Government of Malawi

Global AIDS Response Progress Report (GARPR)

Malawi Progress Report for 2013

31st March 2014

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LIST OF ACRONYMNS

ANC	Antenatal Clinic
ART	Antiretroviral Therapy
BCC	Behaviour Change and Communication
BCI	Behaviour Change Interventions
CBO	Community Based Organisation
CDC	Centre for Disease Control and Prevention
CEDEP	Centre for Development of the People
COWLA	Coalition of Women Living with AIDS
CSO	Civil Service Organisation
DFID	Department for International Development
EID	Early Infant Diagnosis
GARPR	Global AIDS Response Progress Report
GBV	Gender Based Violence
GoM	Government of Malawi
HTC	HIV Testing and Counselling
IEC	Information, Education and Communication
IRT	Independent Review Team
LEA	Legal Environment Assessment
LSE	Life Skills Education
MANET	Malawi Network of People Living with HIV
MDG	Millennium Development Goals
MDHS	Malawi Demographic and Health Survey
MoF	Ministry of Finance
MoH	Ministry of Health
MIAA	Malawi Interfaith AIDS Association
MSM	Men having Sex with Men
MTCT	Mother to Child Transmission
M&E	Monitoring and Evaluation

NAC	National AIDS Commission
NAPHAM	National Association of People Living with HIV and AIDS in Malawi
NASA	National AIDS Spending Assessment
NSP	National HIV and AIDS Strategic Plan
OPC	Office of the President and Cabinet
OSC	One Stop Centre
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child Transmission
PSI	Population Services International
STI	Sexually Transmitted Infections
TB	Tuberculosis
TV	Television
UNAIDS	United Nations Joint Program on HIV and AIDS
UNICEF	United Nations Children's Fund
VMMC	Voluntary Medical Male Circumcision
VPP	Voluntary Pool Procurement
VSU	Victim Support Unit

1. STATUS AT A GLANCE

1.1. Inclusiveness of the stakeholders in the report writing process

Compilation of this report was led by the Malawi National AIDS Commission (NAC) which is a Government of Malawi (GoM) agency responsible for coordinating and monitoring the national response to the HIV and AIDS epidemic in Malawi. Under the guidance of NAC, two independent Malawian consultants collated, reviewed and analyzed relevant policies, strategies, data and reports to generate recent HIV and AIDS indicators for Malawi. With the help of NAC they also identified key stakeholders in the national HIV and AIDS response and interviewed them using the National Commitment and Policy Instrument (NCPI) semi-structured questionnaire. The stakeholders included representatives from the following constituencies; government, National AIDS Commission, human rights watchdogs, development partners, UN agencies, civil society organizations, the private sector and implementing partners. Following the interviews, the consultants prepared a draft report on the findings and presented them to a group of stakeholders (Annex 1.2) at a validation meeting held at Lilongwe Hotel on 28th March 2014. During the meeting, the stakeholders critiqued and validated the compiled indicators and qualitative findings from the NCPI interviews. Based on comments and inputs from the stakeholders, the draft report was revised and circulated to the stakeholders for further comments and approval.

1.2. Status of the epidemic

The first case of AIDS was diagnosed in Malawi in 1985. Since then HIV prevalence increased significantly and reached a peak of 16.4% in 1999 among persons aged 15-49. Thereafter, the prevalence has been declining steadily, reaching 12.0% in 2004 and 10.6% in 2010. The 2010 Malawi Demographic and Health Survey (MDHS) found that HIV prevalence varied markedly by sex, age, urban-rural residence, geographical location and other characteristics. Females had a higher HIV prevalence than males (12.9% vs 8.1% in 2010), with the largest disparity being in the 15-19 year old age group (3.7% in women and 0.4%)[1]. In addition, HIV was more prevalent in urban communities (17.4%) compared to rural communities (9%). Also, the Southern region had a prevalence of 14.5% which was twice as high as that in the Northern and Central regions. Since 2010, there hasn't been any nationally representative survey in Malawi to estimate HIV prevalence. UNAIDS estimates that, by the end of 2012, 1,100,000 Malawians were living with HIV 66,000 acquired new HIV infection and 46,000 died as result of HIV-related conditions.

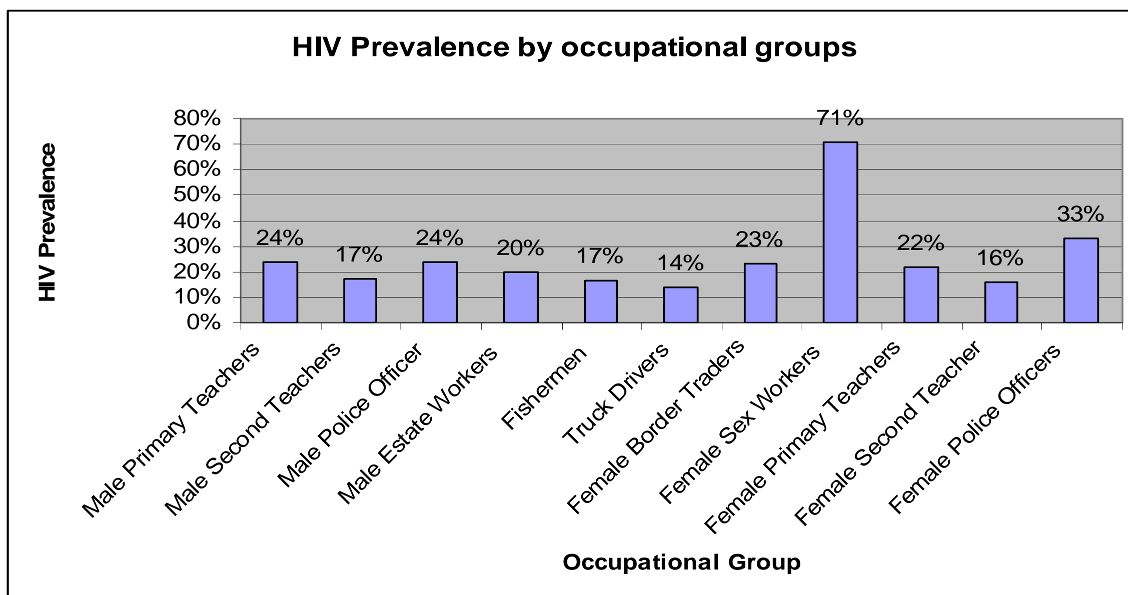
The main mode of transmission of HIV is through heterosexual intercourse, estimated to account for 88% of all new HIV infections while mother-to-child transmission accounts for

[1] NSO/MACRO, Malawi Demographic and Health Survey, 2004; NSO/MACRO, Malawi Demographic and Health Survey, 2010.

~10% of the infections. Approximately 2% of infections are believed to be transmitted through blood transfusions and contaminated medical and skin piercing instruments. Although Malawi has a generalized HIV epidemic, Behavioural Surveillance Surveys (BSS) conducted in 2004 and 2006 indicate that specific social and occupational groups have higher HIV prevalence than the general population[2]. These include female sex workers, female border traders, long-distance truck drivers, police officers, estate workers and fishermen (Figure 1.1). Men who have sex with men (MSM) in Malawi also have a high HIV prevalence (21%).[3]

HIV incidence is estimated to be very high in key populations at higher risk of HIV exposure such as sex workers, clients of sex workers and MSM.[4] However, the contribution of these groups to the number of new infection is estimated to be very low, accounting for <1% of all new HIV infections. Cohabiting HIV-discordant partners, previously assumed to be a low risk population, account for 47% of all new HIV infections in Malawi.

Figure 1.1



1.3. The policy and programmatic response

The HIV and AIDS response in Malawi is guided by the HIV and AIDS Policy which was recently revised and launched in July 2013. The policy is operationalized through the National HIV and AIDS Strategic Plan (NSP) 2011-2016 which provides a framework for

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[2] Malawi Biological and Behavioural Surveillance Survey and Comparative Analysis, 2004 and 2008.
[3] 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.
[4] Department of Nutrition, HIV and AIDS, National HIV Prevention Strategy, 2009-2013.

implementation of HIV and AIDS interventions across various sectors. The HIV Policy and NSP are linked to various laws and strategies which are not HIV-specific but provide the overall legal and policy framework. Key pieces of legislations and strategies which may directly and indirectly impact the prevention and management of HIV and AIDS 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. The Malawi Growth and Development Strategy II (2011-2016) is an overall development agenda for Malawi which also guides the implementation of HIV and AIDS interventions. Currently, Malawi has drafted an HIV and AIDS Bill which aims at strengthening the legal framework for implementing HIV and AIDS interventions. This draft legislation was developed in a transparent and highly consultative manner to ensure that it meets the expectations of key stakeholders and adheres to human rights standards. It is expected that the draft legislation will soon be presented to the Malawi government cabinet for review and approval before further submission to parliament for enactment.

At international level Malawi is also a signatory of a number of conventions and declarations which form a further important guiding framework for national laws, policies and regulations relating to HIV. Key international and regional instruments signed and ratified by Malawi include the following: The Universal Declaration of Human Rights (UDHR) 1948, the 2000 UN Declaration of Commitment on HIV and AIDS, and the 2011 Political Declaration on HIV and AIDS. Malawi has since domesticated these international conventions and declarations in its policies and legislation.

In line with the multisectoral HIV and AIDS response in Malawi, government ministries, non-governmental organizations, civil society organizations and the private sector actively participate in the implementation of various HIV and AIDS intervention. Consistent with the "three ones" principle, the NAC is responsible for coordinating the activities of all agencies implementing HIV interventions and compiling HIV-related indicators. To operationalize the NSP, NAC coordinates the development of an Integrated Annual Workplan (IAWP), which, among other things, outlines key activities to be implemented by partners, performance indicators and budgets. Nevertheless, it is evident that a significant number of HIV interventions which are implemented by partners, not funded through NAC, are not captured in the IAWP.

1.4. Overview of GARPR and Health Sector HIV Indicators

Malawi continues to track the progress made to achieve the ten targets as agreed in the 2011 Political declaration of HIV and AIDS. Table 1.1, below, shows the trend of indicators linked to these targets. It is important to note that 2013 data were unavailable for most

indicators which required the conduct of a nationally representative survey or sentinel surveillance. These surveys are planned for 2015.

Table 1.1: 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
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[6]	Males: 75% Females: 75%	Males: 44.7% Females: 41.8%	Not available	Not available	Not available
	1.2: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15[7].	Not available	Males: 12.3% Females: 14.3%	Not available	Not available	Not available
	1.3: Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	Not available	Males: 9.2% Women: 0.7%	Not available	Not available	Not available
	1.4: Percentage of adults aged 15-49 who had more	Males: 60%	Men: 24.6% Women:	Not available	Not available	Not available

[5] For 2010 the source of information is the 2010 MDHS whose results came out in 2011 unless specified.
[6] These figures are from the 2010 DHS. They will be confirmed once another DHS is conducted
[7] These figures are from the 2010 DHS. They will be confirmed once another DHS is conducted

	than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Women: 40%	27.3%			
	1.5: Percentage of men and women aged 15-49 who received an HIV test in the past 12 months and know their results	Males: 75% Females: 75%	Males: 51.2% Females: 71.6%	Not available	Not available	Not available
	1.6: Percentage of young people aged 15-24 who are living with HIV	Males: 12% Females: 12%	Males: 1.9% Females: 5.2%	Not available	Not available	Not available
Sex workers	1.7: Percentage of sex workers reached with HIV prevention programs	Not available	Not available	Not available	Not available	Not available
	1.8: Percentage of sex workers reporting the use of a condom with their most recent client[8].	Not available	Not available	Not available	Not available	Not available

[8] 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.

	1.9: Percentage of sex workers who have received an HIV test in the past 12 months and know their results	Not available	Not available	29.5%[9]	Not available	Not available
	1.10: Percentage of sex workers who are living with HIV	Not available	Not available	23.1%[10]	Not available	Not available
Men who have sex with men	1.11: Percentage of men who have sex with men reached with HIV prevention programs	Not available	Not available	Not available	Not available	Not available
	1.12: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Not available	Not available	Not available	Not available	Not available
	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	Not available	Not available	Not available	Not available	Not available

[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:** This "prevalence" is based on individual reports by sex workers and not on biomarkers.

[10] 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.

	1.14: Percentage of men who have sex with men who are living with HIV	Not available	Not available	21.0%[11]	Not available	Not available
	1.16.1. Number of women and men aged 15 and older who received HIV testing and counseling in the last 12 months and know their results					1,702,627[12]
	1.16-1a. Percentage of health facilities dispensing HIV rapid test kits that experienced a stockout in the last 12 months					Not available
	1.17.1. STIs: Percentage of women accessing antenatal care (ANC) services who were tested for syphilis					10%
	1.17.2. STIs: percentage of antenatal care attendees who were positive for syphilis					6%[13]
	1.17.3. STIs: percentage of antenatal care attendees					Not available

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

[12] This number includes pregnant women who had HIV tests as part of EMTCT..

[13] 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 an STI.

	positive for syphilis who received treatment					
	1.17.4. STIs: percentage of sex workers (SWs) with active syphilis					Not available
	1.17.5. STIs: percentage of men who have sex with men with active syphilis					Not available
	1.17.6. STIs: number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months					Not available
	1.17.7. STIs: number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months					Not available
	1.17.8. STIs: number of men reported with gonorrhoea in the past 12 months					Not available
	1.17.9. STI s: number of men reported with urethral discharge in the past 12 months					Not available
	1.17.10. STIs: number of					Not available

	adults reported with genital ulcer disease in the past 12 months					
	1.18. Percentage of pregnant women with a positive syphilis serology whose sexual contacts were identified and treated for syphilis					Not available
	1.22 Percentage of men 15-49 that are circumcised		22%[14]			Not available
	1.23. Number of male circumcisions performed according to national standards during the last 12 months				11,000	40,835[15]
Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015[16].	2.1: Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	Not routinely collected	Not routinely collected	Not routinely collected	Not routinely collected	Not routinely collected
	2.2: Percentage of people who inject drugs who report the use of condoms	Not routinely collected	Not routinely collected	Not routinely collected	Not routinely collected	Not routinely collected

[14] This data is from the 2010 Malawi Demographic and Health Survey. Respondents were asked whether they were circumcised or not but the information was not verified

[15] This data was from Q1 and Q2 of 2013. No data were available for Q3 and Q4 of 2013.

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

	at last sexual intercourse.					
	2.3: Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	Not routinely collected	Not routinely collected	Not routinely collected	Not routinely collected	Not routinely collected
	2.4: Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	Not routinely collected	Not routinely collected	Not routinely collected	Not routinely collected	Not routinely collected
	2,5: Percentage of people who inject drugs who are living with HIV	Not routinely collected	Not routinely collected	Not routinely collected	Not routinely collected	Not routinely collected
	2.6. Number of people on opioid substitution therapy (OST)					Not routinely collected
	2.7. Number of NSP and OST sites: - Number of needle and syringe programme (NSP) sites					Not routinely collected
	2.7. Number of NSP and OST sites: - Number of opioid substitution therapy (OSP) sites					Not routinely collected

Target 3: Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS-related deaths	3.1: Percentage of HIV positive pregnant women who receive antiretroviral to reduce the risk of mother to child transmission	65%	44%	44%	67%	73%[17]
	3.2: Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth[18]	Not available	Not available	Not available	10%	30%[19]
	3.3: Mother to child transmission of HIV (Modelled)				-	
	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)					83%[20]

[17] Government of Malawi, Ministry of Health, Integrated HIV Programme Report: 2013 Q1, Q2, Q3 and Q4 Reports
[18] The HIV and AIDs Department in the Ministry of Health only started collecting this data in 2011.
[19] Government of Malawi, Ministry of Health, Integrated HIV Programme Report: 2013 Q1, Q2, Q3 and Q4 Reports
[20] Denominator is the expected number of pregnant women per year (estimated at 607,000 in 2013)

	3.5. Percentage of pregnant women attending ANC whose male partner was tested for HIV in the last 12 months					Not available
	3.6. Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing					Not relevant in the context of Option B+
	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)					92%[21]
	3.9. Percentage of infants born to HIV-infected women started on CTX prophylaxis within two months of birth					86%[22]
	3.10. Distribution of feeding practices					Not available

[21] The denominator is HIV exposed infants discharged from the maternity. The numerator is all HIV exposed infants who were prescribed with nevirapine. Data Source: Government of Malawi, Ministry of Health, Integrated HIV Programme Report: 2013 Q1, Q2, Q3 and Q4 Reports

[22] 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 nevirapine. Data Source: Government of Malawi, Ministry of Health, Integrated HIV Programme Report: 2013 Q1, Q2, Q3 and Q4 Reports

	(exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV-infected women at DPT3 visit					
	3.11. Number of pregnant women attending ANC at least once during the reporting period					627,827[23]
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015	4.1: Percentage of eligible adults and children currently receiving antiretroviral therapy	Not available	63%	67%	65%	83%[24]
	4.1 – additional: HIV treatment: Antiretroviral therapy: Number of eligible adults and children who newly initiated antiretroviral therapy (ART) during the reporting period (2013)					102, 568
	4.2a: Percentage of adults and children with HIV known to be on treatment 12months after initiation	Not available	81%	78%	80%	78%[25]

[23] This indicator was estimated from the number of women who booked at antenatal clinics in 2013. Data Source: Government of Malawi, Ministry of Health, Integrated HIV Programme Report: 2013 Q1, Q2, Q3 and Q4 Reports
[24] Government of Malawi, Ministry of Health, Integrated HIV Programme Report: 2013 Q1, Q2, Q3 and Q4 Reports
[25] Government of Malawi, Ministry of Health, Integrated HIV Programme Report: 2013 Q3 report

	of antiretroviral therapy					
	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 2013					76%[26]
	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 2013					59%[27]
	4.3.a. Number of health facilities that offer antiretroviral therapy (ART)					689
	4.3.b Health facilities: Number of health facilities that offer paediatric antiretroviral therapy (ART)					Not available
	4.4. Percentage of health facilities dispensing ARVs					Not available

[26] Government of Malawi, Ministry of Health, Integrated HIV Programme Report: 2013 Q3 report
[27] Government of Malawi, Ministry of Health, Integrated HIV Programme Report: 2013 Q3 report

	that experienced a stock-out of at least one required ARV in the last 12 months.					
	4.6.a Total number of people enrolled in HIV care at the end of the reporting period					Not available
	4.6.b Number of adults and children newly enrolled in HIV care during the reporting period (2013)					102,568
	4.7a. percentage of people on ART tested for viral load (VL) who have an undetectable viral load in reporting period (2013)					Not available
	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 (2013)					Not available
Target 5: Reduce tuberculosis deaths in people living with HIV by	5.1: Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV[28]	50%	45%	54%	60%	75%

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

50% by 2015	5.2 Percentage of adults and children living with HIV newly enrolled in care who are detected having active TB disease (new)					Not available. Data is only available for those on ART and the figure is 1.6%
	5.3 Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)					56%[29]
	5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit					98%[30]
		2010/2011 (US$)		2011/2012 (US$)		2013[31]
Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low and middle	6.1: Domestic and international AIDS spending by categories[32]	-1. Prevention programs: 45,891,860 2. Treatment and care: 29,376,989 3. OVC: 5,861,433		-1. Prevention programs: 43,418,118 2. Treatment and care: 47,210,628 3. OVC: 5,435,149		Not available

[29] Note that this number is based on a small cohort of HIV positive individuals (<50,000) who are accessing pre-ART care

[30] Note that the status is assessed by asking TB-related questions to individuals attending HIV care.

[31] 2013 data on expenditure is not available.

[32] 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.

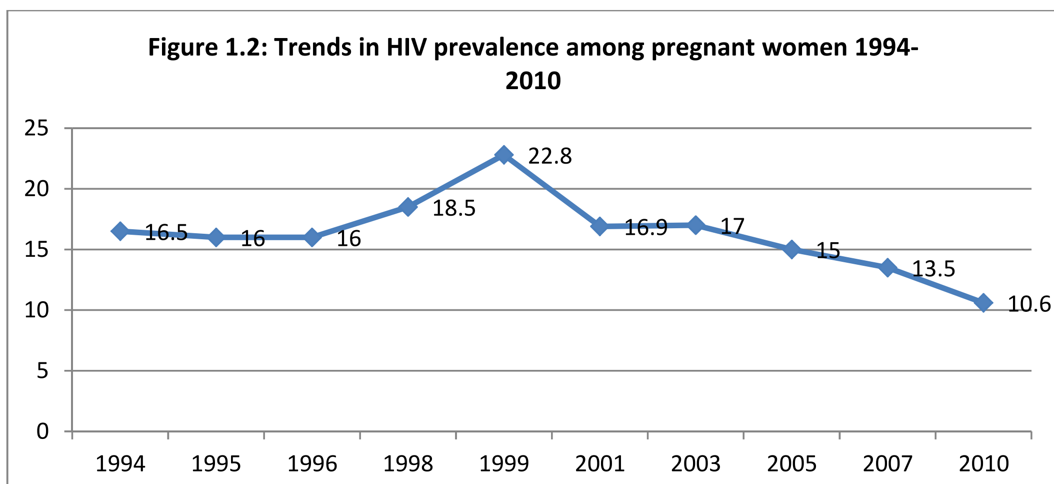
income countries		4. Program management and administration: 42,764,990 5. Human resources: 4,890,721 6. Social protection and social services (excluding OVC): 7,338,811 7. Enabling environment: 11,650,572 8. HIV and AIDS Related Research: 4,196,858 **TOTAL: 151,972,234**		4. Program management and administration: 34,891,301 5. Human resources: 4,052,479 6. Social protection and social services (excluding OVC): 2,907,632 7. Enabling environment: 3,259,433 8. HIV and AIDS Related Research: 4,347,695 **TOTAL: 145,522,435**		
	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**		Not available
Target 7: Eliminate gender inequalities and gender-based abuse and violence	Proportion of ever-married or partnered women aged 15-49 who experienced physical or	Not available	18.5%	Not available	Not available	Not available

and increase the capacity of women and girls to protect themselves from HIV.	sexual violence from a male intimate partner in the past 12 months					
Target 8: Eliminate stigma and discrimination against people living with and affected by HIV	8.1 Discriminatory attitudes towards people living with HIV[33]	Not available	Males: 35.7% Females: 19.7%	Not available	Not available	Not available
Target 10: Strengthen HIV integration	10.1: Current school attendance among orphans and non-orphans aged 10–14	-Not available	Males: 0.95 Females: 0.97 Total: 0.96	Not available	Not available	Not available
	10.2: Proportion of the poorest households who received external economic support in the last 3 months	Not available	2.6	Not available	Not available	Not available

[33] 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"

2. OVERVIEW OF THE AIDS EPIDEMIC

As shown in Figure 1.2 below, HIV prevalence in Malawi has declined steadily since 1999. Since 2010, Malawi has not conducted any nationally-representative HIV survey, hence there is no recent data on HIV prevalence in Malawi. Nevertheless, the observed reduction in HIV prevalence occurring at a time of rapidly increasing coverage of ART and improved survival of PLHIVs suggests declining HIV incidence. However, using indirect methods of measuring HIV incidence, the MoH estimates that ~46,000 people acquire HIV annually.



Source: HIV and Syphilis Sero –Survey and National HIV Prevalence and AIDS Estimates Report for 2010,[34]

3. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

3.1. Introduction

This section summarizes progress made in the implementation of key interventions under three main thematic areas, namely:

(a) HIV prevention;
(b) treatment, care and support, and;
(c) Impact mitigation.

Unless otherwise stated, data provided in this section are based on the findings of December 2013 report produced by the Independent Review Team (IRT) for the NAC, which conducts bi-annual review of the implementation of the multi-sectoral national response to HIV and AIDS. In line with Malawi's fiscal calendar, most quantitative findings in the section cover the period from 1st July 2012 to 30th June 2013. At the time of writing this report, most data from 1st July 2013 to 31st December 2013 were not available. Nonetheless, the quantitative data from the IRT report are supplemented by qualitative findings drawn from in-depth interviews conducted with stakeholders using the National Commitments and Policy Instrument (NCPI).

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

3.2. Prevention

3.2.1. Non Biomedical Interventions

In an effort to reduce incident HIV infections, the Government of Malawi, has developed several policies, strategies and plans to guide the implementation of non-biomedical interventions. These include the HIV Prevention Strategy, Abstinence Strategy, Mutual Faithfulness Strategy, Condom Strategy, and the National Behaviour Change Interventions Strategy. Besides focusing on prevention of primary and secondary HIV infections, behavioural change communication covers cross-cutting issues namely gender, human rights and culture. Modes of communication under this intervention included printed and audio IEC materials, performance-based interactive sessions, sensitisation meetings, debates, market campaigns, video shows and drama performances.

3.2.1.1. Print and audio IEC materials

During the 2012/13 fiscal year, a total of 1,044,284 IEC materials were produced and distributed against a target of 900,000, surpassing the target by 16%. The number of IEC materials produced in 2012/13 was slightly higher than those produced in 2011/12 estimated at 997,494 copies. In both years the target was surpassed. During 2012/13 a cumulative 92 hours of programmes broadcasting HIV/AIDS messages were aired on television against a target of 200 hours, representing a 46% underachievement. This marks a major reduction, as in 2011/12 a total of 322 hours were used for broadcasting HIV and AIDS messages on TV.

Through programmes, slots and jingles, a total of 342 hours of HIV and AIDS messages and information were aired on community radio stations, surpassing a target of 300 hours (114 %). In 2011/12, only 124 hours were utilized to air HIV and AIDS messages surpassing a set target of 100 hours. It is important to note that the numbers of hours spent on broadcasting of HIV and AIDS messages on the radio as reported over the period 2011-2013 are an under-estimate because one study on non-biomedical interventions found that both TV and radio stations in Malawi air HIV and AIDS programs covering more than 4,000 hours annually[35].

3.2.1.2. Interactive Outreach Audio Visual Services

Performance and interactive sessions (drama, debates, and public talks), including public lectures and expert talks on HIV and AIDS, were conducted in schools, communities and workplaces, and achieved the set targets (99% of planned activities). Targets were surpassed in community mobilisation by 346% during the same period. However, set targets for sensitisation of district leaders (local leaders, teachers, parents/guardians, faith leaders, traditional initiators, youth leaders) and volunteers trained (by gender) in HIV prevention Interpersonal/interactive communication, including sign language, were not achieved with only 64% of planned activities successfully achieved in the 2012/13 fiscal year.

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[35] 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.

3.2.1.3. Behavioural Change Interventions for youths

Behaviour change communication 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. The delivery of this subject on a mandatory basis[36] and making it examinable has ensured that all pupils in primary and secondary school access this subject. All students in primary and secondary schools in 2013 were therefore exposed to LSE. Currently the LSE curriculum for secondary schools is being revised in order to incorporate comprehensive sexuality education.

A cumulative total of 134,735 out-of-school youths (135% achievement) were exposed to LSE during the 2012/13 fiscal year against an annual target of 100,000. This represented a decrease (53% achievement) as in 2011/12 a cumulative total of 264,968 out-of-school youths were exposed to LSE. For both years these figures may be under-estimates as not all implementing partners report their activities to NAC[37]. In 2012/13 most targets under this intervention were met and some surpassed such as the training of youth club leaders and patrons, LSE for club leaders of out-of-school youths, youth peer educators, and number of youth sensitisation sessions. In-school (primary, secondary and tertiary schools), and out-of-school youth leaders and peer educators were trained in interpersonal/interactive life skills education.

3.2.1.4. Condom Programming

In 2012/13 a total of 20,957,870 male condoms were freely distributed representing a modest increase from 20,700,000 in 2011/12. The number of socially marketed condoms decreased from 11,362,166 in 2011/12 to 9,358,022 in 2012/13. This trend of decreasing numbers of socially marketed condoms has been observed over the last few years. The number of female condoms distributed decreased from 1,440,262 in 2011/12 to 943,820 in 2012/13. In 2012/13 the promotion and distribution of condoms did not meet set targets, but achieved 79.5% of the 2012/13 target for male condoms which are freely distributed and socially marketed. Assessing the number of condoms distributed vis-a-vis the population indicates that 59.7 condoms were distributed per sexually active male using condoms per year instead of the expected 144 condoms. Ineffective supply chain management system was the major cause of lower than expected condom distribution.

[36] For private secondary schools which follow the Ministry of Education curricula, they will also have this subject as a compulsory subject.

[37] ITAD. (2012). *The independent review of Malawi national response to HIV/AIDS for financial year 2011-2012.* Lilongwe: National AIDS Commission

3.2.1.5. Qualitative Assessment of the quality and effectiveness of non biomedical interventions

During the reporting period, there was no national representative survey to assess the impact of non-biomedical interventions on behavioral change and HIV prevalence. Thus, GARPR indicators on reduction of sexual transmission of HIV could not be assessed. Among stakeholders, there were mixed views on the impact of these interventions with some claiming that some interventions were not evidence-based. However, most respondents acknowledged that assessment of genuine behavioral change is difficult. They expressed a wide range of concerns including inadequate targeting of high risk populations such as prisoners, sex workers and Men having-Sex with Men (MSM) together with their intimate partners, limited capacity (in terms of skills and numbers of staff) at district level to deliver appropriate behavioral change interventions and chronic shortage of condoms, especially at the end-user level. Most respondents appreciated the good coverage of LSE for in and out-of school youths in 2013 and welcomed recent efforts to revise the breadth and depth of LSE curriculum to include comprehensive sexuality education, especially for secondary school students.

3.2.2. Biomedical Interventions

The implementation of biomedical preventive interventions is guided by several policies and strategies and plans including the HIV Testing and Counseling (HTC) Scale-up plan, the National Plan of Action for Scaling up of Sexual and Reproductive Health HIV Prevention Interventions for Young People, National Blood Safety Policy, the VMMC Policy and National Plan on scale-up of VMMC and the PMTCT Scale up Plan.

3.2.2.1. HIV Testing and Counseling

HIV Testing and Counseling (HTC) took place in 825 static and 534 outreach sites during the 2012/13 fiscal year, a slight increase from the 782 static sites in the previous fiscal year, with more ART and PMTCT sites having been integrated in the past year. The number of HIV tests conducted in the fiscal year was 2,188,952, surpassing the target of 1,800.000 by 20%. In 2011/2012 1,429,586 people were tested for HIV and this was lower than 1,773,000 million tests done in 2010/2011. The increased numbers of people tested in 2012/13 was partly attributed to fewer stock outs of test kits, as well as the implementation of an intensive HIV Testing Week aimed at improving HTC access. Those who were being tested for the first time ranged from 34% - 39% of the total, which is slightly less than in 2011/12. The annual target of 80,000 young people tested for HIV through YFHS was exceeded in the first three-quarters of the 2012/13 fiscal year, with 96,780 (52,092 males and 41,490 females) tested by 31 March 2013.

3.2.2.2. Management of Sexually-Transmitted Infections

In the 2012/13 fiscal year, two problems have affected the reporting of data for sexually-transmitted infections (STIs). Firstly, only a minority of districts (5 of 29) submitted reports on STI cases. Secondly, even within those districts which reported, it was estimated that only about 70 per cent of all treated STIs were being reported. Among the reported cases, only about 35% of STI cases were treated according to guidelines. A large proportion of those STI patients who were seen were HIV-positive

and repeaters, implying that a diagnosis of HIV had not changed their high-risk behaviour. Also, there were reports of stock outs of STI drugs and syphilis test kits. Thus, it is likely that a very large proportion of STIs in Malawi are not being properly diagnosed and treated, which may very well be contributing to the continued high rate of HIV transmission. To overcome the challenges experienced with 'passive' reporting in the second quarter of 2013, a decision was taken to actively collect STI reports during the Integrated HIV Program Supervision exercise. Based on the data collected at the facilities, a total of 45,948 STI cases were treated in the 3rd quarter of 2013. Considering the 75% completeness of reporting, this number is estimated to represent a total of 61,264 STI cases treated. This is equivalent to 62% STI treatment coverage of the expected 98,600 STI cases in the population.

3.2.2.3. Blood Safety

During the 2012/13 fiscal year, Malawi Blood Transfusion Services (MBTS) collected 43,012 units of blood (target was 80,000), compared to 56,324 units in 2011/12 (when the target was 40,000). In the 2012/13 fiscal year, there were only three collection sites in the country, so distance and logistics hampered implementation of country-wide blood donation through MBTS. To alleviate this problem, the MBTS opened three satellite collection sites. However, these remain inadequate to meet the demand. Furthermore, periodic shortages of blood-testing reagents, as well as blood collection bags, hampered achievement of targets in the past year.

3.2.2.4. Voluntary Medical Male Circumcision

During the 2012/13 fiscal year, VMMC was actively implemented in only 8 of the 29 districts in Malawi, mostly with support from PEPFAR. As of 30 June 2013, 289 providers and 30 TOTs had been trained (the target was 240 trainers and 15 TOTs), which is an improvement over the previous year. At the same time, 105 sites had been established. This is an increase over the 82 sites seen last year and the 32 sites the year before, but still well below the targeted 240. A target of 10,000 VMMCs for the fiscal year 2012/13 was set but 45,441 circumcisions were reported by 30 June 2013, surpassing the target by a factor of four. During 2011/2012 a total of 8,534 medical circumcisions were performed and this represented 85% of the total target (10,000 circumcisions) for the year. The number of circumcisions performed in 2012/13 represents a major increase over the 2011/12 financial year. In 2012/13 most of VMMCs were performed in the final quarter (April to June 2013) during a VMMC campaign in which more than 30,000 men were circumcised. While the target set seems realistic in terms of the available capacity in the country, it is well below the ideal target of 250,000 per year required to meaningfully improve the prevalence of VMMC among males in the general population.

3.2.2.5. Elimination of HIV Mother-to-Child Transmission (EMTCT)

Malawi has been implementing an integrated ART/EMTCT programme since 1 July 2011 through the introduction of the Option B+. EMTCT/ART services are fully integrated into maternal and child health services. As of June 2013, EMTCT services were available in 588 PMTCT sites (Option B+) sites, an increase from 534 sites in June 2012, but still not reaching the target of 650 sites. In the 2013 calendar year, 497,618

women counseled and tested, which represented 82% of the estimated number of pregnant women and falls slightly short of target of 85%. In the same calendar year, 45,816 women received ART, representing 73% of the estimated 63,000 HIV-positive pregnant women in the country during the year. This figure is close to the national target of 75%. In the calendar year, 29,714 infants born from HIV-positive mothers were prescribed nevirapine prophylaxis, representing 92% of the total number of infants born to HIV positive mothers delivering in health facilities. In addition, 86% of a cohort of 28,445 HIV exposed infants aged 2-months received cotrimoxazole prophylaxis.

As reported in the previous GARPR, Early Infant Diagnosis (EID) remains a major challenge in Malawi. In the 2013 calendar year, Malawi managed to test and provide results to 30% of HIV exposed infants within 2 months of birth. In the Q3 of 2013, the median turn-around time from collection of DBS to dispatch of results was 19 days, which suggests a considerable delay in communicating results to the caregivers of HIV-exposed infants.

3.2.2.6. Qualitative assessment of the quality and effectiveness of biomedical preventive interventions

Consistent with the EMTCT indicators, interviewed stakeholders unanimously agreed that implementation of the Option B+ strategy has been highly successful, especially in terms of screening the majority of pregnant women and prescribing them with ART. However, several respondents expressed concern over the challenges experienced in timely delivery of Early Infant Diagnosis results, loss-to-follow up and ART compliance among mother-infant pairs enrolled in EMTCT programmes.

Stakeholders also expressed their satisfaction with the bold steps Malawi has taken to promote and implement VMMC activities. Although they acknowledged that the current numbers of VMMCs performed were low, they were encouraged with the rapid scale up of this intervention. Some were of the view that demand for VMMC was very high but lamented the infrastructural and human resource challenges in the health sector, which will continue to adversely affect the actual number of VMMCs performed. Most respondents acknowledged that it will take an enormous effort to reach the target of 250,000 VMMCs per year and meaningfully increase the prevalence of VMMC in Malawi. A few respondents questioned the lack of efforts to promote early infant male circumcision.

Most stakeholders noted that the country had successfully overcome the shortage of HIV test kits which adversely affected implementation of HTC services in 2011/12. However, a few noted with concern the low quality of HIV test results with a significant number of false-negative results. Nevertheless, they appreciated efforts taken by the Ministry of Health with support from development partners to retrain all HTC providers and disengage those who perform poorly. However, they advised on the need to replace HTC providers who had been disengaged because of poor performance.

There were mixed views on the availability of adequate quantities of safe blood and good access to STI management. Most respondent were of the view that access to safe blood was good in urban areas but perhaps not in the rural areas. Others, expressed

concern on the quality of STI management in health facilities and the level of integration with other Sexual and Reproductive Health services.

3.3. Treatment, care, and support

3.3.1. Antiretroviral Therapy (ART)

Malawi has continued to implement the 2013 WHO guidelines on HIV treatment by adopting a new CD4 counts threshold for initiating ART (350 cells/cu.mm) and switching first-line ART from d4T- to TDF-containing regimens. ART sites were further decentralized to primary care facilities in the 2013 calendar year. The number of static sites providing integrated ART services increased significantly, from 300 sites in June 2011 to 689 by December 2013. The number of patients being initiated on ART increased steadily during the 2013 calendar year. As of December 2013, the total number of patients alive on ART was 472,865, with 102,586 initiated in the year 2013 alone. Using the CD4 cell count of ≤350 as a threshold for determining eligibility to ART, is estimated that, by the end of December 2013, ART coverage in Malawi was about 83%, up from 65% in 2012. Survival rate at 12-month for ART patients has remained stable at nearly 78% in the year 2013. This is slightly lower than the survival rate of 85% recommended by WHO.

3.3.2. Cotrimoxazole Prophylaxis and Isoniazid Preventive Therapy

By the end of September 2013, 46,419 (31%) of all patients ever registered were retained in pre-ART follow-up; 63,915 (43%) had started ART; 33,434 (22%) had been lost to follow-up; 1,683 (1%) were known to have died. In the third quarter of 2013, Cotrimoxazole Prophylaxis Therapy (CPT) coverage among pre-ART patients was 40,791 (88%). Considering the low coverage of cotrimoxazole prophylaxis in the 2011/12 fiscal year, Malawi seems to have successfully overcome the shortages in cotrimoxazole supplies.

All pre-ART patients with a negative screening outcome for TB symptoms are eligible for Isoniazid (INH) Preventive Therapy (IPT). By the end of September 2013, 23,234 (50%) of 46,419 patients retained in pre-ART were on IPT. This was a marked improvement from 27% (9,613/35,265) recorded at the end of September 2012. However, the proportion of patients on IPT in September 2013 was less than 58% (27,418/47,129) reported at the end of June 2013. IPT coverage was expected to increase further over the next quarters due to increased availability of isoniazid in primary care health facilities.

3.3.3. TB and HIV co-Management

In the 2013 calendar year, 75% (8454/11296) of the estimated number of incident TB cases received both TB treatment and ART. Although this figure falls short of the WHO target of 85%, it has increased markedly from 60% reported in 2012. This is likely due to the large proportion (>95%) of TB patients undergoing HIV screening. In 2013, TB screening, using clinical assessment, was performed in 98% of the patients on ART. However, TB was detected in only 1.6% of patients on ART. This low TB yield suggests poor sensitivity of the clinical assessment or diagnostic tools available at the health

facility level. Some stakeholders expressed concern that health workers in many health facilities have a high case load of HIV patients and may experience time constraints in screening patients for TB thoroughly. TB and HIV programmes at national level experienced challenges in reconciling data suggesting the need to improve TB/HIV integration at health facility level.

3.3.4. Community Home-based Care

During the 2012/13 fiscal year, a total of 178,001 households with chronically ill patients, were supported in various ways, against a target of 200,000 (and a reduction from 202,578 in 2011/12). A cumulative total of 1,236 community volunteers and health personnel were trained in CHBC/palliative care, representing 72% achievement of the annual target. With the continued increase of PLHIV living healthy lives with ART, it can be expected that the number of clients on community-based care will continue to decrease in the coming years.

3.3.5. Qualitative Assessment of the effectiveness of treatment, care and support

There was unanimous agreement among the stakeholders that the ART programme has been a great success in terms of increased coverage, decentralization to primary care facility levels and switching of many patients from the d4T-based ART first-line regimen to TDF-based regimen. However, some respondents felt the need to improve coverage of ART among children and adolescents. Many respondents also expressed the need to develop policies and strategies to improve the management of young adolescents on ART.

Many stakeholders were of the view that TB and HIV activities were well integrated at health facility level and that the coverage of cotrimoxazole and isoniazid prophylaxis had improved. Nevertheless, some respondents expressed concern over the heavy dependence of the ART programme on external financial support ,which may affect its sustainability. Others noted a significant loss-to follow-up of ART patients and the need to intensify efforts in adherence counseling of patients.

Stakeholders expressed concerns over the sub-optimal delivery of the home-based care services. They noted the need for nutritional support for ART patients which may improve their survival. Some were of the view that home-based care could include a component of adherence counseling and psychosocial support.

3.4. Impact Mitigation

In Malawi, impact mitigation activities are guided by the National Policy for orphans and other Vulnerable Children, the National Social Support Policy and the National Action Plan for Orphans and Other vulnerable Children (NPA for OVC) and are led by the Ministry of Gender, Children and Social Welfare. The NPA for OVC expired in 2009 and this was extended to 2011. Currently the GoM and stakeholders are developing a new NPA for children and there will be no separate Plan for OVC. This new Plan will be available by June 2014.

3.4.1. Children in institutional care

The policy of the GoM is that all children should be raised in their own communities and that the institutionalisation of children should be the last resort. However some children may be temporarily or permanently deprived of their family environment and hence they will be provided with alternative care in an institution. A 2010 assessment of children in institutional care found that there were 104 institutions caring for children in Malawi and these include orphanages, special needs centres and reformatory centres. These institutions were taking care of 6,040 children and 71 percent of these children were orphans. In most of these institutions the needs of children such as food, clothes and school fees were being met. These institutions are therefore contributing towards responding to the HIV epidemic by addressing the needs of OVC. There is no current data on the number of such institutions in Malawi as well as the number of children being taken care of by these institutions. However, a 2013 impact evaluation of the NPA for OVC observed that there are no reported activities to prevent institutionalization[38].

3.4.2. Community based child care centres

The GoM promotes the establishment and management of community based child care centres (CBCCs) as one way of responding to the needs to OVC in Malawi. These CBCCs are owned and run by communities themselves. Such centres provide opportunities for children to learn, play and sing and access food. A 2006/7 survey commissioned by UNICEF showed that there were 5,665 CBCCs in Malawi and that a total of 410,000 children were enrolled in these CBCCs. A 2013 report shows that there are 5,609 CBCCs in Malawi caring for 336,499 children[39] a drop from 771,000 children in 2011.

3.4.3. The social cash transfer program

The Malawi Social Cash Transfer Program (SCTP) was designed to alleviate poverty, reduce malnutrition and improve school enrolment by delivering regular and reliable cash transfers to ultra poor households that are also labour constrained. The program was piloted in Mchinji district with support from the Global Fund and UNICEF. As of 2011 the SCTP was being implemented in Mchinji, Salima, Likoma, Chitipa, Mangochi, Machinga and Phalombe districts. One of the major achievements in 2013 was that the program has been extended to 19 districts which implies that more orphans and their households are benefiting from the program. This program is mostly funded by development partners. 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 the current financial year it has increased to MK450 million. Other achievements in 2013 included the establishment of an automated web-based management information system, the piloting of an e-payment system for beneficiaries of the program, the approval by GoM of a structure for implementing the cash transfer program and an increase in transfer levels from MK2,000 to MK2,700 per household. The evaluation of this program has shown that

[38] 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.
[39] 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.

the prevalence of under-weight children has gone down; food security improved; and school enrolment and retention increased among other benefits[40]. The major challenge with the program is that it is very expensive and without donor support, it is not sustainable.

3.4.4. School attendance among orphans

This indicator is measured through the MDHS. The last MDHS was conducted in 2010 and it found that the ratio of current school attendance among orphans to non-orphans among the 10-14 year olds was at 0.96.

3.4.5. Addressing other basic needs for OVC

In the 2012/13 fiscal year, a range of negative socioeconomic and material effects were felt by households, extended families, neighbourhoods, and communities affected by HIV and AIDS. The Caregivers Action Network report in June 2013 identified poverty as a continuing major issue, with many groups 'often unable to meet livelihood challenges, to send children to school and to buy basic necessities for themselves and their families'. Food insecurity, education and employment were also significant problems for People Living with HIV (MANET+ Stigma Index, January 2013).

During 2012/13 fiscal year, a total of 12,001 orphans and other vulnerable children were provided with education bursaries to attend secondary school education, representing a 120% achievement against the set annual target. However, the planned mapping of providers of school bursaries, to enable better coordination and use of the limited resources was not carried out. In addition the planned revision of the bursary guidelines did not take place. Partners, in particular community groups, noted that there are inadequate resources for the education bursaries, given the numbers in need. Additionally 2,181 vulnerable young people were trained in vocational skills during the reporting period (45% underachievement against the annual target.) A total of 101,932 orphans and other vulnerable children were provided with various forms of support including medical, material, financial and psychosocial support, surpassing the annual target by 13 per cent.

3.4.6. Qualitative Assessment of the effectiveness of impact mitigations activities

The delivery of services to orphans and other vulnerable children was rated poorly by stakeholders. They felt that impact mitigation interventions at both national and district levels are not well coordinated in the country. They also expressed the need to assess the impact of current impact mitigation interventions. They recommended the need for NAC to engage the Ministry of Gender, Children and Social Welfare to identify ways of improving services delivery. One other major challenge was that while social cash transfers have demonstrated that they have positive impact in terms of improving access to food, clothes and general welfare the program is very expensive and hence not sustainable. There was also a call that the NPA for children should be finalized quickly so that it can guide the implementation of interventions for OVC and their households.

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

4. BEST PRACTICES

4.1. Political commitment

Malawi continues to demonstrate political commitment to the fight against HIV and AIDS. Her Excellency the President of the Republic of Malawi, Dr Joyce Banda, has demonstrated her commitment through many ways: she is the Minister responsible for HIV/AIDS and both the Department of Nutrition and HIV and AIDS and the National AIDS Commission which oversee and coordinate the national response are in her office. In June 2013 the President hosted the UNAIDS and Lancet Commissioners Conference and she is a Global Ambassador for HIV and AIDS. Malawi also conducted the Legal and Policy Environmental assessment which has among other things informed the drafting of the HIV Bill as well as informing the development of HIV interventions. Once the HIV Bill is passed, it will assist in protecting and promoting peoples' rights in the context of HIV and AIDS.

4.2. Programme Implementation

4.2.1. ART Scale up

Malawi demonstrated has demonstrated that high levels coverage of coverage HTC and ART for pregnant women can be achieved even in resource limited settings through the adoption of the Option B+ strategy and effective use of human resources. To achieve this, ART services were decentralized to primary care facilities and integrated with Maternal and Child Health services. In addition, instead of clinicians prescribing ART, nurses have been trained and are now able to prescribe ART to patients. A large number of primary health care facility staff were successfully trained and are now the backbone of HIV care delivery. ART treatment regimen was simplified, by introducing one regimen for non-pregnant and pregnant adults. This facilitated health workers' familiarity and experience with a specific ART regimen and facilitated the procurement processes.

A group of technical experts from the district, zonal and central level monitor the implementation of EMTCT services at primary care level. The quarterly visits obtain high quality data which can by analyzed quickly and used to inform implementation of activities.

4.2.2. Social Cash Transfer

The Social Cash Transfer Program (SCTP) which was piloted in Mchinji district has now being implemented in 19 districts with support from development partners. An evaluation of the Malawi SCTP, as discussed above, shows that the program has had a positive impact and it is being scaled up. While acknowledging that the program is expensive and hence sustainability needs careful evaluation, it has however impacted on households especially OVC positively for example children remain in school and have access to food.

5. MAJOR CHALLENGES AND REMEDIAL ACTIONS

5.1. Progress made on the key challenges reported in the 2012 Progress Report

A number of challenges were identified in 2012 which hampered the implementation of the national response to the HIV and AIDS epidemic. Some of the challenges still exist and have not been successfully addressed. These challenges include weak supply chain systems, inadequate interventions targeting key populations such as sex workers and MSMs, stigma and discrimination which hinder access to HIV and AIDS services for PLHIVs, non-disbursement of funds from the Global Fund, the lack of standardisation of community engagement tools and service delivery protocols and inadequate implementation of some key interventions such as non-biomedical behavioural change interventions., In addition to this the number of new infections are still quite high. Even though a lot of investments have been made in the implementation of non-biomedical HIV and AIDS preventive interventions which are aimed at bringing about behavioural change, there is still no evidence about the effectiveness of these interventions. In addition to these problems the following have been identified as affecting implementing of the HIV and AIDS interventions in 2013:

- Limited budgetary allocation especially to non-biomedical prevention interventions.
- An overall weak research and M&E system especially at district level.
- There is 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 NGOs interventions and M&E systems to multi-sectoral HIV and AIDS strategic plan.
- A huge funding gap still exists to enable stakeholders fully implement the National HIV and AIDS Strategic Plan.
- A limited range of services targeting youth and HIV+ children.
- There exist some inconsistencies between policies and laws on men having sex with men and sex workers.
- There is some emerging concern that the use of condoms in some areas of the country is dropping because of the belief that VMMC is protective. Coverage for VMMC is still very low. And the health sector lacks capacity to meet the demand for VMMC.
- Early infant diagnosis is still a major challenge.
- The number of OVC and their households being reached with different interventions is still small.
- Weak coordination mechanisms for OVC programs and the lack of the NPA for OVC to guide implementation of interventions.
- HIV Bill is yet to be enacted.
- Limited capacity of implementing partners for behavioural change interventions.
- Sustainability of the social cash transfer program is being questioned.

6. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

6.1. Key support from development partners

In 2013, development partners contributed over 90% of the financial resources for the implementation of the national response to the HIV and AIDS epidemic. These include the Global Fund, PEPFAR, World Bank, DFID, CIDA, Norway and the UN agencies. Most of the development partners have aligned their HIV and AIDS activities to the National HIV and AIDS Strategic Plan and they directly support interventions as detailed in the NSP. Development partners continue being members of the Malawi HIV and AIDS Partnership Forum (MPF) and the Malawi Global Fund Coordinating Committee (MGFCC). The MPF is an advisory body to the NAC Board supporting the leadership and coordination mechanisms of the NAC and serves as a systematic coordination mechanism that minimizes wasteful duplication of efforts in scaling up the national response to HIV and AIDS. The MGFCC is a committee set-up to provide oversight and governance of Global Fund grants in Malawi. They are also members of the HIV and AIDS Development Group (HAGD) whose objectives are to harmonise and coordinate development partners' support to the implementation of the NSP and to align development partners' support to the integrated annual work plan. A number of Technical Working Groups have been formed as part of the national response to the HIV and AIDS epidemic and development partners are members of these TWGs.

In 2012/2013 development partners mainly provided technical assistance as well as financial resources to the National AIDS Commission, the MGFCC and the implementing partners in Malawi. UN agencies have supported the national response by supporting the conduct of several studies which were aimed at generating evidence to inform the development of interventions as well as policies. For example UNAIDS supported the conduct of the NASA in 2013, the "Know Your Epidemic and Response and Modes of Transmission" study and the Biological and Behavioural Surveillance Survey (BBSS). Other UN agencies also provided technical assistance in supply chain management for HIV commodities, the development of the National HIV/AIDS Policy, the Capacity Development Plan and the review of the National HIV/AIDS Strategic Plan. UNAIDS also provided technical assistance to support the interim funding application that Malawi submitted to the Global Fund for funding. In 2013 UNAIDS also supported the first Lancet Commission Conference that took place in Lilongwe.

The UN has also been instrumental in the provision of technical assistance in the review of legislation, including the drafting of the HIV Bill, exploring sustainable financing mechanisms and has provided support in the development of strategic documents. WHO in particular provided technical assistance on the new treatment guidelines and on TB/HIV

integration while UNICEF has been instrumental in addressing EID challenges that Malawi is experiencing through training and transportation of samples. UNFPA has also been quite instrumental in supporting work with key populations such as sex workers, MSMs especially focusing on creating awareness about their rights.

Malawi is now implementing VMMC as one of the interventions for preventing HIV infection. In 2013, this intervention was mostly supported by the US Government, through PEPFAR. In addition to this, the US Government is also supporting a Technical Assistant in the Ministry of Health on VMMC and M&E, as well as BCI interventions.

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

In order to ensure that Malawi achieves 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 Malawi Government 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 mechanisms.
- support more interventions targeting children and adolescents with HIV
- support the introduction and implementation of effective interventions targeting key populations such as MSMs, sex workers 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 non-governmental organization.

7. MONITORING AND EVALUATION ENVIRONMENT

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

Malawi subscribes to the “three ones” principle which calls for one national strategic plan, one national coordinating body and one national M&E system. The national M&E system is coordinated and managed by the National AIDS Commission with oversight from the Department of HIV/AIDS and Nutrition in the Office of the President and Cabinet. The Department of Planning, Monitoring, Evaluation and Research at the National AIDS Commission is responsible for M&E activities including the production of quarterly and

annual M&E reports. Malawi has a Monitoring and Evaluation Plan for the period 2012-2016 and is aligned to the National HIV/AIDS Strategic Plan 2012-2016. The M&E plan provides guidance to all HIV/AIDS implementing partners in Malawi on how they can report their M&E activities to the National AIDS Commission. A Monitoring, Evaluation and Research TWG has been formed and its function is to oversee HIV monitoring and evaluation issues within the national response and it is supposed to meet quarterly.

Implementing partners for HIV and AIDS interventions are supposed to report to the local councils using the Local Authority HIV and AIDS Reporting System (LAHARS) which collects both biomedical and non-biomedical data. The local council, in turn, report to the National AIDS Commission on a quarterly basis. Based on these reports the Commission compiles quarterly and annual reports. Routine M&E data is therefore collected and reported to the Commission. The MoH also implements the HMIS which among other things collects routine data on HIV and AIDS. The Department of HIV in the MoH has also developed a parallel system which is being used for collecting data on biomedical interventions namely HTC, PMTCT and ART on a quarterly basis.

In addition to the routine M&E programme data, there are several population based surveys that also form part of the national HIV and AIDS M&E system. These surveys, since they are conducted after every few years, are used for tracking both the outcome and impact indicators. Such surveys include the Malawi Demographic and Health Survey, the multiple indicators cluster surveys (MICS) and the Biological and Behavioural Surveillance Surveys conducted by the National Statistical Office; and the HIV Sentinel Surveillance Surveys conducted by the Ministry of Health. In addition to this there are also some geographically specific surveys that are carried out by implementing partners to information program design.

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

The implementation of the M&E system in Malawi has been decentralised and local councils are supposed to generate data and compile reports which are sent to the central level. However, one of the major challenges being experienced at local council level is that there is critical shortage of staff to effectively generate data and compile M&E reports. Most of the staff as well lack the requisite M&E skills. District AIDS Coordinators (DACs) play an important role in terms of mobilising various sectors to submit reports which can subsequently be sent the National AIDS Commission. Where DACs are available compliance with national HIV and AIDS reporting requirements are adhered to. However in a number of districts in Malawi these DACs are not available hence affecting reporting to the National AIDS Commission. The shortage of staff is not only at local council level but also in the Department of Planning, Monitoring, Evaluation and Research at the National AIDS

Commission: there are supposed to be 5 officers but for the past 2 years there have been 3 officers which is affecting the operations of the Department.

UNAIDS calls for one M&E system. In Malawi, although there is an M&E Plan, the challenge is that there are a number of implementing partners both at national as well as local council level whose M7E system has not been aligned with the national M&E system being used by the National AIDS Commission. Some partners are implementing their own M&E system and this is especially the case if these partners are not being funded by the National AIDS Commission. The interest for most of these organisations whose M&E systems are not aligned to the national M&E system is to fulfil the M&E requirements of their funding agencies. A significant proportion of the stakeholders do not report to the National AIDS Commission and even where they report the reports are incomplete and untimely.

Financial resources are required in order to implement a comprehensive M&E system. However only about 5% of the HIV program budget is for M&E implementation. The resources allocated to the M&E plan within the National AIDS Commission is inadequate to effectively meet M&E resource requirements. Other implementing partners also fail to report because of the lack of financial resources. Lastly another challenges affecting the M&E framework in Malawi is that there is limited use of data especially at local level for decision making. The M&E plan outlines a number of data sources for the M&E system such as the Malawi Demographic and Health Survey and the Biological and Behavioural Surveillance Surveys. For some of these surveys the National AIDS Commission does not have the powers to ensure that they are done timely to inform the national HIV and AIDS response. The irregularity of the conduct of these surveys affects the overall M&E system as data is not timely available for making decisions.

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

In order to address the shortage of staff at the local council level, the National AIDS Commission is providing financial resources for the recruitment of DACs in districts where these are not available. The filling of these positions at local council level will ensure that DACs are available who can work with CBOs and other implementing partners to provide data/reports for the national response. Within the Department of Planning, Monitoring, Evaluation and Research, while awaiting for the filling of the 2 vacancies, two interns will be recruited to work within the Department. In order to address the problem of non-alignment to reporting systems, plans are being pursued for implementing partners receiving funding outside the National AIDS Commission to sign a Memorandum of Understanding for them to use the M&E system. There have also been attempts to provide resources for training or orienting DACs, data entry clersk and M&E officers on how to use the LAHARC. This initiative will continue. In addition to these interventions there is a need

for stakeholders to advocate for more funds being allocated to M&E at all levels. Lastly there is continued need for building capacity of users in utilisation of M&E and research data for policy and program development.

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

The National AIDS Commission says that it needs technical assistance to address some of the M&E challenges that are being experienced. The M&E system has been decentralized and the one at local council level is not linked to the national level system. These two should be linked. The National AIDS Commission is therefore looking for technical assistance in terms of developing a web-based system such that once the data is entered at local council level then it should immediately be available and accessed at national level. The HIV and AIDS sector is also characterized by parallel M&E systems which are not linked. There is therefore a need for technical assistance to ensure that these parallel systems speak to each other.

8. ANNEXES

8.1. ANNEX 1: Consultation/preparation process for the country report

Provided separately

8.2. ANNEX 2: National Commitments and Policy Instrument (NCPI)

Provided separately

8.3. ANNEX 3: List of participants who attended the validation meeting

NAME		ORGANISATION	DESIGNATION
1.	Mac Bain Mkandawire	YONECO-Zomba	Executive Director
2.	Aurelie Andrialison	UNAIDS	CMNA
3.	Erica Nikolic	UNAIDS	HR & Gender
4.	Alex Shields	CHAI	HIV Financing
5.	Trouble Chikoko	UNAIDS	SIA
6.	Humphreys Shumba	UNFPA	NPO-HIV
7.	Davie Kalomba	NAC	HPMER
8.	Marriam Mangochi	DNHA - OPC	DHA
9.	Dr. Rosemary Kumwenda	UNDP	HIV Policy Advisor
10.	Moses Chikowi	NAC	M & E Officer
11.	Levi Lwanda	NAC	M & E Officer
12.	Zengani Chirwa	HIV/AIDS MOH	T/A Care & Treatment
13.	Mackenzie Chigumula	Malawi Police Service	HIV & AIDS Coordinator
14.	Salome Chibwana	MANET+	PO, M & E
15.	Brenda Kamanga	PSI Malawi	HIV Program Manager
16.	Lusako Munyenyembe	MHRC	Principal Human Rights Officer
17.	Lyness K. Soko	MBCA	Communications Officer
18.	Alice Chilenga	DNHA	M & E Officer
19.	Victor Kanje	DNHA	HIV & AIDS Officer
20.	Victor Billy Gama	CEDEP	Research Officer