REPUBLIC OF MALAWI

MALAWI HIV AND AIDS MONITORING AND EVALUATION REPORT 2007

FOLLOW UP TO THE UN DECLARATION OF COMMITMENT ON HIV AND AIDS

Office of the President and Cabinet

Table of Contents

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ARV	Antiretroviral Therapy
BLM	Banja La Mtsogolo
BSS	Behavioural Surveillance Survey
CBCC	Community Based Child Care Centres
CBO	Community Based Organisation
CDC	Centres for Disease Control
CHAM	Christian Health Association of Malawi
DALE	Disability Adjusted Life Years
DFID	Department for International Development
DHS	Demographic and Health Survey
FBO	Faith Based Organisation
FPAM	Family Planning Association of Malawi
GDP	Gross Domestic Product
HEU	Health education Unit
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
ILO	International Labour Organisation
MACOHA	Malawi Council for the Handicapped
MACRO	Malawi AIDS Counselling and Resource Organisation
MANASO	Malawi Network of AIDS Service Organizations
MANET	Malawi Network of People Living with HIV and AIDS
MBCA	Malawi Business Coalition Against HIV and AIDS
M & E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
MOI	Ministry of Information
MSM	Men having Sex with Men
MTP	Medium Term Plans
NAC	National AIDS Commission
NAF	National HIV and AIDS Action Framework
NAPHAM	National Association of People living with HIV and AIDS in Malawi
NCPI	National Composite Policy Index
NGOs	Non Governmental Organisation
NSF	National HIV and AIDS Strategic Framework
NSO	National Statistical Office
NYCOM	National Youth Council of Malawi
OI	Opportunistic Infections
OVC	Orphans and Other Vulnerable Children
PLHIV	People Living With HIV
PMTCT	Prevention of Mother To Child Transmission
PSI	Population Services International
SAP	Structural Adjustment Programme
STI	Sexually Transmitted Infection
TOT	Training of Trainers
TWG	Technical Working Group

UA	Universal Access
UNAIDS	Joint United Nations Programme on HIV AND AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive summary

Since the submission of the 2005 UNGASS report, Malawi has continued to make good progress in the national response to HIV and AIDS epidemic and this has been possible because of Government commitment and generous support from development partners. The development of the 2007 national monitoring and evaluation report and the UNGASS report for Malawi was highly consultative and involved the participation of civil society, the public and private sectors and development partners. A national stakeholders workshop was conducted where results were presented and consensus reached. One major development in 2006 was the setting up of the targets for universal access to HIV and AIDS services which should be achieved by 2010. Table 1 shows the trends of both UNGASS and national indicators over the period 2005-2007 and targets for universal access. Over this period, the number of HIV sentinel surveillance sites, which are used to estimate HIV prevalence for the 15-49 age group, increased from 19 to 54. Using these new sites, HIV prevalence in the 15-49 years old age group has been estimated at 12.0%. This implies that the universal access target of 14% HIV prevalence rate by 2010 as set in 2006 has since been achieved hence, the need to revise these estimates. HIV prevalence among the high-risk groups namely teachers, female cross border traders, estate workers, the police officers, fishermen, truck drivers and female sex workers is above the national HIV prevalence with an exception of male vendors, among whom prevalence was found to be 7.0%.

While surveys continue showing that HIV and AIDS knowledge is almost universal, comprehensive knowledge is still low. Disparities still exist in terms of access to the media with more men and urban people being more exposed to HIV and AIDS information compared to women and rural residents, respectively. Despite these problems, over the period 2005-2006 there has been an increase in the number of IEC materials disseminated to end users and the number of radio and TV programmes. There is, however, lack of comprehensive data collection for some indicators such as number of peer educators trained and re-trained and number of sensitization meetings conducted among other media activities.

In terms of programming, there has been a tremendous increase in the number of people accessing HIV testing and counseling (HTC), PMTCT and ART services over the last two years. In 2005 and 2006, 482,364 and 661,400 HIV tests were done, respectively, compared to 283,461 tests done in 2004. The number of sites providing HTC services has also increased: there were 146 sites in 2004 and this increased to 250 in 2005 and then 351 in 2006. With regard to PMTCT services, there were 60 sites providing a minimum package of PMTCT services, which translated into 10.3% of the health facilities providing ANC. The number of pregnant women attending ANC who have been counseled and tested for HIV has also increased significantly from 52,904 in 2005 to 137,996 in 2006. The ART programme has also grown significantly over the years. In 2003 only 3,000 persons with advanced HIV infection were receiving ART and in 2004 this figure rose to 13,183 when, with support from the Global Fund, Malawi started providing free ART. As of June 2007, a total of 114,375 persons with advanced HIV infection had ever started on ART. The survival of patients on ART also seems to steadily increase from 55% in 2005 to 78% in 2007 at 12 months interval, which demonstrates the effectiveness of the programme especially in terms of reducing morbidity and mortality hence increasing productivity. The proportion of HIV positive TB patients starting ART has also increased from around 29% in 2005 to 39% in 2006. Although, condom programming has its inherent challenges in the country, the use of condoms among the sexually most active population increased over the years, especially in the urban areas. However, the supply chain of female condoms needs to be strengthened.

The National Plan of Action (NPA) on Orphans and other vulnerable children (OVC) estimates that there are more than 1million orphans and other vulnerable children in Malawi and half of these are due to HIV and AIDS. In general, there are more paternal orphans compared to maternal orphans. It has also been observed that there are more orphans in urban areas than there are in rural areas. This is as a result of the high HIV/AIDS prevalence within urban areas as compared to rural areas. According to NAC, only 14% of OVCs were supported with impact mitigation interventions in 2003/2004 but this increased to 38% in 2005/2006 and 53% in 2006/2007. This demonstrates that a lot of effort has been made by the Government of Malawi with support from civil society and development partners to provide support to OVCs. In terms of school attendance, the 2000 and 2004 DHS and the 2006 MICS have generally revealed that there are no differences between orphaned and non-orphaned children aged 10-14 years. One of the major contributing factors is the introduction of Free Primary Education in 1994 by the Government of Malawi.

The National HIV and AIDS Policy further promotes the development and implementation of HIV and AIDS workplace policies and programmes. As of June 2007, 73% of government ministries and departments, 27% of the parastatal organizations and training institutions and 57% of the members of the MBCA had functional workplace programmes. The number of companies, which are members of the MBCA, has been increasing since the network was established in 2003. In 2003 the MBCA had 15 members and this increased to 30 in 2004 and then 65 in 2005, which has remained the same in 2007. In terms of operating structures, Malawi has fully subscribed to the UNAIDS principle of the 'three ones' with the National AIDS Commission (NAC) as the national coordination body for the national HIV and AIDS response. Donors and implementing partners have accepted this and they also subscribe to one national monitoring and evaluation framework. There is also only one national action framework that provides a basis for coordinating with all partners. Government of Malawi, together with other Pool and Discrete Donors are funding implementation of the NAF. Civil society has been involved in the national response including the development of the NAF and the National AIDS Policy. Currently, some policies and laws are being revised to make them consistent with the National HIV and AIDS Policy. There is a robust monitoring and evaluation system of the national response. It has also been shown in the report, through the administration of the National Composite Policy Index, that there is a lot of good will from the public sector, donor agencies, civil society and other stakeholders in the development and implementation of national HIV and AIDS policies and strategies.

This report summarizes the progress that Malawi has made in the national response to HIV and AIDS since the submission of the last UNGASS report in 2005. Despite challenges, good progress has been made in achieving Universal Access targets for Malawi.

Table 1: Summary of indicators in the national HIV/AIDS response in Malawi

INDICATORS	2005	2007	2010 Targets[1]
HIV prevalence among pregnant women attending ANC	15%	12%	14.0%
HIV prevalence among pregnant women aged15-24 years of age	14.3%	12.3%	12.0%
Percentage of people aged 15-49 years of age who are HIV infected	14.2%	12.0%	12.8%
Percentage of sexually active persons who had sex with more than one partner in the last 12 months	Males: 26.9%	26.9%	18.0%
	Females: 8.3%	8.3%	5.0%
Percentage of sexually most active population using condoms at last high-risk sex	Males: 47.0%	57.0%	60.0%
	Females: 30.0%	37.5%	40.0%
Percentage of sexually active respondents who had sex with more than one partner the last 12 months	Males: 26%	26.0%	18%
	Females: 8.0%	8.0%	5.0%
Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Males: 37%	41.9	75.0%
	Females: 25%	42.1	75.0%
Percentage of people in general population exposed to HIV and AIDS information	Males: 80%	80%	95%
	Females: 66%	66%	95%
Percentage of HIV + pregnant women and their infants receiving a complete package of PMTCT services to reduce the risk of MTCT	5.4%	26.0%	65%
% of health facilities with ANC services providing at least the minimum package of PMTCT services	7.4%	10.3%	100%
Number of pregnant women who have been counseled in PMTCT, tested and received their sero-status	52,904	137,996 (2006)	-
Number of HIV testing and counseling sites (integrated and standalone)	250	351	600
Number of persons with advanced HIV infection receiving ARV therapy	37,840	114,375(by Jun, 07)	208,000
Proportion of those starting treatment that are under 15 years	5.0%	10%	12%
Ratio of patients starting HAART because of TB	29.0%	39.0%	-
Percentage of TB patients who are newly registered in the last 12 months who know their HIV status	47%	66.0%	-
Percentage of OVC whose households receive free basic package of care in caring for child	32.5%	53.3%	80%
% of population accepting attitudes towards PLHIVs (by gender and level of education)	Males: 29.7%	44.3%	75%
	Females: 30.8%	20.3%	75%
Percentage of adults and children with advanced HIV known to be on treatment at 12 months	55%	78%	80%

[1] The process of setting indicators for universal access was done in 2006. However, not all indicators were covered. Where there is a dash, it means that no universal access targets were set for that indicator.

intervals after initiation of ART			
Percentage of sexually most active population who have ever been tested for HIV	Males: 15.1%	29%	-
	Females: 12.9%	27%	-
Median age at first sex among 15-24 year olds	Males: 17 years	16 years	-
	Females: 16 years	16 years	-
Ratio of proportion of school attendance among orphans to proportion of attendance among non-orphans aged the 10-14 year	-	Males: 0.96	-
	-	Females: 1.0	-
Percentage of persons discussing HIV and AIDS with spouse or partner	Males: 87%	87%	-
	Females: 70%	70%	-
Number of information, education and behaviour change communication materials disseminated to end users	# of Radio programmes Produced 365	1,633	-
	# of TV programmes Produced 36	631	-
Number of peer educators trained/retrained in the year	Male	359	-
	Female	311	-
Number of peer educators who were active in the year	Male	279	-
	Female	252	-
Number of people counselled and tested for HIV, and receiving results in the last 12 months	482,364	661,400	1,000,000
Number of sites providing HTC services	250	351	435
Number of free government condoms distributed to end users in the last 12 months	16,185,920	23,570,495 (2006)	-
Number of employees that have benefited from HIV/AIDS workplace programmes in last 12 months	-	38,423 (2006)	-
Percentage of donated blood units screened for HIV in a quality assured manner	-	100% (2006)	-
Number of health workers trained/retrained in accordance with national standards in the last 12 months	-	2,387	-
Percentage of health facilities with drugs in stock and no stock outs of more than 1 week	IOs 65% (2004)	65% (2004)	90%
	ARVs 100%	100%	100%
Number of households receiving external assistance for persons who are chronically ill for 3 or more months	558,364 (2005-06)	427,996 (2006-07)	-
Number of households with vulnerable people reached with impact mitigation interventions	179,000	585,945	-
Number of orphans attending school	439,405	461,621	-
Percent of large companies and public institutions that have HIV/AIDS workplace policies and mainstreaming programmes	-	Government dept:73%	-
	-	Parastatals : 27%	-
	-	Training Institutions :57%	-
Number of companies that are members of the MBCA	65	65	-

1. BACKGROUND

1.1 Population Trends

As Malawi reports on the progress it has made in the fight against HIV and AIDS, it is necessary to examine the demographic and socio-economic context, which might contribute to the spread of HIV and other STIs in Malawi. According to the 1998 population and housing census, Malawi's population was estimated at 9.9 million. In 2007 based on the 1998 census, Malawi's population has been estimated at 13,187,632[2]. Figure 1.1 below shows the trends in population growth in Malawi since 1901.

Figure 1.1: Trends in Population Growth in Malawi 1901-1998 (Source: NSO, 2001)

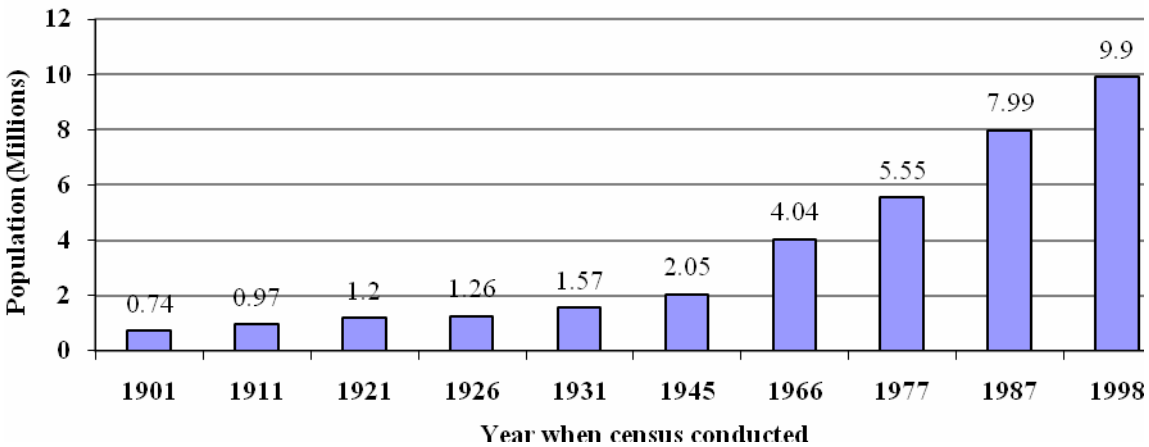


Figure 1.1 shows that Malawi's population grew from 0.74 million in 1901 to 9.9 million in 1998. When Malawi became a republic in 1966, its population was 4.04 million increasing to 5.55 million in 1977 and by 1987 to 7.99 million. Between 1977 and 1998 Malawi's population grew at an annual growth rate of 2.0%[3]. According to the 1998 Population and Housing Census, approximately 86% of Malawi's population lives in rural areas with only 14% living in urban areas. There has been a significant increase in urban population in Malawi since 1977 and 1987 when, 8.5% and 11.0%, respectively, lived in urban areas. A little less than half of the Malawi population (47.0%) lives in the southern region of Malawi while 41.0% and 12.0% live in the central and northern regions of the country, respectively.

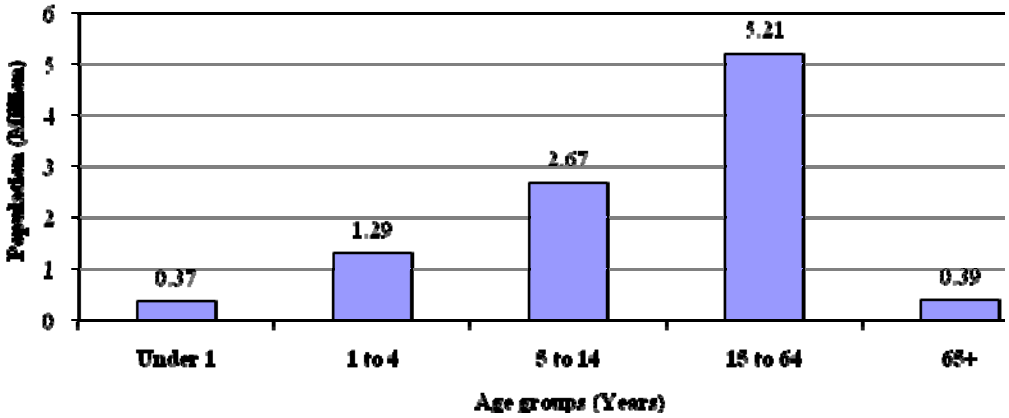
With regard to age distribution, the 1998 census reported that approximately 44% of the population was aged below 15 and 4.0% above 65 years of age and 52% between 15 and 64

[2] National Statistical Office. *1998 Population and Housing Census – population Projections*. Zomba: National Statistical Office.

[3] See National Statistical Office and International Food Research Institute. (2002). *Malawi – An Atlas of Social Statistics*. Zomba: National Statistical Office and Washington: International Food Research Policy Institute.

years. The dependency ratio for Malawi was, therefore, estimated at 0.906[4]. It can also be derived from this that a significant proportion of Malawi's population is composed of young people. Figure 1.2 below shows population distribution according to age.

Figure 1.2: Population distribution according to population groups (Source: NSO, 2002)



It is evident from Figure 1.2 above that the bulk of Malawi's population is aged between 15 and 64 years old. When this is disaggregated further it is found that 23% of the population is aged between 10-19 years old. This demonstrates that Malawi's population is young hence the need to protect it from HIV infection.

1.2 The Socio-economic Environment

Malawi is one of the poorest countries in the world ranking 165 out of 177 countries according to the UNDP human development index[5]. According to the National Statistical Office, 52.4% of the population of Malawi is considered poor[6]. About 22% of the population are ultra poor and cannot meet the recommended daily food requirements[7]. The country has a per capita gross national product of US$190. Soon after independence in 1964 up to 1979 Malawi's economy performed very well as every sector of the economy, especially the agricultural sector, registered rapid growth[8]. During this period, Malawi's economy grew at an average of 6% per annum against a population growth of 2.9%. The favourable climatic conditions that prevailed at the time, the expansion of large-scale estate agriculture and the high level of gross domestic investment constituted some of the factors that led to the impressive economic growth[9].

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[4] National Statistical Office and International Food Research Institute. (2002). *Malawi – An Atlas of social Statistics*. Zomba: National Statistical Office and Washington: International Food Research Policy Institute.

[5] UNDP. (2005). *Malawi Human Development Report 2005: Reversing HIV/AIDS in Malawi*. Lilongwe: UNDP.

[6] National Statistical Office. (2005). *Integrated Household Survey 2004/2005.* Zomba: National Statistical Office.

[7] Government of Malawi and World Bank. (2006). *Malawi Poverty and Vulnerability Assessment: Investing in our future*. Washington: World Bank and Lilongwe: Government of Malawi.

[8] Chilowa, W. and E.W. Chirwa. (1997). The impacts of SAPs on social and human development in Malawi. Bwalo: *A Forum for Social Development*. Issue 1: 39-68.

[9] Chilowa, W., Milner; J. Chinsinga,B. and Mangani,R (2000). *Social Policy in the Context of Economic Reforms: A Benchmark Survey Report*. Harare: SARIPS.

At the end of the 1970s, however, Malawi's economy started declining very sharply. In 1981, for the first time since independence, the GDP was negative at -5.2%. The 1978-79 global oil shocks and the disruption of the trade route through Mozambique as a result of the Mozambican civil war including the influx of refugees from Mozambique constituted some of the factors that led to the decline of Malawi's economy[10]. With the advice of the World Bank and the International Monetary Fund, Malawi started implementing the Structural Adjustment Programmes (SAPs) in the early 1980s in order to improve economic performance. Despite implementing SAPs, their benefits are yet to be seen. Such high prevalence of poverty puts the majority of Malawians at risk of contracting HIV.

Malawi's economy relies heavily on agriculture, which contributes more than 30% of GDP and more than 90% of the export earnings. Nearly 90% of the labour population is engaged in agriculture growing crops such as maize, tobacco, tea, and sugarcane among others. Since Malawi's economy relies heavily on the export of agricultural products, it is particularly vulnerable to external shocks such as drought and declining terms of trade[11]. Malawi's economic programme is set out in the Malawi Growth and Development Strategy (MGDS), which was launched in October 2007. The MGDS outlines the Government's priorities for the five years between 2006/07 and 2010/11 and recognizes that strong and sustainable economic growth is key to reducing poverty. Since 2004, macroeconomic performance has generally improved and government has also pursued sustainable macroeconomic policies. Because of a good track record of good macroeconomic management, Malawi reached the HIPC Completion Point in August 2006 and, subsequently, qualified for the Multilateral Debt Relief Initiative (MDRI). As a result of good macroeconomic management, Malawi now has better macroeconomic indicators. For example, inflation reached 9.2% in January 2007 and this was the first time Malawi hit a single digit inflation in four years. As of June 2007, inflation had reached 7.7 %. Over the period 2004-2006 Malawi's economy has grown at an average of about 5.2 %. As of now Government is trying to ensure that these macroeconomic gains are translated into improved social indicators.

[10] Chinsinga, B. (2004). The politics of poverty alleviation in Malawi: a critical review. In:Englund,H. *A democracy of chameleons: politics and culture in the new Malawi.* Uppsalla: Nordiska Afrikainstitutet

[11] Capplen, A.,Choudhury, R, Kamwana, H, Msowoya,C, Munyenyembe,W and Palamuleni,A. *The 2007/8 Malawi budget: macroeconomic implications*. Oslo: Statistics Norway, Department of Management Support.

2 THE PROVISION OF HEALTH SERVICES IN MALAWI

The policy of the Ministry of Health is to raise the level of the health status of all Malawians through the development of a health care delivery system capable of promoting health, preventing and reducing disease burden, protecting life and fostering the general well being and increased productivity and reducing the occurrence of premature death.[12]. There are a number of stakeholders in Malawi, which provide health services, and these include private practitioners, companies, the army and the police, the Ministry of Health, the Christian Health Association of Malawi (CHAM) and the Ministry of Local Government. The Ministry of Health is by far the largest provider of health services in Malawi followed by CHAM and then Ministry of Local Government. The delivery of health services is done at primary, secondary and tertiary levels. At primary level, rural hospitals, health centres, health posts, outreach clinics and community initiatives such as drug revolving fund committees, which are responsible for the delivery of health care. District and CHAM hospitals constitute the secondary level health care delivery system and are referral facilities for primary level facilities. Central hospitals, which are situated in Mzuzu, Lilongwe, Zomba and Blantyre, provide specialized services. The Primary Health Care approach, which in Malawi focuses on maternal and child health, water and sanitation and early treatment of common illnesses, is the main strategy for the delivery of health care services[13].

All government health facilities provide health services free of charge at the point of delivery. Unlike government, CHAM charges user fees for its health services. However, since the introduction of the Essential Health Care Package (EHP) within the Sector Wide Approach (SWAp), some services, for example, maternal and child health services, are provided free at point of delivery in CHAM facilities, which have signed Service Level Agreements (SLAs) with Ministry of Health. In order to ensure that the majority of Malawians have access to health services, and, bearing in mind that the resources are limited, the Ministry of Health and other stakeholders defined an EHP for Malawi which consists of an effective range of priority health services that Malawi, as a country, can afford to provide to Malawians free of charge. The essential health care package focuses on 11 interventions that predominantly affect the rural poor and among these are prevention and treatment of vaccine preventable diseases and malaria prevention and treatment, among other interventions. The Health SWAp is the vehicle through which the essential health care package is being delivered in Malawi.

[12] Ministry of Health and Population. (1999). *Malawi National Health Plan 1999-2004*. Lilongwe: Ministry of Health and Population.
[13] Ministry of Health and Population. (1999). *Malawi National Health Plan 1999-2004*. Lilongwe: Ministry of Health and Population.

3 HIV AND AIDS SITUATION IN MALAWI

3.1 Trends in HIV Infection

The first case of AIDS was diagnosed in Malawi in 1985 at Kamuzu Central Hospital in Lilongwe after which HIV prevalence grew quite rapidly. Malawi started monitoring HIV prevalence among pregnant women attending antenatal clinics in the late 1980s. At the start of this surveillance, the prevalence of HIV among women attending antenatal clinics was approximately 2% and this rose to 26 percent by 1998[14]. Initially, HIV was most prevalent among urban residents but this did not mean that the rural areas were spared. Studies done at the time showed that HIV prevalence rates in rural areas rose from 6 percent among antenatal women in 1992 to 18 percent by 1998. By the end of the 1990s, HIV prevalence among pregnant women attending antenatal clinics had leveled off at approximately 25 percent in the urban areas. However, UNAIDS reported in 2002 that increases in HIV prevalence among pregnant women were and are still being observed in semi urban populations[15]. As shall be discussed in detail later, HIV prevalence rate among those aged 15-49 years old has remained stable over the last 9 years in Malawi. While HIV prevalence was estimated at 14.4% in 2003, the 2007 sentinel surveillance survey estimated the HIV prevalence rate among those aged 15-49 years old to be at 12%.

There are nearly 100,000 new HIV infections in Malawi annually with at least half of these occurring among young people aged 15-24 and nearly the same number of deaths per annum[16]. As of 2005, there were an estimated 930,000 people including children under the age of 15 who were living with HIV and AIDS. The number of orphans has also increased significantly with current estimates being at over 1 million orphans half of whom are due to HIV and AIDS and related factors[17]. The advent of the HIV and AIDS epidemic has also impacted negatively on Malawi's fight against tuberculosis. In 1985, a little over 5,000 cases of tuberculosis were reported. Fourteen years later in 1999 the total number of reported cases of tuberculosis was at 24,396 and this number rose to 27,000 in 2004. The Ministry of Health estimates that 70% of tuberculosis patients in Malawi are also HIV+[18]. This demonstrates that the HIV and AIDS epidemic is a major public health problem in Malawi hence the need to contain it.

3.2 The National Response to the HIV and AIDS Epidemic: An overview

Since the first case of AIDS was diagnosed in 1985 and realizing that it was a major public health problem, Government instituted mechanisms and strategies which constituted the national response to the epidemic. Initially, Malawi's response to the HIV and AIDS epidemic was slow as public discussion of sex and sexuality issues was not promoted during the pre-1994

[14] Kalipeni, E. (2000). Health and disease in southern Africa: a comparative and vulnerability perspective. *Social Science and Medicine* 50(7/8):965-983

[15] Joint United Nations Programmeme on HIV/AIDS. (2002). *Epidemiological fact sheets on HIV/AIDS and sexually transmitted infectious: Malawi*. www.unaids.org

[16] National AIDS Commission. (2005). *National HIV and AIDS Action Framework 2005-2009*. Lilongwe: National AIDS Commission.

[17] Government of Malawi. (2005). *National Plan of Action for Orphans and other Vulnerable Children 2005-2009*. Lilongwe: UNICEF and Government of Malawi.

[18] Panos Southern Africa. (2006). *Keeping the promise? A study of Progress made in Implementing the UNGASS Declaration of Commitment on HIV/AIDS in Malawi*. Lusaka: Panos Southern Africa.

period. However, there were a number of mechanisms that were put in place in response to HIV and AIDS. The National AIDS Committee was established at the end of the 1980s, which was tasked with the responsibility of coordinating the national response. Blood screening centres were established in all the major cities in Malawi and in order to ensure that Malawians were aware of the HIV and AIDS epidemic. Government also started a very comprehensive nationwide HIV and AIDS awareness campaign. The National AIDS Control Programme (NACP) was established in 1988 to coordinate the national response to the HIV and AIDS epidemic. In 1989 the Malawi Government started having comprehensive multi-year strategic plans for addressing the HIV and AIDS epidemic. Between 1989 and 1999 the national response to the HIV and AIDS epidemic was guided by the Medium Term Plans (MTP). The first MTP, popularly known as MTP I, covered the period 1989-1994. This plan consolidated earlier initiatives and put a lot of emphasis on blood screening, public awareness and setting up of an infrastructure for epidemiological HIV surveillance. Blood screening was essential in order to ensure that only safe blood was used during blood transfusion. The second medium term plan (MTP II) was implemented over the period 1995-1999 and focused on addressing the shortage of human resource, the mobilization of resources for the fight against HIV and AIDS and setting up programmes for the care and treatment of people living with HIV and AIDS.

After the expiry of MTP II, the National HIV and AIDS Strategic Framework (NSF) was developed and the framework guided the national response to the HIV and AIDS epidemic from 2000-2004. The NSF built on the progress made during the implementation of the MTPs. The overall goal of the NSF was to reduce incidence of HIV and STIs and improve the quality of life of those infected and affected by HIV and AIDS. The NSF was multi-sectoral and it also promoted the participation of people living with HIV and AIDS, a community-based approach and had an emphasis on the youth[19].

There were structural changes during the time the NSF was being implemented. In July 2001, the National AIDS Commission was established and replaced the National AIDS Control Programme. During the 2000-2004 period, the National AIDS Commission, the Ministry of Health and other stakeholders, with support from donors, also jointly developed policies and guidelines that further provide guidance in the delivery of HIV and AIDS services in Malawi. For example, guidelines have since been developed and are being implemented by both public and private sector organizations and civil society organizations in areas such as the prevention of mother to child transmission of HIV, HIV testing and counselling, and antiretroviral therapy, treatment of opportunistic infections including STIs and community and home-based care[20]. In addition to these guidelines, a number of interventions have been and are being implemented, targeting People Living with HIV (PLHIV) and their families.

The National HIV and AIDS Policy was also developed and launched in 2003 during the period when the National HIV and AIDS Strategic Framework was being implemented. The policy was developed through a wide consultative process and all the major stakeholders including civil society organizations, the public and private sectors, the media and people living with HIV and AIDS were all involved. The National HIV and AIDS Policy provides the guiding principles for all

[19] National AIDS Commission. (2000). *National HIV/AIDS Strategic Framework 2000-2004.* Lilongwe: National AIDS Commission.
[20] Panos Southern Africa. (2006). *Keeping the promise? A study of progress made in implementing the UNGASS declaration of commitment on HIV/AIDS in Malawi*. Lusaka: Panos Southern Africa.

programmes and interventions[21]. Other policies such as the Orphans and other Vulnerable Children Policy and the ARV Equity Policy were also developed during this period. The evaluation of the NSF (2003) revealed that considerable progress was made in areas such as prevention and behavioural change; treatment, care and support; impact mitigation; mainstreaming, partnerships and capacity building; research, monitoring and evaluation; resource mobilization and utilisation; and policy coordination and programme planning.

After the expiry of the National HIV and AIDS Strategic Framework in October 2004, Malawi developed the National HIV and AIDS Action Framework (NAF), which is guiding the national response for the period 2005-2009. The NAF is a tool for mobilizing an expanded and multisectoral national response to the HIV and AIDS epidemic. The overall goal of the NAF is to prevent the spread of HIV infection among Malawians, provide access to treatment for PLHIVs and mitigate the health, socio-economic and psychosocial impact of HIV and AIDS on individuals, families, communities and the nation[22]. In order to achieve this goal, eight priority areas have been defined in the NAF for the period 2005-2009. These areas are prevention and behaviour change; treatment, care and support; impact mitigation; mainstreaming, partnerships and capacity building; research and development; monitoring and evaluation; resource mobilization and utilisation; policy coordination and programme planning. High-level government commitment and leadership, the 'three ones' principle, multisectoral and multi-stakeholder partnerships, greater involvement of PLHIV, gender considerations and evidence-based interventions constitute some of the important guiding principles for the NAF. A number of strategies are being used to implement the NAF and these include the Behavioural Change Interventions Strategy; the HIV and AIDS Mainstreaming Framework; the ART Equity Policy Paper; Impact Mitigation Framework; the HIV and AIDS Research Strategy; the Monitoring and Evaluation Plan; among others. It can be observed from this discussion that government, civil society and the private sector are all playing an important role in the national response to the HIV and AIDS epidemic in Malawi.

[21] National AIDS Commission. (2003). *The National HIV/AIDS Policy*. Lilongwe: National AIDS Commission.
[22] National AIDS Commission. (2005). *The National HIV/AIDS Action Framework 2005-2009.* Lilongwe: National AIDS Commission.

4 METHODOLOGY FOR PREPARING THE MONITORING AND EVALUATION REPORT

4.1 Introduction

This report presents the progress that Malawi has made towards the fight against HIV and AIDS and focuses on agreed indicators both in the national monitoring and evaluation framework as well as the UNGASS. The development of this report was a participatory process and it involved the public and private sectors and civil society organisations. A number of meetings were conducted where stakeholders deliberated on the progress that Malawi has made in the fight against HIV and AIDS, especially focussing on agreed indicators.

4.2 Methodology

In addition to stakeholder meetings, there were other methods that were used to collect data for the development of this report. Since 1992, a number of nationally representative quantitative studies have been conducted in Malawi. In addition to this, studies have also been conducted in specific locations in Malawi to inform programme development and implementation. These studies were reviewed and further analysis of national survey data was done as described below. In addition to this, a national composite policy index questionnaire was administered to some selected policy makers as detailed in Section 5.

4.2.1 Review of Existing Literature

The National AIDS Commission and the Joint Review Task Force identified a comprehensive list of documents on HIV and AIDS studies including programme documents and possible sources of these documents. These documents included national records; national HIV and AIDS situation analyses; national household survey reports; qualitative studies reports, specific district assessments, modeling and estimates reports and policy documents. The review of these documents helped to determine the trends in the fight against the HIV and AIDS epidemic mainly focusing on the agreed UNGASS and national monitoring and evaluation indicators.

4.2.2 Further Analysis of the National Survey Data

Since 1992 the National Statistical Office has been conducting national surveys, which have included modules on HIV and AIDS. These surveys include the Demographic and Health Surveys, Integrated Household Surveys, Behavioural Surveillance Surveys and the Multiple Indicator Cluster Surveys. Data from these surveys was further analysed and will subsequently assist in the development of the national HIV prevention strategy as well as feed into the production of this report. Stakeholders were consulted in order to determine the type of analysis including cross tabulations that were required from these surveys. Where necessary, the data was disaggregated by sex, socio-economic status, region, district and national levels.

4.2.3 Administration of National Composite Policy Index Questionnaire

The collection of data was done in two parts as stipulated in the guidelines whereby Part A was administered to Government officials and Part B was administered to representatives from non-governmental organizations, bilateral agencies and UN organizations as indicated in Appendix 7. Five government officials and 7 representatives from non-governmental organizations, bilateral agencies and UN organizations completed the questionnaires. In all these agencies and organizations the questionnaires were given to HIV and AIDS focal persons. In answering the questions they were encouraged to consult widely within the Ministries, organizations and agencies in order to have a more accurate assessment of progress. The completed questionnaires had information gaps as some questions were not answered. This reflected mainly the fact that respondents answered those questions they had confidence and more closely related to the mandate of the Ministry, agency or organizations they represented and left out those they were not sure about. This might also be due to differences in mandates relating to HIV and AIDS programming and implementation among the consulted institutions. However, the information gap created by unanswered questions has not in any way affected the accuracy of the information because the gaps have been filled by documentary evidence from other sources.

4.3 Limitations of the report

While this report has comprehensively considered all the UNGASS and National M and E indicators, there were a number of challenges during data collection process. Some indicators for example, the number of condoms distributed to end users through community based organizations and workplace programmes, the number of households with vulnerable people reached with impact mitigation interventions (only OVCs were reported), the number of CBOs supporting PLHIV receiving financial support in the past 12 months, the number of CBOs with trained volunteers and the number of programmes that address the needs of OVCs among other indicators were left out in this report. This is mainly because there are no data collection mechanisms as of now for those indicators. In some cases, the way the indicators are phrased is not the way data is being collected. This led to data being inconsistent and trends could not be established properly. Generally, the issue about data collection and reporting needs to be addressed by all stakeholders in the HIV and AIDS Sector in Malawi. The data collection and reporting process by all stakeholders in the country should be mandatory. District assemblies, too, should be capacitated so that they constitute the hub for data collection and reporting.

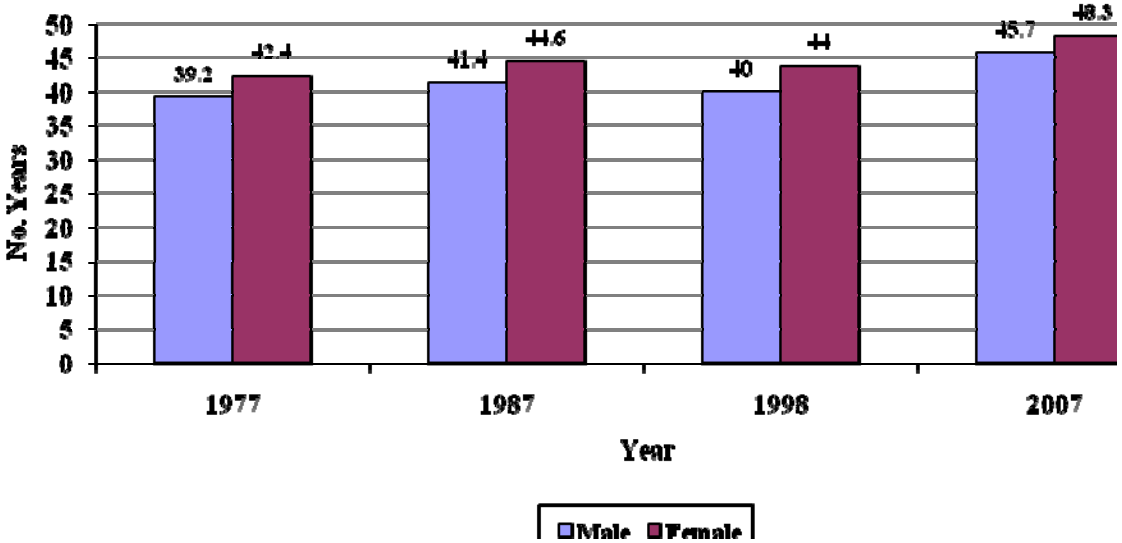
5 RESULTS

5.1 Impact And Outcome Indicators

5.1.1 Life Expectancy at Birth

With a population growth rate of 3.2%, a total fertility rate of 6.3 children born per woman, an infant mortality rate of 117 deaths per 1000 live births and a life expectancy of 40 years, Malawi is one of the countries with the worst health and other social indicators. Figure 5.1 below shows the life expectancy for Malawi for the years 1977, 1987 and 1998 when the censuses were conducted and projections for 2007 made:

Figure 5.1: Life Expectancy Rate for Malawi 1977-2007 (Source: NSO)



Other health indicators such as infant mortality rate have shown some improvements but life expectancy has been on the decrease since the 1990s. In 1977, as can be seen from Figure 5.1 above, life expectancy for men was at 39.2 years and for women it was at 42.4 years. These rates increased to 41.4 years and 44.6 years for men and women, respectively in 1987. During the 1998 census, however, there was a slight drop in life expectancy for both women and men. The projections for 2007, which are based on the 1998 census, show an increase in life expectancy for both men and women[23]. In 1992 the life expectancy for Malawi was estimated at 48 years[24]. This overall life expectancy is significantly higher than the 1998 rates shown in Figure 5.1 above. In 1998 the life expectancy for Malawi was estimated at 40 years but these calculations did not take into consideration the disability adjusted life expectancy (DALEs). The inclusion of the DALE in the calculation of life expectancy, as the WHO did in 2000, found a life expectancy for Malawi at 29.4 years. Whether DALE is incorporated in the determination of life

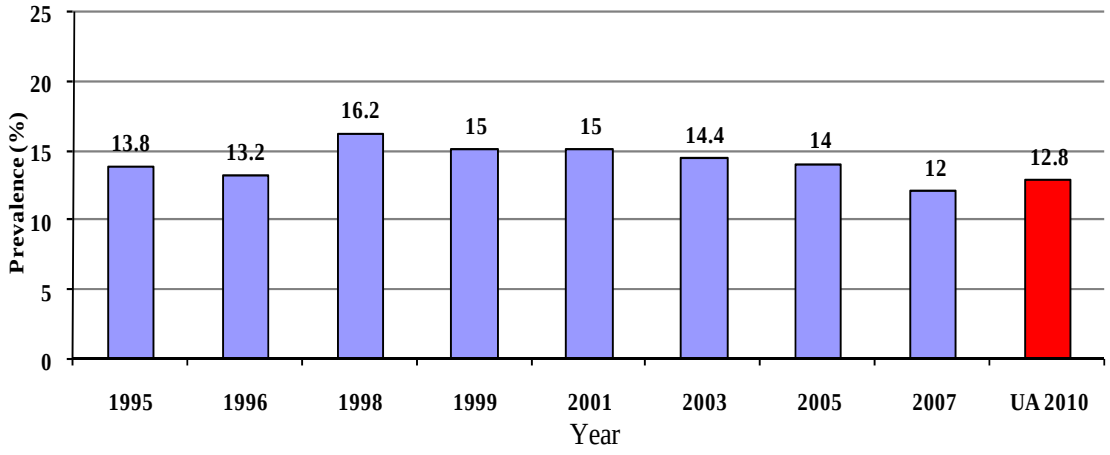
[23] National Statistical Office. (2003). *1998 Malawi Population and Housing Census – population projections report 1999-2023.* Zomba: National Statistical Office.
[24] United Nations and Government of Malawi. (1993). *Situation Analysis of Poverty in Malawi*. Lilongwe: United Nations and Government of Malawi.

expectancy or not, one thing is clear that there has been a precipitous drop in life expectancy in Malawi especially from the 1990s. As is the case with other countries within the Sub-Saharan African region, the drop in life expectancy is mostly due to the HIV and AIDS epidemic[25]. While the first case of AIDS was diagnosed in the mid 1980s, it was only in the 1990s when the impact of the epidemic started being felt. It is clear then that life expectancy has been dropping even though this year's projected estimates are a bit higher than those of the 1998. These higher life expectancy projections for 2007 were made with the assumption that the country would reach tipping off point in the fight against the HIV and AIDS epidemic, which is a major contributing factor towards the huge drop in life expectancy in Malawi.

5.1.2 Percentage of Sexually Most Active Population (15-49) Who are HIV Infected

Sentinel surveillance surveys have been used to estimate HIV prevalence in Malawi since the late 1980s. Currently, there are 54 health facilities spread throughout Malawi that are being used to collect data and estimate HIV prevalence among the sexually active persons aged 15-49 years old. These sites capture both the rural and urban populations. Figure 5.2a below shows national HIV prevalence between 1995 and 2007:

Figure 5.2a: HIV prevalence among 15-49 age group 1995-2005 and UA targets **(Sources: HIV ANC Sentinel surveillance)**

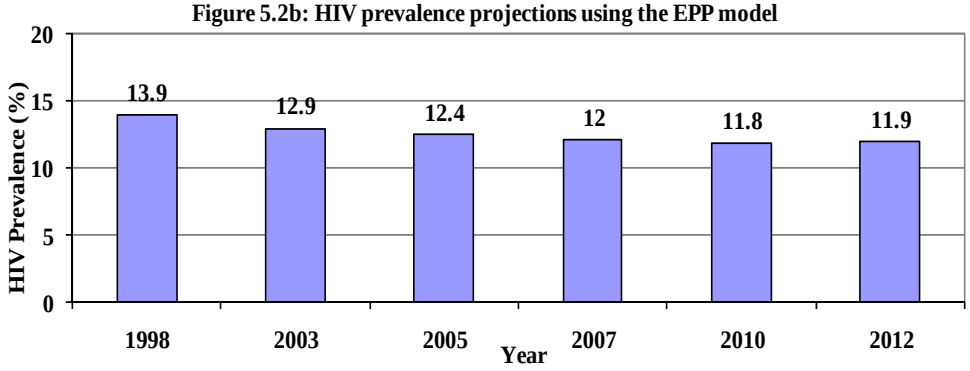


It can be seen from Figure 5.2a above that HIV prevalence among people aged 15-49 years old increased from 13.8% in 1995 to 16.2% in 1998 and then it started declining to 15% in 1999 and 2001, then 14.4% in 2003 and 14% in 2005. It is therefore, clear that HIV prevalence among those aged 15-49 has been stable over the last 9 years. In 2007, the estimate for this age group is 12%. The revised estimates however, still suggest that HIV prevalence has steadily been declining since the peak in 1998. Figure 5.2b below shows the trends in estimated and

[25] World Health Organisation. (2000). *WHO Issues New Health Life Expectancy Rankings: Japan Number one in new HealthLlife System.* Washington and Geneva: World Health Organisation (Press Release 2000).

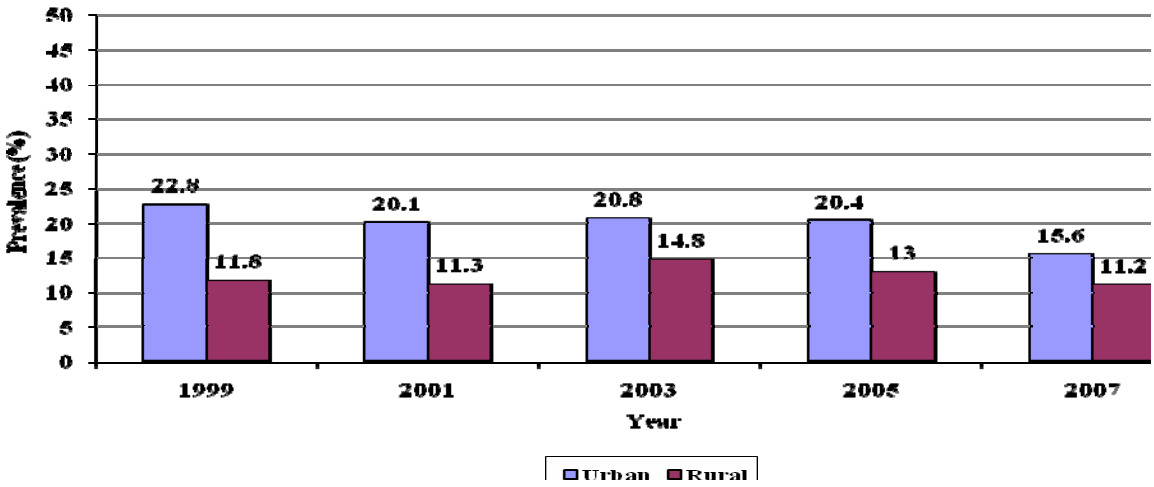
projected HIV prevalence for the period 1998-2012, as done using the Estimation and Projection Package (EPP) model:

Figure 5.2b: HIV prevalence projections using the EPP model



It can be seen from Figures 5.2a and 5.2b that using the EPP model, HIV prevalence and estimates are lower than previously published. The quality and coverage of sentinel surveillance in Malawi has improved over time and surveillance in 2007 has expanded from 19 to 54 sites. In addition, Malawi conducted a national population based survey (MDHS) in which HIV testing was included. Taken together in the estimation process the combined factors resulted in a lower national prevalence of HIV. Furthermore, some of the assumptions and methodologies used to produce the estimates have changed as a result of ongoing enhancement of our knowledge of the epidemic[26]. While Figure 5.2a shows a universal access target of 12.8% HIV prevalence, it is important to revise these targets in light of the new and more accurate HIV projections. Figure 5.3 below shows HIV prevalence by urban and rural residence between 1999 and 2007:

Figure 5.3: HIV prevalence among 15-49 age group by urban/rural 1999-2007 (Sources: HIV ANC Sentinel surveillance)



[26] Ministry of Health and National AIDS Commission. (2007). *HIV and Syphilis Sero-survey and National HIV Prevalence and AIDS Estimates Report 2007*. Lilongwe: Ministry of Health and national AIDS Commission.

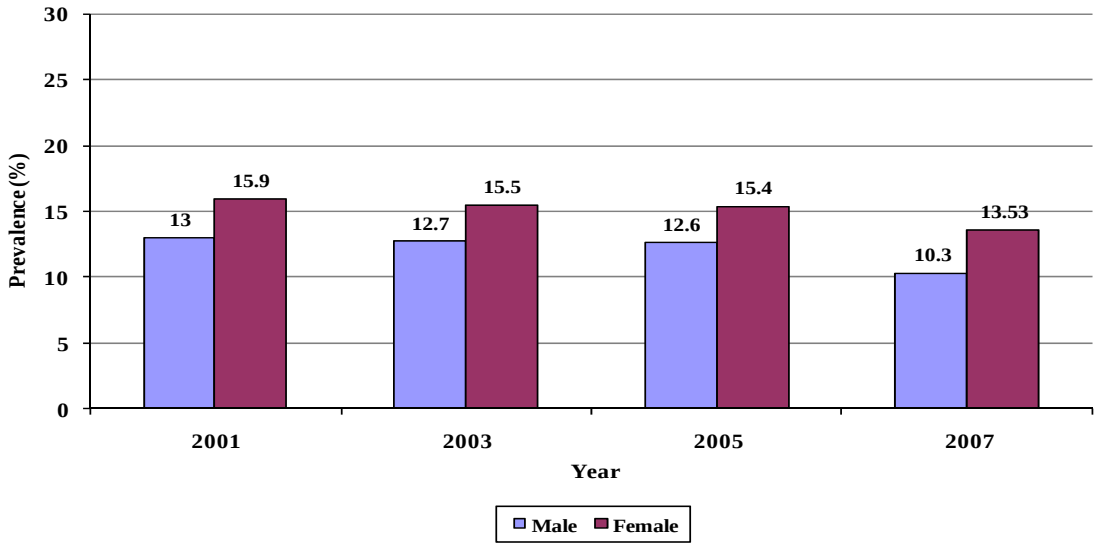
In general HIV prevalence is higher in the urban areas than rural areas. Prevalence of HIV among those aged 15-49 during the period 1999-2005 has generally been on the decline among those resident in the urban areas but the previous increase in rural areas between 2001 and 2005 has been followed by stabilization of prevalence around 11.2% by 2007[27] as indicated in the figure above. Figure 5.4 below shows HIV prevalence among those aged 15-49 years old by region for the period 1999-2007:

It can also be seen from Figure 5.4 above that HIV prevalence among people aged 15-49 is highest in the southern region except in 2001 when the central region had the highest HIV prevalence rate. Prevalence in the northern region significantly increased in the period 2001-2003 and this explains why the 2005 UNGASS report for Malawi reported that HIV prevalence in this region increased during this period[28]. Figure 5.5 below shows HIV prevalence by sex for the period 2001-2007:

[27] Report of a Countrywide Survey of HIV/AIDS Services in Malawi for the Year 2006. HIV Unit, MOH, National TB Control Programmeme, Lighthouse Trust and CDC Malawi

[28] Office of the President and Cabinet. (2005). *Malawi HIV and AIDS Monitoring and Evaluation Report 2005.* Lilongwe: Office of the President and Cabinet.

Figure 5.5: HIV prevalence among 15-49 age group 2001-2005 by gender (Sources: HIV ANC Sentinel surveillance)



It can be seen from Figure 5.5 above that over the period of 2001-2007 HIV prevalence is higher among women than among men. The general trend from the revised estimates suggests a steady decline of prevalence in both males and females although prevalence remains higher among females. Such a gender difference has previously been reported in the 2004 DHS, which also found that HIV prevalence was higher among women than men at 13.3% and 10.2%, respectively. Population level results from the 2004 DHS also show that, in general, HIV prevalence was highest in the southern region at 19.8% followed by the central region at 10.4% and the northern region at 6.6% as can be seen from Figure 5.6 below:

Figure 5.6: HIV prevalence among 15-49 years old by region and rural/urban residence (Source: 2004 DHS)

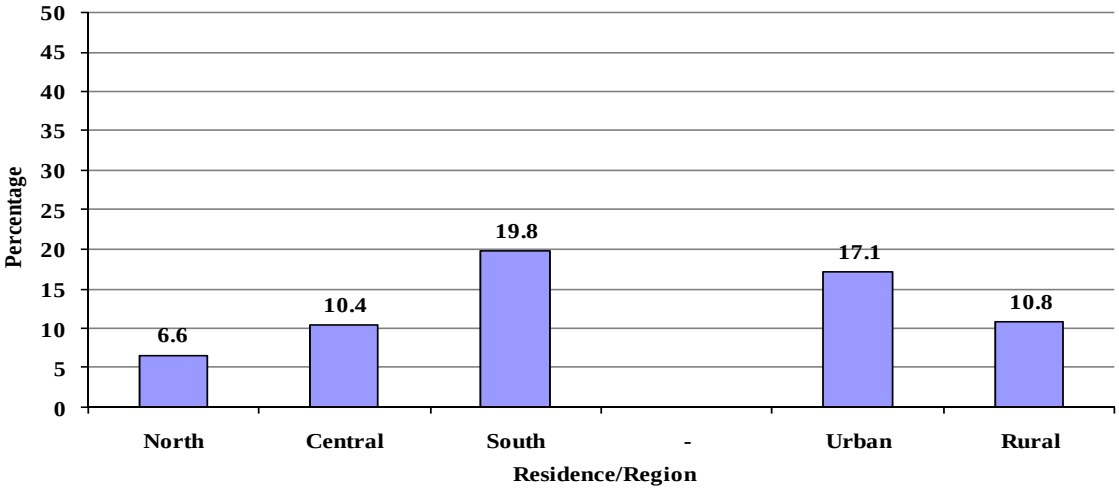
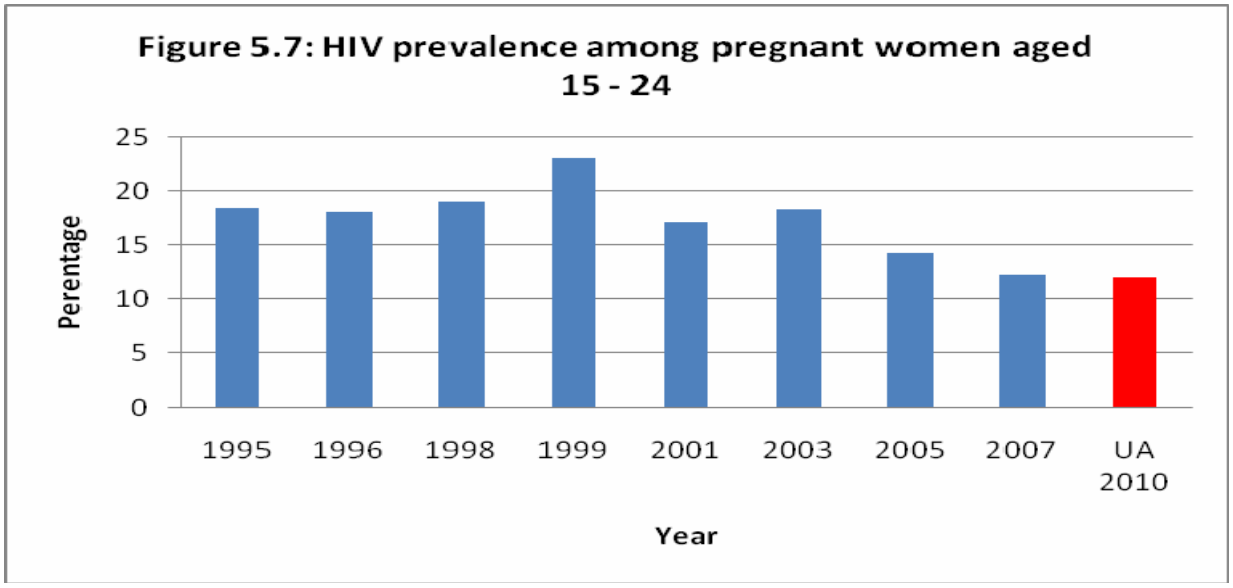


Figure 5.6 above further shows that HIV prevalence is higher in the urban areas than in the rural areas. This further confirms the results from the sentinel surveillance surveys, which have all along shown that HIV prevalence is higher in urban areas than in rural areas. For population based surveys, the 2004 results constitute the baseline and progress will be determined during the next DHS, which will be conducted in 2009. Both the sentinel surveillance survey of 2007 and the 2004 DHS demonstrate that Malawi has reached the universal access target, and this calls for revision of the targets.

5.1.3. Prevalence of HIV Among Pregnant Women aged 15-24 Years Old Attending Antenatal Clinics

The prevalence of HIV in the 15 to 24 years age group from the ANC sentinel surveillance is used as a proxy indicator for incidence in the general population[29]. Figure 5.7 below shows HIV prevalence among pregnant women aged 15-24 years old attending antenatal clinics for the period 1995-2007:



It can be observed from Figure 5.7 above that, as is the case with prevalence at national level, HIV prevalence among pregnant women aged 15-24 years old increased over the period 1995-1999 from 18.5% in 1995 to 23.1% in 1999. After this period, it started declining and as of the last sentinel surveillance survey conducted in 2007 prevalence was at 12.3%. The observed prevalence would suggest that UA target of 12% by 2010 will be reached sooner rather than later.

Figure 5.8 below shows HIV prevalence among pregnant women attending antenatal clinics by urban and rural.

[29] Stover J and Stanecki. (Undated). *Estimating and Projecting the Size and Impact of the HIV/AIDS Epidemic in Generalized Epidemics*: The UNAIDS Reference Group Approach.

Figure 5.8: HIV prevalence among pregnant women aged 15-24 1999-2007 by urban and rural residence

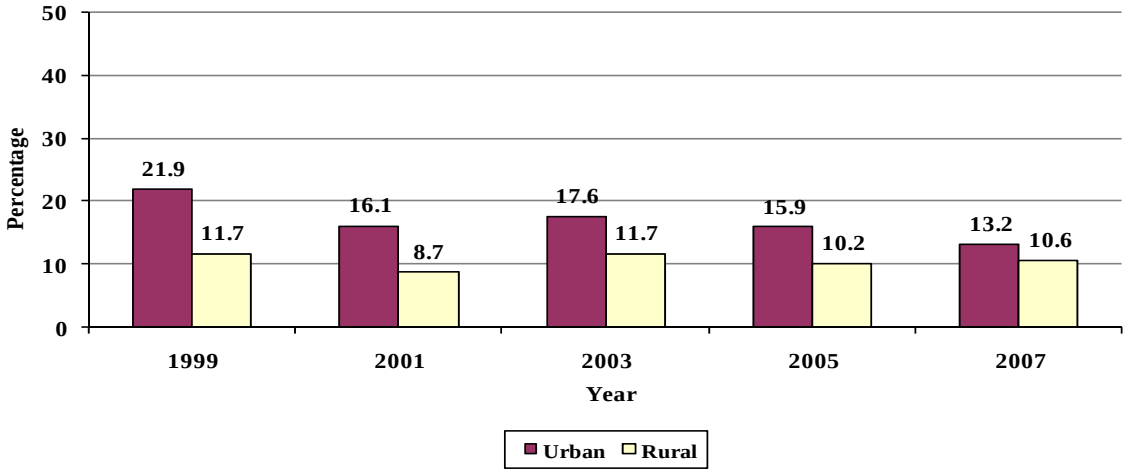


Figure 5.8 above shows that the HIV prevalence decline has been more in urban areas compared to rural areas. The incidence estimates from ANC surveillance are, however, different from those reported in the only population survey conducted so far. The 2004 DHS found that in this age group, new infections were 4 times more likely to occur among women than among men. The Southern region and urban areas had the highest prevalence rates at 8.8% and 7.2%, respectively. Furthermore, urban male youth were at a lower risk of infection (prevalence 0.3%) compared to their counterparts in rural areas (2.5%) and rural male youth were 8 times more likely to be infected compared to their urban counterparts. In contrast, prevalence among urban female youth (13.2%) was higher compared to that among rural female youth (8.2%). These findings suggest that female youth in both rural and urban areas are more vulnerable to HIV infection in comparison to male youth. The difference in absolute estimates from the two approaches above raises possible problems about the reliability of ANC surveillance estimates as proxy for HIV incidence in this age group in Malawi. The observed trend using the two methods is, however, in the same direction.

5.1.4 Prevalence of HIV among High-risk Groups

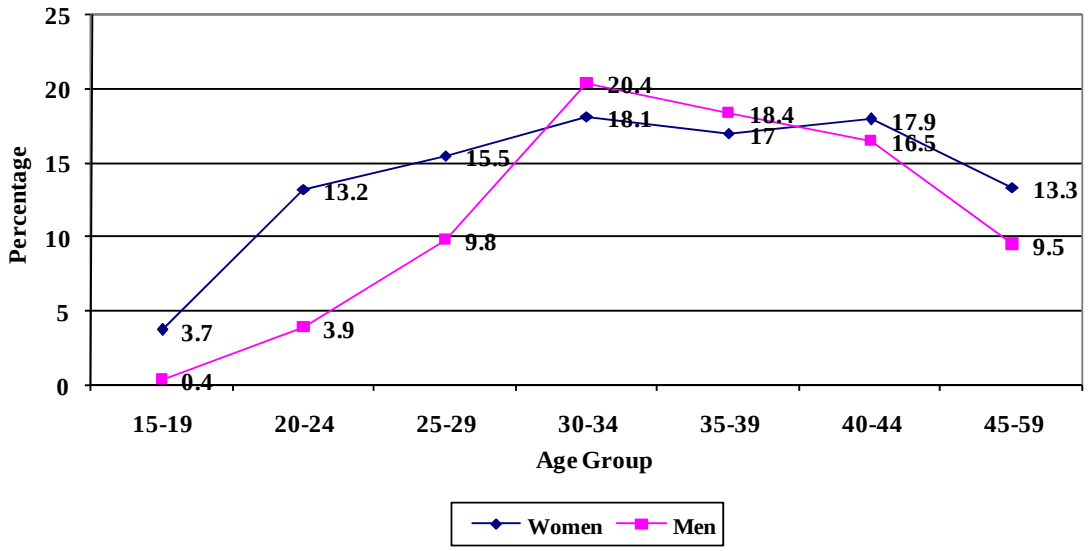
As a way of monitoring trends in HIV and AIDS related knowledge, attitudes and behaviours in sub-populations which are at risk of HIV and STI infection, the National Statistical Office conducts behavioural surveillance surveys (BSS) every two years among high-risk groups. These high-risk populations include primary school teachers, secondary school teachers, female border traders, male vendors, estate workers, police officers, fishermen, truck drivers and female sex workers. In the 2006 BSS, in addition to looking at knowledge and attitudes among these high-risk populations, the survey also included a module on HIV testing. Table 5.1 below shows the prevalence of HIV among high-risk population groups covered by the BSS:

Table 5.1: HIV prevalence among high-risk groups		
Sub groups		**HIV Prevalence rate**
Female sex workers		69.1
Primary school teachers -	Male	24.2
	Female	21.6
Secondary school teachers-	Male	17.6
	Female	16.7
Female border traders		23.1
Male vendors		7.0
Truck drivers		14.7
Fishermen		16.6
Estate workers -	Male	19.5
	Female	17.1
Police -	Male	24.5
	Female	32.1

(Source: BSS 2006)

It can be seen from Table 5.1 above that HIV prevalence is generally lower than the national average among male vendors at 7.0%. HIV prevalence among female commercial sex workers is very high at 69.1% and this is followed by female police officers at 32.1%, male police officers at 24.5%, male primary school teachers at 24.2%, female cross border traders at 23.1% and female primary school teachers at 21.6%. For the rest of the risk groups, prevalence is less than 20% but above national HIV prevalence rate of around 12%. What is observed in Table 5.1 above is that apart from male vendors, the rest of the most at risk groups have an HIV prevalence of much more than the national average. Figure 8a below shows HIV prevalence by age group among men and women aged 15-49 years old using the results from the 2004 DHS:

Figure 8a: HIV prevalence among persons aged 15-49 by age group (Source: DHS 2004)



It can be seen from Figure 8a above that HIV prevalence among adolescents aged 15-19 years old is the lowest : 3.7% for women and 0.4% for men. HIV prevalence then increases with age and reaches a maximum at ages 30-44 after which it starts decreasing. It is also evident that HIV prevalence in all age groups is higher among women than men except the age groups 30-34 and 35-39 where HIV prevalence among males is higher than among females.

5.1.5. Percentage of Adults and Children with Advanced HIV Known to be on Treatment at 12 Months Intervals (at 12, 24, 36, 48, 60 months) after Initiation of ART

Table 5.2 below shows the percentage of adults and children with advanced HIV known to be on treatment at 12 months interval after initiation of ART:

Table 5.2: Percentage of adults and children with advanced HIV known to be on treatment at 12 months intervals (at 12, 24, 36, 48, 60 months) after initiation of ART

Indicator	***2005***	***2006[30]***	***2007***	***UA target 2010***
% of adults and children with advanced HIV known to be on treatment at 12 months intervals (at 12, 24, 36, 48 60 months) after initiation of ART				
12 months	55	71	78	80%
24 months		70	70	

Table 5.2 shows that the survival of patients on ART seems to steadily increase. Presumed 12 month survival has improved from 55% at the start of the ART programme to 78% by June 2007. However, the presumed survival for 12 months includes 11 % transfer outs, which are presumed alive. The assumption is based on follow up studies from some ART clinics, which indicate that such is the case (Lilongwe Central Hospital and Queen Elizabeth Central Hospital follow up data). For 24 months survival, the figure has remained static at 70% presumed survival. If the patients transferred out are not included, survival rates at 12 and 24 months are presently at 67% and 53%, respectively. This would indicate a drop in survival of 14% from 12 to 24 months. The high number of transfers out is explained by the exponential increase in facilities offering ART. Patients who previously were only able to access ART from the few urban centres are now moving closer to their places of residence to access ARTs. The ART programme is, however, in its early stages and the survival figures are based on relatively small numbers of patients. Additionally, in this early phase, there may be an overrepresentation of stage 4 patients who are too sick to benefit substantially from the antiretroviral therapy thereby contributing to the low survival of patients on ART.

5.1.6. Proportion of Children Who are Orphaned

As has been mentioned earlier, HIV and AIDS mostly affect those who are young and economically productive. When they die they leave behind orphans and their grandchildren who

[30] The programme has only been running for 24 months by this date. Data for 2007 not yet available

are generally incapable of taking care of themselves. While the extended family system has been used as a coping strategy for orphans and grandparents, this system is, however, overwhelmed because of the large number of orphans that have arisen since the advent of the HIV and AIDS epidemic. With high prevalence of poverty, it is increasingly difficult for the system to cope. This explains why over the last 20 years of the HIV and AIDS epidemic, Malawi has seen the evolution of novel strategies for taking care of orphans, for example, the use of community-based childcare centres (CBCCs), adoption and orphanages. During this period, there has also been an increase in the number of community-based organizations (CBOs), which are playing an important role in looking after orphans especially in terms of addressing the physical/material needs as well as their psychosocial needs. The DHS and MICS looked at the proportion of children within the household who are orphans and whether they were maternal, paternal or double orphans. Table 5.3 below shows the proportion of children who were orphans:

Table 5.3: Proportion of Children who are orphaned

SEX	TYPE OF ORPHAN	DHS 2004	MICS 2006
Male	Maternal Orphans	0.8	0.6
	Paternal Orphans	5.8	5.2
	Double Orphans	3.6	2.9
Female	Maternal Orphans	0.8	0.5
	Paternal Orphans	5.7	4.8
	Double Orphans	3.4	2.8
Rural	Maternal Orphans	0.7	0.5
	Paternal Orphans	5.8	5.0
	Double Orphans	3.3	2.7
Urban	Maternal Orphans	1.4	0.6
	Paternal Orphans	5.9	4.8
	Double Orphans	4.9	3.9

It can be seen from Table 5.3 that in the 2004 DHS, it was found that 0.8% of the male children were maternal orphans, 5.8% were paternal orphans and 3.6% were double orphans. Among females the corresponding proportions were 0.8%, 5.7% and 3.4%, respectively. In 2006 among male children, 0.6% were maternal orphans, 5.2% were paternal orphans while 2.9% were double orphans and the corresponding proportions among females were 0.5%, 4.8% and 2.8%, respectively. It can be seen, therefore, that irrespective of the sex of the orphans or the year when the survey was done, the proportion of children who were paternal orphans was higher than maternal orphans and this was followed by double orphans and then maternal orphans. This demonstrates that husbands die more than their spouses.

In terms of rural and urban, it can be seen that 0.7% of the children in 2004 were maternal orphans, 5.8% were paternal orphans and then 3.3% were double orphans. The corresponding proportions in the urban areas were 1.4%, 5.9% and 4.9%, respectively. There were also slightly more children in the urban areas who were orphaned compared to rural areas. This could be due to the higher prevalence of HIV within urban areas compared to rural areas. With the introduction of free ART and possibly urban residents having more access to this service than rural residents, the proportion of orphans in the rural areas might surpass those from urban areas.

5.1.7 Percentage of People in the General Population Exposed to HIV and AIDS Media Campaign in the Past 30 days

The radio, schools and teachers; health workers and health facilities; and, friends and relatives are the major sources of information on HIV and AIDS in Malawi. Newspapers and magazines are not popular sources of information. The 2004 DHS asked questions such as whether women aged 15-49 and men aged 15-54 had heard any radio spots or messages on HIV and AIDS, seen any TV spots or programmes on HIV and AIDS and read articles, messages, or advertisements about HIV and AIDS in a magazine or newspaper in the 30 days preceding the survey. The results showed that 66.1%, 11.2% and 4.8% had heard any radio spots or messages on HIV and AIDS, seen any TV spots or programmes on HIV and AIDS and read articles or advertisements about HIV and AIDS, respectively. The corresponding proportions for men were 80.3%, 20.1% and 33.2% as can be seen from Table 5.4 below:

Table 5.4: Proportion of persons exposed to the media by sex

Sex	*Exposure to HIV and AIDS information*	*Percentage*
Men	Radio spots or messages	80.3
	TV spots or programmes	20.1
	Read articles or advertisements about HIV and AIDS	33.2
Women	Radio spots or messages	66.1
	TV spots or programmes	11.2
	Read articles or advertisements about HIV and AIDS	4.8

This data was further disaggregated by rural and urban residence as can be seen from table 5.5 below:

Table 5.5: Proportion of persons exposed to the media by rural and urban residence

Sex	*Television*	*Radio*	*Newspaper*
Rural Men	13.2	79.3	27.0
Women	6.7	64.2	10.8
Urban Men	47.6	86.2	57.8
Women	32.9	80.4	34.4

Table 5.5 above shows that 47.6% of the men and 32.9% of the women in urban areas saw any TV programme or advert on HIV and AIDS within the 30 days preceding the survey. The corresponding proportion of men and women in the rural areas were 13.2% and 6.7%, respectively. This demonstrates that men have more access to TV than women and also that urban residents have more access to TV than their rural counterparts. For the radio, a similar situation arises: 79.3% of the men and 64.2% of the women listened to a radio spot or programme on HIV and AIDS in the rural areas and the corresponding proportion for urban

areas were 86.2% and 80.4% among men and women, respectively. Lastly, 27% of the rural men and 10.8% of the rural women reported having read a newspaper or magazine article on HIV and AIDS within 30 days prior to the survey while among urban residents 57.8% of the men and 34.4% of the women reported this. This shows that radio spots are the most popular sources of information on HIV and AIDS compared to TV spots or programmes and reading magazines and newspapers. It also shows that men are more exposed to the media compared to women.

The revised targets for universal access are that for 2007, 90% of the males and 70% of the females should be exposed to HIV and AIDS media campaigns on the radio. The corresponding figures for men and women in 2009 are 95% and 75%, respectively. The Universal Access targets for exposure to the media (radio) are 90% and 95% for 2008 and 2010 respectively. The corresponding percentages for females are 70% and 95%, respectively. However, not every Malawian woman and man can have access to radio, TV or newspapers for one reason or another including illiteracy. Other mechanisms for dissemination of information need to be put in place in order to ensure that people who have not gone to school and those without radios and TVs are reached. This would include introduction and expansion of community radio and TV listening centres and other innovative strategies. At the moment these information channels are accessible only to those who have radios and TVs and those who are able to read newspapers and magazines.

5.1.8. Percentage of Sexually Most Active Population Who Have eEver Been Tested for HIV

The DHS of 2000 and 2004 and the MICS of 2006 all looked at the proportion of the sexually active population who had ever been tested for HIV and received results. Table 5.6 below shows the proportion of sexually active population who had ever been tested for HIV by sex and urban/rural residence:

Table 5.6: Proportion of sexually most active population who had ever had been tested by sex and urban/rural residence

Residence	Sex	DHS 2000	DHS 2004	MICS 2006
	Male	15.2	15.1	29.0
	Female	8.5	12.9	27.1
Rural	Male	13.7	12.4	27.4
	Female	6.9	10.7	23.7
Urban	Male	21.9	25.1	35.7
	Female	16.9	22.9	43.6

It is evident from Table 5.6 that in 2000, 15.2% of the males and 8.5% of the females were tested for HIV and in 2004 the proportion of males who were tested for HIV and received results remained the same at 15.1% while that of the females increased to 12.9%. The 2006 MICS shows that nearly one third of the men (29.0%) and women (27.1%) were tested for HIV. Among the rural residents, 13.7% of the males and 6.9% of the females were tested for HIV in 2000. In 2004, the corresponding proportion for males and females were 12.4% and 10.7%, respectively. In 2006, 27.4% of the men and 23.7% of the women were tested for HIV.

Among the urban residents 21.9% of the men and 16.9% of the women reported having been tested for HIV while the corresponding proportions in 2004 were 25.1% and 22.9%, respectively. In 2006, 35.7% of the men and 43.6% of the women reported having been tested for HIV in the urban areas. These results demonstrate that except for the 2006 results for urban residents, in all other cases, slightly more men reported having been tested for HIV compared to women and that urban residents are more likely to report having been tested for HIV than their rural counterparts. Generally, all the survey results show that the proportion of sexually active population who have ever been tested for HIV increased between 2000 and 2006. The introduction of the free ART programme has contributed significantly to the demand for HIV testing.

5.1.9 Percentage of Sexually Most Active Population Who had Sex With More Than One Partner in the Last 12 months

The promotion of consistent condom use and partner reduction is important in the prevention of HIV transmission. The DHS collects information on the number of men and women who had sex with a non-marital and non-cohabiting partner in the 12 months period prior to the survey. The 2004 DHS has shown that 8.3% of the females and 26.9% of the males who were sexually active had sex with a non-regular partner. The universal access targets for 2010 are 18% among males and 5% among females and this demonstrates that progress is being made to achieve the 2010 universal access targets. Nearly 14% of the women in urban areas and 7.2% of the women in rural areas reported having had higher risk sex in the 12 months prior to the survey. The corresponding proportions among men in urban and rural areas were 35.0% and 24.8%, respectively. This suggests more risk in urban than rural areas.

It is evident that people in the urban areas are more likely to have higher risk sex compared to their rural counterparts. Men are also more likely to have high-risk sex compared to women. Figure 5.9 below shows the percentage of men and women who reported having higher risk sex in the 12 months prior to the 2004 DHS by age group:

Figure 5.9: Percentage of people who reported having higher risk sex in the past 12 months

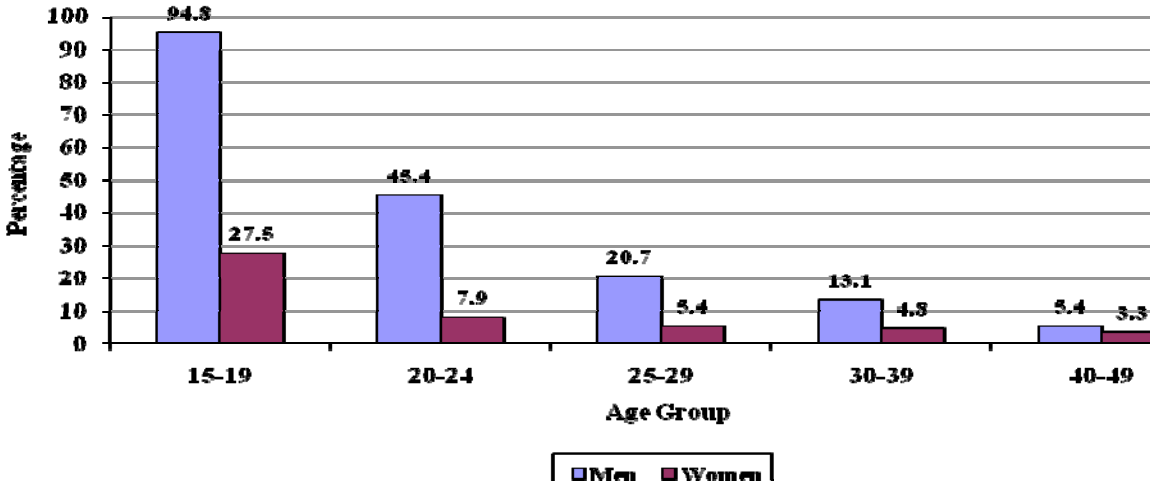
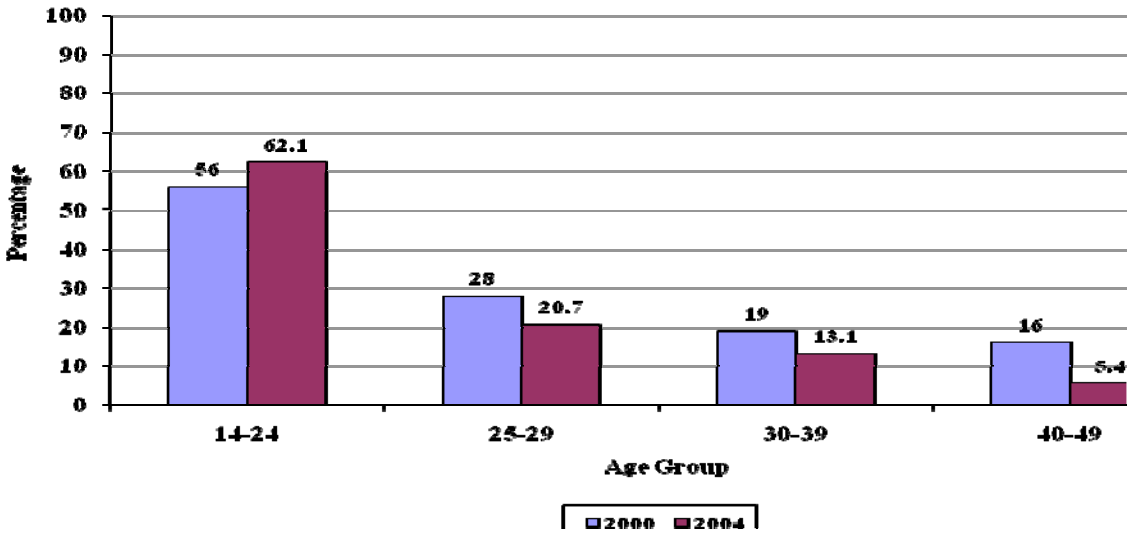


Figure 5.9 above shows that 94.8% of the sexually active males aged 15-19 reported having higher risk sexual intercourse in the past 12 months and this decreased to 45.4% among the 20-

24 year olds, 20.7% among the 25-29 year olds, 13.1% among 30-39 and then 5.4% among those aged 40-49 year old. The corresponding proportions for the females were 27.5%, 7.9%, 5.4%, 4.8% and 3.3%, respectively. Figure 5.9 generally shows that as one gets older, the less likely is that person to be engaged in higher risk sexual intercourse. Figure 5.10 below shows the proportion of males who reported having higher risk sex in 2000 and 2004 by age group[31]:

Figure 5.10: Percentage of men who reported having higher risk sex in the past 12 months

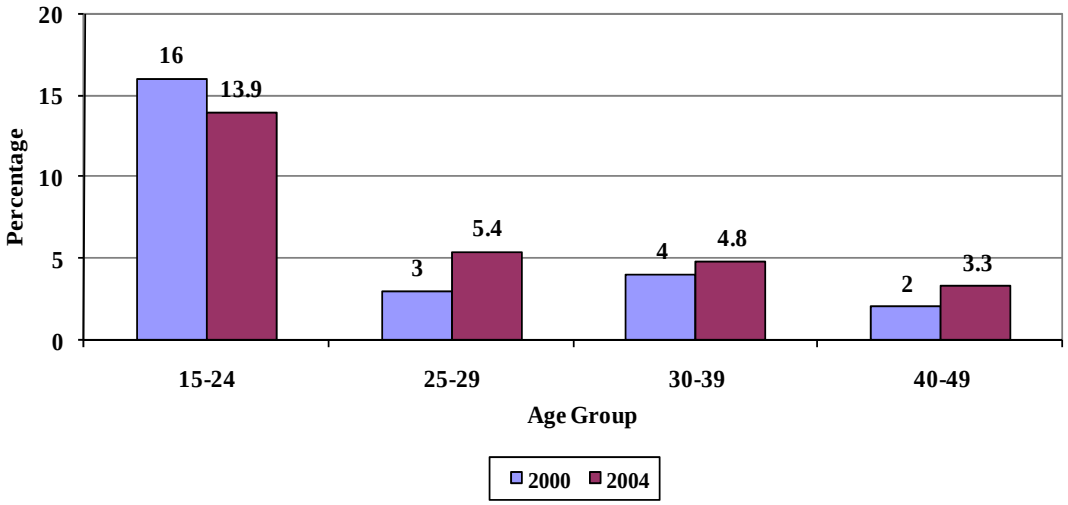


It is evident from Figure 5.10 that in 2000, 56% of the males aged 15-24 reported having higher risk sexual intercourse and this rose to 62.1% in 2004. For older age groups, however, decreases were observed as can be seen from Figure 5.10 above. For example, among the 25-29 year olds 28% reported having higher risk sex in 2000 and this decreased to 20.7% in 2004 while among the 30-39 year olds it decreased from 19% to 13.1% and for the 40-49 year olds it decreased from 16% to 5.4%. In 2004, 34.5% of the men in urban areas reported having higher risk sexual intercourse compared to 23.6% among the rural residents. At regional level, the Southern Region had the highest proportion of male respondents who reported having higher risk sex at 28% and this was followed by the Northern Region at 26% and then the Central Region at 24%.

Figure 5.11 below shows the proportion of females who reported having higher risk sexual intercourse in 2000 and 2004:

[31] Office of the President and Cabinet. (2005). *Malawi HIV and AIDS Monitoring and Evaluation Report 2005.* Lilongwe: Office of the President and Cabinet.

Figure 5.11: Percentage of females who reported having higher risk sex in the past 12 months



Among females it can be observed that in 2000, 16.0% of those aged 15-24 reported having higher risk sexual intercourse and this decreased to 13.9% in 2004. For all the other age groups, it seems that there was a slight increase in the proportion of female respondents who reported having had high-risk sexual intercourse: For the 25-29 year olds, this increased from 3.0% in 2000 to 5.4% in 2004, for the 30-39 year olds it slightly increased from 4.0% to 4.8% while for the 40-49 year olds it increased from 2.0% to 3.3%. At regional level, in 2004 the southern at 10.4%, had the highest proportion of female respondents who reported having had high-risk sexual intercourse and this was followed by the northern region at 7.0% and the central region at 6.2%[32].

5.1.10 Percentage of Sexually Most Active Population Using Condoms at Last High-risk Sex (sex with a non-cohabiting or non-regular partner)

Condoms are used for contraception and for protection against HIV and other STIs. Even though the proportion of people using condoms has been rising, the problem has been consistent condom use. In 1996, 3.5% of the women reported that they used a condom with a spouse the last time they had sex while 19.6% used it with a non-spouse. Among men, the corresponding proportions were 8.7% and 37.5%, respectively. In 2000, 2.5% of the women reported having used a condom with a cohabiting partner and 28.7% with a non-cohabiting partner the last time they had sex. The corresponding figures for males were 5.9% and 38%, respectively.

In the 2004 DHS, women and men who reported having had sex in the 12 months preceding the survey were asked whether they had used condoms the last time they had sexual intercourse. The study has shown that, overall, 47.1% and 30.1% of the male and female respondents reported having used condoms the last time they had sex with a non-regular partner. In 2006 57.2% of the males and 37.5% of the females reported using a condom the last time they had sexual intercourse as can be seen from table 5.7 below:

[32] National Statistical Office. (2004). *Demographic and Health Survey*. Zomba: National Statistical Office.

Table 5.7: Percentage of Sexually Active population using condoms at last high-risk sex (sex with non-cohabiting or non-regular partner)

	MDHS 2000	MDHS 2004	MICS 2006
Male	38.9	47.1	57.2
Female	28.7	30.1	37.5
Rural Male	36.0	43.5	55.7
Female	23.4	24.8	34.6
Urban Male	49.7	57.2	63.3
Female	44.3	43.7	44.9
Young people (15-24)			
Young people (15-24) Male			57.5
Young people (15-24) Female			39.5

It is evident from Table 5.7 that condom use during sexual intercourse has increased considerably over the years. Among rural residents, it can be seen that 36.0% of the males reported using condoms at last high-risk sex and this increased to 43.5% in 2004 and then 55.7% in 2006. The corresponding proportions among females in rural areas were 23.4%, 24.8% and 34.6% in 2000, 2004 and 2006, respectively. Among urban males, 49.7% reported using condoms at last high-risk sex in 2000 and this increased to 57.2% in 2004 and then 63.3% in 2006. The corresponding proportions among females were 44.3%, 43.7% and 44.9%. It is evident that while condom use among females in rural areas has increased considerably, condom use for urban women, though higher, has remained static over the last 6 years. The universal access target for the percentage of sexually active population using condoms at last high-risk sex for 2010 is 60% among males and 40% among females. The results, especially from the 2006 MICS, show that condom use at last high-risk sex has increased significantly and the country seems to be on course to achieve the 2010 targets. If we look at condom use among the 15-24 year old, it can be seen from Table 5.8 that, overall, 57.5% of the males and 39.5% of the females in this age group reported having used condoms at last high-risk sexual intercourse. While condom use has increased significantly, correct and consistent condom use needs to be promoted every time one has high-risk sexual intercourse.

Figure 5.12 below shows the proportion of male respondents who reported using condoms at last high-risk sex by age group:

Figure 5.12: Percentage of males who reportusing condoms during higher risk sex in the past 12 months

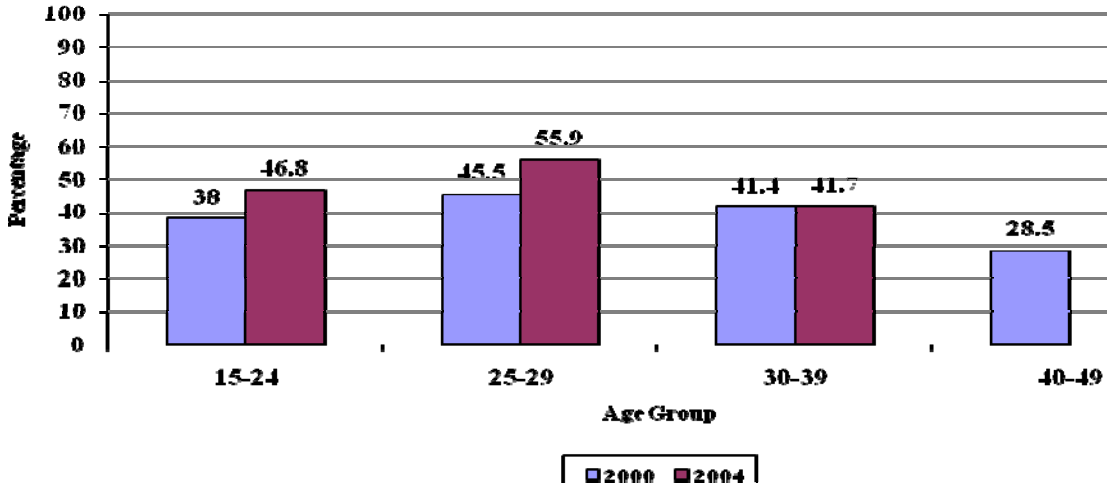


Figure 5.12 shows that the proportion of males using condoms increased over the period 2000-2004. In both years condom use increased from the 15-25 year old age group to the 25-29 age group and then started decreasing. Condom use seems to be highest among the 25-29 year old age group and lowest among those aged 40-49. Similar trends were also observed among females as shown in Figure 5.13, although condom use was highest among the 15-24 year olds and declined with increase in age for both 2000 and 2004.

Figure 5.13: Percentage of females who reported using condoms at higher risk sex in the past 12 months by age group

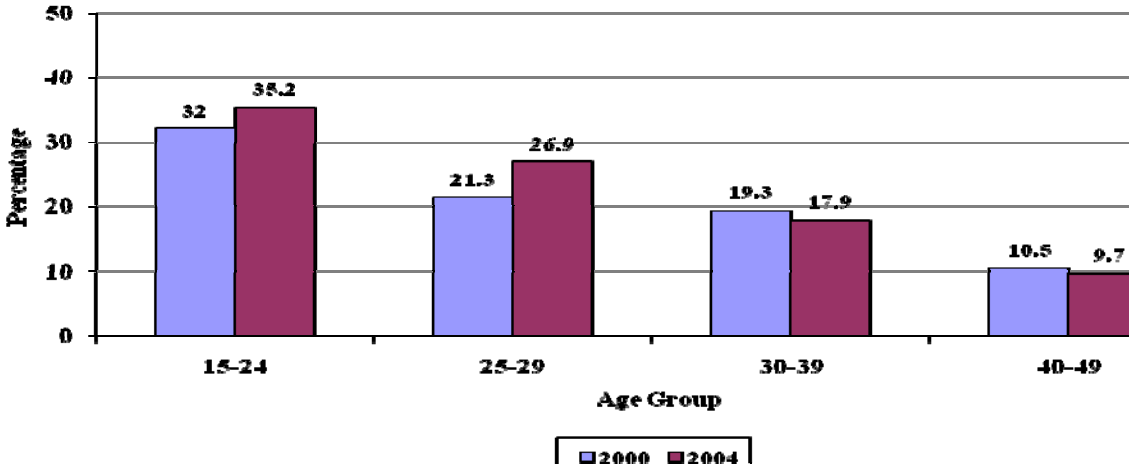


Figure 5.13 above shows that condom use among the 15-24 and 25-29 year olds increased over the period 2000-2004. For the other age groups there was a slight decline in condom use at last high-risk sex.

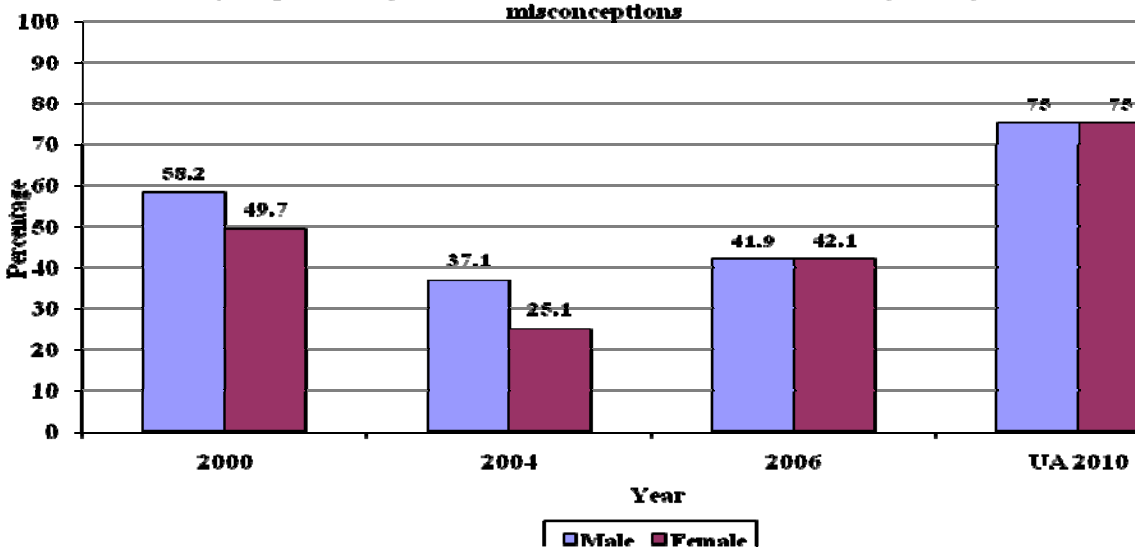
A number of conclusions can, therefore, be made. Significantly, more males than females are using condoms and that urban residents are more likely to use condoms than their rural counterparts. Even though condom use has increased significantly over the years, it is still considered low. The universal access targets for 2007 are that 60% of the males and 40% of the

females should use condoms when having higher risk sex. These targets have nearly been reached especially when we examine the results from MICS. The Universal Access targets set early in 2006 for 2008 are 55% among males and 35% among females and these would increase to 60% among males and 40% among females in 2010. These targets are therefore likely to be achieved.

5.1.11. Percentage of Young People Aged 15-24 Who Both Correctly Identify Ways of Preventing the Sexual Transmission of HIV and Who Reject Major Misconceptions About HIV

With the comprehensive HIV and AIDS awareness campaigns that have been going on in Malawi since the start of the HIV and AIDS epidemic in 1985, as of now, almost everyone has heard about the epidemic. It seems, therefore, that knowledge about AIDS is almost universal. While this is the case, findings from nationwide surveys are increasingly showing that comprehensive knowledge is, however, low[33]: Overall, in 2000 58.2% of the men aged 15-49 years and 49.7% of the females aged 15-49 years had a comprehensive knowledge of AIDS[34]. Among young people aged 15-24, the 2004 DHS reports that 37.1% of the males and 25.1% of the females both correctly identified ways of preventing the sexual transmission of HIV and also rejected major misconceptions about HIV transmission as can be seen from Figure 5.14 below:

Figure 5.14: Percentage of people aged 15-24 year old who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions



As it can be seen Figure 5.14, there was a significant drop in comprehensive knowledge levels for both men and women in 2004 compared to figures in 2000. The MICS, however, shows that in 2006 comprehensive knowledge increased again but not to the same levels as found in 2000. The increase was much higher in women than men. The universal access target for this indicator for 2010 is 75% among both men and women. While comprehensive knowledge is low, it can be seen from Figure 5.14 that there is some progress being made towards achieving the 2010 75%

[33] Respondents with comprehensive knowledge about AIDS say that use of condom for every sexual intercourse and having just one uninfected and faithful partner can reduce the chance of getting HIV and they also say that a health looking person can have the AIDS virus and they also reject the two most common local misconceptions.

[34] National Statistical Office. (2005). *Demographic and Health Survey*. Zomba: National Statistical Office.

target for men and women. Table 5.8 below shows the percentage of young men and women aged 15-24 who report having comprehensive knowledge about HIV and AIDS by urban/rural residence:

Table 5.8: Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV

	MDHS 2000	MDHS 2004	MICS 2006
Rural Male	57.9	34.1	41.1
Female	47.7	23.6	38.7
Urban Male	59.4	48.0	45.8
Female	58.7	31.2	56.3

It can be seen from Table 5.8 above that for those resident in rural areas, more males had comprehensive knowledge about HIV and AIDS compared to females. Among urban residents however, in 2000 there were no differences between men and women while in 2004 there were more males who had comprehensive knowledge than females. The situation however, was different in 2006 as more urban women reported having comprehensive knowledge compared to males.

5.1.12. Median Age at First Sex Among 15-24 Year Olds

As a way of preventing HIV/STI infection and unwanted pregnancies among young people, it is important to raise the age at first sex. The delay of sexual debut among young people results into the postponement of the first time when they may be exposed to HIV. The results of the 2000 and 2004 Demographic and Health Surveys generally show that there has been an increase in the median age at first sex in the age group 20-24 and these vary by sex, region and area of residence. Among males aged 20-24, the median age at first sex increased from 17.7 years in 2000 to 18.1 years in 2004 while the corresponding figures for females of the same age group were 17.1 years and 17.4 years, respectively. In terms of urban and rural areas, the median age at first sexual intercourse among those aged 20-24 years in 2000 was 17.8 years in urban areas and 17.6 years in rural areas.

Young Malawians seem to be starting sex later, which is an important HIV prevention strategy. It might, however, be difficult to raise the age at first sex much more for girls since the median age of marriage for girls is around these years as well. A number of studies including the demographic and health surveys have generally shown that most young Malawians initiate sex at young ages – even before the age of 15 years[35]. While, previously, the emphasis has been on looking at age at first sex among 20-24 years old, the UNGASS indicator looks at the age group 15-24. Table 5.9 below shows the median age at first sex among the 15-24 year olds:

[35] Munthali, A., Chimbiri, A. and Zulu, E. (2004). *Adolescent Sexual and Reproductive Health in Malawi: A Synthesis of Research Evidence*. Protecting the Next Generation, Occasional Report No.15. New York: Allan Guttmacher Institute.

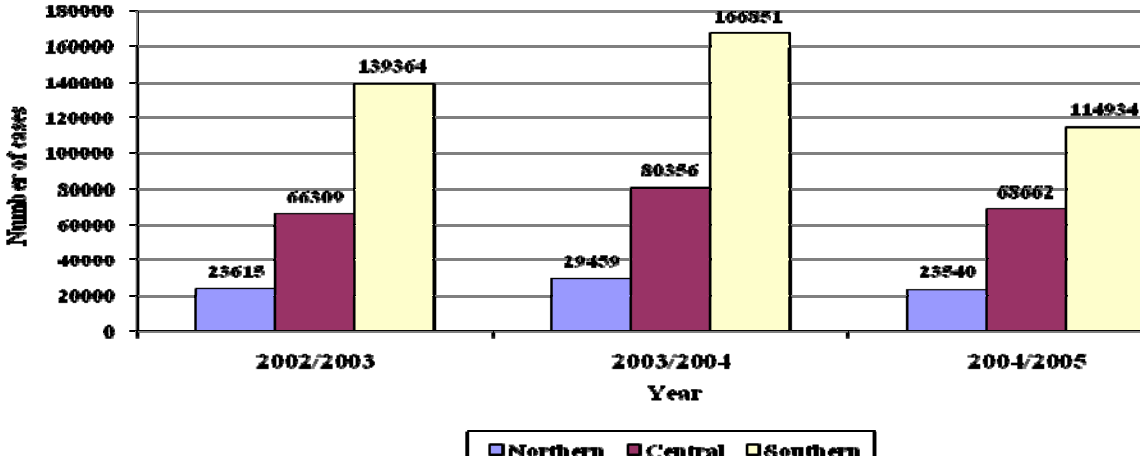
Table 5.9: Median age at first sex among 15-24 years old			
	MDHS 2000	MDHS 2004	MICS 2006
Male	15.0	17.0	16.0
Female	16.0	16.0	16.0
Rural Male	15.0	16.0	16.0
Female	16.0	16.0	16.0
Urban Male	16.0	17.0	16.0
Female	16.0	16.0	16.0

It can be seen from Table 5.9 that the median age at first sex for the 15-24 year olds was at 15 years for males and 16 for females in 2000. For females, this has remained at 16 years for the years 2004 and 2006. For males, the median age at first sex for the 15-24 year olds increased to 17 years in 2004 and then decreased to 16 years in 2006. The median age at first sex for females remained at 16 years for these years in both urban and rural areas. For rural males, the median age at first sex increased slightly from 15 in 2000 to 16 in 2004 and 2006. For urban males it increased from 16 years in 2000 to 17 years in 2004 and then decreased to 16 years again in 2006. One conclusion that can be drawn from this data is that for the period 2000-2006 there has been no change in median age at first sex among the 15-24 year olds.

5.1.13 Percentage of Patients With Sexually Transmitted Infections Who are Diagnosed, Treated and Counseled at Health Facilities According to National Guidelines

Studies have generally shown that STIs pose as a risk for HIV infection. As a preventive measure for HIV infection, the Ministry of Health promotes the timely treatment of STIs. The Ministry of Health, through the Health Management Information System (HMIS), collects data on STI diagnosis, treatment and counseling from all the health facilities in Malawi. At national level, 229,278 cases of STIs were recorded in the 2002/2003 and this number increased to 276,666 in 2003/2004 and in 2004/2005 this decreased to 207,136. Figure 5.15 below shows these national figures disaggregated by region[36]:

Figure 5.15: Number of patients with STIs who are diagnosed, treated and counselled at health care facilities according to national guidelines



[36] The figures on STI cases are for a financial year for example July 2002/June 2003.

The Southern Region had the highest number of STI cases reported in health facilities and this was followed by the central region and the northern region was the last. Overall, it is also apparent that, as was the case at national level, in each region the number of STI cases increased from 2002/2003 to 2003/2004 and then decreased during the year 2004/2005.

This indicator requires that these figures should be reported in percentages. However, data is not available in order to present these as percentages. If we assume that all STI cases are treated according to national standards then we can use HMIS figures on numbers of STIs treated. The figures indicated above are for the number of STI cases treated at national level as well as regional level. There is need for further consultation on this indicator in order to strategise on how best this information can be collected in future. The figures for 2005/2006 are not yet available.

5.1.14 Percentage of OVC Whose Households Receive Basic Package of Care in Caring for Child

The death of young men and women who are economically productive leaves behind orphans and the elderly who in most cases cannot fend for themselves. While orphanhood is not a new phenomenon, the major issue with the current state of affairs is the huge magnitude of this problem in Malawi and other Sub-Saharan African countries. The extended family system is the major coping strategy that has been used to address the needs of orphans and other vulnerable children. This system, however, is overburdened and in major ways failing to cater for the needs of orphaned children largely because of the high prevalence of poverty among Malawian households. Hence, it is important to ensure that the needs of children are adequately catered for. In 2005, the Global Fund approved Malawi's OVC proposal whose overall goal is to reach 1 million orphans and other vulnerable children by 2011 through the improvement of the efficiency, effectiveness and quality of the OVC response at all levels. This proposal will ensure that districts and communities have effective systems and mechanisms for responding to the OVC crisis.

It is therefore, important to monitor the proportion of households keeping orphans and other vulnerable children who are supported. Table 5.10 shows the number and percentage of individual OVCs that were supported with impact mitigation interventions over the period 2003-2007:

Table 5.10: Number and percentage of OVCs supported with impact mitigation interventions

Fiscal Year	Background Characteristics			
	Estimated # of OVCs (Baseline)[37]	Target # of OVCs	# of OVCs Supported	% OVCs Supported
2003/04	880,588	100,000	120,037	13.63
2004/05	908,201	-	179,886	19.81
2005/06	939,388	120,000	358,084	38.12
2006/07	1,100,000	450,000	585,945	53.27

[37] These are based on sentinel estimates.

It can be seen from Table 5.10 that the number of OVC has been increasing over the period 2003-2007. In 2003/2004 there were an estimated 880,588 OVC in Malawi and this increased to 908,201 in 2004/05, 939,388 in 2005.06 and then 1,100,000 in 2006/07. It can also be seen that the number of OVC supported has also been increasing and as of 2006/07 53.3% of all OVC were supported with impact mitigation interventions.

The Multiple Indicator Cluster Survey conducted in 2006 defines orphans as children within the age range of 0-17 years. This study reports that the level and types of support provided to households caring for children orphaned and vulnerable due to AIDS varied with area of residence as can be seen from Table 5.11 below:

Table 5.11: **Percentage of children aged 0-17 years orphaned or made vulnerable due to AIDS whose households receive free basic external support in caring for child, Malawi, 2006**[38]

Background Characteristics	Medical support (in last 12 months)	Emotional and psychosocial support (in last 3 months)	Social/ material support (in last 3 months)	Educational support (in last 12 months)	Any support	All types of support	No support at all
Malawi							
Total	5.5	4.0	8.8	5.8	18.5	0.2	81.5
Urban	4.0	6.1	11.2	4.4	17.9	0.6	82.1
Rural	5.7	3.7	8.4	6.0	18.6	0.1	81.4
Region							
Northern	2.6	1.8	4.3	3.2	8.7	0.3	91.3
Central	6.2	6.7	12.8	4.4	23.1	0.2	76.9
Southern	5.5	2.8	7.1	7.1	17.2	0.2	82.8

It can be seen from Table 5.11 that overall, social and material support is the one which is mostly given to orphaned children and those made vulnerable due to HIV/AIDS. It does not include children made vulnerable due to other factors. There are also variations according to residence with the rural areas getting slightly more support (18.6%) than urban areas (17.9%). The Central Region also registered more support (23.1%) and was seconded by the southern region at 17.2% and then the northern region at 8.7%.

Generally, considerable achievements have been made to create an enabling atmosphere for rapidly scaling up the response to the plight of orphans and other vulnerable children (OVC) in Malawi, currently estimated at over 1 million. The country developed a National Policy on OVC, which was launched in 2004. The Policy focuses on provision of care and support to orphans and other vulnerable children[39]. These were mainly psychosocial, nutritional and financial impact mitigation interventions implemented by NAC and its partner organizations. There is still

[38] These results are based on further analysis of MICS data of 2006 collected by the National Statistical Office.
[39] National AIDS Commission (2006). *An Overview on HIV&AIDS Response in Malawi.* Lilongwe: NAC.

more work to be done since the number of orphans is increasing every year as a consequence of high adult mortality rates mainly because of HIV and AIDS related infections in Malawi.

5.1.15 Ratio of Proportion of School Attendance Among Orphans to Proportion of Attendance Among Non-orphans Aged the 10-14 year

The aim behind the abolition of the payment of school fees in primary school in 1994 was to increase enrolment as school fees was perceived as a major deterrent to pupils accessing education. Even where school fees is available, still more children can drop out of school because of other reasons such as famine, long distances to school and lack of school materials[40]. OVC are particularly vulnerable; hence the need to monitor their school enrolment, attendance and performance. The 2004 DHS showed that 90.2% of the children with both parents alive were in school while 87.4% of the orphans with both parents dead were in school. There were no major differences between orphaned and non-orphaned boys and girls. In 2000 the ratio of school attendance among orphans to non-orphans among the 10-14 year olds was estimated at 0.94 and this figure, according to the 2004 DHS, increased to 0.97 in 2004. Table 5.12 below shows proportion of school attendance among orphans to proportion of attendance among non-orphans aged 10-14 in 2006:

Table 5.12: Ratio of proportion of school attendance among orphans to proportion of attendance among MICS 2006	
Male	0.96
Female	1.00
Rural	0.98
Urban	0.97
Maternal Orphans	0.98
Paternal Orphans	0.97
Double Orphans	0.98

As was the case with the DHS, the MICS results in Table 5.12 above shows that there is no major difference between male and female orphans and type of orphan (maternal, paternal, double orphans) and type of residence (rural/urban) in terms of attending school. The introduction of free primary education is the major reason why there is very little disparity between the 10-14 year old orphaned and non-orphaned children. While this is the case, further analysis of the 2004 DHS shows that the ratio of double orphans to single orphans aged 10-14 currently attending school is at 0.67. It can therefore, be concluded that while there are no differences in the proportion of orphaned and non-orphaned children attending school in Malawi there is a huge difference between double orphaned and single orphaned children attending school.

5.1.16 Percentage of Persons Discussing HIV and AIDS with Spouse or Partner

It is important that spouses or partners should discuss HIV and AIDS issues. In both the 2000 and 2004 DHS respondents were asked if they had ever talked about ways to prevent getting the virus that causes AIDS with their spouses or partners they lived with. Table 5.13 below

[40] Munthali, A. (2003). *The Impact of Hunger on Child Labour: A Case Study of Malawi.* Geneva: International Labour Organisation.

shows the percentage of persons who discussed HIV and AIDS issues with their spouses or partners:

Table 5.13: Percent of persons discussing HIV and AIDS with spouse or Partner

	MDHS 2000	MDHS 2004
Male	85.8	87.0
Female	72.3	70.0
Rural Male	85.8	76.4
Female	70.9	69.9
Urban Male	85.6	90.2
Female	80.5	70.5

Table 5.13 shows that in 2000, 85.8% of the males reported discussing HIV and AIDS with their spouses or partners and this slightly increased to 87.0% in 2004. In 2000 72.3% of the females reported discussing HIV and AIDS with their partners or spouses and this decreased to 70.0% in 2004. Among rural males the proportion that reported discussing HIV and AIDS was at 85.8% in 2000 and this decreased to 76.4% in 2004. Among females in rural areas, there was no major change as 70%-71% of the respondents reported this. Among urban males it can be seen that there was an increase in the proportion of men who reported discussing HIV and AIDS with spouses/partners from 85.6% in 2000 to 90.2% in 2004 while there was a decrease in the proportion of women who reported this from 80.5% in 2000 to 70.5% in 2004. It can be concluded that while the majority of the people discuss HIV and AIDS, this is especially more reported among males and urban residents than females and rural areas, respectively.

5.1.17 Percentage of People Expressing Accepting Attitudes Towards PLHIV

In the DHS and MICS, respondents were asked whether they would be willing to take orphaned children of a relative who died of AIDS, whether they would be willing to buy vegetables from a vendor who has HIV, whether they believe a female teacher who has HIV should be allowed to continue to teach and, lastly, whether they would want the HIV+ status of a family member to remain secret. Table 5.14 below shows the proportion of people expressing accepting attitudes towards PLHIV:

Table 5.14: Percent of population expressing accepting attitudes towards PLHIV

	MDHS 2000	MDHS 2004	MICS 2006
Male	46.2	29.7	44.3
Female	36.8	30.8	20.3
Rural Male	43.3	30.5	41.8
Female	35.3	30.1	19.6
Urban Male	59.0	27.6	54.8
Female	45.0	34.3	23.6

It can be seen from Table 5.14 that in 2000 46.2% of the males expressed accepting attitudes towards PLHIV and this decreased to 29.7% in 2004 and then increased to 44.3% in 2006. Among females it has been decreasing: in 2000 it was 36.8% and this decreased to 30.8% in 2004 and then 20.3% in 2006. This trend is also observed among both rural and urban females as can be seen above. Among rural males 43.3% expressed accepting attitudes towards PLHIV and this decreased to 30.5% in 2004 and then increased to 41.8% in 2006. The corresponding proportions among urban males were 59.0%, 27.6% and 54.8%, respectively. The 2010 universal access targets for this indicator are 75% among both males and females. These results from the 2006 MICS show that stigma and discrimination against PLHIV still exists and Malawi has to work hard to achieve the 2010 targets. Generally, it can be observed that males had more accepting attitudes than females throughout the years and urban residents also had more accepting attitudes than rural residents.

5.1.8 Number of Young People Aged 15 - 24 Exposed to Life-skills-based HIV and AIDS Education (by gender, district and whether they are in-school or out-of-school youth)

Life skills have been defined as abilities for adaptive and positive behaviours that enable individuals to effectively deal with demands and challenges of everyday life[41] and can either be part of formal school curricula or not. In 1998 with support from UNICEF, life skills education was introduced into school curricula on a pilot scale and only in Standard 4. There were two major reasons for choosing this grade: the first was that sexual and reproductive health issues at the time were mainly taught in upper classes hence younger people were not exposed to these issues and, secondly, most pupils dropped out of school at Standard 4 hence it was important that these children should be reached and taught life skills in an attempt to retain them in school[42]. After successful piloting a major recommendation was made and by 2005 the teaching of life skills was extended to all classes in primary school, secondary school and teacher training colleges.

In terms of enrolment, Malawi has seen an increase in the number of pupils enrolled in both primary and secondary school. While there were nearly 2 million pupils enrolled in primary school before 1994, the introduction of free primary school education has seen more than 3 million enrolled in primary schools in Malawi. In 2006 there were nearly 220,000 students enrolled in secondary schools in Malawi (Ministry of education, 2004, 2005 and 2006). While there are problems in terms of teaching life skills education, it can be seen that every year over 3 million primary school pupils and 200,000 secondary school students can potentially be reached with life skills education. This would ensure that these young people are adequately equipped with knowledge and skills to deal with everyday life challenges, which is the major tenet of this approach. Evaluations have revealed however, that even though life skills education has been tabled, this subject is not always taught because of the failure of the teachers to teach sexual and reproductive health issues to children due to cultural reasons and because teachers concentrate on subjects which are examinable. Since the introduction of life skills education, this subject was not examinable hence given very little attention. Government has now made life

[41] Ministry of Education, Sports and Culture. (1998). *Life Skills Education Project – Standard 4.* Domasi: Malawi Institute of Education.

[42] Kasambara, J.C. (2006). *Introduction to Life Skills:* Unpublished Paper [Presented at an Orientation Workshop of Primary School Education Advisors of the South East Education Division on Life Skills, Sexual and Reproductive Health Education, Content and Methodology]

skills examinable hence this will ensure that all the pupils in both primary and secondary school are exposed to life skills education. An independent review team reported, for the year 2006/7, that a total of 5 million young people were exposed to LSE (3.2 million primary, 1.5 million secondary, 3,986 with disabilities, 59,536 Out -of-school youths)[43]. With making life skills education examinable, all the pupils in secondary and primary schools will be reached.

5.2 Monitoring Program Inputs and Outputs

5.2.1 Number of Information, Education and Behaviour Change Communication Materials Disseminated to End Users

One of the most important prerequisites for reducing the rate of HIV infection is accurate knowledge of how HIV is transmitted and strategies for preventing transmission. Correct information is the first step towards raising awareness and giving people the tools to protect them from infection[44]. Table 5.15 below shows the number of radio and television programmes over the period 2004/5-2006/7:

Table 5.15: Number of Media HIV and AIDS radio and television programmes produced and number of hours aired, 2004/05-2006/07

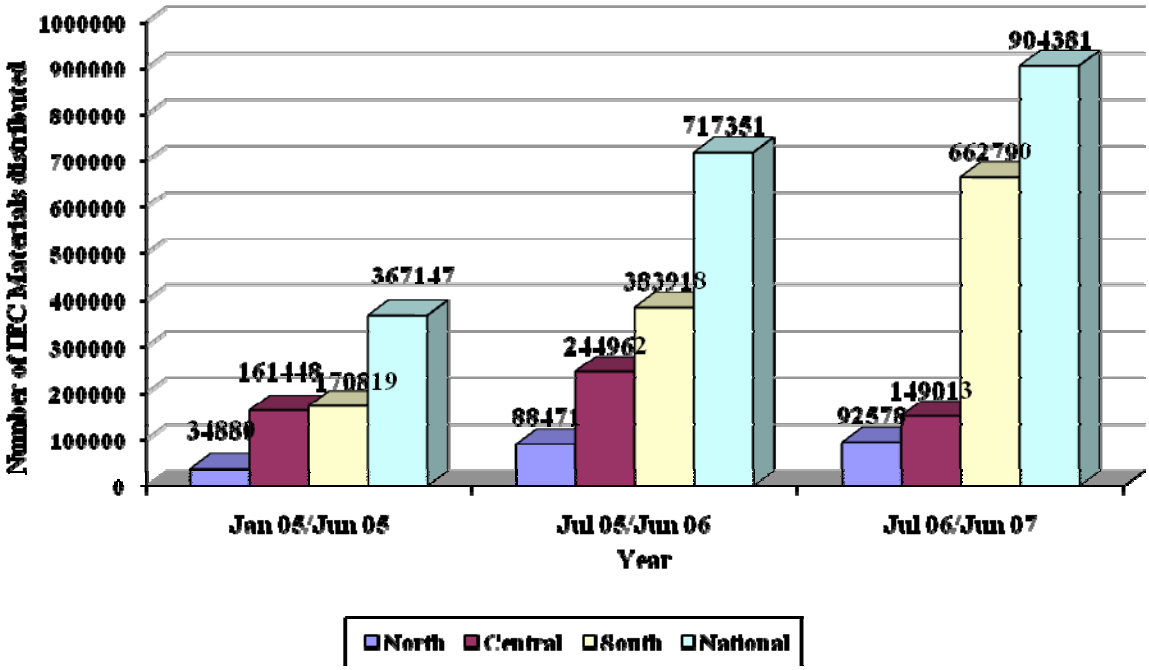
Year	Radio		Television		Total	
	# of Programmes produced	# Hours aired	# of Programmes produced	# Hours aired	# of Programmes produced	# Hours aired
2004/05	365	297.3	36	245.2	**401**	**542.5**
2005/06	1977	27.0	142	15.2	**2119**	**42.2**
2006/07	1633	1528.4	631	750.0	**2264**	**2278.2**
Total	**3975**	**1852.7**	**809**	**1010.4**	**4784**	**2862.9**

Both television and radio programmes have increased significantly since the 2004/05 fiscal year as can be seen from Table 5.15 above. This has been done in order to raise awareness among Malawians about the HIV and AIDS epidemic. However, the total number of hours aired during 2005/06 fiscal year was low and did not correspond to the total number of programmes produced. This could have been due to under reporting. The increase in the number of programmes produced and hours aired of about 91% and 81%, respectively, between 2004/05 and 2006/07 was probably because of the establishment of several community radio stations and other media houses, besides the scaling-up of behaviour change interventions by both NAC and its partners. The programmes ranged from 15 to 45 minutes and covered thematic issues on HIV and AIDS such as stigma and discrimination, gender, HIV prevention, care and support and grant facility.

[43] Health Research for Action. (2007). *Malawi National AIDS Program – Independent Multi-Disciplinary Review Team – Report for the period July 2006-June 2007.* Submitted to National AIDS Commission.
[44] National Statistical Office. (2006). *Multiple Indicator Cluster Survey.* Zomba: National Statistical Office.

The Malawi HIV and AIDS Monitoring and Evaluation Report of 2005/06 fiscal year revealed that the radio was by far the most common source of HIV and AIDS information in Malawi, both in rural and urban areas. The results also revealed that the second most common source of information was the print media (magazines/newsletters/newspapers), and television being third. It was not surprising, therefore, that more airtime was spent on radio programmes than on television programmes since 2004 (Table 5.16). Therefore, for television and radio programmes to be implemented continuously so that more people are reached with HIV and AIDS messages, there is need for proper planning and preparations on scripts and other logistics. It is also necessary that a thorough review on all television and radio HIV and AIDS messages, advertisements, slots, jingles and plays should be carried out in order to determine the effectiveness of these programmes. Appendix 1 shows the number of IEC materials on HIV and AIDS issues, which were distributed between January 2005 and July 2007 by NAC and its Partners (MACOHA, Goal Malawi, MANET+, MSF Greece, MBCA, AYISE, MALGA, MOH (HEU), Baptist Mission, Department of Nutrition and HIV and AIDS, PSI, JAAIDS, MOI, NYCOM, MANASO, SAT, Concern Universal, ECM and CHRR). Figure 5.16 below shows distribution of IEC materials by region:

Figure 5.16: Number of IEC distributed 2005-2007



Overall, the number of IEC materials distributed in each region has been increasing over the period under review. At national level, 367,147 materials were distributed over the period January 2005-June 2005 and this increased to 717,351 in July 2005-June 2006 and then 904,381 over the period July 2006-June 2007. A total of 1,988,879 IEC materials were distributed over the period between January 2005 and June 2007. The share of these IEC materials was also proportionally distributed among the three regions of the country as shown in Figure 5.16 with the Southern Region getting a bigger share of about 73%.

Generally, the number of IEC materials distributed increased significantly (49%) between 2005 and 2006 by almost 20% in the last half of 2006 and first half of 2007. This was probably due to the intensification of sensitization and awareness programmes on HIV and AIDS pandemic.

Available information indicates that most of the behaviour change communication materials were distributed by NAC Partners in 2006/07 fiscal year. A significant amount of IEC materials have been disseminated nationwide covering all districts during the period under review.

5.2.2 Number of HIV and AIDS Sensitisation Campaign Meetings Conducted

Press briefings were conducted, among other things, on presentation of radio programmes, research dissemination conferences and presentation of grants to NGOs and CBOs and male circumcision. Public lectures were conducted in all the regions on the role of faith-based organizations in the fight against HIV and AIDS. Partners with funding from NAC did all these sensitization campaign meetings. Table 5.16 below shows the number of sensitisation meetings conducted in 2006/07.

Table 5.16: Number of sensitization meetings

Type of Campaign	Target 2006/07	Achievement 2006/07
Press Briefings	0	11
Public Lectures	6	3
Media Tours	4	0

As it can be observed from Table 5.16 above, a total of 11 press briefings and 3 public lectures were conducted over this period and these press briefings were done by partners. Coverage of issues on HIV and AIDS with the involvement of the media at different functions was done throughout the country.

On another note, the Centre for Human Rights and Rehabilitation in Malawi was engaged to conduct community sensitization campaigns in all cities and some districts. The organization also conducted sensitization meetings on stigma and discrimination with PLHIV organizations and support groups including the umbrella bodies, NAPHAM and MANET+ in 2005/06 fiscal year. However, data was not readily available for inclusion in this report. NAC and partners will therefore increase the number of sensitization campaign meetings, especially in areas that are deemed risky.

5.2.3 Number of Peer Educators Trained/Retrained in the year

Table 5.17 below shows the number of peer educators trained in some selected institutions where some data was available.

Table 5.17: Peer educators trained/retrained in the year

Source	2006/07 Target			2006/07 Achievement		
	Male	Female	Totals	Male	Female	Totals
MOH	37	8	45	37	8	45
Min. of Labour	69	53	122	69	53	122
NYCOM	300	300	600	250	250	500
FPAM	0	0	0	109	119	228
Totals	**406**	**361**	**767**	**356**	**311**	**667**

The peer education programme started in 2006/07 in all the institutions visited. The national figure from Ministry of Labour was 122 (30 in the North, 42 in the Centre and 50 in the South). In the MoH, the peer education programme was only done at Headquarters and will later roll out to the districts. While other partners have implemented this programme, it was relatively new in MoH and the programme was launched during first week of October, 2007. Data for peer educators trained during 2005/06 FY, under the International Labour Organization Workplace Programme in the Ministry of Labour, could not be traced because the Ministry was renamed and some information, particularly that from Vocational Training Colleges, which are now under Ministry of Education, was not readily available. The Ministry was in the process of formulating training programmes for 2007/08 FY under the HIV Mainstreaming Project. The National Youth Council of Malawi (NYCOM) trained 50 peer educators in each of the high-risk districts namely Rumphi, Mzimba, Lilongwe, Dowa, Ntcheu, Mangochi, Mwanza, Chiradzulu, Blantyre and Nsanje. Three hundred additional peer educators have already been trained in Lilongwe, Dowa, Blantyre, Mwanza, Chiradzulu and Ntcheu districts for 2007/08 fiscal year.

Table 5.18 below shows peer educators distributed by district under NYCOM and FPAM:

Table 5.18: Peer Educators distribution per District under NYCOM & FPAM

District	NYCOM	FPAM	Totals
Rumphi	50	0	50
Mzimba	50	0	50
Kasungu	0	20	20
Lilongwe	100	42	142
Dowa	100	116	216
Dedza	0	30	30
Ntcheu	100	20	120
Mangochi	50	0	50
Mwanza	100	0	100
Blantyre	100	0	100
Chiradzulu	100	0	100
Nsanje	50	0	50
Totals	**800**	**228**	**1028**

This Table 5.18 shows that a total of 1028 peer educators were trained by NYCOM and FPAM and distributed in the districts mentioned above. The data provided in this section does not really represent a national picture. Information on peer education is scattered and comes from different sources. Peer education contributes to behavioural change and is a voluntary activity. Most peer

educators lack commitment hence few were active. There are no financial incentives for peer educators apart from when they are attending out-of station workshops. The frequent transfers of staff in Ministries and Government Departments disrupt training programmes. Mechanisms need to be put in place so that data from institutions and organisations involved in the training of peer educators is collected effectively.

5.2.6 Number of Peer Educators Who were Active in the Year

Table 5.19 below shows the number of active peer educators:

Table 5.19: Active peer educators

Source	2006/07 Achievement		
	Male	**Female**	**Totals**
MoH	19	4	23
Min. of Labour	69	53	122
NYCOM	125	125	500
FPAM	66	70	136
Totals	**279**	**252**	**531**

It can be seen from Table 5.19 that only about half the number of peer educators in the MoH Headquarters, NYCOM and FPAM were reported active due to lack of commitment and support. All peer educators in Ministry of Labour were however, active and this was because of continuous financial support from the Ministry.

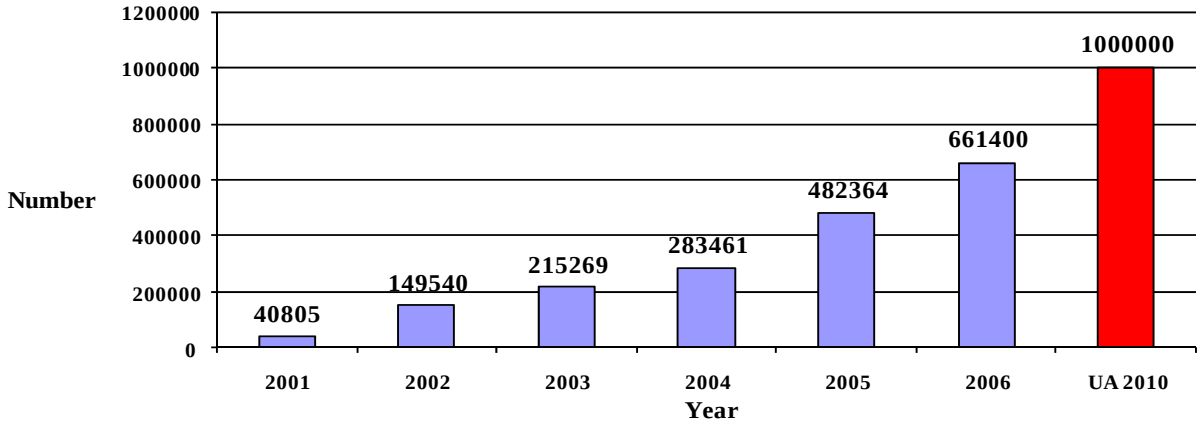
5.2.7 Number and Percentage of Public Sector Condom Distribution Outlets with Condoms in Stock and no Stock-outs of >1 week at Anytime in Last 12 months

There was no information with respect to the number and percentage of public sector condom distribution outlets with condoms in stock and no stock-outs of >1 week at any time in last 12 months. However, according to the Malawi Logistics System Assessment and Stock Status Report (2006), a comparison of 2004 and 2006 assessment results, stock-outs situation for almost all contraceptives, including male condoms, had significantly improved in all hospitals and health centres between 2004 and 2006. The reasons for the stock-outs over the period (6 months), which was assessed, were not due to non-availability at the central level, but due to either non reporting, rationing (whereby facilities were only given one month supply which finished before another delivery occurred), or delays in the delivery of the consignments. It was further reported that condoms were not evenly distributed in the supply chain during the year with some facilities overstocked and others experiencing stock-outs. Nevertheless, it could be safely said that the situation could be much better now in terms of the levels of condom stock-outs and distribution considering the multi-sectoral approach to promoting HIV prevention strategies with condom use being one of the main components.

5.2.8 Number of People Counselled and Tested for HIV, and Receiving Results in the Last 12 months

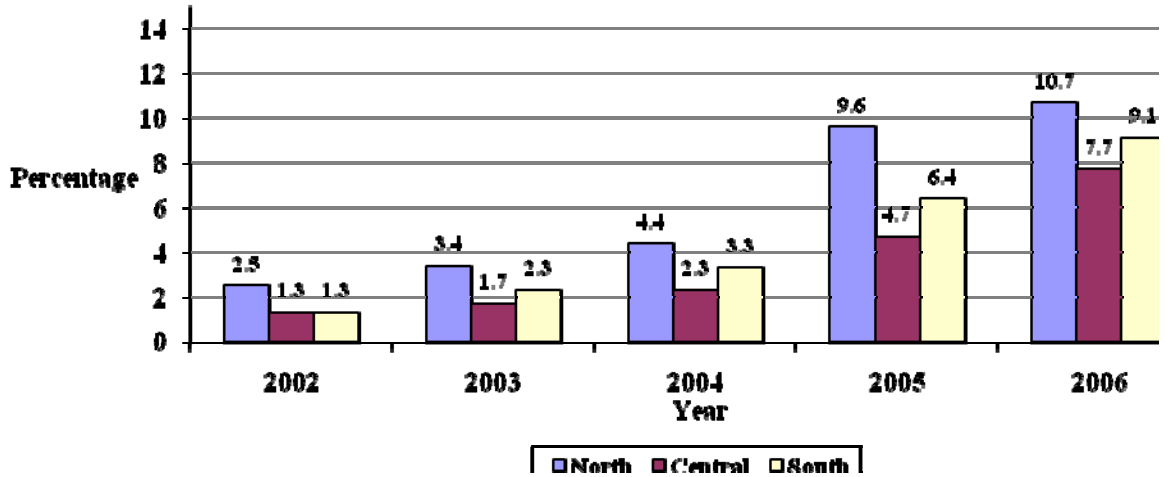
The number of people going for an HIV test has been increasing over the years. Figure 5.17 below shows the number of people who have been counselled and tested for HIV in the last 12 months:

Figure 5.17: Number of people counselled and tested for HIV and receving results in the last 12 months



The trend in testing shows an exponential rise in the number of the sexually active population going for HTC. In 2001 only 40,805 people were counselled and tested for HIV in Malawi and this number rose to 149,540 in 2002, 215,269 in 2003, 283,461 in 2004, 482,364 in 2005 and then 661,400 in 2006. The universal access targets for 2008 and 2010 are 900,000 and 1,000,000 people being counselled and tested for HIV, respectively. The current figures for HTC appear on track to meet the set universal access targets. For 2006, the reported figures represent about 75% of the universal access target for that year. With the introduction of an opt–out policy for PMTCT, the testing figures are expected to increase further and preliminary data for 2007 suggest that the majority of pregnant women are undergoing HTC. Coverage of testing also shows marked regional differences with better coverage in the northern region compared to the southern and central regions as can be seen from Figure 5.18 below:

Figure 5.18: Percentage of people counselled and tested for HIV 2001-2006 by region



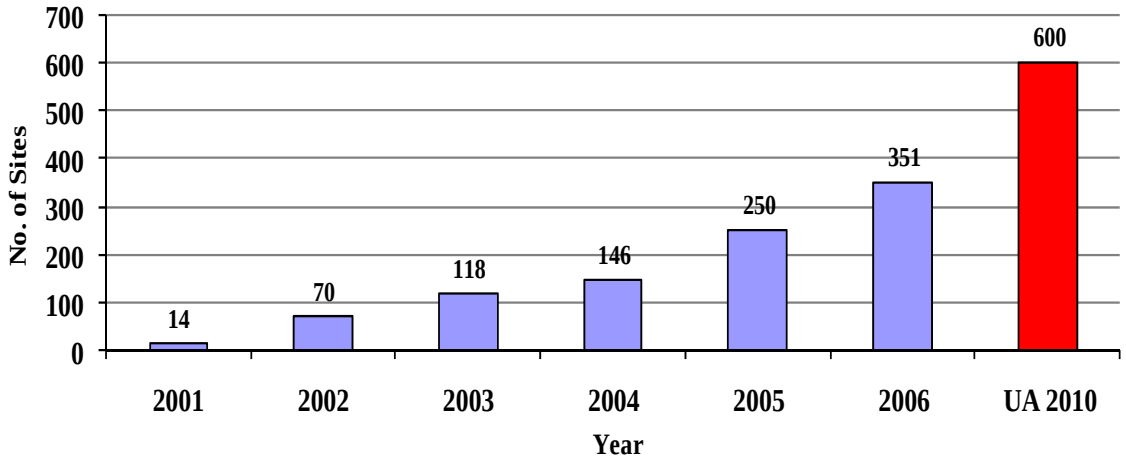
As has been said above it can be observed that the northern region has better HIV testing coverage compared to the other regions and this is despite the fact that the majority of the population and HTC sites are in the central and southern regions and the prevalence of HIV is also high in these regions. The increase in people undergoing HTC is occurring at a faster pace in these two regions compared to the northern region, which is improving at a slower pace. Population based estimates of HTC uptake, though slightly higher, are reasonably comparable to the health facility figures. While there was an initial gender disparity in uptake before 2005, the disparity seems to have been narrowed down by end 2005 when the HTC uptake was estimated at 12% in both males and females. Based on the trend above, strategies to improve uptake of HTC are called for and attention to the regional disparities also warranted. The improvements in uptake have also been attributed to the HTC week, which has been implemented over the past two years.

5.2.9 Number and Percentage of Sites Providing HTC Services

HIV testing and counselling services are offered in Government and CHAM health facilities mostly in integrated sites while the Malawi AIDS Counselling and Resource Organisation (MACRO) offers HTC services in stand-alone sites. These services are offered free of charge in all public health facilities. Over the years, Malawi has seen an increase in the number of people going for HTC services (as discussed above) as well as the number of sites offering these services. If this trend in the increase of sites offering HTC services continues then Malawi will achieve the universal access target, which has been set at 435 facilities by the year 2008[45]. Figure 5.19 below shows the trend in the number of sites offering HTC services in Malawi.

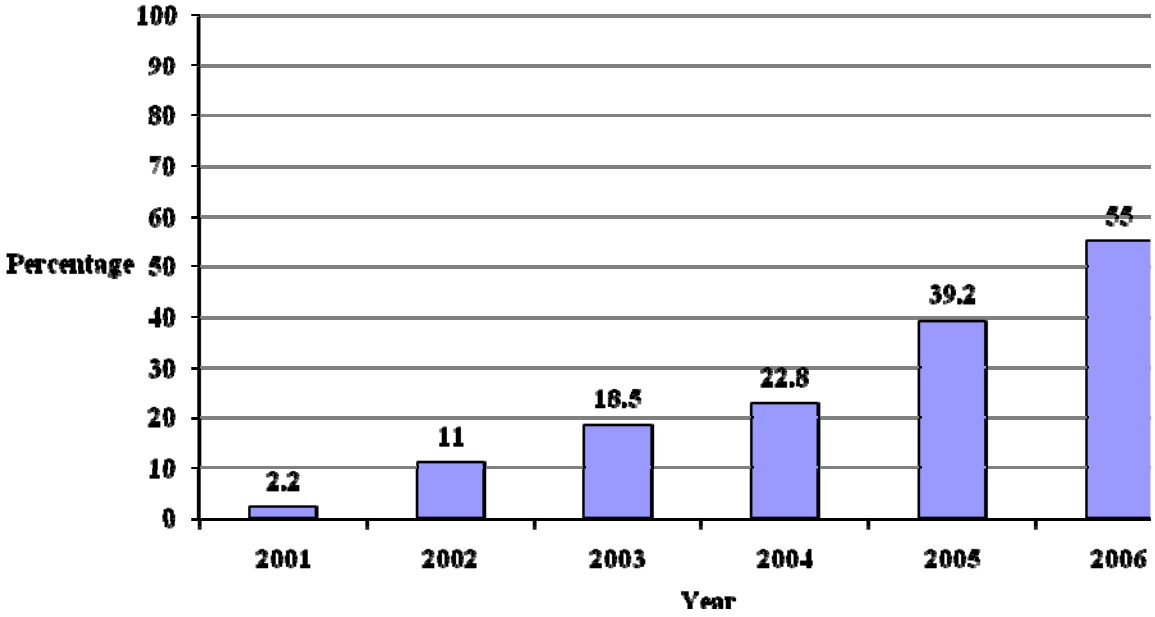
[45] The percentages for national figures are based on estimated 638 health facilities nationally.

Figure 5.19: No. of Sites offering HTC services 2001-2005



As has been said earlier, the number of sites offering HTC services has been increasing: there were only 14 sites in 2001 and then this increased to 70, 118, 146, 250 and 351 in 2002, 2003, 2004, 2005 and 2006, respectively. According to the National AIDS Commission, by 2010, 600 of the 638 facilities providing ANC services should be able to provide HTC services. It might be important, therefore, to look at the proportion of health facilities that also provide HTC services as can be seen in Figure 5.20 below:

Figure 5.20: Percentage of health facilities providing HTC services



It is evident from Figure 5.20 that the proportion of health facilities providing HTC services has been increasing from 2.2% in 2001 to 55% in 2006. There are also variations in the number of facilities providing HTC services at regional level as can be seen from Figure 5.21 below:

Figure 5.21: Number of health facilities providing HTC services by region

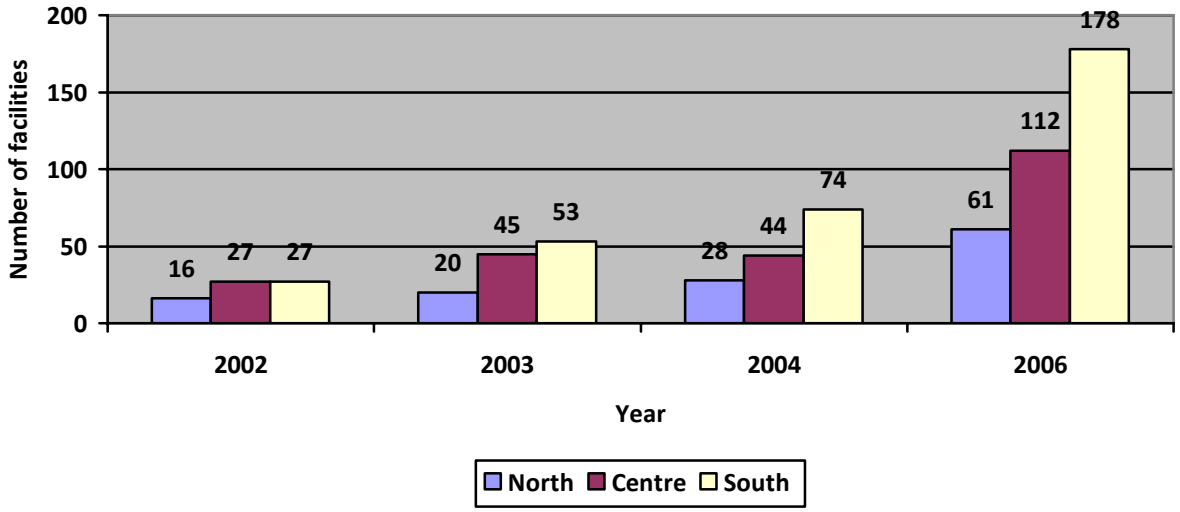
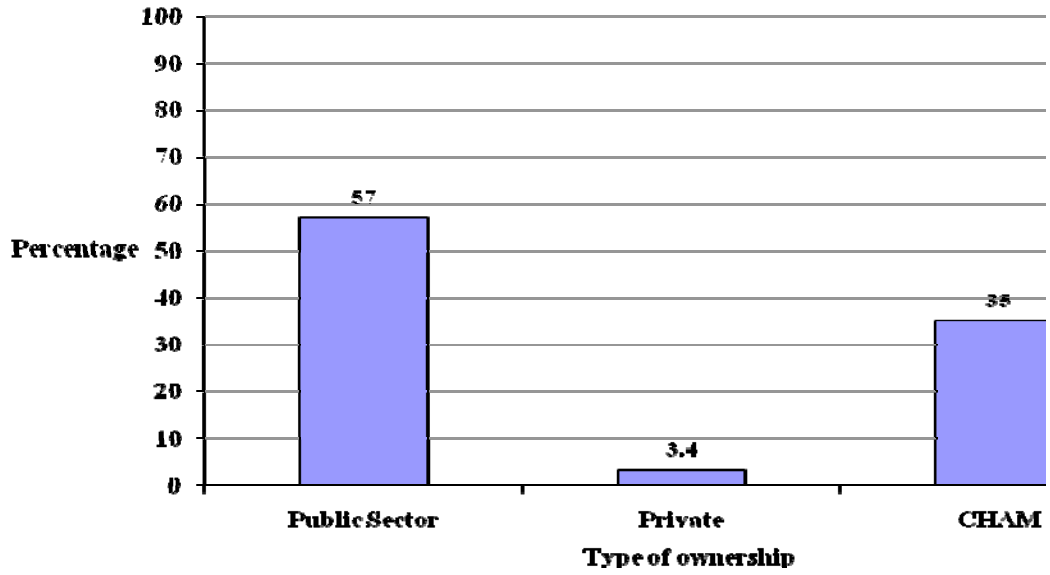


Figure 5.21 shows that there are more health facilities providing HTC services in the South and this is followed by the centre and then the north. This takes into consideration the population in each of the regions: population is much higher in the south compared to the centre and the north. In terms of ownership of facilities, there are three types namely: those belonging to the public sector, private and CHAM. As of 2006, there were 351 facilities providing HTC services in Malawi. Of these 201 belonged to the public sector, 12 belonged to the private for profit and then 124 belonged to CHAM. Figure 5.22 below shows health facilities, in percentages, that are providing HTC services in Malawi by type of ownership:

Figure 5.22: Ownership of facilities providing HTC in Malawi, 2006



It can be seen from figure 5.22 that the largest provider of HTC services in Malawi is the public sector at 57% and this is followed by CHAM at 35%. The private sector does not own many facilities that are providing HTC services. Studies have found that there are a number of reasons why people might want to go for an HIV test and these reasons include plans to get married, being sick for a long time and feeling vulnerable to HIV infection[46]. Because of the high prevalence of stigma and discrimination, some people prefer getting HTC services away from their residential places. It is for the same reason that some people do not want to disclose their sero-status after being tested; they usually reveal if they are found HIV negative[47].

5.2.10 Number and Percentage of Health Facilities with ANC Services with At least the Minimum Package of PMTCT Services

Some steady progress has been made in terms of absolute numbers of sites established and providing PMTCT services. There is a general problem in capturing PMTCT data at facility level because of the various entry points into PMTCT. Because of the different entry points, there may also be an element of double counting which may inflate figures. The 2006 HIV and AIDS situation analysis reports ANC and maternity separately. Since this was not the case previously, it is difficult to comment on trends. However, even with the new system the levels are low. Part of the problem may be because of the requirement for certification and the general human

[46] ORC Macro. (2004). *Voluntary Counselling and Testing (VCT) for HIV in Malawi: Public Perspectives and Recent VCT Experiences.* Calverton, Maryland: ORC Macro.
[47] MANET+. (2003). *Voices for Equality and Dignity: Qualitative Research on Stigma and Discrimination Issues as They Affect PLHIV in Malawi*. Lilongwe, Malawi: MANET+. Also see Munthali, A., J. Kadzandira and P. Mvula. (2003). *Formative Study on the Prevention of Mother to Child Transmission of HIV*. Lilongwe, Malawi: National AIDS Commission and UNICEF.

resource crisis, which renders most facilities not able to provide PMTCT. Figure 5.23 below shows the trends in the number of health facilities with ANC services with at least a minimum package of PMTCT services in Malawi:

Figure 5.23: Number of ANC facilities providing a minimum package of PMTCT services 2002-2006

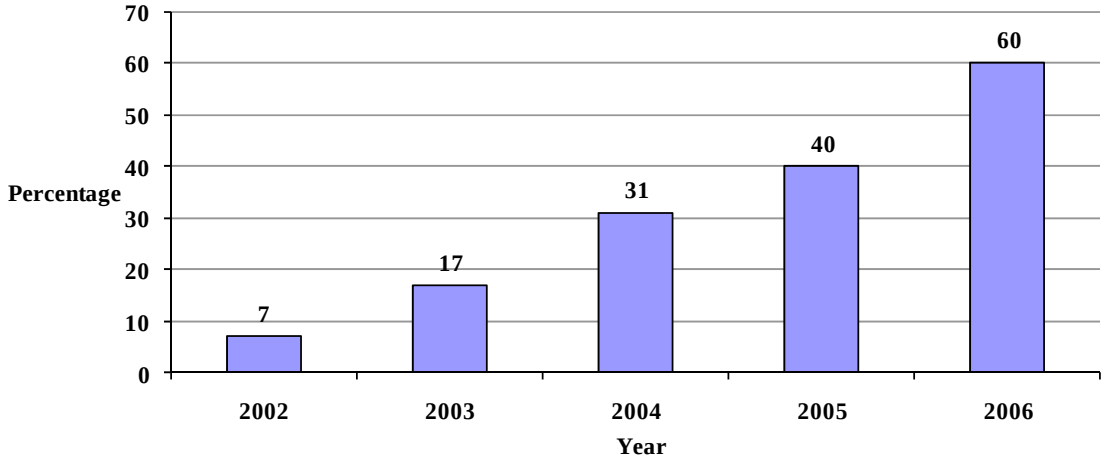
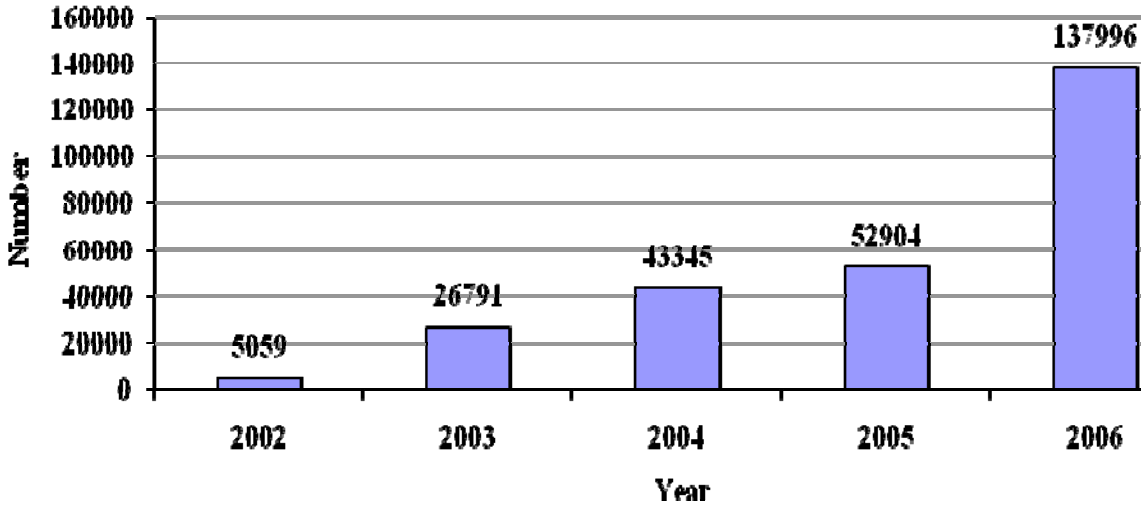


Figure 5.23 shows that in 2002 when the PMTCT programme started, only 7 facilities in Malawi were providing PMTCT services. This figure rose to 17 facilities in 2003, 31 in 2004, 40 in 2005 and then 60 in 2006. There are 542 facilities in Malawi that provide ANC services and these numbers of facilities translate into 1.3%, 3.1%, 5.7%, 7.4% and 10.3% in 2002, 2003, 2004, 2005 and 2006, respectively. The universal access target for this indicator is 100% of the ANC facilities providing PMTCT services by 2010. The Ministry of Health has put in place measures to accelerate the provision of PMTCT services hence the universal access targets are likely to be achieved.

5.2.11 Number and Percentage of Pregnant Women Attending ANC Who are Counselled, Tested and Receive Sero-status

The number of women attending antenatal clinics who have been counselled in PMTCT, tested and received results has been increasing over the last few years from 5,000 in 2002 to 26,700 in 2003 and then 43,345 in 2004. According to MoH/NAC, there were 52,904 women tested in 2005/2006. Figures 5.24 below shows the number of pregnant women attending ANC who are counselled, tested and receive results for the period 2002-2006:

Figure 5.24: Number of Pregnant women attending ANC who are counselled, tested and receive results 2002-2006



Translated into percentages, it is evident that in 2002 only 2%[48] of the pregnant women attending ANC were counselled, tested and received the results and this increased to 5.35% in 2005 and then 26% in 2006. It can be seen that there has been some improvement in the percentage of ANC attendees being tested. The present trend as shown in Figure 5.24 gives encouragement that the universal access target of having 65% of all pregnant women being tested for PMTCT will be achieved by 2010.

5.2.12 Number of Socially Marketed Condoms Distributed to Outlets in the Last 12 Months

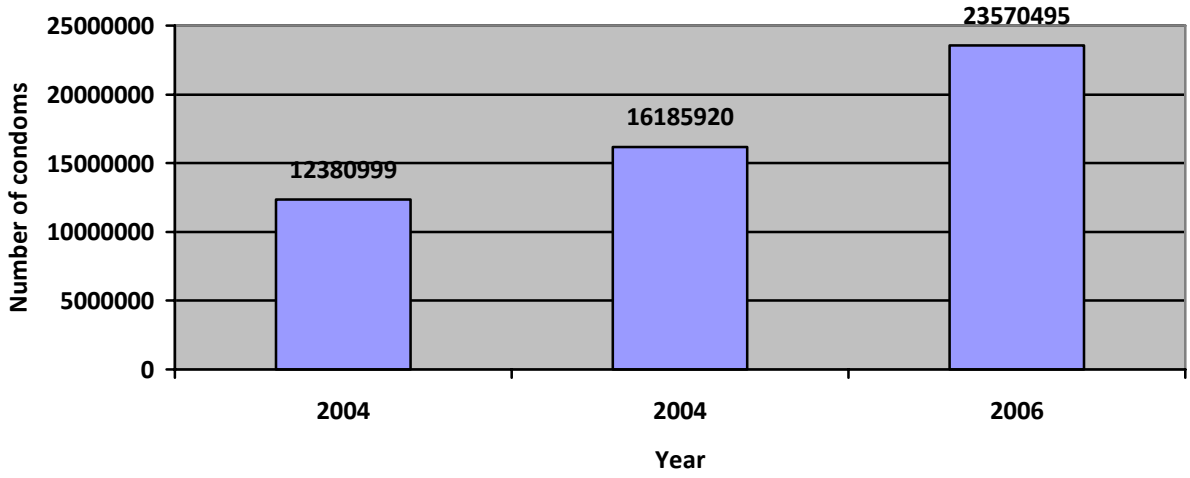
There are two NGOs that are involved in the distribution of socially marketed condoms in Malawi and these are Population Services International (PSI) and Banja La Mtsogolo (BLM). PSI distributes *Chishango* brand of condoms while BLM distributes *Manyuchi* brand and also *Chishango* condoms for PSI. In 2004 a total of 8,563, 494 condoms were distributed by social marketing agents while BLM distributed 6,575,000 condoms. In 2005 PSI distributed 4,541,676 condoms and this number increased to 9,201,726 condoms in 2006 and for the period January-June 2007 a total of 3,817,116 condoms were distributed. In 2005 BLM distributed 8,328,800 condoms and for the period January to June 2006, only 1,312,292 condoms were distributed. These trends show that the share of socially marketed condoms was steadily increasing with increasing awareness on safe sex and family planning.

5.2.13 Number of Free Government Condoms Distributed to End Users in the Last 12 Months

[48] Figures given are for numbers of women tested at ANC. Percentages are based on the estimated number of pregnancies from 2005 based on HMIS.

The Ministry of Health supply chain system supplies condoms directly to user units in the country. Figure 5.25 below shows the total number of condoms freely distributed by Government for the period 2004 to June 2007[49]:

Figure 5.25: Number of condoms freely distributed by Government



It is evident from Figure 5.25 above that the numbers of free condoms that have been distributed by government have been increasing. A total of 12,380,999 condoms were distributed in 2004 and this increased to 16,185,920 condoms in 2005 and then 23,570,495 in 2006. The increase in the number of condoms distributed by government are due to a number of reasons including the increase in the number of outlets[50], the increased campaigns on HIV and AIDS prevention strategies, the use of condoms as a family planning tool and condom use by STI clients. While the number of male condoms has significantly increased, the number of female condoms distributed has been quite low. Only 73,000 female condoms were distributed in 2006 and over the period January-June 2007 138,000 female condoms were distributed. There is therefore, a need to promote the use of female condoms.

5.2.14 Number of Employees That have Benefited From HIV and AIDS Workplace Programmes in the Last 12 Months

The National HIV and AIDS Policy in Malawi promotes the establishment and implementation of HIV and AIDS workplace programmes which should benefit the workers as well as their families. Appendix 2 shows the number of employees and their spouses who were reached by HIV and AIDS workplace intervention programmes in 2006. It can be seen from Appendix 2 that Blantyre had the highest number of employees who were reached by HIV and AIDS workplace interventions at 13,511 and this was followed by Lilongwe at 8,153. This is understandable as these two cities are the commercial centres of the country and most of the employees (especially the private sector) are based in these two districts. The numbers, however, are

[49] For 2007 the figures are for the period January – June 2007.
[50] The use of Non-Human Condom Dispensers is still under pilot.

generally low across the districts probably because of information flow problems on the programme resulting into under reporting. In addition, the HIV and AIDS workplace programme is relatively new in most institutions.

5.2.15 Percentage of Donated Blood Units Screened for HIV in a Quality Assured Manner

Data for this indicator is only available for 2006. From the 2006 figures, 100% of all blood transfused at national level was screened in a quality assured manner. Although this is the case, it should be noted that 20% of the sites conducting blood transfusions had significant stock outs of HIV test kits. For Hepatitis and syphilis, the stock out levels was 27% and 48% respectively.

5.3 Care and Treatment

5.3.1 Number of Persons with Advanced HIV Infection Currently Receiving ARV Therapy

There has been a steady increase in the number of HIV positive people put on ART as can be seen from table 5.20 below:

Table 5.20: Number of persons with advanced HIV infection currently receiving ARV therapy

	2003	*2004*	*2005*	*2006*	*2007*[51]	*Baseline*	*UA target 2010*
National	3000	13183	37840	85200	130488	13183	208000
Male		5274	14819	33238	50890		
Female		7909	23021	51972	79598		

There were 3,000 people with advanced HIV infection who were receiving ARV therapy in 2003. In 2004 this increased to 13,183 and then 37,840 in 2005, 85,200 in 2006 and by September 2007 the number had reached 130,488. Table 5.20 further shows the number of men and women who were on ART. It can be seen that there were more women on ART than men and this is possibly because pregnant women who are HIV+ have access to ART in the PMTCT programme. Progress is therefore being made to achieve the universal access targets for 2010. The HIV situation analysis[52] of 2006 cites some important challenges that have to be overcome to maintain the scale up. Notable challenges include human resources, inadequate infrastructure, pharmacy management, the increasing burden of collecting complete and timely M&E data (quarterly cohort analysis using a paper based system) and difficult access to ART clinics for poor people and people living in remote areas and high early death rates.

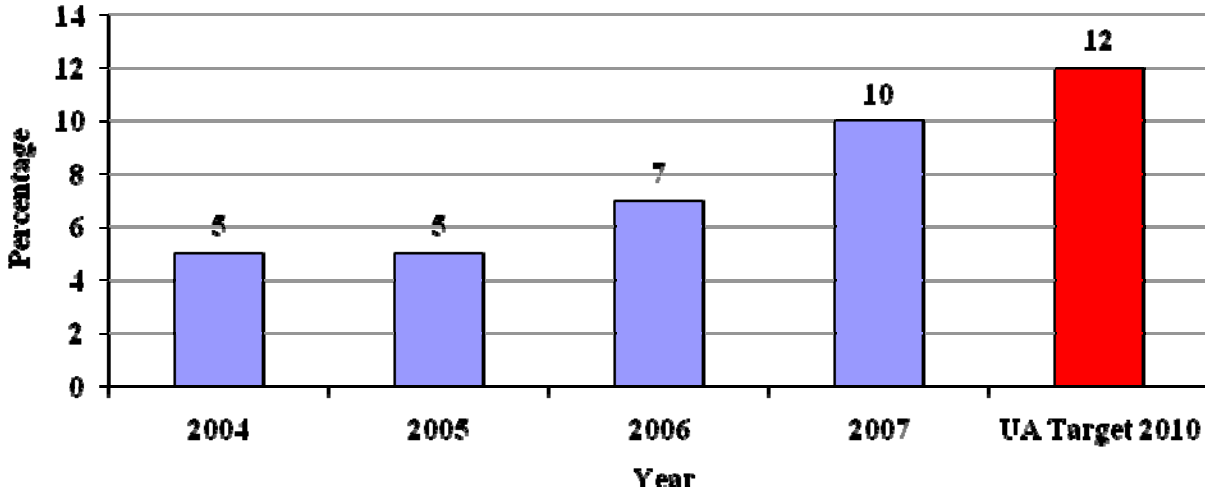
[51] Results up to September 2007 from MOH, ART in the Public and Private Sector in Malawi. Results up to 30th June 2007. The figures exclude transfers who are understood to be counted twice if not adjusted for.

[52] Report of a countrywide survey of HIV/AIDS services in Malawi for the year 2006. HIV Unit, MOH, National TB Control Programme, Lighthouse Trust and CDC Malawi.

5.3.2 Proportion of Those Starting ART Who areCchildren Aged < 15 years Old

The percentage of children in the ART programme has steadily increased and by June 2007, the Universal Access target of 8% by end of 2008 had already been achieved. Figure 5.26 below shows the proportion of children starting on ART who are children aged less than 15 years[53]:

Figure 5.26: Proportion of those starting ART who are children aged < 15 years



In 2004 and 2005; 5% of those starting ART were children aged less than 15%. This increased to 7% and 10% in 2006 and 2007, respectively. The Universal Access targets for 2008, 2009 and 2010 are 8%, 10% and 12%. Looking at the current trends, it is evident that targets as set for Universal Access for 2010 targets will likely be achieved. It is also worth noting that although the percentage of people on ART who are children is currently at 10%, the present levels of coverage is reaching about 50% of the estimated number of children in need of ART according to recent spectrum projections.

5.3.2 Number of Health Workers Trained/retrained in Accordance With National Standards in the Last 12 Months

A total of 2,367 health workers have been trained in ART since 2004 when free ARVs were introduced in Malawi and among these are 256 doctors, 613 clinical officers, 174 medical assistants and 1,324 nurses. Four hundred and six have been trained in ART from the pre-service and 879 health workers have received refresher courses since 2006. In addition to training in ART, 318 health workers have been trained in PMTCT and 20 TOTs, 1,513 have been trained in HTC and 9,989 have been trained in HBC with 297 TOTs.

[53] HIV unit data demarcates at age 13 years unlike the indicator which has 14 years old. This will need to be reworked based on raw data.

5.3.3 Percentage of Health Facilities With Drugs in Stock and no Stock Outs of More Than 1 Week

In 2006 MoH conducted a logistic system and stock status survey, which among other things, was also looking at drugs in stock and no drug stock outs of more than one week. In this report, the drugs under consideration are as follows: drugs for Opportunistic Infections (OIs)OIs and ARVs and then drugs for STIs such as benzanthine penicillin, doxycycline, metronidazole, diffican, nystatin, erythromyacin and HTC kits. Table 5.21 below shows the percentage of health facilities with drugs in stock and no stock outs of more than one week:

Table 5.21: Percentage of health facilities with drugs in stock and no stock outs of more than one week

Type of drug	*2003*	*2004*	*2005*	*2006*	*2007*	*Baseline*	*UA target 2008*	*NAF target 2009*	*UA target 2010*
OIs		65%				35%	70%	90%	90%
ARVs						100%	100%	100%	100%
STIs						35%	70%	90%	90%
Benzanthine penicillin		91%[54]		90%					
Doxycycline		70%							
Metronidazole		42%		80%					
Diflucan		55%		50%					
Nystatin		70%		20%					
Erythromycin		50%		32%					
HTC kits				73%[55]					

[54] There is no harmonization in the data for this indicator with differing definitions for HMIS, MLSAAS and SA.
[55] Based on 37% of facilities experiencing significant stock outs i.e. over 2 weeks.

It can be seen from Table 5.21 that in 2004, 65% of the health facilities had drugs in stock and no stock outs of more than one week for those drugs used in the treatment of OIs. For metronidazole the situation improved quite significantly: while in 2004, 42% of the facilities had drugs in stock and no stock outs of more than 1 week in 2006 the situation improved quite significantly as 80% of the facilities reported having metronidazole. For the other drugs, the situation generally worsened and this could be related to change over in procurement systems and lengthy procurement conditionalities. Such procurement problems are affecting the general health sector.

5.3.6 Number of Households Receiving External Assistance for Persons Who are Chronically ill for 3 or More Months

Chronically ill people require different types of support. NAC and stakeholders monitor different types of support that has been given to chronically ill people. This support is in the form of psychosocial, nutritional, financial, medical or domestic support. Appendices 3 and 4 show the different types of external assistance from NAC and other donor agencies given to households that were caring for the chronically ill in 2006/07 and 2005/06, respectively. This was done through NGOs, CBOs and FBOs. Overall, it can be observed that there has been a decline in the support that is given to households over the last two financial years. A total of 986,380 households received external assistance for persons who were chronically ill for 3 or more months for the period 2005-2007: 558,384 households in 2005/06 and 427,996 in 2006/07 thus representing a drop of 23%. This is seen more clearly from Figure 5.27 below:

Figure 5.27: Number of households receiving external assistance for persons who are chronically ill for 3 or more months

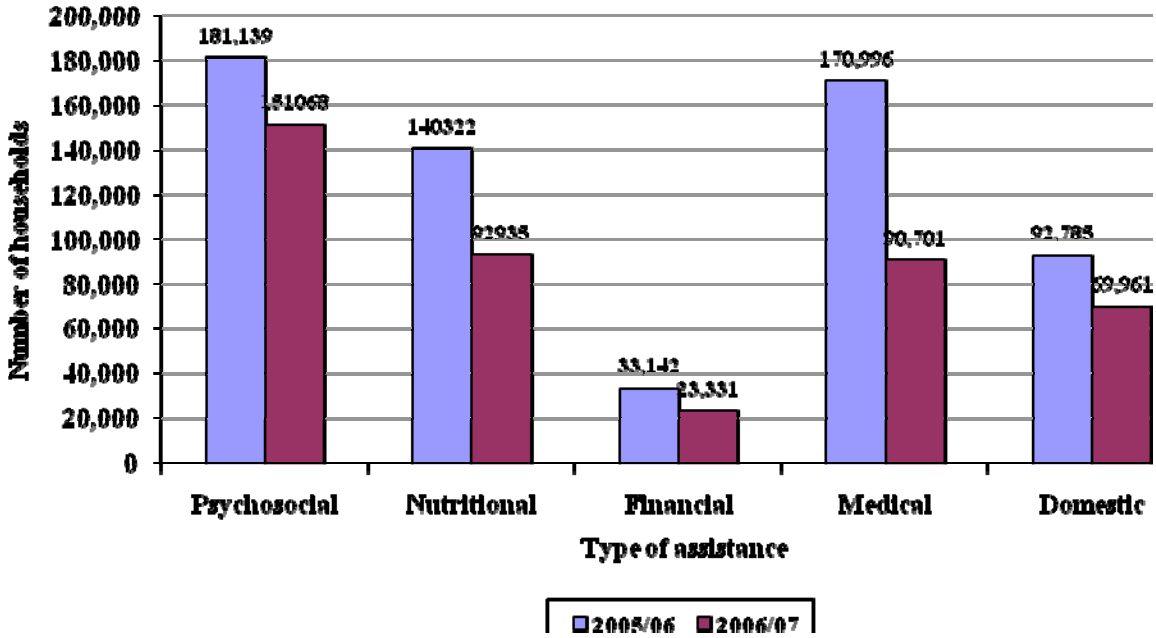


Figure 5.27 above shows that there was a drop in the type of all support given to households with chronically ill persons. The most common types of support provided to households in both

2005/06 and 2006/07 fiscal years were psychosocial support and the lowest was financial assistance. Others included nutritional, domestic and medical support. The Monitoring and Evaluation Report for 2005/06 shows that out of all types of support provided to households, the percentage of households provided with nutritional assistance increased from 18.9% in 2003 to 25% in 2005/06, but decreased by 34% in 2006/07 from 2005/06. The trend may be similar even for the period under report. Generally, the assistance on nutrition was good development because nutrition complements the ART programme.

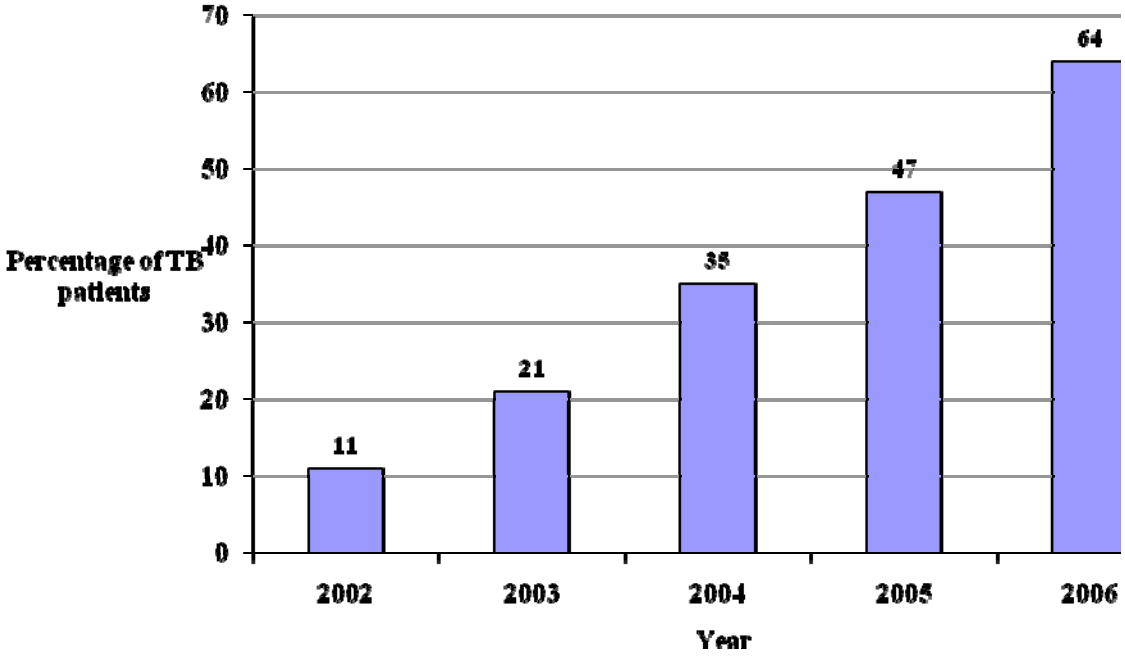
5.3.7 Percentage of TB Patients Who are Newly Registered in the Last 12 Months Who Know Their HIV Status

HIV testing has now been integrated in TB services and more TB patients are being tested for HIV. Even though this is the case, in 2006 a total of 27,015 cases of TB were registered and only 64% of these were tested for HIV and it was found that 70% of the TB cases tested were HIV positive[56]. Part of the reasons for the low coverage of testing for TB patients is the low uptake levels in major central hospitals where TB treatment is done on outpatient basis thereby reducing contact time for initiation of testing. Figure 5.28 below shows the percentage of TB patients who are newly registered in the last 12 months who know their HIV status for the period 2002-2006[57]:

[56] HIV Unit, National TB Control Programme, Lighthouse Trust and Centres for Disease Control. (2007). *Report of a Country Wide Survey of HIV/AIDS Services in Malawi for the Year 2006*. Lilongwe: Ministry of Health.

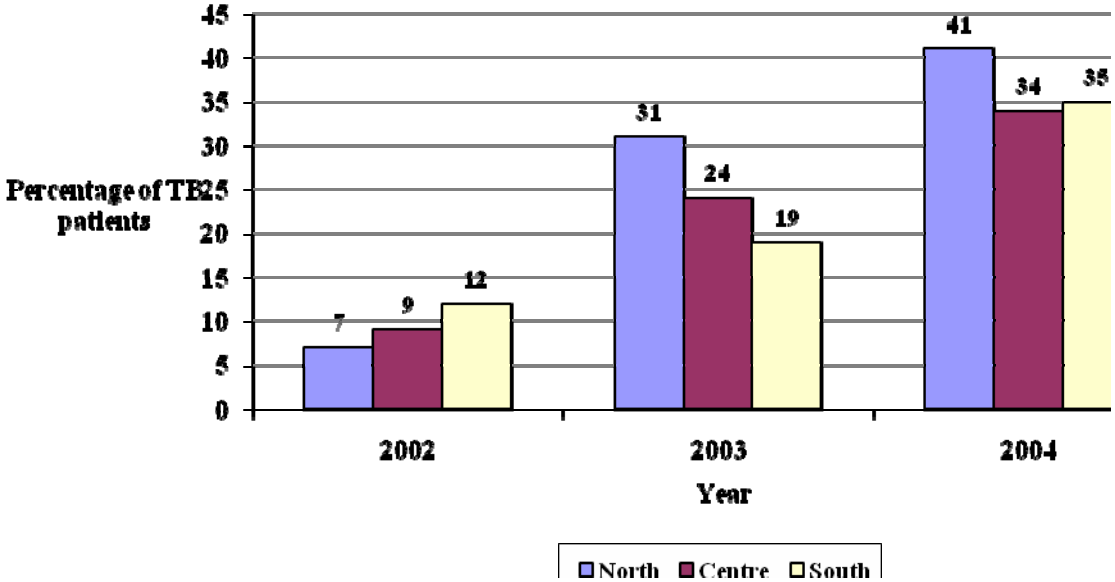
[57] These percentages are for those registered TB patients who were tested for HIV and the assumption is that all those tested know their HIV status.

Figure 5.28: Percentage of TB patients who are newly registered in the last 12 months who know their HIV status



While in 2002 only 11% of the TB patients who were newly registered in the last 12 months knew their HIV status, this has been increasing over the last years: it was 21% in 2003, 35% in 2004, 47% in 2005 and then 64% in 2006. Figure 5.29 below shows variation at regional level:

Figure 5.29: Percentage of TB patients who are newly registered in the last 12 months who know their HIV status by Region

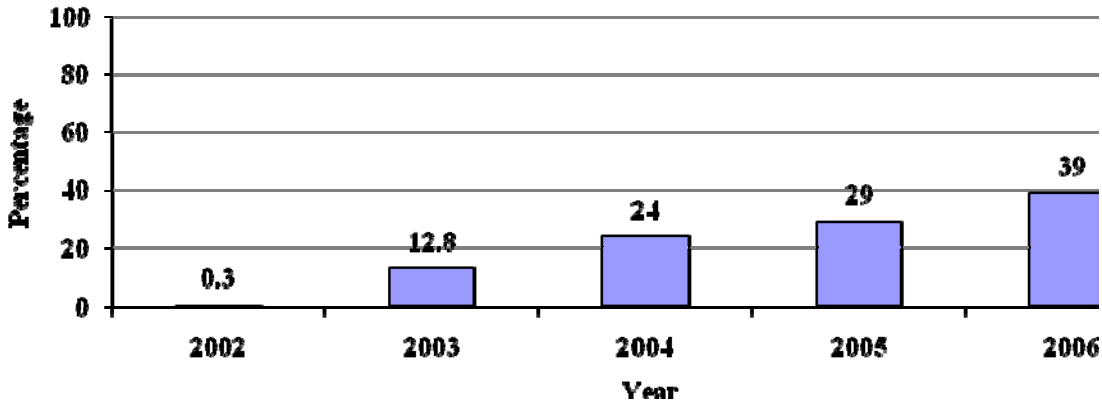


Regionally, it can be seen from Figure 5.29 above that the proportion of TB patients tested is more in the northern region compared to the centre and south where only one third of the TB patients were tested in 2004. It can be seen therefore, that the number of TB patients who are newly registered and who know their HIV sero-status has been increasing over the last few years especially as can be seen in Figure 5.29 above.

5.3.8 Ratio of Patients Starting HAART Because of TB

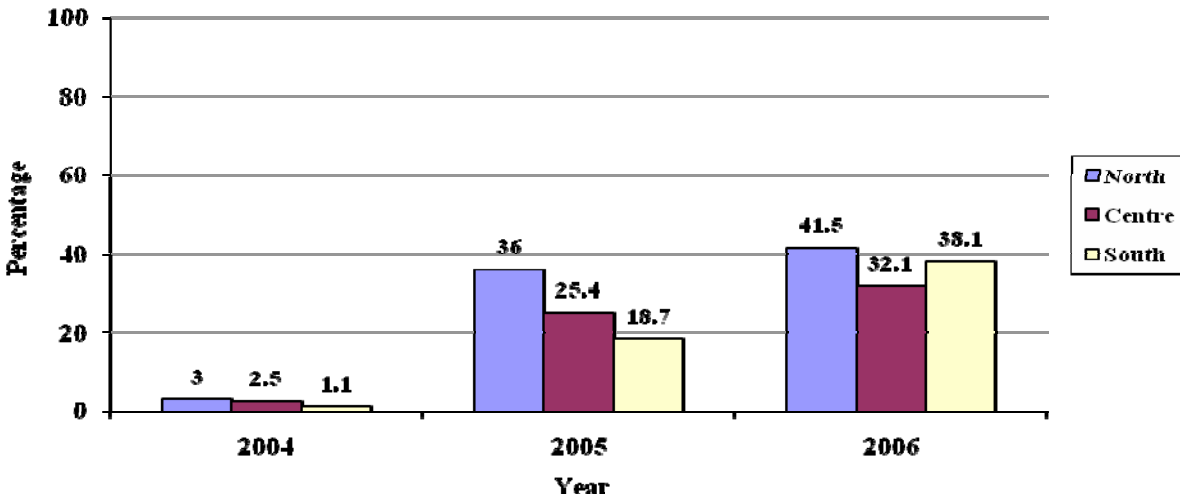
Figure 5.30 below shows the proportion of patients starting on HAART because of TB.

Figure 5.30: proportion of patients satrting on HAART because of TB



The total proportion of HIV positive TB patients starting HAART is estimated to have increased from 0.3 % in 2002 to 39% in 2006[58] (See Figure 5.30 above). There are also regional differences as can be seen from Figure 5.31 below:

Figure 5.31: Proportion of pateints by region starting on HAART because of TB



The increase in proportion of TB patients starting HAART has been marked for the southern region, 18.7% in 2005 to 38.1% in 2006. Similar improvements for the centre and northern region have been less marked although overall, there are more HIV positive patients starting HAART in the northern region compared to the other regions. The differences in proportions of HIV positive TB patients starting HAART are largely explained by differences in TB patient admission practices. Where most patients are admitted for an initial two-week period at start of TB therapy, there is more contact time for HTC while places where TB treatment is on outpatient basis such as in most urban areas, there is less contact time for HTC. This therefore, reduces opportunities for these patients to start HAART following HTC. Implementation of universal testing of TB patients is likely to improve the coverage further and thus identify more people in need of HAART.

5.4 Impact Mitigation

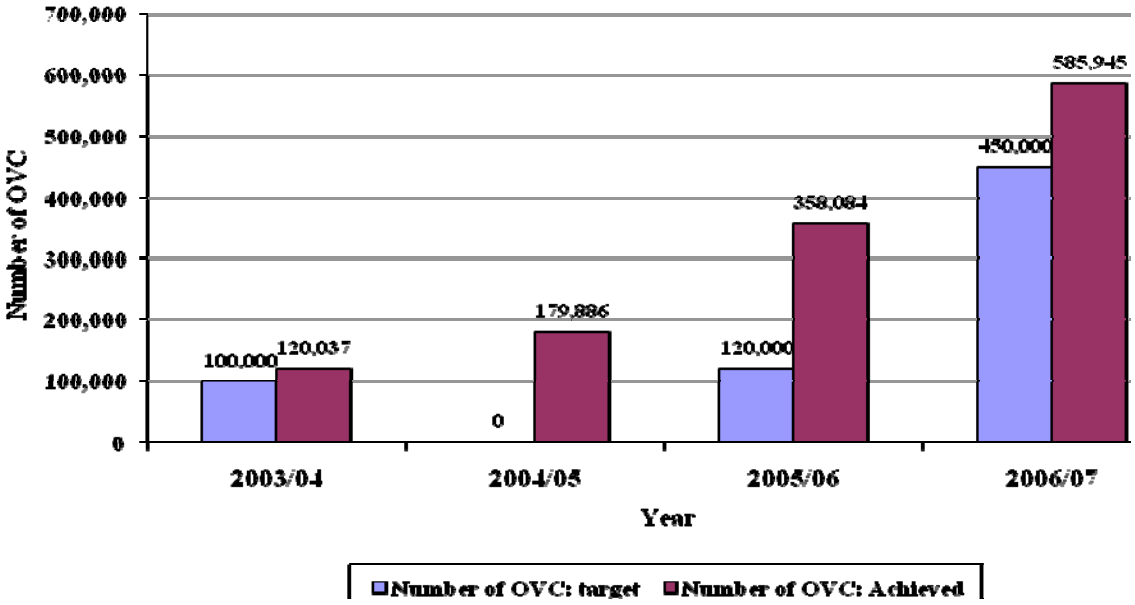
5.4.1 Number of Households with Vulnerable People Reached with Impact Mitigation Interventions

There are 6 categories of vulnerable people and these are people with disabilities, widows, the elderly, OVC, PLHIV and chronically ill persons. It is important that these vulnerable groups should receive support in order to survive and these should be monitored very closely. Data for

[58] The estimation of total number of HIV positive TB patients is based on reported prevalence of HIV among TB patients for that year multiplied by the total number of newly registered TB patients for the same year. The number starting HAART is based on figures from HIV/AIDS Unit of the Ministry of Health and annual situation analysis reports from the same unit.

most of these vulnerable groups is not available with an exception of OVC. Figure 5.31 below shows the number of orphans and other vulnerable children reached with impact mitigation interventions for the period 2003/4-2006/07.

Figure 5.31: Number of OVC reached with impact mitigation interventions



It is evident from Figure 5.31 that the number of OVC that have benefited from different types of impact interventions has been increasing over the period 2003-2007. While only 120,000 OVC benefited in 2003/2004, in 2006/07 nearly 600,000 OVC benefited. It is also important to note that while there have been targets to be reached, programmes have tended to achieve more than the targets: for example, in 2006/07 the target was to reach at least 450,000 OVC but 585,945 OVC were reached. Appendix 5 further shows the distribution of these interventions by district and the type of support given over this period. However, timely and national wide reporting to build a more complete picture of support reaching vulnerable people needed to be improved in the country.

5.4.2 Number of Orphans Attending School

Before the HIV and AIDS epidemic orphanhood was not a major problem as the numbers were low and the extended family system adequately catered for the orphans and other vulnerable children at the time. With the advent of the HIV and AIDS epidemic however, the magnitude of the orphan crisis is so huge such that the traditional mechanisms for caring for orphans such as the extended family system are failing to cope. This is worsened by the death of productive young men and women who are supposed to be taking care of these orphans and their grandparents. Orphans have increasingly dropped out of school due to of lack of necessary school requirements such as exercise books, pens and pencils, school uniform and food. , However, the introduction of free primary school education has helped significantly to retain orphans and other vulnerable children in school. Table 5.22 below shows the number of orphans attending primary school in Malawi for the period 2004-2006:

Table 5.22: Number of orphans attending school (Primary Education)[59]

Background Characteristics	2004	2005	2006
Male	195,644	222,720	234,667
Female	191,084	216,685	226,954
Single Orphans	-	295,245	310,795
Double Orphans	386,728	144,160	150,826
Total # Orphans	**386,728**	**439,405**	**461,621**

It can be seen from Table 5.22 that there were 386,728 orphans attending primary school in 2004 and this increased to 439,405 in 2005 and then 461,621 in 2006. There were more male orphans attending school than female orphans throughout the period 2004-2006. In 2004 data was not disaggregated by single to double orphan but it is evident from 2005 and 2006 figures that single orphans were more likely to attend school than double orphans. Table 5.23 below shows the number of orphans attending secondary school in Malawi for the period 2004-2006:

Table 5.23: Number of orphans attending school (Secondary Education)[60]

Background Characteristics	2004	2005	2006
Male	16,634	21,530	25,210
Female	14,716	18,379	21,258
Single Orphans	-	25930	30,479
Double Orphans	31,350	13,979	15,989
Total # Orphans	**31,350**	**79,818**	**92,936**

As was the case with primary school pupils, there were more male orphans who were attending school in 2004, 2005 and 2006 than female orphans as can be seen in Table 5.23 above. The proportion of single orphans who were attending secondary school in 2005 and 2006 was twice those who were double orphans. In Malawi, primary school education is free while students have to pay fees when they go to secondary school. This possibly explains why there are a few double orphans attending secondary school compared to primary school as they may not afford to pay school fees.

5.5 Mainstreaming, Partnerships and Capacity Building

5.5.1 Number and Percentage of Large Companies and Public Institutions That Have HIV and AIDS Workplace Policies and Mainstreaming Programmes

The National HIV and AIDS policy promotes the development and implementation of HIV and AIDS workplace policies and programmes. Even though the national workplace policy is still in draft form, a number of workplaces including the public sector have developed their respective

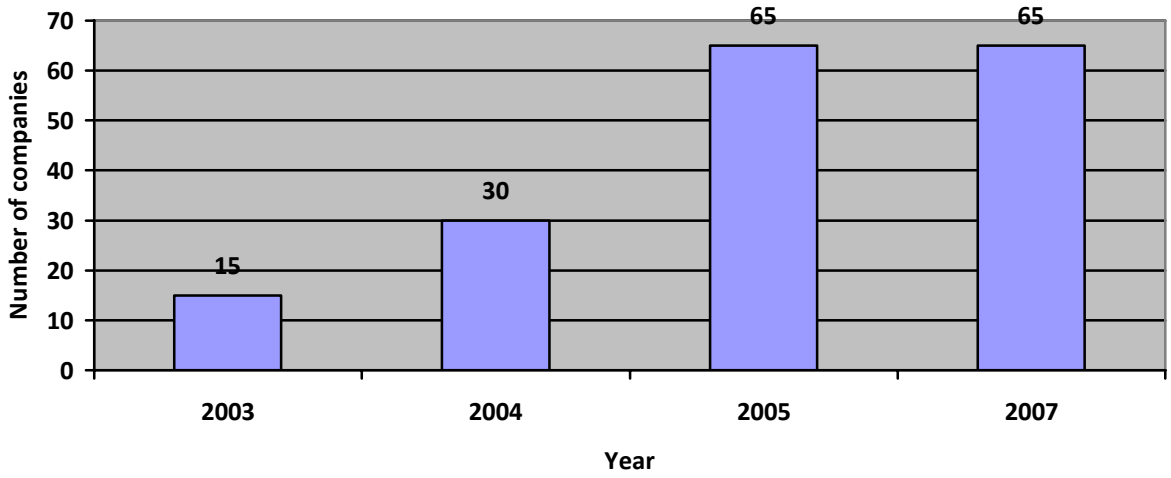
[59] Ministry of education. (2004, 2005, 2006). *Education Management Information System (EMIS).* Lilongwe: Ministry of Education.
[60] Ministry of education. (2004, 2005, 2006). *Education Management Information System (EMIS).* Lilongwe: Ministry of Education.

workplace policies. For the financial year 2006/7, the target was that 75% of large private companies and 90% of public institutions should have HIV and AIDS workplace policies and mainstreaming programmes. A recent evaluation has shown that as of June 2007, 73% of government ministries and departments, 27% of the parastatal organizations and training institutions and 57% of the members of the MBCA had functional workplace programmes[61]. This generally demonstrates that there is some progress being made in terms of the development and implementation of workplace policies and programmes but mainstreaming information is not currently available.

5.5.2 Number of Companies That are Members of the MBCA

The Malawi Business Coalition against HIV and AIDS was first launched in 2003 under the Malawi Confederation of Commerce and Industry and at the time it had 15 member companies. The number of companies, which are members of the MBCA, has been increasing and Figure 5.32 below shows the trends in number of companies, which are members of MBCA:

Figure 5.32: Number of companies that are members of MBCA



It can be seen from Figure 5.32 that in 2003 MBCA had 15 members and this increased to 30 in 2004 and then 65 in 2005 and 2007. This implies that membership has somehow stalled at 65.

5.5.4 Number of Research Proposals Approved

As shall be shown later, all the research proposals in the area of health sciences, including those on HIV and AIDS, are supposed to be submitted to the National Health Sciences Research Committee for approval. In 2007, a number of research proposals were submitted and approved. A total of 93 proposals were approved over this period. More details on monitoring

[61] Health research for Action. (2007). *Malawi National AIDS Programme: Independent Multi-disciplinary Review Team – Report for the Period July 2006-June 2007*. A Report for the National AIDS Commission.

and evaluation activities with regards to the national response to the HIV/AIDS epidemic appear under Section 6.5.

5.6 Financing the national response to the HIV and AIDS epidemic (2002-2005)

Government, with support from donors, has invested a considerable amount of funds in the fight against HIV and AIDS in Malawi. This section presents the financial resources that have been spent on HIV and AIDS in Malawi, the financing sources, financing agents and providers as well as the activities on which these funds have been spent. Currently, with support from the Global Fund, Malawi is undertaking a resource tracking exercise on HIV and AIDS expenditure for the period 2005-2006 and the results will be ready later in 2008. The analysis in this section uses the National Health Accounts for the period 2002-2005, which is the latest comprehensive study looking at resource flows. Before looking at expenditure on HIV and AIDS, the section first examines total expenditure as a percentage of total government expenditure.

5.6.1 Percentage of government budget allocated to the health sector

As it can be observed from Appendix 6a, overall total government expenditure rose from MK56,583 million in 2002/2003 to MK68,790 million in 2004/2005 thus representing a 22% increase. Total expenditure on health has also increased: it was MK14,617 million in 2002/2003 increasing to MK26,213 million in 2004/2005. Over this period, it can also be observed that government expenditure on health increased: it was MK5,174 million in 2002/2003 and increased to MK4,572 million in 2003/2004 and then MK6,417 million in 2004/2005. It can be observed therefore that in 2002/2003 government expenditure on health as a percentage of total government expenditure was 9.1% in 2002/2003 and decreased to 7.1% in 2003/2004 and then rose again to 9.3% in 2004/2005.

The World Health Organisation has also looked at total health expenditure as a percentage of GDP for the period 1996-2005 using the national health accounts[62]. Figure 5.33 below shows total expenditure on health as a percentage of GDP in Malawi for the period 1996-2005:

[62] www.who.int/nha/country/MW1.pdf

Figure 5.33: Total expenditure on health as a percentage of GDP

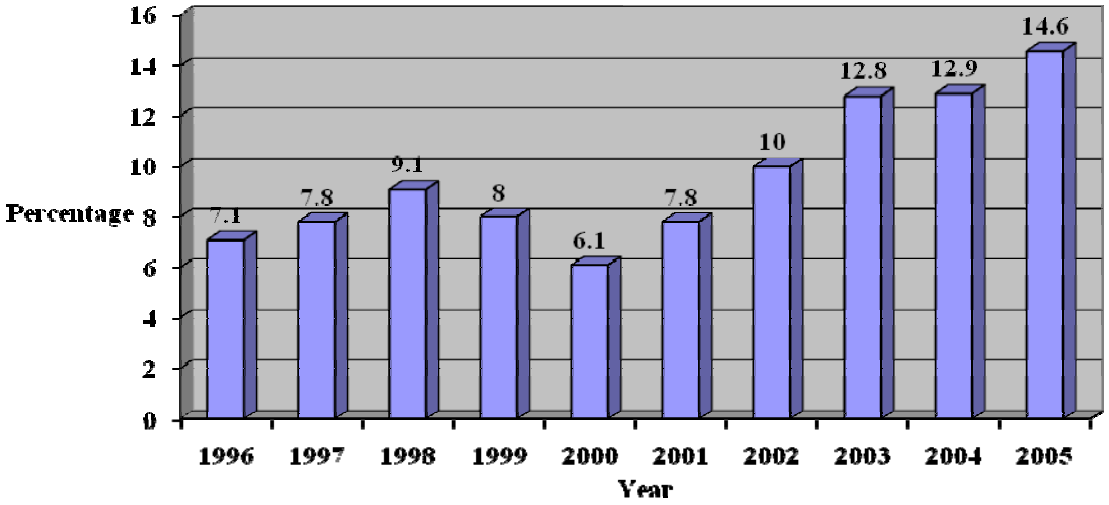


Figure 5.33 shows that total expenditure on health as a percentage of GDP increased between 1996 and 1998 from 7.1% to 9.1% after which it fell to 6.1% in 2000. In 2001, total expenditure on health as a percentage of GDP started increasing again and as of 2005, it was at 14.6%. While previously Government of Malawi contributed quite a lot to expenditure on health, in recent years there has been a lot of external support to the health sector as can be seen from Figure 5.34 below:

Figure 5.34: External resources on health as a percentage of Total health expenditure

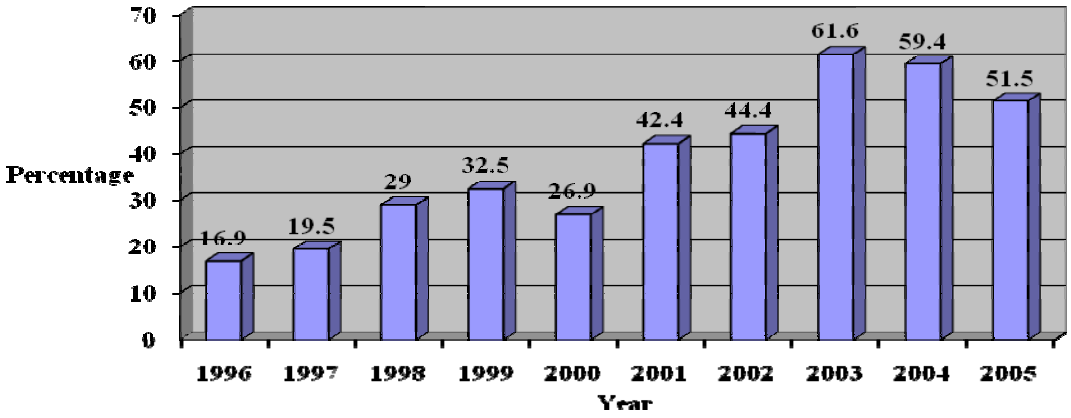


Figure 5.34 above shows that for the years 1996 and 1997 less than 20% of the total expenditure on health was from external resources and this increased to nearly one third of total health expenditure over the period 1998-2000. External resources as a percentage of total health expenditure reached a maximum in 2003 when this accounted for 61.6% of total health expenditure, before slightly dropping down to 59.4% and 51.55 in 2004 and 2005, respectively.

5.6.2 HIV and AIDS financing and expenditures (2002-2005)

Appendix 6b shows HIV and AIDS financing and expenditures for the period 2002-2005 using the National Health Accounts. It can be observed that total HIV and AIDS expenditure increased from MK2,537 million in 2002/2003 to MK6,297 million in 2003/2004 and then MK7,527 million in 2004/2005. Over this period, there was therefore Total HIV/AIDS expenditure increased by nearly 200%. Over the same period, the total HIV and AIDS health expenditure increased from MK2,343 to MK6,254 million thus representing nearly a 170% increase. This increase in expenditure on HIV and AIDS has been possible due to generous support from donors, especially the Global Fund. Between 2002 and 2005 there was also an increase in total HIV and AIDS health expenditures as a percentage of overall health spending: it was 16% in 2002/2003 increasing to 23.6% in 2003/2004 and then 23.9% in 2004/2005. The increase in HIV and AIDS expenditures over this period has mainly been due to influx of external resources as well as the priority that Government of Malawi puts on the HIV and AIDS epidemic.

In terms of financing sources of HIV and AIDS funds, it can also be observed from Appendix 6b that while in absolute terms government funding for HIV and AIDS activities has increased over the years, in terms of percentage of total HIV and AIDS expenditures, it has been decreasing: it was 40% in 2002/2003 and it decreased to 18% in 2003/2004 before increasing slightly to 20% in 2004/2005. Donor funding as a percentage of total HIV and AIDS expenditure rose sharply between 2002 and 2004: it was 46% in 2002/2003 and increased to 76% in 2003/2004 and slightly dropped to 73% in 2004/2005. Both total household spending as a percentage of total HIV and AIDS expenditures and out of pocket spending as a percentage of total HIV and AIDS expenditure decreased over this period as has been demonstrated in Appendix 6a.

Financing agents have been classified into 4 categories namely public sector, NAC, private sector and the rest of the world. It can be observed that the rest of the world, as a financing agent, was at 24% in 2002/2003 and it increased to 47% in 2003/2004 before dropping to 12% in 2004/2005. On the other hand, the public sector as a percentage of total HIV and AIDS expenditures increased from 41% in 2002/2003 to 75% in 2004/2005. This increase is mainly due to two reasons: the requirement that each government Ministry should spend 2% of its Other Recurrent Transactions on HIV and AIDS and the fact that some Ministries, for example the Ministry of Health, are major recipients of external funds for HIV and AIDS. The percentage of total HIV and AIDS expenditures that went through NAC also increased from 11% in 2002/2003 to 57% in 2004/2005 since as a coordinator of the national HIV and AIDS response, the bulk of the funds are channeled through it. The proportion for the private sector has been on the decrease from 24% in 2002/2003 to 13% in 2004/2005.

In terms of providers, it can also be observed from Appendix 6a that as of 2004/2005 the public sector spent the highest proportion of the total HIV and AIDS expenditures at 23%. This was followed by public hospital spending at 21% and then private provider spending at 12%. Public and private health centre spending and private hospital spending as a percentage of total HIV and AIDS expenditures was low, at less that 10%. Over the period under review, curative care as a percentage of total HIV and AIDS expenditure decreased from 57% in 2002/2003 to 34% in 2004/2005 and the same trend is true for inpatient curative (treatment of opportunistic infections). ARV treatment as a percentage of total HIV and AIDS expenditure jumped from 2% in 2002/2003 to 31% the following year and this was due to the introduction of free ARVs with support from the Global Fund. In terms of utilization of funds, it can be observed therefore that between 2002 and 2005 the bulk of the funds were spent on curative care and prevention programmes.

6.0 NATIONAL COMPOSITE POLICY INDEX FOR PUBLIC SECTOR RESPONSE

The National Composite Policy Index (NCPI) is one of the instruments that measures national commitments and action indicators relating to HIV and AIDS. It has been designed to assess progress in the development and implementation of national AIDS policies and strategies. This section summarizes the findings from the interviews that were done with the public sector, the civil society and donor agencies. It should be emphasized that this section presents the views and perceptions of those interviewed and where necessary, other literature sources have been used.

6.1 Strategic Plan

6.1.1 Inclusiveness of the Strategic Plan

Malawi is currently implementing the National HIV and AIDS Action Framework that was launched in 2005[63]. The NAF is multi-sectoral and aims at facilitating the national response to the HIV and AIDS programme and implementation for the period 2005-2009. As has been mentioned earlier, the NAF succeeded the NSF. All respondents recognized that the NAF includes all important sectors as indicated in the National Composite Policy Index questionnaire namely health, education, labour, transport, the military/police, women and young people. All these sectors have earmarked budgets for HIV and AIDS. In terms of budget earmarking, this is more within the context of National AIDS Commission controlled funding that is based on the multisectoral NAF. The implementation of the NAF is financially supported by the Pool Donors (that includes the Government of Malawi) and other Discrete Donors[64]. Each government department in these sectors is supposed to allocate 2% of its ORT to HIV and AIDS activities. It is therefore, seen that there is an earmarked budget for these sectors. In terms of target populations, the NAF has also identified target populations, the settings and other cross cutting issues as can be seen in Table 6.1 below:

Table 6.1: Target Populations, Settings and Cross-cutting Issues that the Multi-sectoral NAF is Addressing in Malawi

TARGET POPULATIONS	**Responses**
a. Women and girls	Yes
b. Young women/young men	Yes
c. Specific vulnerable sub-populations	Yes
d. Orphans and other vulnerable children	Yes
SETTINGS	
e. Workplace	Yes
f. Schools	Yes

[63] National AIDS Commission. (2005). *National HIV/AIDS Action Framework.* Lilongwe: Office of the President and Cabinet

[64] NAC (2005). *National HIV and AIDS Action Framework 2005-2009*, Lilongwe, National AIDS Commission.

g. Prisons	Yes
CROSS-CUTTING ISSUES	
h. HIV, AIDS and poverty	Yes
i. Human rights protection	Yes
j. PLHIV involvement	Yes
k. Addressing stigma and discrimination	Yes
l. Gender empowerment and/or gender equality	Yes

Source: Responses based on the NCPI.

It can be seen from Table 6.1 that the NAF also addresses all the target populations as contained in the questionnaire namely women and girls, young people, specific vulnerable populations and orphans and other vulnerable children. Malawi's strategic plan however, has even gone further in identifying sub-groups within target populations such as pregnant women among women as well as sex workers among young women and young men that are instrumental in appropriate programme targeting. In addition to women and girls, young people and the OVC, the NAF has further identified the following target groups as vulnerable namely high-risk sex workers, long distance drivers, the military and police service personnel, prisoners, PLHIVs and children born from HIV+ mothers. The NAF further promotes HIV and AIDS programmes including awareness activities in the workplace, schools and prisons and it addresses all the cross cutting issues as contained in the questionnaire namely PLHIVs involvement, HIV and AIDS and poverty, human rights protection, stigma and discrimination and gender empowerment.

6.1.2 Funding the Strategic Plan

The NAF also has an operational plan, which has well stipulated goals and clear targets and/or milestones. The NAF is costed and has a detailed budget of costs per programme area. The detailed budget includes indications of funding sources, which include Pool funding arrangements, discrete funding as well as the contribution of the Government of Malawi. While the NAF is costed, the full extent of funding the operational plan may not be established based on the detailed budget or integrated annual workplan because there are a number of funding mechanisms that are done outside NAC and may therefore not be captured despite the fact that such initiatives are derived from the operational plan. In a way the detailed budget in the operational plan is indicative but it is also supported by inflow of financial, technical and material support from some bilateral agencies dealing directly with civil societies and other implementing partners in Malawi.[65] As shall be seen later, in 2006 Malawi set the Universal Access targets and detailed activities that should be implemented in order to achieve the targets. It has been estimated that US$1,166,130,958 is required in order to achieve the Universal Access targets of 2010[66].

[65] Examples of bilaterals directly dealing with civil societies and Government outside NAC include SWAP, USAID, NORAD, Clinton and Hunter Foundation, Religious Partnerships like Caritas International, World Church Council, etc.

[66] National AIDS Commission. (2006). *Universal Access Indicators and Targets for Malawi.* Lilongwe: National AIDS Commission.

6.1.3 Civil Society Involvement

Malawi ensures that there is full involvement and participation of civil society in the development of the multisectoral strategy/action framework because of the belief that fighting against HIV and AIDS requires collective response and collaboration among all stakeholders. CSOs, including those dealing with PLHIVs such as MANET and NAPHAM, were fully involved in the development of the National AIDS Policy, which was launched in 2003[67]. Civil society organizations (CSOs) are implementers and they interact with people at grassroots level. Partnership with civil society ensures wider participation and ability to increase geographical coverage of HIV and AIDS services in the country.

The involvement and participation of civil society in the development and implementation of the NAF is very active. For example, CSOs participated actively in the development of the NAF, the National HIV and AIDS Policy as well as the setting of the Universal Access targets and costing, which was done in 2006.[68] In order for civil society to participate actively, they are represented in National Technical Working Groups (TWGs), particularly those on prevention, treatment, care and support as well as advocacy for protection of vulnerable groups such as women, girls, PLHIVs and OVC. They always participate in annual reviews and consultations and share best practices and provide inputs to the annual review reports. They also contribute to overall assessment of progress made and recognize themselves as stakeholders and partners. This makes CSOs to recognize the fact that the NAF is their framework that depends on them for successful implementation and achievement of milestones.

6.1.4 Endorsement by External Development Partners

All external development partners have endorsed the NAF and they use the framework in planning their support. However, in terms of external development partners aligning and harmonizing HIV and AIDS programmes to the NAF, 60% have done so and effort is being made to achieve 100% alignment and harmonization. This is an indication of the commitment to the Paris Declaration which among other issues emphasized on National Government leadership in HIV and AIDS response through strategic plans which development partners should align their assistance and ensure harmonization of plans as well as capacity building of the government institutions to facilitate planning and implementation of HIV and AIDS initiatives.[69] In Malawi this alignment and harmonization has been facilitated through the NAC Pool funding mechanism and also through examples of Health and Education SWAPs that are aligned to the Malawi Growth and Development Strategy and NAF (in the case of the NAC Pool funding). What seems to be preventing full alignment and harmonization by some external development partners are some of the requirements of funding and reporting to their respective governments and funding agencies.

[67] Panos Southern Africa. (2006). *Keeping the Promise? A study of Progress Made in Implementing the UNGASS Declaration of Commitment on HIV/AIDS in Malawi*. Lusaka: Panos Southern Africa.
[68] NAC(2006). *An Overview on HIV and AIDS Response in Malawi*. Lilongwe:NAC
[69] World Bank, (2005), Paris Declaration on AID Effectiveness, Websites.

6.1.5 Integrating HIV and AIDS into National Development Plans

Respondents to the NCPI questionnaire mentioned that Malawi has integrated HIV and AIDS into its general development plans for example (a) National Development Plans; (b) Common Country Assessments/United Nations Development Assistance Framework (UNDAF)[70]; (c) Poverty Reduction Strategy Papers/Malawi Growth and Development Strategy (MGDS)[71]; and (d) Sector Wide Approach in Health. With decentralization, the focus for funding and activity implementation is at district level. At district level there are District Development Plans (DDPs[72]), which have clearly integrated HIV and AIDS and these are further reflected in their respective District Implementation Plans (DIPs), which have fully been aligned and harmonized with the NAF. The understanding, however, of integration of HIV and AIDS in some of the development plans listed above vary in terms of degree and perceptions of those consulted mainly due to lack of knowledge of what is contained in some of these documents. Further analysis of the development plans demonstrates or gives the evidence that all of them have integrated HIV and AIDS issues. As such, it can be said that the Government of Malawi is demonstrating and fulfilling what is stipulated in the Paris Declaration but it still needs capacity building support in order to comprehensively fulfill this obligation.

Rating for strategy planning efforts

Overall rating of strategic efforts in the HIV and AIDS programmes in 2007	8.4
Overall rating of strategy efforts in the HIV and AIDS programmes in 2005	6.0

6.1.6 Addressing HIV and AIDS among Malawi Uniformed Services

The NAF addresses HIV and AIDS issues among Malawi's uniformed services namely the military, police, peacekeepers and prisons. HIV and AIDS issues for uniformed services in Malawi include the requirement for HIV testing and counselling at recruitment level for fitness to serve and this is particularly the case for the military. Those found HIV positive or have AIDS while already in service are provided with all necessary services outlined in the NAF such as treatment, care and support and are not dismissed on the account of being HIV positive. According to respondents, there are a number of programmes that are being implemented beyond the pilot stage to reach uniformed services and these include behavioural change, communication, condom provision, HIV testing and counseling, STI services, treatment and care and support. It can therefore, be concluded that HIV and AIDS services are being offered to the uniformed services as contained in the NAF as well as the National AIDS Policy.

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[70] UN, *Common Country Assessments/United Nations Development Assistance Framework (CCA/UNDAF) (2007-2011)*. Lilongwe:UNDP

[71] Malawi Government (2005). *Malawi Growth and Development Strategy (MGDS)* and *Poverty Reduction Strategy Paper (1999)*. Lilongwe: Ministry Of Economic Planning and Development.

[72] District Assemblies: *District Development Plans* (Various). All District Assemblies and City Assemblies. In December 2007 NAC and District Assemblies have signed a Memorandum of Understanding that will enable funding to CBOs in all districts to be done by Assemblies and to account for same through the same channel. The objective is to shorten the process to funding of community initiatives. This funding will be based on the respective DDPs and District Implementation Plans.

6.1.7 The Road Towards Universal Access

Malawi as a nation is committed towards achieving Universal Access to HIV and AIDS services. In order to achieve this, Malawi began a process of setting targets for Universal Access in early 2006 and this was coordinated by NAC[73]. Even CSOs came up with their own targets for Universal Access[74]. In June 2006 the targets for NAF indicators were reviewed and it was found that most of the targets as set in early 2006 had already been achieved hence there was a need to revisit the targets for Universal Access. The process of setting targets for Universal Access was participatory and involved all stakeholders such as government, private sector, development partners, civil society organizations and PLHIVs. There were 4 technical committees that guided the setting of targets for Universal Access and these were biomedical prevention; non-biomedical prevention; treatment, care and support; and impact mitigation. In addition, the process reviewed challenges associated with Universal Access and identified appropriate Universal Access indicators for Malawi.[75]

6.1.8 Future Needs of Persons Requiring ART

There are reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy in Malawi. These estimates have been done by the Ministry of Health and the National AIDS Commission, in collaboration with stakeholders. Through the NCPI survey it has been indicated that most of the respondents acknowledge the existence of reliable estimates and projected needs of the number of adults and children requiring antiretroviral therapy. In November 2006, the resource requirements for Universal Access to ART were revisited and estimated again and these are in line with the scale up plans of the Ministry of Health[76]. This was done as part of the process of coming up with Universal Access targets for Malawi.

6.1.9 Monitoring HIV and AIDS Programme Coverage

Malawi HIV programme coverage is monitored by sex (male and female) and by population sub-groups. In addition, HIV programme coverage in Malawi is also monitored by age categories (e.g. 15-24 years; 0-14 years, 15-49 years). There are variations in target sub-groups for different Ministries for various purposes. The generic sub-groups in Malawi include women and girls, young women and young men, sex workers, track drivers, men and women in uniformed services such as military and police, PLHIVs, children born from HIV positive mothers, orphans and other vulnerable children, pregnant women, youth and the elderly. Different sectors also identify specific sub-groups for their own respective purposes. For example, the HIV programme in the Ministry of Education focuses on teachers (both male and female) and pupils/students.

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[73] National AIDS Commission. (2006). *The road towards Universal Access: Scaling up Access to HIV Prevention,Ttreatment, Care and Support in Malawi 2006-2010.* Lilongwe: National AIDS Commission.

[74] Loga, T. and Nkhalamba,M. (2006). *Making Universal Access a Reality: Malawi CSO Engagement.* Lilongwe: Actionaid and Malawi Health Equity Network.

[75] Munthali, A. (2006). *Universal Access Indicators and Targeting for Malawi, Final Report*., Lilongwe: NAC/UNAIDS.

[76] Ministry of Health. (2005). *Treatment of Aids: A five-year Plan for the Provision of Antiretroviral Therapy and Good Management of HIV-related Diseases to HIV Infected Patients in Malawi 2006 – 2010*. Lilongwe: Ministry of Health

While there are these variations, the HIV programme coverage is also monitored by geographical area, which include rural and urban, regional, district and health facility and locations with special characteristics that contribute to HIV spreading such as international borders, mobile market locations and potential commercial sex transaction spots such as tourist resorts, and major liquor drinking places. Like targeting of population sub-groups different stakeholders may use their own geographical areas such as divisions, districts and zones in case of the Ministry of Education whereas Ministry of Health may use health facilities but ultimately the information is presented at national, regional, zonal and district levels.

6.2 Political Support

6.2.1 Existence of Political Support

The political will and support for HIV and AIDS in Malawi cannot be overemphasized and all stakeholders interviewed acknowledged this. The President of Malawi, His Excellency Dr Bingu Wa Mutharika, campaigns at every opportunity and has openly acknowledged that the Malawi Growth and Development Strategy (MGDS) cannot realize its objectives if HIV and AIDS are not tackled and reduced.[77] Secondly, the National HIV and AIDS Partnership Forum is chaired by the former Vice State President, Dr Justin Malewezi (MP) who for a long time has advocated for HIV prevention, treatment, care and support. The approval by the National Assembly of the NAC budget and budgets for government ministries for funding HIV and AIDS activities is a demonstration by politicians to support the national HIV and AIDS response. The Government of Malawi has also shown its commitment to the fight against HIV and AIDS by placing the NAC within the Office of the President and Cabinet for it to receive maximum and urgent attention by the President..

6.2.2 The Role of the Commission

In line with the prevailing high level political will and support, the National AIDS Commission (NAC) was established in 2001 in the Office of the President and Cabinet as an overall coordinating authority of the HIV and AIDS national response in Malawi. The NAC has a Board of Commissioners. The Board of Commissioners is responsible for policy, programme and financial oversight ensuring transparency and accountability of the organization's operations while NAC management is responsible for the administrative and technical operations of the Commission.[78] As contained in the questionnaire, the Commission has terms of reference and as far as the national response is concerned, there is active government leadership and participation. Within the Board of Commissioners, civil society organizations, PLHIVs and the private sector are represented. The Commission has an action plan, a functional Secretariat based in Lilongwe and meets at least quarterly. Its major responsibility is to make decisions on

[77] His Excellency Dr Bingu Wa Mutharika, the State President Key Note Speech during the Annual General Assembly Session, September 2007. He was explicit in his appeal to the international community to support the Malawi Growth and Development Strategy, which he acknowledged that was faced with the HIV/AIDS challenges that the Government of Malawi and her people are trying to tackle with the help from international community. In addition there have been advocacy efforts through the Parliament Women Caucus to encourage Members of Parliament to undergo HCT and National HIV Testing Day Campaign are some of the commitments of the Malawi Government to reduce HIV infection and improve treatment and care.

[78] . NAC TORs

policy issues and strengthen donor coordination to avoid, among other things, parallel funding and duplication of effort. These issues demonstrate that the Commission is fully functional and promotes the participation of civil society, the private sector and the PLHIVs.

6.2.3 NAC as a Recognized National AIDS body

The official recognized national AIDS body that promotes interaction between government, people living with HIV, civil society organizations and the private sector for implementing HIV and AIDS strategies and programmes is the National AIDS Commission. While NAC is the overall authority in coordinating the HIV and AIDS response, there are different constituencies that have been formed to enhance coordination and networking. The most important Constituencies, according to respondents, are contained in Table 6.2 below:

Table 6.2: Network Organizations in Relation to HIV & AIDS Programming & Implementation

Name of network	Constituency representing
1. Malawi Network of AIDS Support Organizations (MANASO)	It is a network of national NGOs, FBOs and CBOs working in the field of HIV and AIDS care and support, home based care and care for OVC.
2. Malawi Network of People Living with HIV (MANET+)	This is a network representing PLHIVs from all constituencies in the country including those who have formed sub-groups as well as individuals.
3. National Association of People Living with HIV in Malawi (NAPHAM).	This promotes formation of PLHIVs support groups throughout the country and these support groups are affiliated to NAPHAM through which they are represented at NAC.
4. Malawi Interfaith AIDS Association (MIAA).	This represents faith-based organizations both Christians and Muslims and facilitates and coordinates their response within the context of the NAF.
Youth HIV and AIDS Network	This is networking representing youth groups working in HIV and AIDS which promote prevention among young people, and advocates for health friendly services including sexual and reproductive health services. This network is instrumental in encouraging youth participation in HIV and AIDS prevention and promotion of HIV testing and counselling and condom distribution and use as well as behaviour change initiatives.
Malawi Business Coalition Against HIV and AIDS (MBCA)	This was formed in 2003 under the umbrella of the Malawi Confederation of Chambers of Commerce and Industry (MCCCI). Its aim is to lead the fight against HIV and AIDS through coordination of private sector efforts. It

Name of network	Constituency representing
	represents about 55 full members and 10 affiliate members.[79]

The listed networks have clearly stipulated terms of reference and constitutions, defined membership, action plans as well as functional secretariats. They also facilitate and organize regular meetings for their respective members and executive committees.

In addition, the formation of the National HIV and AIDS Partnership Forum that brings together all stakeholders including international NGOs, L-NGOs, Government, private sector, CSOs, development partners (both bilateral and UN organizations) and organizations of PLHIV is another important development for Malawi as it ensures policy discussions at the highest level of collaboration. In all these developments, the achievement has been better coordination among stakeholders and improved implementation and coverage of HIV and AIDS programme efforts. It is also showing to be an important prerequisite towards the "Three in One" principle for Malawi and strengthens the central role of NAC in coordinating all sectors within the HIV and AIDS national response. Other achievements as mentioned by stakeholders and as has been demonstrated earlier in the report include: (i) improved advocacy and lobbying by PLHIVs for increased access to services including treatment, care and support (ii) increased HIV testing and counselling; (iii) increased ART services and coverage; (iv) increased nutrition support services for PLHIV; (v) increased coverage of OVC reached with care and support services; and, (vi) increased participation of civil society organizations in annual reviews and other decision-making related to HIV and AIDS programme and implementation.

Whereas Malawi has made some progress, as indicated by some of the achievements stated above, there are still a number of challenges that need to be dealt with. These challenges include (i) the non-availability of legislation on HIV and AIDS and the legal status of the National AIDS Commission; (ii) inadequate resources to support the various HIV and AIDS network organizations; (iii) fewer number of satellite facilities for the delivery of ART and HTC services, particularly in rural areas; and (iv) the inadequate technical capacity among implementing partners to adequately implement and manage human and financial resources for achievement of good results in HIV and AIDS programme. It is the commitment of Government of Malawi and its development partners to tackle these challenges.

6.2.4 The National AIDS Commission as a Supporting Agency for HIV and AIDS Programme Implementers

Respondents to the composite policy index questionnaire were also asked about the type of support that the National AIDS Commission provides to HIV and AIDS programme implementers. All the respondents mentioned that NAC provides information on priority HIV and AIDS needs and services, technical guidance/materials, drugs/supplies procurement and distribution, coordination with other implementing partners and capacity building. In terms of funding, the indication at present is that NAC channeled about 46% of the funding the past year for the implementation of HIV and AIDS programmes through civil society organizations. It is hoped that as the coordination is strengthened at all levels and technical capacities of implementing partners strengthened, more funding than in the past would be channeled through

[79] The Malawi Business Coalition Against HIV/AIDS (MBCA), *A Bi-annual Update Magazine, Vol.1 No. 1.* Blantyre: MBCA.

civil society organizations and ensure increased coverage especially in the rural areas. NAC has been both proactive and responsive to the requirements of its implementing partners and the provision of support has been very instrumental in enabling civil society organizations to play a significant role to absorb about 46% of the funding last year.

6.2.5 Review of Policies and Laws to Incorporate HIV and AIDS

Malawi is reviewing some policies and laws to ensure that they are consistent with national AIDS policies as well as aligning and harmonizing them with international conventions, which the Malawi Government has signed and ratified. In particular, the review process ensures that policies and laws are in compliance with human rights protection protocols not only for PLHIVs but also for everyone including all target vulnerable sub-populations groups. Currently, the following policies and laws have been and are being reviewed and amended:

(a) The Constitution of the Republic of Malawi (in progress and relevant recommendations submitted and final report ready for submission to Parliament for consideration either before end of 2007 or early 2008);
(b) Domestic Violence Act (2006);
(c) Public Health Act (2006);
(d) Wills and Inheritance Act (2000 and 2005)
(e) Decentralization Act (2003);
(f) Employment Act (2004);
(g) Education Act (in progress);
(h) Communication Act (in Parliament);
(i) Gender Act (in progress)
(j) Children and Young Persons Act (in Parliament for action);
(k) Public Service Act (in progress 2007)
(l) HIV and AIDS Act (in progress 2007)

Most of these pieces of legislation are in place. Policies that are operational as of now are: (i) National HIV and AIDS Policy; (ii) National Policy on Orphan and other Vulnerable Children; (iii) National Youth Policy; (iv) National Early Childhood Development Policy; and (v) National Health Policy. In addition to these national policies, there are sectoral policies governing HIV and AIDS in the workplace, which derive their respective framework from NAF.

6.3 Prevention

6.3.1 Key Messages Being Promoted

Malawi has policies and strategies that promote the provision of information, education and communication (IEC) on HIV and AIDS to the general population as contained for example, in the National AIDS Policy and sectoral HIV and AIDS workplace policies. Key messages are explicitly promoted in relation to a number of areas as illustrated in the Table 6.3 below.

Table 6.3: Key messages being explicitly promoted

Key messages	Response

Be sexually abstinent	Yes
Delay sexual debut	Yes
Be faithful	Yes
Reduce the number of sexual partners	Yes
Use condoms consistently	Yes
Engage in safe(r) sex	Yes
Avoid commercial sex	Yes
Abstain from injecting drugs	Yes
Use clean needles and syringes	Yes
Fight against violence against women	Yes
Greater involvement of people living with HIV	Yes
Greater acceptance of men in reproductive health programmes	Yes
Other: Prevention of mother to child transmission (PMTCT)	Yes

The greater involvement of men in reproductive health programmes has recently been intensified in Malawi through the male championship initiative that is closely implemented with the prevention of mother to child transmission of HIV initiatives. This initiative is promoted through health facilities and communities. Malawi has developed a communication strategy explicitly linked to male championship and PMTCT through a consultative process that included the participation of civil society organizations and other relevant stakeholders such as print and electronic media houses.

Malawi also has policies and strategies to promote information, education and communication and other preventive health interventions for vulnerable sub-populations, particularly for sex workers; long distance track drivers; prison inmates; PLHIV; young people; pregnant women and; women and girls. IEC materials for track drivers have been recorded on audiotapes and distributed to them, which they could listen to as they travel across borders. At the same time similar IEC and other preventive health interventions for vulnerable sub-populations are done through television, radio, brochures, posters and public talk shows in urban and rural areas. NAC and some development partners are facilitating the production of various IEC materials and methods, which the civil society organizations implement for the recognized vulnerable sub-populations as has been discussed earlier.

The policy index questionnaire also looks at the sub-populations and elements of HIV prevention that the policy/strategy addresses. From the interviews conducted it was clear that services such as needles and syringes exchange and drug substitution therapy do not feature highly in the Malawian context. Services such as IEC, stigma and discrimination reduction, condom provision, HIV testing, reproductive health and vulnerability reduction are being provided to sub-populations such as sex workers, clients of sex workers, prisoners etc. However, there is need to intensify such services in order to improve reach to these subpopulations, as far as HIV prevention is concerned.

Malawi has not established the extent of injecting drug users (IDUs) and men having sex with men (MSM) in terms of numbers or proportion to the general population. For the issue of men having sex with men, the challenge is that such a sub-population is not officially and legally recognized to be included in the sub-groups. An attempt has been made to establish the existence of such a sexual practice and it has been shown that it is actually common. Cases of

prisoners with STIs and perinatal abscesses have been reported and this is an indication of the existence of anal intercourse[80] hence the need to protect men who have sex with men.

6.3.3 Promoting the Role of the Media

Malawi as a country has been implementing activities or programmes that promote accurate reporting on HIV and AIDS by the media through seminars, workshops and conferences attended by the media representatives from both electronic and print media houses. These are on-going initiatives and efforts are being made to ensure that the rural areas are also well-covered and informed through media channels such as newspapers, radio and drama and role-plays. This combination of IEC methods ensures that even those who cannot read and write are able to access accurate HIV and AIDS information. Malawi has gone even further by producing relevant messages in Braille for the visually impaired persons and also effort is being made to include sign language on Television and on functions where HIV and AIDS message are being communicated to people so that the hearing impaired people also access information. With NAC leadership Malawi has also produced communication guidelines that ensure that appropriate messages and approaches are followed and adhered to in order to avoid using derogatory and demeaning terminologies and languages against certain categories of people that might encourage stigmatization and discrimination.

Rating for policy efforts in support of HIV prevention

Overall rating of policy efforts in support of HIV prevention in 2007	6.0
Overall rating of policy efforts in the HIV prevention in 2005	5.0

6.3.4 Promoting Sexual and Reproductive Health Education

Malawi as a country has a policy or strategy for promoting HIV-related reproductive and sexual health education for young people. This has mainly been in the form of promoting and implementing life skills education among both in school and out school young people. Life Skills education includes sexual and reproductive health and is part of the curriculum in primary and secondary schools as well as teacher training colleges. However, the extent of its teaching needs strengthening[81]. It has been observed that some teachers are still having some difficulties to teach pupils about sexual and reproductive health due to cultural factors but the situation is improving as people are now becoming more open to discuss sexual and reproductive health issues than in the past. For out-of-school young people the strategy has included the formation of youth clubs and support organizations where peer educators in sexual and reproductive health train their colleagues. These youth clubs cover issues of HIV prevention, STI treatment and condom use as well as abstinence. Some clubs such as AIDS Toto are formed in schools in order to promote interaction and discussion of HIV prevention among young people

[80] For example see Panos Southern Africa. (2006). *Keeping the Promise? A Study of Progress Made in Implementing the UNGASS Declaration of Commitment on HIV/AIDS in Malawi*. Lusaka: Panos Southern Africa

[81] Maleta, K. and Munthali, A (2007). *Impact Assessement of the National HIV/AIDS Response in Malawi.* Lilongwe: National AIDS Commission.

6.4 Treatment, Care and Support

6.4.1 Policies on Treatment, Care and Support

Malawi as a country has policies and strategies to promote comprehensive HIV treatment, care and support. These policies include the National HIV and AIDS Policy; The National Health Policy; National Policy on Orphans and Other Vulnerable Children; and the National Community Home Based Care Policy (in draft). There are also strategies such as the National Action Framework; the PMTCT strategy and the National Plan of Action (NPA) on Orphans and other Vulnerable Children (OVC), which explicitly stipulate non-discriminatory treatment, care and support. These policies and strategies recognize the barriers that women, children and most-at-risk populations experience and measures are clearly stipulated in policies and strategies to address the barriers.

6.4.2 District that Need HIV Treatment, Care and Support

Malawi has clearly identified districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services that include administrative districts under District Assemblies; health delivery areas linked to health facilities; and rural and urban areas. Malawi also recognizes the uniformed services such as the military and police as well as prison inmates as some of the constituencies in need of treatment, care and support services. As such treatment, care and support services programmes are targeting these districts according to the nature of the organization implementing the interventions. A number of treatment, care and support services are implemented in Malawi and Table 6.4 below presents public perception with regards to the extent of different levels of implementation of these services as perceived by those who were consulted. However, it is a fact that all districts are in need of all the activities except that knowledge about them varies from one individual and institution to another in Malawi.

Table 6.4: Relevant implementation levels for each activity in district in Need

HIV treatment, care and support services	The Service is available in		
	All Districts in Need	Most Districts in Need	Some Districts in Need
Antiretroviral therapy	Yes	-	-
Nutritional Care	Yes	-	-
Pediatric AIDS treatment	Yes	-	-
Sexually transmitted infection management	Yes	-	-
Psychosocial support for people living with HIV and their families	Yes	-	-
Home based care	Yes	-	-
Palliative care and treatment of common HIV-related infections	Yes	-	-
HIV testing and counseling for TB patients	Yes	-	-
TB screening for HIV-infected people	-	Yes	-
TB preventive therapy for HIV-infected people	-	-	Yes
TB infection control in HIV treatment and care facilities	-	Yes	-
Cotrimoxazole prophylaxis in HIV-infected people	-	-	Yes
Post-exposure prophylaxis (e.g. Occupational exposure to HIV, rape)	-	Yes	-
HIV treatment services in the workplace or treatment referral systems through workplace	Yes	-	-
HIV care and support in the workplace (including alternative working arrangements)	Yes	-	-
Other: PMTCT services	-	-	Yes

Some of these services are needed in all districts but people lack knowledge of their availability and inadequate infrastructure through which people in need could access them. This is the area the Government of Malawi, in partnership with development partners and CSOs, is intensifying to ensure that adequate personnel are trained and relevant supplies are also available in all service delivery places all the time they are needed. These services are being brought closer to the people in both rural and urban areas.

6.4.3 Availability of Policies on Using Generic Drugs or Parallel Importing of Drugs for HIV

Malawi has a policy for using generic drugs or parallel importing of drugs for HIV as opposed to developing them. However, the knowledge about this process is limited among government officials and other stakeholders except Ministry of Health, Department of Nutrition and HIV and

AIDS and NAC, among those consulted. However, it is widely known that Malawi has access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms and opportunistic infection (OI) drugs. These include drugs used in PMTCT and post-exposure-HIV prevention programmes. For example, Malawi procures antiretroviral and OI drugs through UNICEF using its procurement offices in Copenhagen. Malawi also procures condom supplies through more than one channel since there are marketed brands that are being distributed by PSI and Banja la Mtsogolo (an NGO that deals with sexual and reproductive health). Freely distributed condoms are usually supplied by developed countries and are donations. With growing recognition of the importance of nutrition and HIV, nutrition supplies are also being procured through the same regional management mechanisms.

Rating the efforts to meet the needs of OVC	
Overall rating of the efforts to meet the needs of orphans and other vulnerable children in 2007	6.8
Overall rating of the efforts to meet the needs of orphans and other vulnerable children in 2005	5.4

6.4.4 The Availability of the OVC Policy

Malawi launched a National Policy on Orphans and other Vulnerable Children in 2004 and this was followed by the undertaking of Rapid Assessment, Analysis and Action Planning (RAAAP).[82] The evidence from the RAAAP was used by Malawi to develop a more comprehensive National Plan of Action (NPA) (2005-2009)[83], which highlights almost all focus areas in addressing HIV and AIDS-related needs of orphans and other vulnerable children. Major issues targeted in the plan include: protection; education support; early childhood development and nutrition; psychosocial care and support; health care; and strengthening the capacities of families and communities to care and support OVC. The National Policy on OVC in Malawi emphasizes on community-based approaches as opposed to institutional orphanages, which are considered as a last resort. However, due to certain circumstances especially for infant orphans, short-term institutions exist where children continue to have links with members of extended families to which they are expected to return after two or more years.

6.4.5 Defining An Orphan

The operational definition for OVC in Malawi is in two fords: *"An orphan is defined as a child under the age of 18 years who has lost one or both parents through death."* Secondly, "*Other vulnerable children are those who lack proper care and support and lack basic necessities of life such as food, love and shelter and these include children living on the streets, children in families with sick parents and parents with disabilities or guardians, abandoned and neglected children that lack proper care even when parents may be alive as well as children in conflict with the law*"***.***[84] These operational definitions are clearly stipulated in the National Policy on OVC and the NPA for OVC.

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[82] Government of Malawi/UNICEF (2004): *Rapid Assessment, Analysis and Action Planning;* Lilongwe, UNICEF.

[83] Government of Malawi and UNICEF. (2005). *National Plan of Action for Orphans and Other Vulnerable Children,* Lilongwe. Ministry of Women and Child Development and UNICEF.

[84] Government of Malawi and UNICEF. (2003). *National Policy on Orphans and Other Vulnerable Children.* Lilongwe: Ministry of Women and Child Development

The NPA estimated that there were 1,008,000 OVC in 2005 and this was projected to increase to 1,150,000 by 2010.[85] It is estimated that half of these OVC are due to the HIV and AIDS epidemic. On the other hand, those reached with existing interventions are estimated to be about 450,000 based on the records in the Ministry of Women and Child Development. It is believed that more than this figure is reached because reporting and documentation especially by community based organizations is not comprehensive and challenging. So, it is estimated that Malawi has reached about 50% of OVC with interventions of one form or type to the other through Government, CBOs, FBOs, and NGOs and other civil society organizations and private organizations.

The extent to which UN, bilateral and other institutions share their M and E results	4.2

6.5 Monitoring and Evaluation

6.5.1 Existence of an M & E plan and Challenges

Malawi has one national Monitoring and Evaluation Plan, which is the basis of monitoring progress and impact achievement for the HIV and AIDS national response. The M & E was first developed in 2003 through a consultative process that included the participation of government, development partners, CSOs as well as PLHIVs. The M & E Plan is reviewed and updated from time to time to incorporate emerging new indicators. All stakeholders have aligned and harmonized their respective M & E plan to this national plan with some diversity and they are supposed to report their activities to the national AIDS Commission.

The National HIV and AIDS Monitoring and Evaluation Plan[86] provides core indicators for the national response whereas respective stakeholders may have additional indicators in accordance to specific interventions being implemented and the target populations. Therefore, Malawi has a dynamic and flexible M & E Plan. There are global indicators as well as those that are specific to the country and to respective programmes. These global indicators are the ones that are reported on in the UNGASS report. Some of these global indicators have either been adapted to the local realities or left out altogether. For example, in Malawi at the moment, the indicators related to intravenous drug use and MSM are not documented because they are not yet established categories of target sub-populations.

However, the National HIV and AIDS M &E plan is facing some challenges because of under reporting among stakeholders and differences in data requirements. For example, some donors and development partners include additional indicators for purposes of decision-making for their respective agencies and organizations and often such data is not available in the National M & E reports. The National M & E Plan however, encourages these diversities in order that those who collect data should find it relevant in decision-making and planning and hence improve delivery of quality services.

[85] See Government of Malawi and UNICEF. (2005). *National Plan of Action for Orphans and Other Vulnerable Children,* Lilongwe. Ministry of Women and Child Development and UNICEF.
[86] NAC: *National HIV and AIDS Monitoring and Evaluation Plan 2006-2010: Lilongwe:* NAC.

The respondents to the national policy index questionnaire were also asked whether elements as contained in Table 6.5 below are included in the national M & E plan:

Table 6.5: Does the National HIV and AIDS M & E Plan include the following?

Elements that are included in the M & E Plan	Response
A data collection and analysis strategy	Yes
Behavioral surveillance	Yes
HIV surveillance	Yes
A well-defined standardized set of indicators	Yes
Guidelines on tools for data collection,	Yes
A strategy for assessing quality and accuracy of data	Yes
A data dissemination and use strategy	Yes

The M &E Plan include all the elements in the Table 6.5 above whereby standardized set of indicators, guidelines and data collection tools are available at NAC Secretariat and are distributed widely to all implementing partners for use. NAC and other partners are also supporting studies such as the BSS and the DHS, which measure behavioural change among those aged 15-49 years old. With support from NAC, the MoH through the HIV and AIDS Unit and CHSU conducts HIV sero-surveillance surveys in some 54 selected health facilities in Malawi. The results for these monitoring exercises are widely disseminated during the annual dissemination and review workshops, which are organized by the National AIDS Commission.

6.5.2 Budget for the M & E Plan

The M & E Plan has both indicative and actual budgets. The indicative budget estimates the cost of M & E activities over the period of the plan whereas actual budgets are prepared annually according to the planned activities. The planned activities include conducting of surveys, needs assessments, evaluations, field visits, reviews and consultative conferences. The implementation of surveys and reviews involve engaging consultants who are included in the budget. M & E function is considered very essential for assessing progress in the national HIV and AIDS response and implementation of the HIV and AIDS programmes and therefore, funding has always been secured and made available.

6.5.3 Functional M & E Unit/Department

There is a functional M & E Unit within the NAC Secretariat. It was first established in 2002 and currently it has five established full time positions as Table 6.6 below shows:

Table 6.6: Staffing levels for the M & E Unit within NAC

Number of permanent staff	Full/part time	Since
Head of M & E Office	FT	2003
M & E Officer	FT	2003
Data Manager	FT	2003

Research Officer	FT	2002
Planning Officer	FT	2004

Source: National AIDS Commission.

The M & E Unit in NAC works closely with M & E Officers in respective government, NGOs, civil society organizations and development partners in coordinating information gathering and management of the established national database. All stakeholders submit reports to the M & E Unit for review and consideration in the country's national reports. These reports are regularly discussed among implementing stakeholders during bi-annual and annual review meetings. Importantly, there is an M & E Technical Working Group (TWG), which has representation from all constituencies to ensure that the information generated is consistent with the National M & E Plan and this gives the sense of ownership of the database by all stakeholders.

The extent of M and E data use in planning and implementation	4.2

The M & E Unit at NAC works also closely with the M & E Department in the Ministry of Economic Planning and Development that is mandated to monitor the National Development Plans and together they are strengthening M & E capacities of District Assemblies and sectoral Ministries through training and recruitment of M & E personnel placed in these institutions. At the same time all implementing stakeholders including NGOs, civil society organizations, FBOs and CBOs are encouraged to strengthen their respective M & E portfolios.

The mechanism is working and there is adequate collaboration with the National Statistical Office (NSO), Health Management Information System (HMIS) and University Institutions in data collection and sharing. However, the major challenge of this mechanism to work smoothly is the non-reporting by mostly CBOs and FBOs due to inadequate technical capacity in these institutions and non-reporting to NAC by non-NAC funded organizations. Nevertheless, there is an improvement in reporting at all levels.

6.5.4 M & E Technical Working Group

The M & E Technical Working Group is one of several TWGs under NAC and HIV and AIDS programming. It meets regularly. It has representation from all constituencies of the HIV and AIDS programming including civil society organizations and PLHIVs. The role of civil society representation including PLHIVs in the working group is to contribute towards providing guidance and provision of information and data from their respective constituencies. This ensures that all progress indicators are followed and appropriate action is given where necessary based on shared interest and understanding.

6.5.5 Type of Central National Database Managed by the M & E Unit

The central national database managed by the M & E Unit at NAC is Access Database. It has information about content, target populations and geographical coverage of HIV and AIDS programme activities as well as their implementing organizations. The country is implementing a decentralization policy with programming focus being centred at District Assembly level in terms

of planning, implementation and management of resources. NAC facilitation of HIV and AIDS programming is aligned to this arrangement and therefore the information and data on implementing organizations is presented by district and regions which is then consolidated at national level. This process has started with facilitation of District Development Plans to which HIV and AIDS Programming is a significant component and these activities are translated into District Implementation Plans that determine the funding procedures in a particular year from NAC through District Assemblies.

6.5.6 Functional Health Management Information System (HMIS)

Rating the M and E efforts of the AIDS programme	
Overall rating of the M and E efforts of the AIDS programme in 2007	6.6
Overall rating of the M and E efforts of the AIDS programme in 2007	5.8

There is a functional Health Management Information System (HMIS) under the Ministry of Health. It coordinates national level data as well as sub-national levels. The main sub-national levels are situated at District Health Offices (DHO) throughout the country and data is collected from all major hospitals, rural hospitals and health centres which is submitted on monthly basis through the DHO to HMIS at MoH headquarters at national level. Most importantly, the HMIS also collects data that is used to monitor progress for some indicators in the national M & E system. The HMIS is fully functional and provides data upon which decision-making is made.

6.5.7 Publication of M & E Reports

NAC, through the M & E Unit, publishes HIV and AIDS M & E reports every year. Every two years NAC also publishes results of the HIV sentinel surveillance surveys. The data collected through sentinel surveillance surveys is mainly on HIV prevalence. The annual M & E reports focus on behavioural change including stigma and discrimination, condom use, number of sexual partners, STI management, access to HIV and AIDS services such as ART, PMTCT and HTC among others.[87] The annual M & E reports, including available data from other sources, is mainly used when developing annual work plans, funding proposals, revising strategic plans and identifying and listing key drivers of the AIDS epidemic. While data is used in this manner, there are however, challenges to data use and these challenges include inadequate use of the data at sub-national level and, in some sectors, inadequate technical capacity among stakeholders, particularly CBOs and FBOs to use data effectively; and inadequate access to information technology such as e-mail and website that facilitate quick sharing of data. These challenges however, continue to be addressed in order to ensure that decision-making is informed by available data.

6.5.8 Training in M & E

Training in M & E was conducted last year mainly for those working in Government Departments and Ministries. This was conducted at district level and did not include civil society personnel. A total of 100 people were trained, the majority of whom work for District Assemblies.

[87] NAC (2005-2006), *Malawi HIV and AIDS Monitoring and Evaluation Report,* Lilongwe:NAC

6.6. *NCPI Questionnaire Results Based on Representatives from NGOs, Bilateral Agencies and UN Organizations*

Part B of the NCPI questionnaire was administered to representatives from NGOs, bilateral agencies and UN organizations. These included Family Health International (FHI), Malawi Human Rights Commission (MHRC), and National Association of People Living with HIV in Malawi (NAPHAM), USAID, Norwegian Embassy, World Health Organization (WHO) and United Nations Children's Fund (UNICEF). Like the responses in Part A, most of these respondents did not answer most of the questions in the questionnaire. However, there is enough documentary evidence to explain progress Malawi has made in most of the issues the questions covered.

6.6.1 Human Rights

The protection of all individuals regardless of their socio-economic status, physical, race, creed, colour and place of origin is stipulated in the Constitution of the Republic of Malawi, particularly Chapter IV, which is very comprehensive.[88] However, it does not make explicit reference to people living with HIV. Chapter IV, which is on Human Rights, is clear enough as it advocates for the respect of human rights in all aspects. All laws on protection of people under different circumstances derive their authority from the Constitution of the Republic of Malawi. Since 2006 the Malawi Law Commission has been facilitating a process of constitutional review through consultations at all levels, rural and urban and involving all important sub-population groups such as PLHIVs and other sub-groups. The draft report indicates the explicit mention of HIV and AIDS and this is yet to be submitted to the Cabinet and Parliament for approval. In addition to the reviewing of the constitution, the Malawi Law Commission is in the process of formulating a legislation on HIV and AIDS that is expected to include defining the legal status of the National AIDS Commission and PLHIVs' representatives are participating under a special commission established to work on the proposed legislation.

It should also be mentioned that Malawi is bound by some international conventions to which it is a party by ratifying them such as the Convention on the Right of the Child (CRC); the Convention on Elimination of All Discrimination Against Women (CEDAW) and international protocols such as those advocating protection against sexual exploitation and trafficking; protection of internally displaced and international refugees. Some of these conventions and protocols have been domesticated through legislating laws and formulating policies that incorporate relevant non-discriminatory provisions. There is therefore, adequate legislation to protect human rights.

6.6.2 Non-discrimination Laws and Regulations Protecting Vulnerable Sub-populations

There are laws and regulations in Malawi, which specify protection for vulnerable sub-populations. These include:

- The Constitution of the Republic of Malawi;
- The Domestic Violence Act;
- Wills and Inheritance Act;

[88] Government of Malawi. (2000). *The Constitution of the Republic of Malawi,* 2000, Lilongwe: Government of Malawi

- Children and Young Persons Act; and
- The Adoption Act;

In addition to these statutes, there are policies that also specify the protection for vulnerable sub-populations for example:

- The National Policy on Orphans and other Vulnerable Children;
- The National Policy on HIV and AIDS;
- The Gender Policy;
- The National Health Policy;
- The National Youth Policy;
- The Community Integrated Management of Childhood Illnesses (C-IMCI); and
- The National Early Childhood Development Policy;

According to respondents, there are laws and regulations that protect sub-populations such as women, young people, sex workers, prison inmates and migrants and mobile populations. As far as respondents were concerned, there exist no laws and regulations that protect IDUs and MSM as these are not officially recognized in Malawi. While relevant policies and legal instruments are available, the enforcement and implementation of these instruments remains a big challenge in Malawi.[89]

6.6.3 Mechanisms Put in Place to Ensure Laws are Implemented

The Constitution of the Republic of Malawi provides every individual to seek redress through the legal process if one feels his/her rights have been violated. This may be through the courts, human rights organizations; religious institutions and traditional leaders as well as family members depending on the nature of the violation. With exception of the courts, other institutions use arbitration methods in resolving grievances between people. But more importantly Malawi has so many human rights-related organizations, which advocate for the protection of human rights particularly for those considered vulnerable. These human rights advocacy organizations include Malawi Human Rights Commission, Malawi Network for People Living with HIV (MANET+), NAPHAM; Women's Voice; Gender Network; Women in Law in Southern Africa; and the various members of the Malawi Human Rights Consultative Committee. These create awareness about people's rights and how to protect and enjoy them. They also advise people where to go for redress when one feels violated or abused. The same advocacy human rights organizations ensure that laws and regulations protecting vulnerable people are applied and enforced. These are also the organizations that ensure that the Government of Malawi fulfills the commitments to international conventions and protocols by lobbying for the domestication of these conventions through the passing of relevant national laws. Enforcement and implementation of these laws and regulations however, remain a major challenge to the country.

6.6.4 Systems of Redress put in Place to Ensure the Laws are Having their Desired Effect

[89] Rose Smart and Godfrey Banda. (2004). *Orphans and Other Vulnerable Children in Malawi: An Assessment of the Policy Environment, Desk Review and Key Informant Interview.* Lilongwe: USAID-The Policy Project.

Everyone in Malawi who feels aggrieved can go to courts for redress. The nature of the grievance determines the process to take before going to court. This includes going through the police when a criminal offence has been committed, through legal firms, Legal Aid and sometimes direct to courts if it is a civil offence. Sometimes aggrieved persons go through human rights advocacy organizations, which provide legal assistance by hiring lawyers to represent the aggrieved persons or exerting pressure to bear on Government or justice system to deal with the redressing of the offence and at the same time put systems in place so that a similar issue should not happen again. In light of this, the Government of Malawi, through the constitution, has established such institutions as the Legal Aid Department, Malawi Human Rights Commission and Ombudsman as watchdog over protection of human rights. The Malawi Law Commission is also established by Act of Parliament and Constitution of the Republic of Malawi and has the mandate to review laws in order to ensure that they are in line with the principles of human rights protection.

6.6.5 Laws, Regulations or Policies that Present Obstacles to Effective HIV Prevention, Treatment, Care and Support for Vulnerable Sub-populations

Malawi does not have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations. However, obstacles arise in the form of inadequate infrastructure where vulnerable sub-populations can access services. At the same time, there are obstacles created by individual persons by not being proactive to go where HIV prevention, treatment, care and support services are available. This is also affected by inadequate distribution in the country of service providers especially in rural areas. This situation may change under the decentralization process whereby District Assemblies now have the mandate to allocate NGOs and other services to places where services are needed and there is no organization working in that particular area. With this, it is hoped that increased geographical coverage and that of vulnerable sub-populations will be achieved.

6.6.6 HIV Policy or Strategy Promoting and Protecting Human Rights

HIV policy and strategy in Malawi promote and protect human rights and this is so because all policies are aligned to the human rights provision stipulated in the Constitution of the Republic of Malawi and International Conventions and protocols. Some policies and strategies may not explicitly mention HIV like the present Constitution and terms of reference of the Malawi Human Rights Commission, the provisions are broad enough to include HIV and other forms of vulnerable situations and sub-populations requiring protection. However, the National HIV Policy, the Malawi Growth and Development Strategy[90] and the National Action Framework (NAF) include explicit statements promoting and protecting human rights of all Malawians and explicitly mention the protection of those infected and affected by HIV.

6.6.7 Involving Most-at-risk Populations in Policy Design and Programme Implementation

The Government of Malawi involves the most-at-risk populations in HIV and AIDS policy design and programme implementation. Most-at-risk are represented in Technical Working Groups in all

[90] GoM, *The Malawi Growth and Development Strategy,* 2006, Lilongwe.

the priority areas of the NAF and they are also included in special commissions under the Malawi Law Commission in reviewing and formulating legislation relevant to the respective sub-populations. For example, all stakeholders including PLHIVs participated in the development of the national HIV and AIDS policy[91] and that NAPHAM and MANET+ continue to participate in consultative conferences and review meetings together with other civil society organizations and they are represented at every level. They play active role in national HIV-related events such as Candle Light Memorial; World AIDS Day; HIV testing and counselling annual campaigns; review and development of the national action plans and in the formulation of relevant policies that affect the most-at-risk. Attention is paid to sub-populations such as persons with disabilities, women, PLHIVs, and young people and the Government provides funding for all these activities through NAC and other sectors. In addition, NAC has indicated that about 46% of funding for the implementation of HIV-related programmes last year was channeled through civil society organizations including those representing most-at risk.

6.6.8 Provision of Free HIV and AIDS Services

The Government of Malawi, with support from development partners, provides services such as HIV prevention services, ART and HIV-related care and support interventions free of charge. While it is recognized that Malawi is faced with serious resource constraints, it is however, striving to provide services with financial support from the Pool funding arrangements and bilateral support directly to respective implementing NGOs, FBOs and CBOs throughout the country. The Global Fund has enabled Malawi to scale up the provision of free ART, HTC and PMTCT services. The Global Fund also provides funding for the OVC care and support; community home based care (CHBC) and other priority areas that are included in the National Action Framework. Malawi is also supported through bilateral and multilateral funding agencies such as USAID, JICA, EU, GTZ, UN Family, and foundations such as the Clinton and Hunter Foundation. Additional resources are mobilized through FBOs such as the Norwegian Church AID; Danish Church AID; Caritas International through Catholic Health Commission or Catholic Development Commission (e.g. CORDAID, CRS, CAFOD, etc), which greatly support the government initiative to provide HIV and AIDS free services in Malawi. These services such as ART and HTC have been extended to private health facilities where these services are also provided almost free through Global Fund financial support. This ensures that services are available throughout the country close to people. However, the country is facing infrastructure limitations in terms of facilities and personnel to the extent that some areas, which are in need of services, particularly remote rural areas are not adequately served.

6.6.9 Ensuring Equal Access for Women and Men to Prevention, Treatment, Care and Support

The Government of Malawi provides broad opportunities that ensure that both men and women have equal access to prevention, treatment, care and support services. These policies ensure access for women outside the context of pregnancy and childbirth. Based on the provisions of the Constitution of the Republic of Malawi, issues of health are stipulated equally for all Malawian citizens both men and women. For example, in Chapter III: 13 relating to principles of National Policy makes reference to (a) gender equality; (b) nutrition; (c) health, among others.

[91] Panos Southern Africa. (2006). *Keeping the Promise? A study of Progress Made in Implementing the UNGASS Declaration of Commitment on HIV/AIDS in Malawi*. Lusaka: Panos Southern Africa.

For the latter it is stated that: ***"****To provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care"*[92]*.* This principle ensures that men and women have equal access to health services depending on the perception of individuals and availability of services one needs. The Government of Malawi further ensures equal access for most-at-risk population and this access is governed under the principles referred to above, as it is open and broad based without discriminating anyone. Therefore, there is no different approach to most-at risk except that they are strongly encouraged to access services available in their respective communities and to seek professional advice and assistance whenever necessary from relevant institutions and organizations.

Rating policies, laws and regulations in place promoting and protecting human rights	
Overall rating the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007	5
Overall rating the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2005	3

6.6.10 Prohibiting HIV Screening for General Employment Purposes

Malawi has laws and policies prohibiting HIV screening for general employment purposes and these include the Employment Act (2004), the Education Act (in progress); HIV and AIDS Act (in progress) and the Public Services Act. In addition the National HIV and AIDS Policy as well as NAF prohibit HIV screening for employment purposes. There is exception, however, for the uniformed services particularly the military where HIV screening is being applied for recruitment purposes. But when one is found HIV positive while already in service, then all other HIV programmes of treatment, care and support and prevention apply. No one can be dismissed from the military because of being HIV positive. The military is one of stakeholders to the formulation and implementation of the NAF within the context of national response.

6.6.11 Ensuring that AIDS Research Protocols Involving Human Subjects are Reviewed and Approved

All health sciences research protocols in Malawi including AIDS research protocols involving human subjects are reviewed and approved by the National Health Sciences Research Committee whose secretariat is at the Ministry of Health headquarters. It draws its membership from the University of Malawi, Mzuzu University, Ministry of Health and its institutions, research institutions, communities among other organizations. HIV and AIDS research protocols are also submitted to the College of Medicine Research and Ethics Committee (COMREC), which is a sub-set of the National Health Sciences Research Committee. This committee is very technical and civil society representation is insignificant. At national level, the National Research Council of Malawi has been mandated to approve research protocols but it has delegated the responsibility of approving health sciences research protocols to the National Health Sciences Research Committee and COMREC.

[92] GoM, *The Constitution of the Republic of Malawi,* 2000.

6.6.12 Malawi Human Rights Monitoring and Enforcement Mechanisms

The Malawi human rights monitoring and enforcement mechanisms are enshrined in the Constitution of the Republic of Malawi.[93] These exist as independent national institutions for the promotion and protection of human rights including HIV-related issues. The monitoring and enforcement institutions include: (i) the Malawi Human Rights Commission (Chapter XI); (ii) Malawi Law Commission (Chapter XII); (iii) the Ombudsman (Chapter X); and (iv) the National Compensation Tribunal (Chapter XIII). The work of these institutions is supported by a number of human rights civil organizations for example Civil Liberties Committee (CILIC); Centre for Human Rights Rehabilitation (CHRR); Malawi Carer; Women Voices; NAPHAM; Centre for Legal Assistance (CELA) and National Initiative for Civic Education. Although there exists independent human rights monitoring and enforcement institutions, compliance with human rights standards in the context of HIV and AIDS efforts is not yet up to the expected level. This is due to inadequate technical and financial capacity among civil society human rights advocacy organizations. There is an indication however, that the work of these civil society organizations in promoting and protecting human rights has been contributing to the reduction of HIV-related stigma and discrimination in Malawi. Effort is therefore required to build technical and financial capacities of these civil society organizations to ensure that their advocacy initiatives result in compliance with human rights standards in the context of HIV and AIDS efforts. To support the information presented above, results from the MDHS[94] and MICS[95] demonstrate that stigma and discrimination is declining and CSOs' advocacy work is playing an important role.

6.6.13 Training/sensitization of Members of the Judiciary on HIV and AIDS and Human Rights Issues

The judiciary and labour courts/employment tribunals have been trained/sensitized on human rights issues that may come up in the course of their work. However, this training looks at issues of HIV and AIDS as just some of the human rights issues and therefore, they are not dealt with in isolation of other human rights violations. The HIV and AIDS issues are also looked at through existing legal instruments such as Employment Act, Public Health Act, Public Service Act, Wills and Inheritance Act and above all, according to the Constitution of the Republic of Malawi that stresses on the equality of all Malawians.

6.6.14 Legal Support Services Available in Malawi

Legal aid systems are available in Malawi but not specifically for HIV and AIDS casework. They are systems to assist all those whose rights have been violated and would like to have them redressed through the court of law. These legal aid systems are either partial or fully covered. The first and foremost is the Government Legal Aid Department, which helps those who cannot afford hiring of a lawyer or lawyers to represent them in a case. In addition, some of the human rights advocacy organizations also provide legal aid to those whose human rights have been violated but this is done to a limited extent. These include CILIC, MHRC and MHRCC depending

[93] Government of Malawi. (2000). *The Constitution of the Republic of Malawi.* Lilongwe: Government of Malawi.
[94] National Statistical Office. (2005). *Malawi Demographic Health Survey.* Zomba: National Statistical Office.
[95] National Statistical Office. (2007). *Multiple Indicator Cluster Survey.* Zomba: National Statistical Office.

on the nature of the case. There is also a group of women lawyers who provide free legal aid particularly in cases involving women and not specifically related to HIV-related cases. The Law Department of the University of Malawi also provides free legal aid to clients particularly those involving human rights violations. However, most of these services are only available in urban areas and not in rural areas where most poor people live. The other important institution for having human rights violation redressed is the Ombudsman, which assists people who cannot meet the court costs. The legal aid include going through the court process and arbitration out of courts. The latter tend to be the first line of action by civil society organizations in Malawi.

Programmes to educate, raise awareness among people living with HIV concerning their rights are being implemented and this is the whole essence why NAPHAM and MANET+, among other human rights organizations, were established. It is believed that human rights awareness; their protection and fulfillment would be effective if PLHIVs themselves are part of the initiative. They understand better their situation and how to take appropriate action. This is working as evidenced by increased number of NAPHAM branches being established throughout the country and the growing willingness to disclose one's HIV+ status. The involvement of PLHIVs in all aspects of the HIV national response has helped to reduce stigma and discrimination and increased acceptance of each other at workplace and elsewhere.

6.6.15 Programmes Designed to Change Societal Attitudes of Stigmatization

There are a number of programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS understanding and acceptance. These programmes include breaking the silence through positive HIV status and talking about it publicly during prevention, care and support awareness campaign; placement of PLHIV to work for certain organizations such as under the UNV programme implemented by UNDP in collaboration with MANET+; PLHIV participation in CHBC and care and support initiatives as volunteers within their own communities. In addition to the above stated programmes, there are radio and television talk programmes during which both PLHIV and others discuss issues of HIV and AIDS that help to create better understanding of the situation and reduce discrimination. For example, Banja La Mtsogolo has a television talk show programme that tackles issues related to HIV and AIDS by tackling aspects of STI, condom use and high-risk sexual life style of sex workers and their clients. In addition, there is *"Pa Kachere Health Programme*" on Malawi Television where young people discuss issues related to HIV prevention through behaviour change and discussing cultural aspects that have negative influence on HIV prevention.

6.6.17 Civil Society Participation

This section looks at the extent to which civil society participation is rated at different level and different activities. Below is the summary of responses' ratings.

The extent of civil society participation in	**Scores**
1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national policy formulation?	2.9
2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on AIDS for the	2.9

current activity plan (e.g. attending planning meetings and reviewing drafts).		
3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included,	a). In both the National Strategic plans and national reports?	2.9
	b). in the national budget?	1.14
4. Has the country included civil society in a National Review of the National Strategic Plan? Year Review was conducted.	2004	
5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity?	2.43	
6. To what extent is civil society able to access	a). Adequate financial support to implement its HIV activities?	2.9
	b). Adequate technical support to implement its HIV activities.	2.43

According to respondents, the following is the list of types of organizations representing civil society in HIV and AIDS efforts:

- National Association of People Living with HIV in Malawi (NAPHAM);
- Malawi Network for People Living with HIV (MANET+)
- Malawi National Association of AIDS Support Organizations (MANASO);
- Malawi Interfaith AIDS Association of Malawi (MIAA);
- Malawi Youth AIDS Network;
- Community Based Organizations (CBOs);
- Faith Based Organizations (FBOs)
- Malawi Human Rights Consultative Committee (MHRCC);
- NGOs (National and International);
- Malawi Business Coalition Against AIDS (MBCA);
- Gender Network
- Society of Women Against AIDS in Malawi (SWAM);
- Women and the Law in Southern Africa (WILSA).

Since there are so many individual civil society organizations, the formation of networks has helped to streamline the representation in Technical Working Groups and other HIV-related committees in Malawi. These networks represent all constituencies: e.g. PLHIV, young people, women, religious institutions, human rights and community groups. Most of these are in non-biomedical sectors.

Rating efforts to increase civil society participation	**Scores**
Overall rating the efforts to increase civil society participation in 2007	5.43
Overall rating the efforts to increase civil society participation in 2005	4.14

7. CONCLUSION

This report summarizes the progress that Malawi has made in the national response against HIV and AIDS since the submission of the last UNGASS report in 2005. The development of this report involved the participation of all stakeholders namely government, the private sector and civil society organizations. A number of developments have taken place since the submission of the last UNGASS report for Malawi. As has been shown in this report, most of the targets that were set in 2006 have either been reached or are about to be reached while it is unlikely that some of these will be reached by the year 2010. Generally, good progress has been made in achieving Universal Access targets in the country.

Appendix 1: Number of HIV and AIDS Brochures/Booklets Distributed per District

District	Jan 05-Jun 05	Jul 05- Jun 06	Jul 06- Jun 07	Totals
Chitipa	4,094	9,863	1,972	15,929
Karonga	872	11,739	23,680	36,291
Likoma	0	511	486	997
Mzimba	22,428	42,794	33,251	98,473
Mzuzu	3,564	4,806	7,561	15,931
Nkhata-Bay	3,742	17,664	17,165	38,571
Rumphi	180	1,094	8,463	9,737
Total N. Region	**34,880**	**88,471**	**92,578**	**215,929**
Dedza	161	4,395	6,564	11,120
Dowa	27,107	3,255	3,221	33,583
Kasungu	1,090	30,918	10,517	42,525
Lilongwe	79,426	175,727	105,482	360,635
Mchinji	7,590	99	2,961	10,650
Nkhotakota	3,744	5,017	284	9,045
Ntcheu	4,577	6,542	2,608	13,727
Ntchisi	37,249	7,197	2,404	46,850
Salima	504	11,812	14,972	27,288
Total C. Region	**161,448**	**244,962**	**149,013**	**555,423**
Balaka	1,705	13,506	5,577	20,788
Blantyre	53,887	188,152	576,381	818,420
Chikwawa	12,163	7,181	11,715	31,059
Chiradzulu	4,584	3,031	4,519	12,134
Machinga	7,467	7,459	4502	19428
Mangochi	471	9,174	4,100	13,745
Mulanje	34,806	88,159	14,264	137,229
Mwanza	50	2,233	2,741	5,024
Neno	590	6,236	8,343	15,169
Nsanje	1,599	797	3,120	5,516
Phalombe	6,905	10,466	9,151	26,522
Thyolo	32,780	12,445	6,134	51,359
Zomba	13,812	35,079	12,243	61,134
Total S. Region	**170,819**	**383,918**	**662,790**	**1,217,527**
National Totals	**367,147**	**717,351**	**904,381**	**1,988,879**

Appendix 2: Number of Employees That have Benefited from HIV and AIDS Workplace Programmes in the Last 12 Months

DISTRICT	MALE	FEMALE	TOTAL
Balaka	364	690	**1,054**
Blantyre	7,489	6,022	**13,511**
Chikwawa	505	33	**538**
Chiradzulu	11	0	**11**
Chitipa	95	59	**154**
Dedza	1,389	619	**2,008**
Dowa	684	454	**1,138**
Karonga	197	164	**361**
Kasungu	113	82	**195**
Likoma	2	1	**3**
Lilongwe	4,519	3,634	**8,153**
Machinga	14	6	**20**
Mangochi	451	213	**664**
Mchinji	1,129	995	**2,124**
Mulanje	649	652	**1,301**
Mwanza	26	12	**38**
Mzimba	300	216	**516**
Mzuzu	186	122	**308**
Neno	300	346	**646**
Nkhatabay	214	114	**328**
Nkhotakota	615	840	**1,455**
Nsanje	226	144	**370**
Ntcheu	380	250	**630**
Ntchisi	375	413	**788**
Phalombe	243	194	**437**
Rumphi	156	73	**229**
Salima	11	12	**23**
Thyolo	321	350	**671**
Zomba	446	303	**749**
Total	21,410	17,013	**38,423**

Appendix 3: Number of Households Receiving External Assistance for Persons Who are Chronically ill for 3 or More Months, July 2006 to June 2007

	Type of Support					
District:	***Psychosocial***	***Nutritional***	***Financial and Resource Financial***	***Medical***	***Domestic***	***Total***
Balaka	377	637	711	381	1,079	**3,185**
Blantyre	7,393	6,496	906	3,451	3,456	**21,702**
Chikwawa	10,542	2,355	413	2,286	4,332	**19,928**
Chiradzulu	485	253	126	240	444	**1,548**
Chitipa	762	1,150	260	1,492	636	**4,300**
Dedza	2,437	3,127	310	2,791	956	**9,621**
Dowa	2,384	2,049	1,748	2,213	2,618	**11,012**
Karonga	1,577	1,789	420	1,429	1,578	**6,793**
Kasungu	259	1,933	431	4,960	628	**8,211**
Likoma	304	238	139	68	161	**910**
Lilongwe	31,816	25,094	1,760	20,109	8,929	**87,708**
Machinga	1,244	1,039	373	1,124	868	**4,648**
Mangochi	7,083	7,039	174	1,384	500	**16,180**
Mchinji	7,267	3,279	1,378	5,025	2,250	**19,199**
Mulanje	9,727	4,408	5,083	7,018	4,860	**31,096**
Mwanza	4,222	2,703	454	1,379	1,989	**10,747**
Mzimba	5,138	5,011	616	4,734	2,636	**18,135**
Mzuzu	358	329	133	527	363	**1,710**
Neno	1,005	465	271	914	625	**3,280**
Nkhatabay	2,281	2,824	512	2,836	1,789	**10,242**
Nkhotakota	15,001	3,468	1,751	2,945	3,950	**27,115**
Nsanje	5,122	4,818	1,058	1,778	3,833	**16,609**
Ntcheu	208	105	115	177	87	**692**

Ntchisi	757	486	273	475	498	**2,489**
Phalombe	14,003	4,386	2,110	7,959	10,600	**39,058**
Rumphi	7,039	1,364	476	2,507	1,022	**12,408**
Salima	2,085	1,866	489	2,684	1,980	**9,104**
Thyolo	5,988	2,591	577	3,855	2,686	**15,697**
Zomba	4,204	1,633	264	3,960	4,608	**14,669**
Total	**151,068**	**92,935**	**23,331**	**90,701**	**69,961**	**427,996**

Source: Quarterly Service Coverage Report, NAC, July 2006 to June 2007

Appendix 4: Number of Households Receiving External Assistance for Persons Who are Chronically ill for 3 or More Months, July 2005 to June 2006

District	Psychosocial	Nutritional	Financial	Medical	Domestic	Total
Dowa	2,622	8,711	1,007	2,529	3,315	**18,184**
Kasungu	569	2,375	499	2,747	916	**7,106**
Lilongwe	25,064	15,520	5,375	10,917	7,980	**64,856**
Mchinji	3,716	2,351	975	3,198	2,156	**12,396**
Nkhotakota	5,483	1,741	581	2,996	2,766	**13,567**
Ntcheu	998	1,674	741	457	911	**4,781**
Ntchisi	3,233	2,252	710	1,956	2,952	**11,103**
Salima	2,080	2,520	299	1,995	1,899	**8,793**
Dedza	3,074	2,991	687	2,904	2,127	**11,783**
Central	46,839	40,135	10,874	29,699	25,022	**152,569**
Karonga	2,945	3,199	352	1,901	7,717	**16,114**
Likoma	113	156	56	161	59	**545**
Mzimba	9,852	6,062	1,865	6,017	4,958	**28,754**
Mzuzu	419	1,032	265	162	41	**1,919**
Nkhatabay	2,975	2,507	490	2,137	2,808	**10,917**
Rumphi	1,332	546	395	958	634	**3,865**
Chitipa	1,406	954	429	668	844	**4,301**
North	19,042	14,456	3852	12,004	17,061	**66,415**
Balaka	959	1,427	221	1,680	1,287	**5,574**
Blantyre	6,814	11,479	568	7,867	5,537	**32,265**
Chikwawa	3,653	3,586	501	1,065	4,480	**13,285**
Chiradzulu	7,641	5,120	1,221	2,163	2,169	**18,314**
Machinga	2,610	2,975	510	1,610	1,161	**8,866**
Mangochi	21,898	13,110	168	1,861	263	**37,300**
Mulanje	15,550	8,403	4,581	13,038	5,660	**47,232**
Mwanza	3,625	2,802	665	2,528	2,937	**12,557**
Neno	4,270	1,617	3,294	1,909	1,119	**12,209**
Nsanje	4,467	4,250	1,551	2,668	3,560	**16,496**
Phalombe	10,336	16,883	3,403	11,655	11,820	**54,097**
Thyolo	26,976	9,377	505	17,335	5,125	**59,318**
Zomba	6,459	4,702	1,228	3,914	5,584	**21,887**
South	115,258	85,731	18,416	69,293	50,702	**339,400**
Total	**181,139**	**140,322**	**33,142**	**110,996**	**92,785**	**558,384**

Source: Final Monitoring and Evaluation Report, 2005/06 FY

Appendix 5: Number of Orphans and Other Vulnerable Children Reached with Impact Mitigation Interventions (disaggregated)

DISTRICT	PSYCHOSOCIAL	NUTRITION	FINANCIAL	OTHER	TOTAL
Balaka	968	1,456	695	889	**4,008**
Blantyre	18,792	13,818	488	4,490	**37,588**
Chikwawa	20,325	12,455	784	2,567	**36,131**
Chitipa	1,198	779	230	138	**2,345**
Dedza	4,090	7,280	575	1,273	**13,218**
Dowa	7,574	4,401	7,180	3,454	**22,609**
Karonga	11,587	4,065	452	1,259	**17,363**
Kasungu	4,572	4,568	1,026	3,801	**13,967**
Likoma	1,006	615	101	358	**2,080**
Lilongwe	29,271	34,569	1,195	1,947	**66,982**
Machinga	25,183	4,094	431	849	**30,557**
Mangochi	1,820	1,409	105	431	**3,765**
Mchinji	9,616	7,982	2,132	4,553	**24,283**
Mulanje	26,826	17,405	7,842	4,302	**56,375**
Mwanza	9,295	8,991	720	1,955	**20,961**
Mzimba	13,482	8,893	650	2,210	**25,235**
Mzuzu	582	765	238	187	**1,772**
Neno	4,665	4,503	613	860	**10,641**
Nkhatabay	5,935	4,367	729	2,117	**13,148**
Nkhotakota	8,537	4,344	284	2,994	**16,159**
Nsanje	7,224	4,510	752	4,101	**16,587**
Ntcheu	740	391	121	819	**2,071**
Ntchisi	1,601	1,195	172	654	**3,622**
Phalombe	26,299	8,473	1,855	5,585	**42,212**
Rumphi	7,600	2,922	519	957	**11,998**
Salima	30,273	32,418	838	1,482	**65,011**
Thyolo	8,138	1,935	480	894	**11,447**
Zomba	4,427	7,887	157	1,339	**13,810**
Total	**291,626**	**206,490**	**31,364**	**56,465**	**585,945**

Source: Quarterly Service Coverage Report, NAC, July 2006 to June 2007

Appendix 6: Approved research proposals January 2007-December 2007

Appendix 6: NCPI – Part A: Government Official Respondents'Results

Organization	Name/Position	Respondents to Part A				
		A.I: Strategic Plan	A.II: Political Support	A.III: Prevention	A.IV: Treatment, Care & Support	A.V: Monitoring and Evaluation
Ministry of Justice	Mr Kandu, HIV and AIDS Focal Person.	Yes	Yes	Yes	Yes	Yes
Ministry of Education, Science and Technology	Mr. Oscar Mponda, HIV and AIDS Focal Person	Yes	Yes	Yes	Yes	Yes
Ministry of Health & Population	Dr Kamoto /Nkhata, HIV and AIDS Section	Yes	Yes	Yes	Yes	Yes
National AIDS Commission	Dr Bizwick Mwale, Executive Director	Yes	Yes	Yes	Yes	Yes
Department of HIV/ AIDS and Nutrition in the Office of the President and Cabinet	Dr. Mary Shawa, Principal Secretary for HIV and Nutrition Services.	Yes	Yes	Yes	Yes	Yes

NCPI – PART B: Representatives of NGOs, Bilateral Agencies and UN Organizations

Organization	Name/Position	Respondents to Part B			
		B.I: Human Rights	B.II: Civil Society Participation	B.III: Prevention	B.IV: Treatment, Care and Support
UNICEF	Miriam Chipimo, PMTCT Specialist	Yes	Yes	Yes	Yes
World Health Organization	Dr. Limbambala	Yes	Yes	Yes	Yes
Malawi Human Rights Commission (MHRC)	Mr. Charles Malunga, Deputy Executive Secretary	Yes	Yes	Yes	Yes
National Association of People Living with HIV and in Malawi (NAPHAM)		Yes	Yes	Yes	Yes
Family Health International (FHI)	Margret Kaseje, Country Director	Yes	Yes	Yes	Yes
Norwegian Embassy (HIV & AIDS Support)		Yes	No	No	No
Catholic Health Commission	Dr Hinx?	Yes	Yes	Yes	Yes