



Malawi National Strategic Plan for HIV and AIDS

2023–2027

***Sustaining Gains and Accelerating Progress
Towards Ending the Epidemic***

Table of Contents

1	Introduction and Background	14
1.1	Malawi Context	14
2	Situation Analysis	16
2.1	Epidemic Overview	16
2.2	Trends in Total HIV Infections and Incidence	19
2.2.1	Elimination of Mother-to-Child Transmission (eMTCT)	21
2.2.2	New Opportunities for Cost-Effective Prevention Programming	22
2.3	HIV Disease Burden and Mortality.	25
2.3.1	New Opportunities for Reducing Morbidity and Mortality among PLHIV.	28
2.4	Progress Towards the 95:95:95 Treatment Targets	28
2.5	Determinants of HIV Infection	30
3	Mid-Term Review of the NSP 2020-2025	33
4	The Revised National Strategic Plan for HIV and AIDS	38
4.1	Overview	38
4.2	Vision, Mission, and Goal	38
4.2.1	Vision	38
4.2.2	Mission.....	38
4.2.3	Goal.....	38
4.3	Guiding Principles	38
4.4	Legal, Policy and Development Frameworks	40
4.4.1	National Instruments	40
4.4.2	Global Instruments	41
4.4.3	Regional Instruments	41
5	Objectives, Targets, and Strategic Interventions by Pillar	43
5.1	Pillar 1: Combination Prevention	43
5.1.1	Condom and Lubricant Programming	45
5.1.2	Pre-Exposure Prophylaxis	46
5.1.3	Voluntary Medical Male Circumcision	47
5.1.4	Adolescent Girls and Young Women.....	48
5.1.5	Elimination of Mother to Child Transmission (eMTCT)	50

5.1.6	Sexually Transmitted Infections and Sexual and Reproductive Health Services	51
5.1.7	Wellness and Workplace HIV Programmes	53
5.1.8	Blood Safety	54
5.2	Pillar 2: Differentiated HIV Testing Services	55
5.3	Pillar 3: Treatment, Care and Support for HIV and Related Diseases	57
5.4	Pillar 4: TB/HIV	58
5.5	Pillar 5: Key and Other Vulnerable Populations	59
5.6	Pillar 6: Reducing Human Rights and Gender-Related Barriers	62
5.7	Pillar 7: Social and Behaviour Change Communication	64
5.8	Pillar 8: Resilient and Sustainable Systems for Health	66
5.8.1	Governance and Leadership of the Response.....	66
5.8.2	Financial Management.....	67
5.8.3	Coordination of the Response.....	69
5.8.4	Health Products Management Systems	70
5.8.5	Health Information Systems.....	71
5.8.6	Human Resources for Health	72
5.8.7	Infrastructure, Transport, and Equipment	73
5.8.8	Integrated Service Delivery and Quality Improvement	74
5.8.9	Community Systems Strengthening.....	75
5.8.10	Laboratory Systems	77
5.8.11	HIV response in emergency settings	79
6	Implementation Arrangements and Multisectoral Response	81
7	Monitoring and Evaluation and Research	83
8	Costing Results	85
8.1	Overall NSP 2023-2027 Cost	85
8.2	Programmatic Costs	85
8.3	RSSH Costs	86
8.4	Commodities Costs	86
8.5	Financing for HIV NSP 2023-27	87
8.6	Costing Limitations	89
9	Performance Framework	90
9.1	Activities by Objective and Intervention	95

Foreword

As Malawi strives to meet aspirations of the Agenda 2063, government recognises that HIV is one of the major development risks that must be mitigated. Therefore, through the Revised and Extended National Strategic Plan (NSP), the country is committed to ensuring that all necessary HIV and AIDS control measures are implemented to eliminate AIDS as a public health threat by 2030. The legal, policy and political environment in Malawi is favourable to achieve this goal. Government enacted the HIV and AIDS (Prevention and Management) Act No. 9 of 2018 to create a conducive environment to prevent and manage HIV and AIDS. This is in recognition of the fact that HIV and AIDS prevention and management is one of the key priorities that contribute to Human Capital Development, one of the enablers of the Malawi Vision 2063.

I am pleased that, despite the adverse effects stemming from COVID-19 from 2019 to 2022, Malawi has made tremendous progress towards achieving the global 95:95:95 Fast-Track targets set out in the NSP 2020-2025. In addition, recent estimates indicate a continued declining trend in the annual number of new HIV infections in Malawi, particularly among 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 AIDS as a public health threat by 2030, despite the existence of resource constraints. This is an opportune time to revise the NSP 2020-2025 taking advantage of the following strategic frameworks: Health Sector Strategic Plan III 2023-2030; National Health Financing Strategy 2023-2030; 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 current NSP, will ensure effective and efficient implementation of HIV and AIDS programmes.

Despite achievements of the treatment targets, the annual number of new infections and AIDS-related deaths remain unacceptably high. In addition, the macro-economic environment has become increasingly challenging owing to recurrent extreme weather patterns and downstream effects of the Russian-Ukraine War among others. As such, this revised NSP emphasises efficient utilisation of available resources and implementation of targeted client-centred interventions to achieve a steep downtrend in the number of new infections and improve the survival and quality of life of People Living with HIV (PLHIV). The revised NSP will focus on strengthening integration and linkage of services across disease programmes within the health sector. The social sector has also been identified in the NSP as a crucial element to address the multifaceted social determinants of HIV. Lessons learnt during the COVID-19 disruption of health services and the subsequent recovery should help to rebuild the national HIV and AIDS response in emergencies. This revised NSP demonstrates Government of Malawi's strong commitment towards a multi-sectoral HIV and AIDS response, led and coordinated by the National AIDS Commission (NAC), with meaningful participation of all partners and stakeholders. Therefore, the NSP should be used by all stakeholders as a blueprint for planning and implementing HIV and AIDS programmes at all levels.



Dr Chipo Kanjo

Chairperson – NAC Board of Commissioners

Acknowledgements

NAC, in collaboration with the Ministry of Health (MoH), wish to express gratitude to the various organisations working in HIV and AIDS programming including government ministries, departments and agencies; civil society organisations; local and international non-governmental organisations; private sector organisations; and development partners for their valuable contributions towards the revision and extension of the National Strategic Plan (NSP) for HIV and AIDS 2020-2025 to NSP 2023–2027.

The revision of the NSP was spearheaded by the Mid-Term Review (MTR) Steering Committee that was chaired by NAC with active members from the Directorate of HIV, STIs and Viral Hepatitis in the MoH and development partners. A team of five technical consultants led by Prof. Victor Mwapasa from Kamuzu University of Health Sciences produced this revised NSP. Special gratitude should also go to all stakeholders at district and national levels, including traditional and religious leaders, for their critical review of the NSP 2020-2025 and valuable modification suggestions considering the realities of the local context and limited resource envelope. Their continued passion, dedication, and commitment to *sustaining gains and accelerating progress towards ending the epidemic* in Malawi is highly valued.

Finally, we greatly appreciate the support from Joint United Nations Programme on HIV and AIDS (UNAIDS), the World Health Organization (WHO) and the Government of Malawi through NAC, for funding the process of revising the NSP, and the Clinton Health Access Initiative (CHAI) for the comprehensive costing of the revised strategy.



Dr Beatrice Matanje

Chief Executive Officer – National AIDS Commission

Abbreviations and Acronyms

ABYM	Adolescent Boys and Young Men
ADC	Area Development Committee
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ALHIV	Adults Living with HIV
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BBSS	Biological and Behavioural Surveillance Survey
CAB-LA	Long Acting Injectable Cabotegravir
CAC	Community AIDS Committee
CBO	Community-Based Organisation
CCPWs	Childcare Protection Workers
CHAM	Christian Health Association of Malawi
CHT	Community Health Teams
CHW	Community Health Worker
CLHIV	Children Living with HIV
CMAs	Community Midwife Assistants
CMST	Central Medical Stores Trust
CRVs	Civil Registration and Vital Statistics
CSO	Civil Society Organisation
DACC	District AIDS Coordinating Committee
DDC	District Development Committee
DPD	Director of Planning and Development
DHA	Directorate of HIV and AIDS
DHAMIS	DHA Management Information Systems
DHIS-2	Digital Health Information System-2
DHRMD	Department of Human Resources, Management and Development
DICs	Drop-In Centres
DIP	District Implementation Plan
DSD	Differentiated Service Delivery
DTG	Dolutegravir
EID	Early Infant Diagnosis
eHIN	Electronic Health Information Network
EMR	Electronic Medical Records
eMTCT	Elimination of mother-to-child transmission of HIV
EPI	Expanded Programme in Immunisation

ERP	Enterprise Resource Planning
EQA	External Quality Assurance
FASH	Focused Assessment with Sonography for HIV-associated tuberculosis
FBO	Faith-Based Organisation
FGS	Female Genital Schistosomiasis
FSW	Female Sex Worker
GAM	Global AIDS Monitoring
GBV	Gender-Based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoM	Government of Malawi
HAC	Hospital Advisory Committees
HCMC	Health Centre Management Committees
HCW	Health Care Worker
HDA	HIV Diagnostic Assistant
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HPV	Human Papilloma Virus
HRH	Human Resources for Health
HAS	Health Surveillance Assistant
HSSP	Health Sector Strategic Plan
HSV	Herpes simplex virus
HTS	HIV Testing Services
IEC	Information Education and Communication
i-CHS	integrated Community Health Information System
IMCI	Integrated Management of Childhood Illnesses
JAR	Joint Annual Review
KVP	Key and Vulnerable Population
LAHARS	Local Authority HIV and AIDS Reporting System
LGAs	Local Government Authorities
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MBCA	Malawi Business Coalition Against HIV and AIDS
MBC Health	Malawi Business Coalition on Health
MBTS	Malawi Blood Transfusion Services
MCCI	Malawi Confederation of Chambers of Commerce and Industry
MDA	Ministries, Departments, and Agencies
MDHS	Malawi Demographic and Health Survey
MDR	Multi-Drug Resistance

MERS	Monitoring and Evaluation, Research and Surveillance
MICS	Multiple Indicator Cluster Survey
MIPs	Mother-Infant Pairs
MoH	Ministry of Health
MoGCDSW	Ministry of Gender, Children, Disability and Social Welfare
MOU	Memorandum of Understanding
MPF	Malawi HIV and AIDS Partnership Forum
MPHIA	Malawi Population-based HIV Impact Assessment
MSCTP	Malawi Supply Chain Transformation Plan
MSM	Men who have Sex with Men
MSW	Male Sex Worker
MTCT	Mother-to-Child Transmission
MTR	Mid Term Review
NAC	National AIDS Commission
NAF	National HIV and AIDS Framework
NAAT	Nucleic Acid Amplification Tests
NASA	National AIDS Spending Assessment
NCD	Non-Communicable Disease
NCHF	National Community Health Framework
NG	Neisseria Gonorrhoea
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NHRL	National HIV Reference Laboratory
NRB	National Registration Bureau
NSC	National Steering Committee
NSO	National Statistical Office
NSP	National Strategic Plan
OHSP	One Health Surveillance Platform
OPD	Outpatient Department
ORT	Other Recurrent Transaction
OVP	Other Vulnerable Populations
PALMS	Prevention and Adaptive Learning Management System
PEPFAR	US President's Emergency Plan for AIDS Relief
PPE	Personal Protective Equipment
PITC	Provider Initiated Testing and Counselling
PWID	People Who Inject Drugs
PLHIV	People Living with HIV
PMRA	Pharmacy and Medicines Regulatory Authority
PNHAO	Principal Nutrition and HIV and AIDS Officer

POC	Point-of-Care
PrEP	Pre-Exposure Prophylaxis
PPM	Global Fund Pooled Procurement Mechanism
PSM	Procurement and Supply Management
QIs	Quality Improvement
QCs	Quality Controls
RM	Resource Mapping
RSSH	Resilient and Sustainable Systems for Health
SBCC	Social Behaviour Change Communication
SDG	Sustainable Development Goals
SLA	Service Level Agreements
SMA	Syndromic Management Approach
SRHR	Sexual and Reproductive Health Rights
SRHS	Sexual and Reproductive Health Services
STI	Sexually Transmitted Infection
TASP	Treatment As Prevention
TAT	Turn-Around-Time
TB	Tuberculosis
TF	Task Force
TMA	Total Market Approach
TPT	TB Preventive Therapy
TTIs	Transfusion-Transmitted infections
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
VDC	Village Development Committees
VHC	Village Health Committees
VL	Viral Load
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
WLHIV	Women Living with HIV
YFHS	Youth Friendly Health Services
YKP	Young Key Populations
3HP	Isoniazid and Rifapentine
3PL	Third-Party Logistics

List of Figures

Figure 1: Malawi's population by district.....	14
Figure 2: Trends in total PLHIV, new infections, and AIDS deaths in Malawi 1980-2030 (2023 Spectrum model estimates) ¹	16
Figure 3: Geospatial model estimates for population density, adult HIV prevalence and PLHIV density at 1 km ² grid level	18
Figure 4: Incidence distribution by age and sex in the general population 2010 and 2023 ¹⁴	19
Figure 5: Distribution of sources for mother-to-child transmission 2022 ¹⁴	22
Figure 6: Distribution of untreated PLHIV by sex and district in 2023	23
Figure 7: HIV-related deaths averted by biomedical program area 2002-2021. 2022 Goals model.....	25
Figure 8: Disability-adjusted life-years lost and deaths by cause in Malawi 2015-2019 (Tanzi la Onse model estimates)	26
Figure 9: Number of AIDS deaths by age and sex in 2010 and 2023 (2023 Spectrum model estimates) ¹⁴	26
Figure 10: Number of PLHIV by age and sex in 2010, 2020 and 2027 (2023 Spectrum model estimates) ¹⁴	27
Figure 11: Figure 11: Trend in AIDS and non-AIDS deaths among PLHIV 2023-2030. (2023 Spectrum model estimates)	27
Figure 12: Diagnosis, treatment and viral load suppression cascade for children, women and men living with HIV by December 2022.....	29
Figure 13: Status of 95-95-95 treatment targets in 2022 by district.....	30
Figure 14: The main coordinating bodies of the national response in Malawi	81
Figure 15: Funding by Programmatic Function for 2027. Source 2020 NASA	88

List of Tables

Table 1: 2023 Spectrum, Naomi model and UNAIDS key population workbook consensus estimates (for 2023). ¹⁴	18
Table 2: UNAIDS AGYW risk stratification estimates for 2022, for 9 districts with AGYW incidence >0.2% (rounded values).....	21
Table 3: Potential impact (infections averted) and cost-effectiveness of selected prevention interventions. Source: 2022 Goals (2023-2027) model for Malawi. Ranked by cost-effectiveness.	44
Table 4: Total Cost of the NSP 2023-2027	85
Table 5: Programmatic cost of the NSP 2023-2027 (in million USD)	85
Table 6: RSSH cost of the NSP 2023-2027 (in million USD)	86
Table 7: Commodities cost of NSP 2023-2027 (in million USD).....	87
Table 8: HIV Funding Sources for 2026/27 FY. Source - 2020 Malawi NASA Report	87
Table 9: Financial gap of the HIV NSP 2023-27 against total resources projected – USD (in millions)	89
Table 10: Summary performance framework for the National Strategic Plan for HIV and AIDS 2023-2027.....	90

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 and AIDS in Malawi. It extends and replaces the NSP 2020–2025, capitalising on recent local and international developments in policies and strategies on HIV and AIDS. It draws lessons learned from the first 2 years of program implementation, including implications of internal and external shocks such as the COVID-19 pandemic, other disease outbreaks, natural disasters, and global economic crisis. The revised strategy builds on remarkable achievements registered by Malawi by reaching 96:95:94 of the 95:95:95 Fast-Track targets ahead of schedule. It also endeavours to address shortcomings that prevent the country from drastically reducing new HIV infections and AIDS-related deaths. The strategy articulates Malawi’s renewed effort to accelerate the pace towards meeting the goal of eliminating AIDS as a public health threat by 2030.

The vision of the revised strategy remains *a healthy and prosperous nation free from the burden of HIV and AIDS*. The revised NSP outlines the mission, objectives, strategic interventions, implementation arrangements and resources requirements over the 2023-2027 period to realise this long-term vision. The key targets by 2027 are to reduce the annual number of HIV infections from 16,400 in 2022 to 7,400 and AIDS related deaths from 12,100 in 2022 to 7,700 and to achieve virtual elimination of mother-to-child transmission of HIV (<5%). 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, the Global AIDS Coalition 2025 Roadmap, the Global Fund Strategy 2023-2028 and PEPFAR’s Five-year Strategy: *Fulfilling America’s Promise to End the HIV/AIDS Pandemic by 2030*. The strategy has been aligned with local frameworks such as the Constitution of the Republic of Malawi; the Malawi 2063 (MW 2063); the 2018 HIV and AIDS (Prevention and Management) Act; the National HIV and AIDS Policy (2022); the Health Sector Strategic Plan 2023-2030; the National Health Financing Strategy 2023-2030; and other key health and sectoral strategies.

The revised NSP is in sync with the Malawi 2063 and resultantly the Malawi 2063 first 10-year implementation plan (MIP-1). Specific HIV-related indicators that focus on reducing HIV prevalence, that are tracked through Health and Nutrition which falls under enabler 5: Human Capital Development of the MIP-1, are among the paramount indicators of the response.

The revised NSP also recognises the ten Sustainable Development Goals (SDGs) that are key for ending the HIV epidemic, namely *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*. Thus, strategies outlined in the revised NSP will not only be key to achieving the HIV-related targets in the next five years, but also put Malawi on the path to reach SDGs targets. It is envisaged that all sectors that contribute to SDGs will play designated roles towards creating an environment not only for eliminating AIDS as a public health threat but also for positively transforming the socio-economic wellbeing of Malawians. For this reason, the revised NSP emphasises the need for a multisectoral response and highlights the contributions needed from each sector to achieve broader social goals. Success of the revised NSP will depend on strong leadership and commitment from all relevant sectors and a resilient and sustainable health system.

To accelerate progress towards ending AIDS, the NSP continues to implement cost-effective and evidence-based interventions through the public health approach, the hallmark of Malawi’s HIV programme. While implementation of the NSP will target the entire population including those in refugee camps, the strategy utilises available sub-national HIV data to target areas of high HIV incidence and/or potentially vulnerable populations such as children;

high-risk Adolescent Girls and Young Women (AGYW); women aged 25-29 years; men with high disposable income; pregnant and breastfeeding women; key populations; and socially-marginalised populations including migrant labourers living in refugee camps, urban and peri-urban settings. Treatment and care interventions will focus on improving treatment outcomes for children and adolescents living with HIV who continue to lag behind their adult counterparts in terms of achieving the 95:95:95 treatment targets. Accordingly, a key component in the revised NSP is the delivery of client-centred services at facility and community levels prioritising 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 NSP will comprise eight thematic areas: (i) Combination Prevention; (ii) Differentiated HIV Testing Services; (iii) Treatment, Care and Support for HIV and AIDS and Related Diseases; (iv) TB/HIV; (v) Key and 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. Key strategic interventions for the next five years include: (i) Expanding access to HIV services, especially to 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; (vi) 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 and AIDS programmes.

Implementation of the NSP will continue to rely on a wide range of implementing and development partners. The 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. To put Malawi on the path towards ending AIDS as public health threat, implementation of the NSP will cost an estimated **US\$ 1.41 billion** 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 estimates suggest that the country's population may have already reached 20.2 million 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 classified 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 years of age³. Eleven percent of this underage population are orphans, of which 39% is as a result of HIV and AIDS, and 10% of the population aged five and older have at least one type of disability. Both orphanhood and disability increase vulnerability to poverty, gender-based violence (GBV), and other forms of structural violence, resulting in the elevated risk of HIV infections 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 In 2021, Malawi's GDP per capita was estimated at US\$634.80⁶. Agriculture dominates Malawi's economy. It accounts for 22.7% of the GDP,⁷ employs 60% of the workforce,⁸ and constitutes over 80% of national export earnings. Poverty remains widespread. In 2021, the World Bank estimated that nearly three-quarters (71%) of the general population had consumption below the poverty line (less than \$2.15 a day [2017 PPP])⁹. Poverty levels are higher in rural than urban areas and in the Southern Region compared with the northern and central regions. Literacy is not yet universal: in 2021, only 71% of males and 64% of females above the age of 15 were literate.

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. Human Development Report 2021/2022. *Uncertain times, unsettled lives Shaping our future in a transforming world*.

⁶ World Bank. <https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=MW>

⁷ <https://data.worldbank.org/indicator/NV.AGR.TOTL.ZS?locations=MW>

⁸ <https://tradingeconomics.com/malawi/employment-in-agriculture-percent-of-total-employment-wb-data.html>

⁹ World Bank. <https://www.worldbank.org/en/country/malawi/overview>.

Despite the prevailing social-economic challenges, there has been a significant improvement in health indicators over the last decade. According to the Malawi Demographic and Health Survey (MDHS) and Malawi Multiple Indicator Cluster Survey, in the period from 2010 to 2020, 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 Ratio (MMR) decreased from 675 to 439 deaths per 100,000 live births (MDHS 2010 and 2016). In fact, these declining trends in under five and maternal mortality indicators have been observed since 2004.¹⁰ Malawi was one of the few countries that achieved the Millenium Development Goals (MDG) 4 target for child mortality well ahead of schedule.¹¹ The number of AIDS deaths has also significantly declined from 32,000 in 2010 to 13,000 in 2019.¹² Nevertheless, AIDS remains a leading cause of death.¹³

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: e201–214 [http://dx.doi.org/10.1016/S2214-109X\(15\)00294-6](http://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)

2 Situation Analysis

2.1 Epidemic Overview

With an estimated 1,006,000 PLHIV among the total population estimate of 21 million in 2023, Malawi continues to rank among the 10 countries with the highest HIV burden in the world.^{14,15} **Figure 2** shows the estimated trends in total population of PLHIV, new infections and AIDS deaths in Malawi 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 total HIV population started to decline due to 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, ART coverage among all HIV+ adults (15+) had reached 86%. In 2021, the number of new infections was almost equal to the number of AIDS-related deaths marking the point of 'epidemic control'. Since then, the epidemic has declined slowly, with an average annual decline of 0.6% in the number of PLHIV projected between 2020 and 2030.

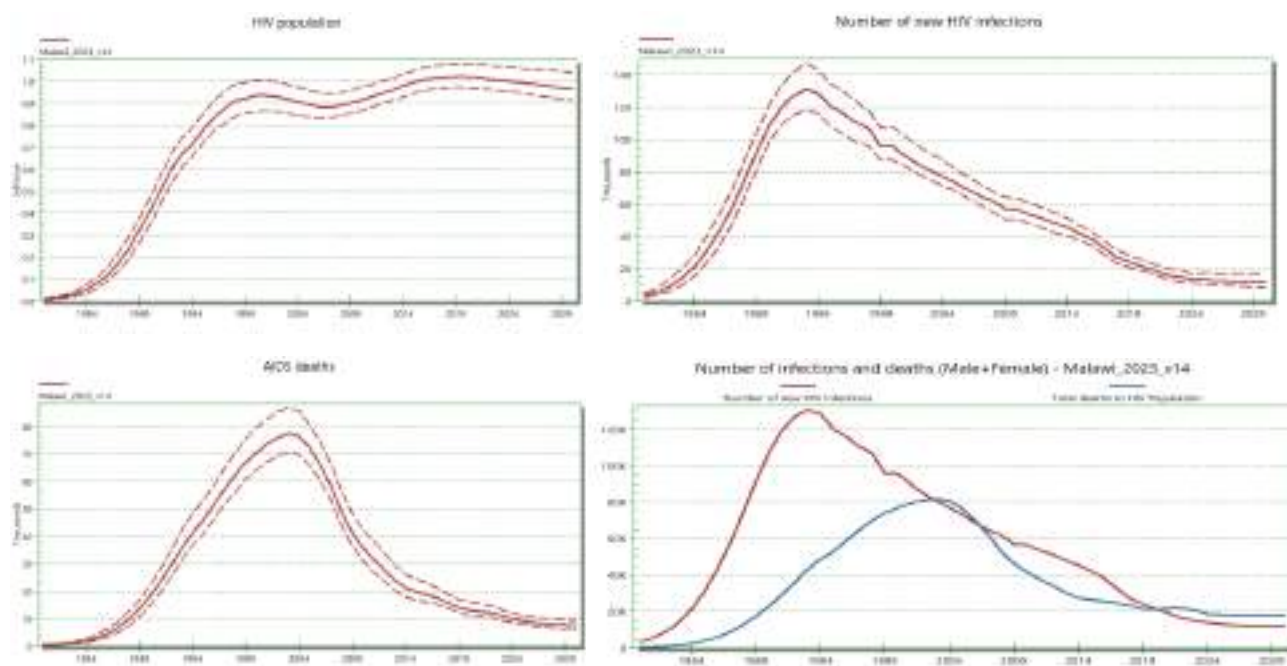


Figure 2: Trends in total PLHIV, new infections and AIDS deaths in Malawi 1980-2030 (2023 Spectrum model estimates)¹⁴. The total population of PLHIV in Malawi has remained relatively stable over the last decade. In 2023, the prevalence of HIV among adults (15+) was estimated at 7.7% but was significantly higher among women (9.3%) than in men (6.0%). The sustained prevalence decline from 2015 onwards was mainly explained by the

¹⁴ 2023 Malawi Spectrum model (preliminary estimates). Subgroups may not add up to totals due to rounding.

¹⁵ [AIDSinfo | UNAIDS](#)

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.

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.

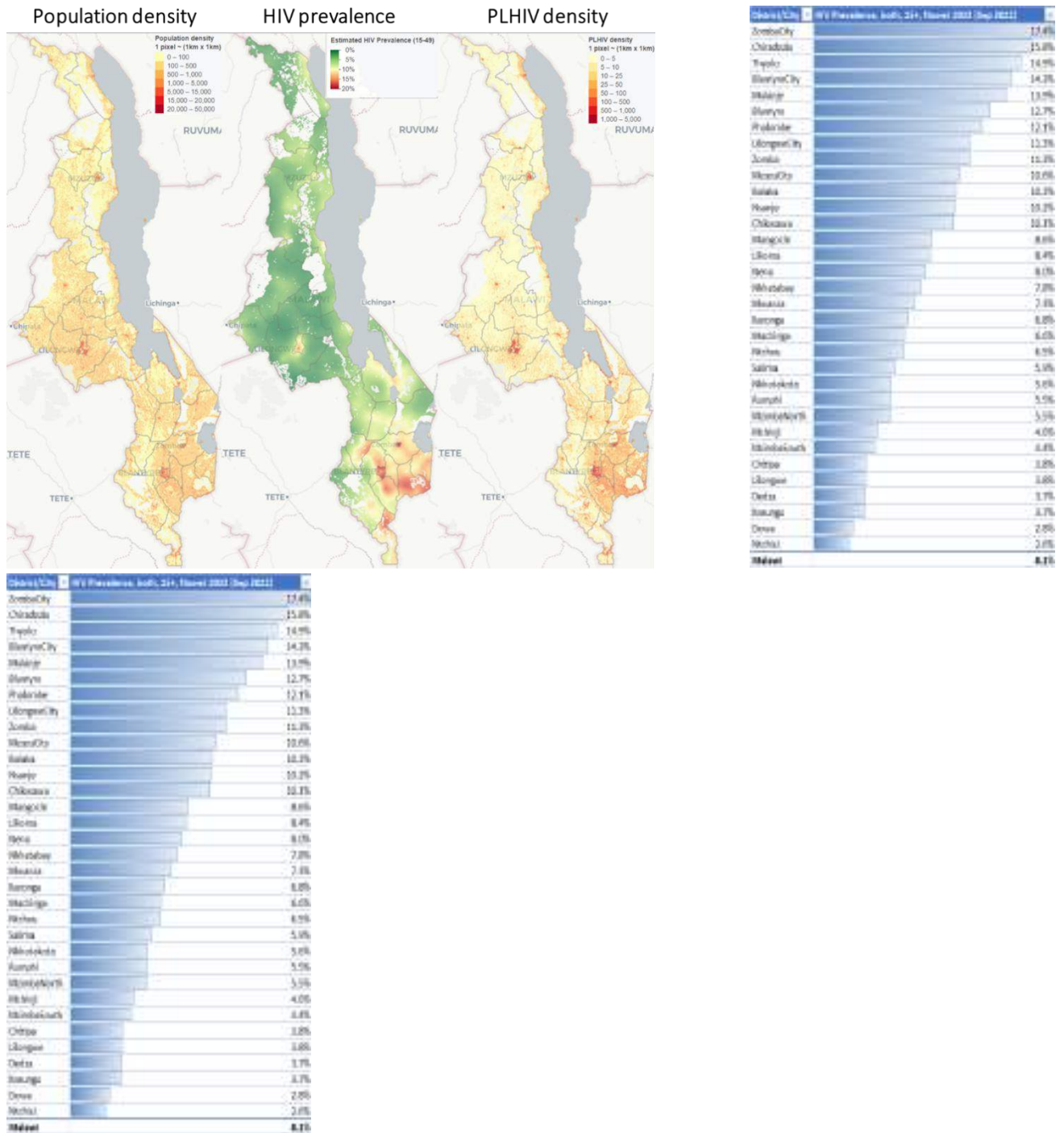


Figure 3: Geospatial model estimates for population density, adult HIV prevalence and PLHIV density at 1 km² grid level ¹⁶

Prevalence ranges from 3% to 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 four cities of Blantyre, Lilongwe, Zomba and Mzuzu. The continued rapid population growth and urbanisation will dramatically increase the population density and the number of people potentially exposed to HIV in these areas over the next decade. This may pose the single greatest challenge of maintaining epidemic control as high population viral suppression must be maintained everywhere to prevent a spill-over and renewed epidemic waves.

Table 1 below 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 (15-24) and 5% were children (0-14). Malawi conducted multiple KPs surveys between 2011 and 2021, covering most districts in all 3 regions. The surveys have helped to estimate the populations of Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgenders (TGs) and People Who Inject Drugs (PWID) as shown in Table 1. Although the absolute numbers of the KP groups are significantly lower than the general population, the prevalence of HIV in all the KP groups is higher than that of the general population. In this regard, poor management of HIV services in these groups may lead to HIV surge in the general population, due to widespread sexual interaction between KPs and the general population.

Table 1: 2023 Spectrum, Naomi model and UNAIDS key population workbook consensus estimates (for 2023). ¹⁴

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

¹⁶ Geospatial model analysis of travel times to the nearest ART clinic in Malawi https://mrc-ide.github.io/mwi-hiv/ART_facilities/index.html

2.2 Trends in Total HIV Infections and Incidence

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%).

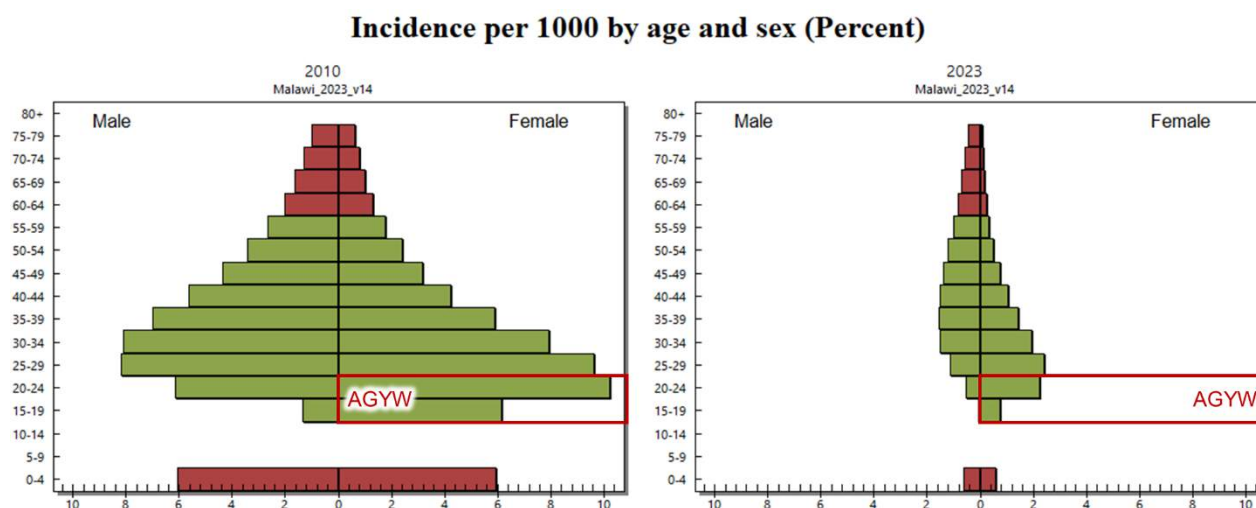


Figure 4: Incidence distribution by age and sex in the general population 2010 and 2023¹⁴

Figure 4 shows that modelled 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 25-29 age group and among males between 34-44 years of age. This means that incidence among AGYW is now lower than that among women of 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 programmes. 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 Adolescent Boys and Young Men (ABYM) aged between 15-24 years, the age group with the highest uptake of Voluntary Medical Male Circumcision (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 Analysis¹⁷ was conducted in 2022 to estimate the impact and cost-effectiveness of such a 'prioritised VMMC scale-up' in 7

¹⁷ 2022 Malawi Goals model analysis for the HIV prevention framework 2023-2027

districts namely Blantyre, Chiradzulu, Mulanje, Phalombe, Thyolo, Zomba and Lilongwe City, which have a higher male incidence than the national average, targeting:

- 90% Male Circumcision (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 in all districts, this targeted strategy suggested that 2-3 times as many new infections could be averted between 2023-2027. However, 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 US\$12,500 per infection averted between 2023-2027. Nonetheless, due to the lifelong prevention effect of VMMC, cost-effectiveness for this prioritised 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. About 3,300 (22%) of all new infections in 2023 are among AGYW and around 1,700 (12%) are among KPs. However, 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 programmes. These granular estimates suggest that AGYW prevention interventions will need to be more specifically targeted at three relatively small groups with elevated incidence in the nine districts with overall AGYW incidence of more than or equal to 0.20% to achieve meaningful impact and acceptable cost-effectiveness (see **Table 2** below). The targeted risk groups include:

1. Young female key populations¹⁸, 15-19 years.
2. Key populations¹⁸ 20-29 years; and
3. Women with multiple partners¹⁹, 20-29 years.

However, the total number of new infections in the nine high HIV burden districts and risk groups (602) represent only about 4% of the estimated total new infections (16,400) in Malawi in 2022. This is limiting the potential HIV prevention impact of targeted AGYW programming at this stage of the epidemic. Recent programme data also shows very low positivity of less than 0.4% among suspected “high-risk” AGYW tested in previously prioritised districts, highlighting the practical challenges of finding high-risk individuals within a large population through community-based programmes.

¹⁸ 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.

¹⁹ Multiple partners, older partners, history of STIs

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

Area	Young Female KP 15-19 Years		Young Female KP 20-29 Years		Multiple Partners 20-29 Years	
	Pop Size	New Infections	Pop Size	New Infections	Pop Size	New Infections
Lilongwe City	1,337	28	1,399	44	11,323	68
Zomba	1,668	23	892	24	5,036	26
Mulanje	1,322	22	726	23	5,878	36
Phalombe	650	11	324	10	2,334	14
Balaka	641	11	412	12	3,541	19
Chiradzulu	449	11	305	12	2,938	22
Blantyre	465	11	333	11	3,693	24
Thyolo	1,188	26	723	26	5,479	38
Chikwawa	1,145	17	708	18	2,872	14
TOTAL	8,865	161	5,822	180	43,094	261

Between 2010 and 2022, HIV incidence has declined at a remarkably similar rate in all districts (58%-78%). In all district estimates, there were overlapping uncertainty HIV incidence ranges.²⁰ There was no evidence of an accelerated decline in districts with large prevention programme investments, but the decline was proportional to the ART coverage level reached in 2022. 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 2022, while more than half of all districts (17) had fewer than 500 new infections this year. However, HIV infections continue 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 2000-2022.²⁰ 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 Prevention of Mother to Child Transmission (PMTCT) in 2011. This resulted in a steep decline in new HIV infections among infants, and significantly accelerated

²⁰ Wolock et al. 2023 <https://doi.org/10.1101/2023.02.02.23285334>

treatment coverage increase among Women Living with HIV (WLHIV). Between 2012 and 2022, an estimated **104,000** infant infections have been averted and ART coverage among all WLHIV (15+) had reached **97%** (Program data). Despite this remarkable achievement, the estimated final transmission rate at the end of breastfeeding in 2022 was **7.8%**, above the eMTCT target of less than 5%. In 2022, new child infections from MTCT which were 1,900 still exceeded the total new infections among KPs estimated to be 1,600. Based on programme data and Spectrum estimates shown in **Figure 5**: Distribution of sources for mother-to-child transmission 2022, 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 during breastfeeding in districts with elevated incidence.
- 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 Pre-Exposure Prophylaxis (PrEP) in high incidence groups / areas.

Source of the 1,900 new child infections (2022)

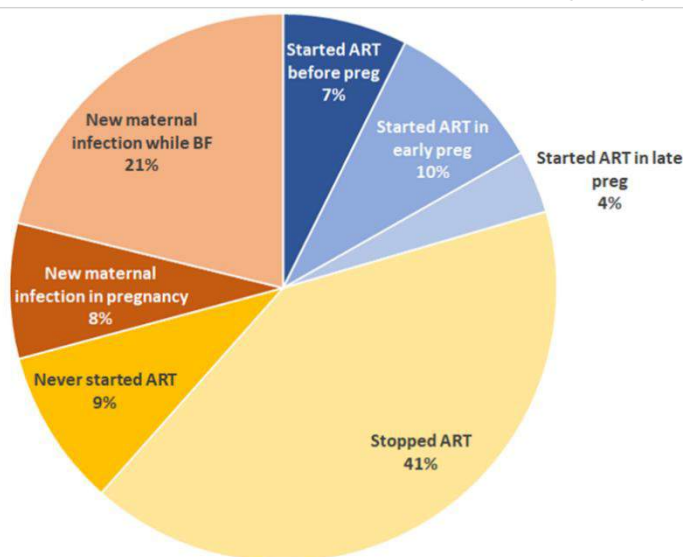


Figure 5: Distribution of sources for mother-to-child transmission 2022 ¹⁴

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 HIV 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 to be averted between 2023-2027 at a cost of **US\$ 900** per infection averted.

Figure 6: Distribution of untreated PLHIV by sex and district in below 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 realise 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 viral load (VL) suppression levels.

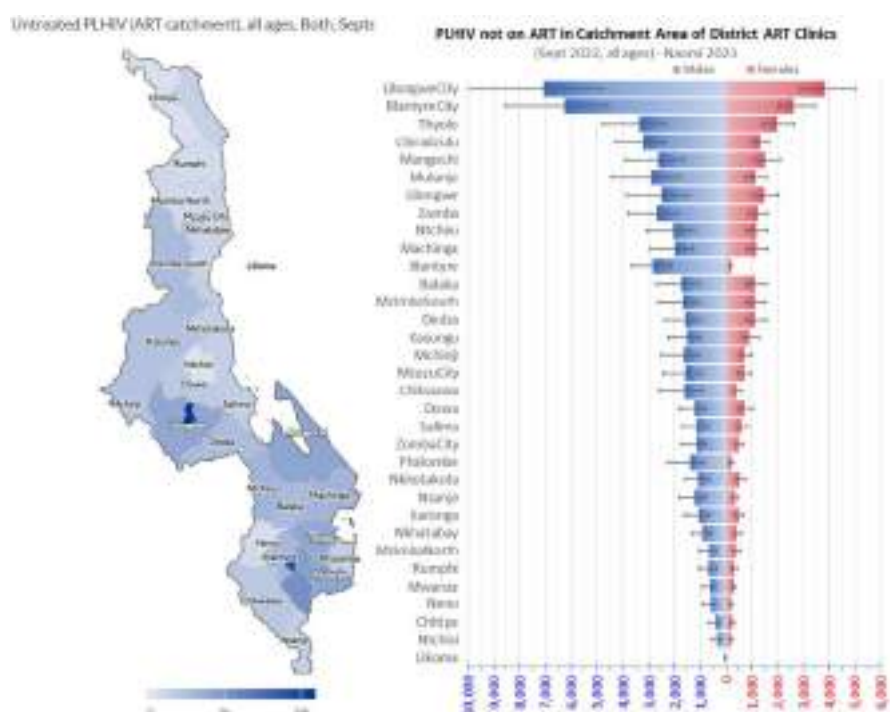


Figure 6: Distribution of untreated PLHIV by sex and district in 2023.

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 Sexually Transmitted Infections (STI) clinics. Malawi registers over 440,000 STI patients per year, but this represents only about half of all estimated symptomatic STI infections in the population.²¹ Low uptake of public STI treatment services is related to stigma, inadequate 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 pharmacies and from traditional healers.

²¹ Michalow, J. Characterising the spatiotemporal burden of symptomatic sexually transmitted infections in Malawi (PhD Thesis 2023)

HIV status ascertainment among STI patients in public clinics reached 91% in 2022 and 18% of these were diagnosed with HIV (routine MOH service reports). Nearly 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 received a new test were newly diagnosed with HIV.

In addition, 1,900 (3%) of PLHIV were not on ART and needed active referral for re-initiation. This 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 indicates that the population of acute HIV infections has gradually declined from 1% to around 0.5%²². Even though this is the case, the prevalence is still high. At the same time, syphilis prevalence among women attending Antenatal Clinic (ANC) 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.

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.

Some of the advantages of targeting STI patients for HIV prevention are:

- Convenient and low-cost integration into an established decentralised service;
- Biological evidence of the 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 to elicit stigmatised behaviour, which is unlikely to be disclosed by many KP members outside of dedicated facilities such as drop-in centres; and
- The unpleasant experience of an acute STI is expected to increase demand for PrEP and VMMC.

It is therefore of high priority to invest in improved STI services, to increase overall attendance rates, to target more than 95% HIV status ascertainment among all STI patients, and to refer for VMMC and PrEP HIV-negative individuals using a 'no questions asked' approach. Considering the elevated prevalence of Hepatitis B and C in these populations, Malawi also needs to fully integrate routine Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) screening in STI clinics, and to provide appropriate active referrals for treatment.

In addition, effective primary prevention interventions such as comprehensive condom programming, which can be implemented at high scale and at low cost should be further promoted. Besides, there is a need for investment in targeted KP prevention and integrated HIV testing programmes, HIV self-test distribution and cost-effective condom distribution channels.

²² Jane S. Chen, Mitch M. Matoga, Claudia F. Gaither, Edward Jere, Esther Mathiya, Naomi Bonongwe, Robert Krysiak, Gabriel Banda, Irving F. Hoffman, William C. Miller, Jonathan J. Juliano, Sarah E. Rutstein. Dramatic shift in the etiology of genital ulcer disease among patients visiting a sexually transmitted infections clinic in Lilongwe, Malawi. Under review. *Sexually Transmitted Disease*. March 2023 <https://onlinelibrary.wiley.com/doi/full/10.1002/jia2.25701>

2.3 HIV Disease Burden and Mortality.

Between 2010 and 2020, the number of AIDS deaths declined by 64%, from 36,000 to 13,000.¹⁴ 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 and 37,000 deaths were averted in 2022 alone. Combined ART and PMTCT scale-ups have cumulatively gained over 7.3 million life-years and averted 90% of all HIV-related deaths between 2002 and 2021 (Error! Reference source not found.).

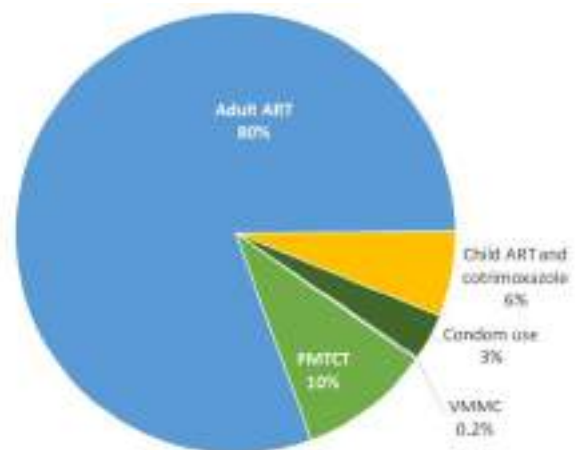


Figure 7: HIV-related deaths averted by biomedical program area 2002-2021. 2022 Goals model

The 2022 Goals Model Analysis of mortality impact by programme area is summarised in Error! Reference source not found.. The proportion of infections and deaths averted by each programme were assessed relative to a scenario without the scale-up of any programmes. 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%) (Error! Reference source not found.), have thus far only made a small contribution to reducing HIV-related mortality. Hence, the future potential impact remains limited as long as high ART coverage and viral suppression at the population level can be maintained.

Error! Reference source not found. 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.

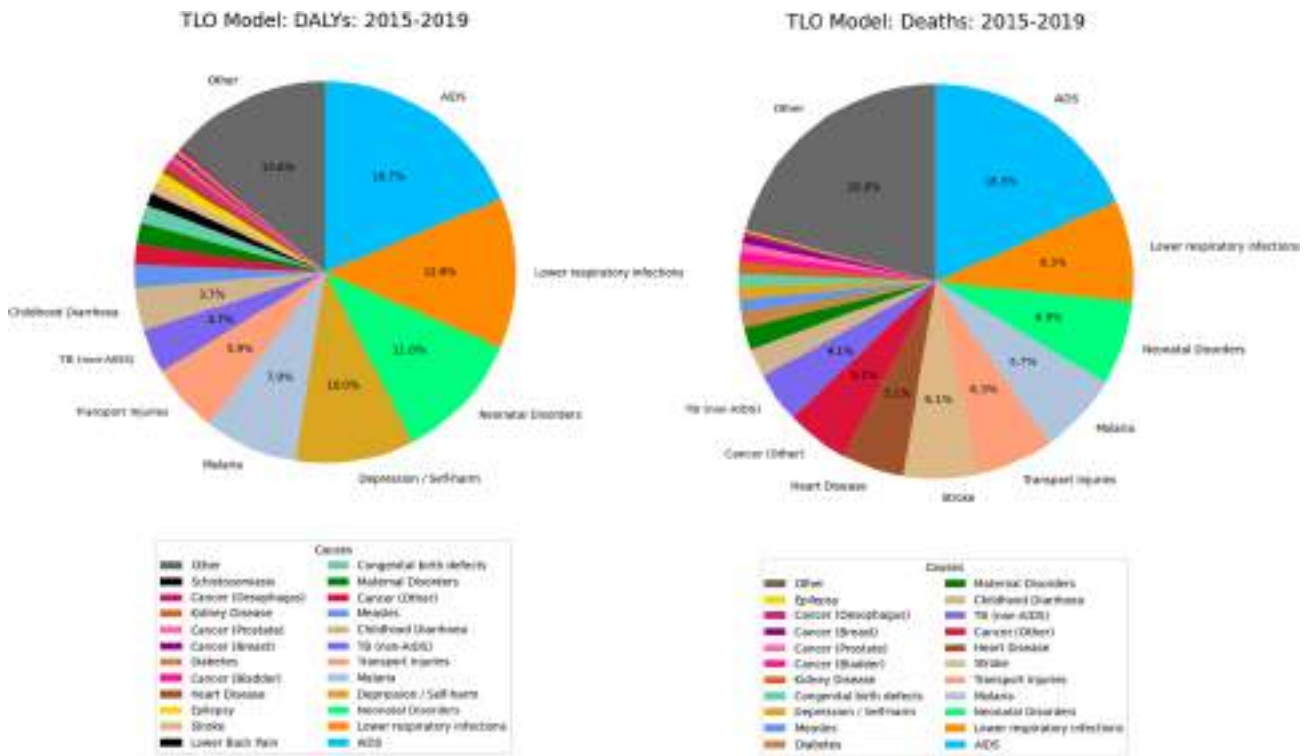


Figure 8: Disability-adjusted life-years lost and deaths by cause in Malawi 2015–2019 (Tanzi la Onse model estimates)²³

Error! Reference source not found. 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.

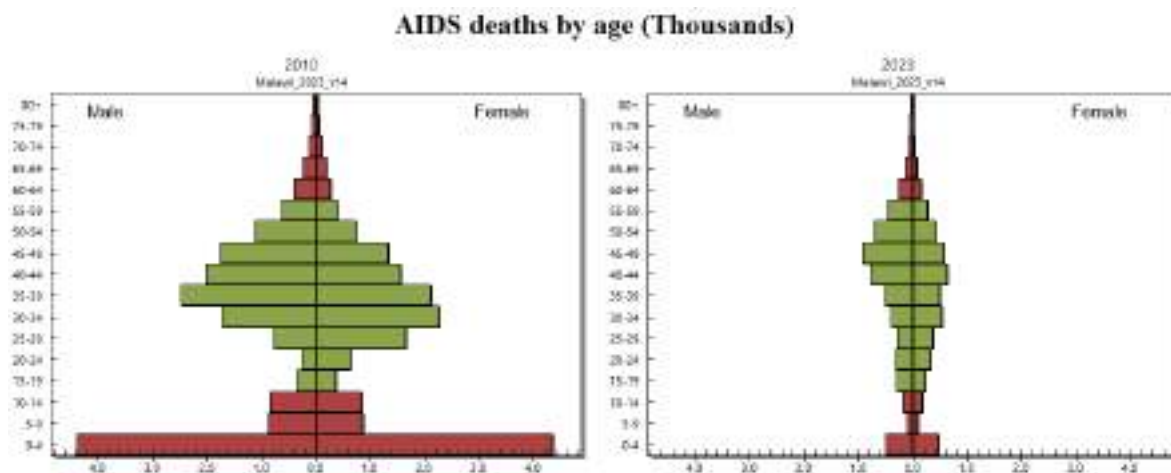


Figure 9: Number of AIDS deaths by age and sex in 2010 and 2023 (2023 Spectrum model estimates)¹⁴

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

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 10** with population pyramids for 2010, 2020 and 2027. The proportion of older PLHIV (40+ years) is projected to grow from 26% to 47% to 63% in these years.

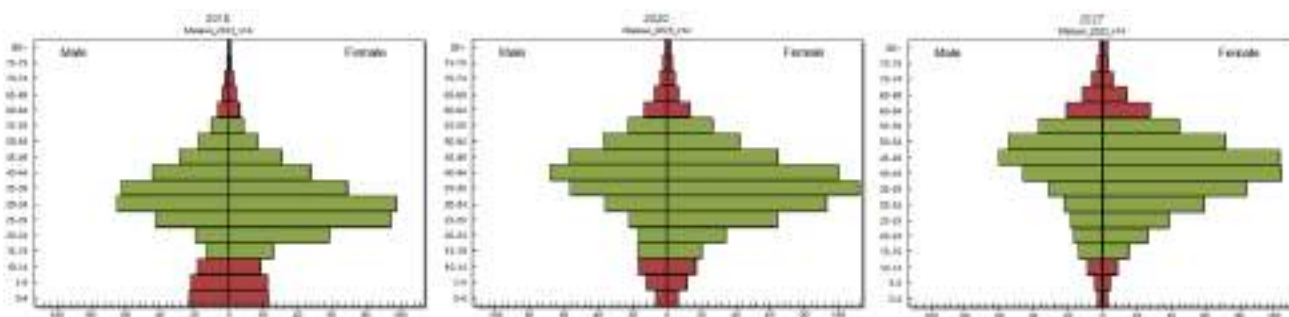
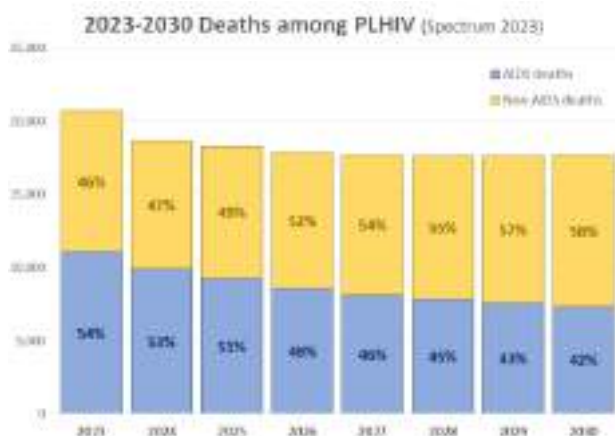


Figure 10: Number of PLHIV by age and sex in 2010, 2020 and 2027 (2023 Spectrum model estimates) ¹⁴

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.



There are no district-level estimates for AIDS and non-AIDS mortality in Malawi. The 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. The Spectrum Model estimates suggest that 18% of PLHIV not on ART in 2023 has a CD4 count of less than 200 cells/ml.

Figure 11: Trend in AIDS and non-AIDS deaths among PLHIV 2023-2030. (2023 Spectrum model estimates)

However, the 2022 HIV programme data shows 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. For 72,000 patients initiated or re-initiated on ART in 2022, access to routine CD4 testing at treatment initiation has remained limited. The programme 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 twice. 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, despite implementation challenges and 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% of the PLHIV patients and 53% of them had CD4 cell count below 200 cells/ml. Among patients tested for opportunistic infections, 16% of them were positive for serum CrAg and 28% were positive for urine LAM. A separate survey in the same setting²⁵ showed that 54% of PLHIV 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 were at 34%, 10%, 4% and 3% respectively. NCDs such as hypertension, cancer, lung disease and diabetes were at 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 programme priorities include:

- Targeted provider-initiated HIV testing and counselling at Outpatient Department (OPD) for all patients with conditions compatible with HIV infection;
- More than 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 programme to confirm infection and re-link to ART;
- Active treatment support to prevent ART interruption and return patients to care, prioritised for groups with elevated risk of discontinuation such as young people, pregnant and breastfeeding women;
- Continued scale-up of differentiated 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; and
- 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 treatment targets (Error! Reference source not found.). By end of 2022, an estimated 95% of all PLHIV had been diagnosed, 97% of whom were on ART and

²⁴ Heller, T. et al. Implementing advanced HIV disease care for inpatients in a referral hospital in Malawi – demand, results, and cost implications. *Annals 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 records. ECHO presentation 9 Feb 2023, Lilongwe

94% of whom had attained viral load suppression²⁶. Despite this achievement, notable gender and age differences have been observed. Among people aged 15 years and 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 that the overall population HIV viral suppression rate surpassed the target of 86% in females (92%) but fell short in males (81%). Among children aged between 0-14 years, only 69% had known HIV status, 100% were initiated on ART, but only 79% were virally suppressed. Thus, the overall viral load suppression was at 55% in children. 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. Overall, these findings underscore the need to target men and children with innovative HIV testing and treatment strategies²⁷.

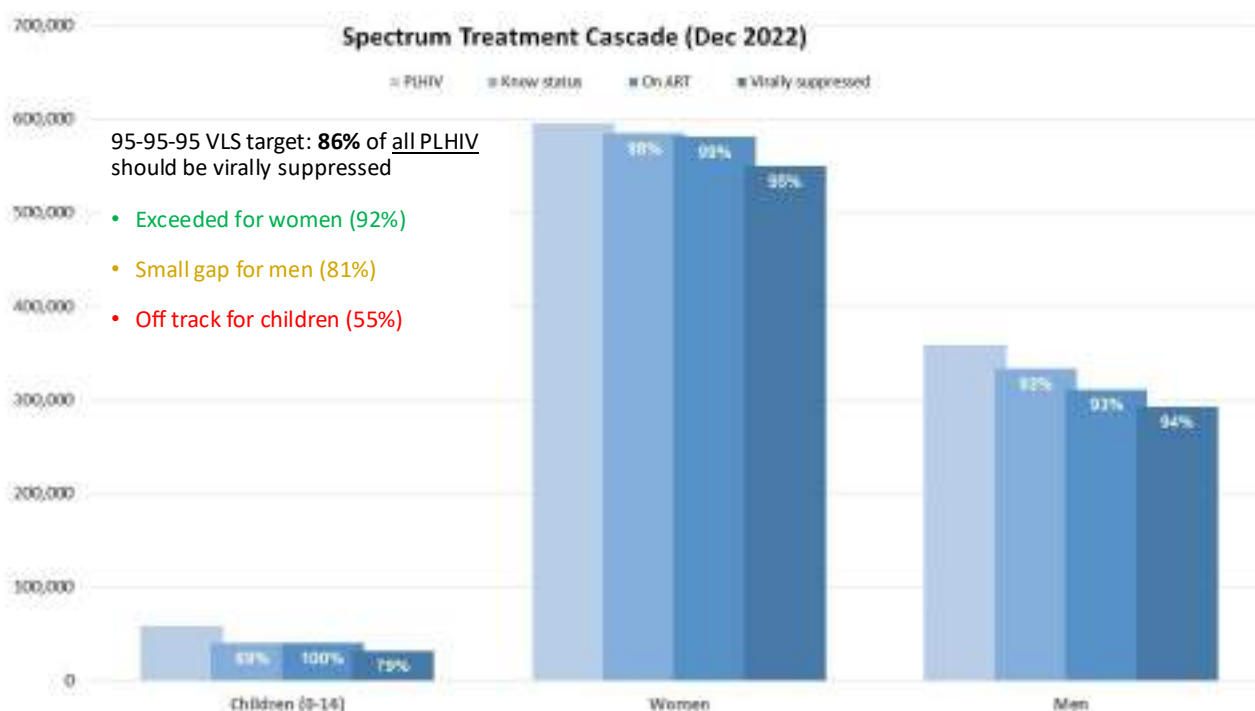


Figure 12: Diagnosis, treatment and viral load suppression cascade for children, women and men living with HIV by December 2022.

Results from sub-national Naomi Models demonstrate geographical disparities in the achievement of the first two of the 95:95:95 treatment targets that are closely associated with population density (**Figure 13**, see also **Figure 3**). The number of PLHIV is highest in districts located in the southern and central regions of Malawi, with Lilongwe and Blantyre cities accounting for 17.7% of all PLHIV. 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

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>

the top 10 list with PLHIV who were unaware of their status and those not on treatment (see also **Figure 6:** Distribution of untreated PLHIV by sex and district in).

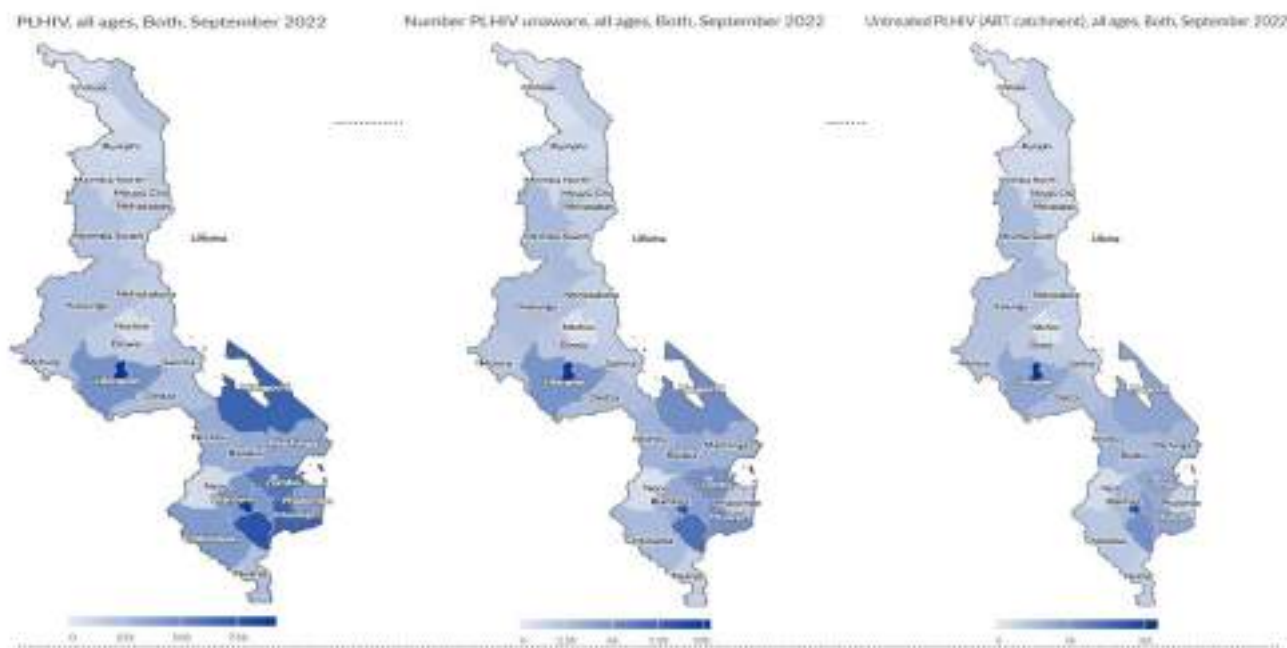


Figure 13: Status of 95-95-95 treatment targets in 2022 by district.

2.5 Determinants of HIV Infection

According to the Global AIDS Strategy (2021-2030) inequalities that underpin stigma, discrimination, and HIV-related criminalisation, 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, cultural, and biological factors. Studies identify the following as key determinants of HIV infection in sub-Saharan Africa: background factors (age, gender, education, region of residence, circumcision, wealth/poverty, religion, and exposure to media), proximate HIV and AIDS factors (HIV and AIDS awareness, stigma, and discrimination), and sexual behaviour factors (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

1. **Poverty:** Malawi is one of the lowest income countries in the world. About 71.0% of the population lives below the poverty line.³⁰ the country’s economy is primarily dependent on agriculture. The sector accounts for 22.7% of GDP³¹ and over 60% of employment.³² Tobacco, tea and sugar dominate exports,

²⁸ <https://doi.org/10.1111/j.1467-9566.2010.01304.x>

²⁹ Gender Assessment of the Malawi National HIV Response, 2014

³⁰ World Bank. <https://www.worldbank.org/en/country/malawi/overview>.

³¹ <https://data.worldbank.org/indicator/NV.AGR.TOTL.ZS?locations=MW>

³² <https://tradingeconomics.com/malawi/employment-in-agriculture-percent-of-total-employment-wb-data.html>

tobacco alone constitutes 60% of the total exports.³³ The country'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 places of work.

2. **Urban and Peri-urban Settings:** Urban settings offer formal and informal employment, trading, and training opportunities for Malawians from all districts. Thus, the cities' populations are 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 cities and sub-urban outskirts. There is a wide social and income inequality in the cities, with a large proportion of the cities' 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 fuelled by heightened economic inequalities and low formal employment despite the existence of a vibrant private sector with a growing middle class. The availability of disposable income among men has been found to promote sexual adventures and attract young women desperate to maintain a high but largely unaffordable lifestyle.³⁵ It is also likely that intimate partner violence, which is associated with increased vulnerability to HIV³⁶, is high in the cities.
3. **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 2016 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 2016 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.
4. **Key Populations (KPs):** Recent population size estimates indicate a relatively small population of FSW, MSM, TGs and PWID in Malawi (**Table 1**). However, due to the stigma surrounding these sub-populations, considerable uncertainty remains about the representativeness and generalisability of the

³³<https://tradingeconomics.com/malawi/exports>

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

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.

estimates. UNAIDS considers prisoners as KPs. 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.³⁹ In 2023, KPs had a higher HIV prevalence than the general population average (**Table 1**). KPs experience discriminatory attitude or abuse from the general population, service providers and law enforcers which limits their access to health and social services and accurate health promotion materials, thereby increasing their risk of HIV infection. Nevertheless, since the NSP 2015–2020, 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 such as drop-in centres (DICs) and KP-friendly health facilities. In addition, efforts have been made to train health care workers in KP-friendly health service delivery and to provide peer-led services at community and facility levels.

5. **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.^{40, 41} In Malawi, many women have limited power over their own sexual health which is a substantial barrier to access to care. While there has been a drastic increase in the percentage of married women who report participation in decision-making about their own health care (68% in 2015/2016, up from 55% in 2010),⁴² there are still far too many women who do not have a say about their own health. 12% of men disagree that if a woman's husband has an STI, she is justified to ask that they use a condom. GBV is both a cause and consequence of HIV and a critical barrier to access services.⁴³ Nearly half (46%) of all women aged 15–49, who have experienced physical violence since age 15, report that their current husbands were the perpetrators of the violence, and 26% report that former husbands were the perpetrators. 55% of females aged between 18–24 years report experiencing some form of violence– sexual, physical, or emotional– during their childhood.⁴⁴ However, recent evidence suggests 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 government and the 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 in influential positions in government (16%), and unequal access to education (15%).⁴⁵

³⁹ The Malawi Biological and Behavioural Surveillance Survey, 2019–2020

⁴⁰ 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>

⁴¹ 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

⁴² NSO. Malawi Demographic and Health Survey. 2015/16.

⁴³ National Statistical Office and DHS Program (2017). Malawi Demographic and Health Survey 2015–16.

⁴⁴ 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>

⁴⁵ 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 NSP 2020-2025

During the first two years of implementing the NSP, major shocks occurred internationally and locally which altered the landscape for HIV and AIDS programming. These include the COVID-19 pandemic and climate-change-related natural disasters resulting in disruption of health and social services and increased vulnerability of displaced populations. Although government established the Department of Disaster Management (DoDMA) to deal with emergencies, there were limited strategies, plans, and emergency service provision packages to address health-related impacts, including sexual and reproductive health risks. In addition to these shocks, other relevant developments such as the launch of several strategic documents⁴⁶ necessitated the need for a Mid-Term Review (MTR) of the NSP. The MTR assessed the progress made in achieving the programme targets and realigned the NSP to new national and global visions and strategies.

From February to March 2023, the WHO external review team conducted an MTR for the joint HIV, TB and Malaria programmes. Information generated by this process informed the MTR of the NSP, this is in addition to supplementary review of literature, programme reports and epidemiological model results, stakeholders' interviews and field visits. The MTR findings were used to review strategic interventions and formulate additional ones, as provided within the eight pillars of this strategic plan.

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

Pillar 1: Combination Prevention

Condom and Lubricant Programming

The MTR found that there were challenges in meeting condom distribution targets, limited understanding of Total Market Approach (TMA) among stakeholders, unharmonized demand creation, minimal engagement of private condom distributors, and suboptimal condom distribution to rural and poor populations. Successes included effective 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 review.

Pre Exposure Prophylaxis (PrEP)

The MoH approved oral PrEP as an additional prevention intervention for individuals at substantial risk of acquiring HIV, such as FSW and MSM. The NSP 2020-2025 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 continuity of PrEP, particularly among AGYW and men. However, successes included the good integration of PrEP with other Sexual and Reproductive Health (SRH) services and the development of the National PrEP Clinical Guidelines and Communication and Advocacy Strategy. Malawi is also planning to conduct implementation research studies on long-acting injectable cabotegravir (CAB-LA) among Key and Vulnerable Populations (KVP) in 2023.

⁴⁶ The strategic documents include Global AIDS Strategy 2021-26, Malawi Vision 2063, including its first implementation plan (the Malawi Implementation Plan, MIP-1) and the Malawi Health Sector Strategic Plan 2023-30.

Voluntary Medical Male Circumcision (VMMC)

Malawi rolled out the VMMC program in 2012, and the NSP 2020-2025 devised strategic interventions to support VMMC scale up. However, based on available data, the MTR found sub-optimal coverage and projected that most of the targets will not be achieved by 2025. The major successes have been the decentralization of VMMC procedures to districts and private clinics and the use of circumcision devices which has resulted in increased uptake. Limited infrastructure and human resource capacity remain the major challenges affecting national scale up.

Adolescent Girls and Young Women (AGYW)

The NSP 2020-2025 set targets to reduce new infections among 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. The MTR found a 17% reduction in new infections among AGYW, but data on other programme indicators were not yet available. Other successes included the successful delivery of comprehensive AGYW packages in partner-supported districts and increased coverage of youth CBDAs providing some components of AGYW services. Challenges included poor coverage of interventions targeting ABYM and their sexual partners, incomplete delivery of Comprehensive Sexuality Education (CSE) among AGYW, and sub-optimal coverage of Community Youth Centres to keep girls in school.

Key and Vulnerable Populations

The strategic interventions for the KVP programme included strengthening governance and coordination, pursuing Service Level Agreements (SLAs) with private providers, scaling up community-based testing, and delivering HIV, GBV, SRHR, and mental health services in emergency situations. The MTR found that targets for coverage of prevention services for FSWs and MSM had been achieved, and almost achieved for viral suppression, but data for other indicators were either not available or unreliable. Other successes in implementing the KVP programme included 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.

Elimination of Mother to Child Transmission (eMTCT)

The eMTCT programme is a priority in Malawi's efforts to eliminate paediatric HIV. The programme's strategic interventions are 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 HIV screening, and strengthening treatment and retention. However, the MTR found that the target of reducing MTCT rate to less than 5% and paediatric HIV infection case rate to less than 50 per 100,000 livebirths had not been met. Key challenges included poor retention of mothers and infants, acute maternal HIV infections during pregnancy and breastfeeding and stock-outs of syphilis test kits. Despite these challenges, there have been successes such as high ANC and ART coverage, good integration of services, and the introduction of HIV retesting guidelines and community-based services.

Sexually Transmitted Infections (STIs)

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 found that none of the STI programme targets had been met, although screening of STI clients for HIV was close to the target. Some of the successes of the STI programme 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 antimicrobial resistance (AMR) monitoring guidelines, and establishment of *Neisseria Gonorrhoea* (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 female genital Schistosomiasis as STIs in some areas.

Wellness and Workplace

The Wellness and Workplace HIV programme is aimed at developing policies and programs for HIV prevention and treatment, targeting formal and informal sectors, migrant labourers, 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 and AIDS. Although data for the programme indicators were not available, the MTR found been a good coordination between the NAC, the Ministry of Labour, and the Malawi Business Coalition for Health (MBCH) in the implementation of the HIV workplace program in various companies. The development of the draft National HIV and AIDS Workplace Policy was also a key success, which is expected to guide the formulation and revision of outdated workplace policies. However, the MTR found poor planning and coordination of HIV workplace policies in most private and public institutions, sub-optimal implementation, poor enforcement, and limited financial resources as key challenges to fully implement the program.

Blood Safety

The NSP 2020-2025 did not set specific targets for blood safety, but the programme aimed to improve the availability, quality, and management of blood transfusion services and set up sentinel sites in major hospitals. The MTR noted successful implementation of universal screening of blood units for transfusion-transmitted infections. Key challenges included the Malawi Blood Transfusion Services' (MBTS) inability to meet national blood demand due to limited blood donors and COVID-19 disruptions, limited sensitivity of serological tests leading to false positive results, and limited infrastructure in districts for blood banks.

Pillar 2: Differentiated HIV Testing

The MTR found that the programme had exceeded the UNAIDS treatment targets, but there was limited awareness of HIV status among males than in females. The programme had been successful in implementing secondary HIV testing and same-day testing and treatment initiation, but there were high costs associated with community-based testing. HIV testing and counselling were not routinely offered to people on remand in prisons, so there was a need to review the HTS protocol for prisons. The programme had successfully implemented a 3-test algorithm and quality assurance programmes but there was a need to sustain good quality assurance performance. HIV Diagnostic Assistants (HDAs) and expert clients had been successful in linking HIV-positive clients to ART care, mostly in partner-supported districts, but the proportion of HIV self-test clients who returned for confirmatory tests remained unknown. The programme had successfully integrated HTS into VMMC, STI services, and moonlight/hotspot testing. The private sector needs to be mobilised to take up more HTS roles, and there was 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 ART coverage targets were surpassed in all PLHIV overall, except in CLHIV aged 0-14 years, adolescents, and men. Although there was a reduction in AIDS-related mortality, there were challenges in the coverage of HIV testing services in males. 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 MTR found key achievements, such as the establishment of the Parliamentary Caucus for TB in Malawi and the availability of molecular TB diagnostic services in all district hospitals. However, challenges included over-reliance on smear microscopy for TB diagnosis in PLHIV 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 (TPT) 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. Of the 1.5 million people supported by the Social Cash Transfer Programme (SCTP) in all the 28 districts, 38% (560,902) were children below the age of 18 years⁴⁷ⁱ. The NSP 2020-2025 aimed to improve HIV sensitive child protection case management, care and support for children affected by HIV and GBV. However, at the time of the MTR, only 275 of the 750 Community Child Protection Workers (CCPWs) were on government payroll. Lack of incentives was a key challenge for volunteers that negatively affected their motivation and engagement in Child Protection work. While enrolment in early child development centers had increased from 409,000 in 2020 to 524,893 in the year 2022, there were large numbers of vulnerable learners (452,623) in primary schools across the country who needed external support⁴⁸. Key achievements noted in the MTR included ongoing child protection awareness campaigns and recruitment of additional CCPWs, while challenges included high CCPW: population ratio, weak coordination among CCPWs and community-based health workers, and lack of resources for the community workers. Additional investment and training are needed for CCPWs and a clear selection criterion for beneficiaries should be established. Innovative use of Constituency Development Fund (CDF) to support vulnerable children was found to be a potentially sustainable government-led initiative.

⁴⁷ Ministry of Gender, 2023, The Social Cash Transfer Programme (Mtukula Pakhomo), Briefing for the New Minister of Gender, Hon Jean Muwonaowauza Sendeza

⁴⁸ Ministry of Education, 2022, Malawi Education Statistics Report, Education Management Information System (EMIS)

Pillar 6: Reducing Human Rights and Gender Barriers

There is improved government commitment to protecting the rights of KPs through the establishment of Technical Working Groups (TWGs) for KPs, Human Rights and Gender, and deployment of district gender officers. Other key successes included increased awareness of GBV cases and improved legal and human rights knowledge. However, pervasive negative social norms and illiteracy limited the impact of ongoing legal literacy campaigns. Other challenges include lack of human, material and financial resources to implement and scale up human rights interventions. There is need for continued advocacy work and community engagement to address entrenched harmful gender norms and practices, including GBV.

Pillar 7: Social and Behaviour Change Communication (SBCC)

The MTR found that the country had established strong foundations for SBCC programmes, including the development of the Health Communication, and Male Engagement strategies. However, there were challenges in engaging community and religious leaders to champion social-cultural changes and in the coverage of SBCC interventions due to limited knowledge, capacity and resources. There is a need to intensify the use of social media to enhance communication and support behavioural change among the youth, males, and key populations, to operationalise the Male Engagement Strategy, and to establish M&E systems for SBCC interventions.

Pillar 8: Resilient and Sustainable Systems for Health (RSSH)

The health sector has strong leadership and governance structures, and NAC has maintained good coordination of the HIV response in line with the 3 Ones Principle of 'one coordinating body, one strategic plan and one monitoring and evaluation framework'.

The MTR established that Malawi's health system continues to face chronic resource constraints that limit the delivery of HIV-related health services, threatening the country's goal of achieving universal health coverage. Additional challenges are limited stakeholder awareness of relevant HIV-related legal instruments, policies and strategies. Other notable challenges include poor tracking of HIV-related expenditure, sub-optimal coordination capacity at the district and community levels, inefficient and unreliable supply chain management and poor maintenance of health equipment and infrastructure. The ageing physical infrastructure hinders optimal implementation of integrated health services.

There is a need for improved tracking of expenditure and ensuring value for money, strengthened capacity for multi-sectoral coordination at the district and community levels, and enhanced data-driven decision-making. In addition, there is a need to strengthen human capital and infrastructure development to support delivery of integrated health services.

4 The Revised National Strategic Plan for HIV and AIDS

4.1 Overview

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

4.2 Vision, Mission, and Goal

4.2.1 Vision

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

4.2.2 Mission

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

4.2.3 Goal

The goal of the plan is to contribute towards ending AIDS as a public health threat in Malawi by 2030.

4.3 Guiding Principles

The Revised NSP 2023-2027 will be guided by the following principles:

- I. **Political Leadership:** To achieve SDG Goal 3 and Target 3.3 on ending AIDS by 2030, successful implementation of this NSP will require strong political leadership and commitment to mobilise resources and garner political support that is essential to sustain an effective national HIV response.
- II. **The Three Ones Principle:** Malawi subscribes to the three ones principle namely (i) one agreed HIV NSP, (ii) one national AIDS coordinating authority, and (iii) one agreed country level monitoring and evaluation framework. This NSP will guide all stakeholders in the implementation of HIV response over the 2023-2027 period, with the NAC as the only coordinating authority. One M&E framework will be used to effectively monitor progress in the implementation of the response.
- III. **Public Health Approach:** To deliver health and social services for most needy people, this NSP prioritises evidence-based cost-efficient interventions that can be delivered up to primary care level, and endeavours to strengthen health and community systems that can deliver high quality services.
- IV. **Investment Approach and Sustainability Plan:** This NSP subscribes to an investment framework, as recommended by UNAIDS and the HSSP III, which 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.

- V. 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 to ensure that NSP 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.
- VI. Leaving No One Behind:** This NSP will also focus on targeting populations that are most at risk of either becoming infected or transmitting HIV. 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, PWID, prisoners, clients of sex workers, migrant labourers, AGYW and ABYM.
- VII. Integrated Service Delivery:** To gain efficiency and improve health outcomes and benefits, this NSP promotes integrated health service 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-morbidities that frequently occur in PLHIV.
- VIII. Multisectoral Engagement:** HIV is linked to biomedical, social-behavioural and cultural factors. Therefore, the national response to HIV and AIDS covers the health and non-health sector interventions implemented by the Ministry of Gender, Community Development and Social Welfare (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).
- IX. Community Participation and Engagement:** This NSP will endeavour to enhance community engagements so that community members can take a lead in the design and delivery of health and social services. During the implementation of this NSP, communities will be capacitated to monitor the delivery of services with assistance from CSOs and the CHWs.⁴⁹
- X. Human Rights-Based Approach to HIV Programming:** Stigma and discrimination constitute major barriers to the implementation of the national HIV response. The NSP encompasses protection and promotion of human rights in the HIV prevention and mitigation of the social and economic impacts of the epidemic.
- XI. Gender Mainstreaming:** This NSP acknowledges that women and girls are disproportionately affected by the HIV epidemic. The NSP promotes CSE, gender transformative interventions and working with

⁴⁹ Communities include community, cultural and religious leaders, the formal and informal segments of the private sector, Community Based Organisations, PLHIV and community groups.

women and girls, men and boys, other genders, and KPs. It also recognises that gender is a key driver of HIV that affects the HIV cascade of prevention, testing, treatment, care and support.

4.4 Legal, Policy and Development Frameworks

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

4.4.1 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. It specifically prohibits any form of discrimination based on age, sex, sexual orientation, disability, and HIV status. Thus, the Strategic Plan will adhere to these human rights principles enshrined in the Constitution and will promote access to HIV services without any form of discrimination.
- **The Malawi 2063:** sets out the collective aspirations of the people of Malawi to be an inclusively wealthy, self-reliant and 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 of the components contributing to HCD.
- **Malawi Implementation Plan 1:** this is an operational plan for the MW2063 from 2021 to 2030, with HCD as one of its enablers. Among other things, the plan outlines strategies, priority interventions and key sectors that are expected to contribute to HCD. The plan describes priority health system strengthening interventions needed to deliver universal health coverage.
- **2018 HIV and AIDS (Prevention and Management) Act:** it provides legal safeguards to human rights of PLHIV and sub-populations who are at risk of HIV infection, establishes legal standards for governing the delivery of HIV interventions and provides for the establishment of NAC to coordinate the HIV response.
- **National Health Policy 2018 - 2030:** provides 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 health system, and positioning the country on the path to achieve universal health coverage. Under this policy, health services are free at the point of delivery in public facilities.
- **2022 National HIV and AIDS Policy:** this policy sets out values, principles and standards that need to be followed by all implementing agencies to have an effective national HIV response.
- **Health Sector Strategic Plan III, 2023-2030:** this overarching MoH's strategy articulates the objectives, strategies and activities needed to accelerate Malawi's progress in achieving UHC targets by 2030. The HSSP III aligns with MW2063's vision, outlining how the health sector will contribute to the HCD and mindset-change enablers of the vision.
- **The National Health Financing Strategy, 2023-2030:** aims at having a sustainable healthcare financing system that supports the achievement of UHC aspirations adopted in the Constitution, the National Health

Policy, and HSSP III. It provides detailed mechanisms through which the National Health Policy and the HSSP III will be financed.

The Revised NSP 2023-2027 has also been aligned to other national plans strategies and guidelines such as the National Community Health Framework; 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; the National Plan of Action on Gender Based Violence in Malawi and other related documents.

4.4.2 Global Instruments

- **Sustainable Development Goals:** Malawi is a signatory to the SDGs; hence, committed to ensuring that SDG targets are achieved. SDG 3, which aims at *ensuring healthy lives and promote wellbeing for all people at all ages*, is particularly relevant to the health sectors. This revised strategy is expected to enable Malawi achieve target 3.3 (*End AIDS as a public health threat by 2030*) and contribute towards target 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*).
- **Global AIDS Strategy, 2021-2026:** seeks to reduce the inequalities that drive the HIV epidemic and is people-centred in its quest to end AIDS as a public health threat by 2030.
- **Global Fund Strategy, 2023-2028:** aims at maximising people-centred integrated systems for health to deliver impact. Key pillars of the strategy are health system resilience and sustainability; engagement and leadership of most affected communities to leave no one behind; health equity; gender equality; and human rights.
- **UNAIDS Fast Track Strategy:** provides 95:95:95 targets for HIV prevention and treatment to achieve SDG 3 Target 3.3 to end AIDS by 2030.
- **The 2021 Political Declaration on HIV and AIDS:** is a renewed commitment made by leaders of UN member states to end inequalities and get back on track to end AIDS by 2030.
- **Global Health Sector Strategies on HIV, Viral Hepatitis, and Sexually Transmitted Infections, 2022-2030:** proposes a common vision to end epidemics and advance UHC, 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 HIV Prevention 2025 Roadmap:** 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 to globally reduce new annual HIV infections to fewer than 370,000 per year by 2025.
- **PEPFAR’s Five-year Strategy: Fulfilling America’s Promise to End the HIV/AIDS Pandemic by 2030:** focuses on strategies that support health equity for priority populations, sustaining the response, public health systems and security, transformative partnerships, and following the science.

4.4.3 Regional Instruments

- **Maputo Plan of Action:** the plan advocates for integrated SRHR; plans 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:** the strategy, whose vision is ‘an integrated, inclusive and prosperous Africa free from its heavy burden of disease, disability and premature death’ among other things, aims at ending AIDS, tuberculosis, malaria and neglected tropical diseases among others⁵⁰.
- **The 2001 Abuja Declaration:** among other things, this aims at strengthening the response to HIV and AIDS, tuberculosis, and malaria by allocating at least 15% of the national annual budgets 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, programmes and projects.

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

⁵⁰ African Union. (2015). African Health strategy 2016-2030. Addis Ababa. African Union.

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 the adoption of the latest evidence-based interventions.⁵¹ 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 prioritises HIV prevention noting that any large increase in new HIV infections will likely put a strain on the health system, threatening Malawi's quest for UHC and social-economic development.

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

- a. Accelerate the reduction of new infections and deaths from 2023-2027 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;⁵²
- c. Reduce annual AIDS-related deaths from 12,100 in 2022 to 7,700 in 2027; and
- d. Build resilient health and social welfare systems.

In pursuit of the vision of a 'healthy and prosperous nation free from HIV and AIDS', this revised NSP focuses on the following pillars adopted from the NSP 2020-2025:

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

5.1 Pillar 1: Combination Prevention

Eliminating AIDS as a public health threat will require a significant reduction in new infections. The revised and extended NSP 2023-2027 aims at reducing new infections from 33,000 in 2019 to 7,400 in 2027. Positively, 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 2027 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 are unlikely to transmit HIV sexually to their partners, this NSP recognises linkage to treatment and adherence to treatment as the key

⁵¹ Ibid.

⁵² 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.

components of an effective prevention strategy. The tremendous progress registered by the country towards the 95:95:95 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 Precision Prevention Strategy⁵³.

To maximise the impact of existing resources, this revised NSP prioritises the scale up of the most cost-effective prevention measures tailored to the respective high-risk populations disaggregated by age, sex/sexual orientation, and geography, in line with the 'Precision Prevention principle'. Error! Reference source not found. **3 b** below shows this analysis ordered by the number of infections averted between 2023 and 2027.

Table 3: Potential impact (infections averted) and cost effectiveness of selected prevention interventions. Source: 2022 Goals (2023-2027) 54 model for Malawi. Ranked by cost-effectiveness.

Programme 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) ⁵⁵	3,752	126,044,688	33,594
AGYW	CSE	250,766 per year	794	118,194,830	148,873
	Economic empowerment	338,873 per year			
ABYM	CSE	233,000 per year	68	51,987,144	762,000
	condoms	82 million per year			
	oral PrEP	2,200 per year			

⁵³ 'Precision Prevention' seeks to target the 'right intervention to the right population at the right time' by addressing social determinants of health and tailoring interventions based on a set of individual factors. Ref: Supplee LH, Parekh J, Johnson M. Principles of precision prevention science for improving recruitment and retention of participants. *Prev Sci* 2018 Jul;19(5):689-694. doi: 10.1007/s11121-018-0884-7.

⁵⁵ 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.

Based on these results, Malawi will scale up ART, VMMC, condoms, and PrEP for FSWs as they are high-impact prevention interventions. While not modelled, WHO also recommends STI services and eMTCT as highly effective interventions that can significantly reduce new infections. Lastly, Malawi will deliver combination prevention to AGYW, ABYM and KVPs based on equity, and oral and injectable PrEP to MSM and high-risk AGYW and 'leave no one behind.' The following sections describe the strategic interventions for each component of the priority combination prevention programmes:

5.1.1 Condom and Lubricant Programming

Condoms are one of the most well-known, cost-effective methods that protect against HIV and other STIs, and prevent unwanted pregnancies. In the previous NSPs, Malawi adopted the TMA as a strategy for ensuring sustainable distribution of condoms to various segments of the population, based on their preferences and financial statuses (market segmentation). However, recent programme 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 sector, most 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 TMA to evenly segment the condom market. The market segmentation will improve access to condoms and lubricants to the remaining sub-populations that do not regularly utilise public health facilities such as sex workers and their clients, MSM, fishermen, male partners of AGYW and other vulnerable populations. In line with this effort, in 2022, the Government launched the 'Last Mile Condom Distribution Guidelines' to optimise condom distribution to marginalised and high-risk populations.

This revised NSP attempts to strengthen coordination at national, district and community levels; improve private sector involvement; and strengthen the monitoring and evaluation systems. Condom distribution will be scaled up to social-economic hubs, fishing communities and other informal sectors to address challenges identified in the MTR of the NSP 2020-2025. The challenges include; poor understanding and implementation of the TMA, limited availability of condoms and lubricants in social-economic hubs and hotspots ⁵⁶, sub-optimal coordination of the condom programmes at district level and low and unharmonized demand creation. It will also capitalise on successes registered with the use of peer-led condoms distribution and the enactment of the Pharmacy Medicines Regulatory Authority (PMRA) Act which, among other things, will support condom quality assurance programmes.⁵⁷

Objective 5.1.1.1: To increase access and uptake of quality condoms and lubricants among high-risk populations using the TMA.

Targets by 2027

- 80% of all sexual acts among KVPs and people with multiple partners are condomized;
- 735.5 million male condoms are distributed;

⁵⁶ 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

⁵⁷ http://www.nsomalawi.mw/images/2019-2020_Malawi_BBSS_Report

- 8.6 million female condoms are distributed;
- 16.1 million lubricants are distributed; and
- 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 of the condom and lubricant programme at national, district and community levels;
2. Strengthen the distribution of condoms and lubricants including distribution to the last mile using the TMA;
3. Strengthen private sector involvement in condom and lubricant programming;
4. Strengthen quality assurance systems for condoms and lubricants and all related services in all sectors;
5. Strengthen innovative demand creation for condoms and lubricants among target populations through SBCC, branding and empowerment of women, girls, and KPs; and
6. Strengthen monitoring, evaluation, research and surveillance for condom and lubricant programming.

5.1.2 Pre-Exposure Prophylaxis

The MoH started providing oral PrEP services in the country in 2021 after a successful pilot implementation which was conducted from 2019 to 2020. Since the roll out, there has been a steady increase in uptake of services. However, the increased uptake skewed towards KPs, and continuity rate has been sub-optimal (51%). 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, 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 MTR of the NSP 2020-2025, particularly low PrEP uptake among AGYW, sub-optimal oral PrEP continuity rate during periods of risk, and stigma associated with oral PrEP. Leveraging on the PrEP Communication and Advocacy Strategy, this NSP will promote PrEP demand creation and uptake through multiple channels including digital media and use evidence generated from the planned CAB-LA implementation science project. To abide to 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 5.1.2.1 Increase access, uptake and quality of PrEP services targeting high risk and key populations in all high incidence districts.

Targets by 2027

- Increase PrEP uptake, as part of combination prevention, to 50% among high-risk groups; and

- Increase PrEP continuity from a baseline of 51% to 65%.

Strategic Interventions

1. Support subnational planning for oral and long-acting injectable PrEP rollout and scale up;
2. Strengthen integration of PrEP with SRH, child health and other service delivery points including 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 and commodities;
5. Identify innovative strategies for mobilising additional resources for PrEP scale-up and diversifying delivery channels, including private sector-governance
6. Promote awareness, uptake and continuity of PrEP among AGYW, KPs and other vulnerable populations through the use of multiple channels including digital media platforms; and
7. Strengthen monitoring, evaluation, research, and surveillance for PrEP services.

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. It also 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 prioritised in high HIV burden districts of Thyolo, Zomba, Mulanje, Phalombe, Lilongwe, Karonga and Blantyre 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 NSP MTR found that VMMC targets were missed mostly due to space and skills limitation at facility level. Thus, increasing VMMC coverage will require substantial investment in infrastructure, and in 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. Therefore, VMMC uptake may improve by providing various forms of incentives, increasing the number of skilled providers, supporting awareness campaigns on circumcision devices and increasing acceleration of access to the devices.

Objective 5.1.3.1: Increase social acceptance, demand, access, and uptake of quality VMMC services targeting partners of AGYW and other high risk vulnerable populations in high incidence districts.

VMMC Coverage Targets by 2027

- Conduct 940,000 VMMCs to attain 60-90% coverage in the 25-39 years age brackets in the 12 priority districts; and
- Maintain current coverage of VMMCs in the low priority districts.

Strategic Interventions

1. Expand the availability of quality VMMC through decentralisation of services for males between 25-39 years including partners of AGYW in health centres, private sector facilities and other institutions.
2. Strengthen VMMC commodity supply chain management at all levels through accurate forecasting and monitoring.
3. Promote the implementation of innovative targeted demand-generation strategies, using a wide range of disciplines, including marketing, behavioural economics, and human-centred design.
4. Integrate VMMC demand creation in all health entry points, including PrEP and STI services.
5. Improve monitoring of program indicators to establish a comprehensive response, flexible M&E system that can support and meet the demands of the program at all levels of the system.

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 AGYW vulnerability are multifactorial including biological⁵⁸, behavioural and structural. In the NSP 2020-2025, 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 MTR found epidemiological model evidence of marked reduction in the number of new HIV infections among AGYW. However, no information was available on programme outcome indicators to adequately assess the success of the AGYW programmes and their contribution to the reduction in HIV incidence. Recent research in South Africa found no impact of the AGYW-focused DREAMS programme on incidences of HIV and Herpes Simplex Virus (HSV), and on Viral Load Suppression (VLS) among AGYW living with HIV⁵⁹. Similarly, in Malawi, there was no evidence of marked reduction in HIV incidence in all districts where the DREAMS interventions were implemented⁶⁰. Nevertheless, it may be too early to discontinue or revise the on-going AGYW programmes in Malawi, considering the potential wider impacts of the interventions beyond HIV. Efforts will be made to closely monitor and evaluate ongoing AGYW programmes.

The revised NSP will intensify the delivery of a prevention package for AGYW and their male partners including HIV status ascertainment, condom use 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 IEC. This NSP maintains most of the

⁵⁸ Untreated men are 3.9-times more likely to transmit HIV than untreated women. See also Section 2.2 on page 22 ff.

⁵⁹ 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

⁶⁰ Wolock TM, Flaxman S, Chimbandule 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.

objectives and strategic interventions such as CSE, social protection, and addressing human rights barriers related to prevention for AGYW and their sexual partners. It will also focus on reaching middle-aged men, who are the partners and main source of new infection for AGYW with interventions such as targeted testing, ART linkage, treatment support for viral load suppression, VMMC and PrEP.

AGYW Program Targets by 2027

- 25% reduction in HIV incidence among AGYW from the 2022 baseline.
- 90% of sexually active AGYW are tested for HIV in the past 12 months and receive their results.
- 95% of sexually active AGYW who test negative for HIV are offered HIV self-test kits for secondary distribution to their male sexual partners.
- 80% of AGYW and ABYM report using a condom the last time they had high risk sexual intercourse.
- 75% of AGYW have comprehensive knowledge about HIV.

Objective 5.1.4.1: To increase access to and coverage of combination HIV prevention, testing, and treatment for AGYW and their male sexual partners.

Strategic Interventions

1. Strengthen multi-sectoral coordination, collaboration and linkages between ministries and partners in the implementation of AGYW and ABYM interventions at national, district and community 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 by extending service delivery platforms beyond health facilities.
3. Enhance HIV services demand creation for AGYW and their male sexual partners through national, district and community avenues.
4. Expand and intensify existing life skills training and CSE 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.

Objective 5.1.4.2: To empower vulnerable AGYW through social, economic and legal interventions.

Strategic Interventions

1. Reduce human rights related barriers to HIV prevention for AGYW by creating an enabling environment to support girls, including ending sexual abuse and child marriages.
2. Support social protection interventions for AGYW to address barriers preventing vulnerable girls from attending or staying in school.
3. Accelerate the building of social support and increase AGYW resilience through delivery of evidence-based social and economic assets interventions of vulnerable AGYW.
4. Strengthen the multi-sectoral M&E system for AGYW programmes to generate data and to assess the cost-effectiveness of various AGYW packages.
5. Support implementation of the 'Male Engagement Strategy' to enhance behavioural change and service utilisation, including HTS and ART access, among male partners of AGYW.

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

5.1.5 Elimination of Mother to Child Transmission (eMTCT)

In Malawi, the use of lifelong ART among pregnant WLHIV (Option B+) since 2011 has led to significant reductions in the annual number of paediatric HIV infections to 2,500 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 7.8%, which is short of the target of less than 5%. In the NSP 2020-2025, 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 some facilities but plans for scale up are underway. Malawi was also implementing several revised guidelines and innovations such as the HIV three-test algorithm, Hepatitis B birth dose vaccine and secondary distribution of HIVST kits through antenatal and postnatal clinics. In addition, the country is also providing 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 MTR, particularly poor implementation of syphilis and viral hepatitis screening guidelines among pregnant women; sub-optimal retention of Mother-Infant Pairs (MIPs) in eMTCT care and low EID coverage coupled with long turn-around time for EID testing. It will capitalise on the MoH's plans to hire community midwife assistants who are expected to champion community-based programmes that provide a continuum of care for MIPs.

Targets by 2027

- Reduce the MTCT rate at the end of the breastfeeding period from 7.8% in 2022 to less than 5%.
- Reduce the case rate of new paediatric HIV infections due to MTCT from 715 cases/100,000 live births in 2021 to less than 350 cases/100,000 live births.
- 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 5.1.5.1: 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. Evaluate and scale-up PrEP for AGYW, pregnant and breastfeeding women.
3. Intensify provision of integrated and YFHS to AGYW and ABYM.
4. Engage male partners of AGYW, pregnant and breastfeeding women with HIV combination prevention services

Objective 5.1.5.2: To reduce unplanned and unintended pregnancies among women living with HIV.

Strategic Interventions

1. Scale up integration of family planning services with other SRH/HIV services.
2. Support the provision of family planning commodities to women living with HIV.
3. Provide counselling on a wide range of family planning methods to women living with HIV.

Objective 5.1.5.3: To prevent vertical transmission of HIV, viral hepatitis, and syphilis.

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. Initiate newly diagnosed pregnant and breastfeeding women living with HIV and monitor them on lifelong ART.
3. Scale up treatment of syphilis and viral hepatitis in pregnant and breastfeeding women and their partners.

Objective 5.1.5.4: To provide treatment, care and support to mothers and infants living with HIV, and exposed infants.

Strategic Interventions

1. Improve linkage of mothers and infants living with HIV to ART , viral load monitoring and support adherence and retention.
2. Strengthen CBOs and community volunteers such as expert clients, supportive groups, mother-to-mother, and PLHIV to support adherence and retention of pregnant and breast-feeding women and infants living with HIV.
3. Improve monitoring and follow-up of HIV exposed infants.
4. Improve retention of mothers and infants living with HIV on treatment and strengthen viral load monitoring on ART.

5.1.6 Sexually Transmitted Infections and Sexual and Reproductive Health Services

STIs are known risk factors for HIV transmission, 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 (HPV), one of the STIs, is a risk factor for cervical cancer and the risk is markedly high in WLHIV. 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. However, inappropriate use of antibiotics leads and fuels emergence of drug resistance.

During the implementation of the NSP 2020-2025, 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 KVPs and the youth. In addition, cervical cancer screening services are continuously being scaled up in health facilities and have been targeted on WLHIV who are at high risk of developing cervical cancer. Viral hepatitis screening has also been introduced for STI clients. Capacity has been established in eight laboratories to monitor resistance to *Neisseria Gonorrhoea (NG)*, one of the STIs.

The MTR established a high coverage of STI screening among PLHIV (91%) and KPs, but sub-optimal syphilis screening among antenatal mothers (79%). Additionally, there was poor cervical cancer screening among WLHIV. Emerging evidence suggests a rising burden of Female Genital Schistosomiasis (FGS) estimated around 21.5% in endemic districts such as Nsanje and Chikwawa. FGS is associated with HIV infection but is often confused with a recurrent STI by most clinicians. This NSP will address significant challenges identified in the MTR 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 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 screening⁶¹.

STI and SRHS Coverage Targets by 2027

- 98% HIV status ascertainment for STI clients;
- 95% of STI clients are tested for hepatitis;
- 95% of STI clients with hepatitis are assessed and/or receive treatment;
- 95% of WLHIV are screened for cervical pre-cancer; and
- 95% of WLHIV with cervical pre-cancerous lesions are treated.

Objective 5.1.6.1: To increase access and uptake of quality STI and other SRH services, including family planning, cervical cancer, syphilis, and post-sexual violence care.

Strategic Interventions

1. Improve demand, access, and utilisation of STI screening and treatment to all populations and Other Vulnerable Populations (OVPs).
2. Strengthen quality of STI/SRH services including ensuring STI commodity security in both public and private facilities.
3. Strengthen engagement and collaboration with the private sector on STIs, hepatitis and HIV management.
4. Strengthen integration of STIs, hepatitis and SRH services including family planning, cervical cancer screening and treatment services, and management of post-sexual violence.
5. Strengthen monitoring of antimicrobial resistance for STIs with focus on *Neisseria Gonorrhoeae*.

⁶¹ 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.

6. Scale up 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, and cervical cancer preventive therapy for those with pre-cancerous lesions.

5.1.7 Wellness and Workplace HIV Programmes

The government recognises that the workplace may create environments that promote HIV transmission but may also be used as a platform for implementing HIV interventions. As such, 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 (DHRMD) is mandated to coordinate the HIV and AIDS Workplace Policy in the public sector while the Malawi Business Coalition for Health (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 implementation of HIV workplace policies.

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

Targets by 2027

- Updated National HIV and AIDS Workplace Policy approved.
- 75% of the formal workplaces have HIV workplace policies and programs.
- 100% of workplaces provide Personal Protective Equipment (PPE) to high-risk workers.
- 100% of Occupational Safety and Health Officers capacitated to implement HIV interventions in the workplace.

Objective 5.1.7.1: To strengthen multi-sectoral governance of HIV workplace programmes.

Strategic Interventions

1. Support efforts to accelerate revision and approval of the National HIV and AIDS Workplace Policy.
2. Develop and implement a robust M&E system for Wellness and Workplace HIV programmes.
3. Support efforts to accelerate the revision and approval of the National HIV and AIDS Workplace guidelines that provide a framework for effective utilisation of the ORT budgetary allocation to HIV interventions.

Objective 5.1.7.2: To strengthen the implementation of HIV workplace programmes in the public sector.

Strategic Interventions

1. Develop regulations that mainstream HIV prevention and management into labour inspection checklists.

2. Capacitate Occupational Safety and Health Officers and Labour Inspectors on HIV interventions enforcement at workplaces.
3. Implement guidelines for the utilisation of funds allocated to Wellness and Workplace HIV programmes in the public and private sector, and support institutions in the operationalisation of the programmes.
4. Develop and implement strategies on economic and workplace empowerment of young women in the public sector.

Objective 5.1.7.3: To strengthen the implementation of HIV workplace programmes in the private sector.

Strategic Interventions

1. Expand the mandate of the MBCH to cover private companies under the Malawi Confederation of Chambers of Commerce and Industry (MCCCI) and Employers Consultative Association of Malawi (ECAM).
2. Build capacity of the private sector to effectively deliver HIV services including HIV prevention and treatment, both directly and through Service Level Agreements (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, HTS, VMMC, PrEP, PEP and ART, and mandating employers to provide PPE for high-risk workers.
5. Enforce the private sector reporting of HIV-related data in line with the HIV Act.
6. Advocate for increased financial contribution of the private sector to the national response towards HIV interventions.
7. Develop and implement strategies on economic and workplace empowerment of young women in the private sector.

5.1.8 Blood Safety

Prevention of Transfusion-Transmitted infections (TTIs) is an integral part of combination prevention. 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. They have also consistently achieved near-universal screening of blood for TTIs. However, they have been unable to meet demand from health facilities. Efforts have been made to decentralise blood collection, screening, and distribution 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 NSP 2020-2025, MBTS successfully established sentinel sites for blood collection and screening and component preparation in all major hospitals. Nevertheless, due to MBTS's 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.

This NSP will address the following challenges lack of capacity for establishing highly sensitive Nucleic Acid Amplification Tests (NAAT) for viral hepatitis; limited resources for blood screening; and sub-optimal infrastructure in districts for blood banks.

Targets by 2027

- Collect 700,000 blood units from blood donors; and
- 100% of all the collected blood units are comprehensively screened for the relevant TTIs (HIV, Hepatitis B, Hepatitis C, syphilis, malaria).

Objective 5.1.8.1: To improve the availability, quality, and management of blood transfusion services.

Strategic Interventions

1. Expand sentinel sites for blood collection, screening, and distribution.
2. Increase investment in blood bank infrastructure at district level.
3. Establish capacity for conducting NAAT at MBTS to optimise diagnosis of TTIs.
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 FSW and MSM, represent 1% each, whilst PWID, ANC women and children born to WLHIV 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, breastfeeding women, KPs, 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 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 mobilising marginalised or hidden populations for HIV testing (social network strategy); and different types of partner notification (passive and active, assisted and 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 to pregnant and breastfeeding women for their sexual partners. In addition, PITC, venue-based testing, index testing, social network testing, family testing and male friendly service provision will be made available. Approaches to reach the undiagnosed children include routine PITC in high burden districts, OPD, under five clinics, nutrition and paediatric wards, 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 Expanded Programme in Immunisation (EPI) and Integrated Management of Childhood Illnesses (IMCI) outreach and village clinics. As part of the HSSP III, the government 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 areas.

Over the years, an increasing trend in the proportion of the population who are aware of their HIV status has led to declining positivity rates among clients tested for HIV. 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. In 2022 Malawi also introduced the use of scanform technology to enhance individual level HIV testing data capture and monitoring. In view of the declining HIV positivity rates, the National HIV Reference Laboratory (NHRL) needs to continue monitoring the quality of HIV testing at facility level through bi-annual proficiency testing and weekly Quality Controls (QCs) and subject all new test kit shipments to batch specific quality assurance at national level.

Targets by 2027

- 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 1,859 CMAs planned in the HSSP III, to support the HTS delivery.

Objective 5.2.1: Increase access, uptake and quality of HIV, syphilis and Hepatitis B testing and counselling services among high-risk key and priority populations.

Strategic Interventions

1. Improve HIV, Syphilis and Hepatitis B case finding among high-risk key and priority populations, including other women, men, and children through adoption of evidence-based strategies and innovative approaches.
2. Strengthen linkage of HTS clients irrespective of their status to comprehensive prevention, treatment, and re-diagnosis for re-engagement services.
3. Strengthen quality assurance for HIV, Syphilis and Hepatitis B diagnosis.

Objective 5.2.2: Strengthen health systems for HIV, syphilis and Hepatitis B testing and counselling services at all levels.

Strategic Interventions

1. Integrate triple testing in other key health services such as SRH, IMCI, EPI, YFHS and TB.
2. Scale up individual level triple testing data capture and management at all levels.
3. Strengthen the use of evidence-based triple testing approaches and best practices through operational research and M&E.
4. Support MoH's efforts under the HSSP III to hire CMAs who will deliver HTS at community level.

5.3 Pillar 3: Treatment, Care and Support for HIV 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 behind in children, adolescents, and males. The 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 and use of 3HP as TB-preventive therapy. Additionally, mental health and substance abuse screening for patients with poor adherence, new viral load monitoring schedules, enhanced pharmacovigilance, are also being provided.

This NSP will address key challenges identified in the MTR such as sub-optimal retention rates, variable provision of integrated HIV/NCD services: especially for hypertension, diabetes and depression. Additional challenges to be addressed include 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, and scale up successful programme innovations such as the use of SMS for communicating viral load results to PLHIV on ART.

Targets by 2027

- To reach 1,015,000 people on ART.
- To improve paediatric ART coverage from 68 to 85%.
- To reduce morbidity and mortality among PLHIV through integration with other HIV related co-morbidities like cancers, NCDs, HIV-Hepatitis coinfection and mental health.
- Scaling up AHD services coverage from 35 to 70%.
- Reach the 95:95:95 treatment targets among all sub-populations including adolescents and men.
- Improve retention in HIV care at 12 months from 81% in 2023 to 85%.
- Improve the quality of HIV services, through increased access, ART drug resistance monitoring and viral load monitoring.
- Strengthen RSSH that will enable effective response to HIV and other epidemics that may threaten the gains already made.

Objective 5.3.1: Increase coverage of high-quality integrated HIV and other related diseases (NCDs, Viral Hepatitis, and Cancer Services)

Strategic Interventions

1. Improve access to high-quality ART (HIV and viral hepatitis), NCDs and cancer services for adults, adolescents, and vulnerable/under-served populations.

2. Improve retention and ART adherence among adults, KPs, and adolescents through enhanced counselling, teen clubs, and strong community-based 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 technologies.

Objective 5.3.2: To increase paediatric ART coverage and clinical outcomes.

Strategic Interventions

1. Improve access to high quality ART services for children at all levels of health care.
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) among CLHIV.
4. Improve timely delivery of viral load results and viral load results utilisation for CLHIV.

Objective 5.3.3: To reduce AIDS, non-AIDS mortality and co-morbidities.

Strategic Interventions

1. Improve monitoring and management of AHD including cancers.
2. Strengthen community-based support system for PLHIV by developing a resource package to support the operations of community health workers (HSAs, CMAs) and volunteers (expert clients, treatment supporters, adherence counsellors).
3. Strengthen the capacity of secondary and tertiary health facilities to manage PLHIV and other co-morbidities.
4. Improve management of opportunistic infections.
5. Strengthen coordination of treatment, care and support at national, district and community levels.

5.4 Pillar 4: TB/HIV

Tuberculosis is the most common opportunistic infection among PLHIV which contributes to significant morbidity and mortality. The 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 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%).

This NSP will address challenges identified in the MTR such as over-reliance of sputum microscopy to investigate PLHIVs suspected of TB, low contact tracing for pulmonary TB patients, diagnostic challenges among children due to lower sensitivity of chest X-rays and sputum. Other challenges include 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 machines in secondary level and some primary care health facilities.

Targets by 2027

- 99% of PLHIV on ART are screened for TB;
- 90% of PLHIV on ART initiated on TPT;
- 90% of PLHIV complete TPT;
- 99% of registered new and relapse TB patients have documented HIV status; and
- 95% of HIV positive new and relapse TB patients are on ART during TB treatment.

Objective 5.4.1: To reduce incidence, morbidity and mortality in TB/HIV co-infected patients.

Strategic interventions

1. Support implementation of routine 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. Screen and effectively manage TPT side effects.
3. Strengthen TB/HIV collaborative and coordination activities at all levels (community, district and national).
4. Improve quality and coverage of intensified case finding and diagnosis for TB among PLHIV and for HIV among persons with TB using sensitive molecular assays like Xpert MTB/RIF Ultra and other WHO recommended methods.
5. Improve adherence support to PLHIV on TPT.
6. Strengthen capacity for optimal management of PLHIV diagnosed with TB at all levels of health care.
7. Scale up the use of focused assessment with sonography for HIV-associated tuberculosis (FASH) to improve access to quality service care delivery for co-infected PLHIV.

5.5 Pillar 5: Key and Other Vulnerable Populations

In Malawi, MSMs, Sex Workers (SWs), TG, PWID, and people in prisons and other closed settings are classified as KPs while the vulnerable and priority population includes migrant labourers, persons displaced due to emergencies, uniformed personnel, fishermen, clients of SWs, children of FSWs, young women with multiple sexual partners, persons with disabilities, and orphans and Other Vulnerable Children (OVC). As the epidemic recedes, the proportion of new infections among key and vulnerable populations (KVPs) is predicted to increase. KPs experience stigma, discrimination, and legal barriers that prevent them from accessing health services including HIV prevention, treatment and care services. Vulnerable populations face logistical barriers to accessing care. In general, such populations are at a higher risk of poor health outcomes because of the lack of social, economic, and environmental resources, as well as limitations due to illness or disability.

Since the launch of the NSP 2020-2025, 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 optimise access and uptake of integrated HIV services by KVPs. These include the use of Drop-In Centres (DICs), KPs-friendly public health facilities and community service delivery models. Malawi has also prioritised interventions aimed at addressing structural barriers that increase the vulnerability of KVPs to HIV and violate their rights. In addition, coordination of KVP programmes has been strengthened through the establishment and support of KP TWG and KP-focussed institutions. The commencement of community-led monitoring programmes is expected to generate data on the quality-of-service provision to KVPs.

To specifically address the issue of OVC, the GoM developed the 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 NSP 2020-2025, there were plans to scale up the case management approach in high HIV burden districts to protect all vulnerable children. However, implementation was adversely affected because of the shortage of childcare protection workers (CCPWs) as there was only one CCPW per TA. The majority of the CCPWs were not formally trained or had not recently received refresher training. Normally, CCPWs visit households with vulnerable children where they monitor the nutritional status of the vulnerable children and support ART adherence among other things. However, the home visits were limited by inadequate logistical support, long distances, and the large geographical areas they covered.

This NSP will address challenges identified in the MTR such as poor coverage of community-led monitoring, parallel M&E systems for KVPs, limited coverage of moonlight services, sub-optimal coverage of training KPs-friendly providers, stock outs of HIV self-testing kits and STI drugs, and lack of reliable population estimates and HIV prevalence data for PWIDs and TGs. It will also intensify the use of community-led and peer-led approaches for enhancing quality and coverage of services. This NSP will also focus on building the capacity of CCPWs and addressing resource 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 to address child protection issues, and improving coordination.

Over the course of the implementation of the NSP, extreme weather events and epidemics caused the marginalisation of certain communities and predisposed them to various forms of human rights violations, including sexual exploitation and disruption of health and social services. Thus, the NSP will incorporate HIV prevention, care, treatment, and support services as part of the relief package for people affected by disasters. Special attention will be given to preparedness for the delivery of HIV services in emergency settings to reduce the vulnerability of affected populations and minimise the disruption of HIV care provision.

KPs coverage Targets by 2027

- 90% of estimated FSWs receive combination prevention services, including annual HIV testing for those not previously diagnosed.
- 43.6% of estimated MSMs receive combination prevention services, including annual HIV testing for those not previously diagnosed.
- 90% of prisoners, including remandees, are tested for HIV at entry and annually, and receive their results.
- 95% of newly diagnosed HIV positive KPs are initiated on ART.
- 95% of KPs initiated on ART are virally suppressed.

OVC 2027 Targets

- Increase the CCPW: population ratio to 1:6,825 from the current baseline of 1:12,000 by recruiting and training 574 CCPWs.
- Increase the number of CCPWs on government payroll from 275 to 750.

Humanitarian Crisis 2027 Targets

- 90% of people displaced through natural disasters receive a comprehensive HIV prevention package.
- 85% of PLHIV displaced through natural disasters are retained in HIV care.
- 85% of PLHIV on ART displaced through natural disasters are virally suppressed.

Objective 5.5.1: To increase access to and coverage of combination HIV prevention, treatment, care, and support among KVPs.

Strategic interventions

1. 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 KVPs to access HIV services.
2. Expand DSD models for KVPs enabling them to access a continuum of HIV and SRH services from multiple service delivery points, including prisons.
3. Promote PrEP uptake and continuity among KVPs, focusing on long-acting injectable PrEP (CAB-LA) for FSW, MSW and other KVPs with continuous and long-term risky behaviours.
4. Scale up delivery of a standard comprehensive package of HIV prevention, treatment, care, and support services for FSWs, their children and clients, MSM, MSW, TGs, PWID and other KVPs, that includes SRHR; GBV; and community mobilisation.
5. Scale up implementation of social network strategy and community-based self-HIV testing for KVPs coupled with access to combination preventive interventions or ART linkage, retention in care, and ART adherence.
6. Sustain access to combination prevention services by maintaining coverage of safe spaces such as DICs and youth clubs in urban and other high HIV-burden districts.
7. Enhance U=U campaign and scale up viral load monitoring to achieve viral load suppression among KVPs.
8. Support development and implementation of harm reduction programs for PWIDs and their partners focussing on high HIV burden urban districts.
9. Establish and scale up pre-service and in-service training in KP-friendly service provision.
10. Strengthen national and district level governance and coordination of KP programmes and community services.
11. Enhance the performance of KP-led organisations through mentorship and supervision.

Objective 5.5.2: 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 or update the population size and coverage of key HIV indicators for FSWs, MSMs, PWIDs, MSWs, prisoners and TGs.
2. Promote research on assessing the effectiveness of various interventions targeting FSWs, MSMs, PWIDs, MSWs, prisoners and TGs to inform the development of evidence-based interventions.
3. Establish a robust but confidential M&E system for KVPs that generates accurate and timely data on KVPs' access to health and social services.
4. Strengthen documentation, reporting, monitoring of human rights violations against KVPs, including community-led monitoring.
5. Enhance the quality of peer-led demand creation products for PWIDs through development and the scaling up of an all-encompassing integrated communication and demand creation tool kit.
6. Scale up HIV prevention communication, information, and demand creation for KVPs.

Objective 5.5.3: To scale up HIV-sensitive child protection case management in high HIV burden districts.

Strategic interventions

1. Improve coordination and referral systems for OVCs at national and district levels.
2. Mobilise communities to establish and operate structures for child protection and development.
3. Strengthen monitoring and reporting of vulnerable children.
4. Increase and sustain investments in HIV-sensitive Child Protection Case Management System, including increasing the number of CCPWs on the government payroll, by strengthening resource mobilisation at all levels.
5. Strengthen community child protection, by training CCPWs in Community Management of Malnutrition.
6. Strengthen SBCC programs on adherence to child rights at the community level.

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

PLHIV and KP and other marginalized groups, including people with disabilities, experience various forms of human rights violations which limit their access to quality health and social services. Similarly, gender inequality hinders social and economic development, thereby increasing people's vulnerability to health problems such as HIV. There has been an increase in number of GBV cases reported from 17,073 in 2021 to 20,827 cases in 2022, indicating either an improvement in reporting of cases and improved legal and human rights knowledge or an increase in vulnerability.

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, the country

has passed various pieces of legislation aimed at eliminating inequalities, such as the Malawi Constitution, Gender Equality Act, Prevention of Domestic Violence Act and the 2018 HIV (Prevention and Management) Act. The GoM has initiated efforts to promote gender rights by deploying gender officers to District Councils.

Noting that lack of legal awareness contributes to perpetration of human rights violations, the NSP 2020-2025 sought to eliminate human rights and gender-related barriers by increasing legal and human rights literacy among health workers, teachers, law enforcers, KP, and the public. As part of this strategy, PLHIV and KP were required to take a lead in creating awareness about their rights. The NSP recognized the importance of participation of local community-based organizations and community leaders in the delivery of comprehensive community packages that promote human and gender rights. To mitigate harmful effects associated with GBV, the NSP focused on promoting a package of clinical and social services to GBV survivors.

This NSP will address challenges identified in the MTR 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.

Targets by 2027

- Zero discrimination for PLHIV and KP.
- Zero difference in HIV incidence among males and females of all age groups.
- 80% of human rights violations and GBV cases reported to appropriate authorities.
- 80% of GBV survivors receive the recommended minimum package of interventions, including legal redress.

Objective 5.6.1: To reduce stigma and discrimination against PLHIV.

Strategic interventions

1. Establish a robust documentation and reporting system for human rights violations experienced by PLHIV.
2. Create awareness/legal literacy about HIV, and HIV/TB-related stigma and discrimination, and legal services to women, girls, vulnerable populations, and KP.
3. Improve access to legal services for PLHIV on issues relating to discrimination, violence protection and other human rights.
4. Strengthen the legal environment for PLHIV, including redress mechanisms in cases of human rights violations in the provision of health care.

Objective 5.6.2: 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 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 community-based HIV service delivery and community-led monitoring.

4. Strengthen the capacity and support the operations of gender officers in Local Authorities to champion gender mainstreaming at institutional and community levels.
5. Establish a robust documentation and reporting system for human rights violations experienced by males, females and KVP.
6. Strengthen programs to prevent and respond to GBV and conflict-related sexual violence by adopting a multisectoral and survivor-centred approach.
7. Accelerate the dissemination of the HIV and AIDS Act, Gender Equality Act, Prevention of Domestic Violence Act, and other laws that safeguard and promote human and gender-related-rights, targeting duty bearers and community leaders, and using communication materials accessible to people with disabilities.
8. Develop and roll-out a standardized package of care and referral for GBV survivors.

5.7 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 NSP 2020-2025 sought to increase uptake of HIV prevention, treatment, and care services by (i) providing strategic information to address social and structural determinants of HIV infection, (ii) empowering individuals and communities to adopt positive health-seeking behaviours, and (iii) increasing demand for HIV services. A strong foundation has been established for implementing SBCC activities through the formation of the SBCC TWG, the launch of the Health Communication Strategy (2021-2026), the development of the Male Engagement Strategy 2023-2030 and, creating and filling health promotion officers' posts at district level. Interpersonal communication has demonstrated to be key in the provision of sensitive information. Social media is increasingly being used for health communication, especially among KPs and the youth.

This revised NSP will address the following challenges: limited coverage of SBCC interventions; weak implementation, coordination, monitoring and evaluation of SBCC interventions; and sub-optimal engagement of traditional and religious leaders to champion socio-cultural changes.

SBCC Targets by 2027

- 80% of males and females aged 15 years and above have comprehensive knowledge of HIV and its social and structural drivers.
- 90% of males and females aged 15 years and above express positive attitudes towards accessing HIV and SRH services.
- 95% of PLHIVs are aware of the health benefits of maintaining HIV viral suppression.
- 80% of community leaders reject harmful cultural and gender norms and practices that fuel HIV transmission and marginalise KPs.

Objective 5.7.1: To provide advocacy and strategic information to address underlying drivers of HIV infection.

Strategic Interventions

1. Scale up community-level dissemination of relevant clauses of the 2018 HIV Act that highlight the key social and structural drivers of HIV infection.
2. Strengthen the capacity of district health promotion officers and district information officers to continuously compile and disseminate district-level information on key social and structural drivers of HIV transmission.
3. Ensure availability of district, regional and national disability friendly SBCC messages and materials targeting specific sub-populations, cultural backgrounds, and age groups, especially AGYW and ABYM, in line with the Health Communication Strategy (2021-2026).
4. Strengthen SBCC coordination structures at national and district levels and support their operations to ensure harmonisation of SBCC efforts by stakeholders.

Objective 5.7.2: To increase demand for HIV services amongst the general population.

Strategic Interventions

1. Strengthen 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, community mobilisation and dialogue, in line with the Health Communication Strategy.
2. Expand the use of mobile and online communication technologies in the dissemination of SBCC messages to target populations including men and KPs.
3. Design and implement comprehensive qualitative studies on barriers that hinder the uptake of HIV prevention and treatment services to inform development of relevant SBCC interventions (gender, human rights)
4. Implement a comprehensive TB and HIV treatment literacy programme among PLHIV and their caretakers.

Objective 5.7.3: 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 individuals and structures as champions/role models and ambassadors of HIV prevention and networks to address harmful cultural practices and gender norms that promote HIV transmission.
2. Advocate to raise resources, political and social commitment to achieve HIV program objectives at district and local levels.
3. Enhance engagement with religious and traditional leaders in advocacy campaigns to address human rights and gender-related violations within their communities.

4. Intensify the use of social media for communication to key and marginalised populations, including the use of interactive virtual/digital platforms.
5. Operationalise the Health Communication Strategy and Male Engagement Strategy to promote service utilisation and address harmful gender norms by males.
6. Intensify development and implementation of high-quality demand creation communication products using evidence-based approaches such as the 'Human-Centred Design' model.
7. Intensify use of granular data to identify sub-populations that need to be targeted with SBCC interventions.
8. Establish and/or strengthen M&E system for SBCC interventions.

5.8 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. 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 sectors⁶². Malawi's resource-constrained health system is a major bottleneck for scaling up HIV and related health services. During the implementation of the NSP 2020-2025, the Ministry of Health developed and launched the 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 strategy resonates with a call from the Global AIDS Strategy (2021-2026) to enhance the delivery of patient-centred integrated health services. This pillar analyses key health system components that are critical for the successful implementation of the NSP 2023-2027.

5.8.1 Governance and Leadership of the Response

Good governance and strong leadership are essential for effective delivery of HIV services, strengthening coordination, and minimizing inefficiencies across the health sector. Due to the multi-faceted nature of the HIV epidemic, an effective institutional framework for the national HIV response requires a multi-sectoral approach. The leadership and governance of the national HIV response entail the establishment of conditions that are necessary for strengthening partnerships among key stakeholders, especially government and civil society. During the period of implementation of the NSP 2020-2025, regulations for the HIV Act. In addition, NAC approved recommendation for the expansion of the mandate of Malawi Business Coalition Against HIV and AIDS from the coordination of HIV and AIDS programs to all health programs in the private sector, hence establishing the MBCH. This will enable a comprehensive private response to the multi-morbidities associated with HIV.

This NSP will address challenges identified during the MTR, such as weak leadership of the decentralised HIV response, sub-optimal participation of traditional and religious leaders in the HIV and AIDS response, lack of awareness among stakeholders of the provisions of the NSP and the 2018 HIV Act and weak accountability of some partner organizations to the local authorities in the implementation of HIV and AIDS interventions.

⁶² UNAIDS, 2021, End Inequalities. End AIDS. Global AIDS Strategy 2021-2026

Objective 5.8.1.1: To advocate for a strong, sustained, and visible role of political, civil, religious, and traditional leaders in the HIV response at the national and sub-national levels consistent with Malawi’s global commitments to end the HIV epidemic by 2030.

Strategic interventions

1. Accelerate the domestication of global HIV strategies, programs, and efforts at national level.
2. Sustain high-level commitment to the HIV and AIDS response, by lobbying the highest political leadership to champion the adoption of the Global HIV Prevention Coalition goals.
3. Build the capacity of political, civil, religious and traditional leaders to lead advocacy efforts on the HIV and AIDS response at the national and sub-national levels.
4. Mainstream the delivery of HIV and AIDS messages in high level political, religious, and traditional events.

Objective 5.8.1.2: To strengthen the governance system of institutions and offices responsible for managing the HIV and AIDS response in line with the provisions of the 2018 HIV and AIDS Prevention and Management Act.

Strategic interventions

1. Support the dissemination of the provisions of the HIV Act to all stakeholders at national and sub-national level.
2. Support duty bearers within the law enforcement agencies and judiciary to enforce regulations of the HIV and AIDS Prevention and Management Act of 2018.
3. Support District Councils to continuously map and develop MoUs with all HIV implementing partners to prevent duplication of efforts and to monitor the impact of HIV investments.
4. Strengthen the capacity of the offices of the Principal Nutrition HIV and AIDS Officers (PNHAO) to improve the leadership of the multi-sectoral decentralised HIV response at district and city levels.

5.8.2 Financial Management

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 program implementation. The Malawi Government, on the other hand, funds the cross-cutting health sector programs. Despite funding commitments from government and development partners, an analysis of resource needs in the HIV response against available commitments shows a funding gap of US\$208.81 million from 2023 to 2027. Conversely, 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. This calls for intensified resource mobilization, particularly on the domestic front. The NAC is mandated to mobilize and equitably disburse resources towards the national response, in line the HIV Act of 2018. In the short to medium term, efforts will be made to strengthen the capacity of the NAC in resource mobilization.

As part of implementing the HSSP III, government has developed a Health Financing Strategy which emphasizes among others on resource mobilization. Key strategies include the need for private health insurance, public-

private partnerships as well as tax hypothecation to finance the ‘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 services⁶³.

Notwithstanding, the MTR 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. The revised NSP will address challenges identified in the MTR such as limited engagement of the MoH Directorate of Finance in budget and expenditure oversight, over vertical programs including HIV. The NSP will also address weak resource mobilization capacity at district-level, limited resource tracking⁶⁴ and perceived weak grants management capacity at district-level.

Objective 5.8.2.1: To strengthen grants management at national and sub-national levels.

Strategic interventions

1. Conduct a baseline assessment of grants management capacity at sub-national level.
2. Strengthen capacity of Local Authorities and implementing partners in grants management.
3. Conduct regular financial risk assessment and mitigation measures for all institutions.

Objective 5.8.2.2: To maximize the efficiency and effectiveness of existing financial commitments and investments in the HIV response.

Strategic interventions

1. Improve periodic implementation of the National Health Accounts (NHA), National AIDS Spending Assessment (NASA) and other resource-tracking exercises.
2. Improve efficiency of resource allocation and utilisation through the Health Financing Framework.
3. Collaborate with the Ministry of Finance to improve absorption of donor funds in the health sector.
4. Develop and operationalize a framework for budget and expenditure information sharing between non-governmental organizations and all Local Authorities.

Objective 5.8.2.3: To strengthen mobilization of governmental and non-governmental domestic resources.

Strategic interventions

1. Support the operationalization of domestic resource mobilization initiatives proposed in the National Health Financing Strategy 2023-2030.

⁶³ Government of Malawi, 2023, National Health Strategic Plan, Ministry of Health

⁶⁴ The last NHA report was completed in 2022 but covered fiscal year 2018/19.

2. Initiate dialogue with Parliament and the private sector to increase domestic investment for the HIV response.
3. Strengthen the capacity of NAC, Local Authorities, private sector and implementing partners in resource mobilization.

5.8.3 Coordination of the Response

The HIV response is multi-sectoral since its social determinants emanate from many sectors and the social impact of the epidemic transcend the health sector. Over the years, the government, through NAC has successfully engaged multiple government MDAs and mobilized many stakeholders to collaborate in the HIV response. The stakeholders include PLHIV, faith-based organizations, traditional leaders, NGOs, CSOs, development partners, the youth, academia, private sector, and key populations. The organisations are coordinated by sectoral coordinating bodies such as the Malawi Interfaith AIDS Association, (MIAA), Malawi Network of AIDS Service Organisations (MANASO), MBCH, Malawi Network of People Living with HIV and AIDS (MANET+) and DHRMD. The stakeholders participate in various TWGs at national and subnational levels to develop 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.

The government has made tremendous efforts to improve coordination of the HIV response. At national level, HIV and AIDS focal persons are present in government ministries to lead mainstreaming of HIV and AIDS and to coordinate implementation of interventions. Due to high HIV burden among the AGYW, government established the AGYW Secretariat within the Ministry of Youth to strengthen the multi-sectoral coordination of AGYW and youth-related interventions.

In addition, the mandate of NAC has been redefined through the enactment of the HIV Act to focus on coordinating and monitoring the response, capacity building and resource mobilization. At Local Authority level, the PNHAOs have been deployed to 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 HIV Implementation Plans within District Implementation Plans (DIPs).

This revised NSP will address challenges affecting coordination that were identified in the MTR such as varying functionality levels of DACCs and CACCs, limited availability of resources to support the PNHAO's functions and sub-optimal accountability of non-governmental organizations. Other challenges include limited awareness of HIV strategic documents among district stakeholders and poor coordination of stakeholders implementing non-biomedical interventions at sub-national level.

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

Strategic interventions

1. Strengthen the capacity of institutions that coordinate the implementation of HIV and health-related programs in the public and private sectors, NGOs and CSOs.
2. Build the capacity of Local Authorities to strengthen multi-sectoral coordination of the HIV response.
3. Accelerate the dissemination and utilization of the NSP at sub-national level.

4. Support Local Authorities to develop and implement Memorandum of Understanding (MoUs) with all non-governmental organizations for harmonized and coherent implementation and monitoring of HIV and AIDS programs.
5. Strengthen the national and subnational M&E system to promote data-driven HIV programming.

5.8.4 Health Products Management Systems

Adequate supply of health commodities, particularly pharmaceutical and medical supplies is one of the key enablers for an effective HIV response. The Central Medical Stores Trust (CMST) is the national warehouse responsible for storage and distribution of health commodities across the country. Government acknowledges that procurement and supply chain management systems need special attention to ensure increased commodity availability for all health commodities. This entails strengthening capacity of the CMST in procurement, warehousing, and distribution.

The MoH Directorate of Health Technical and Support Services coordinates key Procurement and Supply Chain Management (PSM) functions, such as the quantification and procurement planning. However, 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.

The MoH has been implementing reforms at CMST to create the necessary capacity and expertise to procure, warehouse and distribute essential medicines and medical supplies. For example, the MoH has developed and is implementing the Malawi Supply Chain Transformation Plan (MSCTP) which is a strategic roadmap towards achieving uninterrupted supply of medicines for all diseases including TB, malaria and HIV. The roadmap is expected to improve general supply chain management for health products beyond those for HIV, TB, and malaria. Among other things, the MSCTP is expected to create a coherent *End-to-End* product visibility system for pharmaceutical and medical supplies to facilitate inventory management at all levels and reduce wastage. In this regard, various electronic management systems are used including Enterprise Resource Planning (ERP), Open Logistical Management Information System (OpenLMIS), Electronic Health Information Network (eHIN) and C-Stock with plans to ensure interoperability of these systems.

Challenges encountered in the distribution and management of drugs and medical supplies are drug pilferage and poor quality of drugs, hindering the provision of quality of care and attainment of universal health coverage. To address these challenges, the Pharmacy and Medicines Regulatory Authority Act of 2019 includes provisions for improved pharmacovigilance, through enhanced pre- and post-marketing surveillance, and stiff penalties for people involved in theft and misappropriation of health commodities.

This revised NSP will help to address the following challenges: stock-outs of drugs and medical supplies, multiple parallel PSM agencies, sub-optimal capacity for quantification of commodities and medical supplies, limited storage and warehousing capacity and un-harmonized supply chain management software.

Objective 5.8.4.1: To improve the availability, quality, utilization and management of medicines and other health products.

Strategic interventions

1. Support efforts to accelerate the implementation of pharmaceutical and medical supply logistical and management systems in the HSSP-III aimed at improving delivery of quality HIV-related services.
2. Support implementation of the MSCTP by strengthening capacity of the Logistical Management Unit and developing updated policies, guidelines and standards.
3. Support investments that create a robust supply chain system that enables the use of real-time data to guide policy, procurement, and other key decisions at the central level.
4. Support efforts that accelerate harmonization of inventory management electronic systems for improved 'End-to-End' product visibility for all health products including HIV commodities.
5. Accelerate sensitization of stakeholders in relevant provisions of the Pharmacy and Medicines Regulatory Act, including those pertaining to misappropriation and pre- and post-marketing surveillance of drugs and medical supplies.
6. Support efforts to strengthen the capacity of the PMRA to fulfil its 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.
7. Strengthen capacity of relevant health facility staff to perform quantification of health commodities and medical supplies.
8. Support efforts to expand and/or rehabilitate facilities for storage of health commodities and medical supplies in health facilities.
9. Support Integration of HIV commodity supply chain as part of the National Supply Chain Integration Strategy.

5.8.5 Health Information Systems

Functional and coordinated Health Information Systems (HIS) are critical for generating evidence that improves the delivery of programs. HIS provides an opportunity to use client-level data and improve the provision of patient centred care, develop implementation plans, and allocate available resources. The MoH has successfully rolled out various types of HIS to enhance the planning and implementation of health services. These include the Digital Health Information system (DHIS)-2 which provides aggregated data on health outcomes and the One Health Surveillance Platform (OHSP) that captures multi-sectoral data on epidemic-prone conditions and their risk factors. The DHA has successfully established a high-quality HIV data Management Information System (DHA-MIS).

Timely collection and analysis of routine health systems data are essential for data-driven programming of health care. However, data collection in most health facilities remains paper-based and relies on manual entry. This increases the workload of already overburdened health workers and results in poor data quality. During implementation of the NSP 2020-2025, the MoH launched the Digital Health Strategy 2020-2025. The strategy among other things, aims to transform routine data capturing systems from paper to electronic based. The systems will aid in collection of client-level longitudinal data that can be disaggregated. 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.

The government has made various investments to support the scale-up of digital health, including installing fibre backbone network in all districts, establishing two fibre links to the sea for internet access, creating a National Data Centre and gazetting several pieces of legislations to improve digital governance. Currently, there are 200 ART clinics capturing and using Electronic Medical Records (EMRs) in the country. The MoH has successfully piloted the digital scanning of HIV testing registers (Scan form) which removes the need for manual data entry. Further, the NAC is rolling out the Local Authority HIV and AIDS Reporting System (LAHARS), KP database and AGYW database to improve data collection, analysis and reporting of non-biomedical interventions.

The MTR documented the following challenges that the revised NSP will address challenges: sub-optimal data utilization at district level, parallel data reporting systems, and significant resource requirements for collecting DHAMIS data. Additionally, NAC's dependence on a manual HIV M&E system and limited capacity for data utilization at facility level were also cited as challenges. This NSP will also leverage lessons learned from various implementing institutions to improve the use of data for decision-making such as the Prevention Adaptive Learning Management System (PALMS)⁶⁵ developed through the Blantyre Prevention Strategy.

Objective 5.8.5.1: To facilitate the timely generation of quality data for evidence-based decision making in HIV-related programs.

Strategic interventions

1. Facilitate accurate and efficient data collection by implementing comprehensive EMR, Civil Registration and Vital Statistics (CRVS), and supporting infrastructure.
2. Improve quality of data for decision-making at all levels.
3. Increase evidenced-based decision making at all levels.
4. Strengthen HIV surveillance system.

5.8.6 Human Resources for Health

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. During the first two 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 health sector cannot achieve the ambitious coverage targets and delivery of client-centred integrated care set out in this NSP without further investments in human resources for health. In view of this Government, through the HSSP-III has committed to recruit the following cadres of health workers:

⁶⁵ Prevention Adaptive Learning and Management System—a user-friendly electronic data visualization system that uses hand-held devices to facilitate data-driven decision-making by district or facility-level health program coordinators.

- 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 MoH 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 requirements and improve staff motivation so that they can manage the current challenges in programming. Further to this, the NSP will address the following challenges, identified during the MTR such as: poorly coordinated implementation of in-service training and sub-optimal staff performance management. It also leverages on specific HSSP-III strategies aimed at improving human resource management.

Objective 5.8.6.1: Increase the availability, effectiveness, and retention of human resources for health to deliver integrated high-quality services for all diseases, including HIV.

Strategic interventions

1. Support efforts to strengthen capacity of national and district level HR departments in effective workforce management, such as planning, deployment, recruitment, and performance management.
2. Facilitate implementation of human resource development plans in the HSSP-III that support the delivery of quality HIV-related services.
3. Strengthen coordination and integration of relevant pre-service, post-basic and in-service training to meet service delivery needs.
4. Support the development and implementation of human resource for health retention strategies for hard-to-reach areas.
5. Support efforts aimed at providing competitive remuneration, benefits, and working conditions for human resources for health.
6. Engage health worker regulatory authorities to revise the structure and system for continuous professional development for provision of client-centred integrated health care.
7. Engage health worker training institutions to revise curricula and incorporate courses on client-centred integrated health care provision.

5.8.7 Infrastructure, Transport, and Equipment

The MoH has piloted the use of medical drone technology to improve efficiency in samples and results transportation. In addition, it has also purchased key assets that include ambulances. Eight new health centres were constructed and 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

provide essential health services leading to overcrowding and long wait times. Health facilities also have limited equipment to deliver services and limited transport to facilitate referrals.

This NSP will facilitate preventive maintenance of equipment and work towards reducing overcrowding in health facilities, particularly in urban areas. 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, there are plans to construct additional 600 health posts, refurbish health infrastructure such as district hospital laboratories, renovate pharmacies and warehouse space and procure basic equipment for facilities.

Objective 5.8.7.1: Ensure adequate infrastructure for quality HIV service delivery.

Strategic interventions

1. Increase availability of basic medical and non-medical equipment for effective detection and management multi-morbid conditions associated with HIV.
2. Accelerate current plans to construct 20 urban health centres and 600 health posts to improve access to HIV and health care by marginalized urban and rural populations.
3. Improve capacity for preventive maintenance of infrastructure and equipment for HIV and other health services.
4. Accelerate implementation of infrastructure development interventions in the HSSP-III that support the delivery of quality integrated HIV-related services.

5.8.8 Integrated Service Delivery and Quality Improvement

The Global AIDS Strategy calls for implementation of integrated client-centred 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 service delivery needs to be configured to improve psychosocial support for patients, particularly CLHIV, GBV survivors and adolescents living with HIV who are transitioning to adult's care. Currently, some of the well-integrated services include HIV/TB, VMMC/HTS, HTS/STI/PrEP and cervical cancer/ family planning. However, key challenges preventing expansion of service integration include space limitations and inadequate skilled staff to handle co-morbidities. In this regard, the MoH plans to develop models for integrated services that go beyond co-location of service-delivery platforms in a one-stop shop model.

Delivery of quality of services will need development of standards of desired care and continuously assessing the extent to which the standards are being met. This will require investment in service delivery data collection, review, and audit. The MoH Quality Management Directorate developed the Quality Management Policy 2017 and National Health Quality Management Strategy to guide quality improvement efforts. Through the Directorate's leadership various health facilities have established Quality Improvement (QI) structures, such as Quality Improvement Support Teams (QIST) and Work Improvement Teams (WITs) and have gained valuable experience in implementing quality improvement models. These teams will be critical in supporting HIV-related service delivery platforms. Further, the MoH's mortality surveillance system, supported by the National Registration Bureau (NRB), is expected to generate data that support quality improvement. Implementing these programs will require strong clinical leadership and coordination.

The revised NSP will address gaps such as limited health worker training in the management of co-morbidities, limited collaboration between quality improvement support teams and HIV clinics and inconsistent performance of death audits. It will also focus on building strong quality improvement teams and build capacity of health workers in the management multi-morbidity.

Objective 5.8.8.1: Improve the continuum and quality of integrated HIV, SRH, NCD, and nutrition services at all levels of the health care.

Strategic interventions

1. Improve clinical infrastructure to enable implementation of Integrated Service Delivery models for HIV, SRHR, NCDs and other related diseases at the facility level.
2. Support the coordination and implementation of death audits and use the findings for quality improvement.
3. Introduce mobile outreach clinics that use the 'one stop' approach to deliver integrated HIV, SRH and NCDs services.
4. Strengthen the capacity of HCWs to deliver integrated services for HIV and related diseases by conducting integrated training sessions and by developing integrated case management tools.
5. Develop and scale-up integrated supervision and mentorship programs for HCWs delivering integrated HIV care services at all levels.
6. Expand the use of quality improvement frameworks in the delivery of integrated HIV care in all service delivery platforms.
7. Strengthen the capacity of existing quality improvement structures at hospital and health centre (quality improvement support team and work improvement team) to support the implementation of quality integrated HIV, SRH and NCD services.
8. Develop minimum packages of integrated HIV, SRHR and NCDs services that can be delivered at various service delivery platforms in the private and public sector.
9. Strengthen the referral mechanisms between community and health facilities and across various health and social services delivery platforms to ensure clients and PLHIV receive quality continuum of care.
10. Implement paper and electronic information systems to support delivery of integrated services for HIV and related diseases at the community and facility level.

5.8.9 Community Systems Strengthening

A key objective of Global AIDS Strategy 2021-2026 is to increase participation of communities in designing, implementing, and monitoring of HIV and AIDS services to ensure client-centred service delivery. For an organization to be considered community-led, the majority (50 + 1%) of governance, leadership, and staff must come from the community being served. The HSSP-III has made a strong commitment to improve community systems with a view of achieving universal health coverage.

During the NSP 2020-2025, the Ministry of Health reviewed the National Community Health Strategy 2017-2022 and developed the National Community Health Framework (NCHF) 2023-2030. The review noted persistent

challenges in community health systems such as the shortage of Health Surveillance Assistants (HSAs), with an HSA to population ratio of 1: 1,260. In addition, the following challenges were encountered: 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. Their linkages with other community-based development structures such as Village Development Committees (VDCs) and Area Development Committees (ADCs) remained weak. Most members of the community-based structures were untrained and unsupervised. The challenges limited the country'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.

As part of implementing the NSP, a community-led monitoring framework was developed and rolled out, which amplifies the 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 in delivering and monitoring HIV and TB services. In addition, an integrated Community Health Information System (i-CHIS) was developed and rolled out to strengthen health information management for community health services. The MoH continues to strengthen the quality of community health services by recruiting and training additional HSAs and community midwife assistants and providing them with resources for field work. The community health workers are expected to support community structures especially Village Health Committees (VHCs) in creating awareness about HIV and AIDS including HIV prevention, treatment and retention in care and addressing human rights barriers to accessing services. The Ministry is in the process of constructing health posts in hard-to-reach areas. Health Centre Management Committees (HCMC) and Hospital Advisory Committees (HACs) will ensure commodity security in health facilities.

This revised NSP will continue to enhance the multisectoral HIV programming including use of existing structures such as VDCs and ADCs as platforms for community dialogue of HIV and AIDS issues. CSOs and CBOs will continue making efforts to work very closely with these community structures to enhance social accountability mechanisms. It is expected that, through these social accountability mechanisms, communities will identify barriers to accessing HIV services and find solutions to address them. Community health workers will also facilitate delivery of the 'HIV community package'.

This plan will also address challenges identified in the MTR such as lack of coordination among community health workers and volunteers working across various sectors. The NSP will further work on poor reporting of non-biomedical interventions at community-level and limited capacity of traditional and religious leaders to engage with community members in addressing harmful norms and practices, dispel false claims of AIDS cure among other things. It will also accelerate the implementation of the community charter that empowers community organizations to take an active role in the 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)⁶⁶, ADCs and VDCs. The revised NSP will also galvanise efforts to strengthen linkages between health facilities and communities. Above all, all community-based agents, and groups such as Health Surveillance Assistants, CMAs, peer support groups, mother-to-mother groups will be supported to provide community led service delivery of HIV interventions particularly in remote and hard to reach areas. They will also champion demand creation programs and facilitate community-level service delivery with the support of all stakeholders.

Objective 5.8.9.1: To strengthen community systems for HIV epidemic control, child protection and GBV prevention.

Strategic interventions

1. Support on-going efforts by the MoH to recruit, train and deploy community health workers including community midwife assistants and psychosocial counsellors.
2. Accelerate implementation of the 'Community Charter' by strengthening capacity of community structures to deliver health services, including HIV and AIDS, promote health services utilization and address harmful cultural, social and gender norms and practices.
3. Scale up implementation of the 'HIV community package' and community-led monitoring.
4. Strengthen the monitoring and evaluation system for community-based HIV program by scaling up the use and integrated Community Health Information System (i-CHIS) and LAHARS.
5. Enhance engagement of traditional and community leaders to spearhead HIV advocacy efforts and to support delivery of community-based services.
6. Strengthen capacity of CSOs to commission issue-based research, analyse and compile findings to support implementation of evidence-based advocacy.

5.8.10 Laboratory Systems

Laboratory services are essential for provision of quality HIV services. Key laboratory services aim at diagnosing and monitoring the progress of HIV infections, detecting and monitoring ARV and other drug-related toxicities, and diagnosing and monitoring HIV-related co-morbidities. 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 laboratories and deploying GeneXpert and Point-of-Care machines to primary and secondary care facilities. Notably, the National HIV and AIDS Reference Laboratory (NHRL) has been 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.

⁶⁶ 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).

Despite the positive developments in laboratory infrastructure investment, the demand for laboratory services is enormous considering that there are already over 1 million PLHIV on ART who need consistent monitoring for and management of HIV infection and co-morbidities. At the same time, monitoring for advanced HIV disease and scaling up coverage of quality-assured HIV testing requires use of existing inadequate laboratory services. In this respect, the MoH commits to continue providing the following critical laboratory services:

1. Routine VL monitoring for people on ART once every year. This will require continued investment in capacity strengthening of the molecular laboratories in terms of infrastructure, equipment, and HR. It will also entail expansion of sample transportation system and development and implementation of 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. Creatinine monitoring for PrEP clients who are at risk of kidney disease.
6. Point of Care (POC) platforms, such as GeneXpert and other related POC machines for targeted VL testing, EID, and pima for CD4 count testing.
7. Diagnostic tests for NCDs at districts, CHAM, and central hospitals.
8. ARV and TB drug toxicity monitoring in ten sentinel sites.

The MTR identified the following challenges: long turn-around time for viral load assays and CD4 tests, low coverage of HIV quality assurance of HIV tests and viral load assays and lack of a preventive maintenance program for laboratory equipment. Other challenges include limited mentorship of laboratory staff performing HIV-related tests and sub-optimal engagement of the NHRL when acquiring and deploying laboratory equipment. This NSP will mostly leverage strategies outlined in the HSSP-III in addressing the outlined challenges for improved performance of the laboratory services.

Objective 5.8.10.1: To expand the coverage of quality laboratory services for HIV management.

Strategic interventions

1. Scale up availability of quality laboratory services for HIV, VL, syphilis, TB and other HIV related disorders at primary, secondary and tertiary health facilities.
2. Enhance the efficiency of sample transportation system from peripheral to district/central facilities and communication of results to end-users.
3. Strengthen the quality assurance system for laboratory services through accreditations and regular quality assurance assessments, supervision and mentorship.
4. Support investments in scaling up laboratory information management systems to primary and secondary care facilities that provide HIV care, including data dissemination and sharing of best practices.

5. Support efforts by the MoH to implement a robust preventive maintenance system of laboratory equipment and disposal of defunct and obsolete equipment.
6. Accelerate the procurement and deployment of the POC machines for HIV-related diagnostics and treatment monitoring.
7. Support the MoH's Directorate of Health Technical Support Services in enforcing standards for procurement of HIV diagnostic equipment, with involvement of the NHRL.
8. Support capacity building efforts in genomic surveillance, sequencing and bioinformatics at the NHRL and academic or research laboratories to improve the surveillance and management of HIV drug resistance.

5.8.11 HIV response in emergency settings

Malawi is prone to various disease outbreaks and natural disasters such as floods, droughts and cyclones which often have a significant impact on the country's population and economy. Disease outbreaks and disasters are particularly devastating for vulnerable populations, such as those affected by HIV, living in poverty and refugee camps. In recent years, floods have caused significant damage to infrastructure, home 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. Epidemics aggravate the already stretched public health system in Malawi by exerting further strain on human resources for health and infrastructure. Additional indirect adverse effects of epidemics and natural disasters include a rise in mental health conditions and suicide rates, teenage pregnancies and early marriages and disruption of social services such as access to health services.

The continuous cycle of emergencies will likely roll back gains that Malawi has made over the years in achieving high coverage of HIV diagnostic, treatment, care and support services. Access to prevention services will also negatively lead to a rise in HIV incidence which has been declining over the years. The revised NSP will mitigate the impact of emerging epidemics and natural disasters by adopting risk management strategies that enable uninterrupted provision of preventive, diagnostic and curative HIV and AIDS in humanitarian emergency settings.

Objective 5.8.11.1: To minimize adverse HIV outcomes and negative health and social consequences for people affected by humanitarian emergencies.

Strategic interventions

1. Support the development of policy, frameworks and legislation tailored to specific contexts and that provide an initial minimum package of HIV, GBV, SRHR and mental health services.
2. Develop a client-centred and community-led emergency preparedness plans at national and subnational levels that include outreach, peer support and linkages to HIV programmes.
3. Mainstream HIV and AIDS in national disease epidemic preparedness and response plans, policies, strategies, and programmes at all levels.
4. Strengthen rights -based health emergency responses for PLHIV, those at risk and affected by HIV by establishing robust logistics and supply chain systems.

5. Establish systems for enhancing coordination and outreach to people in humanitarian settings to ensure access to HIV prevention services and treatment continuation for PLHIV.
6. Strengthen actions to prevent and respond to GBV and conflict-related sexual violence, with particular attention to people who are most marginalized and vulnerable to HIV in the context of pandemics and other shocks and crises.

6 Implementation Arrangements and 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 14** and the implementing partners are outlined below.

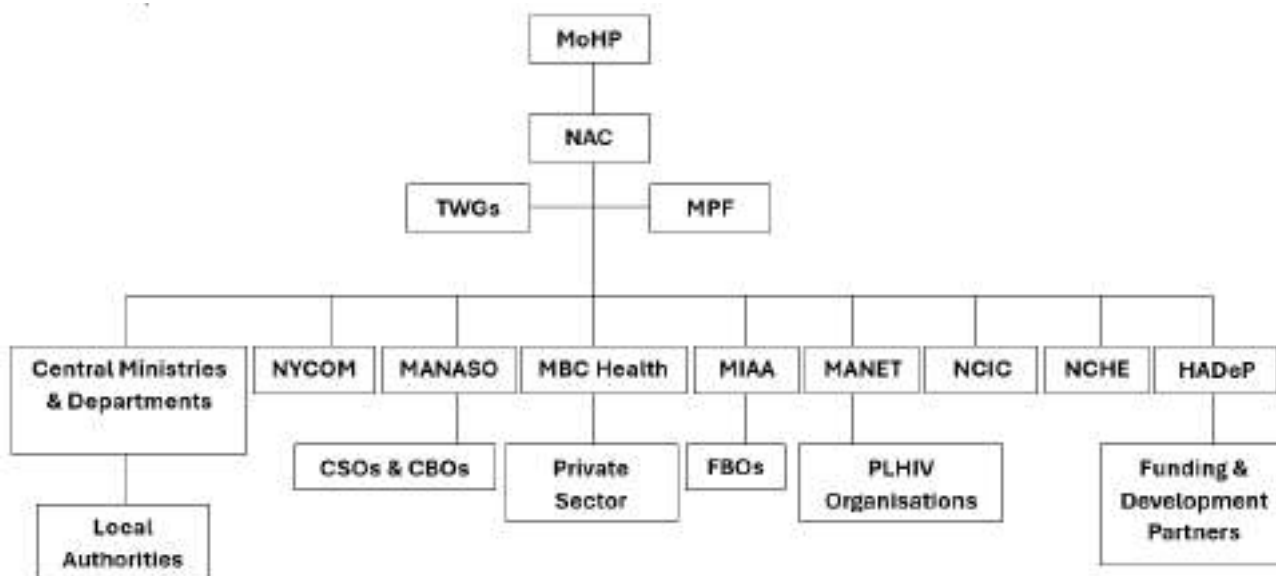


Figure 14: The main coordinating bodies of the national response in Malawi.

Ministry of Health is mandated to provide strategic leadership for the delivery of a comprehensive range of quality, accessible and efficient health services to all Malawians through the creation and sustenance of a strong health system.

National AIDS Commission is mandated by the HIV and AIDS Prevention and Management Act of 2018 to implement, co-ordinate and facilitate the multi-sectoral national response; manage and co-ordinate the implementation of Government policies in liaison with coordinating bodies, government MDAs and the community. The Commission is responsible for facilitating the development and maintenance of an up-to-date HIV information system and establishing suitable mechanisms of disseminating and utilising the information.

Central and other line Ministries are required to support the national response directly or indirectly. Line Ministries provide policy guidance to departments, agencies and parastatal organisations on issues pertaining to their core mandate which are directly or indirectly related to HIV and AIDS. The Ministries have established focal persons 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 are mandated to 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 CACs. District Development Committees (DDCs) and ADCs complement the work of local NGOs. PNHAO who works under the supervision of the Director of Planning and Development (DPD) is responsible 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 for community-based structures in collaboration with NAC.

Private Sector organisations under the coordination of the MBCH, formerly MBCA have the responsibility to mainstream HIV and AIDS through workplace policies and programmes. Following a recent functional review, MBC Health mandate has been expanded to include oversight over all health services provided by the private sector.

Development Partners support government in implementing national priority programmes by funding service delivery and capacity development. The development partners assist the Government's response in areas such as empowering leadership, resource mobilisation, supporting civil society organisations, providing strategic information, and facilitating access to technical and financial resources at national level.

7 Monitoring and Evaluation and Research

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 9 provides the Results Framework for the NSP 2023-2027 which will be utilised to track progress on implementation of the NSP. The NAC and stakeholders in the national response will monitor the progress in the implementation of the NSP 2023-2027 through various ways outlined below:

Joint Annual Reviews (JAR): The Malawi HIV and AIDS Partnership Forum (MPF), through the NAC, will organise joint annual reviews of the national response to HIV, which brings together both implementing and development partners to assess progress in implementing the NSP and provide advice on how to address emerging challenges and scale up best practices. As part of the JAR, the MPF and stakeholders will conduct field visits to observe the status of service delivery platforms at facility and community levels and to interact with clients and service providers. The MPF findings, along with reports from various HIV and AIDS TWGs, will be presented at the JAR. An aide memoir will be produced at the end of the JAR highlighting the key recommendations to be shared with all key stakeholders. Subsequently, the NAC will present reports on the progress in addressing the JAR recommendations at every quarterly MPF meeting. All implementing partners will be expected to monitor progress of implementing their HIV and AIDS programmes, using appropriate tools, and submit a report to the NAC for subsequent dissemination to stakeholders.

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

Development of Epidemiological Estimates: Since 2001, UNAIDS has been mandated through political declarations to support countries in reporting HIV incidence and AIDS-related mortality as key impact indicators that align with SDG 3.3.1 and UN Political Declaration on HIV/AIDS 2016. It is not possible to measure these indicators frequently and directly using population-based surveys. Thus, epidemiological models that triangulate all available high-quality data will be used to estimate the values for these indicators. The estimates will be generated every year to understand the trajectory of HIV epidemic, monitor and improve specific HIV responses, and inform targets for national strategic frameworks. The NAC will continue working with key stakeholders in generating estimates for these key indicators at national, district and community levels.

Local Authority HIV and AIDS Reporting System (LAHARS): There are several partners implementing HIV interventions in each local council. Initially, these partners were expected to submit their HIV programme reports to their respective local councils using the paper-based LAHARS who, in turn, were expected to forward the report to NAC. Recently, an electronic version of the LAHARS has since been developed which will be used by CBOs, FBOs and NGOs to collect and enter non-biomedical data right in the communities. The data will be aggregated at TA and district levels. The NAC will then compile and analyse district-level LAHARS data, prepare reports, and share findings with all stakeholders. The findings will form part of the National HIV and AIDS Response annual progress reports.

Programme Reports: All key stakeholders implementing biomedical, behavioural, and structural interventions periodically collect data, as part of routine programme monitoring. For example, the DHA in the MoH conducts quarterly visits to all health facilities implementing biomedical interventions, collect relevant data and perform

data quality assessments. The data are managed and analysed using a customised DHAMIS. Thereafter, the DHA disseminates quarterly reports to all stakeholders including the NAC. All stakeholders collecting HIV-related data will be required to emulate the DHA example and submit their programme reports to the NAC.

Periodic Surveys and Surveillance: Over the years, the NAC has supported various stakeholders in conducting national surveys that provide population-based estimates of key outcomes and impact indicators used to track progress being made in the national response to the HIV and AIDS epidemic. These surveys include the Malawi Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), Malawi Population-based HIV Impact Assessment (MPHIA), Biological and Behavioural Surveillance Survey (BBSS) and the Stigma Index Survey. In addition, various research institutions periodically conduct population-based surveys at sub-national and national levels and share the findings with the NAC. Through the Monitoring and Evaluation, Research and Surveillance (MERS) TWG, the NAC will continue engaging with relevant stakeholders and the Ethics Committees (that review surveys protocol) to map-out on-going and planned surveys and to minimize duplications and omissions in the coverage of the surveys. Most importantly, the NAC will promote timely review and dissemination of survey and surveillance data so that they can be used for evidence-based HIV programming.

Research: Research is critical for generating information required for evidence-based planning of the National Response. The NAC will continue to encourage universities and research institutes to conduct research studies that identify innovations in HIV prevention, management, and service delivery or those that evaluate the quality of programme implementation and impact of on-going HIV interventions. The MoH, in collaboration with the National Commission of Science and Technology and the National Planning Commission, will periodically update the National Health Research Agenda to provide guidance to researchers on the HIV research priorities that align with the objectives of the revised NSP. Besides investigator-initiated research studies, the NAC, MoH and other stakeholders will commission studies that may help to address emerging HIV-related issues. In this respect, the NAC will continue commissioning studies on HIV drug resistant strains and ART toxicities.

8 Costing Results

8.1 Overall NSP 2023-2027 Cost

The revised and extended NSP is expected to cost approximately US\$ 1.41 billion for the five- year period of implementation of which 64% (US\$906 million) will be needed for commodities; 21% (US\$ 300 million) for programs and 14% (US\$ 201 million) for RSSH.

Table 4: Total Cost of the NSP 2023-2027

NSP Component	Total (\$)	Total (MWK)	Total (Million \$)	Total (Billion MWK)	% of Total Budget
Commodities	906,101,634.71	1,510,199,717,204.74	906.10	1,510.20	64.34%
Programs	300,664,573.51	501,120,651,310.42	300.66	501.12	21.35%
RSSH	201,440,207.86	335,742,408,841.27	201.44	335.74	14.30%
TOTAL	1,408,206,416.08	2,347,062,777,356.44	1,408.201	2,347.06	100%

8.2 Programmatic Costs

The 5-year programmatic budget is approximately US\$300.66 million distributed across all the 8 pillars highlighted in table 5. Slightly above half of the budget (56.4%) is allocated towards HIV combination prevention. Approximately 17.8% of the budget has been allocated towards treatment, care and support. TB/HIV, SBCC and reducing human rights and gender-based related barriers have the least budget allocation of 3.8%, 4.0% and 0.2% respectively. The funds are channelled towards provision of comprehensive services for targeted populations, trainings, and mentorship among other activities.

Table 5: Programmatic cost of the NSP 2023-2027 (in million USD)

Module	2023 (\$)	2024(\$)	2025(\$)	2026(\$)	2027(\$)	Total	% of Total
Combination Prevention	15.71	45.61	28.57	43.06	36.57	169.53	56.40%
Differentiated HIV Testing Services	5.56	2.87	3.23	3.68	4.10	19.42	6.50%
Treatment, Care and Support for HIV/AIDS and Related Diseases Prevention	6.26	10.23	12.15	10.30	14.61	53.56	17.80%
TB/HIV	2.67	1.85	2.09	2.29	2.58	11.47	3.80%
Key and Vulnerable Populations	4.31	7.79	5.10	4.70	11.97	33.91	11.30%
Reducing Human Rights and Gender-Related Barriers	0.23	0.12	0.11	0.13	0.145	0.73	0.20%
Social Behaviour Change Communication	3.51	3.80	1.52	1.60	1.64	12.05	4.00%
TOTAL	38.23	72.25	52.78	65.79	71.61	300.66	100%

8.3 RSSH Costs

The government, through the HSSP-III is committed to recruit more health workers to achieve the ambitious coverage targets and delivery of client-centred integrated care. Therefore, 64.41% of the RSSH budget will be spent on HRH followed by Infrastructure, Transport, and Equipment which accounts for 16.38%. Unlike in the other years, the revised NSP has included resources to allow stakeholders to respond to HIV issues during emergencies as outlined in the table below.

Table 6: RSSH cost of the NSP 2023-2027 (in million USD)

Thematic Area	2023 (\$)	2024 (\$)	2025(\$)	2026 (\$)	2027(\$)	Total (\$)	% of Total Budget
Governance and leadership	0.75	1.17	0.89	1.01	1.16	4.98	2.47%
Financial Management	0.60	0.30	1.23	0.40	0.49	3.02	1.50%
Coordination of the Response	0.64	0.66	0.76	0.87	0.40	3.33	1.65%
Health Products Management Systems	6.66	2.54	0.49	-	-	9.69	4.81%
Health Information System	3.81	0.51	0.37	0.38	0.42	5.48	2.72%
Human Resources for Health (HRH)	104.16	5.32	5.95	6.68	7.63	129.74	64.41%
Infrastructure, Transport, and Equipment	15.47	16.83	0.68	-	-	32.99	16.38%
Integrated Service Delivery and Quality Improvement	0.00	-	-	-	-	0.00	0.00%
Community systems strengthening	0.52	0.19	0.10	0.12	0.14	1.07	0.53%
Laboratory Systems	1.18	0.34	1.74	0.07	0.08	3.41	1.69%
HIV response in emergency settings/Humanitarian Response	7.35	0.19	0.06	0.06	0.06	7.73	3.84%
Grand Total	141.14	28.07	12.26	9.59	10.39	201.44	100%

8.4 Commodities Costs

The commodities costs derivation is largely informed by 2022 Goals model results. Costs for commodities constitute those for diagnostics, prevention, treatment and care and associated costs for Procurement Supply Management (PSM) as explained in Table 7 below. Owing to the high volume of ARVs, treatment commodities have the highest share of costs at 44.14%, followed by diagnostics at 28.10% and prevention commodities at 15.14%. Crosscutting PSM costs amount to approximately 12.59% of the total commodities cost included in the NSP.

Table 7: Commodities cost of NSP 2023-2027 (in million USD)

Category	2023 (\$)	2024(\$)	2025(\$)	2026(\$)	2027(\$)	Total (\$)	% of Total Budget
Diagnostics	40.57	46.55	53.38	55.26	58.84	254.60	28.10%
Prevention	17.87	24.11	30.73	31.73	32.75	137.18	15.14%
Treatment and Care	83.43	81.67	80.21	78.32	76.63	400.26	44.17%
PSM	20.43	21.94	23.66	23.80	24.22	114.05	12.59%
Grand Total	162.30	174.27	187.97	189.11	192.44	906.09	100%

8.5 Financing for HIV NSP 2023-27

The national HIV response is largely funded by development partners, with minimal domestic financing. Financial analytical tools such as the NASA depict that approximately 80% of all HIV funding is derived from donors, while government provides the remaining 20%, and this is inclusive of human resources for health and infrastructure support. Furthermore, volatility in HIV funding commitments against actual disbursements has been evident across previous financing cycles of the NSP.

Expenditure results of the 2020 NASA that covered the FYs 2015/16 to 2018/19 have been used as proxy for funding commitments in the response in absence of recent data from Resource Mapping (RM) exercise which is still ongoing. Relevant data has been analysed and extrapolated to provide details of funding commitments for the response to implement the revised NSP. It is evident that the major funding sources are the Global Fund and PEPFAR accounting for an average of 41% and 37% respectively of the total funding for the revised NSP period. The table below provides details of major funding sources of the HIV and AIDS response.

Table 8: HIV Funding Sources for 2026/27 FY. Source - 2020 Malawi NASA Report

Funding Sources	Funding (Million USD)	Distribution (%)
Malawi Government	79.2	17.69
United States Government ⁶⁷	164.3	36.71
Global Fund	185.8	41.51
UN-Family	1.2	0.27
Other Multilateral Funding Sources	17.1	3.82
TOTAL	447.6	100

The last mile towards the 2030 goal is a crucial period for deliberate planning around sustainability of the response beyond the target year. This among others entails domestic resource mobilization and increased

domestic funding to the response. Strong political will and leadership, collaboration among stakeholders in the multi-sectoral response and enhanced capacity of local and community structures are some of the bedrocks for upholding the gains in the response.

Historically funding trends by major programmatic functions show that treatment care and support take up over 50% of the total funding, while HIV prevention aggregates around 9%. Among commitments included in the 2021 Political Declaration on HIV and AIDS, 25% of the total HIV budget should be allocated towards HIV prevention. However, the trend in the response has not been in line with this commitment area. Notwithstanding the fact, treatment as prevention (TASP) is costed under treatment, care, and support. Nonetheless, deliberate measures to pull resources towards HIV prevention are imperative. The figure below depicts funding by programmatic functions.

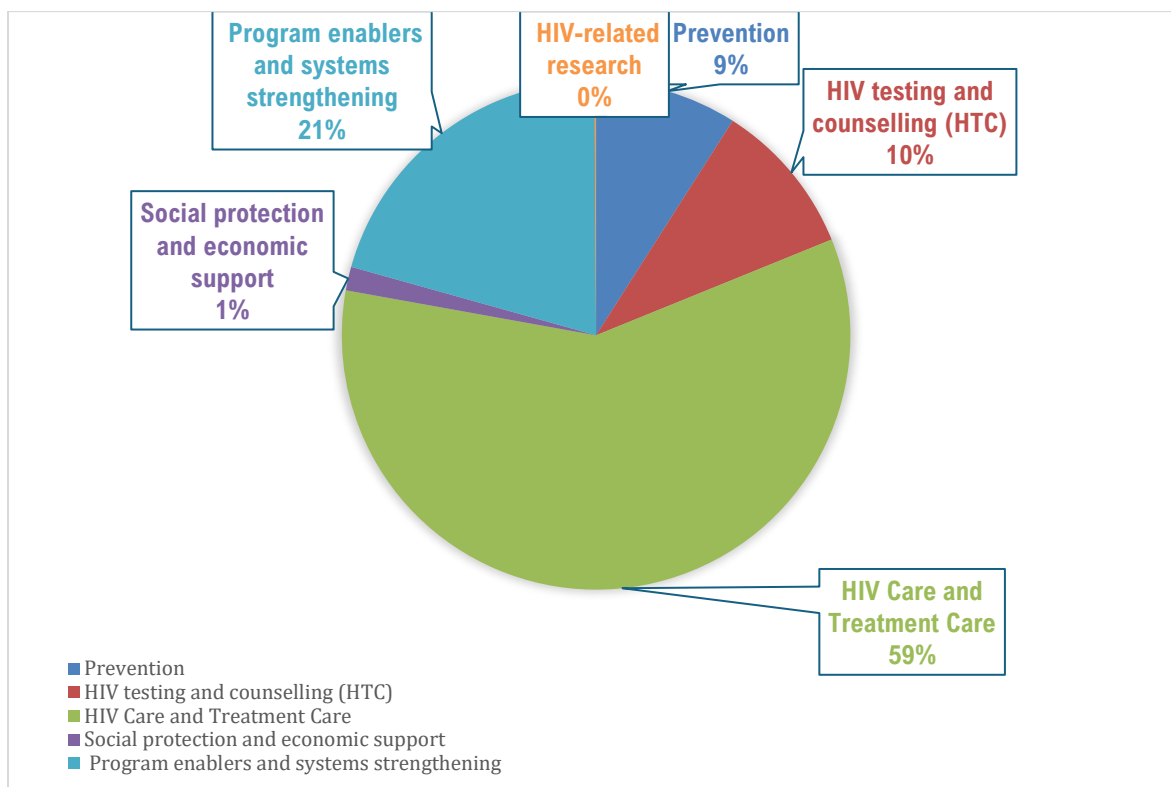


Figure 15: Funding by Programmatic Function for 2027. Source 2020 NASA

The two variables for derivation of the funding gap are the budget (resource needs) and available resources. As alluded to, 2020 NASA figures have been extrapolated and used as proxies for funding commitments for the revised NSP. Further, the assumption that funding will remain constant over the time frame of the revised NSP has been maintained from the initial 2020-25 plan. In this regard, a total of approximately US\$230 million will be available for the response on an annual basis to 2027. Therefore, total resources available amount is US\$1,199.4 million, while the budget is US\$ 1,408.21 million. Table 9 below details the funding gap in implementation of the NSP.

Table 9: Financial gap of the HIV NSP 2023-27 against total resources projected – USD (in millions)

HIV Including Viral Hepatitis and other STIs	2023-2027 (Million USD)
Resources needs 2023-2027	1,408.21.
Resources available 2023-2027	1,199.4
Financial gap	208.81

8.6 Costing Limitations

Costing of the revised NSP presented several limitations. Existence of gaps on costs for activities under specific program areas has a huge bearing on the total resource needs for the NSP. In addition, instability of the economy presents a volatile pricing environment, essentially affecting the NSP budgets. The absence of recent resource mapping data has resulted in use of expenditure data as proxy for funding. Furthermore, subsequent costing assignments should employ rigorous costing methodologies to avoid over/under costing the NSP. Discrepancies in NSP budgets and expenditures have been depicted in findings of the 2020 NASA.

9 Performance Framework

Table 10: Summary performance framework for the National Strategic Plan for HIV and AIDS 2023-2027.

		Indicator	Numerator	Denominator	Disaggregation	Baseline		2023	2024	2025	2026	2027
						Result	Year	Target	Target	Target	Target	Target
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)	All	5.6%	2020	4.8%	4.6%	4.5%	4.3%	4.2%
					Children 0-14	0.8%	2020	0.7%	0.5%	0.5%	0.4%	0.4%
					Females 15+	10.9%	2020	9.3%	9.0%	8.7%	8.5%	8.2%
					AGYW 15-24	3.9%	2020	2.1%	2.0%	1.9%	1.7%	1.6%
					Males 15+	7.7%	2020	6.0%	5.8%	5.6%	5.3%	5.1%
					FSW	51.5%	2019	48.4%	47.0%	45.6%	44.2%	42.9%
					MSM	8.6%	2019	12.3%	11.8%	11.3%	10.9%	10.4%
					Transgender	32.0%	2019	13.2%	12.7%	12.2%	11.7%	11.2%
		*	*	*	*	*	*	*				
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	All	1.13	2020	0.74	0.57	0.47	0.39	0.33
					Children 0-14	0.40	2020	0.22	0.17	0.14	0.12	0.09
					Females 15+	3.46	2020	1.41	1.08	0.88	0.73	0.61
					AGYW 15-24	4.42	2020	1.43	1.09	0.90	0.75	0.63
					Males 15+	2.74	2020	0.86	0.66	0.54	0.44	0.37
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	All	68	2020	52	49	44	38	33
					Children 0-14	19	2020	18	14	12	10	8
					Females 15+	101	2020	66	65	60	55	48
					AGYW 15-24	52	2020	25	24	22	19	16
					Males 15+	109	2020	89	83	72	60	52
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"	None	6.0%	2020	5.5%	5.3%	5.2%	5.0%	4.8%
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)	All	90.2%	2020	98.5%	97.8%	98.3%	98.3%	98.3%
					Children 0-14	67.1%	2020	66.1%	80.1%	90.0%	90.0%	90.0%
					Females 15+	94.5%	2020	102.1%	99.0%	99.0%	99.0%	99.0%
					AGYW 15-24	83.3%	2022	92.2%	95.0%	95.0%	95.0%	95.0%
					Males 15+	87.2%	2020	97.7%	98.0%	98.0%	98.0%	98.0%
1, 6	Coverage	Percentage of KP who have received an HIV test during the reporting period in KP-specific programs and know their results.	Number of KP who have been tested for HIV during the reporting period and who know their results	Estimated number of KP in KP-specific program areas	FSWs	64.0%	2020	44.2%	41.0%	47.4%	49.1%	25.0%
					MSMs	52.4%	2020	30.5%	38.4%	41.5%	43.1%	43.6%
					Transgenders	100.0%	2020	23.4%	23.4%	23.4%	23.4%	23.4%
					Prisoners		2020	139.6%	139.6%	139.6%	139.6%	139.6%
					PWID		2020		36.1%	36.1%	36.1%	36.1%
3, 6	Coverage	Percentage of people on ART among all people living with HIV	Number of people on ART at the end of the reporting period. Annual Spectrum model	Estimated number of people living with HIV. Annual Spectrum model estimates	All	79.8%	2020	93.4%	95.4%	96.5%	96.6%	96.6%
					Children 0-14	70.2%	2020	66.1%	80.1%	90.0%	90.0%	90.2%
					Females 15+	89.1%	2020	97.8%	97.8%	97.9%	97.9%	97.9%
					Females pregnant	*	2020	*	*	*	*	*

		Indicator	Numerator	Denominator	Disaggregation	Baseline		2023	2024	2025	2026	2027
						Result	Year	Target	Target	Target	Target	Target
		at the end of the reporting period	estimates KP: BBSS or annual consensus estimates (MOH/UNAIDS)	KP: BBSS or annual consensus estimates (MOH/UNAIDS)	AGYW 15-24	*	2020	*	*	*	*	*
					Males 15+	67.4%	2020	90.6%	93.3%	95.0%	95.0%	95.0%
					FSWs	85.8%	2020	*	*	*	*	*
					MSMs	99.0%	2020	*	*	*	*	*
					Transgenders	98.8%	2020	*	*	*	*	*
					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	Children 0-14	69.6%	2020	81.4%	84.8%	88.2%	91.6%	95.0%
					Females 15+	94.3%	2020	95.0%	95.0%	95.0%	95.0%	95.0%
					Females pregnant	*		95.0%	95.0%	95.0%	95.0%	
					Males 15+	92.7%	2020	94.2%	94.4%	94.6%	94.8%	95.0%
					FSWs	*		95.0%	95.0%	95.0%	95.0%	95.0%
					MSMs	*		95.0%	95.0%	95.0%	95.0%	95.0%
					Transgenders	*		95.0%	95.0%	95.0%	95.0%	95.0%
					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	All		2020	20.5%	44.0%	67.0%	90.0%	90.0%
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	All 40+	*		56%	62%	68%	74%	80%
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	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	Females 15-49	39.9%	2020	57.1%	62.8%	68.5%	74.3%	80.0%
					Males 15-49	56.6%	2020	66.6%	70.0%	73.3%	76.7%	80.0%
					AGYW 15-24	49.0%	2020	62.3%	66.7%	71.1%	75.6%	80.0%
					ABYM 15-24	64.0%	2020	70.9%	73.1%	75.4%	77.7%	80.0%
					FSW	84.9%	2019	87.5%	88.1%	88.7%	89.4%	90.0%
					MSM	79.4%	2019	84.7%	86.0%	87.4%	88.7%	90.0%
					Transgender	*		*	*	*	*	*
					PWID	*		*	*	*	*	*

		Indicator	Numerator	Denominator	Disaggregation	Baseline		2023	2024	2025	2026	2027
						Result	Year	Target	Target	Target	Target	Target
			their most recent client Source: MICS, DHS, MPHIA, BBSS	12 months Source: MICS, DHS, MPHIA, BBSS								
1	Output	Number of condoms distributed in the reporting period	Number of condoms and lubricants delivered to health facilities and community distribution points in the reporting period DHA-MIS delivery records	Condom Needs Estimation Tool	Male	155,000,000	2020	147,238,001	163,291,433	179,344,865	195,398,296	211,451,728
					Female			0	509,297	569,050	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	DHIS2		115,000	2020	208,889	198,444	193,222	182,778	156,667
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	AGYW 15-24	39.2%	2020	59.6%	64.7%	69.8%	74.9%	80.0%
					ABYM 15-24	43.9%	2020	62.0%	66.5%	71.0%	75.5%	80.0%
1,6	Coverage	Percentage of key and other vulnerable populations reached with HIV prevention programs - defined package of services.	Number of KOVP have received a defined package of HIV prevention services	Estimated number of KOVP in the targeted population (area)	AGYW 15-24			*	*	*	*	*
					Females 25-34			30%	40.0%	50.0%	60.0%	70.0%
					FSWs			93.0%	91.6%	91.6%	91.6%	90.19%
					MSMs			36.1%	38.4%	42.0%	43.1%	43.6%
					Transgenders			*	*	*	*	*
					Prisoners			*	*	*	*	*
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	AGYW 15-24			5,119	5,671	5,671	6,204	6,737
					Females 15+			3,679	6,373	6,651	8,022	9,389
					Males 15+			6,002	10,398	10,852	13,089	15,318
					FSW			2,390	3,154	3,629	4,125	4,621
					MSM			1,694	3,629	2,421	2,768	3,116
					Transgender			282	494	494	586	678
					PWID			410	717	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	All			95.80%	95.80%	96.20%	96.60%	97.10%
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	Estimated number of pregnant women giving birth in the past 12 months	Females pregnant			98%	98%	98%	98%	98%

		Indicator	Numerator	Denominator	Disaggregation	Baseline		2023	2024	2025	2026	2027
						Result	Year	Target	Target	Target	Target	Target
			were HIV-positive at the first antenatal care visit									
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	Females pregnant			95%	95%	95%	95%	95%
1, 2	Coverage	Percentage of HIV-exposed infants receiving a virological test for HIV within 2 months of birth.	Number of HIV exposed infants born during the reporting period who received a virological HIV test within two months of birth	Estimated number of HIV-positive women who delivered during the reporting period	Children 2 months			85%	85%	85%	85%	85%
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	Children 24 months	71.8%	2020	85%	85%	85%	85%	85%
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	All	90.2%	2020	95%	95%	95%	95%	95%
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	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	All	99.0%	2020	99%	99%	99%	99%	99%
8	Output	Number of local councils having management and data review meetings per schedule				35%	2020	44.10%	50.00%	54.30%	54.30%	57.10%
8	Output	Number of national research dissemination workshops conducted				1	2020	1	1	1	1	1

		Indicator	Numerator	Denominator	Disaggregation	Baseline		2023	2024	2025	2026	2027
						Result	Year	Target	Target	Target	Target	Target
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		9.2%	2019	25%	25%	25%	25%	25%

9.1 Activities by Objective and Intervention

Pillar	5.1	Combination Prevention
Module	5.1.1	1.1 Condom and Lubricant Programming
Objective	5.1.1.1	To increase access and uptake of quality condoms and lubricants among high-risk populations using the Total Market Approach
Strategic Intervention	5.1.1.1.1	Strengthen leadership, governance and coordination of the condom and lubricant programme at national, district and community levels.
Activity	5.1.1.1.1.1	Conduct national level CCC meeting
Activity	5.1.1.1.1.2	Conduct orientation of the DCCC's on their TORs
Activity	5.1.1.1.1.3	Conduct quarterly coordination meetings at district level to discuss and assess condom programming
Activity	5.1.1.1.1.4	Continuous Mapping of leadership and coordination gaps at national and district levels
Activity	5.1.1.1.1.5	Develop Standard Operating Procedures (SOPs) and monitoring tools within the public sector and other service providers
Activity	5.1.1.1.1.6	Disseminate Standard Operating Procedures (SOPs) and monitoring tools within the public sector and other service providers
Activity	5.1.1.1.1.7	District Condoms Focal Persons training on CCP and data management
Activity	5.1.1.1.1.8	Print Standard Operating Procedures (SOPs) and monitoring tools within the public sector and other service providers
Strategic Intervention	5.1.1.1.2	Strengthen the distribution of condoms and lubricants including distribution to the last mile using the TMA
Activity	5.1.1.1.2.1	Conduct refresher trainings for stock monitoring at last mile distribution points once a year
Activity	5.1.1.1.2.2	Develop TMA guidelines to guide the 3 sectors of TMA
Activity	5.1.1.1.2.3	Identify and train untraditional outlets focal persons
Activity	5.1.1.1.2.4	Procure simple smart phones for use for stock monitoring at the last-mile distribution points
Activity	5.1.1.1.2.5	Provide monthly internet for stock monitoring at the last mile
Activity	5.1.1.1.2.6	Train HSAs on stock monitoring of condoms at last-mile distribution points
Activity	5.1.1.1.2.7	Train relevant stakeholders of condom and lubricant quantifications
Strategic Intervention	5.1.1.1.3	Strengthen private sector involvement in condom and lubricant programming.
Activity	5.1.1.1.3.1	Conduct annual Private sector and the Public Sector engagement and collaboration meetings
Activity	5.1.1.1.3.2	Develop and execute a private sector engagement plan
Strategic Intervention	5.1.1.1.4	Strengthen quality assurance systems for condoms and lubricants and all related services in all sectors.
Activity	5.1.1.1.4.1	Conduct biannual post-market surveillance of condom physical integrity and storage facility conditions
Activity	5.1.1.1.4.2	Conduct condom program reviews and learning sessions with district teams at zonal level.
Activity	5.1.1.1.4.3	Develop/revise the condom program quality improvement standards in collaboration with PMPB and QMD
Activity	5.1.1.1.4.4	Orient relevant district condom focal persons and pharmacy personnel in the condom QA standards.
Strategic Intervention	5.1.1.1.5	Strengthen innovative demand creation for condoms and lubricants among target populations through SBCC, branding and empowerment of women, girls, and KPs.
Activity	5.1.1.1.5.1	Conduct continuous barrier analysis studies to understand underpinning factors to low condom uptake
Activity	5.1.1.1.5.2	Conduct a service needs assessment for men in the formal sector
Activity	5.1.1.1.5.3	Conduct mass media and digital condom promotion campaigns
Activity	5.1.1.1.5.4	Conduct Mini Community campaigns/Community engagement meetings
Activity	5.1.1.1.5.5	Conduct targeted community dialogue sessions with HIV positive pregnant women and their spouses
Activity	5.1.1.1.5.6	Develop a standardized demand generation package for implementing partners (training package tools)
Activity	5.1.1.1.5.7	Identify and train potential champions (ambassadors) and celebrities across various industries (music, sports, religious and community leaders)
Activity	5.1.1.1.5.8	Message development workshop
Activity	5.1.1.1.5.9	Peer Education
Activity	5.1.1.1.5.10	Review policies and guidelines and coordinating structures to create enabling environment for the distribution of condoms and lubricants amongst KP
Activity	5.1.1.1.5.11	Support districts to map last mile condom distribution points
Activity	5.1.1.1.5.12	Train SRHR champions/ambassadors on Combination prevention
Strategic Intervention	5.1.1.1.6	Strengthen monitoring, evaluation, research and surveillance for condom and lubricant programming
Activity	5.1.1.1.6.1	Conduct research dissemination for studies on condoms and combination prevention
Activity	5.1.1.1.6.2	Conduct biannual monitoring of the CCP at all levels
Activity	5.1.1.1.6.3	Conduct biannual post-market surveillance of condom physical integrity and storage facility conditions
Activity	5.1.1.1.6.4	Conduct condom program reviews and learning sessions with district teams at zonal level.
Activity	5.1.1.1.6.5	Conduct quarterly monitoring of the CCP at district, health facility and community level, private institutions, sops, warehouses Points of Entries (for commercially marketed condoms and socially marketed condoms).
Activity	5.1.1.1.6.6	Conduct quarterly monitoring of the CCP at district, health facility and community level, private institutions, Sops, warehouses Points of Entries (for commercially marketed condoms and socially marketed condoms).
Activity	5.1.1.1.6.7	Develop a condom distribution dashboard
Activity	5.1.1.1.6.8	Develop/revise the condom program quality improvement standards in collaboration with PMPB and QMD
Activity	5.1.1.1.6.9	Develop/revise the condom program quality improvement standards in collaboration with PMRA and QMD
Activity	5.1.1.1.6.10	Maintain the condom and lubricant dashboard
Activity	5.1.1.1.6.11	Orient relevant district condom focal persons and pharmacy personnel in the condom QA standards.
Activity	5.1.1.1.6.12	Support studies on condom uptake and use (MDHS, MBBSS, etc.)
Activity	5.1.1.1.6.13	Train relevant personnel on new data collection tools and the condom dashboard, once a year
Module	5.1.2	Pre-Exposure Prophylaxis (PrEP)
Objective	5.1.2.1	Increase access, uptake and quality of PrEP services targeting high risk and key populations in all high incidence districts.
Strategic Intervention	5.1.2.1.1	Support subnational planning for oral and long-acting injectable PrEP rollout and scale up
Activity	5.1.2.1.1.1	Assess and certify more Health Facilities across all regions to provide PrEP
Activity	5.1.2.1.1.2	Capacitate and empower the district council structures to fully engage the community structures and other stakeholders
Activity	5.1.2.1.1.3	Develop clear guidelines for PrEP Implementation to ensure consistency in policy implementation
Activity	5.1.2.1.1.4	Engage the grass root structures at district council in policy development, implementation, and evaluation
Activity	5.1.2.1.1.5	Involve the district coordinating structures in TWGs
Strategic Intervention	5.1.2.1.2	Strengthen integration of PrEP with SRH, child health and other service delivery points including the community outreach models.
Activity	5.1.2.1.2.1	Incorporate Community PrEP initiation and outreach clinics in the guidelines to cater for the hard-to-reach population

Activity	5.1.2.1.2.2	Operationalize the use of HIVST for screening before PrEP initiation
Strategic Intervention	5.1.2.1.3	Improve human resource and health system capacity to offer PrEP, VMMC, STI services, and family planning through SRH/HIV service integration.
Activity	5.1.2.1.3.1	Adopt the use of HIV self-testing before initiating PrEP to support community PrEP access
Activity	5.1.2.1.3.2	Capacity building of district-based PEs and Navigators on PrEP for HIV prevention - Conduct trainings/orientation among HCWs on provision of gender affirming sessions related to PrEP
Activity	5.1.2.1.3.3	Capacity building of district-based PEs and Navigators on PrEP for HIV prevention - Conduct workshop to review peer education training curriculum to include emerging HIV prevention interventions (PrEP/PEP)
Activity	5.1.2.1.3.4	Conduct Online campaigns on treatment as prevention - Conduct creative workshop to Develop of content for Online Campaigns
Activity	5.1.2.1.3.5	Conduct quarterly PrEP Mentorship
Activity	5.1.2.1.3.6	Integrate HIV Prevention services (PrEP, VMMC, Condom, STI, Family Planning) to be provided under one roof
Activity	5.1.2.1.3.7	Introduce community PrEP access through outreach Clinics to improve access
Activity	5.1.2.1.3.8	Prepare Clinics to be youth friendly to allow easy access of PrEP by AGYWs (YFHS Training)
Activity	5.1.2.1.3.9	Prepare Clinics to be youth friendly to allow easy access of PrEP by AGYWs (YFHS Training) - Registered Nurses (1 per clinic)
Activity	5.1.2.1.3.10	Target the Pregnant & Breast-feeding women as one of the priority groups to access PrEP
Activity	5.1.2.1.3.11	Train additional staff to provide PrEP in new sites
Activity	5.1.2.1.3.12	Train HCW in integrated HIV Prevention services package
Strategic Intervention	5.1.2.1.4	Strengthen supply chain systems for PrEP medicines and commodities.
Activity	5.1.2.1.4.1	Conduct defaulter tracing to understand reasons for dropouts
Activity	5.1.2.1.4.2	Conduct PrEP Subgroup meetings to monitor implementation progress and provide guidance
Activity	5.1.2.1.4.3	Conduct quarterly program review with stakeholders and implementers
Activity	5.1.2.1.4.4	Conduct Quarterly Supervision and Continuous Quality Improvement
Strategic Intervention	5.1.2.1.5	Identify innovative strategies for mobilising additional resources for PrEP scale-up and diversifying delivery channels, including private sector-governance.
Activity	5.1.2.1.5.1	Engage additional stakeholders to align their priorities towards scale up of PrEP
Activity	5.1.2.1.5.2	Engage the private sector to support some of the strategic interventions of PrEP through PPP
Strategic Intervention	5.1.2.1.6	Promote awareness, uptake and continuity of PrEP among AGYW, KPs and other vulnerable populations through the use of multiple channels including digital media platforms.
Activity	5.1.2.1.6.1	Blasting of content through online platforms
Activity	5.1.2.1.6.2	Brand PrEP differently from ARVs used for Treatment to prevent stigma and promote uptake
Activity	5.1.2.1.6.3	Broadcasting of radio products - Airing on national programs
Activity	5.1.2.1.6.4	Broadcasting of radio products - Hiring of production company
Activity	5.1.2.1.6.5	Broadcasting of radio products - Production of radio jingles
Activity	5.1.2.1.6.6	Broadcasting of TV products – Advert
Activity	5.1.2.1.6.7	Broadcasting of TV products - Airing on National TVs (30 min programs)
Activity	5.1.2.1.6.8	Broadcasting of TV products - Collection of audio visuals footage for materials production
Activity	5.1.2.1.6.9	Community Radios - Airing on Community radios (1-hour programs)
Activity	5.1.2.1.6.10	Community Radios - Community Radios Airtime (Jingle)
Activity	5.1.2.1.6.11	Conduct Online campaigns on treatment as prevention - Pretesting of content on treatment as prevention
Activity	5.1.2.1.6.12	Develop and implement integrated PrEP, VMMC, STI and Family Planning demand generation activities
Activity	5.1.2.1.6.13	Develop tailored messages to reach out to the marginalized groups i.e. AGYWs
Activity	5.1.2.1.6.14	Hiring of Online Experts
Activity	5.1.2.1.6.15	Pay hosting fee for social media campaign messages
Strategic Intervention	5.1.2.1.7	Strengthen monitoring, evaluation, research, and surveillance for PrEP services.
Activity	5.1.2.1.7.1	Adopt event driven PrEP to cater for clients in need of short course PrEP (MSMs)
Activity	5.1.2.1.7.2	Adopt WHO recommendation on the use of CrCl testing in individuals with risk factors for renal disease to remove the access barrier due to laboratory capacity
Activity	5.1.2.1.7.3	Review the guidelines to adopt Cabotegravir and Dipivefrine Ring and prepare the system for other sustainable pipeline PrEP products
Module	5.1.3	Voluntary Medical Male Circumcision (VMMC)
Objective	5.1.3.1	Increase social acceptance, demand, access, and uptake of quality VMMC services targeting partners of AGYW and other high risk vulnerable populations in high incidence districts.
Strategic Intervention	5.1.3.1.1	Expand the availability of quality VMMC through decentralisation of services for males between 25-39 years including partners of AGYW in health centres, private sector facilities and other institutions.
Activity	5.1.3.1.1.1	Conduct coordination meeting to support SLA with CHAM facilities to deliver VMMC service in targeted districts
Activity	5.1.3.1.1.2	Conduct DHA quarterly review meetings
Activity	5.1.3.1.1.3	Conduct EQA
Activity	5.1.3.1.1.4	Conduct learning session
Activity	5.1.3.1.1.5	Conduct meetings with Nurses council in Malawi
Activity	5.1.3.1.1.6	Conduct quarterly CQI assessment
Activity	5.1.3.1.1.7	Develop and disseminate women benefits related VMMC messages and other targeted approaches
Activity	5.1.3.1.1.8	Hire local organization (CHAM) to support MOH in implementing VMMC in the selected districts
Activity	5.1.3.1.1.9	Incent vising high-risk clients
Activity	5.1.3.1.1.10	Open new static sites in rural health centres for VMMC at least to reach a minimum coverage of 60%
Activity	5.1.3.1.1.11	Renovate and/or expand health facilities in priority districts to accommodate VMMC scale up
Activity	5.1.3.1.1.12	Train additional health professionals in health centres to deliver VMMC services in targeted districts
Activity	5.1.3.1.1.13	Train influencers as VMMC advocates (MP, Youth organization leaders and student leaders in tertiary inset, Councilors, Ngaliba)
Activity	5.1.3.1.1.14	Train medical Assistants to provide VMMC services
Activity	5.1.3.1.1.15	Train providers from private sectors to provide VMMC services
Strategic Intervention	5.1.3.1.2	Strengthen VMMC commodity supply chain management at all levels through accurate forecasting and monitoring.
Activity	5.1.3.1.2.1	Conduct routine VMMC supply chain trail
Activity	5.1.3.1.2.2	Procure essential commodities and drugs to support the program
Strategic Intervention	5.1.3.1.3	Improve monitoring of program indicators to establish a comprehensive response, flexible M&E system that can support and meet the demands of the program at all levels of the system.
Activity	5.1.3.1.3.1	Conduct quarterly data audit and review meetings
Activity	5.1.3.1.3.2	Conduct research on effective referral mechanism of clients from different service points in a facility to VMMC clinic
Activity	5.1.3.1.3.3	Conduct training of data clerks on VMMC reporting tools

Activity	5.1.3.1.3.4	Printing and distribution of M&E tools
Activity	5.1.3.1.3.5	Printing of VMMC registers, Reporting books and client intake forms
Activity	5.1.3.1.3.6	Train staff (HCW &HMIS) in VMMC data triangulation and interrogation at the district
Strategic Intervention	5.1.3.1.4	Promote the implementation of innovative targeted demand-generation strategies, using a wide range of disciplines, including marketing, behavioural economics, and human-centred design.
Activity	5.1.3.1.4.1	Conduct targeted demand creation orientation for female sex workers as mobilisers of VMMC clients
Activity	5.1.3.1.4.2	Train faith-based women group leaders on VMMC benefits messaging (targeting women in Childbearing age) in targeted districts
Strategic Intervention	5.1.3.1.5	Integrate VMMC demand creation in all health entry points, including PrEP and STI services.
Activity	5.1.3.1.5.1	Develop plan for demand creation
Activity	5.1.3.1.5.2	Develop, pretest, and distribute health promotional materials
Activity	5.1.3.1.5.3	Integrate VMMC messages into other HIV services such as STI clinics, HTS, OVC and DREAMS programming.
Activity	5.1.3.1.5.4	Train health promoters, community gate keepers, women groups mobilizers interactive approaches to VMMC communication
Module	5.1.4	Adolescent Girls and Young Women (AGYW)
Objective	5.1.4.1	To increase access to and coverage of combination HIV prevention, testing, and treatment for AGYW and their male sexual partners
Strategic Intervention	5.1.4.1.2	Strengthen multi-sectoral coordination, collaboration and linkages between ministries and partners in the implementation of AGYW and ABYM interventions at national, district and community levels.
Activity	5.1.4.1.2.1	Conduct annual resource-mapping tied to targets set and achievements for AGYW programming
Activity	5.1.4.1.2.2	Conduct quarterly joint planning, monitoring, and performance review meetings at all levels
Activity	5.1.4.1.2.3	Create awareness of the national AGYW minimum package.
Activity	5.1.4.1.2.4	Enforce standard operating procedures and guidelines at the district and community levels
Activity	5.1.4.1.2.5	Enhance community referral systems using up-to-date referral registers
Activity	5.1.4.1.2.6	Facilitate partner collaboration for complementary implementation of activities to ensure delivery of minimum package
Activity	5.1.4.1.2.7	Hold bi-annual donor group meetings
Strategic Intervention	5.1.4.1.2	Increase availability and access of high-quality YFHS and combination SRHR/HIV services, including post-violence care for AGYW and their male sexual partners by extending service delivery platforms beyond health facilities.
Activity	5.1.4.1.2.1	Conduct weekend clinics for young people
Activity	5.1.4.1.2.2	Empower youth structures such as youth clubs, youth organizations and youth networks in HIV and AIDS and SRHR programming
Activity	5.1.4.1.2.3	Establish youth centres in communities
Activity	5.1.4.1.2.4	Orient community-based structures on YFHS program and their role
Activity	5.1.4.1.2.5	Provide community mobile services
Activity	5.1.4.1.2.6	Provide integrated HIV and AIDS, SRHR and mental health services to AGYW -outreach services
Activity	5.1.4.1.2.7	Train additional services providers for YFHS
Strategic Intervention	5.1.4.1.3	Enhance HIV services demand creation for AGYW and their male sexual partners through national, district and community avenues.
Activity	5.1.4.1.3.1	Develop creative SBCC materials promoting AGYW products and services
Activity	5.1.4.1.3.2	Integrate HIV and AIDS, SRHR mental health SBCC messages
Activity	5.1.4.1.3.3	Train community-based structures in demand creation for AGYW services
Strategic Intervention	5.1.4.1.4	Expand and intensify existing life skills training and CSE 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.
Activity	5.1.4.1.4.1	Conduct school health awareness days
Activity	5.1.4.1.4.2	Conduct trainings and mentorship of CSE facilitators in-school
Activity	5.1.4.1.4.3	Develop community targeted CSE digital platforms
Activity	5.1.4.1.4.4	Develop CSE targeted packages
Activity	5.1.4.1.4.5	Disseminate guidelines and frameworks for CSE programming
Activity	5.1.4.1.4.6	Recruit and enhance capacity of community based CSE facilitators
Objective	5.1.4.2	To empower vulnerable AGYW through social, economic and legal interventions
Strategic Intervention	5.1.4.2.1	Reduce human rights related barriers to HIV prevention for AGYW by creating an enabling environment to support girls, including ending sexual abuse and child marriages.
Activity	5.1.4.2.1.1	Conduct community dialogue sessions with community and religious leaders
Activity	5.1.4.2.1.2	Conduct mobile courts
Activity	5.1.4.2.1.3	Enhance awareness on existing legal provisions related to AGYW issues
Activity	5.1.4.2.1.4	Facilitate formation and support operations of community response committees on AGYW issues
Activity	5.1.4.2.1.5	Implement community norms change interventions
Activity	5.1.4.2.1.6	Implement sexual violence prevention and protection interventions for AGYW and ABYM in and out of school
Activity	5.1.4.2.1.7	Strengthen enforcement of community by-laws
Activity	5.1.4.2.1.8	Strengthen Victim Support Units
Strategic Intervention	5.1.4.2.2	Support social protection interventions for AGYW to address barriers preventing vulnerable girls from attending or staying in school.
Activity	5.1.4.2.2.1	Engage parents and guardians in parenting programmes
Activity	5.1.4.2.2.2	Implement community norms change interventions
Strategic Intervention	5.1.4.2.3	Accelerate the building of social support and increase AGYW resilience through delivery of evidence-based social and economic assets interventions of vulnerable AGYW.
Activity	5.1.4.2.3.1	Build functional literacy of AGYW
Activity	5.1.4.2.3.2	Enroll out-of-school AGYW into vocational programmes and link them to employment and entrepreneurship opportunities
Activity	5.1.4.2.3.3	Strengthen VSL interventions for in-school and out-of-school AGYW
Activity	5.1.4.2.3.4	Train youth clubs, youth organizations and CBOs in resource mobilization and management
Strategic Intervention	5.1.4.2.4	Strengthen the multi-sectoral M&E system for AGYW programmes to generate data and to assess the cost-effectiveness of various AGYW packages.
Activity	5.1.4.2.4.1	Build capacity of data collection and monitoring and evaluation officers
Activity	5.1.4.2.4.2	Conduct joint designing, planning and performance reviews with youth leaders
Activity	5.1.4.2.4.3	Conduct programmes outcomes assessment annually
Activity	5.1.4.2.4.4	Conduct routine monitoring and supportive supervision to youth clubs, organizations, networks, and CBOs
Activity	5.1.4.2.4.5	Conduct routine monitoring and supportive supervision to youth clubs, organizations, networks, and CBOs
Activity	5.1.4.2.4.6	Enforce partner reporting
Activity	5.1.4.2.4.7	Facilitate development of national data collection tools for programmes lacking those
Activity	5.1.4.2.4.8	Harmonize existing data collection tools

Strategic Intervention	5.1.4.2.5	Support implementation of the 'Male Engagement Strategy' to enhance behavioural change and service utilisation, including HTS and ART access, among male partners of AGYW.
Activity	5.1.4.2.5.1	Recruit and empower male peer educators, Ambassadors, and male Champions
Strategic Intervention	5.1.4.2.6	Promote delivery of stigma-free non-judgemental health and social services for young girls engaging in sex work.
Activity	5.1.4.2.6.1	Conduct outreach one-stop-centres for different services targeting AGYW in hard-to-reach areas
Activity	5.1.4.2.6.2	Conduct outreach one-stop-centres for different services targeting AGYW in hard-to-reach areas
Module	5.1.5	Elimination of Mother to Child Transmission (e-MTCT)
Objective	5.1.5.1	To improve primary prevention of HIV in women of childbearing age, specifically for AGYW, pregnant and breastfeeding women
Strategic Intervention	5.1.5.1.1	Increase demand for HIV combination prevention and SRH services among at risk AGYW, FSWs, young mothers, and pregnant and breastfeeding women.
Activity	5.1.5.1.1.1	Intensify SBCC to increase demand and uptake of HIV prevention and SRH services among at risk AGYW, young mothers and pregnant women
Activity	5.1.5.1.1.2	Scale up distribution of self-testing kits to male partners of HIV pregnant and lactating women
Strategic Intervention	5.1.5.1.2	Evaluate and scale-up PrEP for AGYW, pregnant and breastfeeding women.
Activity	5.1.5.1.2.1	Conduct PrEP Service providers training targeting 350 nurses and midwives working in the ANC, Maternity, FP, MCH Clinics
Activity	5.1.5.1.2.2	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
Strategic Intervention	5.1.5.1.3	Intensify provision of integrated and YFHS to AGYW and ABYM.
Activity	5.1.5.1.3.1	Conduct counselling on a wide range of family planning methods to HIV positive women
Activity	5.1.5.1.3.2	Train service providers on integrated YFHS
Strategic Intervention	5.1.5.1.4	Engage male partners of AGYW, pregnant and breastfeeding women with HIV combination prevention services.
Activity	5.1.5.1.4.1	Train service providers on integrated YFHS
Objective	5.1.5.2	To reduce unplanned and unintended pregnancies among women living with HIV.
Strategic Intervention	5.1.5.2.1	Scale up integration of family planning services with other SRH/HIV services.
Activity	5.1.5.2.1.1	Train service providers on service integration
Strategic Intervention	5.1.5.2.2	Support the provision of family planning commodities to women living with HIV.
Activity	5.1.5.2.2.1	Support procurement of diversified family planning and related commodities (e.g. male and female condoms, lubricants, and long acting reversible and permanent contraceptive methods).
Strategic Intervention	5.1.5.2.3	Provide counselling on a wide range of family planning methods to women living with HIV.
Activity	5.1.5.2.3.1	Train service providers on service integration
Objective	5.1.5.3	To prevent vertical transmission of HIV, viral hepatitis, and syphilis.
Strategic Intervention	5.1.5.3.1	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.
Activity	5.1.5.3.1.1	Promote early scheduling of first antenatal visit, and retention for ANC and referrals for HIV care
Activity	5.1.5.3.1.2	Train 175 Nurses and Midwives in Viral Hepatitis.
Activity	5.1.5.3.1.3	Train district-based ToT (including PMTCT, FP, MCH, MNH Coordinators) to orient HSAs on HIV testing for breastfeeding women attending Immunization visits at both facility and community clinics to increase demand uptake of service
Strategic Intervention	5.1.5.3.2	Initiate newly diagnosed pregnant and breastfeeding women living with HIV and monitor them on lifelong ART.
Activity	5.1.5.3.2.1	Conduct integrated bi-annual Quality Improvement Zonal eMTCT/EID review meetings
Strategic Intervention	5.1.5.3.3	Scale up treatment of syphilis and viral hepatitis in pregnant and breastfeeding women and their partners.
Activity	5.1.5.3.3.1	Train service providers to strengthen linkage to care and monitor linkage efficacy between health facilities and community-based services
Activity	5.1.5.3.3.2	Treat syphilis in pregnant and breastfeeding women together with their partners
Objective	5.1.5.4	To provide treatment, care and support to mothers and infants living with HIV, and exposed infants.
Strategic Intervention	5.1.5.4.1	Improve linkage of mothers and infants living with HIV to ART, viral load monitoring and support adherence and retention.
Activity	5.1.5.4.1.1	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.
Activity	5.1.5.4.1.2	Train service providers to strengthen linkage to care and monitor linkage efficacy between health facilities and community-based services
Strategic Intervention	5.1.5.4.2	Strengthen CBOs and community volunteers such as expert clients, supportive groups, mother-to-mother, and PLHIV to support adherence and retention of pregnant and breast-feeding women and infants living with HIV.
Activity	5.1.5.4.2.1	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.
Activity	5.1.5.4.2.2	Orient community-based organizations such as support groups to support adherence and retention of HIV+ pregnant and breastfeeding women and infants
Strategic Intervention	5.1.5.4.3	Improve monitoring and follow-up of HIV exposed infants.
Activity	5.1.5.4.3.1	Improve the EID coverage and documentation
Activity	5.1.5.4.3.2	Optimize lab information management system to facilitate timely management of exposed infants
Activity	5.1.5.4.3.3	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
Strategic Intervention	5.1.5.4.4	Improve retention of mothers and infants living with HIV on treatment and strengthen viral load monitoring on ART.
Activity	5.1.5.4.4.1	Conduct targeted district based Bi-Annual EID Mentorship in all the 28 districts targeting non partner supported facilities
Activity	5.1.5.4.4.2	Cross-departmental and stakeholder meetings to develop and harmonize the policies
Activity	5.1.5.4.4.3	Disseminating policies, strategies, and guidelines
Activity	5.1.5.4.4.4	Print and distribute HIV exposed infant follow up cards
Activity	5.1.5.4.4.5	Print and distribute pathway for screening and tracking HIV exposed infant
Activity	5.1.5.4.4.6	Print Maternity Register
Activity	5.1.5.4.4.7	Printing of maternity registers
Activity	5.1.5.4.4.8	Printing the policies, strategies, and guidelines
Activity	5.1.5.4.4.9	Printing the revised roadmap

Activity	5.1.5.4.4.10	Promote the T=T (Tizirombo tochepa=Thanzi) philosophy among pregnant and lactating mothers, and their partners
Activity	5.1.5.4.4.11	Recruit 200 and deploy CMAs in the community to provide defaulter tracing in districts with high HIV incidence among pregnant and breastfeeding women
Activity	5.1.5.4.4.12	Recruit 200 social workers to provide adherence and psychosocial support services for pregnant and breastfeeding women on ART
Activity	5.1.5.4.4.13	(blank)
Module	5.1.6	Sexually Transmitted Infections and Sexual and Reproductive Health Services (STI)
Objective	5.1.6.1	To increase access and uptake of quality STI and other SRH services, including family planning, cervical cancer, syphilis, and post-sexual violence care.
Strategic Intervention	5.1.6.1.1	Improve demand, access, and utilisation of STI screening and treatment to all populations and Other Vulnerable Populations (OVPs).
Activity	5.1.6.1.1.1	Conduct site (every year) and personnel (every 2 years) certification of all sites and personnel implementing testing services in Malawi
Activity	5.1.6.1.1.2	Disseminate new HIV, syphilis and Hepatitis B testing policies and guidelines
Activity	5.1.6.1.1.3	Printing of referral booklets
Activity	5.1.6.1.1.4	Recruitment, salaries, and pension (advertisement, shortlisting, interviews, selection & report writing) of CMAs as testing providers in non-partner supported facilities without testing providers
Activity	5.1.6.1.1.5	Scale up safe index and social network testing services for all key and priority populations in non-partner supported sites
Strategic Intervention	5.1.6.1.2	Strengthen quality of STI/SRH services including ensuring STI commodity security in both public and private facilities.
Activity	5.1.6.1.2.1	Conduct quarterly supervision targeting private facilities.
Strategic Intervention	5.1.6.1.3	Strengthen engagement and collaboration with the private sector on STIs, hepatitis and HIV management.
Activity	5.1.6.1.3.1	Conduct biannual dialogue meetings with private practitioners to discuss performance and other SRH/STI emerging issues.
Strategic Intervention	5.1.6.1.4	Strengthen integration of STIs, hepatitis and SRH services including family planning, cervical cancer screening and treatment services, and management of post-sexual violence.
Activity	5.1.6.1.4.1	Assessment/Mapping of integrated HTS delivery points (HIVST, Community points, facilities, private facilities)
Activity	5.1.6.1.4.2	Conduct a workshop to revise the STI register and reporting tool in line with the revised guidelines to service providers
Activity	5.1.6.1.4.3	Conduct orientation of data collection clerks and district STI coordinators on the revised M&E tools
Activity	5.1.6.1.4.4	Conduct training for laboratory technicians on antimicrobial resistance monitoring
Activity	5.1.6.1.4.5	Development of Integrated Rapid Testing and Counseling Job Aides
Activity	5.1.6.1.4.6	Finalize the development and print the revised National STI Syndromic Guidelines
Activity	5.1.6.1.4.7	Orientation on integration of services at facility level
Activity	5.1.6.1.4.8	Pilot new HTS registers in selected sites
Activity	5.1.6.1.4.9	Print and disseminate the revised STI registers and reporting forms (booklets)
Activity	5.1.6.1.4.10	Procure and distribute STI drugs
Activity	5.1.6.1.4.11	Procure laboratory reagents for AMR testing for recurrent STIs at district level
Activity	5.1.6.1.4.12	Train health workers in rights and needs of persons to ensure that services accommodate all eligible persons regardless of sexual orientation, gender, disability, or other condition
Activity	5.1.6.1.4.13	Train health workers in the provision of STI services
Activity	5.1.6.1.4.14	Update national HTS registers and monthly forms
Strategic Intervention	5.1.6.1.5	Strengthen monitoring of Anti-Microbial resistance of STI with focus on Neisseria gonorrhoea
Activity	5.1.6.1.5.1	Capacity building for lab personnel in AMR monitoring/testing providers
Strategic Intervention	5.1.6.1.6	Scale up high quality STI services that are linked to combination HIV prevention interventions, including PrEP, for HIV-negative subjects and ART for HIV-positive subjects.
Activity	5.1.6.1.6.1	Develop and implement a mass and social media campaign on STI diagnosis and treatment
Activity	5.1.6.1.6.2	STI and Condom activation sessions
Strategic Intervention	5.1.6.1.7	Scale up cervical cancer screening through cervical self-sampling techniques and HPV testing, using GeneXpert machines, and cervical cancer preventive therapy for those with pre-cancerous lesions.
Activity	5.1.6.1.7.1	Desk review together with reproductive health and other key health services to identify where integration is happening
Activity	5.1.6.1.7.2	Orientation on integration of services at facility level
Module	5.1.7	Wellness and Workplace HIV programmes
Objective	5.1.7.1	To strengthen multi-sectoral governance of HIV workplace programmes.
Strategic Intervention	5.1.8.1.1	Support efforts to accelerate revision and approval of the National HIV and AIDS Workplace Policy.
Activity	5.1.8.1.1.1	Dissemination of HIV and AIDS workplace policy at zonal level
Activity	5.1.8.1.1.2	Dissemination of the National HIV and AIDS workplace policy at national level
Activity	5.1.8.1.1.3	Print copies of the National HIV and AIDS workplace policy
Strategic Intervention	5.1.8.1.2	Develop and implement a robust M&E system for Wellness and Workplace HIV programmes.
Activity	5.1.8.1.2.1	Conduct 4 zonal monitoring and evaluation (M&E) sessions for the public and private sector
Activity	5.1.8.1.2.2	Develop a Workplace M and E system for wellness and workplace HIV programs
Strategic Intervention	5.1.7.1.3	Support efforts to accelerate the revision and approval of the National HIV and AIDS Workplace guidelines that provide a framework for effective utilisation of the ORT budgetary allocation to HIV interventions.
Activity	5.1.7.1.3.1	Conduct a service needs assessment for men in the formal sector
Activity	5.1.7.1.3.2	Conduct engagement meeting on 2% ORT and budget allocation with Ministry of Labour, NAC, ECAM, ILO, MBCHealth, NGO Board, CONGOMA, MUFIS
Activity	5.1.7.1.3.3	Conduct engagement meetings on 2% ORT and budget allocation with Ministry of Labor, NAC, ECAM, ILO, MBCHealth, NGO Board, CONGOMA, MUFIS
Activity	5.1.7.1.3.4	Conduct engagement meetings with 34 Councils on the utilization of the 2% ORT
Activity	5.1.7.1.3.5	Develop and implement branded mass media campaigns to address stigma and promote treatment literacy
Activity	5.1.7.1.3.6	Develop and validate guidelines for utilization of funds allocated to wellness and workplace HIV programs in public and private sector
Activity	5.1.7.1.3.7	Monitor utilization of funds allocated to wellness and workplace HIV programs in the public and private sector
Activity	5.1.7.1.3.8	Peer Education
Activity	5.1.7.1.3.9	Venue mapping
Activity	5.1.7.1.3.10	Workplace Men's Health Talk sessions.
Objective	5.1.7.2	To strengthen the implementation of HIV workplace programmes in the public sector.
Strategic Intervention	5.1.7.2.1	Develop regulations that mainstream HIV prevention and management into labour inspection checklists.

Activity	5.1.7.2.1.1	Conduct development sessions for HIV and AIDS, Gender and Human rights mainstreaming regulations into the labour market for both informal and formal sector
Strategic Intervention	5.1.7.2.2	Capacitate Occupational Safety and Health Officers and Labour Inspectors on HIV interventions enforcement at workplaces.
Activity	5.1.7.2.2.1	Conduct regional capacity building sessions for the occupational health and safety officers to properly run workplace activities
Strategic Intervention	5.1.7.2.3	Implement guidelines for the utilisation of funds allocated to Wellness and Workplace HIV programmes in the public and private sector, and support institutions in the operationalisation of the programmes.
Activity	5.1.7.2.3.1	Review the guidelines for the utilization of the 2% ORT
Strategic Intervention	5.1.7.2.4	Develop and implement strategies on economic and workplace empowerment of young women in the public sector.
Activity	5.1.7.2.4.1	Conduct engagement sessions with prospective funders to lobby support for women small scale businesses in the public sector.
Objective	5.1.7.3	To strengthen the implementation of HIV workplace programmes in the private sector.
Strategic Intervention	5.1.7.3.1	Expand the mandate of the MBCH to cover private companies under the Malawi Confederation of Chambers of Commerce and Industry (MCCCI) and Employers Consultative Association of Malawi (ECAM).
Activity	5.1.7.3.1.1	Conduct sensitization meetings with companies on the mandates of MBC-Health after the functional review.
Strategic Intervention	5.1.7.3.2	Build capacity of the private sector to effectively deliver HIV services including HIV prevention and treatment, both directly and through Service Level Agreements (SLAs).
Activity	5.1.7.3.2.1	Conduct capacity building sessions with health workers from the private health facilities on HIV and AIDS, Malaria and TB.
Activity	5.1.7.3.2.2	Conduct capacity building sessions with private health workers to effectively deliver HIV and AIDS, Malaria, TB, Gender and human rights issues.
Strategic Intervention	5.1.7.3.3	Implement SLAs with the private health facilities.
Activity	5.1.7.3.3.1	Conduct SLAs with private health facilities
Strategic Intervention	5.1.7.3.4	Strengthen HIV prevention and treatment interventions in the workplace including promotion and distribution of condoms, HTS, VMMC, PrEP, PEP and ART, and mandating employers to provide PPE for high-risk workers.
Activity	5.1.7.3.4.1	Conduct engagement meetings with stakeholders on the distribution and utilization of condoms at institutional level.
Strategic Intervention	5.1.7.3.5	Enforce the private sector reporting of HIV-related data in line with the HIV Act.
Activity	5.1.7.3.5.1	Conduct engagement meetings with stakeholders to discuss on the utilization of data.
Strategic Intervention	5.1.7.3.6	Advocate for increased financial contribution of the private sector to the national response towards HIV interventions.
Activity	5.1.7.3.6.1	Conduct lobbying meetings with prospective funders.
Strategic Intervention	5.1.7.3.7	Expand the mandate of the MBCH to cover private companies under the Malawi Chamber of Commerce and Industry and Employers Consultative Association of Malawi.
Activity	5.1.7.3.7.1	Conduct strengthening meetings between MBCH, MCCI and paid members to lobby for health financing.
Strategic Intervention	5.1.7.3.8	Develop and implement strategies on economic and workplace empowerment of young women in the private sector.
Activity	5.1.7.3.8.1	Conduct 4 sessions to orient young women on how to get funds to start small scale businesses.
Module	5.1.8	Blood Safety
Objective	5.1.8.1	To improve the availability, quality and management of blood transfusion services
Strategic Intervention	5.1.8.1.1	Expand sentinel sites for blood collection, screening, and distribution.
Activity	5.1.8.1.1.1	Conduct blood recruitment and donation sessions in schools and communities across the country
Activity	5.1.8.1.1.2	Improve access to supplies of safe blood and blood products from MBTS
Activity	5.1.8.1.1.3	Mass media campaigns to educate, motivate and retain regular blood donors
Activity	5.1.8.1.1.4	Scale up blood collection
Strategic Intervention	5.1.8.1.2	Increase investment in blood bank infrastructure at district level.
Activity	5.1.8.1.2.1	Increase investment for blood bank infrastructure district level and MBTS
Activity	5.1.8.1.2.2	Provide sustainable infrastructure and cold chain
Strategic Intervention	5.1.8.1.3	Establish capacity for conducting NAAT at MBTS to optimise diagnosis of TTIs.
Activity	5.1.8.1.3.1	Align blood transfusion services to international/national standards
Activity	5.1.8.1.3.2	Acquire level 2 accreditation by African Society for Blood Transfusion by 2025
Activity	5.1.8.1.3.3	Acquire level 2 accreditation by African Society for Blood Transfusion by 2026
Activity	5.1.8.1.3.4	Align blood transfusion services to International and National standards
Activity	5.1.8.1.3.5	Development of laboratory dashboard to strengthening information management system to monitor the availability of blood units and blood products, units transfused (traceability) and linked with national Health Management Information System
Activity	5.1.8.1.3.6	Improve capacity for transfusion Medicine
Activity	5.1.8.1.3.7	Improve registration framework for transfusion services
Activity	5.1.8.1.3.8	Promote safety of blood donors
Activity	5.1.8.1.3.9	Review of key Blood safety documents (Clinical Use of Blood Guidelines, Guidelines for Blood Transfusion, National Blood Policy, Communication strategy and Blood Mobilization strategies)
Activity	5.1.8.1.3.10	Strengthen capacity of blood transfusion cadres on blood safety and appropriate clinical use
Activity	5.1.8.1.3.11	To improve quality and safety of blood transfusion
Strategic Intervention	5.1.8.1.4	Devise evidence-based strategies for long-term engagement of regular blood donors.
Activity	5.1.8.1.4.1	Blood Donor Recognition
Activity	5.1.8.1.4.2	Conduct interface meetings with urban and community blood donor patrons
Activity	5.1.8.1.4.3	Print IEC materials to foster a culture of voluntary blood donation
Activity	5.1.8.1.4.4	Reduce waiting time for blood transfusion
Activity	5.1.8.1.4.5	Research and development on blood donor collection, recruitment, and retention
Activity	5.1.8.1.4.6	Scale up Blood donor recognition program - procurement of milestone awards (T- Shirts, Golf-Shirts, Caps and Certificates)
Pillar	5.2	Pillar 2: Differentiated HIV Testing Services
Module	5.2	Differentiated HIV Testing Services
Objective	5.2.1	Increase access, uptake and quality of HIV, syphilis and Hepatitis B testing and counselling services among high-risk key and priority populations
Strategic Intervention	5.2.1.1	Improve HIV, Syphilis and Hepatitis B case finding among high-risk key and priority populations, including other women, men, and children through adoption of evidence-based strategies and innovative approaches.
Activity	5.2.1.1.1	Accredit more private clinics to offer integrated testing services
Activity	5.2.1.1.2	Conduct capacity building activities in HIVST and Active Index testing for providers

Activity	5.2.1.1.3	Distribute self-test kits in the community and pharmacies to key and priority populations and Men aged 25 to 35 years through optimal distribution channels
Activity	5.2.1.1.4	Distribute self-test kits in the community and pharmacies to key and priority populations, through optimal distribution channels
Activity	5.2.1.1.5	Implement the Partner Notification Services system through Active Index Testing
Activity	5.2.1.1.6	Recruitment, salaries and pension (advertisement, shortlisting, interviews, selection & report writing) of CMAs as testing providers in non-partner supported facilities without testing providers
Activity	5.2.1.1.7	Scale up safe index and social network testing services for all key and priority populations in non-partner supported sites
Activity	5.2.1.1.8	Scale up targeted testing in DIC, prisons and KP hotspots
Activity	5.2.1.1.9	Scale up use of HSAs, Expert Clients, and other volunteers to engage with new positive clients and link them to appropriate services
Strategic Intervention	5.2.1.2	Strengthen linkage of HTS clients irrespective of their status to comprehensive prevention, treatment, and re-diagnosis for re-engagement services.
Activity	5.2.1.2.1	Printing of referral booklets
Activity	5.2.1.2.2	Scale up use of CMAs/ Expert Clients, and other volunteers to engage with new positive clients and link them to appropriate services
Strategic Intervention	5.2.1.3	Strengthen quality assurance for HIV, Syphilis and Hepatitis B diagnosis.
Activity	5.2.1.3.1	Build capacity of laboratory facilities at all levels (Train newly employed laboratory personnel in implementation of External Quality Assurance for HIV, Hepatitis B and Syphilis rapid testing)
Activity	5.2.1.3.2	Conduct site (every year) and personnel (every 2 years) certification of all sites and personnel implementing testing services in Malawi
Activity	5.2.1.3.3	Conduct supportive supervision and mentorship
Activity	5.2.1.3.4	Disseminate new HIV, syphilis and Hepatitis B testing policies and guidelines
Activity	5.2.1.3.5	Distribution of Proficiency test specimens for HIV, Hepatitis B and Syphilis to all testing facilities
Activity	5.2.1.3.6	Distribution of Quality Control specimen for HIV, Hepatitis B and Syphilis to testing facilities
Activity	5.2.1.3.7	Implement 3 test algorithm to rule out misdiagnosis - Train providers on new testing algorithms
Activity	5.2.1.3.8	Implement 3 test algorithm to rule out misdiagnosis. Train providers on new testing algorithms
Activity	5.2.1.3.9	Implement corrective active to testing sites that underperform in Proficiency test for HIV, Hepatitis B and Syphilis
Activity	5.2.1.3.10	Preparation of Proficiency test Specimen f+B18:l18or HIV, Hepatitis B and Syphilis
Activity	5.2.1.3.11	Preparation of Quality Control (QC) specimens for HIV, Hepatitis B and Syphilis
Activity	5.2.1.3.12	Procure highly sensitive, specific, and efficient WHO pre-qualified HIV RDTs
Activity	5.2.1.3.13	Procure WHO pre-qualified RDTs for; Hepatitis B Procure WHO pre-qualified RDTs for, HIV. (Quantification, procurement, shipping, storage (Money is available for 2021 to 2024)
Activity	5.2.1.3.14	The cost is for HIV Determine, Unigold, Bio line and Or Quick
Activity	5.2.1.3.15	Procure WHO pre-qualified RDTs for; Syphilis
Activity	5.2.1.3.16	Procurement of cry tubes for HIV, HIVST, Hepatitis B and syphilis Quality Control and Proficiency Test specimen preparation
Objective	5.2.2	Strengthen health systems for HIV, syphilis and Hepatitis B testing and counselling services at all levels.
Strategic Intervention	5.2.2.1	Integrate triple testing in other key health services such as SRH, IMCI, EPI, YFHS and TB.
Activity	5.2.2.1.1	Assessment/Mapping of integrated HTS delivery points (HIVST, Community points, facilities, private facilities)
Activity	5.2.2.1.2	Desk review together with reproductive health and other key health services to identify where integration is happening
Activity	5.2.2.1.3	Orientation on integration of services at facility level
Strategic Intervention	5.2.2.2	Scale up individual level triple testing data capture and management at all levels.
Activity	5.2.2.2.1	Development of Integrated Rapid Testing and Counselling Job Aides
Activity	5.2.2.2.2	Pilot new HTS registers in selected sites
Activity	5.2.2.2.3	Update national HTS registers and monthly forms
Strategic Intervention	5.2.2.3	Strengthen the use of evidence-based triple testing approaches and best practices through operational research and M&E.
Activity	5.2.2.3.1	Activities costed under RSSH-HMIS
Strategic Intervention	5.2.2.4	Support MoH's efforts under the HSSP III to hire CMAs who will deliver HTS at community level.
Activity	5.2.2.4.1	Activities costed under RSSH-HRH
Pillar	5.3	Pillar 3: Treatment, Care and Support for HIV/AIDS and Related Diseases Prevention
Module	5.3	Treatment, Care and Support for HIV/AIDS and Related Diseases
Objective	5.3.1	Increase coverage of high-quality integrated HIV and other related diseases (NCDs, Viral Hepatitis, and Cancer Services)
Strategic Intervention	5.3.1.1	Improve access to high-quality ART (HIV and viral hepatitis), NCDs and cancer services for adults, adolescents, and vulnerable/under-served populations.
Activity	5.3.1.1.1	Conduct ARV toxicity monitoring tests
Activity	5.3.1.1.2	Conduct integrated trainings to service providers (both new and refresher training)
Activity	5.3.1.1.3	Conduct Site assessments to scale up HIV treatment & care services to more health facilities, based on geospatial data available
Activity	5.3.1.1.4	Conduct supervision and support mentorship in all health facilities
Activity	5.3.1.1.5	Conduct training in Quality Improvement initiatives in health facilities (HIV QIST and WITS)
Activity	5.3.1.1.6	Expand reflex genotyping (resistance test) for all unsuppressed follow up VL samples
Activity	5.3.1.1.7	Improve VL result utilization
Activity	5.3.1.1.8	Increase annual VL testing coverage
Activity	5.3.1.1.9	Increase proportion of plasma based VL monitoring
Activity	5.3.1.1.10	Intensify Monitoring of Drug Resistance
Activity	5.3.1.1.11	Introduce baseline VL monitoring for all those initiating ART at a subset of sentinel sites
Activity	5.3.1.1.12	Print M&E materials and procure stationary items
Activity	5.3.1.1.13	Procure ART for HIV and Viral Hepatitis (costed under HIV commodities budget)
Activity	5.3.1.1.14	Renovate/refurbish clinic consultation rooms devoted to HIV services
Strategic Intervention	5.3.1.2	Improve retention and ART adherence among adults, KPs, and adolescents through enhanced counselling, teen clubs, and strong community-based support systems (peer navigators, treatment supporters and expert clients).
Activity	5.3.1.2.1	Build capacity of Health care workers on T=T campaign through monitoring and supportive supervisions to increase awareness
Activity	5.3.1.2.2	Build capacity of Health care workers on T=T campaign through trainings to increase awareness Conduct Back to Care trainings for community-based cadres to Strengthen community structures and systems to improve HIV service delivery
Activity	5.3.1.2.3	Design and develop IEC messages and materials
Activity	5.3.1.2.4	conduct integrated health outreach clinics HIV/SRH/STI/VH and other related services
Activity	5.3.1.2.5	Design and develop IEC messages and materials

Activity	5.3.1.2.6	Develop and implement branded mass media campaigns to address stigma and promote treatment literacy
Activity	5.3.1.2.7	Disseminate T=T messages and materials to all relevant stakeholders
Activity	5.3.1.2.8	Engage community structures on the campaign to increase awareness
Activity	5.3.1.2.9	Establish mechanisms and systems to identify ART side effects earlier and effectively treat them. Implement comprehensive literacy for test and treat, viral load testing, drug toxicity and opportunistic infection symptoms at community level
Activity	5.3.1.2.10	
Activity	5.3.1.2.11	Orient media personnel on T=T campaign
Activity	5.3.1.2.12	Orient PLHIV organizations on T=T
Activity	5.3.1.2.13	Pilot and implement community DSD models (MMD, Integrated Community ART services)
Activity	5.3.1.2.14	Pilot and implement differentiated service delivery models for PLHIV on ART
Activity	5.3.1.2.15	Print IEC materials on T=T
Activity	5.3.1.2.16	Publish T=T policy document
Activity	5.3.1.2.17	Recruit psychosocial counsellors to improve retention and adherence among all patient groups
Activity	5.3.1.2.18	Recruitment of staff at various levels: remuneration and deployment: Assistant Environmental Officer
Activity	5.3.1.2.19	Recruitment of staff at various levels: remuneration and deployment: Clinical technician
Activity	5.3.1.2.20	Recruitment of staff at various levels: remuneration and deployment: Community midwife assistant
Activity	5.3.1.2.21	Recruitment of staff at various levels: remuneration and deployment: Community midwife technician
Activity	5.3.1.2.22	Recruitment of staff at various levels: remuneration and deployment: DCSA (HSA)
Activity	5.3.1.2.23	Recruitment of staff at various levels: remuneration and deployment: Laboratory assistant
Activity	5.3.1.2.24	Recruitment of staff at various levels: remuneration and deployment: Laboratory technician
Activity	5.3.1.2.25	Recruitment of staff at various levels: remuneration and deployment: Medical assistant
Activity	5.3.1.2.26	Recruitment of staff at various levels: remuneration and deployment: Pharmacy assistant
Activity	5.3.1.2.27	Recruitment of staff at various levels: remuneration and deployment: Psychosocial counsellor
Activity	5.3.1.2.28	Recruitment of staff at various levels: remuneration and deployment: Radiography technician
Activity	5.3.1.2.29	To use Influencers and social media to reach out to youth in institutions of higher learning on the T=T campaign
Strategic Intervention	5.3.1.3	Improve treatment monitoring for HIV, Viral Hepatitis and NCDs (viral load, drug resistance and ARV toxicity monitoring).
Activity	5.3.1.3.1	Activities same and costed above
Strategic Intervention	5.3.1.4	Improve viral load turnaround time and timely delivery of viral load results to site level providers and recipients of care, using modern telecommunication technologies.
Activity	5.3.1.4.1	Conduct awareness campaigns at community and national level on VLT and results
Activity	5.3.1.4.2	Conduct VL coordination meetings between DHA, HTSS and key stakeholders Introduce prompt delivery of VL results (Through Integration of LMIS & EMR) from the testing molecular laboratory to healthcare providers & recipients of care using SMS technology (Building on LIMS interoperability)
Activity	5.3.1.4.3	
Activity	5.3.1.4.4	Offer community level sample collection
Activity	5.3.1.4.5	Promote demand for VLT and results through Peer Educators, Faith leaders, Peer educators
Activity	5.3.1.4.6	Promote use of digital transmission of results
Objective	5.3.2	To increase paediatric ART coverage and clinical outcomes.
Strategic Intervention	5.3.2.1	Improve access to high quality ART services for children at all levels of health care.
Activity	5.3.2.1.1	Activities same and costed above
Strategic Intervention	5.3.2.2	Improve retention, adherence, and viral load suppression in children through promotion of child-focused ART clinic model. Establish & promote child friendly ART clinics for children at all levels of health care, to improve retention, adherence and monitoring of viral load suppressions, drug toxicity and resistance in paediatrics
Activity	5.3.2.2.1	
Activity	5.3.2.2.2	Improve timely delivery of viral load results and viral load results utilization for children & adolescents
Activity	5.3.2.2.3	Scale up Teen Clubs and programs to improve treatment retention and adherence for adolescents
Strategic Intervention	5.3.2.3	Improve treatment monitoring (viral load, drug resistance and ARV toxicity monitoring) among CLHIV.
Activity	5.3.2.3.1	Activities same and costed above
Strategic Intervention	5.3.2.4	Improve timely delivery of viral load results and viral load results utilisation for CLHIV.
Activity	5.3.2.4.1	Activities same and costed above
Objective	5.3.3	To reduce AIDS, non-AIDS mortality and co-morbidities.
Strategic Intervention	5.3.3.1	Improve monitoring and management of AHD including cancers.
Activity	5.3.3.1.1	Conduct HIV/TB related death audits
Activity	5.3.3.1.2	Conduct training to health care workers in TB/HIV coinfection.
Activity	5.3.3.1.3	Conduct trainings in Advanced HIV disease management
Activity	5.3.3.1.4	Ensure access to PEP in all hospitals and health centres.
Activity	5.3.3.1.5	Ensure the assessment of patients in emergency rooms, rapid switch to second line and expedite diagnosis for HIV and OIs HRH Management - Procurement of Vehicle and office equipment (Desktops) to support recruitment processes and supervision
Activity	5.3.3.1.6	HRH Management - Procurement of Vehicle and office equipment (Heavy duty photocopier) to support recruitment processes and supervision
Activity	5.3.3.1.7	
Activity	5.3.3.1.8	HRH Management - Procurement of Vehicle and office equipment (Laptops) to support recruitment processes and supervision
Activity	5.3.3.1.9	HRH Management - Procurement of Vehicle and office equipment (Toner) to support recruitment processes and supervision HRH Management - Procurement of Vehicle and office equipment (Utility Vehicle) to support recruitment processes and supervision
Activity	5.3.3.1.10	
Activity	5.3.3.1.11	HRH Management - Review of Retention strategies for Health care workers
Activity	5.3.3.1.12	Procure equipment for advanced HIV in-patient monitoring
Activity	5.3.3.1.13	Procure laboratory reagents for high-quality laboratory testing
Activity	5.3.3.1.14	Procure preventive therapy for all PLHIV (CPT and TPT)
Activity	5.3.3.1.15	Recruitment of staff at various levels: remuneration and deployment: HDAs
Activity	5.3.3.1.16	Recruitment process of health care workers deployed in various districts
Activity	5.3.3.1.17	Scale up screening and diagnosis for advanced HIV disease to all ART sites
Activity	5.3.3.1.18	Screen and effectively treat NCDs in PLHIV, especially hypertension, diabetes and dyslipidemia.
Activity	5.3.3.1.19	Screen and manage patients with HIV-Viral Hepatitis co-infection
Activity	5.3.3.1.20	Support M&E and accountability at the facility level
Activity	5.3.3.1.21	Verification of health care workers deployed in various districts
Strategic Intervention	5.3.3.2	Strengthen community-based support system for PLHIV by developing a resource package to support the operations of community health workers (HSAs, CMAs) and volunteers (expert clients, treatment supporters, adherence counsellors).

Activity	5.3.3.2.1	Development of a resource package for use by community cadres.
Strategic Intervention	5.3.3.3	Strengthen the capacity of secondary and tertiary health facilities to manage PLHIV and other co-morbidities.
Activity	5.3.3.3.1	Procure advanced HIV disease commodities
Strategic Intervention	5.3.3.4	Improve management of opportunistic infections.
Activity	5.3.3.4.1	Conduct trainings in Advanced HIV disease management
Activity	5.3.3.4.2	Provide quality psychosocial support to PLHIV
Strategic Intervention	5.3.3.5	Strengthen coordination of treatment, care and support at national, district and community levels.
Activity	5.3.3.5.1	Conduct treatment, care, and support coordination meetings
Activity	5.3.3.5.2	organize coordination meetings within government and partners
Activity	5.3.3.5.3	Strengthen MBCH
Pillar	5.4	Pillar 4: TB/HIV
Module	5.4	TB/HIV
Objective	5.4.1	To reduce incidence, morbidity and mortality in TB/HIV co-infected patients
Strategic Intervention	5.4.1.1	Support implementation of routine 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.
Activity	5.4.1.1.1	Conduct death audits in all health facilities
Activity	5.4.1.1.2	Develop guidelines/SOPs for conducting TB deaths audits
Strategic Intervention	5.4.1.2	Screen and effectively manage TPT side effects.
Activity	5.4.1.2.1	Conduct training in screening and diagnosis to increase the competence of providers
Strategic Intervention	5.4.1.3	Strengthen TB/HIV collaborative and coordination activities at all levels (community, district and national).
Activity	5.4.1.3.1	Conduct training to health care for patient management
Activity	5.4.1.3.2	print and distribute to all health facilities screening tools (algorithms and job aids) in HTS rooms
Activity	5.4.1.3.3	review and update TB/HIV policies and guidelines
Activity	5.4.1.3.4	Advocacy for TB/HIV integration of services in private clinics with MBCA
Activity	5.4.1.3.5	Capacity Building of Private clinics in Diagnostics for TB/HIV
Activity	5.4.1.3.6	Conduct coordination at the district level
Activity	5.4.1.3.7	Conduct district level coordination meetings
Activity	5.4.1.3.8	Conduct joint field activities at the national level
Activity	5.4.1.3.9	Conduct joint/integrated HIV/TB supportive supervision and mentorship at national level
Activity	5.4.1.3.10	conduct regular review with stakeholders to harmonize the policies and guidelines for TB and HIV.
Activity	5.4.1.3.11	Conduct review meetings at all levels
Activity	5.4.1.3.12	Conduct trainings of Private clinics in screening and Diagnosis for TB/HIV
Activity	5.4.1.3.13	Develop TB/HIV operational framework
Activity	5.4.1.3.14	Increase the competence of providers in diagnostics of advanced HIV AIDS and comorbidities
Activity	5.4.1.3.15	TB/HIV operational framework
Strategic Intervention	5.4.1.4	Improve quality and coverage of intensified case finding and diagnosis for TB among PLHIV and for HIV among persons with TB using sensitive molecular assays like Xpert MTB/RIF Ultra and other WHO recommended methods.
Activity	5.4.1.4.1	Activities costed under Differentiated HTS
Activity	5.4.1.4.2	Attendance of international conference on advanced research for TB/HIV
Activity	5.4.1.4.3	Build the capacity of sentinel sites to improve surveillance of adverse effects
Activity	5.4.1.4.4	cale up TB/HIV screening in key populations: prisoners, minors, maternal, children
Activity	5.4.1.4.5	Conduct awareness on Pharmacovigilance procedures among HCWs at the facility level
Activity	5.4.1.4.6	Conduct training and scale up FASH for improved diagnosis of TB among PLHIV
Activity	5.4.1.4.7	Conduct training in screening and diagnosis to increase the competence of providers
Activity	5.4.1.4.8	Develop social media and digital solutions to disseminate TB/HIV education
Activity	5.4.1.4.9	Incorporate Monitoring and Evaluation tools within existing information systems for TPT to improve quality of recording of clients on TPT
Activity	5.4.1.4.10	Incorporate TB Screening TORs into the community health package
Activity	5.4.1.4.11	Print and distribute health promotion messages on TB screening for PLHIV
Activity	5.4.1.4.12	Print and distribute TB screening tools to all health facilities (paper algorithms and job aids)
Activity	5.4.1.4.13	Printing of screening tool booklets and supporting materials
Activity	5.4.1.4.14	Procure TPT to ensure availability and uninterrupted supply
Activity	5.4.1.4.15	Promote community Involvement in HIV & TB through CSOs including integration of activities to reduce duplication
Activity	5.4.1.4.16	Provide adherence support for people taking TB preventive therapy including using digital health technologies
Activity	5.4.1.4.17	Scale up clinical mentoring for providers to ensure proper treatment
Activity	5.4.1.4.18	Scale up of Xpert RIF testing
Activity	5.4.1.4.19	Scale up TB preventive therapy using updated regimes
Activity	5.4.1.4.20	Scale up TB/HIV screening in key populations: prisoners, minors, maternal, children
Activity	5.4.1.4.21	Scale up TB/HIV screening in key populations: prisoners, minors, maternal, children
Activity	5.4.1.4.22	Scale up Xpert RIF testing (Highly likely to be found in TB NSP too)
Activity	5.4.1.4.23	Scholarship for long term studies (1-year degrees)
Activity	5.4.1.4.24	Strengthening Routine screenings in under 5 clinics, postnatal ward, paediatric wards
Activity	5.4.1.4.25	Training of lay cadres on screening for PLHIV
Activity	5.4.1.4.26	Training of lay cadres on screening for PLHIV
Activity	5.4.1.4.27	Update the policy on TB Preventive Therapy regularly
Strategic Intervention	5.4.1.5	Improve adherence support to PLHIV on TPT.
Activity	5.4.1.5.1	Introduce policy for 3HP for adults and other
Activity	5.4.1.5.2	Capacity building targeting support groups and networks of recipients of care
Activity	5.4.1.5.3	Ensure HCWs conduct routine patient tracing
Activity	5.4.1.5.4	Procure TPT to ensure availability and uninterrupted supply
Activity	5.4.1.5.5	Provide adherence support for people taking preventive therapy including using digital health technologies
Activity	5.4.1.5.6	Provide psychosocial support to PLHIV through support group meetings
Activity	5.4.1.5.7	Research of updated TPT regimes in PLHIV
Activity	5.4.1.5.8	Scale up of implementation of 6-month MMS (Multi months prescriptions) to all ART sites

Activity	5.4.1.5.9	Scale up TB preventive therapy using updated regimes
Activity	5.4.1.5.10	Update mentorship tool: prioritize mentorship needs on new HTS approaches
Activity	5.4.1.5.11	Update the policy on TB Preventive Therapy regularly
Strategic Intervention	5.4.1.6	Strengthen capacity for optimal management of PLHIV diagnosed with TB at all levels of health care.
Activity	5.4.1.6.1	Increase the awareness on Pharmacovigilance procedures among HCWs at the facility level
Activity	5.4.1.6.2	Capacity building targeting support groups and networks of recipients of care
Activity	5.4.1.6.3	Community Involvement in HIV & TB through empowerment of CSOs including integration of activities to reduce duplication
Activity	5.4.1.6.4	Develop social media and digital solutions to disseminate TB/HIV education
Strategic Intervention	5.4.1.7	Scale up the use of focused assessment with sonography for HIV-associated tuberculosis (FASH) to improve access to quality service care delivery for co-infected PLHIV.
Activity	5.4.1.7.1	Procurement of scanning equipment for FASH services in secondary level health facilities
Pillar	5.5	Pillar 5: Key and Vulnerable Populations
Module	5.5	Key and Vulnerable Populations
Objective	5.5.1	To increase access to and coverage of combination HIV prevention, treatment, care, and support among KVPs
Strategic Intervention	5.5.1.01	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 KVPs to access HIV services
Activity	5.5.1.01.1	Advocate for review or suspension of discriminatory laws against sex workers, Trans and Gender diverse Populations blocking uptake of HIV testing, treatment and care among KPs.
Activity	5.5.1.01.2	Conduct periodic advocacy to members of parliament and strategic stakeholders to abolish/repel discriminatory and punitive laws/legislation for both KPs including Prisoners
Activity	5.5.1.01.3	Build capacity of the MHRC to establish a mechanism for coordinating and addressing the violation of rights of key population groups.
Activity	5.5.1.01.4	Develop and Disseminate Prison workplace policy
Activity	5.5.1.01.5	Support regular stakeholder liaison (interface) meetings with law enforcement, judicial and health officials to identify and resolve challenges for program implementation.
Strategic Intervention	5.5.1.02	Expand DSD models for KVPs enabling them to access a continuum of HIV and SRH services from multiple service delivery points, including prisons.
Activity	5.5.1.02.1	Conduct review meetings of DSD models for KPs
Activity	5.5.1.02.2	Establish or Increase the number of drop-in centres for provision of services to KPs that are Gender affirming. Facilitate development, Review, and implementation of standard packages of HIV prevention, care and support services for specific groups of female and male sex workers, MSM, TGs, PWIDS, prisoners and clients of female sex workers.
Activity	5.5.1.02.3	
Strategic Intervention	5.5.1.03	Pursue service-level agreements (SLAs) with private SRH providers to expand delivery points to KPs.
Activity	5.5.1.03.1	Establish Public-private Partnerships (PPP) with existing private health facilities to increase the number of facilities that deliver stigma-free services to KPs and reduce geographic barriers.
Strategic Intervention	5.5.1.04	Promote PrEP uptake and continuity among KVPs, focusing on long-acting injectable PrEP (CAB-LA) for FSW, MSW and other KVPs with continuous and long-term risky behaviours.
Activity	5.5.1.04.1	Scale-up community-led service delivery including self-HIV testing coupled with ART linkage, retention in care, and ART adherence for KP.
Activity	5.5.1.04.2	(blank)
Strategic Intervention	5.5.1.05	Scale up delivery of a standard comprehensive package of HIV prevention, treatment, care, and support services for FSWs, their children and clients, MSM, MSW, TGs, PWID and other KVPs, that includes SRHR; GBV; and community mobilisation.
Activity	5.5.1.05.1	Conduct HTS to Prisoners on entry, During stay and on Exit
Activity	5.5.1.05.2	Develop and implement a social media campaign to address self-stigma and develop self-esteem among KPs
Activity	5.5.1.05.3	Integrate gender-based violence prevention and response efforts into existing Malawi Government programs and guidelines.
Activity	5.5.1.05.4	Meetings to develop service package, SOP and Guidelines
Activity	5.5.1.05.5	Offer index testing at exit
Activity	5.5.1.05.6	Scale up KP-friendly services by integrating KP-friendly service in existing public and private clinics by training HCW on provision of KP-friendly services.
Strategic Intervention	5.5.1.06	Scale up implementation of social network strategy and community-based self-HIV testing for KVPs coupled with access to combination preventive interventions or ART linkage, retention in care, and ART adherence.
Activity	5.5.1.06.1	Promote access to HIV self-testing with increased linkage to care among those testing positive but also increased access to combination prevention among those testing negative.
Activity	5.5.1.06.2	Promote index testing through distribution of self-HIV testing kits to Sex workers, MSM and TGs in drop-in centres and during mobile clinics.
Activity	5.5.1.06.3	Recruit and train peer educators, peer navigators and outreach workers for male and female SW, MSM, Prisoners, PWIDs and TG, establish a standard equipment and supplies package for these service providers and harmonize their incentive packages.
Activity	5.5.1.06.4	Recruit and train peer educators, peer navigators and outreach workers for male and female SW, MSM, Prisoners, PWIDs and TG, establish a standard equipment and supplies package for these service providers and harmonize their incentive packages. – Incentives
Activity	5.5.1.06.5	Recruit and train peer educators, peer navigators and outreach workers for male and female SW, MSM, Prisoners, PWIDs and TG, establish a standard equipment and supplies package for these service providers and harmonize their incentive packages. - Recruitment drive
Activity	5.5.1.06.6	Recruit and train peer educators, peer navigators and outreach workers for male and female SW, MSM, Prisoners, PWIDs and TG, establish a standard equipment and supplies package for these service providers and harmonize their incentive packages. – Stipend
Activity	5.5.1.06.7	Sensitize KP groups about availability of self-testing kits within the hotspots and within the communities through peer distributors and emphasize the need for linkage to treatment and care after the test.
Strategic Intervention	5.5.1.07	Sustain access to combination prevention services by maintaining coverage of safe spaces such as DICs and youth clubs in urban and other high HIV-burden districts.
Activity	5.5.1.07.1	Develop a sustainability plan for KP services in the event of loss of funding for implementing partners or end of program
Activity	5.5.1.07.2	Expand Differentiated models of service delivery (DSD) at a myriad of locations (drop-in centres, mobile outreach, referrals, supported facility care, one-stop Centre for comprehensive SRH and HIV services, and community service delivery for a minimum package).
Activity	5.5.1.07.3	(blank)
Strategic Intervention	5.5.1.08	Enhance U=U campaign and scale up viral load monitoring to achieve viral load suppression among KVPs.
Activity	5.5.1.08.1	Engage a consultant to develop and manage social media campaign
Activity	5.5.1.08.2	(blank)
Strategic Intervention	5.5.1.09	Support development and implementation of harm reduction programs for PWIDs and their partners focussing on high HIV burden urban districts.
Activity	5.5.1.09.1	Develop a comprehensive communication tool kit for PUD on HIV and AIDS Messages

Activity	5.5.1.09.2	Pre-testing the developed comprehensive communication tool kit for PUD on HIV and AIDS Messages exercise in North, central and southern Region
Activity	5.5.1.09.3	(blank)
Strategic Intervention	5.5.1.10	Establish and scale up pre-service and in-service training in KP-friendly service provision.
Activity	5.5.1.10.1	Conduct awareness Meetings for health workers and partners on international prison guidelines (Mandela rules, SADC Minimum standards Medical Package)
Activity	5.5.1.10.2	Include KP (more specifically LGBTI) issues into the training curriculum of medical personnel so that when they qualify, they should just be oriented and be able to provide KP services.
Activity	5.5.1.10.3	Orientation of Academic staff
Activity	5.5.1.10.4	Strengthen police involvement and trainings to reduce stigma and abuse of LGBTI
Activity	5.5.1.10.5	Train 25 HTS counsellors Annually
Activity	5.5.1.10.6	Train Prison Clinical staffs in VMMC
Strategic Intervention	5.5.1.11	Strengthen national and district level governance and coordination of KP programmes and community services.
Activity	5.5.1.11.1	Bi-Annual coordination Supportive supervision of KP-led organizations implementation sites
Activity	5.5.1.11.2	Bi-Annual coordination meetings
Activity	5.5.1.11.3	Bi-Annual coordination Supportive supervision of KP-led organizations implementation sites
Activity	5.5.1.11.4	Promote inclusion and participation of KPs in TWGs at national and at district level to plan activities and programmes together, and implementation of KP related programmes
Activity	5.5.1.11.5	Support and strengthen KP Sub-TWGs at District level.
Activity	5.5.1.11.6	Support District prisons Health coordinators and KP focal persons to ensure that their coordination Capacities are strengthened
Strategic Intervention	5.5.1.12	Enhance the performance of KP-led organisations through mentorship and supervision.
Activity	5.5.1.12.1	Conduct mentorship and Supportive Supervision for Health care workers who have been trained in KP-friendly services to ensure quality service provision
Activity	5.5.1.12.2	Enhance the performance of KP-led organizations through mentorship and supervision
Activity	5.5.1.12.3	Promote KP-led organizations in the provision of HIV and AIDs services in the public and private facilities and sustain outreach clinics in prisons
Objective	5.5.2	To improve the quality of planning for KP interventions through increased generation and use of relevant evidence.
Strategic Intervention	5.5.2.01	Support the design and implementation of representative surveys to estimate or update the population size and coverage of key HIV indicators for FSWs, MSMs, PWIDs, MSWs, prisoners and TGs.
Activity	5.5.2.01.1	Determine size estimates for FSWs, MSM, PWIDs, MSW and TGs and other drug users, including people who inject drugs (PWID). Strengthen coordination and governance of KP programming and increased availability of epidemiological and individual level data needed for evidence based KP programming to ensure effective implementation of KP interventions and support development of KP database for easy access of data
Activity	5.5.2.01.2	Promote research on assessing the effectiveness of various interventions targeting FSWs, MSMs, PWIDs, MSWs, prisoners and TGs to inform the development of evidence-based interventions.
Strategic Intervention	5.5.2.02	Conduct Biological and Behavioural Surveillance Survey on high-risk groups
Activity	5.5.2.02.1	Conduct once off size estimates for FSW, MSM, PWIDs and TGs
Activity	5.5.2.02.2	Quarterly review meetings of the National database
Activity	5.5.2.02.3	Establish a robust but confidential M&E system for KVPs that generates accurate and timely data on KVPs' access to health and social services.
Strategic Intervention	5.5.2.03	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
Activity	5.5.2.03.1	Strengthen documentation, reporting, monitoring of human rights violations against KVPs, including community-led monitoring.
Strategic Intervention	5.5.2.04	Rollout rapid GBV response system that includes prompt reporting of different forms of GBV through appropriate channels.
Activity	5.5.2.04.1	(blank)
Activity	5.5.2.04.2	Enhance the quality of peer-led demand creation products for PWIDs through development and the scaling up of an all-encompassing integrated communication and demand creation tool kit.
Strategic Intervention	5.5.2.05	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
Activity	5.5.2.05.1	Scale up HIV prevention communication, information, and demand creation for KVPs.
Strategic Intervention	5.5.2.06	Conduct dissemination of HIV and AIDS messages via digital platforms- Cost for social media boosting (FB) for 4 months each year.
Activity	5.5.2.06.1	Conduct dissemination of HIV and AIDS messages via digital platforms- Messaging development meeting
Activity	5.5.2.06.2	Conduct dissemination of HIV and AIDS messages via digital platforms- Payment for instore radio slots for 4 months each year
Activity	5.5.2.06.3	Conduct dissemination of HIV and AIDS messages via digital platforms- Quarterly review Meeting with pool of KVP influencers
Activity	5.5.2.06.4	Facilitate development, dissemination, and implementation of standard packages of HIV prevention, care and support services for specific groups of key female and male sex workers, TG, PWIDS, prisoners and clients of female sex workers.
Activity	5.5.2.06.5	Producing demo print materials 3 jingles
Activity	5.5.2.06.6	Producing demo print materials 20 posters
Activity	5.5.2.06.7	Producing demo print materials 3 animations
Activity	5.5.2.06.8	Scale up HIV prevention communication, information, and demand creation for KVPs
Activity	5.5.2.06.9	
Objective	5.5.3	To scale up HIV-sensitive child protection case management in high HIV burden districts.
Strategic Intervention	5.5.3.01	Improve coordination and referral systems for OVCs at national and district levels.
Activity	5.5.3.01.1	Orient Area Child Protection Officers on HIV sensitive child protection
Strategic Intervention	5.5.3.02	Mobilize communities to establish and operate structures for child protection and development
Activity	5.5.3.02.1	Engage private sector, partners, and donors to empower local community efforts on prevention and response to gender-based violence. Orient District TWG and Gender Officers on the National Plan of Action for Vulnerable Children to enable them to mobilize traditional leaders and gatekeepers to abandon harmful practices, adhere to child rights, adopt positive norms
Activity	5.5.3.02.2	Orient Area Child Protection Officers on HIV sensitive child protection
Activity	5.5.3.02.3	
Strategic Intervention	5.5.3.03	Strengthen monitoring and reporting of vulnerable children.
Activity	5.5.3.03.1	(blank)
Strategic Intervention	5.5.3.04	Increase and sustain investments in HIV-sensitive Child Protection Case Management System, including increasing the number of CCPWs on the government payroll, by strengthening resource mobilisation at all levels.

Activity	5.5.3.04.1	Conduct advocacy and lobbying meetings with various government and non-government players to raise funds for child protection activities
Strategic Intervention	5.5.3.05	Strengthen community child protection, by training CCPWs in Community Management of Malnutrition
Activity	5.5.3.05.1	(blank)
Strategic Intervention	5.5.3.06	Strengthen SBCC programs on adherence to child rights at the community level.
Activity	5.5.3.06.1	(blank)
Pillar	5.6	Pillar 6: Reducing Human Rights and Gender-Related Barriers
Module	5.6	Reducing human rights and gender-related barriers
Objective	5.6.1	To reduce stigma and discrimination against PLHIV
Strategic Intervention	5.6.1.2	Establish a robust documentation and reporting system for human rights violations experienced by PLHIV
Activity	5.6.1.2.1	Commission research on child sensitive HIV social protection
Activity	5.6.1.2.2	Conduct a synthesis workshop to review and adapt existing materials for standardized package of care and referral for GBV
Activity	5.6.1.2.3	Conduct workshop to develop regulations for HIV and AIDS, Gender, and Human Rights inspection checklists
Activity	5.6.1.2.4	Develop human rights violation information case management system
Activity	5.6.1.2.5	Validation and rollout of the human rights violation information case management system
Strategic Intervention	5.6.1.1	Create awareness/legal literacy about HIV, and HIV/TB-related stigma and discrimination, and legal services to women, girls, vulnerable populations, and KP.
Activity	5.6.1.1.1	Create awareness/legal literacy about HIV and HIV/TB related stigma and discrimination and legal services to women, girls, vulnerable populations, and key populations
Activity	5.6.1.1.2	Sensitize KPs and community about different forms of GBV and factors that can prevent or perpetuate violence/GBV
Strategic Intervention	5.6.1.3	Improve access to legal services for PLHIV on issues relating to discrimination, violence protection and other human rights.
Activity	5.6.1.3.1	Enhance knowledge and awareness of law enforcers and judicial officials on GBV protection policies, procedures and accountability.
Activity	5.6.1.3.2	Improve access to legal services for PLHIV for issues relating to discrimination, violence protection and other human rights
Strategic Intervention	5.6.1.4	Strengthen the legal environment for PLHIV, including redress mechanisms in cases of human rights violations in the provision of health care
Activity	5.6.1.4.1	Strengthen the legal environment for PLHIV, including redress mechanisms in cases of human rights violations in the provision of health care
Objective	5.6.2	To reduce harmful gender norms, stereotypes, and gender-based violence
Strategic Intervention	5.6.2.1	Support HIV and AIDS related programs to address harmful gender norms and stereotypes
Activity	5.6.2.1.1	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	5.6.2.1.2	Support mobile courts in HIV high-burden districts
Activity	5.6.2.1.3	Train and empower community volunteers to act as first responders, providing initial support and facilitating referrals for GBV survivors
Strategic Intervention	5.6.2.2	Support programs to raise awareness and knowledge by the public, social service providers, law enforcers and judicial officers on human rights and gender equality
Activity	5.6.2.2.1	Conduct dissemination meetings of Male Engagement Strategy targeting gate keepers in all districts
Activity	5.6.2.2.2	Produce, translate in local languages, and disseminate including through social media various IEC materials on HIV prevention and treatment, GBV reduction.
Strategic Intervention	5.6.2.3	Strengthen capacity of community-based structures and KP-led organizations to lead community-based HIV service delivery and community-led monitoring.
Activity	5.6.2.3.1	(blank)
Strategic Intervention	5.6.2.4	Strengthen the capacity and support the operations of gender officers in Local Authorities to champion gender mainstreaming at institutional and community levels.
Activity	5.6.2.4.1	Support the roll-out of the GBVMIS
Activity	5.6.2.4.2	Conduct training on GBV coordination in emergencies
Activity	5.6.2.4.3	Support coordination meetings on GTWG and GBV task force
Strategic Intervention	5.6.2.5	Establish a robust documentation and reporting system for human rights violations experienced by males, females and KVP.
Activity	5.6.2.5.1	(blank)
Strategic Intervention	5.6.2.6	Strengthen programs to prevent and respond to GBV and conflict-related sexual violence by adopting a multisectoral and survivor-centred approach.
Activity	5.6.2.6.1	Conduct training workshops for healthcare providers, law enforcement, and community workers on identifying and responding to gender-based violence and conflict-related sexual violence
Activity	5.6.2.6.2	Conduct engagement meetings with district service providers on GBV prevention and response in emergencies.
Activity	5.6.2.6.3	Orient disaster responders on Prevention of Sexual Exploitation, Abuse and Harassment (PSEAH) and survivor centered approach
Strategic Intervention	5.6.2.7	Accelerate the dissemination of the HIV and AIDS Act, Gender Equality Act, Prevention of Domestic Violence Act, and other laws that safeguard and promote human and gender-related-rights, targeting duty bearers and community leaders, and using communication materials accessible to people with disabilities.
Activity	5.6.2.7.1	Conduct dissemination of HIV and gender-related laws targeting duty bearers, faith and traditional leaders
Strategic Intervention	5.6.2.8	Develop and roll-out a standardized package of care and referral for GBV survivors
Activity	5.6.2.8.1	Develop and distribute pamphlets, brochures, and posters outlining the standardized package of care and referral services for GBV survivors.
Activity	5.6.2.8.2	Orientation of service providers on the ESP for survivors of GBV
Activity	5.6.2.8.3	Support printing and dissemination of ESP Handbook
Pillar	5.7	Pillar 7: Social Behavior Change Communication
Module	5.7	7 Social Behavior Change Communication
Objective	5.7.1	To provide advocacy and strategic information to address underlying drivers of HIV infection.
Strategic Intervention	5.7.1.1	Scale up community-level dissemination of relevant clauses of the 2018 HIV Act that highlight the key social and structural drivers of HIV infection.
Activity	5.7.1.1.1	Conduct advocacy meetings to review policies and laws related to transgender
Activity	5.7.1.1.2	Conduct advocacy meetings with judiciary and MHRC to address discrepancies in the legal and policy environment on KP in Malawi;

Activity	5.7.1.1.3	Conduct sensitization workshops with law enforcers, judiciary
Strategic Intervention	5.7.1.2	Strengthen the capacity of district health promotion officers and district information officers to continuously compile and disseminate district-level information on key social and structural drivers of HIV transmission.
		Develop KP facilitation manual on KP (create understanding of KP, KP rights, KP service access and needs, GBV and legal and policy environment / Develop standardized orientation manual on KP typologies and their needs with regard to access to HIV prevention and SRHR services;
Activity	5.7.1.2.1	Intensify orientation and engagement sessions with HCWs on KP typologies and their respective needs (FSW, MSM, TG, MSW);
Activity	5.7.1.2.2	Orient district HPOs and KP coordinators on KP programing
Activity	5.7.1.2.3	Ensure availability of district, regional and national disability friendly SBCC messages and materials targeting specific sub-populations, cultural backgrounds, and age groups, especially AGYW and ABYM, in line with the Health Communication Strategy (2021-2026).
Strategic Intervention	5.7.1.3	Conduct Pre- testing of Translated materials
Activity	5.7.1.3.1	Conduct Translation of SBCC messages into Braille
Activity	5.7.1.3.2	Strengthen SBCC coordination structures at national and district levels and support their operations to ensure harmonisation of SBCC efforts by stakeholders.
Strategic Intervention	5.7.1.4	Conduct District SBCC TWG Meetings
Activity	5.7.1.4.1	Conduct VMMC demand creation campaign targeting the rural - Develop HIV combination prevention programs in community radios
Activity	5.7.1.4.2	Conduct VMMC demand creation campaign targeting the rural - Train community radio producers on combination prevention
Activity	5.7.1.4.3	
Objective	5.7.2	To increase demand for HIV services amongst the general population
Strategic Intervention	5.7.2.1	Strengthen 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, community mobilisation and dialogue, in line with the Health Communication Strategy.
Activity	5.7.2.1.1	Broadcasting of radio products - Airing of jingle
Activity	5.7.2.1.2	Broadcasting of TV products - Production of one minute video clips
Activity	5.7.2.1.3	Broadcasting of TV products - Production of short TV programmes
Activity	5.7.2.1.4	Broadcasting of TV products - Production of TV adverts
Activity	5.7.2.1.5	Broadcasting of TV products - Production of TV scrollers
Activity	5.7.2.1.6	Broadcasting of TV products - TV airtime scroller
Activity	5.7.2.1.7	Conduct engagement meetings to orient traditional and religious leaders to support demand creation for blood donation in their communities;
Activity	5.7.2.1.8	Conduct HIV prevention and SRHR talks in secondary schools and universities
Activity	5.7.2.1.9	Engage trained leaders to utilize meetings to talk about blood donation
Activity	5.7.2.1.10	Intensify targeted community mobilization campaigns through blood donor activation sessions
Activity	5.7.2.1.11	Intensify peer education session in targeted venues to Create demand for HTS - Train PE on combination HIV prevention
Activity	5.7.2.1.12	Printing of communication materials
Strategic Intervention	5.7.2.2	Expand the use of mobile and online communication technologies in the dissemination of SBCC messages to target populations including men and KPs.
Activity	5.7.2.2.1	Implement a social media campaign on HIV prevention, treatment SRHR and CSE - Campaign Development Workshop
Activity	5.7.2.2.2	Implement a social media campaign on HIV prevention, treatment SRHR and CSE - Implement a social media campaign
Strategic Intervention	5.7.2.3	Design and implement comprehensive qualitative studies on barriers that hinder the uptake of HIV prevention and treatment services to inform development of relevant SBCC interventions (gender, human rights).
Activity	5.7.2.3.1	Document and share emerging issues affecting uptake of SRHR and HIV services amongst AGWY - Conduct annual formative/barrier analysis study
Activity	5.7.2.3.2	Document and share emerging issues affecting uptake of SRHR and HIV services amongst AGWY - Conduct dissemination workshop
Strategic Intervention	5.7.2.4	Implement a comprehensive TB and HIV treatment literacy programme among PLHIV and their caretakers.
Activity	5.7.2.4.1	Develop and implement branded mass media campaigns to address stigma and promote treatment literacy
Objective	5.7.3	To empower individuals, communities, and institutions to adopt positive health, HIV and GBV services-seeking behaviours.
Strategic Intervention	5.7.3.1	Mobilise and build the capacity of existing individuals and structures as champions/role models and ambassadors of HIV prevention and networks to address harmful cultural practices and gender norms that promote HIV transmission.
Activity	5.7.3.3.1	Conduct advocacy meetings with influential leaders on early and child marriages
Activity	5.7.3.3.2	Conduct VMMC demand creation campaign targeting the rural - Air HIV combination prevention programs in community radios
Activity	5.7.3.3.3	Conduct VMMC demand creation campaign targeting the rural - Conduct VMMC activation sessions
Activity	5.7.3.3.4	Hold orientation sessions for mother groups, Ward councilors, Traditional leaders and religious leaders on adolescent SRHR
Activity	5.7.3.3.5	Support District to conduct annual dialogue sessions with Traditional leaders on KP programming
Strategic Intervention	5.7.3.2	Advocate to raise resources, political and social commitment to achieve HIV program objectives at district and local levels.
Activity	5.7.3.2.1	Broadcasting of radio products - Airing on national programs
Activity	5.7.3.2.2	Broadcasting of radio products - Hiring of production company
Activity	5.7.3.2.3	Broadcasting of radio products - Production of radio jingles
Activity	5.7.3.2.4	Broadcasting of TV products – Advert
Activity	5.7.3.2.5	Broadcasting of TV products - Airing on National TVs (30 min programs)
Activity	5.7.3.2.6	Broadcasting of TV products - Collection of audio visuals footage for materials production
Activity	5.7.3.2.7	Community Radios - Airing on Community radios (1-hour programs)
Activity	5.7.3.2.8	Community Radios - Community Radios Airtime (Jingle)
Activity	5.7.3.2.9	Conduct training of drama groups to conduct community mobilization through theatre groups
Activity	5.7.3.2.10	Support districts to map last mile condom distribution points
Strategic Intervention	5.7.3.3	Enhance engagement with religious and traditional leaders in advocacy campaigns to address human rights and gender-related violations within their communities.
Activity	5.7.3.3.1	Conduct KP sensitization meetings among traditional leaders
Strategic Intervention	5.7.3.4	Intensify the use of social media for communication to key and marginalised populations, including the use of interactive virtual/digital platforms.
Activity	5.7.3.4.1	Promote Social media campaign on VMMC benefits - Conduct creative design workshop on HIV prevention with focus on VMMC, Condoms and PrEP
Activity	5.7.3.4.2	Promote Social media campaign on VMMC benefits - Implement a social media campaign on VMMC
Activity	5.7.3.4.3	Men's health campaign - social media development Workshop
Strategic Intervention	5.7.3.5	Operationalise the Health Communication Strategy and Male Engagement Strategy to promote service utilisation and address harmful gender norms by males.
Activity	5.7.3.5.1	Develop and implement a branded mass media campaign to provide correct information about PrEP and its benefits - Conduct a design workshop on PrEP/PEP/Treatment Literacy campaign development sessions

Activity	5.7.3.5.2	Develop and implement a branded mass media campaign to provide correct information about PrEP and its benefits - Review branded PrEP/PEP/Treatment Literacy campaign
Activity	5.7.3.5.3	Develop and implement a branded mass media campaign to provide correct information about PrEP and its benefits -Pretest materials and messages for branded mass media campaign
Activity	5.7.3.5.4	Conduct health talks in workplace (Target 4 sessions per region per month = 12 sessions per month x 12 months)
Activity	5.7.3.5.5	Conduct meetings with private sector to advocate for condom programing in workplaces
Activity	5.7.3.5.6	Conduct targeted community outreach campaigns using mobile videos and activation sessions on combination prevention
Strategic Intervention	5.7.3.6	Intensify development and implementation of high-quality demand creation communication products using evidence-based approaches such as the 'Human-Centred Design' model.
Activity	5.7.3.6.1	Develop leaflets on treatment literacy and available HIV testing modalities for workplaces
Strategic Intervention	5.7.3.7	Intensify use of granular data to identify sub-populations that need to be targeted with SBCC interventions.
Activity	5.7.3.7.1	Conduct continuous barrier analysis on factors underpinning VMMC service uptake
Activity	5.7.3.7.2	Conduct continuous barrier analysis on factors underpinning VMMC service uptake - Conduct Dissemination Session
Strategic Intervention	5.7.3.8	Establish and/or strengthen M&E system for SBCC interventions.
Activity	5.7.3.8.1	Conduct Biannual review meeting to assess implementation of SBCC Indicator data collection and use
Activity	5.7.3.8.2	Conduct supervision to district chapters to monitor implementation of SBCC indicators
Activity	5.7.3.8.3	Conduct working session for SBCC Indicator development
Activity	5.7.3.8.4	Conduct Working Session on Drafting of HIV SBCC Report tool
Activity	5.7.3.8.5	District orientation on SBCC Indicators
Pillar	5.8	Pillar 8: Resilient and Sustainable Systems for Health
Module	5.8.01	Governance and leadership of the response
Objective	5.8.01.1	To advocate for a strong, sustained, and visible role of political, civil, religious, and traditional leaders in the HIV response at the national and sub-national levels consistent with Malawi's global commitments to end the HIV epidemic by 2030.
Strategic Intervention	5.8.01.1.1	Accelerate the domestication of global HIV strategies, programs, and efforts at national level.
Activity	5.8.01.1.1.1	Popularize the Global HIV Prevention Coalition Commitment and other HIV and AIDS Commitments
Strategic Intervention	5.8.01.1.2	Sustain high-level commitment to the HIV and AIDS response, by lobbying the highest political leadership to champion the adoption of the Global HIV Prevention Coalition goals.
Activity	5.8.01.1.2.1	Conduct bi-annual engagement meetings with the parliamentary committee on Health, HIV and Nutrition
Activity	5.8.01.1.2.2	Enjoyment meetings with Ministerial committee on Health
Activity	5.8.01.1.2.3	Facilitate review of the HIV Act
Activity	5.8.01.1.2.4	Lobbying with Minister of finance on more funding for HIV and AIDS
Strategic Intervention	5.8.01.1.3	Build the capacity of political, civil, religious and traditional leaders to lead advocacy efforts on the HIV and AIDS response at the national and sub-national levels.
Activity	5.8.01.1.3.1	Orient/Train political, Civil religious and traditional leaders on HIV and AIDS emerging issues
Strategic Intervention	5.8.01.1.4	Mainstream the delivery of HIV and AIDS messages in high level political, religious, and traditional events.
Activity	5.8.01.1.4.1	Disseminate HIV and AIDS messages at high level Political, Religious and Traditional Events
Activity	5.8.01.1.4.2	Provide HIV and AIDS Services at High Political, Religious and Traditional Events
Objective	5.8.01.2	To strengthen the governance system of institutions and offices responsible for managing the HIV and AIDS response in line with the provisions of the 2018 HIV and AIDS Prevention and Management Act.
Strategic Intervention	5.8.01.2.1	Support the dissemination of the provisions of the HIV Act to all stakeholders at national and sub-national level.
Activity	5.8.01.2.1.1	Print and disseminate the HIV and AIDS Act to stakeholders in the response at national and subnational level
Strategic Intervention	5.8.01.2.2	Support duty bearers within the law enforcement agencies and judiciary to enforce regulations of the HIV and AIDS Prevention and Management Act of 2018.
Activity	5.8.01.2.2.1	Print and disseminate the HIV and AIDS Act to Law enforcement agencies
Strategic Intervention	5.8.01.2.3	Support District Councils to continuously map and develop MoUs with all HIV implementing partners to prevent duplication of efforts and to monitor the impact of HIV investments
Activity	5.8.01.2.3.1	Support in Local Authority in conducting annual HIV stakeholder mapping
Strategic Intervention	5.8.01.2.4	Strengthen the capacity of the offices of the Principal Nutrition HIV and AIDS Officers (PNHAO) to improve the leadership of the multi-sectoral decentralised HIV response at district and city levels.
Activity	5.8.01.2.4.1	Build capacity of NHAOs in multisectoral coordination of the national response
Activity	5.8.01.2.4.2	Conduct annual program performance review
Activity	5.8.01.2.4.3	Conduct engagement meetings with NLGFC, MoLGU&C, DCs and DPDs on Sustainable Funding and Reporting Mechanisms of PNHAOs (every 2 years)
Activity	5.8.01.2.4.4	Lobby for government subvention of the NHAO office
Activity	5.8.01.2.4.5	Train PNHAOs in HIV Programming, Project Management and Resource Mobilization
Module	5.8.02	Financial Management
Objective	5.8.02.1	To strengthen grants management at national and sub-national levels.
Strategic Intervention	5.8.02.1.1	Conduct a baseline assessment of grants management capacity at sub-national level.
Activity	5.8.02.1.1.1	Conduct baseline assessment of grants management capacity
Activity	5.8.02.1.1.2	Coordinate capacity building in grants and financial management
Activity	5.8.02.1.1.3	Coordinate capacity building in resource mobilization
Activity	5.8.02.1.1.4	Procurement of CHS related supplies for CH volunteers to support CHS delivery
Strategic Intervention	5.8.02.1.2	Strengthen capacity of Local Authorities and implementing partners in grants management.
Activity	5.8.02.1.2.1	Conduct capacity building of local NGOs in resource mobilization
Activity	5.8.02.1.2.2	Conduct grants management trainings
Activity	5.8.02.1.2.3	Orient HCMCs on grant management
Activity	5.8.02.1.2.4	Train CHW on Integrated Defaulter tracing, Disease surveillance and response
Activity	5.8.02.1.2.5	Train CHW on Role clarity, guidelines & referral pathways
Activity	5.8.02.1.2.6	Train community structures (VHCs, VDCs) to support CHWs in service delivery
Strategic Intervention	5.8.02.1.3	Conduct regular financial risk assessment and mitigation measures for all institutions.
Activity	5.8.02.1.3.1	Conduct financial pre-audit and compliance checks within government institutions and NAC
Activity	5.8.02.1.3.2	Engage independent external auditors to assess financial risk in government institutions and NAC
Objective	5.8.02.2	To maximize the efficiency and effectiveness of existing financial commitments and investments in the HIV response.

Strategic Intervention	5.8.02.2.1	Improve periodic implementation of the National Health Accounts (NHA), National AIDS Spending Assessment (NASA) and other resource-tracking exercises.
Activity	5.8.02.2.1.1	Conduct the HIV Out of Pocket Expenditure (OOPE) Survey
Activity	5.8.02.2.1.2	Coordinate NASA-NHA-RM data collection
Activity	5.8.02.2.1.3	Support NASA data analysis and report generation
Strategic Intervention	5.8.02.2.2	Improve efficiency of resource allocation and utilisation through the Health Financing Framework.
Activity	5.8.02.2.2.1	Conduct biennial efficiency analysis across programmes to inform reallocation of resources, focusing on high-expenditure areas, such as HIV/AIDS
Strategic Intervention	5.8.02.2.3	Collaborate with the Ministry of Finance to improve absorption of donor funds in the health sector.
Activity	5.8.02.2.3.1	Conduct internal meetings with Ministry of Finance to improve aid absorption
Strategic Intervention	5.8.02.2.4	Develop and operationalize a framework for budget and expenditure information sharing between non-governmental organizations and all Local Authorities.
Activity	5.8.02.2.4.1	Coordinate meeting to develop framework for budget and expenditure sharing between Local authorities and NGOs
Activity	5.8.02.2.4.2	Coordination meeting to develop framework for budget and expenditure sharing between Local authorities and NGOs
Activity	5.8.02.2.4.3	Engage the National Local Government Finance Committee (NLGFC) to strengthen district council's financial management capacity.
Objective	5.8.02.3	To strengthen mobilization of governmental and non-governmental domestic resources
Strategic Intervention	5.8.02.3.1	Support the operationalization of domestic resource mobilization initiatives proposed in the National Health Financing Strategy 2023-2030.
Activity	5.8.02.2.1.1	Conduct high-level national financing dialogues that emphasize that investment in health systems unlocks efficiencies for service delivery in all disease areas
Activity	5.8.02.2.1.2	Develop grant making and governance capabilities in community structures
Activity	5.8.02.2.1.3	Enhance PPP in HIV service delivery
Activity	5.8.02.2.1.4	Strengthen co-financing models between the government and donors to improve sustainability of resources
Activity	5.8.02.2.1.5	Support Task Force meetings for Local ARV Manufacturing
Activity	5.8.02.2.1.6	Support the resource mobilization and communication function of the advocacy strategy for health financing
Strategic Intervention	5.8.02.3.2	Initiate dialogue with Parliament and the private sector to increase domestic investment for the HIV response.
Activity	5.8.02.2.2.1	Conduct high level resource mobilization engagement sessions
Strategic Intervention	5.8.02.3.4	Strengthen the capacity of NAC, Local Authorities, private sector and implementing partners in resource mobilization.
Activity	5.8.02.3.4.1	Conduct capacity building in resource mobilization at sub-national level
Module	5.8.03	Coordination of the Response
Objective	5.8.03.1	To strengthen the coordination and implementation of the response to the HIV epidemic at national and sub national levels in line with the 3 Ones Principle
Strategic Intervention	5.8.03.1.1	Strengthen the capacity of institutions that coordinate the implementation of HIV and health-related programs in the public and private sectors, NGOs and CSOs.
Activity	5.8.03.1.1.1	Conduct follow ups on implementation of functional review results for the sectors-Sectoral meetings
Activity	5.8.03.1.1.2	Conduct functional review of MIAA- Consultancy
Activity	5.8.03.1.1.3	Conduct functional review of MIAA-Validation meeting
Strategic Intervention	5.8.03.1.2	Build the capacity of Local Authorities to strengthen multi-sectoral coordination of the HIV response.
Activity	5.8.03.1.2.1	Support all coordinating bodies to be able to conduct coordination meetings- Biannual meetings
Activity	5.8.03.1.2.2	Support coordination meetings for districts
Strategic Intervention	5.8.03.1.3	Accelerate the dissemination and utilization of the NSP at sub-national level.
Activity	5.8.03.1.3.1	Support dissemination of provisions of the NSP and HIV and AIDS act to all stakeholders at national and district level-Councils
Activity	5.8.03.1.3.2	Support dissemination of provisions of the NSP and HIV and AIDS act to all stakeholders at national and district level-zonal meetings
Strategic Intervention	5.8.03.1.4	Support Local Authorities to develop and implement Memorandum of Understanding (MoUs) with all non-governmental organizations for harmonized and coherent implementation and monitoring of HIV and AIDS programs.
Activity	5.8.03.1.4.1	Support MoU coordination meetings for districts
Strategic Intervention	5.8.03.1.5	Strengthen the national and subnational M&E system to promote data-driven HIV programming.
Activity	5.8.03.1.5.1	Develop NSP Brief
Activity	5.8.03.1.5.2	Support M&E meetings for districts
Activity	5.8.03.1.5.3	Supporting functionality and utilization of LAHARS in Local Authorities
Activity	5.8.03.1.5.4	Supporting the M&E Technical Working Group meetings at National and Subnational levels
Module	5.8.04	Health Products Management Systems
Objective	5.8.04.1	To improve the availability, quality, utilization and management of medicines and other health products
Strategic Intervention	5.8.04.1.1	Support efforts to accelerate the implementation of pharmaceutical and medical supply logistical and management systems in the HSSP-III aimed at improving delivery of quality HIV-related services.
Activity	5.8.04.1.1.1	Procurement of Oxygen Cylinders and accessories (regulators, flow meter and humidifier bottles).
Activity	5.8.04.1.1.2	Procurement of 300 Oxygen concentrators
Activity	5.8.04.1.1.3	Procurement of Heavy duty mobile digital X-ray machines for theatre radiography
Activity	5.8.04.1.1.4	Procurement of maintenance service contracts for CT scan machines
Activity	5.8.04.1.1.5	Procurement of maintenance service contracts for digital X-ray machines
Activity	5.8.04.1.1.6	Procurement of Medical equipment - pulse oximeter, patient monitors, oxygen analyzer, infusion pumps, etc. (13 equipment in all)
Activity	5.8.04.1.1.7	Procurement of respiratory care medical equipment
Activity	5.8.04.1.1.8	procurement of spare parts for respiratory care and imaging equipment
Strategic Intervention	5.8.04.1.2	Support implementation of the MSCTP by strengthening capacity of the Logistical Management Unit and developing updated policies, guidelines and standards.
Activity	5.8.04.1.2.1	Conduct Meeting to develop FASH protocols, training manuals and validation
Activity	5.8.04.1.2.2	Procurement of safety gadgets for waste disposal activities
Activity	5.8.04.1.2.3	Transport of non-usable medical devices and equipment from the health facilities to the district for annual disposal
Strategic Intervention	5.8.04.1.3	Support investments that create a robust supply chain system that enables the use of real-time data to guide policy, procurement, and other key decisions at the central level.
Activity	5.8.04.1.3.1	Annual verification and consolidation exercise of medical devices and equipment for disposal
Activity	5.8.04.1.3.2	Conduct quarterly planned preventive maintenance of medical equipment

Activity	5.8.04.1.3.3	Workshops for consolidation of technical specifications for high tech durable medical equipment for standardized equipment purposes e.g. PSA, incinerators etc.
Strategic Intervention	5.8.04.1.4	Support efforts that accelerate harmonization of inventory management electronic systems for improved 'End-to-End' product visibility for all health products including HIV commodities.
Activity	5.8.04.1.4.1	Maintenance service contract of Incinerators
Activity	5.8.04.1.4.2	Pre-installations works for incinerators
Activity	5.8.04.1.4.3	Procurement of 1 Pharmaceutical grade incinerators
Activity	5.8.04.1.4.4	Procurement of 2 Pharmaceutical grade incinerators
Activity	5.8.04.1.4.5	Procurement of old cargo containers for temporary storage of medical supplies and medical devices
Activity	5.8.04.1.4.6	Site assessment for Incinerators
Strategic Intervention	5.8.04.1.5	Accelerate sensitization of stakeholders in relevant provisions of the Pharmacy and Medicines Regulatory Act, including those pertaining to misappropriation and pre- and post-marketing surveillance of drugs and medical supplies.
Activity	5.8.04.1.5.1	(blank)
Strategic Intervention	5.8.04.1.6	Support efforts to strengthen the capacity of the PMRA to fulfil its 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
Activity	5.8.04.1.6.1	(blank)
Strategic Intervention	5.8.04.1.7	Strengthen capacity of relevant health facility staff to perform quantification of health commodities and medical supplies.
Activity	5.8.04.1.7.1	Train radiographers on the developed FASH protocol
Strategic Intervention	5.8.04.1.8	Support efforts to expand and/or rehabilitate facilities for storage of health commodities and medical supplies in health facilities.
Activity	5.8.04.1.8.1	Integrated supply chain systems capacity building for all staff involved in medicines management
Strategic Intervention	5.8.04.1.9	Support Integration of HIV commodity supply chain as part of the National Supply Chain Integration Strategy.
Activity	5.8.04.1.9.1	disseminate SOPs and train district level staff on storage, transport of expired/non-usable durable and non-durable medical equipment and devices
Activity	5.8.04.1.9.2	Develop disposal policy, guidelines for medical devices and equipment's
Module	5.8.05	Health Information System
Objective	5.8.05.1	To facilitate the timely generation of quality data for evidence-based decision making in HIV-related programs.
Strategic Intervention	5.8.05.1.1	Facilitate accurate and efficient data collection by implementing comprehensive EMR, Civil Registration and Vital Statistics (CRVS), and supporting infrastructure.
Activity	5.8.05.1.1.1	Assist MDAs in the adoption, integration and use of the Birth Certificate and unique ID in the provision of their services
Activity	5.8.05.1.1.2	Clear backlog of transactions at the district level
Activity	5.8.05.1.1.3	CMED and programmes to conduct induction training for data clerks in data management.
Activity	5.8.05.1.1.4	CMED to conduct DHIS2 academy trainings for newly deployed HMIS officers and data clerks
Activity	5.8.05.1.1.5	CMED to review the current data management curriculum in view of incorporation of digitization.
Activity	5.8.05.1.1.6	Collection and distribution of forms and certificates
Activity	5.8.05.1.1.7	Conduct Data Quality Assessment (DQA)
Activity	5.8.05.1.1.8	Conduct Health sector wide annual review meetings
Activity	5.8.05.1.1.9	Conduct joint MoHP and NRB national monitoring exercise of CRVS activities (both birth and death registration) to all districts
Activity	5.8.05.1.1.10	Contracting of payroll management agent/solution to support operation processes and systems for data clerks and IT personal
Activity	5.8.05.1.1.11	Deploy comprehensive lightweight EMR - 550 facilities
Activity	5.8.05.1.1.12	Ensure availability of paper-based system, while we transition to electronic systems
Activity	5.8.05.1.1.13	Establish National Help Desk
Activity	5.8.05.1.1.14	Extend renewable energy generation to all health facilities
Activity	5.8.05.1.1.15	Extend the lightweight EMR to cover for HIV-related modules
Activity	5.8.05.1.1.16	Finalize and maintain patient level central data repository
Activity	5.8.05.1.1.17	Hire 5 ICT personnel per DHO
Activity	5.8.05.1.1.18	Implement integrated CHIS (scale up of integrated CHIS)
Activity	5.8.05.1.1.19	Implement key indicator data quality desk reviews on regular basis
Activity	5.8.05.1.1.20	Improve accountability for computing infrastructure
Activity	5.8.05.1.1.21	Improve connectivity to enable management of patients and data transfer across sites
Activity	5.8.05.1.1.22	Improve the data center at Accountant General Department to a Tier 2 Data Center for management of patient level data
Activity	5.8.05.1.1.23	Install & maintain the computing infrastructure necessary for EMRs
Activity	5.8.05.1.1.24	Institutionalize the birth and death registration in the MoHP
Activity	5.8.05.1.1.25	Link the CR electronic system and DHIS in health for determining proportion of births notified to the civil registration (CR) agency versus actual
Activity	5.8.05.1.1.26	Logistics for recruited data clerks
Activity	5.8.05.1.1.27	Maintenance and support of infrastructure
Activity	5.8.05.1.1.28	Maintenance for comprehensive lightweight EMR
Activity	5.8.05.1.1.29	Make HIS sub-systems interoperable
Activity	5.8.05.1.1.30	Monitor and provide supportive supervision of CRVS activities by joint district team to all health facilities in the district
Activity	5.8.05.1.1.31	Prepare and disseminate regular key indicator data bulletins
Activity	5.8.05.1.1.32	Printing of data collection and reporting tools for all disease programs
Activity	5.8.05.1.1.33	Procure two utility vehicles for the digital health Division
Activity	5.8.05.1.1.34	Procurement of the HWIS-EHR system end user terminals (networking, desktop computers, Tablets, Barcode Printers, regular printers, barcode scanners, nursing movant carts and consumables) for 10 health facilities
Activity	5.8.05.1.1.35	Recruit consultant/partner/TAs to digitalize In Patient Department (IPD) Services to be integrated in the HWIS-EHR system for all programmes care and treatment needs
Activity	5.8.05.1.1.36	Recruit Consultants/partner to conduct consultations and draft Co-Development Guidelines and Standards
Activity	5.8.05.1.1.37	Roll out EPRAs to other high-volume facilities
Activity	5.8.05.1.1.38	Roll out health facility based, and community based (all districts) death registration
Activity	5.8.05.1.1.39	Salaries, pension and benefits i.e. leave grants
Activity	5.8.05.1.1.40	Scale up the CHIS to Health Surveillance Assistants (HSA) & HIV Diagnostics Assistants (HDAs)
Activity	5.8.05.1.1.41	Semiannual Supportive supervision and mentorship over the grant period
Activity	5.8.05.1.1.42	Sustain Electronic Medical Records where existent in high burden sites
Activity	5.8.05.1.1.43	Sustain the Reverse Billing for all Digital Health Solutions accessed at health facility level
Activity	5.8.05.1.1.44	Training of Enumerators
Strategic Intervention	5.8.05.1.2	Improve quality of data for decision-making at all levels.

Activity	5.8.05.1.2.1	Conduct national integrated DQA every two years on selected tracer indicators
Activity	5.8.05.1.2.2	Conduct quality audits on selected data sources
Activity	5.8.05.1.2.3	Conduct quality audits on selected non-biomedical data sources (LAHARS and Key population database)
Activity	5.8.05.1.2.4	Conduct quarterly maintenance of TB EMRs
Activity	5.8.05.1.2.5	Conduct workshops to formulate, configure, pretest, and validate data reporting tool, and indicators
Activity	5.8.05.1.2.6	Develop and disseminate data use job aids
Activity	5.8.05.1.2.7	Develop and implement facility DHIS2 based data visualization dashboards at all levels
Activity	5.8.05.1.2.8	Enforcement of HIS policy SOPs on introduction & revision of data collection and reporting tools (including EMR) Enhance data dictionary and other user focused documentation of data sources and business meaning of data as presented in the central data repository.
Activity	5.8.05.1.2.9	Facilitate key indicator district cross-cutting data reviews
Activity	5.8.05.1.2.10	Facilitate key indicator Zonal level cross-cutting data reviews
Activity	5.8.05.1.2.11	Facilitate zonal LAHARS review meetings
Activity	5.8.05.1.2.12	Facilitate zonal LAHARS review meetings
Activity	5.8.05.1.2.13	Facility integrated data reviews meetings
Activity	5.8.05.1.2.14	Improve health facility reporting forms to remove duplication of entries by health staff (finalize program level indicators) Provide training and capacity building programs to strengthen the skills and knowledge of data entry personnel, data managers, and other users.
Activity	5.8.05.1.2.15	Retention of data clerks
Activity	5.8.05.1.2.16	Review and Conduct Workflow Analysis of health facilities and hospital services including OPD, IPD and referral (3 Primary, 3 Secondary, 2 referral)
Activity	5.8.05.1.2.17	Routine data security guidelines maintained at the facility
Activity	5.8.05.1.2.18	Support districts to conduct DQAs at facility level once a year
Activity	5.8.05.1.2.19	
Strategic Intervention	5.8.05.1.3	Increase evidenced-based decision making at all levels.
Activity	5.8.05.1.3.1	Conduct dissemination of the HIV policies, frameworks, and data
Activity	5.8.05.1.3.2	Develop, implement, and integrate easily customizable dashboards
Activity	5.8.05.1.3.3	Extend access to DHIS2 dashboards to health facilities Extend and implement HMIS curriculum (electronic HIS module) for DHIS2, EMRS, and other electronic solutions (once per year at zonal level)
Activity	5.8.05.1.3.4	Implement Continuous Professional Development through E-Learning
Activity	5.8.05.1.3.5	Initial set up of telehealth solution
Activity	5.8.05.1.3.6	Procurement of IT equipment to facilitate Data quality assurance (Laptops for District and central level staff)
Activity	5.8.05.1.3.7	Set up rotation of clinicians
Activity	5.8.05.1.3.8	Supporting data and performance review meetings
Activity	5.8.05.1.3.9	
Strategic Intervention	5.8.05.1.4	Strengthen HIV surveillance system.
Activity	5.8.05.1.4.1	Capacity building and CBS management of qualified and trained MoHP staff dedicated to CBS
Activity	5.8.05.1.4.2	Conduct Birth defects surveillance
Activity	5.8.05.1.4.3	Conduct KAP Surveys
Activity	5.8.05.1.4.4	Conduct Malawi Population Based HIV Impact Assessment (MPHIA)
Activity	5.8.05.1.4.5	Conduct the Demographic and Health Survey (DHS)
Activity	5.8.05.1.4.6	Conduct the Integrated Behavioral and Biological Surveillance Survey (IBBSS)
Activity	5.8.05.1.4.7	Conduct capacity building and Case Based Surveillance (CBS) of qualified and trained MOH staff dedicated to CBS
Activity	5.8.05.1.4.8	Continue to develop analytic & reporting tools with input from stakeholders that allow monitoring through the clinical cascade
Activity	5.8.05.1.4.9	Establish stakeholders' partnerships and collaboration for CBS
Module	5.8.06	8.06 Human Resources for Health (HRH) and Quality of Care
Objective	5.8.06.1	Increase the availability, effectiveness, and retention of human resources for health to deliver integrated high-quality services for all diseases, including HIV
Strategic Intervention	5.8.06.1.1	Support efforts to strengthen capacity of national and district level HR departments in effective workforce management, such as planning, deployment, recruitment, and performance management.
Activity	5.8.06.1.1.1	HRH Management - Procurement of Vehicle and office equipment (Box files) to support recruitment processes and supervision
Activity	5.8.06.1.1.2	HRH Management - Procurement of Vehicle and office equipment (Desktops) to support recruitment processes and supervision
Activity	5.8.06.1.1.3	HRH Management - Procurement of Vehicle and office equipment (Flash disks) to support recruitment processes and supervision
Activity	5.8.06.1.1.4	HRH Management - Procurement of Vehicle and office equipment (Flat files) to support recruitment processes and supervision
Activity	5.8.06.1.1.5	HRH Management - Procurement of Vehicle and office equipment (Heavy duty photocopier) to support recruitment processes and supervision
Activity	5.8.06.1.1.6	HRH Management - Procurement of Vehicle and office equipment (Laptops) to support recruitment processes and supervision
Activity	5.8.06.1.1.7	HRH Management - Procurement of Vehicle and office equipment (Printing paper) to support recruitment processes and supervision
Activity	5.8.06.1.1.8	HRH Management - Procurement of Vehicle and office equipment (Toner) to support recruitment processes and supervision
Activity	5.8.06.1.1.9	HRH Management - Procurement of Vehicle and office equipment (Utility Vehicle) to support recruitment processes and supervision
Activity	5.8.06.1.1.10	Verification of health care workers deployed in various districts
Strategic Intervention	5.8.06.1.2	Facilitate implementation of human resource development plans in the HSSP-III that support the delivery of quality HIV-related services.
Activity	5.8.06.1.2.1	Conduct capacity building for Physiotherapists in neonatal cardiorespiratory care in acute TB and Covid 19 patients
Activity	5.8.06.1.2.2	Content Development for Digital SOPs for integrated supportive supervision of CHWs: Content Development, platform development/installations & Testing
Activity	5.8.06.1.2.3	Specialized training of biomedical Engineers in laboratory equipment, Theatre equipment, Imaging equipment and Eye equipment
Strategic Intervention	5.8.06.1.3	Strengthen coordination and integration of relevant pre-service, post-basic and in-service training to meet service delivery needs.
Activity	5.8.06.1.3.1	Capacity Building - In-Service Training (FETP) - CMA, AEHO, NMT, LAB TECH, DSCA (HAS) (2 Cohorts, 30 Participants for each cohort)
Activity	5.8.06.1.3.2	Capacity Building - Pre-Service Training (Community Health Nursing Technician) – Scholarships
Activity	5.8.06.1.3.3	Capacity Building - Pre-Service Training (Lab Technicians) – Scholarships
Activity	5.8.06.1.3.4	Capacity Building - Pre-Service Training (Psychosocial Counsellors) – Scholarships
Activity	5.8.06.1.3.5	Conduct competency-based pre-service training: Preservice training for 1000 newly recruited HSAs
Activity	5.8.06.1.3.6	Conduct competency-based pre-service training: Preservice training for 1000 newly recruited HSAs - procure PPEs and practical material package

Activity	5.8.06.1.3.7	Conduct competency-based pre-service training: Upgrading Course for 2500 old HSAs on the new curriculum. Including IMCI
Activity	5.8.06.1.3.8	Conduct competency-based pre-service training: Upgrading Course for 500 old HSAs on the new curriculum: 6 modular release sessions running in 7 sessions
Activity	5.8.06.1.3.9	Conduct integrated supportive supervision of CHWs following standard operating procedures and using digital tools / checklists.
Activity	5.8.06.1.3.10	Conduct Meeting to develop FASH protocols, training manuals and validation
Activity	5.8.06.1.3.11	Conduct Sign Language trainings for health workers on issues related to HIV/AIDS, Sexual Reproductive Health, TB, and Malaria
Activity	5.8.06.1.3.12	Functional review for all Health care workers
Activity	5.8.06.1.3.13	in-service training of Mechanical incinerators by users and biomedical engineers
Activity	5.8.06.1.3.14	Procure various medical equipment for rehabilitation services in the districts (treadmills, stationary bikes, tilt table, parallel bars, physio beds, treatment balls) Procurement of assistive products to improve the quality of life for persons who developed disabilities secondary to TB, HIV/AIDS, and TB complications
Activity	5.8.06.1.3.15	
Activity	5.8.06.1.3.16	Review of deployment policy revamping IHRIS HSSP III Operational plan
Activity	5.8.06.1.3.17	Train radiographers on basic digital X-ray equipment trouble shooting and equipment calibration
Strategic Intervention	5.8.06.1.4	Support the development and implementation of Human resources for Health retention strategies for hard - to reach areas Capacity Building/Build Capacity within the Ministry/Districts on HRH Management - Enhancement of Performance Management for quality health care service delivery.
Activity	5.8.06.1.4.1	
Activity	5.8.06.1.4.2	Develop practice/care standards for midwifery and neonatal care standards
Activity	5.8.06.1.4.3	HRH Management - Review of Retention strategies for Health care workers
Activity	5.8.06.1.4.4	Recruitment of staff at various levels: remuneration and deployment: Assistant Environmental Officer
Activity	5.8.06.1.4.5	Recruitment of staff at various levels: remuneration and deployment: Clinical technician
Activity	5.8.06.1.4.6	Recruitment of staff at various levels: remuneration and deployment: Community midwife assistant
Activity	5.8.06.1.4.7	Recruitment of staff at various levels: remuneration and deployment: Community midwife technician
Activity	5.8.06.1.4.8	Recruitment of staff at various levels: remuneration and deployment: DCSA (HSA)
Activity	5.8.06.1.4.9	Recruitment of staff at various levels: remuneration and deployment: HDAs
Activity	5.8.06.1.4.10	Recruitment of staff at various levels: remuneration and deployment: Laboratory assistant
Activity	5.8.06.1.4.11	Recruitment of staff at various levels: remuneration and deployment: Laboratory technician
Activity	5.8.06.1.4.12	Recruitment of staff at various levels: remuneration and deployment: Medical assistant
Activity	5.8.06.1.4.13	Recruitment of staff at various levels: remuneration and deployment: Pharmacy assistant
Activity	5.8.06.1.4.14	Recruitment of staff at various levels: remuneration and deployment: Psychosocial counselor
Activity	5.8.06.1.4.15	Recruitment of staff at various levels: remuneration and deployment: Radiography technician
Activity	5.8.06.1.4.16	Recruitment process of health care workers deployed in various districts
Strategic Intervention	5.8.06.1.5	Support efforts aimed at providing competitive remuneration, benefits, and working conditions for human resources for Health
Activity	5.8.06.1.5.1	Meeting for tenders of procuring linen
Activity	5.8.06.1.5.2	Procure linen for public health facilities
Activity	5.8.06.1.5.3	Procurement of six Referral Maintenance Unit Utility vehicles.
Strategic Intervention	5.8.06.1.6	Engage health worker regulatory authorities to revise the structure and system for continuous professional development for provision of client-centred integrated health care.
Activity	5.8.06.1.6.1	Revise, print and disseminate code of ethics and conduct for nurses and midwives
Activity	5.8.06.1.6.2	Revise, print and disseminate scope of practice for nurses and midwives
Activity	5.8.06.1.6.3	Revise/develop job descriptions for Nursing & Midwifery cadres in line with new establishments in Salima
Strategic Intervention	5.8.06.1.7	Engage health worker training institutions to revise curricula and incorporate courses on client-centred integrated health care provision.
Activity	5.8.06.1.7.1	Administer licensure exams to ensure safety of the nurses and midwives - development of test items
Activity	5.8.06.1.7.2	Administer licensure exams to ensure safety of the nurses and midwives - development of test items - hiring a consultancy Conduct capacity building and mentorship visits to school health clinics in public and private boarding schools as well as tertiary education institutions
Activity	5.8.06.1.7.3	
Activity	5.8.06.1.7.4	Develop a syllabus and curriculum for direct entry diploma in community health nursing program
Activity	5.8.06.1.7.5	Review, validate, finalize, the Nursing & Midwifery Policy at Chinkho, Mponera including printing
Module	5.8.07	Infrastructure, Transport, and Equipment
Objective	5.8.07.1	Ensure adequate infrastructure for quality HIV service delivery
Strategic Intervention	5.8.07.1.1	Increase availability of basic medical and non-medical equipment for effective detection and management multi-morbid conditions associated with HIV.
Activity	5.8.07.1.1.1	Construction/Renovation of 20 health posts (Including and 40 health post houses) for CHWs
Activity	5.8.07.1.1.2	Procurement of specialized trucks for distribution of oxygen cylinders
Strategic Intervention	5.8.07.1.2	Accelerate current plans to construct 20 urban health centres and 600 health posts to improve access to HIV and health care by marginalized urban and rural populations
Activity	5.8.07.1.2.1	Health facility improvement grants: 30 Health facilities each receiving 1,400,000 MK for facility improvement
Strategic Intervention	5.8.07.1.3	Improve capacity for preventive maintenance of infrastructure and equipment for HIV and other health services.
Activity	5.8.07.1.3.1	(blank)
Strategic Intervention	5.8.07.1.4	Accelerate implementation of infrastructure development interventions in the HSSP-III that support the delivery of quality integrated HIV-related services.
Activity	5.8.07.1.4.1	Assessment of national medical oxygen demand and gaps Piped oxygen distribution systems within health facilities for six district hospitals (Chitipa, Nkhotakota, Dowa, Thyolo, Balaka and Ntchisi).
Activity	5.8.07.1.4.2	
Module	5.8.08	Integrated Service Delivery and Quality Improvement
Objective	5.8.08.1	Improve the continuum and quality of integrated HIV, SRH, NCD, and nutrition services at all levels of the health care.
Strategic Intervention	5.8.08.1.1	Improve clinical infrastructure to enable implementation of Integrated Service Delivery models for HIV, SRHR, NCDs and other related diseases at the facility level.
Activity	5.8.08.1.1.1	(blank)
Strategic Intervention	5.8.08.1.10	Support the coordination and implementation of death audits and use the findings for quality improvement.
Activity	5.8.08.1.10.1	(blank)
Strategic Intervention	5.8.08.1.2	Introduce mobile outreach clinics that use the 'one stop' approach to deliver integrated HIV, SRH and NCDs services.
Activity	5.8.08.1.2.1	(blank)
Strategic Intervention	5.8.08.1.3	Strengthen the capacity of HCWs to deliver integrated services for HIV and related diseases by conducting integrated training sessions and by developing integrated case management tools.

Activity	5.8.08.1.3.1	(blank)
Strategic Intervention	5.8.08.1.4	Develop and scale-up integrated supervision and mentorship programs for HCWs delivering integrated HIV care services at all levels.
Activity	5.8.08.1.4.1	(blank)
Strategic Intervention	5.8.08.1.5	Expand the use of quality improvement frameworks in the delivery of integrated HIV care in all service delivery platforms.
Activity	5.8.08.1.5.1	(blank)
Strategic Intervention	5.8.08.1.6	Strengthen the capacity of existing quality improvement structures at hospital and health centre (quality improvement support team and work improvement team) to support the implementation of quality integrated HIV, SRH and NCD services.
Activity	5.8.08.1.6.1	(blank)
Strategic Intervention	5.8.08.1.7	Develop minimum packages of integrated HIV, SRHR and NCDs services that can be delivered at various service delivery platforms in the private and public sector.
Activity	5.8.08.1.7.1	(blank)
Strategic Intervention	5.8.08.1.8	Strengthen the referral mechanisms between community and health facilities and across various health and social services delivery platforms to ensure clients and PLHIV receive quality continuum of care.
Activity	5.8.08.1.8.1	(blank)
Strategic Intervention	5.8.08.1.9	Implement paper and electronic information systems to support delivery of integrated services for HIV and related diseases at the community and facility level.
Activity	5.8.08.1.9.1	(blank)
Module	5.8.09	Community systems strengthening
Objective	5.8.09.1	To strengthen community systems for HIV epidemic control, child protection and GBV prevention
Strategic Intervention	5.8.09.1.1	Support ongoing efforts by MoH to recruit, train and deploy community health workers including Community Midwife Assistants and Psychosocial Counsellors.
Activity	5.8.09.1.1.1	Activities costed under HRH
Strategic Intervention	5.8.09.1.2	Accelerate implementation of the 'Community Charter' by strengthening capacity of community structures to deliver health services, including HIV and AIDS, promote health services utilization and address harmful cultural, social and gender norms and practices.
Activity	5.8.09.1.2.1	Develop and disseminate Harmonized Community Led Monitoring Guidelines including data management tools and monitoring system
Activity	5.8.09.1.2.2	Orient community structures (VHCs) in score card usage as a community accountability tool, community interface meeting & referral pathways
Activity	5.8.09.1.2.3	Orient community structures (VHCs) in score card usage as a community accountability tool, community interface meeting & referral pathways,
Strategic Intervention	5.8.09.1.3	Scale up implementation of the 'HIV community package' and community-led monitoring.
Activity	5.8.09.1.3.1	Monitor implementation of Community HIV Package
Activity	5.8.09.1.3.2	Strengthen linkage of CBOs and health facilities
Strategic Intervention	5.8.09.1.4	Scale up the implementation of community led monitoring
Activity	5.8.09.1.4.1	Build capacity of CSO and community structures in community led monitoring
Activity	5.8.09.1.4.2	Strengthening reporting systems for CLM data collection
Activity	5.8.09.1.4.3	Strengthening reporting systems for CLM data collection- Validation meeting
Strategic Intervention	5.8.09.1.6	Strengthen the monitoring and evaluation system for community-based HIV program by scaling up the use and integrated Community Health Information System (i-CHIS) and LAHARS.
Activity	5.8.09.1.6.1	Build Capacity of the Community Based AIDS Service Organizations in HIV and AIDS Reporting
Activity	5.8.09.1.6.2	Conduct Data Quality Assurance
Activity	5.8.09.1.6.3	iCHIS - quarterly district led supportive supervision
Activity	5.8.09.1.6.4	iCHIS human resources recruitment- Server administrator and Database administrator iCHIS maintenance, including device management, help desk, supportive supervision, server maintenance - stakeholder collaboration meetings
Activity	5.8.09.1.6.5	iCHIS Module development - Level of effort compensation for programmers (DHD/CHSS/ICT/TAs) - communication costs
Activity	5.8.09.1.6.6	iCHIS Module development - Level of effort compensation for programmers (DHD/CHSS/ICT/TAs) - consultancy fees
Activity	5.8.09.1.6.7	iCHIS Module development - Level of effort compensation for programmers (DHD/CHSS/ICT/TAs) - pretesting, validation and software development meetings
Activity	5.8.09.1.6.8	iCHIS Module development - Level of effort compensation for programmers (DHD/CHSS/ICT/TAs) - system documentation
Activity	5.8.09.1.6.9	Procurement of iCHIS Tablets and Accessories (5578 S/HAS in 11 districts do not have Tablets) - 500 Tablets to reduce this Gap
Strategic Intervention	5.8.09.1.7	Enhance engagement of traditional and community leaders to spearhead HIV advocacy efforts and to support delivery of community-based services.
Activity	5.8.09.1.7.1	Orient Faith leaders, Youth Groups, Vulnerable communities, local leaders on CHS service delivery & support monitoring
Activity	5.8.09.1.7.2	Support participation of traditional and community leaders in delivery of community-based services
Strategic Intervention	5.8.09.1.8	Strengthen capacity of CSOs to commission issue-based research, analyse and compile findings to support implementation of evidence-based advocacy.
Activity	5.8.09.1.8.1	Build capacity of CSOs in research and evidence-based advocacy
Module	5.8.1	Laboratory Systems
Objective	5.8.10.1	To expand the coverage of quality laboratory services for HIV management
Strategic Intervention	5.8.10.1.1	Scale up availability of quality laboratory services for HIV, VL, syphilis, TB and other HIV related disorders at primary, secondary and tertiary health facilities.
Activity	5.8.10.1.1.1	Development of a laboratory dashboard in E Delphine system that shows the availability of blood units and blood products, units transfused in and linked it with the national Health Management Information System.
Activity	5.8.10.1.1.2	Accreditation and maintenance of accreditation of MBTS laboratories to attain international standards - assessment fee
Activity	5.8.10.1.1.3	Accreditation and maintenance of accreditation of MBTS laboratories to attain international standards - travel
Activity	5.8.10.1.1.4	Data collection exercise in readiness for quantification exercise
Activity	5.8.10.1.1.5	Development of reporting forms, tools, and data-quality assessment methods i.e. blood safety registers, cross match registers, etc.
Activity	5.8.10.1.1.6	Procurement of blood bank fridges for MBTS laboratories and distribution centres.
Activity	5.8.10.1.1.7	Procurement of freezer and cold rooms for Odala laboratory
Activity	5.8.10.1.1.8	Review of blood transfusion guidelines and policies (National Blood Policy, Guideline for Blood Transfusion, Guidelines for Clinical use of blood, Communication, and blood retention strategies)
Activity	5.8.10.1.1.9	Service contract and warranty for laboratory ABO and Rh D blood grouping equipment's
Activity	5.8.10.1.1.10	Service contract for laboratory equipment's
Activity	5.8.10.1.1.11	Staff capacity-building through experience-sharing and attending regional and international Blood Safety conferences
Activity	5.8.10.1.1.12	Train radiographers on basic digital X-ray equipment trouble shooting and equipment calibration
Activity	5.8.10.1.1.13	Training of cadres (Doctors, Nurses, Blood Bank Technicians) on blood safety and clinical use

Strategic Intervention	5.8.10.1.2	Enhance the efficiency of sample transportation system from peripheral to district/central facilities and communication of results to end-users.
Activity	5.8.10.1.2.1	Assessment of quality of specimen referral networks for priority diseases and establishment of integrated referral networks
Activity	5.8.10.1.2.2	Procure 2 vehicles to support movement of large volume samples and revise waste management logistics for the northern and southern region
Activity	5.8.10.1.2.3	Procure and support cold chain boxes for cold chain sample transport
Activity	5.8.10.1.2.4	Procure safety equipment for couriers (boots, gloves, safety suits)
Activity	5.8.10.1.2.5	Procure vehicles to support movement of large volume samples and revise waste management logistics for the northern and southern region
Activity	5.8.10.1.2.6	Procurement of 180 Square Wheelie Bins used for collection of solid waste
Activity	5.8.10.1.2.7	Service agreements with courier companies (public or private) for specimen transportation
Activity	5.8.10.1.2.8	Train health workers in proper sample collection, storage, and transportation for genomic surveillance
Activity	5.8.10.1.2.9	Training of courier companies and health facilities on appropriate management of specimens from suspected cases of priority diseases
Strategic Intervention	5.8.10.1.3	Strengthen the quality assurance system for laboratory services through accreditations and regular quality assurance assessments, supervision and mentorship.
Activity	5.8.10.1.3.1	Assessments of current biosafety and biosecurity practices, procedures, and engineering controls at the national level
Activity	5.8.10.1.3.2	Conduct baseline SLIPTA/Slipta assessment to inform needs for training.
Activity	5.8.10.1.3.3	Conduct certification assessments
Activity	5.8.10.1.3.4	Conduct post SLMTA/Slipta training for lab staff in preparation for the enrolment of their labs into accreditations
Activity	5.8.10.1.3.5	Conduct SLMTA/ SLIPTA Training X3 to support Laboratory accreditation
Activity	5.8.10.1.3.6	Development of biosafety/biosecurity SOPs, national framework, guidelines, and other documents, including action plans to replace dangerous pathogen cultures with safer investigation methods
Activity	5.8.10.1.3.7	Enroll and support 6 labs in PT schemes including MBTS and malaria lab
Activity	5.8.10.1.3.8	Oversight, operational management of Essential Diagnostic List (EDL) including, supervision, technical assistance, and communication from national to subnational levels, Perform supportive supervision on QIPs X3
Activity	5.8.10.1.3.9	Oversight, operational management of Essential Diagnostic List (EDL) including, supervision, technical assistance, and communication from national to subnational levels, Perform supportive supervision on QIPs X4
Activity	5.8.10.1.3.10	Oversight, operational management of Essential Diagnostic List (EDL) including, supervision, technical assistance, and communication from national to subnational levels, Perform supportive supervision on QIPs X5
Activity	5.8.10.1.3.11	Oversight, operational management of Essential Diagnostic List (EDL) including, supervision, technical assistance, and communication from national to subnational levels, Perform supportive supervision on QIPs X6
Activity	5.8.10.1.3.12	Procurement of facility-based storage equipment for laboratory commodities (e.g. Refrigerators, Freezers, Containers)
Activity	5.8.10.1.3.13	Procurement of laptops for supply specialist and quality officers
Activity	5.8.10.1.3.14	Procurement of number 10, 500 disposable 5 litre gallons for disposing off the liquid waste in Kilns. Kiln doors can only accommodate 20 litre gallons.
Activity	5.8.10.1.3.15	Quarterly Integrated supervision (HIV VL & Covid-19 testing, supply chain management, waste management)
Strategic Intervention	5.8.10.1.4	Support investments in scaling up laboratory information management systems to primary and secondary care facilities that provide HIV care, including data dissemination and sharing of best practices.
Activity	5.8.10.1.4.1	Connectivity solutions for laboratory equipment and interoperability of middleware with integrated Laboratory Information Systems
Activity	5.8.10.1.4.2	Operating costs to maintain national laboratory functions. Oversight, operational management, supervision, technical assistance, and communication from national to subnational levels
Activity	5.8.10.1.4.3	Procurement charges for software of Equipment management system
Activity	5.8.10.1.4.4	Procurement of 2 vehicles for Supply Chain Reverse Logistics, Rapid Responses to Emergencies, Laboratory Accreditation and Supervisions
Activity	5.8.10.1.4.5	procurement of equipment management system
Strategic Intervention	5.8.10.1.5	Support efforts by the MoH to implement a robust preventive maintenance system of laboratory equipment and disposal of defunct and obsolete equipment.
Activity	5.8.10.1.5.1	Calibration and service of ancillary equipment
Activity	5.8.10.1.5.2	Procure power back up fuel for NHRL
Activity	5.8.10.1.5.3	Procure service contracts for equipment
Activity	5.8.10.1.5.4	Procure service contracts for maintaining freezers
Activity	5.8.10.1.5.5	Service of various laboratory equipment i.e. chemistry, hematology, genome sequencing, biosafety cabinet
Strategic Intervention	5.8.10.1.6	Accelerate the procurement and deployment of the POC machines for HIV related diagnostics and treatment monitoring
Activity	5.8.10.1.6.1	Operating costs to maintain national laboratory functions. Oversight, operational management, supervision, technical assistance, and communication from national to subnational levels
Activity	5.8.10.1.6.2	Procurement of 2 vehicles for Supply Chain Reverse Logistics, Rapid Responses to Emergencies, Laboratory Accreditation and Supervisions
Activity	5.8.10.1.6.3	(blank)
Strategic Intervention	5.8.10.1.7	Support the MoH's Directorate of Health Technical Support Services in enforcing standards for procurement of HIV diagnostic equipment, with involvement of the NHRL.
Activity	5.8.10.1.7.1	Calibration of ancillary equipment like centrifuge, weighing balance, pipettes, thermometers, timers
Activity	5.8.10.1.7.2	Develop an equipment mapping, procurement, and management plan (engage a consultant).
Activity	5.8.10.1.7.3	Develop an equipment mapping, procurement, and management plan as well as Standardization and harmonization of tests and technologies and development of guidance on procurement modalities for diagnostics.
Activity	5.8.10.1.7.4	Procurement of ancillary equipment e.g. Centrifuge and pipettes
Activity	5.8.10.1.7.5	Procurement of ancillary equipment e.g. Centrifuge, timer, pipettes, weighing scales
Activity	5.8.10.1.7.6	Procurement of Power back up equipment (Ups, Inverter, solar, solar batteries)
Strategic Intervention	5.8.10.1.8	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.
Activity	5.8.10.1.8.1	Advanced training of laboratory staff on wet lab sequencing and bioinformatics
Module	5.8.11	8.11 HIV response in emergency settings/Humanitarian Response
Objective	5.8.11.1	To minimize adverse HIV outcomes and negative health and social consequences for people affected by humanitarian emergencies.
Strategic Intervention	5.8.11.1.1	Support the development of policy, frameworks and legislation tailored to specific contexts and that provide an initial minimum package of HIV, GBV, SRHR and mental health services.
Activity	5.8.11.1.1.1	Disseminate revised guidelines for disaster management
Activity	5.8.11.1.1.2	Establish systems for enhancing coordination and outreach to people in humanitarian settings to ensure access to HIV preventive services and HIV treatment continuation for PLHIV.
Activity	5.8.11.1.1.3	Incorporate disaster and disease epidemic issues into the HIV policy documents

Activity	5.8.11.1.1.4	Orient disaster responders on Prevention of Sexual Exploitation, Abuse and Harassment (PSEAH) and survivor centered approach
Activity	5.8.11.1.1.5	Produce disaster risk management plan annually
Activity	5.8.11.1.1.6	Standardize HIV data collection tools in disaster management
Activity	5.8.11.1.1.7	Support Capacitate implementing partners and community structures to deliver HIV, GBV and mental health health services in emergency situations
Activity	5.8.11.1.1.8	Support review of the DRR management plan to incorporate HIV and AIDS mainstreaming in disaster management
Activity	5.8.11.1.1.9	Training of crisis response teams
Strategic Intervention	5.8.11.1.2	Develop a client-centred and community-led emergency preparedness plans at national and subnational levels that include outreach, peer support and linkages to HIV programmes.
Activity	5.8.11.1.2.1	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
Activity	5.8.11.1.2.2	Support review of the DRR management plan to incorporate HIV and AIDS mainstreaming in disaster management
Strategic Intervention	5.8.11.1.3	Mainstream HIV and AIDS in national disease epidemic preparedness and response plans, policies, strategies, and programmes at all levels.
Activity	5.8.11.1.3.1	Produce disaster risk management plan annually
Strategic Intervention	5.8.11.1.4	Strengthen rights -based health emergency responses for PLHIV, those at risk and affected by HIV by establishing robust logistics and supply chain systems.
Activity	5.8.11.1.4.1	EOC -Operators orientation
Activity	5.8.11.1.4.2	National EOC -Content development session; COVID-19 screening protocols embedded in exchange system
Activity	5.8.11.1.4.3	National EOC PBX system infrastructure procurement -(High end server, Power backup UPS, external interface cards, call center monitoring screen, desktops, network switch/router, LAN materials and Labor, IP or GSM Phones, 4G Wi-Fi Routers)
Activity	5.8.11.1.4.4	Support Capacitate implementing partners and community structures to deliver HIV, GBV and mental health services in emergency situations
Strategic Intervention	5.8.11.1.5	Establish systems for enhancing coordination and outreach to people in humanitarian settings to ensure access to HIV prevention services and treatment continuation for PLHIV.
Activity	5.8.11.1.5.1	Conduct a Dissemination Meeting for Co-Development Guidelines and Standards
Activity	5.8.11.1.5.2	Conduct coordination meeting with Immigration, Ministry of Transport - (DSAs, Conference Package, Fuel, Airtime)
Activity	5.8.11.1.5.3	Conduct Hospital-wide enhancement development meetings
Activity	5.8.11.1.5.4	Conduct Hospital-wide implementation meetings
Activity	5.8.11.1.5.5	Conduct Sessions to Review Travel Guidelines- (DSAs, Conference Package, Fuel, Airtime)
Activity	5.8.11.1.5.6	Conduct Training and Deployment - (DSAs for Deployment Team and participants, Conference Package, Fuel, Connectivity/Data)
Activity	5.8.11.1.5.7	Conduct Training and Deployment - Print User Manuals
Activity	5.8.11.1.5.8	Conduct User Acceptance Testing - (DSAs, Conference Package, Fuel, Airtime)
Activity	5.8.11.1.5.9	Hybrid methods of training of health care workers in 20 health facilities - Conduct at least 2 content development workshops
Activity	5.8.11.1.5.10	Integrate and enhance the Traveler Tracking System with Port of Entry and One Health Surveillance Platform (OHSP)
Activity	5.8.11.1.5.11	Procure Hardware - (Desktops, Power Backup System (2 Solar Pannels and Batteries), Networking Equipment, Server, eTicket Printers)
Activity	5.8.11.1.5.12	Standardize HIV data collection tools in disaster management
Activity	5.8.11.1.5.13	Support review of the National Disease Epidemic Preparedness and Response Plans, to incorporate HIV and AIDS mainstreaming in disaster management
Strategic Intervention	5.8.11.1.6	Strengthen actions to prevent and respond to GBV and conflict-related sexual violence, with particular attention to people who are most marginalized and vulnerable to HIV in the context of pandemics and other shocks and crises.
Activity	5.8.11.1.6.1	Conduct peer education Orientation training sessions in holding camps
Activity	5.8.11.1.6.2	Conduct peer education sessions in holding camps outreach services
Activity	5.8.11.1.6.3	Produce disaster risk management plan annually
Activity	5.8.11.1.6.4	Support review of the DRR management plan to incorporate HIV and AIDS mainstreaming in disaster management
Activity	5.8.11.1.6.5	Support review of the National Disease Epidemic Preparedness and Response Plans, to incorporate HIV and AIDS mainstreaming in disaster management

ⁱ Ministry of Gender, 2023, The Social Cash Transfer Programme (Mtukula Pakhomo), Briefing for the New Minister of Gender, Hon Jean Muwonaowauza Sendeza