NATIONAL HIV PREVENTION STRATEGY

2015-2020

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARVs	Antiretroviral
BBSS	Biological and Behavioural Surveillance Survey
BCCI	Behaviour Change Communication Interventions
CACC	Community AIDS Coordinating Committee
CBO	Community Based Organization
CHBC	Community Home Based Care
CHTC	Couple HIV Testing and Counselling
CHW	Community Health Worker
CCP	Comprehensive Condom Programming
CPR	Contraceptive Prevalence Rate
CSS	Community Systems Strengthening
DACC	District AIDS Coordinating Committee
DEC	District Executive Committee
DHRMD	Department of Human Resource Management and Development
EMTCT	Elimination of Mother to Child Transmission of HIV
EPI	Expanded Programme on Immunization
FBO	Faith Based Organization
FP	Family Planning
FSW	Female Sex Worker
GARPR	Global AIDS Response Programme Reporting
GBV	Gender-based Violence
HADG	HIV and AIDS Donor Group
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSA	Health Surveillance Assistant
HSV	Herpes Simplex Virus
HTC	HIV Testing and Counselling
IAWP	Integrated Annual Work Plan
IEC	Information, Education and Communication
JAR	Joint Annual Review
KP	Key Populations

LSE	Life Skills Education
MANASO	Malawi Network of AIDS Service Organisations
MANET+	Malawi Network of People Living with HIV
MARP	Most At Risk Population
MBCA	Malawi Business Coalition Against HIV/AIDS
MBTS	Malawi Blood Transfusion Service
MDHS	Malawi Demographic and Health Survey
MDG	Millennium Development Goals
MGFATMCC	Malawi Global Fund Coordinating Committee
MIAA	Malawi Interfaith AIDS Association
MIS	Management Information System
MNCH	Maternal Newborn and Child Health
MOEST	Ministry of Education, Science and Technology
MoGCSW	Ministry of Gender Community and Social Welfare
MOH	Ministry of Health
MOT	Modes of Transmission model
MPF	Malawi Partnership Forum (MPF)
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission of HIV
NAC	National AIDS Commission
NAF	National Action Framework
NAPHAM	National Association for People Living with HIV and AIDS in Malawi
NSF	National Strategic Framework
NSP	National Strategic Plan
OPC	Office of the President and Cabinet
OPD	Out-Patient Department
OVC	Orphans and Other Vulnerable Children
PEP	Post-Exposure Prophylaxis
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PreP	Pre-Exposure Prophylaxis
SBCC	Social Behaviour Change Communication
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
TFD	Theatre for Development
TWG	Technical Working Group

UNAIDS	Joint United Nations Programme on HIV and AIDS
VMMC	Voluntary Male Medical Circumcision
WHO	World Health Organization
YFHS	Youth Friendly Health Services
YPLHIV	Young People Living with HIV

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The HIV Prevention Technical Working Group (TWG) , under the leadership of the Ministry of Health coordinated the consultation process and the writing of the strategy. The Social and Behaviour Change Interventions Unit, the College of Medicine (University of Malawi), Population Services International and Bridge II Project supported the efforts of the Prevention TWG and worked with the local consultants, Prof. Ken Maleta and Ms Sandra Mapemba, who were tasked with the responsibility of researching and putting together this Prevention Strategy.

The National AIDS Commission wishes to acknowledge the immense special contributions of Dr Michael Kiragu of LVCT Health, Kenya and Dr Juliann Moodley of the South African-based Consultancy InSession for bringing their international and global perspectives into the framing of the National HIV Prevention Strategy. They helped our national consultants rethink the packages of interventions and the results matrix, key pillars of this new Strategy. Alongside the consultants, have been the key individuals who have provided leadership to this process: Ms Marriam Mangochi, Chair of the HIV Prevention TWG; Ms. Aurelie Andriamialison and Mr Trouble Chikoko of UNAIDS Malawi; Dr. Zebedee Mwandi of USAID; Ms. Jennifer Boyle of Bridge II Project; and Dr. Linje Manyozo of the National AIDS Commission. As a Commission, we are indebted to their persistence and dedication to seeing this process through, as well as providing the necessary guidance to the two consultants.

In this form, the Prevention Strategy is not perfect; it is a living document that will be revised as new data emerge. The National AIDS Commission will also rely on the commitment and dedication of partners in the national response to make these data available, as we revise our Strategy.

PREFACE

HIV prevalence in Malawi is declining overall with new infections reducing from 55,000 in 2011 to 34,000 in 2013. Whilst this is encouraging, implementation of effective HIV prevention interventions to reduce new infections still poses a challenge in the national response to HIV and AIDS. At least half of these infections are occurring among young people aged 15-24 years; and the majority of people being infected are those who were previously considered to be at low risk, for example, couples and partners in stable sexual relationships. Identification of a more focused prevention programme is critical for getting to zero infections.

Over the past several years the Government of Malawi in collaboration with its stakeholders has developed and is implementing several prevention strategies and plans aimed at reducing the further transmission of HIV through unprotected sexual intercourse, mother to child transmission, invasive procedures, and blood and blood products. These include: National Behaviour Change Interventions Strategy for HIV/AIDS and Sexual Reproductive Health (2003), National Plan of Action for Scaling up Sexual and Reproductive Health HIV Prevention for Young People (2008-2012); Plan for Scaling up HIV Testing and Counselling (2006-2010); Plan for Scaling up Prevention of Mother to Child Transmission of HIV Services in Malawi (2008-2012); ART Scale up Plan (2006-2010), Condom Strategy (2013); Abstinence Strategy (2008); Mutual Faithfulness Strategy (2008-2012); and the HIV Prevention Strategy 2009-2013 among several others. HIV prevention interventions are being implemented in order to promote normative behaviour change, and also increase demand for medical interventions such as HIV testing and counseling (HTC), Prevention of Mother to Child Transmission (PMTCT) of HIV , Sexually Transmitted Infections (STI) management and blood safety.

The current National HIV Prevention Strategy (2015-2020) has been developed to respond to the current gaps in HIV prevention interventions. The strategy has adopted a results-based management approach with clear activities leading to outputs and outcomes. Eventually, these directly lead to the desired impacts as outlined in the revised 2015-2020 National Strategic Plan for HIV and AIDS (NSP). The primary objective of the current NSP is the achievement of the 90-90-90 targets by 2020, that is,(a) 90% of people living with HIV should know their status, (b) 90% of all people diagnosed with HIV will receive treatment, and that (c) 90% of people receiving treatment will have viral suppression, hence treatment is prevention. This National Prevention Strategy embraces a combination prevention approach for primary and secondary HIV prevention. The Strategy also presents cross-cutting contextual factors and determinants, which need to be addressed to create an enabling environment for sustained positive behaviours in

Malawi. These include gender, human rights, culture, law/legislation, and capacity building. In order to achieve maximum impact, partners in the national response will implement interventions at the national, district and community levels.

The strategy also presents monitoring and evaluation indicators for tracking the progress in its implementation. To enhance coordination in HIV prevention efforts, the Strategy presents key lead agencies for each strategic area.

Lastly, I would like to call upon all partners in the national response to HIV and AIDS to intensify their role in HIV prevention in order to reduce new HIV infections in Malawi.

DR. THOMAS BISIKA
EXECUTIVE DIRECTOR – NATIONAL AIDS COMMISSION

1.0 SUMMARY

The first case of Acquired Immune Deficiency Syndrome (AIDS) was diagnosed in Malawi in 1985. Since then HIV prevalence increased significantly and reached a peak of 16.4% in 1999 among persons aged 15-49 years. Thereafter, the prevalence has been declining steadily, reaching 10.6% in 2010. In 2010 females had a higher HIV prevalence than males (12.9% vs 8.1%), with the largest disparity being in the 15-19 year old age group (3.7% in women and 0.4%). In addition, HIV was more prevalent in urban communities (17.4%) compared to rural communities (9%). The HIV estimates for 2013 depict an estimated prevalence of 10.3%. In the same year, 1,000,000 Malawians were living with HIV, 34,000 acquired new HIV infection and 48,000 died as result of HIV-related conditions.

This National HIV Prevention Strategy (2015-2020) is a critical guiding tool for designing and implementing evidence-based, rights-sensitive, and targeted HIV prevention interventions that will support the achievement of the UNAIDS *Ambitious 90-90-90 Treatment Targets* as adopted in the revised 2015-2020 National HIV and AIDS Strategic Plan (NSP). As laid out in the revised NSP, by 2020, Malawi will have:

- Diagnosed 90% of all people living with HIV (PLHIV)
- Started and retained 90% of those diagnosed on antiretroviral therapy (ART)
- Achieved viral suppression for 90% of individuals on ART.

Furthermore, the HIV Prevention Strategy will assist to move the country along the path of realizing the UNAIDS' "Three Zeros"(Zero new infections, Zero AIDS-related deaths, and Zero stigma and discrimination). The overall goal of the strategy is to achieve a 70% reduction of new HIV infections by 2020. This will be achieved by supporting primary and secondary prevention efforts to realize the 90-90-90 targets with much programmatic focus being paid to keeping those who are negative HIV free. Primary prevention activities will target, in particular, adolescent girls and young women, young men who want to protect themselves through voluntary medical male circumcision (VMMC), and those who test negative through prioritized testing efforts. The Strategy promotes interventions for demand creation for services, knowledge sharing on services, mobilizing communities to access prevention services, conducting referrals of HIV-positive individuals to health facilities, making follow ups on ART clients to ensure treatment adherence, and providing psychosocial support to PLHIV.

It must be emphasized that this prevention strategy provides the context for delivery of HIV prevention activities within the NSP and other relevant strategic documents and policies. The Strategy is not a toolkit but rather a comprehensive framework that offers a programmatic pathway for targeting priority populations with minimum resources whilst maximizing impact. This prevention strategy, unlike the old one, reflects a radical departure from: (a) interventions focus to populations focus; (b) free standing biomedical interventions focus to combination prevention; (c) health sector driven to shared responsibilities; and (d) centralized programming to decentralised programming.

The Strategy is therefore premised on application of evidence-based interventions to achieve set targets as outlined in the results framework, that is aligned to and informed by the NSP. Data on key and vulnerable populations disaggregated by age and sex inform service delivery and prioritization as outlined in the prevention packages (Chapter 4 and Annex 1). The prevention packages capture the biomedical, behavioural and structural change interventions necessary to achieve the 90-90-90 goals with specific target populations, including helping those who are HIV-free stay negative. Epidemiology of each district will determine the most suitable packages per population (high, medium, or low incidence).The current Strategy therefore combines approaches and multiple risk reduction options that address the needs of different populations. The mix of approaches will vary by epidemiology, transmission dynamics, and be tailored to each context. There will be need to continuously assess and modify the combination package to reflect shifts in the epidemic over time while at the same time appreciating that combination prevention is a macro concept, while implementation happens at a micro level. To this end, national goals are set and guidance provided for effective and efficient programming while not being prescriptive, as implementation will need to be informed by prevailing local conditions. The total estimated financial costs for the expected outcomes is outlined in Annex II.

The development of the Strategy was undertaken through a series of consultative processes including a National HIV Prevention Symposium. This forum provided a platform to showcase proven interventions that solidified the need to focus on population based and geographical targeting for cost-effective and efficient delivery of prevention packages. The Symposium and various consultative forums agreed on two critical issues; (i) to prioritize four population groups namely couples, young women, Men who have Sex with Men (MSM) and Female Sex Workers (FSW); and (ii) to emphasize a combination prevention approach that entails biomedical, behavioural and structural dimensions. Late 2013, a Steering Committee was set-up and mandated by the HIV Prevention Technical Working Group (TWG) to oversee the development process which was being coordinated by two consultants. Central to this process were the

programmatic gap analysis, community dialogues which included Key Populations (KPs) and marginalized groups, and TWG meetings. The country office of the Joint United Nations Programme on HIV and AIDS (UNAIDS), provided technical support to the process.

2.0 BACKGROUND

2.1 OVERVIEW OF THE HIV EPIDEMIC IN MALAWI

Malawi is among the countries worst affected by the HIV epidemic. The number of People Living with HIV and AIDS (PLHIV) is estimated at about 1,000,000 which includes 850,000 people aged 15 years and above and 170,000 children below 15 years of age. The most recent estimates on the epidemic are based on modelling using the UNAIDS SPECTRUM, which estimates the prevalence of HIV at 10.3% indicating a slight reduction in prevalence from 10.6% in 2010[1]. It was estimated in 2013 that 34,000 new infections occurred in the year, including 7,400 new infections amongst children aged less than 15 years[2]. Annual AIDS deaths were estimated at 48,000, slightly less than half of what they were at the epidemic's peak in 2004, at 99,000.This early decline follows the natural course of the epidemic and was probably also driven by a reduction of risky sexual behaviour as the population became increasingly aware of HIV as the cause for the massive death wave the country experienced. Between 2000-2004, evidence strongly suggests that behaviour changes (e.g. increases in condom use, decreases in the proportion of men having sex with more than one woman) contributed significantly to decreases in HIV in Malawi's epidemic.[3,4]

The number of new infections has declined to a third of what they were at their peak in 1999, but the rate of decline in new infections has not been uniform chronologically and between adults and children (Figure 1).

[1] National Statistical Office (NSO) and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010.* Zomba,Malawi, and Calverton, Maryland, USA: NSO and ICF Macro

[2] Joint United Nations Program on HIV/AIDS (UNAIDS) Malawi, May 2014 HIV estimates.

[3] Bello, G., B. Simwaka, T. Ndhlovu, F. Salaniponi and T. Hallett (2011). "Evidence for changes in behaviour leading to reductions in HIV prevalence in urban Malawi." Sexually Transmitted Infections 87(4): 296-300.

[4] National AIDS Commission, UNAIDS/Malawi and Futures Institute (2013). Malawi - Prevention response and modes of transmission analysis. Lilongwe, National AIDS Commission, UNAIDS, and Futures Institute.

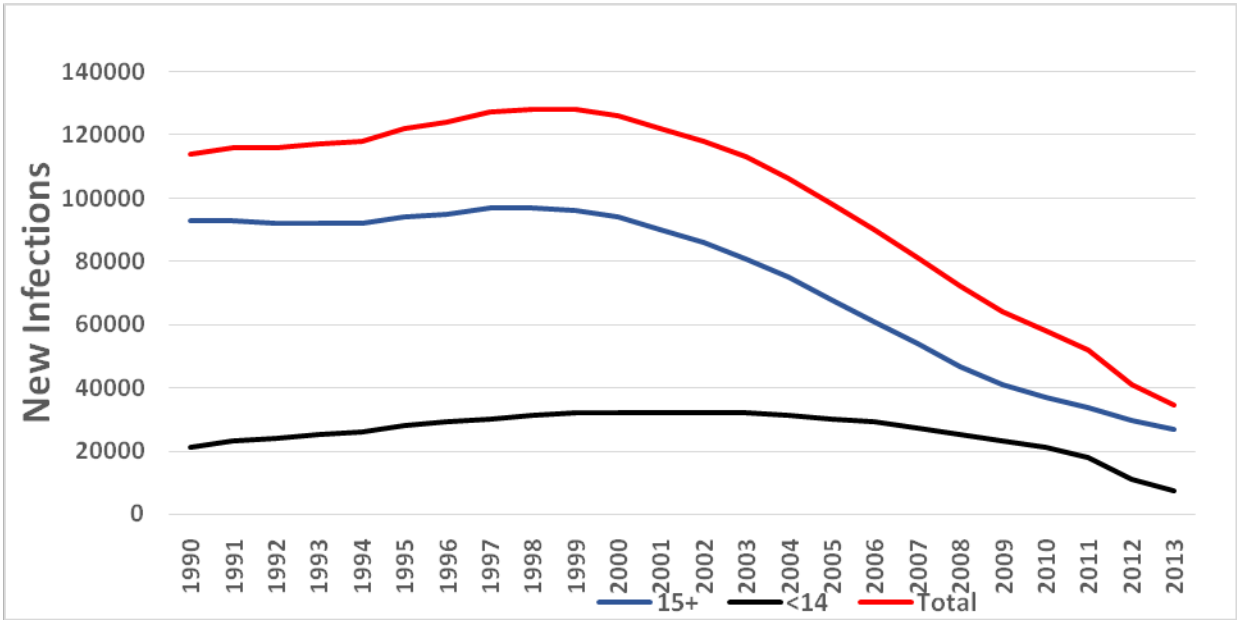


Figure 1. Estimated new infections in Malawi[5]

National sample surveys (Malawi Demographic and Health Survey (MDHS 2010) and Behavioural and Biological Surveillance Survey (BBSS 2006)) and Antenatal Clinic (ANC) surveillance data indicate some heterogeneity in the epidemic. HIV prevalence in Malawi varies substantially over sex, age, urban-rural, geographic and socio-economic characteristics. Women are disproportionately impacted by HIV due to physiological vulnerabilities, gender inequalities and low socio-economic status. In all ages below 35 years, more women than men are living with HIV and in some age groups e.g. 15-19 years, HIV prevalence is almost three times as high amongst females compared to males. Additionally, the epidemic exhibits marked geographical heterogeneity: HIV prevalence is twice as high in urban communities (17.4%) compared to rural communities (9%) and prevalence in the southern region at 14.5%, is double that in the Northern and Central regions[6]. Within these broad geographical regions, variations also exist at district, sub-district and within different socio-demographic groupings. For example, a UNAIDS geospatial analysis shows HIV prevalence hot spots within regions, largely concentrated in southern Malawi (Figure 2). The map clearly shows high HIV prevalence in areas correlated with high economic activity such as rural estates, borders, and urban manufacturing and marketing zones. These areas are characterised by large numbers of mobile men and women with high levels of transactional sex and non-cohabitating partners which may be driving HIV transmission in these settings.

[5]Joint United Nations Program on HIV/AIDS (UNAIDS) Malawi and National AIDS Commission Malawi. Modes of Transmission Analysis and HIV prevention Response. Distribution of new infections in Malawi 2013 and Recommendations for prevention strategies. 2014.

[6]National Statistical Office (NSO) and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010*. Zomba,Malawi, and Calverton, Maryland, USA: NSO and ICF Macro.

Figure 2. Geospatial Mapping of HIV prevalence in Malawi (2013)

The 2006 BBSS also reported high HIV prevalence among certain groups, including truck drivers, male vendors, fishermen, male and female school teachers, male and female police officers, female border traders, MSM, and FSW, which has been correlated to high prevalence of high risk sexual behaviours[7]among these populations These behaviours include multiple concurrent partnerships, coupled with low condom use at high risk sex. These populations therefore have to be prioritized in prevention strategies.

Estimates from the Modes of Transmission (MoT) model of 2013 indicate various subgroups with high incidence rates of infection, especially among MSM, FSW, FSW clients and partners of FSW clients, in whom incidence is estimated at 10.4%, 2.0%, 1.3% and 1.2% respectively. This is compared to the average of 0.65%, estimated for the total 15–49-year-old population, indicating that in these population subgroups, the epidemic is yet to slow down[8]. While the general '*stable heterosexual relationships*' population contributes the majority of new infections because of their population size, there are clear populations which ought to be targeted on account of their contribution to new infections relative to their population size. This therefore calls for an urgent need for population focused prevention strategies.

[7]National AIDS Commission. Biological and Behavioural Surveillance Survey 2006 & Comparative Analysis of 2004 BSS and 2006 BSS.

[8]Joint United Nations Program on HIV/AIDS (UNAIDS) Malawi and National AIDS Commission Malawi. Modes of Transmission Analysis and HIV prevention Response. Distribution of new infections in Malawi 2013 and Recommendations for prevention strategies. 2014.

The 2009–2013 Prevention Strategy called for the integration of programmes addressing discordance and concurrency with other prevention programmes, especially HIV Testing and Counselling (HTC) for both partners. It also promoted the integration of Behaviour Change Communication (BCC) messages and referrals within counselling services. The Strategy further supported the implementation of programmes targeting couples in all age groups with the aim of reducing multiple and concurrent sexual partners among adults. This prevention strategy and its supporting strategies addressed the modes of transmission of the epidemic through a number of behavioural and biomedical interventions, including: HTC, Prevention of Mother to Child Transmission (PMTCT), Sexually Transmitted Infections (STI) management, blood and injection safety, Voluntary Medical Male Circumcision (VMMC), timely initiation of Antiretroviral Therapy (ART), condom programming, community mobilization, Life Skills Education (LSE) and HIV communication. Furthermore the prevention strategy sought to address the structural and cultural factors that increase vulnerability. The strategy was premised on application of evidence based interventions to achieve set targets and goals to reduce sexual transmission of HIV among key groups – young people, Sex Workers (SW), MSM, and prevention programmes targeting prevention of new HIV infections among children and keeping mothers alive, STI prevention among people living with HIV and VMMC to reduce risk of HIV among men.

As stated above, there has been a dramatic reduction in the number of new infections over the period 2009-2013; from 23,000 to 7,400 among people aged 14 years and below and from 41,000 to 27,000 for those between 15 and 49 years. However as noted in the previous section, that decline is slowing down (Figure 1) and Table 1 highlights some of the key gaps in the 2009 – 2013 Prevention Strategy.

Table 1. Summary gap analysis for the 2009-2013 Prevention Strategy

INTERVENTION	CURRENT STATUS	GAPS
HTC	• 31.3 % of men know their HIV status in the past year [DHS 2010][9]	• Identification of new testers • Couple testing and counselling to identify serodiscordant couples • Re-testing of high risk individuals • Identification and linkages to care • Supply chain management to prevent stock outs
Biomedical interventions		

[9]Data for women not captured in the MDHS 2010

Condom promotion and distribution	• 25% consistent condom use among men 15-49 years with partner of discordant or unknown HIV serostatus in the past 12 months [MDHS 2010] • 27% consistent condom use among women 15-49 years with partner of discordant or unknown HIV serostatus in the past 12 months [DHS 2010] • 76% of consistent condom use among MARP (FSW in BBBS 2006)	• 71 % and 75% of women and men respectively, aged 15-49 years reporting non use of condoms with partners of unknown status • 8% of FSW reporting no use of condoms • Lack of programme synergies between private and public sector programming (siloed approaches) • Total market approach missing from public sector response • Weak coordination of supply chain and logistics management systems between private and public sector response
VMMC	• 45,441 VMMC [GARPR[10] 2013] performed against a target of 875,000	• Very low (11.5%) coverage of VMMC nationally • Capacity challenge of health system to absorb increased VMMC demand
Elimination of Mother to Child HIV Transmission (EMTCT)	• 63,000 HIV positive pregnant women annually • 60 % of HIV-positive pregnant women receiving ART [HIV UNIT Q4 2013 REPORT] • 5,600 new HIV infections among children [UNAIDS, 05/2014] • 70% skilled birth attendance [MDHS 2010]	• 30 % of Positive ANC attendees not receiving PMTCT • Poor retention on ART, 71% at 24 months • 50 % of newborns not tested for HIV
ART coverage	• 84% National ART coverage among adults (CD4 < 350 cells/ml^3)[HIV UNIT Q4] • 48% National ART coverage among children (0-14) [HIV UNIT Q4, 2013].	• HIV testing and linkage to care and treatment weak • High number of persons in need of ART • Low coverage for ART for children compared to adults. • Lower uptake for males compared to women • Low pediatric testing compared to adult testing
STI Treatment	• 41% treated according to	• Unknown status of STI treatment for

[10]GARPR = Global AIDS Response Progress Reporting.

	national guidelines [GARPR 2013]	PLHIV and key populations • 59% with STI improperly treated
Behavioural Change Interventions		
Behavioural change programmes	• 40% of men 15-24 years report having 2 more partners and not using condom at last sexual intercourse [MDHS 2010] • 31.4% of women aged 15-24 years report having 2 more partners and not using condom at last sexual intercourse [MDHS 2010]	• Lack of targeted behavioural interventions • Low coverage of behavioural interventions • Inadequately addressed structural barriers to behaviour change • Lack of cost effective analysis of Behavioural Change Communication Interventions (BCCI) and related programmes
Structural Interventions		
Health facility HIV interventions	• 93% of the units of donated blood are screened for HIV, hepatitis B and syphilis (MBTS, Q1 2014)	• 7% of blood still not fully screened
Social protection for orphans and vulnerable children	• 90,000 poor Orphans and other Vulnerable Children (OVC) households covered with interventions [NAC Partner Annual Report 2011 – 12]	• Lack of clearly defined programs and interventions • Lack of coordination of interventions for social protection
Building the resilience of women and girls	• 52.8% of girls enrolled in secondary school (2009)	• Lack of roll out of local best practices to inform programmes. • Guidelines not adequately disseminated • Low enrolment and retention for girls
Targeted interventions for key populations		
Female sex workers (FSW) Men who have sex with Men (MSM) Injecting Drug users	• Coverage of services for key populations programs data not available at national level.	• Limited reliable data on MSM, FSW and other key populations • Low coverage of comprehensive interventions for key population • No legal framework for programming for MSM, current laws still prohibit MSM and FSW.

Full details of progress and achievements of the 2009 -2013 prevention strategy are available in a separate gap analysis document.[11]

[11]National AIDS Commission 2009 -2013 HIV Prevention Strategy Gap Analysis, 2014.

3. IMPACTS AND OUTCOMES OF THE 2015-2020HIV PREVENTION STRATEGY

The 2015-2020 HIV Prevention Strategy adopts the combination prevention thinking that infuses biomedical, behaviouraland structural interventions. The goals, strategic objectives and guiding principles of the 2015-2020 HIV Prevention Strategy build on the following paradigm shifts:

- From interventions focus to populations focus.
- From separate biomedical and non-biomedical interventions focus to combination prevention.
- From largely health sector driven to shared responsibilities.
- From national programming to sub-national programming.

Recognizing that different populations within Malawi have specific HIV prevention needs, and that resources are limited, this Strategy focuses on priority populations with specific and targeted interventions needed to reduce HIV infections among those groups. These priority populations include:

- Key Populations (KP) – MSM and FSW
- Young women, ages 10 -14 years and 15 – 24 years
- Couples (married, cohabitating and/or discordant)
- PLHIV, including Young People Living with HIV (YPLHIV)

This Strategy includes standard packages of interventions for each priority population which are described in Chapter 4 and Annex 1.

Combination prevention is a term used to describe a mix of behavioural, structural and biomedical interventions targeting specific populations based on their needs to optimally mitigate the acquisition or transmission of HIV. These evidence-informed and human rights-based interventions work together to achieve prevention and care outcomes.[12]Often in the past, biomedical and non-biomedical interventions were operating in silos, with little integration between the two. The new Strategy recognizes the importance of making linkages between biomedical and non-biomedical interventions, in order to create demand for services and build health-seeking and maintenance behaviors. Examples of the interventions mix are provided in Chapter 4 and Annex 1.

Biomedical interventions include male circumcision, condoms, STI treatment, and use of ARVs for "treatment as prevention" and pre- and post-exposure prophylaxis (PrEP and PEP).

Behavioural interventions include changing risk perceptions, the need for uptake and adherence to services, addressing multiple partnerships and changing social norms.

[12]Catherine A. Hankins and Barbara O. de Zalduondo AIDS 2010, 24 (suppl 4):S70–S80). Combination prevention: a deeper understanding of effective HIV prevention Core biomedical prevention interventions include condoms, VMMC, PMTCT/ART.

Structural interventions for HIV prevention include changing laws, increasing economic opportunities (social cash transfer, skills training), micro-finance, reduction of stigma, discrimination and violence, safeguarding human rights through promoting gender equity and equality, removing barriers to HIV-associated services.

Health sector driven to shared responsibilities includes leveraging political leadership and social investments, and instituting legal and structural reforms, making HIV prevention everyone's business.

The shift from national programming to sub-national programming reflects the shift to focusing on geographical differences in HIV prevalence, and the Strategy provides guidance on implementation for high, medium and low incidence clusters. Extrapolating incidence from HIV prevalence and concentration of PLHIV, the country has been divided into high, medium and low incidence clusters and program mixes suggested for various levels of implementation and for various populations (Annex 1). The high incidence clusters approximately correspond to South west and South east zones, while medium incidence clusters are Central west and Central east zones, with the low incidence cluster being the Northern zone. The expectation is not to prescribe but to guide local planners at zonal and district levels on appropriate mix of interventions based on the local epidemiology and trends. For example, what may start as a high incidence cluster may transition to a medium or low incidence cluster and the scope and program mix will have to be revised accordingly.

GUIDING PRINCIPLES

The success of the implementation of the National HIV Prevention Strategy will depend on incorporating the following guiding principles:

- Development of synergies and integration with other health sector programmes and other social and economic sector responses;
- Demand creation with active participation of community, cultural and religious leadership and strong government and political commitment;
- Human rights through promoting gender equality, and improving the legal, policy and social environment for PLHIV, key and vulnerable populations and women;
- Focus on key and vulnerable populations to alleviate increased vulnerability and low uptake of HIV services arising from high risk sexual behaviour, marginalization and/or criminalization.
- Applying an investment approach to maximize the benefits of HIV interventions and support more rational resource allocation based on the country epidemiology and context by prioritizing the most cost-effective programmatic activities.

- **Critical enablers**, which include social[13]community and programmatic enablers[14] which support design, access, uptake and expansion of basic programmes.
- **Results based management** approach to select effective interventions that have the likelihood to contribute to the specific and measurable results.

In recognition of the disparities of the HIV epidemic, the Strategy proposes that high impact, evidence-based interventions are sustained and targeted towards districts and different population needs. It emphasizes the need for efficient delivery of combination prevention packages, synergistic integration of biomedical, behavioural, and structural interventions and sustainable investments in HIV prevention research to sharply reduce the annual number of new HIV infections by 70% by 2020.

EXPECTED IMPACT OF THE 2015 – 2020 PREVENTION STRATEGY

The expected overall impact of the 2015 -2020 Prevention Strategy will be that new HIV infections in Malawi will have been reduced by 70%[15] by 2020.

OUTCOMES OF THE 2015-2020 PREVENTION STRATEGY

1. REDUCED NEW HIV INFECTIONS

- Reduced sexual transmission of HIV
- Reduced new HIV infections in adults and children

2. REDUCED STIGMA AND DISCRIMINATION

- Improved social and legal protection for persons living with HIV and AIDS and KPs
- Increased promotion and protection of the rights of women, girls and sexual minorities in the context of HIV

The prevention strategy's impact goals and medium and short term outcome objectives support the NSP's prevention-related objectives and interventions. In Sections 4 and 5 of this prevention strategy, the expected impacts and outcomes are described in detail, noting which NSP

[13]Social enablers support PLHIV or other populations vulnerable to infection by creating a favorable social and legal environment for access to services and that enable them to protect themselves. These include: community mobilization, stigma and discrimination reduction, countering harmful gender norms and practices, women's empowerment and violence prevention, protective HIV legal frameworks, law reform, legal services, human rights and legal literacy, and protection of women's property and inheritance rights.

[14]Program enablers enable implementation and effectiveness of and demand for basic programmes and interventions. These include strengthened programme management, capacity-building and monitoring of service provision for community-based organizations and other service providers; training of health care workers on non-discrimination, informed consent and confidentiality; treatment literacy; treatment adherence support; and linking of HIV, sexual and reproductive rights.

[15]From the baseline of 58,000 new annual infections established in 2010.

objectives and interventions the respective impacts and outcomes support. The NSP's relevant objectives and interventions are as follows:

NSP Objective 1: 90% of PLHIV Know Their Status

- Routine Testing For HIV
- Targeted Outreach Testing for Key and Vulnerable Populations
- Self-Testing
- Pediatric Testing
- Confirmatory Testing

NSP Objective 2: 90% of Known HIV-Positives are Initiated on ART

- Improve Linkages between HIV Testing to ART
- Eliminate diagnostic hurdles for early ART
- Continue ART Scale-Up
- Prevent Mother-To-Child Transmission of HIV
- Pediatric ART

NSP Objective 3: 90% of Patients on ART are Retained In Care

- Public Education
- Opportunistic Infections
- Address HIV/TB Co-Infection
- Facility-Based Adherence Support
- Community-Based Care and Support
- HIV-Exposed Infant Care and Follow Up
- Community-Based Activities
- Nutrition
- Social and Economic Protection for Orphans and Vulnerable Children

- Additional HIV Prevention Interventions
  - Voluntary Medical Male Circumcision
  - Blood Safety
  - Treat Sexually Transmitted Infections
  - Male and Female Condoms
- Stigma, Discrimination and Patient Rights
  - Creating and maintaining an Enabling Legal and Health Services Environment
  - Gender

4. POPULATIONS, CLUSTERS AND PACKAGES

This section offers a comprehensive review of the priority population groups that have been identified within the Prevention Strategy, and highlights their specific needs, in terms of the drivers of the epidemic, the barriers that put them at risk of infection, as well as the proposed combination prevention packages for each. The goal is to reduce risky sexual behaviours and increase uptake of services by targeting specific populations that are most at risk.

The section also details how the paradigm shift, from intervention focus to population focus, and from national to geographical prioritization, impacts the priority populations.

4.1 KEY POPULATION GROUP 1: MEN HAVING SEX WITH MEN

Prevalence and geographic considerations

In Malawi, MSM are a criminalized and underground population due to the political, cultural and legal environment, which makes being seen with a partner of the same sex a challenge and a crime. Across Malawi, 6-24% of the persons identified as homosexual are married/cohabitating or in a sexual relationship with women, and trying to keep their sexual orientation a secret. Most recent data estimate HIV prevalence among MSM ranging from a low of 5.4% in Mzuzu city, to a high of 24.9% in Mulanje;[16,17].This finding is in line with Beyer et al. (2009) previous findings: 21.4% HIV prevalence among all age groups; 15.2% HIV prevalence, men aged 18-23 years; 21.6% HIV prevalence, men aged 24-29 years; 35.3% HIV prevalence, men aged >=30 years and 4.7% know status[18]
Importantly, the data emphasizes that MSM are a key population with higher HIV prevalence as compared to the general population.

Although MSM appear to be concentrated in urban centres, this may well be due to research bias (all available MSM research in Malawi has focused on urban centres). Sexual orientation is not associated with particular geography, and MSM are likely to be geographically spread throughout Malawi.. Therefore, any considerations relating to geographic targeting of MSM interventions should tak into consideration both the national HIV prevalence data and data specific to MSM.

[16]Wirtz AL et al. Journal of the International AIDS Society 2013, 16(Suppl 3):18742
[17] Wirtz, AL et al. HIV Prevalence and Social behavioural Characteristics Among Men Who Have Sex with Men Across Seven Sites in Malawi, 2014. Final Report to UN Joint Team on HIV/AIDS in Malawi through UNDP. Johns Hopkins University and the Center for Development of People.
[18] Beyrer, et al. Sexual concurrency and bisexual practices among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. Abstract W-172, CROI, 2009

Drivers

Structural factors, such as stigma, discrimination and violence based on sexual orientation and gender identity and the criminalization of same-sex sexual practices, hinder the availability, access and uptake of HIV prevention, testing and treatment services among gay men and other men who have sex with men.

Prevailing stigma, discrimination and punitive social and legal environments based on sexual orientation and gender identity, often compounded by the limited availability of and access to sexual and reproductive health services for young people, are among the main determinants of high vulnerability to HIV among young gay men.

Critical barriers to address:

Violence: Very high levels of physical, psychological or sexual violence against gay men and other men who have sex with men.

Criminalization, stigma, discrimination and social exclusion: The high levels of stigma and discrimination associated with men who have sex with men, and the criminalization of such behaviors means that these men are often hard to reach as they are not open about their sexual orientation. Criminalization also makes it less likely these men will seek out services.

Poor access to HIV and other health services: According to surveys, gay men and other men who have sex with men often have extremely limited access to HIV prevention commodities, such as condoms, water-based lubricants, HIV education and support for sexual risk reduction.

Inadequate investment: The inadequate financing of HIV services for gay men and other men who have sex with men impedes efforts to reach them with essential services.

Key interventions for positives (Minimum package)[19]

Key biomedical interventions include quarterly screening for STIs, and uptake of ART services and STI vaccinations. To prevent re-infection or infecting partners, key behavioural interventions include risk reduction interventions, such as reduction in partners and consistent use of condoms and lubricants. , Positive health and dignity and gender based violence prevention are also essential. Key structural interventions include support groups (Psycho-social support), enabling legislation and policies, and improved quality of and access to HIV and AIDS services (safe spaces and drop in centers).

Key interventions for negatives (Minimum package)

Key biomedical interventions include Pre-exposure Prophylaxis (including access to HIV self-testing commodities and services, quarterly screening for STIs, promotion of HTC and STI

[19]Detailed information available from: Vanable, P (2012) What HIV-Positive MSM Want from Sexual Risk Reduction Interventions: Findings from a Qualitative Study. *AIDS Behaviour*. April ; 16(3): 554–563.

vaccinations. Key behavioral and structural interventions for negatives include similar risk reduction, psycho-social, legal, and service quality and access interventions as for positives.

4.2 KEY POPULATION GROUP 2: FEMALE SEX WORKERS

Prevalence and geographic considerations

According to the situation analysis of the magnitude of behaviour patterns and drivers of sex work in Malawi[20], there are roughly about 20,000 sex workers in Malawi. Blantyre has the largest population of sex workers followed by Lilongwe and Mzuzu. Sex work is also thriving in tourist destination districts of Mangochi, Salima and Nkhata Bay. Of late an influx of sex workers have been trekking to Mwanza because of the recent construction of the railway line between Malawi and Mozambique. The transit routes along the highways of Malawi have traditionally always been haven for sex workers. Similarly, heavy tobacco and tea farming districts of Kasungu, Mchinji and Thyolo have significantly hosted sex workers especially during the tobacco selling season. A lot of sex work is happening in border districts with cross border sex trade at about 3%. Very high HIV prevalence estimates among sex workers are reported (71%- BBSS).

Drivers

Sex work in Malawi is generally driven by poverty. Poverty basically has its origins in broken families, loss of marriage or loss of parents. Orphanhood has been one major factor forcing girls into sex work. Peer pressure and desire for possessions such as modern smart phones and generally an opulent life style is also said to be forcing most young girls into sex work. To a certain extent, low salaries among many female workers in Malawi have also been faulted as potentiating sex work in the country.

Critical barriers to address

Criminalization of sex work: Although sex work is not illegal in Malawi, aspects of sex work are criminalized, affecting the extent to which sex workers can access services and products. Generally sex work is traditionally, culturally and socially overtly or covertly disapproved of.

External stigma: Sex workers are stigmatized and discriminated against at all levels of social interaction: by police, community and family members, and service providers. Police brutality and service provider hostility/refusal to provide treatment are common, making sex workers less likely to seek out legal protection, as well as prevention and treatment services. Outdated laws on sex work perpetuate stigmatization and victimization. As well, sex workers are often denied health services, or are poorly assisted in such facilities.

Self-stigma: Self-stigma among sex workers means that this population often do not seek out services or ask for help, meaning they suffer abuses and health scares in silence.

[20] Chizimba, R.M. and G.T. Malera. (2011). *Counting the uncatchables: a report of the situation analysis of the magnitude, behavioural patterns, contributing factors, current interventions and impact of sex work in HIV prevention in Malawi.* Lilongwe: Family Planning Association of Malawi and UNFPA.

Key interventions for positives[21] (Minimum Package)

Key biomedical interventions for positives include improved access to male and female condoms, STI and cervical cancer screening, STI vaccinations, and FP, PMTCT and ART uptake. Critical among the behavioural interventions for sex workers are risk reduction interventions such as consistent condom use, life skills, and positive health, dignity and prevention. Structural interventions include promoting human rights, including working with law enforcement to reduce violence; socio-economic empowerment; GBV prevention and psycho social support; nontraditional condom dispensing; and improving quality of services for sex workers.

Key interventions for negatives (Minimum Package)

Key biomedical interventions are the same as above (minus ART), with the addition of improved access to HTC and PEP. Key behavioural interventions are the same as above.

4.3 KEY POPULATION GROUP 3: YOUNG WOMEN AGES 1024 YEARS

HIV Prevalence

Young women between the ages of 10 to 24 years old face major physical, mental, social and economic changes in their development as they are growing into female adults; during this phase, young women become independent and take risks, including experimenting with sex. According to Malawi Youth Data Sheet, two-thirds of the population of Malawi is under age 25 and vulnerable to STIs and HIV[22]. In 2010, young women had a higher HIV prevalence than young men (12.9% vs 8.1%), with the largest disparity being in the 15-19 year old age group (3.7% in young women and 0.4% in young men)[23].

Drivers

Young women are particularly vulnerable to HIV because of their cultural and socioeconomic status; and lack of education and prevention skills[24].This vulnerability predisposes them to contract HIV; female adolescents are up to five times more likely to become infected with HIV as compared to their male counterparts[25]. In Malawi, early sexual debut and marriages, initiation

[21]UNAIDS Guidance Note on HIV and sex work (2012)

[22]Population Reference Bureau's (PRB) **I**nforming **D**ecisionmakers to **A**ct (IDEA) project and the Department of Population at the Ministry of Economic Planning and Development of Malawi. Malawi Youth Data Sheet 2012.

[23] National Statistical Office (NSO) and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010*. Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro

[24]Bankole A, Biddlecom A, Guiella G, Singh S, Zulu E. Sexual behavior, knowledge and information sources of very young adolescents in four sub-Saharan African countries.African Journal of Reproductive Health. 2007 Dec;11(3):28-43

[25]Laga M et al., To stem HIV in Africa, prevent transmission to young women, *AIDS,* 2001, 15(7):931–934; and UNAIDS, *Report on the Global HIV/AIDS Epidemic*, Geneva: UNAIDS, 2000

and marriage systems, intergenerational and transactional sex, multiple partners, and sexual coercion expose young women to HIV. More than half of Malawian women marry while still in their teens, 30% of young women aged 15–19 years had first sexual intercourse before they were 15 years old[26] and 67% of 19 year olds have started child bearing. Psychologically, young women are not always able to weigh the future benefits of consistent condom use against peer pressure and/or immediate pleasure.

Critical barriers to address

Young women's vulnerability: Lack of control over their own sexuality, due to culture, coercion, socioeconomic status, which results in early sex debut and/or having sex against their will.
Poor educational status: 19% of girls drop out in secondary school due to lack of fees[27]which make them vulnerable to early marriage, childbearing and HIV.

Lack of comprehensive knowledge about HIV: Young women are less likely than young men to have an accurate, comprehensive understanding of HIV. Only 32% of young women cite condom use as an effective prevention strategy compared to over 42% of young men[28].

Lack of knowledge and communication around sex: Adults in the community, health workers and teachers feel uncomfortable to discuss sex and STI issues with young people[29]. Young women lack adequate adolescent sexual and reproductive health (ASRH) information and/or the ability to communicate with peers, potential sex partners and adults on their needs, and often do not realize they are at risk.

Lack of youth friendly services: A substantial proportion of young women do not know where to get SRHR services in Malawi, do not have financial capacity to access services, or are too embarrassed to seek care[30].

Key interventions for positives (Minimum Package)

Key biomedical interventions include HTC, ART, STI screening, HPV screening and family planning for the 15-24 years old. The priority behavioural interventions include life skills education and comprehensive sexuality education, condom use and risk perception training, adherence programme and the "Stop Early Marriages" campaign for all ages. For the 15-24 year old, couple testing and disclosure programme as well as messages around the risk of intergenerational sex should be prioritized. The structural interventions should focus on the reduction of the age of

[26]National Statistical Office (NSO) and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010*. Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro.
[27]Ministry of Education Science and Technology, Department of Education Planning, 2012 EMIS data
[28] National Statistical Office (NSO) and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010*. Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro.

[29]Bankole A, Biddlecom A, Guiella G, Singh S, Zulu E. Sexual behavior, knowledge and information sources of very young adolescents in four sub-Saharan African countries. African Journal of Reproductive Health. 2007 Dec;11(3):28-43.
[30]Biddlecom AE, Munthali A, Singh S, Woog V. Adolescents' views of and preferences for sexual and reproductive health services in Burkina Faso, Ghana, Malawi and Uganda. African Journal of Reproductive Health. 2007 Dec;11(3):99-110.

consent for HTC, "Keep Girls in School" programme, Social Cash Transfer programme, GBV reduction programme, reduction of stigma and discrimination programme at home, in schools and in health facilities.

Key interventions for negatives (Minimum Package)

Key biomedical interventions are the same as above (minus ART), with the addition of improved access to HTC and PEP. Key behavioural and structural interventions are the same as above.

4.4. KEY POPULATION GROUP 4: COUPLES

For the purposes of this strategy, couples are defined as men and women in a sexual relationship, both married and cohabitating. There is a need to focus on men and women who are part of (and consider themselves part of) so-called "stable relationships", due to the prevalence of extra marital relationships. According to The *Modes of Transmission*[31] Analysis conducted by NAC, UNAIDS and Futures Institute for Malawi 67.2% of new HIV infections are estimated to occur in low risk heterosexual relationships - among married or cohabiting partners with one sexual partner per year. Both men and women have sexual relations with partners other than their main partner (concurrent sexual partnerships) – such partnerships put these individuals in sexual networks that connect large numbers of individuals and put everyone, especially women, at risk. These additional partners are not necessarily in the SW and MSM groups.

Men and women who do not live in the same house with their partner (i.e. those with a partner in the fishing, tea estate, prison, and border populations, and those in long term, unmarried relationships - "*chibwenzi*") are also at risk, in some cases from FSW and MSM groups, as well as from multiple and/or concurrent sexual partnerships. (These couples require specific interventions that are detailed in Annex 1.)

Prevalence and geographic considerations

HIV prevalence is higher for cohabitating couples living in the southern region than those living in the central and northern regions. While issues of concurrency are spread throughout Malawi, geographic targeting of interventions should be based on national HIV prevalence data.

Drivers

The drivers of HIV infection among cohabitating and married couples include alcohol use, peer pressure and cultural norms, dissatisfaction in main relationship, economic needs, separation of partners due to job mobility, and unsafe sex with partners other than the main partner.

[31] Joint United Nations Program on HIV/AIDS (UNAIDS) Malawi and National AIDS Commission Malawi. Modes of Transmission Analysis and HIV prevention Response. Distribution of new infections in Malawi 2013 and Recommendations for prevention strategies. 2014

Critical barriers to address

Couple communication – a lack of couple communication is often cited as a reason for seeking sex outside the main partnership, as well as boredom or dissatisfaction with the main partner. Partners often do not discuss issues around sex and intimacy with each other.

Gender inequality – it is essential to strengthen the focus on gender norms that put women at risk, and which impact service utilization – particularly by women, and support couples to reduce risk together.

Consistent condom use - Demand generation needs to be complemented by consistent condom access and use, and strong linkages/referrals to services.

Reduction of partners – a critical piece of risk reduction is the reduction of partners. Couple communication is a crucial entry point since communication about one's own sexual desires and needs, and testing together can take steps to reduce risk of infection (or re-infection) among couples.

Key interventions for positives (Minimum package)

Key interventions for positives are intended to prevent secondary and vertical transmission, and include: couple HIV testing and counseling (CHTC), ART, PMTCT and FP services (uptake and adherence). Social and Behavioural Change Communication interventions include Positive Health and Dignity and Prevention services, partner reduction and partner prevention including condom use, and couple communication including disclosure. Linkages to support groups, life skills, mental health, nutrition and STI screening and treatment are also essential. Structurally, human rights protection and PLHIV involvement and support are needed.

Key interventions for negatives (Minimum package)

Key interventions for negatives are intended to help them stay negative, and include: CHTC services, and risk reduction including condom use, partner reduction and VMMC, as well as couple communication. Structurally, there is a need to reduce harmful cultural practices that put women and men at risk of HIV infection.

OTHER PRIORITY POPULATIONS

On top of these afore-discussed key populations, this Prevention Strategy (in Annex 1) also presents and discusses other priority populations with focus on the minimum packages.

5. IMPACT AREA 1. REDUCED TRANSMISSION OF HIV

The interventions selected under each impact area are guided by the prevention packages in Chapter 4 and Annex 1. Each outcome is supported by specific social and behavioural communication interventions and structural interventions - changing laws, increasing economic opportunities (social cash transfer, skills training) or foregoing social norms (community participation / social behavioural change interventions). Under the impact area of *Reduced transmission of HIV*, there are two medium term outcomes: *Reduced sexual transmission of HIV* and *Reduction in new HIV infections in adults and children* (Figure 3).

During the 2015-2020 period Malawi aims to reduce the number of annual new infections in adults 15-49 years to 17,000 in 2020 from a baseline of 58,000 in 2010 (a 70% reduction). Similarly, efforts will be made to reduce the number of children infected by their mothers to 3,900 annually by 2020. This will be done firstly by making the most strategic investments and secondly, by making prevention of HIV infection the cornerstone of the response to the epidemic. In order to reach these outcomes, robust behavioural and structural interventions will be implemented targeting relevant populations to varying degrees dependent on the epidemiology of the area.

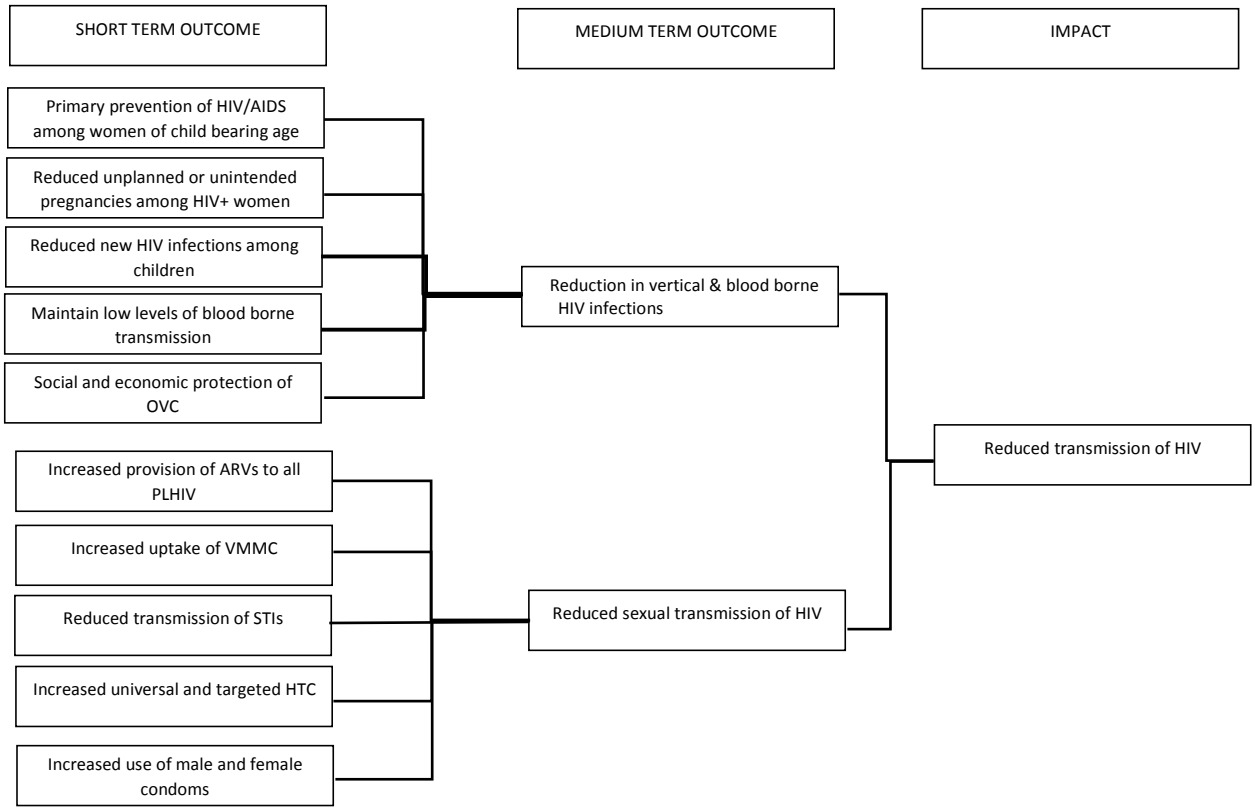


Figure 3: Results Matrix: Reduced transmission of HIV

5.1 MEDIUM TERM OUTCOME 1: REDUCED SEXUAL TRANSMISSION OF HIV

Sexual intercourse is the major route of transmission of HIV in Malawi. The effect of sexual transmission likely lies in context specific factors confounding host and agent alike. These include stage of the disease, associated viral load and other biological factors,[32,33] as well as the socio-economic and policy context.[34,35] Research shows that the key initial drivers of the sexual transmission were a synergistic relationship between multiple and concurrent sexual practices, coupled with individual-level biological factors, namely STIs (in particular, genital ulcer disease,

[32] Baggaley RF, Fraser C: Modelling sexual transmission of HIV: testing the assumptions, validating the predictions. Curr Opin HIV AIDS 2010, 5:269-276.

[33] Miller WC: Role of acute and early HIV infection in the sexual transmission of HIV. Current Opinion in HIV & AIDS 2010, 5:277-282. 27. Robinson NJ, Mulder DW, Auvert B, Hayes RJ: Modelling the impact of alternative HIV intervention strategies in rural Uganda. AIDS 1995, 9:1263-1270

[34] Chigwedere P, Seage GR, Gruskin S, Lee TH, Essex M: Estimating the lost benefits of antiretroviral drug use in South Africa. J Acquir Immune Defic Syndr 2008, 49(4):410-415.

[35] Parkhurst JO: Understanding the correlations between wealth, poverty and human immunodeficiency virus infection in African countries. Bull World Health Organ 2010, 88:481-560.

syphilis and Herpes Simplex Virus-2 (HSV2), and lack of male circumcision.[36,37]These factors also help explain the differences in rate of HIV spread across the country.

5.1.1. Increased universal and targeted HIV Testing and Counselling.

This short term outcome maps to the NSP's "Objective 1: 90% of PLHIV Know Their Status".

People reach HIV treatment, care, and the full range of prevention options through the gateway of HTC. Currently, most PLHIV do not know that they are infected; those who do know often test late; and poor linkages from HTC to care mean that many people start ART when they are significantly immune-compromised, resulting in poor health outcomes and ongoing transmission. At the same time, HTC requires successful linkages to HIV care and treatment for those who test positive. Similarly, those who test negative need to be linked with appropriate information and services to support their staying negative.

During the period 2015-2020 HTC for prevention will have two focuses:1) identifying those that are infected so that they can be put on treatment as early as possible to reduce their probability of transmitting HIV, and 2) helping those who test negative, stay negative. This shift in focus will emphasize opt-out Provider Initiated Testing and Counselling[38] (PITC) through high yield health services settings (e.g., antenatal, maternity, in- and out-patient clinics, linkage with Expanded Programme on Immunization (EPI)). This will be complemented by scaling up targeted community-based HTC amongst key populations (MSM and FSW) and those that have been identified as vulnerable groups, which include prisoners, long distance truck drivers, cross border traders, uniformed services, fishing communities, taxi drivers, and young women aged 15 to 24 years. The focus will be to minimize lost opportunities at every service encounter to increase the number of people on treatment while reinforcing primary prevention, and thus stem transmission. Additionally, a new cadre of service providers, HTC counsellors, whose sole purpose will be to provide HTC in health facilities (static and mobile) as opposed to relying on the heavily overburdened Health Surveillance Assistants (HSAs), will be created to minimize missed opportunities. A total of 3000 "HIV Diagnostic Assistants" will be certified to provide this service across the country. Key activities will include:

[36] Sousa JD, Muller V, Lemey P, Vandamme AM: High GUD incidence in the early 20th century created a particularly permissive time window for the origin and initial spread of epidemic HIV strains. PLoS ONE 2010, 5:e9936.
[37] Sobngwi-Tambekou J, Taljaard D, Lissouba P, Zarca K, Puren A, Lagarde E, Auvert B: Effect of HSV-2 serostatus on acquisition of HIV by young men: results of a longitudinal study in Orange Farm, South Africa. J Infect Dis 2009, 199:958-964.
[38] With PITC we expect to reach annually at least 1.4 million at ANC and maternity, 700,000 children through one year clinics, and 120,000 though prisons, on top of those reached through routine OPD.

- Strengthening the capacity of HTC providers and sites through use of community health workers, lay counsellors and even “expert patients”.
- Conducting operational research to examine the volume of clients that a given cadre of staff is able to see, the accuracy of results given and client satisfaction.
- Continued promotion of self-testing using oral swabs and oral fluid test kits will be explored as a model to increase knowledge of HIV status and testing, especially with key populations.
- Integrating HIV testing into the care of patients presenting with conditions such as tuberculosis (TB) and in ANC facilities has been successful and this will continue, with the introduction of expanded PITC (opt-out testing for all clinic and hospital patients).
- Improving the quality of HTC services through external quality assurance of the testing, appropriate supplies and sufficient human resources, supporting HCW through ongoing mentoring and supervision and, as necessary, refresher training.
- Continuing with the community based HTC models–mobile services and outreach services – shifting focus away from the general population to key and vulnerable populations.
- HTC campaigns - Two major and two minor campaigns will be carried out over the five years. These deliberate campaigns will aim at strengthening political will and buy-in from traditional /religious/opinion leaders. Sensitization meetings with traditional/religious/opinion leaders will be done for these leaders to become champions for the messaging of HTC amongst their constituents. Additionally, five Community Based Organizations (CBO) clusters (including youth organizations) per level will be trained to ensure further advocacy for HTC.
- Implementing a standard package of Couple HIV Testing and Counselling (CHTC) as an entry point for focused prevention work with PLHIV, sero-discordant couples, and cohabiting couples.
- Creating demand for HTC among MSM and FSW - A human rights approach will be promoted, including advocacy to policy makers for an enabling legal environment..
- Mobile and outreach HTC targeting districts and areas with higher numbers of key and vulnerable populations in need of services.

Key outcomes expected include:

Result	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2013	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020
Increased universal and targeted HIV testing and counselling	% of expected new infection identified and linked to care and treatment per annum	80%	40%	50%	60%	70%	80%
	Number of HIV tests per year	1 702 627	2 615 238	2 641 390	3 512 719	4 022 835	4 428 512
	Number of targeted tests for high risk populations (FSW, MSM)	N/A	26 123	25 971	33 484	37 043	39 566

5.1.2 Increased provision of ART to all PLHIV

This outcome supports the NSP's "Objective 2: 90% of Known HIV-Positives are initiated on ART" and "Objective 3: 90% of Patients on ART Are Retained In Care."

Malawi has pioneered the public health approach to ART delivery[39]which involves decentralization of ART delivery to primary health care clinics, task-shifting from clinical officers and doctors to nurses and counsellors, and a reporting system based on collection of facility-level aggregate statistics that allow clear analysis of trends in HIV testing data, uptake of ART and outcomes of ART initiators.[40] By 2013, approximately 442,931 (48%) HIV-infected Malawians had initiated ART.[41]Although the rapid scaling up of ART has been impressive, there are increasing concerns about the effect that an ever-expanding number of patients requiring life-long clinical management will have on staff workload and ART clinic sustainability.

In the period 2015-2020 treatment will be scaled up from the current universal treatment for pregnant and lactating mothers and under five year old children and those with CD4 count below 500 to test and universal treatment from 2016. This approach is envisaged to achieve the most impact on averting new infections in the short term and will be in line with the ambitious 90-90-

[39]World Health Organization: Antiretroviral therapy for HIV infection in adults and adolescents: recommendations for a public health approach. Geneva, Switzerland: World Health Organization; 2010.
[40] Harries AD, Makombe SD, Libamba E, Schouten EJ: Why did the scale-up of hiv treatment work?: a case example from Malawi. J Acquir Immune Defic Syndr 2011, 57(Suppl 2):S64–67.
[41] 2013 MOH Programme Report

90[42] treatment targets that have been advanced as a way to end the HIV epidemic. However, it will have to be combined with ongoing social and behavior change interventions and messaging to ensure adherence.

The proposed scaling up of access to ARVs will require significant strengthening of the health system by among others addressing key weaknesses, such as the demoralization and flight of health care workers from the public sector, inequities in access to facilities, drugs and other forms of infrastructure, and poor relations between users, communities and the health system. Interventions that will be implemented relate to integration, human resource, supervision, IEC and adherence

The implementation of the above interventions will achieve the following results:

Result	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2013	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020
Increased provision of ARVs to all PLHIV eligible for ART receive it	Total number alive and on ART	442,931 (48%)	668,027 (63%)	722,912 (69%)	776,743 (74%)	815,385 (78%)	840,776 (81%)
Scale up availability of high quality ART services for adults and children	Number of HIV+ children age 14 and under were alive on ART treatment	40 019	61 141	67 244	73 182	77 757	79 114
	Number of HIV+ adults age 15+ were alive on ART treatment	402 912	606 886	655 668	703 561	737 629	761 662
Increased retention on treatment at 12 months after initiation of ART	Percentage of Adult ART patients retained on treatment at 12 months after initiation of ART	78%	80.0%	81%	82.0%	83.0%	84.0%
	Percentage of ART patients retained on treatment at 24 months after initiation of ART	75%	77%	78%	79%	80%	81%
Viral load suppression	Proportion of HIV+ population that is	41%	52%	57%	63%	65%	68%

[42]UNAIDS. Reference Discussion Paper. Ambitious Treatment Targets. Writing the Final Chapter of the AIDS Epidemic

among PLHIV	virally suppressed						

5.1.3 Increased uptake of Voluntary Male Medical Circumcision (VMMC) services

This strategy outcome maps to the NSP's "Voluntary Medical Male Circumcision" intervention under "Additional HIV Prevention Interventions."

The National VMMC program was formally launched in 2012 and the National Policy on VMMC, VMMC Standard Operating Procedures for Service Providers and the VMMC Communication Strategy elevated male circumcision as a core intervention in the previous HIV prevention strategy. However, VMMC remains low at 11.5% and is hampered by both religious and cultural beliefs acting as barriers to the uptake of this intervention. There is also limited capacity of the health systems in terms of infrastructure and human resources. To reach the desired VMMC prevalence of 80% among men aged 10-34 years, an estimated 2,101,566 circumcisions need to be undertaken in the whole country, with 1,888,847 in the priority districts.[43] However, by the end of September 2014, a total of 150,000 male circumcisions have been performed. During the 2015-2020 period a more aggressive approach will be used to achieve at least 60% coverage of male circumcision across the country..

Key activities will include Leadership and Advocacy, scaling up implementation and communication. Between 2015 to 2020, the VMMC communication plan will be scaled up from the current 10 districts to the remaining 18 districts. Furthermore targeted demand creation campaigns focusing on the age group 10 – 39 years will be conducted prioritizing (i) Advocacy with traditional and religious leaders to build political will for VMMC; (ii) Social Behaviour Change Communication (SBCC) such as Theatre For Development (TFD), radio spots, and other multi-media for increased understanding by the general public on the procedure and its benefits to elicit motivation for the uptake of VMMC; and (iii) Targeted social mobilization (mainly through campaigns) for increased uptake of the service by these male groups.

The results that will be achieved include:

Result	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2013	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020
Increased uptake of male circumcision	Percentage (number) of males aged 10-49 circumcised in targeted	18% (67 952)	32%	39%	46%	53%	60%

[43]Malawi is working to achieve scale up to 80% coverage of male circumcision among HIV-negative males aged 10-34 years. The determination of targets for each district was informed by the VMMC modelling that showed circumcising 80% of males aged 10-34 year olds would result to a huge impact of preventing 128,819 new HIV infections by 2050. The priority geographical areas thus include all districts in South Eastern and South Western Zones, Ntcheu, Dedza and Lilongwe districts.

services	districts						

5.1.4 Reduced Transmission of Sexually Transmitted Diseases

This outcome supports the NSP's "Treat Sexually Transmitted Infections" intervention under "Additional HIV Prevention Interventions."

Despite the well-documented biological pathways by which sexually transmitted infections (STIs) facilitate HIV transmission, efforts to link STI treatment to improved biological outcomes for HIV prevention at the population level have yielded limited results. STI services remain, however, a recommended component of a comprehensive HIV prevention package with core recommendations that these services focus on key populations and other vulnerable groups with high STI prevalence, people who present with symptomatic STIs, and sexually active adolescents and HIV-positive persons.

In line with the 2015-2020 NSP, the HIV Prevention Strategy will focus STI prevention and treatment efforts for key and vulnerable populations including FSWs, MSM, sexually active adolescents and youth, and mobile populations, rather than for the general population. The goal of the targeted interventions is to expand the numbers of higher risk individuals who receive high-quality STI management services. These activities will be supported by strengthening health systems through infrastructure support and human resources. The following interventions will therefore be implemented:

- Strengthen capacity of health facilities to provide STI services through:
  - Revision of the national STI guidelines, with an emphasis on ensuring alignment with global recommendations for STI screening and treatment in resource-limited settings and to include issues affecting key populations; revision of the training curricula and training of all relevant providers in the updates.
  - Addition of STI service supervision as a component of the quarterly supportive site supervision visits to all facilities.
  - Creation of referral networks of pre-identified healthcare providers for key populations in hot spot areas, with providers trained in syndromic management approaches, appropriate clinical skills and attitudes for working with key populations
- Targeted interventions for key populations (MSM and FSW) and other vulnerable groups, such as sexually active adolescents, or other sub-populations with high STI prevalence, high rates of partner change or both, and who do not access available STI management services. Specifically interventions will include: peer-to-peer education on STI screening, diagnostics

and management, and reorientation of existing "safe spaces" to include targeted and appropriate IEC, strengthened referrals between HTC and STI service providers, and (where possible) 'one-stop shopping' for integrated health services including HTC and STI syndromic and etiological management.

- Promote access to STI screening and treatment within Youth Friendly Health Services (YFHS) for youth 10 – 24 years in age. YFHS providers will be trained on handling young people seeking services. The YFHS trainings and SBCC activities will be provided in an integrated manner, i.e. all messaging will reflect and support the complete HIV prevention package – STI, HTC, condoms, including elements for contraception (family planning).

The implementation of these interventions will advance the achievement of the following result.

Result	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2013	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020
Management of STI syndromically	Percentage of STI cases treated according to national guidelines	41%	50%	60%	65%	70%	75%

5.1.5 Increased use of male and female condoms

This outcome maps to the NSP's "Male and Female Condoms" intervention under "Additional HIV Prevention Interventions."

Malawi's condoms per capita is estimated at a low of about 4 condoms / person / year and less than a third of both males (23.5%) and females (27.5%) report using condoms with non-spousal non-regular partners according to the 2010 MDHS. Most importantly, consistent condom use in high risk sexual encounters amongst key populations is low (60.4% of FSW always used a condom when engaging in transactional sex[44] and 52.1% of MSM always/almost always used a condom with casual male or female partners[45]). There remain periodic stock-outs at facility level, myths especially around the female condom, negative community attitudes especially toward unmarried youth accessing condoms – all of which hinder uptake and general programming. As a result, the total market approach (similar to that of social marketing but inclusive of all players) is being proposed for comprehensive condom programming. This will focus on both the supply and

[44] Key Indicators for Female Sex Worker, 2013 Malawi BBSS

[45] AL Wirtz, G Trapence, V Gama, D Kamba, R Chalera, L Klein, R Kumwenda, T Chikoko, M Mangochi, S Baral. *Final report to UN Joint Team on HIV&AIDS in Malawi through UNDP: HIV Prevalence and Sociobehavioral Characteristics among Men Who Have Sex with Across Seven Sites in Malawi.* Johns Hopkins University and the Center for Development of People. 01 December 2014

demand. Messaging for the general public will flow from this approach mainly to demystify male and female condoms, and strengthen distribution of these commodities. A total of approximately 250 million condoms are therefore expected to be delivered using traditional and non traditional platforms targeting all sexually active men and women, most at risk populations, youths and key and priority populations and double the per capita condom availability in country. Additionally as local studies indicate high incidence of dry sex which may facilitate HIV transmission, the current strategy has included distribution of lubricants to both MSM as well as FSWs. These activities will be complemented by scaling up of sexuality education among in and out of school children and pre-adolescents. Key activities therefore will focus on:

- Strengthening capacity of condom providers in comprehensive condom programming (CCP).
- Strengthening BCC on condom use through "Condomise campaigns" (based on UNFPA's comprehensive condom programming model) to consolidate community condom systems, garner political will and buy-in from traditional/religious/opinion leaders.
- Sensitization meetings at Traditional Authority (TA) level (traditional/religious/opinion leaders).
- Capacitating five CBO clusters (including youth organizations) per TA level to ensure further advocacy for male and female condoms.
- Demand creation for promotion of safe sexual behaviours, including HTC and condom promotion for most at risk populations/key populations, and other priority populations.
- Peer-to-peer education on use of lubricants for MSM and FSW.
- Strengthening of comprehensive SRH and HIV prevention into curricula for schools. The focus will be on advocacy for national and community buy-in for the implementation of this curricular while actual implementation is expected to be undertaken/overseen by the Ministry of Education, Science and Technology (MoEST).
- Institute total market approach for comprehensive condom programming for effective and efficient supply chain.

Key results expected from these outputs include:

Result	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2013	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020
Increased use of male and female condoms	% of women and men aged 15-49 who reported using a condom the last time they had high	M - 23.5% F - 27.3%	M - 30% F - 30%	M - 40% F - 40%	M - 50% F - 60%	M - 60% F - 60%	M - 70% F - 70%

	risk sexual intercourse [46]						
Scale up distribution of condoms (male and female)	Number of condoms distributed to Key Populations	38 922	1 000 000	1 000 000	1 000 000	1 000 000	1 000 000
General population reached by comprehensive HIV prevention programs especially condom use (disaggregate by age, sex, workplace)	Percentage of women and men aged 15–49 years with more than one sexual partner in the past 12 months and who report the use of a condom during their last sexual intercourse	25.10%					
		F-27.3%	F: 35%				
		M-24.6%	M: 30.8%				
Key affected population reached by comprehensive HIV prevention programs especially condom use	Percentage MSM with more than one sexual partner in the past 12 months reporting the use of condoms during last sexual intercourse	N/A					
	Percentage Female sex Workers with more than one sexual partner in the past 12 months reporting the use of condoms during last sexual intercourse	91.80%					
General population reached by comprehensive HIV prevention programs especially condom use (disaggregate by age, sex, workplace)	Percentage of population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (disaggregated by age and sex)	M - 95% F - 95%	M - 78% F - 77%	5%	5%	5%	5%

[46]Non-married non-cohabitating partner disaggregated by age and sex

5.2 MEDIUM-TERM OUTCOME 2: PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV

5.2.1 Primary prevention of HIV among women of childbearing age

This outcome maps to the NSP's "Objective 1: 90% of PLHIV Know Their Status", specifically the sections "Routine Testing for HIV" and "Targeted Outreach Testing for Key and Vulnerable Populations", and under "Objective 2: 90% of Known HIV-Positives are Initiated on ART," "Prevent Mother-To-Child Transmission of HIV - PMTCT Prong 1: Reduce HIV Incidence and Prevalence In Women of Childbearing Age."

Although all women have the same rights and similar needs for reproductive health care, women living with HIV require additional care and counselling during their reproductive life cycle. The 2015-2020 prevention strategy requires that the full range of HIV services should be integrated into SRH services. Where services cannot be integrated, explicit mechanisms of referral for HIV treatment, care, prevention and support will be established. Similarly, the HIV specific programs will address the SRH needs of women and encourage two-way referral maps. Ensuring the full integration of HIV-related interventions within SRH services would reduce overlap in service provision and help remove the stigma of stand-alone HIV services. IEC will continue and in some instances be expanded as this is a critical component of all SRH services.

During 2015-2020, Malawi aims to increase the number of pregnant women attending at least one ANC visit by 50,000, i.e. from 631,000 to 680,000. The plan envisages increasing the HIV ascertainment rate amongst pregnant women from 67% in 2013 to 85% by 2020 and increasing the uptake of ART by HIV positive pregnant women from 81% in 2013 to 85% by 2020. Social Behaviour Change Communication efforts will include the minimum package for young women ages 15-24 years; women who are part of a couple (married or cohabitating); and female sex workers as outlined in Chapter 6 and Annex 1. No targeted SBCC interventions will be implemented outside the already existing PMTCT programming. However, emphasis will be placed on reaching discordant couples, couples, sex workers, and young women (including those beyond 24 years).

The main outcome that will be achieved in the 2015-2020 period include:

Results	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2013	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020

Primary prevention of HIV/AIDS among women of childbearing age	HIV prevalence in reproductive age women (15-24 years)	8.2 (2010)		6.3		5.8	

5.2.2. Reduce unplanned or unintended pregnancies among HIV+ women

This outcome maps to the NSP under "Objective 2: 90% of Known HIV-Positives are Initiated on ART," "Prevent Mother-To-Child Transmission of HIV - PMTCT Prong 2: Reduce Unplanned or Unintended Pregnancies among HIV+ Women."

For women living with HIV who do not want to become pregnant or who wish to delay pregnancy, contraception has the added public health benefit of reducing the number of infants who might acquire HIV and, by extension, the number of children who need HIV-related services. During 2015-2020 Malawi will need to produce dramatic increases in the contraceptive prevalence rates (CPR) to eliminate unmet need for Family Planning (FP) among all women.

Reducing unplanned and unintended pregnancies must firstly honour the rights of women living with HIV — and providing FP counselling and services grounded in these rights — must be the cornerstone of the country's efforts. The rights-based services, in turn, will be part of a wider package of comprehensive SRH that includes the clinical management of HIV, the screening and care of STIs, the prevention and mitigation of Gender-Based Violence (GBV) and the eradication of stigma and discrimination. To achieve this, the following actions will be implemented:

- Link SRH and HIV at the policy, systems and service delivery levels.
- Strengthen community engagement.
- Promote greater involvement of men and boys by establishing male support groups within SRH and HIV services that foster opportunities for men and boys to discuss and reflect upon gender norms and inequalities and develop more gender-equitable attitudes and behaviours.
- Ensure non-discriminatory service provision in stigma-free settings.

The following result will be achieved in the 2015-2010 prevention strategy period:

Results	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
Reduce unplanned or unintended	Number of unplanned or unintended pregnancies among HIV+ women	N/A	42 645	41 962	41 213	40 410	39 565

pregnancies among HIV+ women							

5.2.3 Reduced new HIV infections among children

This outcome maps to the NSP's Objective 1: 90% of PLHIV Know Their Status", specifically the sections "Targeted Outreach Testing for Key and Vulnerable Populations" and "Pediatric Testing."

In 2011, Malawi adopted Option B+ as an approach for Elimination of Mother to Child Transmission (EMTCT), where pregnant and lactating women living with HIV are automatically started on ART for life.[47] With the introduction of Option B+ there has been significant progress in reducing the number of babies born with HIV. Option B+ has improved coverage in HTC among pregnant women through PITC in antenatal clinics, labor and delivery centers, and other health-care settings. The "PMTCT cascade" includes, amongst others, women agreeing to HTC, receiving their results, undergoing ART eligibility screening, initiating treatment or prophylaxis, and adhering to the prescribed regimens. Infants must also undergo appropriately timed HIV testing and those who are infected must urgently initiate antiretroviral therapy.[48] Attrition at each point can be thought of as system inefficiency that limits program impact, reduces overall coverage, and leads to more infant HIV infection.

In 2013, an estimated 83% of pregnant women at ANC were tested for HIV, and this will increase to 85% by 2020. The programme data generates immense optimism for the prospects of reducing pediatric HIV from 3.4% in 2013 to 1% by 2020. Despite the gains made, there is need to improve mechanisms for mothers living with HIV and exposed infants to receive the full array of available services. Poor utilization of available services, lack of coordination between providers and high rates of loss to follow-up have led to persistent high infection rates in exposed children. Even with highly efficacious combination antiretroviral interventions, only marginal reductions in childhood HIV infections can be achieved without improved retention of pregnant mothers and infants within the PMTCT cascade of services.

The 2015-2020 prevention strategy will therefore implement the following activities:

[47]Schouten EJ, Jahn A, Midiani D, Makombe SD, Mnthambala A, Chirwa Z, et al. Prevention of mother-to-child transmission of HIV and the health-related Millennium Development Goals: time for a public health approach. Lancet. 2011;378(9787):282_4.
[48] Ciaranello AL, Park JE, Ramirez-Avila L, Freedberg KA, Walensky RP, Leroy V. Early infant HIV-1 diagnosis programs in resource-limited settings: opportunities for improved outcomes and more cost-effective interventions. BMC Med. 2011; 9:59.

- Aggressively ensure that pregnant women present earlier to care, as the majority (91%)[49] of pregnant women in Malawi attends ANC for their first visit at 13 weeks or later. During the 2015-2020 period, Community Health Worker (CHW) efforts will be intensified to prevent women from refusing care and dropping out, for whatever reason.
- By linking mothers to infants, the CHWs will be able to significantly improve DNA PCR testing and entry into care and thereby improve the rate of prompt ART initiation in infected infants.
- CHW case management will improve not only programme implementation but monitoring as well. A strategy that will be investigated is the routine HIV testing of infants at immunization clinics and inpatient facilities as a means for improving PMTCT monitoring. In implementing this strategy , it would minimize any missed opportunity for effective interventions.
- CHTC with enhanced disclosure support may help reduce refusal during pregnancy. Increasing emphasis on family-centered HIV care may encourage partners to attend clinic together, possibly improving communication and retention in care;
- Increasing rates of male involvement in PMTCT. Several strategies, including inviting men through letters or through antenatal cards, provision of a male-friendly environment that ensures privacy, community-based programs, male education and couple counselling, will be implemented;
- Enhancing the capacity of Maternal, Neonatal and Child Health (MNCH) services for the early detection, care and treatment of HIV and syphilis among pregnant women, their partners and infants;
- Strengthening the surveillance of HIV and syphilis in MCH services and health information systems; integrating interventions for managing HIV and STIs with SRH and other relevant services.

SBCC efforts will include the minimum package for children 0-5 years; young women ages 15-24 years; couples (married or cohabitating); and female sex workers as outlined in Chapter 4 and Annex 1.The targets that will be achieved in the period 2015-2020 are as indicated below

Results	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2013	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020
Reduced new HIV infections among children	Percentage of Infants born to HIV-Infected Mothers that are HIV positive at 6 weeks	3.4%	3.7%	2.8%	1.7%	1.1%	1%

[49] MOH Programme data 2013/2014

	Percentage of Infants born to HIV-infected Mothers that are HIV positive end of breastfeeding	13%	10%	8.2%	6.2%	5.1%	5%
	Percentage of infants born to HIV positive women who are alive at 12 months of age and HIV negative (i.e. 12 month Infant HIV-Free Survival)	82%	82%	83%	85%	87%	87%

5.2.4 Improved HIV exposed infant follow up according to national PMTCT guidelines

This outcome in the strategy supports "HIV-Exposed Infant Care and Follow Up" under the NSP's "Objective 3: 90% of Patients on ART are Retained in Care."

According to the recommendations of the World Health Organization (WHO), infants known to have been exposed to HIV require a virological test at 4 to 6 weeks of age. While early treatment is known to dramatically decrease morbidity and mortality from HIV infection, ART coverage of HIV-infected children still remains low. As of 2013, 92% of exposed infants were given nevirapine at birth. However, the ART infant coverage remains very low (18%). From the gap analysis some of the main challenges to the development of effective early infant diagnosis (EID) services were loss to follow up, lack of integration of infant and young child diagnostics into all routine MNCH services and the lack of availability of effective data management and tools. To address the challenges the following will be implemented:

- Collaboration between implementing partners, coordinated by the Ministry of Health.
- Use of an HIV-Exposed Infant Follow-up Card, which will be able to monitor and track the infant to establish the appropriate required clinical interventions, while providing a record for HIV-exposed infants who may test negative at 6 weeks, but then develop clinical symptoms suggestive of HIV infection thus requiring repeat testing at a later visit. The HIV Follow-up Card will track information about ARV prophylaxis, the parent profile, immunization history, laboratory history, and overall nutrition and development.
- Development of a national EID database to aggregate clinical data from the facilities, as well as test results from the laboratories.
- Promotion of routine HIV screening of mother-infant pairs at every point of contact with the health facility,
- Investment in community engagement to improve both identification and retention of mother-infant pairs within HIV care and treatment services. Community enablers such as the Mentor mothers will be strengthened to ensure that they play a key role in PMTCT.

SBCC efforts will include the minimum package for children 0-5 years; young women ages 15-24 years; couples (married or cohabitating); and female sex workers as outlined in Chapter 4 and Annex 1.

The implementation of the above activities is expected to achieve the following results:

Result	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
Improved HIV exposed infant follow up according to national guidelines	Percentage of HIV infected pregnant women who received antiretroviral to reduce the risk of mother to- child transmission in accordance with national protocols	75%	82%	83%	84%	85%	85%
Increased uptake by exposed infants to Nevirapine at birth	Percentage of exposed infants given Nevirapine at birth (includes only women giving birth at facility)	92%	92%	93%	94%	95%	95%
	Percentage of infants born to HIV infected women started on cotrimoxazole prophylaxis within two months of birth	88%	90%	91%	92%	93%	94%
Increased testing of HIV exposed infants	Percentage of infants born to HIV+ women receiving a virological test for HIV within 2 months of birth	40%	50%	55%	60%	65%	70%
	Infant Art coverage (Early infant treatment access)	18%	25%	30%	35%	37%	40%

5.3 MEDIUM-TERM OUTCOME 3: MAINTAIN LOW LEVEL OF BLOOD-BORNE TRANSMISSION

This outcome corresponds to the "Blood Safety" intervention under the NSP's "Additional HIV Prevention Interventions" section.

Malawi has not yet achieved universal (100%) screening of donated blood for HIV infection; mechanisms to ensure quality and continuity in screening are still inadequate, particularly at the lower levels of the health system. So far, 93% of the donated blood in the country is screened for markers of key blood-borne infectious diseases (HIV, Hepatitis B, and Syphilis) in a quality-assured manner. The 2015-2020 prevention strategy plans to ensure 99% of the donated blood in the country is screened for markers of the key infectious diseases (HIV, Hepatitis B and Syphilis) in a quality-assured manner.

Result	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
Maintain low level of blood-borne transmission	Percentage of donated blood units screened for markers of infectious diseases (HIV, Hepatitis B and Syphilis) in a quality-assured manner.	93%	99%	99%	99%	99%	99%
Increased access to post exposure prophylaxis	Number of persons started on post-exposure prophylaxis (PEP)	2,300	2500	2600	2700	2800	2900

5.4 MEDIUM TERM OUTCOME 4: PEOPLE LIVING WITH HIV RECEIVE CARE AND SUPPORT ACCORDING TO NEEDS

Community and home-based care (CHBC) is an integral component of the continuum of care and support. Services provided in Malawi include palliative care, nursing care, counselling and psychosocial support, spiritual support, and nutrition and referral services. Provision of these services is premised on the partnership between government, civil society organizations, support groups of PLHIV and the communities themselves. The nature of CHBC service has evolved overtime given the impacts of ART on patients who were previously bed ridden and are no longer in such status. As a result new services have emerged based on demand such as promoting treatment adherence, addressing issues of stigma and providing social protection, and strengthening capacity of households to initiate and implement sustainable livelihoods.

Support groups of PLHIV have shown to be effective in providing care and support services and in particular in addressing stigma and discrimination through promotion of positive living and human rights education and awareness. Within the context of positive living support groups have focused on addressing dietary and safe health practices that improve quality of life such as, psychological wellbeing, effects of alcohol and smoking and nutrition. Therefore the 2015-2020 prevention strategy seeks to achieve the following sub-objectives:

5.4.1 Nutritional support

This outcome maps to the NSP's "Objective 3: 90% of Patients on ART are Retained in Care," "Nutrition" intervention.

Food insecurity and malnutrition remain daunting challenges for those infected and affected by HIV and AIDS. The poor, food insecure and nutritionally disadvantaged populations tend to be highly dependent on subsistence farming and have low or often no income. Food security and

adequate nutrition is especially important to PLHIV and OVCs when weight loss and malnutrition are likely to accelerate disease progression and the likelihood for increased mortality. The malnutrition–infection complex which is an outcome of HIV and AIDS is a significant factor among adults, but more severe among children. Furthermore, poor nutrition in children is associated with risk of faltered growth, impaired mental development and even death.

HIV exacerbates under-nutrition through lack of food intake, increased energy needs and reduced absorption of nutrients. Under-nutrition in turn can hasten the progression of HIV and worsen its impact by weakening the immune system, increasing susceptibility to opportunistic infections (OIs), and reducing the effectiveness of treatment. Adherence to ART and its efficacy has a direct correlation to adequate nutrition and diet. Emerging evidence shows that people on ART receiving food supplementation recover much faster. To mitigate these challenges the 2015-2020 NSP will increase the number of people receiving nutritional/treatment support to 48,359 people annually by 2020.

5.4.2 Community Home Based Care (CHBC)

This outcome maps to the "Community-based Care and Support" intervention under the NSP's "Objective 3: 90% of Patients on ART are Retained in Care".

Home Based Care is an integral part of comprehensive treatment and care for PLHIV, which needs to be standardized and integrated into the wider care and support system. The current plan therefore aims to scale up the provision of quality care and support services in support of the Pre-ART and ART programmes, and in a manner that is equitable across all regions of the country. The CHBC interventions are to include interventions within and beyond the health system. In keeping with the refocus on ART, it is expected that there will be reduced need for palliation as more people are put on treatment through universal test and treat. As such the focus will be on alternative community based models of care that respond to the changing dynamics of the epidemic, such as expanded use of adherence and support groups given long term treatment adherence will become more and more critical. These groups could also be useful for tracking loss to follow up patients as well as providing psychosocial support while allowing the communities and patients themselves to be part of the response.

The existing referral system will be strengthened, improved and consolidated. In addition, the strengthening and expansion of HBC services by establishing and strengthening technical and institutional capacities of HBC organizations at county level, e.g. in the field of adherence

monitoring and palliative care. This includes support for community outreach and educational activities for PLHIV. In addition training of community care providers – including peer educators, family members, community leaders and volunteers – and PLHIV support groups in counselling and psychosocial support services in the context of HBC will complement services by professional staff. Special attention will be given to close collaboration between professional and community caregivers. Over the period 2015-2020 the number of HBC patients attended by trained providers will increase from 24,248 in 2013 to 90,000 in 2020.

These interventions will contribute towards achieving the following results:

Result	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2013	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020
People living with HIV receive care and support according to needs	Number of HIV positive people with severe malnutrition who have received nutritional/ treatment support	7772	11 313	34 540	46 895	47 688	48 359
Individually focused but Integrated community and facility based support programs for women, children, adolescents, adults, and key populations	Number of expert patients/volunteers trained to offer home based care	628	3000	3000	3000	3000	3000
	Number of expert patients/ volunteers provided with home based care kit	10	3000	3000	3000	3000	3000

5.5 MEDIUM TERM OUTCOME 5: SOCIAL AND ECONOMIC PROTECTION ARE ENSURED FOR ORPHANS AND VULNERABLE CHILDREN

The HIV and AIDS epidemic is a major catastrophe which threatens Malawi's ability to meet its commitments to the realization of children's rights. The epidemic exacerbates the difficult circumstances of many children in Malawi that result from poverty, lack of access to resources and services, minimal infrastructure, fragmented families, and violence and abuse against women and children.

The epidemic is causing a rapid increase in the number of orphans. AIDS is reducing the pool of traditional caregivers and the numbers of breadwinners resulting in increased poverty and reduced care giving for children. There are many children who care for terminally ill parents or caregivers and this impacts negatively on the psychosocial wellbeing of children due to the difficult living circumstances and awareness of their impending loss. These circumstances compel

many children to withdraw from school as they take on adult responsibilities at a very young age and this exacerbates their vulnerability as they lack protection and are at risk of abuse.

Children are also vulnerable to HIV infection through perinatal exposure, sexual abuse, or unprotected sex and may also be exposed to HIV infection through nursing HIV positive and terminally ill parents or caregivers if they are not properly informed to exercise precautions or do not have the necessary equipment to avoid contact with body fluids. The direct impacts of HIV and AIDS on children occur as material and service problems such as poverty, food security, education and health, and also non-material problems related to welfare, protection and emotional, social and spiritual wellbeing.

The numbers of orphans and children made vulnerable by HIV has increased over the years. The Ministry of Gender Community and Social Welfare (MoGCSW) has been leading activities to protect the rights of orphans, vulnerable children and youths, and to reduce their vulnerability and the impact of HIV and TB. There is a need to scale up these interventions and strengthen initiatives at community level to protect the rights of orphans and, in particular, child– and youth-headed households. Mental health services must also be part of the package of services provided to support orphans and vulnerable children. The HIV prevention interventions will also draw from interventions from the NSP to provide the complete combination packages which will include the interventions listed in Sections5.5.1 and 5.5.2.

5.5.1 Number of OVCs whose households receive social cash transfer

This outcome supports “Targeted Outreach Testing for Key and Vulnerable Populations” under “NSP Objective 1: 90% of PLHIV Know Their Status”, and “Social and Economic Protection for Orphans and Vulnerable Children” under “NSP Objective 3: 90% of PLHIV are Retained in Care”.

For children affected by HIV and AIDS, the risks of poverty and loss of livelihood are compounded by the risk of losing family care - their first line of protection. While cash transfers alone are not the solution, they can be an important element of an overall care package for children.[50] Social protection measures – including social transfers (cash, in-kind [food] or vouchers), family support services, and alternative care – can help mitigate the impact of HIV and AIDS by reducing poverty and family separation. Integrated social protection, in line with the internationally agreed Framework for Orphans and Vulnerable Children Living in a World with HIV and AIDS, can contribute to better health, education and protection outcomes.

[50] UNICEF (2004) A framework for the protection, care and support of orphans and vulnerable children living in a world with HIV/AIDS, New York: UNICEF

Cash transfers are gaining increased support as a means to mitigate the impact of HIV and AIDS on children, and potentially decrease their risk of HIV infection. Regular and predictable cash transfers can provide a consistent income and help reduce the burden of care for households with children. The increasing resources available to mitigate the impacts of AIDS are an important, but as yet untapped, resource for increased financing of cash transfers and other social protection programming.

Malawi's social cash transfer scheme has been in operation for many years. Cash transfers have been implemented in Malawi as an important component of a comprehensive HIV response. Malawi's use of cash payments is directed at reducing HIV risk, by addressing structural risk factors such as poverty and by improving individual well-being. The evidence provided indicates that cash transfers fill the gap and help transform the lives of children. Consistent, regular transfers can enable families to meet immediate needs for food and healthcare, and dramatically reduce a child's vulnerability in the short term. They can also enable children to go to school and thereby contribute to their long-term financial and food security.[51] Critically, cash transfers allow families to set their own priorities. Research shows that when families make their own choices, much of their spending benefits children both directly, for example, by paying school fees, and indirectly through the household becoming more stable. The flexibility of cash transfers means that those affected by HIV and AIDS, and their families and caregivers, can meet their diverse needs effectively.[52]

Based on the evidence provided and the dire state of poverty in Malawi, this prevention strategy envisions continued provision of cash transfers to OVCs and the numbers served will increase to 60,000 annually by 2019.

5.5.2 Current school attendance among orphans and non-orphans aged 10-14

This outcome maps to "Pediatric Testing" under "NSP Objective 1: 90% of PLHIV Know Their Status", and "Social and Economic Protection for Orphans and Vulnerable Children" under "NSP Objective 3: 90% of PLHIV are Retained in Care".

AIDS is claiming the lives of ever-growing numbers of adults just when they are forming families and bringing up children. As a result, orphan prevalence is rising steadily in many countries, while fewer relatives within the prime adult ages mean that orphaned children face an increasingly

[51]Inter-Agency Task Team (IATT) on Children and HIV and AIDS Working Group on Social Protection October 2007
[52]Inter-Agency Task Team (IATT) on Children and HIV and AIDS Working Group on Social Protection October 2007

uncertain future. They are likely to drop out of school owing to discrimination, emotional distress, inability to pay school fees, and/or the need to care for parents or caretakers infected with HIV or for younger siblings.

This indicator is monitored to ensure the rights of the child are upheld. The interventions including those described above would increase the number of orphans 10-14 years that attend school from 83.9% to 93.1% by 2020.

6: IMPACT AREA 2. REDUCE STIGMA AND DISCRIMINATION

6.1 OVERVIEW

More than two decades into the HIV epidemic, stigma and discrimination continue to hamper efforts to prevent new infections and engage people in HIV treatment, care and support programmes. Numerous studies have linked HIV related stigma with refusal of HIV testing, non-disclosure to partners and poor engagement in biomedical prevention approaches.[53][54] Similarly, internalized stigma, which refers to the negative consequences that result when people believe that stigmatizing public attitudes apply to them,[55]is a well-established barrier to medication adherence.[56] In response to this evidence, stigma reduction is now a key priority in PEPFAR's Blueprint for Achieving an AIDS-Free Generation[57] and UNAIDS' HIV investment framework.[58]

The recent shift in the global AIDS response to biomedical prevention will require acceptance and uptake of prevention approaches, such as VMMC, Pre-exposure Prophylaxis and universal testing and treatment, at the population level.[59] Effective interventions to reduce stigma and

[53]Abdool Karim Q, Meyer-Weitz A, Mboyi L, Carrara H, Mahlase G, Frohlich JA, et al. The influence of AIDS stigma and discrimination and social cohesion on HIV testing and willingness to disclose HIV in rural KwaZulu-Natal, South Africa. Glob Public Health. 2008;3(4):351_65.

[54]Turan JM, Bukusi EA, Onono M, Holzemer WL, Miller S, Cohen CR. HIV/AIDS stigma and refusal of HIV testing among pregnant women in rural Kenya: results from the MAMAS study. AIDS Behaviour. 2011;15(6):1111_20.

7. Corrigan PW, Penn DL. Lessons from social psychology on discrediting psychiatric stigma. Am Psychol. 1999;54(9):765.

[55]Corrigan PW,Watson AC. The paradox of self-stigma and mental illness. Clinical Psychology : Science in Practice. 2002;9(1):35_53.

[56]Rintamaki LS, Davis TC, Skripkauskas S, Bennett CL, Wolf MS. Social stigma concerns and HIV medication adherence. AIDS Patient Care STDs. 2006;20: 359_68.

[57]PEPFAR. PEPFAR blueprint: creating an AIDS-Free generation. Washington, DC: The Office of the Global AIDS Coordinator; 2012.

[58]Schwartlander B, Stover J, Hallett T, Atun R, Avila C, Gouws E, et al. Towards an improved investment approach for an effective response to HIV/ AIDS. Lancet. 2011;377(9782):2031_41.

[59]Dai JY, Gilbert PB, Hughes JP, Brown ER. Estimating the efficacy of pre-exposure prophylaxis for HIV prevention among participants with a threshold level of drug concentration. American Journal of Epidemiology. 2013;177(3):256_63.

discrimination are crucial to the success of biomedical prevention.[60] Such interventions need to be integrated into national responses and address the stigmatization process.[61]

Stigma interferes with HIV prevention, diagnosis and treatment and can become internalized by PLHIVs.[62] Importantly, stigma is often enacted through discrimination (defined as the rejection or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, health status or gender), hostility and prejudice against PLHIV (as well as their partners and families), denying them equal access to essential services in many cases.[63]

Stigmatization associated with HIV and AIDS is underpinned by many factors, such as lack of understanding of the disease (including misconceptions about modes of transmission), lack of access to treatment, irresponsible media reporting, the incurability of AIDS, prejudice and fears relating to a number of socially sensitive issues (including sexuality, disease and death, and drug use).[64] Not only is HIV and AIDS-related discrimination a human rights violation, it is also necessary to address such discrimination and stigma in order for public health goals related to HIV and AIDS prevention and management to be achieved.[65]

Malawi's response to HIV and TB recognizes the centrality of human rights. This is based on the understanding that public interest is best served when the rights of those living with HIV and/or TB – or who are at risk of infection – are respected, protected and promoted. Among others, these include the rights to equality, dignity, life, freedom and security of the person and privacy. The 2015-2020 prevention strategy takes as a starting point the constitutional recognition that access to healthcare and other social services – which includes reproductive healthcare – is a human right. In this regard, each result – where appropriate – addresses the specific access needs of particular groups and key populations, including, but not limited to, women, men, adolescents, children and people with disabilities.

Recognizing that the legal framework for respecting, protecting, promoting and fulfilling rights in the context of HIV and TB needs to be strengthened, special attention will be given to groups that

[60]Earnshaw VA, Bogart LM, Dovidio JF, Williams DR. Stigma and racial/ethnic HIV disparities: moving toward resilience. American Psychology Association. 2013;68(4):225_36.
[61]Stangl A, Go V, Zelaya C, Brady L, Nyblade L, Stackpool-Moore L, et al. Enabling the scale-up of efforts to reduce HIV stigma and discrimination: a new framework to inform program implementation and measurement. XVIII International AIDS Conference, July 18_23. Vienna; 2010.
[62]Alonzo AA, Reynolds NR: Stigma, HIV and AIDS: an exploration and elaboration of a stigma trajectory. Social Science Medicine1995, 41(3):303–315.
[63]Link BG, Phelan JC: Stigma and its public health implications. Lancet 2006, 367(9509):528–529.
[64]Herek M: Thinking about AIDS and stigma: a psychologist's perspective. Journal of Law Medical Ethics 2002, 30(4):594.
[65]Aggleton P, Wood K, Malcolm A: HIV-related stigma, discrimination and human rights violation: case studies on successful programmes. Geneva:UNAIDS best practice collection; 2005. http://data.unaids.org/publications/ irc-pub06/jc999-humrightsviol_en.pdf.

are at higher risk in particular key affected populations and youth. Women and young girls will also be supported and enabled to access a comprehensive package of services including sexual and reproductive health services. Where such services are not available, referral mechanisms will be put in place to facilitate access within a reasonable timeframe and limited costs to those seeking care.

6.2 MEDIUM TERM OUTCOME 1: CREATING AN ENABLING ENVIRONMENT TO ACCESS HIV PREVENTION, TREATMENT, CARE AND SUPPORT SERVICES

Men who have sex with men and FSW, prisoners, and other vulnerable populations exist across Malawi and are in need of appropriate HIV treatment, care and support services. Overall, there is limited data available to assist in fully understanding the size of most of these populations in Malawi and the comprehensive impact that HIV has within these populations.

Several influences have been associated with increased vulnerability to HIV among individuals from these populations, and can be broadly classified as structural, social or individual risk factors. To mitigate these barriers the following will be reviewed during the period 2015-2020:

6.2.1 Improved social and legal protection for PLHIV and Key Populations

This outcome maps to "Creating an Enabling Legal and Health Services Environment - Social and Legal Protection for Persons living with HIV and AIDS and Key Populations" under the NSP chapter, "Stigma, Discrimination and Patient Rights."

- *Advocate for legal reform* - PLHIVs should have the same access to services as the rest of the community. Being infected and/or affected by HIV should not constitute a barrier or obstacle to accessing services such as socio-economic, and psychosocial support. Strengthening the provision of non-discriminatory services (i.e., from Police, Health Care providers, Legal personnel) and creation of and/or scale-up safe spaces/drop in centres is the focus of this output. This strategy will be strengthened at all levels of the community national wide to reach people who are HIV positive, the families of PLHIV and also those who may not be HIV positive but who are affected by the virus, particularly OVC. Advocacy for legal reviews will be conducted to formalize the rights of PLHIV. Awareness of the general public concerning the rights of PLHIV will be raised through use of IEC, Theatre For Development, and other interpersonal communication methodologies.

- *Responsiveness of the social legal environment* to the health needs of PLHIV and Key Populations–Besides increasing awareness among PLHIV of their rights, it is also critical to make available information and services that can provide support or receive complaints. This output will look to influencing change in the social and legal arenas mainly through advocacy for building capacity around legal literacy; finalization and dissemination of the HIV Management Bill; workplace policies; school policies (especially regarding YPLHIV); and the review, application and interpretation of laws that affect FSW (i.e., vagrancy laws) through advocacy meetings with judiciary and law enforcers, and longer term review of the Penal Code; among others. Activities will also extend to strengthening the Sex Worker Alliance and other similar bodies that may emerge. Advocacy work will mainly be done at national level; however, dissemination will be done at all levels including communities to ensure the protection of all key populations and PLHIV.
- *Reducing unfair discrimination in access to services* - In this case, the focus is on a range of grounds by which PLHIV and key and vulnerable populations may be denied access to services because of their HIV status or related vulnerability. These grounds include age, race, gender, and sexual orientation, among others, and are inconsistent with the Constitution of the Republic of Malawi. In addition to respecting and protecting people's rights to have access to needed services, this prevention strategy seeks to facilitate the achievement of broader public health goals by ensuring that no person eligible for services is denied access on an arbitrary basis. Denial of access may take place in a number of ways, including services being provided in a manner that fails to address or understand a person's specific needs, and staff attitudes that discourage people from accessing social services.
- *Increased capacity training to prevent unfair discrimination* - While it is important to hold all social service providers accountable through professional disciplinary mechanisms, it is also vital that such professionals have access to dedicated human rights training programmes designed to equip them with the necessary skills to respect, protect and promote equality in the provision of social services. This intervention is, therefore, aimed at all bodies or institutions that train social service providers in HIV and TB care, as well as dedicated services for pregnant women, children and adolescents. In particular, this intervention seeks to ensure that all public and private bodies or institutions providing training in HIV and/or TB include modules dealing with human rights, including a focus on the needs of people with disabilities.

Result	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2013	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020

Result	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2013	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020
Improved social and legal protection for persons living with HIV and AIDS and KPs	Number of people reached who demonstrate increased public knowledge on rights of PLHIV and KPs	N/A	1100	1100	1100	1100	1100
Increased capacity to prevent unfair discrimination	Number of people in major social sector organizations trained in gender programming	170	240	240	240	240	240
Community mobilization and empowerment activities conducted nationwide to address gender and rights issues and harmful cultural practices	Number of community mobilization activities (campaigns) held to address gender and rights of KPs and PLHIVs	N/A	135	135	135	135	135

6.2.2 Human Rights of PLHIV are respected and promoted

This outcome supports the "Human Rights" section in "Creating an Enabling Legal and Health Services Environment" under the NSP chapter, "Stigma, Discrimination and Patient Rights."

- *Advocacy and sensitization on PLHIV rights* - The laws in Malawi do not discriminate against PLHIV on the grounds of HIV status in terms of employment, in society, in health services access. However, many people remain ignorant of the rights of PLHIV (including PLHIV). This is even more critical regarding YPLHIV. Empowerment of PLHIV will be addressed by improving knowledge of the laws, education and skills levels so they can competently access economic opportunities through literacy training, entrepreneurship, and management training. Some of this education will be implemented broadly through social behavior change interventions, interpersonal communication, and mass media for hard-to reach areas (community radios). Advocacy for implementation of these rights will be conducted at all levels.

6.2.3 Reduced level of vulnerability in respect of KPs and sexual minorities in the context of HIV

This outcome maps to "Creating an Enabling Legal and Health Services Environment - Key Population Vulnerability" and "Gender – Mitigating the Harms Associated with Gender-Based Violence Among MSM" under the NSP chapter, "Stigma, Discrimination and Patient Rights."

- *Sensitization on mainstreaming Key Populations into all sectors* - MSM is criminalized in Malawi and FSW remain marginalized. In consultations with both groups, it was evident that these groups feel stigmatized and discriminated against by the general public. Therefore accessing services to protect their rights is a challenge as they are often seen as "different." This output aims at culturally sensitive advocacy campaigns in hotspot areas, and social behavior change communications for a positive shift in social attitudes and practices, especially with faith based and traditional leaders.

Result	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2013	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020
Advocacy and sensitization on PLHIV rights	Number of Advocacy and sensitization workshops		110	102	73	75	73

6.3 MEDIUM TERM OUTCOME2: PROMOTION AND PROTECTION OF THE RIGHTS OF WOMEN, GIRLS AND SEXUAL MINORITIES IN THE CONTEXT OF HIV

6.3.1 Increased protection of women and girls

This outcome maps to "Increased Protection of Women and Girls" under "Gender" in the NSP chapter, "Stigma, Discrimination and Patient Rights."

Implementing interventions to address gender inequities and gender-based violence as drivers of HIV is the focus of this output. Girls and women are particularly vulnerable to HIV infection because of their biological vulnerability and gender norms, roles and practices. Acknowledging the fact that gender inequality hinders social and economic development, the achievement of gender equality remains one of the critical components of the HIV agenda. Malawi is grappling with violence against women, with sexual assault and intimate partner violence contributing to increased risks for HIV infection. This prevention strategy through the MoGCSW will develop a comprehensive approach to reduce GBV in society, which will include both primary and secondary prevention, and scaling-up social change communication programmes dealing with gender stereotypes and harmful cultural norms.

6.3.2 Increased uptake of health services (SRH) by FSWs and women made vulnerable by poverty

This outcome maps to "Increased Uptake of Health Services with Respect to SRH by FSW and Women Made Vulnerable by Poverty" under the "Gender" section of NSP chapter, "Stigma, Discrimination and Patient Rights."

Consultations with FSW highlight vulnerabilities such as discrimination in access to services (especially health); stigma in the community; violence (among themselves and by clients); and high numbers of sexual partners. This output will strive to conduct advocacy for FSW to carry out participatory assessments with their peers in order to assess what puts them at risk for HIV infection and the obstacles they face when trying to protect themselves from HIV. These assessments will form the basis for developing a range of activities for communication, education, skills building, and condom distribution. In tandem, sensitization of health provider to change attitudes will be done concurrently with all the other HIV prevention communication interventions targeting them.

In addition, young girls (10 – 14; 15-18; and 19 -24 years) will be separately appraised of their Sexual Reproductive Health Rights (SRHR) to better understand and demand for these rights. The peer-to-peer approach will be used to help women educate each other on these rights and risk reduction behaviours. Finally, recognizing that the vulnerability of this population group is closely linked to behaviours and attitudes of their sex partners, deliberate effort will be to increase male involvement campaigns, gender-based violence reduction programmes, and psycho-social support. Integration of messaging in areas of family planning and all other HIV prevention interventions and barriers to uptake will be included. Programs with this population group will be carried out mainly in the high incidence zones and played out thinly in the medium and low incidence zones.

Result	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2013	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020
Increased promotion and protection of the rights of women, girls and sexual minorities in the context of HIV	Incidence of gender based violence	N/A					
Women, girls and child protection (from gender inequality and violence) programs	Number of victim support units (VSU) equipped with standard equipment	483	710	982	1200		
Guidelines for integrating rights based, gender transformative	Rights based, and gender transformative guidelines	0	100%	-	-	-	-

Result	Indicator	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
		2013	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020
NCD management and HIV	integrated in HIV guidelines						
Gender transformative, and Rights based capacity development from HBC, psychosocial support, nutrition, NCDs, and HIV for health workers, community cadres, leaders, etc.	% of health workers in HIV and HTC clinics trained in gender and human rights	0	20%	25%	25%	25%	5%

6.3.3 Mitigating the Harms Associated with Gender-based Violence among MSM

This outcome maps to "Mitigating the Harms Associated with Gender-based Violence among MSM" under the "Gender" section of the NSP chapter "Stigma, Discrimination and Patient Rights." Gender-based violence is often (reasonably) construed as primarily an issue affecting women and girls; however, there is growing evidence for the existence of violence targeting men and boys who have sex with men, both from members of the general population (including friends and family) as well as in the context of intimate partner relationships.[66,67] MSM survivors may face additional barriers to accessing medical and social services as well as legal redress due to cultural constructs of masculinity as well as the current criminalization of MSM behavior in Malawi. Gender Based Violence trainings for clinical care providers and law enforcement should include appropriate content for working with male GBV survivors, and promotional activities and materials will include targeted messages for men and boys to inform them of available services (including timely provision of HIV post-exposure prophylaxis).

[66]Wirtz AL et al. HIV among men who have sex with men in Malawi: elucidating HIV prevalence and correlates of infection to inform HIV prevention .Journal of the International AIDS Society 2013, 16(Suppl. 3):18742

[67]Fay H, Baral S, Trapence G, Motimedi F, Umar E, Iipinge S, et al. Stigma, health care access, and HIV knowledge among men who have sex with men in Malawi, Namibia, and Botswana. AIDS Behaviour. 2011;15(6):1088-97.

7. COORDINATION AND MANAGEMENT OF THE NATIONAL RESPONSE

7.1 GUIDING PRINCIPLES

The adoption of multi-sectoral and decentralized approaches in the coordination and management of the national response have created more opportunities for many and diverse stakeholders' involvement. With increased number of stakeholders, coordination has increasingly become complex, challenging and dynamic. The process demands innovation, clarity of roles and responsibilities linked to institutional mandates and comparative advantages. The national response coordination and management is premised on the three ones principle.

The initial guiding principles to formulating the revised structures are summarized below:

- *Access to relevant information:* Information and its use in effective M&E is key to NAC being able to fulfill its coordination and monitoring mandate. Accurately recorded information must be made available 'bottom-up' from all stakeholders involved with the implementation and must adhere to standard formats. Furthermore, it must be made available and shared regularly through NAC structures to be fully reviewed and used in implementing M&E.
- *'Bottom-up' approach:* Governance and reporting arrangements will start at the lowest level through district AIDS councils and finally to NAC. There will be a clear guiding framework to support implementation and set out expected roles and responsibilities.
- *Accountability and Responsibility:* Accountability and responsibility for implementation and coordination activities will be strengthened at all levels with a step-up process for feedback and reporting at the next level of governance. Appropriate ownership for reporting and implementation outcomes will be established.
- *Reporting:* A standard framework of reporting will guide the regular monitoring and tracking of prevention strategy implementation at all levels. Reporting will be completed at each level of implementation coordination, and verified and passed upwards through formal reporting channels to NAC. As already indicated, governance arrangements will require direct ownership of all reports, their content and outcomes.
- *Transparency:* The prevention strategy implementation and coordination process will be based on clear and open communication that leads to a common understanding and discussion of relevant data. There will be no ambiguity in decision-making and there will be a common understanding of expectations and requirements among everyone involved.

- *Meaningful involvement of people living with HIV and affected by TB:* Governance structures will recognize the important role played by people living with HIV and will involve them in governance structures.

7.2 GOVERNANCE AND COORDINATION

The Office of the President and Cabinet (OPC) provides overall leadership on matters of HIV and AIDS in Malawi. The President is the Minister Responsible for HIV and AIDS. The National AIDS Commission (NAC) established by the Malawi Government under a trust deed provides leadership and coordinates the national response to HIV and AIDS in the country. It is governed by a Board of Commissioners led by the Chairperson who is appointed by the President. The other members are selected from all constituencies namely: private, public, faith, civil society, academia, youth and PLHIV. Major roles include reviewing and approving NAC policies and procedures, annual work programme and hiring of secretariat executive staff.

Specific roles of the Commission are to: (i) guide development and implementation of the national strategy; (ii) facilitate policy and strategic planning in sectors, including local government; (iii) advocate and conduct social mobilization in all sectors at all levels; (iv) mobilize, allocate and track resources; (v) build partnerships among all stakeholders in country, regionally and internationally; (vi) knowledge management through documentation, dissemination and promotion of best practices; (vii) map interventions to indicate coverage and scope; (viii) facilitate and support capacity building; (ix) overall monitoring and evaluation of the national response; and (x) facilitate HIV and AIDS research.

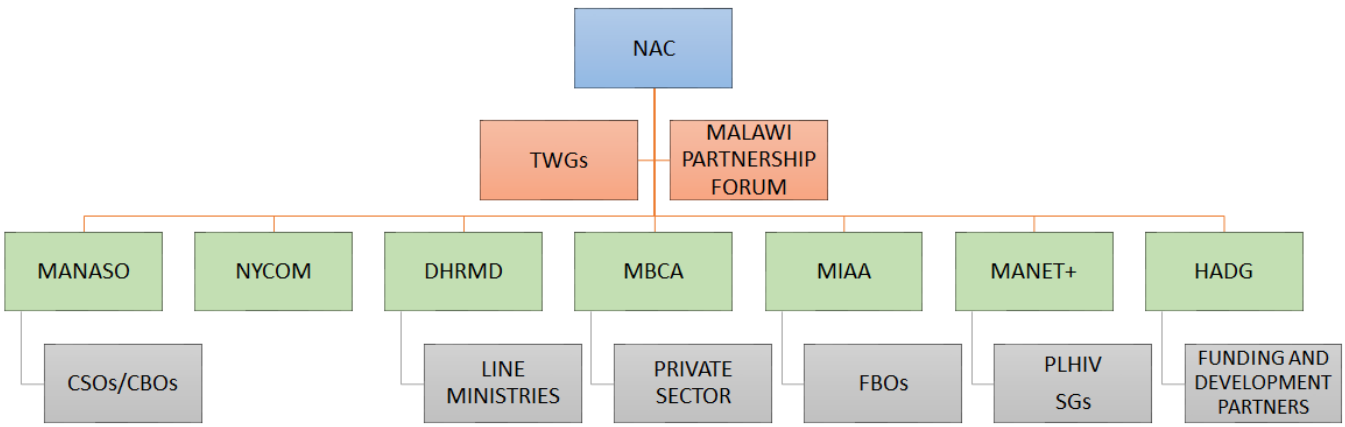
While NAC is at the heart of the institutional framework, there are several coordinating structures and mechanisms for the national response, some of which are managed by NAC whilst others are independent. These are organized as follows (see schematic):

To strengthen the national and multi-sectoral coordination of the response amongst the stakeholders so that they effectively respond to HIV and AIDS and minimize wasteful duplication of efforts, NAC established the Malawi Partnership Forum (MPF) for HIV and AIDS in 2005. The forum provides a formal and representative forum for discussion, information sharing, consensus building, joint planning, and mutual support for all partners in the national response through the Joint Annual Review (JAR), TWGs and other structures such as the HIV and AIDS Development Group (HADG) and sectoral coordinating bodies. The HADG harmonizes and coordinates

development partner's support to the NSP and align development partner's support to the Integrated Annual Work Plan (IAWP)

The sectoral coordination bodies include: (i) the Department of Human Resource Management (DHRMD) which coordinates the HIV and AIDS response, particularly workplace programmes, in the public sector including parastatal organizations. DHRMD also provides policy guidance on workplace programs in Local Councils; (ii) Malawi Business Coalition against AIDS (MBCA) coordinates the response for private companies and business institutions. MBCA's major roles are mobilization of companies, development of workplace programmes, reporting and evaluation of the private sector response; (iii) Malawi Network of People Living with HIV (MANET+) coordinates all organizations for PLHIV. These organizations serve and advocate for issues affecting PLHIV in order to improve their welfare; (iv) Malawi Network of AIDS Service Organizations (MANASO) coordinates local and international Non-Governmental Organizations (NGOs) implementing various HIV and AIDS activities; (v) the Malawi Interfaith AIDS Association (MIAA) coordinates all faith based organizations implementing HIV and AIDS interventions; and (vi) National Youth Council of Malawi (NYCOM) coordinates all youth organizations implementing HIV and AIDS interventions. All these sectoral coordinating institutions are expected to collaborate with Local Councils when coordinating the national response in the districts through the District Executive Committee (DEC) and the District AIDS Coordinating Committee (DACC) who are responsible for coordinating the district response. See schematic below.

Figure 13: Roles of the main coordinating bodies included in



The roles of the main coordinating bodies included in Figure 13 are:

- Malawi Partnership Forum (MPF) – This is an advisory body to the NAC Board of Commissioners, comprising of high profile decision makers drawn from the: public sector, private sector, PLHIV, CSOs, academia, research, National Assembly and development partners. The MPF plays a critical role in planning and reviewing the national response to HIV and AIDS in Malawi. All the coordinating structures outlined below are represented on the MPF. NAC provides management support to the MPF.
- Technical Working Groups (TWGs) – These are HIV and AIDS thematic groups established by NAC to provide technical guidance and make recommendations on various technical issues in the national response. They report to the MPF.
- HIV and AIDS Development Group (HADG) - This is a grouping of HIV and AIDS development partners. The objectives of the HADG are to harmonise and coordinate development partners' support to the NAF and to align development partners' support to the integrated annual work plan.
- Malawi Global Fund Coordinating Committee (MGFATMCC) - The MGFATMCC provides overall guidance on Malawi's Global Fund supported programmes to fight HIV and AIDS, Tuberculosis and Malaria. It is accountable to the GoM and the Global Fund on the utilization of the Global Fund resources, and determines priorities for proposals to the Global Fund based on existing country frameworks and strategies. Membership of the MGFATMCC is composed of the public, private sectors, civil society including people living with HIV and AIDS and development partners. Every MGFATMCC member is nominated by the constituency he or she represents[68].
- Department of Human Resources Management and Development (DHRMD) – Within the Office of the President and Cabinet (OPC), this department coordinates the HIV and AIDS response, particularly workplace programmes in the public sector. These include all government ministries, departments, training institutions and parastatal organisations. There is also a public sector steering committee comprising principal secretaries and chief executives which provides policy leadership and guidance on the public sector response.
- Malawi Business Coalition against AIDS (MBCA) – MBCA coordinates the response for private companies and business institutions. Its major roles are mobilisation of companies, development of workplace programmes, reporting and evaluation of the private sector response.

[68]Operational Manual for the Malawi Global Fund Coordinating Committee (MGFTATMCC)

- Malawi Network of People Living with HIV (MANET +) – this body coordinates all organisations for people living with HIV and AIDS (PLHIV). These member organisations serve and advocate for issues affecting PLHIV in order to improve their welfare.
- Malawi Network of AIDS service organisations (MANASO) – MANASO coordinates local and international NGOs implementing various HIV and AIDS activities.
- The Malawi Interfaith AIDS Association (MIAA) –This association coordinates all faith based organisations implementing HIV and AIDS interventions.
- National Youth Council of Malawi (NYCOM) – This council coordinates all youth organisations implementing HIV and AIDS interventions.

These mechanisms have been functioning for some years, are well-established, and have been regularly reviewed and assessed.

7.3 KEY IMPLEMENTING AGENCIES

Within these governance and institutional frameworks, actual implementation of the NSP is the responsibility of a wide range of implementing partners from the public and private sectors, civil society and development partners. These include:

- Ministry of Health plays a key role in the multi-sectoral response, for technical direction and service delivery in biomedical areas of prevention, treatment and care. The specific roles of the MoH include: (a) developing Policies and Guidelines on biomedical HIV and AIDS interventions; (b) planning and implementing biomedical HIV and AIDS interventions; (c) coordinating health sector thematic areas; (d) providing technical support for HIV and AIDS policy development; (e) providing technical support in implementation of health related HIV and AIDS interventions; and (f) surveillance for HIV/AIDS/STI.
- Central and other line Ministries such as Ministry of Finance, Economic Planning and Development, the Department of Public Sector Management, the Law Commission and the Human Rights Commission directly or indirectly support the national response. Line Ministries provide services up to the community level. Ministries, departments and parastatal organisations have established focal points for HIV and AIDS and are expected to mainstream HIV and AIDS into their sectoral work, provide technical support to the response, and organise workplace interventions for staff. All ministries have a budget line for HIV and AIDS activities.
- Local Authorities coordinate the implementation of the response at district, city level and community levels. They have the responsibility to mobilize resources for community

programmes, implemented through CBOs, Support Groups, and Community AIDS Committees (CACs). District development committees (DDCs) and Area Development Committees (ADCs) complement the work of local NGOs.

- NGOs, FBOs and CBOs form the core of the implementing agencies and among others things carry out advocacy, assist communities to mobilise resources locally, document best community practices and support capacity building programmes in collaboration with NAC.
- Private Sector organisations under the coordination of the Malawi Business Coalition against AIDS (MBCA) have the responsibility to mainstream HIV and AIDS through workplace policies and programmes.
- Development Partners support national priorities; facilitate implementation by funding capacity building. The development partners assist the government's response in areas such as empowering leadership, mobilisation public, private and civil society, strategic information, and facilitating access to technical and financial resources at national level.

As coordination and management remains essential, during the period of 2015-2020 prevention strategy, the focus will be improving efficiency and effectiveness of the national response, governance and leadership, social and resources accountability. More importantly duty bearers and other service providers will adhere to human rights such as the right to health, privacy, protection and the right to nutrition (food), while providing essential services, and that the rights holders (service beneficiaries) are able to access health and nutrition services without fear of being stigmatized or discriminated against. An environment that supports efficiency in service delivery is characterized by well-articulated mandates, roles and responsibilities, a functional joint programme review mechanism, planning and development process, and a strong monitoring and evaluation system.

The National AIDS Commission as the overall coordinating body will ensure that the strategic roles of communities, civil society, PLHIV and the private sector are clearly defined and communicated. It will also ensure that decisions in such an environment are evidence-based and focus on specific results; they are gender sensitive and anchored in a human rights framework. In an environment where resources for HIV and AIDS are declining, coordination of resource mobilization, allocation and distribution is necessary to sustain availability of services. Systems for resource tracking from both the demand and supply side will be improved. The NAC will spearhead the coordination, development, and implementation of strategies for sustainable financing of the national response.

7.4 SYSTEMS STRENGTHENING OVERVIEW

Successful implementation of the prevention response is to a large extent dependent on strong and functional systems. Malawi has prioritized strengthening health and community systems. For health systems strengthening, it will be modelled around the six building blocks articulated by the WHO (services delivery; human resources; strategic information; products, commodities and technology; finance, and leadership and governance). In the case of community systems strengthening, the process will be modelled around six blocks that include enabling environment, community networks and partnerships, resources and capacity development, community activities, organizational and leadership development, and finally M&E.[69] Collectively, these building blocks contribute to improved health and social outcomes, improved efficiency and effectiveness in services delivery, use of financial and human resources.

7.4.1 Health Systems Strengthening

An efficient and effective health system is a pre-requisite for the national HIV and AIDS multi-sectoral response. A functional system helps to scale up services, enhance the harmonisation and alignment of interventions, improves the synergy, integration and implementation intensity. The process results in improved services availability, access and utilisation. Strong health systems facilitate leveraging of resources, the use of strategic information in decision-making and planning; and, the application of appropriate technologies for better outcomes.

The prevention strategy will support the development of a comprehensive human development plan, given the importance of human resources in the health sector and HIV and AIDS service delivery. The plan will include retention strategies for experienced and qualified staff, institutionalization of task shifting, mentorship, and recruitment process. Procurement and supply chain management systems need special attention to ensure no stock out and wastage of important medicines and other commodities.

7.4.2 Community Systems Strengthening

Skills-building for Community Systems Strengthening (CSS) includes organizational skills and management to ensure timely and efficient operational support for services. Technical capacity of community actors needs to be built so that they can develop and deliver effective community

[69] GFATM (May 2010): Community Systems Strengthening Framework

based services and can ensure that communities are well-informed and supported for access to services, referrals, follow-up, adherence etc. This also needs to be equipped with technical skills for documenting experiences and engaging in community research methodologies to determine what works best for communities. Individuals with capacity for leadership will also need to gain skills such as negotiation, multi-stakeholder working and public speaking. Community actors also need to have appropriate understanding of human rights, especially for key affected populations.

During the 2015-2020 Prevention Strategy period, CSS will be implemented towards the achievement of improved health outcomes by developing the role of key affected populations, communities and of CSOs in the design, delivery, monitoring and evaluation of services and activities related to HIV and AIDS and TB in a manner that embraces the principles of equity and human rights. Community systems strengthening will revolve around the following issues

- Strengthening the enabling environment to reduce or eliminate stigma and discrimination.
- Mobilizing and engaging community leaders on community based HIV and AIDS interventions.
- Advocacy especially with opinion formulators and other decision makers.
- Community networks, linkages, partnerships and coordination to leverage existing strategic partnerships and alliances.
- Strengthening district, regional and national level planning and coordination mechanisms.
- Improve community based HIV services availability, use and quality.
- Improve monitoring and reporting on community based HIV services to ensure that all organizations working on community-based HIV services report on their activities.

7.5 STRATEGIC INFORMATION MANAGEMENT

7.5.1 Overview

An effective strategic information management (SIM) is necessary with the adoption of a human-rights, evidence-based and results based planning and management approaches. Strategic information management is premised on the existence of an effective and efficient monitoring and evaluation system, coupled with a functional operational research system. Data collection, analysis and reporting constitute the basis for Strategic Information Management (SIM). Strategic information is necessary for decision-making, planning and resource mobilization and allocation.

Malawi has developed a national M&E plan that will be updated and used for purposes of tracking the implementation of the 2015-2020 prevention strategy. The updated M&E plan will

ensure effective and efficient monitoring and evaluation based on the agreed national priority impact, outcome and output results. These results are articulated in results framework. The plan will also be used to guide, track and monitor Malawi's performance towards achieving its international commitments.

7.5.2 Monitoring & Evaluation Coordination

Monitoring and Evaluation of the multi-sectoral response will require greater coordination of all sectors (public, private, civil society and development partners) to ensure optimal use of the available resources and continuous learning through sharing of experiences. The NAC is responsible for monitoring the epidemic and the national response, analyzing this information and disseminating it to policy makers and programme planners. The monitoring and evaluation of health facility based responses is coordinated and managed by the MOH in collaboration with private sector institutions and civil society organizations that run health facilities. Data are reported through the Health Information System (HIMS). The monitoring of non-health related interventions are monitored by the NAC through the different partnerships, i.e. with donor group, the civil society organizations, faith based organizations, organizations support key populations, traditional leaders and local government to name a few. These coordinating structures will oversee capacity development, data quality assurance, resource mobilization for M&E and data archiving.

ANNEXES

Annex I: PREVENTION STRATEGY PACKAGES FOR THE NATIONAL HIV PREVENTION STRATEGY (2015-2020)

HIGH INCIDENCE CLUSTERS

Priority population	Biomedical interventions	Behavioural interventions	Structural interventions
Priority populations			
Key populations			
MSM	1. Male condoms 2. Lubricants 3. Quarterly HTC, STI and (HPV screening) 4. Anal STI screening 5. STI treatment 6. ART regardless of CD4 count 7. PrEP 8. PEP 9. HPV vaccination 10. HEP B vaccination	1. Reduction of number of partners 2. Demand creation for consistent use of condoms and lube 3. Targeted Campaigns on testing, risk reduction, adherence 4. Alcohol and Substance abuse programmes 5. Positive Health, and Dignity Prevention 6. GBV prevention programmes - Stigma	1. Human rights protection of MSM - Advocacy 2. Create and scale-up safe spaces/drop-in centres 3. Social support – (community awareness/sensitization) 4. Psycho social support mechanisms 5. GBV prevention programmes 6. Coordination, situational analysis, improved and more access to condoms - Total market approach 7. Health care providers and Police sensitivity trainings
Sex Workers	1. Male and female condoms 2. Frequent and regular HTC, STI screening 3. Cervical cancer screening STI treatment 4. ART regardless of CD4 count 5. PEP 6. EMTCT 7. HPV vaccination 8. Family planning including EC 9. Microbicide gel	1. Consistent condom use 2. Targeted Campaigns on testing, risk reduction, and adherence 3. Alcohol and Substance abuse programmes 4. IEC 5. Positive Health, and Dignity Prevention 6. GBV prevention communication for FSW and clients	1. Promote human rights 2. 100% condom use policy (Brothels) 3. Non-traditional condom dispensation 4. Socio-economic empowerment 5. GBV prevention programmes 6. Psycho social support mechanisms 7. Coordination, situational analysis, improved and more access to condoms - Total market approach 8. Health care providers and Police sensitivity trainings 9. Advocacy
Priority Populations			
Young women at risk,	1. HTC 2. STI screening	1. Life skills education 2. Comprehensive sexuality	1. Reduce age of consent for HTC 2. “Keep Girls in School” programmes

10 - 14 years	3. HPV screening 4. HPV vaccination 5. Education of female and male condoms; family planning and emergency contraception Post exposure prophylaxis 6. Post rape care	education/training 3. Evidence-based interventions (adapted for Malawi e.g. Go Girls) 4. Prevention, condom use, and risk perception training 5. Targeted Campaigns on testing, risk reduction, adherence 6. Stop Early marriage campaigns	3. Social cash Transfer programmes 4. Education and access - Total market approach 5. GBV reduction programmes 6. YFHS scale-up 7. Community Protection mobilization for legal action against sexual offenders.
Young women at risk, 15-24 years	1. Post exposure prophylaxis 2. HTC 3. STI screening 4. HPV screening 5. Female and male condoms 6. Family planning and emergency contraception 7. Post-rape care	1. Life skills education 2. Comprehensive sexuality education/training 3. Evidence-based interventions - Healthy choices 4. Prevention, condom use, and risk perception training 5. Couple HTC and disclosure 6. Targeted Campaigns on testing, risk reduction, adherence 7. "Stop Early Marriage" Campaigns 8. Messages on intergenerational sex	1. Human rights protection of young girls (raise age at first marriage) 2. "Keep Girls in School" programmes 3. Social cash Transfer programmes 4. Total market approach to condom programming 5. GBV reduction programmes 6. YFHS scale-up 7. Community Protection mobilization for legal action against sexual offenders
Couples Married and Cohabiting	1. CHTC 2. eMTCT 3.	1. Coupling counselling – risk reduction 2. Campaigns for CHTC; female support for VMMC 3. Couple Communication 4. Male involvement	1. GBV programmes 2. Address harmful cultural practices
People living with HIV.	1. Linkage to care and treatment 2. Couple HTC 3. eMTCT 4. Adherence to treatment 5. Condoms ART regardless of CD4 count 6. Viral load monitoring	1. Positive Health, Dignity and Prevention, condom use 2. Couple HTC and disclosure; and partner prevention 3. Evidence based intervention (adapted to Mw) 4. Establish support groups	1. Zero stigma and discriminatory by-laws 2. Universal access to HIV and sexual and reproductive health services 3. Coordination, increased access - Total market approach
Discordant couples	1. Linkage to care and	1. Motivation for HIV negative	1. Assisted Partner (s) notification for PLHIV

	treatment 2. Couple HTC 3. eMTCT 4. Adherence to treatment 5. Condoms 6. Treatment for HIV prevention 7. PrEP 8. VMMC 9. Family Planning	partner to stay negative 2. Couple HTC 3. Disclosure 4. Partner prevention	2. Zero stigma and discriminatory by-laws 3. Universal access to HIV and sexual and reproductive health services 4. Total market approach to condom programming
Other Priority Populations			
Uniformed services	1. HTC 2. Linkage to care and treatment 3. eMTCT 4. STI screening treatment 5. Adherence to treatment 6. Condoms 7. VMMC 8. Family Planning 9. PEP	1. Risk reduction for HIV negative testers 2. Demand creation for condoms 3. Positive Health, and Dignity prevention 4. Evidence based interventions	1. Review of HIV prevention policies/programmes to include condoms, PrEP, and other biomedical interventions 2. Psycho social support mechanisms for reintegration 3. Coordination, data, and increased access to condoms - Total market approach
Prisoners	1. Linkage to care and treatment 2. Adherence to treatment 3. Condoms 4. Family Planning 5. PEP	1. Risk reduction for HIV negative testers 2. Positive Health, and Dignity prevention 3. Demand creation for condoms 4. Demand creation for FP 5. Evidence based interventions	1. Review of Prison policy on HIV prevention to include condoms, PrEP, and conjugal visits 2. Psycho social support mechanisms for reintegration 3. Coordination, data, and increased access to condoms - Total market approach
Truck and long distance drivers Migrant workers (Estates, construction sites, etc.) Fishing communities Taxi drivers	1. Mobile HTC 2. Mobile SRH services 3. Couple HTC 4. Condoms 5. VMMC 6. ART 7. PEP 8. eMTCT	1. Promotion of condom campaign 2. Targeted Campaigns on testing, risk reduction, adherence 3. SBCC campaigns on harmful cultural practices 4. Positive Health, and Dignity Prevention	1. Enact maximum working hours policies 2. Institute mandatory HIV Workplace policies 3. Enforce child labor laws 4. Coordination, data, and increased access to condoms - Total market approach 5. Review insurance (health) policies
General Population			

0-5 years	1. integration of HTC in immunization programme 2. Infant male circumcision 3. Early infant diagnosis 4. HTC for children 5. Pediatric ART for all HIV positive children 6. ART for all pregnant HIV positive women for PMTCT	1. Exclusive breastfeeding for up to 6 months 2. Male engagement in child HIV testing and HIV prevention for children 3. Demand creation for early infant circumcision	1. Training of pre-school teachers and community health workers as agents of communication for child HIV testing 2. Health Systems Strengthening 3. Advocacy for early infant circumcision
5-9 years	1. HIV and Sexual reproductive health education in clubs and in schools 2. HTC	1. Life skills	1. Sexuality and Sexual and reproductive education in schools 2. Child Rights protection, and GBV elimination programmes
Boys 10-14 years	1. HIV and Sexual reproductive health education in clubs and in schools HTC 2. VMMC 3. PEP 4. Post rape care	1. Life skill training 2. Delayed sexual debut 3. SBCC on harmful cultural practices	1. Sexuality and Sexual and reproductive education in schools 2. Child Rights protection, and GBV elimination programmes 3. "Stop GBV" initiatives/programmes, 4. YFHS scale-up 5. Coordination, data, increased access - Total market approach
Boys 15-24 years	1. HIV and STI testing 2. Sexual and reproductive health and HIV education 3. Condoms 4. HTC 5. VMMC 6. PEP 7. Post rape care	1. Life skills 2. Evidence-based intervention (adapt for Mw) 3. Risk reduction training 4. Intergenerational sex messaging 5. Alcohol Reduction campaign 6. Promotion of condom campaign	1. Child Rights protection, and GBV elimination programmes 2. Economic empowerment through micro-finance programmes 3. YFHS scale-up 4. Coordination, data, increased access - Total market approach
Men and women 24 years and above	1. PITC 2. Family Planning 3. VMMC 4. PEP 5. Post rape care	1. Sustained scaled-up Evidence-based interventions 2. Alcohol Reduction campaign 3. Positive Health, and Prevention 4. Promotion of condom campaign	1. Economic empowerment 2. Programmes to prevent GBV 3. Protection from cultural issues directly linked to HIV risk such as wife inheritance 4. Promote Post HIV test clubs

	6. HPV vaccination 7. Emergency contraceptives		5. YFHS scale-up 6. Total market approach to condom programming

MEDIUM INCIDENCE CLUSTERS

Priority population	Biomedical interventions	Behavioural interventions	Structural interventions
Priority populations			
Key populations			
MSM	1. Male condoms 2. Lubricants 3. Quarterly HTC, STI and (HPV screening?) 4. Anal STI screening 5. STI treatment 6. ART regardless of CD4 count 7. PEP 8. HEP B vaccination	1. Reduction of number of partners 2. Demand creation for consistent use of condoms and lube 3. Targeted Campaigns on testing, risk reduction, adherence 4. Alcohol and Substance abuse programmes 5. Positive Health, and Dignity Prevention 6. GBV prevention programmes	1. Human rights protection of MSM - Advocacy 2. Create and scale-up safe spaces/drop-in centres 3. Social support – (community awareness/sensitization) 4. Psycho social support mechanisms 5. GBV prevention programmes 6. Coordination, situational analysis, improved and more access to condoms - Total market approach 8. Health care providers and Police sensitivity trainings
Sex Workers	1. Male and female condoms 2. Frequent and regular HTC, STI screening 3. Cervical cancer screening STI treatment 4. ART regardless of CD4 count 5. PEP 6. EMTCT 7. Family planning including EC	1. Consistent condom use 2. Targeted Campaigns on testing, risk reduction, and adherence 3. Alcohol and Substance abuse programmes 4. IEC 5. Positive Health, and Dignity Prevention	1. Promote human rights 2. 100% condom use policy (Brothels) 3. Non-traditional condom dispensation 4. Socio-economic empowerment 5. GBV prevention programmes 6. Psycho social support mechanisms 7. Coordination, situational analysis, improved and more access to condoms - Total market approach 8. Health care providers and Police sensitivity trainings 9. Advocacy
Priority Populations			
Young women at risk,	1. HTC 2. STI screening	1. Life skills education 2. Comprehensive sexuality	1. Reduce age of consent for HTC 2. “Keep Girls in School” programmes

10 - 14 years	3. HPV screening 4. Education of female and male condoms; family planning and emergency contraception Post exposure prophylaxis 5. HPV screening 6. Post rape care	education/training 3. Evidence-based interventions (adapted for Malawi) 4. Prevention, condom use, and risk perception training 5. Targeted Campaigns on testing, risk reduction, adherence 6. Stop Early marriage campaigns	3. Social cash Transfer programmes 4. Education and access - Total market approach 5. GBV reduction programmes 6. YFHS scale-up 7. Community Protection mobilization for legal action against sexual offenders
Young women at risk, 15-24 years	1. Post exposure prophylaxis 2. HTC 3. STI screening 4. Female and male condoms 5. Family planning and emergency contraception 6. Post-rape care	1. Life skills education 2. Comprehensive sexuality education/training 3. Evidence-based interventions - Healthy choices 4. Prevention, condom use, and risk perception training 5. Couple HTC and disclosure 6. Targeted Campaigns on testing, risk reduction, adherence 7. "Stop Early Marriage" Campaigns 8. Messages on intergenerational sex	1. Human rights protection of young girls (raise age at first marriage) 2. "Keep Girls in School" programmes 3. Social cash Transfer programmes 4. Total market approach to condom programming 5. GBV reduction programmes 6. YFHS scale-up 7. Community Protection mobilization for legal action against sexual offenders
Couples Married and Cohabiting	1. CHTC 2. EMTCT	1. Coupling counselling – risk reduction 2. Campaigns for CHTC; female support for VMMC 3. Couple Communication 4. Male involvement	1. GBV programmes 2. Address harmful cultural practices
People living with HIV	1. Linkage to care and treatment 2. Couple HTC 3. eMTCT 4. Adherence to treatment 5. Condoms ART regardless of CD4 count 6. EMTCT	1. Positive Health, Dignity and Prevention, condom use 2. Couple HTC and disclosure; and partner prevention 3. Evidence based intervention (adapted to Mw) 4. Establish support groups	1. Zero stigma and discriminatory by-laws 2. Universal access to HIV and sexual and reproductive health services 3. Coordination, increased access - Total market approach

	7. Viral load monitoring		
Discordant couples	1. Linkage to care and treatment 2. Couple HTC 3. Adherence to treatment 4. Condoms 5. Treatment for HIV prevention 6. EMTCT 7. VMMC 8. Family Planning	1. Motivation for HIV negative partner to stay negative 2. Couple HTC 3. Disclosure 4. Partner prevention	1. Assisted Partner (s) notification for PLHIV 2. Zero stigma and discriminatory by-laws 3. Universal access to HIV and sexual and reproductive health services 4. Coordination, data, increased access - Total market approach
Other Priority Populations			
Uniformed services	1. HTC 2. Linkage to care and treatment 3. STI screening treatment 4. Adherence to treatment 5. Condoms 6. EMTCT 7. VMMC 8. Family Planning 9. PEP	1. Risk reduction for HIV negative testers 2. Demand creation for condoms 3. Positive Health, and Dignity prevention 4. Evidence based interventions	1. Review of HIV prevention policies/programmes to include condoms, PrEP, and other biomedical interventions 2. Psycho social support mechanisms for reintegration 3. Coordination, data, and increased access to condoms - Total market approach
Prisoners	1. Linkage to care and treatment 2. Adherence to treatment 3. Condoms 4. Family Planning 5. PEP	1. Risk reduction for HIV negative testers 2. Positive Health, and Dignity prevention 3. Demand creation for condoms 4. Demand creation for FP 5. Evidence based interventions	1. Review of Prison policy on HIV prevention to include condoms, PrEP, and conjugal visits 2. Psycho social support mechanisms for reintegration 3. Coordination, data, and increased access to condoms - Total market approach
Truck and long distance drivers Migrant workers (Estates, construction sites, etc.) Fishing communities Taxi drivers	1. Mobile HTC 2. Mobile SRH services 3. Couple HTC 4. Condoms 5. VMMC 6. ART regardless of CD4 count 7. PEP 8. eMTCT	1. Promotion of condom campaign 2. Targeted Campaigns on testing, risk reduction, adherence 3. SBCC campaigns on harmful cultural practices 4. Positive Health, and Dignity Prevention	1. Enact maximum working hours policies 2. Institute mandatory HIV Workplace policies 3. Enforce child labor laws 4. Coordination, data, and increased access to condoms - Total market approach 5. Review insurance (health) policies
General Population			
0-5 years	1. integration of HTC in immunization	1. Exclusive breastfeeding for up	1. Training of pre-school teachers and

	programme 2. Infant male circumcision 3. Early infant diagnosis 4. HTC for children 5. Pediatric ART for all HIV positive children 6. ART for all pregnant HIV positive women for PMTCT	to 6 months 2. Male engagement in child HIV testing and HIV prevention for children 3. Demand creation for early infant circumcision	community health workers as agents of communication for child HIV testing 2. Health Systems Strengthening 3. Advocacy for early infant circumcision
5-9 years	1. HIV and Sexual reproductive health education in clubs and in schools 2. HTC	1. Life skills	1. Sexuality and Sexual and reproductive education in schools 2. Child Rights protection, and GBV elimination programmes
Boys 10-14 years	1. HIV and Sexual reproductive health education in clubs and in schools HTC 2. VMMC 3. PEP 4. Post rape care	1. Life skill training 2. Delayed sexual debut 3. SBCC on harmful cultural practices	1. Sexuality and Sexual and reproductive education in schools 2. Child Rights protection, and GBV elimination programmes 3. "Stop GBV" initiatives/programmes, 4. YFHS scale-up 5. Coordination, data, increased access - Total market approach
Boys 15-24 years	1. HIV and STI testing 2. Sexual and reproductive health and HIV education 3. Condoms 4. HTC 5. VMMC 6. PEP 7. Post rape care	1. Life skills 2. Evidence-based intervention (adapt for Mw) 3. Risk reduction training 4. Intergenerational sex messaging 5. Alcohol Reduction campaign 6. Promotion of condom campaign	1. Child Rights protection, and GBV elimination programmes 2. Economic empowerment through micro-finance programmes 3. YFHS scale-up 4. Coordination, data, increased access - Total market approach
Men and women 24 years and above	1. PITC 2. Family Planning 3. VMMC 4. PEP 5. Post rape care 6. Emergency contraceptives	1. Sustained scaled-up Evidence-based interventions 2. Alcohol Reduction campaign 3. Positive Health, and Prevention 4. Promotion of condom campaign	1. Economic empowerment 2. Programmes to prevent GBV 3. Protection from cultural issues directly linked to HIV risk such as wife inheritance 4. Promote Post HIV test clubs 5. YFHS scale-up 6. Total market approach to condom

			programming

LOW INCIDENCE CLUSTERS

Priority population	Biomedical interventions	Behavioural interventions	Structural interventions
Priority populations			
Key populations			
MSM	1. Male condoms 2. Lubricants 3. Quarterly HTC, STI and (HPV screening?) 4. Anal STI screening 5. STI treatment 6. ART regardless of CD4 count 7. PEP 8. HEP B vaccination	1. Reduction of number of partners 2. Demand creation for consistent use of condoms and lube 3. Targeted Campaigns on testing, risk reduction, adherence 4. Alcohol and Substance abuse programmes 5. Positive Health, and Dignity Prevention 6. GBV prevention programmes	1. Human rights protection of MSM - Advocacy 2. Create and scale-up safe spaces/drop-in centres 3. Social support – (community awareness/sensitization) 4. Psycho social support mechanisms 5. GBV prevention programmes 6. Coordination, situational analysis, improved and more access to condoms - Total market approach 7. Health care providers and Police sensitivity trainings
Sex Workers	1. Male and female condoms 2. Frequent and regular HTC, STI screening 3. Cervical cancer screening STI treatment 4. ART regardless of CD4 count 5. PEP 6. EMTCT 7. HPV vaccination 8. Family planning including EC	1. Consistent condom use 2. Targeted Campaigns on testing, risk reduction, and adherence 3. Alcohol and Substance abuse programmes 4. IEC 5. Positive Health, and Dignity Prevention	1. Promote human rights 2. 100% condom use policy (Brothels) 3. Non-traditional condom dispensation 4. Socio-economic empowerment 6. GBV prevention programmes 7. Psycho social support mechanisms 8. Coordination, situational analysis, improved and more access to condoms - Total market approach 9. Health care providers and Police sensitivity trainings 10. Advocacy
Priority Populations			
Young women at risk, 10 - 14 years	1. HTC 2. STI screening 3. HPV screening 4. Education of female and male	1. Life skills education 2. Comprehensive sexuality education/training 3. Evidence-based interventions	1. Reduce age of consent for HTC 2. “Keep Girls in School” programmes 3. Social cash Transfer programmes 4. Education and access - Total market

	condoms; family planning and emergency contraception Post exposure prophylaxis 5. HPV screening 6. Post rape care	(adapted for Malawi) 4. Prevention, condom use, and risk perception training 5. Targeted Campaigns on testing, risk reduction, adherence 6. Stop Early marriage campaigns	approach 5. GBV reduction programmes 6. YFHS scale-up 7. Community Protection mobilization for legal action against sexual offenders
Young women at risk, 15-24 years	1. Post exposure prophylaxis 2. HTC 3. STI screening 4. HPV screening 5. Female and male condoms 6. Family planning and emergency contraception 7. Post-rape care	1. Life skills education 2. Comprehensive sexuality education/training 3. Evidence-based interventions - Healthy choices 4. Prevention, condom use, and risk perception training 5. Couple HTC and disclosure 6. Targeted Campaigns on testing, risk reduction, adherence 7. "Stop Early Marriage" Campaigns 8. Messages on intergenerational sex	1. Human rights protection of young girls (raise age at first marriage) 2. "Keep Girls in School" programmes 3. Social cash Transfer programmes 4. Total market approach to condom programming 5. GBV reduction programmes 6. YFHS scale-up 7. Community Protection mobilization for legal action against sexual offenders
Couples Married and Cohabiting	1. CHTC 2. EMTCT	1. Coupling counselling – risk reduction 2. Campaigns for CHTC; female support for VMMC 3. Couple Communication 4. Male involvement	1. GBV programmes 2. Address harmful cultural practices
People living with HIV	1. Linkage to care and treatment 2. Couple HTC 3. Adherence to treatment 8. Condoms ART regardless of CD4 count 9. EMTCT 10. Viral load monitoring	1. Positive Health, Dignity and Prevention, condom use 2. Couple HTC and disclosure; and partner prevention 3. Evidence based intervention (adapted to Mw) 4. Establish support groups	1. Zero stigma and discriminatory by-laws 2. Universal access to HIV and sexual and reproductive health services 3. Coordination, increased access - Total market approach
Discordant couples	1. Linkage to care and treatment 2. Couple HTC 3. Adherence to treatment 4. Condoms 5. Treatment for HIV prevention 6. EMTCT	1. Motivation for HIV negative partner to stay negative 2. Couple HTC 3. Disclosure 4. Partner prevention	1. Assisted Partner (s) notification for PLHIV 2. Zero stigma and discriminatory by-laws 3. Universal access to HIV and sexual and reproductive health services 4. Coordination, data, increased access - Total market approach

	7. VMMC 8. Family Planning		
Other Priority Populations			
Uniformed services	1. HTC 2. Linkage to care and treatment 3. STI screening treatment 4. Adherence to treatment 5. Condoms 6. EMTCT 10. VMMC 11. Family Planning 12. PEP	1. Risk reduction for HIV negative testers 2. Demand creation for condoms 3. Positive Health, and Dignity prevention 4. Evidence based interventions	1. Review of HIV prevention policies/programmes to include condoms, PrEP, and other biomedical interventions 2. Psycho social support mechanisms for reintegration 3. Coordination, data, and increased access to condoms - Total market approach
Prisoners	1. Linkage to care and treatment 2. Adherence to treatment 3. Condoms 4. Family Planning 5. PEP	1. Risk reduction for HIV negative testers 2. Positive Health, and Dignity prevention 3. Demand creation for condoms 4. Demand creation for FP 5. Evidence based interventions	1. Review of Prison policy on HIV prevention to include condoms, PrEP, and conjugal visits 2. Psycho social support mechanisms for reintegration 3. Coordination, data, and increased access to condoms - Total market approach
Truck and long distance drivers Migrant workers (Estates, construction sites, etc.) Fishing communities Taxi drivers	1. Mobile HTC 2. Mobile SRH services 3. Couple HTC 4. Condoms 5. VMMC 6. ART regardless of CD4 count 7. PEP 8. eMTCT	1. Promotion of condom campaign 2. Targeted Campaigns on testing, risk reduction, adherence 3. SBCC campaigns on harmful cultural practices 4. Positive Health, and Dignity Prevention	1. Enact maximum working hours policies 2. Institute mandatory HIV Workplace policies 3. Enforce child labour laws 4. Coordination, data, and increased access to condoms - Total market approach 5. Review insurance (health) policies
General Population			
0-5 years	1. Integration of HTC in immunization programme 2. Infant male circumcision 3. Early infant diagnosis 4. HTC for children 5. Pediatric ART for all HIV positive children 6. ART for all pregnant HIV positive	1. Exclusive breastfeeding for up to 6 months 2. Male engagement in child HIV testing and HIV prevention for children 3. Demand creation for early infant circumcision	1. Training of pre-school teachers and community health workers as agents of communication for child HIV testing 2. Health Systems Strengthening 3. Advocacy for early infant circumcision

	women for PMTCT		
5-9 years	1. HIV and Sexual reproductive health education in clubs and in schools 2. HTC	1. Life skills	1. Sexuality and Sexual and reproductive education in schools 2. Child Rights protection, and GBV elimination programmes
Boys 10-14 years	1. HIV and Sexual reproductive health education in clubs and in schools HTC 2. VMMC 3. PEP 4. Post rape care	1. Life skill training 2. Delayed sexual debut 3. SBCC on harmful cultural practices	1. Sexuality and Sexual and reproductive education in schools 2. Child Rights protection, and GBV elimination programmes 3. "Stop GBV" initiatives/programmes, 4. YFHS scale-up 5. Coordination, data, increased access - Total market approach
Boys 15-24 years	1. HIV and STI testing 2. Sexual and reproductive health and HIV education 3. Condoms 4. HTC 5. VMMC 6. PEP 7. Post rape care	1. Life skills 2. Evidence-based intervention (adapt for Mw) 3. Risk reduction training 4. Intergenerational sex messaging 5. Alcohol Reduction campaign 6. Promotion of condom campaign	1. Child Rights protection, and GBV elimination programmes 2. Economic empowerment through micro-finance programmes 3. YFHS scale-up 4. Coordination, data, increased access - Total market approach 5. Post test clubs
Men and women 24 years and above	1. PITC 2. Family Planning 3. VMMC 4. PEP 5. Post rape care 6. HPV vaccination 7. Emergency contraceptives	1. Sustained scaled-up Evidence-based interventions 2. Alcohol Reduction campaign 3. Positive Health, and Prevention 4. Promotion of condom campaign	1. Economic empowerment 2. Programmes to prevent GBV 3. Protection from cultural issues directly linked to HIV risk such as wife inheritance 4. Promote Post HIV test clubs 5. YFHS scale-up 6. Total market approach to condom programming

ANNEX II ESTIMATED COSTS FOR IMPACT AREAS

TOTAL[70]		$ Million					
		2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	Total
Impact	Reduction in new HIV infections and prevalence	54.3	49.9	62.7	70.3	72.3	309.6
Medium term Outcome	Reduced sexual transmission of HIV	47.1	42.6	55.4	62.5	63.6	271.3
Short-term Outcome	Increased uptake of male circumcision services	31.2	25.3	34.8	39.1	36.9	0.0
Short-term Outcome	Reduced transmission of STI	3.0	3.3	3.7	4.1	4.4	0.0
Short-term Outcome	Increased universal and targeted HIV testing and counselling	6.2	5.6	6.5	6.9	7.5	0.0
short-term Outcome	Increased use of male and female condoms	6.8	8.5	10.4	12.5	14.9	0.0
Short term Outcome	Increased provision of ARVs to all people living with HIV eligible for ART receive it	107.6	115.9	124.4	131.7	137.0	616.7
Short-term Outcome	Scale up availability of high quality ART services for adults and children	107.6	115.9	124.4	131.7	137.0	0.0
Medium term Outcome	Reduction in new HIV infections in adults and children	7.2	7.2	7.3	7.9	8.6	38.3
Short-term Outcome	Primary prevention of HIV/AIDS among women of childbearing age	0.1	0.1	0.1	0.1	0.1	0.0
Short-term Outcome	Reduce unplanned or unintended pregnancies among HIV+ women	3.2	3.4	3.4	3.6	3.8	0.0
Short-term Outcome	Reduced new HIV infections among children	0.2	0.2	0.2	0.2	0.2	0.0
Short-term Outcome	Improved HIV exposed infant follow up according to national guidelines	0.8	0.9	1.0	1.0	1.1	0.0
Short-term Outcome	Maintain low level of blood-borne transmission	3.0	2.8	2.7	3.0	3.5	0.0
Medium term Outcome	People living with HIV receive care and support according to needs	6.5	6.6	6.9	7.1	7.3	34.3

[70]The costing was done as a part of the National Strategic Plan and should be read in conjunction with the overall costs of the NSP

Short-term Outcome	Improved Multi-sector integration and coordination of Department/Ministries focusing on Nutrition for agreed strategies to target PLHIV	6.5	6.6	6.9	7.1	7.3	0.0
Medium term Outcome	Social and economic protection are ensured for orphans and vulnerable children	0.2	0.2	0.2	0.2	0.2	1.0
Short-term Outcome	Increased school attendance among orphans made vulnerable by HIV and AIDS	0.2	0.2	0.2	0.2	0.2	0.0
Impact	Reduced Stigma and Discrimination	2.9	2.8	2.5	2.7	2.7	13.6
Medium Term Outcome	Improved social and legal protection for persons living with HIV and AIDS and KAPs	2.9	2.8	2.5	2.7	2.7	13.6
Short Term Outcome	Improved social and legal protection for persons living with HIV and AIDS and KAPs	2.3	2.3	2.0	2.2	2.2	0.0
Short Term Outcome	Human Rights of PLHIV are respected and promoted	0.5	0.5	0.5	0.5	0.5	0.0
Medium Term Outcome	Increased promotion and protection of the rights of women, girls and sexual minorities in the context of HIV	0.0	0.0	0.0	0.0	0.0	0.0
Short Term Outcome	Increased uptake of health services with respect to SRH by FSWs and women made vulnerable by poverty	0.0	0.0	0.0	0.0	0.0	0.0
Impact	Improved management and coordination of the HIV response in Malawi	5.0	10.1	4.5	10.1	4.4	34.0
Medium term Outcome	Improved coordination of the HIV response	4.8	10.0	4.3	10.0	4.3	33.3
Short-term Outcome	Effective and efficient HIV and AIDS response management	4.8	10.0	4.3	10.0	4.3	0.0
Short-term Outcome	Increased synergy of the multisectoral HIV/AIDS response and improve effectiveness and efficiency	0.0	0.0	0.0	0.0	0.0	0.0
Medium term Outcome	Sustainability and predictability of funding can be established within the five years	0.0	0.0	0.0	0.0	0.0	0.0
Short-term Outcome	Increase domestic expenditure	0.0	0.0	0.0	0.0	0.0	0.0
Medium -term Outcome	Improved functioning of the M&E system	0.2	0.1	0.2	0.1	0.1	0.7
Short-term Outcome	National M&E system tracks progress	0.2	0.1	0.2	0.1	0.1	0.0