Malawi HIV and AIDS Monitoring and Evaluation Report: 2008-2009

UNGASS Country Progress Report

Reporting Period: January 2008-December 2009

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The Office of the President and Cabinet also wishes to sincerely thank the team of consultants comprising Ms. Monique Boivin (Team Leader), Dr. Winford Masanjala (Quantitative Expert) and Mr. John Kadzandira (Qualitative Expert) for compiling the Report.

FORWARD

The Government of Malawi, under my leadership, has achieved tremendous success in the fight against the HIV and AIDS epidemic. The intention of My Government is explicitly expressed in the Malawi Growth and Development Strategy (2006 to 2011)- a national development blueprint-where 'Prevention and Management of Nutrition, HIV and AIDS disorders' is one of the key priority areas. The inclusion of HIV and AIDS comes against my Government's realisation that there cannot be meaningful development if the HIV and AIDS scourge is not adequately addressed.

In order to ensure that the HIV and AIDS agenda is implemented as intended, all public sector institutions continue to set aside a minimum of 2% of their recurrent budget to support HIV programmes in those sectors. A further demonstration of my Government's commitment to the national response to HIV is through the annual budgetary provisions to the HIV Pool and the Health Sector Programme of Work. My Government is also seriously exploring possible options that will ensure that as many People Living with HIV (PLHIV) as possible have access to these life saving drugs, in line with the new 2009 World Health Organisation (WHO) guidelines on early initiation of patients on Antiretroviral Therapy.

The results of my Government's commitment to the fight against HIV and AIDS are evident. With the support of our development and cooperating 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 198,846 as at the end of December 2009. Further increases are expected once Malawi begins to implement the new WHO guidelines. HIV Prevention Programmes are also bearing fruits as evidenced by the stabilization of HIV prevalence at 12%.

Malawi has also been successful in mobilizing 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 Declaration of Commitment 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. It is evident that since the 2007 Report was prepared, progress has been registered in the areas of prevention; treatment, care and support; and impact mitigation. This has been facilitated by decentralisation of the response to HIV and AIDS, among other factors.

The stabilization of national HIV prevalence at 12% means that more work still needs to be done on the prevention front. In this regard, Malawi has produced a comprehensive National HIV Prevention Strategy (2009-2013) that seeks to consolidate all prevention interventions in one single coherent framework with clear management and implementation mandates.

Owing to the dynamic and evolving nature of the HIV and AIDS environment, the HIV and AIDS Policy is currently undergoing a review process. Consultations for the development of a second generation HIV and AIDS Policy have been finalised and an Issues Paper is being drafted based on the findings. The HIV and AIDS Policy will provide the statement of intent of the Malawi Government as well as outline the scope of the national response to HIV and AIDS in Malawi.

Operationalisation of the 2% recurrent allocation for HIV and AIDS in the public sector is expected to be enhanced, now that guidelines were finalized and disseminated.

In fulfilment of the Malawi Government's vision on HIV and AIDS, the Department of Nutrition HIV and AIDS under the Office of the President and Cabinet (OPC) continued to setup structures by recruiting and placing key personnel in strategic government ministries and departments. It is hoped that these personnel will be instrumental in moving the Nutrition, HIV and AIDS agenda in the sectors where they have been placed.

The 2009 Report will be a key resource for all development practitioners and policy makers, as reference point for programme and policy review. The Report has also come at an opportune time since shortly the country will be assessing progress towards meeting the 2010 Universal Access Targets. This Report already provides pointers on how much has been achieved and what remains to be done.

Dr Mary Shawa
SECRETARY FOR NUTRITION, HIV AND AIDS

ACRONYMS

Acronym	Name in Full
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BSS	Behavioural Surveillance Survey
CAC	Community AIDS Committee
CBO	Community Based Organisation
CHAM	Christian Health Association of Malawi
CSO	Civil Society Organisation
DDC	District Development Committee
DHRMD	Department of Human Resources Management and Development
DHS	Demographic and Health Survey
DIP	District Implementation Plan
OPC DNHA	Office of the President and Cabinet, Department of Nutrition, HIV and AIDS
EHP	Essential Health Package
EID	Early Infant Diagnosis
FBO	Faith Based Organisation
FGD	Focus Group Discussion
GFATM	Global Fund on AIDS, TB and Malaria
GOM	Government of Malawi
HADG	HIV and AIDS Development Group
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
IAWP	Integrated Annual Work Plan
INGO	International Non Governmental Organisation
KII	Key Informant Interview
LAHARF	Local Assembly HIV and AIDS Reporting Form
M&E	Monitoring and Evaluation
MANASO	Malawi Network of AIDS service organisations
MANET+	Malawi Network of People Living with HIV
MBCA	Malawi Business Coalition against AIDS
MBTS	Malawi Blood Transfusion Service
MCP	Multiple and Concurrent Partnership
MDHS	Malawi Demographic and Health Survey
MGDS	Malawi Growth and Development Strategy
MGFCC	Malawi Global Fund Coordinating Committee
MHRC	Malawi Human Rights Commission
MIAA	Malawi Interfaith AIDS Association
MICS	Multiple Indicator Cluster Survey
MOA	Ministry of Agriculture
MOH	Ministry of Health

MOU	Memorandum of Understanding
MPF	Malawi Partnership Forum
MSM	Men having Sex with Men
MTR	Mid Term Review
NAC	National AIDS Commission
NACARS	National AIDS Commission Activity Reporting System
NAF	National Action Framework
NASA	National AIDS Spending Assessment
NCPI	National Composite Policy Index
NGO	Non Governmental Organisation
NVP	Nevirapine
NYCOM	National Youth Council of Malawi
OPC	Office of the President and Cabinet
ORT	Other Recurrent Transactions
OVC	Orphans and Vulnerable Children
PLACE	Priorities in Local AIDS Control Efforts
PLHA	People Living with HIV and AIDS
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
R&D	Research and Development
STI	Sexually Transmitted Infections
SWAP	Sector Wide Approach
TA	Traditional Authority
TB	Tuberculosis
TWG	Technical Working Groups
UA	Universal Access
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USG	United States Government
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

1. STATUS AT A GLANCE

1.1 Purpose of the Report

1.1.1 Introduction and Purpose

United Nations General Assembly Special Session on HIV/AIDS (UNGASS)

Malawi takes its commitment to the Response to HIV and AIDS very seriously. As a signatory to the *2001 Declaration of Commitment on HIV/AIDS*, Malawi reports on progress every two years, assessing successes, challenges, and the way forward to achieving Universal Access. This is done through the Malawi HIV and AIDS Monitoring and Evaluation Report, which also serves as the UNGASS Country Progress Report.

Universal Access

As a country, Malawi is committed to Universal Access, which means reaching all people in need of prevention, treatment, care, and support with quality services. We recognise that as a country, we are not alone, but as stated by UNAIDS, are part of a "world-wide movement, enshrined in the 2006 United Nations Political Declaration, led by countries worldwide with support from UNAIDS and other development partners including civil society." The purpose of this movement is to support the achievement of ambitious national targets of near 100% coverage in areas such as ART, prevention of mother to child transmission, prevention programmes for Most at Risk Populations, and testing (UNAIDS website).

Purpose of the Report

This report is both an update on progress achieved in the past two years and a call to action. The report has both a national and global purpose. Regarding our national commitment to Universal Access, it serves as the National HIV and AIDS M&E Report for 2008-2009. It also applies to regional reporting commitments for the Maseru and Abuja Declarations. Internationally, it is the Malawi UNGASS Report (United Nations General Assembly Special Session on HIV/AIDS) as a follow-up to the *2001 Declaration of Commitment on HIV/AIDS*, of which Malawi is a signatory.

Focus of the Report

This report answers the following questions:

- What progress have we made as a country in addressing HIV and AIDS in the past 2 years?
- What will it take to achieve our targets?
- How quickly can we reach near 100% coverage of those in need with quality services?
- What is needed in order to do this?

An abridged version of this report has also been developed targeting different actors on HIV and AIDS in Malawi. This will also be used to galvanize action on Universal Access.

For the effective achievement of Universal Access Targets and related Millennium Development Goals, nine priority areas have been identified globally (UNAIDS Outcome Framework: 2009-2011) and Malawi is working towards these same priority areas:

1. Reducing sexual transmission of HIV
2. Preventing mothers from dying and babies from becoming infected with HIV
3. Ensuring that people living with HIV receive treatment
4. Preventing people living with HIV from dying of tuberculosis
5. Protecting drug users from becoming infected with HIV
6. Removing punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS
7. Empowering young people to protect themselves from HIV
8. Stopping violence against women and girls
9. Enhancing social protection for people affected by HIV

In order to assess progress toward reaching Universal Access and identify key actions for the way forward, this Report focuses on the 25 core UNGASS indicators. These indicators cover the following areas:

- National Commitment and Action (Indicators 1-2)
  1. National Funding Matrix: Domestic and international AIDS spending by categories and financing sources
  2. National Composite Policy Index targeting Government and Civil Society
- National Programmes (Indicators 3 – 11)
- Knowledge and Behaviour (Indicators 12 – 21)
- Impact (Indicators 22 – 25)

A table with an overview of the data for these indicators appears in Section 1.5. The complete National Composite Policy Index Appears in Annex 2. The National Funding Matrix can be found in Annex 3. Throughout this Report, successes, challenges, and the way forward are assessed in reference to Malawi's commitment to achieving Universal Access and the *2001 Declaration of Commitment on HIV/AIDS*.

This report incorporates findings from surveys and monitoring reports drawing from a broad range of available sources. As part of this report, a request made from all respondent during the data collection process, to have concrete, actionable recommendations and this has been done in the form of a detailed narrative description and a way forward action plan in Section 8.

1.1.2 Highlights of the Report

Highlights of the Report

- **Indicator** Overview Table (Section 1.5)
- **Progress** by Topic Area (Section 3)
- Top **Successes** and **Challenges** (Section 5)
- **Human Rights-Based Public Health Approaches** to Specific Groups (Section 8.2.1)
- **Action Plan** for Operationalising the Recommendations (Section 8.2.2)
- National Composite **Policy Index** (Annex 2)
- National **Funding Matrix** (Annex 3)

1.2 Report Preparation Process

1.2.1 Methodology

An overview of the methodology used in the development of the report is contained here, while a more detailed review of the methodology is included in Annex 1. The UNGASS Reporting Guidelines were used to guide the structure of the report, the collection of data for indicators and the design of the consultative process which involved Government and civil society.

A number of entities played key roles in the development of the Malawi UNGASS Country Report, as detailed in the Table 1.1 below.

Table 1.1: Key Roles in the Development of the UNGASS Report

Entity	Role
Office of the President and Cabinet, Department of Nutrition, HIV and AIDS	Oversight
National AIDS Commission	Managerial
UNGASS/NASA Task Force	Technical
Participants in UNGASS Key Informant Interviews and Focus Group Discussions, NCPI Validation Meetings, and National Validation Meeting for the UNGASS Report	Input and Feedback
UNGASS Preparation Team	Data Collection, Analysis, and Report Preparation
NASA Preparation Team	Finance and Expenditure Data Collection and Analysis

The methodology used in the development of the UNGASS Report is detailed in Table 1.2 below.

Table 1.2: Malawi UNGASS Country Report Development Methodology

Method	Notes
Desk Review	See List of Reference Documents the in Annex
NCPI Questionnaires	Completed Prior to Key Informant Interviews
Key Informant Interviews and Focus Groups	To Expand on Information Available from Existing Reports and the Completed NCPI to Gain Critical Information for the Body of the Report
NCPI Validation Meeting	Divided into 2 Sessions: Government and Civil Society
National Funding Matrix Validation Meeting with UNGASS/NASA Task Force	This process was managed by a separate NASA Consultant Team , and was aimed at validated the draft tables on National Funding
National Validation Meeting	Held on Thursday, 18 Feb. 2010

The UNGASS/NASA Task Force decided to adopt the following changes to improve the data collection and validation process for this reporting round in Malawi:

- **Data** Was Gathered from **Previous Monitoring Records, Reports, Population-Based Surveys, and Research** for the 25 UNGASS Indicators
- **Key Informant Interviews and Focus Group Discussions** Were Held with:
  - High-Level Policy and Planning Personnel from Central Offices (Government, Civil Society, Private Sector, and Development Partners)
  - Health Service Providers at District Level (Government and Civil Society)
  - Users of Services—General Population and Most-at-Risk Populations and Marginalised Groups (Sex Workers and Men who have Sex with Men)

The following consultative process was used for the NCPI data collection and validation:

1. **Official letters were distributed with the NCPI questionnaire** by mail and email inviting participants to take part in the NCPI process and requesting that they fill out the questionnaire prior to the scheduled interview.
2. **Introductory visits** were conducted to hand-deliver the letter and questionnaire to key partners with a copy of the previous UNGASS report.
3. **A desk review** was conducted to inform the tailoring of follow-up questions in the Key Informant Interviews and Focus Group Discussions.
4. **Key Informant Interviews and Focus Group Discussions** were conducted to expand on the data entered on the questionnaire by the respondent.

5. The respondents spanned:
   - 18 Government and 14 Civil Society Key Informant Interviews, Each with 1-7 Respondents
   - 11 Focus Group Discussions, Each with 7-18 Participants

   The respondents included a balance of:
   - High-Level Policy and Planning Personnel from Central Offices (Government, Civil Society, Private Sector, and Development Partners)
   - Health Service Providers at District Level (Government and Civil Society)
   - Users of Services—General Population and Most-at-Risk Populations and Vulnerable Groups (Sex Workers and Men who have Sex with Men)

6. All responses were compiled to form **one comprehensive version of the NCPI**.
7. **An NCPI Validation Meeting** was held in two parts, Part A: Government, and Part B: Civil Society, Bilateral Agencies, and UN Organisations.

The overall UNGASS progress report was **reviewed** in the Following Meetings:
- Task Force Meeting
- Internal Government Meeting
- National Validation Meeting

Feedback Received During the Meetings and by Email Was Incorporated in the Revision Process

The Key Findings and Recommendations for the Way Forward which appear in Section 8 of the Report were cleared through an extensive vetting process. Only recommendations which emerged as key themes from all levels (including high-level policy makers, implementers of services, and users of services) and from both Government and Civil Society were able to advance through the vetting stage of analysis to appear in the Report.

1.2.2 Data Limitations

A significant limitation in data collection for the Core UNGASS indicators resulted from the fact that survey-based indicators could only be populated based on DHS from 2004, MICS from 2006 and BSS from 2006. Another DHS was planned for 2008, but was shifted to 2010 because the country had a national census in 2008. At the time when this report was being prepared, the DHS was under preparation for implementation.

The most recent BSS was conducted in 2006. A repeat of the BSS is being planned. It is expected that more data will be available for Most-at-Risk Populations through the BSS and other special studies in the near future, as there is growing recognition of the need to draw on reliable data in the planning of human rights-based public health approaches to meet the needs of Sex Workers, Men who have Sex with Men and people living with HIV, as well as other vulnerable groups. For successful data collection and use to improve the quality and reach of services, there will be a need

for stringent protocol and supervision to ensure the confidentiality and protection of all participants, especially participants from Most at Risk Populations and Vulnerable Groups (UNGASS Consultative Process, 2009-2010).

The last sentinel surveillance survey was conducted in 2007 and planning is underway for the next one. The technical working group focusing on estimations and projections is in the process of reviewing the previous assumptions and data inputted into Spectrum to provide more accurate estimates based on the 2007 sentinel surveillance while awaiting the next sentinel surveillance data.

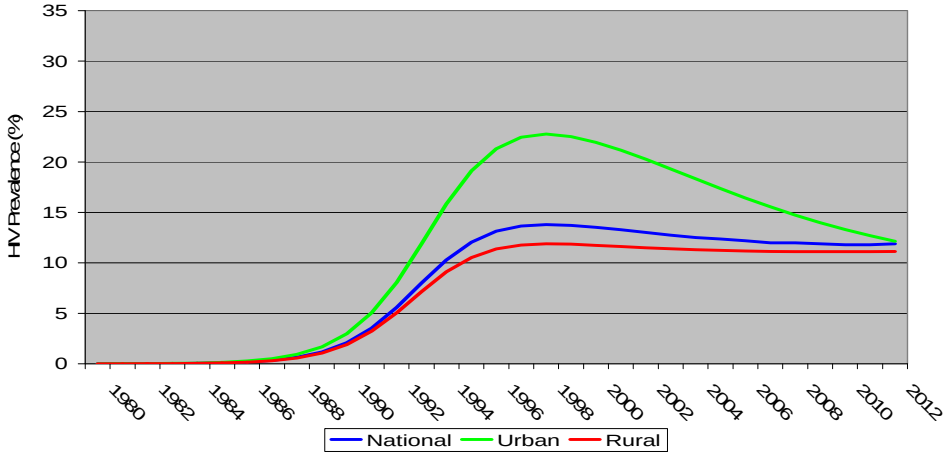
The lack of recent population-based survey data is concerning and should be addressed as a matter of priority. This information is critical to evidence-based programme design, particularly prevention programmes and programmes tailored to reach Most at Risk Populations.

1.3 Status of the Epidemic

1.3.1 Prevalence

Malawi is one of the countries in Southern Africa and therefore lies within the epicentre of the HIV epidemic. The first serological evidence for HIV in Malawi was collected in the early 1980s. HIV prevalence increased sharply in the late 1980s and 1990s, and has stabilized around 12% since then (See Figure 1 below). A total of 840,156 adults and 111,510 children were estimated to be living with HIV in Malawi in 2009 (MoH, HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2007, p. 35 and 37).

Figure 1.1: Estimated and Projected HIV Prevalence from 1980-2012



Source: MoH, HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2007

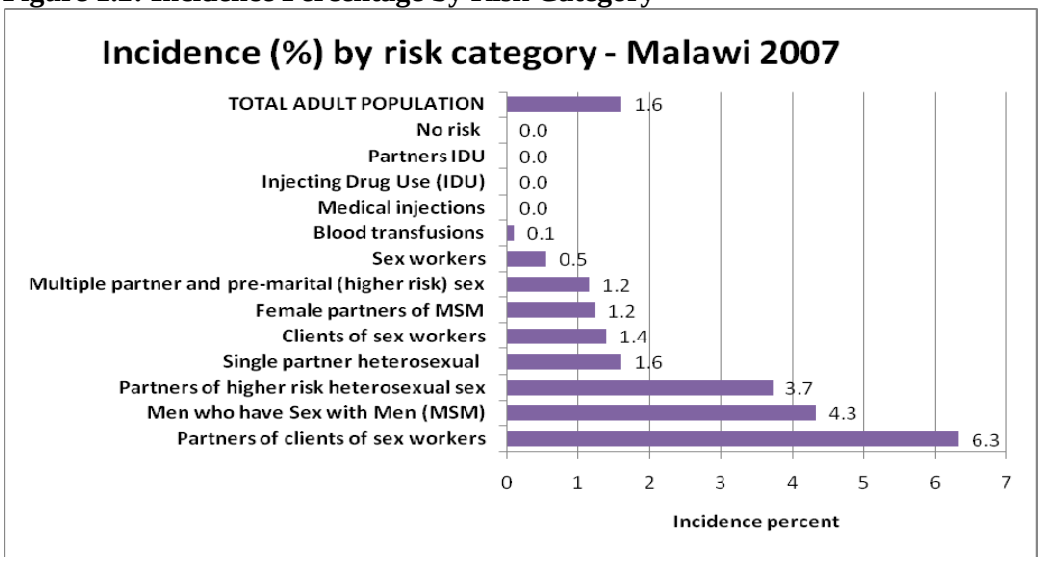
HIV prevalence varies by age, gender and other socio economic characteristics. According to the 2004 Malawi Demographic and Health Survey, prevalence in the age group 15-49 is higher among women (13.3%) than in men (10.2%), and higher in urban (17.1%) than in rural areas (10.8%). For youths aged 15-24, HIV prevalence is estimated at 6.0% and is higher among females at 9.1% compared to males at 2.1%..

HIV prevalence for adolescents (15-19 years old) is 2.1% and the prevalence is much higher among females (3.7%) compared to their male counterparts (0.4%). In the age group 20-24, the prevalence among females is 13.2%, while the prevalence among males is 3.9% (MDHS, 2004).

1.3.2 Modelling New Infections

Based on the UNAIDS Modes of Transmission Model, the HIV Prevention Strategy estimates that 1.6% of the total adult population in Malawi is infected with HIV each year. However, other estimations put the incidence closer to 1% (MoH Consultations). Higher incidence is estimated for partners of clients of Sex Workers (6.3%), partners of higher risk heterosexual sex (3.7%), as well as for Men who have Sex with Men (4.3%). The National HIV Prevention Strategy recognises Men who have Sex with Men as a high priority intervention group owing to its interface with the female population since most Men who have Sex with Men also have female partners (National HIV Prevention Strategy: 2009-2013, p.9).

Figure 1.2: Incidence Percentage by Risk Category



Source: NAC, National HIV Prevention Strategy, p.9

In the National HIV Prevention Strategy (2009-2013), it is noted that most new infections occur within long-term stable sexual relationships. The 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.

In addition, the following cross-cutting determinants have been noted in the Prevention Strategy:

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

A more detailed discussion on the drivers of the epidemic is presented later in Section 2.4 of this report.

1.3.3 Sub-populations

The official target population in Malawi in the national response to HIV and AIDS is the 15 – 49 years age group, as this is the sexually active age group.
It has been recognised that there is a need for specific attention for programmes targeting women and girls, especially young women in stable relationships; men and women in concurrent sexual relationships; armed forces; PLHIV; MTCT; sex workers, clients of sex workers, and partners of clients of sex workers; men who have sex with men; young people (10-24 year olds) in and out of school and orphans and other vulnerable children. It was mentioned that there may be some groups that should be included here but have not yet been identified, such as domestic workers. These groups have been identified through the Know Your Epidemic (KYE) study, PLACE study, BSS and DHS studies and triangulation studies, UNAIDS Modes of Transmission (MoT) study.

In the past the BSS has collected specific data on female sex workers, truck drivers, male and female police, male and female estate workers, male and female primary school teachers, and male and female secondary school teachers, female border traders, male vendors and fishermen.

1.4 Policy and Programmatic Response

Malawi's development agenda is defined in the Malawi Growth and Development Strategy (2006 - 2011) which is the overarching policy framework. The prevention and management of nutrition disorders and HIV and AIDS is one of the six pillars contained within this framework. The Malawi Government recently redefined priorities within priorities in the MGDS and HIV and AIDS is priority area 7. The Extended National Action Framework for HIV and AIDS: 2010-2012 has been aligned with the MGDS with the exception of the timeframe.

Malawi developed an HIV and AIDS Policy in 2003 to guide the implementation of the national response to HIV and AIDS. The policy also laid the legal and administrative boundaries for implementation of HIV and AIDS activities. The HIV Policy expired in 2008 and is undergoing a review that will inform the development of the next generation policy.

Operationally, in line with the Three Ones, the national response to HIV is guided by the National Action Framework which is a strategic reference document containing

key objectives, strategies and action points for the national response to HIV and AIDS in Malawi.

The NAF has just been extended to 2012 and contains seven priority areas as follows:

- Prevention and behaviour change
- Treatment, care and support
- Impact mitigation
- Mainstreaming and decentralisation
- Research, monitoring and evaluation
- Resource mobilisation and utilisation
- Policy and Partnerships

Implementation of the NAF is through annual operational plans-the Integrated Annual Work Plans- which are a costed set of activities to be implemented by partners in a particular year, with funding from key donors.

Since the last UNGASS report, Malawi has recorded significant progress in a number of programme areas, owing to decentralisation efforts and coordination with key partners. A total of 198,846 adults and children were alive and on ART and a social cash transfer programme reaching over 92,700 most vulnerable people by the end 2009, among other achievements.

1.5 Overview Table of the UNGASS Indicator Data

Table 1.3: Overview of UNGASS Indicator Data

Indicators	2008	2009	Target 2010	Target 2012	Sources
National Commitment and Action					
1. Domestic and international AIDS spending by categories and financing sources	See Annex 3	See Annex 3			NASA
2. National Composite Policy Index	See Annex 2	See Annex 2			NCPI
National Programmes					
3. Percentage of donated blood units screened for HIV in a quality assured manner	100%	N/A	**98%**	**100%**	MBTS
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	**50.90%**	**65.02%**	80%		MoH ART Patient Records and Spectrum Estimates
5. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	**40.3%**	38.8%	65%	70%	MoH ANC and Maternity registers, 2008 Census estimates and 2007 Sentinel Surveillance
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	**16.43%**	N/A			National TB Control Programme and WHO Estimates
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	4.5% (M:7.7% F:3.6%)	4.5% (M:7.7% F:3.6%)	**M: 75% F: 75%**	**M: 75% F: 75%**	MDHS 2004
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results	N/A	N/A			
9. Percentage of most-at-risk populations reached with HIV prevention programmes	N/A	N/A			
10. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child	18.5%	18.5%	**80%**	**90%**	MICS 2006
11. Percentage of schools that provided life skills-based HIV education in the last academic year	N/A	N/A	**100%**	**100%**	
Knowledge and Behaviour					

Indicators	2008	2009	Target 2010	Target 2012	Sources
12. Current school attendance among orphans and among non-orphans aged 10–14[1]	0.89	0.89	**.98**	**1.0**	MICS 2006
13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	42.1%	42.1%	**75%**	**75%**	MICS 2006
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	38.4% (FSW)	38.4% (FSW)			BSS 2006
15. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15	14.6%	14.6%			MDHS 2004
16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	3.3%	3.3%	**M: 18% F: 5%**	**M: 9% F: 1%**	MDHS 2004
17. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	37.9%	37.9%			
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	91.8% (FSW)	91.8% (FSW)			BSS 2006
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	N/A	N/A			
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	N/R	N/R			

[1] The purpose of this indicator is to assess progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans. For the purposes of this indicator, an orphan is defined as a child who has lost both parents; and a non-orphan is defined as a child whose parents are both alive and who is living with at least one parent.

Indicators	2008	2009	Target 2010	Target 2012	Sources
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	N/R	N/R			
Impact					
22. Percentage of young women and men aged 15–24 who are HIV infected	12.3%	12.3%	**12%**	13%	MoH, HIV and Syphilis Sero-Survey and National HIV Prevalence and AIDS Estimates Report for 2007
23. Percentage of most-at-risk populations who are HIV infected	70.7% (FSW)	70.7% (FSW)			
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	**76%**	**79%**			ART in the Public and Private Sectors in Malawi: Results Up To 31st December, 2009
25. Percentage of infants born to HIV-infected mothers who are infected	14.6%	13.8**%**		**14%**	Estimates from Spectrum

Note:
N/A: Not Available
N/R: Not Relevant

1.6 Operationalising the Recommendations

The detailed Findings and Recommendations on the Way Forward can be found in Section 8 of this Report.

By way of providing an overview, Section 1.6.1 below summaries the way forward with: Approaches for Specific Groups.

1.6.1 Way Forward: Approaches for Specific Groups

Way Forward: Approaches for Specific Groups			
Group	**Human Rights-based Public Health Approach**	**Best Practice Evidence Reference**	**Can this approach be used NOW in Malawi**
General Population: Every Person in Malawi	▪ Serve every person with the best quality service available, tailored to their needs. Put the person's health first. Do not judge or condemn—that is for God, not for us to do. ▪ Use a patient-centred approach. Respect the freedom of choice for every patient. ▪ Testing: HIV testing and counselling should be voluntary in all cases. Even routine opt-out HIV testing is voluntary. ▪ Prevention: People have a right to practical knowledge and tools for protecting themselves and their partners from contracting HIV, including male and female condoms and condom-safe lubricants and the skills to know how to use them properly. ▪ Consider amending by removing provisions 2a and 2b in Part V. of the Draft HIV Bill (page 92-93) and replace with the following clarification: "A health service provider should not disclose any person's status to their partner without their consent." ▪ Consider amending by removing the criminalisation of HIV transmission in Part X of the Draft HIV Bill (page 101-102)	UN OHCHR and UNAIDS: International Guidelines on HIV/AIDS and Human Rights http://data.unaids.org/Publications/IRC-pub07/JC1252-InternGuidelines_en.pdf UN OHCHR and UNAIDS: Handbook on HIV and Human Rights for National Human Rights Institutions http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf UNAIDS Policy Brief: Criminalization of HIV Transmission http://data.unaids.org/pub/Manual/2008/JC1601_policy_brief_criminalization_long_en.pdf	YES

Way Forward: Approaches for Specific Groups Group	Human Rights-based Public Health Approach	Best Practice Evidence Reference	Can this approach be used NOW in Malawi
Men Who Have Sex with Men	▪ Men who have Sex with Men should be provided with the same level of quality of prevention, treatment, care, and support as any other segment of the population and should not be discriminated against for any reason. ▪ Comprehensive General Services: Health care workers should be given practical training that sensitises them to the needs of specific groups and prepares them to confidently provide comprehensive services that can be tailored to meet the needs of any individual. For instance, during HIV testing and counselling, all clients should receive skill-based training in ABC, including how to use protection for each possible kind of sex, vaginal, anal, and oral. ▪ Consider amending by adding clarity to Part IV. Prohibition of Discrimination of the Draft HIV Bill (pages 91-92): "As stated in Section 20 of the Constitution of Malawi, discrimination based on any status is prohibited. 'Any other status' encompasses most-at-risk groups, and vulnerable populations, including Men who have Sex with Men and Sex Workers."	UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People http://data.unaids.org/pub/Report/2009/jc1720_action_framework_msm_en.pdf UNAIDS Press Release: AIDS Responses Failing Men who have Sex with Men and Transgender Populations http://data.unaids.org/pub/PressRelease/2009/090515_msm_transgender_en.pdf Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity http://www.yogyakartaprinciples.org/principles_en.htm	YES
Sex Workers	▪ Sex Workers should be encouraged, but not forced to have an HIV test and should be treated with the same	WHO: Violence Against Sex Workers and HIV Prevention	YES

Way Forward: Approaches for Specific Groups Group	Human Rights-based Public Health Approach	Best Practice Evidence Reference	Can this approach be used NOW in Malawi
	level of respect as any other user of health services. ▪ Consider amending by adding clarity to Part IV. Prohibition of Discrimination of the Draft HIV Bill (pages 91-92): "As stated in Section 20 of the Constitution of Malawi, discrimination based on any status is prohibited. 'Any other status' encompasses most-at-risk groups, and vulnerable populations, including Men who have Sex with Men and Sex Workers." ▪ Consider amending by removing the following instance from the list of permissible instances of compulsory testing in the Draft HIV Bill (page 95): "For commercial sex workers"	http://www.who.int/gender/documents/sexworkers.pdf Sex Work and HIV/AIDS: UNAIDS Technical Update http://data.unaids.org/Publications/IRC-pub02/jc705-sexwork-tu_en.pdf	
Pregnant Women and Their Partners	▪ Pregnant women and their sexual partners should be encouraged, but not forced to have an HIV test. ▪ Consider amending by removing the following instance from the list of permissible instances of compulsory testing in the Draft HIV Bill (page 95): "For pregnant women and their sexual partners or spouses"	UNAIDS Policy Brief: Criminalization of HIV Transmission http://data.unaids.org/pub/Manual/2008/JC1601_policy_brief_criminalization_long_en.pdf	YES
Young People	▪ Young people should be provided with quality prevention, treatment, care and support services in a	UNESCO and UNAIDS: HIV/AIDS and Human Rights: Young People in	YES

Way Forward: Approaches for Specific Groups Group	Human Rights-based Public Health Approach	Best Practice Evidence Reference	Can this approach be used NOW in Malawi
	youth-friendly environment without judgement or discrimination. ▪ Consider amending by adding clarity number 14. in Part VI of the Draft HIV Bill (page 94): "Proper counselling and support should be available to Children under the age of 13 who seek HIV testing and counselling without the consent of their guardian, and they should be allowed to access this service even if they request to do so without their guardian."	Action http://data.unaids.org/Publications/IRC-pub02/JC669-HIV-AIDS-kit-Updated_en.pdf	
Prisoners	▪ Any person in the custody of the police, whether arrested, in jail, or in prison, should be protected from violence, sexual abuse, and rape, and given full recourse in the event of such instances occurring. ▪ Prisoners should have access to prevention (including access to condoms), treatment, care, and support, and nutritional support for ART.	UNAIDS and WHO: WHO Guidelines on HIV Infection and AIDS in Prisons http://data.unaids.org/Publications/IRC-pub01/JC277-WHO-Guidel-Prisons_en.pdf	YES

1.6.2 Way Forward: Summary of Action Plan

A summary of the recommendations is given below, with full details of these recommendations in Section 8.2.2:

- Review the draft HIV legislation and the HIV Policy
- Enforce the Protection of Human Rights: Fostering a Culture of Equality
- Foster leadership at all levels
- Enhance Sustainable Financing for HIV and AIDS
- Turn Information into Action: Strengthen strategic information use
- Scale-up: Improve Coverage and Quality
- Improving Access and Applicability: Tailoring the Services to the People's Needs
- Bring the Services to all People in need
- Take Evidence-Based Prevention to Full Scale
- Enhance the linkages between HIV and nutrition

2. OVERVIEW OF THE AIDS EPIDEMIC

2.1 Context

The Government of Malawi has been monitoring HIV and syphilis prevalence through antenatal clinic (ANC) sentinel surveillance from the time the first cases of AIDS were confirmed and reported in the mid-80s, initially in the major Central hospitals, before expanding to 19 clinics and hospitals across the country in 1994 and to 54 sites in 2007 covering all the 28 districts in the country. This development is in line with the on-going decentralisation initiatives where district-level planning and implementation of programmes are being championed as well as actions to enhance programme monitoring and evaluation. In addition to the sentinel surveillance system, the Government of Malawi started monitoring HIV prevalence in the general population starting with the Malawi Demographic and Health Surveys (MDHS) for 2004. The second MDHS was scheduled for 2008 but was shifted to 2010 as it coincided with the national population and housing census.

While the sentinel surveillance system and the MDHS provide overall estimates of HIV prevalence in the country, there have been some studies on certain sub-populations which have also been used to provide rough estimates of HIV prevalence among those Most at Risk Populations, including Sex Workers and Men who have Sex with Men, and other Vulnerable Groups. This Chapter provides a trend analysis of HIV prevalence in the general population as well as Most at Risk Populations and Vulnerable Groups. The overall picture though is that HIV prevalence in Malawi seems to have stabilised at around 12% since 2004/05.

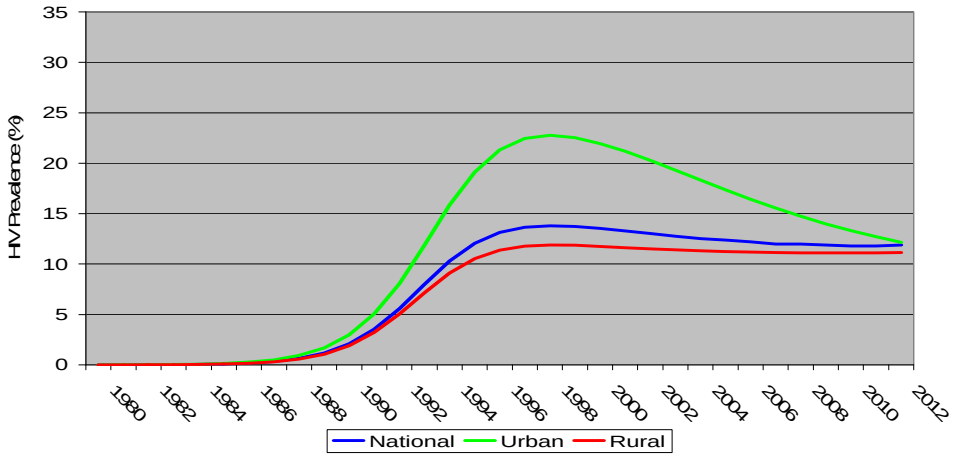
2.2 HIV Prevalence in the General Population

2.2.1 Sentinel Surveillance Data

According to the 2007 Sentinel Surveillance, HIV prevalence in the 15-49 age group has stabilised around 12%. Previous estimates from 2005 put prevalence at 14%. However, this apparent difference in prevalence is entirely explained by adjustments in the mathematical models used for estimation[2], implying that HIV prevalence has previously been overestimated. The revised models estimate that HIV prevalence in adults 15-49 years in 2005 was 12.0%. (MoH, HIV and Syphilis Sero-Survey and National HIV Prevalence and AIDS Estimates Report for 2007). The Universal Access Target for National HIV Prevalence for 2010 (12.8%) was based on previous (over-) estimates of HIV prevalence and needs to be revised.

Figure 2.1: Estimated and Projected HIV Prevalence from 1980-2012

[2] Changed assumptions regarding the time between infection and death as well as calibration with the 2004 Malawi Demographic and Health Survey results

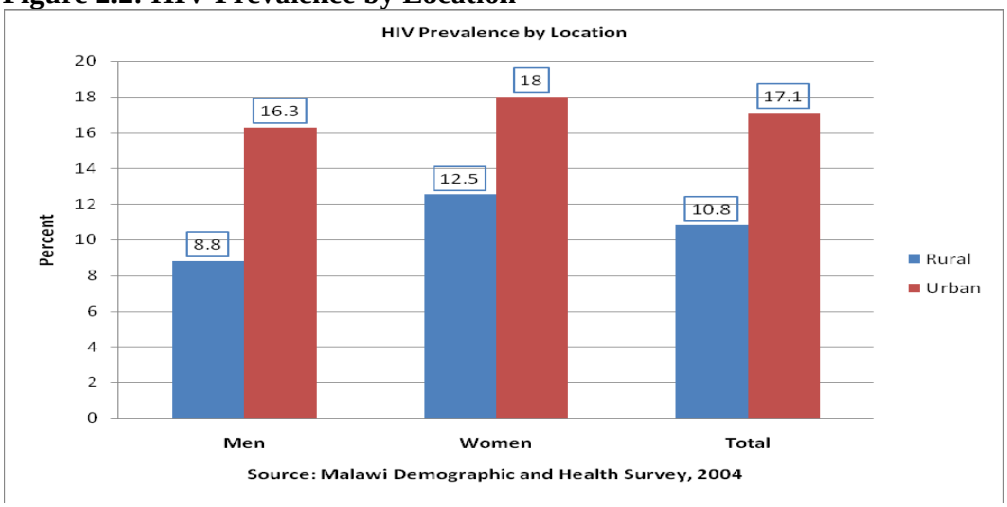


Source: MoH, HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2007

2.2.2 Variations by Location

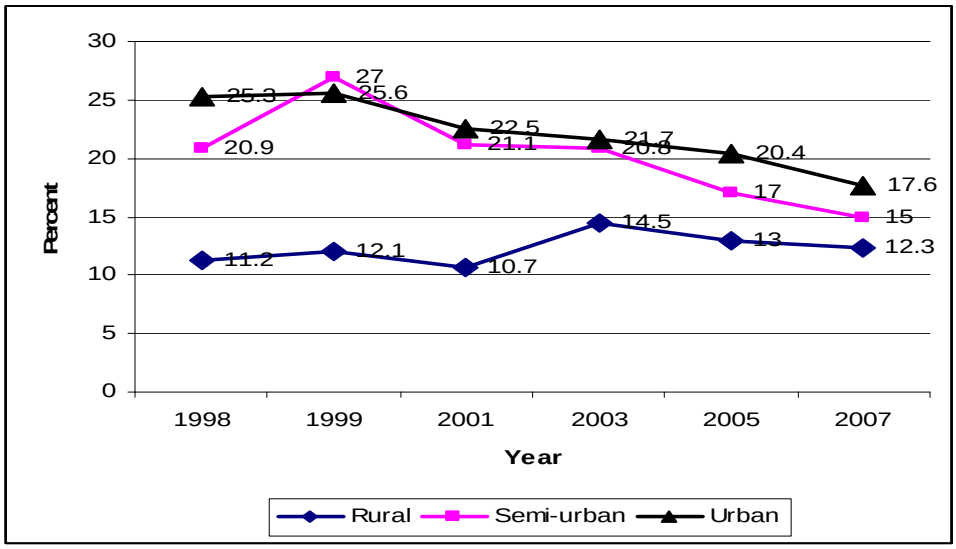
HIV prevalence is higher in the urban (17.1%) as compared to the rural areas (10.8%). However in both the rural and urban settings, HIV prevalence is higher in women than in men. This is mainly due to the younger average age at infection in females, coupled with the age structure of Malawi's population (there are many more young people than older people).

Figure 2.2: HIV Prevalence by Location



The 2007 HIV and Syphilis sentinel survey results also showed that HIV prevalence rate was still higher in the urban areas at 15.6% compared to 11.2% in the rural areas. As the figure below illustrates, HIV prevalence in urban and semi-urban areas has declined considerably from >20% reported in 1990s to ~15-17.6% in 2007 whereas in rural areas, the prevalence has stabilised at around 12%. However, although the prevalence is higher in urban and semi-urban areas, the majority of HIV positive people are in rural areas since over 80% of the population resides in rural areas.

Figure 2.3: HIV Prevalence by Location: 1998-2007



Source: MoH, HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2007

2.2.3 Variations by Region

Malawi has three regions namely North, Centre and South with a population distribution of 13%, 42% and 45%, respectively (NSO 2008). The 2007 sentinel survey results showed that HIV prevalence was higher in the Southern Region (20.5%) followed by the Central Region (10.7%) while the Northern Region had the lowest prevalence at 10.2%.

Table 2.1: HIV Prevalence by region

Region	Total Sampled	HIV+	%HIV+	95% CI
North	4,578	469	10.2	(9.4, 11.2)
Centre	7,369	789	10.7	(10.0, 11.4)
South	10,049	2,063	20.5	(19.7, 21.3)

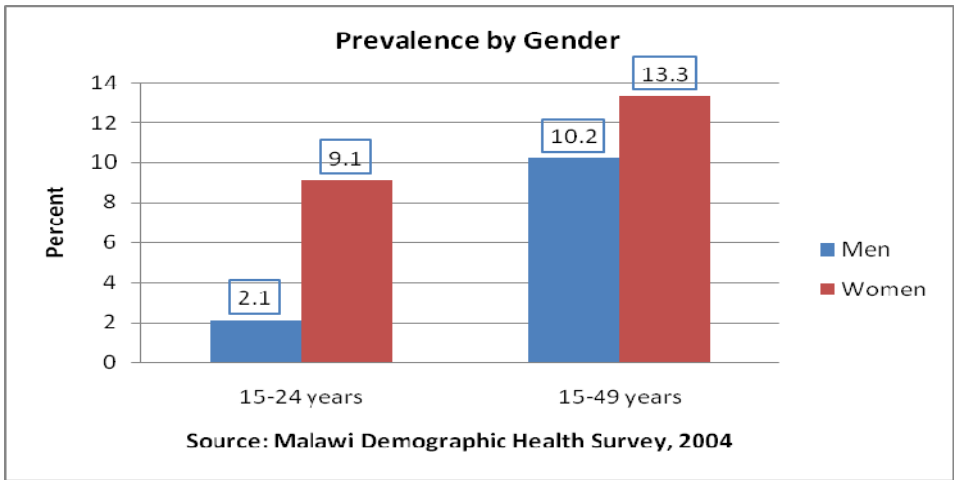
Source: MoH, HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2007

Over the years, HIV prevalence has consistently been higher in the Southern Region.

2.2.4 Variations by Gender

HIV prevalence in both the 15-24 and 15-49 age groups is high amongst females compared to males.

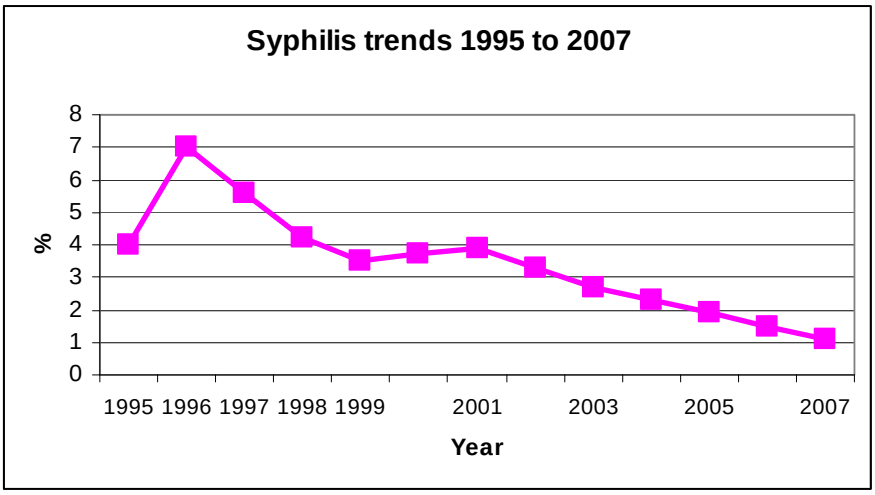
Figure 2.4: HIV Prevalence by Gender



2.2.5 Sexually Transmitted Infections (STIs)

Malawi monitors the prevalence of syphilis together with HIV through the sentinel surveillance surveys. In 2007, the prevalence of syphilis was 1.1%. The prevalence of syphilis has been declining since the mid-1990's when it peaked at around 7%. Figure 9 below shows the trends for the period 1995-2007.

Figure 2.5: Trends in Syphilis Prevalence for the Period 1995 to 2007



The Malawi Demographic and Health Surveys also collect information on STI-related signs and symptoms from the sampled respondents. An analysis of the MDHS for 2000 and 2004 also shows a decline in self-reported STI signs and symptoms with a more pronounced decline observed in young males than females.

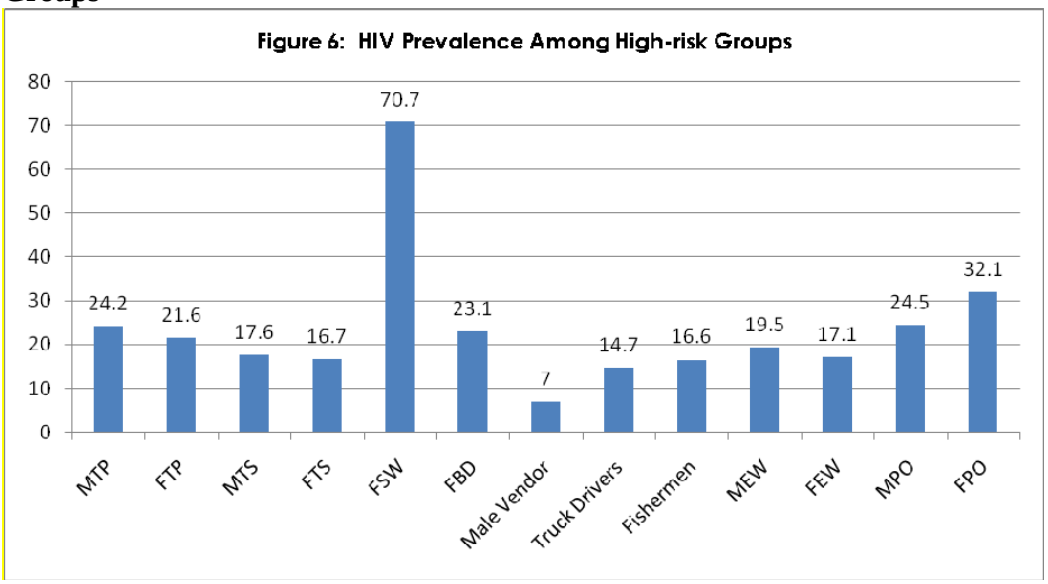
2.3 HIV Prevalence in Most-at-Risk Populations and Vulnerable Groups

The official target population in Malawi in the national response to HIV and AIDS is the 15 – 49 years age group, as this is the sexually active age group. It has been recognised that there is a need for specific attention to programmes for women and girls, especially young women in stable relationships; men and women in concurrent sexual relationships; armed forces; PLHIV; MTCT; sex workers, clients of sex workers, and partners of clients of sex workers; men who have sex with men; young people,10-24 year olds in and out of school, and orphans and other vulnerable children. It was mentioned that there may be some groups that should be included here but have not yet been named, such as domestic workers. These groups have been identified through the Know Your Epidemic (KYE) study, PLACE study, BSS and DHS studies and triangulation studies, UNAIDS Modes of Transmission (MoT) study.

Malawi conducts a Behavioural Surveillance Survey (BSS) ideally every two years. The BSS is a targeted survey that focuses on understanding the sexual behaviours, risk perceptions and attitudes towards HIV and AIDS for sub-populations which are considered to be at risk of HIV and AIDS. The last BSS in Malawi was conducted in 2006, and provided voluntary HIV testing for a sample of the following high risk and vulnerable groups in Malawi: (a) female Sex Workers, (b) long distance truck drivers, (c) secondary and primary school teachers, (d) police officers, (e) estate workers, (f) fishermen, (g) male vendors, and (h) female border traders.

Figure 10 below shows the prevalence of HIV in 13 sub-groups from the 2006 BSS. As observed, HIV prevalence was 70.7% among female sex workers (FSW) followed by female police officers (FPOs), male police officers (MPOs) and male teachers of primary school (MTPs) at 32.1%, 24.5% and 24.2%, respectively. The lowest prevalence was among male vendors at 7.0%.

Figure 2.6: HIV Prevalence among Most at Risk Populations and Vulnerable Groups



2.3.1 Men who have Sex with Men

A study conducted among 200 Men who have Sex with Men that were sampled using a snowball method found 21.4% to be HIV infected. Though this is higher than the 12% prevalence in the adult population, there are important limitations in the sampling method used for the study, making it invalid for representative estimation of HIV prevalence in this group. Anecdotal reports suggest that there is a sizable population of Men who have Sex with Men whose visibility is impeded by the social, moral and legal environment. There was broad consensus in the NCPI Validation meetings with Government and Civil Society that when it comes to access to health and HIV services, a human rights-based approach needs to be applied so as not to deny Men who have Sex with Men access to health services on account of their sexual orientation and to decrease vulnerability to HIV infection amongst this Most at Risk Population (NCPI Validation, 2010).

2.3.2 Sex Workers

Surveillance of HIV infections amongst Sex Workers found HIV prevalence to be 70.7%. It should be noted that more accurate estimates of prevalence may be able to be obtained if limitations in sampling and representativeness can be addressed (NAC, Biological and Behavioural Surveillance Survey 2006 and Comparative Analysis of 2004 BSS and 2006 BBSS, pg 31).

As opposed to Men who have Sex with Men, sex work has become increasingly recognized despite a perception that it is illegal (See discussion in Section 8.1.2). The need to raise more awareness on the rights of Sex Workers was raised during the NCPI Validation Meetings since lack of proper interpretation of the law is resulting in cases of abuse by law enforcers and the general public (NCPI Validation, 2010).

2.3.3 Youth

Prevalence amongst youth was estimated at 6% with prevalence much higher for younger women at 9%, compared to men at 2%. This may be due to transactional sex which is most likely to occur inter-generationally with younger women having intercourse with older men for financial and material gain (MDHS, pg 238). It should be mentioned that the 2004 DHS found the age at sexual debut for the 15-24 year age-group to be lower in women (16) compared to men (17).

2.3.4 Truck Drivers

Prevalence among truck drivers was in 2006 found to be 14.7% which is higher than that in the general adult 15-49 population. However, there is no statistically significant difference when confidence intervals for sampling are considered.

2.3.5 Teachers

The 2006 Behavioural Surveillance Survey collected biomarkers from male and female primary school teachers as well as from male and female secondary school teachers. HIV prevalence was found to be 24% and 22% for male and female primary

school teachers respectively. Male and female secondary school teachers had a prevalence of 17% and 16% respectively.

2.4 Orphans and Vulnerable Children

Orphanhood has been one of the direct social consequences of the HIV pandemic resulting into a considerable number of orphans in Malawi. Vulnerability has also increased as a result of children living in households that have a chronically ill parent or have just lost a chronically ill guardian. 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 vicious cycle (MICS, 2006 p 252).

Current estimates put the orphan population at 1,164,939 orphans, out of which 436,503 were due to AIDS (Sentinel Surveillance, MoH, 2007). Overall, about 12 % of children had one or both parents dead and 18% were found to be orphaned and vulnerable[3]. Though not significant, there were relatively more male compared to female orphans (12.6% vs 12.2%) as well as orphans and vulnerable children (18.1% vs 17.8%). The Southern Region had the highest prevalence of orphans (15.3%) followed by the Northern Region (11.2%) and the Central Region had the lowest (9.8%). The prevalence of orphans was higher in the urban areas (13.8%) compared to rural areas (12.2%) and more orphans in the older age groups relative to the younger age groups. There were also more orphans from the highest wealth quintile (14.1%), while the least are in the middle wealth quintile (10.7%) implying that richer people are proportionately more likely to die of HIV than their poorer counterparts. The table below shows the prevalence of orphans as well as orphans and vulnerable children in the country by age-group, gender, region, residence and wealth quintile.

Table 2.2: Prevalence of OVCs

Background Characteristics	Prevalence of Orphans	Prevalence of Orphans and Vulnerable Children
Sex		
Male	12.6	18.1
Female	12.2	17.8
Region		
Northern	11.2	15.2
Central	9.8	13.9
Southern	15.3	22.7
Residence		
Urban	13.8	18.5
Rural	12.2	17.9
Age		
0-4	3.1	8.8
5-9	11.5	17.1

[3] *Orphanhood is defined as when a child has either parent dead. Vulnerability is defined as when (a) either parent is chronically ill, (b) an adult aged 18-59 in the household is either dead (after being chronically ill) or (c) an adult aged 18-59 in the household was chronically ill in the year prior to the survey. (Source: UNAIDS Monitoring and Evaluation Reference Group, cited in MICS 2006)*

10-14	20.9	26.4
15-17	24.6	30.1
Wealth Index Quintile		
Lowest	11.9	17.4
Second	13.1	18.8
Middle	9.8	15.9
Fourth	13.1	19
Highest	14.0	18.8
Total	12.4	18

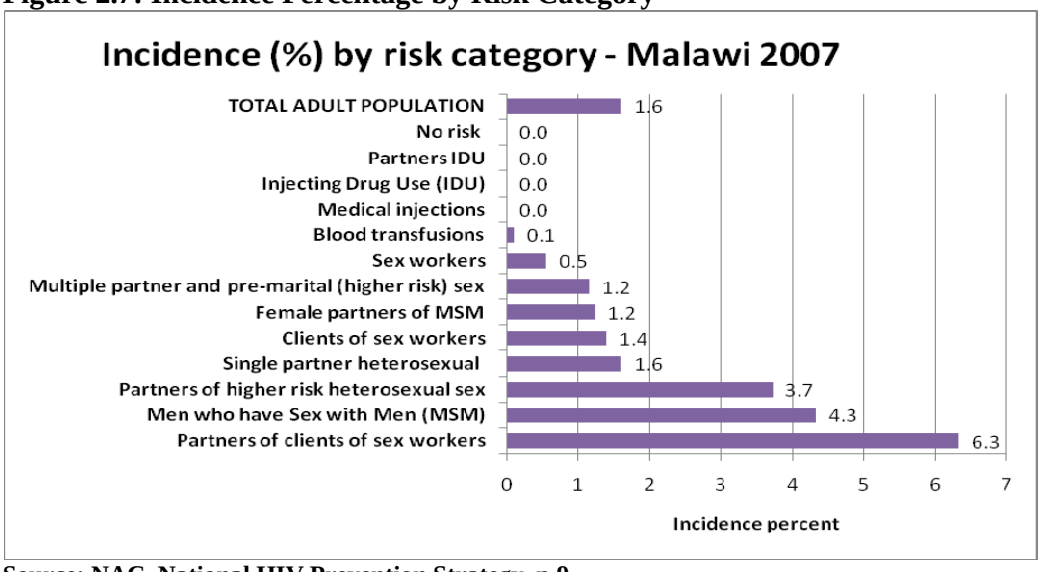
Source: Multiple Indicator Cluster Survey, 2006

2.5 HIV Incidence

2.5.1 Modelling of Incidence

Based on the UNAIDS Modes of Transmission Model, the HIV Prevention Strategy estimates that 1.6% of the total adult population in Malawi becomes HIV-infected each year. However, other estimations put the incidence closer to 1% (MoH Consultations). Higher incidence is estimated for partners of clients of Sex Workers (6.3%), partners of higher risk heterosexual sex (3.7%), as well as for Men who have Sex with Men (4.3%). The National HIV Prevention Strategy recognises Men who have Sex with Men as a high priority intervention group owing to its interface with the female population since most Men who have Sex with Men also have female partners (National HIV Prevention Strategy: 2009-2013, p.9). See figure 11 below:

Figure 2.7: Incidence Percentage by Risk Category



Source: NAC, National HIV Prevention Strategy, p.9

2.5.2 Estimated Annual Number of New Infections

The National HIV Prevention Strategy: 2009-2013 refers to the frequently quoted estimate that there are 90,000 new infections of HIV each year in Malawi.

Spectrum estimates with updated assumptions generated in March 2010, put the number of new HIV infections at just over 84,000 for 2009 (Spectrum Estimates Generated March 2010 – still to be validated).

2.6 Key Drivers of the Epidemic in Malawi

2.6.1 Factors Facilitating the Transmission of HIV

In the HIV Prevention Strategy (2009-2013), it is noted that most new infections occur within long-term stable sexual relationships. The 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.

In addition, the following cross-cutting determinants have been noted in the Prevention Strategy:

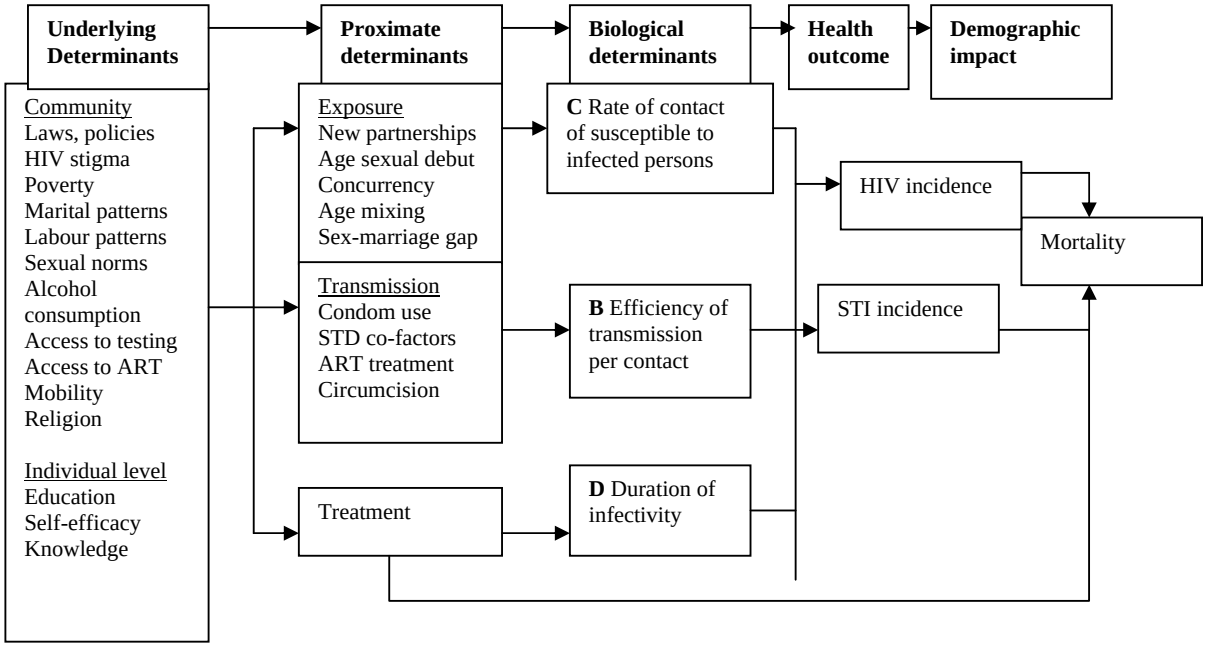
- Transactional sex related to income and other social and material benefits;
- Gender inequalities/imbalances including masculinity;
- Harmful cultural practices; and
- Stigma and discrimination.

A diagram of the key drivers of the epidemic appears in the following section. The key drivers are discussed in more detail throughout Section 3 in relation to efforts to address these factors as a part of the National Response. An overview of harmful cultural beliefs, attitudes, and practices also appears below for background.

2.6.2 Diagram of Key Drivers of the Epidemic

The schema in figure 12 below illustrates the proximate and underlying determinants of HIV infection in Malawi (Weir et al 2008). As would be observed, there are both community and individual level underlying factors that determine peoples' exposure to HIV and increase chances of contracting HIV. New sexual partnerships, age at sexual debut, intergenerational sex, low condom use and concurrency in sexual relations are among the factors highlighted as being key to HIV transmission.

Figure 2.8: Proximate determinants of HIV infection in Malawi



Source: Weir et al (2008)

A study that was conducted to identify and characterise sites and events where people meet new sexual partners in the urban areas of Lilongwe and Blantyre reported high multiple sexual partnerships among the patrons of the sites especially among female patrons. Understandably, this is because the majority of female patrons visit those sites in search of sexual partners in order to earn a living (Assessment of Sites and Events where people meet new Sexual Partners in the Urban Areas of Lilongwe and Blantyre, 2007, Kadzandira and Zisiyana). Among the male patrons, certain attributes appeared to contribute to sexual networking and these included having a car, mobile phone and having cash flow above average (dubbed the 3 Cs) and alcohol consumption. Male patrons with these four attributes were found to be 2.5 times more likely to have another sexual partner in addition to their regular spouses or girl friends than male patrons that have none of the four.

The findings from the study described above are supported by a study which was conducted among girls aged 15-19 in Lilongwe, Zomba and Thyolo districts. This study reported that girls who were part of FGDs and in-depth interviews attributed high prevalence of sexual relations among female peers sometimes with their teachers because they want 3Cs namely cash, car and cell phone (Munthali and Maluwa-Banda

2008). Some FGD participants also reported that boys cheat their parents that they have, for example, lost school books in order to raise cash to satisfy their girlfriends.

While the two studies highlighted above talk of the conventional multiple sexual relations taking place between men and commercial sex workers and among youths, some studies conducted in Malawi are also point to the high prevalence of extramarital sexual affairs among married men and women (Multiple and Concurrent Partners Formative Research: A Key Informant Interviews Report, 2007, Pakachere Health and Development Communications HIV Prevention, Komwa and Sikwese). In their study, Komwa and Sikwese have argued that most studies in Malawi have tended to ignore sexual relationships that are taking place among married men and women which, when managed, tend to take long and as a result of which, trust tends to build between the partners leading to low use of protection. Among others, factors promoting multiple and concurrent sexual partners (MCP) are peer pressure, availability of disposable income especially among men, gender imbalance in employment opportunities and income, alcohol and drug use, the high emphasis on the 'C' in the ABC prevention strategy, working or living away from partners and lack of good sex education among couples.

A qualitative study that was conducted in Chiradzulu, Blantyre and Neno Districts also sheds more insight into underlying factors that promote MCP. These include working or doing business outside of regular homes for long periods, puberty transition adventures, self esteem, the feeling to taste new sexual life especially among men and that due to the social transformations taking place in rural areas, there are certain cultural and social changes that are also unfolding which predispose the youths and women to high risks of contracting HIV (Kadzandira 2010).

2.6.3 Harmful Cultural Beliefs, Attitudes and Practices

While multiple and concurrent partnerships (MCP) and transactional sex have been identified as the key drivers of HIV transmission in Malawi (and sub-Saharan Africa), some studies have also suggested that a potential driver of the epidemic might be certain "cultural factors" (GoM 2005) or cultural practices that act to enhance individuals' risk of contracting the disease (NAC & MOH 2003; Matinga & McConville 2004, Malawi Human Rights Commission 2005; Kadzandira & Zisiyana 2006)). These practices are a significant challenge to HIV/AIDS prevention strategies in Malawi and in some cases, interventions have aimed to substitute risky cultural practices with "healthy practices" (Kornfield and Namate 1997).

A study which was conducted to assess sites and events where people meet new sexual partners in Nsanje district reported several cultural practices that expose people to HIV infection and these included *kulowa kufa* or *kupita kufa*, and *bzwade* (Kadzandira & Zisiyana 2006). In *kulowa or kupita kufa, w*hen a husband or wife dies (regardless of the cause of the death), the remaining widow or widower is culturally obliged to have sexual intercourse with a man so as to protect the relatives and whole village from different kinds of misfortunes and to please the spirits of ancestors. Usually a younger or elder brother of the dead husband does the cleansing. Recent studies have also reported commercially hired sexual cleansers. In *bzwade*, sexual cleansing is done to strengthen the body of a newly born child and usually parents are involved but if the mother has no husband, commercially hired men are

used to perform the practice. These practices are also common in most parts of the southern region.

Over the last 5 years, various newspaper articles have also highlighted numerous cultural practices in various parts of the country that have a bearing on HIV transmission in the country. These practices include *chokolo* (wife inheritance), *fisi* (hyena) to assist childless couples and to introduce sex to the newly initiated girls and unclean methods used during circumcision[4]. While some studies have reported a declining prevalence in most of the cultural practices because of the massive campaigns on HIV and AIDS and gender-based violence, other studies have uncovered and reported that the practices still exist only that they have gone underground because the perpetrators don't want to be humiliated (Munthali et al 2003). A 2009 qualitative study conducted in three districts of the southern region also revealed how young girls indulge in premarital sex because of lessons they get from initiation ceremonies as the thrust of the lessons hinge on sexual pleasing of men and bed work performance (Kadzandira 2010) and upon coming out of the ceremonies, the young girls feel they have been transformed into adults and start looking for men to have sex with.

As the scale-up process continues, the National Response endeavours to ensure that such harmful practices are minimised. Efforts are being made to work with gate-keepers (chiefs, religious leaders, initiators and other local leaders) so as to identify alternative methods of conducting initiation ceremonies. The national adult literacy programme will also be strengthened as a major channel of conveying information to the rural areas (UNGASS Consultation Process, 2009-2010).

[4] The following comprise a sample of some of the headlines found in the popular daily *The Nation*, followed by their author and publication date: "How much of our culture should we preserve" (Phiri, August 2, 2005); "Culture a source of violence" (Malamula, July 11, 2005); "Ban explicit dances" (Mpodaminga, June 19, 2005); "Traditions impinge on safe motherhood" (Kalua, October 8, 2007); "Taking AIDS fight to the people" (Masingati, November 2, 2007).

3. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

3.1 National Commitment

3.1.1 Institutional Context

One National Coordination Authority

Since the discovery of the first HIV case in Malawi, the Government has put in place policies and structures meant to guide the proper implementation of the response. The National AIDS Control Programme was commissioned in 1989 under the Ministry of Health to champion a biomedical response to the epidemic. As the epidemic spread, it was realised that the response needed to be more multisectoral to cover issues beyond health. This resulted into the establishment of the National AIDS Commission in 2001 as a Public Trust, and in concert with the 2001 UNGASS Declaration, this became one coordination authority for the national response to HIV (Report of the Law Commission on the Development of HIV and AIDS legislation, December 2008)

One National Strategic Framework

A multisectoral response to the epidemic has largely been based on a set of agreed priorities, strategies and actions that have been spelt out in various documents. The first National Strategic Framework was developed in 2000 and expired in 2004. A successor plan, the National Action Framework was thereafter developed to cover the period 2005-2009. Since this Framework expired in 2009, it has been reviewed and extended to cover the period 2010-2012. With the exception of the time period covered, there is alignment with the Malawi Growth and Development Strategy-the overarching national development blueprint.

One Monitoring and Evaluation Framework

In order to fully measure progress with the national response, a National M&E Framework was developed in 2003. The Framework was revised in 2006 and extended to the period 2010. A new M&E Plan is expected to be developed in 2010 to be in line with the extended National Action Framework.

Governance Framework of the Response to HIV and AIDS in Malawi

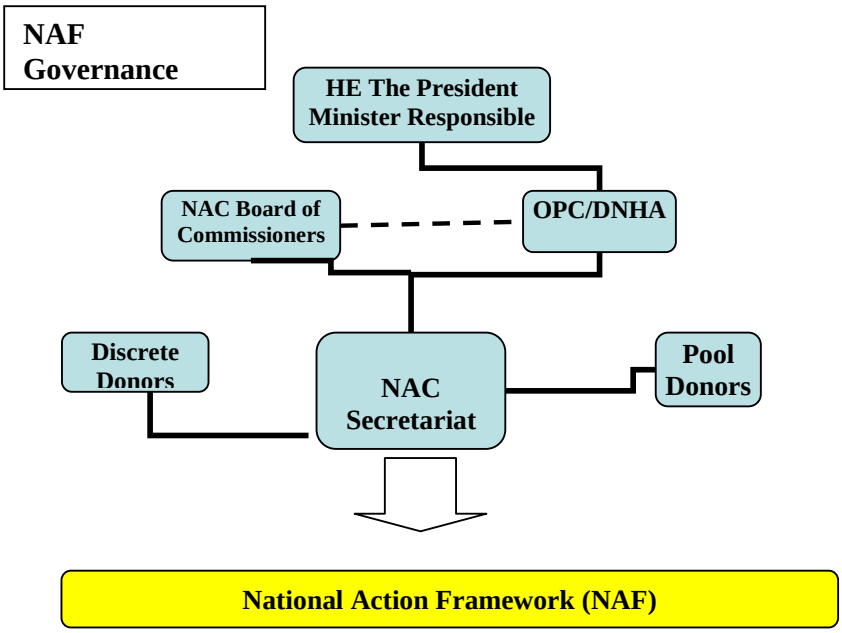
The Office of the President and Cabinet

The President is the Minister responsible for HIV and provides direction on matters of HIV and AIDS. The Department of Nutrition HIV and AIDS under the Presidency is responsible for policy formulation, oversight, facilitating and supervising HIV and AIDS mainstreaming programmes, setting up of operational structures, enactment of HIV and AIDS legislation, and high level advocacy on HIV and AIDS. (Report of the Law Commission on the Development of HIV and AIDS legislation, December 2008, p. 19).

The National AIDS Commission

Established through a trust deed, the National AIDS Commission is responsible for coordination and facilitation of the national response to HIV and AIDS. The Commission is led by a Board Chairperson who is appointed by the President. The specific roles of NAC are as follows:

1) Guide development and implementation of the NAF; 2) Facilitate policy and strategic planning in sectors, including local government; 3) Advocate and conduct social mobilization in all sectors at all levels; 4) Mobilize, allocate and track resources; 5) Build partnerships among all stakeholders in country, regionally and internationally; 6) Knowledge management through documentation, dissemination and promotion of best practices; 7) Map interventions to indicate coverage and scope; 8) Facilitate and support capacity building; 9) Overall monitoring and evaluation of the national response; and 10) Facilitate HIV and AIDS research (Extended NAF 2010-2012).

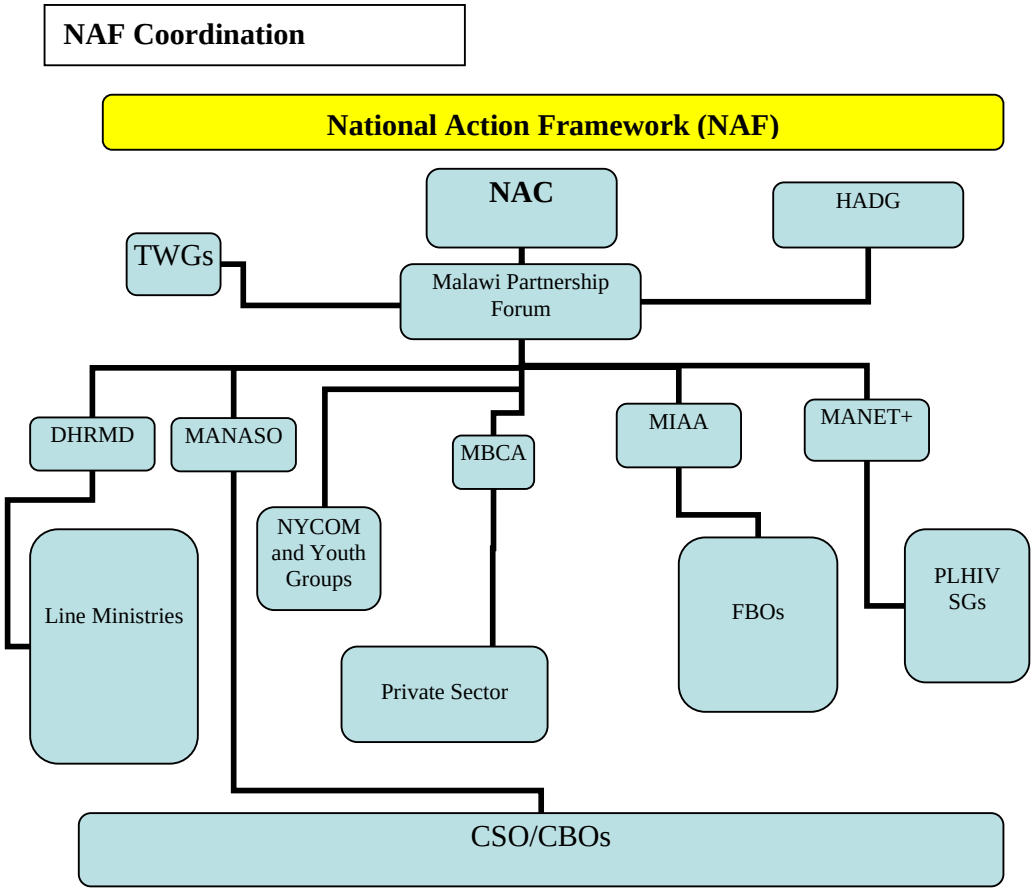


Source: Adapted from the Extended National Action Framework, 2010-2012

Coordination of the National Response[5]

While NAC is at the heart of the institutional framework, there are several coordinating structures and mechanisms, some managed by NAC, some independent, for the national response. These are organised as follows (see schematic):

[5] Discussion adapted from the Extended NAF, 2010-2012



Source: Adapted from the Extended National Action Framework, 2010-2012

Malawi Partnership Forum (MPF) –This [Executive Committee of the Malawi Partnership Forum] 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 (TWGs) – These 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 (HADG) - This 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.

Malawi Global Fund Coordinating Committee (MGFCC) - The MGFCC provides overall guidance on Malawi's Global Fund supported programmes to fight HIV/AIDS, Tuberculosis and Malaria. It is accountable to the Government of Malawi and the Global Fund on the utilization of the Global Fund resources, and determines priorities for proposals to the Global Fund based on existing country frameworks and strategies. Membership of the MGFCC is composed of the public, private sectors, civil society including people living with HIV and AIDS and development partners. Every MGFCC member is nominated by the constituency he or she represents[6].

Department of Human Resources Management and Development (DHRMD) – Within the Office of the President and Cabinet (OPC), this 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.

Malawi Business Coalition against AIDS (MBCA) – It 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.

Malawi Network of People Living with HIV (MANET +) – It 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.

Malawi Network of AIDS service organisations (MANASO) – It coordinates local and international NGOs implementing various HIV and AIDS activities.

The Malawi Interfaith AIDS Association (MIAA) – It coordinates all faith based organisations implementing HIV and AIDS interventions.

National Youth Council of Malawi (NYCOM) – It coordinates all youth organisations implementing HIV and AIDS interventions.

These mechanisms have been functioning for some years, are well-established, and have been regularly reviewed and assessed (see items 10, 11, 12, 14, and 34 in References).

[6] Operational Manual for the Malawi Global Fund Coordinating Committee (MGFCC)

Key Implementing Agencies

Within these governance and institutional frameworks, actual implementation of the NAF is the responsibility of a wide range of implementing partners from the public and private sectors, and civil society.

Ministry of Health: The MoH plays a key role in the multi-sectoral response, for technical direction and service delivery in biomedical areas of prevention, treatment and care. The specific roles of the MoH include 1) Developing Policies and Guidelines on biomedical HIV and AIDS interventions; 2) Planning and implementing biomedical HIV and AIDS interventions; 3) Coordinating health sector thematic areas; 4) Providing technical support for HIV and AIDS policy development; 5) Providing technical support in implementation of health related HIV and AIDS interventions; and 6) Surveillance for HIV/AIDS/STI.

Ministries, Departments, and Parastatal Bodies: Central ministries such as Ministry of Finance, the Ministry of Economic Planning and Development, the Department of Human Resources Management and Development, the Law Commission and the Human Rights Commission directly or indirectly support the national response. Line Ministries provide services up to the community level. Ministries, departments and parastatal organisations have established focal points for HIV and AIDS and are expected to mainstream HIV and AIDS into their sectoral work, provide technical support to the response, and organise workplace interventions for staff. All ministries have a budget line for HIV and AIDS activities.

Local Authorities: coordinate the implementation of the response at district, city level and community levels. They have the responsibility to mobilize resources for community programs, implemented through CBOs, Support Groups, and Community AIDS Committees (CACs). District development committees (DDCs) and Area Development Committees (ADCs) complement the work of local NGOs.

NGOs, FBOs and CBOs form the core of the implementing agencies and among others things carry out advocacy, assist communities to mobilise resources locally, document best community practices and support capacity building programmes in collaboration with NAC.

Private Sector: organisations under the coordination of the Malawi Business Coalition on AIDS (MBCA) have the responsibility to mainstream HIV and AIDS through workplace policies and programmes.

Development Partners: support national priorities; facilitate implementation with funding capacity building. The development partners assist the government's response in areas such as empowering leadership, mobilisation public, private and civil society, strategic information, and facilitating access technical and financial resources at national level.

All these implementation partners are coordinated within the National Action Framework (NAF), using the coordination mechanisms described in the previous section.

3.1.2 HIV and AIDS Financing and Expenditure (Indicator 1)

Methodology

In the first quarter of 2010, a National AIDS Spending Assessment (NASA) aimed at tracking expenditure among public, external and private sources was conducted by a team of consultants. The NASA included AIDS spending from all agencies/organizations for 2007/2008 and 2008/2009, as provided by those consulted (about 90). This was not restricted to pool funding, but included all AIDS resources channelled to Malawi.

After initial notification about the NASA through the local print media and notification letters, the data collection began. In the 1st phase, funding agencies were mainly targeted, followed in the 2nd phase by intermediary organisations channelling funds from donor agencies to implementing organisations. In the last stage, large implementing organisations potentially also in receipt of external funding directly, were visited.

Data analysis occurred in four stages. Stage 1 comprised of data capture in forms inputted into an excel spreadsheet. In Stage 2, this data was transferred into a NASA excel sheet to facilitate Stage 3, i.e. subsequent transfer from NASA excel files into the NASA RTS. Lastly, once in NASA RTS the data were used to generate various tables, including the National Funding Matrix which is required for the UNGASS.

Though funding outputs were not validated as part of the UNGASS National Validation, validation of the NASA outputs were done separately with the UNGASS/NASA Task Force.

Limitations

The results and analysis that follows is based on output from this National AIDS Spending Assessment (NASA) exercise. It should be taken into account that the figures presented may understate the resources mobilised in support of the Malawi national response to HIV and AIDS and thus should be viewed as representing the lower bounds of AIDS resource envelope for a number of reasons:

- First, the NASA did not include capital expenditure by the government through an estimation of the depreciated value. Therefore, the total public expenditure is under-estimated.

- Second, the NASA did not include all private expenditure (except for a few private companies/businesses). Other private expenditures such as private insurance, the businesses community, traditional healers, and household out-of-

pocket payment expenditures were not captured due to time and resource limitations.

- Third, for some organizations/institutions, the NASA did not include data on salaries for personnel working in HIV and AIDS related activities, including for the Ministry of Health. Allocation of salaries on HIV and AIDS activities would require sub-analysis based on the proportion of salaries that went into HIV and AIDS related activities and projects and the proportion of staff time spent on HIV and AIDS related activities.

- Fourth, data on overheads for most organizations/institutions were not included. With the exception of those organizations/institutions that fully specialize in HIV and AIDS activities i.e. UNAIDS and NAC, it was difficult to estimate the proportion of an organization/institution's overheads that could be attributed to its HIV and AIDS activities.

- Fifth, the NASA also excluded expenditures on TB treatment that were related to HIV and AIDS which were difficult to collect.

It is also important to note that the response rate was not 100% based on the sampling frame developed. These limitations will be addressed in future NASAs with regard to the comprehensiveness of data presented.

HIV and AIDS Expenditure

Malawi has made two significant strides in mobilising resources for the National response. First, due primarily to the scaling up of ART, Malawi has managed to mobilise increasing amounts of funds for care and treatment, and has also created an enabling environment for HIV and AIDS-related research. Second, against a background of the global financial crisis, Malawi has managed to maintain funding commitment and momentum from development partners thereby minimising shortfall in resources between actual and those required for achieving universal access target.

In the preceding five years, Malawi has witnessed tremendous growth in funding for HIV and AIDS. Total HIV and AIDS expenditures rose from US$29.1 million in 2002/03 to US$ 69.1 million in 2004/05 on account of steep increase in donor contribution (GoM, National Health Accounts, 2007). This momentum continued in the period covered by this report as the total spending on HIV and AIDS programs rose to US$107.426 million in 2007/08. The bulk of this money went to three categories: Care and Treatment (US$33.5million or 31.2%) followed by Program Management and Administration (US$24.3 million or 22.63%) and Prevention (US$20.9 million or 19.49%). In 2008/09, total spending on HIV and AIDS programs slightly declined by 2.9% to US$104.426 million. Rather than signal intrinsic problems with the national response, this decline merely reflects delays in funds disbursal. Although much of this money, when it came, was allocated to the same three categories, there were changes in relative distribution across spending categories with Care and Treatment accounting for 38%, followed by Program management and Administration at 22% and Prevention accounting for 17% of all funds.

Table 3.1: AIDS Spending by Major categories

AIDS Spending Categories	2007/08	%	2008/09	%	% Change in Funding
Prevention	20,933,660	19.49	17,766,756	17.00	-15.13
Care and treatment	33,488,569	31.17	39,931,108	38.20	19.24
Orphans and vulnerable children	7,787,005	7.25	4,735,504	4.53	-39.19
Programme management and administration	24,305,572	22.63	23,261,727	22.25	-4.29
Human resources	2,574,247	2.40	1,190,008	1.14	-53.77
Social protection and social services excluding OVC	4,777,500	4.45	1,814,367	1.74	-62.02
Enabling environment	12,387,061	11.53	14,615,472	13.98	17.99
HIV and AIDS-related research excluding operations research	1,172,630	1.09	1,219,586	1.17	4.00
TOTAL	**107,426,244**	**100.00**	**104,534,528**	**100.00**	**-2.69**

Aids Spending By Category

1. Care and Treatment

With the intensification of the scale up of ART programme, funding to care and treatment inevitably constitutes the single largest spending category with the amount allocated growing by 19% from US$33.5 in 2007/08 to US$39.9 in 2008/09. This increase also resulted in growth in the share of care and treatment from 31.2% to 38.2 % of total AIDS spending in 2007/08 and 2008/09 respectively. Unfortunately out of the US$33 million and US$39 million in 2008/09 that went to Care and Treatment, it is difficult to pinpoint actual intervention or subcategories because the component receiving most funds (60% in 2008 and 80% of Care and Treatment Funds in 2009) was *Care and treatment services not disaggregated by intervention* followed. Whereas outpatient care used US$12 million in 2008 and represented 38% of the Care and Treatment budget, in 2009 the amount fell down to US$5.2 million and its share in Care and Treatment budget declined to 13%.

2. Prevention

Although the importance of prevention in the overall HIV and AIDS portfolio remained the same, between 2008 and 2009 the total amount of money spent on prevention declined by 15.13% from US$20.9 million to US$17.8 million, resulting in a marginal decline in the share of prevention in the overall AIDS budget. This decline is reflected in the change in the composition of expenditures on AIDS with the resources allocated to HTC falling by 56% from US$7million to US$3million, funding for the prevention of mother to child transmission declined by 19% from US$4.4 million to US$3.6 million and the share of communication for social and behavioural change declined by 63% from US$2.4 million to US$0.87million. In relative terms, whereas funding to HTC services represented 33.4% of the prevention budget in 2007/08, in the 2008/09 its share fell down to 17.21% and the share of

communication and behavioural change also fell from 11.3% to 5 % of the prevention budget. Although the actual amount devoted to PMTC fell by 19%, in relative terms its share of the prevention budget held steady at 21%.

3. Programme Management and Administration

Programme management and administration is the second largest recipient of funding accounting for slightly above 22% of total AIDS funding. Although the amount of funds dedicated to programme management and administration fell by 4.3% from US$24.3 million in 2007/08 to US$23.26 million in 2008/09, there are significant shifts in funding within the category. The two major spending groups within this category i.e. Planning and Coordination and, Administration and Transaction costs associated with managing and disbursing funds, have witnessed an increase in actual funding by 30.4% and 27.9% respectively while their relative shares have risen from 26.5% to 36.2% and 22.61% to 30% respectively. The third largest component however, monitoring and evaluation has witnessed a 19% reduction in funding from US$3.6 million to US$2.9million. The drug supply system's funding has declined by US$2.2 million (76.32%) from US$2.9 million in 2007/08 to just US$0.69 million resulting in a decline in the share of drug supply within the category from 12% in 2007/08 to 3%.

4. Enabling Environment

In a period of cuts in major spending categories, the resources allocated to creating a better enabling environment have increased by approximately 18% from US$ 12.4 million in 2007/08 to US$14.6 in 2008/09. In relative terms, the share of enabling environment in total AIDS spending has risen from 11.5 % to about 14%. There has been an increase in funding for creating an enabling environment that has not been disaggregated by type, from US$8.5 million to US$12.1 million representing an increase in the share from 68.8% in 2007 to 82.6% in 2008/09. The amount allocated to human rights programmes has however remained stable between the two years, at US$1.8 and representing a relative decline from 14.5 % to 12.3 % of resources dedicated to Enabling Environment in 2008 and 2009 respectively.

5. Services for Orphans and Vulnerable Children

Between 2007/08 and 2008/09 finding for Orphans and Vulnerable Children declined by about 40% from US$7.79 million to US$4.74 million. Consequently, the share of OVC services in total AIDS funding declined from 7.3% to 4.5%. Unfortunately much of the spending in this category (91%) has not been disaggregated by category and it is not possible to analyse changes in funding within the category, although in absolute terms the actual funding has declined from US$7.1 million to US$4.3.

6. Social Protection and Social Services, Excluding OVC

Reduction in funding to OVC services that has been observed above seems consistent with general reduction in funding for social protection and social services. Between 2007/08 and 2008/09, funding for social protection declined by 62% from US$4.8 million to US$1.8 million, resulting in a fall in the share of social protection and social services in total AIDS spending from 4.5% to 1.7%. All components within this

spending category experienced reduction in funding, with funds allocated to social protection through provision of social services declining by 85.20 % from US$2.3 million to US$0.34 million and funds allocated to HIV-specific income generation falling by 96.2% from US$1.22million in 2007/08 to just US$0.05million in 2008/09. Like many other programs that witnessed declines, these declines were mainly due to protection against cuts for funds going into Care and Treatment. Since those funds actually increased in a year of overall reduction in total funding, the rest of the programs had to share the remainder of funds which were less than the previous year.

7. Human Resource

Spending on human resources has also experienced a reduction in funding, with a reduction of 53.8 % from US$2.6 million to US$1.2 between 2007/08 and 2008/09 resulting in decline in relative share from 2.4% to 1.1%. This decline comes almost entirely from cuts in funding for training which has suffered a 90% reduction in funding from US$2.5 million to US$0.94 million. Although funding to other human resources programs not disaggregated by type increased between the two years, this component represents a very minute share of overall spending in this category.

8. HIV and AID- related Research

Funding for HIV and AIDS related research marginally increased by 4 percent from US$1.17 million to US$1.2 million. However, between the two years, there was shift in funding from HIV and AIDS-related research activities although much of it is either not elsewhere classified or in other HIV and AIDS spending not disaggregated by type. For identifiable groups bio-medical research received more funding than social research.

AIDS Financing

The Malawi National Health Accounts Report of 2007 shows a funding duality whereby development partners, through NAC, were the major contributors to prevention and mitigation services for HIV and AIDS (information, education and communication [IEC]; prevention of mother-to-child transmission [PMTCT]; distribution of contraceptives; support to orphans and vulnerable children) and the Treasury, (through the Ministry of Health) was the major financier of treatment and care for HIV and AIDS and related opportunistic infections (apart from ARVs).

There is increasing financing for HIV and AIDS over other health services with donors accounting for 73% of HIV and AIDS expenditures but just 54% of general health expenditures (GoM, National Health Accounts 2007). This trend has continued in the period covered by this UNGASS report. International funds remain the bulwark for funding the national response to HIV and AIDS in Malawi accounting for 98% of total funding, with the public and private sectors accounting for the remaining 2%. However, although the relative share of all sources of funds have been stable, behind the veneer of stability actual funding declined in absolute terms between 2007/08 and 2008/08 across all sources. Although, public funding and private funding declined by 29% and 12% respectively the decline of 2.7 % in total AIDS funding from US$107.4

in 2007/08 to US$104.4 in 2008/08 is mostly on account of a 2.3% decline in international funds.

Table 3.2: AIDS Funding Sources

SOURCE	2007/2008 (US$)	%	2008/2009 (US$)	%	% Change
Public Funds	1,896,100	1.8	1,461,800	1.4	-29.71
Private Funds	704,045	0.66	627,615	0.6	-12.18
International Funds	104,826,099	97.6	102,445,113	98.0	-2.32
GRAND TOTAL	**107,426,422**	**100**	**104,534,528**	**100.0**	-27.66

Public Funding

The share of public funding in total funding for HIV and AIDS fell from 40% in 2002/03 to 20% in 2004/05 and now stands 1.8%. An analysis of the allocation of public funds by use or sector shows that a significant portion of public funds goes to care and treatment, with the share of public funds to this spending category rising from 32% in 2007/08 to 46% in 2008/09. In relative terms, funding for all spending categories has been stable except for funding for prevention whose shares in public funding to AIDS has fallen by 57% from US$0.3 million to US$0.1 million translating in a fall in the share of prevention in public funding from 16.4% to 9.2%. Similarly, actual funding for OVCs declined by 70% resulting in a decline in the share of OVC in public AIDS budget from 8.9% to 3.5%, respectively, between 2007/08 and 2008/09.

International Funding

The share of international sources in HIV and AIDS funding has risen tremendously from 46% in 2002/03 to 76% in 2004/05 and now stands at 98%. International funding now accounts for 98% of all HIV and AIDS funds in Malawi. Further analysis of the international component, shows that the bulk of funds come from multilateral contributions, especially the Global Fund to Fight AIDS, TB, and Malaria (GFATM). In 2006/07 this component accounted for 71% of international funding while direct bilateral contributions accounted for 20.9%. Between 2007/08 and 2008/09 the composition of international contributions changed mostly due to a 29% increase in the contributions from direct bilateral sources and stability in contribution from international NGOs. However, this increase was not enough to offset the decline in overall international funding which was due to an 11% reduction in funds from multilateral development partners.

Table 3.3: AIDS Funding from International Sources

Source	2007/2008 (US$)	%	2008/2009 (US$)	%	% Change
Direct Bilateral Contributions	21,267,029	20.9	27,476,324	26.8	29.20
Multilateral		71			-11.86

Contributions	74 568 381		65,727,177	64.2	
International Not For Profit Organisations	8,990,689	8.58	9,241,612	9.0	0.34
Total	**104, 826,099**	**100**	**102,445,113**	**100.0**	**-2.27**

An analysis of the 11% decline, shows that within multilaterals, the major change was the decline in disbursed funding from the Global Fund. Whereas resources from the Global Fund contributed US$69.4 million and accounted for 93 % of funds from multilateral donors in 2007/08, the Global Fund's contribution declined to US$56.8 and accounted for 86 % of multilateral funding in 2008/09. The effects of this decline were partly offset by an increase in World Bank funding which rose from US$1.02 million (the equivalent of 1% of all multilateral funding) in 2007 to US$5.7 million (equivalent to 9% of multilateral funding) in 2008/09. The contribution of other multilateral development partners has remained stable at 4% for UN Agencies and 1 % for other multilateral sources.

Financing Sources and AIDS Spending Categories

Further analysis of overall financing from international sources shows that care and treatment is the largest recipient of funds from international partners, with its share of total AIDS funds rising from 21.3% in 2007/08 to 38.1% in 2008/09. Funding for program management and administration got the second largest share followed by funding for prevention. Much of this picture however is driven by allocation of funds from the Global Fund which has increased resources dedicated towards care and treatment from 39% to about 50% in the past two years with funding for enabling environment and program management coming as a distant second and third respectively.

This overall picture, however, masks significant variation in program emphasis and funding specialisation across donors. For instance, a significant portion of funds from bilateral sources (41% in 2008 and 35% in 2009) went to prevention, followed by program management. In contrast, whereas 83% of World Bank funds in 2008 went to program management, in 2009 the share of program management fell to 13% with the bulk of World Bank's funding going to care and treatment (52.12%) and creating an enabling environment (20.34%). Funding from UN Agencies was more uniformly spread across spending categories. Funds from International NGOs are allocating most of their funding to program management (57-59%) with care and treatment and prevention coming a distant second and third respectively.

AIDS Financing and Universal Access Targets

Through its new HIV and AIDS funding architecture Malawi had done remarkably well in mobilising domestic and international resources and has gone a long way in mobilising resources for achieving universal access targets. Earlier estimates of resource requirement for effective implementation of the National Action Framework [2005-2009] projected that the national response would require US$134,150,135 in 2008 and US$120.4 million in 2009. In hindsight, Malawi's ability to mobilize

US$107.4mn and US$104.5mn in 2008 and 2009 respectively represents a growing resource mobilisation efficiency rate from 80% in 2007/08 to 87% in 2008/09. The estimated shortfall between actual AIDS expenditure and the amount required to achieve Universal Access targets was US$16 million in 2008 and US$7.4 million in 2009.

Similarly, a projection of the resources required to achieve Universal Access for 2009/10 to 2012/13 suggests that the National response will need about US $827 million over the three years (or about US$275 million per year). However, Malawi and her development partners can only raise close to half of that, of which the NAC element totalled $243 million over the 3 years (GFATM plus Pool), and other sources can at most total US$209 million.

Pool Funds Management

The amount and proportion of funds for HIV and AIDS related programmes going through the National AIDS Commission has increased in recent years from 19% in 2005/06 to about 54% [MoH, 2007; NAC, 2009]. Much of this growth is on account increase flows of resources from the Global Fund for the treatment of AIDS, Tuberculosis and Malaria. Of the resources that NAC mobilised, only 11% were expended by NAC while the bulk of expenditures (89% in 2008/09) were incurred on grant disbursements to partners. Between 2007/08 and 2008/09 the amount disbursed to grant recipients declined by 21% from US78.5 million to US62million. Consequently, the composition of expenditures also changed. Treatment, care and support still constituted the single largest component (at 58% of all non-NAC expenditures) and its share remained constant because it was protected from cuts. However, the share of prevention and behavioural change fell by 62%, the share of impact mitigation fell by 59 % and resources devoted to M& E and R&D fell by 75 %. The only exception was an increase in the absolute and relative resources allocated to mainstreaming and capacity building, which rose by 9% from US$12.9 million to US$14.6million. This was on account of the inclusion of salary-top-up for health personnel which had hitherto not been included.

Financial Challenges

Funding for Malawi's AIDS program faces two critical challenges. Firstly, the World Health Organization recently (2009) updated the guidelines for starting people on ART by raising the threshold from a CD4 count of 250 to 350. This will inevitably make more people eligible for ART and significantly raise resource requirements across all components of treatment and care. Secondly, Malawi is heavily dependent on donor support in health financing and in AIDS, which leaves the country vulnerable to shocks. While large donor interventions express donor confidence in and commitment to Malawi's national response, these increasing amounts of financial resources bring into question two policy key issues:

1. Government leadership directing sustainability plans for the National Response to the crisis; and
2. Sustainability of financing for HIV and AIDS goods and services if there were a turnaround in donor support.

Plans are underway from Government to try to cushion against these possible financial challenges, through for example entering into public-private-partnerships for the local production of ARVs.

Cost Benefit Analysis: Building a Business Case for Investment

Malawi's scale-up of ART is in overdrive. The recent change in WHO guidelines, necessitate doubling of resources required for care and treatment, which currently stands at an average of US$3million per month for care and treatment including treatment of opportunistic infections. The analysis of financing and spending categories above suggests that resources so far mobilised fall short of those required to meet the national response or universal access targets. Yet it is in the interest of Malawi and her development partners to increase investments in HIV and AIDS programs. Although there is little literature on the issue in Malawi, evidence from near and far suggests that investment in HIV and AIDS programs, whether Preventive or Care and Treatment are cost effective and good value for money.

Even absent changes in WHO guidelines, the case for rapider scale up of ARV is more compelling. A study in Khayelitsha, South Africa found that the discounted lifetime costs for No-ART and ART were US$2,743 and US$9,435 over 2 and 8 Quality Adjusted Life Years (QALYs) respectively (Cleary, McIntyre and Bouble, 2006). The incremental cost-effectiveness ratio through the use of ART versus No-ART was US$1,102 per QALY and US$984 per life year gained. Similarly, PMTC using Nevirapine has been shown to be cost-effective. A consensus study of 106 HIV-infected children in South Africa found that lifetime treatment costs totaled R19,712 (about US$1,736). The study also found that a program at a scale sufficient to prevent 37% of pediatric HIV infections would cost R3.89 (about US$0.34) per person in South Africa and would be affordable to the health care system. In areas with 15% prevalence, the Nevirapine regimen has a cost-effectiveness ratio of US$19 per DALY or US$506 per case of pediatric HIV averted. In areas with a higher prevalence (30%), the cost-effectiveness is even greater-US$11 per DALY or US$298 per case averted.

A study from Tanzania and Kenya showed that VCT is also cost-effective. The cost per HIV infection averted was US$249 and US$346, in Kenya and Tanzania, respectively. In terms of cost-effectiveness the cost per Disability Adjusted Life Year was US$13 and US$18, respectively. Similarly, a study of the effect of STD services on HIV infection rates, conducted in Mwanza, Tanzania, examined the effects of enhanced STD services (with comparisons to matched communities that did not receive the intervention) and found that the intervention cost US$350 per HIV infection averted or US$13 per DALY gained. Another study which analyzed the cost-effectiveness of the female condom if supplied to a hypothetical cohort of 1000 Sex Workers in South Africa found that this program would generate net savings to the public sector health payer of US$9,163 or about US$9 per Sex Worker served.

In general, funding HIV and AIDS program is a sound investment and much more cost effective than doing nothing or waiting to do something.[7]

3.1.3 Policy/Strategy Development and Implementation (Indicator 2)

Incredible progress has been made in the past two years in the area of policy/strategy development and implementation. A detailed review of these successes is included in Section 5.1. In addition, the National HIV and AIDS Policy is undergoing a review that will guide the development of a new policy. The report detailing findings of the HIV Policy Review is expected to recognize emerging issues in the national response.

The NCPI included in Annex 1 contains a detailed analysis of policy and strategy development and implementation across the last two years. It contains the following two parts:

- Part A: Government
  - Strategic Plan
  - Political Support
  - Prevention
  - Treatment, Care, and Support
  - Monitoring and Evaluation
- Part B: Civil Society
  - Human Rights
  - Civil Society Involvement
  - Prevention

[7] Sources:

Cleary, S.M., Di McIntyre and A.Boulle (2006) "The cost-effectiveness of Antiretroviral Treatment in Khayelitsha, South Africa – a primary data analysis," *Cost Effectiveness and Resource Allocation* 2006, **4:**20doi:10.1186/1478-7547-4-20

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Moses, S., F. A. Plummer, et al. (1991). "Controlling HIV in Africa: effectiveness and cost of an intervention in a highfrequency STD transmitter core group." AIDS **5**(4): 407-11.
Sweat, M., S. Gregorich, et al. (2000). "Cost-effectiveness of voluntary HIV-1 counselling and testing in reducing sexual transmission of HIV-1 in Kenya and Tanzania [see comments]." Lancet **356**(9224): 113-21.

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Guay, L. A., P. Musoke, et al. (1999). "Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomised trial." Lancet **354**(9181): 795-802.

- Treatment, Care and Support

A discussion of selected findings in the areas of programme implementation, with a focus on indicators 3-25 is included in the sections below.

3.2 Prevention

3.2.1 Fair Distribution of Wealth, Good Governance, and Infrastructure

While the discussion in this section focuses primarily on the delivery of health care services, it is important to note that other factors contribute greatly to the conditions that allow for faster spread of the disease and greater impact on the population. These factors include fair distribution of wealth, good governance, transparency, representation, and freedom of speech and assembly, transportation, food security and nutrition. The Malawi Growth and Development Strategy (MGDS) has made a strong attempt to address these factors in a multi-sectoral strategy, emphasising the need to have a highly collaborative multi-sectoral approach in the response to HIV and AIDS.

The effects of **distribution of wealth, governance, and infrastructure** are recognised in Paragraph 11 of the **Declaration of Commitment on HIV/AIDS**:

> Recognising that poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS, and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries and should therefore be addressed in an integrated manner

Health care infrastructure also plays a crucial role in the Response, including distance to health services, health services fees, human resources, quality of care, equipment, supply chain management. The move toward pool funding and greater coordination between parties has strengthened this element of the Response and will be vital in the future given the gap remaining to be addressed. A strong monitoring and evaluation system, with use of data at every level to improve effectiveness of programmes is also critical. Elements of this area are highlighted as both a success and a remaining challenge in Section 5 of this Report.

3.2.2 Ending Stigma and Discrimination and Reducing Vulnerability to HIV

Ending Stigma and Discrimination Based on HIV Status

While it has been noted that recent data on stigma and discrimination levels may be lacking, there are plans underway to utilise an adapted version of the People Living with HIV Stigma Index to track levels on an on-going basis. Stigma and discrimination associated with being HIV positive is gradually decreasing with time, evidenced by increased levels of disclosure. However, it is still a major issue and

programmes continue to focus on this aspect as it impedes prevention efforts (UNGASS Consultative Process, 2009-2010).

Ending Stigma and Discrimination Based on Any Other Status

Efforts are being made to end any form of stigma and discrimination based on other status including race, ethnic group, gender, sexual orientation, and age. Community leaders and community support groups are being encouraged to provide the necessary care and support to people infected and affected by the epidemic.

Stigma and discrimination toward youth and Sex Workers has decreased in recent years. In fact, health service providers are more comfortable reaching this group with health services, as evidenced by the growing numbers of organisations that are tailoring their services to make them more accessible to youth and Sex Workers. Meanwhile, stigma and discrimination toward some Most at Risk Populations is actually increasing due to recent arrests of Men who have Sex with Men and the widespread fear that this has caused for both users of services and providers of health services (NCPI Validation, 2010).

Ending Violence against Women

The importance of **gender equality** is recognised in Paragraph 14 of the **Declaration of Commitment on HIV/AIDS**:

> Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS

At policy level, the National Comprehensive Gender Policy provides a clear framework for advancing the gender agenda in the country and could provide a wonderful window from which the HIV and AIDS subsector could tap. The Malawi National Gender Policy (NGP) recognises that Gender and Development (GAD) is a cross-cutting issue. This is further reflected in the Malawi Growth and Development Strategy (MGDS), the National AIDS Policy, and other guidelines in the national response to HIV and AIDS(UNGASS Consultative Process, 2009-2010).

Gender considerations have been mainstreamed in the National Response as is evident in interventions planned in the Extended National Action Framework. However, it is not clear how much of this is translated operationally through the District Implementation Plans (DIPs) (UNGASS Consultative Process, 2009-2010).

At the implementation level of programmes, there has been strong emphasis against any forms of discrimination on the basis of gender, age or racial and ethnic groups. The PMTCT and HTC programmes currently promote voluntary couple HIV testing as one way of enhancing HIV prevention efforts in the country (UNGASS Consultative Process, 2009-2010).

3.2.3 Reaching Most-at-Risk Populations (Indicator 9)

Indicator 9. Percentage of most-at-risk populations reached with HIV prevention programmes

This indicator specifies the need to report results for male and female Sex Workers and Men who have Sex with Men, since these are two groups that have a higher risk of contracting HIV and have thus been recognised internationally as Most-at-Risk Groups for HIV. The National HIV Prevention Strategy of the Republic of Malawi: 2010-2013 has identified Men who have Sex with Men and Sex Workers as Most at Risk Populations in Malawi, alongside Long Distance Truck Drivers, Secondary and Primary School Teachers, Police Officers, Estate Workers, Fishermen, Male Vendors, and Female Border Traders.

Unfortunately, the only data available at this time is from the 2006 BSS, which only surveyed female Sex Workers. The BSS did not include this indicator, but did ask the respondent some related questions. The percentage of female Sex Workers who know any service site that offers STI services was 92.9% in 2006 and 93.4% in 2004. The Percentage of female Sex Workers who saw an HIV/AIDS program on TV was 54.4% in 2006 (BSS 2006: p. 31 and 34).

In the past two years, some NGOs have been implementing interventions targeting Sex Workers with HIV prevention messages, encouraging them to undertake regular HIV testing and supporting them with capital to start income-generating activities.

Successes in Addressing Emerging Issues: Sex Workers

When the prevalence of HIV amongst Sex Workers first came out as an emerging issue a number of years ago in Malawi, there was heated debate over whether it would even be legal to provide HIV-related services to this segment of the population. However, as an increasing number of health service providers have come to understand the importance of providing HIV prevention, treatment, care and support to all segments of the population, regardless of cultural norms or moral stances, the quality of services provided to Sex Workers has improved. There are now several clinics providing non-biased services in STI treatment that are well-attended by Sex Workers, and have thus reduced the spread of HIV.

Some organisations and health care facilities are comfortable serving Sex Workers because whether a group is illegal or legal, all public health services, including prevention, treatment, care and support should be provided to all segments of the population using a human rights approach. A human rights-based approach to public health means that all individuals should be served without discrimination and no group should be disadvantaged in accessing health services (NCPI Validation, 2010).

Data is not yet available to be able to estimate the percentage of Men who have Sex with Men reached with HIV prevention programmes. There is hesitancy and concern amongst many HIV service implementers that if they serve this population, they may be acting illegally, since the Penal Code criminalises "carnal knowledge against the order of nature", widely understood to mean sodomy, which is anal sex (UNGASS Consultative Process, 2009-2010).

Successes in Addressing Emerging Issues: Men who have Sex with Men

In the National NCPI Validation Meetings, representatives of the Law Commission, the Ministry of Health, and a number of other government and non-governmental entities in Malawi agreed unanimously that a human rights-based approach should be taken to public health and that Men who have Sex with Men should not be discriminated against in any public health matters. Moreover, they agreed that this is a legal stance and an obligation for health professionals, as their duty is to provide health services to all people without discriminating. However, they added that there is a great degree of confusion on this issue amongst providers of services and that this clarification needs to be made known to all to put to rest their fears (NCPI Validation, 2010).

It has been suggested by a few respondents that issues of Men who have Sex with Men could best be handled by looking at the broader issues of anal sex which is practiced between men and women, as well. However, since Men who have Sex with Men are a population specifically at risk because of stigma and discrimination, it was found during the data collection that it is important to also provide tailored programmes to improve access to services for this marginalised population (UNGASS Consultative Process, 2009-2010).

A cross-sectional survey that used a snowballing approach with a sample of 200 Men who have Sex with Men found the prevalence of HIV to be 21.4% which is much higher than the national prevalence of approximately 12%. A survey of a bigger scale needs to be commissioned to better appreciate the size and particular needs of this Most at Risk Population in Malawi. A wide range of participants from Government and Civil Society voiced during the UNGASS consultative process that as long as there is criminalisation of Men who have Sex with Men and fear of arrests, it will be very difficult for this group to be reached with effective prevention, treatment, care, and support (UNGASS Consultative Process, 2009-2010).

It was identified during the UNGASS consultative process that, as with the general population, access to information and skill-building in the practical aspects of prevention is needed particularly among Most at Risk Populations in a sensitive manner that is tailored to their needs. Access to supplies such as lubrication needs to be greatly improved for the general population and, very importantly, for young women and Men who have Sex with Men. Widespread sensitisation of health care workers and the general population is required to give people the specific information they crave in order to know how to operationalise a human rights-based approach for

prevention programmes for Sex Workers and Men who have Sex with Men (UNGASS Consultative Process, 2009-2010).

3.2.4 Life Skills-Based Education in Schools (Indicator 11)

Indicator 11. Percentage of schools that provided life skills-based HIV education in the last academic year

The national 2010 Universal Access Target for this indicator is 100%, with the same target for 2012. Data is not available for this indicator at present, as life skills was compulsory, but not examinable and data was not collected. It has now become examinable as of the 2010-2011 academic year. When it was not examinable, it was difficult to implement and monitor. Some schools did not have teachers to teach this subject. Now that it has become examinable there will be better mechanisms for implementation and monitoring.

3.2.5 Blood Safety (Indicator 3)

Indicator 3. Percentage of donated blood units screened for HIV in a quality assured manner

Blood Safety

The blood safety programme is doing very well with respect to blood collected, tested and distributed by the national blood service. This is largely on account of the fact that MBTS collects blood from safe donors (i.e donors that are voluntary and non-remunerated) and that it encourages regular blood donation.

The Universal Access 2010 Target for this indicator is 98%, with a target of 100% for 2012. Availability of blood and blood products is one of the key objectives of the national response. A public trust, The Malawi Blood Transfusion Service (MBTS) was established to collect, test and supply safe blood. MBTS does screening of donated blood for transfusion transmissible infections, including HIV. However, not all blood comes through MBTS. Its operations have been crippled by financial and infrastructural constraints. As one goal of the Trust is to ensure that they collect blood from voluntary and non-remunerated donors, their small operational base means that health service delivery points have to find alternatives. Shortages in blood supply have led some hospitals to carry out replacement donor top-ups. Thus, quite a large proportion of the blood is collected and screened at individual facilities. Ideally, MBTS should be managing the transfusions entirely. In the future, it would be better not to leave collection of blood for transfusion to emergency situations and screening at facility level.

The 2008 report from Malawi Blood Transfusion Service (MBTS) provides data on the blood screened from the 2 centres managed by MBTS. The report indicates that 100% of the blood from these 2 centres was screened for HIV. The data discussed above pertains to the blood screened by the Malawi Blood Transfussion Service (MBTS) and does not include blood screened at health facilities.

In 2007, MBTS reported that 100% of blood was screened for HIV. However, there were differences in the MBTS-reported figure and the findings of the Ministry of Health at facility-level, which showed that 99% of blood units were screened for HIV and 95% were screened for hepatitis B and syphilis. Some lab registers did not contain information on whether units were screened or not. In such cases, it was assumed that there was no screening.

In 2006, the Ministry of Health reported that the national average for HIV screening of blood was 99.9%. During this year, it was reported that about 36% of all blood units were screened by MBTS (Report of a Country-Wide Survey of HIV/AIDS Services in Malawi for the Year of 2006, MoH, July 2007).

The capacity of MBTS, a trust that is purposely meant to deliver safe blood, has been a concern. Approximately 80,000 units of blood were needed to cover the national requirement for blood in 2008 (MBTS Report 2008). There are not enough volunteers coming forward at present to supply enough blood to meet the national demand. This situation is likely to improve with the decentralisation of their services to regional level.

3.2.6 PMTCT (Indicator 5)

Summary

The **PMTCT** programme has registered **tremendous scale up** with respect to number of sites that are offering the service as well as number of women that are benefiting from it.

However, coverage of HIV testing and ARV prophylaxis has been difficult to track due to the absence of standardised monitoring tools until the end of 2009. Previous data have been subject to possible double counting of women accessing ANC and later maternity (up to 60% of women accessing ANC). New monitoring tools that have recently been devised will go a long way in checking this and enhancing the credibility of data coming from the PMTCT programme. Major strides in PMTCT also include the Early Infant Diagnosis (EID) Programme in over 41 sites. The EID programme is hampered by logistical issues pertaining to transportation of supplies. The programme is also affected by dynamic nature of policies and guidelines with rapid changes taking place to these before full implementation takes place.

Indicator 5. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission

Need: PMTCT

The nation has set a 2012 target of 70% for the Percentage of HIV-infected pregnant women who received ARVs to reduce the risk of MTCT. It is estimated that in 2010, 87,882 pregnant women will be in need of PMTCT. In 2012, it is estimated that 92,872 pregnant women will be in need of PMTCT.

Need: ART for Pregnant Women

While all HIV-positive pregnant women should received PMTCT, some pregnant women are eligible for ART due to their CD4 count. The eligibility cut-off for receiving ART was raised from 250 to 350 CD4 count for pregnant women in June 2009, which greatly increases the number of pregnant women in need of ART from 20% of HIV-positive pregnant women to 50%. It is estimated that there will be around 697,477 pregnant women in 2010, of whom 12.6% are likely to be positive, which means there will be approximately 87,882 pregnant women in 2010, of whom 50% will be in need of ART. According to this estimation, approximately 43,941 pregnant women will be in need of ART in 2010 (Population Census, 2008).

Coverage

PMTCT data does have significant risk of double counting at present. Registers in the antenatal care (ANC) and maternity and delivery are used as sources. With these limitations, as of 2009, 38.8% of HIV positive pregnant women received ARVs for the prevention of mother to child transmission of HIV. (Population Census, 2008 and MoH PMTCT Programme Data, 2009).

Table 3.4: Percentage of HIV-infected pregnant women who received ARVs to reduce the risk of MTCT

Reporting period	Numerator: Number of HIV-infected pregnant women who received ARVs in the last 12 months to reduce MTCT	Denominator: Estimated number of HIV-infected pregnant women in the last 12 months	Percentage of HIV-infected pregnant women who received ARVs to reduce the risk of MTCT
Jan. 2009-Dec. 2009	1. sdNVP: 23,351 2. Prophylactic regiment (2ARVs):4,228 4. ART: 5,577 Total: 33,156	85,488	**38.8%**
Jan. 2008-Dec. 2008	1. sdNVP: 29,417 2. Prophylactic regiment (2ARVs):321 4. ART: 4,100 Total: 33,838	83,160	**40.7%**

Jan. 2007-Dec. 2007	SD NVP and combination regimen (from ANC and maternity records): 18,991 4. ART: 3,961 Total: 22,952	80,895	**28.4%**

Sources: Numerators: MoH PMTCT Programme Reports
Sources: Denominators: 2008 Census estimates of pregnant women x prevalence from 2007 sentinel surveillance

The following international guidance is provided in the UNAIDS Guidelines on Construction of Core Indicators: 2010 Reporting regarding the breakdown of PMTCT by category:

Figure: 3.1: Breakdown of PMTCT regimen

There are four general antiretroviral categories that HIV-infected women can receive for the prevention of mother-to-child transmission.

Categories	Further clarification	Examples
1) Single-dose Nevirapine only	One dose of nevirapine for mother given at or around birth	Single Dose (SD) NVP
2) Prophylactic regimens using a combination of two antiretroviral drugs	A prophylactic regimen that uses more than one antiretroviral drug for mothers to prevent HIV transmission and is started before labour and delivery	- AZT + SD NVP - AZT + SD NVP +7 day post-partum tail of AZT/3TC - AZT + 3TC - AZT + 3TC + SD NVP
3) Prophylactic regimens using a combination of three antiretroviral drugs	Highly active regimen for mother-to-child transmission prophylaxis designed to fully suppress viral replication prior to and during delivery and for a variable duration post partum	- AZT + 3TC + NNRTI or - AZT + 3TC +PI or - AZT + 3TC + NRTI
4) Antiretroviral therapy for HIV-infected pregnant women eligible for treatment	Antiretroviral therapy for HIV positive pregnant women eligible for treatment	Standard national treatment regimen - AZT + 3TC + NNRTI or - AZT + 3TC +PI or - AZT + 3TC + NRTI

HIV-infected women receiving any antiretroviral therapy, including specifically for prophylaxis, meet the definition for the numerator. Countries should report the total number of HIV-infected pregnant women who were provided with any antiretrovirals as the numerator.

In Malawi, this translates into the following breakdown by category:

UNGASS PMTCT Category	Malawi PMTCT Reporting Category
1. SD NVP	Mothers given NVP
2. Prophylactic regimens using a combination of 2 ARV drugs	AZT+sdNVP +7 day post partum tail of AZT/3TC
3. Prophylactic regimens using a combination of 3 ARV drugs	None
4. ART for HIV-infected pregnant women eligible for treatment	Mothers on ART

Quality

There are significant challenges in the scale-up of the PMTCT Programme, among them, drug stock-outs and logistical issues. In October 2009, an assessment of 253 sites visited for ART supervision found that 47% of these facilities had any stock for PMTCT. This includes all major hospitals. The percentage is likely to be even lower at un-visited sites, which are mainly clinics. The drugs may be elsewhere in the country, but more than 50% of the time they are not where they are needed when they are needed (UNGASS Consultation Process, 2009-2010).

In the maternity wards, challenges are still being faced primarily in ensuring that women have the opportunity to be tested when they present late in labour. Meanwhile, the availability of testing in ANC clinics has advanced significantly, becoming much more routine (UNGASS Consultation Process, 2009-2010).

However, in high-volume settings, testing quality is sometimes compromised. Especially when staff are overstretched and there is a lack of supervision, these slippages are more likely to occur. There needs to be a sound logistical system to ensure that people come through the testing process in an organised fashion with enough time for pre and post testing and the period of incubation. However, when facing large numbers of attendees, logistics are sometimes improvised, compromising quality. In some settings, the percentage of ANC attendees being tested raises questions about the level of understanding that testing should be encouraged but not forced. Work spaces are sometimes poorly lit. In addition to lighting, adequate vision may also create difficulties in some circumstances. There are also very specific instructions that must be followed, such as allowing the test to lie flat and not tilting it (UNGASS Consultation Process, 2009-2010).

To achieve Universal Access, there will need to be a dramatic increase in supervision and quality assurance. For instance, the ART programme has been able to scale up by maintaining a strong cohort of 40-50 people who are experienced enough to join during supervision visits. New sites are opened with provision for supervision, standardised training, and a stringent certification process. There are 2-3 times as many PMTCT sites as ART sites, which provides great coverage, but requires even more supervision. The fact that there are no standardised national guidelines approved and released to date create another problem in the midst of frequently changing policies and regimens and the opening of new sites (UNGASS Consultation Process, 2009-2010).

It has been noted that a surprisingly high number of women who come in to start their baby on ART went through PMTCT according to paper records. A meaningful impact assessment on incidence and prevention of transmission needs to be conducted to identify ways in which the PMTCT programme quality can be improved (UNGASS Consultation Process, 2009-2010).

3.2.7 Combination Prevention Programmes

A detailed discussion of progress and the way forward in prevention programmes in included in Section 8. The various items below are all included in the National HIV Prevention Strategy 2009-13 and are pillars to the prevention of the further spread of the epidemic: access to information about HIV, access to treatment, harm reduction measures, waiting longer to become sexually active, being faithful, reducing multiple partners and concurrent relationships, male circumcision, ensuring human rights and the reduction of stigma.

The One Love campaign has made great strides in reaching the general population with prevention messages. Combination Prevention Programmes which build skills in ABC are a critical element in the success of Prevention. There is a need to go beyond just general information on prevention and help people gain practical knowledge on how to actually use protection effectively. People want to know how to use protection for all the different types of sex they have (not just coital, but oral, anal, etc.), how to use lubricants and which ones are safe to use with condoms, how to negotiate safer sex in real-life situations, and how to enhance communication and gender equality in relationships (UNGASS Consultation Process, 2009-2010).

Condom distribution has over the last two years (2008 and 2009) continued to be done through multiple channels and by the government, local and international NGOs and the private sector. However, data on the numbers of condoms distributed in the country is scanty and difficult to consolidate. In the first quarter of 2008, a total of 2,523,378 socially marketed condoms and 2,239,810 free condoms (2,083,520 male and 156,300 female) were distributed in the country. This increased over the period such that in the last half of 2008 only, 4,819,555 socially marketed condoms were also distributed (4,767,298 male and 522,578 female). In the same period, 4,170,578 free condoms were also distributed (3,754,578 male and 417,578 female). In the last half of 2009 only, a cumulative 2,891,377 socially marketed condoms were distributed across the country mainly by NGOs and Local Assemblies and of these, 2,844,500 were male condoms while 46,877 were female condoms. In the same period, a total of 5,994,928 free condoms were also distributed.

There has been an increasing trend in the numbers of condom promotion and advocacy sessions across the country mainly by NGOs and the Local Assemblies. For example, in the last half of 2009 alone, 248 condom promotion sessions were conducted across the country, 291 community based condom distribution agents were trained in condom use and community sensitisation (including the youth) and a total of 128 district officials were also trained in comprehensive condom programming.

While the scale-up in provision of condoms is marked with progressive success in coverage, the disparity between the numbers of male and female condoms is striking. For every nine male condoms distributed, one female condom is made available. This

only serves to increasingly put the power to use protection in the hands of one gender over the other. Condom-safe lubricants are only available on a very limited scale at this point, primarily in urban areas (UNGASS Consultation Process, 2009-2010).

3.2.8 HIV Testing and Counselling (Indicators 7 and 8)

Summary

HIV testing and Counselling is a cornerstone of prevention programmes in Malawi.
In order to ensure that many people access the service, more innovative approaches have been put in place including **mobile** and **outreach services**, and **door to door services**.

Mobile vans for HTC have increased access within communities where HTC testing sites are sparse. This may also help to reduce the fear of being tested by a counsellor who knows your family. Door-to-door Testing was piloted in Zomba and is currently being replicated in Blantyre. Plans are underway to expand it to additional districts in the near future. Malawi has also been conducting an annual HTC week-long campaign aimed at mobilizing more people for testing. An evaluation of the Testing Week is underway (UNGASS Consultation Process, 2009-2010).

Indicator 7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results

The national 2010 Universal Access Target for this indicator is Men: 75% and Women: 75%. The 2012 target is the same. The latest population-based survey available for use in estimating the percentage of men and women aged 15-49 who have received an HIV test in the last 12 months and know their results is from 2004 (DHS, p. 203). Although this figure was very low, at 15.1% for men and 12.9% for women, it is likely that progress has been made since that time. Another DHS is needed to determine current levels of testing.

Indicator 8. Percentage of most- at risk populations who received an HIV test in the last 12 months and who know their results

This indicator specifies the need to report results for male and female sex workers and men who have sex with men. Unfortunately, the only data available is from the BSS which only surveyed female sex workers. The BSS did not include this indicator, but did ask if the respondent had ever had an HIV test. The percentage of female sex workers who ever tested for HIV was 63.5% in 2006 and 47.6% in 2004. This question deviates from the original indicator as it is not limited to the past 12 months (BSS 2006, p. 31 and 34).

Uptake of HTC services in 2008 and 2009

In line with the national HIV and AIDS policy, during the reporting period HTC services continued to be offered through static, mobile, outreach and door-to-door services and by both public and private practitioners. Cumulatively, a total of 716 static sites were operational at the end of December 2009, an increase from 637 sites in June 2008. Uptake of HTC services has also been encouraging between 2008 and 2009, reaching a total of 1,712,170 clients between July 2008 and June 2009 and a further estimate of 1,540,000 clients between July and December 2009.

Data solicited from the various HTC providers also shows that between July 2008 and June 2009, a total of 1,079,598 first-time testers (never tested before) accessed HTC services and these constituted 63% of all the clients tested in the period. Across the three regions of the country, there has been a general upward trend in the uptake of HTC services in all the regions peaking in the October to December 2008 period notably because of the HIV testing week campaign and gradually waning off in the period thereafter. HIV prevalence among the HTC clients ranged from 8.0% in the northern region to 9.5% and 13.9% in the central and southern regions, respectively.

Table 3.5: Uptake of HTC Services between July 2008 and June 2009

	Jul-Sep 08	Oct-Dec 08	Jan-Mar 09	Apr-Jun 09	Total
National Total	449,375	479,771	392,588	390,436	1,712,170
% male clients	*29.0%*	*37.4%*	*34.1%*	*34.0%*	*33.7%*
% first-time testers	*71.0%*	*62.0%*	*60.1%*	*57.8%*	*63.0%*
% clients tested with a partner	*9.6%*	*11.6%*	*11.9%*	*11.9%*	*11.2%*
Regional Distribution					
North (N)	57,018	62,196	48,312	50,530	218,056
% HIV positive	*8.2%*	*7.0%*	*8.3%*	*8.7%*	*8.0%*
Centre (N)	132,603	170,783	135,955	146,051	585,392
% HIV positive	*10.1%*	*8.7%*	*10.1%*	*9.5%*	*9.5%*
South (N)	259,754	246,792	208,321	193,855	908,722
% HIV positive	*12.4%*	*13.7%*	*14.2%*	*15.7%*	*13.9%*

Data source: HIV Department, Ministry of Health (August 25, 2009): an extract

Male participation in HTC services continued to lag behind that of females in the years 2008 and 2009. In the period between July 2008 and June 2009, males accounted for 33.7% of all HTC clients and the trend remained constant in the four reporting quarters of July-September, October-December (2008), January-March and April-June (2009) at 29% and 37.4% 34.1% and 34% respectively. However, there has been some increase (though modest) in the numbers of clients tested and counselled with a partner from 9.6% and 11.6% in the second half of 2008 to 11.6% and 11.9% in the first half of 2009.

The referral system continued to work well in the years 2008 and 2009. Approximately 258,184 HTC clients were referred to various services in the period between July 2008 and June 2009 and of these, 144,900 (57.0%) were referred to ART services, 9,328 (4%) were referred to TB services, 61,091 (24%) were referred to PMTCT services and 42,865 (17%) were referred to other services.

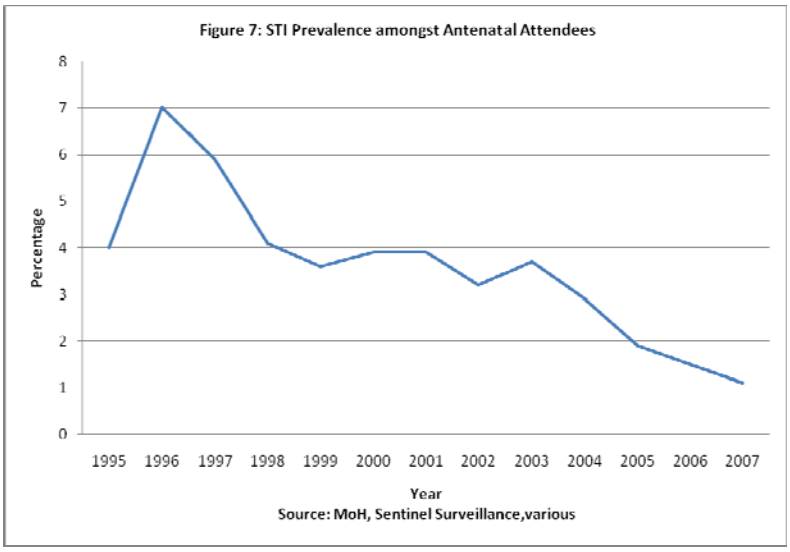
Malawi as a country has guidelines for HTC, ART & PMTCT. The guidelines provide clear direction on the counselling environment, content of the counselling sessions both for pre and post (whether positive or negative results) and infant feeding. If the results are negative, clients are advised to undertake another test 3 months after and are offered advice on safer sexual practices and condoms are also provided if needed. For positive results, clients are encouraged to disclose to their partners and to encourage them to also undertake the test. As the number of service providers increases, the need to improve systematised quality assurance mechanisms will become even more crucial. This will help to ensure that prevention with negatives in the form of risk reduction counseling is undertaken with all clients, as there is evidence that risk reduction counseling with the right level of intensity and maintenance can bring about sustained changes in behaviors, even among negative clients it could be important that there is some awareness and discussions around how to build effective (or at lest more efficacious) post test services for both negative and positive clients.

There has also been an increase in the numbers of HTC service providers and their supervisors in the reporting period. A total of 1,255 new HTC service providers were trained between July 2008 and December 2009 and a total of 34 HTC supervisors were also trained in the same period. This is likely going to contribute to the national scale-up HTC services in the country.

3.2.9 Management of Sexually Transmitted Infections

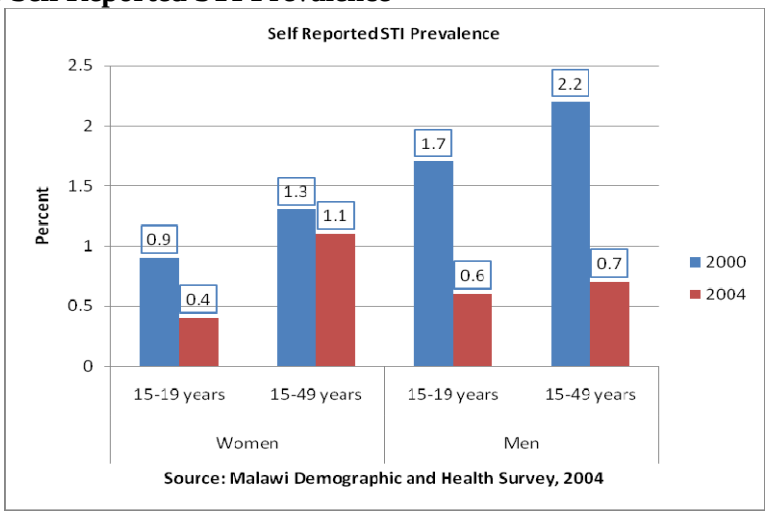
Sexually Transmitted Infections (STI) are an important predictor of HIV. The 2007 Sentinel Surveillance found Syphilis prevalence amongst ANC attendees to be 1.1 % implying that prevalence has been declining in the past decade. Figure 3.2 below shows syphilis prevalence amongst ANC attendees from 1995.

Figure: 3.2: Prevalence of Syphilis (1995 – 2007)



A comparison between the 2000 and the 2004 MDHS results reveals a decline in self reported STI prevalence by gender. It can be seen from the figure below that STI prevalence for all sexes declined between 2000 and 2004 though there was a more marked decline among men as compared to women. For both years, prevalence was higher for younger men compared to younger women in the age group 15-19. See figure 3.3 below:

Figure 3.3: Self Reported STI Prevalence



With respect to STI Management, 69% of STI cases were diagnosed and treated according to national guidelines and 36% of patients with STI were appropriately diagnosed, treated and counselled for HIV. More efforts need to be put into treatment and diagnosis of STIs so as to avert risk of HIV infections. 23% of patients with STI were given advice on condom use and partner notification. However, only 11% of patients presenting with STIs were referred for HIV testing besides being given advice on condom use and partner notification. Integration of HIV testing into the STI programme will go a wrong way to ensuring that all STI clients are accorded an opportunity to undergo an HIV Test (NAC, Health Facility Survey, 2007)

3.3 Treatment

3.3. ART (Indicator 4)

ART Coverage

ART Scale-up

The **rapid acceleration** of the **ART programme** should be lauded as an example of a good treatment programme.

Tremendous progress has been registered: with only **10,761** people on ART **in 2004**, the figures have risen astronomically **to 198,846 in 2009**.

As with programmes of this nature, scale up is largely impeded by a critical shortage of qualified personnel which has resulted in patients having to travel long distances to access the service. The ART Programme is working to ensure that skill level, equipment, and supply availability at health centres are improved to allow them to qualify to initiate patients on ART in the future (UNGASS Consultation Process, 2009-2010).

Malawi in the process of discussing what provisions would be needed to begin conforming to the WHO guidelines on eligibility for ART, which specify the CD4 count threshold as 350 rather than the current 250. In planning for this change, funding must be urgently sourced. The 350 cut-off is already being implemented for pregnant women (UNGASS Consultation Process, 2009-2010).

Incredible progress has been made in scaling up ART access in Malawi at a consistent rate since 2004, as evidenced in the table below. With 10,761 patients on ART in 2004, the number of people alive and on ART has been scaled up to 198,846 as of December 2009. The number of sites has also increased from 9 in 2003 to 377 (279 static clinics and 98 outreach/mobile clinics) as at December 2009 (See table below).

Table 3.6: National ART Programme Statistics, 2003-2009

Table 1: ART programme resume 2003-2009 (public and private sector combined)

	2003	2004	2005	2006	2007	2008	2009
ART delivery sites	9	24	83	141	163	221	377
Patients alive on ART	No data	10,761	29,087	59,980	100,649	147,497	198,846
ART registrations per year	No data	10,183	25,634	46,351	61,688	76,581	88,126
Cumulative registrations	~3,000	13,183	38,817	85,168	146,856	223,437	312,476

Source: Quarterly Report Antiretroviral Treatment Programme in Malawi with Results up to December 2009 p1).

Table 3.7: Indicator 4: Percentage of adults and children with advanced HIV infection receiving ART

Year	Numerator: Number of adults and children with advanced HIV infection who are currently receiving ART at the end of the reporting period	Denominator: Estimated number of adults and children with advanced HIV infection	Percentage of adults and children with advanced HIV infection receiving ART as of December of the given year
2009	Adults: 181,482 Children: 17,364 Adults and Children: 198,846	Adults: 278,868 Children: 26,937 Adults and Children: 305,805	Adults: 65.08% Children: 64.46% Adults and Children: **65.02%**
2008	Adults: 135,697 Children: 11,800 Adults and Children: 147,497	Adults: 263,334 Children: 26,454 Adults and Children: 289,788	Adults: 51.53% Children: 44.61% Adults and Children: **50.90%**
2007	Adults and Children: 100,649	Adults: 252,720 Children: 23,441 Adults and Children: 276,161	Adults and Children: **36.45%**
2006	Adults and Children: 59,980	Adults: 245,205 Children: 20,358 Adults and Children: 265,563	Adults and Children: **22.59%**
2005	Total: 29,087	Adults: 239,300 Children: 19,040 Total: 258,340	Adults and Children: **11.26%**
2004	Total: 10,761	Adults: 232,311 Children: 18,152 Total: 250,463	Adults and Children: **4.29%**
2003	There was no monitoring system in place at this time.	Adults: 222,138 Children: 17,638 Total: 239,776	There was no monitoring system in place at this time.

Source: Numerator: MoH ART Patient Records; Denominator: Spectrum Estimates Generated in 2007 based on a CD4 cut-off of 200[8]

[8] Detailed Review of Sources:
Num. Source for 2004-2008: Quarterly Report ART Programme in Malawi with Results Up To 31st Dec., 2008; MoH; Updated with Quarterly Report Antiretroviral Treatment Programme in Malawi with Results up to December 2009
Den. Source for 2003, 2005, 2007: HIV and Syphilis Sero-Survey and National HIV Prevalence and AIDS Estimates Report for 2007; NAC; August 2008
Target Source for 2010 Num: The Road Towards Universal Access: Scaling up access to HIV prevention, treatment, care, and support in Malawi: 2006-2010; NAC
Target Source for Percentages: Malawi HIV and AIDS Extended National Action Framework (NAF), 2010-2012; OPC; August 2009

The Universal Access 2010 Target for Malawi is to reach 80% of people in need. In 2007, it was estimated that by 2010 324,191 adults would be eligible for treatment. If 80% of those people were reached by 2010, that would mean that 259,352 people would be on treatment. However, this was based on the best available spectrum software at the time, which did not allow for the selection of a 250 CD4 Count cut-off, so a 200 CD4 count cut-off was used to create the above estimation. In addition, other factors in the software underestimated the number of people eligible for treatment, including an overly optimistic assumption about vertical transmission and a lack proper accounting for the accumulation of people on ART.

WHO recently released guidelines for eligibility for ART indicating that a CD4 count threshold of 350 should be used for the general population. The Ministry of Health in Malawi is in the process of determining what would be needed to change from the current threshold of 250 to align with the guidelines at 350. The CD4 Count threshold of 350 changes the denominator substantially for achieving Universal Access, meaning that even more people will be in need of treatment.

In accordance with the advice provided in consultation meetings, to document progress achieved in 2008 and 2009 for the official purposes of the UNGASS Report, the 2007-generated spectrum figures have been used for denominators with the understanding this does underestimate the number of people in need in 2008 and 2009.

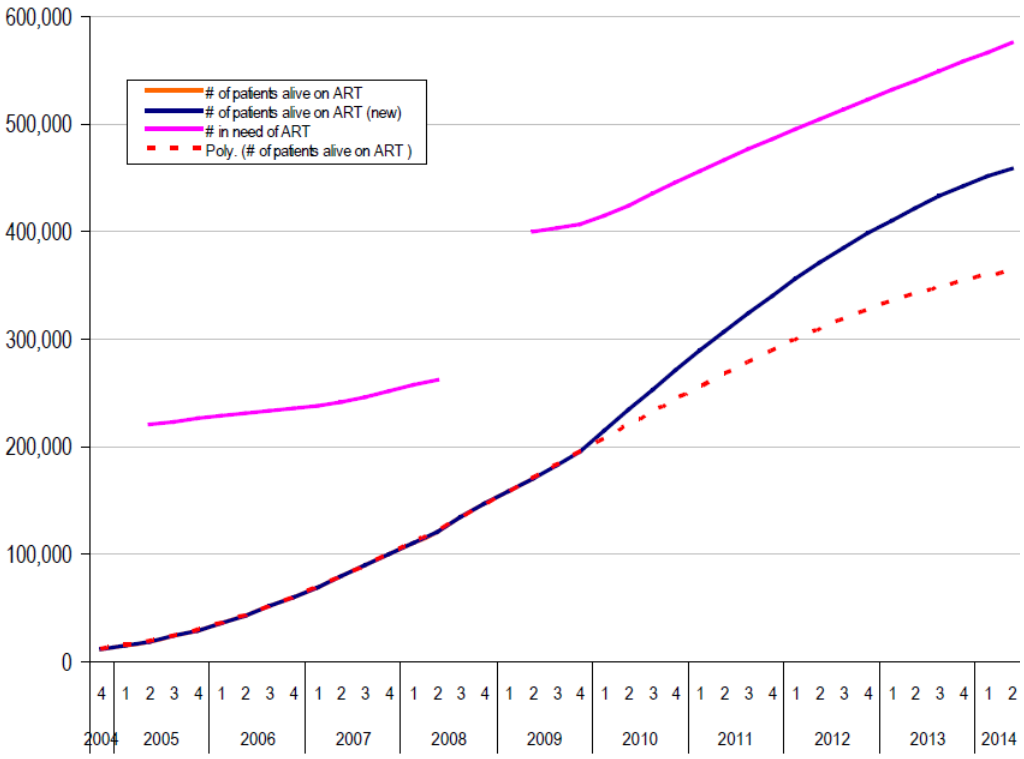
Table 3.8: Trends in Estimated and Projected AIDS Incidence, Mortality and ART Needs from Spectrum 2007-generated Figures at the CD4 Count Threshold of 200

Indicator	1998	2003	2005	2007	2010	2012
Adult prevalence(15-49)	13.9%	12.9%	12.4%	12.0%	11.8%	11.9%
New HIV infections (15+)	63,394	67,248	66,114	65,027	70,320	80,423
New HIV infections (0-14)	20,847	20,787	20,423	19,791	12,024	12,219
Annual AIDS Deaths (15+)	23,728	55,140	55,597	47,774	43,512	42,170
Annual AIDS Deaths (0-14)	12,830	14,941	14,904	13,158	10,889	10,667
Adults needing ART	113,928	222,138	239,300	252,720	295,395	329,706
Children (0-14) needing ART	14,894	17,638	19,040	23,441	28,796	33,564
Adults newly needing ART	41,290	60,679	55,831	45,005	41,768	37,098
Adults on ART (15+)	0	2,880	34,575	108,948	185,273	239,986
Children on ART (0-14)	0	0	1,820	9,440	17,576	23,000
Adults on 2nd Line Therapy	0	0	0	388	3,849	9,986
Children on CTX (0-14)	0	33	665	5,611	37,810	59,192
Mothers receiving PMTCT	0	2,198	5,054	15,200	63,000	68,152
Adult Population (15+)	6,041,434	6,884,159	7,203,704	7,541,674	8,101,830	8,524,303
Child Population (0-14)	5,049,867	5,552,196	5,802,997	6,077,872	6,515,336	6,790,661

Source: MoH, HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2007

However, for a more accurate depiction of future need for purposes of planning and resource allocation it was felt that it would be helpful to be able to use the most accurate available spectrum projections for 2010, 2012, and 2015, at the 350 cut-off. These estimates are not official, and still likely underestimate the total number of people in need of ART due outliers in sentinel surveillance data from some sites. Thus, the estimates will be revised when new sentinel surveillance data becomes available. However, the draft figures included here do give a more accurate depiction of future need than the 2007-generated figures. The CD4 Count threshold of 350 changes the denominator substantially for achieving Universal Access, meaning that approximately 450,000 people will be in need of treatment in 2010 and 525,000 in 2012 (Spectrum Estimates based on a CD4 cut-off of 350).

Figure 3.4: Trends in Estimated and Projected ART Needs from Unofficial Spectrum -generated Figures at the CD4 Count Threshold of 350



In order to achieve Universal Access, the gaps in human resources will need to be addressed. Doubling the patient numbers alive and on treatment will not happen without substantial injections of health workers. The drug costs alone are also an enormous obstacle and this should be addressed with the government and development partners to create a sustainability plan. It was estimated that to adopt the WHO recommendations and use the ART that is currently twice as expensive and initiate at 350 CD4 count, in the next three years the budget needed to buy ARVs would exceed the total government spending on health.

In feasibility planning for the change from a 200 cut-off to a 350 cut-off, the following factors are being taken into consideration. Additional staff and ART sites will be required. New guidelines and curricula should be introduced and in-service and refresher training of current staff will be needed. The additional costs for labs and drugs will need to be covered. There is a risk of introducing waiting lists if these factors are not fully provided for.

Meanwhile, efforts at prevention need to be doubled. There has been no detectible change in incidence and very little impact on vertical transmission up to now. Without prevention, we will be putting a large proportion of the population on ART for life.

A summary of the key issues related to the WHO feasibility study is included below, as per the Malawi ART Programme Report for Quarter 4 2009.

WHO Feasibility study

Malawi conducted a rapid appraisal study to assess the feasibility, impact and risk –benefits of introducing the WHO recommendations in Malawi at the request of the WHO. The results of the study were presented to the WHO technical advisory group in Geneva and were influential in the groups deliberations and recommendations.

Main Challenges

- **New WHO recommendations** for early initiation (CD4-350), phasing out of stavudine and introduction of more efficacious and less toxic drugs such as AZT & TDF, detection of ART failure using CD4 count / viral load monitoring will require extensive in-country consultations bearing in mind the financial, material and human resource implications that were noted after Malawi conducted a rapid WHO supported feasibility study.
- **Training and refresher trainings in the private sector** are not taking place in most districts.
- **Delayed release of funds** for ARVs and other commodities has led to stock outs of alternative first line regimens. There is need to engage our development partners to lobby the Global Fund on flexibility.
- **Transportation of CD4 & DBS samples** and results from the ART sites to the labs and back is still a big challenge.

Way forward and emerging issues under discussion

- **Family HIV care service (Pre-ART)**: A draft guideline has been produced and is currently undergoing final revision. It includes M&E tools such as family HIV care & exposed infants Master cards & registers
- **Strengthening Early Infant Diagnosis** (EID) using DNA-PCR and Early Infant Treatment (EIT) including presumed severe HIV disease detection and treatment in children below 18 months of age
- Discussions on Malawi's road map in terms of the **new WHO recommendations** are underway and the scale up plan 2010-2013 will be revised accordingly.

3.3.2 Co-Management of TB and HIV Treatment (Indicator 6)

Major collaboration exists between the TB and HIV programmes. However, more programming is directed towards reducing the burden of HIV on TB patients and not vice versa. HIV testing amongst TB clients is quite strong with over 85% uptake, and

CPT coverage at over 98%. The death rate from TB has reduced from 20% to 11% (MoH, National TB Control Programme).

Table 3.9: Indicator 6: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV: January-December 2006

Year	Numerator: Number of adults with advanced HIV infection who are currently receiving ART and who were started on TB treatment within the reporting year	Denominator: Estimated number of incident TB cases in people living with HIV	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV
2009	Data not yet available		
2008	4929	30,000	**16.43%**
2007	4,348	34,000	**12.79%**

Source:

Numerator: National TB Control Programme

Denominator: http://www.who.int/tb/country/data/download/en/index1.html

Scaling up coverage from 16.43% to near 100% will require even greater collaboration between the TB and HIV programmes and increased participation of CSOs (UNGASS Consultative Process, 2009-2010).

3.4 Care and Support

3.4.1 Nutrition

A discussion of nutrition occurs in the recommendations section.

3.4.2 OVC Households Receiving Support (Indicator 10)

Summary

Cash transfer programme has gone a long way to pull people out of poverty, including PLHIV, OVC-headed households, and female-headed households.

It is currently a pilot in a few districts. The programme has been dependent on the Global Fund, and delays in disbursement have caused interruptions in accessing the service. When a policy is developed and this becomes a government programme implemented nationally, planning and budgeting should ensure that the flow is continuous and uninterrupted. In addition, community involvement should be strengthened to ensure accountability.

Indicator 10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child

The national 2010 Universal Access Target for this indicator is 80%. The 2012 target is 90%. The following questions were asked as a part of the MICS in 2006:

Exact question in MICS in MICS 2006	***Result in MICS 2006***
1. Has this household received medical support, including medical care and/or medical care supplies, within the last 12 months?	Medical support in the last 12 months: 5.5%
2. Has this household received school-related assistance, including school fees, within the last 12 months?	Educational support in the last 12 months: 5.8%
3. Has this household received emotional/psychological support, including counselling from a trained counsellor and/or emotional/spiritual support or companionship within the last three months?	Emotional and psychosocial support in the last 3 months: 4.0%
4. Has this household received other social support, including socioeconomic support (e.g. clothing , extra food, financial support, shelter) and/or instrumental support (e.g. help with household work, training for caregivers, childcare, legal services) within the last three months?	Social/material support in the last 3 months: 8.8%

Overall, 18.5% of OVCs received some type of support[9], 0.2% received all types of support, and 81.5% received no support at all (MICS 2006, p. 261).

The Extended National Action Framework: 2010-2012 contains a strong commitment to increasing support for OVCs with the following objectives:

> ***Objective 3.1:*** *To increase access for PLHIV, OVC and other affected individuals and households to equitable material support.*
> Material support programmes have been scaled up. NAC and partners supported more than 300 CBOs in 2007/8, who reached over 3,257 beneficiaries with income-generating activities (IGA). Over 2,000 households and more than 2,000 vulnerable people received start-up kits[10]. The National social cash transfer pilot program reached 5,000 ultra-poor households and 10,000 orphans, and the evaluation indicates that more orphans attended school[11]. PLHIV and affected households form a minority among the beneficiaries of material support.
>
> ***Objective 3.2:*** *To increase access for PLHIV, OVC and other affected individuals to psychosocial and spiritual support*
> Almost 9 percent of OVC received psychosocial support over the three months preceding the MICS 2006 survey, more so in urban areas and in the Central region.
>
> ***Objective 3.3****: To promote the enforcement of legal and social rights of PLHIV, OVC and other affected individuals*
> During the period 2004 to 2008, NAC developed a conceptual framework for impact mitigation (2006); the Ministry of Women and Child Development developed an OVC Policy and National Plan of Action (2005 to 2009), and the Ministry of Economic Planning and Development developed a social protection policy (2008) which includes PLHIV. The Law Commission drafted a comprehensive draft HIV and AIDS Bill, awaiting enactment by Parliament.
>
> ***Objective 3.4:*** *To improve access for OVC to social services.* (Objective proposed change)
> OVC receive bursaries to attend secondary school (15,543 in 2007), reducing drop out at secondary school level. The MoE reached 635,000 pupils (82,500 OVC) with a school feeding programme in primary schools[12].
>
> ***Objective 3.5****: To promote food and nutrition security among AIDS affected households*
> Community based child care centres provide food support to 82,000 orphans, 20% of the beneficiaries. Communities have established communal gardens to provide food for CBCC as well as other vulnerable population groups such as PLHIV.

[9] External support is defined as free help coming from a source other than friends, family or neighbours unless they are working for a community-based organization.
[10] Siwale and Nthambi, 2008
[11] Siwale and Nthambi, 2008
[12] Sibale and Nthambi, 2008

Regarding Objective 3, issues of violations of rights for OVCs have not been very commonly reported of late. Usually OVCs face problems with property inheritance and care for school and daily needs.

For inheritance issues, local chiefs and clan leaders play very important roles in ensuring that orphans take custody of the parents' land and other property. When chiefs and clan leaders fail, the District Commissioners handle the cases.

3.4.3 Home-Based Care

A discussion of home-based care achievements occurs in the NCPI, Annex 1.

3.5 Knowledge and Behaviour Change

3.5.1 School Attendance (Indicator 12)

Indicator 12. Current school attendance among orphans and non-orphans aged 10-14

The national 2010 Universal Access Target for this indicator is a ratio of .98, with an increase to 1.0 in 2012. MICS 2006 results are as follows. School attendance of children who are orphaned or vulnerable was 88.8% (M: 87.5%; F: 89.9%). Percentage of children who are orphaned or vulnerable was 26.4% (M: 26.0%; F: 26.8%). Percentage of children who are not orphaned or vulnerable was 73.6% (M: 74.0%; F: 73.2%). School attendance of children who are not orphaned or vulnerable was 90.2% (M: 90.2%; F: 90.2%). (MICS 2006, p. 259-260).

The MDHS reported slightly different results in 2004. For children for whom both parents were dead, the percent in school was 87.4% (M: 85.5%; F: 89.4%). For children for whom both parents were alive, and they were living with at least one parent, the percent in school was 90.2% (M: 89.7%; F: 90.8%) (MDHS 2004, p. 222).

Primary education is free (including text books), but uniforms and other school materials, including meals have to be purchased.

3.5.2 Knowledge (Indicators 13 and 14)

Indicator 13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject misconceptions about HIV transmission

The national 2010 Universal Access Target for the indicator is 75%, with the same target for 2012.

Table 3.10: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject misconceptions about HIV transmission: 2006

Question	Numerator:	Denominator:	Percentage of

	Number of respondents aged 15-24 who gave the correct answer	Number of all respondents aged 15-24 who gave answers, including "don't know"	young women and men aged 15-24 who gave the correct answer
1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partner? **2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?** **3. Can a healthy-looking person have HIV?** **4. Can a person get HIV from a mosquito bite?** **5. Can a person get HIV by sharing food with someone who is infected?** **Additional question: Can AIDS be transmitted by supernatural means?**			
Final: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	Female: Male: Total:	Female: 11,551 Male: 3,031 Total:	**Female: 42.1%** **Male: 41.9%** **Total:**

Source: MICS 2006, p. 225 and 228

Table 3.11: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject misconceptions about HIV transmission: 2004

Question	Percentage of young women and men aged 15-24 who gave the correct answer *(Denominator: Female: 5,262 Male: 1,237)*
1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partner?	**Female: 65.2%** **Male: 77.1%**
2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?	**Female: 58.4%** **Male: 75.8%**
3. Can a healthy-looking person have HIV?	**Female: 80.4%** **Male: 89.3%**
4. Can a person get HIV from a mosquito bite?	**Female: 69.4%** **Male: 66.9%**
5. Can a person get HIV by sharing food with someone who is infected?	**Female: 82.8%** **Male: 89.5%**
Additional question: Can AIDS be transmitted by supernatural means?	
Final: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	**Female: 23.6%** **Male: 36.3%**

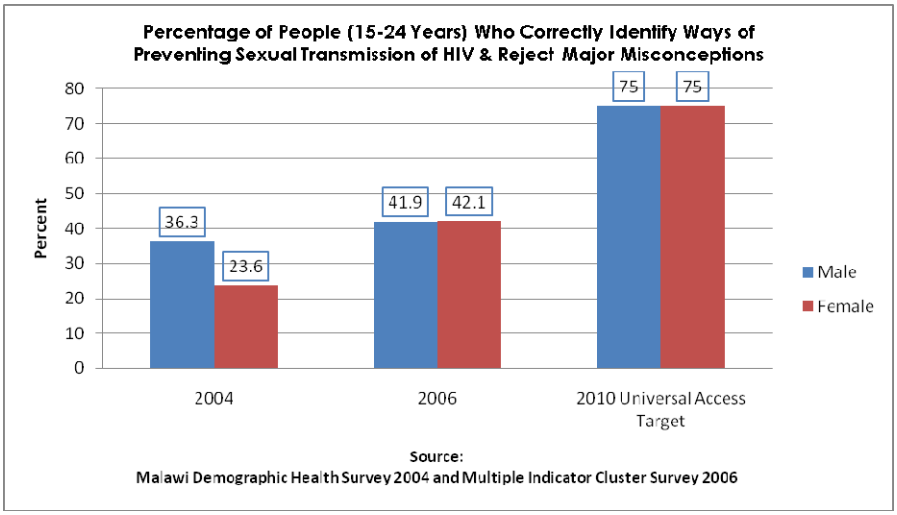
Source: MDHS 2004; p. 187-189

General awareness of HIV is considerably high amongst Malawians owing to rigorous HIV awareness campaigns that have been mainstreamed in a number of programmes. The 2004 MDHS reports that HIV knowledge is almost universal at 98.4% and 99.2% respectively for young men and women in the 15-24 age-group, and 98.6% and 99.5% respectively for the adult population in the 15-49 age group. A similar finding was obtained by the Multiple Indicator Cluster Survey of 2006 that observed knowledge at 99.5%. This notwithstanding, comprehensive knowledge[13] was found to be low in both the 2004 MDHS and the 2006 MICS. In 2004, 36.3% of males and 23.

6% of females had correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions. This means that young males had slightly higher levels of comprehensive knowledge than young females in the 15-24 age group. The MICS 2006 however, did not find any significant difference in comprehensive knowledge between young men (41.9%) and women (42.1%). To achieve the Universal Access target of 75% for this indicator for both young men and women will require concerted efforts aimed at addressing bottlenecks in reaching this population group with key and practical information. There needs to be continued support for peer to peer support groups, mass media targeting the youth with drama, the radio, HIV-related sporting events, TV programmes and school based programmes. The implementation of the National HIV Prevention Strategy (2009-2013) which seeks to focus more on interpersonal and interactive communication strategies may be a good starting point

[13] *Respondents with comprehensive knowledge said that use of condom for every sexual encounter and having just one uninfected and faithful partner can reduce the chance of getting HIV; that a healthy- looking person can have the AIDS virus, and they also rejected the two most common local misconceptions (i.e. that HIV can be transmitted through mosquito bite and through supernatural powers (MDHS, 2004 p.190 and MICS pg 222)*

Figure 3.5: Percentage of people (15 – 24) with comprehensive knowledge on HIV



In a study which was conducted to assess the HIV infection risk among girls aged 15-19 years in three districts of Malawi (Lilongwe, Thyolo and Zomba) in 2008, awareness levels were also found to be universal (Munthali and Maluwa 2008). All the 457 respondents (100%) responded that they had ever heard of an illness called AIDS. This finding mirrors findings from earlier studies as reported in the 2004 DHS and 2006 MICS which showed awareness levels of 99.5% among the respondents. Similar findings were also reported in an evaluation study of the US-funded Malawi BRIDGE I Project in 8 districts of the country where awareness levels reached 99.3% (Rimal R. et al 2009) and in a qualitative assessment of the risk factors and other cultural events that predispose people to HIV infection in Chiradzulu, Blantyre and Neno districts (Kadzandira J. 2010). Respondents to the 15 FGDs and 15 key informant interviews all recognized HIV and AIDS as one of the key health problems affecting their households and communities.

The findings from these recent studies cement findings from earlier studies which have all shown higher awareness levels for HIV and AIDS in Malawi including modes of HIV transmission and prevention. Although there is generally very high awareness of HIV transmission modes, some pockets are still very unclear about other modes of HIV transmission especially mother to child transmission and the fact that some myths still exist with regard to HIV transmission. The future of the HIV and AIDS programme in Malawi will now aim at enhancing these awareness levels and to find mechanisms of translating the awareness into behavior change and adoption of safer sexual practices. In contrast to the rising levels of basic knowledge, the differences in condom use between young men (57.5 %) and young women (39.5%) is high. Approaches should aim to eliminate gender imbalances and positively alter cultural aspects that impede access to and use of condoms (and information) by young women (UNGASS Consultative Process, 2009-2010).[14]

[14] Sources:
Munthali A.C. & Maluwa-Banda, D. 2008: "Assessment of HIV Infection Risk Among Girls in Selected Districts in Malawi". Adolescent Sexual and Reproductive Health. UNICEF and Ministry of Health, Malawi.

Indicator 14. Percentage of most-at-risk population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Table 3.12: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

MOST-AT-RISK POPULATION and question	Percentage of respondents who gave the correct answer *(Denominator: 353)*
COMMERCIAL SEX WORKERS	
1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?	**77.3%**
2. Can using condoms (consistently) reduce the risk of HIV transmission?	**86.1%**
3. Can a healthy-looking person have HIV (instead in Malawi: AIDS)	**95.5%**
4. Can a person get HIV from mosquito bites?	**62.9%**
5. Can a person get the HIV by sharing a meal with someone who is infected?	**90.4%**
Final: All questions answered correctly	**38.4%**

Source: BSS 2006, p. 31

There has been a remarkable increase in knowledge levels with the proportion of female sex workers who indicated knowledge of the three key HIV prevention methods increasing from 47.9% in 2000 to 56.9% in 2004. However, comprehensive knowledge was observed to be low with less than half (38.4%) of those sampled being able to correctly identify ways of preventing the sexual transmission of HIV and rejecting major misconceptions.

3.5.3 Sex before the Age of 15 (Indicator 15)

Indicator 15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15

Rimal R., Mkandawire G., et al 2009: "End of Project Evaluation of the Malawi BRIDGE II Project in 8 Districts and Network Analysis in T/A Njolomole, Ntcheu". John Hopkins University, Baltimore USA

Kadzandira J. 2010: "An Assessment of Factors that Enhance HIV Transmission in Malawi: A Baseline Program Assessment for the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; The Malawi BRIDGE II Project". J & F Consult, Zomba Malawi (Draft)

Table 3.13: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15

Sex and age	Number of all respondents	Percentage of young men and women aged 15-24 who have had sexual intercourse before the age of 15
15-19	Female: 2,392	Female: 14.1%
	Male: 650	Male: 18.0%
20-24	Female: 2,870	Female: 15.5%
	Male: 587	Male: 9.1%
Total: 15-24	Female: 5,262	Female: 4.8%
	Male: 1,237	Male: 13.7%

Source: DHS 2004, p. 213

Table 3.14: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15

Sex and age	Number of all respondents	Percentage of young men and women aged 15-24 who have had sexual intercourse before the age of 15
15-19	Female: 5,124	Female: 14.1%
	Male: 1,566	Male: 16.1%

Source: MICS 2006; p. 243 and 246

Delaying the onset of sexual activity amongst the youth is one of the key strategies for preventing sexual transmission in this group. In the 2004 MDHS, 13.7% of men and 14.8% of women in the 15-24 age group had sex by the exact age of 15. However, for the younger age groups (e.g 15-19), the proportion of men who had sex by the age of 15 is much higher implying that men are introduced to sexual activity much earlier than women. This finding was corroborated by the MICS 2006, which found a 2% difference between men and women in the 15-19 age group who had sex before the age of 15 in favour of women. See Table below:

Table 3.18: Percentage of people 15-24 who had sex before the age of 15[15]

	MDHS 2004		MICS 2006
age group	15-19 years	15-24 years	15-19 years
Male	18.0	13.7	16.1
Female	14.1	14.8	14.1
Rural Male	16.5	-	15.9
Rural Female	15.8	-	14.5
Urban Male	3.7	-	17.1
Urban Female	11.0	-	12.6

Source: MDHS, 2004 and MICS 2006.

[15] *The Malawi Demographic Health Survey has a slight variant to this as it collects on 'sex by the exact age of 15' while the MICS collects on those who had sex before the age of 15.*

It would be argued that the probability of engaging in sexual intercourse while young would be influenced by the environment where the adolescents lives, schools and spends her or his social life and the type of relationships that one gets involved into. Some studies have tended to ascertain whether Malawian girls are involved in sexual relationships at an earlier age. Half (50.1%) of the 457 girls aged 15-19 years who were interviewed in public (government and religious) primary and secondary schools in Lilongwe, Zomba and Thyolo districts reported to have ever had a boyfriend before (Munthali & Maluwa-Banda 2008). The findings also showed that the proportion of girls reporting ever having a boyfriend increased with increasing age and educational levels and chances of ever having a boyfriend was found higher among girls in co-educational institutions than among girls in girls-only schools. In general, a third of the respondents aged 15 years old reported having ever had a boyfriend and this increased to 42.2% for those aged 16 years old. For the girls aged 17-19 years old nearly two thirds reported having ever had a boyfriend.

With regard to knowledge about sexual intercourse, 80% of the girls reported ever having heard about sexual intercourse and nearly two thirds (62.6%) reported that they knew of close friends who had ever had sexual intercourse. Regarding their own engagement, 10.6% of the girls reported ever had penetrative sexual intercourse. Interestingly, girls interviewed in government schools were more likely to report ever having had sexual intercourse (19.8%) compared to those in government-aided religious schools (6.4%).

A more recent qualitative study conducted in Neno, Blantyre and Chiradzulu districts seems to suggest that the advent of 'freedoms' is being blamed on the loosening of cultural norms with regard to control of girls in the communities as parents are failing to take charge of their wards or risk being dragged to community support groups and the police (Kadzandira 2010). At individual and interactional level, peer pressure, the advent of video shows in rural communities, the sporting activities out of parent community and the desire to lead a more decent life matching that of close friends are among the factors driving young girls into early sexual debut.

3.5.4 Reducing the Number of Sexual Partners (Indicator 16)

Indicator 16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months

The national 2010 Universal Access Target for this indicator is Males: 18%; Females: 5%. The 2012 Target is Males: 9%; Females: 1%.

Table 3.19: Percentage of women and men aged 15-49 who reported having sexual intercourse with more than one partner in the last 12 months

Age	Percentage of respondents who have had sexual intercourse with more than one partner in the last 12 months
15-24	Female: 1.1% Male: 5.6%

Source: MICS 2006; p. 248 and 250

Table 3.20: Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months

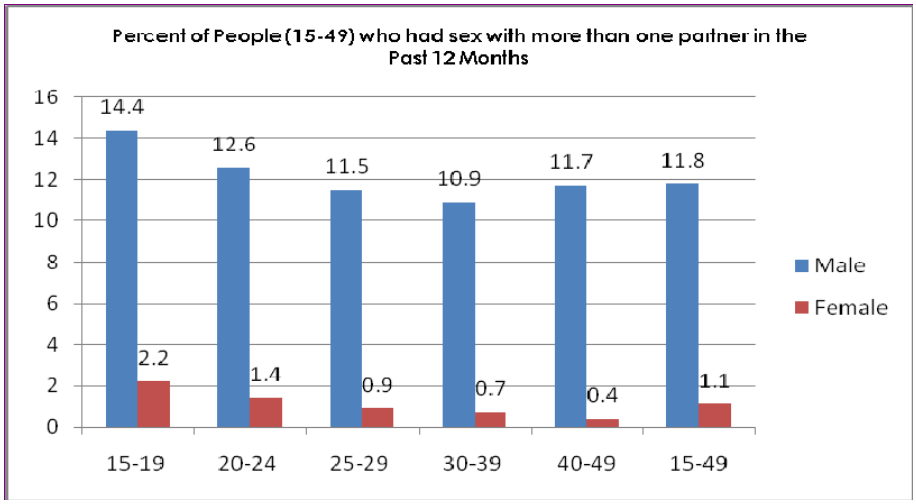
Sex and age	Percentage of respondents who have had sexual intercourse with more than one partner in the last 12 months
15-19	Female: 2.2% Male: 14.4% Total:
20-24	Female: 1.4% Male: 12.6% Total:
15-24	Female: 1.7% Male: 13.2% Total:
25-29	Female: 0.9% Male: 11.5% Total:
30-39	Female: 0.7% Male: 10.9% Total:
40-49	Female: 0.4% Male: 11.7% Total:
Total: 15-49	Female: 1.1% Male: 11.8% Total:

Source: DHS 2004; p. 199

Comparatively, males were over five times more likely to have had sexual intercourse with more than one partners than females. The government will enhance programmes that target men as a special group that promotes MCP and this will include supporting workplace programmes, interventions targeting sites and events where men solicit new sexual partners and owners of rest houses, motels and hotels.

The government of Malawi, through the Pakachere Institute for Development Communication recently launched the 'One-Love' Campaign, a regional initiative providing information on MCP, issues of trust etc. In the future, more emphasis will be placed on sensitising the population that many people living with HIV have been infected by a previous sex partner and thus "trusting each other" can be irrelevant related to whether someone is infected or not.

Figure 3.6: Percentage of People who had Sex with More than One Partner in the Past 12 Months



Several studies have documented the prevalence of multiple sexual partnerships among men, women and the youth in Malawi as one of the key drivers of HIV transmission in the country. A study that was conducted to identify and characterise sites and events where people new sexual partners in the urban areas of Lilongwe and Blantyre reported high multiple sexual partnerships among the patrons of the sites especially among female patrons understandably because the majority of female patrons visit those sites in search of sexual partners in order to earn a living (Kadzandira and Zisiyana 2007). Among the male patrons, certain attributes appeared to contribute to sexual networking and these included having a car, mobile phone and having cash flow above average (dubbed the 3 Cs) and alcohol consumption. Male patrons with the four attributes were found to be 2.5 times more likely to have another sexual partner in addition to their regular spouses or girl friends than male patrons that have none of the four.

The findings from the study described above are supported by a study which was conducted among girls aged 15-19 in Lilongwe, Zomba and Thyolo districts. This study reported that girls who were part of FGD participants and in-depth interviews attributed the high prevalence of sexual relations among girls sometimes with their teachers because they want 3Cs namely cash, car and cell phone (Munthali and Maluwa-Banda 2008). Some FGD participants also reported that boys cheat their parents their parents that they have, for example, lost school books in order to raise cash to satisfy their girlfriends.

While the two studies highlighted above talk of the conventional multiple sexual relations taking place between men and commercial sex workers and among youths, some studies conducted in Malawi are also pointing out the high prelavence of extramarital sexual affairs among married men and women (Komwa and Sikwese 2007). In their study, Komwa and Sikwese have argued that most studies in Malawi have tended to ignore sexual relationships that are taking among married men and women which, when managed, tend to take long and as a result of which, trust tends to built between the partners leading to low use of protection. Among others, factors promoting multiple and concurrent sexual partners (dubbed MCP) are peer pressure,

availability of disposable income especially among men, gender imbalance in employment opportunities and income, alcohol and drug use, the high emphasis on the 'C' in the ABC prevention strategy, working or living away from partners and lack of good sex education among couples.[16]

3.5.5 Condom Use (Indicators 17-21)

Indicator 17. Percentage of women and men aged 15-49 who had more than one partner in the last 12 months who used a condom during their last sexual intercourse

For a related indicator depicted below, the national Universal Access Target for 2010 is Males: 10%; Females: 1.2%. For 2012 the target is Males: 9%; Females: 1%.

Table 3.21: Percentage of women and men aged 15-24 who used a condom at last sex with a non-marital, non-cohabitating partner in the last 12 months

Sex and age	Denominator: Number of women and men aged 15-24 who had sex with a non-marital, non-cohabitating partner	Percentage of women and men aged 15-24 who used a condom at last sex with a non-marital, non-cohabitating partner
15-19	Female: 702	**Female: 37.4%**
	Male: 459	**Male: 53.8%**
20-24	Female: 418	**Female: 43.2%**
	Male: 486	**Male: 61.1%**
Total: 15-24	Female: 1,121	**Female: 39.5%**
	Male: 946	**Male: 57.5%**

Source: MICS 2006: 248-251

[16] Sources:
Kadzandira J.M. & Zisiyana C. 2007: Assessment of Sites and Events where people meet new Sexual Partners in the Urban Areas of Lilongwe and Blatyre". Centre for Social Research, University of Malawi.
Komwa I. & Sikwese S. 2007: "Multiple and Concurrent Partners Formative Research: A Key Informant Interviews Report". Pakachere Health and Development Communications HIV Prevention, Malawi

Table 3.22: Percentage of women and men aged 15-24 who used a condom at last sex with a non-marital, non-cohabitating partner in the past 12 months

Sex and age	Denominator: Number of women and men aged 15-24 who had sex with a non-marital, non-cohabitating partner	Percentage of women and men aged 15-24 who used a condom at last sex with a non-marital, non-cohabitating partner
15-19	Female: 302	**Female: 34.9%**
	Male: 211	**Male: 35.8%**
20-24	Female: 197	**Female: 35.6%**
	Male: 198	**Male: 58.5%**
25-29	Female: 105	**Female: 26.9%**
	Male: 117	**Male: 55.9%**
30-39	Female: 107	**Female: 17.5%**
	Male: 97	**Male: 41.7%**
40-49	Female: 44	**Female: 9.7%**
	Male: 24	**Male: 31.0%**
Total: 15-49	Female: 755	**Female: 30.1%**
	Male: 646	**Male: 47.1%**

Source: DHS 2004: p. 200

Indicator 18. Percentage of female and male sex workers reporting the use of a condom with their most recent client

From the 2006 BSS, 91.8% of the 329 female sex workers sampled reported using a condom the last time they engaged in commercial sex in the last 12 months (BSS 2006; p. 31

Indicator 19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Data has not been collected on this indicator yet. However, a recent pilot study with a sample of 200 (A Cross Sectional Study of HIV Prevalence and Sexual Behaviour Among Men Having Sex with Men in Malawi; CEDEP; 2008) reports the following data. When asked how often you use a condom, respondents indicated 35% always, 22% sometimes, 2.5% rarely, and 10% never used.

When asked about lubricant use, the following responses were received: Unsure/don't know: 7.5%; No condom: 11%; Condom, no lubricant: 7.5%; Saliva: 10.5%; Water-based lubricants: 20.5%; Body/fatty creams: 6.5%; Petroleum jelly: 36.5%. The high use of oil-based lubricants which are not safe to use with condoms indicates that widespread sensitisation needs to be done on which lubricants are water-based and thus safe to use with a condom. The accessibility of condom-safe lubricants needs to be increased considerably as a part of prevention efforts (UNGASS Consultative Process, 2009-2010).

Other relevant information included the following responses. 56% of the men had had multiple female sexual partners. 56% ever accessed information on how they could prevent themselves from HIV when having sex with males, while 43.5% had never. 76.5% indicated no health professional had ever recommended they get and

HIV test. 62.5% had never been tested for HIV. Knowledge especially about HIV transmission during anal sex was low at one out of five respondents having knowledge of this vital prevention information (A Cross Sectional Study of HIV Prevalence and Sexual Behaviour Among Men Having Sex with Men in Malawi; CEDEP; 2008).

The data on HIV knowledge and practices amongst Men who have Sex with Men is concerning and highlights the need for Malawi to collect formal data for Indicator 19 and the need to implement prevention programmes to meet the needs of Men who have Sex with Men. This has been noted, highlighting the need for a national survey (such as DHS) that includes questions on people's sexual orientation. However, given the politics as of today in Malawi it will be difficult to have a survey of Men who have Sex with Men because they will think you want to report them to the police. There is a need for positive leadership from the government on this issue in order to move forward.

3.6 Impact

3.6.1 Prevalence of HIV among Young People (Indicator 22)

The National 2010 Universal Access Target for the percentage of young people aged 15-24 who are infected is 12%. The target for 2012 is 13%. Sentinel surveillance data from 15-24 year-olds is used as a proxy for this indicator. However, the prevalence would be lower in the actual population because the age of sexual debut is 16-17 and women who come to the ANC clinic for pregnancy in the lower age group of 15-16 are not representative of the general population of young people and have a higher probability of being HIV positive, as they have been sexually active.

The next sentinel surveillance was planned for 2009, but reagents were not acquired in time, so it has been postponed to 2010. Previous sentinel surveillance data appears to show a downward trend in prevalence. However, this is due to changes in methodology of sampling (a difference in sample size and number of sites from 19 sites since 1994 to 54 starting in 2007) and assumptions in the mathematical model (1. assumption on average duration of survival after seroconversion, from 5-6 years to 10-11; 2. effect of ART in adding to HIV prevalence). The Sentinel Surveillance report for 2007 states that, "Overall, HIV prevalence in Malawi appears to have stabilized around 12%."

Table 3.23: Percentage of ANC attendees aged 15-24 tested whose HIV results are positive: Jan.-Dec. of the Given Year

Age	Numerator: Number of ANC attendees aged 15-24 tested whose HIV results are positive	Denominator: Number of ANC attendees aged 15-24 tested for their HIV infection status	Percentage of ANC attendees aged 15-24 tested whose HIV results are positive
2007	15-19: 394 20-24: 1,082 Total 15-24: 1,476	15-19: 4,152 20-24: 7,829 Total 15-24: 11,981	**15-19: 9.5%** (8.6,10.4) **20-24: 13.8%**

			(13.1,14.6) **Total 15-24: 12.3%** (11.7,12.9)
2005	15-19: 183 20-24: 554 Total 15-24:	15-19: 1,780 20-24: 3,380 Total 15-24:	**15-19: 10.3%** (8.9,11.8) **20-24: 16.4%** (15.2,17.7) Total 15-24:

Source for 2007 num. and den.: HIV and Syphilis Sero-Survey and National HIV Prevalence and AIDS Estimates Report for 2007; MoH and NAC; August 2008

3.6.2 Prevalence of HIV among Most-at-Risk Populations (Indicator 23)

A discussion of prevalence of HIV amongst Most-at-Risk Populations occurs in the overview of the epidemic in Section 2.3.

3.6.3 Survival on ART (Indicator 25)

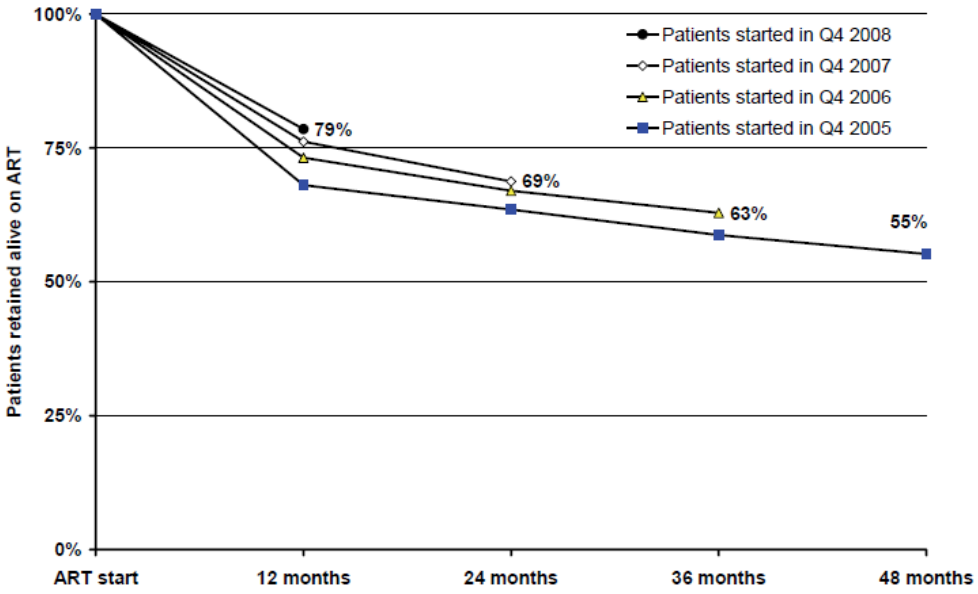
With respect to treatment outcomes, survival figures indicate that 79% of both adults and children were retained alive 12 months after registration and that 69%, 63%, 57% and 54% of patients were retained alive at 24, 36, 48 and 60 months (for all ages) respectively (See Table below). It has been noted that retention among males has been 28% lower than retention among females.

Table 3.24: Cohort Survival Analysis 12, 24, 36, 48 and 60 months from Registration

	12 month (children)		12 month (adults>15 years)		24 month (all ages)		36 month (all ages)		48 month (all ages)		60 months (all ages)	
Total Registered	1,751		19,459		15,718		12,430		7,777		2,012	
Transfers	168	10%	1,794	9%	2,474	16%	2,365	19%	1,714	22%	536	27%
Total patients	1,583		17,655		13,244		10,065		6,063		1,476	
Alive on ART	**1,258**	**79%**	**13,920**	**79%**	**9,140**	**69%**	**6,391**	**63%**	**3,468**	**57%**	**795**	**54%**
Died	105	7%	1,503	9%	1,519	12%	1,771	18%	1,467	24%	402	27%
Lost to follow-up	211	13%	2,166	12%	2,531	19%	1,859	19%	1,082	18%	274	14%
Stopped ART	9	<1%	76	<1%	54	<1%	44	<1%	46	<1%	5	<1%

Source: (Quarterly Report Antiretroviral Treatment Programme in Malawi with Results up to 30th September 2009 p2)

Figure 4: 'Cohort survival analysis' 12, 24, 36 and 48 months after ART initiation



Source: (Quarterly Report Antiretroviral Treatment Programme in Malawi with Results up to 31st December 2009 p5)

The fact that the **ART Programme** is able to **track survival** up to **five** years after registration is a big success in as far as patient survival tracking is concerned. The programme has an impressive M&E System that is able to capture **reliable programme data**.

More effort needs to be put into gradually integrating routine data into the overall Health Management Information System.

Table 3.25: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (Initiated on treatment from Oct.-Dec. 2007)

Sex and age	Number of adults and children who are still alive and on ART at 12 months after initiating treatment	Total number of adults and children who initiated ART during the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up	Percentage of adults and children who are still alive and on ART at 12 months after initiating treatment
<15	733	1,108	**76%**
15+	9,118	13,751	**76%**
Total: All ages			

Source: Quarterly Report ART Programme in Malawi with Results Up To 31st December, 2008

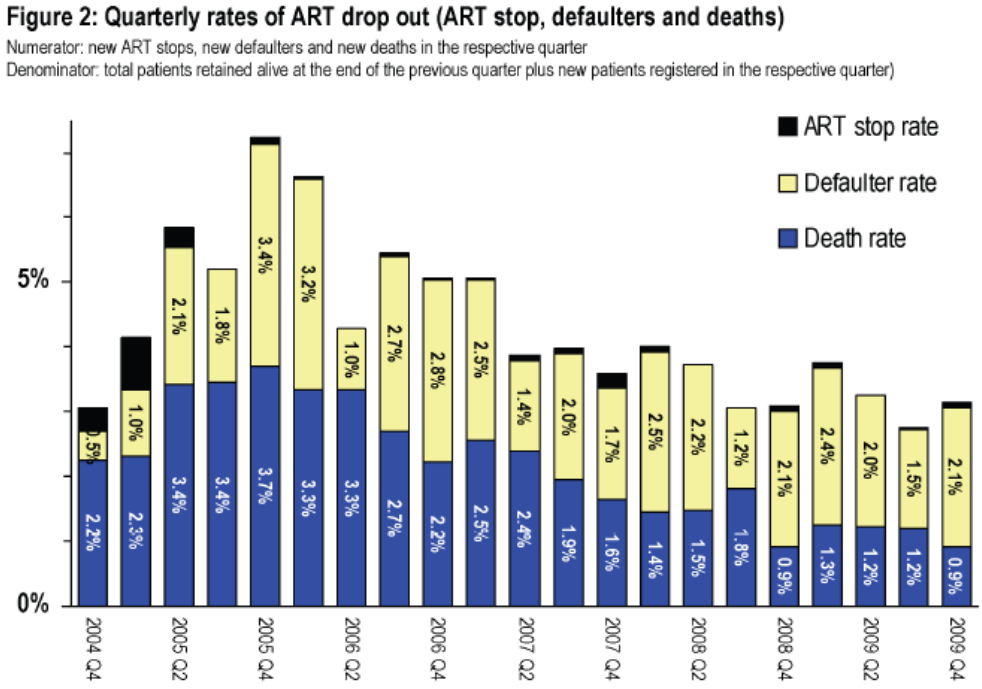
Table 3.26: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (Initiated on treatment from Oct.-Dec. 2006)

Sex and age	Number of adults and children who are still alive and on ART at 12 months after initiating treatment	Total number of adults and children who initiated ART during the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up	Percentage of adults and children who are still alive and on ART at 12 months after initiating treatment
Total: All ages	8,180	12,244	**67%**

Source: ART in the Public and Private Sectors in Malawi: Results Up To 30the December, 2007

The programme has also experienced steady declines in quarter on quarter defaulting and deaths as per the graph below.

Figure 3.7: Quarterly Rates of ART Drop-out



Source: (Quarterly Report Antiretroviral Treatment Programme in Malawi with Results up to 31st December 2009 p4)

3.6.4 Prevention of Mother-to-Child Transmission (Indicator 25)

Indicator 25. Percentage of infants born to HIV-infected mothers who are infected

The national 2012 target for the percentage of infants born to HIV-infected mothers who are infected is 14%. According to the UNGASS guidelines, ideally the data for this indicator should be estimated using spectrum and "calculated using the weighted average of probabilities of MTCT for pregnant women receiving and not receiving HIV prophylaxis, the weights being the proportions of women receiving and not receiving various prophylactic regimes." The spectrum estimate of the number of newly infected children ages 0-14 for 2009 is 11,799 (Sentinel Surveillance 2007, p. 37). However, this estimate through spectrum is only as good as the data fed into it from the PMTCT programme. Since the records in Malawi include up to 60% double-counting, the resulting estimate from spectrum is likely to be wildly optimistic. The denominator is calculated as per the table below.

Actual and Projected Expected Pregnancies (Based on the 2008 Census x population growth of 2.8%)	Estimated number of pregnant women in need of PMTCT (Based on 12.6% estimated prevalence from Sentinel Surveillance 2007)
Actual 2008: 660,000	83,160
Projected 2009: 678,480	85,488

The rough estimate obtained for this indicator is 11,779 / 85,488 = 13.8% for 2009. These estimates include an overly optimistic assumption about percentage of women on PMTCT and will need to be revised.

4. BEST PRACTICES

4.1 Best Practices in the HIV Response: 2008-2009

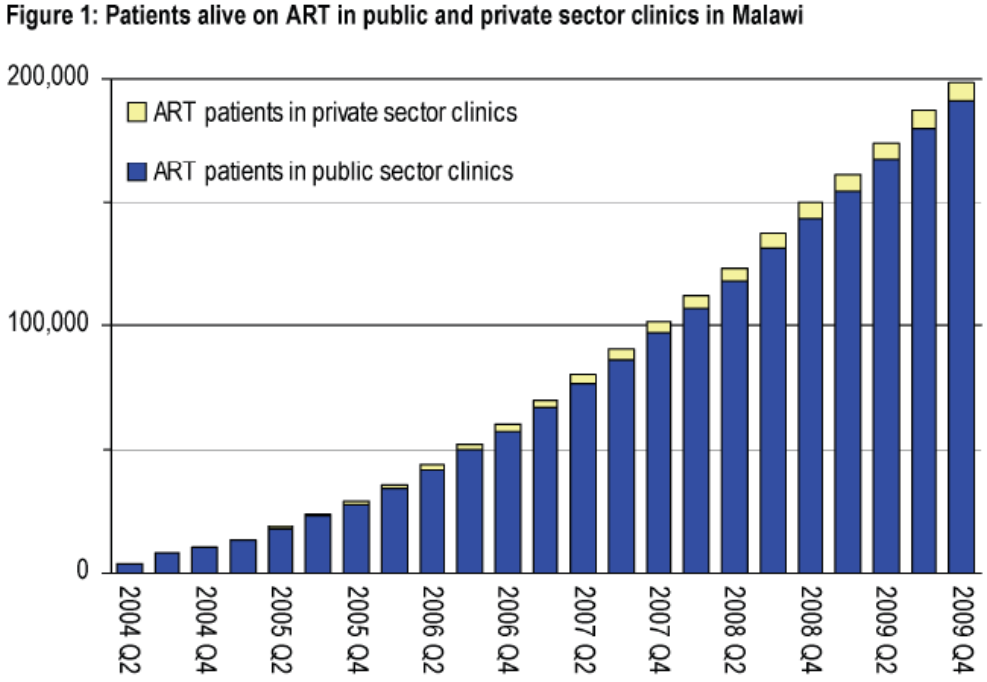
4.1.1 Scale-up of ART

With support from the Global Fund, Malawi has achieved a remarkably sustained ramp-up of the ART Programme. The number of patients alive and on treatment increased from 10,761 in 2004 to 198,846 in 2009 (ART Quarterly Report, MoH, 2009). See figure 4.1 below.

It should be mentioned that this **impressive success** in the scale-up of **ART** Programme **coverage** has been achieved whilst also critically balancing the need not to compromise on **quality.**

In this respect, the programme has only been able to scale up as far as the basic infrastructure, the drug logistics and the human resources can allow.

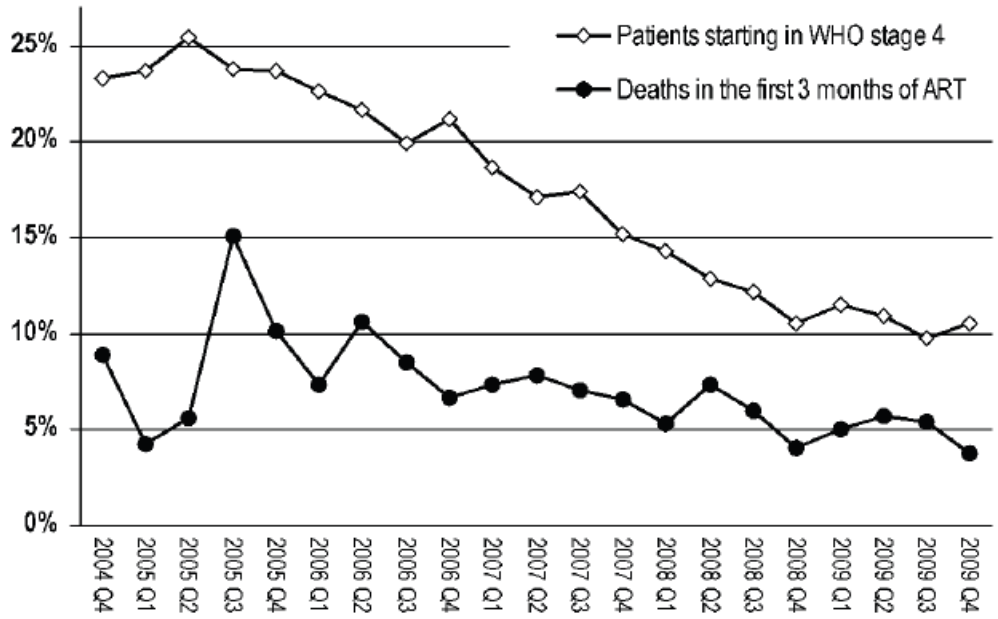
Figure 4.1: ART Programme Scale Up in the Public and Private Sectors



Source: (Quarterly Report Antiretroviral Treatment Programme in Malawi with Results up to 31st December 2009 p3)

Early days of the programme were characterized by high mortality during the first three months of initiation. However, since 2005, the programme has achieved tangible decline in the proportion of deaths in the first three months. The figure below shows a comparison of patients staring ART in WHO stage 4 and deaths in the first three months of initiation. It is evident from the graph that early initiation (WHO stage 3 or due to a low CD4 Count) has resulted into a decline in mortality in the first three months of ART initiation.

Figure 3: Patients starting ART in WHO stage 4 and deaths in the first 3 months after ART initiation. (Shown as proportions among new patients registered each quarter)



Source: Quarterly Report Antiretroviral Treatment Programme in Malawi with Results up to 31st December 2009 p4)

4.1.2 Pooling Arrangements

Malawi has set an example within the region and beyond on how best development partners and the host Government can work together for the common good through **Government-driven pooling systems** that foster **mutual accountability, transparency and efficiency**.

Above all, pooling arrangements have **cut back on transactional costs** of doing business and thus **increased the time spent on actual programme delivery**.

The HIV Pool

Since 2003, Development partners (The Government of Malawi, The Global Fund, the World Bank, Norway/SIDA, CIDA[17], and DFID) have pooled resources together into a common basket for the delivery of HIV and AIDS programmes based on one common framework, the National Action Framework- including common procurement and reporting processes. This arrangement is operationalised by a Memorandum of Understanding (MoU) that is signed between the Government of Malawi on the one hand and the donor partners on the other. This has ensured that donors rally their support harmoniously whilst supporting Government HIV and AIDS priorities.

The Health SWAp

The general health care delivery system is also financed through a SWAp arrangement involving the Government of Malawi and several donor partners (the Global Fund, DfID, Norway/SIDA, the World Bank). Implementation of the SWAp, which commenced in 2004 is meant to deliver an Essential Health Package (EHP), which is a minimum package of services delivered free of cost at the point of delivery. The key rallying point for the SWAp is a six year Joint Programme of Work (2004-2010), which is a framework of key priority strategies and actions. A Memorandum of Understanding between the Government of Malawi and collaborating partners was signed in October 2004. Major achievements under the Health Swap include investments in human resource (through the Six year Emergency Human Resource Plan) as well as infrastructure development. Borrowing from the successes of the health SWAp, other key Government Ministries (Ministry of Water and Ministry of Education, Science and Technology) have also embraced SWAps as a mode of delivery of programmes.

[17] CIDA has pulled out of the HIV pool owing to rationalization of their country portfolios.

4.2 Best Practices in the UNGASS Process: 2010

4.2.1 Counterpart Arrangement

A pairing of the UNGASS Preparation Team Lead, which was in this case the International Quantitative and Qualitative Consultant and a National Focal Person occurred to enhance national ownership, capacity-building and mutual sharing of expertise. This twinning arrangement between the International Consultant and the National Counterpart, a Monitoring and Evaluation Officer from within the National AIDS Commission, facilitated complementary skills-building to increase the sustainable M&E capacity of the National AIDS Response in Malawi. As a result, rapid development of capacity occurred on the part of the National Focal Person, preparing him to take the role of Team Lead on future UNGASS Reports. Due to the close working relationship between the International Consultant, the National Counterpart, and the UNGASS/NASA Task Force, a deepening of participatory methods and an emphasis on systematic application of significant findings resulted to encourage faster scale-up to achieving Universal Access (UNGASS Consultative Process, 2009-2010).

4.2.2 Consultative Process

In response to guidance from the UNGASS/NASA Task Force, Focus Group Discussions were added to the Key Informant Interview Methodology to ensure a more balanced coverage of:

- High-level Policy-makers and Programme Managers
- Service Delivery at District Level
- Users of Services (General Population and Most-at-Risk Groups)

This change resulted in a much greater breadth and depth of information about progress and challenges in achieving Universal Access (UNGASS Consultative Process, 2009-2010).

4.2.3 Application of the Report

The Task Force decided that in addition to the above measures, it would be important for an Abridged Version of the Report to be produced, translated, printed, and widely distributed to make the key information in the report easier to put into action. It was also suggested that the Abridged Version should be translated into key languages and widely distributed so that it is usable at the grassroots levels. The Abridged Version contains an overview of the key data on UNGASS indicators in relation to targets, as well as messages for key audiences (Policy-makers, Implementers, and Users of Services) on how to apply the lessons learned through the report in order to achieve Universal Access. It has been recommended that the Action Plan, Section 8.2, be discussed during the Joint Annual Review to determine how to best move forward the implementation of these recommendations (UNGASS Consultative Process, 2009-2010).

5. MAJOR SUCCESSES, CHALLENGES, AND ACTIONS TO BE TAKEN

5.1 Major Successes: Progress Made in 2008 and 2009

5.1.1 Decentralisation of Service Delivery

In line with the on-going decentralisation programme of public services, the HIV and AIDS national response has also been decentralised to the Local Assemblies (LA) at the District or City Council Levels and beyond to the numerous service providers at the community and household levels.

> The national response to HIV has ensured that HIV services are brought much closer to the local level.

Local Authorities have been empowered to implement this approach by equipping them with key personnel and resources. Key support provided includes finances and equipment (including vehicles and computers).

Refurbishment of key infrastructure has also been undertaken so as to provide an ambient environment for both service providers and their clients. The Ministry of Local Government and Rural Development, the line Ministry responsible for decentralisation, undertook an assessment of capacity needs for all local authorities in 2006. This assessment has led to the development a Capacity Building Plan (2007) aimed at addressing identified capacity issues at Local Authority level (Extended NAF, pg46).

From 2004 to 2007, the National AIDS Commission sub-contracted international NGOs (as umbrella organisations or UOs) to work with and build the capacity of LA's in rolling out the grants facility to the grassroots implementers of HIV services. The UOs, together with the respective LAs have since 2004 been preparing joint District Implementation Plans (DIPs) that incorporates interests of various stakeholders, both government and civil society. This has increased service provision and uptake even in areas that have been underserved because of access and terrain constraints.

From 2008, the contracts with the UOs were terminated and currently, LA's are now in full control of the district level grants facility and together with district level service providers, the LA's plan, implement and monitor district level HIV and AIDS activities. This has enabled programmes on HTC, PMTCT, ART , care and support and impact mitigation to be rolled out quite tremendously in the last 2 years of service decentralisation. There have also been multiplier effects of HIV service decentralisation at the LA levels as the LA's are now moving towards LA level implementation, monitoring and evaluation of the progress being made in achieving targets spelt out in the Malawi Growth and Development Strategy (MDGS). In

collaboration with the Ministries of Local Government and Economic Planning and Development, M&E Officers and District AIDS Coordinators were recruited in 2007-8 to work with the LAs, government departments and the civil society in service provision as well as monitoring and evaluation of public and private services in each LA. Each LA prepares quarterly and annual service coverage reports which are used at the LA level and shared with the National AIDS Commission and respective parent ministries for a national picture. This has also helped to reduce time-lags and duplication in reporting and has empowered the LAs to monitor what is happening in their respective assemblies.

However, it is still acknowledged that, even after the handover of such an activity to the local authorities, must still needs to be done to build sustainable capacity at the local level (Extended NAF, p. 46).

5.1.2 Development of the National HIV Prevention Strategy

The **National HIV Prevention Strategy** has led to a consolidation of hitherto numerous prevention documents into **one singe coherent framework** that will guide the planning, implementation, and monitoring and resource mobilisation for HIV prevention programmes in Malawi.

Malawi recognizes the dynamic nature of HIV and the factors that drive its transmission. It is also recognized that unless prevention efforts are accelerated, the fight against HIV will remain a pipe dream. It has been acknowledged that the estimated 90,000 new infections are unacceptably high. Owing to this understanding, a National HIV Prevention Strategy (2009-2013) was therefore developed to respond to prevailing gaps in HIV prevention.

In 2009, the Government of Malawi developed and launched the National HIV Prevention Strategy for the period 2009-2013. This was developed through a rigorous participatory process involving public service providers, the private sector and civil society. The strategy is a guiding tool for planning, implementing financing, monitoring and evaluating HIV prevention interventions in the country as well as to provide practical guidance for improving current HIV prevention programming for maximum impact in reducing new infections. The main aim of the strategy is to reduce new HIV infections in order to further mitigate the burden and impact of HIV and AIDS in Malawi. The development of the strategy is part of both global and regional effort of intensifying HIV prevention (Government of Malawi, National Prevention Strategy, Final Draft 2009).

Extracts from pages 9-10 of the new HIV Prevention Strategy stipulate that:

> The new National HIV Prevention Strategy differs from previous prevention efforts in Malawi in a number of important respects. Firstly, while the

previous BCI Strategy which guided the prevention response in Malawi since 2003 was largely focused on behaviour change and non-clinical prevention interventions, the new National HIV Prevention Strategy also gives attention to prevention interventions in clinical settings, such as early HIV testing and counselling, linked with positive behaviour change, prevention of mother-to-child transmission, blood and injection safety, safe medical male circumcision, and timely initiation of HIV treatment. At the same time, the strategy seeks to move beyond the sometimes polarizing approaches of "biomedical" and "non-biomedical" HIV prevention, encouraging instead a more integrated approach in which HIV prevention interventions in both clinical and non-clinical arenas are strongly-linked and well-harmonized with one another. Additionally, in comparison to prior efforts which were predominantly focused on individual level behaviour change, the new strategy also gives attention to structural and cultural factors that increase vulnerability to HIV infection, addressing cross-cutting issues such as gender and human rights, and seeking to foster sustainable changes in both individual behaviours and social norms (Government of Malawi, National Prevention Strategy, Final Draft 2009 pages 9-10).

Furthermore, the new Prevention Strategy demonstrates a renewed emphasis on evidence-based and data-driven prevention programming consistent with best practice and firmly supported by strong epidemiologic analysis, formative research (both initially and as interventions develop), and baseline and follow-up evaluations to monitor the effectiveness of programming and continuously improve its quality. Importantly, epidemiologic analysis has already estimated that over 90% of new HIV infections among adults in Malawi occur from two main epidemiologic components: (1) a highly active "rapid" component where individuals engaging in multiple and concurrent sexual partnerships drive transmission through sexual networks; and (2) a more chronic, "slow" component with very substantial transmission, largely driven by existing discordant couples and people entering latter stages of disease when they are potentially more infectious. In light of this data, the new strategy has placed the highest priority on utilising a variety of complementary and evidence-based approaches to: (1) reduce multiple and concurrent partnerships and (2) reduce transmission among existing discordant couples'.

This is a quite commendable achievement in the fight against the further spread of the epidemic in the country. As the strategy has been developed following consultative and participatory processes, the buy-in of various stakeholders has been enormous and it is expected that this will contribute towards greater achievement in reducing the further spread of the epidemic at all levels. A comprehensive implementation plan has been developed with well-defined lead agencies. This will assist in tracking accountability in the HIV prevention response. A set of harmonized indicators at various levels has also been developed to guide implementers in monitoring and evaluation.

5.1.3 Development of the Extended National Action Framework for HIV

Malawi aligns itself to the 3-one's principles: (1). one national coordinating agency (through the NAC); (2). one M&E system and; (3). one national over-arching framework, currently the National Action Framework (NAF) The National Action Framework (2004-2009) is the strategic document guiding the implementation of HIV and AIDS programmes in Malawi.

The **National Action Framework** has been extended to cover the period 2010-2012 in order to align it with the overall Government Development Blueprint-the **Malawi Growth and Development Strategy**.

The NAF was developed through a consultative and participatory process in 2005-06 to provide overall guidance in the national response for the period 2006-10. Through a similar process, the NAF was reviewed in 2009 and a consensus was reached with all implementers and development partners to extend the current NAF to 2013. The development of 2005-2009 NAF benefited from the collaborative efforts of various stakeholders including the government, civil society organisations, development partners and district level implementers of interventions. A review of the NAF was conducted in 2008 so as to ascertain whether the national response was achieving the targets the country had set which were in line with the overall national targets as set out in the Malawi Growth and Development Strategy (MGDS) and the targets set out at the 2001 United Nations General Assembly Special Session on AIDS (UNGASS) to achieve universal access to comprehensive HIV prevention, treatment, care and support by 2010.

The 2008 Mid Term Review (MTR) of the NAF also provided an updated analysis of the epidemic and the response, key successes and challenges and proposed areas that the national response should address. The Extended National HIV and AIDS Action Framework (NAF) for the period 2010 to 2012 therefore follows the NAF 2005 to 2009, and harmonises the national HIV and AIDS response with the Malawi Growth and Development Strategy (MGDS) and other international agreements to which Malawi is a signatory. Just like the 2005-2009, the development of the extended NAF also benefited from broad participation of implementing partners, communities affected by HIV and AIDS and development partners.

Benefiting from evidence-based planning, the Extended NAF also recognises that while the highest HIV prevalence exists among vulnerable groups like sex workers (70.7%) and their clients, the majority of new infections occur in sero-discordant, monogamous couples and among partners of people who have multiple concurrent partners, currently at 27% among men and 8% among women in Malawi (GoM 2009). The Extended NAF also recognises that the prevalence of HIV in Malawi is not uniformly distributed: 78% of HIV-positive individuals live in rural areas and 69% in the Southern region of the country. The Extended NAF was also developed recognising that condom use at last high risk sex is still inconsistent and low and that HIV disproportionately affects the better educated and wealthier people, and people in towns and that comparatively, females are at a higher risk of HIV infection.

The development of the Extended NAF therefore offers a greater opportunity in the fight against HIV and AIDS stemming from the participatory nature of its development which has ensured greater buy-in and ownership by various stakeholders, the highlighting of interventions and targets for reaching out to sero-discordant, monogamous couples and to people who have multiple concurrent partners and other high risk groups (such as sex workers and other vulnerable groups). The Extended NAF also emphasises the need to reach out to the most underserved areas with all interventions including HIV prevention programmes, HTC, ART, PMTCT, care and support programmes and impact mitigation. The Extended NAF has also placed much emphasis on the development and implementation of evidence-based programmes through strengthening of HIV and AIDS research and monitoring activities at all levels. The Extended NAF is a well-costed framework which if properly funded, the national response to HIV and AIDS is set to achieve high levels of accomplishments in line with targets set in the MGDS, the 2015 Millennium Development Goals, the universal access targets and other international instruments.

5.1.4 Development of a Draft Bill on HIV

For some time, Malawi has been aiming at drafting laws and regulations that would protect and promote the rights of HIV infected and affected individuals, families and communities. Following submissions from the Office of the President and Cabinet (Department of Nutrition HIV and AIDS) and the National AIDS Commission, The Law Commission developed a Report and a draft bill in order to guide the development of a comprehensive legislative framework to govern issues related to HIV and AIDS as well as the creation of a legislative institutional framework that would allow for the proper functioning of the National AIDS Commission (See Report of the Law Commission on the Development of HIV and AIDS legislation, pg 9). The draft bill has the potential to become a model law on HIV if several areas are able to be revised. These revisions are discussed in Section 8.1.2 of this Report.

5.1.5 Improvements in the Monitoring and Evaluation System

The revision of the **M&E Plan** also presented an opportunity for incorporation of a data quality framework that will go a long way in **enhancing the timeliness and completeness of data** presented by key providers.

Malawi first developed a comprehensive plan on Monitoring and Evaluation of the National Response to HIV and AIDS in 2003. This plan faced several implementation hurdles including unclear indicator matrices and definitions, unclear data sources and data reporting channels, late reporting, incomplete reporting, data duplications and non-reporting particularly among non-NAC funded implementers. Between 2006 and 2007, a consultative process was initiated through a multi-faceted stakeholder 'Task Force' to review and redefine key national indicators for subsequent development into

a comprehensive national M&E system that would align Malawi to the 3-one's principles.

A new M&E plan for the period 2006-2010 was adopted in 2007 to monitor the progress that the national response is making towards achieving the targets spelt out in the NAF 2006-2010, the Universal Access Indicators and other international instruments. The revised M&E plan also provides clear guidance on the roles and responsibilities of various agencies and sets time lines for data reporting and compilation of reports. A major milestone in the revised M&E plan is the devolution of powers and functions to the Local Assemblies (LAs) to be able to monitor and evaluate local level activities for own programming. District AIDS Coordinators have been placed in all the assemblies and these are now working together with the M&E Officers recruited by the Ministry of Planning and Economic Development (EP&D) in enhancing assembly level monitoring and evaluation both HIV and non-HIV programmes. The reporting forms have been harmonised and unlike in the last 3-4 years where, local implementers were required to complete different activity forms for various donors and agencies, implementers are now only required to fill the Local Assembly HIV and AIDS Reporting Form (LAHARF). The new LAHARF has also been simplified and is a revised form of the previous National AIDS Activity Reporting System (NACARS) which was being criticised by many implementers because of its complexity, difficulties with language and definitions and applicability at the grassroots levels. With the extension of the National Action Framework to 2012, a review and extension of the M&E Plan is planned in 2010.

The National HIV M&E System is aligned with the overall multisectoral National M&E System and hence serves as a subsystem of the latter. This has ensured that the HIV agenda is mainstreamed in the development priorities of the country. One fundamental success of the M&E system is its ability to rally players to collaborate around data collection processes, most notably population-based surveys.

5.1.6 Strengthening Partnerships in Programme Planning, Implementation and Monitoring

One of the biggest and most visible strengths of the Malawi national response to HIV and AIDS has been the ability to set up functional partnerships.

The government of Malawi established the National AIDS Commission in 2001 as a multi-sector coordinating agency of the national response in the country. From its establishment, the NAC has propelled the response in a manner that has enabled the active participation of various stakeholders in the planning, programming, implementation and monitoring and evaluation of HIV and AIDS interventions in the country. In recent years, much has been achieved worth noting in this report. According to the Extended NAF document, several coordinating structures have been established, and are functioning effectively and these include (GoM 2009):

- Malawi Partnership Forum, with membership from all HIV and AIDS partners

- Pooled Donor Group and the HIV and AIDS Development Group
- Malawi Global Fund Coordinating Committee (the Country Coordinating Mechanism)
- Local and International NGO HIV and AIDS Fora
- Malawi Interfaith AIDS Association
- Malawi Business Coalition against HIV and AIDS
- Malawi network of PLHIV (MANET+)
- Coalition of Women Living with HIV and AIDS (COWHLA)

A number of Technical Working Groups (TWGs) have been established for various thematic areas under the National Response and have been meeting and providing critical recommendations on their thematic areas. Through the active collaborative efforts of the various coordinating structures listed above, planning and implementation of interventions on HIV and AIDS is now multi-sector and this is even evidenced in the district level preparation of the District Implementation Plans where local grassroots implementers, district-level partners and NGOs actively take part in the development of the DIPs. This has resulted in enormous service scale-up although more needs still to be done to reach the hard-to-reach areas.

5.1.7 Integration of Nutrition and HIV and AIDS Initiatives

The interaction between HIV/AIDS and nutrition has been widely recognized in Malawi.

The interaction between HIV and AIDS and nutrition has widely been recognized, as HIV is known to affect immunity levels that are exacerbated by nutrition disorders. The Mid-Term Review of the National Action Framework (2005-2009) acknowledges several efforts aimed at enhancing nutrition and HIV linkages. Amongst others, the MTR notes the development of guidelines on nutrition for PLHIV on ARVs. However, it is also acknowledged that targeting of nutrition Support remains a challenge due to household food insecurity in some parts of the country. Nutrition education will also need to be intensified.

The National Response to HIV has demonstrated forward planning in this respect by promulgating a set of actions and strategies that would ensure that the HIV and nutrition linkage is strengthened. Objective 3.5 of the Extended National Action Framework highlights the following strategies and broad action areas:

- Increasing access to public and NGO food security programmes for affected households
- Creating demand for food and nutrition security programmes among PLHIV
- Increasing capacity of affected households to increase agricultural production

With support from GFTAM, an HIV nutrition programme (therapeutic feeding) focusing on adults and adolescents is being implemented in Malawi with particular targeting for the chronically ill, malnourished PLHIV and TB patients. The pilot started in 2005 (6 sites) and rolled out to 60 in 2006, 101 in 2007 and 157 in 2008. The programme follows the roll-out plan for ARVs and has comprises three

components, namely: therapeutic feeding (treatment), prevention, and linkages. Children are supported through Nutrition Rehabilitation Units that are largely supported by UNICEF and the civil society (IRT, 2009)

Tremendous progress has been registered by the Department of Nutrition, HIV and AIDS in the Office of the President and Cabinet in ensuring that the public sector response to HIV is strengthened. Notably, guidelines for the utilization of 2% ORT in the public sector were finalized and dissemination was underway as at the time of preparing the report. Implementation of the guidelines will ensure that the interventions based on the 2% ORT are standardized across sectors. Another major development has been the placement of Nutrition, HIV and AIDS Officers in key institutions.

Leadership for nutrition, HIV and AIDS at the highest level of sectors has been demonstrated through the revival of National Steering Committee on Nutrition, HIV and AIDS, a body constituted by Principal Secretaries (OPC,DNHA 2009).

5.1.8 Social Cash Transfer Programme

The scaling up of the **Social Cash Transfer Programme** could be singled out as one of the **major achievements** that the national response to HIV and AIDS has made in the reporting period.

The Social Cash Transfer Programme (SCTP), which started in September 2006 in Mchinji District as a pilot social intervention programme and was supported by UNICEF through the Ministry of Economic Planning and Development, has since been scaled up to 7 additional districts. The programme involves provision of a financial stipend to targeted beneficiaries (including People living with HIV, Orphans and other Vulnerable Children and the disabled) in the 7 districts where the scheme is in place. The programme is a component of an evolving comprehensive Social Protection Programme (SPP) of the government, which is based on the Social Protection Policy and the Malawi Growth and Development Strategy. The SPP aims at reducing and eventually eliminating ultra poverty and to prevent moderately poor households and non-poor households from falling into ultra poverty. The policy states: “Social Support is defined as all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and the rights of the marginalised, with the overall objective of reducing ultra poverty as well as economic and social vulnerability of the poor and marginalised groups (www.wahenga.net).

By April 2009 the number of beneficiary households reached 23,561 with a population of 92,786, of which 48,036 are OVC; 16,981 are elderly (65+); and 1,951 are people living with disabilities. Approximately 70% of the beneficiary households were HIV and AIDS affected (www.wahenga.net) . The volume of the transfer depends on household size and includes a bonus for households with children who attend school but generally, households receive the equivalent of USD 14 per month.

According to the draft report of the independent review team (IRT) of the national response to HIV and AIDS for the first half of 2009, the pilot cash transfer programme in Mchinji District was successful and that impact was impressive at individual, household and community levels (ITAD 2009). Among others, the SCTP in Mchinji District had resulted in ".....gains in anthropometric measurements among children; gains in school enrolment, reduction in absences and greater expenditure on education; reductions in children working outside the home; gains in use of health services; dramatic improvements in food security and food diversity; gains in asset accumulation; interruption of intergenerational cycle of poverty and important impacts on PLWHA....". (ITAD 2009). The programme was therefore being scaled up to 28 Traditional Authorities covering 218 group villages in 7 districts of Mchinji, Likoma, Salima, Machinga, Mangochi, Phalombe and Chitipa districts through funding by NAC and other partners.

A similar social cash transfer initiative is being piloted and evaluated in Zomba District by the World Bank and the University of Malawi. The Zomba Cash Transfer Program is a randomized, ongoing conditional cash transfer intervention targeting young women in Malawi that provides incentives (in the form of school fees and cash transfers) to current schoolgirls and recent dropouts to stay in or return to school (Baird S., Chirwa E., et al 2009). According to preliminary analysis of the effects of the programme, an average offer of US$10/month conditional on satisfactory school attendance—plus direct payment of secondary school fees is leading to significant declines in early marriage, teenage pregnancy, and self-reported sexual activity among program beneficiaries after just one year of program implementation. For program beneficiaries who were out of school at baseline, the probability of getting married and becoming pregnant have declined by more than 40 percent and 30 percent, respectively. In addition, the incidence of the onset of sexual activity was 38 percent lower among all program beneficiaries than the control group.

Malawi has followed up on the **Declaration of Commitment on HIV/AIDS** commitment to **support OVCs**, as expressed in Paragraphs 65-68:

> [I]mplement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counselling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;
>
> [U]rge the international community, particularly donor countries, civil society, as well as the private sector , to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV/AIDS . . .
>
> [E]valuate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to address the impact at the individual, family, community and national levels; develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods and access to basic social services, with special focus on individuals, familes and communities severely affected by the epidemic. . .

5.2 Challenges Faced in the 2008-2009 Reporting Period

There are several key challenges faced in 2008-2009 that are cross-cutting through all areas. The top three of the most prominent challenges faced are in the areas of human resources, financing, evidence-based decision making, and service uptake and provision among men and in rural areas.

5.2.1 Human Resources

One of the major challenges in the implementation of HIV and services concerns human resource shortfalls. The scale up of health services is largely impinged by a thin human resource base that is struggling to cope with an enormous workload. While task shifting approaches are being employed to abate this shortage, there are limits to how much this can be done without compromising on the quality of delivery of services.

Although support has been solicited from the Global Fund and other development partners to train, recruit and retain more health workers (doctors, nurses and clinical officers), the impact of this support had not yet started being felt as training of the first cohorts was still in progress. The recent data on human resources in Malawi

comes from the 2007 census of health workers. This census reported that Malawi had a Physician Population ratio of 1:53,176; a Nurse Population ratio of 1:2,964; a Clinician Population ratio of 1:7,959 and HSA population ratio of 1:1313 using the 2007 mid-year projected population estimates (Kadzandira, Chunga et al. 2008). While the national situation is like this, rural areas are greatly disadvantaged as most districts do not have qualified doctors and clinicians. There even lesser nursing personnel to work with doctors and clinical officers. At national level, there are 2.67 nurses for every clinician (doctor, clinical officer and medical assistant); 2.6 nurses per clinician in the northern zone, 2.4 nurses per clinician in the central east zone, 2.6 nurses per clinician in the central west zone, 2.7 nurses per clinician in the south west zone and 3.1 nurses per clinician in the south east zone. In urban areas, the nurse to clinician ratio is 3.0 to 1, 3.5 to 1 in semi-urban areas and is lowest in the rural areas at 2.0 to 1 (Kadzandira, Chunga et al. 2008).

The Ministry of Health (MoH) policy relating to implementation of the Essential Healthcare Package (EHP) stipulates that a health facility is deemed to have met the minimum staff norms if it has at least two clinicians (doctors, clinical officers or medical assistants), 2 nurses/midwives and at least 1 environmental health officer or health assistant. In 2007, only 9% of the 553 public primary health facilities (Government and CHAM) met this criteria, 5% of the 104 facilities in the Northern Region, 10% of the 198 facilities in the Central Region and 11% of the 251 facilities in the Southern Region. By ownership status (government or CHAM), of the 438 primary level facilities that belonged to government, only 9% had the minimum staff norms, 10% of the 115 CHAM facilities. In the private sector, only 1% of the primary health care facilities me the minimum staffing norms criteria.

In a study that was conducted to assess the likely effects of HIV programming on general service provision in 9 districts of the country, modest changes in the number of doctors, clinical officers or medical assistants and nurses were observed between January 2006 and January 2008 particularly in rural health facilities. This was despite the facilities registering higher levels of HIV service scale-up, including cumulative ART client volume increase of 2.7 times the levels of 2006 in 2008, which was consistent with the national trends. The study also showed widespread perceptions hinting on increased workload among the service providers, particularly those from rural health facilities.

As a short-term measure, the Government of Malawi, with the support of the Global Fund and other development partners, recruited approximately 6,000 health surveillance assistants (HSAs) in 2007 to help facilitate HIV service scale-up particularly in the rural underserved areas. All the facilities that were visited in the study had received additional HSAs between January 2006 and January 2008 with some rural health centres registering 1.5-2.4 times increases in the numbers of HSAs in the same period. As such, Task shifting of some selected HIV services is being used as a stop-gap measure while the country is still increasing its training capacity as well as developing recruitment and retention measures for the qualified health workers.

5.2.2 Financing

The Extended National Action Framework (2010-2012) acknowledges the enormous goodwill received from financing sources for the implementation of various national HIV and AIDS programmes. To enhance mutual accountability and reduce transactions costs, The Government of Malawi and development partners are implementing a pooling arrangement of HIV resources. With this arrangement, all other partners who are not part of this HIV pool are nevertheless encouraged to align with the priorities of the National Action Framework.

The NAC Grants Facility System was developed in 2003 to facilitate timely disbursement of resources to implementing partners in the National response.

Most of the financing for the national response that has been tracked in the past has largely pertained to resources disbursed through the National AIDS Commission. However, in 2009, Malawi undertook a retrospective expenditure tracking for 2007/2008 and 2008/2009 fiscal years. The results of the National AIDS Spending Assessment (NASA) have informed the finance and expenditure analysis that has been included in this report.

Challenges

1. Global Financial crisis: Since 2008 many western countries and bilateral agencies through which they channel funds have experienced reduction in budget and exercised austerity due to the effects of the global financial crisis. Although this does not yet appear to have been reflected in the funding for the years under review, it was a constant threat to pool and overall funding.
2. Delayed disbursement Due to the delayed signing of MoU between Malawi and Global Fund and also between Malawi and the World Bank, there were delays in funds disbursal which affected the efficacy of the Care and Treatment program.
3. Tracking funds going to the National Response is still problematic. A lot more resources are used by the private sector but not tracked by NAC, within its own monitoring and evaluation system or under the just concluded NASA, because most players believe their obligation to NAC only applies when they receive funding from NAC (NASA Consultative Process, 2010).

5.2.3 Evidence-Based Decision-Making

The Integrated Annual Work Plan- an operational tool for the National Action Framework (NAF)- is an example of how evidence can be used in planning and resource allocation. The Know Your Epidemic Exercise also provided the backdrop of evidence that was used in the development of the National HIV Prevention Strategy. This notwithstanding, there is still a dire need to ensure that data use is institutionalized at all levels of the national response. A more detailed discussion of this challenge and steps for the way forward appear in Section 8.1.

5.2.4 Service Uptake and Provision among Men and in Rural Areas

Service uptake for both HTC and ART in the period 2008 to 2009 continued to be dominated by females than males. Data sourced from the HIV and AIDS Unit in the

MoH for the first quarter of 2008 shows that 17,642 new clients were initiated into the ART programme and of these 6,809 (or 39%) were males whereas 10,833 (or 61%) were females. At the end of that quarter, a cumulative 159,111 had been initiated on the ART programme and females constituted 61% of all the clients ever started on ART (Mwapasa & Kadzandira 2009). Similar trends were also observed among HTC clients where females constituted 60% of all the clients. The only notable exception to this trend has only happened during national annual 1-week HTC campaigns when male participation has tended to level that of females between 2006 and 2009.

Community and district-level studies conducted in the same period have revealed that self and internalized stigma is one of the main challenges contributing to the low uptake of HIV services among males. In addition, the tendency to seek care from traditional healers, fear and shame, travel and problems with staff attitudes have also been reported to affect service utilisation especially among men (Kornfield & Chilongozi 1997). In the years to come, the government will strengthen programmes that aim at reducing the gap in service uptake between males and females including promoting and strengthening community support groups and empowering local leaders to mobilize their residents in service uptake.

As service scale continues to take shape, service provision in the period 2008 to 2009 has continued to be more urban based and is slowly but gradually transcending into the rural areas. Shortages of qualified staff, laboratories and other facility equipment are some of the major constraints against increased service provision in the rural areas. As the country continues with the scale-up process, more emphasis will be placed on bringing the services closer to people by opening more HTC, PMTCT and ART sites as well as promoting other avenues of service provision including the private sector and mobile clinics.

5.3 Actions to be Taken to Ensure the Achievement of Targets

See the Recommendations and Action Plan in Section 8.

6. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

6.1 Key Support Received from Development Partners

6.1.1 General Context: Funding Architecture

The National AIDS Commission is mandated to determine resource requirements for the national response; to mobilise those resources, whether from GoM and development partners; to ensure rational and efficient allocation of those resources across strategies and partners; and monitoring and reporting on resource utilisation. Every implementing partner is encouraged to raise additional resources, either from development partners or locally.

Funds flow through the national response primarily through four routes: First is through voted expenditure. The GoM National Budget covers most of the basic infrastructure and human resources for implementation in the public sector response. Second, resources are pooled into the NAC Pool Fund, which a harmonized pool of primarily donor funding that is is allocated annually for implementation of the NAF through the Integrated Annual Work Plan (IAWP). Oversight and accountability is through NAC to OPC, via quarterly, bi-annual and annual reports. Third, are resources from the Health SWAp Pool Fund. The logic underlying the SWAp is that the Government of Malawi will contribute at least 11% of its domestic resources to the health sector and that all pool funding from donors and other sources will be additional to this Government contribution. Finally there is direct funding to implementers from discrete donors or other funding sources. While NAC receives funding from discrete donors, namely UNDP and CDC which support implementation of the IAWP, other donors provide direct funding to implementing agencies and NAC is not accountable for these funds

6.1.2 Role of Development Partners

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 against AIDS, Tuberculosis and Malaria, the Kingdom of Norway and World Bank. Some development partners are not able to pool funding, but also align their discrete support to the national priorities (the NAF) 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/AIDS in Malawi fully with the extended NAF in order to implement the goals, objectives, strategies and action points of the NAF. It is expected that the NAF and the IAWP/NOPs, will become the frameworks within which all partners and their resources can be fully harmonized and aligned within an effective national response.

In order to ensure coordinated and effective national response, in 2005 the Malawi Partnership Forum was constituted with membership drawn from the Public Sector

Steering Committee, Parliamentary Committee on HIV and AIDS, Nutrition, HIV and AIDS (OPC), line ministries, Uniformed Forces, Malawi Global Fund Coordinating Committee, Health Sector Review Group, PLHIV network (MANET +), Private Sector (MBCA), Civil society - MANASO (Local NGOs and CBOs), International NGO forum, Malawi Interfaith AIDS Association (FBOs), Media (NAMISA), Academia/ research, National Research Council, University of Malawi and other tertiary institutions, Development partners and Chairpersons of TWGs serves as an advisory body to the National AIDS Commission. The partnership structure serves as a systematic coordination mechanism that minimises wasteful duplication of efforts for scaling up of the national response to HIV and AIDS, while supporting the clear leadership and coordination mechanisms of the NAC (.

A notable achievement of MPF was a retreat held in September 2008 which reflected on their performance, reviewed responsibilities and linkage to the technical working groups. The reflection meeting resulted in a review of the TOR for the MPF in order to enhance its effectiveness, identify local resource mobilisation strategies for the national response to HIV and AIDS and replicate the structure of MPF at the Local Assembly level.

Due to delays in funding from the Global Fund, in 2008/09 the NAC budget targets were revised downwards from US$121.5n to US$74mn. As such the actual receipts of funding from partners of US$86.8mn was 17% higher than the revised budget and the preceding year's receipts but lower than the original budget for 2008/09. The bulk of this money was from the Global Fund (US$77.9mn or 89%) followed by DfID at US$3.5 million and Kingdom of Norway at US$2.2 and GoM contributed US$1.5. Also noteworthy was the World Bank for which resources were budgeted at US$8.2 million but the actual receipts were only US$0.7 representing 9% of the budgeted funds and way lower than the previous year's funding of US10.7 million. This delay was largely attributable to the inability of Government of Malawi and the Bank to agree on a new grant programme. The late disbursal of these funds and the resulting carry over, explains the discrepancy between resources tracked under NASA and what NAC received over the reference year.

Receipts from DP	2008/09		2007/08	Performance	
	Budget	**Actual**	Actual	A vs B	Yr on Yr
	US$m	**US$m**	US$m	%	%
Global Fund	92.1	**77.9**	63.2	85%	123%
World Bank	8.2	**0.7**	10.7	9%	7%
Norway	3.0	**2.2**	2.7	73%	81%
DFID	3.9	**3.5**	4.0	90%	87%
GoM	2.0	**1.5**	2.0	75%	75%
UNDP	0.6	**0.3**	0.4	50%	79%
CDC	0.7	**0.7**	0.3	100%	280%
TOTALS	**110.5**	**86.8**	**83.3**	79%	104%

Source: NAC, The Independent Review Of Malawi National Response To HIV And AIDS For Fiscal Year 2008 – 2009, ITAD.

6.1.3 Financing the National Response

This UNGASS report comes against a backdrop of the global financial crisis. Although Malawi seems to have escaped the brunt of the first round of the financial crisis, it is not yet clear if the global economic crisis will have an impact on HIV and AIDS funding. A major challenge faced by NAC has been the delayed availability of resources from the development partners which resulted in delayed disbursement to partners and slowed down implementation of activities with near disastrous consequences for ART. Although the budget for the MoH's HIV responses is one sixth of the entire budget of the MoH, the ARV programme is heavily dependent on donor funding mainly from the Global Fund. Procurement for the HIV programme amounts currently to US$3 million per month, including treatment for opportunistic infections, drugs for STIs and HIV test kits. One of the factors that affected the implementation of some key programmes in the MoH was the protracted negotiation process between the Government of Malawi and GFATM which resulted in delays in approval of Rolling Continuation Channel. The Ministry of health reported stock outs for HIV test kits and alternative 1st line regimen and the programme resorted to redistribution of drugs between clinics (NAC, Independent Review of Malawi Response, 2009).

Section 3.2.1 demonstrated that although Malawi has done well in mobilising resources, these are far from adequate for achieving universal access. A costing exercise for the extended NAF also suggests that going forward the Malawi's ability to mobilise resources may fall short of the financing required for the national response. These estimates suggests that between 2009/10 and 2012/13 the National response will need about US $827 million over three years (or about US$275 million per year). However, the best case scenario, Malawi and her development partners can only raise slightly over to half of that amount (US$452), of which funds going through NAC should total $243 million over the 3 years while other sources will contribute $209 million. These other sources include US Government contribution at $128 million; UN "One Program" $39 million; GFATM to MoH for Health Systems Strengthening $17 million; and 7 INGOs totalling $25 million.

This analysis is likely to understate the total resources available for HIV and AIDS but also overstate the share channelled through NAC due to inability to track all resources going to INGOs, funding and gifts in kind given to local NGOs, CBO and FBOs and spending by the Ministry of Health and other ministries from their voted expenditure including the 2% of ORT, and contribution by the private sector.

6.1.4 AIDS Funds Management

In terms of mobilisation and channelling of funds, the share of funds for HIV and AIDS related programmes going through the National AIDS Commission has increased in recent years from 19 % in 2005/06 to about 54% by 2009 [MoH, 2007; NAC, Independent Review of National Response, 2009]. A summary of the dynamics surrounding these funds has been discussed in section 3.2.1

6.2 Actions Necessary to the Achievement of UNGASS Targets

Malawi has set an excellent example for other countries in the areas of harmonization and alignment with HIV Pool funding and a Health Sector Wide Approach (SWAp) arrangement. Tremendous efforts have been made by the government and development partners to bring about these pooled funding arrangements. This has enabled a reduction in transactions costs of doing business since the partners in the Pool are bound by a Memorandum of Understanding requiring common financing, procurement and reporting arrangements. Notably, there has not been much of a problem with territorialism among the major development partners. Overall, pooling has allowed the country to focus on a common agenda for HIV programmes and encouraged a spirit of mutual accountability. In the end, all partners are able to claim the success of having worked together in a more productive manner.

The national response to HIV has gone a long way to foster lasting partnerships amongst the various structures and layers. This has enabled greater alignment and harmonization with government and within the donor community with resultant effect of leveraging efficiency. However, some players are still acting outside the 'three ones' and this poses a serious threat to the long term sustainability of the partnerships and the response.

The "Three Ones" are preached within countries, but unfortunately not always adhered to by the agencies at a global level. It would be even more helpful if there was alignment amongst the agencies at a global level, and if various international NGOs were obliged to align as well. We would be able to conserve a much greater proportion of our resources if planning, reports, and audits were not done in a duplicative manner, but done right the first time, for all to see!

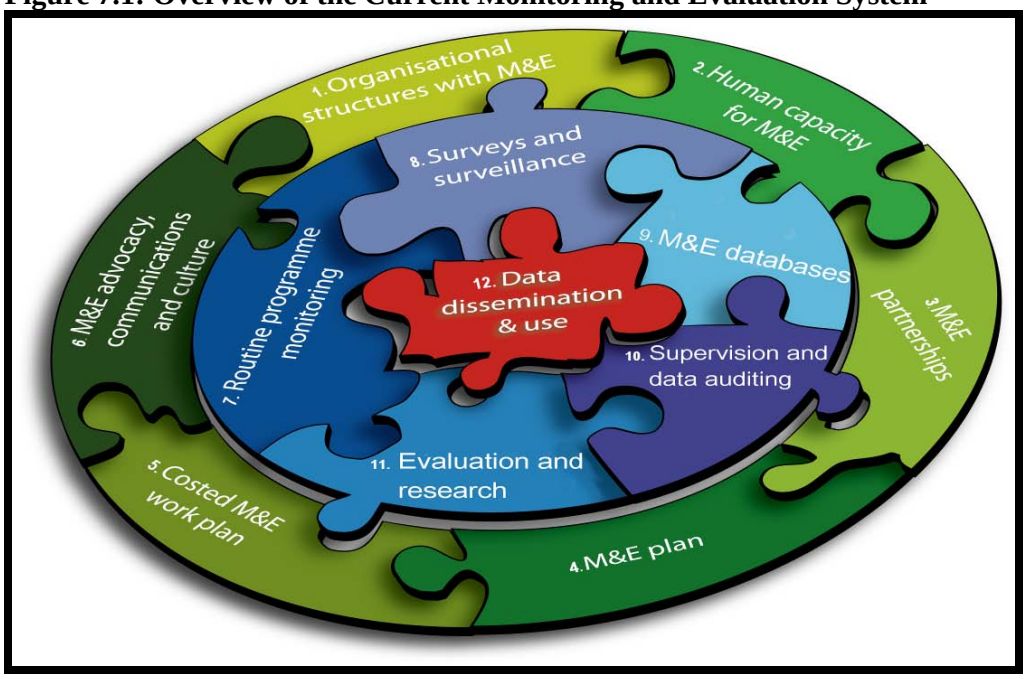
As a next step, if donors could put additional emphasis on building the necessary planning capacity at a national level for sustainability plans, that would be very useful. As one aspect of this, skills and tools for how to make the business case for investment in health would be very useful (Extended NAF: 2010-2012; Independent Review: 2008-2009).

7. MONITORING AND EVALUATION ENVIRONMENT

7.1 Overview of the Current Monitoring and Evaluation System

To structure the overview of the current Monitoring and Evaluation (M&E) System, 12 components of a Functional M&E System, as depicted by UNAIDS in the diagram below have been utilised.

Figure 7.1: Overview of the Current Monitoring and Evaluation System



Source: Adopted from Organizational Framework for a Functional National Monitoring & Evaluation System

7.1.1 Organizational Structures with M&E

All key providers of data in the national response have M&E units or focal persons responsible for reporting on key information in the national response. The Ministry of Development Planning and Cooperation (MDPC) is the lead Ministry in the implementation of the National M&E System which aims at tracking implementation of the Malawi Growth and Development Strategy 2006-2011. Sectoral M&E systems are the responsibility of respective sectors. In the spirit of the 'three ones', the National HIV M&E system, which is a subsystem of the comprehensive national M&E system is coordinated by the National AIDS Commission, with oversight from the Department of Nutrition HIV and AIDS under the Office of the President and Cabinet.

7.1.2 Human Capacity for M&E

The National AIDS Commission has over the past two years expanded its M&E team to four personnel which is complemented by a Research Officer. The Department of Nutrition HIV and AIDS under the Office of the President and Cabinet has a functional Planning, Monitoring, Evaluation and Research Unit that oversees implementation of the M&E system. The Ministry of Health, responsible for the biomedical response to HIV has a Central Monitoring and Evaluation Division. Additional programmatic data is provided by the Directorate of HIV whilst surveillance efforts are largely undertaken by the Epidemiology Unit in the Ministry of Health. Generally, all key providers of data, both at national and sub national levels have trained M&E officers as well as data entry clerks.

7.1.3 M&E partnerships

Monitoring and Evaluation issues oversight is provided by a Monitoring, Evaluation and Information Systems Technical Working Group that meets on a quarterly basis to discuss key M&E agenda in that quarter. Health sector M&E is also guided by a Monitoring and Evaluation TWG. Besides information sharing, these TWGs also foster networking amongst key providers of strategic information in the various sectors.

7.1.4 National M&E Plan

The National Monitoring and Evaluation Plan was developed in 2003 in order to provide progress in the implementation of the Malawi National Action Framework. The Plan underwent a revision in 2006 to take into account emerging changes with respect to decentralization and the need to incorporate data quality tools. The National Action Framework (2005-2009) has undergone revision and extension to 2012 with special consideration in aligning it with the Malawi Growth and Development Strategy (MGDS) (with the exception of the timeframe) which is the overarching development blueprint for Malawi. This change necessitates that the M&E Framework be reviewed and revised in 2010.

7.1.5 Costed M&E Plan

Whilst all M&E activities undertaken by NAC are costed and included as part of the Integrated Annual Work Plan, plans are to have a broader national response inclusive ‘road map’ for implementing the national HIV M&E agenda in the country as part of the planned comprehensive review of the M&E Plan in 2010.

7.1.6 M&E Advocacy, Communications and Culture

Greater attention is aimed at ensuring that M&E is prioritized and that evidence based decision making is the hallmark of programme planning and delivery. Advocacy for M&E is done through the M&E Technical Working Group, Joint Annual Review meetings as well as Annual Research and Best Practice Conferences.

7.1.7 Routine Programme Monitoring

Programme monitoring for HIV is done through the Local Authority HIV and AIDS Reporting System (LAHARS) that essentially populates district wide data from the social and non biomedical subsectors. Health sector HIV and AIDS data is collected through the Health Management Information System which is a key data source for the National HIV and AIDS M&E Plan. Key data on logistics and supplies is captured through the Logistics Supplies Information System. It should be mentioned that migration from the NAC Activity Reporting System (NACARS) to the LAHARF has just occurred in the last six months and efforts are being invested at ensuring that the uptake of the system is as accelerated.

7.1.8 Surveys and Surveillance

Outcome and Impact Indicators are mostly collected through surveys both behavioral and biomedical surveys and surveillance. Key behavioural indicators are collected through the Demographic and Health Survey that is implemented every four years as well as the Behavioural Surveillance Survey that is conducted every two years. Key trends of impact are largely collected through the Antenatal Surveillance of HIV and Syphilis that is undertaken every two years. Owing to a national population and housing census that was conducted in 2009, all the foregoing surveys and surveillance activities are due to be undertaken in 2010.

7.1.9 M&E Databases

Routine HIV and AIDS data is maintained in a database at National Level for national reporting whilst each district also maintains a similar database for district reporting.

7.1.10 Supervision and Auditing

Supervision to key providers of data is undertaken every quarter using for a checklist designed for that purpose. A Data quality framework was developed as part of the revision of the National M&E Plan and focus in the year was to build capacity of major providers of data on the essence of quality data. Major data quality audit exercises are planned to be undertaken in the second quarter of 2010. Quality assurance of HIV programmatic data (especially ART) is done through quarterly supervision visits undertaken by the Ministry of Health's Directorate of HIV to all key service delivery points.

7.1.11 Evaluation and Research

Internal reviews of programmes are undertaken at the end of every programme and Independent Review of the National Response to HIV is conducted every year. A National Research Strategy that guides implementation of priority research in the national response came to an end and plans are that it should be reviewed in 2010. Dissemination of key research findings is conducted every year during an Annual Research conference that is organized for that purpose.

7.1.12 Data Dissemination and Use

Data is disseminated through quarterly zonal/regional workshops that are targeted at key providers as well as users of information. Information Products are also placed in the Resource Centers and disseminated during Joint Annual Review Conferences. Usage of data in programmes is evident in setting of milestones for the Integrated Annual Work Plan which operationalises the National Action Framework (NAF). The development of the National HIV Prevention Strategy heavily benefited from a robust assessment of the Malawi HIV epidemic that was conducted through the Know Your Epidemic Exercise. Usage of the Sentinel Surveillance as well as results from population based surveys in planning processes is not uncommon. HMIS as well as other health sector programmatic data are also used for assessing the performance of the Health SWAp. However, more work needs to be done to ensure that data use is institutionalized at all levels of the national response.

7.2 Challenges Faced in the Implementation of a Comprehensive M&E System

7.2.1 Alignment with the National M&E System

Whilst the National HIV M&E System is fully aligned with the National M&E System, over the years, there has been a proliferation of M&E plans that are not in sync with the National HIV M&E Plan and do not therefore provide the necessary inflow of data. This is compounded by the fact that some providers of data view NAC as a grant making body and hence leave the task of alignment only to those institutions that have benefitted financially from this system.

7.2.2 Data Quality

HIV and AIDS reporting is compromised by issues of incomplete reporting and late reporting. This is symptomatic of M&E capacity gaps at all levels of the national response. The IRT (2009) proposes joint meetings between NAC and MDPC on the operations of the Local Authority HIV and AIDS Reporting Form (LAHARF) as one way of addressing data quality challenges at the local level.

7.2.3 Human Resources for M&E

Notwithstanding the fact that organisations have established M&E structures, the national M&E system is largely affected by staff turnover and difficulties to attract qualified M&E personnel especially at sub national level where most of the data originates.

7.3 Actions that Need to be Taken to Overcome the Challenges

Dialogue amongst the various players in the national response has gone a long way in improving reporting even amongst entities that do not access funds form NAC.

Further improvements are anticipated once the proposed HIV bill is enacted since it will give NAC a full legal standing.

Continuous M&E Capacity development should continue so as to ensure that a critical mass of M&E Personnel is created as a way of addressing gaps in reporting. Data quality training as well as data quality audits should be institutionalized.

All possible opportunities should be utilized to drum up support on the 'three ones' principle as a way of rallying partners around reporting on the national response to HIV.

7.4 M&E Technical Assistance and Capacity-Building Needs

A discussion is included in the Recommendations in Section 8 of the Report. See the NCPI in Annex 2 for more detail.

8. RECOMMENDATIONS

8.1 Overview of Key Findings and Recommendations

8.1.1 Introduction

The Key Findings and Recommendations for the Way Forward which appear throughout this Section of the Report and are summarised in Section 8.2 were cleared through an extensive vetting process. Only recommendations which emerged as key themes from all levels (including High-level policy makers, implementers of services, and users of services) and from both Government and Civil Society were able to advance through the vetting stage of analysis to appear in the Report.

The NASA/UNGASS Task Force and a high number of high-level policy makers, implementers, and users of services who took part in the process of developing the UNGASS report asked for the report to be simple, practical, and to contain recommendations that are actionable. People asked for a way forward that contained not just what should be done, but how to do it and who should lead the process.

Many high-level policy makers, implementers, and users of services expressed a very strong point in common: They want to take a human rights-based approach to public health and asked that this report detail guidance on how to best do this. For instance, policy-makers and even communities brought to the forefront some emerging national issues like Men who have Sex with Men, which have always been occurring here but are just recently being talked about more in public arenas and recognised as populations that need quality services, as well. Requests for specific guidance on the following issues were heard repeatedly: Men who have Sex with Men, Sex Work, Male Involvement, Prevention, and Quality of Services.

In response to these requests, this section addresses these areas and a table has been included at the beginning of Section 8.2 clearly outlining how to use a human rights-based approach to public health to most effectively and quickly achieve Universal Access. The Way Forward recommendations throughout Section 8 come from an extensive process of consultation with policy-makers, implementers, and users of services, and a review of best practices. In the section below, successes are highlighted, remaining gaps are discussed, and the way forward is clearly defined.

There is need for more discussion among stakeholders to identify the best way to operationalise the approaches and action steps outlined in the two tables in Section 8.2. Such discussion will help in more fully incorporating these issues in the regular meetings held by Technical Working Groups at a national level and in progress review meetings by various entities at all levels.

8.1.2 Laws, Policies, and Strategies

Draft HIV Bill

Success

There is enormous success to report in the area of HIV-related laws, policies and strategies. An HIV Bill has been drafted in response to gaps identified in the legal framework related to HIV. This draft bill was released to the public in the form of the Report of the Law Commission on the Development of HIV and AIDS Legislation in December 2008.

Successes in the Drafting of the HIV Bill

The Draft HIV Bill addresses many crucial issues, including the establishment of the National AIDS Commission as an independent State institution with its attendant functions and duties related to the coordination and facilitation of the national response to HIV and AIDS.

One of the strengths of the Draft Bill is that it references to the right to health, the right to human dignity, the right to non-discrimination, the right to privacy, the right to education, and the rights of children and women as stipulated in the constitution. These are rights which belong to all people. The Malawi Human Rights Commission has noted that in the Draft Bill gender is taken into consideration with references to constitutional and treaty obligations, including CEDAW and the MDGs. The discrimination on the basis of actual or perceived HIV status is prohibited.

Gap

While much time and effort has gone into the drafting of the bill, throughout the UNGASS consultative process, respondents raised the concern that some serious human rights implications of various elements of the bill have not been fully considered. There is an urgent need for a careful review of these areas and key revisions and clarifications before passing the bill into law (UNGASS Consultative Process, 2009-2010). This finding was very prominent throughout the UNGASS and NCPI analysis and has also been independently raised by the Malawi Human Rights Commission and the MANET+ in presentations recently made to the Members of Parliament, calling for critical revisions to address human rights concerns prior to the tabling of the bill.

The Position of the Malawi Network of People Living with HIV and AIDS on the Draft HIV Bill

MANET+, the coordinating and facilitating umbrella body of national PLHIV organizations in Malawi made a presentation before Members of Parliament in February 2010, stating the position of People Living with HIV in Malawi as follows:

- The PLHIV sector supports the Bill as it believes it will go a long way to reduce the spread of HIV and mitigate the impact of HIV & AIDS
- Critical issues that were raised during the consultation process were not incorporated in the Draft Bill hence there are areas of concern
- PLHIV sector proposes further consultations on these issues of concern before the Draft Bill is tabled in Parliament

The Malawi Human Rights Commission has summarised the aim of the HIV law development as being to review "all the laws of Malawi that have an impact on the HIV and AIDS pandemic and develop a law that would take into consideration the provisions of the constitution of the Republic of Malawi and any other written laws of Malawi that have an impact on HIV and AIDS, and Malawi's obligation under international and regional conventions, treaties, protocols on HIV and AIDS."

The Malawi Human Rights Commission Calls for Revision of the Draft HIV Bill

The Malawi Human Right Commission has called for revision of the Draft HIV Bill in an official presentation to the Members of Parliament. The Commission has clarified that the Draft Bill is a proposed Draft Bill and can still be altered to be more in line with human rights commitments, stating that:

- In some cases, legislation has been helpful and proactive in addressing some of the factors, be they structural or individual, which sustain or fuel the epidemic. In other cases, sadly, legislation has perpetuated or even compounded the problem.
- It is therefore imperative for Malawi to ensure that the proposed HIV and AIDS legislation will contribute to the two overarching goals in the HIV response; that of the promotion and protection of public health as well as the promotion and protection of human rights espoused by international best practice.
- Most importantly Malawi should not retrogress on the progressive efforts that it has attained this far manifested through the HIV and AIDS related policies in place and a number of laws that have been revisited or enacted with a view to effectively responding to the epidemic.
- While the draft Malawi HIV and AIDS law represents a positive step, the elements in the law highlighted in this report as undermining the draft law's progressiveness call for reconsideration and revision with a view to aligning them with human rights principles and norms.

A list of the resources the Commission has pointed to in order to provide clarification on treaty obligations and best practices in relation to the need to revise the Draft HIV Bill appears in Section 8.2.1 of this Report.

The Malawi Human Rights Commission summarised why integrating a human rights approach in the Response to HIV and AIDS is crucial in the following manner:

- Human rights violations have been recognized as a factor that fuel the spread of HIV and AIDS (e.g. gender inequalities, domestic violence, gender-based violence, harmful cultural practices).
- On the other hand, persons living with HIV and AIDS are largely vulnerable to various human rights abuses such as stigma and discrimination, inequitable access to and interaction with health services including those related to care and treatment, and generally violations of the right to human dignity (confidentiality, privacy, personal autonomy, bodily integrity and reproductive self determination).
- Since the beginning of the epidemic, it has become apparent that every effort must be made to empower people to protect themselves from HIV infection, and if infected, to continue to live productive lives.
- To protect themselves from HIV infection and to live successfully with HIV if infected, people need four things:

  - Access to HIV information and education on how to avoid infection, or re-infection;
  - Access to HIV prevention commodities and services;
  - Social support to encourage and sustain behaviour change; and
  - A social and legal environment that enables people to practice or negotiate safe sex and otherwise take precautions to protect themselves against infection; protects people from discrimination and sexual violence; and ensures access to treatment, care and support, if infected.
- All these are human rights issues.

The negative effects of **discriminatory policies and breaches to confidentiality** are recognised in Paragraph 13 of the **Declaration of Commitment on HIV/AIDS**:

> Noting further that stigma, silence, discrimination and denial, as well as a lack of confidentiality, undermine prevention, care and treatment efforts and increase the impact of the epidemic on individuals, families, communities and nations and must also be addressed

While the Law Commission has completed the initial report on the Draft HIV Bill, the Cabinet can now hold consultations and/or commission for changes to be made in process of adopting the bill before it is tabled in Parliament. The Government stance expressed in the National UNGASS Report Validation Meeting is that the draft bill is not final and that the remaining issues are issues of semantics and will be changed (National UNGASS Report Validation Meeting, 2010).[18]

Action:

Review the Draft HIV Bill, Make Necessary Changes, and Pass the Bill

Deep concerns and reservations were expressed throughout the entire UNGASS report development process by a number of Key Informant Interviewees and Focus Group Discussion Participants regarding some aspects of the Draft Bill from a human rights standpoint. While there is much anticipation regarding the passing of the bill, respondents indicated that it is imperative that these issues be re-visited and resolved prior to the enactment of the legislation (UNGASS Consultative Process, 2009-2010).

[18] Sources:

Legislation on HIV and AIDS: Some Thoughts on the Malawi Proposed Law. Presentation to the Honorable Members of Parliament by the Malawi Human Rights Commission. 10th February 2010.

Malawi Network of People living with HIV & AIDS (MANET+) Presentation to Honorable Members of Parliament. 10th February 2010

Key Outcome of the UNGASS Consultative Process: 2009-2010, Regarding Draft Legislation:

Malawi has the **potential** to put forward a **model law on HIV and AIDS if**

certain areas of the **draft bill** where there are **human rights concerns** can be **revised** and **clarified:**

- Pregnant Women and Their Sexual Partners should be encouraged, but not forced to have an HIV test.
- Proper counselling and support should be available to Children under the age of 13 who seek HIV testing and counselling without the consent of their guardian, and they should be allowed to access this service even if they request to do so without their guardian.
- Domestic Workers should not be forced to have an HIV test.
- Men who have Sex with Men should be provided with the same level of quality of prevention, treatment, care, and support as any other segment of the population and should not be discriminated against.
- Sex Workers should be encouraged, but not forced to have an HIV test and should be treated with the same level of respect as any other user of health services.
- A health service provider should not disclose any person's Status to their partner without their consent.
- The Transmission of HIV should not be criminalised.

The draft HIV bill does contain a chapter on Human Rights (Chapter 3). However, there are some concerns regarding sections of the draft bill which contradict this chapter. For example, provisions for forced testing of pregnant women and certain professions. In addition, since the HIV bill seeks to provide clarity on HIV-related issues where there has been confusion, it would be a pity if this ended up being a missed opportunity to provide explicit clarity on the fact that it is perfectly legal, and in fact an obligation, of health care professionals to provide quality services to all without discrimination, including to most-at-risk populations and vulnerable groups, such as Men who have Sex with Men (UNGASS Consultative Process, 2009-2010).

The Declaration of Commitment on HIV/AIDS states that:

> Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS.

The importance of **enacting laws that eliminate all forms of discrimination** against people living with HIV and members of vulnerable groups (Men who have Sex with Men, Sex Workers, Domestic Workers, Young People, etc.) is recognised in Paragraph 38 of the Declaration of Commitment on HIV/AIDS in the commitment to:

> [E]nact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic

Pregnant Women and Their Sexual Partners

The current draft of the HIV Bill mandates compulsory testing for both pregnant women and their sexual partners. This raises a number of human rights concerns. At present, the PMTCT policy states that women should be encouraged to test, and given counselling to understand the benefits of testing, but should never be forced to test. However, in some areas, this policy has not been implemented in a quality assured manner. Where there has been perceived or actual mandatory testing and local level for pregnant women, it has discouraged women from seeking medical services. Women who were too scared to go for a test, avoided the ANC clinic and the hospital out of fear that they would be forced to undergo an HIV test. Thus, mandatory testing actually has the opposite of the intended effect. Instead, women and their partners should be encouraged but not forced to take an HIV test, and given many opportunities to understand the benefits to themselves and their baby (UNGASS Consultative Process, 2009-2010).

The Malawi Human Rights Commission has noted that compulsory HIV testing is likely to drive people away from health services and increase stigma and discrimination. This was also expressed by respondents in the UNGASS consultative process.

Consider amending by removing the following instances from the list of permissible instances of compulsory testing in the Draft HIV Bill (page 95):

- "For commercial sex workers"
- "For persons intending to enter into polygamous unions"
- "For pregnant women and their sexual partners or spouses"

Children

The Draft HIV Bill states that minors under the age of 13 must have a parent or legal guardian's consent for testing. However, at the age of 12 and younger, children are already learning about HIV in school. For those children who are being abused by their guardian, it may be very difficult for them to get their guardian's consent to have an HIV test. Therefore a provision should be made for children who seek HIV testing and counselling without the consent of their guardian. Meanwhile, according to the original intent of the Bill, children should be protected from any form of coercion into testing and should be provided with adequate support before, during, and after receiving HIV testing and counselling (UNGASS Consultative Process, 2009-2010).

Consider amending by adding clarity to number 14. in Part VI of the Draft HIV Bill (page 94):

- "Proper counselling and support should be available to Children under the age of 13 who seek HIV testing and counselling without the consent of their guardian, and they should be allowed to access this service even if they request to do so without their guardian."

Domestic Workers

The Draft HIV Bill allows for pre-employment HIV testing for Domestic Workers. Mandatory testing for the purposes of pre-recruitment is otherwise outlawed in Malawi. This proposed step of screening Domestic Workers for HIV would further marginalise and invite abuse on an already vulnerable group in Malawi (UNGASS Report Validation Process, 2010).

Consider amending by removing the following provision allowing pre-employment HIV testing from the Draft HIV Bill (pages 97-98):

- "For purposes of assessing the health status of a domestic worker"

Men who have Sex with Men

Globally, there are populations that have a higher prevalence of HIV. These are called Most-at-Risk Populations and include Men who have Sex with Men and Sex Workers. The National HIV Prevention Strategy of the Republic of Malawi: 2010-2013 has identified Men who have Sex with Men and Sex Workers as Most at Risk Populations in Malawi, alongside Long Distance Truck Drivers, Secondary and Primary School Teachers, Police Officers, Estate Workers, Fishermen, Male Vendors, and Female Border Traders.

It is widely understood to be illegal in Malawi for men to have sex with men. There is hesitancy and concern amongst many HIV service implementers that if they serve this population, they may be acting illegally, since the Penal Code criminalises "carnal knowledge against the order of nature", widely understood to mean sodomy, which is anal sex (National Government and Civil Society NCPI Validation Meetings, 2010).

> Since the HIV bill seeks to provide clarity on HIV-related issues where there has been confusion, it would be a pity if this ended up being a missed opportunity to provide explicit clarity on the fact that it is perfectly legal, and in fact an obligation, of health care professionals to provide quality services to all without discrimination, including to most-at-risk populations and vulnerable groups, such as Men who have Sex with Men and Sex Workers (UNGASS Consultative Process, 2009-2010).

In the National NCPI Validation Meetings, representatives of the Law Commission, the Ministry of Health, and a number of other government and non-governmental entities in Malawi agreed unanimously that a human rights-based approach should be taken to public health and that Men who have Sex with Men should not be discriminated against in any public health matters. Moreover, they agreed that this is a legal stance and an obligation for health professionals, as their duty is to provide health services to all people without discriminating. However, they added that there is a great degree of confusion on this issue amongst providers of services and that this clarification needs to be made known to all to put to rest their fears (National Government and Civil Society NCPI Validation Meetings, 2010).

Section 20 of the Constitution of Malawi states that everyone is equal under the law and that no one can be discriminated against on the basis of a number of factors, including "any other status." The Law Commission has clarified that "any other status" is an expansive category, including on whatever grounds someone might be discriminated against. The Law Commission has indicated that "any other status" should not be limited and is meant to take care of issues not foreseen, because the law should be general enough to apply yesterday, today, and tomorrow. For instance, the issue of Men who have Sex with Men is an emerging issue but even so, it is covered in "any other status" (UNGASS Consultative Process, 2009-2010).

The Malawi Human Rights Commission further emphasised that the Constitution is the supreme law of the land. The sodomy clause from the Penal Code, which was

brought over from England during colonial times contradicts Section 20 of the Constitution of Malawi. In such cases where there is a contradiction, the Constitution would prevail, which states that there should be no discrimination. The Penal Code clause criminalising sodomy is thus deemed null and void, because it goes against the Constitution, which is the supreme law of the land (UNGASS Consultative Process, 2009-2010).

As one respondent explained, "People have many different personal views regarding same-sex relationships, but because sex between two consenting adults is a private matter and does not harm anyone, there is no reason to retain this law from the penal code that was inherited from our colonial masters." A number of other respondents expressed a similar frustration, "If people are practicing MSM and it is not harming anyone, then it is senseless to have it be illegal. This just diverts police and court resources to an unnecessary issue, and creates a major obstacle to a segment of the population being able to access health services" (UNGASS Consultative Process, 2009-2010).

Although the Constitution reigns supreme in this matter with its declaration that there should not be discrimination based on "any other status", which includes Men who have Sex with Men, the lack of explicit mention of this group allows for confusion to continue on this matter. Implementers become immobilised, unsure of how to best serve Most at Risk Populations and Men who have Sex with Men become afraid to seek health services (National Government and Civil Society NCPI Validation Meetings, 2010).

It has been strongly recommended in the Key Informant Interviews, Focus Group Discussions, and during the NCPI Validation Meetings that the HIV bill and HIV policy provide clarity on this issue so there is no room for confusion (UNGASS Consultative Process, 2009-2010).

Consider amending by <u>adding clarity</u> to Part IV. Prohibition of Discrimination of the Draft HIV Bill (pages 91-92):

- "As stated in Section 20 of the Constitution of Malawi, discrimination based on any status is prohibited. 'Any other status' encompasses most-at-risk groups, and vulnerable populations, including Men who have Sex with Men and Sex Workers."

<u>Sex Workers</u>

The Draft HIV Bill proposes that Sex Workers may be subject to compulsory testing. While the intent behind this is certainly a positive one, to identify and treat infection, the implications are quite worrisome. While in some areas, quality health care services are being provided to Sex Workers in a trusting environment, many Sex Workers find it difficult to access health services due to the stigma. If HIV testing become compulsory, it is likely that these Sex Workers will go even deeper

underground and have even less access to treatment. The compulsory testing could be subjected on women based on the mere suspicion that they are a sex worker or based on false accusations. Rather than encouraging open dialogue and voluntary disclosure, this would bring about an era of greater secrecy and fear (UNGASS Consultative Process, 2009-2010).

There is already a widespread misunderstanding of the law regarding sex work. The Law Commission clarified that the Penal Code only criminalises living off the proceeds of sex work, which is understood to mean running a brothel. Therefore, Sex Work itself is not criminalised. However, the police often arrest Sex Workers using the rogue and vagabond charge, accusing them of loitering aimlessly in the night. Legally, to arrest someone on this charge, there must be suspicion of criminal activity, loitering for criminal purposes, with intention to commit offence. Since Sex Work is not an offence, the police often arrest Sex Workers illegally (UNGASS Consultative Process, 2009-2010).

Many Sex Workers report being illegally arrested and raped by police, sometimes even on the way to the police station. They feel they have no recourse when this happens. They feel they are at the mercy of the police because the police are the authority. It is very important for people to understand their rights and for the police and the general population to have a thorough understanding of the law. The Constitution of Malawi has already clearly stated these rights, declaring that no one should be discriminated against. Because there is confusion amongst HIV service providers regarding their ability to legally provide quality HIV prevention, treatment, care, and support to the Most at Risk Populations of Sex Workers and Men who have Sex with Men, as well as other vulnerable groups, it would be helpful if the HIV Bill gave clarification on this matter (UNGASS Consultative Process, 2009-2010).

<u>Partner Notification</u>

The Draft HIV Bill proposes that health service providers could notify someone's partner of their HIV status if they feel the person will not do it themselves and if they tell the person they are going to notify their partner. If enacted into law, this policy of involuntary partner notification could significantly hamper progress made in voluntary HIV testing and counselling in recent years. If a person knows that their results might be shared with their partner against their will they are much less likely to go for a test. Instead, we should be encouraging and supporting people in the process of coming to terms with their status and voluntarily telling their partner (UNGASS Consultative Process, 2009-2010).

Consider amending by <u>removing</u> provisions 2a and 2b in Part V. of the Draft HIV Bill (page 92-93) and replace with the following clarification:

- "A health service provider should not disclose any person's status to their partner without their consent."

Criminalisation of HIV Transmission

The Draft HIV Bill proposes criminalisation of the transmission of HIV. Criminalising the transmission of HIV creates a disincentive to be tested, because if a person knows their HIV status, they can be held liable for transmitting HIV to someone, but if they do not know their status, they will not be held liable. Instead, we should all be behaving as though every person is positive and protecting ourselves accordingly. In fact, what should be and is criminalised is rape. If sex is in any way forced on someone, then that is rape. In fact, if two people express that they want to have sex with each other, and one person says they want protection, but the other forces them to have it without protection, that is also rape, because some aspect of that sexual interaction was forced and not consensual. It is these aspects of forced sex that should be and are criminalised. This should be clarified in the bill rather than criminalising the transmission of HIV (UNGASS Consultative Process, 2009-2010).

In fact, it was noted during the National UNGASS Report Validation Meeting that the original intent during the formation of the Draft Bill was to punish those who rape a child and knowingly pass on HIV to them, but that the end result has been phrasing which criminalises the transmission of HIV in general in the Draft HIV Bill. In a presentation made recently to Members of Parliament regarding the Draft HIV Bill, the Malawi Human Rights Commission stated:

> Existing criminal law for Malawi can capture incidences of willful or negligent transmission/exposure e.g. offences of murder and manslaughter, (209, 208) assault (137, 254) (where the act leads to exchange of bodily fluids) criminal recklessness (247), rape, defilement (132, 134, 138, 139) HIV transmission as an aggravating factor in sentencing. Consider the UN guideline obligating states to review and reform criminal laws to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV and AIDS.

Consider amending by removing the criminalisation of HIV transmission in Part X of the Draft HIV Bill (page 101-102)

8.1.3 Policies and Strategies

Success

Many great strides have been made in the past two years in the realm of frameworks, policies, and guidelines in Malawi. The Extended National Action Framework for HIV (2010-2012) has been developed. The current National AIDS Policy is also undergoing a review which is currently in the analysis stage and thus is not available for comment (UNGASS Consultative Process, 2009-2010). The National HIV Prevention Strategy (2009-2013) was also developed in this timeframe. These newly developed documents are highlighted in detail as successes in Section 5 of the Report.

Gap

Two gaps that were identified repeatedly by Key Informant Interviewees were 1. the need to operationalise and implement the guidance documents that exist and 2. the need for clear direction on how to reach and serve Most-at-Risk Populations and Vulnerable Groups with human rights-based public health services (UNGASS Consultative Process, 2009-2010).

Action:

Complete the Review and Update of the National AIDS Policy

The Way Forward outlined in the above discussion of the Draft HIV Bill is applicable to the revision and interpretation of all frameworks, strategies, policies, guidelines, and protocols (UNGASS Consultative Process, 2009-2010).

8.1.3 Enforcement of the Protection of Human Rights: Fostering a Culture of Equality

Success

Throughout the country, there is a strong desire to have human rights-based approach to public health. The Law Commission, Malawi Human Rights Commission, and a number of rights-focused groups in civil society represent a considerable range of expertise and resources in this area (UNGASS Consultative Process, 2009-2010).

Gap

However, there is a need for clearly communicated direction on how to operationalise a human rights-based approach to public health. Revising the Draft HIV Bill and incorporating these changes into the revisions of the National AIDS Policy will go a long way toward providing clarity (UNGASS Consultative Process, 2009-2010).

Sexual Violence and Gender Inequality

Sexual violence and gender inequality contribute constantly to the epidemic in un-noticed ways. The transmission of HIV happens quietly behind closed doors when a wife tries to talk about protection and her husband accuses her that she must be sleeping around if she is now bringing up such issues and proceeds to have sex with her without a condom. Eliminating sexual violence and fostering a culture of equality, respect, and accountability is one of the most influential steps we could make in ending the epidemic (UNGASS Consultative Process, 2009-2010).

Fostering a culture of equality through a deep-seated understanding and respect for each other's rights and a justice system that backs this up could be one of the most critical steps to unblocking the road to success in our prevention efforts. A culture of equality would mean that people's basic human rights are widely understood and respected by everyone, family members, neighbours, authority figures, police, and the

courts. Whether it is a teacher, or a husband, a police commander, or a judge who violates someone's rights, they should be held accountable through disciplinary action in their profession and through the court of law (UNGASS Consultative Process, 2009-2010).

Action:

Know Your Rights

A widespread campaign reaching the entire population with a practical level of civic education could make an enormous difference in the establishing a culture of equality, respect, and accountability. The focus would include a basic understanding of how basic human rights apply in day-to-day situations, awareness-raising and sensitisation about the fact that these rights apply to all people, including Most-at-Risk Populations and vulnerable groups, and practical skills for how to play a positive role in making sure people's rights are protected (UNGASS Consultative Process, 2009-2010).

Sensitise Law Enforcement and Justice Delivery Personnel

Even though the Constitution has gone a long way in establishing these basic Human Rights for all people, the practical application of these rights is not always well-enforced. Understanding of the law by society at large is very limited to the extent that cases of abuse by cadres who are supposed to preserve human rights are widespread. For example, it is very clear that whilst sex work in itself is not illegal, sex workers have been arrested under rogue and vagabond laws even when there were no grounds for suspicion of criminal activity. People are routinely told that if they plead guilty they can be released. Since the prospect of abuse while in jail is so high, many people opt to plead guilty to something they have never done. Thus, unfair sentencing is more common than it should be (UNGASS Consultative Process, 2009-2010).

The police and the courts are two very powerful entities in Malawi that have great potential and authority to enhance the protection of human rights.

A great responsibility is in our hands.

As the police and the judicial system,
we must sensitise ourselves on how we can play this crucial role of
protecting the basic human rights of all people,
especially most at risk populations and vulnerable groups
and hold each other accountable to this calling.

UNGASS Consultative Process, 2009-2010

Decentralise the Mechanism for Reporting Discrimination and Human Rights Abuses

Throughout the consultative process to develop the UNGASS Report, there was a resounding call from the Key Informant Interviews and Focus Group Discussions requesting that the human rights reporting mechanisms be decentralised to district level to facilitate their use by the population and enhance their ability to play a transforming role in the protection of human rights in Malawi. Thus, it is strongly recommended that the Malawi Human Rights Commission have offices in every district to ensure the availability of legal services and more efficient tracking of human rights abuses and local accountability for all actors, including health service providers, police, courts, prisons, etc.). For Human Rights Commission to be fully utilised at district level, the staff should be sensitised to handle all issues faced by PLHIV and Most-at-Risk Populations and marginalised groups, including Sex Workers and Men who have Sex with Men (UNGASS Consultative Process, 2009-2010).

The importance of the **protection of human rights** is recognised in Paragraph 16 of the **Declaration of Commitment on HIV/AIDS**:

> Recognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the hiv/aids pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to hiv/aids and prevents stigma and related discrimination against people living with or at risk of hiv//aids

Strengthen the Independence and Effectiveness of Civil Society

Civil Society groups such as Malawi Health Equity Network and Malawi Economic Justice play an important role in ensuring accountability to human rights principles. Umbrella bodies, networks, and groups uniting and giving voice to PLHIV and Most-at-Risk Populations and Vulnerable Groups should be strengthened and supported in these endeavours. There is a need for greater empowerment of these groups and networks to strengthen capacity, increase visibility, ensure a stronger voice, and facilitate more meaningful engagement with government and the private sector to advance toward the national achievement of Universal Access (UNGASS Consultative Process, 2009-2010).

8.1.4 Leadership: Making the Change

Success

Strong national leadership has been exhibited in the Response to HIV and AIDS in Malawi. The National Response to HIV is championed by His Excellency the President of the Republic, who is also the Minister responsible for HIV. Support at the highest level of Government has ensured that HIV is not only prioritized in the

Malawi Growth and Development Strategy, the overarching policy blueprint, but also that funding for HIV and AIDS programmes is provided to a level that is sufficient to take the response to the next level (UNGASS Consultative Process, 2009-2010).

Gap

Every person in every position at every level has a role to play in the response to the epidemic. There is more that can be done to ensure that people understand exactly what they can do and are encouraged to take action (UNGASS Consultative Process, 2009-2010).

Action:

Create a Conducive Environment for Positive Changes

There has been an exemplary display of leadership on the issue of HIV and AIDS in Malawi. The President has been the minister responsible for HIV and AIDS up until recently. Now the Vice President is taking on this role. Very positive leadership has been shown in the past, and there is great promise that this will be continued in the future. Top-level leadership can help to create a conducive environment for positive changes, allowing for more widespread implementation of the human rights-based public health approach to HIV in Malawi. Such leaders can facilitated all sectors working together and strengthen accountability (UNGASS Consultative Process, 2009-2010).

Maintain the Definition of Roles within a Context of Collaboration and Coordination

Each government entity has a specific function and great effort has gone into defining these functions and understanding the appropriate division of roles. The next step is to foster an open environment of collaboration, sharing information and providing checks and balances for each other for good quality assurance.

As information sharing is systematised and planning and reporting arrangements are synchronised, there will be cost-savings as the response becomes more efficient. For instance, if NAC and the Ministry of Health are able to jointly contribute to a systematic reporting arrangement allowing information to be easily shared, accessed, used, and archived, this would facilitate the use of more comprehensive data analysis in improving programmes. Coordination of the response requires collaboration between each entity playing a distinct role, but continuously sharing information and working together (UNGASS Consultative Process, 2009-2010).

Foster Leadership at All Levels

We each have a role to play.

Each person fits into the HIV Response in a vital way.

Everyone has a stake in the response to the epidemic, from the person at grassroots in the community accessing a health service to top national leaders who are guiding the policies. If we enable people to see how they fit in, encourage leadership at every level, and develop a sense of responsibility and urgency we have a much better chance of being effective in our response to the epidemic (UNGASS Consultative Process, 2009-2010).

In addition, the communication channels from bottom to top and top to bottom need to be strengthened. Sometimes protocol makes people feel that leaders are not accessible to them, and that their ideas do not count. But this is not true. The more people coming up with solutions, the better chances there are of finding innovative, practical solutions. A public health movement emerging from the community with appropriate national leadership in coordination and quality assurance is the most effective type of response (UNGASS Consultative Process, 2009-2010).

In fact, a diversity of viewpoints and strengths brings about a more effective response. If we stimulate innovation and support people in finding new ways to use untapped resources, we will not be as reliant on donor funding for the sustainability of our health system. This can be done by maximising the potential of civil society, government, and the private sector through well-coordinated working partnerships at national and district levels. Strengthening the dynamic and relevant nature of the District Executive Committees could allow for greater accountability to users of services in all multi-sectoral efforts that effect on the HIV response (UNGASS Consultative Process, 2009-2010).

Champion Gender Equity and Eliminate Gender-based Violence

The importance of developing leadership among all generations and genders to champion gender equality and eliminate gender-based violence has been identified in the UNGASS Consultative Process and is widely acknowledged. However, there is the saying “rape cannot happen in the family” or “abuse cannot happen in the family”, meaning that violence and inequality are not recognised or dealt with in the marital and family contexts even though they may occur far too frequently. Strong leaders at every level, from national to local, are needed to set a new status quo and create a positive cultural emphasis on equality (UNGASS Consultative Process, 2009-2010).

The importance of **champions of gender equality** from all genders is recognised in Paragraph 47 of the **Declaration of Commitment on HIV/AIDS** in the commitment to:

> [C]hallenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys

Paragraph 59 expresses the commitment to:

> [D]evelop and accelerate the implementation of national strateies athat promote the advancement of women and women's full enjoyment oaf all human rights; promote shared responsibility of men and women to ensure safe sex; and empower women to have control ofver and decide freely and responsibily on matters related to their sexuality to increase their ability to protect themselves from HIV infection

Paragraph 61 declares the commitment to:

> [E]nsure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of womeon's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as aall forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls

Champion Equality and Eliminate Discrimination toward Most-at-Risk Populations and Vulnerable Groups

There is also a need for champions and role models among men and women, boys and girls to establish a new status quo of equality and respect. This bold step is required to end discrimination toward Most-at-Risk Groups and Gender-based Violence. If champions emerge from churches, the media, schools, all government ministries, and civil society, the effectiveness of the Response will be greatly increased and making the achievement of Universal Access possible (UNGASS Consultative Process, 2009-2010).

In the **Declaration of Commitment on HIV/AIDS** Malawi has committed to reaching Most-at-Risk Populations and Vulnerable Groups with quality prevention, treatment, care and support services. The Declaration states that:

> The vulnerable must be given priority in the response.

The importance of **promoting and protecting the health and human rights of Most at Risk Populations and Vulnerable Groups** is recognised in Paragraph 47 of the Declaration of Commitment on HIV/AIDS in the commitment to:

> [D]evelop and/or strengthen national strategies, policies and programmes, supported by regional and international initiatives, as appropriate, through a participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and must vulnerable to new infection . . .

Ensure Representation from PLHIV and Most-at-Risk Populations and Vulnerable Groups in the Leadership of Initiatives for These Groups

It is widely understood that initiatives related to HIV should have good representation of PLHIV in their leadership. Similarly, for any programme reaching out to Most at Risk Populations and Vulnerable Groups there should be good representation from these groups in their leadership. Effective feedback loops must be put in place to ensure that the communication link between constituencies and leadership remains strong (UNGASS Consultative Process, 2009-2010).

The importance of **representation by People Living with HIV and AIDS, Most at Risk Populations, and Vulnerable Groups** in order to advance the protection of human rights for all marginalized populations and decrease stigma and discrimination is recognised in Paragraph 37 of the **Declaration of Commitment on HIV/AIDS** in the commitment to:

> [E]nsure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people most at risk, particularly women and young people; are resourced to the extent possible from national budgets without excluding other sources, inter alia, international cooperation; fully promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health; integrate a gender perspective; address risk, vulnerability, prevention, care, treatment and support and reduction of the impact of the epidemic; and strengthen health, education and legal system capacity

Mainstream HIV Internally and Externally

Mainstreaming programmes have taken shape in most institutions in both the public and private sectors. Programmes in the private sector have largely been driven by established national and multinational firms and little if any efforts are being undertaken amongst the Small and Medium Enterprises as well as the very informal business sector (UNGASS Consultative Process, 2009-2010).

Government has committed 2% of Other Recurrent Transactions (ORT) for HIV and AIDS programmes in the public sector. Guidelines to this effect were finalised in 2009 to ensure harmonisation in the implementation of workplace programmes. The Malawi Police Service has demonstrated leadership in this area, indicating that the 2% allocation is a definite commitment. Nutrition and financial support from the Other Recurrent Transactions has elicited greater disclosure from employees living positively with the virus. Unfortunately, in many ministries, accounting for the spending of the 2% has been difficult to obtain (UNGASS Consultative Process, 2009-2010).

Mainstreaming means being strategic, for instance, line ministry mainstreaming should be both internal and external. The internal mainstreaming is about workplace programmes. However, external mainstreaming remains a gap in the national response and this is typified by a lack of ownership and a project mode of delivery of HIV programmes with institutions not fully taking advantage of their core mandates (UNGASS Consultative Process, 2009-2010).

"External Mainstreaming requires ministries to look carefully their mandate and see how their work has or could play a critical role in the response to HIV."

Government Participant in theUNGASS Consultative Process, 2009-2010

8.1.5 Enhancing Sustainable Financing for Health and HIV and AIDS

[Section 3.1.2 is currently undergoing validation, as the NASA was completed after the UNGASS Report National Validation Meeting held on 18 February 2010.]

Success

The Health SWAp and HIV and AIDS Pool funding arrangements have helped in mobilising partners and resources and focusing them to priority areas in the fight against HIV and AIDS. A costed Extended NAF ensures that resource allocation will be consistent with programmatic priorities and where there are expected resource shortfalls, these have been anticipated, identified and costed beforehand (NASA Consultative Process, 2010).

Notable success has been made in mobilising resources and maintaining donor interest and momentum to continue funding the national response up to 90% of projected resources required for the national response. Resources allocated to Care and Treatment were protected from cuts and continued to grow in a context of global financial crisis. The signing and existence of multi-year MoUs with development partners have ensured that Malawi is cushioned against the immediate impact of global economic and financial shocks in the short run. There is also high efficiency in fund management in the sense that resources expended by NAC in the administration and transfer of resources represent 10% of all resources channelled through them (NASA Consultative Process, 2010).

Gaps

Malawi continues to be more and more donor dependent in health and more so in funding for HIV and AIDS goods and services. This dependence is unlikely to abate in the foreseeable future given the recent change by the World Health Organization of guidelines for starting people on ARV by raising the CD4 threshold for qualifying to start ART. Second, some of NACs program implementing partners, including Government Ministries have limited capacity for HIV and AIDS funds management. Government Ministries' use of voted allocation, especially the 2% of ORT is not uniform and expenditure reporting is neither activity nor output-validated. Lack of capacity for funds management was reflected in the inability of NGO and other partners to timely report and account on how funds on-lent to them were used which resulted in NAC withholding of funding to some NGOs under the grant disbursement facility. Third, a lot more resources are used by the private sector but not tracked by

NAC, within its own monitoring and evaluation system of under the just concluded NASA, because most players believe their obligation to NAC only applies when they receive funding from NAC (NASA Consultative Process, 2010).

Serious consideration of **financing** challenges and foresight into future needs is expressed in Paragraph 9 of the **Declaration of Commitment on HIV/AIDS**:

> [T]he commitments of African heads of State or Government at the Abuja special summit in April 2001, particularly their pledge to set a target of allocating at least 15 per cent of their annual national budgets for the improvement of the health sector to help to address the HIV/AIDS epidemic; and recognising that action to reach this target, by those countries whose resources are limited, will need to be complemented by increased international assistance

Action:

Develop a Sustainable Financing Plan

The first crucial step in meeting the gaping financial needs with sustainable financing is to fulfil the national pledge to allocate at least 15% of the Annual National Budget to the Health Sector. This Government financing should be complemented with increased support from the Private Sector and Development Partners (Declaration of Commitment on HIV/AIDS, 2001).

Develop a Guideline on Using and Accounting for Public Funds

The OPC Department of Nutrition and HIV and AIDS should spearhead the development of guideline that ensure that Government Ministries uniformly and consistently apply and report on resources from Government voted expenditure (NASA Consultative Process, 2010).

Capacitate NGOs in Financial Management

While NGOs have varying financial management capacity, many require further capacity building in accounting for grant funds, and in management throughout the funding cycle. Just as there is an HIV Pool, there is need for common reporting guidelines which make it easier for grant recipients to satisfy the reporting requirements of many donors without being overwhelmed by donor-specific bureaucracy (NASA Consultative Process, 2010).

Develop a Mechanism for Private Sector Reporting

There is need for a reporting mechanism that ensures that NAC can track private sector resources used in the Response, regardless of the source. The mechanism must

be so designed as to give an incentive to companies for compliance even when those resources are from sources other than NAC (NASA Consultative Process, 2010).

8.1.6 Turning Information into Action: Strengthen Planning, Monitoring, and Reporting Mechanisms

Success

In the area of Planning, Monitoring, and Evaluation, a number of advancements have been made. The revision of the NAC M&E System and decentralisation through the District Coordination Units have brought about many improvements (UNGASS Consultative Process, 2009-2010).

Gap

Limited capacity to analyse and use data on a regular basis to improve services as a part of implementation remains a great challenge (UNGASS Consultative Process, 2009-2010).

Action:

Make Change Happen: Strengthen the Feedback Loop

Throughout nearly all organisations, networks, and government structures, feedback to constituencies is limited. Members of Parliament, Ministries, members of technical working groups, District Executive Committees, and District AIDS Coordination Committees, and all organisations and networks could benefit from establishing a systematic way to ensure that representatives are in regular contact with their constituencies, taking time to understand and represent their concerns and provide feedback on the outcomes.

A practical guide should be created and included as a part of all civic education on how to access representatives, provide constructive input, follow-up, and bring about change. In addition, before a national review takes place, it should be well-informed by district reviews led by a vibrant mixture of civil society and government, with users of services well-represented. A sample of these same people should be present at the national review (UNGASS Consultative Process, 2009-2010).

Revive All Regular Progress Review Meetings at All Levels

For decentralisation to work, there is a need to systematise the analysis and use of data at all levels in all forums. Information is power, and access to information promotes accountability, motivating higher levels of coordinated action. At the district level, it is very important for District Executive Committees and District AIDS Coordinating Committees to be rejuvenated (UNGASS Consultative Process, 2009-2010).

We know there is a problem because new people keep getting infected every day.
There is a saying: 'Know your epidemic.'
Everyone has a piece of the truth.
We need to connect the pieces and pull it all together for true coordination.

We need a Joint Response to HIV!

Participant in the UNGASS Consultative Process, 2009-2010

Use Information to Improve Services: Strengthen the Capacity to Validate, Analyse and Use Data

Under-reporting routinely occurs because people do not see the value in reporting and do not understand how planning, monitoring, and evaluation helps them do their job. We need to strengthen the capacity of people at every level to validate, analyse, and use data (UNGASS Consultative Process, 2009-2010).

Understanding Your Role

Understanding your role means more than just doing exactly what told. It means learning how to think critically about your role in relation to the bigger picture.

You are most effective when you:

- Look at the entire need
- Look at your role
- Set your vision on reaching specific targets by a certain date
- Plan for how to get there
- Communicate and work together with others
- Check in frequently to see how close we are to reaching the target and what we can change to be more effective

UNGASS Consultative Process, 2009-2010

This does not have to be a complicated task. We already do planning, monitoring, and evaluating in our day-to-day living as we monitor the price of household goods and figure out how to make the most of the personal money that we have. These same skills can be applied in a systematic manner to our role in addressing the epidemic to ensure that we are being as effective as possible (UNGASS Consultative Process, 2009-2010).

In fact, the users of services are in the best position to help us understand what we can do to be more effective at our job. Enhancing communication channels with users of services for the purposes of quality improvement will help us reach Universal Access much more quickly (UNGASS Consultative Process, 2009-2010).

The User of the Services is in the best position to tell us about coverage and quality of services. They should be considered our highest level advisor for Universal Access.

Re-Ignite the Universal Access Momentum and Acceleration of the Response to Achieve Universal Access

In order to gain perspective in the Response and re-focus on achieving Universal Access, the Universal Access targets should be on every person's wall. We need to visualise where we are headed and begin to plan accordingly if we are going to reach these targets (UNGASS Consultative Process, 2009-2010).

Cost Benefit Analysis: Examine the Cost of Action Versus the Cost of the Consequences of Not Taking Action

The economic progress that Malawi is registering should provide a platform for bolstering a business case which could translate into more active participation of the private sector in the national response including financing. The fact that HIV is impacting heavily on the work force should be a starting point in this regard.
When we weight the cost of reaching Universal Access as soon as possible, versus the cost of delaying, we find that it will cost Malawi much more both now and in the future if we delay. Lives, productivity, and sustainability of the economy will be in jeopardy. This type of analysis highlights the need for Universal Access in all areas: Prevention, Treatment, Care, and Support. Effective prevention must be scaled up (UNGASS Consultative Process, 2009-2010).

Resources are one of the greatest challenges, yet the private sector is not stagnating. Creating the business case for investment in the Response should be a top priority. This will help to instigate public-private partnership to enhance the sustainability of the Response (UNGASS Consultative Process, 2009-2010).

Plan ahead for Population-Based Surveys

The lack of recent population-based survey data is concerning and should be addressed as a matter of priority. This information is critical to evidence-based programme design, particularly prevention programmes and programmes tailored to reach Most at Risk Populations (See Section 1.2.3).

Comprehensive planning for population-based surveys needs to begin now to ensure that in the future, there will be a benchmark at frequent enough intervals to inform

implementation efforts in the National Response to HIV. These population-based surveys include:

- DHS;
- BSS;
- MICS (All Most at Risk and Vulnerable Groups should be included in future versions); and
- Population size estimates for Most at Risk Populations and Vulnerable Groups and special studies on how best to operationalise a human rights-based approach to meeting the needs of Most at Risk Populations and Vulnerable Groups (UNGASS Consultative Process, 2009-2010).

While planning has taken place, there is need for a comprehensive M&E roadmap, outlining all major M&E activities, financial resources committed by whom, who is responsible and when this will happen. For successful data collection and use to improve the quality and reach of services, there will need to be stringent protocol and supervision to ensure the confidentiality and protection of all participants, especially participants from Most at Risk Populations and Vulnerable Groups (UNGASS Consultative Process, 2009-2010).

The importance of establishing targets for **reaching Most-at-Risk Populations and Vulnerable Groups** with quality services is recognised in Paragraph 48 of the **Declaration of Commitment on HIV/AIDS** in the commitment to:

> [E]stablish national prevention targets, recognizing and addressing factors leading to the spread of the epidemic and increasing people's vulnerability, to reduce HIV incidence for those identifiable groups, within particular local contexts, which currently have high or increasing rates of HIV infection, or which available public health information indicates are at the highest risk of new infection

The National Prevention Strategy states that: "Effort has to be made to reach out to MSM and their female sexual partners with appropriate prevention interventions." On Page 35 of the strategy, the last sentence states: "....Specific research studies including those on emerging issues will be commissioned to provide evidence for further programming and prioritisation of interventions."

8.1.7 Scale-up: Improving Coverage and Quality

Success

The ART scale-up in Malawi has been remarkable in terms of the number of sites and number of people on treatment. It has maintained high standards of quality through a great emphasis on supervision. The monitoring system is able to track patient survival at at 12, 24, 36, 48, and 52 months.

> "Previously we were burying 3-4 people per week. Now we can take 3 months before burying."
>
> **—Community Describing the Impact of ART**

HIV testing and counselling, PMTCT, and other clinical services have also been scaled up considerably.

Gap

While HIV testing and counselling and PMTCT have scaled up to a great extent, and have sound policies, the implementation varies in quality. ART is still in the process of being rolled out to the local level. Overall, there is still a large proportion of the population in need that is not yet accessing the services.

Scale-up means COVERAGE and QUALITY

Coverage= Reaching Everyone In Need of Services

Quality= Making Sure the Service Is Relevant, Timely, Comprehensive, and Effective

Action:

Scale-up Coverage and Quality: Implement the Strategies and Guidelines

Great effort has gone into designing sound policies at national level. However, there are still enormous constraints in the capacity to fully implement the roll-out of HIV-related services. The ART programme has been successful because careful planning and extensive supervision and quality-assurance has accompanied every step of the roll-out. If other areas of the HIV response, such as PMTCT and VCT could undergo strengthening of the supervision and quality assurance systems, this may lead to less confusion and variation in the implementation at service-delivery level (UNGASS Consultative Process, 2009-2010).

Strengthen Systems of Supervision and Mentoring

The only way to ensure quality in the expansion of coverage is to strengthen systems of supervision and mentoring. Surprise quality assurance checks from supervisors appearing to be users of services also help to improve the standard of care. For audits, supervision, and mentoring to be carried out effectively, this requires setting aside the appropriate time, personnel, and budget, but it is well-worth the investment to ensure that the services will be able to make an impact on the population's health (UNGASS Consultative Process, 2009-2010).

Fully Develop and Protect Our Human Resources

Develop the Full Potential of Our Human Resources

There is a high level of volunteerism and commitment at the grassroots levels by individuals of all ages and backgrounds. If we can systematically put in place very well-managed mechanisms for training, mentoring, and supervising these volunteers, it will greatly increase the capacity of our human resources, relieving some of the burden on health care staff by creating a stronger link between the clinic and the community. However, quality of care cannot be compromised. Thus, roles which volunteers can play should be clearly specified and accompanied by training and supervision. By professionalizing volunteerism and introducing quality assurance standards, even greater pride can be taken in the role volunteers play and there can be further validation of the enormous difference they make in communities (UNGASS Consultative Process, 2009-2010).

As these improvements are being made, clear routes to additional education and responsibilities should be put in place as opportunities for advancement for those achieving results in a quality-assured manner (UNGASS Consultative Process, 2009-2010).

Revive and Strengthen Functional Adult Literacy Programmes

In Malawi, a person is considered 'literate' if that person has completed at least four years of primary school education because by four years of primary school education a person (child) is expected to read, understand and write basic Chichewa and English words and to perform basic numeracy functions. Adult literacy in Malawi was last estimated at 64% in 2005, and was found lower among females at 52% than among males at 76%. The youth literacy level was estimated at 76% and was at 81% among male youths compared to 72% among female youths (NSO 2005). Considering these low levels of literacy among both adults and the youths, the national response to HIV and AIDS recognises the challenges that are being faced in the dissemination of information on HIV prevention, treatment, care and support and in the uptake of services particularly in the rural remote areas. While re-enforcing school enrolment initiatives among children of school-going age groups, the national response will also strengthen the national adult literacy programme, which has been under the Department of Community Services in the Ministry of Women, Gender and Child Development, and has just been moved to the Ministry of Education, Sciences, and Technology since February 2010. The support to the national adult literacy programme will be done alongside supporting school enrolment and retention initiatives and the provision of life skills to both in-school and out of school youths and children (UNGASS Consultative Process, 2009-2010).

Malawi has been running adult literacy programmes since the 1960/70's all geared towards teaching of reading, writing and numeracy skills among adults (both men and women) who had never have these skills because either they never had chance to access primary and secondary education or because they dropped out of school in the lower classes. These adult literacy programmes have proved to be very successful in the adoption of modern farming techniques, adoption of family planning methods and

in the adoption of many interventions provided by development NGOs, local grassroots implementers and government agencies. The national response will therefore move towards re-enforcing efforts aimed at moving beyond provision of adult literacy skills to promoting 'Functional Literacy' among adults and adult youths who never went to school. Functional Literacy is a step beyond 'normal' literacy' in that it is geared towards teaching literacy for development in which the illiterate individual is considered as a participant in a development situation. In this particular case, the functional literacy programme will aim to enhance knowledge and skills relating to HIV prevention, treatment, care and support and adoption of safer sexual practices (UNGASS Consultative Process, 2009-2010).

Protect Our Human Resources

> "People are Dying after being Educated."
> **—Participant in the UNGASS Consultative Process, 2009-2010**

As a several participants in the UNGASS Consultative Process noted, "Human resources are our greatest asset. Each person has powerful potential. We must protect our workforce." Even from a business standpoint, if the health of the population is not protected, the market will continue shrinking, and the costs will continue increasing for funerals, recruitment, etc. Larger companies have already realised this and begun paying for ART and workplace prevention programmes. This is actually a good business investment. All companies and small-to-medium enterprises should begin taking this up as a best practice. If we are investing in recruiting and training a strong workforce, we should also be supporting their health (UNGASS Consultative Process, 2009-2010).

Motivation and Accountability: Performance-Based Contracts

NAC, various companies, and some civil society organisations have introduced performance-based contracts as a way to increase motivation and effectiveness. This is the way forward being considered by many organisations (UNGASS Consultative Process, 2009-2010).

The lack of performance-based contracts in the general public sector is impinging on progress in the HIV response. To many, HIV funding simply means the potential for personal gain. Attendance at a meeting related to the epidemic now comes with the expectation of a per diem or a lunch allowance. In fact, trying to get people to come to a meeting has become a bidding war for who can pay the most for lunch allowances and per diems. While recognising the need to appreciate people's participation who are not otherwise paid to do such work, if a person is receiving a salary to do a job, it is questionable why they should receive an extra amount for sitting through a meeting pertaining to their job. If allowances are to remain, there should be one flat rate so people make decisions about which meeting to attend based on its strategic impact on the epidemic rather than its impact on their pocket. There has been an effort from development partners to introduce standards to harmonise the rates. However, NGOs need to respect these standards. Regardless, lunch allowances and per diems increase

attendance only and do not necessarily increase the quality of participation (UNGASS Consultative Process, 2009-2010).

The lack of desire to change that plagues many organisations is fundamentally an issue of individuals wanting to retain power and economic control. People in positions of power have no interest in changing the status quo, because the power is already consolidated in their hands. Those who are at lower levels fear losing the little power that they have. We must create an environment where people want to change for the better, and where it is in their best interest to incite positive change. This is best done through performance-based contracts, which encourage responsibility and progressive action (UNGASS Consultative Process, 2009-2010).

8.1.8 Improving Access and Applicability: Tailoring the Services to the People's Needs

Success

The National HIV Prevention Strategy (2009-2018) was recently developed, highlighting a number of factors that facilitate HIV transmission in Malawi.

Gap

The current approach used in health care service provision and prevention programmes is to have one general approach to all people. While it is good to have a certain standard of care that is provided to all without discrimination, the information and services need to be comprehensive enough to meet the needs of people coming from a vast number of situations (UNGASS Consultative Process, 2009-2010).

Action:

Clarify the Human Rights-Based Public Health Approach in All Programmes, Trainings, Mentoring, and Supervision

Throughout the data collection process and during the NCPI Validation Meeting, the need to set people at ease by helping them to fully understand the human rights-based public health approach was reiterated over and over. Many service providers explained that the place where they see the most confusion on this issue is with regard to serving Sex Workers and Men who have Sex with Men, as some people are afraid that if they provide health services to these individuals, there will be some legal implications (UNGASS Consultative Process, 2009-2010).

However, the opposite is actually true. Health service providers have an obligation to serve all people without discrimination or bias (National NCPI Validation, 2010).

"We are working in public health. Our job is to serve all people without discrimination. When we do our work we should set aside any personal issues we might have, we should set aside all judgement and we should give each person the best possible chance of having health."

Participant in the UNGASS Consultative Process, 2009-2010

Tailor Services to Meet the Needs of Most-At-Risk Populations and Vulnerable Groups

For health care and HIV programmes to be effective, they must be comprehensive enough to allow the individual to tailor the information to their needs. We cannot simply stop at giving people the most general information (UNGASS Consultative Process, 2009-2010).

For instance, if all people are told to use a condom when having sex, but are not told about how to protect themselves when having any possible kind of sex (vaginal, anal, oral, etc.), they might wrongly assume that you only need to use protection when having vaginal sex (UNGASS Consultative Process, 2009-2010).

Imagine the Scenario

When a person walks through the door with an STI or for an HIV test, the nurse or counsellor has no idea what situation this person might be in. If the person is a young man of 23 years old, all you can know is his sex and his age. What you don't know is that he could be a truck driver who is exposed to many peers who are having sex with sex workers along the borders, or he could be a young man who is HIV positive and is about to get married to a young girl he met in university, or he could be a young man who is not attracted to women, but has found a boyfriend he wants to commit to for life.

If the services and information provided are comprehensive enough, they could meet the needs of this young man, no matter who he is and create an environment where he feels comfortable sharing any questions he might have so he can get even more detailed information that is tailored to fit his needs. This is why all health care workers and HIV programme staff need to be trained in how to provide **comprehensive** information, an open, friendly, and non-judgemental way. But they also need to be equipped with the skills to provide **tailored services** to meet the specific needs of an individual if they have certain needs.

For instance, if the comprehensive services are provided in a non-judgemental and friendly manner, then the truck driver might explain that he does not know why the condom breaks so often and the nurse or counsellor might talk with him and discover that he is not pinching the air out of the tip of the condom when he is putting it on. The young man who is about to get married might reveal this fact so the counsellor can encourage him to come with his fiancé for a test and to use protection. The young man who has a boyfriend might explain that he wants to go for an HIV test with his partner, but is afraid that they might not receive confidential services. After inviting him to bring his partner and ensuring that they will be served in a non-judgemental and friendly setting with full confidentiality, the nurse or counsellor might also discuss the need to use water-based lubricants with condoms.

Each person needed the comprehensive information, but they also needed some tailored information to meet their specific needs. Health care service providers need to be equipped with the skills to meet the needs of any person who walks through the door.

Scenarios Arising out of the UNGASS Consultative Process, 2009-2010

In order to equip health service providers with the skills to use a human rights-based approach to public health and to tailor their services to meet the needs of Most-at-Risk Populations and Vulnerable Groups, this needs to be incorporated into the policies, training, and supervision of all staff (UNGASS Consultative Process, 2009-2010).

As a number of respondents explained, "At present, you might not be stopped by anyone from coming through the door of a clinic except by your own fear. But if you get there, you are not given the vital information you need, because the service is not

comprehensive enough to allow you to tailor the messages to your own needs. You fear to ask, because you know that the health care workers have not yet been sensitised to such issues" (UNGASS Consultative Process, 2009-2010).

For a long time, youth were not accessing health services at the levels that one would hope. With the training of health care workers in Youth Friendly Services, the number of youth who feel comfortable accessing health care services and who get proper testing, treatment, and information has dramatically improved. This same approach can be used for all marginalised groups. Once health service providers are sensitised in how to tailor services to meet the needs of various Most-at-Risk Populations and vulnerable groups like Men who have Sex with Men, Sex Workers, Young People, Truckers, Teachers, People with disabilities, widows, OVCs, Domestic Workers, and Prisoners, we will see an improvement in uptake of services from these groups (UNGASS Consultative Process, 2009-2010).

Encourage Regular Check-ups and Integrated of Services

Routine check-ups can help in promoting prevention, improving early-stage diagnosis and ensure that a person is initiated on ART as soon as they are eligible. As advances are made in integrating health care service provision, a more client-centred approach will lead to more comprehensive care (UNGASS Consultative Process, 2009-2010).

8.1.9 Bring the Services to the People

Success

The roll-out of HIV-related services has registered many successes in the past two years. Health care service coverage has greatly improved. NAC District Coordination Units have also allowed for a much closer working relationship with districts. To give another example, as part of the implementation of a decentralized response to HIV, Malawi has every year been conducting Candlelight Memorial Ceremonies which are meant to mobilize grass-root recognition of the effects of the pandemic as well as raise awareness about stigma and discrimination. Owing to the successes that Malawi has registered in mobilizing grass-roots response to HIV through this annual event, Malawi was chosen as the first country to host the Opening Ceremony of the International AIDS Candlelight Memorial event on 18th May 2008. The ceremony was presided over by His Excellency the President, Dr Bingu wa Mutharika, who is also the Minister responsible for HIV in Malawi. It should be mentioned that this was the first time in the history of this event that it was held outside Washington, DC (UNGASS Consultative Process, 2009-2010).

Gap

Despite immense progress in the roll-out of services, initiatives are still clustered primarily in the major urban areas. Many critical services are not yet available at health centres due to a lack of equipment, supplies, or staff expertise (UNGASS Consultative Process, 2009-2010).

Action:

Move the Talent and Incentive to Where the People Are

It has been noted that talent and capacity is clustered in the major cities and lakeshore districts where there is a more attractive setting for people to live. Power and decision-making is also concentrated in these areas. Although decentralisation is effectively being rolled out by the government at present, there are still many steps for government and civil society to take. To ensure that communities build true capacity and ownership of the response, posts in districts need to be given higher levels of responsibility for decision-making. The MoH has managed to do this, creating higher level posts at district level (UNGASS Consultative Process, 2009-2010).

Bring the Services as Close as Possible to the People

Transport is an enormous constraint for many people seeking health care services. The cost of transport constrains people from being able to access services. The solution expanding the service delivery points to allow for easer access is being taken into consideration and needs to be incorporated into all planning efforts (UNGASS Consultative Process, 2009-2010).

The ART programme is working to allow clinics to quality for ART initiation as soon as they can be equipped with the appropriate facilities, staff, and supplies. The HIV testing and counselling programme has already made great efforts to move to mobile services. The aim is to bring HTC to your door and ART, PMTCT, and as many diagnostic and treatment services as possible to your clinic. To complement these initiatives, there is a need to increase the number and capacity of extension workers and to integrate key services for more comprehensive and client-centred care (UNGASS Consultative Process, 2009-2010).

Ensure that Truly Free Services Are Available and Nearby

Even if government services are free, in some areas, a government clinic or hospital is very far away and the nearer CHAM facility charges user fees. At present, CHAM is playing a complementary role with government to provide health services. The government has signed service-level agreements with CHAM so as to provide free maternal health services. If these could be extended to cover the Essential Health Package, that would assist in greatly expanding the assess to HIV-related services.

The importance of **accessibility of treatment** is recognised in Paragraph 24 of the **Declaration of Commitment on HIV/AIDS**:

> [T]he cost, availability and affordability of drugs and related technology are significant factors to be reviewed and addressed in all aspects and that there is a need to reduce the cost of these drugs and technologies in close collaboration with the private sector and pharmaceutical companies

Map All NGOs for More Even Distribution

The civil society is playing a critical role in the national response to HIV by ensuring that the supply side of services is sufficient to meet the demand. However, it is imperative that the civil society be harnessed so as to leverage their contribution to the national response. A starting point could be a mapping of civil society organizations to ensure equitable spread and coverage across the country. The International NGO Forum, which meets quarterly, would be one forum in which this mapping should occur. Ultimately, at the district level the District Assembly should ensure proper coverage and accountability within its jurisdiction. This process is in motion and can be accelerated. In fact, some districts have already begun this process (UNGASS Consultative Process, 2009-2010).

Eliminate Drug Stock-Outs

Drug stock-outs have been a major challenge in the HIV response in Malawi. Capacity for supply chain management urgently needs to be addressed, strengthening quantification of need, forecasting, procurement, distribution and monitoring systems. Efforts are being made to transform Central Medical Stores into a trust to increase efficiency and accountability (UNGASS Consultative Process, 2009-2010).

8.1.10 Prevention

Success

The National HIV Prevention Strategy has just been released and an operational plan developed.

Gap

Current efforts aimed at operationalizing the National Prevention Strategy will go a long way to enhance acceleration of prevention programmes. However, achieving sustainable behavioural change should also be seen as part of a larger developmental agenda and not just an HIV issue alone (UNGASS Consultative Process, 2009-2010).

70,000

New Infections Each Year is UNACCEPTABLE.

We can prevent this!

Participant in the UNGASS Consultative Process, 2009-2010

There cannot be sustainability of the response without effective prevention efforts.

Action:

Move Beyond Knowledge to Practical Skills

The general HIV-related knowledge amongst the population has improved over the years. However, people need more than general information, they need practical skills to be able to put that information to use. For instance, people know that a person should use a condom, but their skills in correctly putting on a condom are much, much lower. People are having all different kinds of sex, including oral sex, anal sex, vaginal sex, but current prevention programmes only talk about how to use prevention when having vaginal sex (UNGASS Consultative Process, 2009-2010).

People are craving the practical sills that will help them most in the situations they find themselves in. They want honest conversation and clear instruction. For instance, people are using many different kinds of lubricants, and need to know which ones are condom-safe, and which ones are not (UNGASS Consultative Process, 2009-2010).

People have a right to information and want to know about topics like the risks of dry sex, the ways that condom-safe (water-based) lubricants can be used, how to achieve pleasure while having safer sex. The emphasis on male involvement should not be to create separate forums for the sexes. In fact, these exist everywhere already. There are many contexts in which men and women separately in casual settings talk about sex (UNGASS Consultative Process, 2009-2010).

What we need are forums where genuine, honest, and respectful communication is fostered between all genders. Such forums have the potential to increase communication and openness between couples to talk about sex, what they like, how to increase pleasure while having safe sex and how to build healthy relationship in all aspects including equality, appreciation of each other, and respect for each other. The better the communication is, the more pleasurable and safe the sex is likely to be (UNGASS Consultative Process, 2009-2010).

Enhance Free Availability and Marketing of Female and Male Condoms and Lubricants

At present, there are still many influential HIV service providers and religious institutions that do not promote condom use or allow condom distribution. This hampers progress in addressing the epidemic. Those religious institutions who are more open-minded regarding the use of condoms should speak out in a unified voice on this issue. The national position on condom distribution can be clarified, strongly recommending condom distribution as a part of all prevention activities. Religious sites can then determine to what extent they will align themselves to this approach (UNGASS Consultative Process, 2009-2010).

"We can begin preventing infections on a much larger scale. **Female condoms**, **male condoms**, and **lubricants** are **essential supplies** in HIV prevention."

Participant in the UNGASS Consultative Process, 2009-2010

The availability and marketing of female condoms, male condoms, and lubricants needs to be taken to full scale. Socially marketed condoms that people buy are available and have been made much more desirable through this approach. We need to use the same marketing approach and branding to make the free condoms as attractive as the condoms that are sold in stores (UNGASS Consultative Process, 2009-2010).

The importance of ensuring the **accessibility of condoms and lubricants** is recognised in Paragraph 23 of the **Declaration of Commitment on HIV/AIDS**:

> [E]ffective prevention, care and treatment strategies will require behavioural changes and increased availability of and non-discriminatory access to, . . . condoms, . . . lubricants, . . . drugs, including antiretroviral therapy, diagnostics and related technologies . . .

Female condoms are not currently available in the quantities that we need and lubricants are very scarce. We must address this gap if we are serious about prevention. Studies should also be conducted to find out how to best market each product in different areas. For instance, in the Focus Group Discussions for the development of this report, users of services at community level mentioned that at first, there was concern about the noise that female condoms are rumoured to make, but after trying them, the response has been that: "If what is happening is good, noise does not matter," and "Noise is the music" (UNGASS Consultative Process, 2009-2010).

Improve the Accessibility of Post-Exposure Prophylaxis (PEP)

Post-Exposure Prophylaxis (PEP) services provide a remedy for health workers and community members who have either been exposed to invasive products or are victims of rape so as to prevent transmission of HIV. Data on uptake of PEP services is scanty. However, it is acknowledged that PEP services are available in all sites providing Antiretroviral Therapy and that PEP data is collected alongside ART data and is thus part of the overall ART monitoring and evaluation system. Anecdotally, uptake of PEP services is low amongst health workers due to fear of stigma and discrimination that may arise in case of a positive test result obtaining from testing and counseling which is a precondition before one accesses PEP. There is need to raise awareness amongst the communities on the availability of PEP services for victims of rape and that this service is only effective within 72 hours of an incident. Victim Support Units (VSU), an important structure for the reporting of rape incidents

at local level, are being encouraged to handle rape cases as emergency situations (UNGASS Consultative Process, 2009-2010).

Take Evidence-Based Prevention to Full Scale

The National HIV Prevention Strategy: 2009-2013 has reviewed the drivers of the epidemic and an operational plan has been developed to move the strategy forward. To achieve full-scale prevention, we need to approach it from a Universal Access standpoint, aiming to reach ever person in need, meaning the entire population (UNGASS Consultative Process, 2009-2010).

To do this, we must approach people with support for carrying out ABC, PMTCT, and Blood Safety from every angle, through every channel, including health care centres, chiefs, initiators, young people, religious institutions, school, after school clubs, workplaces, markets, shops, etc. We should utilise every opportunity to reach people with tailored, applicable prevention skills. When someone goes for a test, there is not much discussion of how to protect themselves based on the different types of sex they might be having or the power dynamics in their relationship and their ability to negotiate for safer sex (UNGASS Consultative Process, 2009-2010).

In scaling up our prevention efforts, we must ensure that we use evidence-based approaches. The closer the intervention gets to allowing people to practice the skills they need in real-life situations, the more likely they are to feel comfortable and confident using those skills when the situation presents itself. For instance, Theatre for a Change is an innovative approach being used where the show is stopped mid-way and members of the audience are invited to come up on the stage and act out a better solution (UNGASS Consultative Process, 2009-2010).

We are doing an **incredible** job **scaling up** access to **treatment** steadily and with quality services.
Current estimates put new HIV infections at 74,000 each year.
At present the treatment programme is only able to enroll up to 70,000 per year.
This means that for every person that is being put on treatment, another one is somewhere else becoming infected.

We MUST do better at PREVENTION, as well!

Participant in the UNGASS Consultative Process, 2009-2010

8.1.11 Nutrition and Food Security at Household Level

Success

The WFP, WHO, and UNAIDS Policy Brief on HIV, Food Security, and Nutrition issued in May of 2008 (page 4), quotes Dr. Mary Shawa, Principal Secretary for Nutrition, HIV and AIDS, Office of the President and Cabinet of Malawi:

> Malnutrition, chronic food shortages and HIV are major problems in Malawi. Micronutrients studies in 2001 showed that 25% of adults were malnourished, with 75% of them being HIV-positive. Recognizing that HIV, poor nutrition and food security are major, interrelated, national challenges that are hindering human capital and economic development in Malawi, His Excellency Dr Bingu wa Mutharika, President of the Republic of Malawi, in 2004 committed himself to championing a solution by creating the Department of Nutrition, HIV and AIDS to provide policy direction, oversight, coordination and monitoring and evaluation of nutrition, HIV and AIDS national responses.
>
> The Malawi Development and Growth Strategy: From Poverty to Prosperity 2006-2011, the overarching policy strategy for development in Malawi, identified the prevention and management of nutrition disorders, HIV and AIDS as one of the priority areas. Addressing the interaction between nutrition and HIV is key, and as the Strategy notes, the "Malawi Government is committed to improving and diversifying the diet of people living with HIV, and increasing the provision of HIV-related nutrition interventions".

Many efforts have been made to ensure that Malawi, as a country, is food secure. In fact, the most economically disadvantaged are eligible for agricultural subsidies in the form of fertilisers and seed (UNGASS Consultative Process, 2009-2010).

Gap

However, at household level, nutrition and food security is not always a reality (UNGASS Consultative Process, 2009-2010).

Action:

Fully Equip Agricultural Extension Workers to Provide Community and Household-Level Nutrition and Food Security Education and Support as an Integrated Part of Their Outreach Activities

Agricultural Extension Workers are a source of knowledge for communities in the areas of nutrition and food security and could be more fully equipped to provide education and support as a part of their outreach activities. For instance, practical skills in how to achieve adequate and balanced nutrition drawing from available and affordable foods and practical knowledge of how to eat a balance diet in resource-constrained environment could be very helpful at a household and community level. The OPC DNHA represents a very influential resource for more fully incorporating

nutrition care and support in extension workers' daily interactions (UNGASS Consultative Process, 2009-2010).

Enhance Access to Agricultural Inputs: Fertilisers, Seed, and Irrigation

Accountability to ensure the integrity of the delivery of the agricultural subsidy programme could be increased. In addition, full consideration of irrigation alternatives using solar and wind power could greatly enhance nutrition and food security, improving HIV-related health outcomes (UNGASS Consultative Process, 2009-2010).

Every Day, 200 People Become Infected with HIV in Malawi.

What role will YOU play in the response?

8.2 Action Plan for Operationalising Recommendations

8.2.1 Way Forward: Action Plan

Way Forward: Action Plan for Operationalising the Recommendations					
Section in Full Report	**Way Forward Topic**	**Action To Take**	**Who Is Responsible**	**Time-frame**	**Reference to Existing Recommendations and Way Forward Discussions**
8.1.2	**Laws, Policies, and Strategies**	**1. Review the Draft HIV Bill and Make Necessary Changes** ▪ See table above and narrative in section 8.1.2 above for recommended revisions While the Law Commission has completed the initial report, the Cabinet can now hold consultations and/or commission for changes to be made in process of adopting the bill before it is tabled in Parliament	Cabinet	By June 2010	Extended NAF objective 3.3; strategy 3.3.1;objective 7.1 strategy 7.1.1; IRT 2007-2008 Section 4.3., National HIV Prevention Strategy Crosscutting Strategic Objective 3
		2. Ensure that the HIV Bill Reflects the Changes and Pass the HIV Bill ▪ Changes detailed in Section 8.1.2 of the Full Version of this Report	National Assembly	By end 2010	Extended NAF objective 3.3; strategy 3.3.1
		3. Complete the Review and Update of the National AIDS Policy	OPC	By end 2010	
8.1.3	**Enforcement of the Protection of**	**1. Know Your Rights Campaign** ▪ Enhance general civic education of	MHRC, Civil Society	By end 2010	Extended NAF objective 3.3; National HIV

Way Forward: Action Plan for Operationalising the Recommendations					
Section in Full Report	**Way Forward Topic**	**Action To Take**	**Who Is Responsible**	**Time-frame**	**Reference to Existing Recommendations and Way Forward Discussions**
	Human Rights: Fostering a Culture of Equality	basic human rights, especially regarding the rights of most at risk persons			Prevention Strategy Crosscutting Strategic Objective 3strategy 3.3.2
		2. Sensitise Law Enforcement and Justice Delivery Personnel ▪ Orient law enforcement officers on the human rights elements of law enforcement	MHRC	By end 2010	Extended NAF objective 3.3; strategy 3.3.2; National HIV Prevention Strategy Crosscutting Strategic Objective 3
		3. Decentralise the Mechanism for Reporting Discrimination and Human Rights Abuses ▪ Build up local capacity for human rights protection by creating MHRC offices at assembly levels	MHRC	By end 2011	
		4. Strengthen the Independence and Effectiveness of Civil Society	Malawi Partnership Forum	By end 2010	
8.1.4	**Leadership: Making the Change**	**1. Create a Conducive Environment for Positive Changes** Encourage Top-level political leaders to continue acting as role models	Government and Civil Society	By June 2010	
		2. Maintain the Definition of Roles within a Context of Collaboration and Coordination ▪ Synchronise planning and monitoring	OPC, NAC; MoH	Continuous	IRT 2007-2008 Section 3.4(1).; IRT 2008-2009 pg 15, Extended NAF

Way Forward: Action Plan for Operationalising the Recommendations					
Section in Full Report	**Way Forward Topic**	**Action To Take**	**Who Is Responsible**	**Time-frame**	**Reference to Existing Recommendations and Way Forward Discussions**
		among public sector stakeholders ▪ Enhance capacity for information sharing			Objective 7.2.
		3. Foster Leadership at All Levels ▪ Strengthen district-level capacity to be more proactive and innovative in addressing HIV and AIDS related problems	All Stakeholders at Every Level	By June 2010	
		4. Champion Gender Equity and Eliminate Gender-based Violence	All Stakeholders at Every Level	By end of 2010	
		5. Champion Equality and Eliminate Discrimination toward Most-at-Risk Populations and Vulnerable Groups	All Stakeholders	By end of 2010	
		6. Ensure Representation from PLHIV and Most-at-Risk Populations and Vulnerable Groups in the Leadership of Initiatives for These Groups ▪ Institute effective communication, input, and feedback mechanisms between leaders and constituents	All Stakeholders	By end of 2010	Extended NAF obj 1.4 strategy 1.4.1 action area 1.4.2.4.
		7. Mainstream HIV Internally and Externally ▪ Encourage deeper understanding of the core mandate of the institution as it	All Government ministries,	By end of 2010	Extended NAF objective 4.1 & 4.2

Way Forward: Action Plan for Operationalising the Recommendations					
Section in Full Report	**Way Forward Topic**	**Action To Take**	**Who Is Responsible**	**Time-frame**	**Reference to Existing Recommendations and Way Forward Discussions**
		pertains to the HIV response	and private sector		
8.1.5	**Enhancing Sustainable Financing for HIV and AIDS**	**1. Develop a Sustainable Financing Plan** ▪ Fulfil the national pledge to allocate at least 15% of the Annual National Budget to the Health Sector ▪ Increase support from the Private Sector and Development Partners	GoM, Private Sector, Development Partners	By end of 2012	
		2. Develop a Guideline on Using and Accounting for Public Funds ▪ Develop a guideline that ensure that Government Ministries uniformly and consistently apply and report on resources from Government voted expenditure	OPC DNHA	By end of 2011	
		3. Capacitate NGOs in Financial Management ▪ Build NGO capacity in accounting for grant funds, and in management throughout the funding cycle ▪ Develop common reporting guidelines which make it easier for grant recipients to satisfy the reporting requirements of many donors without being overwhelmed by donor-specific bureaucracy	All stakeholders	By end of 2011	
		4. Develop a Mechanism for Private Sector	NAC	By end	

Way Forward: Action Plan for Operationalising the Recommendations					
Section in Full Report	**Way Forward Topic**	**Action To Take**	**Who Is Responsible**	**Time-frame**	**Reference to Existing Recommendations and Way Forward Discussions**
		Reporting ▪ Develop a reporting mechanism that ensures that NAC can track private sector resources used in the Response, regardless of the source ▪ Ensure that companies are committed to compliance even when those resources are from sources other than NAC		2011	
8.1.6	**Turning Information into Action: Strengthen Planning, Monitoring, and Reporting Mechanisms**	**1. Make Change Happen: Strengthen the Feedback Loop** ▪ Prepare guide on how constituents can access their representatives, provide input, and make representatives accountable	All organisations, networks, and government structures	By end 2010	
		2. Revive All Regular Progress Review Meetings at All Levels	All organisations, networks, and government structures	By end 2010	IRT 2008-2009 pg 15, extended NAF objective 5.2 strategy 5.2.1 action area 5.2.1.3
		3. Use Information to Improve Services: Strengthen the Capacity to Validate, Analyse and Use Data	All organisations, networks,	By end 2010	Extended NAF objective 5.3

Way Forward: Action Plan for Operationalising the Recommendations					
Section in Full Report	**Way Forward Topic**	**Action To Take**	**Who Is Responsible**	**Time-frame**	**Reference to Existing Recommendations and Way Forward Discussions**
			and government structures		
		4. Re-Ignite the Universal Access Momentum and Acceleration of the Response to Achieve Universal Access	All organisations, networks, and government structures	By June 2010	
		5. Cost Benefit Analysis: Examine the Cost of Action Versus the Cost of the Consequences of Not Taking Action ▪ Cost the current and alternative initiatives ▪ Conduct cost-benefit and cost-effective analysis for achieving UA targets using different modalities or player e.g. private sector	All organisations, networks, and government structures	By end 2011	
		6. Plan ahead for Population-Based Surveys ▪ Ensure that there are not long periods without reference data	National Statistical Office and Development Partners	By end 2010	
8.1.7	**Scale-up: Improving**	**1. Scale-up Coverage and Quality: Implement the Strategies and Guidelines**	MoH and NAC	By end 2011	

Way Forward: Action Plan for Operationalising the Recommendations					
Section in Full Report	**Way Forward Topic**	**Action To Take**	**Who Is Responsible**	**Time-frame**	**Reference to Existing Recommendations and Way Forward Discussions**
	Coverage and Quality	**2. Strengthen Systems of Supervision and Mentoring** ▪ Strengthen supervision and quality assurance system for HIV related services ▪ Introduce and strengthen mentoring programmes ▪ Conduct regular and ad-hoc quality check	MoH, NAC, and All Stakeholders	By end 2010	
		3. Fully Develop and Protect Our Human Resources ▪ Develop human resources through training, mentoring and volunteerism ▪ Create incentives for performance and improvement	All Stakeholders	By end 2011	
8.1.8	**Improving Access and Applicability: Tailoring the Services to the People's Needs**	**1. Clarify the Human Rights-Based Public Health Approach in All Programmes, Trainings, Mentoring, and Supervision** ▪ Mainstream human rights issues in curricula, trainings, mentoring and supervision	All stakeholders	By end 2010	
		2. Tailor Services to Meet the Needs of Most-At-Risk Populations and Vulnerable Groups ▪ Create civic/public health education messages comprehensive enough for	OPC, MoH, NAC, and All stakeholders	By end 2010	

Way Forward: Action Plan for Operationalising the Recommendations					
Section in Full Report	**Way Forward Topic**	**Action To Take**	**Who Is Responsible**	**Time-frame**	**Reference to Existing Recommendations and Way Forward Discussions**
		diverse groups ▪ Customise messages to meet the specific needs of different risk groups			
		3. Encourage Regular Check-ups and Integration of Services	OPC, MoH, NAC, and All stakeholders	By end 2010	
8.1.9	**Bring the Services to the People**	**1. Move the Talent and Incentive to Where the People Are** ▪ Rationalise Human resources to meet service demand ▪ Create conducive environments to motivate health service workers to move to rural areas	Government and Civil Society	By 2011	
		2. Bring the Services as Close as Possible to the People ▪ Explore the possibility of increasing mobile comprehensive services including HTC, PMTCT, ART, and other diagnostic and treatment services	MoH and all service delivery providers	By end of 2011	
		3. Ensure that Truly Free Services Are Available and Nearby ▪ Expand service level agreements with CHAM beyond Maternal service	MoH, CHAM	By end 2011	

Way Forward: Action Plan for Operationalising the Recommendations					
Section in Full Report	**Way Forward Topic**	**Action To Take**	**Who Is Responsible**	**Time-frame**	**Reference to Existing Recommendations and Way Forward Discussions**
		4. Map All NGOs for More Even Distribution	District Authorities	By end of 2010	IRT 2008-2009 pg 20;62.
		5. Eliminate Drug Stock-Outs ▪ Enhance supply chain management capacity ▪ Strengthen the monitoring system for drugs	MoH	By end 2010	
8.1.10	**Prevention**	**1. Move Beyond Knowledge to Practical Skills** ▪ Increase interpersonal and interactive approaches that allow people to build the skills that will help them use protection in day-to-day situations	OPC, NAC, MoH, and all stakeholders	By end of 2010	
		2. Enhance Free Availability and Marketing of Female and Male Condoms and Lubricants	NAC, MoH, and Civil Society	By end 2010	Extended NAF, Objective 1.1 Strategy 1.1.4; National HIV Prevention Strategy 2009-2013.pg 23
		3. Improve the Accessibility of Post-Exposure Prophylaxis (PEP)	MoH	By end 2010	
		4. Take Evidence-Based Prevention to Full Scale	OPC, NAC, and all stakeholders	By end 2011	National HIV Prevention Strategy 2009-2013.
8.1.11	**Nutrition and Food Security at Household Level**	**1. Fully Equip Agricultural Extension Workers to Provide Community and Household-Level Nutrition and Food Security Education and Support as an Integrated Part of Their**	OPC, MoA	By end 2010	Extended NAF objective 3.5.

Way Forward: Action Plan for Operationalising the Recommendations					
Section in Full Report	**Way Forward Topic**	**Action To Take**	**Who Is Responsible**	**Time-frame**	**Reference to Existing Recommendations and Way Forward Discussions**
		Outreach Activities			
		2. Enhance Access to Agricultural Inputs: Fertilisers, Seed, and Irrigation	MoA	By end 2011	

9. CONCLUSION

Throughout Malawi there is a desire for honest, productive discussion that meets people where they are at, that spans and connects the various levels of society from the top leadership positions to the users of services, and that spurs people in every position to constructive action.

The Way Forward Section above details how this can happen. All that is required now is for us to work together to do it as quickly as possible. We need everyone at every level to use the skills and motivation they have to play a vital role achieving Universal Access in Malawi.

ANNEXES

ANNEX 1: Consultation/Report Preparation Process

ANNEX 2: National Composite Policy Index

ANNEX 3: National Funding Matrix

ANNEX 4: Detailed Indicator Table

ANNEX 1 Consultation/Report Preparation Process

Consultation/Report Preparation Process

for the Country Progress Report on Monitoring the Follow-up to the Declaration of Commitment on HIV and AIDS

Malawi HIV and AIDS Monitoring and Evaluation Report: 2008-2009

UNGASS Country Progress Report

TABLE OF CONTENTS

1. CONSULTATION/REPORT PREPARATION PROCESS FORM

1. Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	**Yes**	**No**	
b) NAP	**Yes**	**No**	
c) Others	**Yes**	**No**	**(please specify)**

2) With inputs from

Ministries:			
Education	**Yes**	**No**	
Health	**Yes**	**No**	
Labour	**Yes**	**No**	
Foreign Affairs	**Yes**	**No**	
Others	**Yes**	**No**	**(please specify)** See below
Civil society organizations	**Yes**	**No**	
People living with HIV	**Yes**	**No**	
Private sector	**Yes**	**No**	
United Nations organizations	**Yes**	**No**	
Bilaterals	**Yes**	**No**	
International NGOs	**Yes**	**No**	
Others	**Yes**	**No**	**(please specify)** See below

3) Was the report discussed in a large forum? **Yes** **No**

4) Are the survey results stored centrally? **Yes** **No**

5) Are data available for public consultation? **Yes** **No**

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title:
Mr. Davie Kalomba
Head, Planning, Monitoring, Evaluation & Research
National AIDS Commission

Date:
31 March 2010

Signature:
Davie Kalomba

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2. KEY INFORMANT INTERVIEW AND FOCUS GROUP DISCUSSION PARTICIPANTS

Part A. Government: Key Informant Interviews

Part A. Government: Key Informant Interviews			
	Institution	**Name**	**Designation**
1	Office of the President and Cabinet; Department of Nutrition, HIV and AIDS (OPC, DNHA)	Dr. Mary Shawa	Principal Secretary for Nutrition HIV and AIDS
2	National AIDS Commission (NAC)	Dr. Biziwick Mwale	Executive Director
3	National AIDS Commission	Ms. Bridget Chibwana	Director of Policy & Programmes
4	National AIDS Commission	Mr. Davie Kalomba	Head, Planning, Monitoring Evaluation & Research
5	National AIDS Commission	Mr. Robert Chizimba	Head, Behavioural Change Interventions
6	National AIDS Commission	Ms. Florence Kayambo	Head, Policy Support and Development
7	Ministry of Health (MoH), HIV Department	Dr. Eric Schouten	TA, HIV Coordination
8	MoH, HIV Department	Dr. Zengani Chirwa	TA, ART Programme
9	MoH, HIV Department	Dr. Peggy Chibuye	TA, PMTCT
10	MoH, HIV Department /CMED	Dr. Andreas Jahn	TA, M&E
11	MoH, HIV Department	Dr. Mwai Makoka	HIV Fellow
12	MoH, HIV Department	Mr. Lucious Ng'omang'oma	HTC Programme Officer
13	MoH, HIV Department	Ms. Mtemwa Nyangulu	HTC Programme Officer
14	MoH, HIV Department	Mr. Simon Makombe	ART Programme Officer
15	OPC, Department of Human Resource Management and Development (DHRMD)	Dr. Khembo	HIV Programme Manager
16	Law Commission	Mr. William Y. Msiska	Assistant Law Reform Officer
17	Ministry of Youth & Sports Development	Mr. W. Lichapa	Principal Youth Officer

Part A. Government: Key Informant Interviews			
	Institution	**Name**	**Designation**
18	Malawi Human Rights Commission	Mr. Chrispin Sibande	Principal Legal Officer
19	Malawi Police Service	Mr. Chatsalira	Deputy Commissioner of Police/ HIV and AIDS Coordinator
20	Malawi Defence Force	Lt. Colonel F. Nkhoma	HIV and AIDS Coordinator
21	National Youth Council	Mr. A.Chibwana	Executive Director
22	Ministry of Gender, Child and Community Development	Ms. Linley Kantengeni	Gender Expert
23	Malawi Prison Services	Dr. H. Ndindi	Chief Medical Officer
24	MoH, TB Control Programme	Mr. H. Kanyerere	Director
25	Ministry of Finance (Chair of CCM and Pool Donor Group)	Ms. Madalo Nyambose	Assistant Director On behalf of the Secretary to the Treasury, Mr. Mwanamvekha and the Vice Chairperson of the CCM, Dr. Grace Malenga
26	Ministry of Development Planning & Cooperation	Mr. Phiri	Chief Economist
27	Malawi Human Rights Commission	Mr. Chrispin Sibande	Principal Legal Officer
28	Ministry of Local Government	Ms. Grace Chinamale	HIV and AIDS Coordinator
29	Blantyre District Assembly	Mr. H. Kaumi	District AIDS Coordinator
30	National AIDS Commission	Mr. Ken Chisanga	District Coordination Officer (South)
31	National AIDS Commission	Mr. Jonathan Vumu	District Coordination Officer (Centre)
32	Malawi Blood Transfusion Service	Dr. B. M'baya	Medical Director
33	Ministry of Education, Science & Technology	Mr. C. Mazinga	Deputy Director for Nutrition, HIV and AIDS

Part A. Government: Focus Group Discussions

Part A. Focus Group Discussions			
Focus Group Discussion	**Location/ District**	**Number of Participants Invited**	**Number of Participants Present**
Local-level Service Delivery	Salima	10	3
	Blantyre	10	3

Part B. Civil Society, Bilateral Agencies, and UN Organisations: Key Informant Interviews

Part B. Civil Society, Bilateral Agencies, and UN Organisations: Key Informant Interviews			
	Institution	**Name**	**Designation**
	Partnerships and Coordination		
1	Malawian Business Coalition against AIDS (MBCA)	Mr. Andrew Chikopa	Programme Director
2	Malawi Interfaith AIDS Association (MIAA)	Mr. Robert Ngaiyaye	Executive Director
3	Malawi Interfaith AIDS Association (MIAA)	Ms. E.Hanjahanja	M&E Officer
4	Malawi Network of People Living with HIV (MANET+)	Mr. Safari Mbewe Mr. Victor Kamanga	Executive Director Programme Officer
5	National Association for People Living with HIV and AIDS in Malawi (NAPHAM)	Ms. Amanda Manjolo	Executive Director
6	Family Planning Association of Malawi (FPAM)	Ms. E.Perekamoyo Mr. M. Chatuluka Mr. Ignatio Wachepa Ms. Ireen Kamanga Mr. Lawrent Kumchenga	Executive Director Programmes Director M&E Officer Service Delivery Manager IEC Advocay & Public Relations Officer
7	CEDEP		
8	Malawi Network of AIDS Service Organisations (MANASO)	Ms. Francina Nyirenda Mr. Donald Makwakwa	Executive Director M&E Officer
	International NGOs		
9	Action AID	Ms. Alepha Mwimba	Programme Officer
10	World Vision International (WVI)	Ms. Ethel Kapyepye	Senior Manager, HIV & AIDS
11	Save the Children	Mr. Chris Mzembe	Programme Officer
12	PACT	Mr. Rolex Tolani	M&E Manager
	Development Partners		
13	HADG	Dr. E. Limbambala	WHO
14	PEPFAR/USG	Dr. Mamadi Yilla	Country Coordinator
15	UNAIDS	Mr. Patrick Brenny	Country Coordinator
16	UNICEF	Mr. Caesar Mudondo	Procurement Specialist

Part B. Civil Society, Bilateral Agencies, and UN Organisations: Focus Group Discussions

Part B. Civil Society, Bilateral Agencies, and UN Organisations: Focus Group Discussions			
Focus Group Discussion	**Location/ District**	**Number of Participants Invited**	**Number of Participants Present**
Local-level Service Delivery	Salima	10	7
	Blantyre	10	3
Users of Services	Salima	10	18
	Blantyre	10	8
Users of Services: Sex Workers	Lilongwe	10	11
	Lilongwe	10	
	Blantyre	10	
Users of Services: Men who have Sex with Men	Lilongwe	10	6
	Blantyre	10	8

3. NCPI VALIDATION MEETING PARTICIPANTS: 4 FEB. 2010

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NCPI Validation Meeting: Part A Government				
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4. UNGASS/NASA TASK FORCE PARTICIPANTS AT THE MEETING TO REVIEW THE DRAFT UNGASS REPORT: 15 FEB. 2010

UNGASS/NASA Task Force Participants at the Meeting to Review the Draft UNGASS Report: 15 Feb. 2010		
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5. NATIONAL UNGASS REPORT VALIDATION MEETING PARTICIPANTS: 18 FEBRUARY 2010

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NCPI Validation Meeting: Part B Civil Society, Bilateral Agencies, and UN Organisations				
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6. REFERENCE DOCUMENTS

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NAC 2007: "*The Road Towards Universal Access: Scaling up access to HIV prevention, treatment, care and support in Malawi: 2006-2010"*

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GoM 2005: "*National Plan of Action for Orphans and Other Vulnerable Children, 2005-2009"*.

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http://data.unaids.org/Publications/IRC-pub07/JC1252-InternGuidelines_en.pdf

UN OHCHR and UNAIDS: Handbook on HIV and Human Rights for National Human Rights Institutions
http://data.unaids.org/pub/Report/2007/jc1367-handbookhiv_en.pdf

UNAIDS Policy Brief: Criminalization of HIV Transmission
http://data.unaids.org/pub/Manual/2008/JC1601_policy_brief_criminalization_long_en.pdf

Men Who Have Sex with Men

UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People
http://data.unaids.org/pub/Report/2009/jc1720_action_framework_msm_en.pdf

UNAIDS Press Release: AIDS Responses Failing Men who have Sex with Men and Transgender Populations
http://data.unaids.org/pub/PressRelease/2009/090515_msm_transgender_en.pdf

Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity
http://www.yogyakartaprinciples.org/principles_en.htm

Sex Workers

WHO: Violence Against Sex Workers and HIV Prevention
http://www.who.int/gender/documents/sexworkers.pdf

Sex Work and HIV/AIDS: UNAIDS Technical Update
http://data.unaids.org/Publications/IRC-pub02/jc705-sexwork-tu_en.pdf

Pregnant Women and Their Partners

UNAIDS Policy Brief: Criminalization of HIV Transmission
http://data.unaids.org/pub/Manual/2008/JC1601_policy_brief_criminalization_long_en.pdf

Young People

UNESCO and UNAIDS: HIV/AIDS and Human Rights: Young People in Action
http://data.unaids.org/Publications/IRC-pub02/JC669-HIV-AIDS-kit-Updated_en.pdf

Prisoners

UNAIDS and WHO: WHO Guidelines on HIV Infection and AIDS in Prisons
http://data.unaids.org/Publications/IRC-pub01/JC277-WHO-Guidel-Prisons_en.pdf

General Resources Regarding Treaty Obligations and Best Practice Recommendations

The Universal Declaration of Human Rights
http://www.un.org/en/documents/udhr/

International Covenant on Civil and Political Rights
http://www2.ohchr.org/english/law/ccpr.htm

International Covenant on Economic, Social and Cultural Rights
http://www2.ohchr.org/english/law/cescr.htm

Convention on the Elimination of All Forms of Discrimination against Women
http://www.un.org/womenwatch/daw/cedaw/

African Charter on Human and Peoples' Rights and Protocol to the African Charter on Human and People's Right
http://www.achpr.org/english/_info/charter_en.html

African Union Declarations on HIV and AIDS
http://www.africa-union.org/

UNAIDS Guidelines
http://www.unaids.org/en/default.asp

ANNEX 2 National Composite Policy Index

Malawi

National Composite Policy Index (NCPI)

Indicator 2 for the Malawi HIV and AIDS Monitoring and Evaluation Report: 2008-2009

UNGASS Country Progress Report

Refer: UNAIDS Website

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ANNEX 3 National Funding Matrix

Table 1: National Funding Matrix: 2007-2008

YEAR: 2007/2008 National Funding Matrix
Calendar Year: No AIDS Spending Categories by Financing Sources
Fiscal Year : 1st July 2007 to 30th June 2008
Currency used in Matrix: United States Dollar
Average Exchange Rate for the year: 1 US$=MK140.00

	Financing Sources													
		Public Sources			International Sources							Private Sources		
					International Sub-Total	Bilaterals	Multilaterals				All other International			
AIDS Spending Categories	TOTAL	Public Sub-Total	Central/National	All Other Public			UN Agencies	Global Fund	World Bank	All Other Multilateral		Private Sub-Total	For-profit institutions/ Corporations	All other private
TOTAL	107,426,244	1,896,100	1,798,143	97,957	104,826,099	21,267,029	3,430,843	69,445,865	1,023,393	668,280	8,990,689	704,045	17,234	686,811
Prevention (Sub Total)	20,933,660	311,981	273,784	38,197	20,286,234	8,716,916	514,404	10,098,191	35,645	47,203	873,875	335,445	801	334,644
Communication for social and behavioural change	2,398,088	11,997	11945	52	2,386,091	380,634	486648	1,457,206	34,038	-	27,565	-	-	-
Community mobilization	215,160	5,772	5627	145	209,388	18,113	10851	111,928	1,139	-	67,357	-	-	-
Voluntary counselling and testing (VCT)	7,042,866	154,077	154077	-	6,888,789	1,522,274	14,669	5,014,071	-	47,203	290,572	-	-	-
Risk-reduction for vulnerable and accessible populations	306,702	13,072	13072	-	293,630	35,290	319	246,050	468	-	11,503	-	-	-
Prevention – youth in school	194,062	10,420	10420	-	183,642	34,773	254	148,615	-	-		-	-	-
Prevention – youth out-of-school	114,581	2,055	2055	-	112,526	6,856	50	63,692	-	-	41,928	-	-	-
Prevention of HIV transmission aimed at people living with HIV (PLHIV)	75,813	-	-	-	75,813	42857	-	-	-	-	32,956	-	-	-
Prevention programmes in the workplace	669,282	10,474	10474	-	658,115	-	-	623,948	-	-	34,167	693	357	336
Condom social marketing	444	-	-	-	-	-	-	-	-	-		444	444	-
Prevention, diagnosis and treatment of sexually transmitted	101,911	651	651	-	101,260	2,174	-	99,086	-	-		-	-	-

infections (STI)														
Prevention of mother-to-child transmission (PMTCT)	4,465,468	62,069	62069	-	4,070,152	1,569,989	1,514	2,143,275	-	-	355,374	333,247	-	333247
Blood safety	283,119	3,394	3394	-	279,725	112,441	99	167,185	-	-		-	-	-
Universal precautions	23,135	-	-	-	23,135	-	-	23,135	-	-		-	-	-
Prevention activities not disaggregated by intervention	7,633	-	-	-	7,633	-	-	-	-	-	7,633	-	-	-
Prevention activities n.e.c.	5,035,396	38,000		38000	4,996,335	4991515	-	-	-	-	4,820	1,061	-	1061
Care and treatment (Sub Total)	33,488,569	623,638	622,284	1,354	32,835,519	3,243,318	901,430	26,796,434	0	13,440	1,880,897	29,412	4,313	25,099
Outpatient care	12,062,292	24,514	23,160	1,354	12,017,865	176,499	206,066	10,669,884	-	-	965,416	19,913	-	19,913
Patient transport and emergency rescue	4,002	-		-	-	-	-	-	-	-	-	4,002	4,002	-
Care and treatment services not disaggregated by intervention	20,289,992	585,410	585410	-	19,699,085	1,988,791	695,364	16,116,980	-	13,440	884,510	5,497	311	5186
Care and treatment services n.e.c.	1,132,283	13,714	13714	-	1,118,569	1,078,028	-	9,570	-	-	30971	-	-	-
Orphans and vulnerable children (Sub Total)	7,787,005	168,651	168,651	-	7,454,367	1,638,254	308,675	5,228,845	909	80,305	197,379	163,987	0	163,987
OVC Education	116,407	-	-	-	116,407	-	-	-	-	-	116,407	-	-	-
OVC Basic health care	100,000	-	-	-	100,000	100,000	-	-	-	-	-	-	-	-
OVC Family/home support	200,000	-	-	-	200,000	200,000	-	-	-	-	-	-	-	-
OVC Community support	37,394	-	-	-	37,394	-	37,394	-	-	-	-	-	-	-
OVC Social Services and Administrative costs	6,985	172	172	-	6,813	574	-	5,330	909	-	-	-	-	-
OVC Services not disaggregated by intervention	7,059,051	168,479	168,479	-	6,726,585	1,337,680	4,113	5,223,515	-	80,305	80,972	163,987	-	163,987
OVC services n.e.c.	267,168	-	-	-	267,168	-	267,168	-	-	-	-	-	-	-
Programme management and administration (Sub Total)	24,305,572	223,596	210,393	13,203	24,022,421	4,623,279	452,811	12,442,278	854,542	527,332	5,122,179	59,555	536	59019
Planning, coordination and programme management	6,449,986	18,553	18436	117	6,431,433	2,461,864	27,255	536,065	67,470	267,398	3,071,381	-	-	-
Administration and transaction costs associated with managing and disbursing funds	5,495,715	121,239	108291	12948	5,327,365	458,070	31,592	3,645,138	587,031	101,294	504,240	47,111	536	46575

Monitoring and evaluation	3,639,679	62,119	61981	138	3,565,116	1,224,678	240,890	2,075,692	-	3,187	20,669	12,444	-	12444
Operations research	443,729	-	-	-	443,729	77	30,541	284,733	-	-	128,378	-	-	-
Serological-surveillance (serosurveillance)	557,494	410	410	-	557,084	1,600	-	468,690	86,794	-	-	-	-	-
Drug supply systems	2,913,804	-		-	2,913,804	-	-	2,758,351		155,453	-	-	-	-
Information technology	93,848	2,380	2380	-	91,468	5,104	-	73,787	12,577	-	-	-	-	-
Upgrading and construction of infrastructure	392,843	-	-	-	392,843	392,843	-	-	-	-	-	-	-	-
Mandatory HIV testing (not VCT)	338,231	-	-	-	338,231		-	-	-	-	338,231	-	-	-
Programme management and administration not disaggregated by type	1,132,822	-	-	-	1,132,822	4,702	122,533	-	-	-	1,005,587	-	-	-
Programme management and administration n.e.c	2,847,421	18,895	18895	-	2,828,526	74,341	-	2,599,822	100,670	-	53,693	-	-	-
Human resources (Sub Total)	2,574,247	113,385	68,210	45,175	2,422,320	422,357	115,956	1,417,805	113,633	0	352,569	38,542	2,828	35,714
Monetary incentives for human resources	8,554	206	206	-	8,348	810	-	6,440	1,098	-		-	-	-
Training	2,528,399	113,179	68004	45175	2,412,392	419,967	115,956	1,411,365	112,535	-	352,569	2,828	2828	-
Human resources not disaggregated by type	36,938	-	-	-	1,224	1,224	-	-	-	-		35,714	-	35714
Human resources n.e.c.	356	-	-	-	356	356	-	-	-	-		-	-	-
Social protection and social services excluding OVC (Sub Total)	4,777,500	99,299	99,299	0	4,649,630	1,334,291	793,217	2,348,966	-	-	173,156	28,571	0	28,571
Social protection through monetary benefits	132,576	-	-	-	132,576	-	-	-	-	-	132576	-	-	-
Social protection through in-kind benefits	1,080,051	36,554	36554	-	1,014,926	43446	529187	403611	-	-	38682	28,571	-	28571
HIV-specific income generation projects	2,320,934	62,745	62745	-	2,258,189	309406	1530	1945355	-	-	1898	-	-	-
Social protection services and social services not disaggregated by type	1,224,939	-	-	-	1,224,939	962439	262500	-	-	-		-	-	-
Social protection services and social services n.e.c.	19,000	-	-	-	19,000	19000	-	-	-	-		-	-	-
Enabling environment Sub Total	12,387,061	330,421		0		1,112,755	85,911		0	0		48,533	8,756	39,777

			330,421		12,008,107			10,418,807			390,634			
Advocacy	368,563	-	-	-	349,263	10018	26258	-	-	-	312987	19,300	7357	11943
Human rights programmes	1,846,485	51,564	51,564	-	1,794,868	172090	1258	1598693	-	-	22827	53	-	53
AIDS-specific programmes focused on women	105,600	-	-	-	105,600	-	51594	-	-	-	54006	-	-	-
Programmes to reduce Gender Based Violence	175,241	-	-	-	175,241	-	-	174427	-	-	814	-	-	-
Enabling environment not disaggregated by type	8,525,916	-	-	-	8,525,916	-	-	8525916	-	-	-	-	-	-
Enabling environment n.e.c.	1,365,256	278,857	278,857	-	1,057,219	930647	6801	119771	-	-	-	29,180	1399	27781
HIV and AIDS-related research excluding operations research (Sub Total)	1,172,630	25,129	25,101	28	1,147,501	175,859	258,439	694,539	18,664	0	0	0	0	0
Biomedical research	90,000	-	-	-	90,000	90000	-	-	-	-	-	-	-	-
Social science research	30,956	-	-	-	30,956	-	30956	-	-	-	-	-	-	-
HIV and AIDS-related research activities not disaggregated by type	13,232	118	118	-	13,114	458	8388	3647	621	-	-	-	-	-
HIV and AIDS-related research activities n.e.c.	1,038,442	25,011	24983	28	1,013,431	85401	219095	690892	18043	-	-	-	-	-

Table 2: National Funding Matrix: 2008-2009

YEAR: 2008/2009 National Funding Matrix

Calendar Year: No AIDS Spending Categories by Financing Sources

Fiscal Year : 1st July 2008 to 30th June 2009

Currency used in Matrix: United States Dollar

Average Exchange Rate for the year: 1 US$=MK140.00

	Financing Sources													
		Public Sources			International Sources							Private Sources		
							Multilaterals							
AIDS Spending Categories	TOTAL	Public Sub-Total	Central/National	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	World Bank	All Other Multilateral	All other International	Private Sub-Total	For-profit institutions/ Corporations	All other private
TOTAL	104,534,528	1,461,800	1,455,107	6,693	102,445,113	27,476,324	2,644,150	56,826,532	5,691,185	565,310	9,241,612	627,615	146,001	421,794
Prevention (Sub Total)	17,766,756	134,782	134,287	495	17,569,319	9,622,509	497,460	5,138,442	426,046	441,512	1,443,350	62,655	62,655	-
Communication for social and behavioural change	869,202	10,090	10037	53	858,248	37,873	24,459	701,589	44,706	-	49,621	864	864	-
Community mobilization	679,106	10,047	9993	54	669,059	37,201	12,398	448,535	45,619	-	125,306	-	-	-
Voluntary counselling and testing (VCT)	3,057,880	19,591	19485	106	3,038,289	1,310,941	13,997	1,005,038	88,955	441,512	177,846	-	-	-
Risk-reduction for vulnerable and accessible populations	399,999	6,206	6172	34	393,793	22,977	1,040	277,036	28,177	-	64,563	-	-	-
Prevention – youth in school	256,973	2,054	2028	26	254,919	17,616	797	212,394	21,602	-	2,510	-	-	-
Prevention – youth out-of-school	112,919	4,743	4743	-	108,176	7,550	342	91,026	9,258	-	-	-	-	-
Prevention of HIV transmission aimed at people living with HIV (PLHIV)	279,355	-	-	-	279,355	121,429	-	-	-	-	157,926	-	-	-
Prevention programmes in the workplace	590,915	40,707	40707	-	490,208	-	-	479,316	-	-	10,892	60,000	60,000	-
Condom social marketing	1,791	-	-	-	-	-	-	-	-	-	-	1,791	1,791	-
Prevention, diagnosis and treatment of sexually transmitted infections	385,351	7,087	7049	38	378,264	26,242	1,188	318,653	32,181	-	-	-	-	-

(STI)														
Prevention of mother-to-child transmission (PMTCT)	3,602,202	24,469	24337	132	3,577,733	1,742,756	4,101	1,167,864	111,103	-	551,909	-	-	-
Blood safety	529,054	9,736	9736	-	519,318	36,244	1,638	436,991	44,445	-		-	-	-
Prevention activities not disaggregated by intervention	787,104	-	-	-	787,104	186,555	437,500	-	-	-	163,049	-	-	-
Prevention activities n.e.c.	6,214,905	52	-	52	6,214,853	6,075,125	-	-	-	-	139,728	-	-	-
Care and treatment (Sub Total)	39,931,108	668,481	664,950	3,531	39,256,974	5,943,630	728,324	28,408,470	2,966,347	-	1,210,203	5,653	653	5,000
Outpatient care	5,180,134	64316	64014	302	5110165	986,608	15,718	2,710,091	253,795	-	1,143,953	5,653	653	5000
Care and treatment services not disaggregated by intervention	32,005,974	604165	600936	3229	31401809	2,212,022	712,606	25,698,379	2,712,552	-	66,250	-	-	-
Care and treatment services n.e.c.	2,745,000	-	-	-	2745000	2,745,000	-	-	-	-	-	-	-	-
Orphans and vulnerable children (Sub Total)	4,735,504	51,343	51,068	275	4,396,792	1,392,381	22,635	2,292,107	233,124	-	456,545	287,369	-	287,369
OVC Education	431,844	582	582	-	431262	17,156	97	25,986	2,643	-	385,380	-	-	-
OVC Services not disaggregated by intervention	4,303,660	50761	50486	275	3965530	1,375,225	22,538	2,266,121	230,481	-	71,165	287369	-	287369
Programme management and administration (Sub Total)	23,261,727	183,448	182,577	871	22,943,459	8,391,674	397,861	7,808,470	745,799	123,798	5,475,857	134,820	75,000	-
Planning, coordination and programme management	8,408,867	46780	46522	258	8362087	2,842,128	52,851	2,257,752	216,300	123,798	2,869,258	-	-	-
Administration and transaction costs associated with managing and disbursing funds	7,028,531	124359	123802	557	6769352	1,193,742	35,436	4,639,360	466,918	-	433,896	134820	75000	-
Monitoring and evaluation	2,940,356	10463	10407	56	2929893	2,076,124	240,774	534,889	53,834	-	24,272	-	-	-
Operations research	494,857	-	-	-	494857	16,988	20,000	57,216	-	-	400,653	-	-	-

Serological-surveillance (serosurveillance)	201,988	-	-	-	201988	-	-	201,988	-	-		-	-	-
HIV drug-resistance surveillance	4,583	-	-	-	4583	67	-	4,096	417	-		-	-	-
Drug supply systems	689,971	-	-	-	689971	-	-	26,421	-	-	663,550	-	-	-
Information technology	110,837	1747	1747	-	109090	30,788	293	78,009	-	-		-	-	-
Upgrading and construction of infrastructure	1,160,000	-	-	-	1160000	1,160,000	-	-	-	-		-	-	-
Programme management and administration not disaggregated by type	1,192,509	-	-	-	1192509	1,071,724	-	-	7,934	-	112,851	-	-	-
Programme management and administration n.e.c	1,029,228	99	99	-	1029129	113	48,507	8,739	396	-	971,377	-	-	-
Human resources (Sub Total)	1,190,008	89,408	89,408	-	1,043,457	479,696	132,972	231,467	5,373	-	193,949	57,143	-	57,143
Training	938,531	89408	89408		849123	285,362	132,972	231,467	5,373	-	193,949	-	-	-
Human resources not disaggregated by type	251,477	-	-	-	194334	194,334	-	-	-	-		57143	-	57143
Social protection and social services excluding OVC (Sub Total)	1,814,367	49,130	49,026	104	1,731,308	130,257	484,301	883,255	89,834	-	143,661	33,929	-	33,929
Social protection through monetary benefits	118,214	-	-	-	118,214	57000	-	-	-	-	61214		-	-
Social protection through in-kind benefits	825,523	42286	42216	70	749,308	47915	2169	577708	58758	-	62758	33929	-	33929
Social protection through provision of social services	343,481	6354	6320	34	337,127	23529	1065	283681	28852	-		-	-	-
HIV-specific income generation projects	46,164	490	490	-	45,674	1813	82	21866	2224	-	19689	-	-	-
Social protection services and social services not disaggregated by type	480,985	-	-	-	480,985	-	480985	-	-	-		-	-	-
Enabling environment Sub Total	14,615,472	270,511	269,162	1,349	14,298,915	1,066,307	378,133	11,379,092	1,157,336	-	318,047	46,046	7,693	38,353
Advocacy	183,714	621	621	-	178724	1097	10361	-	-	-	167266	4369	4369	-
Human rights		41,283			1734873	218747	78404	1173349	119338		145035	3324	3324	

programmes	1,779,480		41,141	142						-				-
AIDS-specific programmes focused on women	259,221	-	-	-	259221	-	253475	-	-	-	5746	-	-	-
Programmes to reduce Gender Based Violence	178,901	3,310	3,310	-	175591	12255	555	147753	15028	-	-	-	-	-
Enabling environment not disaggregated by type	12,069,799	223,336	222,129	1,207	11846463	826947	35008	9970442	1014066	-	-	-	-	-
Enabling environment n.e.c.	144,357	1,961	1,961		104043	7261	330	87548	8904	-	-	38353	-	38353
HIV and AIDS-related research excluding operations research (Sub Total)	1,219,586	14,697	14,629	68	1,204,889	449,870	2,464	685,229	67,326	-	-	-	-	-
Biomedical research	350,000	-	-	-	350,000	350000	-	-	-	-	-	-	-	-
Social science research	65,566	-	-	-	65,566	-	35	65531	-	-	-	-	-	-
HIV and AIDS-related research activities not disaggregated by type	679,365	12726	12658	68	666,639	92569	2098	513599	58373	-	-	-	-	-
HIV and AIDS-related research activities n.e.c.	124,655	1971	1971	-	122,684	7301	331	106099	8953	-	-	-	-	-

ANNEX 4 Detailed Indicator Table

Core Indicators for the Implementation of the Declaration of Commitment on HIV and AIDS									
Indicators	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**Target 2010**	**Target 2012**	**Sources**
National Commitment and Action									
1. Domestic and international AIDS spending by categories and financing sources					See Annex 3 of this Report	See Annex 3 of this Report			National AIDS Spending Assessments
2. National Composite Policy Index			See Annex of 2006-2007 Report	See Annex of 2006-2007 Report	See Annex 2 of this Report	See Annex 2 of this Report			National Composite Policy Index
National Programmes									
3. Percentage of donated blood units screened for HIV in a quality assured manner					MBTS: 100% Health Facilities: Not yet available	Not yet available	**98%**	**100%**	MBTS (blood screened by MBTS); MoH (blood screened by health facilities)
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Adults: / 222,138 = Children: / 17,638 = Total: 10,761 / 239,776 = **4.49%**	Adults: / 239,300 = Children: / 19,040 = Total: 29,087 / 258,340 = **11.26%**	Adults: / 239,300 = Children: / 19,040 = Adults and Children: 59,980 / 258,340 = **23.22%**	Adults: / 252,720 = Children: / 23,441 = Adults and Children: 100,649 / 276,161 = **36.45%**	Adults: 135,697 / 263,334 = 51.53% Children: 11,800 / 26,454 = 44.61% Adults and Children: 147,497 / 289,788 = **50.90%**	Adults: 181,482 / 278,868 = 65.08% Children: 17,364 / 26,937 = 64.46% Adults and Children: 198,846 / 305,805 = **65.02%**	80% (Projected **Total in Need CD4 350: 450,000;** CD4 200: 324,191)	(Projected **Total in Need CD4 350: 525,000;** CD4 200: 363,270)	Numerator: MoH ART Patient Records; Denominator: Spectrum Estimates based on a CD4 cut-off of 350 and 200
5. Percentage of HIV-positive				22,952 /	33,517 /	Data is being	(Projecte	70%	Numerators:

Core Indicators for the Implementation of the Declaration of Commitment on HIV and AIDS									
Indicators	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**Target 2010**	**Target 2012**	**Sources**
pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission				80,895 = **28.4%** Note: Double counting could be as much as 60%	83,160 = **40.3%** Note: Double counting could be as much as 60%	aggregated	d **Total in Need: 87,882**)	(Projecte d **Total in Need: 92,872**)	MoH ANC and Maternity registers; Denominators: Calculations based on 2008 Census estimates of pregnant women x prevalence from 2007 sentinel surveillance
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV				4,348 / 34,000 = **12.79%**	4,929 / 30,000 = **16.43%**	Data is being aggregated			Numerator: National TB Control Programme Denominator: http://www.who.int/tb/country/data/download/en/index1.html
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	**M: 15.1% F: 12.9%**				Most recent data is from 2004	Most recent data is from 2004	**M: 75% F: 75%**	**M: 75% F: 75%**	DHS 2004
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results					To be incorporated in future data collection	To be incorporated in future data collection			

Core Indicators for the Implementation of the Declaration of Commitment on HIV and AIDS									
Indicators	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**Target 2010**	**Target 2012**	**Sources**
9. Percentage of most-at-risk populations reached with HIV prevention programmes					To be incorporated in future data collection	To be incorporated in future data collection			
10. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child			**18.5%**		Most recent data is from 2006	Most recent data is from 2006	**80%**	**90%**	MICS 2006
11. Percentage of schools that provided life skills-based HIV education in the last academic year					To be incorporated in future data collection	To be incorporated in future data collection	**100%**	**100%**	
Knowledge and Behaviour									
12. Current school attendance among orphans and among non-orphans aged 10–14[19]	OVC: M: 85.5% F: 89.4% **Total: 87.4%** Non-OVC: M: 89.7% F: 90.8% **Total: 90.2%**		OVC: M: 87.5% F: 89.9% **Total: 88.8%** Non-OVC: was M: 90.2% F: 90.2% **Total: 90.2%**		Most recent data is from 2006	Most recent data is from 2006	**.98**	**1.0**	DHS 2004; MICS 2006
13. Percentage of young women and men aged 15-24 who both correctly identify	**F: 23.6% M: 36.3%**		**F: 42.1% M: 41.9%**		Most recent data is from 2006	Most recent data is from 2006	**75%**	**75%**	DHS 2004; MICS 2006

[19] The purpose of this indicator is to assess progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans. For the purposes of this indicator, an orphan is defined as a child who has lost both parents; and a non-orphan is defined as a child whose parents are both alive and who is living with at least one parent.

Core Indicators for the Implementation of the Declaration of Commitment on HIV and AIDS									
Indicators	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**Target 2010**	**Target 2012**	**Sources**
ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission									
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission			SW: / 352 = **38.4%**		Most recent data is from 2006	Most recent data is from 2006			BSS 2006
15. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15	15-19: **F: 14.1%** **M: 18.0%** 20-24: F: 15.5% M: 9.1% Total: **F: 14.8%** **M: 13.7%**		15-19: **F: 14.1%** **M: 16.1%**		Most recent data is from 2006	Most recent data is from 2006			DHS 2004 MICS 2006
16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	15-24: **F: 1.7%** **M: 13.2%** Total: 15-49 **F: 1.1%** **M: 11.8%**		15-24: **F: 1.1%** **M: 5.6%**		Most recent data is from 2006	Most recent data is from 2006	**M: 18%** **F: 5%**	**M: 9%** **F: 1%**	DHS 2004 MICS 2006
17. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months					To be incorporated in future data collection	To be incorporated in future data collection			

Core Indicators for the Implementation of the Declaration of Commitment on HIV and AIDS									
Indicators	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**Target 2010**	**Target 2012**	**Sources**
reporting the use of a condom during their last sexual intercourse									
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client			**F: 91.8%**		Most recent data is from 2006	Most recent data is from 2006			BSS 2006
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner					To be incorporated in future data collection	To be incorporated in future data collection			
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse					Not applicable	Not applicable			
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected					Not applicable	Not applicable			
Impact									
22. Percentage of young women and men aged 15–24 who are HIV infected		**15-19: 10.3%** (8.9,11.8) **20-24: 16.4%** (15.2,17.7) Total 15-24:		**15-19: 9.5%** (8.6,10.4) **20-24: 13.8%** (13.1,14.6) **Total 15-24: 12.3%** (11.7,12.9)	Most recent data is from 2007	Most recent data is from 2007	**12%**	13%	HIV and Syphilis Sero-Survey and National HIV Prevalence and AIDS Estimates Report for 2007; MoH and NAC; August 2008
23. Percentage of most-at-risk					To be	To be			

Core Indicators for the Implementation of the Declaration of Commitment on HIV and AIDS									
Indicators	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**Target 2010**	**Target 2012**	**Sources**
populations who are HIV infected					incorporated in future data collection	incorporated in future data collection			
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy					**>15:** 733 / 1,108 = **76%** **15+:** 9,118 / 13,751 = **76%**	**All ages:** 8,180 / 12,244 = **67%**			ART in the Public and Private Sectors in Malawi: Results Up To 30th December, 2007
25. Percentage of infants born to HIV-infected mothers who are infected					See estimate for 2009	11,779 / 85,488 = **13.8%** Note: These estimates include an overly optimistic assumption about percentage of women on PMTCT		**14%**	Numerator: MoH, ART Programme Records; Denominator: Spectrum in the Sentinel Surveillance 2007