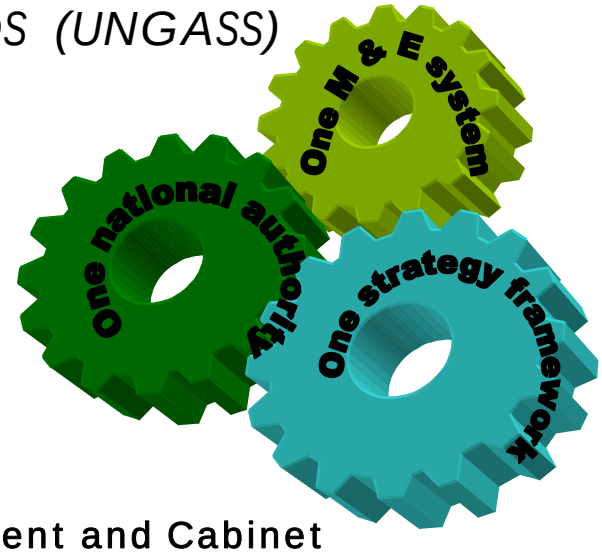
REPUBLIC OF MALAWI

Malawi HIV and AIDS Monitoring and Evaluation Report 2005

Follow-up to the Declaration of Commitment on HIV and AIDS (UNGASS)



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Glossary of Terms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral (treatment)
BCI	Behavioural Change Intervention
BLM	Banja La Mtsogolo
BSS	Behavioural Surveillance Survey
CBO	Community Based Organization
CHAM	Christian Hospital Association of Malawi
CHS Unit	Community Health Sciences Unit
CMS	Central Medical Stores
CWIQ	Core Welfare Indicator Questionnaire
DAC	District AIDS Coordinator
DACC	District AIDS Coordinating Committee
DHS	Demographic and Health Survey
EMAS	Education Methods Advisory Services
FBO	Faith Based Organisation
FMA	Financial Management Agent
GFATM	Global Fund to fight AIDS, Tuberculosis, and Malaria
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPME	Head of Planning, Monitoring & Evaluation at NAC
HTS	Health Technical Services
IAWP	Integrated Annual Work Plan
IT	Information Technology
LMIS	Logistics Management Information System
MASAF	Malawi Social Action Fund
M&E	Monitoring and Evaluation
MEIS	Monitoring, Evaluation and Information Systems
MOEST	Ministry of Education Science and Technology
MOGCS	Ministry of Gender and Community Services
MOHP	Ministry of Health and Population
MOLVT	Ministry of Labour and Vocational Training
NAC	Malawi National AIDS Commission
NAC ARS	National AIDS Commission Activity Report System
NCPI	National Composite Policy Index
NGO	Non-governmental Organization
NSO	National Statistics Office
NTBS	National Blood Transfusion Service
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PLWHA	Persons Living With HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
QSCR	Quarterly Service Coverage Report
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TC	Testing and Counseling
TWG	Malawi Technical Working Group on HIV and AIDS

UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
UNGASS	United Nations Special Session on HIV and AIDS
USAID	United States Agency for International Development
VDRL	Venereal Diseases Reference Laboratories
WFP	World Food Programme
WHO	World Health Organisation

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Foreword

The Government of Malawi has built into the policies and programs comprising the national response its commitments to the General Assembly Special Session on HIV and AIDS (UNGASS) Declaration (2001) which calls for each country to develop and implement a multisectoral national strategy and financing plan for combating HIV and AIDS, and to report biennially on a set of agreed HIV and AIDS indicators, according to specific international HIV and AIDS M&E standards. The Government of Malawi also subscribes fully to the requirement for the international community to jointly report on the various aspects of the HIV and AIDS epidemic in order to contribute and influence global and national policies in the fight against the epidemic. The design of its national programs embraces the basic requirements in the programmatic approaches to fight HIV and AIDS and in financial resource mobilization, among others.

Malawi has designed a response that is government led through a response framework in which the National AIDS Commission takes leadership. The Commission is the hub of national planning, coordination, resource mobilization and disbursement and monitoring and evaluation of programs and is the rallying point for donors, development partners and all agencies engaged in HIV and AIDS action nation wide.

Malawi continues to sustain and scale up its efforts towards combating HIV and AIDS and over the years financial contribution to the cause has increased by a margin of about 6% from the 2003/04 to 2004/05 fiscal years. The policy environment and strategy have continued to evolve, accommodating innovation, adapting to international practice and keeping on the cutting edge of global action. On the whole, the country has made remarkable progress in prevention, advocacy, treatment care and support, monitoring and evaluation of programs and the course of the epidemic and in leadership. More work is underway in less developed areas, notably the legal and human rights framework to address issues of stigma, equity of access to services and protection of the rights and freedoms of all people infected and affected by the epidemic.

Progress made in the Malawi response owes to an environment that promotes and harnesses partnership between Government on the one hand and donors, development partners and stakeholders on the other, all supporting the HIV and AIDS fight in Malawi. Effective partnership has yielded unique innovations including pooling of financial resources and donor subscription to the global principle of ‘Three Ones’. By this principle donors, development partners, implementing agencies and all stakeholder work with National AIDS Commission, guided by one overall HIV and AIDS action framework and applying a common monitoring and evaluation plan.

This report is itself a product of such partnership and comes from Government leadership that recognizes the enormity of HIV and AIDS as a development challenge. While Government takes the lead, the experience in this report presents the effort of all global and national partners and those organizations making contributions from all sectors of the Malawi society.

Dr Bingu wa Mutharika
PRESIDENT OF THE REPUBLIC OF MALAWI

Executive Summary

During the past five years, Malawi has developed a robust architecture to drive and manage the national response to HIV and AIDS. One major achievement has been the institutionalisation of the National AIDS Commission (NAC) as the body to lead and coordinate the response. Through the Commission, Malawi has formulated a groundbreaking, state of the art HIV and AIDS Policy and a National Action Framework to guide the implementation HIV and AIDS activities by various agencies for the subsequent five years. A Grant-making system has been developed and operationalised to support expansion of a multi sector response in which institutional and social capital is effectively harnessed.

In the overall architecture, Malawi fully subscribes to the UNAIDS global principle of 'Three Ones'. Over the period National AIDS Commission has become the rallying point for all donors and development partners supporting the national response and the major reference point for implementing agencies. Donors, development partners and stakeholders subscribe to a robust and widely acclaimed National Monitoring and Evaluation Framework which has become entrenched and efforts are underway to decentralise its application to local assemblies and to increase adherence and reporting to the Commission.

Government commitment to the cause of HIV and AIDS and the overall performance of the National AIDS Commission has made Malawi a 'favoured partner' in the global response, enjoying considerable donor confidence and support. In this vein, Malawi has been successful at mobilizing adequate resources from a wide-range of bilateral and multilateral donors, and disbursing the funds to various institutions and organizations. All sectors [public, private, faith, non-governmental and civil society] have been fully mobilised and using the grants facility in the Commission and other funding sources, various organizations in these sectors have been able to build and strengthen their capacity to implement HIV and AIDS activities.

The progress that Malawi has made towards responding to the HIV and AIDS epidemic is summarized in Table 1, which shows the trends of both UNGASS and national indicators over the past few years. Programmatically, a major achievement for Malawi has been to halt HIV infection level at 14-15% since 2001 with high prospects and indications of reversing the trend in earnest as this report demonstrates. Similarly, awareness and knowledge of HIV and AIDS continues to deepen in all sections of the national population although the challenge of genuine behaviour change is still outstanding in many respects. A hundred percent HIV screening of blood for transfusion policy has been maintained over the years while complementary efforts are underway to ensure the highest infection prevention and control procedures in health institutions.

Malawi boasts of one of the most rapidly expanding ART programmes in the Africa region as the proportion of eligible individuals on ART has increased exponentially from under 5,000 in 2003 to over 30,000 by September 2005. With a survival rate of over 80% there is good potential for Malawi to reduce morbidity and mortality significantly and to sustain a fairly high quality of life for people living with HIV and AIDS.

One of the recognized impacts of the HIV and AIDS epidemic is the increase in the number of orphans. Usually, orphans are marginalized in accessing social services including education. In contrast, the Malawi experience demonstrates no major difference in the rate of school enrolment between orphans and non-orphans in Malawi. From 2003 to 2004 the ratio of school enrolment

between orphans and non-orphans has improved slightly and is now close to 1:1. This gain in part owes to Government commitment to providing free primary school education since 1994.

Notwithstanding these achievements, there are some critical challenges. In general vulnerability to HIV infection still remains high due to combined effects of poverty, gender inequality and harmful cultural practices as well as natural disasters like drought, which have affected many parts of Malawi. Despite the availability of financial resources, absorption and implementation in the public sector, especially in the health, education and social services sectors, has been slow in large part due to severe shortage in human resources, weak systems and inadequate infrastructure. Prevention efforts are curtailed by a limited behavior change especially among young people. At the same time development of HIV testing infrastructure still lags behind demand while more work has to be done to convince Malawians to go for an HIV test. The situation of orphans has been addressed through policy and strategic planning but the scale of current programs is inadequate and calls for radical approaches for expansion. In similar terms, community home based care and support to people living with HIV and AIDS has yet to be consolidated into a program and expanded rapidly to address the health, physical and emotional needs of an increasing number of rural people.

	Summary of major indicators			
No.	**Indicator**	**2003**	**2004**	**2005**
	Disease Burden			
1	% of people infected with HIV	14.4	n/a	14
2	% of infants born to HIV-infected mothers who are infected	-	n/a	n/a
3	HIV prevalence among women in sentinel sample	19.8	n/a	16.9
4	STI prevalence among pregnant women in the sentinel survey	2.7	1.9	1.9
	Treatment			
5	% of HIV+ persons with advanced HIV infection receiving ARVs	2.3	7.7	18.2
6	% adults and children with HIV still alive 12 months after initiation of ARVs	-	83.0	
7	% of HIV+ pregnant mothers receiving a complete course of ARV for PMTCT	2	2.3	
8	% of facilities delivering ART experiencing stock-out of >=1 week	0	0	0
9	TB cure rate	73	75	
	Impact Mitigation			
10	Ratio of current school attendance among dual orphans to that among non-orphans	0.94	0.97	
	Knowledge (among those aged 15-24 years)			
11	% of males correctly identifying ways of preventing HIV/ rejecting misconceptions	-	37.1	37.1
12	% of females correctly identifying ways of preventing HIV/ rejecting misconceptions	-	25.2	
	Preventive Behavior			
13	Median age at first sex among 20-24 year olds (Males)	17.7	18.1	
14	Median age at first sex among 20-24 year olds (Females)	17.1	17.4	
15	% of sexually active men who had sex with a non-regular partner	33	26	
16	% of sexually active females who had sex with a non-regular partner	8	8	
17	% of men using of a condom the last time they had sex with a non-regular partner	38.9	47.1	47.1
18	% of women using a condom the last time they had sex with a non-regular partner	28.7	30.1	30.1
19	Number of facilities providing VCT	118	146	
20	# of clients tested for HIV at CT sites and receiving their serostatus results	154,708	221,071	
	Policy Development and Implementation Status			
21	National Composite Policy Index	6.2	n/a	8.3
	Expenditures			
22	Amount and % of overall funding received by the NAC that is granted to various implementers in the last 12 months			
	Received in US$'000		35,000	22,880
	Granted in Malawi Kwacha (US$1 = MK125)			
	Non-governmental Organisations (NGOs)		1,719,432,847	78,811,750
	Community-Based Organisations (CBOs)		554,324,984	136,914,845
	Faith-Based Organisations (FBOs)		60,212,467	1,805,503
	Private sector		56,918,021	20,864,710
	Public sector		3,099,255,320	678,455,968
	Education/training institutions		16,750,000	305,032,058

CHAPTER 1: INTRODUCTION

1.1 Demographic, Socio-economic and Health profile of Malawi

The spread and impact of HIV in any country is influenced by the demographic profile of the population and the local socio-economic and cultural environment. At individual level, these factors determine one's behavior regarding HIV prevention and mitigation and one's attitude towards people infected with HIV. At national level, these factors determine the level and quality of response by various authorities and communities against the HIV epidemic. This chapter briefly discusses the broad demographic context of Malawi, and the socio-economic environment in which HIV is occurring. The chapter also highlights the broad challenges that the country encounters in its efforts to adequately combat the HIV epidemic and other health-related problems.

1.1.1 Demographic Profile

Malawi's population in 2005 was estimated to be 12,884,000. The population is predominantly young; 43.6% and 46.7% are in the age groups 0 to 14 years and 15 to 49 years, respectively. From 2000 and 2004, the estimated annual population growth has been 2.25% *(United Nations Population Database)*. Geographically, the country is divided into three main regions, namely; the Northern, Central and Southern regions. The population distribution among these regions is 12.4%, 40.9% and 46.6%, respectively. According to the 1998 census, the male to female ratio was estimated to be 51:49. The vast majority of Malawi's population (~86%) resides in the rural areas.

1.1.2 Economic Profile

Economic indicators: Malawi is one of the poorest countries in the world. The country ranked 161 out of 174 on the Human Development Index in 2000 *(UNDP, 2001)*. In 2003, Malawi's GNI per capita was US$160, which was 6th from the bottom among 207 countries worldwide and well below the average for sub-Saharan Africa (GNI per capita of US$500). 65.3% of the population live below the poverty line (<US$1 per day expenditure on basic needs), the proportion being higher among rural residents (66.5%) than urban residents (54.9%). The proportion of poor households is higher in the Southern region (68.1%) than in the Central and Northern regions (62.8% and 62.5%, respectively). In addition to this poor economic index, income is unevenly distributed with a heavy bias towards the rich individuals. The richest 20% of the population consume 46.3% of total goods and services, while the poorest 20% consume 6.3% (Gini coefficient of 0.52 in urban areas and 0.37 in rural areas [GOM, 2002a]).

Malawi's economy is highly reliant on agriculture; it accounts for ~ 90% of its export earnings and 45% of its Gross Domestic Product. Since 2000, the economy has been adversely affected by shortages in rainfall with severe droughts especially in the 2001-2002 and the 2004-2005 agricultural seasons. Due to Malawi's low GNI, its national budget is highly reliant on donor aid. Donors finance as much as 40% of the total budget and 80% of the development budget. Ultimately, the poor and unfavorable macro-economic environment hampers government's expenditures on social services such as health and education.

External and Domestic Debt: By the end of 2004, Malawi's external debt stood at US$3.1 billion, 82% of which was owed to multilateral creditors (IDA, ADF, IMF). In the same year, the total external debt service for Malawi was US$112.9 million. Since the year 2001, the multilateral

donors have permitted Malawi government to utilize 34-42% of its debt service funds towards social service sectors such as health and education, under the Highly Indebted Poor Country (HIPC) initiative. Notwithstanding this arrangement, Malawi's external debt remains unsustainable. A recent Debt Sustainability Analysis revealed that the present value of Malawi's debt relative to exports of goods and services was 267%, well above the threshold of 150% under the enhanced HIPC. Unfortunately, during the 2005 meeting of the G8 countries in Gleneagles, Scotland, Malawi was not listed as one of the countries eligible for 100% cancellation of debts owed to the IDA, ADF and IMF.

In addition to the external debt, by the end of 2004, Malawi had a domestic debt amounting to MK60.2 billion (US$557.7 million; ~37% of GDP) and domestic arrears (outstanding bills) amounting to MK10.3 (US$95.4 million; ~ 7% of GDP). Each year, there are big deficits in the national budgets which have resulted in huge domestic borrowing, compounding on the existing debts. The high domestic debt, with its associated high interest rates, is a very big threat to economic growth. Thus, instead of fostering industrial development, Malawi currently uses a large proportion of its income for debt servicing which limits the country's ability to lift itself out of poverty.

1.1.3 Educational profile

Literacy and School Enrolment rates: In 2002, the literacy rates among people aged 15 and above were 79% for males and 46% for females *(DHS EdData Survey 2002)*. The literacy rates were worse in the rural than in the urban areas; 77% versus 99% for males and 42% versus 72% for females. Despite the introduction of free primary school education by government in 1994, primary school completion rate in 2003 was estimated at only 41% and the rate of absenteeism was estimated at an average of 17 days per student per year *(Education Statistics, 2003)*. Furthermore, of the 2 million youths eligible for secondary education, only 172,108 (8.6%) were enrolled in the public schools in 2005. In general, females were more likely to drop out of school than males. Apart from gender, reasons for high absenteeism and drop out rates in primary schools include poverty and hunger. The low enrolment in secondary schools is partly due to low government investment in the education sector and sub-optimal management of resources.

Government expenditure on education: Internationally, proponents of the "Education For All" goal recommend that at least 26% of national budget should be allocated to education. In Malawi, funding to the sector has decreased from ~28% of the total budget in the 1990s to 17% in the 2004/5 and 13% in the 2005/6 budget. The biggest proportion of the sector's recurrent budget is allocated towards personnel emoluments (~78.0% in the 2005/06 budget) while allocation for "other recurrent transaction (ORT)" is very low (~23.0% in the 2005/06 budget). This low budgetary allocation for ORT adversely affects the availability and quality of learning resources in schools. The development budget sector is mainly financed by donors; estimated at 80% in the 2005/06 budget. The limited investment in infrastructure development in the educator sector has resulted in poor quality of existing classrooms and congestion. In 2005, it was estimated that there was an average of 106 pupils per classroom *(Education Statistics, 2005)*. To reduce this ratio to 60 pupils per classroom, it is estimated that an extra ~14,500 classrooms would be needed.

Teacher student ratio: The education sector, like most other public sectors in Malawi, is facing a huge human resource crisis. With a total primary school enrollment of ~3.2 million in 2004, the qualified teacher: pupil ratio was estimated to be 1: 83 *(Education Statistics, 2005)*. High teacher attrition rate due to HIV and AIDS-related deaths is one of the major reasons for this poor ratio. Between 1999 and 2005, it is estimated that 6, 217 teachers died of HIV and AIDS-related

conditions. To improve the teacher: pupil ratio to the recommended ratio of 1:60, it is estimated that the education sector needs about 25, 500 extra teachers in primary and secondary schools.

1.1.4 Gender Inequality

Ratio of girls to boys in schools: The ratio of female to males in the lower primary school grades (1 to 3) is nearly 50:50. However, from grades 4 to 8 the ratio begins to drop. In secondary school the female: male ratio is estimated at 72:28, while in university it is estimated to be 74:26. Reasons for the high drop out of girls include pregnancies, early marriages and the need for household labor especially in the face of widespread poverty and disease. Ultimately, women's lower educational levels are related to lower work force participation and decreased earnings, and thus poor economic autonomy. This situation increases women's dependence on men.

Proportion of seats in parliament held by women: A study by Kakhongwe (2005) regarding representation of women in Malawi's parliament shows some improvement in the proportion of women in the chamber from 5.7% in 1994 (n=10) to 8.9% in 1999 (n=17) and 14.4% in 2004 (n=27). Although this is the case, women representation is still short of the recommended 30% in the SADCC region.

1.1.5 Health Profile

Mortality Health Indicators: The life expectancy at birth in Malawi has fallen sharply over the past decade; it was estimated at 36.3 years in 2004 compared to around 42 in 1994. This decline has largely been attributed to the HIV and AIDS epidemic. Preliminary data from the Malawi Demographic Health Survey (MDHS) show that, in the period 2000-2004, the Under-five mortality rate was 133 per 1000 live births while the infant mortality rate was 76 per 1000 live births. These recent figures are substantially lower than those reported in the preceding years. The under-five mortality rates were 190 and 187 per 1000 live births in periods 1990-1994 and 1995-1999, respectively. The corresponding figure for infant mortality rates in these preceding years were 104 and 112 per 1000 live births respectively. Despite this recent decline, Malawi's under-five and infant mortality rates remain one of the poorest in sub-Saharan Africa and world-wide.

The maternal mortality ratio (MMR) in Malawi rose sharply from 620 to 1120 per 100,000 live births from 1992 to 2000. Although the MMR for the period 2000-2004 has not yet been officially reported, there are indications that there is a downward trend from the 2000 figure. The preliminary report of the 2004 MDHS shows a figure of 984 maternal deaths per 100,000 live births. Even with this figure of MMR, Malawi remains one of the countries with the highest MMR in the world.

Malnutrition rates: Malnutrition is a serious problem among children in Malawi. The rates of malnutrition or stunting (restriction in growth due to chronic under-nutrition), among under-five children, has remained constant since 2001. MDHS 2004 preliminary data indicate that 48% of under-five children were malnourished/stunted as compared to 49% in 2001. Recurrent food shortages due to poor rains and low education status of rural communities are some of the major reasons for the persistent malnutrition problem. Malnutrition increases children's susceptibility to a host of infectious diseases.

Causes of the poor health indicators: The majority of the causes of morbidity and mortality in Malawi are preventable or curable. In children, infectious diseases such as malaria, pneumonia and diarrhea are the major contributors of morbidity and mortality. In pregnant women, the major causes of death are bleeding before or soon after delivery *(antepartum and postpartum*

hemorrhage) and reproductive system infections which develop after delivery *(puerperal sepsis)*. In the most productive age group (20-49 years), HIV and AIDS is highly prevalent and is currently the leading cause of mortality. As a result of the HIV epidemic, tuberculosis (TB) has become an important direct cause of morbidity and mortality in this age group. The number of reported TB cases increased at least 5-fold, from 4,863 in 1984 to 26,375 in 2004 *(Malawi National TB Control Program)*. The major underlying causes of the poor health indicators include widespread poverty, chronic malnutrition, low education status, poor sanitation, poor access to safe water and inadequate capacity of the health care system to deliver quality and accessible health services.

Health Sector Expenditure: National Health Accounts report for 1988-89 estimated that the annual per capita health expenditure was approximately US$12.4 (~$1 per capita per month). Out of this, the Government of Malawi expenditure accounted for only 25%, donors accounted for nearly 30% and private financing sources accounted for 45% (19% from employers' contributions, and 26% from household's out-of-pocket expenditure). The report observed that 20% of total health costs in the health sector are from out-of-pocket expenditures *(MoH, 2001)*. The most poor of all households spend between 7.4% and 10% of their annual consumption on health care.

Government's budgetary allocation to the health sector has increased from an average of 6-9% of voted expenditures in the 1990s to 12-15% from the year 2000. Despite this increase, a major concern has been raised regarding the intra-sectoral allocation of resources. Prior to the 2004/05 budgetary period, there appeared to be little prioritization of the budgeting and actual expenditure towards lower care health facilities which are meant to deliver essential health care to the poor, mostly residing in rural areas.

Human resource crisis in the health sector: Despite the substantial increase in the commitment and availability of financial resources from donors and government since the mid-1990s, delivery of health services is currently hampered by the lack of skilled health workers, mainly in peripheral health facilities which provide basic health services to rural populations. A health facility survey *(JICA & MoH)* conducted in 2002 showed that of the 26 districts in Malawi, 15 (~60%) had less than 1.5 nurses per health center, while 5 (~20%) had less 1 nurse per health center. Furthermore, the survey showed that of the 26 districts, 10 had no doctor in the government district hospitals and 4 had no doctor at all. On average, Malawi had a population-to-nurse ratio of 3500:1 and population-to-doctor ratio of 64,000:1. These statistics were far worse than those from Malawi's neighboring countries. The Ministry of Health currently estimates that the vacancy rate for doctors, nurses and laboratory technicians in the public health sector range from 44% to 68%. In addition to the above-mentioned shortages, the vacancy rates for specialist doctors (surgeons, obstetricians/gynecologists, physicians, pediatricians, pathologists etc) in the public health sector range from 71% to 100%.

In an effort to resolve the human resource crisis, in 2004, the Ministry of Health (MoH), with the support of its development partners, put together a plan called "The 6-Year Emergency Human Resources Relief Programme [EHRP]". This programme included the expansion of the capacity of health workers training institutions and the retention of health workers in the public sector, through improvements in their remuneration package and provision of incentives to health workers operating in underserved areas. By October 2005, this US$ 273 million programme had been fully funded.

1.2 Brief History of Malawi's Response to the HIV Epidemic

1.2.1 Evolution of institutions coordinating the national HIV and AIDS response

Following the emergence of the HIV and AIDS pandemic in the mid 1980s, the government of Malawi instituted strategies aimed at controlling its spread. This included the establishment of the National AIDS Control Programme (NACP) within the Ministry of Health in 1989. The Cabinet Committee on Health and HIV and AIDS was also formed to provide policy and political direction to the Ministry of Health. In 1996, the government and its partners evaluated the national HIV and AIDS response. Some of the major findings of the evaluation included insufficient coordination of planning, implementation, monitoring and evaluation of activities of various agencies, insufficient institutional support to NACP and over-reliance on the health sector for the national response. In order to improve the multi-sectoral planning, implementation and coordination of HIV and AIDS activities, the government of Malawi established the National AIDS Commission (NAC) in July 2001 within the Office of President and Cabinet, replacing the NACP. A Board of Commissioners consisting of representatives from government, non-government organizations, faith-based organizations and the private sector oversees operations of the NAC. Initially, the NAC reported to the Office of President and Cabinet (OPC) through the minister for Presidential Affairs and to the Cabinet Committee on HIV and AIDS. Currently, NAC reports to OPC through the Principal Secretary for Nutrition, HIV and AIDS.

1.2.2 Strategic Plans

In 1989, the Ministry of Health and Population developed a five-year Medium Term Plan (1989-94) (MTP-I) to guide the implementation of HIV and AIDS activities, which mainly focused on blood screening, HIV and AIDS prevention through public awareness and establishing an infrastructure for epidemiological surveillance. In 1993, a review of the MTP-I showed that a lot of progress had been made especially with regard to implementation of HIV screening programs for blood transfusion and creating awareness about HIV and AIDS. However, the review noted, among other things, a lack of emphasis on care and treatment of AIDS patients. The second Medium Term Plan (1994-98) MTP-II addressed some of the weaknesses in the MTP-I. However, in 1996, a subsequent evaluation of the national HIV and AIDS response found that despite high awareness of HIV and AIDS, behavior change had been limited and HIV incidence continued to increase. The major recommendation was that Malawi needed to develop a comprehensive five-year plan to guide HIV and AIDS prevention, treatment and impact mitigation.

In response to the recommendations of the evaluation, in 1999, the National Strategic Framework (NSF) was developed through a highly participatory process involving a wide range of stakeholders in HIV and AIDS activities. The former President of Malawi launched the NSF, which covered the period 2000-2004, in October 1999, when he also declared HIV and AIDS a national emergency. The main themes in the NSF were prevention, advocacy, and behavior change; treatment, care, and support; sectoral mainstreaming; impact mitigation; and surveillance and monitoring. The NSF also emphasized the need for active participation of various stakeholders including the private sector, and teaching institutions in the design, implementation, and monitoring of multi-sectoral and multidisciplinary HIV and AIDS interventions in the country. In 2003, the NAC developed an implementation plan for the NSF – the Strategic Management Plan (SMP), which covers the fiscal years 2003/04 - 2007/08. The SMP is implemented on the basis of rolling annual work plans, the first of which was for Financial Year 2004/05.

1.2.3 The HIV and AIDS Policy

Throughout the 80s and 90s, Malawi did not have a clear national HIV and AIDS policy guiding the implementation of HIV and AIDS activities. However, after the development of the National Strategic Framework, the process of developing the National AIDS Policy started in 2000 to guide the implementation of the National Strategic Framework. The following eight areas were identified as requiring policy recommendations; multi-sectoral approach; human resources; HIV testing; gender and HIV and AIDS; sex and sexuality; the use of condoms; biomedical response and legal and ethical issues. To ensure that the policy was evidence-based, various studies were commissioned to identify issues and solicit recommendations in these eight policy areas. In addition, a Multi-sectoral Policy Advisory Committee (MPAC) was formed to guide the process of developing the policy. The initial draft policy was presented to various community groups to develop understanding of HIV and AIDS policy issues, build consensus, and seek input. Forums were conducted with parliamentarians and politicians, faith-based organizations, youth organizations and leaders, civil society organizations, government ministries and traditional leaders, healers and birth attendants. The policy drafting team reviewed and synthesized comments from these consensus and advocacy activities for presentation to MPAC. Based on MPAC guidance concerning the comments, a new draft of the policy was compiled for editing and eventually submitted it to Cabinet for approval. The National HIV and AIDS policy was finalized in 2004 and launched by the former president of Malawi in November 2004.

1.3 The National Monitoring and Evaluation System

Malawi has adopted the UNAIDS global principle of '3-ones' in the response to HIV and AIDS: one National Framework, one Coordinating Agency and one Monitoring and Evaluation Plan. Although this is the case, in practice variants to the principle are emerging and details concerning these are discussed Chapter 7 under Programme Management, Coordination, Monitoring and Evaluation. According to the M&E operational plans, there are 59 core indicators that need to be tracked using 20 major sources of data. Out of the 59 indicators, 5 are impact level indicators, 7 are outcome level indicators while 47 are output level indicators.

The NAC Activity Reporting System (NACARS) is one of the data sources that collect information on monthly basis to inform 38 output-level indicators of the M&E system. It is a paper-based recurrent data-gathering tool for collecting output-level indicator data from all implementers of HIV and AIDS interventions in Malawi. Upon completion, the NACARS form is sent to National AIDS Commission (at the moment through the Umbrella Organisations) with copies sent to District and City Assemblies. The data generated through NACARS is used to compile the Quarterly Service Coverage Reports (QSCR) which feed into the annual M&E report.

Since its inception the system has successfully managed all data sources that provided impact and outcome level indicators. The major challenge has been collection of service data. Programme service data is collected in two ways: monthly through NACARS and annually from 11 data sources including the ANC Sentinel Survey, Ministry of Health's HMIS, Ministry of Education, PSI, BLM and special surveys such as the DHS and the BSS. Data collected through NACARS is vital since it provides a useful platform to link programme outputs to outcomes on regular basis, and a mechanism by which weakness can be identified swiftly or great opportunities identified promptly which can be used elsewhere in the national response to HIV and AIDS.

NACARS was characterized by underreporting during the first year of M&E system implementations especially evident with the non-NAC grantees and aggravated by the absence of a

legally binding agreement. Lack of legal requirement on reporting coupled with the lack of harmonized reporting system could possibly explain the non-reporting especially by the non-NAC grantees. Good efforts were made to have such players participate in the system and one of them was through the involvement of funding partners. The process led to most non-NAC grantees, especially USAID funded, to provide reports to NAC as required in line with the '3-ones' principle. Similarly, NAC intensified its dissemination and feedback meetings throughout the country and this too has led to more stakeholders participating in the system. From March 2005, the NAC M&E central unit has been overwhelmed with huge volumes of monthly report forms from various implementers.

Efforts are underway to decentralise the system and to create monitoring and evaluation units in all District and City Assemblies. All district based HIV data will soon be collected and processed at that level, and NAC will at this stage only compile a national picture of the epidemic by consolidating all district HIV and AIDS data for a given period.

1.4 Harmonization of the national M&E with the UNGASS Reports

Malawi is a signatory to the Declaration of Commitment, promulgated at the United Nations General Assembly's Special Session on HIV&AIDS (UNGASS) in June 2001, which makes it imperative that countries produce a report to the UN Secretariat on a set of internationally agreed HIV and AIDS related indicators, on a periodic basis as per the agreed schedule. In 2003 Malawi submitted its first report and is expected to submit another report by end of 2005. The UNGASS reporting process is being viewed as one of the effective tools for citizens to hold their governments accountable for the commitments they have made on HIV and AIDS. Malawi has created various platforms for input into the UNGASS reporting process. This report arises from efforts undertaken by the government of Malawi to harmonize the existing annual M&E report with the UNGASS report.

1.5 The Process of Harmonizing the two Reports and Sources of Data

This report was prepared through a consultation process involving NAC, Ministry of Health, UNAIDS-Malawi, the National Statistical Office and a team of two Consultants who were hired to lead the process. Data pertaining to most of the output level indicators comes from the NACARS. Attempts were made to include data from the time the last report for Malawi was submitted to UNGASS to the time when the report was being prepared. However, because some of the data were not ready at time of writing the report, some indicators reflect the situation as of December 2004 while some indicators present the situation as of October-November 2005, for example, findings from the 2005 ANC HIV prevalence sentinel results.

At the time the report was being written, the 2004 MDHS had not yet finalised. Also, data on self-reported STI prevalence had not been analyzed and the Ministry of Health had not yet conducted the national health facility survey. Furthermore, data were unavailable from the Ministry of Labour's Workplace Survey and Ministry of Health's Health Facility Survey.

CHAPTER 2: THE IMPACT OF THE HIV AND AIDS EPIDEMIC IN MALAWI

This Chapter presents estimates of HIV and STI prevalence in Malawi as estimated from the antenatal clinic (ANC) sentinel surveillance survey, the population-based demographic and health survey(s) and other special studies focusing on HIV and AIDS.

2.1 National and regional prevalence of HIV in Malawi

2.1.1 Estimates from sentinel surveys

Malawi has been monitoring HIV prevalence through antenatal clinic (ANC) sentinel surveillance from the time the first cases of AIDS were confirmed and reported in the mid-80s. In 1994, ANC surveillance HIV monitoring was expanded to 19 clinics and hospitals spread throughout the country when the National AIDS Control Programme (NACP) began monitoring HIV trends. Since then, sentinel surveys have been conducted annually, except for the years 2000 and 2002. Of the 19 facilities, 5 are in the Northern Region, 7 are in the Central Region and the last 7 are in the Southern Region. The location of the sentinel sites are such that rural and urban sub-populations are covered. Data on HIV prevalence among pregnant women attending ANC for the first time at the sentinel sites are used to estimate national prevalence using epidemiologic modeling techniques. For the year 2005, a computer software called 'Estimation and Projection Package (EPP)' was used to derive estimates of national and regional prevalence of HIV.

Table 1 below presents the trends of the national HIV prevalence estimates since 2001. As shown in this table, the 2005 HIV prevalence estimate is 14.0%, similar to the prevalence of 14.4% recorded in 2003 and 14.6% recorded in 2001. When compared to the prevalence in the late 1990s, HIV prevalence in Malawi appears to have declined from 15-16% to around 14% where it seems to have stagnated in the 2000s. The fact that there is no increasing trend of HIV prevalence is encouraging.

Table 1: National HIV Prevalence Rates for 2001, 2003 and 2005

	2001	2003	2005
Area of residence			
Urban	25.0	23.0	21.6
Rural	13.0	12.4	12.1
Region			
Northern	11.4	11.3	13.5
Central	9.9	9.7	9.3
Southern	19.6	19.5	18.6
Malawi	**14.6**	**14.4**	**14.0**

Source: 2005 Sentinel survey preliminary results

HIV prevalence in the urban areas continues to be very high (21.6% in 2005) as compared to the prevalence in the rural areas (12.1%). Just like the national prevalence, HIV prevalence rates in both the rural and urban areas have been declining over the years. However, HIV prevalence in urban areas seems to have declined faster from 25.0% in 2001 to 21.6% in 2005 compared to prevalence in the rural areas. Across the regions, the picture is rather mixed. The prevalence of HIV has consistently remained higher in the Southern than in the other Regions since 2001. However, when data is stratified by regions, HIV prevalence appears to have declined in the Southern and

Central Regions from 2003 to 2005, while it seems to have increased in the Northern Region during the same period (from 11.3% to 13.5%).

2.1.2 Estimates from population based surveys (2004 MDHS)

In 2004, Malawi conducted a nation-wide population-based survey (the Demographic and Health Survey - DHS), which for the first time, included biomarkers of HIV infection. A total of 5,272 respondents were tested for HIV. HIV prevalence at national level was estimated at 11.8% and was higher among women than among men (13.3% versus 10.2%) (Table 2). At regional level, the Southern Region recorded the highest prevalence of 14.4% compared to the Northern and Central Regions (12.1% and 8.3%, respectively). Within regions, large disparities in HIV prevalence were recorded between men and women. In the Southern Region, HIV prevalence among women was more than two times as high as that of men in the same region (19.8% versus 9.2%). A reverse trend was recorded in the Central Region where HIV prevalence was almost twice as high among men (10.3%) compared to women (6.6%). As the findings presented in Table 2 below illustrate, women in the Southern Region are ~2-3 times more likely to be infected than their counterparts in the Central and Northern Regions. Interestingly, HIV prevalence among men in the Northern Region is higher (14.6%) compared to Central Region (10.3%) and Southern Region (9.2%).

When HIV prevalence is compared across areas of residence, a higher prevalence is found in the urban areas (17.1%) than in the rural areas (10.8%). The prevalence is persistently higher among women than among men in both urban and rural areas. The percent-difference of HIV prevalence between women and men is two times higher in the rural areas than in the urban areas (3.7% versus 1.7%). This indicates that rural women are at much higher risk than rural men to become infected whereas in the urban areas, the risks of being infected are almost the same for men and women. However, after stratifying data by gender, it appears that women in urban areas have a higher HIV prevalence (18.0%) than women in the rural areas (12.5%). The same observation holds true among men as men in urban areas are two times more likely to have HIV infection (16.3%) than males in the rural areas (8.8%).

Table 2: HIV Prevalence in Malawi disaggregated by region and area of residence

	Men	**Women**	**Total**
Area of residence			
Urban	16.3	18.0	17.1
Rural	8.8	12.5	10.8
Region			
Northern	14.6	10.4	12.1
Central	10.3	6.6	8.3
Southern	9.2	19.8	14.4
Malawi	**10.2**	**13.3**	**11.8**

Source: 2004 MDHS Preliminary Report

2.1.3 Estimates of HIV prevalence among pregnant women at sentinel sites

Trends in the prevalence of HIV among pregnant women who are part of the sentinel study population also provide an opportunity for assessing and understanding the dynamics of HIV infections in Malawi. Table 3 below presents HIV prevalence rates among pregnant women in 2003 and 2004 at sentinel sites. In 2003, HIV prevalence among ANC attendees was 19.8% and the

prevalence was higher in the Southern Region (23.7%) compared to the Northern Region (20.0%) and the Central Region (15.5%). In 2005, HIV prevalence among pregnant women in the sentinel sample was 16.9% and just like in 2003, the prevalence was higher in the Southern Region.

HIV prevalence of the sentinel sample pregnant women has generally declined among all the age groups (by 1-5%). The decline appears to be large among the young women aged 15-19 years (5%) and among those aged 30-34 years (4%).

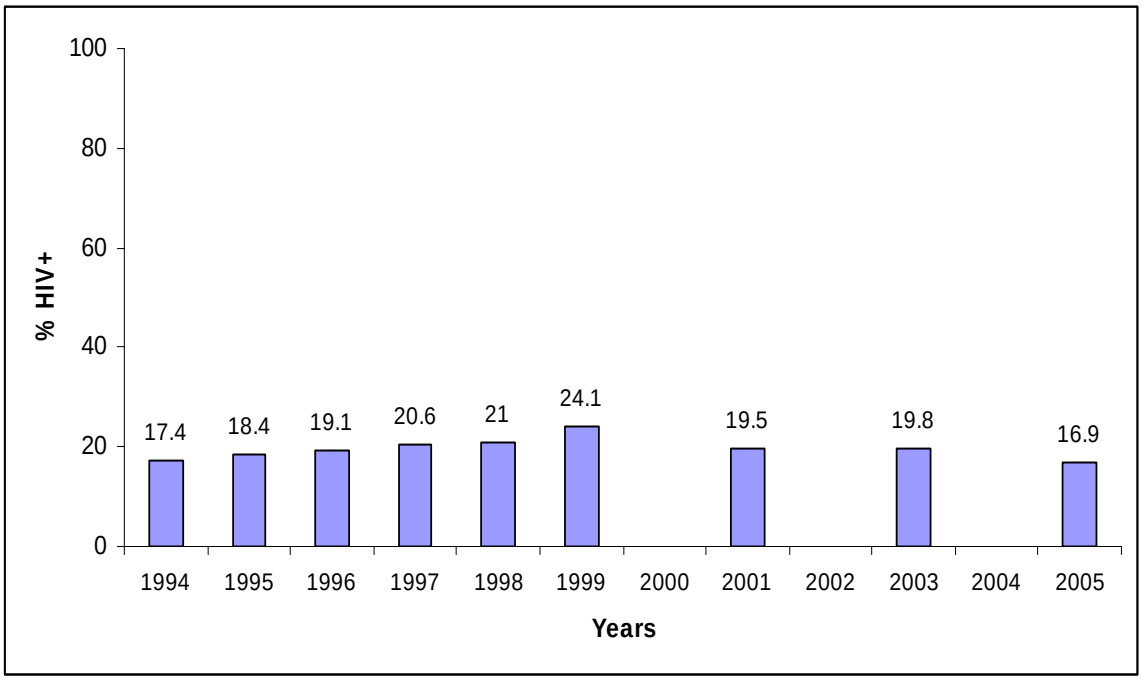
Table 3: HIV prevalence among pregnant women in the sentinel sample in 2003 and 2005

	2003	**2005**
Area of residence		
Urban	21.7	20.4
Rural	14.5	13.0
Region		
Northern	20.0	14.0
Central	15.5	14.3
Southern	23.7	21.7
Age groups		
15-19	15.2	10.3
20-24	19.8	16.4
25-29	22.3	21.6
30-34	24.6	20.6
35-39	17.2	17.6
40+	18.1	14.5
15-24	-	14.3
15-49	-	20.6
Malawi	**19.8**	**16.9**

Source: 2003 ANC Sentinel Report & 2004 Preliminary MDHS Report

Figure 1 below shows trends in HIV prevalence among sentinel sample pregnant women at sentinel sites from 1994 to 2005. As would be noted, HIV prevalence rose gradually from 17.4% in 1994 to 21.0% in 1998 before increasing further to 24.1% in 1999. A subsequent survey in 2001 showed a decline of HIV prevalence to 19.5% and the prevalence remained similar in 2003 (19.8%). The 2001 findings showed a decline from 24.1% in 1999 to 19.5% but the prevalence seemed to have stagnated around the same level in 2003 (19.8%). In 2005, the prevalence has been estimated at 16.9%

Figure 1: Trends in HIV Infection among pregnant women attending ANC at sentinel sites



Source: Various ANC Sentinel Reports

2.1.4 Estimates from programme level data

Data from various HIV and AIDS programmes which are being implemented in Malawi also provide a picture of the HIV prevalence in the country. For instance, PMTCT and VCT data indicate that HIV prevalence is higher in Blantyre (in the Southern Region) than in Lilongwe (in the Central Region). The prevalence has remained stable in Blantyre while it is declining in Lilongwe. Data compiled in 2003 by the Ministry of Health showed higher prevalence of HIV among PMTCT clients in health facilities located in Blantyre district (Limbe: 38.4%, Bangwe: 33.3%; Lunzu DAPP: 23.6%, Mlambe: 36.7% and Queen Elizabeth Central Hospital: 25.6%) than in those facilities located in Lilongwe (Likuni: 12.7%, Lilongwe Central Hospital: 15.1%, Bottom Hospital:15% and Kawale:15.4%). Currently, the NAC is in the process of commissioning a study to find out reasons for this huge disparity in HIV prevalence between these two urban populations.

2.2 STI Prevalence in Malawi

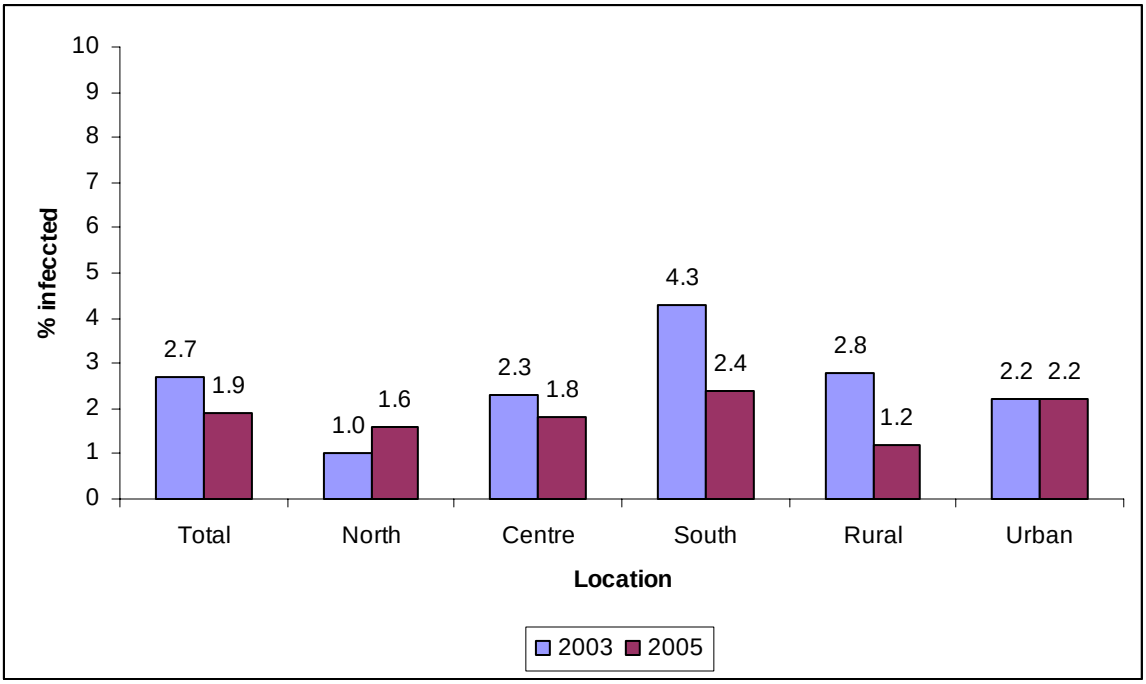
2.2.1 Estimates from ANC sentinel surveys

The Ministry of Health collects data on syphilis and other STIs from ANC attendees at sentinel sites. All women who are reactive on VDRL[1] tests are subjected to the Treponema Haemagglutination Assay (TPHA) test to confirm syphilis infection. This section reports on the prevalence of syphilis in 2005 and compares this with the prevalence in 2003.

[1] VDRL stands for Venereal Diseases Research Laboratory

Figure 2 below shows the prevalence of syphilis in the three regions of the country in 2005 and 2003. In 2005, syphilis prevalence among pregnant women attending ANC at sentinel sites was 1.9% compared to 2.7% in 2003. Across the regions, the Southern region registered the highest prevalence (2.4%) followed by the Central Region (1.8%). A similar trend was also observed in 2003 where the Southern Region recorded the highest prevalence of 4.3% followed by the Central Region (2.3%). There was a big drop in syphilis prevalence in the Southern Region (from 4.3% to 2.4%) compared to the Central region (from 2.3% to 1.8%). When data was examined within regions, syphilis prevalence appeared to have dropped in the Central and Southern regions, while the prevalence in the Northern Region slightly increased from 1.0% in 2003 to 1.6% in 2005. When data was compared across areas of residence, the prevalence of syphilis remained at 2.2% in the urban areas in 2005 while in the rural areas, the prevalence dropped from 2.8% in 2003 to 1.2% in 2005.

Figure 2: Prevalence of Syphilis among sentinel pregnant women in 2003 and 2005



Source: 2003 Sentinel Report & 2005 Preliminary Sentinel Report

2.2.2 Estimations of STI prevalence from population-based surveys

The Malawi Demographic and Health Surveys of 2000 and 2004 collected information on self-reported prevalence of STIs among the respondents. The respondents were asked whether they had a sexually transmitted infection (other than HIV) in the last 12 months. They were also asked whether they had experienced a genital sore or ulcer and whether they had any genital discharge in the last 12 months. At the time of writing this report, data on the 2004 survey was still being analyzed and results were not available.

2.2.3 Estimates of STI prevalence from other studies

Findings from project-based surveys and other cross-sectional surveys on the prevalence of STIs can also be good sources of information on STI prevalence among sub-populations in the country. A study by Joaki et al conducted in Balaka (in the Southern Region) and Rumphi (in the Northern Region) in 2004 showed that the prevalence of Gonorrhea among women in the two districts was 9.7% and 1.6% (respectively) and in both districts, the prevalence was lower among men (0.4% in Balaka and 0.5% in Rumphi). The Behaviour Surveillance Survey (BSS) of 2004 also confirms the problem of STIs in the general population. Among the 13 sub-populations that were studied in the survey, self reported STIs were highest among female sex workers (15.3%) followed by fishermen (11.6%) male estate workers (7%) and male vendors (6%). STIs were also prevalent among male (3%) and female (1.8%) secondary school teachers.

2.3.4 HIV Infection rates among infants

Implementation of prevention of mother-to-child transmission (PMTCT) programmes has started only recently in Malawi (refer to Section 3.4 for details). In 2004, it was estimated that only 2.3% of HIV pregnant women receive a full package of care to prevent mother-to-child transmission (MTCT) of HIV. As such, Malawi has not yet conducted comprehensive descriptive studies to estimate the rate of HIV MTCT. The only results that are available are from research projects, which are not representative of results that would be obtained under non-project conditions. As the coverage of PMTCT services increases, national studies will be conducted to estimate HIV MTCT.

CHAPTER 3: INDICATORS RELATING TO PREVENTION AND BEHAVIOUR CHANGE

Behaviour change is very crucial in the fight against HIV and AIDS. Among others, behavioural change entails sexual abstinence (for those not married), reducing the number of sexual partners or being faithful to only one partner and consistent use of condoms. Success in behavioural change is dependent on a number of factors including the type and quality of information that is provided to the population, the means through which that information is disseminated and social, religious and cultural factors. This Chapter focuses on achievements that have been made with respect to access to HIV and AIDS information and behavioural change.

3.1 Indicators Relating to Sexual Behaviour

3.1.1 Median age at first sex among 20-24 year olds

Table 4 below compares the median ages at first sexual debut for males and females aged 20-24 years between 2000 and 2004. As would be observed, there has been a modest increase in median age at first sex debut in this age group between 2000 and 2004; from 17.7 to 18.1 years among males and from 17.1 to 17.4 years among females. After stratifying data by place of residence, median age at first sexual intercourse increased slightly from 17.8 years in 2000 to 18.5 years in 2005 among urban residents and from 17.0 years to 17.7 years among rural residents. Across the regions, the Southern Region recorded minimal improvements in median ages at first sexual intercourse as compared to the Northern and Central Regions. This observation raises concern considering that the Southern Region already has the highest prevalence of HIV and has the largest proportion of Malawi's population.

Table 4: Median age at first sexual intercourse among people aged 20-24 years by year

	Median age at first sexual intercourse among females aged 20-24 years	
	2000	2004
Location		
Urban	17.8	18.5
Rural	17.0	17.7
Sex		
Males	17.7	18.1
Females	17.1	17.4
Region		
North	17.1	18.2
Centre	17.7	18.8
South	16.7	16.9

Source: 2000 MDHS & 2004 Preliminary MDHS Report

3.1.2 Sexual intercourse with a non-marital, non-cohabiting partner in the last 12 months

Among persons reporting sexual activity in 2004, 13.9% females and 62.1% males aged 15-24 indicated to have engaged in high risk sexual encounter; having sex with non-marital and non-cohabiting partners. This shows an increase in the proportion of male youth having sex with non-regular partners from 56.0% in 2000 to 62.1% in 2004. However, a decrease in the proportion was observed among older males (aged 25 years and above), as shown in Table 5. The proportion of

females did not change much from 16% in 2000 to 14% in 2004. Sex with non-regular partners was higher in urban areas (13.8%) compared to rural areas (7.2%). Also, in 2004, this practice was higher in among females in the Southern Region than among their counterparts in the other two regions. Again this observation raises some concern, in view of the already high prevalence of HIV in that region.

Table 5: Percentage having sex with non-regular partners by year

Background characteristics	Males		Females	
	2000	2004	2000	2004
Age				
15-24	56.0	62.1	16.0	13.9
25-29	28.0	20.7	3.0	5.4
30-39	19.0	13.1	4.0	4.8
40-54	16.0	5.4	2.0	3.3
Area of residence				
Urban	X	34.5	X	13.8
Rural	X	23.6	X	7.2
Region				
North		26		7.0
Central	X	24	X	6.2
South	X	28	X	10.4

Source: 2000 MDHS Report & Preliminary 2004 MDHS Report
X indicates missing data

Findings from the 2004 BSS also indicate that in some sub-populations, there is a high proportion of individuals who have multiple sexual partners. Proportions of BSS respondents reporting having multiple partners were as follows: vendors (73%) truck drivers (48.4%), fishermen (41.2%), female estate workers (31.9%), male secondary school teachers (16.4%), male primary school teachers (14.9%), police-women (26.5%). Lowest proportions were observed among female primary and secondary school teachers, 4.3% and 6.5% respectively.

3.1.3 Proportion reporting condom use in sexual episodes with non-regular partners

Condom use during last sexual intercourse with a non-cohabiting partner was 30.1% and 47.1% among sexually active females and males respectively in 2004. As shown in Table 6 below, between 2000 and 2004 condom use has increased from 38.9% to 47.1% among males whereas a very minimal change was observed among females from 28.7% to 30.1%. The biggest increase was observed among young males aged 15-24 and 25-29. Use of condoms in sexual episodes involving non-regular partners was higher in the urban areas than in the rural areas for both males and females in 2000 and 2004. When data was compared across gender, this practice was much higher among males than females in both the urban and rural areas, irrespective of the year of the survey. Compared to the Central and Northern Regions, the Southern region had the lowest proportion of people using a condom during sexual intercourse with a non-cohabiting partner. In this region, the proportion increased slightly among males and appeared to have dropped in females between 2000 and 2004. This was in contrast to the increasing trend in condom use in the Northern and Southern Regions, especially among men. The finding of poor condom use in the Southern Region is consistent with the previously discussed indicators of high risk sexual behaviour in this region.

Table 6: Proportion reporting condom use in sexual episodes with non-regular partners

Background characteristics	% using condoms at last higher risk sex			
	Males		Females	
	2000	2004	2000	2004
Age				
15-24	38.0	46.8	32.0	35.2
25-29	45.5	55.9	21.3	26.9
30-39	41.4	41.7	19.3	17.9
40-54	28.5	-	10.5	9.7
All ages	38.9	47.1	28.7	30.1
Area of residence				
Urban	49.6	57.2	44.3	43.7
Rural	36.0	43.5	23.4	24.8
Region				
North	49.2	56.5	44.4	43.1
Central	38.7	50.5	28.1	39.0
South	37.4	42.3	27.0	23.6

Source: 2000 MDHS & 2004 Preliminary MDHS Report

3.2 Indicators relating to STI Management

Previous studies have shown that STIs are risk factors for heterosexual transmission of HIV and treatment of STIs may prevent HIV transmission. The Ministry of Health in Malawi routinely collects data on STI diagnosis, treatment and counseling services from all health facilities. Unfortunately, at the time of preparation of this report, the Ministry of Health through the Health Management Information System (HMIS) was in the process of analyzing and consolidating these data. The Ministry was also planning to conduct a nation-wide survey to establish health worker practices with regard to the diagnosis, treatment and counseling of STI patients using methods recommended by the UNGASS. As such, this report does not present any statistics on the proportion of health facilities providing STI diagnosis, treatment and counseling services as well as proportion of men and women properly diagnosed, treated and counseled for STIs. However, this subsection presents aggregate data on STI cases as recorded by the HMIS.

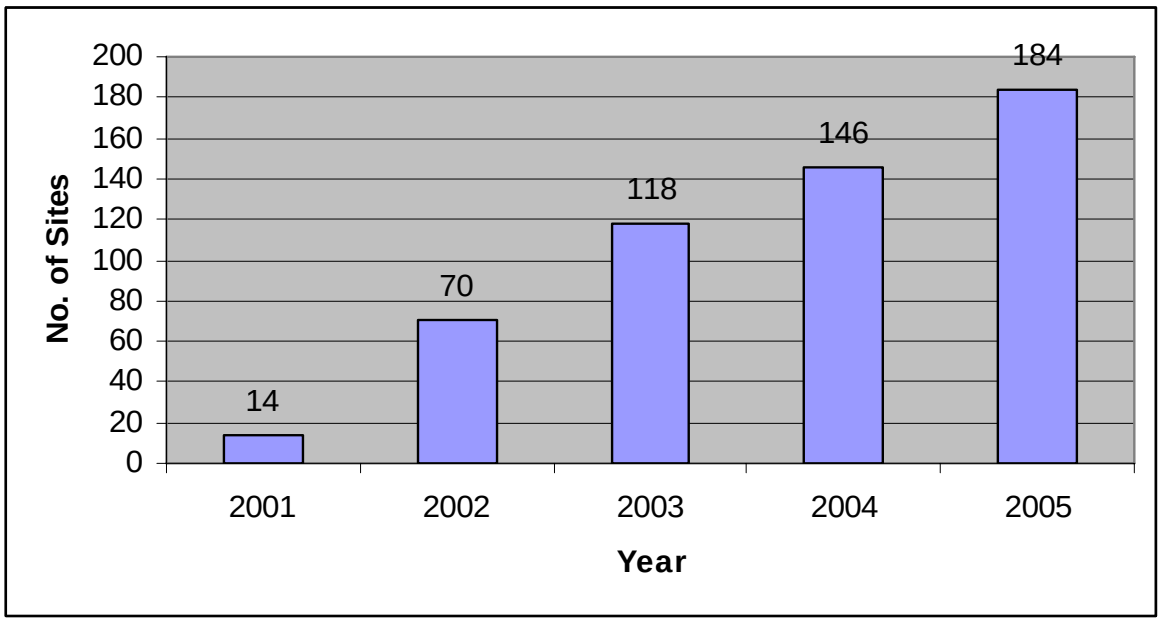
According to the health facility-based data (captured by the HMIS), in 2003-04, approximately 229,278 STI cases (4% of the sexually active population) were recorded whereas in year 2004-05, 276,666 cases (4.7% of the sexually active population) were recorded. In 2003-4, the highest numbers of STI cases relative to sexually active population (SAP) were registered in Balaka (11%), Mwanza (9.2%), Chikwawa (7.4%), Blantyre (6.5%) and Nkhotakota (6.2%). In 2002-3, the highest numbers of STI cases relative to the SAP were registered in Balaka (11.5%), Karonga (3.9%), Mwanza (3.9%), both Chikwawa and Nsanje (2.7%) and Mulanje (2.5%). It is important to emphasize that these figures may not reflect the true prevalence of STIs in the community, because the number of cases recorded in health facilities depends on several factors including the actual numbers of STIs in the community, the health seeking behavior of STI patients and the accuracy of data recording in health facilities. Thus, in future, it may be necessary for Malawi to conduct a comprehensive survey of STI prevalence in the community and, coupled with this, the number of cases reporting to health facilities in that community.

3.3 Indicators relating to HIV Counseling and Testing (CT)

3.3.1 Number and proportion of facilities offering CT services

There has been a steady increase in the number of sites offering HIV testing and counseling services from 2001 to 2005, as illustrated in Figure 3. Considering that there are approximately 617 health facilities in Malawi, this means that 29.8% of these facilities were providing CT services as of June 2005. Of the 146 sites that were offering counseling and testing services in 2004, only 70 (48%) were located in rural areas. Considering that most Malawians reside in the rural areas (~86%), the provision of CT services has so far been biased towards the urban areas. The challenge for Malawi is to rapidly increase CT sites in the rural areas.

Figure 3: Number of facilities offering VCT services



In 2005, data was available only up to June

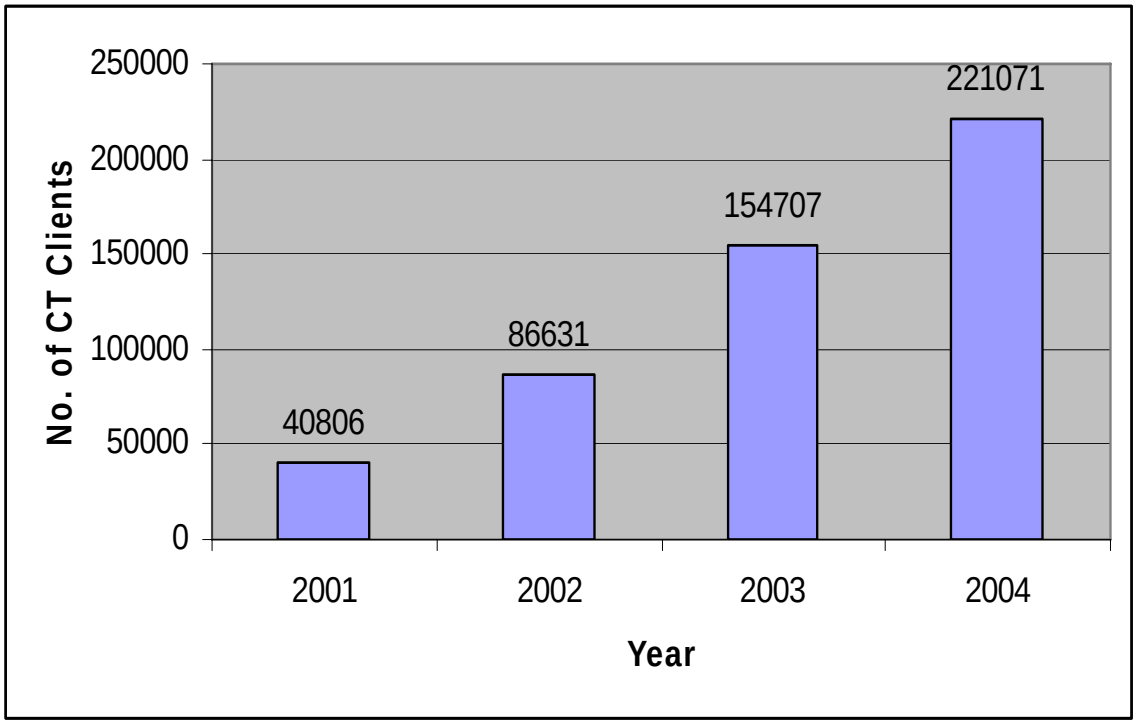
3.3.2 Clients tested for HIV at VCT sites and receiving results

There has been an increase in the numbers of people going for CT services in various sites across the country. From 2001 to 2004, the number of CT clients[1] has increase from 40,806 to 221,071 *(MoH 2005)*, as shown Figure 4 below. Data on the clients' sex and age are routinely collected, but these had not been analyzed at the time of preparing this report.

Although this increase is impressive, the reported data indicate that only 6.9% of males and females aged >15 years have undergone HIV counseling and testing since 2001. Even considering that some women undergo CT as part of PMTCT and that some people might have undergone CT prior to 2001, the proportion of people who have undergone CT is still very low. This is an enormous challenge that Malawi has to overcome over the next few years recognizing that CT is an entry point for HIV and AIDS care and support, and prevention.

[1] these figures exclude blood donors.

Figure 4: Number of clients seen at CT sites between 2001 and 2004



Based on the NACARS data, the coverage of CT is highest in Thyolo district followed by Blantyre, Mzimba (Mzuzu inclusive) and Lilongwe in that order. Mzuzu city alone is second to Thyolo in the ranking. It should be noted that coverage is likely to be higher for Blantyre and Lilongwe cities, however disaggregated data by rural and urban residence were not available for the two cities at the time when this report was being prepared.

MACRO, an NGO specialized in providing CT services, reached 46,286 clients between October 2003 and September 2004 and out of these 32,173 (70%) were males and 14,113 were females (30%). The data also indicate that the majority of clients going for CT at MACRO sites are students (19%) while uniformed security personnel are in the minority (1%).

3.4 Indicators relating to prevention of mother to child transmission (PMTCT) of HIV

3.4.1 Proportion of Health facilities providing at least the minimum package of PMTCT services

In 2002, there were only 9 facilities providing PMTCT services. By December 2004, out of 514 health facilities that had ANC services, 36 (7%) were providing PMTCT services. These were being supported by the MoH, CHAM, UNICEF, MSF, WHO and research institutions. As of the end of 2004, 5 out of the 27 districts in Malawi (Ntchisi, Dedza, Ntcheu, Balaka and Phalombe) had not yet established PMTCT sites.

3.4.2 Proportion of HIV+ pregnant women receiving Nevirapine

According to a report of a country wide Survey of HIV and AIDS services in government facilities (2004), 43,345 pregnant women had been tested for HIV in various antenatal clinics across the country. Out of these 6,069 (14%) were HIV positive and 2,719 (44.8% of HIV positive women) were given Nevirapine (Table 7). Chiradzulu, Mwanza, Dowa and Machinga districts had higher proportions of HIV+ pregnant women who were given nevirapine than the other districts. Considering that 590,774 women were expected to have been pregnant in 2004 and that the 2003 sentinel surveillance reported an HIV prevalence of 19.8% among pregnant women, it can be estimated that there were 116,973 pregnant women who were HIV positive in 2004. If this estimate is correct, then only 2.3% (2,719) HIV+ women received nevirapine in 2004. In 2003, about 2,198 HIV+ pregnant women (2.0%) received Nevirapine.

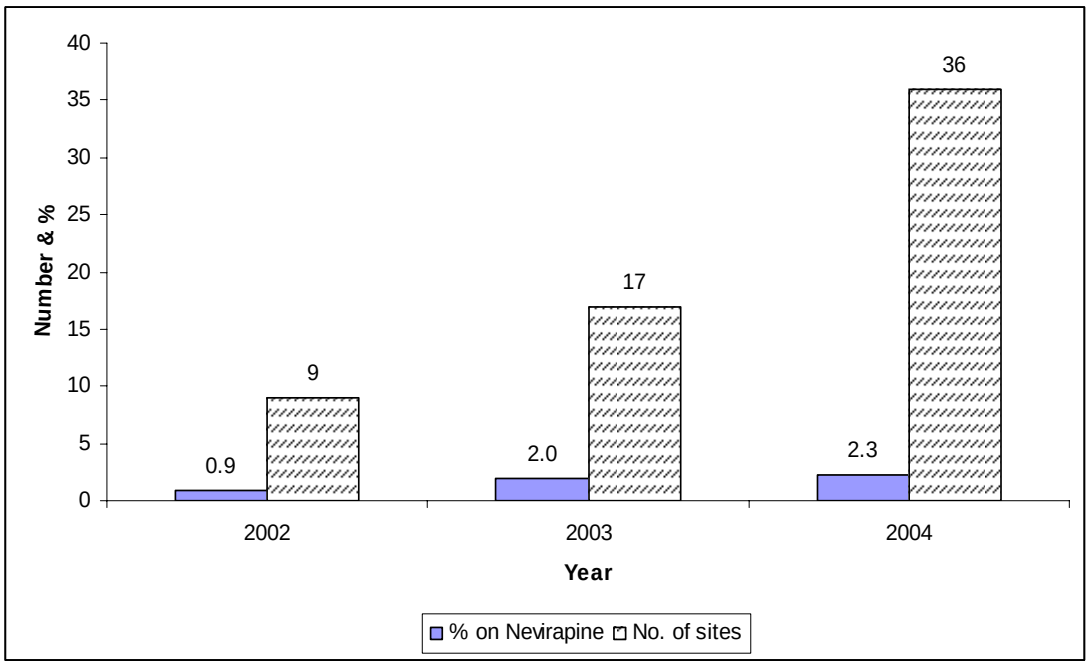
Table 7: Number and percent of HIV+ pregnant women receiving complete course of ARV prophylaxis to reduce the risk of MTCT

Level of aggregation	No. of women tested	No. of women HIV+	No. given Nevirapine	% given Nevirapine
Malawi	43,345	6,069	2,719	44.8
District				
Chitipa	-	-	-	-
Karonga	92	12	1	8.3
Rumphi	-	-	11	-
Mzimba	6,554	689	176	25.5
Nkhatabay	-	-	-	-
Likoma	-	-	-	-
Nkhotakota	142	12	12	100.0
Ntchisi	-	-	-	-
Dowa	999	53	29	54.7
Kasungu	-	-	-	-
Mchinji	666	62	30	48.4
Lilongwe	26,225	3,374	1,268	37.6
Salima	-	-	-	-
Dedza	-	-	-	-
Ntcheu	1	1	0	0.0
Balaka	-	-	-	-
Mangochi	492	101	52	51.5
Machinga	-	-	-	-
Zomba	-	-	-	-
Phalombe	70	36	9	25.0
Mulanje	2,939	662	281	42.4
Thyolo	622	144	79	54.9
Chiradzulu	1,579	163	82	50.3
Mwanza	-	-	-	-
Neno	317	76	11	14.5
Chikwawa	-	-	-	-
Nsanje				

Figure 5 below presents the trend in the proportion of HIV+ pregnant women receiving Nevirapine since 2002 using the projected expected number of pregnancies in a year and the sentinel HIV prevalence rate. As would be observed, the coverage rate is far below the target which the country

had set for 2004 (10%). Nevertheless, considering that the number of PMTCT sites has been increasing rapidly since 2003 and that implementation of PMTCT programs has just started Malawi expects considerably rapid an increase in the coverage of PMTCT services in the coming years.

Figure 5: Number of PMTCT sites and Proportion of women on nevirapine since 2002



3.5 Indicators relating to safety of blood transfusion from HIV infection

3.5.1 Proportion of transfused blood units screened for HIV

A policy on Blood Safety was developed in June 2000, and the Malawi Blood Transfusion Service Project (MBTSP) was officially launched in November 2002. MBSTP started activities in Blantyre in April 2003 aiming at expanding blood transfusion services nation-wide. In 2005 the MBTSP expanded to Lilongwe. MBTS estimates that Malawi requires 50,000 to 60,000 units of blood annually but storage and maintenance of facilities for blood banks are inadequate. According to the MBSTP, all blood that is collected for transfusion is screened for HIV implying a 100% achievement rate. In 2004, the MBSTP collected 5,523 units of blood, of which 4,721 were usable and distributed as safe blood to hospitals. Out of the 5,523 units, 289 units (5.2%) were HIV positive, 67 units (1.2%) tested positive for syphilis and 428 units (7.7 %) tested positive for Hepatitis B. Information on the number of health facilities that apply national guidelines for blood screening, storage, distribution and transfusions was not available when this report was being prepared. However, according to the MoH had collected fresh data which was awaiting analysis.

3.6 Indicators relating to HIV and AIDS awareness

3.6.1 Proportion of population exposed to different media campaign in last 30 days

Various forms of media are being used to disseminate information on HIV and AIDS in Malawi. The 2004 MDHS collected data regarding access to information on HIV and AIDS and the radio

was mentioned as the most common source of HIV and AIDS information both in rural and urban areas. The results revealed that 80.3% males and 66.1% females heard HIV and AIDS radio messages within 30 days prior to the interview day (Table 8). The second most common source of information was the print media (magazines/news letters/news papers) as reported by male (33.2%) and female (14.8%) respondents. Television came third and was mentioned by 20.1% of male respondents and 11.2% of female respondents.

Table 8: Proportion of population exposed to different HIV and AIDS media in last 30 days

Background characteristics	Heard radio messages	Seen TV programmes	Read articles in print media
Females			
Urban	79.8	32.7	34.1
Rural	63.2	6.6	10.6
Total	66.1	11.2	14.8
Males			
Urban	85.9	47.4	57.6
Rural	78.9	13.1	26.9
Total	80.3	20.1	33.2

Source: MDHS 2004 (Preliminary Report)

As indicated above, Malawi conducted a Behavioral Surveillance Survey (BSS) in 2004. Time the MDHS, findings from the BSS indicated that the major source of HIV and AIDS information in the country is the radio[1]. Proportions mentioning radio as the main source of information ranged from 51.7% among female secondary school teachers to 81% among fishermen. The role played by billboards, stickers and fliers was negligible.

As expected, exposure to media is consistently higher in urban areas than in the rural areas as found in both the DHS and BSS. The gap in the source of media between urban and rural areas is wider for television and print media. For instance, 32.7% of the women in the urban areas and 6.6% of the women in rural areas mentioned TV as a source of information. Regardless of the type of media source, exposure to HIV and AIDS messages is higher in males than in females.

3.6.2 Media HIV and AIDS radio/television programs produced and number of minutes aired

In 2004, 877.3 minutes of radio programmes and slots/advertisements were broadcast in Malawi in 472 individual programmes and on various radio stations. There is only one Television service provider in Malawi (Television Malawi – TVM) and in 2004, 99 radio programmes/slots were broadcast on HIV and AIDS covering a total period of 2,153 minutes (Table 9). This is another area where data collection and documentation requires improvement because the expected trend would be more minutes for radio broadcasts than TV since there are more than seven radio stations in Malawi and all these carry programmes, advertisements and slots on HIV and AIDS

Table 9: Number of Media HIV and AIDS radio/television programs produced and number of minutes aired

Category	Radio	Television	Total

[1] Generally, access to radio programmes is higher in Malawi (in excess of 90% although ownership is ~60-70%)

Number of Programs Produced	472	99	571
Number of Minutes Aired	877.3	2,153	3,030.3

Source: NACARS

3.6.3 HIV and AIDS brochures/booklets distributed

Substantial investment has been made to produce and disseminate IEC materials. In 2004 at least 276,539 different types of brochures/booklets and magazines were distributed in Malawi. Between January and September 2005, a total of 515,347 brochures/booklets had been distributed. The government has noted the differences in the way data is captured and reported on the types and numbers of IEC materials being distributed in the districts. Some districts have not been recording the figures properly. Efforts are being made to target these districts in the next coming years so as to ensure that all data relating to IEC materials are correctly reported to NAC. This particularly concerns districts on the furthest extreme ends of the country and districts away from the main road connecting the country's main cities. Some districts such as Mulanje and Thyolo have had experience with NGO work due to the high HIV prevalence in these districts, as such, the number of IEC materials distributed in these districts are likely to be very high. On the overall, however, distribution of IEC materials and the status of reporting seem to have improved in 2005 (Table 10).

Table 10: Number of HIV and AIDS brochures/booklets produced and distributed to districts

District	Number of Brochures/Booklets Distributed	
	2004	2005 (Up to September)
Balaka	883	2,511
Blantyre	90,232	91,561
Chikwawa	266	12,383
Chiradzulu	2,784	4,135
Chitipa	175	5,473
Dedza	3,961	33
Dowa	37,035	29,365
Karonga	50	3,489
Kasungu	-	8,439
Likoma	-	181
Lilongwe	59,999	94,679
Machinga	4,442	13,178
Mangochi	2,885	1,674
Mchinji	60	7,645
Mulanje	15,559	75,583
Mwanza	-	2,263
Mzimba	18,035	26,149
Mzuzu	11,056	4,129
Neno	-	590
Nkhatabay	193	7,431
Nkhotakota	20	2,262
Nsanje	41	1,688
Ntcheu	17,150	5,925
Ntchisi	76	37,727
Phalombe	669	7,925
Rumphi	-	180
Salima	20	771
Thyolo	10,948	37,721
Zomba	-	30,257
Total	276,539	515,347

Source: NACARS

3.6.4 Knowledge of ways of preventing HIV and AIDS

Generally, most people in Malawi are aware that HIV is transmitted mainly through unprotected sexual intercourse followed by transmission from an infected mother to her baby. However, studies conducted in various parts of the country also point out that misconceptions about HIV transmission and prevention still exist. In the 2004 MDHS, respondents were asked whether they thought they can protect themselves from contracting HIV by having sex with only one faithful uninfected partner; whether they thought they can protect themselves from contracting HIV by having sex using condoms; whether a healthy-looking person can have the AIDS virus and if HIV

could be transmitted through mosquito bites and by working together or close to an HIV infected person.

Table 11 below presents an extract of the findings from the preliminary report of the 2004 MDHS. As would be observed, comprehensive knowledge of methods of HIV protection is still low among youth aged 15 to 24 years, despite being higher among males and in urban areas. About 37% of male youth had comprehensive knowledge compared to 25% female youth. Huge differences were observed between young people in the urban and rural areas with more of the rural dwellers lacking the knowledge. The lower knowledge of HIV protection in female and rural inhabitants could be due to the poorer literacy levels in these groups (as compared to males and rural inhabitants, respectively) and low access to HIV and AIDS education messages (as explained above). In addition, the low knowledge in rural inhabitants could be due to the existence of strong cultural beliefs that adversely affect the acquisition of new knowledge on HIV prevention. Across the regions, the Southern Region has a higher proportion of individuals with comprehensive knowledge in HIV prevention than the other two regions.

Table 11: Proportion of young people (15-24 years) who both correctly identify ways of preventing HIV and rejecting misconceptions

Background characteristics	% people aged 15-24 who both correctly identify ways of preventing HIV and rejecting misconceptions	
	females	Males
Age 15-19	22.8	35.5
Age 20-24	27.1	39.1
Age 15-24	25.2	37.1
Urban areas	31.4	48.0
Rural areas	23.6	34.1
Northern Region	28.2	33.1
Central Region	21.6	30.7
Southern Region	27.5	44.5

Source: Preliminary DHS 2004

Intriguingly, BSS also showed that comprehensive knowledge on HIV prevention is relatively low even among well educated adult Malawians, including male secondary teachers (45.3%) and primary school teachers (46.8%). According to BSS, comprehensive knowledge was lowest among male police officers (2.5%), female police officers (6.3%) and female estate workers (27.1%). Both the BSS and DHS indicate that misconceptions on HIV prevention and transmission still exist in the general population. Malawi still needs to intensify general HIV and AIDS education, focusing on sections of society most in need of accurate information on the epidemic.

3.7 Training in life skills-based HIV and AIDS education

In 2002, the proportion of schools with at least one teacher trained in life skills education was estimated at 6.0%. In 2005, it is estimated that all the schools in Malawi have at least one teacher who has been exposed to Life Skills Education (LSE).

In 2005, the Ministry of Education conducted a nation-wide survey in 72 schools drawn from 19 districts on Life Skills Education (LSE) with the purpose of establishing the proportion of teachers trained in life skills and whether LSE was being taught in the schools as expected. Of the 540 primary school teachers who were enumerated in the 49 primary schools, 40.9% had been trained in LSE, 44.8% of the male teachers and 35.7% of the female teachers (Table 12). Among the 133 teachers who were enumerated in 23 secondary schools, 10.5% were trained in LSE, 10.4% of the

male teachers and 10.8% of the female teachers. The findings therefore suggest high LSE training status among teachers in primary schools compared to teachers in secondary schools.

Table 12: Proportion of Teachers Trained in Life Skills Education

Category of teachers	Male	Female	Total
	n=310	n=230	N=540
Primary school teachers	44.8	35.7	40.9
	n=96	n=119	N=133
Secondary school teachers	10.4	10.8	10.5

Source: Life Skills Study Report 2005, MoE

Presented in Table 13 below are absolute figures of male and female youths (both in and out of school) who have been exposed to life skills HIV and AIDS education in the districts across the country. In general, there appears to be an improvement in the levels of reporting and in the numbers of youths being exposed to life skills education on HIV and AIDS. The Government has noted that some districts have been slow in training the youths and that in some cases, trainings have taken place but documentation and reporting has been inadequate. Efforts are currently underway to address the issue of underreporting and to ensure that more youths are exposed to life skills education. The government is also planning to conduct a nation-wide survey to establish the proportion of youth exposed to life skills education because currently, only absolute figures are being reported on. Malawi needs clear strategy and modalities for engaging all institutions in LSE for teachers in an accelerated program of LSE training for teachers of all levels. At the same time funds granted to Ministry of Education by NAC include a large proportion of resources committed to LSE.

Table 13: Numbers of young people aged 15-24 years exposed to life skills based education

District	2004	2005 (Up to September)
Balaka	883	2,511
Blantyre	90,232	91,561
Chikwawa	266	12,383
Chiradzulu	2,784	4,135
Chitipa	175	5,473
Dedza	3,961	33
Dowa	37,035	29,365
Karonga	50	3,489
Kasungu	0	8,439
Likoma	0	181
Lilongwe	59,999	94,679
Machinga	4,442	13,178
Mangochi	2,885	1,674
Mchinji	60	7,645
Mulanje	15,559	75,583
Mwanza	0	2,263
Mzimba	18,035	26,149
Mzuzu	11,056	4,129
Neno	0	590
Nkhatabay	193	7,431
Nkhotakota	20	2,262
Nsanje	41	1,688
Ntcheu	17,150	5,925
Ntchisi	76	37,727
Phalombe	669	7,925
Rumphi	0	180
Salima	20	771
Thyolo	10,948	37,721
Zomba	0	30,257
Total	**276,539**	**515,347**

Source: NACARS

3.8 Distribution of Condoms

In Malawi, condoms are distributed using various channels including social marketing agencies such as Population Service International (PSI) and Banja La Mtsogolo (BLM), health facilities (government, mission and private) and NGOs either at their offices, through peer educators or in clinics and other distribution points in their impact areas. This section presents aggregated figures

of condoms that were distributed in 2004 in the various districts across the country by the various distribution channels. Statistics on this are presented in Table 14 below. Anecdotal information suggests that over 28 Million condoms were distributed in 2004 in Malawi but records were available for 27,519,493. Some districts did not report or under-reported statistics on the numbers of condoms that were distributed and these include Chiradzulu, Mwanza and Nkhotakota. Districts with cities had higher figures for the socially marketed condoms than the free government condoms with the exception of Zomba.

However, assuming that the reported figures are accurate, the crude estimate of the availability of condoms per capita per year among males and female Malawians aged >15 years was approximately 3.8 in 2004. Malawi still experiences challenges in condom distribution while the general attitude towards the use of condom remains largely unsupportive. Meanwhile, Malawi has developed a condom strategy managed by Ministry of Health, and it is expected that procurement promotion distribution and monitoring and evaluation should improve considerably in subsequent years.

Table 14: Numbers of condoms distributed to end-users by various suppliers

Level of aggregation	**Suppliers**				
	Social marketing agents	**BLM**	**Government**	**Other**	**Total**
District					
Balaka	153,576		457,260		610,836
Blantyre	2,618,629		650,035		3,268,664
Chikwawa	218,700		385,624		604,324
Chiradzulu	864		-		864
Chitipa	2,592		1,148,658		1,151,250
Dedza	93,924		109,514		203,438
Dowa	135,864		329,926		465,790
Karonga	195,696		333,994		529,690
Kasungu	137,592		322,187		459,779
Lilongwe	2,184,289		347,940		2,532,229
Machinga	282,851		629,745		912,596
Mangochi	321,661		1,874,328		2,195,989
Mchinji	100,656		271,500		372,156
Mulanje	66,960		874,863		941,823
Mwanza	47,088		-		47,088
Mzimba	815,632		389,042		1,204,674
Nkhatabay	136,080		712,719		848,799
Nkhotakota	98,748		-		98,748
Nsanje	25,488		396,486		421,974
Ntcheu	82,944		538,238		621,182
Ntchisi	111,024		60,000		171,024
Phalombe	68,256		277,759		346,015
Rumphi	162,144		91,232		253,376
Salima	192924		455,668		648,592
Thyolo	139,968		982,463		1,122,431
Zomba	169,344		741,818		911,162
TOTAL	**8,563,494**	**6,575,000**	**12,380,999**		**27,519,493**

Source: PSI, BLM and MOH

CHAPTER 4: INDICATORS RELATING TO TREATMENT, CARE AND SUPPORT

4.1 Indicators relating to infection prevention and clinical care

4.1.1 Number of facilities providing ARVs

By the end of September 2005, there were 60 facilities in Malawi in the public health sector delivering ART free of charge to HIV+ eligible patients (*MOH 2005 report*). There has been a rapid scale-up in the establishment of sites for ART delivery especially in 2004/05, from less than 20 in 2003 to about 60 sites in September 2005. The availability of the ARVs from the Global Fund to fight HIV and AIDS, TB and Malaria (GFATM) has enhanced government's ability to scale up HIV and AIDS treatment to the whole country. The establishment of the Malawi Business Coalition Against AIDS (MBCA) provides another opportunity for coordinating the expansion of ART delivery in the private sector. As of December 2005, 23 Private Sector sites had started providing ARVs at a subsidized rate. Thus, it is expected that in the subsequent years, there is a lot of room for rapid expansion of delivery of ARVs across the country.

4.1.2 Proportion of men and women with advanced HIV infection receiving ARV therapy

In 2003, only 2.3% of eligible HIV+ patients were on ART. At the end of September 2005, a cumulative total of 30,055 patients had ever been started on ART and of these, 39% were males and 61% were females *(MOH 2005 report).* In terms of age groups, 95% of the 30,055 patients ever started on ART were adults (13 years and above) while 5% were children. Considering that there are an estimated 170,000 Malawians with advanced HIV infection, then, as of September 2005, ART coverage was 17.7%. This coverage is slightly short of the target of 23.5% (40,000 HIV-infected individuals) that Malawi had planned to reach by the end of December 2005. Thus, there has been a commendable rapid increase in treatment of AIDS patients with ARVs, considering the enormous logistical requirements for delivering ARVs. However, it is clear that Malawi has one of the most rapidly expanding ART program in the Africa region.

4.1.3 Proportion of patients still alive 12 months after initiation of ARVs

Available data *(MOH 2005 report)* suggests that 83% of the 3,096 HIV+ patients who had started receiving free ART between July and September 2004 from 15 sites were still alive (71% were alive and on ART at the sites while 12% had transferred out to other sites). Of the 30,055 patients ever started on free ART, 77% were still alive and on ART at the site of registration, 9% had died, 7% were lost to follow-up and 1% had stopped treatment. Of the 23,168 patients who were still alive and on ART, 97% were ambulatory, 93% were fit to work, 6% had one or more major side effects. Based on pill counts, 92% showed at least 95% adherence to therapy. When a six-month survival analysis was performed on 4,450 patients starting free ART from 32 sites between January and March 2005, the results showed a survival rate of 84% (77% were alive and on ART at the sites while 7% had transferred out to other sites).

4.1.4 Health facilities without STI and OI drug stock-outs

Stock status for OI and STI drugs was assessed through the 2004 Logistics System Assessment and Stock Status Survey and the findings showed that significant stock outs of STI and OI drugs[φ] occurred in the year (2004)**.** Less than 15% of hospitals had a stock out of benzathine penicillin, doxycycline, metronidazole or fluconozole on the day of the visit while 24% and 35% respectively were stocked out of nystatin and erythromycin. Almost sixty percent (59%) of hospitals and 65% of health centres experienced at least one stock-out of erythromycin between January and June 2004. By implication, only 40% of hospitals and 35% of health centres did not have any STI drug stock-outs in 2004 and these figures are far too below the target of 75%.

The average duration of stock outs occurrences between January and June 2004 was long, ranging from an average of just over 9 days for erythromycin at hospitals to 86 days for nystatin at health centres. The shortest average duration of stock-out at health centres was for benzathine penicillin (31 days). This calls for strengthening of logistical systems so that drugs are moved faster from the Regional Central Medical Stores to the facilities particularly those in the remote areas.

4.1.5 Health facilities without ARV stock-outs

The HIV and AIDS Unit (MOH) assessed ART drug stocks in 60 sites in October and November 2005. There were no stock-outs in any health facility. The observed status in the 60 facilities is an achievement that needs to be maintained. As of November-December 2005, there were enough 'First-Line' drugs to start about 19,000 patients on therapy estimated to last about 8 months at the current rate of new recruitments and enough 'Triomune' to keep the current (September 2005) 30,000 patients and the new patients starting on treatment for about 9 months. Thus, the country had, as of first of December 2005, a 9-month stock of drugs for first line regimen.

4.1.6 Percent of detected TB cases successfully completing treatment

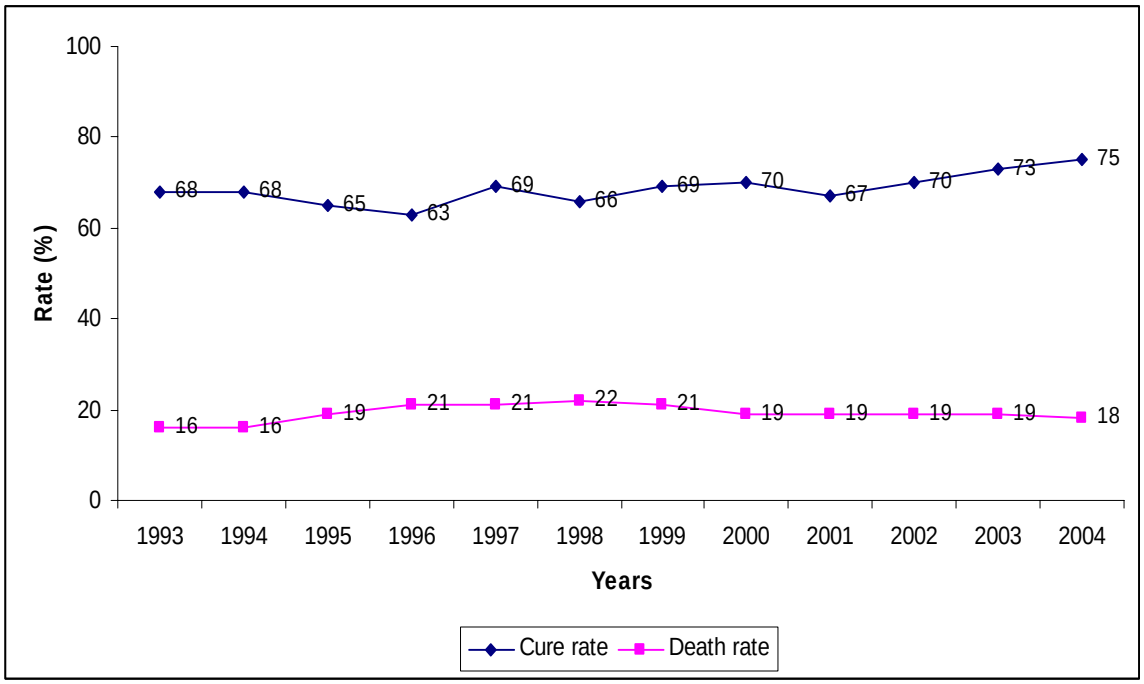
Tuberculosis (TB) in most common opportunistic infection in HIV infected individuals. With increasing prevalence of HIV in Malawi, the number of reported TB case has increased at least 5-fold, from 4,863 in 1984 to 26,375 in 2004 (Malawi National TB Control Program). TB is the single most important cause of death in HIV infected individuals. Thus, effective management of TB has a big impact in reducing mortality in HIV+ individuals. Figure 6 shows the trends of cure rates of sputum positive TB patients from 1993 to 2004, disaggregated by various factors

In the first half of 2004 National TB Control Programme (NTP) registered 3,961 patients. The proportion of patients that successfully completed TB treatment was 75%, while the death rate was 18%, default rate was 3% and transfer-out rate was 2%. Generally, the treatment outcome in 2004 was comparable to the figures registered in the preceding years. For example, in 2003, the NTP registered 28, 234 TB cases and after following up this cohort of patients for 8 months, 73% had successfully completed treatment. This was a small improvement from the previous year (~70%). In 2003, the default rate was 2% while death rate has remained at 19% *(Equi-TB, 2005)*[1].

[φ] OI and STI drugs in the survey included; 2.4 mU vials of benzathine penicillin, 100 mg tablets of doxycycline, 250 mg tablets of metronidazole, 200 mg tablets of fluconazole, nystatin pessaries, and 250 mg tablets of erythromycin

[1] The rest either experienced treatment failure or transferred to other places

Figure 6: Cure and death rates of sputum-positive TB patients (1993-2004)



Source: Equi-TB 2005

4.2 Indicators relating to care and support

4.2.1 Proportion of the population expressing accepting attitudes towards PLWHAs

The 2004 Malawi Demographic and Health Survey collected information on people's attitudes towards People Living with HIV and AIDS (PLWHAs). Specifically, the respondents (both men and women) were asked whether they would care for a family member with HIV and AIDS at home; whether they would buy fresh vegetables from shops for the patient; whether an HIV positive teacher should be allowed to teach; and whether they would want sero-status of HIV+ family member to remain a secret or not. Table 15 provides an extract of the findings on this.

About thirty percent of both females (30.8%) and males (29.7%) expressed accepting attitudes towards people living with HIV and AIDS on all the four questions. Respondents in the urban areas seemed to express more accepting attitudes than their rural counterparts on all the issues in question with the exception of whether the serostatus of their family member should remain a secret or not. For this question, higher proportions of the rural respondents (both males and females) than urban respondents thought they would not want the information to remain a secret. Across the regions, no major differences were observed except on the issue of an HIV+ teacher being allowed to teach or not. Nevertheless, the Southern Region had more respondents (86.1%) who said they had no problem with an HIV+ teacher to continue teaching and the percentages in the other regions recorded were lower (less than 75%). In terms of the issues themselves, willingness to provide care scored highly among the four issues that were asked, the least being whether maintaining or disclosing the serostatus of an infected member of the family.

Table 15: Proportion of the population expressing accepting attitudes towards PLWHAs

Background characteristics	Percentage of respondents who: Willing to care for family member with HIV at home	Would buy fresh vegetables from shopkeeper with AIDS	Believe HIV positive teacher should be allowed to teach	Would not want HIV+ status of family member to remain secret	Percentage expressing acceptance on all 4 measures	Number of respondents who have heard of HIV and AIDS
WOMEN						
Residence						
Urban	93.8	76.5	80.0	57.6	34.3	2,060
Rural	94.0	64.5	63.7	66.3	30.1	9,471
Region						
Northern	92.2	66.0	67.3	62.5	29.6	1,551
Central	91.9	65.9	58.4	61.4	24.9	4,605
Southern	96.3	67.5	73.5	68.3	36.2	5,375
Total	94.0	66.6	66.6	64.8	30.8	11,532
MEN						
Residence						
Urban	95.2	89.5	89.1	39.5	27.3	667
Rural	97.1	81.7	76.9	49.5	30.3	2,579
Region						
Northern	96.2	82.0	72.3	43.8	27.2	420
Central	97.2	82.4	74.4	44.1	24.6	1,360
Southern	96.4	84.4	86.1	51.6	35.1	1,465
Total	96.7	83.3	79.4	47.5	29.7	3,246

Source: 2004 MDHS Preliminary Report

The 2000 MDHS collected some information as to whether HIV+ people should be allowed to keep working or not. The results showed that 49% of women and 53% of men thought that HIV+ people should be allowed to keep working. The 2004 MDHS showed that 66.6% of the women and 79.4% of men said teachers who are HIV+ should be allowed to continue teaching. Although the two questions were not exactly the same, they all pertain to issues of stigma and discrimination. The 2004 MDHS, therefore, showed an improvement in people's attitudes towards PLWHAs. However, more work is needed so as to ensure tat PLWHAs are not discriminated against in any form whether in their families, communities or at workplaces.

4.2.2 External support for HIV and AIDS care

No comprehensive survey has been conducted in Malawi to determine the proportion of households caring for chronically ill patients that receive external support. However, a number of NGOs, CBOs and FBOs have been receiving different types of external support from the Grants facility at NAC and other agencies including MASAF in the last couple of years and of late. These have been submitting their reports to the National AIDS Commission. Presented in Table 16 below are

absolute figures of types of support that households received in 2004 and 2005. In 2004, at least 215,421 different types of support were provided to households caring for HIV and AIDS patients or which were affected in one way or the other. The commonest type of support was psychosocial (33% of households) and nutritional (26% of households) support. According to NACARS data, the proportion of beneficiaries receiving nutritional support has increased from 18.9% in 2003 to 26% in 2004. The proportion of those receiving financial support has remained minimal 2.5% in 2003 and 2% in 2004.

Some districts seemed to have well-established programmes aimed at assisting households caring for chronically ill patients in both 2004 and 2005. These included Phalombe, Thyolo, Lilongwe, Dedza, Mchinji and Mzimba. However, improvements in providing support for chronically-ill patients are being observed in most districts and this trend is expected to continue in the coming years.

Table 16: Number of Households receiving external support for HIV and AIDS care

	2004	**2005 (**Up to **September)**
Balaka	730	2,457
Blantyre	12,159	4,788
Chikwawa	95	3,385
Chiradzulu	1,580	14,818
Chitipa	1	1,206
Dedza	5,831	578
Dowa	2,642	16,099
Karonga	80	3,358
Kasungu	2,703	3,595
Likoma	0	125
Lilongwe	64,836	44,612
Machinga	3,694	6,728
Mangochi	7,659	2,712
Mchinji	2,511	29,660
Mulanje	154	27,239
Mwanza	296	4,916
Mzimba	3,529	28,306
Mzuzu	0	3,868
Neno	0	3,535
Nkhatabay	373	4,955
Nkhotakota	1,310	5,848
Nsanje	3,492	10,258
Ntcheu	1,415	7,948
Ntchisi	1,373	7,277
Phalombe	23,499	24,226
Rumphi	127	2,348
Salima	1,222	3,493
Thyolo	73,414	122,553
Zomba	696	21,084
Total	**215,421**	**411,975**

Source: NACARS

4.2.3 Number of new PLWHAs enrolled at PLWHA organisations

In 2004, 1770 PLWHAs were enrolled at PLWHA organizations against the target of 15,000 PLWHAs for the year (Table 17) whereas as of 2005 of 10,261 PLWHAs were enrolled. Some districts have had problems in documenting numbers of PLWHAs but efforts are being made through Umbrella Organisations to improve the capturing of PLWHA data. It is expected that more data will be captured in 2006 onwards with the increasing availability of ARVs in the districts. Previous studies conducted locally had shown that the absence of treatment and other forms of care was a major reason for HIV+ patients declining to register with PLWHA organisations.

Table 17: Number of Persons Enrolled at PLWHA organisations

	2004	2005 (Up to September)
Balaka	0	1
Blantyre	21	873
Chikwawa	0	14
Chiradzulu	515	244
Chitipa	10	71
Dedza	46	181
Dowa	39	514
Karonga	2	178
Kasungu	141	108
Likoma	0	8
Lilongwe	363	1,510
Machinga	0	56
Mangochi	0	-
Mchinji	5	418
Mulanje	0	1,034
Mwanza	17	98
Mzimba	298	413
Mzuzu	56	43
Neno	0	1
Nkhatabay	0	268
Nkhotakota	3	75
Nsanje	4	142
Ntcheu	0	248
Ntchisi	10	231
Phalombe	4	698
Rumphi	0	421
Salima	20	40
Thyolo	0	1,421
Zomba	0	952
Total	1554	10,261

Source: 2004 NACARS Report and 2005 NACARS Report

4.2.4 Community Home Based Care Visits

NACARS data shows that 123,702 Community Home-based Care (CHBC) visits were made in 2004 and 245,292 visits in 2005 (Table 18). Considering ratios of number of visits to estimated number of PLWHAs for each district, it seems more PLWAs were reached in Dowa, Ntchisi, Thyolo, Kasungu and Lilongwe, compared to other districts. With an estimated 170,000 people with advanced HIV infection requiring care and support in different forms, it can be estimated that in 2004 there were less than 1 (0.7) CHBC visits per chronically-ill patient per year while the figure doubled to 1.4 in 2005. These figures show an extremely low coverage of CHBC visits and this might be due to under-reporting of agencies that perform CHBC activities but are not funded by NAC. However, the figures highlight the enormous challenges that Malawi faces in caring for sick HIV and AIDS patients in the community. And this calls for more financial and other resources to build a truly robust CHBC program, capable of reaching and supporting an increasing number of patients and affected persons.

Table 18: Number of Community Home Based Care Visits

Districts	2004	2005 (Up to September)
Balaka	110	1,325
Blantyre	6,080	3,852
Chikwawa	101	667
Chiradzulu	303	8,027
Chitipa	18	1,044
Dedza	1,631	435
Dowa	19,762	5,173
Karonga	56	1,191
Kasungu	11,442	2,998
Likoma	0	122
Lilongwe	30,580	44,019
Machinga	3,460	2,504
Mangochi	1,384	384
Mchinji	3,154	7,228
Mulanje	27	10,930
Mwanza	0	4,943
Mzimba	1,861	23,186
Mzuzu	53	6,446
Neno	0	1,508
Nkhatabay	6	3,922
Nkhotakota	1,047	3,442
Nsanje	2,870	17,474
Ntcheu	120	1,910
Ntchisi	8,235	3,880
Phalombe	2,652	4,087
Rumphi	0	1,285
Salima	2,449	1,340
Thyolo	26,166	72,006
Zomba	135	9,964
Total	123,702	***245,292***

Source: 2004 NACARS Report and 2005 NACARS Report

CHAPTER 5: INDICATORS RELATING TO IMPACT MITIGATION

Malawi has not yet conducted a comprehensive study to determine the proportion of needy orphans and other vulnerable children that have received some form of external support. This Chapter relies on data from NACARS on the absolute numbers of orphans and other vulnerable children that received support in 2004 and on the recent MDHS on the schooling status of orphans and other children whose parents were alive at the time of the MDHS survey.

5.1 Number of orphans and vulnerable children receiving external support

Considerable achievements have been made to create an enabling atmosphere for rapidly scaling-up the response to the crisis of orphans and vulnerable children in Malawi, currently estimated at over 1 million. The National Policy on OVC was launched in 2004 and it aims at ensuring provision of care and support to orphans and other vulnerable children. In 2003/04, UNICEF supported 200,000 OVCs to access education through school feeding in collaboration with WFP and the Ministry of Education. This programme was run in 249 schools in 10 districts. By end of 2004, MASAF had alone provided 3,330 orphans with training and tools for production.

NACARS data indicates that 47,260 orphans received psychosocial support, 59,996 received nutritional support and 9,990 received financial support (Table 19). The data also shows that at least 60,000 orphans were reached but this figure is below the target of 100,000. There was no gender difference as regards provision of support to orphans (49% were males and 51% were females). The greatest challenge in this area is timely and nation-wide reporting to build a more complete picture of support reaching orphans. Over 600 Community Organisations have been funded through the NAC Grants Facility and a high proportion of these target the needs of orphans. Meanwhile, NAC has also funded the Ministry of Gender Child Welfare and Community Services of which a high proportion of these funds are now reaching orphans and groups working with orphans. A considerable proportion of MASAF grants also target the needs of orphans. Malawi has just been awarded about $85 million for five years through the 5th Round Global Fund resources, and nearly $20 million will go to OVC activities. It is clear with this investment that while present level of support are not adequate, Malawi is poised to expand its OVC program considerably from the 2006/2007 FY.

Table 19: Number of Orphans and other vulnerable children receiving care/support

District	Psychosocial	Nutrition	Financial	Other	Total
Balaka	168	119	-	18	305
Blantyre	8,406	16,479	116	103	25,104
Chiradzulu	941	1,502	6	-	2,449
Chitipa	2	1	3	1	7
Dedza	1,824	1,969	187	38	4,018
Dowa	972	448	37	534	1,991
Kasungu	205	215	100	167	687
Lilongwe	11,507	6,522	241	1,513	19,783
Mangochi	9,980	14,612	1,531	22	26,145
Mchinji	1,666	428	97	146	2,337
Mzimba	737	8,898	318	937	10,890
Mzuzu	-	-	3	36	39
Nkhotakota	794	648	81	2,794	4,317
Nsanje	309	228	23	143	703
Ntchisi	133	14	3	136	286
Phalombe	7	7,370	-	2,542	9,919
Salima	76	1	25	1	103
Thyolo	9,519	542	-	853	10,914
Zomba	14	-	20	6	40
Total	47,260	59,996	2,791	9,990	120,037

Source: NACARS

5.2 School Attendance among Orphans

Education is a vital element in enhancing development of any country. In 1994, the Government of Malawi introduced free primary education as one way of encouraging many children to enroll in schools. Complex issues contribute to withdrawing or continuing with school for most of the children in Malawi including socio-cultural issues, poverty, HIV and AIDS and other chronic illnesses. In recent years, cycles of food crisis have been associated with massive school drop-outs particularly in the rural areas and the situation has been closely associated with HIV and AIDS and household poverty. Monitoring the enrollment, attendance and performance of orphans and other vulnerable children in schools is therefore one of the key issues in the response to HIV and AIDS in Malawi.

The 2004 MDHS collected information on school attendance among children aged 10-14 years in Malawi. Out of 5,413 children with both parents alive (and were living with at least one of them), 90.2% were in school. School attendance rate among orphans (both parents dead) was 87.4% (N=528). When data was stratified by gender, 89.7% (n=2,675) of the male children and 90.8% (n=2,738) of female children with both parents alive were in school. The attendance rates among orphans were 85.5% (n=269) and 89.4% (n=259), respectively. This shows that school attendance rates are almost similar for orphans and non-orphans, irrespective of gender. However, the current data does not show whether there are any differences in the school drop-out rate between orphans and non-orphans.

Further analysis of school attendance data showed remarkable differences between children living in urban areas and those living in rural areas and across regions (Table 20). School attendance is higher among children living in urban areas than in rural areas both among orphans and non-orphans. Across the regions, school attendance rates were higher among children in the Northern Region compared to the other two regions. However, despite the high attendance in the Northern region, the ratio of school attendance between orphans and non-orphans is lowest in this region as compared to the Southern and Central regions. With respect to trends over years, the ratio of school attendance among orphans to that among non-orphans increased somewhat from 0.94 in 2001 to 0.97 in 2004. As Table 20 illustrates, the ratio was higher among female children (0.98) than males (0.95). Across the regions, the Southern Region had the highest ratio of 0.99 with the lowest ratio observed among children in the Northern region (0.93).

Table 20: Percent distribution of orphans attending school and ratio of orphans to non-orphans in school

Background characteristics	% Non-orphans	% Both parents dead	Ratio of orphans to non-orphans
Sex			
Males	89.7	85.5	0.95
Females	90.8	89.4	0.98
Location			
urban	95.3	91.3	0.96
rural	89.4	86.6	0.97
Region			
Northern	97.7	91.3	0.93
Central	89.7	86.4	0.96
Southern	88.4	87.2	0.99
Total	90.2	87.4	0.97

Source: MDHS 2004 (Preliminary report)

CHAPTER 6: MAINSTREAMING AND CAPACITY BUILDING

This Chapter focuses on the progress that was made in 2004 with regard to mainstreaming HIV and AIDS in the public and private sectors.

6.1 HIV and AIDS workplace policies and mainstreaming programmes in public sector institutions and large companies

The target for 2004 was that at least five key government ministries and 30 large private companies should have workplace policies and programmes on HIV and AIDS. For the government ministries, the Department of Human Resource Management and Development was a key department in spearheading workplace interventions in the public sector and the department finalized a Public Sector HIV and AIDS Policy in 2004. In addition, the department reviewed their training policy in order to factor in issues of HIV and AIDS and gender. Furthermore, 15 government ministries (61%) received NAC funding for comprehensive HIV mainstreaming plans focusing on workplace programs at central and district levels. These included Ministry of Agriculture, Ministry of Youth and Culture, Judiciary, Ministry of Gender, Child Welfare and Community Services, Ministry of Health, Ministry of Education, Ministry of Information, Ministry of Defence, Home Affairs, Police, Prison and Immigration, the Malawi Army, and the Department of Statutory Corporation. However, most of the central level programmes for mainstreaming did not trickle to the district level as ministries were at different levels in terms of decentralization.

To strengthen the response to HIV and AIDS in the private sector, the Malawi Business Coalition against HIV and AIDS (MBCA) was established and received funding in 2004. The MBCA is recognized as an umbrella organization for the private sector. By end 2004, 47% of large private companies (70 in total) had HIV and AIDS mainstreaming work plans.

6.2 Reach of HIV and AIDS workplace interventions to employees and their spouses/families

Data that is available from the districts and private from indicate that at least 8,190 workers and their families (spouses) were reached by workplace programmes in 2004, with a male to female ratio of 54:46. A comprehensive survey is needed to document the specific interventions that have been accessed by the workers and whether the figures presented in Table 21 below imply high coverage or low. In the absence of denominator figures on the population of the workers and their families in the institutions which provided the figures, it is not possible to determine whether the figures mean a success story or not.

Looking at the absolute figures presented in Table 21 below, some districts have more beneficiaries compared to others. Blantyre was expected to have high figures being the commercial city of Malawi where most large companies are located, but figures portray a different picture. Only 399 people had been reached by workplace HIV and AIDS interventions in 2004 in Blantyre compared to 2,676 people in Lilongwe and 1,250 people in Mzimba. This picture may signify low coverage of HIV and AIDS workplace interventions in Blantyre or inadequate reporting of statistics from Blantyre-based companies. Overall, Malawi needs to study this area more to gather accurate statistics and to determine the level of response. In addition, Malawi has to undertake more intensive advocacy for the private sector to come on board in full and to subscribe to the monitoring and evaluation framework managed by National AIDS Commission.

Table 21: Beneficiaries of workplace programmes by district and sex

District	MALE	FEMALE	TOTAL
Balaka	30	8	38
Blantyre	254	145	399
Chikwawa	170	178	348
Chiradzulu	37	214	251
Chitipa	6	1	7
Dedza	23	20	43
Dowa	80	89	169
Karonga	21	10	31
Kasungu	10	6	16
Lilongwe	1,646	1,030	2,676
Machinga	375	476	851
Mangochi	116	120	236
Mchinji	0	0	0
Mulanje	195	44	239
Mwanza	46	26	72
Mzimba	632	618	1,250
Mzuzu	12	6	18
Nkhatabay	31	12	43
Nkhotakota	53	18	71
Nsanje	20	11	31
Ntcheu	6	2	8
Ntchisi	242	107	349
Phalombe	97	80	177
Salima	0	0	0
Thyolo	142	150	292
Zomba	160	415	575
Total	4,404	3,786	8,190

Source: NACARS

6.3 Project staff and volunteers trained in HIV and AIDS related issues

Table 22 presents numbers of staff and volunteers who were trained in 2004 for the purposes of HIV and AIDS interventions. A total of 6,166 people were trained in the year and Lilongwe alone had approximately 3,000 people who were trained seconded by Blantyre (752 people). Of the total, there were more volunteers (84%) who were trained than project staff. Very little was done on training staff and volunteers in Chitipa, Mwanza, Nkhatabay, Ntcheu, Phalombe and Zomba. No information was gathered for Chikwawa, Kasungu, Mchinji and Salima districts. As the national response matures and expands, Malawi shall need to invest more in capacity development addressing program personnel, volunteers and households. At the same time support should be made available to ensure accurate and timely reporting for all districts in capacity building action.

Table 22: Number of Project Staff and Volunteers Trained in HIV and AIDS related issues for the purpose of HIV interventions

District	Staff	Volunteers	Total
Balaka	-	90	90
Blantyre	97	655	752
Chiradzulu	32	66	98
Chitipa	5	6	11
Dedza	26	144	170
Dowa	14	165	179
Karonga	5	47	52
Lilongwe	417	2,580	2,997
Machinga	15	157	172
Mangochi	3	288	291
Mulanje	11	12	23
Mwanza	1	-	1
Mzimba	171	287	458
Mzuzu	17	-	17
Nkhatabay	7	-	7
Nkhotakota	36	271	307
Nsanje	-	40	40
Ntcheu	3	-	3
Ntchisi	5	49	54
Phalombe	2	-	2
Thyolo	100	328	428
Zomba	14	-	14
Total	981	5,185	6,166

Source: 2004 NACARS Report

CHAPTER 7: INDICATORS RELATING TO PROGRAMME MANAGEMENT, MONITORING, RESEARCH AND EVALUATION

This Chapter looks at the way the HIV and AIDS response has been managed, coordinated and monitored in the period of reporting (2003 to 2005). Particular focus is made on the amount of national funds contributed to the HIV and AIDS response and the level of commitment the Government of Malawi has made in formulating policies and strategies on HIV and AIDS and how these are being implemented. Detailed achievements made in the programme management and coordination are reported in another report by Bowie et al 2005: 'Malawi AIDS Programme: Independent Multi-Disciplinary Review Team - Second Report'.

The Malawi Government has mobilized considerable financial resources from multilateral and bilateral donors for managing the national response to HIV and AIDS and about two thirds of these resources are channeled through NAC. From April 2003, NAC engaged a Financial Management Agency to administer the Grants Facility. In order to facilitate the uptake of the grants facility by the grassroots implementers and to build the capacity of the district assemblies to coordinate district level responses, NAC engaged five international NGOs as umbrella organisations (UOs) to mobilize district level responses to HIV and AIDS and to coordinate district level proposals and projects from the local CBOs, FBOs and NGOs. This arrangement has enabled various grassroots implementers to access funds from the Grants Facility. As of 2005, disbursement status of funds from the Grants Facility by district was as shown in Table 23 below.

7.1 Amount of national funds spent on HIV and AIDS

The Malawi Government has committed itself to contribute approximately US$2 Million to NAC towards the fight against HIV and AIDS annually. In addition, ~2% of the annual other recurrent transaction of the central government budget for each line Ministry is supposed to be allocated to HIV and AIDS interventions and almost, 60-70% of the Ministry of Health Budget is used to support HIV and AIDS related interventions. In the 2004/05 financial year, the government contributed MK108,231,900 (roughly US$1.0 Million) directly to NAC towards the HIV and AIDS response, an increase from MK 16,000,000 in the 2003/04 financial year. Estimated health sector expenditure on HIV and AIDS for 2005 is MK 3.3 billion. Out of this MK129.4 million was allocated as 2% HIV budget for each line ministry in 2005 central government budget. Total Malawi expenditure on HIV in 2005 is therefore estimated at MK 3.6 billion.

7.2 Amount and Percent of overall funding received by NAC disbursed in 2004 and 2005

In 2004, NAC received a total of US$35.0 million from development partners. Out of this amount US$15.0 million came form the Global Fund on HIV and AIDS, TB and malaria and the rest came from other development partners. In 2005, the total amount of money received by NAC for HIV and AIDS work was US$22.9 million. Of this amount 56% was disbursed to public sector institutions for mainstreaming programs and purchase of antiretroviral drugs and other related drugs for HIV, 11% was disbursed to community based organization for various programs including OVC and other mitigation activities. Table 23 below shows the details of disbursement by type of institutions.

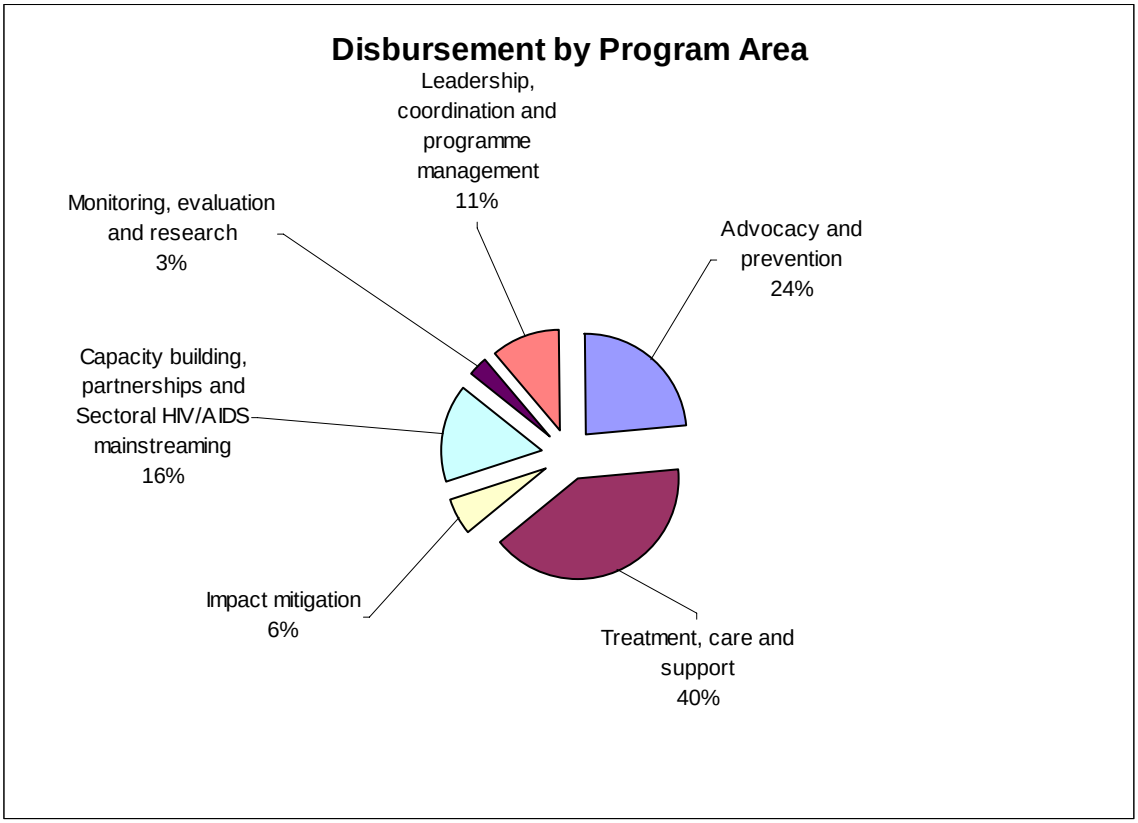
Table 23: Amount and % of funds received by NAC and disbursed in 2004 and 2005 by type of organisation

Institutional Type	Disbursement 2004(MK)	Share of disbursement	Disbursement 2005 (MK)	Share of disbursement
Non governmental organisations	1,719,432,847	31.2%	78,811,750	6.5%
Community- Based Organisations (CBOs)	554,324,984	10.1%	136,914,845	11.2%
Faith Based Organisations	60,212,467	1.1%	1,805,503	0.1%
Private Sector	56,918,021	1.0%	20,864,710	1.7%
Public Sector	3,099,255,320	56.3%	678,455,968	55.5%
Education/training institutions	16,750,000	0.3%	305,032,058	25.0%
Total	**5,506,893,639**		**1,221,884,834**	

Source: NAC Financial Management Agency Report

Figure 7 below shows the proportions of funds disbursed from June 2004 to October 2005. The figure indicates that 58% of the funds were disbursed for treatment, care and support purposes including the purchase of antiretroviral drugs and other health related products. As a program treatment, care and support also include VCT, PMTCT, STI management and blood safety, which are preventative activities in nature. Mainstreaming comprises workplace programmes the majority of which focus on advocacy and prevention.

Figure 7: Proportion of funds disbursed by type of intervention/activity



Source: FMA

7.3 Average period (months) for grant proposals be processed

On average it took 5.1 months for a proposal to be processed (FMA Monthly Report, November 2005); that is from the time a proposal is received to the time it is approved. After that it takes some additional weeks (ranging from 1 to 4 weeks) for the money to be funded. As a result it takes on average not less than 6 months for a project to be funded. The average time for processing proposal increased from June 2004 to April 2005.

7.4 National composite policy index (NCPI) score

The composite index measures the extent to which countries have developed policies and strategies on HIV/ AIDS and covers the following four broad areas: strategic planning, HIV prevention, human rights, and care and support. A number of specific policy indicators have been identified for each of these policy areas. A separate index is calculated for each policy area by adding up the scores (yes=1, no=0) for the relevant specific policy indicators and calculating the overall percentage score. The composite index is calculated by taking the average of the scores for the four components. The maximum points number of points that a country can score is 10.

In the 2005 assessment, the revised NCPI instrument for constructing core indicators was used to collect data from the key informants. Part A of the instrument was administered to the Principal Secretary for HIV and AIDS and Nutrition in the OPC and the Executive Director of the National

AIDS Commission. Part B of the instrument was administered to PLWA organizations, Human rights organizations and staff of the UN. The results of the assessment are shown in Table 24 below. As the table shows, the NCPI for 2005 was 8.3 points up from 6.15 in 2003 and close to the maximum of 10.

Table 24: National Composite Policy index in 2004

Indicator per Section	Year and Score	
	2003	2005
Overall how do you rate strategy planning efforts in HIV and AIDS programmes?	7	9
Overall how do you rate political support for the HIV and AIDS programmes?	6	10
Overall how do you rate policy efforts in support of prevention?	7	9
Overall how do you rate efforts in implementation of HIV prevention programmes?		
Government score	6	7
Civil society score	8	9
Overall how do you rate efforts in Care and treatment?		
Government score	6	9
Civil society score	8	9
Overall how do you rate efforts in OVC?		
Government score	5	8
Civil society score	8	8
Overall how do you rate efforts in M&E?	5	8
Overall how would you rate the policy, Laws , regulations in place to promote and protect human rights in relation to HIV and AIDS?	4	6
Overall how would you rate the effort to enforce the existing policy, Laws , regulations?	4	6
Overall how would you rate the efforts to increase civil society participation?	8	10
Average Score (Government only)	5.8	8.2
Average Score (Government+ civil Society)	6.15	8.3

7.5 Monitoring and Evaluation

7.5.1 Status of achievement

The government of Malawi has 59 core indicators being tracked in national response to HIV and AIDS. Of these, nearly 45 are properly being tracked and reported on, representing 76.0% achievement rate. Failure to properly track other indicators is mainly due to under-reporting or non-reporting by some partners and the postponement of specific surveys, which were supposed to have been undertaken.

A strategy for HIV research was finalized and disseminated in 2004/05 and this document highlights priority areas for HIV and AIDS research in the country including HIV and AIDS surveillance. The first Behaviour Surveillance survey was conducted in 2004 in which 13 high risk and vulnerable sub-populations were included. Data collection for the 2004/5 Demographic and Health Survey (DHS) was finalized successfully and for the first time included HIV testing. Findings from the 2005 sentinel surveillance survey were still being analysed at the time when this report was being finalized. Seventy eight research and best practice abstracts were disseminated in 2004.

7.5.2 Status in the implementation of NAC Integrated work plan

The summary of achievement against planned activities for the whole programme for the 2004/05 financial year is presented below. Table 25 below shows that as of June 2005, nearly 65% of planned activities had been completed or were ongoing activities that had started. A further 20% had started and, it was anticipated, that they would be completed in the first quarter of 2005/06.

Table 25: Summary of achievement in the implementation of the 2004/05 IAWP

Activity status	**Number**	**%**
Completed/Ongoing	257	65
Slipped	81	20
Not started	54	14
Cancelled	6	2
Total	398	

The view of an Independent Review Team was that NAC has had a successful year in coordinating the implementation of activities in the 2004/05 IAWP. While many activities took longer than expected to get off the ground, by year end NAC had successfully negotiated proposal agreements with most of its major implementing partners while the CBO sub-grant scheme had seen uptake grow significantly over the year.

7.6 Status of the national response and the '3-ones' Principle

As stated above, the Government of Malawi has adopted the '3-ones' principle: one national framework, one coordinating agency and one national M&E plan. This section provides an overview of how the '3-ones' principle has been achieved at the national level, district level and sectoral levels.

7.6.1 Assessment of "one" coordination authority

Table 26 shows the status with regard to coordination functions of the national response. Details concerning levels of achievement are contained in another report by Mtonya et al 2005. Initially, concern had been raised that the role and functions of the NAC Board of Commissioners and the Malawi Global Fund Coordinating Agency may be overlapping resulting in duplication of efforts. In addition, there was inadequate clarity on whether NAC reports to the Ministry of Health or the Office of HIV and AIDS and Nutrition in the OPC. These problems appear to have been resolved. An outstanding problem is the lack of legal requirement for implementers of HIV and AIDS activities to submit M&E reports to NAC, especially those that do not receive funding from NAC.

Table 26: Status in implementation of "one" coordination authority

Components on "one" coordinating authority	IMPLEMENTATION STATUS		
	National Level	District Level	Sector Level (Key data sources)
1. There is clear legal mandate for coordinating	Partially met	Partially met	Not met
2. Coordinating body made up of multi-sector representation	Fully met	Fully met	Not met
3. Existence of multi-sectoral partnership representing various constituencies	Fully met	Not met	Not met
4. Existence of effective communication platforms for all partners - such as reviews	Fully met	Not met	Not met
5. Strong full time secretariat (one AIDS team) to assist with coordination	Fully met	Not met	Not met
6. Existence of strong technical working groups for each priority area	Fully met	Not met	Not met
7. Existence of strong institutional capacity in terms of systems to support coordination	Fully met	Not met	Not met
8. Existence of critical human resources to coordinate each priority area	Fully met	Not met	Not met

7.6.2 Assessment of "one" AIDS Action framework

In general, there are some problems particularly at the district and sectoral levels with regard to following the national HIV and AIDS framework apparently arising from multiple demands of donor agencies and lack of capacity at various levels (Table 27).

Table 27: Status on implementation of "One" AIDS Action Framework

Components on "one" AIDS Action framework	IMPLEMENTATION STATUS		
	National Level	District Level	Sector Level (Key data sources)
1. One current Strategic Plan (AIDS Action Plan) available	Fully met	Partially met	Not met
2. Participatory process used to produce "One" AIDS Action Framework	Fully met	Fully met	Fully met
3. "One" annual integrated work plan developed in collaboration with major partners	Fully met	Fully met	Fully met
4. One agreed resource mobilization strategy available	Partially met	Not met	Not met
5. Action plan has clarity on interventions and budgets for interest groups	Fully met	Partially met	Not met
6. Capacity building strategy developed for each intervention area	Not met	Not met	Not met
7. Available technical capacity for each priority area mapped and data base exist	Partially met	Not met	Not met
8. Annual and periodic social mobilization events budgeted for in the annual plan	Fully met	Partially met	Not met

7.6.3 Assessment of "one" monitoring and evaluation framework

Monitoring and Evaluation of HIV and AIDS activities is an area that has lagged among the three components of the '3-ones' principle apparently because many agencies implementing various activities have no legal requirement to report to NAC and multiple powerful donors require different M&E reports. The assessment of this component of the Three Ones, as of December 2005, is contained in Table 28 below.

Table 28: Status in implementing "One" M&E framework

Components on "one" M&E framework	IMPLEMENTATION STATUS		
	National Level	District Level	Sector Level (Key data sources)
1. Designated focal M&E unit	Fully met	Not met	Not met
2. One current M&E plan	Fully met	Not met	Not met
3. Participatory process to produce harmonized indicators	Fully met	Not met	Partially met
4. One matrix on core indicators	Fully met	Not met	Partially met
5. One multi-sector M&E Technical Working Group	Fully met	Not met	Not met
6. Timely production and dissemination of M&E products	Partially met	Not met	Not met
7. Strong functional activity reporting system	Partially met	Not met	Not met
8. Functional data bases	Fully met	Not met	Not met
9. Participatory review processes	Fully met	Not met	Not met
10. Clear legal mandate to carry out M&E functions	Not met	Not met	Not met

CHAPTER 8: SUMMARY OF THE MAJOR SUCCESSES AND CHALLENGES

Malawi has made enormous efforts to establish structures as well as the policy framework to respond effectively to the challenges posed by the HIV and AIDS epidemic. A major step was the establishment in July 2001 of National AIDS Commission as the body that should lead the planning, coordination and monitoring & evaluation of a multi-sector response to HIV and AIDS. Since then Malawi has formulated one of the most innovative National HIV and AIDS Policy and has regularly produced 5-year National HIV and AIDS Frameworks to give strategic guidance to program design, implementation and evaluation.

Through the work of National AIDS Commission Malawi has been successful at mobilizing and effectively managing funds from a wide-range of bilateral and multilateral donors, and disbursing these funds to a wide-range of institutions and organizations. Using available financial resources from NAC and other (non-NAC) funding agencies, various organizations including governmental departments, non-governmental organizations, faith-based organizations and the private sector, have been able to build and strengthen their capacity to implement HIV and AIDS activities. Ministries, Governments departments and all other agencies have been able to formulate guidelines and policies to guide the implementation of sector specific HIV and AIDS action.

During the 2004/2005 financial year a considerable amount of time was taken for various agencies and ministries funded by the Commission to establish systems to effectively manage financial resources. This effort, while vital and key to accountability, resulted in low absorptive of financial resources and program slow-down in various agencies, in large part exacerbated by severe shortage of human resources in the major public sectors, especially in the health and education sectors. This notwithstanding, good progress and success have been achieved even in the context of adverse macro-economic conditions in the country. There is not only evidence of more organizations taking up HIV and AIDS, but also better quality in the manner of implementation of planned action.

Malawi has one of the most acclaimed Monitoring and Evaluation (M&E) systems and an active Unit with the National AIDS Commission to oversee its application. However, there still exists the challenge of under-reporting of HIV and AIDS activities to the Commission by various implementing ministries and other agencies, particularly in the absence of a legal requirement to do, thereby compromising the ability of the Commission to track key indicators. At the same time, Malawi has just initiated a process to decentralise M&E to the district and to build robust capacity for this level to become the lynchpin for all monitoring, evaluation and reporting.

Malawi has made considerable progress in its efforts to fight HIV and AIDS, but not without real challenges. The prevalence of HIV has remained relatively stable over the years, between 14-15% of adults. This could indicate reduced incidence of HIV infection or increasing death rates of HIV-infected people. However, the latter explanation is unlikely as the number of HIV-infected patients accessing ARV treatment has increased rapidly and survival rate of these patients is good (>80%). In addition, the cure rates of TB, the major cause of death in HIV-infected individuals have remained stable (>65%) over the years. But while national prevalence is stable the Southern Region of the country continues to have high HIV prevalence compared to the other regions and there is no evidence at the moment that the prevalence is declining in this region.

The prevalence of HIV remains higher in rural women than in rural men. Considering that the majority of people reside in the rural areas, and females constitute about 51% of the population, this finding highlights the high disproportionate burden of HIV infection among women. One explanation of this is the fact that 'comprehensive knowledge' of HIV prevention methods is lowest among rural women. Other factors that may explain high prevalence of HIV in this group are low participation in economic activities, continual dependence on men, negative gender-based cultural norms in rural communities and the cycles of food crisis, which have hit Malawi in the over the past years. Malawi has breast herself to address issues of gender through increased funding to the sector responsible to various non-governmental and civil society organizations.

The proportions of sexually active people and pregnant women seeking CT and PMTCT services, respectively, are still unacceptably low and considering that CT is an entry point to care and a critical factor in behavioural change, the low coverage of these services indicates missed opportunities for prevention and care. In any case, Malawi has registered rapid increase in CT and to PMTCT sites as well as a steady access, which point to increase in coverage of these services.

There have been some improvements among the population with regards to high-risk sexual behaviour. Of concern are the trends in the Southern Region of the country, which still show that the proportion of people having high-risk sexual behaviours has either increased or remained stagnant over the years. In addition, the proportion of young adults (aged 15-24 years) having multiple sexual partners has increased, although at the same time the proportion of young people using condoms has increased. Despite, the high HIV prevalence in the Southern than other regions, the rate of acceptance of people living with HIV and AIDS is higher in this region. This is a positive sign indicating that HIV-positive people are likely to be become more integrated in the communities of this region.

The coverage of impact mitigation interventions such as home-based care visits and provision of external support for chronically ill patients is low and this clearly calls for more work to make services available and accessible. A great gain is this area is the fact that there appears to be no difference in school enrolment between orphans and non-orphans. However, Malawi still has to establish more clearly whether school dropout rates are higher among orphans compared to than non-orphans

CHAPTER 9: SUMMARY OF THE MAJOR RECOMMENDATIONS

Between 2003 and 2005, a lot of experience has been gained and lessons have been learnt in the area of programme implementation, coordination, monitoring and evaluation of HIV and AIDS activities in Malawi. Thus, the Government of Malawi and its implementing partners recognize the need to implement the following:

1. Strengthening the M&E system at district levels so that the districts can collect, collate, analyze and reflect on district level data on site and submit the report to NAC for compilation of national level indicators. In order to achieve this, the Government will assist the districts in strengthening data management infrastructure system (procurement of computers and installation of internet etc) and human resource development. In addition, the Government and its implementing partners, through NAC, will standardize the M&E data collection tools and data entry templates to ensure consistency in reporting and facilitate consolidation of district data at the national level.
2. Establishing a legal requirement for all implementing agencies of HIV and AIDS activities to report to NAC in a timely manner using similar formats to ease consolidation of data at national level.
3. Implementing several outstanding surveys such as the health facility survey, survey on workplace interventions and a survey on life skills among young people which will enable the M&E system track the progress of various program output indicators.
4. Speeding up capacity building efforts at district level so that the assemblies have the capacity to effectively manage public funds and to plan HIV and AIDS interventions based on local data.
5. Intensifying the implementation of preventive and behavioral change activities especially in the Southern Region where the HIV prevalence is highest and little improvements has been recorded with regards to the adoption of safer sexual behaviors. The Northern Region also needs special targeting as the HIV prevalence does not appear to be declining.
6. Intensifying and targeting the implementation of preventive and behavioral change activities on rural women as they are less knowledgeable about HIV preventive methods and at risk of acquiring HIV due to adverse underlying socio-economic and cultural factors. These interventions should be implemented taking into account the short to medium term shocks (such as hunger) and underlying socio-economic and cultural environment which increase the vulnerability of the women.
7. Intensifying social mobilization for people infected with HIV and AIDS so that they can register with PLWA organizations. PLWHA organisations will be used to motivate people to access CT services and lobby communities and other organizations not to discriminate HIV-infected individuals. They will also be used to create positive attitude of the communities towards HIV-infected people
8. Targeting BCI interventions on the youth, especially life skills education, CT and adoption of condom use. The Government will also evaluate the effectiveness of youth-friendly programmes that are being implemented in various districts aimed at motivating the youth to adopt safer sexual behavior. Successful youth-friendly programs will need to be scaled up rapidly by district assemblies.
9. Scaling-up the establishment and operation of CT and PMTCT sites, especially in the rural areas where most Malawians reside. This will require an increase of human resource capacity in the health sector (especially in underserved areas) and intensification of social mobilization activities.
10. Scaling-up the implementation of impact mitigation activities such as provision of care and support to chronically-ill patients through home visits and support to orphans. Coupled with

this is the need to establish district-level baseline data for the number of chronically-ill patients and orphans which will enable districts to monitor the coverage of impact mitigation activities.

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