REPUBLIC OF MALAWI

NATIONAL AIDS COMMISSION

MALAWI HIV AND AIDS MONITORING AND EVALUATION REPORT

2007-2008
Republic of Malawi

National AIDS Commission

Malawi HIV and AIDS Monitoring and Evaluation Report
2007-2008
PREFACE

The first case of HIV diagnosed in Malawi in 1985 brought about the realization of the need for Malawi to consistently monitor trends in HIV prevalence and behaviours, attitudes and practices that predispose people to acquiring it. Such monitoring has been through programmatic as well as systematic surveillance of the epidemic.

I am therefore very pleased to present the national HIV and AIDS Monitoring and Evaluation (M&E) Report for the July 2007 to June 2008 Fiscal Year, which is a synthesis of evidence gathered through various monitoring, evaluation and surveillance efforts. Production of this report underscores the importance that the National AIDS Commission and its stakeholders accord to M&E in the national response to HIV and AIDS, as information generated not only informs but also has the potential to guide policy and programmes.

Notably, significant progress has been made in the year as evidenced by monitoring results, which have been presented in this report: The nation has seen considerable scale up of prevention and treatment programmes in the year under review as manifested by the number of people enrolled on ART and PMTCT services and the number of sites providing the services. Evidence from HTC sites also points to the need to continue scaling up the numbers in order to ensure that the demand for these services is met. Impact mitigation programmes have also registered notable progress in terms of the number of OVC who are provided with support by various partners.

Notwithstanding these achievements, challenges still exist with regard to monitoring the quality of services being delivered; documentation and reporting of various programmes that are being implemented by various stakeholders; and, ensuring that M&E and research results into appropriate policy change and action.

Let me take this opportunity to extend sincere gratitude to the Malawi Government for providing leadership and financial support; development partners for their financial and technical support to the national response and to all implementers at national, district and community levels for tirelessly working on the noble fight against HIV and AIDS.

Dr Biziwick Mwale

EXECUTIVE DIRECTOR
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<th>Description</th>
</tr>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Clinic</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>BLM</td>
<td>Banja La Mtsogolo</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioural Surveillance Survey</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
</tr>
<tr>
<td>CDC</td>
<td>Centres for Disease Control</td>
</tr>
<tr>
<td>CHAM</td>
<td>Christian Health Association of Malawi</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith Based Organisation</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing and Counselling</td>
</tr>
<tr>
<td>MBCA</td>
<td>Malawi Business Coalition against HIV and AIDS</td>
</tr>
<tr>
<td>M &amp; E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSM</td>
<td>Men having Sex with Men</td>
</tr>
<tr>
<td>NAC</td>
<td>National AIDS Commission</td>
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<tr>
<td>NAF</td>
<td>National HIV and AIDS Action Framework</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non Governmental Organisation</td>
</tr>
<tr>
<td>NSO</td>
<td>National Statistical Office</td>
</tr>
<tr>
<td>Acronym</td>
<td>Meaning</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>OI</td>
<td>Opportunistic Infections</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Other Vulnerable Children</td>
</tr>
<tr>
<td>PIWA</td>
<td>People Living With HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TWG</td>
<td>Technical Working Group</td>
</tr>
<tr>
<td>UA</td>
<td>Universal Access</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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The Commission wishes to extend gratitude to all those who made it possible for the Report to materialize. Special thanks go to NAC Management for their guidance in the entire report writing process.

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Last but not least, all technical staff in NAC deserve thanks for contributing constructively to the production of this report.
Executive Summary

The 2007 HIV Sentinel Surveillance Survey estimates HIV prevalence rate in the 15-49 age-group to be 12%. Estimates from the 2005 Sentinel Surveillance Survey had put prevalence rate at 14%.

The total number of people estimated to be living with HIV in 2007 was 898,888 out of which 381,462 were estimated to be males and 517,427 were females. The total estimated number of children (aged 0-14) living with HIV was 89,056 of which 44,977 were male children and 44,079 were female children.

As a consequence of the HIV epidemic, the number of orphans continues to be on the increase. It is estimated that the total number of orphans in 2007 was 1,164,939 of which 436,503 were due to AIDS related deaths, representing 37% of the entire estimated number of orphans in the country.

Guided by the National Action Framework (2005-2009) and its annual operational tool, the Integrated Annual Work Plan (IAWP), a number of priority areas have registered commendable progress even though there were some challenges which hindered achievement on others. The achievement registered on most indicators calls for a revision of the Universal Access Targets for 2010.

This report therefore synthesizes progress made in the national response to HIV and AIDS in the July 2007 to June 2008 Fiscal Year. Where impact is presented, the report heavily relies on population-based surveys as data sources, whilst for output data, the report is largely based on the NAC Activity Reporting System (ARS).
1.0 Introduction

1.1 Demographic Profile

According to the 1998 Population and Housing Census\(^1\), the 2007 population was projected at 13,187,632. Out of this population, 89% were reported to be living in the rural and 11% were in the urban areas. In terms of regional distribution, the highest proportion of the population (about 47%) lives in the Southern Region, followed by Central Region with 41% and the Northern Region with 12% of the population.

In terms of age structure, Malawi’s population is relatively young with a dependency ratio of 0.906. The 1998 Population and Housing Census reported that about 44% of the population were under 15 years old, 52% were in between the age range of 15 and 64 whilst only 4% were over 65 years of age. It becomes imperative to therefore target the reproductive age group with HIV interventions since the bulk of the population lies in this age category, and that is where the greatest risk of HIV infection falls.

1.2 Economic and Poverty Profile

Malawi’s economy is predominantly agrarian with the agricultural sector contributing about 30% of GDP and over 90% of foreign exchange earnings. Around 90% of the population is engaged in agriculture and Tobacco, Tea and Sugar are the major export commodities.

Malawi’s economic direction is set out in its blueprint, the Malawi Growth and Development Strategy (MGDS, 2006-2011). The strategy earmarks priority areas for development that would spur economic growth which would then lead into sustainable poverty reduction. Economic Growth has averaged 5% in recent times and inflation is in single digits owing to macroeconomic management and good donor inflows.

According to the Human Development Report of 2005, Malawi is ranked 165\(^{th}\) out of the 177 countries in the world. The country has a per capita GNP of US$190 and over 52% of the population is considered poor, living on less than one dollar a day.

1.3 Health Profile

Life expectancy at birth has in the recent past declined to about 40 years mainly as a result of the impact of the HIV and AIDS pandemic. Under-five mortality reduced from 189 to 133 per 1000 live births between 2000 and 2004, implying that one (1) in every seven (7) children die before their 5\(^{th}\) birthday. The Maternal Mortality Rate is at 984 deaths per 100,000 live births (2004), an improvement from 1,120 deaths per 1000 registered in the 2000 DHS. It is estimated that 48% of children under the age of five years may be clinically malnourished or stunted (NSO, 2004).

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\(^1\) Data entry for the 2008 Population and Housing Census underway at the time of writing the Report
The major causes of mortality and morbidity in Malawi are mostly preventable, with malaria as the leading cause of outpatient visits (30% of the OPD visits) followed by diarrhoeal diseases (including cholera) and Acute Respiratory Infections.

Tuberculosis, once thought to be on the decline, has of late reportedly increased five-fold in the past few years and this has also been exacerbated by HIV and AIDS (MoH, 2004).

Table 1: Selected Health Indicators for Malawi

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Infant Mortality Rate per 1,000 live births</td>
<td>104</td>
<td>76</td>
</tr>
<tr>
<td>Under five Mortality Rate per 1,000 live births</td>
<td>189</td>
<td>133</td>
</tr>
<tr>
<td>Life Expectancy at birth</td>
<td>36.3 years</td>
<td>40</td>
</tr>
<tr>
<td>Maternal Mortality Rate/100,000 live births</td>
<td>1120</td>
<td>984</td>
</tr>
<tr>
<td>Antenatal care Coverage (%)</td>
<td></td>
<td>91.4</td>
</tr>
<tr>
<td>Attendance at birth by trained personnel</td>
<td>55</td>
<td>38%</td>
</tr>
<tr>
<td>Contraceptive Prevalence Rate</td>
<td>25</td>
<td>28.1</td>
</tr>
<tr>
<td>Children under 5 years chronically malnourished</td>
<td>49</td>
<td>48</td>
</tr>
<tr>
<td>Immunization Measles</td>
<td>64.2</td>
<td>82%</td>
</tr>
<tr>
<td>Population per physician</td>
<td>101,000</td>
<td>62,000</td>
</tr>
</tbody>
</table>

Source: various

Availability of qualified human resources remains one of the biggest challenges experienced by the health sector in Malawi. The situation is dire considering the burden of disease that has been exacerbated by the advent of HIV. There is currently one doctor per 62,000 people in the country which, compared with other countries in the SADC region, is a very worrying statistic. The doctor population ratio is one per 25,000 in Tanzania, one per 7,200 in Zimbabwe and one per 1,800 in the Republic of South Africa (MoH, 2004).

Malawi has a three-tier health delivery system consisting of primary (dispensary or health centre), secondary (district level) and tertiary (referral) levels of care. Ownership of the facilities is largely by the public sector (MoH), though a reasonable number is also managed by religious institutions under the Christian Health Association of Malawi, not-for-profit NGOs and the private sector.
2.0 Trends in HIV Prevalence

Ever since the first HIV case was diagnosed in Malawi in 1985, various surveillance mechanisms have been put in place to ensure that the country tracks the epidemic in order to inform decision making. Besides monitoring the response through periodic population based surveys and other special studies, biennial sentinel surveillance has been the traditional means with which HIV prevalence is estimated and trends ascertained. Using modeling techniques, prevalence in pregnant women attending antenatal clinics has been used to extrapolate and estimate prevalence rates for the whole population. Traditionally, Malawi has been using 19 antenatal sites but from 2007, the number of sites was increased to 54 such that each district had at least two sites from where pregnant women were recruited into the survey.

2.1 National HIV Prevalence

The 2007 Sentinel Surveillance Survey estimates the national HIV prevalence rate in the 15-49 age-group to be 12%. Estimates from the 2005 Sentinel Surveillance Survey had put prevalence rate at 14%. Owing to new knowledge on the epidemic, including enhanced survival rates, and calibration of sentinel figures using MDHS 2004 figures, the 2005 estimate is 12.3% implying a slight decline in the prevalence rate between 2005 and 2007. Figure 1 shows trends in prevalence rate in the 15-49 age-group. The 2010 Universal Access (UA) Target of 12.8% for this indicator has been surpassed. It is therefore imperative that the UA target be revisited to reflect the new achievements to date and provide another benchmark for assessment.

![Figure 1: HIV Prevalence in 15-49 Age Group](image-url)
2.2 HIV Prevalence by Geographic Location

The 2007 Sentinel Surveillance Survey estimates that HIV prevalence rate in the 15-49 age-group is relatively higher in the urban (15.6%) compared to the rural areas (11.2%). However, compared to previous years, there has been a sharp decline in urban prevalence whilst rural HIV prevalence rate appears to have stabilized. Owing to the fact that over 80% of the population live in the rural areas, it is imperative that prevention efforts be intensified since a significant reduction in HIV prevalence rate in the rural areas could ultimately result in an overall national reduction. Figure 2 below shows prevalence by geographic location between 1999 and 2007.

![Figure 2: Prevalence Trends among 15-49 age group by Geographic Location](image)

2.3 HIV Prevalence by Region

According to the 2007 Sentinel Surveillance, HIV prevalence rate was highest in the Southern Region followed by Central and Northern Regions. In terms of trend, Figure 3 shows that except for 2001 when Central Region recorded the highest HIV prevalence rate, Southern Region has been recording high prevalence rates though the rate has comparatively reduced as at 2007.
2.4 HIV Prevalence by Gender

The 2007 Sentinel Surveillance estimates that in the 15-49 age group, HIV prevalence is higher among females compared to males and this has been the trend since 2001 (see Figure 4 below). This disparity may be attributed to both sociological and biological differences between males and females.
2.5 Prevalence of HIV among High-Risk Groups

Monitoring prevalence is as important as understanding knowledge, attitudes and behaviours associated with HIV transmission, especially amongst sub-populations considered to be most at risk. In addition to behavioural issues, the 2006 Behavioural Surveillance Survey (BSS) included biological surveillance by way of biomarker testing. Figure 5 below shows the prevalence of HIV among high-risk population groups covered by the BSS. It can be seen from the table that HIV prevalence is above the national rate of 12% in all subgroups except for male vendors (7%). The highest prevalence rate was registered among female sex workers (71%) followed by female police personnel (33%).
2.6 New HIV Infections/Incidence Rate

HIV prevalence consists of new infections and those infected in the past. In this case, if prevalence is to decline, number of new infections has to be smaller than the number of deaths due to AIDS. With the advent of Antiretroviral Therapy (ART) and subsequent improvements in survival rates of infected people prevalence is no longer proving to be a robust indicator for measuring the impact of the national response since under the status quo, those already infected are living longer than was the case in the absence of the ART programme. It is therefore important that with the scale up of ART, new infections (incidence) be used to measure the impact of the national response.

However, under current practices and in the absence of molecular biological techniques, incidence is currently being estimated by using HIV prevalence in pregnant young women (15-19 or 15-24). It is more likely that prevalence in these age groups could be attributed to new infections and not necessarily existing infections since these may have just joined the sexually active group. Figure 6 below shows prevalence trends amongst pregnant women in the age groups 15-19 and 15-24. Having peaked drastically between 2001 and 2003, prevalence amongst young pregnant women in the 15-24 age group has consistently dropped. A similar trend can be discerned from the 15-19 age group, where prevalence peaked in 2001 and drastically dropped until 2005, before leveling off in 2007.
Figure 6: HIV Prevalence among Pregnant Women in 15-19 and 15-24 age-group

Source: MoHi, Sentinel Surveillance Reports, various
3.0 STI Prevalence in Malawi

Sexually Transmitted Infections (STIs) are an independent risk factor or a cofactor for HIV infection since the transmission of HIV is accelerated in the presence of STIs. This calls for proper diagnosis and treatment of STIs and integration of HTC into STI case management.

3.1 Prevalence Estimates from ANC Surveys

The 2007 Sentinel Surveillance Survey found that syphilis prevalence was 1.1% implying that prevalence continued to decline in the last 10 years. Figure 7 below shows STI prevalence amongst antenatal attendees since 1995.

![Figure 7: STI Prevalence amongst Antenatal Attendees](image)

3.2 Self Reported STI infections

According to the 2004 MDHS, prevalence of self-reported cases of STI was significantly lower in 2004 compared to 2000. However, the decline was more pronounced in young men compared to young women in the age-groups 15-19 and 20-24 as can be observed from Figure 8 below.
3.3 STI Management

3.3.1 Appropriate Diagnosis and Treatment of STI

According to the Health Facility Survey 2007, the proportion of STI cases diagnosed and treated in STI clinics according to national guidelines was at 69%. The percentage of patients appropriately diagnosed was 84% whilst those appropriately treated (74%) and, appropriately counseled on STI was (56%). As a composite, 36% of patients with STIs were appropriately diagnosed, treated and counseled. It becomes imperative, therefore, that more effort be put into diagnosis and treatment of STIs in order to reduce the potential risk of HIV infection.

3.3.2 Advice on Condom Use, Partner Notification and Referral for HIV Testing

The 2007 Health Facility Survey reports that 23% of patients with STI were given advice on condom use and partner notification. However, only 11% of patients presenting with STIs were referred for HIV testing besides being given advice on condom use and partner notification.
4.0 Progress under Prevention and Behavioural Change

4.1 Sexual Behaviour

4.1.1 Median Age at First Sex among 15-24 Year Olds

One of the means through which HIV transmission could be prevented amongst the youth is by delaying their first sexual encounter and thus delaying their first exposure to HIV.

As it can be observed from Table 2 below, both the MICS 2006 and MDHS 2004 agree that sexual debut among male youth increased between 2004 and 2006. The age at first sex for females has remained static at 16 over the three reporting points. In terms of location, while the age at first sex is static for females in both rural and urban areas, the DHS 2004 and MICS 2006 report an increase from the reported DHS 2000 figure of 15 to 16 for rural males whilst for urban males the median age is 16 in the DHS 2000, 17 in the DHS 2004 and 16 in the MICS 2006. It can therefore be concluded that there has not been any significant change in the median age at first sex amongst both young men and women in the six years and prevention efforts need to vigorously advocate for such an increase. It should, however, be noted that due to structural factors, it could be a challenge to raise age at sexual debut for females since research has shown that the current median age at first sex coincides with the median age for marriage (Malawi Government, UNGASS Report, 2007).

Table 2: Median age at first sex among 15-24 year olds

<table>
<thead>
<tr>
<th></th>
<th>MDHS 2000</th>
<th>MDHS 2004</th>
<th>MICS 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>15.0</td>
<td>17.0</td>
<td>16.0</td>
</tr>
<tr>
<td>Female</td>
<td>16.0</td>
<td>16.0</td>
<td>16.0</td>
</tr>
<tr>
<td>Rural Male</td>
<td>15.0</td>
<td>16.0</td>
<td>16.0</td>
</tr>
<tr>
<td>Female</td>
<td>16.0</td>
<td>16.0</td>
<td>16.0</td>
</tr>
<tr>
<td>Urban Male</td>
<td>16.0</td>
<td>17.0</td>
<td>16.0</td>
</tr>
<tr>
<td>Female</td>
<td>16.0</td>
<td>16.0</td>
<td>16.0</td>
</tr>
</tbody>
</table>


4.1.2 Higher Risk Sex in the Past 12 Months

High risk sex is one of the major factors for HIV transmission. From Figure 9 below, it can be seen that risky sexual behaviors are reportedly more evident in the young age groups for both men and women even though it is much pronounced amongst the male youth. It is also clear that the older one gets, the less likely they are to engage in higher risky behavior.
Between 2000 and 2004, the proportion of men reporting higher risk sex increased in the 15-24 age-group but has shown a reduction in the older age-groups. However, for females, whilst the proportion of young females engaging in higher risk sex reduced between 2000 and 2004, the older age groups have shown an increase. This implies that while older men tend to be less likely to engage in higher risk sex, the converse is true for older women (See Figures 10 & 11 below).
Figure 10: Percentage of males Reporting High Risk Sex in the past 12 months

Source: MDHS 2004

Figure 11: Percentage of Females Reporting High Risk Sex in the past 12 months

Source: MDHS, 2004
4.1.3 Knowledge of HIV

Accurate and comprehensive knowledge of how HIV is transmitted and the strategies for preventing transmission is one of the most important prerequisites for reducing the rate of HIV infection.

While general awareness of HIV is considerably high amongst Malawians owing to rigorous HIV awareness campaigns that have been mainstreamed in a number of programmes, comprehensive knowledge is still low. Figure 12 shows levels of comprehensive knowledge amongst the 15-24 age-group between 2000 and 2006. It can be seen that in 2000, 58.2% of men and 49.7% of women had correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions whilst in 2004, 37.1% of males and 25.1% of females had correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions. This implies that there was a decline in comprehensive knowledge between the two reporting points. MICS 2006 however, does not show any significant difference in comprehensive knowledge amongst men and women. This means there is a need to repackage the various communication messages to ensure that the various myths and misconceptions about HIV are dispelled and to achieve the 2010 Universal Access target of 75% for both men and women.

**Figure 12: Percentage of People aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions**

![Bar chart showing percentage of people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions across years 2000 to 2010.](chart.png)

**Note:** 75% is the Universal Access target for Males and Females by the year 2010

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2 In the DHS, respondents with comprehensive knowledge about AIDS were asked whether use of condom for every sexual encounter 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.
4.1.4 Condom Use

Besides being used for family planning, condoms are one of the effective measures for the prevention of HIV with 90% efficacy.

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

The 2004 MDHS indicates that 47.1% of males and 30.1% of females reported using condoms at last sex with a non regular partner. This represents an increase from 38.9% for males and 28.7% for females in the 2000 MDHS. For 2006, according to the MICS, the corresponding proportions were 57.2% for males and 37.5% for females. The proportion of urban males and females reporting condom use was relatively higher compared to rural males and females though both the rural and urban areas reflected an increase over the 2000 MDHS figures. Generally, statistics are showing that more males are using condoms than females and that those living in urban areas are more likely to use a condom during high risk sex compared to those in the rural areas (See Table 3). This could be attributed to differences in power relations which render women to have little control on the use of condoms. On the other hand, this could also be a result of information asymmetry, with those in the urban set up having more access to information compared to their rural counterparts. Introduction of the female condom into the reproductive health domain as well as intensified reach of Information, Education and Communication messages in the rural areas, and improvements in access and use of condoms could result into a significant shift in this statistic.

<table>
<thead>
<tr>
<th></th>
<th>MDHS 2000</th>
<th>MDHS 2004</th>
<th>MICS 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>38.9</td>
<td>47.1</td>
<td>57.2</td>
</tr>
<tr>
<td>Female</td>
<td>28.7</td>
<td>30.1</td>
<td>37.5</td>
</tr>
<tr>
<td>Rural Male</td>
<td>36.0</td>
<td>43.5</td>
<td>55.7</td>
</tr>
<tr>
<td>Female</td>
<td>23.4</td>
<td>24.8</td>
<td>34.6</td>
</tr>
<tr>
<td>Urban Male</td>
<td>49.7</td>
<td>57.2</td>
<td>63.3</td>
</tr>
<tr>
<td>Female</td>
<td>44.3</td>
<td>43.7</td>
<td>44.9</td>
</tr>
<tr>
<td>Young people (15-24)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young people (15-24) Male</td>
<td></td>
<td>57.5</td>
<td></td>
</tr>
<tr>
<td>Young people (15-24) Female</td>
<td></td>
<td>39.5</td>
<td></td>
</tr>
</tbody>
</table>

Figures 13 and 14 below show the proportion of male and female respondents who reported using condoms at last high-risk sex by age group: The proportion of males reporting condom use in the 15-24 and 25-29 age groups increased between 2000 and 2004 while there was no difference in the 30-39 age-group between the two years. Generally, condom use is highest in the 25-29 age-group and lowest in the 40-49 age group. For females, while condom use increased between 2000 and 2004, condom use was highest among the 15-24 year olds with the older ages reporting declines in condom use between 2000 and 2004.
4.1.4.2 Condom Programming

The introduction of the female condom is an important milestone in reproductive health. The condom will give women power over sex and their sexuality. However, statistics still show that availability of and access to condoms is still a problem. A total of 7,465,429 (7,309,120 male; 321,876 female) free condoms (representing 53% of annual target) and 13,349,224 (13,346,357 male; 2,867 female) socially marketed condoms (representing 67% of annual target) were distributed to end users, in the year under review.

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

4.1.5.1 Print Communication Products

In the year 2007/08, a number of different types of materials were produced and distributed. Materials were produced by a number of organizations on a number of thematic areas including HIV Testing and Counseling, Stigma and discrimination, Nutrition, PMTCT and Gender Based Violence. There has been a decline in the reported number of materials produced and distributed in the 2007/08 financial year compared to the previous year. This could be due to a shift to other alternative and more effective modes of communication such as interactive and interpersonal modes. (See Figure 15 below).
4.1.5.2 Electronic Communication Products

A number of Television (TV) and radio programmes were also produced and aired during the year under review. This has been the situation since July 2004 to June 05 Fiscal Year where we have seen an increase in both radio and television programmes produced and the number of airtime for such programmes. However, whilst the number of radio programmes had tripled between July 2004 to June 2005 and July 2005 to June 2006 Fiscal Years, there was a slight decline in the July 2006 to June 2007 Fiscal Year. The increase in community radio programmes and partners sponsoring various programmes on the radio has been the main reason for the increase in programmes produced. The decline in the number of hours aired for July 2005 to June 2006 and July 2007 to June 2008 Fiscal Years could largely be due to underreporting (See table 4 below).
Table 4: Number of Radio and Television programmes produced and number of hours aired, 2004/05-2007/08

<table>
<thead>
<tr>
<th>Year</th>
<th>Radio</th>
<th></th>
<th>Television</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of Programmes produced</td>
<td># Hours aired</td>
<td># of Programmes produced</td>
<td># Hours aired</td>
<td># of Programmes produced</td>
<td># Hours aired</td>
</tr>
<tr>
<td>2004/05</td>
<td>365</td>
<td>297.3</td>
<td>36</td>
<td>245.2</td>
<td>401</td>
<td>542.5</td>
</tr>
<tr>
<td>2005/06</td>
<td>1977</td>
<td>27.0</td>
<td>142</td>
<td>15.2</td>
<td>2119</td>
<td>42.2</td>
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<tr>
<td>2006/07</td>
<td>1633</td>
<td>1528.4</td>
<td>631</td>
<td>750.0</td>
<td>2264</td>
<td>2278.2</td>
</tr>
<tr>
<td>2007/08</td>
<td>2359</td>
<td>2152</td>
<td>52</td>
<td>353</td>
<td>2411</td>
<td>2505</td>
</tr>
<tr>
<td>Total</td>
<td>6334</td>
<td>4004.7</td>
<td>861</td>
<td>1363.4</td>
<td>7195</td>
<td>5067.9</td>
</tr>
</tbody>
</table>

Source: NAC, Activity Reporting System

4.1.6 Interventions for Young People.

4.1.6.1 Number of Young people exposed to LSE (in and out of school)

Life skills education (LSE) is considered to be one of the potentially most effective interventions with which young people could be reached. Knowledge and skills gained through this intervention assist them to avoid contracting HIV through reduction of risky behaviours by enhancing abstinence, assertiveness skills and increasing safer sex practices.

Overall, Figure 16 below shows that there was a decline in the overall number of young people exposed to life skills education between the year under review and the previous year in all the three regions. Comparatively, the Southern Region had the highest number of young people exposed to life skills, followed by the Northern Region.
4.1.7 Gender, Human Rights and Culture

Deeply entrenched societal values on gender, human rights and culture are some of the contributing factors to HIV transmission. As such, it is important to ensure that innovative approaches are employed in order to reverse this status quo.

In view of this, a total of 121 Local Assembly gender and human rights campaigns were conducted during the year under review. A total of 232 sessions were also conducted focusing on the retention of girls in school and completion of their education.

In a bid to strengthen socio-cultural values that prevent the further spread of HIV, 124 Traditional Authorities were reached with various interventions.

4.1.8 Greater Involvement of People Living with HIV (PLHIV)

Involvement of people living with HIV is one of the guiding principles of the national response. PLHIV know their problems better and can effectively articulate issues that pertain to their lives and how the response can best be tailored to effectively address problems that they face.

PLHIV are part of the platforms and structures for decision making both at national and local levels. PLHIV have become very influential in encouraging positive living and in mobilizing people to get for testing.
It can be seen in Figure 17 below that total enrolment of people in organizations of PLHIV declined in the year July 2007 to June 2008 compared to the previous year. Generally, the membership of youth in the PLHIV organisations is low compared to other age categories. With only 26% of total membership being youth in July 2006 to June 2007, the corresponding proportion marginally declined to 24% in July 2007 and June 2008 year. More needs to be done to advocate for increased youth enrolment in the organisations.

4.2 Biomedical Prevention

4.2.1 HIV Testing and Counselling (HTC)

HIV testing and counselling serves as both a prevention tool and acts as an entry point to treatment, care and support services.

4.2.1.1 Number of People, Counselling, Tested and Received their Results

The number of people counselled, tested and received their results has dramatically increased since 2001 from only 40,805 people tested to 661,400 in 2006 and 1,083,304 in financial year July 2007 to June 2008 (See figure 18). This means that the 2010 Universal Access target of 1,000,000 was reached much earlier than previously anticipated. The increase in HTC uptake was a result of innovative approaches that were put in place.
4.2.1.2 Number of HTC Sites

The number of HTC sites has also increased tremendously between 2001 and 2007 from 14 sites in 2001 to 588 sites in 2007/08 financial year. The 2010 Universal Access target for HTC sites is 600 (See Figure 19 below).
4.2.2 Prevention of Mother to Child Transmission (PMTCT) of HIV

Mother to Child Transmission of HIV accounts for 8% of all HIV transmission in the country. In the year under review, tremendous progress was made in scaling up PMTCT services. However, due to problems with reporting, it is difficult to ascertain the level of utilization of the services. Figures 20 and 21 below show the number of ANC facilities providing a minimum package of PMTCT services and the number of pregnant women enrolled in PMTCT programme since 2002. With sharp increases since 2002, the number of sites providing PMTCT services shot dramatically from only 60 in 2006 to 454 by June 2008 representing an increase of 87%. With respect to the total number of ANC facilities (n=544), the achievement as at June 2008 represents 83%. Correspondingly, the total number of women attending antenatal and offered PMTCT doubled between 2006 and 2007.
Early Infant Diagnosis (EID) needs to be expanded since as an entry point for exposed children to access treatment, care and related services. EID will also ensure that a picture is obtained on the impact of the PMTCT programme.
4.2.3 Infection Prevention, Waste Management and Blood Safety

The 2007 Health Facility Survey shows that 85% of hospitals, 80% of health facilities and 71% of dispensaries followed appropriate waste management practices. Currently, 69% of health facilities are applying national guidelines against an annual target of 90% of health facilities.

However, it should be noted that there is currently no routine system for capturing data on critical blood safety indicators in line with international standards and protocols. Such indicators relate to blood safety (with respect to how much of blood that is collected is from voluntary non-remunerated donors), blood testing (with respect to various biomarkers) and utilization (with respect to guidelines for clinical usage of the blood).

4.2.4 Male Circumcision

Owing to international evidence about the protective potential of male circumcision against HIV acquisition, Malawi is in the process of commissioning a situation analysis in order to determine the feasibility of adopting this intervention as one of the HIV prevention strategies.
5.0 Progress under Treatment, Care and Support.

5.1 Anti Retroviral Therapy (ART)

There has been a rapid expansion of treatment offered to eligible HIV infected people as well as the number of sites where ART is provided. By June 2008, there were a total of 207 sites (162 public, 45 private) offering treatment. As at the same reporting period, a total number of 184,405 people had ever started ART whilst those who were alive and on treatment were 121,707 representing a survival rate of 66% (See Figure 22).

The Ministry of Health reports that out of patients who are alive and on ART as recorded in the public sector health facilities, 96% were on first line regimen, 3.6% on alternative first line and 0.4% on second line regimen. For those patients registered in the private sector health facilities, 92% were on first line regimen, 7% were on alternative first line regimen and 1% were on second line regimen. Generally, this implies that the first line regimen is still an effective regimen for most HIV positive people on treatment in Malawi.
During the reporting period, there were no health facilities with ARV stock outs of more than one week at any given time.

Much as the first line treatment regimen has shown to be tolerated by most patients on treatment, it is important that Malawi should start reconsidering other regimens which could be first line since failure of any regimen after a long time of use may be inevitable. Further the quality of treatment needs to be assessed so that lessons can be learnt.

5.2 Support to Chronically Ill persons

A number of interventions are being implemented in order to mitigate the impact of HIV and AIDS on the chronically ill. Usually, this is in form of psychosocial, nutritional, financial, medical, domestic and other types of support.

The number of households supported was lower in period under review as compared to the previous year (see Figure 23). However, comparatively, most of the support provided was psychosocial and the least amount of support provided was financial across all reporting periods. This could be due to the fact that psychosocial support is relatively cheaper to undertake than the other kinds of support which require a considerable amount of resources.
5.3 Community Home based Care Visits

A reported 87,819 home based care visits were made in the year under review. There were more visits made in the rural areas compared to urban areas and that more visits were made by volunteers, compared to health care workers. This could be a reflection of the shortage of health care workers to support the home based care program (see Figure 24).
Figure 24: Number of Community Home Based Care Visits by Cadre

Source: NAC, ARS
6.0 Progress under Impact Mitigation

6.1 Income Generating Projects and Safety Net Programmes

In the year under review, a number of activities were implemented to ensure that the impact of HIV is alleviated. Activities included 3,257 training sessions in income generating projects and the provision of startup kits to 2,057 households and 2,021 most vulnerable persons.

The Malawi Government has been implementing a Social Cash Transfer Scheme aimed at assisting the ultra poor and labour constrained households that include the elderly, orphans and other vulnerable children, widows, widowers, people living with HIV, and people with disabilities. As at June 2008, 10,014 households and 41,974 beneficiaries were being supported.

6.2 Enforcement of Legal, Ethical and Social Rights for Vulnerable Groups

The development of legislation for HIV and AIDS was underway in the year under review. The legislation is expected to provide a comprehensive framework to govern issues related to HIV and AIDS and to provide an appropriate instrument that will allow effective coordination of the national response.

6.3 Support to Orphans and other Vulnerable Children (OVCs)

6.3.1 Prevalence of Orphans

The HIV pandemic has resulted into a considerable number of orphans left destitute or without proper care and support, thus leaving them at the risk of abuse and exploitation that may ultimately throw them back into the HIV vicious cycle. The 2007 Sentinel Surveillance Survey estimated that there were 1,164,939 orphans, out of which 436,503 were due to AIDS.

Table 5 below shows the prevalence of orphans in the country by age-group, gender, region, residence and wealth quintile. Overall, about 13% of children had one or both parents dead. Though not significant, there were relatively more male compared to female orphans. The Southern Region had the highest number of orphans (15.3%) followed by the Northern Region (11.2%) and the Central Region had the lowest (10.2%). There were more orphans in the urban (14.5%) compared to rural areas (12.3%) and more orphans in the older age groups relative to the younger age groups. There were also more orphans from the highest wealth quintile (14.1%), while the least are in the middle wealth quintile (10.7%) implying that richer people are proportionately more likely to die of HIV than their poorer counterparts.
### Table 5: Prevalence of Orphans

<table>
<thead>
<tr>
<th>Background Characteristics</th>
<th>Prevalence of Orphans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>12.9</td>
</tr>
<tr>
<td>Female</td>
<td>12.2</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td></td>
</tr>
<tr>
<td>Northern</td>
<td>11.2</td>
</tr>
<tr>
<td>Central</td>
<td>10.2</td>
</tr>
<tr>
<td>Southern</td>
<td>15.3</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>14.5</td>
</tr>
<tr>
<td>Rural</td>
<td>12.3</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>3.3</td>
</tr>
<tr>
<td>5-9</td>
<td>11.3</td>
</tr>
<tr>
<td>10-14</td>
<td>20.8</td>
</tr>
<tr>
<td>15-17</td>
<td>24.8</td>
</tr>
<tr>
<td><strong>Wealth Index Quintile</strong></td>
<td></td>
</tr>
<tr>
<td>Lowest</td>
<td>11.8</td>
</tr>
<tr>
<td>Second</td>
<td>13.1</td>
</tr>
<tr>
<td>Middle</td>
<td>10.7</td>
</tr>
<tr>
<td>Fourth</td>
<td>13.3</td>
</tr>
<tr>
<td>Highest</td>
<td>14.1</td>
</tr>
<tr>
<td>Total</td>
<td>12.6</td>
</tr>
</tbody>
</table>

*Source: Multiple Indicator Cluster Survey, 2006*

#### 6.3.2 School Attendance among Orphans

According to the 2006 MICS, 89% of orphans were attending school compared to 91% for non orphans. The ratio of school attendance for orphans and non orphans was 0.97 implying that there is no significant difference between orphans and non-orphans. Amongst male orphans 87.3% were attending school and amongst female orphans 90.3% were in school; whilst amongst orphans in the Northern Region 95.3% were in school, 87.6% from Central Region and 88.5% were from Southern Region, respectively. Ninety three percent (93.7%) of urban orphans were in school while 88.1% of rural orphans were in school. A larger proportion of orphans who are richer were attending school whilst those in the lowest quintile were the least school attendants.
Table 6: School Attendance among Orphans

<table>
<thead>
<tr>
<th>Background Characteristics</th>
<th>School attendance of children who are orphaned</th>
<th>School attendance of children who are not orphaned</th>
<th>School attendance of children who are orphaned vs non orphans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>87.3</td>
<td>90.8</td>
<td>0.96</td>
</tr>
<tr>
<td>Female</td>
<td>90.3</td>
<td>91.4</td>
<td>0.99</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern</td>
<td>95.3</td>
<td>96.7</td>
<td>0.99</td>
</tr>
<tr>
<td>Central</td>
<td>87.6</td>
<td>91.3</td>
<td>0.96</td>
</tr>
<tr>
<td>Southern</td>
<td>88.5</td>
<td>89.2</td>
<td>0.99</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>93.7</td>
<td>94.0</td>
<td>1.00</td>
</tr>
<tr>
<td>Rural</td>
<td>88.1</td>
<td>90.7</td>
<td>0.97</td>
</tr>
<tr>
<td><strong>Wealth Index Quintile</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lowest(1)</td>
<td>85.4</td>
<td>87.1</td>
<td>0.98</td>
</tr>
<tr>
<td>Second(2)</td>
<td>84.9</td>
<td>89.3</td>
<td>0.95</td>
</tr>
<tr>
<td>Middle(3)</td>
<td>88.2</td>
<td>90.8</td>
<td>0.97</td>
</tr>
<tr>
<td>Fourth (4)</td>
<td>90.2</td>
<td>92.7</td>
<td>0.97</td>
</tr>
<tr>
<td>Highest(5)</td>
<td>94.3</td>
<td>95.3</td>
<td>0.99</td>
</tr>
<tr>
<td>Total</td>
<td>88.6</td>
<td>91.0</td>
<td>0.97</td>
</tr>
</tbody>
</table>

Source: Multiple Indicator Cluster Survey, 2006

6.3.3 OVC Registration

One important initiative in the year under review was the commencement of an OVC registration exercise aimed at improving targeting of programmes for this subgroup. As at June 2008, a cumulative total of 456,333 orphans had been registered, against a planned annual target of 500,000.

6.3.4 OVC Support

All regions registered a drastic decline in the reported number of OVC supported over July 2007 to June 2008 financial year compared to the previous year with 815,333 and 388,139 OVC supported respectively over the two years. However, psychosocial support was the most common followed by nutrition support, whilst the least was financial support. The decline in number of OVC supported could largely be due to underreporting (See Figure 25).
Figure 25: Number of OVC receiving External Support

Source: NAC, ARS
7.0 Progress under Mainstreaming, Partnerships and Capacity Building

A number of activities were accomplished in the period under review to ensure that HIV and AIDS issues are integrated in sectoral policies, plans and programmes. This included 72 advocacy sessions with key institutions in all sectors, orientation and training sessions for 608 focal point persons and facilitators in HIV and AIDS mainstreaming in all sectors including local authorities. A total of 90 new workplace committees were established and supported in both the public and private sectors.

To ensure effective integration of HIV and AIDS issues at community level, Local Assembly management structures as well as frontline staff (extension workers) were also trained in HIV and AIDS mainstreaming.

The review of 2% ORT guidelines was underway in the year. The revised guidelines will guide utilization of allocated resources and would ensure maximum benefits to the infected and affected people.

Several planning and coordination meetings were conducted in the year under review. A study on reconstitution and redevelopment of TWGs for the National Response to HIV and AIDS was finalized. The key recommendations from the study lead into the revision of the ToRs for the MPF and TWGs. During the same period partner organizations conducted exchange visits to share lessons. At local level, coordination initiatives were anchored by the District AIDS Coordinating Committee (DACC), which is a Sub Committee of the District Executive Committee (DEC). Technical review of programmes was undertaken through district stakeholder panels.

During the year under review, implementation of the Umbrella Mechanism Exit Strategy was underway in readiness for the withdrawal of Umbrella Organizations from the Local Authorities on 30th September 2008. The Umbrella Exit Strategy was being implemented concurrently with the Local Authorities Accreditation assessment. The assessment was aimed at preparing Local Authorities to take over roles and responsibilities hitherto being performed by the Umbrella Organizations.

Capacity building initiatives were also intensified in the year under review. In this respect, 4,787 service providers were trained in various areas with the aim of providing essential skills required for effective planning and management of HIV services. Several service provision points were also refurbished and equipment was provided to necessitate delivery of services.
8.0 Monitoring, Evaluation and Research

8.1 Research and Development

During the year, draft reports for both the Behavioural Surveillance Survey (BSS) and the Sentinel Surveillance (SS) were produced. The 2006 Behavioural Surveillance Survey included biomarker testing for the 13 high risk groups which is a typical improvement on the 2004 BSS. It also included a comparative analysis of the 2004 and 2006 Behavioural Surveillance Surveys.

Malawi undertook a Know Your Epidemic (KYE) exercise in order to understand trends of the HIV epidemic. This also included incidence modeling to appreciate where new infections are mostly likely to come from. Preliminary evidence indicates that most of new infections are occurring in ‘low risk heterogeneous relationships’ indicating that interventions on reinforcing fidelity and mutual faithfulness need to be properly packaged to bring about real impact and avert the new infections from this group. The KYE will feed into the prevention strategy where a synthesis of emerging evidence will need to be brought into the picture in order to zero in on interventions and programmes that work.

In line with the National Research Strategy, several other research on topical emerging issues were conducted including the ART census; research on the effect of HIV on immunity to Malaria in pregnant women; and a knowledge, attitudes and practice study on health workers on the use of oral morphine in HIV and cancer patients in Malawi.

A Research Dissemination Conference was also held where some key research papers were disseminated as a way of sharing research information and good practices.

8.2 Monitoring and Evaluation

Monitoring and Evaluation serves to track programme performance as well as assess efficiency, effectiveness, relevance and impact of interventions.

Malawi continued to monitor her national response through the operationalisation of the national HIV and AIDS Plan in line with national and global practices. On the biomedical front, the Health Management Information System (HMIS) continued to provide routine data on indicators pertaining to health sector interventions. A semi-annual bulletin was produced with information based on the data from the HMIS Quarterly Programmatic Reports for ART, HTC, PMTCT and CHBC were also provided to complement the HMIS. Social sector data on OVC, as well as women and girls was routinely collected and presented in quarterly reports. An OVC registration exercise is a key data source of the OVC quarterly reports.

In line with the decentralized response, data from the local authorities was collected through activity reporting forms that were continuously transferred to the National AIDS Commission for entry and analysis in the Activity Reporting System. Four (4) Quarterly Service Coverage Reports were produced in the year based on the data received from the Local Authorities through the forms. The data collection tool has since been upgraded and a database which will host the data has been developed and is part of the sector wide district data bank anchored by the Ministry of Development Planning and Cooperation. The database will enable full materialization of the M&E processes at the
local level since this will enable the districts to produce and utilize their own Quarterly Service Coverage Reports. Under this arrangement, NAC will only be responsible for producing national level QSCR as a consolidation of the districts’ QSCR.

As part of the review processes on the national response, joint biannual and annual reviews were held in the year where key actions and timelines for their implementation were agreed upon by all cooperating partners in the response.

The Monitoring, Evaluation and Information Systems (MEIS) Technical Working group was revamped during the year and is providing the oversight role for the national M&E System. Quarterly meetings have been planned for the TWG and a linkage with the Research TWG has been developed.

Key sectors were supported through provision of technical advice as well as supportive supervision mostly hinging on the need for timely and comprehensive reporting.
9.0 Programme Coordination and Management

Various structures continued to play their roles to ensure that the national response attains its objectives.

The Department of Nutrition, HIV and AIDS (DNHA) in the Office of the President and Cabinet continued to provide policy oversight on the national response by ensuring that all players adhere to national policies and standards and providing technical support on the same.

In exercise of its mandate, the National AIDS Commission Board held several meetings in the year under review. Such meetings mainly focused on tracking progress and providing guidance on implementation of the Programme of Work for the year-the Integrated Annual Work Plan. These Board meetings were complemented by Management meetings where programme management issues were discussed.

As part of governance arrangements, a Memorandum of Understanding between NAC and the Anti-Corruption Bureau meant to prevent, detect and curb fraud became operational in the year under review.
10.0 Resource Mobilisation

10.1 Funds Availability

The national response has been very successful in mobilizing resources with 90% of resources coming from development partners and 10% from the Malawi Government. Such funding has been under either a pooled arrangement or discrete arrangement. By June 30, 2008, the total amount of funds made available to the national response through NAC for the year 2007/08 was US$83.3 million dollars.

The 5-year HIV National Response funding cycle came to an end in June 2008 and a number of bilateral arrangements are being signed for the next funding cycle which is meant to align with the Malawi Growth and Development Strategy up to 2011. Consequently, the Memorandum of Understanding (MoU) governing the national response is also being revised in light of the new funding cycle.

10.2 Budgeted versus Actual Receipts for the 2007/08 Financial Year

As at 30th June 2008, 69% of what was budgeted for had been received by NAC (See Table 7 below). Receipts in the year were hampered by protracted negotiations with the Global Fund for the Rolling Continuation Channel (RCC).

Table 7: Budgeted versus Actual Receipts for the 2007/08 Financial Year

<table>
<thead>
<tr>
<th>Source</th>
<th>Budget (US$’million)</th>
<th>Actual Receipts (US$’million)</th>
<th>% of Receipts to Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Fund</td>
<td>104.5</td>
<td>63.2</td>
<td>60</td>
</tr>
<tr>
<td>World Bank</td>
<td>8.30</td>
<td>10.7</td>
<td>128</td>
</tr>
<tr>
<td>Norway</td>
<td>2.00</td>
<td>2.70</td>
<td>135</td>
</tr>
<tr>
<td>CIDA</td>
<td>0.50</td>
<td>0.00</td>
<td>-</td>
</tr>
<tr>
<td>DFID</td>
<td>3.00</td>
<td>4.02</td>
<td>134</td>
</tr>
<tr>
<td>GoM</td>
<td>2.00</td>
<td>2.00</td>
<td>100</td>
</tr>
<tr>
<td>UNDP</td>
<td>0.80</td>
<td>0.38</td>
<td>48</td>
</tr>
<tr>
<td>CDC</td>
<td>0.30</td>
<td>0.25</td>
<td>83</td>
</tr>
<tr>
<td>TOTALS</td>
<td>121.4</td>
<td>83.25</td>
<td>69</td>
</tr>
</tbody>
</table>
10.3 Distribution of Total payments by National Action Framework Priority Year

Total payments made during the year ended 30th June 2008 amounted to MK12.2 billion. These payments were made against an annual budget of MK17.0 billion representing a 72% burn rate. Out of the total payments, MK10.9 billion was channelled through the Grants Facility inclusive of payments amounting to MK3.9 billion (US$28.5 million) transferred directly from the Global Fund to UNICEF Supply Division for the procurement of ARVs and other health products. Total payments amounting to MK1.3 billion were spent on programme management, coordination and institutional support.

As can be seen from Figure 26, overall, treatment received the biggest payments followed by prevention. This could be due to the fact that health products are relatively more expensive compared to other interventions.

Figure 26: Payments by Priority Area 2007/08 Financial Year

Source: NAC, Financial Monitoring Reports

10.4 The Grants Mechanism

In the period under review, 47 new proposals were approved and MK465 million was disbursed for the same. A total of 178 ongoing projects were supported to the tune of MK 6 billion. This means that the total number of Grant Recipient Organizations supported in the year was 225 with MK6.5 billion (US$) disbursed.
Figure 27 shows financial resources committed for each priority area of the response against what was disbursed. It can be observed that in terms of commitments and disbursements, mainstreaming, partnerships and capacity building had the biggest share. Treatment, care and support had the second largest commitment of resources, whilst monitoring, evaluation and research had the least.

The time that it takes between proposal submissions and when all the requisite processes have been fulfilled in order for an organization to commence receipt of resources from NAC is a very important indicator of the efficiency of the grants mechanism. In the year under review, the average time taken between proposal submission and approval remained at 5.4 months. Generally, the delays mostly emanate from potential grant recipients not being able to fulfill critical pre-contractual requirements that would necessitate approval of proposals and subsequent funding.

Beginning 1st July 2008, new granting guidelines would be in force. The new guidelines have been tailored towards addressing the turnaround time and it is envisaged that once implementation is in full force, the time between proposal submission and approval would come down to an average of 3.5 months.
11.0 Major Challenges

11.1 The national response continued to see tremendous improvements with respect to reporting by all players involved. However, isolated cases of underreporting were experienced in the year under review. This may have resulted into under-estimation of the impact, outcomes and outputs of the national response.

11.2 Most interventions are being undertaken in a project mode with a low sense of ownership and a general lack of integration into the mainstream sectoral and institutional mandates.

11.3 Capacity continued to be a serious constraint with respect to the quality and quantity of interventions. Intended scale up of various programmes was limited by the number of personnel available and the availability of infrastructure.

11.4 Malawi has a generalized epidemic implying the need to implement interventions that are focused on the general population. Nevertheless, the intensity of programmes targeting the most at risk populations is relatively low.
12.0 Way Forward

12.1 Continued advocacy for a sustained momentum in reporting as well as the harmonization of key reporting frameworks.

12.2 Continue efforts to develop capacity in mainstreaming for public, private and civil society organizations and to advocate for an integrated setup as well as to instill a sense of ownership of the various HIV and AIDS programmes.

12.3 Continued focus and targeting of interventions for most at risk populations.
References

6. Malawi Government, Demographic and Health Survey, 2000
7. Malawi Government, Demographic and Health Survey, 2004