Republic of Malawi

# NATIONAL HIV PREVENTION STRATEGY

# 2009-2013

June 2009

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**ACRONYMS**

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ANC** | Antenatal Clinic |
| **ART** | Antiretroviral Therapy |
| **ARVs** | Antiretroviral |
| **BCI** | Behaviour Change Interventions |
| **BSS** | Behaviour Surveillance Survey |
| **CDC** | Centres for Disease Control and Prevention |
| **CHAM** | Christian Health Association of Malawi |
| **CRS** | Centre for Social Research |
| **SW** | Sex Work |
| **GBV** | Gender-based Violence |
| **KAPB** | Knowledge, Attitude, Practice and Behaviours |
| **HIV** | Human Immunodeficiency Virus |
| **HTC** | HIV Testing and Counselling |
| **IEC** | Information, Education and Communication |
| **MANASO** | Malawi Network of AIDS Service Organisations |
| **MANET+** | Malawi Network of People Living with HIV |
| **MBTS** | Malawi Blood Transfusion Service |
| **MCH** | Maternal and Child Health |
| **MDHS** | Malawi Demographic and Health Survey |
| **MHRC** | Malawi Human Rights Commission |
| **MIAA** | Malawi Interfaith AIDS Association |
| **MICS** | Multiple Indicator Cluster Study |
| **MIS** | Management Information System |
| **MOEST** | Ministry of Education, Science and Technology |
| **MOEPD** | Ministry of Economic Planning and Development |
| **MOH** | Ministry of Health |
| **MOICE** | Ministry of Information and Civic Education |
| **MOLGRD** | Ministry of Local Government and Rural Development |
| **MOT** | Modes of Transmission model |
| **MSDY** | Ministry of Sports and Youth Development |
| **MSM** | Men who have Sex with Men |
| **MTCT** | Mother to Child Transmission of HIV |
| **NAC** | National AIDS Commission |
| **NAPHAM** | National Association for People Living with HIV in Malawi |
| **NGO** | Non-Governmental Organization |
| **OPC** | Office of the President and Cabinet |
| **PMTCT** | Prevention of Mother to Child Transmission of HIV |
| **SSS** | Sentinel Surveillance Survey |
| **STI** | Sexually Transmitted Infections |
| **UN** | United Nations |
| **UNAIDS** | Joint United Nations Programme on HIV and AIDS |

| | |
|---|---|
| **UNICEF** | United Nations Children Fund |
| **UNFPA** | United Nations Population Fund |
| **WHO** | World Health Organisation |

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## PREFACE

Implementation of effective HIV prevention interventions to reduce new infections still poses a challenge in the national response to HIV and AIDS in Malawi. Although the national HIV prevalence is declining, on average there are nearly 90, 000 new HIV infections each year with at least half occurring among young people aged 15-24. The majority of people being infected are those who were previously considered to be at low risk, for example, couples and partners in stable sexual relationships.

In response to this challenge, the Government of Malawi in collaboration with its stakeholders has developed and implemented several prevention strategies and plans aimed at reducing further transmission of HIV through unprotected sex, mother to child, invasive procedures, blood and blood products. These strategies and plans include: the National Behaviour Change Interventions Strategy, PMTCT Scale up Plan, Abstinence Strategy, Mutual Faithfulness Strategy, National Plan of Action for Scaling up Sexual Reproductive Health HIV Prevention Interventions for Young People, Condom Strategy and HIV Testing and Counselling (HTC) Scale-up plan. HIV prevention interventions have been implemented addressing behaviour change, HTC, Prevention of Mother to Child Transmission of HIV (PMTCT), Sexually Transmitted Infections (STI) management and blood safety.

The National HIV Prevention Strategy (2009-2013) has been developed to respond to the current gaps in HIV prevention interventions. The strategy builds on the various strategic documents mentioned above which have guided prevention efforts in the country. This National HIV Prevention Strategy presents a goal, strategic objectives, approaches and broad activities addressing HIV prevention at individual, group and community levels. The strategy also presents contextual factors and determinants which have been termed in the strategy as Cross-cutting. These cross-cutting issues are factors that need to be addressed to create an enabling environment for sustained positive behaviours in Malawi. These issues include gender, human rights, culture, legal and capacity building. In order to achieve maximum impact, partners in the national response will implement interventions at the national, district and community levels.

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

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

**Dr. Mary Shawa**
**Secretary for Nutrition, HIV and AIDS**
**OFFICE OF THE PRESIDENT AND CABINET**

# 1.0 INTRODUCTION

## 1.1 National HIV Prevention Strategy

The National HIV Prevention Strategy (2009-2013) is a guiding tool for planning, implementation, monitoring and evaluating and resource mobilization for HIV prevention interventions. The strategy will provide practical guidance for improving current HIV prevention programming for maximum impact. The goal of the strategy is to reduce new HIV infections in order to further mitigate the burden and impact of HIV and AIDS in Malawi.

In 2001, Malawi signed the United Nations Declaration of Commitment on HIV and AIDS, which set a wide agenda to address the HIV and AIDS crisis by taking action in a number of areas including prevention. At a regional level in 2006, Malawi signed the Congo Brazzaville Declaration of Commitment to intensifying HIV prevention efforts at country level. In May 2006, Malawi developed its Universal Access Framework to prevention, treatment, care and support which among other things required scaling-up of prevention programmes. This strategy is, therefore, part of the implementation process of these commitments.

The HIV Prevention Strategy demonstrates a renewed emphasis on evidence-based and data-driven prevention programming consistent with best practice and firmly supported by strong epidemiological analysis, formative research and baseline and follow-up evaluations to monitor the effectiveness of programming and continuously improve its quality. Importantly, epidemiological analysis has already estimated that over 90% of new HIV infections among adults in Malawi occur in multiple and concurrent sexual partnerships and discordant couples.

The National HIV Prevention Strategy focuses on both biomedical and behavioural prevention interventions including HIV testing and counselling, prevention of mother-to-child transmission, STI management, blood and injection safety, safe medical male circumcision, timely initiation of ART, condom programming, advocacy, community mobilisation, life skills education and HIV communications among others. In addition, the strategy addresses structural and cultural factors that increase vulnerability to HIV infection to foster sustainable changes in both individual behaviours and social norms.

## 1.2 Rationale

Malawi is among the ten countries with the highest HIV prevalence in the world, estimated at 12% of adults aged 15-49 years. Although trends in HIV prevalence from sentinel surveillance indicate a slight decline, overall the downward trend in prevalence appears relatively shallow. In addition, some behaviour indicators are stagnating or even worsening. For example, the proportion of male youth aged 15-24 years having sex with more than one non-regular partner is high and condom use with non regular partner is low. While the national ART programme has been successful in scaling-up antiretroviral therapy (ART) to about 200,000 Malawians by end December 2008, the number of new infections estimated at 90,000 per year continues to outpace the number of people starting ART each year.

Malawi developed its Universal Access to prevention, treatment, care and support which includes a commitment to scale-up prevention programmes in order to reach as many people as possible. The National HIV Prevention Strategy is therefore a culmination of the national effort to scale-up prevention in line with Universal Access. In this light, it is important to note that prevention and treatment goals of Universal Access are mutually complementary and dependant. To maximise the prevention of transmission, it is important to ensure that people living with HIV have timely access to treatment and positive prevention interventions. In addition, prevention of new infections will assist to reduce further the burden on the health care system in Malawi.

As a continued effort in HIV prevention response, the Government in collaboration with stakeholders developed a number of strategies, guidelines and action plans such as: National Behaviour Change Interventions Strategy for HIV/AIDS and Sexual Reproductive Health (2003), National Plan of Action for Scaling up Sexual and Reproductive Health HIV Prevention for Young People (2008-2012), Plan for Scaling up HIV Testing and Counselling (2006-2010), Plan for Scaling up Prevention of Mother to Child Transmission of HIV Services in Malawi (2008-2012), ART Scale up Plan (2006-2010), Condom Strategy (2006), Abstinence Strategy (2008) and Mutual Faithfulness Strategy (2008-2012). While it is acknowledged that these strategies and plans have assisted in guiding prevention efforts, one major shortcoming was that the various approaches were not optimally integrated, linked and coordinated. The National HIV Prevention Strategy has, therefore, sought to bring the various evidence-based HIV prevention interventions in a cohesive and mutually reinforcing manner in order to have a comprehensive package for effective programming.

Coordination, leadership and accountability mechanisms on HIV prevention are important to the success of the national response. Malawi has therefore developed this National HIV Prevention Strategy to address the gaps that have been identified and ensure that prevention activities are integrated.

### 1.3 Development Process

The development process of the strategy was consultative involving various stakeholders. A concept paper was developed that defined the need to have the strategy and outlined the development process. A national Think Tank meeting was held to isolate drivers of the epidemic, underlying factors and identified key partners to be engaged in the process. This was followed by formation of a National Steering Committee and a Task Force.

The Steering Committee was responsible for overseeing the development process by providing policy guidance and advice to the members of the National Task Force with reference to national and global strategies and conventions. The National Task Force facilitated the process by reviewing draft documents produced by the consultants at various stages of the assignment and providing technical guidance with regard to presentation, clarity and accuracy of issues, data and information.

Two consultants were engaged to review HIV and AIDS reports and facilitate a series of consultative meetings with a range of stakeholders that included: the informal Sector (vendors), private sector, herbalists and traditional healers, health service providers and researchers, experts in human rights and gender issues, members of various HIV and AIDS technical working groups, People Living

with HIV (PLHIV), faith leaders, children living with HIV aged 8-14 years, academia, the youth, persons with disabilities, sex workers, prisoners and members of the general public. The aim of the consultations was to solicit views on factors that are driving the epidemic in Malawi and how they should be addressed.

After the consultations, consensus building workshops involving a core team of experts to develop the strategy were held. The draft strategy was presented to members of the National Task Force for input and finalization and to the members of the National Steering Committee for endorsement.

## 2.0 BACKGROUND

### 2.1 HIV Situation in Malawi

Malawi continues to experience a severe HIV epidemic. Since 1985 when the first AIDS case was reported, HIV prevalence increased significantly particularly among persons aged 15-49. The HIV prevalence rose to 16.2% in 1999, before coming down and stabilising at around 12% since 2007. HIV prevalence among sexually active adults is higher among females at 13% than males (10%). These rates translate into about 1 million Malawians living with HIV, including about 100,000 children under the age of 15 years.

About 88% of all new HIV infections in Malawi are acquired through unprotected heterosexual intercourse and 10% via mother-to-child transmission. About two percent (2 %) of infections are transmitted through blood transfusions, contaminated medical and skin piercing instruments. HIV infection rates show gender, age, social status and geographical variations, with infection more prevalent in women than men, urban than rural populations, and in the Southern region compared to the rest of the regions. The overall prevalence for young people, aged 15 – 19 years, is estimated at 2.1% (0.4% for male and 6.2% for female).

This HIV situation calls for comprehensive programming in HIV prevention so that drivers of the epidemic are addressed and specific key social groups are reached. Presented below are epidemiological patterns of HIV and AIDS in Malawi which show in detail who is infected or is at risk of being infected with HIV in terms of demographic, social, behavioural, economic and geographic factors. This data and information have assisted in developing interventions in the strategy which are audience specific and addressing risk behaviours.

### 2.2 Epidemiological Patterns of HIV in Malawi

#### 2.2.1 HIV Prevalence by age and sex

The HIV prevalence distribution by age in Malawi is typical of HIV epidemics at similar stages in Eastern and Southern Africa. HIV prevalence is high among young people, higher in females aged 15-24, and then increasing slightly in older males and exceeding females older than age 30 **(See Table 1):**

**Table 1: HIV prevalence by age and sex, age 15-49**

| | 15-19 | 20-24 | 25-29 | 30+ | Total |
|---|---|---|---|---|---|
| **Females** | 3.7% | 13.2% | 15.5% | 17.0% | 13.3% |
| **Males** | 0.4% | 3.9% | 9.8% | 17.5% | 10.2% |

***Source:*** *MDHS, 2004*

HIV incidence becomes high in youth as they begin to engage in sexual activity and with minimal consistent condom use. Incidence of HIV occurs at a younger age in females than males but with relatively equal cumulative incidence or prevalence impact over time as male prevalence exceeds that

of females at age 30 and above. Differential age specific incidence rates (early in females and delayed in males) highlight the need to address HIV risk behaviours in youth with attention to underlying gender factors that increase vulnerability to HIV.

### 2.2.2 HIV Prevalence by some socio-economic characteristics

The differentials in HIV prevalence is by place of residence (urban is higher than rural), region (Southern is higher compared to Northern and Central) and by wealth status where increasing income levels particularly in men is associated with higher prevalence. High levels of HIV are also associated with high education level (**See Table 2).**

**Table 2: HIV prevalence (%) by socio-economic characteristics (age 15-49)**

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

Source: MDHS, 2004

HIV prevalence is 1.7 times higher in urban than rural areas, suggesting a higher urban incidence. The prevalence is 2-3 times higher in the Southern region than Central or Northern regions indicating also much higher incidence in the South. The prevalence is particularly higher in the highest wealth category and in persons with post-secondary education. HIV risk is more strongly linked to higher social economic status and education levels among men than among women.

With the exception of type of residence and region, in most cases the relatively small differentials in HIV prevalence suggest that HIV risk is fairly evenly distributed across socio-economic status variables. Differences in HIV prevalence by type of residence and region provide important information for the strategic distribution of HIV prevention interventions and resources as demonstrated in **Table 3** where comparisons are made in HIV prevalence when adjusted in population size.

| Table 3: HIV prevalence (%) and % of total estimated HIV infections | | |
|---|---|---|
| | | |
| **Region** | | |
| North | 8.1 | 8.2 |
| Central | 6.5 | 23.1 |
| South | 17.6 | 68.8 |
| **Residence** | | |
| Urban | 17.1 | 21.7 |
| Rural | 10.8 | 77.8 |

***Source:*** *MDHS, 2004*

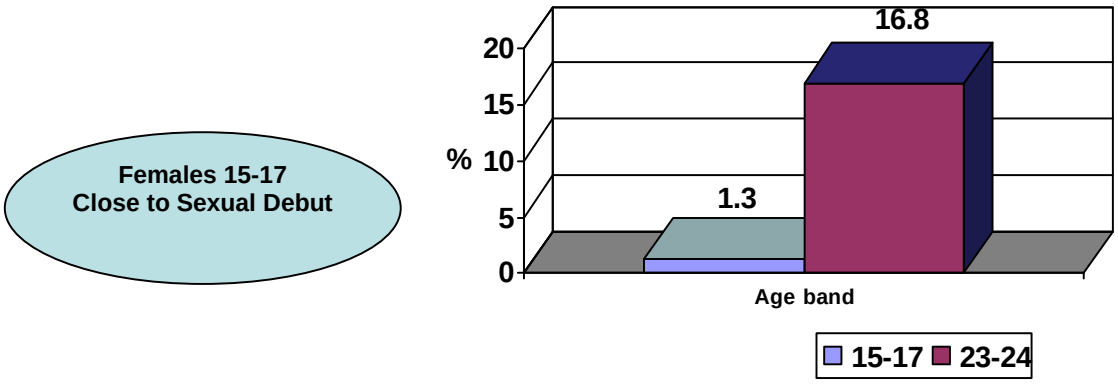
The above data illustrates the important point that the prevalence of HIV in Malawi is not uniformly distributed: 78% of HIV-positive individuals live in rural areas and 69% in the Southern region of the country.

### 2.2.3 HIV prevalence and risk factors among the youth

Risk of HIV infection in male youths is associated with age at sexual debut and the number of sexual partners. Increasing HIV infection rates in youth are strongly correlated with marriage, which occurs at earlier ages in females**.**

The pattern is more likely associated with sexual behaviours related to seeking long–term relations than with casual sexual encounters with older males. HIV prevalence of 17% in women aged 23-24 compared to a prevalence of 18.1% by age 30-34 is evidence that a substantial amount of the burden of HIV infection in women is established early in sexual relationships associated with marriage (either with intended long-term partners or spouses). This is illustrated in **Figure 1** below:

**Figure1: Female Prevalence - Age bands**

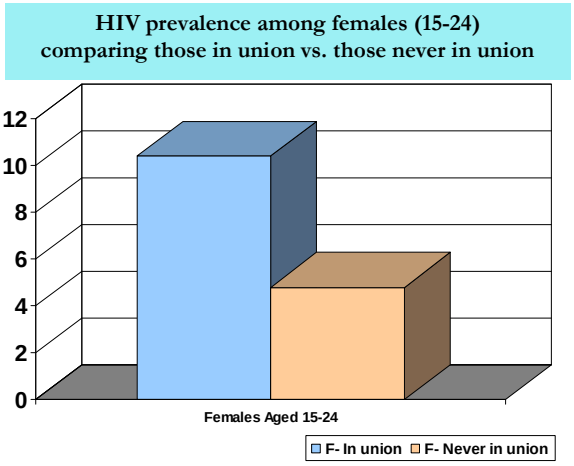



The pattern for males is similar but occurs 5-10 years later. HIV prevalence in males is 10.9% by age 23-24 compared to 20.4% by age 30-34. As with adults, HIV burden among youth is higher in rural areas and in the Southern region. Based on population level HIV prevalence in 2004 MDHS, highest "risk groups" are ages of 18-34 for females and 20-34 for males.

### 2.2.4 HIV prevalence among couples in marital relationships including youth

As **Figure 2** below indicates, young women aged 15-24 who are married or in stable sexual relationships have a much higher prevalence of HIV than those that are not involved in a stable union. This creates evidence that more new infections in Malawi are occurring in groups of people which were previously considered to be at low risk thus those in stable sexual relationships.

**Figure 2: HIV Prevalence among Females (15-24) those in sexual union versus those not in sexual**




***Source:*** *MDHS, 2004*

Among cohabiting couples who were tested for HIV in the 2004 MDHS, 83% of both partners were HIV negative and 7% were both HIV positive **(See Table 5).** Among 10% of couples, one partner was positive and the other was not *(discordant)*. More discordant couples were found in urban areas, in the Southern region of the country, among those with higher education and those with higher wealth status. The majority of HIV discordant couples are in the rural areas and the Southern region.

**Table 5: HIV prevalence among couples**

| Background characteristic | Both partners positive | Man positive, woman negative | Woman positive, man negative | Both partners negative |
|---|---|---|---|---|
| Urban | 14.6 | 13.8 | 4.5 | 67.0 |
| Rural | 6.0 | 4.7 | 3.9 | 85.3 |
| Northern region | 2.1 | 4.8 | 1.7 | 91.4 |
| Central Region | 3.6 | 2.8 | 1.7 | 91.9 |
| Southern Region | 11.7 | 8.8 | 6.9 | 72.6 |
| Total | 7.0 | 5.7 | 4.o | 83.3 |

The data for urban areas indicate that almost 1 in 3 couples has at least one HIV positive individual. In 86% of cases the male partner is infected in such couples, whereas in only 58% of cases is the female partner already infected. This situation calls for a comprehensive provision of prevention interventions to couples such as HIV testing and counselling, condoms, timely initiation of ART, and

other evidence-based positive prevention interventions that would successfully prevent transmission of HIV.

### 2.2.5 HIV by occupation and place

HIV prevalence among the occupational groups in Malawi greatly exceeds the national prevalence of 12% in all instances except male vendors as illustrated in **Table 6** below:

**Table 6: HIV prevalence**

| Sub groups | HIV Prevalence (%) |
|---|---|
| Female sex workers | 70.7 |
| Primary school teachers | |
| Male | 23.5 |
| Female | 22.1 |
| Secondary school teachers | |
| Male | 17.4 |
| Female | 16.1 |
| Female border traders | 23.2 |
| Male vendors | 6.6 |
| Truck drivers | 14.2 |
| Fishermen | 16.6 |
| Estate workers | |
| Male | 19.9 |
| Female | 17.5 |
| Police | |
| Male | 23.7 |
| Female | 32. 8 |

**Source:** BBSS, 2006

### 2.2.6 Paediatric HIV

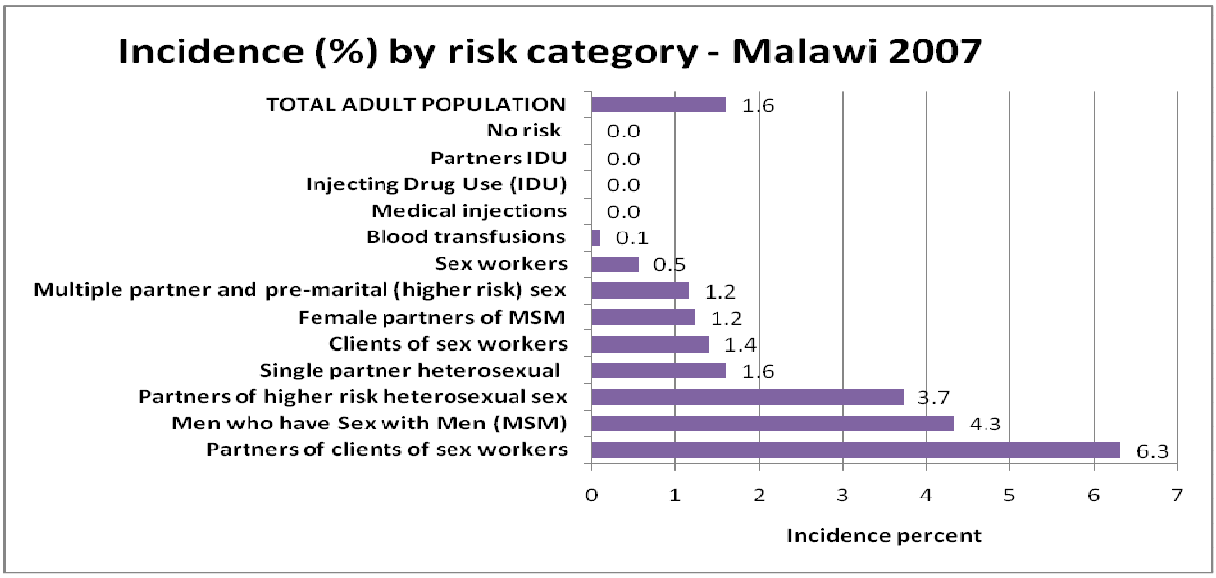
More than half of Malawi's population of 13.1 million is under the age of 18 years and it is estimated that in 2008 there were 17,033 new paediatric infections in children under the age of 18, making a total of 101,939 children living with HIV in Malawi *(Sentinel Surveillance, MOH 2007)*. Over 90% of paediatric HIV infection is acquired through vertical transmission from an HIV infected mother to the child. There is need, therefore, to intensify prevention interventions for women of child bearing age and their partners, HIV positive pregnant mothers and children born to HIV positive mothers.

### 2.2.7 Subgroups with very high incidence of HIV

National HIV incidence studies are expensive, time consuming, and have not yet been carried out in Malawi. In place of national HIV incidence studies, mathematical models have been used to estimate where new HIV infections are occurring based on available data about the size and sexual behaviour of different groups in the community. Analysis using the UNAIDS Modes of Transmission model has provided estimates of new infections in each risk category in Malawi. It is estimated that 1.6% of the total adult population in Malawi becomes HIV infected each year. However, this varies from 1.2% in individuals having higher risk sex to 6.3% in partners of clients of sex workers **(See Figure**

**3).** It is the partners of those high-risk individuals who are at highest risk of HIV infection in the country.

**Figure 3: Distribution of New HIV Infection in Adults by Risk Category based on Modes of Transmission Model Malawi 2007**

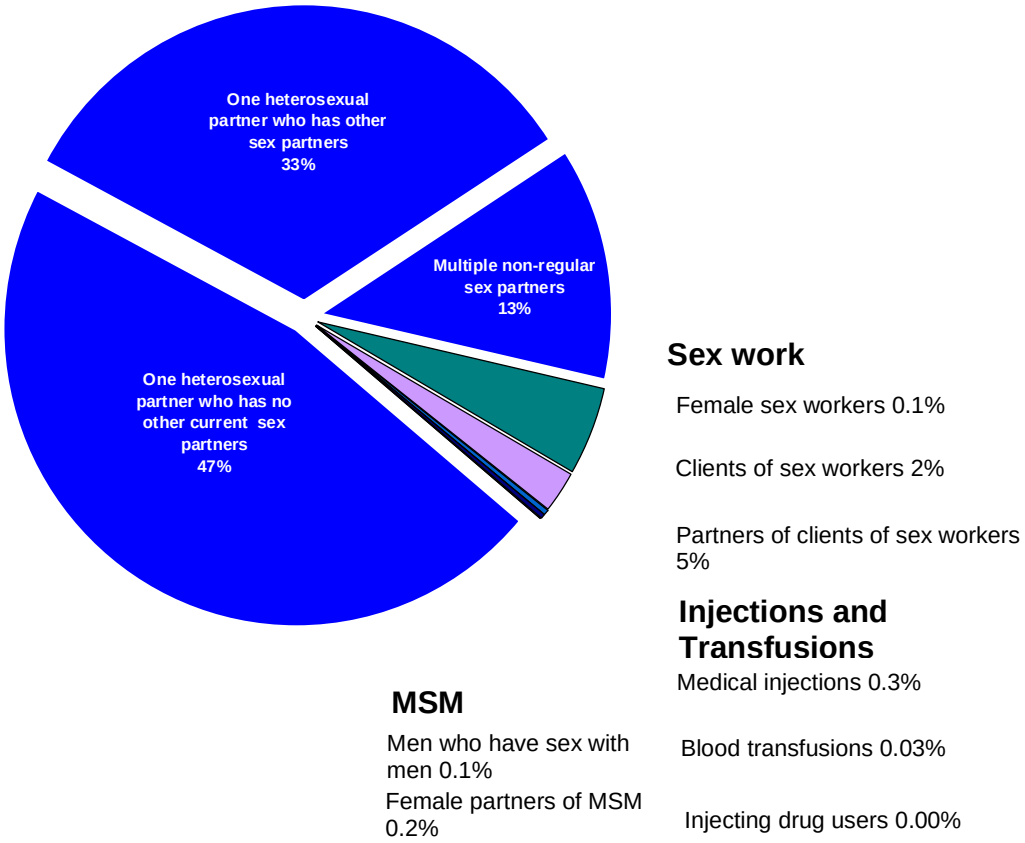



Men who have sex with men (MSM) are a well known high-risk group with very high incidence as has been evident globally since the onset of the epidemic. Data from a study which used a snowball sampling method identified 200 MSM in urban centres of Malawi, and this group had an HIV prevalence of 21%. This is particularly important because high-risk unprotected sexual contact between MSM was prevalent in the group. Many of these men have female sexual partners, thereby increasing the likelihood of HIV transmission to their female partners. Effort has to be made to reach out to MSM and their female sexual partners with appropriate prevention interventions.

### 2.2.8 Sources of new HIV infections

While certain sub-groups within Malawi have a very high HIV prevalence, it is important to recognise that most new infections arise from long-term stable sexual relationships as demonstrated in the Modes of Transmission Model in Figure 3.

**Figure 3 – Estimate of new HIV infections in Malawi 2007**




Based on this model, other sources of new infections include multiple non regular sexual relationships, MSM and sex workers. Clearly, partner concurrency, spousal discordancy, and prevention of HIV transmission through blood and blood products require very different prevention approaches in order to optimally reduce transmission in Malawi.

## 2.3 Factors facilitating HIV transmission in Malawi

As noted above, there are several well-documented factors that facilitate further spread of HIV in Malawi. These include: multiple and concurrent sexual partnerships; discordancy in long-term couples; low prevalence of male circumcision; low and inconsistent condom use; suboptimal implementation of HIV prevention interventions within clinical arenas; late initiation of HIV treatment. Other cross-cutting determinants including transactional sex related to income and other social and material benefits; gender inequalities/imbalances including masculinity, harmful cultural practices; stigma and discrimination and prevalence of male circumcision. Presented below is a summary of key factors that predispose people to HIV infection in the country and have been presented in terms of extent to which they are contributing to new infections.

### 2.3.1 Multiple and concurrent sexual partnerships

Multiple and concurrent sexual partnerships with low condom use is the most important factor driving the HIV epidemic in Malawi. In the 2004 MDHS for example, 27% of men and 8% of women reported having sex with a non marital, non cohabiting partner in the year prior to the survey and condom use was less than 50%. Among the sexually active 15-24 year olds, 62% of men and 14% of women engaged in sex with a non-marital, non-cohabiting partner.

With the generalized AIDS epidemic in Malawi, multiple and concurrent sexual partnerships which connect large numbers of people in a few but large sexual networks put many individuals at risk of HIV. This demonstrates that a person can be linked into a sexual network and at high risk of HIV infection even if that individual has only one partner, if that one partner is currently linked into sexual network or has been linked into one in the past. In order to develop more effective messages and interventions aimed at partner reduction, it will be important to have a strong understanding of the reasons why people engage in multiple concurrent sexual partnerships.

### 2.3.2 Discordancy in long-term couples (one partner HIV-negative and one positive)

HIV transmission between discordant couples in long-term relationships has been noted as one of most important modes of transmission in Malawi, being estimated to account for slightly less than 50% of all new infections. This discordancy occurs in stable partnerships where one partner becomes infected either prior to marriage or when engaging in sexual activity outside the marital relationship. Overall, evidence from several studies indicate that the annual rate of transmission within discordant couples is relatively high, at about 5-10% per year, making this population a high-risk group. Specific interventions have to be designed and implemented to address discordancy.

### 2.3.3 Late initiation of ART

Malawi's national ART programme has been successful in scaling up access to treatment. As of December 2008, about 148, 000 individuals were alive and on ART. However, most people in Malawi start treatment at a late stage of their condition when they have already developed clinical recognisable signs and symptoms of opportunistic infections. It must be noted that people who are HIV positive and are not on ART become highly infectious when they indulge in unprotected sex. Early initiation of ART is a very crucial secondary HIV prevention intervention because it lowers viral load in PLHIV. HIV Testing and Counselling services should therefore be promoted and made available in order to increase access and those found positive are timely referred to ART services.

### 2.3.4 The TB/HIV Co-epidemic

The HIV and AIDS epidemic in Malawi has resulted in a rise in the number of new tuberculosis cases in the past twenty years. The upsurge of TB notifications and TB case rates is partly due to improved case detection within a revitalised TB control programme. However, the most important reason is HIV infection. Tuberculosis is one of the leading causes of adult illness and death in PLHIV and its greatest impact is on the poor. Although up to 28,000 TB cases are reported annually, of which 77% are co-infected with HIV, the TB and HIV and AIDS control programmes have largely implemented activities independent of each other (Kwanjana *et al.* 2001). There is demonstrable evidence on effectiveness of joint TB and HIV and AIDS intervention on reducing morbidity and mortality among the dually TB/HIV infected people. Close to 90% of TB patients in

2008 accessed HTC services either within or outside facilities providing TB services (Ministry of Health, 2009. There is need for the two programmes to closely work together in order to strengthen their capacity to develop, implement and monitor collaborative TB/HIV activities.

### 2.3.6 Low and inconsistent condom use

Low and inconsistent condom use is one of the key factors driving the epidemic. Although the proportion of people using male and female condoms has risen over the last several years, the uptake is still low: Only 57.2% of males and 37.5% of females report using condoms the last time they had sex with a non-regular, non-cohabitating partner. Attitudes towards condom use have generally been negative among high-risk groups and the general population. There are still considerable myths and misconceptions about condoms at community level. Condoms are sometimes associated with promiscuity, commercial sex, or distrust of one's partner, and are also perceived by some to reduce sexual pleasure.

Some individuals reportedly believe that condoms are ineffective. In addition, some people in a new relationship may start with condom use in the initial stages only to abandon them later once *'trust'* appears to have been developed between the partners. Given that most of new adult infections are estimated to occur within the context of long-term discordant couple relationships, correct and consistent condoms use can therefore lead to low risk perception.

### 2.3.7. Suboptimal implementation of HIV prevention within clinical settings including provision of HTC

Malawi has made tremendous progress over the last few years in scaling up HTC and PMTCT services as HIV prevention interventions. By the end of 2008, there were 636 sites offering HTC services and cumulatively about 3 million people have so far tested for HIV and got results. A total 88% of 544 health facilities were providing PMTCT services in Malawi. This led to an increase in the number of pregnant women accessing HIV testing and counseling from only 320 in the year 2002 to 405,694 mothers by December 2008 representing 87.8% of all first time ANC visits. The percentage of pregnant women who tested HIV-positive accessing ARV prophylaxis or ART increased from 26% in 2007 to 81.2% in 2008. Fifty-five percent (55%) of exposed infants received ARV prophylaxis.

Access to HTC and PMTCT services are still limited in some settings and to certain sub-populations as a result some people do not get tested for HIV. The 2007 monitoring report indicated that more women more women accessed HTC services than men. In such situations, most pregnant women who are HIV positive fail to access PMTCT services to protect their babies from HIV infection. Some of these individuals form new sexual relationships and begin to have unprotected sex, thereby infecting other people.

There is also a low uptake of post-exposure prophylaxis (PEP), an intervention which should be available to all who have been subject to coerced sex or occupational exposure. The issue of PEP is an unknown intervention to most Malawians. Provision of HTC, PMTCT and PEP has to be scaled-up and promoted. In addition, treatment of STIs, provision of safe blood and blood products and

ensuring adherence to standards of infection prevention and injection safety have to be promoted and provided.

### 2.3.8 Other determinants facilitating transmission of HIV

Other determinants facilitating further spread of the HIV in Malawi include transactional-sex related to income and other material benefits; alcohol and drug abuse; poverty; intergenerational sex, mobility, low education levels, and stigma and discrimination against PLHIV and those perceived to be HIV positive:

- **Transactional sex:** Although sex work exists in Malawi, transactional sex is primarily informal where women enter into sexual relationships with men to secure basic necessities such as money, food and clothing.

- **Gender inequalities:** Ethnographic studies in the country highlight the relative disempowerment of women and widespread poverty which contributes to women's vulnerability to HIV and AIDS. Due to gender inequalities coupled with poverty, some women and girls indulge in transactional sex thereby being exposed to HIV infection. Women and girls are also victims of gender-based violence like rape, and they are often unable to negotiate condom use with their sexual partners. This situation has predisposed a lot of women and girls to HIV infection. In addition, because of male dominance in certain situations, women are unable to access HIV and AIDS services such HTC and PMTCT without the approval of their partners. Men also engage in multiple and concurrent sexual partnerships because of the behaviour and belief that it is through multiple sexual relationships that they can prove they are real men.

- **Harmful cultural practices:** In Malawi, there are a number of cultural practices which continue to enhance HIV transmission for example, *chokolo* and *kulowakufa*. There are also other beliefs that force widows to have sex with their brothers in-law to cleanse the deceased spirits. In some areas, adolescents undergoing initiation ceremonies are told to experiment with sex as a sign of adulthood. Still in some areas girls are given as *bulageti la mfumu* to a visiting chief. These practices and beliefs are associated with unprotected and earlier sexual activity which increases the risk of contracting or transmitting HIV. Studies have shown that adolescents who have been initiated are more likely to be sexually experienced than those not initiated and condom use in these groups is rare. Although relative contribution to HIV transmission of these cultural practices is small, it must be noted that with the prevailing multiple sexual networks, its contribution can indirectly be significant.

- **Stigma and discrimination:** PLHIV continue to be stigmatised in their communities, at workplace, as well as places of worship and others. For fear of stigma and discrimination some people fail to go for HTC. Those found positive even fail to disclose their HIV status publicly. As a result such people continue to have sexual relationships without disclosing their status to their partners and end up infecting their sexual partners or being re-infected. Strategies have to be designed to address stigma and discrimination.

- **Prevalence of male circumcision:** There is a large body of literature, including several randomised controlled clinical trials done in South Africa, Kenya and Uganda, which demonstrate that male circumcision can significantly reduce not only the risk of HIV acquisition among men by more than 50%, but also dramatically reduce the incidence of other conditions such as human papillomavirus, which is the predominant cause of penile and cervical cancer, the leading cause of cancer deaths for women in Malawi. Based on this evidence, WHO has recommended circumcision as part of a comprehensive package of HIV prevention.

  Prevalence rate of male circumcision in Malawi is 21%. Currently, male circumcision is being performed in some health facilities. It is also offered in some communities as part of initiation ceremonies or for religious reasons. In some traditional and religious settings male circumcision is reported to be unsafe as one blade is sometimes used to perform more than one operation, thereby exposing young men to HIV infection. There is need, therefore, to finalise the situation analysis on male circumcision which will inform policy and programming of male circumcision in Malawi.

The above determinants are systemic and contextual in nature and need to be addressed broadly. For example, legal and structural changes have to be made in order to address women's sexual and reproductive health rights and the rights of PLHIV. Approaches to address these broader issues need to consider feasibility, equitable coverage and sustainable impact relative to other interventions.

## 3.0 HIV PREVENTION RESPONSE IN MALAWI

### 3.1 Coverage and effectiveness of HIV prevention programmes in Malawi

Evidence from population based surveys and qualitative research suggests substantial behaviour change in Malawi since the 1996 MDHS. These changes are apparent across all regions and are likely associated with the observed declines in HIV prevalence in urban ANC attendees as well as the national HIV adult prevalence. Some of the positive changes achieved are reduction in the number of people buying sex; reduction in the number of multiple sexual partners; slight increase in the number of people using condoms; increase in the number of median age of sexual debut; increase in number of people going for HIV testing and accepting results; and universal awareness of HIV and AIDS.

The changes in high risk behaviours are a result of various prevention interventions which have been implemented at different levels using the National Behaviour Change Interventions Strategy that guided prevention efforts in Malawi from 2003 to 2008. Some of the interventions which have been implemented are:

#### 3.1.1 Behaviour change communications

Advocacy, IEC, Community and Social mobilisation interventions have been implemented throughout the country. On average about 2.5 million printed communication materials have been produced and disseminated each year. Over 2,000 radio and television programmes are produced and aired; and thousands of community-based campaigns, dialogue sessions with traditional leaders, role modelling sessions, video shows and drama sessions have been conducted. These interventions have assisted in raising universal awareness on HIV and AIDS. They have also assisted in mobilising people to go for HTC, PMTCT, PEP and other clinical based HIV prevention interventions. Deliberate emphasis has been put on interpersonal type of communication which allows instant feedback with intended audiences. This has enhanced increased knowledge and effective dialogue on HIV and AIDS.

Nevertheless, the intensity and quality of behaviour change communications interventions are still low especially in rural and hard to reach areas where majority of the population live. Most of the community based organisations which conduct campaigns, community dialogue and sensitisation activities have not been evenly distributed throughout the country. Furthermore, the information and messaging is still generalised and not audience specific.

#### 3.1.2 Teaching of life skills education and peer education

Some of the HIV prevention interventions for young people have been life skills and peer education. The Government and its stakeholders have been teaching life skills education targeting out-of-school and in-school youths. Teachers, patrons and youth club leaders at various levels have also been taught life skills education. In addition to life skills, peer education sessions, guidance and counselling and mentoring have been conducted countrywide where young people debate and dialogue about HIV prevention issues that affect them. Special life skills are provided to people with disabilities for example production of HIV and AIDS materials in braille.

The number of in-school youth trained in life skills education has increased. Currently, over 3 million primary school pupils and over 250, 000 secondary school pupils are taught life-skills education each year. Out-of-school youths are also targeted with life skills. The training in life skills education and peer education sessions have assisted youths to be assertive and empowered with right information on HIV and AIDS and be able to protect themselves from the virus. Over 12 million copies of various life skills materials have been produced and distributed countrywide. These include for example teachers' guides, training manuals, and supplementary reading booklets. The challenge with life skills is that some teachers do not teach life skills because they concentrate on examinable subjects and others consider teaching of sex and sexuality to children a taboo.

### 3.1.3 Advocacy sessions and community-based campaigns

A number of interventions on gender, culture and human rights related to HIV and AIDS have been implemented in Malawi. Some of the major interventions include advocacy sessions, community dialogue, orientation sessions and campaigns targeting policy makers, opinion leaders, men and women, youth as well as PLHIV. In addition, specific radio and TV programmes addressing issues of gender, human rights and culture have also been produced and aired. This is done in recognition of the fact that prevention efforts would not be successful if the underlying determinants of vulnerability to HIV infection are not addressed and the rights of PLHIV, people with disabilities and women are not respected, promoted and protected. While these interventions have made significant impact, the coverage and reach is still low. Specifically, involvement of men on gender promotion is still limited, engagement of traditional leaders to modify or eliminate some cultural practices is still a challenge, and laws related to violation of human rights for PLHIV are rarely enforced. The coverage and reach for interventions for people with disabilities is also low and limited in scope.

### 3.1.4 Condom programming

Condom programming interventions in Malawi include procurement of free and socially marketed condoms, training of service providers, promotion campaigns, distribution to end users through various outlets such as saloons, shops and workplaces. Condoms have also been distributed in the communities through community-based distribution agents (CBDAs) of which some are young people. As at December 2008, over 20 million male condoms and about 200, 000 female condoms were distributed in the country. In addition, one-on-one education sessions on correct condom use have been done. Various IEC materials including radio and TV programmes have also been produced and aired aimed at educating people on the benefits of condoms and dispelling rumours and myths surrounding their use. A series of training programmes on condom promotion, storage, usage and disposal have also been conducted targeting health service providers as well as non-health service providers such as youth, CBDAs, shop owners, saloon hair dressers and traditional birth attendants. Major challenges in condom programming have been supply chain management and inconsistent and incorrect condom use by those engaged in high risk sex.

### 3.1.5 HIV testing and counseling (HTC)

HIV testing and counselling service has been intensified in Malawi. The number of sites offering HTC services has increased from only 14 in 2004 to 636 by end 2008. As a result over 3 million people have ever tested for HIV and received results, against an estimated 7 million Malawians of sexual reproductive age group. In 2008 alone, more than one million people tested for HIV and received results. Specific interventions connected with HTC have been community mobilization and promotion campaigns on the benefits of knowing one's status; routine HIV testing and counselling; National HTC Week; door-to-door and outreach HTC services using mobile vans. Other interventions in HTC have been training of both health and non-health workers to conduct HTC, particularly in rural areas and production of education materials including radio and TV programmes. One major challenge on HTC has been to reach the underserved areas.

### 3.1.6 Promotion of prevention of mother to child transmission of HIV

PMTCT services have continued to be offered in the country and is making substantial impact in preventing children from HIV from their infected mothers. The intervention has targeted women of child bearing age, HIV positive pregnant women, exposed children and their families. In 2008 a total of 405,694 women were counselled in PMTCT, tested and received their sero-status results. By December 2008 a total of 499 heath facilities were providing a minimum package of PMTCT including provider-initiated (routine) testing and counselling for HIV at ANC and provision of a single-dose Nevirapine for mother and exposed baby. Sixty four facilities out of 499 are providing combination regimen for PMTCT. A total of 24 PMTCT facilities are providing early infant diagnosis as a continuum of care after delivery.

By December 2008 a total of 4883 infants were tested for HIV using DNA PCR from dry blood spots of whom 20% tested positive by 9 months. Referral and follow-up of infants born to HIV positive mothers to ART services have been done, however most health facilities providing PMTCT are not providing early infant diagnosis of HIV, paediatric HIV counselling, and high quality infant and young child feeding counseling and other support. Therefore, to have maximum impact, the comprehensive package for PMTCT has to be scaled up to effectively reduce paediatric HIV transmission from HIV positive pregnant mothers to their babies.

### 3.1.7 Blood safety and infection prevention

In order to prevent HIV transmission through blood and blood products and other invasive instruments, the Government and partners have intensified screening of all blood and blood products in a quality assured manner before being transfused to any patient. All health facilities in Malawi screen blood and blood products before transfusion in accordance with the national guidelines for blood screening, storage, distribution and transfusions. This has assisted in reducing HIV transmission through blood and blood products and other invasive instruments in the health facilities. PEP is also provided in all health facilities offering ART. The major challenges in this intervention have been enforcement and adherence to blood safety and infection prevention procedure and standards. In addition, access to Post Exposure Prophylaxis (PEP) for people who have been exposed to contaminated blood and blood products is still very low.

### 3.1.8 STI management

Early treatment of all STIs is one way of minimizing possible exposure to HIV infection if those with STIs indulge in unprotected sex. Currently, STI clients are treated, counselled and tested for HIV. Service providers have been trained in STI diagnosis and treatment according to national guidelines. Service providers have also been trained on how to link STI clients to HIV and AIDS services. For example, in 2008 alone a total of 11, 079 STI clients were treated and referred for HIV and AIDS services. Series of education sessions on the dangers of STI as they relate to HIV and AIDS have been conducted at health facilities throughout the country. Major challenges in STI management have been stock-outs of drugs, unwillingness of clients to access STI services due to self stigma and discrimination leading to late presentation to treatment.

### 3.1.9 Education campaigns against stigma and discrimination due to HIV

The effect of stigma and discrimination on PLHIV or those perceived to be positive has posed a challenge in HIV prevention efforts. Due to stigma and discrimination in the country, some people have failed to access condoms, HTC, PMTCT, STI and PEP services. On stigma and discrimination the following interventions have been implemented: PLHIV support group therapy sessions, community campaigns and dialogue sessions, production and airing of radio and TV programmes with specific focus on positive living, and promotion of HTC and PMTCT services involving PLHIV. The major challenge in fighting stigma and discrimination has been lack of comprehensive knowledge about HIV and AIDS that continue to perpetuate myths and misconceptions about the epidemic.

### 3.1.10 Workplace prevention interventions

Development and implementation of HIV and AIDS workplace interventions has been another critical area of focus in HIV prevention. Most public and private institutions implement HIV prevention workplace programmes targeting their employees, their spouses and surrounding communities. Major prevention initiatives have been peer education sessions, condom promotion and distribution to employees, production and dissemination of IEC materials, HTC and referrals to ART services. The major challenges facing workplace HIV prevention interventions have been quality and reach.

## 4.0 GOAL, STRATEGIC OBJECTIVES AND GUIDING PRINCIPLES

### 4.1 Goal

The overarching goal is to reduce new HIV infections in order to further mitigate the burden and impact of HIV and AIDS in Malawi

### 4.2 Strategic objectives

a) Reduce sexual transmission of HIV
b) Prevent mother-to-child HIV transmission of HIV
c) Prevent HIV transmission through blood, blood products and invasive instruments.

### 4.3 Strategic Objectives for cross-cutting issues

a) Increase access to quality of and linkages between services and interventions.
b) Address the cultural, social and economic environment to support reduction of HIV risk and vulnerability.
c) Promote legal and human rights issues that reduce HIV risk and vulnerability.
d) Increase the capacity and strengthen systems and structures to support, manage, expand and sustain the national prevention response.
e) Monitor and evaluate the national prevention response.

### 4.4 Guiding principles

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

a) **Strong and visible leadership** for the HIV prevention response at national, Local Assembly, institutional and community-levels
b) Based on local, national and international **best practices** and **flexible and responsive** to incorporating new evidence
c) **Observance of human rights-based approaches** to HIV programming
d) Adherence to meaningful involvement of People Living with HIV (**PLHIV**)
e) **Gender responsive** programming, information and service delivery
f) Prioritization of prevention responses based on **effectiveness** and ensure **equitable**, **epidemiologically-sound** distribution of resources
g) Adherence to the **"Three One's" Principle**: One national coordinating authority, one national action framework and one monitoring and evaluation plan
h) Alignment with national, regional and international **declarations and commitments**
i) **Integration** of HIV preventive services into the overall health care response
j) **Multi-sectoral approach** to HIV prevention policies and programming including civil society

## 5.0 STRATEGIC OBJECTIVES, APPROACHES AND BROAD ACTIVITIES

In order to address all the three strategic objectives, including those under cross-cutting issues various broad activities will be implemented. During implementation, all strategic approaches and broad activities will be linked and integrated with one another in a cohesive manner to maximize impact.

### 5.1 Strategic Objective 1: Reduce sexual transmission of HIV

| Strategic Approaches | Broad Activities |
|---|---|
| 5.1.1 Reduce multiple and concurrent sexual partners among adults | • Conduct formative research to better understand reasons why men and women engage in multiple and concurrent sexual partnerships in Malawi.<br>• Develop a communication plan and accurate, appropriate, consistent, localised, gender responsive and targeted messages on multiple and concurrent sexual partnerships<br>• Conduct community mobilization and community based empowerment education programs on linkages of harmful cultural practices and beliefs to HIV infection<br>• Produce and disseminate appealing and entertaining messages and communication materials on sex and sexuality that incorporate story-telling and self-identification of intended audiences<br>• Conduct community level mutual faithfulness campaigns targeting influential community groups, sexual partners and individuals<br>• Provide sex and sexuality education including issues of masculinity for couples, focusing on increasing self-efficacy, perceived susceptibility, and self standards and identity on multiple and concurrent sexual partnerships<br>• Produce information, education and communication on the dangers of multiple and concurrent sexual partnerships |

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| | | • Provide training and support to both religious and traditional leaders and other opinion leaders in the communities on the appropriate sexual behaviours and dangers of multiple and concurrent sexual partnerships<br>• Promote awareness on the relationship between alcohol and drug use and increased HIV risk behaviours<br>• Strengthen male involvement in HIV prevention, promoting positive role models among males and<br>• Develop male circumcision policy, interventions and communication guidelines based on international and local evidence.<br>• Target prevention messages and interventions to men who have sex with men and their female partners<br>• Provide gender responsive and sensitive peer education on sex and sexuality for both adults and youth |
| 5.1.2 | Reduce high risk and multiple and concurrent sexual partnerships among youth | • Provide youth friendly health services<br>• Provide life skills education for in and out-of school youth including communication and negotiation skills |
| 5.1.3 | Reinforce both primary and secondary abstinence as prevention options for young people | • Promote role models to increase self esteem<br>• Improve personal risk perception, particularly about risk of multiple concurrent sexual partnerships and risk of HIV transmission per sex act<br>• Improve access to and use of male and female condoms and provide honest and consistent messaging about condom effectiveness |
| 5.1.4 | Scale-up positive prevention among PLHIV | • Intensify HIV testing counselling and including couple counselling<br>• Increase disclosure of sero-status to sexual partners |

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| 5.1.5 | Reduce HIV transmission among HIV-discordant partners | • Promote 100% condom use among discordant couples<br>• Increase knowledge and positive attitudes and decrease misconceptions about HIV and AIDS among discordant couples<br>• Strengthen STI diagnosis and treatment programmes and linkages to prevention and treatment programmes<br>• Provide accurate information on the stereotypes about who is at risk to HIV infection, denial, fatalism and misconceptions about HIV and AIDS |
| 5.1.6 | Increase condom use among transactional, commercial, discordant, multiple and concurrent sexual partners | • Provide condoms and other prevention products to "vulnerable populations"<br>• Target prevention messages and interventions at sex workers and their clients |
| 5.1.7 | Reduce intergenerational sex | • Promote workplace programmes to reduce transactional and non-consensual sex<br>• Target prevention messages and interventions among the "elite" wealthier and better educated sub-section of the population<br>• Enforce by-laws and social and cultural norms that discourage intergeneration sex and protect vulnerable youth |

## 5.2 Strategic Objective 2: Prevent Mother-to-Child transmission of HIV

The focus under this objective is to reduce the number of paediatric HIV infections while at the same time improving survival of all HIV-exposed infants, infected children and parents living with HIV.

| Strategic Approaches | Broad Activities |
|---|---|
| 5.2.1 To provide universal HIV testing and counselling *(including provider initiated testing and counselling)* for women and their partners, adolescents in child bearing age | • Scale up access early infant diagnosis at all PMTCT sites in all the districts<br>• Scale up HIV Testing in hard to reach areas in all the districts through door to door, outreaches and mobile approaches<br>• Train health workers to provide both paediatric and adult HIV counselling and testing services as well as psychosocial support, especially for children<br>• Produce IEC materials on HTC<br>• Conduct advocacy sessions on HTC |
| 5.2.2 Increase access to and quality of PMTCT services | • Provide PMTCT IEC materials in all locations offering primary health services<br>• Support additional facilities to adopt national PMTCT guidelines and guidelines on breastfeeding<br>• Establish new PMTCT sites and train more PMTCT service providers |
| 5.2.3 Strengthen linkages between PMTCT, ART, prevention, reproductive health, maternal and child health, and primary | • Provide HTC, PMTCT and adult and paediatric ART as a comprehensive package for women and all family members in a single location |
| 5.2.4 Increase access to family planning and HIV prevention services for HIV-positive women of child-bearing age | • Strengthen HIV testing and PMTCT service provision at all family planning service delivery points<br>• Refer all HIV-positive and post-pregnancy women to family planning |

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| 5.2.5 Provide comprehensive PMTCT, care, treatment and support to HIV positive pregnant and lactating women and their families | • Scale up PMTCT services through triple therapy combination regimen and infant and young child feeding counselling training at all health facilities providing maternal and child health services<br>• Train health workers in all health facilities providing maternal and child health services |
| 5.2.6 Provide care and support to all HIV exposed infants at facility and community levels | • Scale up paediatric HIV care for HIV exposed infants by linking to cotrimoxazole prophylaxis services, early infant diagnosis, HIV counseling services and referral to ART<br>• Produce IEC materials on the benefits of HTC and on treatment literacy for HIV exposed infants |
| 5.2.7 Promote integration of PMTCT with HTC and ART services | • Provide comprehensive clinical-based prevention services that are family-focused and involve active male participation including couples |
| 5.2.8 Promote male and community involvement in PMTCT | • Produce IEC materials targeting men and community leaders on PMTCT<br>• Engage men and community leaders in PMTCT services at various levels |

### 5.3 Strategic Objective 3: Prevent transmission of HIV through blood, blood products and medical procedures

| Strategic Approaches | Broad Activities |
|---|---|
| 5.3.1 Ensure 100% of blood supply accurately screened for HIV according to national screening and quality assurance standards | • Review guidelines on blood safety<br>• Train laboratory technicians in quality control and assurance<br>• Screen all blood, blood products and tissue products for HIV<br>• Sensitise people on the existing policies and procedures on blood donation<br>• Sensitise people on how to access safe donated blood<br>• Provide adequate disposable materials as well |

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| | | as sterilising equipment for non disposable materials at all health care facilities |
| 5.3.2 | Promote implementation of infection prevention measures in all health facilities | • Disseminate appropriate information on the dangers associated with the use of unsterilised skin piercing materials<br>• Regularly update guidelines on infection prevention and waste disposal management and disseminate to all health care facilities<br>• Train traditional healers, Traditional Birth Attendants and traditional initiation counsellors on use of sterile skin piercing materials<br>• Provide adequate facilities for appropriate disposal of used disposable materials at all health care facilities |
| 5.3.3 | Ensure access to post-exposure prophylaxis (PEP) for people who have been exposed to contaminated blood products and medical procedures | • Provide PEP to all victims of rape and defilement or coerced sex and those accidentally exposed to HIV<br>• Develop and disseminate IEC materials on PEP to all health facilities and the general public |

## 6.0 Cross-cutting Issues

As discussed earlier, the cross-cutting issues are those factors which will be addressed in this strategy in order to create enabling environment for Malawians to change and sustain their positive behaviours. These issues include gender, human rights, culture, legal, TB and HIV co-infection and capacity building.

### 6.1 Cross-cutting objective 1: Increase access to quality of, and linkages between services and interventions

| Strategic Approaches | Broad Activities |
|---|---|
| 6.1.1 Improve access to HIV preventive services within existing services at point-of-care settings including ART, PMTCT, STI, reproductive health, MCH and blood donation facilities | • Identify best practices for integrating HIV prevention with other services and scale-up nationally<br>• Scale-up support groups for prevention and positive living<br>• Strengthen District AIDS Coordinating Committees (DACC), Community AIDS Coordinating Committees (CACC) and Village AIDS Coordinating Committees (VACC) to carry out prevention activities<br>• Develop male circumcision policy, intervention and communication guidelines based on international and local evidence<br>• Develop referral guides to link people to different services in the health centers and communities<br>• Conduct community level education sessions on the importance of timely initiation to ART to those found HIV positive |
| 6.1.2 Ensure community involvement and ownership | • Mobilise communities to actively participate in HIV prevention activities<br>• Link community-based groups with health services to support both facility and community-based prevention activities |
| 6.1.3 Improve access to HIV prevention services among underserved populations and communities | • Develop gender sensitive tailored interventions for populations who are vulnerable to HIV infection because they cannot access information and services through traditional means (e.g. people with disabilities, mentally challenged, orphans, |

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| 6.1.4 | Improve access to HIV prevention services among wealthier and educated people | street kids, etc)<br>• Develop and implement gender resposive tailored interventions for populations who are wealthy and more educated at a time and in settings where they most frequently patronise e.g. clubs, bars, hotels, casinos and other places of entertainment and work |
| 6.1.5 | Improve access to HIV prevention services and products to vulnerable populations | • Develop tailored interventions for populations who are vulnerable to HIV infection because of their behaviours or environments (sex workers, MSM, prisoners, etc)<br>• Engage the media in promoting prevention interventions |
| 6.1.6 | Strengthen capacity of health workers to develop, implement and monitor collaborative TB and HIV prevention programmes | • Provide TB, HIV and AIDS prevention, care and support services as an integral part of a comprehensive package of care for TB/HIV infected persons<br>• Provide a framework for planning, organizing, implementing, monitoring and evaluating delivery of TB, HIV and AIDS intervention<br>• Provide HTC to TB patients<br>• Provide ART to eligible TB/HIV patients<br>• Provide CPT to TB/HIV patients<br>• Provide routine TB screening by all HTC counsellors<br>• Conduct HIV surveillance among TB patients |

## 6.2 Cross-cutting objective 2: Address the cultural, social and economic environment to support reduction of HIV risk and vulnerability

| Strategic Approaches | Broad Activities |
|---|---|
| 6.2.1 Reduce risk of HIV transmission through harmful cultural practices | • Build capacity of traditional and religious leaders and other local opinion leaders to speak against harmful cultural practices, beliefs and norms that perpetuate sexual transmission of HIV while reinforcing cultural practices that are positive<br>• Provide material and financial support to community structures for community mobilisation against harmful cultural practices and promote positive ones<br>• Promote role models in the communities to increase visibility of AIDS |
| 6.2.2 Reduce HIV stigma and discrimination | • Advocate for prominent leaders and PLHIV to act as role models in promoting HIV testing and counselling, partner disclosure, and HIV risk reduction behaviours<br>• Train PLHIV in communication and negotiation skills on positive living<br>• Produce communication materials for PLHIV addressing self-esteem, self-efficacy and perceived risk related to positive living<br>• Conduct community mobilisation on the negative effects of stigma and discrimination both to PLHIV and communities<br>• Promote involvement of PLHIV in policy development, public discussions and HIV and AIDS campaigns<br>• Adopt best practices in reducing and monitoring stigma and discrimination<br>• Mobilise leadership to tackle all forms of stigma and discrimination |

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| 6.2.3 Increase disclosure of sero-status to sexual partners | • Expand and strengthening the reach of support groups for PLHIV<br>• Advocate for prominent leaders to disclose their HIV status |
| 6.2.4 Increase community-level access to reproductive health services, family planning, HTC and PMTCT | • Expand communication about HIV and AIDS among politicians, businessmen and community leaders |
| 6.2.5 Reduce gender-based violence and sexual harassment | • Conduct community mobilisation and empowerment sessions on gender<br>• Conduct education sessions on negotiation skills, relationship norms, perceived trust and self efficacy targeting especially women and girls<br>• Promote social norms that reduce demand for transactional sex<br>• Promote role models in gender among men and boys |
| 6.2.6 Enhance opportunities for women and girls | • Promote alternative livelihood options for sex workers and vulnerable women and girls<br>• Engage the media in accurately addressing cultural, social and economic issues related to HIV including stigma and discrimination<br>• Produce IEC materials addressing issues of culture, gender-based violence, stigma and discrimination |

### 6.3 Cross-cutting objective 3: Promote legal and human rights issues that reduce HIV risk and vulnerability

| Strategic Approaches | Broad Activities |
|---|---|
| 6.3.1 Advocate for the enactment of an HIV and AIDS law following international best practices | • Lobby Parliamentarians to enact HIV and AIDS and sexual health legislation that conforms to international best practices |
| 6.3.2 Promote HIV and AIDS, and sexual health-related legislation | • Lobby Local Authorities to enforce HIV and AIDS and sexual health legislation that conforms to international best practices |
| | • Promote awareness among community members regarding their rights and responsibilities pertaining to HIV and AIDS and sexual health |
| | • Lobby enforcement of laws regarding sexual harassment, raising the age of sexual consent, and inheritance and land rights for women |
| | • Build capacity of the media so that it reports issues of HIV and AIDS and sexual health legislation in a responsible and accurate manner |
| | • Engage human rights organizations, government and civil society in HIV and AIDS and sexual health issues |
| | • Strengthen the Victim Support Units to |

### 6.4 Cross-cutting objective 4: Increase the capacity and strengthen systems to support, manage, expand, and sustain the national prevention response

| Strategic Approaches | Broad Activities |
|---|---|
| 6.4.1 Ensure leadership, ownership and sustainability of the national HIV prevention response through the following: | • Mobilizing communities to actively take part in HIV prevention |
| • Office of the President and Cabinet provides oversight for the implementation of the National HIV Prevention Strategy including government policies and legislation that | • Build capacity of Department of Nutrition, HIV and AIDS to provide overall high level advocacy and oversight in the implementation of the National HIV Prevention Strategy including government policies and legislation that |

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| support the successful implementation of prevention activities | support successful implementation of HIV prevention activities |
| • High-level ownership and leadership within NAC mandated to coordinate and lead implementation of the National Prevention Strategy | • Build capacity of NAC to coordinate and lead the implementation of the HIV prevention strategy |
| • High-level ownership and leadership within various Government ministries mandated to manage and oversee implementation of the overall National Prevention Strategy | • Disseminate and sensitize stakeholders on the National HIV Prevention Strategy |
| • Provide greater opportunity for local participation, action, management and accountability of prevention interventions | • Build capacity of local structures such as DACCs, CACCs, VACCs to plan and implement HIV prevention activities |
| • Community-level ownership with strong involvement of faith-based leaders, PLHIV support groups, women's groups , and other civil society organizations | • Provide IEC and localized data relevant to the communities |
| • Strong Local Authority involvement in developing prevention action plans and advocating for resources | • Disburse funds timely for the implementation of HIV prevention activities |
| • Prevention activities incorporated into the District Implementation Strategy | • Develop local assembly specific work plans on HIV prevention<br>• Provide technical assistance on HIV prevention to local assemblies and communities |
| • Specified departments within the Ministry of Health mandated to implement and | • Review policies, frameworks and guidelines relating to HIV prevention |

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| oversee each of the three Strategic Objectives of the National Prevention Strategy | • Mainstream HIV prevention activities in all government ministries, departments and agencies |
| 6.4.2 Ensure adequate financial resources are available to build infrastructure and implement HIV preventions activities at national, Local Authority and community levels | • Cost the national HIV prevention response<br>• Mobilize resource from Government and development partners |
| 6.4.3 Ensure availability of dedicated and trained staff at all levels to lead and implement the HIV prevention response at all levels | • Build capacity in HIV preventions at all levels |

### 6.5 Cross-cutting objective 5: Monitor and evaluate the national prevention response

| Strategic Approach | Broad Activities |
|---|---|
| 6.5.1 Develop district-level monitoring and evaluation skills | • Build capacity in M&E at all levels<br>• Build capacity for prevention-related operational research, data analysis and use |
| 6.5.2 Provide routine feedback of data to implementing and funding organizations | • Strengthen Local Authority Management Information Systems<br>• Develop community level HIV prevention data base<br>• Conduct national routine surveys on HIV and AIDS |
| 6.5.3 Make research, surveillance and monitoring and evaluation data available at the district and community-levels in a manner that is understandable and that allows them to build the findings into their prevention activities | • Disseminate relevant data to communities to guide planning and implementation of HIV prevention activities |

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| 6.5.4 Strengthen the capacity of community organizations to monitor their activities | • Build capacity of community organizations in research, M&E |
| 6.5.5 Localize data collection for community-specific evidence | • Develop district and community -level monitoring and evaluation plans |
| 6.5.6 Strengthen national surveillance and monitoring and evaluation systems to provide evidence for prevention policies, programmes and targets | • Incorporate research, surveillance and monitoring and evaluation data into the routine review of the national prevention response |
| 6.5.7 Adhere to a single prevention monitoring and evaluation plan | • Enforce adherence to single M and E plan |

## 5.0 COORDINATION MECHANISMS

### 5.1 Implementation

The effective implementation of the strategy will depend on the technical, material and financial support from the Government of Malawi and development partners. It will also rely on commitment from stakeholders at various levels. NAC will lobby and source various forms of support towards implementation of the strategy. The process will require building capacity of stakeholders so that they have requisite knowledge and skills to plan, implement and monitor prevention interventions. The Government through NAC will also work with key lead agencies and other coordinating organisations so that they continue to provide technical directions in HIV prevention programming. During the course of implementation, special attention will be paid to emerging issues so that they are incorporated and addressed depending on the evidence.

For accountability purposes in HIV prevention in Malawi and at the same time adhering to the '*Three Ones principle'*, NAC will provide leadership and coordinate the implementation of the strategy. However, implementation of various components of the strategy will be housed to mandated line government ministries and coordinating organizations.

### 5.2 Monitoring, evaluation and research

In order to track progress made and impact achieved in HIV prevention, NAC will monitor the epidemic and the national response at various levels. The Commission will analyse data and information on HIV prevention and disseminate it to policy makers, programme planners and the general population. All implementing partners including key lead agencies, line ministries and NGOs will be expected to monitor progress of their interventions and assess outcome and impact made based on the indicators presented in the strategy.

Data and information emanating from the implementation of the strategy will be disseminated during joint reviews, research dissemination conferences, best practice conferences, technical working group meetings and other sessions NAC and partners will organise. The Commission will ensure that such data and information dissemination sessions are also conducted at Local Authority level. Specific research studies including those on emerging issues will be commissioned to provide evidence for further programming and prioritisation of interventions.

## 6.0 INDICATORS

The strategy has provided very comprehensive impact, outcome, input and output indicators that will be tracked during the implementation of the strategy. It has also presented targets for the year 2012. The presentation of 2012 targets took into consideration the current Universal Access targets for Malawi, trends in progress in HIV prevention intervention over the past few years, current progress and the need for re-alignment of the strategy to other strategic documents in Malawi like NAF. The target also considered interventions which are being planned and availability of resources. Achievement of these indicators and set targets will depend on the total commitment from different stakeholders at various levels as well as resources mobilised and disbursed to implementers of HIV prevention interventions. The targets will be revised in 2012 in with the NAF.

**ANNEXES**

**ANNEX 1: National HIV Prevention Indicators and Targets**

| INDICATOR NAME | BASELINE (DHS 2004) | BASELINE Most recent | UA TARGET 2010 | TARGET 2012 | Source |
|---|---|---|---|---|---|
| **Impact and outcome indicators** | | | | | |
| **Prevention** | | | | | |
| HIV incidence rate among adult population (15-49) | | 1.6% (2007) | 1.4% | 1.0% | Incidence studies |
| % of sexually active population (15-49) who are HIV-infected | 14.20% | - | 12.80 % | 11.9% | DHS, SSS |
| Prevalence of HIV among pregnant women aged 15-24 years attending ANC | 14.3% | - | 12 % | 13.0% | SSS |
| % of infants born to HIV-positive mothers who are infected | - | 21% (2007) | - | 14.0% | EPP modelling |
| Prevalence of HIV among high risk populations | | (2006) | | | BSS |
| Female sex workers | - | 69.1 | - | 65% | BSS |
| Female police officers | - | 32.1 | - | 28% | BSS |
| Male police officers | - | 24.5 | - | 22% | BSS |
| Female Primary teachers | - | 21.6 | - | 20% | BSS |
| Male Primary teachers | - | 24.2 | - | 22% | BSS |
| Female border traders | - | 23.1 | - | 21% | BSS |
| Male estate workers | - | 19.5 | - | 18% | BSS |
| Male Secondary teachers | - | 17.6 | - | 16% | BSS |
| Female secondary teachers | - | 16.7 | - | 15% | BSS |
| Fishermen | - | 16.6 | - | 15% | BSS |
| Truck drivers | - | 14.7 | - | 13% | BSS |
| Female estate workers | - | 17.1 | - | 16% | BSS |
| Male vendors | - | 7.0 | - | 5% | BSS |

| INDICATOR NAME | BASELINE (DHS 2004) | BASELINE Most recent | UA TARGET 2010 | TARGET 2012 | Source |
|---|---|---|---|---|---|
| % of people in general population exposed to HIV and AIDS media campaign in the past 30 days | 80% males<br>66% females | - | 95%<br>95% | 99%<br>99% | DHS, MICS |
| % of sexually active population who have ever been tested for HIV and received results | 14.9% males<br>7.0% females | - | 75%<br>75% | 75%<br>75% | DHS, MICS |
| % of sexually active population who had sex with more than one partner in the last 12 months | Gen. Population<br>26.9% males<br>8%.3 females | - | 18%<br>5% | 9%<br>1% | DHS, MICS |
| % of sexually active population using condoms at last high-risk sex (sex with non-cohabiting or non-regular partner) | | Youth (15-24)<br>13.3% males<br>1.7% females | 10%<br>1.2% | 9%<br>1% | DHS, MICS, BSS (for high risk groups) |
| | Gen. Population<br>47% of males<br>30% of females | - | 60%<br>40% | 60%<br>40% | DHS, MICS |
| % of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV | 37% of males<br>25% of females | - | 75%<br>75% | 75%<br>75% | DHS, MICS |
| Median age at first sex among 15-24 year olds | 15 yr males<br>15 yr females | 18.1 yr males<br>17.4 yr females | 19.0 yrs<br>18.0 yrs | 19.5 yrs<br>18.5 yrs | DHS |
| % of patients with STI, who are diagnosed, treated and counselled at health care facilities according to national guidelines | - | 36% | 90% | 90% | HFS |
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| INDICATOR NAME | BASELINE (DHS 2004) | BASELINE Most recent | UA TARGET 2010 | TARGET 2012 | Source |
|---|---|---|---|---|---|
| % of persons discussing HIV and AIDS with spouse or partner | - | Males 87%<br>Females 70% | - | 100%<br>100% | DHS |
| % of population expressing accepting attitudes towards PLHIV | Males 29.7%<br>Females 30.8% | - | 75%<br>75% | 90%<br>90% | DHS |
| **Input and output indicators** | | | | | |
| **Prevention** | | | | | |
| # of information education and behaviour change communication materials disseminated to end users (Facilities and Grass roots) | | 904,381 (2007) | - | 3,500,000 | LAHARF |
| # of HIV/AIDS sensitization campaign meetings conducted | | 14 press briefings & public lectures (2006/7) | - | 20 | LAHARF |
| % of schools that provided life skills based HIV/AIDS education within the last academic years | | 6% (2002) | 100% | 100% | EMIS |
| # and % of young people exposed to LSE (in & out of school) | 1,419,065 | 3,200,000 (HERA, 2007) | 2,500,000 | 5,000,000 | EMIS, DHS |
| # of peer educators trained/retrained in the quarter | - | 667 (2006/7) | - | 800 | LAHARF |
| # of Peer Educators who are active in the quarter | - | 531(2006/7) | - | 750 | LAHARF |
| # of people counselled & tested for HIV, and receiving result in the last 12 months | 283,461 | 513,325 (2006) | 1,000,000 | 2,662,000[1] | DHS, MICS, HMIS |
| # and % of sites providing HTC services | 146 | 588 (2008) | 600 | 700 | HFS |
| # and % of health facilities with ANC services with at least the minimum package of PMTCT services | 36 (6.6%) | 499 (60%) (2008) | 574 (70%) | 656 (80%) | HFS |

[1] From Resource Needs Model

| INDICATOR NAME | BASELINE (DHS 2004) | BASELINE Most recent | UA TARGET 2010 | TARGET 2012 | Source |
|---|---|---|---|---|---|
| # and % of pregnant women attending ANC who are counselled, tested, and receive sero-status | 43,345 | 115,000 (25%) (MTR, 2007) | - | 480,000[2] (95%) | LAHARF |
| # and % of HIV+ pregnant women attending ANC who receive a complete course of ARV prophylaxis to reduce mother to child transmission | 2.3% | 13,109 (19%) ( MTR, 2007) | - | 52,000 (70%) | LAHARF |
| # of socially marketed condoms distributed to outlets in the last 12 months (Retail shops, Health facilities) | 29 million | 14 million | 17 million | 20 million 0.5 m female | LAHARF |
| # of (1) free condoms and (2) social marketed condoms distributed to end users in the last 12 months | - | 28 million Male 1,150,000 Female | 34 million 3,4 million | 48 million[3] 3.8 m female | HMIS |
| # of employees that have benefited from HIV/AIDS workplace programmes in the last 12 months – | - | 38,000 (2006) | - | 1,027,000[4] | LAHARF |
| # and % of health care facilities that apply national standards for infection prevention and health care waste storage and disposal | 8% | 29% (2008) | 98% | 98% | HFS |
| % of donated blood units screened for HIV in a quality assured manner | - | 69% (2008) | 98% | 100% | HMIS |
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## Annex II: ACTION PLAN FOR THE NATIONAL HIV PREVENTION STRATEGY, 2009-2012

### Strategic Objective 1: Reduce sexual transmission of HIV

| Strategic Approaches | Broader Activities | Key Lead Agencies |
|---|---|---|
| Reduce multiple and concurrent partners among adults | Conduct formative research to better understand reasons for why men and women engage in multiple and concurrent sexual partnerships in Malawi.<br><br>Develop a communication strategy and accurate, appropriate, consistent, localised gender responsive and targeted messages on multiple and concurrent sexual partnerships<br><br>Conduct community mobilization and community based empowerment education programs on linkages of harmful cultural practices and beliefs to HIV infection<br><br>Produce and disseminate appealing and entertaining messages and communication materials on sex and sexuality that incorporate story-telling and self-identification of intended audiences<br><br>Conduct community level mutual faithfulness campaigns targeting influential community groups, sexual partners and individuals<br><br>Produce information, education and communication on the dangers of multiple and concurrent sexual partnerships | MOE<br>MSDY<br>MIAA<br>MOH<br>MANET+<br>MANASO<br>NGOs<br>MoWCD |

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| | Promote awareness on the relationship between alcohol and drug use and increased HIV risk behaviours<br><br>Strengthen male involvement in HIV prevention, promoting positive role models among males<br><br>Develop male circumcision policy, intervention and communication guidelines based on international and local evidence.<br><br>Target prevention messages and interventions to men who have sex with men and their female partners<br><br>Provide gender responsive and sensitive peer education on sex and sexuality for both adults and youth | |
| Reduce high risk and multiple and concurrent sexual partnerships among youth | Provide youth friendly health services<br><br>Provide life skills education for in and out-of school youth | |
| Reinforce both primary and secondary abstinence as prevention options for young people | Promote role models to increase self esteem<br><br>Improve personal risk perception, particularly about risk of multiple concurrent sexual partnerships and risk of HIV transmission per sex act<br><br>Improve access to and use of male and female condoms and provide honest, consistent messaging about condom effectiveness | |

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| Scale-up positive prevention among PLHIV | Intensify HIV counseling and testing, including couple counseling<br><br>Increase disclosure of sero-status to sexual partners | |
| Reduce transmission of HIV among HIV-discordant partners | Promote 100% condom use among discordant couples<br><br>Increase knowledge and positive attitudes and decrease misconceptions about HIV and AIDS among discordant couples<br><br>Strengthen STI diagnosis and treatment programmes and linkages to prevention and treatment programmes | |
| Increase condom use among transactional, commercial, discordant, multiple and concurrent partners | Provide accurate information on the stereotypes about who is at risk to HIV infection, denial, fatalism and misconceptions about HIV and AIDS<br><br>Provide condoms and other prevention products to "vulnerable populations"<br><br>Target prevention messages and interventions to sex workers and their clients | |
| Reduce intergenerational sex | Promote workplace programmes to reduce transactional and non-consensual sex<br><br>Target prevention messages and interventions among the "elite" wealthier and better educated sub-section of the population<br><br>Enforce by-laws and social and cultural norms that discourage intergeneration sex and protect vulnerable youth<br>vulnerable youth | |

| **Strategic Objective 2: Prevent mother-to-child HIV transmission** | | |
|---|---|---|
| **Strategic Approaches** | **Broad Activities** | **Key Lead Agencies** |
| To provide universal HIV testing and counselling *(including provider initiated testing and counselling)* for women and their partners, adolescents in child bearing age | Scale up access to HIV testing in all districts, including early infant diagnosis at all PMTCT sites.<br><br>Train health workers to provide both paediatric and adult HIV counseling and testing services as well as psychosocial support, especially for children<br><br>Produce IEC materials on HTC<br><br>Conduct advocacy sessions on HTC<br><br>Provide HIV counselling and testing, including couple counseling through door to door, outreaches and mobile | MOH<br>Partners |
| Increase access to and quality of PMTCT services | Provide PMTCT information, education and communication (IEC) materials in all locations offering primary health services<br><br>Support additional facilities to adopt national PMTCT guidelines and guidelines on breastfeeding<br><br>Establish new PMTCT sites and train more PMTCT service providers | |
| Strengthen linkages between PMTCT, ART, prevention, reproductive health, maternal and child health, and primary care services | Provide HTC, PMTCT and adult and paediatric ART as a comprehensive package for women and all family members in a single location | |
| Increase access to family planning and HIV prevention services for HIV-positive women of child-bearing age | Strengthen HIV testing and PMTCT service provision at all family planning service delivery points | |

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| | Refer all HIV-positive and post-pregnancy women to family planning | |
| | | |
| Provide comprehensive PMTCT, care, treatment and support to HIV positive pregnant and lactating women and their families | Scale up PMTCT services, through triple therapy combination regimen and infant and young child feeding counselling<br><br>Train health workers in all health facilities providing maternal and child health services | |
| Provide care and support to all HIV exposed infants at facility and community levels | Scale up paediatric HIV care for HIV exposed infants by linking to cotrimoxazole prophylaxis services, early infant diagnosis, HIV counseling services and referral to ART<br><br>Produce IEC materials on the benefits of HTC and on treatment literacy for HIV exposed infants | |
| Promote integration of PMTCT with HCT and ART services | Provide comprehensive clinical-based prevention services that are family-focused and involve active male participation including couples | |
| Promote male and community involvement in PMTCT | Produce IEC materials targeting men and community leaders<br><br>Engage men and community leaders in PMTCT services at various levels | |

| **Strategic Objective 3: Prevent HIV transmission through blood, blood products and medical procedures** | | |
|---|---|---|
| **Strategic Approaches** | **Broad Activities** | **Key Lead Agencies** |
| Ensure 100% of blood supply accurately screened for HIV according to national screening and quality assurance standards | Review guidelines on blood safety<br><br>Train laboratory technicians in quality control and assurance<br><br>Screen all blood, blood products and tissue products for HIV<br><br>Sensitise people on the existing policies and procedures on blood donation<br><br>Sensitise people on how to access safe donated blood<br><br>Provide adequate disposable materials as well as sterilising equipment for non disposable materials at all health care facilities | MOH<br>MBTS<br>Partners |
| Promote implementation of infection prevention measures in all health facilities | Disseminate appropriate information on the dangers associated with the use of unsterilised skin piercing materials<br><br>Regularly update guidelines on infection prevention and waste disposal management and disseminate to all health care facilities<br><br>Train traditional healers, TBAs and traditional initiation counsellors on use of sterile skin piercing materials<br><br>Provide adequate facilities for appropriate disposal of used disposable materials at all health care facilities | |

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| Ensure access to post-exposure prophylaxis for people who have been exposed to contaminated blood products and medical procedures | Provide PEP to all victims of rape and defilement or coerced sex and those accidentally exposed to HIV<br><br>Develop and disseminate IEC materials on PEP to all health facilities and the general public | |

| **CROSS-CUTTING OBJECTVES, APPROACHES AND ACTIVITIES**<br><br>**Cross-cutting Strategic Objective 1: Increase access to, quality of, and linkages between services and interventions** | | |
|---|---|---|
| **Strategic Approaches** | **Broad Activities** | **Key Lead Agencies** |
| Improve access to HIV preventive services within existing services at point-of-care settings including ART, PMTCT, STI, reproductive health, MCH, blood donation facilities | Identify best practices for integrating HIV prevention with other services and scale-up nationally<br><br>Scale-up support groups for prevention and positive living<br><br>Strengthen District AIDS Coordinating Committees (DACC), Community AIDS Coordinating Committees (CACC) and Village AIDS Coordinating Committees (VACC) to carry out prevention activities<br><br>Develop male circumcision policy, intervention and communication guidelines based on international and local evidence<br><br>Develop referral guides to link people to different services in the health centers and communities<br><br>Conduct community level education sessions on the importance of timely initiation to ART to those found HIV positive | MOH<br>MOLGRD<br>MRH<br>MOICE<br>MBCA<br>NGOs |
| Ensure community involvement and ownership | Mobilise communities to actively participate in HIV prevention activities<br><br>Link community-based groups with health services to support both facility and community-based prevention activities | |

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| Improve access to HIV prevention services among underserved populations and communities | Develop gender sensitive tailored interventions for populations who are vulnerable to HIV infection because they cannot access information and services through traditional means (e.g. people with disabilities or mentally challenged, orphans, street children, etc | |
| Improve access to HIV prevention services among wealthier and educated people | Develop and implement gender sensitive and tailored interventions for populations who are wealthy and more educated at a time and in settings where they most frequently patronise e.g. clubs, bars, hotels, casinos and other places of entertainment and work | |
| Improve access to HIV prevention services and products to vulnerable populations | Develop tailored interventions for populations who are vulnerable to HIV infection because of their behaviours or environments (sex workers, MSM, prisoners, etc)<br><br>Engage the media in promoting prevention interventions | |
| Strengthen capacity of health workers to develop, implement and monitor collaborative TB and HIV prevention | Provide TB, HIV and AIDS prevention, care and support services as an integral part of a comprehensive package of care for TB/HIV infected persons<br><br>Provide a framework for planning, organizing, implementing, monitoring and evaluating delivery of TB, HIV and AIDS intervention<br><br>Provide HTC among TB patients | |

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| | Provide ART to eligible TB/HIV patients<br><br>Provide CPT to TB/HIV patients<br><br>Provide routine TB screening by all HTC counsellors<br><br>Conduct HIV surveillance among TB patients | |
| **Cross-cutting objective 2: Address the cultural, social and economic environment to support reduction of HIV risk and vulnerability** | | |
| **Strategic Approaches** | **Broad Activities** | **Key Lead Agencies** |
| Reduce risk of HIV transmission through harmful cultural practices | Build capacity of traditional and religious leaders and other local opinion leaders so that they speak against harmful cultural practices, beliefs and norms that perpetuate sexual HIV transmission while reinforcing cultural practices that are positive<br><br>Provide material and financial support to community structures for community mobilisation against harmful cultural practices and promote positive ones<br><br>Promote role models in the communities to increase visibility of AIDS | MOWCD<br>MLGRD<br>MANET+<br>MHRC<br>Civil Society Organizations |
| Reduce HIV stigma and discrimination | Advocate for prominent leaders and PLHIV to act as role models in promoting HIV testing and counselling, partner disclosure, and HIV risk reduction behaviours<br><br>Train PLHIV in communication and negotiation skills on positive living | |

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| | Produce communication materials for PLHIV addressing self-esteem, self-efficacy and perceived risk related to positive living<br><br>Conduct community mobilisation on the negative effects of stigma and discrimination both PLHIV and community level<br><br>Promote involvement of PLHIV in policy development, public discussions, HIV and AIDS campaigns<br><br>Adopt best practices in reducing and monitoring stigma and discrimination<br><br>Mobilise leadership to tackle all forms of stigma and discrimination | |
| Increase disclosure of sero-status to sexual partners | Expand and strengthening the reach of support groups for PLHIV<br><br>Advocate for prominent leaders to disclose their HIV status | |
| Increase community-level access to reproductive health services, family planning, HTC and PMTCT | Expand communication about HIV and AIDS among politicians, business and community leaders | |
| Reduce gender-based violence and sexual harassment | Conduct community mobilisation and empowerment sessions on gender<br><br>Conduct education sessions on negotiation skills, relationship norms, perceived trust and self efficacy targeting especially women and girls<br><br>Promote social norms that reduce demand for transactional sex | |

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| | Promote role models on gender among men and boys | |
| Enhance opportunities for women and girls | Promote alternative livelihood options for sex workers and vulnerable women and girls<br><br>Engage the media in accurately addressing cultural, social and economic issues related to HIV including stigma and discrimination<br><br>Produce IEC materials addressing issues of culture, gender-based violence, stigma and discrimination | |
| **Cross-cutting Strategic Objective 3:** | **Promote legal and human rights issues that reduce HIV risk and vulnerability** | |
| **Strategic Approach** | **Broad Activities** | **Key Lead Agencies** |
| Advocate for the enactment of an HIV and AIDS law following international best practices | Lobby Parliamentarians to enact HIV and AIDS and sexual health legislation that conforms to international best practices | DNHA<br>MHRC<br>Malawi Law Commission<br><br>Malawi Police Force<br><br>Civil Society Organizations |
| Promote HIV and AIDS, and sexual health-related legislation | Lobby Local Authorities to enforce HIV and AIDS and sexual health legislation that conforms to international best practices<br><br>Promote awareness among community members regarding their rights and responsibilities pertaining to HIV and AIDS and sexual health<br><br>Lobby enforcement of laws regarding sexual harassment, raising the age of sexual consent, and inheritance and land rights for women<br><br>Build capacity of the media so that it reports issues of HIV and | |

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| | AIDS, and sexual health legislation in responsible and accurate manner<br><br>Engage human rights organizations, government and civil society in HIV and AIDS and sexual health issues | |
| **Cross-cutting Strategic Objective 4: Increase the capacity and strengthen systems to support, manage, expand, and sustain the national prevention response** | | |
| **Strategic Approaches** | **Broad Activities** | **Key Lead Agencies** |
| Office of the President and Cabinet provides oversight for the implementation of the National HIV Prevention Strategy including government policies and legislation that support the successful implementation of prevention activities | Build capacity of DNHA to provide overall high level advocacy and oversight in the implementation of the National HIV Prevention Strategy including government policies and legislation that support successful implementation of HIV prevention activities | DNHA<br>NAC<br>MOF<br>MOLGRD<br>Local Assemblies |
| High-level ownership and leadership within NAC mandated to coordinate and lead implementation of the National Prevention Strategy | Build capacity of NAC to coordinate and lead the implementation of the HIV prevention strategy | |
| High-level ownership and leadership within various Government ministries mandated to manage and oversee implementation of the overall National Prevention Strategy | Disseminate and sensitize stakeholders on the National HIV Prevention Strategy | |
| Provide greater opportunity for local participation, action, management and accountability of prevention interventions. | Build capacity of local structures such as DACCs, CACCs, VACCs to plan and implement HIV prevention activities | |
| Community-level ownership with strong involvement of faith-based leaders, PLHIV support groups, women's groups , and other civil society organizations | Provide IEC and localized data relevant to the communities<br><br>Mobilising communities to actively take part in HIV prevention | |
| Strong Local Authority involvement in | Disburse funds timely for the | |

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| developing prevention action plans and advocating for resources | implementation of HIV prevention activities | |
| Prevention activities incorporated into the District Implementation Strategy | Develop local assembly specific work plans on HIV prevention<br><br>Provide technical assistance on HIV prevention to local assemblies and communities | |
| Specified departments within the Ministry of Health mandated to implement and oversee each of the three Strategic Objectives of the National Prevention Strategy | Review policies, frameworks and guidelines relating to HIV prevention<br><br>Mainstream HIV prevention activities in all government ministries, departments and agencies | |
| High-level ownership and leadership within the Government of Malawi mandated to manage and oversee implementing the overall National Prevention Strategy | Disseminate and sensitize stakeholders on the HIV prevention strategy | |
| High-level ownership and leadership within the National AIDS Commission mandated to coordinate and champion implementing the overall National Prevention Strategy | Build capacity of NAC to coordinate and lead the implementation of the HIV prevention strategy | |
| Office of the President and Cabinet provides oversight for the implementation of the National HIV Prevention Strategy including government policies and legislation that support the successful implementation of prevention activities | Build capacity of DNHA to provide high level advocacy and overall sight in the implementation of HIV prevention including HIV prevention government policies and legislation | |
| Ensure adequate financial resources are available to build infrastructure and implement HIV preventions activities at national, Local Authority and community levels | Cost the national HIV prevention response<br><br>Mobilize resource from Government and development partners | |

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| Ensure there are dedicated, trained staff at all levels to lead and implement the HIV prevention response and activities | Build capacity in HIV preventions at all levels | |
| **Cross-cutting Strategic Objective 5: Monitor and evaluate the national prevention response** | | |
| **Strategic Approaches** | **Broad Activities** | **Key Lead Agencies** |
| Develop district-level monitoring and evaluation skills | Build capacity in M&E at all levels<br><br>Build capacity for prevention-related operational research, data analysis and use | NAC<br>MOEPD<br>MOLGRD<br><br>Research Organizations |
| Provide routine feedback of data to implementing and funding organizations | Strengthen Local Authority MISs<br><br>Develop community level HIV prevention data base<br><br>Conduct national routine surveys on HIV and AIDS<br><br>Strengthen reporting system at all levels | |
| Make research, surveillance and monitoring and evaluation data available at the district and community-levels in a manner that is understandable and that allows them to build the findings into their prevention activities | Disseminate relevant data to communities to guide planning and implementation of HIV prevention activities | |
| Strengthen the capacity of community organizations to monitor their activities | Build capacity of community organizations in research, M&E | |
| Localize data collection for community-specific evidence | Develop district and community -level monitoring and evaluation plans | |
| Strengthen national surveillance and monitoring and evaluation systems to provide evidence for prevention policies, programmes and targets | Incorporate research, surveillance and monitoring and evaluation data into the routine review of the national prevention response | |
| Adhere to a single prevention monitoring and evaluation plan | Enforce adherence to single M and E plan | |

**ANNEX III: References**


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