Government of Malawi

Malawi AIDS Response Progress Report

2015

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List of acronyms and abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
BBSS	Biological and Behavioural Surveillance Survey
BCC	Behaviour Change and Communication
BCI	Behaviour Change Interventions
BLM	Banja La Mtsogolo Malawi
Camfed	Campaign for female education
CBCC	Community-Based Childcare Centres
CBO	Community Based Organization
CDC	Centre for Disease Control and Prevention
CEDEP	Centre for Development of the People
CHAI	Clinton Health Access Initiative
CHAM	Christian Health Association of Malawi
CHBC	Community and Home Based Care
CMED	Central Monitoring and Evaluation Division
CMST	Central Medical Stores Trust
COWLA	Coalition of Women Living with AIDS
CSO	Civil Service Organization
DfFID	Department for International Development
DNA	Deoxyribonucleic Acid
DNHA	Department of Nutrition HIV and AIDS
EID	Early Infant Diagnosis
EMTCT	Elimination of HIV Mother-to-Child Transmission
EU	European Union
FSW	Female Sex Worker
GARPR	Global AIDS Response Progress Report

GBV	Gender Based Violence
GFATM	Global Fund to Fight AIDS Tuberculosis and Malawi
GoM	Government of Malawi
HADG	HIV and AIDS Donor Group
HIV	Human Immunodeficiency Virus
HLM	High Level Meeting
HMIS	Health Management Information System
HSAs	Health Surveillance Assistants
HTC	HIV Testing and Counseling
IAWP	Integrated Annual Workplan
IEC	Information Education and Communication
INH	Isoniazid
IPT	Isoniazid Preventive Therapy
IRT	Independent Review Team
I-TECH	International Training & Education Center for Health
LAHARS	Local Authority HIV and AIDS Reporting System
LEA	Legal Environment Assessment
LSE	Life Skills Education
M&E	Monitoring and Evaluation
MACOHA	Malawi Council for the Handicapped
MANASO	Malawi Network of AIDS Service Organizations
MANET	Malawi Network of People Living with HIV
MBCA	Malawi Business Coalition Against AIDS
MBTS	Malawi Blood Transfusion Service
MCP	Multiple and Concurrent Partnership
MDG	Millennium Development Goals
MDHS	Malawi Demographic and Health Survey
MGDS	Malawi Growth and Development Strategy
MGFCC	Malawi Global Fund Coordinating Committee

MIAA	Malawi Interfaith AIDS Association
MICS	Multiple Indicator Cluster Survey
MoEST	Ministry of Education Science and Technology
MoFEP	Ministry of Finance, Economic Planning and Development
MoGCD&SW	Ministry of Gender, Children, Disability and Social Welfare
MoH	Ministry of Health
MoT	Modes of Transmission
MPF	Malawi Partnership Forum
MPS	Malawi Police Services
MSM	Men having Sex with Men
MTCT	Mother to Child Transmission
NAC	National AIDS Commission
NAPHAM	National Association of People Living with HIV and AIDS in Malawi
NASA	National AIDS Spending Assessment
NCPI	National Commitment and Policy Instrument
NFM	National Funding Matrix
NPA	National Plan of Action
NSO	National Statistical Office
NSP	National HIV and AIDS Strategic Plan
OPC	Office of the President and Cabinet
ORT	Other Recurrent Transactions
OSC	One Stop Centre
OVC	Orphans and other Vulnerable Children
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PHIA	Population-based HIV Indicator Assessment
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child Transmission

PSI	Population Services International
RBM	Reserve Bank of Malawi
SCO	Civil Society Organization
SCTP	Social Cash Transfer Programme
SHA	System for Health Accounts
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOT	Training of Trainers
TV	Television
TWG	Technical Working Group
UDHR	Universal Declaration on Human Rights
UN	United Nations
UNAIDS	United Nations Joint Program on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VMMC	Voluntary Medical Male Circumcision
VSU	Victim Support Unit
WHO	World Health Organization
YFHS	Youth Friendly Health Services
YONECO	Youth Net and Counseling

Chapter I: Status at a glance

1.1. Introduction

The HIV epidemic in Malawi has evolved, since the first case was diagnosed in 1985, to become one of the major causes of mortality and has placed tremendous demands on the health system and the economy. The epidemic has affected all sections of society – children, youths, adults, women and men. The country's response to this epidemic has also evolved over the years from a health sector led response to a multi-sectoral one coordinated by one national authority, one strategic framework and one monitoring and evaluation framework. The response to the epidemic has been improving in tandem with increase in availability of reliable and comprehensive data, which has enabled the country to sharpen its focus on the key HIV transmission areas and populations in order to reduce new infections.

In June 2011, Malawi's President joined other Heads of State and Government to review progress achieved in realizing the 2001 Declaration of Commitment on HIV and AIDS and the 2006 Political Declaration on HIV and AIDS. This High Level Meeting approved the UNAIDS Strategy - ***Getting to Zero 2011-2015.*** The leaders expressed concern regarding the inability of majority of low- and middle-income countries to meet universal access to HIV treatment targets despite the major achievement of expansion in providing access to anti-retroviral treatment. Concern was also expressed that the number of new HIV infections was outpacing the number of people starting HIV treatment by a factor of two to one.

Among others, the leaders committed themselves to redouble efforts to achieve universal access to HIV prevention, treatment, care and support as a critical step towards ending the AIDS epidemic, with a view to achieving Millennium Development Goal 6, and in particular to halt and begin to reverse the spread of HIV by 2015.

This report presents the trends and status of key indicators of the HIV epidemic and the programmatic response in Malawi. This is not an evaluation of the HIV epidemic and response, but rather, a presentation of the most recent data that users can interpret and apply for various purposes.

1.2. Status of the epidemic

Since the Malawi Demographic and Health Survey (MDHS) in 2010, no recent nationally representative survey has been conducted in Malawi to estimate HIV prevalence. However, Malawi is planning an MDHS in 2015 as well as a Population-based HIV Indicator Assessment (PHIA) survey which is expected to estimate the prevalence of HIV. Nevertheless, based on previous survey data, Malawi has a generalized HIV epidemic. HIV prevalence among persons aged 15 to 49 years has been declining steadily from 16.4% in 1999 to 11.8% in 2004 and then 10.6% in 2010. In a previous survey[1], HIV prevalence was noted to be higher in specific occupational groups such as female sex workers, truck drivers, estate workers, police officers, teachers and female border traders compared with the general population.

Additionally, the most recent epidemiological modelling suggests a national average HIV incidence rate of 0.48 (CI 0.41-.46) per 100 person-years amongst people aged 15 – 49[2] in 2012, a decline of 35% from 0.74 in 2009. Malawi's rapid and successful Antiretroviral Therapy (ARV) scale-up from 2004 to 2014 has critically influenced the trajectory of the HIV epidemic, reducing mortality, morbidity, and transmission. In the one decade since starting the national treatment program:

- 1 out of every 20 Malawi adults are now on ART
- 275,000 deaths have been averted
- 1.4 million life-years have been gained, primarily among young adults in their peak productive life period.

1.3. The policy and programmatic response

The Malawi Growth and Development Strategy (MGDS 2011-2016) provides the overall framework for socio-economic development agenda in Malawi. HIV is one of the key priority areas within the wider theme of social development. The MGDS also identified key strategic interventions which should be implemented in order to manage the HIV epidemic. In addition, the National HIV and AIDS Policy (2012), launched in July 2013, offers specific policy guidance to the national HIV and AIDS response.

In 2014, Malawi launched the development of the 2015-2020 National HIV and AIDS Strategic Plan (NSP) to supersede the 2011-2016 NSP. The new NSP aims to translate the National HIV and AIDS Policy into action and provide a new framework for the

[1] National Statistical Office. (2006). Biological and Behavioural Surveillance Survey. Zomba: National Statistical Office.

[2] Joint United Nations Program on HIV/AIDS (UNAIDS) Malawi, May 2014 HIV estimates.

implementation of HIV and AIDS interventions, in line with the UNAIDS 90-90-90 targets[3]. The 2015-2020 NSP emphasizes on the following major programmatic areas;

1. Intensifying the identification of previously undiagnosed HIV infected children and adults by refocusing the provision of high quality Provider Initiated HIV Testing and Counseling (PITC) services in high-yield settings and sub-populations at high risk of HIV infection,
2. Expanding access to Antiretroviral Therapy (ART) by continuing to roll out ART services to peripheral health facilities and increasing the number of HIV positive children and adults eligible for ART, in line with the 2013 WHO ART Guidelines[4],
3. Maintaining high levels of adherence to ART regimens and retention treated HIV-positive individuals in ART programs through intensified public education and engagement and the use of community-based support groups.

The NSP recognizes that human resource shortages in Malawi impede optimal delivery of quality health sector-based HIV and AIDS interventions and undertakes to address this challenge by introducing HIV Diagnostic Assistants, as a new cadre of health workers who will complement skilled health workers in the provision of HIV and AIDS services.

The new HIV Prevention Strategy (2015-2020), aligned to the new NSP, aims at reducing HIV infections in line with the UNAIDS 90-90-90 targets. The new strategy specifically recognizes the need to target specific HIV preventive interventions to key populations such as Men who have Sex with Men (MSM), Female Sex Workers (FSW), couples and young women aged 10-24 years. The strategy provides a framework for overcoming challenges experienced in implementing traditional HIV transmission reduction interventions such as condom use, treatment of sexually-transmitted infections (STIs) and VMMC and promotes the use of a human rights and gender-based approaches in implementing HIV preventive interventions. It also recognizes the importance of high ART coverage in HIV prevention and includes specific interventions to support PLHIVs by promoting treatment adherence, addressing stigma and discrimination and providing social protection.

The development of the NSP and HIV Prevention Strategy was conducted in a transparent and all-inclusive manner. The recommended strategies and interventions were informed by research evidence, Malawi's HIV and AIDS epidemiology and specific country context such as the public health system and the wider socioeconomic, political and cultural environment. To increase efficiency in HIV prevention, treatment, and care, the strategies adopted the investment framework which aims at maximizing the benefits of HIV

[3] 90% of PLHIV will know their status, 90% of people diagnosed will be on ART and 90% of people on ART will be virally suppressed

[4] Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection: Recommendations for a Public Health Approach, World Health Organization, June 2013

interventions by prioritizing and implementing the most cost-effective programmatic activities. The country used these strategies as reference points during the preparation of the Joint HIV/TB concept note which was submitted to the Global Fund in early 2015.

Besides the HIV-specific policies and strategies, Malawi has several pieces of legislations which directly and indirectly impact the prevention and management of HIV and AIDS. These include: The Constitution of Republic of Malawi, The Penal Code, The Public Health Act, The Child Care, Justice and Protection Act, The Marriage Act, The Prevention of Domestic Violence Act, The Deceased Estate (Wills and Inheritance) Act, The Gender Equality Act, The Disability Act, The Occupational Safety, Health and Welfare Act, The Employment Act and The Labour Relations Act. In 2008, the Malawi Law Commission started the process of developing the HIV and AIDS Bill which aimed at consolidating HIV-related provisions spread across various pieces of legislation and strengthening the legal framework for implementing HIV and AIDS interventions. In 2014, stakeholders continued to review provisions of this bill so as to ensure that it meets the expectations of all constituencies and adheres to human rights standards. Thereafter, the Ministry of Justice and Constitutional Affairs finalized the drafting of Bill which is expected to be presented to the GoM cabinet in 2015 for review and approval before further submission to parliament for enactment.

Malawi is also a signatory to a number of international conventions and declarations. These include the 2000 UN Millennium Declaration, the 1948 Universal Declaration on Human Rights (UDHR), the 2001 UN Declaration of Commitment on HIV and AIDS, and the 2011 Political Declaration on HIV and AIDS. These international conventions and declarations have continued to provide an important guiding framework for national laws, policies, plans and regulations relating to HIV and AIDS.

Consistent with the 'three ones' principle, the NAC has the responsibility of coordinating the national response against the HIV and AIDS epidemic. The NAC coordinates the development of an Integrated Annual Workplan (IAWP) which outlines activities to be implemented by different partners and their corresponding budgets. These implementing partners include government ministries, NGOs, CSOs and the private sector working at national and sub-national levels. Nevertheless, it is apparent that a significant number of HIV interventions are implemented by partners not listed in the IAWP which present challenges in accounting for the investments in the HIV and AIDS response and assessing their impacts.

1.4. Inclusiveness of the stakeholders in the report writing process

The National AIDS Commission (NAC), an agency of the Government of Malawi (GoM) responsible for coordinating the national response against the HIV and AIDS epidemic, led the process of compiling the 2015 Global AIDS Response Progress Report (GARPR) for Malawi. Two independent Malawian consultants collated, reviewed and analyzed relevant HIV-related policies, strategies, data and reports to compile 2014 HIV and AIDS indicators for Malawi and to assess the status of the HIV and AIDS response in 2014. A multisectoral Task Force, comprising representatives from UNAIDS, NAC, GoM and civil society organizations (CSOs), was formed to oversee the process of compiling this report and to provide guidance to the consultants. At the beginning of the assessment, the Task Force identified key stakeholders and constituencies in the HIV and AIDS national response who were listed as potential key informants to be interviewed. The stakeholders included representatives from the following constituencies: government, NAC, human rights organizations, development partners, UN agencies, CSOs including organizations for People Living with HIV (PLHIVs), the private sector and implementing partners. A complete list of stakeholders who were interviewed as part of this process is provided in Annex 1. The interviews focused on stakeholders' qualitative assessment of the successes registered and challenges encountered in the implementation of HIV and AIDS interventions in 2014. These interviews also sought to identify and collate any recent HIV and AIDS data which were not yet available to the NAC. A draft report was prepared based on these interviews as well as the review of HIV and AIDS-related policies, strategies, guidelines, reports and other documents. The draft report was reviewed and discussed during a stakeholders meeting which was held on 8th April 2015 in Lilongwe. Annex 2 provides a list stakeholders who attended this meeting. Following the meeting, the report was revised, taking into account stakeholders inputs and recommendation. A final copy was circulated to stakeholders for final approval. The next section provides an overview of the GARPR and health sector HIV indicators.

1.5. Overview of GARPR and Health Sector HIV Indicators

Malawi continues to track the progress made to achieve the ten targets agreed in the 2011 Political Declaration on HIV and AIDS. Table 1, below, shows the trend of indicators linked to these targets. It is important to note that 2014 data were unavailable for some indicators since there was no recent nationally representative survey or sentinel surveillance study. However, recent preliminary results from the Malawi MDG Endline Survey (2014) provided data for most impact indicators. However, it should be noted that this survey included fewer men (6,842) than women (24,230). Thus, the indicators for men will likely have a wider 95% confidence interval and hence less precise than those for women.

Table 1: GARPR and HIV Health Sector Indicator Table

*(Note: Health Sector HIV Indicators are highlighted in **orange**)*

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
Target 1: Reduce sexual transmission of HIV by 50% by 2014 *General population*	1.1: Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Males: 75% Females: 75%	Males: 44.7% Females: 41.8%	N/A	N/A	N/A	Males: 51.1% Females: 44.2%
	1.2: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	N/A	Males: 22.1% Females: 14.3%	N/A	N/A	N/A	Males: 18.2% Females: 14.7%
	1.3: Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	N/A	Males: 9.2% Women: 0.7%	N/A	N/A	N/A	Males: 10.7% Women: 0.9%
	1.4: Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Males: 60% Women: 40%	Men: 24.6% Women: 27.3%	N/A	N/A	N/A	Men: 35.4% Women: 35.4%
	1.5: Percentage of men and women aged 15-49 who received an HIV test in the past 12 months and know their results	Males: 75% Females: 75%	Males: 31.3% Females: N/A	N/A	N/A	N/A	Males: 40.0% Females: 43.3%
	1.6: Percentage of young people aged 15-24 who are living with HIV[7]	Males: N/A Females: N/A	Males: 1.9% Females: 5.2%	N/A	N/A	N/A	Males: 2.5% Females: 3.6%

[5] For 2010, the source of information is the 2010 MDHS, unless otherwise specified.
[6] For 2014, the source of data is the preliminary report of the Malawi MDG Endline Survey (2014), unless specified otherwise.

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
Sex workers	1.7: Percentage of sex workers reached with HIV prevention programs	N/A	N/A	N/A	N/A	N/A	14.0%[8]
	1.8: Percentage of sex workers reporting the use of a condom with their most recent client[9].	N/A	N/A	N/A	N/A	N/A	85%[10]
	1.9: Percentage of sex workers who have received an HIV test in the past 12 months and know their results	N/A	N/A	29.5%[11]	N/A	N/A	94.4%[12]
	1.10: Percentage of sex workers who are living with HIV	N/A	N/A	23.1%[13]	N/A	N/A	24.9%[14]

[7] The 2014 figures are based on UNAIDS estimates and not results from a population-based survey.

[8] Organization providing services to sex workers reported that 7770 out of an estimated 55,000 sex workers received various forms of HIV preventive services.

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

[10] National Statistical Office, Malawi Biological and Behavioural Surveillance Survey 2014, *Preliminary results*

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

[12] National Statistical Office, Malawi Biological and Behavioural Surveillance Survey (BBSS) 2014, *Preliminary results.* Note that the question in BBSS was whether they have **ever** been tested for HIV.

[13] Family Planning Association in Malawi. (2011). *Counting the uncatchables: a report of the situation analysis of the magnitude, behavioural patterns, contributing factors, current interventions and impact of sex work in HIV prevention in Malawi.* Lilongwe: Family Planning Association of Malawi and UNFPA. *Note: The study population in this study was markedly different from the population of sex workers enrolled in the Biological and Behavioral Surveillance Survey (BBSS_. Thus, HIV prevalence from this study should not be compared with results from the 2014 BBSS.*

[14] National Statistical Office, Malawi Biological and Behavioural Surveillance Survey 2014, *Preliminary results*

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
Men who have sex with men	1.11: Percentage of men who have sex with men reached with HIV prevention programs	N/A	N/A	N/A	N/A	N/A	1.8-27.8%[15]
	1.12: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	N/A	N/A	N/A	N/A	N/A	60.9-77%[16]
	1.13: Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	N/A	N/A	N/A	N/A	N/A	60-65%[17]
	1.14: Percentage of men who have sex with men who are living with HIV	N/A	N/A	21.0%[18]	N/A	N/A	5.4-24.9%[19]
HTC, STI and VMMC Health Sector Indicators	1.16.1. Number of women and men aged 15 and older who received HIV testing and counseling in the last 12	N/A	N/A	N/A	N/A	1,702,627	1,895,058[20]

[15] AL Wirtz, G Trapence, V Gama, D Kamba, R Chalera, L Klein, R Kumwenda, T Chikoko, M Mangochi, S Baral. (2014). *Final report to UN Joint Team on HIV&AIDS in Malawi through UNDP: HIV Prevalence and Sociobehavioral Characteristics among Men Who Have Sex with Across Seven Sites in Malawi.* Johns Hopkins University and the Center for Development of People. *Note: The question was whether they received information to prevent HIV with men*

[16] AL Wirtz, G Trapence, V Gama, D Kamba, R Chalera, L Klein, R Kumwenda, T Chikoko, M Mangochi, S Baral. (2014). *Final report to UN Joint Team on HIV&AIDS in Malawi through UNDP: HIV Prevalence and Sociobehavioral Characteristics among Men Who Have Sex with Across Seven Sites in Malawi.* Johns Hopkins University and the Center for Development of People. *Note: The question was on condom use in last sexual act with a casual male partner.*

[17] Study participants were asked whether they were **ever** tested

[18] Umar, E., G. Trapence, W., Chibwezo, D., Nyadani, H., Doyle, C. Beyrer and S. Baral. (2007). *HIV prevalence and sexual behavior among men having sex with men in Malawi*. Lilongwe and Blantyre: CEDEP and CoM. This study did not look at indicators 1.11-1.13.

[19] AL Wirtz, G Trapence, V Gama, D Kamba, R Chalera, L Klein, R Kumwenda, T Chikoko, M Mangochi, S Baral. (2014). *Final report to UN Joint Team on HIV&AIDS in Malawi through UNDP: HIV Prevalence and Sociobehavioral Characteristics among Men Who Have Sex with Across Seven Sites in Malawi.* Johns Hopkins University and the Center for Development of People. *Note: HIV prevalence is provided as a range since there was a wide variation on HIV prevalence in the 7 districts where the study was conducted.*

[20] Integrated HIV Program Reports, Ministry of Health, Government of Malawi. *Note: data collated from quarterly reports January to December 2014. Data from last quarter of 2014 (October to December 2014) were preliminary and could change after verification.*

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
	months and know their results						
	1.16-1a. Percentage of health facilities dispensing HIV rapid test kits that experienced a stockout in the last 12 months	N/A	N/A	N/A	N/A	N/A	2.8%[21]
	1.17.1. STIs: Percentage of women accessing antenatal care (ANC) services who were tested for syphilis	N/A	N/A	N/A	N/A	10%	7%
	1.17.2. STIs: percentage of antenatal care attendees who were positive for syphilis	N/A	N/A	N/A	N/A	6%[22]	4%
	1.17.3. STIs: percentage of antenatal care attendees positive for syphilis who received treatment	N/A	N/A	N/A	N/A	N/A	N/A
	1.17.4. STIs: percentage of sex workers (SWs) with active syphilis	N/A	N/A	N/A	N/A	N/A	N/A

[21] Integrated HIV Program Reports (October to December 2014), Ministry of Health, Government of Malawi. *Note: Data from this quarter of 2014 were preliminary and could change after verification.*

[22] This prevalence is likely to be biased because only 10% of the antenatal attendees were tested. It may be that health workers only tested those who they thought had STIs.

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
	1.17.5. STIs: percentage of men who have sex with men with active syphilis	N/A	N/A	N/A	N/A	N/A	1.4-8.7%[23]
	1.17.6. STIs: number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months	N/A	N/A	N/A	N/A	N/A	N/A
	1.17.7. STIs: number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months	N/A	N/A	N/A	N/A	N/A	N/A
	1.17.8. STIs: number of men reported with gonorrhoea in the past 12 months	N/A	N/A	N/A	N/A	N/A	N/A
	1.17.9. STI s: number of men reported with urethral discharge in the past 12 months	N/A	N/A	N/A	N/A	N/A	N/A
	1.17.10. STIs: number of adults reported with genital ulcer disease in the past 12 months	N/A	N/A	N/A	N/A	N/A	N/A

[23] See AL Wirtz, G Trapence, V Gama, D Kamba, R Chalera, L Klein, R Kumwenda, T Chikoko, M Mangochi, S Baral. (2014). *Final report to UN Joint Team on HIV&AIDS in Malawi through UNDP: HIV Prevalence and Sociobehavioral Characteristics among Men Who Have Sex with Across Seven Sites in Malawi.* Johns Hopkins University and the Center for Development of People. *Note: HIV prevalence is provided as a range since there was a wide variation on HIV prevalence in the 7 districts where the study was conducted.*

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
	1.18. Percentage of pregnant women with a positive syphilis serology whose sexual contacts were identified and treated for syphilis	N/A	N/A	N/A	N/A	N/A	N/A
	1.22 Percentage of men 15-49 that are circumcised	N/A	21.5%[24]	N/A	N/A	N/A	27.5%
	1.23. Number of male circumcisions performed according to national standards during the last 12 months	N/A	N/A	N/A	11,000	77,615	80,419[25]
Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015[26].	2.1: Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	N/A	N/A	N/A	N/A	N/A	N/A
	2.2: Percentage of people who inject drugs who report the use of condoms at last sexual intercourse.	N/A	N/A	N/A	N/A	N/A	N/A
	2.3: Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	N/A	N/A	N/A	N/A	N/A	N/A

[24] This data is from the 2010 Malawi Demographic and Health Survey. *Note: Respondents were asked whether they were circumcised or not but their responses were not verified.*

[25] Data are from organizations which deliver VMMC programs namely Christian Health Association of Malawi (CHAM), Malawi Police Services, Banja La Mtsogolo, Population Services International and I-TECH. *Note: Data from the Ministry of Health were not available.*

[26] No studies have been done on this theme in Malawi.

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
	2.4: Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	N/A	N/A	N/A	N/A	N/A	N/A
	2.5: Percentage of people who inject drugs who are living with HIV	N/A	N/A	N/A	N/A	N/A	N/A
	2.6. Number of people on opioid substitution therapy (OST)	N/A	N/A	N/A	N/A	N/A	N/A
	2.7. Number of NSP and OST sites: - Number of needle and syringe programme (NSP) sites	N/A	N/A	N/A	N/A	N/A	N/A
	2.7. Number of NSP and OST sites: - Number of opioid substitution therapy (OSP) sites	N/A	N/A	N/A	N/A	N/A	N/A
Target 3: Eliminate mother to child transmission of HIV by 2015 and substantially reduce	3.1: Percentage of HIV positive pregnant women who receive antiretroviral to reduce the risk of mother to child transmission	65%	44%	44%	67%	73%[28]	72%

[28] Government of Malawi, Ministry of Health, Integrated HIV Programme Report: 2013 Q1, Q2, Q3 and Q4 Reports

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
AIDS- related deaths[27]	3.1a Percentage of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period	N/A	N/A	N/A	N/A	N/A	87-97%[29]
	3.2: Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth	N/A	N/A	N/A	10%	30%	37%
	3.3: Mother to child transmission of HIV (Modelled)	N/A			-		Will use SPECTRUM
	3.4. Percentage of pregnant women who know their HIV status *(tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status)*	N/A	N/A	N/A	N/A	83%	79%[30]
	3.5. Percentage of pregnant women attending ANC whose male partner was tested for HIV in the last 12 months		N/A	N/A	N/A	N/A	N/A

[27] 2014 Data source, unless specified otherwise: Integrated HIV Program Reports, Ministry of Health, Government of Malawi. *Note: data collated from quarterly reports January to December 2014. Data from last quarter of 2014 (October to December 2014) were preliminary and could change after verification.*

[29] Government of Malawi, Ministry of Health, Integrated HIV Programme Report: 2014, Q1, Q2 and Q3 reports

[30] Denominator used is "the expected number of pregnant women per year" (estimated at 660,964 in 2014)

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
	3.6. Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing[31]		N/A	N/A	N/A	N/A	N/A
	3.7. Percentage of infants born to HIV-infected women provided with antiretroviral (ARV) prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks *(i.e. early postpartum transmission around 6 weeks of age)* [32]		N/A	N/A	N/A	92%	93%
	3.9. Percentage of infants born to HIV-infected women started on cotrimoxazole prophylaxis within two months of birth[33]		N/A	N/A	N/A	86%	85%
	3.10. Distribution of feeding practices *(exclusive breastfeeding, replacement feeding, mixed feeding/other)* for infants born to HIV-infected women at DPT3		N/A	N/A	N/A	N/A	N/A

[31] Not relevant in the context of Option B+

[32] The denominator is "HIV exposed infants discharged from the maternity". The numerator is all HIV exposed infants who were prescribed with nevirapine prophylaxis. Data Source: Integrated HIV Program Reports, Ministry of Health, Government of Malawi. *Note: data collated from quarterly reports January to December 2014. Data from last quarter of 2014 (October to December 2014) were preliminary and could change after verification*

[33] The denominator is "the number of HIV exposed infants who are 2 months old". The numerator is "all children less than 2 months who were prescribed with cotrimoxazole. Data Source: Integrated HIV Program Reports, Ministry of Health, Government of Malawi. *Note: data collated from quarterly reports January to December 2014. Data from last quarter of 2014 (October to December 2014) were preliminary and could change after verification*

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
	visit						
	3.11. Number of pregnant women attending ANC at least once during the reporting period[34]	N/A	N/A	N/A	N/A	627,827	616,783
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015[35]	4.1: Percentage of eligible adults and children currently receiving antiretroviral therapy[36]	85%	63%	67%	65%	83%	67%[37]
	4.1 –Antiretroviral therapy: Number of eligible adults and children who newly initiated antiretroviral therapy (ART) during the reporting period (2014)	N/A	N/A	N/A	N/A	102, 568	110,324
	4.2a: Percentage of adults and children with HIV known to be on treatment 12months after initiation of antiretroviral therapy	N/A	81%	78%	80%	78%	Adults: 77% Children: 76%

[34] This indicator was estimated from the number of women who booked at antenatal clinics. Data Source: Integrated HIV Program Reports, Ministry of Health, Government of Malawi. *Note: data collated from quarterly reports January to December 2014. Data from last quarter of 2014 (October to December 2014) were preliminary and could change after verification*

[35] 2014 Data source, unless specified otherwise: Integrated HIV Program Reports, Ministry of Health, Government of Malawi. *Note: data collated from quarterly reports January to December 2014. Data from last quarter of 2014 (October to December 2014) were preliminary and could change after verification.*

[36] Data Source: Integrated HIV Program Reports, Ministry of Health, Government of Malawi. *Note: data collated from quarterly reports January to December 2014. Data from last quarter of 2014 (October to December 2014) were preliminary and could change after verification. It is estimated that 798,000 HIV+ people needed ART by the end of 2014. This figure is higher than 681,000 estimated in 2013*

[37] Coverage decreased in 2014 since the denominator (number of HIV-positive people eligible for ART) increased resulting from the change in ART eligibility criteria in adults from CD4 cell count of <350 to <500. The denominator increased from 681,000 to 798,000.

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
	4.2b. Percentage of adults and children with HIV still alive and known to be on antiretroviral therapy 24 months after initiating treatment among patients initiating antiretroviral therapy during 2014		N/A	N/A	N/A	76%	73%[38]
	4.2c. Percentage of adults and children with HIV still alive and known to be on antiretroviral therapy 60 months after initiating treatment among patients initiating antiretroviral therapy during 2014		N/A	N/A	N/A	59%	59%[39]
	4.3.a. Number of health facilities that offer antiretroviral therapy (ART)	N/A	N/A	N/A	N/A	689	706
	4.3.b Health facilities: Number of health facilities that offer paediatric antiretroviral therapy (ART)	N/A	N/A	N/A	N/A	N/A	694
	4.4. Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months.	N/A	N/A	N/A	N/A	N/A	N/A

[38] Data Source: Integrated HIV Program Reports (July to September 2014), Ministry of Health, Government of Malawi.
[39] Data Source: Integrated HIV Program Reports (July to September 2014), Ministry of Health, Government of Malawi.

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
	4.6.a Total number of people enrolled in HIV care at the end of the reporting period		N/A	N/A	N/A	N/A	659,844
	4.6.b Number of adults and children newly enrolled in HIV care during the reporting period (2014)		N/A	N/A	N/A	102,568	110,324[40]
	4.7a. percentage of people on ART tested for viral load (VL) who have an undetectable viral load in reporting period (2014)	90%	N/A	N/A	N/A	N/A	85-86%[41]
	4.7 b. Percentage of people on ART tested for viral load (VL) with VL level below ≤ 1,000 copies after 12 months of therapy (2014)	90%	N/A	N/A	N/A	N/A	N/A
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015[42]	5.1: Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	50%	45%	54%	60%	81%	90%
	5.2 Percentage of adults and children living with HIV newly enrolled in care who are	N/A	N/A	N/A	N/A	1.6%	1.5%[43]

[40] Includes only those on ART

[41] Only 18% of eligible patients tested at the scheduled times: 6 and 24 after ART initiation and and then every 24 months. Data were available for Q1 and Q2 of 2014 , only.

[42] 2014 Data source, unless specified otherwise: Integrated HIV Program Reports, Ministry of Health, Government of Malawi. *Note: data collated from quarterly reports January to December 2014. Data from last quarter of 2014 (October to December 2014) were preliminary and could change after verification.*

[43] Data is based on screening for TB in patients on ART

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
	detected having active TB disease (new)						
	5.3 Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	100%	N/A	N/A	N/A	56%[44]	80%
	5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit[45]	100%	N/A	N/A	N/A	98%	96%
		2010/2011 (US$)		2011/2012 (US$)		2013[46]	
Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low and middle income countries	6.1: Domestic and international AIDS spending by categories[47]	-1. Prevention programs: 45,891,860 2. Treatment and care: 29,376,989 3. OVC: 5,861,433 4. Program management and administration: 42,764,990 5. Human resources: 4,890,721 6. Social protection and social services (excluding OVC): 7,338,811 7. Enabling environment: 11,650,572 8. HIV and AIDS Related Research: 4,196,858		-1. Prevention programs: 43,418,118 2. Treatment and care: 47,210,628 3. OVC: 5,435,149 4. Program management and administration: 34,891,301 5. Human resources: 4,052,479 6. Social protection and social services (excluding OVC): 2,907,632		N/A	1. Prevention of sexual transmission of HIV: 42,389.685.02 2. Prevention of mother to child transmission: 9,215,148.92 3. Universal access to treatment: 86,622,399.83 4. Tuberculosis: 5,529,089.35

[44] Note that this number is based on a small cohort of HIV positive individuals (<50,000) who are accessing pre-ART care.
[45] Note that TB status is assessed by asking TB screening questions to individuals attending HIV care. Those who have symptoms and signs suggestive of TB are investigated further.
[46] 2013 data on expenditure are not available.
[47] According to the NASA for the period 2010/2012 more than 90% of the funding for the national response comes from donors. Details of funding by source have been given in the section on closing the resource gap.

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
		TOTAL: 151,972,234		7. Enabling environment: 3,259,433 8. HIV and AIDS Related Research: 4,347,695 **TOTAL: 145,522,435**			5. Governance and sustainability: 23,959,387.19 6. Critical enablers: 1,843,029.78 7. Synergies with development sectors: 9,215,148.92 8. Other: 5,529,089.35 **Total Fund: 184,302,978.36**
	6.1: Domestic and international AIDS spending by financing sources	1. Public funds: 2,666,009 2. Private funds: 415,211 3. Bilateral contributions: 65,687,625 4. Multilateral contributions: 61,369,453 5. International not for profit organisations and foundations: 18,696,708 6. International for profit organisations and foundations: 69,626 7. International funds (n.e.c): 3,067,602 **TOTAL: 151,972,234**		1. Public funds: 11,827,301 2. Private funds: 119,323 3. Bilateral contributions: 67,819,102 4. Multilateral contributions: 56,686,727 5. International not for profit organisations and foundations: 7,122,522 6. International for profit organisations and foundations: 417,469 7. International funds (n.e.c): 1,529,991 **TOTAL: 145,522,435**			1. Public funds: 26,355,325.91 2. Private funds: 3,870,362.53 3. International funds: 154,077,289.91
Target 7: Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV.	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	N/A	18.5%	N/A	N/A	N/A	N/A

TARGETS	INDICATORS	2010 UA* Target	2010[5]	2011	2012	2013	2014[6]
Target 8: Eliminate stigma and discrimination against people living with and affected by HIV	8.1 Discriminatory attitudes towards people living with HIV[48]	N/A	Males: 35.7% Females: 19.7%	N/A	N/A	N/A	N/A
Target 10: Strengthen HIV integration	10.1: Current school attendance among orphans and non-orphans aged 10–14	N/A	Males: 0.95 Females: 0.97 Total: 0.96	N/A	N/A	N/A	0.96
	10.2: Proportion of the poorest households who received external economic support in the last 3 months	N/A	2.6	N/A	N/A	N/A	N/A

[48] This is a new indicator. The figure indicated for 2010 is based on the Malawi Demographic Survey which looked at "Percentage of respondents expressing acceptance attitudes on all four indicators"

Chapter II: Overview of the AIDS epidemic

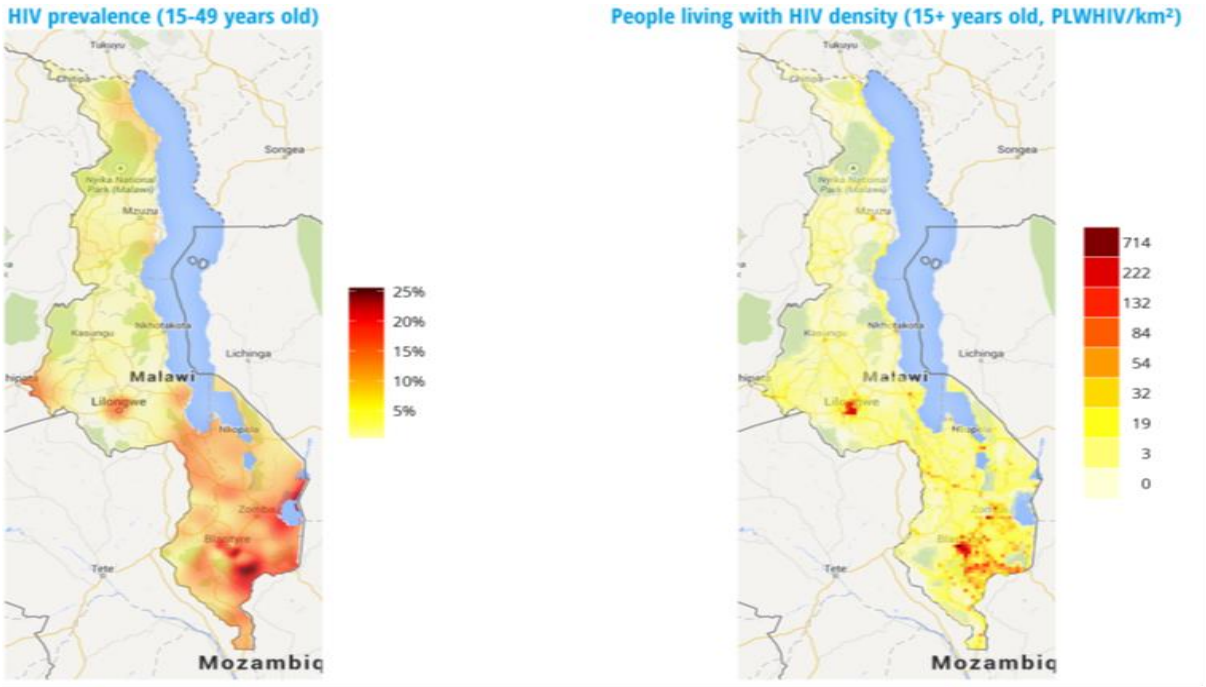
2.1. HIV Prevalence in the general population

As mentioned earlier, in 2014, there were no recent data on HIV prevalence in Malawi. The country is planning to conduct the Population-based HIV Indicators Assessment Survey and the MDHS in 2015. However data from previous MDHS and sentinel surveillance surveys indicate that HIV prevalence in Malawi has been declining steadily from 16.4% in 1999 to 10.6% in 2010. The observed reduction in HIV prevalence occurring in the context of increasing ART coverage and improved survival of PLHIVs on ART suggest a declining trend of HIV incidence.

The 2010 Malawi Demographic and Health Survey (MDHS), the most recent national HIV survey, found a higher HIV prevalence in females aged 15-49 years (12.9%) than in their male counterparts (8.1%)[49]. The survey also found variation in HIV prevalence according to age, sex, residence (rural/urban), geographical location and other characteristics. As shown in Figure 1 below, HIV prevalence and density was high in the urban districts of Lilongwe, Blantyre and Zomba and also in the Southern Region of Malawi. HIV prevalence was also higher in urban than in rural areas with marked differences observed in the northern and central regions of Malawi.

[49] National Statistical Office. *Malawi Demographic and Health Survey 2010*. National Statistical Office.

Figure 1: HIV prevalence and PLHIV density



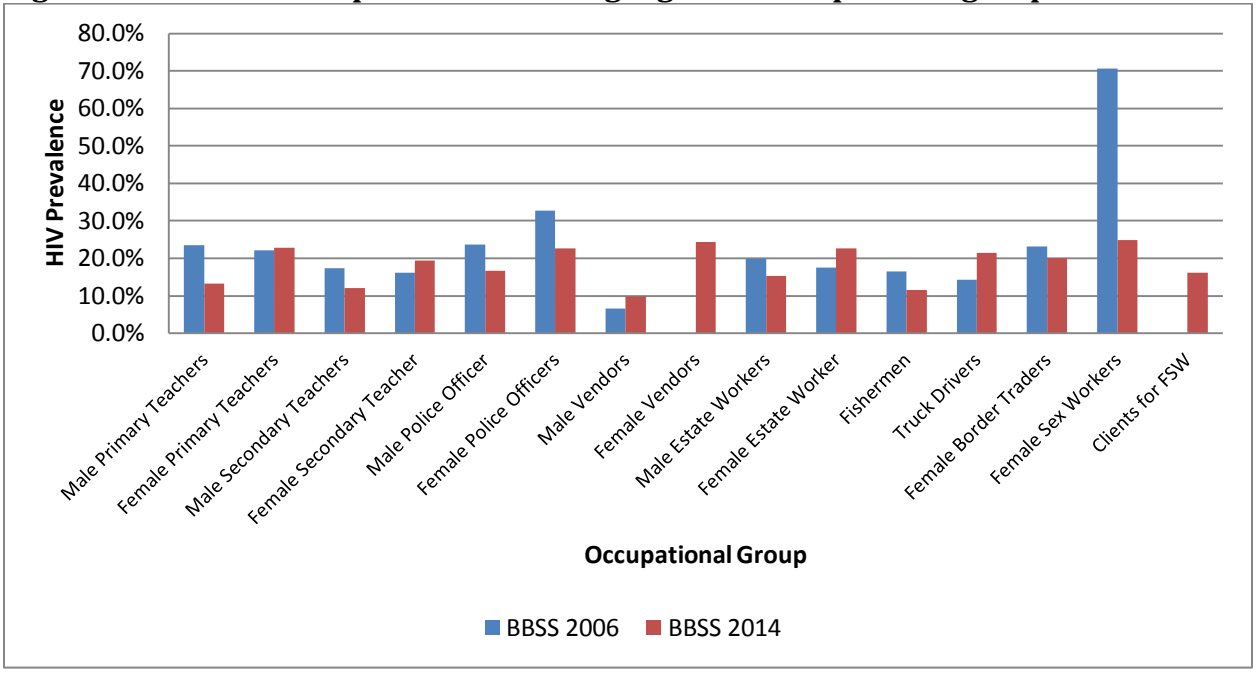
2.2. HIV prevalence in high risk groups

In 2014, Malawi conducted a nationwide survey[50] which estimated HIV prevalence and risky behaviors among specific social and occupational groups which are recognized to be at higher risk of HIV than the general population. These groups include FSWs, female border traders, long-distance truck drivers, police officers, estate workers, teachers and fishermen. Figure 2 below, shows the HIV prevalence in these groups in 2014 compared with results from a similar study in 2006. Overall, HIV prevalence in each of these groups remained higher than the estimated prevalence in the general population, with the exception of male vendors. Nevertheless, HIV prevalence appears to have declined markedly in FSWs, male primary and secondary teachers, male and female police officers and fishermen. There was also a decreasing trend in male estate workers and female border traders. Also, there were no marked changes in HIV prevalence in female primary and secondary school teachers, male vendors and female estate workers. Notably, there was a marked increase in HIV prevalence among truck drivers. There was also a marked gender difference in HIV prevalence among teachers, police officers, vendors and estate workers, with females having a higher prevalence than their male counterparts. While the increasing trend of HIV prevalence and higher prevalence in females do not necessary

[50] National Statistical Office. 2014. *Malawi Biological and Behavioural Surveillance Survey: preliminary results.* Zomba: National Statistical Office.

signify increasing HIV incidence, especially in the context of high ART coverage, these findings underscore the need for further exploring whether these groups are being reached with effective HIV prevention strategies.

Figure 2: Trends in HIV prevalence among high risk occupational groups 2006-2014

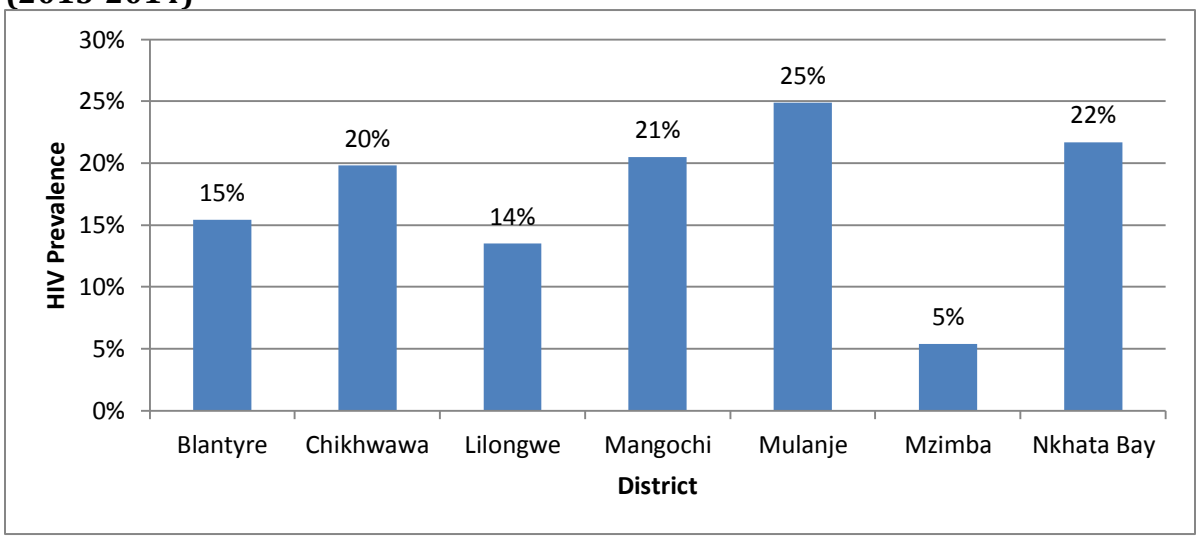


2.3. HIV prevalence in Men who have Sex with Men

In 2013-2014, a study was conducted in selected districts in the three regions of Malawi to estimate HIV prevalence, risky sexual behaviours and access to HIV services among MSM. The study found a considerably geographical variation in HIV prevalence among MSMs ranging from 5.4% to 24.9% (Figure 3), with urban and semi-urban areas in Central and Southern Regions recording higher HIV prevalence than the corresponding areas in the Northern Region. This geographical pattern was generally reflective of HIV prevalence observed in the general population. Using indirect methods, the study crudely estimated that 3% to 4% of men in urban Lilongwe and Blantyre could be MSM. Compared with results from a 2009 study[51] which found HIV prevalence of 21% among MSM, the current results suggest a decline in HIV prevalence in MSM in the cities of Lilongwe and Blantyre. Nevertheless, MSMs remained potentially at high risk of contracting HIV since, in the recent study, 80% erroneously reported that anal sexual intercourse carries a lower risk of HIV transmission than vaginal sexual intercourse and only 23% reported receiving targeted HIV prevention information.

[51] Baral S., et al. "HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana" Plos One, Vol 4 (3), e4997, 2009.

Figure 3: Estimated prevalence of HIV among MSM in selected districts in Malawi (2013-2014)



2.4. Estimates of the burden of HIV in Malawi

The most recent estimates on the absolute burden of HIV in Malawi are based on epidemiological modeling using the UNAIDS SPECTRUM software. It is estimated that 1,100,000 Malawians were living with HIV in 2014 and that 34,000 new infections occurred in 2014, including 7,400 amongst children aged less than 14 years[52]. This represents a marked decline from ~66,000 estimated in 2012. The annual AIDS-related deaths in 2014 were estimated at 48,000, representing at least a 50% reduction from an estimated 99, 000 deaths reported in 2004. This reduction has mostly been attributed to increasing ART coverage in Malawi and the recent policy changes towards early initiation of ART in PLHIVs.

The 2013 Modes of Transmission (MoT) study estimated that people in stable heterosexual relationships (married/co-habiting partners) account for 67% of all new HIV infections in Malawi[53] while casual heterosexual relationships account for 12%. Nevertheless, the study estimated high incidence rates among MSM, FSW and among the clients and partners of FSW[54], signifying that these groups may represent hotspots for high HIV transmission within a generalized epidemic.

[52]Joint United Nations Program on HIV/AIDS (UNAIDS) Malawi, May 2014 HIV estimates.
[53] Futures Institute, UNAIDS and NAC, Malawi Prevention Response and Modes of Transmission Analysis, 2013.
[54] Joint United Nations Program on HIV/AIDS (UNAIDS) Malawi and National AIDS Commission Malawi. Modes of Transmission Analysis and HIV prevention Response. Distribution of new infections in Malawi 2013 and Recommendations for prevention strategies. 2014.

Chapter III: National response to the AIDS epidemic

3.1. Introduction

This section assesses the progress that Malawi has made in the implementation of key interventions under the thematic areas of HIV prevention; treatment, care and support; and impact mitigation. Several sources of data sources were reviewed in conducting this assessment including a report from Independent Review Team (IRT) engaged by NAC in November 2014 to assess annual progress made in the national HIV and AIDS response. Progress on and impact of biomedical interventions was mostly assessed using the results from the MoH Integrated HIV and AIDS Program reports which are produced quarterly. Preliminary results from the nation-wide 2014 MDG Endline Survey and the BBSS were used to assess the population impact of various biomedical and non-biomedical interventions on proxy indicators of HIV transmission (such as risky sexual behaviors) and negative social consequences of HIV (such as stigma and discrimination). In addition, program output data were obtained from various project and program reports compiled by the NAC. However, because the fiscal year in Malawi runs from 1st July to 30th June, some of the program data were only available for the last two quarters of 2013 and first two quarters of 2014. Responses from stakeholders interviewed by the consultants were used to assess the validity of key findings from various reports and also to qualitatively assess the implementation of various programs and their impact.

3.2. Prevention

The HIV Prevention Strategy (2011-2016) provided the overall framework and guidance for all prevention interventions in 2014. Additional strategies and guidelines supported the implementation of specific preventive interventions such as condom use, VMMC, HTC, EMTCT and Behavioral Change Communication (BCC). As stated above, in 2014, Malawi reviewed the 2011-16 HIV Prevention strategy and developed a new 2015-2020 HIV Prevention Strategy. The new strategy focuses on delivering tailor-made HIV prevention intervention to specific high risk groups and incorporates ART as one of the prevention strategies.

3.2.1. Non Biomedical Interventions

Key non-biomedical interventions implemented in 2014 included community sensitization and mobilization for HIV prevention through various IEC approaches and behavioural change activities which included life skills education for in-school and out of school youths, promotion of mutual faithfulness and use of male and female condoms. In addition, various activities sought to address cross-cutting human rights violations that promote HIV transmission such as gender inequality and gender-based violence, stigma and discrimination and harmful cultural practices. These interventions were coordinated by various stakeholders including government ministries, NGOs and CBOs. Programme implementers attempted to link demand creation with service provision.

3.2.1.1. Print and audio IEC materials

In 2013/2014, only 769,933 IEC materials of out a target of 1,500,000 materials were produced and distributed. This represents an achievement of only 51.3% of the target. In the previous year (2012/2013), 900,000 out of a target of 1,044,284 were produced, representing an achievement of 86.2%. The IEC materials produced in 2013/2014 focussed on themes such as: sex and sexuality; HTC; ART/PMTCT; harmful cultural practices; condom use; HIV discordancy; VMMC; and multiple and concurrent sexual partnership (MCP). Some of these materials especially those on PMTCT, VMMC, HIV and AIDS, and Sexual and Reproductive Health Rights (SRHR) were also printed in braille by the Malawi Council for the Handicapped (MACOHA), in order to ensure access to IEC materials on HIV and AIDS for persons with visual impairment..

3.2.1.2. Communication through radio and television

During the 2013/2014 fiscal year, a total of 220.5 hours of radio time was used to air programmes, slots and jingles on HIV and AIDS, representing a 73.4% achievement of the planned target of 300hrs and underperformance compared with the preceding year. In an effort to increase the target audience, various national and community radio stations were involved in disseminating information on HIV and AIDS in many languages. The radio messages covered a wide range of HIV and AIDS related themes including reduction of MCP, stigma and discrimination, while some specifically focussed on the youth issues. Television (TV) playtime on HIV and AIDS-related messages complemented radio messages, utilizing 61.3hrs of the targeted 100hrs in 2013/2014. Thus, TV playtime underperformed compared to the target set for the year and the preceding year. It has been argued that the reported number of hours spent on broadcasting of HIV and AIDS messages on the radio is actually underestimated because a previous study assessing the coverage of

non-biomedical interventions found that both TV and radio stations in Malawi airing HIV and AIDS programs covered more than 4,000 hours annually[55].

3.2.1.3. Other HIV and AIDS Communication Modes

To increase coverage of HIV prevention messages, a total of 316 interactive outreach audio-visual shows against a target of 1,200 sessions were conducted in communities, schools and places of entertainment/hotspots. These interactive sessions targeted the general and most-at-risk populations. This indicates that only 26% of the targeted interactive outreach audio visual shows were achieved. However, 4,389 of the planned 3, 500 interactive sessions; and public talks and expert talks were conducted in schools, communities and workplaces. This represents an achievement of 125% which was higher than the 99% accomplishment in the 2012/13 fiscal year. To increase the effectiveness of these interactive sessions, targeted audiences were linked to HIV preventive service provision such as condom distribution, HTC and referral to reproductive health services.

In the 2013/2014 fiscal year, efforts were made to reach out to key populations at risk of HIV infection. A total of 2816 people were trained as peer interpersonal HIV and AIDS educators, surpassing the planned target by 41%. Additionally, 4,831 MSM were successfully mobilized in 7 of the 28 districts in Malawi to participate in a research project estimating the prevalence of HIV and assessing the needs of MSMs, in terms of HIV prevention and treatment. This was a major achievement considering that homosexual practices remain illegal in Malawi.

To address SRHR violations, several NGOs conducted community awareness campaigns on HIV and AIDS through theatre performances targeting police officers, FSWs, sexually exploited young girls and primary school teachers. The aim was to promote condom uptake, build confidence of FSWs to negotiate condom use and promote awareness of rights of FSWs among law enforcers and the community. Through this initiative, about 47 girls were sent back to school, while others went into vocational training. In addition, during stakeholder interviews, representatives from law enforcers and NGOs reported decreased incidents of illegal arrests and sexual exploitation of FSWs by police officers.

[55] Munthali, A.C., P. Mvula, J. Milner and P. Kishindo. (2011). *A situation analysis of non-biomedical interventions in Malawi.* Zomba: Centre for Social Research.

3.2.1.4. Behavioural Change Interventions for youths

Behaviour change interventions for young people were implemented through various initiatives, including Life Skills Education (LSE) for in-school and out-of-school young people; and the provision of Youth-Friendly Health Services (YFHS) aimed at increasing youths' access to sexual and reproductive health services. Before 2010, LSE for in-school youth was being offered irregularly. In 2014, all students in primary and secondary schools in 2014 were exposed to LSE. This follows an earlier decision by government to make the LSE subject mandatory and examinable for all pupils in primary and secondary school.

In 2013/2014, only 53,622 out of the set target of 150,000 out-of school youths were taught LSE representing only 36% of the targeted out-of-school youths. This indicates a major setback from a total of 134,735 out-of-school youths exposed to LSE in 2012/2013 and 264,968 out-of-school youths exposed in 2011/12. Training sessions on LSE and interpersonal/interactive communication were provided to only 4,350 out-of-school youth club leaders, members/club patrons out of a target of 150,000. Stakeholder interviews revealed that funding challenges to NGOs and CBOs adversely affected the implementation and supervision of out-of-school LSE programmes. Nevertheless, the low programme output figures may be under-estimates as many implementing partners not funded by NAC fail to submit programme output reports to the NAC[56]. However, these finding underscore the need to refocus HIV prevention activities in this groups of youths who are not easily and consistently accessible.

3.2.1.5. The delivery of Youth-friendly Health Services

The MoH and stakeholders have been implementing YFHS since 2010. Progress in the implementation of these services has been slow: a 2013/14 evaluation of the delivery of YFHS[57] found that less than one-third of community survey respondents had heard about YFHS and only 13% reported to have ever accessed YFHS. The majority of young people who reported accessed YFHS did so for the first time in the 12 months prior to the survey, suggesting that the YFHS program has gained more prominence over the last year or two. More than 60% of those who reported accessing YFHS went to government health facilities for those services. Among young people interviewed, misconceptions about who should benefit from YFHS were evident, with more than half stating that YFHS are only for married youth.

[56] ITAD. (2012). *The independent review of Malawi national response to HIV and AIDS for financial year 2011-2012.* Lilongwe: NAC

[57] E2A Project and CSR. (2014). Evaluation of youth friendly health services in Malawi. Eashington: E2A Project and Zomba: CSR.

In 2013/14, only 12.4% of young people from an estimated target 4,000,000 accessed various health services. Nevertheless, by the end of the fiscal year, a total of 82,221 youths were tested for HIV and received results in YFHS facilities, representing 103% achievement of the annual target of 80,000. A total of 1,025,719 (34% achievement) condoms were distributed to youths in the YFHS facilities in order to prevent infection of HIV, other STIs and unwanted pregnancies**.**

While some progress has been made in the provision of YFHS, the 2013/14 evaluation indicates persistent challenges. These include lack of knowledge about the programme among young people themselves, their parents and community leaders, lack of privacy and confidentiality in the YFHS facilities, the requirement by some health providers that young people accessing YFHS should be tested for HIV before being offered other health services (which discourages youth from accessing such services), inadequate YFHS outreach services and weak parental and community support for young people seeking Sexual and Reproductive Health (SRH) services[58]. Interviewed stakeholders also confirmed poor motivation of health worker to deliver YFHS as they mostly did not consider provision of this service part of their routine responsibilities. A long term solution to this problem could be the inclusion of YFHS in the pre-service curriculum for clinicians and nurses.

3.2.1.6. Condom Programming

In 2013/2014, stakeholders in the HIV and AIDS response planned to distribute 67 million condoms. Out of these, 57 million were to be free of charge while 10 million were to be socially marketed. By the end of the fiscal year in June 2014, only 60% (40,478,216) of the total target number of condoms were distributed. Out of these 24,108,849 condoms were free and distributed through the MoH and CBOs. Only 996,970 of the total free condoms distributed were female condoms. A total of 16,369,367 socially marketed condoms were distributed mainly through BLM and PSI, of which 38,568 were female condoms. Thus, despite missing the target for free condoms, the target for socially marketed condoms was surpassed by 64%. Between January and December 2014, PSI alone distributed 15 million condoms and this was the highest number of condoms the organization has ever distributed since it started operating in Malawi. The total number of free male condoms distributed in 2013/2014 was at least twice the number distributed in 2012/13 (20,957,870). The number of socially marketed condoms in 2013/2014 was nearly 75% higher than in 2012/13 (9,358,022). Despite these achievements, shortages of condoms were frequently reported in the 2013/2014 fiscal year, especially in rural areas. This was

[58] E2A Project and CSR. (2014). Evaluation of youth friendly health services in Malawi. Eashington: E2A Project and Zomba: CSR.

partly due to supply chain management challenges experienced by the Central Medical Stores (CMS) in the distribution of condoms to peripheral outlets. The 2014 IRT report suggested that the actual national requirements for condoms was 90,547,220[59] which is higher than 67 million condoms that Malawi had planned to distribute in 2013/14.

Stakeholders reported that the demand and supply of female condoms remained unsatisfactory, consistent with findings from a Female Condom Evaluation study conducted in 2013. Among low risk females, barriers included the shortage of the condoms, poor knowledge and perceived difficulties in putting on the condoms, negative social connotations on females using the condoms (being associated with promiscuous behavior), and a myriad of negative myths and misconceptions. Among FSWs, the major barriers appear to be poor preference of female condoms by male clients due to concerns by clients that FSWs do not change the condoms between successive clients. Many respondents concluded that the female condom will unlikely be a major intervention of choice for preventing HIV in females.

3.2.2. Assessment of the impact of non-biomedical interventions

3.2.2.1. General Population

Although there were no recent HIV prevalence and incidence data in the general population, comparisons of data from the MDHS 2010 and 2014 MDG Endline Survey found mixed results in several proxy indicators for sexual transmission of HIV in the general population. On the positive side, the proportion of young people (15-24 years old) having comprehensive knowledge of HIV slightly increased, among males (44.7% to 55.1%) but remain largely unchanged females (41.8% to 44.2%). However, the 2014 proportions were far below the 75% Universal Access targets. On the negative side, the proportion of young people having sexual debut before 15 years remained stagnant in females (14.3% to 14.7%) and decreased slightly in males (22.1% to 18.2%). It is hoped the recent enactment of the Marriage Law which has increased the minimum age of marriage from 15 to 18 may indirectly assist in reducing early sexual debut. However, this law had not yet assented by the President at the time of writing this report.

The proportion people having sexual intercourse with a non-marital or non-cohabiting partner remained largely unchanged or slightly increased from 2010 to 2014, both in males (9.2% to 10.7%) and females (0.7% to 0.9%). Nevertheless, the proportion of people using condoms when having sexual intercourse with a non-marital or non-cohabiting partner increased in both males (24.6% to 35.4%) and females (27.3% to 35.4%). However, the

[59] ITAD. (2014). *The independent review of Malawi national response to HIV and AIDS for financial year 2013-2014.* Lilongwe: NAC

2014 condom coverage for males and females missed the universal access targets (60% and 40%, respectively).

3.2.2.2. Key Populations

Comparisons of the Biological and Behavioral Surveillance Surveys (BBSS) conducted in 2006 and 2014 indicate a major decrease in HIV prevalence (from 77% to 25%) among FSWs. However, the prevalence recorded in 2014 is similar to 23.1% found in a study conducted in a study conducted 2011[60]. Despite these encouraging results, it is clear that HIV prevalence among sex workers remains unacceptably high. Data from the BBSS 2014 suggest positive trends in the adoption of desirable behaviours by FSWs which may, in the long term, help to further reduce HIV transmission risk. For example, the proportion of FSWs reporting using a condom with the most recent client was extremely high (85%) and the majority of them (94.4%) reported to have ever had an HIV test.

As reported before, the prevalence of HIV among MSMs appeared to have dropped in the major cities of Lilongwe and Blantyre from 21.1% in 2009[61] to 13.5-15.4% in 2014[62], but caution should be exercised in making this interpretation because of the different methodologies used to select participants in these two studies. Of major concern was the fact that 30-45% of MSMs is 7 of the 28 districts in Malawi did not know their HIV status. Also, high risk behaviours remained common among MSM, including multiple sexual partnerships, inconsistent condom use and exchanging sex for money. Only 23% of MSM reported receiving targeted HIV prevention information and 80% erroneously reported that anal sexual intercourse carries a lower risk of HIV transmission than vaginal sexual intercourse.

In summary, the above reports underscore the need to intensify HIV prevention interventions among youth, couples and key populations including female sex workers and MSM. Fortunately, the 2015-2020 HIV Prevention Strategy focuses interventions in these groups.

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

[61] Baral S.,Trapence G, Motimedi F, Umar E, Iipinge S, Dausab F, Beyrer C.. "HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana" Plos One, Vol 4 (3), e4997, 2009.

[62] AL Wirtz, G Trapence, V Gama, D Kamba, R Chalera, L Klein, R Kumwenda, T Chikoko, M Mangochi, S Baral. (2014). *Final report to UN Joint Team on HIV&AIDS in Malawi through UNDP: HIV Prevalence and Sociobehavioral Characteristics among Men Who Have Sex with Across Seven Sites in Malawi.* Johns Hopkins University and the Center for Development of People.

3.2.2. Biomedical Interventions

Several policies, strategies, guidelines and plans guided the implementation of biomedical HIV preventive interventions in 2014. Apart from the HIV Prevention Strategy (2011-2016), these included the HIV Testing and Counselling Scale-up Plan, the National Plan of Action for Scaling up of Sexual and Reproductive Health, National Blood Safety Policy, the VMMC Policy, the National Plan on Scale-up of VMMC, and the Elimination of Mother to Child Transmission of HIV Plan.

3.2.2.1. HIV Testing and Counseling

By the end of September 2014, 724 static sites and 188 outreach sites were offering HTC services, which was lower than the target of 800 static and 700 outreach sites. Actually, there was a decrease in number of sites providing HTC services from 2012 to 2014, potentially affecting access to HTC. In the 2014 calendar year, 1,895,058 people received HTC, compared with 1,702,627 in 2013, representing an increase of 11%. However, of the people receiving HTC in 2014, only 31% were newly tested whereas 69% were having repeated tests. Females comprised the majority (66%) of the people tested, Nevertheless, when pregnant women were excluded, there was no marked gender difference in the numbers tested. Actually, pregnant women comprised nearly half (46%) of the females tested. Of the people tested, 9% were younger than 15 years old, 40% were between 15 and 24 years old while 52% were older than 25 years. Almost 7% (130,970) of the people tested positive for HIV.

The shortage of HIV test kits, which compromised the HTC programme in 2013, were infrequently reported in 2014, perhaps due to the introduction of a toll free calling line for health facility-based health workers to report impending stock-outs or expired kits. However, interviewed stakeholders identified shortage of skilled staff and heavy dependence of sub-optimally supervised Health Surveillance Assistants (HSAs) as one of the key challenges affecting the implementation of HTC. Most skilled clinical and nursing staff did not see HTC as one of their responsibilities. There were also concerns about HSAs' suboptimal adherence to HTC standard operating procedures as evidenced by a low proportion of people diagnosed as HIV-positive receiving confirmatory tests and a significant proportion of false negative HIV results arising from interpretation of HIV Rapid Test results too quickly. On the demand side, there were concerns about low participation of males in HTC and poor disclosure of HIV status among people in middle and high socioeconomic classes.

The 2014 MDG endline population-based survey found that only 43.3% of the females and 40% of the males reported undergoing HIV testing and receiving results in preceding 12

months. From 2010 to 2014, this proportion increased from 31.3% to 40.0% among males. In females, there was no comparative estimate in 2010. The 2014 coverage fell short of the Universal Access target of 75%. Several factors may explain this failure to meet the target. First, the demand for HIV testing among previously untested people was low since less than one third of all people receiving HTC in 2014 were new clients. Second, most skilled health workers (clinicians and nurses) were reported to have delegated performance of HTC to less skilled HSAs, potentially compromising the implementation of the MoH policy of offering HTC to all patients seeking health care. Third, although the general supply of HIV test kits improved from the previous years, there were still reports of intermittent shortages in several health facilities. Lastly, as reported above, the number of HTC outreach clinics was below the planned target which may have limited access to HTC services to people living in hard-to-reach areas and key populations (MSM, FSWs, female border traders, fishermen etc).

These results suggest a large unmet need for HTC among sexually-active Malawians and underscore the need for expanding HTC delivery sites. In an effort to address this challenge, the soon to be launched NSP and HIV Prevention Strategy seek to adopt new strategies to intensify HTC and focus it to high yielding sites. There are also plans to introduce HIV Diagnostic Assistants, as a new cadre of health workers, which may help to address the quality issues described above.

3.2.2.2. Management of Sexually-Transmitted Infections

From 1st January to end September 2014, 151,380 STI cases reported at health facilities with 32% classified as abnormal vaginal discharge, 25% as urethral discharge and 18% as genital ulcer disease. Of these, 40% were males and 60% were females. Nearly 13% of the females were pregnant. Among the cases, 67% were 25 years or older, 24% were between the ages of 20 and 24 years while 9% were less than 20 years old. The total reported cases were estimated to represent 88% of all cases reporting to facilities, since some facilities had challenges with documentation of STI cases. Assuming complete reporting of cases over this period, the MoH estimates that only 60% of all STI cases in the population sought treatment at health facilities.

The current STI management guidelines recommend PITC in all patients diagnosed with STIs. Those with negative or unknown results are required to have follow-up HIV tests. However, during this period, nearly half (49%) of the STI cases were screened for HIV, of whom 26% were found to be HIV-positive. Only 30% of STI cases with negative or unknown HIV tests were referred for follow-up HIV testing. This suggests sub-optimal implementation of guidelines on STI management. It was also noted that over 75% of the HIV-positive STI cases already had previous HIV diagnosis, of whom 73% were already on

ART. This suggests poor adoption of safer sexual behavior or increase risk of recurrent STIs among PLHIVs.

The proportion of pregnant women screened for STIs (including syphilis) remain extremely low (<10%). Screening tests appear to be preferentially performed in women clinically suspected of having STIs. Nevertheless, the yield of positive syphilis screening tests was low; only 3% tested positive. To improve syphilis screening in pregnant women, the MoH may need to consider introducing combined syphilis and HIV test kits.

3.2.2.3. Blood Safety

From 1st January to end September 2014, a total of 56,436 units of blood were collected. Of these, 65% were collected by the Malawi Blood Transfusion Services (MBTS) from voluntary donors while 35% were collected by health facilities from replacement donors. The blood units collected represents 94% of an annual target of 60,000 units and 63% of the 90,000 (30,000 per quarter) ideally required for 9 months, nationally. The MBTS screened the blood for the key Transfusion Transmissible Infections (HIV, syphilis, Hepatitis B and C and malaria), while health facilities always conducted screening tests for HIV, syphilis and Hepatitis B but infrequently for Hepatitis C and malaria. Health facilities used various screening algorithms for Transfusion Transmissible Infections (TTIs), perhaps determined by the availability of test kits. To guarantee the safety of blood transfusions, the MBTS is striving to increase its blood collection and screening efforts so as to meet the demands of health facilities across the country and decrease the proportion of blood collected and screened by health facilities. However, in 2014, the MBTS experienced funding challenges which interrupted the supply of blood screening test kits.

3.2.2.4. Voluntary Medical Male Circumcision

In 2014, implementation of VMMC focused on 8 districts in Southern and Central Malawi with high prevalence of HIV. Provision of VMMC services is mostly funded by PEPFAR and USAID. The national target for VMMCs remained 250,000 per year. Data available from four NGOs (BLM, I-TECH, PSI and Malawi Police Service (MPS) and CHAM facilities indicate that 80,419 circumcisions were performed in 2014. These data exclude circumcisions performed in the MoH facilities which were not readily available at the time of preparing this report. This reported number of circumcisions is slightly higher than 77,615 circumcisions performed in 2013, but markedly lower than the annual national target. Also, fewer than the planned trainers and service providers were reported to have received VMMC training in 2014. As a reflection of the slow implementation of the VMMC program,

the prevalence of all types of male circumcision in the general population increased only marginally from 21.5% in 2010 to 27.5% in 2014.

One of the major implementation challenges of the VMMC, cited by stakeholders, was misconceptions about the efficacy and unintended consequences of this intervention. Some people perceived VMMC as a guaranteed protection against HIV, which may promote high risk sexual behavior, while others fear about its adverse effects on sexual pleasure and performance. There were also concerns about serious surgical complications (infections and gangrene) that were reported to have occurred in some districts. These issues may have negatively affected demand for VMMC. To address these challenges, I-TECH is working with traditional institutions emphasizing the importance of the intervention. Stakeholders also raised concern about the capacity of health sector to deliver the VMMC program and achieve the national targets. Some feared that expansion of the program may drain skilled clinicians from public health system who may seek jobs in the well-paying NGOs implementing VMMC. In an attempt to reduce the dependency of the VMMC program on skilled clinicians, a pilot study has been completed assessing the feasibility of using a circumcision devise, Prepex, which can be administered by non-skilled health workers. Results of this study are expected by mid-2015. To increase the number of clinician with VMMC surgical skills in health facilities, Malawi is also considering including VMMC in pre-service training curriculum for clinicians.

3.2.2.5. Elimination of HIV Mother-to-Child Transmission

3.2.2.5.1. HIV Testing and ART coverage in pregnant women

An integrated ART/EMTCT programme has been implemented in Malawi since 1 July 2011 with the introduction of the Option B+. EMTCT/ART services are fully integrated into maternal and child health services. By 30th September 2014, there were 638 health facilities providing EMTCT services in Malawi, an increase from 588 in June 2013, but significantly short of the target of 700 sites. A total of 520,789 (79%) of the 660,964 expected pregnant women received HTC in 2014, which is slightly higher than 497,618 in 2013. However, the proportion of pregnant women tested falls short of the national target of 85%, which may be as a result of sub-optimal implementation of PITC in antenatal clinics. Of the 520,789 women receiving HIV test results, 7.7% (40,158) were HIV positive.

ART was prescribed to 37,022 (92%) of the HIV positive pregnant women attending ANC which represents only 72% of expected 51,484 HIV+ pregnant women, nationally. This ART coverage in HIV-positive pregnant women, was similar to that obtained in 2013 (73%) and remains close to the national target of 75%.

3.2.2.5.2. Coverage of nevirapine and cotrimoxazole prophylaxis, HIV Testing and ART initiation in children

In 2014, 34,046 HIV-exposed infants were discharged from maternity, of whom 31,745 (93%) received nevirapine prophylaxis. Cotrimoxazole prophylaxis was administered to 85% of HIV exposed infants less than 2 months old. These coverage rates were unchanged from 2013.

By the end of September 2014, there were 619 health facilities were providing EMTCT services and 7 laboratories performing HIV DNA PCR for early infant HIV diagnosis. However, as reported in 2013, HIV ascertainment in HIV-exposed children less than 24 months old and early initiation of ART remained a major challenge in 2014. Of the entire cohort of infants less than 2 months old, ~37% received HIV DNA PCR results, of whom 1% had positive HIV results. There were significant challenges with turn-around times for HIV DNA PCR results. Some of strategies employed by Malawi to address these problems include the use specialized blood sample transporters (Riders for Health) to collect blood samples from health facilities to central HIV DNA PCR testing facilities and the use SMS to communicate results from the laboratories to the health facilities.

ART was initiated in only 36-53% of the infants less than 2 months old who had positive HIV results or diagnosed with severe HIV disease. Considering the estimated number of new infections per quarter of 1025, ART coverage in children less than 2 months may be as low as 12%. The most important bottleneck for early infant treatment remained poor HIV ascertainment in pregnant women, breastfeeding women and infants. Similarly, of the entire cohort of infants less than 12 months old, only 35-39% had documented evidence of ascertainment of HIV status and 2% were HIV positive. ART was initiated in 81-85% of the infants less than 12 months old who had positive HIV results or diagnosed with severe HIV disease. Furthermore, of the entire cohort of children less than 24 months old, only 39-41% of infants had documented evidence of HIV status ascertainment, of whom3% had positive results. ART was initiated in 82-89% of the infants less than 24 months old who had positive HIV results or diagnosed with severe HIV disease.

3.2.2.5.3. Retention of Mother-Infant Pairs in EMTCT care

The proportion of HIV positive mothers on Option B+ retained in care was 71-73% at 12 months and 69-71% at 24 months. This lower than expected retention rate is mostly attributed to failure by up to 15% of pregnant women to initiate prescribed ART. This could be due to poor counseling of newly diagnosed HIV-positive pregnant women in health facilities, poor male involvement in EMTCT issues and sub-optimal HIV disclosure to spouses and family. The proportion of HIV-exposed infants retained in care was 90-93% at 2 months postpartum, 67-70% at 12 months and 12-16% at 24 months. Confirmed losses to follow-up for the HIV-exposed infants were 7-8% at 2 months, 26-29% at 12 months and 39-46% at 24 months. Results from MoH supervisory visits to health facilities indicate

challenges with documentation of follow-up outcomes, including HIV DNA PCR results, in infants' cards which led to underreporting ascertainment of HIV status among infants. Malawi, with the support of the WHO, is currently conducting cluster-randomized studies[63, 64] to identify strategies to reduce this high loss to follow up.

3.3. Treatment, care, and support

3.3.1. Antiretroviral Therapy (ART)

3.3.1.1. Changes in the ART initiation Guidelines

Provision of ART remains a key component of the national response. In April 2014, Malawi started implementing new guidelines for Clinical Management of HIV in Children and Adults which requires ART initiation in all HIV+ children under five years old and HIV+ children older than 5 years or adults with CD4 cell count of <500 (compared with a previous cut-off point of <350) and those co-infected with hepatitis B. Following these changes, the estimated number of HIV+ adults and children in need of ART increased from 681,000 to 798,000. In an effort to improve early initiation of ART, Malawi introduced CD4 count machines (including 'point of care' machines) to identify pre-ART HIV-positive patients needing treatment. By the end of September 2014, the machines were installed at 183 sites, of which 165 (91%) of these had produced at least 1 result.

3.3.1.2. ART coverage and retention in care

By the end of December 2014, 706 static sites were providing integrated ART services, a marked increase from 300 sites in June 2011 and a slight increase from 689 by the end of December 2013. Out of the facilities providing ART in December 2014, 77 were in the private sector which charge MK500 (US$1.11) per month for drugs. A total of 110,324 HIV-positive individuals were newly initiated on ART. This represents a slight increase (7.5%) from 102,568 initiated in 2013. The greatest increase in ART patient numbers was seen at sites with fewer than 500 patients on ART, which were mostly primary health care facilities. By the end of December 2014, 533,027 people were alive on ART. This represents

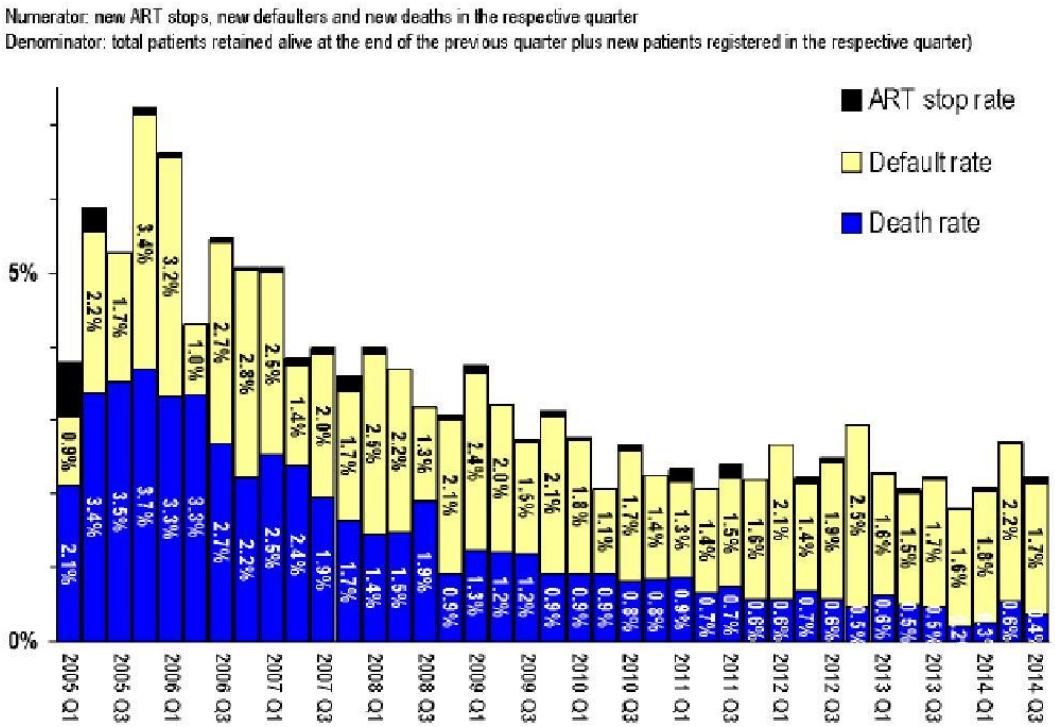
[63] Mwapasa V, Pro G, Chinkhumba J, Mukaka M, Kobayashi E, Stuart A, Gunda A, Joseph J, Sugandhi N, Chimbwandira FM, Eliya M. Mother-infant pair clinic and SMS messaging as innovative strategies for improving access to and retention in eMTCT care and Option B+ in Malawi: a cluster randomized control trial (the PRIME study). J Acquir Immune Defic Syndr. 2014 Nov 1;67 Suppl 2:S120-4.

[64] Rosenberg NE, van Lettow M, Tweya H, Kapito-Tembo A, Bourdon CM, Cataldo F, Chiwaula L, Sampathkumar V, Trapence C, Kayoyo V, Kasende F, Kaunda B, Speight C, Schouten E, Eliya M, Hosseinipour M, Phiri S; PURE Malawi Consortium. Improving PMTCT uptake and retention services through novel approaches in peer-based family-supported care in the clinic and community: a 3-arm cluster randomized trial (PURE Malawi). J Acquir Immune Defic Syndr. 2014 Nov 1;67 Suppl 2:S114-9.

an increase of 13% from 472,865 on ART by the end of December 2013. This number represents 67% of those needing ART, based on the new treatment guidelines, which is well below the 85% Universal Access target.

By the end of September 2014, of the 745,133 patients ever initiated on ART, 521,319 (69%) were retained alive on ART, 71,525 (9%) were known to have died, 158,580 (21%) were lost to follow-up and 3,418 (<1%) were known to have stopped ART. At the same time, 78% of HIV-positive individuals were retained alive on ART after 12 months on treatment. This is slightly lower than the survival rate of 85% recommended by the WHO. At 24 and 60 months, the proportions of HIV-positive individuals retained in HIV care were 73% and 59%, respectively. From 1st July to 30th September 2014, there were 2,006 new deaths, 9,275 new defaulters, and 464 new ART stops. This translates into a quarterly death rate of 0.4% and a defaulter rate of 1.7% among the patients alive and on treatment in this quarter. As shown in Figure 4 below, the quarterly death and defaulter rates have been declining steadily since Q1 of 2005.

Figure 4: Quarterly rates of ART dropout (ART stop, defaulters and deaths)



3.3.1.4. Virological monitoring of individuals on ART

To improve early detection of treatment failure and initiation of second-line ART, Malawi adopted viral load monitoring of patients on ART at the following times: 6 months and 24 months after initiating ART and at 24-monthly intervals thereafter. In 2014, a total of 8 laboratories were performing HIV viral load assays. Based on the number of patients on ART it is estimated that 70,000 people need viral load monitoring every quarter but, in the first two quarters of 2014, only 17-18% of ART patients had viral load measurements on scheduled visits. This was mostly due to poor adherence of health workers to monitoring guidelines and logistical challenges with blood sample transportation. Of the people receiving viral load tests at scheduled visits, 85-86% of them had viral load of <1000 copies per microliter. This proportion was higher than that found in a previous community-based cross-sectional study[65] conducted in 2013 in Chiradzulu districts in Southern Malawi, which found that 61.9% of people on ART had viral load <1000 copies per microliter.

3.3.1.5. ART Adherence and Tolerability

In July 2013, Malawi's started transitioning first line ART from stavudine/lamivudine/ nevirapine (Regimen 1 A) to tenofovir/lamivudine/ efavirenz (Regimen 5A). By the end of September 2014, 513,600 (99%) of patients were on first line and 5,240 (1%) were on second line regimens; 471 (<1%) were on non-standard regimens. Of the 488, 020 adults on first line ART, 454,763 (93%) were receiving regimen 5A, 26,686 (5%) were on zidovudine/lamivudine/nevirapine (regimen 2A), while 1,925 (<1%) were on regimen 1A ("the old regimen"). Among 25,580 HIV-positive children on pediatric ART formulations, 24,401 (95%) were on zidovudine/lamivudine/nevirapine (regimen 2P) which is the new standard first line for children. The prevalence of side effects in all ART patients stabilized at ~2% which is lower than when the majority of patients were on regimen 1A. Based on pill count and self reported missed doses, almost 91% of the patients on ART were classified as >95% adherent.

3.3.1.6. Cotrimoxazole Prophylaxis and Isoniazid Preventive Therapy

According to the MoH HIV Treatment Guidelines, all pre-ART HIV+ patients without active TB are eligible for Isoniazid (INH) Preventive Therapy (IPT) while pre-ART and ART patients are eligible for cotrimoxazole prophylaxis. By the end of September 2014, 94% of pre-ART and ART patients were on cotrimoxazole prophylaxis which is higher than 88% reported at a similar time point in 2013. At the same time, 31,300 (81%) of 38,741 patients on pre-ART were on IPT which is a tremendous improvement from 50% reported at a similar time in 2013 and 27% in 2012. Thus, Malawi has successfully addressed the

[65] Chiradzulu HIV Impact in the Population Survey, April 2014, Ministry of Health, Medecins Sans Frontieres and Institut de Recherché pour Developpment

challenges in supply chain management of INH and cotrimoxazole reported in the 2011/12 fiscal year, which had adversely affected coverage of these prophylactic interventions.

3.3.2. TB and HIV co-Management

In 2014, 9,495 (90%) of the 10524 HIV-TB co-infected patients received both TB treatment and ART, a marked increase from 75% reported in 2013. Thus, Malawi surpassed the WHO target of 85%. The majority of TB cases (~2/3) were already on ART at the time of TB diagnosis. Of note, HIV screening was performed in 91% of newly diagnosed TB patients while clinical screening for TB was performed on 96% of pre-ART and ART patients. However, TB was detected in only 1.5% of HIV+ patients in care, similar to 1.6% reported in 2013. This low TB detection yield among HIV-positive individuals suggests poor sensitivity of the clinical assessment or diagnostic tools available in health facilities. Some stakeholders expressed concern that overburdened health workers did not strictly adhere to TB screening guidelines when following up HIV+ patients.

3.3.3. Community Home-based Care (CHBC)

In 2014, there was limited support for CHBC and palliative care activities for chronically-ill patients. This could partly be due to continued increase of PLHIV on ART living healthy lives. During the preceding year (2012/13), 178,001 households with chronically ill patients received home-based care services, which was lower than 202,578 households in 2011/12. There were also limited training of community volunteers and health personnel in CHBC/palliative care when compared with the achievements in 2012/13 when 1236 people received training. It was also noted that nutrition support coming from the 2% of "Other Recurrent Transactions (ORT)" budgets from District Implementation Plans was not adequate to meet the food and nutrition requirements of PLHIV.

3.3.4. Impact Mitigation

The National Social Support Policy and the National Action Plan for Vulnerable Children in Malawi (2015-2019) guide the implementation of impact mitigation in Malawi. The Ministry of Gender, Children, Disability and Social Welfare (MoGCD&SW) is the line ministry which deals with impact mitigation interventions. One of the major activities carried out in 2014 by the ministry was the development and finalization of the National Plan of Action (NPA) for Vulnerable Children in Malawi. Before the development of this

NPA which covers all vulnerable children, there were separate NPAs for orphans and other vulnerable children. This section discusses impact mitigation interventions implemented in 2013/2014.

3.3.4.1. Community based child care centres

Community-based child care centres (CBCCs), run by community members, constitute one way of addressing to the needs of OVCs in Malawi. It is estimated that 21% of the children who attend CBCCs are orphans[66]. Such centres provide opportunities for children to learn, interact socially and access food. In 2013/2014, the target was to support 200 CBCCs countrywide but only 176 were reached. A 2013 report showed that there were 5,609 CBCCs in Malawi caring for 336,499 children[67]. This demonstrates that the 2013/14 target of 200 falls markedly short of the number of CBCCs available, nationally.

3.3.4.2. The social cash transfer program

The Social Cash Transfer Program (SCTP) was introduced in Malawi in 2006 with support from the Global Fund. The programme aims at reducing malnutrition and improving school enrolment through the delivery of regular and reliable cash transfers to ultra poor and labour-constrained households. In the 2013/14 financial year, the program was mostly funded by development partners (EU, Irish AIDS, World Bank and KFW) which contributed MK4 billion. UNICEF provided technical assistance to the implementation of the SCTP. Over the years, the financial contribution by the GoM has been increasing. For example in 2011/12, GoM contributed MK70 million and in 2012/13 this increased to MK206 million and in 2013/2014 it increased to MK450 million. However, in 2014/2015 GoM contribution has decreased to MK350 million, mainly because of cash-flow problems in the public sector.

The program was initially piloted in Mchinji district in central Malawi. By the end December 2014, the program had been rolled out to 18 districts of the 28 districts in Malawi. In December 2013, there were 13,029 households benefitting from the SCTP programme. As shown in Figure 5 below, this number increased to 18,126 in January 2014. By the end of December 2014, a total of 41,264 households were benefiting from the programme, with the most rapid increase was observed in the last 6 months of 2014. The majority (74%) of households benefitting from this programme were female-headed while 52% were elderly-headed. As of March 2015 the programme had reached 82,000 households with over 373,000 beneficiaries.

[66] USAID and UNICEF. (2013). Impact evaluation of the National Plan of Action for Orphand and other vulnerable children 2005-2009 and 2010-2011). Lilongwe: USAID and UNICEF.
[67] USAID and UNICEF. (2013). Impact evaluation of the National Plan of Action for Orphand and other vulnerable children 2005-2009 and 2010-2011). Lilongwe: USAID and UNICEF.

Figure 5: Number of households benefiting from SCTP 2014

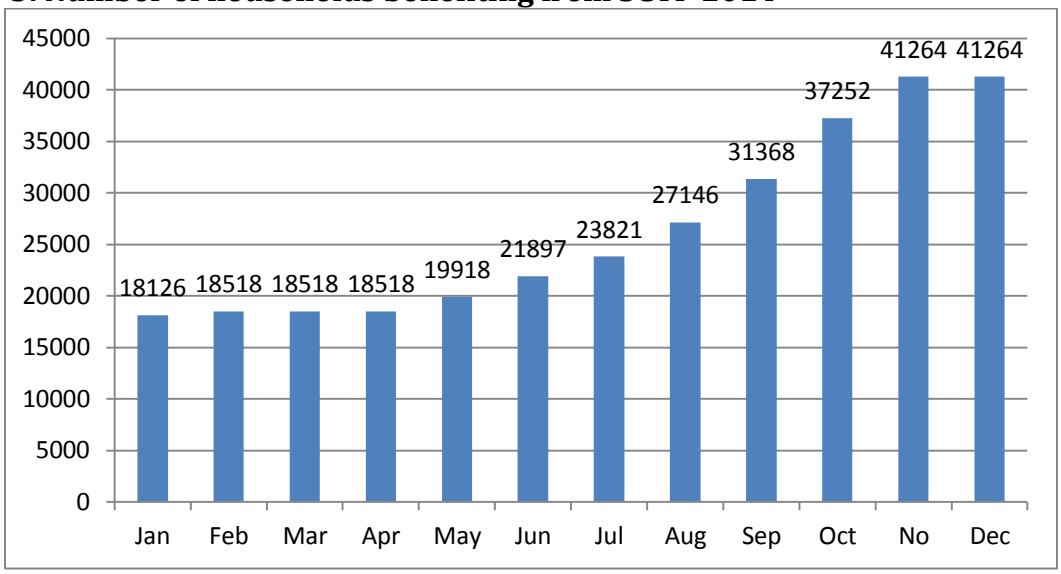
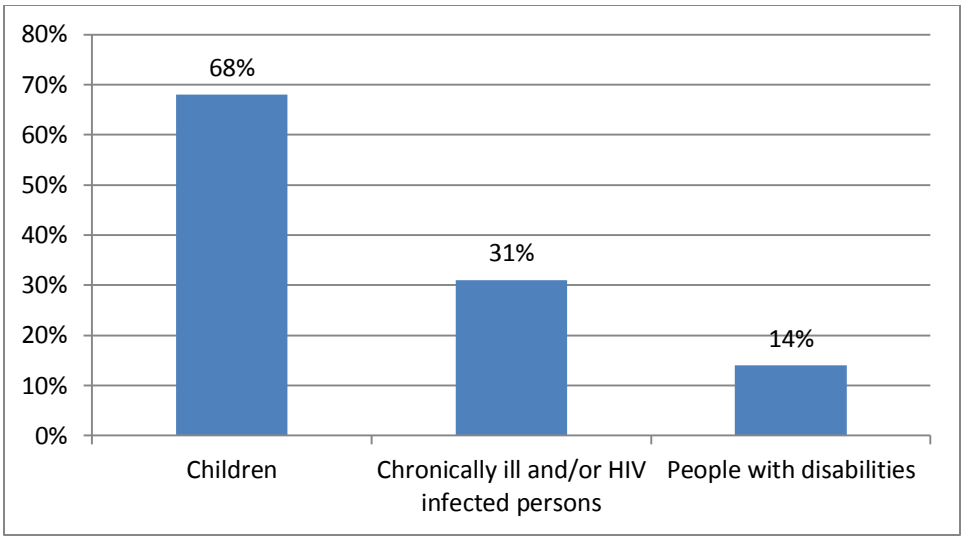


Figure 6 below, shows the proportion of individuals in SCTP targeted households who benefited from the intervention. The majority (68%) of individuals benefitting from the SCTP were children (including orphans), while 31% were chronically ill and/or HIV infected persons (31%). A recent study found that the SCTP is significantly contributing to the national response to the HIV and AIDS epidemic[68].

Figure 6: Percentage of Individuals benefiting from SCTP

[68] Kainja, E. (2015). *Side event on the Malawi social cash transfer programme.* Paper presented at a workshop on Investing in children and women for community transformation, New York 19 March 2015.



Currently, the amount of cash beneficiary households receive ranges from US$2 to US$5/month depending on the size of households. Families with school-going children receive US$0.6/month per child enrolled in primary school and US$1.2/month per child enrolled in secondary school. These payments are made at village clusters identified by district councils. These payments are made every month and, in 2014, payments to beneficiary households were made electronically[69]. The extra cash which beneficiary households receive when they have primary and secondary school children makes them direct more resources to education.

Evaluation of SCTP in Malawi and globally has generally demonstrated that it has expanded income generation activities, increased access to productive resources such as farming tools and livestock[70], increased school enrolment, reduced secondary school dropouts and reduced incidence of marriage[71]. In addition, SCTP reduced the prevalence of under-weight children and improves food security[72]. Furthermore, the program led to beneficiary households spending less time on casual labour. Instead, members of these households spend more time working in their own farms[73]. A 2013 study found that a higher

[69] Kainja, E. (2015). *Side event on the malawi social cash transfer programme.* Paper presented at a workshop on Investing in children and women for community transformation, New York 19 March 2015.
[70] See De La I-Campos, A.P. Davis and S. Dandone. (2015). Women's empowerment and social protection: cash transfers and beyond. Paper presented at a workshop on Investing in children and women for community transformation, New York 19 March 2015.
[71] Baird et al. (2011). Cash or condition: evidence from a cash transfer experiment. *The Quarterly Journal of Econmics* 126: 1709-1753.
[72] Miller, C.M., M. Tsoka. (2011). *ARVs and cash too: caring and supporting people with HIV AND AIDS with the Malawi Social Cash Transfer.*
[73] See De La I-Campos, A.P. Davis and S. Dandone. (2015). Women's empowerment and social protection: cash transfers and beyond. Paper presented at a workshop on Investing in children and women for community transformation, New York 19 March 2015.

proportion of beneficiary households than that of comparison households have members living with HIV[74]. In addition, the study found that beneficiary households experienced fewer deaths in the 10 years preceding the survey compared to comparison households. Despite the positive results from the SCTP, stakeholders noted that the bulk of the funds supporting this program come from donors. Thus, they questioned the long term sustainability of this intervention without donor support.

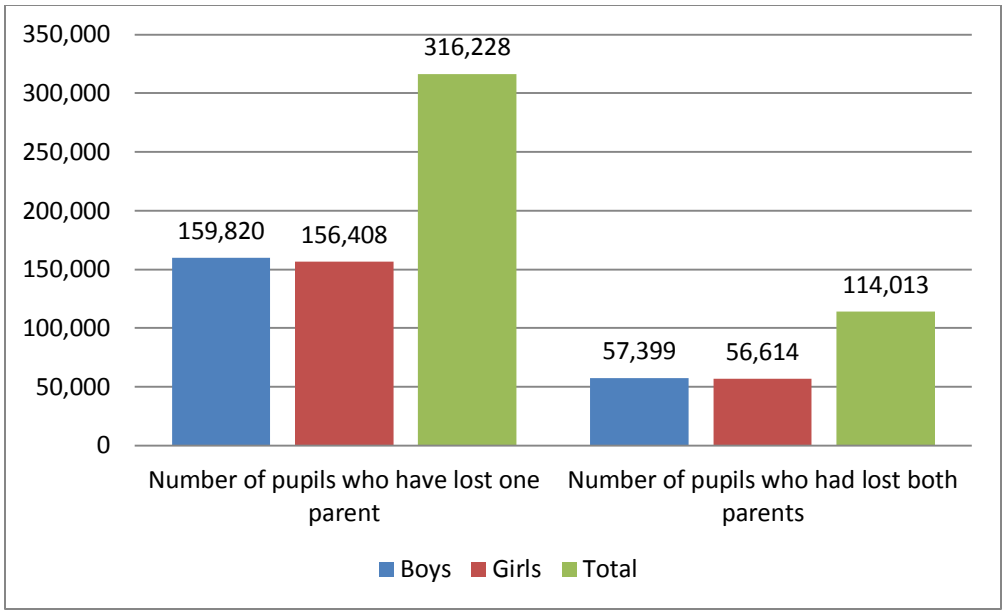
3.3.4.3. School attendance among orphans

This indicator on the ratio of current school attendance among orphans to non-orphans among the 10-14 year olds is measured through the MDHS. The last MDHS was conducted in 2010 and it found that this ratio was at 0.96. The 2013/2014 MDG endline survey for Malawi found that the ratio has remained constant at 0.96.

In 2013/2014 there were a total of 4,670,279 school pupils in primary school in Malawi, with equal proportions of boys and girls. Overall 9.2% of the school pupils were orphans[75]. Figure 7 below shows the number of school pupils, in 2013/2014, who lost one or both parents. There were slightly more boys than girls who were orphaned. In addition, there were more school pupils who lost one parent (6.7%) than those who lost both parents (2.4%).

Figure 7: Number of school pupils who are orphans

[74]Chirwa, E.W. and P. Mvula. (2013). *External evaluation of the performance and impact of the social cash transfer scheme in Malawi*. Lilongwe: National AIDS Commission.
[75] 2013/2014 Education Management Information System Report for Ministry of Education, Science and Technology.



3.3.5. Addressing other basic needs for OVC

3. 3.5.1. Provision of school bursaries

Bursaries are offered to secondary school students since primary education in Malawi is offered free of charge. In addition to the NAC, other stakeholders which provide bursaries include GoM, Campaign for female education (Camfed) for girls only, Red Cross, NGOs such as World Vision International, individual Members of Parliament etc. The MoGCD&SW and the Ministry of Education, Science and Technology (MoEST) provide bursaries but they use different criteria in selecting beneficiaries and different ways of channeling the funds to beneficiaries. The bursaries provided by the MoEST are administered at division offices in collaboration with schools and this is funded by the World Bank. The MoGCD&SW provides bursaries through their district social welfare offices[76]. Thus, there is a need to improve coordination between government ministries in the provision of bursaries.

During 2013/2014 fiscal year, only 1,206 bursaries were reported to have been offered to OVCs against a target of 10,000. This represents a significant reduction from 2012/2013 when a total of 12,001 bursaries were offered. These figures are markedly lower than those reported by the MoEST. A 2014 study found that in 2012/2013, 14,058 learners received bursaries and this number went down to 12,936 in 2013/2014 school year[77]. Data from the district social welfare offices were not available on number of scholarships offered the MoGCD&SW. The implementation of bursary program is adversely affected by the late

[76] Ndala, K. (2014). Nationwide secondary school bursary review. Lilongwe: National AIDS Commission.
[77] Ndala, K. (2014). Nationwide secondary school bursary review. Lilongwe: National AIDS Commission.

submission of financial reports by local councils and delays in the disbursement of funds from NAC.

3. 3.5.2. Provision of vocational training

In 2013/2014 2,205 vulnerable young people were trained in vocational skills against a target of 1,500 vulnerable young people, representing a 47% over-performance. However, the number trained was only slightly higher than the 2,181 trained in 2012/2013. Vocational training also aims at training young people in business and entrepreneurship management as well as providing them with start-up capital. In 2013/2014, 1,565 young people were trained in business and entrepreneurship against a target of 1,500. However, only 21.4% young people were provided with start-up capital. Thus, overall the provision of vocational training to young people seems inadequate.

In addition to the training of vulnerable young people, there were also other initiatives targeting married adolescent girls. Under the Gender Equality and Women's Empowerment program, married adolescent girls were trained in vocational skills and were provided with start-up equipment including sewing machines, hair dressings kits and baking machines[78]. A total of 144 women benefited from this intervention which was implemented in 13 districts.

3.3.5.3. Provision of psychosocial, material and medical support for OVC

In 2013/2014, only 28,301 OVC were reached with psychosocial, material and medical support against a target of 70,000, representing a 60% shortfall. Compared with the 2012/2013 fiscal year when 101,932 OVC were reached, 2013/2014 figure represents a big decrease in program output. This marked decrease could partly be explained by poor reporting from implementing partners. Nevertheless, it is clear that there is a need to improve the delivery of this program.

3.4. Gender-based Violence

3.4.1. Prevalence of gender based violence (GBV)

The Violence Against Children Survey (VACS) conducted in 2013 and published in December 2014, explored physical, emotional and sexual violence among male and female persons aged 13-24. This study found that a higher proportion of females (21.8%) than

[78] Government of Malawi, UNFPA and EU. (2014). *Gender equality and Women Empowerment Programme*. Lilongwe: Government of Malawi, UNFPA and EU

males (14.8%) aged 18-24 reported experiencing sexual violence before the age of 18 years. Among those who experienced sexual violence, more males (74.4%) than females (68.4%) reported experiencing multiple incidents of violence. Among females, most of the perpetrators of violence were spouses, boyfriends or romantic partners (33.4%) while among males most were friends (29.1%). Most males (64.7%) and females (61.2%) who reported to have been sexually abused received professional services. In the same study, young people aged 13-17 were also asked whether they ever experienced sexual violence in the 12 months prior to the survey. Again, a higher proportion of females (22.8%) than males (12.7%) reported experiencing sexual violence during this period. The most common type of sexual violence experienced by both males and females during childhood was unwanted attempted sex followed by unwanted sexual touching.

In terms of physical violence, a higher proportion of males (64.5%) than females (42.4%) aged 18-24 reported experiencing physical violence before the age of 18 years. Among both males and females aged 18-24, this physical violence was mainly perpetrated by parents/adult relatives, childhood peers and community members. A higher proportion of females (64%) than males (50.8%) experienced physical violence informed someone about it but very few (10.3% among females and 4.8% among males) received any support. Among adolescents aged 13-17, 40.9% of the females and 59.5% of the males reported they experienced physical violence. There were no differences between males (59.2%) and females (59.9%) who reported the physical violence to someone else and very few of these adolescents (11.3% females and 6.1% males) reported having received support after experiencing physical violence[79]. It is evident that a good proportion of young people do not report incidences of violence and females are most unlikely to report compared to males. Even if young people report very few, actually less than 10% will receive services.

3.4.2. Addressing GBV cases

Victim support units (VSUs) were established within the Malawi Police Service (MPS) in 2001 with an aim providing support to people, particularly women and girls experiencing violence and abuse. In 2014, there were 225 VSUs throughout the country manned by an officer trained on how to handle cases of violence. However, only 2 of these VSU (Kanengo and Lilongwe Police Stations) fulfilled the requirements of a standard VSU. Training for VSU officers were ad hoc and were almost exclusively supported by development partners

[79] Ministry of Gender, Children, Disability and Social Welfare. (2014). *Violence against children and young women in Malawi: findings from a national survey 2013.* Lilongwe: Ministry of Gender, Children, Disability and Social Welfare.

During stakeholder interviews, it was reported that police officers manning VSUs visit schools and communities in order to create awareness about gender based violence and the need to report such cases to the VSUs. As a result of these activities there are a number of cases of violence which are reported to the police, which was not the case previously. It was learnt that most of the case of defilement of girls are done by persons whom the child trusts. In 2014 there were about 14,000 cases which were reported to VSUs, nationally. These cases of violence were supposed to have been investigated and followed up, but in most cases this was not done due to shortage of transport. The other challenge experienced by VSUs was that cases of violence were supposed to be handled with privacy and confidentiality but in most cases this could not be guaranteed because of infrastructure problems. For example, some VSUs do not have separate rooms or buildings while others operate under a tree. While the MPS has oriented quite a number of its officers on VSU activities, most of the police officers handling these cases have not received formal training on how to properly handle these cases.

3.4.3. Other achievements

There are a number of other activities which took place in 2014 with regard to addressing gender inequality as follows:

- In 2014 the MoGCD&SW, with support from UNFPA and the EU and under the Gender Equality and Women's Empowerment Project, revised the National Gender Policy. This policy was approved by the Principal Secretaries Committee on Gender and HIV and AIDS. The policy has since been submitted to the Office of the President and Cabinet (OPC) for approval.
- Discussions are underway to establish undergraduate programmes in gender studies at University of Malawi and Lilongwe University of Agriculture and Natural Resources.
- In 2014, the national GBV Response plan was revised and finalized.
- In 2014 the Gender equality and Women's Empowerment program also supported mobile courts in Salima and Mchinji Districts to facilitate prosecution of GBV cases in hard-to-reach areas which either did not have courts or legally authorized personnel to preside over GBV cases.

In addition to these issues, the Programme also established and operationalized the GBV Crisis Support Hotline which is being run by Youth Net and Counseling (YONECO). A total of 15 people were trained to man the hotline. These activities were supported by the EU and

UNFPA under the Gender Equality and Women Empowerment program being implemented by the MoGCD&SW [80].

3.5. Financial resources for the national response

3.5.1. Methodology for expenditure analysis

This section details the approach adopted by Malawi to compile domestic and international AIDS spending by categories and financing sources during 2013/14. For the 2015 GARPR, data entered in the Funding Matrix pertains to the fiscal year 2013/14. Where this is at variance with some partners' reporting year, such as reporting FY 2014 for USG partners, appropriate adjustments were made. For the United Kingdom, the reporting year used is April 2013 – March 2014. An ad-hoc expenditure analysis was agreed upon by the GARPR Task Team because the latest National AIDS Spending Assessment (NASA) as well as System of Health Accounts (SHA) did not cover the reporting period.

To this end, a "*pareto rule*"[81] was applied whereby expenditure data was collected from only a few funding source covering over 90% of the national HIV and AIDS response. These sources included GoM, PEPFAR, GFATM, United Nations, selected multilateral and bilateral agencies with active HIV projects and the private sector. As the spending was reported in various currencies, an average exchange rate with the US Dollar was applied. This was obtained from the Reserve Bank of Malawi (RBM)[82]. Below, are specific data sources which were used from each of the funding sources:

- **GoM**: Spending data was obtained from audit reports of selected key ministries, departments and agencies of government (namely NAC, HIV Department in MoH, DNHA and Ministry of Local Government and Rural Development).
- **PEPFAR:** PEPFAR Expenditure Analysis data for fiscal year 2014 was used.
- **GFATM**: Expenditures by program area were obtained from the Principal Recipient which is the Ministry of Health.
- **United Nations**: All HIV spending by various participating UN agencies in the Joint UN Programme of Support on AIDS were obtained for annual year 2014. These were derived from the annual report of the Joint Programme
- **Selected bilateral and multilateral agencies**: Based on expert opinion of the Task Force, it was agreed that data should be sought and collected from the following

[80] Government of Malawi, UNFPA and EU. (2014). *Gender equality and Women Empowerment Programme*. Lilongwe: Government of Malawi, UNFPA and EU

[81] In economic theory, pareto rule posits that for many events, roughly 80% of the effects come from 20% of the causes.Based on past resource tracking exercises, it is clear that over 80% of all HIV funding comes from only 5 entities. It is on this premise that the purposive sampling discussed in this report was adopted.

[82] See: https://www.rbm.mw/stats_financial.aspx

development partners: World Bank, DfID, Clinton Foundation, Medecins Sans Frontiers, Sweden, Oxfam Affiliates, Abbot and, World Vision. Expenditure data per programme area was collected directly from the above entities. Where it was not possible to directly obtain this information, it was extracted from the latest CHAI Resource Mapping round database.

- **Private sector**: Expenditure data per programme area were extracted from the latest CHAI Resource Mapping database. Two issues are worth noting. First, data were obtained for selected private companies that have traditionally had a substantial investment in HIV and AIDS. Secondly, out-of-pocket spending was excluded. The reason for exclusion was the lack of readily available data.

Finally, as the Funding Matrix used has undergone revision with corresponding revised classification of AIDS programmes, a "cross-walk" was undertaken so as to directly map the reported spending categories to the ones used in the Matrix. This has enabled provision of information of greater relevance for policy and better information on the core indicators built to embrace the 10 targets of the 2011 UN Political Declaration on HIV and AIDS. Table 2 below illustrates an example of cross-walk of the PEPFAR Expenditure Analysis into the Program categories used in this report.

Table 2: An illustration of a cross-walk of PEPFAR expenditure analysis programme categories into the GARPR Funding Matrix programme categories

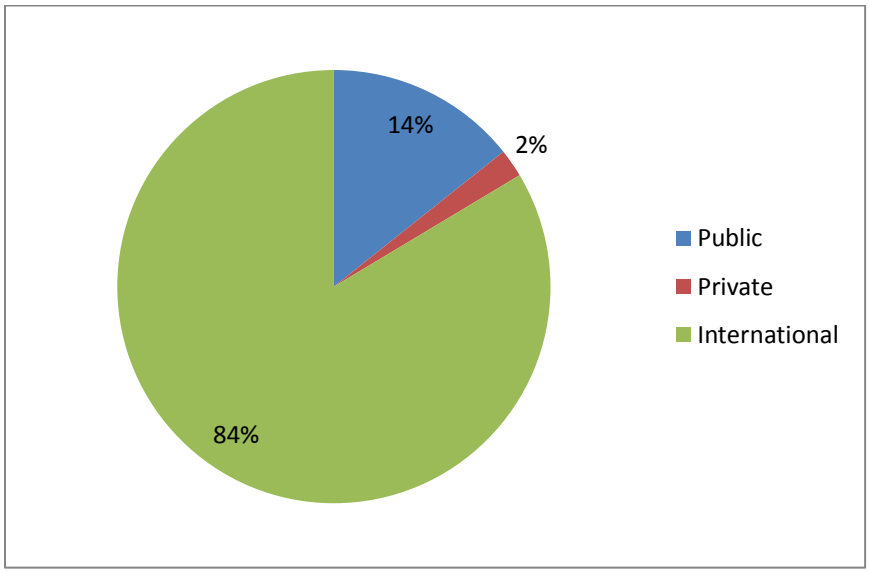
PEPFAR EA categories	Corresponding GARPR category
Bloody safety	8.5. Synergies with the health sector
Facility-based care, treatment and support	4.3. Adult antiretroviral treatment
Community-based care, treatment and support	1.10. Community mobilization 7.4. AIDS-specific institutional development / community mobilization
HIV testing and counselling	4.1. HIV testing
Lab	8.5. Synergies with the health sector
Orphans and Vulnerable Children	8.1. Social Protection
Surveillance	Others (specifically "Other essential programmes outside the suggested framework of core HIV and AIDS programmes"
Voluntary Medical Male Circumcision	1.3. Voluntary medical male circumcision

A Programme-Oriented Resource Tracking and Investment Analysis (PORTIA) has been planned in 2015 and will collect detailed spending and output data for the financial years 2012/13 – 2014/15. To this end, the spending data collected through this *ad-hoc* method should be treated as provisional. As soon as comprehensive spending data becomes available, this matrix shall be updated.

3.5.2. Domestic and international expenditure on HIV and AIDS

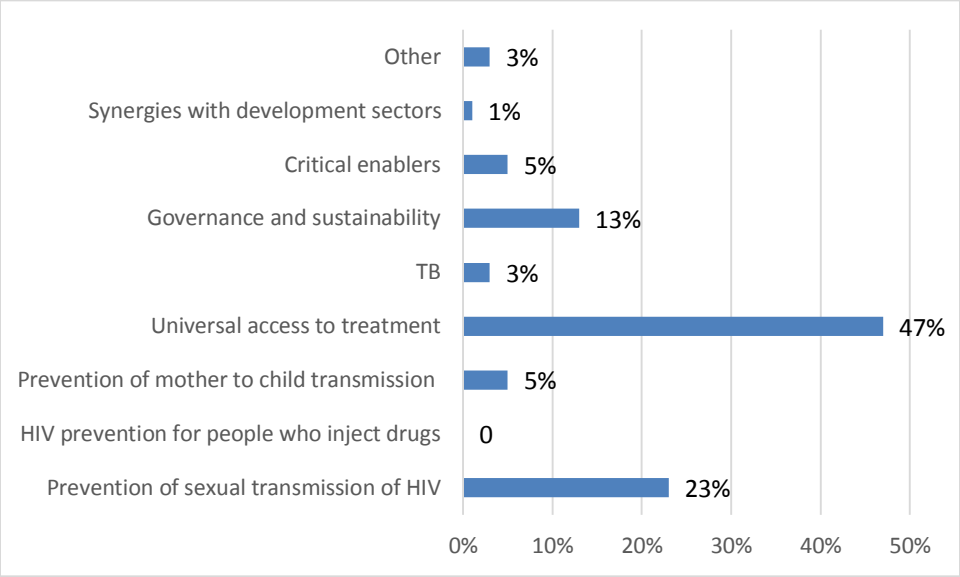
The national response to the HIV and AIDS epidemic is still largely funded by external sources. The contribution from public funds increased from 1.7% in 2010/2011 to 8.1% in 2011/12 and then in 2013/2014 it has been estimated at 14.3%. In 2013/2014 2.1% of the expenditure came from private sources while 83.6% came from the international community as can be seen in Figure 8 below:

Figure 8: HIV and AIDS investment by source of funding in FY 2013/14



In 2011/2012 a total of US$133,575,811 was spent on the national response and this was a decrease from US$148,891,014 in 2010/2011. Figure 9 below shows that 47% of the total expenditure in 2013/2014 was on treatment and care and this was an increase from 32% in 2011/2012 when the last NASA was conducted. Only 5% of the expenditure was on PMTCT and 23% of the expenditure was on the prevention of sexual transmission of HIV.

Figure 9: HIV investment by programme area in FY 2013/2014



3.5.3. Closing the resource gaps for financing the national response

In the last quarter of 2014, Malawi developed the HIV NSP for the period 2015-2020. In early 2015 the country submitted the joint HIV/TB Concept Note to the Global Fund. The total NSP budget for the period 2015-2017 is estimated at US$498,828,650 and only 46% (US$258,445,335) of these funds are available leaving a financial gap of US$269,311,273. Table 3 below shows the main donor commitments by HIV activity for the period 2014-2017[83]:

[83] Joint TB/HIV Concept Note for the Government of Malawi submitted to Global Fund, 2015

Table 3: Main donor commitments by HIV activity (in US$)[84]

Main Funding Source	Fiscal year 2014 – 2017 Total**	Main Activities Funded
GoM	39,601,257	ART, VMMC, Cross-cutting HIV platform
GFATM (dispersed)	73,285,288	HIV Commodities, Cross Cutting HIV activities
GFATM (excluding NFM; including forecasts up to June 2015)	112,861,013	HIV Commodities, cross-cutting HIV platform, HTC, OIs, Labs
USG	236,342,654	BCC, Condoms, VMMC, ART, Cross-cutting HIV platform
World Bank	18,360,000	VMMC, Cross-cutting HIV platform
MSF	20,710,126	Viral load assays, ART, HTC, Cross-cutting HIV platform
UKAid/DfID	19,746,880	Early Infant Diagnosis, HTC, PMTCT
CHAI	9,749,523	ART, CD4 testing

In an attempt to close the huge funding gap, Malawi will start implementing the "Sustainable Financing Strategy" in July 2015. Even with the implementation of this strategy, there will still be a huge financial gap for implementing the national HIV and AIDS response. It is within this context that the Government of Malawi, with support from development partners, has applied for funding from the Global Fund to finance the national response.

[84] Data taken from HIV-TB JCN Financial Analysis, version GF Final.

Chapter IV: Best practices

As part of the process of developing this report, stakeholders were requested to identify best practices with regard to the national response to the HIV and AIDS epidemic. The following were mentioned as best practices in the national response to the HIV and AIDS epidemic.

4.1. The delivery of Option B+

Almost all the stakeholders who were interviewed said that one of the best practices in the national response to the HIV and AIDS response in Malawi is the delivery of Option B+ which Malawi started implementing in July 2011. In this approach all pregnant women who are found HIV+ are put on ART for the rest of their lives regardless of clinical staging or CD4 count. At the time when Malawi was introducing Option B+ there were concerns that the intervention was quite expensive and that Malawi would not be able to successfully implement this. Due to the success of this strategy pioneered in Malawi, 12 other countries had adopted this approach, as of end December 2014.

4.2. The ART programme

With support from the Global Fund and other partners, Malawi started implementing a free ART programme in 2004, using a public health approach. At that time there were about 3,000 people on ART. By the end of 2014, more than half a million people are on ART, representing coverage of 67%. There is emerging evidence that a very large proportion of patients on ART have successfully suppressed HIV viral replication and very few are experiencing side effects. Most stakeholders who were interviewed acknowledged that the delivery of ART using a public health approach has been successful since the biggest expansion in the ART programme has occurred at primary health care facilities. The program has been successful at addressing social inequities in the provision health care.

4.3. Availability of biomedical data

Most stakeholders acknowledged that the MoH has very good HIV programme data especially on HTC, ART and PMTCT. These data are available every quarter. The Department of HIV in the MoH, supported by a grant from PEPFAR, has generally done a good job in terms of collecting high quality data from health facilities across the country,

cleaning it and analyzing it and disseminating it to stakeholders for decision making in a timely manner. Every facility is visited once every quarter to collect real time data and, where challenges in data collection are noted, coaching and mentoring is performed.

4.4. Task shifting

Both the Health Sector Strategic Plan (2011-2016) and the HIV NSP (2015-2020) acknowledge that the shortages in Human Resources for Health at all health care delivery points in Malawi pose huge challenges in the provisions of high quality health services. The introduction and expansion of the HIV programme could have overwhelmed the health system in Malawi and resulted in a chaotic delivery of HIV and AIDS services. However, Malawi has successfully implemented a task shifting approach in the delivery of HIV and AIDS services which has expanded access to HIV and AIDS services without significantly compromising quality of the services.

4.5. Existence of an effective national coordinating mechanism for HIV and AIDS

The GoM has established a good coordinating mechanism for the national response to the HIV and AIDS epidemic which enables transparency and inclusiveness in all process of planning, implementing and reviewing HIV and AIDS programs. In line with the 'three ones' principle, the NAC is the only agency which has been charged with the responsibility of coordinating the national response to the HIV and AIDS epidemic. The NAC is governed by a Board of Commissioners, appointed by the President, which includes members from various constituencies namely: private, public, faith, civil society, youth and PLHIV. The roles of the Board include reviewing and approving NAC policies and procedures, annual work plans and hiring and monitoring the performance of secretariat staff. The NAC Board reports to the Office of the President and Cabinet (OPC). The President is the Minister Responsible for HIV and AIDS, and provides overall leadership on matters of HIV and AIDS for Malawi. As mentioned earlier, the NAC coordinates the development of an Integrated Annual Workplan (IAWP) which outlines HIV and AIDS activities which will be implemented by different implementing partners at different levels. These implementing partners include government ministries, NGOs, CSOs and the private sector and they submit reports on their activities to NAC. The government also established the Department of Nutrition, HIV and AIDS (DNHA), previously in OPC and now in the MoH, which is responsible for policy oversight and high level advocacy on HIV and Nutrition.

To complement the oversight functions of the NAC Board, the Malawi Partnership Forum (MPF), which brings together implementing and development partners, advises the NAC on strategic and technical matters and ensures mutual accountability of the resources

committed in the national response against HIV and AIDS. Other, specific partnership fora which support the planning and implementation of HIV and AIDS activities include the HIV and AIDS Donor Group (HADG); the International NGO forum and Local NGO Forum; the Malawi Interfaith AIDS Association; and the Malawi Business Coalition on AIDS (MBCA). The MBCA coordinates the private sectors' response to the HIV and AIDS epidemic.

Chapter V: Major challenges and remedial actions

5.1. Progress made on the key challenges reported in the 2013 Progress Report

During the financial year 2012/2013, a number of challenges were identified which affected the implementation of the national response against the HIV and AIDS epidemic. Most of these challenges still prevail and there is an urgent need to address them. These challenges include:

- A huge funding gap still exists which hinders stakeholders' ability to fully implement the National HIV and AIDS Strategic Plan. As of a result of this, there is limited budgetary allocation to HIV programmes, especially for non-biomedical prevention interventions.
- An overall weak research and M&E system especially at district level.
- A general lack of sharing of data at district and lower levels and the capacity to utilize data for decision making is low.
- Non-alignment of some iNGOs interventions and M&E systems to multi-sectoral National HIV and AIDS Strategic Plan.
- A limited range of services targeting youth and HIV+ children.
- Inconsistencies between policies and laws on MSMs and FSWs.
- Low coverage for VMMC and limited capacity in the Malawian public health sector to meet the demand for VMMC.
- Low proportion of HIV exposed infants undergoing Early infant diagnosis for HIV and the long turn-around time from sample collection to receipt of results.
- Small number of OVC and their households being reached with different interventions.
- Weak coordination mechanisms for OVC programs.
- Slow progress in the enactment of the HIV Bill.
- Questionable sustainability of the social cash transfer program.

5.2. Major challenges experienced in 2014 and remedial actions planned

Most of the above-cited challenges have been articulated in reported in previous the Global AIDS Response Progress Reports since in 2012. For the current Global AIDS Response Progress Report, stakeholders were asked to identify additional challenges which were experienced in 2014. The following challenges were mentioned, including the

corresponding concrete remedial actions that are planned to ensure achievement of the agreed targets:

- **Lack of financial resources:** A number of organisations which were consulted reported that there was a general lack of resources to implement their planned interventions. It was also reported that even if NAC approves the funding there are delays in the disbursement of funds for programme implementation. For example, MANASO coordinates the work of 30 international NGOs, 100 local NGOs and 795 CBOs and it reported that members of its network have many challenges in sourcing funding and most of them rely on NAC as the sole funding agency. The lack of funding as experienced by NGOs and CBOs affects the delivery of services.

  During the validation meeting for this GARPR, stakeholders expressed concern over the fact that the national response is heavily dependent on external resources since >80% of the financial resources being used in the national response are from donors and 100% of the drug budget if financed by external sources. They feared that if PEPFAR and the Global Fund were to stop funding the national response the whole national HIV and AIDS response would collapse. Therefore, stakeholders recommended that Malawi, as a country, should start identifying alternative sources of funding for the response to the HIV and AIDS epidemic, including domestic resources. One of the suggestions was to engage the private sector more and also explore the introduction of "sin taxes". Malawi has developed a Sustainable Financing Strategy which, initially focussed on HIV intervention but has now expanded to include other interventions in the health sector. Malawi's Cabinet has approved the strategy and the Ministry of Finance will start implementing this in July 2015. It is hoped that the implementation of the Sustainable Financing Strategy will contribute significantly to the mobilisation of resources for implementing HIV and other health interventions.

- **Lack of predictability of funding:** There are a number of development partners which commit themselves to funding some interventions in the national response to the HIV and AIDS epidemic. It is not unusual for some donors to provide less than what they committed and fail to meet agreed disbursement timelines. The unpredictability of funding adversely affect the planning and implementation of HIV and AIDS interventions.

- **Lack of knowledge of HIV and AIDS reporting forms:** A number of stakeholders were concerned with sub-optimal reporting of HIV and AIDS activities at all levels. While the NAC has conducted a number of training programmes on how organisations should report their activities, challenges still existed. For example,

there are a number of stakeholders, especially CBOs, which did not understand NAC reporting forms leading to inaccurate and inconsistent reports.

- **Lack of HIV legislation:** Stakeholders acknowledged the existence of an HIV and AIDS policy as well as a progressive HIV and AIDS NSP in Malawi. The policy environment is therefore quite conducive for the delivery of HIV and AIDS interventions. However, while some stakeholders, especially CSOs, acknowledged the fact that Malawi's constitution provides for non-discrimination and felt that there was a need for a specific piece of legislation that would deal with issues of HIV and discrimination. They were particularly concerned that the HIV Bill was drafted a long time ago had not been enacted into law. The HIV Bill, among other things, provides for prosecution of people and organizations who deny PLHIVs access to services.

- **High staff turnover:** Local council, in some cases, experienced challenges in effectively coordinating the implementation of HIV and AIDS interventions in their districts mainly because of shortage of staff. Some districts lacked required key staff such as District AIDS Coordinators, M&E officers and Directors of Planning and Development. Staff turnover was quite high which is exacerbated by brain drain from the public system to NGOs.

- **Supply chain management:** Procurement, distribution and accounting for health commodities remain a major challenge in Malawi. The CMS Trust continue to experience capacity challenges in handling the large volume of items which are supposed to be procured for the national HIV and AIDS response as well as for the wider health sector. For example, in 2014 the CMS Trust had challenges in distributing 20 million condoms at a time rural areas in Malawi experienced condoms shortages. Because of these capacity constraints there are many parallel supply chain management systems which have been established.

- **Early infant diagnosis:** Besides long turn-around times for HIV DNA PCR results in HIV-exposed children, described above, there are challenges with the documentation of HIV status ascertainment in most facilities. Also, there are a lot of missed opportunities for HIV status ascertainment in potentially high yield settings such as during EPI programme, pediatric clinics and wards and nutritional rehabilitation unit. As a result of this, there are serious delays in ART initiation among children and pediatric ART coverage remains low. The soon to be launched HIV Prevention Strategy and NSP seek to implement new approaches to address these challenges.

Chapter VI: Support from the country's development partners

6.1. Key support from development partners

As was the case in 2012/2013, in 2013/2014 development partners contributed about 83.6% of the financial resources for the implementation of the national response to the HIV and AIDS epidemic in Malawi. These include the Global Fund, PEPFAR, World Bank, DFID, CDC and UN agencies. Some partners for example I-TECH with support from PEPFAR have provided technical assistants in the area of Treatment, Care and Support, monitoring and evaluation, supply chain management and health informatics to the MoH. I-TECH is also providing support for the Global Fund Coordinator. WHO continues providing technical support in the areas of treatment, care and support and the development of protocols.

As was the case in 2012/2013, development partners continued being members of the Malawi HIV and AIDS Partnership Forum (MPF) and the Malawi Global Fund Coordinating Committee (MGFCC). These development partners are also members of the HIV and AIDS Donor Group (HADG) as well as the Technical Working Groups (TWG) on Prevention, Treatment and M&E etc.

In 2013/2014, development partners contributed towards the development of the HIV NSP covering the period 2015-2020. In addition, they also supported the development of the Joint TB/HIV Concept Note which was submitted to Global Fund in early 2015. Over the reporting period there were also a number of studies which were supported by development partners, including the MDG Endline Survey and the BBSS.

6.2. Actions needed by development partners to ensure achievement of targets

In order to support Malawi in achieving the targets as set in the 2011 Political Declaration on HIV and AIDS development partners will need to do the following:

- continue supporting the NAC and implementing partners and close the funding gap that has been identified.
- continue supporting operations research including surveillance in order to inform programming and policy formulation.

- ensure that GoM takes the lead in deciding the allocation of financial resources for HIV and AIDS, based on local research evidence
- in line with the Paris Declaration, support interventions as defined in the NSP and not creating and funding their own parallel implementing and reporting mechanisms.
- support more interventions targeting children and adolescents with HIV
- support the introduction and implementation of effective interventions targeting key populations such as MSMs, FSWs and prisoners, while appreciating the need to adhere to acceptable democratic processes for changing the legal environment.
- support the building of technical and management capacity of Malawian individuals, institutions and NGOs.

Chapter VII: Monitoring and evaluation environment

7.1. An overview of the current monitoring and evaluation (M&E) system

The NAC coordinates and manages the national HIV and AIDS M&E system. The M&E Unit at the NAC is the Secretariat for the Monitoring, Evaluation and Research TWG and is responsible for the production of quarterly and annual M&E reports. In 2014, Malawi has developed an M&E Framework for the period 2015-2020 which is aligned to the HIV NSP. The M&E Framework provides guidance to all HIV and AIDS implementing partners in Malawi on data and indicators needed to measure progress in the national response to the HIV and AIDS epidemic. These indicators were developed and designed to meet the regional and international reporting requirements. The National M&E and Research TWG, which meets quarterly, provides the overall technical guidance to NAC and other stakeholders on data and research requirements to inform the national HIV and AIDS response.

7.1.1. Routine data collection

In each district there are a number of partners implementing HIV and AIDS interventions. These partners are required to report to their local councils using the Local Authority HIV and AIDS Reporting System (LAHARS). This system mostly collects non-biomedical data. The local council, in turn, is required to report to the NAC on a quarterly and yearly basis. Although each district is supposed to have an M&E coordinating committee to coordinate data collection and collation process at district levels, these committees are not active in most districts. Apart from district councils, implementing partners are supposed to report to the NAC three weeks after the close of the quarter but only a few comply with this requirement. Thus, the NAC is unable to compile comprehensive quarterly and annual reports from stakeholders, including district councils, to produce national M&E reports.

Within the MoH, the Central Monitoring and Evaluation Division and the HIV Department provide overall guidance to implementing partners on M&E pertaining to biomedical interventions. The MoH's Health Management Information Systems (HMIS) is used, among other things, to collect routine data on biomedical interventions from all health facilities. These data are submitted to the District Health Offices (DHOs) on monthly basis for consolidation. The DHOs are supposed to review and enter the health facilities' data into an electronic platform, conduct limited analysis and then send monthly reports to MoH. The MoH is required to share the data with the NAC. However, in view of the inefficiencies of this passive reporting system and challenges with data accuracy, the Department of HIV in the MoH developed a parallel system to actively collect data on biomedical interventions,

such as HTC, PMTCT, ART, STIs, opportunistic infections and safety of blood transfusions, from health facilities every quarter. Through this parallel system, all health facilities, regardless of ownership, are visited by a team of data collectors, mentors and supervisors who review the quality of their records and data on HIV and AIDS before compiling and analyzing the data. Besides data collection, these visits provide an opportunity for the mentors and supervisors to provide on-the-job training for health workers and support staff to improve the quality of data. PEPFAR funds the implementation of this parallel system while I-TECH provides technical support to the MoH on data management and analyses and production of quarterly reports.

7.1.2. Non-routine data collection

Apart from routine data collection, Malawi government, through the National Statistical Office conducts several population-based surveys to track both outcome and impact HIV indicators. These include the Malawi Demographic and Health Survey (MDHS), the Multiple Indicators Cluster Surveys (MICS), the Biological and Behavioural Surveillance Surveys (BBSS) and the ANC Sentinel Surveillance Surveys. The last MDHS was conducted in 2010 and plans are underway to conduct another survey in 2015. In 2013/14 Malawi conducted the MDG Endline survey and the BBSS. At the time of writing this report, preliminary reports from these surveys were available but data analyses were still ongoing. The HIV NSP also provides for a mid-term and end of term evaluation of the national response to the HIV and AIDS epidemic.

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

The national HIV and AIDS M&E system is dependent on partners implementing HIV and AIDS interventions to report their activities to the NAC. Interviewed stakeholders cited several challenges being experienced in the implementation of the M&E system. First, implementing partners who are not funded by the NAC do not feel obliged to report through the NAC M&E system. Thus, the quarterly and annual reports being produced by the NAC do not present a comprehensive national picture of the HIV and AIDS response. To address this problem, NAC is developing MoUs requiring district and city councils to report to NAC, irrespective of the funding agencies. Further, through Malawi Partnership Forum, the NAC has secured support from development partners funding CSOs and NGOs, to include in their contracts with sub-grantees the requirement to report to NAC and to withhold further financial disbursement to any sub-grantee organizations which do not comply with this requirement.

Second, there is critical shortage of staff responsible for the compiling of data from all stakeholders and subsequently submitting the same to the NAC. In most of the districts,

there are no M&E officers with the requisite data management and analyses skills. To address this problem, in 2014, the NAC, in collaboration with the Department of Economic Planning and Development, conducted training sessions for relevant district-based officers on data management and analyses and M&E. Also, the NAC visited implementing partners to provide on-the-job technical support on data analysis and M&E. Despite these efforts, reporting challenges have persisted mostly due to high turnover of the trained officers.

Third, stakeholders were concerned with the delayed funding and implementation of national surveys which are meant to assess the impact of the national response against HIV and AIDS. For example, the MDHS which was scheduled for implementation in 2014 has been delayed to 2015. The dependence on external agencies to fund and design these surveys were cited as some of the reasons for the delays.

7.3. Remedial actions planned to address the M&E challenges being experienced

The absence of District AIDS Coordinators and M&E officers in some districts negatively affects the functioning of the M&E system. Plans are underway to fill the vacant positions and to provide M&E training to the hired officers. In 2012/2013 it was reported that implementing partners who receive funding from outside the NAC will sign a Memorandum of Understanding demonstrating commitment to adhere with the national M&E system and fulfil their obligations in report data as detailed in the HIV and AIDS M&E framework. This has not been accomplished but is still being pursued by the NAC.

7.4. The need for M&E technical assistance and capacity-building

High quality data on biomedical interventions has been available every quarter and is used for planning and reporting the successes and challenges of health sector-based interventions. This is possible because of the technical assistance that development partners are providing to the MoH HIV Department. However, stakeholders were concerned that limited capacity development for HIV and AIDS data management has taken place in the MOH HIV Department which may threaten the sustainability of the parallel M&E system for biomedical interventions. However, they welcomed new financial support from the Bill and Melinda Gates Foundation which is aimed at building local capacity in this area. In addition, stakeholders expressed the need for technical assistance in compiling, analyzing and reporting non-biomedical interventions in view of the waning support for these interventions due to limited availability of data. They also stressed the importance of focusing capacity building efforts at district council levels and in all organizations responsible for implementing and/or coordinating HIV and AIDS activities.

ANNEX 1: Consultation/preparation process for the country report

Organization	Name	Position
National AIDS Commission	Mrs. Chimwemwe Mablekisi	Acting Head of Planning, Monitoring and Evaluation
	Dr. Andrina Mwansambo	Acting Head of Policy and Programs
Department of Nutrition HIV and AIDS	Mr Gawamadzi	Chief Research and Evaluation Officer
	Mrs Khataza Chawanda	Chief HIV and AIDS Officer
Min of Gender, Children Disability and Social Welfare Development	Joseph Kazima	Assistant Director of Gender
	Harry Satumba	Policy and Social Welfare Officer - OVC
MoH – HIV and AIDS Department	Dr Zengani Chirwa	Technical Assistant Care and Treatment
	Dr Andreas Jahn	Technical Assistant Monitoring and Evaluation
MoH – TB Control Programme	Andrew Dimba	TB Officer
	Kanyerere	TB Officer
Ministry of Education Science and Technology,	Peter Katuma	Counseling Specialist
	Fiona Ngulube	
National Youth Council of Malawi	Felix Pacharo Chiyenda	Project Associate
	Asharn Kossam	Project Associate
Malawi Police Services	Alf Mbewe	Deputy HIV and AIDS Coordinator
	Dorothy Chingaipe	Deputy in-Charge of VSU
CEDEP	Rodney Chalera	Programmes Manager
MANET +	Safari Mbewe,	Executive Director
	Salome Chibwana	Project Officer :Monitoring and Evaluation
MANASO	Abigail Dzimadzi	Executive Director
	Mr Kingsley Chasanga	Program Manager

MACOHA	Mercy Mpunga	Senior Rehabilitation Officer, Women and Children
UNICEF	Emmanuel Saka,	HIV/AIDS Officer
UNAIDS	Charles Birungi	Strategic Investments and Efficiency Advisor
UNFPA	Humphreys Shumba	HIV/AIDS Specialist
WHO	Ishmael Nyasulu	TB/HIV National Professional Officer
DFID	Ruth Mwandira,	HIV and AIDS Advisor
CDC	Sundeep Gupta	Country Director
PEPFAR	Dan Craun-Selka	Country Director
I-TECH	Desiree Mhango	Deputy Country Director
PSI	Sarah Gibson	Country Representative
Pakachere	Grace Kumwenda	
	Basimenye Nhlema	
BLM	Donald Makwakwa	Senior Programmes Manager

Annex 2: List of participants during the stakeholders' validation workshop

No.	NAME	DESIGNATION	ORGANISATION	ADDRESS/TEL No.	EMAIL ADDRESS
1.	Thulason C. Msuku	Economist	Department of Nutrition, HIV and AIDS	P/Bag B401 Lilongwe 3 0888537652	msukutc@gmail.com
2.	Dickens Kolondo	Assistant Programmes Manager	NAPHAM	P/Bag 355 Lilongwe 3 0888899585	dkolondo@napham.org
3.	Sylvester B. Gawamadzi	Chief Planning Officer	Department of Nutrition, HIV and AIDS/MOH	P/Bag B401 Lilongwe 3 0888305551	sgawamadzi@gmail.com
4.	Mackenzie Chigumula	Program Coordinator	Malawi Police Services	P/Bag 305 Lilongwe 3 0884237567/0999389980	chigumulah@yahoo.com
5.	Stuart Mvula	Economic, Social & Cultural Rights Officer	MHRC	P/Bag 378 Lilongwe 0882417001	stuartmvula@gmail.com
6.	Stephen Iphani	Programs Manager	COWHLA	P.O. Box 2874 Lilongwe 0888596920/0999896920	iphanisteven@gmail.com
7.	Malocho Phoso	Programme & Training Manager	Mothers 2 Mothers	P/Bag B315 Lilongwe 3 0888365448	Malocho.phoso@m2m.org
8.	Jessie Khaki	M & E Officer	NAC	Box 30622 Lilongwe 3 0995313478/088124421	khakij@aidsmalawi.org.mw

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9.	Ishmael Nyasulu	TB/HIV National Professional Officer	WHO	Box 30390 Lilongwe 3 0999941324	nyasului@who.int
10.	Masida Gondwe	Economist	Ministry of Local Govt.	P.O. Box 30312 Lilongwe 3 0992212208/0881673127	ceader.mgm@gmail.com
11.	Salome Chibwana	P.O. M & E	Manet+	P/Bag B377 Lilongwe 0881505365	chibwanasalome@gmail.com
12.	James Njovuyalema	HIV Policy Officer	NAC	P.O. Box 30622 Lilongwe 3 0999349462	njovuyalemaj@aidsmalawi.org.mw
13.	Levi Lwanda	M & E Officer	NAC	P.O. Box 30622 Lilongwe 3 0888873267	lwandal@aidsmalawi.org.mw
14.	Dominic Likongwe	HIV Prevention Officer	NAC	P.O. Box 30622 Lilongwe 3 0992221776	likongwed@aidsmalawi.org.mw
15.	Thokozani Mbendera	Executive Director	FPAM	P/Bag B404 Lilongwe 0999250021	tmbendera@fpamalawi.org tmbendera@gmail.com
16.	Kingsley Chisanga	Program Manager	MANASO	Box 30473 Lilongwe 3 0888506644	chasangak@manaso.org
17.	Blackson Matatiyo	Research Officer	NAC	Box 30622 Lilongwe 3 0888343049	matatiyob@aidsmalawi.org.mw
18.	Thomas Salimu	HIV Policy Officer	NAC	P.O. Box 30622 Lilongwe 3	salimut@aidsmalawi.org.mw

				0997739866	
19.	Desiree Mhango	Deputy Country Director	I - Tech	Box 30369 Lilongwe 3 0992961998	dmahango@itech-malawi.org
20.	Dr. Andrina Mwansambo	Ag. DOP	NAC	Box 30622 Lilongwe 3 0888355603	mwansamboa@aidsmalawi.org.mw
21.	Davie F. Kalomba	Ag. ED	NAC	Box 30622 Lilongwe 3 0888208140	kalombad@aidsmalawi.org.mw
22.	Brenda Kamanga	HIV Program Manager	PSI Malawi	P.O. Box 30132 Lilongwe 0993270754	bkamanga@psimalawi.org
23.	Shawn Aldridge	Technical Advisor	NAC	Box 30622 Lilongwe 3 0884869096	aldridges@aidsmalawi.org.mw
24.	Chimwemwe Mablekisi	Ag HPMER	NAC	Box 30622 Lilongwe 3 0888893065	mablekisic@aidsmalawi.org.mw
25.	Maziko Matemba	Executive Director	Health & Rights Education Programme	P.O. Box 30322 Blantyre 3 0999951274	mazikomatemba@gmail.com
26.	Mahara Longwe	P & L Officer	NAC	P.O. Box 30622 Lilongwe 3 0995620559	longwem@aidsmalawi.org.mw
27.	Jacqueline R.C. Nkhoma	HIV and AIDS Specialist	UNICEF	Box 30375 Lilongwe 3 0991443620	jnkhoma@unicef.org
28.	Charles Birungi	Advisor	UNAIDS	Box 30135 Lilongwe 3	BirungiC@unaids.org
29.	Ellious Chasukwa	Ag. HPSD	NAC	Box 30622 Lilongwe 3	chasukwae@aidsmalawi.org.mw

				0999948583	
30.	Roberta Makoko		DNHA-MOH	P/Bag B401 Lilongwe 3 0992846449	
31.	Maggie Chalanga	AA	NAC	Box 30622 Lilongwe 3 0888441474	chalangam@aidsmalawi.org.mw