Republic of Malawi

REVISED NATIONAL HIV PREVENTION STRATEGY

2018-2020

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TABLE OF CONTENTS

LIST OF FIGURES

TABLES

ABBREVIATIONS AND ACRONYMS

3TC	Lamivudine
ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BBSS	Biological and Behavioral Surveillance Survey
BCCI	Behavior Change Communication Interventions
CAC	Community AIDS Committee
CACC	City AIDS Coordinating Committee
CBDA	Community Based Distribution Agents
CBO	Community Based Organization
CCC	Condom Coordinating Committee
CCP	Comprehensive Condom Programming
CHTC	Couple HIV Testing and Counseling
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
CSS	Community Systems Strengthening
DACC	District AIDS Coordinating Committee
DEC	District Executive Committee
DHRMD	Department of Human Resource Management and Development
DIC	Drop-in Centre
DREAMS	Determined Resilient Empowered AIDS-free Mentored and Safe
DSD	Differentiated Service Delivery
DTG	Dolutegravir
EFV	Efavirenz
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother to Child Transmission of HIV

EPI	Expanded Program on Immunization
FBO	Faith Based Organization
FP	Family Planning
FRS	Family Referral Slip
FSW	Female Sex Workers
FTC	Emtricitabine
GBV	Gender-based Violence
GFATM	Global Fund Against AIDS Tuberculosis and Malaria
GoM	Government of Malawi
HAC	Health Advisory Committee
HCW	Health Care Worker
HEI	HIV Exposed Infant
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
IEC	Information Education and Communication
KP	Key Populations
LGBTI	Lesbian Gay Bisexual Transgender and Intersex
LSE	Life Skills Education
MANASO	Malawi Network of AIDS Service Organisations
MANET+	Malawi Network of People Living with HIV
MBCA	Malawi Business Coalition Against HIV/AIDS
MDHS	Malawi Demographic and Health Survey
MHRC	Malawi Human Rights Commission
MIAA	Malawi Inter-faith AIDS Association
MIS	Management Information System
MNCH	Maternal Newborn and Child Health
MOEST	Ministry of Education, Science and Technology
MoGCDSW	Ministry of Gender, Children, Disability and Social Welfare
MOH	Ministry of Health
MOT	Modes of Transmission
MPF	Malawi Partnership Forum
MPHIA	Malawi Population HIV Impact Assessment

MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission of HIV
NAC	National AIDS Commission
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	US President's Emergency Program for AIDS Relief
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PNC	Postnatal Care
PrEP	Pre-Exposure Prophylaxis
PSI	Population Services International
SBCC	Social Behavior Change Communication
SCT	Social Cash Transfer
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
TDF	Tenofovir disoproxil fumarate
TDF/3TC	A fixed dose combination of Tenofovir disoproxil fumarate (TDF) plus Lamivudine (3TC)
TG	Transgenders
TWG	Technical Working Group
UIC	Unique Identification Code
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAPN	Voluntary Assisted Partner Notification
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
YFHS	Youth Friendly Health Services
YPLHIV	Young People Living with HIV

FOREWORD

In 2015, the Government of Malawi (GoM), in collaboration with its stakeholders, released the 2015-2020 National HIV Prevention Strategy that provided a broad framework for implementing HIV prevention interventions, in support of the overall 2015-2020 National HIV and AIDS Strategic Plan. This overarching strategy complemented several sector-specific strategies, including the following: The National Condom Strategy (2015-2020); Malawi Voluntary Medical Male Circumcision Strategy and National Operational Plan for Scale up (2015-2020); Malawi Voluntary Medical Male Circumcision Communication Strategy (2012); The National Youth Friendly Health Services Strategy 2015–2020; The Child Protection Strategy; The National Girls' Education Strategy (2014); The HIV & Gender Strategy and The Gender Based Violence Strategy. Collectively, all these strategies were designed to provide a framework for achieving maximum reduction in the number of new HIV infections.

The estimated number of new HIV infections in Malawi declined from 59,000 in 2010 to 36,000[1] in 2016. The steepest decline has been observed in children under the age of 15 years, among whom the estimated number of new infections dropped from 17,000 to 4,300 over the same period. Whilst this is encouraging, the prevailing number of new infections remains unacceptable, considering the availability of several effective evidence-based HIV preventive interventions. Most new HIV infections appear to occur among specific sub-populations including HIV sero-discordant couples, adult men and Adolescent Girls and Young Women (AGYW). Female Sex Workers (FSW) and Men who have Sex with Men (MSM), also, have high rates of HIV infection.

The scale up of Antiretroviral Therapy (ART) was one of the key strategies of the National HIV Prevention Strategy (2015-2020). Evidently, increased ART coverage has contributed tremendously to the reduction of new HIV infections. However, it is recognized that ART alone would not be effective in meeting the target set forth by the Global HIV Prevention Coalition of reducing the estimated number of new infections in Malawi from 36,000 in 2016 to 11,000 in 2020. This revised strategy represents GoM's commitment to accelerate the progress towards achieving this target by re-doubling its efforts on primary HIV prevention. It identifies key evidence-based HIV biomedical interventions, such as condoms, Voluntary Medical Male Circumcision (VMMC) and Pre-Exposure Prophylaxis (PrEP), which need to be scaled up particularly in high HIV burden areas, to curtail new HIV infections. It also emphasizes targeting these interventions at specific populations with unacceptably high HIV incidence, such as AGYW, HIV sero-discordant couples, FSW, MSM, and Transgender Women (TG). Recognizing that availability of biomedical

[1] 2016 UNAIDS SPECTRUM estimates (http://www.unaids.org/en/regionscountries/countries/malawi)

interventions at service delivery points does not guarantee their optimal uptake and does not address underlying social determinants and behaviors that lead to HIV transmission, this strategy embraces the combination prevention approach that entails synergistic implementation of biomedical, behavioral and structural interventions.

The revised strategy harmonizes priority intervention areas outlined in various thematic- or sectoral-specific HIV prevention strategies, mentioned above. Hence, it must be read together with these strategies, which provide additional details about HIV preventive interventions and activities. This strategy has adopted a results-based management approach, with activities leading to outputs and outcomes. To facilitate tracking of the progress of program implementation, this strategy includes a monitoring and evaluation framework with selected outcome and impact indicators. To enhance coordination in HIV prevention efforts, the strategy presents a governance structure and key implementing agencies. In this strategy, Civil Society Organizations (CSOs) have been assigned a special responsibility of ensuring social accountability in the implementation of HIV interventions, while Community-Based Organizations (CBOs) have been tasked to assume a leading role in the implementation of interventions in their communities or sub-populations, thereby ensuring that community needs are sufficiently addressed.

In order to achieve maximum impact and to avoid implementation gaps, stakeholders in the national HIV and AIDS response should use this strategy as a blueprint for implementing HIV prevention interventions at national, district and community levels. I would like to call upon all stakeholders to intensify their roles in HIV prevention, in order to achieve the targets set forth in this strategy.

Hon. Atupele A. Muluzi, MP

Minister of Health and Population

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NAC expresses its sincere gratitude to the National HIV Prevention Taskforce, working under the National HIV Prevention Technical Working Group, which steered the consultation process and writing of the Strategy. NAC also greatly appreciates the contribution from Bridget Chibwana, who conducted the 2017 Rapid Assessment of the 2015-2020 HIV Prevention Strategy and highlighted the strengths, weaknesses and opportunities in HIV prevention efforts that prepared the foundation for the revision of the Strategy. NAC also acknowledges enormous time and intellectual commitment from members of the HIV prevention thematic teams, who collated, reviewed and analyzed literature to generate specific recommendations for the intervention areas included in this revised Strategy. The following leaders of the thematic teams deserve special thanks: James Njobvuyalema from NAC (VMMC theme); Flora Khomani from HP+ , Francis Mayrand from PSI and Stanley Ngoma from Ministry of Health and Population (Condom theme); Aayush Solanki from CHAI (PrEP theme); Shawn Aldridge from NAC (Key Populations theme); Beth Deutsch from USAID (AGYW theme); Michael Eliya from MoHP (PMTCT theme), Joel Suzi and Christopher Teleka from NAC (SBCC theme), and Abigail Dzimadzi and Grace Massa from MANASO (Community Systems Strengthening theme).

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This Revised 2018-2020 HIV Prevention Strategy is a living document that is subject to further revision as new data and evidence emerge. NAC will rely on the commitment and dedication of partners in the national response to HIV and AIDS to make this evidence available in order to facilitate evidence-informed refinement of the strategy.

Davie F. Kalomba

Chief Executive Officer

National AIDS Commission

EXECUTIVE SUMMARY

The first case of AIDS was reported in Malawi in 1985. In the following years, HIV prevalence increased significantly, reaching a peak of 16.4% in 1999 among persons aged 15-49 years, but then declined steadily to 11.8% in 2004 and 8.8% in 2015/16 .[2] The declining trend during the period of increasing ART coverage and declining AIDS-related deaths after 2004 strongly suggest a reduction in HIV incidence.

Despite this encouraging trend, HIV infections are unevenly distributed in Malawi. The 2015/16 Malawi Demographic and Health Survey (MDHS) found that females had higher HIV prevalence than males (10.8% vs 6.4%, respectively). The largest gender disparity in HIV prevalence was observed in the 15-24 year old age group (4.9% in females and 1.1% in males). The 2015/16 MDHS also found large geographical variability in HIV infection rates with the Southern region having markedly higher HIV prevalence (12.8%) than the Central (5.6%) and Northern (5.1%) regions. In the same survey, HIV prevalence was higher in urban (14.6%) than in rural areas (7.4%). For the first time, the 2015/16 Malawi Population HIV Impact Assessment (MPHIA) survey found higher annual HIV incidence in females (0.39%) than in males (0.24%)[3] aged 15-49 years.

This Revised 2018-2020 National HIV Prevention Strategy provides a framework for HIV prevention programs that will guide Malawi in reducing HIV infections, in line with the targets set forth by the Global Coalition on HIV Prevention. While there is compelling evidence that increased ART coverage reduces HIV incidence, it is recognized that ART alone will not achieve the targeted reduction in new HIV infections. Again, without focused primary prevention strategies, future need and demand for ART will increase, thereby threatening the capacity of the country to sustain care and support a large population on ART.

The goal of this revised strategy is **to reduce the estimated annual number of new HIV infections to 11,000 by the end of 2020**, from a baseline of 36,000 in 2016. This goal will be reached by achieving the following outcomes:

1. Increased use of condoms among males and females during high risk sexual encounters, including lubricants, among key populations;
2. Increased VMMC coverage among males aged 10-34 years;
3. Initiation and scaling-up of PrEP implementation, taking into account of its feasibility and cost-effectiveness in specific sub-populations at high risk of HIV infection;

[2] To measure the trend of HIV prevalence, these results are based on the parallel HIV testing algorithm used in the 2010 and 2015/16 MDHS. Note that the official HIV prevalence in 2015/16 was 8.8% based on a new algorithm that includes additional confirmatory tests for blood samples that tested HIV positive using the parallel HIV testing algorithm.

[3] Ministry of Health, Malawi. Malawi Population-based HIV Impact Assessment (MPHIA) 2015-16: First Report. Lilongwe, Ministry of Health. November 2017.

4. Increased coverage of tailored combination HIV prevention packages among high risk sub-populations including AGYW, KP and HIV sero-discordant couples;
5. Increased ART coverage among HIV-infected pregnant and postpartum women and HIV-infected male partners of HIV-uninfected pregnant and postpartum women.

This strategy focuses on scaling up the coverage of condoms, VMMC and PrEP in fourteen districts with the highest HIV burden in Malawi and in population groups with the highest HIV incidence and prevalence, including adolescent girls and young women, adult males, HIV sero-discordant couples, FSW, and MSM. To address both the proximate and more distal risk factors for HIV and increase demand for high impact biomedical interventions, the strategy adopts a combination prevention approach that includes high impact biomedical, behavioral and structural interventions.

Prior to the development of this strategy, a rapid mid-term review of the implementation of the 2015-2020 HIV Prevention Strategy was undertaken. The review identified successes, challenges and emerging opportunities in HIV prevention. Subsequently, a team of experts used the social-ecological model to categorize factors that are associated with HIV infections or that hinder the delivery of effective interventions at community and facility levels. Thereafter, appropriate HIV prevention intervention areas were identified through consultations with relevant program implementers. The identified intervention areas were then aligned to those specified in existing sector-specific HIV prevention strategies. Thus, this strategy attempts to consolidate key HIV prevention interventions across multiple sectors and thematic areas.

The success of this strategy will depend on robust monitoring of the performance of HIV prevention programs and using the results to refine implementation of these programs. To this end, this strategy includes a monitoring and evaluation framework and key program indicators and targets. Implementing partners will be required to use this framework and collect and report data promptly to enable district and national level HIV program managers to assess progress and gaps in implementing HIV preventive programs and, where necessary, modify the implementation of interventions. This strategy advocates for use of electronic data collection devices to ensure speedy reporting and timely data analyses.

1. BACKGROUND

1.1. Overview of the HIV Epidemic in Malawi

1.1.1. HIV prevalence, distribution and trend in the general population

In 2016, Malawi's estimated population was 17,931,637 with nearly 20% and 46% of population in 15-24 and 15-49 years age-groups, respectively. According to the 2015/16 MDHS, HIV prevalence was 8.8% in the 15-49 years age-group and 3% in the 15-24 years age-group. The prevalence varied markedly according to demographic factors and geographical location. Females had a higher HIV prevalence (10.4%) than males (6.4%). Also, HIV prevalence in the Southern region (12.8%) was at least twice as high as in the Central (5.6%) and Northern (5.1%) regions. In addition, HIV prevalence in the urban areas was almost double (14.6%) that in rural areas (7.4%). As shown in Figure 1, a declining trend of HIV prevalence was observed from 2004 to 2015/16[4], particularly among females.

Figure 1: Trend in HIV prevalence by gender, 2010-16 (Sources: MDHS 2004, 2010 and 2015/16)

The 2015/16 MPHIA survey that was conducted over the same period as the 2015/16 MDHS provided further insights on HIV distribution in Malawi. Two large urban districts had very high HIV prevalence: Blantyre had the highest HIV prevalence in Malawi (17.7%) while Lilongwe had the highest HIV prevalence in the Central region (11.5%). In addition, gender difference in HIV prevalence was particularly prominent in the age groups 15-19, 20-24 and 25-29 years (Figure 2). HIV prevalence increased steeply

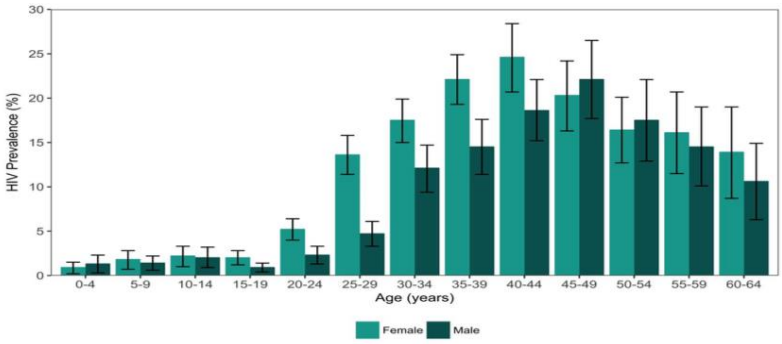

Figure 2: HIV prevalence by age and sex (Source: MPHIA 2015/16)

[4] Overall prevalence in the MDHS 2015/16, which is comparable to that in the 2015/16 Malawi Population HIV Impact Assessment (10.0%), is based on a sequential HIV testing algorithm. In the 2015/16 MDHS, all samples testing positive on two sequential ELISA tests were subjected to a third confirmatory HIV test, in an attempt to reduce false-positive results. Using this new testing algorithm, overall HIV prevalence in the 15-49 year old group was estimated to be 8.8%. However, owing to the change in testing algorithm from previous MDHS, the prevalence estimate for 2015/16 cannot be used to analyze the trend in HIV prevalence over time.

from the 15-19 to 25-29 age groups among females, and from the 20-24 to 30-34 age groups among males, suggesting high HIV incidence in the older age cohorts.

1.1.2. HIV Incidence in the general population

In the past, HIV incidence in Malawi has been estimated using the UNAIDS SPECTRUM models. According to this model, the annual incidence of HIV in the 15-49 years age-group declined from 0.74%[5] in 2009 to 0.38%[6] in 2015. The 2015/2016 MPHIA, for the first time, estimated HIV incidence directly through a population-based survey. As shown in Table 1, the annual HIV incidence among persons aged 15-49 years was 0.36%, which is consistent with the SPECTRUM model estimate. Females aged 15-49 years had a higher annual HIV incidence (0.46%) than males (0.26%)[7], although the difference was not statistically significant. This gender difference in HIV incidence was highest in the 15-24 and 25-34 year age groups. The highest incidence was in females aged 25-34 years (0.87%), followed by that in males aged 35-49 years old (0.49%), although the confidence intervals for these data were very wide. These data provide some insights on the age groups that need to be targeted to have the biggest impact of HIV transmission in the population.

Table 1: HIV incidence by age and sex (2015/16 MPHIA)

Annual incidence of HIV among persons aged 15-64, by sex and age, MPHIA 2015-2016

	Males		Females		Total	
Age	Percentage annual incidence	95% CI	Percentage annual incidence	95% CI	Percentage annual incidence	95% CI
15-24	0.05	(0.00, 0.19)	0.40	(0.04, 0.77)	0.23	(0.03, 0.43)
25-34	0.40	(0.00, 0.91)	0.87	(0.11, 1.63)	0.63	(0.19, 1.07)
35-49	0.49	(0.00, 1.09)	0.06	(0.00, 0.25)	0.28	(0.00, 0.57)
15-49	0.26	(0.04, 0.48)	0.46	(0.18, 0.75)	0.36	(0.19, 0.53)
15-64	0.26	(0.05, 0.47)	0.52	(0.22, 0.82)	0.39	(0.22, 0.57)

1.1.3. Burden of HIV in Malawi

Based on the UNAIDS SPECTRUM estimates, in 2016 there were 1,000,000 (uncertainty range: 970,000-1,100,000) people living with HIV (PLHIV) in Malawi, including 110,000 children (aged 0 to < 15 years) and 920,000 adults (aged > 15 years). This number has been increasing steadily over the years owing to the number of new infections exceeding AIDS-related deaths. For example, in 2016 an estimated 36,000 new infections and 24,000 AIDS-related deaths occurred in Malawi[8], hence increasing the cumulative number of PLHIV by 12,000. With increasing ART coverage, this increasing trend in the number of PLHIV will continue unless the number of new infections is curtailed.

[5] National AIDS Commission. (2015). National HIV and AIDS Strategic Plan 2015-2020. Lilongwe: National AIDS Commission.
[6] National AIDS Commission. (2015). Official HIV and AIDS statistics. Lilongwe: National AIDS Commission.
[7] Ministry of Health, Malawi Population HIV Impact Assessment (MPHIA), *Op. cit.*
[8] 2016 UNAIDS SPECTRUM, *Op. cit.*

1.1.4. HIV Prevalence among key populations

In 2013, a nationally representative study of selected high-risk populations, found an extraordinarily high HIV prevalence among Female Sex Workers (FSW, 62.7%[9]). Program data from the Malawi LINKAGES project, in 2017, also suggest high rates of HIV infection in FSW residing in six high burden districts (Blantyre, Lilongwe, Mzimba North, Mangochi, Machinga and Zomba). In a cohort of 9930 FSW, 5596 (60.2%) tested HIV-positive. Among the HIV-infected FSW, 1549 (25.9%) were newly diagnosed.

There are no national data on HIV prevalence among MSM. However, a study carried out between 2011 and 2014 in several sites found a high average HIV prevalence in MSM (18.2%[10]). In contrast, program data from the LINKAGES project, in 2017, found a lower than expected HIV case detection rate among MSM. In a cohort of 2246 MSM residing in four high burden districts (Blantyre, Lilongwe, Mzimba North and Mangochi), 160 (7%) tested HIV-positive. Of these, 107 (66.9%) were newly diagnosed. The unexpected lower prevalence of HIV among the MSMs could be due to challenges in reaching high-risk hidden MSM networks, among other factors.

1.1.5. Relative contribution of different sub-populations to new HIV infections

The 2015/16 MDHS found that 8.4% of all married/cohabiting couples were HIV sero-discordant (Figure 3). Although the annual incidence of HIV in the general population is relatively low (0.36%), HIV sero-discordant couples are likely to contribute a large number of new HIV infections owing to their large population size. In contrast, HIV incidence is estimated to be high in MSM, FSW, FSW clients and partners of FSW clients (10.4%, 2.0%, 1.3% and 1.2%, respectively.[11]) However, the total population of FSW and MSM is low in Malawi, estimated at 32,000[12] and 42,600[13], respectively. Thus, it is very unlikely that these key populations, *per se*, directly contribute a large proportion of new infections in Malawi. However, to the extent that their sexual networks overlap with those of the general population, MSM and FSW may indirectly contribute a more significant proportion of new HIV infections in Malawi.

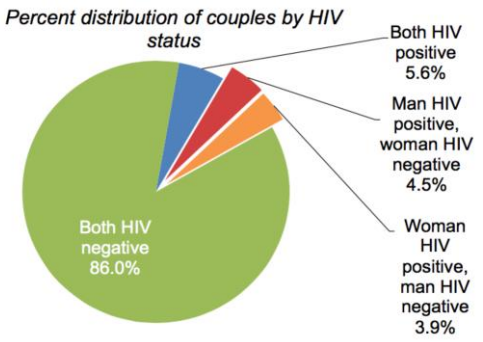

Figure 3: Prevalence of HIV sero-discordant couples (Source: 2015/16 MDHS)

[9] National Statistical Office. Malawi Biological and Behavioural Surveillance Survey 2013-14. Zomba: 2014.
[10] Wirtz AL, Trapence G, Kamba D, et al. Geographical disparities in HIV prevalence and care among men who have sex with men in Malawi: results from a multisite cross-sectional survey. *Lancet HIV*. 2017;4(6):e260-e269.
[11] Joint United Nations Programme on AIDS UNAIDS, National AIDS Commission, and Futures Institute: Malawi Prevention Response and Modes of Transmission Analysis: Distribution of New HIV Infections in Malawi for 2013.
[12] Estimate based on available FSW population size estimates and program service data.
[13] Estimate derived from seven sites through the MSM study conducted by Johns Hopkins University, CEDEP and College of Medicine.

2. MID-TERM REVIEW OF THE 2015-16 HIV PREVENTION STRATEGY

2.1. Achievement of the strategy goals

The first of two overarching goals of the 2015–2020 National Prevention Strategy was to reduce the number of annual new infections in adults aged 15-49 years by 70% in 2020, from a baseline of 42,000 in 2010. Annual HIV incidence was expected to decline from 0.49% in 2013 to 0.36% in 2016 and 0.20% in 2020. The 2015/16 MPHIA found that the annual HIV incidence in the 15-49 year old age-group was 0.36% (95% confidence interval: 0.19%-0.57%). Thus, Malawi was on track to achieve the incidence target set in the National Prevention Strategy. Based on the UNAIDS SPECTRUM model, the estimated number of new infections among adults (15 years and older) in Malawi was 32,000 in 2016, almost 24% lower than in 2010. Nevertheless, these estimated HIV infections appear to be concentrated in specific sub-populations. Over one-third (37.5%) of adult HIV infections were among young people aged 15-24 years. In this 15-24 age group, young females accounted for almost 71% of new infections. Thus, AGYW are a priority group in need of targeting with effective interventions.

The second overarching goal of the strategy was to reduce the rate of Mother-To-Child Transmission (MTCT) of HIV by the end of the breastfeeding period to less than 5% by 2020, in line with global targets.[14] Based on this target, 6,749 HIV infections were expected among children in 2016 and 3,753 in 2020. The UNAIDS SPECTRUM model estimated that 4,300 new HIV infections occurred among children in 2016, which exceeded the 2016 target. This major success is largely attributed to increased ART coverage among pregnant and postpartum women (detailed below).

2.2. Assessment of achievements of the strategy outcomes

The 2015-2020 National HIV Prevention Strategy adopted a combination HIV prevention approach, which entails the use of biomedical, behavioral and structural interventions to address risk factors for HIV infection at multiple levels. Thus, in addition to reducing sexual and MTCT of HIV through high impact biomedical interventions, the strategy also focused on creating a supportive environment for reducing vulnerability to HIV and safeguarding the rights of PLHIV and KP. Specifically, the strategy aimed at reducing stigma and discrimination against PLHIV and KP and promoting social protection and human rights of women and sexual minorities. The successes and challenges experienced in achieving key outcomes of the combination prevention approach are summarized below.

[14] Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive

2.2.1. Assessment of "HIV sexual transmission reduction" outcome indicators

Table 2, below, summarizes the progress made in achieving outcomes of the key interventions under the theme *"Reducing sexual transmission of HIV"*, that included achievement of the 90-90-90[15] treatment targets; scaling up of VMMC; use of male and female condoms; and improved diagnosis and management of Sexually-Transmitted Infections (STIs). Generally, the use of ART treatment as prevention has been successful, although there were notable challenges with HIV testing among males and HIV viral suppression among males and young people. In contrast, the pace of VMMC uptake has been very slow, especially among sexually-active older males. The prevalence of condom use during high-risk sex, although increasing, remained low among females. Furthermore, there was poor treatment seeking behavior among people with STI and sub-optimal quality of STI management.

Table 2: Successes and challenges in HIV sexual transmission reduction programs

Outcomes	Key achievements	Key challenges	Lessons Learned
Increased universal and targeted HTC.	In the 2015/16 MPHIA survey,[16] 73% of PLHIV knew about their HIV status.	In the MDHS 2015/16, HIV testing coverage was lower among males (68%) than females (76%) and in the 15-24 years age groups (50%) than in the 25-34 years age-group (66%).	There is a need to find innovative ways of reaching men and young people with HTC. The majority of tests are performed in health facilities, which limit HTC access for these populations.
Increased provision of ART to all PLHIV.	In the 2015/16 MPHIA survey, 90% of PLHIV who had been diagnosed HIV positive (15-64 years) were on ART.	In the 2015/16 MPHIA survey, 79% of people self-reporting as previously diagnosed with HIV but not on ART were immunosuppressed (CD4 count < 500)	There is a need to intensify the test and treat approach. The use of community-led differentiated service delivery models such as expert clients, and peer navigators may improve linkage to care.
Increased retention in HIV care and ART adherence so as to achieve viral suppression.	In the 2015/16 MPHIA survey, 91% of PLHIV (15-64 years) on ART were virally suppressed.	The MPHIA survey found low levels of viral suppression among children, adolescents, adult males and in the Southern region of Malawi.	There is a need to intensify ART adherence and retention support for groups with low viral suppression.
Increased uptake of VMMC	Annual number of VMMC performed increased by 46% from 129,975 in 2016 to 187,298 in 2017[17].	VMMC population coverage remained low. Cumulatively, only 23% of the planned number of VMMCs was performed by December 2017. Majority of VMMCs were performed among young adolescents (< 15 years), which limits epidemiologic impact.	There is a need to intensify demand creation and find innovative outreach strategies to reach older males, aged 15-34 years.
Increased the use of male and female condoms during high-risk sex.	In the 2015/16 MDHS, 75% of males and 50% of females reported using condoms during high-risk sex. The	Condom stock-outs were frequently reported. The 2015/16 MDHS found low condom use among	There is a need to improve condom supply chain management to increase the availability of condoms and

[15] This entails 90% of People Living with HIV (PLHIV) know their status; 90% PLHIV who know their status receive Antiretroviral Therapy (ART) and 90% of people on ART are retained in HIV care and have suppressed HIV viral load.
[16] Ministry of Health, Malawi. Malawi Population-based HIV Impact Assessment (MPHIA), *Op. cit.*
[17] National AIDS Commission, Malawi Global AIDS Monitoring Reports for years 2016 and 2017.

	percentage was highest in young people (15-24 years).	uneducated rural females, and those in the Southern region. There was also low demand for female condoms.	intensify demand creation campaigns, particularly in rural areas.
Increased provision of quality treatment for STIs.	The proportion of people reporting with STIs at health facilities who were screened for HIV increased from 75% in 2016 to 83% in 2017.[18]	In the 2015/16 MDHS, only 42% of females and 41% of males who had STI symptoms sought advice or treatment from a clinic, hospital, private doctor, or other health professional. The reach and treatment of partners of STI partners was sub-optimal.	There is a need to explore ways of improving demand for STI services, access to STI drugs, and improve the quality of STI management (including implementation of PITC).

2.2.2. Assessment of "HIV MTCT reduction" outcome indicators

Table 3, below, summarizes the progress made in achieving outcomes of the key interventions under the theme *"Reducing HIV Mother-To-Child Transmission"*. Great success has been achieved in reducing the HIV MTCT rate, which was estimated at 4.7% among HIV-Exposed Infants (HEI) aged 4-26 weeks.[19] This has primarily been due to high coverage of HTC and ART among pregnant women, with a large proportion of women already on ART at the time of conception. Nevertheless, low rates of disclosure of HIV status to spouses and family members and low retention in HIV care remain major challenges to optimal coverage of ART.

Table 3: Successes and challenges in HIV MTCT reduction programs

Outcomes	Key achievements	Key challenges	Lessons Learned
Reduced number of unplanned or unintended pregnancies among HIV+ women.	Unmet need for family planning has declined in the general population.	Pregnancies among those with unknown HIV status and a large proportion (29%) of teenage pregnancies.[20]	There is a need to expand the integration of family planning in HIV service delivery points.
Increased ART provision to HIV infected pregnant women	ART coverage in diagnosed HIV+ pregnant women exceeded 90%.	An estimated 16.4% of HIV+ pregnant women offered ART dropped out of HIV care within 30 days of ART initiation.[21]	Couple HTS and facilitation of HIV disclosure to spouses may lead to higher successful treatment initiation rates
Increased antiretroviral prophylaxis uptake by HEI at birth.	Very high nevirapine prophylaxis coverage (> 90%) among HEI.	Poor spousal/family HIV disclosure may limit treatment administration of and adherence to nevirapine prophylaxis among HEI.	Implementation of standardized clinical management protocols for HEI has been critical factor for success.
Increased coverage of HIV testing of HEI	Increasing trend of Early Infant Diagnosis (EID) reaching 71% in Q4 2017.	Long turn around times for HIV DNA PCR.	There is a need to accelerate implementation of point-of-care HIV virological tests.
Improved retention in HIV care among HEI.	HEI 12-month retention has remained stable over many years.	Sub-optimal 12 months retention rate (74%).	Use of expert clients and peer navigators may promote retention.

[18] Integrated HIV Program Report, Ministry of Health from Jan 2016 to December 2017.
[19] van Lettow M, Landes M, van Oosterhout JJ, et al. Prevention of mother-to-child transmission of HIV: a cross-sectional study in Malawi. *Bull World Health Organ.* 2018;96(4):256-265.
[20] NSO, MDHS 2015/16, *Op. cit.*
[21] Landes M, Sodhi S, Matengeni A, Meaney C, van Lettow M, Chan AK, van Oosterhout JJ. Characteristics and outcomes of women initiating ART during pregnancy versus breastfeeding in Option B+ in Malawi. BMC Public Health. 2016 Aug 4;15:713. doi: 10.1186/s12889-016-3380-7. PubMed PMID: 27487775; PubMed Central PMCID: PMC4973045

2.2.3. Assessment of "stigma and discrimination reduction" outcome indicators

Table 4, below, summarizes the progress made in achieving outcomes of the key interventions under the theme *"Reducing stigma and discrimination against PLHIV and KP"*. A significant reduction in stigma and discrimination against PLHIV has been recorded, as evidenced by 2012 and 2016 Stigma Index studies showing that the proportion of PLHIV reporting physical harassment reduced from 16.1% to 9.8%[22]. Another key success has been the passage of the HIV and AIDS Prevention and Management Act that has strong anti-discrimination clauses and dovetails very well with the protection of basic human rights enshrined in the Constitution of Malawi. The new Act is expected to strengthen HIV-related policies and strategies. In addition, the High Court of Malawi declared unconstitutional "Public Nuisance" clauses of the penal code that were used to arrest FSW. Furthermore, the court prohibited mandatory HIV testing of FSW.

Since the approval of the 2015-2020 HIV Prevention Strategy, KP and PLHIV NGOs participate in key decision-making bodies at national level and operate largely without restrictions at national and district levels. They provide health and social services tailored for KP and PLHIV. They have also sensitized key government officials and service providers on the need to protect the rights of minorities, including sexual and gender minorities. The outstanding challenge is to increase legal and human rights literacy among the general public and social service providers.

Table 4: Successes and challenges in stigma and discrimination reduction programs

Outcomes	Key achievements	Key challenges	Lessons Learned
Legal reforms implemented to reduce vulnerability of PLHIV and KP.	HIV Prevention and Management Act passed by Parliament in Nov 2017. "Rogue and Vagabond" clause of the penal code declared unconstitutional.	Same-sex relationships are still illegal in Malawi, punishable by up to 14 years imprisonment. Certain aspects of commercial sex work are also illegal.	Strong engagement with donors, Parliament, Malawi Human Rights Commission, law enforcement, judiciary, Law Commission and Law Society key to legal reforms
Sensitization on KP mainstreaming into all sectors.	KP identified as a priority group for HIV prevention and treatment strategies and policies. Sensitization of officials in the health sector, judiciary and police commenced.	There has been a slow progress in sensitizing health care workers and other social service providers about rights of key populations.	There is a need to engage high profile leaders and decision-makers in sensitization campaigns.
Reduced discrimination against MSM and FSWs when accessing health services.	NGOs commenced capacity building for health workers on KP-responsive service delivery.	A large proportion of health facilities do not deliver KP-responsive services. Stigma and discrimination against KP is still unacceptably high. Self-stigma among KP is also high.	There is a need to include KP-responsive services delivery in pre-service curriculum for health professionals, as well as in-service training.
Reduced discrimination of PLHIV.	A decreasing proportion of men and women with	While continuing to improve, levels of	Meaningful involvement of PLHIV in key decision-

[22] MANET+ . (2016). The people living with HIV stigma index study in Malawi. Lilongwe: MANET+

	discriminatory attitudes toward PLHIV[23] from 2012 to 2016. The "HIV Prevention and Management Act" includes strong provisions for discrimination reduction.	discrimination against PLHIV remain unacceptably high.	making committees and HIV programs facilitate the design, implementation and monitoring of programs to reduce discrimination.
Increased number of PLHIV receive care and support according to national standards and guidelines.	Public sector policy requires allocation of 2% of "Other-Recurrent-Transaction" funds to support PLHIV and HIV workplace programs.	Actual allocation of funding for HIV workplace programs remained inadequate leading to low implementation of PLHIV supportive policies.	Availability of PLHIV support services and social protection programs positively increases voluntary HIV disclosure.
Strengthened individually focused, integrated community- and facility-based support programs for women, children, adolescents, adults, and key populations.	Expert clients/peer navigators and peer-educators (community volunteers) successfully supported the delivery of HIV preventive programs.	No harmonized training curriculum or incentive package for community volunteers.	Community workers are effective in increasing uptake of services and increasing retention in HIV care.
Increased advocacy and sensitization on KP, youth and PLHIV rights.	KP, youth and PLHIV represented in all key HIV decision-making bodies at national level. Several strong KP, youth and PLHIV NGOs engage national authorities.	There is a weak involvement of KP, youth and PLHIV representatives at district level.	Local leaders and champions are crucial in sensitization campaigns.

2.2.4. Assessment of "social protection and human rights protection" outcome indicators

Table 5, below, summarizes the progress made in achieving outcomes of the key interventions under the theme *"Promoting social protection and human rights of girls and women"*. The major achievement in this thematic area has been the constitutional amendment that raised the legal age of marriage to 18 years. This is expected to complement existing laws that promote gender equality, prohibit domestic violence and promote the protection of child rights. In spite of these positive developments, legal literacy and access to justice remain low. At community level, there is poor detection, reporting and legal redress of human rights violation against girls and women, despite wide media coverage on the need to protect women and girl rights.

The GoM and stakeholders successfully launched the National Action Plan for Orphans and Vulnerable Children (OVC) and rolled out the social cash transfer program to all districts, complementing existing social safety nets such as the school bursaries and school feeding programs. Encouragingly, the MDHS 2015/16 found no differences in school primary attendance between children living in households in different wealth quintiles. In addition to promoting school attendance, the GoM formulated and rolled out the National Youth-Friendly Health Services (YFHS) Strategy. However, implementation of the strategy remains a challenge, partly, due to shortage of health workers, lack of

[23] MANET+ , *Op. cit.*

commodities and supplies, and inadequate trained health workers to provide quality and stigma-free services. An evaluation of the YFHS program found that only 13% of the youth reported to have ever heard about youth-friendly health services[24]. Screening for GBV and management of sexual violence cases remain sub-optimal.

Table 5: Successes and challenges in girl and women rights protection programs

Outcome	Key achievements	Key Challenges	Lessons Learned
Increased utilization of Youth Friendly Health Services (YFHS).	YFHS strategy approved and capacity building of health care workers commenced.	Limited availability of trained health care workers and resources to implement quality YFHS. Low awareness and utilization of YFHS among the youth.	Youth representatives must be engaged in planning, delivery and monitoring of services to improve their acceptability and utilization.
Increased number of OVCs whose households receive social cash transfer (SCT).	National Action Plan for OVC operationalized and social safety nets, including SCT and school bursaries, available for OVC.	Limited domestic resources to fully implement SCT and school bursary programs.	To be effective, SCT programs need to be combined with other social asset building programs.
Legal reforms implemented to reduce vulnerability of adolescent girls and young women.	Malawi's constitution amended, raising the legal age of marriage to 18 years.	Poor legal awareness and lack of access to justice.	CSOs are key in creating legal awareness in the community.
Increased school attendance among orphans and non-orphans aged 10-14 years.	Net Attendance Ratio for primary school was similar across wealth quintiles.[25].	Poor continuation rates from primary to secondary school and lower net attendance ratio for secondary school among children in the lower wealth quintiles, as well as lower entry and completion rates for girls.	Multiple interventions implemented at personal, family and community levels are required to keep young people in school and address their social needs.
Increased awareness of community members on the need to address gender and rights issues and harmful cultural practices.	Availability of mass media campaigns on girls' and women's rights, including the "Stop early marriages" campaign.	High community tolerance of GBV[26] and harmful cultural practices.	Engagement of champions among community leaders is crucial in addressing gender and cultural norms.
Reduced incidence of GBV	Adequate legal framework[27] for addressing GBV. High effort levels from media to raise awareness of GBV.	High incidence of GBV[28] coupled with poor reporting of GBV by community members and poor GBV screening by health and social workers.	Community awareness of a GBV referral system may increase reporting and improve the quality of GBV management.

2.2.5. Summary of key successes and challenges and way forward

Overall, Malawi has made great strides in achieving the 90-90-90 treatment targets in adults and pregnant/postpartum women, thereby contributing to the reduction of HIV transmission. However, implementation of HIV primary prevention interventions,

[24] The Evidence for Action. Evaluation of the Youth-Friendly Health Services Strategy, June 2014,
[25] NSO, MDHS 2015/16, *Op. cit.*
[26] In the 2015/16 MDHS, 13% of men and 16% of women believed wife beating is justified in specific circumstances.
[27] These include The Prevention of Domestic Violence Act (2006), Will, inheritance and Protection Act (2011) and Marriage, Divorce and Family Relations Act (2015)
[28] In the 2015/16 MDHS, 13% and 14% of the women experienced physical and sexual violence, respectively, in the preceding 12 months.

particularly VMMC, is lagging behind. Valuable lessons have been learnt during the first half of the strategy implementation period and new evidence has emerged from implementation research, necessitating mid-stream changes in program implementation. Revision of the strategy will enable Malawi to refocus its interventions to achieve maximum impact on HIV transmission reduction and also align its HIV transmission reduction targets with global and regional targets.

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

3.1. Goals and outcomes

The goal of the Revised 2018-2020 HIV Prevention Strategy is to **reduce the annual number of new HIV infections to 11,000 by the end 2020**, from a baseline of 36,000 in 2016. The goal will be realized by achieving the following outcomes:

1. Increased use of condoms among males and females during high-risk sexual encounters, including condoms and lubricants for key populations;
2. Increased VMMC coverage among males aged 10-34 years;
3. Initiation and scaling-up of PrEP implementation, taking into account of its feasibility and cost-effectiveness in specific sub-populations at high risk of HIV infection;
4. Increased coverage of tailored combination HIV prevention packages among high risk sub-populations including AGYW, KP and HIV sero-discordant couples;
5. Increased ART coverage among HIV-infected pregnant and postpartum women and HIV-infected male partners of HIV-uninfected pregnant and postpartum women.

3.2. Approach

The Revised 2015-2020 HIV Prevention Strategy embraces the combination prevention approach[29] that integrates biomedical, behavioural and structural interventions. In line with this approach, the Social Ecological Model (Figure 4) was used as a framework for analyzing factors that increase vulnerability to HIV which operate at different levels, namely: individual; family/peers; community; service delivery institutions and wider society. Based on these analyses, the revised strategy identifies key intervention areas. The strategy also capitalizes on lessons learned by government and stakeholders in the implementation of HIV prevention programs particularly among KP and AGYW. In addition, the strategy harmonizes existing sectoral-specific strategies that have implications on HIV transmission.

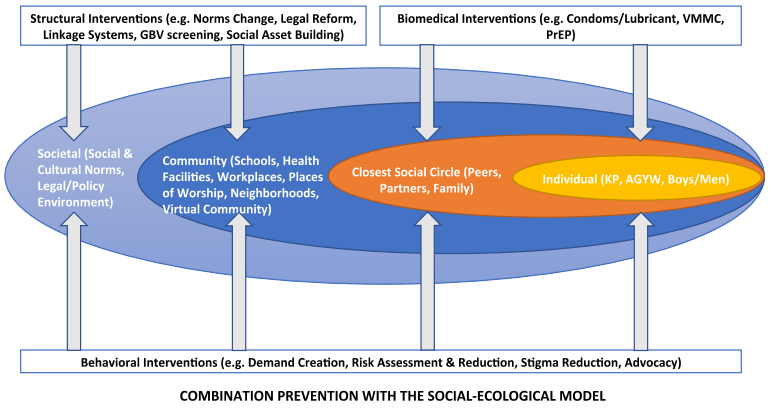

Figure 4: Application of Social-Ecological Model to HIV prevention

[29]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.

To ensure maximum impact on reducing HIV infections, the strategy focuses on intensifying the implementation of combination intervention packages in high HIV burden areas in Malawi (Figure 5) and high burden sub-populations. To ensure sustainability of HIV prevention programs, the revised strategy emphasizes a community-led HIV response. It seeks to strengthen involvement and leadership of community members and specific sub-populations to advocate, plan, deliver, monitor and evaluate targeted HIV prevention programs.

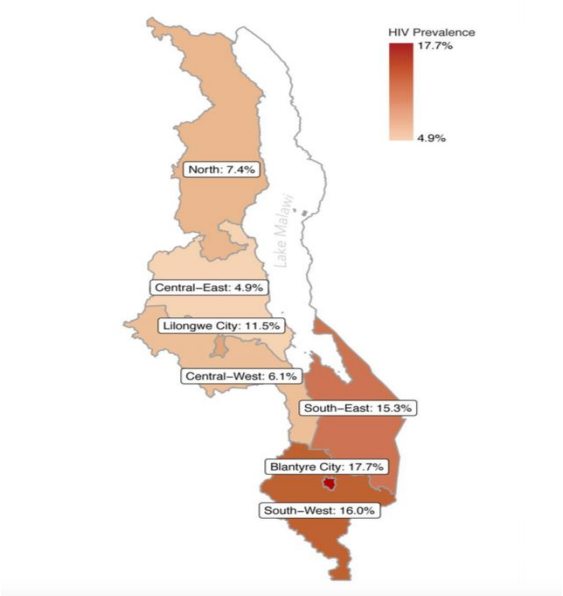

Figure 5: HIV prevalence by zone (Source: 2015/16 MPHIA)

4. GUIDING PRINCIPLES

Success in implementation of the Revised 2018-2020 National HIV Prevention Strategy will depend on adopting the following guiding principles:

1. **Government leadership at national and sub-national levels** to serve the best interests of Malawians and to ensure coordinated implementation of HIV prevention interventions and adherence to national protocols and standards.
2. **Meaningful involvement of people most at risk of or affected by HIV** in the planning, delivery, monitoring and evaluation of HIV interventions to ensure that HIV-related services are appropriately tailored to people's needs.
3. **Meaningful involvement of community and opinion leaders in HIV prevention advocacy** to stimulate demand for HIV prevention services and to effectively address negative cultural or religious norms.
4. **Enhancement of synergies and integration** with other health sector programs and other social and economic sector responses to ensure efficiency in service delivery.
5. **Adherence to an evidence-based, public health approach** to ensure that resources are appropriately allocated and interventions are appropriately selected, targeted and implemented to maximize the impact of HIV prevention efforts.
6. **Adherence to human rights** to ensure respect and preservation of the dignity for PLHIV and those at high risk of HIV-infection.
7. **Adherence to social accountability** to ensure that all stakeholders, including community representatives, are involved in the assessment of the inputs, outputs, outcome and impact of specific HIV interventions.
8. **A focus on key and vulnerable populations** to alleviate increased vulnerability to HIV infection and low uptake of HIV services, to ensure that no one is left behind and to achieve maximum impact of the interventions.
9. **Flexibility in the selection and delivery of interventions** to enable revision and modification of interventions in response to emerging evidence.
10. **Utilization of a results-based management** approach to select effective interventions with the high likelihood of contributing to specific and measurable results.

5. PROGRAM OUTCOMES

5.1. Increased use of condoms among males and females during high-risk sexual encounters.

Background

In Malawi a higher percentage of men than women engage in high-risk sex. In the 2015/16 MDHS, 27% of men and 10% of women reported having sex with a non-regular partner and 13% of men and 1% of women reported having more than one partner in the preceding 12 months. In the same survey, 18% of men had ever paid for sex. These behaviors put individuals at high risk of HIV infection. The use of condoms is a proven effective method for reducing the risk of infection through high-risk sexual behavior.

Prevalence of condom Use

- The proportion of men and women who knew that using condoms and limiting sexual intercourse to one uninfected partner reduces HIV risk increased slightly among men from 63% in 2004 to 70% in 2015/16 but considerably among women from 47% to 70% over the same period.[30]
- In 2015/2016, condom use was reported among 50% of females and 75% of males who had sex with a non-marital and non-cohabiting sexual partner in the preceding 12 months. However, condom use at last high risk sex was lowest in the Southern region where the burden of HIV is the highest. In addition, reported condom use at last high risk sex was lower among both females and males residing in rural areas than those in urban areas.
- Condom use among men reporting paying for sex increased to 75% in 2015/16, from 61% in 2010.

Condom and lubricant distribution

- In 2016/17, an estimated 58.9 million male condoms were distributed: 27.5 million through Ministry of Health (MoH) facilities and the rest (27.4 million) through social marketing. Since 2012, the number of both free and socially-marketed male condoms distributed annually has increased substantially.[31]
- According to the 2015/16 MDHS, the most common sources of condoms were health centers (32%) and shops (31%). Community-based distribution agents (CBDAs) were the least common source of condoms (0.4%). This, potentially,

[30] All data on rates of condom use are from the Malawi Demographic and Health Surveys, 2000, 2010 and 2015/16
[31] Ministry of Health, Condom distribution program report, June 2016 to July 2017

limits accessibility of condoms to poor individuals living in rural areas that are located far from health facilities.

- From June 2016 to July 2017, about 470,000 female condoms were distributed[32] which was short of the target of 1.1 million proposed in the National Condom Strategy. Demand and market share for female condoms remained low and the female condoms played a very limited role in HIV prevention.
- In 2017, about 762,000 lubricant sachets were distributed to KP, which was short of the target of 1.5 million set forth in the National Condom Strategy. [33]

Factors associated with condom availability and use

Table 6, below, summarizes factors associated with condom use in Malawi. Demand for condoms was greatly hampered by factors that are deeply entrenched in cultural and gender norms. Institutional and structural factors limited the supply of condoms particularly to poor males and young people who are less likely to consider health facilities as a convenient source of condoms.

Table 6 Key factors associated with poor condom use.

Level Social Ecological Model	Factors
Individual	• Low risk perception possibly due to low comprehensive knowledge of HIV. • Gender barriers, including economic insecurity, that disempower women, girls and FSW in negotiating for safe sex. • Gender barriers, which disempower females, including FSWs from using condoms.
Family/peers	• Perception that male condoms diminish sexual pleasure. • Gender-based violence, including sexual violence. • Male sexual partners' dislike of female condom use.[34]
Community	• Cultural beliefs that emphasize the importance of exchanging body fluids during sex. • Male masculinity norms that promote multiple sexual partners and "condom-less" sex. • Perceived association between condoms and promiscuity.[35]
Institutional	• Poor condom supply chain management in the public sector resulting in stock-outs, especially at lower levels. • Insufficient condom distribution points and outlets, especially at high-risk venues. • Sub-optimal condom quality due to sub-standard storage facilities. • Insufficient communication programs addressing cultural barriers associated with condom use. • Sub-optimal delivery of comprehensive sexuality education.
Structural	• Policies and regulations that restrict access to condoms in schools and prisons. • Low profit margins for commercial condoms, which limit private sector investment. • Limited capacity for condom programming at the district level.

[32] Health Policy Plus, Condom Program Technical Advisor, personal communication.
[33] Health Policy Plus, Condom Program Technical Advisor, personal communication.
[34] Mandere, G., S. Mupemba, and J. Chingwalu. 2014. *Acceptability of Female Condoms in Malawi*. Lilongwe, Malawi: National AIDS Commission.
[35] Limbani, F. 2011. *Acceptability of Female Condoms in HIV and STI Prevention in Malawi*. Blantyre, Malawi: University of Malawi, College of Medicine

Opportunities and promising program innovations

The following developments occurred during the first half of the implementation period of the 2015-2020 HIV Prevention Strategy, which may facilitate the design and implementation of new interventions in the final half of the implementation period:

- Malawi launched the National Condom Strategy that provides a framework for a Total Market Approach[36] to condom programming.
- The use of parallel distribution channels to the public sector supply chain system, including the use of CBDAs and a dedicated distribution channel for condoms and lubricants for key populations service providers, has been associated with increased condom availability at community level.
- District-based condom focal persons successfully facilitated coordination of various stakeholders in condom programming at district levels.
- Mapping of condom distribution points and outlets proved useful in identifying gaps in access to condoms.
- The GoM approved the introduction of lubricants into ongoing KP programs, which may facilitate correct and consistent condom use among KP.

Revised condom program targets

Considering that the use of condom during high-risk sex among males and females in 2015/16 exceeded the targets set in the 2015-2020 HIV Prevention Strategy, the following are the revised program targets for the year 2020:

a) 90% of males and 85% of females (aged 15-49 years) are aware that using condoms correctly and consistently and limiting sexual intercourse to one uninfected partner can reduce the risk of HIV infection.

b) 85% of males and 75% of females (15-49 years) engaging in high-risk sexual encounters correctly use high quality male or female condoms.

c) The annual male condom distribution will reach 22, 24 and 26 per man (aged 15-64 years) in 2018, 2019 and 2020, respectively.[37]

d) The distribution of female condoms will reach 1.4 million per year, in line with the National Condom Strategy.

e) The distribution of lubricant sachets for KP will reach 1.5 million per year, in line with the National Condom Strategy.

[36] Total Market Approach is a way of developing and implementing programmes, in which all market players—including but not limited to public, private, nonprofit, civil society, social marketing, and commercial private sectors—work together to deliver health choices for all population segments.

[37] This is based on targets for Malawi calculated using UNAIDS Condom Forecasting Fast Tracking Tool, which are 109,517,274, 122,035,275 and 135,385,617 in 2018, 2019 and 2020, respectively.

Program Objectives

The GoM is committed to supporting comprehensive condom programming (CCP) and to operationalizing the 2015-2020 National Condom Strategy. CCP will ensure that condoms are available and accessible at locations where users need them, increase demand for condoms, and foster an enabling environment that promotes condom use. To achieve the stated targets, the program has set out the following objectives:

a) Expand availability and accessibility of high quality condoms and condom-compatible lubricants

This objective is linked to strategic objective number 3 in the National Condom Strategy *(Strengthening the supply chain management system of CCP*). To achieve this objective, the following activities will be undertaken:

1. **Adopt the Total Market Approach to procure and distribute condoms to outlets easily accessible to men, women, youth and KP, together with lubricants for key populations**. This will entail the following priority actions:

i. Mobilize resources and collaborate with donors to procure the targeted number of male and female condoms and lubricants.
ii. Expand the utilization of NGO condom distribution system alongside the health sector condom distribution system, to increase the number of non-health sector service delivery points, including CBOs.
iii. Strategically expand condom distribution points outside the health sector for both free and socially-marketed condoms, with special emphasis on high-risk venues such as bars and hotels, easily accessible commercial locations such as retail shops, and community-based outlets that are acceptable and accessible to youth.
iv. Explore non-traditional approaches to condom distribution in hard-to-reach communities, including CBDAs, existing cadres of government and NGO outreach staff and other private sector agents.
v. Promote the branding and targeting of socially-marketed condoms to better segment the market and scale up distribution for different target populations.
vi. Strengthen the supply chain system at all levels to prevent shortages and stock-outs of male and female condoms distributed by the public sector.

2. **Strategically target condoms to potentially high-risk men and women and the youth**. This will entail the following priority actions:

i. Integrate provider-initiated condom offering within HIV and SRH service delivery platforms such as STI, ANC, PMTCT, Family Planning and Postnatal clinics; "drop-in centers" for KP; HIV and TB clinics and wards; and Wellness Center mobile clinics.
ii. Link in-school and out-of-school youth clubs to accessible CBDA/NGO condom distribution points.
iii. Target female condoms to specific groups who have a favorable attitude towards their use, such as socially-empowered and educated women in urban areas.

3. **Ensure post-distribution physical integrity of condoms.** This will entail the following priority actions:

i. Increase the frequency and coverage of post-market surveillance of condom physical integrity

ii. Expand and improve storage facilities to address processes and environments that degrade condom quality.

b) **Intensify Social and Behavior Change Communication (SBCC) for condoms to increase demand and use**.

This objective is mapped to strategic objective number 2 in the National Condom Strategy: *Raise demand and improve access to increase use of male and female condoms and condom-compatible commodities*. To achieve this objective, the following activities will be undertaken:

1) **Conduct condom promotion mass campaigns**. This will entail the following priority actions:

i. In partnership with donors, implementing partners and local CSOs, continue to support the on-going "Condomize!" campaign, a systematic large-scale initiative to generate demand for condoms.

ii. Leverage available platforms to engage in dialogue with community and religious leaders and their members to foster a more supportive environment for condoms.

iii. Develop and execute campaign activities that use multifaceted mass media to change societal norms and address cultural barriers to condom use.

iv. Within campaign activities, emphasize messaging on the importance of consistent and correct use of condoms, especially in the context of high-risk sex. Highlight the non-health benefits of condoms, such prolonging sexual intercourse and pleasure and preventing unwanted pregnancies.

v. Ensure that comprehensive sexuality education in schools includes robust information about condoms and skills building on condom negotiation and use.

2) **Enhance interpersonal communication with clients.** This will entail the following priority actions:

i. Identify and train local champions to raise awareness about male and female condoms and lubricants for key populations.

ii. Ensure availability of high quality job aids to support condom promotion at the community level.

iii. Strengthen interpersonal communication on the female condoms by health workers with potential clients, including use of pelvic models to demonstrate use and increase women's comfort with female condoms.

c) Strengthen cross-sector collaboration in condom programming

This is mapped to strategic objective number 1 in the National Condom Strategy: *Strengthen CCP leadership and coordination structures at all levels*). To achieve this objective, the following activities will be undertaken:

i. Through the National and District-level Condom Coordination Committees (CCCs), mainstream condom provision in policies, plans, and budgets of other relevant sectors, such as agriculture, education, prisons, and police.

ii. Appoint designated coordinators for condom programming at national, zonal and district levels.

iii. Provide district-level CCCs with sufficient resources to support district-level coordination, implementation of key activities and sharing of best practices.

iv. Develop linkages between schools and health facilities or NGO service-delivery points to facilitate access to condoms for youth attending educational institutions.

v. Integrate condom programming and negotiation skills and expand condom distribution outlets for young women within social and economic empowerment projects and cash transfer schemes.

vi. Engage CSOs in advocacy for wider condom access for all target groups, and in leading community sensitization, advocacy and demand creation.

vii. Involve key beneficiary groups, especially KP and adolescents/young people, in developing strategies to improve their access to condom services and better meet their special needs.

5.2. Increased VMMC coverage among males aged 10-34 years.

Background

In 2007, the World Health Organization (WHO) formally recommended VMMC as an evidence-based method of HIV prevention for 13 countries, including Malawi, with generalized HIV epidemics, high prevalence of HIV, and low prevalence of male circumcision.[38] According to the NSP, a total of 2,458,727 VMMCs needed to be performed among males aged 10-34 years in Malawi from 2015 to 2020 in order to achieve 60% coverage. If sustained, this level of coverage would avert 91,746 new infections by the year 2050.[39] The MOH and its partners currently provide VMMC services through two different approaches:

- Support to District Heath Management Teams (DHMT) to integrate VMMC services on an ongoing basis in static public health facilities alongside other health services; and
- Deployment of dedicated outreach teams that provide VMMC services on designated days at health facilities or in the communities.

At each VMMC service delivery point, VMMC is provided as part of a minimum but comprehensive package of clinical and preventive services.[40]

Number and prevalence of circumcision

- Overall, the prevalence of reported male circumcision in Malawi increased slightly from 22% in 2010 to 28% in 2015/16,[41] although the district prevalence varied widely. In the 2015/16 MDHS, reported male circumcision prevalence was highest in the districts located in the South Eastern region of Malawi, owing to greater reliance on traditional male circumcision.
- Traditional male circumcision, practiced by certain ethnic/tribal groups in Malawi, accounts for roughly two-thirds of all reported circumcisions. Among some tribes, traditional male circumcision involves only partial removal of the foreskin, undermining the preventive benefits of male circumcision and creating challenges for communicating the need for increased uptake of VMMC.

[38] World Health Organization, Joint United Nations Programme on HIV/AIDS. New data on male circumcision and HIV prevention: policy and program implications. 2007. Available at http://libdoc.who.int/publications/2007/9789241595988_eng.pdf

[39] Kripke K, Chimbwandira F, Mwandi Z, et al. Voluntary Medical Male Circumcision for HIV Prevention in Malawi: Modeling the Impact and Cost of Focusing the Program by Client Age and Geography. *PLoS One.* 2016;11(7):e0156521.

[40] The VMMC minimum package includes: group education, HIV testing and counseling, STI management, and age-appropriate reproductive health services including risk reduction counseling, post-operative care, and provision of condoms.

[41] Data for 2010 and 2015/16 are drawn from the MDHSs conducted in those years.

The annual number of VMMC performed increased steadily from 2015 to 2017.[43] However, from 2012 to 2017, a cumulative total of 561, 313 VMMCs were were performed, representing 23% of the number of VMMCs required to reach the 60% coverage target. Only 2 of the 14 high priority districts performed at least one-half of the number of VMMCs needed to achieve the coverage target.

- The population coverage of VMMC was highest in the 15-24 years age-group[44] meaning that most sexually-active males are yet to benefit from this intervention. Program data indicate that demand for VMMC remains high among boys less than 15 years old but poor among older men.

Factors associated with poor uptake of VMMC

Table 7, below, summarizes factors associated with poor VMMC uptake in Malawi. Many males shunned VMMC services due to the misperception of the link between male circumcision and cultural identity and perceived complications and inconveniences associated with the procedure. There were also several institutional and structural factors that limit VMMC delivery, particularly limited availability of trained health workers, infrastructure and health commodities.

Table 7: Key factors associated with poor VMMC uptake

Level Social Ecological Model	Factors
Individual	• Fear of pain, HIV testing and surgical complications and concerns with out-of-pocket expenses.[45] • Unwillingness to abstain from sexual activity six weeks after undergoing the VMMC procedure.
Family/peers	• Perception that VMMC diminishes sexual pleasure.
Community	• Perception that male circumcision reflects cultural and religious identity.
Institutional	• Inadequate financial resources to support service delivery. • Poor collaboration between traditional circumcisers and VMMC service providers. • Periodic shortages of VMMC commodities at some sites. • Limited number of health service providers trained to perform VMMC. • Limited infrastructure for delivering VMMC services. By the end of 2017, there was an average of two sites per district providing VMMC services, with few regularly scheduled mobile and/or outreach services. • Sub-optimal referrals between HTS and VMMC clinics. • Sub-optimal coordination among stakeholders implementing VMMC activities, including communication, demand creation and service provision. • Seasonal VMMC demand creation that mostly target young school-age boys and not older males.
Structural	• Regulations requiring only high-cadre clinicians to perform VMMC. • Lack of policies allowing men to take paid sick leave after undergoing VMMC.

[42] Ministry of Health, Malawi. Malawi Population-based HIV Impact Assessment, *Op. cit.*
[43] National AIDS Commission. (2016). Malawi AIDS response progress report 2016. Lilongwe. National AIDS Commission.
[44] Ministry of Health, Malawi. Malawi Population-based HIV Impact Assessment, *Op. cit.*
[45] National AIDS Commission, UK AID, Invest in Knowledge and the World Bank. Report of a qualitative study on facilitators and barriers of voluntary male medical circumcision in Malawi. December 2015.

Emerging opportunities and promising program innovations

The following developments occurred during the first half of the implementation period of the 2015-2020 HIV Prevention Strategy, which may facilitate the design and implementation of new interventions in the final half of the implementation period:

- A "VMMC Strategy and National Scale-up Plan" was launched to guide VMMC implementation.
- New non-surgical VMMC devices, in particular the Shang Ring and PrePex, were successfully piloted, locally. Because of the simplicity of using these devices, performance of VMMC can potentially be task-shifted to nurse midwives technicians and medical assistants.
- Successful collaborations between the health and education sector has spurred demand for VMMC for school age boys.
- Engagement of traditional and religious leaders has been shown to improve acceptance of VMMC services among men from traditional non-circumcising districts and faith traditions. In addition, VMMC promotion by groups of mothers at the community level, who emphasize the benefits of VMMC beyond HIV prevention, has been shown to increase demand for VMMC among males.[46]
- Regulatory authorities for medical and nursing practitioners have been fully engaged in reviewing the policy barring task-shifting of VMMC to lower-cadre clinicians and nurses. Revision of the policy could potentially lead to an increased pool of VMMC service providers, particularly in primary health care facilities.
- Considering service delivery challenges, private sector healthcare providers could be engaged to expand availability of VMMC services, especially in urban areas where HIV prevalence is high. Such services could potentially be more acceptable to older and more affluent men. The private business sector could also help to generate demand for VMMC among its employees.

VMMC program targets

Considering the slow scale-up of VMMC and the limited availability of financial resources for the program, the GoM expects to reach the following VMMC targets by end of 2020:

1. Reach at least 60% VMMC coverage among males aged 10-34 years in 14 high HIV burden districts.
2. From 2018 to 2020, perform at least 780,000 VMMCs according to national standards, focusing on the 14 highest HIV burden districts.

[46] World Bank Group, UK AID, Invest in Knowledge. Impact evaluation on improving VMMC demand in Malawi through the use of incentives. March 2017.

VMMC program objectives

During the remaining period of the 2015-2020 HIV prevention strategy the GoM is committed to operationalizing the VMMC strategy by focusing on the following objectives:

a) Expand the availability of quality VMMC services

This objective is mapped to the VMMC Strategy element number 2 (*Service delivery*) and will entail the following activities:

1. Mobilize sufficient budgetary resources to achieve the revised program targets.
2. Expedite the performance of the VMMC Shang Ring device surveillance and develop appropriate guidelines for its use.
3. In consultation with health worker regulatory authorities, fast-track the updating of the VMMC policy to include VMMC task shifting to lower-cadre clinicians and nurse/midwives.
4. Provide year-round VMMC services in static health facilities in high burden districts.
5. Adopt and scale up utilization of the WHO-recommended "MOVE[47]" approach to maximize efficiency.
6. Renovate and/or expand health facilities in priority districts to accommodate VMMC scale up.
7. Liaise with health practitioner training institutions to incorporate VMMC in pre-service medical and nursing training.
8. Establish strong linkages between VMMC and other HIV and health services; promote referral of HIV-negative men for VMMC from primary health care, HIV testing, STI and outpatient services.
9. Engage with and provide training and VMMC kits to certified private health services providers in high burden urban districts.
10. Optimize supply chain management system for VMMC commodities to avoid stock-outs at all levels, including coordinating commodity planning by volume and age of clients at site-level.
11. Develop an immediate plan for a phased approach for reusable kits, including training and mapping of sites where sterilization may be conducted.
12. Implement VMMC quality improvement and assurance in public health facilities.

[47] MOVE is the acronym for "Model for optimizing volume and efficiency"

b) Intensify SBCC to enhance demand for and social acceptance of VMMC

This objective is mapped to the VMMC Strategy element number 2 (*Communication and Demand creation*) and will entail the following priority actions:

1. Develop research-based demand creation and service delivery strategies to attract sexually-active men in the 15-29 years age group.
2. Design health promotional materials that emphasize other motivational factors (such as improvement of personal hygiene, sexual appeal and prevention of penile and cervical cancer) in addition to HIV prevention in demand creation efforts and address the misconception of linking VMMC and religious/cultural identity.
3. Maximize interactive approaches to VMMC communication including awareness-raising on VMMC, provision of information on where to access services, and education on new VMMC devices, when they become available.
4. Utilize both traditional media (radio, TV, newspapers) and new media (internet, mobile phones) for demand creation; strategically tailor the choice of channels to specific target populations.
5. Explore the utilization of community leaders and/or community-based women groups to promote VMMC uptake among sexually-active men in the 15-29 years age-group.
6. Promote year-round VMMC demand creation to males aged 15-29 years; align demand creation with availability of services. As districts near saturation (towards 80% coverage of 15-29 year olds), the priority should shift to 10-14 year olds for a longer-term, sustainable approach to maintain high MC coverage.
7. Through service delivery partners, integrate VMMC messages into other HIV services such as STI clinics, HTS, OVC and DREAMS programming.
8. Expand engagement of chiefs, village headmen, and religious leaders in VMMC demand creation and in addressing socio-cultural barriers to VMMC uptake.
9. Involve satisfied older male VMMC clients to motivate their peers.
10. Engage women, both as partners and mothers, to influence their husbands' and sons' decisions to seek circumcision and to promote VMMC in their communities.
11. Involve youth-serving organizations including youth ministries in churches, mosques and other places of worship, to generate demand for VMMC among young men.
12. Monitor and measure impact of demand creation approaches and maintain adequate number of mobilizers to meet consistent demand.

c) Strengthen multi-sectoral collaboration

This objective is mapped to the VMMC Strategy element number 1 (*Leadership, Governance and Coordination*) and will entail the following activities:

1) Review and update the "2012 Malawi VMMC Communication Strategy," which prescribes communication approaches and messages for various target audiences. Subsequently, operationalize the updated Communication Strategy by requiring that all implementing partners utilize this resource in demand creation, while adapting activities to local community needs.
2) Coordinate all VMMC communication activities with the National Behaviour Change Communications Subgroup of the HIV Prevention TWG and the Health Education Unit in the MoH.
3) Harmonize community mobilization training and share best practices.
4) Decentralize VMMC planning to DHMTs; strengthen institutional and technical capacity of priority districts to plan, implement and monitor their VMMC programs.
5) Designate focal persons in all priority districts to facilitate collaboration between the education and health sectors and to expand VMMC uptake among male students of secondary and tertiary educational institutions.
6) Advocate for paid sick leave policy for VMMC clients.

5.3. Increased coverage of combination HIV prevention interventions among adolescent girls and young women.

Background

Girls in Malawi are vulnerable to poor sexual and reproductive outcomes, including HIV infection, partly due to early sexual debut and marriage. In 2015/16, 19% of women aged 25 - 49 reported sexual debut before age 15 and 64% before age 18. Thirteen percent were married by age 15 and 47% by age 18.

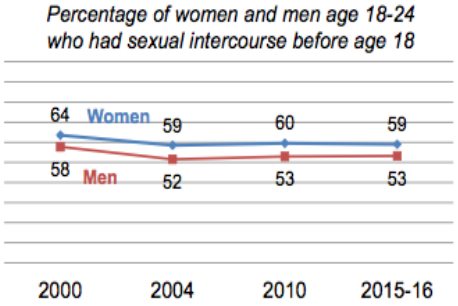

Figure 6: Trends in percentage of women who had sexual debut before the age of 18 (Source: MDHS)

The percentage of young people who had their sexual debut before the age of 15 was highest in the Southern region for both females and males (17% and 21%, respectively). The percentage of young people aged 18-24 who have had sex by age 18 decreased only marginally from 2000 to 2015-16 (Figure 6).

Unsurprisingly, Malawi's adolescent fertility rate is one of the highest in the Southern African Development Community (SADC) at 141 births per 1,000 girls aged 15-19 years,[48] with 29% of adolescent girls (15-19 years) having begun child bearing[49] and 35% of girls age 20-24 having given birth before age 18. In the MDHS 2015/16, unmet need for family planning was 10.8% among unmarried 15-19 year olds and 22.2% among currently married 15-19 year olds.

HIV knowledge, prevalence and incidence among young people

- In the MDHS 2015/16, comprehensive knowledge about HIV was low among young females (41%) and males (44%) aged 15-24 years.
- In the 2015/16 MDHS, 3% of young people aged 15-24 were HIV-positive. HIV prevalence was almost five times higher in AGYW (4.9%) than in adolescent boys and young men (ABYM, 1%). HIV prevalence was higher among young women in urban areas than in rural areas, and in the Southern region than in the Central and Northern regions.[50]
- In the 2015/16 MPHIA survey, the estimated HIV incidence was eight times higher among AGYW aged 15-24 years (0.40%) than among ABYM of the same age group (0.05%), although the difference was not statistically significant.
- In 2016, UNAIDS SPECTRUM model estimated that of the 32,000 new HIV cases that occurred among people aged 15 years and above, 8,500 (27%) were in AGYW aged 15-24 years.

[48] https://data.worldbank.org/indicator/SP.ADO.TFRT
[49] NSO, MDHS 2015/16, *Op. cit.*
[50] NSO, MDHS 2015/16, *Op. cit.*

Uptake of key HIV interventions among young people

- In the MDHS 2015/16, among young people (15-24 years) reporting sex with non-marital, non-cohabiting partners, 76% of young males used a condom compared to 54% of young females.
- In the MDHS 2015/16, 68% of AGYW aged 15-24 years had ever had an HIV test and received results, compared to 50% of same-age ABYM. The percentages were lower for female and male adolescents aged 15-19 years (42% and 33%, respectively).
- HIV-positive young people on ART were significantly less likely to achieve v suppression than older adults (Figure 7): 52% of females and 37% of males aged 15-24 on ART were virally suppressed, compared to 68% of all adults aged 15 – 64 on ART.[51]

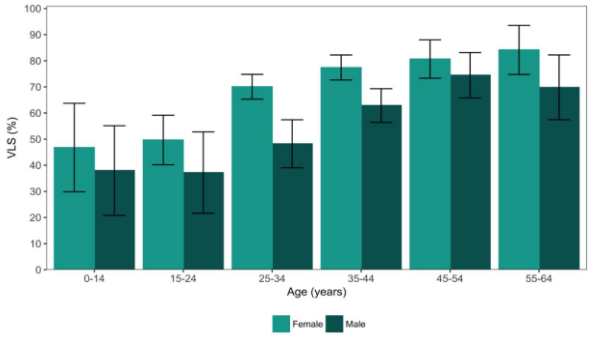

Figure 7: Viral load suppression by age group (Source: 2015/16 MPHIA)

Factors contributing to poor sexual and reproductive health outcomes among AGYW

As shown in Table 8, below, many factors were associated with increased vulnerability to HIV among AGYW, including cultural disempowerment of girls and women, negative gender norms and stereotypes, poor educational attainment, poverty and poor economic empowerment. The risk of HIV was exacerbated by cultural and social norms promoting high-risk sexual behavior by male partners of the AGYW. Poor stakeholder coordination in delivery of social services, particularly in the health, education and social welfare sectors, limited the effectiveness of proven HIV preventive interventions.

Table 8: Factors associated with HIV infection and poor SRH outcomes among AGYW

Social Ecological Model Level	Factors
Individual	○ Low comprehensive knowledge of HIV infection among young people.[52] ○ Low education attainment: in 2014, 62% of young people aged 15-24 years had not completed primary school.[53] ○ Early sexual debut exposing young women to the risks inherent in sexual activity.[54] ○ Inability of AGYW to negotiate safer sex and condom use due to female submissiveness. ○ Diminished HIV risk perception among sexually-exploited children. ○ Alcohol and substances abuse.
Family/peers	○ GBV among AGYW[55] particularly those who are economically dependent and with disabilities.

[51] Ministry of Health. Malawi, MPHIA, *Op. cit.*
[52] In 2015/16, comprehensive knowledge was only 41% among women aged 15-24 and 44% among young men
[53] National Education Profile, 2014. Data accessed through https://www.epdc.org/sites/default/files/documents/EPDC%20NEP_Malawi.pdf on 19th June 2018.
[54] This risk is evident in women age 15-17; 27% had ever had sex, of whom 65% had sex with a non-marital, non-cohabiting partner
[55] Ministry of Gender, Children, Disability and Social Welfare of the Republic of Malawi, United Nations Children's Fund , The Center for Social Research at the University of Malawi, and the Centers for Disease Control and Prevention.

	o Lack of financial independence limiting AGYW's access to healthcare. o Negative gender stereotypes reduce parental support for girls' education and promote excessive household responsibilities. o Low risk perception among male partners of AGYW and their poor uptake of HTC
Community	o Societal and cultural norms underpin community acceptance of child marriage and violence against children and women.[56] o Gender norms limit girls' mobility, selection of peer groups, and access to important social capital, financial assets and social services. o Societal norms which tolerate multiple and concurrent extramarital sexual partnerships among men.[57] o Disapproval of condom use by young people for religious and moral reasons, owing to the association of condoms with promiscuity. o Transactional sex by AGYW seeking basic necessities such as food or school fees as well as luxury consumer items from their male partners. o Negative masculinity and harmful cultural practices such as polygamy and initiation rites for young girls practiced by some tribes.
Institutional	o Poor availability and quality of youth-friendly health services (YFHS). o Limited coverage of post-violence care through "one stop" centers and victim support units. o Low and uneven coverage and quality of comprehensive sexuality and HIV education in schools. o Poor coordination among stakeholders implementing various types of AGYW interventions. o Lack of standard AGYW intervention package.
Structural	o High unemployment and under-employment rates among women, particularly among poorly-educated AGYW. o Stigma and discrimination experienced by ALHIV at home, in healthcare facilities, and in school.

Emerging opportunities and promising program innovations to improve AGYW welfare

The following developments have occurred during the first half of the implementation period of the 2015-2020 HIV Prevention Strategy, which may facilitate the design and implementation of new interventions in the final half of the implementation period:

- Malawi formulated several laws[58], policies[59], strategies[60] and plans of action[61] which, if well implemented, could create a good environment for reducing the vulnerability of AGYW to engaging in high risk sex and/or becoming victims of sexual violence. An

Violence against Children and Young Women in Malawi: Findings from a National Survey, 2013. Lilongwe, Malawi: Government of Malawi, 2014

[56] Up to 16% of young women found it acceptable for a husband to beat his wife

[57] In 2015/16, 71% of sexually-active 15-24 year old men and 24% of women engaged in sex with a non-marital, non-cohabiting partner.

[58] The Prevention of Domestic Violence Act (2006), The Wills Inheritance and Protection Act (2011), The Gender Equality Act (2013), The Divorce and Family Relations Act (2015) which raised the minimum age of marriage to 18, The Child Care, Protection and Justice Act and The HIV Prevention and Management Act (2017)

[59] National Gender Policy (2014).

[60] The National Strategy for Adolescent Girls and Young Women 2017 – 2020 (draft), The National Youth Friendly Health Services Strategy 2015–2020, The Child Protection Strategy, The National Girls' Education Strategy, (2014), The HIV & Gender Strategy and The Gender Based Violence Strategy

[61] The National Plan of Action to Combat GBV in Malawi (2014-2020), The National Plan of Action for Vulnerable Children (2015-2019), The draft National Violence Against Children Plan of Action, The draft National Gender and HIV Implementation Plan (year), Joint Sector Support Plan on Children, Youth and Gender (2012-2017), National Plan of Action for Scaling Up SRH and HIV prevention interventions for young people, National Plan of Action to Combat Gender- Based Violence (2014) and Gender, HIV and AIDS Implementation Plan 2016 -2020,

AGYW Strategy, to be launched in 2018, is expected to facilitate the coordination of AGYW programs implemented by different ministries.

- MoGCDSW and other stakeholders launched the National Action Plan for OVCs, successfully piloted screening tools and approaches for identifying orphans and vulnerable children and established protocols for their management and follow-up. The Ministry also developed the National Gender and HIV implementation Plan (2016-2020), which seeks to intensify national action to reduce HIV related gender inequality and women and girls vulnerability to HIV and AIDS.

- The One Community Project, funded by PEPFAR and USAID, has successfully refined the tools and implemented multidisciplinary case management for high-risk orphans and vulnerable children in Zomba and Machinga districts. The use of these tools could be scaled up to other high burden districts.

- Malawian NGOs, particularly the DREAMS[62] program, have a wealth of experience in programming for AGYW in school and community settings. The DREAMS program has achieved high reach of the most vulnerable AGYW in Machinga and Zomba districts, provided models for comprehensive interventions (such as social assets, economic strengthening, parenting, community change, back to school efforts) and has demonstrated promising outcomes and best practices.

- GFATM resources are already being used to support a streamlined DREAMS package in additional five districts in Malawi.

- GoM and donors have made significant investments in the "Keep girls in school" campaign through infrastructure investment (such as construction of girls hostels), school feeding programs, educational bursaries, social cash transfer and other social safety nets.

- GoM has devolved powers to local government, which will strengthen the authority of district-based government officials to coordinate activities of implementing partners and stakeholders for youth programs.

AGYW program targets

In view of the multiple risk factors underlying poor SRH outcomes among AGYW, including HIV, and the need to address these factors through multi-sectoral strategies, the

[62] DREAMS is a large-scale initiative funded by PEPFAR, Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, Gilead Sciences, and ViiV Healthcare, which strategically targets the most vulnerable AGYW in the highest HIV prevalence localities. It supports a comprehensive package of interventions including HIV risk reduction education; HIV and sexual and reproductive health services; household economic support; parenting support; education subsidies; safe spaces/social assets building; and efforts to change harmful social norms and create a supportive environment. DREAMS programs emphasis on "layering" and coordinating multisectoral interventions to ensure that each individual girl is reached with the full package of interventions. The program also reaches out to male partners of AGYW with HIV testing and linkage to ART and VMMC.

Revised HIV Prevention Strategy sets out to achieve the following targets by the end of 2020:

1. 75% of in-school and out-of-school AGYW and ABYM have comprehensive knowledge about HIV.

2. 75% and 85% of sexually-active AGYW and ABYM, respectively, report using a condom at last sexual intercourse with a non-marital and non-cohabiting partner.

3. 80% and 70% of sexually-active AGYW and their male partners, respectively, report undergoing an HIV testing in the preceding 12 months and receiving results.

4. 80% of in-school and out-of-school AGYW and ABYM and community leaders have comprehensive knowledge about children and gender rights and reject negative gender norms, stereotypes and practices.

5. 80% of most vulnerable AGYW access financial and economic support and skills development programs.

6. 90% of AGYW and ABYM experiencing GBV or sexual violence seek external support.

AGYW program objectives

This Revised HIV Prevention strategy recognizes that isolated interventions are ineffective in promoting the welfare of AGYW and reducing their risk to poor SRH outcomes, including HIV. Thus, the GoM of Malawi, has set out the following broad-based multi-sectoral objectives, which are aligned to the National AGYW Strategy:

1) Strengthen key SRH services, including HIV, for AGYW and their male sexual partners

This objective is mapped to strategic objective number 1 in the AGYW strategy "***Health***: *Increase access to and uptake of comprehensive nutrition, sexual and reproductive health and HIV services for young people aged 10 to 24 with a focus on AGYW*". Addressing this objective will entail undertaking the following priority activities:

a) Increase coverage of comprehensive, youth-friendly SRH services for AGYW, through expanded and improved mobile and facility-based services tailored to AGYW and delivered by trained providers (health care workers, peer-educators, CBDAs).

b) Expand and improve GBV management, including screening and referrals to post-violence care, within existing health facilities, outreach clinics and other platforms, by operationalizing GBV protocols, providing training and sensitization to health providers, teachers, and police, and ensuring availability of PEP.

c) Improve access to both free and subsidized condoms through increased coverage of community-based outlets in venues that are acceptable and accessible to young people.

d) Intensify efforts to reach male partners of AGYW with male-friendly mobile and community-based HIV testing services, with robust linkages to ART initiation for HIV-positive men, and to VMMC for high-risk negative men.

2) Intensify social and behavior change communication to increase demand for and uptake of SRH and HIV prevention services by AGYW and their male partners

This objective is mapped to strategic objective number 2 in the AGYW strategy "***Gender Equality**: Remove cultural barriers and negative gender stereotypes that contribute to gender based violence (GBV) and discrimination against AGYW*" and strategic objective #3 "***Education:** Increase access to and completion of quality primary and post-primary education, including informal and vocational learning for AGYW"*. Addressing this objective will entail undertaking the following activities:

a) Strengthen the quality and coverage of comprehensive education on HIV and sexuality, violence prevention and on gender and child rights, including robust information and skills building on use of male and female condoms, in primary and secondary schools, and through age and marital status segmented after-school and community clubs. To ensure effectiveness of HIV and sexuality education, incorporate best practice, including adoption of evidence-based curricula, teacher training, appropriate learning materials, and interactive pedagogical methods.

b) Utilize innovative youth-friendly communication channels, including mass and social media and innovative new media that appeal to AGYW, to create demand and utilization of SRHR and HIV services and to promote risk reduction and service uptake with fidelity and quality assurance.

c) Reach ABYM through schools, community clubs, and young men's groups, including in faith-based settings, to positively influence gender norms and attitudes.

d) Engage communities in social dialogue to foster a supportive environment for AGYW through the following actions:

i. Utilize Parent Teacher Associations and mothers groups as channels for sensitizing the community about the relevant child protection and gender laws and the reporting/referral structure for human rights violation against AGYW, including early child marriages.

ii. Mobilize local faith, traditional and community leaders to address harmful social and gender norms and cultural practices and to support the reporting of human rights violations against AGYW, including early child marriages.

iii. Work with opinion leaders to reduce tolerance of GBV, especially sexual violence against children and women;

iv. Raise awareness among traditional leaders about harmful consequences of child marriage and recent changes in the legal age of marriage and nullify illegal child marriages.

a) Target all stakeholders (traditional, community and faith-based leaders, health and social workers, teachers) with evidence-based messages and tool-kits regarding the special vulnerability of and need for support by AGYW.

b) Engage parents and care-givers, through mother groups, religious gatherings or other appropriate community structures, to support young girls aged 10-14 years in HIV risk avoidance by improving parenting and parent-child communication skills.

c) Engage female teachers to serve as "caring adults" and mentors for AGYW. In addition, operationalize the Teachers Code of Conduct that prohibits male teachers from having any form of sexual relationships with female pupils.

d) Target high risk AGYW and typical male partners with evidence-based, peer reviewed messages about risk reduction and GBV prevention; in particular, the importance of consistent and correct use of condoms during high-risk sexual activity.

e) Roll out the Malawi National Alcohol Policy, launched in 2017, to reduce vulnerability of AGYW to engaging in high-risk sex and to becoming victims of sexual abuse as a result of alcohol abuse. In addition, review and update the policy to incorporate emerging issues on substance abuse.

f) Promote access to HTS for typical male partners of AGYW, through HIV self-testing and other acceptable approaches (such as mobile HTC facilities) and link HIV-positive individuals to ART services.

3) Social and economic empowerment of vulnerable AGYW

This objective is mapped to strategic objective number 4 in the AGYW strategy "*Youth Development: Enhance opportunities and meaningful participation in social, economic and political processes for AGYW*". Addressing this objective will entail undertaking the following activities:

a) Utilize small group structures such as after-school and community clubs to deliver evidence-based social assets interventions to build social support and increase girls' resilience. Differentially target these clubs to specific age groups and to married and unmarried girls and young mothers, who have different experiences and needs.

b) Support the scale up of OVC screening tools, developed by the MoGCDSW and refined by One Community Project, to identify the most vulnerable AGYW[63] who need to be targeted with social and economic empowerment programs.

c) Provide cash transfers, sanitary pads and education bursaries to keep at risk girls in school, and to facilitate the return to school/ reintegration of girls who have previously dropped out.

d) Provide economic strengthening for the most vulnerable AGYW through Village Savings and Loan groups and vocational training.

4) Promote cross-sectoral collaboration and coordination in the implementation of AGYW interventions

This objective is mapped to the "*Coordination, Oversight and Management"* theme in the AGYW strategy. Addressing this objective will entail undertaking the following activities:

a) At national level, strengthen coordination of youth and AGYW stakeholders through the High-level Inter-ministerial Taskforce on Youth and Adolescents to ensure effective multi-sectoral planning, implementation, monitoring and evaluation of AGYW programs.

b) Strengthen multisectoral coordination, referral and linkages at the district level by building capacity of the District AGYW Steering Committee, under the leadership of the District Youth Officer.

c) Establish and maintain a database of all stakeholders implementing youth programs at district level to ensure coordination in the implementation of programs.

d) Develop and implement a robust supervisory and mentorship support system for youth clubs and CBOs to ensure delivery of quality SRH and HIV services and linkages with social support services.

e) Appoint, train and allocate adequate resources to Social Workers and Child Protection Workers to enable them to implement relevant AGYW activities at community level and ensure that implementing partners and structures at community and institutional levels adhere to national service delivery standards and the reporting/referral system for GBV and other human rights violations.

f) Establish a system for capturing GBV data at health facility level and other social service delivery platforms to facilitate better care, referrals and tracking.

g) In line with the AGYW Strategy, scale up the referral/linkage and tracking system for vulnerable AGYW to facilitate their access to critical social services provided in schools, health facilities, victim support units and other relevant service delivery points and also the justice system. In addition, review the feasibility of scaling up

[63] Most vulnerable AGYW are defined as "those living in the lowest three wealth quintiles and have two additional vulnerability factors". Details are provided in the National Plan of Action for Vulnerable Children (2015-2019).

the referral/linkage and tracking system, piloted in the DREAMS project in Machinga and Zomba.

h) Review, revise and scale-up the training toolkit for vulnerable AGYW, piloted in the DREAMS project in Machinga and Zomba, to ensure that it is locally relevant and feasible to implement in different settings.

Prioritization and targeting of AGYW package of interventions

- The focus of HIV prevention efforts targeting AGYW will be on districts with high HIV prevalence, high numbers of people living with HIV, low treatment uptake, high prevalence of teen pregnancy and high school drop-out rates. Details of the AGYW intervention packages are provided in Annex A1. These are differentiated to address needs of youth in different age-bands and contexts. In high burden districts, vulnerable girls will receive a comprehensive multilayered package of interventions. In medium and low burden districts, an effective linkage/referral system will be established to ensure that AGYW access broad-based services across different sectors.

5.4. Increased coverage of combination HIV prevention interventions among key populations.

Background

In Malawi, MSM and transgenders (TG) are largely an underground population due to the unfavorable cultural and legal environment. As a result, they frequently fail to access social services that adequately meet their needs. Although FSW operate visibly in Malawi, they face similar challenges as MSM and TG due to perceived illegality of sex work and cultural and religious disapproval of commercial sex. Since the Constitution of the Republic of Malawi guarantees basic rights for all people irrespective of their social characteristics, GoM believes that FSW, MSM and TG should access all social services without impediment or discrimination. Failing to provide them with HIV preventive and curative services increases their vulnerability to HIV, which can be spread further through their sexual networks.

HIV prevalence among key populations

- In 2013, the Malawi Biological and Behavioural Surveillance Survey (BBSS), which studied selected high-risk populations across Malawi, found average prevalence of HIV among FSW to be 62.7%[64], much higher than among women in the general population (12.2-12.9%[65]). In the same study, 20% of FSW tested positive for syphilis. Among clients of FSW, the prevalence of HIV and syphilis were 16% and 4%, respectively. Other small scale and more localized studies have also found very high HIV rates in FSW. Additionally, recent program data confirm persistent high HIV case detection in a cohort of FSW.[66]
- In a study conducted 7 districts between 2011 and 2014, HIV prevalence among MSM was 18.2%[67] which was higher than among men in the general population (8.1-8.3%[68]). However, prevalence across study sites ranged from 4% to 25%. Recent program data indicate low HIV case detection within HIV programs that serve MSM communities, perhaps reflecting the challenges in reaching MSM networks.[69]

Sexual behavior among key populations

- In 2013-14, 93.4% of FSW reported using a condom the last time they engaged in commercial sex. However, only 60.4% of FSW reported consistent use of condoms during commercial sex.

[64] NSO, Malawi Biological and Behavioural Surveillance Survey 2013-2014, *Op. cit.*
[65] MDHS 2010 and MDHS 2015/16, *Op. cit.*
[66] In 2017, USAID LINKAGES project found that among 8,687 FSWs in six high burden districts, 5,698 tested HIV positive (65.6%). Among the HIV-infected FSWs, 1,529 (17.6%) were newly diagnosed.
[67] Wirtz AL, *Op. cit.*
[68] MDHS 2010 and MDHS 2015, *Op. cit.*
[69] In 2017, the USAID LINKAGES project found a lower HIV positivity rate among MSM (8.8%) than reported in a previous surveys. Among 1730 MSMs, 152 were found to be HIV positive. Of these, 99 (65.1%) were newly diagnosed.

- In the survey conducted in 2011-2014, 70.2% of MSM reported using a condom during last anal sex with a casual partner and 59.5% reported condom use during last anal sex with their main partner[70]. Consistent condom use among MSM was low.

Uptake of HTC and ART among key populations

- In the 2013 BBSS, 94% of FSW had ever been tested for HIV. Among FSW clients, 80% had ever tested for HIV. Yet a study conducted in Lilongwe district found that although 70% of HIV-positive FSW had sought HIV care, only 52% reported current ART use (of whom 80% were virally suppressed.)[71]

- HIV testing rates are low among MSM; two different studies found that only slightly more than half of MSM had ever been tested. In the 2011-2014 study, fewer than 1% of MSM had been diagnosed with HIV and initiated ART.[72]

Factors associated with HIV infections in KP

As shown in Table 9, below, low risk perception, fatalistic attitudes, stigma and discrimination and poor understanding of the laws on KP result in poor health and social services access and utilization by FSW, MSM and TG. Limited awareness of rights and legal protection of KP by government officials and service providers at district-level negatively affect the operations of NGOs delivering services to KP and provision of KP-responsive services.

Table 9: Factors associated with HIV and STIs among KP

Social Ecological Model Level	Factors
Individual	• Fatalistic attitude among FSW limit their access to SRH and HIV services.[73] • Low HIV risk perception among MSM when engaging in receptive anal sexual intercourse.[74] • Self-stigma among FSW, MSM and TG results in reluctance to access services geared for the general population. • Due to the illegality of same-sex relationships[75] and perceived illegality of sex work,[76] MSM and FSW fail to disclose their sexual orientation and occupation, respectively, to health workers, which negatively affects the appropriateness of services provided to them.

[70] Wirtz, AL, *Op cit.*
[71] Lancaster KE, Powers KA, Lungu T, Mmodzi P, Hosseinipour MC, et al. (2016) The HIV Care Continuum among Female Sex Workers: A Key Population in Lilongwe, Malawi. PLOS ONE 11(1): e0147662. https://doi.org/10.1371/journal.pone.0147662
[72] Wirtz, AL. *Op. cit.*

[73] Family Planning Association of Malawi. (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
[74] Wirtz AL, *Op cit.*
[75] Section 153c of the Penal Code makes "carnal knowledge of male persons against the order of nature" a criminal offense punishable for 14 years. Section 154 of the Penal Code makes "attempts of a male person to have carnal knowledge with another male against the order of nature" an offense punishable for seven years.
[76] "Living of the earnings from sex work" is as well as "engaging in reckless/negligent action that could spread a life-endangering infection; e.g. HIV or other STI" are both illegal.

	• FSW's lack of empowerment to negotiate condom use partly due to economic hardship, power asymmetry with their clients, and/or to prevent physical or sexual violence. • Low legal and human rights literacy among FSW, MSM and TG women limit their access to justice.
Family/peer	• Widespread stigma and discrimination against FSWs, MSM and TG.
Societal	• Widespread community stigma and discrimination against FSW, MSM and TG. • Community tolerance of physical violence against FSW, MSM and TG.
Institutional	• Low literacy on the rights of FSW and MSM coupled with limited technical skills on FSW, MSM and TG specific health needs among social service providers limit the provision of quality KP-responsive services. • Inadequate availability of quality, stigma-free KP-responsive services limits client access and utilization. • Lack of national service provision standards and guidelines on core components of HIV programs for FSW and MSM limit KP access to quality prevention and treatment interventions across districts. • Poor linkage, referral and retention mechanisms for KP accessing HIV prevention, treatment and support services. Highly mobile FSW face challenges to initiate and maintain ART, including timely refill of their medications and adherence to scheduled check-ups. Health care workers experience challenges in tracking FSW and providing them with a continuum of HIV and SRH services due to the lack of unique identifiers. • Inconsistent supply of condoms and lubricants in KP "drop-in-centres". • Limited interventions to reach MSM who use online dating applications. • Inconsistent and weak delivery of peer outreach and HIV prevention interventions targeting both HIV negative and positive FSW and MSM.[77]
Structural	• Conflicting laws[78] on the legality of same-sex relationships and sex work and KP-targeted stigma and discrimination facilitate abuse of FSW and MSM and create an unfavorable working environment for NGOs providing services to MSM. • Weak advocacy for the needs and rights of FSW, MSM and TG at district level • Limited stakeholder harmonization in the delivery of interventions for KP in different geographical locations. • Inadequate technical capacity at district level to implement or coordinate programs targeted at KPs, especially MSM and TGs.

Emerging Opportunities, Promising Developments and Innovations for KP Programing

The following developments have occurred during the first half of the implementation period of the 2015-2020 HIV Prevention Strategy, which may facilitate the design and implementation of new interventions in the final half of the implementation period:

- Despite structural challenges described in Table 9, above, there have been significant improvements in the legal and human rights environment for KP in Malawi. The 2015-2020 National HIV/AIDS Strategic Plan and National HIV Prevention Strategy recognized the need to prioritize KP in the provision of HIV interventions. Malawi's Global Fund TB/HIV grants from 2016 to 2020 include dedicated funding for FSW and MSM interventions.

[77] There are high attrition rates among volunteer peer educators (PEs) and peer navigators (PNs). This is exacerbated by a lack of harmonized incentives and differences in PE/PN management capacities among KP service partners working in the same geographic areas.

[78] Section 153c of the Penal Code criminalizes "carnal knowledge of male persons against the order of nature", punishable with up to 14 years imprisonment. Similarly, Section 154 of the Penal Code criminalizes "attempts of a male person to have carnal knowledge with another male against the order of nature" punishable with up to seven years imprisonment.

- Within the framework of the 2015-2020 HIV Prevention Strategy, various CSOs and NGOs have initiated KP-targeted health and social services, including moonlight clinics and established safe spaces for KP, such as DICs, to facilitate and expand service provision and access.
- KP NGOs and CSOs have successfully engaged in policy dialogue with national authorities including the Parliamentary Committee on HIV and AIDS and Malawi Human Rights Commission (MHRC). As part of this engagement, they have implemented various programs to orient the judiciary, law enforcement, and policy holders on KP rights and challenges within the current legal and policy framework. In 2017, a KP TWG was established at the national level to guide programming of KP activities. Membership on the Malawi Partnership Forum was expanded in 2017 to include two KP representatives.
- The number of NGOs providing comprehensive package of KP-targeted services are few but slowly growing. Geographic service coverage has expanded. Some KP partners have reported good relationships and engagement with community stakeholders, including bar owners, hotspot managers and the police to facilitate program implementation. Their experience provides an opportunity to share lessons with government and other NGOs that will promote the scale up of quality interventions nationally.
- LINKAGES project has successfully piloted the use of Unique Identification Codes (UIC) for KP, which facilitates tracking and referrals of mobile KP and clients across the HIV services continuum.
- Several surveys, studies and project activities were conducted between 2011 and 2017 to identify, validate and update hotspots and generate and update key population size estimates for FSWs and MSM. This lays the foundation for better targeting and allocation of resources for KP programming.
- In early 2017, the Malawi High Court declared unconstitutional Section 184(1)(c) of the Penal Code (the "Rogue and Vagabond Act"), which was used by police to arrest and abuse sex workers. In the same year, Malawi enacted the "HIV Prevention and Management Act" that prohibits discrimination against individuals based on actual and perceived HIV status. A presidential moratorium prohibiting arbitrary arrest and prosecution of LGBTI persons reactivated in 2015, which has contributed to a reduction in the arrest and prosecution of LGBTI persons.

KP program targets

In view of the challenges affecting quality delivery of HIV and SRH interventions to KP, this strategy has set out the following targets to be achieved by the end of 2020:

1. Achieve the 90-90-90 treatment targets among FSW, MSM and TG.

2. 90% of MSM and TG women consistently use condoms and lubricants during anal sex.

3. 90% of FSW and their clients consistently use condoms (and lubricants) during high-risk sexual encounters.

4. 100% of public sector service providers have positive attitude on KP human rights.

5. 80% of community leaders have positive attitude on KP human rights.

KP Program Objectives

This Revised HIV Prevention Strategy recognizes the need to address poor delivery of health and social services to KPs that increases the risk of HIV infections to themselves and members of their social networks. Thus, to achieve the above-mentioned targets, the GoM has set out the following objectives:

1) **Improve access to quality, HIV prevention, treatment and support services by FSW and their clients, MSM, TG and KP family members.** This entails the following activities:

a) Scale up facility-based and self-HIV testing coupled with ART linkage, retention in care and ART adherence for KP.
b) Initiate and scale up a standard comprehensive HIV prevention, care and support service package[79] for FSW and their clients, MSM and TG and KP family members.
c) Expand a differentiated service delivery (DSD) model for KP[80] enabling them to access a continuum of HIV and SRH services from multiple service delivery points (DICs, mobile outreach, supported facility care), especially for mobile KP and those who are highly stigmatized. This will entail the following activities:

i. Use of service outreach activities (e.g. moonlight testing), DICs and other safe spaces for KP meetings and service provision venues, in addition to peer-based interventions, linked with public and/or private health facilities.

ii. Recruit and train peer educators, peer navigators and outreach workers for FSW, MSM and TG, establish a standard equipment and supplies package for these service providers and harmonize their incentive packages.[81] In addition, provide regular supervision and mentorship of the workers to ensure quality delivery of services.

iii. Use of innovative outreach approaches such as internet, social media and mobile phone application-based outreach and LINKAGES project's

[79] Refer to Annex A2.
[80] Peer-led programming, safe spaces in high burden catchment areas, routine outreach services in hotspots, supported referrals to trained health facilities and providers
[81] Such as stipend/allowance, capacity building, team building activities, team bicycle for transport, enhanced relationships with HCWs, police and other community members

Expanded Peer Outreach Approach to engage hard-to-reach and hidden populations.

iv. Test and expand use of the UIC to better track and report results for KP client referrals and service provision across the HIV services cascade as well as track service provision for mobile KPs, especially FSWs, across districts, providers and programs.

d) Rollout rapid GBV response system that includes prompt reporting through appropriate channels, uptake of PEP and emergency contraception and STI screening/management.

i. Improve coordination and quality of KP responsive services in health facilities by identifying KP focal persons in public health facilities, conducting in-service training and periodic refresher training for frontline healthcare workers in provision of quality, stigma-free KP-responsive services and providing basic training in KP-responsive service provision in pre-service health care provider training institutions.
ii. Develop, finalize and roll-out cross-sector referral system and guidelines for FSW, MSM, TG and sexually-exploited children.
iii. Expand the use of KP community-centered monitoring systems, such as the SMS2[82], to monitor KP experiences with stigma and discrimination and human rights violations at health facilities and in other settings.
iv. Strengthen supply chain management for pharmaceutical and medical supplies in health facilities and DICs (e.g. ARVs, condoms, lubricants, STI drugs and PEP).

2) **Strengthen social and behavioral change communication on KP among community leaders, the general public and social service providers**. This entails the following activities:

a. Produce/ approve IEC/SBCC materials for FSW, MSM and TG using print, social media and interpersonal communication.

b. Conduct mass awareness campaigns for the general public with emphasis on the rights of FSW, MSM and TG (and other sexual and gender minorities).

c. Conduct targeted awareness campaigns for traditional gate-keepers and opinion leaders (particularly, religious and traditional leaders), law enforcement agents and judicial officers, bar owners and hot-spot managers, including the use of values clarification and attitude transformation activities.

[82] Service quality monitoring system, successfully piloted by the Linkages project, for reporting/ addressing of stigma/discrimination and providing feedback loop between KP individuals and health service providers.

d. Implement awareness campaigns for FSW, MSM and TG on violence prevention.

3) **Establish a robust system for reporting and redressing human rights violations against KP.** This entails the following activities:

a. Increase access and referral linkages to psychosocial, safe home, medical and legal services for KP whose rights are violated, particularly those who suffer physical and sexual violence.
b. Pilot and operationalize a real-time reporting and monitoring system for human rights violations perpetrated against FSWs, MSM, TGs and other sexual and gender minority members, such as the Rainbow SMS Platform[83], the SMS2 or telephone hotlines.
c. Strengthen capacity of the MHRC to establish a mechanism for coordinating and addressing the violation of rights of key population groups.

4) **Strengthen district level coordination of KP programs and KP community service provision capacity.** This entails the following activities:

a) Build capacity for KP CSOs and NGOs at district level in several domains including; leadership and management; service delivery; KP legal and human rights, evidence-based advocacy and monitoring and evaluation.

b) Increase the number of CSOs with capacity in human rights programming so as to reduce reliance on KP-specific CSOs.

c) Support regular stakeholder liaison (interface) meetings with law enforcement, judicial and health officials to identify and resolve challenges in program implementation.

d) Review and revise TORs for the DACC to include FSW and MSM representatives.

e) Support the operations of the FSW Coordination Committee and the establishment of MSM and TG committees at district levels.

f) Streamline the registration requirements for NGOs and CSOs working on KP issues at district level.

5) **Strengthen national-level coordination of KP activities.** This entails the following activities:

a) Conduct spatial mapping of KP site clusters, service providers and program implementers at national level to identify service area gaps and overlaps and foster rational resource allocation and synergistic collaboration among service providers.

[83] Developed by Innovations for Change (IFC)

b) Conduct studies to estimate to size of other KP, including TG and their utilization of HIV services.

c) Standardize reporting indicators, systems (including adoption of a UIC) and use of easily modifiable client-level data systems (such as DHIS2 platforms) to facilitate tracking of cascade performance across districts and providers.

d) Develop and finalize SRH intervention packages and guidelines for FSW, MSM and TG.

e) Standardize DSD models, prevention and care packages and SOPs for comprehensive KP prevention, treatment and care services.

f) Standardize curriculum and tools for peer-educators and peer-navigators for FSW, MSM, and TGs.

g) Saturate comprehensive KP prevention interventions tailored for HIV- and HIV+ cohorts in current priority (highest burden) districts, based on validated KP size estimates and expansion.

h) Advocate for review or suspension of discriminatory laws against sex workers and sexual and gender minorities

5.5 Increased ART coverage among pregnant and postpartum women and infants with HIV-infection.

Background

In 2010, an estimated 17,000 new HIV infections occurred among children under the age of 15 years[84]. Thereafter, Malawi developed the National Action Plan for the elimination of MTCT (EMTCT), which sought to achieve virtual elimination of HIV MTCT by 2015[85]. To meet this target, in 2011, the MoH adopted new ART/PMTCT guidelines that entailed commencement of lifelong combination ART (TDF/3TC/EFV regimen) in all HIV-positive pregnant women, irrespective of their immune status, starting from the antenatal period [referred to as "Option B+ " PMTCT regimen]. Also, the government embraced the four-pronged WHO PMTCT strategy comprising the following elements: primary prevention of HIV/AIDS among women of childbearing age, reduction of unplanned or unintended pregnancies among HIV+ women, prevention of HIV transmission from pregnant women living with HIV to children and provision of treatment care and support for HIV positive women, their children and families.

The first prong of PMTCT (primary prevention of HIV among women of childbearing age) has special relevance to HIV-negative pregnant women. Studies from other countries in the region suggest that HIV-negative women may be more susceptible to sero-conversion to HIV during pregnancy, probably due to hormonal changes.[86] Women who sero-convert during pregnancy may also be at high risk of transmitting the virus to their unborn child during the period of acute infection immediately after sero-conversion, when viral load is very high. Also, Malawi has high rates of HIV sero-discordancy among married/cohabiting couples; in about half of such couples, the HIV-positive partner is male and in the other half the positive partner is female. Since ART use is much higher among women than men, HIV-positive male partners of HIV-negative pregnant women are less likely to be on ART and virally suppressed. For these reasons, there is a need to focus on HIV-negative as well as HIV-positive pregnant women, particularly with regard to partner testing.

HIV MTCT rates and coverage of key interventions in Malawi

- The National Evaluation of Malawi's Prevention of Mother-To-Child Transmission Program (NEMAPP) Study (2013 – 2018) has estimated that the rate of HIV MTCT was 4.7% among HEI aged 4-26 weeks.[87] Thus, it is highly unlikely that the target HIV MTCT rate of 5% at the end of breastfeeding had been reached.

[84] UNAIDS SPECTRUM estimates.
[85] HIV MTCT rate of less than 5%.
[86] Gray RH, Li X, Kigozi G, et al. Increased risk of incident HIV during pregnancy in Rakai, Uganda: a prospective study. *Lancet.* 2005;366(9492):1182-1188.
[87] van Lettow M, Landes M, van Oosterhout JJ, et al. Prevention of mother-to-child transmission of HIV: a cross-sectional study in Malawi. *Bull World Health Organ.* 2018;96(4):256-265.

- Knowledge of methods of prevention of HIV MTCT is high among males (78%) and females (82%) in the general population.
- In the general population, the contraceptive prevalence rate (CPR) for modern methods of family planning increased from 42% in 2010 to 58% in 2015/16, and unmet need for family planning decreased from 21% in 2010 to 19% in 2016.[88] However, program data from Q3 of 2017 indicate that only 24% of the women on ART were receiving contraceptives.[89]
- In 2015/16, coverage of HTC in pregnant and postpartum women and ART coverage among pregnant PLHIV exceeded 95%.[90] Almost two-thirds of HIV+ women were already on ART at the time of getting pregnant.[91]
- Retention of mothers and their HIV exposed children in care is sub-optimal, estimated at 74% at 12 months postpartum. Also, only 49% of HIV-exposed infants received virological tests by 2 months of age in 2016. However, recent program data from July to September 2017 indicated improvements in EID, with coverage estimated at 70%.[92] Also, ART coverage among infants was estimated at 66%.

Factors associated with poor adoption of HIV MTCT interventions

As shown in Table 10, below, demand for EMTCT was negatively affected by stigma and discrimination, poor spousal engagement and religious beliefs. On the other hand, limited availability of health services providers and sub-optimal integration between PMTCT and other SRH services present challenges in delivering quality EMTCT services.

Table 10: Key factors associated with sub-optimal EMTCT coverage.

Social Ecological Model Level	Factors
Individual	• Pregnant women on ART incur indirect cost to reach health facility in terms of transport and meals.
Family/peers	• Low male/spouse support in PMTCT adoption, which results in ART discontinuation and low retention in care. • Fear of abandonment and/or divorce as a result of HIV status disclosure.
Societal	• False religious beliefs about an HIV cure which lead to ART discontinuation. • Stigma and discrimination.
Institutional	• Inconvenient clinic operation hours and human resources challenges. • Long distances to reach health facilities. • Weak integration of PMTCT with other programs such as immunization, SRH and outreach clinics. • Weak data ownership by lower level facilities due to centralized data analysis and parallel data reporting system affecting timely decision making and planning.

[88] NSO, MDHS 2015/16, *Op. cit.*
[89] Ministry of Health. Integrated HIV Programme Report, July-September 2017
[90] Ministry of Health, Malawi. Malawi Population-based HIV Impact Assessment, *Op. cit.*
[91] Ministry of Health. Integrated HIV Programme Report, July-September 2017
[92] Ministry of Health. Integrated HIV Programme Reports, January-December 2017

Structural	• Same day HIV "tests and treat" policy results in early ART loss-to-follow up for some women who are not psychologically prepared to be on lifelong ART[93].

Emerging Opportunities, Promising Developments and Innovations for MTCT programs

The following developments have occurred during the first half of the implementation period of the 2015-2020 HIV Prevention Strategy, which may facilitate the design and implementation

of new interventions in the final half of the implementation period:

- The MoH adopted the 'Test and Treat" approach in non-pregnant individuals which has normalized the approach of prescribing ART to otherwise healthy PLHIV.
- Health Advisory Committees (HACs), comprising local community representatives, have begun to support health facility staff in tracking of PMTCT indicator results in the community.
- Studies have shown the effectiveness of "expert clients" and "mentor mothers"[94] in providing psychosocial support and helping in default tracing.[95]
- A self-administered injectable hormonal contraceptive (Sayana Press) has been shown to be highly acceptable among women and self-providers[96] and to have lower discontinuation rates than provider-administered injectable contraceptive.[97] This approach may further prevent unwanted pregnancies among HIV-positive women.
- Pilot studies have shown the feasibility of implementing point-of care diagnostic tests for infants.[98]
- The newly enacted HIV Prevention and Management Act prohibits discrimination and false claims of HIV cure and permits Voluntary Assisted Partner Notification (VAPN). This may promote provision of stigma-free health services for PLHIV including

[93] Chan AK, Kanike E, Bedell R, et al. Same day HIV diagnosis and antiretroviral therapy initiation affects retention in Option B+ prevention of mother-to-child transmission services at antenatal care in Zomba District, Malawi. *J Int AIDS Soc.* 2016;19(1):20672.

[94] HIV positive women volunteers who openly disclose their status and commit to support other women to cope with HIV infection and remain treatment compliant

[95] Rosenberg NE, van Lettow M, Tweya H, Kapito-Tembo A, Bourdon CM, Cataldo F, Chiwaula L, Sampathkumar V, Trapence C, Kayoyo V, Kasende F, Kaunda B, Speight C, Schouten E, Eliya M, Hosseinipour M, Phiri S; PURE Malawi Consortium. Improving PMTCT uptake and retention services through novel approaches in peer-based family-supported care in the clinic and community: a 3-arm cluster randomized trial (PURE Malawi). J Acquir Immune Defic Syndr. 2014 Nov 1;67 Suppl 2: S114-9. doi: 10.1097/QAI.0000000000000319. PubMed PMID: 25310116; PubMed Central PMCID: PMC4197136.

[96] Burke HM, Packer C, Buluzi M, Healy E, Ngwira B. Client and provider experiences with self-administration of subcutaneous depot medroxyprogesterone acetate (DMPA-SC) in Malawi. *Contraception.* 2018.

[97] Burke HM, Chen M, Buluzi M, et al. Effect of self-administration versus provider-administered injection of subcutaneous depot medroxyprogesterone acetate on continuation rates in Malawi: a randomised controlled trial. *Lancet Glob Health.* 2018;6(5):e568-e578.

[98] MOH, UNITAID, UNICEF, CHAI. Malawi POCT EID Implementation Pilot Report September 2015 to June 2016. February 2017

pregnant women and improve retention in care for HIV-positive mother-infant pairs who are influenced to disengage from care by false claims of cure by religious and traditional healers.

- A randomized clinical trial in Malawi found that VAPN was a feasible and effective method for reaching male partners of HIV+ pregnant and postpartum women.[99] Another study found that HIV self-tests delivered by pregnant women to spouses enhance HIV testing coverage in men.[100] Implementation of these interventions could facilitate couple HIV testing and counseling (cHTC).

EMTCT program targets

In view of the challenges associated with the delivery of EMTCT, this strategy has set out to achieve the following targets by the end of 2020:

- Reduce the estimated number of new infections among children less than 15 years old from 4,300 in 2016 to less than 1,000 in 2020.
- Maintain ART coverage of at least 95% among HIV-positive pregnant and postpartum women.
- Reduce unmet need for family planning among HIV+ postpartum women to less than 10%.
- Achieve the 90-90-90 targets among infants born to HIV positive women.
- Achieve HIV screening coverage of at least 80% among spouses/partners of pregnant or postpartum women

EMTCT program objectives

This Revised HIV Prevention Strategy recognizes the need to achieve virtual elimination of HIV among infants and make HIV+ women an entry point for HIV care for other family members. Thus, to achieve the above-mentioned targets, the GoM has set out the following objectives:

1. **Increase the availability and quality of HIV testing and treatment services for women and HIV-exposed infants that are integrated with SRH and MNCH service delivery points.** This entails implementation of the following activities:
    a. Promote adherence to current HTS and ART guidelines that have been successful in achieving 95% coverage of HTS and ART initiation among pregnant and postpartum women.

[99] Rosenberg NE, Mtande TK, Saidi F, et al. Recruiting male partners for couple HIV testing and counselling in Malawi's option B+ programme: an unblinded randomised controlled trial. *Lancet HIV.* 2015;2(11):e483-491.
[100] Choko AT, Kumwenda MK, Johnson CC, et al. Acceptability of woman-delivered HIV self-testing to the male partner, and additional interventions: a qualitative study of antenatal care participants in Malawi. *J Int AIDS Soc.* 2017;20(1):21610.

b. Strengthen the functioning of HIV Care Clinics[101] and integration of PMTCT and other programs particularly SRH and EPI, by orienting and mentoring health service providers in EMTCT protocols.

c. Promote HIV screening of HIV-exposed infants and linkage to ART by decentralizing infant HIV testing to primary health care facilities, in high HIV burden areas.

d. Engage expert clients in service provision at health facility level to support HIV+ pregnant and postpartum women, particularly in counseling those who are newly diagnosed with HIV or experiencing challenges with adherence.

e. Expand mobile integrated MNCH clinics to hard-to-reach areas.

f. Strengthen referral system for pregnant and postpartum women newly-diagnosed with HIV.

g. Strengthen supply chain management for HIV commodities.

2. **Expand HIV outreach services for families of pregnant and postpartum women.** This entails implementation of the following activities:

   a. Promote HIV counseling for HIV-negative pregnant and postpartum women to increase awareness of their risk, encourage their partners undergo HIV testing, and discuss methods of prevention.

   b. Expand the implementation of protocols for partner notification for both HIV-positive and HIV-negative pregnant and postpartum women through the use of family referral slips or VAPN.

   c. Assess the feasibility of implementing an approach of reaching spouses of both HIV-positive and HIV-negative women with HIV self-testing, delivered through pregnant and postpartum women.

   d. Scale up the use of mentor mothers to support HIV positive pregnant or postpartum women and their families, at community level, in ART adherence, retention in HIV care and managing stigma, discrimination and GBV.

3. **Strengthen social and behavioral change communication for sexual and reproductive health, including HIV prevention and management services.** This entails implementation of the following activities:

   a. Target men, adolescents and youth with EMTCT IEC messages, including anti-discriminatory provisions of the HIV Prevention and Management Act.

[101] Ministry of Health clinics that integrate clinical monitoring and provision of preventive and treatment services for family members affected by HIV, especially HIV-positive mothers and their children.

b. Engage with and sensitize community and religious leaders on the relevant provisions of the HIV Prevention and Management Act and to promote partner testing of pregnant women.

c. Utilize CSOs, HACs and local women groups for advocacy on EMTCT and other HIV services at community level.

4. **Strengthen management of EMTCT programs at health facility level.** This entails implementation of the following activities:

   a. Capacitate HMIS units at district level to analyze data for local decision-making.

   b. Build capacity of health workers to review EMTCT reports for decision making at health facility level.

   c. Engage HACs in the regular review of the performance of EMTCT programs.

5.6 Initiate and scale-up implementation of Pre-Exposure Prophylaxis

Background

Although Malawi has a generalized HIV epidemic, several groups are disproportionately affected by HIV. These include AGYW, HIV sero-discordant couples, FSW and MSM. Some members of these subgroups experience challenges in engaging their sexual partners to use proven HIV prevention interventions, such as voluntary medical male circumcision (VMMC), male or female condoms, or in getting their partners to access HIV testing to know their status. Since 2015[102], WHO recommends Pre-exposure prophylaxis (PrEP) as part of combination HIV prevention strategy. PrEP refers to the provision of a daily fixed-dose combination tablet of ARVs to HIV negative persons who are at substantial risk of HIV infection. In Malawi, the approved combination is of tenofovir and lamivudine (TDF/3TC). Aligned with WHO's recommendation, the Malawi 2018 HIV Treatment Guidelines recommended the use of PrEP as part of HIV prevention services within the public health system of Malawi for individuals at substantial risk of HIV infection.

Research Evidence for PrEP

Evidence from randomized control trials indicate that the use of oral PrEP (TDF plus 3TC/FTC) has protective efficacy against HIV among HIV sero-discordant couples ranging from 62%-75%.[103, 104] Based on this evidence, in July 2012, the WHO recommended the use of PrEP with TDF plus FTC in HIV sero-discordant couples, as a method of HIV prevention.[105] The recommendation highlighted that this intervention would be cost-effective for groups with annual HIV incidence exceeding 3%.[106] However, the protective efficacy of oral PrEP in the RCTs was highly dependent on adherence to the drug regimen. Also, a recommended PrEP formulation, FTC/TDF (Truvada), was associated with a low incidence of reversible kidney impairment and loss of bone mineral density. Hence, people using this drug will require monitoring using clinical and laboratory methods.

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[102] World Health Organization. WHO expands recommendation on oral pre-exposure prophylaxis of HIV infection (PrEP). Policy brief. 26 November 2015. Available on website: https://www.who.int/hiv/pub/prep/en/. Accessed on 28th February 2018

[103] Baeten JM, Donnell D, Ndase P, et al. Antiretroviral prophylaxis for HIV prevention in heterosexual men and women. *N Engl J Med.* 2012;367(5):399-410.

[104] Thigpen MC, Kebaabetswe PM, Paxton LA, et al. Antiretroviral preexposure prophylaxis for heterosexual HIV transmission in Botswana. *N Engl J Med.* 2012;367(5):423-434.

[105] World Health Organization. Guidance on oral pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV: recommendations for use in the context of demonstration projects. July 2012. Available on website: http://apps.who.int/iris/bitstream/handle/10665/75188/9789241503884_eng.pdf;jsessionid= 72B861DB39EE842F76474CFC8A83E140?sequence= 1 accesssed on 19th June 2018.

[106] World Health Orgaization. Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. September 2015. Available on website: http://apps.who.int/iris/bitstream/handle/10665/186275/9789241509565_eng.pdf?sequence= 1 accessed on 19th June 2018

Roadmap for PrEP implementation in Malawi

Based on evidence from clinical trials in other countries, the Pharmacy Medicines and Poisons Board (the pharmaceutical regulatory authority in Malawi) approved various PrEP formulations for local use. The GoM, through the National Health Sciences Research Committee, has approved several demonstration and implementation science projects to address relevant implementation questions. Following the endorsement of PrEP as a public health intervention in Malawi, the tools currently in use in existing demonstration projects under implementing partners shall be modified into national tools.

Target populations

Considering the high HIV prevalence in Malawi and the high incidence in specific sub-populations, PrEP could be a powerful tool for reducing HIV incidence in Malawi. The following sub-populations will be targeted:

1. Female sex workers (FSW)
2. High risk adolescent girls and young women (AGYW)
3. Sexual partners of HIV-positive persons
4. Men who have sex with men (MSM)
5. Discordent couples

Objectives

1. Define service delivery approaches and models, and capacity-building plan for service providers
2. Develop a strong monitoring and evaluation (M&E) plan for PrEP rollout, including reporting requirements, data collection tools and reporting mechanisms
3. Develop a communications and advocacy plan to increase stakeholder awareness and knowledge of PrEP
4. Identify innovative strategies of mobilising additional resources for scale up of Oral PrEP
5. Define PrEP commodities supply chain to align with existing national ARV commodities quantification, procurement and distribution system

Core package for PrEP

- Risk screening and eligibility assessments
- Risk reduction counselling
- Client education and evaluation of readiness to take PrEP
- HIV testing and STI screening
- Hepatitis B screening and assessments of renal function (creatinine clearance)
- Prescription and dispensing of tenofovir/lamivudine tablets and management of side effects
- Provision of condoms and other prevention interventions

- Linkage from HTS and STI screening to oral PrEP screening
- Client-centered and non-judgmental adherence monitoring and retention strategies

Where can PrEP be provided

Two approaches are recommended:

- Integration into routine HIV service delivery points within the health facility, including the designation of a space and time schedule for confidentiality
- Integrated with district outreach services and stationary outlets

Who can provide PrEP

- Certified ART providers will prescribe PrEP
- Lay cadres will provide psychosocial support

Operational Requirements

- Include PrEP supplies into existing HIV commodity supply system
- Create space within integrated service delivery points such as HIV testing, STI and Family Planning services
- Additional health workers to cover the increasing range of HIV services
- Transport and communication support for DHOs
- Monitoring and evaluation tools and provision of regular supportive site supervision

Strategic information

- Routine monitoring indicators will include number of persons eligible, offered, enrolled and retained on PrEP (by risk group and delivery mode), as well as follow-up HIV test results and adverse drug reactions

5.7. Increased use of antiretroviral drugs among HIV sero-discordant couples

Background

The MDHS 2015/16 estimated that 66% of females and 57% of males aged 15-49 years were married or cohabiting[107] and 13% of married females were in a polygamous relationship. Many married people have their first sexual encounter before marriage;[108] some have extramarital sexual relationships or casual sex during marriage. For example, in the 2015/16 MDHS, 13% and 1% of males and females, respectively, reported having two or more partners within 12 months before the survey and 27% and 10%, respectively, reported having sex in the past 12 months with a person who was not their regular sexual partner. The prevalence of these potentially risky sexual behaviors has not changed markedly from 2000 to 2016. Extramarital relationships, early sexual debut[109] and polygamy[110] are all risk factors for HIV infection and likely contribute to high prevalence of HIV sero-discordancy in Malawi.

HIV burden among married/cohabiting couples

- In the 2015-16 MDHS, 14% of couples were affected by HIV, including couples in whom both partners were HIV positive (5.6%), those in whom the man was HIV-positive and the woman was HIV-negative (4.5%), and the woman was HIV positive and the man was HIV negative (3.9%). The proportion of HIV sero-discordant couples was higher in the Southern than in the Central and Northern regions.
- Several factors contribute to the risk of HIV transmission within an HIV discordant relationship. These include frequency of sex, which may be higher in couples who are in a stable, cohabiting relationship than in single persons. Additionally, high viral load in the HIV-infected partner significantly increases risk of transmission, most notably during early acute infection and untreated, late-stage, disease progression. The presence of ulcerative STIs is another factor that increases risk of both HIV transmission and acquisition.
- The population impact of discordancy on new infections could be substantial, given that discordant couples represent roughly 8% of all married/cohabiting couples in Malawi.

[107] NSO, MDHS 2015-16, *Op. cit.*
[108] In the 2015-16 MDHS, The median age at first sexual intercourse is 1.4 years earlier than the median age at first marriage for women and 4.5 years earlier for men; this indicates that both women and men engage in sex before marriage.
[109] In the 2015-16 MPHIA, Women who reported first sexual intercourse before the age of 16 had higher HIV prevalence than women who had first sex at an older age. HIV prevalence among women who had sexual intercourse before age 16 was 13.9% compared with 10.4% of women who first had sexual intercourse at age16 or 17.
[110] In the 2015-16 MPHIA, HIV prevalence among women and men is higher in those who reported being in a polygynous union than those who are not in a polygynous union and those who are not currently in union (14.3% versus 9.3% and 7.1%, respectively).

Challenges in access to preventive HIV interventions among couples

- Adoption of primary HIV prevention methods is low among couples; condoms are hardly used in marriages and the majority of males in Malawi are uncircumcised.
- The probability of being HIV-positive in HIV discordant couples is slightly higher for males than females. However, women are more likely than men to know about their HIV status due to their better access to HIV screening services through MNCH and SRH clinics. Additionally, HIV-positive women are more likely to be on ART and to be virally suppressed, mitigating the risk to HIV-negative male partners. Given low rates of testing, ART uptake and viral suppression among HIV-positive men, HIV-negative female partners in discordant relationships are likely to be at high risk of HIV infection.
- Moreover, awareness and risk perception relating to discordancy is low. Men especially often use their female partner/spouse's HIV-status as a proxy for their own. Many HIV-positive men and women also do not disclose their status to their spouse/partner for fear of stigma and discrimination. Women especially may be less likely to disclose their status for fear of divorce/abandonment, or spousal mistreatment/abuse.
- There are missed opportunities for identifying HIV discordant couples in PMTCT and ANC clinics, HTS sites and HIV Care clinics due to low utilization of the Family Referral Slips (FRS) and HIV Index case testing.

Factors associated with risk of HIV among married and cohabiting couples

As shown in Table 11, below, gender inequality and cultural norms underpin most of the risk factors that promote HIV transmission among couples. On the other hand, sub-optimal access to HTS and ART by men is mostly due to provision of health services that do not meet their expectations and fear of stigma and discrimination.

Table 11: Key factors associated with HIV transmission among couples

Social Ecological Model Level	Factors
Personal	• Low self-efficacy to adopt HIV preventive measures among women due to low levels of education and economic dependence on men. • Low levels of comprehensive knowledge of HIV and of risk perception. • Alcohol use, mostly among men, contributing to unprotected sex. • Poor male health seeking behavior due to norms relating to masculine invincibility.
Close social circles (family/peers)	• Peer pressure on men to have multiple sexual partners and/or have sex without a condom. • Sexual dissatisfaction contributing to extramarital relationships with non-regular partners. • Poor spousal communication on sexual matters. • Low rates of disclosure of HIV status and notification of partners due to fear of domestic violence/abandonment. • Poor adoption of HIV preventive interventions (condoms and VMMC) among married and cohabiting couples.
Societal	• Cultural norms tolerating male infidelity. • Cultural norms that reinforce gender inequality and submissiveness of women.

	• Harmful cultural practices (e.g. sexual cleansing of women). • Gender inequality and gender norms that put women at risk, and that impact service utilization.
Institutional	• Poor access to HIV services for men who appear healthy, and lack of male-friendly health services • Low rates of index testing and partner notification. • Poor implementation of couple HIV Testing and Counseling (cHTC) in health facilities. • Poor linkage to VMMC services for sexually-active HIV-negative males.
Structural	• Separation of partners due to job mobility. • High unemployment among women contributing to their vulnerability to transactional sex. • Stigma and discrimination which inhibits men and women from disclosing their status to partners

Promising developments and innovations

The following developments occurred during the first half of the implementation period of the 2015-2020 HIV Prevention Strategy that may facilitate the design and implementation of new interventions in the second half of the implementation period:

- Research studies on novel methods for and approaches to increasing HIV testing have generated the following findings, that offer opportunities for enhancing HIV prevention in HIV sero-discordant couples:
    - The use of a combination of two Non-Nucleoside Reverse Transcriptase Inhibitors and dolutegravir (DTG, integrase strand transfer inhibitor) among PLHIV has been shown to be potent and highly effective at suppressing HIV viral load.[111] The WHO has recommended this regimen.[112]
    - HIV self-testing is accurate, feasible and acceptable to men.[113]
    - Using women-delivered HIV self-testing to male partners is feasible and acceptable.[114] This finding suggests that HIV screening among pregnant women may be an entry point for male partner HTC.
    - HIV index case testing was successful in facilitating identification and linkage to care of HIV-positive children and young people.[115]
    - The use of invitation cards with active contact tracing in PMTCT clinics facilitated cHTC.[116]

[111] Kanters S, Vitoria M, Doherty M, et al. Comparative efficacy and safety of first-line antiretroviral therapy for the treatment of HIV infection: a systematic review and network meta-analysis. *Lancet HIV.* 2016;3(11):e510-e520.
[112] Transition to new antiretroviral drugs in HIV programmes: clinical and programmatic considerations. Geneva: World Health Organization; 2017 (WHO/HIV/2017.23). Licence: CC BY- NC-SA 3.0 IGO. Available on website: http://apps.who.int/iris/bitstream/handle/10665/255887/WHO-HIV-2017.23-eng.pdf?sequence= 1 accessed on 19th July 2018.
[113] Indravudh PP, Choko AT, Corbett EL. Scaling up HIV self-testing in sub-Saharan Africa: a review of technology, policy and evidence. *Curr Opin Infect Dis.* 2018;31(1):14-24.
[114] Choko AT, Kumwenda MK, Johnson CC, et al. Acceptability of woman-delivered HIV self-testing to the male partner, and additional interventions: a qualitative study of antenatal care participants in Malawi. *J Int AIDS Soc.* 2017;20(1):21610.
[115] Saeed Ahmed Rachael A. Sabelli, Katie Simon, Nora E. Rosenberg, Elijah Kavuta, Mwelura Harawa, Spencer Dick, Frank Linzie, Peter N. Kazembe and Maria H. Kim. Index case finding facilitates identification and linkage to care of children and young persons living with HIV/AIDS in Malawi. Tropical Medicine and International Health doi:10.1111/tmi.12900
[116] Rosenberg NE, Mtande TK, Saidi F, et al. Recruiting male partners for couple HIV testing and counselling in Malawi's option B+ programme: an unblinded randomised controlled trial. *Lancet HIV.* 2015;2(11):e483-491.

- There are promising models of male-friendly HIV services including extended HTS opening hours; Wellness mobile clinics that provide integrated HIV and non-communicable disease prevention and treatment services and HIV testing at social and recreational hotspots.
- Improvements in the legal environment have the potential to encourage partner notification and reduce the potential for violence against women related to disclosure of HIV status within families. For example, the HIV Prevention and Management Act allows for VAPN, in line with WHO's recommendation.[117] In addition, increased awareness of the Prevention of Domestic Violence Act may potentially discourage GBV against women who disclose their HIV status to their husbands.

Program targets

In view of the high HIV prevalence of HIV sero-discordant couples and the risk of HIV sexual transmission within these couples, this strategy has set out to achieve the following targets by the end of 2020:

- Reach 90-90-90 targets among HIV sero-discordant couples (i.e. identifying HIV-positive partners, enroll them on DTG-based ART regimen, and achieve viral suppression).
- Achieve condom coverage of at least 85% in HIV sero-discordant couples, especially during the first 6 months of ART initiation of the infected partner (before confirmation of HIV viral suppression).
- Achieve PrEP coverage of 85% in HIV-uninfected partners of high risk married and co-habiting couples, based on the feasibility and cost-effectiveness of PrEP *(refer to section 5.6).*
- Reach 60% VMMC coverage among HIV-negative married or cohabiting men in high burden districts, especially those men in known discordant relationships (*refer to Section 5.2 for details*).

Program objectives

This Revised HIV Prevention strategy recognizes the need to identify HIV discordant couples and reach them with evidence-based HIV prevention and treatment interventions. Thus, to achieve the above-mentioned targets, the GoM has set out the following objectives:

[117] World Heaalth Organization. Guidelines on HIV self-testing and partner notification: supplement to consolidated guidelines on HIV testing services. Available on website: http://apps.who.int/iris/bitstream/handle/10665/251655/9789241549868-eng.pdf?sequence= 1 accessed on 19th June 2018

1. **Expand access to HTC, ART and other SRH services to couples, particularly for men.** Key activities to fulfill this objective include:

   a) Promote the use of FRS, invitation cards and VAPN among people attending HTS and PMTCT clinics, as a means of identifying HIV-discordant couples.

   b) Intensify opt-out HTC and partner notification in all clinics, particularly STI clinics.

   c) Strengthen the efficiency of referral/integration across SRH, MNCH and HIV service delivery points to facilitate HTC and ART initiation on DTG-based regimens.

   d) Promote programs that strengthen ART referral and adherence, especially for married or cohabiting HIV positive males.

   e) Provide primary HIV prevention interventions to men such VMMC (*refer to the "VMMC" section of this strategy*).

   f) Explore the establishment of male-friendly health services in high burden districts, such as extended or weekend HTC clinic hours, workplace HTC, social hotspot testing and Integrated Wellness clinics.

2. **Intensify Social and Behavioral Change Communication for PLHIV, community leaders, married or cohabiting couples regarding HIV sero-discordancy, safer sexual practices and HIV services-seeking behavior.** Key activities to fulfill this objective include:

   - Sensitize the general public, including religious and traditional marriage counselors, about the existence and magnitude of HIV sero-discordancy and the dangers of using HIV status of a sexual partner as a proxy for one's own HIV status.
   - Sensitize the general public about the effectiveness of ART adherence and HIV viral suppression in reducing HIV transmission.
   - Engage with religious and traditional marriage counselors to sensitize married or co-habiting partners on the importance of HIV-testing, ART adherence and fidelity among married or cohabiting couples.
   - Using evidence-based SBCC approaches, engage male role models/champions and women's groups as change agents for promoting HTC among males.
   - Sensitize community leaders and members on the elements of the HIV Prevention and Management Act and Prevention or Domestic Violence Act that prohibit harmful cultural practices, stigma and discrimination and GBV.
   - Strengthen delivery of "Positive Health and Dignity and Prevention" services at facility and community HIV service delivery points to promote complete adoption of HIV transmission reduction interventions by PLHIV.

- Engage CSOs to implement stigma reduction interventions in the community.

3. **Evaluate the feasibility of implementing novel HIV testing and prevention approaches that target high-risk couples.** Key interventions to fulfill this objective include:
    - Conduct and facilitate demonstration projects on VAPN.
    - Conduct and facilitate studies on the efficacy and feasibility of the use of PrEP among high-risk sero-discordant couples (*refer to the PrEP section [5.6] of this strategy*).
4. **Establish a harmonized framework for effective control and management of HIV among sero-discordant couples.** Key interventions to fulfill this objective include:
    - Review and revise the HTC policy to incorporate relevant elements of the HIV Prevention and Management Act, such as VAPN, which may facilitate the identification of discordant couples.
    - Review and revise the HIV Treatment Guidelines to incorporate findings from PrEP demonstration projects relevant to HIV discordant couples.
    - Establish efficient and effective reporting systems for cases of human rights violations, such as stigma and discrimination and post HIV-disclosure GBV.

8. SOCIAL BEHAVIOR CHANGE COMMUNICATION STRATEGY

Introduction

Modifying HIV-related knowledge, perceptions, attitudes, social norms and practices are key in promoting safer sexual behaviors and utilization of effective HIV prevention services. Current strategies and implementation experiences in HIV prevention in Malawi reveal gaps in strategic guidance, as well as the quality, comprehensiveness and relevance of existing SBCC interventions. This revised strategy adopts the social-ecological framework to identify factors that drive social and behavior change at individual, family, community, social and structural levels. To address these factors, the strategy promotes the design and implementation of multi-level and multi-dimensional communication interventions necessary to influence normative social and individual behavior change. Such communication should be guided by relevant theories of behavior change, including cutting-edge approaches from emerging fields such as behavioral economics and habit formation theory, with the aim of modeling positive behaviors in order to reduce new HIV infections.

Intended strategic outcomes for Social and Behaviour Change Communication (SBCC) interventions

This strategy presents broad guidance for accelerating SBCC efforts intending to achieve the following strategic outcomes:

1. Increased demand and uptake of priority HIV prevention services and care services, (including condoms, STI treatment, VMMC, HTC, PMCT, PrEP and ART) at all levels.
2. Increased adoption of safer sexual behaviors and reduction in risky sexual behaviors.
3. Improved structural environment that mitigates drivers of HIV infections and barriers to utilization of HIV Prevention Services.

Details of the specific interventions to achieve these outcomes are provided in sections 5.1 to 5.7 under the HIV prevention thematic areas. Nevertheless, the key interventions for each of the above-cited outcomes are summarized, as follows:

1. Outcome number 1: Increased demand and uptake of priority HIV prevention and care services (including condoms, STI treatment, VMMC, HTC, PTMCT, PrEP and ART) at all levels.

Background

Survey and program data indicate that low demand for the interventions is one of the major factors for poor coverage of various HIV prevention and care services. This problem is well documented for condom use among females and FSWs, VMMC

uptake among older males (15-34 years) and non-circumcising tribes and religions and HTC uptake among men. SBCC interventions need to be carefully designed to take into account the characteristics and behaviors of the target audience. The interventions should also provide information on where, when and how to access evidence-based HIV services. There are several national and/or regional evidence-based SBCC approaches, tools that need to be reviewed and standardized for expansion. These include curricula designed for schools, AGYW clubs, parenting, GBV prevention, couples counseling and gender transformation. Nationally, the "Girl Effect" mass media program has been effective in reaching girls, boys, and communities through transformative norms and has great opportunity to leverage community youth networks to expand reach and amplify voice.

This SBCC component of the Revised HIV Prevention Strategy aims to provide information, empower and mobilize individuals and communities to promote health seeking behaviors and increase demand for and uptake of health services, while addressing underlying drivers of HIV infection.

Key interventions

- Review and adapt regional and national SBCC messages, materials and approaches so that they are relevant to different priority sub-populations, cultural background and age-groups.
- Conduct on-going national, district and community level dialogue on barriers to health seeking behavior for HIV preventive and treatment services to inform the development or revision of health promotion messages and materials, service delivery approaches, behavior change interventions for targeted groups and new ways of reaching/promoting and delivering services.
- Considering the importance of ART as an effective prevention strategy, sensitize the general public and community leaders about the role of HIV sero-discordancy in HIV transmission among couples and the importance of active case finding, early ART initiation and adherence and HIV viral suppression in preventing HIV transmission.
- Conduct targeted demand creation SBCC strategies for the general population and specific groups using a mix of effective and evidence-based channels, which may include mass media, interpersonal communication (IPC), and community mobilization and dialogue. However, IPC and community dialogue will be priority approaches complemented by mass media and other techniques.
- Explore, develop and expand the use of mobile and on-line based communication approaches targeting men, couples and KP to promote utilization of HIV prevention and treatment services, particularly among sub-populations with poor access to HIV services.

- Mobilize and orient peer support groups and voluntary agents within existing community structures (such as faith groups, mother groups, local market committees, bicycle taxi operators, community football clubs) who will conduct individual and group sessions to mobilize and refer potential clients to HIV prevention and treatment services.
- Engage youth clubs and men's organizations to conduct community mobilization and sensitization activities to promote health-seeking behaviors among sexually-active males.
- Strengthen the delivery of quality HIV services through the provision of training, mentorship, and job aids to service providers in interpersonal communication skills and client friendly attitudes.
- Establish SBCC coordination structures at national and district level and support their operations to ensure harmonization of SBCC efforts by stakeholders.
- Develop and disseminate guidelines for vetting priority SBCC strategies, content, messages and materials to strengthen stakeholder collaboration in planning and implementing SBCC activities.
- With the guidance of the NAC, standardize and customize approaches and content of materials for demand creation.

2. Outcome number 2: Increased adoption of safer sexual behaviors and reduction in risk taking behaviors.

Background

It is widely recognized that negative socio-cultural norms underpin high-risk sexual behaviors such as multiple and concurrent partnerships, transactional and age-disparate sex, GBV and stigma. Hence, modifying these behaviors will require robust evidence-based SBCC interventions that directly seek to change these negative norms. Involvement of communities in the design and implementation of interventions is key to ensure relevance and effectiveness of SBCC interventions and approaches. This revised strategy proposes several key SBCC interventions and approaches to promote safer sexual behavior.

Key interventions

- Review, develop and disseminate SBCC targeted messages and materials to model positive lifestyle change and to address multiple and concurrent partnerships, intergenerational sex and low condom use among men and women.
- Expand and intensify existing life skills modules and SRH and HIV education for in-school and out-of-school youth, with a focus on delaying sexual activity and avoiding transactional and age-disparate sex.

- Explore, develop and scale-up the use of mobile, on-line and new media communication approaches to reach and engage men, couples and KP with interactive SBCC content, to help them personalize risk perception and promote behavior change.
- Reach and engage men and boys with interactive sessions, through existing social structures and networks (such as social clubs, market committees, sports, faith groups, schools), which challenge masculinity social norms, risky sexual behaviors and GBV.
- Convene and facilitate community level dialogue on sexual behaviors, GBV, stigma and discrimination, and harmful cultural practices through existing community structures and networks.
- Establish partnerships with private sector institutions to integrate targeted messages to promote safer sexual behavior into ongoing communication to their workforce.
- Strengthen policy guidance, quality assurance and capacity to design, implement and monitor effective behavior change communications through existing coordination mechanisms.
- Develop and disseminate guidelines for community dialogue on sexual behaviors and socio-cultural norms that are easily understood and can be used by community volunteers.
- Revitalize a knowledge and information system that documents and provide easy access to lessons and best practices in SBCC for HIV prevention.

3. Outcome number 3: Improved structural environment that mitigates drivers of HIV infections and barriers to utilization of HIV prevention services

Background

Unfavorable legal and policy frameworks, human rights violations, harmful cultural practices, stigma and discrimination are some of the key structural factors that increase the risk and vulnerability to HIV infection among priority populations for HIV prevention in Malawi. To mitigate these factors, this revised strategy underscores the need for advocacy to: create a conducive legislative and policy environment; revitalize political leadership for HIV prevention at all levels; reduce stigma and discrimination; and enhance engagement with community and religious leaders to address harmful socio-cultural and gender norms, beliefs and practices.

Key interventions

- Recruit and engage leaders as champions/role models and ambassadors of HIV prevention at all levels – from the presidency, parliament, and local government to religious and traditional leaders.

- Conduct transformational dialogue sessions with political leaders, civil society and law enforcement to address the legal environment and challenges that could potentially hinder HIV prevention efforts.
- Mobilize and build capacity of existing structures and networks to address harmful socio-cultural and gender norms and support protection of human rights, including access to justice, for girls, women, PLHIV and key populations.
- Develop advocacy frameworks and tools and build capacity of CSOs, CBOs and other community groups to conduct effective advocacy work for HIV prevention.
- Advocate for effective implementation of policies, and for the enforcement and monitoring of laws and policies that address HIV prevention, GBV, discrimination and related issues.

9. SYSTEMS STRENGTHENING

Successful implementation of the Revised HIV Prevention Strategy will to a large extent depend on strong and functional public systems. Strengthening the health sector role in prevention is necessary for implementing biomedical interventions, but is not sufficient to deliver all the components of this revised strategy. The success of this strategy will depend to a large extent on investments in capacitating other sectors, such as education, gender and social welfare, youth development, internal security and the justice system, to enable them mount effective HIV prevention interventions. Fortunately, GoM and developing partners have made significant commitments to strengthen the social sectors. For example, key investments have been made in the education sector, through construction of secondary school girls' hostels as part of the 'Keep Girls in School" campaign and construction of community colleges as part of the youth skills development program. However, additional investments will be required in the following sectors to achieve the following outcomes:

- *Education:* reduce school drop-outs and improve the quality of life skills education (LSE) and comprehensive sexuality education (CSE).
- *Internal security:* support the establishment and operations of additional victim-support units and improve the speed and quality of investigation of human rights violation cases.
- *Gender, Children and Social Welfare:* increase the number of Community Development Assistants and Child Protection Workers and support their operations, and strengthen the referral system for OVC and women requiring supportive social services.
- *Justice:* improve access to justice for victims of human rights violations.
- *Civil Society:* build technical skills for evidence-informed advocacy and provide supervision and mentorship to CBOs and youth clubs.
- *Youth Development:* provide vocational skills and job opportunities to the youth.

9.4.1 Health Systems Strengthening

Health system strengthening requires investments in the six building blocks articulated by the WHO, namely: service delivery; human resources; strategic information; products, commodities and technology; finance; and leadership and governance. A functional system helps to scale up services, enhance the harmonisation and alignment of interventions, and improves synergy, integration and implementation intensity. The process results in improved availability of, access to and utilisation of services. 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.

GoM's capacity strengthening efforts in the health sector are articulated in the Health Sector Strategic Plan II (2017-2022) and the National Community Health Strategy (2017-2022), which outline key interventions in the health sector to strengthen all six building blocks. Several development partners complement GoM's efforts in capacity strengthening. These include PEPFAR, GFATM, the UK Department for International Development (DfID) and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) which support a large proportion of the "products, commodities and technology" building block, but also a significant proportion of the "human resources", "service delivery" and "strategic information" building blocks. PEPFAR's capacity strengthening investments are detailed in the Country Operating Plan (2018), while GFATM investments are detailed in the Concept Note 2018-2020.

Given the importance of human resources in the health sector and HIV and AIDS service delivery, the GoM and development partners will support the engagement and operations of community volunteers, including expert clients, peer educators and peer navigators, to enable delivery of personalized HIV preventive interventions to community members. It will also support the orientation and re-training of existing health care providers to deliver quality SRH and HIV services at service delivery points and strengthen supervision and mentorship to all community health volunteers. Curricula for pre-service training shall be revised to include contemporary issues on HIV prevention service delivery, including VMMC, provision of services responsive to KPs and other at-risk populations.

In the past, unpredictable availability of key health commodities, such as condoms and VMMC equipment and supplies, has adversely affected delivery of HIV preventive services. To minimize stock-outs and wastage of important medicines and other commodities, the GoM will strengthen the public procurement and supply chain management systems for all HIV prevention commodities, particularly condoms, VMMC devices and ARVs. In addition, the GoM will support a parallel NGO-led supply chain system as a back-up to the public system in order to ensure continuous availability of the commodities in the community and at service delivery points.

9.4.2 Community systems strengthening

Since the focus of primary HIV prevention and SBCC interventions is at community level, there is need to strengthen the community system's six blocks that include: enabling environment; community networks and partnerships; resources and capacity development; community activities; organizational and leadership development, and M&E.[118] Collectively, these building blocks contribute to improved health and social outcomes and improved efficiency and effectiveness in service delivery and utilization of financial and human resources.

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

In the Revised HIV Prevention Strategy, community systems will endeavour to achieve three main strategic objectives:

1. Hold national, district and community leaders, program managers and service providers accountable and make them responsive to the human rights and gender-related needs of different high-risk groups.
2. Strengthen the engagement and/or involvement of key and vulnerable populations, networks and CBOs in HIV-related services to ensure effective implementation of HIV-related and SBCC interventions.
3. Establish and implement mechanisms for community-based monitoring of HIV-related services.

Key outcomes of the community systems strengthening interventions will include the following:

- Increased adoption of HIV and SBCC interventions by the community and its leaders.
- Expanded availability and quality of community-based and community-led HIV-prevention programs through social contracting mechanism for civil society implementers.
- Increased availability of functional HIV-related community networks and partnerships on which strong linkages to service delivery point in the social sector, including health; education; youth, gender and children; judiciary and internal security.
- Increased participation of community representatives in relevant decision-making structures at district level.
- Greater accountability and reporting of outcomes on HIV-related programs at community and district levels.
- Improved effectiveness of CSO evidence-based advocacy for HIV Prevention to achieve increased financing.
- Reduced levels of all forms of human rights violations against AGYW, KP and PLHIV, through advocacy activities led by community or religious leaders.
- Availability of a robust community-based monitoring and reporting system for human rights violations including early marriages, GBV or gaps in service delivery.

To achieve these outcomes, various community-based structures (such as CBO, youth clubs, women groups, Parent-Teacher Associations, Village Savings and Loans groups), actors (such as traditional and religious leaders) and representatives of key affected populations will be at the center of designing, delivering, monitoring and evaluating services and programs related to SRH, in a manner that embraces the principles of equity

and human rights. To ensure effectiveness and efficiency of these community players, investments will be made in building and strengthening their knowledge and skills in several domains, such as leadership and management, advocacy, networking, human and legal rights, resource mobilization and strategic data collection. CSO networks will be tasked with the responsibility of mapping community structures and actors, assessing their management and technical capacities and delivering appropriate capacity building and strengthening interventions, through training, supervision and mentorship. To effectively fulfill this role, the CSO networks will also need to strengthen their capacities in several critical areas including monitoring and evaluation, operational research methodology, quality assurance, research review and synthesis, policy analysis, resource mobilization, evidence-informed advocacy, effective media engagement and conflict resolution.

10. GOVERNANCE AND MANAGEMENT OF THE HIV PREVENTION RESPONSE

As part of its mandate to lead and coordinate the national response to HIV and AIDS, the NAC will be responsible for overseeing the operationalization and implementation of this Revised HIV Prevention Strategy. However, the responsibility of implementing specific HIV interventions will rest on various stakeholders including government ministries, departments and agencies, local and international NGOs, CSOs, the private sector and CBOs (described in Section 9). In line with the HIV Prevention and Management Act of 2017, NAC will continue to perform the following key responsibilities:

- Provide technical leadership within government in the formulation of policies to advance HIV prevention.
- Develop and maintain an up-to-date information system for HIV prevention and establish sustainable mechanisms for disseminating and utilizing the information.
- Accredit materials and messages on HIV prevention or treatment produced by any persons or organizations before dissemination.
- Monitor the allocation and effective and efficient use of resources towards the national HIV prevention response.
- Promote and commission research, information sharing and documentation on HIV prevention.
- Provide technical guidance, capacity building and support to all stakeholders implementing HIV prevention programs, and
- Advocate for a strong, sustained and visible role of political, civil and traditional leaders in HIV Prevention activities so that HIV prevention remains on the national developmental agenda.

To fulfill these responsibilities, NAC will utilize governance structures, shown in Figure 9, which have already been established to manage the national HIV and AIDS response. The NAC will serve as a secretariat for Malawi Partnership Forum (MPF), which will have the overall oversight responsibility for the HIV Prevention Strategy. The HIV Prevention Technical Working Group (TWG) will be the main structure for engaging all stakeholders operating at national level on various technical matters relating to HIV prevention and for making recommendations to the MPF. Various subgroups and taskforces may be formed under the Prevention TWG to perform detailed review and analyses of any technical matter relating to specific HIV prevention themes (such as condoms, VMMC, PrEP etc). Key functions of the Prevention TWG will include monitoring progress made in achieving various program outcomes and targets, identifying gaps and best practices in the implementation of the strategy and reviewing emerging research results and regional or

international policy and strategic recommendations on HIV prevention. The HIV Prevention TWG will also work closely with several other TWGs, including the following; the HIV Treatment TWG owing to the critical role of biomedical products such HIV test kits, PrEP and ART in HIV prevention; the HIV Research and Surveillance TWG in its role of coordinating the development of the HIV research agenda and evaluating the impact of key HIV interventions; and the newly established KP TWG responsible for coordinating technical programs for KP. In addition, the HIV Prevention TWG will liaise with any other sectoral and multi-sectoral committees and taskforces established by government to oversee the implementation of programs that may have a bearing on HIV prevention, such as the High Level Inter-ministerial Taskforce on Youth and Adolescents and the AGYW Taskforce.

To harness opportunities for synergy with other sectors involved in HIV prevention programing, the HIV Prevention TWG will liaise with relevant government agencies and non-governmental umbrella organizations (Figure 9), including the following:

- **The Department of Human Resource Management (DHRMD),** which coordinates the HIV and AIDS response, particularly workplace programs in the public sector including parastatal organizations. DHRMD also provides policy guidance on workplace programs in Local Councils;
- **Malawi Business Coalition against AIDS (MBCA),** which coordinates HIV and AIDS responses for private companies and business institutions. Its major roles are mobilisation of companies, development of workplace programmes, monitoring and evaluation of the private sector response.
- **Malawi Network of People Living with HIV (MANET+),** which coordinates all organisations for PLHIV. Member organisations serve and advocate for issues affecting PLHIV in order to improve their welfare.
- **Malawi Network of AIDS Service Organisations (MANASO),** which coordinates local and international NGOs implementing various HIV and AIDS activities. Member organisations comprise mainly community-based actors who provide linkages between the community and the health facilities as well as advocating increased access to health services.
- **The Malawi Interfaith AIDS Association (MIAA)**, which coordinates all faith-based organisations implementing HIV and AIDS interventions.
- **National Youth Council of Malawi (NYCOM),** which coordinates all youth organisations implementing HIV and AIDS interventions.

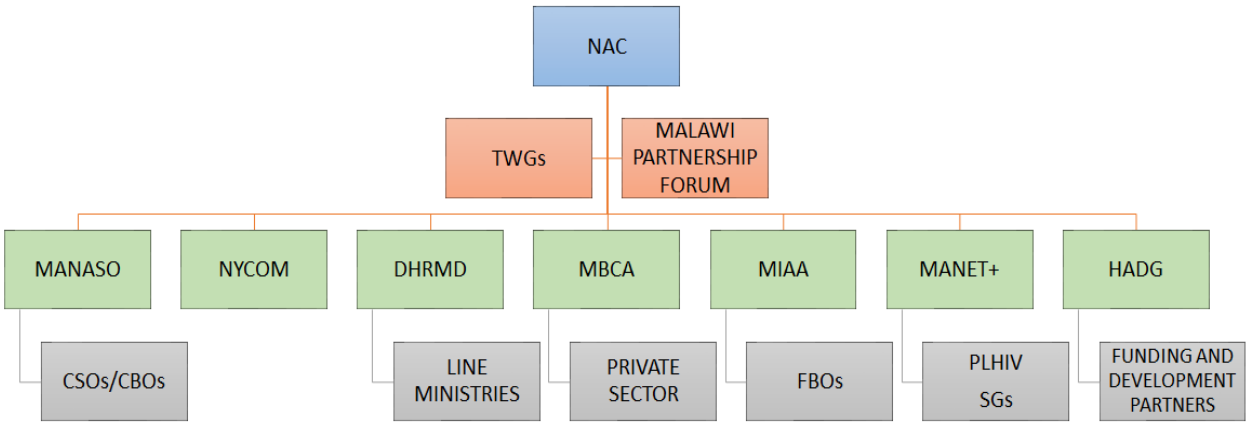

Figure 8: Coordinating committees and bodies for HIV programs in Malawi

As part of the decentralization policy, central government has devolved powers to local councils to plan and manage various programs at district level. The central government has maintained its role of providing policy and strategic guidance, quality assurance and monitoring and evaluation. Thus, all sectoral coordinating institutions and NGO umbrella organizations will interface with local councils through the District AIDS Coordinating Committees (DACC) and City AIDS Coordinating Committees (CACC) which are responsible for coordinating HIV responses in districts and cities, respectively.

11. KEY IMPLEMENTING AGENCIES

A wide range of implementing partners from the public and private sectors, civil society and development partners, working at district level, will implement programs and activities articulated in this revised strategy. Key implementing agencies include:

- **The Ministry of Local Government and Rural Development [MoLGRD]** will be the overall coordinating ministry in the HIV and AIDS response at district levels, through the DACC or CACC. Various sub-committees will be established within the DACC and CACC to review policies and program performance of specific HIV prevention thematic areas, such as condoms, VMMC, KP, AGYW and PrEP. The MoLGRD will be responsible for mobilizing resources for ministries, CBOs, support groups, and Community AIDS Committees (CACs), which implement various components of HIV and AIDS programs. The MoLGRD cadres will also lead the development of the overall District Implementation Plan (DIP) which shall include HIV and AIDS prevention programs. The District AIDS Coordinator working under the MoLGRD's Director of Planning and Development will be responsible for collating HIV data from all sectors and preparing HIV and AIDS M&E reports. He/she will liaise closely with focal persons for specific HIV prevention thematic areas such as condoms, VMMC, AGYW, KP, EMTCT and PrEP. To ensure coordination of all district implementing agencies, MoLGRD will map and register all NGOs working on HIV and AIDS at district level.
- **Ministry of Health and Population (MoHP)** will continue to play a key role in managing biomedical interventions such as condoms, VMMC, ART and eMTCT. Specific roles of the MoH will include: procurement and supply chain management of HIV and AIDS commodities (condoms, VMMC and ARVs); integrating biomedical HIV preventive intervention in all SRH service delivery points; operationalizing the NYFHS Strategy (2015–2020); recruiting and training health care providers in delivering quality biomedical HIV preventive interventions; supervising lay community-based health volunteers; and providing technical advice to other ministries, NGOs and CBOs in managing biomedical HIV interventions; and conducting HIV and STIs surveillance.
- **The Ministry of Education, Science and Technology (MoEST)** will provide leadership in various school-based HIV prevention programs including: delivering LSE and CSE; mentoring out-of-school girls through mothers groups; and providing teacher training in primary and secondary schools. The key aim of these programs will be to ensure that girls and boys have comprehensive knowledge of HIV and AIDS and increased awareness of basic human rights and legal protections for women, children and KP. The Ministry will also expand comprehensive GBV programming to reach OVC and AGYW in clubs and schools. More broadly, as part of the "Keep Girls in School" campaign, the ministry will engage with relevant stakeholders to implement

programs that reduce drop-out rates from school, improve the availability of teaching and learning materials and increase the number of girls' hostels. Parent-Teacher Associations (PTA) will be engaged to ensure that knowledge, skills and values acquired by young people at school are reinforced at home and to promote the protection of basic child and adolescent rights.

- **The Ministry of Gender, Children, Disability and Social Welfare (MoGCDSW)** will lead the implementation of child protection and gender equality programs, including the operationalization of the National Action Plan for Orphans and Vulnerable Children (2015-2019), the National Plan of Action to Combat GBV in Malawi (2014-2020) and the Gender, HIV and AIDS Implementation Plan (2016 -2020). The Ministry will be responsible for hiring and training a sufficient number of social workers and child protection workers who will work collaboratively with relevant community structures to identify vulnerable children and people experiencing human rights violations and ensure that they are referred to appropriate social services. The Ministry will also manage the social cash transfers, education bursaries and other social safety nets, in collaboration with the MoLGRD.
- **The Ministry of Home Affairs,** through the Police department, will ensure that cases of human rights violations, including GBV and child marriages, are adequately investigated and culprits properly prosecuted. The Ministry will work with relevant stakeholders to scale-up the number of victim support units and one-stop centres and adequately resource them with trained officers, supplies and equipment. It will also liaise with other social service ministries to ensure prompt referral and management of victims of all forms of human rights violations.
- **Ministry of Labor, Youth, Sports and Manpower Development** (MoLYMD) will be responsible for enhancing opportunities for young people and their meaningful participation in social, economic and political processes. It will take the lead in the implementation of all youth programs including: supervision and mentorship of youth clubs; linking out-of-school youth to leadership and skills development programs; and creating opportunities for meaningful employment. It will also be responsible for coordinating the implementation of the National Strategy for Adolescent Girls and Young Women 2017 – 2020, through the District AGYW Steering Committee chaired by the District Youth Officer.
- **NGOs, FBOs and CBOs** will be the basic implementing units for HIV-related interventions at community level. They will carry out various activities including, advocacy work, community mobilization of resources, promotion of SBCC programs, facilitating client referrals and documentation of best community practices. They will also ensure that community members have continuous access to core HIV prevention commodities and services.

- **Civil Society Organizations** will play a critical role in advocating for HIV prevention interventions; strengthening capacity of FBOs and CBOs to deliver HIV prevention programs; and be a watchdog for investment in HIV and AIDS prevention by creating systems for tracking resources allocated to implementing agencies. (*Refer to details in Section 7.4.2 of this strategy*).
- **Private Sector** organisations under the coordination of MBCA have the responsibility to mainstream HIV and AIDS through workplace policies and programs. Specifically, they will promote access of their members to core preventive interventions, foster adoption of safer sexual behaviours and create conducive environment for HIV programing.

12. RESULTS COORDINATION: MONITORING AND EVALUATION

Strategic information is necessary for decision-making, planning and resource mobilization and allocation. 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).

The Malawi National HIV and AIDS Monitoring and Evaluation Framework 2015-2020 is the main guiding framework for tracking programmatic performance of the national HIV prevention strategy. The strategic objective of the framework is the *"enhanced utilization of reliable and timely available strategic information for National HIV and AIDS Response management"*. The development of the revised 2018-2020 National HIV Prevention Strategy has resulted in the development of a separate performance monitoring and results framework and a supporting Results Based Monitoring & Evaluation Plan for guiding the monitoring and evaluation of the implementation of the revised strategy in Malawi. Monitoring and Evaluation allows for tracking programmatic processes and accounting for invested funds (accountability function). The M&E function in this strategy will aim to provide crucial information for decision making and identifying best practices, as well as gaps and weaknesses of programs and enables learning and feedback. A separate Results Based M & E framework that tracks performance of key indicators for the various intervention pillars will enable key stakeholders to collect data on key indicators at all levels and enable strategic information to be gathered through the M & E processes.

The Revised HIV Prevention Strategy M & E Plan is guided by the overall goal of this revised strategy that aims to reduce the annual number of new HIV infections to 11,000 in the year 2020, from a baseline of 36,000 in 2016. The tracking of indicators provides a platform to show what works or what does not work in light of the overall goal. This will ensure that lessons are drawn and decisions based on evidence crafted and implemented. It is critical that a functional national M & E system is maintained and supported to ensure monitoring and evaluation of the Revised National HIV Prevention Strategy.

The success of the prevention strategy implementation in the multi-sectoral response to HIV and AIDs will require coordination of all sectors (public, private, civil society and development partners) to achieve results based on agreed indicators. NAC is responsible for monitoring the epidemic and the national response, analyzing this information and disseminating it to policy makers and program planners. The monitoring and evaluation of health facility based responses is coordinated and managed by the MOH in collaboration with private sector institutions and CSOs that run health facilities. Data are collected and reported through the Health Information System (HIMS) and DHS2. Monitoring of non-health related interventions is conducted by NAC through different partnerships, i.e. with donor group, CSOs, FBOs, organizations that support key populations, traditional leaders

and local government to name a few. The main tool for collection of data at district level is the district based Local Authority reporting form. Data from these forms is captured and analyzed by the Local Authority Reporting system. These coordinating structures will oversee capacity development, data quality assurance, resource mobilization for M&E and data archiving.

Key Performance Indicators

The impact indicator for all the strategy outcome is the Incidence of HIV among all the key groups outlines. However the strategy M&E Framework provide details of outcome and output indicators for all the outcomes listed in this strategy and approaches for data collection. Key indicators that will be monitored are listed in the table below, by each outcome.

Table 12: An outline of Key Performance Indicators

No	Key performance Indicators	Baseline	Target
A	**Comprehensive Condoms Programming Key Indicators**		
A.1	Percentage of women and men ages 15–49 who reported using a condom at last sexual intercourse with a non-marital, non-cohabiting partner (*sex &age*).	M: 75% F: 50%	M: 80% F: 75%
A.2	Percentage of men and women ages 15–49 who know that consistent and correct use of condoms reduces risk of HIV acquisition.	M: 70% F: 70%	M: 90% F: 85%
A.3	Number of male and female condoms distributed, annually (*disaggregated by target groups*).	Male Condoms (MC): 60,700,000 Female Condoms (FC): 470,000	MC: 135,000,000 FC: 1,000,000
B	**VMMC Key Indicators**		
B.1	Percentage of males circumcised according to national guidelines.	28%	60%
B.2	Percentage of circumcised males who were tested for HIV as part of VMMC services.	0	100%
B.3	Number of clients reached.	187,298	280,000
C	**AGYW Key Indicators**		
C.2	Percentage of AGYW who experienced GBV or sexual violence and sought external support in the past 12 months (*disaggregated by age*).	15 - 19y: 45.1% 20-24y: 38.4%	15-19y: 90% 20-24y: 90%
C.3	Percentage of sexually-active AGYW aged 10–24 years reporting having had HIV testing in the preceding 12 months and received results (*disaggregated by age*).	15-19y: 31.9% 20-24y: 52.3%	15-19y: 75% 20-24y: 90.0%

No	Key performance Indicators	Baseline	Target
C.4	Percentage of teenage (15 – 19) pregnancies.	29%	< 20%
C.5	Percentage of most vulnerable AGYW accessing social protection interventions to (including bursaries and household targeted social cash transfers) to keep them in school.	0	60%
D	**Indicators – KP**		
D.1	Percentage of KPs (FSW, MSM and TGs) enrolled in HIV who are virologically suppressed at 6 and 24 months post ART initiation.	60%	95%
D.2	Percentage of newly diagnosed HIV positive KP (FSW, MSM and TG) initiated on ART.	89%	95%
D.3	Number of people in KP (FSW, MSM and TG) who tested for HIV in the past 12 months and received their results (*disaggregated by type of KP*).	FSW 8,000 MSM 7,000	FSW 15,000 MSM 10,000
D.4	Number of condoms distributed to KPs.	MC: 7,355,238 FC: 105,551	MC: 15,000,000 FC: 300,000
D.5	Number of Lubricants distributed to KPs.	761,535	5,000,000
E	**PrEP Key Indicators**		
E.1	Proportion of KP and other high risk population enrolled in Malawi PrEP demonstration projects retained in HIV prevention programs at 3, 6 and 12 months.	0	95%
E.2	Number of KP and other high-risk population newly enrolled in PrEP demonstration projects (*disaggregated by sub-population type*).	0 FSW 0 AGYW	560 FSW 500 AGYW *(estimated target in the protocol for the PrEP demonstration project)*
F	**eMTCT Key Indicators**		
F.1	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%	90%
F.2	Percentage of HIV+ postpartum women initiated on ART who are retained in HIV care at 12 and 18 months postpartum.	74%	95%

No	Key performance Indicators	Baseline	Target
F.3	Percentage of pregnant and postpartum women who were tested for HIV and received results in the past 12 months.	95%	95%
F.4	Percentage of HIV-exposed infants who received virological results for HIV within 2 months of birth.	54%	> 70%

13. COSTING AND FUNDING LANDSCAPE FOR HIV PREVENTION

13.1. Funding Landscape for HIV Prevention

Malawi is a signatory to the 2016 UN Political Declaration on HIV and AIDS: *On the Fast Track to Accelerating the Fight against HIV and to Ending AIDS Epidemic by 2030.* One of the commitments in this declaration is that countries should ensure that a quarter (25%) of all HIV and AIDS resources should go towards HIV prevention. However, for Malawi, the trends in HIV financing show that investments towards HIV prevention programming have consistently been less than a quarter and even lower over the recent years. For instance, resource mapping data for the 2015/ 2016 Financial Year indicates that only 19% of total HIV funding was apportioned to HIV Prevention against Treatment and Care getting the bulk of the resources at 52%.

With regard to the overall financing of HIV Prevention in Malawi, statistics show a declining pattern in the level of expenditure overtime. This is in comparison to forecasts of annual HIV prevention resources in the current NSP. In terms of sources of funding, majority of the resources for HIV Prevention are drawn from development partners - Global Fund and the United States Government (through PEPFAR). The trends in expenditure against annual budgets are summarized in the chart below:

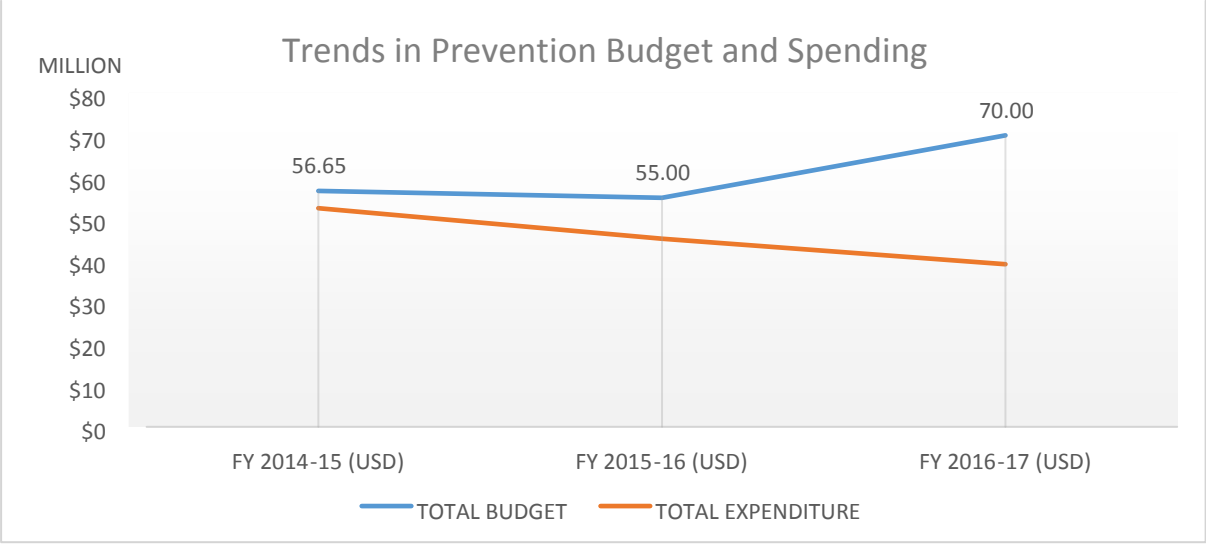

Figure 9: Trends in Prevention Budget and Spending

Although the total HIV and AIDS expenditure has been increasing over the years, the share towards HIV prevention spending has been declining. According to the Global AIDS

Monitoring reports[119], the expenditure figures for the FYs 2014/15, 2015/16, and 2016/17 were US$52 million, US$45 million and US$39 million respectively. These levels of expenditure are far below the corresponding annual budgets. This illustration clearly highlights the need to intensify resource mobilization for the successful implementation of prevention interventions. One of the initiatives to be undertaken is holding high-level dialogue on financing and sustainable funding for HIV prevention.

13.2. Costing of the Revised Prevention Strategy

The total resource needed for the revised HIV Prevention Strategy for the period 2018 to 2020 is **US$174,211,052.78**. On the other hand, the planned resources over this period are **US$83,191,078.50** representing a financing gap of 52%. The various interventions within HIV Prevention have specific resource needs as reflected in the graphical presentation below:

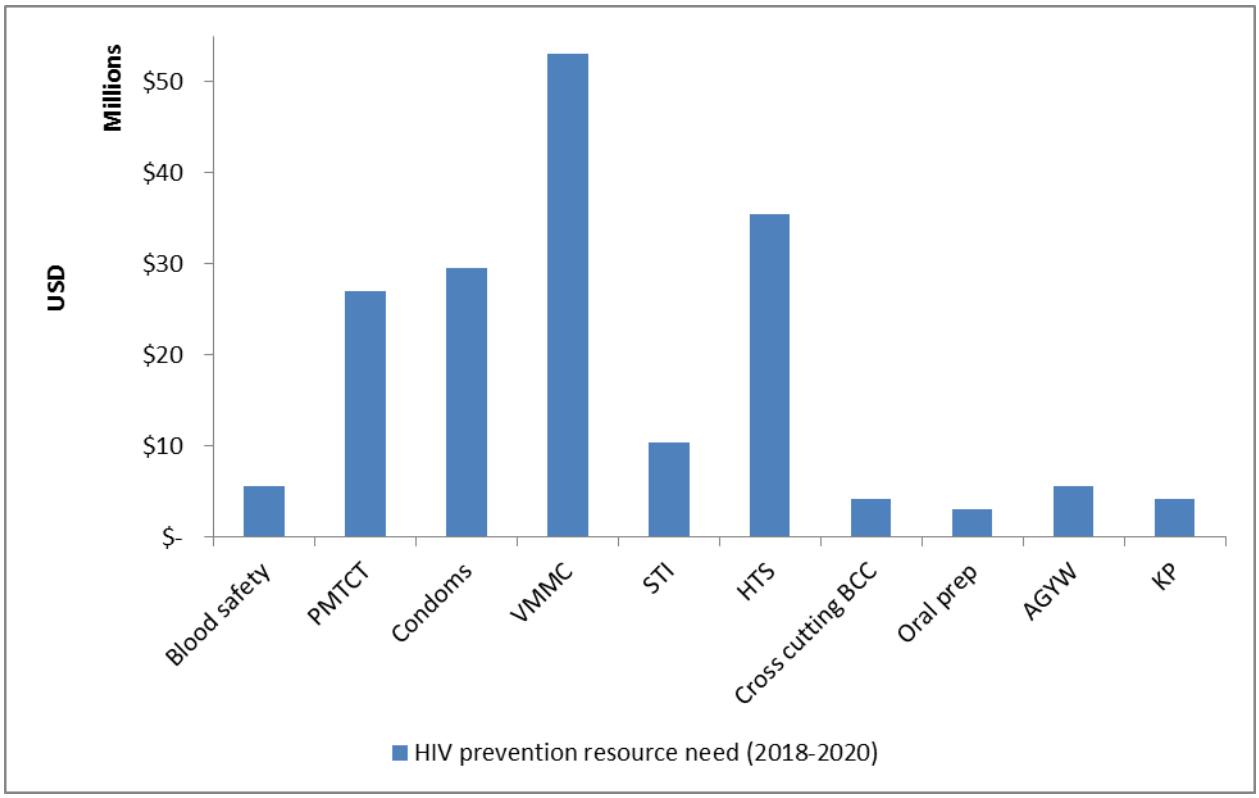

Figure 10: HIV Prevention resource need by intervention area

AGYW and KP are among the key pillars globally agreed as pivotal in the reduction of new HIV infections, however, the graph depicts minimal resource needs under these areas. The AGYW programme includes cross-cutting activities whose costs are reflected in other intervention areas, namely: condoms, VMMC, HTS, and STI. There are a few activities

[119] The methodology for gathering HIV expenditure for the Global AIDS Monitoring Report has not been consistent across the years, and that has implications on comparability of the HIV expenditure data across time.

directly linked to this programme, these include, coordination and monitoring activities, as well as operationalization of teen clubs. Therefore, although the resource needs for AGYW appears to be low, the programme absorbs a significant amount of resources from the other intervention areas. Similarly, KP programme and oral PrEP have costs included in the other intervention areas hence the seemingly low planned resources.

Below is a graph illustrating how AGYW has a substantial amount of resources embedded within other intervention areas. For instance, under VMMC, the overall resource need is quite low compared to the AGYW/ABYM resource need in this area.

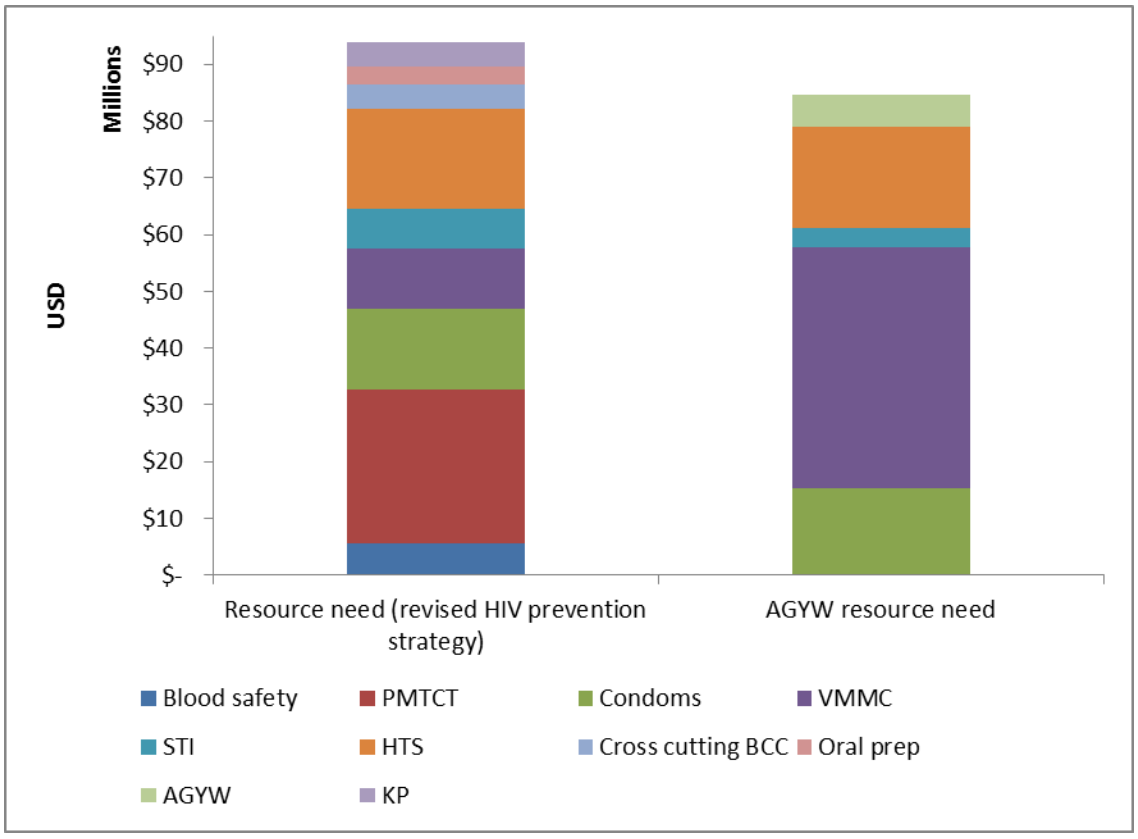

Figure 11: HIV Prevention resource need, highlighting resources for general pop vs. AGYW/ABYM (2018-2020)

The detailed costing needs per strategy for HIV Prevention over the 2018-2020 period are summarized in the table below. Furthermore, the table provides percentage of AGYW/ABYM costs embedded under selected intervention areas. In summary, AGYW/ABYM takes up 50% and 48% of total HIV prevention resources in 2018-2019 and 2019-2020 respectively.

Table 13: A Summary of the required resources for the revised strategy

		2018-2019	2019-2020	2018-2019	2019-2020
Strategic objective	**Eliminate mother-to-child transmission**				
Strategy	Primary prevention of HIV/AIDS among women of childbearing age	$ 1,474,576.19	$ 1,474,576.19		
Strategy	Prevention of vertical transmission from mother to child	$ 1,272,844.29	$ 1,272,844.29		
Strategy	Provide appropriate treatment, care and support to mothers living with HIV, their children and families	$ 4,282,417.34	$ 4,263,313.88		
Strategy	Reduce unwanted pregnancies among HIV+ and HIV- women	$ 6,377,106.57	$ 6,642,078.89		
Strategic objective	**Maintain low levels of blood-borne transmission of HIV**				
Strategy	Blood donor mobilization and blood safety	$ 2,779,193.89	$ 2,779,193.89		
Strategy	Ensure access to post exposure prophylaxis	$ 47,596.68	$ 46,104.33		
Strategic objective	**Reduce sexual transmission of HIV**				
Strategy	Reduce transmission and morbidity from STI	$ 5,048,090.57	$ 5,422,792.17	25%	25%
Strategy	Scale-up PITC and targeted key populations HIV testing and counseling	$ 17,420,968.04	$ 18,056,566.18	34%	34%
Strategy	Scale-up VMMC	$ 27,053,236.07	$ 25,995,733.84	44%	44%
Strategy	Scale-up VMMC (neonatal)				
Strategy	Supply male and female condoms to all national response programs	$ 13,927,437.43	$ 15,653,474.67	34%	34%
Strategy	Introduce oral prep to select KPs	$ 464,750.96	$ 2,611,000.00		
Strategy	AGYW prevention package	$ 2,778,447.03	$ 2,778,447.03		
Strategy	KP prevention package	$ 2,021,849.78	$ 2,266,412.59		
Strategy	SBCC (Cross cutting and not already included)	$ 2,303,662.32	$ 1,941,782.49	Total AGYW	
Total		$ 84,948,514.83	$ 89,262,537.95	$ 42,055,214.24	$ 42,544,559.75

ANNEXES

Annex A 1: Standardized HIV service packages for Adolescent Girls and Young Women

Type of package	Package of interventions
Standard service package *(intensity of demand creation and outreach tied to HIV incidence)*	• Male and female condoms and lubricants *(provision of information or access depending on age)* • STI and HIV testing and counseling for AGYW and male partners, linked to treatment, care and support *(provision of information or access depending on age)* • Contraceptive *(provision of information or access, depending on age)* • GBV prevention, screening and post violence care; • Pregnancy testing; • Life skills education and comprehensive sexuality education, including HIV risk avoidance *(All in-school adolescents);* • Social asset building, through existing clubs and structures; • VMMC (for all ABYM); • Parenting skills: caregivers for girls 10-14 years, young mothers; • Harm reduction for people who use drugs *(All adolescents who use drugs);* • Prevention programs for sex workers and sexually-exploited girls *(all adolescent girls who sell sex).*
Policy and structural actions *(intensity of demand creation and outreach not tied to HIV incidence, relevant outside high HIV incidence settings)*	• Advocacy with leaders and promotion of young women's leadership • Legal protection (prevention of underage marriages and GBV) and access to justice • Social and behavior change programs and community mobilization around issues of cultural and gender norms and SRH • Integration (and access to) with gender-based violence prevention and management • Innovative multimedia and new media • Access to STI services including vaccines and other health care • Measures to keep girls in school (school feeding or sanitary pads) • Economic strengthening: Savings and Loans, linkage to microfinance (targeting caregivers for ages 10-14 years) • Food security and nutrition support. • Safety nets: cash transfers, school bursaries and other social protection programs
Extremely high risk setting *(incidence at least 2.0)*	• Vulnerability screening and individualized case management • Enhanced parenting support and other programs to keep girls in school and increase parental monitoring. • Back-to-school support • PrEP access, including outreach and adherence support.

Annex A 2: Standardized HIV service packages for Key Populations

<table>
<tr><th colspan="2">CORE</th></tr>
<tr><td colspan="2">

Peer education, risk assessment, counseling, risk reduction planning
HIV testing and counseling (HTC)
GBV screening, post-exposure prophylaxis (PEP) and emergency contraception (EC) services, and referral to clinical, psychosocial, legal aid or other GBV services
Family planning: education, counseling, screening for pregnancy risk, and provision of short-acting methods and referral for long-acting and permanent methods
Promotion of partner/client and children HTC
Condom and lubricant use promotion and distribution, condom negotiation skills
Sexually transmitted infection (STI) syndromic screening and referral
Cervical cancer screening
Under-age girls: referral to OVC, child protection and other support services

</td></tr>
<tr><th colspan="2">EXPANDED</th></tr>
<tr><th>Sero-negative</th><th>Sero-positive FSW on Anti-Retroviral Therapy (ART) – Positive Health, Dignity & Prevention (PHDP) package</th></tr>
<tr><td>

All of core
Quarterly HTC and STI screening
Repeated and regular risk-reduction counseling

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All of core, except HTC
All of expanded services for sero-positive not yet on treatment
Use of PLHIV support groups to assess treatment and adherence issues and refer accordingly (“linked to Community Care”)

</td></tr>
<tr><th>Sero-positive not yet on treatment</th></tr>
<tr><td>

All of core, except HTC
Measurable linkage to care and treatment services with strengthened referral tools between CBOs/Peer educators/mobilizers and clinics
TB screening and referral for treatment
Test & Treat: Enrollment in ART at health facilities; counseling on initiation, adherence, regular attendance
For FSW who are pregnant: referral for PMTCT enrollment
Promotion of community-based HTC to partners and children of sex workers
Assessment of STI and other opportunistic infections (OIs) and referral

</td></tr>
</table>

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