Government of Malawi

2024 Global AIDS Monitoring Report for Malawi

DRAFT

April, 2024

Table of Contents

LIST OF ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
AGYW:	Adolescent Girls and Young Women
ANC:	Ante Natal Care
CSO:	Civil Society Organization
DEC:	District Executive Committee
eMTCT	Elimination of Mother to Child Transmission
FGD	: Focus Group Discussion
FSW:	Female Sex Worker
GAM :	Global AIDS Monitoring
GBV:	Gender Based Violence
HIV:	Human Immunodeficiency Virus
KII:	Key Informant Interview
KPs :	Key Populations
MDHS:	Malawi Demographic Health Survey
MoGCDSW:	Ministry of Gender, Children, Community Development and Social Welfare
MPHIA:	Malawi Population-Based HIV Impact Assessment
MSM:	Men Having Sex with Men
NAC:	National AIDS Commission
NCPI :	National Commitments and Policy Instrument
NGO:	Non-Governmental Organization
NSP:	National Strategic Plan
PEP:	Post Exposure Prophylaxis
PLHIV:	People Living with HIV
PMTCT:	Prevention of Mother to Child Transmission
PrEP:	Pre-Exposure Prophylaxis
PWID:	People who Inject Drugs
SDGs :	Sustainable Development Goals
SRHR:	Sexual Reproductive Health Rights
TB:	Tuberculosis
TG:	Trans Gender
UN:	United Nations
UNAIDS:	Joint United Nations Programme on HIV/AIDS
VLS:	Viral Load Suppression
WHO:	World Health Organization

List of Figures

Executive Summary

Malawi has made progress towards ending AIDS as a public health threat based on the benchmarking to global program targets of 95:95:95 as it has achieved 97:97: 95. Both new infections and AIDS related deaths are on constant decline. . In this respect, efforts need to be directed and concentrated on young people (15-24) particularly girls and young women and key populations including FSW and PWID and SMS where new infection are concentrating. This calls for a combination of preventive measures particularly targeted HIV testing services and treatment services to reduce new cases. This calls for a combination of preventive measures particularly targeted HIV testing services and treatment services to reduce new cases and AIDS related deaths. This is the direction that has been spelt out in the revised National HIV and AIDS Strategic Plan (NSP) of 2023-2027. This progress notwithstanding, the country's faces barriers that would jeopardize and derail the national response. The main one being heavy reliance on external financing from international development partners that would prove inimical in the face of external shocks as was the case with CoVID 19 and of late fighting in Eastern Europe and Middle East that may affect external resource flows. Others barriers include criminalization of consented MSM and some aspects of sex work and inadequate attention paid to PWID and Transgender Persons.

The national response is coordinated by the National AIDS Commission that provides guidance to government ministries, departments and agencies. Both government (internal) and cooperating partners (external) provide resources to the national response. However, over 95% of financing comes from external partners particularly PEPFAR and the Global Fund. The current resource allocation both from internal and external resources is skewed towards Treatment, Care and Support program areas. This is critical as it is one of the pivotal HIV prevention strategic interventions. This allocation is followed by a combination of preventive measures (Condom, PreP and HTS) and program enablers that would ensure that young people (15-24) particularly girls and young people and key populations (FSW, MSM) as populations at higher risk of exposure to HIV are identified and prioritized. The use of key populations led civil society organization and community led organization would accelerate the progress of meeting the diverse needs of these key populations.

The country uses both facility based and outreach modalities for HTC and PreP services with the involvement of government (Ministry of Health), CHAM and community serving non-governmental organizations. Currently all health services including HIV testing and ART provided by the government are free of charge. This makes it possible for the majority of the country's population to have equitable access to these services. HIV testing services are the gateway to HIV prevention and treatment hence the NSP 2020-2025 outlines strategic activities to optimize testing services. The adoption of the WHO-recommended three-test algorithm is expected to improve results outcomes by reducing false positives.

The country provides HIV testing to pregnant women during antenatal clinic (ANC) visits. This is part of the triple testing for HIV, Syphilis, and Hepatitis B. Testing is done on initial contact, mainly in the first trimester. Testing is also conducted in the third trimester and immediately on admission to maternity. In 2023 , 99% of all pregnant women were tested for HIV, 80% for

Syphilis and 57% for Hepatitis B. The national guidelines recommend that HIV-exposed infants should be tested for HIV before 2 months of age. A nucleic acid test (NAT or DNA PCR) is recommended at 6 weeks. Malawi adopted a point-of-care testing to increase access to testing. Testing is provided in pediatric inpatient wards, outpatient clinics, TB clinics, and other settings. In 2023 89% of exposed infants were tested. This is still lower than 95% testing target for HIV-exposed infants at 2 months of age.

The country has laws, policies and strategies that are meant to tackle Gender-Based Violence in general and elimination of all forms of violence against women and girls and harmful cultural and social norms in general. These include Gender Equality Act of 2015, Marriage, Divorce and Family Relations Act of 2018, National Plan of Action on Gender Based Violence in Malawi, National Strategy to Combat GBV and Sexual and Reproductive Health Right (SHRR) policy and The National Male Engagement Strategy for Gender Equality, Gender Based Violence, HIV and Sexual Reproductive Health and Rights. In addition, structures such as the One Stop Centres manned by law enforcement, health and social welfare practitioners and the Victim Support Units in police service establishments have been pivotal in providing legal, medical and psychosocial support to survivors of GBV although gaps persist on the adequacy of human, financial and material resources. For adolescent girls and young women, the NSP the National Gender and HIV Implementation Plan outline the contextual and intersecting underlying factors that need to be dealt with to reduce their vulnerabilities. These include gender equality and equity in accessing education at all levels as a matter of right, and economic empowerment of women and girls. In addition, Malawi has committed itself to ensure that adolescent girls and young women (AGYW) as a vulnerable group make informed choices, enjoy their sexuality, and are free from harmful social and cultural practices in gender-equitable and violence-free societies. Currently, there are no legal age restriction on accessing contraception but there are legal restrictions on access to HIV services particularly HTC and ART. The stipulated legal age is 13.

The country's laws , regulations, and policies promote the involvement of PLHIV in the national response. They are part of the greater national response but also organize themselves into specific community-led organizations within the confines of the legal framework that is there to provide guidance and accountability and not necessarily to curtail the rights. Thus, PLHIV can register community-led organizations to respond to their community-specific HIV-related needs. These organizations can provide HIV services including KP-specific services but are expected to report such programming to the coordinating agency the National AIDS Commission for continued guidance in relation to prevailing guidelines or Standard Operating Procedures. It is also allowed that Community-led organizations and PHIV led organizations can mobilize resources locally and externally without any hinderances. As is the case with the national response, the bulk of community based, PLHIV led and KP programs are externally financed. As a country Malawi uses a holistic and inclusive approach to the HIV response whereby relevant community based, PLHIV led and KP led organizations are involved in the development plans at community, district and national levels either through their representatives or networks. Further, the Malawi HIV program recognizes the role of young people in the fight against the pandemic. Young people are involved and participate in various fora at all levels. These include national HIV response

coordinating and monitoring mechanisms and various Technical Working Groups (TWGs) that include those on gender and HIV and AGYW.

The country does not have laws that criminalize HIV non-disclosure, exposure, or transmission. The CSOs fought and lobbied against it when the 2018 HIV and AIDS Prevention and Management Act was being debated in parliament. Although same-sex relationships and some elements of sex work such as earning a living out of sex work, pimping and running a brothel are criminalized, the HIV response in Malawi takes a public health approach for the provision of health care and HIV and AIDS related services to these (FSW and MSM) key populations. There have been efforts to decriminalize these through strategic litigation and the cases are still with the courts unconcluded. No one including transgender people, PWID and all KP communities is restricted from accessing health services in Malawi although instances of verbal hostilities and discrimination towards KPs are at times reported. The national response recognizes trans-gender people and PWID as key populations that are to be mobilized to play their roles in the national response as until recently they have been underground. Efforts to establish population estimates are underway. In addition, efforts are being made to develop guidelines to protect the PWID and enhance their access to HIV services and prevent transmission of HIV while pinning down on the suppliers and peddlers. On the overall, violence, stigma and discrimination on the basis of one's status is illegal and punishable in Malawi. The affected can seek legal redress using the public funded Legal Aid Bureau and other pro bono legal services. Although there might not be special and direct programs for the PLHIV , the various social protection mechanisms do not discriminate against anyone on the basis of HIV status.

Cervical cancer screening is recommended in the national health sector strategic plan, national strategic plan governing the AIDS response, National HIV treatment and/or testing guidelines including the Malawi Standard Treatment Guidelines, and the Reproductive Health Services Guidelines. The country has adopted WHO recommendations for screening and treatment of cervical pre-cancer lesions although the guidelines are not yet fully implemented. The WHO guidelines recommend HPV testing followed by VIA. The country has the following co-infection policies: Isoniazid preventive therapy (IPT) or latent TB; Intensified TB case finding among people living with HIV; TB infection control in HIV health-care settings. Antiretroviral providers deliver antiretroviral therapy within 2 weeks of initiation of TB treatment; Co-trimoxazole prophylaxis; Hepatitis B screening and management in antiretroviral therapy clinics; Hepatitis B screening and management in antenatal care clinics to prevent vertical transmission of Hepatitis B virus; Hepatitis C screening and management in antiretroviral therapy clinics; Hepatitis B vaccination provided at antiretroviral therapy clinics; Timely Hepatitis B birth and dose vaccination provided at delivery services (within 24 hours of birth). The country has national treatment guidelines and plans for the control, prevention, and management of sexually transmitted infections (STIs) that are periodically updated in tandem with new evidence and guidance.

1.0 Introduction and Background

1.1 Introduction

Malawi is a signatory to the 2001 Declaration of Commitment on HIV and AIDS of the United Nations. The country has progressively reaffirmed its commitment through the subsequent 2006, 2011, and 2016 political declarations. Ending AIDS is a critical target under Sustainable Development Goals (SDGs), especially SDG 3, target 3.3. It underlines that by 2030, countries should end the epidemics of AIDS, Tuberculosis, Malaria. To this end, United Nations (UN) Member States during the UN General Assembly High-Level Meeting on AIDS in June 2021 further reasserted their commitments and adopted a new pact of Political Declaration on ending AIDS. As a UN member state, the country is required to submit an annual report to the UN—the Global AIDS Monitoring (GAM) Report and the country has been making submissions since 2003.

The declaration is based on the Global AIDS Strategy 2021–2026: End Inequalities, End AIDS, a bold new approach that uses an inequalities lens to identify and close the gaps that are preventing progress towards ending AIDS. The focus of the current Global AIDS Strategy is to reduce inequalities that drive the AIDS epidemic by prioritizing people who are not yet fully benefiting from life-saving HIV services. It also aims to remove structural barriers that create or maintain those inequalities and prevent access to services. The overriding aim is to ensure that the HIV response works for everyone and leaves no one behind. The strategy estimates that if the global community is to achieve the full range of targets, the global AIDS response will be on track to prevent 3.6 million new HIV infections and 1.7 million AIDS-related deaths by 2025.

This is the narrative report of the GAM 2024 . It principally interprets and elucidates on the information collected from both quantitative and qualitative data. The 2024 GAM framework revolves around the following themes: combination HIV prevention for all; 95–95–95 for HIV testing and treatment; end paediatric AIDS and eliminate vertical transmission; gender equality and empowerment of women and girls; community leadership; realize human rights and eliminate stigma and discrimination; universal health coverage and integration; investments and resources[1]. This narrative provides a cursory summary of the state of the HIV and AIDS in Malawi for the period January – December 2023.

1.2 Background

Historically, Malawi has been one of the world's poorest countries, with a significant portion of its

[1] The Joint United Nations Program on HIV/AIDS. Indicators and questions for monitoring progress on the 2021 Political Declaration on HIV and AIDS — Global AIDS Monitoring 2023. https://www.unaids.org/en/resources/documents/2022/global-aids-monitoring-guidelines

population living below international poverty lines. According to the Multidimensional Poverty Index[2], 49.9% of the population in Malawi (9,922,000 people in 2021) is multidimensionally poor while an additional 27.5% is classified as vulnerable to multidimensional poverty (5,476,000 people in 2021)[3]. Furthermore, 56.8% of people in female-headed households were poor in 2019/2020 compared to 48.5% in male-headed households[4]. Malawi has a generalized HIV epidemic and one of the highest burdens of HIV in Sub-Saharan Africa. The country has so far registered significant achievements in controlling the HIV and AIDS epidemic and attained an epidemic control from 2020 and has also registered progress toward the achievement of the UNAIDS 95-95-95; having reached 96-98-94[5] for all adults (99:100:95 for females and 90:95:94 for males) in 2023 up from 88-97-96[6] in 2021. However, HIV continues to cause a significant burden of disease in the country notably disproportionate with females bearing the heavier burden than their male counterparts.

While challenges remain, the country has made significant progress toward epidemic control through a well-coordinated and multi-sectoral response. This has ranged from the implementation of high-impact interventions such as the scale-up of Option B+ for prevention of mother-to-child transmission (PMTCT) and HIV self-testing to transitioning to more optimal and efficacious ART regimens and scale-up of combination HIV preventions. Overall, these efforts have contributed to the significant decline in new infections from around 111,000 in 1992 to an estimated 13,000 in 2023. AIDS deaths have also been on the decline from around 71,000 in 2004 to an estimated 12,000 in 2023. HIV programming is currently anchored by the National HIV and AIDS Strategy (2020-2025), a plan aligned to the Health Sector Strategic Plan III and the global AIDS targets.

Overall, HIV prevalence rates are higher among females, FSW, MSM, Transgender Individuals (TG) and among the PWID than the general population. According to the 2023 estimates among the KPs, HIV prevalence was highest among FSWs (49.9%), and the prevalence in MSM (12.8%), TGs (13.8%) and PWIDs (27.0%) was higher than in the general population aged 15 years and over (7.7%).

Nearly one in five households in Malawi is HIV-affected. Approximately twice the percentage of female-headed households have a head of the household who is living with HIV as compared to male-headed households (21.3%) of female household heads were HIV-positive in contrast to 12.2% of male household heads[7]. The 2020-2021 MPHIA reports that among adults aged 15 + years, HIV prevalence was higher among those with no education, compared to those with more than secondary school education 11.1% and 5.5% respectively. HIV prevalence in females with

[2] *The global Multidimensional Poverty Index (MPI) measures acute multidimensional poverty by measuring each person's overlapping deprivations across 10 indicators in three equally weighted dimensions: health, education and standard of living.*
[3] Multidimensional Poverty Index 2023. Unstacking global poverty: data for high impact action
[4] NSO. Malawi Poverty Report 2020
[5] Malawi HIV Estimates 2023
[6] MPHIA 2020-21
[7] Ibid

no education was 11.7%, compared to 9.7% and 6.5% in those with secondary and more than secondary education, respectively. HIV prevalence in males with no education was 9.6%, compared with 6.3% among those with secondary education. Among those aged 15+ years who have never married—a group dominated by younger segments of the population—the HIV prevalence was 2.1%. Among those who were married or living with a partner, HIV prevalence was 9.6%; in comparison, HIV prevalence was nearly twice as high (16.4%) among those who were divorced or separated and twice as high (23) among those who were widowed.

2.0 Methodology

2.1 Documents Review

Global, and national HIV and AIDS related documents were reviewed to get a comprehensive understanding of the Response and milestones achieved. Some of the documents reviewed included the Global AIDS Strategy (2021 to 2026), the Global Fund Strategy (2023-2028), the National Strategic Plan for HIV and AIDS (2020-2025), the Revised and Extended National Strategic Plan for HIV and AIDS (2023-2027) and National HIV Prevention Strategy (2015-2020)

2.2 Quantitative Data Collection

2.2.1 The HIV Program Indicator Matrix

To assess the profile of the HIV and AIDS epidemic in the country, a systematic review of the data was conducted on the UNAIDS-sanctioned HIV Program Indicator Matrix. Data were synthesized from the Data Management Information Systems (DAMIS), a data repository managed by the Department of HIV and AIDS. This included routine program data from across the above stated themes and complemented by national surveys that include the Malawi Demographic Health Survey, the Malawi Population-Based HIV Impact Assessment (MPHIA); Multiple Indicator Cluster Surveys , the Biological and Behavioral Surveillance Surveys and other key population-targeted surveys. For the key populations, there was also the use of the Design and Analysis Toolkit for Inventory and Monitoring (DATIM). The national Spectrum file, including subnational HIV data estimates (NAOMI) provided a summary of the national and subnational epidemic trend, including the 95-95-95 program targets. The UNAIDS provided guidelines and guidance on populating the data into the online GAM 2024 reporting portal.

2.2.2 **National Funding Matrix**

The funding matrix captured the flow of financial resources and expenditures associated with the HIV and AIDS programming in 2023 . In the absence of NASA, adhoc data collection from major funders in the response was done. Data on HIV program expenditures were obtained from various

partners in the national HIV response. These included the Department of Planning and Policy Development in the Ministry of Health, United Nations agencies, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), United States Government, World Vision International (WVI), the Global Fund's Program Implementation Unit.

2.2.3 Medicines and Diagnostic Survey

The WHO medicines and diagnostic survey collects ARV regimens that are used by different subgroups and viral load monitoring.

2.3 Qualitative Data Collection

2.3.1 The National Commitment and Policy Instrument

The scope of the 2021 Political Declaration on AIDS extensively extends to include government ministries, departments and agencies (MDAs);), PLHIV serving and led organizations at national and subnational levels most affected, key populations (mainly FSW and MSM) organizations and non-governmental organizations (NGOs). The National Commitment and Policy Instrument (NCPI) data collection tool captured progress across a wide spectrum of HIV and AIDS related issues.

Table 1. Consulted Organizations and Commitment Areas

Organization	Commitment Area
Ministry of Gender, Community Development and Social Welfare,	• Gender Equality and Empowerment of Women and Girls • Community leadership • Combination HIV Prevention for ALL
Ministry of Education, Science and Technology	• Combination HIV Prevention for ALL • Gender Equality and Empowerment of Women and Girls
Malawi Human Rights Commission,	• Realize Human Rights and Eliminate Stigma and Discrimination • Gender Equality and Empowerment of Women and Girls
Malawi Police Service	• Realize Human Rights and Eliminate Stigma and Discrimination
Malawi Prison Services	• Combination HIV Prevention for ALL • Realize Human Rights and Eliminate Stigma and Discrimination
Ministry of Health (Reproductive Health	• Combination HIV Prevention for ALL • Universal Health Coverage

Directorate	
Ministry of Health (Department of HIV & AIDS)	• End paediatric AIDS and eliminate vertical transmission • 95–95–95 for HIV testing and treatment • Combination HIV prevention for all • Universal health coverage and integration
National AIDS Commission	• Community leadership • Combination HIV Prevention for ALL
AGYW Secretariat (Palladium Propel Health)	• Combination HIV Prevention for ALL • Gender Equality and Empowerment of Women and Girls
FHI 360,	• Combination HIV Prevention for ALL • Realize Human Rights and Eliminate Stigma and Discrimination
MANET +	• Combination HIV Prevention for ALL • Realize Human Rights and Eliminate Stigma and Discrimination

2.3.2 Multisectoral Stakeholders Validation Workshop

In tandem with GAM 2024 guidelines, another source of information was the stakeholders' validation workshop, convened to present , discuss and come to an agreement of the critical elements of the country's state of the HIV and AIDS response. The presentation and dialoguing were centered on findings pertaining to epidemic indicator profile, NCPI information , ARV volumes, and resource flow and receipts supporting various pillars of the national HIV and AIDS response. The workshop was attended by stakeholders from the Ministry of Health, Ministry of Gender, Community Development and Social Welfare , Malawi Police Services, Malawi Prisons Services, UNAIDS, NAC; civil society organizations (CSOs) working in the HIV and AIDS sector and Key populations-led organizations.

2.4. 2024 GAM Reporting

This was mainly in two equally reinforcing realms. There is online posting of indicators onto the reporting portal and follow-on activities to resolve queries after submission. The deadline was 31st March, 2024. However, resolving of queries and making of correction persisted throughout April, 2024 and a narrative report of the results from both Epidemiological Data capturing and qualitative National Commitment and Policy Instrument. It highlights the major findings on the UNAIDS areas of commitment as per the GAM 2024 guidelines.

3.0 Results

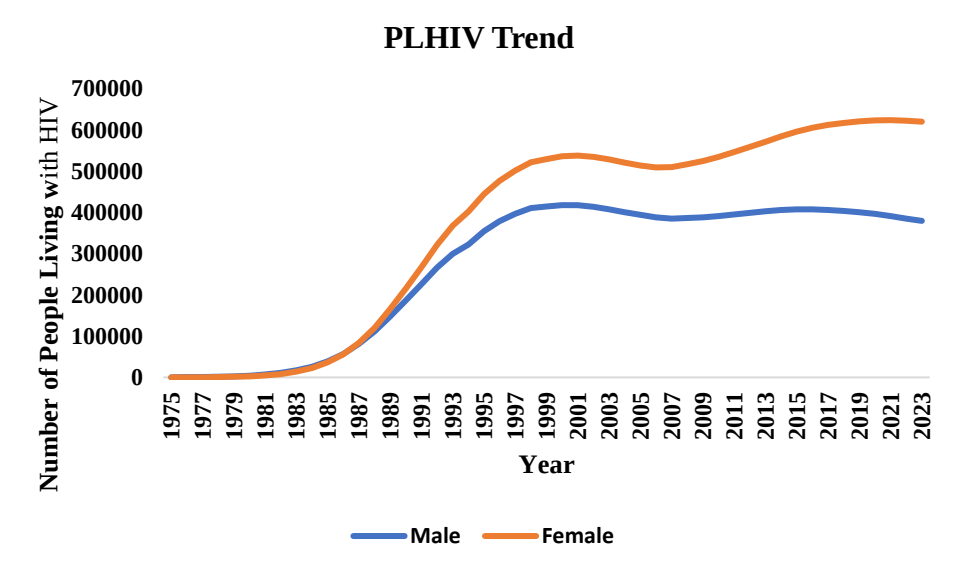
The results presented are laid using the sub headings in the GAM 2024 Reporting Guidelines.

3.1 Combination Prevention for All

The combination of a wide range of HIV prevention interventions has resulted mostly in the observed reduced spread of HIV in the general population . In this respect, two indicators have been isolated to highlight the progress. These are new HIV infections and AIDS deaths.

Figure 1 presents the trends in people living with HIV (PLHIV) in Malawi. The epidemic has passed through a number of stages from times of constant and persistent spread at a high rate of incidence and prevalence affecting all age groups (hyperendemic) to declines in both new infections and deaths. The number of PLHIV is estimated at around 1,000,000[5] with an annual decline of 0.6% in the past five years. However, the distribution of PLHIV is markedly skewed towards females (62%).

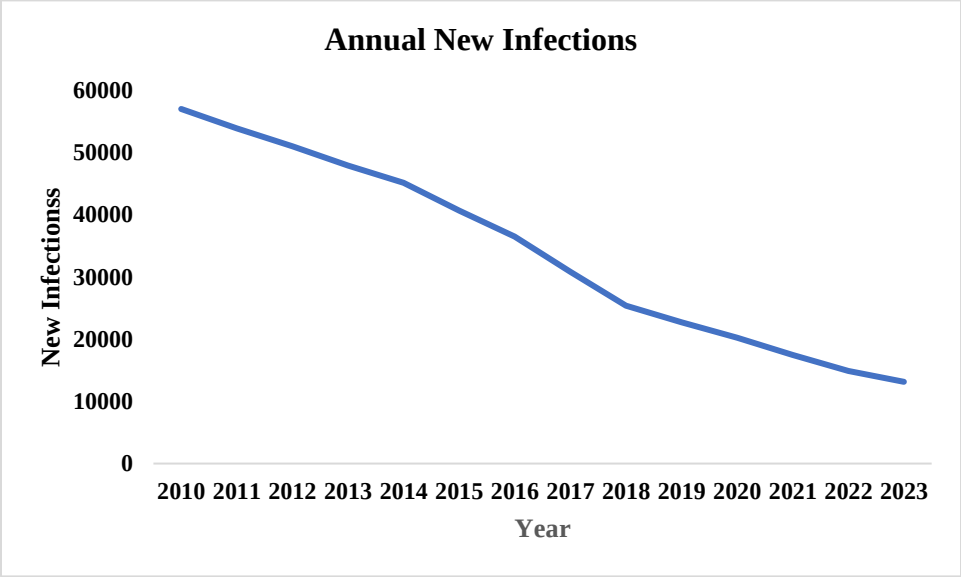
Figure 1: Trends in PLHIV



Source: 2024 Draft HIV Estimates

In terms of new infections, the country's HIV estimates show continued year-on-year decline in new HIV infections. As reflected in Figure 2, between 2010 and 2023, new infection declined by 77% . Of note is also the estimation that the new infections declined by 12% between last reporting period and the current reporting period (2023) .

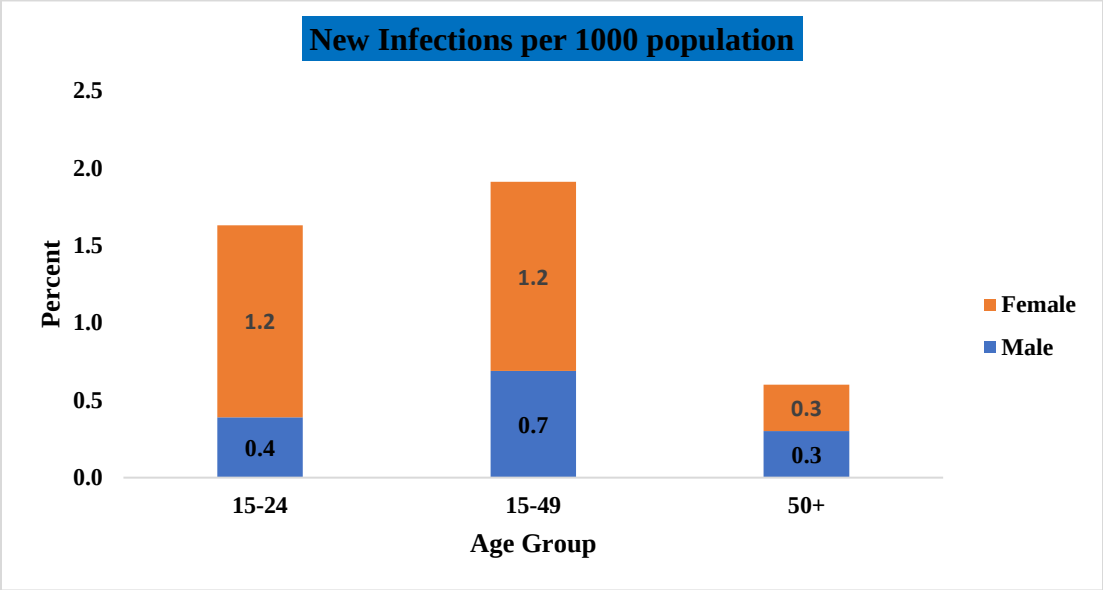
Figure 2: Trends in New Infections



Source: 2024 Draft HIV Estimates

It is also noted as reflected in Figure 3 that the incidence is three times higher among girls and young women (15-24) than their male counterparts (15-24). This identification of the source of new infections is critical in understanding transmission dynamics that provide guidance in the scaling up of prevention strategies that can maximize reductions in HIV infections among this group and by extension all age groups.

Figure 3: HIV Incidence, 2023



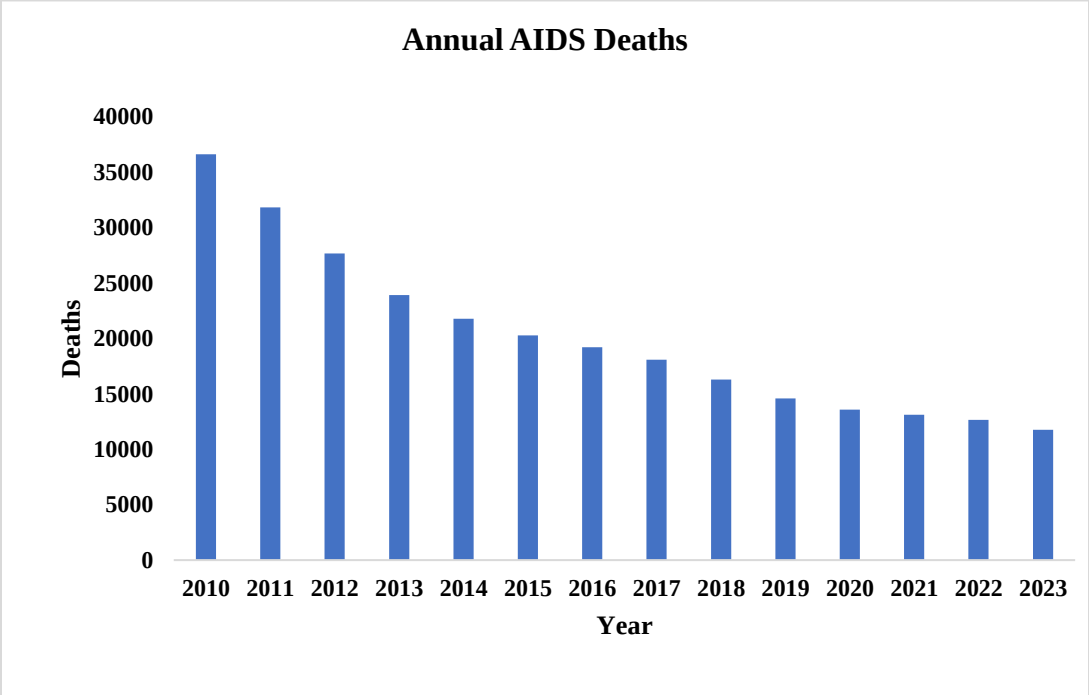
Source: 2024 Draft Estimates

During key informant interviews with stakeholders there were a number of factors as influencing risky sexual behaviors among the girls and young women. The most persistent ones included poverty and harmful social and cultural norms that perpetuate gender inequalities, GBV and sexual exploitation and abuse. These affect socio- economic wellbeing of the girls and young women that eventually precipitate HIV transmission.

While the country has a range of HIV prevention strategies including condoms, PrEP and PEP, male circumcision, comprehensive sexuality education, behavioral change interventions , young people in general and girls and young women in particular exhibit peculiar vulnerabilities and needs, that calls for innovative and targeted HIV interventions. The National Gender and HIV/AIDS Implementation Plan (2015-2020) clearly outline these strategic interventions.

In terms of HIV related deaths, the estimates as depicted in Figure 4 show that there were 12,000 HIV deaths in 2023.

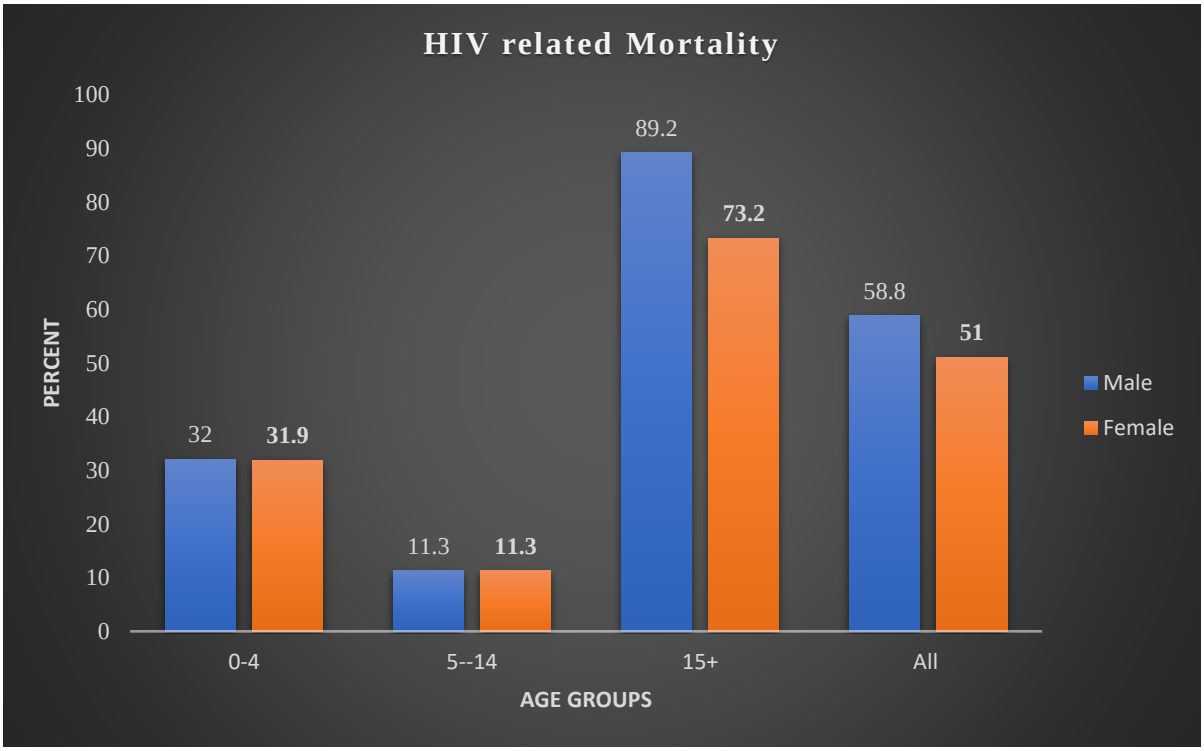
Figure 4: Trends in AIDS Related Deaths



Source: 2024 Draft HIV Estimates

This is a 7 % decline from the previous reporting period. Since 2010, there has been a decline of 68% in AIDS deaths.

Figure 5: Incidence of AIDS Related Deaths



Source: 2024 Draft HIV Estimates

Figure 5 above depicts deaths per 100,000 population (incidence) of that age group . It is generally observed that there were more deaths per 100,000 among males (59) than among females (51). However, it was noted that progress has been made in 2023. As depicted in Figure 7, an estimated 36, 026 deaths were averted due to ART programming while 7,748 new infections were averted as a consequence of PMTCT programming.

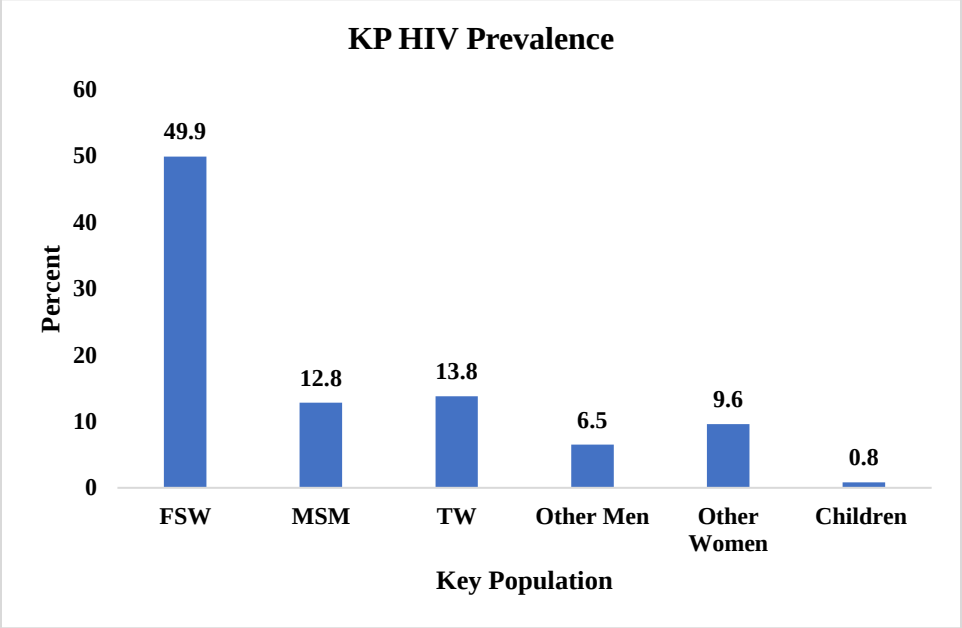
3.1.1 Key Populations

Although some graphs are presented in this report it should be noted that no new data were available from population-based surveys undertaken during the reporting period. For this reason, 2023 GAM KP indicators are not discussed with reference given to prior reports. This notwithstanding, it still presents a cursory picture worth noting.

In Malawi, key populations comprise people with different sexual practices and orientation including FSWs, male sex workers (MSWs), MSM, TGs, and people who use/inject drugs (PWIDs) while prisoners, migrants, persons displaced due to emergencies, uniformed personnel, AGYW and persons with disabilities (PWD) are considered vulnerable populations. Key populations are at high risk of HIV infection due to their sexual behaviors, social and/or legal

barriers that increase their vulnerability to HIV infection. They are described as key populations because they are at substantial risk of acquiring HIV due to risky sexual behaviors and social and legal contexts. They often experience stigma and discrimination which restrict their accessing HIV prevention and treatment services thereby amplifying the burden of HIV among their communities. In terms of HIV prevalence, the figures show very high rates as compared to the general population. As depicted in Figure 6, estimated HIV prevalence among sex workers in the highest at 49%.

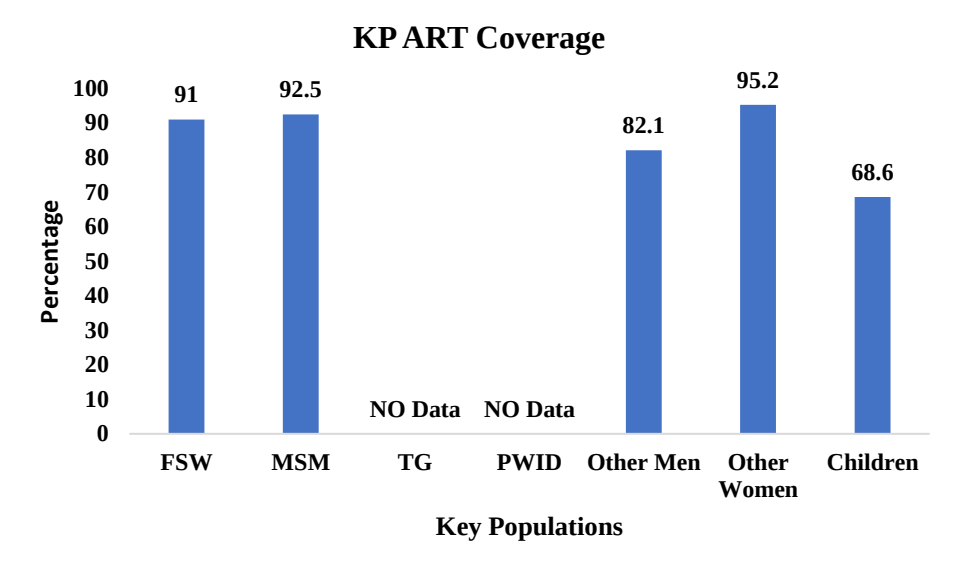
Figure 6: Key Population HIV Prevalence Estimates



MSM happen to be at an increased risk of HIV transmission from unprotected anal intercourse, generally higher levels of sexual partnering within relatively closely connected partnership networks, and the ability of MSM to serve as both the insertive and receptive partner in acts of anal intercourse. On the overall, due to hostile environment, KPs particularly TGs and PWIDs continue to remain hidden and underground communities. It is critical that structural bottlenecks that affect key populations' access to services be identified and addressed to enhance contribution towards reduction of circular transmission of HIV among key populations. Failure to attend to their HIV and AIDS related needs and those of their sexual partners may ultimately increase the burden of disease.

In terms of ART coverage among key populations, as reflected in Figure 7, they compare favorably with the general population. FSW are at 91.0% while MSM are at 92.5%. However, data for people who inject drugs and transgender people has been unavailable from both program reports and surveys.

Figure 7: ART Coverage for Key Populations, 2023



3.1.2 HIV and AIDS in Prisons

Research has shown that HIV prevalence in closed settings such as prisons is 7 times higher compared to the general population. The 2024 MDHS will target refugees camp and special BBSS has been planned for prisons. It is worth noting that prison population is a very transitory population with high turnover in a year. Based on prison services records, the population of persons in prison by the end of 2023 was at 15,796 of which 15,478 (98%) were males and 318 (2%) were females. Out of 15796 persons in prisons , 3203 (20.3 percent) were living with HIV with females twice as likely to be positive as males. .

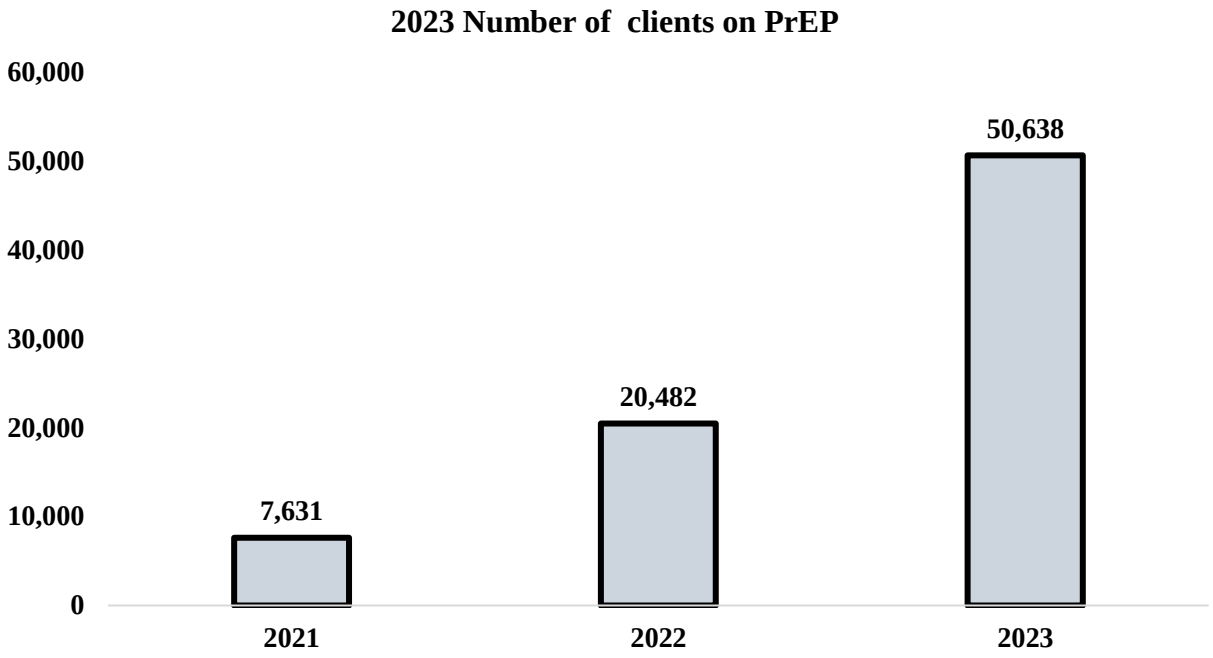
In the reporting period, 24,773 prisoners were tested for HIV with 229 (1%) found positive. Greater proportion (9.4%) were found positive compared to almost 1% for males. Of the 3203 inmates living with HIV all of them were on ART. Such huge sex differentials among prisoners were attributed among other reasons to the small proportion of females in prisons and the self-selection nature of the females who end up in prisons. Most of them are those connected to sex work.

3.1.3 Pre-Exposure Prophylaxis (PrEP)

The number of sites providing PreP increased from 202 in 2022 to 263 in 2023 an increase of 61 new sites. This is in line with the NSP (2020-2025) that recommends for targeted provision of PrEP services among key and other vulnerable populations particularly Adolescent Girls and

Young Women (AGYW). By the end of 2023, a total of 50,638 clients (DHAMIS) were documented to have utilized PrEP services at least once; more than double the numbers (30,000 more) observed during the previous reporting period. PrEP services are also integrated within other existing service delivery channels such as STIs and family planning clinics.

Figure 8: Number of Prep Clients Retained in Care, 2023

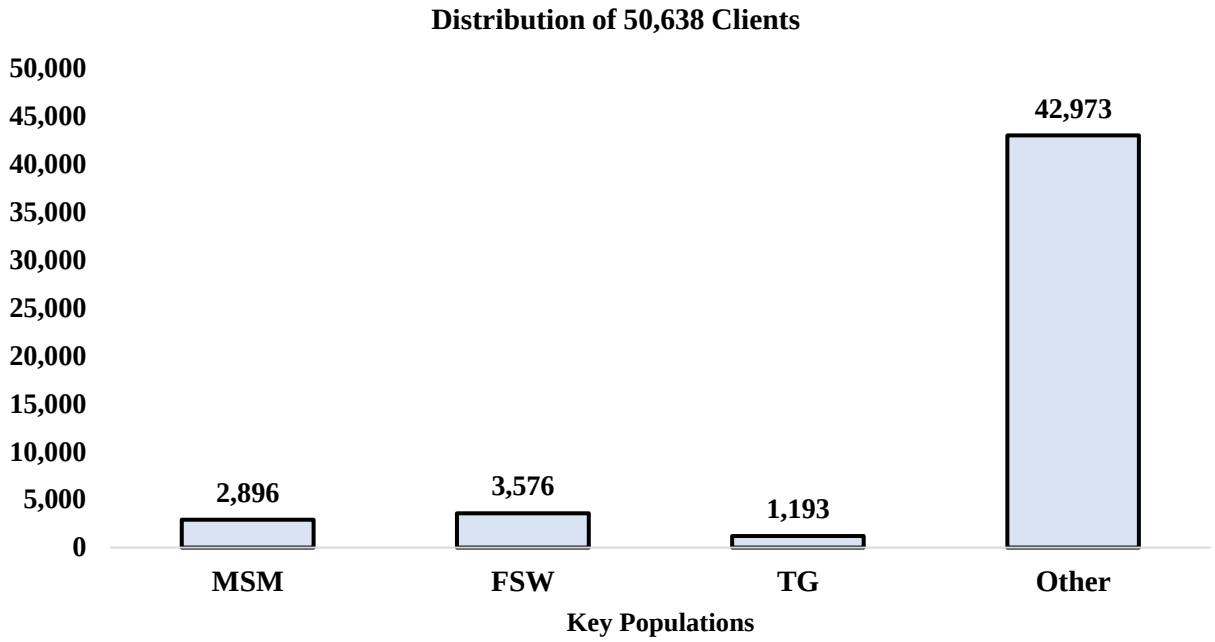


Source: DHAMIS

To further enhance PrEP provision, the national HIV and AIDS response has revised the PrEP guidelines to be more accommodative and has also incorporated more PrEP options to include injectable, oral event driven and enhanced community provision .

It is also noteworthy to highlight how the targeted key populations have fared. Figure 9 shows that out of the total 50,638 clients , a total of 7665 (15.1%) were key populations. However, because of the hostile environment faced by key populations , some clients might not have revealed themselves to the providers hence being counted among the other (general population).

Figure 9: Distribution of Prep Clients by Key Population, 2023



Source: DHAMIS

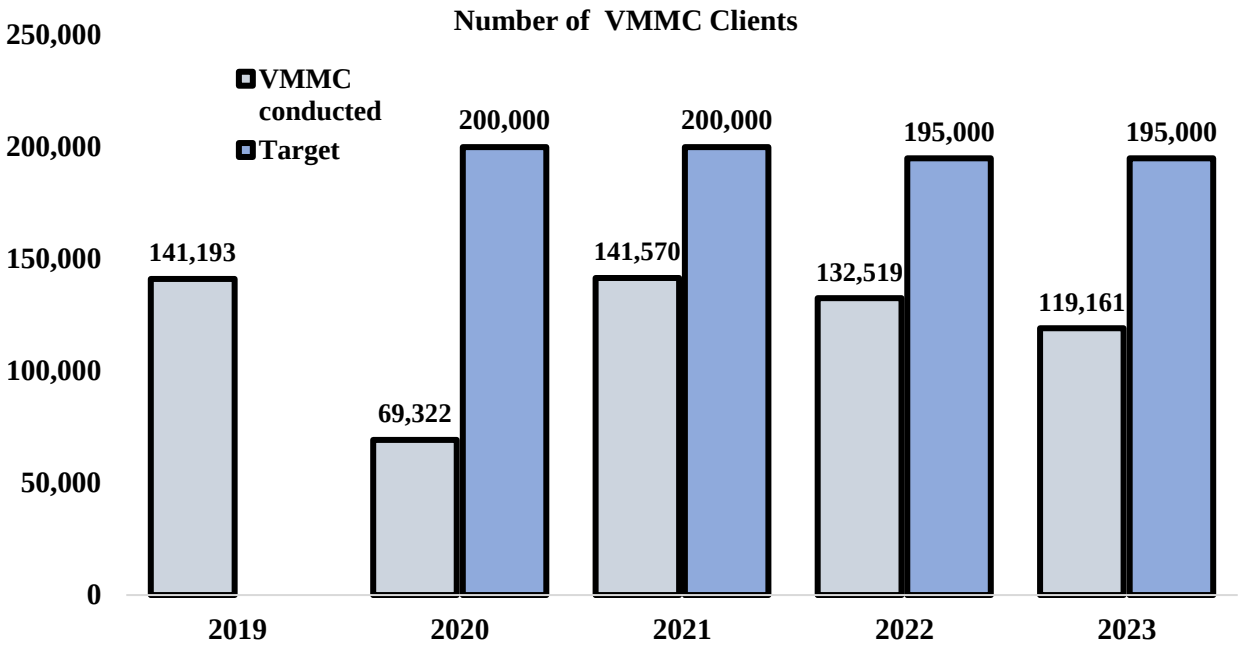
3.1.4 Voluntary Medical Male Circumcision

Medical male circumcision provides lifelong partial protection against HIV and other STIs proven to significantly reduce the risk of heterosexual transmission of HIV. Its impact is particularly greater in settings with high HIV prevalence and low levels of male circumcision. Following WHO recommendations, Malawi rolled out voluntary male medical circumcision (VMMC) services as a choice HIV prevention intervention in 2012. The provision of VMMC services is undertaken through both static and mobile facilities supported by governments and partners. Considering resource limitations and the need for efficiency, implementation of VMMC has been prioritized in high HIV burden districts and in the 25-39 years age-group.[8] The National Strategic Plan for HIV 2020-2025 targets to conduct 900, 000 VMMCs in selected high burden districts. However, external shocks such as the recent COVID-19 pandemic clearly disrupted VMMC programming and contributed to less-than-optimal yields given the NSP target. Based on the synthesis of data from program reports and the District Health Information System (DHIS2). For example, Figure 10 shows that there were only 69,332 clients against the target of 200,000. VMMC volumes were

[8] HIV NSP, 2020 to 2025

also 6% less in 2022 compared to 2021 and the 2023 figure is lower (119,161) than that of 2022 (132,519) .

Figure 10*:* Number of Voluntary Male Medical Circumcision Clients, 2023



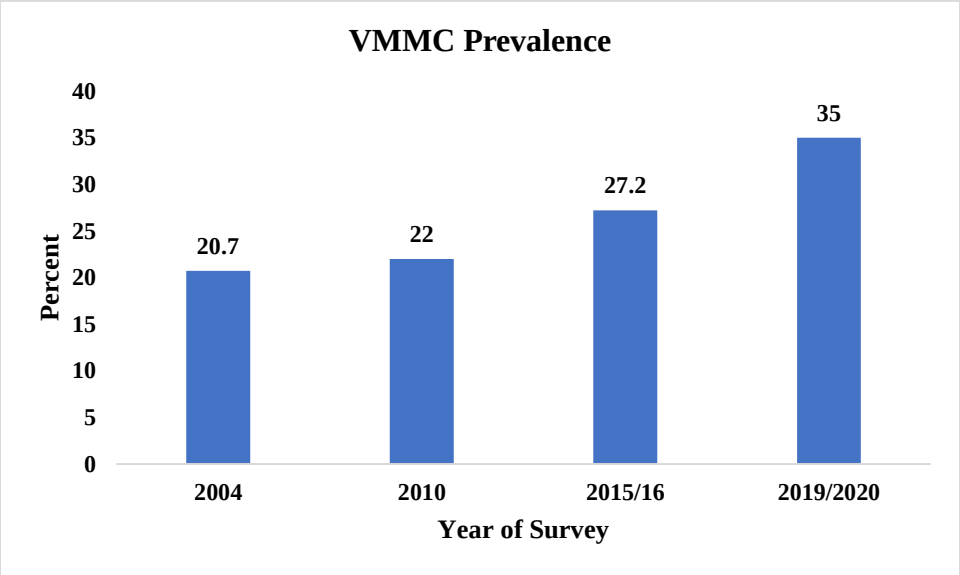
Source: Program reports and the District Health Information System (DHIS2)

However, the prevalence has been increasing as reflected in the Figure 11. Over the years, there has been a steady increase in the national coverage of VMMC from around 22% in 2010 to 28% in 2015 though district prevalence varies[9]. In 2021, the national coverage of VMMC was estimated at 35%[10] based on the Malawi Population-based HIV Impact Assessment (MPHIA).

[9] National Statistical Office. Malawi Demographic Health Survey 2015-16. Zomba, Malawi.

[10] Columbia University. Malawi Population-Based HIV Impact Assessment 2020-2021. New York, United States.

Figure 11: VMMC Prevalence, 2023



Source: 2010 and 2015-16 MDHS and 2016 and 2020 MPHIA

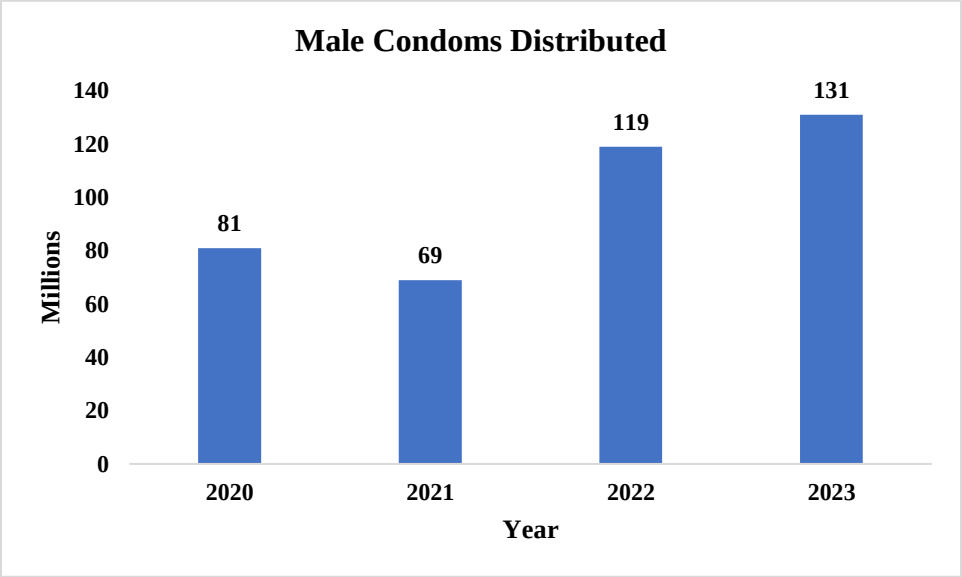
There have been efforts to scale up implementation of VMMC services through the decentralization of VMMC procedures to districts and private clinics and community engagement through male agents and leaders. Of late the Ministry of Health and the Christian Health Association of Malawi have finalized a service provision agreement whereby 31 sites in 5 districts have been earmarked for scaling up of VMMC services targeting 12,000 clients. In addition, there has been an increased number of service providers by allowing Medical Assistants to offer VMMC services However there are persistent challenges that include human resource capacity and limited infrastructure including inadequate space in health facilities especially in rural areas; Cultural and religious perceptions about the procedure especially the link between male circumcision and cultural and religious identities and inadequate integration of VMMC into routine service delivery and HIV prevention programming.

3.1.5 Condoms

Condom programming has been a key strategy in the country's HIV prevention plans as a simple and low-cost intervention; highly effective in preventing HIV and other sexually transmitted diseases (STDs), like gonorrhea and chlamydia. Despite being integral components of many national HIV, STI, and reproductive health initiatives, condoms have not received consistent distribution or proactive promotion to an adequate degree amongst some sections of the

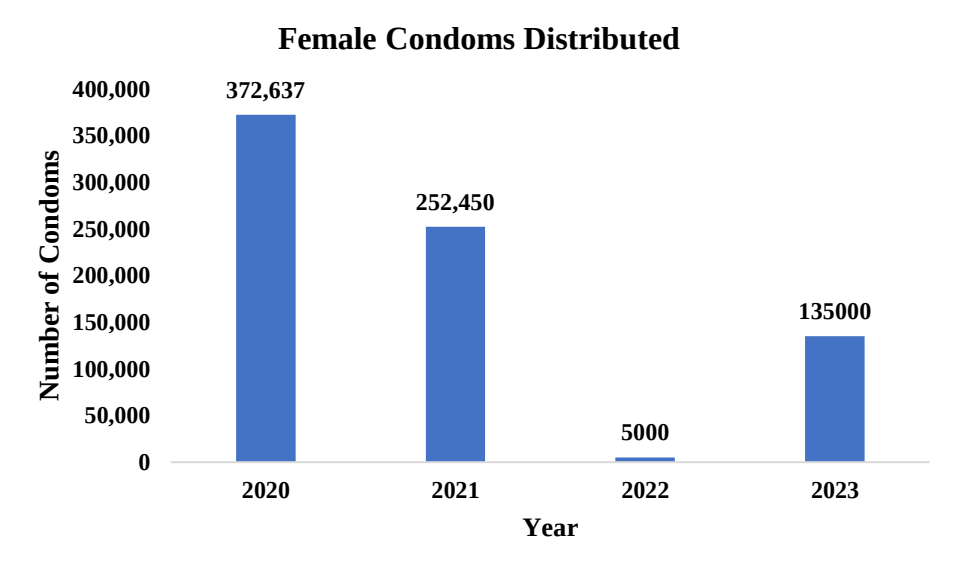
population. However, currently condom programming is anchored by the national condom strategy and other HIV prevention strategies that elucidate strategic interventions and targets. In addition, the country has also been implementing condom to the last mile strategy being piloted in Mangochi, Mulanje and Lilongwe. In addition, trainings of distributors are being undertaken in the rest of the districts. There has also been a Hotspots identification exercise for targeted condom distribution . Figure 12 shows a steady increase, except in 2021, in total condom volumes distributed although all these years there have been below NSP targets. In 2023, 131 million male condoms were distributed , 19 million lower than the target of 150 million condoms per year.

Figure 12: Male Condoms Distribution, 2023



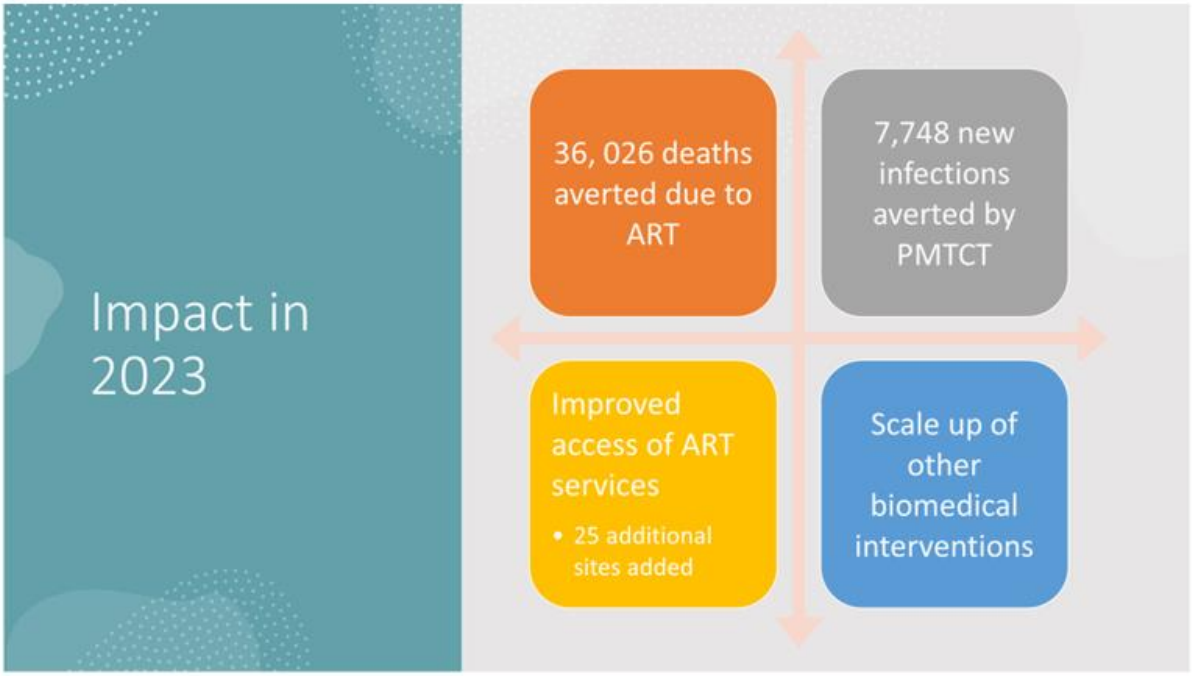
Consistently, condom use among females has been lower than that of their male counterparts. The trend in Figure 13 is showing that the figures distributed have been going down from a high of 372,637 in 2020 to a low of 135,000 in 2023. Key informants elaborated that the vulnerability of women due to social, cultural and economic factors limits their ability to negotiate safer sexual practices unless initiated by their male partners. Additionally, the accessibility (outlets and prices) of male condoms tends to be higher than that of female condoms, granting men greater control over their use compared to women.

Figure 13: Female Condom Distribution, 2023



Efforts to scale up have included improved distribution system to key and vulnerable groups using hotspots and peer and social marketing and the enhancement of parallel distribution channels to the public sector supply chain system, including community-based distribution agents (CBDAs) and a dedicated distribution channel for condoms and lubricants for KP service providers; and the introduction of lubricants into ongoing KP programs. The above efforts notwithstanding challenges remain that include low risk perceptions and low condom use in the populations with the highest HIV burden including male and female partners in regular sexual relationships; suboptimal distribution to rural and poor populations, poor access to female condoms, stigma associated with a female carrying a condom or wearing a female one in advance and policy restrictions on availability of condoms in school premises and prisons.

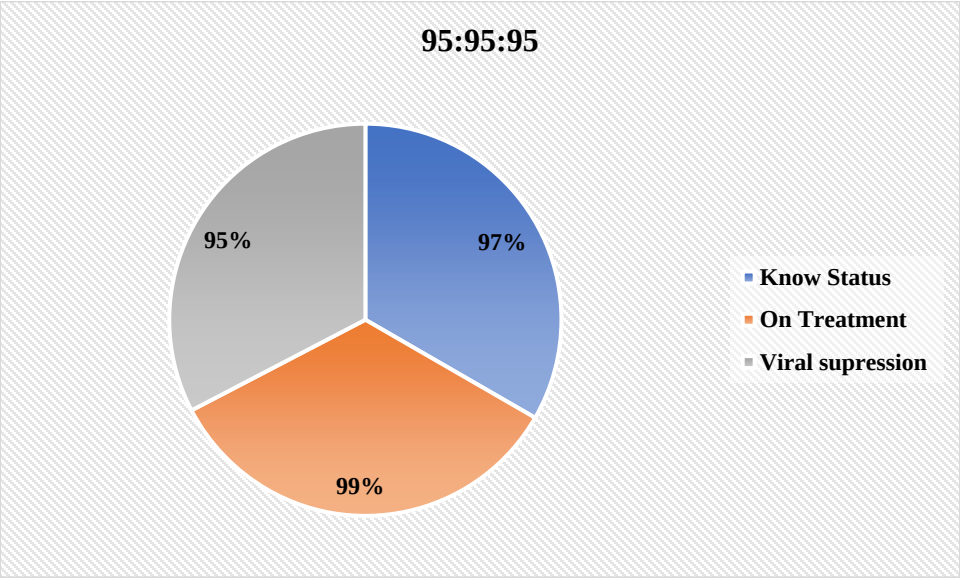
Figure 14: Impacts of HIV Prevention Efforts , 2023



3.2 95–95–95 for HIV testing and treatment

In terms of 95,95,95 Figure 15 suggests that the country is on the right trajectory to achieve those targets. According to the draft 2024 Spectrum estimates, 97% of people living with HIV are aware of their status (End of December 2023). This shows that the country has surpassed its 2025 targets.

Figure 15: Treatment Cascade for All Ages



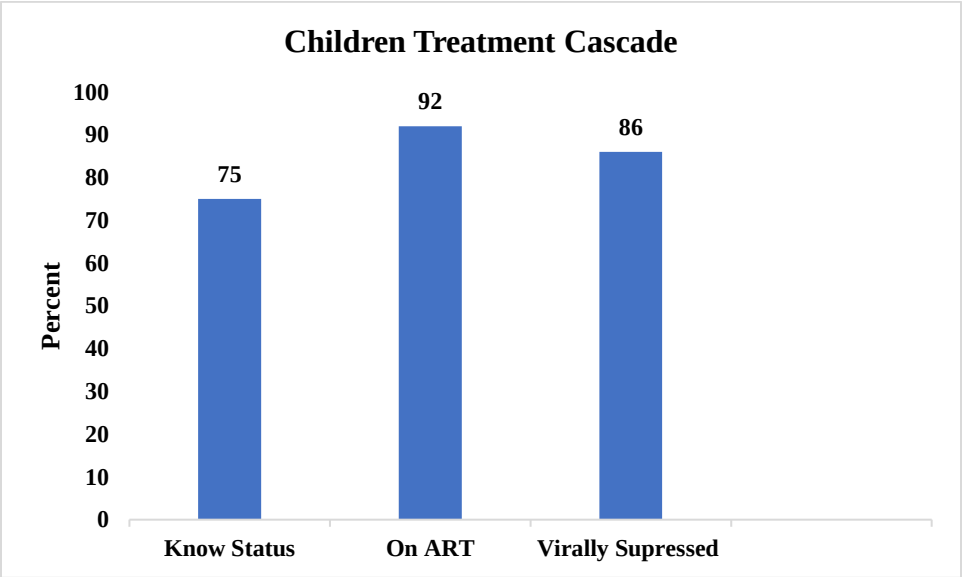
Source: ***Source: 2024 Draft HIV Estimates***

For the 2nd 95%, the programmatic gains are evident. The HIV treatment program surpassed the global (2025 AIDS target) as well as the country's target as outlined in the National HIV and AIDS Strategic Plan (NSP). 98% of those who know their status were on ART by end of December 2023. The country needs to sustain this by continuously improving its HIV treatment program.

Turning to the 3rd 95%, gains are also noticeable. The country attained 95% coverage of viral suppression across all ages—a percent increase compared to 2022. The existing trend suggests both AIDS 2025 targets have been attained.

However, the viral load suppression rate was slightingly lower among some youth age groups. The most prominent is among the youth aged 0-9 years. For example, as shown in Figure 16, up to 25% of children living with HIV in that age group do not know their status of which 92% are on ART while 86% are virally suppressed. This calls for intensification of HTC services among the youth 0-9 years some of whom might have been living with HIV since birth without them knowing.

Figure 16: Treatment Cascade for Children



Source: 2024 Draft HIV Estimates

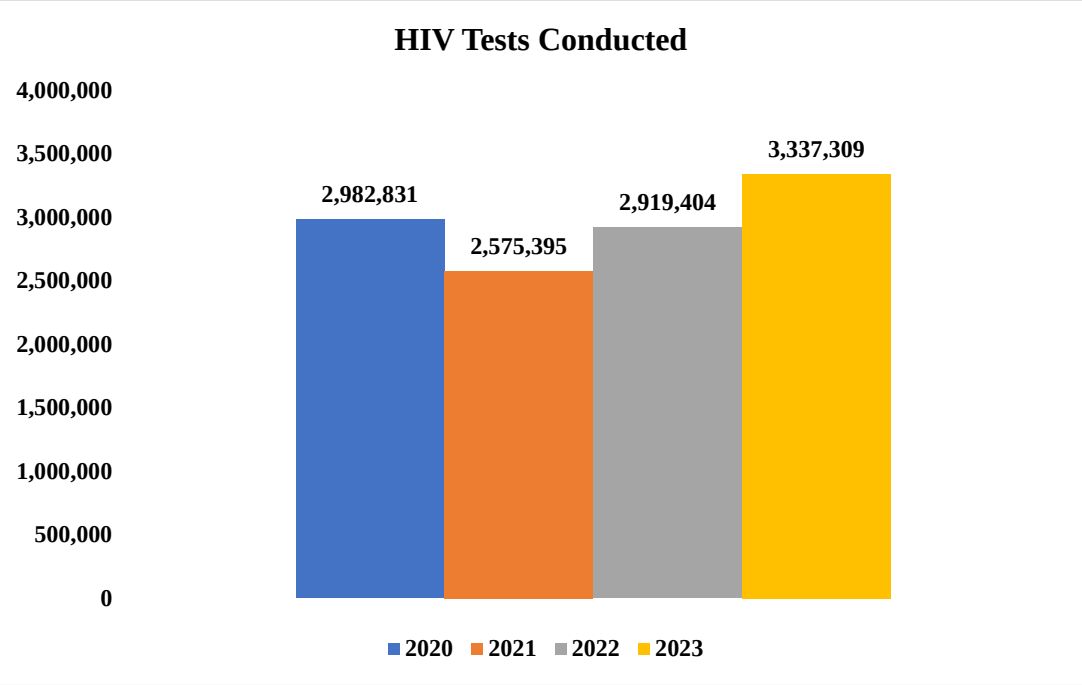
In this respect, the country has put in place strategies to improve pediatric HIV outcomes. These include dealing with low case detection and mother to child transmission through tracing and finding all pregnant and breastfeeding women, reviewing of PITC and index testing as most of Children Living with HIV (CLHIV) not on ART are older and timely access to early infant diagnosis (EID). On treatment, the strategies include enhancing linkages, retention and adherence through standardized patient education, disclosure and provision of psychosocial support through use of child friendly counsellors. On low uptake and poor result utilization the strategy is the adoption of FDC regimen.

3.3 HIV Testing volume and positivity

HIV testing services are the gateway to HIV prevention and treatment. To this end, the HIV strategic plan 2020-2025 outlines strategic activities to optimize testing services. Among others, this included the adoption of the WHO-recommended three-test algorithm. This is expected to reduce false positives. The HTS optimization model predicted testing volumes of around 5.7 million tests for 2022 for the NSP. However, as reflected in Figure 17, the country registered nearly 3.3 million tests across all testing channels with an overall yield of 2.0%. This was a 12

% increase from the previous reporting period. However, disaggregated reporting of testing data has been a challenge not only for HTS but for other programs as well. Deployment of the ScanForm technology is expected to simplify matters and allow the program to report more granular level data.

Figure 17: Number of HIV Tests Conducted



Source: DAHMIS

3.4 End paediatric AIDS and eliminate vertical transmission

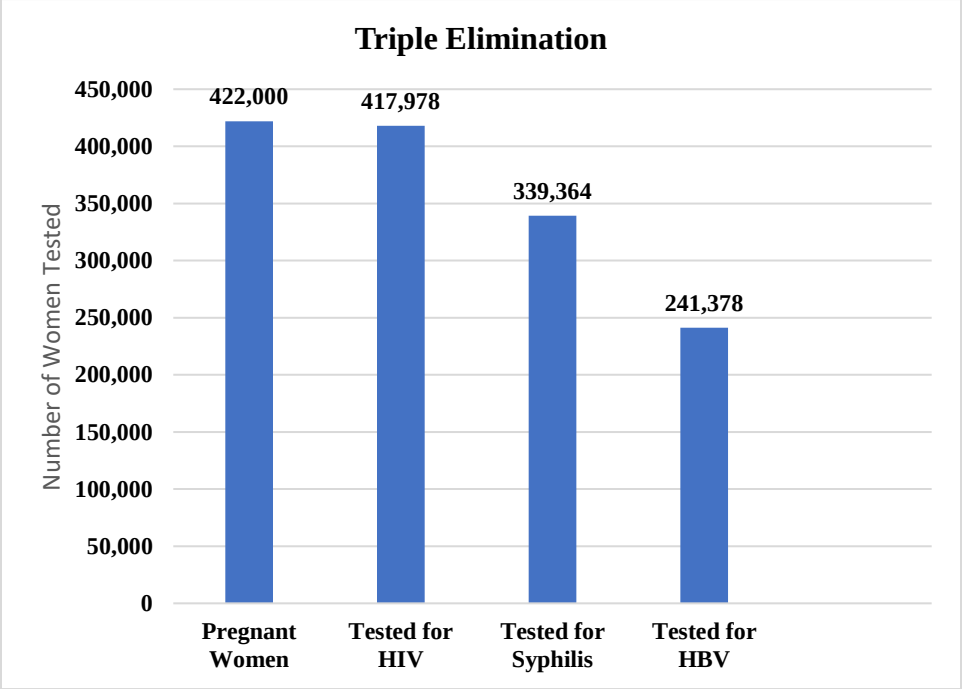
Testing is also conducted in the third trimester and immediately on admission to maternity. In 2023 , 99% of all pregnant women were tested for HIV, 80% for Syphilis and 57% for Hepatitis B. The national guidelines recommend that HIV-exposed infants should be tested for HIV before 2 months of age. A nucleic acid test (NAT or DNA PCR) is recommended at 6 weeks. Malawi adopted point-of-care testing to increase access to testing. Testing is provided in pediatric inpatient wards, nutrition centers, immunization clinics, outpatient clinics, TB clinics, and other settings. In 2023 89% in 2023 were tested still lower than 95% testing target for HIV-exposed infants at 2 months of age.

The country is transitioning to 3 test-algorithm.T his will happen in 601 sites out of expected 800+ sites . There is also the implementation of new patient level data capturing tool called ScanForm that that will make it possible to produce finer data disaggregated by age, sex and modality that

will culminate into automatic monthly data reports.

Malawi provides HIV testing to pregnant women during antenatal clinic (ANC) visits. This is part of the triple testing for HIV, Syphilis, and Hepatitis B. Testing is done on initial contact, preferably in the first trimester. Testing is also conducted in the third trimester and immediately on admission to maternity. The NSP recommends a target of 95%. In 2023 out of 422,000 pregnant women, 417,978 were tested for HIV re[presenting 99% of all pregnant women. Eighty percent were tested for Syphilis while 57% were tested for Hepatitis B as summarized in Figure 18.

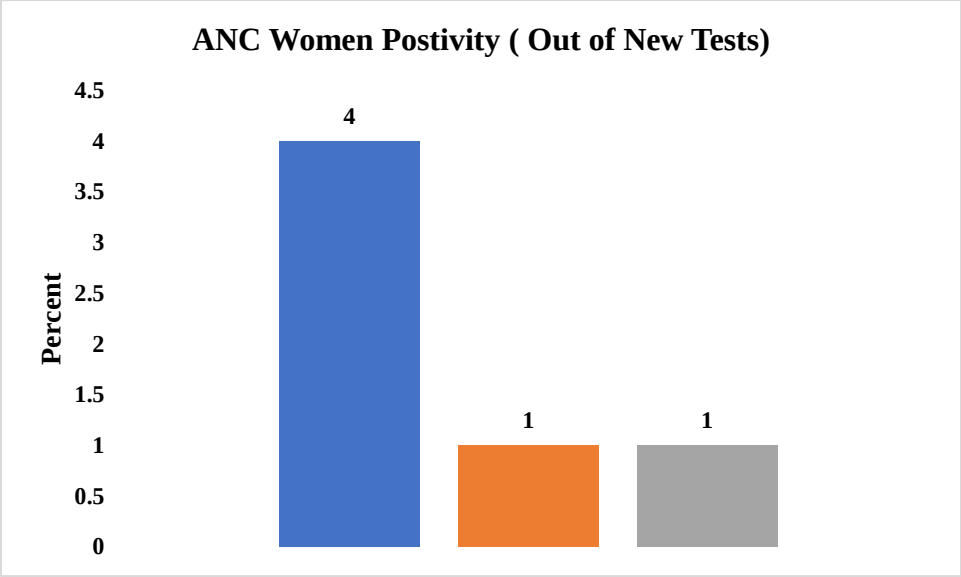
Figure 18: ANC Women Testing For Syphilis, HepB and HIV



Source: Program Data (ScanForm)

On the positivity , Figure 19 below shows that there was 4% and 1% apiece for syphilis, HepB and AIDS positivity.

Figure 19: Positivity for HIV, Syphilis and HepB, 2023

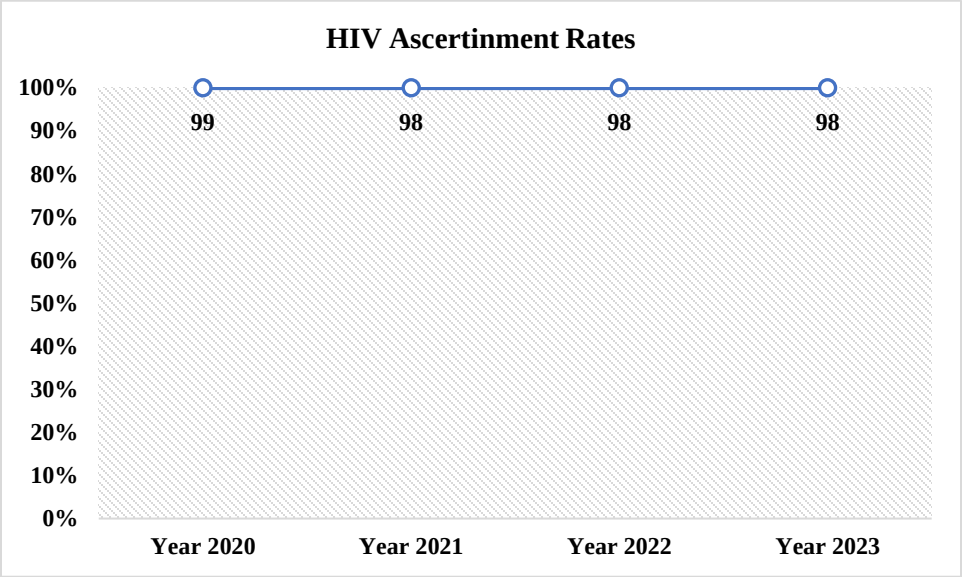


Source: Program Data (ScanForm)

3.4.1 HIV Testing in Pregnant Women

Malawi provides HIV testing to pregnant women during antenatal clinic (ANC) visits. This is part of the triple testing for HIV, Syphilis, and Hepatitis B. Testing is done on initial contact, preferably in the first trimester. Testing is also conducted in the third trimester and immediately on admission to maternity. The has been constant high rate of 98% (also being the target) from 2021 to 2023 as reflected in Figure 20.

Figure 20: HIV Testing Among ANC Women

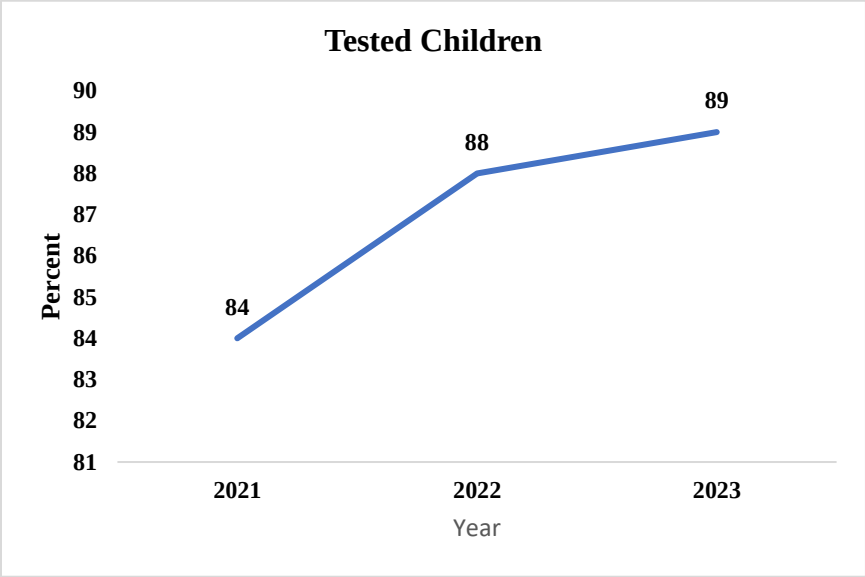


Source: DHAMIS

3.4.2 Early infant diagnosis

The national guidelines recommend that HIV-exposed infants should be tested for HIV before 2 months of age. A nucleic acid test (NAT or DNA PCR) is recommended at 6 weeks. Malawi adopted point-of-care testing to increase access to testing. Testing is provided in pediatric inpatient wards, nutrition centers, immunization clinics, outpatient clinics, TB clinics, and other settings. There has been progression from 77% in 2020 to 89% in 2023 the country still is yet to meet the 95% testing target for HIV-exposed infants at 2 months of age (Figure 21).

Figure 21: Coverage of exposed Children Tested at 2 months, 2023

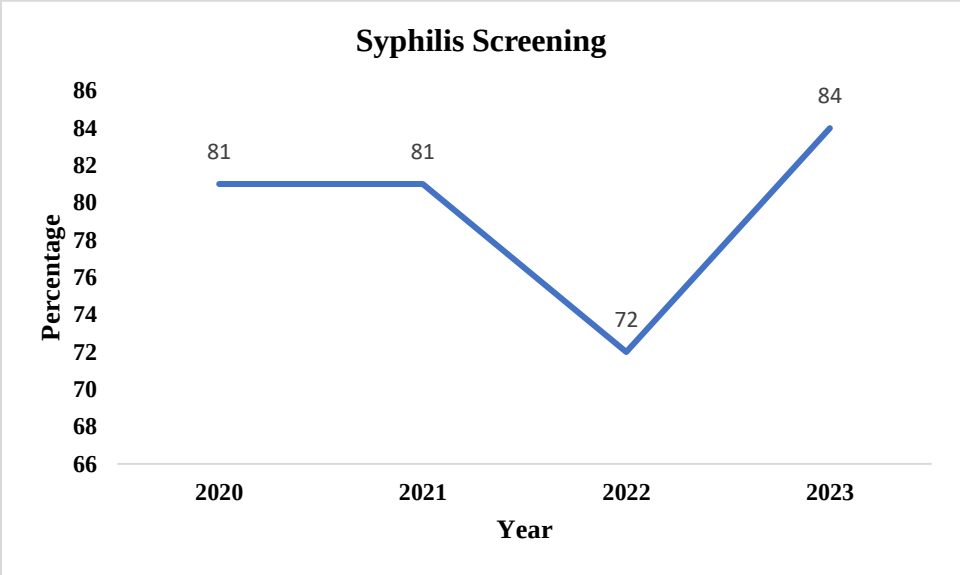


Source: DHAMIS

3.4.3 Syphilis Screening Among Pregnant Women

The HIV clinical guidelines emphasize triple-elimination of HIV, syphilis, and viral hepatitis B in pregnant women. Syphilis testing is conducted at the same time as HIV and Hepatitis B testing during ANC. Malawi adopted the public health approach and therefore uses the rapid syphilis treponemal test. Figure 22 presents the percentage of women attending antenatal care services who received syphilis testing . The graph shows that syphilis testing has consistently been below the 95% target with a big dip (72%) in 2022. The testing coverage in 2022 was 84% representing a 12 percentage point increase from 2022 coverage.

Figure 22: Syphilis Screening for ANC Women, 2023



Source: DHAMIS

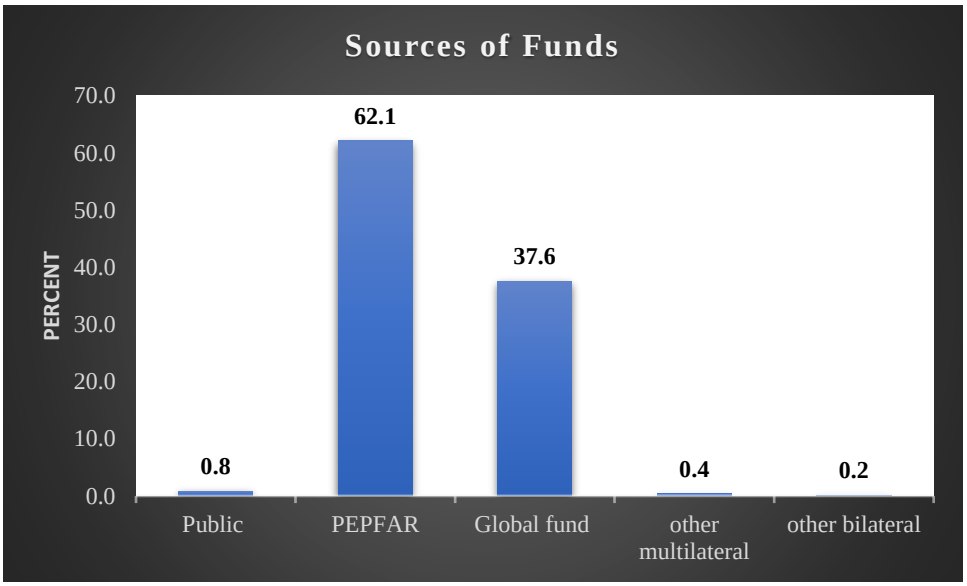
4.0 Investments and Resources

GAM expenditure analysis utilizes an ad hoc approach and target mainly the major sources of financing sources to gain insights into the expenditure pattern. Consequently , there is a possibility that the estimated expenditures are under estimated as no figures were supplied by private sector and others. It is worth noting that the Ministry of Gender, Community Development and Social Welfare that accounts for some public sector expenditure particularly on community focused social protection and development interventions as well as social cash transfer programs. This notwithstanding, it is evident that , the HIV and AIDS program in Malawi is heavily dependent on financing from international/external sources. The expenditure figures show that domestic financing was less than 1 percent in 2023. This suggests that government contribution towards the HIV response has been erratic and minimal .

As discussed earlier, the Malawi HIV program is heavily funded by cooperating partners and major players are PEPFAR and the Global Fund with other bilateral partners also contributing to the national response. On the basis of the 2024 GAM expenditure information matrix, the bulk (62.1%) of all HIV funding during in 2023 originated from the PEFPFAR. This was followed by the Global Fund at 35.5 % and the fund is reputed to provide nearly 20% of all HIV programming

globally. These two constitute nearly 97 percent of all funding.

Figure 23: Sources of Funding for HIV Programs



Source: Supplied by partners

Analysis of HIV expenditures across program areas reveals that most HIV resources (53%) are spend on Treatment, Care and Support. This reflects the heavy expenditure on the procurement of antiretroviral commodities to maintain patients on treatment . The critical enablers (those to do with the conducive environment for the national response) consumed 28% of the HIV resources while gender and HIV related interventions used 15%. The rest were spread on community mobilization and prevention among other interventions. This is a reflection that the national response requires a mixture of program focus areas to ensure that people are maintained on ART and new infections and deaths are being reduced. Table 2 summarizes program expenditures by program areas.

Table 2 : Expenditure by Program Area

Program	**Public sources (US$)**	**International sources (US$)**	**Total (US$)**	**% total Expenditure**
Treatment, care and support	113,127	130,392,223	130,505,349	53%

Prevention (Including PMTCT)		3,934,602	3,934,602	2%
Gender Programmes		37,266,726	37,266,726	15%
Programmes for children and adolescents		118,908	118,908	0%
Social Protection		66,924	66,924	0%
Community mobilization		5,224,854	5,224,854	2%
Governance and sustainability		421,068	421,068	0%
Critical enablers	1,945,021	66,161,926	68,106,947	28%
TB/HIV co-infection, diagnosis and treatment		180,693	180,693	0%
Total	**2,058,148**	**244,287,795**	**246,345,943**	**100%**

Source: Supplied by partners

5.0 ARV Volumes and Diagnostic Survey

The largest volume of packs taken by the clients included Dolutegravir + Lamivudine +Tenofovir Disoproxil fumarate (TDF+3TC +DTG)/ 50mg + 300mg+ 300mg at 2.3 million packs and followed by Abacavir + Lamivudine dispersible tabs (ABC + 3TC)/ 120mg/60mg at 2.3 million packs. Based on available estimates, the cost of ARV ranged from a low of $1.25 for Dolutegravir (DTG) 50mg to a high of $ 43 for Darunavir (DRV) 600mg. Maintaining adequate stock levels is crucial to ensuring that PLHIV on treatment including new patients being initiated have uninterrupted supply of drugs to maximize the benefits of HIV treatment. This should be anchored by an effective supply chain system for timely receipt of supplies. However, ARVs have historically been procured with assistance from donors, the Global Fund and PEPFAR. While there has been continued support to date, the sustained exposure of the HIV program to external forces threatens program sustainability and the need for sustainable domestic financing for HIV and health programs in general becomes more critical . Table 3 highlights volume of ARVs procured during the reporting period.

Table 3: ARV Volumes and Unit Prices Distributed in 2023

Antiretroviral Regimen/Formulation	Posology	Number of pills	Number of Packs	Average Price	Number of Packs taken

		per pack	procured	per pack	by beneficiaries
Abacavir + Lamivudine (ABC+ 3TC)	600mg + 300mg	30	43,847	7.69	106,098
Abacavir + Lamivudine (ABC+ 3TC)	600mg + 300mg	30	40,000	7.69	-
Abacavir + Lamivudine (ABC+ 3TC)	600mg + 300mg	30	30,000	7.69	
Lamivudine+Zidovudine (3TC+ZDV)	150mg+300mg	60	50,149	5.55	-
Lamivudine+Zidovudine (3TC+ZDV)	150mg+300mg	60	-	5.55	-
Dolutegravir + Lamivudine +Tenofovir Disoproxil fumarate (TDF+3TC+DTG), no carton	50mg + 300mg+ 300mg	90	961,401	11.17	2,343,663
Dolutegravir + Lamivudine +Tenofovir Disoproxil fumarate (TDF+3TC+DTG), no carton	50mg + 300mg+ 300mg	90	961,401	11.17	-
Dolutegravir + Lamivudine +Tenofovir Disoproxil fumarate (TDF+3TC+DTG), no carton	50mg + 300mg+ 300mg	90	961,401	11.17	-
Dolutegravir + Lamivudine +Tenofovir Disoproxil fumarate (TDF+3TC+DTG), no carton	50mg + 300mg+ 300mg	30	300,000	3.24	1,354,881
Dolutegravir + Lamivudine +Tenofovir Disoproxil fumarate (TDF+3TC+DTG), no carton	50mg + 300mg+ 300mg	30	300,000	3.24	-
Dolutegravir + Lamivudine +Tenofovir Disoproxil fumarate (TDF+3TC+DTG), no carton	50mg + 300mg+ 300mg	30	459,581	3.24	-
Dolutegravir (DTG)	50mg	30	100,000	1.25	317,850
Dolutegravir (DTG)	50mg	30	178,218	1.25	-
Efavirenz +Lamivudine+Tenofovir Disoproxil Fumarate (TDF +3TC+EFV), no carton	400+300mg+300mg	30	5,509	4.62	4,809
Lamivudine+Tenofovir (TDF +3TC)	300mg +300mg	30	2,345	3.20	3,984
Lopinavir/Ritonavir (LPV/r)	200mg+50mg	120	644	18.65	1,203
Atazanavir/Ritonavir (ATV/r)	300mg + 100mg	30	9,317	12.50	8,016
Efavirenz (EFV), double scored	200mg	90	-		-
Lamivudine + Zidovudine(3TC+ZDV)	30mg+60mg	60	2,582	1.70	-
Abacavir + Lamivudine dispersible tabs (ABC + 3TC)	120mg+60mg	30	108,974	2.95	517,758
Abacavir + Lamivudine dispersible tabs (ABC + 3TC)	120mg+60mg	30	100,000	2.95	-

Ritonavir (RTV), film coated	100mg	30	1,661	7.00	-
Lopinavir/Ritonavir (LPV/r)	100mg+25mg	60	10,761	5.50	816
Darunavir (DRV)	600mg	60	1,296	43.00	963
Darunavir (DRV)	150mg	240	89	40.45	-
Emtricitabine/Tenofovir	200mg+300mg	30	17,980	3.40	-
Nevirapine 10mg/ml, oral suspension w/syringe, Bottle, 240 ml	10mg	240ml	13,925	1.25	-
Dolutegravir	10mg	90	50,003	4.27	93,639
Dolutegravir	10mg	90	50,000	4.27	-
Efavirenz	600mg	30	268	2.44	450
Lamivudine+Nevirapine+Zidovudine dispersible tabs (3TC+ZDV+NVP)	30mg + 50mg + 60mg	60	26,168	3.00	1,179

Source: Supplied by partners

6.0 National Commitments and Policy Instrument (NCPI)

The National Commitment and Policy Instrument (NCPI) has been the main vehicle of measuring progress in developing policies, strategies, and laws related to the HIV response. This is achieved through national-level multi-stakeholders dialogue involving government, civil society, and communities affected by HIV. The NCPI also helps countries to assess the status of their HIV response and identify barriers, gaps, and drivers needed to strengthen HIV programming. The HIV response in Malawi is anchored by an Act of Parliament, the HIV Prevention and Management Act (No.9 of 2018)[11]. The Act makes provisions for the prevention and management of HIV and AIDS; provide for the rights and obligations of persons living with HIV or affected by HIV and AIDS; and provides for matters incidental thereto. The NCPI thus helps to assess progress on some of these areas, including respect for human rights, stigma, and discrimination.

6.1 Gender Equality and Empowerment of Women

It was established from key informants that the country has a plethora of laws and strategies that protect women, girls and PLHIV from gender based violence. These include, these include the Gender Equality Act, Gender Equality Act, Marriage, Divorce and Family Relations Act, National Plan of Action on Gender Based Violence in Malawi, National Strategy to Combat GBV and Sexual and Reproductive Health Right (SHRR) policy and The National Male Engagement Strategy for Gender Equality, Gender Based Violence, HIV and Sexual Reproductive Health and Rights, (2023 to 2030). The country covers all the elements of comprehensive post rape care based on (WHO) guidelines are provided through: (1) first-line support, psychological first aid and psychosocial support; (2) emergency contraception; (3) sexually transmitted infection (STI) prophylaxis or treatment; (4) HIV post-exposure prophylaxis (PEP) except (5) on safe abortion because abortion is still illegal in Malawi unless under very strict conditions. Post rape services

[11] Government of Malawi. HIV and AIDS (Prevention and Management) Act No.9 of 2018. Lilongwe, Malawi.

are found in more than 50 percent of the health facilities in the country. The country also Guidelines for Provision of Comprehensive Services for Survivors of Physical and Sexual Violence at Health Facilities in Malawi that established One Stop Centers. with specialized staff to deal with violence against women. The expects include those from the Police Service, health workers and social workers to provide a range of support services. Further, it has and Victim Support Units that are principally manned by trained police officers. Currently the country's focus is on supporting the survivors, as such the country does not have programs specifically for the for the perpetrators of violence.

6.2 Adolescent Girls and Young Women (AGYW)

Malawi has committed itself to ensuring that adolescent girls and young women (AGYW) as vulnerable group make informed choices, enjoy their sexuality, and are free from harmful social and cultural practices in gender-equitable and violence-free societies. To this end the AGYW are found in the NSP in a broader view and in AGYW Strategy in particular. Currently there are no legal age restriction on access to contraception but there are legal restrictions on access to HIV services particularly HTC and ART. The stipulated legal age is 13.

Poverty and Intergenerational (> 10 years age differences) in sexual liaisons , GBV particularly various forms of sexual assaults and social and cultural norms are the critical factors affect AGYW. There are many interventions for both in school and out of school through youth clubs that are targeting the AGYW. Although poverty is the main push factor into risky sexual behaviors among the AGYW, it has been established that it is difficult to source funding for their economic empowerment due to the fact that organizations find it difficult to link such interventions to reductions in new infections among the AGYW. The unavailability of information establishing direct link of the impact of economic empowerment interventions on reduced new HIV infections is exacerbated by lack of data, appropriate models for estimations and research the area.

6.3 Community Leadership

The country's laws , regulations, and policies promote the involvement of PLHIV in the national response. They can be part of the greater national response or can organize themselves specific community-led organizations within the confines of the legal framework that is there to provide guidance and accountability and not necessarily to curtail the rights. Thus, PLHIV can register community-led organizations to respond to community-specific HIV-related needs. These organizations can provide HIV services including KP-specific services but are expected to report such programming to the coordinating agency the National AIDS Commission for continued guidance in relation to prevailing guidelines or Standard Operating Procedures. It is also allowed that Community-led organizations and PHIV led organizations can mobilize resources locally and externally without any hinderances. As is the case with the national response, the bulk of community based, PLHIV led and KP programs are externally financed. As a country Malawi uses a holistic and inclusive approach to the HIV response whereby relevant community based, PLHIV led and KP led organizations are involved in the development plans at community, sub national and national levels either through their representatives or networks. Further, The Malawi

HIV program recognizes the role of young people in the fight against the HIV pandemic. Young people are involved and participate in various fora and at levels. These include national HIV response coordinating and monitoring mechanism, various Technical Working Groups (TWGs) that include those on gender and HIV, AGYW among other that develop national plans and reviewing programs to enable young people and other vulnerable groups have access to HIV services based on their needs.

6.4 Realize Human Rights and Eliminate Stigma and Discrimination

The country does not have laws that criminalize HIV non-disclosure, exposure, or transmission. The CSOs lobbied against it when the 2018 The HIV and AIDS Prevention and Management Act was being debated in parliament. Although same-sex relationships and some elements of sex work such earning a living out of sex work, pimping and running a brothel are criminalized, the HIV response in Malawi takes a public health approach for the provision of health care and HIV and AIDS related services to these (FSW and MSM) key population. There have been efforts to decriminalize these through strategic litigation and the cases are still with the courts unconcluded. No one including transgender people, PWID and all KP communities is restricted from accessing health services in Malawi although instances of verbal hostilities and discrimination towards KPs are not rare occurrences. The national response recognizes trans-gender people and PWID as some of the key populations that are to be mobilized to play a part in the national response but until recently they have been underground as such efforts to establish population estimates are underway. In addition, efforts are being made to develop guidelines to protect the users and enhance their access to HIV services and prevent transmission of HIV while pinning down on the suppliers and peddlers. On the overall, violence stigma and discrimination on the basis of one's status is illegal and punishable. The affected can seek legal redress using the public funded Legal Aid Bureau and other pro bono legal services. Although there might not be special and direct programs for the PLHIV , the various social protection mechanisms do not discriminate anyone on the basis of HIV status.

6.5 Prisons and Closed Settings

It was established that a wide range of HIV related information and services are available in prisons but not much in police cells perhaps due to the transitory nature of the inmates in police cells. The country recognizes persons in prisons and other closed settings as an example of a key population. Consequently, it is also contained in the NSP. There is free access to voluntary HIV testing at three points (upon entry, while inside, upon exit) in the course of the incarceration. Those found positive, there is free access to ART throughout the time of incarceration. However, there are no post Currently there are no explicit post release interventions and follow up interventions principally because the Prison service’s mandate starts and ends at the prison gates. Although, consensual MSM is suspected to be rampant in prisons, condom and lubricants for HIV prevention are not provided since the practice is illegal both inside and outside prison.

HIV related information is provided through a variety of means particularly peers. The Centre for Human Rights Education Advice and Assistance CHREA and paralegals provide some limited legal assistance to prisoners. They are not enough to cover all the 23 prisons in the country.

6.6 Universal health coverage and integration

The country has adopted WHO recommendations for screening and treatment of cervical pre-cancer lesions although the guidelines are not yet fully implemented. The WHO guidelines recommend HPV testing followed by VIA. Cervical cancer screening is also recommended in the national health sector strategic plan, national strategic plan governing the AIDS response, National HIV treatment and/or testing guidelines including the Malawi Standard Treatment Guidelines and the Reproductive Health Services Guidelines.

In the realms of co-infection, the country has a number of policies related to co-infection that include Isoniazid preventive therapy (IPT) or latent TB; Intensified TB case finding among people living with HIV; TB infection control in HIV health-care settings (Several approaches used, including structural design to allow ventilation, use of UV lights to kill TB bacteria; prioritizing clients coughing the most to give them masks, cough booths as well are used to provide sputum.); Antiretroviral providers deliver antiretroviral therapy within 2 weeks of initiation of TB treatment; Co-trimoxazole prophylaxis; Hepatitis B screening and management in antiretroviral therapy clinics; Hepatitis B screening and management in antenatal care clinics to prevent vertical transmission of Hepatitis B virus; Hepatitis C screening and management in antiretroviral therapy clinics; Hepatitis B vaccination provided at antiretroviral therapy clinics; Timely Hepatitis B birth and dose vaccination provided at delivery services (within 24 hours of birth). The country has national treatment guidelines and plans for the control, prevention, and management of sexually transmitted infections (STIs) that are periodically updated in tandem with new evidence and guidance.

7.0 Conclusions

On the overall, Malawi has made substantial progress towards ending AIDS as a public health threat at least based on the benchmarking to global program targets. Available evidence suggests that the country has nearly met the 95—95—95 HIV testing and treatment targets. Of the nearly 1,000,000 people living with HIV, 97% know their HIV status, whereas 97% of those were retained on ART, and viral suppression was observed in 95% of the people on ART. Both new infections and AIDS related deaths are on constant decline. In this respect, efforts need to be directed and concentrated on young people (15-24) particularly girls and young women and key populations including FSW and PWID and SMS where new infection are concentrating. This calls for a combination of preventive measures particularly targeted HIV testing services and treatment services to reduce new cases. This is the direction that has been spelt out in the NSP of 2020-2025. This might be critical to ensure both efficiency and effectiveness of the national

response that leverages and maximizes on the unpredictable resource flows. This would ensure that number of new infections and AIDS related deaths continue to decline hence consolidate gains in controlling the epidemic. The progress withstanding the country's faces barriers that would jeopardize and derail the national response. The main one being heavy reliance on external financing from outside development partners that would prove disastrous in the face of external shocks as was the case with CoVID 19 and of late fighting in Eastern Europe and Middle East that may affect external resource flows. Others barriers include criminalization of consented MSM and some aspects of sex work , inadequate attention paid to PWID and Transgender Persons.

On the legal front , there are no laws that criminalize HIV non-disclosure, exposure, or transmission. This was vehemently opposed by Civil Society Organizations working in HIV and AIDS realms as it had potential to increase stigmatization particularly in cases of vertical transmission of HIV. There are also no laws, policies or approved practices that prohibit any member of the key population groups from access ant HIV and AIDS related services in both public and private facilities. For public facilities, although the country may not have a prescribed universal health insurance, health services including HIV related services are provided free of charge in all primary, secondary and tertiary facilities. In terms of community participation and involvement, there are no laws or policies that restricts operations of local and community based, people of interest led organizations. The NGO laws that are there are just meant to ensure that the organizations are accountable to the people they serve. These CBOs are critical in enhancing the national HIV response as they reach out to communities that may be difficult to reach as is the case with the KP-led (FSW and MSM) organizations.

The country has a good number of laws, policies and strategies to deal with Gender-Based Violence. In addition, structures such as the One Stop Centres manned by various law enforcement, health and social welfare practitioners and the Victim Support Units in all police service establishments have been pivotal in proving all sorts of legal, medical and psychosocial support to survivors of GBV although gaps persist on the adequacy of human, financial and material resources. with law enforcement agencies fully involved. Overall, Malawi, like many other resource-constrained settings rely on development partners to technically and financially support the bulk of health care, including HIV programming. Consequently, the national response might be affected by global shocks as was the case with the COVID 19 epidemic and hostilities in Eastern Europe and the Middle East that may constrain the flow of external funding. Hence risking the sustainability of the HIV national response recorded this far.

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