Malawi Government

2012 GLOBAL AIDS RESPONSE PROGRESS REPORT: Malawi Country Report for 2010 and 2011

3/31/2012

FOREWORD

The 2012 AIDS Response Progress Report for Malawi presents the major highlights of the progress made in the fight against HIV and AIDS for the period from January 2010 to December 2011. The compilation for this report is part of my Government's commitment to the 2011 United Nations General Assembly Political Declaration to achieve; ***Zero new HIV infections, Zero Discrimination and Zero AIDS Related Deaths***. This report will also provide a good baseline for monitoring progress towards the associated targets that call for the reduction on sexual transmission of HIV; increasing the number of people on treatment; halving TB-related deaths amongst people living with HIV; and, elimination of new HIV infections among children by 2015. My Government continues to regard HIV and AIDS as a high priority on the country's socio-economic development agenda. Prevention and Management of Nutrition, HIV and AIDS disorders' is one of the key priority areas in the MGDS II (2011 to 2016). My Government realises that there can never be any meaningful development if the HIV and AIDS epidemic is not adequately addressed through clear prioritization, implementation and monitoring of high impact interventions.

In order to ensure that the HIV and AIDS agenda is implemented as intended, both the Public and Private Sector have been mobilized to mainstream HIV and AIDS into their programs. The Public Sector continues to set aside a minimum of 2% of their recurrent budget to support HIV and AIDS programmes in the work place and the core business of those sectors. The Private Sector on the other hand has the Malawi Business Coalition Against AIDS, which is working with both multinational and local business entities on issues of HIV and AIDS mainstreaming at organizational level. My Government continues to fund the national response to HIV and AIDS through the annual budgetary provisions to the HIV Pool and the Health Sector Strategic Plan.

The results of my Government's commitment to the fight against HIV and AIDS are evident. With the support of our Funding and Development Partners, Malawi has been able to scale up its HIV and AIDS treatment programme to unprecedented levels. Whilst there were 10,761 patients alive and on treatment in 2004, the number of patients alive and on treatment reached 322,209 as at the end of December 2011. Further increases are expected now with the adoption of the WHO Guidelines. HIV Prevention Programmes are also bearing fruits as evidenced by the decline in HIV prevalence from 12% in 2004 to 10.6% in 2010.

Malawi continues to be a success story in mobilizing the Civil Society and grassroots for HIV and AIDS action. This has been facilitated through community based organizations (CBOs) that my Government has allowed to flourish to serve this purpose. This arrangement has gone a long way towards expansion of service coverage, particularly in the areas of HIV prevention and impact mitigation.

I want to reiterate my Government's dedication to fulfilling her commitments to national, regional and international protocols and conventions, including the 2011 Political Declaration on HIV and AIDS, for which this report is specifically intended. It is my sincere hope that this Report has managed to highlight the gains that Malawi has attained in the past two years, as well as areas for which more work will need to be done for us to win the fight against the HIV and AIDS pandemic.

Dr Bingu wa Mutharika

PRESIDENT OF THE REPUBLIC OF MALAWI

PREFACE

Malawi continues to register significant progress in the national response to HIV as evidenced by results highlighted in this report. The 2012 AIDS Response Progress Report provides evidence that Malawi continues to register progress in the areas of prevention; treatment, care and support; and impact mitigation. This has been facilitated by development, implementation and monitoring of evidence based policies and strategies in the response to HIV and AIDS, among other factors.

The period 2004 to 2010 saw the decline in the national HIV prevalence from 12% to 10.6%. This reduction is encouraging although more work still needs to be done in order to continue decreasing the number of new infections, which is still quite high at the moment. Malawi has produced a comprehensive National HIV Prevention Strategy (2009-2013) with an implementation plan that seeks to consolidate all prevention interventions in one single coherent framework with clear management and implementation mandates.

The period under review also saw a number of key documents being reviewed and developed. Some of these are: the HIV and AIDS Policy that has been reviewed and finalized and is awaiting approval; the National HIV and AIDS Strategic Plan (2011-2016); the Male Circumcision Policy; and, the new M&E Plan (2011-2016). All these have been produced in order to ensure that the National Response to HIV and AIDS remains focused and produces tangible results.

The 2012 Response report therefore comes at an opportune time where we can review the achievements and challenges that the country has registered and encountered, so that we can consolidate the gains and effectively address the challenges identified. This process will therefore ensure that the country fulfils its own aspirations as well as contribute towards the global efforts to fight against HIV and AIDS.

Dr Mary Shawa

SECRETARY FOR NUTRITION, HIV AND AIDS

ACKNOWLEDGEMENT

Development of the 2012 Country AIDS Response Progress Report was a collective effort with support from various organisations and individuals, too numerous to mention. Some of them though deserve special mention.

The Government of Malawi would like to sincerely thank UNAIDS for providing financial support and the technical guidance during this process. By the same token, the report preparation team in the Planning, Monitoring, Evaluation and Research Unit of the National AIDS Commission ably facilitated the process by mobilising the relevant documents and setting up meetings and interviews with key stakeholders. These efforts provided most of the necessary information on achievements of the national HIV and AIDS response and the challenges, including all required data that had been collected by various organisations and agencies. In addition, success of this process is indebted to all stakeholders from the public sector; civil society; funding and development partners; beneficiary population groups (including PLHIV) and Most at Risk Populations; who generously gave their time for interviews and also validated all draft reports.

Lastly but not list, the Government of Malawi would also like to thank the consultants who facilitated development of the report namely; Dr Mercy Bannerman and Dr Alister Munthali.

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ABBREVIATIONS

ANC	Antenatal Clinic
ART	Antiretroviral Therapy
BBSS	Biological and Behavioural Surveillance Survey
BLM	Banja La Mtsogolo
CBCC	Community Based Childcare Centre
CCI	Child Care Institution
CEDEP	Centre for Development of the People
CHBC	Community and Home Based Care
CoM	College of Medicine
CSO	Civil Society Organisation
FBO	Faith Based Organisation
FGD	Focus Group Discussion
FPAM	Family Planning Association of Malawi
GoM	Government of Malawi
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counseling
IEC	Information, Education and Communication
LSE	Life Skills Education
MARP	Most at Risk Populations
MBTS	Malawi Blood Transfusion Service
MCP	Multiple and Concurrent Partnerships
MDHS	Malawi Demographic and Health Survey
MGDS	Malawi Growth and Development Strategy
MoH	Ministry of Health
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NAC	National AIDS Commission
NAF	National HIV and AIDS Action Framework
NCPI	National Commitments and Policy Instrument
NGO	Non-Governmental Organisation
NPA	National Plan of Action
NSO	National Statistical Office
NSP	National Strategic Plan
OVC	Orphans and other Vulnerable Children
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
SADC	Southern Africa Development Community
SCTP	Social Cash Transfer Program
STI	Sexually Transmitted Infections
TWG	Technical Working Group
UNGASS	United Nations General Assembly Special Session
UNAIDS	United Nations Joint Program on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VPP	Voluntary Pooled Procurement
WHO	World Health Organisation

1. STATUS AT A GLANCE

1.1 Report writing process

The 2012 Malawi Global AIDS Response Progress Report is based on comprehensive data on both the status of, and response to the HIV and AIDS epidemic and the future directions as detailed in the 2011 United Nations Political Declaration on AIDS. The Declaration has planned for a dramatic reshaping of the AIDS responses by setting bold targets to achieve ***Zero new HIV infections, Zero discrimination*** and ***Zero AIDS-related deaths***. This progress report covers four areas, namely:

(i) Policy, laws and regulations (the NCPI);
(ii) The financial sources and expenditure;
(iii) Core indicators; and
(iv) A narrative summary with details on achievements and challenges in Prevention, Treatment, Care and Support; Impact Mitigation; Management, Coordination, Monitoring and Evaluation.

UNAIDS has developed guidelines for monitoring the progress towards achieving the targets set in the 2011 UN Political Declaration on AIDS and for the development and compilation of country progress reports consisting of a narrative report and also indicator data. There are 'Core indicators' for the Global AIDS Response Progress Report, with methods for collecting, constructing and analysing data. The guidelines also have discussions on indicator's strengths and weaknesses.

Based on the strategic plan, the nation's goals, objectives, actual achievements and challenges are the issues that are supposed to be contained in the progress report in addition to the assessment of whether or not the national AIDS response has had an impact on HIV prevalence and AIDS-related deaths, how large that impact has been, and who has benefited or not and to acquire an in-depth insight into the experiences gained by implementing partners and beneficiaries. The findings of the progress report will help to inform evidence-based policy making and contribute to future HIV and AIDS programming. The progress report for Malawi was coordinated by NAC, with support from the country's UNAIDS office. The report was compiled by two independent consultants who reviewed existing reports for the period 2010–2011, collected data on core indicators and had discussions on HIV and AIDS challenges and responses that need further action, and also areas needing scaling-up.

As part of compiling this report, discussions were conducted with various stakeholders in the national HIV and AIDS response. These discussions focused on their understanding of factors that influenced the development and implementation of HIV and AIDS interventions and implications and challenges experienced in the various thematic areas of the national response and how these challenges can be addressed. Consultations were held with Government of Malawi (GoM) officials at national and district levels, staff from the National AIDS Commission (NAC), civil society organisations (CSOs) including development partners and the UN agencies, the private sector and key population groups such as People Living with HIV (PLHIV), Men who have Sex with Men (MSM) and sex workers.

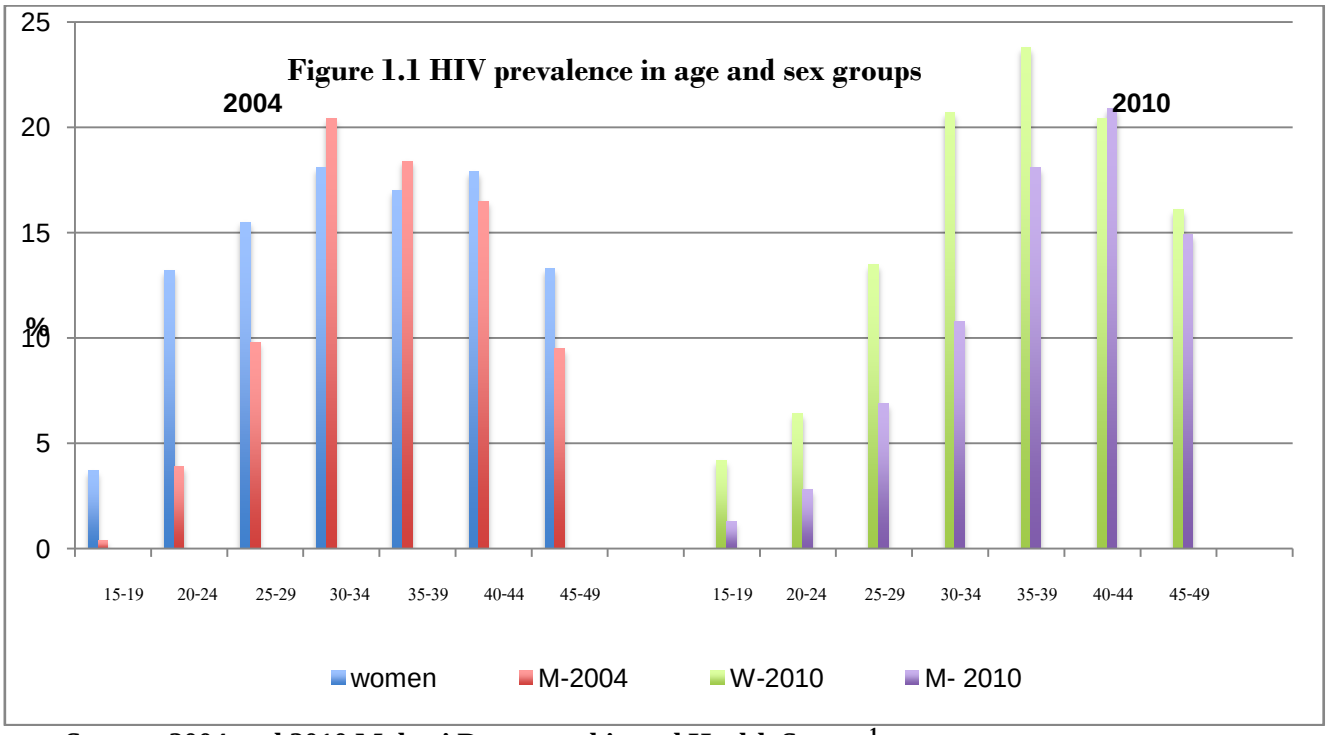
Annex 1 shows a detailed list of organisations and individuals who were consulted in this process. Because of time constraints, it was not possible for the consultants to meet other key informants at district level, other Government agencies and CSOs, particularly those agencies working in HIV and related interventions. This limitation was somewhat mitigated by contacts made during validation meetings for the National Commitment and Policy Instrument as well

as the narrative report. Annex 2 provides a list of persons and organisations who participated in the validation of the progress report.

1.2 The status of the epidemic

1.2.1. HIV prevalence in the general population and by socio-economic status

Since 1985 when the first case of AIDS was diagnosed at Kamuzu Central Hospital in Lilongwe, central Malawi, HIV prevalence increased significantly among persons aged 15-49: it rose to a peak of 16.4% in 1999 among persons aged 15-49, after which it started declining. The Malawi Demographic and Health Survey (MDHS) results show that in 2004 HIV prevalence in Malawi was estimated at 12.0% among persons aged 15-49 and in 2010 this decreased to 10.6%. This demonstrates that over the last decade or so the prevalence of HIV has been going down. In 2004 HIV prevalence was higher among women at 13.3% compared to men at 10.2%. In 2010 HIV prevalence was also higher among women at 12.9% compared to men at 8.1%. In 2004 HIV prevalence was highest in both men and women aged 30-34 at 18.1% in women and 20.4% in men. The lowest prevalence was for the age group 15-19 at 3.7% in women and 0.4% in men. In 2010, while the lowest HIV prevalence was still at age 15-19, for women, HIV prevalence was highest among those aged 35-39 (24%), which is six times the prevalence among women age 15-19 (4%). For men, the highest prevalence was among those aged 40-44 after which it dropped as can be seen in Figure 1.1 below.



Source: 2004 and 2010 Malawi Demographic and Health Survey[1]

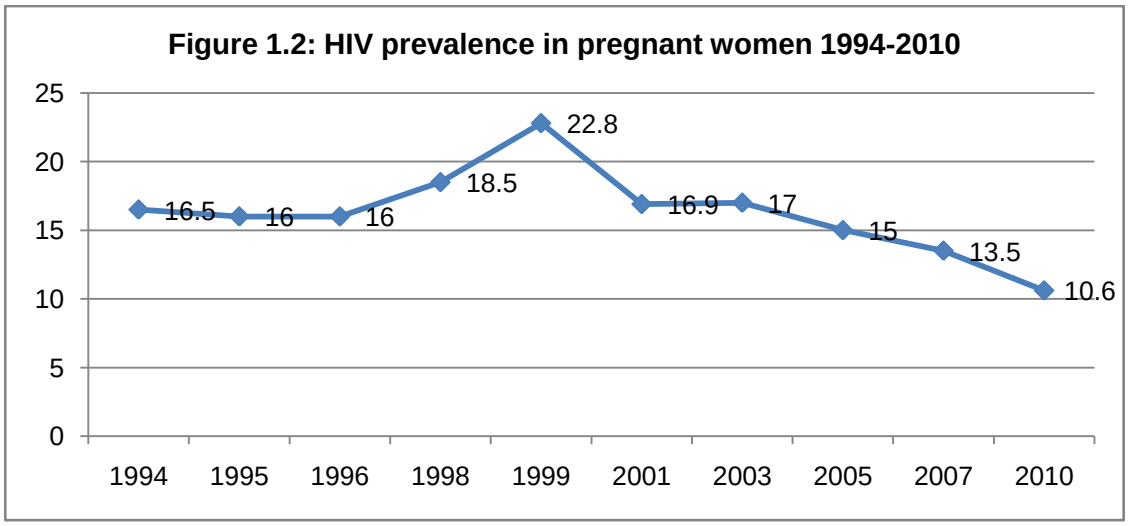
With regard to geographical location, HIV prevalence in urban areas is twice that of rural areas; 17% of women and men aged 15-49 in urban areas are infected with HIV compared to 9% in rural areas, with women in urban areas having an even high prevalence of 22.7% compared to their rural counterparts, with a prevalence of 10.5%. HIV prevalence in the southern region is twice that of the central and northern regions. HIV prevalence has decreased significantly in the Southern Region from 17.6% in 2004 to 14.5% in 2010 and also the

[1] National Statistical Office. (2005). *Malawi Demographic and health survey 2004.* Zomba: National Statistical Office; National Statistical Office. (2011). *Malawi Demographic and health survey 2010.* Zomba: National Statistical Office

northern region from 8.1% in 2004 down to 6.6% in 2010. In the central region, however, HIV prevalence has increased from 6.5% in 2004 to 7.6% in 2010.

HIV prevalence among young people has been on the decline over the period 2004-2010 though for young people aged 15-17 HIV prevalence has increased. The overall HIV prevalence for youth aged 15–19 in 2004 was 2.1%; 0.4% among men and 3.7% among women. In 2010 HIV prevalence among men and women aged 15-19 increased to 2.7%; 4.2% for females and 1.3% for males. HIV prevalence among young people aged 15-24 was estimated at 6% in 2004 and it was higher among women (9.1%) compared to men (2.1%). In 2010 the overall HIV prevalence among young people aged 15-24 decreased to 3.6% and, just as was the case in 2004, HIV prevalence was higher among women (5.2%) compared to men (1.9%). Both the 2004 and 2010 MDHS demonstrate that HIV prevalence among young people increased with increasing number of sexual partners; and for those who had concurrent partners, HIV prevalence was even much higher. For example HIV prevalence among young men aged 15-24 with concurrent partners was estimated at 6.4% while among those with one partner it was at 2.1%.

HIV prevalence increased significantly among pregnant women from 1985 when Malawi had the first case of AIDS and it reached a maximum of 22.8% in 1999. In 2001 HIV prevalence started declining. ANC data shows that prevalence of HIV in pregnant women has declined from 16.9% in 2001 to 10.6% in 2010 as can be seen in Figure 1.2 below.



Source: HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2010[2]

The MDHS also looks at the prevalence of HIV by socio-economic characteristics. Both the 2004 and 2010 MDHS show that HIV prevalence generally increases with the educational level. Persons with higher educational qualifications are the ones who are at higher risk of contracting HIV and yet they are the ones who are more knowledgeable about HIV, including how it is transmitted and prevented.

For both surveys, it is also evident that HIV prevalence is higher among the unemployed compared to those who are employed. HIV prevalence is also higher the higher the wealth quintile. Several socio-cultural factors influence the HIV epidemic in Malawi. Importantly, the low socio-economic status of women and gender inequalities constitute one of the major drivers of the epidemic in several ways for example barriers to accessing services, and also

[2] Ministry of Health. (2012). *HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2010*. Lilongwe: Ministry of Health

cultural practices such as widow inheritance, and gender-based violence (GBV) and poor bargaining power for condom use or faithfulness, a context which creates lower than expected prevention therefore is low condom use. Another factor contributing to high levels of HIV infections is the high prevalence of multiple and concurrent partnerships, which are due to low-levels of risk perception especially amongst young people and low self-efficacy in general.[3]

1.2.2 HIV prevalence among high risk groups[4]

In 2006 a Behavioural Surveillance Survey was conducted by the National Statistical Office (NSO) and it targeted high risk groups namely truck drivers, sex workers, fishermen, young vendors, male and female school teachers, male and female police officers and female border traders. All these high risk groups had much higher HIV prevalence than the national average of 14%, with sex workers having the highest prevalence of 70.7%. In a sex work study conducted by the Family Planning Association of Malawi (FPAM) in 2011, 23.1% of the sex workers reported they had HIV[5] and it should be emphasised that this percentage was based on self-reporting by the sex workers themselves. A survey conducted among men who have sex with men (MSM) in Blantyre in 2007 an HIV prevalence of 21.4% was found. The prevalence of HIV among MSM was higher than the general population[6]. However, recent studies looking at HIV prevalence among high risk groups are not available and there is no system which routinely collects such prevalence data. Periodic studies are required which will provide HIV prevalence among high risk groups and demonstrate Malawi's progress in its response to HIV and AIDS especially among such groups.

1.2.3 Mortality from AIDS

The epidemic has impacted negatively on individuals, households, communities and the nation. The impact on health was devastating in the past, with AIDS mortality increasing from 22,000 in 1985 to 76,000 in 2005. Substantial progress has been made in the provision of antiretroviral therapy (ART). In 2006, a total of 59,980 people had been started on ARVs By the end of 2011, 67% of all adults and children in need of ART were receiving ART. AIDS mortality has decreased dramatically to 43,000 in 2011 and this is due to the success in the scale-up of the ART program that Malawi has been implementing since 2004 with support from the Global Fund. There are approximately 600,000 orphans in Malawi due to HIV and AIDS[7]

1.2.4 Key socio cultural and economic drivers of the epidemic

- High prevalence of unprotected heterosexual sex, multiple and concurrent sexual partners and discordance in long-term couples- 80% of new infections occur among partners in stable relationships.

[3] Mwapasa V (2010). *Magnitude of and reasons for Multiple Concurrent Partnerships (MCP) and low condom use in Malawi despite high knowledge of HIV prevention methods: Triangulation of research findings from 1995 to 2010.* Lilongwe: National AIDS Commission

[4] Munthali, A et al. (2009). *Know your epidemic: where is it going?*.Lilongwe: National AIDS Commission

[5] Chizimba, R.M. and G.T. Malera. (2011). *Counting the uncatchables: a report of the situation analysis of the magnitude, behavioural patterns, contributing factors, current interventions and impact of sex work in HIV prevention in Malawi.* Lilongwe: Family Planning Association of Malawi and UNFPA.

[6] Umar, E., G. Trapence, W., Chibwezo, D., Nyadani, H., Doyle, C. Beyrer and S. Baral. (2007). *HIV prevalence and sexual behavior among men having sex with men in Malawi*. Lilongwe and Blantyre: CEDEP and CoM.

[7] Ministry of Health. (2012). *HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2010.* Lilongwe: Ministry of Health.

- Low and inconsistent use of condoms - resulting from poor supply chain systems and stock-outs, lack of demand, and inadequate behaviour change communication programs.
- Low rates of medical male circumcision.
- Low socioeconomic status of women and gender inequalities drive the epidemic by: (a) creating barriers to access to services; (b) adverse cultural practices; (c) gender based violence; and (d) poor bargaining power for condom use or faithfulness.
- Significant levels of transactional sex, particularly as it relates to income, social status, and material benefits.
- Poverty and poor overall health which increases vulnerability and susceptibility to HIV and AIDS.
- High level of knowledge on methods of infection is not reflected in prevalence data which suggests inadequate follow-up interventions. Comprehensive knowledge about HIV is still low at just above 40%.
- Despite a reduction in STI prevalence, prevention and treatment of STIs is still a critical issue in Malawi.
- Harmful cultural practices that expose people to the risk of HIV infection.
- Stigma and discrimination and other economic and social factors often result in PLHIV delaying treatment start up and, in some instances, dropping out of treatment.
- Difficulty reaching members of vulnerable populations and most at risk populations.
- Discriminatory legislation against MARP prevents effective prevention and treatment programs being implemented.

1.2.5 Overview indicator table

Table 1.1 below shows the overview indicator table for the national HIV response for the period 2010-2011. The table has indicators and where possible the target that was set for universal access to HIV and AIDS services and what was achieved in 2010 and 2011. It has sections on (1) reduction of sexual transmission of HIV in the general population, sex workers and MSMs; (2) reduction of the transmission of HIV among people who inject drugs by 50 per cent by 2015; (3) elimination of mother to child transmission of HIV by 2015 and substantially reduce AIDS- related deaths; (4) Having 15 million people living with HIV on antiretroviral treatment by 2015; (5) reduction of tuberculosis deaths in people living with HIV by 50% by 2015; (6) reaching a significant level of annual global expenditure (US$22-24 billion) in low and middle income countries; and (7) critical enablers and synergies with development sectors. Data collection is a problem especially for sex workers, MSMs and injection drug users and this explains why such data is not available. Specific studies are required to come up with HIV prevalence among these populations as was the case for the 2006 BBSS, but plans are underway for the implementation of another BBSS in 2012.

Table 1.1: Core indicators for Global AIDS response progress reporting for Malawi 2012

TARGETS	INDICATORS	2010 Universal Access Target	2010[8]	2011
Target 1: Reduce sexual transmission of HIV by 50% by 2014 *General population*	1.1: Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Males: 75 Females: 75	Males: 44.7 Females: 41.8	-
	1.2: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	-	Males: 22.1 Females: 14.3	-
	1.3: Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	Men: 18 Women: 5	Men: 9.2 Women: 0.7	-
	1.4: Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Men: 60 Women: 40	Men: 24.6 Women: 27.3	-
	1.5: Percentage of men and women aged 15-49 who received an HIV test in the past 12 months and know their results	Men: 75 Women: 75	Men: 31.3 Women: -	-
	1.6: Percentage of young people aged 15-24 who are living with HIV	Men: 12 Women: 12	Women: 8.2	-
Sex workers	1.7: Percentage of sex workers reached with HIV prevention programs	-	-	-
	1.8: Percentage of sex workers reporting the use of a condom with their most recent client[9].	-	-	-
	1.9: Percentage of sex workers who have received an HIV test in the past 12 months and know their results	-	-	29.5[10]
	1.10: Percentage of sex workers who are living with HIV	-	-	

[8] For 2010 the source of information is the 2010 MDHS whose results came out in 2011 unless specified.

[9] Chizimba, R.M. and G.T. Malera. (2011). *Counting the uncatchables: a report of the situation analysis of the magnitude, behavioural patterns, contributing factors, current interventions and impact of sex work in HIV prevention in Malawi.* Lilongwe: Family Planning Association of Malawi and UNFPA. **NOTE:** The study by Chizimba and Malera did not look at use of a condom with their most recent partner but whether they have ever used condoms or not. The study showed that all the sex workers interviewed had ever used condoms but that in some cases they did not use condoms for varied reasons.

[10] Chizimba, R.M. and G.T. Malera. (2011). *Counting the uncatchables: a report of the situation analysis of the magnitude, behavioural patterns, contributing factors, current interventions and impact of sex work in HIV prevention in Malawi.* Lilongwe: Family Planning Association of Malawi and UNFPA. **NOTE:** This "prevalence" is based on individual reports by sex workers and not on biomarkers.

TARGETS	INDICATORS	2010 Universal Access Target	2010[8]	2011
Men who have sex with men	1.11: Percentage of men who have sex with men reached with HIV prevention programs	-	-	-
	1.12: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	-	-	-
	1.13: Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	-	-	-[11]
	1.14: Percentage of men who have sex with men who are living with HIV	-	-	21.0[12]
Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015[13].	2.1: Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	N/A	N/A	N/A
	2.2: Percentage of people who inject drugs who report the use of condoms at last sexual intercourse.	N/A	N/A	N/A
	2.3: Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	N/A	N/A	N/A
	2.4: Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	N/A	N/A	N/A
	2,5: Percentage of people who inject drugs who are living with HIV	N/A	N/A	N/A
Target 3: Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS- related deaths	3.1: Percentage of HIV positive pregnant women who receive antiretroviral to reduce the risk of mother to child transmission	65	59	63
	3.2: Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth[14]	-	-	-
	3.3: Mother to child transmission of HIV (Modelled)	-	27.1	24.7
Target 4: Have 15 million people	4.1: Percentage of eligible adults and children currently receiving antiretroviral therapy	-	63	67

[11] Umar, E., G. Trapence, W., Chibwezo, D., Nyadani, H., Doyle, C. Beyrer and S. Baral. (2007). *HIV prevalence and sexual behavior among men having sex with men in Malawi*. Lilongwe and Blantyre: CEDEP and CoM. This study did not look at indicators 1.11-1.13. Another study is currently on-going among MSMs.
[12] This is based on the 2007 study by Umar et al.
[13] No studies have been done on this in Malawi.
[14] The HIV and AIDS Department in the Ministry of Health only started collecting this data in 2011.

TARGETS	INDICATORS	2010 Universal Access Target	2010[8]	2011
living with HIV on antiretroviral treatment by 2015	4.2: Percentage of adults and children with HIV known to be on treatment 12months after initiation of antiretroviral therapy	-	81	80
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015	5.1: Percentage of estimated HIV-positive TB cases that received treatment for both TB and HIV[15]	50	45	79
Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low and middle income countries	6.1: Domestic and international AIDS spending by categories and financing sources			
Target 7: Critical enablers and synergies with development sectors	7.1: National commitments and policy instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and monitoring and evaluation)			
	7.2: Proportion of ever married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	-	31	-
	7.3: Current school attendance among orphans and non-orphans aged 10-14	Male: 1.0 Female: 1.0	Male: 0.95 Female: 0.97	-
	7.4: Proportion of the poorest households who received external economic support in the last 3 months[16]	-	20	-

[15] These figures are from the National TB Control Program. The 2010 UA Progress Report shows that approximately 70% of HIV infected TB patients were receiving ART in first quarter of 2010 (MoH, Malawi ART Programme Report for 2010 First Quarter, p.7)

[16] Indicator based on **'% of very sick persons whose households received social/material support in the past 30 days'**, National Statistical Office. (2011). *Malawi Demographic and health survey 2010.* Zomba: National Statistical Office

1.3 The policy, strategic and legislative response

Malawi has developed a number of legislations, policies and strategic plans that guide HIV and AIDS interventions. Since HIV is a cross cutting issue, most of the sectoral policies and strategic plans have included sectoral responses to the HIV epidemic. This section discusses some key policies, strategic plans and legislative responses.

1.3.1 Malawi Growth and Development Strategy

In 2006, the country developed the Malawi Growth and Development Strategy (MGDS) which covered the period 2006-2011. This has since been replaced by MGDS II covering the period 2011-2016 in which HIV and AIDS is recognised as a cross cutting issue. The goal of the MDGS II as it relates to HIV is to prevent the spread of HIV infection and mitigate the health, socio-economic and psychosocial impacts of HIV and AIDS. The MGDS II identifies three medium term expected outcomes namely: (i) reduced HIV infection and transmission rate; (ii) improved dietary practices of PLHIV, OVCs and affected individuals and households; and (iii) improved quality of lives of PLHIV, OVC and affected individuals and households. The areas of emphasis for the MGDS II include promoting HIV testing and counselling (HTC); (ii) promoting Prevention of Mother to Child Transmission (PMTCT) of HIV; (iii) capacity building for HIV management; promoting advocacy and awareness campaigns; (iv) promoting access to quality Community Home-Based Care (CHBC) (v) promoting support to PLHIV, OVCs and affected individuals and households; and (vi) increasing access to ARVs and treatment of opportunistic infections; among other interventions. The MGDS II was developed through wide consultations and involved CSOs, development partners and public as well as private sectors.

1.3.2 National HIV and AIDS Strategic Plans

The National HIV and AIDS Action Framework (NAF) guided the development and implementation of HIV and AIDS interventions for the period 2005-2009. The goal of the NAF was to prevent new HIV infections and to provide access to treatment for PLHIV, and to mitigate the health, socioeconomic, and psychosocial impact of HIV on individuals, families, communities, and the nation. Following the midterm review, the NAF was extended for the period 2010-2012 (now referred to as the extended NAF) and was submitted to the Global Fund as a strategic application. The 7 priority areas in the extended NAF were: (i) Prevention and behaviour change, (ii) Treatment Care and Support, (iii) Impact mitigation, (iv) Mainstreaming and Decentralisation, (v) Research, Monitoring and Evaluation, (vi) Resource mobilization and utilization, and (vii) Policy and Partnerships.

A new national strategic plan (NSP) 2011-2016 replacing the extended NAF, is in the process of development and a final draft was produced in December 2012. The NSP provides strategic direction for next the 5 years, and aims to reduce new infections by 20% and AIDS deaths by 8% including a 50% reduction in children's deaths. The NSP will guide all GoM ministries and departments, CSOs, development partners and the private sector, building on work done in the past decades. It is informed by the findings of the Community and Stakeholder consultations on the National HIV and AIDS Policy Review conducted in March 2010, the MGDS II, the Health Sector Strategic Plan (HSSP) 2011–2016; and the National HIV Prevention Strategy 2009-2013 and developments in medical and scientific knowledge.

The overall goal of the 2012-2016 NSP is to prevent the further spread of HIV infection, promote access to treatment for PLHIV and mitigate the health, social-economic and psychosocial impact of HIV and AIDS on individuals, families, communities and the nation.

The costed NSP prioritizes the same areas as in the Extended NAF, including sustainability and effectiveness of the HIV and AIDS response.

The NSP was also informed by the National HIV Prevention Strategy which was developed in 2009. It addresses key gaps in HIV prevention programming in Malawi's national HIV response. The Prevention Strategy calls for a strategic focus on the main drivers of the epidemic to reduce sexual transmission. This includes a concerted effort to reduce multiple and concurrent sexual partnerships, identifying discordant couples and reducing HIV transmission between them. The Strategy also highlights new areas of concentration namely male circumcision, HIV prevention initiatives for young people, condom programming, gender programming, HIV prevention for most at risk populations (MARPs) and promotion of mutual faithfulness among couples. The national strategy also presents cross-cutting issues such as gender, culture, human rights, legal and behaviour change interventions which should be addressed in order to create an enabling environment to change the population's behaviours and sustain positive ones.

National efforts, coupled with support from various donors and development partners, have contributed to a significant scaling up of prevention, care and treatment programmes aimed at combating the epidemic. Similarly, efforts have been made to strengthen monitoring and evaluation systems for HIV response activities as the country seeks to continue supporting evidence-based decision making for a more efficient and effective response.

1.3.3 National HIV and AIDS Policy

In 2003 Malawi developed the National HIV and AIDS Policy and this was a major milestone in the national response to the HIV and AIDS epidemic. The policy incorporated most of the international policy principles at the time. It laid down the administrative and legal framework for all interventions. The national goal as stated in the policy was "to reduce infections and vulnerability; to improve provision of treatment, care and support for PLHIV; and to mitigate the socio-economic impact of the epidemic. It is now 9 years since the national policy was developed. A new HIV and AIDS policy is being developed[17]. In the final draft dated December 2011, the policy renews its commitment to spearhead the National HIV and AIDS Response based on the ***"three ones principle"*** and ***"the three zeros"*** (zero new HIV infections, zero discrimination and zero AIDS related deaths) with increased GoM stewardship and ownership, respect for protection and fulfillment of relevant human rights and fundamental freedoms in accordance with the Constitution of the Republic of Malawi and existing international human rights standards. The Policy will operate within existing legal and policy frameworks at different levels.

1.3.3.1 The Constitution of Republic of Malawi

The National HIV and AIDS Policy has been aligned with the Constitution of the Republic of Malawi under Principles of National Policy and Human Rights which provides for relevant and specific rights, such as, the rights to life, dignity, prohibition of cruel, inhuman and degrading treatment and torture, prohibition of discrimination, privacy and confidentiality, protection from violence, harassment and abuse, freedom to participate in a culture of choice, right to develop, freedom of expression, the right to participation, access to information, access to effective legal remedies and equality before the law.

1.3.3.2 Other legislation

[17] Final National HIV AIDS Policy Dec 2011

Currently there is no specific law that deals with HIV and AIDS issues in Malawi. There is however a report of the Law Commission on HIV and AIDS legislation. Discussions are however underway to discuss some contentious issues (such as mandatory HIV testing as contained in the report by the Law Commission on AIDS). The freedoms and liberties conferred to by the Constitution do not have operative legislation aimed at ensuring protection, participation and empowerment of individuals within the context of the HIV and AIDS epidemic. There is also a gap in the domestication of international instruments which are aimed at re-enforcing domestic tools. As such, most violations go unpunished as there is absence of tools to effectively assist public institutions entrusted with enforcement of legislation and rights in general and PLHIV and other vulnerable groups, particularly women and young girls who are often left without remedies. In very broad terms, penal legislation criminalizes conduct that puts the general population at risk of infection, such as rape, defilement and other sexual assaults, unlawful wounding and other grievous bodily harm conduct. The new National HIV and AIDS Policy is aligned with other pieces of legislation such as the Penal Code, the Public Health Act, the 2000 Employment Act, the Occupational Safety, Health and Welfare Act, the Workers Compensation Act, the Child Care, Justice and Protection Act and Deceased Estates (Wills, Inheritance and Protection) Act. All these pieces of legislation prohibit the practice of discrimination. The development of the HIV and AIDS legislation that is in line with human rights principles and its subsequent passing into law by Parliament is long overdue as it will help to address legal issues surrounding HIV and AIDS and related issues.

1.3.3.3 International Instruments

The Policy has also been informed or guided by other HIV and AIDS and related instruments at regional and global levels, such as, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of all Forms of Discrimination Against Women, the Convention on the Rights of the Child, the African Charter on Human and Peoples Rights and its relevant protocols, the SADC Protocol on Gender and Development, the 2000 UN Declaration of Commitment on HIV and AIDS.

2. OVERVIEW OF THE AIDS EPIDEMIC

This section covers the detailed status of prevalence of HIV in Malawi during the period January 2010 to December 2011 based on the 2010 HIV sentinel surveillance and 2010 MDHS. The source of information for all data provided is included. Sentinel surveillance in antenatal clinics has been the primary source of data for monitoring trends of HIV and syphilis in Malawi despite known limitations associated with surveying pregnant women for national HIV prevalence estimation. ANC sero-surveys are still a valuable and convenient source of information on the current HIV epidemiological situation. The MDHS offers the opportunity to better understand the magnitude and patterns of HIV infection within the general reproductive-age population not included in sentinel surveillance surveys, especially for men age 15-54.

2.1 HIV prevalence based on the 2010 MDHS

Data from the 2010 MDHS shows that HIV prevalence in Malawi is still high and close to one million people are living with HIV. The current data also continues to show regional and rural and urban disparities and, that over the years, HIV prevalence has been going down.

2.1.1 HIV prevalence by age and sex

In 2010, 10.6% of adults aged 15-49 in Malawi were infected with HIV. Among women of the same age group (15-49), HIV prevalence was estimated at 12.9%, while among men it was at 8.1%. HIV prevalence increased with age for both men and women. For women, HIV prevalence is highest among those aged 35-39 (23.8%), which is six times the prevalence among women aged 15-19 (4.2%). For men, the prevalence increased sharply from 1.3% among those aged 15-19 to 20.9% among those aged 40-44 after which it drops as can be seen in Table 2.1 below.

Table 2.1: HIV prevalence among men and women (2010 MDHS)

Age	Women		Men		Total	
	Percentage HIV+	**Number**	**Percentage HIV+**	**Number**	**Percentage HIV+**	**Number**
15-19	4.2	1,545	1.3	1,703	2.7	3,248
20-24	6.4	1,401	2.8	1,176	4.7	2,577
25-29	13.5	1,407	6.9	1,041	10.7	2,448
30-34	20.7	937	10.8	885	15.9	1,821
35-39	23.8	806	18.1	757	21.0	1,563
40-44	20.4	533	20.9	506	20.7	1,039
45-49	16.1	462	14.9	429	15.5	891
Total 15-49	12.9	7,091	8.1	6,497	10.6	13,588
50-54	N/A[18]	N/A	13.1	341	N/A	N/A
Total men 15-54	**N/A**	**N/A**	**8.4**	**6,839**	**N/A**	**N/A**

Table 2.1 shows that HIV prevalence is much higher among women than men for those aged 15-44. After this age, HIV prevalence is slightly higher in men than women.

2.1.2 HIV Prevalence by geographic characteristics

HIV prevalence is still higher in urban areas than in rural areas as was the situation in 2004. Prevalence in urban areas is twice that of rural areas: In 2010, 17% of women and men aged 15-49 in urban areas were infected with HIV compared to 9% in rural areas. The same pattern is observed for young women and men in these areas. The difference is very pronounced among young women, as women living in urban areas are almost three times infected with HIV (11.0%) than their rural counterparts (4%). Figure 2.1 below shows HIV prevalence by geographical area:

[18] N/A = Not applicable in the MDHS women aged 15-49 and men aged 15-54 who were interviewed and tested, to attain the percentage HIV positive, by age in Malawi 2010.

Figure 2.1: Prevalence of HIV by region

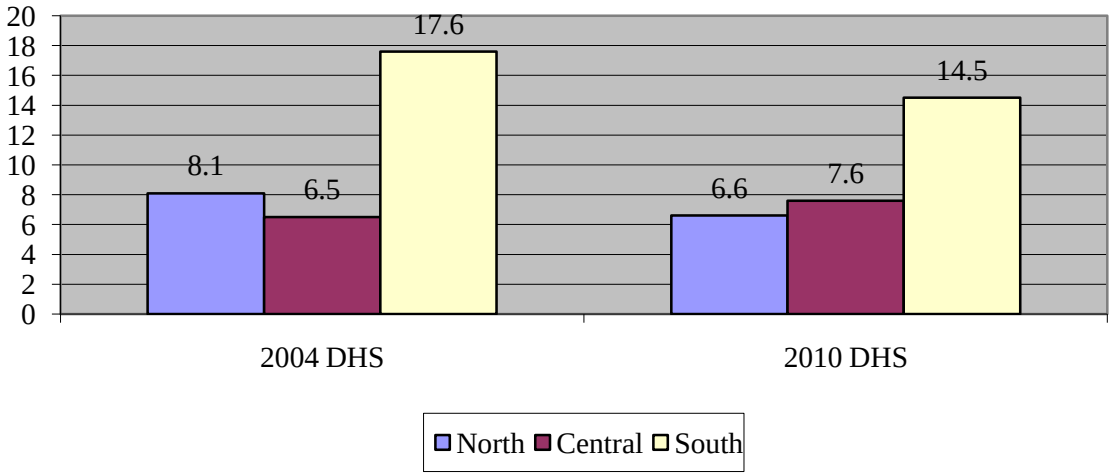


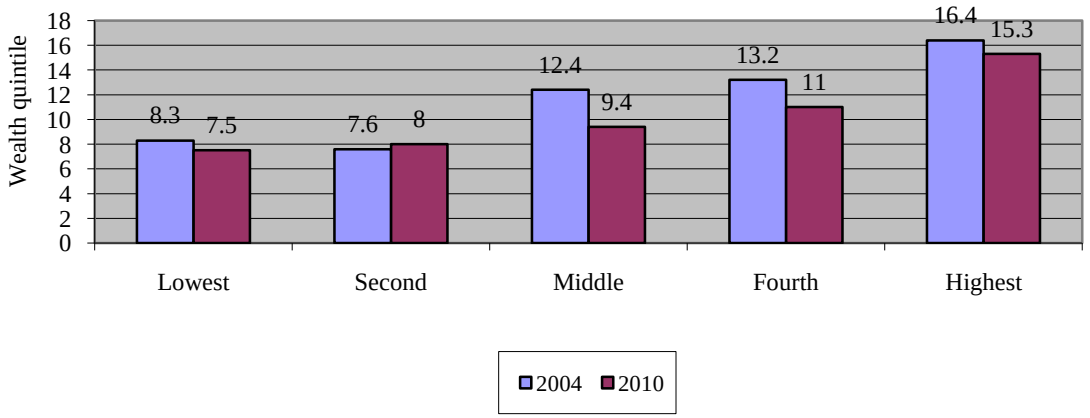
Figure 2.1 shows that the Southern Region had the highest HIV prevalence (15%) in 2010, which is about twice that of the Central (8%) and Northern Regions (7%). Prevalence varies across regions as well as prevalence within regions. It is also clear that overall, HIV prevalence declined between 2004 and 2010 and in both the South and the North but for the Centre prevalence increased slightly.

2.2.3 HIV prevalence by socio-economic status

Both the 2004 and 2010 MDHS show that HIV prevalence generally increases the higher the educational level. Persons with higher educational qualifications are the ones who are at higher risk of contracting HIV and yet they are the ones who are more knowledgeable about HIV including how it is transmitted and prevented.

Figure 2.2 below shows HIV prevalence by wealth quintile:

Figure 2.2: HIV Prevalence by socio-ecocomic status



Over the period 2004-2010 HIV prevalence went down in all wealth quintiles with an exception of the second one. It is also evident that HIV prevalence increases the higher the wealth quintile. This implies that people who are wealthier are at more risk of contracting HIV.

2.2.4 HIV prevalence by marital status

Table 2.2 below shows HIV prevalence by marital status for both the 2004 and 2010 MDHS:

Table 2.2: HIV prevalence by marital status

Marital status	Women	Men	Total	Women	Men	Total
	2004			2010		
Currently in Union	12.5	14.1	13.2	11.7	11.5	11.6
Widowed	37.4	-	35.6	50.1	20.7	49.8
Divorced/separated	25.5	16.0	23.3	24.8	-	23.9
Never in union	5.3	1.8	3.0	4.2	2.1	2.8

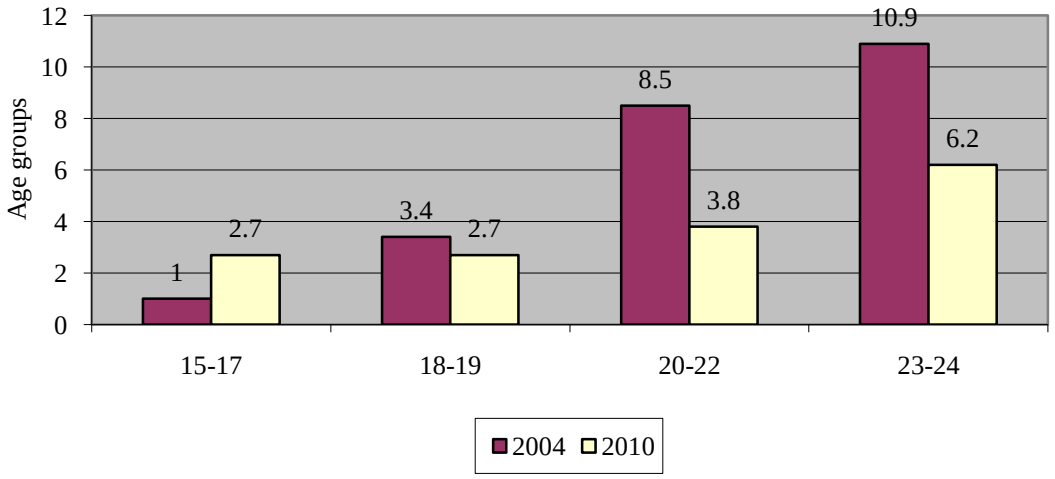
Table 2.2 above shows that for those who are currently in union or have never been in union, HIV prevalence decreased during the period 2004-2010 and that not much change occurred in those who were either divorced or separated. For those who were widowed the situation is, however, different: in 2004, 37.4% of the widowed women were found HIV+ and this increased to 50.1% in 2010. Overall, 23.3% of the widowed persons were HIV positive and this increased to 49.8% in 2010. The 2010 ANC sero-surveillance survey also shows that among pregnant women attending ANC, those who were widowed had the highest HIV prevalence at 41.4% and this was followed by those who were divorced (18.7%), married (11.8%) and then those who never married at 9.1%.

The high prevalence of HIV among the widows can be explained by the wide availability of ARVs in Malawi which have played an important role in survival of PLHIV. Both surveys also show that HIV prevalence in polygymously married men and women is higher than those who are in non-polygymous marriages. The 2010 MDHS and the 2010 HIV sero-prevalence survey show that the higher the number of lifetime partners, the higher the HIV prevalence: e.g. the 2010 MDHS shows that for those who had only one lifetime partner HIV prevalence was at 5.7% while for those with 10+ partners it was at 25.4%.

2.2.5 HIV prevalence among the youth aged 15-24

HIV prevalence among young people aged 15-24 was estimated at 6% in 2004 and it was higher among women at 9.1% than men (2.1%). In 2010, the overall HIV prevalence among young people decreased to 3.6% and, just as was the case in 2004, HIV prevalence was higher among women (5.2%) compared to men (1.9%). HIV prevalence was higher in urban compared to rural areas in both years. Figure 2.3 below shows HIV prevalence among young people by age group:

Figure2.3: HIV prevalence among youth



The overall picture is that among young people HIV prevalence has been on the decline over the period 2004-2010. As can be seen in Figure 2.3 above except for the young people aged 15-17 where HIV prevalence increased, for the older age groups there was some significant decrease in HIV prevalence. It is also evident in both years that in general, HIV prevalence increases with age. The 2004 and 2010 MDHS also show that HIV prevalence among young people increased the higher the number of sexual partners and for those who had concurrent partners HIV prevalence was even much higher. For example HIV prevalence among men aged 15-24 with concurrent partners was estimated at 6.4% while among those with one partner it was at 2.1%.

2.2.6 HIV prevalence among high risk groups

2.2.6.1 HIV prevalence among high risk groups based on 2006 BBSS

During the 2006 BBSS a number of high risk groups were identified and HIV testing among respondents was one of the key activities that was conducted. The high risk groups that were identified at the time were sex workers, long distance truck drivers, secondary and primary school teachers, police officers, estate workers, fishermen, male vendors and female border traders. The *Know Your Epidemic Report* gives the rationale for the choice of these *high risk groups*. Table 2.3 below shows the HIV prevalence among these high risk groups. In 2006 when the BBSS was being conducted HIV prevalence in Malawi was estimated at 14%. All the high risk groups had much higher HIV prevalence than the national average, with sex workers having the highest prevalence at 70.7%. While these groups were defined as high risk in 2006, some recent studies have also shown that there is a need to revisit the definition of high risk groups. The UNAIDS modes of transmission study has shown that clients of sex workers, partners of clients of sex workers and MSMs are some of the people who should also be included in high risk groups. Since 2006 there has not been any other BBSS conducted among high risk groups, hence up to date information for the period 2010-2011 as required for this reporting is not available. However, another BBSS is currently underway in 2012.

Table 2.3: HIV prevalence among high risk groups

Sub groups	**HIV Prevalence rate (%)**
Female sex workers	70.7
MSM[19]	214
Primary school teachers	
Male	24.2
Female	21.6
Secondary school teachers	
Male	17.6
Female	16.7
Female border traders	23.1
Male vendors	7.0
Truck drivers	14.7
Fishermen	16.6
Estate workers	
Male	19.5
Female	17.1
Police	
Male	24.5
Female	32.1

2.2.6.2 HIV prevalence among MSM

The BSS did not include MSM. In 2007, a small survey was conducted among 200 MSM and it was found that 21% of them were HIV positive. Other studies are still on-going but the results are not yet out. The 2007 survey also found that most of the participants had secondary or higher levels of education, most were aged between 18 and 25 and that a significant proportion had concurrent relationships with men or girls[20]. The prevalence of HIV among MSMs was higher than the general population at the time in 2007. This study had

[19] The 2006 BSS study did not include MSM. The prevalence of HIV among MSM comes from another study conducted by CEDEP, College of Medicine and Johns Hopkins University.

[20] Umar, E., G. Trapence, W., Chibwezo, D., Nyadani, H., Doyle, C. Beyrer and S. Baral. (2007). *HIV prevalence and sexual behavior among men having sex with men in Malawi*. Lilongwe and Blantyre: CEDEP and CoM.

methodological challenges as snowballing was used to find respondents and the sample size was small. A more representative survey is therefore required.

2.2.6.3 HIV prevalence among sex workers and access to condoms

In 2011 a study was commissioned by the Family Planning Association in Malawi (FPAM) supported by the United Nations Population Fund (UNFPA) on sex workers. The most frequently mentioned mode of accessing condoms among sex workers was through buying (81.5%) followed by getting them free of charge from public hospitals (44.5%), getting free condoms from NGO-affiliated health centers/clinics (16.8%) and getting them free of charge from places of entertainment (8.8%). The most frequently mentioned place where respondents said they buy condoms were: bottles stores (57.4%), shops/hawkers (54.8%), salons (2.8%), rest houses (2.3%), and private clinics (1.6%). For those who indicated that they had previously bought condoms, 87.4% bought male condoms, 0.5% female condoms and 12.1% both.

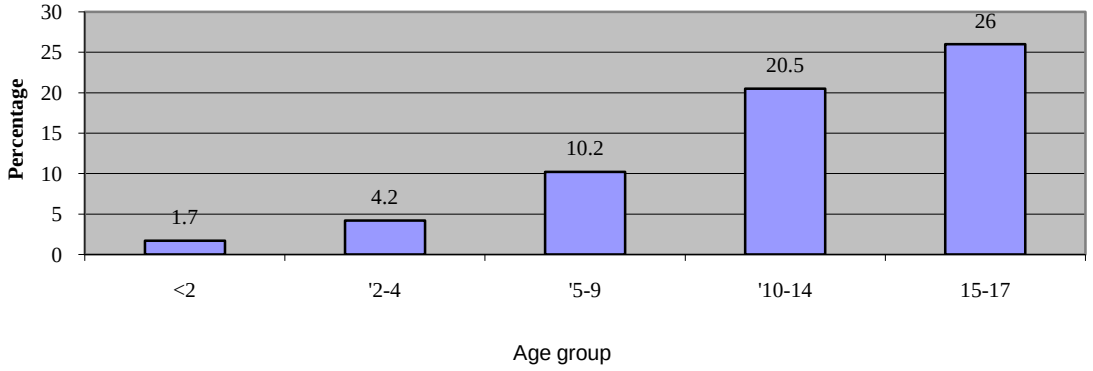
The FPAM study did not include any bio-markers, so there was no HIV testing. It relied on commercial sex workers self reporting their HIV status. This study estimated that there are 19,295 sex workers in Malawi. Thirty percent (29.5%) of the sex workers interviewed reported having received an HIV test 12 months prior to the study. Out of all the sex workers interviewed, 23.1% of them reported that they were HIV positive[21]. There is therefore a need for representative studies to be designed that will establish the prevalence of HIV among high risk groups. These high risk groups also need to be defined based on the studies that have been carried out in Malawi.

2.2.7 Orphans and other vulnerable children

Orphanhood is not a new phenomenon in Malawi but due to the HIV and AIDS epidemic the number of orphans has increased tremendously. The first case of AIDS was diagnosed in Malawi in 1985 and a total of 17 cases were identified by December that year. A lot of young and productive men and women have died and continue dying leaving behind children and elderly men and women who cannot take care of themselves. Earlier, at the start of the epidemic, nearly 100,000 people were dying annually. The 2010 ANC sero-surveillance survey has shown that this number has been reduced to about 48,000 deaths per annum. At the beginning of the epidemic the numbers of orphans were low but this has been increasing. In 2004, about 12% of children aged below 18 years lost their father, 6.0% lost their mother and 4% lost both parents. In 2010, about 12.6% of the children aged less than 18 years were orphans. Figure 2.4 below shows the orphanhood by age group:

[21] Chizimba, R.M. and G.T. Malera. (2011). *Counting the uncatchables: a report of the situation analysis of the magnitude, behavioural patterns, contributing factors, current interventions and impact of sex work in HIV prevention in Malawi.* Lilongwe: Family Planning Association of Malawi and UNFPA.

Fig 2.4: Orphans by age



In 2010 the number of orphans increased by age group: among children aged less than 2, 1.7 were orphaned and this increased to 26% among those aged 15-17. According to the 2010 ANC sero-surveillance survey, there were 576,458 children who were orphaned due to AIDS in Malawi in 2010, and in 2011 this increased to 612,908 after reaching a maximum number of 623,466 in 2008.

Vulnerability due to AIDS has also increased, with children living in households with chronically ill parents or having lost one of their chronically ill guardians. Inevitably, owing to an overstretched social fabric, some of these orphans and vulnerable children have been left destitute or without proper care and support which leaves them at risk of abuse and exploitation that may ultimately bring them into the HIV and poverty vicious cycle. Overall, 17% of children aged below 18 years were either orphans and/or vulnerable. Orphanhood and vulnerability has not significantly changed since 2004, as can be seen in Table 2.4 below, where there were slight decreases in children who were either orphans and/or vulnerable since 2004.

Table: 2.4 Percentage of children who are orphans and/or vulnerable

Characterises		**2004**	**2010**
Age	**0 - 4**	8.8	7.1
	5 - 9	17.1	14.8
	10 - 14	26.4	24.9
	15 - 17	30.1	30.9
Sex	**Male**	18.1	17.4
	Female	17.8	16.5
Residence	**Urban**	18.5	17.2
	Rural	17.9	16.9

Source: 2004 and 2010 Malawi Demographic and Health Survey[22]

[22] National Statistical Office. (2011). *Malawi Demographic and health survey 2010.* Zomba: National Statistical Office

2.2.8 Incidence rates

HIV incidence was estimated at 0.54% in 2010. Analysis by health zones showed that most new infections in 2011 occurred in Central West and both of the Southern Zones (South East and South West). HIV incidence was highest in the southern region and ranged from 0.24% in central east to 0.77% in the south west. The number of PLHIV was also estimated to be higher in these three zones compared to the central east and the northern zones. HIV incidence was projected to continue declining in the next five years. The total number of new HIV infections was 52,000 in 2010 (33,000 adults and 19,000 children) and 42,000 total new infections in 2011 (30,000 adults and 12,000 children). HIV incidence among adults aged 15-49 was 0.52% in 2010 and 0.46% in 2011[23].

2.3 Prevalence from HIV sentinel surveillance

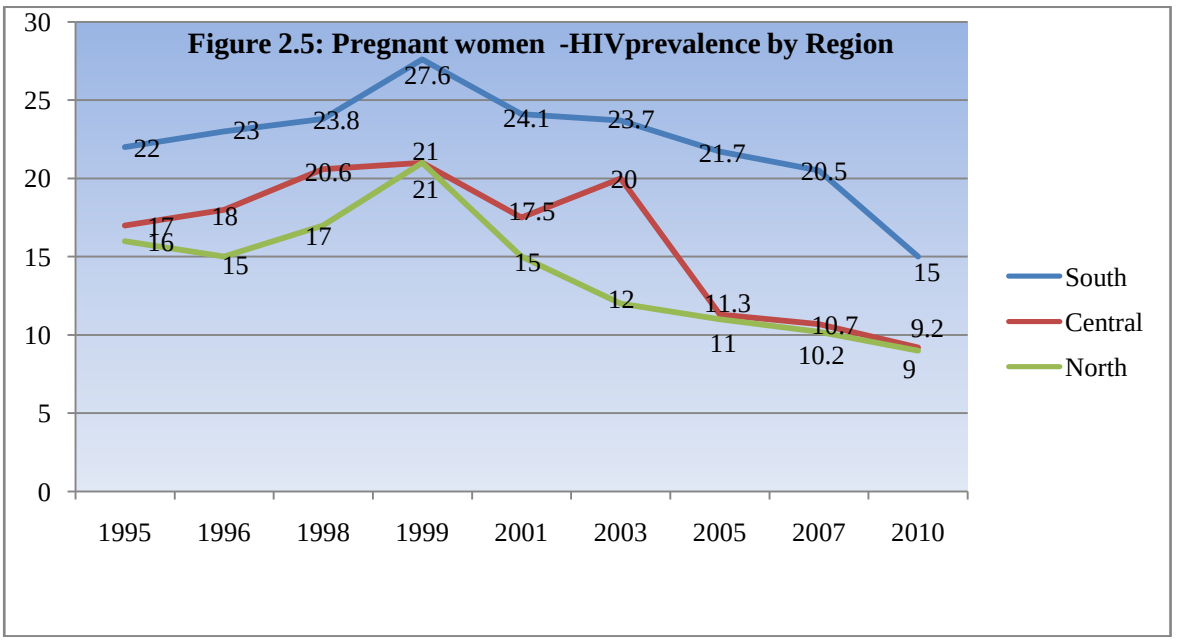
In Malawi much of the information on the national HIV prevalence estimates is derived from the HIV sentinel surveillance surveys. Surveillance data provides results specific to women attending antenatal clinics (ANCs) but this data is used to estimate prevalence in the general population including men**.** The 2010 sentinel surveillance survey was a cross sectional survey targeting women attending selected antenatal clinics in Malawi. While initially 19 health facilities were being used, in 2007 a decision was made to have 54 sites for the HIV sentinel surveillance survey. Analysis of the data was done using STATA to calculate HIV prevalence and other important demographic factors. Spectrum was used to project and estimate the national HIV prevalence in the general population and to estimate ART needs.

2.2.1 HIV Prevalence of pregnant women

There were a total of 23,788 pregnant women who participated in the 2010 HIV sentinel surveillance survey. The median HIV prevalence in pregnant women was **10.6%** demonstrating that prevalence of HIV in pregnant women has declined from 12.6% in 2007. HIV prevalence increased with increasing age up to the age group 30–34. The lowest prevalence was in those aged below 15 years (1.5%) with those in the 30–34 age group having the highest prevalence (18.6%). Prevalence was 5.8% in those aged 15-19 and 9.7% in those aged 20-24 years. Declining HIV prevalence trends have also been observed in each region in this country. In the central and northern region HIV prevalence among pregnant women has declined from about 10% in 2007 to 9% in 2010 but much more declines were observed in the southern region where prevalence declined from 20.5% in 2007 to about 15% in 2010. Despite observing only a modest change of HIV prevalence in central region between 2007 and 2010, the trend suggests that HIV prevalence in the central region is declining rapidly[24].

Figure 2.5 below shows the prevalence of HIV among pregnant women between 1996 and 2010 based sentinel surveillance surveys:

[23] Ministry of Health. (2012). *HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2010*. Lilongwe: Ministry of Health.
[24] Ministry of Health. (2012). *HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2010*. Lilongwe: Ministry of Health.



Just as HIV prevalence in the general population, HIV prevalence among pregnant women reached a peak in 1999 after which it started going down. At regional level, after 1999 there has been a decline in prevalence in the north and south but in the central region in 2003 there was an increase before starting to go down again. The 2010 HIV sentinel surveillance survey shows that pregnant women who had never been married had the lowest prevalence at 9.1%, and widowed women had the highest at 41.4%. Among those who had ever been married, prevalence differed by number of times married. HIV prevalence increased with increasing number of times the person got married: the prevalence among those who were married twice was more than twice that of those who married once. The prevalence in the never married and in those who were married once was the same.

2.2.2 Estimation of national HIV prevalence from ANC data and Spectrum[25]

National HIV prevalence and its demographic impacts were estimated and projected from HIV prevalence from the sentinel surveillance data in pregnant women attending ANC, using recommended methods by UNAIDS and partners. HIV surveillance and program (ART coverage) data were entered into SPECTRUM to generate a national adult prevalence curve over time. Data was entered by location i.e. urban and rural. The combined national prevalence curve was weighted according to the population sizes in the different locations. HIV prevalence from the MDHS for 2004 and 2010 that included HIV testing, were used to calibrate the ANC based prevalence.

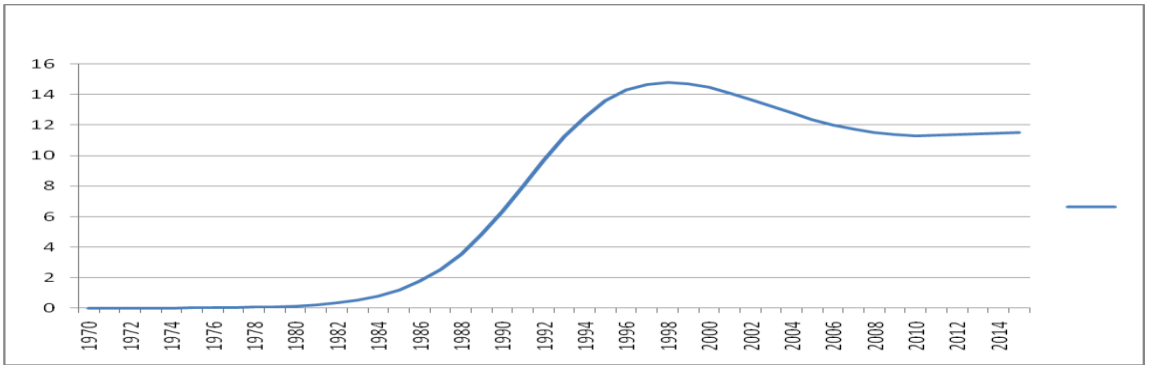
2.2.2.1 Projection of national HIV prevalence and impacts

The national HIV prevalence curve generated together with population estimates and parameters, epidemiological assumptions and ART program and PMTCT coverage data were used to calculate the numbers of adults and children living with HIV and AIDS, number of pregnant women infected with HIV, AIDS related deaths, new HIV infections and treatment needs[26]. The 2010 ANC sentinel surveillance survey found that HIV prevalence in the general population was estimated at 10.5%. This survey also estimated that in 2011 HIV prevalence would be at 10.03%. Figure 2.6 below shows HIV prevalence from the 1980s up to 2010 and

[25] Ministry of Health. (2012). *HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2010*. Lilongwe: Ministry of Health.
[26] Ministry of Health. (2012). *HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2010*. Lilongwe: Ministry of Health.

projections up to 2014. At the beginning of the epidemic in the mid 1980s HIV prevalence was very low and started increasing and that in 1998 or thereabouts the prevalence reached its peak and then started declining possibly due to the impact of the HIV interventions.

Figure 2.6: Trends in national HIV prevalence[27]



Prevalence from the 2010 sentinel surveillance survey is very similar to prevalence in the general population found using the 2010 MDHS (10.6%). In 2010 the total number of HIV positive adults and children was 923,000 with 181,999 HIV+ children (0-14yrs). In 2011 the total number of adults and children was 917,000 of which 176,000 were 0-14 year old children.

2.2.2.2 AIDS mortality

An effective health sector response to HIV based on increased ART uptake has dramatically reduced deaths due to HIV in Malawi. In 2010, AIDS mortality was 53,000 and 46,000 died in 2011. The sentinel surveillance survey also estimated that in 2010 there were 612,908 children in Malawi who were orphaned due to HIV related deaths and projected that this figure will be declining to 452,576 by 2015.

2.2.3 Current drivers of the HIV and AIDS epidemic in Malawi

Most new infections occur within long-term stable sexual relationships. The HIV Prevention Strategy has identified key factors that facilitate the spread of HIV, including:

- Multiple and concurrent sexual partnerships;
- Discordancy in long-term couples (one partner HIV-negative and one positive) where protection is not being used;
- Low prevalence of male circumcision;
- Low and inconsistent condom use;
- Suboptimal implementation of HIV prevention interventions within clinical arenas including the provision of HTC;
- Late initiation of HIV treatment; and
- TB/HIV Co-infection[28].

The following cross-cutting determinants have been noted in the HIV Prevention Strategy:

[27] Ministry of Health. (2011). *HIV and Syphilis Sero–Survey and National HIV Prevalence and AIDS Estimates Report for 2010*. Lilongwe: Ministry of Health.

[28] Office of the President and Cabinet. (2011). *National HIV and AIDS Strategic Plan 2012-2016*. Lilongwe: Office of the President and Cabinet.

- Transactional sex related to income and other social and material benefits;
- Gender inequalities/imbalances including masculinity;
- Harmful cultural practices; and
- Stigma and discrimination.

3. NATIONAL RESPONSE TO THE HIV and AIDS EPIDEMIC

Interventions that address priority areas of the national response to the HIV and AIDS epidemic have been continued during the period 2010-2011. The national response was guided by the extended NAF and operationalized through Integrated Annual Work Plans (IAWPs). The interventions are largely focused on curbing multiple and concurrent partnerships by increasing HIV comprehensive knowledge amongst most at risk as well as the general population and intensifying safer sex education. In addition, they focus on scaling up the ART programme as well as mitigating the socio-economic impact of the HIV and AIDS epidemic. Commendable processes have been followed up to enhance implementation of the strategies in all areas of the national response in the two years under review. However, implementation in some areas was a bit slow or diminishing while quite a fair amount was effective and progressive.

3.1 The Institutional and Funding Environment

3.1.1 The Institutional Framework

3.1.1.1 The Office of the President and Cabinet-Department of Nutrition, HIV & AIDS

The President is the Minister Responsible for HIV and AIDS, and provides overall leadership on matters of HIV and AIDS for Malawi. The Department of Nutrition, HIV and AIDS (DNHA) in the Office of the President and Cabinet (OPC) is the lead Government agency in the national response to Nutrition and HIV and AIDS, responsible for policy, oversight and high level advocacy. DNHA is thus central for policy issues and overall guidance for all levels of the national response. The Council level response therefore relies on the DNHA for policy development and guidance.

3.1.1.2 The National AIDS Commission

The National AIDS Commission (NAC) was established by the Malawi Government under a trust deed to provide leadership and coordination for the national response to HIV and AIDS in Malawi. It is governed by a Board of Commissioners led by the Chairman who is appointed by the President. The other members are selected from all constituencies namely: private, public, faith, civil society, youth and PLHIV. Major roles include reviewing and approving NAC policies and procedures, annual work programme and hiring of secretariat executive staff. NAC has specific roles which include the following

- Guiding the development and implementation of the NSP.
- Facilitate policy and strategic planning in sectors, including local government.
- Advocating and conducting social mobilization in all sectors at all levels.
- Mobilizing, allocating and tracking resources.
- Building partnerships among all stakeholders in country, regionally and internationally.
- Knowledge management through documentation, dissemination and promotion of best practices.
- Mapping interventions to indicate coverage and scope.

- Facilitating and supporting capacity building.
- Overall monitoring and evaluating of the national response.
- Facilitating HIV and AIDS research.

3.1.2.3 Malawi Partnership Forum

The Malawi Partnership Forum (MPF) is an advisory body to the NAC Board of Commissioners, comprising of high profile decision makers drawn from the following constituencies: public sector, private sector, PLHIV, CSOs, academia, research, national assembly and development partners. The MPF plays a very critical role in planning and reviewing the national response to HIV and AIDS in Malawi. All the coordinating structures outlined below are represented on the MPF. NAC provides management support to the MPF.

Technical Working Groups

Technical Working Groups (TWGs) are HIV and AIDS thematic groups established by NAC to provide technical guidance and make recommendations on various technical issues in the national response. They report to the MPF.

HIV and AIDS Development Group

The HIV and AIDS Development Group (HAGD) is a grouping of HIV and AIDS development partners. The objectives of the HADG are to harmonise and coordinate development partners' support to the NAF and to align development partners' support to the integrated annual work plan.

3.1.2.4 Sectoral Response Coordination

(i) Department of Public Services Management

The Department of Public Services Management (DPSM) is a department within the OPC which coordinates the HIV and AIDS response, particularly workplace programmes, in the public sector. These include all government ministries, departments, training institutions and parastatal organisations. There is a also a public sector steering committee comprising of principal secretaries and chief executives which provides policy leadership and guidance on the public sector response. Workplace programs in Local Councils will rely on DPSM on policy and central level guidance on all aspects of planning and implementation to ensure effectiveness

(ii) Malawi Business Coalition against AIDS (MBCA)

Coordinates the response for private companies and business institutions. Its major roles are mobilisation of companies, development of workplace programmes, reporting and evaluation of the private sector response.

(iii) Malawi Network of People Living with HIV (MANET +)

Coordinates all organisations for people living with HIV and AIDS (PLHIV). These organisations serve and advocate for issues affecting PLHIV in order to improve their welfare.

(iv) Malawi Network of AIDS service organisations (MANASO)

Coordinates local and international NGOs implementing various HIV and AIDS activities.

(v) The Malawi Interfaith AIDS Association (MIAA)

Coordinates all faith based organizations implementing HIV and AIDS interventions.

(vi) National Youth Council of Malawi (NYCOM)

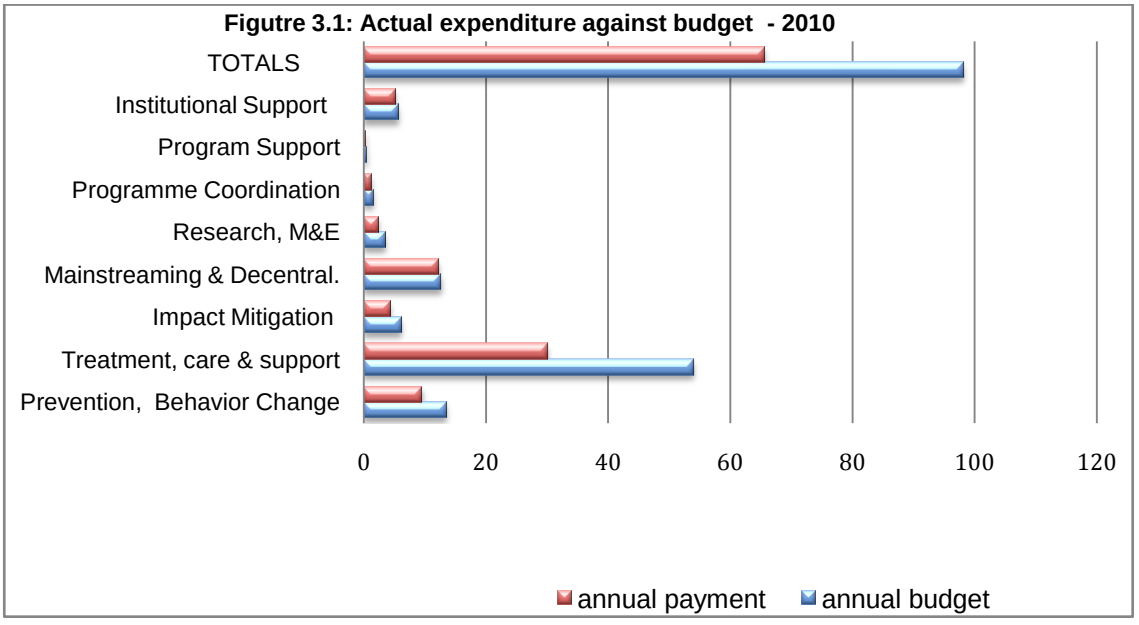
Coordinates all youth organisations implementing HIV and AIDS interventions.

All these sectoral coordinating institutions are expected to collaborate with Local Councils when coordinating the national response in the districts.

3.2 Funding of the national response 2010-2011

3.2.1 Funding and grants management

The NAC has developed over time an effective system that encourages good practices in financial management systems and reporting for all the financial resources it receives to address the national response to the HIV and AIDS epidemic. Risk management has been incorporated as a key element to improve efficiency and effectiveness. In the year 2010 the total annual budget was US$98.1 million and 66% (US$ 65.6million) was spent. In 2011 the budget was increased to US$113.51 million and the annual expenditure was US$ 77.4million, 68% of the budget[29].



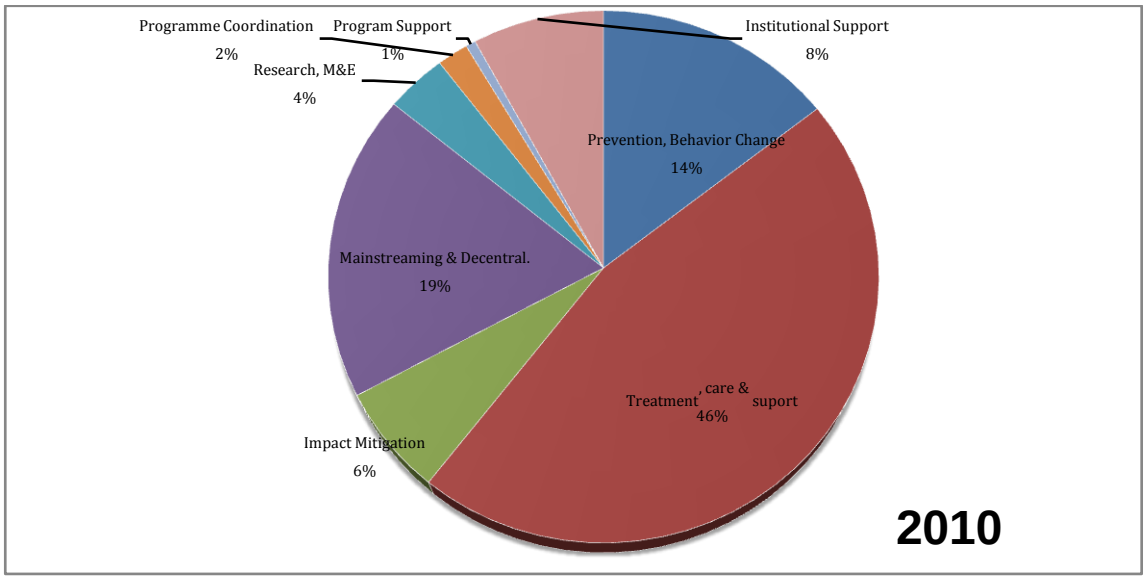
In both 2010 and 2011, the budgets were revised in order to address the impact of foreign exchange movement experienced in the first half of the year. The revised budgets also provided an opportunity to critically examine programme performance against set targets and implications of emerging issues resulting in either scaling up or down of targets, removal of

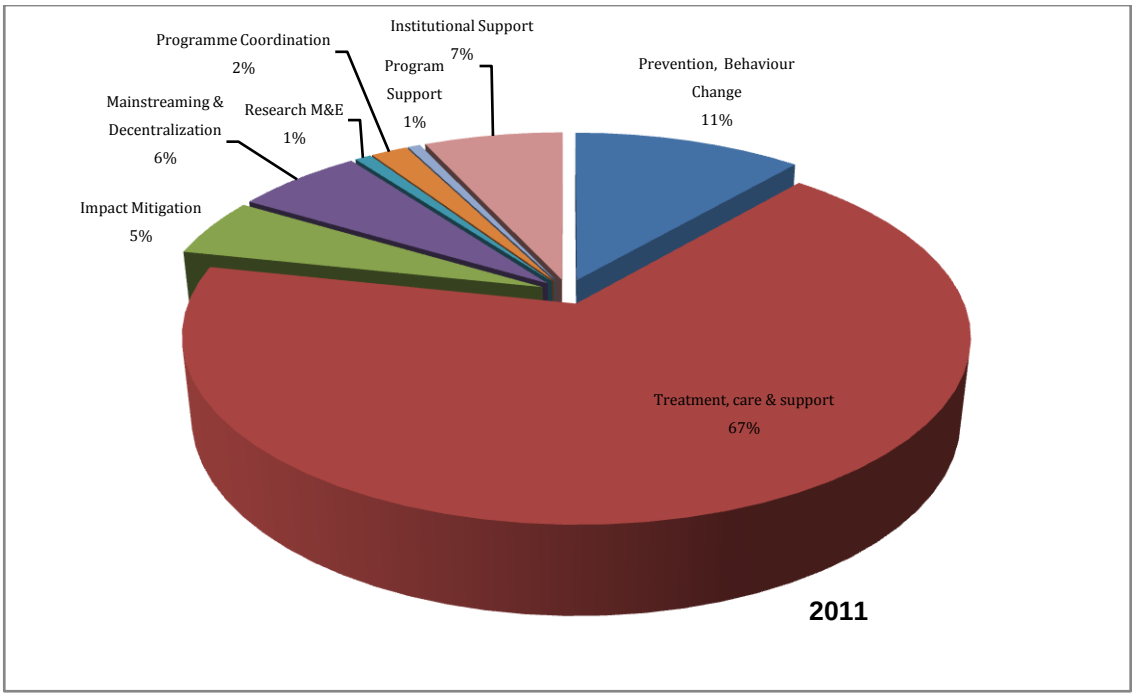
[29] Over the period 2010-2011 no NASA was conducted and hence only annual budgets and annual expenditures for the National AIDS Commission has been provided. It should be noted that the bulk of funding for HIV and AIDS activities in Malawi are through the National AIDS Commission.

unattainable activities and introduction of new activities that would be financed from re-allocation of cost savings.

The bulk of the annual budget goes to treatment, care and support which covered 46% in 2010 and increased to 65.9% of the total funding in 2011 based on the high ART levels with the change in initiation of ART from a CD4 of 250 to CD4 of 350. This priority area, namely treatment care and support, was followed up by prevention: in 2010 14% of the total expenditure was on prevention activities and this slightly decreased to 11% in 2011. Research Monitoring and Evaluation and program support are the smallest amounts of payment both less than 1% of the total amounts paid.

Figure 3.2: Priority areas allocation of the pool fund



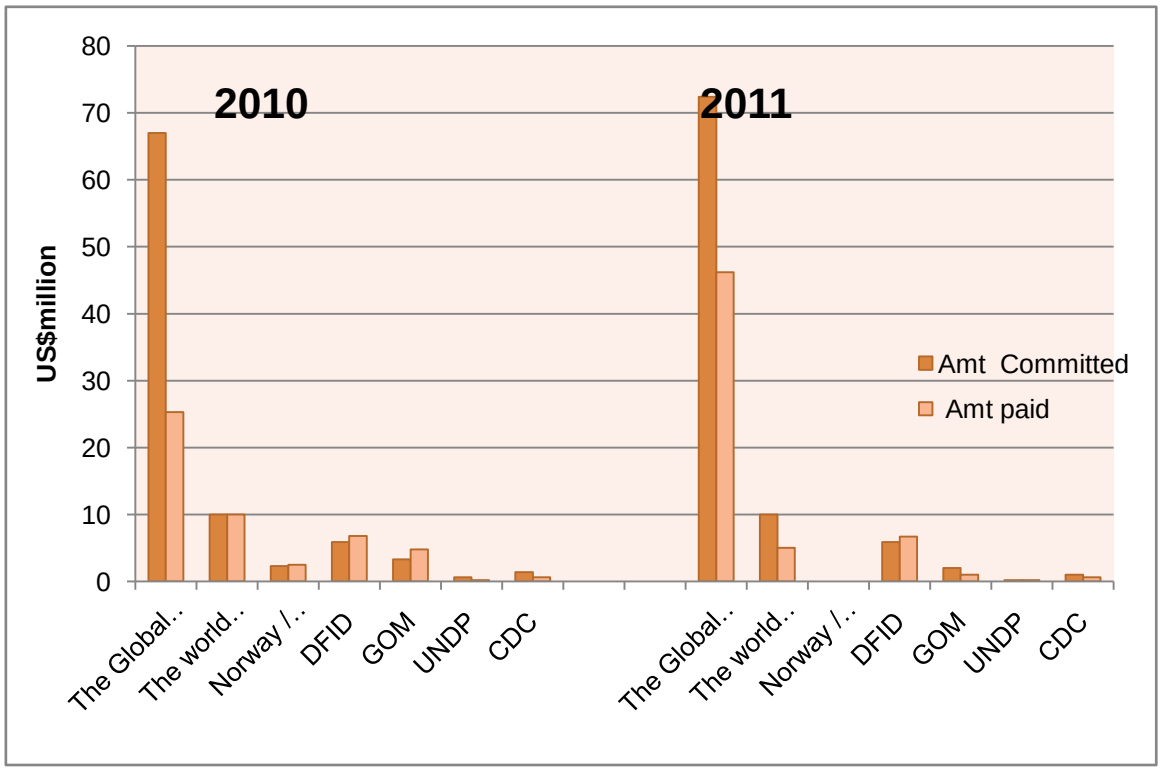


3.2.2 Contributions to the NAC Pool Fund

The total resources received by NAC in the two years under review still indicated a heavy dependence on donors, as previous reviews observed that the national response to HIV and AIDS was dependent on international funds. The donor partners to the Pool Funding Mechanism contributed 98% of the total value of receipts to NAC. Sustained and increased funding from the international donor community and the national government is necessary for the national response.

The HIV and AIDS response had challenges of actual payments into the NAC Pool Fund in 2010 and 2011. Generally, global trends indicate that the funding from donor countries to low and medium income countries such as Malawi is declining. The Global Fund, which is the major donor for the national response to the HIV and AIDS epidemic, had low disbursements to NAC: 37.8% of the US$67million budget in 2010 and 63.8% in 2011 of the US$72.4 million budget. The World Bank, the second highest contributor paid 100% of the US$10 million budget in 2010 and 50% of the US$10 million budget in 2011. The Kingdom of Norway/SIDA reported an over-disbursement of its committed funds due to foreign exchange gains realized based on the depreciation of the Malawi Kwacha (MK) to the US Dollar. Norway/SIDA commitment was US$2.3 million and paid US$2.5 million in 2010. In 2011 Norway/SIDA stopped funding to the national response. DFID also provided an over-disbursement due to foreign exchange gains on the depreciation of the MK to the US Dollar. DFID fully disbursed its commitment for both 2010 and 2011. In 2010, the GoM provided an over-disbursement of its committed payment of US$3.3 million and paid an additional US$1.8 million over budget. In 2011, the GoM paid 50% of its budget. Figure 3.3 below shows funding commitments and actual receipts by the NAC over the period 2010-2011.

Figure 3.3: Graph showing funding commitments and actual receipts (2010 – 2011)



While funding partners can pledge amounts to fund the national response, in some cases what is actually paid to the NAC is much lower. In terms of funding of the national response, financial resources from domestic sources tend to be a much more sustainable and extremely

valuable source of funding for responding to the epidemic. Initiatives to have sustainable and alternative financing sources for the national HIV and AIDS response are being explored.

3.3 HIV prevention Interventions

The primary mode of HIV transmission in Malawi is heterosexual intercourse. The priority area for the prevention and reduction of new HIV infections in Malawi is through the reduction of the sexual transmission of HIV; prevention of mother to child transmission of HIV and other additional areas of prevention of infection i.e. modes of HIV transmission through blood and blood products and invasive medical procedures; and, creation of a supportive environment for HIV prevention. The period 2009-2011 was Phase I of the National HIV Prevention Strategy 2009-2013[30]. The first phase registered some success and some challenges. The successes during Phase I included strengthening of coordination structures at national level with the reconstitution of various Technical Working Groups (TWGs) and Sub-Technical Working Groups (Sub-TWGs). During Phase I, voluntary male circumcision also emerged as a priority area for HIV prevention. Access to existing biomedical prevention interventions such as HTC, ART, PMTCT, PEP, safe blood products through all entry points also increased. Phase I also witnessed the scaling up of mass media campaigns, interactive communication and innovative interpersonal approaches to address issues of multiple and concurrent sexual partnerships in HIV Prevention.

Phase 1 also had comprehensive programmes addressing gender and in particular the vulnerability of the girl child. It however did not have clear interventions targeting most at risk populations (MARPS). In addition, Phase I witnessed challenges in condom programming. Although coordination structures appeared strengthened and operational at national level, district level structures were not fully operational and strengthened except in districts with strong presence of NGOs specialising in HIV prevention and communication. The national HIV Prevention Strategy is, among other things, aimed at raising awareness and sustaining knowledge levels in the most at risk and general population through the implementation of innovative mass mobilization as well as interpersonal and interactive approaches that will lead to behavioural change and sustainable positive living.

3.3.1 Behavioural change communication

3.3.1.1 Distribution of leaflets and HIV radio and TV programs

Behavioural change communication covers HIV prevention, treatment, care and support and cross-cutting issues namely gender, human rights and culture. Communication modes include print media and electronic media (radio and television) which are being extensively used to reach a lot of the targeted population groups. During the 2009-2010 financial year, a total of 2,883 radio and 420 television programmes were produced and aired for an airtime of 904 and 190 hours, respectively, surpassing the annual targets. In the 2010-2011 financial year, a cumulative total of 1,477 radio and 429 television (TV) programs produced and aired for a total airtime of 1,159 hours and 202 hours, respectively. To upgrade community enhancement for behavioural change and prevention of HIV, some communities were provided with cinema, video and interactive drama shows and community based interactive sessions were conducted. The targets projected to assess most-at-risk and general populations were exceeded.

3.3.1.2 Knowledge about HIV and AIDS in general population

Malawians have high awareness of HIV but are not yet rolling out significant levels of behaviour change. National surveys have generally demonstrated that knowledge about HIV

[30] Revision of HIV prevention national operational plan Eliam Oct 2010

and AIDS is universal: everyone has heard about HIV and AIDS. The 2010 MDHS for example shows that 99.4% of the women and 99.3% of the men both aged 15-49 reported that they had heard about AIDS. This has come about because of the large investments in the HIV awareness campaigns that have been implemented over the years since the start of the epidemic in the mid 1980s. While almost everyone aged 15-49 has heard about AIDS, comprehensive knowledge about AIDS is still low and has not changed much since 2004 and 2006. In 2010, **the proportion of women aged 15-49 who had comprehensive knowledge about AIDS was estimated at 41%. The corresponding proportion among men aged 15-49 was 44.8%.** The universal access target for comprehensive knowledge as set in 2006 was that by 2010 75% of the men and women aged 15-49 would have comprehensive knowledge. This target has not been achieved. The 2010 MDHS also shows that knowledge about MTCT including that the risk of MTCT can be reduced by pregnant women taking special drugs during pregnancy was lower than knowledge about AIDS: e.g. 91.1% of the women aged 15-49 reported knowing that HIV can be transmitted through breastfeeding and the corresponding proportion among men was 85.8%. In general knowledge about MTCT among women is higher than among men[31].

3.3.1.3 Trends in levels of stigma and discrimination

The HIV and AIDS epidemic has generated a lot of fear and anxiety. The stigma and discrimination associated with HIV and AIDS can affect people's willingness to participate in HIV prevention interventions such as HTC. One of the reasons why some people do not go for HIV testing is that they fear to be found HIV+ after which they will suffer from stigma and discrimination. Stigma and discrimination exist in our societies but evidence shows that there is continuing decrease and this is evident from the MDHS data. In the 2004 MDHS approximately 94% of the female and 97% of the male respondents said that they were willing to care for relatives with HIV and AIDS at home. In the 2004 and 2010 MDHS there were also other questions included exploring issues of stigma and discrimination. These questions were whether respondents would buy fresh vegetables from a shopkeeper with AIDS, whether an HIV+ teacher should be allowed to teach and, lastly, whether they would want the HIV+ status of a family member to remain secret. The results have shown that in 2004, 82%, 72.3% and 43.8% of the male respondents would buy vegetables from a shopkeeper with HIV, an HIV+ teacher should be allowed to teach and the status of an HIV+ family member should be kept secret, respectively. The corresponding figures for females were 66.6%, 66.6% and 64.8% respectively[32].

In 2010, 96.8% of the female respondents said that they were willing to care for a family member with the AIDS virus in their homes. The corresponding proportion among males was 97.8%. Eight one percent (81.3%) of the female respondents said that they would buy fresh vegetables from a shopkeeper who has the AIDS virus, 87.5% said that a female teacher with the AIDS virus and is not sick should be allowed to continue teaching and that 29.2% said that they would not want to keep secret that a family member got infected with the AIDS virus. Among the male respondents the corresponding proportions were 90.1%, 92.0% and 41%. It is evident that men are more likely than women not to want to keep secret a family member's infection with HIV. **The 2010 MDHS generally showed that more men (35.6%) had acceptance attitudes towards PLHIV than females (19.7%)[33].**

In addition to the MDHS, PLHIV stigma index is another approach for measuring stigma and discrimination at community level. A PLHIV Stigma Index study was conducted in Malawi in

[31] National Statistical Office. (2011). *Malawi demographic and health survey 2010.* Zomba: NSO.
[32] National Statistical Office. (2005). *Malawi demographic and health survey 2004.* Zomba: NSO.
[33] National Statistical Office. (2011). *Malawi demographic and health survey 2010.* Zomba: NSO.

2010[34] and Figure 3.4 shows the proportion of PLHIV who experienced different forms of stigma over the 12 months period before the survey:

Figure 3.4: Levels of stigma

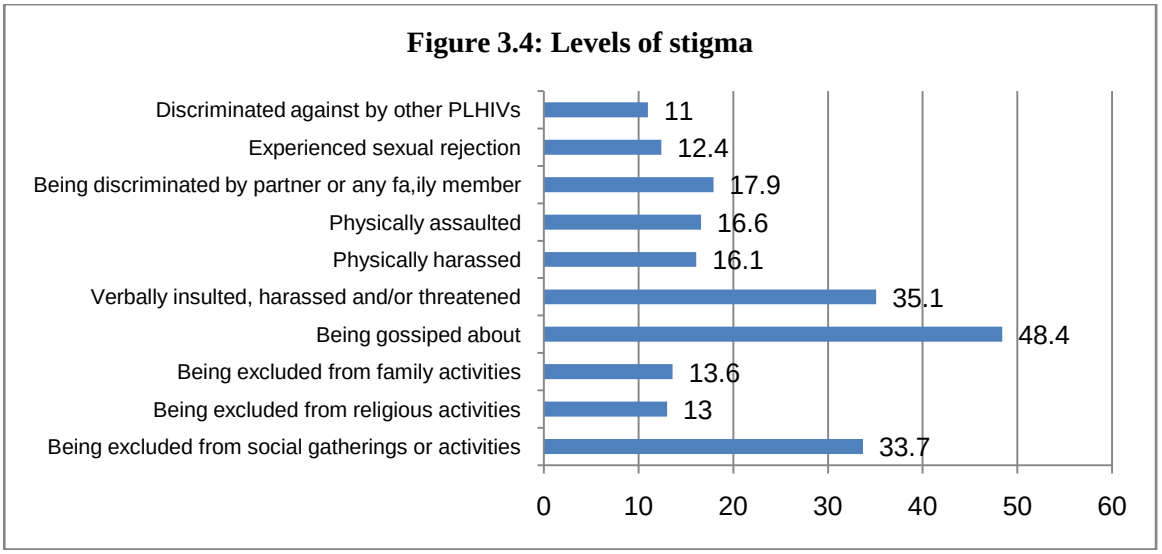


Figure 3.4 does confirm that stigma exists in Malawi: Nearly half of the respondents reported being gossiped about and this was followed by those who reported that they were verbally insulted, harassed or threatened at 35.1%. About a third of the respondents (33.37%) also talked about being excluded from social gatherings, being discriminated by a partner or any family member (17.9%), being physically assaulted (16.6%) and being physically harassed (16.1%). In terms of health care, 4.5% of the respondents reported to have been denied health services because of their HIV status, 8.3 % reported to have been denied family planning or sexual health services, some coerced to terminate pregnancy and on selection of infant feeding practices. The findings show that the mostly affected age groups were 30 to 39 and 40 to 49 for both males and females. It is evident that HIV related stigma and discrimination remains a potent stressor to PLHIV in Malawi. Multifaceted strategies that include protecting human rights and provision of high quality health services sustained over time are needed to prevent stigma, challenge discrimination occurring in different settings, and ultimately promote quality of life. It is therefore recommended that collective efforts be made by politicians, policy makers, civil societies, opinion leaders and general public including PLWHIV themselves to curtail stigma and discrimination.

3.3.1.4 Religious effects on behaviour change

A study on multiple concurrent partnerships found that religiosity *per se* was not associated with abstinence and mutual faithfulness. The most important component of religion on sexual behaviour was the content of religious teachings and monitoring sexual behaviours of members. The study also found that 95% of religious institutions privately advised members to refrain from promiscuous behaviour and 50% conducted sexual surveillance on its members, thus religious institutions could be critical in reducing high risk sexual behaviour[35].

3.3.1.5 The teaching of life skills education

The reduction of HIV prevalence in the general population is achieved globally when there are reductions in new infections among young people. This is achieved when the youth

[34] Chirwa, M., D. Kamkwamba and E. Umar. *Stigma and discrimination experienced by people living with HIV and AIDS in Malawi*. Blantyre: College of Medicine.
[35] Multiple Concurrent Partnerships (MCP) and low condom use in Malawi despite high knowledge of HIV prevention methods: *Triangulation of research findings from 1995 to 2010*

increasingly adjust their sexual behaviours by delaying sexual debut, reducing multiple sexual partnership and consistent and correct use of condoms. In 2010 and 2011, each year had a total of around 3.8 million young people (50% males and 50% females) exposed to life skills education (LSE) against an annual target of 4 million (97% of annual target) within and outside the conventional educational system. These figures generally represent a significant increase in the proportion of young people exposed to LSE. This is mainly because this subject became examinable during the 2010-2011 academic year; hence making it mandatory for teachers to teach this subject. Previously, ***it was difficult to know the percentage of schools which were teaching LSE as it was not examinable*** and the teaching of this subject was not consistent.

In terms of knowing the number of pupils exposed to LSE, this will easily be monitored as it will be mandatory for all students to participate in these classes. In 2010, the universal access target was that **100% of schools in Malawi should provide life skills-based HIV education. This was also the target in 2012.** Since LSE is examinable this target has been reached as it is mandatory for all schools to teach the subject. While LSE has been made examinable, there are challenges that still need to be addressed in order to ensure that the subject is effectively taught. A 2010 study commissioned by UNFPA found that there was a general lack of teaching and learning resources, inadequate training on the part of teachers, lack of knowledge by teachers on SRH issues including HIV transmission, not being comfortable to teach sex and sexuality and that there was a feeling that mentioning private parts in public was a taboo[36]. These issues need to be addressed for effective teaching of LSE. In 2010-2011, 4,692 school teachers from both primary and secondary schools were also trained in the teaching of life skills representing 63% of the annual target. In 2011 5,078 out-of-school youth leaders were also trained in interactive and interpersonal LSE. Although full targets for youth training and teachers training were not achieved the training of club patrons and youth peer educators were exceeded.

3.3.1.6 Youth friendly health services

Health services aim at providing the youth with access to sexual and reproductive health services in a setting that is most convenient and conducive to them. Young people continued to access services at youth friendly SRH service sites across the country. In the 2009-2010 financial year, a total of 541,084 youths were reported to have accessed services from 1,609 youth friendly SRH service sites, and a total of 671 service providers were also trained to provide youth friendly services. In 2010-2011 there was an increase and 969,530 young people accessed youth friendly services and a total of 599 service providers were providing youth friendly services at 1,633 sites across the country.

The MoH and CSOs are some of the providers of youth friendly services in Malawi. While there is progress in the number of young men and women accessing youth friendly services, a recent study found that barriers exist for these young men and women to access services. These barriers include (i) not being aware of the existence of such services; (ii) long distances to facilities that provide youth friendly services and the high cost of transport; (iii) infrequent outreach services and people not being told when the outreaches will be conducted; (iv) young people being shy; (v) the lack of money to pay for services; (vi) fear of being found HIV+; (vii) services being provided by a member of the opposite sex; (viii) young people being denied by parents to access youth friendly services. In addition to these factors, the study also found that religion also plays an important role in terms of accessing youth friendly services. For example, being a member of the Zion Church is itself a barrier to accessing FPAM

[36] See Mbano, N. Et al. (2010). *An assessment of life skills education program in Malawi.* Lilongwe: UNFPA and UNICEF.

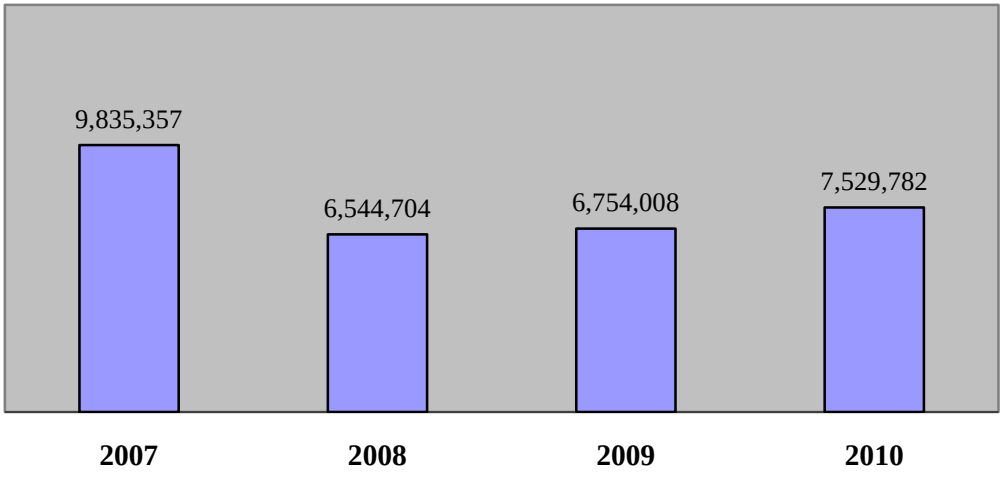
services as members are prohibited from receiving services. These barriers to accessing youth friendly services need to be addressed[37].

3.3.1.7 Condom promotion and use

In the national response to HIV and AIDS, condoms are recognised as an important prevention tool, not only against unwanted pregnancies but also against HIV infection. Proper and consistent condom use is one of the proven methods known to avert the risk of sexually transmitted infections (STIs). Making female condoms available was one of the priorities of the national response to prop up negotiation of safer sex among women and girls. To promote the adoption of safer sex, the GoM and the private sector have been procuring and distributing condoms throughout the country. Since 2003, the number of condoms distributed per capita has been increasing. Nevertheless, the number of condoms distributed remains well below the target every year, especially for female condoms, raising doubts about their availability and accessibility to the general population.

The universal access target for male condoms was estimated at 35,000,000 for 2010 and 34,000,000 for 2011. Condoms are accessed freely or through social marketing. Cumulatively, a total of 8,722,174 socially marketed condoms (98% male condoms) and 12,327,418 free non-branded condoms (94% male condoms) were distributed in the 2009-2010 fiscal year, representing 44% and 82% of the annual targets for socially marketed and free condoms, respectively. There are two NGOs that are involved in the social marketing of condoms in Malawi and these are PSI and BLM. In 2008 a total of 6.6 million condoms were distributed through their clinics and this decreased to 3.97 million in 2009 and then increased slightly to 4.3 million in 2010. Over the 3 year period it is evident that the number of free condoms distributed by BLM decreased. Figure 3.5 below shows the number of condoms distributed by PSI for the period 2006-2010:

Figure 3.5: No. of condoms distributed by PSI 2007-2010



Over this period, PSI sold more than 9 million condoms in 2006 and 2007 and then the numbers decreased in 2008 and 2009 when less than 7 million condoms were sold. In 2010 more than 7 million condoms were sold but still fell short of the 2006 and 2007 levels.

During the year 2010-2011 a 25% increase over the achievement of 2009-2010 fiscal year was realised. By June 2011 the annual cumulative total of 13,338,381 (99% male condoms) of the

[37] Munthali, A. and B. Zakeyo. (2011). *Do they match? Adolescents' realities and needs relating to sexuality and youth friendly service provision in Dowa District, Central Malawi.* Amsterdam: RNG.

targeted 20,000,000 condoms were distributed through social marketing agents, representing 67% achievement. A total of 13,122,698 condoms (91% male condoms) were also distributed freely at all service delivery points across the country, against an annual target of 15,000,000 representing 87%. Social marketing of condoms has been declining while free condoms are progressively increasing although socially marketed condoms in past years had been known to be better accessed then free condoms. Even though targets for both free and socially marketed female condoms were increased, in the reports the uptake of female condoms was noted as being slothful. In 2009-2010, 218 district officials were trained in comprehensive condom programming in order to effectively facilitate logistics of condoms, and training of community condom distribution agents and district officials all exceeded targets.

In addition to distribution of condoms there is also a need to look at utilisation of condoms. The 2010 MDHS looked at **the percentage of never married young men and women aged 15-24 who used a condom at last sexual intercourse.** The percentage of females who used a condom at last sexual intercourse in 2010 was at 48.8% and the corresponding proportion among males aged 15-24 was at 51.4%. The use of condoms increased the higher the educational level and that more young people in urban areas used condoms compared to rural ones. There are a number of challenges with regard to condoms and these mainly relate to availability, accessibility and affordability and the reactions of religious leaders to condoms:

Availability: Within the review period 2010-2011, obstruction in free condom distribution has been due to serious procurement and supply chain management bottlenecks. Supply chain management factors continued to constrain the supply and availability of condoms as evidenced by the level of performance against annual targets. The efforts in 2010-2011 were directed at implementing a Voluntary Pooled Procurement (VPP)[38] mechanism. The VPP delivered substantial quantities of condoms to be distributed in the future fiscal year and beyond. A 2010 study noted problems with availability and accessibility of condoms, particularly in entertainment places, rest houses and rural areas. The vast majority did not have condoms and most of the places did not stock them.

Accessibility: A study[39] on Multiple and Concurrent Partnership (MCP) and low condom use analyzed reasons for the low prevalence of consistent condom use despite high knowledge of HIV prevention methods. Several reasons were found to explain the low levels of consistent condom use. First, there were strong negative views regarding purpose, efficacy and physical properties of condoms and their reduction of sexual pleasure. Among married or cohabiting partners and regular sexual partners, condoms were consistently found to interfere with feelings of mutual trust. A recent study conducted among young people found similar results: (i) that condoms are not 100% perfect and each time they have sex they are not sure if the girl will be pregnant; (ii) that condoms can also burst; (iii) some young men cut off the tip of the condom because it is like having unprotected sexual intercourse which is pleasurable[40]. Gender and financial power disparities, between sexual partners among married or cohabiting partners or intergenerational sex meant that most women could not demand condom use for the fear of breakdown of the relationship and financial support.

Religious opposition to condoms: Conventionally, faith-based organizations (FBOs) are known to denounce the use of condoms, in direct contrast with the government and development partners. However, some FBOs were changing their stance on condom use and

[38] Annual technical progress report NAC, 15/08/2011

[39] Mwapasa, V. (2010). *Magnitude of and reasons for Multiple Concurrent Partnerships (MCP) and low condom use in Malawi despite high knowledge of HIV prevention methods: Triangulation of research findings from 1995 to 2010.* Lilongwe: National AIDS Commission.

[40] Munthali, A. and B. Zakeyo. (2011). *Do they match? Adolescents' realities and needs relating to sexuality and youth friendly service provision in Dowa District, Central Malawi.* Amsterdam: RNG.

were privately encouraging their members to use condoms, if they cannot maintain abstinence or mutual faithfulness[6].

3.3.1.8 Age at first sexual intercourse

It is widely accepted that young people who initiate sex at an early age are considered at higher risk of becoming pregnant or contracting an STI than those who delay sexual activity. The 2010 MDHS found that **14.3% of the women aged 15-24 and 22.1% of the men aged 15-24 had sexual intercourse before age 15**. Among both males and females, those in the rural areas (Men=22.7%; Women=15.0%) were more likely to have had sex before the age of 15 than their urban counterparts (Men=20%; Women=11.4%). Table 3.1 below shows the proportion of men and women aged 15-24 who had sexual intercourse before age of 15 by region, educational level and wealth quintile:

Table 3.1: Percentage of men and women who had first sex before age 15

Background characteristic	Women age 15 - 24	Men age 15 - 24
Residence		
Urban	11.4	20.0
Rural	15.0	22.7
Region		
Northern	11.9	15.0
Central	8.9	19.8
South	20.1	26.1
Education		
No education	27.0	9.3
Primary	16.2	25.2
Secondary	6.8	17.2
More than secondary	4.5	7.8
Wealth quintile		
Lowest	17.6	24.1
Second	17.7	25.9
Middle	14.2	25.2
Fourth	14.7	19.4
Highest	8.9	18.5

Table 3.1 above generally shows that the southern region had the highest proportion of young people aged 15-24 who had sexual intercourse by the age of 15 and this was for both men and women. In terms of educational attainment, the table shows that the higher the educational level, the less likely would a young man or woman have sexual intercourse before the age of 15. Lastly, the richer an individual the more likely for him or her not to engage in sex before the age of 15.

3.3.1.9 Multiple sexual partners among youth

The 2010 MDHS found that **0.7% of the women aged 15-24 reported having 2+ partners in the 12 months period preceding the survey. The corresponding proportion among men was 6.5**%. Among ever married young men aged 15-24, 10.1% reported that they had two or more partners in the 12 months period preceding the 2010 MDHS. About a quarter (24.1%) reported that they used a condom at last sex. There was no difference between urban and rural

young men who reported they had 2 or more partners in the past 12 months. The proportion of young men who reported having 2 or more partners varied between 4.5% in the northern region to 7.2% in the south. In the central region this was at 6.4%.

A number of studies have been done to determine why young people have multiple relationships. Among young women, one of the major reasons why some girls have multiple relationships is that they would like to get money from more than one boyfriend. If their boyfriend comes from a poor household, girls will find another one who can give them money. Poverty therefore seems to be a major factor why girls have many relationships. In some cases girls are actually forced to have multiple relationships as a retaliatory response if their boyfriends have many relationships. In some cases girls have multiple relationships in order to ensure that if one relationship ends they still have another one. Comparing how good men are in bed is also an important reason why young women have multiple relationships[41]. Among young men there are also a number of reasons why they may have multiple sexual partners and these include: the refusal by a girl friend to have sex with him, the girl's performance in bed, *to be famous*, peer pressure, they would want to have someone with whom they can have sex when one goes away and the prevailing belief that they should be perceived as *real men*[42]. Other studies, for example those done by Pakachere Institute for Health and Development, have found similar results[43].

3.4 Biomedical Prevention Interventions

3.4.1 Sexually transmitted infections

3.4.1.1 STI diagnosis and treatment services

In Malawi there is a high prevalence of STIs in the general population and one study reported a prevalence of gonorrhoea in women at 9.7%, and STI in general at 15.3% in commercial sex workers. Diagnosis and management of STI is an inclusive package in the prevention of HIV infection. In nine months from July 2010 to March 2011, a total of 126,420 STI clients had their HIV status ascertained and the numbers exceeded the annual target by 26% in spite of the fact that this achievement was lower than the estimated STI cases in the population. Milestones for STI service provider training as well as STI drug availability fell short of the annual targets due to supply chain bottlenecks. For HIV/STI linkages, the testing of HIV was relatively low on STI clients, due to a weak crossing point with the PITC initiatives as well as weak referrals. A significant number of patients who already knew their HIV status came up with STI which shows their weaknesses in ascertaining prevention practices. The MDHS also collects data on prevalence of STI but this is based on self reporting among participants. There were more women aged 15-49 who reported having an STI at 2.1% compared to men of the same age group at 1.7%.

[41] Munthali, A. and B. Zakeyo. (2011). *Do they match? Adolescents' realities and needs relating to sexuality and youth friendly service provision in Dowa District, Central Malawi.* Amsterdam: RNG.
[42] Munthali, A. and B. Zakeyo. (2011). *Do they match? Adolescents' realities and needs relating to sexuality and youth friendly service provision in Dowa District, Central Malawi.* Amsterdam: RNG.
[43] For example see Pakachere Institute for Health and Development Communication. (2008). *Multiple and Concurrent Sexual Partnerships in Malawi: A Target Audience Research Report.* Blantyre: Pakachere Institute for Health and Development Communication.

3.4.1.2 STI diagnosis of pregnant women

The HMIS managed by the MoH collects routine data on STIs especially syphilis[44]. Figure 3.6 below shows the prevalence of STIs among pregnant women for the period 2004/05-2009/10:

Figure 3.5: Trends in syphilis prevalence in Malawi 2004-2010

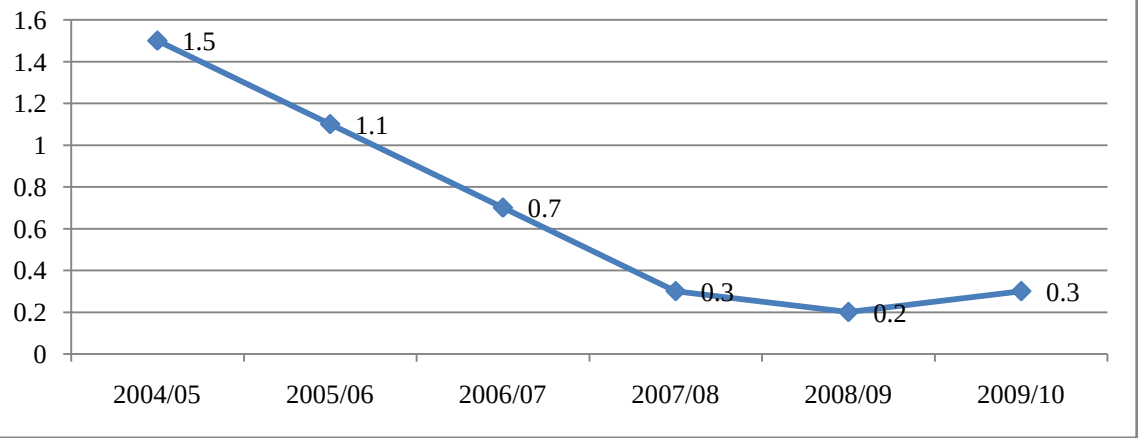


Figure 3.5 shows that between 2004/05 and 2008/09 the prevalence of syphilis among pregnant women has been going down with an exception of 2009/2010 when there was a slight increase to 0.3% from 0.2% in 2008/09. Of the 127,260 women who started ANC between October and December 2010 and finished ANC by June 2011, 28,460 (22%) of women were tested for syphilis and 1,015 (4%) were syphilis positive. Targets for syphilis screening as well as testing for exposed children were not met, perhaps reflecting systemic problems in the supply chain of test-kits and reagents.

The syphilis testing rate remains low although there is some increase from 15% coverage to 19% of all the pregnant women. The testing rate is expected to increase due to improvements in the supply of test kits to sites. The proportion of women with a positive syphilis test result is higher than expected (<1% in ANC sentinel surveillance 2007). This is probably due to selective testing of women who are perceived at higher risk of infection due to limited supplies of test kits. Relevant guidelines and training curricula including the new STI guidelines and the new PMTCT/ART integrated guidelines were developed but funding constraints have limited the roll out of the various training activities especially at the facilities. It was noted in some facilities that health workers were still operating using the old guidelines especially in management of STIs due to non-availability of the drugs on the new guidelines.

Apart from routine data on which the above section is based, sentinel surveillance surveys are also used to collect data on prevalence of syphilis. The 2010 survey found that the prevalence of syphilis was estimated at 1.2%, with a range of 0% to 7.6%. The highest prevalence of syphilis (7.6%) was found at Mulanje Mission Hospital in the South. The prevalence of syphilis was lowest in the northern region at 0.5% followed by the centre at 0.7% and then the south at 1.8%. In 2007, the prevalence of syphilis was at 1.1% meaning that this has not changed much and has remained low. In 2010, the highest prevalence was in Mulanje while in 2007 highest was at Thyolo district hospital both in the South[45]. These results generally demonstrate that routine data collected from ANC shows a higher prevalence of women with syphilis compared to sentinel surveillance surveys as found in 2007 and 2010.

[44] Ministry of Health HIV programme Q2 2011 report
[45] Ministry of Health. (2011). *HIV and Syphilis Sero–Survey and National HIV Prevalence and AIDS Estimates Report for 2010*. Lilongwe: Ministry of Health

3.4.2 HIV Testing and Counselling (HTC)

3.4.2.1 Sites for provision of HTC services

The number of sites providing HTC services has been increasing over the years. The universal access target for the number of sites providing HTC services was set at 600 sites by 2010. By the end of December 2009 a total of 716 sites were providing HTC services in Malawi and by June 2010 this increased to 742 sites thus by far exceeding the 2010 universal access target. By June 2011 a total of **778** static and **614** outreach HTC sites were providing HTC services.

3.4.2.2 Number and proportion of persons tested

In 2010, the universal access target for number of people accessing HTC services was 1,000,000. For the period July 2009-June 2010 the total number of people tested and counseled for HIV was 1,724,190**.** This was an increase of just 12,000 persons from the previous fiscal year July 2008-June 2009, in which 1,712,170 people were tested. It can be seen that the universal access target for the number of people tested per year of 1,000,000 has been exceeded. The total number of people tested and counselled in the fiscal year (July 2010-June 2011) was **1,773,267**[46] which represents 28% of the sexually active population**.** HIV testing among couples was only at 338,679 couples. In addition to testing that occurs in the static and outreach sites there are now Mobile and Door-to-Door HTC initiatives mainly done by NGOs e.g. MACRO. This has significantly increased the coverage of HTC in Malawi.

In 2010, there was a lot of stress in test kits availability due to supply chain management constraints**.** The supply of test kits to sites appeared to have improved by June 2011 and this is reflected in the considerable increase in the number of tests done during the period. This was probably partly due to a centrally coordinated distribution of test kits alongside ARVs, and consignments for delivery of test kits directly to health facilities by UNICEF which is the current procurement agency.

3.4.2.3 Proportion of persons aged 15-49 tested for HIV based on MDHS

In the 2010 MDHS respondents were asked if they knew where to get an HIV test and whether they had ever been tested for HIV. Among women aged 15-49, 96.9% reported that they knew where to get an HIV test. Seventy three percent (73.1%) of the female respondents said that they had ever been tested for HIV. Among men of the same age group 96.4% reported knowing where to go for an HIV test. The proportion of men who reported having been ever tested for HIV was at 52.2%, a figure much lower than that of women. Among young people aged 15-24, 81.3% of the women and 52.9% of the men reported having ever been tested for HIV and receiving results. It is evident that reported HIV testing among males is much lower compared to women. In general the percentage of men and women who reported that they were tested for HIV increased with level of education as well as wealth quintile. The universal access target for percentage of the population tested for HIV for 2010 was 75% among both males and females. These targets have not been reached for both men and women as can be seen from figures presented here.

3.4.2.4 Reasons for not being tested

As described earlier, the number of Malawians who have been tested for HIV has been increasing over the years reaching close to 2 million per year over the last 3 years. While such is the case, some people have not yet gone for an HIV test for various reasons. This is also the case among young people. A recent SRH study found several reasons why young people do

[46] Ministry of Health HIV programme Q1 2011 report

not go for an HIV test: (i) They are afraid they may be found HIV+ and they will be worried; (ii) Others have already lost hope and think they are HIV+ hence there is no need for going for HTC services and such thoughts come in because of the way they have sexually behaved over the years; (iii) Some people do not want to go for HTC because they think they do not have the virus; (iv) Some people have committed suicide on their way from HTC centres (v) There are also others who do not go because they belong to some religious groups such as Zion whose members are prevented from going for HTC services including donating blood; (vi) They may also not go because they are ignorant about the availability of HTC services[47]. These barriers to HTC need to be addressed.

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3.4.2.3 Development of HTC human resource capacity

Relevant guidelines and training curricula including HTC facilitators, trainers and participants' manuals, integrated guidelines were developed but funding constraints have limited the rolling out of the various training activities. The MoH, Management Sciences for Health, World Vision International, MANET+, CHAM and BLM have organised training of new counsellors: 219 new counsellors were trained using the standard national HTC curriculum and certified as PITC providers bringing the total number of PITC providers to 154 in the country. By mid June 2011, almost all sites reviewed had adequate HTC providers and most sites had reagents. HTC guidelines were available in the HTC rooms and many sites had participated in Proficiency Testing. Challenges identified regarding the provision of HTC services include: (i) Refresher trainings on HTC have not been done for some years now; (ii) IEC materials for HIV and AIDS are not found in most of the sites assessed; (iii) A proportion of counsellors have not received feedback from the proficiency testing exercise; (iv) There is lack of supervision in some sites by the district supervisors due to lack of resources; and (v) No stopwatches in some of the sites.

3.4.3 Prevention of Mother to Child Transmission (PMTCT)

3.4.3.1 Number of sites providing PMTCT services

PMTCT services are fully integrated into maternal and child health services and PMTCT services are currently available in 544 sites as at June 2011. The number of sites providing PMTCT services has also been increasing. In 2006 for example, 152 facilities were providing PMTCT services in Malawi and this increased to 357 in 2007. As of June 2011, 544 sites were providing PMTCT services in Malawi[48].

3.4.3.2 Coverage of PMTCT services

The PMTCT goal is to reduce the number of paediatric HIV infections and improve the quality of life for HIV exposed infants, infected children and parents living with HIV. Between July 2010 and March 2011 among new pregnant women who registered for antenatal services 7% had already tested for HIV and 71% were newly tested for HIV. Out of the 31,529 women that were HIV positive, 82% received ARVs. By June 2011 a total of 328,032 pregnant women attending ANC had been counselled and tested for HIV, representing 73% of the target and 54% coverage of the estimated pregnancies in the population. A total of 24,258 HIV+ pregnant women (representing 45%) received ARV prophylaxis and 11% of HIV pregnant women received ARVs in the July 2010 – June 2011 financial year[49].

[47] Munthali, A. and B. Zakeyo. (2011). *Do they match? Adolescents' realities and needs relating to sexuality and youth friendly service provision in Dowa District, Central Malawi.* Amsterdam: RNG.
[48] See Ministry of Health. (2011). *Annual report of the work of the Malawi health sector: July 2010-June 2011.* Lilongwe: Ministry of Health.
[49] IRT report for IAWP 2010-2011

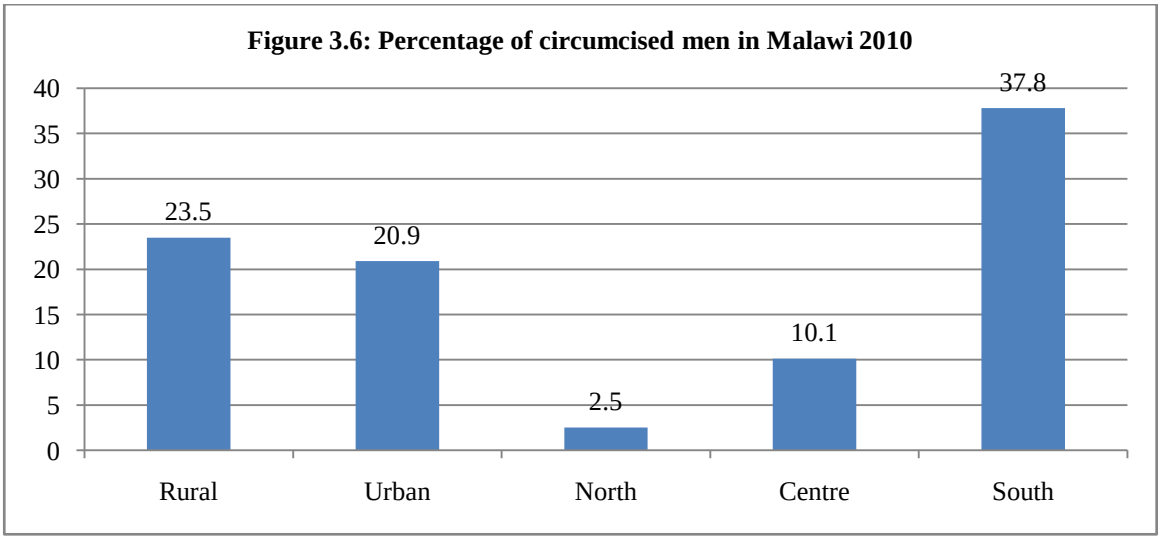
Malawi started implementing an integrated ART/PMTCT programme from 1st July 2011, following adoption and adaptation of the 2010 WHO recommendations. All HIV positive pregnant women, regardless of their CD4 count, are now put on a more efficacious regime for life. As an intervention to identify HIV infection in children so that they access treatment, early infant diagnosis services have been scaled up. HTC providers and counsellors have been trained and followed by mentorship. Of the 544 PMTCT sites, 200 sites are able to collect blood for DNA PCR for early infant diagnosis. A total of 24,682 children have been tested for HIV through DNA PCR test and 11.3% tested positive. This may not be used to measure effectiveness of PMTCT interventions since not all children tested accessed PMTCT services and some were tested because they were sick. New standard M&E tools for ANC and maternity were implemented in Malawi in January 2010. These tools consist of a set of clinic registers and reporting forms that fully integrate patient management information as well as all relevant data elements for M&E of the maternal and child health and PMTCT programs[50].

During FGDs with PLHIV support groups and also during interviews with District HIV and AIDS service providers in Mchinji in central Malawi, participants provided information on community mobilisation and education to increase uptake of PMTCT services. In Mchinji traditional leaders have created village bylaws which require pregnant women to go to the health centres to deliver, otherwise they pay fines if they deliver at home under traditional birth attendants. This has had positive impacts and a lot of women are delivering in health facilities.

3.4.5 Male circumcision

Studies have generally shown that male circumcision has the potential of averting the risk of HIV transmission by more than 60%. Within the National HIV Prevention Strategy 2009-2013 circumcision has been recognized as one of the prevention measures that will be implemented to reduce the sexual transmission of HIV. Circumcision is practiced widely in Malawi mainly for religious and cultural reasons. The 2010 MDHS found that 21.6% of the men aged 15-54 are circumcised. Figure 3.6 below shows the proportion of males aged 15-49 who were circumcised by residence and region:

Figure 3.6: Percentage of circumcised men in Malawi 2010



There is not much difference between rural and urban areas in the percentage of men aged 15-49 who are circumcised. Regional variations are, however, huge: 37.8% of the men in the

[50] Ministry of Health HIV programme Q2 2011 report

south are circumcised while only a 10th of men in the central region are circumcised. In the northern region 2.5% are circumcised. Circumcision is widely practiced among the Yao (86.8), Lomwe (28.9%) and the Mang'anja (22.9%). For those men who reported that they are circumcised, 85% reported that a traditional practitioner performed the circumcision, and 87% of these men reported that the circumcision was performed in a *'simba'*, a traditional location for circumcision practices for boys. Eighty-seven percent of circumcised men report that their circumcision occurred between the ages of 0-15 years. Seventy percent of circumcised men underwent the procedure between the ages of 5 and 13, whereas 22% were circumcised at age 14-19, and only 4% were circumcised at age 20 or older.[51]

The 2010 MDHS also found that HIV prevalence was higher among the circumcised at 10.3% than those uncircumcised at 7.6%, but further analysis is needed to establish the association with the type of circumcision. Among the circumcised HIV prevalence increased with age, educational levels and by wealth quintile. Among young people aged 15-24 HIV prevalence was higher among the uncircumcised compared to the circumcised. Since the adoption of circumcision as a preventive measure, some progress has been made in Malawi: (i) standard operating procedures (SoPs) have been developed; (ii) several district teams have been trained to conduct clinical circumcisions; and (iii) a situation analysis of male circumcision has been done and that a communication strategy and a national policy on circumcision have been drafted. As of November 2011 medical circumcision was being piloted in 32 static sites by BLM out of which two model sites have been identified and several district teams have been trained to conduct medical circumcisions. A total of 40 service providers were trained in the 2010/2011 fiscal year. Malawi plans to intensify voluntary medical male circumcision to reduce HIV transmission.

3.4.6 Post exposure prophylaxis (PEP)

Interventions in the 2010-2011 fiscal year were focused on increasing access to PEP for health workers and communities. Annual targets pertaining to awareness, provision and access to PEP services were over passed. Targets for the year were quite conservative as past experience had shown the lack of significant movements in this area. Partners have since embarked on a major awareness drive to mobilize uptake of PEP services across the country[52].

3.4.7 Prevention of blood transmission of HIV

The universal access target for the percentage of transfused blood units screened for HIV, HBV and syphilis for 2010 was at 98%. The mandate of the Malawi Blood Transfusion Service (MBTS) is to ensure that all blood collected at its centres are tested against transmissible markers to ensure availability of safe blood in health facilities. As such, all blood (100%) collected by the MBTS is tested for specific infections. MBTS increased on its blood unit collection from 54% direct contributions to about 64% of the total national needs. A total of 45,473 blood units were collected nationally by MBTS alone and 80% of this was from voluntary non-remunerated donors[53]. Between July 2010 and June 2011 (MBTS) could only supply 48% of requests from hospitals (54,526 units against requests of 113,310). A Ministry of Health's Department of HIV routine supervision reported that 99.6% of blood collected in health facilities was screened for HIV, Hepatitis B and Syphilis in the year 2010. A Safe Blood Policy was developed in 2010. All blood banking reagents are imported and in some instances it takes more than one year for the procurement processes to be completed. The MBTS has increased its coverage through the establishment of another centre in Mzuzu which covers the northern region.

[51] MDHS 2010
[52] Annual technical progress report NAC, 15/08/2011
[53] IRT report of IAWP 2010-2011

3.5 Treatment

3.5.1 Access to ART

By June 2011 there were **449** ART clinics, owned by government, mission, NGOs and the private sector (**303** static clinics and **146** outreach / mobile clinics). Out of these **58** were ART facilities in the private sector, charging a nominal MK500 per monthly prescription of drugs per patient.

Table 3.2: Trends in ART

ART Programme December 2003- June 2011 (public and private sector)									
	Dec 2003	**Dec 2004**	**Dec 2005**	**Dec 2006**	**Dec 2007**	**Dec 2008**	**Dec 2009**	**Dec 2010**	**June 2011**
ART sites	9	24	83	141	163	221	377	417	449
Coverage of pop. in need of ART	No data	3%	9%	17%	28%	41%	53%	63%	67%
New ART Registration in year	No data	10,183	25,634	46,351	61,688	76,581	88,126	88,813	46,707
Patients ever initiated on ART (cumulative)	3000	12,848	35,621	75,503	129,276	200,901	271,105	345,598	382,953
Patients alive on ART	No data	10,761	29,087	59,980	100,649	147,497	198,846	250,987	276,897

By the end of June 2011, there were a cumulative total of **451,546** clinic registrations, representing **382,953** (85%) patients with newly initiated ART and **68,190** (15%) ART patients transferred between clinics. Out of all clinic registrations, 39% were males and 61% were females, 91% were adults and 9% were children (<15 years). Private sector clinics accounted for **17,099** (3.8%) of total patient registrations[54].

ART coverage by geographical zones was inversely related to the absolute population in need of ART and ART coverage was lowest in the South East Zone which has the highest estimated HIV burden: 25,305 **(98%)** of 25,768 people in need of ART in the **Central East Zone** were on ART, while only 61,592 **(45%)** of 138,368 people in the **South East Zone** were covered. Coverage among children and adults was **32%** and **76%** respectively. ART coverage has increased much faster in the Central East and Northern Zone than in the South East Zone. The high estimated coverage in the Central East and Northern Zone may be due to patients who are regular residents elsewhere, but who are accessing ART in these zones (for confidentiality, as migrant workers, patients from neighbouring countries, etc.). The MoH is addressing the situation of low ART coverage by accelerating the opening of new ART sites in the South East zone and by assessing other potential factors such as access to HTC.

[54] Ministry of Health HIV programme Q2 2011 report

3.5.2 ART Regimens

The total number of PLHIV aged 15+ years who needed ART in 2010 was at 278,000 and this increased to 381,000 in 2011. Among children aged 0-14, 100,000 needed ART in 2010 and this slightly decreased to 99,000 in 2011. Eighty nine percent (**89%)** of HIV positive patients were on the first line, **9%** were on alternative first line and less than **1%** were on the second line regimen while **1%** were on a non-standard ART regimen. Non-standard regimens are not necessarily substandard regimens and include patients continuing an ART regimen that was started outside Malawi, patients in research programmes and patients in specialist care.

3.5.3 ART side effects

There is under-ascertainment of the true rate of drug side effects. The MoH estimates that 20-25% of patients develop at least mild side effects from Triomune. Malawi continues to increase access to alternative first line regimens for such patients.

3.5.4 Survival on ART

By the end of June 2011, **276,987** patients were alive and on ART in Malawi, equivalent to **67%** coverage of the estimated population in need of ART. An effective health sector response to HIV based on increased ART has dramatically reduced AIDS death. In 2010 AIDS mortality was at 53,000 and 46,000 in 2011 as can be seen in Table 3.2 below.

Figure 3.7: AIDS deaths in 2010 and 2011

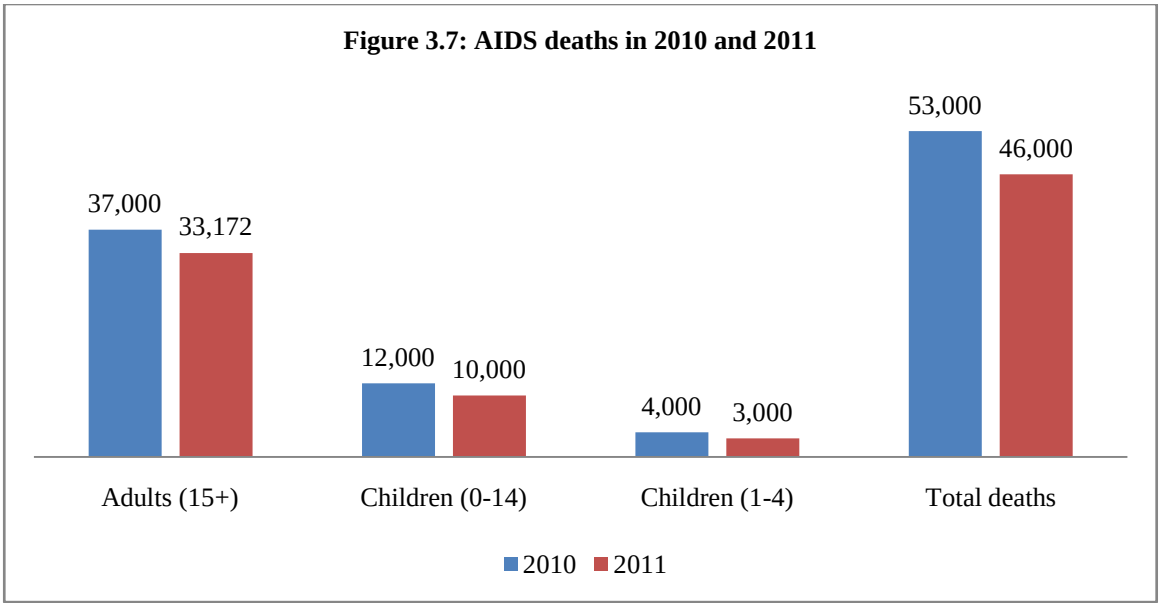


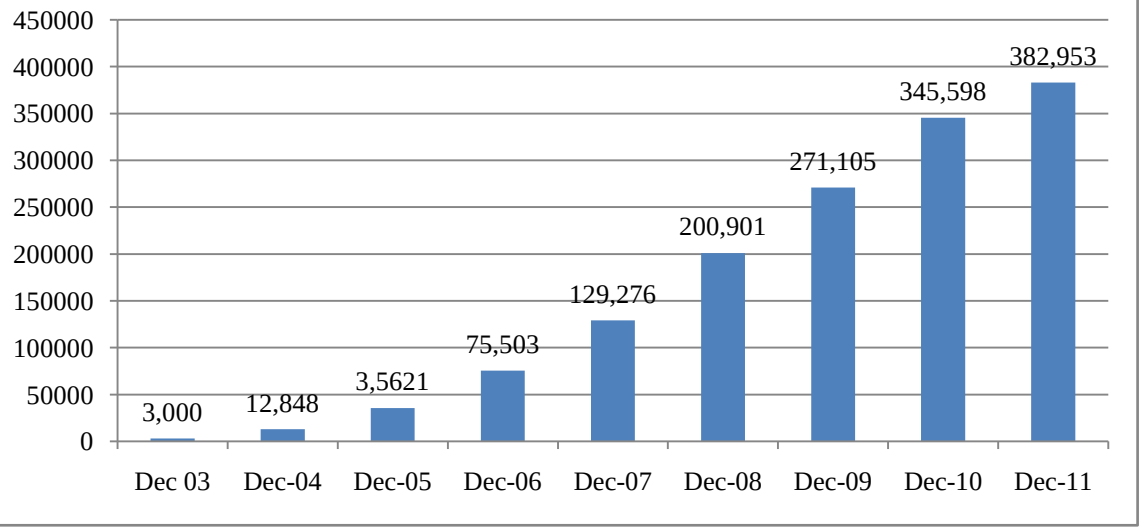
Figure 3.7 above shows that there has been a decrease in the number of deaths over the period 2010-2011. In 2010 it was estimated that there were 612,000 AIDS orphans and in 2011 this declined to 597,000. Out of the **382,953** patients ever initiated on ART, **276,987** (**72%**) were retained alive on ART, **44,390** (12%) had died, **60,555** (16%) were lost to follow-up (defaulted) and **1,424** (<1%) were known to have stopped ART. Eighty percent (**80%)** of adults and **81%** of children were retained alive on ART 12 months after ART initiation. An estimated **249,281** adults and **27,706** children (<15 years) were alive on ART by the end of June 2011.

3.5.5 ART Trends

The ART program in Malawi has grown significantly since it started in 2003. In 2003 only 3,000 PLHIV were on treatment. At the time ARVs were not free and were costing about

MK2,500 per month which most people could not afford. With the introduction of the free ART program largely supported by the Global Fund the number of people on ART started growing: it was 12,848 by December 2004 and by December 2011 382,953 had ever been started on ART as can be seen in Figure 3.8 below:

Figure 3.8: Number of persons ever started on ART 2003-2011



The growth of numbers of patient alive has been very consistent over time allowing for reliable forecasting and quantification of ARVs. New national integrated PMTCT/ART guidelines and training curricula were developed and implementation started in June 2011, with 120 trainers successfully trained.

3.5.6 Preventive Therapy (Cotrimoxazole)

At the end of June 2011, 94% of ART patients were on Cotrimoxazole Preventive Therapy (CPT). A cumulative total of 319,789 patients (pre-ART and ART) had been entered in CPT registers.

3.5.7 Co-Management of TB and HIV Treatment

The National TB Control Program (NTP) works very closely with the Department of HIV. However, more programming is directed towards reducing the burden of HIV on TB patients and not vice versa. The treatment success rate for tuberculosis in 2009 was 86%. Mortality due to tuberculosis is estimated at 8%, a significant reduction from 20% in 2006. The decrease in death rates and the increase in treatment success rates are partly due to effective HIV interventions. The TB/HIV co-infection rate is estimated at 63%, a reduction from 77% in 2000. Currently, 86% of TB cases have been tested for HIV. Of those tested positive, only 54% are on ART and 94% provided with Cotrimoxazole Prophylaxis. There is need for the NTP and Department of HIV to ensure that ART eligible TB patients receive treatment on time.

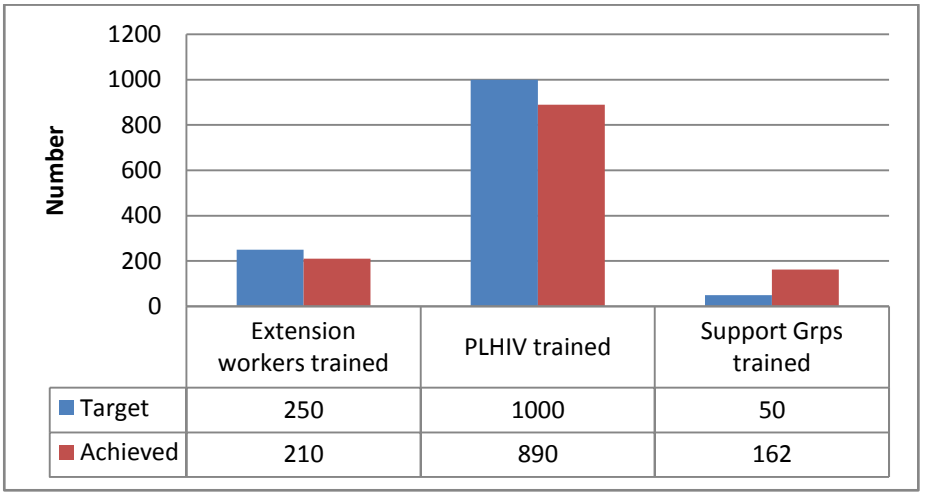
3.6 Care and support

3.6.1 Nutrition

There are a number of initiatives that are being implemented in Malawi in order to address nutritional requirements of PLHIV, orphans and other vulnerable children. For the period 2010-2011, Figure 3.9 below shows the number of extension workers and PLHIV who were

trained in food processing and utilisation and support groups supported with food and nutrition security programmes including provision of farm inputs and labour saving technology. Even though the achievements were short of target, these interventions were empowering:

Figure 3.9: Food and nutrition security Interventions 2010-2011



3.6.2 Orphans and other vulnerable children

There are a number of initiatives that target OVC in Malawi. These include the establishment and running of community based child care centres (CBCCs), the establishment of child care institutions (CCIs) and the social cash transfer program.

3.6.2.1 Legislative and policy environment

In 2003, the GoM and stakeholders developed the National Policy for orphans and other Vulnerable Children. In 2005, the GoM with support from UNICEF developed the National Plan of Action (NPA) for OVC for the period 2005-2009 which was then extended to 2011. The NPA called for the urgent scale up of interventions supporting children affected by the HIV epidemic. The overall goal of the NPA is to build and strengthen government, family and community capacity to scale up the national response for the survival, growth, protection and development of children affected by AIDS. The National Policy and the NPA therefore provide a solid framework for the national response to the OVC crisis facing Malawi. Another major milestone in the national response to OVC was the enactment of the Child Care, Protection and Justice Act in 2010. This Act provides a comprehensive framework that addresses the issue of children affected by HIV. The Act has provisions to protect children from discrimination and exclusion from essential services on the basis of their HIV status. The Act further provides for the establishment of alternative care structures for children affected by AIDS.

3.6.2.1 Establishment of Child Care Institutions

In Malawi, as is the case with other countries, some children are temporarily or permanently deprived of their family environment and such a context necessitates that they be provided with alternative care in an institution. The institutionalisation of orphans and other vulnerable children is the last resort after failing to take care of them in the community. Factors such as HIV, child abuse and neglect, endemic poverty, migration and family breakdown have contributed to an increase in the number of children requiring alternative care. A 2010 survey

found that there are 104 CCIs in Malawi and these are orphanages, special needs centres and reformatory centres. It was found that out of these CCIs 63 were orphanages. A total of 6,040 children were in these institutions and 66% of these children were in orphanages. Seventy one percent of the children in institutions were orphans. Children including orphans in these CCIs appreciated the fact that they were in institutions because their needs such as food, clothes and school fees for those in secondary school were being met. It is evident therefore that CCIs in Malawi are contributing significantly towards responding to the HIV epidemic by addressing the needs of OVC.

3.6.2.2 Establishment of CBCCs

Over the years the Ministry of Gender, Children and Community Development has been promoting the establishment and management of CBCCs as one way of responding to the needs of OVC in Malawi. These CBCCs are owned by communities and run by communities themselves. In such centres children are exposed to learning, they also play using outdoor as well as indoor play materials, they sing and above all they are given food. In most cases members of the community contribute food, money and other resources in order to run these centres. They also have communal gardens which are a major source of food for the CBCCs.

The attendance by children of these centres ensures that orphans especially have access to food at least once a day. There is further evidence that pre-primary schooling as it happens in CBCCs, enhances school readiness, increases enrolment and retention in schools, reduces class repetition, improves academic performance, increases primary completion rates and overall it also improves the health and nutrition status of children. A 2006/7 commissioned by UNICEF and conducted by the Centre for Social Research shows that there are 5,665 CBCCs in Malawi with half of them located in the southern region.

A total of 410,000 children were enrolled in the CBCCs in 2006/07. The number of children enrolled in 2010 is not available. UNICEF estimates that in 2011 a total of 771,000 children aged 3-5 accessed CBCCs and a further 187,500 accessed children's corners[55]. The CBCC study also looked at the proportion of children who attend CBCCs who are orphans or children with special needs. Overall 21.9% of the children enrolled in the CBCCs in Malawi are orphans while a smaller proportion (3.5%) being children with special needs[56].

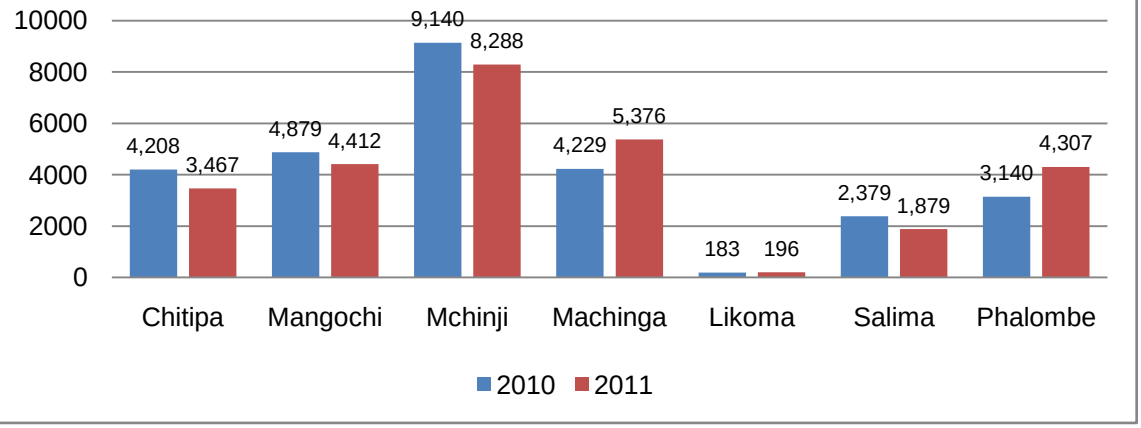
3.6.2.3 The social cash transfer program

The Malawi Social Cash Transfer Program (SCTP) was designed to alleviate poverty, reduce malnutrition and improve school enrolment by delivering regular and reliable cash transfers to ultra poor households that are also labour constrained. It was designed to reach Malawi's 10% poorest households. The program started as a pilot in Mchinji District with support from the Global Fund and UNICEF. Following a 2006 cabinet directive, the Program was extended to 6 other districts. As of 2011 the SCTP was being implemented in Mchinji, Salima, Likoma, Chitipa, Mangochi, Machinga and Phalombe. Ministry of Gender, Children and Community Development is the line ministry responsible for implementing the SCTP. The SCTP activity implementation is decentralised and managed by Local Councils where the District Social Welfare Office is key. The National Social Support Policy (NSSP) [57] provides policy guidelines for the SCTP. On average each household in the program receives MK2,000

[55] UNICEF. (2011). *Vulnerability and child protection in the face of HIV: report of the UN Technical Review Team on programming for children affected by HIV and AIDS in Malawi.* Lilongwe: UNICEF.
[56] Munthali, A., P. Mvula and L. Silo. (2008). *An inventory of CBCCs in Malawi*. Zomba: Centre for Social Research.
[57] Currently awaiting approval by Cabinet

(US$12) per month depending on the size of the household and number of school aged children in the household. Figure 3.10 below shows the number of households that have benefited from the SCTP for the years 2010 and 2011:

Figure 3.10: Number of households benefiting from SCTP 2010-2011



It can be seen that in 2010 and 2011 Mchinji had the highest number of households that benefitted from the program with Likoma being the least. In Mchinji the program has been running since 2006 hence it is understandable that it has the highest number of beneficiaries. SCTP data generally shows that in 2010 a total of 28,138 households benefitted from the SCTP in 2010 but in 2011 there was a decrease and 27,925 households benefitted. In 2010 a total of 50,895 orphans benefited from the program and in 2011 this number slightly went down to 48,220. It should be noted that out of the 7 districts only three districts namely, Likoma, Mchinji and Phalombe where the SCTP is being implemented to scale implying that 10% of the district population has been reached. An evaluation of the Malawi SCTP has generally shown that recipients reported that prior to the transfers their households were living in destitute, lacking food and basic necessities, facing HIV related stigma and were often sick. With the transfers, things changed: the prevalence of under-weight went down; food security improved; and school enrolment and retention increased among other benefits[58]. The major sources of funding for the program are the Global Fund, Irish Aid, GoM, KfW, the European Union and UNICEF.

In Zomba District in Southern Malawi, Baird et all implemented schooling conditional cash transfer (CCT) program in which they enrolled 1,225 girls aged 13-22 out of the 3,805 girls identified. These girls were given US$10/month: US$100 was transferred to these girls in equal amounts for the 10 months long school year. In addition to this for those in secondary school, school fees was paid for them. These transfers were only paid if the girls attended school for at least 75% of the days that school was in session in the previous month. This program led to a large increase in enrolment among girls, especially among those who were not in school at baseline. The CCT also led to a reduction in dropout rate among participants by 35%, reduced marriage rate by 40%, and it also reduced self reported sexual activity among program beneficiaries after one year of implementation[59]. Pettifor et al argue that Baird et al study provides a proof that alteration of the structural environment with cash payments can affect HIV risk in young women. Although payment of individuals to stay healthy might seem

[58] Miller, C.M., M. Tsoka. (2011). *ARVs and cash too: caring and supporting people with HIV and AIDS with the Malawi Social Cash Transfer.*

[59] Baird, S., E. Chirwa, C. McIntosh and B. Ozler. (2009). T*he short term impacts of a schooling conditional cash transfer program on the sexual behaviour of young women. Policy research working paper 5089.* Washington: World Bank.

expensive, it is still probably cost effective, at a cost per case of HIV averted of US$5000-12500, making it cheaper than other biomedical interventions[60].

3.6.2 4 School attendance among orphans

With regard to schooling, OVC experience a wide range of problems which can affect attendance and enrolment and these include lack of clothes including uniform, lack of school materials such as exercise books and pens and for those in secondary school the lack of school fees. There may also be a need for them to help with household chores. They lack these things mainly because of prevailing poverty. Hence OVC may be at a greater risk of dropping out of school. The 2010 MDHS looked at school attendance rates for children aged 10-14 by survivorship of parents and OVC status. The universal access target for the ratio of current school attendance among orphans to non-orphans among the 10-14 year olds was 0.98. The 2010 MDHS found that **the ratio of current school attendance among orphans to non-orphans among the 10-14 year olds was at 0.96.** Among females this was at 0.97 compared to males at 0.95.

3.6.2.5 Basic material needs

The 2010 MDHS also looked at the proportion of OVC who had minimum basic materials needs met. In this context the basic needs meant shoes, two sets of clothes and a blanket. The survey found that 52.6% of the children aged 5-17 had all the basic needs. On the other hand **41.1% of the OVC possessed all the three basic needs** and this was lower than among non-OVC where it was found that 55.7% possessed all the three basic needs.

3.6.2.6 External support for households with OVCs

The 2010 MDHS also looked at the extent to which households with OVC received external support. The majority (82.7%) of the households did not receive any type of support while 17.3% received at least one type of support. There were 4 types of support that such households received and these were medical, emotional, social/material and school related assistance. The study found that:

- 8.9% of the households with OVC received medical support in the past 12 months.
- 3.3% of the households with OVC received emotional support in the past 3 months.
- 2.6% of the households with OVC received social/material support in the past 3 months.
- 7.6% of the households with OVC received school-related assistance in the past 12 months.

3.7 Physical and sexual violence

Violence against women seems to be quite prevalence among women in Malawi. In 2010 28.2% of the women aged 15-49 reported that they have ever experienced physical violence since the age of 15 years. There were more women in the urban areas who reported this at 34.9% compared to rural areas (26.6%). Nineteen percent (18.6%) of the never married women aged 15-49 reported having ever experienced physical violence since age 15 and this increased to 27.8% among those who were married or living together; among those who were divorced/separated/widowed, 44.5% reported having experienced physical violence since age

[60] Pettifor, A., S. McCoy and N. Padian. (2012). Paying to prevent HIV infection in young women? The Lancet. doi:10.1016/S0140-6736(12)60036-1.

15. Over the 12 months period preceding the MDHS 3.7% of the women reported having experienced physical violence often during this reference period; 10.5% reported sometimes while 14.2% often/sometimes. Among women who were ever married, it was mainly the current husband/partner who perpetrated violence (54.5%) and this was followed by former husband/partner at 23.2%. With regard to sexual violence, 25.3% of the women aged 15-49 reported that they have experienced sexual violence and this was more common in the rural areas (25.9%) compared to urban areas (22.9%). Sexual violence is more common in the northern region as reported by 32.2% of respondents than in the central (25.2%) and the south (23.7%).

4. Some examples of best practices in the HIV and AIDS response in Malawi

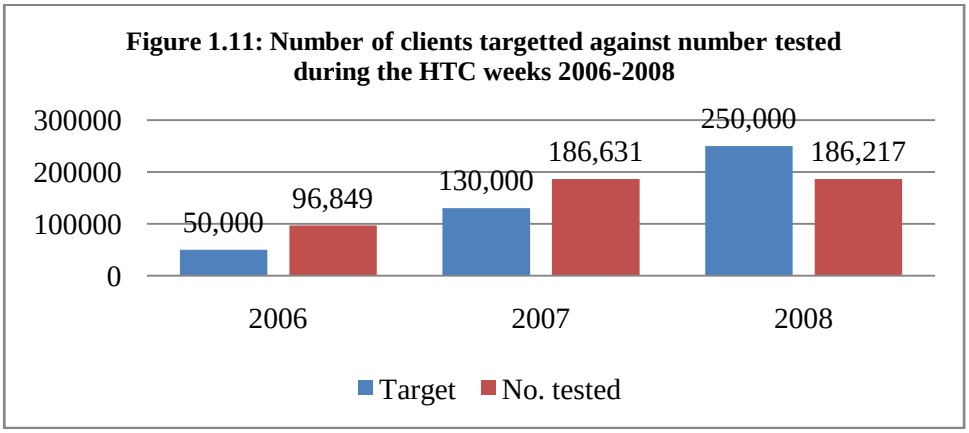
During the period 2010-2011 there were a number of interventions implemented in Malawi that can be described as best practices in the national HIV and AIDS response. One of these, the door to door HTC service, even though it was carried out a bit earlier in 2008-2009, will also be described because it was quite unique and was not documented in 2010.

4.1 Door to door HTC, moonlight HTC services and HTC week campaign

Normally HTC services are offered in static as well as outreach clinics. Over the last decade or so the number of HTC facilities has increased tremendously and this has also resulted into an increase in the number of people tested for HIV. Over the last three years, the number of people tested annually has stagnated at about 1.7 million. There is a need therefore to find innovative ways of increasing the number of people going for HTC services. One such innovative way is door to door provision of HTC services. This program was piloted in Zomba by St. Luke's Door to Door HTC Program in 2007 and its objective was to provide home-based HIV Testing & Counseling (HTC) services which encourage couple counseling and to assess the feasibility and acceptability of such district-wide program in Zomba. The counselors conduct village mobilization campaigns and then moved from house to house offering HTC to all consenting adults & exposed children. The program reached out to 120,000 individuals who underwent an HIV test. This is close to 10% of the number of people tested annually. The results showed that there was a satisfactory uptake of home-based HTC services in Zomba and that the demand and acceptance of this service remained high.

In addition to door to door HTC services, another innovative approach is the moonlight HTC service that has been introduced by MACRO where clients patronize services at night but this service was piloted in Karonga. Currently MACRO is analyzing the data from this pilot and preliminary results show that it can contribute significantly towards increasing the number of people being tested in Malawi. The population targeted includes couples, ordinary people, high profile individuals, youth and high risk behavioral groups. Overtime MACRO has realized that the urban population is reducing in terms of HTC uptake possibly attributable to saturation of the population by static sites and as such strategies to use mobile van, *moonlight* and outreach programs have been intensified to target the rural community.

As was mentioned earlier on, the number of HIV tests done over the last three years has been stagnant at approximately 1.7 million annually. In 2006, 2007 and 2008 Malawi conducted HTC week campaigns during which people were encouraged to go for HTC. Figure 3.11 below shows the targets for HTC during the HTC week campaigns against the actual number of people who were tested:



In both 2006 and 2007, the target for the number of clients to be tested during the HTC week was surpassed unlike in 2008 when it was off target. At national level it seemed that agreeing on targets for the HTC week was problematic and people got carried away by the fact that the bigger the target the better the campaign. Unlike in 2006 and 2007 where the issue of stockouts of HIV test kits was an issue, in 2008 the situation improved and the expectation was that it was possible to reach the target. The HTC week contributes significantly towards the number of people tested per year. The conduct of the HTC week is therefore one of the best practices that Malawi has been implementing contributing over 10% of total clients tested annually and especially reaching people in hard to reach areas.

4.2 Social cash transfer programs

The Malawi Social Cash Transfer Program (SCTP) started as a pilot in 2006 in Mchinji District with support then from the Global Fund and UNICEF. The program has however been extended to 6 other districts as detailed above. In 2011 alone a total of 27,925 households benefitted. Of these households, 236 were child headed and 17,381 were female headed. There were a total of 102,787 individual beneficiaries including 48,220 orphans benefited from the program. An evaluation of the Malawi SCTP has generally shown that recipients reported that the prevalence of under-weight went down; food security improved; and school enrolment and retention increased among other benefits. While acknowledging that the program is expensive it is important to scale up the program as it is having very high impact in terms of ensuring that children remain in school and have access to food as it is reported that food security improved greatly due to the program.

4.3 Encouraging uptake of PMTCT services through development of bylaws

The 2010 MDHS shows that there is still a significant proportion of pregnant women who deliver with the help of TBAs for various reasons. Delivering at TBAs and seeking ANC services from them can constitute a major barrier in terms of expanding access to PMTCT services as TBAs do not provide such a service. Initiatives that encourage delivery at health facilities in the presence of a skilled attendant should be promoted. In Mchinji traditional leaders have created village bylaws which require and encourage pregnant women to go to health centres to deliver. If they deliver at TBAs they are fined and this has made many women to start delivering at health facilities.

4.4 Option B+ for PMTCT services

In 2010 Malawi revised its policy for PMTCT of HIV and for ART in response to WHO's 2010 guidelines. The WHO guidelines specify a higher CD4 count and that HIV+ pregnant women should be on ART but this should be discontinued when they stop breastfeeding.

Access to CD4 cell count analysis in Malawi is a major challenge and unlikely to improve soon. Instead of relying on CD4 cell count, as a nation, Malawi has decided to offer all HIV positive pregnant women lifelong ART which is being referred to as Option B+. Since the start of this program in July 2011, the PMTCT program in Malawi has expanded and this is advantageous for countries which have very high fertility rates. It is argued that universal lifelong ART for pregnant women would help eliminate paediatric HIV and AIDS in the long run[61].

4.5 Mainstreaming HIV and AIDS in the private sector

The MBCA has done well in terms of ensuring that HIV and AIDS mainstreaming is done in the private sector. Mainstreaming HIV in the workplace especially in the private sector is done well both internally and externally as private businesses and companies are an integral part in the response to the HIV and AIDS. Internal programmes at the workplaces consist of training and peer education to ensure that workers are aware of HIV transmission and how this can be prevented. Within the workplaces condoms and ART are provided. HIV programs in the workplace have helped reduce stigma and discrimination. Some companies go further than their own workplace and advocate for increased engagement in HIV and AIDS work by other companies, sectors, communities, consumer groups and governments. Several businesses and companies are seen as an additional financing source in an environment of limited resource availability. MBCA represents the private sector response to the epidemic and is a good example of how mainstreaming should be done and coordinated in the private sector.

5. Major challenges and remedial actions

5.1 Challenges in the implementation of the national response

There are quite a number of challenges faced during the period (2010-2011)[62] which hindered the national response, in general, and the progress towards achieving targets, in particular;

1. High incidence of HIV.

2. Despite the fact that there has been some improvement in knowledge in some parts of the population, comprehensive knowledge is still low and available evidence suggests that current behaviour change programs have not had the desired impact as is evidenced by the stable and relatively high incidence across the country.

3. Weak supply chain systems are a significant barrier to the achievement of key HIV outcomes and it is essential that national health procurement and supply chain management systems are able to deliver a continuous and reliable flow of high quality, effective and affordable medicines and supplies in order to achieve satisfactory HIV outcomes.

4. Sustainability of the national HIV and AIDS response will be a major challenge in the coming years due to the suspension of the Global Fund Round 11

5. As is evidenced by available data, Malawi's epidemic is higher in women and girls but viable gender specific programs to address their needs are limited. The United Nations Development Assistance Framework (UNDAF) reports that the continuing

[61] Schouten, E. et al. (2011). Prevention of mother-to-child transmission of HIV and the health-related Millennium Development Goals: time for a public health approach. ***Lancet* 2011; 378: 282–84**
[62] NSP(2012-2016)

rise in HIV infection rates among young people, particularly girls, is due to several psychosocial and economic factors, including cultural/sexual initiation practices that often expose young girls to HIV. Malawi has a very young population, with approximately 44% of Malawians younger than 15, making youth prevention programs very important for containing and reducing the size of the epidemic.

6. Marginalised and vulnerable populations have access to available prevention, treatment, and care facilities but the national response is not adequately reaching these groups because programs do not specifically target them.

7. Uptake of services by PLHIV is being hampered by stigma and discrimination.

8. Standardisation of community engagement tools and service delivery protocols are crucial to ensure that services provided by the community, especially for PMTCT, HTC, and ART, are consistent and that communities share and disseminate common messages and themes, and engender the confidence of health providers.

9. Inadequate implementation and governance capacity and issues are hampering the efficient implementation of the national response.

10. Opportunities for more effective prevention and treatment outcomes are often lost because referrals and linkages between individual health care services and between health care services and communities are weak and not producing the desired result.

11. In Malawi over 95% of the population belong to some religious organization and a vast majority regularly attend religious ceremonies. It is an established fact that religious organizations strongly advocate abstinence and mutual faithfulness as effective strategies of preventing the spread of HIV and strongly oppose condom use arguing that it promotes sexual immorality. Thus, religious beliefs, teaching and practices have a significant influence on people's sexual behaviour

12. Reported shortages of condoms for the period 2010-2012.

13. Reports of stock outs of test kits.

A few challenges were identified in accessing health services. Some areas have no proper health facilities and the nearest facilities are costly. It was also reported that in some areas, some churches discourage their members from seeking health services. Other challenges mentioned include:-

- Poor road networks.
- Inadequate human resource at health facilities.
- Corruption among medical personnel.
- Sex workers being harassed by some medical personnel

5.2 Concrete remedial actions that are planned to ensure achievement of agreed targets.

The following recommendations are made in order to address the challenges detailed above:

- Expand effective HIV and AIDS behaviour change communications for the general population;

- Promote safer sex practices among young people in high risk groups and settings;
- Scale up interventions designed to fight HIV transmission among young people;
- Reduce the vulnerability of young people to HIV infection, especially among girls and young women;
- Expand advocacy and social mobilization for HIV prevention at the district and community levels.
- Develop an HIV law that is in line with the laws of Malawi and international human rights instruments.
- Address procurement bottlenecks and ensure that there are adequate supplies including test kits and condoms.
- Implementation of voluntary medical male circumcision as per the National HIV Prevention Strategy 2009-2013.
- Implementation of Option B+ as a strategy for eliminating MTCT.
- Development of a sustainable financing strategy for the national HIV and AIDS response, that also explores alternative sources of funding

6. Support from the country's development partners

Development partners in Malawi have invested significant levels of funds into HIV prevention, care and treatment and support and associated activities over the years. In particular major funding partners have been the Global Fund; World Bank; the Government of the United Kingdom; The Kingdom of Norway; Government of Canada; the US Government; and the United Nations.

In 2003, the GoM entered into an MoU with development partners to harmonise their support in a Pooled Funding Arrangement. These partners included the Canadian International Agency, the UK's Department for International Development, Global Fund to Fight AIDS, Tuberculosis and Malaria, the Kingdom of Norway and the World Bank. Some development partners are not able to pool funding but align their discrete support to the national priorities (the NSP) and take part in the HIV and AIDS Development Group. The new Partnership Framework between US Government (USG) and GoM aligns USG support for HIV and AIDS in Malawi fully with the NSP in order to implement the goals, objectives, strategies and action points of the NSP.

Development partners are also members of and actively participate in coordinating, advisory and governance bodies i.e. The Malawi Partnership Forum (MPF) and the Malawi Global Fund Coordinating Committee (MGFCC). The MPF is an advisory body to the NAC Board supporting the leadership and coordination mechanisms of the NAC and serves as a systematic coordination mechanism that minimizes wasteful duplication of efforts in scaling up of the national response to HIV and AIDS, The MGFCC is a committee set-up to provide oversight and governance of Global Fund grants in Malawi.

Development partners are also members of the HIV and AIDS Development Group (HAGD) , whose objectives are to harmonise and coordinate development partners' support to the NSP and to align development partners' support to the integrated annual work plan.

Other partners have provided funding directly to implementing partners. While support from donors is acknowledged as a country there have also been challenges in terms of accessing donor funding for HIV and AIDS programs. It has become evident that external funding for HIV and AIDS is becoming more difficult for developing countries as a result of the global financial crisis and the contraction of the economies of key donor countries. In addition to providing funding, the development partners also provide technical support to the HIV and

AIDS response and participate in various technical working groups set-up to provide technical guidance in specific areas of the national HIV response, and reporting to the MPF.

It is critical that the NSP focuses on priority interventions which will have a major and lasting impact on the epidemic in the short term and the medium term. The new financing environment also means that the issue of sustainability and the coordination of the national response within national structures should be at the forefront of policy makers' thinking and actions. This NSP focuses on the development of strategic interventions which attract most benefits and synergies between programs. Accountability and transparency for all implementers and stakeholders will also be a major factor to ensure the NSP can be funded and is implemented effectively; this requires a proficient national and integrated monitoring and evaluation system.

7. Monitoring and evaluation environment

7.1 An overview of the current HIV monitoring and evaluation system

The GoM developed the MGDS, a national development agenda for Malawi, in 2011 for the period 2011-2016. The MGDS domesticates the MDGs and it has a comprehensive list of indicators and their targets including those on HIV and AIDS. The Ministry of Finance, Planning and Development Cooperation has the overall responsibility of tracking progress made towards achieving indicator targets as detailed in the MGDS. The MGDS is multi-sectoral in nature and, hence, sectoral monitoring and evaluation systems have the responsibility of monitoring what is happening in their sector. The National AIDS Commission in conjunction with other stakeholders developed a National Monitoring and Evaluation System in 2003 and such a system is coordinated by the National AIDS Commission with oversight from the Secretary for the Department of Nutrition, HIV and AIDS in the Office of the President and Cabinet.

Within the National AIDS Commission there is a Department of Planning, Monitoring, Evaluation and Research which is responsible for among other things, monitoring and evaluation of the national response to the HIV and AIDS epidemic. A similar section is also in the Department of Nutrition, HIV and AIDS that oversees the M and E functions. The MoH implements the HMIS which among other things collects routine data on HIV and AIDS. The Department of HIV in the MoH has also developed a parallel system which is being used for collecting data on biomedical interventions namely HTC, PMTCT and ART among others. Surveillance efforts are being done by the Epidemiology Unit of the MoH at Community Health Sciences Unit. All organizations that implement HIV and AIDS interventions are also supposed to report on a quarterly basis to the National AIDS Commission and the M and E section in the National AIDS Commission compiles this data into a National M and E Report. A Monitoring, Evaluation and Research TWG has been formed and its function is to oversee HIV monitoring and evaluation issues within the national response and it is supposed to meet quarterly. While M & E is important very little funds are allocated for this activity.

7.2 Routine HIV and AIDS program monitoring

It has been mentioned above that the different organizations implementing HIV and AIDS interventions are supposed to report to the National AIDS Commission on a quarterly basis. The monitoring of these activities is done through the Local Authority HIV and AIDS Reporting System (LAHARS). The LAHARS is used to collect data on both biomedical and non-biomedical interventions at district level and once this is done the data is sent to the National AIDS Commission. In 2010-2011 significant efforts were made to institutionalize

LAHARS even though data quality was still questioned and the continued lack of capacity for research and M&E. The HMIS also collects routine data within the health sector.

7.3 The Department of HIV M & E System

As has been mentioned earlier, the M & E Unit in the Department of HIV in the MoH is responsible for collecting data on ART, PMTCT and HTC among other biomedical interventions. A recent report found that the M&E Unit for the ART Program is well staffed and well organized with significant level of external technical assistance. The M&E Unit collects data from the health facilities as part of supervisory visits and data is cleaned on-site and the supervisors' copy is taken to the M&E Unit for further aggregation. The only weaknesses noted in this report included minor incompleteness of source documents and the supervisors'copies of the quarterly facility reports[63]. Both availability and timeliness of reports was 100%; completeness was 96.4%. Within the M & E Unit, staff positions necessary for the reporting needs of the program/system have been filled; program staff at all levels have received training on data management processes and tools; the review and aggregation of data and reports are done in teams at all levels; and that supervisory visits that are done as part of data collection and reporting help to improve the quality of the program's reported data.

7.4 Surveys and surveillance

In addition to routine data there are also special surveys that are conducted in order to determine coverage of interventions or impact of different interventions that are being implemented. Examples of such surveys are the MICS, the BBSS and the MDHS. These are national level surveys conducted by the NSO. The MDHS is conducted every 4 years and is key in determining behavioural outcomes. ANC HIV sero-surveillance surveys are also conducted by the MoH every two years in order to determine HIV prevalence and this is further used to estimate the prevalence at national level. The last such survey was conducted in 2010.

7.5 Challenges faced in the implementation of a comprehensive M&E system

During an M & E assessment in 2011, the following challenges were identified:

- While a lot of improvements have been made in the HIV M & E system, there are still a number of problems with regard to quality of data. A significant proportion of the stakeholders do not report to the National AIDS Commission and even where they report the reports are incomplete and untimely.
- Shortage of human resource in M & E and research and limited disciplinary scope of the M&E.
- Inadequate financial resources for managing an effective HIV and AIDS M & E system.
- Insufficient disaggregation of data.
- Limited use of data.
- Non-functional M & E TWG at district level.
- Limited appreciation of HIV M&E at district levels and discretional involvement of M&E personnel
- Lack of reporting forms beyond the local authorities.

[63] JSI/Global Fund DQA final review report July 2011

- The BBSS have not been as regular as desired.
- Limited internet connectivity hampering the functionality of the data bases.
- Non-availability of the Research agenda.

7.6 Recommendations to address challenges in M & E

The following recommendations are therefore being made in order to address the challenges prevailing within the HIV M& E environment. These recommendations are based on the M&E assessment conducted in 2011.

- Fill existing vacancies in M&E sections and build the capacity of M&E officers.
- Conduct regular M&E capacity assessments.
- Include district representation in the National M&E TWG.
- Revitalise the District M&E TWG.
- Advocate for more funds to be allocated to M&E at all levels.
- Provide reporting forms at district and lower levels.
- Provide funding to ensure regular and timely conduct of surveys such as the BBSS.
- Build capacity of users in utilisation of M&E and research data for policy and program development.
- Develop a research agenda for Malawi.

Annex 1: List of persons and organisations consulted during the development of the report

	Name	Institution	Position
	LILONGWE		
1.	Dr. Mary Shawa	OPC-DNHA	Principal Secretary
2.	Doreen Kumwenda	DNHA	Planning Officer
3.	Sylvester Gawamadzi	DNHA	Chief Planning Officer
4.	Ishmael Nyasulu	WHO	TB/HIV National Professional Office
5.	Patrick Brenny	UNAIDS	Country Coordinator,
6.	Pepukai Chikukwa	UNAIDS	M&E Adviser
7.	Tanye Nystedt Coelho	UNAIDS	Programme Analyst
8.	Christopher Teleka	NAC	Ag. Head of Behaviour Change Interventions
9.	Davie Kalomba	NAC	Head of Planning, M&E & Research Unit
10	Chimwemwe Mablekisi	NAC	Planning Officer
11.	Chimango Jere	NAC	Head of Procurement
12.	Levi Lwanda	NAC	M&E officer
13.	Wellington Kafakalawa	NAC	M&E officer
14.	Moses Chikowi	NAC	M&E officer
15.	Mwai Makoka	NAC	Ag. Head of Policy, Support and Development
16.	Mahara Longwe	NAC	Ag. Head of Partnership and Liaison
17.	Jonathan Vumu	NAC	District Coordination Officer-Central Region
18.	Ellious Chasukwa	NAC	Policy Officer-Socio Economic
19.	Yohane Kamgwira	NAC	Head of District Coordination
20.	Blackson Matatiyo	NAC	Research Officer
21.	Marriam Mangochi	NAC	Director of Programmes
22.	Washington Kaimvi	NAC	Director of Finance & Admin
23.	Wellington Enoch Limbe	MACRO	Executive Director
24.	Safari Mbewe	MANET+	Executive Director
25.	Mumderanji Mwamlima	MANET+	Administrative Assistant

26.	Clara Banya	MANET+	Accounts Assistant
27.	Robert Ngaiyaye	MIAA	Executive Director
28.	Victor Chayamba	CCM secretariat	Program development Specialist
29.	Ivy Zingano	Central Medical Stores	Procurement and Supply manager
30.	Irene Banda	Save The Children	Project Manager Bridge II project
31.	Emmanuel Zenengeya	Save The Children	RMC coordinator Education and Child development sector
32.	Chisomo Zileni	National Youth Council	Program Officer SRH/HIV
33.	Rodney Chalera	CEDEP	Program officer
34.	Chifundo Chikaonda	CEDEP	Program officer
35.	Frank Chisambula	MHRC	Chief Human Rights Resource Officer
36.	Macdonald Sembereka	HRCC	Acting National Coordinator
37.	Wilfred Lichapa	MOYDS	Director
38.	Alick Kalima	MOYDS	Deputy Director
39.	Frank Chimbwandira	MOH-HIV/AIDS	Director
40.	Augustine Mnthambala	MOH-HIV/AIDS	Deputy Director
41.	Lyson Tenthani	MOH-HIV/AIDS	M&E officer
42.	Andreas Jahn	MOH-HIV/AIDS	M&E Technical Expert
43.	Libby Levison	MOH-HIV/AIDS	Supply chain management consultant
44.	Robert Phiri	Southern Africa AIDS Trust	Country Program Manager
45.	Daisy Chizomola	LL City Council	City AIDS Coordinator
46.	Roberto Campos	UNAIDS	Partnership Adviser
47.	Edward Chatsalira	Malawi Police Service	HIV & AIDS Coordinator
48.	Cynthia Mambo	IMPACT/CRS	M&E Technical Quality Coordinator
49.	Jessie Ching'oma	MCTU	HIV & AIDS Coordinator
50.	George Chiusiwa	MHRC	Investigations Officer
51.	Patrick Makono	National Youth Council	Program Officer
52.	Mathias Ghatsa Chatuluka	FPAM	Executive Director
53.	Claire Walsh	Theatre for A Change	M&E manager

54.	Amanda Sefu	National Youth Council	Intern
55.	Maxi Haler	CEDEP	Intern
56.	Margaret Lwanda	Min of Agriculture	Deputy Director
57.	Cathreen Chirwa	MANERELA+	Program Support Associate
58.	Malla Mabona	FHI 360 Malawi	Ag Country Director
59.	Dafter Khembo	DPSM	Program Manager
60.	Mtemwa Nyangulu	MoH HIV AIDS	HTC coordinator
61.	Laureen Mkupu	Malawi Defence Force	M&E officer
62.	Maxwell Dzikanyanga	Education	SHN Coordinator
63.	Milward Chanza	MANASO	Regional Coordinator
64.	Ellen Thom	Mother 2 Mother	Country Manager
65.	Sam Phiri	Light house Trust Clinic	Executive Director
66.	Saulos Mhlanga	Lighthouse Trust Clinic	Financial Administrator
67.	6 MSM	CEDEP	
	MCHINJI		
68.	Gasten Macheka	District Council	District Commissioner
69.	Patrick Mulenga	District Council	District AIDS coordinator
70.	Emmanuel Sohaya	District Council	District M&E officer
71.	Chiyanjano Gondwe	MOH –district Hospital	PMTCT coordinator
72.	Edda Sani	MOH - district Hospital	CHBC coordinator
73.	Eric Mittochi	MOH - district Hospital	ART coordinator
74.	Esnatu Chirambo	MOH- district Hospital	STI provider
75.	Geroge Chimadzuma	MOH- district Hospital	HTC coordinator
76.	Edson Kamba	MOH- district Hospital	Clinician
78.	PLHIV Support groups	Mchinji AIDS Support Organization	8women 5 men

	BLANTYRE		
79.	Forbes Msiska	Badilika Foundation	Founder , researcher and trainer
80.	Clement Jere	Badilika Foundation	Secretary
81.	Harold Zenengeya	Badilika Foundation	Volunteer
82.	Purity Msiska	Badilika Foundation	Director
83.	Carolyn Wadi	Badilika Foundation	Project coordinator
84.	Masozi Mkolongo	Badilika Foundation	Finance Officer
85.	Irene Makwinja	Badilika Foundation	Volunteer
86.	Bridon M'baya	MBTS	Medical Director
87.	Macklay Ndileke	MBTS	Senior Lab technician
88.	Petros Mazunda	NAC - District Coordination Unit Blantyre	Grants Officer
89.	Ken Chisagana	NAC - District Coordination Unit Blantyre	District AIDS coordinator
90.	Angela Chipeta-Khonje	BLM	Innovation /Best practice Manager
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92.	Veronica Chikafa	MBCA	Capacity Building Coordinator
93.	Gift Mwamlima	MBCA	M&E coordinator
94.	Lyness Soko	MBCA	Communication and Advocacy coordinator
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	CHIRADZULU		
96.	Robert Mangani	Kadewere Community	Senior Chief of Kadewere
97.	Chriss Nawata	District Council	District AIDS coordinator
98.	Chrissie Kamtsitsi	District Council	District AIDS coordinating Committe
99.	Mercy Chisuwo Banda	District Council	Human Resource management officer
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101.	Regnald Nakhumwa	District Council- Trade	Assistant district trade officer
102.	Chifuniro Mbozi	District Council- Environment	Environmental District officer
103.	Alice Nyalugwe	District Council - Education	District Education officer

104.	Chingoni Chatha	District Council - Information	District Information officer
105.	Thom Immani	District Council - Social	Community child protection worker
106.	Anderson Selemani	District Council- Community	Senior community development assistant
107.	Janet Banda	District Council - Health	HTC coordinator
108.	Witson Ngalugwe	Police	RIP
109.	16 females 5 males	Ndunde PLHIV Support Group	
			2 NAPHAM members
			4 HBC members
			1 health surveillance assistant
		ZOMBA	
110.	Michael Gondwe	Youth Net and Counselling	Program Manager

Annex 2: List of persons and organisations that participated in the validation workshop for the GARP Report for Malawi

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