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Agenda item 4

**Joint United Nations Programme on AIDS
Case Study: Malawi**

This case study has been prepared to provide an example of the support of the Joint Programme to the national response in a particular country. As such, the conference room paper supplements the PCB documents for the agenda items related to the Unified Budget, Results and Accountability Framework (UBRAF). It is intended as an illustration of UNAIDS work at country level to inform the deliberations of the Programme Coordinating Board.

INTRODUCTION

1. This case study provides an overview of the role of UNAIDS in Malawi's AIDS response, describing how the contributions of the Cosponsors are coordinated, funded and managed through the Joint UN Programme and Team on AIDS.
2. The study highlights successes in the national response and how UNAIDS can further contribute to setting national priorities in Malawi and achieving concrete results.

BACKGROUND

3. HIV prevalence in Malawi decreased substantially from 2001-2011, from 16.9% to 10.6%. Approximately 80% of all new infections are acquired through unprotected heterosexual intercourse, and almost one in five new infections are children born to HIV-positive mothers. A small percentage of infections are transmitted through blood transfusions and contaminated medical injections or skin piercing instruments.
4. Several factors influence the HIV epidemic in Malawi, including multiple concurrent sexual partnerships, low-level condom use, significant gender inequalities, and stigma and discrimination towards people living with HIV and key populations, particularly sex workers and men who have sex with men.
5. The national AIDS response in Malawi is guided by the National HIV and AIDS Policy 2011-2016 (Sustaining the National Response) and the Malawi National HIV and AIDS Strategic Plan, 2011-2016, which prioritize: prevention; treatment, care and support; promoting a comprehensive multi-sectoral and multidisciplinary response to HIV and AIDS; impact mitigation; protection, participation and empowerment of people living with HIV and other vulnerable populations; mainstreaming and linkages; sustaining the national HIV and AIDS research agenda; capacity development; and monitoring and evaluation.
6. The national policy and national strategic plan are aligned to the global AIDS targets of the 2011 Political Declaration on HIV and AIDS, with a primary focus on four of the 10 global AIDS targets¹ as well as the UNAIDS Strategy 2011-2015: Getting to Zero.
7. The estimated cost of the national AIDS response in Malawi is US\$ 1.3 billion for the period from 2012 to 2016. Development partners have committed to about 40% of that amount (including US\$ 120 million from UNAIDS). The national response, however, remains highly dependent on external funding. Consequently UNAIDS is working with the Government and development partners towards sustainable AIDS funding, in line with the policies and strategies of Shared Responsibility and Global Solidarity adopted by the African Union (AU).

¹ Target 1: reduce sexual transmission of HIV by 50%; Target 3: eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths; Target 4: reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015; and Target 8: eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms.

JOINT UN PROGRAMME AND TEAM ON AIDS

8. The Government of Malawi and UNAIDS have identified the national AIDS response as a priority area of investment by the UN system since 2004, and HIV remains one of four priority themes under the five-year UN Development Assistance Framework (2012-2016) for Malawi. The key goal of the UNDAF Malawi HIV theme is to provide coherent and unified support and to leverage UNAIDS funding to scale up the national response to achieve universal access to prevention, treatment, care and support, in line with the Government's commitments to the targets set at the UN General Assembly High Level Meeting on AIDS in 2011. The HIV theme focuses on four key programme areas that are aligned to the Malawi Growth and Development Strategy-2 (2012-2016), the national HIV policy, and the national HIV and AIDS strategic plan:
- Prevention: Key populations have equitable access to quality, gender-sensitive HIV preventive service (lead agency UNFPA)
 - Treatment and care: The population has an increased and equitable access to quality HIV and tuberculosis treatment and care services (lead agency WHO)
 - Impact mitigation: Communities in selected districts are protected from the social, psychological and economic impact of HIV and AIDS (lead agency UNICEF)
 - Enabling legal and policy environment: The national AIDS response is evidence-informed, coordinated, sustainably resourced, efficient and based on a supportive legal and policy environment by 2016 (lead agency UNDP)
9. The Joint UN Team in Malawi assembles all the key UNAIDS partners working under the UNDAF HIV Theme in the spirit of Delivering as One. Its membership comprises of 24 international and national professional officers from across the UNAIDS partners in Malawi. The Joint UN Team is chaired by the UNAIDS Country Coordinator (UCC) and has four outcome leads from the Cosponsors, who report to the UCC and who each chair one of the four HIV Theme outcome areas.
10. The total UNAIDS budget for support through the UNDAF HIV Theme for 2012-2016 is US\$ 98,660,144. The projected workplan budget for 2012/2013 constitutes about US\$ 33 million² as distributed below between the global AIDS targets set at the high level meeting on AIDS in 2011:

Joint UN Programme of Support on AIDS Work Plan for 2012/2013		% of overall budget
Reduce sexual transmission of HIV by 2015	9 247 000	28
Eliminate new HIV infections among children by 2015	7 520 000	23
Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015	6 840 000	20
Reduce tuberculosis deaths in people living with HIV by 2015	1 300 000	4
Close the global AIDS resource gap by 2015	2 160 000	7
Eliminate stigma and discrimination against people living with and affected by HIV	4 905 000	14
Governance and accountability	1 500 000	4
	\$33 472 000	100%

KEY ACHIEVEMENTS

² The UN HIV-related expenditure in 2012 was US\$ 50,932,633.

11. Malawi is making significant progress towards achieving its commitments to the global AIDS targets set at the UN General Assembly High Level Meeting on AIDS in 2011. There is strong consensus among UNAIDS and other stakeholders that the Joint UN Team has played a central role in achieving the following successes in Malawi:

Expansion of antiretroviral therapy to pregnant women

12. Malawi offers pregnant women a special programme, called Option B+³. Since the Option B+⁴ roll-out (from June 2011 to 2012), there has been a seven fold increase in the number of pregnant and breastfeeding women starting antiretroviral therapy, from 1,257 to 10,663.

13. There has been a sharp increase in people registered for treatment in Malawi, from 18,442 in July 2011 to 29,707 in the third quarter of 2012, an increase of almost 100%. This is due to antiretroviral services being integrated, with UNAIDS and development partners' support, into antenatal care/maternal and child health clinics, so the number of sites providing treatment rose from 303 in June 2011 to 641 in September 2012, again an increase of more than 100%.

14. This also led to the establishment of an HIV-exposed child follow-up programme in 517 sites, further transforming prevention of mother-to-child transmission (PMTCT) services and serving as a model for other countries⁵. For the Malawian experience to serve as a best practice for others, it would be essential that it stresses support for women to make informed and voluntary choice for Option B+.

15. Other examples of UNAIDS support included:

- Strategic guidance to the Government to develop a national eMTCT scale-up plan, including district action plans following the launch by UNAIDS and the US President's Emergency Plan for AIDS Relief of the global plan to virtually eliminate mother-to-child transmission.
- Training for more than 600 providers in the new antiretroviral therapy/ PMTCT transmission regimen ensured the PMTCT programme was mentored and supervised.
- Raised PMTCT awareness and worked with local partners to produce 12 radio programmes that the national broadcaster aired to up to four million listeners. An additional 2,641 families were reached through door-to-door activities and 102,050 people through public performances by community club members with messages on PMTCT.
- Early infant diagnosis through rapid SMS technology was launched in 16 districts. More than 4,500 new health surveillance assistants were trained in this technology, resulting in 267 sites using the SMS technology to transmit early

3 MMWR Vol. 62 No. 8, March 1, 2013 p.148

4 Option B+ comprises one pill a day starting in the 14th week of pregnancy (or as soon as the woman is diagnosed HIV+, if she comes after the 14th week), with the woman remaining on ART for life once initiated. The single pill comprises three potent antiretroviral drugs already recommended for first-line therapy, and the non-interruption of treatment enhances the public health approach to ART in Malawi due to extremely high fertility levels in the country. This simpler regimen and approach greatly eased supply chain, laboratory testing, and general service delivery in Malawi. The only prerequisite was that the pregnant woman test positive and she was offered the once-a-day antiretroviral pill. Because pregnancy is a finite period, it is essential to minimize disruptions and simplify the woman's access to services both during and after her pregnancy. Option B+ was offered in regular antenatal clinics, transforming these clinics into HIV treatment sites in a matter of months.

5 Countries that have already visited Malawi to learn from its experience are: Democratic Republic of the Congo, Rwanda and Senegal.

infant diagnosis results to polymerase chain reaction (PCR) laboratories at the country's two main referral hospitals.

- Supported a sexual and reproductive health (SRH) and HIV linkages project in 15 health centres in three districts, improving the capacity of health care workers, ensuring SRH/HIV services were included in the district implementation plans and increasing the demand for such services.
- Currently supporting a study to assess the human rights, ethical and equity dimensions of the country's decision to adopt Option B+.

16. A diagram of the results chain detailing UNAIDS comprehensive contributions to the eMTCT efforts can be found in the Annex.

Malawi establishes itself as a global leader in rolling out antiretroviral therapy in resource-constrained settings with an estimated 450,000 Malawians on treatment

17. Prior to the UNAIDS/WHO-led launch of the 3 by 5 initiative (putting three million people living with HIV on life saving antiretroviral treatment by the end of 2005) in 2003/4, there were fewer than 3,000 people on treatment in Malawi and there was an ambitious government plan to place 10,000 people living with HIV on treatment by the end 2005.

18. Under 3 by 5, and with a substantial grant from the GFATM, Malawi exceeded all expectations and scaled up treatment coverage to 27,088 people by 2005. This rapid scale up has continued, resulting in 391,388 people living with HIV reported to be on antiretroviral therapy at the end of 2012.

19. Today, 450,000 people are estimated to be on treatment in Malawi. Coverage has been augmented by the recent Option B+ roll-out, which effectively integrated antiretroviral therapy into maternal and child health clinics. Such coverage has meant more than 70% of Malawians eligible for treatment have access to it. More women than men have benefitted from the scale-up.

20. As with the Option B+ roll out, UNAIDS has also played a key role in starting and accelerating the treatment programme in Malawi. Its contributions can be categorized in five main areas.

21. **Advocacy:** Initially, not all key stakeholders and actors were convinced that a treatment agenda was feasible in Malawi. UNAIDS, backed by crucial WHO guidelines for scaling up antiretroviral therapy in resource-constrained settings, led an aggressive but inclusive advocacy for a treatment agenda for Malawi. UNAIDS advocated with and mobilized bilateral and multilateral development partners to support the agenda and ensure their funding activities and programmes were aligned with national treatment scale-up priorities.

22. **Normative and technical guidance:** UNAIDS helped develop policy and strategy documents, and cost, complete and endorse the antiretroviral scale-up plan. UNAIDS shared with the Government and national partners new WHO treatment guidelines, adapting them to the local context, and helped the Ministry of Health and the National Aids Commission develop protocols and tools. It also advocated for and continued to support a generalized national HIV testing policy to drive the treatment scale-up agenda.

23. **Mobilizing resources and facilitating support:** UNAIDS, particularly the UNAIDS Secretariat, UNDP, UNFPA, UNICEF and WHO, have helped mobilize resources for

the national response, providing technical support for Malawi's programme proposals to the World Bank and the GFATM, which have generated more than US\$ 400 million in funding. UNAIDS Secretariat and WHO also play key roles in the Malawi GFATM Coordinating Committee, particularly in the work of the oversight committee to ensure grants are effectively managed and recipients held accountable. UNAIDS ensures affected communities and civil society partners have a voice at these important forums.

24. UNAIDS initiated and brokered the HIV Pool Funding Group, with initial investments from UNDP, the World Bank, Norway, the Canadian International Development Agency, the GFATM and the Government of Malawi. The HIV Pool (which serves as a sector-wide approach) has continued to bring coherence and continuity to the external financial support for the national response.
25. UNAIDS also initiated and brokered the HIV/AIDS Development Group, which shares information and brings together development partners to pursue various aspects of the national response, including treatment.
26. **Implementation support:** procurement and supply chain management (stock-outs, oversupply and expiration of drugs) has been a long-term challenge for government due to weaknesses in national systems and inadequate institutional and human capacity. When asked what kept him awake at night, the Ministry of Health HIV Director said "ensuring availability and timely delivery of drugs and test kits is my greatest concern". UNAIDS intervened directly to address the pivotal bottleneck, without which, treatment scale-up in Malawi would not have been possible. For the past 10 years, UNAIDS (through UNICEF) has helped the Government procure and deliver GFATM-financed antiretroviral drugs and HIV commodities. The GFATM has taken over procurement for Malawi, through voluntary pooled procurement (VPP), but UNICEF will continue to distribute commodities for another year while the Government builds system capacity. UNICEF is providing technical assistance and training. According to the National AIDS Commission Director, "treatment scale-up in the country would not have succeeded without the UN support".
27. Through the One UN Fund, isoniazid was procured to implement isoniazid preventive therapy in people living with HIV in the pre-antiretroviral therapy phase as recommended in the new antiretroviral therapy/prevention of mother-to-child transmission guidelines.
28. **Capacity building:** UNAIDS helped lay the foundations to reduce the human resources capacity gap and scale up treatment. In 2004/5, jointly with DFID, it brokered and supported a six-year emergency relief programme for human resources for health, and helped mobilize US\$ 270 million to implement it. DFID contributed USD 100 million towards the initiative. The main components of the programme included retaining staff through salary top-ups, a special tutor incentive initiative, securing specialist UN Volunteer physicians (contracted through UNDP and UN Volunteers and funded with resources provided by GFATM (HIV grants for Malawi) and encouraging retirees to return to service.
29. The emergency human resources programme accomplished its primary goal to increase the number of professional health workers in Ministry of Health and Christian Health Association of Malawi institutions, the latter being a key government collaborator in delivering public health in Malawi. Across the 11 priority cadres, the total number of professional health workers increased by 53%, from 5,453 in 2004 to 8,369 in 2009. At the outset of the programme in 2004, the total health provider density, including health surveillance assistants, was 0.87 per 1000 population in the public sector (Ministry of Health and Christian Health Association of Malawi). This figure rose to 1.44 by 2009, a 66% increase. Malawi has, thanks to this critical

initiative, moved beyond the emergency stage for staffing and producing health workers. Sizeable gains (increases of more than 50%) have been made in the number of staff in the workforce and enrolled students in health training colleges.

30. A five-year Ministry of Health-UN joint programme continues to provide specialist UN Volunteer physicians while medical professionals are trained, with continued support and part-funding from the GFATM and UNAIDS.
31. UNAIDS also implemented programmes that supported treatment scale-up. WHO and UNICEF helped train health-care workers in the new WHO guidelines on laboratory and health facility standards.

Interventions targeting key populations and human rights have led to a better enabling environment: Government of Malawi announcing a moratorium on criminalization of same sex relations opens an unprecedented national debate on the subject.

32. In early 2013, the Minister of Justice of the Government of Malawi announced a moratorium on enforcing the criminalization of same sex relations and authorized an unprecedented national debate on the issue to stimulate the protection of human rights and equitable access to health services for all Malawians.
33. The Joint UN Team has also contributed at various levels, promoting human rights and gender equality, and helping the Government develop key policy documents to ensure a rights-based, sustainable and comprehensive AIDS response.
34. **Enabling environment:** the Joint UN Team helped the Department of Nutrition and HIV/AIDS and the National AIDS Commission finalize a National HIV Policy, the National HIV Strategy and the National Monitoring and Evaluation Plan to ensure a comprehensive national AIDS response. The new policy takes into account the needs and rights of key and vulnerable populations, and includes contributions from the UNAIDS and GFATM Executive Directors as well as the UN Secretary-General to encourage Malawi to avoid criminal punishment of sexual minorities. UNAIDS Secretariat, UNDP and UNFPA helped establish a national sex worker's alliance in Malawi. The UN system also contributed to the Gender Equality Act, which aims to promote the rights to reproductive health and end of violence against women.
35. The Joint UN Team, led by UNAIDS Secretariat and UNDP, helped finalize and disseminate the "*Policy and legal environment assessment report*". The report facilitated policy advocacy and influenced government policy directions and has been cited by civil society organizations in public debates to advocate human rights and key populations (lesbian, gay, bisexual and transgender community, sex workers) in the context of AIDS and Right to Health, among others. UNAIDS Secretariat and UNDP are currently supporting the Ministry of Justice and the Malawi Law Commission in the review and redrafting of an updated HIV Bill which is to be considered in Parliament later in 2013.
36. **Strategic information:** UNAIDS supported, finalized and disseminated a study that showed high HIV prevalence among prisoners (40.6%) compared with the general population (10.6%). The study's recommendations are being used by the prison service to develop a strategic plan and review the HIV and AIDS policy for prisons and the Prison Act. Additionally, a demographic and economic model for the long-term sustainability of the AIDS response was completed and validated. UNAIDS also helped generate evidence on the numbers of men who have sex with men, and develop a sex work study and stigma index⁶.

⁶ In 2011, UNAIDS supported the implementation of the Stigma Index, a community based research initiative to measure HIV-related stigma and discrimination within the three regions of Malawi. The key results of the Stigma Index include:

37. **Policy advocacy:** The Joint UN Team has worked to ensure access to comprehensive HIV programmes for all Malawians, including key populations and vulnerable populations. UNAIDS has advocated privately and publically for the right to health of all Malawians. In particular, UNAIDS has supported groups of people living with HIV and marginalized populations to interact with and lobby Parliamentarians in support of policy and legal reforms needed to address key challenges to the national AIDS response in Malawi.
38. **Service delivery:** UNAIDS has worked to ensure service delivery and an uninterrupted supply chain, and to ensure the logistics management information system is used, especially for scaling up antiretroviral therapy. Five civil society organizations were involved in the service delivery initiative targeting key populations.
39. Other notable successes for the UNAIDS family include scaling up education and social protection systems, such as cash transfer programmes for families with adolescent girls affected by HIV.

CHALLENGES AND RECOMMENDATIONS FOR FUTURE UNAIDS ACTION

40. Further UNAIDS support for Malawi's AIDS response is recommended in the following areas:

Basic programme activities

41. **Behaviour change:** The most significant factors influencing the HIV epidemic in Malawi are: multiple concurrent sexual partnerships and low condom use, as 80% of HIV infections are acquired through unprotected heterosexual intercourse with an infected person. UNAIDS will support comprehensive condom programming and an expanded elimination of mother-to-child transmission plan to reduce HIV infections.
42. **HIV testing and counselling:** These services remain the critical entry point for HIV prevention, treatment and care services. To date, only about 50% of people living with HIV in Malawi know their status. UNAIDS will invest in capacity development and quality control for voluntary HIV testing and counselling services, and in expanding male involvement.
43. **Male circumcision:** Malawi is a latecomer to the regional initiative to promote circumcision for sexually active adult men. UNAIDS will continue expanding advocacy efforts to promote voluntary medical male circumcision as a complement to national initiatives financed by the World Bank, the UK Department for International Development and the United States Government.

Critical enablers

44. **Stigma and discrimination:** Stigma and discrimination continue to be reported by about half those living with HIV in Malawi. They stand in the way of effective HIV prevention, treatment, care and support services for key and vulnerable populations, and UNAIDS will continue to invest in strategies to address these challenges.

45. **Enabling environment and key populations:** Policies and laws to guide HIV interventions and create an enabling environment are in the process of development, and are critically needed to enhance. HIV prevention treatment, care and support services for key populations and vulnerable populations.
46. **Gender Inequality:** Malawi continues to lag behind in achieving the gender-related MDGs, and gender inequality and gender-based violence continue to enhance risks of and vulnerability to HIV infection for women and young girls. UNAIDS, in close collaboration with the new UNAIDS Cosponsor UN Women, is currently augmenting gender programming to more effectively address these challenges.
47. **Commodities:** Persistent national stock-outs of commodities such as male and female condoms and HIV test kits is one of the most pressing challenges for HIV programming and prevention. Creating demand for condoms and other commodities can only succeed if complementary services and commodities are readily accessible for end users, and UNAIDS will continue to work collaboratively with the Government and other development partners to find sustainable solutions to these challenges.
48. **Sustainable financing:** A national sustainable financing strategy is being developed, based on the findings of a sustainable financing options report and the AIDS investment framework. The strategy aims to raise awareness of the need to reverse Malawi's heavy dependence on external funding for HIV.

Synergies

49. Linking formal health systems and community outreach systems to expand HIV prevention, treatment and care services will require continuity of services between health facilities and community systems. Integrating and mainstreaming HIV and AIDS into broader national development agenda with particular attention to human rights and gender inequalities to ensure progress towards the 2011 global AIDS targets and Political Declaration as well as the MDGs.
50. The Joint UN Programme and Team on AIDS must continue to support national partners in accordance with the Paris Declaration on delivering aid and the Accra Agenda for Action, and remains accountable, based on the UNAIDS Malawi Division of Labour and the UN Development Action Framework results.
51. UNAIDS should continue its support in the critical areas of Option B+ and the antiretroviral therapy scale-up programme, and needs to ensure new policies and strategies are aligned, rights-based and integrate the needs of key and vulnerable populations.

KEY HIV AND AIDS INFORMATION FOR MALAWI (UNAIDS 2011)

Population: 15 883 000	Women aged 15+ living with HIV: 430 000 [410 000 - 470 000]
Epidemic type: Generalized	Children aged 0–14 living with HIV: 170 000 [150 000 - 200 000]
Modes of transmission: Sex workers and their clients, stable partnerships, multiple heterosexual partners	Annual deaths due to AIDS: 44 000 [38 000 - 50 000]
Number of people living with HIV: 910 000 [850 000 - 970 000]	Annual new infections: 46 000 [40 000 - 56 000]
Adults aged 15–49 prevalence rate: 10.0% [9.5% - 10.6%]	Antiretroviral therapy coverage: 67% [62%-72%]
Adults aged 15+ living with HIV: 740 000 [690 000 - 790 000]	Prevention of mother-to-child transmission coverage: 53% [46%-61%]

Source: AIDS Info.

**eMTCT Results Chain UN Joint Programme
Malawi**

