Malawi National Strategic Plan for HIV and AIDS

Revised and Extended Strategy for 2023–2027

Sustaining Gains and Accelerating Progress

Towards Elimination

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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; Government recognizes that HIV is one of the major development risks that has to be mitigated. Therefore, through this Revised National Strategic Plan (NSP) the country is committed to ensure that all necessary HIV and AIDS control measures are implemented so that the impact of HIV and AIDS is reduced and HIV eliminated as a public health threat by 2030 in line with the 2016 and 2021 United Nations General Assembly Political Declarations on HIV and AIDS and the 2021-2026 Global AIDS Strategy. The legal, policy and political environment is favourable to achieve this goal. My Government enacted the HIV and AIDS (Prevention and Management) Act number 9 of 2018 in order to create the conducive legal environment to prevent and manage HIV and AIDS; and HIV and AIDS prevention and management is one of the key priorities that contributes to human capital development, a key focal area of the Malawi 2063.

I am pleased that, in spite of the adverse effects of the COVID-19 from 2019 to 2022, Malawi made tremendous progress towards achieving the global 95:95:95 Fast-Track Targets set out in the 2020-2025 NSP by exceeding these targets in females and almost reaching the targets in males ahead of the 2025 deadline. In addition, recent estimates indicate a continued declining trend in the number of new HIV infections in Malawi, particularly in adolescent girls and young women, and AIDS-related deaths. This gives us great confidence that, together with our implementing partners, we can accelerate the pace of our journey towards the elimination of HIV by 2030, despite existing resource constraints. This is an opportune time for revising the 2020-2025 NSP taking advantage of the following developments locally and internationally: the launch of Malawi's Health Sector Strategic Plan 2022-2030 and the National Health Financing Strategy 2022-2030 in January 2023; the publication of the Global AIDS Strategy 2021-2026 and the discovery of a novel injectable HIV preventive drug, cabotegravir. These coupled with lessons learned from the first 2 years of the implementation of the 2020-2025 NSP will ensure efficient and effective implementation of HIV and AIDS programs, locally to achieve the elimination goal.

The revised NSP comes at a time when there are some challenges. Despite achievements on the treatment targets, the number of new infections and AIDS-related death in remain unacceptably high. In addition, the macro-economic environment has become increasingly challenging owing to extreme weather patterns and downstream effects of the Russian-Ukraine War and the negative effects of COVID-19 interruptions on the global industry. As such, this revised NSP emphasizes on efficient utilization of available resources and implementation of targeted client-centred interventions to achieve a steep downward dent in the number of new infections and improve the survival and quality of life of people living with HIV. Special efforts will be made to establish or strengthen integration and linkage of services across disease programs within the health sector and across the social sector to address the multifaceted social determinants and consequences of HIV and to ensure a resilient health and social sector system that can withstand external shocks while guaranteeing success in the fight against HIV and AIDS. Lesson learned during the COVID-19 disruption of health services and the subsequent recovery should help us to rebuild the national HIV and AIDS response to better respond to emergencies. This revised NSP will focus on the delivery of high impact interventions that targets vulnerable and high populations whilst contributing to strengthening the health and wider social system, within tangible contributions of the formal and informal private sector.

This revised NSP demonstrates Government of Malawi's strong commitment towards a multi-sectoral HIV and AIDS response led by the Ministry of Health and coordinated by National AIDS Commission (NAC), with the meaningful participation of all partners and stakeholders, including the private sector. It should be used by all stakeholders as blueprint for planning and implementing HIV and AIDS programs at all levels.

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, the private sector and Development Partners that contributed to the revision of the 2020-2025 NSP for HIV and AIDS and extending it to 2027.

The revision of the NSP was informed by comprehensive mid-term internal and external review of the current 2020-2025 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 revision process of the NSP was fully participatory and consultative; it was coordinated by a Mid-Term Review (MTR) Steering Committee that was chaired by the Acting Chief Executive Officer of the National AIDS Commission working under the guidance by the Director of the Department of HIV and AIDS in the MoH and with technical advice from the UNAIDS and the WHO External Review Team. A team of five technical consultants led by Prof Victor Mwapasa put this revised NSP together and the MoH Senior Management Team and the NAC Board of Commissioners inputted into and approved the final version.

We would like to thank all members of the MTR Steering Committee for their enduring commitment in revising this NSP. Special appreciation should also go to all stakeholders at district and national levels for their critical review of the 2020-25 NSP and valuable proposals for modifications taking into account the realities of the local context and limited resource envelope. Your continued passion, dedication and commitment to *'sustaining gains and accelerating progress towards HIV epidemic control'* in Malawi is highly valued.

Finally, we would like to thank the UNAIDS, WHO and NAC for funding the process of revising the NSP, providing technical assistance and the Clinton Health Access Initiative for the special valuable input in costing the revised strategy.

Dr Charles Mwansambo

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
CAB-LA	Long Acting Injectable Cabotegravir
CHW	Community Health Worker
CMST	Central Medical Stores Trust
CSO	Civil Society Organisation
DHA	Department of HIV and AIDS
DSD	Differentiated Service Delivery
EID	Early Infant Diagnosis
EMR	Electronic Medical Records
e-MTCT	Elimination of Mother to Child Transmission of HIV
EQA	External Quality Assurance
FSW	Female Sex Worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoM	Government of Malawi
HCW	Health Care Worker
HAD	HIV Diagnostic Assistant
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HRH	Human Resources for Health
HAS	Health Surveillance Assistant
HSSP	Health Sector Strategic Plan
HTS	HIV Testing Services
IEC	Information Education and Communication
KP	Key Population
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MBCH	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
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
eMTCT	Eliminaton 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 Revised Malawi National Strategic Plan (NSP) for HIV and AIDS 2023–2027 is the guiding document for the multi-sectoral response to the HIV epidemic for this period. It extends and replaces the 2020-2025 HIV NSP, capitalizing on recent local and international developments in policies and strategies on HIV and AIDS. It draws lessons learnt from the first 2 years of program implementation, including the implications of internal and external shocks such as the COVID-19 pandemic, other disease outbreaks and global economic crisis. On one hand, the revised strategy builds on remarkable achievements registered by Malawi by reaching 96-95-94 of the 95:95:95 UNAIDS Fast-Track targets ahead of schedule. On the other hand, it endeavours to address shortcomings that prevent the country from further reduction of new HIV infections and AIDS-related deaths. This strategy articulates Malawi’s renewed effort for accelerating the pace towards meeting the goal of eliminating HIV as a public health threat by 2030. The key targets by 2027 are to reduce the annual number of HIV infections from 33,000 in 2019 to 8,000, and AIDS related deaths from 13,000 in 2019 to less than 5,000 and to achieve elimination of mother-to-child transmission of HIV (<5%).

The vision of the revised strategy remains “*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 2023-2025 to realise this long-term vision. The strategy is aligned to various global frameworks such as, the Sustainable Development Goals, the UNAIDS Fast Track Strategy and the Global AIDS Strategy 2021-2026 and the Global AIDS Coalition 2025 Roadmap. The strategy is also *in tandem* with to local frameworks such as the Constitution of the Republic of Malawi, the Malawi Vision 2063, the HIV and AIDS (Prevention and Management) Act, the National HIV and AIDS Policy (2023-2027, the National Health Policy, the Health Sector Strategic Plan 2023-2030, the National Health Financing Strategy 2023-2030 and other key health and other sectoral strategies.

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). It is envisaged that these sectors will play their role to contribute towards the elimination of HIV as a public Health threat in Malawi. Strong leadership and governance in all relevant sectors and strong, resilient and sustainable health systems are critical to the HIV response. Thus, this revised 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, the strategy capitalizes on available sub-national HIV data to target areas of high HIV incidence and/or potentially vulnerable populations such as high-risk adolescent girls and young women (AGYW), women aged 25-29, men (including the elite), children, pregnant and breastfeeding women, key populations, and socially-marginalized populations including migrant labourers living in urban and peri-urban settings. Treatment and care interventions will focus on improving treatment outcome for children and adolescents living with HIV who continue to lag behind their adult counterparts in achieving the 95-95-95 treatment targets. A key strategy in the revised NSP is the delivery of client-centred services at facility and

community levels prioritizing integration of various HIV prevention, treatment, and care interventions that address the broad social determinants of HIV and multi-morbidity experienced by PLHIV.

The Revised and Extended NSP conveys 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 two and half years include: (i) Expanding access to HIV services, especially children, pregnant and breastfeeding women, 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) strengthening community systems; (vii) Implementing integrated service delivery and multi-sectoral approaches to governance and programming; (viii) Expanding condom and lubricant access for high risk populations 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 funding towards HIV epidemic control.

This revised NSP will comprise 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) Other vulnerable populations(vi) Reducing Human Rights and Gender-Related Barriers; (vii) Social and Behaviour Change Communication; and (viii) Resilient and Sustainable Systems for Health. However, in view of the likely occurrence of health and climatic emergencies that disrupt provision of health and social services, the strategy incorporates interventions to address HIV during humanitarian crisis and pandemics and within the thematic areas. Implementation of the NSP will continue to rely on a wide range of implementing partners including the public and private sectors, CSOs, FBOs, traditional leaders and development partners. As the Ministry of Health provides overall leadership for the HIV response, the National AIDS Commission (NAC) will exercise its role as the coordinating body for the national response across various sectors and will 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 $ million US [full costing pending] dollars over the five-year period.

1 Introduction and Background

1.1 Malawi context

Malawi is a Southern African country that borders Tanzania, Zambia, and Mozambique. As per the 2018 Population and Housing Census, Malawi had 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%.[1] Recent UN reports suggest the country could have about 20.2 million population in 2022.[2] 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), group villages 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. Lilongwe and Mangochi are the two most populous districts (Figure 1). Malawi's population is young – 51% of the population is under 18.[3] 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.[4]

Population, all ages, Both, September 2022

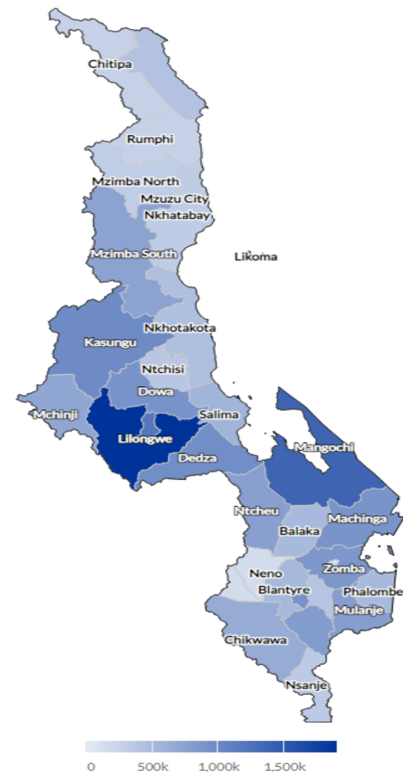

Figure 1: Malawi's population by district

Malawi is ranked 169 out of the 191 countries and territories on the 2021 Human Development Index.[5] Literacy is not yet universal– in 2018, an estimated 72% of males and 66% of females above age 5 were literate.[6] 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% in urban areas. The prevalence of poverty is highest in the Southern Region at 65%, followed by the Northern Region at 60% and then finally the Central Region at 54%.[7] Malawi's GDP is estimated

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[1] NSO. (2019). Malawi Population and Housing Census 2018. Zomba: NSO.

[2] https://www.unfpa.org/data/world-population/MW

[3] NSO. (2019). Malawi Population and Housing Census 2018. Zomba: NSO.

[4] UNAIDS. (2017). Disability and HIV. Geneva: UNAIDS.

[5] UNDP. (2018). Human Development Indices and Indicators-Malawi. Lilongwe: UNDP.

[6] NSO. (2019). Malawi housing and population census 2018. Zomba: NSO.

[7] NSO & World Bank. (2018). Methodology for poverty measurement in Malawi 2016/17. Zomba: National Statistical Office & World Bank.

at US$381 per capita. Agriculture dominates Malawi's economy– it accounts for a third of GDP,[8] employs 64% of the workforce,[9] 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 health indicators. health status of Malawians as demonstrated by various health outcomes. In the period from 2010 to 2019/20– as measured by the Malawi Demographic and Health Survey and Malawi Multiple Indicator Cluster Survey respectively– the infant mortality rate decreased from 66 deaths per 1,000 live births to 40 deaths per 1,000 live births; the under-five mortality rate decreased from 112 to 56 deaths per 1,000 live births; and the maternal mortality rate decreased from 675 to 439 deaths per 100,000 live births (MDHS 2010 and 2015/16). These declining trends in mortality among under five children and pregnant women have been observed since 2004.[10] Malawi was one of the few countries that achieved the MDG 4 target for child mortality well ahead of schedule.[11] The number of AIDS deaths has also significantly reduced from 32,000 in 2010 to 13,000 in 2019.[12] Despite this decline, AIDS remains a leading cause of death.[13]

1.2 Legal, policy and development frameworks

The section highlights the legal, policy and development frameworks which guided and will influence the implementation of the NSP. It also features international instruments that have informed the development of the NSP.

1.2.1 National Instruments

The Revised NSP 2023-2027 is aligned to national policies and legislations as described below:

- **The Constitution of the Republic of Malawi:** 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.
- **The Malawi 2063 (MW2063):** articulates the collective aspirations of the people of Malawi to be an inclusively wealthy and self-reliant industrialised upper-middle-income country by the year 2063. It includes Human Capital Development (HCD), as one of the key thematic areas, to enable the country to achieve the vision. Universal health coverage is one the components contributing to HCD.

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[8] GoM. (2017). Malawi growth and development strategy III. Lilongwe: GoM

[9] GoM. (2017). Malawi growth and development strategy III. Lilongwe: GoM

[10] NSO. (2017. Malawi demographic and health survey 2015-2016. Zomba: NSO.

[11] Kanyuka, M., et. al. (2016). Malawi and Millennium Development Goal 4: a Countdown to 2015 country case study. Lancet Global Health 2016; 4:e201–214http://dx.doi.org/10.1016/S2214-109X (15)00294-6.

[12] MoH/UNAIDS. (2019). 2020 Malawi Spectrum Model

[13] Global Health Data Exchange. Global Burden of Disease Study 2017 (GBD 2017)

- **Malawi Implementation Plan 1 (MIP-1):** this is an operational plan for the MW2063 from 2021 to 2030. Universal health coverage is one components of the plan contributing to Human Capital Development (HCD), a key pillar of the MW2063. Thus, the plan prioritizes health system strengthening interventions).
- **HIV and AIDS (Prevention and Management) Act (2018):** it aims to safeguard human rights of PLHIVs and sub-populations who are at risk of HIV infections, establishes legal standards for governing the delivery of HIV interventions and provides the establishment the NAC to coordinate the HIV response.
- **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 (2022):** This policy provides guidance to the national HIV and AIDS response including the various interventions that should be included.
- **Health Sector Strategic Plan III (HSSP III), 2023-2030**: this overarching Ministry of Health's strategy articulates the objectives, strategies and activities needed to accelerate Malawi's progress in achieving Malawi's Universal Health Coverage (UHC) targets by 2030. The HSSP III aligns with Malawi 2063's vision, outlining how the health sector will contribute to the human capital development and mindset-change pillars of the vision.
- **The National Health Financing Strategy, 2023-2030**: aims to have a fully functional healthcare financing system that supports the achievement of UHC aspirations espoused in the Constitution, the National Health Policy, and HSSP3. It provides detailed mechanisms through which the National Health Policy and the HSSP 3) will be financed.

The Revised NSP 2020-2025 has also been aligned to other national plans strategies and guidelines such as the National Community Health Strategy, HIV Prevention Framework, 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 on Adolescent Girls and Young Women (2018-2022); 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.

1.2.2 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.
- **Global AIDS Strategy 2021-2026**—that seeks to reduce the inequalities that drive the AIDS epidemic and put people at the centre to get the world on-track to end AIDS as a public health threat by 2030.

- **Global Fund Strategy (2023-2028)—** which aims at maximizing People-centred Integrated Systems for Health to Deliver Impact, Resilience and Sustainability; Engagement and Leadership of Most Affected Communities to Leave No One Behind and Health Equity, Gender Equality and Human Rights
- **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 2021 Political Declaration on HIV and AIDS**: which made renewed commitments to ending inequalities and getting on track to end AIDS by 2023
- **Global Health Sector Strategies on HIV, viral hepatitis, and sexually transmitted infections 2022-2030 (GHSS)-** propose a common vision to end epidemics and advance universal health coverage, primary health care and health security in a world where all people have access to high-quality, evidence-based and people-centred health services.
- **Global Prevention Coalition 2025 Roadmap—**which builds on the "2017 Global HIV Prevention Road Map" and identifies ten priority actions that countries must take to resolve the remaining gaps and rebuild momentum to end AIDS as a public health threat by 2030. The roadmap has set a goal of reducing new annual HIV infections, globally, to fewer than 370 000 per year by 2025.

1.2.3 Regional Instruments

- **Maputo Plan of Action:** the plan advocates for an integrated sexual and reproductive health rights (SRHR) Plan and provides guidance to countries on the integration of family planning, STIs and HIV and AIDS services.
- **Maseru Declaration on HIV and AIDS:** adopted by Member States in the Southern Africa Development Community (SADC) in 2003, the declaration commits to eradicate HIV and AIDS in the SADC region, which has one of the highest HIV prevalence rates in the world.
- **African Health Strategy 2016-2030:** whose 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 Strategy aims at ending AIDS, tuberculosis, malaria and neglected tropical diseases among others.[14]
- The 2001 A**buja 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.

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[14] African Union. (2015). African Health strategy 2016-2030. Addis Ababa. African Union.

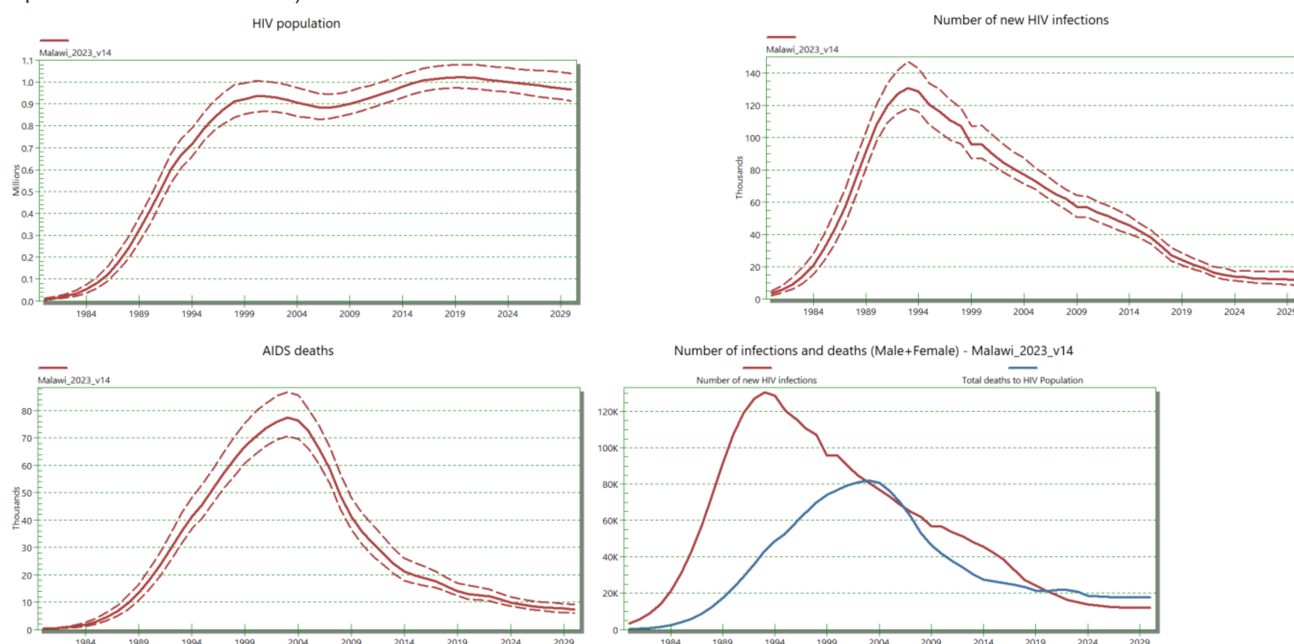
2 Situation Analysis

2.1 Epidemic Overview

With an estimated **1,006,000 PLHIV** among **21 million population** in 2023, Malawi continues to rank among the 10 countries with the highest HIV burden in the world.[15,16]

Figure 2 shows the estimated trends in PLHIV, new infections, AIDS deaths, and all-cause deaths among PLHIV from 1980 to 2030. By the early 1990s, HIV had reached hyperendemic level with sustained transmission in the general population in all districts. Following an initial peak of 930,000 around 2000, the HIV population started to decline due the steep decline in new infections that started in 1992, and the AIDS death wave that peaked before the start of treatment scale-up in 2004. ART rapidly extended the life expectancy of PLHIV, and the number of AIDS deaths declined faster than new HIV infections from 2007. This resulted in a renewed growth of the HIV population, reaching a maximum of 1.02 million around 2020. At that time, 86% of all adults (15+) were on ART, and the annual number of new infections and deaths (from all causes) among PLHIV reached an equilibrium at around 21,000, marking the point of "**epidemic control**". Since then, the epidemic has started to contract slowly, with an average annual decline in PLHIV of 0.6% projected between 2020 and 2030.

Figure 2: Trends in PLHIV, new infections, AIDS deaths, and deaths from all causes among PLHIV 1980-2030 (2023 Spectrum model estimates)[1]



Before the background of a relatively stable HIV population over the last decade, the sustained prevalence decline from 2015 was mainly explained by the exponential population growth: Malawi's population doubled between 1990 and 2020 and it is projected to increase by 29% to reach 25.2 million by 2030. Prevalence among adults

[15] 2023 Malawi Spectrum model (preliminary estimates pending MOH endorsement). Subgroups may not add up to totals due to rounding.

[16] AIDSinfo | UNAIDS

(15+) was estimated at 7.7% in 2023. Prevalence remains significantly higher among women (9.3%) than in men (6.0%).

Figure 3 illustrates the close association between HIV prevalence and population density in Malawi. PLHIV are highly concentrated in the densely populated south, in urban centres, and the surrounding areas. Prevalence ranges from 3-8% in the less populated districts in the Northern and Central regions, to 12% to 17% in the densely populated districts in the Southern region, and in the 4 cities. The continued rapid population growth and urbanization will increase the population density in these areas dramatically over the next decades. This may pose the single greatest challenge for maintaining epidemic control as high population viral suppression must be maintained everywhere to prevent a spill-over and renewed epidemic waves.

Figure 3: Geospatial model estimates for population density, adult HIV prevalence and PLHIV density at 1 km^2 grid level [17]

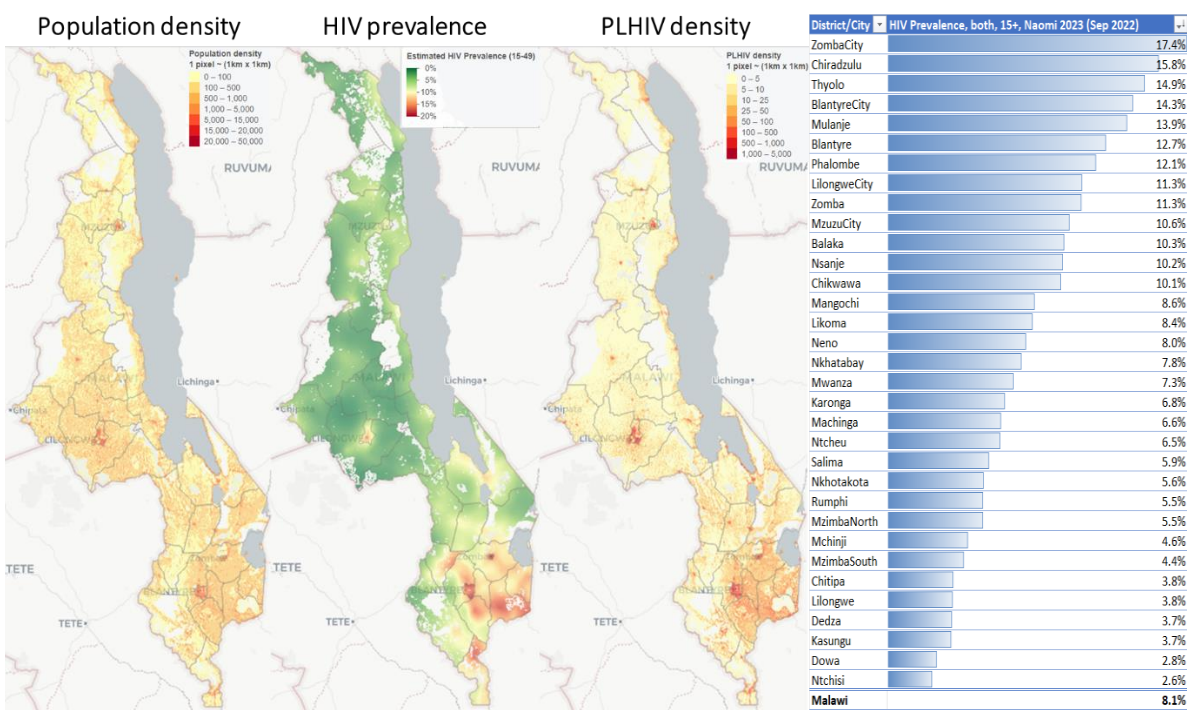


Table 1 shows the 2023 estimates for population sizes, PLHIV, prevalence, new infections, incidence, and AIDS deaths. Around 95% of all PLHIV were adults (15+), 72% were in the reproductive age group (15-49), 5% were AGYW (female 15-24) and 5% were children (0-14).

[17] Geospatial model analysis of travel times to the nearest ART clinic in Malawi https://mrc-ide.github.io/mwi-hiv/ART_facilities/index.html

Table 1: 2023 Spectrum, Naomi model and UNAIDS key population workbook consensus estimates (for 2023). [15]

Population	Age	Gender	Pop. size	PLHIV	HIV Prev.	New inf.	Incidence	AIDS deaths
General	All	All	21179,000	**1,006,000**	*4.8%*	**15,000**	*0.08%*	**11,100**
	15+	All	12,320,000	**954,000**	*7.7%*	**13,000**	*0.12%*	**9,500**
		F	6,441,000	**355,000**	*9.3%*	**8,200**	*0.14%*	**4,300**
		M	5,879,000	**598,000**	*6.0%*	**4,800**	*0.09%*	**5,200**
General	15-49	All	10,683,000	**723,000**	*6.8%*	**12,300**	*0.13%*	**6,800**
Pregnant		F	680,000	**35,000**	*5.2%*	**900**	*0.13%*	
*FSW**		*F*	*39,000*	***19,500***	*49.9%*	***1,500***	*7.50%*	
*MSM**		*M*	*35,400*	***4,500***	*12.8%*	***150***	*0.49%*	
*TG**		*All*	*4,900*	***700***	*13.8%*	***20***	*1.18%*	
*PWID**		*All*	*8,400*	***2,300***	*27.0%*	***70***	*0.50%*	
General	15-24	F	2,340,000	**49,000**	*2.1%*	**3,300**	*0.15%*	**600**
General	0-14	All	8,860,000	**52,000**	*0.6%*	**1,900**	*0.02%*	**1,600**
	<1		663,000	**1,200**	*0.2%*	**1,600**		**400**

Malawi has conducted multiple KP surveys between 2011 and 2021, covering most districts in all 3 regions. Surveyed populations included FSW, MSW, MSM, TG and PWID

2.2 New HIV Infections

Between 2010 and 2020, the annual number of new infections declined by 62%, from 56,500 to 21,400. This is a remarkable achievement, but it fell short of the UNAIDS fast-track target of a 75% reduction for this period. However, the 75% reduction target was nearly reached by 2023 (74%).

Figure 4: Incidence distribution by age and sex in the general population 2010 and 2023[15]

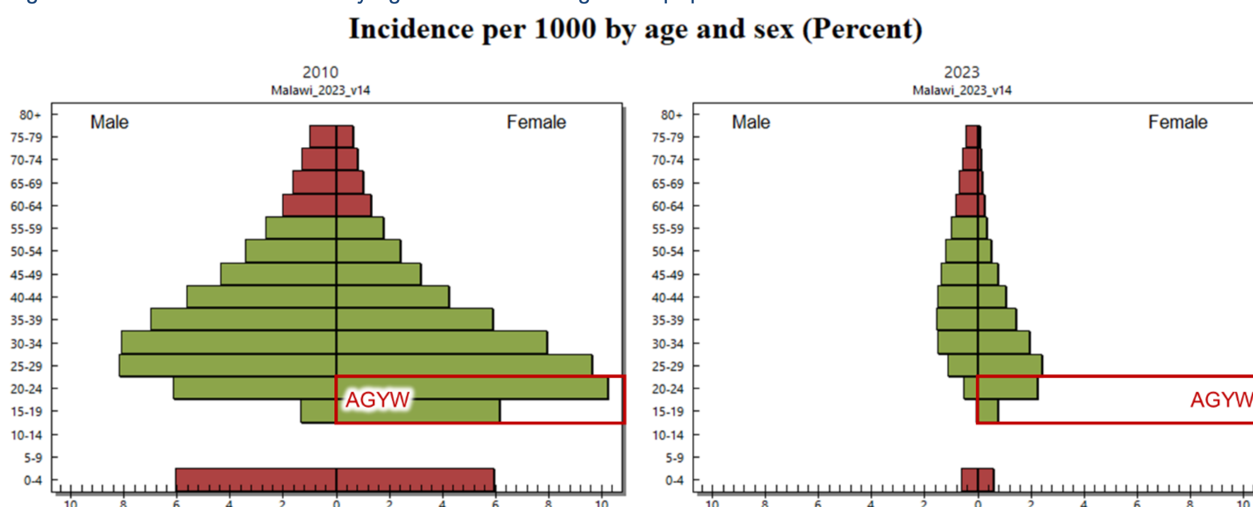


Figure 4 shows that incidence declined significantly in all age groups in the general population. The largest reduction was in children, AGYW, young men and middle-aged adults. All age groups are now below the *moderate risk* threshold of 0.3% annual incidence. Concomitantly, the incidence distribution has shifted towards older ages: in 2023, the highest incidence among females was in the age group 25-29, and among males between 34-44 years. This means that incidence among AGYW is now lower than among women 25-34 years, a group that is currently not specifically targeted for prevention interventions. The decline in incidence and age-shift has

further important implications for the targeting of primary and secondary prevention programs. Considering these low incidence levels across most subgroups in all districts, meaningful impact and value for money can only be achieved if prevention interventions are:

- Low cost per person reached and easy to scale to high coverage, or
- Highly effective and easy to target to subgroups with substantial risk.

For example, incidence among ABYM (15-24 years), the age group with the highest uptake of VMMC, has declined to very low levels (0.03%, equivalent to 1 new infection in over 3,300 ABYM in 2023). Considering the projected continuous incidence decline in future years, this limits the potential impact and cost-effectiveness of VMMC unless it can be targeted at high-risk subgroups in areas with higher incidence. A formal Goals model analysis [18] was conducted in 2022 to estimate the impact and cost-effectiveness of such a "prioritized VMMC scale-up" in 7 districts with higher male incidence (Blantyre, Chiradzulu, Mulanje, Phalombe, Thyolo, Zomba, Lilongwe City), targeting:

- 90% MC coverage among all men 15-24 in the 7 districts
- 90% MC coverage among men 25-49 with multiple partners in the 7 districts
- Maintaining 2021-levels of MC coverage in all other districts.

Compared with an equal VMMC scale-up across all districts, this prioritized strategy suggested that 2-3 times as many new infections could be averted between 2023-2027, but the overall impact of VMMC remained modest at 0.6% of all new infections averted. Consequently, cost-effectiveness in the medium term was unfavourable with USD 12,500 per infection averted between 2023-2027. However, due to the lifelong prevention effect of VMMC, cost-effectiveness for this prioritized VMMC scale-up looked better over very long time-horizons with USD 3,300 per infection averted between 2023-2045.

National AGYW incidence has reduced over 5-fold from 0.81% to **0.15%** between 2010 and 2023 and it is projected to decline by a further 25% between 2022 and 2026 (mid NFM4 period). About **3,300 (22%)** of all new infections in 2023 are among AGYW and around **1,700 (12%)** are among KP. FSW remain the single population group with very high incidence (**7.5%** annual incidence).

A new UNAIDS tool for district-level AGYW risk stratification supports strategic planning for prevention programs. These granular estimates suggest that AGYW prevention interventions will need to be more specifically targeted at 3 relatively small groups with elevated incidence in the 9 districts with overall AGYW incidence ≥0.20% to achieve meaningful impact and acceptable cost-effectiveness (see **Table 2** below). The targeted risk groups include:

1. Young women key populations (YWKP) [19], **15-19 years**
2. Key populations[19] **20-29 years**
3. Women with multiple partners[20], **20-29 years**

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[18] 2022 Malawi Goals model analysis for the HIV prevention framework 2023-2027

[19] Illustrative behavioural risks: paid sex, injection of drugs, transgender women, history of STIs, sexual violence. The tool does not cover age-groups 30+ years, but it is implied that FSW of all ages should be targeted.

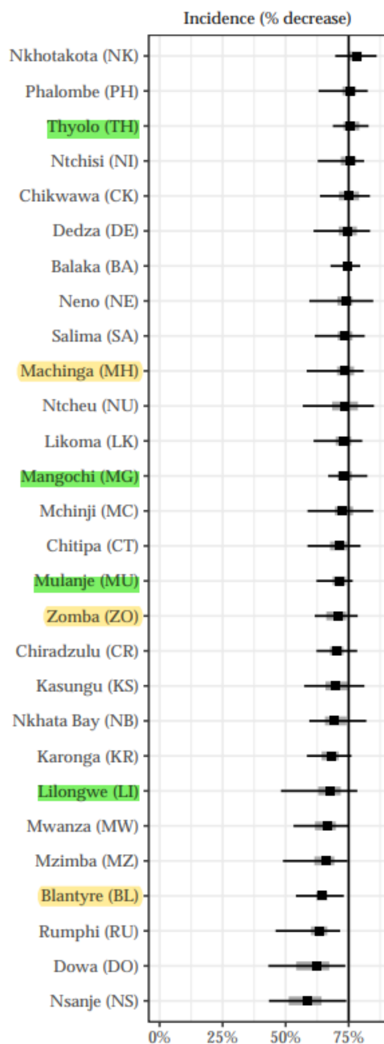
[20] Multiple partners, older partners, history of STIs

However, the total number of new infections in the target districts and risk groups (1,570) represent only about 10% of the estimated total new infections (16,300) in Malawi in 2022, limiting the potential HIV prevention impact of targeted AGYW programming at this stage of the epidemic. Recent program data also show very low positivity (<0.4%) among suspected "high-risk" AGYW tested in previously prioritized districts, highlighting the practical challenges with finding high-risk individuals within a large population through community-based programs.

Table 2: UNAIDS AGYW risk stratification estimates for 2022, for 9 districts with AGYW incidence >0.2% (rounded values)

	YWKP 15-19 years		**KP 20-29 years**		**Multiple partners 20-29**	
Area	Pop size	**New inf**	Pop size	**New inf**	Pop size	**New inf**
Zomba	2,200	**30**	3,600	**70**	18,100	**90**
Balaka	800	**10**	1,400	**80**	10,100	**50**
Chiradzulu	600	**10**	1,100	**90**	8,700	**60**
Blantyre	1,400	**30**	3,700	**100**	36,200	**230**
Thyolo	1,500	**30**	2,600	**60**	16,400	**100**
Mulanje	1,600	**20**	2,600	**60**	17,600	**90**
Phalombe	800	**10**	1,300	**20**	6,900	**40**
Lilongwe City	1,600	**30**	4,400	**100**	30,400	**160**
Total	**10,500**	**170**	**20,700**	**580**	**144,400**	**820**

Figure 5: Adult HIV incidence decrease by district between 2010 and 2021.[20] Districts with DREAMS and Global Fund supported AGYW prevention programs are highlighted.



Between 2010 and 2021, HIV incidence has declined at a remarkably similar rate in all districts (58%-78%, note overlapping uncertainty ranges in **Figure 6** for all district estimates). [21] There was no indication for an accelerated decline in districts with large prevention program investments, but the decline was proportional to the ART coverage level reached in 2021. Twelve districts had achieved epidemic control based on an incidence-prevalence ratio (IPR) below 0.03. If the IPR is maintained below this threshold, the epidemic is bound to contract, and HIV will be eventually eliminated from the population.

Six districts (Lilongwe, Blantyre, Mangochi, Thyolo, Mulanje, and Zomba) accounted for 52% of all new infections in 2023, while more than half of all districts (17) had fewer than 500 new infections this year. However, HIV infection continues to occur in every district in the country.

Notably, the incidence trend analysis also suggests that the transmission rate from untreated PLHIV remained stable around 0.1 transmission events per year throughout 2000-2021.[21] There was limited evidence for the additional impact of other interventions significantly reducing the transmission rates in this period. Untreated men were 3.9-times more likely to transmit HIV than untreated women. This is consistent with the 2023 Spectrum model estimates that show incidence remains considerably higher among women (0.14%) than in men (0.09%).

These findings underline the critical need to close the treatment and viral load suppression gap among men to accelerate epidemic control.

2.2.1 Elimination of Mother-to-Child Transmission (eMTCT)

Malawi was the first country in Africa to adopt a *Universal Test and Treat* (UTT) policy for all HIV infected pregnant and breastfeeding women with the *Option B+* initiative for PMTCT in 2011. This resulted in a steep decline in new infant infections, and significantly accelerated treatment coverage increase among WLHIV. Between 2012 and 2022, an estimated **104,000** infant infections have been averted and ART coverage among all WLHIV (15+) had reached **97%**. Despite this remarkable achievement, the estimated final transmission rate at the end of breastfeeding in 2022 was **7.8%**, above the eMTCT target of 5%. In 2022, new child infections from MTCT (1,900) still exceed the total new infections among KP (around 1,600). Based on program data and Spectrum estimates shown in **Figure 6**, the main contributors for the remaining child infections were:

- ART discontinuation in pregnancy or breastfeeding: 41% of child infections
- New maternal infections during pregnancy or breastfeeding: 29% of child infections

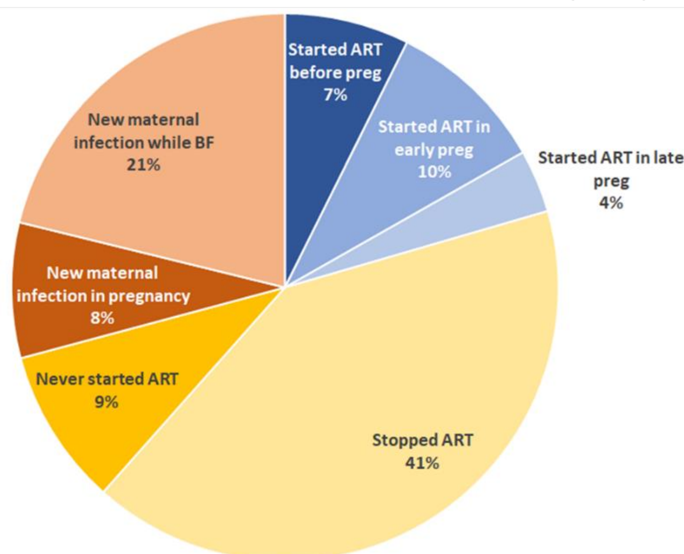
Reaching the elimination target will require targeted scale-up of the following critical interventions:

- Repeated HIV testing in pregnancy and breastfeeding in districts with elevated incidence

[21] Wolock et al. 2023 https://doi.org/10.1101/2023.02.02.23285334

- Active treatment support and return to care throughout pregnancy and breastfeeding
- (Self-) testing and early ART linkage for male partners
- There is a potential role for maternal PrEP in high incidence groups / areas

Figure 6: Distribution of sources for mother-to-child transmission in 2022 [15]



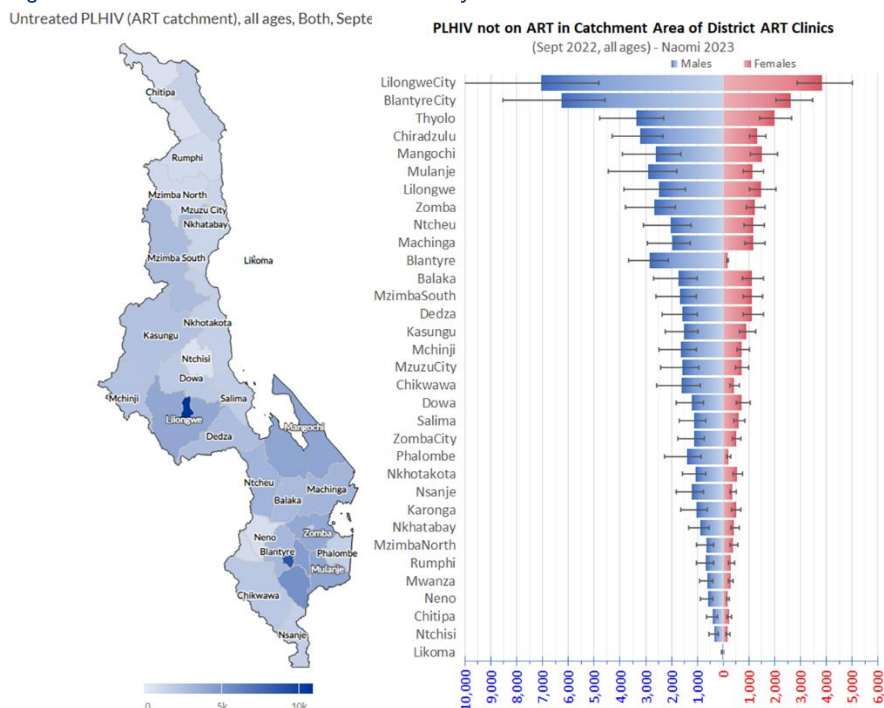
2.2.2 New opportunities for cost-effective prevention programming

By the end of 2022, only **138,000 (14%)** of all PLHIV were not virally suppressed and therefore still able to transmit to others. The 2022 Goals model demonstrated that further ART scale-up to 89%, 98% and 83% among men, women and children, and a simultaneous increase in viral suppression to 95-98%, has by far the greatest potential impact with **14,700** new infections averted between 2023-2027 at a cost of **USD 900** per infection averted.

Figure 7 shows the district estimates for the number of untreated males and females in 2023, reflecting the actual "catchment area" of district ART facilities which may include residents from neighbouring districts. This confirms the larger treatment gap for men in all areas, and the high concentration of all remaining untreated PLHIV in 5 districts, offering opportunities for geographically targeted implementation. To realize the full potential of *Treatment as Prevention* (TasP), Malawi aims to:

1. Increase and maintain ART coverage in all districts, focusing on areas with larger gaps
2. Increase ART coverage and viral suppression among men
3. Monitor closely and act early on emerging HIV drug resistance to safeguard the long-term VL suppression levels.

Figure 7: Distribution of untreated PLHIV by sex and district in 2023



In the era of low and declining HIV incidence, one particularly promising approach for reaching a large proportion of high-risk individuals with primary prevention and linkage to ART is through **STI clinics**. Malawi registers over 440,000 STI patients across the whole country per year, but this represents only about half of all estimated symptomatic STI infections in the population. [22] Low uptake of public STI treatment services is related to stigma, weak staffing, unappealing services, and frequent stock-outs of basic antibiotics. While there is little representative data, many STI patients are believed to self-treat, or seek treatment in poorly regulated private clinics and from traditional healers.

HIV status ascertainment among STI patients in public clinics reached **91%** in 2022 and **18%** of these were HIV positive (routine MOH service reports). 90% of all HIV positive STI patients had been previously diagnosed and 97% of these were already on ART. However, this also means that **over 40,000 (9%)** of STI patients were missed with HIV testing, and **7,500 (10%)** of patients who did receive a new test were newly diagnosed with HIV.

In addition, **1,900 (3%)** of known positives were not currently on ART and needed active referral for (re-)initiation. This is group is a critical source of new infections, as they evidently engaged in high-risk unprotected sex and were not virally suppressed. Long-term surveillance in Lilongwe's largest STI clinic indicate that the proportion of acute HIV infections among HIV positive patients has gradually declined from 1% to around 0.5%, which is still high (Prof. Hosseinipour, UNC, personal communication). At the same time, syphilis prevalence among ANC women has increased from **1%** in 2018 to **2.5%** in 2022, indicating uncontrolled transmission and undertreatment of syphilis in the population. Malawi has also recorded high STI rates among PrEP clients: **12%** of 16,600 clients who were retained on PrEP and screened for STI had an acute STI.

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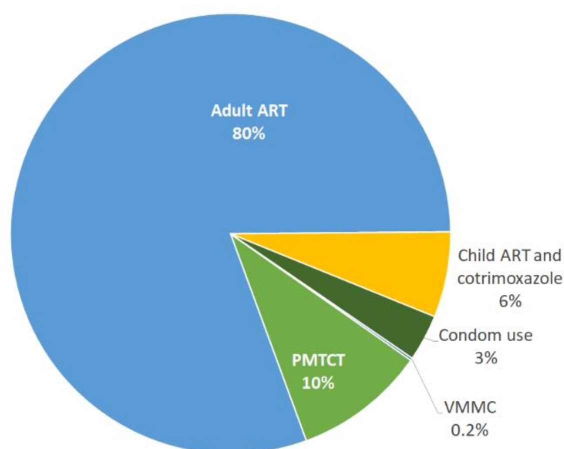
[22] Michalow, J. Characterising the spatiotemporal burden of symptomatic sexually transmitted infections in Malawi (PhD Thesis 2023)

These results demonstrate the need for refocusing on STI control, and the considerable potential of STI services as an entry point for HIV prevention and treatment scale-up, particularly if investments into the quality of services can achieve an increase in STI clinic attendance.

Among the practical advantages of targeting STI patients for HIV prevention are:

- Convenient and low-cost integration into an established decentralized service
- Biological evidence of current high risk for all STI patients, avoiding unreliable and costly active risk-screening to identify clients in need of primary prevention.
- Convenient access to a substantial proportion of all KP groups without the need for eliciting stigmatized behaviour, which is unlikely to be disclosed by many KP members outside of dedicated facilities such as Drop-in Centres.
- The unpleasant experience of an acute STI is expected to increase demand for PrEP and VMMC

Figure 8: HIV-related deaths averted by biomedical program area 2002-2021. 2022 Goals model



It is therefore a high priority to invest into improved STI services to increase overall attendance rates, to target >95% HIV status ascertainment among all STI patients, and active referral for VMMC and PrEP using a "*no questions asked*" approach. Considering the elevated prevalence of hepatitis B and C in these populations, Malawi will also fully integrate routine HBV and HCV screening in STI clinics, and appropriate active referrals for treatment.

In addition, effective primary prevention interventions such as comprehensive condom programming, which can be implemented at high scale and low cost should be further promoted. In addition to targeted KP prevention programs, the integrated professional testing program and self-test distribution are reaching millions of clients each year are established, cost-effective channels for condom distribution.

2.3 HIV burden of disease and mortality: AIDS is not over

Between 2010 and 2020, the annual number of AIDS deaths declined by **64%**, from 36,000 to 13,000.[15] This means the UNAIDS fast-track target of a 75% reduction for this period was not met. By 2023, the reduction in AIDS deaths reached **69%**.

High ART and PMTCT coverage have dramatically reduced the number of AIDS-related deaths: over **600,000 deaths** have been averted by ART scale-up between 2004 and 2022 – **37,000** in 2022 alone. Combined ART and PMTCT scale-up have cumulatively gained over **7.3 million life-years** and averted 90% of all HIV-related deaths between 2002-2021.

The 2022 Goals model analysis of mortality impact by program area is summarized in **Table 3** on **page 44**. The proportion of infections and deaths averted by each program were assessed relative to a scenario without scale-up of any programs. Effects of historic scale-up of structural or behaviour change interventions, except condoms, are implicit in the model's behavioural assumptions and shared across all scenarios considered. The historic impact of these interventions could therefore not be quantified in this analysis. Primary prevention interventions

that could be quantified in this model, such as condom use (3%) and VMMC scale-up (0.2%), have thus far only made a small contribution to reducing HIV-related mortality, and the future potential impact remains limited as long as high ART coverage and viral suppression at the population level can be maintained.

Figure 9 shows that, despite this success, HIV remained the leading cause of death (18.3%) and responsible for most disability adjusted life-years (DALY, 18.7%) lost in Malawi between 2015-2019. However, with the continuous decline in AIDS deaths and the emergence of other health threats such as COVID-19, it is likely that HIV has declined below respiratory infections as the leading cause of illness and death in Malawi in the last 3 years.

Figure 9: Disability-adjusted life-years lost and deaths by cause in Malawi 2015-2019 (Tanzi la Onse model estimates) [23]

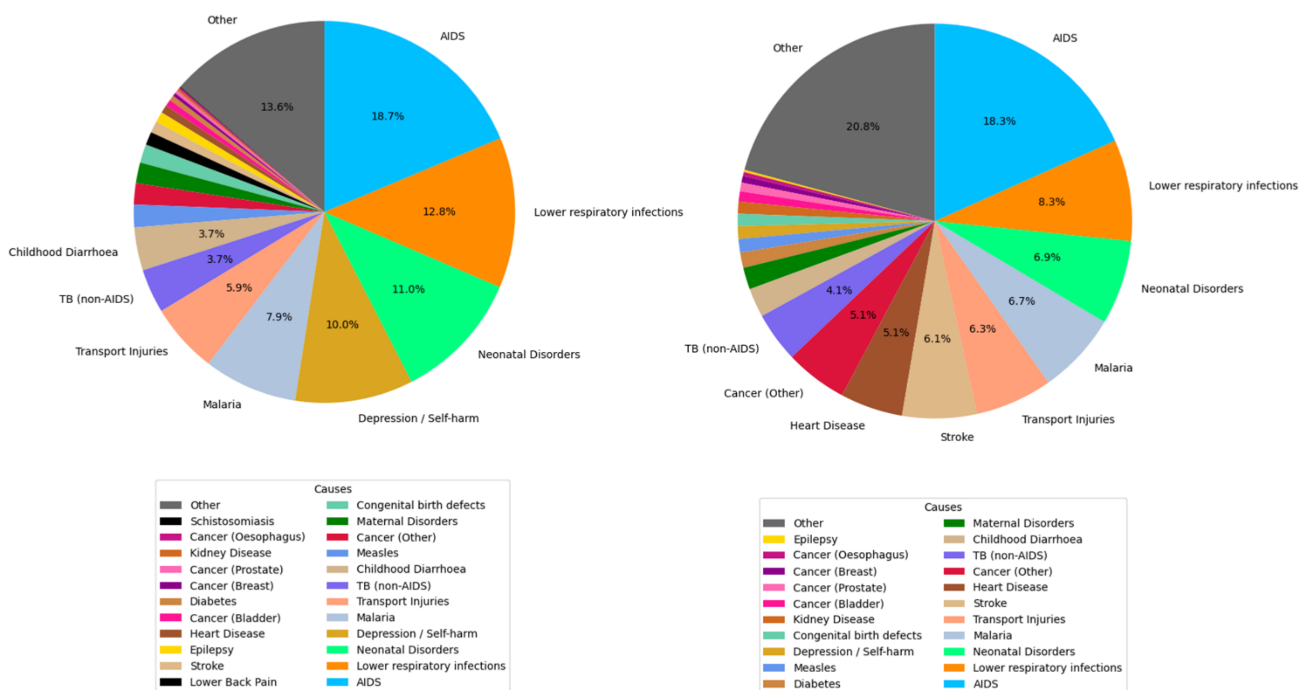
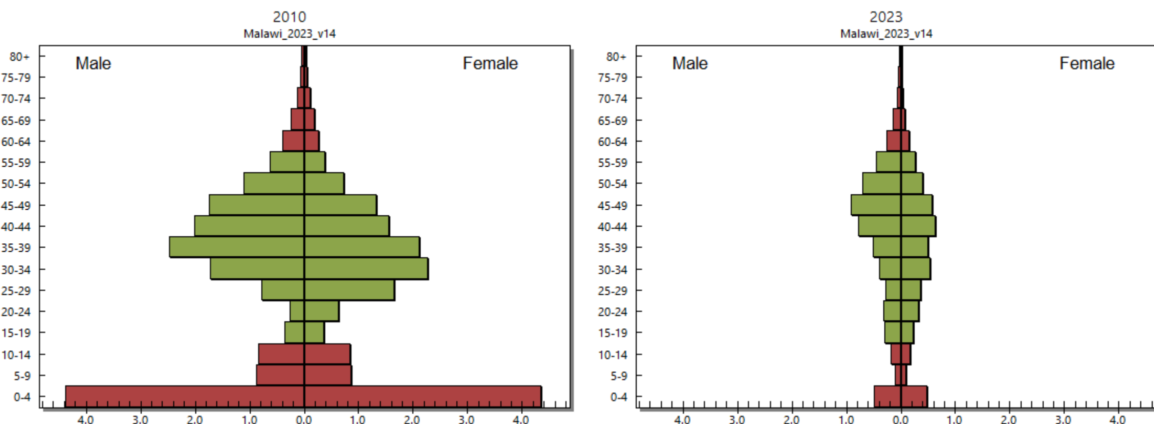


Figure 10 shows the substantial decline of AIDS deaths in all age groups between 2010 and 2023. The most significant reduction was achieved among children 0-9 years and middle-aged adults. The age distribution of AIDS deaths in 2023 has shifted towards older adults 40-55 years.

[23] Tanzi la Onse modelling project, MOH Malawi, Imperial College, UK (2023)

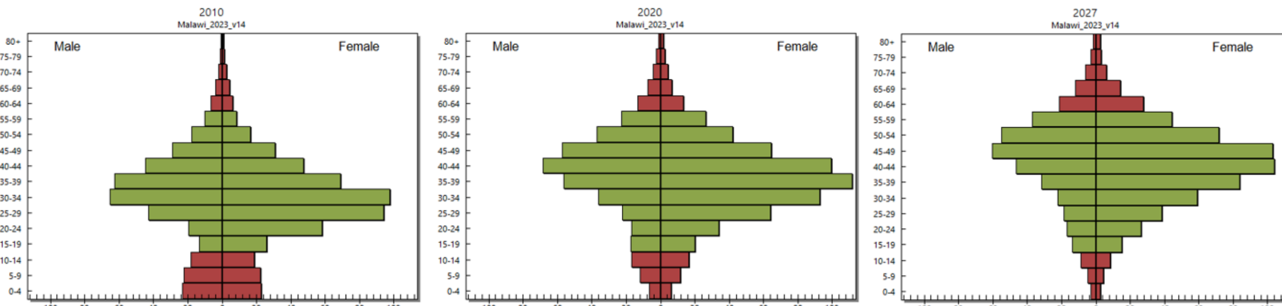
Figure 10: Number of AIDS deaths by age and sex in 2010 and 2023 (2023 Spectrum model estimates) [15]

AIDS deaths by age (Thousands)



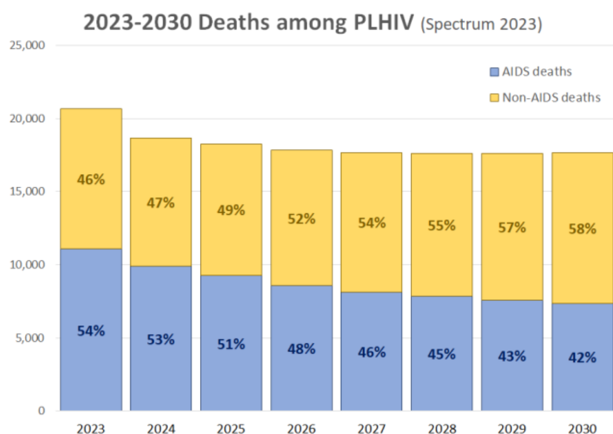
This shift in the mortality distribution is explained by the general aging of the HIV population and to a lesser extent by differences in age-specific ART coverage. Due to the steep decline of new infections among children and young adults and the increased survival of PLHIV on ART, the number of young PLHIV continues to decrease and large infected age cohorts from the past are continuing to move up in the age pyramid each year. The aging of the HIV population is illustrated in **Figure 11** with population pyramids for 2010, 2020 and 2027. The proportion of older PLHIV (40+ years) is projected to grow from 26%, 47% to 63% in these years.

Figure 11: Number of PLHIV by age and sex in 2010, 2020 and 2027 (2023 Spectrum model estimates) [15]



Due to these effects, non-AIDS deaths among PLHIV are projected to outnumber AIDS deaths from 2024. A coordinated scale-up of NCD screening and quality treatment within HIV care settings will be required to reduce this anticipated NCD burden and to ensure longevity and quality of life among PLHIV.

Figure 12: Trend in AIDS and non-AIDS deaths among PLHIV 2023-2030. (2023 Spectrum model estimates) [15]



There are no district-level estimates for AIDS and non-AIDS mortality in Malawi and routine death registration and cause of death ascertainment is still too incomplete for routine mortality surveillance.

Similarly, there is little empirical data on the burden of specific conditions among patients with advanced HIV disease (AHD), and for NCDs among PLHIV in Malawi. Spectrum model estimates suggest that 18% of PLHIV not on ART in 2023 have a CD4 count <200 cells/ml (=AHD).

However, 2022 HIV program data show that 28% of all 28,200 patients who received a CD4 test in 2022 had AHD. Most of these were routinely screened at ART initiation or re-initiation. This suggests that, despite the *universal test and treat* policy that has been in place since 2016, many PLHIV are still starting or returning to treatment with advanced disease. With 72,000 patients initiated or re-initiated on ART in 2022, access to routine CD4 testing at treatment initiation has remained limited. The program has therefore implemented a policy of routine screening for disseminated TB (urine-LAM) and cryptococcal antigen (serum CrAg) for all HIV positive in-patients and for outpatients in WHO clinical stage 3 and 4, regardless of CD4-based confirmation of AHD. The number of urine LAM and serum CrAg tests (20,000 and 17,600) in 2022 therefore exceeded the number of low CD4 results (8,000) more than two-fold. Positivity of urine LAM was high at 18% (3,600 cases) and low for serum CrAg (900 cases). Based on extrapolation from (incomplete) treatment records, the estimated number of patients with Kaposi sarcoma in Malawi in 2022 was around 1,900.

The high HIV-related disease burden and, despite implementation challenges, the potential impact of enhanced AHD disease screening and management, was demonstrated in a 2022 study at Kamuzu Central Hospital in Lilongwe. [24] HIV status was ascertained for 77% of 1,549 patients admitted to the medical wards and 32% of these were HIV positive. CD4 testing was done for 65% and 53% of these were below 200 cells/ml; 16% of patients with a serum CrAg test and 28% with a urine LAM test were positive. A separate survey in the same setting [25] showed that 54% of HIV positive in-patients were diagnosed with an infectious disease only while 28% had only an NCD and 19% had both. Infectious diseases such as TB, pneumonia, sepsis and cryptococcal meningitis accounted for 34%, 10%, 4% and 3%, respectively. NCDs such as hypertension, cancer, lung disease and diabetes accounted for 18%, 17%, 12% and 10%, respectively.

2.3.1 New opportunities for reducing morbidity and mortality among PLHIV

The continued high burden of AHD and the growing NCD burden among PLHIV in Malawi require refocusing on timely diagnosis, effective screening, and access to high-quality clinical care across all levels of health services. Key program priorities include:

- Targeted provider-initiated HIV testing and counselling at OPD for all patients with conditions compatible with HIV infection.
- >90% HIV ascertainment coverage for all in-patients. This requires 24/7 staffing of testing providers in all medical wards.
- Facilitated return to care: embrace the role of the testing program to confirm infection and re-link to ART.
- Active treatment support to prevent ART interruption and return patients to care, prioritized for groups with elevated risk of discontinuation such as young people, pregnant and breastfeeding women.
- Continued scale-up of intensive ART service models for high-risk groups such as Teen Clubs.
- Scale-up of integrated NCD screening and quality management in ART services
- Ensure availability of diagnostics, medication, and high-quality clinical services for HIV-related diseases and NCD.

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[24] Heller, T. et al. Implementing advanced HIV disease care for inpatients in a referral hospital in Malawi – demand, results and cost implications. Annuals of Global Health. 2022 88(1): 16, 1-11. DOI: https://doi.org/10.5334/aogh.3532

[25] Jere, Z. et al. Admission diagnoses and post-discharge outcomes of adults with HIV at KCH Medicine Department: an audit of arecords. ECHO presentation 9 Feb 2023, Lilongwe

- Improve scheduled viral load monitoring coverage, quality of intensive adherence support, and access to genotyping for drug-resistance testing and timely regimen switching.

2.4 Progress towards the 95-95-95 treatment targets

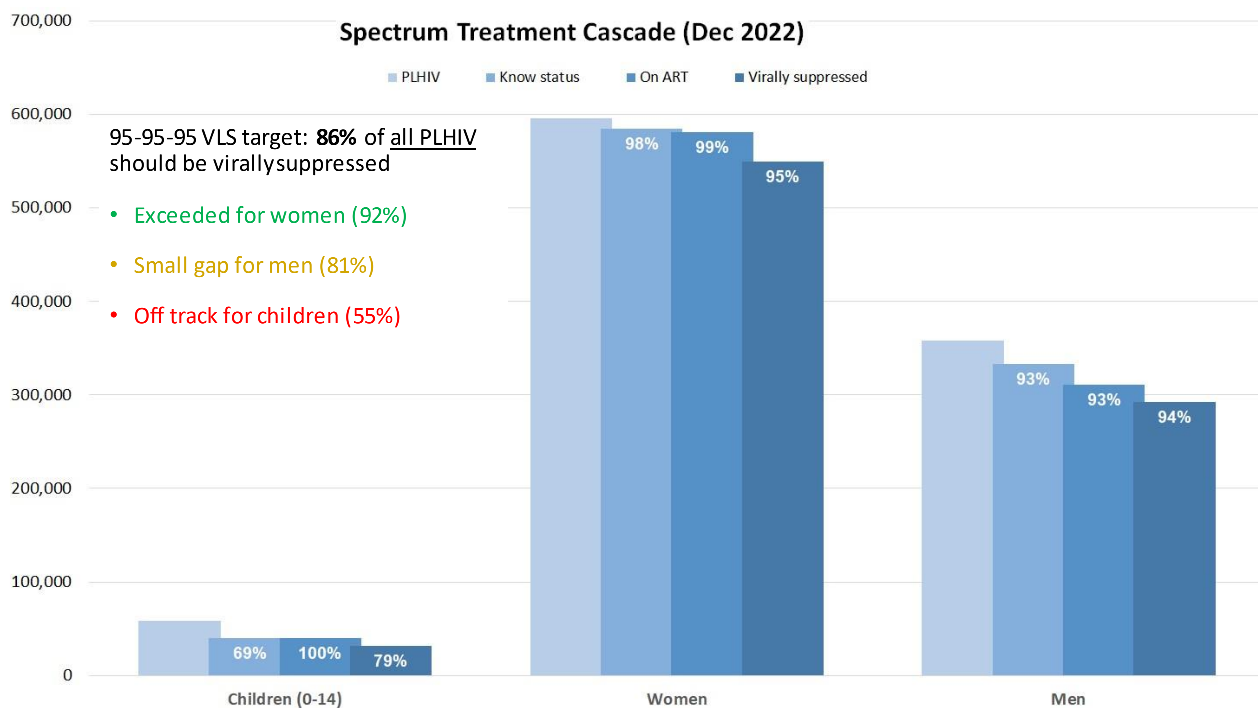
Malawi has made significant progress towards the 95-95-95 HIV testing and treatment targets (**Figure 13**). By end of 2022, an estimated 95% of all PLHIV had been diagnosed, 97% of whom were on ART and 94% of whom had attained viral load suppression[26]. Despite this achievement notable gender and age differences have been observed. Among people aged 15 years above, females had higher HIV status awareness (98%), ART coverage (99%) and viral load suppression rates (95%) than their male counterparts (93, 93% and 94% respectively). This means the overall population HIV viral suppression rate surpassed the target of 86% in females (92%) but fell short in males (81%).   Among children aged 0-14 years only 69% were on treatment of whom only 79% virally suppressed. There are no direct estimates for previous diagnosis and awareness of HIV status among children. Awareness is likely lower than previous diagnosis and the number on ART since HIV status is usually only disclosed to older children.

This overall population HIV viral load suppression rate of among women, men and children was 92%, 81% and 55%, respectively. This is markedly below the 95-95-95 target of 86% viral suppression for men and children. These findings underscore the need to target men and children with innovative HIV testing and treatment strategies[27].

[26] Malawi Ministry of Health HIV programme 2022 as cited in the midterm joint HIV-TB-leprosy concept note

[27] Malawi Ministry of Health, integrated HIV programme report January-March 2022. https://dms.hiv.health.gov.mw/dataset/malawi-integrated-hiv-program-report-2022-q1

Figure 13: Diagnosis, treatment and viral load suppression cascade for children, women and men living with HIV by December 2022



Results from sub-national Naomi models demonstrate geographical disparities in the achievement of first two of the 95-95-95 treatment targets that are closely associated with population density (Figure 5). The number of PLHIV is highest in districts located in the Southern and Central districts of Malawi, with Lilongwe and Blantyre cities where 17.7% of all PLHIV reside. The numbers of PLHIV unaware of their HIV status and those not on ART are also highest in the same cities. In general, Southern region districts dominate the top 10 list with PLHIV who were unaware of their status and those not on treatment (see also **Figure 7**).

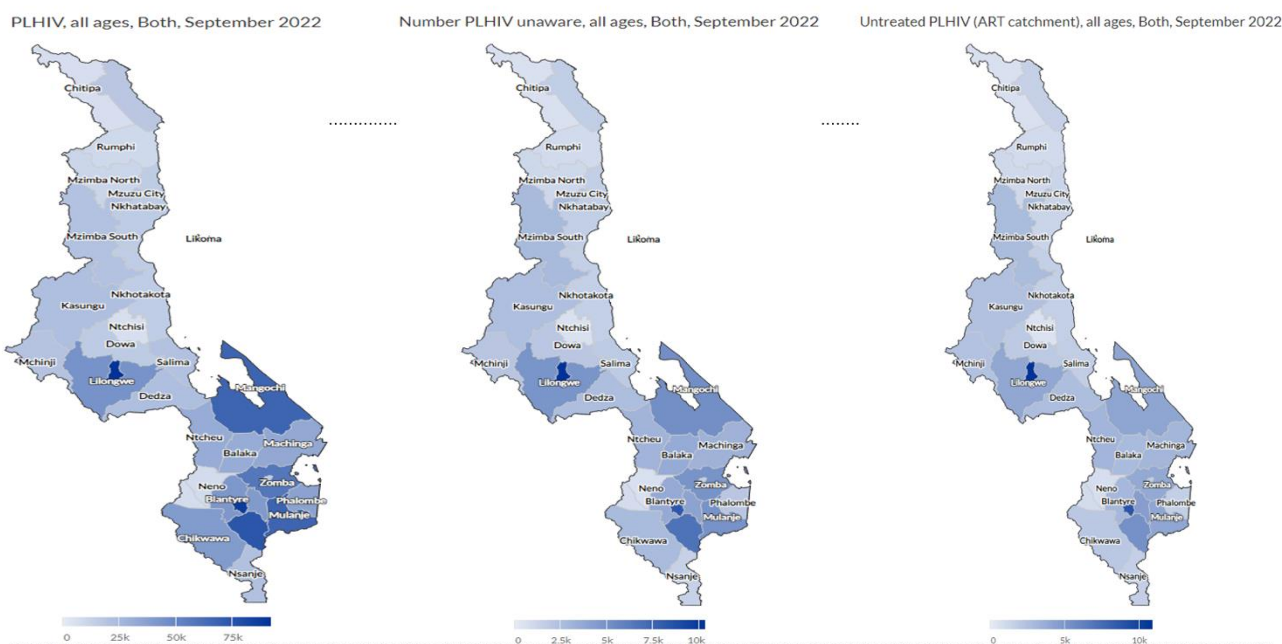


Figure 14: Status of 95-95-95 treatment targets in 2022, by district

2.5 Determinants of HIV Infection

According to the Global AIDS Strategy (2021-2030) inequalities that underpin stigma, discrimination and HIV-related criminalization, enhance people's vulnerability to acquire HIV and make people living with HIV more likely to die of AIDS-related illnesses. HIV transmission in Malawi, like most other countries continues to be 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).[28] The section below describes determinants and inequalities that increase vulnerability to HIV infection– all of which result in increased susceptibility of women, girls and key population groups to HIV.[29]

Poverty: Malawi is one of the lowest income countries in the world. About 50.7% of the population lives below the poverty line.[30] Malawi's economy is primarily dependent on agriculture. The sector accounts for 38% of GDP[31] and over 76% of employment.[32] Tobacco, tea and sugar dominate exports – tobacco alone constitutes 60% of the total exports from Malawi.[33] Malawi's heavy dependency on agriculture creates economic vulnerabilities exacerbated by factors such as 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.[34] 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.

Urban and peri-urban settings: urban settings offer formal and informal employment, trading and training opportunities for Malawians from all districts. Thus, the city population is culturally and socially diverse. The urban population has increased exponentially over the past 20 years which has led to the expansion of informal residential areas within the city and sub-urban outskirts. There is a wide social and income inequality in the city, with a large proportion of city population living in abject poverty in densely populated residential areas with poor access to basic social amenities. The cities have many entertainment venues, bars, restaurants, and commercial lodging places (rest houses, motels and hotels) which create opportunities for the sex business. Increased risky sexual behaviour in the cities may be fueled by heightened economic inequalities, low formal employment, despite the existence of a vibrant private sector, agriculture, energy, and real estate sector with a growing middle class. Availability of disposable income among men has been found to promote sexual adventures and attract

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[28] Magadi, 2011; see also Fox, 2012

[29] Gender Assessment of the Malawi National HIV Response, 2014

[30] https://www.worldbank.org/en/country/malawi/overview

[31] https://tradingeconomics.com/malawi/gdp-from-agriculture

[32] https://data.worldbank.org/indicator/SL.AGR.EMPL.ZS?locations=MW

[33] https://tradingeconomics.com/malawi/exports

[34] NSO. Malawi Demographic and Health Survey. 2015/16.

young women desperate to maintain a high but largely unaffordable lifestyle[35]. It is also likely that intimate partner violence (IPV), which is associated with increased vulnerability to HIV[36], is high in the cities.

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.[37] 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%).[38] 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.

Key Populations (KPs): Recent population size estimates indicate that there are 39,000 FSW, 35,400 MSM, 4,900 TG and 8,400 PWID in Malawi. 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. In addition, UNAIDS considers prisoners as key populations.[39] As of early 2023, there were approximately 17,500 prisoners in 5 central prisons in Malawi, of whom 3,000 were females (personal communication, Prison Chief Medical Officer). In 2020, 10% of MSM reported drug use in the past 3 months.[40] In 2023, HIV prevalence was estimated at 49.9% among FSWs, 12.8% among MSM, 13.8% among TG, 27.0% among PWID [41] and 17% among prisoners. Key populations experience discriminatory attitude or abuse from the general population, service providers and law enforce which limits their access to health and social services and accurate health promotion materials, thereby increasing their risk of HIV infection. Nevertheless, since the 2015-2020 NSP significant efforts have been made to improve the legal environment to reduce human rights violations against KPs and provide health and social services in safe spaces (Drop-in -Centres [DICs] and KP friendly health facilities). In addition, efforts have been made to train health

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[35] Dynamics of sexual relationship among adolescent girls and young women in Blantyre, Malawi and levels of HIV services utilization among their male partners. Jesse Khaki, Wanangwa Chimwaza, Vincent Samuel, Effie Chipeta, Jerome Galagade, Dumbani Kayira, Wezi Msungama, Evelyn Kim, Sanyukta Mathur, Victor Mwapasa, Kenneth Maleta. June 2020, *unpublished*

[36] World Health Organization (2004). Violence against women and HIV/AIDS: Critical intersections. Intimate partner violence and HIV/AIDS. Geneva, Switzerland: Information Bulletin Series 1.

https://www.who.int/hac/techguidance/pht/InfoBulletinIntimatePartnerViolenceFinal.pdf

[37] Ibid.

[38] Ibid.

[39] UNAIDS

[40] The Malawi Biological and Behavioural Surveillance Survey, 2019-2020

[41] NAC Semi-Annual Progress Report, April to September 2022

care workers in KP-friendly health service delivery and to provide peer-led services at community and facility levels.

Gender and human rights: Gender norms influence access to HIV prevention, testing, treatment, care and support for women and girls, men and boys, other genders, and key populations.[42, 43] 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),[44] 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.[45] 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 aged 18-24 years, 55% report experiencing some form of violence– sexual, physical, or emotional– during their childhood.[46] However, recent evidence suggest high levels of community awareness of the importance of addressing GBV. An Afrobarometer survey in 2022 found that Malawians consider GBV as the most important women's-rights issue that the government and society should address. At least four in 10 respondents (44%, including 47% of women) identified GBV as their top priority, well above other priorities such as unequal opportunities or pay in the workplace (16%), lack of participation influential positions in government (16%), and unequal access to education (15%).[47]

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[42] Sia, D., Onadja, Y., Hajizadeh, M. *et al.* What explains gender inequalities in HIV/AIDS prevalence in sub-Saharan Africa? Evidence from the demographic and health surveys. *BMC Public Health* 16, 1136 (2016). https://doi.org/10.1186/s12889-016-3783-5

[43] Dezimey Kum. Women's Rights Gone Missing: Gender Inequality and HIV Prevalence in Malawi. *Global Majority E-Journal, Vol. 10, No. 1 (June 2019), pp. 30-42 http://www.bangladeshstudies.org/files/Global_Majority_e_Journal_10_1_Kum_not_accessible.pdf*

[44] NSO. Malawi Demographic and Health Survey. 2015/16.

[45] National Statistical Office and DHS Program (2017). Malawi Demographic and Health Survey 2015-16.

[46] UN Women (2018). Perceptions Study on Social Norms around Violence against Women and Girls In Malawi. https://www2.unwomen.org/-/media/field%20office%20africa/attachments/publications/2019/perceptions%20study%

20on%20social%20norms%20around%20violence%20against%20women%20and%20girls%20in%20malawi-web.pdf?la=en&vs=144

[47] Joseph J. Chunga and Raphael Nedi, 2022, Malawians see gender-based violence as a top priority – and a criminal matter Afrobarometer Dispatch No. 576

3 Mid-Term Review of the 2020-2025 NSP

During the first two years of implementing the NSP for HIV 2020-2025 several major shocks have occurred internationally and locally which have altered the landscape for HIV and AIDS programming. These include the COVID-19 pandemic, and climate-change-related natural disasters which resulted in disruption of health and social services and increased vulnerability of displaced populations. Although the government established the Department of Disaster Management (DoDMA) to deal with these emergencies, there were limited strategies, plans and emergency service provision packages to address health-related impacts, including sexual and reproductive health risks. Other relevant developments included the launch of several strategies such as the Global AIDS Strategy 2021-26, Malawi Vision 2063 and the Malawi Health Sector Strategic Plan 2023-30. This necessitated the conduct of a Mid-Term Review (MTR) of the HIV NSP to assess the progress made in achieving the program targets; to evaluate the level of implementation of the NSP strategic interventions and to ensure realignment of the NSP with new national and global visions and strategies.

Between February and March 2023, an independent team of local consultants and WHO external review team conducted the MTR by reviewing literature, program reports and epidemiological model results; interviewing stakeholders at district and national levels; and conducting field visits (Refer to Annex X for a detailed methodology).

The MTR findings were used to revise existing strategic interventions and to formulate additional ones, as provided within the eight Pillars in the Section 17 of this strategy.

The following section provides highlights and key recommendations from the MTR under each NSP pillar.

Pillar 1: Combination prevention

Condom and lubricant programming

Mid-term review findings show challenges in meeting distribution targets, poor understanding of TMA among stakeholders, unharmonized demand creation, minimal engagement of private distributors, and suboptimal distribution to rural and poor populations. Successes include good coordination at the national level and development of Last Mile Condom Distribution Guidelines. Data on the targets for percentage of condomized sexual acts and knowledge about consistent and correct use of condoms were not available at the time of the MTR.

PrEP

The Ministry of Health in Malawi approved oral PrEP as an additional prevention intervention for individuals at substantial risk of acquiring HIV, such as female sex workers and men who have sex with men. The NSP 2020-25 devised strategic interventions to support PrEP scale-up, but progress towards achieving the targets by the end of 2022 has been slow due to challenges such as low uptake and adherence to PrEP, particularly among adolescent girls and young women and men. However, successes were achieved in the good integration of PrEP with other SRH services and the development of national PrEP guidelines and communication strategy. Malawi is also planning to conduct implementation studies on long-acting injectable cabotegravir among key and vulnerable populations in 2023.

VMMC

Malawi rolled out the VMMC program in 2012, and the NSP 2020-25 devised strategic interventions to support VMMC scale up. However, based on available data, it is evident that most of the targets may not be achieved by 2025. The major success has been the decentralization of VMMC procedures to districts and private clinics which has resulted in increased uptake, but limited infrastructure and human resource capacity remains the major challenge affecting VMMC scale up, nationally.

AGYW

The 2020-25 NSP has set targets to reduce new infections among Adolescent Girls and Young Women (AGYW) by 22% through interventions such as strengthening multi-sectoral coordination, increasing access to quality SRHR/HIV services, and engaging with young networks to disseminate prevention messages. There has been a mid-term reduction of 17% in new infections among AGYW, but data on other program indicators is not yet available. Successes include the successful delivery of comprehensive AGYW packages in partner-supported districts and increased coverage of youth CBDAs providing some components of AGYW services. Challenges include poor coverage of interventions targeting Adolescent Boys and Young Men (ABYM) and their sexual partners, incomplete delivery of comprehensive knowledge/sexuality education among AGYW, and sub-optimal coverage of Community Youth Centers to keep girls in school.

Key Populations

The strategic interventions for the KVP programme include strengthening governance and coordination, pursuing SLAs with private providers, scaling up community-based testing, and delivering HIV, GBV, SRHR, and mental health services in emergency situations. Mid-term progress shows that targets for coverage of prevention services for FSWs and MSM have been achieved, and almost achieved for viral suppression, but data for other indicators are either not available or unreliable. Successes in implementing the KVP programme include the availability of DICs and training of HCWs in KP-friendly services, as well as improvements in the legal environment. However, challenges persist, including limited coverage of DICs and moonlight SRH/HIV services, persistent stigma and discrimination, and frequent stockouts of STI drugs.

eMTCT

The eMTCT program is a priority in Malawi's efforts to eliminate pediatric HIV, with strategic interventions focused on increasing demand and uptake of SRH and HIV prevention services, offering integrated youth-friendly health services, engaging male partners, supporting family planning, improving screening, and strengthening treatment and retention. However, progress towards targets set for reducing MTCT rates and new pediatric infections has been slow, with challenges of poor retention of mothers and infants, stock-outs of test kits, and inadequate coverage of services. Despite these challenges, there have been successes such as high ANC and ART coverage, good integration of services, and the introduction of retesting guidelines and community-based services.

STI

STIs are a known risk factor for HIV transmission and acquisition, and the WHO recommends STI services as part of a comprehensive HIV prevention package. However, the MTR suggests none of the STI program targets had been met, although screening of STI clients for HIV was close to the target. Some of the successes of the STI program included the increased availability of integrated STI/SRH services delivery platforms in health

facilities and DICs, introduction of cervical cancer screening and treatment services in some facilities, availability of AMR monitoring guidelines, and establishment of NG AMR sentinel surveillance. However, some of the key challenges included poor collaboration between public and private facilities in the provision of integrated STI/SRH services, frequent STI drug stockouts, increasing NG AMR, sub-optimal integration of cervical cancer screening and treatment services, and the misclassification of FGS as STIs in some areas.

Wellness and workplace

The Wellness and Workplace HIV program aims to develop policies and programs for HIV prevention and treatment, targeting formal and informal sectors, migrant laborers and young women. It also focuses on empowering private sectors to effectively deliver HIV services, adherence to standards and regulations, and increasing financial contributions towards combating HIV/AIDS. Although data for the program indicators are not available, there has been a good coordination between the National AIDS Commission (NAC), the Ministry of Labour, and the Malawi Business Coalition for Health (MBCH) in the implementation of the program. The revision of the National HIV and AIDS Workplace Policy is also a key success, which will guide the formulation and revision of workplace policies in outdated sectors. The mid-term review highlights poor planning and coordination, sub-optimal implementation, poor enforcement, and limited financial resources as key challenges to fully implementing the program.

Blood safety

The 2020-25 NSP did not set specific targets for blood safety, but the program aimed to improve the availability, quality, and management of blood transfusion services and set up sentinel sites in major hospitals. The program has been successful in universal screening of blood units for transfusion-transmitted infections, but challenges include the MBTS's inability to meet national blood demand due to limited blood donors and COVID-19 disruptions, the limited sensitivity of serological tests leading to false positive results, and limited infrastructure in districts for blood banks.

Pillar 2: Differentiated HIV testing

The program has exceeded the UNAIDS testing and treatment targets, but awareness levels are lower in males than in females. The program has been successful in implementing secondary HIV testing and same-day testing and treatment initiation, but there are high costs associated with community-based testing. HIV testing and counselling are not offered to people on remand in prisons, so there is a need to review the HTS protocol for prisons. The program has successfully implemented a 3-test algorithm and quality assurance programs but there is a need to sustain good quality assurance performance. HIV Diagnostic Assistants (HDAs) and expert clients have been successful in linking HIV-positive clients to ART care, mostly in partner-supported districts, but the proportion of HIV self-test (ST) clients who return for confirmatory tests remained very low. The program has successfully integrated HTS into VMMC, STI services, and moonlight/hotspot testing. The private sector needs to be mobilized to take up more HTS roles, and there is a need to promote access to testing coverage among outpatient attendees with suggestive symptoms.

Pillar 3: Treatment, care, and support

By the end of 2022, all targets were surpassed in all PLHIV overall, but not in children living with HIV aged 0-14 years, adolescents, and men. Although there was a reduction in AIDS-related mortality, there were challenges in implementing the strategic interventions in the Differentiated HIV Testing Pillar. The findings call for enhanced

efforts to increase testing and treatment coverage, improve retention in care for PLHIV, and improve the quality of care for PLHIV. There is a need for increased investment in infrastructure, medicines, equipment, and human resources to manage co-morbidities in PLHIV on ART. The priority areas for improvement include increasing access to treatment for children, adolescents, and men, improving retention and adherence in ART, strengthening treatment monitoring, and improving the management of advanced HIV disease and other HIV-related diseases and co-morbidities.

Pillar 4: TB/HIV

The mid-term review found key achievements, such as the establishment of the Parliamentary Caucus for TB in Malawi and the availability of diagnostic services in all district hospitals. However, challenges include over-reliance on smear microscopy for diagnosis and insufficient integration of TB screening in facility service delivery points. Lessons learned include the need for robust pharmacovigilance for co-treated patients and the promotion of TB preventive therapy among all household contacts.

Pillar 5: Vulnerable children

Malawi identifies vulnerable children through criteria such as living in low-income households, not living with biological parents or in households with uneducated adults or single/double orphans. The NSP 2020-25 aimed to improve HIV sensitive child protection case management, care and support for children affected by HIV and gender-based violence. Key achievements include ongoing awareness campaigns and recruitment of additional Community Child Protection Workers, while challenges included weak coordination and lack of resources. Additional investment and training is needed for CCPWs and a clear selection criteria for beneficiaries should be established. Innovative use of Constituency Development Fund (CDF) to support vulnerable children is potentially sustainable.

Pillar 6: Reducing human rights and gender barriers

The Malawi Government has shown commitment to protecting the rights of key populations, including establishing Key Population TWGs, Human Rights and Gender TWGs, and deploying Gender Officers. However, pervasive negative social norms and illiteracy limit the impact of legal literacy campaigns. Challenges also include lack of human, material, and financial resources to implement and scale up interventions. The key success of the program includes increasing awareness of GBV cases and improving legal and human rights knowledge. The need for continued advocacy work and community engagement is emphasized for addressing harmful gender norms and reducing gender-based violence.

Pillar 7: SBCC

The mid-term review found that while the country has established strong foundations for SBCC programs, there are challenges in engagement with community and religious leaders to champion socio-cultural changes and limited coverage of SBCC interventions due to limited capacity and resources. There is a need to intensify the use of social media for communication, operationalize the Male Engagement Strategy, and establish M&E systems for SBCC interventions.

Pillar 8: RSHH

Malawi's health system faces chronic resource constraints that limit the delivery of HIV-related health services, threatening the country's goal of achieving universal health coverage. While the health sector has a strong leadership and governance structure, there are challenges in terms of limited stakeholder awareness, poor tracking of HIV-related expenditure, and sub-optimal coordination capacity at the district level. The health infrastructure also hinders the expansion of service integration. However, there are positive developments in financial management, coordination of the response in line with the 3 Ones Principles, health products management systems, health information systems, human resources for health, availability of infrastructure, transport, and equipment, integrated service delivery and quality improvement, and strengthened community systems. Recommendations include tracking expenditure and value for money, strengthening capacity for multi-sectoral coordination at the district level, strengthening the capacity of data-driven decision-making, accelerating in-service training, and expanding health infrastructure to support integrated service delivery.

4 Vision of the Revised and Extended Malawi HIV Strategic Plan

Overview

This section provides an overview of the overall vision, mission, goal, guiding principles and objectives for the strategic plan. The vision, mission and goal and key objectives are a continuity from the 2020-2025 strategic plan, including a focus on acceleration reach the 2030 targets.

Vision, Mission, and Goal

Vision

The vision of the strategic plan is to achieve *a healthy and prosperous nation free from HIV and AIDS.*

Mission

The mission is to provide high-quality HIV prevention, care treatment and support services to all Malawians affected by the HIV and AIDS epidemic.

Goal

The goal of the plan is to contribute towards ending HIV as a public health threat in Malawi by 2030. Progress towards this goal will be measured through the performance framework (see page 100).

Guiding Principles

The Revised NSP 2023-2025 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 NSP will guide all stakeholders in the implementation of HIV and AIDs response over the period 2023-2025, with the NAC as the only coordinating authority. One M&E system will be used to effectively monitor progress in the implementation of the HIV and AIDS response.

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 and the HSSP3, 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.[48]

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

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

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.

Key objectives

The key objectives of the revises and extended Malawi HIV Strategic plan will be to:

a. **Accelerate the reduction** of new infections and deaths 2023-2037 to reach the UNAIDS 90% reduction target by 2030
b. Reduce annual new HIV infections from **16,400** in 2022 to **7,400** in 2027 [49]
c. Reduce annual AIDS-related deaths from **12,100** in 2022 to **7,700** in 2027 [49]
d. Build resilient health and social welfare systems

[49] The revised NSP targets are set to meet the 90% reduction for annual infections and AIDS deaths by 2030 from the 2010 baseline. Estimates for 2010-2022 are based on the 2023 Spectrum model estimates. Annual targets 2024-2027 based on spline interpolation to meet the 2030 end point.

5 Objectives, Targets, and Strategic Interventions, by Pillar

This revised NSP focuses on consolidating the tremendous gains made in increasing access to ART and accelerating the reduction of new HIV infections through adoption of the latest evidence-based interventions.[50] Considering that the vast majority of PLHIV in Malawi are aware of their status and are on ART, the revised NSP strives to ensure that they attain a high quality of life and contribute positively to national development. In addition, the NSP prioritizes HIV prevention noting that any large increases of new HIV infection will likely put a on health system threatening Malawi's quest for universal health coverage and socio-economic development. Thus, this Revised NSP endeavours to make a key contribution to Malawi 2063 human capital development goals, with an expected impact that goes beyond SDG Target 3.3 of ending the AIDS epidemic by 2030.

In pursuit of the vision of "*healthy and prosperous nation free from HIV and AIDS",* this Revised NSP maintains the following thematic areas from the 2020-2025 NSP:

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

5.1 Pillar 1: Combination Prevention

Eliminating HIV as a public health threat will require a significant reduction in new infections. The 2020-2025 NSP aimed to reduce new infections from 33,000 in 2019 to 8,000 in 2027. Encouragingly, the recent epidemiological model estimates that 15,000 new infections will occur in 2023. With the country's commitment to the Global HIV Prevention 2025 Roadmap, Malawi is confident that it will attain the 2025 targets. 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 the key component of an effective prevention strategy. The tremendous progress registered by the country towards the 95:95:95 testing and treatment targets will help to prevent further community HIV transmission thereby adding momentum to efforts for meeting its prevention target. This NSP will further prioritise and strengthen existing primary prevention interventions following the strategy of ***Precision Prevention***.

To maximise the impact of existing resources, this revised NSP prioritizes the scale-up of the most cost-effective prevention measures tailored to the respective high-risk populations disaggregated by age, sex/sexual

[50] Ibid.

orientation, and geography. **Table** below shows this analysis, ordered by the number of infections averted between 2020 and 2035.

Table 3: Potential impact (infections averted) and cost effectiveness of selected prevention interventions. Source: 2022 Goals (2023-2027) [51] model for Malawi. Ranked by cost-effectiveness.

Program area	Costed interventions	Target Coverage	Infections Averted	Additional USD	USD/ Infection Averted
PMTCT	ARVs, service delivery	95% from 2023	3,244	-399 (saving)	-1,294,356
ART	ARVs, service delivery	95% in 2027	14,671	13,247,913	903
Condom promotion	Condoms, promotion activities	80% use in people with multiple partners	1,043	5,885,649	5,643
VMMC	Commodities, service delivery	80% in 2027	859	11,569,871	13,469
KP: FSW, MSM, PWID	Comprehensive prevention package, oral PrEP, needle exchange, service delivery	73,000 per year	1,984	33,952,192	17,113
PrEP AGYW max.	Oral PrEP, service delivery	80% of all high-risk (2% incidence) [52]	3,752	126,044,688	33,594
AGYW	CSE Economic empowerment	250,766 per year 338,873 per year	794	118,194,830	148,873
ABYM	CSE condoms oral PrEP	233,000 per year 82 million per year 2,200 per year	68	51,987,144	762,000

Based on these results, Malawi will scale up ART, VMMC, STI screening and management 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 oral and injectable PrEP for MSM and high-risk AGYW, as well as combination prevention to AGYW, ABYM and key and vulnerable populations on the basis of equity and "leave no one behind." The following sections describe the strategic interventions for each component of the priority combination prevention programs

5.1.1 Condom and Lubricant Programming

Condoms are one of the most well-known, cost-effective methods that protect against HIV and other sexually transmitted infections and prevent unwanted pregnancies. In the previous NSPs Malawi adopted the "Total Market Approach (TMA)" as a strategy for ensuring sustainable distribution of condoms to various segments of the population, based on their preferences and financial status (market segmentation). However, recent program

[51] Goals model assumes a baseline of 2023 and coverage target of 2027

[52] Theoretical scenario where 80% of the high-risk AGYW (2% annual incidence) are continuously on PrEP achieving 30% daily dose adherence as measured in 2022 studies in Malawi.

data showed that 68% of condoms were distributed through the public sector, 30% through social market outlets while only 2% through commercial outlets. Within the public sectors, the vast majority of condoms were distributed through static health facilities while only 7% were distributed through community structures. This distribution pattern suggests that there is need to strengthen the Total Market Approach in order to evenly segment the condom market. The market segmentation will improve access of condoms and lubricants to the remaining sub-populations that do not regularly utilize public health facilities such as Sex Workers and their clients, MSM, fishermen, male partners of adolescent girls and young women (AGYW) and other vulnerable populations. In 2022, the Government launched "Last mile condom distribution strategy" to optimize condom distribution to marginalized and high-risk populations.

This revised NSP attempts to strengthen coordination at national, district level and community levels, improve private sector involvement, and strengthen the monitoring and evaluation systems. Condoms distribution will be scaled up to social-economic hubs, fishing communities and other informal sectors to address challenges identified in the Mid-Term Review of the 2020-2025 NSP. The challenges include poor understanding and implementation of the TMA, limited availability of condoms and lubricants in socio-economic hubs and hotspots [53], sub-optimal coordination of the condom programs at district level and low and unharmonized demand creation. It will also capitalize on successes registered with the use of peer-led condom distribution and the enactment of the PMRA Act which, among other things, will support condom quality assurance programs.[54]

Objective 1.1.1: To increase access and uptake of quality condoms and lubricants among high-risk populations using the Total Market Approach.

Targets by 2027

- 80% of all sexual acts of key and other vulnerable populations and their partners are condomized.
- 735.5 million male condoms are distributed by 2027.
- 8.6 million female condoms are distributed by 2027.
- 16.1 million Lubricants are distributed by 2027.
- 85% of women and 90% of men aged 15-49 know that consistent and correct use of condoms reduces the risk of HIV acquisition.

Strategic interventions

1. Strengthen leadership, governance and coordination at national, district-level, and community levels.
2. Strengthen the distribution of condoms and lubricants including distribution to the last mile using the Total Market Approach.
3. Strengthen private sector involvement for condom & lubricant programming.

[53] E Singogo, S Weir, E Kudowa et al. Are avenue-based strategies the ticket to the last mile in HIV prevention in Malawi. CROI 2023, Seattle Washington

[54] http://www.nsomalawi.mw/images/2019-2020_Malawi_BBSS_Report

4. Strengthen quality assurance systems for condoms and lubricants and all related services across all sectors.
5. Strengthen innovative demand creation for condoms and lubricants among target populations through SBCC, branding, and empowerment of women, girls, and KP.
6. Strengthen monitoring, evaluation, research and surveillance for condom and lubricant programming.

5.1.2 Pre-Exposure Prophylaxis

The Ministry of Health started providing oral PrEP services in Malawi in 2021 after a successful pilot implementation conducted from 2019 to 2020. Since the roll out, there has been a steady increase in and uptake of services, however the increased uptake skewed towards KP and continuity rate has been sub-optimal (51%). Since the inception of the current NSP, in 2022 the WHO recommended long-acting injectable cabotegravir (CAB-LA) as an additional prevention option for people at substantial risk of HIV. CAB-LA is expected to improve adherence to PrEP among clients. In Malawi, CAB-LA implementation science projects are scheduled to commence in 2023 which will provide guidance on the implementation modalities in the Malawian context. WHO has in 2022 provided guidance on simplified and differentiated use of PrEP among eligible clients which aims at improving access, will improve uptake, persistence and effective use of PrEP. In line with the recent WHO guidance, Malawi has adopted community PrEP delivery and Event Driven PrEP.

This NSP will endeavour to address challenges identified in the mid-Term Review of the 2020-2025 NSP particularly low PrEP uptake among AGYW, sub-optimal oral PrEP continuation during periods of risk, and stigma associated with oral PrEP. Leveraging on the PrEP Communication Strategy, this NSP will promote PrEP demand creation and uptake through multiple channels including digital/social media and also use evidence generated from the planned CAB-LA implementation science project. In line with the recent WHO recommendation, Malawi has adopted event-driven PrEP and community PrEP delivery to key and priority populations (MSM, TG, SW, PWID and their sexual partners) and other vulnerable populations with limited access to the formal health care.

Objective: Increase access, uptake and quality of PrEP services targeting high risk and key populations in all high incidence districts.

Targets

- Increase PrEP uptake, as part of combination prevention, to 50% among high-risk groups
- Increase PrEP continuity from a baseline of 51% to 65%

Strategic interventions

1. Support subnational planning for PrEP rollout and scale-up.
2. Strengthen integration of PrEP with SRH, Child health and other service delivery points including in the community outreach models.
3. Improve human resource and health system capacity to offer PrEP, VMMC, STI services, and family planning through SRH/HIV service integration.
4. Strengthen supply chain systems for PrEP medicines.
5. Identify innovative strategies for mobilizing additional resources for oral PrEP scale-up and diversifying delivery channels, including the private sector- governance issue.

6. Promote awareness and uptake and continuity of PrEP among AGYW, KPs and other vulnerable populations through use of digital/social media platforms.
7. Accelerate introduction and scale up for long-acting injectable PrEP.

5.1.3 Voluntary Medical Male Circumcision

In contrast to all other prevention interventions, VMMC offers partial life-long protection against HIV. The government promotes multiple VMMC methods of circumcision including WHO prequalified devices and delivers VMMC services through several platforms including theatres, clinics and mobile camps. There is strong evidence that the use of circumcision devices is popular among men. Considering resource limitations and the need for efficiency, implementation of VMMC has been prioritized in high HIV burden districts and in the 25-39 years age-group. Since HIV incidence is declining it is important to continue with the judicious implementation of the VMMC programme so that this intervention remains cost-effective.

The mid-term review found that VMMC targets were missed mostly due to space and skills limitation at facility level. Thus, increasing VMMC coverage will require substantial investment into infrastructure and expanding the availability of service providers. Overall, demand for VMMC continues to be a challenge especially among older men who are concerned with privacy and fear loss of income during the recovery period following circumcision. Thus, VMMC uptake may improve by providing various forms of incentives, increasing the number of skilled providers, supporting awareness campaigns on circumcision devices and increasing accelerating access to.

Objective 1.3.1: Increase social acceptance, demand, access, uptake and of quality VMMC services targeting partners of AGYW and other high risk vulnerable populations in all high incidence districts.

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

Strategic interventions

1. Expand the availability of quality VMMC through decentralisation of services for males 15-49 including partners of AGYW in health centres, private sector facilities, and other institutions.
2. Strengthen VMMC commodity supply chain management at all levels through appropriate forecasting and monitoring.
3. Improve monitoring of program indicators to establish a comprehensive response, flexible M&E system taha can support and meet the demands of the program across all levels of the system.
4. Strengthen the use of a wide range of disciplines, populations including marketing, behavioral economics, and human-centered design, to inform targeted demand-generation strategies.
5. Integrate VMMC demand creation across all health entry points, including PrEP, STI.

5.1.4 Adolescent Girls and Young Women

Young people, especially AGYW, are highly vulnerable to HIV infection compared to older people. Factors associated with AGYM vulnerability are multifactorial including biological[55], behavioural and structural (age difference between partners, poverty, illiteracy, lack of comprehensive knowledge about HIV, power imbalance with their sexual partners and poor access to quality SRH services). In the 2020-2025 NSP, the government developed and started delivering a package of interventions to reduce AGYW's vulnerability to HIV. It also established the AGYW Secretariat, as an agency for promoting multisectoral coordination for AGYW-related programs.

The Mid-Term Review found epidemiological model evidence of marked reduction in the number of new HIV infections among AGYW. However, no information was available on program outcome indicators to adequately assess the success of the AGYW programs and their contribution to the apparent reduction in HIV incidence. Although research evidence found no impact of the AGYW-focused DREAMS program in South Africa on incidence of HIV and HSV, and on VLS among HIV infected AGYW [56] and in Malawi we found a lack of impact across all districts where the of the DREAMS intervention was implemented [57] , it may be too early to discontinue or revise the on-going AGYW programs in Malawi considering the potential wider impacts of the interventions beyond HIV. Nevertheless, efforts will be made to closely monitor and evaluate ongoing AGYW programs.

The revised NSP will intensify the delivery of prevention package for AGYW and their male partners including HIV status ascertainment, condom promotion, STI screening and management. Integrated SRH/STIs/GBV prevention and management for AGYW and male sexual partners will be provided at both health facility and through outreach services in the communities where AGYW and male sexual partners including ABYM will access condoms and lubricants, PrEP, family planning and other prevention communication and information. The Revised NSP maintains most of the objectives and strategic interventions such as comprehensive sexuality education, social protection and addressing human rights barriers related to prevention for AGYW and their sexual partners. The revised NSP will focus on reaching middle-aged men who are the partners and main source of new infection for AGYW with intervention such as targeted testing, ART linkage, treatment support for viral load suppression, VMMC and PrEP. The Revised NSP maintains most of the objectives and strategic interventions but emphasizes on the need to monitoring and evaluation of the interventions.

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[55] Untreated men are 3.9-times more likely to transmit HIV than untreated women. See also Section 2.2 on page 22 ff.

56 Mthiyane, Nondumiso Baisley, Kathy; Chimbindi, Natsayi; et al. The association of exposure to DREAMS on sexually acquiring or transmitting HIV amongst adolescent girls and young women living in rural South Africa. AIDS 36(Supplement 1):p S39-S49, June 15, 2022. | DOI: 10.1097/QAD.0000000000003156

57 Wolock TM, Flaxman S, Chimpandule T, et al. Subnational HIV incidence trends in Malawi: large, heterogeneous declines across space. medRxiv [Preprint]. 2023 Feb 4:2023.02.02.23285334. doi: 10.1101/2023.02.02.23285334.

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

AGYW Program 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

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 YFHS and combination SRHR/HIV services including post-violence care for AGYW and their male sexual partners including ABYM and middle-aged men by scaling up locations beyond the health system to community and youth centres.
3. Increase HIV communication, information and demand creation for AGYW and their males sexual partners through community-based, digital, and private sector avenues.
4. Expand and intensify existing life skills and CSE modules and SRH and HIV education for in-school and out-of-school youth.
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 with a focus on high burden districts.
6. Provide nutritional education, screening and support for AGYW living with HIV, including refugee AGYW

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

Strategic interventions

7. Reduce human rights related barriers to HIV prevention for AGYW to create an enabling environment to support girls; end child marriage, sexual abuse, and stigma; promote HIV prevention; and recognise the rights of women and girls.
8. Support social protection interventions for AGYW to address barriers preventing vulnerable girls from attending or staying in school.
9. Accelerate the building of social support and increase AGYW resilience through delivery of evidence-based social and economic assets interventions of vulnerable AGYW.
10. Strengthen the multi-sectoral M&E system for AGYW programs to generate data and to assess the cost-effectiveness of various AGYW packages.
11. Support the implementation of the “Male Engagement Strategy” to enhance behavioural change and service utilization, including HTS and ART access, among male partners of AGYW.

12. Promote the delivery of stigma-free non-judgemental health and social services for young girls engaging in sex work.

5.1.5 Key and Vulnerable Populations

In Malawi, FSWs, male sex workers (MSWs), MSM, TGs, PWID, people in prisons and other enclosed settings are classified as Key Populations while vulnerable and priority population include migrant labourers, persons displaced due to emergencies, uniformed personnel, fishermen, men who purchase sex, clients of female sex workers, children of female sex workers, Young women with multiple sexual partners, persons with disabilities and orphans and other vulnerable children (OVC). As the epidemic contracts, the share of new infections among key and vulnerable populations (KVPs) is predicted to increase. Key populations experience stigma, discrimination, and legal barriers that prevent them from accessing prevention services and care. Vulnerable populations such as people with disabilities; people displaced in emergency settings; and migrant labourers who work on tobacco estates or sugar, tea, and coffee plantations, mines, infrastructure projects, or sugar, tea, and coffee plantations face logistical barriers to accessing care. In general, the vulnerable populations are at a higher risk for poor health outcomes because of the barriers they experience due to social, economic, political, and environmental resources, as well as limitations due to illness or disability.

Since the launch of the 2020-2025 NSP, several strategies have been implemented to increase access and reduce barriers to health services among KVPs. Notably, Malawi has adopted and implemented differentiated models of service delivery (DSD) to optimize access and uptake of integrated HIV services by KVP. These include the use of drop-in centres, community service delivery model and use of KP –friendly public health facilities. Malawi has also prioritized interventions aimed at addressing structural barriers that increase the vulnerability of KVP to HIV and violate their rights (detailed in the “Reducing Human Rights and Gender-related barriers” Pillar of this strategy). In addition, coordination of KVP programs has been strengthened through the establishment and support of KP TWGs and KP-focussed institutions. The commencement of community-led monitoring programs is expected to generate data on the quality-of-service provision to KVP.

To specifically address the issue of OVC, Government of Malawi developed a Child Protection Case Management Framework which describes the management of children experiencing abuse, neglect, violence, exploitation, and the impact of HIV and AIDS. Over the course of implementing the 2020-2025 NSP, there were plans to scale up case management approach in high HIV burden districts to protect all vulnerable children. However, implementation was adversely affected because of a shortage of Child Care Protection Workers (CCPWs) as there was only one CCPW per traditional authority. The majority of the CCPWs were not formally trained and those trained were trained a long time ago. Normally, CCPWs visit households with vulnerable children where they monitor, among other things, the nutritional status of the vulnerable children and support ART adherence. However, the home visits were limited by inadequate mobility capacity, logistical support, long distances and large geographical areas covered.

The revised NSP will address challenges identified in the Mid-Term Review such as poor coverage of community-led monitoring, parallel M&E systems for KVPs, limited coverage of DICs and moonlight services, sub-optimal coverage of training of KP-friendly providers, stock outs of HIV self-testing kits and STI drugs and lack of reliable population estimates and HIV prevalence data for PWUDs and TGs. It will also intensify the use of community-led and peer-led approaches for enhancing quality and coverage of services. Special attention will be made to focus strengthen governance and emergency preparedness for delivery of HIV services in emergency settings

to reduce vulnerability of affected populations and minimize disruption of HIV care provision in these settings.This revised NSP will also focus on building the capacity of CCPWs and addressing resources challenges that affect their operations. Additionally, it will focus on 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.

OVC Targets

- Recruit and train 574 CCPWs, to increase the CCPW population ratio to 1 per 6,825 from the current baseline of 1 per 12,000
- Increase the number of CCPWs on government payroll from 275 to 750

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

KP Coverage Targets

- 90% of 45,000 FSW receive combination prevention services, including annual HIV testing for those not previously diagnosed.
- 33% of 39,000 MSM receive combination prevention services, including annual HIV testing for those not previously diagnosed.
- 90% of prisoners are tested at entry and annually for HIV and receive their results.
- 95% of newly diagnosed HIV positive KPs are initiated on ART.
- 95% of KPs initiated on ART are virally suppressed.

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. Promote PrEP uptake and continuity among KVP, focusing on long-acting injectable PrEP (CAB-LA) for SW and other KVP with long-term continuous risk behaviour.
6. Scale-up delivery of a standard comprehensive package for FSWs, their children and clients, MSM, MSW, and TG including other vulnerable and priority populations, provision that includes HIV prevention, treatment, care, and support services; SRHR; GBV; and community mobilisation.
7. Scale-up implementation of social network strategy and community-based and self-HIV testing for KP coupled with access to combination preventive interventions or ART linkage, retention in care, and ART adherence.
8. 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. Support the design and implementation of representative surveys to estimate the population size and coverage of key HIV indicators among FSW, MSM, PWUDs, MSW, and TGs.
2. Coordinate research and implementing partners to understand findings on interventions targeting FSW, PWUDs, MSWs, and TGs to inform the development of interventions.
3. Establish and scale up pre-service and in-service training in KP-friendly service provision.
4. Establish a robust but confidential M&E system for KVPs that generates accurate and timely data on KVP's access to health and social services.
5. Strengthen documentation, reporting, monitoring of human rights violations against KVPs, including community-led monitoring.
6. Sustain access to combination preventions services by maintaining coverage of safe spaces such as DICs and youth clubs.
7. Finalize size estimate studies for PUDs and TGS and disseminate findings to enhance planning for services.
8. Support the development and implementation of harm reduction programs for PUDs and their partners focussing on high HIV burden urban districts.
9. Enhance the quality of peer-led demand creation products for PUDs through the development and scale-up an all-encompassing integrated communication and demand creation tool kit.
10. Scale up HIV prevention communication, information, and demand creation for KVPs.
11. Enhance the performance of KP-led organizations through mentorship and supervision.

Objective 1.5.3: To scale up HIV sensitive child protection case management in high HIV burden districts.

Strategic interventions

1. Improve coordination and referral systems at national and district levels.
2. Strengthen the monitoring and reporting of vulnerable children.
3. Build the capacity of Community Child Protection, including training CCPWs in Community Management of Malnutrition (CMAM)
4. Strengthen resource mobilisation at all levels, including lobbying the Malawi Government and Local Government Authorities (LGA) to increase the number of CPWs on government payroll, to increase and sustain investments into the HIV sensitive Child Protection Case Management System
5. Strengthen SBCC activities at community level for the communities to adhere to child rights.
6. Mobilise communities to operate structures for child protection and development

Objective 1.5.4: 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 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. Intensify coordination and outreach to people in humanitarian settings to ensure HIV treatment continuation, through provision of the initial minimum package of HIV services (including combination prevention) and expanding to comprehensive services.
6. Establish and scale up pre-service and in-service training in KP-friendly service provision.
7. Establish a robust but confidential M&E system for KVPs that generates accurate and timely data on KVP's access to health and social services
8. Strengthen documentation, reporting, monitoring of human rights violations against KVPs, including community-led monitoring.
9. Sustain access to combination preventions services by maintaining coverage of safe spaces such as DICs and youth clubs.
10. Finalize size estimate studies for PUDs and TGS and disseminate findings to enhance planning for services.
11. Support the development and implementation of harm reduction programs for PUDs and their partners focussing on high HIV burden urban districts.
12. Enhance the quality of peer-led demand creation products for PUDs through the development and scale-up an all-encompassing integrated communication and demand creation tool kit.
13. Intensify coordination and outreach to people in humanitarian settings to ensure HIV treatment continuation, through provision of the initial minimum package of HIV services (including combination prevention) and expanding to comprehensive services.
14. Scale up HIV prevention communication, information, and demand creation for KVPs.
15. Enhance the performance of KP-led organizations through mentorship and supervision

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

In Malawi, the use of lifelong ART among pregnant women living with HIV (Option B+) since 2011 has led to significant reductions in the annual number of paediatric HIV infections to 2500 in 2022 from 15,000 in 2010. Nevertheless, the rate of mother-to-child transmission at the end of the breastfeeding period is estimated at 7.4%, which is short of the target of <5%. In the 2020-27 NSP Malawi adopted WHO recommendations to eliminate mother-to-child transmission of HIV, viral hepatitis, and congenital syphilis (triple elimination). As of

2022, HIV and syphilis screening was well established in most health facilities while screening for viral hepatitis only started in 2022 in some facilities but plans for scale up are underway. Malawi is also implementing several revised guidelines and innovations such as the HIV three-test algorithm; Hepatitis B birth dose vaccine; secondary distribution of HIVST kits through antenatal and postnatal clinics; repeated HIV testing of pregnant and breastfeeding mothers; enhanced HIV prophylaxis for HIV-exposed infants; and the use of point-of-care (PoC) diagnostic tests for early infant diagnosis (EID) of HIV.

This revised NSP will address challenges identified during the Mid-Term Review particularly poor implementation of syphilis and viral hepatitis screening guidelines among pregnant women; sub-optimal retention of mothers-infant pairs (MIP) in eMTCT care and low EID coverage coupled with long turn-around time for EID testing. It will capitalize on the MoH plans to hire community midwife assistants who are expected to champion community-based programs that provide a continuum of care for MIPs.

Targets

- Reduce the MTCT rate at the end of the breastfeeding period from 7.6% to less than 5% by 2027
- 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 2027
- 95% of antenatal mothers are screened for syphilis
- 95% of antenatal mothers with syphilis receive treatment
- 95% of antenatal mothers are screened for hepatitis
- 95% of antenatal mothers with hepatitis are assessed and/or receive treatment

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. Increase demand for HIV combination prevention and SRH services among at-risk AGYW, FSWs, young mothers, and pregnant and breastfeeding women
2. Empower women of childbearing and their partners to make informed decisions to seek HIV prevention and other related (FP, SRH) services
3. Increase access and uptake of comprehensive biomedical HIV prevention services (PrEP, STI screening, VMMC, Condoms, HTS) among AGYW, FSWs, young mothers, and pregnant women and their partners.
4. Intensify provision of integrated and youth-friendly health services (YFHS) to AGYW and Adolescent boys and young men
5. Scale up engagements with male partners of high-risk AGYW, pregnant and breastfeeding women and reach them with evidence-based combination prevention interventions including PrEP.

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

Strategic interventions

1. Intensify counselling and provision of wide range of family planning methods to HIV positive women

2. Scale up integration of family planning services with other SRH/HIV service to expand coverage

Objective 1.6.3: To prevent vertical transmission of HIV, viral hepatitis and syphilis through screening and identification of women and their partners during pregnancy and breastfeeding.

Strategic interventions

1. Strengthen integrated testing for HIV, viral hepatitis, and syphilis for triple elimination among pregnant and breastfeeding women including young pregnant mothers and their partners in both public and private facilities
2. Enhance retesting of at-risk HIV-negative mothers during delivery and breastfeeding period in maternal and child health, under-five, and postnatal, family planning clinics.
3. Scale up access to HIV testing among male partners of high risk pregnant and breastfeeding women (through secondary distribution of HIV self-test kits and index and family testing) and link them to ART initiation and adherence support or combination preventive interventions.
4. Scale up treatment of syphilis in pregnant and breastfeeding women and their partners
5. Intensify initiation and monitoring of newly HIV and Hepatitis B 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 infant to ART treatment, viral load monitoring and support adherence and retention through strengthening of CBOs
2. Improve screening, monitoring and follow-up of HIV exposed infants including at immunization, under-five, TB, in-patient visits and campaigns
3. Scale-up mother-infant pairs clinics for HIV positive breastfeeding women and their exposed infant.
4. Strengthen adherence support by recruiting social workers to provide psychosocial support services for pregnant and breastfeeding women on ART.
5. Scale up coverage of enhanced postnatal prophylaxis for HIV-exposed infants and PoC devices for diagnosis
6. Strengthen routine quality improvement initiatives for EID services including mentorship of staff.
7. Support the CHW recruitment and engagement (community midwife assistants) for enhanced community-based strategies; male involvement in EMTCT services, defaulter tracing, testing services and retention in care for MIPs.

5.1.7 Sexually Transmitted Infections and Sexual and Reproductive Health Services

STIs are known risk factors for HIV transmission and acquisition and poor reproductive and birth outcomes. 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. Human Papilloma Virus, one of the STIs, is a risk factor for cervical cancer and the risk is

markedly high in HIV-infected women. The WHO recommends STI services as part of a comprehensive HIV prevention package. For a long time, Malawi has been using the syndromic management approach (SMA) for diagnosing and treating STIs. The SMA approach requires adequate supply of antibiotics to treat multiple STIs. Inappropriate use of antibiotics leads and fuels emergence of drug resistance.

During the implementation of the 2020-25 NSP, STI management services have continued to be integrated with several service delivery platforms, including antenatal and family planning clinics, HIV clinics and VMMC clinics to improve case detection and access to treatment. Peer-led approaches have been used to extend STI management services to key and vulnerable populations and the youth. In addition, cervical cancer screening services are continuously being scaled up in health facilities and have been targeted on women living with HIV (WLHIV) who are at high risk of developing cervical cancer. Viral hepatitis screening has also been introduced for STI clients. Capacity had been established in eight laboratories to monitor resistance to *Neisseria Gonorrhoea*, one of the STIs. The Mid-term Review found fair coverage of STI screening among PLHIV (91%) and KPs but sub-optimal syphilis screening among antenatal mothers (79%). Also, there was poor cervical cancer screening among WLHIV. There is emerging evidence of the rising burden of female genital schistosomiasis (FGS) estimated around 21.5% in endemic districts such as Nsanje and Chikwawa. FGS is often confused with a recurrent STI by most clinicians and is associated with HIV infection.

This revised NSP will address significant challenges identified in the Mid-Term Review that affect the implementation of the STI programme such as frequent STI drug stockouts; poor collaboration between the public and private facilities in the provision of integrated STI/SRH services; poor STI management and referral and misdiagnosis of female genital schistosomiasis (FGS) as STIs in some areas. Recent studies have shown the feasibility of cervical self-sampling techniques and HPV testing using widely available GeneXpert machines as a way of scaling up cervical cancer screening 58. The revised NSP will utilize this innovation to improve cervical cancer screening coverage in WLHIV.

Objective 1.7.1: To increase access and uptake of quality STI and other SRH services delivery points, including family planning, cervical cancer, syphilis, and post-sexual violence care.

STI and SRHS Coverage Targets by 2025

- 98% HIV status ascertainment for STI
- 95% of STI clients are tested for hepatitis
- 95% of STI clients with hepatitis are assessed and/or receive treatment
- 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

Strategic interventions

1. Improve demand, access, and utilisation of STI screening and treatment to all populations and other vulnerable populations (OVP)

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58 Chinula L, Topazian HM, Mapanje C, et al. Uptake and safety of community-based "screen-and-treat" with thermal ablation preventive therapy for cervical cancer prevention in rural Lilongwe, Malawi. Int J Cancer. 2021 Jul 15;149(2):371-377. doi: 10.1002/ijc.33549.

2. Strengthen quality of STI/SRH services including STI commodity security in both public and private facilities.
3. Strengthen engagement and collaboration with the private sector on STI, hepatitis and HIV prevention service delivery
4. Strengthen integration of service delivery of STI, hepatitis and SRH services including family planning, cervical cancer screening including treatment services and management of post-sexual violence.
5. Strengthen monitoring of antimicrobial resistance for STI with focus on Neisseria gonorrhoeae
6. Scale up to high quality STI services that are linked to combination HIV prevention interventions, including PrEP, for HIV-negative subjects and ART for HIV-positive subjects.
7. Scale up cervical cancer screening through cervical self-sampling techniques and HPV testing using GeneXpert machines.

5.1.8 Wellness and Workplace HIV Programmes

The Malawi government recognizes that the workplace may create environments that promote HIV transmission but may also be used as a platform for implementing HIV interventions. As such, in 2010, 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 Department of Human Resource Management and Development was mandated to coordinate the HIV and AIDS Workplace Policy in the public sector while the Malawi Business Coalition against HIV and AIDS (MBCH) is mandated to do the same in the private sector. In the public sector the government introduced and has been implementing a policy of allocating 2% of the "Other Recurrent Transaction (ORT)" budget to support the implementation of HIV Workplace policies.

This NSP will address challenges identified in the Mid-Term review such as lack of an approved National HIV and AIDS Workplace Policy; outdated institutional workplace policies; poor implementation and oversight over workplace policies and unstructured utilization and monitoring of 2% ORT budget allocated to support workplace policy implementation and lack of high-level commitment to implement workplace policies in the private sector.

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

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 MBCH 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
7. Support efforts to accelerate the revision and approval of National HIV and AIDS Workplace guidelines
8. Implement high-level advocacy campaigns for increased ring-fenced budget allocation to Wellness and Workplace HIV programs in both the public and private sector
9. Develop and implement guidelines for the utilization of funds allocated to Wellness and Workplace HIV programs in the public and private sector and support institutions in the operationalization of the programs
10. Develop and implement a robust M&E system for Wellness and Workplace HIV programs.

5.1.9 Blood Safety

Prevention of transfusion-transmitted infections (TTIs) is an integral part of combination prevention. In Malawi, the Malawi Blood Transfusion Services (MBTS) is mandated to screen blood units for TTIs and distribute safe blood units to health facilities. In this regard, the MBTS has set up robust quality control and assurance and M&E systems and has consistently achieved near-universal screening of blood for TTIs. However, it has been unable to meet demand from health facilities. Efforts have been made to 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. During the initial period of the 2020-2025 NSP, MBTS successfully established sentinel sites for blood collection and screening and component preparation in all major hospitals. Nevertheless, due to MBTS inability to satisfy demand, some health facilities independently collect, screen and transfuse blood. Periodically, epidemics and disasters such as COVID-19 and floods disrupt blood collection exercises and worsen the blood supply gap, thereby increasing the proportion of blood supplies collected, screened and transfused at health facility levels. Due to lack of quality assured testing facilities at these facilities, there is a risk of TTIs.

This revised NSP will address the challenges identified in the Mid-Term Review such lack of capacity for establishing highly sensitive nucleic acid amplification tests (NAAT) testing for viral hepatitis; limited resources for blood screening; and sub-optimal infrastructure in districts for blood banks.

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

Strategic interventions

1. Set up sentinel sites for blood collection, screening, and distribution and all major hospitals
2. Increase investment for blood bank infrastructure at district level.
3. Establish capacity for conducting NAAT at MBTS to optimize diagnosis of transfusion transmitted infection.
4. Devise evidence-based strategies for long-term engagement of regular blood donors.

5.2 Pillar 2: Differentiated HIV Testing Services

The 2023 HIV Spectrum estimates indicate that there are currently 95,000 undiagnosed PLHIV within the Malawi population and the GOALS model has disaggregated them by age, sex and population. Out of these, other men represent 41%, other children 23%, other women 15%, STI clients 10%, partners of ANC women 6% and partners of index clients 2%. Key and priority populations, such as female sex workers and men who have sex with men, represent 1% each, whilst people who inject drugs, ANC women and children born to HIV positive women represent less than 1% each. The majority of these are in the Southern region and the cities.

Malawi will continue making HTS available to all populations including other men, women and children, breast feeding women, key populations, refugees, migrant labourers, prisoners, students in higher education institutions, people living in cities, asylum seekers and the internally displaced populations. However, special focus will be on other men and children. Various approaches for differentiated HTS have been adopted and will be scaled up (integrated, mobile, out-reach, index, PITC and self-testing); innovative ways of mobilizing marginalized or hidden populations for HIV testing (social network strategy); and different types of partner notification (passive and active assisted or unassisted). Provision of HTS and subsequent ART to FSW and their

clients could avert 34% HIV infections. Status neutral testing approach will also be used to ensure that individuals – irrespective of one's HIV serostatus – receive the appropriate referrals, whether to initiate ART treatment, re-engage in care, or to receive appropriate prevention services.

Approaches to increase uptake of HTS services for men include primary and secondary distribution of HIVST kits in both formal and informal workplaces, during PrEP refills, to KPs in DICs for their partners and also to pregnant and breastfeeding women for their sexual partners, PITC, venue-based testing, index testing social network testing, family testing and male friendly service provision. Approaches to reach the undiagnosed children include Routine PITC in high burden districts in OPD, under five clinics, nutrition and paediatric wards, also family testing, safe index testing for biological children of index clients as well as distribution of HIVST kits to eligible children according to the age of consent. Testing will also be intensified at the community level through integration with immunization (EPI) and IMCI outreach and village clinics. The Government (included in the HSSP III) has committed to recruit community midwife assistants (CMAs) who will be trained and resourced to reach people with testing and counselling services within their communities especially those living in hard-to-reach settings.

High rates of awareness especially in previously diagnosed PLHIV have led to declining positivity among clients tested for HIV. In order to identify the remaining long-term infected PLHIV, the 2022 HIV, Syphilis and Hepatitis B integrated rapid testing and counselling guidelines and standard operating procedures for Malawi include policies on triple testing for HIV, syphilis and Hepatitis B, three-test algorithm for HIV diagnosis and use of scan form technology to digitalise data. Malawi has been using a 2-test algorithm to diagnose clients living with HIV, however, with the declining positivity in the population tested of below 5%, the 3-test algorithm was adopted as per the WHO normative guidance to prevent false positives. HIV, syphilis and Hep B tests need to be quality assured. Quality of testing at facility level must be validated through bi-annual proficiency testing and weekly quality controls (QCs), coordinated by the National HIV Reference Laboratory (NHRL) at all testing points within facilities. At central level, all new test kit shipments should be subjected to batch specific QA at the NHRL.

Objective 2.1.1: Increase access, uptake and quality of HIV, syphilis and Hepatitis B testing and counselling services among high-risk key and priority populations through proven innovative approaches.

Targets

- Conduct 21.3 million HIV tests
- Conduct 6.9 Million syphilis tests
- Conduct 4.3 million Hepatitis B tests
- Diagnose 95% of all PLHIV
- Link over 95% of diagnosed clients to treatment
- Support the recruitment of 10% of the 1859 community midwife assistants planned in the HSSP-III, to support of HTS delivery

Strategic interventions

1. Improve case finding among high-risk key and priority populations including other women, men and children through implementation of high impact interventions.
2. Strengthen quality assurance for HIV, Syphilis and Hepatitis B diagnosis.

3. Strengthen linkage of HTS clients irrespective of their status to comprehensive prevention, treatment and re-diagnosis for re-engagement services

Objective 2.1.2 Strengthen health systems for HIV, syphilis and Hepatitis B testing and counseling services at all levels.

Strategic Interventions

1. Integrate testing in other key health services such as SRH, Prison, IMCI, EPI, YFHS and TB
2. Improve testing data management at all levels.
3. Strengthen use of evidence-based interventions and best practices through operational research and M&E.

5.3 Pillar 3: Treatment, Care and Support for HIV/AIDS and Related Diseases

Using the “Universal Test and Treat policy” by December 2022 Malawi had surpassed the second “95” and almost achieved the third “95” of the 95-95-95 treatment targets in adults aged 15 and above. However, the country is lagging in children, adolescents, and males. The Ministry of Health (MoH) also successfully transitioned to Dolutegravir-based ART which is more tolerable and more potent. With nearly 1 million people on ART, the country has been implementing various types of differentiated service delivery models to ease congestion in ART clinics. To ensure quality of care for PLHIV, Malawi revised its HIV Clinical Guidelines to incorporate new WHO recommendations. Some of the major changes include new treatment regimens for HIV-related co-infections and cancers; introduction of rapid CD4 count test for new ART clients; use of 3HP as TB-preventive therapy; mental health and substance abuse screening for patients with poor adherence; new viral load monitoring schedules; enhanced pharmacovigilance and others.

This revised NSP will address key challenges identified in the Mid-Term Review such as sub-optimal retention rates; variable provision of integrated HIV/NCD services (especially for hypertension, diabetes and depression); poor access to ART services in some rural (hard-to-reach) areas; poor ART adherence among adolescents; transition problems to adult care among ALHIV in teen clubs; poor virological suppression in children; sub-optimal quality of management of PLHIV with advanced HIV disease and long turn-around time for viral load test results. Many of these challenges stem from health system constraints in the areas of human resource capacity, infrastructure, supply chain management and community systems. Thus, the NSP will support efforts that create a resilient and sustainable system for health (Pillar 8). It will leverage on various reforms and initiatives articulated in the HSSP-III. In addition, it will scale up successful program innovations such as the use of SMS for communicating viral load results to PLHIV on ART.

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

Targets

- To reach 1,015,000 people on ART by 2027.
- To improve paediatric ART outcomes and coverage from 68% to 85% by 2027.
- To reduce morbidity and mortality among people living with HIV through integration with other HIV related comorbidities like cancers, NCD, HIV-Hepatitis coinfection, mental health).

- Scaling up Advanced HIV Disease (AHD) services coverage from 35% to 70% by 2027
- Reach 95-95-95 treatment targets among all sub-populations including children, adolescents and men by 2027.
- Improve retention in HIV care at 12 months from 81% in 2023 to 85% by 2027.
- Improve the quality of HIV services, through increased access, ART drug resistance monitoring, viral load monitoring.
- Strengthen resilient and sustainable health systems that will enable effective response to HIV and AIDS and other epidemics that may threaten the gains already made.

Strategic interventions

1. Improve access to high-quality ART (HIV and viral hepatitis), NCDs and cancer services for adults, children, and vulnerable/underserved populations.
2. Improve retention and adherence in ART among adults, KP, adolescents, and children, through enhanced personal community mentorship and support systems (peer navigators, treatment supporters and expert clients).
3. Improve treatment monitoring for HIV, Viral Hepatitis and NCDs (viral load, drug resistance and ARV toxicity monitoring)
4. Improve viral load turnaround time and timely delivery of viral load results to site level providers and recipients of care, using modern telecommunication technology.
5. Strengthen community structures and systems to improve and expand ART access.

Objective 3.1.2: To increase paediatric ART outcome and coverage from 68% to 85% by 2027.

Strategic interventions

1. Improve access to high-quality ART services for children.
2. Improve retention, adherence, and viral load suppression in children through promotion of child-focused ART clinic model.
3. Improve treatment monitoring (Viral Load, drug resistance and ARV toxicity monitoring)
4. Improve timely delivery of viral load results and viral load results utilization.

Objective 3.1.3: To reduce AIDS, non-AIDS mortality, and co-morbidities.

Strategic interventions

1. Improve monitoring and management of advanced HIV disease including cancers.
2. Strengthen community-based support system for PLHIVs by developing a resource package to support the operations of community health workers (HSAs, community midwife assistants) and volunteers (expert clients, treatment supporters, adherence counsellors etc).
3. Strengthen Capacity of secondary and tertiary facilities to manage PLHIV and other comorbidities.
4. Improve Viral load, toxicity, and ART resistance monitoring for PLHIV.
5. Improve management of opportunistic infections.

6. Strengthen coordination of treatment, care, and support at national and district level.

5.4 Pillar 4: TB/HIV

Tuberculosis is the commonest opportunistic infection among PLHIV which contributes to significant morbidity and mortality. Malawi's Ministry of Health (MoH) recommends symptom-based routine TB screening and TB preventive therapy (TPT) using Isoniazid-Rifapentine (3HP). Radiologic, molecular and urine-LAM are the recommended TB screening methods for TB in PLHIV suspected to have TB. MoH also recommends universal HIV screening in all patients diagnosed with TB. HIV/TB Committees were established at facility-level to coordinate implementation of diagnostic and treatment activities. In 2022, the HIV/TB program has consistently achieved high coverage of HIV testing among TB patients and high coverage of TB screening among PLHIVs. TPT coverage among new ART clients is also very high (96%).

The revised NSP will address challenges identified in the Mid-Term Review such as over-reliance of sputum microscopy to investigate PLHIVs suspected of TB, low contact tracing of adult contacts of pulmonary TB patients, diagnostic challenges among children due to lower sensitivity of chest X-rays and sputum, lack of data on TPT completion rates, lack of toxicity data among ART patients co-treated for TB, intermittent stock outs of 3HP and inconsistent operations of HIV/TB Committees. TB diagnostic capabilities will capitalize on the wide availability of GeneXpert machine in secondary-level and some primary care health facilities.

Objective 5.4.2: To reduce incidence of TB in PLHIV

Targets

- 99% of PLHIV on ART are screened for TB.
- 90% of PLHIV on ART initiated on TPT.
- 90% of PLHIV on TPT to complete prophylaxis.
- 95% of child contacts of adult TB patients are screened for infection.

Strategic interventions

1. Strengthen TB/HIV collaborative and coordination activities at all levels (community, district and national).
2. Increase coverage of TB Preventive Therapy (TPT)
3. Improve adherence support to PLHIV on TPT.
4. Provide patient education on TPT benefits and risk of developing active TB disease.
5. Screen and effectively manage TPT side effects.

Objective 5.4.3: To reduce morbidity and mortality in TB/HIV co-infected patients.

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.

Strategic interventions

1. Support implementation of routine HIV/TB death audits in central hospitals and sentinel district hospitals to identify service gaps that contribute to all deaths of patients with Tb who are HIV positive.
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. Conduct training in FASH to improve access to quality service care delivery for co-infected PLHIV.
4. Conduct HIV/TB training for service providers in non-partner supported prisons to intensify TB case finding among PLHIV.
5. Conduct clinical mentorships to cover health care provider knowledge gap on TPT.
6. Comprehensive management of PLHIV diagnosed with TB.
7. Strengthen HIV/TB committees.

5.5 Pillar 6: Reducing Human Rights and Gender-Related Barriers

PLHIV and key populations and other marginalized groups, including people with disabilities, experience various forms of human rights violations which limits their access to quality health and social services. Similarly, gender inequality hinders social and economic development. Malawi is a signatory of the UN Political Declaration on HIV and AIDS (2021) which seeks to end all forms inequalities (social, economic, racial, gender and others) that drive the AIDS epidemic. In addition, it has passed various pieces of legislation aimed at eliminating inequalities. These include the Malawi Constitution, Gender Equality Act and the HIV Prevention and Management Act.

Noting that lack of legal awareness contributes to the perpetration of human rights violations, the 2020-25 NSP sought to eliminate human rights and gender-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. As part of this strategy, PLHIVs and key populations were required to take a lead in creating awareness about the rights of PLHIV and key populations. Since some social and cultural norms promote violation of human and gender rights, the NSP recognized/prioritized the participation of local structures and players sometimes entrenched in the delivery of comprehensive community packages to promote human and gender rights. To mitigate the harms associated with GBV, the NSP focused on promoting a package of clinical and social services will be promoted and provided to GBV survivors. Over the course of implementation of the NSP extreme weather events and epidemics caused marginalized of certain communities and predisposed them to various forms of human rights violations, including sexual exploitation and disruption of health and social services.

This NSP 2020-2025 will address challenges identified in the Mid-Term Review such as incomplete coverage of legal awareness campaigns, lack of robust systems for documenting and reporting human and gender-rights violations, low coverage of training of health care workers in KP-friendly health services delivery and sub-optimal coverage of community-led monitoring. The NSP will also incorporate HIV prevention, care, treatment and support services and part of the relief package for people affected by disasters.

Objective 6.1.1: To reduce stigma and discrimination against PLHIVs

Target

- Zero discrimination for PLHIV and KP by 2030

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 legal services for PLHIV for issues relating to discrimination, violence protection and other human rights.
3. Strengthen the legal environment for PLHIV, 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 raise awareness and knowledge by the general public, social service providers, law enforcers and judicial officers on human rights and gender equality.
3. Strengthen capacity of community-based structures and KP-led organizations to lead the implement community-based HIV service delivery and community-led monitoring.
4. Establish a robust documentation and reporting system for human rights violations experienced by key and vulnerable populations.
5. Strengthen programs to prevent and respond to gender-based violence and conflict-related sexual violence by adopting a multisectoral and survivor-centred approach.
6. Accelerate the dissemination of provisions of the HIV Prevention and Management Act, Gender Equality, Prevention of Domestic Violence Act and other laws that safeguard and promote human and gender-related-rights, targeting duty bearers and community leaders, including in formats accessible to people with disabilities.
7. Develop and roll-out a standardized package of care and referral for GBV survivors

5.6 Pillar 7: Social and Behaviour Change Communication

Social and Behaviour Change Communication (SBCC) is the systematic application of interactive, theory-based and research-driven communication processes and strategies to address change at individual, community, and societal levels. The 2020-2025 NSP sought to increase 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. A strong foundation for SBCC has been established for implementing SBCC activities through the formation of the SBCC Technical Working Group, the launch of the Health Communication Strategy, 2021-2026, development of the Male Engagement Strategy and creating and filling post of Health Promotion Officers at district level.

Interpersonal communication has demonstrated to be key in provision of sensitive information. Social media is increasingly being used for health communication, especially among key populations and the youth.

This revised NSP will address challenges identified in the Mid-Term review such as limited coverage of SBCC interventions; weak implementation, coordination and monitoring and evaluation of SBCC interventions; and sub-optimal engagement of traditional and religious leaders to champion socio-cultural changes.

The NSP will contribute to increasing the uptake of HIV prevention, treatment and care services by implementing strategic activities that achieve three objectives as explained below:

Objective 7.1.1: To provide advocacy and strategic information to address underlying drivers of HIV infection

Strategic Interventions

1. Develop a successor HIV Prevention framework for Malawi for the period 2023-2027
2. Develop district, regional and national disability-friendly 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 a comprehensive TB and HIV treatment literacy programme among PLHIVs and their caretakers

Objective 7.1.2: To increase demand for HIV services amongst the general population

Strategic Interventions

1. 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
2. Expand the use of mobile and on-line communication technologies in the dissemination of SBCC messages to target populations including men and key populations
3. Strengthen SBCC coordination structures at national and district level and support their operations to ensure harmonization of SBCC efforts by stakeholders

Objective 7.1.3: To empower individuals, communities and institutions to adopt positive health, HIV and GBV services seeking behaviours

Strategic Interventions

1. Mobilise and build the capacity of existing structures and networks to address harmful cultural practices and gender norms that promote HIV transmission
2. Mobilise community structures to conduct community mobilization and sensitization activities to promote health-seeking behaviours among sexually active males
3. Recruit and engage leaders as champions/role models and ambassadors of HIV prevention at all levels including political, religious and traditional leaders

4. Conduct advocacy to raise resources as well as political and social leadership commitment to HIV actions and goals at district and local level
5. Promote male engagement activities to enhance access to and utilization of HIV services by men as proposed by the Male Engagement Strategy
6. Enhance engagement with religious and traditional leaders in advocacy campaigns to address human rights and gender-related violations within their communities
7. Intensity the use of social media for communication for key and marginalized populations., including the use of interactive virtual/digital platforms
8. Operationalize the Health Communication Strategy and Male Engagement Strategy to promote service utilization and address harmful gender norms by males.
9. Establish and/or strengthen M&E system for SBCC interventions
10. Develop and implement high-quality demand creation products using evidence-based approaches such as the "Human-Centred Design" model successfully piloted in the Blantyre Prevention Strategy.
11. Use granular data to identify sub-populations that needs to be targeted with SBCC interventions

5.7 Pillar 8: Resilient and Sustainable Systems for Health

Effective service delivery of biomedical interventions is critically dependent on a resilient health system that can withstand external shocks. Apart from funding, Malawi's strained health system constitutes the main bottleneck for scaling up HIV and related health services. The Global AIDS Strategy (2021-2026) priority number 3 calls for a fully resourced and sustainable response that is integrated into the health systems, among other sectors[59]. During the implementation of the National HIV and AIDS NSP 2020-2025, the Ministry of Health developed and launched the National Health Sector Strategic Plan III 2023-2030 (HSSP III) which aims to achieve the goal of universal health coverage. The HSSP-III includes a review and analysis of the successes and challenges associated with health care delivery, including HIV-related care. The HSSP-III resonates with a call from the Global AIDS Strategy (2021-2026) to enhance the delivery of patient-centred integrated health services. This section analyses health system components that are directly associated with the objectives of the National HIV and AIDS NSP 2023-2027.

[59] UNAIDS, 2021, End Inequalities. End AIDS. Global AIDS Strategy 2021-2026

6 Governance and Leadership of the Response

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. During the period of implementation of the 2020-2025 NSP, Regulations for the HIV and AIDS (Prevention and Management) Act of 2018 were developed to facilitate the implementation of its provisions. The NAC recommended the expansion of its mandate from coordinate HIV and AIDS programs to all health programs in the private sector, hence establishing the Malawi Business Coalition on Health. (MBCH) This is important in view of the multi-morbidity associated with HIV.

This revised NSP will address challenges identified during the Mid-Term-Review such as weak leadership of the HIV and AIDS response at district level; lack of awareness among stakeholders of the provisions of the NSP or the HIV Act and weak accountability of some partner organizations to the district authorities in implementing HIV and AIDS interventions.

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. Domesticate global HIV strategies, programs, and efforts at National level.
2. 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.
3. Mainstream the delivery HIV and AIDS messages in high level political, religious, and traditional speeches
4. Mainstream the delivery of HIV and AIDS services during cultural activities.
5. Capacitate leaders through targeted information provision on the key HIV and AIDS issues at the national and sub-national levels to effectively play their leadership roles in the response.

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
3. Continuous dissemination of the provisions of the HIV and AIDS Prevention and Management Act of 2018
4. Strengthen the continuous mapping of all implementing partners in all districts.

5. Support District Councils to develop MoUs with implementing partners to ensure reporting of HIV and AIDS interventions, preventing duplication of efforts, and monitoring of resources invested.
6. Strengthen the capacity of the offices of the Principal Nutrition HIV and AIDS Officers (PNHAO) to improve the coordination of the multi-sectoral HIV response at district level.
7. Support the dissemination of the provisions of the NSP and the HIV Act to all stakeholders at national and sub-national level.
8. Support the operationalization and enforcement of the HIV Act and regulations.
9. Strengthen the capacity of institutions that coordinate the implementation of the HIV and health-related programs among different sectors and stakeholders including the MBCH, MANASO, MIAA and MANET+

7 Financial Management

Sustainable funding is critical for delivery of the HIV and AIDS response. The national response is predominantly funded by multiple development partners, the Global Fund (GF) and US President's Emergency Plan for AIDS Relief (PEPFAR) remain the major funding agencies for commodities and programme implementation. The Malawi Government, on the other hand funds the cross-cutting health sector platform. The country has established control systems inform of public fiduciary management frameworks to govern the management of public funds. This is further resulted to the existence of the Project Implementation Unit (PIU) that provides oversight for GF resources with support from an independent fiscal agent. PEPFAR resources are channelled through Non-Governmental Organizations which manage the funds in accordance with US Government financial guidelines and management systems.

An analysis of resource needs against investments in the HIV and AIDS response depict a funding gap of MKW [costing to be completed] Required for comprehensive implementation of interventions to 2027. The current financial landscape calls for the need for deliberate resource mobilization, particularly on the domestic front. Through the HIV and AIDS Prevention and Management Act of 2018; the National AIDS Commission (NAC) is mandated to mobilize and equitably disburse resources towards the national response.

As part of the recently launched HSSP III, the Malawi Government has developed a Health Financing Strategy which includes a resource mobilization strategy. Key strategies include the need for private health insurance, public-private partnerships as well as tax hypothecation to finance the newly launched "health benefits package". Accountability and efficiency are key operative principles of the Health Financing Strategy, with several reforms already underway towards greater resource mobilization and accountability in the health sector. These include the enhancement of Local Authorities' role in public finance management, greater unification of payment systems to motivate donor alignment with Government systems, and a movement towards strategic purchasing that is key to ensuring resources are allocated based on population need and volume of services[60]. Despite these positive developments, the HIV and AIDS response predominantly depends on external funding due to the constrained national fiscal space exacerbated by the downstream effects of the COVID-19 pandemic, international conflicts and resulting economic instability, recurrent epidemics and national disasters and sluggish local economic growth. Unsurprisingly, over the first 2-years of the 2020-27 NSP, the Government has been unable to adhere to the commitments of the Abuja Declaration, requiring the allocation of 15% of the national budget to the health sector, with allocations averaging 10% over the period.

The Mid-Term-Review noted the expansion of coverage of health insurance for civil servants, operationalization of private clinics and wards in some government hospitals and strong commitment by the MBCH to enhance private sector engagement which will go a long way in kick-starting domestic resource mobilization for the health sector. The revised NSP will address challenges identified in the Mid-Term-Review such as limited engagement of the Ministry of Health Directorate of Finance in budget and expenditure oversight for vertical programs; limited resource tracking (National Health Accounts and National AIDS Spending Assessment were overdue)[61]; sub-optimal sharing of budget and expenditure data between Government and NGOs at district-level; and perceived weak grants management capacity at district-level. In the short to medium term, efforts will be made to strengthen the capacity of the NAC in resource mobilization.

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[60] Government of Malawi, 2023, National Health Strategic Plan, Ministry of Health

[61] The last NHA report was completed in 2022 but covered fiscal year 2018/19

Objective 8.2.1: To strengthen grants management

Strategic interventions

1. Support the implementation of the National Health Financing Strategy which includes sustainable HIV and AIDS financing
2. Support systems to periodically track available financial 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.

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 through strategies proposed in the Health Financing Framework
3. Mobilize donor support for health systems strengthening;
4. Support the unification of Government payment systems

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. Support the operationalization of domestic resource mobilization initiatives proposed in the National Health Financing Strategy, 2023-2030.
6. Improve periodic implementation of the National Health Accounts, National AIDS Spending Assessment and other resource-tracking exercises such as a web-based aid management system a that informs health sector allocative efficiency and equity decisions.
7. Develop and operationalize a framework for budget and expenditure information sharing between non-governmental organization and District Councils
8. Conduct a baseline assessment of grants management capacity at District Council level and develop plans for capacity development, including the use of digital solution for grants and financial management.
9. Strengthen the capacity of NAC, District and City Authorities and MBCH's in resource mobilization.

8 Coordination of the Response

The management of HIV needs a multi-sectoral response since social determinants of HIV emanate from many sectors and the social impact of HIV transcend the health sector. Over the years, the government, through the National AIDS Commission (NAC), has successfully engaged multiple government Ministries Departments and Agencies (MDAs) and mobilized many stakeholders to collaborate in the HIV and AIDS response. As part of the Three One's principle, the National Strategic Plan for HIV and AIDS is a blueprint that guides HIV and AIDS programs of all stakeholders. The stakeholders include PLHIV, religious organizations, traditional leaders, non-governmental organizations, civil society organizations, development partners, the youth, academia, private sector, and key populations. The organisations are coordinated by Sectoral Coordination Bodies that includes Malawi Interfaith AIDS Association, (MIAA) Malawi Network of AIDS Service Organisation (MANASO) , MBCH for Health, Malawi Network of People Living with HIV and AIDS (MANET+) , and Department of Human Resources Management and Development (DHRMD), National Construction Industry Council (NCIC) and National Council for Higher Education (NCHE). The stakeholders participate in various Technical Working Groups at National and subnational levels that have successfully developed policies, strategies, and guidelines for various HIV thematic areas. They also participate in the periodic review and assessment of the performance of the national response. In addition, government deployed HIV and AIDS Officers within key government ministries to lead the mainstream HIV and AIDS within their mandates and coordinating implementation of interventions. Recently, to strengthen the multi-sectoral coordination of Adolescent Girls and Young Women (AGYW) interventions, the AGYW Secretariat was established within the Ministry of Youth. Since the enactment of the HIV (Prevention and Management Act) of 2018, the NAC's mandate was redefined to focus on coordinating and monitoring the response, capacity building and resource mobilization. At district-level, the Nutrition and HIV Officers (NHAOs) based in District and City Councils lead the multi-sectoral coordination of the response, through District AIDS Coordinating Committees (DACCs) and City AIDS Coordinating Committees (CACCs). The DACC and CACCs are mandated to provide oversight in the development of District AIDS Implementation Plans within District Implementation Plans.

This revised NSP will address challenges affecting coordination that were identified during the Mid-Term- Review such as variable functionality levels of DACCs and CACCs; weak resource mobilization capacity at district-level; sub-optimal accountability of non-governmental organizations to the District or City Councils; limited availability of resources to support the NHAO's functions; limited awareness of the NSP and HIV Act among district stakeholders; limited involvement of traditional leaders in the HIV responses; and poor coordination of the non-biomedical response at district level.

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 multi-sectoral 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. Improve mapping of AIDS Service Organisation organisations at national and subnational level
5. Harmonise existing reporting tools and metrics in order to implement the Three Ones Principle
6. Support District and City Assemblies strengthen multi-sectoral coordination of the HIV and AIDS response (non-biomedical response
7. Accelerate the dissemination of the NSP and HIV Act at district and sub-district levels and support the utilization of the NSP in the development of District Implementation Plans
8. Support District and City Councils to develop and implement MoUs with all non-governmental organizations in the districts to ensure reporting of HIV and AIDS interventions as well as preventing duplication of efforts
9. Support efforts to strengthen coordination mechanisms and enhancing linkages between the coordinating bodies for various stakeholders and the implementing organizations to improve the effectiveness of HIV programs and avoid duplication of efforts.

9 Health Products Management Systems

Uninterrupted supply of health commodities, particularly pharmaceutical and medical supplies is essential for an effective HIV and AIDS response. The Central Medical Stores Trust (CMST) is the National warehouse responsible for storage and distribution of pharmaceutical and medical supplies to public health facilities across the country. 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. The Directorate of Health Technical and Support Services in the Ministry of Health (MoH) coordinates key Procurement and Supply Chain Management (PSM) functions, such as the quantification, procurement planning and Logistics Management Information Systems (LMIS) for Essential Medicines and Health Supplies (EMHS). Other PSM functions for the HIV Program 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 MoH is implementing reforms at CMST to create the necessary capacity and expertise to procure, warehouse and distribute essential medicines. In the interim, MoH has had to maintain outsourced service providers for procurement, warehousing and distribution services for HIV commodities. MoH has developed and is implementing the Malawi Supply Chain Transformation Plan (MSCTP) through the Logistics Management Unit (LMU). The MSCTP is strategic roadmap towards achieving uninterrupted supply of medicines for all diseases including TB, malaria and HIV and is expected to improve general supply chain management for health products beyond those for HIV, TB and malaria. Among other things, the MNSCTP is expected to create a coherent 'End-to-End' product visibility system for pharmaceutical and medical supplies to facilitate inventory management at all levels, from the manufacturer to the health facility level and reduce wastage as well as expiration. In this regard, various electronic management systems are used including Enterprise Resource Planning (ERP), Open Logistical Management Information System (OpenLMIS), eHIN and C-Stock with plans to ensure interoperability detailed within the MSCTP.

Drug pilferage and poor quality of drugs hinder the provision of quality of care, threatens people's lives and prevents the attainment of universal health coverage. The Pharmacy and Medicines Regulatory Authority Act of 2019 includes provisions for improved pharmacovigilance and stiff penalties for people involved in theft and diversions of health commodities. Development of regulations for the Act have been completed which, among other things, will facilitate prosecution of drug theft suspects and establishment of pre- and post-marketing surveillance system for health commodities.

This revised NSP will address challenges noted in the Mid-Term Review including stock-outs of drugs and medical supplies; multiple parallel PSM agencies resulting in inefficiencies; sub-optimal capacity for quantification of commodities and medical supplies; limited storage and warehousing capacity and un-harmonized supply chain management software. The HSSP-III and the Supply Chain Management Transformation Plan includes strategies to address SCM challenges.

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

Strategic interventions

1. Strengthen policy and 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 at central, regional and facility level
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.
6. Support the implementation of the Malawi Supply Chain Management Transformation Plan by strengthening the capacity of the Logistical Management Unit and developing updated policies, guidelines and standards that facilitate implementation of the Plan (such as the Medical Equipment Policy, the Waste Management Policy, Equipment Decommissioning Policy) and standard specifications of equipment guidelines)
7. Accelerate the sensitization of stakeholders in the provisions of the Pharmacy and Medicines Regulatory Act
8. Support for capacity building efforts at the CMST that enable efficient procurement, storage and distribution health commodities and medical supplies and disposal of expired drugs.
9. Enhance capacity of health facilities to perform quantification of health commodities and medical supplies.
10. Support efforts to expand and/or rehabilitate facilities for storage of health commodities and medical supplies in health facilities.
11. Support efforts to strengthen the capacity of the PMRA to fulfil mandate in areas such as quality assurance, pharmacovigilance, supply chain audits, and enforcement of regulations that penalize institutions and individuals involved in drug pilferage and wastage Support investments that create a robust supply chain system for health commodities and medical supplies and enables the use of real-time data to guide policy, procurement and other key decisions at the central level. Support efforts to accelerate the implementation of pharmaceutical and medical supply logistical and management systems in the HSSP-III that support the delivery of quality HIV-related services

10 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.

The Ministry of Health has successfully rolled out DHIS-2 as the national aggregate data warehouse and the One Health Surveillance Platform (OHSP) which may facilitate the detection of epidemics. Over the years, the Department of HIV and AIDS has established a high-quality HIV data management system (DHA-MIS). Underpinned by the Digital Health Strategy, 2020-2025, the Ministry of Health is now transitioning from paper-based systems to a functional comprehensive electronic solution which may facilitate collection of data disaggregated by age, sex, and other characteristics. Such data may be used for development of targeted interventions for specific groups and facilitate continuity of care for clients who transfer from one clinic to another. Government has laid strong foundations to support digital health by extending the fibre backbone network to all districts, has established two fibre links to the sea for Internet access, established a National Data Center and has gazetted several pieces of legislations to improve digital governance. Currently, there are 200 ART clinics capturing and using electronic medical records in Malawi. Despite these positive developments most of data collection in the health data facilities is paper-based and relies on manual entry. Data recording and entry increase the workload of already overburdened health workers and results on poor data quality. Nevertheless, the Ministry of Health successfully piloted the digital scanning system which removes the need for manual data entry. The HSSP-III has articulated further strategies to improve data collection and data use for decision-making and HMIS interoperability to achieve amore optimal data sharing. If successfully implemented this will contribute positively to the management of the HIV response.

This revised NSP will address challenges noted in the Mid-Term Review such as suboptimal data sharing among implementing partners at district-level; parallel reporting systems; enormous resource requirements for collecting DHAMIS data and limited capacity for data utilization at facility level. The NSP will leverage lessons learned from various implementing institutions to improve the use of data for decision-making. Furthermore, NAC is rolling out databases to improve data collection, analysis and reporting of non-biomedical interventions. This is being done through operationalisation of the Local Assembly HIV and AIDS reporting System (LAHARS), Key Population database and Adolescent Girls and Young Women (AGYW) database.

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 efficiency of infrastructure and implementation of new technologies at data repositories.
3. Improve the quality of data for decision-making at all levels
4. Increase evidence-based decision-making at all levels
5. Integrate data surveillance activities

6. Build and expand capacity for data use for decision-making through the adoption of user-friendly technologies
7. Scale up the use of EMRs and other digital solutions to improve the efficiency and cost of HIV data collection and verification and support the improvement of quality of HIV service delivery such as ScanForm efficient digitization of paper records.
8. Support District Councils to develop MoUs with implementing partners that require data sharing at the local level.
9. Scale up the deployment of mobile DHIS-2 and OHSP to strengthen HIV surveillance.
10. Support the implementation of the MoH's data quality improvement plans including Data Quality Assessments to ensure that all the data that are collected, reviewed and shared through its DHIS2 system are accurate and reliable.
11. Develop, deploy, expand and sustain a management information system to assist NAC consolidate HIV and AIDS M&E data.
12. Support the implementation of the NAC's data quality improvement plans including capacity building in DHIS2 management, and data quality audits on LAHARS and a KP database.
13. Support efforts to implement the Malawi Demographic and Health Survey (DHS) and Integrated Behavioural and Biological Surveillance Survey (IBBSS) to establish accurate data (that the DHS is too high-level to capture) on baseline HIV prevalence and STI rates amongst the general and key populations, as well as a detailed data on their HIV-related risk behaviours and access to health services.
14. Support efforts to accelerate the implementation of health information systems interventions in the HSSP-III and Digital Health Strategy that facilitate the delivery of HIV-related services.
15. Support the implementation of the NAC's data quality improvement plans including capacity building and data quality audits on LAHARS and a KP database.

11 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 required a substantial increase in the health workforce. Over the first 2 years of the NSP 2020-2025, over 5,000 health workers were hired at primary and secondary care level in response to the COVID-19 pandemic, which led to a reduction in the vacancy rate for these cadres from 60% to 51%. Nevertheless, the persistent shortage of service providers remains one of the biggest barriers to achieving the coverage targets and client-centred integrated care set out in this NSP.

Government will continue to prioritize the recruitment of the following cadres:

- 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 to replace HIV Diagnostic Assistants (HDAs) who currently are not part of the MoHP staff establishment
- Community Midwife Assistants, Psychosocial Counsellors, 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

The revised NSP will continue to support the deployment of health workers based on staffing needs and improving staff motivation to ensuring that Malawi can manage the current challenges in programming and sustain the gains made during the past decades. The revised NSP will also address the following challenges identified during the Mid-Term- Review such as poorly coordinated implementation of in-service training and sub-optimal staff performance management. It leverage on the HSSP-III strategies aimed at improved human resource management.

Objective 8.6.1: Increase the availability, effectiveness and retention of human resources 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 for improved quality of care.
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
6. Institute and provide for competitive remuneration, benefits, and working conditions for human resources for health.

7. Engage health worker regulatory authorities to revise the structure and system for
8. Continuous professional development (CPD) so that health workers acquire skills necessary for provision of client-centred integrated health care.
9. Engage Health worker training institutions to revise curricula to incorporate topics on client-centred integrated health care provision.
10. Support efforts to accelerate the implementation of human resource development plans in the HSSP-III that support the delivery of quality HIV-related services, such as the recruitment and training of community midwife assistants, psychosocial counsellors, community health technicians and laboratory technicians and implementation of staff performance management system.

12 Infrastructure, Transport, and Equipment

Adequate health infrastructure, transport, and equipment are critical for the provision of HIV services. During the first half of the NSP 2020-25, the MoH has purchased key pieces of assets such as ambulances and piloted the use of medical drone technology to improve efficiency in samples and results transportation. Eight new health centres were constructed, with a further fourteen were rehabilitated. However, the gaps in infrastructure remain formidable, hence the continued need for improvements. Many health facilities have limited working space to perform essential health services – overcrowding and long wait times also decrease demand for services and limit the delivery of client-centred integrated care. Health facilities also have limited equipment to deliver services and limited transport to facilitate referrals.

The revised NSP will address challenges identified during the Mid-Term Review such as weak stewardship of physical infrastructure; including weak preventive maintenance of equipment; overcrowding, particularly in urban areas. Fortunately, government plans to construct 20 new urban health centres to serve the rapidly growing population in unplanned high-density areas with high HIV burden. Furthermore, the NSP will support current efforts to construct additional 600 Health Posts to allow the decentralization of HIV services to rural facilities; the refurbishment of health infrastructure, such as district hospital laboratories; the renovation of pharmacies and warehouse space; basic equipment for facilities; and implementation of a preventive management system for equipment.

Besides, the revised NSP will also galvanise efforts to strengthen linkages between health facilities and communities through a 360° model where each is interdependent on the other. Above all, all community level structures like Health Surveillance Assistant, Community Midwife Assistants, Peer support groups, mother to mother groups will be supported to provide community led service delivery of HIV interventions in a cost-effective manner including in remote and hard to reach areas. They will also champion demand creation and be the enablers of service delivery with the support of all stakeholders including CSO's.

Objective 8.7.1: Ensure adequate infrastructure for HIV services delivery

Strategic intervention

1. Refurbish and construct new 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 Procurement, maintenance and management of equipment supply.
3. Accelerate current plans to construct 20 urban health centres and 600 health posts to improve access to health care by marginalized urban and rural populations.
4. Improve capacity for preventive maintenance of infrastructure and equipment by engaging physical asset managers.
5. Accelerate the implementation of infrastructure development interventions in the HSSP-III that support the delivery of quality integrated HIV-related services.

13 Integrated Service Delivery and Quality Improvement

The Global AIDS Strategy calls for the implementation of integrated client-centred services. The NSP 2020-2025 identified the need for the delivery of comprehensive health services that meet the needs of clients accessing both HIV and SRH services. With increased survival and ageing of PLHIV, the need for integrated services will go beyond SRH and include a wide range of NCDs, such as hypertension, cardio-vascular diseases, diabetes and cervical cancer. Apart from managing co-morbidities, health services delivery need to be configured to improve psychosocial support of patients, particularly children living with HIV, adolescents living with HIV who are transitioning to adults care and GBV survivors. Fortunately, the most health facilities have some experience with integrated services delivery. Some of the well-integrated services include HIV/TB, VMMC/HTC, HTC/STI/PrEP and Cervical Cancer/ FP. Key challenges preventing expansion of service integration include inadequate skilled staff handle co-morbidities and space limitations. Thus, in the short to medium term, the MoH will develop models of integrated services that does not necessarily mean co-location of service-delivery platforms in a one-stop shop model.

Delivery of quality of services will require developing standards of desired care and continuously assessing to what extent the standards are being met. This will require investment in data collection, review and audit Fortunately, MoH Quality Management Directorate has experience in implementing QI models and has already established QI structures, such as quality improvement support teams (QISTs), in district and central hospitals and in some health facilities. These teams will also support HIV-related clinics. These efforts will be underpinned by MoH Quality Management Policy (2017) and National Health Quality Management Strategy. Further, the MoH's mortality surveillance system, supported by the National Registration Bureau, will be used to generate data that support quality improvement. Implementing these programs will require strong clinical leadership and coordination.

The revised NSP will address gaps identified in the Mid-Term Review, which include limited health worker training in the management of co-morbidities, limited collaborations between of Quality Improvement Support Teams and HIV clinics and inconsistent implementation of death audits. The NSP will also focus on building strong quality improvement teams and build capacity of health workers in the management multi-morbidity.

Objective 8.8.1: 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 HIV with SRHS, NCD, and nutrition services at all health sector levels for the continuum of care

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.
10. Through CPD, build capacity of health workers in HIV clinics to manage multimorbidity.
11. Strengthen the implementation of quality improvement models in HIV clinics
12. Support the coordination and implementation of death audits and using the findings for quality improvement.
13. Introduce mobile outreach clinics that use the “one stop” approach to deliver integrated HIV/SRH services (HTS, STI screening and management, Condom promotion, PrEP, VMMC, Cervical Cancer screening, contraceptives)
14. Strengthen Community Management of Malnutrition for children living with HIV, including refugee children

14 Community Systems Strengthening

A key objective of Global AIDS Strategy (2021-26) is to increase participation of communities in design, implementation and monitoring of HIV and AIDS services to ensure client-centred service delivery. For an organization to be considered community-led, the majority (at least fifty percent plus 1) of governance, leadership, and staff comes from the community being served. The HSSP-III has made a strong commitment to improve community system with a view of achieving universal health coverage. During the course of the NSP 2020-2025, the Ministry of Health developed the National Community Health Framework (NCHF) 2023-2030 after review of the National Community Health Strategy, 2017-2022. The review noted persistent challenges in community health system such as the shortage of Health Surveillance Assistants (HSAs), with an HSA to population ratio of 1: 1, 260; inadequate resources for HSAs; insufficient community engagement on matters affecting their health; and insufficient infrastructure such as health posts and housing for HSAs. Community-based health structures (Village Health Committees, Community Health Action Groups, Community Health Management Committees) were mostly non-functional and uncoordinated and their linkages with other community-based development structures (Village Development Committees and Area Development Committees) remained weak. Most members of the community-based structures were untrained and unsupervised. The challenges limited Malawi's potential to meet the Global AIDS Strategy's target of having *"80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community-, key population- and women-led organizations"*. Despite these challenges, during the course of the NSP 2020-2025, a community-led monitoring framework was developed and rolled out, with support from partners, which is contributing to strengthening community voice and oversight in service delivery. Consultations with CSO partners indicate that it is yielding positive results, including improved community service delivery oversight. There was also active participation of Health Management Committees and community health volunteers (expert clients, treatment supporters etc.) in delivering and monitoring HIV and TB services. In addition, an Integrated community Health information system (i-CHIS) has been developed and is being further being rolled out, which should strengthen health information management for community health services.

The MoH had also continued its efforts of strengthening the quality of community health services by the recruiting and training of additional HSAs and community midwife assistants, providing them with resources for field work and constructing health posts in hard-to-reach areas. The community health workers are expected to support community structures especially VHCs in creating awareness about HIV and AIDS including HIV prevention and HIV treatment and retention and in addressing human rights barriers to accessing services. Health Centre Management Committees (HCMC) and Hospital Advisory Committees (HACs) will ensure commodity security in health facilities. This document will continue to enhance the multisectoral HIV programming including use of existing structures such as Village and Area Development Committees. Deliberate effort will be made to ensure that decentralised structures mainstream HIV and AIDS issues. CSOs and CBOs will continue making efforts to work very closely with the community structures with 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. Community health workers will also facilitate the delivery of the "HIV community package" which includes following up of partners of index testing for testing, supporting distribution of HIVST to targeted populations through peers, tracing defaulters of ART including mother infant pairs, distribution of condoms, provision of Oral PrEP, family planning and other services, referral of clients to relevant HIV services and creating awareness about HIV and AIDS.

This revised NSP will address challenges identified in the Mid-Term-Review such as lack of coordination among community health workers and volunteers working across various sectors (HSAs, Community Child Protection Workers and Agriculture Extension Workers); poor reporting of non-biomedical interventions at community-level; and limited capacity of traditional, religious leaders to engage with community members and address harmful social norms and practices (including GBV), dispel false claims of AIDS cure and support treatment adherence and retention in care. It will also accelerate the implementation of the Community Charter that empowers community organizations to take an active role in community HIV response. Beyond awareness creation and community led monitoring, efforts will be made to actively engage community structures, their leaders and civil society organizations through Community Health Teams (CHTs). The CHTs are composed of Community Health Volunteers (CHVs), Health Surveillance Assistants (HSAs), Senior Health Surveillance Assistants (SHSAs), Community Midwife Assistants (CMAs), Community Health Nurses (CHNs) and Assistant Environmental Health Officers (AEHOs). Further, Area Development Committees (ADCs) and Village Development Committees (VDCs) which oversee Health Centre Management Committees (HCMCs) within the jurisdiction of the ADC at the Traditional Authority and Group Village level will be engaged to support the response.

The revised NSP will also galvanise efforts to strengthen linkages between health facilities and communities through a 360° model where each is interdependent on the other. Above all, all community level structures like Health Surveillance Assistants, Community Midwife Assistants, Peer support groups, mother to mother groups will be supported to provide community led service delivery of HIV interventions in a cost-effective manner including targeting in remote and hard to reach areas. They will also champion demand creation and be the enablers of service delivery with the support of all stakeholders including CSOs.

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, including hard to reach areas in a cost-effective manner.
2. Strengthen community structures and systems to prevent and redress GBV and human rights violation cases in a timely manner, and eradicate harmful practices
3. Strengthen community-based monitoring and reporting on HIV and SRHSs
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
6. Support on-going efforts by the MoH to recruit, train and deploy community health workers including community midwife assistants and psychosocial counsellors
7. Scale up the implementation of the HIV community package
8. Strengthen the coordination, mentoring, and monitoring of activity implementation by community structures through their volunteers

9. Enhance the engagement of traditional and community leaders in supporting the delivery of community-based services Expand geographical coverage and reporting of community-led monitoring results
10. Expand geographical and disease coverage including and reporting of community-led monitoring results and integrate malaria and TB
11. Scale up the implementation of Integrated community Health information system (i-CHIS)
12. Accelerate the implementation of the "Community Charter" by strengthening the capacity of community-based structures to lead the delivery of health and social services.
13. Support the establishment of a robust centralized community-led monitoring data management and monitoring system that facilitates data collection, analysis, and feedback.
14. Strengthen the capacity of CSOs to commission issue-based research, compile and analyze research findings that support the implementation of evidence-based advocacy.
15. Support efforts to accelerate the implementation of community systems development interventions in the HSSP-III and the National Community Health Framework that facilitate the delivery of quality HIV-related services such as the maintenance, scale up, and development of additional modules in the Integrated Community Health Management System (iCHIS).

15 Laboratory Systems

Laboratory services are an essential component for the implementation of comprehensive and quality HIV services. Key laboratory services that underpin quality HIV services aim at diagnosing and monitoring the progress of HIV infections (HIV diagnostic tests, viral load assays, HIV viral genotype, CD4 count); detecting and monitoring ARV and other drug-related toxicities (biochemical and haematological assays); and diagnosing and monitoring HIV-related co-morbidities such as diabetes and cervical cancer. Provision of these services requires substantial human resources and infrastructural investment. Malawi has made significant progress in improving laboratory services including increasing the number of trained laboratory scientists and technicians; initiating university-level training of Biomedical Engineers; constructing and/or refurbishing of laboratories and deployment of GeneXpert and Point-of-Care machines to primary and secondary care facilities. Notably, the National HIV and AIDS Reference Laboratory (NHRL) was strengthened to provide quality assurance support for HIV tests and to perform HIV genotyping and sequencing. In addition, the MoH successfully implemented personalized SMS-based communication of viral load results to patients.

Despite the positive developments in laboratory infrastructure investment the demand for laboratory services cannot be underestimated considering that there are already over 1 million PLHIV on ART who need consistent monitoring for and management of HIV infection and co-morbidities and the need to improve the management of advanced HIV disease while at the same time scaling up the coverage of quality-assured HIV testing. In this respect, the MoH commits to continue providing the following critical laboratory services:

1. Routine Viral Load (VL) monitoring for people on ART once every year. There will require continued investment increasing 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. HIV Genotyping for all patients with diagnosed treatment failure and therapeutic monitoring for patients with advanced HIV disease
3. External Quality Assurance (EQA) for HIV testing to minimize the occurrence of false-positive and false-negative results
4. Viral hepatitis and syphilis tests to achieve the triple elimination goal
5. Biochemistry tests (creatinine monitoring) for PrEP clients who are at risk of kidney disease.
6. Point of Care (POC) platforms, such as GeneXpert and other related POCs machines for targeted VL testing, EID and PIMA for CD4 count testing
7. Diagnostic tests for non-communicable diseases (NCDs) at districts, CHAM and central hospitals
8. ARV and TB drug toxicity monitoring in ten (10) sentinel sites.

This revised NSP will address challenges identified in the during the Mid-Term Review such as long turn-around time for viral load assays and CD4 tests; low coverage of HIV quality monitoring of HIV tests and viral load assays; lack of a program for preventive maintenance of laboratory equipment; limited mentorship of laboratory staff performing HIV-related tests; and sub-optimal engagement of the National HIV Reference Laboratory (NHRL) during the acquisition and deployment of laboratory equipment. The NSP will leverage of strategies for improving the performance of the Laboratory services outlined in the HSSP-III.

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.
3. Accelerate the procurement and deployment of the POC machine for HIV-related diagnostics and treatment monitoring.
4. Strengthen the quality assurance system for laboratory services through accreditations and regular quality assurance assessments and mentorship and supervision.
5. Support efforts by the MoH to implement a robust preventive maintenance system of laboratory equipment and disposal of defunct and obsolete equipment.
6. Support the MoH's Directorate of Health Technical Services in enforcing standards for procurement of HIV diagnostic equipment, with involvement of the NHRL.
7. Enhance the efficiency of sample transportation system from peripheral to district/central facilities and communication of results to end-users.
8. Support capacity building efforts in genomic surveillance and sequencing and bioinformatics at the NHRL and academic or research laboratories to improve the surveillance and management of HIV drug resistance.
9. Support investments in scaling up Laboratory Information Management Systems to primary care facilities that provide HIV care.
10. Support efforts to accelerate the implementation of laboratory systems development interventions in the HSSP-III that facilitate the delivery of quality HIV-related services.

16 HIV response in emergency settings

Malawi is prone to various natural disasters, including floods, droughts, and cyclones, which often have a significant impact on the country's population and economy. These disasters are particularly devastating for vulnerable populations, such as those living in poverty or those affected by HIV. Floods are a common natural disaster in Malawi, particularly in the southern part of the country. In recent years, floods have caused significant damage to infrastructure, homes, and crops, leading to food insecurity and displacement of populations. The floods also exacerbate the risk of water-borne diseases, such as cholera, which can spread rapidly in crowded living conditions.

Almost every year Malawi has experienced several devastating natural disasters, including floods including the most recent cyclone Freddy, which affected over a million people and caused extensive damage to homes, crops, and infrastructure and often led to multiple internally displaced person death. Additionally, the country is not spared from emerging global health outbreaks. Malawi has experienced multiple COVID-19 waves since 2020 and the wo worst prolonged cholera epidemic since 2022 to date which could partly be attributed to the damage that tropical storms have wreaked on the country. So far, over 114,637 displaced households, 508,244 displaced people, 499 deaths and 427 missing people were registered in the situation report #7 of the Tropical Cyclone Freddy. Concerning cholera, as of 23rd March 2023, the country registered 55,367 confirmed cumulative cases and 1, 693 deaths representing a case fatality rate of 3.06%. The humanitarian crises due to natural disasters and emerging outbreaks have compelled the State President to declare a State of National Disaster. The disaster declaration is a part of an appeal for national and international assistance for the victims of the cyclone and epidemics.

The emerging pandemics pose new and aggravate already stretched public health system in Malawi by exerting further strain our manpower and facilities. Some of the key emerging challenges identified in Malawi are worsening population health and socio-economic status; health system challenges like inadequate financing and human resources, disruption of essential health services; a rise in mental health conditions and suicide rates; teenage pregnancies and early marriages; and changes in some health policies. Despite the progress that Malawi has made over the years in scaling up HIV diagnosis, treatment, care and support services, the continuous cycle of emergencies is likely to continue disrupting the provision of HIV services, and the rhythm of life of people living with HIV which includes loss of their medication and care documentation... Consequently, due to disruptions in HIV services, which limit access to prevention services, Malawi will most likely witness a rise in HIV incidence that may sabotage previous efforts and take a long time to rectify.

The revised NSP will ensure that the national response to HIV and AIDS is well equipped to contribute to the delivery of resilient, sustainable and quality health services in emergency settings to promote progress towards the achievement of Universal Health Coverage (UHC) and Sustainable Development Goals (SDG) in Malawi.

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 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. Mainstreaming Disaster and Disease epidemic issues into the HIV response systems and policies
4. Strengthen emergency preparedness and logistics mechanisms.
5. Develop and deliver a package of HIV, GBV, SRHR and mental health services in emergency situations.

17 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.

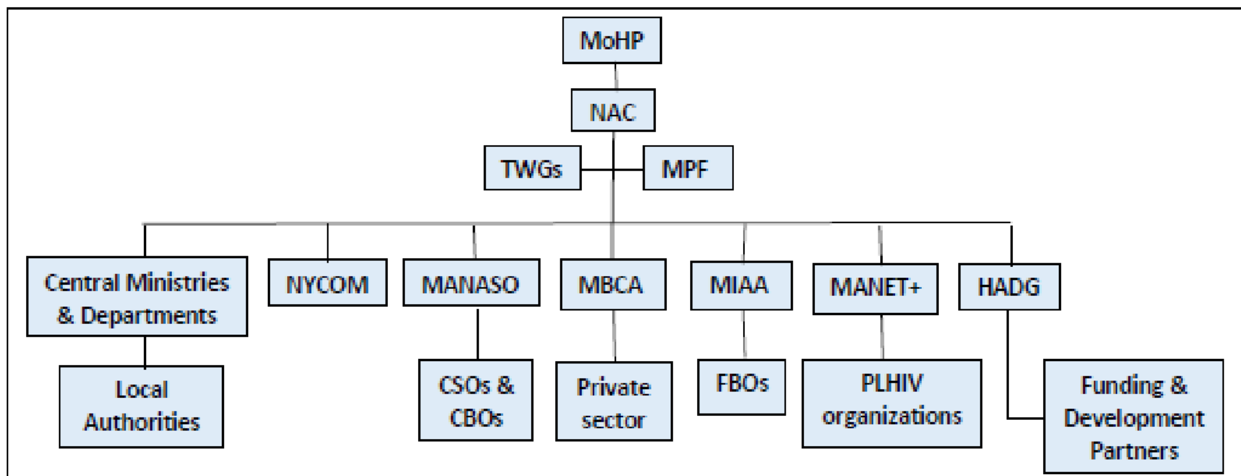

Figure 16: The main coordinating bodies in the national response in Malawi

Ministry of Health and Population is mandated by the Health Sector Strategic Plan III (HSSP III) to improve the health status of all Malawians and increase client satisfaction and financial risk protection towards attainment of universal health coverage. Further to this, the mandates the MOH to lead the national response through formulating and reviewing national biomedical HIV and AIDS policies and guidelines. It also 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 in liaison with coordinating bodies, government MDAS and the community. The Commission also facilitates development and maintenance of an up-to-date information system and establish suitable mechanisms of disseminating and utilizing the information.

Central and other line Ministries directly or indirectly support the national response. Line Ministries provide policy guidance to departments, agencies and parastatal organisations who 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. The Principal Nutrition and HIV and AIDS Officer (PNHAO), who works under the supervision of the Director of Planning and Development, is response for leading the multi-sectoral coordination of HIV and AIDS at the local authority level.

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 and Health (MBCH), formerly Malawi Business Coalition for HIV and AIDS (MBCH), have the responsibility to mainstream HIV and AIDS through workplace policies and programmes. Following a recent functional review, MBCHs mandate has been expanded to include oversight over all health services provided by the private sector.

Development Partners support national priorities; facilitate implementation by funding service delivery and capacity development. 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.

18 Monitoring and Evaluation

The NAC has overall responsibility of monitoring and evaluating the implementation of the revised NSP 2023-2027. 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 2023-2027 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 2023-2027.

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. Field visits might be organized for the MPF and stakeholders to observe what is happening in the field and compile a report. The TWGs, through the MPF shall present their findings at the JAR. At the end of the JAR an aide memoir will be produced highlighting the key recommendations to be shared with all key stakeholders. 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 2023-2027. All implementing partners will be expected to monitor progress of implementing their HIV and AIDS programmes and share with NAC for subsequent dissemination 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 and shared with relevant stakeholders. Once the GAM report has been compiled, resources will be mobilized to disseminate the report at national level.

Development of Epidemiological Estimate: Since 2001 UNAIDS has been mandated through political declarations to support countries to monitor and report on their HIV epidemics. Sustainable Development Goal 3.3.1: HIV incidence per 1,000 uninfected population. UN Political Declarations on HIV/AIDS 2016: specific targets on HIV incidence and AIDS-related mortality. These indicators are not possible to measure directly over frequent intervals and modelling is used to estimate these values. The estimates are generated every year to understand the trajectory of HIV epidemic; monitor and improve their HIV response; inform targets for national strategic frameworks and donor agreements and triangulates all available, high quality, data to calculate the best estimate. NAC will continue working with key stakeholders in developing HIV estimates and projections to inform the country's HIV programming.

Local Authority HIV and AIDS Reporting System (LAHARS): There are a number of partners implementing HIV and AIDS interventions in each local council. 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 Department of HIV and AIDS (DHA) in the Ministry of Health 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 DHAMIS. The DHA disseminates such quarterly reports to all stakeholders including the NAC.

Periodic surveys and surveillance: 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 other population-based surveys which are conducted periodically by various research institutions. 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. NAC will also be instituting Biological and Behavioural Surveillance Surveys and estimation for key and vulnerable populations.

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 and need based studies, evaluations, and assessments. 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. The Ministry of Health will coordinate revision of the National Health Research Agenda which includes HIV research priorities that can aid effective planning of the national response. These will be in tandem with the priorities of the current NSP.

19 Costing Results

As detailed in **Table** 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 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 4: Programmatic cost of the NSP 2022-27 (in million USD)

Module	2022-23	2023-24	2024-25	2025-26	2026-27	Total	% of Total
Integrated Programme Management	15.15	15.25	15.35	15.45	15.55	76.75	56%
Prevention - Key Populations	5.89	5.79	5.80	5.05	5.12	27.65	20%
Prevention - AGYW	4.89	4.14	3.79	3.30	3.40	14.63	11%
Prevention - Condoms	0.56	0.56	0.56	1.05	1.25	3.98	3%
Treatment, care & support	1.76	1.76	1.86	1.20	1.40	7.98	6%
Prevention - STI and SRH	1.10	0.38	0.40	0.38	0.38	2.64	2%
Wellness and Workplace HIV programmes	0.94	0.09	0.09	0.10	0.02	1.24	1%
HIV Testing Services	0.07	0.08	0.05	0.05	0.03	0.28	0%
Prevention - VMMC	0.21	0.34	0.19	0.19	0.19	1.12	1%
Blood Safety	0.37	0.01	0.01	0.02	0.02	0.43	0%
Prevention - PrEP	0.12	0.12	0.12	0.12	0.12	0.60	0%
E-MTCT	0.03	0.02	0.01	0.01	0.01	0.08	0%
TOTAL	26.20	28.54	28.23	26.92	27.49	137.38	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 5: RSSH cost of the NSP 2023-27 (in million USD)

Module	2022-2023	2023-2024	2024-2025	2025-2026	2026-2027	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%

Module	2022-2023	2023-2024	2024-2025	2025-2026	2026-2027	Total	% of Total
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 6: Commodities cost of NSP 2022-27 (in million USD)

Category	2022-2023	2023-2024	2024-2025	2025-2026	2026-2027	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**

19.1 Financing for HIV NSP 2022-27

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 7 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 7: Major Funding Sources for HIV/AIDS in Malawi (For FY2019/20, Million USD). Source: Resource Mapping (Round 6) [62]

Funding Sources	Funding (Million USD)	Distribution (%)
Government of Malawi	**0.6**	**0.29%**
Global Fund	134.4	65.00%
United States - PEPFAR[63]	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

[62] 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).

[63] The funding available from United States Government (USG) entities including PEPFAR and CDC, reflects the financing channelled 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.

million, USD223 million and USD209 million, respectively.[64] 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.

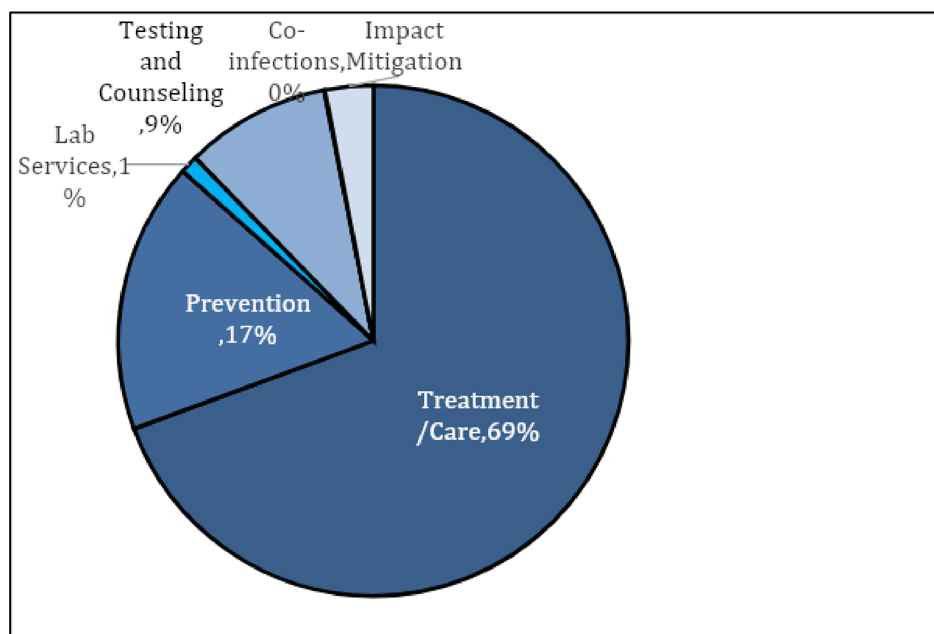

Figure 17: Funding by programmatic functions for 2020. Source: MoHP, Resource Mapping Round 6, 2020

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: TBD: Financial gap of the HIV NSP 2022-27 against total resources projected – USD (in millions)

HIV Including Viral Hepatitis and other STIs	2022-2027 (Million USD)
Resources needed 2022-27	1,178
Resources available 2022-27	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.

[64] Ministry of Health. Resource Mapping Round 5. 2019.

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.

20 Performance Framework

Table 8: Summary performance framework for the National Strategic Plan for HIV and AIDS 2023-2027. A complete framework in Excel format with additional columns is available from [Document Management System (hiv.health.gov.mw)](hiv.health.gov.mw)

NSP Pillar	Domain	Indicator Description	Numerator Source/Definition	Denominator Source/Definition	Intention	GFATM code	Disaggregation	2020 Baseline				2022 Mid-term (Year 2)									2023 (Year 3)		2024 (Year 4)		2026 (Year 6)		2027 (Year 7)	
									Achievement			Target				Achievement					Target		Target		Target		Target	
								Baseline Year	Num	Den	Result	Num	Den	Result	Change from 2020	Num	Den	Result	Change from 2020	Rating	Result	Change from 2022	Result	Change from 2022	Result	Change from 2022	Result	Change from 2022
1, 2, 3, 6	Impact	Percentage of people living with HIV	Number of people living with HIV Annual Spectrum model estimates KP: BBSS or annual consensus estimates (MOH/UNAIDS)	Total population Annual Spectrum model estimates KP: BBSS or annual consensus estimates (MOH/UNAIDS)	Decrease	HIV I-13 HIV I-9a HIV I-9b HIV I-10 HIV I-11	All	2020	1,021,109	19,612,320	5.2%	1,112,208	20,318,362	5.5%	-2.7%	1,012,135	20,645,061	4.9%	-5.8%		4.8%	-2.5%	4.6%	-6.1%	4.3%	-11.7%	4.2%	-14.4%
					Decrease		Children 0-14	2020	70,538	8,513,511	0.8%	56,483	8,657,590	0.7%	-16.8%	58,564	8,743,286	0.7%	-19.2%		0.7%	-1.3%	0.5%	-22.3%	0.4%	-40.0%	0.4%	-47.3%
					Decrease		Females 15+	2020	588,216	5,807,673	10.1%	631,308	5,969,558	10.6%	-3.3%	595,660	6,224,472	9.6%	-5.5%		9.3%	-2.9%	9.0%	-5.8%	8.5%	-11.3%	8.2%	-14.0%
					Decrease		AGYW 15-24	2020	55,136	2,105,587	2.6%	75,543	2,152,479	3.5%	-9.3%	50,843	2,265,049	2.2%	-14.3%		2.1%	-6.6%	2.0%	-12.3%	1.7%	-22.6%	1.6%	-27.5%
					Decrease		Males 15+	2020	362,355	5,291,136	6.8%	424,417	5,691,213	7.5%	-3.6%	357,911	5,677,304	6.3%	-7.9%		6.0%	-4.1%	5.8%	-8.0%	5.3%	-15.2%	5.1%	-18.6%
					Decrease		FSW	2019	19,680	38,193	51.5%			48.0%	-6.8%	19,463	39,004	49.9%	-3.2%		48.4%	-2.9%	47.0%	-5.8%	44.2%	-11.3%	42.9%	-14.0%
					Decrease		MSM	2019	4,197	48,801	8.6%			8.0%	-7.0%	4,530	35,391	12.8%	48.8%		12.3%	-4.1%	11.8%	-8.0%	10.9%	-15.2%	10.4%	-18.6%
					Decrease		Transgender	2019	223	697	32.0%					673	4,876	13.8%	-56.9%		13.2%	-4.1%	12.7%	-8.0%	11.7%	-15.2%	11.2%	-18.6%
					Decrease		PWID																					
1, 2, 6	Impact	Number of new HIV infections per 1,000 uninfected population	Number of people newly infected with HIV during the reporting period Annual Spectrum model estimates	Number of uninfected population (or person-years exposed) x 1,000 Annual Spectrum model estimates	Decrease	HIV I-14	All	2020	21,355	18,591,211	1.15	20,103	19,206,154	1.05	-7.3%	16,270	19,632,926	0.83	-27.9%		0.74	-10.6%	0.57	-31.2%	0.39	-52.9%	0.33	-60.2%
					Decrease		Children 0-14	2020	2,912	8,442,973	0.34	3,102	8,601,107	0.36	-10.2%	2,922	8,684,722	0.34	-2.4%		0.22	-34.4%	0.17	-49.1%	0.12	-65.7%	0.09	-71.9%
					Decrease		Females 15+	2020	11,557	5,219,457	2.21	17,001	5,338,250	3.18	-8.0%	8,432	5,628,812	1.50	-32.3%		1.41	-5.9%	1.08	-28.2%	0.73	-51.4%	0.61	-59.0%
					Decrease		AGYW 15-24	2020	4,590	2,050,451	2.24	8,437	2,076,936	4.06	-8.0%	3,357	2,214,206	1.52	-32.3%		1.43	-5.7%	1.09	-27.8%	0.75	-50.7%	0.63	-58.2%
					Decrease		Males 15+	2020	6,886	4,928,781	1.40	13,241	5,266,796	2.51	-8.2%	4,916	5,319,393	0.92	-33.9%		0.86	-6.6%	0.66	-29.0%	0.44	-52.2%	0.37	-59.7%
3, 4	Impact	Number of AIDS related deaths per 100,000 population	Number of people dying from AIDS-related causes during the reporting period Annual Spectrum model estimates	Total population regardless of HIV status x 100,000 Annual Spectrum model estimates	Decrease	HIV I-4	All	2020	12,977	19,612,320	66	12,313	20,318,362	61	-11.0%	12,006	20,645,061	58	-12.1%		52	-10.0%	49	-15.7%	38	-34.7%	33	-43.3%
					Decrease		Children 0-14	2020	2,139	8,513,511	25	1,582	8,657,590	18	-4.9%	1,669	8,743,286	19	-24.0%		18	-6.0%	14	-25.9%	10	-50.1%	8	-60.7%
					Decrease		Females 15+	2020	4,902	5,807,673	84	5,477	5,969,558	92	-9.0%	4,659	6,224,472	75	-11.3%		66	-11.3%	65	-12.9%	55	-27.2%	48	-35.6%
					Decrease		AGYW 15-24	2020	679	2,105,587	32	999	2,152,479	46	-9.9%	657	2,265,049	29	-10.1%		25	-12.5%	24	-15.7%	19	-34.0%	16	-43.9%
					Decrease		Males 15+	2020	5,936	5,291,136	112	5,254	5,691,213	92	-15.0%	5,678	5,677,304	100	-10.9%		89	-11.3%	83	-17.4%	60	-39.8%	52	-48.2%
1	Impact	Percentage of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months	Number of children newly infected with HIV via mother-to-child transmission Annual Spectrum model estimates: "Number of new child infections due to mother-to-child transmission"	Number of women living with HIV delivering in the past 12 months Annual Spectrum model estimates: "Mothers needing PMTCT"	Decrease	HIV I-6	None	2020	2,912	41,632	7.0%	2,160	39,265	5.5%	-8.9%	2,922	37,290	7.8%	12.0%		5.5%	-29.4%	5.3%	-32.4%	5.0%	-36.2%	4.8%	-38.7%
2	Outcome	Percentage of people living with HIV who know their HIV status at the end of the reporting period.	Number of people living with HIV who know their HIV status Annual Spectrum model estimates KP: BBSS or annual consensus estimates (MOH/UNAIDS)	Number of people living with HIV Annual Spectrum model estimates KP: BBSS or annual consensus estimates (MOH/UNAIDS)	Increase	HIV O-11	All	2020	920,571	1,021,109	90.2%	1,089,964	1,112,208	98.0%	8.6%	958,153	1,012,135	94.7%	5.0%		98.5%	4.0%	97.8%	3.3%	98.3%	3.8%	98.3%	3.9%
					Increase		Children 0-14	2020	46,274	70,538	65.6%	39,595	56,483	70.1%	4.5%	40,163	58,564	68.6%	4.5%		66.1%	-3.6%	80.1%	16.8%	90.0%	31.2%	90.0%	31.2%
					Increase		Females 15+	2020	557,300	588,216	94.7%	605,424	631,308	95.9%	1.5%	584,558	595,660	98.1%	3.6%		102.1%	4.0%	99.0%	0.9%	99.0%	0.9%	99.0%	0.9%
					Increase		AGYW 15-24			55,136			75,543			42,352	50,843	83.3%			92.2%	10.7%	95.0%	14.0%	95.0%	14.0%	95.0%	14.0%
					Increase		Males 15+	2020	316,997	362,355	87.5%	388,342	424,417	91.5%	4.9%	333,432	357,911	93.2%	6.5%		97.7%	4.9%	98.0%	5.2%	98.0%	5.2%	98.0%	5.2%
1, 6	Coverage	Percentage of KP who have received an HIV test during the reporting period	Number of KP who have been tested for HIV during the reporting period	Estimated number of KP in KP-specific program areas	Increase	HTS-3c	FSWs	2020	14,188	22,152	64.0%	12,119	41,289	29.4%	-54.2%	18,206	41,289	44.1%	-31.2%		44.2%	0.2%	41.0%	-7.1%	49.1%	11.4%	25.0%	-43.3%
					Increase	HTS-3a	MSMs	2020	2,047	3,904	52.4%	4,477	35,391	12.7%	-75.9%	6,367	35,291	18.0%	-65.6%		30.5%	69.2%	38.4%	112.7%	43.1%	138.8%	43.6%	141.7%
					Increase	HTS-3b	Transgenders	2020	407	407	100.0%	1,049	4,876	21.5%	-78.5%	1,049	4,876	21.5%	-78.5%		23.4%	8.9%	23.4%	8.8%	23.4%	8.8%	23.4%	8.8%

NSP Pillar	Domain	Indicator Description	Numerator Source/Definition	Denominator Source/Definition	Intention	GFATM code	Disaggregation	2020 Baseline: Baseline Year	2020 Baseline Achievement: Num	Den	Result	2022 Mid-term (Year 2) Target: Num	Den	Result	Change from 2020	2022 Mid-term (Year 2) Achievement: Num	Den	Result	Change from 2020	Rating	2023 (Year 3) Target: Result	Change from 2022	2024 (Year 4) Target: Result	Change from 2022	2026 (Year 6) Target: Result	Change from 2022	2027 (Year 7) Target: Result	Change from 2022
		in KP-specific programs and know their results.	and who know their results		Increase	HTS-3f	Prisoners	2020	13,713			20,000	17,956	111.4%		24,001	17,956	133.7 %			139.6%	4.5%	139.6%	4.5%	139.6%	4.5%	139.6%	4.5%
					Increase	HTS-3d	PWID	2020															36.1%		36.1%		37.0%	
3, 6	Coverage	Percentage of people on ART among all people living with HIV at the end of the reporting period	Number of people on ART at the end of the reporting period. Annual Spectrum model estimates KP: BBSS or annual consensus estimates (MOH/UNAIDS)	Estimated number of people living with HIV. Annual Spectrum model estimates KP: BBSS or annual consensus estimates (MOH/UNAIDS)	Increase	TCS-1.1	All	2020	864,503	1,021,109	84.7%	978,743	1,112,208	88.0%	10.3%	931,690	1,012,135	92.1%	8.7%		93.4%	1.5%	95.4%	3.6%	96.6%	4.9%	96.6%	5.0%
					Increase	TCS-1c	Children 0-14	2020	46,274	70,538	65.6%		56,483			40,163	58,564	68.6%	4.5%		66.1%	-3.6%	80.1%	16.8%	90.0%	31.2%	90.2%	31.5%
					Increase	TCS-1b	Females 15+	2020	542,294	588,216	92.2%		631,308			580,657	595,660	97.5%	5.7%		97.8%	0.3%	97.8%	0.4%	97.9%	0.4%	97.9%	0.5%
					Increase		Females pregnant	2020	40,275	41,632	96.7%	36,917	37,290	99.0%		33,488	37,290	89.8%	-7.2%									
					Increase		AGYW 15-24	2020		55,136		66,478	75,543	88.0%		49,084	50,843	96.5%			0.0%	-100.0%	0.0%	-100.0%	0.0%	-100.0%	0.0%	-100.0%
					Increase	TCS-1b	Males 15+	2020	275,935	362,355	76.2%		424,417			310,870	357,911	86.9%	14.1%		90.6%	4.3%	93.3%	7.4%	95.0%	9.4%	95.0%	9.4%
					Increase		FSWs	2020		19,680	85.8%			91.0%	6.1%	17,711	19,463	91.0%	6.1%									
					Increase		MSMs	2020		4,197	99.0%			99.0%	0.0%	4,190	4,530	92.5%	-6.6%									
					Increase		Transgenders	2020		223	98.8%			99.0%	0.2%		673											
					Increase		PWID	2020																				
3, 6	Coverage	Percentage of people living with HIV and on ART who are virologically suppressed	Number of people living with HIV on ART for at least 6 months and with at least one routine VL test result who have virological suppression (<1000 copies/mL) during the reporting period LMIS: ART patients with a routine VL monitoring result <1000 copies/ml. Note: extrapolation of cohort level VL suppression rates from routine monitoring is 3-4% lower than survey based VLS rate due to reliance on DBS samples that produce some false high results.	Number of people living with HIV on ART for at least 6 months with at least one routine VL result in a medical or lab record during the reporting period LMIS: ART patients with a routine VL monitoring result in the reporting period	Increase	HIV O-12	Children 0-14	2020	29,162	41,871	69.6%			78.0%	12.0%						81.4%		84.8%		91.6%		95.0%	
					Increase	HIV O-12	Females 15+	2020	524,845	556,535	94.3%			95.0%	0.7%						95.0%		95.0%		95.0%		95.0%	
					Increase		Females pregnant							95.0%							95.0%		95.0%		95.0%		95.0%	
					Increase	HIB O-12	Males 15+	2020	287,039	309,796	92.7%			94.0%	1.5%						94.2%		94.4%		94.8%		95.0%	
					Increase		FSWs							95.0%							95.0%		95.0%		95.0%		95.0%	
					Increase		MSMs							95.0%							95.0%		95.0%		95.0%		95.0%	
					Increase		Transgenders							95.0%							95.0%		95.0%		95.0%		95.0%	
					Increase		Prisoners							95.0%							95.0%		95.0%		95.0%		95.0%	
3	Coverage	Percentage of health facilities providing advanced HIV disease screening	Number of facilities that provided at least one of each of the following tests in the reporting period: CD4, TB (urine LAM or Xpert), serum CrAg DHA-MIS data from quarterly site supervision	Number of facilities with at least 1 patient on ART during the reporting period	Increase		All	2020						50.0%		167	813	20.5%			20.5%	0.0%	44.0%	114.2%	90.0%	338.1%	90.0%	338.1%

NSP Pillar	Domain	Indicator Description	Numerator Source/Definition	Denominator Source/Definition	Intention	GFATM code	Disaggregation	2020 Baseline				2022 Mid-term (Year 2)									2023 (Year 3)		2024 (Year 4)		2026 (Year 6)		2027 (Year 7)	
									Achievement			Target				Achievement					Target		Target		Target		Target	
								Baseline Year	Num	Den	Result	Num	Den	Result	Change from 2020	Num	Den	Result	Change from 2020	Rating	Result	Change from 2022	Result	Change from 2022	Result	Change from 2022	Result	Change from 2022
3	Coverage	Proportion of ART patients screened for hypertension	Number of ART patients 40+ years who had at least one BP result documented in the last 12 months DHA-MIS: quarterly ART cohort reports	Number of patients currently 40+ years who were retained on ART at the end of the reporting period DHA-MIS: cumulative cohort report and age-disaggregated cohort report from EMRS	Increase		All 40+											50%			56%	12.0%	62%	24.0%	74%	48.0%	80%	60.0%
1	Outcome	Percentage of people who reported using a condom at last sexual intercourse with a nonmarital, noncohabiting partner	General population groups: number of people who reported using a condom at the last sexual intercourse with a nonmarital, noncohabiting partner MSM and TG: condom use at last anal sex FSW: condom use with their most recent client Source: MICS, DHS, MPHIA, BBSS	General population groups: number of people who reported a non-marital partner in the last 12 months MSM and TG: reported anal sex in the last 12 months FSW: reported sex with client in the last 12 months Source: MICS, DHS, MPHIA, BBSS	Increase		Females 15-49	2020			39.9%			51.4%	28.7%						57.1%		62.8%		74.3%		80.0%	
					Increase		Males 15-49	2020			56.6%			63.3%	11.8%						66.6%		70.0%		76.7%		80.0%	
					Increase	HIV O-10	AGYW 15-24	2020			49.0%			57.9%	18.1%						62.3%		66.7%		75.6%		80.0%	
					Increase	HIV O-7	ABYM 15-24	2020			64.0%			68.6%	7.1%						70.9%		73.1%		77.7%		80.0%	
					Increase	HIV O-5	FSW	2019			84.9%			86.8%	2.3%						87.5%		88.1%		89.4%		90.0%	
					Increase	HIV O-4a	MSM	2019			79.4%			83.4%	5.0%						84.7%		86.0%		88.7%		90.0%	
					Increase	HIV O-4.1b	Transgender																					
					Increase	HIV O-9	PWID																					
1	Output	Number of condoms distributed in the reporting period	Number of condoms delivered from the warehouse to health facilities and community distribution points in the reporting period DHA-MIS delivery records		Increase		Male	2020			##### #####	155,000,000		###### ####	0.0%	#########		##### #####	-30.6%		89,459,357	-16.8%	####### ###	-5.7%	####### ###	16.4%	####### ###	27.4%
					Increase		Female					675,000		675,000		0		0			449,545		509,297		628,802		688,555	
1	Output	Number of medical male circumcisions performed according to national standards	Number of voluntary medical male circumcisions performed during the reporting period according to national standards		Increase	YP-6			115,000		115,000	195,000		195,000	69.6%													
7	Outcome	Percentage of young people with comprehensive knowledge of HIV prevention	Number of respondents who have comprehensive knowledge about HIV transmission MICS, DHS	Number of young people 15-24 in the population survey MICS, DHS	Increase		AGYW 15-24	2020			39.2%			54.5%	39.0%						59.6%		64.7%		74.9%		80.0%	
					Increase		ABYM 15-24	2020			43.9%			57.4%	30.8%						62.0%		66.5%		75.5%		80.0%	
1, 6	Coverage	Percentage of key and other vulnerable populations	Number of KOVP have received a defined package	Estimated number of KOVP in the targeted population (area)	Increase	YP-2	AGYW 15-24																					
					Increase	KP-1e	Females 25-34														30%		40.0%		60.0%		70.0%	
					Increase	KP-1c	FSWs											87.1%			93.0%	6.8%	91.6%	5.1%	91.6%	5.1%	90.19%	3.5%

NSP Pillar	Domain	Indicator Description	Numerator Source/Definition	Denominator Source/Definition	Intention	GFATM code	Disaggregation	2020 Baseline Baseline Year	2020 Baseline Achievement Num	2020 Baseline Achievement Den	2020 Baseline Achievement Result	2022 Mid-term (Year 2) Target Num	2022 Mid-term (Year 2) Target Den	2022 Mid-term (Year 2) Target Result	2022 Mid-term (Year 2) Target Change from 2020	2022 Mid-term (Year 2) Achievement Num	2022 Mid-term (Year 2) Achievement Den	2022 Mid-term (Year 2) Achievement Result	2022 Mid-term (Year 2) Achievement Change from 2020	2022 Mid-term (Year 2) Achievement Rating	2023 (Year 3) Target Result	2023 (Year 3) Target Change from 2022	2024 (Year 4) Target Result	2024 (Year 4) Target Change from 2022	2026 (Year 6) Target Result	2026 (Year 6) Target Change from 2022	2027 (Year 7) Target Result	2027 (Year 7) Target Change from 2022
		reached with HIV prevention programs - defined package of services.	of HIV prevention services		Increase	KP-1a	MSMs											34.6%			36.1%	4.2%	38.4%	10.8%	43.1%	24.4%	43.6%	25.9%
					Increase	KP-1b	Transgenders																					
					Increase	KP-1f	Prisoners																					
					Increase	KP-1d	IDUs																					
1, 6	Output	Number of key and other vulnerable populations who received any PrEP product at least once during the reporting period.	Number of KOVP prescribed or dispensed any form of PrEP at least once during the reporting period.	NA	Increase	YP-4	AGYW 15-24														5,119		5,671		6,204		6,737	
					Increase		Females 15+									6,531		6,531			3,679	-43.7%	6,373	-2.4%	8,022	22.8%	9,389	43.8%
					Increase		Males 15+									10,655		10,65 5			6,002	-43.7%	10,398	-2.4%	13,089	22.8%	15,318	43.8%
					Increase	KP-6c	FSW									3,982		3,982			2,390	-40.0%	3,154	-20.8%	4,125	3.6%	4,621	16.0%
					Increase	KP-6a	MSM									1,936		1,936			1,694	-12.5%	3,629	87.5%	2,768	43.0%	3,116	60.9%
					Increase	KP-6b	Transgender														282		494		586		678	
					Increase	KP-6d	PWID														410		717		851		985	
8	Outcome	Percentage of facilities with tracer health products for HIV available on the day of the visit or day of reporting (on-shelf availability)	Number of facilities with physical stock of standard first line ART during quarterly integrated supervision (at least 1 pack of standard 1st line ART / TB treatment on the shelf on the day of supervision).	Number of facilities with at least 1 patient on ART during the reporting period	Increase	RSSH-O3	All									743	782	95.0%			95.80%	0.8%	95.80%	0.8%	96.60%	1.7%	97.10%	2.2%
1, 2	Coverage	Percentage of pregnant women who know their HIV status.	Number of pregnant women attending antenatal clinics and/or giving birth at a facility who were tested for HIV during pregnancy, at labour and/or delivery, or who already knew they were HIV-positive at the first antenatal care visit	Estimated number of pregnant women giving birth in the past 12 months	Increase	VT-1	Females pregnant							98%							98%		98%		98%		98%	
1, 2	Coverage	Percentage of women accessing antenatal care services who were tested for syphilis.	Number of women attending antenatal care services who were tested for syphilis at first ANC visit. DHA-MIS: ANC cohort report for women who completed ANC in the reporting period	Number of women attending antenatal care services at first ANC visit. DHA-MIS: ANC cohort report for women who completed ANC in the reporting period	Increase	VT-3	Females pregnant							95%		472,863	660,888	71.5%			95%	32.8%	95%	32.8%	95%	32.8%	95%	32.8%
1, 2	Coverage	Percentage of HIV-exposed infants receiving a virological test	Number of HIV exposed infants born during the reporting period	Estimated number of HIV-positive women who delivered	Increase	VT-2	Children 2 months									29,397	37,290	78.8%			85%	7.8%	85%	7.8%	85%	7.8%	85%	7.8%

NSP Pillar	Domain	Indicator Description	Numerator Source/Definition	Denominator Source/Definition	Intention	GFATM code	Disaggregation	2020 Baseline				2022 Mid-term (Year 2)									2023 (Year 3)		2024 (Year 4)		2026 (Year 6)		2027 (Year 7)	
									Achievement			Target				Achievement					Target		Target		Target		Target	
								Baseline Year	Num	Den	Result	Num	Den	Result	Change from 2020	Num	Den	Result	Change from 2020	Rating	Result	Change from 2022	Result	Change from 2022	Result	Change from 2022	Result	Change from 2022
		for HIV within 2 months of birth.	who received a virological HIV test within two months of birth	during the reporting period																								
1, 2	Outcome	Percentage of infants born to HIV-infected women discharged uninfected at 24 months of age (24 months infant HIV-free survival)	Number of HIV exposed children with a negative HIV test result from 6 weeks after cessation of breastfeeding DHA-MIS 24m age cohort report: discharged uninfected	Number of children retained alive in the HIV exposed follow-up program until at least 6 weeks after cessation of breastfeeding DHA-MIS 24m age cohort report: Total not transferred out	Increase		Children 24 months	2020	31,132	43,340	71.8%			85%	18.3%	32,541	40,750	79.9%	11.2%		85%	6.4%	85%	6.4%	85%	6.4%	85%	6.4%
1, 2	Coverage	Percentage of STI clinic patients who know their HIV status	Number of patients attending STI clinics who were tested for HIV, or who already knew they were HIV-positive	Number of patients attending STI clinics during the reporting period	Increase		All	2020	348,500	386,346	90.2%			95%	5.3%	404,399	445,348	90.8%	0.7%		95%	4.6%	95%	4.6%	95%	4.6%	95%	4.6%
3	Output	Number of HIV-positive women on ART screened for cervical cancer	Number of HIV-positive women on ART screened for cervical cancer	NA	Increase	CXCA_SCRN	Females 15+																158,147					
1	Output	Percentage of blood units screened for HIV, syphilis, hepatitis B and hepatitis C	Number of blood units collected that were screened for at least HIV, syphilis, hepatitis B and C	Total blood units collected from voluntary non-remunerated donors by MBTS and from replacement donors by hospitals	Increase		All														99%		99%		99%		99%	
8	Output	Number of local councils having management and data review meetings per schedule			Increase																							
8	Output	Number of national research dissemination workshops conducted			Increase			2020	1		100.0 %	1		1	0.0%	1		1	0.0%		1	0.0%	1	0.0%	1	0.0%	1	0.0%
8	Output	Proportion of national funding allocated to the National HIV Prevention Program	Annual expenditure for the HIV combination prevention pillar 1 (MKW) NASA	Annual expenditure for the whole HIV response (MKW) NASA	Increase			2019	23,580,500,000	#############	9.2%			25%	171.7%						25%		25%		25%		25%	

21 Annex

21.1 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**	

21.2 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		THREE TEST			
Summary Outputs	**2022**	**20234**	**2024**	**2025**	**2026**	**2027**
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.

21.3 Activities by Objective and Intervention

21.3.1 Combination Prevention Activities

Level	*Code*	*Description*
Sub theme	**1.1**	**Condom and Lubricant Programming**
Objective	**1.1.1**	**To increase access and uptake of quality condoms (male & female) and lubricants among high-risk populations using the Total Market Approach.**
Strategic Intervention	1.1.1.1	Strengthen leadership, governance, 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

Level	Code	Description
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 access and uptake of quality PrEP services among high risk and other vulnerable populations**
Strategic Intervention	1.2.1.1	Strengthen integration of PrEP with SRH/childcare and the community outreach services
Activity	1.2.1.1.1	Conduct capacity building of service providers in PrEP services provision targeting providers from SRH, childcare and community health providers.
Activity	1.2.1.1.2	Conduct integrated PrEP and SRH supervision

Level	Code	Description
Strategic Intervention	1.2.1.2	Improve quality of PrEP services in both public and private facilities.
Activity	1.2.1.2.1	Conduct quartrly PrEP mentorship in public and private facilities targeting poor performing facilities.
Activity	1.2.1.2.2	Conduct biannual PrEP dialogue meetings with representatives of private practitioners to discuss performance and other PrEP emerging issues.
Activity	1.2.1.2.3	Conduct capacity building of service providers in PrEP services provision from both public and private facilities
Activity	1.2.1.2.4	
Activity	1.2.1.2.5	
Strategic Intervention	1.2.1.3	Scale up PrEP services to additional Public and private facilities
Activity	1.2.1.3.1	Conduct site readiness assessment in public and private facilities.
Activity	1.2.1.3.2	
Activity	1.2.1.3.3	
Activity	1.2.1.3.4	
Objective	**1.2.2**	**To increase demand and uptake of PrEP services uptake**
Strategic Intervention	1.2.2.1	Strengthen demand for PrEP services
Activity	1.2.2.1.1	Conduct meeting with stakeholders to develop/revise PrEP IEC materials.
Activity	1.2.2.1.2	Print PrEP IEC materials
Activity	1.2.2.1.3	Conduct training of PrEP mobilizers to be conducting interpersonal communication in community.
Activity	1.2.2.1.4	
Strategic Intervention	1.2.2.2	
Activity	1.2.2.2.1	
Activity	1.2.2.2.2	
Sub theme	**1.3**	**Voluntary Medical Male Circumcision**
Objective	**1.3.1**	**Increase access, uptake and quality of VMMC services targeting high risk and priority populations in all high incidence districts**

Level	*Code*	*Description*
Strategic Intervention	1.3.1.1	**Expand the availability through Integration and routinization VMMC with other services. and program management into the MOH structures across all levels**
Activity	1.3.1.1.1	Building capacity for the private sector
Activity	1.3.1.1.3	Conduct Convention and device Trainings for HCWs and selected providers from both public and private sector.
Activity	1.3.1.1.4	Provision of routine VMMC services according to MOH guidelines.
Activity	1.3.1.1.7	Conduct quarterly Supportive supervision
Activity	1.3.1.2.1	
Strategic Intervention	1.3.1.3	**Strengthen VMMC commodities supply chain management at all levels through appropriate forecasting and close monitoring of commodity quantities and storage to be taken under PSM general section**
Activity	1.3.1.3.1	Conduct routine supply chain trail. Conduct quarterly mentorship visits to all VMMC sites

Level	Code	Description
	1.3.1.3.2	
Strategic intervention		Improve monitoring of program efficiency indicators to establish a comprehensive, responsive, and flexible M&E system that can support and meet the demands of the program across all levels of the health system.
Activity	1.3.1.3.3	Conduct data validation in all sites.
Activity	1.3.1.3.4	Train M&E staff in data management and triangulation.
Activity	1.3.1.3.5	Printing registers and reporting books
Strategic Objective 2	1.3.1.5	**Increase social acceptance and demand for VMMC interventions among key and priority population**
Strategic Intervention	1.3.1.6	Integrate VMMC demand creation across all health entry points, including PrEP, ST
Activity	1.3.1.6.1	Development and printing of integrated messages for HI prevention
Activity	1.3.1.6.2	Conduct targeted demand creation orientation for female sex workers as mobilisers of VMMC clients.
Activity	1.3.1.6.3	Revision of the national VMMC communications strategy
Activity	1.3.1.6.4	
Strategic intervention Activity		Strengthen the use of a wide range of disciplines, including marketing, behavioral economics, and human-centered design, to inform targeted demand-generation strategies
Activity		Train community, FSW and faith-based groups for demand creation
		Continuously monitor the market and changes in beliefs and values, and adapt the interventions used to maintain relevance and efficacy
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**

Level	*Code*	*Description*
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.
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 assessment of challenges and successes in current youth centre formats/types

Level	Code	Description
Activity	1.4.1.2.1 6	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	1.4.1.2.1 0	Increase the number of YFHS Master Trainers at district level to provide decentralized YFHS training for providers within and outside the YFHS programme
Activity	1.4.1.2.1 1	Promote initiatives reaching out to out-of-school youths with YFHS information, education, communications (IEC) and integrated behavioural change communications (BCC) interventions.
Activity	1.4.1.2.1 2	Promote the use of innovative client/provider feedback appropriate technologies by YFHS providers at all levels for targeted client responsive interventions.
Activity	1.4.1.2.1 7	Provide tools to support programming and collaboration between the YFHS coordinator and district youth officer (DYO) for implementation of SRHR activities.
Activity	1.4.1.2.1 3	Refurbishment of youth centers and health centers
Activity	1.4.1.2.1 4	Strengthen and scale up support groups for ALHIV including peer led enhanced adherence support
Activity	1.4.1.2.1 5	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

Level	*Code*	*Description*
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
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

Level	*Code*	*Description*
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 PWUIDs 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
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

Level	Code	Description
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.
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

Level	Code	Description
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 labelled 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, PWUIDs, MSW, and TGs
Activity	1.5.2.1.1	Integrate studies for MSW, PWUD and TGs and conduct adapted survey to estimate the number of FSW, MSM, MSW, TGs, PWUID (assure representative country wide sample)
Strategic Intervention	1.5.2.2	Coordinate research and implementing partners to understand findings on interventions targeting PWUDs, MSW, and TGs to inform the development of interventions.
Activity	1.5.2.2.1	Conduct a national validation meeting on research findings on PWUDs, MSW, and TGs
Activity	1.5.2.2.2	Conduct district-based dissemination meetings on research findings on PWUDs, MSW, and TGs

Level	*Code*	*Description*
Activity	1.5.2.2.3	Conduct transformative study on PWUDs, 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
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
Activity	1.5.3.2.6 5	Set up and strengthen coordination mechanisms for HIV and AIDS response into the overall emergency response Build capacities of (include health care workers, gender officers, police, DSWO) communities and their structures to implement HIV and AIDS related activities in humanitarian assistance programs
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.

Level	*Code*	*Description*
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
Activity	1.6.1.1.3	Conduct district based quarterly PMTCT Community awareness and linkage meeting in 10 districts with high HIV incidence.
Activity	1.6.1.1.4	Develop the job aids on new policies including e-MTCT and integrated testing.
Activity	1.6.1.1.5	Conduct a validation workshop for the developed job aids
Activity	1.6.1.1.6	Print and distribute 3000 copies of job aids on new policies including e-MTCT and integrated testing to be distributed in all (over 750) the facilities providing ANC
Activity	1.6.1.1.7	Train 245 Volunteer mentor mothers on HIV self-testing
Strategic Intervention	1.6.1.2	Evaluate and the scale-up of PrEP for AGYW, pregnant and breastfeeding women.
Strategic Intervention	1.6.1.3	Offer integrated and youth-friendly health services (YFHS) to AGYW and boys
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

Level	*Code*	*Description*
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
Activity	1.6.1.3.6	Conduct PrEP Service providers training targeting 350 nurses and midwives working in the ANC, Maternity, FP, MCH Clinics
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 counselling on a wide range of family planning methods to HIV positive women.
Activity	1.6.2.1.1	Conduct counselling 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.

Level	*Code*	*Description*
Activity	1.6.3.1.1	Optimize screening of pregnant and lactating women for HIV, syphilis and viral hepatitis in ANC, labour and post-natal
Activity	1.6.1.1.2	Train 175 Nurses and Midwives in Viral Hepatitis.
		Support the provision adequate HIV, syphilis and hepatitis, HIVST testing commodities to pregnant and breastfeeding women and their partners
Activity	1.6.3.3.1	Train district-based ToT (including PMTCT, FP, MCH, MNH Coordinators) to orient HSAs on HIV testing for breastfeeding women attending Immunisation visits at both facility and community clinics to increase demand uptake of service.
Activity	1.6.3.1.3	Promote early scheduling of first antenatal visit, and retention for ANC and referrals for HIV care
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	Conduct integrated bi-annual Quality Improvement Zonal eMTCT/EID review meetings
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.

Level	Code	Description
Activity	1.6.4.1.4	Conduct targeted community dialogue session with male partners (Train male champions) of pregnant and breastfeeding women on various topic including HIV combination prevention, and care and treatment.
Strategic Intervention	1.6.4.2	Improve monitoring and follow-up of HIV exposed infants.
Activity	1.6.4.2.1	Procure 500 push bicycles for defaulter tracing, index testing, and client follow-up in the community by the Community Midwives Assistance and Social Workers in Non partner supported facilities.
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	Promote the T=T (Tizirombo tochepa=Thanzi) philosophy among pregnant and lactating mothers, and their partners
Activity	1.6.4.3	Recruite 200 social workers to provide adherence and psychosocial support services for pregnant and breastfeeding women on ART
Activity	1.6.4.3	Recruit 200 and deploy CMAs in the community to provide defaulter tracing in districts with high HIV incidence among pregnant and breastfeeding women
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	1.6.4.3.10	Print Maternity Register
Activity	1.6.4.3.10	Print and distribute HIV exposed infant follow up cards
Activity	1.6.4.3.10	Print and distribute pathway for screening and tracking HIV exposed infant
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	1.6.4.3.14	Procurement of POC machines
Activity	1.6.4.3.14	Procurement of cartilages m-PIMA
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	1.6.4.3.17	Conduct targeted district based Bi-Annual EID Mentorship in all the 28 districts targeting non partner supported facilities
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**

Level	*Code*	*Description*
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	Conduct mass media campains for STIs and SRH services
Activity	1.7.1.1.2	Print STI/SRH IEC materials.
Activity	1.7.1.1.3	Conduct orientation meetings of STI and SRH services targeting community health workers
Activity	1.7.1.1.4	Conduct Annual STI/Cervical cancer awareness week.
Activity	1.7.1.1.5	
Activity	1.7.1.1.6	
Strategic Intervention	1.7.1.2	Strengthen quality of STI/SRH services in both public and private facilities
Activity	1.7.1.2.1	Conduct quarterly supervision targeting private facilities.
Activity	1.7.1.2.2	Conduct biannual dialogue meetings with private practitioners to discuss performance and other SRH/STI emerging issues.
Activity	1.7.1.2.3	Conduct meetings with STI/SRH stakeholders to revise STI/SRH job-aids and SOPs
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 STI services provision trainings targeting SRH service provides.
Activity	1.7.1.3.2	Conduct integrated STI/SRH mentorship targeting poor performing facilities
Activity	1.7.1.3.3	Conduct Integrated STI/SRH supervision.
Strategic Intervention	1.7.1.4	
Activity	1.7.1.4.1	
Activity	1.7.1.4.2	
Activity	1.7.1.4.3	
Activity	1.7.1.4.4	
Activity	1.7.1.4.5	

Level	*Code*	*Description*
Activity	1.7.1.4.6	
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 lab personnel in AMR monitoring/testing providers
Activity	1.7.1.5.2	
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.

Level	*Code*	*Description*
Activity	1.8.1.4.1	Conduct quarterly spot checks targeting construction and plantation sectors to assess implementation of standard HIV and AIDS package
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 labour inspection checklist to include HIV and AIDS prevention
Activity	1.8.2.1.2	TOT training targeting labour 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 MBCH to cover private companies under the MCCI and ECAM
Activity	1.8.3.1.1	Conduct and implement functional review of MBCH 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

Level	Code	Description
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
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 MBCH 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.

21.3.2 Differentiated HIV Testing Activities

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

Level	Code	Description
Activity	2.1.1.1.13	Promote targeted testing in prison and confined settings (refugee camps)
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 barriers 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	MBCH 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

Level	*Code*	*Description*
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
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

Level	Code	Description
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 approaches, 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

Level	Code	Description
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

21.3.3 Treatment, Care, and Support and TB/HIV Activities

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 Site assessments to scale up care to more facilities, based on geospatial data available
Activity	3.1.1.1.2	Construction of extra prefab Storage units
Activity	3.1.1.1.3	Conduct integrated trainings to service providers (both new and refresher training)
Activity	3.1.1.1.4	Procure ART for HIV and Viral Hepatitis
Activity	3.1.1.1.5	Conduct supervision and support mentorship in all health facilities
Activity	3.1.1.1.6	Conduct training in Quality Improvement initiatives in health facilities (HIV QIST and WITS)
Activity	3.1.1.1.7	Print M&E materials and procure stationary items

Level	*Code*	*Description*
Activity	3.1.1.1.8	Renovate/refurbish clinic consultation rooms devoted to HIV services
Strategic Intervention	3.1.1.2	Improve retention and adherence in ART among adults, adolescents, and children
Activity	3.1.1.2.1	Recruit psychosocial counsellors to improve drug retention and adherence among all patient groups
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	Pilot and implement differentiated service delivery models for PLHIV on ART
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) for adults, children, and vulnerable/underserved populations
Activity	3.1.1.3.1	Conduct ARV toxicity monitoring tests
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

Level	*Code*	*Description*
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)
Activity	3.1.1.4.2	Conduct VL coordination meetings between DHA, HTSS and key stakeholders
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 community DSD models (MMD, Integrated Community ART services)
Activity	3.1.1.5.2	Deliver integrated health post level HIV/SRH/STI/VH and other related services
Activity	3.1.1.5.3	Conduct Back to Care trainings for community-based cadres
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 co-morbidities and mortality**
Strategic Intervention	3.1.2.1	Improve monitoring and management of advanced HIV disease including cancers
Activity	3.1.2.1.1	Conduct trainings in Advanced HIV disease management
Activity	3.1.2.1.2	Conduct HIV/TB related death audits
Activity	3.1.2.1.3	Procure preventive therapy for all PLHIV(CPT and TPT)
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	Procure equipment for advanced HIV in-patient monitoring

Level	Code	Description
Activity	3.1.2.1.6	Procure laboratory reagents for 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
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	Procure Advanced HIV disease commodities (PSM)
Strategic Intervention	3.1.2.4	Strengthen coordination of treatment, care and support at national and district level.
Activity	3.1.2.4.1	conduct, care and support coordination meetings
Activity	3.1.2.4.2	Support M&E and accountability at the facility level
Activity	3.1.2.4.4	Strengthen MBCH (costed under workplace)
Strategic Intervention	3.1.2.5	Ensure access to PEP in all hospitals and health centres.
Activity	3.1.2.5.1	Procure PEP

Sub theme	**4.1**	**TB/HIV**

Level	*Code*	*Description*
Objective	**4.1.1**	**To reduce incidence, morbidity and mortality in TB/HIV co-infected patients**
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 workers in TB/HIV coinfection.
Activity	4.1.1.1.3	Review and update TB/HIV policies and guidelines with key stakeholders
Activity	4.1.1.1.4	Promote advocacy for TB/HIV integration of services in private clinics with MBCH
Activity	4.1.1.1.5	Conduct trainings of Private clinics in screening and Diagnosis for TB/HIV
Activity	4.1.1.1.6	Conduct district level coordination meetings
Activity	4.1.1.1.7	Conduct joint/integrated HIV/TB supportive supervision and mentorship at national level
Activity	4.1.1.1.9	Develop 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	Conduct training in screening and diagnosis to increase the competence of providers
Activity	4.1.1.2.2	Print and distribute screening tools to all health facilities (algorithms and job aids)

Level	*Code*	*Description*
Activity	4.1.1.2.3	Promote community Involvement in HIV & TB through CSOs including integration of activities to reduce duplication
Activity	4.1.1.2.4	Incorporate TB Screening TORs into the community health package
Activity	4.1.1.2.6	Print and distribute health promotion messages on TB screening for PLHIV
Activity	4.1.1.2.7	Conduct training and scale up FASH for improved diagnosis of TB among PLHIV
Activity	4.1.1.2.8	Scale up Xpert RIF testing
Activity	4.1.1.2.9	Scale up TB/HIV screening in key populations: prisoners, minors, maternal, children
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	Develop guidelines/SOPs for conducting TB deaths audits
Activity	4.1.1.3.5	Conduct death audits in all health facilities
Strategic Intervention	4.1.1.4	Increase coverage of TB Preventive Therapy (TPT).
Activity	4.1.1.4.1	Procure TPT to ensure availability and uninterrupted supply
Activity	4.1.1.4.2	Incorporate Monitoring and Evaluation tools within existing information systems for TPT to improve quality of recording of clients on TPT
Activity	4.1.1.4.3	Conduct awareness on Pharmacovigilance procedures among HCWs at the facility level
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

Level	Code	Description
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	4.1.1.4.13	Update the policy on TB Preventive Therapy regularly

21.3.4 Vulnerable Children, Reducing Human Rights & Gender-Related Barriers, and SBCC Activities

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

Level	Code	Description
Strategic Intervention	5.1.1.3	Build the capacity of Community Child Protection Workers through innovative approaches including training programme, provision of incentives such equipment and logistics support to enable them effectively to perform their roles.
Activity	5.1.1.3.1	Training case managers in case management.
Strategic Intervention	5.1.1.4	Strengthen resource mobilisation at all levels, including lobbying the Malawi Government and Local Government Authorities (LGA) to increase the number of CPWs on government payroll, to increase and sustain investments into the HIV sensitive Child Protection Case Management System
Activity	5.1.1.4.1	Conduct advocacy and lobbying meetings with various government and nongovernmental players to raise fund for child protection activities
Activity	5.1.1.32.21	Strengthen engagement between Ministry of Gender, Treasury and Ministry of Local Government to incorporate all CCPW on the payrollConduct advocacy and lobbying meetings with various government and notngovenment players to raise fund for child protection activities
Strategic Intervention	5.1.1.5	Strengthen SBCC activities at community level for the communities to abandon harmful

Level	*Code*	*Description*
		practices, adhere to child rights, adopt positive norms and are mobilised to run community based structured for child protection and development. NPA for OVC, 2022 to 2026
Activity	5.1.1.5 .1	Train District TWG and gender officers on HIV and traditional norms to enable them mobilise traditional leaders and gatekeepers to abandon harmful practices, adhere to child rights, adopt positive norms
Activity	5.1.1.53.21	Train traditional leaders District TWG and gender officers on HIV and traditional norms to enable them mobilise traditional leaders and gatekeepers to abandon harmful practices, adhere to child rights, adopt positive norms
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.

Level	*Code*	*Description*
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.
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.

Level	Code	Description
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.

Level	*Code*	*Description*
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
Activity	6.1.2.1.5	TOT training to change agents in community awareness models including SaSa-Faith toolkit, Barbershop toolkit, HeForShe model

Level	*Code*	*Description*
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

Level	*Code*	*Description*
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

Level	*Code*	*Description*
Activity	7.1.1.3.2	Validate the findings of the consultant
ObjectiveObjective	**7.1.27.1.2**	**To increase demand for HIV services amongst the general population.** **To increase demand for HIV services amongst the general population.**
Strategic Intervention	7.1.2.1	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	7.1.2.1.1	Hire a local consultant to perform comprehensive qualitative studies to inform the development of relevant SBCC interventions
Activity	7.1.1.2.1	Validate the findings of the consultant
Objective	**7.1.3**	**To empower individuals, communities and institutions to adopt positive health, HIV and GBV services seeking behaviours** **Strategic Interventions**
Strategic Intervention	7.1.3.1	Mobilize and build the capacity of existing structures and networks to address harmful cultural practices and gender norms that promote HIV transmission

Level	*Code*	*Description*
Activity	7.1.1.3.1	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.
Activity	7.1.1.3.2	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	7.1.3.2	Mobilise community structures to conduct community mobilization and sensitization activities to promote health-seeking behaviours among sexually-active males.
Activity	7.1.3.2.1	Conduct quarterly district-based meetings to promote health-seeking behaviours among sexually-active males
Strategic Intervention	7.1.3.3	Recruit and engage leaders as champions/role models and ambassadors of HIV prevention at all levels including political, religious and traditional leaders.
Activity	7.1.3. 3.1	Capacitate and support agents
Activity	7.1.3. 3.21	Implement HIV priority activities in the male engagement strategy to enhance access to and utilization

Level	*Code*	*Description*
		of HIV services by men as proposed by the Male Engagement Strategy
Strategic Intervention	7.1.3.4	Conduct a comprehensive TB and HIV treatment literacy programme among PLHIVs and their caretakers
Activity	7.1.3.4.1	Support group awareness meetings
Strategic Intervention	7.1.3.5	Establish SBCC coordination structures at national and district level and support their operations to ensure harmonization of SBCC efforts by stakeholders.
Activity	7.1.3.5.1	Refer to cross-listed Activity 1.6.1.1.2: Establish AGYW and SBCC coordination structures at national, district, and community level

21.3.5 RSSH Activities

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	*Code*	*Description*
		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.
Activity	8.1.2.1	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

Level	*Code*	*Description*
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.

Level	*Code*	*Description*
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.
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

Level	Code	Description
Activity	8.3.1.1.4	Structural review of all programmatic coordinating bodies (Manet+, MIAA, MBCH, DRD for Public Sector, MANASO) to assess the viability of increasing 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

Level	*Code*	*Description*
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 [Develop, deploy and expand a web-based HIV and AIDS data pipeline for NAC M&E]
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.
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)

Level	*Code*	*Description*
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

Level	*Code*	*Description*
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
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

Level	*Code*	*Description*
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

Level	Code	Description
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
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

Level	*Code*	*Description*
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.

Level	*Code*	*Description*
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
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

Level	*Code*	*Description*
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

Level	*Code*	*Description*
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
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

Level	Code	Description
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
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

Level	Code	Description
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

Level	*Code*	*Description*
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
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

Level	Code	Description
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

Level	*Code*	*Description*
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 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

Level	*Code*	*Description*
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
Activity	8.9.1.1.1	Build the capacity of Village Health Committees

Level	Code	Description
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

Level	*Code*	*Description*
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