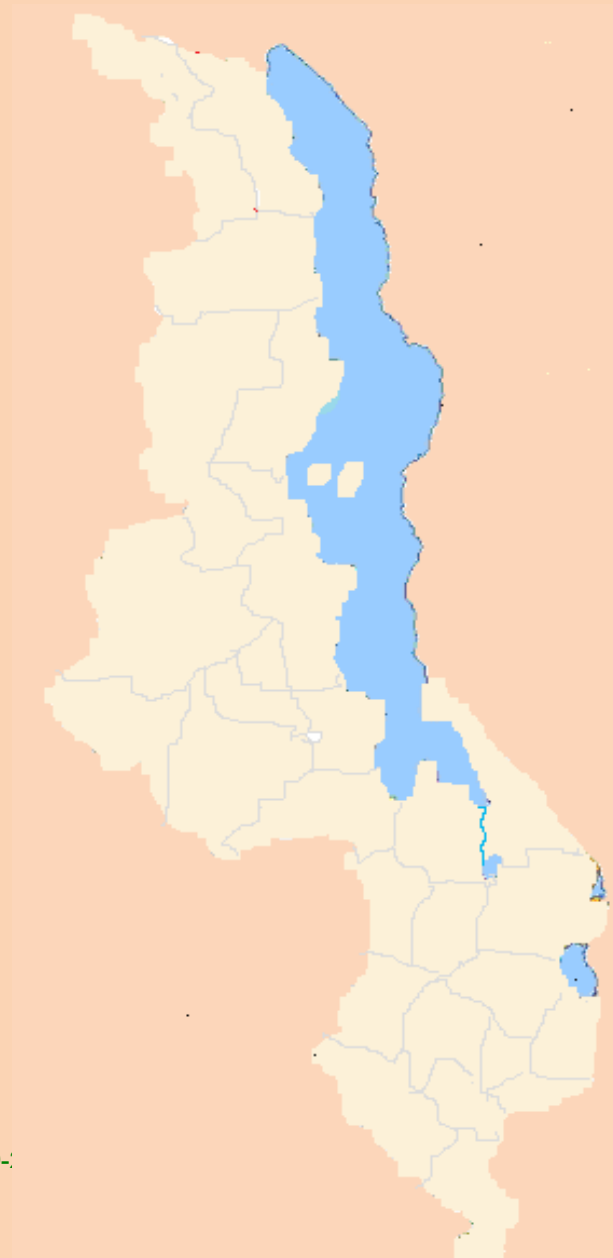




Malawi Government

Malawi HIV and AIDS Extended National Action Framework (NAF), 2010-2012 DRAFT



Office of the President and the Cabinet
National AIDS Commission
April 2009

FOREWORD

**His Excellency Dr Bingu Wa Mutharika
PRESIDENT OF THE REPUBLIC OF MALAWI**

PREFACE

**Dr Mary Shawa
Secretary for Nutrition and HIV and AIDS**

ACKNOWLEDGEMENTS

The development of the extended National HIV and AIDS Action Framework was a result of a combined effort and support of various organisations and individuals. It is difficult to acknowledge all, but some deserve special mention.

The National AIDS Commission would like to acknowledge the team which conducted the Mid Term Review (MTR). The results of the MTR guided the extension of the NAF. Besides, the Technical Working Groups and all the participants of the consensus building workshops deserve our gratitude for providing guidance on strategies, broad actions and targets for the next years.

The Commission is grateful to the consultants who supported the development of the extended NAF, and the costing of the key actions planned.

Finally, the support of development partners who supported the process is much appreciated, especially the Global Fund for inviting Malawi to participate in the National Strategy Application; UNAIDS, TSF and ASAP for providing technical and strategic support to the NAF development process; and the Pool Partners of NAC for their continued support in implementing the NAF.

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LIST OF ABBREVIATIONS

ADC	Area Development Committee
ART	Antiretroviral Therapy
ARV	Antiretroviral medications
ASAP	AIDS Strategic and Action Planning
BCC	Behaviour Change Communication
BLM	Banja La Mtsogolo
BSS	Behavioural Surveillance Survey
CAC	Community AIDS Committee
CBCC	Community Based Child Care Centres
CBO	Community Based Organisation
CDC	Centre for Disease Control
CHAM	Christian Health Association of Malawi
CHBC	Community Home-Based Care
CIDA	Canadian International Development Agency
DA	District Assembly
DACC	District AIDS Coordinating Committee
DFID	Department for International Development
DHRMD	Department of Human Resource Management and Development
DHS	Demographic and Health Survey
DNHA	Department of Nutrition, HIV and AIDS
EMIS	Education Management Information System
FBO	Faith Based Organisation
FMA	Financial Management Agency
FP	Family Planning
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People living with AIDS
GoM	Government of Malawi
HCBC	Home and Community Based Care
HIV	Human Immuno-Deficiency
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
IAWP	Integrated Annual Work Plan
IDU	Intra-venous Drug Use
IEC	Information Education and Communication
IGA	Income Generating Activities
IGP	Income Generating Projects
LA	Local Authority
LAHARF	Local Assembly HIV and AIDS Activity Reporting Form
LSE	Life Skills Education
M&E	Monitoring and Evaluation
MANASO	Malawi Network of AIDS Service Organisations
MBCA	Malawi Business Coalition Against AIDS
MBTS	Malawi Blood Transfusion Service
MCH	Maternal and Child Health
MDG	Millenium Development Goals
MEPD	Ministry of Economic Planning and Development
MGDS	Malawi Growth and Development Strategy

MGFCC	Malawi Global fund Coordinating Committee
MIAA	Malawi Interfaith AIDS Association
MICS	Multiple Indicator Cluster Survey
MK	Malawi Kwacha
MoAFS	Ministry of Agriculture and Food Security
MoE	Ministry of Education
MoH	Ministry of Health
MoJ	Ministry of Justice
MoLGRD	Ministry of Local Government and Rural Development
MoU	Memorandum of Understanding
MoWCD	Ministry of Women and Child Development
MoYDS	Ministry of Youth Development and Sport
MP	Member of Parliament
MSM	Men who have Sex with Men
MTEF	Medium term Expenditure Framework
MTR	Mid Term Review
NAC	National AIDS Commission
NAF	National HIV and AIDS Action Framework
NGO	Non-Governmental Organisation
NOVOC	Network of Organisations for Vulnerable and Orphaned Children
NRCM	National Research Council of Malawi
NSA	National Strategic Application
NSF	National HIV and AIDS Strategic Framework
NSO	National Statistical Office
NYC	National Youth Council
OI	Opportunistic Infection
OPC	Office of the President and Cabinet
ORT	Other Recurrent Transactions
OVC	Orphans and other Vulnerable Children
PEP	Post-Exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
RH	Reproductive Health
SADC	Southern Africa Development Community
STI	Sexually Transmitted Infection
SWAP	Sector Wide Approach
TSF	Technical Support facility
TWG	Technical Working Group
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UO	Umbrella Organisation
USG	United States Government
WB	World Bank

EXECUTIVE SUMMARY

The Malawi Extended National HIV and AIDS Action Framework (NAF) for the period 2010 to 2012 follows the NAF 2005 to 2009, and harmonises the national HIV and AIDS response with the Malawi Growth and Development Strategy (MGDS). The Extended NAF has been developed on the basis of several studies, including the Mid Term Review (MTR) of the NAF, which provided an updated analysis of the epidemic and the response. Development of the extended NAF benefited from broad participation of implementing partners, communities affected by HIV and AIDS and development partners.

In Malawi, the HIV prevalence among adults aged 15 – 49 years seems to have stabilized at 12%. But the highest HIV prevalence exists among vulnerable groups like sex workers and their clients, among women than men and in (semi)urban populations. However, the majority of new infections occur in sero-discordant, monogamous couples and among partners of people who have multiple concurrent partners. Mother to child transmission is estimated to account for almost a quarter of new infections. Around one million people are estimated to live with HIV, 10% of them are children.

The national response is based on the ‘Three Ones’ principle, and scaled up tremendously since the start of the NAF in 2005. Scale up of HTC and ART have been the biggest success, with over 147,000 people alive and on ART out of 276,161 of those in need of ART as of December 2008. Yet, for every person started on ART in 2008, one person got infected, so prevention efforts need to keep up with care and treatment. Hundreds of CBOs received grants to deliver community and home-based care, OVC care and impact mitigation services, but the effectiveness of these interventions needs to be assessed and the capacity of Local Authorities to maintain support for community groups needs to be further strengthened. Mainstreaming HIV in public and private sector has increased through workplace interventions, but external mainstreaming, i.e. addressing HIV and AIDS in organisational mandates and strategies, is lagging behind.

The goal of the Extended NAF remains the same as in the original NAF: to prevent the spread of HIV infection among Malawians, provide access to treatment to PLHIV and mitigate the health, socio-economic and psychosocial impacts of HIV and AIDS on individuals, families, communities and the nation. There were 8 pillars in the original NAF but Research and Monitoring and Evaluation have been merged into one pillar. The extended NAF therefore has 7 priority areas as listed below:

1. Prevention and behaviour change
2. Treatment, care and support
3. Impact mitigation
4. Mainstreaming and decentralisation
5. Research, monitoring and evaluation
6. Resource mobilisation and utilisation
7. Policy and Partnerships

This strategic plan presents for each of the priority areas, achievements made so far, objectives, strategies and key action areas.

Several documents accompany this extended strategic plan, and will facilitate its implementation:

1. Integrated Annual Work Plans will be developed each year
2. The National M&E framework 2006 to 2010 provides details on measuring results and tracking the response
3. Conceptual frameworks, technical strategies and guidelines give details on interventions

1. BACKGROUND AND CONTEXT

1.1 Rationale for the extension of the National Action Framework

The Government of Malawi commissioned a mid-term review (MTR) of the National HIV and AIDS Action Framework (NAF) for 2005 – 2009. The MTR took place in late 2008, with the objective of identifying key achievements, as well as shortfalls and challenges affecting progress in key priority areas. The review also provided an opportunity to redefine technical programme components and key activities that Malawi should focus on during the remaining year of the NAF, and beyond, in order to achieve the Universal Access to HIV Prevention, Treatment, Care and Support, and the relevant Millennium Development Goals (MDG).

The Malawi Growth and Development Strategy 2006-2011 (MGDS) was developed after the design of the NAF 2005 to 2009. The GoM wants to align the two strategies, by extending the NAF implementation period to 2012.

1.2 The development process of the Extended NAF

The development of the Extended NAF 2010 to 2012 has been a participatory and evidence driven process. Firstly, a Mid Term Review of the NAF 2005 to 2009 was undertaken under the guidance of the NAC through a participatory process. Consultants who conducted the MTR reviewed literature and also conducted interviews with a cross section of informants. This was then validated by the various Technical Working Groups (TWGs). Secondly, the drafting of the Extended NAF included workshops with TWGs to validate the MTR recommendations and the NAF key objectives and strategies, as well as recommend coverage targets. NAC also organised consensus building workshops with a range of stakeholders from the three regions. A resource needs estimation exercise identified resource needs and the resource gap for implementing the Extended NAF.

The Extended NAF should be seen as a living document. Some of the current debates are highlighted in the extended NAF, and will be addressed more fully in the next NAF (2012 to 2016).

1.3 Policy and planning environment

Malawi Growth and Development Strategy 2006 to 2011

The Malawi Growth and Development Strategy (MGDS) 2006 to 2011 is the overarching development strategy, with the purpose of facilitating achievement of the Millennium Development Goals (MDGs). The MGDS identifies six pillars, one of which is ‘Prevention and Management of Nutrition Disorders, HIV and AIDS’. Other priority areas include agriculture; water; transport; infrastructure; energy; and rural development. The MGDS incorporates the objectives of the NAF, and supports the ‘three ones’ principle: one national HIV and AIDS coordinating authority; one multisectoral HIV and AIDS action framework; and one monitoring and evaluation framework.

International HIV and AIDS Commitments

Malawi is signatory to several international agreements and declarations relevant to HIV and AIDS, including the 2001 UN General Assembly Special Session on AIDS (UNGASS) Declaration, the 2001 Abuja and 2003 Maseru (SADC) Declarations. In 2006 Malawi developed targets and roadmap for Universal Access to HIV and AIDS services by 2010, as part of the international effort to scale up the global response.

The National HIV and AIDS Policy

In 2003 Malawi developed a National HIV and AIDS Policy, which serves as an important milestone in the fight against HIV and AIDS. The policy addresses HIV and AIDS in Malawi and incorporates most of the current international policy principles. It lays down the administrative and legal framework for all programmes and interventions, and states the national goal as “to reduce infections and vulnerability, to improve provision of treatment, care and support for people living with HIV (PLHIV) and to mitigate the socio-economic impact of the epidemic.

The National Health Policy

Malawi adopted the Sector-Wide Approach (SWAP) to health development and implementation in 2004. The health SWAP is the vehicle through which the Ministry of Health and its collaborating partners seek to deliver the Essential Health Package. The package details a range of priority health services that Malawi can afford to provide to all Malawians free of charge, including HIV prevention and treatment.

2. SITUATION AND RESPONSE ANALYSIS

2.1 The HIV and AIDS Situation in Malawi

Malawi is experiencing a severe HIV epidemic. Since 1985 when the first AIDS case was diagnosed, HIV prevalence increased significantly and among persons aged 15-49, it rose to 16.2% in 1999, before coming down and stabilising at around 12% since 2005. HIV prevalence among sexually active adults is higher among females at 13% than males (10%). These rates translate into 800,000 to 1 million Malawians living with HIV, including 100,000 children under 15 years.

HIV infection rates show gender, age, social status and geographical variations, with infection more prevalent in women than men, urban populations, and in the Southern Region (See Table 1). The overall rate for youth, 15 – 19 years, is estimated at 2.1%: 0.4% for male and 6.2% for female adolescents.

Almost three quarters of HIV infections are acquired through unprotected heterosexual intercourse with an infected person, and almost one in four new infections are children born to positive mothers. A small percentage of infections are transmitted through blood transfusions and injections with contaminated medical injections and skin piercing instruments¹.

Several socio-cultural factors influence the HIV epidemic in Malawi. One such driver is the high prevalence of multiple and concurrent sexual partners. Eleven percent of men, regardless of their age have had sexual partners besides their spouses or cohabiting partners, especially adolescents 15-19 years (30%), as well as migrant men such as male vendors (73%) and long distance truck drivers (48%). A second driver is low condom use. Thirdly, prevalence of STIs in the general population is high: one study reported a prevalence of Gonorrhoea in women at 9.7%, and STI in general at 15.3% in commercial sex workers. Finally but importantly, the low socioeconomic status of women and gender inequalities are driving forces of the epidemic in several ways, from barriers to access to services, cultural practices like widow inheritance, and gender-based violence and poor bargaining power for condom use or faithfulness.

Incidence: where will the next 1,000 HIV infections happen?

Epidemic modelling suggests that HIV incidence is 1.6 % in the adult population, ranging from 1.2% to 6.2% in different population subgroups. Incidence is very high in most-at-risk populations like sex workers and men who have sex with men (MSM)²; however their population is not large enough to have a major impact on total new HIV infections in Malawi. It is estimated that over 80% of sexually transmitted HIV infections occurred in stable, heterosexual relationships of HIV sero-discordant partners, so they must be the key priority for prevention efforts. Mother to child transmission is estimated to account for almost a quarter of all new

Table 1. HIV prevalence by socio-economic characteristics (age 15-49)

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

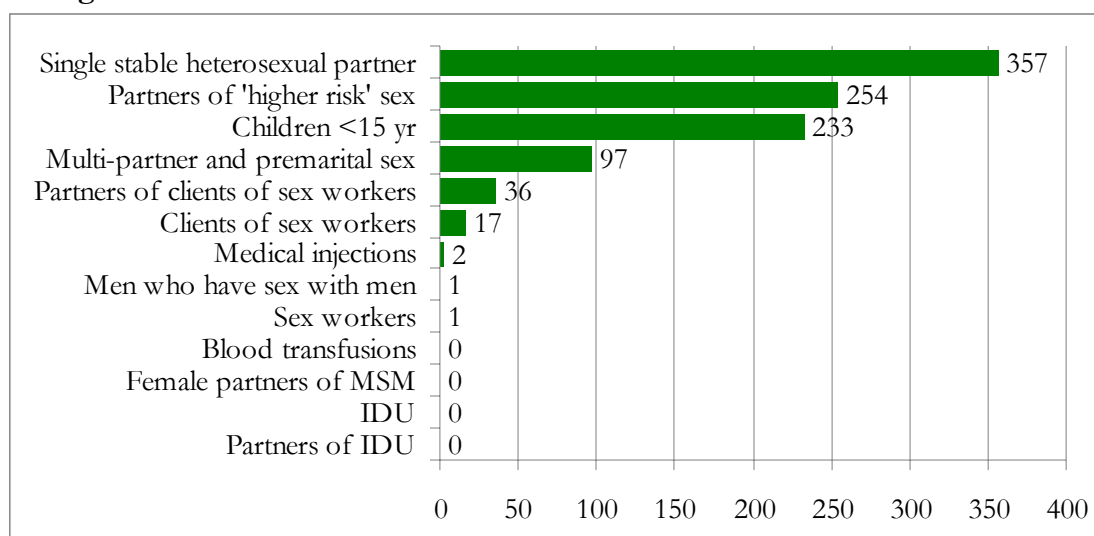
Source: 2004 MDHS

¹ Munthali A, Maleta K et al 2009

² Munthali A, Maleta K et al 2009

infections, so PMTCT is another key priority for prevention. Figure 1. shows the distribution of new infections, as they happened in 2007.

Figure 1. One thousand new HIV infections³



Source: 2007 Epidemiological projections and estimates

2.2 Impact of HIV and AIDS

Since the first case of AIDS was diagnosed in Malawi in 1985, the impacts of the epidemic started being felt in the early 1990s. The epidemic has impacted negatively on individuals, households, communities and the nation. The impact on health has been most evident, with AIDS mortality increasing from 22,000 in 1985 to 87,000 in 2005⁴. AIDS has reduced life expectancy negatively from an estimated 56 years to 36 years at present. Due to the epidemic, tuberculosis increased from about 5,000 cases in 1985 to roughly 30,000 cases now. Nearly 80% of the people with pulmonary tuberculosis are also HIV positive. HIV and AIDS have also increased demands on Malawi's health care system: more than 50% of the hospital beds in Malawi are occupied by people suffering from AIDS related illnesses. The epidemic has increased the workload of the already poorly staffed Ministry of Health, and households are spending a good proportion of their resources to care for chronically ill persons.

The HIV and AIDS epidemic has a profound impact on Malawi's human capacity, as it mostly affects economically productive people. Between 1990 and 2006 the Ministries of Education (MoE), Agriculture (MoAFS) and Health (MoH), as well as the Malawi Police Service lost 1,550 teachers; 2,275 workers; 3,258 workers; and 2,552 police officers, respectively, and the major cause of attrition was death⁵. Most of the staff who died were aged less than 40 years, indicating AIDS mortality⁶. AIDS deaths prevent the civil service to effectively deliver public services like health and education. The same situation exists in private companies where many skilled personnel have died due AIDS, and productivity has gone down because of absenteeism and death of productive members. Government and employers face high costs to take care of the sick, pay life insurance claims, death gratuities and the cost of burials.

³ 'Higher risk' sex means multi-partner sex or premarital sex. Of the infections in the under 15 group, almost all are from mother to child

⁴ Ministry of Health, 2005

⁵ Malawi Institute of Management, 2008

⁶ UNDP, 2001

The epidemic contributes to food insecurity as over 80% of Malawians depend on agriculture for food and as a source of income. During illness, agricultural work is neglected or abandoned, negatively affecting agricultural output. Studies indicate that the loss of adult labour leads families to leave the land to fallow. Orphans may not have acquired enough skills to perform some agricultural activities; hence they may resort to simpler activities such as petty trading. Reduction in human resources also negatively affects the ability of agricultural institutions to provide agricultural support services⁷. It has been estimated that by 2020 Malawi's agricultural workforce will be 14% smaller than it would have been without HIV and AIDS.

The death of parents leaves behind orphans and the elderly. The 2006 MICS estimated that there were 12.4% orphaned children aged 0-17 years old, about 45% of them due to AIDS⁸. Most are single orphans (9.5%) compared to double orphans (2.8% of the children aged 0-17)⁹. In total there were 1,277,399 OVC in Malawi in 2006¹⁰. The number of OVC has overwhelmed the extended family system and this has led to the emergence of child headed households. Many orphans face the challenge of accessing food and households cannot afford school fees and other related costs; hence they drop out of school, especially girls and double orphaned children.

It is important that the HIV and AIDS epidemic is contained so that these impacts are reversed. The development of this extended National HIV and Action Framework is an attempt to address the negative impact of the epidemic on individuals, households, communities and the nation.

2.3 The national response – institutional framework

The GoM has been implementing various HIV and AIDS programmes since 1985. In 2000 a National HIV and AIDS Strategic Framework (NSF 2000 to 2004) was approved, heralding a truly multisectoral and decentralised response. The Government established a National AIDS Commission (NAC) in 2001 as a national coordinating authority. The 'three ones' were complete with the development of a single national M&E framework in 2003. Different stakeholders are playing a role in the national response as follows:

The Office of the President and Cabinet (OPC). The President is the Minister Responsible for HIV and AIDS, and provides overall leadership on matters of HIV and AIDS. The Minister also appoints the NAC Board of Commissioners. The Department of Nutrition, HIV and AIDS in the OPC is the lead Government agency in the national response to HIV and Nutrition, responsible for policy, oversight and high level advocacy. The National AIDS Commission provides leadership and coordination of the response. The specific roles that NAC plays are: 1) Guiding development and implementation of the NAF; 2) Facilitating policy and strategic planning in sectors, including local government; 3) Advocating and conducting social mobilization in all sectors at all levels; 4) Mobilizing, allocating and tracking resources; 5) Building partnerships among all stakeholders in country, regionally and internationally; 6) Knowledge management to document, disseminate and promote best practices; 7) Mapping interventions to indicate coverage and scope; 8) Facilitating and supporting capacity building; 9) Overall monitoring and evaluation of the response; and 10) Identifying and facilitating HIV and AIDS research priorities.

⁷ Ngwira et al, 2001

⁸ Multi Indicator Cluster Survey, 2006

⁹ National Statistical Office, 2008

¹⁰ Munthali et al, 2008

Ministry of Health. The MoH plays a key role in the multi-sectoral response, for technical direction and service delivery in biomedical areas of prevention and care. The specific roles of the MoH include 1) Planning and implementing the Health Sector AIDS Strategy; 2) Coordinating health sector thematic areas; 3) Providing technical support for HIV and AIDS policy development; 4) Providing technical support to other sectors; and 5) Surveillance for HIV/AIDS/STI and behavioural surveys.

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

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

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

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

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

The Malawi Global Fund Coordinating Committee (MGFCC) provides governance and oversight to programmes supported by the GFATM, and consists of GoM, development and implementing partners, and communities affected by HIV and AIDS, TB and Malaria.

2.4 The national response - update of national response

In 2004, the National HIV and AIDS Action Framework (NAF) 2005 to 2009 was approved. The NAF has eight priority areas: 1) Prevention; 2) Treatment, care and support; 3) Impact mitigation; 4) Mainstreaming; 5) Research; 6) Monitoring and Evaluation; 7) Resource Mobilization; and 8) Policy Coordination and Programme Planning. During the implementation period, GoM developed Universal Access targets for 2010, and several technical and operational plans to achieve these targets, including the National HIV Prevention Strategy; PMTCT roll out plan; ART scale up plan; National Impact Mitigation Strategy; and OVC national plan of action.

Other supporting strategies include the HIV and AIDS Research Strategy and National M&E Framework.

In order to support implementation, the Malawi Government established a harmonised pool funding arrangement with most of its development partners (CIDA, DFID, GFATM, the Kingdom of Norway and World Bank). A Grants Facility enables NAC to channel most of the resources to implementing partners. Malawi applied successfully for three GFATM grant application rounds and received funding for scaling up ART; for implementing the OVC workplan; and for HIV prevention among young people.

Achievements during the period 2005 to 2009

Chapters 4 to 9 provide details on progress in the core strategic areas of the response. According to the mid term review, the following are the major achievements during the implementation of the NAF:

1. Highest political commitment and the establishment of the Department of Nutrition, HIV and AIDS in the OPC.
2. The number of new HIV infections per year (incidence) has stabilized, reflected in a stable prevalence at around 12% in the adult population since several years.
3. A national HIV and AIDS bill has been drafted to create a supportive public policy environment for PLHIV and the national response, and awaits approval by Parliament. Policies, strategies and action frameworks have been agreed in many technical areas of the response
4. In the area of HIV prevention, a national strategy is nearing completion. HIV testing and counselling, PMTCT and blood safety have been scaled up significantly, as well as life skills education for youth in and out of school.
5. The massive expansion of antiretroviral treatment services has been one of the most dramatic achievements.
6. Impact mitigation services have increased and attracted funding, especially OVC services as well as social protection, poverty reduction and food security for poor households
7. Several ministries have mounted sectoral responses. Decentralisation of the response is happening through support for Local Authorities and DACCs
8. The M&E framework was updated, a research strategy was developed, and the epidemic modelling and projection effort helped to inform the national response
9. Establishment of the Malawi Partnership Forum, and Technical Working Groups contributed expertise to national strategies
10. Significant resources have been mobilised from various donors and development partners; financial support is harmonised and aligned to the national financial and workplans, and the number of grants under the Grant Facility has increased drastically.

2.5 Emerging issues for the national response

Below is a brief description of cross cutting challenges and emerging issues for consideration in the period 2010 to 2012.

1. Behaviour change has not happened in proportion to the massive IEC efforts¹¹. The National HIV Prevention Strategy calls for more effective BCC methods, more focus on key behaviours, and better audience segmentation.
2. Pre-ART services need to be emphasised for all people who test positive, complementing the roll out of ART services. Pre-ART enables patients to be monitored after diagnosis, present more timely for ART, and so improves treatment outcomes. The continuum of care needs to include home based care, which requires updating of models and guidelines to account for the impact of ART.
3. Mainstreaming needs to be better conceptualised to improve effectiveness of efforts to engage more ministries in the response, and more commitment is needed from sectors and local authorities.
4. The limited capacity of the health sector remains a barrier to scaling up the largest part of biomedical prevention and care services. Health systems strengthening needs to be a major component of the response.
5. Decentralisation of the response to district level, and strengthening community systems are hampered by limited institutional, human and technical capacity, thus affecting planning, implementation, tracking and reporting progress on service delivery.
6. Interventions need to be more evidence based, better evaluated on impact and cost-effectiveness, and better targeted, especially in the areas of prevention and impact mitigation.
7. Allocation of resources between and within core strategies needs to be more rational. The (cost)effectiveness and sustainability of interventions needs to be improved
8. Research and surveillance efforts generate ample strategic information, but it is not effectively disseminated and not often used for evidenced-based policy development an intervention design.
9. Despite numerous campaigns and advocacy, taboos, silence, stigma and gender inequity still fuel the epidemic and hamper the response. Open debate is needed about sex, sexuality, sexual rights and sexual violence, as well as sensitive but evidence based interventions like condoms and male circumcision.

¹¹ Munthali et al, 2009; BSS 2007

3. THE EXTENDED NATIONAL HIV and AIDS ACTION FRAMEWORK 2010 to 2012

3.1 The overall goal of the Extended NAF 2010 to 2012

The overall goal of the Extended National HIV and AIDS Action Framework (NAF) 2010 to 2012 is *to prevent the spread of HIV infection among Malawians, provide access to treatment for PLHIV and mitigate the health, socio-economic and psychosocial impact of HIV and AIDS on individuals, families, communities and the nation.*

3.2 Priority areas, goals and objectives

The priority areas that drive the national response for the period 2010 to 2012 are:

1. Prevention and behaviour change
2. Treatment, care and support
3. Impact mitigation
4. Mainstreaming and decentralisation
5. Research, monitoring and evaluation¹²
6. Resource mobilisation and utilisation
7. Policy and Partnerships

Each of these priority areas are further discussed in detail in Sections 4 to 9. Each priority area has a goal, objectives, key strategies and action areas. Key results, targets are mentioned in the relevant chapters. The policy holders and lead implementing partners are mentioned, although in most action areas many partners work together. Annex 1 provides the complete list of national core indicators, Universal Access targets and targets for 2012. The estimated resource needs are presented per priority area in Annex 2 and 3.

3.3 Guiding principles of the Extended NAF

1. High-level government commitment, national leadership and ownership: Government commitment and support at all levels will continue to characterise Malawi's multi-sectoral response to HIV and AIDS. The GoM, through the National AIDS Commission, will provide the required leadership for a sustained and more effective management of the national HIV and AIDS response that reflects the priorities of the country.

2. Three Ones: The national response will conform to the "Three Ones" principle; 1) one national HIV and AIDS coordinating authority, 2) one national HIV and AIDS action framework, and 3) one monitoring and evaluation framework. This includes the "Three Ones" at the Local Authority level.

¹² These were two separate pillars in the NAF

3. Multi-sectoral and multi-stakeholder partnerships: For enhanced and sustainable HIV and AIDS response and in recognition of the epidemic as a crosscutting and development issue, all sectors of society mainstream and address HIV and AIDS in their plans and programmes. Collaboration and sharing of experiences among stakeholders, including government, development partners, NGOs, religious organisations, private institutions, traditional institutions and communities are key principles in the design, implementation and monitoring of multi-sectoral and multi-disciplinary programmes.

4. Greater involvement of people living with AIDS (GIPA): The greater involvement of PLHIV at all levels is crucial for an effective response to HIV and AIDS.

5. Human Rights: All Malawians have a right to know their HIV status and to appropriate pre-test education for informed consent. People living with HIV, orphans, widows and women have the right to protection against discrimination and stigmatisation with equal access to education, and health including access to treatment, employment and other services. Non-discrimination, equal protection and equality before the law for all Malawians, are key guiding principles.

6. Gender: All actors in the HIV and AIDS response will pay attention to gender issues, which pose unique and ever-changing challenges to the programme and exacerbate the course and impact of the epidemic.

7. Evidence-based interventions: It is essential that the national response to HIV and AIDS be based on sound, current, empirically based research.

8. Public health approach: A public health approach promotes the most effective prevention interventions that reduce the risk of HIV transmission, without bias.

9. Community empowerment approach: A community empowerment approach strengthens the capacity of families and communities to address vulnerabilities for HIV infection and to care for PLH, OVC, widows, widowers and the affected elderly. Hence there is a need for their full involvement for an effective national response to HIV and AIDS.

10. Good governance, transparency and accountability: An effective national response to the epidemic requires that there is good governance, transparency and accountability at all levels in the management of the national responses, especially in resource allocation and utilisation.

3.4 Implementation arrangements for the Extended NAF

1. Governance

Governance is the responsibility of the OPC, delegated to the NAC, and with oversight from the Department of Nutrition, HIV and AIDS (DNHA).

2. Policy development

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

3. Programmatic leadership and coordination of implementation

The NAC coordinates the national response and implementation of the NAF. This involves reviewing and updating the national strategy, and coordination of all relevant implementing partners, and monitoring and evaluation of the national response. To this end, NAC coordinates development and implementation of the Annual Integrated Workplans, identifying actions, implementers and budgets. The Malawi Global Fund Coordinating Committee (MGFCC) provides governance and oversight to programmes supported by the GFATM, and consists of GoM, development and implementing partners, and communities affected.

4. Partnerships

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

5. Technical support and technical leadership

Technical support for design and implementation of interventions is provided by several actors. The technical ministries (e.g. MoH, MoE and MoWCD) provide technical leadership in their areas, often supported by Technical Assistance from development partners and INGOs. Technical Working Groups bring together technical experts and advice on national technical strategy development.

6. Capacity building

Capacity building is a core and crosscutting effort in the national response. Capacity building refers to institutional, system and human capacity development. Examples of institutional development include the support for strengthening health facilities, and grant support for community based organisations. Support for policy and strategy development is an example of system building. Human capacity development targets many players including service providers, programme planners and managers. NAC provides guidance and oversight to national capacity building efforts, but most stakeholders have a role to play in capacity building of others.

7. Service delivery

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

8. Monitoring and evaluation

NAC is responsible for monitoring the epidemic and the national response, analysing this information and disseminating it to policy makers and programme planners. NAC commissions joint reviews of the national response through the Malawi Partnership Forum. All implementing partners, ministries and NGOs alike, are expected to monitor progress of their efforts and evaluate their responses on outcome and impact. This information is shared with NAC for further dissemination.

9. Joint Reviews of the national programme

Joint reviews of progress towards the Joint Annual Integrated Workplan takes place quarterly with the executive committee of the Malawi Partnership Forum. The complete MPF meets

biannually to review progress. Besides, NAC and pooled donors have quarterly meetings to review progress towards agreed milestones.

10. Resource mobilisation, financial management and procurement

NAC is responsible for assessment of the resource requirements for the national response; for mobilisation of resources from GoM and development partners; for ensuring rational allocation of resources across strategies and partners; monitoring and reporting on resource utilisation. Every implementing partner is encouraged to raise additional resources, either from development partners or locally. NAC uses procurement manual, specifying the procurement arrangements as agreed with the pooled donors. The procurement system is under review, and will be aligned with the Malawi Public Procurement Act. Procurement of drugs and medical equipment for ART services has been contracted out to UNICEF under an MoU between MoH and UNICEF, but should be handed over to MoH Central Medical Stores, planned for 2011.

11. Harmonisation and alignment with development partners

The GoM entered into an MoU with development partners in 2003 to harmonise their support in a Pooled Funding Arrangement. This involved the CIDA, DFID, GFATM, the Kingdom of Norway and World Bank. Some development partners are not able to pool funding, but also align their discreet support to the national priorities (the NAF) and take part in the HIV and AIDS Development Group.

12. Grant management

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

3.5 Resource needs for the Extended NAF

The cost of implementing the Extended NAF is estimated to be 650 m US\$ over the three-year period, as per details in annexes and 3. Out of this amount, 241 m US\$ (37 percent) is earmarked for prevention; 207 m US\$ (32 percent) for treatment, care and support, and 92 m US\$ (14 percent) for impact mitigation. The resource needs have been identified through application of the Resource Needs Model¹³, based on demographic and epidemiological data, unit costs of services, and proposed coverage targets for the next three years. The resource needs were validated through a comparison with HIV and AIDS expenditure data of recent years (See also Annex 4). In terms of absorptive capacity, the HIV and AIDS programme expenditure through NAC increased from almost 26 m US\$ (36% of the budget available) in 2005/6, to more than 86 m US\$ (71%) in 2007/8. It should be noted that only an estimated 60% of national HIV and AIDS expenditures go through NAC, the rest includes line ministries' budgets (incl. 2% of ORT) and discreet donors such as PEPFAR¹⁴.

Financial support to implement NAF will come mainly from external funding partners. The tentative commitments of pooled and discrete funding partners, including the GoM contribution to the pool, will total over US\$ 400 million. This leaves a funding gap of around US\$ 250 million, to be sourced from elsewhere.

¹³ The Futures Institute

¹⁴ MEP&D, 2007, National AIDS sub-account report

4. PREVENTION AND BEHAVIOUR CHANGE

4.1 Introduction

HIV prevention constitutes the major challenge for Malawi's national response: although the epidemic is leveling off, every year there are roughly 100,000 new infections. HIV prevention measures include behaviour change interventions, supported by biomedical services namely HTC, PMTCT, STI management and safe blood and medical procedures.

Achievements in recent years

Several strategies and plans have been developed, including the National HIV Prevention Strategy, and technical strategies for Abstinence; Mutual Faithfulness; HIV Prevention for Young People; and PMTCT scale up.

During implementation of the NAF 2005-2009, the distribution of communication materials significantly increased to 2.5 million copies in 2007/8; and TV and radio programs and jingles produced have gone beyond 2,000 per annum. There has also been an increase in the number of resource centres and outreach HIV awareness activities. These AIDS awareness campaigns have resulted into universal awareness about HIV and AIDS, but not into much sustained behaviour change.

Life skills education has been scaled up to all primary and secondary schools, now potentially reaching 3 million primary and over 250 thousand secondary school students. In 2007 there were almost 7,000 Edzi Toto Clubs, one-third of them out of school.

MoH increased coverage of biomedical HIV prevention services like STI management, HTC and PMTCT. HTC especially scaled up effectively to 1.4 million Malawians tested in the last year. Blood safety remains high; 99% of blood is screened for HIV. Post exposure prophylaxis (PEP) is available in ART centres, but demand is low. MoH also introduced the female condom, although condom uptake remains low in general.

Key issues for the next 3 years

The main driver of the epidemic is multiple and concurrent sexual partners, which is high (27% men, 8% women). Condom use at last high risk sex is still inconsistent and low. While HIV incidence is high among most-at-risk groups such as MSM and sex workers, most HIV infections occur within stable, discordant relationships, where condom use is only 3%. HIV disproportionately affects the better educated and wealthier people, and people in towns.

The medium term review of the NAF and the draft national HIV prevention strategy highlight a number of priorities for the next three years.

1. Targeting people in stable sexual partnerships including discordant couples
2. Targeting most-at-risk groups: sex workers, MSM and prisoners
3. More effective communication methods for behaviour change, e.g. peer education and interpersonal education, rather than reliance on IEC materials and electronic media
4. Evidence based planning and prioritisation of prevention interventions
5. Ensuring that LSE is effectively taught in and out of schools, addressing known barriers
6. Creating an enabling environment for implementing behavioural change programs
7. Community participation in programme design, implementation and M&E
8. Increasing human resource, infrastructure and technical capacity at all levels
9. Increasing commitment and investments in prevention programs at all levels
10. Improved and sustainable decentralised district-based HIV prevention response

Goal: To reduce new HIV infections in Malawi

Core Indicator	Target		
	Baseline	2010	2012
HIV prevalence among pregnant women (15- 24 yr) attending ANC	12.3% (2007)	12%	11%
HIV incidence rate among adult population (15-49)	1.6% (2007)	1.4%	1.0%

Objective 1: To reduce sexual transmission of HIV

Strategies and broad action areas

1. Reduce multiple and concurrent partners
 1. NAC to commission a communication strategy specifically targeting couples
 2. NGOs, MIAA and companies to provide one-on-one sex education to couples
 3. NAC to commission multi media campaigns on mutual faithfulness
2. Reduce HIV transmission among discordant couples
 1. MoH and partners to develop 'positive prevention' strategies
 2. MoH and partners to target discordant couples for condom use through multi media
 3. MANET+ and partners to develop positive prevention for PLHIV and partners
3. Increase delayed sex, and safer sex among young people
 1. MoE and partners to provide life skills education and assess behavioural impact
 2. MoYSD and partners to provide life skills one-on-one to out of school youth
4. Increase condom use with non-regular partners
 1. MoH and partners to increase distribution of free male and female condoms
 2. PSI & BLM & partners to scale up condom social marketing to general and high risk population
5. Increase access to prevention and care services for most-at-risk populations¹⁵
 1. NAC to commission targeted prevention interventions for MARP
 2. Malawi Prison Service to ensure access to prevention services for inmates
 3. Malawi Defence Force and Malawi Police Service to undertake prevention services for uniformed women and men
 4. MoE and partners to undertake prevention services targeting teachers
6. Increase use and quality of HTC services
 1. MoH and partners to increase the number and capacity of HTC sites
 2. MoH and partners to intensify multi media campaign to promote demand for HTC
 3. MoH and partners to provide couple counselling and testing, and referral services
 4. MoH and partners to promote provider initiated HTC, ensuring informed consent
7. Increase use and quality of STI services
 1. MoH and partners to increase the capacity of STI service providers
 2. MoH and partners to increase demand for STI services and awareness of symptoms through IEC

¹⁵ MSM, sex workers, high risk professional groups (transport, police, teachers)

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8. Increase use and quality of male circumcision services
 1. MoH and partners to develop male circumcision policy, intervention and communication guidelines based on international and local evidence
 2. MoH and partners to pilot safe circumcision services and assess demand and outcome

Objective 2: To prevent mother-to-child HIV transmission

Strategies and broad action areas

1. Advocacy and community mobilisation for increased demand and male involvement in PMTCT
 1. MoH and partners to develop communication strategies and materials targeting men and community leaders
 2. MoH and partners to provide services that are family-focused and involve male participation in couple counselling
2. Strengthen linkages between PMTCT, care, prevention, RH/MCH and primary care services
 1. MoH and partners to provide HTC, PMTCT and adult & paediatric care and treatment as a comprehensive package
 2. MoH and partners to strengthen HTC at family planning service delivery sites
 3. MoH and partners to intensify essential nutritional actions
3. Capacity building of relevant health care providers and health systems
 1. MoH and partners to establish more PMTCT sites at all ANC sites
 2. MoH and partners to review and update PMTCT protocols and guidelines
 3. MoH and partners to train more PMTCT service providers

Objective 3: To prevent HIV transmission through blood, blood products and invasive procedures

Strategies and broad action areas

1. Increase blood safety, voluntary blood donations and rational blood use
 1. MoH to review guidelines on blood safety
 2. MoH and partners to promote voluntary donation of blood
 3. MoH and partners to train health workers on rational use of blood and blood products
2. Improve infection prevention and waste management in the health service
 1. MoH to review guidelines and standard operating procedures
 2. MoH and partners to provide training and IEC materials in health care settings
 3. MoH and partners to provide adequate facilities and materials for safe disposal
3. Increase availability and use of Post Exposure Prophylaxis in the health services.
 1. MoH and partners to provide PEP to health workers and general population in need
 2. MoH and partners to promote awareness and demand for PEP through IEC

Objective 4: To create a supportive environment for HIV prevention

Strategies and broad action areas

1. Increase linkages between services and interventions
 1. NAC and MoH to identify best practices for linking HIV services
 2. MoH to develop referral guides to link people to different services in the health centres and communities
 3. LAs and partners to link community-based groups with health services to support both facility and community-based prevention activities

2. Address the cultural, social and economic environment, and gender inequalities to support reduction of HIV risk and vulnerability
 1. MoLGRD, LAs and partners to build capacity of opinion leaders to speak against harmful practices, stigma and discrimination
 2. NAC, LAs and partners to fund community mobilization against harmful cultural practices
 3. NAC and partners to support leaders and PLHIV to act as role models or to disclose their HIV status and fight stigma
 4. MANET+ and partners to promote involvement of PLHIV in policy and programme development
 5. NAC and Media Council of Malawi to train media professionals to accurately address issues related to HIV, stigma and discrimination
 6. MoWCD to provide economic opportunities for women vulnerable to transactional sex

3. Promote legal and human rights issues that reduce HIV risk and vulnerability
 1. NAC, MoH and partners to lobby to enact sexual and reproductive health legislation
 2. LAs and partners to promote community awareness regarding their rights
 3. LAs and partners to monitor law enforcement, e.g. regarding sexual harassment, domestic violence and inheritance rights for women and children
 4. MoE to integrate health-related legal issues into life skills education
 5. NAC to engage human rights and support NGOs to address sexual health issues

5. TREATMENT, CARE AND SUPPORT

5.1 Introduction

Care and treatment relates to improving the healthcare system capacity to provide equitable access to HIV care, and increasing access to complementary community and home based care.

Achievements in recent years

During recent years, the capacity of the health system to respond to HIV and AIDS has greatly increased, guided by the scale up plan for anti-retroviral treatment (ART) and opportunistic infections (OI), and the six year emergency human resource plan. This involved training of health care workers, preparing health facilities to introduce ART, and building the support services in terms of drug procurement and logistics and systems for supervision and monitoring. Paediatric formulations have been introduced, and laboratory back up for diagnosis has been strengthened with 35 CD4 cell count machines. In 2005 there were 66 public and 23 private facilities offering ART to 37,840 and 977 patients respectively. During 2008, almost 64,000 people were newly enrolled on ART, and by March 2009 the number of patients on ART had increased to 147,000. This is more than half of those in need of ART, with 61% female enrolment.

The ART programme however faces several challenges. They include manpower shortage, clinic and pharmacy space inadequacy, low paediatric patient enrolment. Early mortality is high, due to delayed start of treatment. In rural areas access to ART remains limited due to the long distance to ART centres. Stock outs of ARV have been avoided, but stock outs OI drugs happen and cause disruption. The extent of ART drug resistance is below 5%¹⁶, and is monitored regularly.

Care and support services have however not developed as rapidly and systematically as ART, and have focused mainly on community home based care. NAC and partners made more than 2,750 grants to NGOs and CBOs including FBOs to implement home and community based care, providing home care kits, palliative care, and nutritional support for people with HIV and other chronic diseases. By end of 2008, the CHBC programme reached 744,000 households with chronically ill patients, while almost 147,000 households received external assistance. Over 19,000 PLHIV received nutritional support; 11.6% of patients on ART received therapeutic feeding.

Key issue for the next 3 years

The mid term review, and the TWG Care and Treatment have identified several opportunities for improving the care and treatment response:

1. Improving further access to ART to beyond 50% of those in need, especially for paediatric cases and populations in underserved areas; improving management of TB/HIV co-infection. Strengthening the health systems remains a necessary condition for scaling up care and treatment, especially the areas of drug logistics and laboratory support
2. Improving the management of people after HIV diagnosis until eligible for ART (pre ART care)
3. Community and home based care needs to adjust, as patients are less bedridden. This will require adjusted models, guidelines and training of providers
4. Referral systems and coordination between health services and with home and community based care services, needs to improve
5. Nutritional support needs to be rationalised; the focus needs to sharpen on therapeutic feeding for PLHIV; food supplements will be cheaper and more sustainable if locally produced and procured where possible.

¹⁶ MoH, Threshold study 2007

Goal: To provide and expand equitable treatment for PLHIV and mitigate the health impact of HIV and AIDS

Core Indicator	Target		
	baseline	2010	2012
Percentage of adults with HIV still alive 12 months after initiation of ART	76%	80%	85%

Objective 1: To improve the capacity of the health care system to manage HIV and related diseases

Strategies and broad action areas

1. Train, treat and retain health workers
 1. MoH and partners to increase the number of health workers available
 2. MoH and partners to undertake in- and pre-service training on HIV management
 3. MoH and partners to continue piloting and scaling up task shifting strategies
2. Strengthen infrastructure, systems and quality assurance
 1. MoH and partners to increase the number and capacity of sites for pre-ART and ART services, i.e. adequate counselling space and storage capacity
 2. MoH to undertake quality assurance and supportive supervision and strengthen capacity at zonal and district level
 3. MoH to develop and disseminate guidelines for continuum of care services
3. Strengthen referral systems within and between health facilities and community
 1. MoH to develop referral guidelines for all levels of health services
4. Strengthen drug procurement and logistics
 1. MoH to build capacity of Central Medical Stores
 2. MoH and partners to improve capacity in supply management at facility level
5. Strengthen laboratory support services for HIV diagnosis and management
 1. MoH to regularly update and disseminate HIV diagnostic protocols
 2. MoH and partners to train all relevant staff in protocols and guidelines
 3. MoH and partners to undertake quality assurance/quality improvement of lab support

Objective 2: To increase access to a continuum of HIV treatment and care services

Strategies and broad action areas

1. Increase use and quality of pre-ART management for people with HIV
 1. MoH to develop and update guidelines for pre-ART services
 2. MoH and partners to implement a pre-ART package of services

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2. Increase use and quality of ART and OI management
 1. MoH and partners to monitor and improve ART treatment protocols, and train health providers
 2. MoH and partners to evaluate barriers to access/ adherence and develop strategies to address them
 3. MoH and partners to increase understanding among general population and special groups about HIV treatment and care services
 3. Increase use and quality of paediatric HIV care, including ART
 1. MoH and partners to update and disseminate guidelines for paediatric HIV management and build capacity of health care providers in paediatric HIV care
 2. MoH and partners to increase awareness about paediatric HIV treatment
 3. MoH and partners to strengthen linkages of HIV services for exposed infants and children
 4. Increase use and quality of HIV/TB co-infection management
 1. MoH and partners to update and monitor guidelines for HIV/TB co-infection
 2. MoH and partners to increase provider initiated HTC among TB patients
 3. MoH and partners to promote TB awareness and screening among PLHIV
 5. Increase use and quality of therapeutic feeding for HIV patients
 1. MoH to review and update therapeutic feeding guidelines and protocols
 2. MoH to develop and disseminate nutritional counselling guidelines and IEC materials
 6. Increase use and quality of palliative care for HIV patients
 1. MoH to finalise guidelines and standards for palliative care
 2. MoH and partners to train health workers and volunteers in palliative care
 3. MoH and partners to increase the number and capacity of palliative care sites

Objective 3: To increase access to quality community home based care (CHBC) and support services

Strategies and broad action areas

1. Increase quality of community home based care models
 1. MoH to review and update the CHBC guidelines and package
 2. MoH and partners to train health workers and CBO/NGO staff in CHBC
 3. MoH, MoWCD and partners to promote participation of men and boys in CHBC
2. Increase coverage of home based care for people in need
 1. NAC, LA and partners to fund NGOs/CBOs to undertake CHBC
 2. MoH and partners to strengthen referral linkages between HTC/ART and CHBC
 3. LAs and partners to increase awareness about CHBC

6. IMPACT MITIGATION

6.1 Introduction

Impact mitigation aims at alleviating the impact of HIV and AIDS on individuals and households affected by HIV, including but not limited to PLHIV, orphans, widows/widowers and the elderly. Impact mitigation interventions include psychosocial support, education, legal and material support¹⁷. Impact mitigation interventions are largely undertaken by households, communities, CBOs, NGOs, FBOs and the government.

Achievements in recent years

During the period 2004 to 2008, NAC developed a conceptual framework for impact mitigation (2006); the Ministry of Women and Child Development developed an OVC Policy and National Plan of Action (2005 to 2009), and the Ministry of Economic Planning and Development developed a social protection policy (2008) which includes PLHIV. The Law Commission drafted a comprehensive draft HIV and AIDS Bill, awaiting enactment by Parliament.

Material support programmes have been scaled up. NAC and partners supported more than 300 CBOs in 2007/8, who reached over 3,257 beneficiaries with income-generating activities (IGA). Over 2,000 households and more than 2,000 vulnerable people received start-up kits¹⁸. The National social cash transfer pilot program reached 5,000 ultra-poor households and 10,000 orphans, and the evaluation indicates that more orphans attended school¹⁹. PLHIV and affected households form a minority among the beneficiaries of material support.

The Network of Organizations for Vulnerable and Orphaned Children (NOVOC) provide input on issues of OVC and possible interventions. A GFATM grant supports the OVC National Plan of Action 2005 to 2009. OVC receive bursaries to attend secondary school (15,543 in 2007), reducing drop out at secondary school level. The MoE reached 635,000 pupils (82,500 OVC) with a school feeding programme in primary schools²⁰. Community based child care centres provide food support to 82,000 orphans, 20% of the beneficiaries. Communities have established communal gardens to provide food for CBCC as well as other vulnerable population groups such as PLHIV. Almost 9 percent of OVC received psychosocial support over the three months preceding the MICS survey, more so in urban areas and in the Central region.

Key issues for the next 3 years

The mid term review 2008 identifies several opportunities to improve and scale up impact mitigation interventions:

1. Strengthening the capacity of the social welfare system at all levels
2. Improving access to schools and other social services by OVC and affected groups
3. Expanding the provision of psychosocial counselling, and including monitoring the quality of services provided
4. Increase the capacity of Local Authorities and CBOs to provide support.
5. Food security strategies to become more sustainable, e.g. seed provision and labour saving technologies
6. Improve the effectiveness and sustainability of material support strategies

17 Macro-economic and sectoral impact mitigation is addressed under mainstreaming and public policy development.

18 Siwale and Nthambi, 2008

19 Siwale and Nthambi, 2008

20 Siwale and Nthambi, 2008

Goal: To mitigate the economic and psychosocial effects of HIV and AIDS and improve the quality of life of PLHIV, OVC and other affected individuals and households

Core Indicator	Target		
	Baseline	2010	2012
Number of households with vulnerable people reached with impact mitigation interventions	10,458 (2008)		60,000 ²¹
Number of orphans attending school	554,560	-	880,000

Objective 1: To increase access for PLHIV, OVC and other affected individuals and households to equitable material support

Strategies and broad action areas

1. Increase quality and access for PLHIV, OVC and affected households to income generating and micro-credit programmes
 1. MoWCD and partners to identify and train PLHIV and OVC as beneficiaries of IGP
 2. MoWCD and MoAFS and partners to support IGP and link them to markets.
 3. MoWCD, LAs and partners to advocate for evidence-based micro-finance programs to support PLHIV, OVC and affected households

2. Increase quality and access for PLHIV, OVC and affected households to the GoM Social Cash Transfer programme
 1. MoWCD through LAs and partners to provide access to social cash transfers to AIDS-affected ultra poor households.
 2. MEPD to accelerate design and implementation of a national social cash transfer policy

²¹ Based on source needs model: 60,000 for social cash transfer, 15,000 households seeds & inputs and IGA

Objective 2: To increase access for PLHIV, OVC and other affected individuals to psychosocial and spiritual support

Strategies and broad action areas

1. Build capacity of professional and lay counsellors in public sector and civil society
 1. MoWCD to develop guidelines and regularly monitor quality of psychosocial support
 2. MoWCD and partners to train and support district officials, community structures and organisations, and volunteers in the provision of psychosocial support
 3. MANET+, LAs and partners to promote formation and capacity building of PLHIV groups
 4. MIAA and partners to advocate for inclusion of Theology of Hope into curricula for training faith leaders and lay persons
 5. MIAA to build its capacity and to coordinate training in spiritual counselling
 6. MoWCD and partners to advocate for inclusion of psychosocial support in teacher training curriculum
2. Increase coverage of psychosocial and spiritual support
 1. MoWCD and partners to scale up provision of psychosocial counselling
 2. MIAA and partners to scale up provision of spiritual counselling

Objective 3: To promote the enforcement of legal and social rights of PLHIV, OVC and other affected individuals

Strategies and broad action areas

1. Advocate for review, enactment and enforcement of national and sectoral HIV and AIDS legislation
 1. Parliament to enact outstanding bills²² into law
 2. The Law Commission and MoWCD to develop new laws to enhance protection of OVC, PLHIV, widows and widowers
 3. MoJ, MoWCD and partners to build institutional capacity for enforcement of relevant laws and policies to ensure human rights and fundamental freedoms of PLHIV, OVC, widows and widowers
 4. The Malawi Police service and partners to provide survivors of abuse, violence, exploitation or trafficking with appropriate services
2. Increase legal literacy and awareness among PLHIV, OVC and affected communities
 1. NAC and partners to undertake public awareness campaigns about the new legislation
 2. MoWCD to train and support community-based paralegals to carry out community education campaigns on human rights, legal and ethical needs of affected groups

²² The HIV and AIDS Bill and several other relevant bills

Objective 4: To improve access for OVC to social, educational and health services

Strategies and broad action areas

1. Strengthen capacity of health, education and social welfare service providers
 1. Local Authorities and partners to expand bursaries and material support to increase OVC access to primary and secondary school
 2. MoE and partners to provide training in vocational training and livelihood skills to out of school OVC and provide them with start up kits
 3. MoE and partners to scale up school feeding programmes to increase enrolment of OVC
 4. MoWCD and partners to train NGOs, FBOs, CBOs, service providers, district (including social welfare staff) and community structures in social and child protection
 5. MoH and partners to monitor access of OVC to essential health services
 6. NAC and partners to advocate for integration of OVC in the national social protection programme
2. Strengthen capacity of families and communities to care for OVC
 1. MoWCD and partners to promote and support foster parenting and adoption
 2. MoWCD and partners to upgrade CBCCs and children's corners
 3. MoWCD and partners to train CBCC caregivers

Objective 5: To promote food and nutrition security among AIDS affected households

Strategies and broad action areas

1. Increase access to public and NGO food security programmes for affected households
 1. MoAFS and partners to support food and nutrition security programs for PLHIV, OVC and affected households
 2. MoAFS to coordinate networking activities with agencies involved in promoting food and nutrition security
 3. MoAFS and partners to train extension workers in food and nutrition security
2. Create demand for food and nutrition security programmes among PLHIV
 1. MoAFS and partners to mobilise community based groups for increased food and nutrition security
 2. MoAFS and partners to establish community grain banks and sensitise communities
3. Increase capacity of affected households to increase agricultural production
 1. MoAFS to identify and promote labour saving technologies for diversified food production, processing, preservation and utilisation
 2. MoAFS and partners to provide agricultural inputs to affected households
 3. MoAFS and partners to establish community grain banks and garden based learning sites

7. MAINSTREAMING AND DECENTRALISATION

7.1 Introduction

HIV and AIDS mainstreaming aims to engage and support each relevant sector in the multisectoral response, and to ensure that the response is decentralised to local government and communities. 'Internal mainstreaming' relates to workplace policies and programmes for staff. 'External mainstreaming' relates to the impact of organisations' policies on the spread of HIV and the potential contribution of their programmes to the national response.

Achievements in recent years

NAC developed a Mainstreaming Conceptual Framework in 2006, and involved many more government ministries in the national response. Several ministries now have HIV workplace policies; a process facilitated by the Government allocation of 2% of the ORT budget in each Ministry and Department for mainstreaming. External mainstreaming however, i.e. sectoral responses beyond workplace programmes, has lagged behind.

Civil society organisations have played a big role in advocating for mainstreaming HIV and AIDS. In the private sector, many workplace programmes have been started with technical and/or financial support from NAC, MBCA and the International Labour Organisation (ILO).

During the 2007/8 year, 72 advocacy sessions were reported to have been conducted and 608 mainstreaming facilitators were trained in various sectors, 70 new workplace committees have been formed in both public and private sectors while 147 workplace committees were supported.

Decentralisation of the response and strengthening local authorities and community level players remains a challenge, due to the low institutional and human capacities at local level. Umbrella Organisations have supported local authorities to institute grant management to local CBOs, but after the handover in 2008 capacity in this area remains low.

Key issues for the next three years

The MTR and TWG workshops identified the following priorities for the Extension of the NAF:

1. External mainstreaming remains a conceptually difficult topic for several ministries
2. There seems to be a general misunderstanding in the public sector of the use and on the functionality of the ORT Guidelines
3. Need to create clear understanding of mainstreaming and develop pathways to engage more sectors in the response
4. Institutional and human resource capacities are weak at all levels in the public sector
5. NAC and partners will have to continue to build ministries' commitment and capacity to assess sectoral HIV impact and respond appropriately
6. Decentralisation of the HIV and AIDS response remains a challenge
7. NAC needs to find innovative approaches to effectively support local responses, including grant making

Goal: To increase the involvement and contribution of public sectors, private sector and civil society in the HIV and AIDS response

Core Indicator	Target		
	baseline	2010	2012
Composite Policy Index: Overall rating of strategic efforts in the HIV and AIDS programmes ²³	8.4 (2007)		9.0

Objective 1: To support sectors to address HIV and AIDS in their organisational policies and strategies

Strategies and broad action areas

1. Establish clear understanding on HIV and AIDS external mainstreaming in all sectors
 1. NAC to update the HIV and AIDS Mainstreaming Conceptual Framework
 2. NAC to conduct baseline on HIV and AIDS mainstreaming in all sectors
 3. DHR&MD to create understanding of mainstreaming in the public sector, including the use of ORT guidelines
 4. MLG&RD to create understanding of mainstreaming in local authorities
 5. MANASO to create understanding of mainstreaming for the NGO sector
 6. MBCA to create understanding of mainstreaming in the private sector

2. Support inclusion of macro-economic impact mitigation measures in the key national planning and development frameworks (MGDS and MTEF)
 1. MEP&D and partners to support research on the macro-economic impact of HIV and AIDS
 2. DNHA and partners to advocate for higher-level leadership for HIV and AIDS mainstreaming in all sector programmes
 3. MEPSD to integrate HIV and AIDS in MGDS and other sector policies

3. Include HIV and AIDS in sectoral and organisational policies and strategies
 1. NAC to develop and implement a capacity building strategy to support sectoral impact assessments and sectoral policy development
 2. DNHA to institute liaison meetings between Finance and EP&D to ensure integration of HIV and AIDS before budget ceilings are sent to sectors
 3. Central and line ministries to develop/revise mainstreaming policies and programmes
 4. MoLGRD to support LAs to include HIV and AIDS into local development planning and programmes
 5. MBCA to support companies to develop and implement mainstreaming strategies
 6. MANASO to support CSOs to develop and implement mainstreaming strategies

²³ See UNGASS Progress report 2008

Objective 2: To expand workplace programmes on HIV and AIDS in public, private sector and civil society

Strategies and broad action areas

1. Expand workplace interventions in public sector
 1. NAC to commission training in HIV and AIDS workplace programming
 2. DHRMD to build capacity of central ministries and line ministries and departments in HIV and AIDS workplace programming
2. Expand workplace interventions in private and NGO sector
 1. MBCA to facilitate HIV and AIDS workplace programmes in the private sector
 2. MANASO and MIAA to facilitate capacity building in HIV and AIDS workplace programmes in CSOs

Objective 3: To develop the capacity of local authorities to respond to HIV and AIDS at district and community level

Strategies and broad action areas

1. Build capacity of local authorities to mount, implement and monitor local responses to HIV and AIDS
 1. MoLGRD and partners to train LAs to coordinate HIV and AIDS activities in districts and communities
 2. MoLGRD and partners to support LAs with necessary resources to coordinate the response at the local level

8. RESEARCH, MONITORING AND EVALUATION

8.1 Introduction

Programme planners and policy makers need strategic information about the epidemic and the responses through M&E and research. Surveillance consists of several methods to regularly track the epidemic (HIV Sentinel Surveillance, HSS) and the outcomes and impact of the response (BSS, DHS). Programme activity monitoring (LAHARS, HMIS) enables managers to track service coverage. Research, for example operational or evaluative research, also provides evidence to practitioners and planners.

Achievements in recent years

NAC developed a National M&E Plan 2006 to 2010, to implement the M&E component of the NAF 2005 to 2009. The M&E Plan conforms to international standards in terms of methods, data management, and using gender-disaggregated indicators. M&E structures have been strengthened at NAC, MoH and MoWCD.

Key surveys were implemented to generate up to date information on the epidemic and the status of the response, including the HSS and BSS, and HIV related items were incorporated into the Demographic and Health Survey (DHS) and Multi Indicator Cluster Survey (MICS).

The Activity Reporting System has been strengthened, in order to provide quarterly progress reports, through posting of M&E officers in each district. This system is still suffering from low capacity and interest of implementers to report on service delivery, so NAC provided training on data audit to key users. NAC also initiated work on HIV specific databases within NAC and key partner organizations, including local authorities.

The National Research Council of Malawi (NRCM) developed the National HIV and AIDS Research Strategy 2005-2007. This strategy identified research priorities, and NAC and partners funded several studies but mainly biomedical studies. NAC organised successful annual research dissemination conferences for researchers and programme implementers. NAC also supported the CoM to publish special AIDS issues of the Malawi Medical Journal. Finally, NAC supported institutional capacity building of NRCM, CSR and other institutions to conduct HIV and AIDS research. However, funds allocated to research remain under-utilised and the MTR highlighted the lack of capacity to conduct or commission operational research, especially within the MoH.

Key issues for the next three years

The MTR and TWGs Research and M&E have identified the following issues for the next period:

1. Data is underutilized. NAC and partners need to improve synthesis and dissemination of strategic information to policy makers and programme planners
2. Routine data collection and analysis capacity needs to be improved at district level and among civil society
3. Better use of spatial data (geographical information system) for programme planning
4. The national monitoring and evaluation plan needs to be widely disseminated and implemented by all partners and stakeholders at all levels
5. Repackage and simplify research findings for the benefit of specific groups, e.g. community organizations
6. Update the National HIV and AIDS Research Strategy based on a prior research needs assessment, and develop a National Surveillance Strategy
7. Build the capacity of MoH and NAC to commission or conduct HIV and AIDS research

Goal: To generate and disseminate information about the HIV and AIDS epidemic and response, to inform appropriate policy and evidence-based practice

Core Indicator	Target		
	Baseline	2010	2012
Number of HIV and AIDS related and M & E and research studies in Malawi approved by appropriate research committees that are in line with the national HIV and AIDS research strategy	93 (2007)	120	150

Objective 1: To strengthen the capacity of institutions to undertake monitoring and evaluation, and research

Strategies and broad action areas

1. Strengthen capacity of NAC and national agencies to collect and report HIV and AIDS data using the National M & E Plan
 1. MoH to commission a National HIV Surveillance Strategy
 2. NAC to commission review and update the National M&E Framework
 3. NAC to finalise and roll-out HIV and AIDS geographical information system (GIS)

2. Strengthen capacity of implementing partners and service providers to monitor and report on programme activities
 1. MEPD, NAC and partners to align and update key data sources e.g. HMIS, EMIS, MOWCD and LAHARS
 2. NAC and partners to strengthen HIV and AIDS Activity Reporting System in all sectors including local authorities
 3. MEPD to develop participatory monitoring guidelines to facilitate monitoring at community level
 4. NAC and partners to build and sustain capacity for M&E in sector ministries, LAs (targeting district M&E officers) and civil society organizations through training, workshops, and provide IT infrastructure and equipment

3. Strengthen the capacity of institutions to undertake HIV and AIDS research
 1. NAC to commission a review and update of the HIV and AIDS Research Strategy
 2. NRCM to commission a mapping and capacity assessment of research institutions
 3. NRCM to develop an inventory of research institutions involved in HIV and AIDS related research
 4. MoH in collaboration with institutes of higher learning to strengthen capacity of organisations to conduct operational (biomedical and non-biomedical) research
 5. NRCM to facilitate collaboration and coordination of HIV and AIDS research through networking and partnerships

Objective 2: To collect and generate strategic information on the epidemic and the response at national, district and community levels

Strategies and broad action areas

1. Support collection of routine and periodic programmatic data.
 1. Implementing partners to report on progress of activities
 2. MoH to scale up HMIS, including incorporating Electronic Data Systems
 3. Local Authorities and partners to conduct quarterly/annual programme reviews
2. Support implementation of national HIV surveillance strategy
 1. NAC to commission HIV and behavioural surveillance surveys of general, high risk and ANC populations
 2. MoH to coordinate and implement STI case detection and sentinel surveillance
 3. MoH to coordinate and implement HIV incidence monitoring surveillance
 4. MoH to undertake national HIV drug resistance surveillance
3. Implement quality HIV and AIDS related research
 1. NRCM to prepare, update and distribute guidelines on the legal, ethical and intellectual property related to HIV and AIDS research
 2. NAC and partners to support HIV and AIDS research in priority areas as detailed in the National HIV and AIDS Research Strategy, to guide programming and interventions.
 3. NAC to facilitate impact evaluation of the various programme areas in the national response

Objective 3: To increase access and utilization of strategic information by policy makers and programme planners at all levels

Strategies and broad action areas

1. Strengthen mechanisms for analysis and packaging of surveillance and research findings
 1. NAC to repackage and simplify research and survey findings for targeted audiences including districts, community organizations and policy makers
 2. LAs and partners to support information documentation, sharing, analysis and utilization at local level
 3. NAC to create an accessible national HIV and AIDS research database
2. Dissemination of strategic information to policy makers and programme planners
 1. NAC to disseminate reports related to HIV and AIDS through different modalities including Internet
 2. NAC and LAs to organise joint annual review meetings at national and district level
 3. MoH to organize HMIS quarterly zonal meetings
 4. NAC to arrange national and zonal annual HIV and AIDS research dissemination conference and support publication of results

9. RESOURCE MOBILISATION AND UTILISATION

9.1 Introduction

Resource mobilisation and utilisation refers to ensuring that financial resources are raised, allocated and distributed so that the aspirations of the National Action Framework are turned into real prevention, treatment, care and support services.

Achievements in recent years

There has been impressive resource mobilization and goodwill from the international community. The Government of Malawi and several development partners pooled HIV and AIDS resources to harmonize accounting systems and reporting timeframes, and aligned procurement and fiduciary systems. NAC has been able to encourage donors who cannot pool resources, to at least harmonise their support with the National Action Framework priorities.

NAC developed a grants management system in 2003 and contracted a Financial Management Agency (FMA) to manage the Grants Facility. Many implementers, especially at community level, have been able to access available funds. In the financial year 2007/8, the FMA reviewed 143 proposals and made 265 disbursements to grantees. In 2008, the FMA successfully handed over grants management to a Grant Management Unit in the NAC. Umbrella Organisations have supported local authorities to contract and sub-grant funds to CBOs for community initiatives. However, in 2008 Umbrella Organisations handed over the CBO grants management to the Local Authorities.

In terms of absorptive capacity, the HIV and AIDS programme expenditure through NAC increased from 25,65 m US\$ (36% of the budget available) in 2005/6, to 86,35 m US\$ (71%) in 2007/8 (See also Annex 4).

Key issues for the next three years

The MTR identified several opportunities to improve resource mobilisation, allocation and disbursement:

1. Allocation of resources within and between priority areas of the NAF is more responsive than need based. NAC could use established planning tool such as the GOALS model to improve efficient allocation
2. The response remains abundantly dependent on external resources. The cost-effectiveness of the national response, and sustainability of funding needs to be monitored
3. The efficiency and transparency of grants management has room for improvement
4. Rolling out grant making to the district level, in the absence of Umbrella Organisations, needs capacity building of Local Authorities and monitoring
5. The budgeting and absorption capacity of implementing partners is weak across the board, and hampers progress as well as national level absorption of donor funding

Goal: To enhance HIV and AIDS financial resource mobilisation and management at all levels

Objective 1: To strengthen financial resource mobilisation and tracking for the national response

Strategies and broad action areas

1. Use the Extended NAF as a guide for resource mobilisation
 1. NAC to undertake full costing of the NAF
 2. NAC and MEPD to develop and implement a resource mobilisation strategy
 3. NAC to disseminate and popularise the NAF as a resource mobilisation tool
 4. OPC to advocate for increased resource allocation for HIV and AIDS in government budgeting processes at national and district levels
2. Promote resource mobilisation for HIV and AIDS activities in the private and non-profit sector
 1. NAC to identify local and sustainable sources of financing for the AIDS response
 2. NAC to develop and disseminate guidelines for resource mobilisation to all partners
 3. NAC and partners to strengthen capacity of partners in proposal writing, resource mobilisation, management and accountability
3. Develop mechanisms for resource allocation and tracking, and monitoring of the response²⁴
 1. NAC to undertake resource needs modelling and resource allocation exercises with relevant planners and implementing partners
 2. NAC to undertake biennial National AIDS Spending Assessment to assess and report on national expenditures on HIV and AIDS services

Objective 2: To enhance timely disbursement of funds to partners and implementers at all levels

Strategies and broad action areas

1. Improve mechanisms for proposal processing by NAC and Local Authorities
 1. NAC and partners to develop procedures to expedite the process of fund disbursements
 2. NAC and partners to strengthen capacities of Local Authorities in proposal processing
 3. NAC and partners to regularly review and improve the proposal assessment process
2. Institute systems for monitoring impact of the Grants Facility
 1. NAC and partners to track and report on grants disbursement
 2. NAC to commission joint reviews and external evaluation of the Grants Facility

²⁴ Moved from PP&P

Objective 3: To develop capacities of implementing agencies to absorb and account for financial resources

Strategies and broad action areas

1. Develop capacity of grant recipient organisations for timely implementation of activities
 1. NAC, and partners to train grant recipient organisations in production of timely reports
 2. NAC and partners to orient grant recipient organisations regularly about accountability procedures

2. Institute transparent and simple measures for timely accountability
 1. NAC and partners to disseminate accountability guidelines to Local Authorities and grant recipient organisations
 2. NAC and partners to train LAs and other grant recipient organisations in budgeting and financial reporting

10. POLICY AND PARTNERSHIPS

10.1 Introduction

An effective national response to HIV and AIDS requires a supportive public policy environment, and laws that clarify national strategies and roles and responsibilities; that ensure rights of PLHIV and vulnerable people; and that enable effective prevention and care interventions. Partnerships are needed to coordinate implementation of the response.

Achievements in recent years

Malawi developed a national HIV and AIDS Policy, ‘A renewed call to action’, in 2003. Recently, the Law Commission undertook a review and proposed a HIV and AIDS Bill, which is yet to be passed by Parliament. Several other proposed bills are relevant for HIV and AIDS programming, including legislation related to Children, Inheritance rights and other topics.

In the area of partnerships, much has been achieved in recent years. Several platforms have been established, and are functioning effectively:

1. the Malawi Partnership Forum, with membership from all HIV and AIDS partners
2. the Pooled Donor Group and the HIV and AIDS Development Group
3. The Malawi Global Fund Coordinating Committee (the Country Coordinating Mechanism)
4. the Local and International NGO HIV and AIDS Fora
5. the Malawi Interfaith AIDS Association
6. the Malawi Business Coalition on AIDS
7. the Malawi network of PLHIV (MANET+)

The NAC pro-actively facilitates these partnerships, and supports coordination between stakeholders.

Key issues for the next three years

In the area of supportive public policy development, the following issues have been identified:

1. The HIV and AIDS bill needs to be approved by Government and enacted by Parliament
2. Sectoral legislation must be aligned with provisions in the HIV and AIDS Bill
3. Law enforcement personnel, advocates and judges need to be sensitized about the new legislation
4. Enforcement, monitoring and redress systems need to be developed and implemented

The key issues for partnerships and coordination include:

1. Maintain the momentum for collaboration and joint action, ensuring added value of networking for participants
2. Use networks more effectively for mutual capacity building
3. Engaging the partnerships and networks in joint review and revision of national strategies
4. Improving communication mechanisms and follow up on agreements or consensus reached
5. Reviewing and redefining the role and functioning of TWGs in the light of the establishment of the Malawi Partnership Forum

Goal: To facilitate and coordinate multisectoral implementation of the National HIV and AIDS Action Framework

Core Indicator	Target		
	baseline	2010	2012
National Composite Policy Index: Overall rating the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS ²⁵	5.0		6.5

Objective 1: To create a supportive public policy environment and increased political leadership for HIV and AIDS action

Strategies and broad action areas

1. Adopt and disseminate of the national HIV and AIDS bill
 1. MoJ to facilitate the passing of the HIV and AIDS Bill into law
 2. DNHA, NAC & MoJ and partners to conduct comprehensive awareness campaigns on the HIV and AIDS Bill
2. Align sectoral policies and strategies to the National HIV and AIDS bill
 1. NAC and partners to disseminate national policies to all sectors
 2. DNHA and NAC to support line ministries to review and align sectoral policies to the HIV and AIDS Bill
3. Implement national and sectoral HIV and AIDS policies and strategies
 1. DNHA and ministerial HIV and AIDS staff to train law enforcement personnel
 2. LAs and partners to sensitize communities and stakeholders on HIV legislation and their rights
 3. Law Commission and partners to sensitize legal practitioners

Objective 2: To build and sustain partnerships for effective and coordinated HIV and AIDS action

Strategies and broad action areas

1. Develop and streamline existing partnerships at all levels
 1. NAC to strengthen the management and role of Quarterly Progress Review Meetings with key implementing partners and with principal donors
 2. NAC to coordinate meetings of the Malawi Partnership Forum
 3. NAC to strengthen the TWGs as a technical arm of the MPF

²⁵ See UNGASS progress report 2008

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2. Promote new partnerships at national level.
 1. NAC to map all stakeholders' interventions and activities in the country
 2. NAC to update a data bank of stakeholders working on HIV and AIDS
 3. NAC to institute regular planning, review and monitoring meetings with the MEPD and key community development agencies
 4. MANASO to coordinate the Local and International NGO Forums on HIV and AIDS

 3. Promote partnerships at district levels.
 1. Local Authorities to map all stakeholders' activities in the district
 2. Local Authorities to establish a data bank of stakeholders working on AIDS
 3. Local Authorities to support key coordination structures at district level

 4. Promote partnerships at international and regional levels.
 1. NAC to coordinate Malawi participation in regional (e.g. SADC) platforms
 2. NAC to coordinate Malawi participation in international (e.g. UN) platforms

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**ANNEX 1:
Results Framework: National Core Indicators and Universal Access targets**

INDICATOR NAME	BASELINE (DHS 2004)	BASELINE Most recent	UA TARGET 2010	TARGET 2012	Source
Impact and outcome indicators					
Prevention					
Life expectancy at birth		40 years males 45 years females	45 years (MGDS)	-	Census
% of sexually active population (15-49) who are HIV-infected	14.20%		12.80 %	11.9%	DHS, SSS
Prevalence of HIV among pregnant women aged 15-24 years attending ANC	14.3%		12 %	13.0%	SSS
% of infants born to HIV-positive mothers who are infected	-	21% (2007)	-	14.0%	EPP modelling
Prevalence of HIV among high risk populations		(2006)			BSS
Female sex workers	-	69.1	-	65%	BSS
Female police officers	-	32.1	-	28%	BSS
Male police officers	-	24.5	-	22%	BSS
Female Primary teachers	-	21.6	-	20%	BSS
Male Primary teachers	-	24.2	-	22%	BSS
Female border traders	-	23.1	-	21%	BSS
Male estate workers	-	19.5	-	18%	BSS
Male Secondary teachers	-	17.6	-	16%	BSS
Female secondary teachers	-	16.7	-	15%	BSS
Fishermen	-	16.6	-	15%	BSS
Truck drivers	-	14.7	-	13%	BSS
Female estate workers	-	17.1	-	16%	BSS
Male vendors	-	7.0	-	5%	BSS
% of people in general population exposed to HIV and AIDS media campaign in the past 30 days	80% males 66% females		95% 95%	99% 99%	DHS, MICS
% of sexually active population who have ever been tested for HIV and received results	14.9% males 7.0% females		75% 75%	75% 75%	DHS, MICS
% of sexually active population who had sex with more than one partner in the last 12 months	Gen. Population 26.9% males 8%/.3 females		18% 5%	9% 1%	DHS, MICS

INDICATOR NAME	BASELINE (DHS 2004)	BASELINE Most recent (15-24)	UA TARGET 2010	TARGET 2012	Source
% of sexually active population using condoms at last high-risk sex (sex with non-cohabiting or non-regular partner)		Youth (15-24)	10%	9%	DHS, MICS,
		13.3% males 1.7% females	1.2%	1%	BSS (for high risk groups)
% 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		Gen. Population	60%	60%	DHS,
		47% of males 30% of females	40%	40%	MICS
Median age at first sex among 15-24 year olds		37% of males 25% of females	75%	75%	DHS,
		15 yr males 15 yr females	75%	75%	MICS
% of patients with STI, who are diagnosed, treated and counselled at health care facilities according to national guidelines		18.1 yr males 17.4 yr females	19.0 yrs 18.0 yrs	19.5 yrs 18.5 yrs	DHS
		-	90%	90%	HFS
Treatment care and support					
% 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: 76%	80%	85%	MoH HIV unit
Impact mitigation					
Proportion of children who are orphaned	-	12.4%	-	11%	DHS, MICS
% of OVC whose households receive free basic package of care in caring for child	-	32.5% (in 2006)	80%	90%	DHS, MICS
Ratio of current school attendance among orphans to that among non-orphans	0.94		0.98	1.0	DHS, MICS
% of persons discussing HIV and AIDS with spouse or partner		Males 87% Females 70%	-	100% 100%	DHS
		Males 29.7% Females 30.8%	75% 75%	90% 90%	DHS
% of population expressing accepting attitudes towards PLHIV					
Input and output indicators					
Prevention					
# of information education and behaviour change communication materials disseminated to end users (Facilities and Grass roots)		904,381 (2007)	-	3,500,000	LAHARF
# of HIV/AIDS sensitization campaign meetings conducted		14 press briefings & public lectures (2006/7)	-	20	LAHARF
% of schools that provided life skills based HIV/AIDS education within the last academic years		6% (2002)	100%	100%	EMIS

INDICATOR NAME	BASELINE (DHS 2004)	BASELINE Most recent	UA TARGET 2010	TARGET 2012	Source
# and % of young people exposed to LSE (in & out of school)	1,419,065	3,200,000 (HERA, 2007)	2,500,000	5,000,000	EMIS, DHS
# of peer educators trained/retrained in the quarter	-	667 (2006/7)	-	800	LAHARF
# of Peer Educators who are active in the quarter	-	531 (2006/7)	-	750	LAHARF
# of people counselled & tested for HIV, and receiving result in the last 12 months	283,461	513,325 (2006)	1,000,000	2,662,000 ²⁶	DHS, MICS, HMIS
# and % of sites providing HTC services	146	588 (2008)	600	700	HFS
# and % of health facilities with ANC services with at least the minimum package of PMTCT services	36 (6.6%)	499 (60%) (2008)	574 (70%)	656 (80%)	LAHARF
# and % of pregnant women attending ANC who are counselled, tested, and receive serostatus	43,345	115,000 (25%) (MTR, 2007)	-	480,000 ²⁷ (95%)	LAHARF
# and % of HIV+ pregnant women attending ANC who receive a complete course of ARV prophylaxis to reduce mother to child transmission	2.3%	13,109 (19%) (MTR, 2007)	-	52,000 (70%)	LAHARF
# of socially marketed condoms distributed to outlets in the last 12 months (Retail shops, Health facilities)	29 million	14 million	17 million	20 million	LAHARF
# of (1) free condoms and (2) social marketed condoms distributed to end users in the last 12 months	-	28 million Male 1,150,000 Female	34 million 3,4 million	48 million ²⁸ 3.8 m female	HMIS
# of employees that have benefited from HIV/AIDS workplace programs in the last 12 months –	-	38,000 (2006)	-	1,027,000 ²⁹	LAHARF
# and % of health care facilities that apply national standards for infection prevention and health care waste storage and disposal	8%	29% (2008)	98%	98%	HFS
% of donated blood units screened for HIV in a quality assured manner	-	69% (2008)	98%	100%	HMIS
Care and treatment					
# of persons with advanced HIV infection currently receiving ARV therapy	13,183 (7.7%)	196,368 (2009)	280,000	360,000	HMIS
Proportion of those starting ART who are children (<15 years old)	5%	8% (2009)	10%	10%	HMIS
% of health facilities with drugs in stock and no stock outs of more than 1 week	OI = 35% ARV = 100%	OI = 10% ARV = 100% STI= 40% (2008)	OI = 90% ARV = 100% STI=90%	OI = 92% ARV= 100% STI=92%	HFS
# of patients on ART who have started therapeutic feeding from ART facilities in the last 12 months	-	11.6% (2008)	-	-	HMIS

²⁶ From Resource Needs Model

²⁷ From Resource Needs Model

²⁸ From Resource Needs Model

²⁹ From Resource Needs Model

INDICATOR NAME	BASELINE (DHS 2004)	BASELINE Most recent	UA TARGET 2010	TARGET 2012	Source
# of households receiving external assistance for persons who are chronically ill for 3 or more months	57,000	146,766 (2008)	880,000	1,000,000	LAHARF
% of TB patients who are newly registered in the last 12 month who know their HIV status	-	64% (2008)	-	70%	HMIS
Ratio of patients starting HAART because of TB	-	13% (2008)	-	18%	HMIS
Impact mitigation					
# of households with vulnerable people reached with impact mitigation interventions ³⁰	-	10,458 (2008)	-	1,000,000	LAHARF
# of CBOs supporting PLWA receiving financial support in the past 12 months ³¹	-	728 (2008)	-	1,000	LAHARF
# of orphans attending school	-	554,560 (2006)	-	800,000	EMIS
# of programs that address the needs of OVC	-	7	-	7	LAHARF
Mainstreaming and capacity building					
# of companies that are members of MBCA	-	65 (2005)	-	75	Progress report
Research and M&E					
# of HIV and AIDS related M&E and research studies approved by research committees that are in line with national AIDS research strategy	-	93 (2007)	-	150	Progress report

³⁰ Data are available for the number of chronically ill persons reached with impact mitigation measures, not vulnerable people.

³¹ Data is not available. At the NAC, there is data on number of CBOs supported but not by type of intervention.

ANNEX 2:

Resource Needs Estimate per Broad Activity of the Response (Resource Needs Model)

Cost centre	Resource needs estimate (million US\$)				
	2010	2011	2012	Total	%
Prevention	60.0	76.5	100.0	236.5	36%
Priority populations					
Youth focused interventions	1.5	2.3	3.9	7.6	1%
Female sex workers and clients	0.3	1.0	2.4	3.7	1%
Male sex workers and clients	0.0	0.1	0.1	0.2	0%
Workplace	6.1	7.0	7.9	21.0	3%
Injecting drug users	-	-	-	-	0%
Men who have sex with men	0.1	0.2	0.3	0.7	0%
Community mobilization	-	-	-	-	0%
Couples	5.0	7.6	12.8	25.3	4%
Discordant couples	2.0	4.0	6.1	12.2	2%
Prisoners	0.2	0.2	0.2	0.7	0%
Truck drivers	0.2	0.3	0.5	1.0	0%
Other vulnerable populations	-	-	-	-	0%
Service delivery					
Condom provision	9.2	9.6	10.0	28.8	4%
STI management	0.5	0.7	0.8	2.0	0%
VCT	18.7	22.5	26.6	67.9	10%
Male circumcision	4.0	6.2	10.7	21.0	3%
PMTCT	7.6	9.4	11.4	28.5	4%
Mass media	0.5	0.5	0.5	1.5	0%
Health care					
Blood safety	1.4	1.4	1.5	4.3	1%
Post-exposure prophylaxis	0.3	0.4	0.5	1.2	0%
Safe injection	-	-	-	-	0%
Universal precautions	2.3	3	3.7	9.1	1%
Care and treatment services	44.9	49.5	57.1	151.6	23%
ARV therapy	41.9	47.3	55.5	144.6	22%
Care and prophylaxis in the absence of ART	2.9	2.2	1.6	6.8	1%
Diagnostic testing	-	-	-	0.1	0%
Palliative Care	-	-	-	-	0%
Home-based care	-	-	-	-	0%
Training for ART care	-	-	-	-	0%
Nutritional support	-	-	-	-	0%
Tuberculosis	-	-	-	-	0%
Mitigation	9.8	18.5	28.5	56.7	9%
Education	2.2	5.3	9.3	16.9	3%
Health care support	1.4	2.3	3.6	7.2	1%
Family/home support	3.3	5.6	7.7	16.7	3%
Community support	1.5	2.9	4.2	8.6	1%
Organization costs	1.3	2.4	3.7	7.4	1%
Policy, Admin., Research, M&E	38.9	50.6	65.5	154.9	24%
Salary top-up MoH (HIV and AIDS)	16.0	16.5	17.5	50.0	8%
Total	169.6	211.6	268.6	649.7	100%

ANNEX 3:

Resource Needs Estimate per NAF 2010-2012 Objectives (Resource Needs Model)

Core Strategy and Objectives	Resource needs estimate (million US\$)				
	09-okt	10-nov	11-dec	Total	%
1. Prevention & behaviour change					
1. Reduce sexual transmission of HIV	38.3	50.1	68.0	156.4	24%
2. Prevent mother to child transmission of HIV	7.6	9.4	11.4	28.4	4%
3. Prevent HIV transmission through blood	1.4	1.4	1.5	4.3	1%
4. Create supportive environment for prevention	6.6	8.6	11.3	26.4	4%
<i>salary top up health workers MoH (50%)</i>	8.0	8.3	8.8	25.0	4%
Sub total prevention/behaviour change	61.9	77.8	101.0	240.6	37%
2. Treatment care and support					
1. Improve capacity of health care system	10.1	12.5	15.8	38.3	6%
2. Increase access to continuum of care services	37.7	42.6	50.0	130.2	20%
3. Increase access to quality HCBC	5.0	4.6	4.4	13.9	2%
<i>salary top up health workers MoH (50%)</i>	8.0	8.3	8.8	25.0	4%
Sub total Treatment care and support	60.8	68.0	79.0	207.4	32%
3. Impact mitigation					
1. Increase access of affected households to support	3,3	5.6	7.7	16.6	3%
2. Increase access to psychosocial & spiritual support	1,4	2.7	4.0	8.0	1%
3. Promote legal and social rights of PLWH and OVC	1,4	2.7	4.0	8.0	1%
4. Access of OVC to social, educational and health services	3,6	7.6	12.9	24.1	4%
5. Promote food security to affected households	8.0	11.7	15.5	35.2	5%
Sub total impact mitigation	17.7	30.2	44.0	91.9	14%
4. Mainstreaming & decentralisation					
1. Mainstream HIV in sectoral policies and all sectors	0,6	0.7	0.9	2.2	0%
2. Expand workplace programs in all sectors	6.1	7.0	7.9	21.0	3%
3. Develop capacity of local authorities	1.2	1.4	1.9	4.5	1%
Sub-total mainstreaming & decentralisation	7.8	9.2	10.7	27.7	4%
5. Research, monitoring & evaluation					
1. Strengthen capacity of institutions	2,3	2.9	3.7	8.9	1%
2. Collect and generate strategic information	4,6	5.8	7.4	17.8	3%
3. Increase access to & utilisation of strategic info.	4,6	5.8	7.4	17.8	3%
Sub-total Research & M&E	11.4	14.4	18.6	44.4	7%
6. Resource mobilisation & utilisation					
1. Strengthen financial resource mobilisation	0,6	0.7	0.9	2.2	0%
2. Enhance timely disbursements	0,6	0.7	0.9	2.2	0%
3. Develop partner capacities to account for financial resources	1,2	1.4	1.9	4.5	1%
Sub total resource mobilisation	2.3	2.9	3.7	8.9	1%
7. Policy & partnerships					
1. Create supportive public policy environment	4.0	5.0	6.5	15.6	2%
2. Build and sustain effective stakeholder partnerships	3,5	4.3	5.6	13.4	2%
Sub-total policy & partnerships	7,5	9.4	12.1	28.9	4%
Grand total	169.4	211.8	269.0	649.8	100%

**ANNEX 4:
Budget and Expenditure Trends for the National AIDS Commission³² 2006-2009**

NAF Priority area	2005/2006		2006/2007		2007/2008		2008/2009	
	Budget (m US\$)	Actual (m US\$)	Budget (m US\$)	Actual (m US\$)	Budget (m US\$)	Actual (m US\$)	Budget (m US\$)	Actual (m US\$)
1. Prevention & behaviour change	12.19	0.98	11.02	8.5	15.51	14.41	16.53	2.96
Percentage of total (%)	17%	4%	14%	16%	13%	17%	15%	10%
2. Treatment, Care & support	26.04	8.53	30.01	22.77	64.75	35.72	42.19	17.46
Percentage of total (%)	36%	33%	39%	43%	53%	41%	38%	58%
3. Impact mitigation	6.43	1.3	2.9	4.01	7.35	11.5	9.41	3.62
Percentage of total (%)	9%	5%	4%	7%	6%	13%	9%	12%
4. Mainstreaming	17.86	10.05	20.15	11.33	19.11	13.43	20.59	2.04
Percentage of total (%)	25%	39%	26%	21%	16%	16%	19%	7%
5. Research, monitoring & evaluation	2.37	0.77	1.41	1.3	1.88	3.42	5.47	0.66
Percentage of total (%)	3%	3%	2%	2%	2%	4%	5%	2%
6. Resource mobilisation & 7. Policy & Partnerships	6.88	4.01	11.62	5.61	12.83	7.87	16.27	3.29
Percentage of total (%)	10%	16%	15%	10%	11%	9%	15%	11%
Total (US\$ million)	71.77	25.65	77.12	53.51	121.43	86.35	110.45	30.02
Percentage of budget spent (%)		36%		69%		71%		27%

³² Note: Expenditures channeled through NAC constitute roughly 60% of the total national expenditure

**ANNEX 5:
Current and Indicative HIV and AIDS Financing for Malawi, 2010 to 2012**

SOURCE	Total Amount Committed (m US\$)	Timeframe Agreements	FY2 2009/2010	FY 2010/2011	FY 2011/2012	Total Amount (m US\$)
Pooled Financing Partners						
(MoU 2007 to 2011)						
Ministry of Finance		MOU to 2011	2.00	2.00	2.00	6.00
Global Fund						-
Round 1	178.61	2003 - 2008	-	-	-	-
RCC Round 1	375.00	2012 - 2014	51.46	54.30	64.31	170.07
OVC Round 5	17.71	2006 - 2010	3.40	3.40	3.40	10.21
Round 7	36.03	2008 - 2013	3.81	4.18	3.04	11.03
World Bank		2007 - 2012	10.00	10.00	10.00	30.00
DFID	£8.4 m ³³	2007 - 2011	6.01	6.01		12.03
Kingdom of Norway	7.50	MOU to 2011	2.50	2.50	-	5.00
(Non-Pooled)						
Earmarked funds						
US Government (including CDC)			38.00	38.00	38.00	114.00
UNICEF			9.47	9.47	9.47	28.41
European Development Fund	12.00 € ³⁴	2010 - 2013	1.88	1.88	1.88	5.63
UNFPA			3.30	3.30	3.30	9.90
WHO			2.80	2.80	2.80	8.40
UNDP			0.57	0.57	0.57	1.71
UNAIDS			0.50	0.50	0.50	1.50
TOTALS			135.70	138.91	139.27	413.89

³³ DFID's commitment is £4.2m per year from 2009/10 until 2010/11 - This GB£ commitment is converted to US\$ with exchange rate £1: \$1.432 as of 30 March 2009

³⁴ To be split between gender and HIV and AIDS