2015 - 2020

National Strategic Plan for HIV and AIDS: Review Report

Contents

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Acronyms

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Clinic
ART	Ante-Retroviral Treatment
BBSS	Biological Behavioural Surveillance Survey
CBDAs	Community Based Distribution Agents
CCC	Condom Coordination Committee
CCP	Comprehensive Condom Programming
COP	Country Operational Plan
CSO	Civil Society Organization
DACC	District AIDS Coordination Committee
DBS	Dried Blood Spot
DHRMD	Department of Human Resource Management and Development
DIC	Drop In Centre
DSD	Differentiated Service Delivery Model
EID	Early Infant Diagnosis
FSW	Female Sex Worker
GBV	Gender Based Violence
GDP	Gross Domestic Product
GTC	Guanidnium Thiocyanate
3HP	Rifapentine
HDAs	HIV Diagnostic Assistants
HIV	Human Immune Virus
HIVST	HIV Self Testing
HRH	Human Resources for Health
HTS	HIV Testing Services
ICF	Intensified Case Finding
IPT	Isoniazid Preventive Therapy
KP	Key populations
LAHARF	Local Authority HIV and AIDS Reporting Form
LAHARS	Local Authority HIV and AIDS Reporting System
MANASO	Malawi Network of AIDS Service Organizations
MANET +	Malawi Network of People Living with HIV
MBCA	Malawi Business Coalition Against HIV and AIDS
MDHS	Malawi Demographic and Health Survey
M&E	Monitoring and Evaluation
MEISRS	Monitoring, Evaluation, Information Systems and Research
MHRC	Malawi Human Rights Commission
MGDS	Malawi Growth and Development Strategy
MIAA	Malawi Interfaith AIDS Association
MNCH	Maternal, Neonatal and Child Health
MOH	Ministry of Health
MPF	Malawi HIV and AIDs Partnership Forum
MPHIA	Malawi Population Based HIV Impact Assessment
MSM	Men who have Sex with Men
NAC	National AIDS Commission

NCD	Non-Communicable Disease
NCHE	National Council for Higher Education
NCIC	National Construction Industry Council
NGO	Non-Governmental Organization
NHRL	National Health Reference Laboratory
NSP	National HIV and AIDS Strategic Plan
NYCOM	National Youth Council of Malawi
OVC	Orphan and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PEPFAR	Presidential Emergency Plan for AIDS Relief
PITC	Provider Initiated Testing and Counselling
PLACE	Priorities for Local AIDS Control Efforts
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
QC	Quality Control
SADC	Southern Africa Development Community
SBCC	Social Behavioural Change Communication
SC	Steering Committee
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TF	Task Force
TG	Trans Gender
TMA	Total Market Approach
TWG	Technical Working Group
UNAIDS	United Nations Joint Programme on AIDS
UNC	University of North Carolina
VAPN	Voluntary Assisted Partner Notification
VLT	Viral Load Testing
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
Y+	Young People Living with HIV

Executive Summary

The National HIV and AIDS Strategic Plan (NSP) is the guiding document for the HIV and AIDS response in Malawi, with the current plan running from 2016 – 2020. The NSP outlines four priority areas that are crucial in tackling the HIV and AIDS epidemic, namely: HIV Prevention; Treatment, Care and Support; Impact Mitigation; and Management and Coordination. The current NSP was also built around the UNAIDS 90-90-90 goals, anchored by the Fast Track Agenda of eliminating HIV and AIDS as a public health threat by 2030.

The global health landscape and emerging evidence within the HIV and AIDS space presented various challenges and opportunities for the HIV and AIDS response in Malawi. Thus, a mid-term review of the NSP was essential to assess achievements and challenges to inform HIV and AIDS programming. However, the process was not commissioned due to programmatic constraints. Thus, it was imperative that a review of the current NSP be commissioned in cognizant of the fact that findings and lessons from the process will play a crucial role to informing the development of the next NSP (2020-2025). Consequently, the National AIDS Commission (NAC) commissioned an internal review of the current NSP atleast within its life course. This was a collaborative initiative and involved several partners within the HIV response. The process also involved wide consultations with key stakeholders, and complemented by pragmatic desk reviews of relevant documents.

Overall, the country is on track to achieve the *90:90:90 targets*. As of March , 2019, a total of 1,062,622 people were estimated to be living with HIV. In the 90-90-90 cascade and focusing on the 15-59 age bracket, was estimated that 91% of People Living with HIV (PLHIV) knew their status; 83% of those diagnosed were initiated on ART; and 90% of those on treatment achieved viral suppression. Overall, ART coverage was estimated around 79% in adults, while PMTCT coverage was over 95%. Based on Spectrum estimates the prevalence of HIV dropped from 9.8% in 2015 to 9.2% in 2018, representing a 6% decrease. Similarly, the incidence of HIV dropped from 0.54% in 2015 to 0.45% in 2018, representing 17% drop. Over the same period, there was a 2% decrease in the annual AIDS-deaths from 8,319 in 2015 to 8181 deaths in 2018. For children(0-14 years), there was a 17% decrease in the number of Children Living with HIV (CLHIV) from 89,406 in 2015 to 73810 in 2018. Similarly, there was a 10% and 50% decrease in the prevalence and incidence of HIV respectively. In absolute terms, the number of new infections dropped by 45% from 6430 in 2015 to 3527 in 2018, and pediatric ART coverage was estimated around 61%. For key populations, the size of female sex workers, men having sex with men, and prisoners were estimated at 36,000, 9,600 and 15,000 respectively. However, there was no data for injecting drug users and transgender.

The review process also revealed other high impact interventions whose implementation should seriously be considered in the upcoming NSP. These include Voluntary Medical Male Circumcision (VMMC), condom programming and targeting new frontiers such as PrEP, among others. Comprehensive assessment of progress requires availability of quality, and routine disaggregated data in-terms of uptake of interventions as well as targeting. To sustain the current gain, it is inevitable that we need to mobilize additional resource to scale up and maintained bold strategic evidence based result oriented innovative interventions that prioritize the key and vulnerable populations. Overall, an inter-sectoral coordination will ensure an integrated approach to achieving the goal of ending HIV and AIDS as a public health threat.

1.0 Background

The HIV and AIDS response in Malawi is guided by the National HIV and AIDS Strategic Plan (NSP), with the current plan running from 2015 to 2020. The NSP is further aligned to the country development plan, the Malawi Growth and Development Strategy (MGDS). The current NSP was aligned to the MGDS II covering the period 2011- 2016. In cognizance of this and given the implementation of varied programmatic activities enshrined in the NSP, there is need to review the current strategy so it informs development of the new NSP (2020 -2025) and aligned to the MGDS III, and other global priorities. On the global front, the NSP is linked to the UNAIDS Fast Track Agenda, with the intermediate goal of achieving the 90:90:90 targets. The targets envisage that by the year 2020, 90% of People Living with HIV (PLHIV) should be diagnosed, 90% of this population should be initiated on treatment, and 90% of those on treatment should achieve viral suppression. This aspiration goal also speaks to the "three zeros" principle of achieving zero HIV infections, Zero stigma and discrimination, and Zero HIV related deaths. In order to achieve these targets, the current NSP was anchored on four main thematic areas, namely, Prevention; Treatment, Care and Support; Impact Mitigation; and Management and Coordination.

1.1 Vision and Mission

The Vision of the 2015/2020 NSP was to have a healthy and prosperous nation free from HIV and AIDS.
The Mission of this NSP was to provide high-quality HIV prevention, treatment and care services for all Malawians.

The 90-90-90 target was the main fulcrum of the 2015-2020 NSP for HIV and AIDS. In order to realise this, the NSP focussed on identification of critical program and system gaps and ensured that the identified gaps are closed within the NSP implementation period. In addition, the NSP had a multi sectoral outlook cutting across multiple sectors including health, and created a common understanding for all HIV and AIDS stakeholders: government, civil society, the private sector, and development partners to work together towards achieving the expected results. The current NSP was also not intended to replace or duplicate other strategies, but rather serve as an overarching document that would provide guidance within which other sectoral strategic plans and budgets were formulated, monitored, and coordinated.

According to spectrum estimate, from 2013 to 2018 Malawi recorded a steady declined in HIV prevalence from 10.1% to 9.2% among the age group 15-49 years, and a reduction of new infection from 37,552 to 33,764. This can be alluded to the effectiveness of the national response. It is imperative to note that most of the new infections occur among young people aged 15-24 years and among individuals that were previously considered low risk such as couples and people in stable relationship. There are a number of key lessons the country learned through a successful public health approach of the treatment program. It is now clear that HIV testing and treatment not only improve lives of those infected but also contribute substantially to prevention on all spheres, including influencing the legal and social landscape for key populations such as Men who have Sex with Men (MSM) and sex workers. During the review period, it was recognised that early Antiretroviral Treatment (ART) as one of the most effective intervention to reduce HIV morbidity and mortality, particularly in the context of Malawi's health services with limited capacity to diagnose and manage HIV-related diseases.

There is overwhelming evidence, that early ART reduces TB risk by 51%, AIDS-defining clinical events by 51%, and primarily clinical events by 27%[1]. Malawi's rapid and successful Antiretroviral Therapy (ARV) scale-up from 2004 to 2014 had significantly influenced the trend of the HIV epidemic, reducing mortality, morbidity, and transmission. A decade since starting the national treatment program:

- 1 out of every 20 Malawi adults was on ART;
- 275,000 deaths had been averted;
- 1.4 million life-years had been gained, primarily among young adults at the peak of their productive life.

In 2011, Malawi started implementing Prevention of Mother to Child Transmission (PMTCT) *Option B+* policy, making life-long ART available for all HIV infected pregnant and breastfeeding women, regardless of clinical stage or CD4 count. This had resulted in a 66% reduction of vertical transmission within 3 years. This Malawi-pioneered strategy had been included in global guidance by World Health organisation (WHO). As of February 2014, 12 other African countries were implementing Option B+. Based on Malawi's proven ability to sustain a rapid ART scale-up in spite of severe health system constraints, this 5 year strategic plan aimed to meet the ***Ambitious 90-90-90 Treatment Targets*** released by UNAIDS in 2014, preparing to control the HIV epidemic by 2030.

Achieving the **90-90-90 goals** in 2020 would result in 760,000 (**73%**) of the projected 1,042,000 PLHIV being virally suppressed, leading to a drastic reduction in sexual and vertical transmission at the population level. Thus by 2020, the NSP aimed to reduce adult (15-49 years) HIV incidence to 0.2, equivalent to 17,000 new infections annually; and reduce the number of children infected by their mothers to 3,900 annually. Within the 5 year period covered by this plan, Malawi was expected to:

- Prevent an **additional 78,000** new adult (15-49 years) infections, compared with a scenario of maintaining the ART cohort at the 2014 level; and
- Prevent **75,000** child infections through Option B+.

Given the goal of extending survival of PLHIV through early treatment, HIV prevalence targets were replaced by a dynamic target ratio, relating incidence to treatment coverage. Treatment targets had been elaborated through the adoption of improved guidelines and programme scale-up; stigma and discrimination targets were set on the basis of routinely conducted nationally representative studies. The NSP also included a focus on strengthening the management and coordination of the HIV response, and was complemented by a costed action plan and other tools (e.g. the National M & E Framework) for its implementation and monitoring.

1.2 Regional and Global Commitments

The Government of Malawi is a signatory to several recent regional and global commitments relating to HIV and AIDS, and include:

- The 2012 Tunis Declaration on Value for Money, Sustainability and Accountability in Health aimed to increase domestic funding through cooperation between Ministries of Health, Ministries of Finance, technical and financial partners;
- The 2012 African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa;

[1] Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. N Engl J Med 2012;365(6):493-505.

- The 2011 UN Political Declaration on HIV AIDS of June, 2011;
- The2011 Global Plan towards elimination of new HIV infections among children and keeping their mothers alive ;
- Global Response of three-zeros (zero infection, zero death and zero discrimination);
- The Maputo Plan of Action on Sexual and Reproductive Health and Rights (2007 to 2010); and
- The Maseru Declaration of SADC Heads of State.

Adherence to these regional and global commitments has been demonstrated through political leadership and government's fiscal investment in the national response resulting in achievement of some commendable gains. Although this has been the case, the level of financial investment towards HIV has been steadily declining over the implementation years of the NSP.

1.3 Country Context and Epidemiology

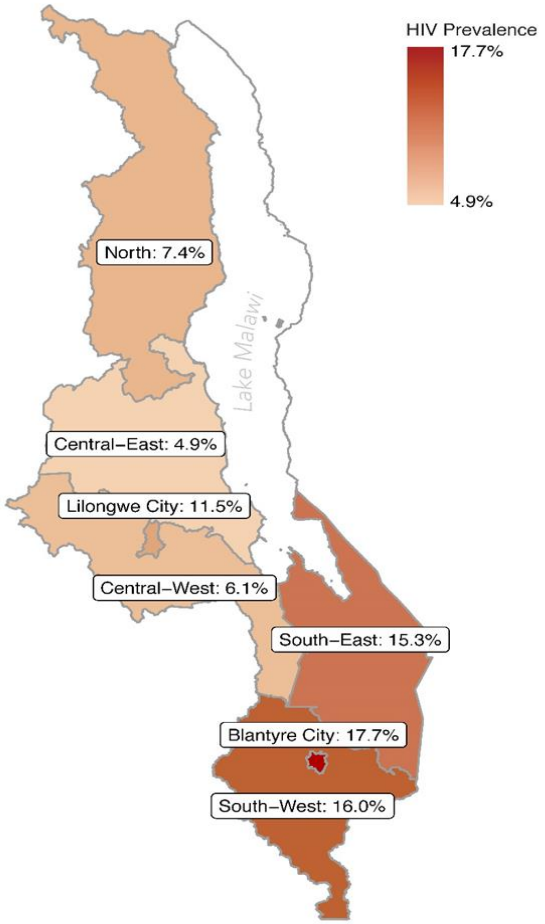
1.3.1 HIV Prevalence

Malawi is among the countries worst affected by the HIV epidemic, with a prevalence of 10.0% among ages 15-49 year [2] as at 2016. The most recent epidemic modelling prevalence estimates is 9.6% indicating a slight reduction since 2016. SPECTRUM modelling also estimates that about 38,878 new infections will occur in 2020[3]. Current estimates suggest that in the absence of significant programmatic shifts, HIV prevalence will continue a slow decline to about 8.7% in 2020. Decline in prevalence may be due to decreased incidence or increased mortality among unidentified or untreated PLHIV. The 2018 HIV estimates put the number of people living with HIV a (PLHIV) at about 1,049,373 and it is anticipated that this number will increase to about 1,082,610 in 2020, partly due to increased survival as a result of the scaled up and integrated ART and PMTCT programme.

Evidence from the Malawi Demographic and Health Survey (MDHS), BBSS and antenatal surveillance data indicate some degree of heterogeneity in the epidemic. HIV prevalence in Malawi varies substantially by sex, age, urban-rural, geographic and socio-economic characteristics. Women are disproportionately affected by HIV, particularly those under the age of 40. In addition, HIV prevalence is almost twice as high in urban (17.4%) as in rural communities (9%). The 2006 Biological Behaviour Surveillance Survey (BBSS) reported considerable variation in HIV prevalence across occupations, with truck drivers, male vendors, fishermen, male and female school teachers, male and female police officers, female border traders, and Female Sex Workers (FSWs) all having higher prevalence than the general population [4]. The survey also revealed high-risk behaviour in these populations, including multiple concurrent sex partners and low condom usage. HIV prevalence in these populations also differs by geographic location (Northern, Central, and Southern Regions).

[2] Ministry of Health, Malawi. Malawi Population-Based HIV Impact Assessment (MPHIA) 2015-2016: Final Report. Lilongwe, Ministry of Health. September 2018.
[3]Joint United Nations Program on HIV/AIDS (UNAIDS) Malawi, May 2014 HIV estimates.
[4]National AIDS Commission. Biological and Behavioral Surveillance Survey 2006 & Comparative Analysis of 2004 BSS and 2006 BSS.

Figure 1. Distribution of HIV Prevalence by zone (MPHIA 2016)



Population based surveys indicate high geographical variability of HIV prevalence on a relatively small spatial level in Malawi. HIV prevalence in the Southern West zone is 16.0%, almost twice as high as the Northern or Central zones[5]. Within these broad geographical zones, significant prevalence variation exists between urban and rural, district and sub-district, and between socio-demographic groupings. The population based surveys and SPECTRUM estimates have both confirmed a decreasing trend in HIV prevalence and HIV-related deaths in both men and women, which peaked in 1999. The decrease in mortality is largely attributable to the scale-up of ART. The decrease in prevalence is most likely explained by the natural course of the epidemic and behaviour change resulting in declining incidence.

1.3.2 HIV Incidence

HIV incidence is usually estimated from epidemiological models (e.g. SPECTRUM) and Malawi Population based HIV Impact Assessments (MPHIA). The most recent modelling suggests a national average HIV incidence rate of 0.4 percent amongst people aged 15 – 49 years in 2018. However, the most significant decline in new HIV infections started in the late 1990's, before the scale up of prevention interventions. HIV incidence in adults (15-49 years) peaked at 2.2 per 100 adults in 1999 and was estimated at 1.4 per year at the beginning of the ART program in 2004. This early decline follows the natural course of the epidemic and was probably also driven by a reduction of risky sexual behaviour as the population became aware of HIV as the cause for the massive death wave that peaked at over 90,000 death in 2004.[6]

A decade after the roll out ART – mid 2014, about half of the 1 million PLHIV were on ART, and incidence had declined further to 0.4. Presently, there has been a sustained reduction of the absolute

number of people newly infected each year from 120,000 in 1999 to 38,874 in 2018. Significant gains have also been made in reducing paediatric infections through implementation of Option B+ in 2011: In just 3 years, the number of children infected by their mothers (including during the breastfeeding period) has declined by 66% (from 30,000 in 2010 to 10,000 in 2014). This trend decreased further by 68% from 2015 to 2018.

The HIV incidence estimates have recently been corroborated by a high quality, Population-based HIV Impact Assessment (MPHIA 2016). This survey directly measured HIV incidence and prevalence, ART coverage and viral suppression rates among the HIV population. HIV prevalence among adults (15-49 years) was **10%** and incidence was **0.33** (0.44 in women and 0.22 in men). This low incidence in spite of high HIV prevalence was consistent with excellent coverage along the treatment cascade in the population. According to the 2018 spectrum estimate, among HIV positive adults 76.8% has been previously diagnosed, 91.4% were on sustained ART while 91.3% were virally suppressed.

1.3.3. Factors Influencing HIV Transmission in Malawi

HIV transmission in Malawi, like most other countries, is influenced by an interaction of structural, economic, social, biological and cultural factors. Several studies have sought to identify key determinants of HIV infection in sub-Saharan Africa. An analysis of the determinants of HIV infection presents background factors (such as age, education, region of residence, circumcision, wealth/poverty, religion and exposure to media), proximate HIV and AIDS factors (HIV and AIDS awareness, stigma and discrimination) and sexual behaviour factors (such as condom use, number of sex partners, marital status) as underlying factors to HIV infection within the region,[7] inequalities which increase susceptibility of women, girls, transgender and key population groups to HIV.[8] Most of these determinants relate to Malawi and are discussed below.

Malawi is one of the poorest countries in the world with an economy primarily dependent on rainfall agriculture, which accounted for 30% of GDP by 2015 (Commencement period of NSP) and currently at 28%. More than 80% of the labour force in 2015 was employed in the agriculture sector and currently the sector employs about 64.1% of the labour force. Malawi's heavy dependency on agriculture creates economic vulnerabilities to factors like poor rains or fluctuating prices of agricultural commodities on the international market. GDP growth in 2018/2019 was estimated at 4.6% which is higher than the 2015/2016 GDP which was estimated at 2.7%. About 39% of the population lived in poverty by 2010 (MGDS II, 2010) and currently at 50.7%. High levels of unemployment, poverty and low earnings were some of the factors leading to transactional sex, and condom use has been noted to be low and inconsistent in casual relationships (BBSS, 2013). The 2017 Priorities for Local AIDS Control Efforts (PLACE) study reported that overall, condom use at last sex among key populations was low. Condom use at last sex with a man was reported among 59% of all women and 65% among FSW. Among MSM, only 44% reported using a condom at last sex with a man. Taking into consideration the problem of low condom use, Malawi has included intensification of Social and Behavior Change Communication (SBCC) for condoms to increase demand and use of the commodity.

HIV and AIDS awareness is almost universal (99%) in Malawi, although comprehensive knowledge is around 41%[9]. About 75% of men and women aged 15–49 years know that consistent condom use

[7]Magadi, 2011; see also Fox, 2012
[8]Gender Assessment of the Malawi National HIV Response, 2014
[9]Knowing that consistent condom use, having one uninfected faithful sex partner reduces chances of contracting HIV and that a healthy looking person can have HIV plus rejecting the two most common transmission misconceptions about HIV transmission (that HIV can be transmitted by mosquito bites or supernatural powers

prevents the spread of HIV. Eighty seven percent (87%) of women and 85% of men know that limiting sexual intercourse to one uninfected HIV negative partner reduces the chances of contracting HIV. Seventy nine percent (79%) of women and 77% of men know that abstinence reduces the risk of HIV infection. Women remain vulnerable to HIV infection due to socio-cultural practices. This includes widow inheritance, initiation ceremonies, and agreeing to dry sex to please the male partner. The overall male dominance around issues of sexuality has also been noted to propel the spread of HIV in Malawi. Women generally have a lower socio-economic status and are oriented from childhood to be submissive to males. This results in an expectation that women should impress their spouses/partners at all costs, even at the expense of their health. Situations where women are unable to negotiate safer sex are well documented, for instance: abusive and significantly age-disparate relationships.

Multiple concurrent partnerships combined with low or inconsistent condom use have also been noted to play a role in the transmission of HIV. The 2016 MDHS reported that among both men and women with multiple partners in the past year, 27% of women and 30% of men used a condom at last intercourse. Men report having 1.4 more lifetime sexual partners than women (2.1 for women versus 4.5 for men). Women in the highest wealth quintile constitute the majority of women reporting having multiple sex partnership (MDHS, 2016). Unavailability of condoms, particularly in rural areas, entertainment places and commercial accommodation facilities, has been observed and argued to contribute to low and/or inconsistent condom use. The perception that condoms reduce sexual pleasure is also believed to be a contributing factor to low and/or inconsistent condom use.

Voluntary medical male circumcision has been demonstrated to reduce the acquisition of HIV among men engaging in penetrative vaginal sex by over 60%.[10] In Malawi, however, only 28% of men aged 15–49 years are circumcised either traditionally or medically. Self-reporting may over estimate circumcision prevalence by up to 50% and the actual proportion of Malawian men fully circumcised may be only 11%. Uptake of VMMC in Malawi has been initially slow but has picked up with over 70,000 circumcisions conducted by the end of 2013 and 250,145 circumcisions by the end of the 2017/2018 Financial year. The national response has been able to provide VMMC services in high prevalence districts to ensure maximum impact. The main challenges have been demand creation, inadequate qualified providers to conduct the circumcision and issues with supplies of commodities/consumables for male circumcision.

MSM are considered a key population in HIV epidemics, based on the increased risk of HIV transmission from unprotected anal intercourse. Generally, higher levels of sexual partnering within relatively closely connected partnership networks, and the ability of MSM to serve as both the insertive and receptive partner in acts of anal intercourse further puts them at increased risk of contracting HIV. While MSM show higher levels of HIV prevalence than members of the general population in every region of the world, MSM in sub-Saharan Africa continue to be an understudied population. A recent survey assessing HIV risk and prevalence, along with human rights indicators, among MSM in Botswana, Malawi and Namibia shows considerable levels of sexual risk behaviour, HIV prevalence and human rights violations.[11] Around 42% of respondents across all sites reported experiencing at least one indicator for stigmatization and marginalization, including fear of seeking health services or moving freely in their communities. These findings are not surprising for Malawi, given that same-sex relations are criminalized under the Penal Code.

[10]Gray, 2007, 2013

[11]Baral, S., et al. (2009). "HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana." PLoS Medicine**4**(3): e4997.

Figure 4 shows recent Key population sizes in some selected districts and cities in 2017. Estimating the MSM population size is fraught with difficulties and may be subject to bias due to the criminalization and marginalization of this group in Malawi.

Figure 4: Size estimates for Key Populations in Malawi (2017 PLACE study)

District/City	FSW	MSM
Lilongwe	7,333	2,916
Blantyre	6,959	3,141
Mangochi	1,145	238
Machinga	1,311	-
Mzuzu	1,431	429
Zomba	1,355	270

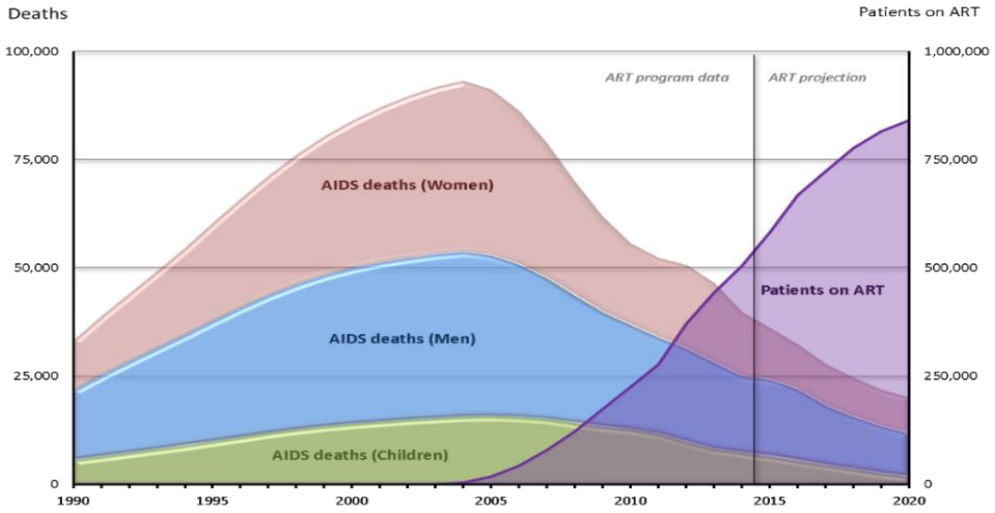
Key populations are a key driver of HIV transmission if not given due attention considering the multiple concurrent partnerships and high risk behaviours practiced by these populations. Similar to other studies in the region, in the 7-site study around 50 - 60% of MSM participants reported consistent condom use; self-reported use of water-based lubricants was low; and, about half reported multiple concurrent partners in the last year (Wirtz, 2014). Over 50% reported their first homosexual contact below the age of 21 years. There was low awareness of the increased risk of HIV transmission associated with anal sex. The majority of participants identified as homosexual, but substantial proportions said they were married, cohabitating, and/or in sexual relationships with women. A 2010 study also found that among surveyed MSM in Malawi, 63% reported having both male and female partners in the last six months".[12] This confirms that exclusive heterosexual behaviour should not be assumed for all married men, and risk reduction counselling should cover the specific risk associated with anal sex and specific protective measures.

Only slightly over half of the MSM study participants reported ever being tested for HIV. With respect to structural risk, some 8-22% of MSM reported a history of jail/prison. This was associated with HIV infection in both Lilongwe and Blantyre; not a surprising finding, as a 2012 Malawi prison survey revealed HIV prevalence exceeding 40% in some prisons in Malawi.[13] Sex workers face visible forms of stigma within their communities (Chizimba, FPAM, 2011). Once identified as sex workers, they are actively denied access to alternative income-generating opportunities. Sex work is also criminalized under the law relating to rogue and vagabond. However, sex workers operate clandestinely in major urban areas, transport routes, tourist destinations, and all sites of potential economic activity which poses a threat to HIV transmission. Despite FSW representing a relatively small proportion of the general population (as is the case with MSM), they have disproportionate high risk of HIV with limited access Health services especially HIV prevention, care and treatment service. Hence FSW, their clients and, partners of clients of female sex workers constitute a big challenge in the control of the epidemic. As with MSM, sex workers frequently do not disclose their sexual risk behaviours while accessing health services because of real or perceived stigma from health providers. This limits opportunities for the health system to provide additional high impact interventions targeting sex workers, including

[12]Beyrer, C., et al. (2010). "Bisexual concurrency, bisexual partnerships, and HIV among Southern African men who have sex with men (MSM)." Sexually Transmitted Infections**86**: 323-327.
[13] Mwapasa, V. et al (2012). Prevalence and Risk Factors for HIV, Sexually-Transmitted Infections and Tuberculosis in Malawian Prisons .Malawi Prison Services.

routine HIV and STI screening and testing, and consistent access to condoms and other modern family planning methods.

Figure 5: Estimated AIDS deaths (2014 Spectrum model) and ART scale-up (MOH program data up to mid-2014)



An estimated **834,000** Malawians have died of AIDS since the start of the epidemic in 1985.
Figure 5 shows the estimated number of annual AIDS deaths among men, women and children between 1990 at the end of the 2015/2020 NSP. The AIDS death wave is thought to have peaked at 93,000 in 2004 and started to decline rapidly with introduction of free ART later that year. With the 2017 implementation of HIV test and treat policy , there has been a dramatic declined in HIV related morbidity and mortality nevertheless, HIV still remain the leading cause of death among adults(15-49 years) and a significant cause of childhood mortality. In 2013, an estimated 38,000 (66%) o of 56,500 adult (15-49 years) deaths in the population were HIV-related and 10,000 (**10%**) of 104,000 child deaths (0-14) were attributed to HIV. Almost 80% of estimated pregnant women living with HIV are on ART through the implementation of Option B+ in 2011. This has led to significant gains in reduction of paediatric infections: in just 4 years, the number of children infected by their mothers (including during the breastfeeding period) has declined by 66% (from 30,000 in 2010 to 10,000 in 2014). It was envisaged, with the 90-90-90 targets, that new mother to child paediatric infections would be reduced to less than 3900 by 2020.

1.3.4 Combination Prevention

Evidence-informed and human rights based combination prevention recognizes the importance of biomedical, behavioural and structural interventions working together to achieve prevention and care outcomes.[14] A mixed approach addressing both immediate risks and underlying causes of vulnerability of key and vulnerable populations is both possible and necessary.

Behavioural and structural interventions support the continuum of prevention, treatment, care and support through mobilization for HIV related services and commodities, linkages, and community based interventions to prevent primary and secondary transmission. Based on epidemiological analysis,

[14]Catherine A. Hankins and Barbara O. de Zalduondo AIDS 2010, 24 (suppl 4):S70–S80). Core biomedical prevention interventions include condoms, VMMC, PMTCT/ART.

targeted and tailored interventions are designed and delivered for each of the key and vulnerable populations to ensure that approaches to reach them address critical barriers impacting their adoption of positive health behaviours, including condom use and demand for services; facilitate access to biomedical prevention services (i.e. Condoms, HTC, VMMC) and encourage utilisation of HIV treatment and care services for known PLHIV. Behavioural and structural programs continue to address critical barriers to service utilisation including disclosure, adherence and long-term retention by (i) addressing damaging gender norms and practices, (ii) stigma and discrimination, and (iii) strengthening community based service delivery including condom distribution, targeted community HTC, care and support groups, and robust bi-directional referral systems. Behavioural and structural elements also need to include access to economic strengthening interventions, cash transfer and other emerging evidence-based interventions.

The National Strategic Plan adopted a combination prevention approach for each targeted vulnerable population, appropriately tailoring comprehensive interventions and minimum packages of mutually reinforcing interventions. Together, these services and interventions would have the potential to significantly reduce HIV transmission and improve care outcomes. Since rarely one institution or system provides every element within a defined package, these packages are underpinned by effective referral systems and, where appropriate, community-based case management. Implementation approaches would require innovative population-targeted interventions. While most services would be delivered within facility settings, other interventions recognize that marginalized populations face barriers and would rely on different types of outreach and mobile models to be reached.

2.0 Methodology of the 2015-2020 NSP Review Process

A highly participatory and consultative approach in which all the relevant stakeholders participated was adopted in reviewing the achievements and challenges in the national responses over the lifespan of the current NSP. A multi-disciplinary Steering Committee (SC) as well as a Taskforce were formed to provide overall guidance to the review of the 2015/2020 NSP, and these structures are also expected to inform development of a successor NSP covering the period 2020 to 2025. Thematic groups were constituted to review performance of each pillar of the 2015/2020 NSP. Each group reviewed achievements registered, challenges experienced as well as proposed way forward to improving HIV and AIDS programming. This process was complemented by pragmatic desk review, and consultations with varied stakeholders.

A pragmatic desk review was undertaken for each of the thematic areas, namely, Prevention; Treatment, Care and Support; Impact Mitigation; and Management and Coordination. The review followed a systematic process of abstracting relevant information to assess performance of the 2015/2020 National Strategic Plan. Particular emphasis was put on documenting progress of implementation of the NSP against set targets during the years 2015/2020. Information on the indicators under each thematic area was sought from programme reports, annual performance reviews and from annual surveys. International and national experts in HIV Prevention, as well as programme managers, development partners and relevant stakeholders participated in this process.

3.0 Findings

3.1 NSP Objective 1: 90% OF PLHIV Know their Status

3.1.1 Country Context

HIV Testing Services (HTS) remains the gateway to accessing HIV treatment and care services in Malawi. HTS service are available in almost all 750 Antiretroviral Therapy (ART) sites as well as offered through integrated outreach and mobile clinics. The National HTS Guidelines, 2017 (currently under review) largely anchors HTS programming and complemented by auxiliary guidelines, namely:

- HIV Self-Testing (HIVST) Guidelines;
- Medical Laboratory Manuals
- Quality Control (QC) guidelines;
- EID protocols and algorithms;

By December 2018, there were 1,062,622 People Living with HIV (PLHIV) and out of which 968,855 were aware of their HIV status, representing 91%.

3.1.2 General Achievements

- Introduction of the HIV Diagnostic Assistants (HDAs). This followed successful piloting of the HDA cadres in PEPFAR supported sites. The introduction of this cadre has largely increased the uptake of HTS.
- Launch of the HIV Self-Testing (HIVST) as a national program. Implementation of HIVST provides the country with synergistic approach of early diagnosis of HIV, linkage to care as well as experiencing good treatment outcomes, thus in the process remove perceived barriers to accessing HIV services. HIVST has also proven to be safe, effective and acceptable to populations that are hard to target such as men, adolescents and young people, key and vulnerable populations. To date, HIVST has been incorporated in the integrated HIV/TB support supervision tool, and lab personnel have been dully trained on how to conduct QCs on HIVST.
- The program has also introduced the use of Voluntary Assisted Partner Notification (VAPN) strategy. This is a targeted approach to HIV testing where household members of a person who has tested HIV positive are also offered HIV testing services.This helps to increase uptake of HIV testing services among partners of HIV positive clients. In addition, this approach has a potential to increase HIV yield among the target population. The strategy is also important in aiding linkage to care for partners of HIV positive people.
- The program has also intensified targeted outreach testing focusing on key and vulnerable populations using different innovative approaches such as moonlight testing and work place testing. The aim is to identify more new HIV positive clients and enroll and retain them on treatment.
- Sustenance of the Provider Initiated Testing and Counselling (PITC). PITC continues to be implemented across all health facilities country wide, and there is also increased coverage of PITC in TB, ANC, STI and maternity settings. The introduction of HDAs has also improved provision of PITC.
- The Malawi program has also strengthened confirmatory testing of HIV in order to improve diagnostic accuracy and rule out misdiagnosis prior to enrolment into ART. Conduct of confirmatory tests has ensured that only true positives are initiated on ART. HTS inconclusive results are referred to National Health Reference Laboratory (NHRL) for further analysis.

- Malawi is also piloting recency testing in pilot districts as a strategy for detecting new infections and enrolling them on treatment. Thus, lessons from the pilot phase will information wide scaling up of recency testing as policy guideline.

3.1.3 Achievements against indicators

- By December 2018, 91% of PLHIV were aware of their status, well ahead of the UNAIDS timelines of achieving the 90-90-90 goals.

3.1.4 Challenges

- Repeat testing by known HIV positives who hide their status. For instance, out of the 1,106,090 people tested for HIV during October – December 2018, 854,593(77%) were repeat testers.
- Low uptake of HTS services by men. For example, the proportion of males accessing HTS services in 2018 was estimated 36% compared to 64% for women.
- HIV-related stigma and discrimination remains a barrier to targeted outreach testing, and more so among KP in communities;
- Low uptake of HTS among prisoners, and there is less involvement of implementing partners targeting prisoners.
- Low coverage of HTS among vulnerable population involved in seasonal jobs.

3.1.5 Way Forward

- Strengthen and compliment HTS services with VAPN strategy.
- Intensify regular QC services for HTS protocols and algorithms.
- Enhance strategies to reduce stigma and discrimination among KPs, as well as promote provision of opt-out HTS package in prison settings.

3.2 Condom Programming

3.2.1 Country Context

The Government of Malawi recognises that condom use is an important biomedical intervention for preventing HIV and Sexually Transmitted Infections (STIs), including and enhancing family planning. The Government is committed to supporting Comprehensive Condom Programming (CCP) to ensure that condoms are available and accessible at point of use. In this regard, Malawi has adopted a **Total Market Approach (TMA)** to harness efficiencies in the condom supply chain as well as achieve comprehensive condom programming. The TMA approach acknowledges the contribution of all players at all levels within the condom market, and highlights the importance of leveraging market players' irrespective of strengths in procuring and distribution of condoms to outlets easily accessible to men, women, youth and KP.

The condom program also integrates with several strategies, namely, the HIV National Guidelines on HIV Testing Services, National Guidelines on STI Syndromic Management, HIV Treatment Guidelines, VMMC Policy, HIV and AIDS Work Place Policy, Reproductive Health Policy and Guidelines, and Family Planning Policy and Guidelines. Condom outlets in Malawi include: Free condoms distributed in health facilities and socially marketed condoms sold in shops. The 2015/16 MDHS reported that the most common sources of condoms were health facilities (32%) and shops (31%). While health centres serve communities at the last mile, distribution of condoms to them has not been prioritised leading to inefficiencies in the supply chain.

3.2.2 General Achievements

- Malawi established the National Condom Coordination Committee (CCC) comprising key stakeholders from Government agencies, development partners, implementing partners, local NGOs, and the private sector. The CCC meets quarterly to provide technical expertise to MOH on CCP development and execution, and collaboratively work to expand the condom program and market.
- Establishment of district level condom coordination committees and district-based condom focal persons has successfully facilitated coordination of various stakeholders in condom programing at district level. The CCC also monitors implementation and distribution of condoms in order to gain a better understanding of critical bottlenecks in the distribution system and address emerging challenges.
- Development and distribution of condom reporting tools to capture condom distribution at all points.
- Integration of peer-to-peer education, condoms and lubricants distribution for MSM and FSWs in the national response.
- Development and dissemination of the National Condom Strategy 2015 – 2020. The strategy seeks to improve the availability and accessibility of quality male and female condoms by all sexually active persons. Ultimately, this is expected to contribute towards prevention of HIV infection, STIs, and unintended pregnancies. The strategy also provides a framework for Total Market Approach to condom programming.
- Dissemination of the revised HIV Prevention Strategy (2018 to 2020). This contains a strong component of comprehensive condom programming and aims to increase use of condoms among males and females during high risk sexual encounters.
- Use of parallel condom distribution channels to the public sector supply chain system, including of Community-Based Distribution Agents (CBDAs) and a dedicated condoms and lubricants distribution channels for key populations' service providers.
- Successful coordination of various stakeholders in condom programing at district level, championed by the district level condom coordination committees and focal persons.
- Introduction of lubricants to support ongoing KP programs which may facilitate correct and consistent condom use among KP.

3.2.3 Achievements against indicators

Table 2: Summary of Condoms Distribution Against NSP Targets

Commodity	Distribution 2018	Yearly targets (Millions)
Male Condoms	76, 942,632	135m
Female Condoms	743,382	1.4m
Lubricants	1,195,344	1.5m

3.2.4 Challenges

- Resource constraints continue to affect condom programming, coordination, research, and sharing of best practices.
- Inadequate condom programing support at district level. Only eight of the 28 districts have active condom program focal persons.
- Weak condoms distribution system from health facility to the last mile.

- Isolated implementation of demand creation programs continue to affect effective uptake of condoms and lubricants at project level.
- Gaps in condom reporting at health center and community level affect the condom supply chain system.
- Introduction of lubricants lacked proper messaging and led misconceptions which put the general population at risk of HIV infection.
- Cultural practices remain to inhibitors to translating individuals' knowledge into action.
- Implementation of Sexual and Reproductive Health Rights (SRHR) services at secondary and primary schools remains a challenge. Current government policies and regulations advises against condoms distribution in schools due to condoms' negative association with sex.
- Inadequate advocacy and policy dialogue for political awareness, government ownership, and commitment to reduce policy barriers and promote condom access and use.

3.2.5 Way Forward

- Expand utilization of CBDAs alongside the heath sector condom distribution system to increase the number of non-health sector service delivery points.
- Leverage community but outside-of-the-public health sector but high-potential distribution points to maximise uptake of condoms.
- Explore non-traditional approaches to condom distribution in hard-to-reach communities.
- Strengthen condoms supply chain system at all levels to prevent shortages and stock outs of both male and female condoms.
- Complement roll out of the condom reporting tools with capacity building initiatives.
- Support Condom Coordination Committees (CCCs) at various levels to mobilise and proactively allocate resources to implement key activities.
- Conduct periodic social, behavioural, and operational research initiatives to generate evidence for high-impact programs and shared with key stakeholders to inform programming.
- Strengthen female condom promotion and explore targeted programming to groups with favorable attitude towards their use.as well as increase condom accessible and empower women to use female condoms.
- Use and strengthen peer education systems to raise awareness about male and female condoms and lubricants for key populations.
- Re-introduce a standardized communication strategy on the use of lubricants to clear the underlying misconceptions as well as integrate distribution of the product into the national supply chain – increase accessibility.
- Eliminate policy barriers for youth to accessing SRH services, including linking of in-school and out-of-school youth clubs to accessible community condom distribution points.

Table 3: Status of the Epidemic as of December 2018[15]

Summary Indicators	2015	2018	% Change
Adults 15-49			
PLHIV	759,963	795,490	5%
Prevalence	9.8%	9.2%	-6%
Incidence	0.54	0.45	-17%
New infections	36,472	33,764	-7%
Annual AIDS Deaths	8,319	8,181	-2%
Children 0-14 years			
PLHIV	89,406	73,810	-17%
Prevalence	1%	0.9%	-10%
Incidence	0.08	0.04	-50%
New infections	6,430	3,527	-45%
Annual AIDS Deaths	4,335	2,565	-41%

3.3 Voluntary Medical Male Circumcision (VMMC)

3.3.1 Country Context

Medical Male Circumcision (VMMC) has been proven to be an effective intervention in reducing the risk of HIV acquisition by HIV negative by over 60% [quote source]. Malawi developed its first National VMMC Policy in 2012, and since then Malawi has produced VMMC Standard Operating Procedures, a VMMC Communication Strategy and VMMC Strategy and National Scale up Plan. VMMC services were also provided through different approaches such as outreach, static, mobile clinics. In order to institutionalize and ensure ownership of the VMMC programs implementing districts were encouraged to develop implementation plans and monitor program performance. According to the 2015-2020 NSP, the country committed to an ambitious VMMC scale-up plan targeting a total of 2,458,727 VMMCs to be performed among males aged 10-34 years in Malawi in order to achieve 60% coverage. This was estimated to ultimately avert over 91,000 new infections by 2050[16].

The demand creation component of the VMMC program is led by the Ministry of Health (MOH) and guided by the National Communication Strategy for Voluntary Medical Male Circumcision. The overall goal of the communication strategy is to increase demand for VMMC services in the country. The program uses approaches aimed at influencing an individual's decision and motivation to seek VMMC services through a variety of means at society, community, relationship, and individual and peer networks. Thus, Malawi has established several operational structures at national and district levels to spearhead the demand creation activities.

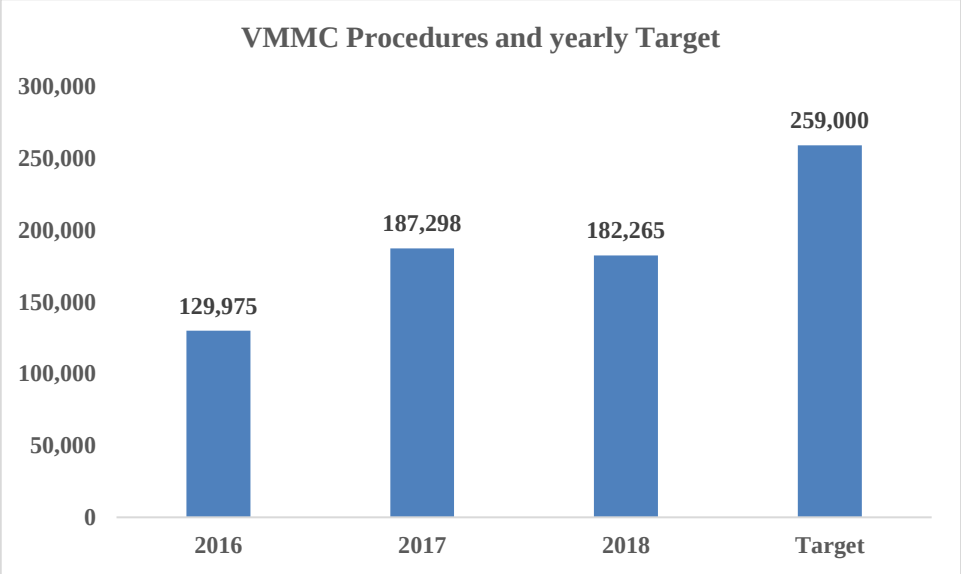
3.3.2 General achievements

- Overall, the prevalence of reported male circumcision in Malawi increased slightly from 22% in 2010 to 28% in 2015/16 though the district coverage widely varies.
- By December 2018, a total of 756,780 VMMCs were conducted, representing 31% of the number of VMMCs required to reach the 60% coverage target.

[15] Spectrum estimates
[16] The Malawi HIV Prevention Strategy - 2018 edition

- The Government has laid the foundation for the sustainability of VMMC program in the country. These include: promotion of the full integration of VMMC in routine health service delivery; procurement of VMMC related equipment and supplies and trained a pool of service providers and support staff in the target districts;
- Cultivated a strong coordination and meaningful collaboration with partners at all levels; and ensure ownership of the VMMC program at district and community levels.
- In order to increase uptake of services, the Malawi VMMC program successfully piloted, use of user-friendly and widely preferred devices for performing VMMCs compared to the surgical method.

3.3.3 Achievements against indicators



3.3.4 Challenges

- Uptake of VMMCs remain low despite several efforts of scaling up its implementation with PEPAFR working in only 8 of the 28 districts classified as high burden.
- Inadequate demand generation activities and this partly led to men being reluctant to undergo the procedure.
- Concerns about pain, fears of being rendered impotent and abstaining from sexual activity for 6 weeks still remain in our communities.
- Supply-side challenges, namely, severe HRH constraints, shortages of VMMC commodities and lack of decentralisation of VMMC services.
- Delivery of VMMC services are primarily partner-driven, relying on the provision of VMMC by PEPFAR partners and this threatens sustainability.
- VMMC services provided during scheduled campaigns on *ad hoc* basis and not demanded by clients per se.
- Limited institutionalization and integration of VMMC into the HIV prevention programs at all levels (national, regional/zonal, district and health facility level).

3.3.5 Lessons learnt and way forward

- Investments in social and behavioral change programs helped to reduce misconception surrounding VMMCs.
- Decentralized of VMMC services increased uptake of services.
- Promotion of linkages among other key health services like STI, MNCH, ART and HTS is critical to achieving the objective of controlling HIV.
- Sound planning and procurement of all inputs is vital to the delivery of quality and uninterrupted services.
- Adoption of a robust M and E system aligned to the MOH is critical to monitoring progress towards set targets.
- Use of expert client, interpersonal and community education information proved effective in increasing uptake of services.
- Training of all eligible service providers and inclusion of VMMC skills training in pre-service curriculum appears a more sustainable and cost-effective strategy for sustainability of the program.
- Engagement of traditional leaders, religious and other influential local leaders is key to improving the uptake of services even in traditionally non-circumcising communities.
- Involvement of different sectors is key to increasing demand and uptake of VMMC services. Among others, this include; education, social welfare, private, NGOs, civil Society.
- Districts and communities are capable of organizing themselves and working together to create demand for VMMC so long they are empowered and equipped with necessary resources and capacity building.
- Use of community structures and mobilizers is effective in increasing demand for the services.
- Continuous and sustained demand creation interventions (not focusing on campaigns only) is critical in increasing uptake of VMMC services.

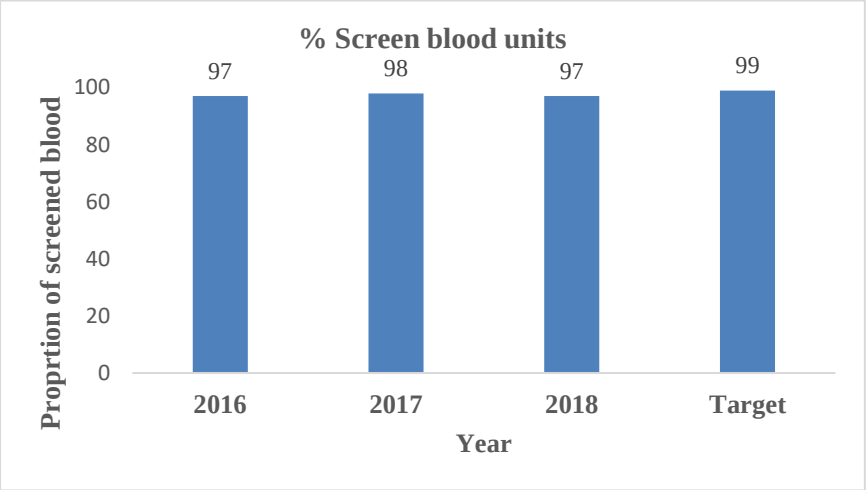
3.4 Blood Safety

3.4.1 Country Context

Transfusing blood that has not been screened for HIV infection puts the recipient at an increased risk of HIV and other blood-borne infections. At present, Malawi is yet to achieve universal screening of donated blood for HIV infection. Partly, this is due to lack of supplementary supply of blood products from the Malawi Blood Transfusion Services which is rather ad-hoc collection. In addition, mechanisms to ensure quality and continuity in screening are still inadequate, particularly at the lower levels of the health system. However, the 2015-2020 NSP retained the goal of screening 99% of the donated blood in the country for markers of key infectious diseases (HIV, Hepatitis B and Syphilis) in a quality-assured manner from a baseline of 93% in the pre NSP period.

3.4.2 Achievements

While yearly targets were not met, the percentage of donated blood units screened for markers of infectious diseases (HIV, Hepatitis B and Syphilis) was nearly consistent and high over the three years of the NSP. During this period, the Malawi Blood Transfusion Services (MBTS) continued to implement the Malawi Blood Donor Mobilization Strategy (2014-2016) which largely contributed to the observed performance.



3.4.3 Challenges

- Incomplete blood safety data at facility level due to poor documentation
- Some facilities not using MOHP approved blood safety registers thereby affecting reporting
- Low volume of voluntary non-remunerated blood donors leading to unmet need of national blood supplies.
- While being utilized, the Blood Donor Mobilization Strategy is expired
- Inadequate blood safety indicators in the current NSP hence affecting programming

3.4.5 Proposed Way Forward

- Improve blood safety data quality through strict monitoring and retraining
- Provide and re-orient facilities on the use of blood safety registers
- Allocate enough funds to mobilize more non-remunerated blood donation
- Develop a new edition of the Malawi blood donor mobilization strategy to replace the older version which expired in 2016,
- Include the following indicators in the next NSP , to be in line with WHO strategy
    - *Proportion of blood collected from the VNRBD.*
    - *number of units screened for HIV only*
    - *number of units screened for HIV, Hep B, Hep C and syphilis)*

3.5 Social and Behavioral Change Communication (SBCC)

3.5.1 Country Context

Social and Behaviour Change Communication (SBCC) programs use coordinated approaches to provide information, empower and mobilize individuals and communities to promote health seeking behaviours and increase demand of health services. Modifying HIV-related knowledge, perceptions, attitudes, social norms and practices relies on active participation of community leadership, cultural and religious leadership, formal and informal segments of the private sector, Community Based Organisations, PLHIV leadership and community groups for a set of behaviours. Collectively, this promotes t increased demand and uptake of priority HIV prevention and care services including

condoms, STI treatment, VMMC, HTC, PMCT, PrEP and ART, at all levels; increased adoption of safer sexual behaviours and reduction in risky sexual behaviours, and improved structural environment that mitigates drivers of HIV infections and barriers to utilization of HIV Prevention Services.

The country has over the years used national and/or regional evidence-based SBCC tools to create demand for services. Almost all the HIV programs have an SBCC/communication strategies focusing on mass media and community mobilization approaches. Uptake of HIV related services is attributed to the quality of SBCC interventions. On the other hand, low demand is one of the major drivers for poor coverage of various HIV prevention and care services. This problem is well documented for condom use among females and FSWs, HTC uptake among men, VMMC uptake among older males (15-34 years) and non-circumcising tribes and religions. Mass media programs such as that of the "Girl Effect" project has been effective in reaching girls, boys, and communities through transformative norms and has great potential to leverage community youth networks to expand reach and amplify voice.

3.5.2 General Achievements

The impact of SBCC interventions can only be established through deliberate population based studies. Therefore, there is need to invest in evaluation studies on effectiveness of SBCC on uptake of services and behavioural change.

3.5.3 Achievements against indicators

The NSP did not include any specific indicators for this component, and this could be due the lag in establishing results as this requires specified studies and surveys.

3.5.4 Challenges

- Most of the community SBCC networks are not functional thereby limiting community involvement in creating awareness and demand for services.
- From the faith community there has been an issue of faith healing which has resulted in some PLHIV on treatment defaulting treatment.

3.5.5 Way forward

- There is need for evaluation studies on effectiveness of SBCC on uptake of services and behavioral change
- SBCC interventions need to be carefully designed to take into account the characteristics and behaviors of the target audience. The interventions should also provide information on where, when and how to access evidence-based HIV services.
- There is need to mobilize and engage with community leaders; revitalize Village Health committees, Community networks, linkages, partnerships and coordination. This includes conducting on-going national, district and community level dialogue on barriers to health seeking behaviours for HIV prevention and treatment services. The dialogue sessions will inform the development or revision of health promotion messages and materials, service delivery approaches, behaviour change interventions for targeted groups and new ways of reaching/promoting and delivering services.
- Considering the importance of ART as an effective prevention strategy, the general public and community leaders will have to be sensitized about the role of HIV sero-discordancy in HIV transmission among couples, and the importance of active case finding, early ART initiation and adherence and HIV viral suppression in preventing HIV transmission.
- There is need for review and adapt regional and national SBCC messages to ensure that materials and approaches are relevant to different priority sub-populations, cultural background and age-groups.

- The country should implement targeted demand creation SBCC strategies for the general population and specific groups using a mix of effective and evidence-based channels. This may include mass media, interpersonal communication (IPC), and community mobilization and dialogue.
- There is need to explore, develop and expand the use of mobile and on-line based communication approaches targeting men, couples and KP to promote utilization of HIV prevention and treatment services, particularly among sub-populations with poor access to HIV services.
- Strengthen delivery of quality HIV services, training, mentorship, and job aids for service providers through varied trainings in interpersonal communication skills and client friendly attitudes. Establish SBCC coordination structures at national and district level and support their operations to ensure harmonization of SBCC efforts by stakeholders.
- Standardize and customize approaches and content of materials for demand creation.

3.6 NSP Objective 2: 90% of People with known HIV Positive Status are Retained on ART

3.6.1 Country Context

Given the goal of ending HIV and AIDS by 2030, and the intermediate objective of reaching the UNAIDS 90-90-90 targets, the 2015-2020 NSP recommended for early identification of People Living with HIV (PLHIV) and enrolment in care. This was thought to maximize the effectiveness of existing program strategies to virtually eliminate progression to AIDS, premature death and HIV transmission. Consequently, the HIV and AIDS program rolled out the Test and Treat strategy in 2016. While this increased uptake of ART services, there is a significant gap between the number of people testing HIV positive and those starting ART. Clients are lost at various stages in the continuum of care. The retention rate is also challenged by health system constraints represented in the form of chronic health worker shortages, a fragile health infrastructure that is highly donor dependent, and limited scale of facility-and community-level interventions.

There is also low uptake of ART by children living with HIV. The integrated HIV and AIDS report indicate that as of Q3, 2018 (July – September), coverage of ART for children below 15 years was at 65%. Treatment adherence and retention are further compounded by pill burden, treatment illiteracy by care givers and weight-based dosage. Infants born to HIV-infected mothers are supposed to receive an HIV test for early diagnosis of infection and immediate initiation of AR. This is on the basis that disease progression in HIV-positive infants is particularly rapid in the first few months of life, and early ART initiation has been shown to significantly reduce the risk of mortality. Diagnosis of HIV infection in infants is done by testing for HIV genetic material in a blood sample through Polymerase Chain Reaction (PCR). Currently PCR testing is mostly done in 10 molecular laboratory spread across the country. In addition, there were 96 Point of Care machines in the country with capacity to test HIV in infants as of May2018.

3.6.2 General Achievements

- Out of the 1,064,676 estimated people diagnosed with HIV by end of December, 2018, (83%) were retained on ART. Some of the reasons clients were not initiated on treatment after immediately after being found HIV positive include; inadequate referral mechanisms within the facility and between the community and facility; repeat testers and inadequate counselling services.
- Cumulatively as of **2018 Q4**: Out of the 1,258,214 patients ever initiated on ART, **805,232 (63.9%)** were retained alive on ART, **112,688 (9%)** were known to have died, **350,381 (27%)** were lost to follow-up and **6,597 (<1%)** were known to have stopped ART.

- Uptake of HTS in children under the age of 15 was estimated at12%.
- ART coverage among children below 15 years was at 68%.
- Uptake of Early Infant Diagnosis was as follows;
  - At age-2 months - 75% had an EID test and out of which1% tested HIV positive and 70% of those were initiated on ART.
  - At age 12-months - 74% received either DNA-PCR or Rapid test. Out of these, 2% tested HIV positive and 86% of those that tested HIV positive started ART.
  - At age-24-months - 68% received either DNA-PCR or Rapid test, while 4% tested HIV positive and 86% started ART.

3.6.3 Achievements against indicators

Overall, the target of the second 90 is to ensure that 90% of PLHIV identified under the first 90. To date, 83% of PLHIV have been initiated to care.

3.6.4 Challenges

- There is moderate retention rates for women enrolled under option B+. Retention rates were 77%, 74%, 70% and 64% at 6, 12, 24 and 36 months respectively after treatment initiation.
- Low uptake of DNA-PCR services at age months as well as retention of mother infant pairs who started ART during pregnancy or breastfeeding.
- Linkage to care remains a challenge among those diagnosed with HIV.
- Increased volume of repeat testers for healing confirmatory purposes. Low coverage of HIV counselling services to support ART initiation and adherence.
- Limited scope of community outreach services and use of peer educators, and KP led organizations.
  Differentiated Service Delivery Models (DSD) not fully actualized.
- Integration of HIV and other related services is yet to be fully materialized and HTS remain limited in women after delivery.
- Use of point of care machines for EID remains limited.

3.6.5 Proposed Way Forward

- Enhance distribution of referral registers in all ART sites to facilitate tracking of clients that fail to report for ART initiation.
- Explore strategies for linking patients to care such as use of clinic navigators
- Follow-up known HIV positive clients not in ART clinic for treatment initiation.
- Expand the use of expert clients' model within the HIV and AIDS continuum of care.
- Intensify IEC activities to support overall linkage to ART services.
- Decentralize ART further services and make full use of community-based resources to support PLHIV.
- Leverage existing community outreach services, peer educators, and KP led organisations for implementation of KP interventions.
- Scale-up and sustain implementation of DSD models.
- Ensure full scope integration of HIV services to routine service delivery. Proactively expand provision of HTS in post-natal clinics to diagnose those sero-converting late in pregnancy or after completing ANC visits.
- Introduce use of hub and spoke model (also known as a cluster system) for point of care DNA-PCR.
- Leverage teen club model to expand coverage of HIV services among teenagers.

3.7 Prevention of Mother to Child Transmission (PMTCT)

3.7.1 Country Context

Malawi has one of the highest fertility rates in the world. Thus, controlling Mother-To-Child Transmission (MTCT) of HIV was a key priority, as well as major challenge during implementation period of the NSP. Consequently, the HIV and AIDS program oversaw the implementation of MTCT to reduce the HIV burden among mothers, and their children. These strategies are grouped into the 4 prongs of the national PMTCT program, namely;

i. Prong 1: Reduce HIV incidence and prevalence in women of childbearing age.
ii. Prong 2: reduce unplanned or unintended pregnancies among HIV+ women.
iii. Prong 3: Increase ART coverage among HIV infected pregnant and breast feeding women.
iv. Prong 4: Care, treatment and support for HIV-infected women and their children and families.

The synergistic implementation of these strategies resulted in a drastic reduction of HIV infections among children. Further scale-up is expected to virtually eliminate new paediatric HIV infections and AIDS deaths among children.

3.7.2 General Achievements

- The HIV program reported estimated HIV ascertainment and ART coverage at 98%, 88% respectively. This implies that the set targets of 85% for each by 2020 have been attained.
- In addition, 71% of clients whose HIV positive status was ascertained were already on ART before ANC and only 29% started ART during ANC or delivery.
- High coverage of NVP for HIV exposed infants estimated at 96% in 2018. From a program integration perspective, 22% of women received Depo Provera from ART clinics and 50% of PMTCT/ART sites had stock of Depo Provera.

3.7.3 Achievement against indicators

Table 4: Summary of indicator achievements against targets

Indicator	2016	2017	2018	Target
% of HIV infected women using a documented type of modern family planning method (Depo- Provera) from PMTCT clinics	0.26	0.27	0.22	0.26
Percentage of Infants born to HIV-Infected Mothers that are HIV positive end of breastfeeding	0.05	0.02	0.03	0.05
Percentage of infants born to HIV positive women who are alive at 12 months of age and HIV negative (i.e. 12 month Infant HIV-Free Survival)	0.53	1.0	1.0	0.87
Percentage of HIV infected pregnant women who received antiretroviral to reduce the risk of mother to- child transmission in accordance with national protocols	0.87	0.93	0.89	0.85
Percentage of exposed infants given Nevirapine at birth	0.95	0.92	0.95	0.95
Percentage of infants born to HIV infected women started on cotrimoxazole prophylaxis within two months of birth	0.95	0.96	0.88	0.94
Percentage of infants born to HIV+ women receiving a virological test for HIV within 2 months of birth	0.45	0.60	0.69	0.70
Infant ART coverage (Early infant treatment access)	0.08	0.18	0.20	0.4

3.7.4 Challenges

- Cultural disempowerment of girls and women, negative gender norms and stereotypes, poor educational attainment, poverty and poor economic empowerment contributed to poor sexual and reproductive health outcomes among AGYW.
- Limited effectiveness of HIV prevention interventions among Adolescent Girls and Young Women (AGYW) due to poor stakeholder coordination across key stakeholders; particularly in the health, education and social welfare.
- Low comprehensive knowledge on HIV among young females (41%) aged 15-24 years.
- High incidence of HIV among AGYW estimated to be 0.57% compared to 0.23% males counterparts
- High unmet need for family planning, with key challenges manifesting in uptake of family planning including: low male involvement in PMTCT and SRH activities, and stock outs of family planning commodities.

3.7.5 Proposed way forward

- Scale up implementation of the AGYW strategy.
- Scale up HIV self-testing services targeting AGYW among other groups with high risk of contracting HIV.
- Explore strategies of collecting disaggregated programmatic data.
- Enhance index testing to improve HIV diagnosis among AGYW.
- Stock ART sites with sufficient amounts of Depo Provera and integrate ART and family planning services.

3.8 TB-HIV Co-Infection

3.8.1 Intensified Case Finding (ICF)

3.8.2 Country context

Tuberculosis remains one of the most common cause of death in PLHIV with an estimated mortality rate of 22 cases per 100,000 population. Thus, to achieve the UNAIDS second 90, there is need to increase the proportion of TB/HIV co-infected patients put on ART. The national integrated HIV guidelines recommend routine screening for TB at every HIV clinic visit, with provision of Isoniazid Preventive Therapy (IPT) for patients who screened negative for TB, and are residing in high TB burden locations. Currently, ICF is conducted using a standard symptom checklist, and results for TB screening are documented on ART master card. PLHIV presumed to have TB are tested using GeneXpert or Urine LAM where available. Notably, there is a higher burden of TB and HIV in urban settings. Groups at higher risk of acquiring TB include contacts of sputum positive cases, children under five, health workers and people in correctional facilities. Recent literature also shows that patients with diabetes and malnutrition are at higher risk of developing active TB, with between 10-16% of PLHIV having diabetes [cite source]. Such settings and populations need to be prioritized in intensive case finding for TB.

3.8.3 General achievements

- About 99% of all patients (768,688) retained on ART were screened for TB at their last visit to the ART clinic. Out of these, 13,516 (2%) patients were classified as presumptive TB cases.
- Steady increase in the number of microscopy sites, 333 (51%) microscopy sites against 650 ART sites in the country.
- Successful roll-out use of Genexpert and Urine LAM for TB diagnosis.

- As at May 2019, there were 76 GeneXpert sites in the country, with 92 machines. During the same period, there were seven (7) mobile vans for TB diagnostics (GeneXpert and microscopy) in the five (5) major districts (Lilongwe, Blantyre, Mzuzu, Zomba and Mangochi).

3.8.4 Achievement versus NSP Targets/Indicators

Out of all estimated PLHIV population, 99% were screen for TB and fully met the NSP targets

3.8.5 Challenges

- Limited competence in TB screening by service providers.
- High work burden associated with microscopy resulting in poor turnaround times sue to large volume of samples.
- Limited availability and use of TB screening algorithm among providers.
- Poor patient seeking behaviors leading to delayed diagnosis of TB when already advanced.
- Low case finding especially in children with TB/HIV coinfection.
- Genexpert platforms and Urine LAM not available in most facilities.

3.8.6 Key Lessons Learnt

- Intensify TB case finding at community level, especially among men and people aged over 55 years.
- Symptomatic TB screening for PLHIV is possible and should be complemented by staff training.
- Use of Genexpert and Urine LAM can improve TB diagnosis in PLHIV.
- Enhance TB and HIV screening in prisons as currently it is only done on biannual basis.

3.8.7 Way Forward

- Increase the number of microscopy sites.
- Initiate and sustain training and mentorship of laboratory staff to improve the quality of TB screening services.
- Implement quality improvement activities to improve TB screening and turnaround times.
- Introduce set targets for turnaround time for microscopy results.
- Scale-up of Genexpert machines and LAM to majority of ART sites.
- Scale-up use of mobile TB and HIV screening services.
- Prioritize TB screening among clients with diabetes and malnutrition in HIV setting.
- Scale-up TB and HIV screening in all correctional facilities (not only maximum security prisons).
- TB screening algorithms should be available and reinforced at all ART facilities.

3.9 TB-HIV Integration

3.9.1 Country Context

There is an observable gap between decentralization of ART and TB treatment services. As a result, the national HIV and TB programs are working on a strategy to increase the number of health facilities with integrated TB and ART services. Currently, there are three models of integration of TB and HIV services in Malawi, namely, collaborative, partial integration and full integration and use of each is dependent on the settings: on setting.

3.9.2 General achievements

- It is estimated that 768, 688 (99%) of all patients retained on ART were screened for TB at their last visit to the ART clinic.

- As of December 2018:
    - 99% of TB patients had documented HIV status (49% were positive), 99% of HIV positive patients were on ART.
    - There were 7 mobile vans for both TB screening and diagnostics (GeneXpert and microscopy) and HIV testing in the 5 major districts (Lilongwe, Blantyre, Mzuzu, Zomba and Mangochi).
- Bi-annual mass screening for both TB and HIV in maximum-security prisons
- Full integration of HIV and TB supervision since April 2015.

3.9.3 Achievement versus NSP Targets/Indicators

Table 5: Summary of indicator performance against targets

Indicator	2016	2017	2018	Target
Percentage of HIV positive TB patient on ART	0.93	0.96	0.93	0.83
Proportion of TB/HIV co-infected patients				
Percent of HIV+ patients screened for TB	0.97	0.96	0.99	0.99
Percent of TB patients with known HIV status	0.96	0.89	0.97	0.85

3.9.4 Challenges

- High pill burden from anti-TB drugs and ART (NCD drugs in some cases).
- Full integration of TB and HIV (One-stop-Shop/care) is not possible in some facilities due staffing capacity, clinic renovation and TB infection control standards.
- Staff capacity in the management of TB-HIV co-infected patients.

3.9.5 Key Lessons Learnt

- Service integration has the potential to improve efficiency of health services.
- Integrating services is convenient for both patients and providers.
- Integration of TB and HIV services through mobile vans is possible, and has resulted in diagnosis of new HIV infections.
- Biannual TB and HIV screening in prisons has resulted in improved TB-HIV integrated services in prisons.

3.9.6 Way Forward

- Initiate continuous professional development for staff in management of TB-HIV co-infected patients.
- Introduce Fixed Dose Combination in order to address pill burden.
- Scale-up integration of TB and HIV services through mobile vans, including in prisons nationwide.

3.10 Isoniazid Preventive Therapy (IPT)

3.10.1 Country context

Isoniazid Preventive Therapy is an essential intervention for TB prevention. Given daily for six months, it reduces the overall risk of TB in PLHIV by about 33%. In addition, it protects children aged 5 years and below from developing TB if they are exposed to pulmonary TB episodes. During the lifespan of the current NSP, Malawi changed its IPT strategy by targeting five high TB burden districts; Lilongwe,

Blantyre, Chiradzulu, Zomba and Thyolo. However, children under five years who are contacts of pulmonary TB cases receive IPT regardless of their geographical location. The country is also planning to switch from IPT to Isoniazid and Rifapentine (3HP) for TB preventive therapy. 3HP has a higher efficacy, lower pill burden (taken once a week) and a shorter course (3 months). Studies on 3HP are currently ongoing in the 5 high TB burdened districts of Malawi.

3.10.2 General achievements

- Improved coverage of IPT in under 5 children with 81% treatment completion rate.
- IPT has been successfully implemented in the five highest TB burden districts.
- By June 2018, 255,420 (33%) of eligible clients in the five districts were on IPT.

3.10.3 Achievement against indicators

IPT is a key intervention to prevent TB, particularly if administered to children below the age of 5. However, IPT services are only offered in 5 high burden districts, and current NSP did not have specific indicator against the service.

3.10.4 Challenges

- Unwillingness to take IPT due to pill burden and adverse effects among other reasons.
- Increased number of clients on IPT suffering from Pellagra though the association between IPT and Pellagra remains uncertain.
- Concerns of other adverse effects, hepatotoxicity and peripheral neuropathy among others.

3.10.5 Key Lessons Learnt

- Symptomatic TB screening for <5 children is critical to ruling out TB.
- Active screening of adverse effects in PLHIV taking INH need to be prioritized.

3.11.6 Way Forward

- There is need to intensify active screening of adverse effects in PLHIV on IPT.
- Standardized replacement of INH with 3HP.
- Active screening of adverse effects of 3HP in PLHIV.
- Strengthen patient counselling/education.

3.11 NSP Objective 3: 90% of Patients on ART Achieve Viral Suppression

3.11.1 Country Context

Viral load testing (VLT) is critical for monitoring efficacy of ART especially, disease progression, indicating patient health and levels of ART adherence, and highlighting potential ARV resistance. Provision of routine VLT to ART patients in Malawi is an ongoing commitment and willingness by the MoH to provide comprehensive, high-quality care to HIV-infected patients. Routine VL monitoring for patients on ART was introduced in 2012 and the number of patients receiving VLT has increased overtime. The routine monitoring schedule was at 6 and 24 months after ART initiation and every 2 years thereafter. To-date, there are 13 platforms in 10 molecular labs performing PCR for VL testing. The 10 molecular labs are available at the following sites; DREAM Blantyre, DREAM Balaka, KCH, MCH, ZCH, Mzimba District Hospital, Nsanje District Hospital, Thyolo District Hospital, Partners in Hope and QECH. The median results turn-around time is 28 days (range; 14-57 days). While plasma is preferred sample of choice for the viral load testing, lack of a robust sample transport system and inadequate human resource, Dried Bundle Spot (DBS) samples are used, and this has increased coverage of VL testing.

3.11.2 General achievement

- Malawi has changed routine VL schedule from every 2 years to every year.
- VL suppression rates were significantly lower for samples classified as "routine" among children 0-9 years at 55%, and adolescents 10-19 years at 67% compared to adults in the age group 20-29, 30-39 and 40+ years who had viral suppression rates of 90%, 91% and 93% respectively.
- Intensive adherence support was completed in 56% of patients by September 2018, and follow-up samples were drawn for 43%, whereas35% of these were re-suppressed (<1000 copies/ml).
- A final treatment decision was available for 3,335 out of 9,218 patients with high VL. 67% were maintained on current regimen, 31% were switched to 2nd line and 2% were referred to HIV specialist.

3.11.3 Achievements against indicators

Indicator	2016	2017	2018	Target
Proportion of HIV+ population that is virally suppressed	0.88	0.86	0.90	0.68

3.11.4 Challenges

- Long turnaround time: The most significant delays occur between sample receipt and processes run in the Lab (median-12days).
- Based on facility level data, almost 98% of the samples had documented results. Specifically,
    - 44% of the results were received at the facility within 4 weeks of sample collection;
    - 41% between 5-8 weeks;
    - 6% between 9-12 weeks and
    - 9% were received after 12 weeks or were still missing;
    - 20% were notified of their sample results within 4 weeks of sample collection;
    - 19% were notified of their sample results within 4-7 weeks;
    - 14% were notified of their sample results within 8-11 weeks and 47% were notified after 12 weeks or notification was still pending.
- The overall VL system capacity still remains challenged by the high number of samples. Other key challenges include:
    - Poor quality of samples drawn and sent to the lab;
    - inadequate sample transportation system;
    - Long sample results turn-around time mainly due manual system of processing samples;
    - Shortage of staff at both molecular laboratories and at hubs to process samples and enter results in the LIMS computers;
    - Delayed results notification to clients and delayed clinical action on the VL results.
- Poor waste management and disposal from the molecular labs due to viral load tests. Most viral load platforms produce hazardous substances which contain a chemical known as Guanidinium thiocyanate (GTC) that is incinerated at temperatures over 1000. °C.

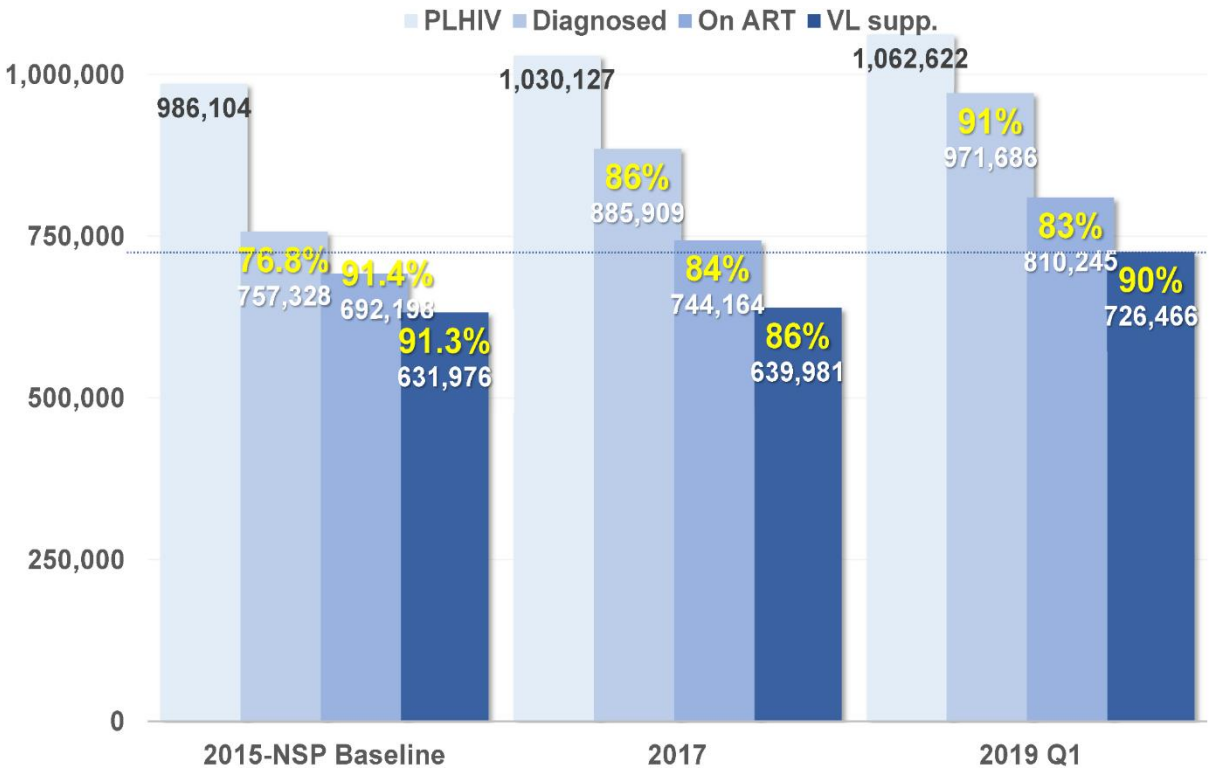
3.11.5 Key Lessons Learnt

- Engagement of stakeholders is key.
- Double manual entry of samples and results is tedious.

3.11.6 Proposed Way Forward

- Use point of care or near point of care GeneXpert machines for integrated testing of HIV and TB.
- Increase the number of conventional VL machines to cope with increased sample load.
- Intensify mentorship targeting laboratory staff in molecular labs, personnel involved in sample collection, hub automation so that double entry of samples and results is removed, and use of mobile technology for notification of results to clients.
- The country needs to procure high temperature incinerators that can over 1000 °C.
- Entry of DNA-PCR samples and documentation of results is being done manually in a repetitive way hence contribute to long turnaround time for results to get to the requesting facility.

Figure 1: Summary of Progress to the 90-90-90



4. Key Populations Programming

4.1 Country Context

During the period under review, Malawi made tremendous strides in shifting the focus of HIV prevention interventions from general population access, to a more focused and targeted approach on key and vulnerable populations. In the Malawian context, key and vulnerable populations are some of the groups with the highest incidence and prevalence of HIV. Key population groups include: Female Sex Workers (FSW) and their clients, Transgender (TG), Men who have Sex with Men (MSM), prisoners, fishermen, estate workers, discordant couples in high prevalence geographic zones and

hotspots, family members of known PLHIV, young women aged 10-24 years and children, including Orphans and Vulnerable Children (OVC). It is documented that key and vulnerable populations face barriers to HIV testing and service utilization due to age, gender, marginalization, and stigma. This is further compounded by an unfavourable cultural and legal environment, low risk perception, fatalistic attitudes, stigma and discrimination. Although FSW operate visibly in Malawi, they face similar challenges as MSM and TG due to perceived illegality of sex work and cultural and religious disapproval. Limited awareness of rights and legal protection of KP by the government and service providers at district-level negatively affect the operations of NGOs delivering services to KP, as well as provision of KP-responsive services. However, the Constitution of the Republic of Malawi guarantees basic rights for all people irrespective of their social characteristics, and thus it is expected that FSW, MSM and TG should access all social services without discrimination of any kind. Failure to provide these groups with HIV preventive and curative services only increases their vulnerability to HIV, which can be spread further through their sexual networks.

4.2 Achievements

- The MOH in collaboration with National AIDS Commission (NAC) and the UNC Project conducted the PLACE study. The study estimated the size of MSM and KPs in 20 of the 28 districts.
- The MOH and NAC together with other stakeholders are in the process of conducting the Integrated Biological Behavioral Surveillance Survey (IBBSS). The IBBSS will test HIV and syphilis biomarkers among MSM and FSW, establish the current size estimates and assess the behavior patterns of these populations for programming purposes.
- Increased funding for CSOs and NGOs to implement KP-targeted health and social services, including moonlight clinics and established safe spaces for KP, such as DICs, to facilitate and expand service provision and access.
- Successful policy dialogue involving KP, NGOs and CSOs with national authorities, including the Parliamentary Committee on HIV and AIDS and Malawi Human Rights Commission (MHRC). As part of this engagement, various programs have been planned to orient the judiciary, law enforcement, and policy holders on KP rights and challenges within the current legal and policy framework.
- Establishment of Drop In Centers (DIC) in hotspots which provide FSW and MSM friendly health services. Services offered in DICs include: HTS, ART, adherence support, condom promotion and distribution, GBV victim management, psychosocial support and referral. Overall, this has helped to increase coverage of SRH, HIV and AIDS related services for key populations in Malawi.
- The MOH in collaboration with partners is developing health service providers' training tool on stigma free KP friendly services.
- MOH and partners has developed KP health service standard package and SOPs (currently in draft form).
- In order to promote treatment retention, MOH approved the use of differentiated ART Service Delivery Model for FSW and MSM. For instance, one client collects a three months' supply of ARVs for a group of peers without each of them visiting the health facility. This helps to reduce attrition, including fear of stigma and discrimination.
- Establishment of the national KP TWG in 2017 to guide programming of KP activities as well as expansion of geographic service coverage.
- Engagement with community stakeholders, including bar owners, hotspot managers and the police to facilitate program implementation.

- The Malawi Government officially registered a number of community led KP organizations to operate in the country thereby breaking barriers to KP programming
- Enactment of the HIV and AIDS (Prevention and Management) Act which among other things provides for the rights and obligations of persons living with HIV or affected by HIV and AIDS.
- Repealing of section 184 (1) (c) of the Penal Code that dealt with rogue and vagabond offences created an enabling environment for sex work in the country.

4.3 Achievements against indicators

Indicator	2016	2017	2018	Target
Number of targeted tests for high risk populations (FSW, MSM)	2261	14259	17688	39,566
Number of condoms distributed to KAPs	685,037	3,559,866	5,070,164	1,000,000
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	**MSM:** TBD	0.44	TBD	TBD
	FSW: TBD	0.65	TBD	TBD

4.4 Challenges

- Stigma and Discrimination at community and facility level still exists and this prevents key populations from accessing health services.
- Not all service providers are trained in the provision of KP friendly health services.
- Messaging and communication around KP remains a challenge due to stigma, legal environment, and societal resistance.
- Reaching out to the elites and home-based KPs is a challenge as most do not belong to the peer support networking.
- High levels of loss to follow-up among sex workers due to the mobile nature of commercial sex work. FSWs are counted as drop outs in one project and enrolled as new client in another project or health facility.
- Lack of harmonization of incentives packages for peer educators/navigators by different projects results in high volunteer turnover.
- Duplication of efforts as in some cases more than one implementing partner target the same group of KPS in the same area with the same interventions.

4.5 Proposed Way Forward

1) **Improve access to quality, HIV prevention, treatment and support services by FSW and their clients, MSM, TG and KP family members.** This entails the following activities:
   a) Scale up facility-based and self-HIV testing coupled with ART linkage, retention in care and ART adherence for KP.
   b) Initiate and scale up a standard comprehensive HIV prevention, care and support service package for FSW and their clients, MSM and TG and KP family members.

c) Expand a differentiated service delivery (DSD) model for KP enabling them to access a continuum of HIV and SRH services from multiple service delivery points (DICs, mobile outreach, supported facility care), especially for mobile KP and those who are highly stigmatized. This will entail the following activities:

   i. Use of service outreach activities (e.g. moonlight testing), DICs and other safe spaces for KP meetings and service provision venues, in addition to peer-based interventions, linked with public and/or private health facilities.

   ii. Recruit and train peer educators, peer navigators and outreach workers for FSW, MSM and TG, establish a standard equipment and supplies package for these service providers and harmonize their incentive packages.[17] In addition, provide regular supervision and mentorship of the workers to ensure quality delivery of services.

   iii. Use of innovative outreach approaches such as internet, social media and mobile phone application-based outreach and LINKAGES project's Expanded Peer Outreach Approach to engage hard-to-reach and hidden populations.

   iv. Test and expand use of the UIC to better track and report results for KP client referrals and service provision across the HIV services cascade as well as track service provision for mobile KPs, especially FSWs, across districts, providers and programs.

d) Rollout rapid GBV response system that includes prompt reporting through appropriate channels, uptake of PEP and emergency contraception and STI screening/management.

i. Improve coordination and quality of KP responsive services in health facilities by identifying KP focal persons in public health facilities, conducting in-service training and periodic refresher training for frontline healthcare workers in provision of quality, stigma-free KP-responsive services and providing basic training in KP-responsive service provision in pre-service health care provider training institutions.

ii. Develop, finalize and roll-out cross-sector referral system and guidelines for FSW, MSM, TG and sexually-exploited children.

iii. Expand the use of KP community-centered monitoring systems, such as the SMS2[18], to monitor KP experiences with stigma and discrimination and human rights violations at health facilities and in other settings.

iv. Strengthen supply chain management for pharmaceutical and medical supplies in health facilities and DICs (e.g. ARVs, condoms, lubricants, STI drugs and PEP)

2) **Strengthen social and behavioral change communication on KP among community leaders, the general public and social service providers**. This entails the following activities:

   a. Produce/ approve IEC/SBCC materials for FSW, MSM and TG using print, social media and interpersonal communication.

   b. Conduct mass awareness campaigns for the general public with emphasis on the rights of FSW, MSM and TG (and other sexual and gender minorities).

   c. Conduct targeted awareness campaigns for traditional gate-keepers and opinion leaders (particularly, religious and traditional leaders), law enforcement agents and judicial

officers, bar owners and hot-spot managers, including the use of values clarification and attitude transformation activities.

d. Implement awareness campaigns for FSW, MSM and TG on violence prevention.

3) **Establish a robust system for reporting and redressing human rights violations against KP.** This entails the following activities:
   a. Increase access and referral linkages to psychosocial, safe home, medical and legal services for KP whose rights are violated, particularly those who suffer physical and sexual violence.
   b. Pilot and operationalize a real-time reporting and monitoring system for human rights violations perpetrated against FSWs, MSM, TGs and other sexual and gender minority members, such as the Rainbow SMS Platform[19], the SMS2 or telephone hotlines.
   c. Strengthen capacity of the MHRC to establish a mechanism for coordinating and addressing the violation of rights of key population groups.
4) **Strengthen district level coordination of KP programs and KP community service provision capacity.** This entails the following activities:
   a) Build capacity for KP CSOs and NGOs at district level in several domains including; leadership and management; service delivery; KP legal and human rights, evidence-based advocacy and monitoring and evaluation.
   b) Increase the number of CSOs with capacity in human rights programming so as to reduce reliance on KP-specific CSOs.
   c) Support regular stakeholder liaison (interface) meetings with law enforcement, judicial and health officials to identify and resolve challenges in program implementation.
   d) Review and revise TORs for the DACC to include FSW and MSM representatives.
   e) Support the operations of the FSW Coordination Committee and the establishment of MSM and TG committees at district levels.
   f) Streamline the registration requirements for NGOs and CSOs working on KP issues at district level.
5) **Strengthen national-level coordination of KP activities.** This entails the following activities:
   a) Conduct spatial mapping of KP site clusters, service providers and program implementers at national level to identify service area gaps and overlaps and foster rational resource allocation and synergistic collaboration among service providers.
   b) Conduct studies to estimate to size of other KP, including TG and their utilization of HIV services.
   c) Standardize reporting indicators, systems (including adoption of a UIC) and use of easily modifiable client-level data systems (such as DHIS2 platforms) to facilitate tracking of cascade performance across districts and providers.
   d) Develop and finalize SRH intervention packages and guidelines for FSW, MSM and TG.
   e) Standardize DSD models, prevention and care packages and SOPs for comprehensive KP prevention, treatment and care services.

f) Standardize curriculum and tools for peer-educators and peer-navigators for FSW, MSM, and TGs.

g) Saturate comprehensive KP prevention interventions tailored for HIV- and HIV+ cohorts in current priority (highest burden) districts, based on validated KP size estimates and expansion.

h) Advocate for review or suspension of discriminatory laws against sex workers and sexual and gender minorities.

4.6 Stigma, Discrimination and Human Rights

4.6.1 Country Context

Stigma and discrimination exists in different forms across the different populations. This has over the years hampered efforts to prevent new infections and engage people in HIV treatment, care and support programmes. The Stigma Index Study, 2016 indicated that HIV related stigma was an integral part of life for PLHIV. PLHIV have been verbally assaulted and harassed. In some cases, PLHIV have been dismissed, suspended or prevented from attending education institutions. Stigmatisation associated with HIV/AIDS is fuelled by factors such as misconceptions about HIV and its modes of transmission), prejudice and fears relating to socially sensitive issues (including sexuality, sex work) among many others.

4.6. 2 General achievements

- The country has made considerable progress in addressing issues of stigma and discrimination and promoting Human rights. The Stigma Index study of 2016 indicates reduced levels of stigma and discrimination.
- The HIV (Prevention and Management) Act was enacted in 2017. The act prohibits any discrimination on the basis of HIV and AIDS. Any person living with HIV or vulnerable to HIV shall have the dignity of his person, physical life, integrity and health, practise a profession of his or her choice and have compensation for any infringement of those rights. There is therefore need to ensure that the Act is widely publicized.
- Guidelines for the elimination of HIV related stigma and discrimination have been developed to address the fundamental question of why stigma and discrimination persists despite increased knowledge and awareness about HIV and AIDS.
- Various programs are being implemented targeting Key Population and PLHIV and there is a General acceptance of Key Population especially Female Sex Workers.

4.6.3 Achievements against indicators

Assessment of progress requires population based surveys. Further, the new NSP to consider crafting indicators around this component.

4.6.4 Challenges

- Most people are not aware of their obligations and rights in relation to HIV related stigma and discrimination and may therefore fail to seek redress.
- Ineffective HIV Workplace Committees, therefore limited in facilitating access to HIV services and limiting HIV related stigma and discrimination.

4.6.5 Way Forward

- There is need for Sensitization of the community justice structure and other structures on the HIV and AIDS Prevention and Management Act,

- Promote acceptance of the KPs in the health care for them to access services without stigma.
- Every institution should have an effective Workplace committee on HIV and AIDS. This will encourage the company to consider its response in terms of potential interventions in its operations, medical interventions, and senior management support and community participation. This is in addition to the establishment of networks such as support groups.
- Employers as well as unions of small enterprisers should make sure that there are compliant.
- Reporting mechanisms to address stigma and discrimination.
- There should be a deliberate effort by communities to establish linkages with public sector services to refer persons to necessary services.

4.7 Nutrition

4.7.1 Country Context

The national clinical protocol provides for routine nutritional assessments for pre-ART and ART patients at every clinical visit. Clients who are categorized as having moderate or severe malnutrition are referred for nutritional supplementation. In the community, nutrition assessments are done by Care Group Promoters who make further referral for the identified clients to the health facilities. The rationale of the nutrition element in HIV and AIDS programming is to ensure that people living with HIV receive necessary care and support that reciprocate their needs.

4.7.2 General Achievements

- CMAM (*Targets 0-<15 Years for children and Pregnant and Lactating Mothers*) implemented in all 29 districts and covering 628 Health Facilities
- NCST (*Programme for adults and adolescents*) implemented in 21 districts and covering 221 facilities.
- SAM admission in 2018 (Jan to Dec 2018) was 45,085. Out of these 37,897 (84.05%) were referred for HTC and 36,336 (95.9%) children were tested. And out of those tested 3,896 (10.7%) children were reactive. Out of these 3,623 (92.9%) were put on ART.
- MAM admission in 2018 (Jan to Dec 2018) was 88,467. Out of these 65,946 (74.5%) were referred for HTC and 62,712 (95%) were tested. And 2,386 (3.8%) were reactive and out these 2,334 children (97.8%) were initiated on ART

4.7.3. Achievements against indicator

- As of December 2018, the number of HIV positive people with severe malnutrition who have received nutrition/treatment support was estimated at 6,230 from a baseline of 7,772. The target was to reach 48,359 by the end of the NSP period.
- An assessment of the provision of rights-based capacity development for healthcare workers in the provision of ART services was yet to be conducted.

4.7.4 Key Challenges

- Inadequate resources both at district and national level for scale up of the programme
- Overweight and Obesity increasing among clients in NCST
- Weak linkages between NRU admissions and general Health services
- Some CMAM sites do not have HTC Counsellors therefore no testing is being done.
- Inadequate supplies for testing (if there are few supplies are earmarked for Pregnant Mothers in ANC.

- Some HIV+ MAM Children being treated in SFP while the protocol demands that they should be admitted in OTP

4.7.5 Key Lessons Learnt

- Community management of acute malnutrition has greatly reduced cases of malnutrition.
- A good proportion of children who are severely malnourished not being referred for HTC (15.05%)
- CMAM is another key entry to pediatric ART as a good proportion of children start ART through CMAM programme.

4.7.6 Proposed Way forward

- NSP should advocate for nutrition supplies for malnourished adults
- Strengthen linkages between NRU and general health services centers within the health facilities
- Capacity building for the HTC counselor to provide nutrition counselling
- Integrate NCD counselling during HTC

4.8 Management of Sexually Transmitted Infection

4.8.1 Country context

Contracting Sexually Transmitted Infections (STIs) increases the risk of acquiring and transmitting HIV. Thus, early prevention and appropriate treatment for STIs reduces the risk of acquiring HIV. In view of this strengthening the national system around STI prevention, diagnosis, and treatment is critical to containing the spread of HIV. Diagnosis of STIs in well-resourced settings often relies on identifying pathogens through laboratory tests, however, this is expensive and can be impractical in resource-constrained countries like Malawi. In view of this, the Malawi Government adopted the Syndromic Management Approach for the management of STIs in the early 90s, and with revisions made over time. In 2017, Malawi developed a new edition of Guidelines for Syndromic Management of STIs, replacing the previous edition. The new guidelines included new drugs for the management of Genital Ulcer Disease (GUD), Lower abdominal pain in women, and anal-rectal Infections (ANRI). Sexually transmitted anal-rectal infections are prevalent in men who have sex with men (MSM), in female sex workers, and male-to-female transgendered individuals by virtue of practicing anal sex.

4.8.2 General achievements to date

- The rate of HIV status ascertainment at STI clinics has improved considerably over time. This is likely due to increased numbers of dedicated testing staff available at the sites. For example, during the 3rd quarter of 2018, the Ministry of Health reported that HIV status was ascertained for 79,639 (89%) of clients and 1,544 (19%) of these were HIV positive. In addition, 3,799 (25%) of the positives were identified through a new test initiated at the STI clinic, while 11,646 (75%) presented with a documented previous positive HIV test result.
- Out of 21,003 partner notification slips issued, (15,862) (76%) of those notified presented to the clinic.
- Referral of HIV positive STI clients for ART improved overtime, and 3,799 (77%) new positives were referred for ART. Presumably, the low ART referral rate is due to protocol deviation among providers.

- The involvement of the HIV reference laboratory on STI drug efficacy studies and antimicrobial resistance studies.
- Establishment of STI centers of excellence (QECH and KCH);
- The Inclusion of STI drugs in the essential drug list (this has reduced the incidences of STI drug stock outs);
- Intensifying quarterly supervision and mentorship of service providers, especially the inclusion of STI program in the integrated HIV program supervision conducted quarterly by the MOH.

4.8.3 Key Challenges faced

- Minimal private sector engagement especially around training, supervision and mentorship and this has led to protocol deviation.
- Under treatment of STI syndromes in public health facilities due to drug stock-outs. Equally, private facilities deviate from national guidelines and fail to pay full course of drugs by clients.
- Inadequate primary prevention efforts thereby increasing the number of STIs in the general population, including re-infection and re-occurrence of STIs after a recent episode.
- The increase in known HIV positive clients reporting with an STI could also be an issue of inadequate primary prevention interventions.
- Emerging antimicrobial resistance is a threat to STI management.
- Inadequate laboratory reagents and limited funding for STI surveillance.

4.8.4 Proposed way forward

- Strengthen the engagement of private providers through capacity building trainings, mentorship, supervision and provision of national registers and M&E tools.
- Intensify primary prevention efforts for STIs through awareness campaigns, mass media, electronic media and printed IEC materials (posters, leaflets, brochure's and other information materials with messages targeting different audiences).
- Improve the supply chain management of STI drugs in all public facilities and proactively monitor prescription patterns in private facilities to avoid under treatment of STI syndromes and protocol deviation.
- Strengthen prevention of antimicrobial resistance through public awareness, monitoring of STI treatment, laboratory tests for difficult to treat STIs/non-responders, enforcement of policies and laws governing use, selling and use of antibiotics.
- Adopt the Voluntary Active Partner Notification (VPN) initiative (used in HTS and ART) to treat more partners affected by the index cases.
- Strengthen STI center of excellence at Kamuzu Central Hospital, Mzuzu, Zomba and Queen Elizabeth.
- Strengthen National Reference laboratory through training personnel and equipping the laboratory

5. Strategic Information Management

5.1 Country Context

In an effort to strengthen the implementation of the 'One Monitoring and Evaluation System' for the HIV and AIDS programme in Malawi, a National HIV & AIDS M&E framework was developed alongside the 2015-2020 NSP. Due to the shrinking resource envelope towards HIV and AIDS, the NSP focused on high impact interventions anchored by evidence -based programming. The M and E systems was also operationalized as an instrument for improving quality in the delivery of HIV and AIDS

interventions. Thus, the county tracked programme outcomes and impacts, and in the process created opportunities to reprogram and ensure wide involvement of major stakeholders in research activities. The 2015-2020 National Strategic Plan was also complemented by a National HIV&AIDS research agenda that highlighted key areas of research. In view of this, NAC held annual Research and Best practices dissemination conferences. The conferences presented a platform for sharing research and best practices findings. In addition, NAC also worked with partners to conduct Population-based-surveys in an effort to track progress against the UNAIDS 90- 90-90 goals. This promoted reprogramming of interventions especially around resource mobilization and allocation. Malawi has developed a national M&E plan as an operational tool for tracking implementation of the 2015-2020 NSP. The updated M&E plan ensured effective and efficient research, monitoring and evaluation of the 2015-2020 NSP based on the agreed national priority areas based on the NSP Results Framework. Overall, the M and E plan helped to track and monitor Malawi's performance towards achieving NSP targets.

5.2 M&E Coordination

Coordination is key to effective M & E involving various players within the HIV and AIDS response (public, private, civil society and development partners) to ensure optimal use of available evidence and continuous learning and sharing of experiences and best practices. As the coordinating authority for the national response, NAC is responsible for monitoring response to the HIV epidemic by analysing data, and disseminating information to policy makers and programme planners. The Commission also oversees capacity development, data quality assurance, resource mobilisation for M&E and data archiving. The monitoring and evaluation of health facility-based responses is coordinated and managed by the MOH in collaboration with private sector institutions and civil society organisations that run health facilities with data reported through the Health Information System. Within the M and E framework, monitoring of non-biomedical interventions is conducted by NAC through the through Local Authority HIV and AIDS Reporting Form (LAHARF). This is done in collaboration with different partners, i.e. with donor group, the civil society organisations, faith based organisations, organisations supporting key populations, traditional leaders and local government to name a few. Non-biomedical date collected through the LAHARF is entered into the Local Authority HIV and AIDS Reporting System (LAHARS), from where various reports can be generated.

5.3 Achievements

During the period under review the following achievements were realized;

- The Local Authority HIV and AIDS Reporting Form (LAHARF) was reviewed and district stakeholders were oriented.
- District-based targets were introduced, shared and tracked to monitor the district contributions to the national targets.
- The Health Situation Room which included HIV indicators was introduced and launched by the Head of State.
- The Terms of Reference for the Monitoring, Evaluation, Information Systems, Research and Surveillance (MEISRS) TWG were revised.
- Quarterly MEISRS TWG meetings were conducted.

5.4 Challenges

The following challenges were realized;

- Delayed reporting by partners who submit relevant indicators to NAC.
- Low utilization of monitoring data to improve HIV/AIDS programming.

- Lack of commitment by partners towards TWG activities.
- Low reporting in some programs areas such as the Adolescent Girls and Young Women (AGYW).

5.5 Way Forward

- Conduct regular TWGs at national and district level.
- Facilitate sharing of reports and research findings at all levels.
- Map all AGYW partners and strengthen coordination in this area.

6. Research and Surveillance

Research and Surveillance activities are critical to generating information that facilitates evidence-based planning of the National Response. The country continued to monitor HIV prevalence and incidence in the general population as well as in key populations by conducting regular surveys. Malawi conducted its first AIDS indicator survey in 2015. This measured HIV incidence, viral load, CD4, ARV metabolites, and paediatric HIV prevalence, among others. Collectively, this helped to measure the impact of the national response. Surveillance activities also helped in the identification of critical gaps in the national response, as well as monitoring development and transmission of HIV drug resistant strains. In 2015, the National AIDS Commission coordinated development of an HIV and AIDS Research Strategy which identified research priorities to facilitate effective planning of the national response.

6.1 Achievements

During the period under review the following achievements were realized;

- The Malawi Population Based HIV Impact Assessment (2015/16) was conducted for the first time in Malawi. This also coincided with the routine Malawi Demographic and Health Survey (2015/16).
- Implemented the HIV Drug Resistance survey.
- Piloting of the HIV Recency surveillance.
- Implemented the Acceptability of Voluntary Assisted Partner Notification Study.
- Initiated the Birth Defects Surveillance initiative to establish relation between ART and development of defects in new born babies.
- Implementation of PLACE I & II Studies in 2016 and 2017.
- Development of Annual HIV Estimates using Spectrum.
- Conducted the annual National HIV & AIDS Research and Best Practice Conferences.

6.2 Challenges

During the period under review the following challenges were encountered;

- Conflicting HIV prevalence results for the country produced by two different studies conducted within the same period (MPHIA and DHS).
- Lack of resources for revision of the National HIV & AIDS Research Agenda.
- Limited dissemination of key research findings at district level.
- Minimal inclusion into operations of research activities implemented at district level.
- Lack of resources to conduct key population research.

6.3 Way forward

To address the stated challenges, the following recommendations were proposed:

- Coordination and timing of population based surveys to avoid conflicting findings.
- Mobilization of resources for timely revision and development of the National HIV & AIDS Research Agenda.
- Identification of more avenues/opportunities for research and Best Practice disseminations at district level.
- Mobilization of resources for capacity building in operations research at district level.

Table 6. National Research Priorities

Technical Area	**Key Research Topics**
Epidemiology	• Evaluating factors affecting HIV/AIDS service coverage including unmet need for ART. • Determining trends and impact of HIV and AIDS on productivity of the private and public sector. • Evaluating trends in ART uptake. • Understanding the determinants of defaulting on Option B+ programs. • Assessing the impact of HIV and AIDS on cultural perceptions of disease, death and the dying. • Understanding factors affecting early infant diagnostic programmes.
Prevention	• Assessing the role of ART as a means of preventing HIV infection. • Evaluating unique vulnerability for youth and other KVPs in urban and semi-urban areas. • Assessing gender related vulnerability amongst the youth and other KVPs. • Exploring HIV and AIDS information needs for the youth and other KVPs. • Investigating factors affecting low uptake of preventive measures such as condom use.
Diagnostics	• Validating CD4 count and viral load point of care tests kits. • Evaluation of new candidates of Whole Blood for rapid and ELISA test kits for HIV. • Assessing alternative models of HIV self-testing such as oral test kits.
Treatment	• Evaluating the effect of early ART initiation on patient outcomes. • Investigating clinical management options of patients with TB/HIV co-infection. • Monitoring ART resistance emergence in children and adults. • Determining and monitoring side effects of new ART regimen. • Assessing the effectiveness of Option B+ on HIV transmission.
Care and Support	• Investigating models on how to integrate HIV and SRH. • Evaluating determinants of acceptance of a positive HIV test result. • Assessing the extent and degree of stigma and discrimination. • Assessing the influence of gender in accessing HIV/AIDS services.

	• Evaluating factors that influence cervical cancer screening amongst HIV+ women.

6.4 Achievements

- The National HIV Prevention Strategy was revised and disseminations conducted at national and sub-national levels.
- Joint Annual Reviews to track progress towards the agreed milestones were conducted throughout the period under review

6.5 Challenges

- The scheduled mid-term revision of the NSP was not conducted due to limited time and resources.
- Annual reviews were not conducted due to competing programmatic priorities.
- Limited data in some HIV prevention priority areas such as AGYW.

6.6 Way Forward

- Mobilize funding for Annual Joint Annual Reviews.
- Strengthen data collection for AGYW interventions through mapping, formation of AGYW coordination sub-groups and including AGYW indicators in LAHARF.
- Mobilize funding for recruitment of an independent team to evaluate the national response.

7. Health Information System

7.1 Achievements

- Finalization of the Local Authority HIV&AIDS Reporting System
- Roll out of Electronic Medical Records with modules for ART and HTS
- Introduction of the e-master card for ART program
- Roll out of the logistics and laboratory information systems

8. Coordination and Management of the National Response

8.1 Country Context

Coordination and management of the HIV response is guided by the 'three ones' principle. This entails one coordinating authority which is National AIDS Commission, one strategic plan which is the National HIV and AIDS strategic plan and one monitoring and evaluation framework. Multi-sectoral and decentralised approaches have been employed in coordination and management of the national response with a diverse range of stakeholders involved in the response. In order to enhance effectiveness and efficiency in the manage of stakeholders, the country has established sectoral coordinating bodies, namely: MANASO responsible for civil society organization, MANET+ for the PLHIV, NYCOM responsible for the youth, DHRMD for government sectors, MBCA for private sector and MIAA for

faith-based organizations. Recently, the national HIV response has also included National Council for Higher Education (NCHE) and National Construction Industry Council (NCIC) as coordinating bodies for their respective sectors. On the overall, enactment of the HIV (Prevention and Management) Act 2017 has transformed the legal environment and has provided legal backing for the coordinating bodies.

The country has national HIV strategic documents whose dissemination is key in driving the response. The established Technical Working Groups (TWGs) are one of the most effective channels of sharing information within the response. The current TWGs include: HIV Prevention; HIV Treatment and Care; Social Behavior Change and Communication; Monitoring, Evaluation, Research and Surveillance; Gender, Human Rights, Culture and Youth; and Key Population. At the helm of the TWGs is the Malawi Partnership Forum (MPF) - A multi-sectoral technical advisory body to the NAC Board and has membership from all sectors and constituencies. It organizes and facilitates joint reviews on HIV and AIDS, and oversees progress in the various TWGs.

8.2 Achievements

Salient achievements during the review period include:

- Actualization of joint annual review meetings by the Malawi HIV and AIDS Partnership Forum.
- Implementation of Research and Best practices annual conferences meeting, including introduction of annual National Conference on Youth, HIV and AIDS and SRHR programming.
- Greater involvement and participation of Civil Society Organization (CSO) in the development of PEPFAR Country Operation Plan (COP) 19 and approval processes. Consultation meetings were done during the development of COP 19.
- Participatory development of the 2016-2019 Global Fund country application, andhere is a principal recipient for civil society organizations and government sectors.
- Develop and dissemination of the community charter in the 90 90 90. This increased participation of the community in the response to attain the set targets by 2020.
- Establishment of Female Sex Workers coordination structures in all Local Councils. FSW are part of District AIDS Coordinating committees and actively participate in the prevention and Key population TWGs.
- The country has finalized the established of Y+ and it's a recognized structure.
- Integration of Nutrition, HIV and AIDS programs. The government has introduced the position of Principal Nutrition, HIV and AIDS officers to coordinate both nutrition, HIV and AIDS in all the Local Councils

8.3 Challenges

- Donor pushing implementation of policies without thorough consideration of the technicalities and local landscape.
- Decline in financial resources to support the national HIV and AIDS.
- Difficulties in accessing Global Fund resources at country level to implement varied HIV and AIDS related intervention.
- HIV response coordinating bodies are not financially supported hence downsizing of operations.
- The national HIV and AIDS response is largely funded by donors, and this threatens sustainability of the national response. The 2% earmarked proportion on ORT is not sufficient to support HIV and AIDS programming.

- Parallel coordinating mechanisms for HIV and AIDS activities with partners unwilling to disclose the level of investment.
- Duplication of partners' activities in some districts while others lack partners' support. No clear mechanism on district selection by partners to implement HIV and AIDS related programs.
- Weak linkages between and among coordinating entities. The coordination structures lack capacity to efficiently and effectively manage organizations under their portfolios.
- There is week reporting and monitoring systems for non-biomedical interventions. Very few organizations submit reports to NAC.
- Limited integration of biomedical and non-biomedical interventions. The country should foster combined prevention in order to successfully address the new HIV infections.

8.4 Key Lessons Learnt

Promote a culture of data utilization to make varied programming decisions.

8.5 Way Forward

- Enactment of the HIV Prevention and Management Act of 2017 should drive NAC and district Councils to strengthen coordination of the response at national and sub national levels.
- Develop MOUs between CSO with local councils to enforce reporting, including disclosure of sources of funds.
- Map NGOs based on their scope of activities and geographic locations to enhance efficiencies in HIV and AIDS programming.
- Government should introduce a reference system for all implementing partners by their coordinating bodies.
- Review policies and procedures on accessing Global Fund resources – process too heavy at the moment.
- Increase domestic financing to HIV and AIDS. The 2% earmarked on ART is way too little to support implementation of HIV programs.
- Develop standard operating guidelines for coordinating structures with membership of organizations regulated in line with the HIV Prevention and Management Act.
- Include addition output indicators in monitoring the national response under this component, namely:

    - Number of HIV and AID projects/programmes properly coordinated.
    - Number of organizations reporting to NAC and district councils/ reports on quarterly basis.
    - Number of organizations implementing HIV and AIDS activities.
    - Amount of resources mobilized and utilized.
    - Number of quarterly TWGs meetings.
    - Number of programmes jointly monitored.
    - Number of national biannual or annual coordination (performance review and strengthening) meetings.
    - Number of strategic documents developed/reviewed.
    - Number of research findings/strategic information dissemination sessions conducted.

9. HIV and AIDS Financing

9.1 Country Context

Malawi is one of the countries with lowest national income in the world. In 2018, the GDP per capita was estimated US$516.8, and annual GDP growth rate was 3.7% down from 5.1% in 2016/17% - this remains relatively low. Overall, Malawi's health expenditure is high relative to its income status albeit inadequate to improve and sustain effective performance of the health system. Total health expenditure per capita was equally low at USD34 compared to USD 114 in the wider Sub-Saharan Africa region. In-terms of disease burden, Malawi is dominated by infectious diseases and child health causes. The 2015 Burden of Disease Study estimates that HIV contributed about 17% of Disability Adjusted Life Years (DALYs), 19% of Years of Life Lost (YLL) and 19% of total deaths.

Between 2016 and 2018, total expenditures for the HIV program was estimated at USD 658.6 million, and funding over the years is on decline. In addition, annual HIV spending was estimated to average USD 219 million based on Global AIDS Monitoring report submission for the period. As a proportion of the HIV budget, HIV treatment programs consumed a larger share of the total HIV budget compared to prevention programs. In-terms of program financing, provision of HIV services in Malawi is heavily donor-reliant. This raises sustainability concerns given the volatility and unpredictability in global health financing. Major donors include, the Global Fund, PEPFAR, and other bilateral agencies and foundations. The over reliance of external funding continue to create pressure on Malawi to increase its share of domestic financing of HIV programs. Thus, the HIV and AIDS program in Malawi need long-term financial and technical assistance and gradual increase of domestic financing of the HIV sector. Figure 6 summarises HIV and AIDS spending for the period under review.

Figure 6a: Estimated HIV and AIDS related Expenditures

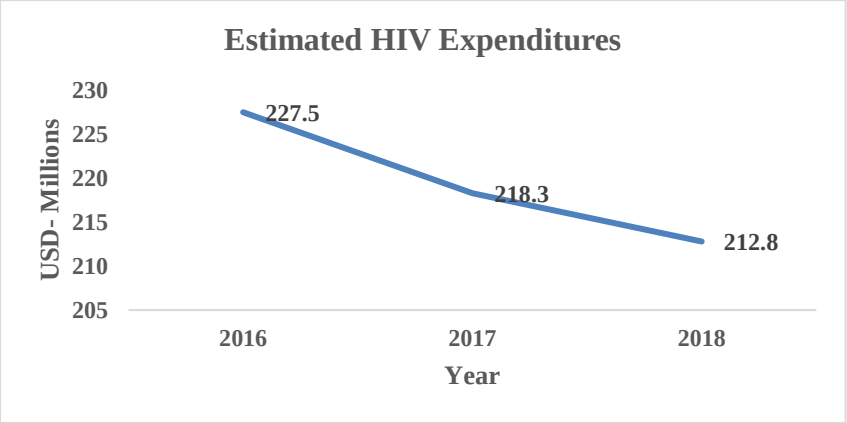
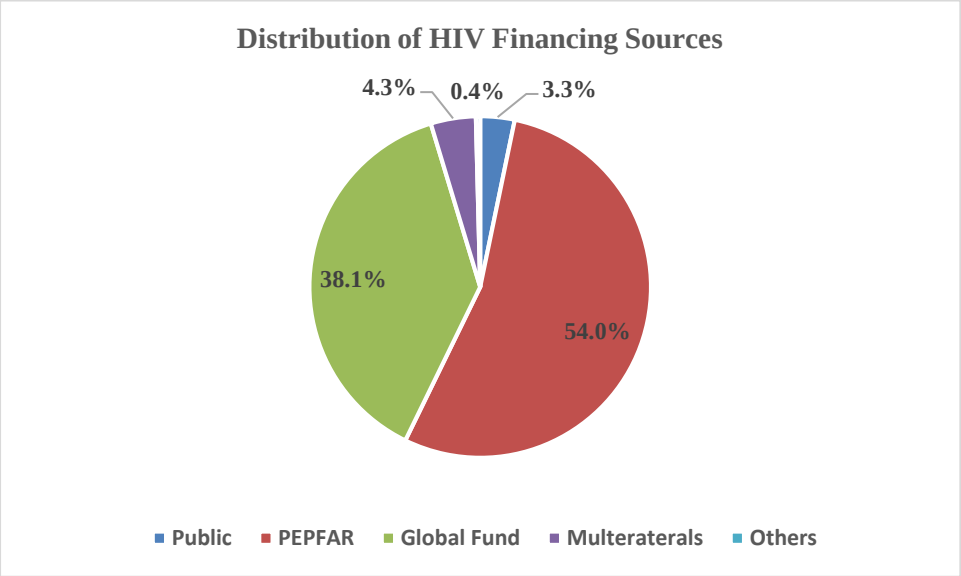


Figure 6b: Distribution of HIV Financing Sources based on GAM Report



9.2 Key Achievement

- The HIV program is relatively well funded compared to other programs
- Strong financial commitments to sustain current programmatic gains. Major sources of finances include multilateral and bilateral agencies including Non-governmental Organizations and Foundations such the Global Fund and PEFFAR.
- Sufficient availability of HIV and AIDS commodities needed to increase coverage of HIV/AIDS services

9.3 Challenges

- Donor dependency threatens sustainability of current gains
- Limited domestic financing to the HIV sector
- Donor-driven policy directives and given without due consideration of the wider health sector constraints
- Limited infrastructure, including human resources for health
- Process of accessing GF resources at the moment is too heavy and involving

9.4 Way forward

- Development of a health financing strategy will provide a basis for financing the health sector, including HIV/AIDS
- Gradually increase domestic financing for HIV and AIDS program
- Consider integration of the major health supply chain system. Integration can potentially generate efficiency savings with gains reprogrammed to other pressing areas in the health sector

10. Conclusion

Malawi has made tremendous progress in the fight against HIV and AIDS. It is evident that the country is among one of the first in the region expected to achieve the UNAIDS 90-90-90 goals. The target is to ensure that by 2020 Malawi should diagnose 90% of people living with HIV and AIDS, initiate 90% of those tested on ART and achieve viral suppression in 90% of those on treatment. Current performance indicate that the country has achieved 91-83-90 relative to the global targets. Sustaining the observed programmatic gains will require continued and concerted efforts by partners in the HIV and AIDS space. The enactment of the HIV Prevention and Management Act has also created an enabling environment for coordinating the national response in the fight against the epidemic, especially among key and vulnerable populations. However, the over-dependency on donors raises serious challenges on program sustainability and the risk of donor-driven policies without due consideration of the impact of the policies on the delivery of HIV and AIDS services.

10. Appendices

Level of Results	Results Statement	Performance Indicators	Baseline	Target by end of strategy period	Yr1 achievement	Yr2 achie
Impact	Reduction in new HIV infections and prevalence	Incidence of new HIV infections in adults (15-49)	0.49	0.2	0.33	
Medium term Outcome	Reduction in new HIV infections in adults and children	Number of new HIV infections in adults (15+)	37209	11000	37994	
		Number of new infections among infants (0-14 years)	8619	2532	5104	
		Number of new infections among infants (0-11 months)	6250	2532	4214	
Outcome	Primary prevention of HIV/AIDS among women of childbearing age	HIV prevalence in reproductive age women (15-24 years)	8.2% (2010)	5.8% (Y4 Target)	4.60	
Outcome	Reduce unplanned or unintended pregnancies among HIV+ women	Percentage of HIV infected mothers using a modern family planning method.	22%	39565 (26%)	27%	
Outcome	Reduced new HIV infections among children	Percentage of Infants born to HIV-Infected Mothers that are HIV positive at 6 weeks	0.034	0.01		
		Percentage of Infants born to HIV-Infected Mothers that are HIV positive end of breastfeeding	0.13	0.05	0.05	
		Percentage of infants born to HIV positive women who are alive at 12 months of age and HIV negative (i.e. 12 month Infant HIV-Free Survival)	0.82	0.87	0.53	
Outcome	Improved HIV exposed infant follow up according to national guidelines	Percentage of HIV infected pregnant women who received antiretroviral to reduce the risk of mother to- child transmission in accordance with national protocols	0.75	0.85	0.83	
Outcome	Increased uptake by exposed infants to Nevirapine at birth	Percentage of exposed infants given Nevirapine at birth (includes only women giving birth at facility)	0.92	0.95	0.95	
		Percentage of infants born to HIV infected women started on cotrimoxazole prophylaxis within two months of birth	0.88	0.94	0.91	
Outcome	Increased testing of HIV exposed infants	Percentage of infants born to HIV+ women receiving a virological test for HIV within 2 months of birth	0.4	0.7	0.45	
		Infant ART coverage (Early infant treatment access)	0.18	0.4	0.227644652	
Outcome	Maintain low level of blood-borne transmission	Percentage of donated blood units screened for markers of infectious diseases (HIV, Hepatitis B and Syphilis) in a quality-assured manner.	0.93	0.99	0.97	
Outcome	Increased access to post exposure prophylaxis	Number of persons started on post- exposure prophylaxis (PEP)	2300	2900	6217	
Medium term Outcome	Reduced sexual transmission of HIV	Prevalence (15-49)	0.103	0.087	8.8	
	Reduced sexual transmission of HIV	Percentage of sex workers living with HIV	0.231	0.5		
	Reduced sexual transmission of HIV	Percentage of men who have sex with men who are living with HIV	0.15	0.5	TBD	
Outcome	Increased uptake of male circumcision services	Percentage (number) of males aged 10-49 circumcised in targeted districts	18.0% (67,952)	307, 057	206394	
Outcome	Management of STI syndromically	Percentage of STI cases treated according to national guidelines	0.41	0.75	0.81	
Outcome	Increased universal and targeted HIV testing and counselling	% of expected new infection identified and linked to care and treatment per annum	0.8	0.8	0.9	
Outcome	Increased universal and targeted HIV testing and counselling	Number of HIV tests per year	1702627	4, 428, 512	2585739	
		Number of targeted tests for high risk populations (FSW, MSM)	N/A	39, 566	2261	
Outcome	Increased use of male and female condoms	% of men aged 15-49 who reported using a condom the last time they had high risk sexual intercourse (non-married non-cohabitating partner) (disaggregated by age and sex)	0.235	0.7	0.3	TBD
		% of women aged 15-49 who reported using a condom the last time they had high risk sexual intercourse (non-married non-cohabitating partner) (disaggregated by age and sex)	0.273	0.7	0.27	TBD
Outcome	Scale up distribution of condoms (male and female)	Number of condoms distributed to KAPs	38922	1000000	685037	
Outcome	General population reached by comprehensive HIV prevention programs especially condom use (disaggregate by age, sex, workplace)	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 a condom during their last sexual intercourse	0.251	TBD	TBD	TBD

10. Appendices

11. References