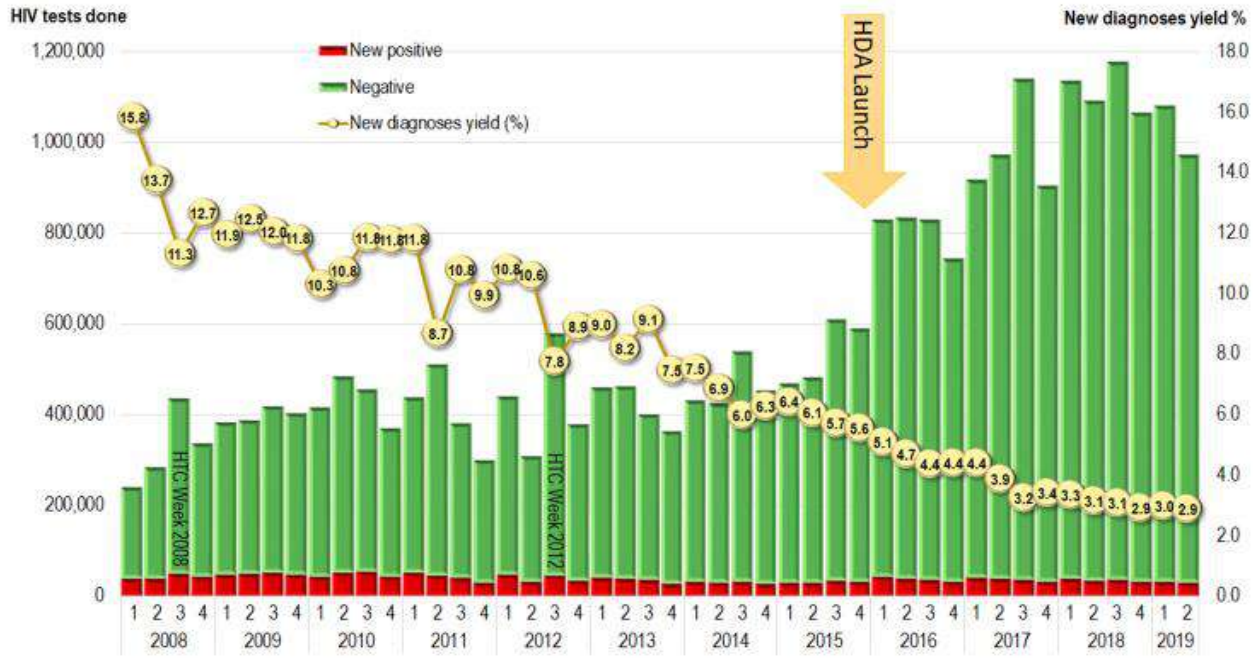


Figure 11: Trends in HIV tests performed and new diagnosis yield by year. Source: Department of HIV and AIDS.

During the NSP 2015-2020 period, Malawi achieved the first 90 of the 2020 90:90:90 targets with 92% of PLHIV aware of their status. This is due to the prioritization of provider-initiated testing and counselling (PITC) efforts at ANCs, the scaling up of the Family Referral Slip (FRS), increased access to VCT and overall increased testing coverage. The deployment of HIV Diagnostic Assistants (HDAs) has significantly contributed to this increase. Other approaches that have helped to identify more PLHIV include index case testing, the implementation of intensified outreach testing activities targeting key and vulnerable populations, HIV self-testing (HIVST) and voluntary assisted partner notification services (VAPN). Since 2019, HIVST, active index case testing and VAPN are national policies in Malawi. The positivity yield of HIV testing declined over the years as the prevalence of unidentified PLHIV reduced as well. In the last decade, the number of HIV tests more than doubled, while the number of PLHIV identified reduced by 40%.[106] Women continue to receive more testing services than men, and volumes of testing among children and adolescents fall behind adults.

Ninety percent of known HIV positives are initiated on ART and retained on care: During the NSP 2015-2020 large numbers of people were started on ART. The rate of growth of PLHIV on treatment is slowing down because the pool of PLHIV not on ART is getting smaller. **Figure 12** shows the number of PLHIV and ART coverage and a projection based on current levels of interventions.

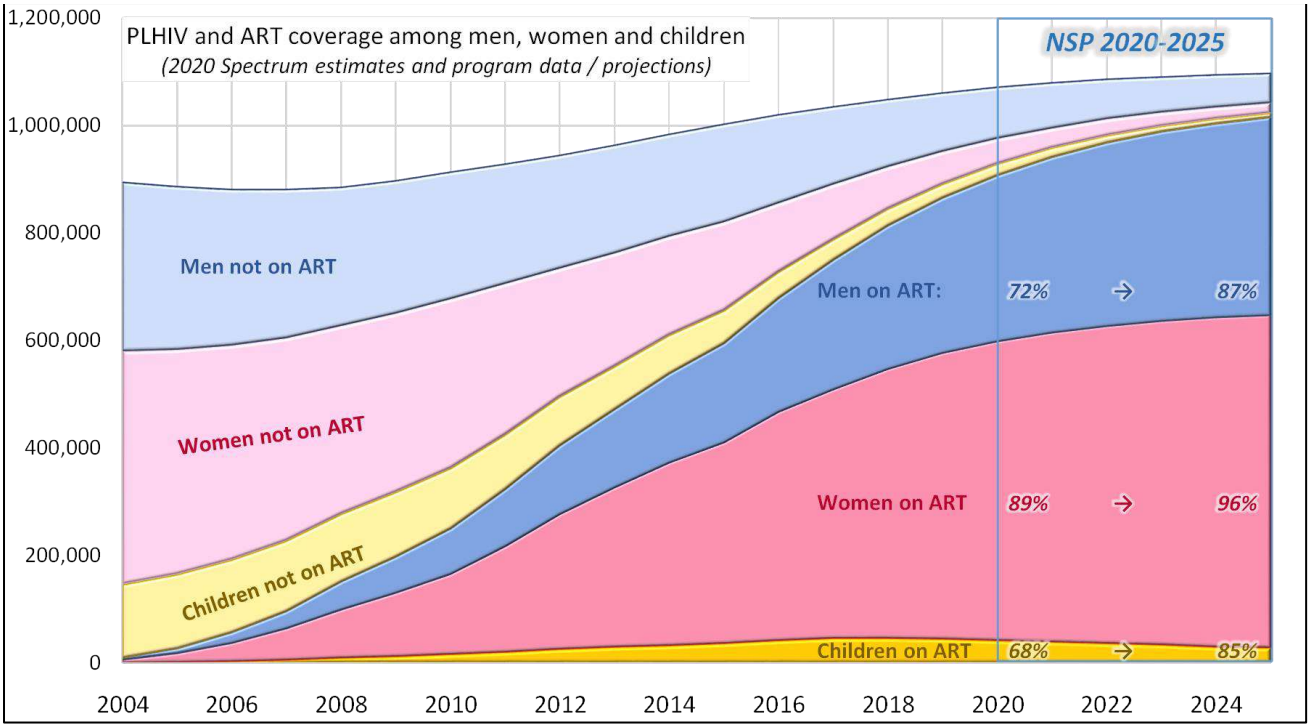


Figure 12: PLHIV and ART coverage among men, women and children and projections from 2019 onwards. Source: 2020 Spectrum estimates and program data / projections.

The target was that by 2020 90% of known HIV positives should be initiated on ART and retained in care. Malawi has successfully implemented the 'test and treat' policy with same day initiation and is well on track to reach this target. The number of people alive and on treatment was 828,324 by the end of June 2019 and is estimated to reach 905,416 by December 2020. Linkages from HIV testing to the ART clinic work well and, in many clinics, patients are escorted by HDAs or Expert Clients. In June 2019, the coverage was 78% in adults and 70% in children. It is also important to note that 86% of adult women living with HIV are on treatment, compared to 68% of adult men – this could be related to gender factors that decrease the likelihood of men accessing HIV testing or seek, use and adhere to ART.[107],[108]

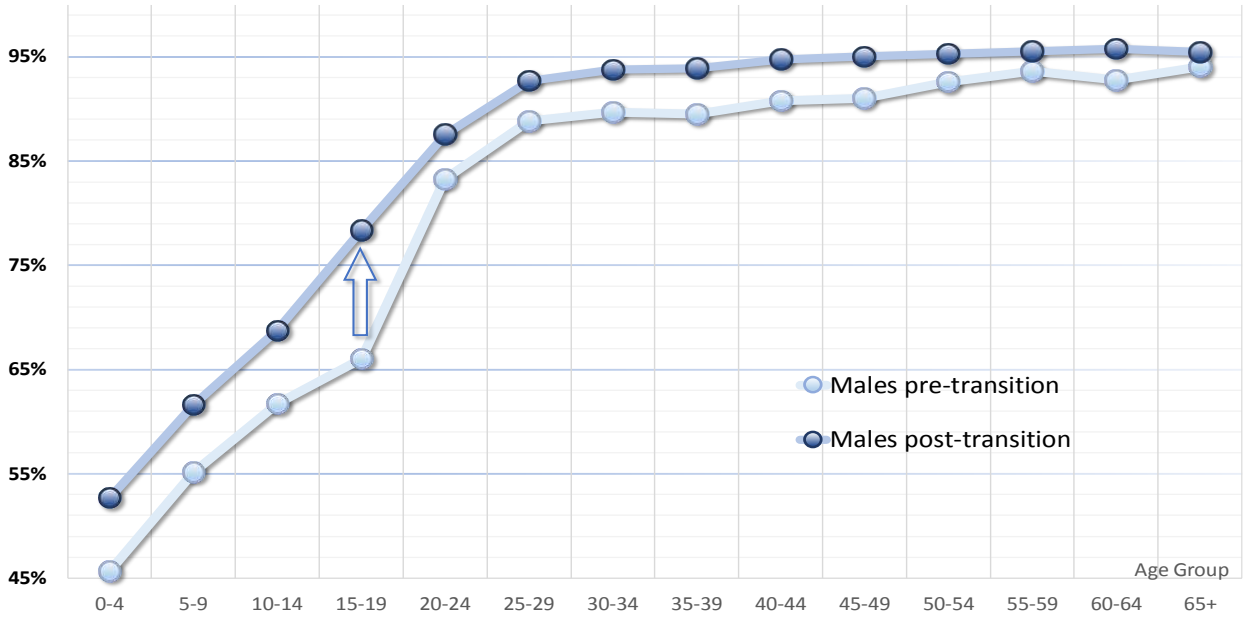
Challenges in the treatment program include (i) the low uptake of ART among children living with HIV,[109] (ii) a suboptimal ART regimen for children, (iii) the shortage of health workers, (iv) underdiagnosis of HIV-related diseases and opportunistic infections, (v) limited service integration, mainly because of infrastructure challenges and staff shortages, and (vi) a fragile health infrastructure, and inadequate linkages between the community and facility.[110] Seventy two percent of adults and 75% of children were retained alive on ART after 12 months on treatment. These programmatic monitoring results remain below the WHO target of 85%, but actual retention rates are thought to be about 10% higher due to misclassification of 'silent transfers' as 'defaulters' in clinic-based survival/retention analysis. Eighty five percent of the AIDS related deaths are in people already on ART.[111] Therefore, the focus of reducing the morbidity and mortality should target people already on ART.

Malawi's population is rapidly growing at 2.9% per year and the rate in (peri-) urban areas is even higher. Most urban growth will occur in informal and unplanned peri-urban townships and as a result these areas have a high ratio of population per public health facility. In Blantyre and Lilongwe, 8 health centres have a catchment population of over 100,000 with the maximum catchment population of over 300,000. The

government is challenged with expanding adequate public services, including decent health services for these rapidly growing townships.

Patient outcomes in the HIV Care and Treatment Program is related to geographical area. In 2019, 12-month retention rates among ART patients was 75% in rural areas, but 63% in urban and 68% in peri-urban areas. The reason for this difference is most likely related to different factors, but overcrowding in clinics may be one of the reasons as a recent study in eSwatini identified overcrowding as a key driver for attrition.[112] By the end September 2019, the average number of patients per public ART site was 2,600 in urban, 3,100 in peri-urban, and 900 in rural areas. A study in Blantyre provided clear evidence that TB case notification rates are strongly affected by poverty and distance from the health facility.[113] There is strong justification for the HIV program to invest in decentralization and improved coverage of health facilities in high density peri-urban areas in order to improve early access and retention on ART, as well as reduce the morbidity and mortality of HIV-related diseases, such as TB.

***90% of people on ART are virally suppressed*:** Viral load (VL) monitoring was scaled up during the NSP 2015-2020 and the capacity of molecular laboratories was expanded. In addition, a national sample transportation network was established. By June 2019, 91% of people on ART were virally suppressed. While the target has been achieved, there are some challenges that need to be addressed such as delays in TAT for VL test results and high workloads at molecular laboratories, especially with implementation on the horizon of the policy to increase to one VL test per year. Viral suppression (VLS) rates in children and adolescents remained low as seen in **Figure 13**. However, routine monitoring data suggest an early increase in VLS following transition to DTG. The greatest increase was among patients selected for an early unconditional transition, where pre-transition VLS had been unsatisfactory. By September 2019, 61% of all patients were on DTG-based regimens. VLS among the 311,956 results collected since the start of transition had increased to 93%. The VL gender gap in adults had disappeared. Boys and male adolescents showed the greatest increase in VLS.



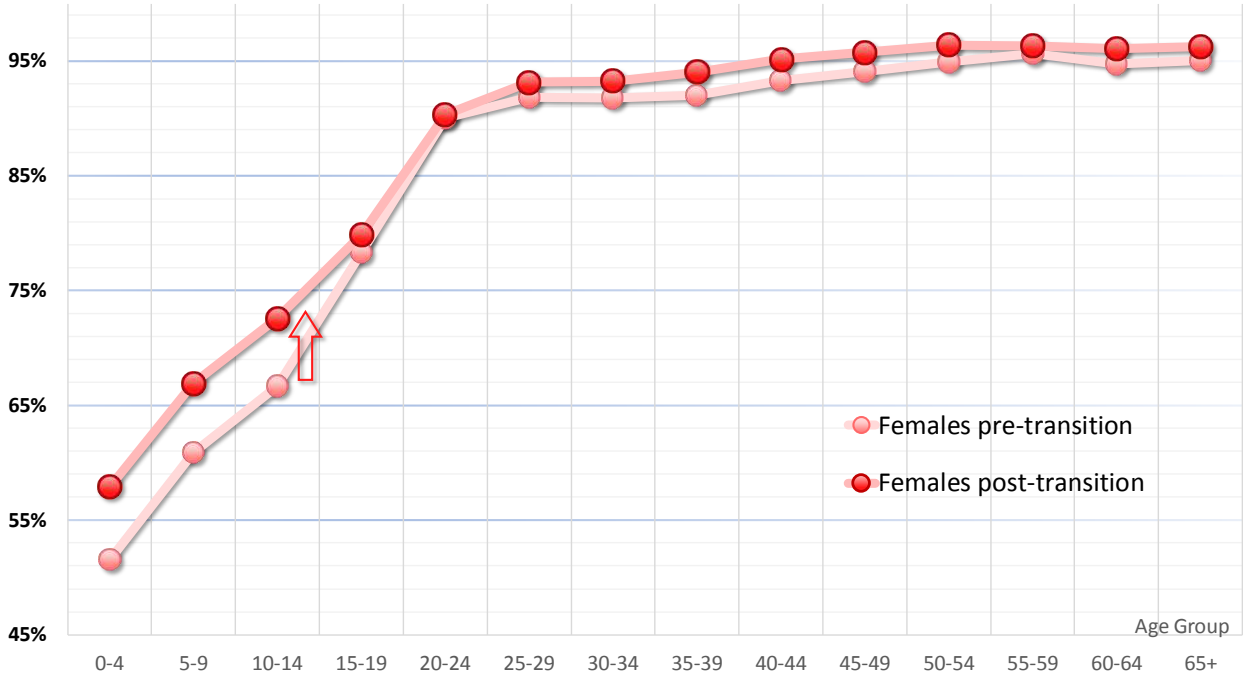


Figure 13: Viral load suppression rates in routine VL monitoring before and after transition to dolutegravir-based regimens. Source: HIV Program Updates, September 2019 TWG.

2.3.3 Resilient and Sustainable Systems for Health

A strong health system will be essential for ending the AIDS epidemic. Investments in the health system will also yield outcomes for all other disease areas. Resilient and sustainable systems for health (RSSH) in Malawi are essential for fast tracking progress toward universal health coverage (UHC) and preparing for emerging public health threats. However, underinvestment in Malawi's health systems has led to significant bottlenecks to service delivery. This NSP focuses on the following HIV program priorities: building adequate health workforce and infrastructure; improving procurement and supply chain and laboratory systems; strengthening data systems and improving data utilisation; strengthening community responses and systems; and promoting a more integrated and efficient service delivery.

Leadership and Governance: MoHP recognizes "improving leadership and governance across the health sector and at all levels of the health care system" as a core objective of HSSP II. Good governance, strong leadership and effective planning are essential to ensuring effective delivery of HIV services, strengthening coordination and minimizing inefficiencies across the health sector, and ensuring efficient utilisation of limited resources. Health sector governance and planning are also essential in the face of on-going decentralization of services to sub-national levels, which has come to prominence since the HIV NSP 2015-2020. In 2018, the Government of Malawi took bold steps to improve the efficient governance of the national HIV and AIDS response through the HIV and AIDS (Prevention and Management) Act. The Act legislated overall leadership of the response to MoHP, while the NAC was charged with overall coordination, implementation, and facilitation of the response.

Financial Management: In Malawi, development partners contribute over 60% of the total health expenditure and 95% of the expenditure for the HIV/AIDS response. Due to concerns about limitations in public financial management, a significant proportion of donor funds to the health sector are channelled directly to implementing partners. This has contributed to non-alignment and lack of harmonisation of

aid to GoM priorities, thus increasing administrative costs and reducing the efficiency of investments in the sector.

Government has consistently endeavoured to strengthen financial capacity and management systems in all entities to effectively manage funds. Government established institutions at both the executive and legislative level to increase management and accountability of government resources. This includes the Parliamentary Public Accounts Committee; Parliamentary Committee on Health and Parliamentary Committee on Nutrition, HIV and AIDS; The National Audit Office; the Anti-Corruption Bureau; and Financial Intelligence Unit. Each government agency has also strengthened its internal auditing and compliance units. Recognising the strength in the existing financial management systems, the Office of the Inspector General for Global Fund grants is building capacity of the National Audit Office to conduct independent audits for Global Fund investments in the country in the future.

Specific to the health sector, MoHP recently implemented systems and reforms to improve financial management, aid accountability, and risk mitigation and build capacity of all HIV organizations that manage funds. The 2018 HIV and AIDS Prevention and Management Act tasked the NAC with coordination of the response, including grant management. Malawi Government in general, and MoHP and NAC in particular, are now better positioned to manage and coordinate investment in order to effectively support the HIV and AIDS response.

Human Resources for Health: Malawi continues to face severe health worker shortages – the country has a 48% vacancy rate for established clinical and nursing positions.[114] Current staffing levels have reached only 33% of the WHO recommended minimum ratio of 4.45 health workers per 1,000 population. The HSSP II requires around 31,000 facility-based health workers to effectively deliver the EHP,[115] representing a need for a three-fold increase from current staffing levels.[116] There is also a significant shortage of community health workers – the country had 7,728 Health Surveillance Assistants (HSAs) and 1,172 senior HSAs in 2018, far below the National Community Health Strategy scale-up targets of 15,000 and 1,500 by 2022, respectively.[117] Critical shortages also exist for Pharmacy and Laboratory Assistants and Community Midwife Assistants. These critical staffing shortages constitute one of the most significant challenges for implementation of key emerging HIV policies such as active index testing and partner notification, HIV self-test distribution, PrEP, diagnosis and management of advanced HIV disease, VMMC, and treatment and care for a projected 1,015,000 patients on ART by 2025. Related HRH challenges include coordination of nationwide in-service training following policy changes and fragmentation of interventions across health services. Current projections predict a widening gap with inadequate numbers of health workers graduating from pre-service training institutions to meet the basic needs of a growing population.

Health Products Management Systems: Malawi has been affected by stock-outs of essential medicines in its facilities, with central hospitals having a supplier fill rate of 46% in FY 2018-2019.[118] In contrast, the supply management of the HIV program has performed exceptionally well, with 98%[119] availability of ARVs and few isolated stock-outs of HIV test kits. Malawi's health products management system is divided into many parallel supply systems due to different funding sources and vertically organized programs. In response to these long-standing challenges, MoHP decided to integrate all parallel systems under the responsibility of the Central Medical Stores Trust (CMST) with support from the Global Fund.

The quality of primary stock records has remained a particular challenge at many facilities, leading to over- and under-supply and expiry of pharmaceutical products in some instances. However, significant stock-outs for the integrated HIV program have only been reported on drugs for the management of opportunistic infections and STIs. The recent installation of 448 prefabricated pharmacy storage facilities has increased the overall storage capacity but added complexity to site-level stock management. There is a need for further increase of well-planned storage space in most health facilities. Proactive monitoring, reporting and management of adverse drug reactions is another critical area for increased support given the large-scale introduction of new ARVs and TPT regimens in the program. The capacity of the national pharmacovigilance centre also needs further strengthening.

Health Services Infrastructure: In many instances, Malawi's health system infrastructure is inadequate to provide essential services. The 2014 Malawi Service Provision Assessment (MSPA) showed that of the 509 government health facilities, only 63% had regular electricity and 91% had an improved water source. Most public health facilities in Malawi are in urgent need of repair and refurbishment. Other challenges within the health system include the shortage of transport: only 24% of health facilities have ambulances; transport is critical because infrastructure (health facilities, staff houses) is particularly insufficient in rural and hard to reach areas, where people still walk beyond the recommended maximum of 8km to the nearest health facility.[120]Particular health system needs for the HIV program include additional consultation rooms for delivering integrated services, drug resistance monitoring, and basic laboratory capacity.

Community Health Systems: The MoHP developed the National Community Health Strategy (NCHS) 2017-2022 which outlines the various community structures that are key to delivery and accountability of health services. These structures include HSAs, Village Health Committees (VHCs), Community Health Action Groups (CHAGS), Health Centre Management Committees (HCMCs) and Hospital Advisory Committees (HACs). Traditional and religious leaders also constitute part of the community system. One of the major challenges is that most of the community structures remain untrained; hence, they do not effectively deliver their functions. There is also a gross shortage of HSAs as mentioned above and limited participation of communities in the delivery of health services[121] including HIV and AIDS services. Lastly, the community HIV prevention, treatment and care package is sparsely implemented at the community level.

Health Information Systems (HIS): In the past NSP period, GoM made significant progress towards HIS improvement. MoHP implemented DHIS2 as the national aggregate data warehouse, implemented drug and essential supply logistics management information systems, scaled up cStock as a last mile drug management tool, extended the fibre backbone network to all districts, and supported the steady rise of ICT penetration. However, significant governance, infrastructure, culture, and resource challenges remain. The lack of harmonization and coordination of M&E indicators, forms, and systems results in an inability to aggregate data at the district and facility-level, an inability to see the complete picture when making decisions, and an increased data reporting burden on an already-strained health workforce. Other challenges include unreliable electronic medical records (EMRs) due to unreliable connectivity and power; low digital literacy amongst the health workforce; high dependence on paper-based approach to service delivery; temporary systems failures that result in paper back-logs that need additional labour to enter into EMRs; lack of sustainability and inadequate coverage of existing digital health solutions; and minimal trust in data quality leading to a lack of data use.

Efforts to address these challenges are underway. The 2017-2022 Monitoring, Evaluation, and Health Information Systems Strategy and 2019-2023 Digital Health Strategy include an array of comprehensive strategies to improve HIS, infrastructure, and governance. In this context, Malawi has piloted the use of unique health identifiers to improve patient monitoring, linkage, and referral/transfer. The introduction and roll out of the National Registration and Identification System (National Identity Cards) for Malawi citizens and residents as part of the national Civil Registration and Vital Statistics system will further strengthen patient identification. However, even though the country has made progress on data disaggregated by sex, age and geographic area, challenges remain on retaining capacity to continue conducting such deep disaggregation of information according to gender identity, sexual orientation, socioeconomic status, disability.

Integrated Service Delivery and Quality Improvement: As Malawi expands access to a package of high-quality, safe, and acceptable integrated, people-centred health services, service delivery management and quality improvement systems are critical. The WHO has found that "health systems oriented around the needs of people and communities are more effective, cost less, improve health literacy and patient engagement, and are better prepared to respond to health crises."[122] Currently, HIV services are inadequately integrated with SRH and GBV services. Additionally, caring for an aging ART cohort will require service integration with NCDs while mental health services remains critical for children, adolescents, and their caregivers – particularly to increase adherence and prevent PLHIV from defaulting on treatment and becoming lost to follow up. Malawi's health system needs improvement to provide integrated care. In many facilities, infrastructure, digital information systems, and additional human resources and trainings will be required. Strong referral systems between disease areas and levels of the health system are also needed to effectively integrate all services.

Improving the quality of services delivered is also critical to achieving HIV targets. Poor quality services can result in misdiagnosis, false test results. A 2016 analysis of the health sector identified poor quality of care as a major barrier to achieving UHC. This led to the inclusion of quality of care as a priority in HSSP II as well as the establishment of the Quality Management Directorate, a cross-cutting directorate tasked with coordinating quality improvement (QI) initiatives across MoHP.

Coordination of the National HIV and AIDS Response: The coordination and management of the national HIV and AIDS response in Malawi is guided by the 'three ones' principle which entails (i) one coordinating authority (NAC), (ii) one strategic plan (National HIV and AIDS Strategic Plan), and (iii) one M&E framework. The NAC is legally mandated by the 2018 HIV and AIDS (Prevention and Management) Act to implement, coordinate, and facilitate the national response; manage and coordinate the implementation of Government HIV and AIDS policies; and monitor and evaluate the implementation of HIV and AIDS interventions among several other responsibilities. In order to strengthen the national and multi-sectoral coordination of the response amongst the stakeholders and enhance effectiveness and efficiency, NAC established structures such as the Malawi Partnership Forum (MPF) for HIV and AIDS which provides a formal and representative forum for discussion, information sharing, consensus building, joint planning, and mutual support for all partners in the national response through the Joint Annual Review (JAR). There are also TWGs and other structures such as the HIV and AIDS Development Group (HADG) and sectoral coordinating bodies. The HADG harmonises and coordinates development partner's support and

alignment to the NSP. The Malawi Global Fund Coordinating Committee (MGFCC) provides overall guidance on Malawi's Global Fund supported programmes to fight HIV/AIDS, Tuberculosis and Malaria. It is accountable to the GoM and the Global Fund on the utilization of the Global Fund resources and determines priorities for proposals to the Global Fund based on existing country frameworks and strategies. The UN Agencies support the national HIV and AIDS response through defined areas in the UN Sustainable Development Framework 2019-2023. This framework is implemented through a Division of Labour and UN agencies operate within their comparative advantages to minimize duplication and increase efficiency.

The sectoral coordination bodies include: (i) the Department of Human Resource Management (DHRMD) which coordinates the HIV and AIDS response, particularly workplace programmes, in the public sector including parastatal organisations. DHRMD also provides policy guidance on workplace programs in Local Councils; (ii) Malawi Business Coalition against AIDS (MBCA) coordinates the response for private companies and business institutions. Its major roles are mobilisation of companies, development of workplace programmes, and reporting and evaluation of the private sector response; (iii) Malawi Network of People Living with HIV (MANET+) coordinates all organisations for PLHIV. These organisations serve and advocate for issues affecting PLHIV in order to improve their welfare; (iv) Malawi Network of AIDS Service Organisations (MANASO) coordinates local and international NGOs implementing various HIV and AIDS activities; (v) the Malawi Interfaith AIDS Association (MIAA) coordinates all faith based organisations implementing HIV and AIDS interventions; (vi) National Youth Council of Malawi (NYCOM) coordinates all youth organisations implementing HIV and AIDS interventions; (vii) National Council for Higher Education (NCHE) to coordinate HIV response in tertiary education institutions and (viii) National Construction Industry Council (NCIC) for the construction sector. All these sectoral coordinating institutions collaborate with Local Councils which coordinate the national response in the districts through the District Executive Committees (DEC) and the District AIDS Coordinating Committees (DACC).

While these coordinating agencies are playing an important role in their respective sector, a number of challenges have been observed and these include (i) a significant decline in financial resources which has resulted into downsizing of operations of coordinating agencies including NAC, (ii) reliance on development partners which threatens sustainability of the national response, (iii) existence of parallel coordinating mechanisms for HIV and AIDS activities, (iv) duplication of partners' activities as it is difficult to know who is implementing what at district and sub-district levels, (v) weak linkages between and among coordinating agencies, and (vi) the lack of capacity among coordinating agencies to efficiently and effectively manage organizations in their sectors.[123]

HIV and AIDS response in Emergency Settings: Malawi has begun to experience the devastating effects of climate change and environmental degradation; and emerging diseases such as the Corona Virus which causes Covid-19 disease. Over the recent years, heavy rains have caused flooding in some parts of Malawi, affecting at least half a million people annually across the affected districts as estimated by the Department of Disaster Management Affairs (DODMA). Internally displaced populations are particularly vulnerable to disease outbreaks. Districts commonly affected by disasters include Chikwawa, Nsanje, Mangochi, Mulanje, Phalombe, Thyolo, Zomba and Karonga. Due to the Corona Virus Disease (Covid-19) global pandemic, the Government of Malawi on 20th March, 2020 declared Malawi as a state of national

disaster. Malawi registered the first cases of Covid-19 on 2nd April and by the end of July 2020, the country had cumulatively registered over 4,000 confirmed cases and 114 deaths.

People with chronic illnesses, including HIV and AIDS, require reliable access to ART and clinical care. Disasters and emerging diseases can also aggravate the effects of poverty and social vulnerability and may increase HIV transmission and disease progression to AIDS. Women and girls also experience heightened vulnerability to HIV in emergency settings due to sexual violence and adoption of high-risk behaviours such as selling transactional or survival sex.[124] Consequently, the health system in the affected areas is greatly stressed and supply chain ruptures may hamper HIV prevention and management efforts.

Monitoring, Evaluation, and Research: As a coordinating authority, NAC is responsible for monitoring the response to the HIV epidemic by collecting and analysing data and disseminating information to policy makers and programme planners. The monitoring and evaluation of health facility-based responses is coordinated and managed by the MoHP in collaboration with private sector institutions and civil society organisations (CSOs) that run health facilities with data reported through the HIS. Within the M&E framework, NAC monitors non-biomedical interventions through the Local Authority HIV and AIDS Reporting Form (LAHARF). This is done in collaboration with different partners such as donor agencies, CSOs, FBOs, organizations supporting key populations, traditional leaders and local government. Non-biomedical data collected through the LAHARF is entered into the Local Authority HIV and AIDS Reporting System (LAHARS), from where various reports are generated. The current challenges include (i) Limited use of the LAHARS; (ii) delayed reporting by partners who submit relevant indicators to NAC; (iii) low utilization of monitoring data to improve HIV/AIDS programming; (iv) multiplicity of reporting tools and systems; and (v) low reporting in some program areas such as AGYW, young men, key populations, elderly and people with disabilities. The LAHARS has been reviewed; roll out and capacity building will take place soon. This will be supported by the National M&E database that NAC is currently developing. Evidence based programming and learning has also been affected by the inability to undertake all required research activities. This is due to inadequate financing to support research and subsequent dissemination of findings. The research agenda is currently outdated and needs revision and approval.

Fiscal Space: It is considered that the Government of Malawi's direct contribution towards HIV and AIDS activities is dwarfed by that of development partners in the health sector. However, this is a misinformed notion, as a vast amount of the public health sector budget is utilised to support the provision of HIV and AIDS-related activities on an annual basis. For instance, Government spent a total of $107 million USD on wages and salaries at the central and district-level (for further details see **Annex 1**), including health workers in community health posts, health facilities, district hospitals, and central hospitals. The total wage budget – and therefore the Government contribution to the response – for health workers has increased year-upon-year and now includes the salaries for CHAM health facility workers. The increasing amount of resources available for health worker recruitment is a significant enabling factor for the increased provision of HIV and AIDS services. Similarly, Government investments in infrastructure across the country have allowed for greater accessibility of health services in hard-to-reach areas; allowing for partner-funded medical commodities to reach the patients affected by HIV and AIDS.

The MoHP evaluated co-financing options for the 2019 Global Fund Co-Financing Report. This report cited a 2017 World Bank study that concluded that, "the potential for increasing fiscal space for health is limited due to the weak macro-economic environment. The modest economic growth, high fiscal deficit

(estimated at 4.3% of GDP in 2016/17) and huge total public debt (estimated at 52% of GDP in 2016/17) would make it difficult to adequately provide public services particularly health and other social services. As such, it would also be difficult to re-prioritize the national budget given the high debt-service ratio, competing priorities from other sectors, and the increasing public wage bill as a share of GDP."

The report also concluded that the potential for raising significant additional revenues for health through earmarked taxes is limited. Proposed earmarked taxes would imply a US$0.63 per capita per year for the period 2016/17 to 2021/22, a small contribution to expanding financing for health. The report found that a viable option for expanding resources and improving results in the health sector was enhancing efficiency of spending and promoting greater predictability and effectiveness of external financing for health. Based on global estimates, a crude efficiency savings estimate of US$10.6 per capita per annum could be generated if inefficiencies in the health sector in Malawi were addressed.

3. Development of the NSP 2020-2025

The NSP 2015-2020 ends in June 2020, hence, there was a need for a new NSP which would consider emerging evidence and provide guidance on effective interventions that contribute towards the shared global vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. This new NSP provides strategic direction to funders, planners, and implementers on how Government plans to end HIV as a public threat in Malawi by 2030. It should also guide resource mobilization and local coordination efforts.

The development of the NSP 2020-2025 involved the formation of the National Steering Committee (NSC) and the Task Force (TF), the review of literature, consultations with key stakeholders, modelling, and finally several prioritization and stakeholder validation workshops.

3.1 Formation of the National Steering Committee and the Task Force

The NAC facilitated the formation of a multi-disciplinary National Steering Committee (NSC) in early 2019, composed of senior officials from GoM ministries and departments, development partners, technical cooperating and coordinating organizations. The NSC provided policy and strategic guidance during the development of the NSP 2020-2025. NAC also formed a multidisciplinary Task Force (TF), composed of experts drawn from key HIV and AIDS implementing agencies including MoHP and NAC. Partners such as the UN agencies, the Bill & Melinda Gates Foundation through the Clinton Health Access Initiative, and other cooperating partners provided technical assistance. The TF, co-chaired by NAC and Department of HIV and AIDS (DHA), provided routine technical and logistical guidance and support to the development of the NSP 2020-2025. The TF reviewed all deliverables and recommended them for approval to the NSC.

The draft NSP 2020-2025 was developed after an extensive inclusive consultation process. Draft sections, particularly those of the thematic areas, were further reviewed with the support of experts. A draft of the costed NSP 2020-2025 with a detailed results framework was presented to stakeholders. The team incorporated comments from stakeholders including senior management of the Ministry of Health and the Board of the NAC to produce a final draft of the NSP 2020-2025 that was endorsed by both bodies.

3.2 Literature Review

The NSP 2015-2020 had four pillars namely Prevention; Treatment, Care and Support; Impact Mitigation; and Management and Coordination. For each of these pillars, a comprehensive review of documents was undertaken to assess progress in the implementation of the NSP 2015-2020 against set targets. The documentation reviewed included programme reports, annual performance reviews and survey reports, and the 'internal'[125] and 'external'[126] review of the NSP 2015 implemented by NAC and WHO, respectively. Thematic groups were responsible for performing the reviews and focused on achievements made and challenges experienced during the implementation of the NSP 2015-2020, and then proposed interventions and activities to improve HIV and AIDS programming in Malawi for the period 2020-2025.

3.3 Stakeholder Consultations

During the review of the NSP 2015-2020, various stakeholder consultations were conducted from 28th October 2019 to 16th December 2019. These consultations explored the achievements and challenges during the implementation of the NSP 2015-2020 and the recommendations on the interventions that

need to be implemented over the period 2020-2025. These consultations involved individual and group meetings with people from various thematic areas of the NSP 2015-2020. Traditional and religious leaders, staff from GoM ministries and departments, development partners, UN agencies, academic institutions and CSOs representing PLHIVs, key and vulnerable populations including young people participated in these consultations. The consultations further explored what would constitute game changers in the fight against HIV and AIDS and contribute towards the achievement of Target 3.3 of the SDGs. The task force facilitated these consultations with key stakeholders and special interest groups at national, sectoral and district levels. Over 100 stakeholders representing other MoHP directorates/units, other Ministries, development partners, civil society organizations, traditional leaders, youth representatives, and private sector participated in the development of this NSP through the following: a two-day workshop to develop the RSSH strategies, a three-day series of workshops to develop the narrative and finalize the strategies, and a full-day workshop to validate the final strategies.

3.4 Modelling and Economic Analysis

Mathematical models are extensively being utilized to determine the impact and cost-effectiveness of health programs (Malaria, HIV and other diseases), including funding allocations to reach specified program targets. These analyses have proven essential to inform the development of NSPs, Global Fund (GF) applications and investment cases in the region, including Malawi. The development of this NSP leveraged two mathematical models: (i) the GOALS-Age-Structured Model (ASM), an age-variant of the traditional GOALS model and (ii) the Optima HIV Model.

Collectively, the two models helped to address the following questions: how much funding is required to achieve the NSP goals? What goals can be achieved with the available resources? What is the effect of alternate patterns of resource allocation, including impact? What is the best mix of interventions and optimal distribution of resources? The rationale of utilizing two models was to triangulate outputs, and in the process inform prioritization and synthesis of cost-effective interventions expected to yield the highest impact in-terms of averting new infections and deaths. Both models are full dynamic transmission models, and thus reflect the socio-biological transmission of the HIV disease. On this basis, both primary and secondary transmissions of HIV were fully considered in the analysis. For example, the onward transmission of HIV to AGYW by preventing primary infection in men through VMMC.

In-terms of data, the two models utilized epidemiological data from the Malawi AIM Spectrum file. This file contains data on key statistics and epidemiological trends of the HIV epidemic. Some data elements for parametrizing the models were also extracted from the MDHS, MPHIA, the PLACE Study[127], the UNAIDS Atlas for KPs and other KP targeted programs. Cost data were abstracted from available program data on the cost of implementing the HIV and AIDS program in Malawi. In the absence of local cost data, regional cost estimates and expert opinions were utilized to determine cost parameters. Primarily, costs for interventions were captured as fully loaded cost - cost of delivering an intervention per person per year. **Table 2** contains cost data used in the analyses. The impact modelling assumed a 'health system (payer's) perspective,' that is, the cost of delivering services by the funding entity. Future costs and benefits were discounted at 3% based on regional discounting rate.

Table 2: Interventions unit cost "fully loaded" per client per year. Source: Department of HIV and AIDS.

Cost	Unit cost (USD)
ART	165.0
VMMC	120.0
SW – Outreach services	180.0
MSM - Outreach Services	245.0
Condoms	0.03**
PrEP SW	121.0
PrEP MSM	121.0
PrEP AGYW	121.0

Table 3: Estimated Coverage Targets-2020-2025

Intervention	Coverage Targets – 2025	Absolute numbers 2025
ART	92.5%	1,015,291
VMMC - in high burden districts	80%	900,000
SW – Outreach services	100%	42,986
MSM – Outreach services	1%	8,037
Condoms (Female)	80%	3,185,481
Condoms (Male)	80%	742,814,698
PrEP SW	45%	12,896
PrEP MSM	7%	3,446
PrEP-TG people	30%	85
PrEP AGYW	1%	23,474

To assess the potential impact and cost-effectiveness of each intervention, a hypothetical scale-up of each intervention was assumed to the specified coverage by 2025 (see **Table 3**), and then maintained coverage at that level up to 2035. The time horizon for the projected impact of interventions was extended to 15 years (2020-2035) in order to capture the long-term impact of VMMC. A cost-effectiveness threshold of USD 10,000 per infection averted was defined for prioritization, determined as twice the lifetime cost of ART based on programmatic cost of providing ART per person per year.

The GOALS model applied an optimization algorithm to determine the impact of expected resources over the NSP period. Firstly, the algorithm uses cost-effectiveness analyses to select the most cost-effective interventions for full scale implementation. Iteratively, the next cost-effective intervention is selected until available resource envelope is used – last intervention is thus partially implemented. On this basis, the following interventions were recommended:

- ART scale-up;
- Prevention of mother-to-child transmission;
- Provision of condoms and promotion services;
- VMMC scale-up noting that the benefits take longer to accrue;
- Targeted PrEP for FSWs, and MSM and AGYW at high risk of acquiring HIV;
- Outreach programs for FSWs and MSM especially in places with high population sizes of these groups;
- HIV testing services - client-initiated testing, PITC, and HIVST; and
- Structural and behavioural interventions - in school and out-of-school sexuality programs.

3.5 Costing Methodology and Process

The resources required for implementation of the HIV NSP 2020-2025 were estimated using a detailed costing. The method assumes that discrete activities produce services or products and consume resources. All the relevant resource items for the activities are identified and measured separately, thus trying to improve the accuracy and reliability of the cost estimation and, ultimately, allowing for the identification of relatively small but significant differences in costs that could have a considerable impact on decisions about resource allocation.

The activity-based costing was conducted for three distinct categories under NSP i.e. programs, RSSH and commodities. The costing was carried out from a health sector perspective, including costs incurred by government, development partners, NGOs, civil society and the private sector, which excludes patients' out-of-pocket expenses for travel and other steps required for them to receive their care. Whereas the unit costs were taken from DHA/ NAC; for costs that varied between implementers, a set of standard costs were established in line with approved government and harmonized development partner daily subsistence allowance and transport refund rates. These standard costs were then applied to all relevant activities, irrespective of the implementer.

For RSSH costs, select cross-cutting health systems strengthening activities were identified and prioritized for costing, as well as costs of health systems improvements required for the planned scale up of the HIV response. RSSH costs include community systems strengthening; coordination; financial management; health products management system; HMIS; human resources for health; infrastructure and transport; integrated services; leadership and governance; medical equipment; OVC; quality of services; reducing HR-related barriers to HIV services; and socio-economic/cultural factors.

In addition to costing programmatic and cross-cutting systems strengthening activities, costs were calculated for public sector procurement of each of the core commodities needed to deliver HIV programs through a quantification model. The commodity quantifications were based on existing demographic data, epidemiological assumptions in terms of the need for each specific commodity (e.g. the number of people who need a particular ARV in any given year of the HIV NSP period), and the unit cost of the commodity based on recent procurement costs. As was done for the definition and validation of activities, epidemiological assumptions were agreed upon through a participatory process. A specific model was built for each commodity, using the same assumptions across different quantification exercises (e.g. the agreed upon number of people receiving ART each year was used in the ARV, OI medication and laboratory medication quantification).

The granularity of the activity-based costing carried out made it possible to identify and flag duplications and parallel activities, hence allowing for activity streamlining and harmonization to find efficiencies. A series of consultations were conducted by DHA/ NAC with all the relevant stakeholders including national and international technical experts, health care providers, implementing and development partners as well as representatives from both civil society and communities. For programs costing, detailed lists of activities were generated and validated through a participatory process and detailed costing assumptions for each of the activities were defined through the same forums. The programs costed include prevention (including STI and SRH; key populations; AGYW); treatment and care (including HIV-TB); PMTCT and HIV testing. Several rounds of activity validation meetings were held between the costing team, government staff members and other stakeholders in order to ensure that costing assumptions and computations were accurate, logical, consistent and comprehensive.

4. Policy & Legislative Context, Guiding Principles and Goals

This section describes (i) the policy and legislative context in which this NSP will be implemented, (ii) the guiding principles, (iii) the vision, mission, goal and overall objectives of the NSP; the thematic areas; and (iv) the key changes in the NSP.

4.1 Legislative and Policy Context

The GoM is a signatory to several global and regional commitments relating to HIV and AIDS. In addition to this, various legislation and policies guide the development and implementation of the NSP.

4.1.1 Global Instruments

- **Sustainable Development Goals (SDGs):** Out of the 17 SDGs, 10 have a direct impact on HIV. Malawi is a signatory to the SDGs; hence, committed to ensuring that SDG targets are achieved especially SDG 3 on HIV and AIDS: 'Ensure healthy lives and promote wellbeing for all people at all ages" and its targets 3.3 'End AIDS as a public health threat by 2030' and 3.8 'Achieve universal health coverage, access to quality health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all' are the most important and applicable to HIV and AIDS.
- **UNAIDS Fast Track Strategy:** In order to achieve SDG 3 Target 3.3 to end AIDS by 2030, Malawi is being guided by the UNAIDS fast track strategy which set targets for prevention and treatment known as the 90:90:90 targets by 2020 and 95-95-95 by 2030.
- **The 2016 Political Declaration on HIV and AIDS:** In 2016 the General Assembly of the United Nations made a Political Declaration to end the AIDS Epidemic by 2030. The declaration set new goals, targets and commitments and an urgent agenda to accelerate efforts towards ending the AIDS epidemic by 2030. The Political Declaration provides a global mandate to Fast-Track the AIDS response.
- **The 2017 Global HIV Prevention Road Map:** This road map focussed on key interventions that countries should take to reduce new HIV infections by 75 per cent by 2020. The areas of focus include combination prevention for AGYW and their partners; combination prevention for KPs; comprehensive condom programming; VMMC and SRH services for men and boys; and rapid introduction of PrEP. This NSP is aligned with the global roadmap as it has included all these focus areas. The roadmap also advocates for the allocation of 25% resources for HIV prevention.
- **The Global TB commitment:** Commitment on Ending TB focuses on improving access to people-centred TB prevention and care, mobilising adequate resources for implementation of TB programmes and conducting research and a commitment to tracking and reviewing progress on ending TB including minimising the spread of drug resistance. This NSP and the Malawi TB NSP are both aligned to this global TB commitment as they both focus on ending TB.
- **The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW):** This convention addresses women's rights within the political, social, economic, cultural, and family life. It calls for state parties to overcome barriers of discrimination against women in areas of legal rights, education, employment, health care, politics, and finance.

4.1.2 Regional Instruments

- **Maputo Plan of Action:** Malawi is a signatory of the African Union Maputo Plan of Action on sexual and reproductive health rights (SRHR). This Plan of Action advocates for an integrated SRHR Plan. This

NSP is in line with the Maputo Plan of Action as it also promotes the delivery of integrated family planning, STIs and HIV and AIDS services.

- **Maseru Declaration on HIV and AIDS:** Malawi is one of the countries that are signatories to the Maseru Declaration on HIV and AIDS that was adopted by Member States in the Southern Africa Development Community (SADC) on 4th July 2003, in Maseru, Lesotho. The main objective of the treaty is eradication of HIV and AIDS in the SADC region, which is one of the regions with the highest prevalence rate of HIV.
- **African Health Strategy 2016-2030:** This was developed by the African Union and its vision is 'An integrated, inclusive and prosperous Africa free from its heavy burden of disease, disability and premature death'. In line with the SDGs, the African Health Strategy 2016-2030 aims at ending AIDS, tuberculosis, malaria and neglected tropical diseases among others.[128]
- A**buja Declaration:** Malawi is also a signatory to the 2001 Abuja Declaration which, among other things, aims to strengthen the response to HIV and AIDS, tuberculosis and malaria and allocate at least 15% of the annual budget to health.
- **The Southern African Development Community Protocol on Gender and Development 2008:** This provides for the empowerment of women, to eliminate discrimination and achieve gender equality by encouraging and harmonising the development and implementation of gender responsive legislation, policies and programmes and projects.

These international instruments have also been domesticated, demonstrating GoM's commitment to invest in the national response to the HIV and AIDS epidemic and achievement of sustainable results.

4.1.3 National Instruments

The NSP 2020-2025 is aligned to national policies and legislations as described below.

- **The Constitution of the Republic of Malawi:** The constitution guarantees the fundamental rights of all Malawians to life, personal liberty, dignity and freedom. Any form of discrimination, for example, based on age, sex, sexual orientation, disability and HIV status is prohibited. This strategic Plan will be implemented using a human rights approach and promotes access to HIV and AIDS services without discrimination.
- **HIV and AIDS (Prevention and Management) Act:** This legislation makes provision for the prevention and management of HIV and AIDS; the rights and obligations of people infected and affected by HIV and AIDS; the establishment, organization, administration, general powers, duties and functions of NAC as an independent state institution; and incidental matters.
- **National Health Policy 2018 - 2030:** Provide a unified guiding framework for achieving the health sector goals through addressing the identified key challenges and their root causes, thereby improving the functioning of the Malawi Health System and positioning the country on the path to achieving the health-related Sustainable Development Goals.
- **National HIV and AIDS Policy:** This policy provides guidance to the national HIV and AIDS response including the various interventions that should be included.
- **Malawi Growth and Development Strategy 2017-2022:** This is the overall development agenda for Malawi and recognises HIV and AIDS as a priority area. It acknowledges that 10% of the country's GDP is spent on the epidemic and, particularly, on treatment. The interventions, as detailed in the MGDS, focus on the reduction of new infections, HIV and AIDS deaths and stigma and discrimination. This NSP is aligned to the MGDS as it also focuses on these three areas.

- **Health Sector Strategic Plan 2017-2022:** The GoM has developed the Essential Health Package (EHP) which is a list of priority conditions and diseases that affect most Malawians. Treatment for these conditions and diseases is provided free of charge for all Malawians irrespective of their socio-economic status. HIV is one of the conditions covered in the EHP.

The NSP 2020-2025 has also been aligned to other national plans strategies and guidelines such as the HIV Prevention Strategy; National Community Health Strategy, Malawi National Condom Strategy 2015-2020, National Key Population Standard Operating Procedures (SOPs), Pre-exposure Prophylaxis (PrEP) Guidelines, Digital Health Strategy, HRH Strategic Plan; Health Information Systems Strategy; SRH/HIV integration Strategy, National Viral Hepatitis Strategy, National Youth Friendly Health Services Strategy 2015–2020; the National Strategy for Adolescent Girls and Young Women (AGYW); the National Strategy for Ending Child Marriages in Malawi, and the National Plan of Action on Gender Based Violence in Malawi and other related documents.

4.2 Guiding Principles

The NSP 2020-2025 will be guided by the following principles:

Political Leadership: To achieve SDG Goal 3 and Target 3.3 on ending AIDS by 2030, strong political leadership and commitment is essential in order to sustain an effective national HIV and AIDS response.

The Three Ones Principle: Malawi subscribes to the three ones principle namely (i) one agreed HIV NSP, (2) one national AIDS coordinating authority, and (3) one agreed country level monitoring and evaluation system. This has been adequately embraced in this NSP. Over the period 2020-2025 Malawi will have this NSP to guide HIV and AIDS programming and the NAC will be the only coordinating authority on HIV and AIDS issues. This NSP also defines the M&E system that will be used to effectively monitor progress in the implementation of the HIV and AIDS programme.

Public Health Approach: There is a need to maximize impact by prioritizing evidence-based cost-efficient interventions, strengthening health systems to enable high-quality service delivery, and integration of services to deliver combination prevention.

Investment Approach and Sustainability Plan: The investment framework, as recommended by UNAIDS, prioritises the design and implementation of HIV interventions that (i) significantly reduce HIV risk, transmission, morbidity and mortality; (ii) promote community engagement and synergies with the wider development work; and (iii) ensures the rational allocation of resources in line with the country's epidemiology and context.

Evidence-Based Programming for High Quality Impact Interventions: The development of this NSP was based on evidence and interventions having the highest impact were prioritised. This was necessary in order to ensure that 2025 targets are achieved and; hence, effectively contribute towards ending AIDS by 2030. Furthermore, efforts will be made to continue improving coverage of HIV services in the current NSP, but this will be complemented by ensuring that these services are of very high quality and delivered in line with national and international standards.

Leaving No One Behind: This NSP will also focus on targeting populations that are most at risk of either becoming infected with HIV or of infecting others. Service delivery including HTS will be offered in settings where most at risk populations are found or can easily be identified and linked to treatment. Key and vulnerable populations that will be targeted include MSM, FSWs, MSWs, prisoners, clients of sex workers migrant labourers, AGYW and ABYM.

Integrated Service Delivery: In order to gain efficiency and improve health outcomes and benefits, this NSP promotes integrated health services delivery: more specifically integrating HIV with TB, SRHR, NCDs, Viral Hepatitis, mental health and Nutrition. Effective coordination and integration are essential for the management of co-infections.

Multisectoral Engagement: HIV disease is linked to biomedical, socio-behavioural and cultural factors. The national response to HIV and AIDS therefore covers the health and non-health sector interventions by MoGCDSW), the Ministry of Education, Science and Technology (MoEST), the Ministry of Youth, Sports and Culture (MoYSC) and the Ministry of Local Government and Rural Development (MoLGRD).

Community Participation and Engagement: To achieve the 2025 targets and ensure that AIDS ends as a public health threat by 2030, there is an urgent need to engage communities. During the implementation of this NSP, communities will be capacitated and will monitor the delivery of services with the assistance from CSOs and the CHWs.[3]

Human Rights-Based Approach to HIV Programming: Stigma and discrimination constitute major barriers to the implementation of the national response to the HIV and AIDS epidemic. The NSP encompasses protection and promotion of human rights in the prevention of HIV transmission and mitigation of the social and economic impacts of the pandemic.

Gender Mainstreaming: This NSP acknowledges that women and girls are disproportionately affected by the HIV and AIDS epidemic. The NSP promotes comprehensive sexuality, gender transformative interventions and working with women and girls, men and boys, other genders, and key populations. It also recognizes that gender is a key driver of HIV that affects the HIV cascade of prevention, testing, treatment, care and support.

4.3 Strategic Direction

- **Vision:** To have a healthy and prosperous nation free from HIV and AIDS.
- **Mission:** To provide high-quality HIV prevention, treatment, care and support services to all Malawians affected by the HIV and AIDS epidemic.
- **Goal:** To contribute towards ending AIDS as a public health threat in Malawi by 2030.
- **Objectives:** The overall objectives of the NSP are to:

[3] Communities include community, cultural and religious leaders, the formal and informal segments of the private sector, Community Based Organisations, PLHIV and community groups.

1. Reduce new HIV infections from 33,000 in 2019 to 11,000 in 2025.
2. Reduce HIV and AIDS related morbidity and mortality.
3. Reach 95-95-95 treatment targets.
4. Improve the quality of HIV services.
5. Build resilient health and social welfare systems for effectively responding to the HIV and AIDS epidemic.

4.4 Key Changes

The key strategic changes in the NSP 2020-2025, among others, focus on the following:

1. Expanding access to HIV prevention, treatment, and care services (males, KPs, youths) through public private partnerships, additional urban health centres and health posts;
2. Improving district and community capacity for epidemic response;
3. Strengthening private sector involvement through HIV and AIDS service delivery and contribution to funding;
4. Prioritising high-impact cost-effective prevention interventions
5. Improving HIV and STI surveillance, toxicity and drug resistance monitoring;
6. Revitalizing HIV and AIDS workplace policies and programmes;
7. Implementing integrated service delivery and multi-sectoral approach to programming;
8. Distributing condoms to the last mile using the Total Market Approach (TMA); and
9. Improving domestic funding towards HIV epidemic control.

4.5 Thematic Areas

The thematic areas of the 2020-2025 NSP are as follows:

1. Combination Prevention
2. Differentiated HIV Testing Services
3. Treatment, Care and Support for HIV/AIDS and Related Diseases
4. TB/HIV
5. Vulnerable Children
6. Reducing Human Rights and Gender-Related Barriers
7. Social and Behaviour Change Communication (SBCC)
8. Resilient and Sustainable Systems for Health (RSSH)

5. Objectives, Targets, and Strategic Interventions

This chapter presents the objectives, targets, and strategic interventions of the eight thematic areas of the 2020-2025 NSP. By describing the strategic direction of Government, this chapter also serves as a guide for stakeholders and funding agencies to align with Malawi's priorities. For additional details, see **Annex 3** for the full list of activities required to implement the strategic interventions.

5.1 Combination Prevention

Achieving epidemic control will require a significant reduction in new infections. Malawi is determined to meet the prevention goals required to end HIV/AIDS as a public health threat in the next decade. The 2015-2020 NSP aimed to reduce new infections from 56,000 in 2010 to 25,000 in 2020. With the country's commitment to the Global HIV Prevention Coalition, Malawi revised this 2020 target to be even more ambitious – 11,000 new infections in 2020. However, the latest epidemiological model estimates that there were 33,000 new infections in 2019. While Malawi has made tremendous progress towards the 90:90:90 testing and treatment targets, the country may not meet its prevention goal. This NSP will further prioritise and strengthen existing prevention efforts.

Given that the predominant source of new infections is sexual transmission from PLHIV who are not yet virally suppressed, and that HIV positive individuals on ART with undetectable viral loads cannot sexually transmit HIV to their partners, this NSP recognizes linkage to treatment and adherence to treatment as important components of an effective prevention strategy. However, ART alone will not be enough to achieve Malawi's prevention goals; transmission also occurs from those who are not yet aware of their infection status, experience treatment failure, or have issues with adherence. Malawi must focus not only on treatment for the PLHIV who can transmit, but also on protecting those who can be infected. The gap must be closed on the other side as well.

Malawi must continue to build on the progress made so far and make strategic shifts to accelerate progress in the number of infections averted. The Revised National HIV Prevention Strategy 2018-2020 adopted the combination prevention approach, which considers biomedical, behavioural, and structural interventions.[129] Malawi will continue existing efforts to scale-up high-impact cost-effective primary and combination prevention interventions targeted to uninfected high-risk populations, especially KP, AGYW, and their partners through differentiated service delivery. In this NSP period, Malawi will strengthen critical leadership and financing for prevention. Malawi will also shift to increase collaboration with the private sector and harness its untapped power through establishment of multiple service-level agreements, strengthened workplace policies and programmes, and other partnerships.

To maximise the impact of existing resources, this NSP prioritizes the scale-up of the most cost-effective prevention measures targeting high-risk populations disaggregated by age, sex/sexual orientation, and geography. **Table 4** below shows this analysis, ordered by the number of infections averted between 2020 and 2035.

Table 4: Infections averted and cost effectiveness of selected prevention interventions. Source: 2020 Optima Model for Malawi.

Intervention	Assumed maximum coverage by 2025	Infections Averted (2020-2035)	Additional USD (2020-2035)	Average USD/ Infection Averted (2020-2035)
ART	95%	169,880	137,727,739	811
VMMC	80%	39,841	496,325,583	12,458
Condom promotion	90%	29,758	89,203,654	2,998
Community mobilization	90%	22,099	453,458,886	20,520
HTS	90%	20,052	206,483,033	10,298
PrEP for AGYW	30%	10,254	1,228,688,331	119,820
Out of school programs	90%	8,885	2,700,155,511	303,912
Cash transfers	25%	8,223	1,396,464,726	169,834
PrEP for FSW	30%	783	6,335,950	8,090
FSW outreach	90%	678	13,818,445	20,394
MSM outreach	90%	380	167,476,276	440,762
PrEP for IDU	30%	349	18,214,834	52,168
PrEP for MSM	30%	317	31,661,299	99,941

Based on these results, Malawi will implement ART, VMMC, condoms, and PrEP for FSWs as they are high-impact prevention interventions. While not modelled, WHO also recommends STI services and e-MTCT as highly effective interventions that can significantly reduce new infections. Lastly, Malawi will deliver PrEP for MSM and high-risk AGYW, as well as combination prevention to AGYW and key and vulnerable populations on the basis of equity and "leave no one behind."

However, despite acknowledging the urgent need to reduce new infections and meet global commitments, the reality of the disease trajectory and the size of the funding envelope will not be sufficient to achieve prevention targets. Even if Malawi achieves its coverage targets for all prevention programs set out in this NSP, this will only reduce new infections to 24,000 by 2025.[130] Achieving the aspirational target of 11,000 by 2025 will require a monumental increase in resources.

The following sections describe the strategic interventions for each of the prevention programs.

5.1.1 Condom and Lubricant Programming

Condoms are one of the most well-known, cost-effective methods of HIV prevention. Previous prevention efforts have thus prioritised condom distribution with remarkable results – implementation of the Total Market Approach (TMA) contributed to a 73% increase in condom distribution from mid-2016 to 2019 alone. [131] Further increasing condom use will require new ways of distribution and increased demand creation.

GAME CHANGER:

TAKING TO SCALE TOTAL MARKET APPROACH

The condom programme aims to increase condom coverage by 45% over the NSP period, equalling a distribution of an average of 155 million male condoms per year. This will prevent an additional 15,000 new infections during this NSP period. Further expansion of the TMA will ensure that condoms are always available in every sector and every location. Establishment of distribution points is prioritised in social settings such as bars, concerts and shops; in workplace settings such as the private sector and offices of uniformed forces; in everyday settings such as shops and pharmacies; and in other settings frequented by target populations such as prisons, in-school and out-of-school youth clubs, and higher education institutions. TMA efforts will focus on districts with high HIV incidence. The NSP also prioritises demand creation amongst target populations by using SBCC, strengthening premium branding for publicly distributed condoms to decrease barriers to motivated use for youth, and assessing the feasibility of revising comprehensive sexuality education in schools to decrease barriers due to low health literacy. Lastly, strengthening the TMA and going to the last mile to increase knowledge and demand will require leadership and multi-sectoral coordination. To meet this need, Malawi will strengthen condom coordination committees at all levels and revise guiding documents to ensure that efforts are coordinated and implemented to maximise impact.

Condom and Lubricant Coverage Targets by 2025

- 80% of all sexual acts are condomized.
- 155 million male condoms are distributed annually.
- 675,000 female condoms are distributed annually.
- 1.25 million Lubricants are distributed annually.
- 85% of women and 90% of men aged 15-49 know that consistent and correct use of condoms reduces the risk of HIV acquisition.

Objective 1.1.1: To scale-up the use of quality condoms and lubricants among all target populations

Strategic interventions

1. Strengthen leadership and coordination at national, district-level, and community levels.
2. Strengthen the TMA for procurement and distribution of condoms and lubricants, with an emphasis on increasing distribution points at the facility, community, and partner institutions.
3. Engage private sector to promote and distribute condoms and lubricants.
4. Link in-school and out-of-school youth clubs to accessible CBDA/NGO condom distribution points, including secondary schools and higher education institutions.
5. Ensure that condoms and lubricants on the market are high quality.
6. Increase demand for condoms among target populations through SBCC, branding, and empowerment of women, girls, and KP.

5.1.2 Pre-Exposure Prophylaxis

GAME CHANGERS:

- *INTEGRATE PREP SERVICES INTO STI AND FP CLINICS*
- *IMPLEMENT LONG-ACTING PREP*

PrEP is the use of antiretroviral medication to reduce the risk of infection for people who are uninfected. Members of key and vulnerable populations (KVPs) face barriers to traditional avenues of prevention (e.g. for FSWs, structural gender inequities hamper their ability to negotiate consistent condom use with clients). As a prevention method that can be used independently of the choices of one's sexual partner, PrEP presents a promising opportunity to fill the gap in effective prevention methods available to these KVPs. On the other hand, PrEP can have significant risks (e.g. decreased renal function) and requires substantial laboratory capacity to handle the quarterly tests recommended to monitor for seroconversion. Thus, balancing the opportunity with the risks, WHO recommended the use of PrEP in 2015 to population groups "at substantial risk of HIV infection [defined as incidence greater than 3%, which] maximizes the benefits relative to the risks and costs."[132]

In the past several years, Malawi initiated two in-country demonstration projects to assess the feasibility of wide-distribution of PrEP. In order to achieve the intended impact with PrEP, Malawi will need to address a number of challenges identified in these pilots: (i) insufficient HRH to screen for eligibility, ensure adherence, and perform client follow-up; (ii) limited capacity and availability of laboratory equipment, infrastructure, and staff to run initial creatinine and Hepatitis B screening tests and conduct quarterly monitoring tests for negative side-effects and; (iii) limited resource efficiency relative to other prevention interventions; (iv) geographic barriers as few facilities have capacity to provide PrEP; and (v) FSWs concerns that they could experience a loss of business if clients find PrEP in their possession and mistake it for ARVs. It was further identified that FSWs prefer receiving PrEP at family planning clinics or NGO-run drop-in centres.[133] For AGYW, Malawi will also need to consider issues of consent, confidentiality, partner resistance, cost, and gendered norms regarding sexuality.[134]

To address these bottlenecks to scaling-up coverage of PrEP, Malawi will focus on improving health systems readiness for the delivery of PrEP – including the integration of PrEP into STI and family planning clinics – and delivering counselling and targeted messaging in order to increase uptake and adherence. Given the aforementioned challenges with system capacity, Malawi will target implementation of PrEP to population groups with the highest incidence and establish a service level agreement with a private provider to increase the number of facilities capacitated to provide PrEP.

PrEP Coverage Targets

Programmatically, feasible adherence rates for PrEP are estimated at 30%. Thus, for FSWs, MSM, and TGs, this NSP will aim to achieve 30% coverage of the reachable uninfected population.[4] This translates to the following coverage targets during the NSP period:

[4] For MSM and TG, the estimate for the reachable population is from the PLACE study (9616 MSM in 2018) and FHI program data (697 TG in 2019 of which 283 are uninfected). For FSW, an assumption was made that 100% FSW are reachable; the PLACE study found 36000 FSWs in 2018 of which 45% are uninfected. To estimate the uninfected subpopulation sizes in 2025, an

- 13,000 FSWs
- 3,500 MSM
- 285 TGs
- 23,500 AGYW, targeting girls under 18 who are considered high-risk because they are exploited into selling transactional or survival sex

Objective 1.2.1: To improve system readiness for implementation of PrEP for target populations in high-burden districts

Strategic interventions

1. Strengthen PrEP governance and coordination systems.
2. Improve the capacity of the health system to offer PrEP through SRH/HIV service integration.
3. Establish and implement monitoring and evaluation systems for PrEP.

Objective 1.2.2: To increase PrEP uptake and adherence.

Strategic interventions

1. Develop and implement PrEP demand generation activities.
2. Provide health messaging and counselling to address barriers to PrEP adherence, such as stigma, side-effects and IPV.

5.1.3 Voluntary Medical Male Circumcision

In contrast to all other prevention interventions, VMMC reduces the risk of HIV transmission from female to male by 51-64% for life.[135] Thus, the impact of VMMC can accrue over decades, depending on the age at circumcision.

GAME CHANGERS:

- *GEOGRAPHICAL TARGETING ON HIGH INCIDENCE DISTRICTS*
- *PRIORITIZE OLDER (25-39) AGE GROUPS TO INCREASE IMPACT*

However, HIV incidence in the general population is already relatively low (around 0.29% among men 15-49 years in 2020) and epidemiological models suggest a continued decline in incidence over the next 20 years. Thus, while VMMC is generally targeted to men between 15-49 years, the GOALS model shows that the greatest population impact can be achieved by prioritizing middle-aged men (25-39) as soon as possible, given that this age group currently has the highest incidence and contributes most onward transmission to younger women. In fact, the GOALS model suggests that ART and VMMC scale-up among middle aged men will by far have the greatest impact on reducing new infections among AGYW, compared with other prevention interventions that target AGYW directly. Because past program experiences have shown that there are significant challenges to VMMC uptake among middle aged men, innovative demand creation strategies and targeted approaches will be deployed to implement the new strategy.

annual population growth rate of 3% (from the 2018 Census) and prevalence targets were applied to the UNAIDS KP Atlas population estimates.

The potential impact and cost-effectiveness for VMMC scale-up at the district level is a function of (i) size of the overall male population; (ii) incidence among men and (iii) the baseline proportion of circumcised men in the population. Based on cost-effectiveness and the latest district incidence-risk profile, the VMMC programme plans to conduct 900,000 VMMCs over the NSP period across the 12 priority districts of Machinga, Mangochi, Zomba, Blantyre, Chiradzulu, Balaka, Mulanje, Phalombe, Thyolo, Nsanje, Chikwawa, and Lilongwe. The VMMC target coverage at the district-level varies on the background prevalence of circumcision; they range between 60 -90%. The country will maintain status quo efforts in the low priority districts and serve anyone seeking VMMC (without additional investment in demand creation, etc). Finally, in order to address previous barriers that limited achievement of VMMC coverage targets, VMMC services will be (i) integrated into routine services in public and private health facilities; (ii) decentralized to health centres; and (iii) task-shifted to Medical Assistants and Nurse Midwife Technicians. The programme will look for opportunities to collaborate with the faith, private, and local communities to increase demand for VMMC services.

VMMC Coverage Targets

- Conduct 940,000 VMMCs to attain 60-90% coverage in the 15-49 age brackets in the 12 priority districts
- Maintain current coverage of VMMCs in the other low priority districts

Objective 1.3.1: To scale up the delivery of quality VMMC services among the target districts and populations

Strategic interventions

1. Expand the availability of quality VMMC services for males 15-49 in public facilities, private sector facilities, and other institutions.
2. Strengthen the capacity of public health facilities to deliver VMMC.
3. Improve demand creation for VMMC.
4. Improve quality and management of VMMC data.
5. Implement operational research to inform VMMC planning and programming.
6. Strengthen multi-sectoral collaboration, leadership, and coordination at all levels in support of VMMC.

5.1.4 Adolescent Girls and Young Women

In comparison to ABYM, HIV prevalence is almost five times higher and HIV incidence is eight times higher in AGYW.[136] Such disproportionate prevalence and incidence, coupled with low rates of condom use, low comprehensive knowledge about HIV, and unacceptable rates of early sexual debut and child marriage increase the vulnerability of AGYW to HIV and impede their ability to live to their full potential.[137,138] In response, the GoM developed a number of inter-ministerial strategies – including the National Strategy for Adolescent Girls and Young Women 2017-2022 – and passed multiple pieces of legislation to guide the implementation of AGYW interventions. The AGYW Strategy recognises the programmes already implemented by GoM, including but not limited to National Youth Friendly Health Services (YFHS), Keeping Girls in School, Action for Adolescents, DREAMS, Gender Equality and Women Empowerment, and Jobs for Youth.

GAME CHANGERS:

- *INCREASED ACCESS AND UTILISATION OF A COMPREHENSIVE PACKAGE OF YFHS THROUGH COMMUNITY YOUTH CENTRES*
- *KEEPING GIRLS IN SCHOOL*

This NSP aims to strengthen multisectoral coordination in the implementation of AGYW interventions in alignment with the AGYW Strategy. It foremost focuses on what is the direct responsibility of the health sector – increasing access to and coverage of biomedical HIV and SRH interventions for young people. This is aligned with Objective 1 of the AGYW Strategy. Implementation of comprehensive YFHS is already aligned with the YFHS Strategy and will be further strengthened to include emerging interventions and expand services to locations beyond health facilities. Barriers to HIV, HPV, GBV prevention and care, and other SRH services will be minimised on the supply side by increasing the number of locations (community and youth centres) and staff capacitated to provide YFHS. Condom distribution will expand to locations where AGYW frequent, such as youth clubs, higher education institutions, bars, and after-school clubs. On the demand side, uptake of HIV and SRH services will be increased through social media and community-based demand creation and expansion of comprehensive sexuality education (CSE). Further, as the primary source of infection of AGYW are middle-aged men, prevention interventions targeting men – including ABYM – such as condom use, VMMC, and STI services will be key to reducing new infections in AGYW.[139] Efforts on CSE, YFHS, and demand creation will further support ABYM.

In alignment with objectives 2-4 of the AGYW Strategy, this NSP also seeks to address the underlying social, educational, and economic interventions that increase risk and vulnerability of AGYW to HIV. From cash transfers to keeping girls in school to transforming social norms, this NSP further seeks to collaborate with other ministries and partners to implement a combination prevention approach to minimising new infections in AGYW. Finally, given that alcohol or substance abuse can lead to situations that increase vulnerability of AGYW and ABYM (i.e. high-risk sex and/or cases of sexual assault), this NSP aims to minimise the number of these high-risk situations by advocating for implementation of the Malawi National Alcohol Policy and addressing mental health issues that can lead to substance or alcohol abuse.

AGYW Targets

- 22% reduction in new HIV infections among AGYW
- 90% of sexually active AGYW are tested for HIV in the past 12 months and receive their results
- 90% of AGYW and ABYM aged 15-19 and 91% of AGYW and ABYM aged 20-24 report using a condom the last time they had high risk sexual intercourse
- 75% of AGYW have comprehensive knowledge about HIV

Objective 1.4.1: To increase access to and coverage of combination HIV prevention, testing, and treatment for AGYW, ABYM, and their sexual partners

Strategic interventions

1. Strengthen multi-sectoral coordination, collaboration and linkages between ministries and partners in the implementation of AGYW and ABYM interventions at national, district and sub-district levels.
2. Increase availability and access of high-quality combination SRHR/HIV services for AGYW, ABYM and their sexual partners by scaling up to locations beyond the health system to community and youth centres.
3. Increase adolescent demand for HIV and related services through community-based, digital, and private sector avenues.
4. Engage with networks of young people to disseminate prevention messages and support education programmes that allow young people to understand and exercise their rights to information and to services.
5. Expand and intensify existing life skills modules and SRH and HIV education for in-school and out-of-school youth, with a focus on delaying sexual activity, preventing GBV, avoiding transactional and age-disparate sex, and building self-efficacy.

Objective 1.4.2: To empower vulnerable AGYW through social, economic, and legal interventions

Strategic interventions

1. Engage and collaborate with influential leaders to transform and implement community and social norms change programming at the individual, community, and structural levels to create an enabling environment to support the girl child; end child marriage, sexual abuse, and stigma; promote HIV prevention; and recognise the rights of women and girls.
2. Increase access to and completion of quality primary, secondary and tertiary education, including informal and vocational learning, for AGYW.
3. Build social support and increase AGYW resilience through delivery of evidence-based social and economic assets interventions of vulnerable AGYW through small group structures such as after-school and community clubs.

5.1.5 Key and Vulnerable Populations

Key and vulnerable populations (KVPs) regardless of age, are at a disproportionately high risk of acquiring and transmitting HIV. KPs such as MSM, FSWs, MSWs, TGs, and PWIDs experience stigma, discrimination, and legal barriers that prevent them from accessing prevention services and care. Vulnerable populations such as prisoners; people with disabilities; people displaced in emergency settings; and migrant labourers who work on tobacco estates, mines, infrastructure projects, or sugar, tea, and coffee plantations face logistical barriers to accessing care.

GAME CHANGERS:

- *HIGH LEVEL ADVOCACY*
- *ROLL OUT KP SERVICES THROUGH EXISTING PUBLIC HEALTH FACILITIES AND PRIVATE PARTNERSHIPS*

In order to address the barriers that KVPs experience in receiving services, there is need for a pragmatic paradigm shift from partner-driven programming to an approach that is more efficient, data-driven, and community-centred. A number of interventions will be implemented to reduce barriers for KVPs. Implementation of differentiated models of service delivery (DSD) at a myriad of locations (drop in centres, mobile outreach, referrals, supported facility care, one-stop shops for comprehensive SRH and HIV services, and community service delivery for a minimum package) will reduce barriers for KVPs, especially subpopulations that are migratory or highly stigmatized. Establishment of service-level agreements (SLAs) with existing private health facilities will increase the number of facilities that deliver stigma-free services to KPs and reduce geographic barriers. High-level advocacy to decriminalise and normalise identities and behaviours of KPs will further reduce sociocultural barriers and increase uptake of services. Strengthened governance and emergency preparedness for delivery of HIV services in emergency settings and during emerging disease epidemics will ensure access to displaced and vulnerable populations who face increased vulnerability and risk of HIV infection during emergency situations. Finally, strengthened coordination and governance of KP programming and increased availability of individual level data needed for evidence-based KP programming will ensure effective implementation of the above interventions.

KP Coverage Targets[5]

- 43,000 FSW receive combination prevention services, including annual HIV testing.
- 8,000 MSM receive combination prevention services.
- 11,000 MSM are tested annually for HIV and receive their results.
- 20,000 prisoners are tested annually for HIV and receive their results.
- 95% of newly diagnosed HIV positive KPs (FSW, MSM and TG) are initiated on ART.
- 95% of the FSWs, MSM, TGs initiated on ART are virally suppressed.

[5] Similar to PrEP, the raw number of MSM and TG targeted is from estimates of those that are reachable (as determined by the Place Study). To achieve target coverage percentiles, this is divided by total population estimates from the UNAIDS KP Atlas.

Objective 1.5.1: To increase access to and coverage of combination HIV prevention, treatment, care, and support among KPs

Strategic interventions

1. Strengthen national and district level governance and coordination of KP programs and community services.
2. Engage and advocate with high-level government, political, civil society, faith, and other opinion leaders to address legal barriers and foster an enabling environment for KPs.
3. Expand a DSD model for KVP enabling them to access a continuum of HIV and SRH services from multiple service delivery points, including prisons.
4. Pursue SLAs with private SRH providers to expand delivery points to KPs.
5. Scale-up delivery of a standard comprehensive package for FSWs, their children and clients, MSM, MSW, and TG provision that includes HIV prevention, treatment, care, and support services; SRHR; GBV; and community mobilisation.
6. Scale-up community-based and self-HIV testing coupled with ART linkage, retention in care, and ART adherence for KP.
7. Strengthen U=U campaign and scale-up viral load monitoring to achieve KP viral load suppression.

Objective 1.5.2: To improve the quality of planning for KP interventions through increased generation and use of relevant evidence

Strategic interventions

1. Modify and routinely conduct studies to determine size estimates for FSWs, MSM, PWIDs, MSW, and TGs and other drug users, including people who inject drugs (PWID)
2. Coordinate research and implementing partners to understand findings on interventions targeting PWIDs, MSWs, and TGs to inform the development of interventions

Objective 1.5.3: To support GoM and various disaster risk management stakeholders to deliver the minimum required multi-sectoral response to HIV and AIDS during emergency situations and disease pandemics

Strategic interventions

1. Mainstream HIV and AIDS in Disaster Risk Reduction (DRR) policies, strategies and programmes at all levels.
2. Mainstream HIV and AIDS in National Disease Epidemic Preparedness and Response Plans, policies, strategies and programmes at all levels.
3. Strengthen emergency preparedness and logistics mechanisms.
4. Develop and deliver a package of HIV, GBV, SRHR and mental health services in emergency situations.

5.1.6 Elimination of Mother to Child Transmission (e-MTCT)

The PMTCT program made significant progress during the NSP 2015-2020. **Figure 14** below shows the reduction in the number of paediatric infections (reflected in the size of the balloons), MTCT transmission rates, HIV prevalence in pregnancy, and the projection for this NSP. In 2020, Malawi will pursue the path to elimination of mother-to-child transmission of HIV, viral hepatitis, and congenital syphilis.

GAME CHANGERS:

- *HIV SELF-TEST TO MALE PARTNERS OF HIV NEGATIVE PREGNANT AND BREASTFEEDING WOMEN*
- *VIRAL LOAD SCREENING IN PREGNANT AND BREASTFEEDING WOMEN ALREADY ON ART AT FIRST ANC VISIT*
- *HIGH LEVEL ADVOCACY FOR E-MTCT*

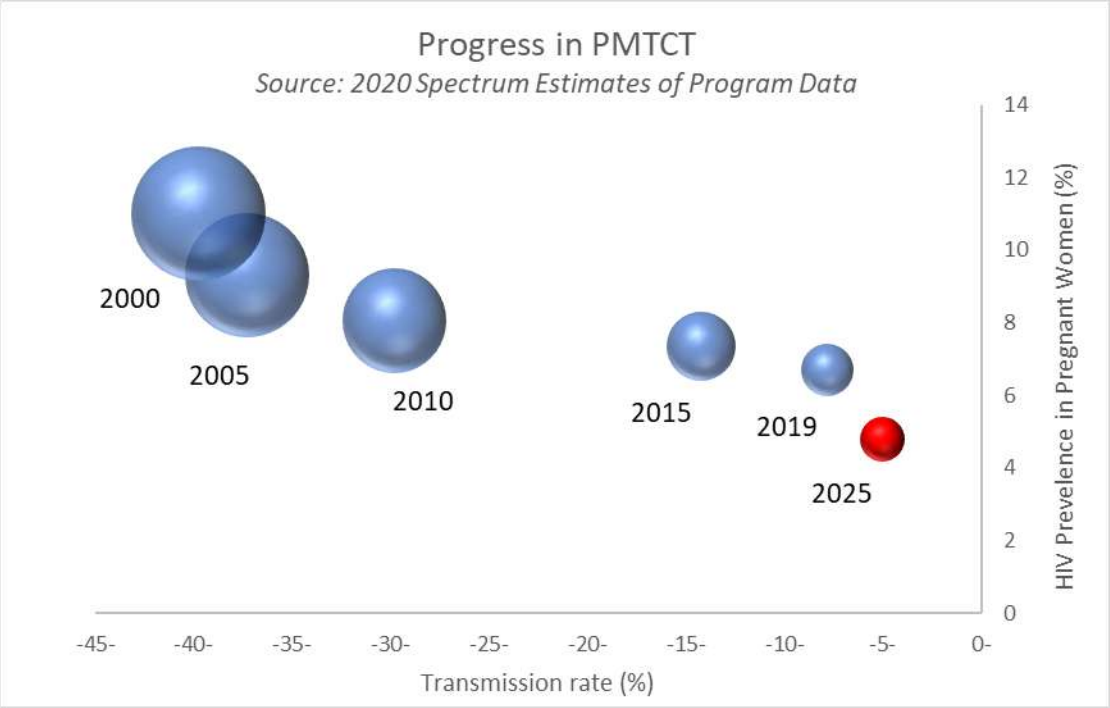


Figure 14: Target for the e-MTCT program (red balloon). Source: 2020 Spectrum estimates of program data

To address the challenges mentioned in the situation analysis, the MoHP will strengthen the integration of family planning services into HIV care and treatment in both public and private health facilities. Timely diagnosis of HIV in pregnant and breastfeeding women as well as their partners – and access to treatment and support services – is critical to reducing MTCT. Strategies will be implemented to reduce the time between conception and the first ANC visit so that HIV screening can occur earlier in the pregnancy. Universal HIV, viral hepatitis and syphilis retesting of mothers at maternity will be scaled up. Additionally, breastfeeding women and their partners will be systematically screened and tested for HIV to prevent not only MTCT, but also new infections among mothers.

Health care facilities and staff will strengthen linkage to complementary and supportive services in order to improve treatment outcomes for mothers and their HIV-exposed children. This will include active tracing for mothers who miss appointments and the use of expert clients and/or mentor mothers to improve retention in care. Similarly, as communities are integral partners in e-MTCT and their engagement is necessary to provide-quality services, community engagement will be done across the cascade of e-MTCT services.

Targets

- Reduce the MTCT rate at the end of the breastfeeding period from 7.6% to less than 5% by 2025
- Reduce the case rate of new paediatric HIV infections due to MTCT from 715 cases/100,000 live births to less than 350 cases/100,000 live births by 2025

Objective 1.6.1: To improve primary prevention of HIV in women of childbearing age, specifically for AGYW, pregnant and breastfeeding women

Strategic interventions

1. Intensify SBCC to increase demand for and uptake of SRH and HIV prevention services by AGYW, pregnant and breastfeeding women and their male partners as highlighted in the Malawi AGYW, HIV prevention strategies, HIV strategy for higher education institutions, and all other applicable strategies
2. Evaluate and scale-up PrEP for AGYW, pregnant and breastfeeding women
3. Offer integrated and youth-friendly health services (YFHS) to AGYW and boys
4. Engage male partners of AGYW, pregnant and breastfeeding women

Objective 1.6.2: To reduce unplanned and unintended pregnancies among HIV infected women

Strategic interventions

1. Support counselling on a wide range of family planning methods to HIV positive women
2. Support the provision of family planning commodities to HIV positive women
3. Ensure linkage of family planning with provision of other SRH services to increase coverage

Objective 1.6.3: To prevent vertical transmission of HIV through screening and identification of women and their partners during pregnancy and breastfeeding

Strategic interventions

1. Strengthen screening for HIV, viral hepatitis, and syphilis throughout pregnancy and breastfeeding period
2. Treat syphilis in pregnant and breastfeeding women together with their partners
3. Initiate and monitor newly HIV diagnosed pregnant and breastfeeding women on lifelong ART

Objective 1.6.4: To provide treatment, care and support to infected mothers and infected and exposed infants

Strategic interventions

1. Improve linkage of HIV+ mothers and infants (e.g. through strengthening CBOs) to support adherence and retention
2. Improve monitoring and follow-up of HIV exposed infants

3. Improve retention of HIV+ mothers and infants on treatment, viral load monitoring of HIV+ mothers and infants on ART treatment

5.1.7 Sexually Transmitted Infections and Sexual and Reproductive Health Services

Studies show that there is significant underdiagnosis of STIs.[140] However, programme data in recent years have shown an increasing demand for STI services in the country – in just two years between 2016 to 2018, diagnosed cases increased 48%.[141] Much of this success can be attributed to the training, mentorship, and M&E of private facilities in the past NSP period. Private facilities are critical to the health system's STI treatment capacity due to their ability to provide services in confidential settings.

GAME CHANGER:

- *EXPAND ACCESS TO INTEGRATED STI/SRH SERVICES THROUGH INCREASED COLLABORATION WITH THE PRIVATE SECTOR*

However, availability of commodities remains a challenge for the STI program. PPM procures STI commodities based on commodity consumption. However, in the previous NSP period, the STI program lacked comprehensive data for decision making due to an insufficient budget that led to inconsistent supportive supervision and limited supply of M&E tools. This resulted in an underestimation of STI cases. In this new NSP, Malawi is prioritising integrated STI/SRH routine supervision, Public Private Partnerships, and timely supply of STI M & E tools to facilities to ensure timely availability of and access to STI drugs.

In addition to increasing collaboration with private sector clinics, this NSP recognises that strengthening integration of HIV and SRH services will also be a critical strategy to increase comprehensive coverage and uptake of STI services. Malawi will also pursue service level agreements with existing private providers to (i) expand comprehensive STI screening and treatment to at-risk populations such as STI clients, MSM, FSWs, prisoners and AGYW (ii) provide family planning, cervical cancer screening, and cervical cancer treatment to women aged 25-49 living with HIV and on ART. On the demand side, Malawi will also increase utilisation of STI services through high-level public awareness campaigns. Lastly, to address the emerging threat of antimicrobial resistance (AMR), Malawi will continue to strengthen AMR monitoring for STIs.

STI and SRHS Coverage Targets by 2025

- 98% of STI clients are tested for HIV
- 95% of antenatal mothers are screened for syphilis
- 95% of WLHIV are screened for cervical Pre-cancer
- 95% of WLHIV with cervical pre-cancerous lesions are treated

Objective 1.7.1: To increase quality STI and other SRH services at HIV service delivery points, including family planning, cervical cancer, syphilis, and post-sexual violence care coverage

Strategic interventions

1. Improve demand, access, and utilisation of STI screening and treatment to all populations

2. Strengthen engagement and collaboration with the private sector on STI and HIV prevention service delivery
3. Strengthen integration of service delivery of STI and SRH services including family planning, cervical cancer screening including treatment services
4. Improve monitoring and evaluation systems of STI and other SRH services at national and subnational levels
5. Strengthen monitoring of antimicrobial resistance for STI with focus on Neisseria gonorrhoeae

5.1.8 Wellness and Workplace HIV Programmes

GAME CHANGER:

- *ACCESS TO HIV SERVICES THROUGH THE WORKPLACE*

In Malawi, MBCA coordinates the HIV and AIDS response for private companies and business institutions. However, MBCA's coverage is limited because it is based on membership. While the Ministry of Labour drafted the National HIV and AIDS Workplace Policy in 2010 to contribute towards HIV prevention and impact mitigation efforts for workers and their families, the policy was never finalised and proposed interventions were not implemented to scale. The GoM recognises that AIDS continues to pose a threat in the workplace hence, there is a need to strengthen workplace HIV programmes. GOM is also currently developing the Decent Work Country Programme, which outlines the interventions to promote decent work.

While the private sector's financial contribution to the national response is low, it nevertheless has great potential to provide critical resources in the fight against HIV and AIDS. This NSP prioritises the active engagement of the private sector by promoting expansion of HIV service delivery in private facilities (i.e. establishing SLAs with private health facilities), advocating for increased sustained private sector financial contributions to the HIV response, and ensuring the availability of an effective system to monitor the implementation of workplace HIV programmes. The mandate of the MBCA will also be reviewed so that it covers all private workplaces under the Malawi Confederation of Chambers of Commerce and Industry and Employers Consultative Association of Malawi (ECAM).

The GoM will develop and revise policies and strategies to guide implementation of overall workplace HIV programmes in all sectors. The public sector will specifically focus on overall governance as well as implementation of public sector workplace programmes.

Targets

- 75% of the formal workplaces have HIV and AIDS workplace policies and programs
- 100% workplaces provide PPE to high risk workers
- 100% Occupational Safety and Health officers capacitated on implementation of HIV and AIDS in the workplace

Objective 1.8.1: To strengthen multi-sectoral governance of HIV and AIDS workplace programmes

Strategic interventions

1. Develop the National HIV and AIDS Workplace Policy and ensure that it addresses gender equality, human rights and social inclusion of key and vulnerable populations
2. Develop and implement a comprehensive costed HIV and AIDS in the workplace strategic plan for both the public and private sectors for the period 2020-2025
3. Develop and implement HIV and AIDS policies and programmes targeting the informal sector
4. Develop and implement tailored comprehensive HIV and AIDS package for migrant laborers including the construction and plantation sectors
5. Develop and implement strategies on economic and workplace empowerment of young women

Objective 1.8.2: To strengthen the implementation of HIV and AIDS workplace programmes in the public sector

Strategic interventions

1. Develop regulations to mainstream HIV and AIDS prevention and management into Labour Inspection checklists
2. Capacitate Occupational Safety and Health Officers and Labour inspectors on HIV and AIDS enforcement at workplaces
3. Revise the MoL HIV and AIDS and workplace guidelines including on ORT

Objective 1.8.3: To strengthen the implementation of HIV and AIDS workplace programmes in the private sector

Strategic interventions

1. Review the mandate of the MBCA to cover private companies under the MCCI and ECAM
2. Build the capacity of the private sector to effectively deliver HIV and AIDS services including HIV prevention and treatment both directly and SLAs
3. Implement SLAs with the private health facilities
4. Strengthen HIV prevention and treatment interventions in the workplace including promotion and distribution of condoms, HIV Testing Services, VVMC, PrEP, PEP and ART and encouraging employers to provide Personal Protective Equipment for high-risk workers such as health care workers
5. Enforce the private sector reporting of data in line with the 2018 HIV and AIDS Prevention and Management Act
6. Advocate for increased financial contribution of the private sector to the national response towards HIV and AIDS

5.1.9 Blood Safety

MBTS will decentralise blood collection, screening, and distribution in order to ensure timely access and adequate supplies of safe blood and blood products to meet the needs of all patients. This NSP will provide for the infrastructure, human resources, equipment, and commodities to set up sentinel sites at all major hospitals.[142, 143]

Objective 1.9.1: To improve the availability, quality, and management of blood transfusion services

Strategic intervention

- Set up sentinel sites for blood collection, screening, and distribution and all major hospitals

5.2 Differentiated HIV Testing Services

HIV testing services aim to increase the number of PLHIV identified and linked to timely prevention, care and treatment services. Over the last 5 years the annual testing numbers have more than doubled, putting a strain on the health system, including human resources, commodities, quality assurance, and monitoring and evaluation systems. The proportion of unidentified PLHIV in the population is estimated to be at 2%.

GAME CHANGERS:

- *USE OF ULTRA-RAPID HIV TESTS*
- *INTEGRATED ACTIVE INDEX TESTING AND ASSISTED HIV SELF-TESTING BY COMMUNITY WORKERS*

To improve testing efficiency and accuracy, and reduce the number of false positives, Malawi plans to adopt the WHO recommended three-test algorithm, including the use of an ultra-rapid first test to reduce time to results delivery. To expand case finding, Malawi will expand the scale up of active index testing and assisted HIV self-testing using community-based cadres. Malawi will target men, children, FSWs and their clients, MSM, refugees, migrant labourers, prisoners, students of higher education institutions and colleges, and people in uniform in a differentiated manner. To reach these key and priority populations, HTS will be fully integrated with SRH and other key health services.

Targets

See **Annex 2** for the methodology used to determine the testing targets

1. Conduct 6.9 million HIV tests
2. Identify 56,000 HIV positive clients
3. Link 44,000 clients to treatment

Objective 2.1.1: To improve HIV case finding among high risk populations through proven innovative approaches

Strategic interventions

1. Strengthen integrated and targeted facility and community testing of all key and priority populations
2. Improve the quality of HTS diagnoses through better planning, management, and QA systems
3. Strengthen linkage of HTS clients to comprehensive prevention and treatment services
4. Integrate HTS into SRH and other key health services
5. Improve governance and coordination of the HTS program across the public and private sectors with a focus on decentralization
6. Strengthen health system capacity to implement HTS policies
7. Improve HTS data systems at facility and community level

5.3 Treatment, Care and Support for HIV/AIDS and Related Diseases

Since Malawi's adoption of the "Universal Test and Treat policy" in 2016,[144] many PLHIV have been initiated on ART regardless of their CD4 count**.** The current NSP aimed to put 90% of known HIV positives on ART and retain them in care.[145] By end of September 2019, the number of PLHIV alive and on treatment was 837,060; this is estimated to reach 905,416 by December 2020.

GAME CHANGERS:

- *EXPANDING ACCESS THROUGH PRIVATE SECTOR AND FURTHER DECENTRALIZATION OF SERVICES*
- *IMPROVING RETENTION IN & QUALITY OF CARE*
- *IMPROVING PAEDIATRIC TREATMENT OUTCOMES*

Malawi has found success with linkage from HIV testing to ART care. In many ART clinics, newly diagnosed HIV positive patients are escorted by HDAs or Expert Clients from testing rooms to ART clinics. In June 2019, viral load coverage was 78% in adults and 70% in children. Viral load (VL) monitoring was scaled up and by September 2019, 92% of people on ART were virally suppressed.[146]

For the duration of this NSP, Malawi is expected to have 273,000 patients lost to follow up (LTFU). Reducing LTFU and deaths on ART will be critical to achieving the targeted ART scale-up. Over 560,000 ART initiations are needed to offset the current LTFU rates. This number far exceeds the estimated number of PLHIV not on ART in the population. **Figure 15** shows ART scale up in Malawi from 2004-2025. Programmatic monitoring results remain below the WHO target of 85%, but actual retention rates are thought to be about 10% higher due to misclassification of 'silent transfers' as 'defaulters' in clinic-based survival/retention analysis. Additionally, 85% of AIDS related deaths occur in people already on ART. Therefore, reduction of morbidity and mortality should target people already on ART.

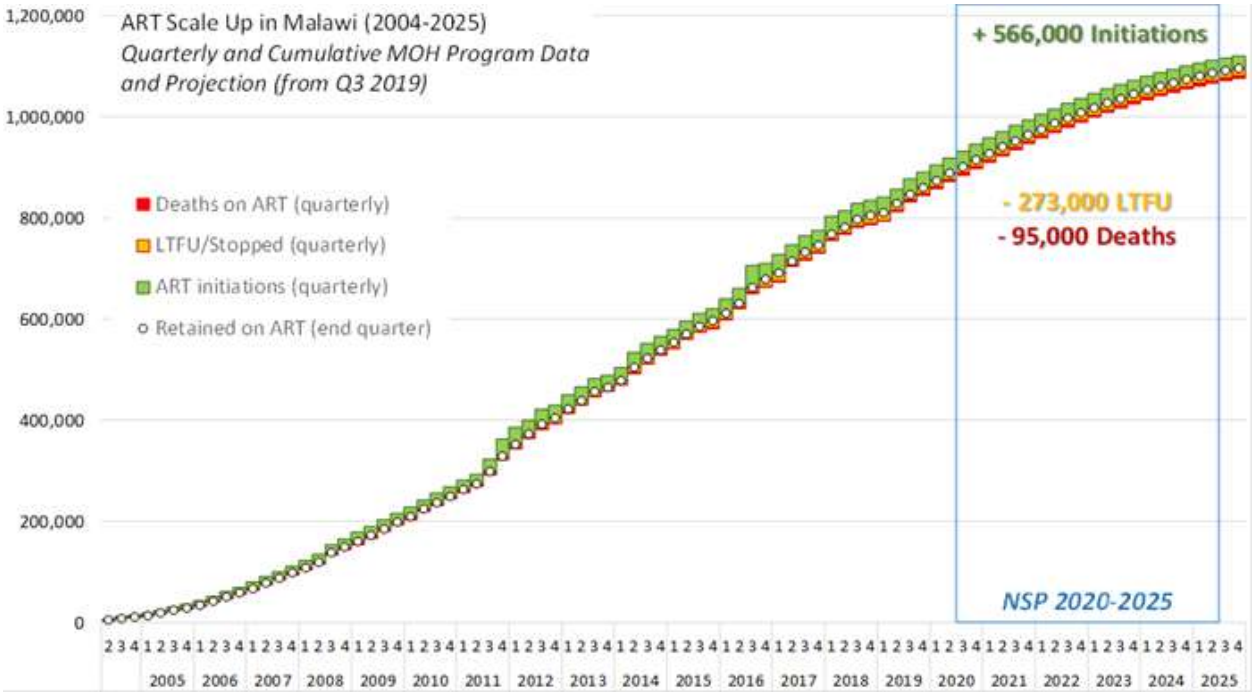


Figure 15: ART Scale Up in Malawi. Source: Quarterly and Cumulative MoH Program Data from 2005 to Q3 2019; Projection from Q3 2019 to 2025.

The incidence of opportunistic infections (OIs) has also decreased tremendously with implementation of "the Test and Treat policy." However, OIs remain an important problem in patients who are unaware of their HIV serologic status and in those not receiving ART; even for those who are receiving ART, OIs remain a problem due to poor adherence, failure and cross resistance. From programmatic data, between 2015 and September 2019, 574,781 PLHIV were enrolled in care in ART sites across the country. Cryptococcal meningitis treatment was administered to 2.2% (12,811) while 2.6% (14,811) were treated for Oesophageal Candidiasis.[147]

Rapid scale-up of antiretroviral therapy over the past decade has reduced the burden of HIV related cancers for the three AIDS-defining malignancies which are Kaposi Sarcoma (KS), cervical cancer, and non-Hodgkin Lymphoma (NHL). However, a recent study done in Malawi showed that KS had the highest attack rate (634.7 per 100 000 person-years) followed by cervical cancer (36.6) while Non-AIDS defining illness (NADCs) accounted for 6% of new cancers.[148] Chemotherapy protocols have been utilized to manage cancers in both public and private health facilities while advanced cases are referred outside Malawi for radiotherapy. A cancer centre has recently been constructed and will be providing radiotherapy treatment.

With an aging HIV-infected population on ART, this cohort is associated with increased NCDs risk. With NCD prevalence rising, NCD screening and treatment are urgently needed, in particular among PLHIV, who face an increased risk. To reduce morbidity and mortality in the aging cohort of people on ART,[6] improvement in identification, management and monitoring of opportunistic infections, NCDs, cancers,

[6] By the end of 2019, 32% of patients on ART were 45 years of age and above. Resource: Department of HIV and AIDS

viral hepatitis and mental health interventions in an integrated manner is required to benefit not only PLHIV, but also the general population.

This NSP will focus on improving ART outcomes, access, coverage and retention in care particularly for (peri-) urban population, men, and key populations. Men friendly clinics that provide integrated services (prevention and treatment) will be established through public private partnerships. Paediatric outcomes will be improved through introduction of Dolutegravir containing fixed dose combination for children below 20kgs and continued improvements in EID and supporting caregivers by ongoing development of teaching aids for current and emerging paediatric regimens. Through the differentiated service delivery mode, teen clubs will continue to be scaled up and incorporated into youth friendly health services.

The transition to Dolutegravir as first-and second-line treatment in 2019 has resulted in a measurable increase of viral load suppression rate at the cohort level (from 89% to 93%).[149] In the next five years. the treatment program will focus on safeguarding this second 'lease of life' by enhanced VL monitoring, intensive adherence support for any patient not fully suppressed and genotyping for patients who fail to re-suppress. Additionally, toxicity issues and adverse events associated with ARVs are currently identified only intermittently and not being widely reported.[150] To increase the identification of these events, 10 sentinel sites in a selection of larger clinics will be established and equipped with routine laboratory monitoring.

Targets

- To reach 1,015,000 people on ART by 2025
- To increase paediatric ART coverage from 68% to 85%
- To reduce morbidity and mortality among people living with HIV including other disease related conditions (opportunistic infections, HIV related cancers, NCD, HIV-Hepatitis coinfection, mental health)
- Improve retention in HIV care at 12 months from 72% in 2019 to 85% in 2025

Objective 3.1.1: To increase coverage and provision of high-quality integrated HIV and other related diseases (NCD, Viral Hepatitis, and cancer services)

Strategic interventions

1. Improve access to high-quality ART services for adults, children, and vulnerable/underserved populations
2. Improve retention and adherence in ART among adults, adolescents, and children
3. Improve treatment monitoring (Viral Load, Drug Resistance and ARV Toxicity Monitoring)
4. Improve timely delivery of viral load results to site level providers and recipients of care
5. Strengthen community structures and systems to improve HIV service delivery

Objective 3.1.2: To reduce AIDS, non-AIDS mortality and co-morbidities

Strategic interventions

1. Improve monitoring and management of advanced HIV disease including cancers
2. Improve monitoring and management of other HIV related diseases and comorbidities (non-communicable diseases, viral hepatitis and mental health in PLHIV

3. Support primary, secondary and tertiary facilities to manage AIDS and non-AIDS related morbidities
4. Strengthen coordination of treatment, care and support at national and district level
5. Ensure access to PEP in all hospitals and health centres

5.4 TB and HIV Co-infection

In 2019, MoHP rolled out TB prevention therapy (TPT) using Isoniazid-Rifapentine (3HP). This NSP will increase adherence support and toxicity monitoring of TPT in these groups.

GAME CHANGERS:

- *TB PREVENTIVE THERAPY USING 3HP FOR ALL PATIENTS STARTING ON ART*
- *INTENSIVE TB SCREENING OF ART*

The priorities for the TB/HIV program are to strengthen TB/HIV collaboration at all levels. The TB/HIV operational framework will be used to guide this collaborative work. Priorities include increasing case finding and diagnosis for TB and HIV among PLHIV or persons with TB; improving the coverage of high-quality treatment to all HIV/TB co-infected people and scaling up TPT to all people starting ART.

Targets

- 99% of registered new and relapse TB patients have documented HIV status
- 95% of HIV positive new and relapse TB patients are on ART during TB treatment
- 99% of PLHIV on ART are screened for TB
- 87% of PLHIV on ART initiated on TPT

Objective 4.1.1: To reduce incidence, morbidity and mortality in TB/HIV co-infected patients

Strategic interventions

1. Strengthen TB/HIV collaborative and coordination activities at all levels
2. Improve quality and coverage of intensified case finding and diagnosis for TB and HIV among PLHIV or persons with TB, including the use of sensitive molecular assays like Xpert MTB/RIF Ultra and other WHO recommended methods
3. Improve coverage of high-quality treatment to all TB/HIV co-infected people
4. Increase coverage of TB Preventive Therapy (TPT)

5.5 Vulnerable Children

The GoM developed a Child Protection Case Management Framework. It details how children experiencing abuse, neglect, violence, exploitation, and the impact of HIV and AIDS can best be taken care of. Over the course of implementing the 2020-2025 NSP, the case management approach will be scaled up in HIV burden districts to protect all vulnerable children.

GAME CHANGERS:

- *SCALING UP HIV SENSITIVE CASE MANAGEMENT APPROACH.*
- *SCALE UP CARE FOR GBV SURVIVORS.*

As mentioned earlier, there is a shortage of CCPWs who are required to effectively implement the Child Protection Case Management Framework. These CCPWs visit households with vulnerable children where they monitor, among other things, the nutritional status of the vulnerable children and ensuring that those on ART adhere to HIV treatment. This NSP will focus on building the capacity of these CCPWs. Other interventions include improving sources of livelihoods for orphans and their households, GBV prevention and care, strengthening local structures that help with addressing child protection issues, and improving coordination.

Objective 5.1.1: To scale up HIV sensitive child protection case management in high HIV burden districts.

Strategic interventions

1. Improve coordination at national and district levels
2. Strengthen the monitoring of vulnerable children
3. Build the capacity of Community Child Protection Workers for them to effectively implement the Child Protection Case Management Framework

5.6 Reducing Human Rights and Gender-Related Barriers

This NSP 2020-2025 aims to eliminate human rights and related barriers to HIV and other services through increasing legal and human rights literacy among health workers, teachers, law enforcers, key populations and the general public. Among other strategies, this will be achieved by the involvement of PLHIVs and key populations in creating awareness about the rights of PLHIV and key populations.

GAME CHANGERS:

- *IMPROVE LEGAL LITERACY*
- *LOBBY FOR REVIEW OF DISCRIMINATORY LAWS*

Further, acknowledging the fact that gender inequality hinders social and economic development, the achievement of gender equality remains one of the critical components of the HIV agenda. Within targeted geographic settings, CSOs, CBOs, OVC committees, and communities are critical players in the delivery of comprehensive community packages which address gender barriers and a package of clinical and social services will be promoted and provided to survivors to mitigate the harms associated with GBV.

Target: Zero discrimination for PLHIV and KP by 2030

Objective 6.1.1: To reduce stigma and discrimination against PLHIVs and other KPs

Strategic interventions

1. Create awareness/legal literacy about HIV and HIV/TB related stigma and discrimination and legal services to women, girls, vulnerable populations and key populations
2. Improve access to health services for key populations
3. Improve access to legal services for PLHIV and KPs for issues relating to discrimination, violence protection and other human rights
4. Strengthen the legal environment for PLHIV, KPs, and other discriminated minorities, including redress mechanisms in cases of human rights violations in the provision of health care

Objective 6.1.2: To reduce harmful gender norms, stereotypes and gender-based violence

Strategic interventions

1. Support HIV and AIDS related programs to address harmful gender norms and stereotypes
2. Support programs to reduce gender-based violence

5.7 Social and Behaviour Change Communication

GAME CHANGER:

USING SOCIAL MEDIA FOR INTERPERSONAL COMMUNICATION

In order to effectively contribute towards ending HIV and AIDS as a public health threat by 2030, this NSP encompasses a multi-level, evidence-based and theory-driven SBCC interventions that addresses the needs, characteristics and behaviours of target audiences. This NSP will contribute to increasing the uptake of HIV prevention, treatment and care services by (i) providing strategic information to address underlying drivers of HIV infection, (ii) empowering individuals and communities to adopt positive health seeking behaviours, and, (iii) increasing demand for HIV services. Specific SBCC interventions have also been developed under each of the HIV programmes/modules.

Objective 7.1.1: To facilitate positive behaviour change at individual and community levels

Strategic interventions

1. Develop a successor HIV Prevention strategy for Malawi for the period 2020-2025
2. Develop district, regional and national SBCC messages and materials targeting specific sub-populations, cultural background and age groups, especially AGYW and ABYM
3. Design and implement comprehensive qualitative studies on barriers to uptake of HIV prevention and treatment services to inform the development of relevant SBCC interventions (gender, human rights, etc)

4. Conduct targeted demand creation SBCC strategies for the general population and specific groups using a mix of effective and evidence-based channels, which may include mass media, interpersonal communication and community mobilization and dialogue
5. Expand the use of mobile and on-line communication technologies in the dissemination of SBCC messages to target populations including men and key populations
6. Mobilise and build the capacity of existing structures and networks to address harmful cultural practices and gender norms that promote HIV transmission
7. Mobilise community structures to conduct community mobilization and sensitization activities to promote health-seeking behaviours among sexually active males
8. Recruit and engage leaders as champions/role models and ambassadors of HIV prevention at all levels including political, religious and traditional leaders
9. Conduct a comprehensive TB and HIV treatment literacy programme among PLHIVs and their caretakers
10. Establish SBCC coordination structures at national and district level and support their operations to ensure harmonization of SBCC efforts by stakeholders

5.8 Resilient and Sustainable Systems for Health

A good health system is of utmost importance to the HIV program. This is because an HIV program can only be as good as the health system it is built on. Apart from funding, Malawi's strained health system constitutes the main bottleneck for scaling up HIV and related health services. This chapter focuses on elements of Malawi's health system that are essential for the effective and efficient delivery of quality HIV services as described in the National Health Sector Strategic Plan II 2017-2022 (HSSP II). The NSP 2020-2025 will support all components of the health system directly linked to the HIV program to ensure that all gains made in the national HIV and AIDS response are sustained and that efficiencies in service delivery are unlocked. Over the period of this NSP Malawi will increase access to service delivery, actively engage the private sector, and make greater use of community-based approaches. Interventions and targets were determined based not only cost-effectiveness, but also the limited capacity of the health system, especially in terms of human resources and available infrastructure.

5.8.1 Leadership and Governance

Good governance and strong leadership are essential to ensuring effective delivery of HIV services, strengthening coordination and minimizing inefficiencies across the health sector. The leadership and governance of the AIDS responses entail the implementation conditions that are necessary for ensuring an effective and harmonized national response to AIDS and developing and strengthening partnerships between key stakeholders, especially government and civil society. Due to the multi-faceted nature of the HIV/AIDS epidemic, an effective institutional framework for the national HIV and AIDS response requires a multi-sectoral approach. This includes partnerships, consultations and coordination between government and all relevant stakeholders – including the private sector, CBOs, NGOs, FBOs and PLHIV – in the design, implementation, review, monitoring and evaluation of the national response to HIV/AIDS.

As recommended by the Global HIV Prevention Coalition, strong political leadership and commitment at all levels is essential for a sustained and effective response to HIV and AIDS. The HIV and AIDS Prevention and Management Act of 2018 mandates the Minister of Health and Population to lead the national HIV

and AIDS response and the NAC to implement, coordinate and facilitate the national multisectoral response. Domestication of this Act is needed to successfully coordinate the HIV response throughout this NSP period.

Objective 8.1.1: To advocate for a strong, sustained and visible role of political, civil, religious, and traditional leaders in the HIV response at the national and subnational levels

Strategic interventions

1. Lobby the highest political leadership to champion the Global HIV Prevention Coalition of the Malawi chapter as a demonstration of high-level commitments to accelerate the pace of decline in new adult HIV infections
2. Mainstream the delivery HIV and AIDS messages in high level political, religious, and traditional speeches
3. Mainstream the delivery of HIV and AIDS services during cultural activities

Objective 8.1.2: To domesticate the HIV and AIDS Prevention and Management Act of 2018

Strategic interventions

1. Ensure that the national response continues to be inclusive, multisectoral and is implemented in line with the HIV and AIDS Prevention and Management Act of 2018
2. Develop and enforce regulations to guide the implementation of the provisions of the HIV and AIDS Prevention and Management Act of 2018

5.8.2 Financial Management

While there have been challenges within government financial management systems in the past, Government has implemented systems and reforms to demonstrate accountability of the resources that it receives for the HIV/AIDS response. Examples include creation of the Project Implementation Unit (PIU) which provides oversight for GF resources and the Fiscal Agent within PIU who enforces compliance for financial management and procurement to reduce financial risk.

Further, in order to comply with the financial requirements of the HIV and AIDS Management Act, Public Financial Management Act, Public Procurement Act, Public Audit Act and development partners funding requirements, NAC has strengthened its financial and risk management systems. NAC has installed an enterprise resource planning package (ERP), enhanced the grants management system, revised all financial and risk management policies and manuals and oversight functions. NAC has an independent and competent Board of Commissioners that were competitively recruited in accordance with the HIV and AIDS Management Act. GoM and NAC are now better positioned to manage funds for the HIV and AIDS response.

Several challenges remain to ensuring that resources are adequately managed and coordinated – most significantly, limited capacity and accountability to enable resource mapping in the NGO sector. DPPD manages a list of all NGOs which will now be tracked. Malawi continues to identify strategies to continue improving financial management, strengthening grants management, and increasing the impact of existing resources.

Objective 8.2.1: To strengthen grants management

Strategic interventions

1. Support the development of the National Health Financing Strategy which includes sustainable HIV and AIDS financing
2. Support systems to track available resources and expenditure on HIV and AIDS
3. Conduct regular financial risk assessment and mitigation measures for all institutions, including government
4. Build the capacity of implementing partners in grants management
5. Applying gender responsive budgeting to the HIV response[151,152]

Objective 8.2.2: To increase the impact of existing resources

Strategic interventions

1. Collaborate with the Ministry of Finance to improve absorption of donor funds in the health sector
2. Improve efficiency of resource allocation and utilisation
3. Mobilize donor support for health systems strengthening

Objective 8.2.3: To strengthen mobilization of governmental and non-governmental domestic resources

Strategic interventions

1. Initiate dialogue with government, civil society and partners to increase domestic investment for essential HIV prevention, SRHR, GBV, and social protection policies, per Global Prevention Coalition commitments
2. Mobilize resources from and partnerships with the private sector to support the HIV response
3. Build the capacity of implementing partners in resource mobilisation
4. Advocate with Parliament to gradually increase domestic financing for the HIV and AIDS program

5.8.3 Coordination of the Response

Malawi has made significant progress towards epidemic control and the 90:90:90 targets under the leadership and coordination efforts of the NAC. There are a number of sectoral coordinating bodies that have been established as part of the national response. The situation analysis has highlighted a number of challenges including the lack of resources for effective coordination of the national response. During the implementation of this NSP, the capacity of the NAC and other coordinating agencies will be strengthened to ensure effective and efficient coordination of the response and create an enabling environment for achieving and sustaining epidemic control. Regulations will be developed to fully implement the provisions of the HIV and AIDS (Prevention and Management) Act of 2018 so that the national response is implemented in line with the law; and a functional review of coordination agencies will be conducted to clearly redefine their mandate and roles so that they are focused on their core mandates. During this NSP the focus will also be on increasing domestic funding for the national response and ensuring that implementing partners have the capacity to develop proposals and efficiently manage resources.

NAC will ensure that the response is evidence based, gender sensitive and responsive to human rights. The M&E system will be strengthened to respond to the needs of the stakeholders in the national

response. In an environment where resources for HIV and AIDS are declining, coordination of resource mobilisation, allocation and distribution is necessary to sustain the response. Through the HIV and AIDS Prevention and Management Act of 2018; NAC is mandated to mobilize and equitably disburse resources towards the national response. Therefore, NAC will spearhead the coordination, development and implementation of strategies for sustainable financing of the national response including systems for resource tracking from both the demand and supply side. District councils will have MoUs with implementing partners in order to ensure reporting of HIV and AIDS interventions as well as preventing duplication of efforts while at the same time ensuring that HIV interventions at district and sub-district levels are in line with national priorities.

Objective 8.3.1: To strengthen the coordination and implementation of the response to the HIV and AIDS epidemic at national and sub national levels in line with the 3 Ones Principle

Strategic interventions

1. Improve national coordination and multisectoral governance of the response to the HIV/AIDS epidemic
2. Improve district and community level coordination and governance of the response to the HIV/AIDS epidemic
3. Strengthen the national and subnational M&E system to effectively respond to national, regional and global requirements for HIV reporting
4. Harmonise existing reporting tools and metrics in order to implement the Three Ones Principle

5.8.4 Health Products Management Systems

The MoHP coordinates key PSM functions, such as the quantification, procurement planning and Logistics Management Information Systems (LMIS) for Essential Medicines and Health Supplies (EMHS), HIV, Viral Hepatitis, Cervical Cancer Screening and treatment, malaria and TB program commodities. Other PSM functions such as procurement, warehousing and distribution are currently being outsourced to the Global Fund Pooled Procurement mechanism (PPM), third party procurement agents and third-party logistics (3PL) providers respectively. The GoM acknowledges that procurement and supply chain management systems need special attention to ensure increased commodity availability for all health products including HIV. This entails capacitating the Central Medical Stores Trust (CMST) in procurement, warehousing and distribution.

GAME CHANGER:

- *INTEGRATION OF SUPPLY CHAIN SYSTEMS*
- *NEW PHARMACY AND MEDICINES REGULATORY AUTHORITY ACT 2019*
- *END-TO-END COMMODITY VISIBILITY*

In 2012, the GoM and development partners developed a joint strategy for integrating the parallel supply chains into one supply chain managed by CMST. Reforms at CMST are ongoing to create the necessary capacity and expertise to procure, warehouse and distribute essential medicines. As such the MoHP has had to maintain outsourced service providers for procurement and warehousing and distribution services.

In 2017, CMST demonstrated significant improvement in the implementation of supply chain integration benchmarks and following an independent assessment, the GoM and partners in the health sector developed a roadmap of activities required for full integration of the parallel supply chains (PSC). The activities included the establishment of a National Steering Committee to oversee the integration process.

An 'End-to-End' product visibility system will be implemented and utilized to facilitate inventory management at all levels, from the manufacturer to the health facility level. C-Stock will be revived in order to compliment end-to-end tracking at the community level, for tracer items. There will also be a focus on improving inventory management at facility level by strengthening LMIS data including increased availability and utilization of recording forms, transaction forms and reporting forms. This will in turn assist in the reduction of wastage as well as expiration of medicines and medical supplies. In order to further reduce the risk of wastage of health products the system for redistribution of products between health facilities will be strengthened. There is also a need to develop an effective transport system for the appropriate incineration of expired medicines and used laboratory products.

While USAID/DFID funded the construction of 448 prefabricated pharmacies across Malawi, many health facilities providing HIV services are facing constraints, both in capacity and quality of their storage capacity for pharmaceutical products. The refurbishment of health facilities will address storage space quality and capacity. The country will engage with CSOs and community systems, such as the Health Centre Management Committees to improve on accountability systems at health facilities across the country.

The legal environment for health supply chain management has been enhanced by the passing of the PMRA Act 2019 that helps to spearhead the ISO 17025 accreditation of the national quality control laboratory for pre- and post-marketing surveillance of health commodities in Malawi. However, in order to speed up the enforcement of the new law that also introduces stiff penalties for thefts and diversions of health commodities, MoHP needs support in the public sensitisation of the Act, stakeholder consultation on regulations and crafting of the regulations. The MoHP will also support Pharmacovigilance activities that are implemented through the PMRA. This will include improving knowledge in Pharmacovigilance through the continuous training of health staff in the clinical HIV guidelines. There will also be establishment of 10 sentinel sites, 5 of which will be the referral hospitals and the other 5 will be a district hospital in each zone where patients will be more closely followed up.

Objective 8.4.1: To improve the availability, quality, utilization and management of medicines and other health products

Strategic interventions

1. Strengthen governance structures at central and district levels to enforce accountability of commodities
2. Strengthen inventory management to improve End-to-End product visibility for all health products including HIV commodities (ARVs, condoms, OI and STI medicines, diagnostics, self-test kits and family planning commodities)
3. Expand warehousing and distribution and increase storage capacity
4. Ensure quality products are provided to clients (including regulation of HIV test kits in the private sector)

5. Support Integration of HIV commodity supply chain as part of the National Supply Chain Integration Strategy.

5.8.5 Health Information Systems

Functional and coordinated Health Information Systems (HIS) are critical to the ability of the health system to improve delivery of programs in a way that reflects the reality in facilities and in the community. HIS provides an opportunity to integrate patient data and improve the provision of patient centred care; and improved capacity to plan, deliver, and manage policy, planning, and resource allocation.

GAME CHANGER:

INSTITUTIONALISATION OF DATA MANAGEMENT FOR DECISION MAKING AT DISTRICT LEVEL

Increasing demand for data disaggregated by age and sex /gender identity/sexual orientation will certainly strain a system already overburdened by excessive data collection and reporting requirements. These reporting requirements demand a transition from paper-based systems to a functional comprehensive electronic solution. Developed in alignment with the 2017-2022 Monitoring, Evaluation, and Health Information Systems and the draft Digital Health Strategy, this NSP will implement the following strategies to facilitate this transition: address infrastructure and staffing needs; decentralize M&E, data analysis, and EMR operations to the district level; and involve all levels of government – led by the Directorate of Quality Management and Digital Health – in EMR activities to ensure a seamless transition between EMRs. The MoHP further seeks to increase the use of data for planning and decision-making at the district and facility level, as well as conduct integrated surveillance to improve government's ability to respond.

Objective 8.5.1: To improve HIS governance, infrastructure, and electronic systems in order to facilitate evidence-based decision-making

Strategic interventions

1. Facilitate accurate, efficient data collection and improved patient outcomes by implementing a comprehensive EMR, CRVS, and supporting infrastructure
2. Improve the quality of data for decision-making at all levels
3. Increase evidence-based decision-making at all levels
4. Integrate data surveillance activities

5.8.6 Human Resources for Health, including Community Health Workers

A health workforce of adequate size, skill, and distribution is critical to ensuring the effective delivery of HIV services. The continued shortage of well-trained, highly skilled, and equitably distributed health workers remains one of the most significant barriers to universal health coverage in Malawi. Achieving NSP 2020-2025 coverage targets and ensuring the delivery of quality services will require a substantial increase in the health workforce. The severe shortage of service providers will be one of the biggest barriers to achieving the coverage targets set out in this NSP.

Thus, recruitment of the following cadres is prioritized:

- Clinical Officers, Medical Assistants, Nurse Midwifery Technicians, who will be critical for service delivery including achieving PrEP, HTS, and Treatment and Care targets at health centre and community hospitals. Laboratory Assistants will slowly replace the HIV Diagnostic Assistants (HDAs) who currently are not part of the MoHP staff establishment
- Community Midwife Assistants, Health Surveillance Assistants, and Social Workers are essential to linkage to care as well as increasing the reach for all programs, including GBV prevention services
- Pharmacy Assistants are essential to maintaining a growing population of nearly 1,000,000 on ART, providing PrEP, and providing drugs for STI and family planning

In addition to expanding the community and health centre workforce, redistributing based on staffing needs and improving staff motivation are critical to ensuring that Malawi can manage the current challenges in programming and sustain the gains made during the past decades. The following strategies are developed in alignment with the 2018-2022 HRH Strategic Plan.

Objective 8.6.1: Increase the availability, effectiveness and retention of human resources in order to deliver integrated high-quality services for all diseases, including HIV

Strategic interventions:

1. Utilise evidence to allocate health workers to areas of priority and greatest need
2. Recruit and redistribute health workers based on the staffing needs updated annually in the HRH Strategy
3. Strengthen national and district level HR departments to enable effective workforce planning, deployment, recruitment, and management
4. Strengthen coordination and integration of relevant pre-service, post-basic and in-service training to meet service delivery needs
5. Develop and implement human resource for health retention strategies for hard-to-reach areas of the country

5.8.7 Infrastructure, Transport, and Equipment

Adequate health infrastructure, transport, and equipment are critical for the provision of HIV services. Many health facilities have limited working space to perform essential health services – overcrowding and long wait times also decrease demand for services. Health facilities also have limited equipment to deliver services and limited transport to facilitate referrals. Overcrowding is a particular issue in (peri-) urban areas. Thus, construction of 20 new urban health centres will be prioritised to serve the rapidly growing population in unplanned high-density areas with high HIV burden. Furthermore, the NSP will provide for the construction of an additional 600 Health Posts to allow the decentralisation of HIV services. This NSP will also provide for the refurbishment of health infrastructure, such as district hospital laboratories; the renovation of pharmacies and warehouse space; basic equipment for facilities; and a management system for equipment.

Objective 8.7.1: To ensure adequate infrastructure for HIV services delivery

Strategic intervention

Refurbish and construct essential health infrastructure

Objective 8.7.2: To ensure availability of essential medical and non-medical supplies and utilities at all levels

Strategic intervention

1. Increase availability of basic medical and non-medical equipment for effective service delivery
2. Improve capacity for management of equipment supply

5.8.8 Integrated Service Delivery and Quality Improvement

GAME CHANGER:

INTEGRATED QUALITY SERVICE DELIVERY

Implementation of the NSP 2020-2025 will require delivery of comprehensive health services that meet the needs of clients accessing both HIV and SRH services. Since Malawi began providing HIV services in 2004, the size of the ART cohort has grown substantially. Now, the ART cohort is aging. Infected children on treatment are transitioning into adolescents and adults, forcing the health system to cope and change how it meets their health and psychological needs. Provision of HIV services alone is not enough. The health system needs to proactively meet their SRHR through provision of quality integrated HIV, SRHS, and GBV services.

Malawi's health system is marked by fragmentation and weak health systems, both of which are key bottlenecks for delivery of high-quality and integrated care. Strong governance, accountability, infrastructure, HRH, and M&E systems are critical bottlenecks to the delivery of clinical and client safety practices that can meet standards. Similarly, integrated service delivery across the continuum of care, between disease areas, and at all levels of the health sector require information systems that display and can transfer all patient history; infrastructure that physically allows for delivery of all services on one campus; and a health workforce that recognizes what related services a patient may need and delivers those services if the patient so desires. Integration of services also increases effectiveness, reduces costs, improves access, increases coverage, and is catalytic to overall system strengthening by coordinating governance, accountability, infrastructure, HRH, and M&E systems. Further, MoHP will scale up QI models that have the capacity to promote adherence to guideline recommendations among ART providers and improve data quality by working with existing QI structures such as quality improvement support teams (QISTs) at district and facility level. The strategies below are developed in alignment with relevant strategies including the draft National Health Quality Management Strategy and the National Multi-sector Nutrition Strategic Plan 2018-22.

Objective 8.8.1: To improve the quality of all services delivered

Strategic intervention

1. Develop and implement HIV services quality improvement framework to promote adoption of quality improvement approaches in the delivery of integrated HIV care

Objective 8.8.2: To strengthen and integrate the health system in order to deliver integrated comprehensive HIV services with SRHS, NCD, and nutrition across the continuum of care at all levels of the health sector

Strategic interventions

1. Deliver comprehensive HIV, SRHR and GBV services package to clients accessing services in all levels of health facilities including the private sector
2. Strengthen the referral and disease linkage between community and health facilities at all levels of the health system
3. Referral/linking vulnerable PLHIV to community-based economic strengthening, livelihoods and food security support in their areas for a continuum of care
4. Integrate HIV programs policy strategic documents and program implementation plans that aligns to national strategic policy documents
5. Conduct integrated trainings and develop integrated monitoring tools to equip HCWs to deliver integrated services for HIV and related diseases
6. Conduct integrated HIV care supervision, mentorship, program management, monitoring and coordination meetings at national and sub national levels
7. Implement paper and electronic information systems to support delivery of integrated services of HIV and related diseases at the community and facility level
8. Improve infrastructure to enable implementation of ISD models for HIV, SRHR and other related diseases at the facility level
9. Integrate the supply chain of HIV commodity and supply system into normal government supply chain system

5.8.9 Community Systems Strengthening

GAME CHANGER:

COMMUNITY LED MONITORING

The GoM is implementing the National Community Health Strategy (NCHS) 2017-2022. The NCHS details the various structures that are responsible for the delivery of health services including HIV and AIDS at community level. These structures include Village Health Committees (VHC), Community Health Action Groups (CHAGs), health centre management committees (HCMC) and Hospital Advisory Committees (HACs). Malawi's community health system experiences challenges which affect the effective delivery of health services and these include the critical shortage of HSAs, inadequate and low-quality transport for HSAs, insufficient community engagement on matters affecting their health and insufficient infrastructure such as health posts and housing for HSAs. Most VHCs, CHAGs and HCMCs remain untrained and this affects effective delivery of services including HIV services at community level.[153] The review of the 2015-2020 NSP found that the uptake of HIV prevention services such as VMMC and condoms, especially female condoms is low; the uptake of HTS among men and key populations is low; that although people can be started on ART, retaining them on treatment is difficult as some are lost to follow up.[154] There are many people who have abandoned treatment after being influenced by various religious groups that believe in or emphasize faith healing.

In order to address these problems, the MoHP will recruit and train additional HSAs (see HRH section), provide bicycles to HSAs and construct health posts especially in hard to reach areas. The community structures especially VHCs will support HSAs and create awareness about HIV and AIDS including HIV prevention and HIV treatment and retention and address human rights barriers to accessing services. HCMCs and HACs will ensure commodity security in health facilities. All the community structures will work very closely with CSOs and CBOs in order to enhance social accountability mechanisms at community level. These social accountability mechanisms will help to identify barriers to accessing HIV services and ensuring that PLHIV and KPs have access. The Department of HIV and AIDS in the MoHP has also developed an HIV community package for HSAs: this package includes following up of partners of index testing for testing, supporting community members with HIVST, tracing defaulters of ART, the distribution of condoms, promoting referral of community members to relevant HIV services (such as family planning) and creating awareness about HIV and AIDS.

As part of community systems strengthening, there is also a need to capacitate community and religious leaders, community-based organisations (CBOs) and CSOs to help create awareness at community level and also address issues of faith based healing, supporting adherence and retention in care and help to address gender-based violence and modification or eradication of harmful practices and protection of human rights. The NAC and UNAIDS supported CSOs to develop a Community Charter that empowers community organisations to take an active role in community HIV response. This NSP further emphasizes on strong participation of communities including PLHIVs and KPs, community organisations and networks in the design, delivery, monitoring and evaluation of integrated HIV/AIDS and reproductive health services. The strategies below are developed in alignment with the NCHS.

Objective 8.9.1: To strengthen community systems for HIV epidemic control, child protection and GBV prevention

Strategic interventions

1. Improve the capacity of community structures to deliver health and HIV/AIDS services such as YFHS, peer support, and adherence and retention to care
2. Strengthen community structures and systems to report and address GBV and human rights violation cases in a timely manner, and eradicate harmful practices
3. Strengthen community-based monitoring and reporting on HIV and SRHS
4. Strengthen community-led advocacy and accountability systems
5. Strengthen SBCC capacity of community systems to effectively achieve positive behavioural change and increase demand for services

5.8.10 Laboratory Systems

Laboratory services are an essential component for the implementation of comprehensive HIV services. In this NSP, a number of interventions that will be initiated or scaled require an increased capacity of the laboratory systems.

GAME CHANGERS:

- *SCALE UP HIV GENOTYPING SERVICES*
- *ESTABLISH SENTINEL SITE*

LABORATORY CAPACITY FOR ART TOXICITY MONITORING

Multiple interventions drive this demand for increased lab capacity, including:

1. The increase in the frequency of routine Viral Load (VL) monitoring for people on ART once every year. There will be a need to increase the capacity of the molecular laboratories in terms of infrastructure, equipment and HR, expand/improve the sample transportation system and develop and implement a patient information system to further reduce the turn-around-time (TAT)
2. The introduction of genotyping for all patients with diagnosed treatment failure and therapeutic monitoring for patients with advanced HIV disease
3. The implementation of an External Quality Assurance (EQA) for HIV testing already described in the NSP 2015-2020, but the implementation never materialized
4. The rolling out of PrEP will be supported by an increased capacity to test for viral Hepatitis before PrEP is started and biochemical parameters such as creatinine monitoring
5. There is an increased demand for Point of Care (POC) platforms, such as GeneXpert and other related POCs machines for targeted VL testing, EID and PIMA for CD4 count testing
6. Improved monitoring of patients on ART, including the monitoring of non-communicable diseases (NCDs) which will require that laboratories in districts, CHAM and central hospitals be brought up to speed to provide tests for improved care for PLHIV, such as CD4 count, biochemistry and hematology
7. Ten (10) sentinel sites will be established for enhanced monitoring of ARV toxicities. These sentinel sites will be established in hospitals and need to be supported by a well-functioning laboratory

In order to deliver on these developments, this NSP prioritises investments in lab infrastructure, equipment, furniture, supplies, accreditation, LMIS and M&E, sample transportation systems, and specialized laboratory staff. The strategies below are developed in alignment with the National Laboratory Strategic Plan 2017-2022.

Objective 8.10.1: To strengthen laboratory services for HIV control

Strategic interventions

1. Provide quality laboratory services for HIV, TB, VH and other HIV related disorders
2. Provide dedicated laboratory sample transportation system

6. Implementation Arrangements & Multisectoral Response

Within the governance and coordination frameworks explained in the above sections, the actual implementation of the NSP is the responsibility of a wide range of implementing partners from the public and private sectors, and civil society. The main coordinating bodies are illustrated in **Figure 16** and the implementing partners are outlined below.

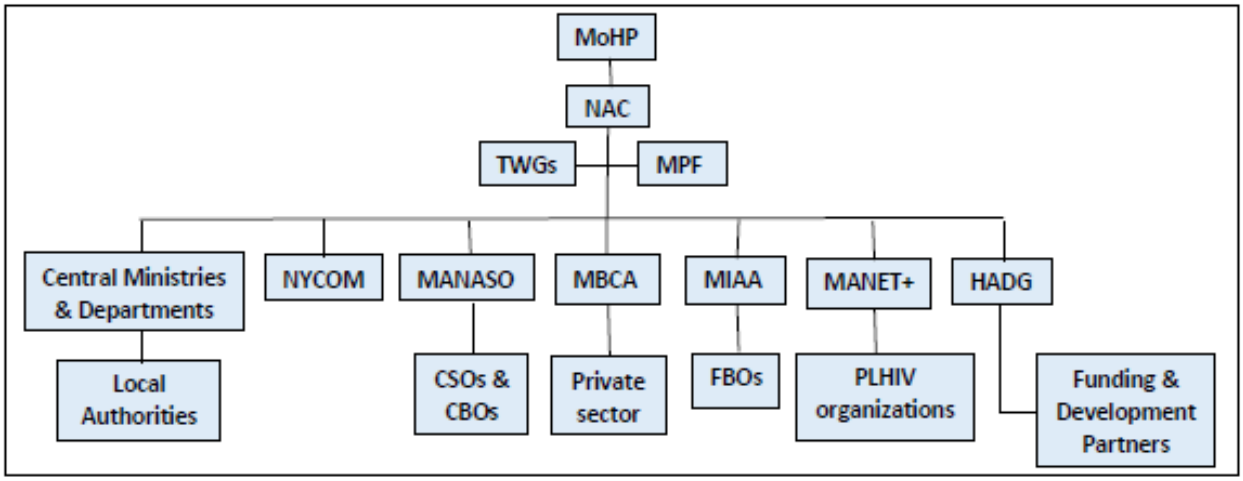


Figure 16: The main coordinating bodies in the national response in Malawi

- **Ministry of Health and Population** is mandated by the HIV and AIDS Prevention and Management Act of 2018 as the line Ministry for HIV and AIDS prevention and management. It is charged with leading the national response through formulating and reviewing national biomedical HIV and AIDS policies and guidelines; supervising sectoral policies relating to HIV and AIDS; facilitating the mainstreaming of HIV and AIDS in all sectors; conducting surveillance, monitoring and evaluating the national response; commissioning research and innovation; overseeing the activities and finances of NAC and the proper administration of the HIV & AIDS Act. The MOHP plans and provides technical direction and service delivery in biomedical areas of prevention, treatment and care.
- **National AIDS Commission** is mandated by the HIV and AIDS Prevention and Management Act of 2018 to implement, co-ordinate and facilitate the national response; manage and co-ordinate the implementation of Government policies; provide technical support to Government in the formulation and review of HIV and AIDS policies; develop and maintain an up-to-date information system and establish suitable mechanisms of disseminating and utilizing the information; in liaison with the Secretary for Health and Population, monitor and evaluate progress and impact of the national response; mobilize and equitably disburse resources towards the national response; monitor the distribution, and effective and efficient utilization of resources towards the national response; promote and commission research, information sharing and documentation; liaise with all Government Ministries, Departments and Agencies on matters relating to the national response and to ensure that there are no barriers to information; advocate for a strong, sustained and visible role of political, civil and traditional leaders; accredit HIV and AIDS information produced by any person before dissemination; develop and maintain profiles; provide technical guidance, capacity building and support to stakeholders; and submit reports to the Minister of Health and Population on the implementation of the national response.

- **Central and other line Ministries** such as Ministry of Finance and Economic Planning, the Department of Human Resource Management and Development, the MoGCDSW, the Law Commission and the Human Rights Commission directly or indirectly support the national response. Line Ministries provide policy guidance and include departments and parastatal organisations have established focal points for HIV and AIDS and are expected to mainstream HIV and AIDS into their sectoral work, provide technical support to the response, and organise workplace interventions for staff. All ministries have a budget line for HIV and AIDS activities.
- **Local Authorities** coordinate the implementation of the response at district, city and community levels. They have the responsibility to mobilize resources for community programmes, implemented through CBOs, Support Groups, and Community AIDS Committees (CACs). District development committees (DDCs) and Area Development Committees (ADCs) complement the work of local NGOs.
- **NGOs, FBOs and CBOs** coordinated through MANASO, MANET+, MIAA and NYCOM form the core of the implementing agencies and among other activities, carry out advocacy, assist communities to mobilise resources locally, document best community practices and support capacity building programmes in collaboration with NAC.
- **Private Sector** organisations under the coordination of the Malawi Business Coalition against AIDS (MBCA) have the responsibility to mainstream HIV and AIDS through workplace policies and programmes.
- **Development Partners** support national priorities; facilitate implementation by funding capacity building. The development partners assist the government's response in areas such as empowering leadership, mobilisation public, private and civil society, strategic information, and facilitating access to technical and financial resources at national level.

7. Monitoring and Evaluation

The NAC has overall responsibility of monitoring and evaluating the implementation of the NSP 2020-2025. It will also be responsible for analysing the data emanating from the M&E system and ensuring that this is disseminated to policy makers, programme planners and other stakeholders. Chapter 17 provides the Results Framework for the NSP 2020-2025 which will be utilised to track progress on implementation of the NSP. There are a number of ways through which the NAC and stakeholders in the national response will monitor the progress in the implementation of the NSP 2020-2025.

Joint annual reviews: The NAC will commission joint annual reviews of the national response to the HIV and AIDS epidemic through the Malawi HIV and AIDS Partnership Forum (MPF). The MPF meets every quarter and brings together both implementing and development partners to advise NAC and for mutual accountability. Every year NAC will conduct an annual internal review of the national response to the HIV and AIDS epidemic which will feed into the joint annual review (JAR). Before the JAR, field visits will be organized for the MPF and stakeholders to observe what is happening in the field and compile a report. The TWG, the internal NAC review and the MPF shall present their findings at the JAR. At the end of the JAR a meeting will be held with development partners and an aide memoir will be signed which will highlight the key recommendations. At every quarterly MPF meeting the NAC will present progress reports on the progress in addressing the JAR recommendations. Resources will be mobilized in order to ensure that the JARs are conducted over the period of the NSP 2020-2025. All implementing partners will be expected to monitor progress of implementing their HIV and AIDS programmes and share with NAC which will subsequently disseminate the information to stakeholders.

Global AIDS Monitoring Reports (GAM): UNAIDS requires that countries should submit progress reports in the national response to the HIV and AIDS epidemic. Each year NAC will work with various stakeholders and compile Global AIDS Monitoring reports (GAM) which shall be submitted to UNAIDS. Once the GAM report has been compiled, resources will be mobilized to disseminate the report at national level.

Local Authority HIV and AIDS Reporting System (LAHARS): There are a number of partners implementing HIV and AIDS interventions in each district. Initially, these partners reported to their respective local councils using the paper-based Local Authority HIV and AIDS Reporting System (LAHARS) on the interventions they were implementing and local councils in turn reported to NAC. An electronic version of the LAHARS has since been developed which will collect non-biomedical data right from the communities where implementing agencies including CBOs, FBOs and NGOs will enter data. The data will be aggregated at TA, district and national level. The NAC will then be able to compile reports based on data from LAHARS and share these reports with stakeholders in the national response to the HIV and AIDS epidemic. This will also be the basis for producing annual reports on progress being made in the implementation of the non-biomedical interventions.

Program reports: All key providers of data conduct routine monitoring. For example, the DHA conducts quarterly visits to all health facilities collecting biomedical data on the national response to the HIV and AIDS epidemic. This data is managed using the DAMIS. The DHA disseminates such quarterly reports to all stakeholders including the NAC.

Periodic surveys: There are a number of surveys supported to provide data to check on the progress being made in the national response to the HIV and AIDS epidemic. These surveys include the MDHS, MICS and the biological and behavioural biological surveys (BBSS) which are conducted periodically by the National Statistical Office. In addition to this, the MoHP conducts the MPHIA which, among other indicators collects data on global targets. This will need to form part of evidence-based programming if sustained.

Research: Research is also critical to generating information that will facilitate evidence-based planning of the National Response. The country will continue to monitor HIV indicators by conducting regular and specific surveys, studies, evaluations and assessment. These will help to determine Malawi's program coverage as well as measuring the impact of the national response and to target interventions where there is a critical need. The monitoring of HIV drug resistant strains and others for instance, will also be conducted regularly. NAC will coordinate the revision of the HIV Research Strategy and identified research priorities that can aid effective planning of the national response. These will be in tandem with the priorities of the current NSP.

8. Costing Results

As detailed in **Table 5** below, the five-year total cost of the activities and commodities included in the HIV NSP 2020-25 is approximately USD 1.22 billion. Commodities assume the largest part of the costs at 66.0% (USD 804 million over the NSP period). RSSH consists of 19.3% (USD 236 million) of total NSP cost while the program cost has a share of 14.7.1% (USD 179 million).

Table 5. Total cost of the NSP 2020-25 - USD (in millions)

Component	2020-21	2021-22	2022-23	2023-24	2024-25	Total	% of Total
Programmes	42	35	40	29	33	179	14.7%
Commodities	149	157	162	167	168	804	66.0%
RSSH	28	53	42	56	57	236	19.3%
TOTAL	**219**	**245**	**244**	**251**	**259**	**1218**	**100%**

Table 6, Table 7, and Table 8 show further details of programmatic, RSSH and commodities cost, respectively. The programmatic budget in **Table 6** comprises of the integrated program management category which includes meetings, mentorships and supervision activities from the programs, accounting for 37.17% of the total programmatic budget. The remaining budget is distributed across the various program areas and include mostly program implementation and research-related activities.

Table 6: Programmatic cost of the NSP 2020-25 - USD (in millions)

Module	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	Total	% of Total
Integrated Programme Management	20.54	15.25	20.54	15.25	20.54	92.12	51.55%
Prevention - Key Populations	6.31	7.07	5.89	5.79	5.80	30.87	17.27%
Prevention - AGYW	5.39	7.03	4.89	4.14	3.79	25.25	14.13%
Prevention - Condoms	3.79	0.56	3.65	0.56	0.56	9.13	5.11%
Treatment, care & support	1.62	1.59	1.76	1.76	1.86	8.58	4.80%
Prevention - STI and SRH	1.90	0.38	1.90	0.38	0.40	4.96	2.78%
Wellness and Workplace HIV programmes	1.16	0.32	0.94	0.09	0.09	2.61	1.46%
HIV Testing Services	0.14	1.56	0.07	0.08	0.05	1.91	1.07%

Prevention - VMMC	0.30	0.22	0.21	0.34	0.19	1.27	0.71%
Blood Safety	0.00	0.38	0.37	0.00	0.00	0.76	0.42%
Prevention - PrEP	0.13	0.13	0.12	0.12	0.12	0.62	0.35%
E-MTCT	0.35	0.12	0.03	0.02	0.01	0.52	0.29%
TOTAL	41.65	34.65	40.41	28.55	33.43	178.69	100 %

As illustrated in Table 5, RSSH makes up 19.3% of the total budget and is aimed at improving the broader health system at national, district, and community level. **Table 7** provides the further details on RSSH categories and costs. Particular focus is put on expanding the reach of facility and community-based HIV services, which is reflected in the large shares of the total RSSH budget the human resources for health and the infrastructure and transport modules account for. The NSP seeks to deploy an additional 4,267 facility- and community-based health workers with cadres prioritized (laboratory assistants, NMT, medical assistants, medical officers, clinical assistants, pharmacy assistants, midwife assistants and HSAs) in accordance with the MoHP human resource training and hiring plans. Furthermore, it is planned to construct 600 health posts and 20 urban health centres, additional 67 health centres in 8 districts as well as 40 youth centres to improve access and quality of care not only for HIV patients, but for all individuals seeking care in Malawi. HMIS, leadership and governance, health products management system and diagnostics are additional core cost within the RSSH budget. HMIS costs are largely driven by the purchase of equipment for EMR sites. Leadership and governance include activities to enhance these functions at national, district and community-level. Health products management system costs are largely determined by the inclusion of the implementation of the end-to-end tracking systems for drugs to enhance the redistribution of drugs across health facilities and the construction of the CMST central warehouse. The diagnostics module includes the cost for the refurbishment of 17 district hospital laboratories.

Table 7: RSSH cost of the NSP 2020-25 - USD (in millions)

Module	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	Total	% of Total
HMIS	7.43	6.87	3.05	21.73	20.38	59.46	25.24%
Human Resources for Health	6.40	8.01	9.65	10.11	11.05	45.21	19.20%
Infrastructure, Transport, and Equipment	8.18	8.18	8.18	7.54	8.07	40.15	17.05%
Health Products Management System	0.19	12.59	5.05	5.46	5.35	28.64	12.16%

Reducing human rights and gender-related barriers	0.09	6.38	4.33	4.34	4.31	19.45	8.26%
Laboratory Systems	3.23	3.22	3.22	3.22	3.22	16.11	6.84%
Coordination of the Response	1.30	1.67	2.28	1.37	2.28	8.89	3.78%
OVC	0.94	1.37	0.94	0.94	0.94	5.13	2.18%
Integrated Service Delivery and Quality Improvement	0.03	0.12	3.62	0.01	0.01	3.79	1.61%
Social Behaviour Change Communication	0.00	2.88	0.20	0.04	0.20	3.31	1.41%
Leadership and Governance	0.00	0.51	0.52	0.44	0.52	1.98	0.84%
Financial Management	0.12	0.26	0.72	0.12	0.70	1.91	0.81%
Community systems strengthening	0.10	0.52	0.29	0.29	0.29	1.51	0.64%
Total	**28.00**	**52.56**	**42.04**	**55.62**	**57.31**	**235.53**	**100%**

The costs for commodities are in three categories, namely commodities for prevention, treatment and diagnostics as explained in **Table 8**. Owing to the high volume of ARVs (1 million people on treatment), treatment commodities have the highest share of commodities cost (including PSM cost) of 51.9%, (USD 416.86 millions) followed by diagnostics at 30.0% (USD 241.18 millions) and prevention commodities at 18.1% (USD 145.48 millions). PSM costs amount to approximately 12% of the total commodities cost included in the NSP. Depending on the commodity category, PSM costs vary between 10% and 25% of the value of the goods purchased.

Table 8: Commodities cost of NSP 2020-25 – USD (in millions)

	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025	Total
Treatment & Care - Commodities	71.98	73.79	75.80	77.38	78.58	377.54
Treatment & Care PSM	7.49	7.68	7.89	8.06	8.19	39.32
Prevention - Commodities	24.00	24.81	24.99	25.60	23.35	122.75
Prevention PSM	4.46	4.61	4.63	4.75	4.29	22.73
Diagnostics - Commodities	35.00	39.65	41.23	43.95	45.73	205.57
Diagnostics PSM	6.15	6.85	7.14	7.59	7.88	35.61
Total Commodities Cost	131.00	138.25	142.03	146.93	147.66	705.86
Total PSM Cost	18.09	19.14	19.66	20.39	20.37	97.66
Grand Total	**149.8**	**157.39**	**161.69**	**167.32**	**168.03**	**803.52**

Financing for HIV NSP 2020-25

The annual MoHP Resource Mapping exercise allows for a comparison of the projected costs of the HIV NSP 2020-25 against the indicative funding envelope for the Malawian HIV response as currently budgeted by the Government of Malawi, CHAM, development partners, nongovernmental organizations and other stakeholders. Resource mapping data provides a macro-level consolidated overview on where health sector investments have been and will be occurring across districts, disease programs, interventions, activities and cost categories. Conducting a financial landscape analysis through comparing the HIV NSP 2020-2025 funding needs to Resource Mapping data is aimed at improving coordination, budgeting and planning of the health programs. The most recent round of Resource Mapping (RM) collected budget and expenditure data for the 5-year period ending December 2020. Data was collected and categorized both on a programmatic and cost-item basis. For the calendar year 2020 (January to December), USD 177 million was budgeted for HIV by the Government of Malawi and partners.

The Government of Malawi will invest the USD 599,894.47 for HIV in 2020. Most of the funding for HIV in Malawi is from external donors and partners, therefore, the trend over 5 years fluctuates annually based on varying budgets of donors and partners.

Table 9 below shows the direct funding for HIV-related activities by the various financing sources in the Malawian health sector in FY2019/20. These figures include the costs of commodity procurement for HIV treatment and testing. There are two major financing sources - the Global Fund (65%) and PEPFAR (20.8%). Together, they constitute 85.8% of the funding for HIV.

Table 9: Major Funding Sources for HIV/AIDS in Malawi (For FY2019/20, Million USD). Source: Resource Mapping (Round 6)[7]

Funding Sources	Funding (Million USD)	Distribution (%)
Government of Malawi	**0.6**	**0.29%**
Global Fund	134.4	65.00%
United States - PEPFAR[8]	43.1	20.80%
United States - CDC excluding PEPFAR	14.6	7.10%
Bill and Melinda Gates Foundation (BMGF)	4.4	2.10%
World Bank	4.1	2.00%
Others	5.6	2.71%
Total	**206.8**	**100%**

To move towards sustainability, Malawi needs to increase domestic financing of the HIV response. In 2014/15, 2015/16 and 2016/17, HIV and AIDS resources from both Government and Donors were estimated at USD 278 million, USD223 million and USD209 million, respectively.[155] This trend suggests that the overall resources for HIV and AIDS are in decline. The economic reality of Malawi and disease burden pose a challenge meeting financial resources required for the national response to the HIV epidemic despite the political will.

Almost 69% resources have been allocated for treatment and care followed by 17% for prevention. **Figure 17** shows the breakdown of funding by programmatic function for 2020 from all funding sources.

[7] The table displays direct contributions towards HIV/AIDS interventions and activities, by various financing sources in the financial year 2019/20. The information was captured as part of Malawi's Resource Mapping exercise (Round 6).

[8] The funding available from United States Government (USG) entities including PEPFAR and CDC, reflects the financing channeled towards implementing agencies for the implementation of activities related to HIV/AIDS. The funding does not reflect the financing contributions made towards salaries of health workers and administrative staff, nor do they reflect contributions made towards infrastructure projects. The total budget for PEPFAR across cost types (including salaries and infrastructure) was $159 million USD, in FY2019/20.

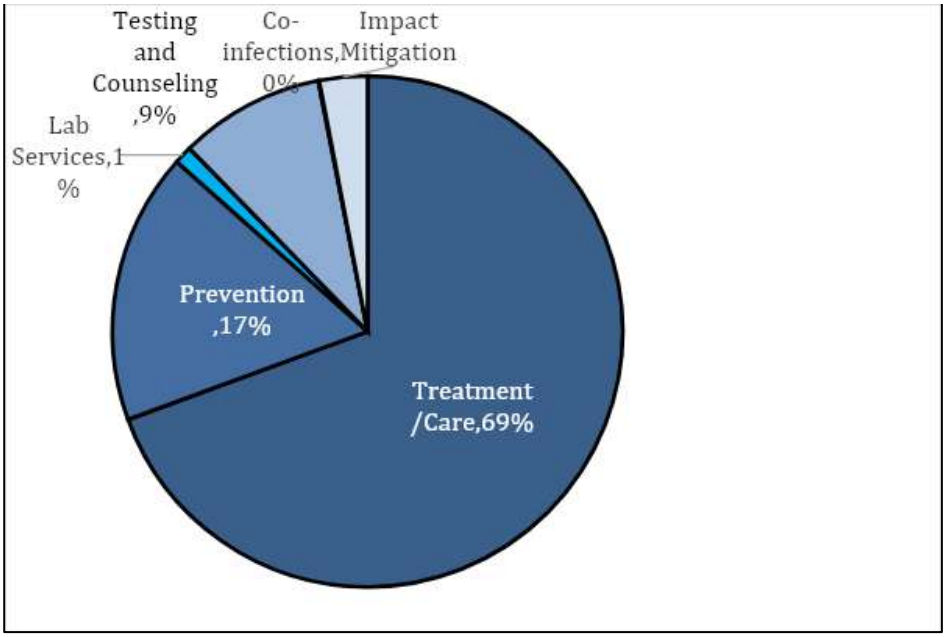


Figure 17: Funding by programmatic functions for 2020. Source: MoHP, Resource Mapping Round 6, 2020

Based on historical resource tracking, there is little evidence to suggest that resources will increase or decline over the coming 5 years. Therefore, the financial gap was calculated based on the conservative assumption that funding for HIV in Malawi remains constant at USD 206.9 million per year between 2020 and 2025. **Table 10** provides the total financial gap for the 5-year period 2020-2025 which amounts to approximately USD 182.8 million.

Table 10: Financial gap of the HIV NSP 2020-25 against total resources projected – USD (in millions)

HIV Including Viral Hepatitis and other STIs	2020-2025 (Million USD)
Resources needed 2020-25	1218
Resources available 2020-25	1,034.9
Financial gap	**139.3**

Note: Our methodology was to assume a constant trend across the years of the NSP for the resources available.

As health systems interventions are cross-cutting, it was not possible to disaggregate HIV-specific RSSH data from the Resource Mapping dataset. Therefore, no HIV RSSH financial gap was quantified. Instead, a financial gap is presented for the entire health sector for the largest cost categories within the HIV NSP RSSH costing, namely health workforce and capital investment. MoHP, during the formation of its most recent HRH Strategic Plan, conducted an analysis of the number of additional health workers needed to deliver existing levels of services with no inappropriate task-shifting or rushing through clients. The number of additional health workers was costed using salary and pre-service training needs. For infrastructure and equipment, MoHP has developed the Capital Investment Plan which is a costed plan for unfunded prioritized construction, rehabilitation, refurbishment, and adequate equipping of health facilities. The total financial gap for the two categories amounts to USD 340 million and USD 2110 million for 5 years, respectively.

Costing Limitations

There are several limitations of the costing and the financial gap analysis of the HIV NSP. Given the difficulty in predicting price changes in the health sector, the costing does not include an inflation assumption. The budgeting for the NSP balanced operational feasibility and cost efficiency. For example, the government strives to integrate program management across programmatic areas through harmonizing meetings, trainings, supervisions and mentorships as outlined above. While this would unlock potential resources, it is contingent upon the realization of this program management structure. Furthermore, the current costing does not include essential commodities such as family planning commodities and antibiotics, the inclusion of which would similarly increase the present financial gap. However, HIV-specific commodities are included in the calculation of resource availability.

9. Results Framework

No	Type of Indicator	Indicator Description	Numerator Source/Definition	Denominator Source/Definition	Disaggregation level	Num	Den	Year-baseline	Baseline (Absolute numbers	Yr 1 Target - 2021	Yr2 Target- 2022	Yr3 Target- 2023	Yr4 Target - 2024	Final Target - 2025
1	Impact	Number of new infections	Numerator: Spectrum	Denominator: NSO/Spectrum	Males 15+	12,645	NA	2019	12,645	11,346	10,778	10,248	9,868	9,554
					Females 15+	16,466	NA	2019	16,466	14,784	14,051	13,366	12,874	12,472
					AGWY (20-24)	4196	NA	2019	4,196	3,753	3,558	3,375	3,245	3,140
					AGYW 15-19	3895	NA	2019	3,895	3,474	3,293	3,124	2,994	2,881
					Children (0-14)	2616	NA	2019	2,616	2,272	2,135	1,995	1,874	1,761
2	Impact	Percentage of people living with HIV	Spectrum: Est. number of PLHIV during the reporting period	Spectrum/NSO: Estimated country population over the reporting period	Male - 15+	407,062	5,345,065	2020	407,062	7.4%	7.2%	7.0%	6.8%	6.6%
					Female - 15+	609,564	5,679,903	2020	609,564	10.5%	10.3%	10.0%	9.8%	9.5%
					Female - 20-24	50,306	924,785	2020	50,306	5.12%	4.81%	4.49%	4.19%	3.91%
					Female - 15-19	27,787	1,089,811	2020	27,787	2.40%	2.25%	2.10%	1.95%	1.79%
					Children (0-14)	58,340	2,934,978	2020	58,340	1.7%	1.5%	1.3%	1.1%	1.0%
3	Impact	Number of AIDS-related deaths per 100,000 population	Spectrum: Number of people dying from AIDS-related causes reported over the reporting period	Spectrum: Total country population per 100,000 over the reporting period	<5	870	2,934,978	2020	30	27	24	21	18	19
					5-14	712	5,295,526	2020	13	11	8	6	4	2
					15+ (both gender)	11,529	11,024,968	2020	105	104	103	102	102	101
					Male - 15-19	413	1,090,304	2020	38	37	36	35	32	30
					Male - 20-24	459	914621	2020	50	51	51	51	51	51
					Female - 15-19	394	1,089,811	2020	36	36	35	33	31	29
					Female - 20-24	644	924785	2020	70	69	69	69	68	66

No	Type of Indicator	Indicator Description	Numerator Source/Definition	Denominator Source/Definition	Disaggregation level	Num	Den	Year-baseline	Baseline (Absolute numbers	Yr 1 Target - 2021	Yr2 Target- 2022	Yr3 Target- 2023	Yr4 Target - 2024	Final Target - 2025
					Female - 15+	5727	5,679,903	2020	101	102	103	103	103	103
					Male - 15+	5802	5345065	2020	109	106	104	102	100	98
	Impact	Number of new HIV infections per 1000 uninfected population	Numerator: Spectrum/HIV program data - number of new infections	Denominator: NSO/Spectrum - Total number of uninfected population	None	30,059	19,416,848	2020	1.55	1.4	1.3	1.2	1.1	1.1
4	Impact	Estimated percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months	Spectrum: Estimated number of children newly infected with HIV from mother-to-child transmission among children born in the previous 12 months to women living with HIV (New infant HIV infections)	Spectrum: Estimated number of children delivered by women living with HIV who delivered in the previous 12 months (Mothers needing PMTCT)	None	2,432	40,297	2020	2,432	5.6%	5.5%	5.3%	5.2%	5.1%
5	Impact	Percentage of KPs who are living with HIV	BBSS or KP Specific programs: Number of KPs testing HIV positive over the reporting period	BBSS: Estimated population size for KPs over the reporting period	FSWs	19,860	38,193	2020	19,860	50.2%	47.6%	46.2%	44.4%	42.40%
					MSM	4,197	48,801	2020	4,197	8.3%	7.9%	7.6%	7.3%	6.90%
					Transgender	223	697	2020	223	TBD	TBD	TBD	TBD	TBD
8	Impact	Percentage of key populations on ART	KP implementing organizations: Number of KPs within their sub-	KP implementing organizations: Population size estimate for each	FSWs	16,881	19,860	2020	16,881	88.0%	91.0%	92.0%	94.3%	95.0%
					MSMs	4,155	4,197	2020	4155	99.0%	99.0%	99.0%	99.0%	99.0%

No	Type of Indicator	Indicator Description	Numerator Source/Definition	Denominator Source/Definition	Disaggregation level	Num	Den	Year-baseline	Baseline (Absolute numbers	Yr 1 Target - 2021	Yr2 Target- 2022	Yr3 Target- 2023	Yr4 Target - 2024	Final Target - 2025
			groups who are on ART	KP sub-group who are HIV positive										
					Transgenders	402	407	2020	402	99.0%	99.0%	99.0%	99.0%	99.0%
					Prisoners	TBD	TBD	2020	TBD	TBD	TBD	TBD	TBD	TBD
					IDUs	NA	NA	2020	NA	TBD	TBD	TBD	TBD	TBD
	Outcome	Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV	Number of pregnant women living with HIV who delivered during the past 12 months and received antiretroviral medicines to reduce the risk of mother-to-child transmission of HIV.	Estimated number of women living with HIV who delivered within the past 12 months	None	41,158	41574	2020	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%
6	Outcome	Percentage of key population reached with a defined/minumim package of HIV prevention services	KP implementing organizations: Numbers of KP reached with a defined/minimum package of prevention services within their sub-groups	KP implementing organizations: Population size estimate for each KP sub-group	FSWs	22,152	38,193	2020	22,152	62.0%	68.0%	74.0%	80.0%	86.00%
					MSM	3904	48,801	2020	3,904	9.0%	9.4%	9.8%	9.9%	10.00%
					Transgender	407	679	2020	407.00	TBD	TBD	TBD	TBD	TBD
					Prisoners	TBD	TBD	2020	TBD	TBD	TBD	TBD	TBD	TBD
					IDUs	TBD	TBD	2020	TBD	TBD	TBD	TBD	TBD	TBD
7	Outcome	Percentage of key population who received an HIV test	KP implementing organizations: Number of people who were tested for HIV	KP implementing organizations: Population size estimate for each KP sub-group who were reached with	FSWs	14,188	22,152	2020	64%	70.0%	77.0%	84.0%	90.0%	95.0%
					MSMs	2,047	3,904	2020	2047	19.0%	21.0%	24.0%	25.0%	27.5%
					Transgenders	407	407	2020	407	100.0%	100.0%	100.0%	100.0%	100.0%
					Prisoners	13,713	TBD	2020	TBD	TBD	TBD	TBD	TBD	TBD
					IDUs	TBD	TBD	2020	TBD	TBD	TBD	TBD	TBD	TBD

No	Type of Indicator	Indicator Description	Numerator Source/Definition	Denominator Source/Definition	Disaggregation level	Num	Den	Year-baseline	Baseline (Absolute numbers	Yr 1 Target - 2021	Yr2 Target- 2022	Yr3 Target- 2023	Yr4 Target - 2024	Final Target - 2025
		and received their results		a prevention services										
9	Outcome	Percentage of key populations who were on ART with viral load <1000 copies	KP implementing organizations: Number of KPs within their sub-groups who are on ART with VL<1000 copies	KP implementing organizations: Number of KPs within their sub-groups who are on ART	FSWs	TBD	TBD	2020	TBD	TBD	TBD	TBD	TBD	TBD
					MSMs	TBD	TBD	2020	TBD	TBD	TBD	TBD	TBD	TBD
					Transgenders	TBD	TBD	2020	TBD	TBD	TBD	TBD	TBD	TBD
					Prisoners	TBD	TBD	2020	TBD	TBD	TBD	TBD	TBD	TBD
					IDUs	NA	NA	2020	NA	TBD	TBD	TBD	TBD	TBD
10	Outcome	Percentage of men reporting the use of a condom the last time they had anal sex with a non-regular partner	MDHS: Number of men reporting the use of a condom the last time they had anal sex with a non-regular partner	MDHS: Total number of male respondents (15-49) who reported using a condom the last time they had sex with a non-marital, noncohabiting partner	Age (U25, 25+)	TBD	TBD	2020	TBD	TBD	TBD	TBD	TBD	TBD
11	Outcome	Percentage of people living with HIV who know their HIV status at the end of the reporting period	HIV program data: Number of people who were tested for HIV and received their results over the reporting period	PHIA/Spectrum: Estimate number of PLHIV during the reporting period	0-14	39,146	58,340	2020	39,146	68.10%	70.10%	72.10%	72.90%	73.90%
					Females 15+	576,038	609,564	2020	576,038	95.3%	95.9 %	96.4%	96.8%	97.1%
					Males - 15+	356,702	409,062	2020	356,702	90.30%	91.50%	92.40%	93.10%	93.70%
12	Coverage	Percentage of people on ART among all people living with HIV at the end of the reporting period	HIV Program data/Spectrum: Number of people on ART according to national treatment guidelines	Spectrum/HIV Program data: Number of people living with HIV	None	971,886	1,076,966	2020	971,886	85.8%	88.0%	89.7%	91.1%	92.1%
13	Coverage	Percentage of people on ART among all	HIV Program data/Spectrum: Number of	Spectrum/HIV Program data:	Male -15+	309,796	407,062	2020	309,796	79.3%	81.9%	84.1%	85.8%	87.2%

No	Type of Indicator	Indicator Description	Numerator Source/Definition	Denominator Source/Definition	Disaggregation level	Num	Den	Year-baseline	Baseline (Absolute numbers	Yr 1 Target - 2021	Yr2 Target- 2022	Yr3 Target- 2023	Yr4 Target - 2024	Final Target - 2025
		people living with HIV at the end of the reporting period	people on ART according to national treatment guidelines	Number of people living with HIV										
					Female - 15+	556,535	599,505	2020	556,535	92.3%	93.1%	94.4%	95.3%	95.9%
					Children (0-14)	42,969	61,537	2020	42,969	80.3%	84.6%	88.4%	91.5%	93.1%
14	Coverage	Percentage of people living with HIV and on ART who are virologically suppressed	PHIA/HMIS: Number of people living with HIV and on ART who are virologically suppressed over the reporting period	PHIA/HMIS: Number of PLHIV on ART over the reporting period	0-14	29,162	41,871	2020	29,162	74%	78%	81%	84%	87%
					Females	524,845	556,535	2020	91.70%	95%	95%	96%	96%	97%
					Males	287,039	309,796	2020	93.70%	94%	94%	95%	96%	96%
15	Coverage	Number of medical male circumcisions performed according to national guidelines	HMIS: Number of medical male circumcisions performed according to national standards	NA	None	115,000	NA	2019	115,000	200,000	195,000	185,000	180,000	180,000
16	Coverage	Percentage of eligible key population who initiated oral antiretroviral PrEP during the reporting period	HMIS: Number of eligible men who have sex with men who initiated oral antiretroviral PrEP during the reporting period	IBBS/ KP Programs: Estimated total HIV negative MSMs	FSWs	7,250	17,187	2020	7,250	42%	39%	36%	17%	16%
					MSMs	1199	48,801	2020	1,199	2%	2%	3%	1%	1%
					Trans genders	99	291	2020	99	34%	43%	79%	18%	17%
17	Coverage	Percentage of eligible adolescent	HMIS: Number of eligible adolescent girls	NSO/Spectrum: Total number of HIV negative	None	7,500	96000	2020	7,500	7.4%	7.4%	7.3%	4.6%	4.1%

No	Type of Indicator	Indicator Description	Numerator Source/Definition	Denominator Source/Definition	Disaggregation level	Num	Den	Year-baseline	Baseline (Absolute numbers	Yr 1 Target - 2021	Yr2 Target- 2022	Yr3 Target- 2023	Yr4 Target - 2024	Final Target - 2025
		girls and young women who initiated oral antiretroviral PrEP during the reporting period	and young women who initiated oral antiretroviral PrEP during the reporting period	AGYWs over the reporting period										
18	Coverage	Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	HMIS: Number of HIV-positive new and relapsed TB patients started on TB treatment during the reporting period who are already on ART or who start on ART during TB treatment	HMIS: Number of HIV-positive new and relapsed TB patients registered during the reporting period.	None	TBD	TBD	2020	95%	95%	95%	95%	95%	95%
19	Coverage	Number of condoms distributed	NA	NA	Male	NA	NA	2020	155m	155m	155m	155m	155m	155m
					Female	NA	NA	2020	675K	675K	675K	675K	675K	675K
20	Coverage	Percentage of young people aged 10–24 years attending school reached by comprehensive sexuality education and/or life skills–based HIV education in schools	AGYW secretariat/ NYCOM and Partners in the AGWY space: Number of adolescent girls and young women reached with HIV prevention programs- defined package of services over	NSO/Spectrum: Total number of AGYWs over the reporting period	In-school	337,355	1571242	2020	337,355	22%	22%	22%	22%	23%
					Out-school	TBD	TBD	2020	TBD	TBD	TBD	TBD	TBD	TBD

No	Type of Indicator	Indicator Description	Numerator Source/Definition	Denominator Source/Definition	Disaggregation level	Num	Den	Year-baseline	Baseline (Absolute numbers	Yr 1 Target - 2021	Yr2 Target- 2022	Yr3 Target- 2023	Yr4 Target - 2024	Final Target - 2025
			the reporting period											
21	Coverage	Percentage of adolescent girls and young women reached with HIV prevention programs - defined package of services	Number of AGWY reached with combination HIV preventive services	NSO/Spectrum: Total Number of AGWY over the reporting period		19,200	96,000	2020	19,200	45,900	47,700	61,040	77,280	92,800

Annex 1: Government Health Spending

Table A1 - Total Health Sector Budget for Malawi (FY 2019/20)

	2019/20 Approved Budget for Health (USD)	Contribution to HIV and AIDS
Central-level Budget (Vote 310)	**119,242,779**	
of which is:		
-Wages and Salaries (PE)	44,609,845	This includes the salaries of MOHP staff including the Department of HIV and AIDS (DHA), additionally it covers the salaries of health workers at the five central hospitals in Malawi. Additionally, the wage budget includes the salaries of health workers at a significant proportion of CHAM health facilities.
-Routine Recurrent Costs (ORT)	40,924,413	The routine operational costs for the MOHP are captured within this budget component. In addition, the budgets of the central hospital operations are included here. These central hospital budgets cover the cost of provision of all health care services, including the cost of medical commodity procurement. This covers the cost of provision of HIV and AIDS services, as well as treatment of its co-morbidities.
-Infrastructure (Government Funded)	5,068,493	The Government budget for infrastructure provides the outlay for the development of various health centers, district hospitals and central hospital upgrades throughout Malawi. All health facilities are equipped to provide basic HIV and AIDS services, at the very least.
-Infrastructure (Partner Funded)	28,640,028	
District Budget (Vote 900 series)	**98,343,891**	
of which is:		
-Wages and Salaries (PE)	63,004,781	The wage budget at district-level covers the majority of workers in community health posts, health facilities and district hospitals. These are the individuals who are the primary providers of health care services in Malawi. Across all geographies and all levels, the provision of services for HIV and AIDS is significant and is therefore a large component of these health worker's time.

	2019/20 Approved Budget for Health (USD)	Contribution to HIV and AIDS
Central-level Budget (Vote 310)	**119,242,779**	
-Medical Commodities	23,287,671	The district budget for medical commodities covers the cost of all drug procurements for services provided at the district-level. Whilst Malawi has a significant amount of support from development partners for commodity costs related to HIV and AIDS services, there is not nearly as much support for the cost of commodities for HIV co-morbidities, which are substantial.
-Routine Recurrent Costs (ORT)	12,051,439	The routine operational budget for the districts covers all recurrent costs incurred through the provision of services at the health facilities and district hospitals. It does not include the cost of commodities, but it does include all other medical expenses, and administrative expenses incurred.
Subvented Organizations	**5,080,479**	
Total Government Budget for Health	**222,667,149**	

Annex 2. HIV Testing Target Methodology

The HTS optimization model was developed to ensure resources are efficiently, effectively, and equitably allocated to identify Malawi's remaining undiagnosed PLHIV. The main output of the model is a baseline estimate of the number of tests that would be needed - and the number of initiations a program could expect to obtain - under certain assumptions about the population. These assumptions include population size, HIV prevalence, testing coverage, testing yield, and linkage rates for clinical departments where HIV testing is conducted (eg. TB, OPD, Under 5, etc), and various testing strategies (e.g. Index Testing, Outreach, Key Populations, etc.). Baseline data input into the model include DHA programmatic supervision data, partner provided figures from their supported sites and/or studies, as well as data collected through a sub-national data collection exercise at 50 health facilities. These baseline assumptions were validated by DHA and partners.

Using baseline assumptions, the model calculates the number of negative and positive tests necessary to reach initiation targets. The model can then be adjusted through scaling coverage at different entry points over the timeframe to attempt to meet initiation targets– based on DHA programmatic data – while also allowing the user to consider testing volume and cost associated with any changes. In this way, the testing mix and scale-up of services can be best aligned with DHA priorities, programmatic capacity, and budget. The model also estimates a baseline cost per positive and negative test result based on commodity costs and percent of patients expected to receive each assay in the algorithm considering the sensitivity and specificity of the assay combination. It then applies the cost per negative and positive result, respectively, to the volume of people to be tested to calculate the total cost of a specific mix of testing strategies and coverages.

The model was run separately with commodity volumes and costs adjusted for both the two-test and three-test algorithms. The final results apply the two-test algorithm in Years 1 and 2 of the NSP and the three-test algorithm in subsequent years. A dashboard summarizes both the total number of people to be tested and the overall volume and cost of the required commodities each year 2020-2025. The initiation target provided by DHA is calculated in order to achieve a linearly scaled treatment target of 93% by 2025, with a goal of achieving 95% by 2030, in line with 95-95-95 targets. Self-testing volumes were informed by an HIVST Commodity Forecasting done by Population Services International (PSI), as this projection closely aligns with national expectations for scale-up. The model coverage targets were adjusted to meet these commodity procurement targets.

The model projects a total of 34,353,760 clients (not accounting for repeat testers) would need to be tested between now and 2025 to reach 384,166 total initiations within the same timeframe.

	TWO TEST	TRANSITION				THREE TEST
Summary Outputs	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
DHA Initiation Target	122,311	120,051	92,282	88,892	85,349	82,493
Number of Initiations (Model)	79,085	75,750	70,796	59,053	55,394	44,088
Initiation Shortfall (DHA Target vs. Model)	-43,226	-44,301	-21,486	-29,839	-29,955	-38,405
Required # to Test to Achieve Model Prediction of Initiations	4,469,342	5,255,052	5,776,459	5,599,912	6,384,557	6,868,438
Total Actual Test Kits to be Procured	**4,746,791**	**4,820,749**	**6,133,726**	**5,889,142**	**6,650,218**	**7,078,280**
Total Annual Commodity Cost of Testing (USD)*	$ 6,778,673	$ 9,464,601	$ 12,246,274	$ 12,677,970	$ 14,296,156	$ 15,217,209

**includes consumables, wastage, and SCM*

This volume of testing would lead to a shortfall in meeting the DHA initiation targets by 21,000-44,000 each year, however, this testing level was recommended in order to maintain testing volume and cost expenditure caps. Meanwhile, the HR time savings generated by the switch to a three-test algorithm could be strategically reallocated to quality of care improvements and interventions to increase retention, which would in turn reduce the testing volume and cost to reach initiation targets faster.

Annex 3. Objectives, Strategic Interventions and Activities

Combination Prevention Activity Table

Level	*Code*	*Description*
Sub theme	**1.1**	**Condom and Lubricant Programming**
Objective	**1.1.1**	**To scale-up the use of quality condoms and lubricants among all target populations**
Strategic Intervention	1.1.1.1	Strengthen leadership and coordination at national, district-level and community levels
Activity	1.1.1.1.1	Conduct district level CCC meetings
Activity	1.1.1.1.2	Conduct national level CCC meeting
Activity	1.1.1.1.3	Develop and disseminate IEC materials
Activity	1.1.1.1.4	Engage policy makers (members of parliament, cabinet ministers, sub-committee of cabinet members on health issues, religious leaders)
Activity	1.1.1.1.5	Evaluation of the communications strategy
Activity	1.1.1.1.6	Review and revise the communications strategy
Activity	1.1.1.1.7	Review and revise the national condom strategy
Activity	1.1.1.1.8	Revise the communications strategy
Activity	1.1.1.1.9	Strengthen condom community distribution systems
Activity	1.1.1.1.10	Strengthen data management at national, district, and community level
Strategic Intervention	1.1.1.2	Strengthen the TMA for procurement and distribution of condoms and lubricants, with emphasis on increasing the distribution points at the facility, community, and partner institutions
Activity	1.1.1.2.1	Conduct annual post-market surveillance of condom physical integrity and storage facility conditions
Activity	1.1.1.2.2	Explore non-traditional approaches to condom distribution in hard -to-reach communities
Activity	1.1.1.2.3	Identify and strengthen HIV at work responses, specifically for condoms and lubricants
Activity	1.1.1.2.4	Implement condom dispensing boxes at public events such as concerts and festivals
Activity	1.1.1.2.5	Implement condom dispensing boxes for army, police, and security officers
Activity	1.1.1.2.6	Promote the use of socially-marketed condoms to better segment the market and scale up distribution for different target populations.
Activity	1.1.1.2.7	Strengthen condom and lubricant distribution into other health service delivery points
Activity	1.1.1.2.8	Strengthen Malawi Business Coalition
Activity	1.1.1.2.9	Train Nurses, clinicians and HSAs on condom use and distribution
Strategic Intervention	1.1.1.3	Engage private sector to promote and distribute condoms
Activity	1.1.1.3.1	conduct high-level meetings with the private sector to explore public-private partnerships to promote and distribute of condoms

Level	*Code*	*Description*
Strategic Intervention	1.1.1.4	Link in-school and out-of-school youth clubs to accessible CBDA/NGO condom distribution points, including secondary schools and higher education institutions
Activity	1.1.1.4.1	Advocate within institutions to support policy changes within the schools
Activity	1.1.1.4.2	Ensure condoms are available for in-school and out-of-school youths
Strategic Intervention	1.1.1.5	Ensure that condoms and lubricants on the market are of high quality
Activity	1.1.1.5.1	Conduct mapping of stakeholders involved in commercial sector condom distribution
Strategic Intervention	1.1.1.6	Increase demand for condoms among target populations through SBCC, branding, and empowerment of women, girls, and KP
Activity	1.1.1.6.1	Condom use education at the community level
Activity	1.1.1.6.2	Conduct condom promotion mass media campaigns
Activity	1.1.1.6.3	Design, test and distribute premium brand condoms
Activity	1.1.1.6.4	Leverage available platforms to engage in dialogue with community and religious leaders and their members to foster a more supportive environment for condom use
Activity	1.1.1.6.5	Point of distribution promotional materials
Activity	1.1.1.6.6	Promote use and understanding of female condoms and lubricants
Activity	1.1.1.6.7	Social media engagement
Sub theme	**1.2**	**Pre-Exposure Prophylaxis**
Objective	**1.2.1**	**To improve system readiness for implementation of PrEP for target populations in high-burden districts**
Strategic Intervention	1.2.1.1	Strengthen PrEP governance and coordination systems
Activity	1.2.1.1.1	Conduct a PrEP guideline plan launch
Activity	1.2.1.1.2	Finalize and validate PrEP communications guidelines
Activity	1.2.1.1.3	Mid-strategy review and update guidelines
Activity	1.2.1.1.4	Strengthen coordination at the national level
Activity	1.2.1.1.5	Strengthen coordination the district level
Strategic Intervention	1.2.1.2	Improve the capacity of the health system to offer PrEP through SRH/HIV service integration
Activity	1.2.1.2.1	Conduct public and private facilities readiness assessment
Activity	1.2.1.2.2	Engage Private Partners in the provision of PrEP
Activity	1.2.1.2.3	Equip private sector facilities to offer PrEP
Activity	1.2.1.2.4	Infrastructure upgrade
Activity	1.2.1.2.5	Training for service providers
Strategic Intervention	1.2.1.3	Establish and implement monitoring and evaluation systems for PrEP
Activity	1.2.1.3.1	Conduct surveillance for AMR to PrEP
Activity	1.2.1.3.2	Mid-term review of PrEP program
Activity	1.2.1.3.3	Re-tracking of clients and client follow up on AMR surveillance
Activity	1.2.1.3.4	Strengthen M&E systems for PrEP

Level	*Code*	*Description*
Objective	**1.2.2**	**To increase PrEP uptake and adherence**
Strategic Intervention	1.2.2.1	Develop and implement PrEP demand generation activities
Activity	1.2.2.1.1	Conduct trainings for members of CBS
Activity	1.2.2.1.2	Engage district level stakeholders
Activity	1.2.2.1.3	Engage Policy makers
Activity	1.2.2.1.4	Message development
Strategic Intervention	1.2.2.2	Provide health messaging and counseling to address barriers to PrEP adherence, such as stigma, side-effects and IPV
Activity	1.2.2.2.1	Develop PrEP counseling materials for service providers
Activity	1.2.2.2.2	Targeted media campaign (MSM, AGYW, FSW, Discordant couples)
Sub theme	**1.3**	**Voluntary Medical Male Circumcision**
Objective	**1.3.1**	**To scale up the delivery of quality VMMC services among the target population**
Strategic Intervention	1.3.1.1	Expand the availability of quality VMMC services for males 15-49 in public and private sector facilities
Activity	1.3.1.1.1	Building capacity for the private sector
Activity	1.3.1.1.2	Conduct Convention Training for HCWs at the national level, quarterly
Activity	1.3.1.1.3	Conduct Convention Trainings for HCWs and selected providers
Activity	1.3.1.1.4	Conduct HIV Testing and STI screening in each Mobile site
Activity	1.3.1.1.5	Conduct Quality VMMC and post op care for MC clients at all the levels
Activity	1.3.1.1.6	Conduct routine quality assessment activities
Activity	1.3.1.1.7	Conduct Shang Ring training for HCWs and selected providers
Activity	1.3.1.1.8	Ensure all MC clients are tested and screened
Activity	1.3.1.1.9	Ensure Registration of MC clients
Activity	1.3.1.1.10	Establish men's health clinics through private sector service-level agreements and integrate male HIV prevention with other services (VMMC, STIs, PrEP, ART, NCDs)
Activity	1.3.1.1.11	Perform circumcision in mobile and outreach clinics
Activity	1.3.1.1.12	Provision of material for counselling and education
Activity	1.3.1.1.13	Supportive supervision
Strategic Intervention	1.3.1.2	Strengthen the capacity of rural health facilities to deliver VMMC.
Activity	1.3.1.2.1	Renovation and refurbishment of Selected Health centers
Strategic Intervention	1.3.1.3	Improve demand creation for VMMC
Activity	1.3.1.3.1	Conduct recurrent Community Dialogs at the district level with community leaders, traditional and religious leaders
Activity	1.3.1.3.2	Development of a Mass media campaign for encouraging adult MC, message development
Activity	1.3.1.3.3	Reinforce Interpersonal Communication (IPC) using trained mobilizers/teachers/expert clients
Activity	1.3.1.3.4	Routine Awareness campaigns in health facilities and mobile sites
Activity	1.3.1.3.5	Using faith-based structures to create demand for VMMC

Level	*Code*	*Description*
Strategic Intervention	1.3.1.4	Improve quality and management of VMMC data
Activity	1.3.1.4.1	Data triangulation at the district level
Activity	1.3.1.4.2	Tracking of adverse events
Strategic Intervention	1.3.1.5	Implement operational research to inform VMMC planning and programming
Activity	1.3.1.5.1	Quality Control of current performance of procured devices and piloting of new devices
Strategic Intervention	1.3.1.6	Strengthen multi-sectoral collaboration, leadership, and coordination at all levels in support of VMMC
Activity	1.3.1.6.1	Organization of meetings with partners and stakeholders and DHOs
Activity	1.3.1.6.2	Review of M&E tools for VMMC data
Activity	1.3.1.6.3	Revision of the national VMMC communications strategy
Activity	1.3.1.6.4	Revision of the national VMMC strategy
Sub theme	**1.4**	**Adolescent Girls and Young Women**
Objective	**1.4.1**	**To increase access to and coverage of combination HIV prevention, testing, and treatment for AGYW**
Strategic Intervention	1.4.1.1	Strengthen multi-sectoral coordination, collaboration and linkages between ministries and partners in the implementation of AGYW interventions at national, district and sub-district levels.
Activity	1.4.1.1.1	Establish and maintain a database of all stakeholders implementing AGYW programs at national and district level to ensure coordination in the implementation of programs
Activity	1.4.1.1.2	Strengthen AGYW referral and linkages at district level and community level
Activity	1.4.1.1.3	Strengthen district AGYW coordination
Activity	1.4.1.1.4	Support inter-ministerial, sector and technical working group meetings
Strategic Intervention	1.4.1.2	Increase availability of high-quality combination HIV services for AGYW and their sexual partners by training more HCWs in YFHS and scaling up to locations beyond the health system to community and youth centers
Activity	1.4.1.2.1	Conduct a comprehensive capacity audit for the YFHS programme including M&E across sectors.
Activity	1.4.1.2.2	Develop and implement gender-sensitive and age-appropriate YFHS SBCC campaigns at national, district and community levels
Activity	1.4.1.2.3	Develop the capacity of staff in referral centers including those in communities to receive and promptly manage the referrals including GBSV and LARCs.
Activity	1.4.1.2.4	Disseminate YFHS SRH/HIV/FP clinical guidelines and procedures and ensure that these are posted publicly and visibly at all facilities.
Activity	1.4.1.2.5	District level consultations for the development/construction of youth centers
Activity	1.4.1.2.6	Document and scale up in-service/on-the-job training approaches for service providers at all levels.

Level	Code	Description
Activity	1.4.1.2.7	Establish and maintain a cohort-based database for all stakeholders implementing AGYW programs
Activity	1.4.1.2.8	Expand provision of YFHS, SGBV package beyond facilities to community youth centres
Activity	1.4.1.2.9	Hire a consultant to conduct a mapping of all youth centers across the country - undertake assesment of challenges and successes in current youth centre formats/types
Activity	1.4.1.2.16	Identify platforms for coordination mechanisms for key line ministries at the national level to effectively execute the implementation of the YFHS regulatory instruments (policies, strategies, guidelines, and laws) for quality coordinated delivery and reporting.
Activity	1.4.1.2.10	Increase the number of YFHS Master Trainers at district level to provide decentralized YFHS training for providers within and outside the YFHS programme
Activity	1.4.1.2.11	Promote initiatives reaching out to out-of-school youths with YFHS information, education, communications (IEC) and integrated behavioural change communications (BCC) interventions.
Activity	1.4.1.2.12	Promote the use of innovative client/provider feedback appropriate technologies by YFHS providers at all levels for targeted client responsive interventions.
Activity	1.4.1.2.17	Provide tools to support programming and collaboration between the YFHS coordinator and district youth officer (DYO) for implementation of SRHR activities.
Activity	1.4.1.2.13	Refurbishment of youth centers and health centers
Activity	1.4.1.2.14	Strengthen and scale up support groups for ALHIV including peer led enhanced adherence support
Activity	1.4.1.2.15	Support MoH to annually accredit YFHS sites based on provision of YFHS standards (minimum package)
Strategic Intervention	1.4.1.3	Increase adolescent demand for HIV and related services through community-based, digital, and private sector avenues
Activity	1.4.1.3.1	Adapt the KP package for adolescent girls under 18 years old who are exploited into selling survival sex or transactional sex
Activity	1.4.1.3.2	Conduct HIV hot spot mapping and estimate the number of under aged sexually exploited AGYWs that are engaging in transactional sex in the identified hotspots to inform prevention responses
Activity	1.4.1.3.3	Develop a revised YFHS package to include, amongst other interventions, social behaviour change interventions to increase recognition of individual risk of HIV for both AGYW and ABYM
Activity	1.4.1.3.4	Increase role of social marketing organizations and private sector to expand service delivery points (SDPs) to hard-to-reach areas for the provision of information and SRH/HIV services.
Activity	1.4.1.3.5	Partner with pharmacies to provide YFHS-branded information on age-appropriate SRH/HIV and general health information.

Level	*Code*	*Description*
Activity	1.4.1.3.6	Train peer educators including adolescents in demand creation and SRH advocacy, including information on LARCS, and referral for services.
Activity	1.4.1.3.7	Utilize community-based participatory learning approaches to sensitize communities in urban, peri urban, and community settings on how modifying harmful gender norms can improve equity, SRH and HIV outcomes.
Activity	1.4.1.3.8	Utilize mass media and mHealth to popularize YFHS safe spaces.
Strategic Intervention	1.4.1.4	Engage with networks of young people to disseminate prevention messages and support education programmes that allow young people to understand and exercise their rights to information and to services.
Activity	1.4.1.4.1	Refer to cross-listed activities under Strategic Intervention 1.4.1.2: Engage and collaborate with influential leaders to transform and Implement community and social norms change programming at the individual, community, and structural levels to create an enabling environment to support the girl child, end child marriage, sexual abuse, stigma and promote HIV Prevention and activities under Objective 7.1.1: To facilitate positive behaviour change at individual and community levels
Strategic Intervention	1.4.1.5	Expand and intensify existing life skills modules and SRH and HIV education for in-school and out-of-school youth, with a focus on delaying sexual activity, preventing GBV, avoiding transactional and age-disparate sex, and building self-efficacy.
Activity	1.4.1.5.1	Develop an integrated curriculum for out-of-school CSE
Activity	1.4.1.5.2	Engage with policymakers to advocate for the inclusion of high-quality comprehensive CSE in school curriculum (incl. advocacy for inclusion in pre-service training of teachers)
Activity	1.4.1.5.3	Train SHN teachers on updated school curriculum including high-quality comprehensive CSE
Activity	1.4.1.5.4	Update the school curriculum to include comprehensive CSE
Objective	**1.4.2**	**To empower vulnerable AGYW through social, economic, and legal interventions**
Strategic Intervention	1.4.2.1	Engage and collaborate with influential leaders to transform and implement community and social norms change programming at the individual, community, and structural levels to create an enabling environment to support the girl child; end child marriage, sexual abuse, and stigma; promote HIV Prevention; and recognise the rights of women and girls
Activity	1.4.2.1.1	Develop communications campaign to be distributed at the community level
Activity	1.4.2.1.2	Engage communities in social dialogue to foster a supportive environment for AGYW
Activity	1.4.2.1.3	Reach ABYM through workplace settings
Activity	1.4.2.1.4	SBCC and engaging with gate keepers and community and traditional leaders to abolish the practice of intergenerational child marriage

Level	*Code*	*Description*
Activity	1.4.2.1.5	Utilize billboards at the community level
Strategic Intervention	1.4.2.2	Increase access to and completion of quality primary and secondary education, including informal and vocational learning, for AGYW
Activity	1.4.2.2.1	Advocate for implementation of the Malawi National Alcohol Policy, launched in 2017, to reduce vulnerability of AGYW in engaging in high-risk sex and to becoming victims of sexual abuse as a result of alcohol abuse
Activity	1.4.2.2.2	Advocate for implementation of the National HIV and AIDS Strategy for Higher Education Institutions
Activity	1.4.2.2.3	Coverage of CSE in primary and secondary schools, and through age and marital status segmented after-school and community clubs
Activity	1.4.2.2.4	Keep girls in higher primary and secondary schools
Activity	1.4.2.2.5	Promote access to HTS for typical male partners of AGYW, through HIV self-testing and other acceptable approaches (such as mobile HTC facilities) and link HIV-positive individuals to ART services
Activity	1.4.2.2.6	Review and update the policy to incorporate emerging issues on substance abuse
Strategic Intervention	1.4.2.3	Build social support and increase AGYW resilience through delivery of evidence-based social and economic assets interventions of vulnerable AGYW through small group structures such as after-school and community clubs.
Activity	1.4.2.3.1	Establish Village Savings Loans (VSLs) for AGYWs including mobilize parents and caregivers of AGs under 18 years to participate in VSLs which would financially empower them
Activity	1.4.2.3.2	Identify and support Ambassadors for AGYWs to reach out to peers as role models mobilizing them to access HIV services and to learn skills like beads and sanitary pad making
Activity	1.4.2.3.3	Implement a variety of social asset building activities in clubs, with an aim of building sustainable protective assets such as self-esteem, problem solving abilities, confidence and social networks
Activity	1.4.2.3.4	Provide enablers to keep at risk girls in school, and to facilitate the return to school/ reintegration of girls who have previously dropped out
Sub theme	**1.5**	**Key and Vulnerable Populations**
Objective	**1.5.1**	**To increase access to and coverage of combination HIV prevention, treatment, care, and support among KPs**
Strategic Intervention	1.5.1.1	Strengthen national and district level governance and coordination of KP programs and community services
Activity	1.5.1.1.1	Address legal barriers with criminalization of MSM, FSW, MSW, TGs and PWIDs including awareness on moratorium on LGBTI sexual relations
Activity	1.5.1.1.2	Conduct recurrent TWG at the district level
Activity	1.5.1.1.3	Disseminate curriculum and tools for peer-educators and peer-navigators for FSW, MSW, MSM, and TGs

Level	Code	Description
Activity	1.5.1.1.4	Eliminate duplication of efforts between NGO's / implementing partners
Activity	1.5.1.1.5	Hold regular KP TWG meetings at the national level
Activity	1.5.1.1.6	National roll out of the SADC 3 phase model for care for prisoners
Activity	1.5.1.1.7	Operationalize the data pipeline
Activity	1.5.1.1.8	Print curriculum and tools for peer-educators and peer-navigators for FSW, MSW, MSM, and TGs
Activity	1.5.1.1.9	Promote UCD frameworks for use in designing KP interventions
Activity	1.5.1.1.10	Review curriculum and tools for peer-educators and peer-navigators for FSW, MSW, MSM, and TGs
Activity	1.5.1.1.11	Saturate comprehensive KP prevention interventions tailored for HIV- and HIV+ cohorts in current priority (highest burden) districts, based on validated KP size estimates and expansion
Activity	1.5.1.1.12	Standardize reporting indicators and systems (including adoption of a UIC) to facilitate tracking of cascade performance of KPs across districts and providers, especially for mobile KPs
Strategic Intervention	1.5.1.2	Engage and advocate with high-level government, political, civil society, faith, and other opinion leaders to address legal barriers and foster an enabling environment for KPs
Activity	1.5.1.2.1	Conduct high level annual planning and review meetings on legal barriers to accessing HIV services by KPs
Activity	1.5.1.2.2	Conduct regular meetings between KP stakeholders and legal and social protection services
Activity	1.5.1.2.3	Conduct transformative dialogue meetings with members of parliament, the Judiciary, Malawi Human Rights Commission, Malawi Law Commission, Malawi Police and Prison Services, Civil Society Organisations, Faith leaders, Traditional leaders and journalists
Activity	1.5.1.2.4	Design awareness campaigns
Activity	1.5.1.2.5	Establish and support MSM, MSW and TG committees at district levels
Activity	1.5.1.2.6	Establish/strengthen a referral system in case of human right violation through peer educators to police, legal support and social protection services
Activity	1.5.1.2.7	Increase the proportion of CSOs with capacity in human rights programming to reduce reliance on KP-specific CSOs
Activity	1.5.1.2.8	Review and revise ToRs for the DACC to include FSW and MSM representatives
Activity	1.5.1.2.9	Roll out awareness campaigns
Activity	1.5.1.2.10	Support regular stakeholder liaison (interface) meetings with law enforcement, judicial and health officials to identify and resolve challenges in program implementation.
Activity	1.5.1.2.11	Support the operations of the FSW Coordination Committee
Strategic Intervention	1.5.1.3	Expand a DSD model for KP enabling them to access a continuum of HIV and SRH services from multiple service delivery points, including prisons.

Level	Code	Description
Activity	1.5.1.3.1	assure the SRH and HIV package is comprehensive including at least: HTS, FP, STI treatment, PEP/PrEP, ARV provision, SGBV care, VL monitoring and ideally TB screening and treatment, cervical cancer screening and treatment and Hep B vaccination
Activity	1.5.1.3.2	Expand use of the UIC to better track and report results for KP client referrals and service provision across the HIV services cascade as well as track service provision for mobile KPs, especially SWs, across districts, providers and programs
Activity	1.5.1.3.3	Print registers
Activity	1.5.1.3.4	provide regular supervision and mentorship of the workers to ensure quality delivery of services
Activity	1.5.1.3.5	recognizing their vulnerability and impact on transmission, KP should be prioritized where applicable when rolling out new effective prevention and treatment strategies
Activity	1.5.1.3.6	Recruit and train peer educators and outreach workers for FSW, MSW, MSM and TG
Activity	1.5.1.3.6	Roll-out of U=U (T=T) Campaign alongside direct electronic transmission of Viral load results from testing labs to recipients of care using SMS technology
Activity	1.5.1.3.7	Use of service outreach activities (e.g. moonlight testing, STI screening, FP, cervical cancer screening, PrEP, ART provision, link to VL testing), DICs and other safe spaces for KP meetings and service provision venues
Strategic Intervention	1.5.1.4	Pursue SLAs with private SRH providers to expand delivery points to KPs
Activity	1.5.1.4.1	Conduct annual stakeholders planning and review meetings on SLA
Activity	1.5.1.4.2	Conduct audit of transactions in service delivery points
Activity	1.5.1.4.3	Conduct mentorship of service providers
Activity	1.5.1.4.4	Conduct quarterly service level planning and review meetings on SLAs
Activity	1.5.1.4.5	Conduct supportive supervision to service delivery points
Activity	1.5.1.4.6	Conduct training of service providers
Strategic Intervention	1.5.1.5	Scale-up delivery of a standard comprehensive package for FSWs, their children and clients, MSM, MSW, and TG provision that includes HIV prevention, treatment, care, and support services; SRHR; GBV; and community mobilisation
Activity	1.5.1.5.1	Develop training manual on comprehensive HIV prevention, care and support services for FSW and their clients, MSM, MSW, TG and KP family members
Activity	1.5.1.5.2	Establish and support SMS platform
Activity	1.5.1.5.3	Establishment of a rapid response system which acts as the first point of contact for victims at the community level including PEP initiation and emergency contraceptives at community level with referral to KP friendly services for further follow up
Activity	1.5.1.5.4	Identify service delivery platform such as health facility and community structure such as DIC

Level	*Code*	*Description*
Activity	1.5.1.5.5	Know-your-rights training
Activity	1.5.1.5.6	service provision within community including peers as service providers with extra attention for the hard to reach KP's, including home-based sex workers
Strategic Intervention	1.5.1.6	Scale-up community-based and self-HIV testing coupled with ART linkage, retention in care, and ART adherence for KP
Activity	1.5.1.6.1	Develop curriculum for integrated training on quality counselling and procedure for HTS and self-testing, On providing KP friendly service delivery and stigma reduction and On adherence support for KP and their clients
Activity	1.5.1.6.2	Establish toll free line to support self-testing
Activity	1.5.1.6.3	Identify KP referral focal person for health facilities
Activity	1.5.1.6.4	insure nonbinary labeled services, intake forms, places, for accessing health care for people not self-identifying binary
Activity	1.5.1.6.5	Promote the provision of KP friendly services in health facilities for scale up of HIV prevention, treatment and support services
Activity	1.5.1.6.6	provide adapted HIV prevention for prisoners (include condoms and lubricants)
Activity	1.5.1.6.7	Recruit and Support "next generation peers" to facilitate linkages and retention in care of HIV-positive key population members
Activity	1.5.1.6.8	Scale up the establishment of Drop in Centres to all priority districts with a reasonable capacity per center or clinician to assure comprehensive care during a visit
Objective	**1.5.2**	**To improve the quality of planning for KP interventions through increased generation and use of relevant evidence**
Strategic Intervention	1.5.2.1	Modify and routinely conduct studies to determine size estimates for FSWs, MSM, PWIDs, MSW, and TGs
Activity	1.5.2.1.1	Integrate studies for MSW, PWID and TGs and conduct adapted survey to estimate the number of FSW, MSM, MSW, TGs, PWID (assure representative country wide sample)
Strategic Intervention	1.5.2.2	Coordinate research and implementing partners to understand findings on interventions targeting PWIDs, MSW, and TGs to inform the development of interventions.
Activity	1.5.2.2.1	Conduct a national validation meeting on research findings on PWIDs, MSW, and TGs
Activity	1.5.2.2.2	Conduct district based dissemination meetings on research findings on PWIDs, MSW, and TGs
Activity	1.5.2.2.3	Conduct transformative study on PWIDs, MSW, and TGs
Objective	**1.5.3**	**To support GoM and various disaster risk management stakeholders to deliver the minimum required multi-sectoral response to HIV and AIDS during emergency situations**
Strategic Intervention	1.5.3.1	Mainstream HIV and AIDS in Disaster Risk Reduction (DRR) and Disease Epidemic Preparedness and Response Plans, policies, strategies and programmes at all levels
Activity	1.5.3.1.1	Conduct annual national stakeholders meeting on HIV response during disasters

Level	*Code*	*Description*
Activity	1.5.3.1.2	Conduct needs assessment of HIV services during national disasters
Activity	1.5.3.1.3	Conduct validation meetings on findings of needs assessment exercise
Activity	1.5.3.1.4	Conduct dissemination meetings of findings of needs assessment exercise
Strategic Intervention	1.5.3.2	Strengthen emergency preparedness and logistics mechanisms
Activity	1.5.3.2.1	Assess availability, accessibility and capacity of health services including HIV and AIDS in emergency settings
Activity	1.5.3.2.2	Conduct annual district planning and review meetings on HIV management during disasters
Activity	1.5.3.2.3	Conduct supervision of disaster stricken areas
Activity	1.5.3.2.4	Integrate logistics for HIV commodities with existing emergency response logistics
Activity	1.5.3.2.5	Set up and strengthen coordination mechanisms for HIV and AIDS response into the overall emergency response
Strategic Intervention	1.5.3.3	Develop and deliver a package of HIV, GBV, SRHR and mental health services in emergency situations.
Activity	1.5.3.3.1	Conduct a workshop to develop a minimum package of services for disaster victims
Activity	1.5.3.3.2	Conduct outreach clinics in disaster stricken areas
Sub theme	**1.6**	**Elimination of Mother to Child Transmission (e-MTCT)**
Objective	**1.6.1**	**To improve primary prevention of HIV in women of childbearing age, specifically for AGYW, pregnant and breastfeeding women**
Strategic Intervention	1.6.1.1	Intensify SBCC to increase demand for and uptake of SRH and HIV prevention services by AGYW, pregnant and breastfeeding women and their male partners as highlighted in the Malawi AGYW, HIV prevention strategies, HIV strategy for higher education institutions, and all other applicable strategies.
Activity	1.6.1.1.1	Develop and implement targeted demand creation SBCC strategies utilizing innovative youth-friendly communication channels, including mass and social media and innovative new media that appeal to AGYW and their partners, to create demand and utilization of SRHR and HIV services and to promote risk reduction and service uptake with fidelity and quality assurance
Activity	1.6.1.1.2	Establish AGYW and SBCC coordination structures at national, district, and community level
Strategic Intervention	1.6.1.2	Evaluate and the scale-up of PrEP for AGYW, pregnant and breastfeeding women.
Activity	1.6.1.2.1	Implement PrEP for HIV negative pregnant women and for breastfeeding women and generate evidence for scale up-Develop policy on use of PrEP for AGYW who are pregnant and breast feeding
Strategic Intervention	1.6.1.3	Offer integrated and youth-friendly health services (YFHS) to AGYW and boys

Level	*Code*	*Description*
Activity	1.6.1.3.1	Strengthen communication and counselling to increase demand and knowledge of condom use
Activity	1.6.1.3.2	Build capacity of health-care providers to deliver quality education, counselling and support, and referral to SRH services for adolescents and young people in a friendly manner -Facilitate YFHS training for health-care providers
Activity	1.6.1.3.3	Diversify and ensure availability of family planning and related commodities (e.g. male and female condoms, lubricants and long acting reversible and permanent contraceptive methods) - Supplement the supply of modern contraceptive to 45,000 women in need for PMTCT services
Activity	1.6.1.3.4	Offer integrated youth friendly health services - Develop and integrate SRHR into national YFHS guidelines
Activity	1.6.1.3.5	Offer integrated youth friendly health services -Integrate YFHS at youth centers
Strategic Intervention	1.6.1.4	Engage the male partners of AGYW, pregnant and breastfeeding women
Activity	1.6.1.4.1	Scale up to reach spouses of both HIV-positive and HIV-negative women with HIV self-testing, delivered through pregnant and postpartum women - Scale up distribution of self-testing kits to male partners of HIV pregnant and lactating women
Objective	**1.6.2**	**To reduce unplanned and unintended pregnancies among HIV infected women.**
Strategic Intervention	1.6.2.1	Support counseling on a wide range of family planning methods to HIV positive women
Activity	1.6.2.1.1	Conduct counseling on a wide range of family planning methods to HIV positive women
Strategic Intervention	1.6.2.2	Support the provision of family planning commodities to HIV positive women
Activity	1.6.2.2.1	Diversify and ensure availability of family planning and related commodities (e.g. male and female condoms, lubricants and long acting reversible and permanent contraceptive methods)
Strategic Intervention	1.6.2.3	Ensure linkage of family planning with provision of other SRH services to increase coverage
Activity	1.6.2.3.1	Improve integration of family planning with HIV and syphilis services
Objective	**1.6.3**	**To prevent vertical transmission of HIV through screening and identification of women and their partners during pregnancy and breastfeeding**
Strategic Intervention	1.6.3.1	Strengthen screening for HIV, viral hepatitis and syphilis throughout pregnancy and breastfeeding periods
Activity	1.6.3.1.1	Optimize screening of pregnant and lactating women for HIV, syphilis and viral hepatitis in ANC, labor and post-natal
Activity	1.6.3.1.2	Promote early scheduling of first antenatal visit, and retention for ANC and referrals for HIV care

Level	*Code*	*Description*
Strategic Intervention	1.6.3.2	Treat syphilis in pregnant and breastfeeding women together with their partners
Activity	1.6.3.2.1	Treat syphilis in pregnant and breastfeeding women together with their partners
Strategic Intervention	1.6.3.3	Initiate and monitor newly HIV diagnosed pregnant and breastfeeding women on lifelong ART
Activity	1.6.3.3.1	Initiate and monitor newly HIV diagnosed pregnant and breastfeeding women on lifelong ART
Objective	**1.6.4**	**To provide treatment, care and support to infected mothers and infected and exposed infants.**
Strategic Intervention	1.6.4.1	Improve linkage of HIV+ mothers and infants (e.g. through strengthening CBOs) to support adherence and retention.
Activity	1.6.4.1.1	Build capacity of service providers to strengthen linkage to care and monitor linkage efficacy between health facilities and community-based services
Activity	1.6.4.1.2	Investigate reasons for low/late ART initiation of HIV-exposed infants (HEI) who are found to be HIV positive
Activity	1.6.4.1.3	Scale up systems to support active patient tracing of patients on ART who miss appointments and mother infant pairs (e.g. appointment books, EDS (electronic data system) with flags)
Activity	1.6.4.1.4	Strengthen community-based organizations such as clients, supportive groups, mothers to mothers, PLHIV to support the adherence and retention for HIV+ pregnant and breast-feeding women and infants
Strategic Intervention	1.6.4.2	Improve monitoring and follow-up of HIV exposed infants
Activity	1.6.4.2.1	Improve the EID coverage and documentation
Activity	1.6.4.2.2	Optimize lab information management system to facilitate timely management of exposed infants
Strategic Intervention	1.6.4.3	Improve retention of HIV+ mothers and infants on treatment and strengthen viral load monitoring of HIV+ mothers and infants on ART treatment.
Activity	1.6.4.3.1	Cross-departmental and stakeholder meetings to develop and harmonize the policies
Activity	1.6.4.3.2	Dissemination of the policies
Activity	1.6.4.3.3	Printing the policies
Activity	1.6.4.3.4	Disseminating the Strategy
Activity	1.6.4.3.5	Printing the strategy
Activity	1.6.4.3.6	Disseminating the guidelines
Activity	1.6.4.3.7	Printing the community PMTCT guidelines
Activity	1.6.4.3.8	Consultative meetings to review and revise the roadmap
Activity	1.6.4.3.9	Distribution of the revised roadmap
Activity	1.6.4.3.10	Printing the revised roadmap

Level	*Code*	*Description*
Activity	1.6.4.3.11	Engage expert clients in service provision at health facility level to support HIV+ pregnant and postpartum women, particularly in counselling those who are newly diagnosed with HIV or experiencing challenges with adherence
Activity	1.6.4.3.12	Ensure the implementation of interventions to support adherence counselling and support for pregnant women, in PMTCT and serodiscordant couples and young women living with HIV
Activity	1.6.4.3.13	Routinize viral load monitoring for all HIV-positive pregnant women at ANC and breast-feeding women and enhanced adherence counselling for those who are not suppressed
Activity	1.6.4.3.14	Increasing testing coverage for exposed children, especially on POC/GeneXpert
Activity	1.6.4.3.15	Routinize viral load monitoring for all HIV-positive infants
Activity	1.6.4.3.16	Revise and deploy digital PMTCT monitoring tools
Activity	1.6.4.3.17	Strengthen PMTCT and EID performance at sub-national
Activity	1.6.4.3.18	Establish a national forum to review progress to global targets
Sub theme	**1.7**	**Sexually Transmitted Infections and Sexual and Reproductive Health Services**
Objective	**1.7.1**	**To increase quality STI and other SRH services at HIV service delivery points, including family planning, cervical cancer, syphilis, and post-sexual violence care coverage**
Strategic Intervention	1.7.1.1	Improve demand, access, and utilization of STI screening and treatment to all populations
Activity	1.7.1.1.1	Develop and strengthen syphilis testing and tracking
Activity	1.7.1.1.2	Engage with private sector health institutions to standardize the package of services for comprehensive management of STIs in the general population.
Activity	1.7.1.1.3	Engaging high-level individuals in awareness campaigns
Activity	1.7.1.1.4	Introduce etiological diagnostics for STIs
Activity	1.7.1.1.5	Mass media campaign
Activity	1.7.1.1.6	Strengthening targeted community interventions
Strategic Intervention	1.7.1.2	Strengthen engagement and collaboration with private sector on STI and HIV prevention service delivery
Activity	1.7.1.2.1	Conduct supervisions for private pharmacies
Activity	1.7.1.2.2	Engage with private sector health institutions to standardize the package of services for comprehensive management of STIs in the general population.
Activity	1.7.1.2.3	Engagement meetings with private pharmacies
Strategic Intervention	1.7.1.3	Strengthen integration of service delivery of STI and other SRH services including family planning, cervical cancer screening and treatment as well as STI syndromic diagnosis and treatment.
Activity	1.7.1.3.1	Conduct screening and linkage to treatment
Activity	1.7.1.3.2	Develop and implement an integrated training curriculum
Activity	1.7.1.3.3	Support the development of the SRH-HIV integration strategy within Malawi

Level	*Code*	*Description*
Strategic Intervention	1.7.1.4	Improve monitoring and evaluation systems of STI and other SRH services at national and subnational levels
Activity	1.7.1.4.1	Develop and disseminate IEC materials for STIs
Activity	1.7.1.4.2	Develop and disseminate STI communications strategy/plan
Activity	1.7.1.4.3	Formation and regular meetings of the STI technical sub working group
Activity	1.7.1.4.4	Operational research to investigate reasons for low turn up of Partners of STI clients for treatment
Activity	1.7.1.4.5	Strengthen data use for decision making through capacity building of staff on data analysis at the facility and district
Activity	1.7.1.4.6	Update and revision of the STI Guidelines, job aids, and M&E guidelines
Strategic Intervention	1.7.1.5	Strengthen monitoring of antimicrobial resistance for STI with focus on Neisseria gonorrhoeae
Activity	1.7.1.5.1	Capacity building for service providers
Activity	1.7.1.5.2	Strengthening the laboratory capacity
Sub theme	**1.8**	**Wellness and Workplace HIV Programmes**
Objective	**1.8.1**	**To strengthen multi-sectoral governance of HIV and AIDS workplace programmes**
Strategic Intervention	1.8.1.1	Develop the National HIV and AIDS Workplace Policy and ensure that it addresses gender equality, human rights and social inclusion of key and vulnerable populations.
Activity	1.8.1.1.1	Develop and validate National HIV and AIDS Workplace Policy
Activity	1.8.1.1.2	Dissemination of National HIV and AIDS workplace policy at regional level
Strategic Intervention	1.8.1.2	Develop and implement a comprehensive costed HIV and AIDS in the workplace strategic plan for both the public and private sectors for the period 2020-2025
Activity	1.8.1.2.1	Dissemination of costed HIV and AIDS workplace strategic plan district level
Activity	1.8.1.2.2	Dissemination of costed HIV and AIDS workplace strategic plan national level
Activity	1.8.1.2.3	Provide technical backstopping support in the implementation of the costed HIV and AIDS workplace strategic plan in both public and private sectors
Strategic Intervention	1.8.1.3	Develop and implement HIV and AIDS policies and programmes targeting the informal sector.
Activity	1.8.1.3.1	Conduct bi-annual information sharing conferences on HIV and AIDS interventions in the informal sector
Activity	1.8.1.3.2	Develop Informal Sector Strategic Plan
Activity	1.8.1.3.3	Dissemination of Informal sector Strategic Plan
Strategic Intervention	1.8.1.4	Develop and implement tailored comprehensive HIV and AIDS package for migrant laborers including the construction and plantation sectors.
Activity	1.8.1.4.1	Conduct quarterly spot checks targeting construction and plantation sectors to assess implementation of standard HIV and AIDS package

Level	*Code*	*Description*
Activity	1.8.1.4.2	Develop standard HIV and AIDS package for migrant laborers, and workers in construction and plantation sectors
Strategic Intervention	1.8.1.5	Develop and implement strategies on economic and workplace empowerment of young women.
Activity	1.8.1.5.1	Utilise existing AGYW coordination bodies to develop and implement strategies on access to work, vocational training, entrepreneurship training, small business loans, and savings groups for young women
Objective	**1.8.2**	**To strengthen the implementation of HIV and AIDS workplace programmes in the public sector**
Strategic Intervention	1.8.2.1	Develop regulations to mainstream HIV and AIDS prevention and management into Labor Inspection checklists.
Activity	1.8.2.1.1	Revise labor inspection checklist to include HIV and AIDS prevention
Activity	1.8.2.1.2	TOT training targeting labor inspection team
Strategic Intervention	1.8.2.2	Capacitate Occupational Safety and Health Officers and Labor inspectors on HIV and AIDS enforcement at workplaces.
Activity	1.8.2.2.1	Train Capacitate Occupational Safety and Health Officers and Labour inspectors on HIV and AIDS enforcement at workplaces
Strategic Intervention	1.8.2.3	Revise the MoL HIV and AIDS and workplace guidelines including on ORT
Activity	1.8.2.3.1	Disseminate the revised HIV and AIDS workplace guidelines and ORT guidelines
Activity	1.8.2.3.2	Revise HIV and AIDS workplace guidelines and ORT guidelines for MoL
Objective	**1.8.3**	**To strengthen the implementation of HIV and AIDS workplace programmes in the private sector.**
Strategic Intervention	1.8.3.1	Review the mandate of the MBCA to cover private companies under the MCCI and ECAM
Activity	1.8.3.1.1	Conduct and implement functional review of MBCA to better coordinate the private sector response
Activity	1.8.3.1.2	Conduct situation analysis of private sector involvement in the response through MCCI and ECAM
Activity	1.8.3.1.3	Dissemination of results and development of action plan
Strategic Intervention	1.8.3.2	Build the capacity of the private sector to effectively deliver HIV and AIDS services including HIV prevention and treatment both directly and through SLAs.
Activity	1.8.3.2.1	Training of private sector in HIV and AIDS services including HIV prevention and treatment
Activity	1.8.3.2.2	Increase number of ART sites in the private sector
Strategic Intervention	1.8.3.3	Strengthen HIV prevention and treatment interventions in the workplace including promotion and distribution of condoms, HIV Testing Services, VVMC, PreP, PEP and ART and encouraging employers to provide Personal Protective Equipment for high-risk workers such as health care workers.
Activity	1.8.3.3.1	Develop workplace specific HIV risk screening tools to guide provision of services such as PrEP, VMMC, self-testing

Level	Code	Description
Activity	1.8.3.3.2	Implement demand creation initiatives (advocacy events e.g. family wellness days, Institutional WAD and Candlelight
Activity	1.8.3.3.3	Install condom dispensers
Strategic Intervention	1.8.3.4	Enforce the private sector reporting of data in line with the 2018 HIV and AIDS Prevention and Management Act.
Activity	1.8.3.4.1	Mapping of all formal workplaces as base line
Activity	1.8.3.4.2	Support MBCA to develop private sector HIV database
Strategic Intervention	1.8.3.5	Advocate for increased financial contribution of the private sector to the national response towards HIV and AIDS.
Activity	1.8.3.5.1	Introduce HIV and AIDS levy in the private sector
Activity	1.8.3.5.2	Enforce companies to fund their HIV and AIDS and wellness programs through law enforcement
Sub theme	**1.9**	**Blood Safety**
Objective	**1.9.1**	**To improve the availability, quality and management of blood transfusion services**
Strategic Intervention	1.9.1.1	Set up sentinel sites for blood collection, screening and distribution and all major hospitals
Activity	1.9.1.1.1	Improve supply of blood to health facilities
Activity	1.9.1.1.2	Provide equipment for blood donor mobilization, blood collection, blood testing and blood storage

Differentiated HIV Testing Services Activity Table

Level	Code	Description
Sub theme	**2.1**	**Differentiated HIV Testing Services**
Objective	**2.1.1**	**To improve HIV case finding among high risk populations through proven innovative approaches**
Strategic Intervention	2.1.1.1	Strengthen targeted facility and community testing of all key and priority populations
Activity	2.1.1.1.1	Strengthen the passive family referral slip (FRS) system and HIVST integration
Activity	2.1.1.1.2	Implement the active voluntary assisted index testing (AIT) system
Activity	2.1.1.1.3	Distribute self-test kits at pharmacies to key and priority populations
Activity	2.1.1.1.4	Distribute self-test kits in the community to key and priority populations, through optimal distribution channels
Activity	2.1.1.1.5	Diversify self-test kit market by promoting availability of different high performing products across distribution points
Activity	2.1.1.1.6	Develop MOH screening tool considering available partner tools
Activity	2.1.1.1.7	Validate MOH screening tool
Activity	2.1.1.1.8	Printing of screening tool booklets and supporting materials
Activity	2.1.1.1.9	Training on MOH screening tool
Activity	2.1.1.1.10	Promote targeted testing at static outreach sites
Activity	2.1.1.1.11	Promote targeted testing in DICs and KP outreach sessions
Activity	2.1.1.1.12	Promote targeted testing in identified hotspots
Activity	2.1.1.1.13	Promote targeted testing in prison and confined settings (refugee camps)

Level	Code	Description
Activity	2.1.1.1.14	Increase number of public and private sites offering quality HTS (all sites must be assessed and approved as HTS delivery points)
Activity	2.1.1.1.15	Standardize user fees for HTS at private sites (to reduce financial barries to HTS uptake at private for-profit facilities)
Strategic Intervention	2.1.1.2	Improve quality of HTS diagnoses through better planning, management, and QA systems.
Activity	2.1.1.2.1	Develop SOPs and Job Aides
Activity	2.1.1.2.2	Train providers on new algorithms
Activity	2.1.1.2.3	Strengthen biannual proficiency testing implementation for all HTS providers
Activity	2.1.1.2.4	Validate, field-test and procure highly sensitive, specific and efficient WHO pre-qualified HIV RDTs
Activity	2.1.1.2.5	Develop policy on waste management considering BB HIVST kits
Activity	2.1.1.2.6	Develop feedback mechanism for clients to communicate on quality of HTS delivery (used to inform mentorship needs) - could be a client exit survey
Activity	2.1.1.2.7	Establish ECHO (extension for community healthcare outcomes) Hub and spoke sites
Activity	2.1.1.2.8	Strengthen human capacity through training of lab personnel at national level
Activity	2.1.1.2.9	MBCA to monitor private for-profit and not-for profit HTS delivery points for quality delivery of HTS, including HR and infrastructure
Strategic Intervention	2.1.1.3	Strengthen linkage of HTS clients to comprehensive prevention and treatment services
Activity	2.1.1.3.1	Conduct sensitization meeting
Activity	2.1.1.3.2	Develop eHealth tool to support HIVST linkage
Activity	2.1.1.3.3	Develop HIVST distribution slip for client to bring to provider at facility for HIVST follow up
Activity	2.1.1.3.4	Procurement of commodities
Strategic Intervention	2.1.1.4	Integrate HTS into SRH and other key health services
Activity	2.1.1.4.1	Desk review together with reproductive health and other key health services to identify where integration is happening
Activity	2.1.1.4.2	Orientation on integration of services at facility level
Activity	2.1.1.4.3	Validate MOH screening tool
Strategic Intervention	2.1.1.5	Improve governance and coordination of the HTS program across the public and private sectors with a focus on decentralization
Activity	2.1.1.5.1	Conduct Advocacy meetings with PMPB
Activity	2.1.1.5.2	District review meetings conducted by DHO, quarterly including district staff and HTC providers within district (30+)
Activity	2.1.1.5.3	HTS Core Group meetings (quarterly)
Activity	2.1.1.5.4	HTS Supervisor at facility to conduct monthly review meetings with HTS staff
Activity	2.1.1.5.5	National mapping of partner activities, private sector activities and HTS resources - reviewed at HTS core group meetings to avoid duplication

Level	Code	Description
Activity	2.1.1.5.6	Zonal review(monitoring) meetings with DHO and district staff
Strategic Intervention	2.1.1.6	Strengthen health system capacity to implement HTS policies
Activity	2.1.1.6.1	Assess and map all cadres of HTS providers
Activity	2.1.1.6.2	Renovation of sites based on assessment from annual site certification reports
Activity	2.1.1.6.3	Construction of new public sites based on assessment (no evidence on number or cost per site - would need deeper assessment)
Activity	2.1.1.6.4	Conduct supervision visits
Activity	2.1.1.6.5	Conduct national and district supervisors training
Activity	2.1.1.6.6	Identify set of mentors per district
Activity	2.1.1.6.7	Conduct training for district mentors
Activity	2.1.1.6.8	Mentorship at every facility for all HTS providers (frequency to be determined)
Activity	2.1.1.6.9	Refresher training for all cadres delivering HTS at district level (Skills Intensive Training accounting for new national testing apporaches, PNS, HIVST, etc)
Activity	2.1.1.6.10	Staff certification of all 6,000 providers every two years
Activity	2.1.1.6.11	Site certification of all HTS sites every year
Activity	2.1.1.6.12	Update mentorship tool; prioritize mentorship needs on new HTS approaches
Activity	2.1.1.6.13	Update the supervision tools, including Sit-in observation tool, to capture HTS provider mentorship needs,
Activity	2.1.1.6.14	Review and revise national HTS guidelines
Activity	2.1.1.6.15	Disseminate national HTS guidelines
Strategic Intervention	2.1.1.7	Improve HTS data systems at facility and community level
Activity	2.1.1.7.1	Update national HTS registers and monthly forms
Activity	2.1.1.7.2	Pilot new HTS registers in selected sites
Activity	2.1.1.7.3	Finalize HTS registers and disseminate

Treatment, Care, and Support and TB/HIV Activity Tables

Level	Code	Description
Sub theme	**3.1**	**Treatment, Care and Support for HIV/AIDS and Related Diseases**
Objective	**3.1.1**	**To increase coverage and provision of high-quality integrated HIV and other related diseases (NCD, Viral Hepatitis, and cancer services)**
Strategic Intervention	3.1.1.1	Improve access to high-quality ART services for adults, children, and vulnerable /underserved populations
Activity	3.1.1.1.1	Conduct Negotiations with MBCA and private clinics on assuring affordable service fee for patients
Activity	3.1.1.1.2	Construction of extra prefab Storage units
Activity	3.1.1.1.3	Construction of new health posts for high density areas
Activity	3.1.1.1.4	Ensure availability of ART

Level	Code	Description
Activity	3.1.1.1.5	Ensure high quality of care (e.g. reasonable wait time, respectful treatment etc.)
Activity	3.1.1.1.6	Increase the number of staff in these facilities
Activity	3.1.1.1.7	Print M&E materials and procure stationary items
Activity	3.1.1.1.8	Renovation/refurbishment of clinic consultation rooms devoted to HIV services
Activity	3.1.1.1.9	Scale up clinical mentoring for providers to ensure proper treatment
Strategic Intervention	3.1.1.2	Improve retention and adherence in ART among adults, adolescents, and children
Activity	3.1.1.2.1	Cross-cutting interventions to improve drug retention and adherence among all patient groups
Activity	3.1.1.2.2	Develop and implement programs to improve drug retention and adherence among adult patients
Activity	3.1.1.2.3	Develop and implement programs to improve drug retention and adherence among pediatric patients
Activity	3.1.1.2.4	Establish mechanisms and systems to identify ART side effects earlier and effectively treat them.
Activity	3.1.1.2.5	Implement differentiated service delivery for clients on ART
Activity	3.1.1.2.6	Improve access to optimal ART treatment regimens
Activity	3.1.1.2.7	Scale up Teen Clubs and programs to improve treatment retention and adherence for adolescents
Strategic Intervention	3.1.1.3	Improve treatment monitoring (Viral Load, Drug Resistance and ARV Toxicity Monitoring)
Activity	3.1.1.3.1	ARV Toxicity Monitoring
Activity	3.1.1.3.2	Expand reflex genotyping (resistance test) for all unsuppressed follow up VL samples
Activity	3.1.1.3.3	Improve VL result utilization
Activity	3.1.1.3.4	Increase annual VL testing coverage
Activity	3.1.1.3.5	Increase proportion of plasma-based VL monitoring
Activity	3.1.1.3.6	Intensify Monitoring of Drug Resistance
Activity	3.1.1.3.7	Introduce baseline VL monitoring for all those initiating ART at a subset of sentinel sites
Strategic Intervention	3.1.1.4	Improve timely delivery of viral load results to site level providers and recipients of care
Activity	3.1.1.4.1	Introduce prompt delivery of VL results from the testing molecular laboratory to healthcare providers & recipients of care using SMS technology (Building on LIMS interoperability)
Strategic Intervention	3.1.1.5	Strengthen community structures and systems to improve HIV service delivery
Activity	3.1.1.5.1	Pilot and implement 13 ART refill systems in existing community pharmacies in the four major cities
Activity	3.1.1.5.2	Deliver integrated health post level HIV/SRH/STI and other related services
Activity	3.1.1.5.3	Promote back to ART care interventions for children, women, adolescents and adults

Level	*Code*	*Description*
Activity	3.1.1.5.4	Implement comprehensive literacy for test and treat, viral load testing, drug toxicity and opportunistic infection symptoms at community level
Objective	**3.1.2**	**To reduce AIDS, non-AIDS mortality and co-morbidities**
Strategic Intervention	3.1.2.1	Improve monitoring and management of advanced HIV disease including cancers
Activity	3.1.2.1.1	Effectively treat advance HIV disease
Activity	3.1.2.1.2	Ensure linkage of patients and referrals to the community to the health patients
Activity	3.1.2.1.3	Ensure provision and uptake of preventive therapies for all PLHIV
Activity	3.1.2.1.4	Ensure the assessment of patients in emergency rooms, rapid switch to second line and expedite diagnosis for HIV and OIs
Activity	3.1.2.1.5	Improve capacity for advanced medical management i.e. access to ventilators, etc.
Activity	3.1.2.1.6	Provide reliable and high-quality laboratory testing
Activity	3.1.2.1.7	Scale up screening and diagnosis for advanced HIV disease to all ART sites
Activity	3.1.2.1.8	Screen and manage patients with HIV-Viral Hepatitis co-infection
Activity	3.1.2.1.9	Train HWs of management of Advanced HIV disease
Strategic Intervention	3.1.2.2	Improve monitoring and management of other HIV related diseases and comorbidities (non-communicable diseases, viral hepatitis and mental health in PLHIV
Activity	3.1.2.2.1	Provide quality psychosocial support to PLHIV
Activity	3.1.2.2.2	Screen and manage mental health in PLHIV.
Activity	3.1.2.2.3	Screen and effectively treat NCDs in PLHIV, especially hypertension, diabetes and dyslipidemia.
Strategic Intervention	3.1.2.3	Support primary, secondary and tertiary facilities to manage AIDS and non AIDS related morbidities
Activity	3.1.2.3.1	Procurement Advanced HIV disease commodities (PSM)
Activity	3.1.2.3.2	Procurement of equipment (costed under RSSH , medical equipment)
Strategic Intervention	3.1.2.4	Strengthen coordination of treatment, care and support at national and district level.
Activity	3.1.2.4.1	Implement treatment, care and support coordination structures
Activity	3.1.2.4.2	Support M&E and accountability at the facility level
Activity	3.1.2.4.3	coordination meetings (under integrated program management)
Activity	3.1.2.4.4	Strengthen MBCA (costed under work place)
Strategic Intervention	3.1.2.5	Ensure access to PEP in all hospitals and health centers.
Activity	3.1.2.5.1	Procure PEP
Sub theme	**4.1**	**TB/HIV**
Objective	**4.1.1**	**To reduce incidence, morbidity and mortality in TB/HIV co-infected patients**

Level	Code	Description
Strategic Intervention	4.1.1.1	Strengthen TB HIV collaborative activities and Coordination at all levels
Activity	4.1.1.1.1	Conduct training to health care for patient management
Activity	4.1.1.1.2	Conduct training to health care for patient management-
Activity	4.1.1.1.3	review and update TB/HIV policies and guidelines
Activity	4.1.1.1.4	Advocacy for TB/HIV integration of services in private clinics with MBCA
Activity	4.1.1.1.5	Capacity Building of Private clinics in Diagnostics for TB/HIV
Activity	4.1.1.1.6	Conduct coordination at the district level
Activity	4.1.1.1.7	Conduct joint field activities at the national level
Activity	4.1.1.1.8	conduct regular review with stakeholders to harmonize the policies and guidelines for TB and HIV.
Activity	4.1.1.1.9	TB/HIV operational framework
Strategic Intervention	4.1.1.2	Improve quality and coverage of intensified case finding and diagnosis for TB and HIV among PLHIV or persons with TB, including the use of sensitive molecular assays like Xpert MTB/RIF Ultra and other WHO recommended methods
Activity	4.1.1.2.1	Increase the competence of providers in diagnostics
Activity	4.1.1.2.2	print and distribute to all health facilities screening tools (algorithms and job aids) in HTS rooms
Activity	4.1.1.2.3	Community Involvement in HIV & TB through empowerment of CSOs including integration of activities to reduce duplication
Activity	4.1.1.2.4	Incorporate TB Screening TORs into the community health package
Activity	4.1.1.2.5	Increase the competence of providers in diagnostics of advanced HIV AIDS and comorbidities
Activity	4.1.1.2.6	print and distribute health promotion messages on TB screening for PLHIV
Activity	4.1.1.2.7	scale up FASH for diagnosis of TB among PLHIV
Activity	4.1.1.2.8	Scale up of Xpert RIF testing
Activity	4.1.1.2.9	Scale up TB/HIV screening in key populations: prisoners, minors, maternal, children
Activity	4.1.1.2.10	Train health care providers in PITC
Strategic Intervention	4.1.1.3	Improve coverage of high-quality treatment to all HIV/TB co-infected people
Activity	4.1.1.3.1	Expand death audits to all hospital
Activity	4.1.1.3.2	Initiate TB-HIV Co-infected patients (DS and DR) are initiated on ART within 2 weeks of starting TB treatment
Activity	4.1.1.3.3	Train health workers in management of TB-HIV co-infected patients
Activity	4.1.1.3.4	Conduct meetings for deaths audits to standardize the system
Activity	4.1.1.3.5	Develop guidelines for conducting TB deaths audits
Strategic Intervention	4.1.1.4	Increase coverage of TB Preventive Therapy (TPT).
Activity	4.1.1.4.1	Ensure availability of interrupted supply of TPT
Activity	4.1.1.4.2	Improve quality of recording of clients on TPT

Level	Code	Description
Activity	4.1.1.4.3	Increase the awareness on Pharmacovigilance procedures among HCWs at the facility level
Activity	4.1.1.4.4	Introduce policy for 3HP for adults and other
Activity	4.1.1.4.5	Build the capacity of sentinel sites to improve surveillance of adverse effects
Activity	4.1.1.4.6	Community Involvement in HIV & TB through empowerment of CSOs including integration of activities to reduce duplication
Activity	4.1.1.4.7	Develop social media and digital solutions to disseminate TB/HIV education
Activity	4.1.1.4.8	Provide adherence support for people taking preventive therapy including using digital health technologies
Activity	4.1.1.4.9	Scale up TB preventive therapy using updated regimes
Activity	4.1.1.4.10	Scale up TB/HIV screening in key populations: prisoners, minors, maternal, children
Activity	4.1.1.4.11	Training of lay cadres on screening for PLHIV
Activity	4.1.1.4.12	Training of lay cadres on screening for PLHIV
Activity	4.1.1.4.13	Update the policy on TB Preventive Therapy regularly

Vulnerable Children, Reducing Human Rights & Gender-Related Barriers, and Social Behaviour Change Communication Activity Table

Level	Code	Description
Sub theme	**5.1**	**Vulnerable Children**
Objective	**5.1.1**	**To scale up HIV sensitive child protection case management in high HIV burden districts**
Strategic Intervention	5.1.1.1	Improve coordination at national and district levels
Activity	5.1.1.1.1	Support OVC TWGs at national and district levels
Strategic Intervention	5.1.1.2	Strengthen the monitoring of vulnerable children
Activity	5.1.1.2.1	Strengthening the monitoring of vulnerable children
Strategic Intervention	5.1.1.3	Build the capacity of Community Child Protection Workers for them to effectively implement the Child Protection Case Management Framework
Activity	5.1.1.3.1	Training case managers in case management.
Sub theme	**6.1**	**Reducing Human Rights and Gender-Related Barriers**
Objective	**6.1.1**	**To reduce stigma and discrimination against PLHIVs and other KPs**
Strategic Intervention	6.1.1.1	Create awareness about HIV related stigma and discrimination
Activity	6.1.1.1.1	In collaboration with PLHIVs undertake the national stigma index studies every two years.
Activity	6.1.1.1.2	Engage peer groups/expert clients to educate communities about stigma and discrimination.
Activity	6.1.1.1.3	Produce and distribute SBCC materials for FSW, MSM and TG using print, social media and interpersonal communication.

Level	*Code*	*Description*
Activity	6.1.1.1.4	Undertake HIV and TB prevention and treatment literacy for the faith based religious leaders to understand the key treatment related issues including 'undetectable vis a vis faith health'.
Strategic Intervention	6.1.1.2	Improve access to health services for key populations
Activity	6.1.1.2.1	Build the capacity of health workers including community health workers on the human rights and ethics including stigma and discrimination; confidentiality and the rights of PLHIV and KPs to services.
Activity	6.1.1.2.2	Lobby for the provision of condoms and lubricants in Malawi prisons.
Activity	6.1.1.2.3	Scale up the establishment of drop in centers for KPs.
Strategic Intervention	6.1.1.3	Improve access to legal services for PLHIV and KPs for issues relating to discrimination, violence protection and other human rights.
Activity	6.1.1.3.1	Build the capacity of law enforcers (police, prison officials, immigration, magistrates and judges) on HIV and human rights with a focus on PLHIVs and key populations.
Activity	6.1.1.3.2	Support PLHIV and KP friendly legal service providers to legal services to PLHIV and KPs
Strategic Intervention	6.1.1.4	Strengthen the legal environment for PLHIV, KPs, and other discriminated minorities, including redress mechanisms in cases of human rights violations in the provision of health care.
Activity	6.1.1.4.1	Build capacity of PLHIVs, and KPs (FSWs, MSWs and LGBTI communities) on rights, gender and legal rights including what to do in case of violations.
Activity	6.1.1.4.2	Conduct advocacy meetings with chiefs, religious leaders and the general community on minority rights.
Activity	6.1.1.4.3	Lobby with parliament for the review or suspension of discriminatory laws against sex workers and sexual and gender minorities.
Activity	6.1.1.4.4	Provide legal support to PLHIVs and LGBTI in court.
Objective	**6.1.2**	**To reduce harmful gender norms, stereotypes and gender based violence**
Strategic Intervention	6.1.2.1	Support HIV and AIDS related programs to address harmful gender norms and stereotypes
Activity	6.1.2.1.1	Conduct knowledge building workshops, peer group discussions, and theatre for development to challenge gender inequalities through communication for development.
Activity	6.1.2.1.2	Identify and train role models/male champions/change agents and engage them to roll out men-to men, brother to brother peer education activities that challenge toxic social and gender norms.
Activity	6.1.2.1.3	Produce, translate in local languages and disseminate including through social media various IEC materials on HIV prevention and treatment, GBV reduction.
Activity	6.1.2.1.4	Provide comprehensive, age appropriate SRH, HIV and AIDS education for young people that addresses gender norms

Level	*Code*	*Description*
Activity	6.1.2.1.5	TOT training to change agents in community awareness models including SaSa-Faith toolkit, Barbershop toolkit, HeForShe model
Strategic Intervention	6.1.2.2	Support programs to reduce gender-based violence
Activity	6.1.2.2.1	Disseminate linkages and referral system across medical and legal service points for survivors of sexual abuse
Activity	6.1.2.2.2	Lobby through support to the Ministry of Justice for the expedited strengthening and enforcing laws that eliminate violence against women
Activity	6.1.2.2.3	Provide TOT training to AGYW/ female patrons in safer sex negotiation and life skills.
Activity	6.1.2.2.4	Strengthen accountability structures for political, traditional and religious leaders to implement legislation and policies
Activity	6.1.2.2.5	Support awareness raising activities of gender related laws to all law enforcers and judicial officers and communities
Activity	6.1.2.2.6	Timely and appropriate provision of healthcare screening and medical documentation for individuals wishing to pursue legal redress.
Activity	6.1.2.2.7	Train services providers under VSUs, one stop centers, MOH, Judiciary on effective post GBV care and support for survivors and ensure continuity of trained staff
Sub theme	**7.1**	**Social Behavior Change Communication**
Objective	**7.1.1**	**To facilitate positive behaviour change at individual and community levels**
Strategic Intervention	7.1.1.1	Develop a successor HIV Prevention strategy for Malawi for the period 2020-2025.
Activity	7.1.1.1.1	Conduct stakeholder meetings to develop the HIV Prevention Strategy for 2020-2025
Strategic Intervention	7.1.1.2	Develop district, regional and national SBCC messages and materials targeting specific sub-populations, cultural backgrounds, and age groups, especially AGYW and ABYM
Activity	7.1.1.2.1	Conduct stakeholder meetings, involving stakeholders from all levels, to develop targeted SBCC messages
Strategic Intervention	7.1.1.3	Design and implement comprehensive qualitative studies on barriers to uptake of HIV prevention and treatment services to inform the development of relevant SBCC interventions (gender, human rights, etc.)
Activity	7.1.1.3.1	Hire a local consultant to perform comprehensive qualitative studies to inform the development of relevant SBCC interventions
Activity	7.1.1.3.2	Validate the findings of the consultant
Strategic Intervention	7.1.1.4	Conduct targeted demand creation SBCC strategies for the general population and specific groups using a mix of effective and evidence-based channels, which may include mass media, interpersonal communication and community mobilization and dialogue.
Activity	7.1.1.4.1	Conduct targeted SBCC campaigns

Level	Code	Description
Strategic Intervention	7.1.1.5	Expand the use of mobile and online communication technologies in the dissemination of SBCC messages to target populations including men and key populations.
Activity	7.1.1.5.1	Support electronic platforms to disseminate SBCC messages
Strategic Intervention	7.1.1.6	Mobilize and build the capacity of existing structures and networks to address harmful cultural practices and gender norms that promote HIV transmission
Activity	7.1.1.6.1	Conduct participatory engagement dialogues with communities including CBOs, opinion leaders, traditional and religious leaders in attitude and behavioural change efforts to modify harmful cultural practices.
Strategic Intervention	7.1.1.7	Mobilise community structures to conduct community mobilization and sensitization activities to promote health-seeking behaviours among sexually-active males.
Activity	7.1.1.7.1	Conduct quarterly district-based meetings to promote health-seeking behaviours among sexually-active males
Strategic Intervention	7.1.1.8	Recruit and engage leaders as champions/role models and ambassadors of HIV prevention at all levels including political, religious and traditional leaders.
Activity	7.1.1.8.1	Capacitate and support agents
Strategic Intervention	7.1.1.9	Conduct a comprehensive TB and HIV treatment literacy programme among PLHIVs and their caretakers
Activity	7.1.1.9.1	Support group awareness meetings
Strategic Intervention	7.1.1.10	Establish SBCC coordination structures at national and district level and support their operations to ensure harmonization of SBCC efforts by stakeholders.
Activity	7.1.1.10.1	Refer to cross-listed Activity 1.6.1.1.2: Establish AGYW and SBCC coordination structures at national, district, and community level

RSSH Activity Table

Level	Code	Description
Sub theme	**8.1**	**Leadership and Governance**
Objective	**8.1.1**	**To advocate for a strong, sustained and visible role of political, civil, religious, and traditional leaders in the HIV response at the national and subnational levels.**
Strategic Intervention	8.1.1.1	Lobby the highest political leadership to champion the Global HIV Prevention Coalition of the Malawi Chapter as a demonstration of high-level commitments to accelerate the pace of decline in new adult HIV infections.
Activity	8.1.1.1.1	Conduct high level dialogue sessions on HIV prevention
Activity	8.1.1.1.2	Produce and mount billboards on HIV prevention messages by high level leaders
Strategic Intervention	8.1.1.2	Mainstream the delivery HIV and AIDS messages in high level political, religious, and traditional speeches.

Level	*Code*	*Description*
Activity	8.1.1.2.1	Conduct HIV and AIDS mainstreaming workshops for Personal Assistants/ Ministry or Departmental Spokespersons
Activity	8.1.1.2.2	Conduct media advocacy for Personal Assistants/ Ministry or Departmental Spokespersons
Strategic Intervention	8.1.1.3	Mainstream the delivery of HIV and AIDS services during cultural activities.
Activity	8.1.1.3.1	Support delivery of HIV prevention services during cultural events.
Activity	8.1.1.3.2	Support HIV prevention dissemination during pre-event workshops for duty bearers.
Activity	8.1.1.3.3	Support information dissemination on HIV prevention during cultural events.
Objective	**8.1.2**	**To domesticate the HIV and AIDS Prevention and Management Act of 2018**
Strategic Intervention	8.1.2.1	Ensure that the national response continue to be inclusive, multisectoral and is implemented in line with the HIV and AIDS Prevention and Management Act of 2018.
Activity	8.1.2.1.1	Conduct dissemination sessions for the HIV and AIDS (Prevention and Management) Act to key stakeholders
Activity	8.1.2.1.2	Participate in annual professional bodies and societal conferences to disseminate the HIV and AIDS
Strategic Intervention	8.1.2.2	Develop and enforce regulations to guide the implementation of the provisions of the HIV and AIDS Prevention and Management Act of 2018.
Activity	8.1.2.2.1	Support development of guidelines to operationalize the Act in different sectors
Activity	8.1.2.2.2	Support production of an abridged version of the Act
Activity	8.1.2.2.3	Support translation of the Act into key local languages
Sub theme	**8.2**	**Financial Management**
Objective	**8.2.1**	**To strengthen grants management**
Strategic Intervention	8.2.1.1	Support the development of the National Health Financing Strategy which includes sustainable HIV and AIDS financing.
Activity	8.2.1.1.1	Conduct stakeholder meetings to develop the National Health Financing Strategy
Strategic Intervention	8.2.1.2	Support systems to track available resources and expenditure on HIV and AIDS.
Activity	8.2.1.2.1	Conduct annual resource mapping exercise
Strategic Intervention	8.2.1.3	Conduct regular financial risk assessment and mitigation measures for all institutions, including government.
Activity	8.2.1.3.1	Conduct financial pre-audit and compliance checks within government institutions and NAC
Activity	8.2.1.3.2	Engage independent external auditors to assess financial risk in government institutions and NAC
Activity	8.2.1.3.3	Build government and NAC capacity in financial management
Activity	8.2.1.3.4	Provide banking and cash management services for government and NAC

Level	*Code*	*Description*
Strategic Intervention	8.2.1.4	Build the capacity of implementing partners in grants management.
Activity	8.2.1.4.1	Conduct grants management trainings for implementing partners
Strategic Intervention	8.2.1.5	Apply gender responsive budgeting to the HIV response
Activity	8.2.1.5.1	Train costing experts in gender responsive budgeting
Objective	**8.2.2**	**To increase the impact of existing resources**
Strategic Intervention	8.2.2.1	Collaborate with Ministry of Finance to improve absorption of donor funds in the health sector
Activity	8.2.2.1.1	Conduct internal meetings with Ministry of Finance to improve aid absorption
Strategic Intervention	8.2.2.2	Improve efficiency of resource allocation and utilisation
Activity	8.2.2.2.1	Collaborate with Ministry of Finance to improve absorption of donor funds in the health sector
Activity	8.2.2.2.2	Track resources and expenditure on HIV and AIDS
Strategic Intervention	8.2.2.3	Mobilize donor support for health systems strengthening
Activity	8.2.2.3.1	Conduct high-level national financing dialogues that emphasize that investment in health systems unlocks efficiencies for service delivery in all disease areas
Objective	**8.2.3**	**To strengthen mobilization of governmental and non-governmental domestic resources**
Strategic Intervention	8.2.3.1	Initiate dialogue with government, civil society and partners to increase domestic investment for essential HIV prevention, SRHR, GBV, and social protection policies, per Global Prevention Coalition commitments.
Activity	8.2.3.1.1	Conduct high-level national financing dialogues on the importance of investment in essential HIV prevention and SRHS
Strategic Intervention	8.2.3.2	Mobilize resources from and partnerships with the private sector to support the HIV response
Activity	8.2.3.2.1	Conduct high-level national financing dialogues with the private sector to explore CSR, TMA, and other partnership opportunities
Strategic Intervention	8.2.3.3	Build the capacity of implementing partners in resource mobilisation.
Activity	8.2.3.3.1	Conduct resource mobilisation trainings for implementing partners
Strategic Intervention	8.2.3.4	Advocate with Parliament to gradually increase domestic financing for the HIV and AIDS program.
Activity	8.2.3.4.1	Conduct regular dialogues with parliamentarians
Sub theme	**8.3**	**Coordination of the Response**
Objective	**8.3.1**	**To strengthen the coordination and implementation of the response to the HIV and AIDS epidemic at national and sub national levels in line with the 3 Ones Principle.**
Strategic Intervention	8.3.1.1	Improve national coordination and multisectoral governance of the response to the HIV/AIDS epidemic.

Level	*Code*	*Description*
Activity	8.3.1.1.1	Conduct a biannual comprehensive mapping of CSOs, FBOs and CBOs working on HIV and AIDS and related activities in order to determine their scope of activities and geographic locations to enhance efficiencies in HIV and AIDS programming.
Activity	8.3.1.1.2	Disseminate and popularize national HIV and AIDS strategic frameworks
Activity	8.3.1.1.3	Assess avenues for inter-sectoral collaboration (MoE, Ministry of Youth Development) through engagement with CBOs at national and sub-national level
Activity	8.3.1.1.4	Structural review of all programmatic coordinating bodies (Manet+, MIAA, MBCA, DRD for Public Sector, MANASO) to assess the viability of increasing the their health sector engagement
Activity	8.3.1.1.5	Central-level Planning Meeting to discuss Advocacy Strategy
Activity	8.3.1.1.6	Finalise and disseminate Aid Coordination Guidelines
Activity	8.3.1.1.7	Provide support to the civil society coordination bodies for coordination meetings and for providing supportive supervision to districts
Strategic Intervention	8.3.1.2	Improve district and community level coordination and governance of the response to the HIV/AIDS epidemic.
Activity	8.3.1.2.1	Enforce MoUs between CSOs and local councils to enforce reporting, including disclosure of sources of funds.
Activity	8.3.1.2.2	Enhance capacity of leadership and accountability structures at the community level through CSOs
Activity	8.3.1.2.3	Establish CBOs around health centre committees
Activity	8.3.1.2.4	Improve engagement of partners in DIP developments and district review meetings
Activity	8.3.1.2.5	Leverage/Engage existing CBOs for district/community-level activities
Activity	8.3.1.2.6	Orient Directorates of Health and Social Services on their role
Activity	8.3.1.2.7	Strengthen partner harmonization forums at the district level
Activity	8.3.1.2.8	Support district councils to conduct quarterly supervision visits to implementing partners including CBOs.
Activity	8.3.1.2.9	Support the coordination meetings for the districts
Strategic Intervention	8.3.1.3	Strengthen the national and subnational M&E system to effectively respond to national, regional and global requirements for HIV reporting.
Activity	8.3.1.3.1	Conduct regular Data Quality Audits to all key sources of data
Activity	8.3.1.3.2	Conduct regular Reviews and evaluations of the national response
Activity	8.3.1.3.3	Develop a comprehensive M&E framework for the NSP
Activity	8.3.1.3.4	Develop and operationalize the national HIV and AIDS database to meet the M&E demands of the response
Activity	8.3.1.3.5	Introduce and sustain Quality Assessment and Improvement tools and processes
Activity	8.3.1.3.6	Operationalize and sustain the LAHARS
Activity	8.3.1.3.7	Support periodic research, surveys and studies
Activity	8.3.1.3.8	Train District Staff and other partners on the LAHARS and other data collection tools
Strategic Intervention	8.3.1.4	Harmonise existing reporting tools and metrics in order to implement the Three Ones Principle.

Level	*Code*	*Description*
Activity	8.3.1.4.1	Refer to cross-listed activities under Activity 8.5.1.2.2: Enforcement of HIS policy SOPs on introduction & revision of data collection and reporting tools (including EMR)
Sub theme	**8.4**	**Health Products Management Systems**
Objective	**8.4.1**	**To improve the availability, quality, utilization and management of medicines and other health products**
Strategic Intervention	8.4.1.1	Strengthen governance structures at central and district levels to enforce accountability of commodities
Activity	8.4.1.1.1	Formulation of regulations and increase awareness for the new law for the pharmacy medicines regulatory authority (PMRA)-Increase stakeholder awareness
Activity	8.4.1.1.2	Strengthen and build capacity of oversight committees (e.g. DTC, DPAT, HPAT)
Activity	8.4.1.1.3	Support and supervise DPAT (DTCs) meetings at district level
Strategic Intervention	8.4.1.2	Strengthen inventory management to improve End-to-End product visibility for all health products including HIV commodities (ARVs, condoms, OI and STI medicines, diagnostics, self-test kits and family planning commodities)
Activity	8.4.1.2.1	Conduct situational analysis on use of logistics data at facility, district, central hospital and central level.
Activity	8.4.1.2.2	Enhance staff capacity on logistics management
Activity	8.4.1.2.3	Ensure adequate staff capacity in inventory and dispensing management
Activity	8.4.1.2.4	establish an end to end tracking system for drugs to enhance re-distribution of drugs across health facilities when needed
Activity	8.4.1.2.5	Outsource quality control testing for samples collected during post-market surveillance
Activity	8.4.1.2.6	Review logistics data
Activity	8.4.1.2.7	Supervise inventory and dispensing management at health facility level
Strategic Intervention	8.4.1.3	Expand warehousing and distribution and increase storage capacity
Activity	8.4.1.3.1	Assessment of storage capacity at all health facilities
Activity	8.4.1.3.2	Procure storage services as a short-term measure whilst supporting construction of warehouse
Activity	8.4.1.3.3	Renovations and extensions of existing health facility / pharmacy storage structures
Activity	8.4.1.3.4	Support construction of central level warehouse at CMST
Strategic Intervention	8.4.1.4	Ensure quality products are provided to clients
Activity	8.4.1.4.1	Support implementation of post market surveillance plan
Activity	8.4.1.4.2	Support implementation of the costed pharmacovigilance implementation plan
Activity	8.4.1.4.3	Support pharmacy medicines regulatory authority QC lab to attain ISO 17025 accreditation
Strategic Intervention	8.4.1.5	Support Integration of HIV commodity supply chain as part of the National Supply Chain Integration Strategy

Level	*Code*	*Description*
Activity	8.4.1.5.1	Central supervision to support districts
Activity	8.4.1.5.2	Lobby with Treasury for additional resources to recapitalize CMST
Activity	8.4.1.5.3	Strengthen the capacity of HTSS Pharmaceuticals to provide oversight to CMST as the policy holder
Activity	8.4.1.5.4	Support implementation of the costed supply chain master plan
Sub theme	**8.5**	**Health Information Systems**
Objective	**8.5.1**	**To improve HIS governance, infrastructure, and electronic systems in order to facilitate evidence-based decision-making.**
Strategic Intervention	8.5.1.1	Facilitate accurate, efficient data collection and improved patient outcomes by implementing a comprehensive EMR, CRVS, and supporting infrastructure.
Activity	8.5.1.1.1	Assist MDAs in the adoption, integration and use of the Birth Certificate and unique ID in the provision of their services
Activity	8.5.1.1.2	Clear backlog of transactions at the district level
Activity	8.5.1.1.3	Collection and distribution of forms and certificates
Activity	8.5.1.1.4	Conduct joint MoHP and NRB national monitoring exercise of CRVS activities (both birth and death registration) to all districts
Activity	8.5.1.1.5	Deploy comprehensive lightweight EMR - 550 facilities
Activity	8.5.1.1.6	Ensure availability of paper-based system, while we transition to electronic systems
Activity	8.5.1.1.7	Establish National Help Desk
Activity	8.5.1.1.8	Extend renewable energy generation to all health facilities
Activity	8.5.1.1.9	Extend the lightweight EMR to cover for HIV-related modules
Activity	8.5.1.1.10	Implement integrated CHIS (scale up of integrated CHIS)
Activity	8.5.1.1.11	Improve accountability for computing infrastructure
Activity	8.5.1.1.12	Improve connectivity to enable management of patients and data transfer across sites
Activity	8.5.1.1.13	Improve the data center at Accountant General Department to a Tier 2 Data Center for management of patient level data
Activity	8.5.1.1.14	Install & maintain the computing infrastructure necessary for EMRs
Activity	8.5.1.1.15	Institutionalize the birth and death registration in the MoHP
Activity	8.5.1.1.16	Link the CR electronic system and DHIS in health for determining proportion of births notified to the civil registration (CR) agency versus actual
Activity	8.5.1.1.17	Maintenance and support of infrastructure
Activity	8.5.1.1.18	Maintenance for comprehensive lightweight EMR
Activity	8.5.1.1.19	Make HIS sub-systems interoperable
Activity	8.5.1.1.20	Monitor and provide supportive supervision of CRVS activities by joint district team to all health facilities in the district
Activity	8.5.1.1.21	Roll out EPRAs to other high-volume facilities
Activity	8.5.1.1.22	Roll out health facility based and community based (all districts) death registration
Activity	8.5.1.1.23	Scale up the CHIS to Health Surveillance Assistants (HSA) & HIV Diagnostics Assistants (HDAs)
Activity	8.5.1.1.24	Sustain Electronic Medical Records where existent in high burden sites

Level	*Code*	*Description*
Strategic Intervention	8.5.1.2	Improve the quality of data for decision-making at all levels
Activity	8.5.1.2.1	Assess ICT security of health system on annual basis
Activity	8.5.1.2.2	Enforcement of HIS policy SOPs on introduction & revision of data collection and reporting tools (including EMR)
Activity	8.5.1.2.3	Hire 5 ICT personnel per DHO
Activity	8.5.1.2.4	Hire and train 2 data clerks per lab (1200 data clerks total)
Activity	8.5.1.2.5	Improve Health Facility Reporting forms to remove duplication of entries by health staff (finalize programme level indictors)
Activity	8.5.1.2.6	Retention of data clerks
Activity	8.5.1.2.7	Routine data security guidelines maintained at the facility
Strategic Intervention	8.5.1.3	Increase evidenced-based decision-making at all levels
Activity	8.5.1.3.1	Conduct national integrated DQA every two years on selected tracer indicators
Activity	8.5.1.3.2	Develop, implement and integrate easily customizable dashboards
Activity	8.5.1.3.3	Extend access to DHIS2 dashboards to health facilities
Activity	8.5.1.3.4	Extend and implement HMIS curriculum (electronic HIS module) for DHIS2, EMRS, and other electronic solutions (once per year at zonal level)
Activity	8.5.1.3.5	Implement Continuous Professional Development through E-Learning
Activity	8.5.1.3.6	Initial set up of telehealth solution
Activity	8.5.1.3.7	Set up rotation of clinicians
Activity	8.5.1.3.8	Support districts to conduct DQAs at facility level once a year
Activity	8.5.1.3.9	Supporting data and performance review meetings
Strategic Intervention	8.5.1.4	Integrate data surveillance activities
Activity	8.5.1.4.1	Birth defects surveillance
Activity	8.5.1.4.2	Capacity building and CBS management of qualified and trained MoHP staff dedicated to CBS
Activity	8.5.1.4.3	Continue to develop analytic & reporting tools with input from stakeholders that allow monitoring through the clinical cascade
Activity	8.5.1.4.4	Enhance data dictionary and other user focused documentation of data sources and business meaning of data as presented in the central data repository.
Activity	8.5.1.4.6	Establish routine EQA for testing program
Activity	8.5.1.4.7	Establish stakeholders' partnerships and collaboration for CBS
Activity	8.5.1.4.8	Finalize and maintain patient level central data repository
Activity	8.5.1.4.10	IBBS
Activity	8.5.1.4.11	KAP Surveys
Activity	8.5.1.4.12	MDHS
Activity	8.5.1.4.9	MPHIA
Sub theme	**8.6**	**Human Resources for Health**
Objective	**8.6.1**	**Increase the availability, effectiveness, and retention of human resources in order to deliver integrated high-quality services for all diseases, including HIV.**

Level	Code	Description
Strategic Intervention	8.6.1.1	Utilize evidence to allocate health workers to areas of priority and greatest need
Activity	8.6.1.1.1	Advocate for the importance of licensure and CPD with the district councils, for districts to hold managers accountable for the licensure and CPD of their staff.
Activity	8.6.1.1.2	Annually review and operationalize the staffing need projections in the HRH Strategic Plan based on workload analyses to inform health worker recruitment
Activity	8.6.1.1.3	Annually review and operationalize the training projections in the HRH Strategic Plan based on workload analyses to inform student training enrolments
Activity	8.6.1.1.4	Conduct functional review for districts
Activity	8.6.1.1.5	Conduct regular analysis of HRH data in order to produce an annual HRH status report to inform the budgeting and planning cycle.
Activity	8.6.1.1.6	Develop and maintain knowledge management platforms (e.g.. HRH observatory) to maximize the distribution and utilization of HRH information across the health sector
Activity	8.6.1.1.7	Install location tracking apps on HSAs and SHSAs mobile devices and procurement of monthly airtime so that the location tracking apps can be routinely used
Activity	8.6.1.1.8	Lobby DHRM&D to better incorporate evidence on service delivery needs and optimal workforce staffing as part of the functional review
Activity	8.6.1.1.9	Orient the SHSAs on Integrated Community Health Information Systems (including location tracking)
Activity	8.6.1.1.10	Procure mobile phones for all HSAs and SHSAs
Activity	8.6.1.1.11	Promote continuous use of HRH information systems for HRH planning and management.
Activity	8.6.1.1.12	Review staffing establishment for the different types of health facilities based on workload analyses conducted in this HRH Strategic Plan and revised establishment targets defined in functional reviews completed at the district and central level.
Activity	8.6.1.1.13	Strengthen and where possible integrate HRH information systems (including TRAINSMART, HRIS Manage, HRIS Train, DHIS, HMIS) providing easy access to accurate data and promoting interoperability of the systems
Activity	8.6.1.1.14	Support and advocate for the evaluation and review of the accreditation tools developed and implemented by Regulatory Bodies
Activity	8.6.1.1.15	Support implementation of CPD for all staff in the district to monitor in-service training programmes and link to renewal of registration.
Strategic Intervention	8.6.1.2	Recruit and redistribute health workers based on the staffing needs updated annually in the HRH Strategy
Activity	8.6.1.2.1	Advocate and lobby for better working conditions of health workers, with key stakeholders
Activity	8.6.1.2.2	Assess the quality of in-service training programmes, and hold those responsible for the trainings accountable to ensure a high quality of these activities

Level	Code	Description
Activity	8.6.1.2.3	Bring together teams from the MoHP directorates to orient on job analysis and evaluation to define current scopes of work by cadre
Activity	8.6.1.2.4	Build capacity of mentors for integrated mentorships of clinicians, nurses, environmental health assistants, and HSAs
Activity	8.6.1.2.5	Build capacity within the districts to conduct Training Needs Assessments and develop annual training plans in alignment with the national in-service training policy's requirements on training needs by cadre
Activity	8.6.1.2.6	Build the capacity of existing teaching staff at training institutions based on needs (eg. improving clinical skills teaching)
Activity	8.6.1.2.7	Conduct annual training and scholarship harmonization meeting
Activity	8.6.1.2.8	Conduct assessment of existing retention strategies from other sectors and countries
Activity	8.6.1.2.9	Conduct compliance monitoring and quality assurance visits by regulatory bodies
Activity	8.6.1.2.10	Conduct curriculum delivery and curriculum review workshops
Activity	8.6.1.2.11	Conduct in-service training of existing HSAs
Activity	8.6.1.2.12	Conduct integrated mentorships of clinicians, nurses, environmental health assistants, and HSAs
Activity	8.6.1.2.13	Conduct integrated monitoring and M&E activities
Activity	8.6.1.2.14	Conduct integrated training for clinicians, nurses, pharmacy, and lab staff
Activity	8.6.1.2.15	Conduct monthly mentorships of HSAs by SHAs on iCCM service delivery and reporting
Activity	8.6.1.2.16	Conduct supervision visits by training institutions and MOH
Activity	8.6.1.2.17	Conduct training institution assessment and implement recommendations such as infrastructure for teaching and learning to increase capacity of training institutions (increasing number of housing units for tutors; and constructing additional classrooms, skills laboratories, hostels)
Activity	8.6.1.2.18	Conduct training of trainers
Activity	8.6.1.2.19	Conduct training of trainers at QMSO (Quality Management Settelite Office)
Activity	8.6.1.2.20	Decentralize recruitment and bonding of students using targeted admission to enroll students with rural background in training programs as a strategy to increase likelihood of graduates choosing to practice in rural areas
Activity	8.6.1.2.21	Develop and roll out an electronic record system to document all in-service and post-basic training of health workers in a district and link to personnel records, CPD, and performance management systems
Activity	8.6.1.2.22	Develop costed, actionable incentive implementation framework that includes rural incentive packages to improve the recruitment and retention of health workers
Activity	8.6.1.2.23	Develop or update Scopes of Practice for all cadres in line with service needs

Level	Code	Description
Activity	8.6.1.2.24	Develop teaching hospital quality standards and guidelines which outline education staffing, infrastructure, equipment, policy and management needs for clinical training
Activity	8.6.1.2.25	Develop/Review of a national in-service training policy with training needs and requirements for all cadres
Activity	8.6.1.2.26	Development of integrated in-service training curriculum and materials based on the national in-service training policy, including integrated M&E tools, for HIV/AIDS, including integration with other disease areas like SRHR, TB, malaria, etc.
Activity	8.6.1.2.27	Employ prioritized cadre for health service delivery
Activity	8.6.1.2.28	Encourage training committees to set and use clear criteria based on the training requirements by cadre per the national training policy, to determine the selection of health workers to attend trainings and ensure transparency throughout the process, non-duplication of trainings, and minimal absence of health workers from health facilities
Activity	8.6.1.2.29	Enforce student bonds by benchmarking HESLB model
Activity	8.6.1.2.30	Enforce the teaching role of all qualified health workers in health facilities by including this into job descriptions, reviewing teaching during performance appraisals, and rewarding those who demonstrate to be exemplary teachers.
Activity	8.6.1.2.31	Ensure adequate availability of clinical mentors to support students during clinical rotations by identifying and training the mentors
Activity	8.6.1.2.32	Field visits for the job analysis and evaluation to define current scopes of work by cadre
Activity	8.6.1.2.33	Formation of a core team and TORs
Activity	8.6.1.2.34	Improve coordination and collaboration between training colleges and clinical sites to avoid congestion during clinical rotations and ensure adequate learning.
Activity	8.6.1.2.35	Lobby for private sector involvement (e.g. water, power, telecom, infrastructure, and other local investors) to improve health worker housing, network connectivity, water, and electricity
Activity	8.6.1.2.36	Meeting with Stakeholders and partners, clinician, nurse, community, pharmacy labs.
Activity	8.6.1.2.37	Operationalize and customize job descriptions that take into account varying roles in a decentralized health system
Activity	8.6.1.2.38	Provide scholarships, bursaries and other education subsidies at district council level with enforceable agreements of return of service in rural or remote areas
Activity	8.6.1.2.39	Reconstitute and orient training committees at national and district levels on their TORs, with a focus on their integration with the overall management system within the District Health Management Teams and coordination with district partners
Activity	8.6.1.2.40	Reinforce the use of approved training guidelines and curriculum for all in-service trainings
Activity	8.6.1.2.41	Report-writing workshop for job analysis

Level	*Code*	*Description*
Activity	8.6.1.2.42	Review and strengthen internship programmes for relevant cadres by clarifying the learning objectives and standards for interns
Activity	8.6.1.2.43	Review existing or develop incentive and retentions strategies, conduct an in-country problem analysis for health workforce
Activity	8.6.1.2.44	Review generic job descriptions at national level taking into account results of the job analysis and varying roles in a decentralized health system
Activity	8.6.1.2.45	Scale up the training of specialists in HRH with a focus on skills transfer from foreign technical assistance and staff
Activity	8.6.1.2.46	Set clear guidelines to encourage standardized step ladder training before staff can undertake further studies and implement mechanisms to control unauthorized upgrading training
Activity	8.6.1.2.47	Strengthen cost-effective post-basic and in-service training through innovative approaches such as e-learning, distance learning, coaching, mentoring, applied and part-time learning
Activity	8.6.1.2.48	Strengthen peer-learning between training institutions, including the regulatory bodies
Activity	8.6.1.2.49	Train SHSAs in supervision and mentorship
Strategic Intervention	8.6.1.3	Strengthen national and district level HR departments to enable effective workforce planning, deployment, recruitment, and management
Activity	8.6.1.3.1	Conduct quarterly district HRH technical working group meetings
Activity	8.6.1.3.2	Develop health-specific ToRs (including HR management) for Area Development Committees
Activity	8.6.1.3.3	Orient and train community structures, including VHCs, CHAGs, and HCACs, on revised roles and responsibilities based on updated TORs (e.g. HR management, drug monitoring, etc.) and build their capacity to deliver
Activity	8.6.1.3.4	Revise and disseminate SOPs on management of recruitment and deployment , including district level functions
Activity	8.6.1.3.5	Support and mentor districts to develop HRH plans as part of the annual District Implementation Plan (DIP) and multi-year planning that are aligned to national strategies, policies, and plans, including the HRH Strategic Plan, including workforce and training requirements.
Strategic Intervention	8.6.1.4	Strengthen coordination and integration of relevant post-basic and in-service training to meet service delivery needs.
Activity	8.6.1.4.1	Develop integrated in-service training curriculum
Activity	8.6.1.4.2	Build capacity within the districts to conduct Training Needs Assessments and develop annual training plans in alignment with the national in-service training policy's requirements on training needs by cadre
Sub theme	**8.7**	**Infrastructure, Transport, and Equipment**
Objective	**8.7.1**	**To ensure adequate infrastructure for HIV services delivery**
Strategic Intervention	8.7.1.1	Refurbish and construct essential health infrastructure
Activity	8.7.1.1.1	Desk review of spaces for service delivery based on design of health facilities

Level	*Code*	*Description*
Activity	8.7.1.1.2	Hire consultant to review standard health facility designs (3 months)
Activity	8.7.1.1.3	Long-term orientation of district level staff for supervision of construction of health posts and health facilities (based on infrastructure guidelines)
Activity	8.7.1.1.4	Recruit building planning staff at district level to support MOHP PIU and Director of Public Works
Activity	8.7.1.1.5	Constructing Health Posts
Activity	8.7.1.1.6	Constructing Urban Health Centers
Activity	8.7.1.1.7	Construction of Health Centre Incinerator
Activity	8.7.1.1.8	Equipping newly constructed health posts
Activity	8.7.1.1.9	Equipping newly constructed Urban Health Centers
Activity	8.7.1.1.10	Installation of utilities in lacking facilities
Activity	8.7.1.1.11	Procure 1 motorcycle for each health facility
Activity	8.7.1.1.12	Procure utility vehicles at district level (1 per district)
Activity	8.7.1.1.13	Rehabilitate existing health facilities
Activity	8.7.1.1.14	Recruit building planning staff at district level to support MOHP PIU and Director of Public Works
Activity	8.7.1.1.15	Rehabilitate existing health facilities
Activity	8.7.1.1.16	Wider stakeholder consultations with QMOs and representative districts to finalise strategy
Activity	8.7.1.1.17	Zonal level meetings for dissemination of CIP and infrastructure guidelines to DHOs
Objective	**8.7.2**	**To ensure availability of essential medical and non-medical supplies and utilities at all levels**
Strategic Intervention	8.7.2.1	Increase availability of basic medical and non-medical equipment for effective service delivery
Activity	8.7.2.1.1	Equip all HSAs and SHSAs with basic equipment
Activity	8.7.2.1.2	Procure medical equipment
Strategic Intervention	8.7.2.2	Improve capacity for management of equipment supply
Activity	8.7.2.2.1	Orientate health facility personnel and district maintenance personnel on use the medical equipment inventory system (small pilot to be scaled up)
Sub theme	**8.8**	**Integrated Service Delivery and Quality Improvement**
Objective	**8.8.1**	**To improve the quality of all services delivered**
Strategic Intervention	8.8.1.1	Develop and implement HIV services quality improvement framework to promote adoption of quality improvement approaches in the delivery of integrated HIV care
Activity	8.8.1.1.1	Conduct QI collaborative learning sessions
Activity	8.8.1.1.2	Conducting regular mentorship visits to technically support Health Facility Quality Improvement teams
Objective	**8.8.2**	**To strengthen and integrate the health system in order to deliver integrated comprehensive HIV services with SRHS, NCD, and nutrition across the continuum of care at all levels of the health sector**

Level	*Code*	*Description*
Strategic Intervention	8.8.2.1	Deliver comprehensive HIV, SRHR, and GBV services package to clients accessing services in all levels of health facilities including the private sector
Activity	8.8.2.1.1	Conduct a district consultative meeting
Activity	8.8.2.1.2	Develop SRHR/HIV, integrated training package for service providers
Activity	8.8.2.1.3	Training of providers on SRH integration with HIV services
Strategic Intervention	8.8.2.2	Strengthen the referral and disease linkage between community and health facilities at all levels of the health system
Activity	8.8.2.2.1	Provide Linkage and Referral services in all health facilities
Strategic Intervention	8.8.2.3	Integrate HIV programs policy strategic documents and program implementation plans that aligns to national strategic policy documents
Activity	8.8.2.3.1	Develop and disseminate protocols and management for community health cadre
Activity	8.8.2.3.2	Orientate DHOs on HIV guidelines and procedures
Activity	8.8.2.3.3	Printing the revised HIV supportive supervision tool
Activity	8.8.2.3.4	Review and Harmonize the Integrated Supportive Supervision
Activity	8.8.2.3.5	Review the HIV supportive supervision tool
Strategic Intervention	8.8.2.4	Conduct integrated trainings and develop integrated monitoring tools to equip HCWs to deliver integrated services for HIV and related diseases
Activity	8.8.2.4.1	Monthly supportive supervision visits by district staff to health posts for HIV
Activity	8.8.2.4.2	Train community health cadre on protocols and management for community health care
Activity	8.8.2.4.3	Train lab staff on integrated services
Strategic Intervention	8.8.2.5	Conduct integrated HIV care supervision, mentorship, program management, monitoring and coordination meetings at national and sub national levels
Activity	8.8.2.5.1	Integrated National Community Health Supervisions to district
Strategic Intervention	8.8.2.6	Implement paper and electronic information systems to support delivery of integrated services of HIV and related diseases at the community and facility level
Activity	8.8.2.6.1	Integrate HIV indicators into ISS tool (If not already included)
Strategic Intervention	8.8.2.7	Improve infrastructure to enable implementation of ISD models for HIV, SRHR and other related diseases at the facility level.
Activity	8.8.2.7.1	Improvement of Infrastructure with focus on SRHR
Strategic Intervention	8.8.2.8	Integrate the supply chain of HIV commodity and supply system into normal government supply chain system
Activity	8.8.2.8.1	Integration of Supply chain systems

Sub theme	**8.9**	**Community Systems Strengthening**
Objective	**8.9.1**	**To strengthen community systems for HIV epidemic control, child protection and GBV prevention**
Strategic Intervention	8.9.1.1	Improve the capacity of community structures to deliver health and HIV/AIDS services such as YFHS, peer support, and adherence and retention to care

Level	*Code*	*Description*
Activity	8.9.1.1.1	Build the capacity of Village Health Committees
Activity	8.9.1.1.2	Orient and support HSAs to provide a defined community HIV package
Activity	8.9.1.1.3	Implement the Community Charter that empowers community organisations to take an active role in community HIV response
Strategic Intervention	8.9.1.2	Strengthen community structures and systems to report and address GBV and human rights violation cases in a timely manner, and eradicate harmful practices
Activity	8.9.1.2.1	Refer to cross-listed activities under Strategic Intervention 6.1.2.2: Support programs to reduce gender-based violence
Strategic Intervention	8.9.1.3	Strengthen community-based monitoring and reporting on HIV and SRHS.
Activity	8.9.1.3.1	Implement integrated community scorecard, using both qualitative and quantitative data]
Strategic Intervention	8.9.1.4	Strengthen community-led advocacy and accountability systems
Activity	8.9.1.4.1	Improve community-led advocacy based on score cards
Strategic Intervention	8.9.1.5	Strengthen SBCC capacity of community systems to effectively achieve positive behavioural change and increase demand for services.
Activity	8.9.1.5.1	Refer to cross-listed Activity 1.6.1.1.2: Establish AGYW and SBCC coordination structures at national, district, and community level
Sub theme	**8.1**	**Laboratory Systems**
Objective	**8.10.1**	**To strengthen laboratory services for HIV control**
Strategic Intervention	8.10.1.1	Provide quality laboratory services for HIV, TB, VH and other HIV related disorders
Activity	8.10.1.1.1	Accredit molecular and district laboratories
Activity	8.10.1.1.2	Conduct EQA of district laboratories
Activity	8.10.1.1.3	Construct joint National Malaria Reference Lab and National HIV Reference Lab
Activity	8.10.1.1.4	Hire 20 MSc as Laboratory staff
Activity	8.10.1.1.5	Hire 6 PhDs as Laboratory staff
Activity	8.10.1.1.6	Lab Consumables Procurement
Activity	8.10.1.1.7	Lab Equipment procurement
Activity	8.10.1.1.8	Lab Supplies Procurement
Activity	8.10.1.1.9	Provide Connectivity for LMIS and Hub Automation
Activity	8.10.1.1.10	Refurbish 17 District Hospital Laboratories
Activity	8.10.1.1.11	Refurbish 3 Central Hospitals
Activity	8.10.1.1.12	Routine M & E - Supervisions
Activity	8.10.1.1.13	Training of Data Clerks
Strategic Intervention	8.10.1.2	Provide dedicated laboratory sample transportation system
Activity	8.10.1.2.1	Laboratory Sample Transportation

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