National HIV/AIDS Action Framework (NAF)
2005 to 2009

FOREWORD

The first AIDS case was diagnosed in Malawi in 1985, two decades ago, and since then HIV/AIDS has had a devastating impact on individual Malawians, families, communities and the nation. To counteract this, in 1999/2000 Malawi developed a National Strategic Framework for HIV/AIDS to cover the period up to 2004.

Now, based on an End of Term Review of the National Strategic Framework (NSF), which used a nationwide participatory and consultative approach, Malawi has completed a National HIV/AIDS Action Framework (NAF), which will galvanise an expanded, multi-sectoral, national response to the epidemic for the period 2005 to 2009. The End of Term Review revealed challenges and new developments in the fight against HIV/AIDS that were not envisaged when the NSF was developed.

The NAF is a fundamental reference point for all stakeholders involved in the national response to HIV/AIDS. It defines Eight Priority Areas for the next five years, namely; (i) prevention and behaviour change, (ii) treatment, care and support, (iii) impact mitigation: economic and psychosocial, (iv) mainstreaming, partnerships and capacity building, (v) monitoring and evaluation, (vi) research, (vii) resource mobilisation, tracking and utilisation, and (viii) national policy coordination and programme planning.

With well coordinated and concerted efforts, we should be able to harness all the available resources to bring the HIV/AIDS prevalence down, currently estimated at 14.4%, and at the same time provide treatment, care and support to our people living with HIV/AIDS, and all those affected by the epidemic, especially orphans and other vulnerable children, widows, widowers and the elderly.

I, therefore, urge all Malawians and cooperating development partners to be forthcoming in translating this framework into action for a healthy and prosperous nation of Malawi.

His Excellency Dr Bingu wa Mutharika

PRESIDENT OF THE REPUBLIC OF MALAWI

PREFACE

The National HIV/AIDS Strategic Framework expired at the end of October 2004, necessitating the development of a new National HIV/AIDS Action Framework to guide the national response. This National HIV/AIDS Action Framework (NAF) 2005 - 2009 is a culmination of the End of Term Review of the National Strategic Framework (NSF). While the review acknowledged the achievements during the past five years, it also recognised the challenges and the gaps in the response. These gaps exist in service coverage for HIV/AIDS prevention, treatment, care and support.

The biggest challenge is to translate universal awareness of HIV/AIDS into behaviour change. Despite awareness of the modes of HIV transmission, during the past five years prevalence rates have stabilised but remained high. Moreover, mitigation interventions have largely remained undeveloped, and treatment is an emerging, critical issue that needs to be addressed.

The Framework will guide the National AIDS Commission (NAC) and stakeholders, including the public and private sectors, non-governmental organisations, community-based and faith-based organisations and communities nationwide.

I wish to take this opportunity to call upon all Malawians and all stakeholders to use this National Action Framework as a point of reference in planning and implementing HIV/AIDS interventions and thereby contributing towards the realisation of our national goal which is "to prevent the spread of HIV infection among Malawians, provide access to treatment for people living with HIV/AIDS and mitigate the health, socio-economic and psychosocial impact of HIV/AIDS on individuals, families, communities and the nation".

Dr Mary Shawa
Principle Secretary for Nutrition and HIV/AIDS

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LIST OF ABBREVIATIONS

ABC	-	Abstinence, Be Faithful and Condom Use
ARVs	-	Antiretrovirals
BCC	-	Behaviour Change Communication
BCI	-	Behaviour Change Intervention
CACC	-	Community AIDS Coordinating Committee
CBO	-	Community Based Organisation
CHAM	-	Christian Health Association of Malawi
CHBC	-	Community Home-Based Care
DACC	-	District AIDS Coordinating Committee
DDC	-	District Development Committee
DHRMD	-	Development of Human Resource Management and Development
EP&D	-	Economic Planning and Development
ETR	-	End of Term Review
FBO	-	Faith Based Organisation
FP	-	Family Planning
GFATM	-	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoM	-	Government of Malawi
IEC	-	Information Education Communication
IGAs	-	Income Generating Activities
IGPs	-	Income Generating Projects
M&E	-	Monitoring and Evaluation
MCH	-	Maternal Child Health
MK	-	Malawi Kwacha
MoGCWCS	-	Ministry of Gender Child Welfare and Community Services
MoH	-	Ministry of Health
MoHP	-	Ministry of Health and Population
MPRSP	-	Malawi Poverty Reduction Strategy Paper
MPs	-	Members of Parliament
MTCT	-	Mother to Child Transmission
MTR	-	Mid Term Review
NAC	-	National AIDS Commission
NACP	-	National AIDS Control Programme
NAF	-	National HIV/AIDS Framework
NGO	-	Non-Governmental Organisation
NPA	-	National Plan of Action
NRC	-	National Research Council
NSF	-	National Strategic Framework
OIs	-	Opportunistic Infections
OPC	-	Office of the President and Cabinet
OVC	-	Orphans and other Vulnerable Children
PEP	-	Post-Exposure Prophylaxis
PLHA	-	People Living with HIV/AIDS
PMTCT	-	Prevention of Mother to Child Transmission
PPP	-	Public-Private Partnership
PSI	-	Population Services International
PTWG	-	Pillar Technical Working Group
STIs	-	Sexually Transmitted Infections
TBAs	-	Traditional Birth Attendants

THs	-	Traditional Healers
ToR	-	Terms of Reference
UNAIDS	-	United Nations Joint Programme on HIV/AIDS
UNICEF	-	United Nations Children's Fund
VACC	-	Village AIDS Coordinating Committee
VCT	-	Voluntary Counselling and Testing
VDC	-	Village Development Committee

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ANNEX 1: LOGICAL FRAMEWORK 1

EXECUTIVE SUMMARY

The National HIV/AIDS Action Framework (NAF) for Malawi was developed to cover the period 2005-2009 and it is based on the findings of the End of Term (ETR) review of the National Strategic Framework (NSF) for HIV/AIDS that guided the response from 2000-2004. The ETR of the NSF aimed at identifying key achievements, challenges, and emerging issues in the management of the national HIV/AIDS response. The review was intended to offer the country an opportunity to redefine key priority areas, identify key strategies and activities, and indicators that Malawi should focus on during the next five years. This NAF was carried out using a highly participatory and nationwide consultative approach under eight pillars. The pillars, which at the same time constitute key priority areas of the NAF, include the following:

- Prevention and behaviour change
- Treatment, care and support
- Mitigation: socio-economic and psychosocial
- Mainstreaming, partnerships and capacity building
- Research and development
- Monitoring and evaluation
- Resource mobilisation, tracking and utilisation
- National policy coordination and programme planning

Drawing from the findings of the ETR of the NSF, and in keeping with the goal of the National HIV/AIDS Policy for Malawi, the overall goal of this NAF is:

> *To prevent the spread of HIV infection among Malawians, provide access to treatment to PLHA and mitigate the health, socio-economic and psychosocial impacts of HIV/AIDS on individuals, families, communities and the nation.*

In addition to the overall goal of the NAF, a goal has been formulated for each of the eight priority areas. The eight goals are:

- To reduce the spread of HIV in the general population and in high-risk subgroups
- To provide equitable treatment for PLHA and mitigate the health impact of HIV/AIDS
- To mitigate the economic and psychosocial effects of HIV/AIDS and improve the quality of life of PLHA, OVC, widows, widowers and the elderly affected by the epidemic
- To scale-up mainstreaming of HIV/AIDS in the public and private sectors including in civil society—NGOs, FBOs -- and build capacity and enhance partnerships among all stakeholders
- To generate empirical data and information about HIV/AIDS that inform policy, practice and HIV-related interventions
- To track progress in the implementation of the NAF
- To enhance HIV/AIDS resource mobilisation and management at all levels
- To facilitate and monitor multi-sector capacity implementation of National HIV/AIDS Policy

Its related objectives, key strategies and key action areas presented in the narrative and further shown in the logical framework define each priority goal. The logical framework of this NAF further presents the indicators, responsible government ministry/agency and key collaborating agencies in implementing or coordinating the implementation of the key action areas. Government ministries/agencies will be responsible for quality assurance and provide policy guidance according to the NAF, National HIV/AIDS Policy and other related tools. They will further ensure that resources mobilised for the response are appropriately managed and utilised. Finally, the logical framework indicates the estimated cost of key action areas, and the assumptions and risks.

The existing National Monitoring and Evaluation Plan and other tools developed by the National AIDS Commission (NAC) will strengthen the implementation of the NAF. To track implementation, to identify gaps and strengthen the national coordination role of NAC, partners and development partners (donors) are urged to use the NAF as a point of reference. This will enhance the principle of the "Three Ones - one national HIV/AIDS coordinating authority; one national framework for action; and one Monitoring and Evaluation (M&E) framework to track and monitor the national response".

1.0 BACKGROUND AND CONTEXT

1.1 Rationale for the End of Term Review of NSF and Re-planning

In July 2004, the Malawi Government, through the National AIDS Commission (NAC) requested an End of Term Review (ETR) of the National Strategic Framework for HIV/AIDS Activities 2000-2004 to identify key achievements, challenges, and emerging issues in the management of the national HIV/AIDS response. The Review offered the country an opportunity to redefine the key priority areas for the national response to the HIV/AIDS epidemic, and identify key activities, targets and indicators that Malawi should focus on during the next five years. These, along with the following specific factors, provide the rationale for re-planning the national response:

- With the expiry of the NSF (2000-2004), a new National HIV/AIDS Action Framework (NAF) was required to continue driving the timely and effective management of the national HIV/AIDS response for the next five years (2005-2009), particularly addressing the emerging issues in the fight against HIV/AIDS that occurred after the first NSF (2000) was developed.
- Since 2000 when the implementation of the NSF began, Malawi has developed several policies and guidelines that are supportive of the national response. These include the National HIV/AIDS Policy (2003); the Orphans and Other Vulnerable Children (OVC) Policy; ARV Guidelines; VCT Guidelines; the ARV Equity Policy. A new NAF was therefore required both to help translate these national policies and guidelines into action and to take advantage of the conducive policy and planning environment.
- Malawi has committed herself to the Millennium Declaration and the Millennium Development Goals, which are spelt out in the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). Goal six of the MDGs refers to halting and reversing the trend in the spread of HIV infection by 2015. Malawi will also aim at implementing the NAF based on the three indicators stipulated in the convention, namely: reducing HIV prevalence among 15-24 year-old pregnant women; increasing the condom use rate, and reducing the number of children orphaned by HIV/AIDS. Malawi has met goals 65-67 of the same UNGASS Declaration of Commitment on HIV/AIDS, which refers to the rights of orphans and other children made vulnerable by HIV/AIDS, recently developing and endorsing the National Plan of Action to scale up the response to OVC, with a framework of 2005-2009, which coincides with the timeframe of the NAF.
- The HIV/AIDS prevalence rate at the beginning of implementation of the NSF in 2000 was estimated at 14.66% (NAC, 2003). Currently, the estimated HIV/AIDS prevalence in adults (15-49) is 14.4%, reflecting a stabilisation of the epidemic at a very high level during the last five years. Thus, translating the universal awareness of HIV/AIDS into behaviour change remains a challenge, which the NAF has to address in order to reverse the epidemic.

1.2 The Development Process of the NAF

When formulating the new National Action Framework for 2005 – 2009, Malawi adopted a participatory approach, which involved all the relevant stakeholders. A multi-disciplinary Steering Committee (SC) was formed to provide overall guidance to the development process of the NAF. A team of seven consultants, comprising one international and six national consultants, was recruited to facilitate the ETR that provided inputs for the development of the NAF. The Steering Committee endorsed the results of the ETR of the NSF, the outline of the NAF and the completed NAF 2005-2009 before its launch.

A two-day national workshop was organised between August 5-8, 2004 to formally kick start the ETR and subsequent development of the NAF. Participants representing a cross-section of the stakeholders in the country at district and national level attended the workshop to provide feedback for the task ahead. Following the workshop, consultants developed tools and undertook consultations at national, sectoral, district and community levels. A total of 10 out of 28 districts were sampled and visited by the review team to gather primary data. The selection criteria were as follows:

- Regional representation
- Level of HIV infection in the general population
- Other characteristics that potentially affect the transmission of HIV

The findings of the consultations, which were disseminated to national stakeholders on October 26, 2004, inform this NAF.

1.3 Policy and Planning Environment

1.3.1 Vision 2020[1]

The major development challenges for Malawi are poverty, HIV/AIDS and food insecurity. In recognition of the magnitude of these problems, the GoM formulated the Vision 2020 to provide guidance to Malawi's development aspirations. The vision defines the national goals, policies, and strategies that will help the public and private sectors, civil society, and the general populace to improve development management. The national priorities are defined from the nine Vision 2020 components, which are as follows:

- Governance
- Sustainable economic development
- Vibrant culture
- Economic infrastructure
- Social development
- Science and technology-led development
- Fair distribution of income and wealth
- Food security and nutrition
- Sustainable natural resources and environmental management.

The Vision has created a new relationship between the state and the citizens based on a social contract through which the state is expected to create an enabling environment and responsible government ministries/agencies will be in charge of quality assurance, provide policy direction, guided by the NAF, National HIV/AIDS Policy and other related tools, and ensure that resources mobilised for the response are appropriately managed and utilised.

1.3 2 Malawi Poverty Reduction Strategy Paper (MPRSP) and HIV/AIDS[2]

In response to the need to operationalise Vision 2020 and to address the deep-rooted poverty, Malawi developed the MPRSP. According to the 1998 Integrated Household Survey[3] poverty in

[1] *Vision 2020: The National Long term Development Perspective for Malawi*
[2] *Malawi Poverty Reduction Strategy Paper, April 2002*

Malawi is widespread, deep and severe. The survey showed that 65.3% of the population or about 6.3 million people were poor, of who around 52% were female. Analysis of the data in the survey also established that the key causes of poverty were limited access to land, low education, poor health status, limited off-farm employment and lack of access to credit.

The MPRSP is a comprehensive statement of GoM policy that defines Malawi's pro-poor growth strategy and will serve as a focal point for GoMs efforts to reduce poverty. It also serves as a framework for all GoM interventions and the key instrument for programming to be used by government private sector, civil society and donors. MPRSP has considered HIV/AIDS mainly as a health issue even though it recognises the epidemic as cross cutting, requiring intervention beyond the health sector. The plan recognises the impact of HIV/AIDS on economic and social development that is the inability of the labour force to effectively meet the demands of the society in the production sectors and social services; as well in family life.

1.3.3 The National HIV/AIDS Policy

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

1.3.4 The National Health Policy

The overall national health policy is to raise the health status of all Malawians by reducing the incidence of illness and death by developing a sound delivery system capable of promoting health; preventing, reducing and curing disease; protecting life and fostering general well-being and increased productivity. In addition, the national health policy and strategy for the nation will continue to provide the general operational guidance on issues of HIV/AIDS prevention; treatment, care and support; and impact mitigation. The Malawi National Health Plan for 1999 – 2004 aims to increase access to quality health facilities and services.

1.3.5 National Policy on Orphans and Other Vulnerable Children

The National Policy on Orphans and Other Vulnerable Children (2003) is a comprehensive guide for the provision of care to orphans and other vulnerable children. The mission statement of the policy and the goal articulate the need to care for OVC. The Mission Statement of the policy is to:

> *Promote an environment in which OVC are adequately cared for, supported and protected physically, psychologically, materially, socially, morally, spiritually and legally to grow and develop to their potential (GoM, 2003: 5)*

The Mission Statement, the Goal and the ten Guiding Principles of the OVC policy are clearly articulated in the NPA for OVC, which forms the basis for concerted interventions and strategies for mitigating the impact of HIV/AIDS on OVC.

[3] *Profile of Poverty in Malawi: Poverty Analysis of the Integrated Household Survey, 1998*

1.4 The HIV/AIDS Situation in Malawi

1.4.1 Mode of HIV transmission in Malawi

The first AIDS case in Malawi was diagnosed and confirmed in 1985 (NSF, 2000) and since then, HIV/AIDS has spread to all parts of the country. The primary mode of HIV transmission in Malawi is unprotected sexual intercourse, and therefore HIV/AIDS in Malawi, like in other countries in the region, affects mainly the sexually active population. The following is a breakdown of the modes of HIV transmission in Malawi (NAC, 2003).

- Unprotected heterosexual contact with an infected partner accounts for 88% of new infections
- Mother-to-child transmission (MTCT) accounts for about 10% of cases
- Other modes of HIV infection are insignificant and together account for about 2%. These include use of infected blood, infected needles and health care waste handling, intravenous drug use and homosexual sex.

1.4.2 Prevalence and incidence

HIV prevalence in Malawi has stayed at a high level for the past five years, ranging between 14.67% in 1999 and 14.33% in 2004, with women being more infected than men (NAC, 2003). Out of the 760,000 infected adults (15-49 years) in 2003, 58% were women (NAC, 2003).

Differences in HIV prevalence are also evident between urban and rural areas in Malawi. According to available data, HIV prevalence in the urban areas is 22.83% (NAC, 2003) and semi-urban 20.8% (GoM/MoHP, 2003), while in the rural areas it is 14.5% (GoM/MoHP, 2003). According to the HIV Sentinel Surveillance Report (GoM/MoHP, 2003), site-specific prevalence for the period mid February to mid April 2003, HIV prevalence ranged from 6.7% at Kamboni Health Centre, a rural site in central region, to 32.9% at Nsanje District Hospital, a semi-urban site in the southern tip of the country. Overall, a fifth of the population (19.5%) tested HIV positive, similar to the 2001 results. The southern region has the highest prevalence (23.7%) followed by the northern (20.0%) and central (15.5%). Similar prevalence was observed across the 20-24, 25-29 and 30-34 age groups.

Educational levels revealed disparities too. HIV prevalence was significantly higher among women who had gone up to secondary school level (secondary 23.2% and post secondary 27.9%) compared to women with no education and up to primary school i.e. 19.2% and 19.1% respectively.

1.5 Impact of HIV/AIDS

For almost two decades since the first AIDS case was diagnosed in Malawi, HIV/AIDS has had a severe impact on individual, household, community, and national/societal levels.

Without AIDS, the number of deaths among adults (15-49 years) in Malawi would have remained constant from 1985 until today at about 22,000. However, with AIDS the deaths of adults have more than tripled to nearly 80,000 annually (NAC, 2003). The life expectancy with AIDS is estimated at 40 years, while without AIDS it would have been 56 years. AIDS mortality among

adults has resulted in a dramatic increase in the number of orphans[4] in Malawi. It is estimated that there are about 840,000 orphans, 45% of them are due to AIDS. NAC also reports that at least 950,000 orphans and vulnerable children need support. In addition, AIDS is one of the leading causes of child morbidity and mortality. Almost all pediatric AIDS cases acquire HIV through MTCT, underlining the need for scaled up PMTCT interventions. HIV/AIDS has taken a heavy toll in the informal and formal sectors, and the family. Productivity has been lowered due to absenteeism and to deaths of the most productive members of society. Families have lost breadwinners, and they have had to divert scarce resources and time from development activities to care and support of the sick. Moreover they are then saddled with huge funeral expenses.

According to the recent AIDS Impact Assessment Study in the Public Sector, HIV/AIDS was identified as the major cause of high mortality rates in the public sector (GoM/UNDP, 2002). It was noted that due to illnesses, funeral attendance, and caring for sick relatives, HIV/AIDS is resulting in increased absenteeism, causing, *inter alia*, low productivity. It has also increased funeral costs as the number of deaths continues to rise, increased death benefits, increased training costs to replace the deceased professionals, and higher costs for care and support.

The National HIV/AIDS Policy (2003) in its preamble succinctly summarises the impact of HIV/AIDS as:

- A public health issue because it directly affects the health of large numbers of people in society and reduces the overall health status and well-being of the nation.
- A social issue because it adversely impacts families and communities resulting in excessive medical expenses, depleted family savings and leading to disposal of assets.
- An economic issue because it leads to a decline in economic growth, by reducing the productivity of the labour force.
- A development issue because it is weakening institutions and destroying institutional memory in both the public and private sectors—destroying their capacity to formulate, analyse and manage public policies, and develop programmes and strategies essential for economic growth.

HIV/AIDS reduces agricultural production dramatically in a country that is heavily dependent on agriculture. Agriculture accounts for over 60% of exports. Thus, if the impact is not contained, with a per capita income of US $ 180 and approximately 65% of her population estimated to be living in poverty and 85% residing in rural areas (NAC, 2003), Malawi will be pushed further in poverty. This will not only affect mitigation efforts, but also adversely undermine prevention efforts.

[4] A child under the age 18 that has lost one or both parents

2.0 THE NATIONAL HIV/AIDS STRATEGIC FRAMEWORK (NSF) 2000-2004

2.1 NSF development process

The Government of Malawi developed the first Malawi National HIV/AIDS Strategic Framework (2000-2004) after a countrywide consultation process that was carried out between October 1998 and April 1999. The Strategic Planning Unit in the National AIDS Control Programme (NACP), which was based in the Ministry of Health, facilitated the process. The implementation of the approved NSF began in January 2000. The NSF was intended to provide guidance for a multicultural approach to the national HIV/AIDS responses at all levels, namely: community, district and national levels.

2.2 Overall goal, components and strategies

2.2.1 Overall goal

The NSF 2000-2004 was developed to support the overall policy goal of the health sector, which was:

> *To raise the level of the health status of all Malawians by reducing the incidence of illness and occurrence of death in the population through the development of a sound delivery system capable of promoting health; preventing, reducing and curing disease; protecting life and fostering general well-being and increased productivity.*

In view of the overall policy goal, and in recognition of the fact that HIV incidence continued to increase, having an adverse psychosocial and economic impact on the society, the NSF goal was to:

> *Reduce incidence of HIV and sexually transmitted infections and improve the quality of life of those infected and affected by HIV/AIDS.*

This was to be realised by implementing nine components, which were doubled as objectives of the framework.

2.2.2 Components, goals and strategies

Nine components reflecting the national priority areas were developed, with each constituting a chapter in the Framework. Each nine components had a goal, objectives and strategies. The goals for each of the component were at the same time the objectives of the framework. See Table 1.

Table 1: Summary of the NSF 2000-2004 components, goals and strategies

Components	Goals	Strategies
Culture and HIV/AIDS	To bring about socio-cultural changes that will help reduce the spread of HIV/AIDS and minimise its impact on individuals, families and communities.	• Changing sexual beliefs and attitudes • Adapting rites of passage • Adapting the socialisation of men, women, boys and girls
Youth, Social change and HIV/AIDS	To strengthen the authority of and coordination among youth socialisation institutions in order to bring about change in the behaviours that predispose the youth to HIV infection.	• Promoting positive cultural values • Strengthening socialising institutions • Developing positive democratic

Components	Goals	Strategies
		values • Strengthening law and policy • Strengthening the media
Socio-economic status and HIV/AIDS	To bring about change in the socio-cultural and economic environment for women and men in order to address gender imbalances and reduce the spread and impact of HIV/AIDS.	• Addressing gender relations • Promoting skills development • Formulating and enforcing legislation
Despair and hopelessness	To bring about hope, faith and a spirit of acceptance of the reality of the HIV/AIDS epidemic among all Malawians in order to facilitate prevention and the mitigation of its impact.	• Building hope and faith among Malawians • Building confidence
HIV/AIDS management	To provide adequate and high quality management services to PLHA, and affected individuals, families and communities.	• Strengthening stakeholder coordination • Mobilising and allocating adequate resources • Institutionalising HIV/AIDS management and support at the work place • Improving home-based care and hospital care • Eliminating all forms of discrimination against PLHA and affected individuals and families
HIV/AIDS and orphans, widows and widowers	To strengthen and support sustainable capacities for the care of orphans, widows and widowers particularly at family and community levels.	• Strengthening laws, policies and support mechanisms • Improving care and support • Increasing life skills training
Prevention of HIV transmission	To strengthen the effectiveness of HIV prevention programmes and practices and expand their scope to reduce HIV incidence among Malawians.	• Promoting abstinence and mutual faithfulness • Encouraging safe sex practices • Improving management of STIs • Reducing the risk of MTCT • Promoting safe blood supply and infection control
HIV/AIDS Information, education and communication	To establish a standardised, comprehensive and effective IEC strategy to reduce the spread of HIV and cope with the impact of the epidemic.	• Strengthening partnerships in IEC activities • Developing relevant and effective IEC messages and materials • Establishing mechanisms for quality control of IEC activities

Components	Goals	Strategies
Voluntary counselling and testing	To strengthen and promote accessible and ethically sound Voluntary Counselling and Testing (VCT) services that offer psychosocial support to men, women, children and youth in order to reduce the transmission of HIV and impact of HIV/AIDS.	• Building a safe environment • Advocating for VCT services • Increasing capacity for VCT

At the time the NSF was developed, the primary emphasis was on prevention, which was reflected in all priority areas. This also influenced the strategies and activities of the various actors involved to largely concern themselves with prevention activities, and less on mitigating the health, socio-economic and psychosocial impact of the epidemic.

2.3 Institutional framework

The End of Term Review of the NSF affirmed that a fairly complex institutional framework for planning and delivering interventions in the national response had evolved since the first AIDS case was identified in Malawi in 1985. The framework included public (national and local) and private institutions, development partners (donors), NGOs, religious organisations, women's groups and various community organisations including associations of people living with HIV/AIDS. All these were operating at national, district and community levels as well as across all sectors, and were mandated in the NSF to play key roles in the national response.

2.3.1 National AIDS Commission

Established in 2001, under the Office of the President and Cabinet (OPC), NAC is the overall coordinating authority of the HIV/AIDS response in Malawi. The role of NAC includes:

- Facilitating policy development
- Guiding the National HIV/AIDS Action [Strategic] Framework
- Facilitating policy and strategic planning in sectors and locally
- Advocacy and social mobilisation on HIV/AIDS in all sectors at all levels
- Mobilising resources, allocation and tracking of effective utilisation
- Building partnerships among all stakeholders in the country with regional and international linkages
- Development of knowledge management approaches to document best practice, dissemination and promotion of the best practice
- Mapping interventions to indicate coverage and scope geographically
- Facilitation and support for capacity building
- Overall monitoring and evaluation
- Identification of HIV/AIDS research priorities

The ETR noted that NAC has performed well in executing her mandate with the exception of disbursing grants to implementing agencies, which was affected by the initial development and putting in place procedures for funds disbursement, utilisation and accountability. In the next five

years, NAC will play the same role, and specifically move to ensure that similar functions occur at the district and lower levels where implementation of HIV/AIDS activities largely take place.

2.3.2 Ministry of Health and Population

At the time the NSF was formulated, the MoHP was the sector Ministry responsible for the National AIDS Control Programme (NACP). Its role was to provide direction and monitor implementation. Given the recognition that HIV/AIDS is not only a health issue, but also a development issue and hence necessitating a multi-sectoral approach, the government of Malawi established the National AIDS Commission (NAC) in 2001 to replace NACP.

The Ministry of Health (MoH) will continue to play a key role in implementation of NAF especially in the advent of accessing ARVs to Malawians. The specific role of the MoH includes:

- Planning and implementing the Health Sector HIV/AIDS Strategy
- Providing technical support for HIV/AIDS policy development
- Coordinating thematic areas in the health sector
- Providing technical support to other sectors
- Surveilling HIV/AIDS and STIs, as well as epidemiological and behavioural surveys
- Coordinating and managing the Biomedical and Health Responses such as BCC interventions including condom programming, HIV testing and counselling, PMTCT, and care, including providing ART and palliative care

As much as HIV/AIDS requires multi-sectoral and concerted efforts, the public health sector occupies a strategic place to provide direction especially in treatment and care for PLHA. This calls for examining and strengthening the capacity of the health sector that includes personnel, equipment and other logistics for effective delivery of the services including ARVs.

2.3.3 Central Ministries and Departments

Central government ministries and departments at the time the NSF was developed were indicated as OPC, Ministry of Finance, the Law and Human Rights Commission and NACP. The OPC in liaison with the Cabinet Committee on HIV/AIDS Prevention and Care was expected to provide political and technical support for adequate allocation of resources to line ministries, departments and parastatals, including NACP. Ministry of Finance was to allocate adequate funds and monitor their disbursement to government ministries and departments. The OPC and the Ministry of Finance remain key to give the response a political commitment so that all sectors are obliged to offer support, and to allocate resources respectively.

2.3.4 Line Ministries and Departments

Line ministries, departments and parastatal organisations were also charged with establishing focal points for HIV/AIDS activities, mainstream HIV/AIDS, prepare budget lines for HIV/AIDS activities and review existing policy guidelines relating to HIV/AIDS and human resource management. Among the line ministries, there are those that reach the majority of the population and are represented at the lower levels. Such ministries like the Gender Child Welfare and Community Services, Education, Agriculture as well as Defence are key line ministries. It will be critical in the next five years for these line ministries to be supported to mainstream HIV/AIDS in their activities.

The Ministry of Gender Child Welfare and Community Services is one of the line ministries that has already developed a National Plan of Action (NPA) to scale up the response to OVC. To effectively manage the NPA, NAC and UNICEF has supported the ministry in establishing an OVC Technical Support Unit. The main role of the unit is to coordinate all planning, implementation and monitoring of activities for the NPA.

2.3.5 Development Partners

Partners were to support priorities set by NACP and other players, facilitate implementation by funding programmes and support capacity building for government to take a leading role in HIV/AIDS issues. Partners were to step up their role in advocating for increased allocation of resources from the international community. It is expected that development partners, particularly the UN, will assist the government's response in such areas as empowering leadership for effective response, mobilisation and empowering public, private and civil society, promoting and strengthening strategic information, building capacities to track, monitor and evaluate the country response and facilitating Malawi to access technical and financial resources at national level.

2.3.6 Private Sector

Private sector organisations were to mainstream HIV/AIDS activities as components of human resource development and management. They were to review and adopt policies affecting personnel management, and conduct ongoing HIV/AIDS impact assessment at all levels, including the medical and health needs of employees. The ETR revealed that little has been achieved by the private sector, and it needs to be brought on board as a key player in the response. Effective mainstreaming of HIV/AIDS by the private sector is an entry point for the sector's involvement in the next five years.

2.3.7 NGOs

In the NSF 2000-2004, NGOs were envisaged to form the core of the implementing agencies and work in collaboration with formal and informal CBOs to carry out advocacy, assist communities to mobilise resources locally, document best community practices and support capacity building programmes in collaboration with NACP. The ETR revealed that the NGO sector went beyond what it was envisaged to play, has been instrumental in helping communities cope with the socio-economic and psychosocial effects of HIV/AIDS. With enhanced capacity and other resource support, NGOs' role in the NAF 2005-2009 will be mainly complementary to the government's role in driving the response. The NGO sector is not an alternative to the government and hence cannot constitute or drive the core response.

2.3.8 Faith-Based Organisations

In the NSF, FBOs were to work directly with communities after being trained in HIV/AIDS prevention and provision of social and psychological support. Over the years FBOs, like NGOs and CBOs, have been instrumental in the response, and will continue to play a pertinent role in the prevention and mitigation of the HIV/AIDS impact. However, they will need training and will need to develop messages that do not send contradicting signals to the population.

2.3.9 Community-Based Organisations

CBOs play a critical role in implementing the strategic framework, which emphasised capacity building for individuals, families and communities. Capacities of CBOs were to be built by NACP,

NGOs and faith-based organisations. CBOs were to utilise existing social capital to respond to the HIV/AIDS challenges and continue to advocate for volunteers. The ETR revealed that CBOs as grassroot structures are filling the gap by mitigating the socio-economic and psychosocial impact. However, they have been faced with severe limitations of funding and also experienced turnover of their volunteer workforce due to lack of "facilitation".

2.3.10 Organisations of People Living with HIV/AIDS

The NSF recognised the role of people living with HIV/AIDS (PLHA) as the backbone of efforts in the national response, especially for increased acceptance of PLHA. Through their associations, PLHA will continue to play a vital role in the response. However, they need to be supported with more secure and substantial funding with clearly defined roles (such as CHBC and counselling) in the delivery of services. Supporting associations of PLHA has a potential to make them vibrant, which in turn can enable them to attract a wider membership including people in high societal positions and those living in remote rural areas.

2.4 Status of the Response 2000-2004

The status of the response in the last five years is derived from the ETR of the NSF 2000-2004. A brief narrative of the achievements and challenges, and emerging key issues for consideration in the NAF 2005-2009 constitute the status of the priority areas examined during the ETR under respective pillars. The ETR was conducted under eight pillars, prevention and behaviour change; care, treatment and support; impact mitigation: socio-economic and psychosocial; mainstreaming, partnerships and capacity building; research and development; monitoring and evaluation; resource mobilisation and utilisation; and national policy, coordination and programme planning.

2.4.1 Prevention and behaviour change

Achievements and challenges

The ETR revealed that some progress had been made in the area of prevention especially in attaining universal awareness; identification of key cultural practices that fuel HIV infection and development of IEC materials. Overall, prevalence of HIV has stabilised, but at a high level (14-15%), which requires intensive efforts to bring it down. Challenges and gaps still exist in prevention and behaviour change. Behaviour change has occurred only slowly largely as a result of deep-rooted cultural values and traditions that thrive in an environment of widespread poverty, especially in rural areas.

Scaling up of initiatives is essential especially advocacy for modification of some cultural practices such as widow inheritance, death cleansing and initiation. Improving the socio-economic status of the vulnerable and marginalised groups, especially widows, orphans, widowers, is yet another area requiring attention. HIV testing and counselling services should receive an increased focus because they are an important bridge between prevention and treatment especially in the advent of ARVs. Accessibility to ARVs is not only for mitigating the health impact created by HIV/AIDS, but also serves prevention purposes. They are a motivating factor for scaled up HIV testing and thus enabling people to know their sero status.

Emerging and key issues for consideration:

- Increased availability of ARVs and HIV testing and counselling will have a direct bearing on the need for a consolidated and linked approach to prevention and behaviour change.

- Increased recognition of radically scaled up HIV testing and counselling is a measure to universal awareness of HIV status.
- Increased collaboration with traditional leaders/chiefs and elders is critical in the response in order to minimise the role played by culture in the transmission of HIV.
- Influx of people from neighbouring countries through the porous borders calls for the need to examine cross border issues closely.

2.4.2 Treatment, care and support

Achievements and challenges
Treatment, care, including pediatric care, and support is a new and emerging priority in the national response. Although there has been some progress in planned strategies and activities, capacity in the health sector needs to be built in order to scale up provision of ARVs. CBOs and NGOs, the major providers of community and home-based care, should be given additional technical and financial support. Also, palliative care and herbal treatment deserve more attention in the NAF.

Emerging and key issues for consideration

- Scaled up treatment, care and support of PLHA not only requires increased resources, but also adequate human capacity in the public health sector
- Pediatric AIDS care initiatives require unique approaches including treatment formulations and counselling approaches
- Nutrition is increasingly occupying a central position on a continuum of care
- CHBC initiatives are critical in treatment, care and support, but there is need to define what constitutes CHBC
- A comprehensive approach prevention, care, treatment and support should be developed, along with guidelines for their implementation at different levels of the national programme and to different categories of partner institutions. This is particularly important in the advent of ARVs, PMTCT, HIV testing and counselling and with regard to children's access to treatment.

2.4.3 Impact mitigation: socio-economic and psychosocial

Achievements and challenges
Mitigation interventions for the socio-economic and psychosocial impact still remain undeveloped and affected by limited resources, along with delayed disbursement of resources. The existing interventions are largely carried out by affected families themselves, CBOs, FBOs and some NGOs, but without a clear and coordinated strategy. Providing economic and material support to PLHA, fulfilling legal rights of the infected and affected, and establishing workplace policies have not progressed as planned. Likewise, the strategies and activities directed to vulnerable groups, especially OVC, widows and widowers, called for in the NSF have not been fully achieved. Mitigation interventions are further affected by the need for enforcement of clearer policies, laws, guidelines and definitions. It has to be noted also that safety nets are not adequately covered in the macro-economic and key development planning frameworks of the country such as the Malawi Poverty Reduction Strategy Paper (MPRSP).

Emerging and key issues for consideration

- Mapping or an inventory of key actors involved in impact mitigation (geographical and programmatic level), and development of a strategy to coordinate actors is needed.
- Timely and quick disbursement of resources to identified actors involved in mitigation of impact is essential.
- Enhanced awareness and implementation or enforcement of the various laws, policies and legislation will help protect the rights of those made vulnerable by the epidemic.
- Food security is a critical factor in the mitigation of the socio-economic and psychosocial impact created by HIV/AIDS.
- Development of integrated safety net mechanisms to provide a multi-dimensional support package to the most vulnerable (PLHA, orphans, widows, widowers and affected elderly) is important.

2.4.4 Mainstreaming, partnerships and capacity building

Achievements and challenges

Over the last five years, mainstreaming both in public and private sectors was not seriously undertaken. The ETR revealed that little was done to prepare the various sectors for mainstreaming, which was exacerbated by lack of a common understanding of the concept. Nonetheless, achievements were noted in the area of partnerships, which have emerged at all levels. Government and NAC have provided the overall leadership with the support of development partners. Partners such as NGOs, FBOs and CBOs played a commendable role in implementing activities in various areas including CHBC, IEC, orphan care and provision of other services. The ETR further noted that some progress had been made in building capacity for the response in sectors at the national level, but at the district level and in the communities, capacity was yet to be built and strengthened. Thus, the review noted lack of capacity; human (quantity and quality), financial resources, and logistical management at the district level.

Emerging and key issues for consideration

- Stakeholders do not commonly understand mainstreaming HIV/AIDS, and hence different approaches are being used or nothing at all is being done.
- Capacity building should be elevated beyond training and workshops with special emphasis on district and community levels.
- A need exists for more implementation/application/utilisation of skills and experiences gained in capacity building activities.
- A forum bringing together partners needs to be constituted and strengthened, and parameters for partnering defined.
- Gap in coordination structures within government and partners needs to be filled.
- More M&E is required at all levels

2.4.5 Research

Achievements and challenges

The HIV/AIDS Research Strategy developed by the National Research Council (NRC) in collaboration with the MOH and NAC has outlined priority HIV/AIDS research areas for the country. The Research Strategy also provides key strategies for HIV/AIDS research and makes

capacity building recommendations, namely training, and strengthening infrastructure, institutional support, networking and collaboration.

Emerging and key issues for consideration

- Increased attention is required to ensure that the developed research strategy is fully coordinated.
- Collaboration between biomedical research and research in traditional treatment is important.
- Sharing strategic information—this area needs a great deal of support and strengthening to ensure that the elements already in place, i.e. the National AIDS Resource Centre, the NAC website, research and other documentation are truly accessible and helpful to those who need them to contribute to a stronger response.
- The majority of the past research has been donor-driven and as a result, its impact on national policy and decision-making has been minimal.

2.4.6 Monitoring and evaluation

Achievements and challenges

In monitoring and evaluation, progress has been achieved in the development of a department in-charge of M&E as well as research at NAC in 2003. In the short time this department has been in existence, a national M&E plan has been developed with national indicators and targets. Now, however, this ambitious plan must be put into place and implemented at all levels to support the NAF.

Emerging and key issues for consideration

- M&E need to be included in the NAF as a key priority area to ensure that the M&E plan is fully implemented in the next five years.
- Improving NAC's ability to collect, synthesise and disseminate strategic information is also advised to assist with planning initiatives as is using a systematic approach to set priorities in the NAF.
- Capacity needs at the district level and among civil society must be addressed to ensure that the programme is properly monitored and evaluated.
- The numerous databases and tracking systems developed by various partners must be reviewed and justified to ensure that M&E is carried out efficiently and effectively without overburdening the end point manager who has to provide the requested data.

2.4.7 Resource mobilisation, tracking and utilisation

Achievements and challenges

The review noted tremendous achievement in resource mobilisation, but painfully noted as well that a considerable amount of resources have not been utilised despite the massive needs created by HIV/AIDS in Malawi. The limitations in disbursing resources or funds due to detailed disbursement and accountability procedures need to be addressed. It was also found in the ETR that the NSF was not well disseminated and several partners did not know of its availability or how it could be used to guide planning and resource mobilisation.

Emerging and key issues for consideration

- Ensuring timely and quick resource disbursement and accountability, but not to be swamped by bureaucratic details. Systems can be developed and strengthened as implementation goes on.
- Strengthening HIV/AIDS local resource mobilisation, accessibility and utilisation at all levels.
- Clarifying the true costs of the various key priority areas and interventions being undertaken in the national response to HIV/AIDS in order to make NAF a resource mobilisation tool and more action-oriented.

2.4.8 National policy coordination and programme planning

Achievements and challenges

Programme management, coordination, resource mobilisation and utilisation were at the heart of the NSF and constitute the primary role of the NAC. Considerable progress in this area, including the development of the NSF by NACP, the establishment of NAC to provide overall coordination of the national response, along with the recent efforts to build capacity of NAC, was noted. Several policies, laws, guidelines and legislations have been formulated, but most Malawians are unaware of them. The challenge is how to inform the people and their enforcement.

Emerging and key issues for consideration

- The HIV/AIDS NSF did not optimally provide for programming and utilisation of resources, and hence was not action-oriented with indicative/estimated costs, clear strategies and indicators.
- The NSF (2000-2004) did not identify the lead agency for implementation of major actions, rendering coordination and programme management difficult.
- Mapping to determine programme coverage is a top priority. It is an important connection between the technical/programmatic themes and the management themes assessed during this ETR as well as a critical information bridge between the first NSF and the new NAF.
- A need exists to ensure that the many developed policies and laws are enforced and that there is better coordination between partners from the different sectors who work at all levels, especially at district level.
- Effective coordination of the response is needed at the district and lower levels where implementation largely takes place.
- More resources available to support national response to HIV/AIDS will necessitate increased capacity for coordination at all levels.
- The spirit of the "Three Ones" has to guide the national response, and an effort has to be made to ensure that all the three are accorded equal priority in the response and partners comply.
- Although a replica of NAC is not being suggested by this review at the district level, some form of coordination structure needs to be created at district level with NAC providing technical support.

3.0 THE NATIONAL HIV/AIDS ACTION FRAMEWORK (NAF) 2005-2009

3.1 The Overall Goal of NAF 2005-2009

The overall goal of the National HIV/AIDS Action Framework (NAF) 2005-2009 is based on the goal of the National HIV/AIDS Policy, which brings to the forefront the emerging issue of treatment in the response. The response for the next five years is therefore:

> ***To prevent the spread of HIV infection among Malawians, provide access to treatment for PLHA and mitigate the health, socio-economic and psychosocial impact of HIV/AIDS on individuals, families, communities and the nation.***

3.2 Priority areas, goals and objectives

Eight priority areas will drive the Malawi national response for 2005-2009. These include:

- Prevention and behaviour change
- Treatment, care and support
- Mitigation: socio-economic and psychosocial impact
- Mainstreaming, partnerships and capacity building
- Research and development
- Monitoring and evaluation
- Resource mobilisation, tracking and utilisation
- National policy, coordination and programme planning

Each of these priority areas as presented in Sections 4.0-11.0 has a goal, objectives, key strategies and action areas. These are again summarised in the Logical Framework, which further indicates the expected outcome by the end of 2009, indicators and means of verification, responsible government ministry/agency and key collaborating partners, estimated costs of key action areas and assumptions and risks.

3.3 Guiding Principles of the NAF 2005-2009

High-level government commitment, national leadership and ownership: Government commitment and support at all levels will continue to characterise Malawi's multi-sectoral approach/response to HIV/AIDS. Government will sustain a conducive environment for expansion and a scaled up HIV/AIDS multi-sectoral response. For a sustained and more effective management of the national HIV/AIDS response that reflect the priorities of the country, the Government, through the National AIDS Commission, will provide the required leadership.

Three Ones: The national response will conform to the "Three Ones" approach; (i) one national HIV/AIDS coordinating authority, (ii) one national HIV/AIDS action framework, and (iii) one monitoring and evaluation framework.

Multi-sectoral and multi-stakeholder partnerships: For enhanced and sustainable HIV/AIDS response and in recognition of the epidemic as a crosscutting and development issue, all sectors of society will mainstream HIV/AIDS in their plans and programmes. Collaboration and sharing of experiences among stakeholders, including government, development partners (donors) NGOs,

religious organisations, private institutions, traditional institutions and communities is a key principle in the design, implementation and monitoring of multi-sectoral and multi-disciplinary programmes.

Greater involvement of people living with AIDS (GIPA): The greater involvement of PLHA at all levels is key for an effective response to HIV/AIDS

Public health approach: A public health approach reduces the risk of HIV transmission by focussing on the most effective prevention and medical care information and interventions (GoM, 2003)

Community empowerment approach: A community empowerment approach strengthens the capacity of families and communities to care for PLHA, OVC, widows, widowers and the affected elderly, hence the need for their full involvement for an effective national response to HIV/AIDS

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/AIDS, 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.

Gender Considerations: All actors in the HIV/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.

Evidence-based interventions: It is essential that the national response to HIV/AIDS be based on sound, current, empirically-based research (GoM, 2003)

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.

4.0 PREVENTION AND BEHAVIOUR CHANGE

4.1 Introduction

One of the major achievements in Malawi's response has been the creation of almost universal awareness of HIV. The challenge still remains to translate this awareness into behaviour change. Modifying and changing risky cultural practices such as widow inheritance, death cleansing, passage of rites and circumcision remain a daunting challenge especially in rural communities. Obstacles to behaviour change include poverty, gender inequality and poor legal protection of women and girls. This NAF therefore attempts to galvanise efforts that translate the HIV awareness into behaviour change.

4.2 Goal

To reduce the spread of HIV in the general population and in high-risk subgroups

4.3 Objectives, key strategies and action areas

PBC 1: Objective 1
To expand the scope and depth of HIV/AIDS communication for effective behaviour change

Key strategies

PBC 1.1: Scale up effective, mutually reinforcing and culturally appropriate modes of communication

Key action areas

PBC 1.1.1: Develop specific interventions for targetting men, women, girls and boys on values of mutual faithfulness and abstinence as well as condom use
PBB 1.1.2: Develop and support targetted communication interventions that address specific cultural and gender challenges
PBC 1.1.3: Support and work with traditional and faith leaders and initiation counsellors to disseminate information that perpetuate the notion of community
PBC 1.1.4: Increase coverage and mutual reinforcement of life skills education in schools, colleges and community
PBC 1.1.5: Develop a communication strategy for the HIV/AIDS response, which includes all communication interventions, positive approaches, defines their role and guides the scale up required.
PBC 1.1.6: Ensure large scale development of communication products to support key action areas, based on the communication strategy
PBC 1.1.7: Establish appropriate resources and resource centres that meet the needs of rural and urban Malawians
PBC 1.1.8: Develop specific communication interventions that support policy changes and emerging issues
PBC 1.1.9: Translate the BCI Strategy into local languages (Chewa, Tumbuka and Yao)
PBC 1.1.10: Disseminate the national BCI strategy
PBC 1.1.11: Enhance capacity of stakeholders to implement BCI strategy
PBC 1.1.12: Develop and disseminate a National Condom Strategy based on agreed values identified through a consultative process

PBC 1.1.13: Identify and support the role of PLHAs in communication for behavioural change and referral to testing services
PBC 1.1.14: Increase the engagement of PLHAs in promoting safer sex
PBC 1.1.15: Support emerging developments in safer sex options, ensuring appropriate community sensitization
PBC 1.1.16: Support safe sex and communication skills training for groups of married women and couples

PBC 2: Objective
To promote and support HIV protective interventions specifically designed for young people

Key strategies
PBC 2.1: Scale up HIV/AIDS interventions specifically designed for youth

Key action areas
PBC 2.1.1: Develop a National Abstinence Action Plan relevant to specific age groups
PBC 2.1.2: Increase the number of supportive life skills activities for boys and girls
PBC 2.1.3: Develop communication interventions targetting parents to improve dialogue and interaction with children on sexuality and HIV/AIDS
PBC 2.1.4: Develop specific communication interventions on preventive behaviour for young people
PBC 2.1.5: Develop targeted communication interventions to support abstinence before marriage
PBC 2.1.6: Develop and implement a research agenda to deepen understanding of abstinence and other preventive behaviour to inform policy and programmes
PBC 2.1.7: Establish and strengthen youth networking
PBC 2.1.8: Strengthen Youth Centres as potential avenues for HIV/AIDS interventions for young people

PBC 3 Objective
To reduce the vulnerability of Malawians to HIV infection, especially girls and women

Key strategies
PBC 3.1: Improve the capacity and skills of women and youth, especially girls, to participate in interventions that raise their economic and social status and help them fulfill their potential.

Key action areas
PBC 3.1.1: Develop and implement a research agenda and facilitate dissemination to improve the understanding of the linkages between vulnerability of women and girls and HIV/AIDS, and define and direct policies and programmes
PBC 3.1.2: Develop specific communication interventions to increase advocacy activities targeting particularly women and girls
PBC 3.1.3: Engage vulnerable groups in the development and review of national strategies

PBC 3.1.4: Support interventions that reduce vulnerability of women and girls to HIV/AIDS
PBC.3.1.5: Develop communication interventions and support legal structures to discourage intergenerational sexual relations and abuse
PBC 3.1.6: Promote positive roles for boys and men essential for HIV/AIDS prevention
PBC 3.1.7: Ensure the HIV/AIDS policy legal framework addresses, communicates and enforces protection for women and girls
PBC 3.1.8: Support initiatives to keep girls in school
PBC 3.1.9: Support initiatives to improve services for rape survivors including post-exposure prophylaxis (PEP) and emergency contraception

PBC 4: Objective
To strengthen socio-cultural values and practices that prevents the spread of HIV

Key strategies

PBC 4A: Transform gender dynamics that predispose various population categories to HIV/AIDS in the broader socio-cultural and economic environment

PBC 4B: Promote positive cultural values and practices and discourage harmful cultural practices that predispose people to infection with HIV

Key action areas

PBC 4.1.1: Identify and document cultural practices and values that affect the national response
PBC 4.1.2: Develop a strategy to overcome the identified harmful practices
PBC 4.1.3: Develop and disseminate IEC materials on legal issues, especially rights of women and girls
PBC 4.1.4: Support communication programmes that reach many people in communities e.g. Stepping Stones, "Mzake ndi Mzake", Rights of the child and HIV/AIDS, and Rights approaches to HIV/AIDS

PBC 5: Objective
To promote safer sex practices among the high-risk groups and in high-risk settings

Key strategies

PBC 5A: Intensify BCC interventions for behaviour change

PBC 5B: Increase appropriate access to and use of male and female condoms as directed by the strategy

PBC 5C: Promote mechanisms for targetting high-risk groups

Key action areas

PBC 5.1.1: In the advent of treatment availability, conduct research among high-risk groups and settings to examine implications for both risky and protective behaviour. Ensure findings are incorporated into communication policy and interventions
PBC 5.1.2: Develop programmes addressing risk reduction for high risk groups
PBC 5.1.3: Increase access for high-risk groups to information, condoms and medical services

PBC 6: Objective
To enhance equitable access by all Malawians to HIV testing and counselling services

Key strategies

PBC 6A: Expand the scope and coverage of HIV testing and counselling services throughout the country especially in rural areas
PBC 6B: Improve the quality of testing and counselling service provision, including referral to support services
PBC 6C: Promote the uptake of HIV testing and counselling

Key action areas

PBC 6.1.1: Strengthen systems and capacity to support expansion of quality HIV testing and counselling services
PBC 6.1.2: Increase access to HIV testing and counselling services e.g. through outreach, mobile services and workplace programmes
PBC 6.1.3: Integrate HIV testing and counselling in all health facilities to increase uptake
PBC 6.1.4: Disseminate HIV testing and counselling guidelines to all health facilities
PBC 6.1.5: Establish supervisory and quality assurance system to support compliance
PBC 6.1.6: Increase the availability and referral to appropriate post test treatment and support services
PBC 6.1.7: Support programmes to address testing and counselling needs of special groups, for example, health service providers, youth and couples
PBC 6.1.8: Ensure testing and counselling services meet needs of clients e.g. through routine supervision, operational research and client feedback
PBC 6.1.9: Institute pre-service training module on HIV testing and counselling and strengthen the in-service training programme so as to continually update the knowledge and skills of health workers
PBC 6.1.10: Strengthen collaboration and coordination of key implementing partners of HIV testing and counselling services
PBC 6.1.11: Support communication interventions that increase demand for testing services

PBC 7: Objective
To expand quality services for prevention of mother to child transmission (PMTCT) of HIV

Key strategies

PBC 7A: Expand the scope, quality and coverage of PMTCT services throughout the country
PBC 7B: Develop a conducive environment and support structure for PMTCT implementation

Key action areas

PBC 7.1.1: Develop and strengthen systems and capacity to support the expansion of quality PMTCT services
PBC.7.1.2: Integrate quality PMTCT services into routine MCH services to meet the needs of clients and increase up-take

PBC 7.1.3: Ensure PMTCT service are of high quality through supportive supervision, operational research and client feedback
PBC 7.1.4: Support HIV positive women and their partners to access ART and other HIV/AIDS-related services.
PBC. 7.1.5: Disseminate PMTCT policy and guidelines to all health facilities and establish systems to support adherence
PBC 7.1.6: Strengthen follow up and referral of infants born to HIV positive mothers for care and support services
PBC 7.1.7: Promote education and support safe infant feeding according to PMTCT guidelines
PBC 7.1.8: Conduct studies on individual perceptions of MTCT risk and treatment options
PBC 7.1.9: Develop programmes to destigmatise PMTCT and encourage partner involvement in the interventions and community support.
PBC 7.1.10: Strengthen linkages with TBAs to improve uptake of PMTCT services
PBC 7.1.11: Strengthen collaboration and coordination of key implementers of PMTCT services
PBC 7.1.12: Institute pre-service training module on PMTCT and strengthen the in-service training programme so as to continually update the knowledge and skills of health workers
PBC 7.1.13: Implement communication activities in support of PMTCT guidelines

PBC 8: Objective
To prevent the risk of HIV transmission through blood products or invasive procedures.

***Key* strategies**

PBC 8A: Increase access to safe blood, blood products and tissue services throughout the country
PBC 8B: Increase availability of adequate infection prevention materials and procedures
PBC 8C: Support communication interventions to increase awareness of infection prevention

Key action areas

PBC 8.1.1: Ensure all blood banks in all districts adhere to safe blood provision standards
PBC 8.1.2: Ensure that provision of safe tissue services adhere to standards that comply with the provision of safe blood
PBC 8.1.3: Develop capacity of the health service providers to ensure effective handling of blood products and tissue in the health care system
PBC 8.1.4: Ensure infection prevention products and materials are universally available, and universal precautions and control followed
PBC 8.1.5: Develop and disseminate infection prevention guidelines for traditional initiators and other relevant practitioners and practices
PBC 8.1.6: Support initiatives for post-exposure prophylaxis services to professional groups and others at risk
PBC 8.1.7: Support facilities to become certified in infection prevention
PBC 8.1.8: Support regular supervision and monitoring after certification

PBC 9: Objective
To increase access to quality STI syndromic management, counselling and information

Key strategies

PBC 9A: Strengthen evidence-based STI communication interventions
PBC 9B: Strengthen the STI surveillance system
PBC 9C: Improve the clinical diagnosis, treatment and management of STI patients

Key action areas

PBC 9.1.1: Strengthen human capacity to support expansion of quality STI services
PBC 9.1.2: Ensure adequate STI equipment supply and supplies
PBC 9.1.3: Promote the integration of STI prevention and treatment in reproductive health service and HIV/AIDS clinics to better meet client needs and increase uptake
PBC 9.1.4: Ensure STI services meet the needs of specific vulnerable groups
PBC 9.1.5: Support targetted promotion of STI services
PBC 9.1.6: Ensure quality STI management and service delivery throughout the country
PBC 9.1.7: Strengthen the STI drug procurement and distribution system throughout the country
PBC 9.1.8: Strengthen public-private partnership in the management and monitoring of STI services
PBC 9.1.9: Increase access and encourage use of condoms among STI clients and partners
PBC 9.1.10: Support interventions that increase effective partner notification and treatment
PBC 9.1.11: Establish a Reference Laboratory STI drug efficacy clinical trials
PBC 9.1.12: Ensure adequate laboratory infrastructure and reagents supply
PBC 9.1.13: Strengthen a national STI surveillance system for prevalence, incidence and distribution of STIs
PBC 9.1.14: Develop routine and referral mechanisms between STI management and HIV testing and counselling
PBC 9.1.15: Develop linkages with traditional healers to improve uptake of formal STI services
PBC 9.1.16: Institute pre-service training module on STI management and strengthen the in-service training programme so as to continually update the knowledge and skills of health workers

PBC 10: Objective
To expand advocacy and social mobilisation for increased HIV/AIDS action especially at the district and community level

Key strategies

PBC 10A: Intensify the active involvement of traditional, faith and opinion leaders, decentralised departments and local governments in the district HIV/AIDS response
PBC 10B: Intensify community mobilisation based on meeting their perceived and actual needs and rights

Key action areas

PBC 10.1.1: Conduct advocacy and mobilisation activities for HIV/AIDS prevention and behaviour change

PBC 10.1.2: Conduct consultations for consensus building on the mandates and roles of leaders at district and community levels

PBC 10.1.3: Support communities to plan, implement and monitor prevention and behaviour change

PBC 10.1.4: Encourage positive and constructive dialogue and discourse about HIV/AIDS at all levels

PBC 10.1.5: Strengthen linkages between senior leadership and PLHA organisations

PBC 10.1.6: Develop guidelines for the district level HIV/AIDS response

PBC 10.1.7: Support local government with materials and logistics to effectively integrate community voices and actions

5.0 TREATMENT, CARE AND SUPPORT

5.1 Introduction

Treatment, care and support increasingly dominate national responses with support from international development partners. Malawi is benefiting from the global support through GFATM to address issues of treatment, care and support of PLHA. Malawi has developed guidelines and scale up plans for ART, treatment of HIV/AIDS-related infections, and other related services. However, since the government announced that ARV drugs would be provided to Malawians, pressure is mounting from the community for the government to deliver. But the health delivery system is faced with constraints that have to be overcome for effective implementation of treatment, care and support programmes. These include human resource capacity, ARV drug procurement and distribution, data collection, the possibility of emerging drug resistance and sustainability of funding.

5.2 Goal

To provide and expand equitable treatment for PLHA and mitigate the health impact of HIV/AIDS.

5.3 Objectives, key strategies and action areas

TCS 1 Objective
To improve the capacity of the health delivery system to provide equitable access to ARVs and drugs for management of HIV-related infections

Key strategies

TCS 1A: Strengthen an integrated ART infrastructure and logistic systems and a national quality assurance programme for ART
TCS 1B: Increase and sustain the human resource capacity for delivery of high quality ART and management of HIV-related infections to both adults and children
TCS 1C: Increase equitable access to ARVs

Key action areas

TCS 1.1.1: Strengthen laboratories of health units with ART and HIV-related infections programme
TCS 1.1.2: Procure adequate ARVs and other drugs to treat HIV-related diseases
Procure and equip health service systems with testing kits and reagents
TCS 1.1.3: Maintain infrastructure for ART and VCT
TCS 1.1.4: Develop and implement mechanisms for tracking stock levels of drugs and other supplies
TCS 1.1.5: Develop and implement a systematic pre-service and in-service training programme for health care personnel in ART and management of HIV-related diseases
TCS 1.1.6: Monitor and supervise ART and HIV treatment programmes and strengthen support systems
TCS 1.1.7: Intensify and monitor advocacy to address obstacles to equitable access to ART
TCS 1.1.8: Support provision of pediatric OIs and ARV drug formulations

TCS 1.1.9: Conduct widespread public education campaigns on HIV care, and support behaviour change campaigns to promote access and adherence to ARV therapy
TCS 1.1.10: Support behaviour change campaigns to destigmatise people on ARVs
TCS 1.1.11: Develop the quality of management of Central Medical Stores (CMS) and regional offices to procure and distribute health products including ARVs
TCS 1.1.12: Strengthen the in-service training programme so as to continually update the skills of clinical staff and institute a pre-service training module on ARV therapy and management of HIV-related diseases for the colleges of medicine, nursing and health sciences
TCS 1.1.13: Strengthen referral systems in health facilities and between different levels of health care delivery

TCS 2: Objective
To increase access to high quality community home-based care (CHBC)

Key strategies
TCS 2A: Expand provision of community home-based care (CHBC) including palliative care and psychosocial support
TCS 2B: Develop an integrated CHBC package that involves all health care providers including traditional healers, traditional birth attendants, social workers and civil society service providers
TCS 2C: Increase involvement of PLHA in planning and implementation of CHBC
TCS 2D: Increase numbers and capacity of volunteers in provision of CHBC
TCS 2E: Develop a mechanism for retention of volunteers
TCS 2F: Ensure that CHBC links up at peripheral level with the provision of ARV therapy from health facilities

Key action areas
TCS 2.1.1: Develop CHBC guidelines that spell out the roles of families, communities and service providers
TCS.1.2.2: Standardise provision of CHBC including palliative care and psychosocial support
TCS 2.1.3: Standardise the CHBC kit
TCS 2.1.4: Build the capacity of CBOs, FBOs and NGOs involved in CHBC
TCS 2.1.5: Support the CHBC activities of CBOs, NGOs and FBOs involved in CHBC
TCS 2.1.6: Develop coordination mechanisms of implementers of CHBC programmes
TCS 2.1.7: Support referral mechanisms between CHBC providers and facility-based care
TCS 2.1.8: Promote greater involvement of PLHA and OVCs in planning and implementation of CHBC
TCS 2.1.9: Support community mobilisation in the provision of CHBC, including palliative care and psychosocial support
TCS 2.1.10: Support the integration of palliative care in the national health system and training curricula for pre-service and in-service training
TCS 2.1.11: Support, build capacity and facilitate volunteers involved in provision of CHBC
TCS 2.1.12: Fund programmes targeting boys and men to become involved in providing CHBC

TCS 2.1.13: Develop the integrated CHBC Model and training package
TCS 2.1.14: Expand the usage of integrated CHBC package

TCS 3: Objective
To expand programmes and interventions for nutritional support and education to vulnerable PLHA within their communities

Key strategies
TCS 3.1.: Establish and increase mechanisms to deliver nutritional support to vulnerable PLHA
Key action areas
TCS 3.1.1: Develop mechanism for monitoring PLHA nationally on ARVs
TCS 3.1.2: Establish nutritional needs of PLHA
TCS 3.1.3: Identify and document local options and sources of meeting nutritional needs of vulnerable PLHA
TCS 3.1.4: Develop guidelines on nutrition for PLHA on ARVs
TCS 3.1.5: Integrate nutrition support of PLHA in the HIV/AIDS comprehensive care package
TCS 3.1.6: Provide nutritional education and counselling to PLHA
TCS 3.1.7: Provide nutritional education to caregivers of PLHA and affected families
TCS 3.1.8: Provide nutritional supplements to hard hit households of PLHA

6.0 IMPACT MITIGATION: SOCIO-ECONOMIC AND PSYCHOSOCIAL

6.1 Introduction

HIV/AIDS has had a severe socio-economic and psychosocial impact on Malawian society. Over the past five years, interventions aimed at addressing the needs of PLHA, OVC, widows, widowers and the elderly have remained undeveloped. During the period 2005 – 2009, the Malawian HIV/AIDS response will scale up interventions and support coping mechanisms that minimise pain, suffering, anxiety and loss of service delivery at the individual, household, community and national levels.

6.2 Goal

To mitigate the economic and psychosocial effects of HIV/AIDS and improve the quality of life of PLHA, OVC, widows, widowers and the elderly affected by the epidemic.

6.3 Objectives, key strategies and action areas

IM 1: Objective
To promote sustainable income generating projects (IGPs) to PLHA, OVC, widows, widowers, and the affected elderly.

Key strategies

IM 1A: Strengthen mechanisms to promote sustainable economic and material support
IM 1B: Increase advocacy for micro-finance programmes
IM 1C: Strengthen the capacity of IGP groups in business management
IM 1D: Promote linkage to market outlets of different commodities

Key action areas

IM 1.1.1: Develop a conceptual framework and strategy for impact mitigation
IM 1.1.2: Assess the nature and skills of PLHA, OVC, widows, widowers and the elderly affected by HIV/AIDS to plan and manage simple IGPs.
IM 1.1.3: Train beneficiaries on how to develop and manage IGPs
IM 1.1.4: Advocate for micro-finance programmes to support IGPs for PLHA, OVC, carer of carers, widows and widowers
IM 1.1.5: Support advocacy campaigns for mobilisation of resources to support IGPs
IM 1.1.6: Facilitate formation and management of IGP groups (cooperatives and associations)
IM 1.1.7: Develop an inventory of buyers of different commodities

IM 2: Objective
To enhance the provision of psychosocial support to PLHA, OVC, widows, widowers and the elderly affected by the epidemic

Key strategies

IM 2A: Strengthen capacities of communities and districts to provide psychosocial support to PLHA, OVCs and affected families
IM 2B: Increase capacity of PLHA associations and post-test support groups to provide psychosocial support to other PLHA and affected families

Key action areas

IM 2.1.1: Train counselors, counselor aides and other volunteers at the community and district levels—Community Resource Persons (CRPs)
IM 2.1.2: Provide appropriate and sustainable incentives/facilitation to community resource persons
IM 2.1.3: Build capacity of community institutions
IM 2.1.4: Support and strengthen CBOs, FBOs and the family institutions in the psychosocial care activities and support of PLHA and OVCs
IM 2.1.5: Train PLHA in the provision of psychosocial support
IM 2.1.6: Train CBOs, NGOs and FBOs in Care, Counseling and psychosocial support for PLHA, OVC and the affected families
IM 2.1.7: Promote formation and capacity building of PLHA groups
IM 2.1.8: Promote formation and capacity building of OVC peer counseling groups
IM 2.1.9: Support activities of PLHA and OVC to provide psychosocial support and peer counseling

IM 3: Objective

To promote the enforcement of legal, ethical and social rights of PLHA, OVC, widows and widowers

Key strategies

IM 3:A Advocate for enforcement of policies and laws that promote and protect rights of PLHA, OVC, widows and widowers
IM 3:B Increase community awareness on legal, ethical and social rights of PLHA, OVC, widows and widowers
IM 3:C Establish partnerships with legal institutions/organisations

Key action areas

IM 3.1.1: Review existing laws and advocate for their amendments in order to reflect issues affecting PLHA, OVC, widows and widowers
IM 3.1.2: Develop new laws, where necessary, to enhance the protection of OVC, PLHA, widows and widowers
IM 3.1.3: Conduct advocacy campaigns on policies and laws on rights of PLHA, OVC and widows
IM 3.1.4: Develop capacities for enforcing relevant laws and policies to ensure human rights and fundamental freedom by PLHA
IM 3.1.5: Develop programmes and curricula on rights-based approach to HIV/AIDS to be incorporated in training institutions
IM 3.1.6: Build institutional capacity for enforcement of relevant laws and policies to ensure human rights and fundamental freedoms of PLHA, OVC, widows and widowers
IM 3.1.7: Identify and support institutions to undertake public education on human rights, legal, and ethical needs of affected groups.
IM 3.1.8: Train and support community-based paralegals to carry out community education campaigns on human rights, legal and ethical needs of affected groups
IM 3.1.9: Provide survivors of abuse, violence, exploitation or trafficking with appropriate services

IM 3.1.10: Develop IEC materials to promote positive attitudes among caregivers and the general public towards PLHA, OVC, widows and affected families

IM 4: Objective

To improve access of OVC to essential social services, integrated and comprehensive community-based support services

Key strategies

IM 4A: Enhance access for OVC to essential quality services such as education, health, good nutrition, water and sanitation and birth registration with increased support from social safety nets

IM 4B: Strengthen the capacity of families and communities to care for OVC by providing support to enhance their economic security, social and emotional well-being

IM 4C: Protect the most vulnerable children through improved policy and legislation, provision of leadership, effective coordination at all levels and through meaningful child participation

IM 4D: Build and strengthen the technical, institutional and human resource capacity of key OVC service providers

IM 4E: Raise awareness at all levels through advocacy and social mobilisation to create a supportive environment for children and families supported by poverty and HIV/AIDS

Key action areas

IM 4.1.1: Advocate for the integration of OVC in the national social safety net programme

IM 4.1.2: Increase the provision of school bursaries and school feeding programmes

IM 4.1.3: Increase access of OVC to essential health package

IM 4.1.4: Disseminate widely the National OVC Policy and NPA especially at community level

IM 4.1.5: Mobilise support for the implementation of integrated care, protection and OVC support package

IM 4.1.6: Provide in-school life skills training

IM 4.1.7: Provide alternative education and vocational skills training for out-of-school OVC

IM 4.1.8: Support caregivers of OVC with IGPs

IM 4.1.9: Support foster parenting and adoption

IM 4.1.10: Establish community-based child care centres

IM 4.1.11: Support foster parenting and adoption

IM 4.1.12: Provide an education package for the most vulnerable children

IM 4.1.13: Train NGOs, FBOs, CBOs, service providers, district and community level structures, in social and child protection issues for OVC

IM 4.1.14: Build capacity of Social Protection (Welfare) staff at national, district and community levels

IM 4.1.15: Reinforce laws that protect OVC from abuse, exploitation, stigma, discrimination and property dispossession

IM 4.1.16: Monitor and assess the situation of OVC and measure the gaps

IM 4.1.17: Establish a system for easy identification and registration of OVCs.

IM 4.1.18: Support advocacy programmes for OVC issues

IM 5: Objective
To enhance involvement of FBOs in offering spiritual counselling to PLHA and affected families

Key strategies

IM 5A: Integrate the "Theology of Hope" in counselling curriculum of FBOs
IM 5B: Increase involvement of FBOs in providing psychosocial care and support to PLHA and affected families

Key action areas

IM 5.1.1: Develop "Theology of Hope" Curriculum
IM 5.1.2: Train pastors/priests/lay leaders on the concept of the "Theology of Hope" and counseling, using the concept
IM 5.1.3: Integrate HIV/AIDS education in the regular activities of religious organisations
IM 5.1.4: Integrate HIV/AIDS education in the training curriculum of FBOs or denominations
IM 5.1.5: Fund production and dissemination of IEC based on the "Theology of Hope"
IM 5.1.6: Conduct workshops to popularise the content of the "Theology of Hope"
IM 5.1.7: Train members of the FBOs in spiritual counseling
IM 5.1.8: Support FBOs to provide spiritual counseling
IM 5.1.9: Establish and build capacity of faith-based HIV/AIDS committees at community level

IM 6: Objective
To promote food security and nutrition measures among HIV/AIDS affected households and communities

Key strategies

IM 6A: Strengthen measures at community and household level to ensure food and nutrition security
IM 6B: Enforce appropriate food and nutrition security measures in key national planning and development frameworks
IM 6C: Strengthen collaboration among institutions involved in promotion of food and nutrition security

Key action areas

IM 6.1.1: Develop training materials for agriculture extension workers
IM 6.1.2: Conduct training needs assessment of agriculture extension workers
IM 6.1.3: Train agriculture extension workers to promote food processing technologies and utilisation among PLHA and affected households
IM 6.1.4: Provide agricultural inputs to families with PLHA and OVC (fertilizers and other inputs)
IM 6.1.5: Establish community grain banks and sensitise communities
IM 6.1.6: Promote lobbying campaigns with policy makers on the implementation of food security and nutrition technologies

IM 6.1.7: Support mobilisation of community-based groups for increased food and nutrition security (backyard farming, indigenous fruit and vegetable farming)
IM 6.1.8: Support networking activities with agencies involved in promoting food and nutrition security
IM 6.1.9: Promote labour-saving technologies for food production

IM 7: Objective
To advocate for inclusion of macro-economic impact mitigation measures in the key national planning and development frameworks (MPRSP, SWAP, MTEF)

***Key* strategies**
IM 7A: Deepen the evidence base on the impact of HIV/AIDS on macro-level
IM 7B: Enhance national action on mitigation of HIV/AIDS in national planning

Key action areas
IM 7.1.1: Develop a conceptual framework and strategy for impact mitigation programmes
IM 7.1.2: Support research on the impact of HIV/AIDS at the macro level
IM 7.1.3: Disseminate the research findings on the impact of HIV/AIDS
IM 7.1.4: Develop and implement a national strategy to address the socio-economic effects of HIV/AIDS
IM 7.1.5: Integrate HIV/AIDS in MPRSP and other sector policies
IM 7.1.6: Develop technical capacity for preparation of development plans
IM 7.1.7: Develop capacity of planners and HIV/AIDS experts to integrate HIV/AIDS in the sector programmes
IM 7.1.8: Develop a mechanism to ensure that development programmes are responding to the HIV/AIDS epidemic.

7.0 MAINSTREAMING, PARTNERSHIPS AND CAPACITY BUILDING

7.1 Introduction

The NSF 2000-2004 emphasised the role of various partners in implementing the multi-sectoral response. It called for greater collaboration among institutions and organisations to ensure effective targeting of interventions and positive exploitation of comparative advantage. Lack of capacity and coordination and little reference to the NSF by several partners made the realisation of partnerships benefits difficult. Alongside partnerships development, NSF was intended to ensure that both public and private sectors mainstreamed HIV/AIDS, but lack of common understanding of what the concept entailed and lack of guidance, meant that mainstreaming largely remained rhetoric.

7.2 Goal

To scale-up mainstreaming of HIV/AIDS in the public and private sectors including civil society—NGOs, FBOs, CBOs and build capacity and enhance partnerships among all stakeholders.

7.3 Objectives, key strategies and action areas

MPC 1: Objective
To build the capacity of public, private and civil society sectors to effectively mainstream HIV/AIDS in their policies, plans and sector strategies

Key Strategies

MPC 1A: Develop a shared and common understanding of mainstreaming in both public and private sectors including civil society—NGOs, CBOs and FBOs

MPC 1B: Institutionalise the process of mainstreaming in all sectors—policies, planning, budgeting, implementing

Key action areas

MPC 1.1.1: Develop and implement a conceptual framework and strategy for mainstreaming HIV/AIDS

MPC 1.1.2: Advocate for and ensure the strategic integration of HIV/AIDS in the national economic development tools

MPC 1.1.3: Conduct capacity building activities for HIV/AIDS mainstreaming facilitators

MPC 1.1.4: Advocate for higher level leadership for HIV/AIDS sector programmes

MPC 1.1.5: Build capacity of District Assemblies and DACCs to guide implementers at district level to carry out mainstreaming

MPC 2: Objective
To strengthen the capacity of public, private sector institutions and organisations to plan and manage HIV/AIDS interventions

Key strategies

MPC 2.1: Strengthen the capacity of planning and programme officers in public and other institutions to mainstream HIV/AIDS

Key action areas

MPC 2.1.1: Train all planning and programme officers in managing HIV/AIDS interventions

MPC 2.1.2: Institute liaison meetings between Finance, EP&D and NAC to ensure integration of HIV/AIDS before ceilings are sent to sectors

MPC 2.1.3: Promote participation of employees at sector level in HIV/AIDS activities

MPC 2.1.4: Disseminate and implement the national and civil service workplace policy to all sectors

MPC 2.1.5: Promote partnerships, coordination, knowledge and skill transfer in HIV/AIDS mainstreaming

MPC 3: Objective

To develop the capacity of Districts Assemblies to coordinate HIV/AIDS action at district and community levels.

Key strategy

MPC 3.1: To increase the capacity of District Assemblies to oversee HIV/AIDS **activities in their districts**

Key actions

MPC 3.1.1: Train DAs on the coordination of HIV/AIDS activities in the district and communities

MPC 3.1.2: Support DAs with necessary logistics to coordinate the response at the district level

MPC 4: Objective

To strengthen multi-sector partnerships among stakeholders in all sectors at all levels

Key strategies

MPC4A: Develop and regularly update an inventory of partners' interventions by locality, nature and beneficiaries.

MPC4B: Promote partnership at national and district levels.

MPC4C: Develop and streamline existing coordination mechanisms at all levels

Key action areas

MPC4.1.1: Commission mapping and/or inventory exercise of all stakeholders interventions and activities in the country

MPC4.1.2: Establish data bank of stakeholders working on HIV/AIDS interventions

MPC4.1.3: Support networking mechanisms for partners to share and utilise strategic information.

8.0 RESEARCH AND DEVELOPMENT

8.1 Introduction

The HIV/AIDS in Malawi is still a complex interplay of biomedical, social, cultural, economic, human rights, legal and ethical issues. Coordinated, appropriate and relevant HIV/AIDS research that covers both biomedical and social sciences issues is an essential part of comprehensive national HIV/AIDS research. Very little research has been carried out to explain the nature of and extent of the HIV/AIDS impact. There is still a need to monitor the spread of HIV by paying attention to emerging issues, identifying and analysing further factors which place women, men, girls and boys at risk of infection and to understand the psycho-social management of HIV/AIDS. Operational research should be a priority in the management of HIV/AIDS response during the next five years.

8.2 Goal

To develop appropriate HIV/AIDS policies, practices and interventions

8.3 Objectives, key strategies and major action areas

Broad Objective
To generate empirical data and information about HIV/AIDS that informs policy, practice and interventions.

RD 1: Specific Objective
To promote HIV/AIDS-related research on priority areas at all levels (epidemiology, socio cultural, socio economic, prevention, treatment, mitigation, care and support)

Key Strategies

RD 1A: Implement the National HIV/AIDS Research Strategy
RD 1B: Carry out research initiatives and activities to guide programming and interventions
RD 1C: Facilitate HIV/AIDS research networking and partnerships

Key action areas

RD 1.1.1: Disseminate the National HIV/AIDS Research Strategy
RD 1.1.2: Support coordination of research by the National Research Council of Malawi (NRCM)
RD 1.1.3: Strengthen the capacity of NRCM
RD 1.1.4: Undertake mid term periodic and end term review of the research strategy
RD 1.1.5: Prepare and distribute guidelines on the legal, ethical and intellectual property rights related to HIV/AIDS research
RD 1.1.6: Support HIV/AIDS research in priority areas
RD 1.1.7: Establish research networks and partnerships

RD 2: Specific Objective
To strengthen the capacity of institutions to undertake HIV/AIDS research at all levels.

Key strategies

RD 2.1: Enhance institutional capacity to carry out HIV/AIDS-related research

Key action areas

RD 2.1.1: Assess capacity of research institutions

RD 2.1.2: Train health workers and other players in the conduct of operational research

RD 2.1.3: Establish an HIV/AIDS research centre of excellence

RD 2.1.4: Develop an inventory of research institutions involved in HIV/AIDS related research

RD 2.1.5: Develop a national HIV/AIDS research plan based on the needs and priorities of different sectors

RD 2.1.6: Support collaborative HIV/AIDS research

RD 2.1.7: Recruit and retain researchers

RD 3: Specific Objective

To make available HIV/AIDS research based information

Key strategies

RD 3A: Establish and maintain a centrally updated and nationally accessible HIV/AIDS research database.

RD 3B: Ensure utilisation of research findings in the policy-making and programme identification

Key action areas

RD 3.1.1: Develop and update an inventory of research information in HIV/AIDS (institutions, experts, research projects)

RD 3.1.2: Develop and update a national HIV/AIDS research data base

RD 3.1.3: Organise annual HIV/AIDS dissemination conferences

RD 3.1.4: Support publication of HIV/AIDS research results locally and internationally

RD 3.1.5: Evaluate policy making and programme development in light of research findings

RD 3.1.6: Collate and document HIV/AIDS information

RD 3.1.7: Support creation of institutional HIV/AIDS research databases

RD 3.1.8: Present summary of authenticated HIV/AIDS research results to decision-makers and policy-makers for utilisation

9.0 MONITORING AND EVALUATION

9.1 Introduction

In the 2000-2004 NSF, M&E was not well articulated and given clear focus. The establishment of a Department of Planning, Monitoring, Evaluation and Research (DPMER) at NAC in 2003 with a mandate to guide M&E of the national response has led to the development of a national M&E system for HIV/AIDS. The NAF calls for the national operationalisation of the M&E plan that articulates priority national indicators and targets.

In order to facilitate the operationalisation of the M&E plan a set of mid term and end term targets have been identified against each priority indicator of M&E plan. These indicator targets will permit monitoring of measurable aspects of various actions, program outcomes, and impact objectives envisaged in the NAF. Information obtained on these indicators will be incorporated into annual M&E report for broader dissemination and discussion. The indicators targets are contained in the logical framework in annex 1 below. The logical framework will assist in monitoring what is happening on the ground, analyze it for strategic implications, and feed it back into program planning aimed to address weaknesses or take advantage of opportunities identified through the monitoring effort.

9.2 Goal

To track progress in the implementation of the National HIV/AIDS Action Framework (NAF).

9.3 Objectives, key strategies and action areas

ME 1: Objective
To strengthen capacity of NAC and implementing agencies to collect and report HIV/AIDS data using the National M & E Plan

Key strategies

ME 1A: Scale up operationalisation of National M&E Plan
ME 1B: Strengthen coordination of M&E activities at national, district and grassroots levels

Key action areas

ME 1.1.1: Develop and sustain capacity for M&E at NAC
ME 1.1.2: Build and sustain capacity for M&E in ministries, districts and civil society
ME 1.1.3: Review and disseminate the National M&E Plan
ME 1.1.4: Allocate and/or, advocate for allocation of funds for M&E at all levels of implementation of the response
ME 1.1.5: Establish simple M&E systems for District Assemblies.
ME 1.1.6: Establish district level electronic information systems
ME 1.1.7: Develop National Accounts for HIV/AIDS

ME 2: Objective
To improve HIV/AIDS data collection, dissemination and utilisation at both national, district and community levels.

Key strategies

ME 2A: Strengthen HIV/AIDS electronic information systems at NAC and key institutions
ME 2B: Enhance the capacity of DACs, District Assemblies to create and maintain HIV/AIDS databases

Key action areas

ME 2.1.1: Strengthen and develop databases in key institutions
ME 2.1.2: Support creation and maintenance of databases at District Assembly level
ME 2.1.3: Strengthen NAC Activity Reporting System reporting in the budget of all NAC grants
ME 2.1.4: Produce and disseminate annual and quarterly HIV/AIDS reports
ME 2.1.5: Establish a database for tracking programme activity and financial data for grant recipients;
ME 2.1.6: Develop capacity of implementing agencies in M&E.
ME 2.1.7: Identify and support a lead organisation or institution to train in M&E

ME 3: Objective
To promote and strengthen capacity to manage strategic information for HIV/AIDS

Key strategies

ME 3A: Strengthen the HIV/AIDS surveillance system
ME 3B: Expand capacity for HIV/AIDS information and knowledge management at all levels

Key action areas

ME 3.1.1: Conduct annual sentinel sero-prevalence surveys
ME 3.1.2: Develop capacity for planning and managing behavioural surveys
ME 3.1.3: Conduct periodic behavioural surveillance surveys
ME 3.1.4: Expand the HIV surveillance system to ensure socio-demographic and district representation
ME 3.1.5: Strengthen institutional capacity to generate and disseminate timely national surveillance data and information
ME 3.1.6: Strengthen VCT/PMTCT information system
ME 3.1.7: Support NBTS information system
ME 3.1.8: Conduct four yearly DHS
ME 3.1.9: Conduct district specific population based behaviour and sero-surveys
ME 3.1.10: Collect and analyse STI data
ME 3.1.11: Conduct evaluation of the national response

10.0 RESOURCE MOBILISATION AND UTILISATION

10.1 Introduction

Resource mobilisation and utilisation refers to the mechanism for financing the NAF activities and the application of funds to those activities thus turning the aspirations of the national response into reality. There has been impressive resource mobilisation and goodwill from the international community. However, although Malawi has mobilised substantial amount of resources, this has not translated into major shifts in fighting the epidemic. The major challenges centre on the timely resource disbursement to implementers and better financial resource absorption rate. Very few implementers, especially at community level, have been able to access the available funds.

The full cost of NAF implementation was calculated to be US$620 million over the five-year period as per details in annex 2 and 3 below. Out of this amount US$245 million (40 per cent) is earmarked for preventive initiatives while US$205 million (33 per cent) is expected to be spent on treatment, care and support interventions.

The major proportion of financial support to fully implement NAF will come from external funding partners with the Global Fund being the major contributor. There are indications that funding partners, including the government of Malawi, will contribute a total of US$421 million towards financing NAF activities, representing 68 per cent of the total required funds. This leaves a funding gap of US$199 million which will have to be sourced from elsewhere during the implementation of NAF. The multilateral funding partners are expected to contribute US$314 million, representing 75 per cent of total expected contribution while the rest of the funds are expected to come from bilateral funding partners and government of Malawi as per annex 4.

10.2 Goal

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

10.3 Objectives, key strategies and action areas

RMU 1: Objective
To strengthen financial resource mobilisation, utilisation and management for the national response

Key strategies

RMU 1A: Utilise the NAF as a guide for programme development and basis for resource mobilisation
RMU 1B: Promote resource mobilisation for HIV/AIDS activities in the private sector

Key action areas

RMU 1.1.1: Disseminate and popularise the NAF as a resource mobilisation tool
RMU 1,1.2: Develop and disseminate guidelines for resource mobilisation to all stakeholders
RMU 1.1.3: Develop guidelines to mobilise financial resources and equitable allocation of resources for HIV/AIDS interventions in all sectors
RMU 1.1.4: Strengthen capacity of partners and stakeholders in proposal writing

RMU 1.1.5: Strengthen the capacity of partners and stakeholders in financial resource mobilisation, management and accountability

RMU 1.1.6: Advocate for increased resource allocation for HIV/AIDS in government budgeting processes at national and district levels

RMU 1.1.7: Explore other innovative ways of providing direct and timely financial support for community-led HIV/AIDS responses

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

Key strategies

RMU 2.1: Design mechanisms for speeding up proposal processing by both the Financial Management Agency (FMA) and the Umbrella Organisations (UOs)

Key action areas

RMU 2.1.1: Develop policies and procedures that expedite the process of fund disbursements

RMU 2.1.2: Train the proposal review teams at NAC and UOs on the quality of fundable proposals

RMU 2.1.3: Fund regular (i.e. quarterly) proposal reviewers' review meetings to rationalise the proposal assessment process

RMU 2.1.4: Develop capacities of the District Assemblies, DACC, CACCS, VACCs and civil society service providers in areas of proposal writing

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

Key Strategies

RMU 3A: Develop capacity of HIV/AIDS grantees on skills for timely implementation of activities

RMU 3B: Institute transparent and simple measures for timely accountability

Key action areas

RMU 3.1.1: Train implementing agencies in proposal writing skills

RMU 3.1.2: Train accounting officers in budgeting and financial reporting

RMU 3.1.3: Train grants beneficiaries in production of timely reports

RMU 3.1.4: Popularise accountability guidelines and procedures to all beneficiaries of the resources

RMU 3.1.5: Reorient staff regularly in implementing agencies about accountability procedures

RMU 4: Objective
To develop and apply appropriate methods and systems for tracking grants and monitoring the impact of the Grants Facility

Key strategies

RMU 4.1: Institute systems for tracking grants and monitoring their impact

Key action areas

RMU 4.1.1: Develop and popularise systems for tracking grants disbursement
RMU 4.1.2: Develop tools for monitoring the impact of Grants Facility
RMU 4.1.3: Develop capacity of NAC, FMA and district assemblies to track grants

11.0 NATIONAL POLICY COORDINATION AND PROGRAMME PLANNING

11.1 Introduction

In response to the HIV/AIDS epidemic, the Government of Malawi established the National AIDS Commission (NAC) in July 2001 with an overall mandate to coordinate the national HIV/AIDS response in the country. Since its creation, the NAC has become a strong rallying point for donors, development partners and implementing agencies. Considerable programme progress has been made, but much work remains to be done to build the response in the sectors, and in the districts and the communities where most of the implementation should be concentrated. At district level, the legal framework for implementing HIV/AIDS programme is derived from the Local Government Act 1998, the National HIV/AIDS Policy, the HIV/ AIDS Action Framework and other relevant policies and guidelines.

11.2 Goal

To facilitate and monitor multi-sector implementation of National HIV/AIDS Policy

11.3 Objectives, key strategies and action areas

NPC 1: Objective
To build and sustain effective government-led national level stakeholder partnerships for effectively coordinated HIV/AIDS action

Key strategies

NPC 1A: Strengthen the role of the Board of Commissioners of the National AIDS Commission in building and managing partnerships and facilitating the relationship between Government and donors in HIV/AIDS

NPC 1B: Strengthen existing coordination, policy development and strategic planning structures and create mechanisms for cross fertilisation of knowledge, skills and experience

Key action areas

NPC 1.1.1: Institute regular meetings of the Board of Commissioners and donors, development partners, implementing agencies and representatives of government

NPC 1.1.2: Reconstitute membership of NAC board and orient members

NPC 1.1.3: Undertake various training and field activities that develop the capacity of the Board of Commissioners to lead an effective national response

NPC 1.1.4: Institute regular planning, review and monitoring meetings with the Department of Economic Planning and Development and key community development agencies

NPC 1.1.5: Strengthen the management and role of Quarterly Progress Review Meetings with key implementing partners and with principal donors

NPC 1.1.6: Conduct quarterly Pillar Technical Meetings to review progress, share experiences and address challenges in implementation of the Action Framework

NPC 1.1.7: Facilitate review of mandates, purpose, operational modalities and relationships among key coordination structures at national and district level

NPC 1.1.8: Facilitate establishment and management of a Government-led National HIV/AIDS Partnership Forum and an HIV/AIDS Donor sub-committee of the Donor Coordination Group

NPC 1.1.9: Facilitate establishment of a National Forum for NGOs in HIV/AIDS

NPC 1.1.10: Develop criteria for establishment and recognition of coordination structures and provide on-going support for the operations of coordination structures key to the response

NPC 2: Objective
To develop capacities at all levels for effective implementation of the national response including the National HIV/AIDS Policy and National Action Framework

Key strategies

NPC 2A: Undertake key activities that support wide availability, appropriate interpretation and effective application of the HIV/AIDS Policy at all levels
NPC 2B: Develop and implement appropriate tools and systems for monitoring application of national policy at all levels of the response
NPC 2C: Develop a mechanism for a consultative preparation of an Integrated Annual Work Plan [IAWP] that represents all sectors and sources of funding

Key action areas

NPC 2.1.1: Produce and distribute adequate copies of the National HIV/AIDS Policy to all sectors, institutions, organisations and agencies implementing HIV/AIDS action and/or engaged in policy development
NPC 2.1.2: Engage grants, coordinating and network umbrella organisations in distribution and induction of stakeholders in the interpretation and use of the national policy
NPC 2.1.3: Train a multi-sector gender balanced cadre of 'champions' to disseminate the HIV/AIDS policy nationally using multi-media approaches
NPC 2.1.4: Develop the capacity of planning and coordination structures and divisions in districts and the sectors to implement and to monitor national policy
NPC 2.1.5: Create and strengthen CBO/NGO networks and forums at district and community levels to support monitoring and review of policy implementation
NPC 2.1.6: Synchronise the MPRSP monitoring framework with the National HIV/AIDS monitoring framework
NPC 2.1.7: Strengthen tools and instruments for review of grant applications to ensure adherence of programme design to national policy and policy monitoring framework
NPC 2.1.8: Undertake regular multi-disciplinary supportive field visits to implementing agencies, especially at district and local levels
NPC 2.1.9: Commission regular detailed studies of implementing agencies excelling in operations and publish best practice reports for dissemination
NPC 2.1.10: Review the process of developing IAWP to integrate input from all sectors, key stakeholders and sources of funding

NPC 3: Objective
To advocate for and monitor implementation of the "Three Ones Principle" of planning and policy implementation

Key strategies

NPC 3A: Increase awareness and support of stakeholders and implementers for the principle of "Three Ones" as the basis for effective national coordination

NPC 3B: Develop capacity among implementing organisations in the sectors and at district level to apply the "Three Ones" in planning and coordination

Key action areas

NPC 3.1.1: Produce and distribute adequate copies of the guidelines on the key principals of the "Three Ones" for key stakeholders in all sector

NPC 3.1.2: Produce multi-media communication materials [leaflets, brochures, radio and television programmes] on the principal of the "Three Ones" as a basis for country-led coordination

NPC 3.1.3: Develop and place information briefs and other communication formats on the NAC Website

NPC 3.1.4: Organise a series of stakeholder seminars on National Coordination and the application of the principal of the "Three Ones" targeting all key sectors

NPC 3.1.5: Organise a series of district training seminars on the rationale for the "Three Ones" and its application to coordination, planning and monitoring of the district response

NPC 3.1.6: Undertake on-going advocacy with donor and development partners to align technical support and funding of the national response to the "Three Ones" guidelines

NPC 4: Objective
To increase high-level political and civil leadership for accelerated HIV/AIDS Action nationwide.

Key strategies

NPC 4.1: Undertake activities that support creation and maintenance of high-level political will and leadership at all levels of the national response

Key action areas

NPC 4.1.1: Organise a series of HIV/AIDS Leadership Seminars for the political leadership structure: the Cabinet, Cabinet Committees and Parliamentary Committees.

NPC 4.1.2: Organise regular HIV/AIDS leadership and advocacy training for policy level public and private sector executives

NPC 4.1.3: Conduct regular HIV/AIDS and Development seminars for Board Chairs of statutory corporations key to the national response

NPC 4.1.4: Conduct six-monthly briefing seminars for the Cabinet, Committees of Parliament and Principal Secretaries

NPC 4.1.5: Organise Annual State-Faith Community HIV/AIDS seminars involving senior faith, government and NGO leaders

NPC 4.1.6: Facilitate establishment of and support the operations of an Independent Multi-sector THINK TANK to provide Malawi visionary leadership to the nature and course of the national response to HIV/AIDS

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ANNEX 1: LOGICAL FRAMEWORK

Overall Goal: To prevent the spread of HIV infection among Malawians, provide access to treatment for PLHA and mitigate the health, socio-economic and psychosocial impact of HIV/AIDS on individuals, families, communities and the nation.

LEVEL, AREA AND OBJECTIVE	Strategies	Verifiable Indicators	Means of Verification	Related Objective
IMPACT ASSESSMENT				
Reduced HIV Incidence		*% of people who are HIV-infected (by age group (15 – 19, 20 – 24 and 25 – 49), gender and residence) (GFATM) reduced **from 14.2% in 2004 to 14% in 2007 and 13.5% in 2009***	Sentinel surveillance report	PBC1;
			Second generation surveillance – to determine national prevalence estimates	
		*Syphilis prevalence among pregnant women (by age group (15-19, 20 – 24 and 25 – 49), and residence) (GFATM) reduced **from 2.5% in 2004 to 2.0% 2007 and 1.8%in 2009***	Sentinel surveillance report	PBC3; PBC5;
		*% of adults and children with HIV still alive 12 months after initiation of ART (by gender, age, location) **increased from 81% in 2004 to 85% in 2007 and to 88% in 2009***	Surveys	TCS1
		*% of HIV-infected infants born to HIV-infected mothers reduced **from 21% in 2004 to 18% in 2007 and 15% in 2009***	Formula-based estimate	PBC1; PBC7
Improved quality of life of those infected and affected		*% of orphans and other vulnerable children to whom community support is provided (by gender and residence) increased **from 21% in 2004 to 60%in 2007 and to 80% in 2009***	Population-based survey (e.g. DHS, BSS, CWIQ)	IM4; IM2
Mitigated the impact of HIV/AIDS on society		*Ratio of current school attendance among orphans to that among non-orphans, among 10-14 year-olds (by gender and residence) **improved from 0.94 in 2003 to 0.99 in 2007 and to 1 in 2009***	Population-based survey (e.g. DHS, BSS, CWIQ)	PBC3; IM4
OUTCOME ASSESSMENT				

Reduced high-risk sexual behaviours		*% of sexually active respondents who had sex with a non-regular partner within the previous 12 months (by gender, residence and marital status) reduced* ***from 26% in 2004 to 20% in 2007 and to 18% in 2009 for males and reduced from 8% in 2004 to 6.5% in 2007 and to 5% in 2009 for females***	Population-based survey (e.g. DHS, BSS)	PBC5;
		% of people reporting the consistent use of a condom during sexual intercourse with a non-regular sexual partner (by gender, residence and age (15 – 24, 25 – 49)) ***increased from 47% in 2004 to 55% in 2007 and to 60% in 2009 for males*** *and increased* ***from 30% in 2004 to 35% in 2007 and to 40% in 2009 for females***	Population-based survey (e.g. DHS, BSS)	PBC1; PBC2; PBC3; PBC5;
		Median age at first sex among 15-24 year-olds (by gender, residence) ***increased from 18.1 years in 2004 to 18.6 years in 2007 and to 19.0 years in 2009 for males*** *and increase* ***from 17.4 years in 2004 to 17.7 years in 2007 and 18.0 years in 2009 for females***	Population-based survey (e.g. DHS, BSS)	PBC2; PBC3;
		% of young people aged 15-24 who had sex with more than one partner in the last 12 months (by gender, residence) reduced from …….in 2004 to ……in 2007 and …… in 2009	Population-based survey (e.g. DHS, BSS) [Indicators not well calculated in Preliminary 2004 DHS hence difficult to project]	PBC2; PBC5;
Increased knowledge of HIV/AIDS prevention		*% of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (by gender and residence) improved* ***from 37% in 2004 to 40% in 2007 and to 42% in 2009 for males*** *and improved* ***from 25% in 2004 to 28% in 2007 and 30% in 2009 for females***	Population-based survey (e.g. DHS, BSS)	PBC2; PBC3;

		% of people in general population exposed to HIV/AIDS media campaign (by gender, type of employment and residence) expanded ***from 80% in 2004 to 90% in 2007 and 95% in 2009 for males*** *and* ***from 66% in 2004 to 70% in 2007 and 75% in 2009 for females***	Population-based survey (e.g. DHS, BSS, CWIQ)	PBC3; PBC10;
Decreased stigma and discrimination among general population towards PLWAs		*% of population expressing accepting attitudes towards PLWH/As (by gender and level of education) increased* ***from 29.7% in 2004 to 31% in 2007 and to 32% in 2009 for males*** *and increased* ***from 30.8% in 2004 to 32% in 2007 and 34% in 2009 foe females***	Population-based survey (e.g. DHS, BSS)	PBC4;
PROGRAMME OUTPUTS				
Area 1: Prevention and Behavior Change				
Objective: To Reduce the spread of HIV in general population and in high risk sub groups				
	Information, Education and Communication (IEC)			
	Improve, standardise, comprehensive and effective IEC strategy	# of HIV/AIDS radio/television programs produced (by type of media) increased from **300 in 2004 to 350 in 2007 and to 500 in 2009**	Quarterly Service Coverage Report	PBC1; PBC10;
		# of HIV/AIDS radio/television hours aired (by type of media) from **3,030 hours in 2004 to 4,000 in 2007 and to 4,500 hours in 2009**	Quarterly Service Coverage Report	PBC1; PBC10;
		# of HIV/AIDS brochures/booklets produced increased from ***20*** **in 2004 to** ***50*** **in 2007 and to** ***100*** **in 2009**	Quarterly Service Coverage Report	PBC10;
		# of HIV/AIDS brochures/booklets copies distributed in last 12 months (by district) increased **276,539 in 2004 to 350,000 in 2007 and to 500,000 in 2009**	Quarterly Service Coverage Report	PBC10;
	Promotion of Safer Sex Practices (ABCs)			

	Reduce high-risk sexual behaviour, especially among priority groups such as youth	*% of schools with teachers who have been trained in life-skills-based HIV/AIDS education and taught it during the last curriculum year* (by type of school (primary/secondary, school proprietor (public / private) and school location (rural / urban)) increased from **.......in 2004 to 90% in 2007 and to 100% in 2009**	School based survey & education program review [Baseline data not available]	PBC2; PBC3; PBC4;
		# of young people aged 15 – 24 exposed to life-skills-based HIV/AIDS education (by gender, district and whether they are in-school or out-of-school youth) increased from **133,946 in 2004 to 600,000 in 2007 and to 900,000 in 2009**	Quarterly Service Coverage Report	PBC2; PBC3; PBC4;
		# of condoms distributed by social marketing agencies to retail outlets (i.e. for selling) or to clinics (for free distribution by clinics) (by district, relating distribution to population size in district) increased from **29,272,493 in 2004 to 40,000,000 in 2007 to 60,000,000 in 2009**	Quarterly Service Coverage Report Data from social marketing agencies	
		# of condoms dispensed to end user (by type of institution and district)	Supply Chain Manager Report [Same as above]	
	Prevention of Mother-to-Child Transmission (PMTCT)			
	Reduce mother-to-child (vertical) transmission of HIV	*% of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT* (by type of provider) improved from **2.3% in 2004 to 73% in 2007 and to 80% in 2009**	Census Data HMIS Annual Report	PBC7
		% of health facilities providing at least the minimum package of PMTCT services (by location and district) increased from **7% to 13.6% in 2007 and 17.9% in 2009**	Health Facility Survey	PBC7
		% of pregnant women who have been counseled in PMTCT, tested and received their serostatus results (by age	Quarterly Service Coverage Report	PBC3; PBC7

		group (15 – 24, 25 – 49), type of institution (private/public) and district) increased from **43,345 in 2004 to 230,000 in 2007 and 230,000 in 2009**	HMIS Annual Report	
		% of pregnant women that have been tested, who are HIV positive (by age group (15 – 24, 25 – 49) and district) improved from **6,069 (14%) in 2004 to 46,000 (20%) in 2007 and to 46,000 (20%) in 2009**	Quarterly Service Coverage Report HMIS Annual Report	PBC2; PBC7
		% of HIV positive pregnant women who have been provided with 3 month supply of alternative infant feeding (by district)	Quarterly Service Coverage Report *(no data)*	
		% of HIV positive pregnant women offered PMTCT who are referred for care and support services in the past 12 months (by district) from ***418 in 2004 to 27,600 in 2007 and 36,800 in 2009***	Quarterly Service Coverage Report *(2009 projection at 80% of HIV+ mothers)*	PBC7; TCS1
	STI Treatment			
	Improve management and reduce incidence of STIs other than HIV	*% of patients with STIs at health facilities who have been diagnosed, treated, and counselled according to national management guidelines* (by gender and age (> 20, and 20 years and older) reduced from **…….in 2004 to 70% in 2007 and to 85% in 2009**	Health facility survey [No baseline data]	PBC9
		% of health facilities with STI drugs in stock and no STI drug stock outs of >1 week (by district) increased from **35% in 2004 to 70% in 2007 and to 90% in 2009**	Drug Stock Supply Report	PBC9
		# of STI cases seen at health facilities (by type of case (new case or referred partner), district and by gender) reduced from **157,371 in 2004 to 300,000 in 2007 and to 350,000 in 2009**	HMIS Annual Report	PBC9
	Blood Safety, Injection Safety, and Health Care Waste Management			

	Improve blood safety, injection safety, and health care waste management	% of health facilities that apply national guidelines for blood screening, storage, distribution & transfusions (by district) increased from **…..in 2004 to 80% in 2007 and 100% in 2009**	Health facility survey [No baseline data]	PBC8
		% of health care facilities that apply national standards for infection prevention and health care waste storage and disposal (by district) increased from **8% in 2004 to 57% in 2007 and 100% in 2009**	Health facility survey	PBC8
		% transfused blood units that have been screened for HIV according to national guidelines (by district) maintained at **100% from 2004 to 2009**	Annual National Blood Transfusion Services report	PBC8
	Voluntary Counseling and Testing (VCT)			
	Improve access to ethically sound VCT services	% of *sites* VCT sites (integrated or stand alone) increased **from 146 sites in 2004 to 215 sites in 2007 and to 230 sites in 2009**	HMIS Annual Report	PBC6
		# of clients tested for HIV at VCT sites and receiving their serostatus results (by age (15 – 24 , 25 – 49), district and gender) increased from **177,726 tested and 66,182 (37%) receive results in 2004 to 793,000 tested and 475,800 (60%) receive results in 2007 and to 993,000 tested and 794,400 (80%) receive results in 2009**	Quarterly Service Coverage Report	PBC6
			HMIS Annual Report	
		% of clients who have been tested for HIV, who are HIV positive (by age (15 – 24 , 25 – 49), district and gender) reduced from **22% in 2004 to 18% in 2007 and to 15% in 2009**	Quarterly Service Coverage Report	PBC6

		# of HIV positive VCT clients who are referred to care and support services in the past 12 months (by age (15 – 24 , 25 – 49), district and gender) increased from **16,055 in 2004 to 215,000 in 2007 and to 477,000 in 2009**	Quarterly Service Coverage Report	PBC6
Area 2: HIV/AIDS Treatment, Care and Support				
Objective: To provide and expand equitable treatment for PLHA and mitigate the health impact of HIV/AIDS				
	Clinical Care (including OI Treatment and ARV Therapy)			
	Increased access to improved and comprehensive health treatment for persons infected with HIV	*# of persons with advanced HIV infection receiving ARV therapy* (By age group (< 20 and 20 and older), gender and by type of health facility (public/private)) increased from **13,183 (6.6%) in 2004 to 50,000 in 2007 and to 80,000 in 2009**	Quarterly Service Coverage Report	TCS1
		% of AIDS cases managed for OIs (by gender and district) increased from **4,649 in 2004 to 102,000 in 2007 and reduced to 76,500 in 2009**	HMIS Annual Report	TCS1
		% of health facilities with drugs for OIs in stock and no stock outs of > 1 week (by district) increased **from 35%in 2004 to 70% in 2007 and to 90% in 2009**	Drug Stock Supply Report	TCS1
		% of health facilities where ARV services are being offered with no ARV drug stock outs of > 1 week (by district) **maintained at 100% in 2007 and 2009**	Drug Stock Supply Report	TCS1
		% of detected TB cases who have successfully completed the treatment (by gender, district and by type of TB) increased from **73% in 2004 to 80% in 2007 and to 90% in 2009**	HMIS Annual Report	TCS1
	Community and Home based Care and Support			
	Improved quality of life for PLWAs and affected communities	# of households receiving external assistance to care for adults who have been chronically ill for 3 or more months (by residence, district and type of help) increased from **56,782 in 2004 to 80,000 in 2007 and to 90,000 in 2009**	Quarterly Service Coverage Report	

		% of orphans and other vulnerable children whose households received free basic external support in caring for the child (by gender and residence) increased from ……. in 2004 to ……in 2007 and ……..in 2009	Quarterly Service Coverage Report [Data not available]	
		# of persons enrolled at PLWA organisations per year (by gender, district and age group (15 – 24, 25 – 49)) increased from **1,770 in 2004 to 5,000 in 2007 and 10,000 in 2009**	Quarterly Service Coverage Report	IM2
		# of community home based care visits (by residence, district and by type of visit (health care worker / volunteer)) increased from **123,702 in 2004 to 250,000 (255,000) in 2007 and to 500,000 visits in 2009**	Quarterly Service Coverage Report	TCS2
Area 3: HIV/AIDS Impact Mitigation				
Objective: To mitigate the economic and psychosocial effects of HIV/AIDS and improve the quality of life of PLHA, OVC, widows, widowers and the elderly affected by the epidemic.				
	Support for Orphans and Vulnerable Children (OVC)			
	Increase social, financial and legal support for orphans and vulnerable children	# of orphans and other vulnerable children receiving care/support (by type of support (psychosocial, nutrition, financial), district and gender) increased from **59,996 in 2004 to 200,000 in 2007 and to 300,000 in 2009**	Quarterly Service Coverage Report	IM2; IM4
		# of community initiatives or community organizations receiving support to care for orphans (by district) increased from **250 in 2004 to 500 in 2007 and to 800 in 2009**	FMA Financial Management System Report	IM4
Area 4: Sectoral Mainstreaming				
Objective: To scale-up mainstreaming of HIV/AIDS in the public and private sectors including civil society—NGOs, FBOs, CBOs				

	Increase level of resources, effort, and coordination to respond to the HIV/AIDS epidemic in all sectors of the economy	*% of large private companies and public institutions that have HIV/AIDS workplace policies and mainstreaming programmes* (by type of institution (public/private) and by type of expenditure) increased from **61% public and 47% private in 2004 to 100% public and 65% private in 2007 and to 100% public and 85% private in 2009**	Workplace survey	MPC1 ????
Area 5: Capacity Building and Partnerships				
Objective: To build capacity and enhance partnerships among all stakeholders.				
	Increase capacity and participation in decision-making and action among all organizations engaged in the national response to the HIV/AIDS epidemic	Amount and % of overall funding received by the NAC that is granted to CBOs, local NGOs, international NGOs, FBOs, government, private sector, educational institutions and international organisations (by type of organisation) increased **from 32% in 2004 to 65% in 2007 and to 80% in 2009**	FMA Financial Management System Report	MPC1; MPC2; MPC3
		Amount of funds disbursed by governments in low and middle income countries		
		Average # of days for grant proposals received by NAC to be processed (from when the grant proposal is received to when funding is provided) reduced from **3.8 months in 2004 to 3.0 months in 2007 and to 2.5 months in 2009**	FMA Financial Management System Report	
		# of project staff and volunteers trained in HIV/AIDS related issues for the purposes of HIV interventions in the past 12 months (by gender and district) increased from **6,166 in 2004 to 12,000 in 2007 and to 18,000 in 2009**	Quarterly Service Coverage Report	MPC1; MPC2;
MONITORING NATIONAL EFFORT				
	National Management and Commitment			

	Improve national commitment, leadership, and management of the national response to the HIV/AIDS epidemic	*Amount of funds spent on HIV/AIDS (*by category of expenditure and funding source (government, civil society and donor agencies))	UNAIDS/NCPI Financial Resource Flow survey	NPC2
		National Composite Policy Index (by questionnaire component) improved from **85% in 2004 to 95% in 2007 and to 99% in 2009**	NCPI Questionnaire	
		# of times in which the NAC decision-making structures operate to review progress data or to decide program management issues (# of meetings, agenda, list of participants, decisions made) (GFATM) maintained at **12 management meetings and 4 NAC Board meetings per year**	NAC meeting minutes	NPC1
	Monitoring and Evaluation			
	Generate empirical data and information through biological and behavioural surveillance, research, programme monitoring, and financial monitoring that will direct HIV/AIDS prevention, care and support, and impact mitigation efforts.	Dissemination of annual publication, the National HIV/AIDS M&E Report, by NAC at the annual NAC M&E dissemination seminar (by sector) **done every quarter, half yearly and at the end of year**	National HIV/AIDS M&E Report	

ANNEX 2: Cost Summary of National HIV and AIDS Action Framework (NAF) 2005-2009 by key priority area

PRIORITY AREA	YEARLY SUB-TOTALS (US$)					TOTAL (US$)	MWK	%
	Year 1	Year 2	Year 3	Year 4	Year 5			
Prevention and Behaviour Change	71,003,223	47,203,290	52,732,825	42,498,305	31,879,555	***245,317,196***	*26,984,891,505*	39.6
Treatment Care and Support	27,578,590	30,957,550	45,783,900	47,330,900	53,634,900	***205,285,840***	*22,581,442,400*	33.1
Impact Mitigation (Socio-economic and Psychosocial)	23,708,110	21,509,770	20,920,770	19,251,520	17,184,660	***102,574,830***	*11,283,231,300*	16.6
Mainstreaming, Partnerships and Capacity Building	3,586,350	1,852,210	1,597,060	1,179,810	742,310	***8,957,740***	*985,351,400*	1.4
Research and Development	4,048,920	4,111,330	4,358,990	4,505,440	4,715,940	***21,740,620***	*2,391,468,200*	3.5
Monitoring and Evaluation	6,009,780	2,220,090	5,426,340	3,049,940	1,057,940	***17,764,090***	*1,954,049,900*	2.9
Resource Mobilisation and Utilisation	997,000	248,000	329,750	68,000	27,000	***1,669,750***	*183,672,500*	0.3
National Policy Coordination and Programme Planning	4,367,600	3,896,500	2,990,500	2,548,000	2,536,000	***16,338,600***	*1,797,246,000*	2.6
GRAND TOTAL	**141,299,573**	**111,998,740**	**134,140,135**	**120,431,915**	**111,778,305**	**619,648,666**	**68,161,353,205**	100.0

ANNEX 3: Cost Summary of National HIV and AIDS Action Framework (NAF) 2005-2009 by key priority area objectives

	Overall Goal: ***To prevent the spread of HIV infection among Malawians, provide access to treatment for PLHA and mitigate the health, socio-economic and psychosocial impacts of HIV/AIDS on individuals, families, communities and the nation.***		
Code	**Priority Area/Goal/Objective**	**Lead Government Agency**	**Estimated Costs in US$**
	Prevention and Behavior Change		
	Goal: To reduce the spread of HIV in the general population and in high-risk subgroups		
	Objectives		
PBC 1	To expand the scope and depth of HIV/AIDS communication for effective behaviour change	MOH, MOGCWCS, MOE	**132,863,263**
PBC 2	To promote and support HIV protective interventions specifically designed for young people	NYC, MOYSC	**8,672,900**
PBC 3	To reduce the vulnerability of Malawians to HIV infection, especially girls and women	MOGCWCS, MOE	**7,041,048**
PBC 4	To strengthen socio-cultural values and practices that prevent the spread of HIV	MOGCWCS	**547,500**
PBC 5	To promote safer sex practices among the high-risk groups and in high-risk settings	MOH	**11,503,200**
PBC 6	To enhance equitable access by all Malawians to HIV testing and counseling services	MOH	**45,095,180**
PBC 7	To expand quality services for prevention of mother to child transmission (PMTCT) of HIV	MOH	**8,973,905**
PBC 8	To prevent the risk of HIV transmission through blood products or invasive procedures	MOH	**4,746,450**
PBC 9	To increase access to quality STI syndromic management, counseling and information	MOH	**14,952,750**
PBC 10	To expand advocacy and social mobilization for increased HIV/AIDS action especially at the district and community level	MOLGRD	**10,921,000**
	Treatment, Care and Support		
	Goal: To provide and expand equitable treatment for PLHA and mitigate the health impacts of HIV/AIDS.		
	Objectives		
TCS 1	To improve the capacity of the health delivery system to provide equitable access to ARVs and drugs for management of HIV related infections	MOH	**143,632,600**
TCS 2	To increase access to high quality community home-based care (CHBC)	MOH	**16,122,150**

TCS 3	To expand programs and interventions for nutritional support and education to vulnerable PLHA within their communities	OPC	**45,531,090**
	Impact Mitigation: Socio-economic and Psychosocial		
	Goal: To mitigate the economic and psychosocial effects of HIV/AIDS and improve the quality of life of PLHA, OVC, widows, widowers and the elderly affected by the epidemic		
	Objectives		
IM 1	To promote sustainable income generating projects (IGPs) to PLHA, OVC, widows, widowers, and the affected elderly	MOGCWCS	**14,001,300**
IM 2	To enhance the provision of psychosocial support to PLHA, OVC, widows, widowers and the elderly affected by the epidemic	MOGCWCS	**12,757,740**
IM 3	To promote the enforcement of legal, ethical and social rights of PLHA, OVC, widows and widowers	MOHA/ MOJ	**2,714,000**
IM 4	To improve access of OVC to essential social services, integrated and comprehensive community based support services	MOGCWCS	**71,143,240**
IM5	To enhance involvement of FBOs in offering spiritual counseling to PLHA and affected families	OPC/ MOE	**1,545,750**
IM6	To promote food security and nutrition measures among HIV/AIDS affected households and communities	MOAIFS	**287,000**
IM7	To advocate for inclusion of macro-economic impact mitigation measures in the key national planning and development frameworks (MPRSP, SWAP, MTEF)	EPD	**125,800**
	Mainstreaming, Partnerships and Capacity Building		
	Goal: To scale-up mainstreaming of HIV/AIDS in the public and private sectors including civil society—NGOs, FBOs, CBOs build capacity and enhance partnerships among all stakeholders		
	Objectives		
MPC 1	To build the capacity of public, private and civil society sectors to effectively mainstream HIV/AIDS in their policies, plans and sector strategies	DHRMD, MBCA	**757,450**
MPC 2	To strengthen the capacity of public, private sector institutions and organizations to plan and manage HIV/AIDS interventions	DHRMD	**3,335,560**
MPC 3	To develop the capacity of Districts Assemblies to coordinate HIV/AIDS action at district and community levels	MOLGRD	**3,885,980**
MPC 4	To strengthen multi-sector partnerships among stakeholders in all sectors at all district level	OPC ????	**978,750**

	Research and Development		
	Goal: To develop appropriate HIV and AIDS policies, practices and interventions		
	Objectives		
RD 1	To promote HIV/AIDS related research on priority areas at all levels (Epidemiology, Socio cultural, Socio economic, Prevention, Treatment, Mitigation, Care and Support)	NRCM	**8,907,520**
RD 2	To strengthen the capacity of institutions to undertake HIV/AIDS research at all levels	NRCM	**9,395,350**
RD 3	To make available HIV/AIDS research based information	NRCM	**3,437,750**
	Monitoring and Evaluation		
	Goal: To track progress in the implementation of the National HIV/AIDS Action Framework (NAF)		
	Objectives		
ME 1	To strengthen capacity of NAC and implementing agencies to collect and report HIV/AIDS data using the National M & E Plan	NAC, MOLGRD (DAs)	**10,901,150**
ME 2	To improve HIV/AIDS data collection, dissemination and utilization at both national and district levels	NAC, MOLGRD (DAs)	**3,246,940**
ME 3	To promote and strengthen capacity to manage strategic information for HIV/AIDS	NAC, MOLGRD (DAs)	**3,616,000**
	Resource Mobilization and Utilization		
	Goal: To enhance HIV/AIDS financial resource mobilization and management at all levels		
	Objectives		
RMU 1	To strengthen financial resource mobilization, utilization and management for the national response	OPC	**1,150,750**
RMU 2	To enhance timely disbursement of funds to partners and implementers at all levels	NAC	**83,500**
RMU 3	To develop capacities of HIV/AIDS implementing agencies to absorb and account for financial resources	MOLGRD (DAs)	
RMU 4	To develop and apply appropriate methods and systems for tracking grants and monitoring the impact of the Grants Facility	NAC, MOLGRD (DAs)	**435,500**
	National Policy Coordination and Program Planning		

	Goal: To facilitate and monitor multi-sector implementation of National HIV/AIDS Policy		
	Objectives		
NPC 1	To build and sustain effective government-led national level stakeholder partnerships for effectively coordinated HIV/AIDS Action	OPC	**12,562,000**
NPC 2	To develop capacities at all levels for effective implementation of the national response including the National HIV/AIDS Policy and National Action Framework	NAC/OPC	**2,788,350**
NPC 3	To advocate for and monitor implementation of the “Three Ones Principle” of planning and policy implementation	NAC/OPC	**705,250**
NPC 4	To increase high-level political and civil leadership for accelerated HIV/AIDS Action nationwide	OPC	**283,000**
	TOTAL US$		***619,648,666***

ANNEX 4: Current and Indicative HIV and AIDS Financing for Malawi, 2005-2009

FINANCIAL SOURCE	TOTAL AMOUNT COMMITTED FOR HIV/AIDS--US$M	TIME FRAME OF SIGNED AGREEMENTS	2005	2006	2007	2008	2009	TOTAL AMOUNT (INCL. PROJECTIONS IN US$M)
BILATERAL DONORS								
USAID	31.20M	2005-2007	10.40	10.40	10.40	10.40	10.40	52.00M
DFID	7.20M	2005-2008	1.80	1.50	1.50	1.50	N/A	7.20M
CDC	3.59M	2005	3.59	2.40	2.40	2.40	2.40	13.19M
CIDA	6.40M	2005-2008	1.60	1.60	1.60	1.60	N/A	6.40M
NORWAY	8.40M	2005-2008	2.10	2.10	2.10	2.10	2.10	10.50M
EUROPEAN UNION	Not available							
REP. OF CHINA (T)	Not available							
JICA	0.73M	2005-2008	0.16	0.31	0.26	N/A	N/A	0.73
Sub-Total	**US$57.52M**							**US$90.02**
MULTILATERAL DONORS AND UNITED NATIONS								
GLOBAL FUND	184.00M	2005-2008	29.65	44.35	56.29	53.73	N/A	184.00M
AFRICAN DEV. BANK	Not available							
WORLD BANK	47.32M*	2005-2008	12.70	12.70	12.70	9.22	2.22	**49.54M**
UNICEF	11.91M	2005-2006	7.71	7.10	7.53	7.30	7.00	**36.64M**
WFP	17.92M**	2007-2007	14.73	14.73	14.73	N/A	N/A	**17.92M**
UNFPA	4.21M	2005-2006	2.01	2.20	3.30	3.30	3.30	**14.11M**
WHO	2.20M	2005-2007	0.42	0.89	0.89	0.89	0.89	**4.47M**
UNDP	2.11M	2005-2006	1.11	1.00	0.75	0.725	0.725	**3.31M**
UNAIDS (Secretariat)	1.38M	2005-2006	0.69	0.69	0.85	0.85	0.85	3.93
OTHER UN Agencies	Not available							
Sub-Total	**US$271.05M**							**US$313.92M**
GOVERNMENT OF MALAWI								
– NAC **– Ministries, 2% ORT**	8.0M 5.44M	**2005-2008**	**2.0** **1.08**	**2.0** **1.27**	**2.0** **1.45**	**2.0** **1.64**	**2.0** **1.64**	**10.00** **7.08**
Sub-Total	**150.00M**		**30.13**	**35.21**	**39.82**	**44.84**	**N/A**	**US$17.08M**
GRAND TOTAL	**US$478.57M**							**US$421.02M**