Malawi Report NCPI

NCPI **Header**

is indicator/topic relevant?: Yes
is data available?: Yes
Data measurement tool / source: NCPI
Other measurement tool / source:
From date: 03/14/2014
To date: 03/28/2014
Additional information related to entered data. e.g. reference to primary data source, methodological concerns::
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source::
Data measurement tool / source: GARPR

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any: Mr. Davie Kalomba, Head of Planning, M&E and Research

Postal address: National AIDS Commission P.O. Box 30622, Lilongwe 3

Telephone: +265888208140

Fax: +2651776249

E-mail: kalombad@aidsmalawi.org.mw

Describe the process used for NCPI data gathering and validation: The NCPI process was undertaken by two Consultants who were engaged by the National AIDS Commission and stakeholders to work on the 2014 Global AIDS Response Progress Report for Malawi. These consultants were supported by the Department of Planning, Monitoring, Evaluation and Research of the National AIDS Commission. Interviews were conducted with staff from Government of Malawi (GoM) ministries and departments, development partners, civil society organisations (CSOs) and the private sector. Organisations working with key populations such as sex workers and men who have sex with men were also consulted. These interviews were guided by the questions as contained in the NCPI. In addition to interviews, a desk review of key documents provided by the National AIDS Commission and stakeholders was also conducted. This report was compiled after wide consultations and it was circulated among all key stakeholders.

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions: The process for resolving disagreements was through comprehensive discussions at the validation meeting.

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like): None

NCPI - PART A [to be administered to government officials]

Organization	Names/Positions	Respondents to Part A
Office of President and Cabinet, Department of Nutrition, HIV and AIDS (OPC, DNHA)	Mrs. Edith Mkawa, Principal Secretary	A1
Office of President and Cabinet, Department of Nutrition, HIV and AIDS (OPC, DNHA)	Ms. Marriam Mangochi, Director HIV and AIDS	A1
Ministry of Health, Department of HIV and AIDS	Dr. Zengani Chirwa	A5
National AIDS Commission	Mr. Davie Kalomba, Head of Planning M&E and Research	A1,A6
National AIDS Commission	Dr. Andrina Mwansambo, Head of Policy Support and Development	A4,A5
National AIDS Commission	Moses Chikowi, M&E Officer	A1,A6
National AIDS Commission	Levi Lwanda, M&E Officer	A1,A6
National AIDS Commission	Christopher Teleka, BCI Officer	A4
Malawi Prison Service	Henry Ndindi	A3
Ministry of Gender, Children and Social Welfare	Peter Msefula, Director for Gender	A3
Ministry of Gender, Children and Social Welfare	Esme Kainja	A5
Ministry of Gender, Children and Social Welfare	Laurent Kansinjiro	A5
Ministry of Education	John Mswayo	A4
Malawi Human Rights Commission (MHRC)	Wycliffe Maso	A3
Malawi Human Rights Commission (MHRC)	Harry Migochi	A3
Malawi Police Service	Mackenzie Chigumula, HIV and AIDS Coordinator	A1,A3
Malawi Human Rights Commission (MHRC)	Lusako Munyenyembe, Principal Human Rights Officer	A3
Office of President and Cabinet, Department of Nutrition, HIV and AIDS (OPC, DNHA)	Alice Chilenga, M&E Officer	A6
Office of President and Cabinet, Department of Nutrition, HIV and AIDS (OPC, DNHA)	Victor Kanje, HIV and AIDS Officer	A2,A3

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Names/Positions	Respondents to Part B
UNAIDS	Amakobe Sande, UCD	B1,B5
UNAIDS	Trouble Chikoko, SI Advisor	B1,B5
UNFPA	Humphreys Shumba, NPO HIV	B1,B3
Malawi Interfaith AIDS Association	Robert Ngaiyaye, Executive Director	B1
National Association of People Living with HIV in Malawi (NAPHAM)	Master Mphande, Executive Director	B3
UNICEF	Mirriam Kalua, Social Policy Officer	B5
Centre for the Development of People (CEDEP)	Gift Trapence, Executive Director	B3
Centre for the Development of People (CEDEP)	Victor Gama, Research Officer	B3
UN Women	Pamela Mkwamba	B3
CDC	Wezi Msungama	B4
CDC	Nellie Wadonda-Kabondo	B4
UNICEF	Kennedy Warren	B4,B5
UNICEF	Emmanuel Saka	B4,B5
Pakachere Institute of Development Communication	Simon Sikwese, Executive Director	B3,B4
Malawi Network of AIDS Service Organisations (MANASO)	Mr. Lawrence Khonyongwa	B1
Malawi Network of People Living with HIV (MANET+)	Safari Mbewe, Executive Director	B1
DFID	Dr. Ruth Mwandira, Health and HIV AIDS Adviser	B1,B2,B4
Malawi Business Coalition Against AIDS (MBCA)	Stuart Chuka	B4
Malawi Business Coalition Against AIDS (MBCA)	Lyness Soko	B4
Malawi Network of People Living with HIV (MANET+)	Salome Chibwana, M&E Officer	B5
Population Services International (PSI) Malawi	Brenda Kamanga, HIV Programme Manager	B1,B2,B4
Youth Net Counselling (YONECO)	MacBain Mkandawire	B3
UNAIDS	Aurelie Andriamialison, CMNA	B4
UNAIDS	Erica Nikolic, HR and Gender	B3
UNDP	Dr. Rosemary Kumwenda, HIV Policy Advisor	B1,B3,B5
CHAI	Alex Shields, HIV Financing	B5

A.I Strategic plan

1. Has the country developed a national multisectoral strategy to respond to HIV?: Yes

IF YES, what is the period covered: 2011-2016

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.: Malawi developed the National HIV and AIDS Framework (NAF) which covered the period 2005-2009 and this was extended in 2009 to cover the period 2010-2012. In 2012 a new National HIV/AIDS Strategic Plan (NSP) was developed covering the period 2012-2016. The NSP and the NAF have the same goal and same priority areas. The focus for the current strategic plan and the previous one is to prevent HIV transmission and improve treatment, care and support for the infected and affected populations. Unlike the NAF, the NSP has interventions for key populations and also new interventions such as circumcision and integrated ART/PMTCT and that it has a comprehensive results framework. Interventions for men having sex with men are also included.

IF YES, complete questions 1.1 through 1.10; IF NO, go to question 2.

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?: Department of HIV/AIDS and Nutrition in Office of the President and Cabinet

1.2. Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Education:

Included in Strategy: Yes

Earmarked Budget: Yes

Health:

Included in Strategy: Yes

Earmarked Budget: Yes

Labour:

Included in Strategy: No

Earmarked Budget: Yes

Military/Police:

Included in Strategy: Yes

Earmarked Budget: Yes

Social Welfare:

Included in Strategy: Yes

Earmarked Budget: Yes

Transportation:

Included in Strategy: No

Earmarked Budget: Yes

Women:

Included in Strategy: Yes

Earmarked Budget: Yes

Young People:

Included in Strategy: Yes

Earmarked Budget: Yes

Other:

Included in Strategy: No

Earmarked Budget: No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?:

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS:

Discordant couples: Yes

Elderly persons: Yes

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: No

Sex workers: Yes

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations: No

SETTINGS:

Prisons: Yes

Schools: Yes

Workplace: Yes

CROSS-CUTTING ISSUES:

Addressing stigma and discrimination: Yes

Gender empowerment and/or gender equality: Yes

HIV and poverty: Yes

Human rights protection: Yes

Involvement of people living with HIV: Yes

IF NO, explain how key populations were identified?:

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country?

People living with HIV: Yes

Men who have sex with men: Yes

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: No

Prison inmates: Yes

Sex workers: Yes

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific key populations/vulnerable subpopulations [write in]::

: No

1.5 Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?: Yes

1.6. Does the multisectoral strategy include an operational plan?: Yes

1.7. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?: Yes

b) Clear targets or milestones?: Yes

c) Detailed costs for each programmatic area?: Yes

d) An indication of funding sources to support programme implementation?: Yes

e) A monitoring and evaluation framework?: Yes

1.8. Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?: Active involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organised.: The development of the multisectoral strategic plan was developed with full participation of civil society organisations. CSOs representing key populations such as PLHIVs, sex workers and MSMs constituted part of the team that was developing the Plan – they attended meetings and contributed ideas in the process of developing the Plan. CSOs are also key partners in the implementation of the NSP and in most cases they do not implement any interventions outside the NSP. CSOs are members of Malawi HIV and AIDS Partnership Forum (MPF), TWGs, planning and review meetings, NAC Board and MGFCC.

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case.:

1.9. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?: Yes

1.10. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?: Yes, all partners

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:

2.1. Has the country integrated HIV in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS:

Common Country Assessment/UN Development Assistance Framework: Yes

National Development Plan: Yes

Poverty Reduction Strategy: Yes

National Social Protection Strategic Plan: Yes

Sector-wide approach: Yes

Other [write in]:

:

2.2. IF YES, are the following specific HIV-related areas included in one or more of the develop-ment plans?

HIV-RELATED AREA INCLUDED IN PLAN(S):

Elimination of punitive laws: No

HIV impact alleviation (including palliative care for adults and children): Yes

Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support: Yes

Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support: Yes

Reduction of stigma and discrimination: Yes

Treatment, care, and support (including social protection or other schemes): Yes

Women's economic empowerment (e.g. access to credit, access to land, training): Yes

Other [write in]:

:

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?: Yes

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evalua¬tion informed resource allocation decisions?: 2

4. Does the country have a plan to strengthen health systems?: Yes

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications and children: Malawi developed the Health Sector Strategic Plan in 2011 covering the period 2011-2016. This plan among other issues has interventions aimed at strengthening Malawi's health system through the training of human resources, construction and renovation of health facilities, ensuring availability of drugs and other medical supplies, improving transport infrastructure and ensuring availability of data to inform decision making at all levels of health system.

5. Are health facilities providing HIV services integrated with other health services?

a) HIV Counselling & Testing with Sexual & Reproductive Health: Many

b) HIV Counselling & Testing and Tuberculosis: Many

c) HIV Counselling & Testing and general outpatient care: Many

d) HIV Counselling & Testing and chronic Non-Communicable Diseases: None

e) ART and Tuberculosis: Many

f) ART and general outpatient care: Many

g) ART and chronic Non-Communicable Diseases: Many

h) PMTCT with Antenatal Care/Maternal & Child Health: None

i) Other comments on HIV integration: :

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2013?: 7

Since 2011, what have been key achievements in this area: Since 2011 Malawi has developed a new costed and results-oriented National HIV/AIDS Strategic Plan which is guiding the national response to the HIV and AIDS epidemic. This Plan was developed with full participation of the all stakeholders namely the private sector, the public sector, development partners and civil society organisations. At National level Malawi also developed the Health Sector Strategic Plan. The NSP is aligned with the HSSP and both are for the period 2011-2016. Malawi has also included new interventions such as Option B+ and voluntary medical male circumcision and other interventions targeting key populations such as MSMs and sex workers. There is also a comprehensive and reliable M&E system for health sector biomedical HIV interventions (PMTCT, HTC and ART) although there are questions of cost and sustainability of the system. Other key achievements include the rapid scale up of PMTCT and ART services and the conduct of the Legal Environment Assessment report which has informed the National Strategic Plan, HIV Policy and draft HIV Bill.

What challenges remain in this area:: 1. HTC is still a challenge. 2. Poor budgetary allocation to non-biomedical interventions. 3. Research and overall M&E implementation is weak—there is some evidence of poor absorptive capacity and poor reporting to NAC. As such the HIV prevention strategy is not well-informed. 4. Some iNGOs activities not aligned to multi-sectoral strategy. 5. Shifting goal posts by funding agencies, especially the GFATM, which takes very long to start disbursing funds after approval (There haven't been any GF financial disbursements since 2012). 6. Emerging issues on HIV and AIDS from stakeholders which require frequent review of the NSP and HIV Policy. This has also delayed the finalization of the HIV Bill. 7. Focus of the strategy and allocation of resources are influenced by external entities.

A.II Political support and leadership

1. Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

A. Government ministers: Yes

B. Other high officials at sub-national level: Yes

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?: Yes

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership: The President and Minister of Health speak publically and favourably about HIV in major fora. However, most ministers and other sub-national officials do not. In the past 12 months, the president has taken action that demonstrate leadership in the response to HIV for example she is a Global Ambassador for HIV and AIDS and she also hosted the UNAIDS and Lancet Commissioners Conference in June 2013. Additionally, The President has been and still is the Minister responsible for HIV and AIDS. HIV is a priority area in the Malawi Growth and Development Strategy which is an overall development agenda for Malawi.

2. Does the country have an officially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?: Yes

IF NO, briefly explain why not and how HIV programmes are being managed::

2.1. IF YES, does the national multisectoral HIV coordination body:

Have terms of reference?: No

Have active government leadership and participation?: No

Have an official chair person?: No

IF YES, what is his/her name and position title?:

Have a defined membership?: No

IF YES, how many members?:

Include civil society representatives?: No

IF YES, how many?:

Include people living with HIV?: No

IF YES, how many?:

Include the private sector?: No

Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?: No

3. Does the country have a mechanism to promote coordinationbetween government, civil societyorganizations, and the private sector for implementing HIV strategies/programmes?: Yes

IF YES, briefly describe the main achievements:: The main achievements are that the Government of Malawi (GoM), development partners, civil society are all working together in the fight against HIV and AIDS. They have worked together in the development of HIV and AIDS and related strategic plans and policies as well as during the implementation and monitoring of the National HIV and AIDS response. Every year all stakeholders attend the annual and biannual reviews. GoM and development partners are working very closely to ensure that resolve stock-out of HIV test kits

What challenges remain in this area:: There are still a number of challenges being experienced for example resources are still scarce to fully implement the NSP, untimely submission of data by implementing partners to the National AIDS Commission, non-alignment of some of the implementing partners M&E systems to the national one, limited involvement of persons with disabilities and limited availability of services targeting youth and HIV+ children.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?: 10

5. What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Capacity-building: Yes

Coordination with other implementing partners: Yes

Information on priority needs: Yes

Procurement and distribution of medications or other supplies: Yes

Technical guidance: Yes

Other [write in]: Financial Support

: Yes

6. Has the country reviewed national policies and laws to determine which, if any, are incon-sistent with the National HIV Control policies?: Yes

6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?: Yes

IF YES, name and describe how the policies / laws were amended: Proposals have been made to amend the penal code to repeal anti-sodomy laws and anti-nuisance laws (rogue and vagabond) provisions so that they are consistent with provisions of the Constitution. There is also an on-going review of the Public Health Act and HIV draft bill.

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:: Some of the inconsistencies which remain between policies and laws include the illegality of men having sex with men and the victimisation of sex workers based on the Penal Code.

7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the political support for the HIV programme in 2013?: 6

Since 2011, what have been key achievements in this area:: One of the major achievements is the strengthening of the DNHA in the OPC to provide effective oversight of HIV activities

What challenges remain in this area:: Most districts are underfunded which negatively affects CBO activities and that there is high attrition of District AIDS Coordinators

A.III Human rights

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Select yes if the policy specifies any of the following key populations and vulnerable groups:

People living with HIV: Yes

Men who have sex with men: No

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: No

Prison inmates: Yes

Sex workers: No

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]:

: No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?: Yes

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:: Section 20 of the Constitution prohibits all forms of discrimination. The Gender Equality Act promotes gender equality and prohibits discrimination based on gender.

Briefly explain what mechanisms are in place to ensure these laws are implemented:: There are institutions such as the Malawi Human Rights Commission which were established established to among other things create awareness among Malawians about legislation including human rights. They are also there in order to investigate violations of human rights and seek proper redress, through hearings. They can also propose new legislation or amendment or repeal of existing legislation. If anyone feels that he or she is aggrieved he or she can also seek redress from the courts of law.

Briefly comment on the degree to which they are currently implemented:: 1. There were feelings that it is hard to assess the extent to which the law is implemented. Nevertheless, political and civil rights are well protected. However, economic, social and cultural rights are poorly protected since implementation is dependent on the availability of state resources. In general most people do not claim their rights when violated. Even though there are laws against MSMs as well as sex workers, there is a degree of tolerance as interventions are being implemented targeting these groups. As far as implementing HIV interventions among MSMs and sex workers is concerned there is no discrimination.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?: Yes

IF YES, for which key populations and vulnerable groups?:

People living with HIV: No

Elderly persons: No

Men who have sex with men: Yes

Migrants/mobile populations: No

Orphans and other vulnerable children: No

People with disabilities: No

People who inject drugs: Yes

Prison inmates: Yes

Sex workers: Yes

Transgender people: Yes

Women and girls: No

Young women/young men: No

Other specific vulnerable populations [write in]::

: No

Briefly describe the content of these laws, regulations or policies:: Some current laws, regulations and policies present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable people. For example there are provisions in the in the Penal Code which criminalise MSMs. The Penal Code also has “anti-prostitution” elements which prohibit one to earn a living from the proceeds of prostitution – this limits access to preventive and curative services.

Briefly comment on how they pose barriers:: The existing legislation limits access to services by MSMs and sex workers. People are punished, discriminated against because of their sexual orientation and gender. There were widespread accusations by interviewed sex workers of police officers forcing the workers to have sex with them to buy their freedom since prostitution is criminalized

A.IV Prevention

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?: Yes

IF YES, what key messages are explicitly promoted?:

Delay sexual debut: Yes

Engage in safe(r) sex: Yes

Fight against violence against women: Yes

Greater acceptance and involvement of people living with HIV: Yes

Greater involvement of men in reproductive health programmes: Yes

Know your HIV status: Yes

Males to get circumcised under medical supervision: Yes

Prevent mother-to-child transmission of HIV: Yes

Promote greater equality between men and women: Yes

Reduce the number of sexual partners: Yes

Use clean needles and syringes: Yes

Use condoms consistently: No

Other [write in]::

: No

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?: Yes

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?: Yes

2.1. Is HIV education part of the curriculum in:

Primary schools?: Yes

Secondary schools?: Yes

Teacher training?: Yes

2.2. Does the strategy include

a) age-appropriate sexual and reproductive health elements?: Yes

b) gender-sensitive sexual and reproductive health elements?: Yes

2.3. Does the country have an HIV education strategy for out-of-school young people?: Yes

3. Does the country have a policy or strategy to promote information, education and communi-cation and other preventive health interventions for key or other vulnerable sub-populations?: Yes

Briefly describe the content of this policy or strategy:: The country has a policy/strategy promoting IEC and other preventive health interventions for key and other vulnerable populations. These interventions are contained in the National HIV and AIDS Strategic Plan and are being implemented by different stakeholders including civil society organisations.

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

People who inject drugs:

Men who have sex with men: Condom promotion,Drug substitution therapy,HIV testing and counseling,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education

Sex workers: Condom promotion,Drug substitution therapy,HIV testing and counseling,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education,Vulnerability reduction (e.g. income generation)

Customers of sex workers: Condom promotion,Drug substitution therapy,HIV testing and counseling,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education

Prison inmates: Condom promotion,Drug substitution therapy,HIV testing and counseling,Reproductive health, including sexually transmitted infections prevention and treatment,Stigma and discrimination reduction,Targeted information on risk reduction and HIV education

Other populations [write in]::

:

3.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate policy efforts in support of HIV prevention in 2013?: 8

Since 2011, what have been key achievements in this area:: The key achievements since 2011 in this area are the scaling up of VMMC program as well as the scaling up of Option B+ as a way of preventing mother to child transmission of HIV. Another key achievement is in the area of condom programming and the establishment of condom committees. Other key achievements include: a. Rapid scale up of PMTCT services, responding to evidence b. Adoption of the Legal Environment Assessment report which has increased awareness and interest of authorities to improve key population's access to prevention and treatment. c. Review and revision of life-skills training programme

What challenges remain in this area:: With regard to VMMC people do not understand the benefits of this intervention. There is some evidence which shows that the use of condoms in some areas of the country is dropping because of the belief that VMMC is protective hence there is a need to address this. For Option B+ retention is still a major problem - most of the women who are in this program are not sick and once they start on ART they have to receive this for life. Other challenges include: a. Lack of capacity to implement prevention promoting activities especially at istrict and lower levels. b. Poor reach out especially in rural communities. c. Poor supply chain management of condoms. d. New infections are still high. e. Stigma and discrimination which is counterproductive to prevention and treatment efforts. The churches (faith community) still promote stigma.

4. Has the country identified specific needs for HIV prevention programmes?: Yes

IF YES, how were these specific needs determined?: The National HIV Prevention Strategy expired in 2013 and currently a new Strategy is being developed. This Strategy will specify the needs for HIV prevention programmes. However, the National HIV/AIDS Strategic Plan also specifies the needs for prevention programs and these needs were identified through a very consultative process in which all stakeholders namely GoM, private sector, civil society and development partners were involved. These needs have also been identified through specific studies such as Know Your Epidemic and Modes of Transmission.

IF YES, what are these specific needs? : The Policies and Plans promote delayed age at first sex, the practice safer sex among young people through use of condoms and encouraging them to go for HTC among other interventions. The Ministry of Education is responsible for exposing in school youth to life skills education while the Ministry of Youth and other stakeholders such as CSO provide life skills to out of school youth. The focus on PMTCT, interventions for people in stable relationships and ART for prevention.

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…:

Blood safety: Agree

Condom promotion: Disagree

Economic support e.g. cash transfers: Agree

Harm reduction for people who inject drugs: N/A

HIV prevention for out-of-school young people: Agree

HIV prevention in the workplace: Agree

HIV testing and counseling: Agree

IEC on risk reduction: Agree

IEC on stigma and discrimination reduction: Agree

Prevention of mother-to-child transmission of HIV: Agree

Prevention for people living with HIV: Agree

Reproductive health services including sexually transmitted infections prevention and treatment: Agree

Risk reduction for intimate partners of key populations: Agree

Risk reduction for men who have sex with men: Disagree

Risk reduction for sex workers: Agree

Reduction of gender based violence: Disagree

School-based HIV education for young people: Strongly agree

Treatment as prevention: Agree

Universal precautions in health care settings: Agree

Other [write in]::

:

5. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in implementation of HIV prevention programmes in 2013?: 6

A.V Treatment, care and support

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?: Yes

If YES, Briefly identify the elements and what has been prioritized:: These elements include providing HTC services, ART, screening for opportunistic infections and providing treatment, providing family planning mainly depo, early infant diagnosis and follow up and screening for TB in HIV+ patients. A minimum OVC package has been determined which looks at clothing, blankets and possession of shoes. GoM is also implementing a social cash transfer program in which beneficiary households get MK2700 per month and this program is in 19 districts.

Briefly identify how HIV treatment, care and support services are being scaled-up?: Initially ART was only being given in hospitals and people had to walk long distances in order to get to these facilities and ART was only being prescribed by clinicians. However ART is now being provided at health centres as well and nurses are being trained to provide ART. This has led to rapid scale up of ART such as as of now more than 500,000 people have ever been started on ART. Over the years the number of ART sites has increased significantly from around 300 in 2011 to about 700 in 2013. The social cash transfer program benefits households and in most cases these households have orphans as well. This program was piloted in Mchinji but it is now in 19 districts and the plan is to scale up this program to all the districts in Malawi. It is largely being supported by donors and GoM makes a contribution of 10%.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to…:

Antiretroviral therapy: Agree

ART for TB patients: Agree

Cotrimoxazole prophylaxis in people living with HIV: Agree

Early infant diagnosis: Disagree

Economic support: Disagree

Family based care and support: Agree

HIV care and support in the workplace (including alternative working arrangements): Agree

HIV testing and counselling for people with TB: Agree

HIV treatment services in the workplace or treatment referral systems through the workplace: Agree

Nutritional care: Disagree

Paediatric AIDS treatment: Disagree

Palliative care for children and adults Palliative care for children and adults: Disagree

Post-delivery ART provision to women: Agree

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault): Agree

Post-exposure prophylaxis for occupational exposures to HIV: Agree

Psychosocial support for people living with HIV and their families: Agree

Sexually transmitted infection management: Agree

TB infection control in HIV treatment and care facilities: Agree

TB preventive therapy for people living with HIV: Agree

TB screening for people living with HIV: Agree

Treatment of common HIV-related infections: Agree

Other [write in]::

:

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?: Yes

Please clarify which social and economic support is provided: The Ministry of Gender, Children and Social Welfare with support from donors and in conjunction with CSOs and other stakeholders provides psychosocial, education, nutritional, legal and material support to vulnerable populations such as orphans and other vulnerable children. Community based childcare centres have been established throughout the country which are providing early education to children aged 3-5 as well as providing at least one meal a day. 21% of the children enrolled in these CBCCs are orphans while about 4% have different types of disabilities. A social cash transfer for OVCs and their households is being implemented in Malawi with support from donors.

3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?: Yes

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitu-tion medications?: No

IF YES, for which commodities?:

5. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?: 8

Since 2011, what have been key achievements in this area:: Malawi has managed to put over 500,000 people on ART and the survival rate is at over 70%. The country has also transitioned to a less toxic regimen. In addition to this because of the introduction of Option B+ there has been a 700% fold increase in the number of pregnant women put on ART since this program started. In terms of the social cash transfers the program is being extended to other districts (now at 19) and the transfer levels are increasing.

What challenges remain in this area:: Early infant diagnosis is still a major challenge. the proportion of children put on ART is still at 9% lower than the recommended proportion by WHO. Other challenges include: a. Pediatric ART treatment for young people. b. Retention of patients or clients in care. The number of OVC and their households being reached with different interventions is still small hence there is a need to expand provision of services to OVC and their households. There is also a need to strengthen coordination mechanism in the national response to the OVC and their households and the need to increase funding for these programs.

6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?: Yes

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?: Yes

6.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?: No

7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?: 4

Since 2011, what have been key achievements in this area:: The scaling up of the social cash transfer program to 19 districts which implies that more OVC and their households will benefit.

What challenges remain in this area:: Weak coordination mechanisms, shortage of funding for OVC programs and the lack of the NPA to guide implementation of interventions.

A.VI Monitoring and evaluation

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?: Yes

Briefly describe any challenges in development or implementation:: The major challenges in the implementation of the M&E Plan are the shortage of personnel at all levels especially at the local council level since the implementation of the Plan has been decentralised following the decentralisation policy. The National AIDS Commission’s M&E Unit is also understaffed. In addition to this there is lack of M&E skills among staff responsible for these functions. Despite having one M&E Plan one of the major challenges is that there is limited alignment to this plan by implementing partners – some have their own M&E frameworks. There is also a lack of adherence to reporting requirements as required in the M&E Plan and this is especially the case with those implementing partners who receive funding outside the National AIDS Commission. The financial resources allocated to M&E are also inadequate.

1.1. IF YES, years covered: 2011-2016

1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indi-cators) with the national M&E plan?: Yes, some partners

Briefly describe what the issues are:: Some implementing partners have their own M&E frameworks and they prioritise these instead of the M&E framework that is led by the National AIDS Commission. They have an obligation to fulfil to their funding agencies.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy: Yes

IF YES, does it address::

Behavioural surveys: Yes

Evaluation / research studies: Yes

HIV Drug resistance surveillance: Yes

HIV surveillance: Yes

Routine programme monitoring: Yes

A data analysis strategy: Yes

A data dissemination and use strategy: Yes

A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate): Yes

Guidelines on tools for data collection: Yes

3. Is there a budget for implementation of the M&E plan?: Yes

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?: 5

4. Is there a functional national M&E Unit?: Yes

Briefly describe any obstacles:: Over 1 year now the Monitoring and Evaluation Unit at the National AIDS Commission has been running under capacity in terms of human resource. Instead of having 5 officers there are currently 2 of them. At district level there are shortages of staff as well and lack of appropriate M&E skills. The financial resources allocated for M&E are inadequate.

4.1. Where is the national M&E Unit based?

In the Ministry of Health?: No

In the National HIV Commission (or equivalent)?: Yes

Elsewhere?: No

If elsewhere, please specify:

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles]	Fulltime or Part-time?	Since when?
M&E Officer	Full-time	2012
M&E Officer	Full-time	2012
Head of Planning M&E and Research		2004

POSITION [write in position titles]	Fulltime or Part-time?	Since when?

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?: Yes

Briefly describe the data-sharing mechanisms:: National AIDS Commission produces quarterly and annual M&E reports which are shared with stakeholders during biannual and annual review dissemination meetings. These reports are also put on the website of the National AIDS Commission. Official statistics on the epidemic are also published in the newspapers. The Ministry of Health also circulates among stakeholders the quarterly HIV programme reports with data on access to ART, PMTCT, HTC and STIs. Local councils collect M& E data monthly and report to National AIDS Commission quarterly from all partners involved in HIV programs.

What are the major challenges in this area:: Data sharing among stakeholders is done quite well at national level. The National AIDS Commission ensures that this is disseminated at the national level. However data sharing at local council level is not done properly and in some cases it is not done at all. There are also challenges in terms of reporting of data: it is not timely and its validity is questionable and this is why some implementing partners have established parallel data collection mechanisms.

5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?: Yes

6. Is there a central national database with HIV- related data?: No

IF YES, briefly describe the national database and who manages it.:

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?:

IF YES, but only some of the above, which aspects does it include?:

6.2. Is there a functional Health Information System?

At national level: Yes

At subnational level: Yes

IF YES, at what level(s)?: districts

7.1. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?: Estimates of Current and Future Needs

7.2. Is HIV programme coverage being monitored?: Yes

(a) IF YES, is coverage monitored by sex (male, female)?: Yes

(b) IF YES, is coverage monitored by population groups?: Yes

IF YES, for which population groups?: Not for key populations.

Briefly explain how this information is used:: This information is used for quantification and forecasting of health products as well as identification of sites that require services.

(c) Is coverage monitored by geographical area?: Yes

IF YES, at which geographical levels (provincial, district, other)?: At zone and district level.

Briefly explain how this information is used:: This information is used for quantification and forecasting of health products as well as identification of sites that require services. This data is also used for program improvement as well as revising the national response.

8. Does the country publish an M&E report on HIV, including HIV surveillance data at least once a year?: Yes

9. How are M&E data used?

For programme improvement?: Yes

In developing / revising the national HIV response?: Yes

For resource allocation?: No

Other [write in]::

: No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:: M&E data are used to inform development of policies as well as programming. These data are disseminated during annual dissemination and other conferences. The major challenge is the lack of use of data at points of source to inform strategic planning. There is also a lack of capacity for data collection on a routine basis especially at district level and among members of the civil society.

10. In the last year, was training in M&E conducted

At national level?: No

IF YES, what was the number trained::

At subnational level?: Yes

IF YES, what was the number trained: 18 people were trained. This training targeted M&E officers, District AIDS Coordinators and Data Entry Clerks.

At service delivery level including civil society?: Yes

IF YES, how many?: 12 members from the sector of People Living with HIV and AIDS

10.1. Were other M&E capacity-building activities conducted other than training?: Yes

IF YES, describe what types of activities: National AIDS Commission conducted data quality assessment for selected indicators and this involved MBTS, BLM and District Hospitals.

11. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?: 6

Since 2011, what have been key achievements in this area:: The number of local councils reporting their M&E data has been increasing over the year and that a number of District AIDS Coordinators have been recruited for the local councils.

What challenges remain in this area:: The major challenge is that local councils still lack the capacity to generate and use the data for strategic decision making at points of source. Even if they generate the data it is not sent timely to the National M&E Unit at the National AIDS Commission. Designated M&E officers also lack the knowledge and skills on M&E.

B.I Civil Society involvement

1. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) has civil society contrib¬uted to strengthening the political commitment of top leaders and national strategy/policy formulations?: 4

Comments and examples:: CSOs are conducting advocacy campaigns aimed at strengthening the political commitment of top leaders and national strategy/policy formulation. For example in 2013 CSOs such as Malawi Interfaith AIDS Association, MANET+, NAPHAM and COWLA advocated for new ART regimen because the old regimen had side effects. The new regimen is expensive but it has no side effects. Through such advocacy Malawi has changed to the new regimen which has no side effects. Over the years CSOs have also advocated for the inclusion of PLHIVs in national working groups such as CCM. CSOs have also contributed to the development of the National HIV/AIDS Strategic Plan, National AIDS Policy and other related plans/policies and the HIV Bill. Some CSOs have also sensitised the Executive on the need for a sustainable financing mechanism for the national response. CSOs have also contributed to discussions on resolution of stock-outs of health commodities. They are also promoting the review of laws so that same sex relationships and sex work are decriminalised.

2. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) have civil society repre¬sentatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?: 3

Comments and examples:: CSOs are involved in the planning process for the National Strategic Plan on HIV. It was reported that as the current Strategic Plan was being developed CSOs participated and contributed on the types of interventions that should be included in the Plan. Their involvement in budgeting is limited but they do provide the type of interventions and budgeting is done by National AIDS Commission. They have an opportunity to comment on the IAWP budget prepared by NAC which is pre-determined by availability of earmarked resources . Thus, they do not have a say on allocation of resources.

3. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?: 4

b. The national HIV budget?: 3

c. The national HIV reports?: 3

Comments and examples:: The NSP is a multi-sectoral plan and it includes most of the HIV and AIDS interventions that are supposed to be implemented over the period of the Plan. CSOs, especially which are funded through the National AIDS Commission, develop annual workplans and they are funded based on their plan. They do not implement anything outside the NSP. All their proposals to National AIDS Commission are in line with the NSP. The challenge however is that funding CSOs get outside National AIDS Commission is not captured by the National AIDS Commission. CSOs submit their M&E reports to the National AIDS Commission on a quarterly basis and this is especially the case for those CSOs which are funded through the National AIDS Commission. Civil society organisations participate in the development and validation of key national HIV and AIDS reports. For CSOs not funded through the National AIDS Commission reporting is very low. Data on biomedical interventions is readily available from the MoH Directorate of HIV but data on non-biomedical interventions is still problematic.

4. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?: 4

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?: 4

c. Participate in using data for decision-making?: 3

Comments and examples:: CSOs participate in the development of the national M&E plan in two ways: they are invited to take part in the development of the Plan itself. Once the M&E tools have been developed, the National AIDS Commission orients CSOs on use of these tools. CSOs are also members of the M&E TWG. These CSOs also contribute to the national M&E system by contributing data/reports as they are supposed to submit reports quarterly. Some CSOs reported that they do participate in the use data for decision making for example data from studies (for example the MoT study) that have been commissioned by National AIDS Commission. Some CSOs report that decision making is based on experience and not on evidence.

5. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, community based organisations , and faith-based organizations)?: 4

Comments and examples:: In Malawi civil society is working very closely with PLHIVs, sex workers, MSMs and other key population. They have taken the lead in working with these populations. Some CSOs such as MANET+ constitute of persons living with HIV. There was a feeling that there has been too much focus on PLHIVs and not much attention has been paid to organisations for persons with disabilities. Most district based CSOs are not involved.

6. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society able to access:

a. Adequate financial support to implement its HIV activities?: 2

b. Adequate technical support to implement its HIV activities?: 3

Comments and examples:: While most CSOs access funding through the National AIDS Commission a good proportion also access funding through iNGOs and other donors. Technical support is provided by NAC and organisations such as World University Schools of Canada, MSH, UNAIDS, EdStar, PEPFAR. People also felt that the allocation of resources is not consistent with drivers of the HIV epidemic. There is too much focus on treatment activities at the expense of non-biomedical interventions.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for key-populations:

People living with HIV: >75%

Men who have sex with men: >75%

People who inject drugs:

Sex workers: >75%

Transgender people:

Palliative care : >75%

Testing and Counselling: 51–75%

Know your Rights/ Legal services: >75%

Reduction of Stigma and Discrimination: >75%

Clinical services (ART/OI): <25%

Home-based care: >75%

Programmes for OVC: >75%

8. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to increase civil society participation in 2013?: 7

Since 2011, what have been key achievements in this area:: a. Mainstreaming human rights in the draft HIV Bill which has been presented to cabinet b. NSP formulation c. CSOs working with key populations such as MSM and sex workers. d. Helped government to mobilize financial resources for new less toxic HIV treatment through its lobbying efforts to GF and PEPFAR e. PLHIV are represented on all key bodies dealing with HIV including the NAC Board, Malawi Partnership Forum and MGFCC. f. Participated in concept note development to the GF. g. Influenced government to include key populations in national policies, strategies and programmes. h. Increased participation of CSOs in review meetings. i. Advocated on moratorium on antisodomy laws in the penal code j. Advocated on resolution of stock-outs of health commodities

What challenges remain in this area:: (i) CSOs can’t implement all their interventions because of lack of resources both human and financial; (ii) Capacity problems in terms of HR availability and skills in data management, research and evidence-based decision making. and (iii) poor reporting of activities especially at district level. (iv) Poor coordination at district level.

B.II Political support and leadership

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?: Yes

IF YES, describe some examples of when and how this has happened:: Malawi has ensured “full involvement and participation” of the civil society in the development of the multi-sectoral HIV strategy, the National HIV Policy and CSOs are also involved in planning meetings, review meetings and TWG. A significant proportion of CSOs implement interventions as contained in the NSP and HIV Policy. Most of them do not implement activities outside the Plan. Most CSOs are also funded through the National AIDS Commission which is a Government of Malawi organisations coordinating the national response to the HIV and AIDS epidemic..

B.III Human rights

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

People living with HIV: Yes

Men who have sex with men: No

Migrants/mobile populations: No

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: No

Prison inmates: No

Sex workers: No

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]::

: No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?: Yes

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:: Section 20 of the Constitution of the Republic of Malawi prohibits any form of discrimination and all persons are, under any law, guaranteed equal and effective protection against discrimination on grounds of race, colour, sex, language, religion, political or other opinion, nationality, ethnic or social origin, disability, property, birth or other status. The Constitution, however, allows for positive discrimination to address inequalities in society and prohibiting discriminatory practices and the propagation of such practices. Any person that propagates discriminatory practices may be amenable to criminal sanctions before the courts of law. Malawi has drafted the HIV Bill which once enacted will prevent HIV-related discrimination.

Briefly explain what mechanisms are in place to ensure that these laws are implemented:: There are challenges in the implementation of the laws because of poor legal literacy among the general population and also because of enormous resource limitations especially in the public sector. However anyone who feels that he or she has been discriminated against or his or her rights have been infringed has the right to seek redress in courts of law. In addition CSOs report that all their programs are not discriminatory and that no one is denied services because of their status such as being gay.

Briefly comment on the degree to which they are currently implemented:: In general most people do not claim their rights when violated and they are not aware of the laws. Judiciary has not delivered decisive judgments especially for key populations (mandatory testing of sex workers and convicted gay couple). Legal aid system is not accessible to people in the rural areas. The Malawi Police Services has the Victims Support Units which are not well developed. However it is a good start but there is a need to equip the VSU and capacitate the police officers.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?: Yes

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

People living with HIV: No

Men who have sex with men: Yes

Migrants/mobile populations: No

Orphans and other vulnerable children: No

People with disabilities: No

People who inject drugs: Yes

Prison inmates: No

Sex workers: Yes

Transgender people: Yes

Women and girls: No

Young women/young men: No

Other specific vulnerable populations [write in]::

: No

Briefly describe the content of these laws, regulations or policies:: Some current laws, regulations and policies present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable people. For example the Malawi Penal Code criminalises same sex sexual relationships such as men having sex with men. The Penal Code limits people engaged in same sex relationship to access preventive (health education, condoms, lubricants) and curative services and they are subject to abuse by health workers. The Penal Code (Cap.7:01) of the laws of Malawi governs the practice of sex work. In spite of the common view that prostitution or sex work is illegal in Malawi, the law does not expressly criminalise sex work. The law prohibits one to earn a living from the proceeds of prostitution – this limits access to preventive and curative services. Immigration Laws prohibits gay individuals from entering the country. Since homosexuality is prohibited in the laws of Malawi the distribution of condoms is also prohibited in prisons despite the fact that HIV education is allowed.

Briefly comment on how they pose barriers:: These laws generally limit access to preventive and curative services for key populations as they are considered a “marginalized population” and predisposes them to abuse by law enforcers. In addition for prisoners, they do not have access to condoms as homosexuality is prohibited in Malawi.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?: Yes

Briefly describe the content of the policy, law or regulation and the populations included.: Malawi has policies, laws and regulations aimed at reducing violence against women, including victims of sexual assault or women living with HIV. These include (i) Gender Equality Act; (ii) Wills, Inheritance and Protection Act; (iii) Prevention of Domestic Violence Act and (iv) Various International Treaties such as CEDAW which form part of our law. There are also penal code provisions on assault and GBV. In addition to these, the constitution provides that women have the right to full and equal protection by the law and have the right not to be discriminated against on the basis of their gender and marital status which include the right to be accorded the same rights as men in civil law.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?: Yes

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy::

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?: No

IF YES, briefly describe this mechanism:: The promotion and protection of human rights is explicitly mentioned in Malawi’s HIV/AIDS policy and strategic plans. They are mentioned as forming part of framework governing or guiding the policies or strategies

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle “yes” or “no” as applicable).

Antiretroviral treatment:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV prevention services:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV-related care and support interventions:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

If applicable, which populations have been identified as priority, and for which services?: PLHIVs and pregnant women are a priority. Pregnant women are prioritized for prevention services to reduce the risk of mother to child transmission. In terms of prevention people can access free condoms for prevention. The challenge however is that free condoms are sometimes not available. The social cash transfer program provides OVC with economic, nutrition and education support. Such support is also provided to PLHIV including home based care but this is limited.

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?: Yes

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?: Yes

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?: Yes

IF YES, Briefly describe the content of this policy/strategy and the populations included:: Malawi has the National HIV Strategic Plan and the National HIV/AIDS Policy which promote equal access for all people in Malawi to HIV prevention, treatment and care. Key populations such as sex workers and men having sex with men and PLHIVs have been included in the policy and plan and there are specific interventions for these populations. Although key populations are mentioned in the plan and policy the policy is generalized and does not consider the unique needs of key populations. It does not deal with the structural barriers that prevent access to services by key populations. There is a need for “key population” strategies.

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?: Yes

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:: The country has a policy and strategy to ensure equal access for key populations to HIV prevention, treatment, care and support. However, the policy does not specify different delivery approaches to ensure equal access. For some populations these are specified for example pregnant women have access to HIV prevention measures at ANC.

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?: Yes

IF YES, briefly describe the content of the policy or law:: The country has a policy prohibiting HIV screening except for the armed forces. However, some employers have included tacitly included HIV tests among the pre-employment medical

check-up tests.

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work: Yes

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts: No

IF YES on any of the above questions, describe some examples::

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?: Yes

b. Programmes for members of the judiciary and law enforcement46 on HIV and human rights issues that may come up in the context of their work?: Yes

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework: Yes

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV: Yes

13. Are there programmes in place to reduce HIV-related stigma and discrimination?: Yes

IF YES, what types of programmes?:

Programmes for health care workers: Yes

Programmes for the media: Yes

Programmes in the work place: Yes

Other [write in]::

: No

14. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?: 5

Since 2011, what have been key achievements in this area:: (i) Organizations for PLHIVs have participated in formulation and review of national policies and strategies; (ii) Inclusion of key populations in the HIV Policy; (iii) Formulation of the HIV draft bill. In addition to these the passing of the Gender Equality Bill is also another major achievement.

What challenges remain in this area:: HIV Law has not been enacted. HIV activities are currently guided by policies and guidelines which do not have the force of the laws. Although other non-HIV legislation can be used to protect rights of PLHIVs, key and other vulnerable populations they are inadequate to address unique problems arising from HIV and AIDS. There is also

poor legal literacy especially at community level and most people depend on the customary justice system which is not well conversant with human rights issues. There are still inadequate financial and human resources to fully implement the policies and plans.

15. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?: 7

Since 2011, what have been key achievements in this area:: (i) Policy implementation in terms of care and support of PLHIV, including in the workplace has been good; (ii) For the first-time, NAC funded CEDEP to conduct peer-education programmes for MSMs; (iii) DNHA/OPC has funded an MSM study; (iv) CEDEP partnered with the DNHA/OPC to sensitize parliament about key populations; (v) Representative from key populations participating in TWGs and MGFCC; (vi) There have been some efforts to implement the policies as evidenced for example by high ART coverage among pregnant women and the general population (vii) Conducting of Legal Environment Assessment and incorporation of findings of Legal Environment Assessment in policies

What challenges remain in this area:: (i) Legal redress of HR violations remain low due to lack of HIV specific laws, limited awareness of other protective laws and poor access to the justice system. (ii) Court cases involving mandatory testing of sex-workers and anti-sodomy laws still not decided; (iii) Failure to report abuses suffered by key populations; (iv) Poor implementation of the law; (v) continued conflict between the constitution and the Penal Code.

B.IV Prevention

1. Has the country identified the specific needs for HIV prevention programmes?: No

IF YES, how were these specific needs determined?: The National HIV Prevention Strategy expired in 2013 and a new one is being developed. However there are interventions outlined in the NSP. Action plans for vulnerable and key populations are yet to be developed. These interventions include PMTCT, VMMC, HTC, IEC and ART for prevention.

IF YES, what are these specific needs? :

1.1 To what extent has HIV prevention been implemented?

The majority of people in need have access to…:

Blood safety: Agree

Condom promotion: Strongly agree

Harm reduction for people who inject drugs: N/A

HIV prevention for out-of-school young people: Agree

HIV prevention in the workplace: Agree

HIV testing and counseling: Agree

IEC on risk reduction: Agree

IEC on stigma and discrimination reduction: Agree

Prevention of mother-to-child transmission of HIV: Strongly agree

Prevention for people living with HIV: Agree

Reproductive health services including sexually transmitted infections prevention and treatment: Agree

Risk reduction for intimate partners of key populations: Agree

Risk reduction for men who have sex with men: Disagree

Risk reduction for sex workers: Agree

School-based HIV education for young people: Strongly agree

Universal precautions in health care settings: Agree

Other [write in]::

:

2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?: 8

Since 2011, what have been key achievements in this area:: a. Rapid scale up of PMTCT services b. Adopting VMMC in the prevention strategy and obtaining government buy-in. c. The development of a policy on VMMC. d. Review and revision of life-skills training programme which includes comprehensive sexuality education especially among secondary school students. e. Good access to condoms in the private sector.

What challenges remain in this area:: a. Weak delivery capacities for biomedical interventions because limited infrastructure and human resources constraints b. Poor coverage of VMMC. c. Weak capacity of CBOs to deliver preventive interventions. d. Stigma and discrimination still exists and this is counterproductive to prevention and treatment efforts. e. Few high profile people are declaring their HIV status. f. High levels of multiple and concurrent partnerships and transactional sexual intercourse despite behavioural change interventions. g. Unavailability of condoms to end-users. h. Poor supply chain management resulting into stockout of commodities such as test kits. i. Limited interventions for key populations such as MSMs and sex workers. j. Limited capacity of implementing partners for behavioural change interventions. k. Lack of direction and strategic planning on what to focus on. There is a tendency to focus on what is already known. l. Limited financial resources for preventive activities m. Disorganized informal private sector—there is a need to form some kind of an association for them to facilitate access to HIV interventions n. Lack of an HIV legislation mandating small to medium size enterprises and companies to adopt and implement workplace policies. o. The health sector capacity challenges to meet the demand for VMMC. p. Poor implementation of workplace policies in public sector and civil society organizations (including NAC). The general workplace policy in public sector has not been modified to fit the needs of each sector.

B.V Treatment, care and support

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?: Yes

IF YES, Briefly identify the elements and what has been prioritized:: These include the provision of HIV testing and counselling services, ART, treatment of opportunistic infections and providing treatment, providing family planning, early infant diagnosis and follow up and screening for TB in HIV+ patients. The basic needs for OVC are shoes, two pairs of clothes and a blanket. With support from USAID the Government of Malawi is piloting the quality improvement standards.

Briefly identify how HIV treatment, care and support services are being scaled-up?: Initially the provision of ART was only being done at hospitals but now this has been extended to health centres and other primary facilities. This has significantly increased the number of facilities providing ART in Malawi. In addition while initially these services were being prescribed by clinicians now even nurses who man most of the lower level facilities do prescribe ART. For OVC a new plan for OVC is being developed. The social cash transfer program has been extended to 19 districts and plans are that this program should be in all districts.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to…:

Antiretroviral therapy: Agree

ART for TB patients: Agree

Cotrimoxazole prophylaxis in people living with HIV: Agree

Early infant diagnosis: Disagree

HIV care and support in the workplace (including alternative working arrangements): Agree

HIV testing and counselling for people with TB: Agree

HIV treatment services in the workplace or treatment referral systems through the workplace: Agree

Nutritional care: Disagree

Paediatric AIDS treatment: Disagree

Post-delivery ART provision to women: Agree

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault): Agree

Post-exposure prophylaxis for occupational exposures to HIV: Disagree

Psychosocial support for people living with HIV and their families: Agree

Sexually transmitted infection management: Agree

TB infection control in HIV treatment and care facilities: Agree

TB preventive therapy for people living with HIV: Agree

TB screening for people living with HIV: Agree

Treatment of common HIV-related infections: Agree

Other [write in]::

:

1.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?: 8

Since 2011, what have been key achievements in this area:: Rapid scale-up of ART services and over half a million Malawians have ever been started on ART. Malawi has successfully implemented the new ART regimen. Survival rate on ART is also very high

What challenges remain in this area:: a. Adolescent ART treatment. b. EID implementation. c. Retention of patients or clients in care. d. Huge donor dependency. e. Weak health systems. f. Inadequate follow-up mechanisms for people on ART of HIV Exposed infants who have defaulted. g. Side effects of the new regimen (dizziness and hallucinations) h. HRH and infrastructure challenges including space for drug storage.

2. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?: Yes

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?: Yes

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?: No

3. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?: 4

Since 2011, what have been key achievements in this area:: A comprehensive evaluation of the NPA 2009-2011 has been done and this is informing the development of the National Plan of Action for Children. There will not be a separate NPA for children but for children in general. The social cash transfer program is being implemented and a lot of OVC and their households are benefiting. The program is being expanded to cover all districts in Malawi.

What challenges remain in this area:: 1. The general lack of funding for OVC programs. 2. Lack of the NPA to guide implementation of interventions. 3. Lack of effective coordination of OVC activities at all levels.. 4. Huge donor dependence. 5. Sustainability of the social cash transfer program is being questioned.