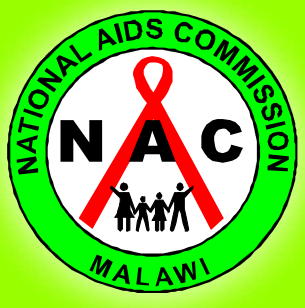
Malawi National HIV and AIDS Strategic Plan 2011-2016



December, 2011

Malawi National HIV and AIDS Strategic Plan 2011-2016

December 31, 2011

TABLE OF CONTENTS

FOREWORD

As Malawi launches the National HIV and AIDS Strategic Plan (NSP) for the period 2011 to 2016, I am pleased to report that the country is winning the battle against HIV and AIDS. This is evident through the decline in the number of new HIV infections and the decline in AIDS related deaths. These are a result of concerted effort, including the provision of free antiretroviral therapy, which my Government continues to scale up. The implementation of free ART is a sign of my Government's commitment to universal access to HIV prevention, care and treatment services. This policy has converted AIDS into more of a chronic disease and not a certain cause of death, which was the case previously.

Malawi's response to HIV and AIDS pandemic started with the establishment of the National AIDS Control Program (NACP) in the Ministry of Health, which was replaced by the National AIDS Commission (NAC) in 2001. NAC has the responsibility to coordinate and spearhead the national response to HIV and AIDS and contribute to the regional and global response. To further strengthen this structure, Government went on to establish a Department of Nutrition, HIV and AIDS within the Office of the President and Cabinet in 2006 to coordinate the linkage between public policy development and implementation. I have therefore taken direct responsibility to lead the fight against HIV and AIDS, and mitigate its impact on the Malawian population. Malawi is as a result, one of the most successful countries in Sub-Saharan Africa in the fight against the pandemic.

Realising that HIV and AIDS is a multi-dimensional problem covering biomedical, economic, social and political aspects, Malawi has initiated a multi-sectoral and multi-disciplinary national response to halt and reverse the spread of HIV, which harnesses the resources of the private, public, civil society, faith-based organizations, traditional leaders, youth and people living with the HIV (PLHIV) organisations whose contributions are greatly appreciated. Factors that drive the epidemic are largely known, and all these, including the overriding factor of poverty are prioritised in the Malawi Growth and Development Strategy II for 2011 - 2016.

I wish to acknowledge the support that Malawi has had from the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATMATM), the United Nations Joint Program on HIV and AIDS (UNAIDS); the United States Government, UKaid (Department for International Development) and other bilateral and multilateral donors. With their support, the country has made significant progress. I wish to appeal to all of them to continue with their spirit of cooperation in the implementation of this new Strategic Plan.

HER EXCELLENCY MRS JOYCE BANDA
PRESIDENT OF THE REPUBLIC OF MALAWI

PREFACE

The Malawi National HIV and AIDS Strategic Plan (NSP 2011 – 2016) is a follow up of the National HIV and AIDS Action Framework (NAF 2005 – 2009), which was extended to 2012. The NSP seeks to provide continued guidance to the national response to HIV and AIDS, building on work done in the past decade. It is informed by the findings of the Community and Stakeholder consultations on the National HIV and AIDS Policy Review (March 2010), the Malawi Growth and Development Strategy II (2011 – 2016) and the Health Sector Strategic Plan (HSSP) 2011 – 2016; as well as developments in medical and scientific knowledge.

This NSP aims to reduce new infections by 20% through reductions of children's infection by 30% and adult infections by 15%. AIDS deaths will be reduced by 8% which will include 50% reduction of children's death. Since the future course of the HIV and AIDS epidemic hinges in many respects on behaviour change, the NSP addresses the reduction of the number of new infections among people in the 15- 24 age group.

The interventions that are needed to reach the NSP's goals are structured under five key priority areas of (a) prevention of primary and secondary transmission of HIV; (b) improvement in the quality of treatment, care and support services for PLHIV; (c) reduction of vulnerability to HIV infection among various population groups; (d) strengthening multi-sectoral and multi-disciplinary coordination and implementation of HIV and AIDS programs; and (e) strengthening monitoring and evaluation of the national HIV and AIDS response. An assessment of the implementation of the NAF has been useful in defining the capacities of the implementing agencies.

The implementation plan of the NSP further takes into consideration geographic variations whereby some regions of Malawi are more severely affected than others. Based on the review of epidemiological and socio-cultural issues the NSP, among other things, addresses the (a) high prevalence of unprotected heterosexual sex, multiple and concurrent sexual partnerships and discordance in long-term couples; (b) increased numbers of people in need of antiretroviral therapy; (c) low and inconsistent use of condoms; and, (d) gender inequalities, including harmful cultural practices that put women at greater risk to HIV infection.

The Government of Malawi is committed at the highest level to the fight against HIV and AIDS in Malawi. This has been demonstrated through financial support and creation of an enabling policy environment. Development Partners have also continued to provide financial and technical support for the national response. We owe them gratitude.

Mrs Edith Mkawa
SECRETARY FOR NUTRITION, HIV AND AIDS
OFFICE OF THE PRESIDENT AND CABINET

ACKNOWLEDGEMENTS

The development process of the National HIV and AIDS Strategic Plan (NSP 2011 – 2016) was a combined effort and support of various organisations and individuals. It is difficult to acknowledge all, but some deserve special mention.

The National AIDS Commission is grateful to the consultants who supported the development of this Strategic Plan.

Finally, Development Partners who supported the process, especially the World Bank, UKaid (Department for International Development) and Clinton Health Access Initiative (CHAI) are greatly commended. In addition, all other Partners such as the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM); the United States Government; the United Nations Joint Program on HIV and AIDS (UNAIDS); and other Discrete Donors are appreciated for their continued support in the development and implementation of the NSP.

LIST OF ABBREVIATIONS

ADC	**Area Development Committee**
AIDS	**Acquired Immune Deficiency Syndrome**
AIP	**Annual Implementation Plan**
ANC	**Antenatal Clinic**
ART	**Antiretroviral Therapy**
AWP	**Annual Work Plan**
BCC	**Behavioural Change Communication**
CBCC	**Community Based Child Care Centres**
CBO	**Community Based Organisation**
CAC	**Community AIDS Committees**
CHBC	**Community Home-Based Care**
CMS	**Central Medical Stores**
CSO	**Community Based Organisation**
CSW	**Community Social Worker**
DAC	**District HIV and AIDS Coordinator**
DDC	**District Development Committee**
DHS	**Demographic and Health Survey**
DIP	**District Implementation Plan**
DNHA	**Department of Nutrition, HIV and AIDS**
DPSM	**Department of Public Sector Management**
EQA	**External Quality Assurance**
FBO	**Faith Based Organisation**
GARPR	**Global AIDS Response Progress Report**
GFATM	**Global Fund for HIV/AIDS, Tuberculosis and Malaria**

GoM	**Government of Malawi**
GRO	**Grant Recipient Organisation**
HADG	**HIV and AIDS Development Partners Group**
HIV	**Human Immunodeficiency Virus**
HSSP	**Health Sector Strategic Plan**
HTC	**HIV Testing and Counselling**
IAWP	**Integrated Annual Work Plan**
IEC	**Information, Education and Communication**
IT	**Information Technology**
LC	**Local Council**
M&E	**Monitoring and Evaluation**
MANASO	**Malawi Network of AIDS Service Organisations**
MANET+	**Malawi Network of People Living with HIV**
MARP	**Most at Risk Populations**
MBCA	**Malawi Business Coalition against AIDS**
MGDS	**Malawi Growth and Development Strategy**
MGFCC	**Malawi Global Fund Coordinating Committee**
MIAA	**Malawi Interfaith AIDS Association**
MLGRD	**Ministry of Local Government and Rural Development**
MoEST	**Ministry of Education Science and Technology**
MoAFS	**Ministry of Agriculture and Food Security**
MoGCCD	**Ministry of Gender, Children and Community Development**
MoH	**Ministry of Health**
MoU	**Memorandum of Understanding**
MOVE	**Model of Optimising Volumes and Efficiency**
MPF	**Malawi Partnership Forum**
MSM	**Men having Sex with Men**

NAC	**National AIDS Commission**
NAF	**National HIV and AIDS Action Framework**
NGO	**Non-Governmental Organisation**
NPA	**National Action Plan**
NSP	**National HIV and AIDS Strategic Plan**
NYCOM	**National Youth Council of Malawi**
OI	**Opportunistic Infection**
OPC	**Office of the President and Cabinet**
ORT	**Other recurrent Transactions**
OVC	**Orphans and Vulnerable Children**
PEP	**Post Exposure Prophylaxis**
PITC	**Patient Initiated Testing and Counselling**
PLHIV	**People Living with Human Immunodeficiency Virus**
PMTCT	**Prevention of Mother to Child Transmission**
PR	**Public Relations**
PwP	**Prevention with Positives**
SADC	**Southern African Development Community**
SG	**Support Group**
STI	**Sexually Transmitted Infection**
SWAp	**Sector Wide Approach**
TB	**Tuberculosis**
TWG	**Technical Working Group**
UN	**United Nations**
UNAIDS	**United Nations Joint Program for HIV and AIDS**
UNGASS	**United Nations General Assembly Special Session for HIV and AIDS**
UNICEF	**United Nations Children Fund**
USG	**United States Government**

VMMC	**Voluntary Medical Male Circumcision**

EXECUTIVE SUMMARY

Introduction

The National HIV and AIDS Strategic Plan (NSP) provides: (a) an overview of the HIV and AIDS epidemic in Malawi and its impact; (b) an analysis of the national response to the epidemic; (c) the NSP; (d) a cost estimate of the NSP strategic actions and an analysis of the expected funding gap; and (e) the governance and institutional framework for the national response. It provides the strategic direction for the five year period July 2011 to June 2016. It does not provide a detailed and comprehensive implementation guide.

Five documents provided fundamental input into the preparation of the NSP. These are:

(i) Malawi Growth and Development Strategy II (2011-2016)
(ii) Findings from the Community and Stakeholders on the National HIV and AIDS Policy Review (March 2010);
(iii) National HIV and AIDS Policy (September 2011);
(iv) Health Sector Strategic Plan (HSSP) 2011-2016; and
(v) National HIV Prevention Strategy (2009-2013).

The NSP is evidence based and is the product of extensive consultations which took place during preparation of the five documents above and specific consultations during the preparation of the NSP. Spectrum was used to model Malawi's epidemic.

Situation Analysis

Historical epidemiological data between 2006 and 2010 shows the following trends.

(i) Levels of new infections across the entire population are estimated to have declined by about 9 percent between 2006 and 2010 but they have remained relatively static at around 80,000 since 2008.
(ii) Levels of new infections in children are estimated to have declined by about 15 percent between 2006 and 2010 and estimated new adult infections are estimated to have declined by about 7 percent over the same period.
(iii) The estimated HIV population (in 2010) stands at 966,000 which is up by about 5 percent from 2006. Over the same period, prevalence (numbers) in adults and children has increased by 3 percent and 16 percent, respectively. Adult prevalence percent is down from 11.3 percent in 2006 to 10.4 percent in 2010.
(iii) In 2006 adult women comprised 60 percent of the total adult HIV population and this increased marginally to an estimated 61 percent in 2010.
(iv) The estimated annual number of AIDS deaths declined by about 6 percent between 2006 and 2010.

Projected epidemiological data between 2010 and 2016 (using NSP assumptions and targets) shows the following trends.

(i) Total new infections are estimated to be down by 20 percent between 2010 and 2016 to about 64,000; children's new infections estimated to be down by 30 percent and adults new infections estimated to be down by 15 percent.
(ii) HIV population estimated to increase by about 8 percent between 2010 and 2016
(iii) Women comprise 60 percent of the adult HIV population in 2016
(iv) Total AIDS deaths down by about 8 percent between 2010 and 2016 but children's deaths down by about 50 percent over the same period.

A review of epidemiological, social, cultural and economic issues concluded that the major factors driving Malawi's general epidemic are:

(i) High prevalence of unprotected heterosexual sex, multiple and concurrent sexual partners and discordancy in long-term couples- 80 percent of new infections occur among partners in stable relationships.
(ii) Insufficient numbers of people accessing ART- about 250,000 people receive ART compared to one million PLHIV.
(iii) Low and inconsistent use of condoms- resulting from poor supply chain systems and stock-outs, lack of demand, and inadequate behaviour change communication programs.
(iv) Low rates of medical male circumcision
(v) Low socioeconomic status of women and gender inequalities drive the epidemic by: (a) creating barriers to access to services; (b) adverse cultural practices; (c) gender based violence; and (d) poor bargaining power for condom use or faithfulness.
(vi) Significant levels of transactional sex, particularly as it relates to income, social status, and material benefits.
(vii) Poverty and poor overall health which increases vulnerability and susceptibility to HIV and AIDS.
(viii) High level of knowledge on methods of infection is not reflected in prevalence data which suggests inadequate follow-up interventions.
(ix) Despite a reduction in STI prevalence, prevention and treatment of STIs is still a critical issue in Malawi.
(x) Harmful cultural practices that expose people to the risk of HIV infection
(xi) Stigma and discrimination and other economic and social factors often result in PLHIV delaying treatment start up and, in some instances, dropping out of treatment.
(xii) Difficulty reaching members of vulnerable populations and most at risk populations.
(xiii) Discriminatory legislation against MARP prevents effective prevention and treatment programs being implemented.

Response Analysis

Malawi has recorded significant achievements during the implementation of the National Action Framework (2005-2009) and the Extended National Action Framework (2010-12). Most notably:

(i) Between 2006 and 2010 the number of sites providing HIV Testing and Counselling services has increased 2.2 times and the number of tests undertaken per year has increased 2.6 times over the same period.
(ii) The number of anti-natal care clinics providing the minimum package has increased 8.2 times between 2006 and 2010 and the number of pregnant women attending ANC who are counselled, tested, and received results has increased by a factor of 3.1
(iii) Between 2006 and 2010 the number of sites providing antiretroviral therapy has increased by a factor approaching 3 times and the number of people currently alive and on treatment has increased by a factor of 4.2
(iv) An average of 20 million condoms have been distributed annually
(v) To-date 68,000 OVC have benefitted from the cash transfer program
(vi) Total number of AIDS deaths was down by 17 percent between 2006 and 2010.
(vii) The number of new child infections was down by 40 percent between 2006 and 2010.

(viii) The HIV and AIDS national response has been decentralised to Local authorities and beyond to the numerous service providers at the community and household level.
(ix) The National HIV Prevention Strategy and other technical strategies were developed and launched.
(x) BCC programs have been scaled up through intensified advocacy, community mobilisation, and communication interventions.
(xi) Gender, human rights, and culture has been introduced into HIV and AIDS programs as mainstreaming at national, district and community levels.
(xii) The number of young people exposed to life skills education programs has increased to 3.8 million in 2010.
(xiii) Blood safety levels are high- 99 percent of blood is screened for HIV
(xiv) Post exposure prophylaxis (PEP) is available at ART centres
(xv) Voluntary medical male circumcision has been accepted as a key prevention strategy.

The NSP provides an analysis of issues which impacted on the implementation of the national response. This analysis included an assessment of prevention programs, treatment and care, support programs, cross cutting issues, and program management. The lessons learned from this review and the main messages are:

(i) Unless incidence is reduced significantly, ART for PLHIV is not sustainable in the long term at current growth rates because of lack of financial and trained human resources.
(ii) Despite the fact that there has been some improvement in knowledge in some parts of the population, available evidence suggests that current behaviour change programs have not had the desired impact as is evidenced by the stable and relatively high incidence across the country.
(iii) Weak supply chain systems are a significant barrier to the achievement of key HIV outcomes and it is essential that national health procurement and supply chain management systems are able to deliver a continuous and reliable flow of high quality, effective and affordable medicines and supplies in order to achieve satisfactory HIV outcomes.
(iv) As is evidenced by available data, Malawi's epidemic is concentrated on women and girls but viable gender specific programs to address their needs are limited.
(v) Marginalised and vulnerable populations have access to available prevention, treatment, and care facilities but the national response is not adequately reaching these groups because programs do not specifically target them.
(vi) Uptake of services by PLHIV is being hampered by stigma and discrimination.
(vii) Standardisation of community engagement tools and service delivery protocols are crucial to ensure that services provided by the community, especially for PMTCT, HTC, and ART, are consistent and that communities share and disseminate common messages and themes, and engender the confidence of health providers.
(viii) Opportunities for more effective prevention and treatment outcomes are often lost because referrals and linkages between individual health care services and between health care services and communities are weak and not producing the desired result.
(ix) Inadequate implementation and governance and capacity issues are hampering the efficient implementation of the national response.

Despite considerable progress during the implementation of the NAF and Extended NAF as is clearly evidenced by the rapid scale up of the: (a) HTC program; (b) PMTCT program; (c) ART program; and other major achievements noted in the NSP, the overall program's sustainability and targets for universal access will not be attainable unless: (a) current high incidence levels are

reduced significantly; (b) further program implementation efficiencies can be developed and implemented; and (c) ongoing high levels of financial support and commitment can be obtained.

Overall goal
Prevent HIV infection and mitigate the impact of HIV and AIDS on the Malawian population

Objectives
Specific objectives:
(i) Prevent primary and secondary transmission of HIV
(ii) Improve the quality of treatment, care and support services for PLHIV
(iii) Reduce vulnerability to HIV infection among various population groups
(iv) Strengthen multi-sectoral and multi-disciplinary coordination and implementation of HIV and AIDS program.
(v) Strengthen monitoring and evaluation of the national HIV and AIDS response

National Strategic Plan, priority areas, and strategies

Priority areas have been established according to need, potential impact, and cost effectiveness. They are: (a) reducing incidence by scaling up evidenced based prevention interventions and improving the coverage and effectiveness of ART; (b) scaling up treatment, care and support for PLHIV to reduce the impact of HIV and AIDS; and (c) improving national program implementation efficiency to help deliver an effective response. Strategies have been arranged in nine thematic areas which were derived from the National HIV and AIDS Policy (September 2011). A summary of the NSP appears in the following table.

Summary of Strategies by Themes with Priorities and Costing[1]

Strategic theme, goal, objectives and strategies[2]		Priority		Strategy cost ($M)	
		High	S'dard	High	S'dard
1	**Prevention** *Goal: Reduce new HIV infections in order to further mitigate the burden and impact of HIV and AIDS in Malawi* *Objective: Reduce HIV incidence*				
1.1	Reduce HIV transmission between heterosexual couples and reduce the number of people who are multiple and concurrent heterosexual partners	●		2.71	
1.2	Provide universal HIV testing and counselling focusing on services for young people, couples and other MARP	●		113.40	
1.3	Target young people with interventions specifically developed to reduce HIV incidence in both young females and males	●		3.24	
1.4	Scale up voluntary medical male circumcision and neonatal circumcision	●		82.76	
1.5	Reduce paediatric infections by increasing access to an effective PMTCT program	●		0.00	
1.6	Supply male and female condoms to all national response programs and ensure constant availability to all members of the community[3].	●		0.45	
1.7	Develop and disseminate effectively targeted and interactive behavioural and social change communication initiatives.	●		1.06	

[1] Strategic actions showing zero costs have costs disbursed through other strategic actions
[2] Strategic actions for each strategy are located in Section 4.6
[3] Condoms distributed through prevention and service delivery programs

	Strategic theme, goal, objectives and strategies[2]	Priority		Strategy cost ($M)	
		High	S'dard	High	S'dard
1.8	Reduce transmission of and morbidity from sexually transmitted infections	●		0.03	
1.9	Prevent unwanted pregnancies among women living with HIV	●		0.05	
1.10	Provide timely access to ART (as a prevention tool)	●		0.00	
1.11	Prepare and implement prevention programs which specifically target most at risk populations and vulnerable groups		●		13.23
1.12	Promote prevention with positives interventions		●		0.03
1.13	Deliver effective early infant diagnosis programs		●		5.28
1.14	Prevent HIV infections from unintended exposure to blood and other body fluids (PEP)		●		0.70
1.15	Prevent HIV transmission through blood, blood products, and invasive procedures		●		4.57
2	**Treatment, Care and Support** *Goal: Reduce morbidity and mortality of HIV related illness in adults and children*				
2A	**Treatment** *Objective: To increase access to a continuum of HIV and AIDS treatment*				
2.1	Scale up availability of high quality ART services	●		563.87	
2.2	Scale up availability of high quality PMTCT services (prongs 1 and 2)	●		53.20	
2.3	Implement a national pre-ART action plan		●		0.03
2B	**Care and Support** *Objective: To increase access to a continuum of HIV and AIDS services to PLHIV and their dependants*				
2.4	Improve nutritional status of PLHIV	●		137.15	
2.5	Improve access to quality community home based care and support services		●		10.85
3	**Comprehensive multi-sectoral and Multi-disciplinary response to HIV and AIDS** *Goal: An effective and sustainable multi-sectoral national response to HIV and AIDS* *Objective: Deliver effective management, coordination, and service delivery of HIV and AIDS interventions at national, local council, and community level*				
3.1	Improve program management and coordination efficiency at national, local council, and community level	●		3.68	
3.2	Secure adequate funding to ensure that national response can be implemented	●		0.06	
3.3	Develop human and infrastructure capacity and Central Medical Stores (CMS) and providers of other supply chain services to deliver drugs, services, and other inputs efficiently	●		3.20	
3.4	Expand the infrastructure and human capacity for health facilities to meet the needs of the national response	●		0.03	
3.5	Develop the capacity of local authorities to plan, implement and monitor local responses to HIV and AIDS at district	●		0.61	
3.6	Support to the National AIDS Commission (NAC) to oversee program implementation	●		44.05	

	Strategic theme, goal, objectives and strategies[2]	Priority		Strategy cost ($M)	
		High	S'dard	High	S'dard
3.7	Develop capacity of laboratory services to provide timely and accurate support of the HIV and AIDS program		●		1.62
4	**Impact mitigation** *Goal: Mitigate the socio-economic impact of HIV and AIDS on individuals, households, and communities* *Objective: Improve provision of impact mitigation services to individuals and households affected by HIV and AIDS*				
4.1	Provide all OVC, adolescents, PLHIV, and their families with services which will mitigate the impact of HIV and AIDS	●		240.15	
5	**Protection, participation and empowerment of PLHIV and other vulnerable populations** *Goal: Protect human rights, fundamental freedoms, and human dignity for all HIV affected people* *Objective: Provide a conducive environment so that the rights of PLHIV and affected people can be protected and so they may take advantage of available services*				
5.1	Reduce stigma and discrimination in all settings	●		0.66	
5.2	Promote gender sensitivity in all program interventions	●		1.02	
5.3	Promote a legal and policy environment that protects, upholds and respects human rights and dignity of PLHIV		●		0.38
5.4	Facilitate effective participation of vulnerable people in decision making, designing, implementing, monitoring, and evaluating HIV and AIDS programs		●		0.22
5.5	Promote access to and delivery of HIV and AIDS services and other services provided by the public and private sectors to PLHIV		●		0.31
5.6	Advocate for the enforcement of legal and social rights of PLHIV, OVC, and other affected people		●		0.00
6	**Mainstreaming and linkages** *Goal: HIV and AIDS programs of all affected public and private sectors and stakeholders are linked and provide synergised outcomes* *Objective: Deliver networking and effective partnerships in the national response*				
6.1	Integrate HIV and AIDS programs into the policies, workplaces, and core businesses of all private and public enterprises	●		4.96	
7	**Sustaining national HIV and AIDS research agenda** *Goal: Research contributes to the implementation of evidenced based programs and interventions in the national response* *Objective: Generate evidence to support the development and implementation of high impact interventions and programs in the national response*				
7.1	Provide sufficient evidence to warrant high impact interventions and programs in the national response		●	7.55	
8	**Capacity development**				

	Strategic theme, goal, objectives and strategies[2]	Priority		Strategy cost ($M)	
		High	**S'dard**	**High**	**S'dard**
	Goal: A well-equipped private and public sector with adequate capacity *Objective: Adequate capacity in all sectors to enable the efficient and effective implementation of the national response*				
8.1	Equip the private and public sectors so they can effectively participate in the implementation of the national response	●		0.03	
9	**Monitoring and evaluation** *Goal: M&E effectively contributes to the implementation of evidenced based programs and interventions in the national response* *Objective: Generate and disseminate reliable and timely strategic information on HIV and AIDS to facilitate the implementation of the national response*				
9.1	Strengthen capacity to monitor and evaluate the national response at national, district, and community levels	●		1.38	
9.2	Develop and maintain effective HIV and AIDS information systems	●		0.16	
	TOTAL FOR FIVE YEAR STRATEGY ($ million)			**1,265.46**	**37.22**

1.0 INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

Malawi's National HIV and AIDS Strategic Plan 2011-2016 (NSP) has been prepared to guide the management and implementation of the national HIV and AIDS response and to highlight the priorities for the allocation of financial and technical resources. It has been developed using the latest available evidence about the epidemic, the factors that influence the transmission of HIV in the country, and lessons learned from past implementation experience.

The NSP has been specifically developed to provide the strategic direction of the program from 2011 to 2016. It does not provide a comprehensive guide for the implementation of the national response; it does not provide specific details as to how the proposed strategies should be implemented. The NSP highlights the necessity for the Government of Malawi (GoM), with support from stakeholders, to prepare fully costed annual work plans (AWP). These AWP will use the NSP as the basis for preparation but, by their very nature, they will draw on implementation experience and provide the requisite implementation detail. In addition, the NSP provides: (a) an overview of the epidemic in Malawi and its impact; (b) an analysis of the national response to the epidemic; (c) the NSP; (d) a cost estimate of the NSP strategic actions and an analysis of the expected funding gap; and (e) the governance and institutional framework for the national response.

1.2 POLICY AND PLANNING ENVIRONMENT

Information used for the preparation of the NSP has come from many documents and from a range of technical discussions and consultations. Most particularly the Malawi Growth and Development Strategy II 2011-2016 (MGDSII) provides the overarching medium term strategy for the country which is designed to attain its long term aspiration as spelled out in its Vision 2020. The MGDS II identifies six thematic areas: (i) sustainable economic growth; (ii) social development; (iii) social support and disaster risk management; (iv) infrastructure development; (v) improved governance; and (vi) cross cutting issues. The MGDS II has further identified nine key priority areas from the six themes which include public health, sanitation, malaria, and HIV and AIDS management. For HIV and AIDS management the goal is: to prevent the spread of HIV infection and mitigate the health, socioeconomic and psychosocial impact of HIV and AIDS. MGDS II identifies three medium term expected outcomes which are: (i) reduced HIV infection and transmission rate; (ii) improved dietary practices of people living with HIV and AIDS (PLHIV), orphans and vulnerable children (OVCs), and affected individuals and households; and (iii) improved quality of lives of PLHIV, OVC, and affected individuals and households. Additionally, the MGDS II identifies twelve strategies which are used as the basis of the proposed response outlined in the NSP.

Four additional national documents were fundamental to the preparation of the NSP: (i) Findings from the Community and Stakeholders on the National HIV and AIDS Policy Review (March 2010); (ii) the National HIV and AIDS Policy (September 2011); (iii) the Health Sector Strategic Plan (HSSP) 2011-2016; and (iv) the National HIV Prevention Strategy (2009-2013). The first document provides a detailed analysis of each major intervention area including an assessment of: (a) achievements; (b) issues and gaps; (c) opportunities; and (d) recommendations. The second document took this information and developed goals, objectives and key intervention strategies according to nine strategic themes: (a) prevention, (b) treatment, care and support; (c) comprehensive multi-sectoral and multi-disciplinary response to HIV and AIDS; (d) impact mitigation; (e) protection, participation and empowerment of PLHIV and other vulnerable populations; (f) mainstreaming and linkages; (g) sustaining the National HIV and AIDS research agenda; (h) capacity development; and (i) monitoring and evaluation. These strategic themes form the basis of the strategies and strategic actions included in the NSP. The HSSP outlines a Sector

Wide Approach (SWAp) to health development and implementation and it is the vehicle by which MOH seeks to deliver the Essential Health Package. This package details a range of priority health services that Malawi will provide to all citizens free of charge, including HIV prevention and treatment. The National HIV Prevention Strategy is a guiding tool for planning, implementation, monitoring and evaluation, and resource mobilisation for HIV prevention strategies.

In summary, the National Policy guides the implementation of the National Response and the NSP (the strategy) is the implementation instrument of the policy document which aims to achieve the objectives of the MGDS II. Further, HIV and AIDS is now fully integrated into the Health Sector SWAp II and this means that HIV and AIDS is now an integral part of the Health Sector.

In addition to the consultative process which was used in the preparation of the five input documents noted above, two further rounds of consultations were held with key technical working groups and stakeholders[4] during the preparation of the NSP. The first round consultation focused on providing input into the NSP situation and response analyses and priority areas and the second round provided input into an evaluation of the proposed strategies included in the draft NSP July 2011-June 2016. The NSP is not a replication of any of the five documents noted above. It is a blend of the information, data, strategies, and guidelines provided in the documents in addition to other inputs collected during the NSP review, consultations, and drafting process.

1.3 NSP EVIDENCE BASE

The NSP has utilised epidemiological data which has been derived using the epidemiological tool Spectrum[5]. Base data from the HIV and Syphilis Sero-Survey and National HIV Prevalence and AIDS Estimates Report for 2007 (Dated August 2008) were used but other key data including latest population estimates, treatment coverage (past and projected) and type, changes to CD4 policy, national fertility rates, and incidence targets were upgraded to reflect the 2011 position and NSP requirements. The data generated by this 2011 analysis has been important in formulating the NSP. Additionally, NSP utilises data from the Preliminary Report of the Malawi Demographic and Health Survey (July 2011) (DHS). Data used in the NSP that did not come from these two studies was drawn from the most recent programme data available. NSP notes that a behaviour surveillance survey (BSS) is planned for 2011-2012 and that information derived from this survey will be used to develop detailed activities in the appropriate years of the AWP. Despite the lack of up-to-date objective behavioural information, the process followed in the preparation of the NSP has provided evidence of a number of important issues which were used for the preparation of the strategy.

Further evidence has been drawn from the considerable implementation experience which has been gained by GoM from the implementation of the National HIV and AIDS Action Framework (NAF) and the Extended NAF. Sections which follow show a significant growth in health care facilities and services provided to PLHIV and the general population. These facilities are linked into an effective national HIV and AIDS monitoring and evaluation program which is, in turn, linked to MoH and the Department of Nutrition, HIV and AIDS (DNHA). Data provided by this network of health care facilities and other service providers delivers critical information for planning in the short term and for the development of documents such as the NSP.

[4] Groups included: (a) HIV and AIDS Development Group (HADG); (b) Prevention Technical Working Group (TWG); (c) Treatment Care and Support TWG; (d) Impact Mitigation TWG; (e) PLHIV Forum; (f) International NGO Forum; and (g) Local NGO Forum. Each of these groups comprises members from a wide cross section of the community and key stakeholders.

[5] Data for Spectrum model upgraded by NAC

1.4 FUNDING PARTNERS FOR PRIOR YEARS

Malawi and its development partners have invested significant levels of funds into HIV prevention, care and treatment, and support and their associated activities over the years. In particular major funding partners have included: the Government of Malawi (GoM); the Global Fund to fight AIDS, Tuberculosis and Malaria; the World Bank; the Government of the United Kingdom; The Kingdom of Norway; Government of Canada; Government of the United States of America; and the United Nations Family of organisations. Other partners have provided funding directly to implementing partners which has not been channelled through the National AIDS Commission (NAC).

Over the last two to three years, it has become evident that external funding for HIV and AIDS is becoming more difficult for developing countries as a result of the global financial crisis and the contraction of the economies of key donor countries. These problems clearly affect Malawi's ability to attract donor funding. As a consequence, it is critical that the NSP focuses on priority interventions which will have a major and lasting impact on the epidemic in the short term and the medium term. The new financing environment also means that the issue of sustainability and the coordination of the national response within national structures should be at the forefront of policy makers' thinking and actions. This NSP focuses attention on the development of strategic interventions which attract most benefits and synergies between programs. Accountability and transparency for all implementers and stakeholders will also be a major factor to ensure the NSP can be funded and is implemented effectively; this requires a proficient national and integrated monitoring and evaluation system.

2.0 SITUATION ANALYSIS

2.1 OVERVIEW OF EPIDEMIC

2.1.1 Trends in HIV incidence, prevalence, and deaths

Historical and projected trends of incidence, prevalence and AIDS deaths are shown in Tables 1 and 2 below.

Table 1 Historical trends in selected HIV and AIDS epidemiological indicators 2006 to 2010[6]

Indicator/Year	2006	2007	2008	2009	2010
Estimated new infections					
- # Adults (15+)	61,107	57,535	56,204	56,671	56,477
- # Children (0-15)	26,743	25,966	24,469	23,958	22,863
- Total	87,850	83,501	80,673	80,629	79,340
- Estimated adult incidence (%)	1.05	0.96	0.91	0.89	0.86
Estimated total HIV population					
- # Adults (15+)	760,811	766,080	771,311	778,512	786,603
- # Children (0-15)	155,603	163,247	169,677	174,978	179,844
- Total	916,414	929,327	940,988	953,490	966,447
- Estimated adult prevalence (%)	11.3	11.0	10.8	10.6	10.4
Estimated adult HIV population					
- # Males (15+)	302,204	302,875	303,923	306,149	309,069
- # Females (15+)	458,608	463,205	467,387	472,364	477,534
- Total	760,811	766,080	771,311	778,512	786,603
Estimated AIDS deaths					
- # Adults (15+)	51,812	52,156	52,223	52,068	52,144
- # Children (0-15)	13,495	12,797	11,343	10,723	9,089
- Total	65,307	64,953	63566	62,791	61,233

From an historical perspective the data show the following trends between 2006 and 2010:

(i) Levels of new infections across the entire population are estimated to have declined by about 9 percent between 2006 and 2010 but they have remained relatively static at around 80,000 since 2008.

(ii) Levels of new infections in children are estimated to have declined by about 15 percent between 2006 and 2010 and estimated new adult infections are estimated to have declined by about 7 percent over the same period.

(iii) The estimated HIV population (in 2010) stands at 966,000 which is up by about 5 percent from 2006. Over the same period prevalence (numbers) in adults and children has increased by 3 percent and 16 percent respectively. Adult prevalence percent is down from 11.3 percent in 2006 to 10.4 percent in 2010.

(iii) In 2006 adult women comprised 60 percent of the total adult HIV population and this increased marginally to an estimated 61 percent in 2010.

(iv) The estimated annual number of AIDS deaths declined by about 6 percent between 2006 and 2010.

[6] NAC Spectrum analysis 2011

Table 2 Projected trends in selected HIV and AIDS epidemiological indicators 2010 to 2016[7]

Indicator/Year	2010	2012	2014	2016
Estimated new infections				
- # Adults (15+)	56,477	60,377	54,555	47,787
- # Children (0-15)	22,863	18,574	17,497	16,142
- Total	79,340	78,951	72,052	63,929
- Adult incidence (%)	0.86	0.86	0.73	0.6
Estimated total HIV population				
- # Adults (15+)	786,603	809,705	836,199	846,655
- # Children (0-15)	179,844	188,154	192,622	193,421
- Total	966,447	997,859	1,028,821	1,040,076
Estimated adult HIV population				
- # Males (15+)	309,069	318,396	329,665	334,834
- # Females (15+)	477,534	491,310	506,534	511,821
- Total	786,603	809,706	836,199	846,655
- Adult prevalence (%)	10.4	10.1	9.8	9.3
Estimated AIDS deaths				
- # Adults (15+)	52,144	54,764	48,777	51,944
- # Children (0-15)	9,089	4,570	4,617	4,631
- Total	61,233	59,334	53,394	56,575

Based on the projections above the following assumptions, targets and trends are important to note:

(i) Model assumptions include: (a) a decline in adult incidence from 0.86 percent in 2010 to 0.6 percent in 2016; (b) a decline in fertility rate from 5.7 (children per family) in 2010 to 4.5 (children per family) in 2016; and (c) combined ART and PMTCT program scaled up to that projected in NSP.

(ii) Total new infections are estimated to be down by 20 percent between 2010 and 2016 to about 64,000; children's new infections estimated to be down by 30 percent and adults new infections estimated to be down by 15 percent.

(iii) HIV population estimated to increase by about 8 percent between 2010 and 2016

(iv) Women comprise 60 percent of the adult HIV population in 2016

(v) Total AIDS deaths down by about 8 percent between 2010 and 2016 but children's deaths down by about 50 percent over the same period.

A sensitivity analysis was undertaken to test the impact of reducing the adult incidence target to 0.6 percent and reducing the total fertility rate (children per family) to 4.5. In the sensitivity analysis both these assumptions were left at 0.86 percent and 5.7 respectively for the five years of the projection (the 2010 level for both). The results were:

(i) Estimated total new infections in 2016 were: (a) adults 68,300; and (b) children 20,800. This is about 40 percent above the NSP target.

(ii) Estimated number of people in need of first line therapy in 2016 was 732,000 (689,100 adults and 42,900 children). This compares to 713,000 in the NSP targets. This difference will increase significantly in years beyond 2016.

(iii) Estimated total HIV population in 2016 was: (a) adults 891,200; and (b) children 204,600. This is about 5 percent above the NSP target.

[7] NAC Spectrum analysis 2011

(iv) Estimated total AIDS deaths in 2016 were: (a) adults 52,100; and (b) children 5,200. This is about 1 percent above NSP target

2.1.2 Review of epidemiological factors impacting Malawi's general epidemic

Malawi is among the countries worst affected by the HIV epidemic. HIV prevalence in adults (15+) was about 12 percent in 1999 where it stabilised till about 2002 when it gradually started to decline. Projections suggest that HIV prevalence will continue declining slowly up to 2016 where it is expected to reach about 9.3 percent given the assumptions used in the analysis. People are now living longer with HIV and AIDS due to the successful ART program. Current estimates put the number of people living with HIV and AIDS (PLHIV) at about 960,000 and it is anticipated that this number will increase to about 1,040,000 in 2016 largely as a result of the scaled up and integrated ART and PMTCT program.

HIV prevalence is highest in the most populous Southern Region (18 percent) and lowest in the Central Region (7 percent) and Northern Region (8 percent). In 2010, 65 percent of new HIV infections among adults were estimated to occur in the southern region[8]. A mode of transmission study has identified that 80 percent of new infections occur among partners in stable relationships within the general population driven by concurrent and multiple sexual partnerships[9]. HIV prevalence is higher among women (13 percent) than men (8.8 percent) and, in 2010, HIV prevalence among young people aged 15 to 24 was estimated at 5.2 percent. Epidemiological estimates show that HIV incidence among young people 15 to 24 years has declined from 2.9 percent in 1992 to 1 percent in 2010[10].

The primary mode of HIV transmission is unprotected heterosexual sex. Mother to child transmission is the second major mode of transmission accounting for approximately 25 percent of new infections. Intra-partum vertical transmission rates are estimated to have declined only marginally from 16.5 percent in 2008 to 13.8 percent by the end of 2009[11].

Limited sentinel sero-surveillance of high risk (and often invisible) populations has been conducted. The most recent, in 2006, reported the following prevalence rates; sex workers 71 percent, female border traders 23 percent, male vendors 7 percent, fishermen 17 percent, male long distance truck drivers 14 percent, male estate workers 20 percent, female estate workers 18 percent, male police officers 24 percent, female police officers 33 percent, male primary school teachers 24 percent, female primary school teachers 22 percent, male secondary school teachers 17 percent, and female secondary school teachers 16 percent. A sero-survey conducted among men who have sex with men (MSM) in Blantyre in 2009 reported an HIV prevalence of 21.4 percent. More than 95 percent of MSM were unaware of their status and were less likely to be aware of the risks around unprotected anal sex. In addition, 17 percent of the men in the study reported being in bi-sexual concurrent relationships with over half of the respondents reporting both male and female sexual partners in the previous six months.

Approximately 1,650 young people are infected with HIV in Malawi each month. In the 2004 DHS, HIV prevalence among young women 15-24 years of age was 9.1 percent compared with 2.1 percent among young men. More young women get infected with HIV at a much younger age than men[12].

Risk of HIV infection in male youths is associated with age at sexual debut and the number of sexual partners. Increasing HIV infection rates in youth are strongly correlated with marriage,

[8] Global Fund Round 10 Application
[9] Know Your Epidemic Study 2008
[10] Global Fund Round 10 Application
[11] UNGASS 2010
[12] Malawi HIV Prevention Partners Visit, February 2011: Trip Report

which occurs at earlier ages in females. Young women aged 15-24 who are married or in stable sexual relationships have a much higher prevalence of HIV than those that are not involved in a stable relationship. This suggests that many new infections are occurring in groups of people which were previously considered to be at low risk.

UNGASS 2010 estimates the orphan population to be about 1.16 million of which about 0.44 million (38 percent) were due to AIDS (Sentinel Surveillance, MOH 2007). The number of orphans is increasing. Despite the impact of the National Plan for Action (NPA) for orphans and vulnerable children (OVC) 2005-2010, most OVC lack access to basic needs such as food, health care, education and protection. UNGASS 2010 also reports that, overall, 18.5 percent of OVC received some type of support, 0.2 percent all types of support, and 81.5 percent received no support at all. Data from the NAC Spectrum analysis 2011 estimates total orphans to be 1.23 million in 2016 of which 0.73 million are AIDS orphans. Much of the current support for OVC is provided by Non-Government Organisations (NGO) and Community Based Organisations (CBO) and a cash transfer program is currently being piloted in seven districts and this is providing support to about 68,000 OVC.

Most PLHIV start ART treatment at a late stage when they have already developed clinically recognisable symptoms and opportunistic infections (OI). People who are HIV positive and in later stages of the disease requiring ART can be highly infectious and these people pose a significant risk to their sexual partners. ART side effects often results in low adherence to treatment and drugs in some patients.

Table 3: HIV prevalence by socio-economic characteristics (age 15-49)[13]

Population Characteristic	Women % HIV	Men % HIV	Total % HIV
Residence			
Urban	18.0	16.3	17.1
Rural	12.5	8.8	10.8
Region			
Northern	10.4	5.4	8.1
Central	6.6	6.4	6.5
Southern	19.8	15.1	17.6
Education			
None	13.6	9.2	12.3
Primary (1-4)	12.3	6.5	9.7
Primary (5-8)	13.2	10.8	12.0
Secondary +	15.1	12.9	13.7
Wealth			
Lowest	10.9	4.4	8.3
Second	10.3	4.6	7.6
Middle	12.7	12.1	12.4
Fourth	14.6	11.7	13.2
Highest	18.0	14.9	16.4

HIV infection rates show gender, age, social status and geographical variations (as shown in Table 3) with infection more prevalent (in percentage terms) in women, urban populations, and in the southern region. Because of the much larger rural population, however, 78 percent of the PLHIV live in rural areas and 69 percent in the Southern Region of the country. Prevalence varies across regions as does prevalence within regions. At Nthalire (in the Northern Region) prevalence is estimated at 2 percent while at Thyolo (in the Southern Region) prevalence is estimated at 38 percent[14]. Interestingly, people with the highest levels of education have the highest prevalence (percent) and this is consistent with levels of wealth which shows the highest wealth levels also have the highest prevalence (percent) for both women and men. In the case of women, prevalence (percent) levels are about 65 percent higher when the wealthiest group is compared to the lowest wealth group, and in the case of men it is about three times higher for the highest wealth group. This wealth data seems consistent with the fact that wealthier people live in urban areas where, as noted, prevalence (percent) in both men and women is significantly higher than in rural areas. It is not totally clear why behaviour change programs and other interventions

[13] MDHS 2004
[14] HIV and Syphilis Sero-Survey and National HIV Prevalence and AIDS Estimates Report for 2007

have not been more effective in the two groups (urban and comparative wealth) who should be much easier to reach and more receptive to behaviour change communication (BCC) programs than lower income rural dwelling Malawians. However, issues in urban areas are more complex, there is often a mix of cultures, and urban areas often lack cohesive community structures which are present in rural areas.

2.1.3 HIV incidence

UNGASS 2010 reports that the UNAIDS Modes of Transmission Model estimates that 1.6 percent of the total adult population becomes infected each year. Other estimates put the incidence at closer to 1 percent[15]. The data which follows, which is not current and needs to be brought up-to-date, reflects the number of new infections per one thousand new HIV infections[16].

(i) Single stable heterosexual partner- 357 (from 1000 new infections)
(ii) Partners of high risk sex- 254 (from 1000 new infections)
(iii) Children < 15 years (almost all are from mother to child) - 233 (from 1000 new infections)
(iv) Multi-partner and premarital sex- 97 (from 1000 new infections)
(v) Partners of clients of sex workers- 36 (from 1000 new infections)
(vi) Clients of sex workers- 17 (from 1000 new infections)
(vii) Medical injections- 2 (from 1000 new infections)
(viii) Men who have sex with men- 1 (from 1000 new infections)
(ix) Sex workers- 1 (from 1000 new infections)

Key messages from the data include:

(i) Most infections occur in heterosexual relationships so these groups of people must be the focus of the NSP's prevention strategy.
(ii) Mother to child transmissions are high and must remain a priority area.
(iii) High risk groups have high incidence percentages but the actual numbers are relatively low when compared to other transmission methods. Targeting these high risk groups can be cost effective so they should not be excluded from proposed intervention simply because numbers are not having a significant impact on total national incidence.

2.1.4 Knowledge of prevention methods and behavioural patterns

Tables 4 and 5 below show the knowledge of HIV prevention methods and risk reduction behaviour respectively for 2004 and 2010 for men and women in the age range 15-49[17]. It is not clear if the behaviour patterns and knowledge levels revealed in the surveys are reflected in actual behaviour.

[15] UNGASS 2010 and NAC 2011 Spectrum analysis
[16] 2007 Epidemiological projections and estimates
[17] Malawi Demographic and Health Survey 2010 Report, and Malawi Demographic and Health Survey 2004

Table 4. Knowledge of HIV prevention methods

Respondents	Using condoms (%)	Limiting sex to one uninfected partner (%)	Using condoms and limiting sex to one uninfected partner (%)
Women			
2004 DHS	57.3	67.6	46.6
2010 DHS	72.0	86.7	66.4
Men			
2004 DHS	75.6	79.9	63.4
2010 DHS	72.6	85.3	66.0

Key messages from the survey data are:

(i) Women's knowledge level of HIV prevention methods has increased significantly between 2004 and 2010 and it is now roughly in line with men's knowledge levels.
(ii) Still, about 30 percent of men and 30 percent of women do not know that using condoms is an effective HIV prevention method.
(iii) Men's knowledge levels have not increased (or decreased) significantly in the six years between the two surveys.

Table 5. Risk Reduction Behaviour- multiple sexual partners

Respondents	% who had 2+ partners in the last 12 months	Among people with 2+ partners- % using condoms in last sexual intercourse	Among people who have ever had sex, mean number of partners in life
Women			
2004 DHS	1.1	30.1	
2010 DHS	0.7	27.3	1.7
Men			
2004 DHS	11.8	47.1	
2010 DHS	9.2	23.5	3.8

Key messages from the survey data are:

(i) The percentage of women surveyed who had two or more sexual partners in the last twelve months has declined significantly to below 1 percent.
(ii) The percentage of males survey who had two or more sexual partners in the last twelve month has also declined but has not declined by as much as the data for women.
(iii) The percentage of men who have had two or more partners in the last twelve months is some 13 times higher than the percentage of women.
(iv) The percentage of men and women who have two or more partners and who used a condom in last sexual intercourse is about 25 percent for each. For women the percentage in 2010 is slightly lower than 2004 but for men it is significantly lower; about half what it was in 2004.
(v) Results from risk reduction messages seem mixed. On the one hand the percentage of people who had two plus partners has declined but those who had two plus

partners the risk reduction behaviour seems to have slightly regressed for women and significantly regressed for men.

2.2 SOCIAL, CULTURAL AND ECONOMIC ISSUES

According to the 2008 national census the population of Malawi was 13.1 million; over 60 percent higher than it was in 1987 at 8 million. Over the period 1998-2008 the annual population growth rate was estimated at 2.8 percent. Spectrum[18] estimates that by the end of 2016 Malawi's population will be around 16.7 million at current fertility rates; about 3.6 million more than in 2008. From the perspective of HIV and AIDS this means that: (a) there will be greater strain on HIV and AIDS resources unless incidence can be reduced; (b) family planning interventions are not having the necessary impact on reducing population increases; and (c) programs to increase condom use are not being highly effective which means exposure to HIV in vulnerable groups. From the perspective of general health and levels of government expenditure; 2008 estimates of $5.7 per capita expenditure on general health, falls considerably short of the cost of the Essential Health Package of $28 in 2008. Current funding on health is inadequate and the expected increase in the population will place added strain on the delivery of health services.

Poverty in Malawi is severe with about 65 percent of the population living in absolute poverty; that is, subsisting on less than $1 per day. Poverty disproportionally affects women and is a major driver of the epidemic in the country. Conversely, HIV and AIDS aggravate the poverty situation. People living in poverty are more vulnerable and less likely to take affirmative action to protect themselves and to seek treatment, care, and support. Closely linked to poverty is nutrition. Malawi has serious malnutrition problems; malnutrition is universal, endemic and in some cases, an overwhelming problem that affects all districts. Deficiencies of micronutrients, especially vitamin A, iodine, iron and zinc are also a public health concern. Micronutrient studies in 2001 showed that 25 percent of adults were malnourished, with 75 percent of that group being HIV positive. Data also shows that there has been no significant change over several years in the level of malnutrition in the first 24 months of life of children, despite improvements in the country's overall economic status and increases in food security. There is a strong link between HIV and AIDS and nutritional status; good nutrition is essential for building the immune system, drug effectiveness is decreased in undernourished patients, drug toxicity is increased if patients are malnourished, and malnutrition accelerates the onset of AIDS. Because much of the HIV and AIDS spending has not been disaggregated into sufficiently small categories it is difficult to assess the national responses funding to nutrition support in the context of HIV and AIDS.

Malawi has a gender equality index of 0.374 which suggests that large inequalities exist between men and women. Women are known to have limited influence over their sexual and reproductive health due to entrenched negative gender norms which are embedded in a culture that promotes male dominance in relationships, and views multiple and concurrent sexual partnerships as normal. Excessive poverty and a lack of education often lead women into exploitative transactional and intergenerational sexual relationships. They are, therefore, being exposed to HIV infection at a younger age than their male peers. Women and girls are also victims of gender based violence, including rape, and they are often unable to negotiate condom use. Additionally, because of male dominance in some situations, women are unable to access HIV and AIDS services without the approval of their partners.

UNGASS 2010 reports that stigma and discrimination associated with being HIV positive is gradually decreasing as is evidenced by the number of disclosures. A recent study[19] used a community based research approach to measure HIV related stigma and discrimination (The

[18] NAC Spectrum analysis 2011
[19] MANET+ Draft Stigma and Discrimination Experienced by People Living with HIV and AIDS in Malawi- Undated

People Living with HIV Stigma Index). The study reviewed experience in stigma and discrimination that had occurred in the previous twelve months and the effect it had on quality of life for PLHIV. Major findings, which will provide a base line, included: (a) there were no major differences in experience between men and women; (b) almost 20 percent of respondents reported some form of discrimination from partners or a member of their family; (c) more that 10 percent of respondents reported discrimination from other PLHIV; (d) about 48 percent reported they had been gossiped about- 51 percent female and 43 percent males; (e) few people (4.5 percent) reported having been denied health services because of their HIV status, and 8.3 percent were denied family planning or sexual health services; (f) young people were discriminated more when compared to adults; (g) confidentiality was an issue for those accessing ART; and (h) about 28 percent of respondents reported that they were discriminated against by their employers and 35 percent felt obliged to stop work because the job description and the nature of their job changed.

2.3 IMPACT OF HIV AND AIDS

The impact of HIV and AIDS has been very significant across the country. In particular:

(i) AIDS has reduced average life expectancy from 56 years pre-epidemic to 48.8 years at present.

(ii) OI such as tuberculosis have increased dramatically; about 5,000 cases in 1985 compared to about 23,000 cases per annum now.

(iii) More than 50 percent of the country's hospital beds are occupied by patients with AIDS related illness and the epidemic has placed considerable strain on administrative and financial capacity of MoH.

(iv) Because AIDS mainly affects economically productive people, the epidemic has had a major impact on the productivity of the public and private sectors- both rural and urban through prolonged absenteeism and death. UN 2010 [20] estimates that countries such as Malawi could face decreases in the size of its workforce of between 10 and 30 percent by 2020.

(v) Food insecurity is intensified because farmers are no longer able to be productive during illness. Food insecurity and reduced nutrition levels may result in family members being more vulnerable to infection of HIV and other illness in addition to reduced effectiveness and increased side effects of anti-retroviral therapy (ART).

(vi) The death of parents has left more than one million OVC (about 50 percent due to HIV) and this has had a major impact on the extended family system and the public support program. OVC are also more likely to drop out of school which will have an ongoing impact on their family and the community. Girl OVC are particularly vulnerable to HIV risk and abuse.

2.4 KEY DRIVERS OF THE EPIDEMIC

Major factors impacting on the spread of AIDS in Malawi's general epidemic are:

(i) High prevalence of unprotected heterosexual sex, multiple and concurrent sexual partners and discordancy in long-term couples- 80 percent of new infections occur among partners in stable relationships.

(ii) Insufficient numbers of people accessing ART- about 250,000 people received ART compared to one million PLHIV.

(iii) Low and inconsistent use of condoms- resulting from poor supply chain systems and stock-outs, lack of demand, and inadequate behaviour change communication (BCC) programs.

(iv) Low rates of medical male circumcision- this is a proven prevention method.

[20] Malawi Country Assessment Report (2010) cites International Labour Organisation (ILO)

(v) Low socioeconomic status of women and gender inequalities drive the epidemic by: (a) creating barriers to access to services; (b) adverse cultural practices; (c) gender based violence; and (d) poor bargaining power for condom use or faithfulness.

(vi) Significant levels of transactional sex, particularly as it relates to income, social status, and material benefits.

(vii) Poverty and poor overall health- increases vulnerability and susceptibility to HIV and AIDS.

(viii) High level of knowledge (as suggested by the 2010 DHS) on methods of infection is not reflected in prevalence data which suggests inadequate follow-up interventions.

(ix) Despite a reduction in reported STI prevalence, prevention and treatment of STIs is still a critical issue in Malawi.

(x) Harmful cultural practices result in early initiation of sex for boys and girls, multiple sexual partners and this, in turn, contributes to social norms of acceptance.

(xi) Stigma and discrimination and other economic and social factors often result in PLHIV delaying treatment start up and, in some instances, dropping out of treatment, particularly men.

(xii) Difficulty reaching members of vulnerable populations and most at risk populations (MARP).

(xiii) Discriminatory (or lack of) legislation towards MARP prevent effective prevention and treatment programs being implemented.

3.0 RESPONSE ANALYSIS

3.1 LEVELS OF EXPENDITURE ON THE AIDS RESPONSE

Levels of funding for the national response have increased from $29.1 million in 2002/03 to $107 million in 2007/08 falling marginally in 2008/09 to $104 million.[21]

3.1.1 Levels of expenditure by category

Table 6 shows spending by major categories for all donors and GoM for 2007/08 and 2008/09 for all programs in the national response[22]

Table 6 AIDS Spending for all donors and GoM by Major Categories[23]

AIDS spending category	2007/08 $million	2007/08 %	2008/09 $million	2008/09 %	% funding change
Prevention	20.9	19.5	17.8	17.0	-15.1
Care and treatment	33.5	31.2	39.9	38.2	+19.2
Orphans & vulnerable children (OVC)	7.8	7.3	4.7	4.5	-39.2
Program management & administration	24.3	22.6	23.3	22.2	-4.3
Human resources	2.6	2.4	1.2	1.1	-53.8
Social protection & social services	4.8	4.4	1.8	1.7	-62.0
Enabling environment	12.4	11.5	14.6	14.0	+18.0
HIV & AIDS related research	1.2	1.1	1.2	1.2	+4.0
Total (may not add due to rounding)	**107.4**	**100.0**	**104.5**	**100.0**	**-2.7**

Data assessment:

(i) Percentage of available funds allocated to prevention has declined by 15 percent despite the importance of prevention and the fact that incidence has not declined appreciably.
(ii) Expenditure on care and treatment reflects the scale up of the ART program.
(iii) Support to OVC declined by some 40 percent but data has not been disaggregated so it is not possible to determine where services have been reduced.
(iv) Program management and administration is the second highest recipient of funding taking about 22 percent. In this general category:
  (a) Planning and coordination costs, and administration and transaction costs have increased by 30 percent and 28 percent respectively
  (b) Monitoring and evaluation expenditure has declined by 19 percent from $3.6 million to $2.9 million.
  (c) Drug supply system funding has declined by 76 percent from $2.9 million in 2007/08 to $0.69 million in 2008/09 despite its importance and parlous state.
(vi) Expenditure on enabling environment increased but data shows the amount allocated to human rights remained stable over the two years.
(vii) All subcategories within the social protection category declined

[21] UNGASS 2010
[22] Later data not available
[23] UNGASS 2010

(viii) Almost all the decline in human resources expenditure came from cuts in training.

3.1.2 Program cost effectiveness

Despite high levels of investment the UNGASS 2010 reports that resources so far mobilised fall short of those needed to meet the national response or universal access targets. There is little evidence specifically available for increasing investment in HIV and AIDS in Malawi but evidence from other Southern African countries and elsewhere is clear; increased investment in HIV and AIDS programs, whether preventive or care and treatment is cost effective.[24]

3.2 KEY PROGRAM INDICATORS AND MAJOR ACHIEVEMENTS

3.2.1 Key program indicators

Table 7 below provides details of key selected program indicators between 2006 and 2010

Table 7 Trends in key selected program indicators 2006 to 2010[25]

Indicator/Year	2006	2007	2008	2009	2010
PREVENTION					
HIV testing and counselling					
- # sites providing HTC services	351	588	713	735	772
- # tests undertaken (million)	0.66	1.08	1.71	1.72	1.73
- # 1st time tests (million)	NA	NA	NA	1.08	0.93
PMTCT					
- # ANC clinics providing min. package	60	454	454	454	491
- # pregnant women attending ANC who are counselled, tested & receive results	137,996	411,204	327,400	333,335	432,354
Condom distribution					
- # Condoms distributed	32,090,000	20,980,000	18,601,000	21,100,000	NA
TREATMENT					
ART Program					
- # sites providing ART	141	163	221	377	417
- # people ever started on ART	85,168	146,856	223,437	312,476	345,598
- # people currently alive and on treatment	59,980	100,649	147,497	198,846	250,987
IMPACT MITIGATION					
Cash transfers					
- # OVC supported with cash transfers	NA	16,900	47,000	67,900	68,400

3.2.2 Major achievements

(i) Tables 1 and 6 show the following achievements:

(a) Between 2006 and 2010 the number of sites providing HIV Testing and Counselling (HTC) services has increased 2.2 times and the number of tests undertaken per year has increased 2.6 times over the same period.

(b) The number of ANC clinics providing the minimum package has increased 8.2 times between 2006 and 2010 and the number of pregnant women attending ANC who are counselled, tested, and received results has increased by a factor of 3.1

[24] UNGASS 2010
[25] Various sources

(c) Between 2006 and 2010 the number of sites providing ART has increased by a factor approaching 3 times and the number of people currently alive and on treatment has increased by a factor of 4.2
(d) An average of 20 million condoms distributed annually since 2007
(e) To-date 68,000 OVC have benefitted from the cash transfer program
(f) In percentage terms, adult incidence and prevalence is down from 1.05 to 0.86 percent, and 11.3 to 10.4 percent respectively from 2006 to 2010 (see Table 1).
(g) Total number of AIDS deaths was down by 6 percent between 2006 and 2010 (see Table 1).
(h) The number of new children infections was down by about 15 percent between 2006 and 2010 (see Table 1).

(ii) The HIV and AIDS national response has been decentralised to Local authorities and beyond to the numerous service providers at the community and household level but major challenges still exist at district and community levels.
(iii) The National HIV Prevention Strategy and other technical strategies were developed and launched.
(iv) BCC programs have been scaled up through intensified advocacy, community mobilisation, and communication interventions.
(v) Gender, human rights, and culture has been introduced into HIV and AIDS programs as has mainstreaming at national, district and community levels.
(vi) The number of young people exposed to life skills education programs has increased to 3.8 million in 2010.
(vii) Blood safety levels are high- 99 percent of blood is screened for HIV
(viii) Post exposure prophylaxis (PEP) is available at ART centres
(ix) Acceptance of voluntary medical male circumcision (VMMC) as a key prevention strategy with standard operating procedures and draft communication strategy developed.
(x) New integrated ART/PMTCT guidelines adopted which will result in a safer and more effective treatment program.
(xi) Mobile technology has been piloted to strengthen quality of care
(xii) Establishment of Department of Nutrition HIV and AIDS (DNHA) under the Office of the President and Cabinet (OPC).
(xiii) Creation of Nutrition, HIV and AIDS units in most ministries
(xiv) Establishment of structures to facilitate implementation of Three Ones Principles.
(xv) Development of improved environment for service providers and clients by providing financial and material support, equipment, and infrastructure refurbishment.
(xvi) Preparation of capacity development plan.
(xvii) Increase in youth participation and empowerment and reduction in prevalence among youth by more than 25 percent
(xviii) New services and innovations; (a) national HTC week; and (b) mobile vans and door to door.
(xix) Improved integration of HIV and TB
(xx) Drafting legal instruments for HIV and AIDS.
(xxi) Stigma index study conducted for PLHIV by PLHIV around reported perceptions and experiences of stigma and discrimination suggests significant progress in reduction of stigma and discrimination

3.2.3 Financing sources

Table 8 below provides a breakdown of sources of funding for 2007/08 and 2008/09

Table 8 AIDS Funding sources[26]

Source	2007/08 $million	2007/08 %	2008/09[27] $million	2008/09 %	% funding change
Local Public funds	1.9	1.8	1.5	1.4	-30
Local Private funds	0.7	0.7	0.6	0.6	-12
International funds	104.8	97.6	102.4	98	-2
Total (may not add due to rounding)	**107.4**	**100.0**	**104.5**	**100.0**	**-2.7**
International funds made up of					
- Direct bilateral	21.3	20.9	27.5	26.8	29.2
- Multilateral	74.6	71	65.7	64.2	-11.9
- International not for profit	9.0	8.6	9.2	9.0	.3
Total (may not add due to rounding)	**104.8**	**100.0**	**102.4**	**100.0**	**-2.3**

Key points to highlight from 2002/03 figures not shown:

(i) The share of public funding for HIV and AIDS fell from 40 percent in 2007/08 to 1.4 percent in 2008/09; a significant amount of this 1.4 percent goes to care and treatment

(ii) The share of international funding has increased from 46 percent in 2007/08 to 98 percent in 2008/09 with the bulk of this funding coming from multilateral organisations, especially the Global Fund.

3.3 KEY GAPS IN THE NATIONAL RESPONSE

3.3.1 Prevention

The National Response prevention program is not providing the results necessary to check incidence levels. Closely linked to this issue are the behavioural change program, which is not providing the desired outcomes and the free condom distribution program which has frequent stock-outs, low distribution numbers, and accessibility problems in remote areas. Women, especially younger ones, are impacted most.

Though women have access to HIV testing and counselling (HTC) services through ANC visits, inadequate numbers of men are being tested for HIV or accessing ART services. There is a pressing need to engage men more in health seeking behaviours and the promotion of HTC as a gateway to accessing HIV care. Similarly, there is a low uptake of ART among children[28]. Low uptake of ART has a significant negative impact on incidence. Other issues and gaps in the current HTC program include:

(i) Reaching underserved communities

[26] UNGASS 2010

[27] In 2009 about 54 percent funds for HIV and AIDS were channeled through NAC- up from 19 percent in 2005/06- Source UNGASS 2010

[28] UN Country Assessment 2010

(ii) Missed prevention opportunities due to inadequate integration of HTC in other health services
(iii) HTC is not routinely available to all patients in health facilities
(iv) Inadequate access and uptake of paediatric HIV testing and counselling
(v) Low acceptance of couple counselling and testing at the community level

The PMTCT program is working but its impact is limited; many patients drop out from the program. There is a need to raise the platform of maternal, newborn and child health (MNCH) care delivery systems to attract more women and children to health facilities and to access overall MNCH interventions including PMTCT and paediatric treatment. Interventions that address primary prevention of HIV infection among pregnant mothers and prevention of unwanted pregnancies among HIV positive mothers need to be scaled up. Current arrangements are also complex because of the number of treatment regimens and gender dimensions but the program will be simplified from July 2011 because all HIV positive pregnant women will access ART regardless of their CD4 count. Other issues and gaps in the PMTCT program include:

(i) Lack of male involvement, couple counselling, and a family centred approach in the program
(ii) Lack of involvement of traditional leaders and practitioners as motivators in PMTCT
(iii) Early infant diagnosis services have been scaled up but these services are still only available at few sites.
(iv) Infant feeding counselling is poor due to inadequately trained counsellors and lack of support from implementers
(v) Lack of follow-up of mother and child due to inadequate institutional capacity, poor community based systems, and follow up tools
(vi) Many women start antenatal care late and deliver at home- affects provision of care
(vii) Weak maternal, neonatal and a child health delivery system- this system is the platform for the delivery of PMTCT services and to attract pregnant women and their children to health services
(viii) Limited access to CD4 testing for HIV positive women to access their need for antiretroviral treatment
(ix) Inadequate tools to identify HIV exposed children at health facilities

Despite significant achievements in blood and tissue safety there are still a number of key issues which include:

(i) Shortages of blood at health care facilities
(ii) Lack of a national blood transfusion strategy
(iii) Inadequate procedures to mobilise national blood donors
(iv) Improving access to safe blood

Post exposure prophylaxis (PEP) is an important health service which is available at ART health centres but significant issues and gaps in the provision of PEP services include:

(i) Weak links between health services and law enforcement providers
(ii) Lack of awareness of PEP services resulting in low demand
(iii) Some health providers do not follow PEP guidelines

Malawi's relatively high prevalence of HIV and low prevalence of voluntary medical male circumcision (VMMC) make it an excellent candidate for VMMC programs. It has been shown to reduce men's risk of contracting HIV by 50 to 60 percent. Even in regions where high rates of HIV appear to overlap with elevated rates of traditional male circumcision, HIV is more prevalent in uncircumcised men. Importantly though, physical examinations have shown that 25 percent of men in Malawi who believe themselves to be circumcised are either uncircumcised or only partially circumcised. VMMC is an intervention which will not achieve population wide benefits

in the short term; a critical mass of between 60 and 80 percent of the general population needs to be circumcised before benefits start to accrue to women.

Condom availability is a major issue in Malawi despite it being a cornerstone of the prevention strategy. There are frequent stock-outs at different locations throughout the country and accessibility is especially difficult in rural areas for both male and female condoms. Distribution numbers also appear low; UNGASS 2010 report the distribution of about 14 million condoms in 2008 compared to Zimbabwe, which has a similar population, which distributed 95 million in the same year. Condoms are not consistently promoted and there is evidence that many more female condoms would be used if they were available[29]. Promotion of condom use to long- term discordant couples has not been a focus of condom programing to date despite the fact that more than 40 percent of new infections are estimated to occur within this group.

Malawi monitors the prevalence of syphilis through sentinel surveillance surveys. In 2007 syphilis prevalence was 1.1 percent- significantly down from the mid-1990s when it peaked at around 7 percent. The MDHS also collects information on sexually transmitted infections (STI) and an analysis of this data for 2000 and 2004 also shows a decline in self-reported STI signs and symptoms with a more pronounced decline observed in young males (from 1.7 percent to 0.6 percent) than females (from 0.9 percent to 0.4 percent). Major issues affecting STI management have been stock-outs of drugs and condoms, unwillingness of clients to access STI services due to stigma and discrimination and this, in turn, leads to late presentation to treatment.

3.3.2 Treatment

The ART program is effective and needs to be sustained and built upon including scaling up early infant diagnosis and paediatric treatment. One reason for the program's relative success is that it is not complex because treatment regimens are standardised; but this beneficial feature may be compromised with changes to CD4 count policy and more complex treatment programs. The importance of early intervention and ART is also critical as a major input into the prevention program. The overall program will be further strengthened with the integration of the PMTCT program with ART and the implementation of new integrated PMTCT and ART guidelines but a critical missing link is the integration of HIV and TB services. Other key issues which impact on the ART program include:

(i) Lack of a pre-ART package and nutrition support- patients are not followed up before they enrol and many patients present late
(ii) Lack of well-defined follow-up mechanisms, and support and referral at community level
(iii) Distance to clinics is problematic and this often contributes to late presentation, high default rates, and non-compliance to drugs and treatment
(iv) Some health centres are still not providing nutrition, care and support, and nutrition services are not integrated into ART services
(v) The number of health facilities delivering paediatric treatment is still limited compared to adult ART services

3.3.3 Care and support

Community based care programs have the opportunity to play an important role in facilitating uptake of HTC, PMTCT, and ART services. However, there is little evidence that community based programs are having an impact. Significant issues include:

(i) Lack of capacity and funding in local authorities to develop and implement programs, and train people at community level
(ii) Stock-outs of test kits and condoms at community level

[29] Malawi HIV Prevention Partners

(iii) Inadequate referrals and monitoring between communities and health centres
(iv) Lack of capacity of community service providers

3.3.4 Program management and financing

The supply chain management system used for acquiring and distributing inputs into the national response is inadequate and this often results in stock-outs of key drugs, test kits, condoms, and other critical supplies. Major weaknesses in the supply chain management system include:

(i) Inadequate forecasting, quantification, inventory management, and reporting skills and procedures of system users
(ii) Inadequate logistics management information and monitoring systems
(iii) Inadequate storage capacity at key sites
(iv) Inadequate procurement capacity within the supply chain management structure
(v) Disruptions to supply chain management and procurement resulting from challenges within and about Central Medical Stores (CMS)

Decentralised programs in the national response are currently funded through Local authorities (LCs) which access funding for HIV and AIDS programs directly from NAC through the Ministry of Local Government and Rural Development (MLGRD). LCs receive technical guidance and support from NAC but the variability of capacity at this level is an issue and, as a result, districts have faced many challenges in the preparation of District HIV and AIDS Implementation Plans (DIP). Districts have DIP budget details but not a program plans; they do not define results or reflect the use of evidence. The result is a lack of a well-coordinated district response, poor resource tracking, limited evidenced based and informed programing, inadequate monitoring, and sub-optimal intervention results at district and community levels. UNAIDS 2010[30] notes that there is inadequate district capacity to coordinate and plan for an evidenced based response due to inadequate financial resources, competing priorities, and high vacancies in District HIV and AIDS Coordinator (DAC) offices. These weaknesses at the decentralised level also impact on the effectiveness of mainstreaming efforts and the effectiveness of community programs. The importance of decentralised programs is clearly demonstrated by the fact that about 80 percent of PLHIV live in rural areas.

Health centre infrastructure is inadequate in many instances. Shortcomings include: patient and client privacy considerations, pharmacies are small and inadequate, inadequate ventilation, inadequate consultation and waiting rooms, inadequate staff housing, and poor sanitation. Inadequate health care infrastructure and facilities impact significantly on the level and quality of services supported by health centres as well as on the ability of programs to retain personnel. Problems will be exacerbated with the introduction of the integrated PMTCT and ART programme and rapid program scaling up.

A number of key implementation and governance issues emerged during the implementation of the Extended NAF which impacted on the response implementation efficiency. These are:

(i) Inadequate government stewardship to track resource utilisation, and lack of transparency and accountability for resources allocated and utilised among implementing partners.
(ii) Confusion among some key stakeholders regarding the roles and responsibilities of DNHA, the NAC, and Department of Public Sector Management (DPSM).
(iii) Unclear definition of roles and responsibilities in some sectors and among sectors at local level- reporting lines are often unclear
(iv) Technical assistance is often used to implement projects rather than for building sector capacity

[30] Assessment of Challenges and Gaps for a coordinated and evidenced informed HIV and AIDS response at the district level- December 2010

(v) Weak coordination of development partners at local authority and community level
(vi) Weak institutional and human resource capacity is compounded by few training opportunities in the public sector.

Despite the global financial crisis Malawi has maintained a funding commitment and momentum from development partners which has meant that it has been able to minimise the shortfall in resources between those received and those needed to achieve national response targets. Nevertheless, Malawi faces a number of significant financial challenges:

(i) The increase in the CD4 count threshold from 250 to 350 will mean that more people will be eligible for ART and significantly raise resource requirements for diagnostics, treatment and care
(ii) Malawi's apparent inability to significantly reduce incidence will also mean that more people will require ART and other services and increase resource needs for treatment, care, and support
(iii) Malawi's rapid population growth will place added pressure on available funds for health care and HIV and AIDS
(iv) Malawi is very dependent on donor support for the HIV program, which leaves the country vulnerable to external shocks such as the failure of the Global Fund Round 10 application
(v) Inadequate funds at district and community level to implement local programs impacts on national response effectiveness

3.3.5 Impact mitigation

Current OVC programs are working but they are supporting comparatively few children; support provided to OVC is not universal and programmes are erratically spread through the country. This is largely a function of NGO and CBO programmes targeting specific districts and the GoM's pilot cash transfer program which is currently providing support in seven districts only. As at April 2009 the number of beneficiary households was 23,560 with a population of 92,800 of which 48,000 were OVC. Approximately 70 percent of beneficiaries were HIV and AIDS affected[31]. The major issue impacting on OVC programmes is lack of capacity at district level. District Social Welfare Officers (DSWO), who are responsible for the administration of the OVC support program at the district level, are funded from the national office of the Ministry of Gender, Children and Community Development, not district councils. The program is not decentralised and DWOs lack capacity and financial resources to manage programmes at district level including the coordination of inputs from donors and organising and managing collaborative programmes.

3.3.6 Protection and empowerment of vulnerable populations

Advocacy, Information Education Communication (IEC), community and social mobilisation interventions have assisted in raising universal awareness of HIV and AIDS and they have also assisted in mobilising people to go for HTC, PMTCT, PEP and other clinical based prevention interventions. However, the intensity and quality of targeted evidenced based behaviour change communication (BCC) is low, especially in rural and difficult to reach areas where the majority of the population live. Most CBOs which conduct campaigns, community dialogue, and sensitisation activities have not been evenly or equitably distributed throughout the country. Furthermore, the information and messaging is still often generalised and not targeted towards specific audiences. More specific issues and gaps include:

(i) Most IEC materials are generic and national, they are not evidence based, they do not adequately draw on relevant theses, and they are not well targeted to specific audiences

[31] UNGASS 2010

(ii) Messages in key areas do not provide the evidence to link behaviour to risk
(iii) Messages are often monotonous and not responsive to the dynamic nature of the pandemic
(iv) Some population categories (e.g. MSM and CSW) are not targeted with comprehensive combination prevention interventions
(v) There is inadequate material and curriculum for people with disabilities

Despite progress, stigma and discrimination is still a major issue and programmes continue to focus on stigma and discrimination because of its ongoing impact on prevention efforts, treatment and care services. Current stigma and discrimination programmes, while improving, are only marginally successful[32] and it is apparent that a strengthened approach is needed to address this critical issue. Key weaknesses include:

(i) Lack of integration of stigma and discrimination prevention strategies into HIV programmes
(ii) Lack of multifaceted strategies to protect human rights and provide high quality health services.

A number of interventions on gender, culture and human rights related to HIV and AIDS have been implemented. These interventions have had some impact but the coverage and reach is still low. Specifically, involvement of men on gender promotion is still limited, engagement of traditional leaders to eliminate harmful cultural practices is limited, and laws relating to violation of PLHIV are rarely enforced. The HIV Bill has been drafted but it has not yet been enacted into law.

Progress has been made with the delivery of services to youth but there still a number of key gaps. These include:

(i) Inadequate youth friendly health services that meet required standards
(ii) Inadequate parent to adult communication skills
(iii) Lack of disclosure and discrimination against HIV positive youth
(iv) Inadequate economic empowerment of young people

Programmes and interventions have been implemented to protect and provide services to vulnerable populations[33] but there are still gaps which include:

(i) Knowledge of location and numbers of vulnerable groups
(ii) Structural barriers including a lack of a legal framework for MSM and CSW, and acknowledgement of human rights
(iii) Inadequate linkages to HIV treatment and care and HTC
(iv) Inadequate guidelines, procedures, and packages for targeted interventions.

3.3.7 Mainstreaming and linkages

HIV and AIDS mainstreaming aims to: engage and support relevant sectors in the multi-sector response; and ensure that the response is decentralised to local government and communities. Considerable progress has been made in this area and in particular: (a) the establishment of Nutrition, HIV and AIDS Units in some government ministries; (b) development and dissemination of guidelines for the implementation of the 2 percent HIV and AIDS allocation under the Other Recurrent Transactions (ORT); (c) the development and dissemination of mainstreaming conceptual framework and guidelines; (d) development of the public sector workplace policy and advocacy and training of mainstreaming facilitators; and (e) many organisations in the public sector now have HIV workplace policies and programmes facilitated by the 2 percent ORT allocation. Despite this progress, considerable on-going effort and inputs are

[32] DHS 2004
[33] Includes fishing communities, estate workers, truck drivers, uniformed personnel, teachers, people with disabilities, prisoners and mobile populations

needed to ensure mainstreaming objectives are achieved. In particular, considerable effort is needed at the district and community levels to ensure that key private and public sector partners at the district level and communities embrace the national response and to ensure that they have adequate resources to do so. Ongoing effort is also required to retain the momentum of prior year successes and to build on these successes both in rural and urban areas.

3.3.8 Research and development

Generating and dissemination of local practical evidence is fundamental to an effective national response and a lack of resources in Malawi should not prevent a practical research and development program from being implemented. The national research strategy expired in 2008 and, for HIV and AIDS; it needs to be renewed on the basis of a practical approach to delivering benefits. The most critical area for research and development is: (a) trialling new prevention, treatment and care products and procedures; (b) evaluating medicine effectiveness, reactions and resistance build-up; and (c) delivering findings to stakeholders.

3.3.9 Capacity development

Malawi has a draft National Capacity Building Strategy which needs to be finalised, approved, disseminated and implemented by key national response stakeholders. In addition, staffing levels, staff capacity, ongoing training, and supervision of health providers is a fundamental challenge. These issues will be addressed by a revue of staffing levels and the preparation and implementation of a training program framework. Staff retention in health centres is an ongoing issue as will be the numbers of new staff required for the anticipated increase in demand for services. These may be addressed, in part, with the proposed staff training program, upgrading of health care facilities, deployment of additional staff, and zonal mentoring program.

3.3.10 Monitoring and evaluation

Monitoring and evaluation systems are working and they are providing valuable inputs into the planning and management of the national response. However, as patient numbers further expand and services become more complex and integrated it is anticipated that many of the current paper based systems will become overloaded and they will be unable to be managed and operated, especially at district level. Particular gaps include:

(i) Lack of joint reviews to share lessons and best practices at local council level
(ii) Lack of joint M&E programme at local council level
(iii) A lack of knowledge as to where the last 1,000 new HIV infections occurred to inform better targeting of prevention efforts

3.4 LESSONS LEARNED

The major lessons learned during the implementation of the NAF and the Extended NAF include:

(i) Unless incidence is reduced significantly, ART for PLHIV is not sustainable in the long term at current growth rates because of lack of financial and trained human resources.
(ii) Despite the fact that there has been some improvement in knowledge in some parts of the population, available evidence suggests that current behaviour change programmes have not had the desired impact as is evidenced by the stable and relatively high incidence across the country.
(iii) Weak supply chain systems are a significant barrier to the achievement of key HIV outcomes and it is essential that national health procurement and supply chain management systems are able to deliver a continuous and reliable flow of

high quality, effective and affordable medicines and supplies in order to achieve satisfactory HIV outcomes.

(iv) As is evidenced by available data, Malawi's epidemic is concentrated on women and girls but viable gender specific programmes to address their needs are limited.

(v) Marginalised and vulnerable populations have access to available prevention, treatment, and care facilities but the national response is not adequately reaching these groups because programmes do not specifically target them with combined prevention.

(vi) Uptake of services by PLHIV is being hampered by stigma and discrimination.

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

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

(ix) Inadequate implementation and governance capacity and issues are hampering the efficient implementation of the national response.

3.5 MAIN MESSAGE

Despite considerable progress during the implementation of the NAF and Extended NAF as is clearly evidenced by the rapid scale up of the: (a) HTC program; (b) PMTCT program; (c) ART program; and other major achievements noted in the NSP, the overall program's sustainability and targets for universal access will not be attainable unless: (a) current high incidence levels are reduced significantly; (b) further program implementation efficiencies can be developed and implemented; and (c) ongoing high levels of financial support and commitment can be obtained.

4.0 NATIONAL STRATEGIC PLAN JULY 2011 TO JUNE 2016

4.1 VISION, MISSION, OVERALL GOAL, AND OBJECTIVES[34]

Vision
A healthy and prosperous nation free from AIDS

Mission
Promote quality HIV prevention, treatment, care and support services for all Malawians

Overall goal
Prevent the further spread of HIV infection, promote access to treatment for PLHIV and mitigate the health, social-economic and psychosocial impact of HIV and AIDS on individuals, families, communities and the nation.

Objectives
Specific objectives are:
(i) Prevent primary and secondary transmission of HIV
(ii) Improve the quality of treatment, care and support services for PLHIV
(iii) Reduce vulnerability to HIV infection among various population groups
(iv) Strengthen multi-sectoral and multi-disciplinary coordination and implementation of HIV and AIDS programmes
(v) Strengthen monitoring and evaluation of the national HIV and AIDS response

4.2 DURATION OF THE NATIONAL STRATEGIC PLAN

The duration of the NSP is five years, from July 2011 to June 2016.

4.3 GUIDING PRINCIPLES OF THE NATIONAL STRATEGIC PLAN

Guiding principles of the NSP are:

(i) High level government commitment, national leadership, and ownership: government commitment and support at national and district level will continue to characterise the multi-sectoral response.
(ii) Evidenced based interventions and value for money: cost effectiveness will guide the allocation of resources according to NSP priorities and available evidence.
(iii) Multi-sectoral: HIV and AIDS is a complex and multi-dimensional problem so multi-sectoral involvement is essential to national, district, and community responses.
(iv) Gender sensitivity: women and girls in Malawi are particularly vulnerable to HIV and youth and men also have their particular issues which must be addressed by gender specific interventions.
(v) District and community empowerment: resourcing districts and communities to actively participate in the national response will be critical for its success.
(vi) Human rights: the NSP will uphold human rights by promoting dignity, non-discrimination, and welfare of all people and it will promote the participation of PLHIV and affected people in the national response.

[34] National HIV and AIDS Policy (September 2011)

(vii) Three ones principle: implementation of the national response will be coordinated by one organisation; there will be one strategic plan, and one monitoring and evaluation framework.
(viii) Universal access: will be promoted for all HIV and AIDS services.
(ix) Good governance, transparency, and accountability: is required at all levels for the effective management of the national response.

4.4 NATIONAL STRATEGIC PLAN PRIORITY AREAS

Priority areas have been established according to need, potential impact, and cost effectiveness. Key priority areas are noted immediately below and these, and additional priority areas, are detailed in Section 4.6 below according to their thematic areas. Key high priorities are:

(i) Reducing incidence by scaling up evidenced based prevention interventions and improving the coverage and effectiveness of ART
(ii) Scale up quality treatment, care and support for PLHIV to reduce the impact of HIV and AIDS
(iii) Improving national program implementation efficiency to help deliver an effective national response

4.5 STRATEGIC FRAMEWORK

The results framework of the NSP is based on the goals, objectives, strategies, and strategic actions as described in Section 4.6 below for the years 2011 to 2016. It links expected results with indicators and targets in a single Results-Based Framework. Indicators from the national M&E plan are aligned to the results of the NSP's objectives, strategies, and action areas. The results framework in ***Annex 1***.

4.6 STRATEGIC THEMES, STRATEGIES, AND STRATEGIC ACTIONS

The strategies and strategic actions have been arranged according to the nine thematic areas outlined in Section 1, which were derived from the National HIV and AIDS Policy (September 2011) and strategic priorities. Strategies within each specific thematic area are grouped according to their priority- either high priority or standard priority. High priority strategies are enclosed in boxes. Strategies and strategic actions have been derived after due consideration of available evidence, the situation analysis, response analysis, and lessons learned outlined above and these have been reviewed by all key stakeholders.

It is inevitable that there is some overlap between some strategies included in the HIV and AIDS NSP and some strategies noted in the Health Sector Strategic Plan. Despite this overlap it is critical that all strategies relating to HIV and AIDS be embraced in one comprehensive HIV and AIDS specific document[35]; the NSP.

4.6.1 Strategic Theme 1- Prevention

Goal
Reduce new HIV infections in order to further mitigate the burden and impact of HIV and AIDS in Malawi

Objective

[35] Costs for these overlapping elements have been included in the NSP cost estimate

Reduce HIV incidence- new infections reduced by 20 percent by 2016[36]

Theme 1 PREVENTION- <u>High Priority</u>

Strategy 1.1 Reduce HIV transmission between heterosexual couples and reduce the number of people who are multiple and concurrent heterosexual partners.

Strategic actions

(i) Implement specific strategies detailed in the National HIV Prevention Strategy which target couples of all age groups which: (a) aims to reduce multiple and concurrent sexual partners among adults and youth; and (b) reduces HIV transmission between couples.

(ii) Integrate programmes for discordancy and multiple and concurrent partners with other prevention programmes, especially HTC for both partners.

(iii) Integrate behaviour change messages and referrals within counselling services.

(iv) Provide guidelines and training to HTC counsellors, NGOs, and other stakeholder to assist counselling and sex education to couples of all ages and ensure integration of prevention and referral within counselling.

(v) Review, revise and launch multimedia campaigns targeting mutual faithfulness.

Strategy 1.2 Provide universal HIV testing and counselling focusing on services for young people, couples and other MARP

Strategic Actions

(i) Develop and implement specific HTC strategies which target most at risk groups and couple counselling.

(ii) Develop and implement regular and focussed training programmes for existing and new testing and counselling personnel.

(iii) Scale up staffing in existing clinics as required.

(iv) Open new testing sites and mobile clinics as demand for increased service coverage.

(v) Ensure the availability of test kits, condoms, and IEC material at HTC facilities including community based facilities (HTC delivery points).

(vi) Develop and implement follow-up procedures to ensure all tested people know their status.

(vii) Develop effective M&E tools and supervision procedures to ensure the provision of quality HIV testing and counselling services.

(viii) Integrate HTC services with other health services including provider initiated testing and counselling (PITC).

Strategy 1.3 Target young people with interventions specifically developed to reduce HIV incidence in both young females and males.

Strategic actions

(i) Develop a minimum prevention package for different age groups for both young females and males.

(ii) Develop programmes which specifically target adolescent behaviour including: (a) intergenerational sex; (b) alcohol and other drug abuse; and (c) high risk sex.

(iii) Prepare and implement BCC programmes which specifically target different age bands for both males and females and address access to commodities and referral to relevant services.

(iv) Develop programmes to ensure that service delivery points are youth friendly.

[36] Children's new infections reduced by 30 percent, adult new infections reduced by 15 percent, and EMTCT < 5 percent.

(v) Retrain teachers and outreach people on programmes which specifically target different age groups and sex.
(vi) Promote abstinence as a prevention tool.
(vii) Monitor program effectiveness and adjust as needed.

Strategy 1.4 Scale up voluntary medical male circumcision (VMMC) and neonatal circumcision

Strategic actions

(i) Strengthen capacity of MoH to provide leadership for VMMC at national and district level.
(ii) Finalise the national male circumcision communication strategy.
(iii) Develop and implement a national scale-up plan for VMMC and neonatal male circumcision, which will include a plan to generate demand.
(iv) Strengthen linkages and referral between HTC and VMMC services.
(v) Prepare and implement an intensive VMMC pilot program in a high prevalence district which utilises a mobile clinic and existing health care facilities.
(vi) Based on results of the pilot program scale up VMMC services through Models of Optimising Volumes and Efficiency (MOVE) facilities.
(vii) Provide support and supervision, including M&E to all VMMC service delivery sites including quality assurance mechanisms.
(viii) Conduct operational research and M&E to improve the quality VMMC services which will include post-operative care and sustained risk reduction strategies.
(ix) Develop and implement neonatal circumcision program across all districts.

Strategy 1.5 Reduce paediatric infections by increasing access to an effective PMTCT program[37]

Strategic Actions

(i) See strategies 1.1 (Reduce HIV transmission between heterosexual couples), 1.2 (Provide universal HIV testing and counselling), and 1.3 (Target young people with interventions specifically developed to reduce HIV incidence).
(ii) See strategies 1.6 (Supply male and female condoms), and 1.9 (Prevent unwanted pregnancies among women living with HIV).

Strategy 1.6 Supply male and female condoms to all national response programmes and ensure continuous availability to all members of the community

Strategic Actions

(i) Develop and implement a strategy to integrate free condom distribution throughout the country and to all national response programmes including traditional and non-traditional distribution outlets.
(ii) Integrate condom procurement and distribution into the national supply chain system.
(iii) Develop and implement BCC and IEC programmes targeting specific community groups, which will aim to increase the number of people who correctly and consistently use condoms.
(iv) Implement the public sector marketing plan.
(v) Procure and distribute condoms.
(vi) Strengthen monitoring and evaluation system, which will focus on providing better distribution, reducing stock-outs and increasing condom usage.

[37] Strategic actions designed to achieve outcomes under Prong 1 which is to prevent HIV among women of reproductive age within services related to reproductive health; and Prong 2 which is to provide counselling and support, and contraceptives to women living with HIV.

Strategy 1.7 Develop and disseminate effectively targeted and interactive behavioural and social change communication initiatives.

Strategic Actions

(i) Review effectiveness of existing BCC programmes and revise BCC strategy which targets specific groups of the population especially women, youth, PLHIV, MARPS and other vulnerable groups for HIV and AIDS and STIs.
(ii) Develop and implement training programmes for key stakeholders who will, in turn, develop and implement BCC programmes.
(iii) Competitively select stakeholders to implement BCC programmes including the distribution of material and other messages to existing national response programmes.
(iv) Strengthen the role of the media in prevention activities.
(v) Monitor BCC program effectiveness on an ongoing basis and make adjustments as needed.

Strategy 1.8 Reduce transmission of and morbidity from sexually transmitted infections

Strategic Actions

(i) Review and strengthen national guidelines for the identification and treatment of STIs.
(ii) Integrate STI testing and treatment into the national response program and ensure availability of test kits, drugs, and condoms in health centres.
(iii) Develop and implement an STI capacity building program for key health workers.
(iv) Where possible follow up STI patients to ensure treatment is completed and HIV status is known for both partners.

Strategy 1.9 Prevent unwanted pregnancies among women living with HIV

Strategic Actions

(i) Promote modern family planning methods among HIV infected women and men.
(ii) Strengthen the integration of HIV testing and counselling in family planning services.
(iii) Promote male involvement in family planning.
(iv) Ensure the availability of male and female condoms to all PLHIV.

Strategy 1.10 Provide timely access to ART (as a prevention tool)

Strategic Actions

(i) Strengthen national pre-ART program to ensure that people testing positive receive regular follow up care.
(ii) Scale up access to periodic CD4 and viral load testing so that PLHIV can initiate treatment at earlier stages.

Theme 1- Prevention- <u>Standard Priority</u>

Strategy 1.11 Prepare and implement prevention programmes which specifically target most at risk populations[38], and vulnerable groups[39]

Strategic actions- MSM

(i) Develop procedures, guidelines, and minimum packages for interventions to reach MSM.

[38] MSM and sex workers
[39] Includes fishing communities, estate workers, truck drivers, uniformed personnel, teachers, people with disabilities, prisoners, and mobile populations

(ii) Identify the locations and numbers of MSM to reach and their health needs.
(iii) Scale up a comprehensive risk reduction package of combination prevention interventions in high prevalence geographic areas.
(iv) Strengthen linkages to HIV prevention and treatment, and HTC services.
(v) Create an enabling environment for the implementation of an effective strategy.

Strategic actions- sex workers

(i) Develop procedures, guidelines, and minimum packages for interventions to reach sex workers.
(ii) Identify the number and location of sex workers to reach and their health and economic needs.
(iii) Scale up comprehensive risk reduction package of combination prevention and behaviour change interventions for sex workers in high prevalence geographic areas.
(iv) Provide an enabling environment for sex workers to protect themselves.
(v) Strengthen availability, access and distribution of female and male condoms and appropriate education programmes within hotspots.
(vi) Strengthen linkages to HIV prevention, treatment and HTC services.
(vii) Create an enabling environment for the implementation of an effective strategy.

Strategic actions- vulnerable populations

(i) Develop procedures, guidelines, and minimum packages for interventions to reach vulnerable populations including released prisoners.
(ii) Map priority intervention areas in targeted districts for vulnerable groups.
(iii) Strengthen referrals and linkages to HIV prevention, treatment, care and support services for fishing communities, estate workers and their families.
(iv) Deliver integrated gender sensitive and gender transformative social and behaviour change communication
(v) Deliver free condoms as part of the comprehensive HIV prevention package to identified vulnerable populations.
(vi) Ensure that vulnerable populations have access to male and female condoms.
(vii) Strengthen linkages to HIV prevention, treatment and HTC services.

Strategy 1.12 Promote Prevention with Positives (PwP) interventions

Strategic actions

(i) Review and revise existing guidelines relating to targeting gender specific prevention interventions in all settings.
(ii) Develop and deliver gender differentiated PwP interventions in all service points that offer HTC, PMTCT, ART and the community.
(iii) Promote PwP among PLHIV.

Strategy 1.13 Deliver effective early infant diagnosis programmes.

Strategic Actions

(i) Strengthen and scale up early infant diagnosis (EID) in all districts including training for key personnel in district health centres and effective referral procedures.
(ii) Strengthen follow-up of HIV-exposed infants and HIV positive children.
(iii) Promote follow-up and support to care givers for program adherence.
(iv) Promote community mobilisation on EID.

Strategy 1.14 Prevent HIV infections from unintended exposure to blood and other body fluids (PEP).

Strategic Actions

(i) Ensure most at risk populations, including rape and accident victims, are aware of the availability of PEP service.

(ii) Strengthen capacity in PEP to service providers and other institutions including communities.
(iii) Ensure the availability of PEP kits in all health centres and other locations where risk of infection is high.
(iv) Develop a rape strategy and response guidelines.
(v) Promote community sensitization on PEP.
(vi) Print and disseminate the National Blood Policy

Strategy 1.15 Prevent HIV transmission through blood, blood products and invasive procedures

Strategic Actions

(i) Develop and implement national blood transfusion strategy.
(ii) Ensure adequate screening of blood according to national screening and quality assurance standards.
(iii) Promote infection prevention and waste management in the health service.
(iv) Strengthen mobilisation of national blood donors.
(v) Strengthen blood transfusion services to improve access to safe blood.

4.6.2 Strategic Theme 2- Treatment Care and Support

Overarching Strategic Theme 2 Goal

Reduce morbidity and mortality of HIV related illnesses in adults and children

Strategic Theme 2A- Treatment

Objective

To increase access to a continuum of HIV and AIDS treatment to a target of 446,000 adults and 50,000 children receiving ART treatment by 2016

Theme 2A- Treatment- <u>High Priority</u>

Strategy 2.1 Scale up availability of high quality ART services

Strategic actions

(i) Strengthen the capacity of implementing agencies to manage ART scale up.
(ii) Expand provision of integrated pre-ART, PMTCT, ART, and OI services.
(iii) Deliver an effective and gender sensitive ART program according to WHO guidelines, which encourages male involvement.
(iv) Develop and implement regular training programmes: (a) for existing and new personnel, which will focus on quality service delivery and integrated PMTCT and ART services; and (b) community groups who will assist with mother/child follow-up and promotion of health service delivery.
(v) Review staffing levels at existing facilities and increase with trained personnel as needed as flagged in the HSSP.
(vi) Procure and supply ARV drug regimens and other drugs and commodities for ART, and OI to all service outlets.
(vii) Strengthen medical record keeping and drug stock management for the HTC, pre-ART, PMTCT, ART, and OI programmes in all locations and harmonise activities with Strategy 2.3, which focuses on improving the efficiency of supply chain management services.
(viii) Develop and implement a strategy to improve treatment retention and drug adherence among PMTCT, ART/OI and STI clients.
(ix) Strengthen TB and HIV integration, especially in pre-ART and ART programmes.
(x) Establish and support mentoring teams to provide mentorship on integrated ART, PMTCT/HTC/pre-ART/TB/STI/FP care.

(xi) Provide incentives for retention of professional health workers and HSAs to enable scale up health service delivery for HIV and AIDS care and treatment.
(xii) Promote the philosophy of ART being an integral part of the prevention program.

Strategy 2.2 Scale up availability of high quality PMTCT services[40]
Strategic actions
(i) Strengthen the capacity of implementing agencies to manage paediatric services scale up.
(ii) Deliver an effective and gender sensitive PMTCT program according to WHO guidelines which encourages male involvement.
(iii) Review staffing levels at existing facilities and top up with trained personnel as needed as flagged in the HSSP.
(iv) Procure and supply PMTCT drug regimens and other drugs and commodities for PMTCT, and OI to all service outlets.
(v) Strengthen coordination between maternal and newborn health.
(vi) See Strategies- 1.13 (Deliver effective early infant diagnosis), 2.4 (Improve nutritional status of PLHIV) and 2.5 (Improve access to quality community home based care and support services).

Theme 2A- Treatment- <u>Standard Priority</u>

Strategy 2.3 Implement a national pre-ART action plan
Strategic Actions
(i) Develop and implement a national pre-ART action plan.
(ii) Scale up and promote quality pre-ART services.
(iii) Promote timely initiation of ART.
(iv) Scale up implementation of new ART guidelines.

Strategic Theme 2B- Care and Support

Objective
To increase access to a continuum of HIV and AIDS services to PLHIV and their dependants.

Theme 2B- Care and Support- <u>High Priority</u>

Strategy 2.4 Improve nutritional status of PLHIV
Strategic Actions
(i) Scale up nutrition care, support and treatment services in all ART sites.
(ii) Strengthen nutrition counselling service for HIV infected adults, infants and children.
(iii) Strengthen institutional and technical capacity for provision of quality nutrition care, support and treatment services including support groups.
(iv) Provide ready to use therapeutic food to the eligible infants, children and adults living with HIV.
(v) Fortify complementary food with micronutrients.
(vi) Integrate infant feeding with PMTCT services.

[40] Strategic actions designed to achieve outcomes under Prong 3 which is to ensure availability of HIV testing and counselling and access to ART drugs to prevent transmission from HIV positive pregnant women to their babies during pregnancy, delivery, and breastfeeding, and Prong 4 is to provide HIV care, treatment and support for women and children living with HIV and AIDS and their families

Theme 2B- Care and Support- Standard Priority

Strategy 2.5 Improve access to quality community home based care (CHBC) and support services

Strategic Actions

(i) Improve access to psycho-social support and quality palliative care for terminally ill patients.
(ii) Scale up quality community home based care models.
(iii) Strengthen systems of referral, follow up, monitoring and evaluation between community and health facility services.
(iv) Strengthen integration of palliative care in the already existing CHBC network.
(v) Strengthen the capacity of community service providers in home based care services.
(vi) Integrate palliative care into the pre-service curriculum of nursing and medical institutions.

4.6.3 Strategic Theme 3- Comprehensive Multisectoral and Multi – Disciplinary Response to HIV and AIDS

Goal

An effective and sustainable multi-sectoral national response to HIV and AIDS

Objective

Deliver effective management, coordination, and service delivery of HIV and AIDS interventions at national, local council, and community level.

Theme 3- Comprehensive Multisectoral and Multi –Disciplinary Response to HIV and AIDS - High Priority

Strategy 3.1: Improve program management and coordination efficiency at national, local council and community level

Strategic Actions

(i) Undertake an efficiency audit of current implementation arrangements including roles and capacity of lead institutions, local authorities, and community based organisations.
(ii) Strengthen institutional, financial and technical capacity, including issues of accountability, transparency, good governance, management, coordination structures and personnel according to audit recommendations.
(iii) Strengthen capacity of stakeholders to access and effectively utilise local funding.
(iv) Re-enforce implementation of ORT allocation for HIV and AIDS activities in the public sector.
(v) Develop a strategy and program for the integration of the HIV response with other health services.
(vi) Provide financial, material, and technical support to stakeholders.
(vii) Strengthen the capacity of NAC to provide national leadership for the implementation of HIV prevention, treatment and care and particularly strengthen its capacity to address gender, decentralisation and community based interventions.
(viii) Strengthen the capacity of service providers for management and coordination of HIV prevention, treatment, care and support services.
(ix) Strengthen the capacity of key civil society networks and coalitions in health policy analysis.

(x) Prepare HIV and AIDS Annual Work Plans and assist Local authorities with annual HBIV and AIDS planning.

Strategy 3.2: Secure adequate funding to ensure that national response can be implemented

Strategic Actions

(i) Appoint a NAC led, adequately resourced, finance committee comprising key stakeholders and specifically skilled personnel to prepare a resource mobilisation strategy, which would cover potential funding and other resources from: (a) the international community; (b) national level including government and the private sector; (c) district level stakeholders; and (d) communities.

(ii) Implement resource mobilisation strategy with the highest priority.

Strategy 3.3: Develop human and infrastructure capacity of Central Medical Stores (CMS) and providers of other supply chain services to deliver drugs, services, and other inputs efficiently

Strategic Actions

(i) Undertake audit of procurement and supply chain management systems including the procurement and delivery of drugs, test kits, condoms and other supplies and the delivery of specimens to laboratories for testing.

(ii) Develop strategy and program and secure resources to strengthen supply chain services according to audit recommendations, which will specifically include the integration of services included in the national response.

(iii) Build capacity of health care workers who have input into the supply chain management system including the rational use of medicines by carers and users.

(iv) Strengthen logistics management information systems and design and implement an effective supply chain management monitoring system.

(v) Strengthen mechanisms for the quantification and forecasting of key drugs, commodities and supplies.

(vi) Improve storage capacity for drugs, commodities and supplies at key distribution points including district health centres.

(vii) Improve inventory management of medicines and medical supplies at all levels including district health centres and communities.

(viii) Accelerate the transformation of CMS into a Trust.

(ix) Develop national procurement capacity and procure inputs for the national response.

Strategy 3.4 Expand the infrastructure and human capacity for health facilities to meet the needs of the national response

Strategic actions

(i) Prepare guidelines for a review of health centre infrastructure and staffing levels.

(ii) Undertake review of all health centres and hospitals which will include but not be limited to: (a) size, adequacy, and layout of buildings to provide integrated services- clinics, counselling rooms, and waiting areas; (b) suitability of privacy provisions of layout; (c) ventilation; (d) water and sanitation; (e) pharmacy facilities; (f) equipment such as drug cupboards, medical equipment, refrigeration if required and if electricity available; (g) staff numbers and training levels; (h) availability of treatment and care manuals and guidelines.

(iii) Implement prioritised program.

Strategy 3.5	***Develop the capacity of local authorities to plan, implement and monitor local responses to HIV and AIDS at district and community levels***

Strategic Actions

(i) Review and update the Guidelines for Local Authority Response to HIV and AIDS in Malawi (2004) into a comprehensive evidenced based planning tool, which will include guidelines and checklists for local communities and guidelines for the inclusions of HIV and AIDS programmes into local development programmes.
(ii) Train local authorities to plan, implement and monitor HIV and AIDS activities in districts and communities using informed evidence.
(iii) Train local authorities to train communities so that they can implement local authority initiated programmes at the community level.
(iv) Support local authorities with necessary resources to coordinate the response at the local level.

Strategy 3.6	***Support the National AIDS Commission to oversee program implementation.***

Strategic Actions

(i) Support program coordination.
(ii) Provide inputs into program support.
(iii) Provide resources for institutional costs

Theme 3- Comprehensive Multisectoral and Multi –Disciplinary Response to HIV and AIDS – <u>Standard Priority</u>

Strategy 3.7 ***Develop capacity of laboratory services to provide timely and accurate support to the HIV and AIDS program***

Strategic Actions

(i) Increase laboratory human resource capacity through revised pre and in-service training programmes.
(ii) Improve quality of laboratory services through training, external quality assurance (EQA), and good clinical laboratory practice.
(iii) Strengthen the national reference laboratory to coordinate and implement an integrated national EQA system.
(iv) Strengthen laboratory infrastructure to support scale up of HIV programmes.
(v) Strengthen laboratory supply chain management practices to attain commodity security.
(vi) Establish and regularise Sample Transport System and referral reporting system.
(vii) Strengthen laboratory IT infrastructure and capacity.

4.6.4 <u>Strategic Theme 4</u>- Impact Mitigation

Goal

Mitigate the socio-economic impact of HIV and AIDS on individuals, households, communities, institutions and the nation at large.

Objective

Improve provision of impact mitigation services to individuals and households affected by HIV and AIDS

Theme 4- Impact Mitigation – High Priority

Strategy 4.1 Provide all OVC, adolescents, PLHIV, and their families with services which will mitigate the impact of HIV and AIDS
Strategic Actions (i) Strengthen referral systems so that OVC, their guardians, affected adolescents and PLHIV are aware of available services. (ii) Scale up social cash transfers and linkages to other social support services to compensate for loss of income due to HIV and AIDS. (iii) Promote business development services and strengthen linkages with financial services (microfinance and social insurance schemes), as well as employment related training. (iv) Strengthen the provision of comprehensive support (including education support) to OVC and other vulnerable groups. (v) Promote food and nutrition security interventions for OVC, adolescents and PLHIV. (vi) Strengthen alternative care systems (e.g.) CBCC, children's corners, and institutional care. (vii) Develop specific training and employment support programmes to assist adolescents integrate into the community.

4.6.5 Strategic Theme 5- Protection, Participation and Empowerment of PLHIV and Other Vulnerable Populations

Goal
Protect human rights, fundamental freedoms and human dignity for all HIV affected people.

Objective: Provide a conducive environment so that the rights of PLHIV and affected people can be protected and take advantage of available services.

Theme 5- Protection, Participation and Empowerment of PLHIV and Other Vulnerable Populations - High Priority

Strategy 5.1 Reduce stigma and discrimination in all settings
Strategic actions (i) Strengthen national capacity to challenge and address HIV related stigma and discrimination to improve uptake of services. (ii) Develop and implement mechanisms for integration of persons affected with HIV and AIDS to effectively participate in economic and productive sectors.

Strategy 5.2 Promote gender sensitivity in all program interventions
Strategic actions (i) Facilitate the implementation of the National Gender Policy. (ii) Develop and implement gender specific prevention programmes. (iii) Sensitise health providers on gender specific needs (iv) Incorporate specific gender related topics into all national response training programmes.

Theme 5- Protection, Participation and Empowerment of PLHIV and Other Vulnerable Populations - Standard Priority

Strategy 5.3 Promote a legal and policy environment that protects, upholds and respects human rights and dignity of PLHIV

Strategic Actions

(i) Expedite enactment of HIV and AIDS-related legislation that protects human rights, freedoms, and responsibilities.
(ii) Ensure timely review and dissemination of legislation and policies that affect rights of PLHIV.
(iii) Promote media coverage on issues affecting rights of PLHIV.
(iv) Ensure creation of conducive environment for reporting cases of violations of HIV and AIDS related human rights.
(v) Ensure monitoring of HIV and AIDS human rights-related violations.
(vi) Facilitate the provision of legal assistance and legal remedies to PLHIV and vulnerable populations.
(vii) Ensure review and modification of harmful cultural practices that facilitate the spread of HIV infection.

Strategy 5.4 Facilitate effective participation of vulnerable people in decision making, designing, implementing, monitoring, and evaluating HIV and AIDS programmes

Strategic Actions

(i) Develop and implement policy, guidelines and mechanism for the engagement of PLHIV and vulnerable populations on participation in the national response.
(ii) Strengthen capacity of PLHIV and others to effectively participate.
(iii) Monitor effectiveness of participation by PLHIV.

Strategy 5.5 ***Promote access to and delivery of HIV and AIDS services and other services provided by the public and private sectors to PLHIV***

Strategic Actions

(i) Ensure service providers and PLHIV are aware of the rights and responsibilities of PLHIV.
(ii) Develop and implement public programmes that advocate for elimination of all forms of discrimination against PLHIV and other vulnerable populations.

Strategy 5.6 Advocate for the enforcement of legal and social rights of PLHIV, OVC and other affected people

Strategic Actions

(i) Advocate for laws and policies that promote greater involvement of PLHIV in governance and leadership.
(ii) Advocate for the enactment of legislation that protect men, boys, women and girls from being vulnerable to HIV infection.
(iii) Advocate for the enactment of legislation that eliminates all forms of gender-based violence.

4.6.6 Strategic Theme 6- Mainstreaming and Linkages

Goal
HIV and AIDS programmes of all affected public and private sectors and stakeholders are linked and provide synergised outcomes.

Objective
Provide networking and effective partnerships in the national response

Theme 6- Mainstreaming and Linkages - <u>High Priority</u>

Strategy 6.1. Integrate HIV and AIDS programmes into the policies, workplaces and core businesses of all public and private enterprises.

Strategic Actions

(i) Review and revise national mainstreaming programmes and strategies.
(ii) Strengthen HIV and AIDS management and coordination in the public and private sectors.
(iii) Ensure HIV and AIDS is mainstreamed in sectoral, organisational policies, strategies and core businesses according to national policy and strategy.
(iv) Scale up HIV and AIDS workplace interventions in all sectors including the informal and private sector.
(v) Provide training and IEC material to key workplace partners to ensure effective participation in the program.
(vi) Monitor implementation and effectiveness of workplace programmes.

4.6.7 <u>Strategic Theme 7</u>- Sustaining National HIV and AIDS Research Agenda

Goal
Research contributes to the implementation of evidence based programmes and interventions in the national response.

Objective: Generate evidence to support the development and implementation of high impact interventions and programmes in the national response.

Theme 7- Sustaining National HIV and AIDS Research Agenda – <u>Standard Priority</u>

Strategy 7.1 Provide sufficient evidence to warrant high impact interventions and programmes in the national response

Strategic Actions

(i) Determine key informational requirements for the national response which can be delivered by research programmes.
(ii) Prepare a prioritised program which identifies research needs (including social research) and institutions and others who can assist with the delivery of research information.
(iii) Brief research community on the needs of the national response and hold regular briefing and debriefing seminars for research stakeholders.
(iv) Test new prevention, treatment, care products and procedures as they relate to the Malawi context.

(v) Disseminate research findings to development partners, service providers and communities.
(vi) Monitor the effectiveness of research which has been placed into the national response program.
(vii) Harmonise and coordinate national research effort.
(viii) Provide research funds to research institutions.

4.6.8 Strategic Theme 8- Capacity Development

Goal
A well-equipped public and private sector with adequate capacity

Objective: Adequate capacity in all sectors to enable the efficient and effective implementation of the national response

Theme 8- Capacity Development - High Priority

Strategy 8.1.1: Equip the private and public sectors so they can effectively participate in the implementation of the national response
Strategic actions (i) Disseminate the National Capacity Building Strategy, advocate for its adoption and implementation by key stakeholders. (ii) Review staffing level findings from health centre assessment undertaken as part of Theme 3. (iii) Determine key impact and priority areas for the national response and determine staffing needs of each to enable national response to be effectively implemented. (iv) Review current training requirements and programmes for staff and for staff to be hired to bring numbers to required levels. (v) Prepare training program framework for new and existing health centres, supply chain, administrative personnel, support staff and communities at national, regional and community level. (vi) Recruit and train additional staff as required. (vii) Train existing staff according to the provisions of the training program framework.

4.6.9 Strategic Theme 9- Monitoring and Evaluation

Goal
M&E effectively contributes to the implementation of evidence based programmes and interventions in the national response.

Objective: Generate and disseminate reliable and timely strategic information on HIV and AIDS to facilitate the implementation of the national response.

Theme 9- Monitoring and Evaluation - High Priority

Strategy 9.1 Strengthen capacity to monitor and evaluate the national response at national, district and community levels.
Strategic actions (i) Assess information technology equipment and software requirements at all HIV and AIDS data sources. (ii) Review the national HIV and AIDS M&E system according to needs. (iii) Mentor zonal and district level staff in basic IT, database management and M&E.

(iv) Review and harmonise implementing partners' M&E systems with the national HIV and AIDS M&E system.
(v) Introduce M&E and operational research modules at all tertiary levels of training.
(vi) Provide standard basic training for M&E personnel at all levels.
(vii) Conduct integrated biological & behavioural surveillance of targeted high risk and vulnerable populations to support the national prevention program.
(viii) Conduct population size estimation and biological and behavioural surveillance among MSM and sex workers.
(ix) Conduct service provision assessment.
(x) Review and harmonise key data source M&E data bases.
(xi) Review and implement data quality protocols.
(xii) Improve monitoring of adverse drug side effects, drug resistance and monitor the timely delivery of program inputs.
(xiii) Disseminate strategic information.

Strategy 9.2 Develop and maintain effective HIV and AIDS information systems

Strategic actions

(i) Strengthen M&E capacity for the HIV and AIDS Department of MoH.
(ii) Mentor MoH zonal and district level staff in database management and general IT skills.
(iii) Train medical records clerks in the data collection tools and registers.
(iv) Review tools and systems currently in place for collecting, analysing and reporting male circumcision data and implement improvements.
(v) Review Family Planning M&E tools.
(vi) Develop and implement integrated pre-ART, ART and PMTCT M&E tools.
(vii) Provide financial support for upgrading HIV and AIDS Department websites.
(viii) Undertake routine data quality audits for all HIV and AIDS services provided by the national response.

5.0 NATIONAL STRATEGIC PLAN (2011-2016) COSTING

Table 5.1 below provides a summary of the cost of the National Strategic Plan for the programme's five year implementation period.

	Table 5.1 Cost Summary by Theme and Strategy (US$ million)	2011/12	2012/13	2013/14	2014/15	2015/16	Total	%
	Estimated NSP Program Cost (US$ million)	**193.43**	**226.18**	**265.86**	**300.63**	**316.57**	**1,302.66**	**100.0%**
	Percent of Total Five Year Program	**15%**	**17%**	**20%**	**23%**	**24%**		
1	**Prevention**	**29.35**	**34.29**	**46.14**	**56.65**	**61.07**	**227.50**	**17.5%**
1.1	Reduce HIV transmission between heterosexual couples	0.77	0.62	0.48	0.42	0.42	2.71	0.2%
1.2	Provide universal HIV testing & counseling	20.43	20.12	22.16	25.08	25.62	113.40	8.7%
1.3	Target young people with interventions	0.03	0.14	1.03	1.03	1.03	3.24	0.2%
1.4	Scale up VMMC & neonatal circumcision	4.83	8.61	16.61	24.64	28.08	82.76	6.4%
1.5	Reduce Paediatric infections by access to effective PMTCT	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
1.6	Supply male and female condoms to all programmes	0.00	0.15	0.10	0.10	0.10	0.45	0.0%
1.7	Disseminate behaviour and social change initiatives	0.15	0.25	0.22	0.22	0.22	1.06	0.1%
1.8	Reduce transmission of and morbidity from STI	0.03	0.00	0.00	0.00	0.00	0.03	0.0%
1.9	Prevent unwanted pregnancies among PLHIV	0.02	0.01	0.01	0.01	0.01	0.05	0.0%
1.10	Provide timely access to ART	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
1.1	Implement prevention programmes for MARP	1.64	2.47	2.92	2.89	3.30	13.23	1.0%
1.1	Promote prevention with positives	0.00	0.00	0.03	0.00	0.00	0.03	0.0%
1.1	Deliver EID programmes	0.42	0.88	1.56	1.21	1.21	5.28	0.4%
1.1	Prevent infections from unintended exposure	0.12	0.13	0.13	0.15	0.17	0.70	0.1%
1.2	Prevent HIV transmission through blood products,	0.92	0.91	0.91	0.91	0.91	4.57	0.4%
2	**Treatment Care and Support**	**111.84**	**131.24**	**158.41**	**176.11**	**187.49**	**765.09**	**58.7%**
2 A	**Treatment**	**91.31**	**104.44**	**126.66**	**142.37**	**152.31**	**617.09**	**47.4%**
2.1	Scale up availability of high quality ART services	78.40	94.61	116.63	132.19	142.03	563.87	43.3%
2.2	Scale up availability of high quality PMTCT services	12.92	9.80	10.03	10.18	10.28	53.20	4.1%
2.3	Implement a national pre-art action plan	0.00	0.03	0.00	0.00	0.00	0.03	0.0%
2 B	**Care and support**	**20.53**	**26.80**	**31.75**	**33.74**	**35.18**	**148.00**	**11.4%**
2.4	Improve nutritional status of PLHIV	19.12	24.61	29.01	31.48	32.92	137.15	10.5%
2.5	Improve access to quality community based care	1.41	2.19	2.73	2.26	2.26	10.85	0.8%
3	**Multisectoral and multi disciplinary response**	**10.19**	**10.68**	**10.66**	**10.96**	**10.75**	**53.24**	**4.1%**

	Table 5.1 Cost Summary by Theme and Strategy (US$ million)	2011/12	2012/13	2013/14	2014/15	2015/16	Total	%
3.1	Improve program management & coordination	0.53	0.70	0.86	0.81	0.78	3.68	0.3%
3.2	Secure funding to implement national response	0.03	0.01	0.01	0.01	0.01	0.06	0.0%
3.3	Develop capacity of CMS & other supply chain services	0.56	0.76	0.67	0.69	0.51	3.20	0.2%
3.4	Expand infrastructure & human capacity of health facilities	0.00	0.03	0.00	0.00	0.00	0.03	0.0%
3.5	Develop local authority capacity	0.10	0.20	0.10	0.10	0.10	0.61	0.0%
3.6	Support NAC to oversee program implementation	8.81	8.81	8.81	8.81	8.81	44.05	3.4%
3.7	Develop capacity of laboratory services	0.15	0.17	0.21	0.54	0.54	1.62	0.1%
4	**Impact mitigation**	**40.17**	**46.69**	**47.00**	**53.11**	**53.18**	**240.15**	**18.4%**
4.1	Provide affected people with services to mitigate impact	40.17	46.69	47.00	53.11	53.18	240.15	18.4%
5	**Protection, Participation & empowerment of PLHIV**	**0.19**	**0.39**	**0.60**	**0.65**	**0.76**	**2.59**	**0.2%**
5.1	Reduce stigma and discrimination	0.08	0.15	0.15	0.13	0.15	0.66	0.1%
5.2	Promote gender sensitivity in all program interventions	0.00	0.12	0.20	0.30	0.40	1.02	0.1%
5.3	Promote a protective environment for PLHIV	0.08	0.06	0.08	0.06	0.08	0.38	0.0%
5.4	Facilitate participation of vulnerable people in programmes	0.03	0.06	0.05	0.05	0.03	0.22	0.0%
5.5	Promote PLHIV access to services	0.00	0.00	0.11	0.10	0.10	0.31	0.0%
5.6	Advocate for enforcement of legal and social rights of PLHIV	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
6	**Mainstreaming & linkages**	**0.00**	**0.90**	**1.24**	**1.30**	**1.52**	**4.96**	**0.4%**
6.1	Integrate HIV & AIDS programmes into all enterprises	0.00	0.90	1.24	1.30	1.52	4.96	0.4%
7	**Sustaining National HIV and AIDS Research**	**1.51**	**1.51**	**1.52**	**1.51**	**1.51**	**7.55**	**0.6%**
7.1	Provide evidence to warrant high impact interventions	1.51	1.51	1.52	1.51	1.51	7.55	0.6%
8	**Capacity Development**	**0.03**	**0.01**	**0.00**	**0.00**	**0.00**	**0.03**	**0.0%**
8.1	Equip private and public sectors to participate	0.03	0.01	0.00	0.00	0.00	0.03	0.0%
9	**Monitoring & evaluation**	**0.16**	**0.47**	**0.29**	**0.34**	**0.28**	**1.54**	**0.1%**
9.1	Strengthen M&E capacity	0.12	0.39	0.28	0.32	0.28	1.38	0.1%
9.2	Develop and maintain effective HIV information systems	0.04	0.08	0.02	0.01	0.00	0.16	0.0%

The total cost of the NSP is estimated to be approximately $1,302 million over the five years (2011-2016). The programme cost for 2011/12 is estimated at $193 million and this rises to an expected $317 million in 2015/16; an increase of some 60 percent. This significant increase is largely a result of the planned up-scaling of programme interventions- in particular the anti-retroviral program, HIV testing and counselling, voluntary male circumcision, and the prevention of mother to child transmissions. Program costs are further increased by the anticipated increase in the cost of anti-retroviral drugs which are expected to increase from an average of about $90 per patient per year to $143 per patient per year- a 60 percent increase.

Of the nine thematic areas, Prevention is estimated to take 17.5 percent of resources, Treatment Care and Support 58.7 percent of resources, Impact Mitigation 18.4 percent of resources, and Multi-sectoral Response 4.1 percent of resources. The balance, about 1.3 percent, is spread between the remaining four thematic areas.

All of the costs in the estimates include Government of Malawi costs for health personnel inputs into ART, PMTCT, VMMC, and HTC programmes in addition to an up-scaling of personnel into programme supervision. In addition, cost estimates include an allowance for the rental or maintenance of clinics and for clinic utilities. The estimated cost of all these inputs is about $430 million over the five year period, which means that if these costs are excluded from the costing, total programme costs would decline from $1,375 million to approximately $945 million.

6 GOVERNANCE, INSTITUTIONAL FRAMEWORK, AND IMPLEMENTATION ARRANGEMENTS

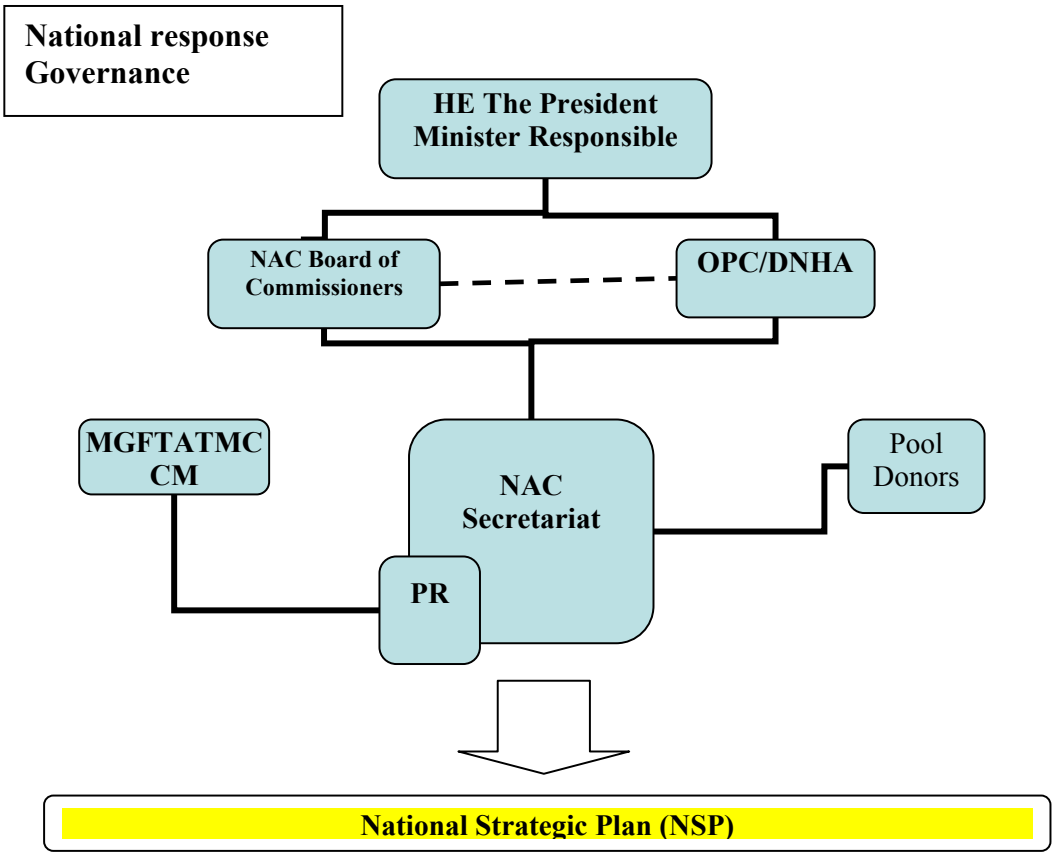
6.1 GOVERNANCE

The governance structure of the national response is as follows:

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. The Department of Nutrition, HIV and AIDS in the OPC is the lead Government agency in the national response to HIV and Nutrition, responsible for policy oversight and high level advocacy.

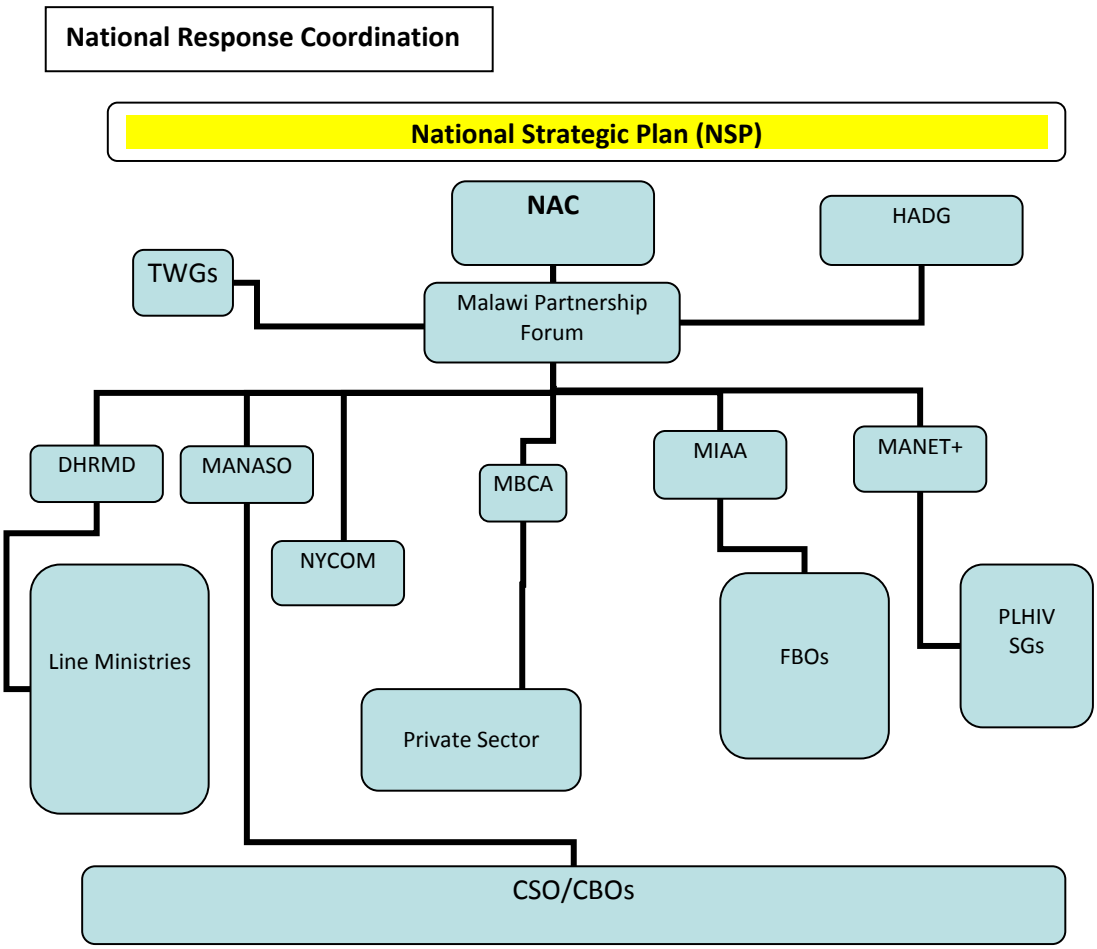
The National AIDS Commission (NAC): NAC was established by the Malawi Government under a trust deed to provide leadership and coordinate the national response to HIV and AIDS in Malawi. It is governed by a Board of Commissioners led by the Chairman who is appointed by the President. The other members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

Specific roles of the Commission are to: (i) guide development and implementation of the national strategy; (ii) facilitate policy and strategic planning in sectors, including local government; (iii) advocate and conduct social mobilization in all sectors at all levels; (iv) mobilise, allocate and track resources; (v) build partnerships among all stakeholders in country, regionally and internationally; (vi) knowledge management through documentation, dissemination and promotion of best practices; (vii) map interventions to indicate coverage and scope; (viii) facilitate and support capacity building; (ix) overall monitoring and evaluation of the national response; and (x) facilitate HIV and AIDS research. See schematic below.



6.2 INSTITUTIONAL ARRANGEMENTS

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



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

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

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

Malawi Global Fund Coordinating Committee (MGFATMCC) - The MGFATMCC provides overall guidance on Malawi's Global Fund supported programmes to fight HIV/AIDS, Tuberculosis and Malaria. It is accountable to the GoM and the Global Fund on the utilization of the Global Fund resources, and determines priorities for proposals to the Global Fund based on existing country frameworks and strategies. Membership of the MGFATMCC is composed of the

public, private sectors, civil society including people living with HIV and AIDS and development partners. Every MGFATMCC member is nominated by the constituency he or she represents[41].

Department of Human Resources Management and Development (DHRMD) – Within the Office of the President and Cabinet (OPC), this department coordinates the HIV and AIDS response, particularly workplace programmes, in the public sector. These include all government ministries, departments, training institutions and parastatal organisations. There is also a public sector steering committee comprising principal secretaries and chief executives which provides policy leadership and guidance on the public sector response.

Malawi Business Coalition against AIDS (MBCA) – **MBCA** coordinates the response for private companies and business institutions. Its major roles are mobilisation of companies, development of workplace programmes, reporting and evaluation of the private sector response.

Malawi Network of People Living with HIV (MANET +) – his body coordinates all organisations for people living with HIV and AIDS (PLHIV). These member organisations serve and advocate for issues affecting PLHIV in order to improve their welfare.

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

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

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

These mechanisms have been functioning for some years, are well-established, and have been regularly reviewed and assessed.

6.3 KEY IMPLEMENTING AGENCIES

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

Ministry of Health plays a key role in the multi-sectoral response, for technical direction and service delivery in biomedical areas of prevention, treatment and care. The specific roles of the MoH include: (a) developing Policies and Guidelines on biomedical HIV and AIDS interventions; (b) planning and implementing biomedical HIV and AIDS interventions; (c) coordinating health sector thematic areas; (d) providing technical support for HIV and AIDS policy development; (e) providing technical support in implementation of health related HIV and AIDS interventions; and (f) surveillance for HIV/AIDS/STI.

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

[41] Operational Manual for the Malawi Global Fund Coordinating Committee (MGFTATMCC)

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

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

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

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

All these implementation partners are coordinated, using the coordination mechanisms described in the previous section (6.2 above).

6.4 IMPLEMENTATION ARRANGEMENTS FOR THE NSP

6.4.1 Governance and Accountability

Governance and accountability are the responsibility of the OPC, delegated to NAC and with oversight from the DNHA.

6.4.2 Policy Development

GoM is responsible for public policies. The DNHA coordinates the link between public policy development and implementation and NAC provides technical assistance for policy development and coordinates programme implementation.

6.4.3 Programmatic Leadership, Planning and Coordination of Implementation

NAC coordinates the national response and implementation of the NSP. This involves reviewing and updating the national strategy, coordination of all relevant implementing partners, and, monitoring and evaluation of the national response. NAC coordinates development and implementation of the Integrated Annual Work Plans (IAWP), which identifies actions, implementers and budgets to be funded by its Pool Fund and other discrete donors. These Work Plans should, ideally, include all implementers within the IAWP framework including local authorities and community based organisations. The Malawi Global Fund Coordinating Committee (MGFCC) provides governance and oversight to programmes supported by the the Global Fund to fight against AIDS, Tuberculosis and Malaria (GFATM), and comprises GoM, development and implementing partners and affected communities.

6.4.4 Partnerships

The Malawi HIV and AIDS Partnership Forum brings together implementing and development partners, to advise NAC and for mutual accountability. Other specific partnership forums include the Pooled Donor Group and HIV and AIDS Development Partner Group; the International NGO Forum and Local NGO Forum; the Malawi Interfaith AIDS Association; and, the MBCA.

6.4.5 Technical Support and Technical Leadership

Technical support for design and implementation of interventions is provided by several stakeholders. The technical ministries (e.g. MoH, MoEST, MoAFS and MoGCCD) provide technical leadership in their areas, often supported by Technical Assistance from development partners and international NGO (INGO). Technical Working Groups bring together technical experts and advice on national technical strategy development. The NSP will provide the overall framework for these policies, strategies and sets of guidelines for all its areas.

6.4.6 Capacity Building

Capacity building is a core and crosscutting effort in the national response. Capacity building refers to institutional, system and human capacity development. NAC provides guidance and oversight to national capacity building efforts, but most stakeholders have a role to play in capacity building. The NSP contains many interventions for capacity building and there is a specific theme (and strategies) for this key area of the national response.

6.4.7 Service Delivery

Implementation of HIV prevention, treatment, care, support and impact mitigation is the role of a range of implementing partners in public and private sectors and civil society. Services are implemented by the public sector and the NGO sector, including FBOs supporting the MoH, CBOs working at community level, community groups like PLHIV organisations, larger NGOs, and companies in the private sector.

Of particular concern with service delivery in the public sector are human resource shortages. This issue was flagged in the extended NAF, but it is still problematic in terms of numbers of personnel, their level of training, mentoring and supervision. The NSP tackles these issues with strategies specifically developed to strengthen services delivery points in the national response.

6.4.8 Monitoring and Evaluation

NAC is responsible for monitoring the epidemic and the national response, analysing this information and disseminating it to policy makers and programme planners. The National M&E Framework was reviewed and revised in order to align it with the MGDS II and the NSP. ***Annex 1*** provides the Results Framework Matrix that outlines impact, outcome, output and process indicators as well as annual and periodic targets that will be used to track progress on implementation of the NSP.

NAC commissions joint reviews of the national response through the Malawi HIV and AIDS Partnership Forum. All implementing partners, ministries and NGOs alike, are expected to monitor progress of their efforts and evaluate their responses on outcome and impact. This information is shared with NAC for further dissemination.

Routine monitoring is conducted by all key providers of data as well as sampled service delivery points on a quarterly basis using tools and checklists that provide a basis for tracking

implementation against established standards and protocols. Routine feedback is provided through a debrief that happens immediately after a monitoring visit as well as during scheduled quarterly meetings held at sub-national levels with players from both the public and civil society. The supervision is meant to be supportive and not punitive so as to build a culture of self- reflection and ensure that service providers are mentored on the best service delivery mechanisms available. Issues of quality are continuously tracked through indicators that are included in the existing national M&E Plan and data quality audits are undertaken to ensure that programme design and implementation are based on M&E systems that are capable of providing credible, valid and reliable data and information.

Despite a robust national M&E programme and systems, the current M&E programme is not without challenges. This has become more evident in recent years as the national response has gained momentum and has been scaled up. To overcome weaknesses and to facilitate an effective process, a specific strategic theme is included in the NSP which deals with M&E.

6.4.9 Joint Reviews of the National Programme

Joint reviews of progress on implementation of the Annual Integrated Work Plan takes place quarterly with the executive committee of the Malawi HIV and AIDS Partnership Forum. The complete MPF meets bi-annually to review progress. Additionally, NAC and pooled donors have quarterly meetings to review progress towards agreed milestones.

6.4.10 Resource Mobilisation, Financial Management and Procurement

Resource mobilisation- NAC is responsible for the assessment of the resource requirements for the national response; for mobilisation of resources from GoM and development partners; for ensuring rational allocation of resources across strategies and partners; and monitoring and reporting on resource utilisation. Every implementing partner is encouraged to raise additional resources, either from development partners or locally. The NSP highlights the importance of resource mobilisation and foreshadows that resource availability and mobilisation will be critical if the goals and objectives of the NSP are to be achieved. To emphasise the significance of this task, the NSP includes a strategy to assist with resource mobilisation.

Financial management- Funds flow through the national response in four ways:

(i) Through the GoM National Budget: most of the basic infrastructure and human resources for implementation in the public sector are general GoM budget; accountability is through standard GoM channels.

(ii) The NAC Pool Fund (see 6.4.11 below): this is a harmonized pool of primarily donor funding that is allocated annually for implementation of the NSP through the Integrated Annual Work Plan (IAWP). Oversight and accountability is through NAC to OPC, via quarterly, bi-annual and annual reports. These reports form the basis for quarterly meetings with Pool Donors, as stipulated in the MoU.

(iii) The Health SWAp Pool Fund; the SWAp MoU states that the GoM will contribute 11% of its domestic resources to the health sector and that all pool funding from donors and other sources will be additional to this Government contribution. Within the health SWAp-pool planned activities and outputs are reflected in the Annual Implementation Plan (AIP); accountability is through the SWAp MoU, subject to the achievement of indicator targets and benchmarks set annually.

(iv) Directly to implementers from discrete donors or other funding sources. NAC receives funding from discrete donors, which support implementation of the IAWP. Other donors provide direct funding to implementing agencies; NAC is not accountable for these funds.

Procurement- Based on an agreement between the pool funding partners, the World Bank was chosen as the custodian of the fiduciary requirements for procurement. Procurement under the NSP will, therefore, be governed by the World Bank Procurement guidelines.

From these World Bank procurement guidelines, NAC developed its own procurement manual with a specific annex which provides guidelines for procurement under the grants facility. Under this arrangement, GROs are allowed to procure on their own goods and services not exceeding $30,000 in value while the NAC secretariat will procure on behalf of the GROs any goods and services that exceed $30,000. In this regard, then NAC reviews and approves procurement plans from all implementing agencies and develops its own procurement plan to include any items that it has to procure on behalf of the GROs.

These procurement guidelines are only applicable for procurement that is being financed by resources that are channelled through NAC but implementing agencies are allowed to use alternate procurement procedures if funding is not channelled through NAC. For instance, MoH which is the major implementing agency in the national response also uses the Malawi Government procurement guidelines if the resources for the procurement have not been channelled through NAC. It should , however be noted that the Malawi Government procurement guidelines were also derived from the World Bank procurement guidelines and the implementation of both the NAC and Malawi Government guidelines is fully supported by the Malawi Public Procurement Act.

Because of the special and demanding requirements for procurement of drugs and medical equipment for ART services and the capacity constraints that exist at the Central Medical Stores, procurement for these items has been contracted to UNICEF. UNICEF produces its own procurement plan and uses their own procurement guidelines for the procurement of the health products but these items are also included in the Procurement and Supply Chain Management Plan which the Principal Recipient (PR) develops for each funding mechanism. UNICEF operates as a procurement agent under a MoU between MoH and UNICEF and this will remain effective until such a time that local capacity is fully developed. Strengthening Central Medical Stores and Malawi's supply chain management system is a prioritised intervention in the NSP and this will, hopefully, ensure the procurement of these commodities will return to CMS before the conclusion of the NSP in 2016.

6.4.11 Harmonisation and Alignment with Development Partners

GoM entered into a MoU with development partners in 2003 to harmonise their support in a Pooled Funding Arrangement (see 6.4.10 above). Some development partners are not able to contribute to pool funding, but also align their discreet support to the national priorities (the NAF/NSP) and take part in the HIV and AIDS Development Partner Group. The Partnership Framework between the United States Government (USG) and GoM aligns USG support for HIV/AIDS in Malawi fully with the NAF/NSP in order to implement the goals, objectives, strategies and action points. The NSP and the Integrated Annual Work Plan/National Operational Plans is the framework within which all partners and their resources can be fully harmonized and aligned within an effective national response.

6.4.12 Grant Management

NAC is used as a conduit for most of the HIV and AIDS resources from several donors (the Pooled Donors and some Discreet Donors) and the GoM. The NAC Grant Management Unit is responsible for ensuring that these resources are distributed efficiently and transparently to implementing partners, according to priorities as stated in the NSP and Integrated Annual Work Plans.

Annex 1: NSP Consolidated Results Framework 2011 – 2016

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
	Goal: Prevent HIV Infection and Mitigate the Impact of HIV and AIDS on the Malawian Population	1	Percentage of young women and men aged 15–24 who are HIV-infected	3.60% (Males-1.9%) (Females-5.2%)			M1.8% F3.7%		2.20% (M-1.7%) F - 3.0%)	4 Years	DHS,SS	GARPR / MDG /GFATM /SADC
		2	Prevalence of HIV among pregnant women aged 15-24 years attending antenatal care (GARPR/GFATM /SADC)	8.20%			6.2 (GFATM)		5.2	2 Years	HIV Sentinel Surveillance	National
		3	Percentage of Key Populations (Most-At-Risk Populations) Who Are HIV-Infected	FSW-69.1%			66%		64%	2 Years	BBSS,	GARPR /SADC
				FBT:23.1 %			20%		19%			
				MV: 7%								
				TD: 14.7%								
				Fisherme n:16.6%			14%		13%			
				EW: M-19.5%			M17%		M16%			
				F: 17.1%			F14%		F13%			
				Police: M-24.5%			M22%		M21%			
				F-32.1%								
				MSM: TBD			TBD		TBD			

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
		4	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	78% (GFATM report)	79%	80%	81.50%	83%	84.5%	Quarterly	Program Data,	GARPR/ GFATM /SADC
		5	Percentage of Infants born to HIV-Infected Mothers	30%	25%	16%	11%	9%	5%	Annually	Modeling	GARPR
		6	AIDS Related Deaths (AIDS Related Mortality)	61233 (NSP baseline) Adults-52144 Children-9089			53,394 Adult 48,777 children 4,617		56,575 Adult 51,944 children 4,631	Annually	HIV/AIDS Estimates Report	National
		7	HIV Incidence (disaggregated by age and sex)	0.86%			0.73		0.6% (NSP assumption)	2 Years	HIV/AIDS Estimates Report	National
Strategic Theme 1: Prevention	**Goal: Reduced morbidity and mortality of HIV related illnesses in adults and children**											
	Objective: Reduce HIV incidence	8	Percentage of women and men aged 15–49 years with more than one sexual partner in the past 12 months and who report the use of q condom during their last sexual intercourse	25.10% F-27.3% M-24.6%			F: 35% M: 30.8%		F-40% M 35%	4 Years	DHS	GARPR / MDG /GFATM /SADC

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
		9	Percentage of most at risk populations with more than one sexual partner in the past 12 months reporting the use of condoms during last sexual intercourse	91.8% (the baseline is only for sex workers)			92.8		93.8	2 Years	BBSS	National
		10	Percentage of young women and men aged 15-24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (disaggregated by sex,)	Women-41% Men-44.8%			F:52.4% M: 57%		Women:60% Men: 65%	4 Years	DHS	GARPR/ MDG /SADC
		11	No of HIV tests conducted per year	1,747,574	1,400,000	2,502,897	3,226,399	3,500,000	4,000,000	Quarterly	Programme Data	National
		12	Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results of the last test	F:TBD M:31.3%			F:TBD M:49.2%		F: TBD M: 61.2%	4 Years	DHS	GAPR/ SADC
		13	Percentage of most at risk populations who received an HIV test in the last 12 months and who know the results	63.50%			69.5%		73.50%	2 Years	BBSS	GARPR/ SADC

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
		14	Percentage of young women and men (15-24 yrs) who have had sexual intercourse by the age of 15	F14.3% M22.1%			F:18.8% M:19.1%		F:13.5% M: 17.1%	4 Years	DHS	GAPR
		15	Percentage of young people aged 15-19 who have never had sex	F: 75.9% M:46.8%			F:78% M:50%		F:80% M: 52%	4 Years	DHS	GFATM
		16	Number of visits by young people who accessed youth friendly SRH/HIV services	690,400	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	Quarterly	Programme Data	GFATM
		17	Number of health facilities offering VMMC and neonatal circumcision services	36 static BLM sites	44 NSP targets	80	116	136	146	Quarterly	Programme Data Health Sector Qoc& Service Delivery Survey	National
		18	Number of males aged 15 to 49 medically circumcised	8,310 (2011 Programme Reports)	125,000	250,000	500,000	750,000	875,000	Quarterly	Programme Data	SADC
		19	Percentage of ANC with trained health care workers in PMTCT and ART services	57%	90%	95%	1100%	100%	100%	Quarterly	HIV Department Programme Report	National
		20	Number of socially marketed condoms distributed to outlets in the last 12 months	Male-13, 210,154 F: 128 227	M 13,500,000 F 150,000	M 14,000,000 F 180,000	M 14,500,000 F 200000	M 15,000,000 F 250,000	M 15,005,000 F 300,000	Quarterly	Programme Data, LMIS	National

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
		21	No of male and female condoms distributed	24,558,579 (GFATM)	27,500,000	29,632,629 (GFATM)	33,993,124	35,000,000	36,000,000	Quarterly	Programme Data, LMIS	GFATM / SADC
		22	Number of people trained in Interpersonal communication HIV/AIDS communication with adults and young people	3,692	750	1,125 (GFATM)	2,000	2,625	3,000	Quarterly	Prog Data	GFATM
		23	Percentage of STI cases treated according to national guidelines	41%	45%	49% (GFATM)	51% (GFATM)	53%	55%	Quarterly	Prog Data	GFATM
		24	Percentage of HIV infected women using a modern family planning method	8%	10%	20%	30%	40%	50%	Quarterly	Programme Data	National
		25	Percentage of most-at-risk populations (MARP) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	38.40%			45%		53.8%	2 Years	BBSS	GARPR
		26	Number of couples taking HTC together.	280,000	350,000	420,000	490,000	560,000	630,000	Quarterly	Programme Data	National
		27	Number of sites providing Early Infant Diagnosis (EID)	192	250	300	350	400	450	Quarterly	Programme Data	National
		28	Number of persons provided with post-exposure prophylaxis (PEP)	2,000	2,100	2,200	2,300	2,400	2,500	Quarterly	Programme Data	National

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
		29	Percentage of donated blood units screened for markers of infectious diseases (HIV, Hepatitis B and Syphilis) in a quality-assured manner.	99%	99%	99%	99%	99%	99%	Quarterly	Programme Data	GARPR/ SADC
Strategic Theme 2: Treatment, Care And Support	**Goal: Reduce morbidity and mortality of HIV related illnesses in adults and children**											
Strategic Theme 2a: Treatment	**Objective: To increase access to a continuum of HIV and AIDS treatment**	30	Number and percentage of adults and children with advanced HIV infection currently receiving antiretroviral therapy (Disaggregated by age)	276,897 (67%) adult 249,281 Children 27706	Total 361,404 Adults: 313,000 Children 38,000	T: 439,535 A 368,000 C 43,000	T: 501,202 A 398,000 C 46,000	T: 571,202 A 416,000 C 48,000	T: 641,202 A 446,000 C 50,000	Quarterly	Programme Data Modeling	GARPR/ MDG/ SADC)
		31	Percentage of infants born to HIV positive women in HIV programmes who are alive at 12 months of age and HIV negative (i.e. 12 month Infant HIV-Free Survival)	Not yet available	50%	58%(GFATM)	62%GFATM	65%	70%	Quarterly	cohort and estimates	GFATM / SADC
		32	Percentage of HIV infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission in accordance with national protocols	41%	58%	67%	75%	77%	78%	Quarterly	HIV Programme Reports	GFATM

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
		33	Number and percentage of pregnant women attending ANC who received HIV counseling and testing for PMTCT and received their test results	76% (June 2011 Programme Reports)	80%	85%	90%	95%	95%	Quarterly	Programme Data	National
		34	Number and percentage of health facilities that are ART and PMTCT certified	57%	90%	95%	1100%	100%	100%	Quarterly	Programme Data	National
		35	Percentage of ART sites reporting any stock-out of 1 week and above of adult formulation of D4T, 3TC, NVP in the reporting quarter	1.5%	1.5%	1.5%	1%	1%	1%	Quarterly	Programme Data	GFATM
		36	Number and percentage of adults and children enrolled in HIV care and eligible for co-trimoxazole prophylaxis (according to national guidelines) who are currently receiving co-trimoxazole prophylaxis	88% (Sep 2011 Programme Report)	411,014 95%	551,378 95%	640,112 95%	726,292 95%	841,198 95%	Quarterly	Programme Data	GFATM
		37	New patients starting treatment based on CD4 test	45,000	46,000	47,000	48,000	49,000	50,000	Quarterly	Programme Data	National
		38	No of health care workers trained and certified in provision of integrated ART/PMTCT services	3,366	1,000	1,000	1,000	1,000	1,000	Quarterly	Programme Data	National
		39	Number of CD4 tests conducted per quarter	168,742	213,742	259,742	306,742	354,742	403,742	Quarterly	Programme Data	National

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
		40	Percentage of HIV infected clients screened for TB	91%			92.2%		93%	Quarterly	Programme Data	National
		41	Percentage of TB patients with known HIV status	yr 2011 88%	85%	85%	85%	85%	85%	Quarterly	Programme Data	GFATM
		42	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	5%	20%	30%	40%	50%	60%	Quarterly	Programme Data	GARPR
Theme 2b: Care and Support		43	Number of households with chronically ill patients supported with food and nutritional support	184,000	230,000	276,000	322,000	368,000	414,000	Quarterly	Programme Data	National
		44	Number of HBC patients followed up and provided with treatment by trained people	51,948	50,948	49,948	48,948	47,948	46,948	Quarterly	Programme Data	SADC
Strategic Theme 3: Comprehensive Multi-Sectoral and Multi – Disciplinary Response To HIV and Aids	**Goal: An effective and sustainable multi-sectoral national response to HIV and AIDS**											
	Objective. Deliver effective management, coordination, and service delivery of HIV and AIDS interventions at national, local authority, and community	45	Number and Percentage of sector ministries, departments and local authorities with HIV and AIDS programmes	75	85	95	100	100	100	Quarterly	Programme Data	National
		46	Number of people in implementing organizations (Ministries, Districts, CSOs, NGOs, CBO private sector,	200	300	400	500	600	650	Quarterly	Programme Data	National

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
			FBOs,)trained in HIV and AIDS programme management									
		47	National Commitments Policy Instrument (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and M&E)	Na						2 Years	Desk review and informant interviews	GARPR
		48	Total Amount of Domestic and international AIDS spending by categories and financing sources	Domestic 2% Int. 98%	Domestic 3% Int. 97%	Domestic 4% Int. 96%	Domestic 5% Int. 95%	Domestic 6% Int. 94%	Domestic 7% Int. 93%	2 Years	Resource flow survey	SADC
		49	Number of health workers and stores management staff trained in inventory and logistics management (waged on health worker Vs stores and staff)	TBD	TBD	TBD	TBD	TBD	TBD	Quarterly	Programme Data	National
		50	Percentage of health centres with minimum staff norms to offer EHP services	Clinicians 30% Nurse/MWs50%	Clinicians 40% Nurse/MW55%	Clinicians 50% Nurse/MW60%	Clinicians 60% Nurse/MW 65%	Clinicians 70% Nurse/MWs 70%	Clinicians 80% Nurse/MWs 75%	Bi-annually	HMIS	National

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
		51	Number of laboratory staff (laboratory technicians) trained to provide the expected range and quality of accredited HIV and AIDS investigative services as per national guidelines	TBD	TBD	TBD	TBD	TBD	TBD	Annually	Health Sector Service Delivery/ Quality Of Care Survey Health Facility Survey	National
		52	Number of students currently enrolled in medical, nursing, pharmacy, laboratory and premedical training	Yr 2011: 229 (cumulative)	123	123	187	-	-	Annually	Sector Assessment Report	GFATM
Strategic Theme 4: Impact Mitigation	**Goal: Mitigate the social-economic impact of HIV/AIDS on individuals, households, community, institutions and the nation**											
	Objective: Improve provision of impact mitigation services to individuals and households affected by HIV and AIDS	53	Percentage of children aged less than 18 years who are orphans by type (double, paternal, maternal)	12.60%			11.0%		10.0%	4 Years	DHS	National
		54	Current school attendance among orphans and non-orphans aged 10-14 (a Ratio of % among orphans to % among nonorphans)	89.3/93.1 =0.96			0.97		0.99	4 Years	DHS, EMIS	GARPR/ SADC

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
		55	Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	17.3%			20%		30%	4 Years	DHS	GARPR, SADC
		56	Number of vulnerable young people trained in vocational skills	6,868	300	1,500	1,500	1,800	2,000	Quarterly	Programme Data	GFATM
Strategic Theme 5: Protection, Participation and Empowerment of PLHIV and Other Vulnerable Populations	**Goal: Protect human rights fundamental freedoms and human dignity for all HIV affected people**											
	Objective: Provide a conducive environment so that the rights of PLWHA and affected people can be protected and so they may take advantage of available services	57	Percentage of population expressing accepting attitudes in relation to people living with HIV	19.7% F 35.7 M			25%F 40% M 21.7F 37.7M		30%F 45%M 23.7F 39.7M	Quarterly	DHS	National
		58	Number of stakeholders sensitized on cultural and traditional /practices that fuel HIV infection (SADC)	2,000	2,000	2,250	2,500	2,750	3,000	Annually	LAHARS Programme Data	National

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
		59	Number of HIV and AIDS related laws reviewed and enacted	2			1		1	2 Years	NCPI	National
Strategic Theme 6: Mainstreaming and Linkages	**Goal: HIV/AIDS programmes of all affected public and private sectors and stakeholders are linked and provide synergized outcomes**											
	Objective: Deliver networking and effective partnerships in the national response	60	# and % of large public and private labour enterprises with HIV and AIDS Work Place policy and programmes	42	52	62	72	82	92	Quarterly	Programme Data	SADC
		61	Number and percentage of people in major social sector organizations that have been trained in HIV and AIDS mainstreaming	2,700	2,800	3,000	3,200	3,400	3,600	2 Years	Programme Data	National
Strategic Theme 7: Sustaining National HIV and AIDS Research Agenda	**Goal: Research contributes to the implementation of evidence based programmes and interventions in the national response**											

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
	Objective. Generate evidence to support the development and implementation of high impact interventions and programmes in the national response	62	Existence of a current HIV & AIDS research and evaluation agenda and a functional execution framework							2 Years	Ind Assessment Prog Data	National
		63	Evidence of utilization of research findings to inform policy development and planning/ programme development							Annually	Ind Assessment	National
Strategic Theme 8: Capacity Development	**Goal: A well equipped public and private sector with adequate capacity**											
	Objective: Adequate capacity in all sectors to enable the efficient and effective implementation of the national response	64	Existence of a functional national HIV and AIDS multi sectoral or thematic capacity building plan (s)							Adhoc (need based)	Independent Assessments	National
Strategic Theme 9: Monitoring and Evaluation	**Goal: M&E effectively contributes to the implementation of evidence based programmes and interventions**											

Strategic Theme	Goals and Objectives	No	Indicators	Baseline 2010/11	Target 2011/12	Target 2012/13	Target 2013/14	Target 2014/15	Target 2015/16	Monitoring Frequency	Data Source (s)	Harmonization
	Objective: Generate and disseminate reliable and timely strategic information on HIV and AIDS to facilitate the implementation of the national response.	65	Number of policy briefs prepared (based on M&E and research information) presented to policy makers	2	2	4	4	4	4	Annually	Programme Data, Indpendent Assesments	National
		66	Number and % of implementing partners submitting reports regularly to NAC as per national protocols/ guidelines	45	50	55	60	65	70	Annually	Programme Data, Indpendent Assesments	National

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